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 (OHTs) to deliver effective and cost-efficient health care, community-based rehabilitation must be integrated into their models of care. This resource provides information and actionable recommendations for integrating innovative community-based models of rehabilitative care to help address key challenges faced by Ontario's health system, including access and flow, alternate level of care (ALC) and chronic disease management.

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.
- Promotes health and well-being, prevents injury and illness and enables re-integration into and participation in community living for an improved quality of life.
- Is based on the stage of recovery and the needs and goals of the person and their care partner.

Rehabilitative Care Alliance

Hip and Knee Osteoarthritis Provincial Pilot Project: The Good Life with Arthritis (GLA:D) Program

For: Conservative management of moderate to severe osteoarthritis.

Benefits: Effective self-management strategies, pain reduction, improved strength, surgery avoidance.

See full Case Study in the Appendix.

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 sole practitioners and/or within interdisciplinary teams) 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 and speech-language pathology, among other disciplines.

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 centre 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, social and cognitive function so they can return to day-to-day activities, including school, work and leisure.

Regional Cardiovascular Rehabilitation Programs: Champlain Region

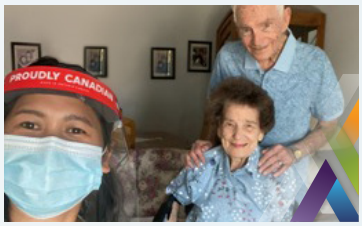
For: Secondary prevention for newly-diagnosed heart or cardiovascular conditions.

Benefits: Improved self-management, reduced mortality and morbidity with better survival and fewer cardiovascular events.

See full Case Study in the Appendix.

- **In-home:** In-home rehabilitation supports people's rehabilitation goals that are best met in the home setting. Patients receive care either as part of their transition from hospital to home or in 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.

SE Health Acute Transitions Models: Integrated Home and Community Care



For: Those more likely to visit the ED, experience caregiver stress, or at risk of premature LTC placement.

Benefits: Improved or maintained function, decreased ED visits, seamless transitions from hospital to home.

See full Case Study in the Appendix.

- **Primary care:** By integrating rehabilitation within their services, interdisciplinary primary care models such as Community Health Centres (CHCs) 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, such as chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF). 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.

The Chronic Disease Management Program at the Windsor Essex Community Health Centre (weCHC)

For: Adults with chronic conditions who otherwise would not have access to rehabilitation.

Benefits: Improved quality of life, physical fitness, and ability to complete daily activities.

See full Case Study in the Appendix.

Regardless of the setting in which rehabilitative care is delivered, the literature strongly validates its benefits for both patients and the broader health care system.

Community-based rehabilitation is needed:

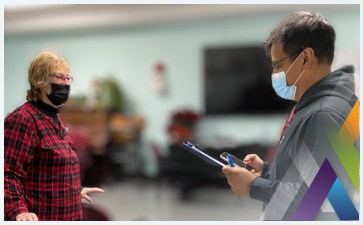
- More than 600,000 Ontarians currently live with frailty. This is projected to increase to more than 1.1 million by 2040 (Provincial Geriatrics Leadership Ontario).
- Of all the days patients were in Ontario hospitals, 15.5% were spent waiting to receive care elsewhere (Ontario Health Quality).
- Falls are the number one reason for injury-related death, hospitalization and emergency department visits for older adults in Canada. Falls 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).

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. These include:

- **Reducing ALC 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]

Integrated Community-Based Care: West Toronto Community Health Services



For: Vulnerable and at-risk persons, including those with increased risk of falls, deconditioning, social isolation, mental health challenges, long COVID symptoms.

Benefits: Improved balance, wellbeing, access to rehab, fall prevention.

See full Case Study in the Appendix.

