Rehabilitative Care Alliance

Ontario
Local Health Integration Network

Hamilton Niagara Haldimand Brant (HNHB) Rehabilitative Care Alliance (RCA)

May 2017

Kim Young, HNHB LHIN, Advisor Access to Care

Rehabilitative Care Alliance

Outline

- Rehabilitative Care Alliance (RCA)
- Rehabilitative care
- Provincial RCA governance structure
- HNHB RCA governance structure
- HNHB RCA implementation work plan
- HNHB RCA and Patient's First principles
- Adoption of Bedded Definitions Frameworks
- Four Levels of Bedded Rehabilitative Care
- Bedded referral options tools
- Eligibility Criteria
- Bedded rehabilitative care maps and tables
- Referral Decision Tree
- Adoption of the Community Definitions Frameworks
- Two levels of Community Rehabilitative Care
- Eligibility Criteria
- Community Referral Decision Tree
- Community Rehabilitative Care Tools Under Development
- Key documents and contact information

Rehabilitative Care Alliance

Rehabilitative Care Alliance

- The Rehabilitative Care Alliance (RCA) is a provincial collaborative funded by Ontario's 14 LHINs.
- The RCA works with partners across the province to strengthen and standardize rehabilitative care through better planning, performance management and evaluation and by integrating best practices across the care continuum.

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Introduction

What is “Rehabilitative Care”?

“Rehabilitative Care” is a broad range of interventions that result in the improved physical, mental and social wellbeing of those suffering from injury, illness or chronic disease.”

CCC/Rehab Expert Panel – Definitions Working Group, 2011

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Mandate II RCA Governance

QBP TJR Task & Advisory Groups	QBP Hip Fracture Task & Advisory Groups	Definitions & CP Task & Advisory Groups	Outpatient / Ambulatory Task & Advisory Groups	FS/MC / A&R Task & Advisory Groups	System Eval Task & Advisory Groups	LHIN & HSP Leads Advisory Group
Debra Carson Trillium Health Partners	**Roy Butler** St. Joseph's Health Care, London	**Dale Clement** WW CCAC **Mark Edmonds** CW LHIN	**Marie Disotto-Monastero,** Sunnybrook **Michael Gekas,** Sinai Health System **Chris Sulway,** TC LHIN	**Dr. Jo-Anne Clarke,** North East SGS **Carol Halt,** NE LHIN	**Imtiaz Daniel,** OHA **Michelle Collins,** MH LHIN & **Marilee Suter,** CE LHIN	**Mark Edmonds,** CW LHIN & **Andrea Lee,** Health Sciences North

ENABLERS

GTA Rehab Network Secretariat Support (Communication, Stakeholder Engagement, Coordination/Administration, Decision Support etc.)

Contextual/Influencing Initiatives (Assess & Restore, Health System Funding Reform, Integrated Funding Pilots, Coordinated Access, etc.)

Patient/Caregiver Advisory Group

Charissa Levy, RCA Executive Director

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A Virtual HNHB LHIN Rehabilitative Care Alliance ... Engaging Partners

HNHB RCA Governance

HNHB LHIN Leadership Team

Rosalind Tarrant
Director, Access to Care

HNHB Rehabilitative Care Alliance
HNHB LHIN lead: Kim Young
Advisor, Access to Care

Provincial Rehabilitative Care Alliance RCA
(refer to RCA governance structure)

Hamilton	Niagara	Haldimand Norfolk	Brant	Burlington	System Evaluation	HNHB LHIN Advisory Group
Kathryn Leblanc HHSC **Jane Loncke** SJHH	**David Ceglie** HDS **Leanne Hammond** NHS	**Patti Bruder** NGH **Pam Whalen** NGH	**Wendy Pomponio** BCHS **Deb Neale** BCHS	**Cheryl Gustafson** JBH **Christine Hnatiuk** JBH	**Stefan Pagliuso** CSRSN **Erin Kelleher** HHSC	**Kim Young, HNHB LHIN Advisor, Access to Care Task group co-chair members**

ENABLERS

Leverage existing HNHB committees for communication, updates and feedback (Regional Rehabilitation Network [RRN], Patient Flow Steering Committee [PFSC], complex care post implementation steering committee [CCPISC] and Transitional Care Steering Committee.

Contextual/Influencing Initiatives
(Assess & Restore, Health System Funding Reform, Integrated Funding Pilots, Coordinated Access, etc.)

Patient/Caregiver Advisory Group

Kim Young, HNHB LHIN Advisor, Access to Care.

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Implementation HNHB LHIN Work Plan

Mapping Tool

Complete mapping tool of current programs against standard definitions for rehabilitative care.

Bedded and Community
Dec 2015

Alignment Strategies

Identify opportunities / challenges with achieving full alignment with the RCA definitions.

Jan-Mar 2016

Implementation and Adoption

Develop work plan to address strategies identified to support implementation and adoption of new standard definitions.

