Rehabilitative Care Alliance

Ontario
Local Health Integration Network

Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) Rehabilitative Care Alliance (RCA)

HNHB LHIN Communication Webinar

Kim Young, HNHB LHIN, Advisor, Planning

August 22, 2018 12:00 – 1:00 p.m.

For audio, you must call in by phone:

Toll Free: 855-392-2520

Access Code: 8716134 (conference ID)

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How to participate in the webinar

- For audio, you must call in by phone:
  Toll Free: 855-392-2520
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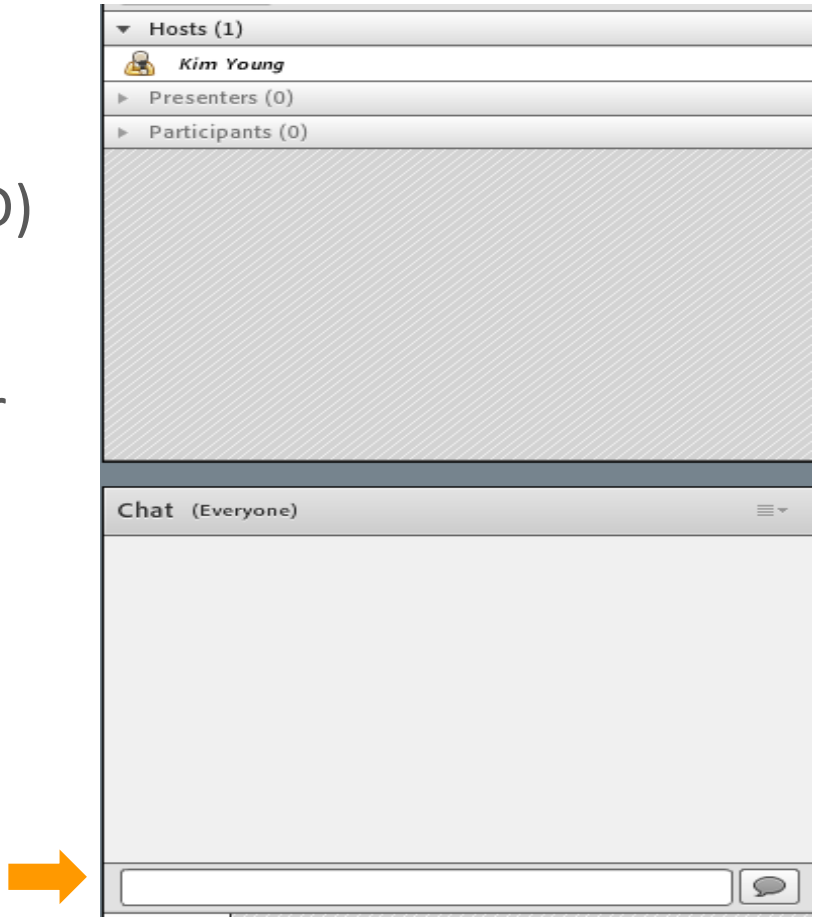
- All lines will be muted to avoid background noise due to the number of participants
- Questions may be entered into the chat function here for discussion



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Agenda

- Brief overview of the RCA
- Rationale for Definitions Frameworks for Rehabilitative Care
- Understanding the Definitions Frameworks for Rehabilitative Care
  - Key Features
  - Implementation
- HNHB LHIN Referral option tools
  - Bedded
  - Community
- RCA naming convention
- HNHB LHIN Rehabilitative Care Web page
- Appendix: Resources to determine where does the person fit?
  - Bedded levels of rehabilitative care
  - Community-based levels of rehabilitative care
  - Development of definitions framework

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Brief overview of the RCA Provincial and HNHB LHIN

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- The Rehabilitative Care Alliance (RCA) is a provincial collaborative that was established by Ontario's 14 LHINs in April 2013. With an initial two-year mandate it was created to effect positive changes in rehabilitative care through a focus on supporting improved patient experiences and enhancing the adoption and effectiveness of clinical and fiscal priorities.

- A renewed two-year and three-year mandate has supported ongoing work from April 2015 – March 2019.

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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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Provincial RCA Mandate III 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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Mandate III HNHB LHIN RCA Vision

- Imagine what we can achieve together in rehabilitative care when we are responsive to patients and families and have expectations to optimize outcomes and improve access to rehabilitative care.

http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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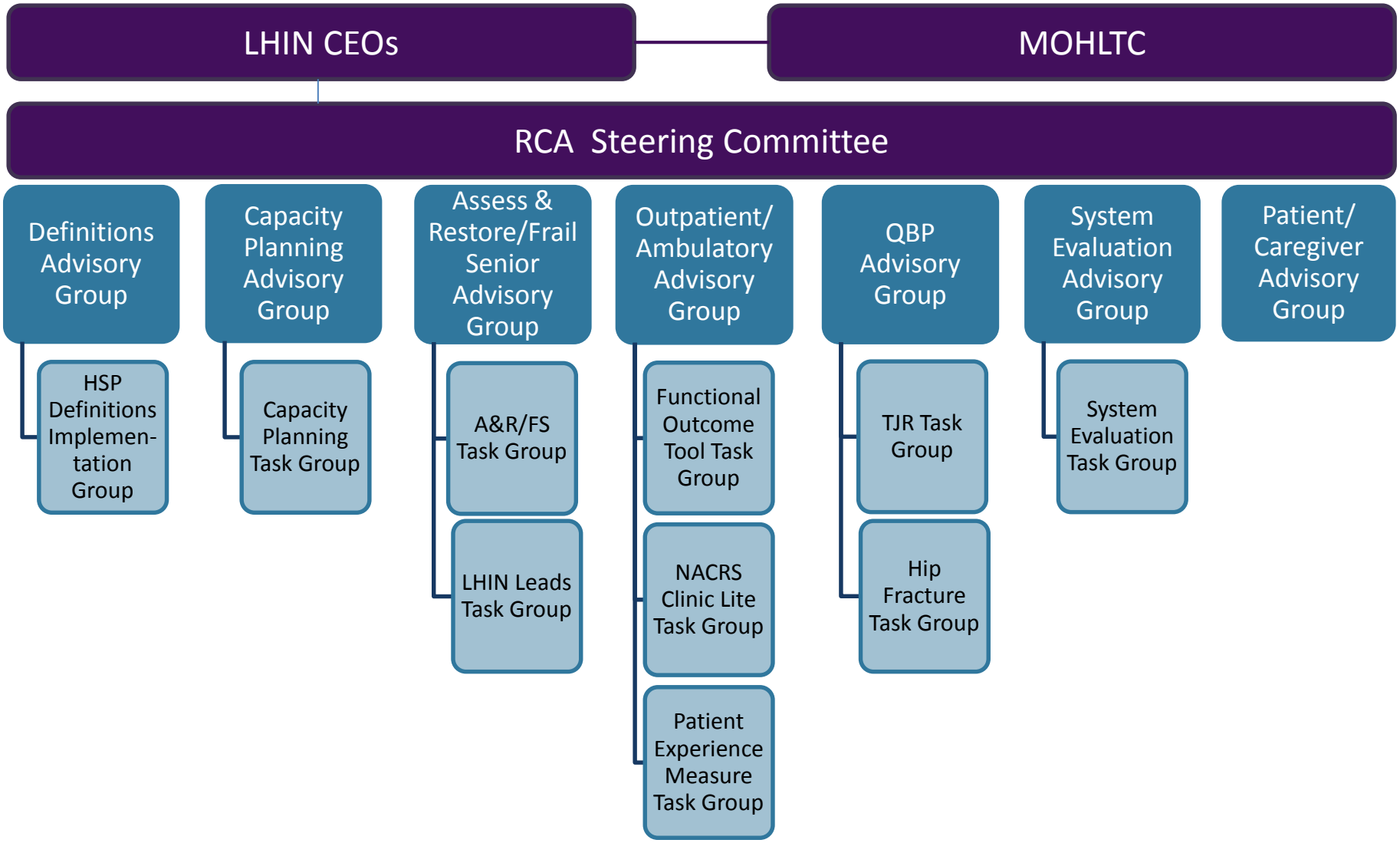
Provincial RCA Governance Structure Mandate III: 2017-2019



