Rehabilitative Care Alliance

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Work Plan 2019 – 2022

For audio, you must call in by phone:

416-764-8673 or 1-888-780-5892,

Enter passcode 7677451#

Telephone lines open will be muted

Webinar begins at 12:05 p.m.

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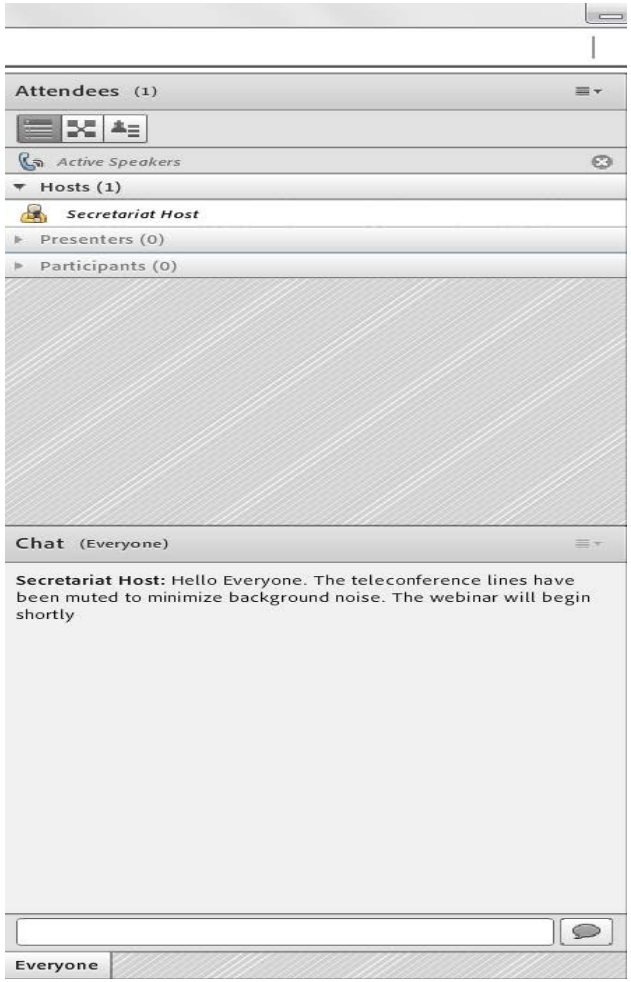
How to participate in the webinar

- For audio, you must call in by phone: (416) 764-8673 or Toll Free: 1-888-780-5892
- Passcode: 7677451#
- Telephone lines are muted
- The webinar is being recorded and will be posted to the RCA website within 1 week
- Questions may be entered into the chat function here for discussion



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Webinar Objectives

- This webinar will provide an overview of the 2019-2022 work plan for the next three years.

- This is the first webinar of a series of quarterly webinars for the 2019-2022 mandate to provide stakeholders with an overview of the RCA's work and progress.

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RCA Mandate

- LHIN-Funded since 2013
- 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 consistency and integration of best practices across the care continuum