Dec 2016

Capacity Planning

Utilize standardized rehabilitative care capacity planning framework.

Mar 2017

System Evaluation

Apply standardized system evaluation toolkit.

Mar 2017

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2016-17 HNHB RCA Advisory Direction

Alignment of HNHB RCA priorities with provincial priorities

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Vision – A Truly Integrated Health System through Patients First

The vision for the health care system in Ontario is a higher-performing, better connected, more integrated and patient-centred system for patients and care providers.

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Why Were the Definition Frameworks for Rehabilitative Care Created?

There has been a lack of standardization and clarity across the province regarding…

- The **focus and clinical components** of rehabilitative care across the continuum
- The **eligibility criteria** for levels of rehabilitative care across the continuum

The lack of standardization results in confusion for patients/families and referrers regarding rehabilitative care. It also limits our ability to produce and utilize comparable data thereby compromising our understanding of resource utilization as well as system and patient level outcomes.

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Organizing Rehabilitative Care

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Issue

- Lack of standardized language and definitions
- Lack of knowledge regarding what is rehabilitative care and what to expect
- Lack of consistency related to planning rehabilitative care services

All of the above can impact an individual's ability to access rehabilitative care services.

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Scope of the Definitions Framework for Bedded Levels of Rehabilitative Care

- The definitions for the bedded levels of rehabilitative care reflect the understanding that the focus of rehabilitative care across the 4 levels may vary;
    - For example, where it is a primary focus in Rehabilitation and Activation/Restoration to a more secondary focus in others where the medical complexity of the patient is higher than in other levels in Short and Long Term Complex Medical Management.

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Scope of the Definitions Framework for Bedded Levels of Rehabilitative Care

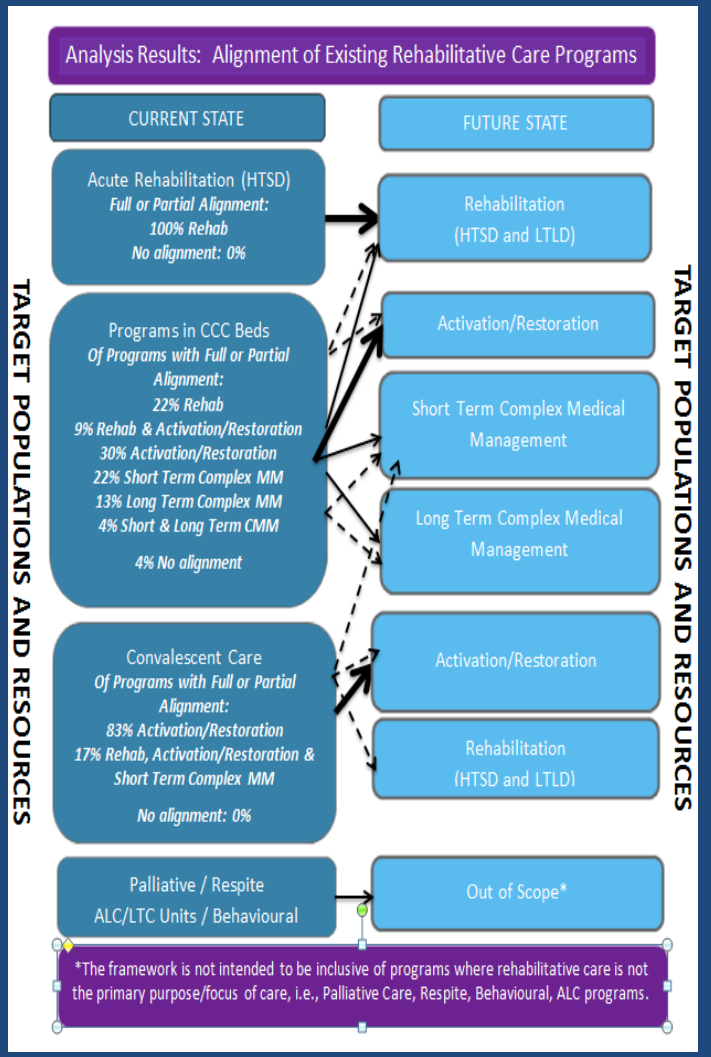
- ***The framework is not intended to be inclusive of all beds within CCC or Acute Care where rehabilitative care is not the primary purpose/focus of care*** (i.e. Palliative Care, Respite, Behavioural programs as well as programs where patients are waiting for an alternate level of care). However, there is recognition that patients within these programs may receive some rehabilitative care for maintenance during their admission.

Bedded Rehabilitative Care provided in Hospital & Long Term Care Homes

Mapping tool results align current programs to the new definitions (right)

- Lack of standardized language
- Lack of knowledge
- Lack of coordination
- Lack of consistency related to planning rehabilitative care services.

All of the above can impact an individual's ability to access rehabilitative care services.



