Rehabilitative Care Alliance

Rehabilitative Care Alliance

Provincial Webinar

October 3, 2017

Agenda

Time	Item	Presenter
12:00 – 12:05	**Welcome**	Charissa Levy Executive Director, Rehab Care Alliance
12:05 – 12:40	**Overview of RCA Mandate III Initiatives**	Sue Balogh, Rebecca Ho, and Kelly McIntyre-Muddle Project Managers Rehab Care Alliance
12:40 – 12:55	**Questions and Discussion**	Everyone
12:55 – 1:00	**Key Messages and Wrap-up**	Charissa Levy
Next Webinar: January 10, 2018		

Ontario
Local Health Integration Network

Rehabilitative Care Alliance

Rehabilitative Care Supports Health System Objectives

- Rehabilitation – provided along a continuum of care ranging from hospital to rehabilitation in the community, can **improve health outcomes**, **reduce costs** by shortening hospital stays, reduce disability, and **improve quality of life**.
- **Rehabilitation that begins early produces better functional outcomes** for almost all health conditions associated with disability.

World Health Organization. World Report on Disability, 2011
Chapter 4, Rehabilitation

RCA Vision

Patient and system outcomes are optimized through the integration of rehabilitative care at all levels of health services policy, planning and delivery.

Demand for Rehabilitative Care

- Demand for rehabilitation services in Ontario is expected to increase significantly, especially after 2021 when the first baby boomers turn 75.
- In 2014/15 approximately half of inpatient rehabilitation admissions were for people over 75 years of age.

Auditor General of Ontario
Follow-Up Value-for-Money Report, 2015

RCA Mandate

- Work with LHINs, provincial stakeholders, client and caregiver representatives to strengthen and standardize rehabilitative care in Ontario, through:
  - Better planning
  - Improved performance management and evaluation
  - Increased integration of best practices across the care continuum

Mandate II Reports

- *Transforming Rehabilitative Care in Ontario, 2015-2017 Report*
  - Work and accomplishments of the RCA's second mandate
  - Links to tools and resources
  - Recommendations to guide the next mandate

Full and Summary Report available on RCA website

Ontario
Local Health Integration Network

Overview of Key Activities

LHIN CEOs

MOHLTC

RCA Steering Committee

- Definitions Advisory Group
  - HSP Definitions Implemen-tation Group
- Capacity Planning Advisory Group
  - Capacity Planning Task Group
- Assess & Restore/Frail Seniors Advisory Group
  - A&R/FS Task Group
  - LHIN Leads Task Group
- Outpatient/ Ambulatory Advisory Group
  - Functional Outcome Measure Task Group
  - NACRS Clinic Lite Task Group
  - Patient Experience Measure Task Group
- QBP Best Practices Advisory Group
  - TJR Task Group
  - Hip Fracture Task Group
- System Evaluation Advisory Group
  - System Evaluation Task Group
- Patient/ Caregiver Advisory Group

RCA Information Exchange (Quarterly update across all initiatives)

Hip Fracture & Total Joint Replacement QBP Best Practices Initiative

Initiative Goal

Hip Fracture and TJR QBP Best Practice Frameworks

Establish and support implementation of standardized rehabilitative care best practices for hip fracture and primary hip & knee replacement.

Achievements to Date

- Hip fracture and TJR frameworks developed by provincial task groups with feedback from external stakeholders
  - Frameworks describe the processes, resources and structures that support best practices, optimal patient outcomes and patient flow
- RCA's referral decision tree adapted for use with frameworks
- Process indicators identified to evaluate uptake of the best practices

Best Practice Framework
Primary Hip and Knee Replacement

Rehabilitative Care Best Practices for Patients with Primary Hip and Knee Replacements Best Practice Framework				
Processes of Care	*Pre-Operative Care*	*Bedded Levels of Rehabilitative Care*	*Community-Based Ambulatory Rehabilitative Care*	*In-home Rehabilitative Care*
Screening				
Assessment				
Treatment/Interventions • Individual (1:1) and Individualized Group-based Interventions • *Functional Training (e.g. ADLs & Mobility)*				
Patient & Family Education				
Pain				
Transition Care Planning				
Clinical Outcome Measures				

Best Practice Framework
Hip Fracture

Rehabilitative Care Best Practices for Patients with Hip Fracture Best Practice Framework				
Processes of Care	*Bedded Levels of Rehabilitative Care*	*Community-Based Ambulatory Rehabilitative Care*	*In-home Rehabilitative Care*	*Long Term Care*
Orientation: Family and Patient				
Assessments/Monitoring				
Delirium, Dementia and Depression				
Treatment Interventions				
Pain				
Pressure Ulcer Prevention				
Fluid/Nutrition & Elimination				
Osteoporosis Management				
Fall Prevention/Fall Risk Mitigation				
Mobility and Function o *ADLs (Bathing and Grooming, Dressing, Toileting, Eating)* o *Mobility*				
Client and Family Perspective/Education				
Discharge Planning				
Tests				
Medication				

Key Activities

Hip Fracture and TJR QBP Best Practice Frameworks

1. Develop tools/resources to support implementation of the RCA rehabilitative care best practice frameworks for patients with hip fracture and TJR.
2. Develop self-assessment tools for organizations, across the care continuum, to evaluate practices relative to frameworks.
3. Undertake a voluntary self-assessment of cross-sectoral practices, relative to the best practice frameworks.