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RCA Vision

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

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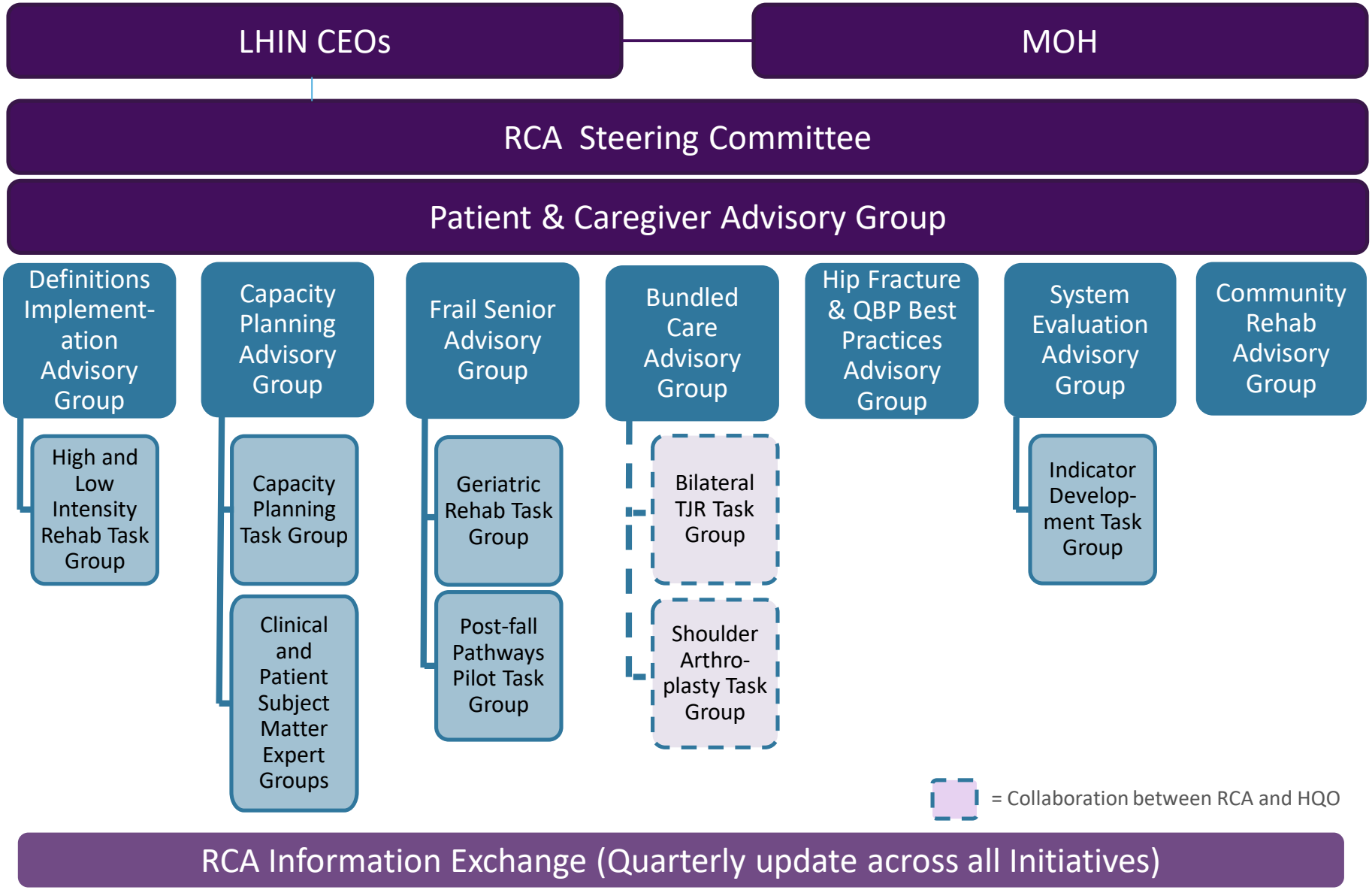
RCA 2019-2022



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Hip Fracture/TJR QBP Best Practices Initiative

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How far we've come

2015

Lack of detailed guidance regarding rehabilitative care best practices in the Hip Fracture and TJR populations

2019

Hip Fracture and TJR Rehabilitative Care Best Practice Frameworks and tool kits

Provincial and LHIN-level self-assessment analyses provide a basis for informing and improving quality rehabilitative care for these QBP populations

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Hip Fracture/TJR QBP Best Practices Work Plan 2019 – 2022

Objective	Deliverable/End State
Build on the findings of the self-assessment analysis to: • Promote alignment with TJR rehabilitative care best practices in support of continued implementation and spread of the Ministry's Hip & Knee Bundled Care initiative • Support quality improvement in outcomes and flow for frail seniors who sustain a hip fracture	• Utilize the Quality Improvement Process developed by the System Evaluation Initiative to guide development of quality improvement plans and implementation for interested regions/Ontario Health Teams • Develop resource guides to share existing best practice tools, approaches and resources • Convene forum(s) for knowledge exchange supporting best practice implementation strategies, sharing successes and challenges

Value Add:

- Support the generation of regional plans to execute best practice implementation strategies based on opportunities for improvement identified in the self-assessment analyses

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Definitions Initiative

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How far we've come

2013

Lack of standardization/clarity across the province regarding eligibility for and the focus and clinical components of rehabilitative care

Confusion and limited ability to understand and plan for rehabilitative care.

2019

Clearly defined provincial standards for levels of rehabilitative care implemented across Ontario

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Definitions Work Plan 2019 – 2022

Objective	Deliverable/End State
Clarification on the distinction between high and low intensity rehab and minimum staffing ratios for each.	• Guidelines on the distinction between high and low intensity rehab and minimum staffing ratios for each*.
	*Parameters for this work are under discussion

Value-Add:

- Further standardization of rehabilitative care programs within the *Rehabilitation* level of care
- Supports HSPs/LHINs in the planning for rehabilitative care resources
- Promotes greater equity in the provision of high and low intensity rehabilitative care across the province

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Definitions Work Plan 2019 – 2022

Objective	Deliverable/End State
Engagement of regionally-based HSPs and/or Regional Rehab Networks to support operationalization of the Definitions Frameworks within their region.	• There is awareness and understanding of the definitions framework and terminology at frontline level (e.g., staff and physicians) based on pre-post surveys of information needs.

