Inspiring New Directions in Rehabilitative Care

Rehabilitative Care Alliance 2013-2015 Report
Message from the RCA Steering Committee Co-Chairs

Two years ago, we were granted the privilege of co-leading a provincial initiative to effect positive changes in rehabilitative care. Building on the work of the Rehabilitation and Complex Continuing Care Expert Panel, the Rehabilitative Care Alliance (RCA) was given a two-year mandate (April 2013 – March 2015) by Ontario’s 14 LHIN CEOs to support improved patient experiences and clinical outcomes and to enhance the adoption and effectiveness of clinical and fiscal priorities.

The recommendations outlined in this report represent the culmination of thousands of hours of complex and rewarding work that involved unprecedented stakeholder engagement across the province including representation from government, multiple health care sectors and disciplines, and patients and caregivers. Under the leadership of the RCA secretariat (as provided by the GTA Rehab Network), and with the enthusiastic support of members of the RCA task and advisory working groups, we were able to extend our reach to ensure that our work touched on every aspect of the rehabilitative care sector that contributes to the patient experience.

Given the complexity involved in working to transform rehabilitative care, stakeholder engagement was critical in validating the tools, guidelines and resources that will aid LHINs and health service providers in implementing RCA recommendations.

Once implemented, the RCA recommendations in this report are expected to result in system-wide impacts that lead to improved long-term clinical outcomes, increased community capacity for rehabilitative care, greater clarity on the eligibility and clinical components of rehabilitative care programs, direct admissions to bedded levels of rehabilitative care to avoid ER, acute care and/or long-term care admission (where feasible and appropriate), and better support for high risk older and medically complex adults with restorative potential.

Our thanks to the many individuals in government, health care and our communities whose contributions of time, expertise and insights were invaluable in informing recommendations that will truly make a difference in the way we deliver rehabilitative care in Ontario. Special thanks to the GTA Rehab Network whose leadership as secretariat was exemplary in keeping the work of our task and advisory groups on track and ensuring we were able to complete all deliverables on time and on budget. It would not have been possible to accomplish what we did in two years without access to the GTA Rehab Network’s impressive knowledge base and well-established relationships with key stakeholders.
This small team is a model for what can be accomplished on a grand scale when you have the agility, expertise and drive to succeed.

Now the real work begins as LHINs and health service providers across Ontario work together to implement the recommendations that will help ensure Ontarians have access to rehabilitative care when and where they need it.

As we release this report, we are pleased to report that the LHIN CEOs have approved a second two-year mandate for the RCA that will run from April 1, 2015 to March 31, 2017. This second mandate will allow for continuity in planning as the RCA continues to build upon the tremendous progress made to date in supporting transformation of rehabilitative care across Ontario.

Donna Cripps
Co-Chair, Rehabilitative Care Alliance Steering Committee

Dr. Peter Nord
Co-Chair, Rehabilitative Care Alliance Steering Committee
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Executive Summary

Throughout Ontario, rehabilitative care is delivered by multiple organizations in a variety of settings including homes, community-based locations, long-term care homes and hospitals, but a lack of standardization at the system level is cause for confusion for patients, families and referrers regarding the type and level of service available. This confusion ultimately leads to ineffective and inefficient use of system resources and undermines the ability of health care providers to connect patients/clients with the most appropriate care.

The Rehabilitative Care Alliance (RCA) was established by Ontario’s 14 Local Health Integration Networks (LHINs) in the spring of 2013 in response to a recognized need for greater standardization across Ontario’s rehabilitative care system. As LHINs and health service providers focus on improving system integration and ensuring the quality and sustainability of services, the clinical and system benefits of rehabilitative care are being recognized as key enablers to the optimization of patient/client outcomes in support of health system objectives.

The RCA is a provincial, task-oriented, collaborative group created to effect positive changes in rehabilitative care across Ontario. Building on the previous work of the Rehabilitation and Complex Continuing Care (CCC) Expert Panel, the RCA laid a solid foundation for success shortly after inception by recruiting strong executive leadership, a small, but highly engaged and productive secretariat (GTA Rehab Care Network), and a diverse, provincial roster of clinicians, administrators and policy-makers to advance the RCA’s work through various task and advisory groups. It further reinforced its efforts through a commitment to broad stakeholder engagement to help inform the development of key deliverables.

To address key system gaps and issues within rehabilitative care, the RCA developed a two-year work plan (April 1, 2013 – March 31, 2015) focused on four key priorities:

- **Definitions.** Provide clarity for patients, families and referring professionals through the development of common terminology, clear definitions and standards of practice for all levels of rehabilitative care across the continuum.

- **Capacity Planning & System Evaluation.** Support monitoring and evaluation of rehabilitative care services, programs and system performance through development of a standard rehabilitative care capacity planning and evaluation toolkit.

- **Frail Senior/Medically Complex.** Develop a rehabilitative care approach for frail senior/medically complex populations to support operationalization of priority elements of the “Assess and Restore Framework to Support Aging in Place”.

- **Outpatient/Ambulatory.** Inform evaluation and planning at the provincial, regional, organizational and program levels through development of a comprehensive and standardized minimum data set for outpatient/ambulatory rehabilitation.
Several months into the first year of its mandate, the RCA added a fifth initiative based on stakeholder input:

- **Planning considerations for re-classification (PCRC) of Rehab/CCC beds.** Provide LHINs and Health Service Providers (HSPs) with a standardized provincial process that ensures due diligence is followed in situations where a potential need to re-classify CCC to inpatient rehabilitation beds is identified.

Each priority was supported by Task and Advisory Groups with cross-province representation thanks to an overwhelming response to an ‘expression of interest’ to participate on one of the working groups. Advisory Groups were also established for LHIN Leads and for HSPs, both of which helped inform the work of the priority-focused working groups. This work has led to an unprecedented level of engagement across the province in all aspects of the RCA’s work plan ensuring that deliverables truly reflect a provincial lens.

Key highlights from successful completion of the RCA’s first two-year mandate include, but are not limited to:

1. **Definitions Framework for Bedded Levels of Rehabilitative Care.** This deliverable was released to LHINs and HSPs in advance of other RCA deliverables to support the roll-out of the Provincial Referral Standards (PRS) for referral to rehabilitation and Complex Continuing Care beds. The LHINs can use the framework as part of a capacity planning process to evaluate rehabilitative care resources within the context of specific patient and local/regional planning needs.

2. **Capacity Planning Framework.** This deliverable was developed to support LHINs and HSPs to identify “opportunities for improved care, potential for cost reductions relative to current expenditure, and estimates of the need for re-investment or re-allocation of funding” within local rehabilitative care systems. Completing regular rehabilitative care system capacity planning (i.e., every 3-5 years), will not only support the development of sufficient local rehabilitative care system capacity across the care continuum, but will also proactively identify where system/service gaps exist, opening the doors to developing required services locally or establishing cross-LHIN partnerships to ensure accessible, high quality rehabilitative care for all.

3. **Standardized Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED.** This deliverable targets early identification/screening of frail elderly/medically complex patients/clients with restorative potential, assessment to determine the need for bedded rehabilitative care, and streamlined referral to support timely access to bedded levels of rehabilitative care directly from the community. The process is designed to remove Acute Care as the sole point of access to rehabilitative care beds, and supports provincial Assess and Restore directions related to the

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care of frail seniors while considering the immense variability in structures and resources in place across the province.

4. **Outpatient/Ambulatory Rehabilitative Care Minimum Data Set (MDS).** This deliverable was developed by the Outpatient/Ambulatory Rehab Task and Advisory Groups and is for applications within the ‘Access and Transition’ and ‘Financial Performance’ quadrants of the GTA Rehab Network’s ‘Evaluation Framework and Indicators for Performance Measurement of Outpatient Rehabilitation’\(^2\), which the groups endorsed. For many chronic conditions, outpatient rehabilitation means increased functional independence, faster discharge from hospitals, less reliance on expensive in-home supports and avoidable premature Long Term Care Home admissions. The basic essential data the MDS provides will enable LHINs to describe the cost of different care settings and services actually being provided, and inform comprehensive capacity planning.

5. **PCRC Toolkit.** Released earlier this year, the toolkit was developed incorporating broad provincial feedback and was informed through regular liaison with the Health System Funding Reform (HSFR) CCC/Rehab Working Group and the Ministry of Health and Long-Term Care (MOHLTC) to ensure alignment with provincial directions. The toolkit will help rehabilitative care system stakeholders more fully understand the implications of HSFR on patient flow and resource allocation for rehab and CCC beds and to mitigate any potential risks. LHINs can use the toolkit as part of a broader rehabilitative care system capacity planning exercise that includes use of the RCA Definitions Framework, the RCA Capacity Planning Framework, and the RCA System Evaluation Framework.

To maximize knowledge exchange, pique interest in RCA engagement activities, and generate awareness and understanding of the RCA and its mandate, a comprehensive communication strategy was launched shortly after implementation of the RCA’s work plan. It included development of an RCA website, an e-newsletter, online key messages (following Steering Committee meetings), webinars, a dedicated email address for queries, and an annual provincial forum for Task and Advisory Group members and other key stakeholders.

As outlined later in this report, formal presentations were also made to several groups across the province to showcase the RCA’s work and to ensure alignment with other key provincial initiatives.

This report outlines each of the RCA priorities in greater detail, including advice to support LHINs in the implementation of RCA deliverables.

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**Second Mandate**

As of April 1, 2015, the RCA will prepare for a second two-year mandate. Its work will continue to be informed by evidence and data, as available, and by extensive provincial stakeholder engagement and input in the final deliverables, all characteristic of the same approach used to complete the successful first mandate.

The course of work during the RCA’s second mandate will fall under three main pillars:

1. Continue to support LHINs and the Ministry of Health and Long-Term Care with Assess and Restore (A&R) related initiatives; participate as partners in knowledge exchange related to implementation of the A&R Guideline and associated funding.

2. Provide project management support to the LHINs to guide their implementation of the standardized RCA tools, processes and frameworks developed through the first mandate.

3. Support implementation of existing quality-based procedures (QBPs) through identification of standardized rehabilitative care best practices across QBP handbooks (where not already defined).

The second mandate will allow for continuity of planning as the RCA continues to build upon the tremendous progress made to date in supporting transformation of rehabilitative care across Ontario.

“In what now seems like an incredibly short two years, the RCA has drawn from the contributions of hundreds of committed professionals from all facets of Ontario’s complex rehab landscape to create an evidence-based, patient-focused and action-oriented blueprint toward a true integrated provincial system of rehabilitative care that will improve patient outcomes while reducing avoidable costs.”

Erik Hellsten, Senior Specialist – Quality-Based Funding Health Quality Ontario
About the Rehabilitative Care Alliance

Background

Rehabilitative care is delivered in a wide variety of formal and informal locations across bedded and community care settings, but without the benefit of a consistent, province-wide approach to the identification and evaluation of the availability of resources, access to services or standards of care. As LHINs and health service providers focus on improving system integration and ensuring the quality and sustainability of services, the clinical and system benefits of rehabilitative care are being recognized as key enablers to the optimization of patient/client outcomes in support of health system objectives.


In an effort to take the first necessary steps towards evolving the rehabilitative sector, a Rehabilitation and Complex Continuing Care (CCC) Expert Panel was formed in 2010 as a sub-committee of the province’s ER/ALC Expert Panel. Its purpose was to “fundamentally re-think the delivery of rehabilitation and complex care across the acute and post acute continuum including community settings, hospitals, transitional and convalescent care settings and in long-term care”.

The Panel’s work focused on accelerating the uptake of best practices for rehab-intensive conditions associated with substantial alternate level of care (ALC) challenges and identifying the enablers and barriers to best practice implementation. To better reflect the nature of the care provided, the Panel replaced the terms “rehabilitation” and “complex continuing care” with “rehabilitative care” which it defined as:

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

Rehabilitative Care Alliance (2013)

The Rehabilitative Care Alliance (RCA) was established in April 2013 by Ontario’s 14 Local Health Integration Networks (LHINs) to build on the work of the Rehabilitation and CCC Expert Panel. The RCA is a provincial, task-oriented, collaborative group with representatives from all Local Health Integration Networks (LHINs), the Ministry of Health and Long-Term Care (MOHLTC), health service providers from hospital and community sectors, and other clinical experts. It is funded by and reports quarterly to the CEOs of the 14 LHINs.

The RCA was created to effect positive changes for rehabilitative care across Ontario. Through the development of standardized frameworks, toolkits, and processes, the Alliance has worked with provincial stakeholders to promote best practice to enhance outcomes for people receiving rehabilitative care.

3 Rehabilitation and Complex Continuing Care Expert Panel, Phase 1 Report, June 2011. 
RCA deliverables were based on a work plan that reflected a shared agenda for rehabilitative care as developed through extensive consultation and engagement with provincial partners. Through this process, four priority initiatives were identified, with an additional initiative identified part way through the mandate.

Leveraging existing rehabilitative care planning bodies and using extensive consultation and engagement strategies, the work of the RCA focused on priority areas that align with and build upon MOHLTC priorities such as the Seniors Strategy, Health Links, Resource Matching and Referral (RM&R), Health System Funding Reform (HSFR), and Quality-Based Procedures (QBPs). The priority areas were also well aligned to address many of the recommendations for rehabilitation that were outlined in the Auditor General of Ontario’s 2013 Annual Report.

Secretariat Support

The GTA Rehab Network, a recognized leader in improving and planning the delivery of rehabilitation care, was hand-picked by the province’s 14 LHIN CEOs to provide secretariat support to the RCA in fulfilling its two-year mandate.

The Network consists of publicly-funded hospital and community-based organizations from across the Greater Toronto Area (GTA) that are involved in the planning and provision of rehabilitation services. Throughout its history, the Network has earned a reputation as a unified voice for the rehabilitation sector and is highly respected by government, health care and other key system partners for its solutions-focused, results driven initiatives and its ability to bring stakeholders together to strengthen the influence of the sector at regional and provincial levels.

The secretariat is a lean but productive project management and administrative team of 4 FTEs who were charged with keeping the RCA’s work plan on track, conducting background reviews, engaging and consulting with key stakeholders from across the province, providing support to the RCA’s task and advisory groups, and ensuring the successful completion of all RCA deliverables on time and on budget.

Mandate

The RCA was given a two-year mandate (2013-2015) to effect positive changes in rehabilitative care. Leveraging existing rehabilitative care planning bodies, its work focused on supporting improved patient experiences and clinical outcomes and enhancing the adoption and effectiveness of clinical and fiscal priorities.

To fulfill its mandate, the RCA focused on addressing the following five priorities:

- Provide clarity for patients, families and referring professionals through the development of common terminology, clear definitions and standards of practice for all levels of rehabilitative care across the continuum.
• Support monitoring and evaluation of rehabilitative care services, programs and system performance through development of a standard rehabilitative care capacity planning and evaluation toolkit.

• Develop a rehabilitative care approach for frail senior/medically complex populations to support operationalization of priority elements of the "Assess and Restore Framework to Support Aging in Place".

• Inform evaluation and planning at the provincial, regional, organizational and program levels through development of a comprehensive and standardized minimum dataset for outpatient/ambulatory rehabilitation and a mechanism for collection, analysis and sharing of the data.

• Identify current issues related to the re-classification of CCC to inpatient rehabilitation beds across the province and develop a re-classification toolkit that outlines considerations and provides an analysis of implications in a systemic and standardized manner.

Governance

The RCA brought together the expertise of provincial stakeholders and rehabilitative care providers from across the continuum and reported quarterly to the LHIN CEOs under the following governance structure:
The RCA Steering Committee (Appendix A) was co-chaired by Donna Cripps, CEO, Hamilton Niagara Haldimand Brant LHIN, and Dr. Peter Nord, Vice President and Chief Medical Officer & Chief of Staff, Providence Healthcare.

Task and Advisory Groups

The work of the RCA was advanced through Task and Advisory Groups (Appendix B) aligned with each of the five priorities. The RCA secretariat received an enthusiastic province-wide response to the ‘expression of interest’ to participate on one of the working groups, and every effort was made to include a balance of perspectives on each group, taking into account clinical background and expertise, geographic region, organization type and sector.

1. Definitions
   Develop provincial standards (i.e., definitions and common terminology) for programs and services across the continuum of care.

2. Capacity Planning and System Evaluation
   Standardize the approach in evaluating and planning rehabilitative capacity at the provincial, regional and local level by developing a toolkit to support this.

3. Frail Senior/Medically Complex
   Develop a provincial, system-wide best practice rehabilitative care approach to the care of the frail senior/medically complex populations who have experienced recent and reversible functional decline that threatens their independence.

4. Outpatient/Ambulatory
   Develop a standardized minimum data set for Ministry-funded, outpatient/ambulatory rehabilitative care programs.

5. Planning Considerations for Re-classification (PCRC) of Rehab/CCC Beds
   Develop a toolkit to support LHINs and Health Service Providers (HSPs) with the decision-making process if the potential need to re-classify CCC to inpatient rehabilitation beds is identified.

Task Groups met monthly to advance the objectives of the respective priority, while the Advisory Groups met quarterly to receive updates on the task group directions and to provide feedback on these directions. The groups approached the priorities with a true provincial focus, leveraging the diverse expertise afforded by each group’s cross continuum membership, and expanding those insights through the formal and informal engagement of other stakeholders.

LHIN Lead and Health Service Provider Advisory Groups (Appendix C) were also established with across-the-province representation and met monthly to ensure the work of the task groups was developing in alignment with local directions and priorities. A Patient/Caregiver Advisory Group with representation from 10 of the 14 LHINs helped inform the work of the RCA (Appendix D)

Operationalization and Impact of RCA Deliverables

To demonstrate alignment between RCA initiatives, including a proposed sequence of how the deliverables from the first mandate may be implemented, the RCA developed an overview document, Operationalization and Impact of RCA Deliverables, that illustrates the connections across RCA deliverables and the associated system value and impact.
Definitions

Gap/Issues Identified

Across the province, rehabilitative care is offered by multiple organizations in a variety of settings – in hospital-based inpatient beds, outpatient/ambulatory clinics, community-based clinics, and within the home. While the overarching goal of rehabilitative care is the same across these organizations and settings - to enable individuals to reach and maintain their optimal functioning⁴ - there is no consistency in the focus, clinical components, eligibility criteria, and even the names of similar-type programs at the local, regional and provincial level. This lack of standardization results in confusion for patients, families and referrers about what is available in rehabilitative care. It also limits the health system’s ability to produce and use comparable data on rehabilitative care across organizations thereby compromising an understanding of resource utilization as well as system and patient level outcomes.

Deliverables

To address the lack of consistency in rehabilitative care, the Definitions Task and Advisory Groups were given the mandate to develop standardized definitions that describe rehabilitative care resources across the continuum through the development of a Definitions Framework for Rehabilitative Care.

Objectives:

- Establish provincial standards for rehabilitative levels of care across the continuum of care
- Provide clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care
- Provide a foundation to support system and local capacity planning through a common understanding of rehabilitative care.

These objectives were achieved by:

- Developing recommendations that describe provincial standards (i.e. definitions and terminology) for rehabilitative care across the continuum which may include, but are not limited to, descriptions of the following:
  - levels of rehabilitative care
  - eligibility and discharge criteria
  - restorative potential
- Identifying key considerations for the implications of implementing the recommendations.

Deliverables:

⁴ World Health Organization, 2007
1. **Definitions Framework for Bedded Levels of Rehabilitative Care** (December 2014)

The framework describes the levels of rehabilitative care and for each level, the recommended standard components and human resources. The framework provides the structure to establish a baseline assessment of current services by using it to conduct a gap analysis of the current state relative to the bedded levels within the framework. The analysis can then be used, in conjunction with the Capacity Planning and System Evaluation Toolkit (see Chapter 3), to inform the development of a future state of rehabilitative care.

The framework was released in advance of other RCA deliverables in response to a request by many Health Service Providers (HSPs) that were initiating reviews of their rehabilitative care programs/services. The early release of the framework, with its standardized eligibility criteria for rehabilitative care, also supported the roll-out of the Provincial Referral Standards (PRS) for referral to rehabilitation and complex continuing care beds.

