

Collective voice for rehab Actionable solutions Collaboration and partnerships Advancing best practices Improving service delivery Ensuring equitable access System-wide planning Collective voice for rehab Actionable solutions Collaboration and partnerships Advancing best practices Improving service delivery Ensuring equitable access System-wide planning Collective voice for rehab Actionable solutions Collaboration and partnerships

Strategic Plan 2010 – 2013



GTA REHAB
NETWORK

rehab Actionable solutions Collaboration and partnerships Advancing best practices

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Executive Summary

The GTA Rehab Network, celebrating its 10th anniversary in 2009, takes pride in a range of accomplishments over its first ten years. The collaborative efforts of its members have resulted in evidence-based rehab program definitions, practice guidelines for referral and discharge, tools for improving system access and transitioning across the continuum of care, and forums for sharing innovation and best practices. The Network has contributed substantially to redesigning and streamlining care processes for stroke and musculoskeletal patients. It has also been instrumental in collaborating for system change through policy and planning initiatives in the Toronto area Local Health Integration Networks (LHINs).

Ontario’s healthcare system has undergone a number of changes in recent years and many of the changes are important to the Network’s future. The establishment of the LHINs, the articulation of several health system priorities, the emphasis on accountability and performance measurement, and the attention to collaboration and partnership provide a new context for the future priorities of the Network.

Over 2009, the Network instituted a review and consultation process to revisit its strategic plan and refresh the strategies, goals and activities for 2010 to 2013. The Network’s new vision, mission, strategic directions and goals provide the roadmap for the Network’s activities over the next three years.

GTA Rehab Network Strategic Plan 2010 -2013

Vision

An integrated healthcare system in which patients have equitable and timely access to the highest quality rehabilitation services.

Mission

Together as partners, we strengthen the organization and delivery of rehabilitation services through all healthcare sectors by promoting innovation and best practices, developing tools, guidelines and measures for performance improvement, and leading system integration.

Strategic Directions	Goals
1. Champion and help shape health system change, bringing expert knowledge in rehabilitation	1-1 Engage with healthcare providers and policy leaders to advance health system changes that optimize the impact of rehabilitation interventions on patient outcomes and system efficiency. 1-2 Advise on, and promote the role of, rehabilitation in health services delivery through active engagement with LHIN-led and other initiatives.
2. Continually improve the quality of, and access to, rehabilitation services	2-1 Expand the development of general policies and practice guidelines that optimize patient flow through rehab and complex continuing care. 2-2 Enhance the quality of, and increase timely access to, post-acute rehab care for specific medically complex patient populations.

Strategic Directions	Goals
	2-3 Pursue initiatives to support smooth transitioning from pediatric to adult rehabilitation services.
	2-4 Explore the role of outpatient rehabilitation programs within the care continuum and link to Network initiatives in targeted areas, i.e., stroke and MSK.
3. Lead the development and application of measures for rehabilitation services planning and performance improvement	3-1 Move forward on establishing and applying standard rehabilitation program definitions. 3-2 Develop a rehabilitation performance measurement framework.
4. Promote best practices and knowledge exchange	4-1 Expand mechanisms for identifying, sharing and promoting best practices across the continuum of care. 4-2 Further the Network’s role in supporting knowledge translation – bringing new knowledge to clinical practice.

In addition to the above strategies and goals, the Network identified the importance of renewing its governance model and format, as well as finding alternative mechanisms to optimize member engagement as the Network moves forward in all areas.

Several immediate priorities are targeted for attention in the first year to lay important groundwork for larger system initiatives:

- Begin a planning process to address the access and care needs of patients hospitalized due to hip fracture.
- Continue to work with partners to analyze and improve the Resource Matching and Referral (RM&R) system.
- Complete evidence-based rehab definitions, program standards and self-assessments for remaining populations.
- Conduct a survey of member organizations to better understand the current supply, utilization of, and access to outpatient rehab services.
- Begin to develop a performance measurement framework for rehabilitation, leveraging currently available data and indicators.
- Connect with clinical rehabilitation researchers in Toronto and other Ontario university centres to explore possible collaborations for knowledge translation.

The GTA Rehab Network continues to function as a catalyst for system change by focusing on the importance of rehabilitation interventions across the full care continuum. The Network has built a strong foundation of success and is well placed to continue to make substantial contributions to “an integrated healthcare system in which patients have equitable and timely access to the highest quality rehabilitation services.”

