BRIEFING NOTE

Rehabilitative Care Alliance

Realizing the potential of community-based rehabilitative care

Innovative models of community-based rehabilitative care play a critical role in delivering high quality, patient-centred care and supporting pandemic recovery within Ontario's health care system.

Access to rehabilitation in the right place at the right time is essential to patients and to the health care system. Rehabilitation delivered in the community improves patient outcomes by promoting health, reducing pain, restoring function and getting people back to their homes, workplaces and communities as safely and as independently as possible. At a system level, innovative models of community-based rehabilitative care address key pressure points within the system by reducing emergency department visits, inpatient admissions, and family physician visits, while also supporting earlier inpatient discharge, and improving patient flow

However, despite several innovative, evidence-based models of rehabilitative care in Ontario, many have yet to be implemented in a standardized approach across the province. In order for Ontario Health Teams to deliver effective and cost-efficient approaches to health care, community-based rehabilitative care must be integrated into their models of care.

About community-based rehab

People require rehabilitation for many reasons, including recovery from illness, injury, surgery, or disability; for management of a chronic disease; and/or to remain active and independent as they age.

Regulated rehabilitative care professionals (as a sole practitioner and/or within an interdisciplinary team) provide community-based rehabilitation, both in-person and virtually, across a variety of publicly and privately funded settings. This can include, but is not limited to: kinesiology, occupational therapy, physiotherapy, speech-language pathology, among others.

To reach optimal health outcomes, some people require rehab in more than one of the following settings, either concurrently or consecutively. It is critical that the patient be at the center of care planning and delivery, and that care be coordinated and integrated across the continuum.

- **Outpatient/community clinics:** Rehabilitation in community-based clinics, or outpatient programs in hospitals, provide assessment and treatment to individuals with needs ranging from rehabilitation for uncomplicated single diagnosis injuries to conditions that affect mobility and function, to more complex care. Outpatient/community clinics also enable discharge from hospital and support people recovering from surgery or who have experienced life-changing illness/injury (e.g., stroke, brain injury, multiple trauma, cardiac event). Both clinics and outpatient programs help patients improve and/or regain their physical and cognitive function so they can return to day-to-day activities, including school, work and leisure.
- **In-home:** In-home rehabilitation supports people's rehabilitation goals that are best met in the home setting. Patients access care either as part of their transition from hospital to home or directly from their home without a hospital stay. The focus is on optimizing function, which enables people to successfully remain in or return to their homes and communities, preventing the need for long-term institutional care.
- **Primary care:** By integrating rehabilitation within their services, interdisciplinary primary care models such as Community Health Centres (CHC) and Family Health Teams help people get the rehabilitative care they need at first contact with the health care system and throughout their recovery or management of chronic conditions. Rehabilitative care within primary care supports comprehensive, integrated health care, including population-based programming. In many cases, CHCs provide care to specific vulnerable populations that otherwise would not be able to access rehabilitation.

Community-based rehabilitation enables people with impairments and disabilities to reach, maintain and/or maximize their optimal physical, sensory, cognitive, communicative, psychological and social functional levels.

It promotes health and well-being, prevents injury and illness and enables re-integration to and participation in community living for an improved quality of life.

Community-based rehabilitation is based on the stage of recovery and the needs and goals of the person and their care partner.

Improving patient and system outcomes: the evidence

Community-based rehabilitation delivers significant improvements in patient and system outcomes that are critical to the priorities of Ontario Health Teams and Ontario's health system:

- **Reducing Alternate Level of Care and keeping older adults independent and in their homes:** Older adults with frailty typically have multiple chronic conditions, frequently use health services and have a significantly greater risk of hospitalization or admission to long-term care if their functional decline becomes permanent.
  - Community-based rehabilitation helps older adults age at home by optimizing their strength, balance and mobility; addressing cognitive issues; preventing hospital readmissions; supporting earlier transitions from hospital to home; preventing/delaying admission to long term care; and reducing caregiver burden.[1 2 3 4 5 6 7] In-home rehabilitation has also been shown to reduce personal support worker requirements and costs.[8]
  - Fall prevention programs and services contribute to significant reductions in fall-related injuries, hospitalizations and associated health care costs among older adults in Ontario.[9]
- **Managing chronic disease:** Rehabilitation is effective in preventing and/or managing chronic conditions (e.g., hypertension, emphysema, type 2 diabetes, Parkinson's, multiple sclerosis, arthritis).[10] People with chronic disease who receive rehabilitation in outpatient/community clinics have improved outcomes, lower utilization of costly health services and reduced hospital admissions/readmissions.[11]
- **Improving efficiency**: Direct access to rehabilitative care means people are able to see a rehabilitative care professional (where appropriate) without first seeing a primary care practitioner. Direct access has been shown to be effective for people with musculoskeletal issues. For example, compared with patients seen by a family physician, patients who are directly assessed and treated by a physiotherapist show significantly improved health-related quality of life; reduced pain, sick time and disability; accelerated recovery; and fewer instances of acute problems becoming chronic.[12 13 14]
- **Strengthening primary care:** Integrating rehabilitative care into primary care settings improves patient outcomes, reduces rates of referral to specialists (e.g., orthopaedic surgeons, rheumatologists), reduces hospital readmissions, delays admission to long-term care and increases levels of satisfaction of both patients and physicians.[15 16 17 18]

