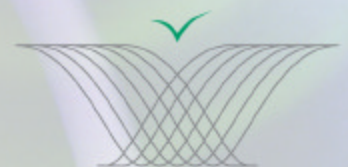


Rehabilitation in the Greater Toronto Area: A Vision for the Future

**A supplementary report to:
GTA Rehab Network Strategic Plan 2005-2008**

June 2005



**GTA REHAB
NETWORK**

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INTRODUCTION

In January 2005, the Greater Toronto Area (GTA) Rehab Network initiated a strategic planning exercise to develop a multi-year plan. A key deliverable for this planning process includes a document that proposes a vision of rehabilitation in the GTA, which is based on membership input, broad consultation and an environmental analysis.¹ This vision will be used to guide the strategic directions of the Network for the next three to five years.

The GTA Rehab Network is a self-funded network of providers who receive funding primarily from the public purse. While recognizing the need to interface with the privately funded component of the sector, this visioning exercise has largely been focused on the public component of rehabilitation.

Background

Throughout the 1990s, the Ministry of Health and Long-Term Care (MOHLTC) initiated a number of policy-oriented activities designed to reform the rehabilitation sector. The potential of the 1993 report, a *Rehabilitation Strategic Framework*, was overtaken by the broader issues of health care funding cut-backs and the definition of insurable services under the Automobile Insurance Act. In 1996,² the *Rehabilitation Action Plan* identified problems of service fragmentation, cost control and inequitable access and the associated system weaknesses – and was overtaken by the directives of the HSRC. In response, the MOHLTC established the Provincial Rehabilitation Reference Group (PRRG) to provide consultation to the Ministry on its *Rehabilitation Reform Initiative*.

The goals of the *Rehabilitation Reform Initiative* were:

- To improve service to clients by creating a client-centred, coordinated, integrated continuum of services.
- To provide regions, districts and local areas with a planning framework they can use to develop locally-relevant rehabilitation service delivery plans that reflect the MOHLTC's overall goals and objectives.
- To provide the MOHLTC with a planning framework to facilitate resource allocation decisions and improve coordination both within the Ministry and with other affected ministries.

The PRRG's final report in March 2000, *Managing the Seams*,³ was intended to be the precursor to development and implementation of a focused policy framework for rehabilitation. While a number of service delivery pilot projects were supported across the

¹ The preparation of this document was informed by a literature review, broad stakeholder consultation from within and outside the GTA, critical feedback on the vision at the GTA Planning Retreat in March 2005 and iterative review by the GTA Rehab Strategic Planning Committee.

² In that same year, the release of "*Planning Guidelines for the Development of a Speech and Language Services System for Pre-School Children*" signalled the start up of what is now a well-coordinated, locally implemented program for pre-school children across the province.

³ Provincial Rehabilitation Reference Group (March 2000). *Managing the Seams: Making the Rehabilitation System Work for People, a Rehabilitation Reform Initiative*. Toronto.

province the major thrust of this initiative was not advanced and no further attempts have been made to fill this vacuum.

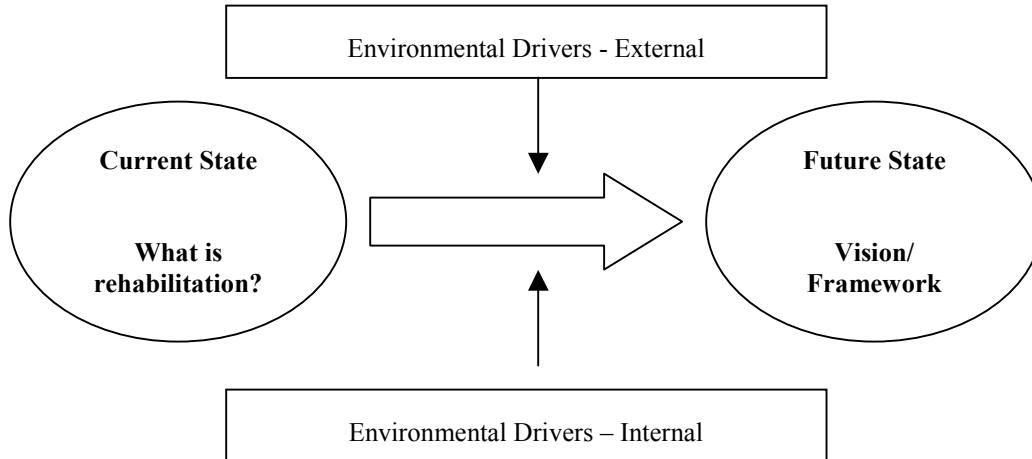
In the absence of a comprehensive vision or method to guide the growth of rehabilitation service delivery, programs and services have been developed largely along program (inpatient general and specialized), population health (ABI, cardiac and stroke) or payer demand (WSIB) lines. For example, the expansion of inpatient rehabilitation capacity across the GTA, and to varying degrees across the province, was a result of the Health Services Restructuring Commission (HSRC) directives in the late '90s. The explosion of private sector providers has been driven by a variety of legislative changes directed at workplace safety and the automobile industry. Ironically, while these service areas expanded, capacity in other areas (e.g., publicly funded out-patient programs) dropped dramatically.

