Terms of Reference: Rehabilitative Care Alliance Frail Seniors Advisory Group

Background

The Rehabilitative Care Alliance (RCA) was created by Ontario's Local Heath Integration Networks (LHINs) in 2013 to bring about the system transformation that no single LHIN could achieve on its own. Through significant engagement of provincial stakeholders including health service providers, subject matter experts, patient and family representatives and others, the RCA has set in motion significant change across the province.

By standardizing many aspects of planning, evaluation and clinical care across the province, the RCA and its partners are ensuring that health care resources are used more effectively and that Ontarians receive high quality rehabilitative care no matter where they live.

The RCA's next work plan from 2019 – 2022 will allow the RCA to continue its successful efforts to strengthen and standardize rehabilitative care across the province. The benefits of rehabilitative care — better health outcomes, shortened hospital stays and reduced hospitalizations among older adults — are particularly relevant today, as stakeholders seek to improve flow, divert patients from emergency departments, maintain and enhance function in the community, and reduce hallway medicine.

Over the next three years, the RCA will build on the impact of its current work with a focus on the following:

- **Frail Seniors:** Continue to support efforts to reduce preventable emergency department visits and maintain and improve the functional status of community-based frail seniors who fall.
- **Capacity Planning:** Support regions in applying a standardized, needs-based approach to capacity planning for rehabilitative care so that resources are optimally allocated to address patient needs.
- **Bundled Funding:** Continue to work with the MOHLTC and rehabilitative care providers to support expansion of bundled funding projects.
- **Hip Fracture/Total Joint Replacement (TJR) QBP Best Practices:** Increase alignment across province with hip fracture and TJR rehabilitative care best practices to support implementation and spread of quality initiatives and the MOHLTC hip & knee bundled care initiative.
- **Community-Based Rehab Initiative:** Improve understanding of how community-based rehabilitative care models could be used to support enhanced patient outcomes, better flow and improved patient transitions.
- **System Evaluation:** Continue to standardize evaluation of rehabilitative care services at the regional and provincial level to support evidence-based practice and system-wide improvement.
- **Definitions:** Continue to guide and support the spread and integration of the definitions frameworks to drive standardization across the province.
- **Assess & Restore:** Analyze provincial outcomes of Assess & Restore funding to illustrate impact on clinical outcomes and system efficiencies.

From the beginning, the RCA's strength has been the tremendous engagement and support of stakeholders from across the province.

Objectives Mandate IV (April 1, 2019 – March 31, 2022)

Building on the previous work of the RCA's Frail Seniors Initiative, the current work plan will continue to support emerging opportunities to implement best practice care for community-dwelling older adults. The Frail Seniors Advisory Group will provide oversight to the work of the Geriatric Rehab Task Group and the Post-Fall Pilot Task Group on the following objectives:

To define the key components of geriatric rehabilitative care across the continuum, leveraging existing resources and evidence-informed geriatric best practices. This work will be completed in collaboration with provincial stakeholders (i.e., the RGPO / Provincial Geriatric Leadership Office).

The development of a sector-specific framework outlining best practices and models of care will:

- Improve clarity on key components of geriatric rehabilitative care across the continuum that can be used for program planning
- Support implementation of senior friendly care and improved outcomes for seniors receiving rehabilitative care services

To pilot the pathways to rehabilitative care for frail older adults in the community who present to primary care or the ED post-fall. These pathways were developed and validated by patients, caregivers and stakeholders across the province during the last work plan. A pilot of these pathways will:

- Launch a system-level initiative that focuses on quality improvement opportunities on maintaining and improving the functional status of community-based frail seniors who fall.
- Support action on RCA System Evaluation Scorecard Indicator: Repeat ED visits for falls for community-dwelling seniors

To analyze provincial outcomes and the impact of Assess & Restore funding, thereby highlighting the provincial impact Assess & Restore initiatives are having on how frail seniors are cared for, their clinical outcomes and their impact on system efficiencies.