Meeting frequency will be determined by the work plan. Groups may need to meet more or less frequently in order to achieve the deliverables of this mandate

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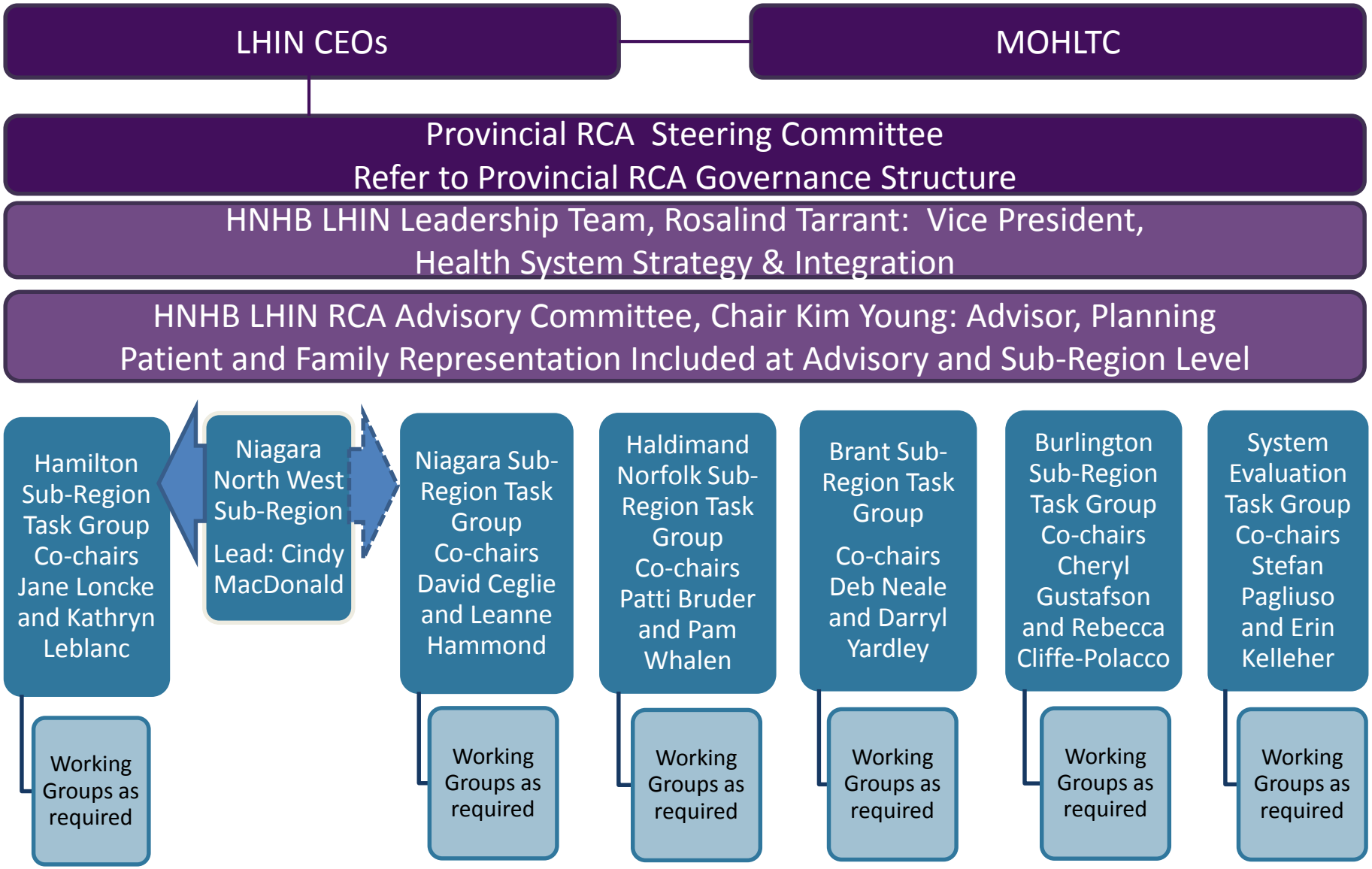
HNHB LHIN RCA Governance Structure Mandate III: 2017-2019



Meeting frequency will be determined by the deliverables; groups may need to meet more or less frequently in order to achieve the deliverables mandate III.

Meeting Frequency:

- Quarterly: Steering Committee
- Monthly: Advisory Committee and Sub-Region Task Groups
- Ad hoc: Working Groups

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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

HNHB LHIN Work Plan April 2017-March 2019

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Systems Evaluation

Systems evaluation group to develop HNHB LHIN specific report card for provincial priority indicators based on provincial report card to drive improved outcomes.

Capacity Planning

HNHB LHIN to adopt simplified provincial approach to CP

HNHB LHIN lead participate on provincial CP working and advisory group and test simplified approach.

Sub-Region planning

Community Referral Option Tool completion

HNHB LHIN RCA to link with sub-region directors to integrate and refine RCA work related to overall sub-region planning.

Patient and Family Advisory

Co-design rehabilitative care capacity plan together with patients and families. Communication Plan. Thesis work to focus on co-designing rehabilitative care.

Re-Evaluate

Evaluate the implementation of the new standardized definitions utilizing provincial RCA evaluation framework.

Demonstrate change.

http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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Rationale for the Definitions Frameworks

Work of the RCA Supports the MOHLTC 10-Point Plan to Strengthen Home & Community Care

Create a Levels of Care Framework

- ***MOHLTC to create a Levels of Care Framework*** *to ensure services and assessments are consistent across the province. Will be an easily accessible way for the public to understand the level of care they can expect. Represents a significant system-wide improvement, addressing service and information gaps.*
- **RCA's Standardized Bedded & Community Definitions Framework for Levels of Rehabilitative Care:**
  - Establishes provincial standards for levels of rehabilitative care
  - Provides clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care programs
  - Describes what should be provided to guide planning for bedded and community-based rehabilitative care services.

Patients First: A Roadmap to Strengthen Home and Community Care, May 2015
http://www.health.gov.on.ca/en/public/programs/ccac/roadmap.pdf

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Definitions

LHIN implementation of the RCA Definitions Frameworks for Bedded & Community-Based Levels of Rehabilitative Care including:

- LHIN-level adoption of new terminology, eligibility criteria and re-categorization of rehabilitative care resources according to the levels of rehabilitative care in the Definitions Frameworks

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Rehabilitative Care Before

Lack of standardization and clarity across the province regarding:

- The **focus and clinical components** of rehabilitative care
- The **eligibility criteria** for rehabilitative care

- Confusion for patients/families & referrers
- Limited ability to produce and understand data on resource utilization compromising our understanding of system and patient level outcomes.