The net effect of policy drift is a series of strong, but disjointed programs, multiple access streams associated with an overall access deficit,⁴ and a loss of system-wide client-centeredness that is characterized by formidable barriers for clients and families to navigate as they attempt to move through the health care continuum.

⁴ which discriminates against those members of society who are unfortunate enough to incur the need for rehabilitation in the “wrong location” and whose income/employment status makes them vulnerable.

CREATING A VISION FOR REHABILITATION

The case for creating a vision for rehabilitation in the GTA will be built by first reflecting on rehab’s current state and then exploring the impact of environmental drivers (both internal and external). The current state will attempt to describe what rehabilitation is in the year 2005. The environmental and policy drivers sections will explore the strengths, challenges and opportunities that rehabilitation must consider in creating an ideal vision of the future.



The Current State of Rehabilitation

What is Rehabilitation?

Rehabilitation is most often defined as “a goal-oriented and often time-limited **process**, which enables individuals with impairments, activity limitations and participation restrictions to identify and reach their optimal physical, mental and/or social functional level through a client-focused partnership with family, providers and community. Rehabilitation focuses on abilities and aims to facilitate independence and social integration”.⁵ Indeed, it could be said that “the ultimate test of rehabilitation is how well an individual is able to participate actively in his or her environment.”⁶

By definition, rehabilitation requires a **team** approach and typically includes at least one of the self-regulated rehabilitation professionals who are regarded as unique to rehabilitation science: occupational therapists (OT), physical or physiotherapists (PT), speech-language pathologists (SLP) and physiatrists. A multidisciplinary rehabilitation team will often also include one or more of the following:

- physicians
- nurses
- audiologists
- dietitians
- orthotic and prosthetic professionals
- rehabilitation assistants
- social workers
- pharmacists
- psychologist
- home care workers

⁵ Provincial Rehabilitation Reference Group (March 2000). Managing the Seams: Making the Rehabilitation System Work for People, A Rehabilitation Reform Initiative. Toronto.

⁶ Mark Rochon (October, 2004): Speakers notes for presentation to IBC/WSIB Conference, Toronto.

Rehabilitation in today's health care system believes strongly that clients and their families are central in the process. To achieve this client-centred approach, the client's role in decision-making at the level of the team and the organization must be recognized.⁷ As such, the client and family are expected to be actively involved with the team in setting and working to achieve the client's rehabilitation goals.

Funders use a variety of definitions to differentiate between program types and to delineate their particular focus e.g., WSIB funds only programs of care that help workers to return to work, while automobile insurers fund only rehabilitation programs and services for individuals who have been injured in a motor vehicle accident. Similarly, the Ministry of Health and Long-Term Care (MOHLTC) directly funds rehabilitation that is provided by hospitals in their designated rehabilitation beds, by select community programs through annual grants (e.g., Community Arthritis Society services) and by the community care access centres network of home care services.

Beyond these narrowly defined program silos, even in the public sector, the definition of rehabilitation varies by program stream. Thanks to the Canada Health Act, public (MOHLTC) funds must be used to support *select* rehabilitation services (e.g., physiotherapy) for inpatients in hospitals. This is done through the hospital's global budget allocation e.g., immediately following knee surgery or for treatment of an acute exacerbation of chronic obstructive pulmonary disease). But, this also means that not all of the required services (e.g., occupational or speech therapy) are "guaranteed" or protected under the Act; and there are no provisions to protect services for hospital outpatients. Similarly, rehabilitation services required by patients in complex continuing care or long-term care beds are neither protected, explicitly incorporated into the funding formula nor officially recognized as *additional* costs. As a result, the provision of these services is determined by the budgetary policy of each individual provider, rather than a cohesive, client-centred provincial or regional policy.