- **Managing chronic disease.** Rehabilitation is effective in preventing and/or managing chronic conditions (e.g., COPD, CHF, hypertension, type 2 diabetes, Parkinson's, multiple sclerosis, arthritis).[10] People with chronic disease and chronic pain who receive rehabilitation in outpatient/community clinics have improved outcomes, lower utilization of costly health services, reduced hospital admissions/readmissions and lower likelihood of receiving an opioid prescription.[11, 12]
- **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. For example, direct access has been shown to be effective for people with musculoskeletal issues. Compared with patients seen first 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.[13, 14, 15]
- **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 among both patients and physicians.[16, 17, 18, 19]

Toronto Primary Care Rehabilitation Network

For: Persons with pain and/or functional/mobility limitations who otherwise would not have access to rehabilitation.

Benefits: Improved function, pain reduction, pain medication/substance use reduction, appropriate specialist referrals.

See full Case Study in the Appendix.

Community-based rehab in practice

Community rehabilitation helps people achieve and maintain independence in communities and reduces dependence on additional services and care. The comprehensive, interprofessional approach of rehabilitative care delivers improvements in patient and system outcomes.

This approach includes the following:

- **Patient as partner:** Rehabilitative care professionals use a person-centred approach, working with the patient and their care partner to understand how the person was functioning previously, their circumstances and social supports, what's important to them and what activities they want return to or engage in. These insights form the foundation for the rehabilitation care plan, developed with the full participation of the patient and care partner.
- **A focus on function:** Rehabilitative care professionals look at a person's function across all domains – physical, cognitive, sensory, communicative, psychological, social and pain and symptom management – and in collaboration with the patient and care partner, they determine what interventions would maintain or improve that function.

- **Importance of physical and social environment:** The rehabilitative approach is comprehensive, recognizing that recovery from illness/injury and day-to-day life with chronic disease takes place within a physical and social environment. Therapies may address physical issues (e.g., strength or balance), cognitive issues (e.g., reasoning and judgement) or sensory issues (e.g., hearing and vision loss). Interventions may include modifying the physical environment (e.g., grab bars, ramps), adding behavioural cues (e.g., digital monitors, visual cues), connecting the person with community supports (e.g., community services for transportation and meals), providing support for care partners (e.g., care for caregiver programs) or encouraging opportunities for social interaction (e.g., communication rehab, community recreation).

Home and Community Care Support Services Champlain: Community Stroke Rehabilitation Program

For: Adult community-dwelling stroke survivors with rehab goals.

Benefits: Access to care that improves performance and mental health; reduced hospital length of stay.

See full Case Study in the Appendix.

- **Support for self-management:** Rehabilitative care empowers people with the tools they need to manage and improve their own health (e.g., chronic pain/illness self-management groups, such as COPD and CHF), increasing their independence and quality of life while reducing reliance on the health care system.
- **Flexibility in service models:** Successful rehabilitative care models balance the realities of limited health human resources, geography and patient preferences with the need to provide adequate support to achieve the goals of the rehabilitation plan.

North West Regional Rehabilitative Care Program: Outreach Team

For: Provision of OT and PT services where current hospital vacancies limit access and shared care OT/PT with local therapists (hospital, home care, primary care) to provide more specialized care locally.

Benefits: Improved rehab access and wait times with significant cost savings.

See full Case Study in the Appendix.

Recommendations for action

Rehabilitation is a critical aspect of integrated care that will enable OHTs to achieve the shared vision of improved population health. Innovative models of community-based rehabilitation offer a significant opportunity for OHTs to meet the needs of populations within their communities and deliver better patient outcomes along with efficient, cost-effective care. To realize that opportunity, OHTs must:

1. Ensure timely, equitable access to quality community-based rehabilitative care for all people served by your OHT, inclusive of diverse communities and independent of an individual's socioeconomic status or geographic location.

2. Apply a population-based approach to the provision of rehabilitative care to better respond to community needs. For example, if your catchment area includes a high number of older adults with frailty, community-based models of rehabilitative care can play a significant role in addressing health needs, helping older adults age at home, decreasing hospital admissions and reducing primary care visits (see RCA/PGLO Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience Framework).