Community-based rehabilitation is needed:

- More than 600,000 Ontarians currently live with frailty. This is projected to increase to more than **1.1 million by 2040**. (*Provincial Geriatrics Leadership Ontario*)
- Of all the days patients were in Ontario hospitals, 15.5% were spent waiting to receive care elsewhere. (*Ontario Health Quality*)
- **Falls are the No. 1 reason** for injury-related death, hospitalization and emergency department visits for older adults in Canada. They **cost $5.6 billion in 2018** – nearly 20 per cent of the total cost of injury in Canada. (*Parachute*)
- 70% of Canadians aged 45 and above have two or more chronic diseases. (*Rumball-Smith, J. et al, 2014*)
- 80% of adult visits to primary care in Canada are for chronic disease management. (*Rumball-Smith, J. et al, 2014*)

Recommendations for action

Innovative and cost-effective models of community-based rehabilitation present a significant opportunity to deliver better patient and system outcomes. To realize that opportunity, decision-makers must take action on the following:

1. Fund and resource community-based rehabilitative care sufficiently to ensure timely, equitable access to high-quality rehabilitative care for all Ontarians, inclusive of diverse communities and independent of an individual's socioeconomic status or geographic location.

2. Provide community-based rehabilitative care as close to home as possible, using virtual care options as necessary and appropriate.

3. Ensure the delivery of rehabilitative care services is integrated across primary care, hospitals and community settings.

4. Implement a provincial data collection and reporting system for community-based rehabilitation that captures the system-level and patient outcome data necessary to ensure efficiency and effectiveness and inform program, policy and funding decisions.

5. Include rehabilitative care professionals at regional and provincial planning tables so that opportunities to deliver care more efficiently and effectively using community-based models can be identified and implemented from the onset of planning.

6. Address the ongoing and growing shortage of rehabilitative care professionals by including rehabilitative care professionals in provincial discussions of health human resource challenges and considering insights and recommendations from the RCA's Rehab Workforce Task Group (work currently underway).

7. Build on the Community Stroke Rehab initiative – to enable an equitable, integrated and patient-centered system of care that supports recovery of patients after stroke – and apply learnings to other rehab populations.

Information on innovative community-based rehabilitation models and further recommendations to support their implementation are available in the Rehabilitative Care Alliance's four-part white paper, Community-Based Rehabilitation: Providing High-Value Rehabilitative Care in the Community.

Appendix

Community-based rehabilitative care: Delivering on the Quadruple Aim

Improving patient experience of care [2 3 4 5 6 10 19 20 21]	Improving the health of populations [2 3 4 5 22 23 24 25]
• Minimizing the impact of disability • Managing acute and chronic pain and symptoms • Optimizing high quality of life, regardless of the trajectory of the patient's condition • Improving participation in the community – school, workplace, community activities • Reducing social isolation/enhanced peer support • Increasing opportunity for care partners to play an integral role in care planning • Enabling people to remain safely in their home rather than needing institutional or congregate care • Helping both patient and care partners participate in meaningful life activities	• Improving function and quality of life • Decreasing the rate and risk of falls • Improving strength, endurance, balance and coordination • Improving physical, sensory, cognitive, communicative, psychological and social function • Decreasing symptoms and improved daily functioning • Supporting management and preventing complications of chronic conditions • Reducing mental health conditions/addictions • Reducing morbidity and mortality
Reducing the per capita cost of health care [2 3 4 5 7 26 27]	**Improving provider experience** [28 29]
• Reducing hospital inpatient length of stay, with earlier discharge home to community, rehabilitation and support services • Providing cost-effective structured programs • Reducing the need for pharmaceuticals and diagnostic imaging • Delivering safe transitional care • Reducing emergency department utilization • Preventing hospital re-admission • Reducing the need for in-home personal support • Preventing or delaying the need for long-term care • Enabling people to participate in meaningful life activities • Reducing utilization of community and social services and social assistance (e.g., employment insurance or disability support)	• Supporting a culture of quality fueled by continuous learning • Developing relevant human health resources, such as advanced practice practitioners, to improve access to specialist care • Contributing to a happier, healthier, more resilient and productive rehabilitative care workforce • Providing satisfaction in positive patient and care partner outcomes • Meeting quality assurance requirements and standards through implementation of best practice models of rehabilitation • Increasing awareness and recognition of the roles, skills and scope of individual members of the interprofessional team • Improving the experience of other team members in delivering interprofessional primary care

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