Overall Strengths

Rehabilitation is characterized by an impressive array of services that are woven into the fabric of the health care continuum.

- Rehabilitation plays an essential role with varying degrees of intensity in each phase of the health care continuum ranging from primary, secondary and tertiary acute services through community, ambulatory, in-home, inpatient rehabilitation, day hospital settings, to long-term and complex continuing care.
- Programs range in complexity and intensity depending on the needs of clients and the goals of the program e.g., post-operative therapy versus ambulatory cardiac rehabilitation.
- Services have expanded to meet the needs of local and regional populations, with adequate capacity in selected program areas. There are highly specialized pediatric rehabilitation services which serve the entire province.

⁷ Ontario Hospital Association, Hospital Report Rehabilitation, 2003, p. 110

With the recent investments in the education sector and with some exceptions, a more adequate supply of providers is slowly becoming a reality. In addition, professionals in this sector are amongst the brightest and best educated in the community at-large and therefore bring substantial intellectual capacity to the challenges that face it.

Internal Environmental Drivers

Access and Capacity

Access to rehabilitation services is determined largely by where you live and who pays for the service, as determined by cause or location of injury or disease. While access to inpatient rehabilitation in a hospital setting is guaranteed under the Canada Health Act, no such protection is afforded those whose needs must be met in an ambulatory/clinic setting. The Romanow report avoided the issue of differential access to rehabilitation, where rehabilitation was limited to a discussion of home health care services.

One measure of access is the extent to which there is capacity in a given region. Capacity, as measured by inpatient beds across Ontario, provides a snapshot of the disparity in access that currently exists in Ontario, with a range from of 11 to 24 beds per 100,000 population in the GTA and as wide a variation as 1.7 to 44.6 beds per 100,000 population in other parts of the province.⁸ This variation is also reflected in access to those services, where stroke patients accessed rehabilitation on a rehabilitation unit at rate of 11.9% at the low end and 24.8% at the high end of the range. Still worse, rehabilitation following total knee replacement exhibits wide variation in access with rates of 7.7% at the low end and 68% at the high end.⁹

Ultimately, it is the most vulnerable in our society who suffer the most from inequities in health, quality of life and access to health services like rehabilitation. In addition to limited capacity in many rehabilitation services, barriers to access include the inability to pay for services that are available only in the private sector, wait times for limited services provided by the public sector (especially true for outpatient services) and a lack of knowledge by the consumer and potential referral sources (physicians, nurse practitioners) of the availability of services.¹⁰

Multiplicity of Payers, Providers and Services

The success of rehabilitation's reach across the continuum of care and the absence of a unified system has contributed to a fragmented patchwork of services and a multiplicity of providers and payers. Rehabilitation is available in varying degrees throughout the continuum of care in various sectors and settings (acute, in-home, outpatient clinics, inpatient rehab hospitals, LTC, CCC) in this current configuration of services.

⁸ 2001 Clinical Committee Survey Report: Current Status of Rehabilitation in the GTA, p.23

⁹ Mark Rochon (October, 2004): Speakers notes for presentation to IBC/WSIB Conference, Toronto.

¹⁰ Cott C.A., Devitt, R., Falter, L.B., Soever, L., and Wong, R. (2003). *Adult Rehabilitation and Primary Health Care in Ontario*. Working Paper. Toronto: Arthritis Community Research & Evaluation Unit (ACREU).

The result is:

- substantial variation in capacity across the province (e.g., out-patient, sub-acute and inpatient rehabilitation)
- variation in service scope, definition, performance measurement and reporting of data (outside of the NRS-mandated facilities)
- challenges for streaming patients to the “right” service, in the “right” location/setting at the “right” time
- limited or inconsistent access to certain inpatient program types (e.g., LTLTD, ABI, geriatric) and outpatient program types (e.g., COPD, amputee rehabilitation and developmental pediatrics)
- patients with complex needs experience lengthy delays in access that in some cases amounts to a denial of service (the complexity of rehab requirements make it difficult to place these patients in appropriate programs)
- inconsistent access to in-home care

Barriers to Discharge from Acute Care (ALC cases)

Now that long-term care capacity has increased in the system and access is no longer the challenge it was a few years ago, it is suggested access to rehabilitation services remains a barrier to discharge from acute care.