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HNHB LHIN Programs Aligned To Four Bedded Levels of Rehabilitative Care

- Rehabilitation, high and low intensity
- Activation Restoration
- Short-Term Complex Medical Management
- Long-Term Complex Medical Management

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New Bedded Referral Options Tool for Rehabilitative Care

Introduction

The Referral Options for Bedded Rehabilitative Care Programs/Services was developed by the Rehabilitative Care Alliance (RCA) to assist referrers when looking for rehabilitative care programs in bedded levels of care.

This Referral Options tool is a standardized provincial tool that provides information on rehabilitative care provided by Regulated Health Professionals (RHPs) in hospital-based designated inpatient rehab beds, complex continuing care beds and convalescent care beds that fall within the following 4 bedded levels of rehabilitative care:

- Rehabilitation
- Activation/Restoration
- Short Term Complex Medical Management
- Long Term Complex Medical Management

Standardized provincial definitions for each of these levels of rehabilitative care as well as eligibility criteria have been developed by the RCA. Key features of each of the bedded levels of rehabilitative care are described on the next page. The eligibility criteria for bedded levels of rehabilitative care can be found in the Appendix section. For full details, see the complete Definitions Framework for Bedded Levels of Rehabilitative Care.

While this resource was developed as a standardized provincial tool, each LHIN has adapted the tool to provide information on rehabilitative care within its region.

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☒ Rehabilitation	☐ Activation/Restoration	☐ Short-Term Complex Medical Management	☐ Long-Term Complex Medical Management
Functional Goal: *Progression* *Time-limited, coordinated interprofessional rehabilitation plan of care ranging from low to high intensity through a combined and coordinated use of medical, nursing and allied health professional skills.* **Target Population:** Medically stable, able to participate in comprehensive rehabilitation program **Average LOS**: <90 Days **Discharge Indicator:** Rehab goals met, access to MD/nursing care no longer required **Medical Care:** Daily physician access **Nursing Care:** Up to 3 hrs/day. Some may go up to 4 hrs. **Therapy Care:** Direct care by regulated health professionals and as assigned to non-regulated professionals **Therapy Intensity:** 15-30 mins of therapy 3x/day to 3 hrs/day. Based on patient's tolerance.	***Functional Goal:*** *Progression* *Exercise and recreational activities offered to increase strength and independence. Goal achievement does not require daily access to a full interprofessional rehabilitation team & coordinated team approach.* **Target Population:** Medically stable, cognitively and physically able to participate in restorative activities **Average LOS**: (56-72 days) <90 Days **Discharge Indicator:** Rehab goals met, access to MD/nursing care no longer required **Medical Care:** Weekly physician access/follow-up **Nursing Care: <**2 hrs/day **Therapy Care:** Consulted by regulated health professionals, delivered mostly by non-regulated professional as assigned **Therapy Intensity:** Group or 1:1 setting, throughout the day 30 mins or up to 2 hrs/day (5-7 days/week).	***Functional Goal:*** *Stabilization & Progression* *Medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient.* **Target Population:** Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support. On admission, may have limited physical and/or cognitive capacity due to medical complexity but believed to have restorative potential. **Average LOS**: Up to 90 Days **Discharge Indicator:** Medical/functional recovery to allow patient to safely transition to next level of rehab care or alternate environment **Medical care:** Access to scheduled physician care/daily medical oversight **Nursing Care:** >3hrs /day **Therapy Care:** Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professionals as assigned. **Therapy Intensity:** Up to 1 hr, as tolerated by the patient	***Functional Goal:*** *Maintenance* *Medically complex and specialized services over an extended period of time to maintain/slow the rate of, or avoid further loss of, function* **Target Population:** Medically complex with long-term illnesses/disabilities, requiring on-going medical/nursing support that cannot be met at home or in a LTCH **Average LOS**: Will remain at this level **Discharge Indicator:** Patient is designated to be more or less a permanent resident in the hospital and will remain until medical/functional status changes **Medical care:** Access to weekly physician follow up/oversight – up to 8 monitoring visits per month **Nursing Care:** >3hrs /day **Therapy Care:** Regulated health professionals to maintain/maximize cognitive, physical, emotional, functional abilities. Supported by non-regulated health professional as assigned. **Therapy Intensity:** Regulated health professional available to maintain and optimize functional abilities.

Bedded Referral Option Tools Developed For Each Sub Region

Hamilton Niagara Haldimand Brant (HNHB)

Local Health Integration Network (LHIN) Sub-Regions as follows:

- Hamilton
- Niagara
- Niagara North West
- Haldimand Norfolk
- Brant
- Burlington

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Eligibility Criteria for Bedded Levels of Rehabilitative Care

- The patient has **restorative potential**. That is, there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's/client's:
  - Premorbid level of functioning
  - Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
  - Ability to participate in and benefit from rehabilitative care within the context of the patient's/client's specific functional goals and direction of care needs

Note 1: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression and delirium should not be used in isolation to influence a determination of restorative potential.

Note 2: While some patients being considered for Long Term Complex Medical Management may not be expected to undergo functional improvement, the restorative potential of patients can be considered from their ability to benefit from rehabilitative care (i.e. maintaining, slowing the rate of or avoiding further loss of function).