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Definitions Frameworks for Levels of Rehabilitative Care

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Key Features

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Definitions Frameworks

Definitions provide …

A shared understanding among patients, families and referring professionals on the levels of rehabilitative care including:

- a definition of restorative potential
- eligibility criteria
- goals of care
- patient/client characteristics
- medical/health care resources
- intensity of therapy for each level

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Bedded Levels of Rehabilitative Care

DEFINITIONS FRAMEWORK FOR BEDDED LEVELS OF REHABILITATIVE CARE					
Bedded Levels of Rehabilitative Care (i.e. Hospital-based designated inpatient rehab beds and complex continuing care beds as well as convalescent care/restorative care beds within LTCH)					
		Rehabilitation (Low to high intensity)	***Activation/ Restoration***	***Short Term Complex Medical Management***	***Long Term Complex Medical Management***
Functional Trajectory		Progression	Progression	Stabilization & Progression	Maintenance
Level of Care - Goal					
Patient Characteristics	***Target Population***				
	Functional Characteristics				
	Estimated Average LOS				
	Discharge Indicator				
Medical/Allied Health Resources	***Medical Care***				
	Nursing Care				
	Therapy Care				
	Intensity of Therapy				
Reporting Tools					

The full framework is available at http://rehabcarealliance.ca/definitions-1

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What do the Definitions mean for us?

Level of Care	Acute	Short-Term Complex Medical	Rehabilitation	Activation / Restoration	Long-Term Complex Medical
Care objective	• Achieve medical stability • Limit loss of function	• Enhance & maintain medical stability • Avoid further loss of function	• Provide & deliver a rehabilitation plan of care ranging from low to high intensity	• Promote activity • Increase strength, endurance, independence and ability to manage ADL's	• Supportive care and maintenance of functional status
Need for active medical management	HIGHEST				LOWEST
Nursing and ADL care needs					
Therapy					
			HIGHEST		

Source: www.rehabcarealliance.ca
Modified by Helen Johnson, ESC LHIN Rehabilitation Lead

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Definitions Frameworks

1. **Definitions Framework for Bedded Levels of Rehabilitative Care**
    - Hospital-based inpatient rehab beds / some complex continuing care beds / convalescent care beds
        - Does not include beds within CCC where rehabilitative care is not the primary purpose/focus of care (e.g., Palliative Care, Respite, Behavioural programs, ALC units)

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Definitions Frameworks

2. **Definitions Framework for Community-Based Levels of Rehabilitative Care**
   - LHIN or MOHLTC-funded programs with a primary rehabilitative care focus provided by or under the supervision of regulated health professionals.
   - Includes programs with a primary rehabilitative care focus towards progression or maintenance of functional status.

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Referral Decision Tree for Rehabilitative Care – To be used with the Rehabilitative Care Alliance Definitions Framework for Rehabilitative Care

STEP 1: Determine eligibility for rehabilitative care

Does the patient/client have restorative potential? That is,
- Is the patient/client medically stable enough to participate in and benefit from rehabilitative care within the context of his/her specific functional goals and environment?
- Does the patient/client have identified goals that are specific, measurable, realistic and timely?

Note: The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's/client's:
- o Premorbid level of functioning
- o 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?)

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

YES → YES Go to Step 2

NO → Consider other care plans

STEP 2: Determine if patient's needs can be met by community-based rehabilitative care

Does the patient/client require 24 hour nursing care? → NO → Do the patient's/client's rehabilitative treatment plan and functional goals require daily, inter-professional intervention? → NO → Consider community-based-services → Go to Step 3

Do the patient's/client's rehabilitative treatment plan and functional goals require daily, inter-professional intervention? → YES Go to Step 4

STEP 3: Determine overall functional trajectory/goal and setting/ location of community based rehabilitative care

Can the patient's/ client's functional goal(s) be met in an outpatient/ community setting that is outside of the home?

YES → Is the overall functional trajectory of rehabilitative care "progression" (i.e. to restore or maximize functional abilities)? *

- YES → Based on patient/client complexity, the service delivery model (e.g. individual vs. group) and setting (e.g. hospital-based or community clinic) that can best address goals of treatment, refer to:
  - A single discipline or
  - Interdisciplinary team or
  - A specialized rehabilitative care service
- NO → Is the overall functional trajectory of rehabilitative care "maintenance" (i.e. to prevent functional decline/injury or maintain functional performance)? *
  - YES → Based on patient/client complexity, the service delivery model (e.g. individual vs. group) and setting (e.g. hospital-based or community clinic) that can best address goals of treatment, refer to:
    - Community clinics / specialized rehabilitative care services (e.g. seating clinic, prosthetic clinic etc.) / other resources
  - NO → Consider other care plans

NO → Regardless of functional trajectory, (i.e. progression or maintenance), if a client lives:
- At home – Refer for in home rehabilitative care services**
- In a LTCH – Contact the LTCH to discuss referral to rehabilitative care services.

*Refer to Definitions Framework for Rehabilitative Care

**In-Home Rehabilitative Care Eligibility
- Typically a valid OHIP card is required and services are provided by Community Care Access Centres. For eligibility, see Home Care and Community Services Act, 1994, Ontario Regulation 386/99, Section 3.4

http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_990386_e.htm
- There may be other local publicly funded programs with their own requirements that are available

STEP 4: Determine which bedded level of rehabilitative care would meet the needs of your patient

Of the 4 bedded levels of rehabilitative care:
- Which level's descriptions of Goal, Functional Trajectory, Target Population and Functional Characteristics are best aligned with your patient's/client's rehabilitative care needs?*
- Which level has the resources to safely manage the medical care needs of your patientclient?*

*Refer to Definitions Framework for Rehabilitative Care

Bedded Levels Of Rehabilitative Care
- Rehabilitation?
- Activation / Restoration?
- Short Term Complex Medical Management?
- Long Term Complex Medical Management?

→ Refer to appropriate bedded level of rehabilitative care

[2] Health Quality Ontario.Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care. Retrieved from http://www.hqontario.ca/Portals/0/Documents/bp/bp-traditional-care-planning-1404-en.pdf

At each transition point, mechanisms for the coordination and communication of the post-discharge rehabilitative care plan with the receiving provider(s) and patient and families/caregivers should be in place to support a successful transition.[2]

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Community-Based Levels of Rehabilitative Care – Part A

	CONCEPTUAL DEFINITIONS FRAMEWORK FOR COMMUNITY LEVELS OF REHABILITATIVE CARE			
Part A: *Determine which level of community-based rehabilitative care would meet the needs of the patient/client*	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.			
	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			

Note:

- Wellness/health promotion programs provided by non-regulated health professionals are beyond the scope of the framework. However, these programs help individuals manage health problems and support community re-integration and should be considered by providers when discharge planning and transitioning clients to self-management activities.

▲ **Detailed definitions for each cell available at http://rehabcarealliance.ca/definitions-1**

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Definitions Frameworks for Levels of Rehabilitative Care

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Implementation

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Implementation Means:

1.
- Programs have been re-categorized according to the levels of rehabilitative care

2.
- Admission criteria for rehabilitative care programs are aligned with the Eligibility Criteria and Definition of Restorative Potential

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Implementation Means:

3.

- The standardized RCA naming convention has been applied to rehabilitative care programs

4.