Challenges cited include:

- too many different points of access, requiring multiple referrals using varying processes
- wide variation in criteria for admission and in the way organizations process referrals, assess the application and reply to referrals¹¹
- the most challenging cases (resource intense) are routinely rejected and are the slowest to transfer from acute care (i.e. largest number of ALC days), with little assistance offered to find the appropriate post-acute care.

Adaptability, Responsiveness and Complexity

While acute care services have shifted tremendously in the past decade to shorter lengths of stay, highly focused discharge planning early on in a patient’s acute care stay and aggressive strategies to improve acute care bed management, rehabilitation programs and services have not shifted to the same degree to accept patients earlier in their clinical course. Further, concern is expressed about the adaptability and responsiveness of rehabilitation programs to new and emerging needs, such as rehabilitation for oncology or transplantation patients. For their part, regional and provincial rehabilitation programs are challenged to meet the needs of progressively more acute *and* complex patients who have survived multiple trauma and/or a range of co-morbidities not previously seen at this stage in the continuum. This holds true for pediatric and adult populations, thanks to rapid advances in medicine, trauma management and bio-technological innovations. In addition, pediatric rehab services are progressively more challenged by the needs of youth with complex genetic and congenital

¹¹ Addressing these issues has been a major focus of the GTA Rehab Network, with progress being made through Rehab Finder, the Common Referral and Response form and the ALC guidelines.

disabilities who are living into adulthood, placing ever-growing pressure on the pediatric-adult interface in rehabilitation services. To compound the problem, tools to measure the system, service or clinical impacts of these population changes are wholly inadequate.

Perceptions and Myths

There persists, at many levels of government and acute care hospital corporations, the out-dated perception that rehabilitation is still a 9-to-5, Monday to Friday service. This perception fuels the belief that rehabilitation professionals in particular, and the sector in general, is unable or unwilling to address the barriers to patient flow through the continuum and thus facilitate the success of the health care system overall.

External Environmental Drivers

Burden of Chronic Disease

The demand for rehabilitation is increasing, in part, as the overall burden of chronic disease and disability increases. In Canada, 16 million people live with chronic illness and chronic disease accounts for 87% of disability. The growing number of seniors is also increasing both the demand and

The estimated number of people who require rehabilitation services at any point in time is 1.5% of the population, i.e. about 90 million people. The number of disabled people continues to be estimated at 7% to 10% of the population, although individual countries have given numbers that vary from approximately 4% to 20%. These estimates reflect many persons whose needs for rehabilitation services, and for equal rights and full participation, have not been met.
 [Source: <http://www.who.int/ncd/disability/trends.htm>]

complexity of rehabilitation services. Additional high risk groups are those who belong to vulnerable communities (e.g., aboriginals) and those who are socio-economically disadvantaged. The economic burden is characterized by direct health care expenditures at 67% of the total direct costs and 60% of the total indirect costs (approximately \$52 Billion), which translates into lost productivity and foregone income. All of these numbers will increase as the population ages and as the anticipated prevalence of some risk factors, e.g., obesity, continue to increase. “The ‘rehab approach’ to disability (especially its sensitivity to systemic and upstream causes) is under-utilized by the current health care system”.¹²

The Changing Role of Rehabilitation

The importance of rehabilitation in the health care system is taking on new meaning and direction in a renewed health care system.

The very high functional performance expectations of the aging baby boomers, the rising prevalence of chronic diseases as a result of the success of biomedicine (people living longer, sicker, and therefore needing and expecting more rehabilitation), and of course, the impact of demographic shifts with an aging population have caused an explosion of interest in rehabilitation. We anticipate not only an increased demand for rehabilitation services, but also positive convergence around rehabilitation themes as discoveries in neuroscience, tissue-engineering and non-biotechnology all lead to new rehabilitation modalities. [Source: University of Toronto, Faculty of Medicine Academic Plan 2004-2010]

¹² John Frank (2004). *Disability, Rehabilitation and Population Health: An Underutilized Research Practice Collaboration*. Keynote Address: GTA Rehab Network Best Practices Day 2004, Toronto.