3. Integrate rehabilitative care into your core services; community-based rehabilitation can be delivered in primary care, outpatient/community clinics and in patients' homes.

4. Maximize efficiency and enhance care by engaging rehabilitative care professionals to provide chronic disease care and management (e.g., for arthritis, COPD, CHF), triage for orthopaedic surgery (vs. conservative management), or other care within their full scope of practice.

5. Fund and resource interprofessional community-based rehabilitative care sufficiently to ensure timely, high-quality rehabilitation is provided as close to home as possible, using virtual care options as necessary and appropriate.

6. Measure and report patient experience and outcomes related to rehabilitation using standardized and validated tools regardless of the care delivery mechanism (e.g., in-person care, virtual care) or model of care. Regularly review and make systemic improvements based on these outcomes.

7. Include community-based rehabilitative care providers at your planning tables so that opportunities to deliver care more efficiently and effectively through the integration of rehabilitative care services can be identified, explored and implemented.

Appendix

Case Studies

These case studies provide examples of innovative models of community-based rehabilitation across Ontario. See www.rehabcareontario.ca for more information on other rehabilitation services by region.

Outcomes of these case studies are presented based on the Quintuple Aim:[20]

- Improving patient experience of care
- Improving the health of populations
- Reducing the per capita cost of health care
- Improving provider experience
- Advancing Health Equity

CASE STUDY

Hip and Knee Osteoarthritis Provincial Pilot Project: The Good Life with Arthritis (GLA:D) Program

The model

Leveraging existing community-based rehabilitation agencies, including primary care, outpatient clinics and private clinics, to provide timely, local and coordinated access to an exercise and education program. Referrals accepted from Rapid Access Clinics and Primary Care Teams. Currently available in 3 regions: Champlain, North West & Toronto.

Populations served

Individuals with a diagnosis of moderate to severe osteoarthritis, who are not surgical candidates or who would prefer an exercise-based approach to management.

Services

Individualized goal-oriented assessment. Interventions delivered in a group format, both in person and virtually. Includes 12 exercise sessions and 2 education sessions. Delivered by GLA:D certified rehab professionals (PT, RKin, OT).

Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE	POPULATION HEALTH	VALUE/EFFICIENCY	CARE TEAM WELLBEING
Overall Program is Beneficial *(Positive client report: TO: 84.4%, Ch: 87.2%, NW: 80.5%)*	**Reduced Pain** *(Numeric Pain Rating Scale: TO:-1.1, Ch:-0.7, NW:-1.2)*	**Surgery Avoidance** *(Client report do not want surgery at baseline: TO: 72.9%, Ch: 64%, NW: 71.2% and 3 month follow-up: TO: 73.8%, Ch: 69.9%, NW: 75%)*	**Support for Program Referrals** *(100% of RAC therapists had information to make appropriate referrals, n=13)*
Implemented self-management strategies *(Client report used learnings at least weekly: TO: 85.8%, Ch: 89.4%, NW: 80.1%)*	**Improved Strength** *(Improved number of sit-to-stands in 30 sec: TO: 4.4, NW: 3.8, Ch: 4.3)*		**Comfortable making referrals** *(100% of RAC therapists somewhat or very comfortable, n = 13)*
Client Satisfaction *(Positive client report: TO: 86.2%, Ch: 85.6%, NW: 75.5%)*			

ADVANCING HEALTH EQUITY

Not available for sharing at time of publication

Q1,2021-Q2,2022 data. Toronto N=334, Champlain N=265, NW N=46
For more information: https://4villageschc.ca/wp-content/uploads/2022/10/Hip-and-Knee-OA-Conservative-Management-Pilot_April-1-2021.pdf

CASE STUDY

Regional Cardiovascular Rehabilitation Programs: Champlain Region

The model

Cardiovascular rehabilitation is offered through 13 health care centres in the Eastern Ontario (Champlain) Region: 8 hospital outpatient settings, 2 Community Health Centres and 3 Family Health Teams.