- RCA resources/tools have been customized to reflect programming in the HNHB LHIN

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HNHB LHIN Referral Option Tools Bedded and Community

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Referral Options Resources for Bedded & Community-Based Levels Rehabilitative Care

Bedded Levels of Rehabilitative Care			
Rehabilitation	**Activation/Restoration**	**Short-Term Complex Medical Management**	**Long-Term Complex Medical Management**
Functional Goal: *Progression*	***Functional Goal:*** *Progression*	***Functional Goal:*** *Stabilization & Progression*	***Functional Goal:*** *Maintenance*

Publicly-Funded Programs provided by Regulated Health Professionals for Progression (i.e. to restore or maximize functional abilities)			
Outside of Home			**In Home**
Hospital-Based Outpatient Programs/Services	**Community Physio Clinics**	**Other Community Programs/Services**	**In-Home Rehabilitative Care Programs**

Publicly-Funded Programs provided by Regulated Health Professionals for Maintenance (i.e. to prevent functional decline/injury or maintain functional performance)		
Outside of Home		**In Home**
Falls Prevention Programs	**Other Clinics/Services**	**In-Home Rehabilitative Care Programs**

- Resources also provide additional information on eligibility criteria and key features of the levels of rehabilitative care.

www.rehabcarealliance.ca

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RCA maps and Bedded Referral Option Tools (CROT)

- Final Bedded Referral Option Tools (BROT) and RCA maps are posted on HNHB LHIN website by sub-region.
  - Brant
  - Burlington
  - Haldimand Norfolk
  - Hamilton
  - Niagara
  - Niagara North West

http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

Bedded Referral Option Tools (BROT)

HNHB LHIN Sub-Regions	Community Referral Option Tool
Hamilton	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Niagara	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Niagara North West	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Haldimand Norfolk	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Brant	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Burlington	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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

Eligibility Criteria for Bedded Rehabilitative Care

- The patient has restorative potential*, (i.e. 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);

  Note: 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).

  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.[4] 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

  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.

*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, delirium or discharge destination should not be used in isolation to influence a determination of restorative potential.

This checklist highlights the key features of the bedded levels of rehabilitative care to help you determine which level best meets the rehabilitative care needs of your patient. Full descriptions of the levels are available at http://rehabcarealliance.ca/definitions-1

☐ 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. Based on best practice targets and discharge indicator considerations. Rehab team to confirm LOS for specific program. **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.

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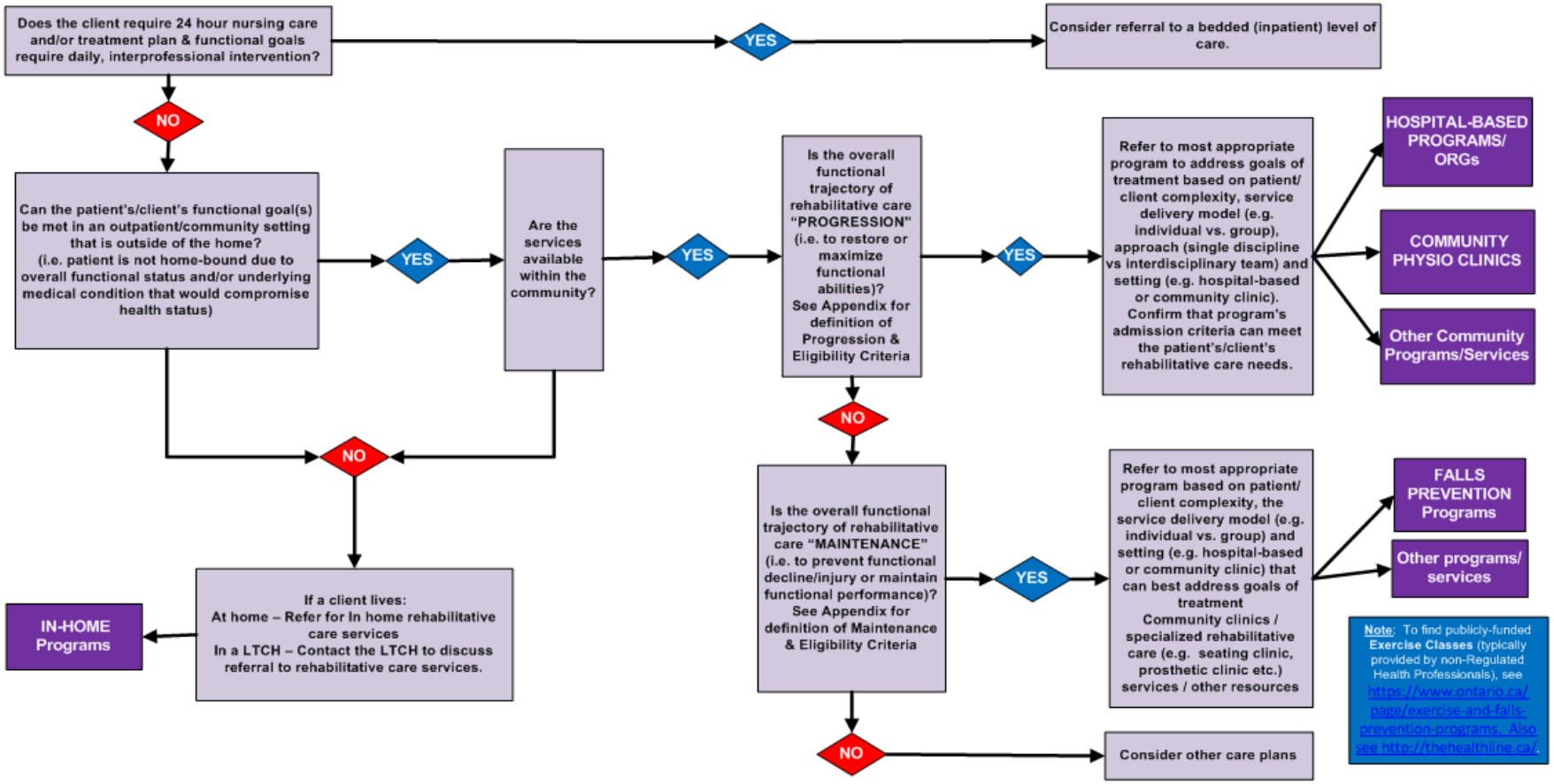
Referral Flowchart For Community-Based Rehabilitative Care*

(MOHLTC/LHIN funded hospital-based outpatient/ambulatory programs, community clinics and in-home programs/services provided by Regulated Health Professionals)



*Refer to the RCA Definitions Frameworks for Rehabilitative Care for comprehensive definitions on levels of rehabilitative care. http://rehabcarealliance.ca/definitions-1

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Referral Options Resource for Community-Based Levels Rehabilitative Care

Rehabilitative Care Program Descriptions and Admission Criteria

Programs provided by Regulated Health Professionals for Progression (i.e. to restore or maximize functional abilities)			
Hospital-Based Outpatient Programs/Services	Community Physio Clinics	Other Community Programs/Services	In-Home Programs

Programs provided by Regulated Health Professionals for Maintenance (i.e. to prevent functional decline/injury or maintain functional performance)			
Falls Prevention Programs	Exercise Classes	Other Clinics/Services (e.g. seating clinics)	In-Home

* Note: The availability of publicly-funded Exercise Classes (typically provided by non-Regulated Health Professionals) is region-specific. For a general overview and links to region-specific programs, see links at https://www.ontario.ca/page/exercise-and-falls-prevention-programs. Also see http://thehealthline.ca/.