…Cont'd

Eligibility Criteria for Bedded Levels of Rehabilitative Care (cont'd)

And

- The patient is **medically stable** such that s/he can be safely managed with the resources that are available within the level of rehabilitative care being considered. There is a clear diagnosis for acute issues; co-morbidities have been established; there are no undetermined acute medical issues (e.g. excessive shortness of breath, congestive heart failure); vital signs are stable; medication needs have been determined; and there is an established plan of care. However, some patients (particularly those in the Short and Long Term Complex Medical Management levels of rehabilitative care) may experience temporary fluctuations in their medical status, which may require changes to the plan of care.

…Cont'd

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Eligibility Criteria for Bedded Levels of Rehabilitative Care (cont'd)

And

- The patient/client has identified goals that are specific, measurable, realistic and timely;

And

- The patient/client is able to participate in and benefit from rehabilitative care (i.e., carry-over for learning) within the context of his/her specific functional goals (See note);

  Note: Patients being considered for short term complex medical management may not demonstrate carry-over for learning at the time of admission, but are expected to develop carry-over through the course of treatment in this level of care.

And

- The patient's/client's goals/care needs cannot otherwise be met in the community.

...Cont'd

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Bedded Rehabilitative Care Maps and Tables

- Bedded Rehabilitative Care Maps and Tables Developed
  - HNHB LHIN level
  - For Each Sub-region of the HNHB LHIN
    - Hamilton
    - Niagara
    - Niagara North West
    - Haldimand Norfolk
    - Brant
    - Burlington

*Refer to RCA maps and tables presentation for further detail.

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Bedded Rehabilitative Care Program Partners

St. Joseph's Healthcare Hamilton

Hotel Dieu Shaver Health and Rehabilitation Centre

Norfolk General Hospital

Joseph Brant Hospital

Brant Community Healthcare System
The Willett, Paris
The Brantford General

Shalom Village

Pleasant Manor
serving seniors with excellence, love and dignity

Haldimand War Memorial Hospital

wellington park care centre

Hamilton Health Sciences

niagarahealth
Extraordinary Caring. Every Person. Every Time.

Hamilton Niagara Haldimand Brant CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires

Dundurn Place Care Centre

Niagara Region

St. Joseph's Villa Dundas

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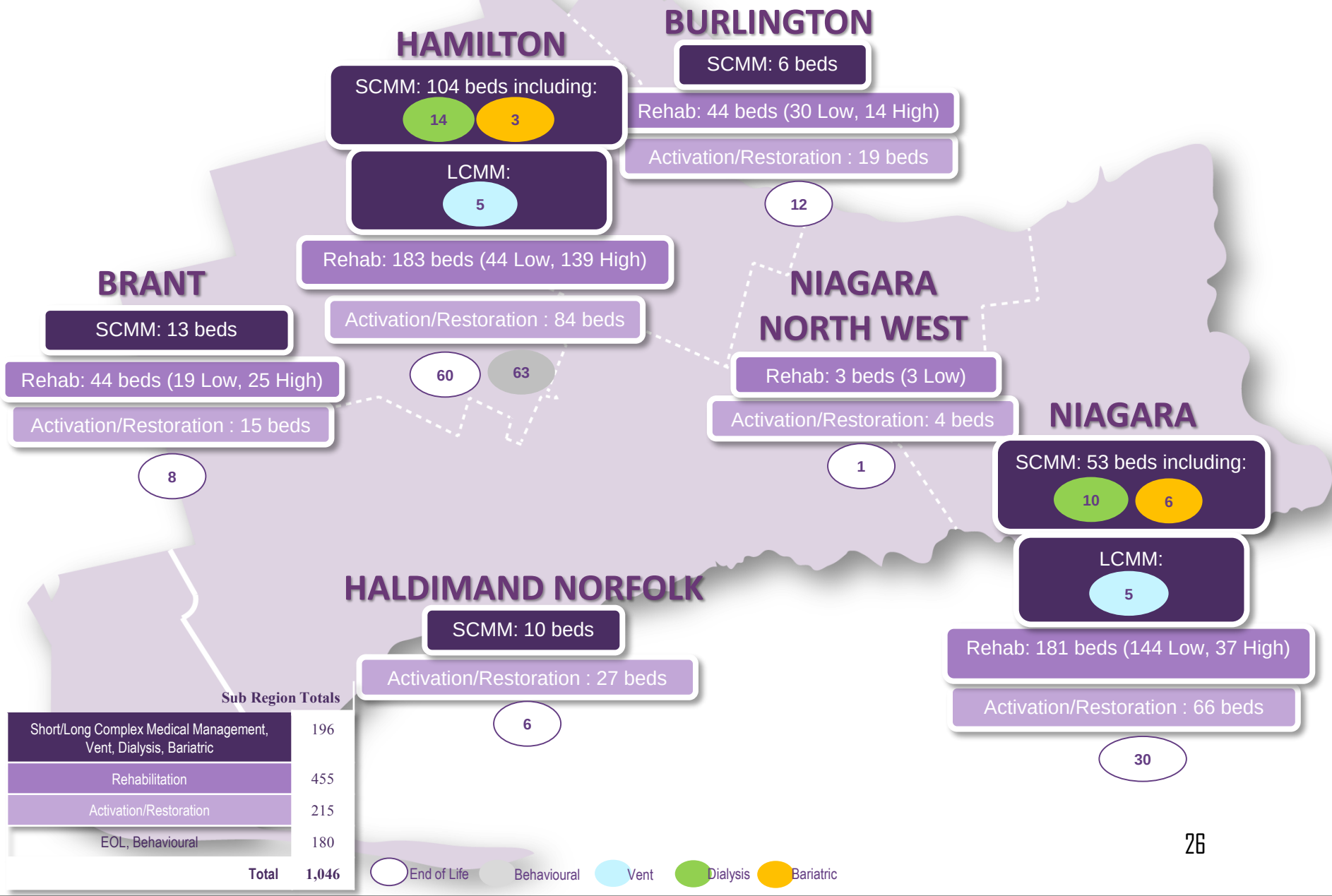
HNHB LHIN Sub-Region Totals (as of April 1, 2017)