Populations served

Individuals with newly diagnosed heart or cardiovascular conditions requiring secondary prevention.

Services

Individualized, goal-oriented assessment and interventions provided by a combination of nursing, PT and other rehab professionals (including MD, RKin, RT, RD, SW, OT, psychologists and administrative staff), focusing on risk factor awareness and strategies to self-manage. Group programs for education and exercise, offered virtually and/or onsite at various locations around the region. CR Team provides case management, including referrals to the relevant partners across the continuum.

> The program gave me the encouragement I needed to take better care of myself. It was eye-opening.

Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE	POPULATION HEALTH	VALUE/EFFICIENCY	CARE TEAM WELLBEING
Improved Self-Management *(91% client agreement that they understand risk factors and how to successfully manage them. n=214)*	**Reduced Mortality & Morbidity** *(Participation in Cardiac Rehab shown to significantly impact mortality & morbidity. 2012 participants in 2021.)*	**Better Survival & Fewer Cardiovascular Events** *(Resulting from enhanced cardiovascular fitness. Improved functional capacity shown on the DASI measured in METs – pre avg 6.3 post avg 7.5. 0.5 MET improvement is related to health benefit.)*	**To be collected**
Client Satisfaction *(96% of clients would recommend the cardiac program to others. n=228)*	**Improved Diet** *(2.5% improvement in fruit and vegetable intake)*		
	Improved Mental Health *(32% improvement on the GAD7 - pre avg 3.5; post avg 2.4)*		

ADVANCING HEALTH EQUITY

Not available for sharing at time of publication

University of Ottawa Heart Institute 2021 site data
For more information: https://www.ottawaheart.ca/patients-visitors/clinics-and-programs/cardiac-rehabilitation-program/community-cardiac

CASE STUDY

SE Health Acute Transitions Models: Integrated Home Community Care

The model

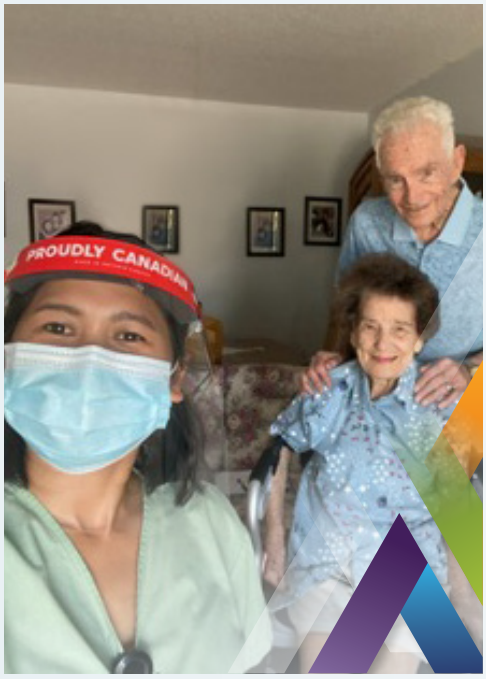
Care is delivered by an interdisciplinary, self-directed team in the home and community setting for a period of up to 16 weeks.

Populations served

Individuals who present with daily pain, unsteady gait, or unmanaged chronic conditions; are more likely to visit the ED; experience caregiver stress; or are at risk of premature LTC placement.

Services

Interdisciplinary team of nursing, PSW, OT, PT, RD, SLP, SW, RA is led by a primary clinician who is accountable to manage client care needs from admission to discharge, per client care goals.



Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE	POPULATION HEALTH	VALUE/EFFICIENCY	CARE TEAM WELLBEING
Improved or Maintained Function *(98% maintained or improved score on the ADL Hierarchy Scale.)*	**Improved MAPLeScores** *(94% maintained or improved on this interRAI Outcomes Scale used to prioritize those needing community or facility-based services and help plan allocation of resources.)*	**Decreased ED Visits** *(4% clients had ED visit within 7 days. 15% clients had ED visit within 30 days.)* **Seamless transitions hospital to home** *(87% received first home visit within 24 hours.)*	**Improved staff experience** with self-directed model *(92% of providers would recommend this program to someone looking for a job in home care).*

ADVANCING HEALTH EQUITY

Not available for sharing at time of publication

Data: Average across 8 at home programs over 6 months
For more information: https://acutecare.sehc.com

Rehabilitative Care Alliance

CASE STUDY

The Chronic Disease Management Program at the Windsor Essex Community Health Centre (weCHC)

The model

An extension of outpatient services that offer therapeutic exercise and education with the goal of promoting self-management of chronic conditions, maintenance of physical fitness and improvement in overall quality of life for the community of Windsor-Essex.

Populations served

Adults with chronic conditions causing pain, functional or mobility limitations requiring modified/supervised exercise. Services for individuals who otherwise would not have access to rehabilitation.

Services

Individualized intake with pre and post fitness assessments. Group exercise programs provided by an interdisciplinary team including RN, PT, OT, RT, RKin, RAs and admin supports both in-person and virtually for 20-22 weeks, meeting twice weekly. Exercise videos on the website and local TV serve as a maintenance program.

> **I have regained my independence and ability to help with household chores. I'm extremely pleased with the program and staff.**

Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE	POPULATION HEALTH	VALUE/EFFICIENCY	CARE TEAM WELLBEING
Improved Quality of Life *(63.6% strong client agreement)* **Sense of Belonging** *(54.5% strong client agreement)*	**Improved Physical Fitness** *(71.4% increase in cardiovascular endurance, 70.5% increase in upper body strength, 63.4% increase lower body strength and 56.8% maintained balance scores)* **Improved Ability to do Daily Activities** *(54.5% strong client agreement)*	**Wait Times** *(~1 week for initial triage, ~1 month to begin program)*	**To be collected**

ADVANCING HEALTH EQUITY

Not available for sharing at time of publication

For more information: https://www.wechc.org

Rehabilitative Care Alliance

CASE STUDY

Integrated Community Based Care – West Toronto Community Health Services

The model

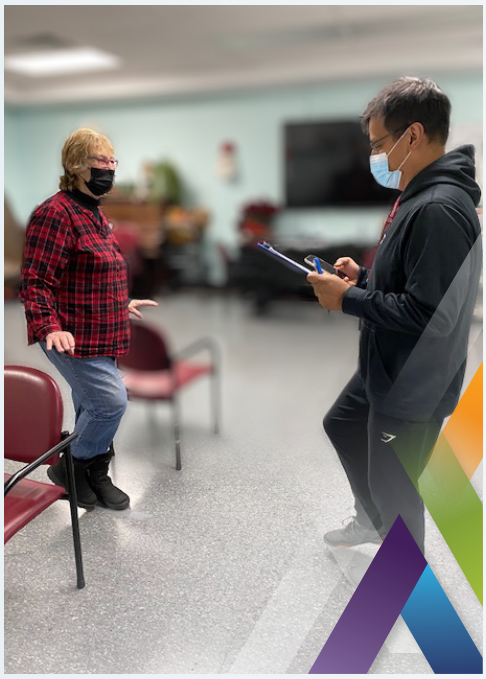
Expanded delivery of integrated, accessible and streamlined services, including rehab (occupational therapy and kinesiology), mental health (social work) and community supports (community health worker, peer support), to address emerging pandemic-related health and social needs.

Populations served

Seniors, persons with chronic conditions, home-bound and other social determinants of health-vulnerable and at-risk persons; including those with an increased risk of falls, deconditioning, social isolation, mental health challenges, and long COVID symptoms.

Services

1:1 and/or groups, including Falls Prevention (OT/RKin/SW), Memory and Cognition (OT), Activation/Nordic Pole Walking (RKin), Mindfulness (SW) format, Life skills (CHW/Peer Support), Long COVID Peer Support (OT, SW, RKin) in person and/or virtually.



Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE	POPULATION HEALTH	VALUE/EFFICIENCY	CARE TEAM WELLBEING
Satisfaction with Service *Falls Prevention (87%, n=25)* *Social Work Services (85%, n =28)* *OT and Cognition (100%, n=10)* **Access** *(80% of SW clients reported they would not be able to access services elsewhere due to cost, limited availability, etc, n = 28)*	**Improved Balance/ Mobility** *(100% improved on 1 of 3 measures, n = 25)* *Timed Up and Go, 4 stage balance, Sit to Stand* **Falls Prevention** *(100% reported they learned how to prevent falls, n=25)* **Improved Wellbeing** *(82% reported they felt better after their SW session, n=28)*	**Surpassed Targets** *At end of Q2, 95% of unique client target reached* **Increased access and support of PCPs** *At end of Q2, 78% of clients served were rostered to PCPs in the community (i.e. Not WTCHS)*	**To be collected**

ADVANCING HEALTH EQUITY

80% report being unable to access services if not offered at the CHC
(Unable to afford, no private insurance, unsure where to go)

Rehabilitative Care Alliance

CASE STUDY

Toronto Primary Care Rehabilitation Network

The model

Physiotherapy (PT) is collaboratively integrated into 13 community health centres (CHCs) and five family health teams (FHTs) in the Toronto Region.

Populations served

Individuals across the entire age span, from infants to older adults with pain, functional or mobility limitations, who otherwise would not have access to rehabilitation.

Services

Individualized goal-oriented assessment and treatment, delivered in a 1:1 or group format,
in person and/or virtually. Direct access to PT (ie. self referral/ no physician referral). Provide consultation to internal and external partners to support development of wellness services. 21.8 physiotherapy FTEs across 18 teams with expansion with some teams to include OT
(3.0 FTEs) and RKin (3.0 FTEs) in some teams.

> I think [this program] is great – please don't take it away. Patients benefit from it so much.

Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE	POPULATION HEALTH	VALUE/EFFICIENCY	CARE TEAM WELLBEING
Reduced Pain *(reported by 99% of clients, n=327)*	**Reduced use of Other Substances (alcohol, cannabis, street drugs) to control pain** *(reported by 88% of using clients, n=92)*	**Reduced Pain Med Prescription** *(reported by 58% of PCPs, n =33)*	**Feeling Valued** *100% of PTs reported feeling valued by PCPs at their centre.*
Improved Function *(reported by 99% of clients, n=271)*	**Improvement in Condition** *(81% reported improvement in Global Rating of Change Scale, n=17% of all unique clients)*	**More Appropriate Specialist Referrals** *(reported by 76% of PCPs, n=33)*	*94% of PTs felt comfortable to raise concerns with peers.*
Satisfaction with Service *(reported by 100% of clients, n=327*		**Reduced Need for Diagnostic Imaging** *(reported by 42% of PCPs, n =33)*	

ADVANCING HEALTH EQUITY

76% report they would be unable to access PT if not offered at the CHC
(Unable to afford, no private insurance, unsure where to go).

Per 2018 data, 11% do not have provincial insurance; 35% are low income; 147 different countries of origin; 72 preferred languages

For more information: https://4villageschc.ca/wp-content/uploads/2022/10/Rehabilitation-in-Primary-Care-in-Toronto-Region_Posted-Oct-2022.pdf

CASE STUDY

Home and Community Care Support Services Champlain: Community Stroke Rehabilitation Program

The model

Specialized, interdisciplinary stroke rehab service designed to support better functional outcomes and community integration for stroke survivors following hospital discharge.

Populations served

Adult community-dwelling stroke survivors within first year post-stroke who have rehab goals and are willing to participate.

Services

Individualized, goal-oriented assessment & intervention with intensive biweekly sessions with OT, PT, SLP & SW for up to 12 weeks. Supported by care coordination teams, referrals to community-based support/online services, external partnerships with additional specialized services and caregiver support available. In urban areas, caseloads 100% stroke rehab. In rural areas, therapists carry mixed caseloads.

Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE

Improved Performance
(Median significant change of 3 points on COPM for functional goal performance representing 75% improvement.) FY21-22, Ottawa, n=132

Satisfaction with Goal Attainment
(Median improvement of 3.7 points on COPM representing 103% improvement.) FY21-22, Ottawa, n=132

Improved Ability to Manage Stroke
(93% agreement now able to manage condition & stroke recovery) n=164, whole program since 2016

POPULATION HEALTH

Improved Integration to Normal Living
(15% improvement on the RNLI. >7% clinically important.) FY21-22, Ottawa, n=123

Improved Mental Health
(23% reported moderate to high depression on PHQ-9 at admission. Reduced to 5% at discharge) FY21-22, Ottawa, n=142

VALUE/EFFICIENCY

Improved Access to Care
(Previously no specialized outpatient stroke services except in Ottawa.)

Improved Hospital Length of Stay
(Regional stroke hospital saved 3.48 days average length of stay, compared to previous year.)

CARE TEAM WELLBEING

Four key contributing aspects of this program's exemplary care:*

- *Personalized care*
- *Flexibility of approach*
- *Attention to emotional needs*
- *Caregiver integration into care plan*

According to interviews with patients, care partners, rehabilitation providers, administrators as part of the CIHR grant number 368026 report entitled Regional results from the project **Community-based rehabilitation: towards ethical design and allocation*

ADVANCING HEALTH EQUITY

Not available for sharing at time of publication

Rehabilitative Care Alliance

CASE STUDY

North West Regional Rehabilitative Care Program- Outreach Team

The model

Provides hospital-based rehabilitative care services (both in person and virtually) in the client's home community where local PT and OT vacancies exist, using local rehabilitation assistants as appropriate and available. The shared care service also supports "generalist" rehabilitation professionals throughout the region with specialized rehabilitation providers for clinical consultation and care management.

Populations served

Usual hospital-based rehabilitation (OT and PT) provision for residents in the North West. Shared care available to Home and Community Care Support Services and primary care rehabilitation providers as well.

Services

PT & OT hospital-based acute, outpatient, and long-term care rehabilitation provided in-person one week/month and virtually remaining weeks. Shared care consultations provided by phone, virtual or in-person as required.

> It is a three-hour drive to go to the next closest rehabilitation facility, which is a long way to go for a half-hour appointment! I would not have traveled.

Outcomes Based on Quintuple Aim

PATIENT EXPERIENCE	POPULATION HEALTH	VALUE/EFFICIENCY	CARE TEAM WELLBEING
Improved Access *(54% clients reported no access to rehab if not provided locally. Reported inability to travel more than 3 hrs. due to winter conditions, cost & family obligations)*	**Improved Access** *(Provided 1039 visits to 347 patients who would have otherwise had no access to rehab)*	**Improved Wait Times** *(89 wait time days reduced for "urgent" outpatient PT)*	**Addressing HHR shortages** *(Provided mentorship to meet regulatory requirements enabling hiring of new graduate physiotherapist)*
Client Satisfaction *(100% client agreement that service was convenient in own community. >50% satisfied with technology & virtual equipment.)*		**Cost Savings** *($21,600 annual cost savings compared to contracted agency)*	**Shared Care Model** *(Reports from remote generalist therapists of reassurance, help, support and comfort in RRCOP program to ask for advice or help)*
			**FY2021-22 – first year of program*

ADVANCING HEALTH EQUITY

Not available for sharing at time of publication

For more information: https://www.rrcp.sjcg.net

The Rehabilitative Care Alliance would be pleased to provide consultation support to Ontario Health Teams to discuss priority populations and explore how rehabilitative care can be integrated as part of a connected health care system. For more information or to contact someone regarding a specific model of care, please email us at info@rehabcarealliance.ca.

For more information, please see the complete white paper: Community-Based Rehabilitation: Providing High-Value Care in the Community.

Endnotes

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