2. **Referral Decision Tree for Rehabilitative Care**

The Referral Decision Tree was released together with the Definitions Framework for Bedded Levels of Rehabilitative Care. It is a tool to assist referrers and provide consistency in determining the kind of rehabilitative care that is needed (e.g., bedded vs. community-based) and which level of rehabilitative care is most appropriate for patients/clients.

3. **Definitions Framework for Community Based Levels of Rehabilitative Care**

The framework defines two levels of rehabilitative care and for each, definitions that describe the goal, target population, medical and healthcare professional resources, and the overall focus and underlying principles of therapy services provided in the community.

4. **Recommendations to Support the Implementation of the Definitions Framework for Rehabilitative Care**

Key considerations for LHINs as they move forward with implementation of the framework have been outlined.

**Approach**

The work of the Task Group was conducted in two phases:

Phase 1 (Fall 2013 – Fall 2014)

This phase focused on the development of the RCA Definitions Framework for Bedded Levels of Rehabilitative Care, a validation exercise to evaluate the framework, and the development of a Referral Decision Tree.
Phase 2 (Spring 2014 – Winter 2015)\textsuperscript{5}
This phase focused on the development of the RCA Definitions Framework for Community-Based Levels of Rehabilitative Care.

While the development of the RCA Definitions Framework for Rehabilitative Care was informed by an extensive review of the literature and consultations with rehabilitative care providers across Canada (including rehabilitation programs/centres in Canada and elsewhere\textsuperscript{6}), it was the many rich discussions held with members of the Definitions Task and Advisory Groups from across the province that provided the opportunity to work through disparate perspectives and practices in rehabilitative care and to come to consensus on the key components and definitions of rehabilitative care within a standardized framework.

A key challenge for the Task Group in developing a standardized framework for rehabilitative care was to think outside of the current “rehabilitative care box” and leave behind preconceived ideas that were based on the status quo of rehabilitative services and delivery models. The Task Group was also challenged to find a balance between its desire to develop a framework to describe the ideal rehabilitative care system based on best practice evidence (where available), and a need to produce a framework that was feasible and achievable given current policies and funding/reporting constraints, and the preconceived ideas and divergent practices of rehabilitative care both locally and regionally.

Phase 1: Approach for Defining the Bedded Levels of Rehabilitative Care
The first drafts of the bedded levels within the rehabilitative care framework intentionally made use of generic, non-specific labels (i.e., Level A, B, C, etc.) in order to allow for more creative thinking and lessen the influence of pre-conceived rehabilitative care practices or biases attached to existing terminology. The definitions were developed by first using a clinical lens in which considerations regarding patient/client profiles were identified, and with agreement that the descriptions within the levels would be based on the “80-20 rule” to accommodate the needs of the majority of patients. It was only after the levels of rehabilitative care and the definitions within were developed that financial/reporting considerations were addressed.

The Task Group also discussed inclusion of the Functional Groups (as previously identified by the Rehab/CCC Expert Panel) in the new framework. It was agreed, however, that the Functional Groups as previously described did not easily map onto the individual levels of bedded care, particularly with respect to the delineation of capacity for functional improvement in each functional grouping, as they often overlapped across more than one of the bedded levels proposed.

Through discussion, the Task Group also agreed that the framework, with its focus on rehabilitative care, is not intended to be inclusive of all beds within Complex Continuing Care (CCC) or Acute Care where rehabilitative care is not the primary purpose/focus of care.

\textsuperscript{5} There was some overlap between these two phases to ensure that all meetings were used as productively as possible. As a result, while the draft Definitions Framework for Bedded Levels of Rehabilitative Care was undergoing a validation exercise in February-March 2014, the Task Group began work on developing a preliminary draft of the community-based framework.
\textsuperscript{6} See Definitions Task Group Backgrounder Document, October 2013.
The RCA Definitions Framework for the Bedded Levels of Rehabilitative Care was developed through an iterative process. The Task Group identified the key components that would be described (e.g., Functional Trajectory, Level of Care Goal, Patient Characteristics and Medical/Allied Health Resources), the levels of rehabilitative care, and the definitions within each level. The group achieved its first major milestone with development of the eligibility criteria for rehabilitative care and the definition of restorative potential and their subsequent endorsement by the Definitions Advisory Group and the RCA Steering Committee in January and February 2014, respectively.

Work on the RCA Definitions Framework for Bedded Levels of Rehabilitative Care was well-informed throughout its development via the following mechanisms:

- Review and discussion with other key stakeholder groups including the Definitions Advisory Group, the Frail Seniors/Medically Complex Task Group and the LHIN Leads and HSP Advisory Groups

- A province-wide validation exercise where the framework was distributed via the LHIN Leads to HSP organizations with rehabilitative care programs located in inpatient rehab and CCC beds, and convalescent care programs in Long Term Care Homes (LTCH). The validation exercise was used to (i) seek additional input on how well existing rehabilitative care programs in bedded levels of care fit within the proposed levels of care in the framework, and (ii) obtain overall feedback on the Definitions Framework for Bedded Levels of Care. The survey results on 366 rehabilitative care programs were used to further inform the framework. A LHIN-specific analysis of the results was also conducted for each LHIN. (See Appendix E for a summary of survey findings).

The definitions for the bedded levels of rehabilitative care were approved by the Task Group in June 2014. The LHIN Leads/HSP Advisory Groups were given a final opportunity for review and feedback before additional approval was sought from the Definitions Advisory Group and the Steering Committee in September 2014. Following the endorsement of the framework by these two committees, the RCA Definitions Framework for the Bedded Levels of Rehabilitative Care, as well as recommendations regarding considerations to support the implementation of the framework, were shared with the LHIN CEOs in October 2014. Following informal endorsement by the LHIN CEOs, a communication strategy was developed to support the release of the framework.

The Definitions Framework received formal approval by all 14 LHIN CEOs and was released in December 2014 to the Definitions Task and Advisory Groups, the RCA Steering Committee and the LHIN Leads/HSP Advisory Groups with a communication package that included the following:

- One-page bulletin and accompanying Q&A
- Definitions Framework for Bedded Levels of Rehabilitative Care
- Referral Decision Tree for Rehabilitative Care
- PowerPoint presentation to support LHINs/HSPs in sharing information with key stakeholders
- Operationalization and Impact of RCA Deliverables document
Phase 2: Approach for Defining the Community-Based Levels of Rehabilitative Care

The approach for developing the RCA Definitions Framework for Community-Based Levels of Rehabilitative Care was similar to that used to develop the Definitions Framework for Bedded Levels of Rehabilitative Care in that the framework went through many iterations and discussions to determine its structure and content. External validation of the framework was also obtained albeit through a different process.

In addition to input from the Definitions Task Group, preliminary content within the framework was informed by feedback from the Ontario Association of Community Care Access Centres (OACCAC), the Ontario Long Term Care Association (OLTCA) and the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS).

The Task Group agreed that the parameters for the framework would be confined to publicly-funded community-based rehabilitative care (i.e., LHIN or MOHLTC funded); however, the delineation of what should be included within the framework raised many questions for the Task Group since the range of community-based services and service providers is quite broad relative to those involved with bedded levels of rehabilitative care. Following extensive discussion, the Task Group identified two levels of rehabilitative care within the framework: (i) rehabilitative care focused on progression (i.e., to improve function) and (ii) rehabilitative care focused on maintenance (i.e., to prevent functional decline). The definitions within these two levels was confined to rehabilitative care that is provided by Regulated Health Professionals. Recognizing that there are many wellness focused/health promotion programs that are offered by non-regulated health professionals to support community reintegration, the framework gives due acknowledgement to the role that these programs play in supporting an individual’s successful return to their community.

In developing the structure of the RCA Definitions Framework for Community-Based Levels of Rehabilitative Care, the Task Group maintained consistency with the bedded framework by using a structure that described what is provided within each level of care rather than where the level of care is provided (e.g., in-home vs. hospital-based outpatient/ambulatory clinics vs. community-based clinics). The group acknowledged that the description of rehabilitative care that is focused on a particular functional trajectory should be the same regardless of where it is provided. It was also recognized that in order to meet the objective of providing clarity to patients/clients, families and referrers, a mechanism to help determine where the most appropriate location to attend community-based rehabilitative care relative to the patient’s/client’s need was required. To address this, a Referral Decision Tree was developed for use with the bedded and community-based framework to assist referrers in determining eligibility for rehabilitative care and identifying where the rehabilitative care needs can best be met.

Work on the RCA Definitions Framework for Community-Based Levels of Rehabilitative Care was well-informed via the following mechanisms:

- Review and discussion at the Definitions Advisory Group and LHIN Leads/HSP Advisory Groups (Fall 2014)
- External feedback on the framework obtained through a province-wide webinar (December 1, 2014):
  - 40 individuals or groups signed into the webinar; participants offered some specific suggested changes to wording/content and posed a few general questions;
  - In general, there was support for the overall structure of the framework and its content.

Webinar feedback was reviewed by the Definitions Task Group and revisions were incorporated into the framework. The final draft of the RCA Definitions Framework for Community-Based Levels of Rehabilitative Care received endorsement by the Definitions Advisory Group in December 2014 and by the LHIN Leads/HSP Advisory Groups in January 2015.

**Key Learnings**

i. **Diversity in rehabilitative care.** One of the key learnings from this initiative was a more thorough understanding of the diversity that exists in rehabilitative care across the province. There are regional differences with respect to population density, geography and the availability of rehabilitative care resources. These differences surfaced from the discussions at the Task Group meetings and received further confirmation through analysis of the validation survey results. While some areas are within relatively close proximity to a number of rehabilitation programs, convalescent care programs and LTCH, other areas rely on the use of their CCC beds to fill gaps in these areas. As a result, the Task Group recognized the need to develop a Definitions Framework for Rehabilitative Care that would be able to accommodate the diversity in rehabilitative care across the province.

While the Definitions Framework strives to describe the ideal model of what should be provided in rehabilitative care, the Task Group recognized that not all rehabilitative care resources can be available in all settings. To address this, the framework describes the rehabilitative care resources for each level of rehabilitative care and identifies the target population whose needs can be accommodated within each level based on the resources that would be available. The validation exercise served to confirm that the Definitions Framework is inclusive of patients currently seen for rehabilitative care.

ii. **Inconsistency in interpretation of “restorative potential” and its influence on access to rehabilitative care.** Through this initiative, inconsistency in the interpretation of ‘restorative potential’ and its influence on access to rehabilitative care was a central focus of discussion. There was much debate about whether to include a statement indicating that delirium, cognitive impairment, depression and discharge destination should not be used as exclusion criteria for determining restorative potential. In particular, it was noted that the presence of cognitive impairment is often viewed as an acceptable exclusion criterion by some rehab programs. However, others stressed that cognitive impairment should not be used as an exclusion criterion and that instead the presence of cognitive impairment should be considered...
within the context of the patient’s/client’s ability to participate in and benefit from rehabilitation. It was also noted that there may be patients/clients who may not demonstrate carry-over upon admission, but for whom this is expected to improve over the course of treatment. Through much discussion and consultation with other Task Groups (i.e., the Frail Seniors/Medically Complex Task Group and the LHIN Leads/HSP Advisory Task Groups), consensus was reached to include a clear statement that delirium, cognitive impairment, depression and discharge destination should not be used in isolation as exclusion criteria for determining restorative potential.

iii. **Realities of existing funding and data collection methodologies associated with current bed types.** As the RCA Definitions Framework for Bedded Levels of Rehabilitative Care was developed, it became clear that operationalization of the framework may be challenged by the realities of existing funding and data collection methodologies associated with current bed types. For example, in the future state, as defined in the RCA Definitions Framework for the Bedded Levels of Rehabilitative Care, the majority of the Low Tolerance Long Duration (LTLD) population will be served most appropriately within the Rehabilitation level of care, while some may be appropriate for the Activation/Restoration or Short Term Complex Medical Management levels of care. However, the existing National Rehabilitation Reporting System (NRS) funding structure provides a financial disincentive to admit patients with complex medical needs who, although they require and can benefit from rehabilitation, would likely require a longer length of stay.

There was recognition by the Task Group, that failure to make any recommendations regarding this issue had the potential to undermine the uptake of the new framework. To address this, the Definitions Task Group supported a recommendation to the MOHLTC’s Health Service Funding Reform (HSFR) Rehab/CCC Working Group to consider inclusion of additional (i.e., new) groups to the existing NRS ‘grouper’ for the slowstream/LTLD patients.

**LHIN Value/Impact**

The philosophical driver underpinning the Definitions initiative was the belief that, in an ideal state, rehabilitative care across Ontario would be based on a shared understanding of:

- Restorative potential and eligibility criteria for rehabilitative care;
- Identified levels of rehabilitative care (both bedded and community-based), goals of care and the characteristics of patients/clients who would be served within each level; and
- The medical and healthcare professional resources and intensity of therapy that would be available within each level of rehabilitative care.

Moreover, within this ideal state, rehabilitative care would be supported by:

- Funding systems that accurately reflect the characteristics of the patients within each level of rehabilitative care;
• Standardized reporting tools for each level of rehabilitative care for measurement of both patient outcomes and system performance; and

• A referral decision tree to assist referrers and provide consistency in determining what kind of rehabilitative care is needed (e.g., bedded vs. community-based) and which level of rehabilitative care is most appropriate for the patient/client.

The RCA Definitions Framework for Rehabilitative Care supports this standardized view of rehabilitative care. The descriptions of the goals for care, the target populations and medical and healthcare professional resources within each level, and the overall focus and underlying principles for therapy services, all provide a common organizing structure and language for understanding current rehabilitative care resources relative to the proposed vision of rehabilitative care. Through its implementation, the RCA Definitions Framework for Rehabilitative Care lays the foundation to help inform capacity planning - in conjunction with the RCA Capacity Planning and System Evaluation Toolkit - and the appropriate/efficient use of rehabilitative care system resources. It also provides a framework for inclusion of best practices (where they exist) for specific populations.

Tools/Resources to Support LHIN Implementation

The responsibility for implementation of the Definitions Framework rests with the LHINs who are in the best position to understand the rehabilitative care needs and resources at local and regional levels and can implement the framework accordingly. As the framework defines the target population and resources for the levels of rehabilitative care, the LHINs can use the framework as part of a capacity planning process to evaluate rehabilitative care resources within the context of specific patient and local/regional programming needs.

Figures 1 and 2 provide a visual for how implementation of the bedded framework may be considered relative to the current state of bedded rehabilitative care.
<table>
<thead>
<tr>
<th>Step 1: Review Definitions Framework(s) for Levels of Rehabilitative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confirm understanding of the bedded and community-based levels of rehabilitative care</td>
</tr>
<tr>
<td>• Review graphic of “Envisioning new levels of bedded rehabilitative care” (See Figure 2)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Conduct analysis of current state relative to the levels of rehabilitative care</th>
</tr>
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<tbody>
<tr>
<td>• Align each local rehabilitative care program within a level of rehabilitative care</td>
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</table>

<table>
<thead>
<tr>
<th>Step 3: Understand the gaps between current state &amp; levels of rehabilitative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do current program goals and/or target populations served need to be re-defined?</td>
</tr>
<tr>
<td>• Do the current allied health/nursing/medical resources meet the definitions? Do the staffing mixes/patient ratios need to be revamped?</td>
</tr>
<tr>
<td>• Are resources provided in a location that optimizes value (e.g., activation/restoration provided in CCC vs. convalescent care bed)?</td>
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**Definitions Framework for Rehabilitative Care Implementation Considerations for LHINs**

**Engagement of Health Service Providers**

**Building the foundation to support local and system capacity planning**

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Figure 1 – Definitions Framework for Rehabilitative Care – Implementation Considerations for LHINs
When envisioning implementation of the new bedded levels of rehabilitative care, the results of the validation exercise indicated that the majority of current rehabilitative care programs align directly with one of the four bedded levels of rehabilitative care. It is anticipated that the current LTLD/slow stream population will be most appropriately served within the Rehabilitation level of care as described within the Definitions Framework. However, in light of the current diversity of patients within this cohort, there may be some who would be more appropriate for the Activation/Restoration level of care or the Short Term Complex Medical Management level. Given that the development of a new group(s) within the NRS, if undertaken, is expected to take 3-5 years, it is recommended that the LTLD population, in the interim, would be best accommodated within the Short Term Complex Medical Management level of care (i.e., provided in CCC beds/Continuing Care Reporting System (CCRS)) to support operationalization of the RCA Definitions Framework in the interim. Once the new group for the LTLD population is developed within the NRS, the Rehabilitation LTLD cohort within the Short Term Complex Medical Management level of care would be moved to the Rehabilitation level of care and would be reported using the NRS.
A final consideration for the implementation of the RCA Definitions Framework for Rehabilitative Care is that implementation of the Definitions Frameworks should be further considered in conjunction with the tools provided in the RCA Capacity Planning Framework and the RCA Rehabilitative Care System Evaluation Framework (see Chapter 3).

The following are the components of the communications package that was released together with the RCA Definitions Framework for Bedded Levels of Rehabilitative Care:

- One-page bulletin and accompanying Q&A
- Definitions Framework for Bedded Levels of Rehabilitative Care
- Referral Decision Tree for Rehabilitative Care

“The approach used by the RCA has been very balanced, taking into account system considerations, operational processes and client-centred perspectives”.

Terrie Dean, Primary Care Lead, Waterloo Wellington CCAC
Capacity Planning and System Evaluation

Gap/Issues Identified

“There is a need for a provincially coordinated rehabilitation system. Rehabilitation services across the province have evolved over many years such that there are now significant variations in the availability and type of services provided, which can impact patient access to services. The lack of a coordinated system has led to individual hospitals—some with input from their Local Health Integration Network (LHIN)—generally determining which inpatient and/or outpatient rehabilitation services they will offer, if any.”

Auditor General of Ontario

The lack of coordinated, system-level planning has resulted in a rehabilitation system in Ontario that is fragmented and that faces challenges in meeting the needs of the populations it serves.

Several LHINs have engaged in reviews of and are implementing strategies for rehabilitative care within their respective regions. There is concern however, that inconsistency in the application of approaches to evaluate rehabilitative care services will result in variation in planning across the province. The role of the Capacity Planning and System Evaluation (CP&SE) Task and Advisory Groups was to draw on a shared interest to standardize the approach in evaluating and planning rehabilitative capacity within each region through development of a toolkit. Standardizing the planning and evaluation of rehabilitative care services at the local, regional, and provincial level will support evidence-based practice and system-wide improvement.

Deliverables

The CP&SE Task and Advisory Groups were given the mandate to support the development of a standardized rehabilitative care capacity planning and evaluation toolkit. The Task Group developed the following deliverables to support the achievement of its mandate:

1. **Rehabilitative Care Capacity Planning Framework**
   The framework can be used by LHINs to identify the existing rehabilitative care services/programs across the rehabilitative care continuum and to support planning activities.

2. **Rehabilitative Care System Evaluation Framework**
   This includes the framework and a set of key indicators that can be used to evaluate rehabilitative care system performance at the local, regional and provincial levels.

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Approach

The work of the Task Group was conducted in two concurrent phases: the Capacity Planning Framework and the System Evaluation Framework were developed independent of one another, but by the same task group during the same time period. This approach ensured that the two frameworks remained connected and complementary while allowing them to both fulfill their distinct purposes.

Guiding Principles:

- Build on the work of the Definitions Task Group to support implementation of the standardized definitions and framework
- Use the best available data derived from existing and reliable data resources
- Address the cross continuum nature of rehabilitative care
- Optimize alignment with HSFR & Quality Based Procedures (QBP) provincial directions
- Avoid duplication of provincial health care initiatives (e.g., Ontario Stroke Network Stroke Report Cards)
- Ensure data to inform applicable indicators is easy to collect and report
- Include patient outcome and/or patient identified indicators, where appropriate
- Provide evidence of the benefits of rehabilitative care in achieving health system goals.