Rehabilitation "...is changing as a result of breakthroughs in technology, molecular biology and the human genome, expanding beyond an emphasis on social science in kinesiology and anatomy. More attention is focusing on multifactoral determinants, the influence of genetics, the environment and psychosocial health status as well as knowledge translation. Interventions are changing with more interdisciplinary linkages and the need to work with people who have different skills and knowledge."¹³

Indeed, "the rehabilitation sector is undergoing rapid and fundamental change on a number of fronts"¹⁴ as evidenced by:

Shift to Private Sector Rehabilitation

Private sector activity has grown significantly with outpatient and ambulatory rehabilitation services shifting away from a largely publicly-funded environment to one predominantly involving private providers and payers. This shift is most pronounced where there have been reductions in publicly-funded outpatient rehabilitation services by local hospitals and where limited services, funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC) and provided by physiotherapists and audiologists, have been either limited or eliminated. This trend would have been accelerated with the proposed elimination of funding of all ambulatory physiotherapy; however, in February of this year, the Ministry announced its intention to continue funding outpatient physiotherapy services for children up to 18 years of age and seniors over the age of 65 and to explore physiotherapy needs in long-term care homes.¹⁵

Disintegration of Sub-Acute Outpatient Rehabilitation

There has been a shift in emphasis from acute care to ambulatory and home care across the health system, particularly since the 1998 mandated restructuring of Ontario hospitals. Ironically, in rehabilitation, where the ambulatory service delivery model was already well established in the hospital sector, the trend was reversed. Outpatient rehabilitation services with little perceived impact on a hospital's ability to discharge inpatients were discontinued. While hospitals were usually motivated by shrinking budgets, the availability of enhanced home care and, for select cases, inpatient rehabilitation services, was seen as a viable alternative. The result has been the disintegration of the sub-acute outpatient rehabilitation sector, leaving patients who are not appropriate candidates for either "alternative" with few options, and a loss of momentum for what were, previously, smooth transitions through the continuum of care.¹⁶

¹³ Martha Piper (2001). *The Future of Academic Rehabilitation*. Keynote Address, University of Toronto

¹⁴ West Park Healthcare Centre (2003). *Taking a Closer Look at Rehabilitation*. Toronto.

¹⁵ Letter from Dawn Ogram, ADM Health Services Division to Tony Melles, Schedule 5 Physiotherapy Association, February 25, 2005.

¹⁶ Insurance Bureau of Canada (2001). "At the provincial level, there are typically no forums for the major funders and providers to share information, plan and develop mutually compatible policies. As a result, the wall of the silos within rehabilitation can seem particularly thick to the people needing services."

Clinical and Program Shifts

Changes in clinical practice resulting from new and emerging technology and knowledge e.g., the Integrated Stroke Strategy for Ontario¹⁷ has led to the redesign of therapeutic strategies and rehabilitation programs across the province.

There are renewed efforts to support the long-awaited shift from acute care to home care by the recent expansion of funds for home care services in the first wave of the government's Transformation Plan announcements.¹⁸ As the results of more focussed programs of rehabilitation research are converted into best practice guidelines, progressively more significant shifts in the location and timeline within which rehabilitation services are delivered for some patient groups will take place.¹⁹

Funding and Data Management

Funding formula models are expected to be announced in the near future for rehabilitation in-patient services. While a formula that is tied to patient progress is welcomed, the choice of the FIM™-based NRS tool is deemed to be problematic in some areas, e.g., where assistive devices support independence.

Mandatory implementation of the National Rehabilitation Reporting System (NRS) project provides a set of indicators to assist hospitals providing adult rehabilitation programs to evaluate individual and program specific outcomes as well as development of benchmark data for comparison with peers across the nation. Funding models in pediatric rehabilitation have not been addressed.

Human Resources

The introduction of new professional, Masters level, entry-to-practice programs in occupational therapy and physical therapy has brought these professions in line with speech-language pathology's long-standing entry-to-practice education standards, and is part of a national mandate that aims to match standards in the United States.

Some of the consequences include:

- *Expanded researcher and academic faculty capacity:* In combination with increased enrolment, this move is expected to increase interest and further enrolment in teaching

¹⁷ Ontario Ministry of Health and Long-Term Care and Heart and Stroke Foundation of Ontario (June 2000). *Towards an Integrated Stroke Strategy for Ontario. Report of the Joint Stroke Strategy Working Group.* Toronto: Author.