Introduction

The GTA Rehab Network marked its 10th anniversary in 2009. We have much to be proud of. Looking back to the days prior to the Network, rehabilitation services were disparate across organizations and isolated from each other. Over these past 10 years, Network members have collaborated to develop uniform rehabilitation service definitions, guidelines for referral and discharge, and tools for improving system access, while strengthening the coordination and transition for patients through acute, rehabilitation and outpatient services. We have raised the bar significantly on sharing innovation and best practices for rehab and continue to provide an expert resource to LHINs and others. The stage is set for moving forward into substantial areas of system and performance improvement over the next three to five years.

Tina Smith, Chair, Coordinating Council

The GTA Rehab Network, established in 1999 on the direction of the Health Services Restructuring Commission, is comprised of Greater Toronto Area publicly-funded hospitals, community care access centres and others that are involved in the provision of rehabilitation services. Committed to the integration of rehabilitation throughout the continuum of care, the Network focuses on innovative solutions to system-wide issues so that patients receive high quality rehab services when and where they need them.

Since 2005, the Network's priorities have been guided by its Strategic Plan 2005-2008. Over this period, the Network has been very successful in engaging stakeholders across multiple organizations and sectors to develop a range of shared clinical and administrative tools and guidelines, as well as promoting innovation and best practices in rehabilitation. With the number of changes making an impact on the healthcare system in recent years, it is timely to re-evaluate the Network's strategies and priorities to ensure alignment with the directions of the healthcare system and Network members.

GTA Rehab Network Membership

Rehabilitation Hospitals (7)
Acute Care Teaching Hospitals (4)
Community Hospitals (14)
Community Care Access Centres (3)
Ex-officio members (3)

In September 2008, the GTA Rehab Network Coordinating Council reviewed the existing strategic plan and agreed to refresh the priorities, goals and activities for 2010 to 2013. The planning process included extensive key informant interviews and discussion sessions with key contacts as well as a broad consultation session with stakeholders on June 1, 2009. The consultation process identified a range of goals and actions for the Network over the next three years. It also highlighted the importance of a clear and distinct mission and mandate for the Network given the context of LHINs, their priorities and their planning mandates.

Reflecting on Network Achievements 2005 – 2009

The 2005 Strategic Plan outlined a number of goals and activities for four key strategic priorities, reflected below. The Network takes pride in the scope and depth of its achievements, all of which could only have been possible through a collective and collaborative approach by committed Network members.

Strategic Priorities 2005	Network Achievements
1. Align with and influence Ontario's Health Transformation agenda	<ul style="list-style-type: none"> • Representation on key LHIN task groups and committees. • Assisting Toronto Central LHIN with the implementation of its resource matching and referral initiative. • Providing consultation to the five GTA LHINs on a range of rehabilitation planning initiatives.
2. Improve service delivery and access	<ul style="list-style-type: none"> • Common tools for referral to inpatient rehab, complex continuing care, community care access centres and outpatient rehab programs. • Discharge planning guidelines for inpatient rehabilitation. • Standard definitions for rehab programs, including definitions for rehab ready, medically stable and ALC rehab designation. • Referral guidelines with benchmarks for referral response. • <i>Rehab Finder</i> database of all member rehab services. • Patient specific tools including community-based <i>Stroke Information Card</i> and patient education website on total joint replacements. • Triage tool for referral to inpatient geriatric rehab. • Demonstration project in High Tolerance Long Duration stroke rehab.
3. Inform planning and performance measurement	<ul style="list-style-type: none"> • ALC surveys and snapshots to inform planning on referral guidelines and planning work for the geriatric/medically complex population, LTLD stroke and MSK. • System analysis reports, including: <i>Exploring the Hip Fracture and Joint Replacement Landscape; Implications and Recommendations for Low Tolerance Long Duration Stroke Rehab; Clarifying the Complexities of Inpatient Geriatric Rehab; Consensus and Collaboration in the Care of Hip Fracture Patients.</i> • Analysis of performance results in <i>Hospital Report 2005: Rehabilitation.</i>

Strategic Priorities 2005

Network Achievements

4. Share best practices and enhance knowledge exchange

- Annual *Best Practices Day* conference, attracting attendees from across Ontario.
- Targeted workshops, e.g., *What Ontario's Osteoporosis Strategy Means for Rehabilitation – Building on Each Other's Work; Excellence in Total Joint Replacement Care; Educational Research Workshops on Pain Management for Hip Fracture Patients; Forum on Flow: Principles and Performance Indicators.*
- Best practices in pain assessment collaboration.
- Best practices across the continuum of care for total joint replacement.

