FAQs: Implementing the RCA Definitions Bedded Framework

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LHINs and Health Service Providers (HSPs) across the province are currently involved in a process to implement definitions frameworks developed by the Rehabilitative Care Alliance (RCA) by March 2017. The following Q&A addresses some of the most common questions about implementing the *Definitions Framework for Bedded Levels of Rehabilitative Care*.

Q. What are we trying to achieve with the new definitions frameworks?

A. The two definitions frameworks (for bedded levels and community-based levels of rehabilitative care) were developed to establish consistent provincial standards for levels of rehabilitative care: how programs are categorized (level of care), the components of care provided and the human resources needed to deliver that care. Establishing consistent definitions provides clarity for patients, families and referring professionals. It also supports LHINs and health services providers in planning services.

Q. How is the Definitions Framework for Bedded Levels of Rehabilitative Care organized?

A. The framework describes four levels of rehabilitative care. Rehabilitative care is the primary focus of two levels: **Rehabilitation** and **Activation/Restoration**. Rehabilitative care is still prominent in the other two levels—**Short Term Complex Medical Management** and **Long Term Complex Medical Management**—but is provided in the context of more complex medical needs, so rehab may be less of a focus. The detailed framework is available at www.rehabcarealliance.ca

Q. What are the expectations for LHIN implementation of the definitions frameworks?

A. It is expected that all 14 LHINs will work toward implementing the frameworks by March 2017. This includes adopting the new terminology and eligibility criteria and categorizing existing rehabilitative care resources according to the levels of care laid out in the frameworks. LHINs and HSPs are also asked to consider how to communicate with referring professionals and the public to help them understand the level of care they can expect in each program. We recognize that full implementation may not be possible in all LHINs by March 2017. LHINs that can't meet that timeline are to identify any challenges or barriers they are facing and develop an implementation plan to address them, with support as required from the RCA.

Q. How well are bedded programs across the province currently aligned with the framework?

A. An analysis of the mapping surveys that the HSPs and LHINs completed and submitted to the RCA at the end of 2015 indicates that 66% of bedded programs are fully aligned and 27% are partially aligned; only 6% of programs indicated no alignment with the definitions for a variety of reasons.

Q. What is required of programs that are not fully aligned?

A. Programs that can't fully align by March 2017 will need to develop a plan to identify the barriers they are facing and how they plan to address them. To do that, it will be important to dig deeper into the survey findings to understand why there isn't alignment. Some questions that you may need to consider include the following:

- **Providing care in the wrong bed:** Are rehab beds being used for activation/restoration?
- **Admission criteria:** Is the program's admission criteria too restrictive compared to the eligibility criteria set out in the framework? Are patients who would benefit from rehabilitative care not getting access?

- **Staffing resources:** Are changes needed to the medical/nursing/therapy resources in the program to align with those laid out in the framework? Does the program have the right number of staff to provide the intensity of therapy required? Does the program have the right staff mix to provide the therapy?
- **Categorizing programs:** Is the name of the program misleading given the level of rehabilitative care it provides? e.g., The "Activation Program" is actually providing a rehabilitation level of care.

Once the reasons for non-alignment are clarified, LHINs and health service providers will need to identify strategies to address this. The RCA is providing opportunities for the LHINs to discuss and share their strategies with each other to help this process.

Q. Are we expected to reclassify beds and change our MIS reporting in order to align with the definitions framework?

A. No. In fact, the initial changes needed to meet the March 2017 deliverables can be made without reclassifying beds. It may be helpful to think of the framework as an overlay to the existing system. For example, with some adjustments, a program may meet the standard of the Rehabilitation level of care as described in the framework. However, if that program is currently delivered in a designated Complex Continuing Care (CCC) bed, it may be necessary to continue to deliver it there given current funding and reporting requirements. At this point, the change would be in how HSPs/LHINs categorize that care and how they name and describe it.

Categorizing programs according to the levels of care in the framework will lead to more consistency and clarity across the system about what rehabilitative resources exist and where. It will also provide referrers and patients with clarity about what level of rehabilitative care is being provided. This is a significant system change initiative and there will be ambiguities until longer term issues such as funding and reporting are addressed. However, this is an important step in reaching our ultimate goal: levels of rehabilitative care that are clear and consistent, no matter where someone is in the province.

Q. Some LHINs are talking about reclassifying beds. Why?

A. Some LHINs may choose to reclassify beds in order to address local needs and pressures and to improve resource utilization and patient flow. **Reclassifying beds is NOT required to meet the March 2017 deliverables.** If LHINs *choose* to reclassify beds, no new funding is available.

Q. If we are not expected to reclassify beds, why is the RCA asking the Health Services Funding Reform (HSFR) Hospital Advisory Committee to look at the NRS Grouper?

A. The bedded framework was developed through the lens of "what is best for the patient" and expanded the admission criteria for the Rehabilitation Level of Care to include Low Tolerance Long Duration (LTLD)/slow stream rehab, which is currently delivered in CCC beds. We recognize this is likely to have implications for reporting –and funding—in the long term. As a result, we are asking the HSFR Committee to consider the possibility and implications of developing new groups in the NRS grouper (or modifying the weights of existing groups) to reflect the needs and resource requirements of LTLD patients included in the Rehabilitation level of care. This is a follow-up to a request submitted to the Rehab/CCC HSFR Working Group in September 2014. The RCA has also met with Ministry officials to discuss how the framework's levels of care relate to the Ministry's levels of care initiative.

Q. What are the next steps in the implementation process?

A. LHINs have been asked to engage with HSPs over the next few months to discuss the results of the mapping survey and to get further clarity on the programs that reported no or partial alignment with the definitions frameworks. They will also talk about strategies to achieve alignment by March 2017 and either take those steps or develop an implementation plan to do so. The other task is to consider how to communicate with referring professionals and the public about these changes.