Approach to Developing the Capacity Planning Framework

The Task Group started its journey towards development of a capacity planning framework by completing a visioning exercise that asked the question, “What are the key questions to be answered by a rehabilitative care system capacity planning exercise?” The Task Group identified these key fundamental questions and organized them within five dimensions (Population, Resources, Utilization, Access, and Effectiveness) to support both analysis of the current state and design of the future state in consideration of current and target performance, alignment with the RCA Definitions Framework, and projected population needs. The Task Group then added ‘Gap Analysis’ and ‘Future State Design’ sections to the framework. To complete the framework, the group, acknowledging that each sector of the rehabilitative care system has unique capacity planning needs and considerations, further organized the framework by sector, in alignment with the sectors described in the RCA’s Definitions Framework (Figure 3).

With the framework and key fundamental questions identified (and validated with provincial stakeholders including the RCA Steering Committee, the LHIN Leads/HSP Advisory Groups, and the CP&SE Advisory Group), the CP&SE Task Group then identified ‘Potential Measures/Considerations’ within each sector and within each dimension of the framework.
Several efforts were undertaken to validate the framework:

- Recently completed, provincial rehabilitative care system capacity plans were reviewed to incorporate considerations being used contemporaneously in the field.
- The RCA reached out to six health care system consulting firms, as subject matter experts in the field of capacity planning, to seek feedback regarding the draft capacity planning framework.
- The Capacity Planning Framework was validated by a working group of provincial system stakeholders who had either recently completed or had planned to complete a rehabilitative care system capacity plan. This group reviewed the framework both for its format and content and made suggestions to enhance its ease of use and utility in the field.

The final RCA Capacity Planning Framework contains the following components:

- Introduction
- Capacity Planning Framework
  - Current State Analysis
  - Future State Design
  - Gap Analysis
  - Action Plan
- List of consultant feedback and LHIN rehab reports that were reviewed and incorporated into the RCA Capacity Planning Framework
- QBP Handbook Cohort Definition and Patient Grouping Approach (as of November 11, 2014)
- Rehabilitative Care Capacity Planning Framework data elements/considerations by source
- Glossary of acronyms.

“Thank you for leading this work. The quality and volume of work that has been completed has been stellar and has greatly supported me in my role as a Rehabilitation Network Lead in my own LHIN. We now have a roadmap to build a coordinated and sustainable system of rehabilitative care in Ontario.”

Helen Johnson, Rehabilitation Network Lead, Erie St. Clair LHIN
## Figure 3 – RCA Capacity Planning Evaluative Framework

<table>
<thead>
<tr>
<th>Questions To Be Answered by Capacity Planning Process</th>
<th>Potential Measures/Considerations</th>
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<tbody>
<tr>
<td></td>
<td>Acute Care</td>
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<tr>
<td>Current State</td>
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<tr>
<td>Population</td>
<td></td>
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<tr>
<td>Resources</td>
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<td>Effectiveness</td>
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<td>Complete Evaluation of Current State</td>
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<td>Future State</td>
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<td>Population</td>
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<td>Effectiveness</td>
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<td>Redesign</td>
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Approach to Developing the Rehabilitative Care System Evaluation Framework

Health Quality Ontario’s “Nine Attributes of a High-Quality Health System”\(^8\) were identified by the Task Group as being the foundational dimensions around which to structure an evaluation framework for a provincially coordinated rehabilitation system in Ontario. A search for existing logic models and evaluation frameworks utilizing these dimensions was undertaken by the RCA secretariat and surfaced the ‘LHIN Accountability Agreement Logic Model’.

The ‘LHIN Accountability Agreement Logic Model’ was developed by the Health System Indicator Initiative (HSII) to “produce the ‘logic’ in support of the performance indicator measurements being used to improve the health system”\(^8\). The logic model was developed to articulate the provincial drivers, system imperatives and local strategies and evaluate provincial health system performance indicators within the context of these provincial directions\(^9\). The ‘LHIN Accountability Agreement Logic Model’ also provides “LHINs and health service providers with a common tool for their conversations around the system level changes that the provincial indicators were meant to drive”. Given this provincial initiative and direction related to performance evaluation and the model’s alignment with the Nine Quality Dimensions, the CP&SE Task Group agreed to adopt the ‘LHIN Accountability Agreement Logic Model’ and develop a Rehabilitative Care System Evaluation Framework that directly aligns with the LHIN model.

An early version of the evaluation framework was then developed around the nine quality dimensions and the ‘LHIN Accountability Agreement Logic Model - Health System Imperatives’. This was used to organize existing, validated indicators currently in use across the health care system. Supported by task group member and subject matter expert, Imtiaz Daniel, Senior Consultant, Financial Analytics and System Performance, Ontario Hospital Association, and Adjunct Lecturer, Institute of Health Policy, Management and Evaluation, University of Toronto, the group then identified and incorporated existing rehabilitative care and other health system indicators into the RCA Rehabilitative Care System Evaluation Framework. Where indicators did not exist or were not specific to the rehabilitative care system, the Task Group developed high level indicator descriptions to support a comprehensive (i.e., inclusive of all sectors of the system) and balanced (i.e., around the nine quality dimensions) evaluation framework.

Using the HSII Indicator Evaluation Tool, the Task Group then undertook an exercise to attempt to identify ‘Priority Indicators’ within the framework that might be considered provincially as priority measures of rehabilitative care system performance. The indicators that were identified through this analysis were not deemed by the Task Group to be representative of priority measures of rehabilitative care system performance. As a result, the Task Group made recommendations regarding the principles to be used to support the prioritization of the existing indicators\(^*\) within the RCA Rehabilitative Care System Evaluation Framework in the RCA’s second two-year mandate:

- Relevancy to health system objectives

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\(^9\) Health System Indicator Initiative Steering Committee, Agenda Package. Wednesday, July 11, 2012, Retrieved on March 6, 2015 from [www.southwestlhin.on.ca/~/media/sites/sw/uploadedfiles/Public](www.southwestlhin.on.ca/~/media/sites/sw/uploadedfiles/Public).
• Alignment with other provincial initiatives
• Alignment with stated objectives of RCA System Evaluation Framework i.e.,
  o Demonstration of the contribution of the rehabilitative care system to overall health care system objectives
  o Prioritization of regional and provincial quality improvement opportunities
  o Standardized performance evaluation regionally and provincially
• Importance to stakeholders (e.g., patients, clinicians, administrators, LHINs, MOHLTC)
• Data should be adequate to support the measures
• Measures should be
  o Valid, reliable, and responsive
  o Actionable
  o Meaningful/easy to understand
  o Outcome-focused
  o Based on best practice
  o Informative to evaluative, planning, and policy decisions
• Measures/indicators are clearly and directly affected by rehabilitative care system performance
• Unintended consequences of the measures.

*NOTE: The Task Group strongly suggests that consideration of any priority indicators needs to be in the context of the intended objective of this framework (i.e., to provide a balanced perspective of the performance of the entire rehabilitative care system) and cautions against the use of any single indicator or small group of indicators to evaluate the system on either the local, regional or provincial levels.

In June 2014, the RCA Secretariat held a ‘Think Tank’ meeting of provincial system subject-matter experts (including some CP&SE Task Group members and some external stakeholders) to seek direction regarding the identification of targets/benchmarks within the RCA Rehabilitative Care System Evaluation Framework. These targets and benchmarks strengthened the framework by enabling its use for its intended purpose of supporting evaluation, planning of rehabilitative care resources and the identification of quality improvement opportunities within the provincial rehabilitative care system. The Think Tank group recommended that the CP&SE Task Group develop a methodology to organize the indicators within the framework into three categories related to the availability of existing targets/benchmarks and data to inform development of a target/benchmark. Based on this recommendation, and in alignment with language within LHIN Service Accountability Agreement Indicators, the Task Group included identifiers within the framework to reflect whether the indicators are explanatory or developmental and defined or not defined.

Key next steps for this work, which are included in the RCA’s second mandate work plan, include:
• Development of targets and benchmarks for indicators with existing data
• Identification of priority indicators within the framework (as per the guiding principles of the CP&SE Task Group)
• Development of definitions for Undefined Explanatory and priority Developmental indicators
Key Learnings

An overarching imperative consideration moving forward is related to data quality. Specifically, definitional clarity and precision with respect to metrics and data will be critical. In particular, as data are gathered from across the continuum, ensuring that data with respect to discharge sources and destinations and other parameters are consistently specified and linked will be critical.

Capacity Planning Framework

i. **Capacity planning analysis questions.** Capacity planning needs to look pragmatically at how best to provide optimal rehabilitative care to all patient populations given current capacity restrictions and the need to share this capacity amongst all populations requiring rehabilitation. The RCA Capacity Planning Framework was to include a comprehensive list of considerations inclusive of all potential scenarios and needs and is intended to be used, in whole or in part, to develop a capacity plan for either a broad or specific rehabilitative care population depending on availability of information and specific local needs. Analysis questions should be framed to meet local objectives prior to undertaking the capacity planning process i.e., only those questions/measures required to address local objectives/issues should be addressed to avoid excessive data burden.

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

iii. **Aligned levels of rehabilitative care.** The levels of rehabilitative care included in the Capacity Planning Framework are aligned with the levels described within the RCA Definitions Frameworks.

iv. **Use of minimum data set in Community/Ambulatory sector.** The Task Group encourages use of the RCA Outpatient/Ambulatory Minimum Data Set (MDS) to inform the analysis within this sector. Use of the MDS will begin to help to standardize definitions and data collection elements within this sector ahead of the provincial implementation of the MDS.

v. **Definitions/language across data bases.** The lack of congruence of definitions/language across data bases (e.g., discharge destinations, diagnostic descriptions, etc.) creates challenges for capacity planning.

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10 Adapted from: Quality-Based Procedures: Clinical Handbook for Hip Fracture Health Quality Ontario & Ministry of Health and Long-Term Care (May 2013)
11 RCA Definitions Framework for Bedded Levels of Rehabilitative Care (2014).
12 RCA Definitions Framework for Bedded Levels of Rehabilitative Care (2014).
vi. **Detailed level of data.** In order to quantify expected capacity needs, it is ideal to have the most detailed level of data available i.e., patient level should be used where available, and where not, the lowest most detailed level data from that database should be used.

vii. **Preventing double counting.** Recognizing the challenges that exist with respect to incongruent definitions across sectors/databases (e.g., patient classifications/diagnostic descriptors, discharge destinations, etc.), significant effort is required to ensure that an individual episode of care can only be categorized into a single condition/population to prevent double counting.

viii. **Detailed analysis of ALC rates.** In addition to including ALC rates in the current state analyses, consider a more detailed analysis of these ALC rates to develop an understanding of unmet need versus needs met in an untimely manner.

ix. **Supporting development of a common language.** Bolded “Potential Measures/Considerations” are those considered to be essential for completion by all LHINs/regions completing rehabilitative care system capacity plans. Doing so will support the development of a common language and foundational understanding of provincial rehabilitative care system resources and could potentially be used in the future to inform the development of a provincial rehabilitative care system capacity plan.

x. **Secondary objective review.** A secondary objective review by an outside source (e.g., LHIN staff or an HSP from another LHIN) may strengthen the regional capacity planning process and facilitate more cross-LHIN dialogue on rehab capacity planning.

xi. **Standardized models/assumptions.** The Task Group suggests that a key system benefit resulting from this work is the development of standardized models/assumptions for predicting growth and projecting bed numbers for rehabilitative care.

**System Evaluation Framework**

i. **Explanatory indicators.** The Task Group recognizes that targets and benchmarks are required to advance system change and support the inclusion of development of targets and benchmarks for the indicators within the RCA Evaluation Framework as part of the RCA’s second mandate. In the meantime, explanatory indicators can be used for local quality improvement in the absence of a provincial target/benchmark.

ii. **Population-specific indicators.** The evaluation framework was developed to be a balanced reflection of rehabilitative care system performance. As such, population-specific indicators were only included when doing so supported achievement of this objective. NOTE: Existing rehabilitative-care specific QBP indicators are included in the appendix of the framework.
iii. **Measure of integration of pediatric and adult rehabilitative care systems.** In order to evaluate and support improved transitions between the pediatric and adult rehabilitative care systems, the Task Group recommends development of a measure of the integration of the pediatric and adult rehabilitative care systems vis à vis the progress within the Ontario Special Needs Strategy.

iv. **Standardized process.** A key requirement to operationalize the RCA Rehabilitative Care System Evaluation Framework is the development of a standardized process* to support data collection, analysis and distribution.

*NOTE: The RCA has included this in its second mandate work plan.

v. **Patient experience.** Given the significant gap in the literature related to the measurement of patient experience across the (rehabilitative care) continuum, the Task Group included a placeholder for patient experience and recommends that an emerging system-level measure of patient experience be leveraged for inclusion in the RCA Rehabilitative Care System Evaluation Framework, once available.

**LHIN Value/Impact**

**Capacity Planning Framework**

The RCA Capacity Planning Framework was developed to support LHINs and HSPs to identify “opportunities for improved care, potential for cost reductions relative to current expenditure and estimates of the need for re-investment or re-allocation of funding”¹³ within local rehabilitative care systems and, once completed, to form the foundation of a provincial rehabilitative care system capacity plan. Once the current state analysis and ideal future state design are complete, the framework suggests completion of a gap analysis between the current and desired future states. This gap analysis will reveal the changes that are required to realize the desired future state and will support the development of an action plan and risk assessment. Completing regular rehabilitative care system capacity planning (i.e., every 3-5 years) will not only support the development of sufficient local rehabilitative care system capacity across the care continuum to optimize value and flow within the existing local system resources, but it will also proactively identify where system/service gaps exist and enable the opportunity to either develop the required services locally or develop cross-LHIN partnerships to ensure that high-quality rehabilitative care is accessible to all.

**Rehabilitative Care System Evaluation Framework**

The RCA Rehabilitative Care System Evaluation Framework will support:

- Demonstration of the contribution of the rehabilitative care system to overall health care system objectives
- Prioritization of regional and provincial quality improvement opportunities
- Standardized performance evaluation regionally and provincially.

In the short term, i.e., until a standardized process is developed for data extraction, analysis and reporting, and targets/benchmarks are identified, LHINs can use the framework to support local rehabilitative care system capacity planning efforts by reviewing local performance of these key rehabilitative care system indicators. Once the standardized process is developed and targets/benchmarks are identified, the framework will then allow LHINs to compare local performance on these key rehabilitative care system indicators against that of other LHINs and targets/benchmarks (where available). Doing so will support optimization of rehabilitative care performance both regionally and provincially as a key enabler of overall health care system objectives and imperatives as identified in the ‘LHIN Accountability Agreement Logic Model’.

**Tools/Resources to Support LHIN Implementation**

**RCA Capacity Planning Framework and Toolkit**

**RCA Rehabilitative Care System Evaluation Framework**
Frail Senior / Medically Complex

Gap/Issues Identified

In December 2012, Living Longer, Living Well. Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario was released. Authored by Dr. Samir K. Sinha, Provincial Lead for Ontario’s Seniors Strategy, the report includes a description of an ‘Assess and Restore Framework to Support Aging in Place’ (Figure 4) and recommendations related to ‘Enhanced Screening and Detection of Functional Loss’ and ‘Enhanced Assess and Restore Services Provision’ intended to support the development of the Assess and Restore Framework.

In response to the framework, the MOHLTC developed an Assess and Restore Guideline in collaboration with LHINs, HSPs, and clinical experts from across the province. The Guideline, published in October 2014, outlines expectations and defines the roles and responsibilities of LHINs, HSPs, and care providers in delivering Assess and Restore interventions across five areas: screening, assessment, navigation and placement, care delivery, and transitions home. Concurrently, in the spring/summer of 2013, the RCA was engaging rehabilitative care system stakeholders to develop the work plan and deliverables for the RCA’s first two-year mandate. Among the key priorities identified was the need to develop a provincial approach to support operationalization of an Assess and Restore philosophy with a particular focus on the needs of frail senior/medically complex populations.

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Deliverables

The Frail Senior/Medically Complex (FS/MC) Task and Advisory Groups were given the mandate to develop a rehabilitative care approach for frail senior/medically complex populations to support operationalization of priority elements of the Assess and Restore Framework.

Objective:

- Develop recommendations to support an evidence-based, cross continuum, rehabilitative care approach, including best practices guidelines, for frail senior/medically complex populations who have experienced recent and reversible functional decline that threatens their independence by:
  - Developing a standardized cross continuum process to support high-risk older and/or medically complex adults with restorative potential to access the level of rehabilitative care that is required to safely and most efficiently address their functional goals. This will align with the “Essential Elements of Assess and Restore Framework”, Ontario’s

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15 Sinha, S. Living Longer, Living Well. Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario (December, 2012).
Senior Strategy and the framework that is to be developed by the Rehabilitative Care Alliance’s Definitions Working Groups.

- Recommending screening tool(s) and clinical practices to support early identification of at risk/high-risk older and/or medically complex adults with restorative potential.

**NOTE:** This objective is aligned with recommendation #46 from *Living Longer, Living Well*:

> “The Ministry of Health and Long-Term Care should support the development of an evidence informed simple screening tool that can be self-administered or administered by a health or social care provider to help an older adult or caregiver determine whether the support of a local exercise or falls prevention class may be beneficial vs. a more formalized assessment by a community-based care coordinator.”

- Recommending existing assessment tools for use in combination with the clinical judgement of rehabilitative care providers and reflective of the individual’s functional trajectory to assess the care needs of high-risk older and/or medically complex adults with restorative potential.

- Identifying existing evidence-based interventions and clinical practices that are effective for rehabilitative care providers to use with high-risk older and/or medically complex adults who have restorative potential.

- Recommending standardized, measurable, outcomes measures (including patient/caregiver reported outcomes and experience) that can be used to evaluate the effectiveness of rehabilitative care delivered to frail senior/medically complex populations.

- Highlighting potential policy and process barriers that relate to this initiative.

**Deliverables:**

1. **Standardized ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’** (Figure 5)

This process includes three steps – i) Early Identification/Screening, ii) Assessment to Determine Need for Bedded Rehabilitative Care, and iii) Streamlined Referral. Implementation of the ‘Priority Process’ will require local contextualization of the standard process in consideration of available community resources.

**NOTE:** This element of the Assess and Restore Framework was prioritized by the Task Group to support recommendation #50 from *Living Longer, Living Well* – “The Ministry of Health and Long-Term Care should support LHINs to increase the availability and accessibility of sub-acute and geriatric rehabilitative care programs and support entry to them directly from the community, not only from hospital, and ensure timely access to assess and restore services, both inpatient and community-based. Through various

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16 Sinha, S. Living Longer, Living Well. Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario (December, 2012).
mechanisms, including accountability agreements, the LHINs should support the systemic adoption of best practices in the utilization of Assess and Restore services regardless of location.”

Figure 5 - Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED

<table>
<thead>
<tr>
<th>Step #1 Early Identification/Screening</th>
<th>Community</th>
<th>Primary Care</th>
<th>ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where</td>
<td>CCAC</td>
<td>CSS</td>
<td>GEMS or Delegate</td>
</tr>
<tr>
<td>When</td>
<td>• Referral for ADL/IADL support</td>
<td>• A change in functional status</td>
<td>• A change in functional status</td>
</tr>
<tr>
<td>• A change in functional status</td>
<td>• Part of 90 day re-Ax</td>
<td>• At time of check-up</td>
<td></td>
</tr>
<tr>
<td>How</td>
<td></td>
<td></td>
<td>• Upon presentation with functional impairment(s)</td>
</tr>
</tbody>
</table>

* If the screen identifies the patient as being ‘high risk’, an urgent comprehensive assessment may be required if clinically appropriate and/or not recently completed.
* The assessment in Step #2 is to be completed collaboratively with Primary Care, SG3 & other involved community providers

<table>
<thead>
<tr>
<th>Step #2 Assessment to Determine Need for Bedded Rehabilitative Care</th>
<th>CCAC</th>
<th>Specialized Geriatric Services</th>
<th>Primary Care Provider(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>Arrange for Completion of a Comprehensive Clinical Assessment by a Healthcare Provider(s) with Geriatric Expertise that Considers the Geriatric Syndromes and Baseline and Current Functional Status including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Confirmation that Patient is “High Risk” ii</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Recent ADL/functional decline</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Risk of needing ED, hospital or LTC if nothing is done</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Confirmation of Restorative Potential ii</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Ruling Out an Acute Medical Cause of Functional Decline</td>
<td></td>
<td>Primary Care/ED Practitioner</td>
</tr>
</tbody>
</table>

Complete Referral Form and Send to Most Appropriate ‘Lead Provider’ (as identified in collaboration w LHIN partners) who will lead/navigate Step #3.