It is evident that the GTA Rehab Network has added significant value to both health services planning in the GTA and rehabilitation services delivery across its member organizations. In its first ten years, the Network has built a strong foundation of rehabilitation knowledge and common tools for use by all sectors of the health system. The Network has also demonstrated a proven track record in facilitating collaboration among organizations and across sectors to improve service delivery.

The Changing Healthcare Environment

Over the past several years, the healthcare environment has undergone a number of changes, many of which are relevant to the Network's future planning:

- The Ontario government has changed the way healthcare services are planned, funded and managed through the establishment of **Local Health Integration Networks**. There are a total of 14 LHINs in Ontario and five LHINs that span the healthcare services across the Greater Toronto Area. The GTA Rehab Network, therefore, must foster relationships with five GTA LHINs.
- The Ministry of Health and Long-Term Care and the LHINs, through their Integrated Health Service Plans, have outlined specific **health system priorities** for attention in the next several years:
 - Reducing wait-times, particularly for emergency care
 - Reducing ALC days
 - Improving access to primary care
 - Chronic disease prevention and management with a priority focus on diabetes
 - Improving access to mental health and addiction services
 - Aging at home strategies
 - E-Health
 - Health human resources

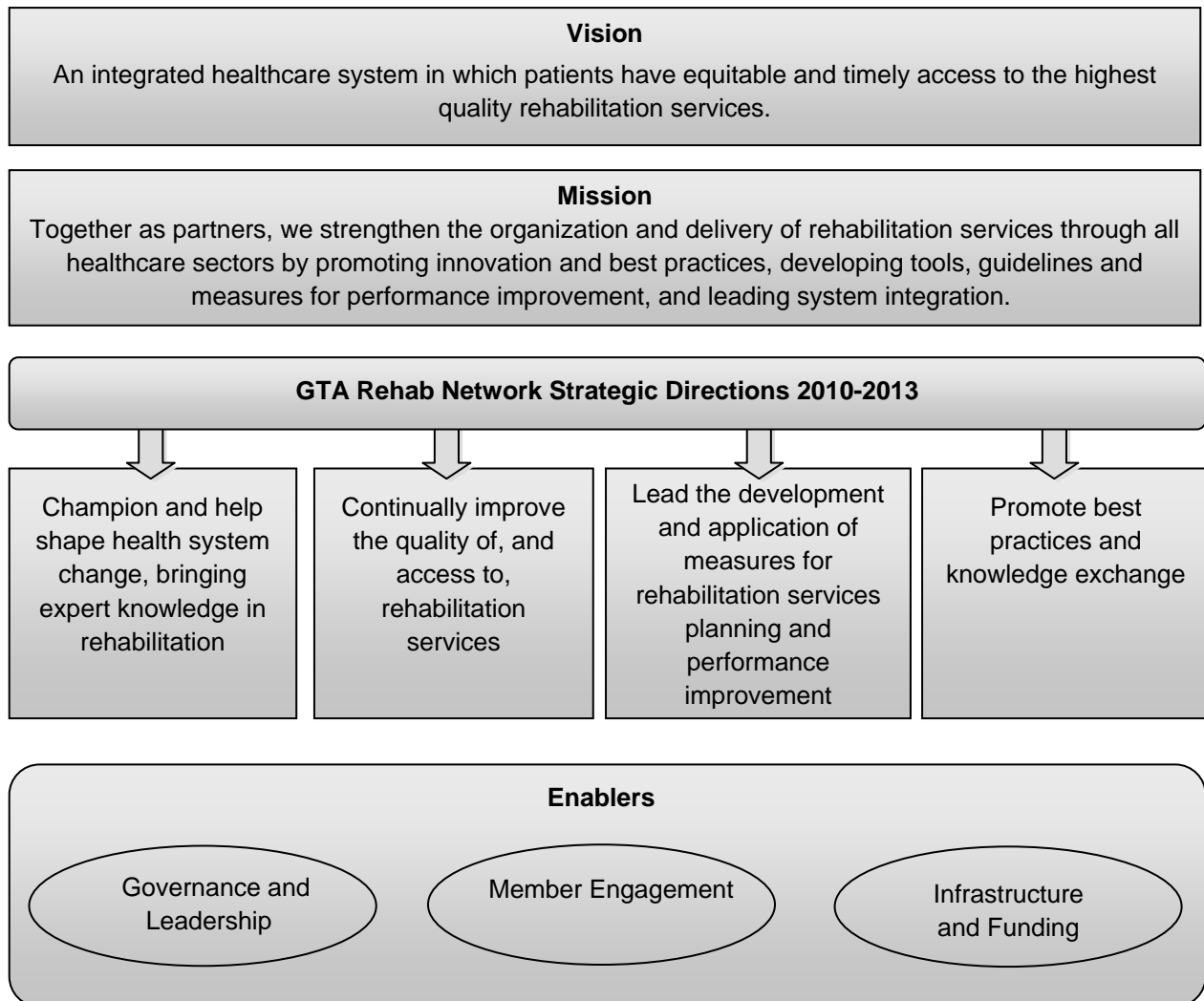
The GTA Rehab Network will align its activities, including those pertaining to patient flow, development of performance and capacity measures, with those of the LHINs in order to contribute to system improvement and have a voice in system planning.