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*, (i.e. 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) or s/he requires rehabilitative care to prevent functional decline *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.

***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.

*See http://rehabcarealliance.ca/definitions-1 for the complete Definitions Framework for Bedded Levels of Rehabilitative Care

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Referral Options for Community-Based Levels of Rehabilitative Care

Appendix

☐ 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

*For full details, see http://rehabcarealliance.ca/definitions-1 for the complete Definitions Framework for Bedded Levels of Rehabilitative Care

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RCA maps and Community Referral Option Tools (CROT)

- Final CROT tools and RCA maps posted on HNHB LHIN website.
  - Brant
  - Burlington
  - Haldimand Norfolk
  - Hamilton
  - Niagara
  - Niagara North West

http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

Community Referral Option Tools (CROT)

HNHB LHIN Sub-Regions	Community Referral Option Tool
Hamilton	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Niagara	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Niagara North West	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Haldimand Norfolk	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Brant	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx
Burlington	http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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Wellness Programs (Out of Scope)

- Hamilton wellness programs, Live Well YMCA, added to hnhbhealthline.ca.

http://www.hnhbhealthline.ca/displayService.aspx?id=179814

*CROT Note: The availability of publicly-funded Exercise Classes (typically provided by non-Regulated Health Professionals) is region-specific. For HNHB LHIN programs listed by sub-region, refer to the link below: http://www.hnhblhin.on.ca/goalsandachievements/integrationpopulationbased/olderadultstheirfamiliesandcaregivers/supportingseniorshealthandwellness/ExerciseFallsPrevention.aspx

For a general overview and links to region-specific programs, see links at: https://www.ontario.ca/page/exercise-and-falls-prevention-programs

Also see http://thehealthline.ca/

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Customization of Provincial RCA Resources: HNHB LHIN

- HNHB LHIN customized the Referral Options Tools through an extensive consultative process with stakeholders from across HNHB LHIN sub-regions.

- Customization of the Community Referral Options Tool was particularly challenging given:
  - Multiple community rehabilitative care stakeholders
  - Community rehabilitative care programs have to be assessed individually as well as in relation to one another.
  - Achieving consensus and consistency on:
    - Alignment of similar-type programs across sub-regions.
    - Alignment for programs which may have been aligned with both progression and maintenance levels of rehabilitative care.
    - Which programs to include/exclude given the scope of the definitions framework

http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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Customization of RCA Resources: HNHB LHIN

Consensus was achieved across HNHB LHIN rehabilitative care programs/services related to where programs align with progression:

- All Caring for my Caring for My COPD programs
- All Community Physiotherapy Clinics (CPC) programs
- Single service 1:1 rehabilitative care
- Some OP/AMB clinics aligned with progression
- OT, PT, SLP, Hydrotherapy
- Swallowing clinics
- Amputee therapy program
- Hand therapy
- The HNHB LHIN customized RCA Referral Options Tools:
  http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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Customization of RCA Resources: HNHB LHIN

Consensus was achieved across HNHB LHIN rehabilitative care programs/services related to where programs align with maintenance:

- All Regional aphasia programs
- All Falls prevention programs
- Some OP/AMB clinics aligned with maintenance
- Cardiac rehabilitation
- Spasticity management
- Pain management
- The HNHB LHIN customized RCA Referral Options Tools: http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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RCA Naming Convention

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Using the RCA Standardized Naming Convention

The standardized naming convention:

- Minimizes variation in descriptors and provides a shared understanding of rehabilitative care.
- Will be used for reporting and navigation purposes in future (e.g., Access to Care Wait Time Information System-ALC reporting; in navigation tools such as Rehab Finder; Resource Matching &Referral systems).
- Is applied at the front end of existing program names.

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RCA Standardized Naming Convention

Bedded Programs

Rehabilitation:	• Low Intensity Rehab • High Intensity Rehabilitation
Activation / Restoration:	• Convalescent Care (governed by LTCH Legislation) • Activation/Restoration (hospital-based programs)
Complex Medical Management:	• Short Term Complex Medical Management • Long Term Complex Medical Management

Community-Based Programs

Progression:	• Name of program/service
Maintenance:	• Name of program/service

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RCA Standardized Naming Convention

Steps for Applying the Standardized RCA Naming Convention

Bedded Rehabilitative Care

All bedded programs will be named according to the following steps:

1. Name the level of Rehabilitative Care
2. For the Rehabilitation Level:
   a. Indicate high or low intensity (as applicable)
   b. Indicate rehab population (if applicable).
3. For the Activation Level:
   a. Indicate Convalescent Care or Hospital-based program
4. For the Short Term and Long Term Complex Medical Management levels, only step 1 is required.

Example:

Current Name		Renamed:
MSK Rehabilitative Care	---------->	Rehabilitation: High Intensity – MSK
Restorative Care Program	---------->	Activation/Restoration: Restorative Care Program

Community-Based Rehabilitative Care

Categorize the program under its level of rehabilitative care (i.e., progression, maintenance or both progression and maintenance).
No need to change the descriptive program name.

Example:

Current Name		Renamed:
Day Treatment	---------->	Progression: Day Treatment Program

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Where does my patient fit?

- Refer to provincial RCA webinar slides and audio for a review of the following:
  - Bedded rehabilitative Care
  - Rehabilitation vs. Activation/Restoration
  - Short and Long Term Complex Medical Management
  - Community-Based Levels of Rehabilitative Care
  - Progression versus Maintenance

- http://rehabcarealliance.ca/webinars
- Refer to appendix slides for additional detail

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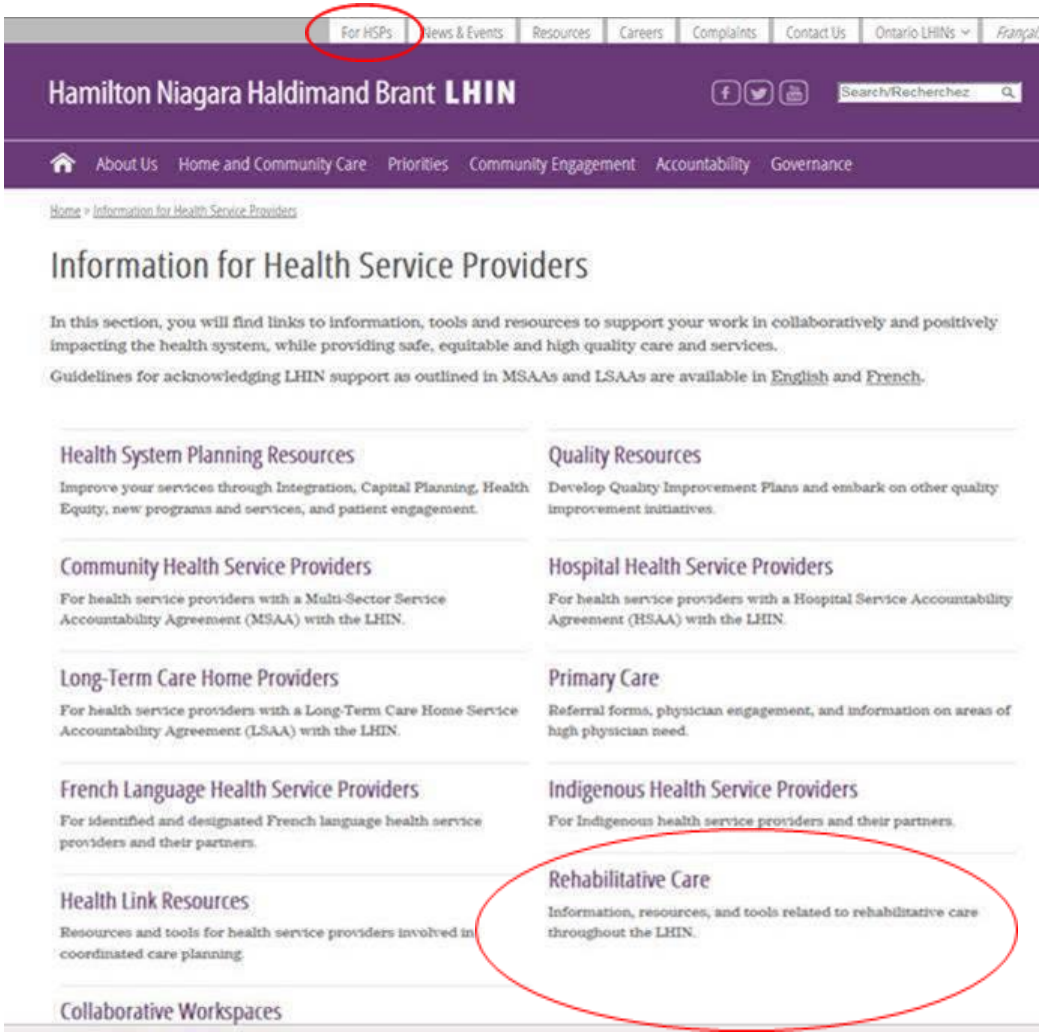
Communication