Rehabilitative Care Alliance

Dissemination & Implementation

Communication Toolkit

- **Information & Resources to support dissemination & implementation:**
  - Purpose/Intent of the Best Practice Frameworks
  - Why implement best practice rehabilitative care?
  - Quick Reference Guides to the Hip Fracture & TJR Frameworks
  - Referral Decision Trees
  - Self-assessment tool(s) to support mapping of best practice alignment
  - Indicators to support performance monitoring/QI evaluation

Ontario
Local Health Integration Network

Definitions Initiative

Initiative Goal

Definitions

Develop a shared understanding among patients, families and referring professionals on the levels of rehabilitative care including a definition of restorative potential, eligibility criteria, goals of care, patient/client characteristics, medical/health care resources, and intensity of therapy for each level.

Achievements to Date

- Development of resources
  - *Definitions Framework for Bedded Levels of Rehabilitative Care*
  - *Definitions Framework for Community-Based Levels of Rehabilitative Care*
  - *Referral Decision Tree*
  - *Patient/Caregiver Information Letter for Bedded Levels of Rehabilitative Care*
  - *Referral Options Resources for Bedded and Community-Based Levels of Rehabilitative Care*

- LHIN implementation of the Definitions Frameworks

Key Activities

Definitions

1

Work to address common barriers to full implementation and sustainability of the definitions frameworks:

- Realign Provincial Referral Standards.
- Work with Access to Care to align provincial & LHIN-level reporting of ALC data with the bedded definitions framework.
- 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.

Rehabilitative Care Alliance

Key Activities

Definitions

2 Identify/develop standardized information and naming convention for rehabilitative care and address challenges to implementing the definitions frameworks.

3 Develop and implement a centralized rehabilitative care portal for the public.

4 Develop and implement a framework to evaluate uptake of the definitions frameworks for levels of rehabilitative care across the province.

Rehabilitative Care Alliance

Capacity Planning

Initiative Goal

Capacity Planning

Support LHINs in applying a standardized approach to capacity planning for rehabilitative care.

Ontario
Local Health Integration Network

Rehabilitative Care Alliance

Key Activities

Capacity Planning

1. Develop a simplified approach to help LHINs apply the *Capacity Planning Framework*.
2. Provide LHINs with the necessary standardized data, methodology and definitions to implement.
3. Work with a sub-group of LHINs to create a process map and help others apply it to their regional capacity planning.

Key Activities

Define Scope

- Review evidence based frameworks
- Set key parameters, inputs, target populations
- Consider contextual factors

Future State Analysis

- Apply clinical guidelines
- Consult clinical & system design experts
- Co-design with patients and families
- Develop targets for inputs, as appropriate

Gap analysis

Develop a Strategy

- Develop approaches to meet future need

Communication, Engagement, and Knowledge Sharing

Share the model, the approach, and key learnings for broader application across all LHINs

Develop a Process Map

Rehabilitative Care Alliance

System Evaluation

Initiative Goal

System Evaluation

Standardize evaluation of rehabilitative care services at the regional and provincial level to support evidence-based practice and system-wide improvement.

Rehabilitative Care Alliance

Key Activities

System Evaluation

1. Develop the next iteration of the provincial rehabilitative care system scorecard and a process for ongoing annual reporting.
2. Identify quality improvement opportunities to help LHINs improve their regional performance against provincial benchmarks.

Ontario
Local Health Integration Network

Achievements to Date

Mandate I

- **Evaluation Framework** 39 Indicators
  - **Defined Indicators without an Existing Benchmark**
  - **Defined Indicators with an Existing Benchmark**
  - **Undefined Indicators**

Mandate II

3 Indicators with Benchmarks +

Ontario
Local Health Integration Network

Priority Benchmarks and Indicators

Indicator	Recommended Benchmark
Wait time for inpatient rehabilitative care: time from most recent discharge destination determined from acute care to discharge date	3 days
Wait time for in-home rehabilitative care services: time from service authorization to date of first visit by regulated health professional	5 days
Repeat ED visits for falls in the past 12 months at the beginning of the rolling 12-month period per 100,000 people aged 65 years and older	4,551 repeat visits per 100,000 people aged 65 years and older