¹⁸ Minister G. Smitherman (September, 2004). *Ontario's Health Transformation Plan: Purpose and Progress.* Notes for speech delivered in Toronto. ("\$103 million more on home care", p. 25)

¹⁹ For example, in 2005, a joint University of Toronto-Toronto Rehabilitation Institute research project sponsored by Toronto CCAC will determine whether hip and knee arthroplasty patients experience better functional outcomes as a result of a protocol of 3 days acute/rehabilitation care followed by 7 days in a rehabilitation hospital versus a protocol of 5 days acute/rehabilitation care followed by rehabilitation in the home setting. The results of this project alone could significantly alter when and where services will be delivered to these patient groups.

and research graduate programs, thereby expanding the supply of rehabilitation researchers and educators

- *Recruitment challenges:* In addition to the already competitive recruitment environment for these professionals, public sector providers are concerned about their ability to match the elevated expectations of these new graduates with respect to remuneration and quality of work life
- *Student placement challenges:* Enrolment expansion in these and other rehabilitation programs has also generated concerns about the availability of clinical placements for students related to the reduced availability of resources among rehabilitation providers, in all sectors, for supervision and support

For inpatient programs in particular, there is a looming crisis in nursing supply forecast for the next 5-10 years, due to the large cohort of baby boomer nurses that are approaching retirement age. This challenge has implications for the health system at-large, and is expected to exacerbate an already challenging and competitive recruitment and retention environment. There are major concerns throughout the industry that the supply is not keeping pace with the growing demand and need for rehabilitation services.

Rehabilitation Research

Opportunities for rehabilitation research have been growing exponentially in recent years, due to new and expanding sources of external research funding [such as the Canadian Institutes of Health Research (CIHR) led by the Institute for Musculoskeletal Health and Arthritis (IMHA), the Canada Foundation for Innovation (CFI), and the Ontario Research and Development Challenge Fund] and the development of a provincial rehabilitation research program [led by the Toronto Rehabilitation Institute (TRI)]. In addition, the new research institute at the Bloorview MacMillan Children's Centre and the two research institutes at the Baycrest Centre for Geriatric Care, with their varied foci, contribute significantly to the ever expanding body of knowledge in rehabilitation. Evolving partnerships and collaboration in a number of research areas (e.g., stroke, arthritis, neurological conditions, childhood disabilities, home care and aging) are providing opportunities to link with large academic initiatives and are leveraging still more opportunities from the collective expertise and infrastructure within the rehabilitation sector.

Current Policy Drivers

MOHLTC Transformation Plan

In September 2004, Minister George Smitherman presented Ontario's Health Transformation Plan.²⁰ Selected elements²¹ include:

- the health system will provide "better access to the right care, at the right time, in the right place"

²⁰ http://www.health.gov.on.ca/english/media/speeches/archives/sp_04/sp_090904.pdf

²¹ George Zegarac (November 4, 2004). Speakers notes for presentation to Association of Ontario Community Health Centres. Niagara Falls.

- the Future Health System as described by the MOHLTC includes a *continuum of care*, revolving around the consumer/patient, that emphasizes:
 - disease prevention
 - health promotion
 - primary care
 - chronic disease management
 - community services
 - emergency services
 - acute services

Enablers in this model include: Drugs and Alternative Therapies, Health Human Resources, Funding, Capital, I.T., Research and Innovation, Medical Technologies and Diagnostic Services. While implicit in each area of the model, Rehabilitation is not explicitly identified in the MOHLTC model.

- MOHLTC is building an integrated system through creation of Local Health Integration Networks (LHINs) and renewal of primary care in parallel to the LHINs
- MOHLTC is building an accessible system by reducing wait times for acute care procedures – many with post-operative rehabilitation implications e.g., some cardiac procedures, cancer care and hip and knee replacements. In so doing, the Ministry intends to create a sustainable system through a determination to “bend the cost curve” of hospital services, which will “enable hospitals to focus on (acute)/highly specialized health care.”

Local Health Integration Networks (LHINs)

The Ontario Ministry of Health and Long-Term Care (MOHLTC) announced the introduction of Local Health Integration Networks (LHINs) in October 2004 “as part of our goal of transforming the healthcare system [...] to better integrate and coordinate health services at the local level.” “LHINs are a “made-in-Ontario” solution that engages communities in health system transformation by enhancing and supporting local capacity to plan, coordinate, integrate, and fund the delivery of health services at the community level. Unlike the integrated models in place in other provinces of Canada, LHINs will not be providers of clinical services, but will coordinate service delivery.”²²

In community workshops held around the province in late 2004, rehabilitation was ranked 18th (out of 22) on the overall list of top priorities for integration.²³ However, the key themes reaffirmed the value of rehabilitation to the system as a whole:

- Rehabilitation services are part of the continuum of health care
- The value to the health system is that rehabilitation services keep people out of acute care, in the community, at home and at school (enhancing quality of care and saving money for the system)
- Rehabilitation services could be provided to the community through long-term care facilities.