HNHB LHIN: Rehabilitative Care Web Page



HNHB LHIN website: http://www.hnhblhin.on.ca/

Select 'For HSPs' tab from along the top menu (white tabs above the purple header).

Select 'Rehabilitative Care'

Webpage updates: send to kim.young@lhins.on.ca

http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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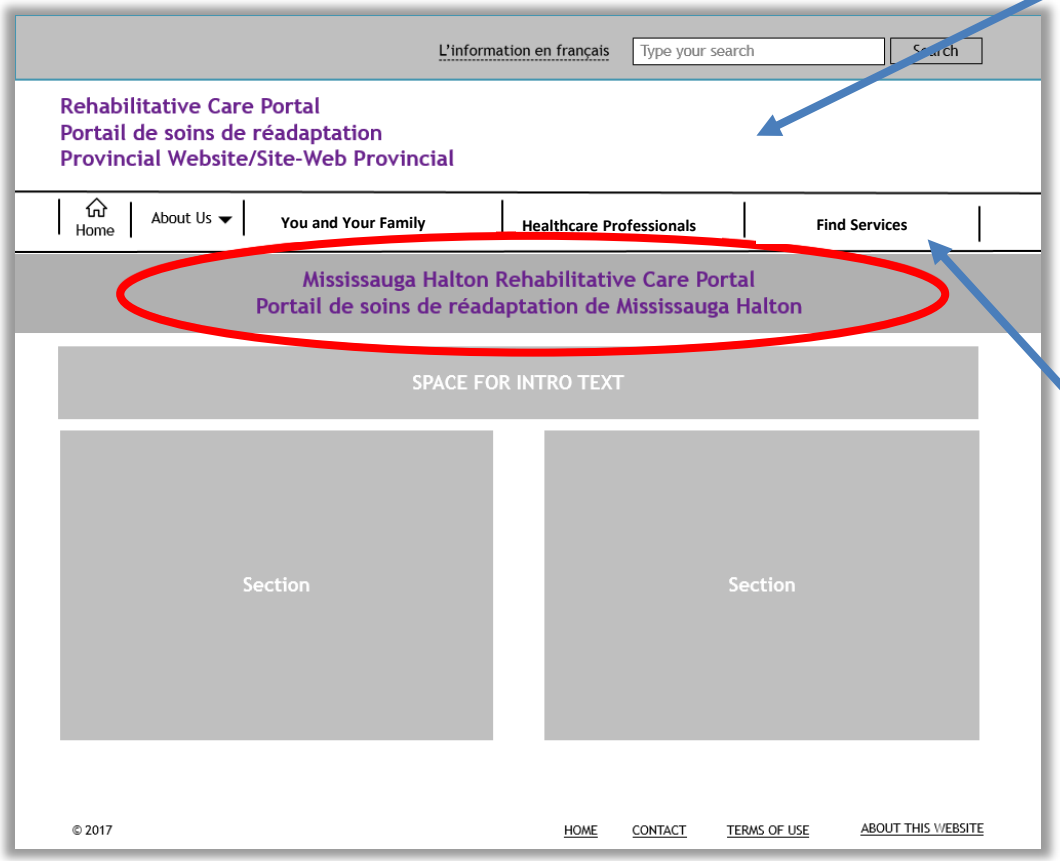
Provincial Rehabilitative Care Portal – *WHAT WOULD IT LOOK LIKE?*



Regional page with tabs containing custom content, custom page copy, images, events

Regional services

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

Harry S. Truman

http://www.hnhblhin.on.ca/forhsps/Rehabilitative%20Care.aspx

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Questions?

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Please enter questions/comments in the chat window of the webinar

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Feedback

• • •

Please complete feedback survey:

https://www.surveymonkey.com/r/R6VWPS3

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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

Rehabilitative Care Alliance Referral Decision Tree
http://rehabcarealliance.ca/uploads/File/Toolbox/Definitions/Referral_Decision_Tree_for_Rehabilitative_Care_FINAL__Dec_11_2014_.pdf

Formatting Guideline for Referral Options Resources
http://rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/Definitions/Format_Guideline_July_2017.pdf

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Stay Informed

Sign up to receive:

- RCA newsletter
- Announcements of new resources/tools
- Opportunities to engage in RCA initiatives

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

Please encourage others in your organization to sign up, in order to stay informed about the work of the Rehabilitative Care Alliance

Thank you!