Rehabilitative Care Alliance

Ontario
Local Health Integration Network

Outpatient/Ambulatory Reporting

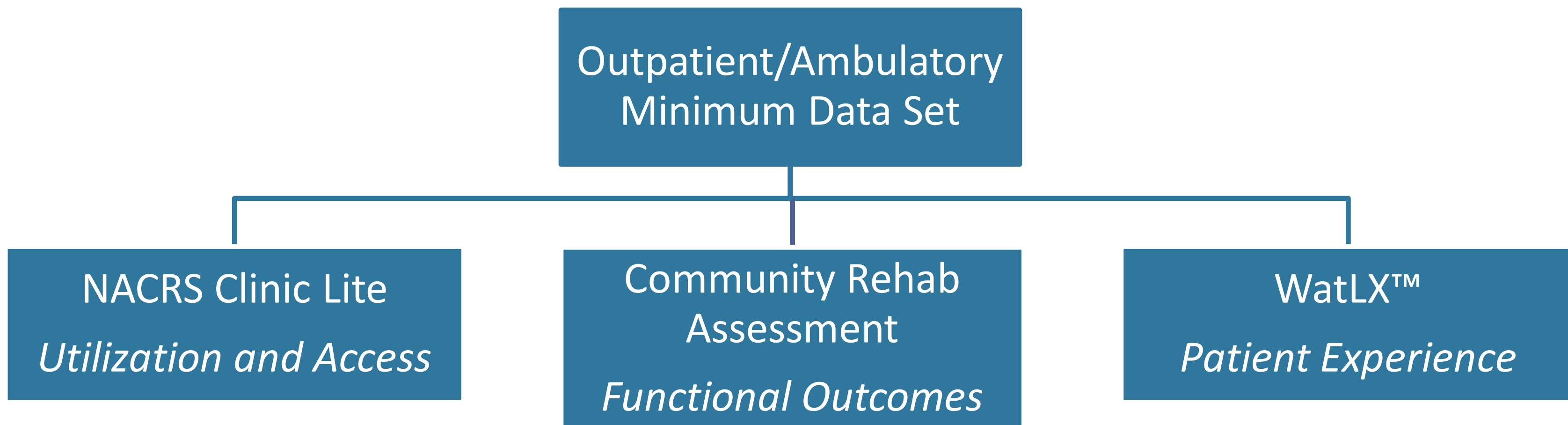
Initiative Goal

Outpatient / Ambulatory

Address a data gap in this part of continuum to help inform outpatient rehab contribution to bundled care and HSFR; inform LHINs how to optimize use of resources to improve and maintain functional status of people in the community.

Achievements to Date

Provincial Proof of Concept of the Outpatient/Ambulatory Minimum Data Set



- 5560 records submitted
- 567 patients
- 9 sites; 8 hospital and 1 CPC

- 647 completed assessments: 413 admission; 234 discharge
- 130 patients participated
- 10 sites; 8 hospital based and 2 CPCs

- 1090 surveys submitted
- 13 hospital clinics
- 19 sites overall

Key Activities

Outpatient/ Ambulatory

1. Report the findings from the provincial proof of concept including ICES analysis of resource utilization in relation to pilot data.
2. 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.

Mandate III Deliverables

Outpatient/ Ambulatory: Develop a strategy for broader roll out of the outpatient/ ambulatory minimum data

1. Develop a strategy to enable all ambulatory/outpatient rehab programs to report utilization data to CIHI through NACRS Clinic Lite.
2. 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.
3. Work with the developers of the WatLX™ tool to explore integration of this patient experience tool across outpatient/ambulatory rehab programs as feasible.

Ontario
Local Health Integration Network

Assess & Restore/Frail Senior

Initiative Goal

Assess and Restore/ Frail Seniors

Standardize best practice rehabilitative care for frail older adults by developing evidence-informed care pathways and processes; support implementation and evaluation of Assess & Restore initiatives

Key Activities

Assess and Restore/ Frail Seniors

1. Hold annual A&R knowledge exchange events in spring 2017 and 2018.
2. Support LHINs in standardized indicator reporting and evaluation of the provincial impact of A&R funding.
3. Complete, and submit to HQO, geriatric-focused Quality Standard Feasibility Analyses, in collaboration with the RGPs of Ontario.
4. Work with the Frail Senior Advisory Group and provincial stakeholders to develop secondary falls prevention care pathways.

Ontario
Local Health Integration Network

Why Falls Prevention?

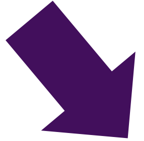
- Falls are marker of frailty and risk for functional decline, among community-dwelling older adults
- Provincial data indicate variability in the rate of repeat ED visits for falls among older adults, illustrating the need for standardized implementation of best practices
- Developing standardized restorative care pathways, for community-dwelling older adults who present with a fall, will support continued efforts to implement an A&R approach to care, across sectors

Discussion

Rehabilitative Care Alliance

Your Feedback

- Please complete our 2-minute webinar evaluation survey
  - Use the link in the “chat” window at the right of your screen



- A PDF of today’s presentation will be provided when you submit the survey

Next webinar: January 10, 2018