<table>
<thead>
<tr>
<th>Step #3 Streamlined Referral</th>
<th>Lead Provider*</th>
<th>Centralized Intake</th>
<th>Receiving Bedded Rehabilitative Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>A. Confirm patient is eligible for bedded level of Rehabilitative Care iv</td>
<td>B. Determine most appropriate level of bedded Rehabilitative Care iv</td>
<td></td>
</tr>
<tr>
<td>What</td>
<td></td>
<td>NOTE: Expedited “priority” access may be considered for patients who present to ED or are anticipated to imminent require institutionalization</td>
<td></td>
</tr>
</tbody>
</table>

* Denotes potential Lead Provider. LHINs may identify another organization/group to lead Steps #3 based on local resources

1ii As defined in “Specialized Geriatric Services - Review Template” (July 7, 2014), Ministry of Health and Long-Term Care (MOH/LTC)
2ii As per Rehabilitative Care Alliance definition of ‘High Risk’. An AU/Score of approximately 5 or 6 reflects “High Risk”
3ii As per Rehabilitative Care Alliance definition of Restorative Potential
4iv As per Rehabilitative Care Alliance Definitions Framework

2. Priority Process Toolkit

Development of new tools, as part of a Priority Process Toolkit, to support operationalization of the provincial priority process including:

- A description of the Target Population
- A definition of Restorative Potential (developed in collaboration with the Definitions Task and Advisory Groups)
- A Checklist to Rule Out an Acute Cause of Functional Decline
- A Priority Process Referral Map
- Proposed Process Timelines
- A Priority Process Decision Tree
3. **Assessment Urgency Algorithm as Standardized Provincial Screening Tool**

Endorsement of the Assessment Urgency Algorithm (AUA) as the standardized provincial screening tool to support early identification of at risk/high-risk older and/or medically complex adults.

The AUA was selected by the Task Group as the screening tool within the provincial ‘Priority Process’ for three reasons: i) The AUA is the only tool that the group identified as having the potential to be used across the continuum of care (i.e., CCAC, Community Support Services, Primary Care, and Emergency Department); ii) the AUA offers six levels of risk stratification that support individualized care and treatment options rather than simply identifying a patient as “At Risk” or “Not at Risk”; and iii) The AUA was selected because of the potential for these six levels of risk stratification to inform the development of local referral pathways based on risk score. See ‘[AUA Referral Pathway Summary](#)’.

4. **Provincial Standard Referral Form**

Identification of the Provincial Referral Standard (PRS) for Rehab/CCC as the provincial standard referral form to be piloted to support direct admissions to bedded levels of rehabilitative care from the community/ED.

**NOTE:** Given provincial directions to implement the PRS Referral for Rehab/CCC by March 31, 2015, the Task Group suggests that the PRS be piloted for appropriateness to support direct referrals to rehabilitative care beds from the community as part of the ‘Priority Process’. The Task Group acknowledges that the PRS for Rehab/CCC was developed to support referrals from Acute Care and requires analysis of its appropriateness for referrals from the community.

5. **Process and Outcome Indicators**

Identification of process and outcome indicators to support evaluation of the effectiveness of the ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’.

6. **Compendium of Rehabilitative Care Best Practices**

Development of a ‘Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes’ that may contribute to functional decline/frailty.

**Approach**

The work of the Task Group was organized around the two main deliverables – the Priority Process and the Compendium. The development of the FS/MC deliverables was informed by an extensive review of the literature and consultations with rehabilitative care providers across Canada including rehabilitation programs/centres in Canada and elsewhere and by the amalgamation of contributions of the diverse perspectives and geriatric expertise of the members of the FS/MC Task and Advisory Groups from across

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17 See [RCA Frail Senior/ Medically Complex Backgrounder Document, October 2013](#).
the province. These efforts culminated in consensus on the key components of the standardized ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’ and ‘Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes’.

**Development of the Priority Process**

The objective of the ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’ is to support timely access to bedded levels of rehabilitative care directly from the community for the target population i.e., high risk community-dwelling adults:

- who have restorative potential
- who have experienced potentially reversible functional loss/decline
- for whom home-and/or ambulatory-based rehabilitative care is either not a safe, effective or available option, and
- who are at risk of institutionalization (Acute Care or LTC) if nothing is done.

The Priority Process is intended to remove Acute Care as the sole point of access to rehabilitative care beds. The priority process is not intended to replace community-based options that are available to support achievement of the client’s/patient’s functional goals. In fact, the Task Group emphatically recommends that all community-based options be considered prior to considering referral to a bedded level of rehabilitative care.

The FS/MC Task Group developed the Priority Process to support provincial standardization of direct admission to bedded levels of rehabilitative care for the target population while acknowledging the need for local contextualization based on existing resources, structures etc. It is intended that each LHIN, when implementing the provincial standard, will identify clear local pathways, processes and lead providers that best position the local providers and resources to support operationalization of the ‘Priority Process’ within the proposed timelines.

Extensive provincial stakeholder consultation was completed throughout the development of the Priority Process including with the MOHLTC, to ensure alignment between the priority process and the Assess and Restore Guideline. As a result, the Priority Process represents a provincial standard that supports provincial health system directions related to care of frail seniors and considers the immense variability in structures and resources currently in place across the province.

**Development of the ‘Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes’**

The Compendium is a collection of rehabilitative care-specific best and leading practices derived from a selection of existing gold standard references. It is organized in chapters corresponding to sectors of the rehabilitative care system (Acute Care, Bedded Levels of Rehabilitative Care, In-Home Rehabilitative Care, Long Term Complex Medical Management and Long-Term Care Homes, Outpatient/Ambulatory Rehabilitative Care, and Community Based Rehabilitative Care) enabling providers working within a
specific sector of the system to easily review best practice information related to the rehabilitative care management of geriatric syndromes specific to their sector. Within each chapter, the content is organized by geriatric syndromes that may contribute to frailty (Delirium, Cognitive Impairment, Polypharmacy, Falls/Mobility, Depression, Incontinence, Nutrition status, Pain Management, Pressure Ulcers, Frailty, Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs)). It is anticipated that use of the Compendium will begin to increase the knowledge and competency of rehabilitative care practitioners to complete a more comprehensive assessment and treatment of frail patients with geriatric syndromes that may be contributing to the presenting functional issues.

**Key Learnings**

i. **Diversity in geriatric and rehabilitative care resources.** One of the key learnings from this initiative was an understanding of the diversity in availability and types of geriatric and rehabilitative care resources across the province. There are regional differences with respect to access to geriatricians, geriatric rehabilitative care beds and community based rehabilitative care.

ii. **Diversity in referral processes to access rehabilitative care beds.** Another variation in local resources that was considered by the Task Group and considered in the development of the Priority Process is related to current and planned structures and process to support centralized coordination of referrals to rehabilitative care beds. While these provincial variations made the development of a feasible provincial standard challenging, it also presented a significant opportunity to begin to develop common nomenclature and practice standards related to the Priority Process.

iii. **Assessment to determine need for bedded rehabilitative care.** Step #2 of the ‘Priority Process’ is ‘Assessment to Determine Need for Bedded Rehabilitative Care’. This step would be triggered if a patient was screened as being at ‘high risk’ for institutionalization in Step #1 of the ‘Priority Process’ (either through screening with the AUA (i.e., a score of 5 or 6) or through clinical judgement). The Task Group considers the gold standard for assessment of a ‘high risk’ patient to be a Comprehensive Geriatric Assessment (CGA), intervention and treatment by an interdisciplinary Specialized Geriatric Services (SGS)\(^{18}\) team. However, the Task Group recognized that this resource is not available, or not available in a timely manner, in all parts of the province and did not want the absence of this resource to be a barrier to the ‘Priority Process’. Therefore, Step #2 is intended to be a comprehensive clinical assessment completed by the local resource with the most specialized expertise, which, in some cases, may be a geriatrician, SGS, or other interdisciplinary team of healthcare providers. It is expected that LHINs and regional HSPs will collaboratively identify a standardized regional process/pathway to operationalize the ‘Priority Process’ that includes identification of the most appropriate

\(^{18}\) As per definition provided in “Specialized Geriatric Services - Review Template” (July 7, 2014). Ministry of Health and Long-Term Care (MOHLTC).
provider(s) (i.e., those with the highest level of expertise in the assessment and treatment of geriatric syndromes and frailty) who are available to complete the assessment within the proposed timelines. Operationalization of the ‘Priority Process’, and an Assess and Restore philosophy in general, necessitates the development of geriatric care capacity within the community and primary care, where SGS do not exist, and strengthening existing services – including those in bedded levels of rehabilitative care.

iv. **Access to rehabilitative care beds for community referrals.** Successful implementation of the Priority Process will require timely access to rehabilitative care beds for community referrals. The Assess and Restore Guideline states, ‘LHINs should work with CCACs and hospitals offering facility-based A&R interventions to promote acceptance by hospitals with rehabilitation and CCC beds of direct referrals from the community and the admission of targeted seniors and other persons with stable but complex medical needs to rehabilitation beds” and should work with hospitals to develop patient prioritization processes that do not arbitrarily disadvantage people based on their current location or referral source (e.g., in the community, another hospital, another hospital network, an acute bed, or an emergency department)\(^1\). Given patient flow pressures in acute care, there was significant discussion amongst provincial stakeholders about how to best accomplish this. While the Task Group has proposed timelines for this process based on subject-matter expert opinion/direction, it has suggested that until the Priority Process is piloted, decisions related to prioritization of community versus acute referrals are best made at the local level. However, in alignment with the Auditor General’s recommendation regarding access to required outpatient services, prioritization of eligible patients based on need rather than on source of referral\(^2\), may be prudent.

v. **Due diligence on part of referring providers.** A concern with admitting patients directly from the community is that they will not have had a recently completed comprehensive acute care work-up and may be admitted to a facility that does not have intensive medical resources. To mitigate this risk, the FS/MC Task Group developed the Checklist to Rule Out an Acute Cause of Functional Decline to support due diligence on the part of referring providers and boost confidence amongst receiving providers that patients being referred to rehabilitative care beds from the community are medically appropriate. The group has included an indicator intended to monitor medical appropriateness of direct admissions to rehabilitative care beds within its set of indicators. The Task Group also suggests that, in order to support Emergency Department avoidance, receiving sites may consider a formal partnership with an acute care organization and/or a detailed, formal plan to manage patients who are directly admitted to a rehabilitative care bed from the community but who require diagnostic services to support their rehabilitative care treatment plan.


Alternatively, where multiple providers are available to provide bedded rehabilitative care, regions may consider identifying a single rehabilitative care provider who has an existing partnership with an acute care organization offering diagnostic services, to be the regional provider that accepts direct referrals from the community. This model would also promote development of a geriatric rehabilitative care critical mass and expertise in the management of frail, geriatric patients with functional needs.

vi. **Risk of institutionalization/long-term care.** Another concern with admitting high risk, frail adults directly from the community, is related to their risk of potentially needing institutionalization/Long Term Care (LTC). This may create hesitancy at receiving sites to admit these high risk adults for fear that if the patient does not achieve their functional goals they may end up requiring LTC and impair flow through the rehabilitative care unit. The Task Group suggests that in order to reduce this concern, that local processes be developed to support those who do end up requiring LTC to wait in the community with intensive CCAC services (e.g., Home First) rather than in a rehabilitative care bed.

vii. **Lack of data and evidence to drive process timelines.** The Task Group was challenged by the lack of data and evidence to guide the development of the Proposed Process Timelines. The target for admissions to rehabilitative care from the emergency department is based on Pay for Results (P4R) targets and is most likely achievable in a scenario involving an internal transfer. The proposed timelines are a standard to strive towards and are expected to be informed by pilots of the Priority Process.

viii. **Application of the AUA in Primary Care.** The RCA Secretariat received feedback from stakeholders that, while the AUA was effective and appropriate for screening for the target population, utilization of the tool in Primary Care may be challenged by the sheer volume of screening tools currently being presented to this group. As such, it was suggested that efforts to integrate the AUA into Electronic Medical Record (EMR) platforms may enable the use of the AUA amongst Primary Care providers.

ix. **Translating Compendium best practices into practice changes.** While the Compendium provides an opportunity for rehabilitative care providers to review relevant, existing best practices related to the assessment and treatment of geriatric syndromes, review of the Compendium alone will not translate into practice changes. Realization of the full benefit of the Compendium will require organizations and health service providers to identify and implement deliberate structures, processes and opportunities for rehabilitative care providers to translate the best practices in the Compendium into new knowledge, skill and practice patterns. For example, the successful implementation of senior friendly hospital approaches required LHIN

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wide leadership and implementation of processes that were multi-level and organization wide in order to observe the desired outcome of increase uptake of best practices in geriatric care.

**LHIN Value/Impact**

Implementation of the Priority Process and its supporting tools will enable LHINs to continue their journey towards ensuring that the right patients are accessing the right services at the right time. By removing acute care as the sole point of access to rehabilitative care beds and by identifying and stratifying frail patients earlier, LHINs can begin to proactively support the needs of the target population. Development of local AUA referral pathways based on AUA risk scores will support local capacity planning of resources for this frail senior/medically complex population. This capacity planning will support the availability of services to most appropriately meet the needs of that target population.

For LHINs to successfully implement an Assess and Restore Framework as described by Dr. Sinha in Ontario’s Seniors Strategy and an Assess and Restore philosophy as described by the MOHLTC in the Assess and Restore Guideline, the full continuum of resources needs to be developed. Specifically, timely access to rehabilitative care beds, outpatient and other community-based rehabilitative care services, in-home rehabilitative care and support services (e.g., to support patients to wait at home for a rehabilitative care bed as part of the Priority Process), as well as increased capacity in comprehensive geriatric assessment, are required to fully and successfully operationalize a regional Assess and Restore philosophy. Development of this philosophy is being advanced by the MOHLTC’s Assess and Restore 2014/15-2016/17 funding. The RCA will continue to support LHINs in the implementation of Assess and Restore funded initiatives and in cross-LHIN coordination of Assess and Restore project objectives and learnings.

Utilization of the ‘Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes’ will support the development of competency within the rehabilitative care system to identify and manage geriatric syndromes. Use of the Compendium will support rehabilitative care practitioners (i.e., health care providers who are working with patients with functional goals) to contribute to the health system’s need to distribute knowledge and skills related to frailty and geriatric syndromes amongst all providers so that practitioners with specialized geriatric expertise can be reserved for the patients with the greatest and most complex geriatric needs.

**Tools/Resources to Support LHIN Implementation**

The following tools are available to support implementation of the ‘Provincial Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED’:

- A description of the Target Population
- A definition of Restorative Potential (developed in collaboration with the Definitions Task and Advisory Groups)
- A Checklist to Rule Out an Acute Cause of Functional Decline
- A Priority Process Referral Map
- Proposed Process Timelines
A Priority Process Decision Tree

Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes

“The work of RCA has helped to bring providers together to work on some very challenging topics. The work impacts the whole health care system and dovetails nicely with other initiatives that focus on the needs of seniors.”

Dr. Barbara Liu
Executive Director, Regional Geriatric Program of Toronto
Associate Professor, Department of Medicine, University of Toronto
Outpatient / Ambulatory

Gap/Issues Identified

Several reports and stakeholders have identified a need to clarify the role of outpatient/ambulatory-based rehabilitative care as well as a need for standardized data collection on outpatient rehabilitation services. Clinical decision makers have long expressed interest in evaluating outpatient rehabilitation, particularly given the reported erosion of outpatient rehab services over the last 10-15 years and observed access issues in the literature. According to the results of a provincial survey of outpatient rehabilitation services completed between September 2010 and January 2011, “there is no comprehensive cross sectorial system that must be used to report all services delivered. It is therefore difficult to determine the exact amount and type of ambulatory rehabilitation therapy provided across the province or in any given LHIN”\(^{22}\). Additionally, multiple sources reveal concurrent restrictions on eligibility requirements and the supply of hospital-based outpatient/ambulatory services in response to reductions in overall hospital funding\(^{19,23}\).

Confounding and contributing to this problem is that clinical information related to patient-level services delivered, service volumes, or the level of rehab intensity, is absent from the MOHLTC’s data holdings\(^ {24}\). The need for standardized data collection has been linked to a renewed focus on understanding the role of outpatient rehabilitation within an integrated and efficient healthcare system\(^ {25}\).

The need for standardized data collection is also being highlighted by Health Quality Ontario. Five of HQO’s Quality Based Procedure Handbooks have specific reference to the absence of, and need for, standardized data collection within outpatient rehab: Stroke, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Hip Fracture, and Total Joint Replacement (TJR). For example, the Clinical Handbook for Primary Hip and Knee Replacement suggests that since hospitals are not required to report on outpatient rehabilitation clinic activity, there is “a significant gap in provincial information systems”\(^ {26}\). HQO’s Clinical Handbook for Hip Fracture suggests that the “absence of standardized provincial reporting of outpatient rehabilitation clinic activity creates a void in understanding the pathway of hip fracture patients”. Most recently, the integrated Clinical Handbook


for COPD indicates that, “virtually no patient-level data on COPD-related outpatient clinic services are currently collected or reported in Ontario. The ministry should adopt this as a priority area for new data collection, starting with the collection of activity data from outpatient pulmonary rehabilitation clinics.”

Further, in 2013, the Auditor General of Ontario released a report indicating that in order to ensure that patients have timely access to required outpatient services, hospitals should collect information regarding the efficiency and effectiveness of outpatient resources, such as “information on the number of appointment cancellations and patient no-shows, and on the change in patient functionality between when outpatients start and when they complete outpatient rehabilitation.” The AGO went on to recommend that, “in order to have good information for current and future decision-making, the Ministry should establish, in conjunction with its stakeholders, what information should be collected on restorative inpatient and outpatient services and how best to collect the data.”

**Deliverables**

To address the lack of standardized reporting of performance related to outpatient/ambulatory rehabilitative care, the Outpatient/Ambulatory (OP/AMB) Task and Advisory Groups were given the mandate to develop a standardized minimum data set for MOHLTC-funded, outpatient rehabilitative care programs (i.e., hospital-based and other ambulatory clinics). The data set will enable standardized data collection and the development of comparable performance metrics, evaluation and planning at the provincial, regional, local and organizational levels as well as inform LHINs and health service providers of the role of outpatient rehabilitative care in supporting other aspects of hospital and community-based services.

Deliverables:

1. **Evaluative Framework**
   An evaluative framework (Figure 6) to support comprehensive consideration of the critical questions to be answered by the Outpatient/Ambulatory Rehabilitative Care MDS.

2. **Outpatient/Ambulatory Rehabilitative Care Minimum Data Set**
   An Outpatient/Ambulatory Rehabilitative Care Minimum Data Set within the ‘Access and Transition’ and ‘Financial Performance’ quadrants.

3. **Comprehensive Review of Existing Functional Outcome Measures**
   A comprehensive review of existing functional outcome measures validated for use in the outpatient/ambulatory rehabilitative care setting at the activity/participation level.

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4. **Preliminary Measure of Patient Experience**
   A preliminary measure of patient experience for the outpatient/ambulatory rehabilitative care setting.