Sub Region Totals	
Short/Long Complex Medical Management, Vent, Dialysis, Bariatric	196
Rehabilitation	455
Activation/Restoration	215
EOL, Behavioural	180
Total	**1,046**

End of Life Behavioural Vent Dialysis Bariatric

HNHB LHIN Current State Bedded Level of Rehabilitative Care (as of April 1, 2017)

Location	Total	Short & *Long Term Complex Medical Management				Rehabilitation		Activation/ Restoration
		SCMM	Vent	Dialysis	Bariatric	Low Intensity	High Intensity	
JBH	50	6				30	14	
*SJHH	66	24	*5	14	3		20	
HHS	233	63				47	119	4
SPH	107	63				44		
Juravinski	45						45	
Regional Rehab	74						74	
WLMH	7					3		4
HDS	129	10				68	37	14
*NHS	144	27	*5	10	6	76		20
DMH	35	10				22		3
GNG	40	10			3	26		1
PCG	40	7			1	18		14
*WHS	29		*5	10	2	10		2
NGH	23	6						17
BCHS	72	13				19	25	15
HWMH	14	4						10
Dundurn Place	28							28
Linhaven	20							20
Shalom Village	15							15
St. Joseph's Villa	41							41
WPCC	19							19
Pleasant Manor	12							12
LHIN TOTAL	**866**	**153**	***10**	**24**	**9**	**240**	**215**	**215**

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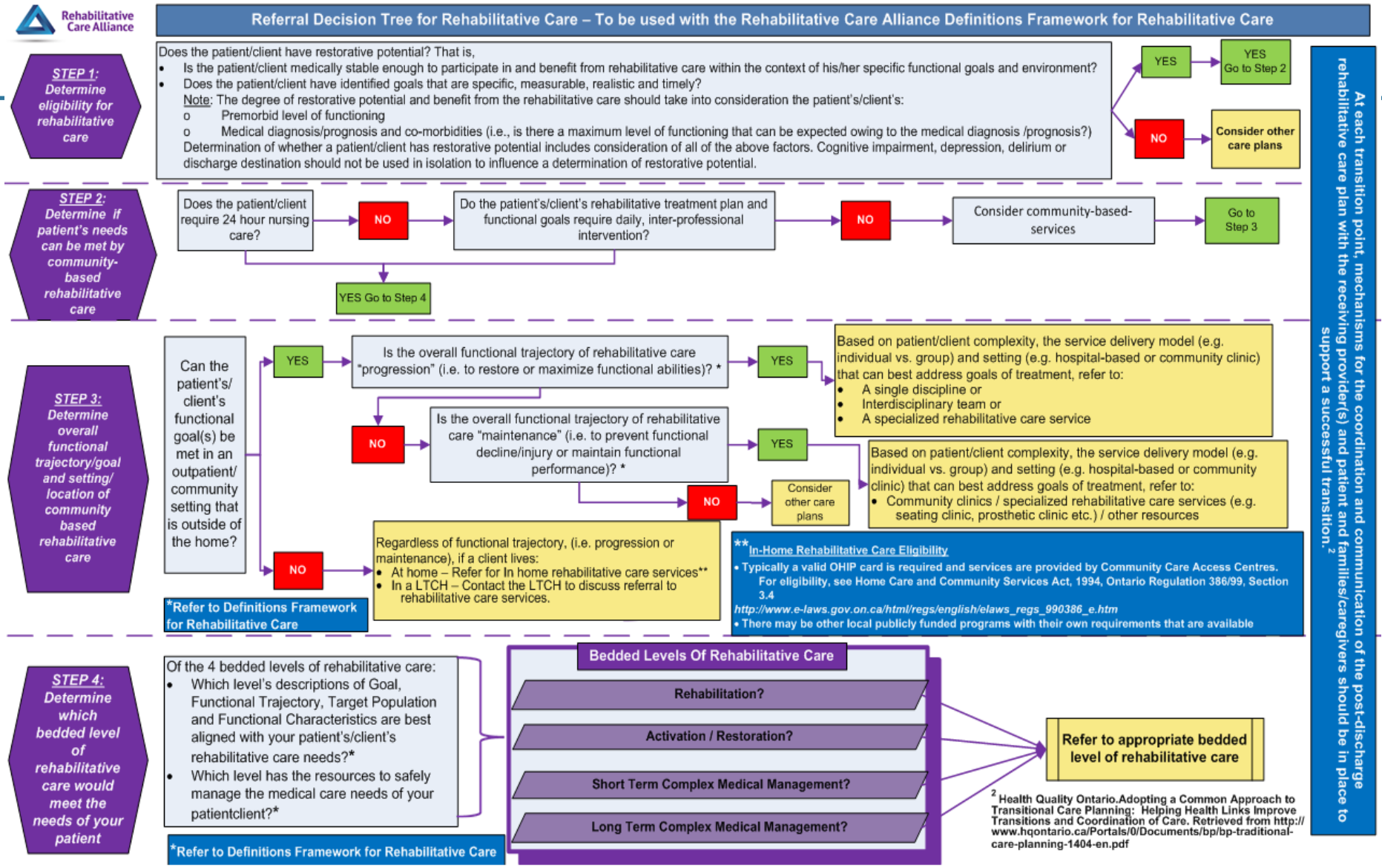
Referral Decision Tree