- An emphasis on **accountability and performance management** has resulted in service accountability agreements between funders and providers, as well as initiatives for increasing transparency of performance indicators, e.g., public reporting of wait times for targeted procedures or services. An opportunity exists for the GTA Rehab Network to lead some of the developmental work related to accountability indicators and performance measures for rehabilitation services.
- A heightened focus on **collaboration and partnership** is evident across the system. Health service providers are strongly encouraged to look at partnerships in proposing new initiatives to the LHINs. There are raised expectations for system-oriented improvements, requiring collaboration across sectors. The Network has a solid track record in collaborating and working in partnerships.

The GTA Rehab Network continues to raise the profile of rehabilitation within the ever-changing healthcare environment. The Network is a strong voice for rehabilitation among its partners, the Local Health Integration Networks and the Ministry of Health and Long-Term Care.

Strategic Directions 2010-2013

The GTA Rehab Network recognizes that it must build on the solid foundation of accomplishments of its first ten years and refine its priorities to align with the directions of the health system environment. The following revised vision, mission and strategic directions will provide a roadmap for the Network over the next three years.



Goals and actions have been developed for each of the four strategic directions and the enablers.

Strategic Direction #1: Champion and help shape health system change, bringing expert knowledge in rehabilitation

The GTA Rehab Network has increased its engagement with the LHINs over recent years, contributing to discussions and planning to improve system performance. The Network has been a key player in system planning initiatives to improve patient flow in areas such as ALC, rehabilitation capacity, and resource matching and referral. Successes in these areas are steps toward larger system improvement.

The Network is increasingly recognized as a leading resource on rehabilitation and anticipates an expanded role in health system planning. Recently, the Toronto Central LHIN outlined a specific role for the Network in addressing issues related to enhancing patient flow for rehab and complex continuing care. Several of the other GTA LHINs have sought out the Network as a key body for engaging the rehab/CCC sector.

Opportunities exist to contribute to system improvement through the LHIN priorities, including rehabilitation interventions that enhance patient flow and reduce ALC days and support the transition of complex populations through the continuum.

The following goals and actions are proposed:

1-1 Engage with healthcare providers and policy leaders to advance health system changes that optimize the impact of rehabilitation interventions on patient outcomes and system efficiency.

Proposed actions:

- Promote the recognition and practice of rehabilitation as a process that enhances recovery and functional independence, spanning the continuum of care.
- Leverage information and knowledge on health services performance to influence changes in service delivery models, capacity and resources.
- Foster accountability across Network members against collectively set benchmarks as a means of driving system change.

1-2 Advise on, and promote the role of, rehabilitation in health services delivery through active engagement with LHIN-led and other initiatives.

In helping to shape health system change, rehabilitation must be seen as a process in which functional abilities are restored, developed or maintained. As such, we need to advocate for a health services system that facilitates rehabilitation interventions effectively and efficiently as early as possible in the patient's care to enable the best possible outcomes.

Dr. Gaetan Tardif
Vice President Patient Care & Chief Medical Officer, Toronto Rehabilitation Institute
Director, Division of Physiatry, University of Toronto
Division Head, Physiatry, University Health Network & Mount Sinai Hospital

Proposed actions:

- Identify targeted areas and opportunities where the Network can contribute its rehabilitation knowledge and expertise to key MOHLTC or LHIN priorities and Integrated Health Service Plans.
- Support Network leadership in advocating for rehabilitation services at policy and LHIN tables.
- Participate on LHIN committees and task forces to ensure the importance of rehabilitation as part of the solution to system integration is heard. Take a lead role where appropriate.

Expected Benefits:

Network efforts and attention to the above goals and proposed actions are expected to yield the following benefits:

- Greater recognition of rehabilitation as a process across the continuum, resulting in health system changes and targeted resources to support timely access to rehabilitation interventions throughout the patient’s care journey.
- Enhanced accountability across Network members against set benchmarks.
- The importance of rehabilitation in improving patient outcomes and system performance is well recognized and supported.