5. **Outpatient/Ambulatory MDS Toolkit**
   A ‘toolkit’ containing the following documents/tools to describe and support the development of the outpatient/ambulatory minimum data set:
   - Technical Report describing the data elements within each quadrant of the MDS
   - ‘Rationale for Data Elements Within MDS’
   - ‘Rationale for Advancing Outpatient Rehab MDS’
   - ‘Assessing Patient Experience Across the Rehabilitative Care Continuum’ - Report Prepared for the Waterloo-Wellington Local Health Integration Network Rehabilitative Care Council by The Geriatric Health Systems Research Group, University of Waterloo

6. **Provincial Validation Survey**
   A provincial validation survey, including 14 LHIN-specific reports as well as a provincial analysis to:
   - Generate a list of outpatient rehab (OPR) programs funded by the MOHLTC/LHINs and an estimate of service volumes (patients served, episodes of care, visits) across programs.
   - Understand the type of data currently collected by the OPR programs.
   - Understand the potential implications of implementing the proposed Minimum Data Set.
Figure 6 - Evaluative Questions within the ‘Framework for Performance Measurement in Outpatient Rehabilitative Care’

**Assumptions** – A patient grouping/classification tool will be identified and utilized to capture:
- the patient’s functional need
- the reason for referral/for accessing service
- diagnostic code

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<tbody>
<tr>
<td>1. What is the primary reason for which the patient is seeking treatment in the outpatient/ambulatory program?</td>
<td>B1. What is the patient’s / caregiver’s reported experience of their outpatient rehabilitative care?</td>
<td>C1. How much functional change occurred in activity and/or participation while attending an outpatient/ambulatory program whose primary function is to restore/optimize function?</td>
<td>D1. Which type of organization referred the patient to OP rehab? (acute care, home care, inpatient rehab, etc.)</td>
<td>E1. Was the treatment plan completed? If not, why?</td>
</tr>
</tbody>
</table>
| 2. What is the primary diagnosis for which the patient is seeking treatment in the outpatient/ambulatory program? |                                                                                                   | C2. Where the objective of outpatient/ambulatory program was maintenance, education, self-management or consultative/assessment, was that objective achieved? | D2. How many days did the patient wait (once ready for rehab)
  • for the first treatment appointment date? | E2. What is the average direct cost for an episode of care to treat each discharged patient by patient population? |
|                                                                                         |                                                                                                   | C3. Did the outpatient/ambulatory program influence the caregivers’ level of stress/burden associated with caring for the patient? | D3. Of the patients requesting treatment, how many actually received treatment? | a) How many discharged patients were treated by the program per reporting period? |
|                                                                                         |                                                                                                   |                                                                                      | D4. How many referrals were declined?
  Reason for declined referral?                                                          | b) What types of health discipline services did the patients receive?                 |
|                                                                                         |                                                                                                   |                                                                                      | D5. How many patients were accepted to be treated by the Outpatient program but the patient did not accept? | c) What was the average length of each episode of care? |
|                                                                                         |                                                                                                   |                                                                                      |                                                                                      | d) How many visits/attendances (average/median) per health discipline functional centre and for all health discipline functional centres did each patient receive in the episode of care? |
|                                                                                         |                                                                                                   |                                                                                      |                                                                                      | e) How much time is the program providing to the patient per episode of care? |
Approach

The following guiding principles supported the development of the RCA Outpatient/Ambulatory Minimum Data Set:

- Consideration of the relative ease of collection and reporting of data elements.
- Recommended data elements will align with data elements currently collected within other sectors (e.g., Community Clinics, CCAC) to support cross continuum data collection and reporting (where possible).
- Elements included in the dataset will demonstrate evidence of the benefits of outpatient/ambulatory rehabilitative care in achieving health system goals (e.g., patient outcomes, implementation of best practices, costs).
- The interests of all levels of stakeholders will be considered in the development of the MDS, where possible/appropriate (Figure 7).

Figure 7 – Consideration of Stakeholder Interests in the Development of the Outpatient/Ambulatory Minimum Data Set

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Approach for Developing the Evaluative Framework & Minimum Data Set

The OP/AMB Task Group endorsed the GTA Rehab Network’s ‘Evaluation Framework and Indicators for Performance Measurement of Outpatient Rehabilitation’ which includes quadrants for

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Patient/Caregiver Experience, Clinical Outcomes, Access and Transition, and Financial Performance. This framework was used to structure the development of the fundamental questions upon which the provincial Rehabilitative Care Minimum Data Set was developed. Once the fundamental questions were identified, the MDS was developed for the ‘Access and Transition’ and ‘Financial Performance’ quadrants by creating categories/definitions, indicators, data elements and calculations to support the answer to each fundamental question. The evaluative framework and MDS are detailed in the RCA’s Outpatient Data Collection Technical Report.

In an effort to ensure that only data required to make critical decisions was included in the MDS, the following key stakeholders were consulted regarding their requirements for an outpatient ambulatory rehabilitative care MDS:

- Provincial LHINs
- Health Quality Ontario (HQO)
- MOHLTC (Implementation Branch, Health Services Branch)
- MOHLTC (Information Management, Strategy and Policy Branch)
- MOHLTC (Health System Funding Policy Branch)
- Ontario Hospital Association (OHA).

Comparison of this feedback with the draft MDS provided validation that the MDS developed by the OP/AMB Task Group was aligned with stakeholder needs and did not contain redundant/excessive data elements. (See Appendix F).

In addition to monthly and quarterly meetings with the RCA OP/AMB Task and Advisory Groups, respectively, additional feedback on the draft Rehabilitative Care Minimum Data Set was sought through a province-wide validation exercise where the MDS was distributed through the LHIN Leads to HSP organizations with outpatient/ambulatory rehabilitative care programs. The RCA also distributed the survey to all MOHLTC-funded Community Physiotherapy Clinic operators across the province. The validation exercise sought to:

i) Generate a list of outpatient rehab (OPR) programs funded by the MOHLTC/LHINs and an estimate of service volumes (patients served, episodes of care, and visits) across programs

ii) Understand the type of data currently collected by the OPR programs

iii) Understand the potential considerations of implementing the proposed MDS

iv) Collect general feedback on the MDS

The survey results from 160 organizations offering outpatient/ambulatory rehabilitative care programs (out of 278 – a 58% response rate) were used to further refine the MDS. A LHIN-specific analysis of the results was conducted for each LHIN as well. (See Appendix G for a summary of the survey findings)

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Approach to Selecting a Measure of Clinical Outcomes

Key stakeholder consultations to date suggest that a measure of patient functional status at intake and discharge be included in the data set to support:

- Measurement of functional outcomes and the effectiveness of services delivered
- Case mix/risk adjustment of populations to support funding models and evaluation of outcomes
- Evaluation of resource utilization and to inform capacity planning across regions and populations.

The OP/AMB Task Group identified the following evaluative questions to be answered within the ‘Clinical Outcomes’ quadrant of the evaluative framework:

- How much functional change occurred in activity and/or participation\(^{31}\) while attending an outpatient/ambulatory program whose primary function is to restore/optimize function?
- Where the objective of outpatient/ambulatory program was maintenance, education, self-management or consultative/assessment, was that objective achieved?
- Did the outpatient/ambulatory program influence the caregivers’ level of stress/burden associated with caring for the patient?

In order to answer these evaluative questions, the group set out the following guiding principles to support its efforts to evaluate and select a measure of clinical outcomes for inclusion within the MDS:

1. Development of an MDS creates opportunity to:
   - address a significant system need
   - align with/inform system directions related to Post-Acute Care HSFR
   - demonstrate the value of OP/AMB rehabilitative care.
2. There are no new resources/funds. Need to consider time to complete, training requirements, collection of follow-up measures.
3. It is intended that the MDS will align with existing datasets to support data flow across continuum of rehabilitative care and broader health care system (where possible).
4. There is no perfect tool.
5. Appropriate focus is the activity/participation level\(^{29}\) (i.e., execution of a task and involvement in life situations).

Under these principles, the group underwent a modified Delphi process to identify and evaluate existing outcome measures (including RNLI, EQ-5D\(^{TM}\), AusTOMs, CORE™ instrument, and the Barthel) to support the evaluation of broad, system level, non-population specific outcomes at the activity/participation level. This modified Delphi process also supported the development of criteria against which these outcome measures were evaluated. The process revealed that the existing tools were largely equal and none demonstrated sufficient psychometric properties for the diverse range of patients served in the outpatient rehabilitative care setting.

The OP/AMB Task and Advisory Groups engaged in significant discussion about the decision to focus on the identification/development of a non-population specific outcome measure at the activity/participation level\textsuperscript{29} that considered multiple dimensions of function and enablers of function (e.g., mobility, mood, ADLs, psychosocial, cognition etc.). It was felt that this approach best addressed the needs of stakeholders (i.e., MOHLTC, LHINs, HSPs, Patients/Caregivers) and the potential uses of the MDS (e.g., to inform funding, program evaluation, clinical goal/care plan development, etc.). Due to the heterogeneity of the populations typically seen in the outpatient rehabilitative care setting, there was some concern that selection of a single tool for all populations may be challenged by a lack of sensitivity to functional change, and/or burdensome with respect to data collection (especially for higher functioning populations that have a localized impairment). However, the groups felt that exploring a non-population specific outcome measure at the activity/participation level, that was both sensitive to functional change and adaptive in its’ questioning, was prudent.

The RCA Steering Committee endorsed the following direction in September 2014:

\textit{In order to enhance the feasibility of adoption of the RCA MDS, and in response to stakeholder suggestions and system directions (i.e., alignment with existing data sets and reporting systems), alignment with an existing data reporting system should be prioritized.}

As a result of the Task and Advisory Groups’ decision and the RCA Steering Committee’s direction, the CORE™ instrument (reported through NRS) and the InterRAI Community Health Assessment (reported through CCRS) were the two tools short-listed by the group given the mandated use of these system level tools across other segments of the healthcare continuum. However, after completing a detailed comparative analysis of the two tools, the Task Group concluded that the CORE™ instrument should no longer be considered for the RCA Outpatient/Ambulatory Minimum Data Set as there are concerns with the sensitivity of the tool to detect change with the modified 3-point Sigma FIM™ scale. The remaining items of the CORE™ instrument are comprised of Uniform Data System for Medical Rehabilitation’s (UDSMR) LIFeware\textsuperscript{SM} System which do not align with existing data sets and therefore do not support data flow across the continuum. The Task Group directed the Secretariat to reach out to both InterRAI and UDSMR regarding potential opportunities to develop a new/revised functional outcome measurement tool within the guiding principles outlined by the Task Group:

- The development process needs to involve strong collaboration with the field in order to ensure that the appropriate sensitivity is captured.
- The developed tool will need to be piloted across a variety of outpatient/ambulatory rehabilitative care programs/clinics to test its psychometric properties and appropriateness for the OP/AMB Rehabilitative Care sector.
- The patient classification system for the outpatient/ambulatory rehabilitative care setting will need to be a priority within the development parameters. Patient classification system will need to align with the inpatient and community sectors to support the flow of information across the system.
- Time to complete and additional burden of data collection should be another development parameter. The developed tool should include the concept of screening/triaging using core questions for all patients and a more comprehensive assessment where clinically appropriate.

UDSMR declined the offer but InterRAI responded with an interest in partnering in a joint effort to develop an OP/AMB InterRAI Tool for consideration by the RCA’s stakeholders and for potential piloting. Preliminary efforts of this partnership with InterRAI are described in Figure 8 - specifically, a tool that includes adaptive questioning across multiple dimensions to support both a comprehensive assessment as well as to minimize unnecessary data collection for higher functioning patients. The vision includes condition specific functional outcomes measures as mandated/directed by best practice. Further development of this tool, in partnership with InterRAI, will be a focus of the RCA’s second mandate.

**Figure 8 – Preliminary Directions to Develop a Measure of Functional Outcomes with InterRAI**

**Approach to Developing a Measure of Patient Experience**

In early 2014, a report commissioned by the Waterloo Wellington Rehabilitative Care Council, “Assessing Patient Experience Across the Rehabilitative Care Continuum”, was completed by the Geriatric Health Systems Research Group at the University of Waterloo. This report was “a systematic analysis of peer-reviewed literature”, which “identified 25 valid and reliable survey tools and accompanying patient experience measures and uncovered a number of constructs that are particularly salient to rehabilitative care clients. These constructs were thematically consistent with the insights
provided by rehabilitative care clients participating in a large ethnographic study in the Waterloo Wellington region, and were member-checked by patients and their caregivers who had experienced care across the system.32

Several RCA Task and Advisory Groups (including the Patient/Caregiver Advisory Group) received presentations from Dr. Josephine McMurray regarding the initiative and endorsed the report’s finding as being a foundation upon which to build a measure of patient experience for the OP/AMB rehabilitative care setting. The development of this measure in continued partnership with Dr. McMurray and Dr. Stolee will be a focus of the RCA’s second mandate.

Key Learnings

i. **Implementation timelines and coordination.** There is broad awareness and appreciation amongst system stakeholders of the need for standardized data collection in the OP/AMB rehabilitative care setting. Details regarding implementation timelines and coordination are required and will be a key focus of the RCA’s second mandate.

ii. **Change management support.** As with any transformational system change, a change management strategy will be required to support the successful implementation of the MDS. One of the learnings from the validation survey was that a high percentage of provincial respondents are already collecting the majority of the proposed data elements. However, stakeholders still expressed the need to consider the burden of data collection relative to the benefits of doing so. This has illustrated that the data elements will need to be considered and quantified in order to distinguish between the collection of new data elements versus simply reporting/recording already collected data in a different way.

iii. **Minimizing the burden of data collection.** Every effort was made to ensure that the MDS is both balanced and comprehensive while minimizing the burden of data collection. Regular reviews and analysis were completed by the Task Group to ensure that each distinct data element was “need to know” rather than “nice to know”. The document demonstrating this alignment can be accessed [here](http://regionalhealthprogramsww.com/Files/Assessing%20Patient%20Experience%20Across%20the%20Rehabilitative%20Care%20Continuum_Final_submitted.pdf). Retrieved March 4, 2015.

iv. **Balancing MDS with all quadrants of framework.** Based on the assumption that data collected by the MDS will be used to inform funding and evaluation of OP/AMB rehabilitative care services, the Task Group is unequivocal in its recommendation to ensure that the final MDS be balanced with information from all quadrants of the framework, i.e., to ensure that ‘Access & Transition’ and ‘Financial Performance’ data elements are balanced by information regarding ‘Patient/Caregiver Experience’ and ‘Clinical Outcomes’.

In summary, implementation of the MDS will require:

1. Development of a classification system/diagnostic codes for an outpatient/ambulatory rehabilitative care setting. To ensure an accurate understanding of the utilization of services, a patient classification system that captures patient severity/complexity (inclusive of functional need, reason for referral and diagnostic code) is required. This will provide a rationale for service utilization and ensure that resources are planned, evaluated and remunerated appropriately based on individualized patient need rather than simply by diagnostic group.
2. Identification and operationalization of a reporting system.
3. A mandate to collect and report the data.
4. Resources to support implementation/change management.

Attainment of these requirements will be sought as part of the RCA’s second mandate as per its work plan, in consultation with system stakeholders.

**LHIN Value/Impact**

Regional implementation of QBPs with outpatient/ambulatory rehabilitative care system contribution (i.e., Stroke, COPD, CHF, Hip Fracture, and TJR) will be challenged by the lack of information that is currently available regarding the activity, outcomes and efficiencies in this important sector of the system. The OP/AMB MDS has been developed to include the data elements that are required to answer fundamental questions about the sector in order to optimally implement QBPs.

In September 2014, the Premier gave the Minister of Health and Long-Term Care three mandate priorities that reinforce the importance of an Outpatient/Ambulatory Rehabilitative Care Minimum Data Set to broader system changes:

1. **Ensure that “patients receive timely access to the most appropriate care in the most appropriate place” (Appropriate Care)**
   a. For many conditions, rehabilitation is delivered in multiple settings that serve overlapping populations. Because there is a lack of data on patient complexity and acuity in OPR, it is not possible to determine if Ontarians are getting the care they need in the most suitable settings, achieving the same or better outcomes, at the most affordable price.
   b. For conditions where the MOHLTC and the field have developed clinical handbooks in which community rehabilitation is the expected or default setting, it is challenging to know if patients
are actually receiving this care, if not, why, what outcomes are being achieved, and at what cost.

Reporting the RCA’s Outpatient Rehabilitative Care Minimum Data Set will inform the best setting for defined types of therapy for specific conditions by filling the data gap that currently exists within this part of the care continuum.

2. “[Invest] in community infrastructure to help shift care from hospitals to community settings” (Community Capacity)
   a. As the MOHLTC continues to transfer services from hospitals to the community, there must be an appropriate community ‘receptor site’ to assume these services. However, in the absence of standardized data reporting within OP/AMB rehabilitative care to enable tracking, funding and target-setting for activity, a growing number of hospitals and LHINs across the province have opted to close completely or scale down their OP/AMB rehabilitative care services. Stakeholder feedback suggests that because outpatient rehabilitative care is neither a core nor a priority service for many hospitals, more reductions can be expected. This is a major impediment to downward substitution. Under existing funding rules, efficient hospitals also have no incentive to redeploy rehabilitation resources from the inpatient to the outpatient setting. Due to the lack of data collection and quality reporting, the LHINs and the MOHLTC have no means to validate or measure the consequence of these claims. These closures and cutbacks have occurred despite increasing evidence demonstrating both the effectiveness and cost-efficiency of OP/AMB rehabilitative care, as well as recommendations in provincial reports such as “Caring For Our Aging Population and Addressing Alternate Levels of Care”, “Living Longer, Living Well: Recommendations to Inform a Seniors Strategy for Ontario”, Health Quality Ontario’s QBPs, etc. that have reaffirmed OP/AMB rehabilitative care as a key component of the provincial rehabilitation system.

33 The Ontario Orthopaedic Expert Panel established a provincial target of discharging 90% of primary hip and knee replacement patients directly home from acute care. According to the HQO episode analyses for TKR and hip fracture: Primary knee replacement – Between 2007/08 and 2009/10, 31.3% of patients were discharged home with no recorded rehab services provided in the 30 days following discharge. In addition, HQO’s clinical handbook for hip fractures indicates that “patients who are medically stable, cognitively intact, and able to mobilize short distances benefit from early supportive discharge home to receive a community-based rehabilitation program”. The QBP for short-stay medically complex home care clients identifies community-based rehab clinics, including hospital outpatient facilities, as the ideal destination for patients recovering from strokes and COPD.

34 The Ontario Society of Occupational Therapists, the Ontario Physiotherapy Association, the Ontario Bone and Joint Health Network and the Ontario Orthopaedic Expert Panel completed a joint survey between September 2010 and January 2011 intended to inventory the amount of ambulatory rehabilitation treatment available, with a focus on musculoskeletal patients, through outpatient rehabilitation departments associated with acute, rehabilitation and complex continuing care hospitals. The results of the survey revealed that “There has been a marked increase in reductions/closures of outpatient services in the past two years. 3% of respondents reported having no services, and 50% of respondent sites who had indicated they provide outpatient services had reduced those services within the past two years. Additionally 16% indicated planned reductions in 2011”.

35 Walker, D. Caring For Our Aging Population and Addressing Alternate Levels of Care. Report Submitted to the Minister of Health and Long-Term Care (June, 2011).

36 Sinha, S. Living Longer, Living Well. Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario (December, 2012).
b. Data about the services delivered to patients with similar diagnoses could inform analyses of service gaps and health human resource needs. Capacity planning will not be possible without a better sense of what OPR services are currently available. Standardized data collection and reporting from OP/AMB rehabilitative care services will provide information that is required to complete capacity planning and evaluation of outpatient rehabilitative care resources/services in order to:
- Ensure sufficient capacity within the Community Care sector
- Fully operationalize an Assess and Restore philosophy
- Evaluate delivery of best practices/patient outcomes
- Evaluate access to OP/AMB rehabilitative care

In the absence of standardized data collection and reporting in the outpatient/ambulatory rehabilitative care sector, there is no clear picture of where and what services are being offered. This limits LHINs’ ability to effectively evaluate and plan for capacity and how to make informed decisions about investments that will maximize community infrastructure.