(Available at from http://rehabcarealliance.ca/definitions-1)

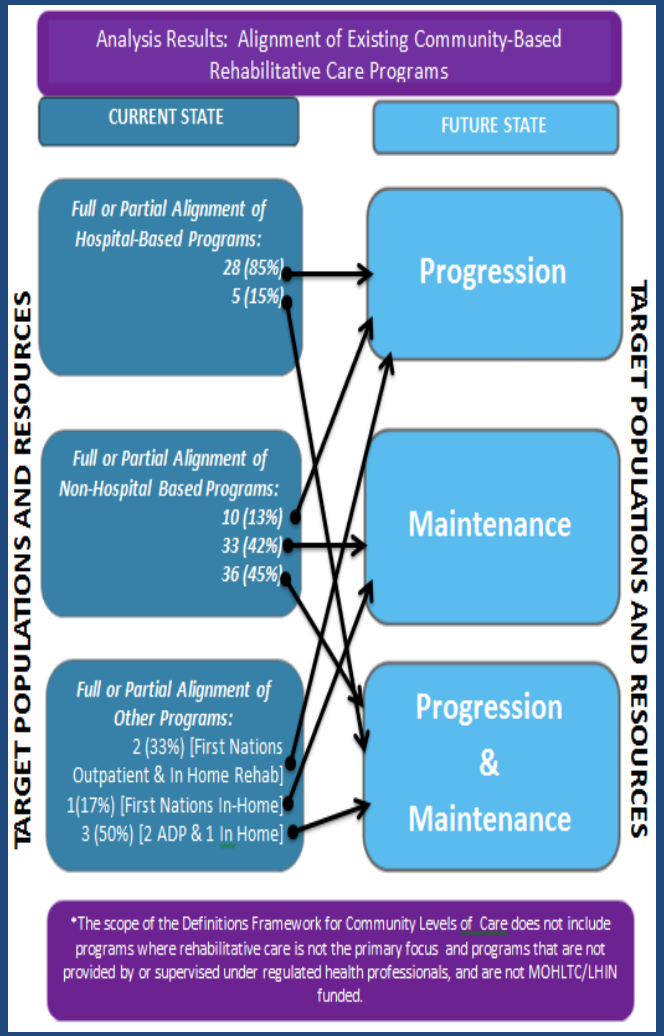


Community Rehabilitative Care

Mapping tool results align current programs to the new definitions (right)

- Lack of standardized language
- Lack of knowledge
- Lack of coordination
- Lack of consistency related to planning rehabilitative care services.

All of the above can impact an individual's ability to access rehabilitative care services.



HNHB LHIN Programs Aligned To Two Community Levels of Rehabilitative Care

- Progression
- Maintenance
- Some HNHB LHIN community rehabilitative care programs provide both progression and maintenance

☐ Key Features of Both Progression & Maintenance Focused Rehabilitative Care*

Healthcare Professionals: Provided by or under the supervision of a minimum of one regulated health professional or by an integrated, inter-professional team of regulated health professionals in individual or group format to maximize community integration.