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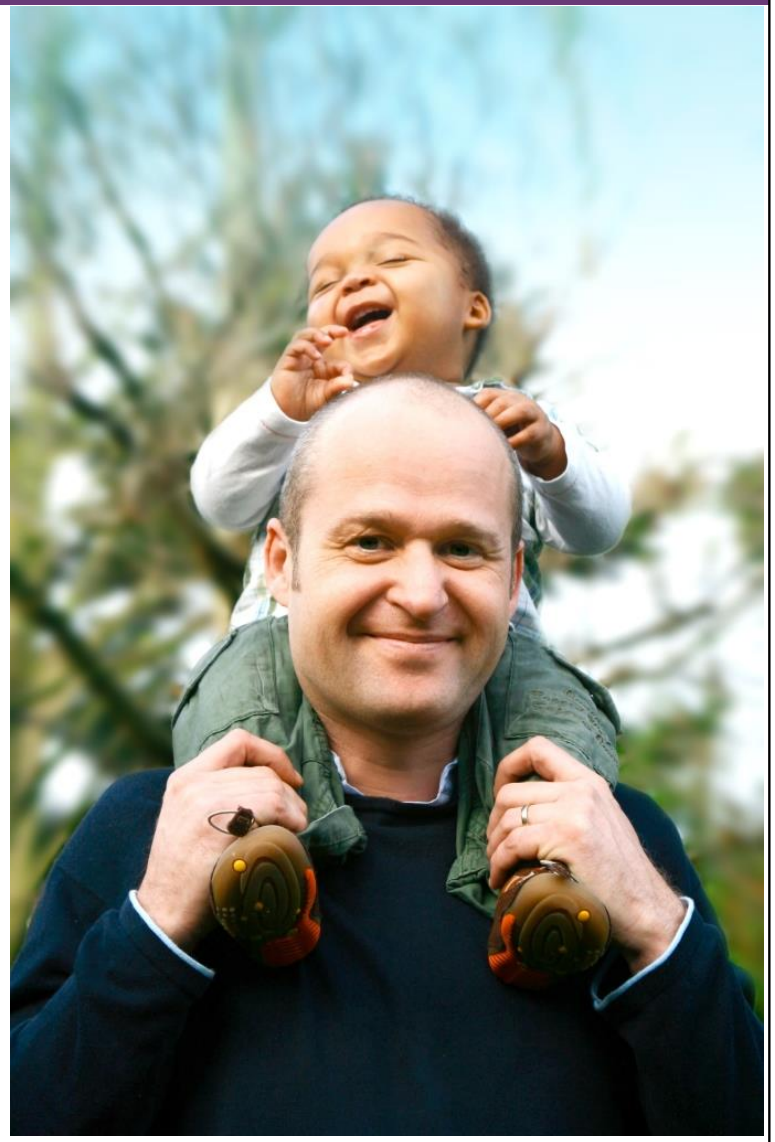
@HNHB_LHINgage

www.youtube.com/HNHBLHIN

www.hnhblhin.on.ca



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Appendix

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Bedded Levels of Rehabilitative Care

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Rehabilitation vs. Activation/Restoration

Where does the patient fit?

Rehabilitative Care Alliance

Functional Trajectories/Goals

	Rehabilitation (Low to high intensity)	***Activation / Restoration***
Functional Trajectory	Progression	
Level of Care - Goal	To develop and provide ***a time limited coordinated, inter-professional rehabilitation plan of care*** ranging ***from low to high intensity*** *Uses* ***a combined and coordinated use of medical, nursing and allied health professional skills.***	To ***promote activity, increase strength, endurance, independence and ability to manage activities of daily living*** by providing access to therapies with a focus on restoring function. *Uses* ***functional practice opportunities, wellness and self-care activities*** that support the return of patients to their previous living environment or other appropriate community environment.

Rehabilitative Care Alliance

Target Population

	Rehabilitation (Low to high intensity)	*Activation / Restoration*
Target Population	Pts are medically stable with ***significant functional impairments*** and require and are able to participate in a ***comprehensive inter-professional rehabilitation program*** at a low to high intensity to enhance functional & cognitive ability.	Pts are medically stable and ***physically and cognitively able to participate in restorative activities* designed to enable pts to return home by increasing their strength, endurance and ability to manage ADLs*** following an acute care hospital stay or admission from the community *Assistance with walking and self care and participate in individual and/or group exercise programs, recreational activities and group dining

Rehabilitative Care Alliance

Functional Characteristics

	Rehabilitation (Low to high intensity)	*Activation / Restoration*
Functional Characteristics	Achievement of goals requires: • ***daily interventions*** • ***frequent/ daily re-assessment by regulated health professionals*** • ***a coordinated team approach by a dedicated/in-house interprofessional team of Regulated Health Professionals***	Achievement of goals primarily addressed through: • ***exercise*** • ***recreational activities.*** Goal achievement **does not require** daily access to a comprehensive, interprofessional rehabilitation team using a coordinated team approach.

Rehabilitative Care Alliance

Functional Characteristics

	Rehabilitation (Low to high intensity)	***Activation / Restoration***
Functional Characteristics	Although the patient's initial functional tolerance may fluctuate, the patient has the ***cognitive ability and the physical tolerance to participate in and progress through low or higher intensity rehabilitation***  Pts are expected to return to their previous living environment or other appropriate community environment	Although the patient's functional tolerance may fluctuate, the patient has the ***cognitive ability and physical tolerance to participate in restorative activities*** provided at an intensity available at this level of care  Patients are expected to have a discharge location, typically home. Some patients could be preparing for active rehabilitation before returning home.

Rehabilitative Care Alliance

Medical and Nursing Care

	Rehabilitation (Low to high intensity)	***Activation / Restoration***
Medical Care	Physician assessment on admission 24/7 on-call physician	
	Access to <u>daily</u> physician or applicable alternate designate assessment is available if needed	***Access to <u>weekly</u> physician follow-up/oversight***
Nursing Care	Typically, requires ***<u>up to 3 hours</u> nursing care per day***; however, some patients may require up to 4 hours per day	Requires ***nursing care <u>≤ 2 hours/day.</u>***

Rehabilitative Care Alliance

Therapy Care

	Rehabilitation (Low to high intensity)	*Activation / Restoration*
Therapy Care	**Direct daily therapy** (in alignment with treatment plan and patient tolerance) is **provided by regulated health professionals within a dedicated, interprofessional team model of care** with expertise in rehabilitation populations. Establishment of achievable treatment goals, the **daily/frequent assessment and documentation of the functional status of patients and the occurrence of regular case discussion amongst treating practitioners**.	**Delivered largely by non-regulated health professionals, who may or may not be under the direction/supervision of a regulated health professional** to provide programming for restoration/activation

Rehabilitative Care Alliance

Therapy Care

	Rehabilitation (Low to high intensity)	***Activation / Restoration***

Therapy Care	The interprofessional team of ***regulated health professionals*** should include:
	• clinical dietitian,
	• discharge planner (as filled by: social worker, discharge planner/coordinator, patient flow coordinator, etc.),
	• nurse,
	• occupational therapist,
	• pharmacist,
	• physiotherapist,
	• physiatrist and/or geriatrician,
	• social worker,
	• speech-language pathologist.
	
	Ideally, ***consultation*** is available from all of the following professionals:
	Chaplain/pastoral care provider, chiropodist, psychiatrist and/or geriatric psychiatrist, psychologist and/or neuropsychologist, recreation therapist, neurologist and wound care specialist.
		• Delivered largely by ***non-regulated health professionals, who may or may not be under the direction/supervision of a regulated health professional***
		• On-site therapy resources are limited to:
		  ○ Physiotherapy (limited to providing an exercise program of 15 min/day on a 1:1 basis)
		  ○ Non-regulated Activation / Recreational staff
		  ○ Nursing
		  ○ Social worker
		  ○ Dietitian
		  ○ Occupational Therapy and Speech Language Therapy may be available on a consultation basis.

Rehabilitative Care Alliance

Intensity of Therapy Care

	Rehabilitation (Low to high intensity)	*Activation / Restoration*
Intensity	To accommodate differing levels of tolerance among patients on admission and increases in tolerance during the inpatient stay, the **intensity of rehab may vary from low to high intensity (from at least 15 – 30 minutes of therapy 3x per day to 3 hours per day) up to 7 days per week.**  Ideally therapy hours are increased as the patient's tolerance increases to achieve all patient goals.	Restorative activities may be provided in a group or 1:1 setting throughout the day **(i.e. 30 minutes or up to 2 hours per day) 5 – 7 days per week**

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High vs. Low Intensity Rehab

- Determination of whether the patient is appropriate for high or low intensity would depend on consideration of:
  - Activity tolerance level to participate in therapy in terms of minutes per day and number of days per week
  - Length of stay to achieve rehab goals
  - Best practice guidelines
  - Availability of rehabilitative care resources in high vs. low intensity programs

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Short and Long Term Complex Medical Management

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Where does the patient fit?