3. “Continue to change Ontario’s funding system for hospitals ... so that it reflects that care that people need and receive” (Value for Tax Dollars)
   a. As an integrated service provider within the existing continuum of rehabilitative care, OP/AMB rehabilitative care services facilitate flow within the system by supporting timely and coordinated discharges for patients from inpatient rehab settings. Expanded OP/AMB rehabilitative care services have the potential to generate system-wide cost savings as an alternative to the use of expensive inpatient rehabilitation beds for patients who do not require them (e.g., patients with primary, unilateral joint replacements and mild strokes). In some cases, OP/AMB rehabilitative care can also be a more cost-effective option than one-to-one in-home rehabilitation services. In the absence of case costing data, it is uncertain what an episode of care price should be for OP/AMB rehabilitative care services relative to other care settings (CPCs, CCACs) for the same condition.

   b. The lack of requisite data also creates accountability issues across the continuum as it is not possible to connect costs to actual services delivered in OP/AMB rehabilitative care clinics to individual patients. To address the issue of accountability and sustainability under HSFR, the MOHLTC over time will move towards an integrated price for QBPs across the continuum of service providers. However, in the absence of reliable and valid OP/AMB rehabilitative care data, this evolution will be frustrated and OP/AMB rehabilitative care services will continue to erode.

   c. With these gaps in our provincial data on episodes of care, it will be very difficult to plan for HSFR/QBPs for Post-Acute and Rehab sectors, and very challenging to implement ‘bundled payment’ type models that include Post-Acute Care, e.g.,
- What is the relative value of rehab being provided in one setting versus another?
Given that many conditions can be treated in multiple rehab settings, which setting is the most cost efficient and offers the highest quality patient outcomes?

For many chronic conditions, outpatient rehab means increased functional independence, faster discharge from hospitals, less reliance on expensive in-home supports and avoidable premature LTCH admissions. These benefits will be realized and managed by implementing the RCA Outpatient/Ambulatory Minimum Data Set, as the basic essential data it provides will enable LHINs to describe the cost of different care settings and services actually being provided and inform comprehensive capacity planning.

**Tools/Resources to Support LHIN Implementation**

The following ‘tools’ are available to describe and support the development of the outpatient/ambulatory minimum data set:

- Technical Report describing the data elements within each quadrant of the MDS
- ‘Rationale for Data Elements Within MDS’
- ‘Rationale for Advancing Outpatient Rehab MDS’
- “Assessing Patient Experience Across the Rehabilitative Care Continuum” - Report Prepared for the Waterloo-Wellington Local Health Integration Network Rehabilitative Care Council by The Geriatric Health Systems Research Group, University of Waterloo

“The tools presented by the RCA have been developed with complete stakeholder input. They are clear, well laid out and easy to share; I feel I have what I need to move this forward in our community.”

Susan Franchi
Director of Outpatient Rehabilitation and Chronic Disease
St. Joseph’s Care Group, Thunder Bay
Planning Considerations for Re-Classification of Rehab/CCC Beds

Gap/Issues Identified

The Planning Considerations for Re-classification (PCRC) of Rehab/CCC Beds initiative was established in January 2014 in response to significant discussion amongst stakeholders regarding re-classification of Complex Continuing Care (CCC) to inpatient rehabilitation beds in the context of HSFR and the emerging RCA Definitions Framework.

Given the intense interest in this topic, the PCRC initiative was added as a fifth priority within the RCA’s first mandate to provide LHINs and HSPs with a standardized provincial process that ensures due diligence is followed in situations where a potential need to re-classify CCC to inpatient rehabilitation beds is identified.

The goal of this initiative is to support consistent decision-making across the province and to ensure that patient and system implications are considered when considering re-classification. The toolkit is meant to serve as a support if local planning identifies the need to consider re-classification, and not as a policy directive. The Alliance sought provincial stakeholder feedback on a PCRC Toolkit prior to finalizing its contents and liaised regularly with the HSFR CCC/Rehab Working Group and MOHLTC to ensure the work continued to align with provincial directions.

Deliverables

The mandate of the PCRC Task and Executive Working Groups was to identify a standardized approach that both LHINs and HSPs could use when considering the re-classification of CCC to rehabilitation beds. Their work has resulted in the development of a toolkit that outlines considerations and supports the process of completing due diligence if a potential need to re-classify beds is identified. The toolkit also describes a process to be undertaken to prepare the business case for the re-classification of Rehab/CCC beds – should this be deemed to be appropriate/required.

The PCRC Toolkit contains the following tools:

1. Process to Assess Need for Re-classification of Rehab/CCC Beds
2. Education Modules
   a. Financial and Clinical Considerations for Re-classification
   b. Implications of the RCA Definitions Framework for Bedded Levels of Rehabilitative Care and Proposed Directions to Move from Current to Future State
3. Stakeholder Risk/Benefit Considerations
4. PCRC Case Studies/Scenarios describing the experiences of organizations that:
   • are considering re-classification
• have completed re-classification
• have collected dual coded data\(^{37}\) (including why it was collected and what story the data told)

6. HBAM Calculator
7. Potential System-Level Data Analysis to Support Re-Classification Considerations
8. Re-Classification Evaluation Criteria Guidelines for Hospital Beds Re-Classification, LHIN Liaison Branch, Relations and Coordination Unit, MOHLTC

**NOTE:** The PCRC initiative and Toolkit is NOT about re-classifying all CCC beds to inpatient rehabilitation beds across the province. The work of the PCRC initiative is about providing a standardized provincial approach to ensure due diligence is practiced if a need for re-classification has been identified. Understanding the clinical, financial and policy implications of the re-classification as well as the impact on the system will be critical before any changes are made.

**Approach**

Three provincial working groups supported the completion of the PCRC Toolkit:

1. **The PCRC Task Group** was formed to identify current issues related to the re-classification of CCC to inpatient rehabilitation beds across the province and to provide advice and direction on the development of a toolkit that outlines considerations and provides an analysis of implications in a systematic and standardized manner.
2. **The PCRC Financial Working Group**, inclusive of finance and decision support subject matter experts from across the province, aided in the development of the financial aspects of the toolkit.
3. **The PCRC Executive Working Group** was developed to liaise with subject matter experts and key system stakeholders to identify additional potential considerations and information to ensure the toolkit is comprehensive and inclusive of relevant and timely information.

The PCRC Task Group consulted with the HSFR CCC/Rehab Working Group and the OHA to support the development of a comprehensive description of the considerations and potential unintended consequences within the evolving funding environment that should be considered when making decisions regarding re-classification. As a key stakeholder, several branches of the MOHLTC were also consulted regularly to ensure alignment with provincial directions.

**Guiding Principles:**

The PCRC Toolkit will:

- follow the MOHLTC “Guidelines for Hospital Beds Re-Classification” developed by the LHIN Liaison Branch

\(^{37}\) ‘Dual Coded Data’ refers to the collection of both NRS and MDS measurement tools for patients who are receiving rehabilitative care in either rehabilitation or Complex Continuing Care beds.
• consider clinical outcomes, financial and policy implications
• consider the impact on patients/caregivers, HSPs, LHINs and the MOHLTC
• make recommendations related to re-classification within the context of HSFR and an analysis of system-wide implications.

The Toolkit originated with the development of the tool “Stakeholder Risk Benefit Considerations”. This tool was created to support the identification of potential clinical, financial and policy implications of re-classification to all implicated stakeholders (i.e., patients, HSPs, LHINs). The Task Group then set out to develop tools to support LHINs and HSPs to complete due diligence (i.e., comprehensive consideration of all implications) when considering the re-classification of Complex Continuing Care (CCC) beds to inpatient rehabilitation beds.

Key Learnings

i. **Awareness of HSFR and its impact.** There is significant variation across the province in the knowledge and awareness of HSFR and its impact on the funding on rehabilitative care beds. The PCRC Education Modules (‘Financial and Clinical Considerations for Re-classification of Rehab/CCC Beds’ & ‘Implications of the RCA Definitions Framework & Proposed Directions’) were developed to support improved understanding amongst stakeholders.

ii. **Variations in current state.** As demonstrated through the ‘PCRC Case Studies/Scenarios’ tool in the PCRC Toolkit, there is also significant variation in the current state of considerations/completions of re-classification of rehab to CCC beds. There is significant opportunity to leverage the completed and planned re-classification experiences of others to inform future regional and provincial re-classification directions.

iii. **Accountability for re-classification.** Through the work of the PCRC initiative, it was clarified that accountability for re-classification rests with each LHIN. This was not necessarily clear amongst all stakeholders at the outset of work on the PCRC initiative.

iv. **Implications of re-classifying Rehab/CCC beds.** The ‘Stakeholder Risk Benefit Considerations’ document is intended to support consideration of critical questions and issues when considering the need for and implications of re-classifying rehab/CCC beds. The tool offers partial or complete enabling/mitigation strategies (where available); however, solutions to all potential implications are not currently available, but will be informed by leveraging lessons learned from LHINs/HSPs who comprehensively consider and/or complete re-classification of rehab to CCC beds.

v. **Impact of financial realities and data collection methodologies.** A key potential driver of consideration of the need to re-classify CCC to rehab beds is the RCA’s Definitions Framework for Bedded Levels of Rehabilitative Care. Operationalization of that standardized provincial framework may be challenged by the realities of existing funding and data collection
methodologies associated with current bed types. For example, in the future state, as defined in the Definitions Framework for the Bedded Levels of Rehabilitative Care, the majority of the LTLD population will be served most appropriately within the Rehabilitation level of care, while some may be appropriate for the Activation/Restoration or Short Term Complex Medical Management levels of care. However, the existing NRS-based funding structure provides a financial disincentive to admit patients with complex medical needs who, although they require and can benefit from rehabilitation, would likely require a longer length of stay. To address this issue, and as mentioned in the Definitions section of this report, the Definitions Task Group supported a recommendation to the MOHLTC’s HSFR Rehab/CCC Working Group to consider inclusion of additional (i.e., new) groups to the existing NRS ‘grouper’ for the slow stream/LTLD patients.

vi. **Provincial level analyses** of the questions contained in the ‘Potential System-Level Data Analysis to Support Re-Classification Considerations’ tool may provide further standardized direction to LHINs / HSPs who may be considering reclassification of CCC/Rehab beds.

vii. **Insight for all system planners.** While a few components of the toolkit (e.g., the ‘HBAM Calculator’; some sections of the education module) apply only to HBAM-funded hospitals, the toolkit provides all system planners with insights into potential considerations associated with determining the need for and/or completing the process of reclassifying Rehab/CCC beds as part of a comprehensive rehabilitative care system capacity planning exercise.

viii. **Evaluation of impact of re-classification.** The Task Group endorses the ‘Re-classification Evaluation Criteria’ tool to support systematic evaluation of the impact of re-classification both at the regional and provincial levels to ensure that the implications of any changes made to bed classification are fully understood and leveraged to inform future decisions.

**LHIN Value/Impact**

The PCRC Toolkit will provide rehabilitative care system stakeholders with guidance to more fully understand the implications of HSFR on patient flow and resource allocation for rehab and CCC beds. Within rehab beds, funding is now tied to RPG-derived LOS targets, whereas in CCC beds, funding is based on complexity/resource intensity without a LOS target. To be successful under HSFR, HSPs will need to be clear about what type of patient is in what type of bed, and consider re-classification if it supports quality clinical outcomes. The PCRC Toolkit affords the rehabilitative care system the opportunity to get ahead of the issue in order to mitigate any potential risks within the context of HSFR. It is recommended that LHINs leverage the toolkit as part of a broader rehabilitative care system capacity planning exercise that includes use of the RCA Definitions Framework, the RCA Capacity Planning Framework and the RCA System Evaluation Framework.
Tools/Resources to Support LHIN Implementation

As components of the ‘PCRC Toolkit’, the following ‘tools’ are available to support the process of completing due diligence once a potential need to re-classify beds is identified:

1. **Process to Assess Need for Re-classification of Rehab/CCC Beds**
2. **Education Modules**
   a. **Financial and Clinical Considerations for Re-classification**
   b. **Implications of the RCA Definitions Framework for Bedded Levels of Rehabilitative Care and Proposed Directions to Move from Current to Future State**
3. **Stakeholder Risk/Benefit Considerations**
4. **PCRC Case Studies/Scenarios** describing the experiences of organizations that:
   • are considering re-classification
   • have completed re-classification
   • have collected dual coded data\(^{38}\) (including why it was collected and what story the data told)
6. **HBAM Calculator**
7. **Potential System-Level Data Analysis to Support Re-Classification Considerations**
8. **Re-Classification Evaluation Criteria Guidelines for Hospital Beds Re-Classification**, LHIN Liaison Branch, Relations and Coordination Unit, MOHLTC

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“This has been an amazing amount of work and collaboration. Congratulations and thank you so much for your leadership.”

Gwen Brown, Regional Stroke Community and LTC Coordinator
Stroke Network of Southeastern Ontario
Kingston General Hospital

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\(^{38}\) ‘Dual Coded Data’ refers to the collection of both NRS and MDS measurement tools for patients who are receiving rehabilitative care in either rehabilitation or Complex Continuing Care beds.
Alignment with Other Provincial Initiatives

Auditor General of Ontario’s Report

The 2013 Annual Report of the Office of the Auditor General of Ontario (AGO) was released in December 2013, nine months after the RCA was established and initiated a two-year mandate to effect positive provincial changes in rehabilitative care.

As part of its annual report, the AGO conducts Value-for-Money (VFM) Audits to examine how well government ministries, organizations in the broader public sector, agencies of the Crown and Crown-controlled corporations manage their programs and activities\(^\text{39}\). In its 2013 Annual Report, the AGO’s VFM Audit included Rehabilitation Services at Hospitals.

Although the RCA was in the early stages of addressing its key priorities at the time of the report’s release, it was able to identify several areas where work was underway to address AGO recommendations for rehabilitation. The chart below provides an overview of the 2013 Auditor General Recommendations regarding Rehabilitation Services at Hospitals relative to the deliverables of the RCA.

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<tr>
<th>Auditor General Recommendations</th>
<th>Initiatives of the Rehabilitative Care Alliance</th>
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<tbody>
<tr>
<td>To better ensure that Ontarians requiring rehabilitation have equitable access to services, the Ministry of Health and Long-term Care (Ministry) should work with the Local Health Integration Networks (LHINs) to:</td>
<td>The Definitions Task Group has developed:</td>
</tr>
<tr>
<td>• establish a province-wide co-ordinated system for rehabilitation, including both regular (shorter-term) and restorative (longer-term) inpatient services and all community-based outpatient services</td>
<td>• descriptions of level of care across the rehabilitative care continuum as outlined in bedded and community-based frameworks;</td>
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<td>• standardized components of each level of care across the rehabilitative care continuum;</td>
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<td></td>
<td>• eligibility and discharge criteria for each level of care;</td>
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<td>• a definition of restorative potential.</td>
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These standardized definitions describing rehabilitative care resources across the care continuum will provide clarity for patients, families and referring professionals regarding the focus and clinical components of rehabilitative care.

The Capacity Planning and System Evaluation Task Group has developed standardized rehabilitative care system capacity planning and evaluation frameworks. These frameworks will support LHINs to evaluate their rehabilitative care resources and

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<tr>
<td>In order to have good information for current and future decision-making, the Ministry should establish, in conjunction with its stakeholders, what information should be collected on restorative inpatient and outpatient services and how best to collect the data.</td>
<td>The RCA has engaged with provincial stakeholders to identify and define a minimum dataset for the collection and reporting of outpatient/ambulatory data to inform quality improvement, performance and capacity planning. Mechanisms for how best to collect the data are being explored.</td>
</tr>
<tr>
<td>To better ensure that inpatient rehabilitation meets patients’ needs as efficiently and equitably as possible, hospitals should:</td>
<td>The RCA has worked closely with the Provincial Standards and Sustainability Office (PSSO) in defining the eligibility criteria for bedded levels of rehabilitative care.</td>
</tr>
<tr>
<td>• implement systems for accepting patient referrals and uploading associated patient data electronically.</td>
<td>Further, the RCA has outlined definitions for data elements in how to track referrals including “patients accepted” for those referred to outpatient/ambulatory rehab programs.</td>
</tr>
<tr>
<td>• in conjunction with the Ministry of Health and Long-term Care (Ministry) and the Local Health Integration Networks (LHINs), develop standardized practices regarding patient eligibility for similar programs, prioritization of patients based on patient need, and the frequency and duration of therapy.</td>
<td>Within the RCA’s first two-year mandate, the Definitions Task Group developed standardized criteria within each level of rehabilitative care. This foundational work to define each level of rehabilitative care was deemed by stakeholders to be required before condition-specific practices could be defined. The work plan for the RCA’s second mandate will include a focus on rehabilitative care pathways for QBP populations where one currently does not exist, including total joint replacements and hip fracture.</td>
</tr>
<tr>
<td>• in conjunction with the Ministry of Health and Long-Term Care (Ministry) and Local Health Integration Networks (LHINs), develop standardized practices for common patient conditions, such as total joint replacements, regarding when to begin outpatient therapy, as well as the type and duration of therapy.</td>
<td>Over the course of the RCA’s first mandate, the Outpatient/Ambulatory Task Group produced the following deliverables:</td>
</tr>
<tr>
<td>Further, hospitals should collect information to better ensure that available outpatient resources are utilized efficiently and effectively, such as information on the number of appointment cancellations and patient no-shows, and on the change in patient functionality between when outpatients start and when they complete outpatient rehabilitation.</td>
<td>• An evaluative framework to support comprehensive consideration of the critical questions to be answered by the minimum data set.</td>
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<td></td>
<td>• A Rehabilitative Care Minimum Data set within the ‘Assess and Transition’ and ‘Financial Performance’ quadrants</td>
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<tr>
<td>Auditor General Recommendations</td>
<td>Initiatives of the Rehabilitative Care Alliance</td>
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<td>• A comprehensive review of existing functional outcome measures validated for use in the outpatient/ambulatory rehabilitative care setting at the activity/participation level.</td>
<td>• A toolkit containing the following documents/tools to describe and support the development of the outpatient/ambulatory minimum data set:</td>
</tr>
<tr>
<td>• A preliminary measure of patient experience for the outpatient/ambulatory rehabilitative care setting</td>
<td></td>
</tr>
<tr>
<td>• A comprehensive review of existing functional outcome measures validated for use in the outpatient/ambulatory rehabilitative care setting at the activity/participation level.</td>
<td>o Technical Report describing the data elements within the ‘Assess and Transition’ and ‘Financial’ quadrants of the MDS</td>
</tr>
<tr>
<td>• A preliminary measure of patient experience for the outpatient/ambulatory rehabilitative care setting</td>
<td>o Evaluative Framework &amp; Rationale for Data Elements</td>
</tr>
<tr>
<td>• A toolkit containing the following documents/tools to describe and support the development of the outpatient/ambulatory minimum data set:</td>
<td>o Minimum Data Set Stakeholder Benefits</td>
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</table>

In order to enhance the performance of hospitals providing rehabilitation services, hospitals should:
- in conjunction with the Ministry of Health and Long-term Care (Ministry), develop standardized performance measures that will provide hospitals with useful and comparative information, such that they can benchmark their performance against other hospitals and better identify areas, if any, requiring improvement; and
- survey patient caregivers, as required under the Excellent Care for All Act, 2010 (Act), and conduct outpatient satisfaction surveys.

The RCA developed a standardized Capacity Planning and System Evaluation Toolkit to support LHINs to evaluate their rehabilitative care resources and enable standardized performance measurement of the rehabilitative care system at both the LHIN and provincial level.

As outlined, the Outpatient/Ambulatory Task Group developed a preliminary measure of patient experience for the outpatient/ambulatory rehabilitative care setting, based on a report by Dr. McMurray et al. Further development on this measure will be part of the work plan of the RCA’s second mandate.

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The Ministry of Health and Long-Term Care welcomed the advice and recommendations highlighted in the VFM Audit of hospital-based rehabilitation services and noted the work of the 14 Local Health Integration Networks (LHINs) in establishing the RCA as:

- taking a system-wide view of rehabilitation in Ontario
- developing recommendations that will help guide provincial standards for rehabilitative care programs across the continuum that are expected to help better track services and costs
- helping LHINs to develop a standardized rehabilitative care evaluation framework and indicators to evaluate rehabilitative care system performance
- identifying what information should be collected on outpatient services and how best to collect the data.