Strategic Direction # 2: Continually improve the quality of, and access to, rehabilitation services

All members of the GTA Rehab Network are highly committed to improving the quality of, and access to, rehabilitation services across the continuum of care, including acute care, rehabilitation programs, outpatient services and community or home-based services. The work of the Network in the past few years has focused on integrating best practices and standardizing processes across providers as foundational elements to supporting quality and access. Examples include: standardized rehab definitions and assessment tools; common rehab referral forms and referral processes; rehab referral guidelines; and rehab discharge planning guidelines.

The Network has been a key player in partnership with providers from multiple sectors to develop and implement models of care/service that improve quality

One of the biggest differences the Network has made is that it has allowed for greater advocacy on common issues. The Network has brought post acute care to the decision-making table on issues like patient flow and ALC, giving rehabilitation a voice. It has also done a lot of work to improve the process of accessing rehabilitation -- for example introducing a common rehab referral form across hospitals. We use it for both internal and external referrals. It saves time, improves communication and smoothes transitions. That's helpful for us and the system.

Karl Wong
Manager, Outpatient Rehabilitation & Corporate Rehabilitation Services
Rouge Valley Health System

and access for targeted patient populations, including stroke and joint replacement. The Network has also provided its members with comprehensive and accessible resources on rehabilitation services and programs (e.g., *Rehab Finder* and quick reference referral guide).

The Network will continue its work on patient flow and transitions across sector providers. Initiatives for standard referral practices, models of care and related performance measures are key to overall system performance. Network members have identified the need to better understand outpatient rehabilitation services and how they support the model of care for targeted patient populations.

In looking to the future, the Network will focus on populations that experience difficulty with transitions across programs/services, and, in partnership with a range of providers, develop models of care for improving the quality of and access to care. It is widely recognized that rehabilitation services across all sectors of the care continuum are critically important to supporting optimal outcomes, particularly in the more complex patient groups. The Network will focus initially on the hip fracture population, building on previous initiatives that identified gaps for this population.

The following goals and actions are proposed:

2-1 Expand the development of general policies and practice guidelines that optimize patient flow through rehab and complex continuing care.

Proposed actions:

- Identify and strengthen general policies and practices that have an impact on patient flow, e.g., standard bed holding policies, seven-day-a-week referral processing and admissions.
- Develop a comprehensive Resource Guide that outlines best practices, responsibilities and accountabilities for sending, receiving and responding to rehab and CCC referrals.

2-2 Enhance the quality of, and increase timely access to, post-acute rehab care for specific medically complex patient populations.

Proposed actions:

- Develop patient information and tools to support the transition to post-acute rehab care (e.g., transition communication tools, patient information and self-management tools).
- Define an appropriate resource incentive strategy to proactively transition patients out of acute care into rehabilitation/CCC programs.
- Identify administrative processes, performance indicators, and organizational practices/infrastructure that enable, limit or delay access for medically complex patients, beginning with those hospitalized due to hip fracture. Address these with standardized approaches across organizations.

- Evaluate successes and identify areas for ongoing improvement in the implementation of the FHRAT¹ model.
- Work with clinical experts to confirm and implement integrated clinical care guidelines for medically complex individuals who are hospitalized after hip fracture to support enhanced quality of care and facilitate timely patient flow.

2-3 Pursue initiatives to support smooth transitioning from pediatric to adult rehabilitation services.

Proposed actions:

- Undertake a process evaluation of the LIFEspan transition service model to identify opportunities to expand to other patient groups.
- Identify target patient groups that experience challenges in transitioning from pediatric to adult services and areas for potential growth. Support provider partners with processes and tools to improve transitions.

2-4 Explore the role of outpatient rehabilitation programs within the care continuum and link to Network initiatives in targeted areas, i.e., stroke and MSK.

Proposed actions:

- Conduct a survey of member organizations to better understand current supply, utilization of and access to outpatient rehab services.
- Apply survey findings to models of service and expected pathways for patient groups related to MSK and stroke care.
- Through the rehab definitions initiative, develop standards of practice for rehabilitation outpatient care, based on the best evidence.

Expected Benefits:

Network efforts and attention to the above goals and proposed actions are expected to yield the following benefits:

- Adoption of standardized policies and practice guidelines that streamline patient flow through acute to post-acute care and support optimal patient outcomes.
- Coordinated and integrated care management approach for medically complex individuals who are hospitalized due to hip fracture.