Rehabilitative Care Alliance

Functional Trajectories/Goals

	Short Term Complex Medical Management	*Long Term Complex Medical Management*
Functional Trajectory	Stabilization & Progression	Maintenance
Level of Care - Goal	To provide medically complex and specialized services ***to avoid further loss of function, increase activity tolerance and progress patient*** so that the patient may be able to go home OR may be able to be discharged to another level of (rehabilitative) care wherever possible.	To provide medically complex and specialized services over an extended period of time ***to maintain, slow the rate of or avoid further loss of function*** where "in the opinion of the attending physician, the patient requires chronic/complex continuing care and is, and will continue to be more or less a permanent resident in the hospital".*

* MOHLTC, Hospital Complex Continuing Care (CCC) Co-payment, Questions and Answers, Resource to LHINs and Hospitals, Updated May 2010.

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Target Population

	Short Term Complex Medical Management	*Long Term Complex Medical Management*
Target Population	Pts are medically complex, with long-term illnesses or disabilities typically requiring: ○ Ongoing medical / nursing support ○ Skilled, technology-based care not available at home or in long-term care facilities. ○ Assessment and active care management by specialized inter-professional teams.	
	On admission, pts typically have limited physical and/or cognitive capacity to engage in a rehabilitative care program due to medical complexity.  ***However, it is believed that the patient has restorative potential and that this level of care will provide the opportunity to optimize restorative potential where possible*** and assess the patient's rehabilitative care needs following further stabilization of medical condition.	
	May require access to a physician on a 24/7 on-call basis	

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Functional Characteristics

	Short Term Complex Medical Management	*Long Term Complex Medical Management*
Functional Characteristics	Patients are ***medically stable*** (although the patient may be at risk for an acute exacerbation) such that there is: • a clear diagnosis/prognosis; • co-morbidities have been established; • no undetermined acute medical issue(s) (e.g. excessive shortness of breath, congestive heart failure); • vital signs are stable; • medication needs have been determined; • an established plan of care; ***Some patients may experience temporary fluctuations in their medical status, which may require changes to medications/plan of care***.	

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Functional Characteristics

	Short Term Complex Medical Management	*Long Term Complex Medical Management*
Functional Characteristics	Pts require skilled nursing and medical care that cannot be met on an ongoing basis in other levels of rehabilitative care  ***Pts for whom it is anticipated as their medical condition and tolerance improves, that they will be able to engage in limited rehabilitative activities***	Pts require skilled nursing and medical care that cannot be met on an ongoing basis in LTC or other community setting  ***Pts for whom it is anticipated, due to limited physical and/or cognitive capacity, that the degree of additional functional gain will be low***

Rehabilitative Care Alliance

Estimated LOS and Discharge Indicator

	Short Term Complex Medical Management	*Long Term Complex Medical Management*
Estimated LOS*	Up to 90 days	Will remain in this level because the patient's functional status/medical care needs cannot be met in the community.
	*The rehabilitative care team in the bedded program will inform patients after admission about the anticipated length of stay of the specific program to which the patient has been admitted.	
Discharge Indicator	***Medical/functional recovery so as to allow patient to safely transition to the next level of rehabilitative care or an alternative level of care environment.***	***The patient is designated to be more or less a permanent resident in the hospital and will remain until the medical/functional status changes*** so as to allow the patient to safely transition to another level of care or to the community.
	Note At each transition point, ***mechanisms for the coordination and communication of the post-discharge rehabilitative care plan*** with the receiving provider(s) and patient and families/caregivers should be in place to support a successful transition.	

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Medical and Nursing Care

	Short Term Complex Medical Management	*Long Term Complex Medical Management*
Medical Care	Physician assessment on admission 24/7 on-call physician	
	Access to ***scheduled physician care/daily medical oversight as clinically necessary***	Access to ***weekly physician follow-up/oversight.*** Up to 8 monitoring visits per month.
Nursing Care	Requires ***nursing care > 3 hours/day***	

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Therapy Care & Intensity

	Short Term Complex Medical Management	*Long Term Complex Medical Management*
Therapy Care	***Regulated health professionals available to maintain and maximize cognitive, physical, emotional and functional abilities through limited rehabilitative activities**** *e.g. regain sitting balance, improve upper extremity strength and coordination, increase transfers and functional mobility, assess and train patient/caregiver on optimal positioning, learning how to sequence activities through functional tasks, self-care with assistance, being up/walking for short periods	***Regulated health professionals are available to maintain and optimize cognitive, physical, emotional and functional abilities***
Intensity	***Up to 1 hour of rehabilitative activities*** as tolerated based on the patient's medical condition/ tolerance.	***Regulated health professionals*** are available to maintain and optimize cognitive, physical, emotional and functional abilities.

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Community-Based Levels of Rehabilitative Care

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Where does the patient fit?

Rehabilitative Care Alliance

Key Features:
Progression & Maintenance Focused Rehab

Healthcare Professionals:

Provided by or under the supervision of a

regulated health professional

or

by an integrated, inter-professional

team of

regulated health professionals

individual or group format

to maximize community integration.

Rehabilitative Care Alliance

Key Features:
Progression & Maintenance Focused Rehab

Transition Indicator:

Rehab goals met

or

reasonably equivalent gains can be achieved independently or with caregiver or self-care/wellness/health promotion classes

or

plateau has been reached

Medical Care:

Medical care/management may be provided by:
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)

Rehabilitative Care Alliance

Key Features: Progression-Focused Rehab

Functional Goal:

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/rehab hospital

or

to provide opportunity to learn/practice in a familiar, stimulating and supportive environment

Rehabilitative Care Alliance

Key Features: Progression-Focused Rehab

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.

Rehabilitative Care Alliance

Key Features: Maintenance-Focused Rehab

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 individual regulated health professional or interprofessional/team.

Rehabilitative Care Alliance

Key Features: Maintenance-Focused Rehab

Target Population:

Individuals with reduced 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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Development of Definitions Frameworks

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Approach and standardized definitions/criteria for eligibility, restorative potential, medical stability, goals

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Definition Frameworks - Approach

- The frameworks were developed using a clinical lens and the "80-20 rule" to reflect the needs of most patients
- The frameworks are not population-specific – foundational documents

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Standardized Eligibility Criteria: Definition of Restorative Potential

(bedded and community-based programs)

There is reason to believe (based on clinical assessment, 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.

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Standardized Eligibility Criteria: Definition of Restorative Potential (bedded and community-based programs)

Determination of restorative potential includes consideration of all of the following patient factors:

1. Premorbid level of functioning
2. 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)
3. 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

Cognitive impairment, depression and delirium should not be used in isolation to influence a determination of restorative potential.

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Standardized Eligibility Criteria: Medical Stability - Bedded

This means, the patient:

- Can be safely managed within the level of rehabilitative care being considered.
- Has a clear diagnosis for acute issues
- All acute medical issues and medication needs determined
- Has an established plan of care

Some patients (e.g., 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.

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Standardized Eligibility Criteria: Goals & Ability to Participate (bedded & community-based programs)

This means, the patient:

- Has identified goals
- 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

Patients being considered for short term complex medical management might 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.