With the RCA recently receiving direction from the LHINs to move forward with a second two-year mandate, it will continue to build upon the work-to-date that aligns with provincial recommendations from the AGO to improve the rehabilitation experience in Ontario.

**Other Provincial Initiatives**

Since its inception, the work of the RCA has been conducted with a view to obtaining a clear understanding of broader influencing health system initiatives. To achieve this during the course of its first two-year mandate, while also generating awareness of its own initiatives, the RCA reached out to a number of provincial organizations and tables to share updates on initiatives, leverage learnings and tools from work in other areas, and ensure stakeholders were engaged in and understood the linkages between provincial initiatives.

The following are examples of some of the engagement activities undertaken by the RCA across initiatives:

- Working collaboratively with the Implementation Branch of the MOHLTC and LHINs to inform development of the Assess and Restore Guideline.

- Consulting with various branches of the MOHLTC (including the Health Services Branch, Implementation Branch, Data Quality, Health System Funding Policy, Health Information Management Strategy & Policy, Quality Performance and Evaluation) to provide updates and seek input on the RCA’s development of a minimum dataset for outpatient/ambulatory rehabilitation.

- Engaging with the Provincial Standards Sustainability Office (PSSO) regarding their role in implementing provincial referral standards for referral to rehabilitation and Complex Continuing Care beds and relative to the work of the RCA to develop standardized eligibility criteria for bedded levels of rehabilitative care.

- Holding discussions with LHINs and CCACs regarding the work of the RCA to develop a standardized definitions framework relative to the implementation of Coordinated Access.
• Consulting with representatives from the Regional Geriatric Programs, physician stakeholders, the OACCAC, and the provincial Seniors Lead (Dr. Samir Sinha) and other provincial stakeholders regarding the work of the Frail Senior/Medically Complex Task Group.

• Hosting a joint provincial webinar for members of the Ontario Society of Occupational Therapists, Ontario Physiotherapy Association and Ontario Speech Language Association.

• Making regular presentations to the OHA Rehab/CCC Leadership Council, the Provincial ALC Advisory Committee, and the Ontario Trauma Advisory Committee.

• Consulting with representatives from Health Quality Ontario regarding development of a measure of patient experience and in development of the outpatient/ambulatory minimum dataset.

• Making presentations to the Provincial Client Services CCAC Table, CCAC/LHIN Coordinated Access to Rehabilitative Care Knowledge Exchange Group, and the Ontario Association of Community Care Access Centres.

• Presenting to regional rehabilitation networks, as invited, including North East, North West, Waterloo Wellington, Toronto Central, Mississauga Halton and North Simcoe Muskoka.

• Consulting with the Ontario Association of Children’s Rehabilitation Services, Ontario Community Support Association, and the Ontario Association of Non-Profit Homes and Services for Seniors.

• Making invited presentations at provincial conferences including:
  o OACCAC annual conference (2014)
  o OSOT annual conference (2014)
  o OLTCA annual Education Day conference (2014)

Physician Engagement
Physician engagement has played a key role in informing RCA deliverables to date, with several physicians assuming active roles as members of the RCA’s Task and Advisory Groups, complemented by efforts to reach out and invite province-wide physician input on priority RCA initiatives.

• A briefing note was prepared and disseminated to support HSP & LHIN Leads Advisory Group members and already-engaged physicians on other working groups to engage physicians and to invite feedback regarding the work-to-date and the planned directions of the RCA.

• A briefing note was also sent to the OMA, OCFP & CPSO for distribution to their membership or to leverage the content for use in publications, as appropriate.

• An introductory article on the RCA was published in the June 2014 issue of the Ontario Medical Review.
The voice of clients/patients and caregivers was an important element in helping to inform the work of the RCA. The Patient/Caregiver Advisory Group was established in March 2014 and met four times prior to completion of the RCA’s two-year mandate.

Members included 14 caregivers and clients/patients from 10 LHINs who were receiving or had previously accessed rehabilitative services, or who were providing care for someone who needs or currently accesses rehabilitative services. Meetings were held virtually to allow for maximum participation. The group provided feedback on RCA activities and directions to ensure consideration of the patient/client perspective in advancing recommendations to improve rehabilitative care at a health system level.

Among the RCA activities that received input from the Patient/Caregiver Advisory Group:

- Funding and budgetary constraints in health care and its impact on rehabilitative care
- Patient experience question set in the Outpatient/Ambulatory Minimum Data Set
- Patient-centred indicators being reviewed to support Capacity Planning & System Evaluation
- Proposed process for use of screening tool for Frail Senior / Medically Complex to support access to bedded levels of rehabilitative care from the community

Ongoing discussions regarding the personal experiences of advisory group members helped paint a picture of the current patient experience in rehabilitative care with regards to what is working well and what could be improved. Based on that feedback, the advisory group put forward the following advice for health system decision-makers:

**Better System Navigation**
A cross-sector patient coordinator or navigator would help reduce the gaps in services between health service providers and enhance the effectiveness of community and outpatient rehabilitative care services.

**Better Access**
There needs to be better transportation options to get to and from rehabilitative care appointments as well as improved wait times for pick-up/drop-off, and navigational support at the point of care.

**Reduced Redundancy**
There needs to be fewer redundant assessments across healthcare teams, with greater reliance on each other’s findings and more focus on interventions.

**Improved Coordination**
There needs to be enhanced communication and coordination of information between health service providers.

**More Consistency**
Programs and services should be consistent regardless of geographic location.

**Focus on Outpatient Rehab**
The availability of outpatient and community-based rehabilitative care services are critical to ensuring patients maintain their functional gains and remain out of hospital.
Focus on Inpatient Rehab

Inpatient rehabilitation programs are a critical component of the rehabilitative care system (i.e. cannot be replaced by community-based programs/services). The length of stay should be specific to the individual patient’s needs and potential to improve.

An ongoing dialogue with patients and caregivers needs to be maintained to help inform decision-making with regards to planning for rehabilitative care services across the province. Embracing an understanding of care from the patient/caregiver perspective will help minimize any unforeseen issues during the planning of services.

This experience demonstrated the importance of engaging client/patients and caregivers in the conversation about transforming rehabilitative care in Ontario and they will continue to remain an important and valued voice during completion of second mandate deliverables.

“I wanted to be involved with the RCA because of its mandate to effect positive changes in rehabilitative care. I have been proud to be a part of this group which provides a voice for patients and caregivers alike. We all participate with the common goal of providing insight to our experiences with the healthcare system with the hope of improving it for everyone. Thanks to the RCA Secretariat’s strong leadership we have been able to do that. We have been brought together to highlight issues that are not identified, and offer solutions, because we care. This group’s work cannot be understated and I am happy to hear that their mandate has been extended and look forward to my continued participation.”

Robert Craft
Champlain LHIN Representative, Patient/Caregiver Advisory Group
A Future State for Rehabilitative Care

Pooled together, the deliverables outlined in this report have tremendous potential to chart a new vision for rehabilitative care in Ontario. If successfully implemented by LHINs and HSPs, the impact on the rehabilitative care system could be significant.

A review by priority sheds some insight into what a future state for rehabilitative care might look like:

Definitions

That rehabilitative care across Ontario:

• Is guided by the patient/client perspective

• Optimizes resource utilization

• Reflects standardized and streamlined resources through a shared understanding of rehabilitative care across the continuum throughout the province and by doing so provides:
  o Clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care and
  o A foundation to support system and local capacity planning.

• Is based on a shared understanding of:
  o Restorative potential and who is eligible for rehabilitative care
  o The levels of rehabilitative care (both bedded and community-based), the goals of care and the characteristics of patients/clients who would be served within each level (including estimated average length of stay and discharge indicators)
  o The medical and healthcare professional resources and intensity of therapy that would be available within each level of rehabilitative care

• Is supported by:
  o Funding systems that accurately reflect the characteristics of the patients within each level of rehabilitative care
  o Standardized reporting tools for each level of rehabilitative care for measurement of both patient outcomes and system performance.
Capacity Planning and System Evaluation

That LHINs and HSPs utilize the frameworks to:

• Use standardized metrics when measuring and comparing performance across services and regions to enhance cross-LHIN learnings and identification of regional and provincial priorities for quality improvement

• Ensure future state design of capacity planning includes a focus on rehabilitative care

• Illustrate the contribution of the rehabilitative care system to overall health care system objectives

• Focus on ‘community capacity’ to identify opportunities where it may be appropriate to shift care from hospitals to community settings and plan for sufficient capacity

• Support the objective of ‘Value for Money’ –
  o In being able to demonstrate the delivery of high quality rehabilitative care and report on the resulting patient outcomes
  o In identifying opportunities to optimize the delivery of rehabilitative care in the most cost-effective settings.

• Enhance recognition of the benefits of rehabilitative care as a critical enabler that optimizes patient outcomes

Frail Senior/Medically Complex

• Acute care is removed as the sole point of access for bedded levels of rehabilitative care
• Enhanced capability in bedded levels of rehabilitative care to recognize, assess and effectively manage geriatric syndromes that may be contributing to frailty

Outpatient/Ambulatory

Information from this dataset will be used by organizations, LHINs and MOHLTC as a basis to:

• Inform quality improvement within and across programs

• Inform development of clinical models of care

• Inform development of equitable funding for episodes of care based on patient complexity

• Illustrate demand for services

• Enable capacity planning; and

• Demonstrate the value of outpatient / ambulatory rehabilitation as a key enabler of a high performing healthcare system.
Second Mandate

As of April 1, 2015, the RCA will prepare for a second two-year mandate. Its work will continue to be informed by evidence and data, as available, and by extensive provincial stakeholder engagement and input in the final deliverables, all characteristic of the same approach used to complete the successful first mandate.

The course of work during the RCA’s second mandate will fall under three main pillars:

1. Continue to support LHINs and the Ministry of Health and Long-Term Care with Assess and Restore (A&R) related initiatives; participate as partners in knowledge exchange related to implementation of the A&R Guideline and associated funding.

2. Provide project management support to the LHINs to guide their implementation of the standardized RCA tools, processes and frameworks developed through the first mandate.

3. Support implementation of existing quality-based procedures (QBPs) through identification of standardized rehabilitative care best practices across QBP handbooks (where not already defined).

The second mandate will allow for continuity of planning as the RCA continues to build upon the tremendous progress made to date in supporting transformation of rehabilitative care across Ontario.
Acknowledgements

GTA Rehab Network
Special thanks to the GTA Rehab Network for their exceptional leadership in support of the Rehabilitative Care Alliance. It is largely owing to their previous work in the rehab sector, extensive knowledge of the health care system, and established stakeholder relationships, that we were able to complete our first two-year mandate on time and on budget.

Provincial Subject Matter Expert Consultations
The RCA has also invested considerable effort to engage provincial subject matter experts to help inform RCA activities and we thank the following for sharing their knowledge and expertise:

Dr. Katherine Berg, Executive Chair, Rehabilitation Sciences; Chair & Associate Professor, Department of Physical Therapy; Chair, Graduate Department of Rehabilitation Sciences, University of Toronto

Dr. Andrew Costa, Assistant Professor, Department of Clinical Epidemiology & Biostatistics Research Lead, Michael G. DeGroote School of Medicine, Waterloo Regional Campus McMaster University

Imtiaz Daniel, Senior Consultant, Financial Analytics and System Performance, Ontario Hospital Association and Adjunct Lecturer, Institute of Health Policy, Management and Evaluation, University of Toronto

Gail Dobell, Director, Evaluation and Research, Health Quality Ontario

Leslie Eckel, Knowledge Exchange Associate, Department of Health Studies and Gerontology, University of Waterloo

Dr. George Heckman, RIA-UW Schlegel Research Chair in Geriatric Medicine; Associate Professor, School of Public Health and Health Systems, University of Waterloo; Lead Geriatrician, Waterloo Wellington LHIN

Erik Hellsten, Senior Specialist for Quality-Based Funding, Health Quality Ontario

Dr. John Hirdes, Professor and Ontario Home Care Research and Knowledge Exchange Chair, School of Public Health and Health Systems, University of Waterloo

Dr. Josephine McMurray, Assistant Professor, School of Business & Economics/Health Studies, Wilfrid Laurier University

Dr. Samir Sinha, Provincial Lead, Ontario’s Seniors Strategy

Dr. Paul Stratford, Professor in the School of Rehabilitation Science; Associate Member in the Department of Clinical Epidemiology and Biostatistics, McMaster University

Dr. Walter Wodchis, Associate Professor, Institute of Health Management Policy and Evaluation, University of Toronto and Adjunct Scientist, Institute for Clinical Evaluative Sciences
Appendices

Appendix A – Rehabilitative Care Alliance Steering Committee

Donna Cripps (co-chair) Hamilton Niagara Haldimand Brant LHIN
Dr. Peter Nord (co-chair) Providence Healthcare

Peter Biasucci Ministry of Health and Long-Term Care
Heather Binkle Ontario Association of Community Care Access Centres
Tracy Buckler St. Joseph’s Care Group – Thunder Bay
Roy Butler St. Joseph’s Health Care – London
Candace Chartier (past member) Ontario Long Term Care Association
Dale Clement Halton Healthcare Services
Dr. Jo-Anne Clarke North East Specialized Geriatric Services
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Mark Edmonds Central West LHIN
Enza Ferro Ontario Hospital Association
Michael Gekas Bridgepoint Active Healthcare
Elaine Gibson (past member) St. Joseph’s Health Care – London
Erik Hellsten Health Quality Ontario
Sheila Jarvis Holland Bloorview Kids Rehabilitation Hospital
Andrea Lee Health Sciences North
Dr. Barbara Liu Regional Geriatric Program of Toronto
Karyn Lumsden Central West Community Care Access Centre
Malcolm Moffat Sunnybrook Health Sciences Centre
Barry Monaghan Member at Large
Vivian Ng Ministry of Health and Long-Term Care
Chris O’Callaghan Ontario Stroke Network
Kathryn Pilkington Ontario Association of Non-Profit Homes and Services for Seniors
Simon Rabinovitch Ministry of Health and Long-Term Care
Shirlee Sharkey St. Elizabeth Healthcare
Dr. Gaétan Tardif University Health Network – Toronto Rehab
Marianne Walker Guelph General Hospital
Lynn Woods Lynn Woods Communications

Rehabilitative Care Alliance Secretariat

Executive Director Charissa Levy
Office Manager Karen Allison
Project Manager Sue Balogh
Project Manager Emmi Perkins
Project Coordinator Mark Unwin
### Appendix B – RCA Task and Advisory Groups

#### Definitions Advisory Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Position</th>
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<tbody>
<tr>
<td>Dale Clement (Chair)</td>
<td>Halton Healthcare Services</td>
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<tr>
<td>Adrienne Bell-Smith</td>
<td>Quinte Health Care</td>
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<tr>
<td>Janine Black</td>
<td>St. Joseph’s Care Group – Thunder Bay</td>
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<tr>
<td>Christine Brenchley</td>
<td>Ontario Society of Occupational Therapists</td>
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<tr>
<td>Colleen Bronicheski</td>
<td>Health Sciences North</td>
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<tr>
<td>Mary Cardinal</td>
<td>Huron Perth Healthcare Alliance</td>
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<tr>
<td>Elaine Chemeris (past member)</td>
<td>William Osler Health System</td>
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<tr>
<td>Winston Cheuk</td>
<td>Mackenzie Health</td>
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<tr>
<td>Karen Conway</td>
<td>Grand River Hospital</td>
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<td>Debra Cooper Burger</td>
<td>Unionville Home Society</td>
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<tr>
<td>Lindsey Crawford</td>
<td>Royal Victoria Regional Health Centre</td>
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<tr>
<td>Natalie Damiano</td>
<td>Canadian Institute for Health Information (CIHI)</td>
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<tr>
<td>Alexis Dishaw</td>
<td>Providence Care</td>
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<tr>
<td>Michelle Du Boulay</td>
<td>Mount Sinai Hospital</td>
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<tr>
<td>Jim Elliott</td>
<td>Providence Healthcare</td>
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<td>Kathy Greene</td>
<td>Bruyere Continuing Care</td>
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<tr>
<td>Mary Grace Grossi</td>
<td>University Health Network – Toronto Rehab</td>
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<tr>
<td>Angela Hovey (past member)</td>
<td>We Care Home Health Services</td>
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<tr>
<td>Shandra Hunter-Trottier</td>
<td>Ontario Association of Speech-Language Pathologists</td>
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<tr>
<td>Leslie Iancovitz</td>
<td>Baycrest</td>
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<td>Dr. Derek Krete</td>
<td>Peterborough Regional Health Centre</td>
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<td>Kerry Kuluski</td>
<td>Bridgepoint Active Healthcare</td>
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<tr>
<td>Dr. Nathania Liem</td>
<td>Hotel-Dieu Grace Healthcare</td>
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<tr>
<td>Jane Loncke</td>
<td>St. Joseph’s Healthcare – Hamilton</td>
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<tr>
<td>Pamela Madan-Sharma</td>
<td>West Park Healthcare Centre</td>
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<tr>
<td>Annette Marcuzzi</td>
<td>Central CCAC</td>
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<tr>
<td>Joanne Maxwell (past member)</td>
<td>University Health Network – Toronto Rehab</td>
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<tr>
<td>Daile Moffat</td>
<td>Ontario Long Term Care Association</td>
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<tr>
<td>Dr. Shanker Nesathurai</td>
<td>Hamilton Health Sciences &amp; St. Joseph’s Healthcare</td>
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<tr>
<td>Tamara Nowak-Lennard (past member)</td>
<td>Georgian Bay General Hospital</td>
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<td>Tina O’Neill (past member)</td>
<td>Georgian Bay General Hospital</td>
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<tr>
<td>Sonia Pagura</td>
<td>Holland Bloorview Kids Rehabilitation Hospital</td>
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<tr>
<td>Ellen Richards (past member)</td>
<td>Huron Perth Healthcare Alliance</td>
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<tr>
<td>Susan Salway</td>
<td>Georgian Bay General Hospital</td>
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<tr>
<td>Jennifer Santos</td>
<td>William Osler Health System</td>
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<tr>
<td>Dorianne Sauve</td>
<td>Ontario Physiotherapy Association</td>
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<tr>
<td>David Simpson</td>
<td>St. Thomas Elgin General Hospital</td>
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<tr>
<td>Joan Southam</td>
<td>We Care Home Health Services</td>
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<tr>
<td>Andrea Thompson</td>
<td>Trillium Health Partners</td>
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<tr>
<td>Kaylyn Ward</td>
<td>Southlake Regional Health Centre</td>
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<tr>
<td>Deborah Willems</td>
<td>London Health Sciences Centre</td>
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<tr>
<td>Karl Wong</td>
<td>Rouge Valley Health System</td>
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</tbody>
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Definitions Task Group

Dale Clement (Chair)  Halton Healthcare Services
Susan Andrew  Bellwoods Centres for Community Living
Janine Black  St. Joseph’s Care Group – Thunder Bay
Jennifer Boucher  Ontario Association of Community Care Access Centres
Colleen Bronicheski  Health Sciences North
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Karen Conway  Grand River Hospital
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Jim Elliott  Providence Healthcare
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Andrea Thompson  Trillium Health Partners
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Deborah Willems  London Health Sciences Centre
Karl Wong  Rouge Valley Health System