Value Add:

- Supports full integration of the Definitions Frameworks for Rehabilitative Care by targeting smaller regional groups and focusing on their specific information needs and operationalization challenges.

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Definitions Work Plan 2019 – 2022

Objective	Deliverable/End State
Categorization of and communication about rehabilitative care programs.	• Analysis of rehabilitative care programs listed in the RCA portal and how community-based resources are being used within and across regions. • Access To Care ALC WTIS reporting of discharge destinations is aligned with Def Frameworks to ensure ALC reporting is reflective of demand issues for rehabilitative care in a standard way across the province.

Value Add:

- A better and more comprehensive understanding of rehabilitative capacity supports patient flow by knowing where services are.
- Consistency in the understanding and reporting of ALC data across the province

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Frail Seniors Initiative

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How far we've come

2013

No shared approach to collecting data, assessing impact and sharing learning of A&R initiatives

Lack of clarity on the role of rehabilitative care services in preventing secondary falls among older adults

2019

RCA's annual analysis assesses impact of A&R initiatives and supports knowledge transfer.

New evidence-based pathways to connect older adults who fall with rehabilitative care to prevent functional decline and additional falls

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Frail Seniors Work Plan 2019 – 2022

Objective	Deliverable/End State
Pilot the pathways to rehabilitative care for frail older adults in the community who present to primary care or the ED post-fall	• Lead implementation of a pilot of the post-fall pathways in 3-4 regions across Ontario • Finalize the pathways, including heightened awareness and use of the Direct Access Priority Process (DAPP) • Develop an operational and clinical toolkit based on recommendations from the pilot • Develop a broader communication and implementation strategy

Value-Add:

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

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Frail Seniors Work Plan 2019 – 2022

Objective	Deliverable/End State
Define the key components of geriatric rehabilitative care across the continuum, leveraging existing resources and evidence-informed geriatric best practices, working in collaboration with the RGPO / Provincial Geriatric Leadership Office	• Standardized geriatric rehabilitative care best practices framework that builds on existing evidence and frameworks (e.g., sfCare Framework[1], Competency Framework for Interprofessional CGA[2], RCA Definitions Frameworks)

Value-Add:

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

[1]RGP of Toronto, October, 2017 https://www.rgptoronto.ca/wp-content/uploads/2017/12/sfCare_Framework.pdf
[2]RGPs of Ontario, October, 2017 http://seniorscarenetwork.ca/wp-content/uploads/2018/11/RGPS_CompetenciesFramework_FinalEditOnlineVersion.pdf

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Frail Seniors Work Plan 2019 – 2022

Objective	Deliverable/End State
Analyze provincial outcomes and impact of Assess & Restore funding	• Annual report of provincial A&R projects, including analysis of sector-specific indicators that illustrate the provincial impact of initiatives for frail seniors

Value Add:

- Highlight the provincial impact Assess & Restore initiatives are having on how frail seniors are cared for, their clinical outcomes and impact on system efficiencies

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Outpatient Rehab Reporting Initiative

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How Far We've Come

2013

Data gap for outpatient/ambulatory rehabilitative care.

2019

An outpatient/ambulatory rehabilitative care minimum data set has been derived

A strategy for broader roll out of the outpatient/ambulatory minimum data set developed

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Bundled Care

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Bundled Care 2019 – 2022

Objective	Deliverable/End state
Continue to work with the MOH and rehabilitative care providers to support expansion of bundled care.	• Provide onboarding support with CIHI to participating sites re: use of NACRS Clinic Lite & ongoing guidance re: use of NACRS Clinic Lite • Provide oversight on and input to the MOH re: operational issues re: rehabilitative care across the bundles

Value Add:

- Improved understanding of available outpatient rehab resources for bundled care projects
- Sites supported to identify and address operational issues
- Outpatient rehab sector can better articulate value in a bundled care model

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Bundled Care 2019 – 2022

Objective	Deliverable/End state
Continue to work with the MOH and rehabilitative care providers to support expansion of bundled care.	• In collaboration with Health Quality Ontario, develop a concise set of provincial recommendations on best practices for rehabilitative care following simultaneous bilateral knee and hip replacement. To be released as an addendum to the Total Joint Replacement Rehabilitative Care Best Practices Framework.

Value Add:

- Standardizes post-discharge care pathways for Bilateral Total Joint Replacement, addressing potential efficiency opportunities
- Addresses some of the variation across hospitals in the use of different post-acute rehab settings – specifically, discharge to inpatient rehabilitation vs. discharge home to in-home care, outpatient rehab or other services.