²² Health Results Team (2004). *Local Health Integration Networks: Building a True System*. Bulletin No.1 – Oct 6. Toronto: MOHLTC

²³ Health Results Team (2005): *Summary of Findings from LHIN Community Workshops*. Toronto: MOHLTC

The emergence of LHINs may have a significant impact on the planning, organization and delivery of rehabilitation services, as the LHINs move into their roles of integrating and coordinating services. The current distribution of specialized rehabilitation services will require inter-LHIN planning to coordinate access to specialized services across LHINs. Experience in other jurisdictions across Canada with regional health authorities has confirmed the value of networks in bringing together communities of practice, informing guidelines and facilitating access and coordination for targeted populations. This presents an important opportunity for the GTA Rehab Network to establish itself as the “go to resource for rehab” for system access initiatives, evidence-based practice and outcomes (for standards and evaluations), professional education and applied research across multiple LHINs.

Rehabilitation Policy Initiatives

Responsibility for policy development related to the rehabilitation sector is vested in a number of different Ontario Government ministries, namely:

- The Ministry of Health and Long-Term Care (MOHLTC)
- The Ministry of Finance (administers automobile casualty insurance legislation)
- The Ministry of Labour (primarily through its agency, the Workplace Safety and Insurance Board that has a defined rehabilitation policy)
- Other ministries of the Ontario government whose policies impact on those who receive rehabilitation services²⁴ (e.g., policies related to income support and transportation programs).

MOHLTC policies impacting on the rehabilitation services sector are being “woven” into a number of program areas (i.e., long-term care, home care, complex continuing care, stroke strategy, etc.) so that rehabilitation is addressed in seven Divisions, 20 Branches and up to 30 Units.

Internal restructuring at the MOHLTC has expanded the scope of the Integrated Policy and Planning Division to the Population Health Policy and Planning Division. The Division continues to hold the Mental Health and Rehabilitation Reform Branch, which is commissioning health services research that will lead to policy development in areas consistent with the Transformation Plan e.g., primary care and chronic disease management. The Ontario Rehabilitation Research Advisory Network (ORRAN) provides advice to the Branch with respect to the generation of feasible research questions.

The Ontario Hospital Association has recently established a new Complex Continuing Care and Rehabilitation Council that will be focused on key policy issues in rehab, including funding and human resources. With representation from 17 hospitals across the province, this group should be in a stronger position to advocate and influence changes in public policy with respect to needs and gaps in rehab services.

²⁴ MOHLTC has developed a new Health Human Resource Division that will collaborate with the Ministry of Colleges and Universities.