¹ Fractured Hip Rapid Assessment and Treatment Model, Bone and Joint Health Network

- Enhanced patient engagement with post-acute rehabilitation care through the use of self-management and patient information supports.
- Improved patient transitions from pediatric to adult rehabilitation services.
- Improved quality of, and access to, outpatient rehabilitation services for MSK and stroke care.
- Shared standards of practice for outpatient rehabilitation services.

Strategic Direction #3: Lead the development and application of measures for rehabilitation services planning and performance improvement

The GTA Rehab Network has made considerable strides in laying the groundwork to identifying and using relevant performance measures for rehabilitation. The development of standard definitions for rehab programs and the creation of self-assessment tools have formed the basis for a common language around rehab services and practices. The standard definitions work is expected to evolve to specific measures that will assist in quantifying capacity, utilization and other dimensions of rehabilitation services.

Looking to the future, the Network can expect to complete the development of standard rehab definitions for remaining population groups and facilitate their implementation. Opportunities exist to also leverage the work on referral and discharge guidelines to develop measures for utilization, capacity and other indicators. The Network continues to assist in the implementation of the Toronto Central LHIN Resource Matching and Referral (RM&R) initiative and will take a lead role in applying the data from the RM&R system, the National Rehabilitation Reporting System (NRS) and other data sources to develop a performance measurement framework.

The following goals and actions are proposed:

3-1 Continue to move forward on establishing and applying standard rehabilitation program definitions.

Proposed actions:

- Complete evidence-based rehab definitions, program standards and self-assessments for remaining populations, and update frameworks as required.
- Monitor the application of rehabilitation program definitions in quality improvement and rehab services delivery and organization.

3-2 Develop a rehabilitation performance measurement framework.

Proposed actions:

- Implement a systematic approach for the review and analysis of data (e.g., RM&R system and NRS) and other information sources (e.g., definitions, self-assessment findings) to identify

system questions and develop recommendations for rehabilitation services capacity, distribution, and quality improvements.

- Continue to work with partners to analyze RM&R data to inform improvements in data collection and reporting, and understand and address factors contributing to delays in patient flow.
- Work with providers and funders to obtain agreement on key performance measures/indicators (e.g., flow, utilization, capacity measures, occupancy, outcome measures, others).
- Lead the development of new measures/indicators and a performance measurement framework for application across rehab providers.
- Integrate measures and indicators into the development of care models and pathways for targeted populations (e.g., hip fracture).
- Continue to work in collaboration with the Toronto area Stroke Networks to support the development of a quality-driven, coordinated approach to the provision of rehabilitation after stroke.

Expected Benefits:

Network efforts and attention to the above goals and proposed actions are expected to yield the following benefits:

- A rehabilitation performance measurement framework that identifies system questions relative to rehabilitation service demand, capacity, distribution and quality.
- Use of data to improve processes and practices that support and facilitate patient flow and optimal rehabilitation interventions.
- Strengthened measurement of rehabilitation access and quality to support ongoing performance improvement.

Strategic Direction # 4: Promote best practices and knowledge exchange

The GTA Rehab Network’s work to promote best practices is well-known and highly regarded. The annual *Best Practices Day* conference has grown tremendously and has become the premier province-wide conference focused on rehabilitation. Topic-specific workshops have also been popular across the rehab community. These events have supported broad dissemination of research, innovation and best practices, as well as provided a forum for networking and community building.

The GTA Rehab Network website is a source of valued information for rehabilitation planners and managers in Alberta — it's an effective "go to" place for information.

Marg Mooney, Director, Physiotherapy Strategies, Allied Health Strategies
Alberta Health Services

In looking ahead, the Network proposes to expand the mechanisms for sharing and promoting best practices, building on the annual conference and workshops to include formalized communities of practice initiatives and alternate forums for information sharing and knowledge transfer. The Network will reach out to a broader base of researchers in rehabilitation, capitalizing on its infrastructure to support research transfer and knowledge exchange opportunities across clinicians and researchers.

The following goals and actions are proposed:

4-1 Expand mechanisms for identifying, sharing and promoting best practices across the continuum of care.

Proposed actions:

- Continue to host annual *Best Practices Day* conference and topic specific workshops.
- Pursue additional venues for knowledge exchange, e.g., establish communities of practice, create web-based discussion forums.
- Recognize and profile innovative and leading practices, leveraging the Network's website and communications vehicles where possible.
- Engage with other rehabilitation-related networks on shared issues and learnings.