Transition Indicator: Rehab goals met or reasonably equivalent gains can be achieved independently or with caregiver or through self-care/wellness/health promotion classes or plateau has been reached

Medical Care: Medical care/management may be provided by a primary care practitioner (e.g. Family Physician, Nurse Practitioner) as well as by those focused on rehabilitative care (e.g. physiatrists, geriatricians, paediatricians and/or other specialists)

☐ Key Features of Progression-Focused Rehabilitative Care

Functional Goal: *To provide assessment and time limited treatment through a single service or coordinated, inter-professional approach to restore or maximize functional abilities, promote adaptation of/to home, support timely transition from or prevent admission to acute or rehab hospital or to provide opportunity to learn/practice in a familiar, stimulating and supportive environment*

Target Population: Individuals who after acute episodes or worsening of symptoms have decreased function and require rehabilitative care to achieve functional goals, increase self-management skills and maximize community reintegration. Individuals who do not require a bedded level of care.

☐ Key Features of Maintenance-Focused Rehabilitative Care

Functional Goal: *To prevent functional decline/injury or maintain functional performance (e.g. strength, mobility, balance, falls prevention etc.) through individual assessment/treatment and/or periodic assessment/oversight of care plan by regulated health professional/team*

Target Population: Individuals with reduced physical, cognitive and/or speech-language functioning (e.g. neuromuscular, musculoskeletal and cardio-respiratory etc.) who require rehabilitative care to prevent a decline in functional status and/or to promote their capacity to remain at home. Individuals include those living in the community (home, retirement homes, LTCHs) who have functional goals that can be met by participating in group intervention, which could include falls prevention classes.

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Eligibility Criteria for Community-Based Rehabilitative Care

The community-based levels of rehabilitative care within this framework are to be applied to patients/clients who meet the following eligibility criteria:

- The patient/client has restorative potential *and*
- The patient/client is medically stable enough such that s/he is able to participate in and benefit from rehabilitative care (i.e., carry-over for learning) within the context of his/her specific functional goals; *and*
- The patient/client has identified goals that are specific, measurable, realistic and timely.

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Eligibility Criteria for Community-Based Rehabilitative Care

Definition of Restorative Potential

- Restorative Potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's/client's:
  - Premorbid level of functioning
  - Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
  - Ability to participate in and benefit from rehabilitative care within the context of the patient's/client's specific functional goals and direction of care needs

Note: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression and delirium should not be used in isolation to influence a determination of restorative potential.

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Under Development: Community Rehabilitative Care Tools

- Community referral option tool provincial template; currently under development, draft completed.
- Community rehabilitative care maps and tables; draft HNHB LHIN maps and tables completed.
- Community referral options tool by sub region to be developed once provincial template is finalized and released.

RCA Definitions Framework for Community-Based Levels of Rehabilitative Care

(Available at http://rehabcarealliance.ca/definitions-1)

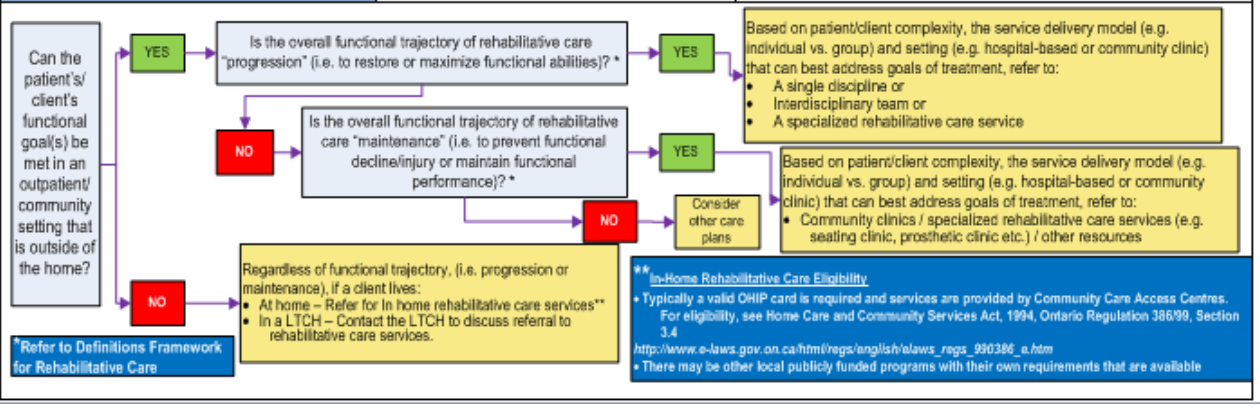
CONCEPTUAL DEFINITIONS FRAMEWORK FOR COMMUNITY LEVELS OF REHABILITATIVE CARE (Draft)

These definitions pertain to publicly-funded programs (i.e. LHIN or MOHLTC funded) with a primary rehabilitative care focus provided by or under the supervision of regulated health professionals.