The work of the Frail Seniors Advisory Group will be guided by evidence and data, informed by stakeholder engagement, and aligned with provincial initiatives with shared objectives and content.

Deliverables

The following are anticipated deliverables for this initiative. These may be subject to change depending on the discussions of the task group and the potential influence of other provincial initiatives. Any significant change in deliverables will be discussed with the task group and Steering Committee.

- Define the key components of geriatric rehabilitative care across the continuum, leveraging existing resources and evidence-informed geriatric best practices through the following activities:

  - Review existing literature, frameworks and best practice guidelines, engage with provincial stakeholders including clinical subject matter experts and RGPO/PGLO to identify key best practices and models of care related to geriatric rehabilitation
  - Based on this literature review, update the 2015 RCA Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of Geriatric Syndromes
  - Develop criteria to define the scope of best practice inclusion into RCA Geriatric Rehabilitative Care Best Practice Framework
  - Develop sector-specific best practice framework based on evidence and clinical subject matter experts and outline best practices and models of care in each level of care as per the RCA Definitions Framework

- Pilot the pathways to rehabilitative care for frail older adults in the community who present to primary care or the ED post-fall in 3-4 regions across Ontario.
    - Determine the operational requirements to embed the pathways into ED/primary care clinical practice
    - Ensure that all components of the pathways are actionable
    - Understand the ease of use for clinicians
    - Establish the effectiveness of the pathways to guide healthcare providers in navigating older adults who have fallen to the appropriate rehabilitative care program/service
  - Finalize the pathways based on evaluation and recommendations from this pilot, including a heightened awareness and use of the Direct Access Priority Process (DAPP)
  - Develop and release a toolkit and broader communication and implementation strategy based on recommendations from this pilot
- Pending Ministry reporting requirements for Assess & Restore Initiatives, deliver annual analysis and summary report of the provincial impact of Assess & Restore Initiatives.

Roles and Responsibilities

- The advisory group will be supported by the Rehabilitative Care Alliance Secretariat.
- The Rehabilitative Care Alliance Steering Committee will act to support the Frail Seniors Advisory Group and remove/eliminate barriers, as able, to facilitate the work of the group.
- If Advisory Group members share documents pertaining to the work of the group with stakeholders outside of the committee, members will provide contextual information to the recipient to explain the purpose of the work as well as any other information that is required to provide clarity around the work and the information contained within the document(s).
- Members are expected to review distributed materials in advance of the meeting.
- If members are unable to attend a meeting, members may identify an alternate representative who will attend meetings on their behalf and provide the alternate attendee with information required to support

their participation. The alternate will communicate the proceedings, decisions and any actions required to the member.

Accountability

- The Frail Seniors Advisory Group is accountable to the Rehabilitative Care Alliance Steering Committee for fulfilling its mandate and producing the deliverables (as described above) by agreed upon timelines.

Membership

Given that the focus of this initiative is on developing and implementing best practice care pathways and frameworks for older adults, this Advisory Group will be composed of individuals who play a role in caring for older adults, across the continuum, or who are involved in implementing or influencing best practice care for older adults.

Advisory Group

Chair: Dr. Jo-Anne Clarke, North East Specialized Geriatric Centre

Term

The term of this Advisory Group is through March 2022.

Decision Making

The Advisory Group will strive for consensus and will use voting when there is no clear agreement.

Meetings

The Advisory Group will meet quarterly or as required to achieve the deliverables, throughout the course of the mandate. Additional meetings may be required to complete work according to project timelines. Webinars, teleconference and other formats will be used to facilitate meeting attendance.

Minutes

Minutes shall be recorded for all meetings and circulated to committee members for dissemination/distribution to relevant stakeholders within each organization.

Communication

The RCA secretariat will distribute meeting materials, via email, in advance of each meeting. Any documents that solicit feedback from committee members will be distributed via email. All documents approved for broad distribution will be posted on the Rehabilitative Care Alliance website.