Rehabilitative Care Alliance

RCA 2017-19 Deliverables

Definitions

- Identify a standardized naming convention for rehabilitative care.
- Address, where possible, challenges in implementing the definitions frameworks for rehabilitative care as identified in 2015 mapping results (e.g., adhering to the standardized eligibility criteria, health human resources, intensity of rehabilitation, etc.) and develop recommendations for next steps.
- Identify and implement required changes to the Provincial Referral Standards (PRS) to support alignment with the *Definitions Framework for Bedded Levels of Rehabilitative Care* and disseminate the revised PRS through LHIN Leads across the province.
- Develop and implement a centralized rehabilitative care portal through *thehealthline.ca* to provide rehabilitative care information for the public.
- Develop standardized information for the centralized provincial rehabilitative care portal, including descriptions of the RCA, rehabilitative care and levels of care and a listing of rehabilitative care programs in each LHIN.
- Work with Access to Care (ATC) to align provincial- and LHIN-level reporting of alternate level of care data with the levels of care in the *Definitions Framework for Bedded Levels of Rehabilitative Care*.
- Develop and implement a framework to evaluate uptake of the definitions frameworks for levels of rehabilitative care across the province.
- Work with the MOHLTC's HSFR Inpatient Rehabilitation Care Technical Task Group to evaluate the current inpatient rehab grouper and make recommendations for refinements to the re-designated case mix methodology and weights to be used for funding.

Capacity Planning

- Develop a simplified approach to help LHINs apply the *Capacity Planning Framework*. The approach will define planning scope, data analysis questions and key considerations.
- Provide LHINs with standardized data, methodology and definitions (as needed) to implement this approach.

- Work with a sub group of LHINs to create a process map and help other LHINs apply the simplified approach to their regional capacity planning.

Assess & Restore/Frail Seniors

- Complete geriatric-focused *Quality Standard Feasibility Analyses* in collaboration with the RGPs of Ontario and submit to Health Quality Ontario with recommendations for potential Quality Standards topics.
- Hold annual A&R knowledge exchange events in spring 2017 and 2018.
- Produce analysis and summary reports of the provincial impact of 2016/17 and 2017/18 Assess & Restore funding.
- Identify shared process and outcome indicators to support standardized evaluation and reporting across A&R-funded initiatives.
- Work with the Frail Senior Advisory Group, the RGPs of Ontario, the Inter-LHIN Falls Prevention Collaborative and other provincial stakeholders to develop and support implementation of secondary falls prevention care pathways for frail older adults.
- Leverage key learnings from provincial Assess & Restore initiatives to explore interest on the part of provincial stakeholders with expertise in geriatrics to develop an education module for primary care providers.

System Evaluation

- Develop the next iteration of the provincial rehabilitative care system scorecard and a process for ongoing annual reporting via a performance report.
- Identify opportunities for the LHINs to help them improve quality with respect to their regional performance against provincial benchmarks.

Hip Fracture and TJR QBP Best Practice Frameworks

- Develop and implement a communication strategy to support dissemination of the RCA rehabilitative care best practices frameworks for patients with hip fractures and TJR.
- Develop tools and resources to support system and/or organizational implementation of the RCA rehabilitative care best practices frameworks for patients with hip fractures and TJR.
- Develop self-assessment tools for organizations across the care continuum to evaluate practices relative to rehabilitative care best practices for patients with hip fractures and TJR.
- Complete an audit process of alignment with TJR/hip fracture rehab best practices utilizing self-assessment tools.

- Analyze responses across organizations participating in voluntary self-assessment of alignment with best practices.
- Provide sector-specific, LHIN-level gap analyses to inform opportunities for quality improvement in the implementation of rehabilitative care best practices for patients with hip fractures and TJR.

Outpatient/Ambulatory Minimum Data Set

- Produce a detailed report of the findings from the provincial proof of concept in the collection and reporting of outpatient/ambulatory rehabilitative care data.
- Develop a strategy for broader roll out of the outpatient/ambulatory minimum data set that reflects the recommendations from the provincial proof of concept and includes refined reporting parameters.
- Develop a strategy to enable all ambulatory/outpatient rehab programs to report utilization data to CIHI through NACRS Clinic Lite.
- Work with InterRAI researchers and provincial stakeholders to review the results of the provincial proof of concept , make modifications to streamline the Community Rehab Assessment tool and pilot the next version with sites on a voluntary basis.
- Work with the developers of the WatLX™ tool to explore integration of this patient experience tool across outpatient/ambulatory rehab programs as feasible.

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