Part A: Determine which level of community-based rehabilitative care would meet the needs of the patient/client

Functional Trajectory		Progression	Maintenance
Level of Care - Goal			
Patient Characteristics	Target Population / Functional Characteristics		
	Transition Indicator		
Medical / Healthcare Professionals	Medical Care		
	Nursing/Therapy Care		
Reporting Tools			

Part B: Determine location of community-based rehabilitative care



Wellness/Health Promotion Post-Rehabilitation Community Reintegration*

- Wellness/health promotion programs provided by non-regulated health professionals * after illness/injury to halt/slow disease process, help individuals manage health problems and to support community re-integration
- These programs should be considered by providers within the defined levels of rehabilitative care when discharge planning and transitioning clients to self-management activities.

*Note: While wellness focused health promotion/prevention programs that are not provided by or supervised under regulated health professionals are beyond the scope of the Definitions Framework for Community Levels of Rehabilitative Care, it is acknowledged that such programs play an important role in the system by promoting overall health and supporting patients' reintegration into the community. Examples of these programs include: Group exercise; wellness promotion classes; swimming; walk-fit; yoga; Tai-Chi; Pilates; peer support and friendly visiting programs.

Note: The full Referral Decision Tree is included on slide 28

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"It's amazing what you can accomplish if you do not care who gets the credit"

Harry S. Truman

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Key Documents

Rehabilitative Care Alliance Definitions Framework for Community Based Levels of Rehabilitative Care

http://rehabcarealliance.ca/uploads/File/Final_Report_2013-15/Definitions/Def_Framework_for_Community_Based_Levels_of_Rehabilitative_Care__Final_March_2015_.pdf

Rehabilitative Care Alliance Definitions Framework for Bedded Levels of Rehabilitative Care

http://rehabcarealliance.ca/uploads/File/Toolbox/Definitions/Definitions_Framework_for_Bedded_Levels_of_Rehabilitative_Care__FINAL_Dec_2014_.pdf

Rehabilitative Care Alliance Eligibility Criteria for Bedded Levels of Rehabilitative Care

http://rehabcarealliance.ca/uploads/File/Toolbox/Definitions/EligibilityCriteria_Definitions_.pdf

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Help the Provincial RCA Keep You Informed

Consider subscribing to receive the provincial RCA quarterly newsletter 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.

Thank you!

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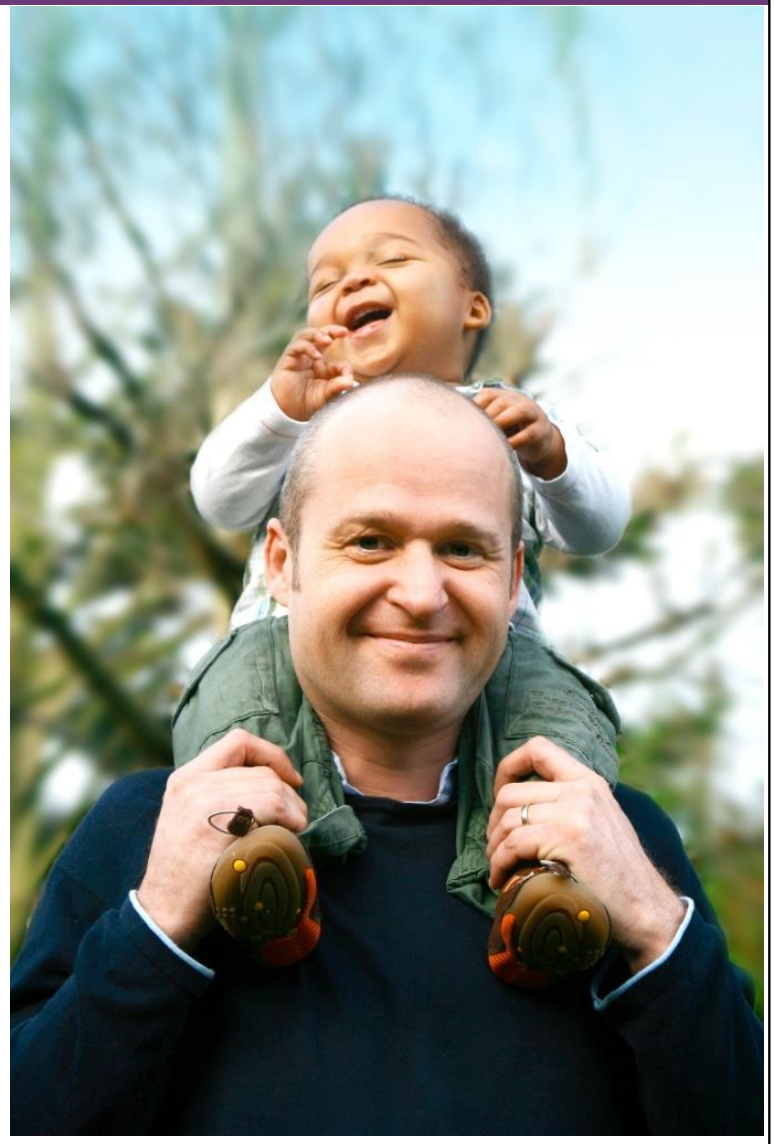

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