4-2 Further the Network's role in supporting knowledge translation – bringing new knowledge to clinical practice.

Proposed actions:

- Strengthen collaborative relationships with clinical researchers across major centres of rehabilitation research in Ontario (e.g., academic programs in Toronto, Hamilton, London and Ottawa; Institute for Clinical Evaluative Sciences and the Institute for Work and Health) to engage in bringing new research findings to clinical practice and to bring forward questions for research.
- Pursue opportunities to strengthen and support research-clinical knowledge exchange, i.e., shared workshops, specific knowledge communities.

Expected Benefits:

Network efforts and attention to the above goals and proposed actions are expected to yield the following benefits:

- Enhanced profiling and increased sharing of innovation and best practices.
- Broad recognition of innovation and best practices from audiences beyond the Network.
- More timely adoption of new research findings to clinical practice.
- New research ideas spawned from greater interchange between practitioners and the research community.

Strengthening our Organizational Enablers

The Network's success in achieving its strategies and goals is directly related to the strength of three important enablers:

1. Governance and leadership
2. Member engagement
3. Infrastructure support and funding

Since the formation of the Network in 1999, the Network has been governed by a Coordinating Council of 16 members. This has served the Network well in providing leadership, identifying priorities and ensuring oversight to the broad range of activities in which the Network has been engaged. The new LHIN environment, however, has called upon Network members to participate in numerous LHIN-led committees, task forces and initiatives. Considering these new realities and the ten-year experience with the current Coordinating Council, it is an appropriate time to renew the approach and nature of governance for the Network, aiming to create a more robust model for governance and leadership. It is also critical that the Network's mandate be clear, relevant in the current context and fully supported by its members.

The considerable productivity and quality outputs of the Network have been a function of very committed and engaged members, including many front-line professionals. In the LHIN environment, health professionals are being pulled in many directions, contributing to both internal organizational initiatives as well as LHIN-specific initiatives. The Network will continue to find creative ways to engage and support its members in contributing to the Network plans and priorities.

As always, there is more work than resources to do it. The dedicated and highly effective Secretariat for the Network is well regarded by all members. The Secretariat operations are funded through Network membership fees, along with a small amount of special project funding. It will be important to continue to seek out alternate funding sources to support the Network and its many initiatives.

The following actions are proposed.

- Renew the Network's governance model.
- Refine communications strategies to meet the needs and preferences of members.
- Introduce alternative mechanisms to optimize member engagement in the planning and implementation of new initiatives.
- Continue broad member meetings, e.g., bi-annual, to discuss key issues, priorities and policy topics.
- Seek alternative and supplemental funding sources to support the initiatives of the Network, where possible.

Moving Forward – Implementation Priorities

The strategies and goals will guide the work of the Network over the next three years. Not all actions can be addressed at the same time, so the Network has identified the more immediate priorities to address in the first year. These first year activities will lay important groundwork for moving forward on larger system initiatives over time.

Year 1 Priorities

The following are proposed as priorities for attention in the first year:

1. Renew the Network’s governance model and membership engagement strategy.
2. Begin a planning process to address the access and care needs of patients hospitalized due to hip fracture:
 - a. launch a multi-sector clinical/research expert task group to develop clinical care guidelines for care management of hip fracture across the continuum.
 - b. evaluate successes and identify areas for ongoing improvement in the implementation of the FHRAT model.
 - c. identify administrative processes, performance indicators, and organizational practices/infrastructure that enable, limit or delay access for the medically complex hip fracture patient. Address these with standardized approaches across organizations.
3. Continue to work with partners to analyze Resource Matching and Referral (RM&R) data to:
 - a. inform improvements in RM&R data collection and reporting,
 - b. understand and address factors contributing to delays in patient flow, and
 - c. identify and develop standard approaches for processes, policies and other issues to enhance patient flow through inpatient rehab and complex continuing care.
4. Complete evidence-based rehab definitions, program standards and self-assessments for remaining populations.
5. Continue to engage with LHIN initiatives and support LHIN Integrated Health Service Plan activities.
6. Conduct a survey of member organizations to better understand the current supply, utilization of and access to outpatient rehab services.
7. Begin to develop a performance measurement framework for rehabilitation, leveraging currently available data and indicators.

8. Connect with rehabilitation clinical researchers in Toronto and other Ontario university centres to explore possible collaborations for knowledge translation.

Action on the above priorities will position the Network favourably in the areas of health system advancement, access and service enhancements, performance measurement and best practices. As new directions and priorities arise from the LHINs or Network members, it will be critical for the Network to be sufficiently nimble to adjust its work plan and priorities accordingly.