Capacity Planning & System Evaluation Advisory Group

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Karen Atkins  Tillsonburg District Memorial Hospital
Frederic Beauchemin  The Ottawa Hospital
Adrienne Bell-smith  Quinte Health Care
Krista Bray Jenkyn  South West LHIN
Christine Brenchley  Ontario Society of Occupational Therapists
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Beverley Cole  St. Joseph’s Healthcare – Hamilton
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Imtiaz Daniel  Ontario Hospital Association
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Laura Forma  West Park Healthcare Centre
Debbie Galet  Lakeridge Health
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Vinita Haroun  
Lina Johnson  
Nancy Jones  
Daryn Kilfoyle  
Dr. Derek Krete  
Marianne Kulp  
Beth Linkewich  
Anne Marie MacLeod  
Louise MacRae  
Anne Mantha  
Cally Martin  
Crystal McCollom  
Josie McGee  
Janine Mels-Dyer  
Benedict Menachery  
Sabine Mersmann  
Matthew Meyer  
Nicola Morris (past member)  
Dana Naylor  
Chris O’Callaghan  
Kristin Parise  
Carrie Parkinson (past member)  
Kiran Pattini  
Veronica Pepper  
Amy Porteous (past member)  
Dorianne Sauve  
Jennifer Scott  
Dr. Richard Seeley  
Liveleen (Lynn) Singh  
Nancy Snobelen  
Julie Sullivan  
Denise Swartz  
Arlene Vasconcelos  
Marnie Weber  
Karen Woo  
Riki Yamada  
Ed Ziesmann  
Helen Zipes (past member)  

St. Joseph’s Health Care – London  
University Health Network – Toronto Rehab  
Ontario Stroke Network and ICES  
North East LHIN  
Ontario Long Term Care Association  
Cambridge Memorial Hospital  
Baycrest  
Mississauga Halton LHIN  
Peterborough Regional Health Centre  
St. Joseph’s Care Group – Thunder Bay  
North & East GTA Stroke Network  
Sunnybrook Health Sciences Centre  
Hamilton Health Sciences  
Bruyère Continuing Care  
Stroke Network of Southeastern Ontario  
March of Dimes  
CBI Health Group  
Providence Care  
South East LHIN  
Pembroke Regional Hospital  
Western University – Ontario Stroke Network  
Revera Home Health  
Royal Victoria Regional Health Centre  
Ontario Stroke Network  
Saint Elizabeth Health Care  
Mississauga Halton LHIN  
Mississauga Halton LHIN  
HNHB Acquired Brain Injury Network  
Bruyère Continuing Care  
Ontario Physiotherapy Association  
Central CCAC  
St. Peter’s Hospital – Hamilton Health Sciences  
Central LHIN  
Chatham-Kent Health Alliance  
Markham Stouffville Hospital  
CBI Health Group  
University Health Network  
University Health Network  
Bellwoods Centres for Community Living  
Southlake Regional Health Centre  
The Arthritis Society  
The Ottawa Hospital
Capacity Planning & System Evaluation Task Group

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Christine Brenchley  Ontario Society of Occupational Therapists
Gwen Brown  Stroke Network of Southeastern Ontario
Charlene Brown  Central CCAC
Penny Cardno  Huron Perth Healthcare Alliance
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<td>Dr. Barbara Liu</td>
<td>Regional Geriatric Program of Toronto</td>
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<td>Kasia Luebke</td>
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<td>Kelly Milne</td>
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<td>Dorianne Sauve</td>
<td>Ontario Physiotherapy Association</td>
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Rhonda Schwartz
Joan Scott (past member)
Carmell Tait
Karie Warnar
Kathy Wolfer
Ken Wong

Central East Regional Specialized Geriatric Services
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Participation House Support Services – London & Area
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St. Joseph’s Healthcare – Hamilton
St. Joseph’s Care Group – Thunder Bay
Mount Sinai Hospital
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Ian Joiner  Heart & Stroke Foundation
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Patrice Lindsay  Heart & Stroke Foundation
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Beth McCarthy  St. Joseph’s Health Care – London
Crystal McCollom  March of Dimes
Ryan Metcalfe  Canadian Institute for Health Information (CIHI)
Matthew Meyer  Western University – Ontario Stroke Network
Carol Miller  Canadian Physiotherapy Association
Jacqueline Minezes  Halton Healthcare Services
Scott Munro  St. Joseph’s Care Group – Thunder Bay
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<tr>
<td>Sharon Ocampo-Chan</td>
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<tr>
<td>Stefan Pagliuso</td>
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**Outpatient/Ambulatory MDS Task Group**

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### PCRC Executive Working Group

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<td>Dr. Peter Nord (Chair)</td>
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<td>Dr. Gaétan Tardif</td>
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PCRC Clinical Group

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Nancy Jones Baycrest
Jane Keppy Grey Bruce Health Services
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Kim Young Hamilton Niagara Haldimand Brant LHIN

Appendix C – RCA LHIN Leads and HSP Advisory Groups

LHIN Leads Advisory Group

Mark Edmonds (Chair) Central West LHIN
Alexander Anderson Erie St. Clair LHIN
Gillian Bone Toronto Central LHIN
Kelly Bradley (past member) Champlain LHIN
Sandra Easson-Bruno North Simcoe Muskoka LHIN
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Keren Reiser Champlain LHIN
Liveleen (Lynn) Singh Central LHIN
Simmy Wan Central LHIN
Susan Warner South West LHIN
Zach Weston Waterloo Wellington LHIN
Kim Young Hamilton Niagara Haldimand Brant LHIN

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Francesca Fiumara
Debbie Galet
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Helena Hutton (past member)
Helen Johnson
Annette Jones
Jennifer Kodis
Dr. Nathania Liem
Ann Loyst
Kathleen Lynch
Beth McCarthy
Janine Mels-Dyer
Dr. John Puxty
Jan Raine
Ellen Richards (past member)
Donelda Sooley (past member)
Mike Tierney
Marianne Walker
Karl Wong
Joanne Zee
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William Osler Health System
William Osler Health System
Lakeridge Health
North Bay Regional Health Centre
Southlake Regional Health Centre
Erie St. Clair LHIN Rehabilitation Network
Southlake Regional Health Centre
Hamilton Health Sciences
Hotel Dieu Health Care Centre
North Bay Regional Health Centre
St. Joseph’s Care Group – Thunder Bay
St. Joseph’s Health Care – London
Providence Care
Providence Care
Campbellford Memorial Hospital
Huron Perth Healthcare Alliance
Royal Victoria Regional Health Centre
The Ottawa Hospital
Guelph General Hospital
Rouge Valley Health System
University Health Network – Toronto Rehab
The Ottawa Hospital
## Appendix D – Patient/Caregiver Advisory Group

<table>
<thead>
<tr>
<th>Name</th>
<th>LHIN</th>
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<tbody>
<tr>
<td>Dawn Armstrong</td>
<td>Central LHIN</td>
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<tr>
<td>Bernie Campbell</td>
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<td>Robert Craft</td>
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<td>Mona Crawford</td>
<td>North East LHIN</td>
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<tr>
<td>Peg DiCarlo</td>
<td>Waterloo Wellington LHIN</td>
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<td>John Eastwood</td>
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<td>Pam Goldsilver</td>
<td>Central LHIN</td>
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<tr>
<td>Jeff Wolfenden</td>
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### Appendix E – Provincial Definitions Validation Survey Results

#### Provincial Validation Survey Results on Definitions Framework for Bedded Levels of Rehabilitative Care (May 2014)

| Response Rate:                      | 145 organizations (some of which have multiple sites) with designated rehab, CCC or Convalescent Care beds received a survey  
<table>
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<th>• Of these organizations, 114 (79%) completed surveys</th>
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| Total No. of Programs (with completed survey information): | 366 completed surveys from Rehab, CCC and LTC/Convalescent Care Programs were received  
|                                    | • Of these surveys, 275 (75%) programs indicated alignment with a level of rehabilitative care within the framework |
| No. of Surveys from Rehab & CCC    | 338 completed surveys from Rehab and CCC (92% of total surveys) were received  
|                                    | • Of these surveys, 251 (74%) programs indicated alignment with a level of rehabilitative care within the framework |
| No. of surveys from Convalescent Care Programs in LTCH | 29 completed surveys from Convalescent Care Programs in LTC were received  
|                                    | • Of these surveys, 25 (86%) programs indicated alignment with a level of rehabilitative care within the framework  
|                                    | • Of these, 14 (60%) indicated alignment with Activation/Restoration and 11 (44%) indicated alignment with Rehabilitation |

*Click here for further details on survey findings.*
Appendix F – Summary of Stakeholder Requirements for a Minimum Data Set for Outpatient/Ambulatory Rehabilitative Care

This document was developed to reflect alignment between the data elements proposed by the RCA Outpatient/Ambulatory (OP/AMB) Task Group to be included within the Minimum Data Set for OP/AMB Rehabilitative Care services and data element requirements described by key system stakeholders. In addition to the key stakeholders listed, the RCA has also engaged with the Information Management, Strategy and Policy Branch of the MOHLTC and the Ontario Hospital Association. **NOTE:** Data elements that can be derived from existing ADT systems (i.e., those that are not net new data collections) are asterisked/shaded grey.

### Socio-demographic Information

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<th>DATA ELEMENTS</th>
<th>MOHLTC - IB</th>
<th>LHINs</th>
<th>HQO</th>
<th>AGO</th>
<th>MOHLTC - HSB</th>
<th>RCA</th>
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<td><strong>Service Provider Information</strong></td>
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<tr>
<td>Service Provider ID*</td>
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<tr>
<td>Service Provider Name (derived)*</td>
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<tr>
<td><strong>Patient Demographics</strong></td>
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<tr>
<td>Health Card Number41*</td>
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<td>Patient DOB*</td>
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<td>Province/Territory Issuing Health Card*</td>
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<td>Postal Code*</td>
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<tr>
<td>Sex*</td>
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<td><strong>Patient Diagnosis</strong></td>
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<tr>
<td>Primary Diagnosis Code*</td>
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<tr>
<td>Primary Diagnosis Description*</td>
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<tr>
<td>Most responsible/primary health condition for which patient is seeking treatment*</td>
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<table>
<thead>
<tr>
<th><strong>VALUE TO GOVERNMENT</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity to measure performance of HSPs</td>
<td></td>
</tr>
<tr>
<td>Produce patient-level data for care to measure costs, quality and equity</td>
<td></td>
</tr>
<tr>
<td>Enable cross sector analysis of the patient journey</td>
<td></td>
</tr>
<tr>
<td>Better-informed QBPs - Understand demand for &amp; utilization of outpatient/ambulatory based rehabilitative care services by specific populations</td>
<td></td>
</tr>
<tr>
<td>As per AGO recommendation, hospitals should prioritize eligible patients based on need, to better ensure that patients have timely access to required outpatient services</td>
<td></td>
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</tbody>
</table>

* Data is attainable from an ADT interface, if it is available/provided
41 LHINs are responsible for oversight of the hospital based clinics within this model; LHINs cannot presently access Health Card data; this has created a challenge when supporting LHINs to develop complimentary data collection and analysis systems (MOHLTC HSB)
### Access and Transition

<table>
<thead>
<tr>
<th>DATA ELEMENTS</th>
<th>MOHLTC-IB</th>
<th>LHINS</th>
<th>HQO</th>
<th>AGO</th>
<th>MOHLTC-HSB</th>
<th>RCA</th>
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<tr>
<td>Reason for Referral</td>
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<tr>
<td>Date Referral is Sent/Received</td>
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<tr>
<td>Referral From (type of provider and/or facility name/number)*</td>
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<tr>
<td>Date of discharge from acute care (if applicable)*</td>
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<tr>
<td>Referral To (facility name/number)</td>
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<tr>
<td>Date of First Visit*</td>
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<tr>
<td>Referral Rejected</td>
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<tr>
<td>Reasons for Rejection of Referral</td>
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<tr>
<td>Reasons for Cancellation</td>
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</tbody>
</table>

**VALUE TO GOVERNMENT**
- Measures wait times
- Track patients through continuum of care
- Identify obstacles to access

### Financial Performance Quadrant

<table>
<thead>
<tr>
<th>DATA ELEMENTS</th>
<th>MOHLTC-IB</th>
<th>LHINS</th>
<th>HQO</th>
<th>MOHLTC-HSB</th>
<th>RCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Cost for Service</td>
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<tr>
<td>Number of attendances per health professional functional cost centres</td>
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<tr>
<td>Number of visits per nursing functional cost centres</td>
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<tr>
<td>Service Activity Levels</td>
<td></td>
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<tr>
<td>Service recipient time - individual session/each health profession</td>
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<tr>
<td>Service recipient time – group therapy session/each health profession</td>
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<tr>
<td>Number of Visits*</td>
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</tbody>
</table>

**VALUE TO GOVERNMENT**
- Better-informed QBPs, i.e.,
  - Average direct cost/episode of care and relative to QBP price
- Better-informed QBPs:
  - Informs understanding of models of delivery / inputs, illustrates variation
  - Information on resource utilization relative to cost
<table>
<thead>
<tr>
<th>DATA ELEMENTS</th>
<th>MOHLTC-IB</th>
<th>LHINs</th>
<th>HQO</th>
<th>AGO</th>
<th>MOHLTC-HSB</th>
<th>RCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure(s) of patient functional status at intake and discharge</td>
<td>As per AGO recommendation, ensures available outpatient resources are utilized efficiently and effectively</td>
<td>Supports monitoring and evaluation of QBP Performance</td>
<td>Informs value question, i.e., outcomes achieved for inputs</td>
<td>Enhanced measurement of quality of care</td>
<td>Absolutely essential for measuring functional outcomes and the quality of outpatient rehab</td>
<td>Required for case mix/risk adjustment of funding models and outcome measures</td>
</tr>
<tr>
<td>Measure of Caregiver Burden</td>
<td>Determine additional supports that may need to be put in place to ensure informal supports are maintained in the community.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Measure of Patient/Caregiver Experience</td>
<td>Informs how quality of care/delivery/transition may be improved.</td>
<td>Aligns with HQO Common Quality Agenda &amp; MOHLTC priorities.</td>
<td></td>
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</tbody>
</table>

41 Discharge should be based on patient reaching pre-established treatment goals and or plateauing or reaching a point where improvement could be managed with community exercise classes or self-care
Appendix G – Summary of Provincial Outpatient/Ambulatory Minimum Data Set Validation Survey Results

The Outpatient/Ambulatory Task Group of the Rehabilitative Care Alliance worked with multiple branches of the Ministry of Health and Long-Term Care, Health Quality Ontario (HQO), and the Ontario Hospital Association (OHA) to develop a validation survey for the proposed Outpatient/Ambulatory Rehabilitative Care Minimum Data Set. Surveys were distributed to Outpatient/Ambulatory Rehabilitative Care (OPR) providers on November 3, 2014 and to Community Physiotherapy Clinics (CPCs) on November 10, 2014 with a deadline for submission of November 21, 2014. The purpose of the OP/AMB MDS Validation survey was:

1. To generate a list of OPR providers funded by the MOHLTC/LHINs and an estimate of service volumes across programs.
2. To understand the type of data currently collected by the OPR programs.
3. To understand the potential implications of implementing the proposed minimum dataset.

In order to reduce the burden of data collection/reporting for survey respondents, the RCA requested one survey per organization, not per program. Therefore the provincial numbers cannot be interpreted to represent the full number of programs/services offered across the province, nor does it represent a comprehensive count of the volume of patients served.

Regional variances were noted in the approaches used to collect data, and the implementation considerations expressed by outpatient/ambulatory rehabilitative care providers. As a result, a summary analysis of the completed surveys within each LHIN was distributed to LHIN Leads across the province.

Response Rate

A total of 278 OP/AMB MDS validation surveys were distributed to providers across the province. Including 113 Health Service Provider corporations and 165 Community Physiotherapy Clinics (CPCs).

- A total of 160 surveys were completed representing a 58% total response rate.
  - 75 health service provider corporations completed a survey representing a 66% response rate.
  - 85 CPCs completed a survey representing a 52% response rate.

Estimate of Outpatient/Ambulatory Rehab Programs and Service Volumes

HSP corporations reported the following programs, patient volumes, and service descriptions for the fiscal year 2013/2014:

- 95 sites offering outpatient/ambulatory rehabilitative care services
- 357 programs offering outpatient/ambulatory rehabilitative care.
- 230,803 patients served
- 1,321,217 health discipline attendances
- 258,039 nursing visits

CPCs were not asked to report volumes as these are reported to the MOHLTC. Additionally, due to the response rates and the limitations organizations expressed in reporting the data, the provincial numbers cannot be interpreted to represent the full number of programs/services offered across the province, and does not represent a comprehensive
The primary objective of 70% of the above programs is to restore or optimize function, as reported by providers. The primary objective of the remaining 30% of programs was comprised of: maintain function; education, peer support, self-management; primarily consultative or assessment-based (assistive device needs and other).

None of the proposed data elements within the MDS are new data elements for all providers. However, there is variability in the approaches used to collect data by outpatient/ambulatory rehabilitative care providers.

- 90% of the data elements within the access and transition and financial performance quadrants are collected by the majority of providers (>50%).
  - 79% (26/33) of data elements within the access and transition and financial performance quadrants are collected by the majority of providers (>50%) when only respondents with the top 80% of patient volumes are included.
- 40% of providers reported collecting a measure of patient/caregiver experience.
- 107 different clinical outcome measures are currently being collected by HSP corporations in outpatient/ambulatory rehabilitative care.
- 4% of providers are collecting a measure of caregiver burden.

As anticipated, a change management strategy would be required to mitigate implementation challenges and capitalize on the opportunities throughout implementation (e.g., training, standardized data collection, a patient classification system, etc.).

In review of respondents who reported the top 80% of patient volumes, 74% indicated that: “Reporting on the proposed data elements within the ‘Access and Transition’ and ‘Financial Performance’ quadrants through a standardized data collection and patient classification system would bring value to the data elements that are currently collected and would require IT solutions, and decision support/information management.”

Click [here](#) for further details on survey findings.
### Appendix H – Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;R</td>
<td>Assess and Restore</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>ADT</td>
<td>Admission, discharge and transfer system</td>
</tr>
<tr>
<td>AGO</td>
<td>Auditor General of Ontario</td>
</tr>
<tr>
<td>ALC</td>
<td>Alternate Level of Care</td>
</tr>
<tr>
<td>AUA</td>
<td>Assessment Urgency Algorithm</td>
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<td>AustOMs</td>
<td>Australian Therapy Outcome Measures</td>
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<td>Community Care Access Centre</td>
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<td>Complex Continuing Care</td>
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<tr>
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<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
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<td>Capacity Planning &amp; System Evaluation</td>
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<tr>
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<td>College of Physicians and Surgeons of Ontario</td>
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<td>Community Support Services</td>
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<td>EMR</td>
<td>Electronic Medical Record</td>
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<td>EQ-5D™</td>
<td>Euroqol 5 Dimensions</td>
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<td>FIM</td>
<td>FIM® instrument</td>
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<td>FS/MC</td>
<td>Frail Senior/Medically Complex</td>
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<td>GEM</td>
<td>Geriatric Emergency Nurse</td>
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<td>HBAM</td>
<td>Health Based Allocation Model</td>
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<td>Health Quality Ontario</td>
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<td>Health System Indicator Initiative</td>
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<td>Health Service Provider</td>
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<td>High Tolerance Short Duration</td>
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<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
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<tr>
<td>IHPME</td>
<td>Institute of Health Policy, Management and Evaluation</td>
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<tr>
<td>InterRAI</td>
<td>International Resident Assessment Instrument</td>
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<td>Local Health Integration Network</td>
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<td>LOS</td>
<td>Length of Stay</td>
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<td>Minimum Data Set</td>
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<td>Ministry of Health and Long-Term Care</td>
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<td>OLTCA</td>
<td>Ontario Long Term Care Association</td>
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<td>Abbreviation</td>
<td>Description</td>
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<td>OMA</td>
<td>Ontario Medical Association</td>
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<td>OP/AMB</td>
<td>Outpatient/Ambulatory</td>
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<td>OPR</td>
<td>Outpatient Rehabilitation</td>
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<td>OSOT</td>
<td>Ontario Society of Occupational Therapists</td>
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<td>Planning Considerations for the Reclassification of CCC/Rehab Beds</td>
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<td>Quality-Based Procedures</td>
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<td>RM&amp;R</td>
<td>Resource Matching and Referral</td>
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<td>Reintegration to Normal Living Index</td>
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<td>TJR</td>
<td>Total Joint Replacement</td>
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<td>UDSMR</td>
<td>Uniform Data System for Medical Rehabilitation</td>
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