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Bundled Care 2019 – 2022

Objective	Deliverable/End state
Continue to work with the MOH and rehabilitative care providers to support expansion of bundled care.	• Through a collaboration between the Rehab Care Alliance and Health Quality Ontario, develop a guidance document on best practices for rehabilitative care following total/hemi shoulder arthroplasty and reverse arthroplasty.

Value Add:

- Standardizes post-discharge care pathways for shoulder arthroplasty and reverse arthroplasty, addressing potential efficiency opportunities

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System Evaluation Initiative

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How Far We've Come

2013

Lack of standardized reporting for rehab specific indicators

2019

Annual RCA system evaluation performance report released with standardized indicators, benchmarks, and data definitions, including analysis from a rehab perspective.

Provincial QI work beginning for the rehab system.

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System Evaluation 2019 – 2022

Objective	Deliverable/End state
Enhance provincial and LHIN system evaluation report to include performance at the organization level	• Continue annual rehabilitative care performance reporting with enhancements to the scorecard, including reporting at the organizational level • Conduct a review and refresh indicators • Incorporate outpatient indicators on wait time and utilization into the system evaluation report card

Value Add:

- Addresses the needs of LHINs in how indicators are calculated and reported for improved consistency across the province
- Site level reporting enables identification of quality improvement opportunities within LHINs

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System Evaluation 2019 – 2022

Objective	Deliverable/End state
Develop a unifying approach to quality improvement for the 3 priority indicators	• In collaboration with regional and provincial partners, in alignment with health system directions and in support of OHTs, support quality improvement for rehabilitative care relative to performance on benchmarked indicators

Value Add:

- Addresses the need expressed by provincial stakeholders to reduce wait times for rehabilitative care
- Improves quality of care for patients who have fallen by reducing ED visits through quality improvement initiatives

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Community-Based Rehab

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Community-Based Rehab 2019 – 2022

Objective	Deliverable/End state
Profile the role of community-based rehab in supporting people to return home, enhance or maintain functional status as a basis to support knowledge exchange and identify opportunities for spread of innovative, cost-effective models of rehabilitative care.	• A white paper that summarizes community-based rehab models in practice and in the literature that have demonstrated an impact on client and system level outcomes. Community-based rehab models to include a focus on rehab delivered in ambulatory, in-home and primary care settings.

Value Add:

- Improved understanding of how community based rehabilitative care models are and could be used to support enhanced patient outcomes and more efficient care.

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Capacity Planning Initiative

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How Far We've Come

2013

Each region plans for rehab separately; disparity in the approach, the outcome of the process; variable resources available for planning

2019

Developed a standardized needs-based planning approach for rehab services across regions, using hip-fracture as a population-based example, includes patient input

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Capacity Planning 2019 – 2022

Objective	Deliverable/End State
Support LHINs in applying a standardized approach to capacity planning for rehabilitative care, using hip fracture as the population-specific example	• Work with interested regions to further test and evaluate the hip fracture capacity planning tools using a PDSA approach • Coaching and leadership on the application of the capacity planning approach provided to all interested regions • Develop local, needs-based capacity plans for hip fracture patients with interested regional planners

Value Add:

- LHINs have a clear understanding of the steps involved in conducting a needs-based capacity plan for hip fracture
- Standardization in capacity planning approaches for rehabilitative care

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Capacity Planning 2019 – 2022

Objective	Deliverable/End State
Apply the capacity planning methodology developed for hip fracture rehabilitative care services to another population, as determined through a prioritization exercise	• Based on current health system directions and needs of OHTs, apply and test capacity planning approach for a second patient population • Support development of local, needs-based capacity plans with interested regional planners

Value Add:

- According to population projections, Ontario's senior population is expected to double by 2041 and Ontario's overall population will increase by roughly 30% by 2041[1] and these demography changes will significantly impact the availability of healthcare in the province that will need to be planned for[1].
- Needs-based capacity planning provides an opportunity to consider innovative ways to plan for increasing populations and ensure timely and appropriate access to health care

[1]Hallway Health care: System Under Strain; 1st report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine

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Help the Provincial RCA Keep You Informed

Consider subscribing to receive RCA quarterly newsletters and other news from the Alliance, to keep updated on:

- Announcements of new resources and tools supporting best practice in rehabilitative care
- Opportunities to engage in and contribute to RCA projects and initiatives

To subscribe, visit http://rehabcarealliance.ca/subscribe
You can choose to unsubscribe at any time.

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Questions?