Concluding Remarks

The GTA Rehab Network has made a difference in the healthcare delivery system of the GTA. The Network's many initiatives have promoted greater consistency across programs and organizations, supported measurement of performance, improved referral and discharge processes impacting patient flow, and engaged the rehabilitation community in a common direction. Building on its many accomplishments, the Network is well placed to continue to make substantial contributions towards an "integrated healthcare system in which patients have equitable and timely access to the highest quality rehabilitation services."

Appendix A

GTA Rehab Network Members

The member organizations of the GTA Rehab Network include hospital and community-based providers of rehabilitation services, and other planning and coordinating organizations in the Greater Toronto Area.

Rehabilitation Hospitals

Baycrest
Bloorview Kids Rehab
Bridgepoint Health
Providence Healthcare
St. John's Rehab Hospital
Toronto Rehab
West Park Healthcare Centre

Acute Teaching Hospitals

Mt. Sinai Hospital
St. Michael's Hospital
Sunnybrook Health Sciences Centre
University Health Network

Community Care Access Centres

Central CCAC
Central West CCAC
Toronto Central CCAC

Community Hospitals

Credit Valley Hospital
Halton Healthcare Services
Humber River Regional Hospital
Lakeridge Health
Markham Stouffville Hospital
Rouge Valley Health System
The Scarborough Hospital
Southlake Regional Health Centre
St. Joseph's Health Centre
Toronto East General Hospital
Toronto Grace Health Centre
Trillium Health Centre
William Osler Health Centre
York Central Hospital

Ex-Officio Members

Regional Geriatric Program of Toronto
Toronto Acquired Brain Injury Network
University of Toronto

Appendix B

Strategic Planning Forum Participants

The following individuals attended the a broad consultation session with stakeholders on June 1, 2009:

Angela Chan	Program Director, Rehabilitation and Geriatric Assessment, Professional Practice Leader, Physiotherapy	Baycrest
Sheila Jarvis	President & Chief Executive Officer	Bloorview Kids Rehab
Tracy Kitch	Vice President, Programs and Services	Bloorview Kids Rehab
Marian Walsh	President & Chief Executive Officer	Bridgepoint Health
Jane Merkley	Vice President Programs, Services & Professional Affairs and Chief Nurse Executive	Bridgepoint Health
Jackie Eli	Director, Rehab, Activation and Ambulatory Services	Bridgepoint Health
Dionne Williams	Director of Transitional Care and Utilization	Bridgepoint Health
Johanna Skippon	Case Manager, Day Treatment Program	Bridgepoint Health
Leanna Ringler	Director of Client Services	Central West Community Care Access Centre
Jennifer Scott	Senior Manager, Placement Services	Central Community Care Access Centre
Gerry Sinclair	Senior Manager, Client Services	Central Community Care Access Centre
Karyn Lumsden	Director of Rehab Services, Social Work and Psychology	Credit Valley Hospital
Diane McLaughlin	Coordinator, Seniors and Rehab Day Hospital, Occupational Therapy and Therapeutic Recreation	Credit Valley Hospital
Charissa Levy	Executive Director	GTA Rehab Network
Sue Balogh	Project Coordinator/Planner	GTA Rehab Network
Sarah Dimmock	Project Coordinator/Planner	GTA Rehab Network
Judy Moir	Project Coordinator/Planner	GTA Rehab Network
Hannah Seo	Project Coordinator/Planner	GTA Rehab Network
Linda Huestis	Communications Consultant	GTA Rehab Network
Anne Tompkins	Manager, Rehab Services	Halton Healthcare Services

Barb Willitts	Program Director, Acute Medicine and Emergency Services and Primary Care	Humber River Regional Hospital
Maryam Pourtangestani	Manager, A3S Rehab, C1 Geriatric, Endoscopy, DBC, Medical Daycare	Humber River Regional Hospital
Shelley Santerre	Interim Program Leader	Lakeridge Health
Kathryn Fairchild	Clinical Leader, Post Acute Specialty Services	Lakeridge Health
Neil Walker	Chief Operating Officer	Markham Stouffville Hospital
Dianne Cairney	Session Facilitator	MMDC Consulting Inc.
Sharon Currie	Director of Rehabilitation	Mt. Sinai Hospital
Jill Pascoe	Social Worker, General Medicine	Mt. Sinai Hospital
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Dr. Karima Velji	Vice-President, Patient Care and Chief Nursing Executive	Toronto Rehab
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