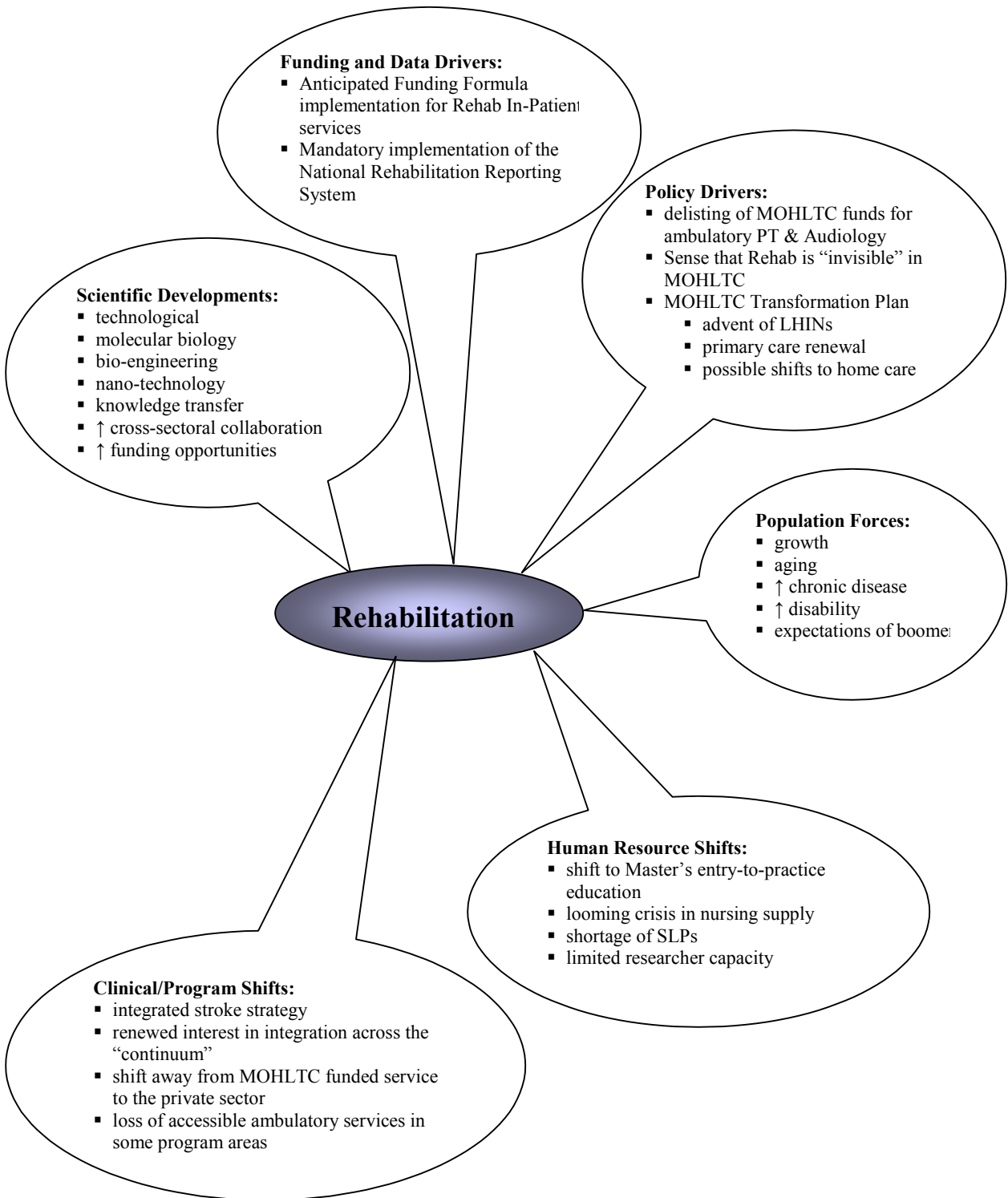
Summary

Figure 2 below summarizes the environmental thrusts that publicly funded rehabilitation programs and services in the GTA are facing:

- population forces that range from advancing growth and age, with the associated increases in chronic disease and disability, particularly for socio-economically disadvantaged, vulnerable populations to the “very high functional performance expectations” of the large and powerful baby boomer cohort
- scientific developments in basic, clinical, technological and physical science whose impact are accelerated by enhanced knowledge transfer, cross-sectoral collaboration and funding opportunities
- new initiatives in funding and data management
- progressive changes in clinical practice resulting from new and emerging knowledge that are counter-balanced by inequitable access to and gaps in service, disintegration of the sub-acute ambulatory rehabilitation sector and an ongoing shift towards privatization
- human resource shifts characterized by new graduate degree entry-to-practice standards, escalating demand due to new and emerging research and clinical program developments, and shortages in key disciplines at a time when significant cohorts of the professional workforce are approaching retirement age
- the urgency of a provincial transformation plan that all but ignores the existence and potential of rehabilitation while applying indirect pressure through the acute care sector and the emerging influence of new regional structures (LHINs) that are charged with addressing service access and coordination issues
- a sense of ongoing policy drift associated with piecemeal delisting of services and the absence of a focused, coordinated approach to rehabilitation policy at the Ministry of Health and Long-Term Care.

All of these drivers will significantly impact the evolving future for rehabilitation in the GTA.

Figure 2. Environmental Drivers



A VISION FOR THE FUTURE

Rehabilitation services are used by people of all ages. The need for rehabilitation can arise at birth, as a result of illness or injury or following injury at work, home or play. Though seniors comprise a large component of rehabilitation service users, virtually every member of society can expect to need rehabilitation services at some point in their lifetime – and for some the need extends across much of their lifespan. As the need for rehabilitation services varies widely, the vision must respond to this variation in need.

Rehabilitation encompasses a range of professional services and programs that are integrated throughout the continuum of health care from the home, school or workplace (e.g., enabling community integration through assistance with ADL²⁵) through acute care (e.g., post-operative physiotherapy following hip fracture fixation, speech-language pathology intervention post-stroke for management of speech or swallowing impairments) and sub-acute rehabilitation programming for disease/health system specific purposes (e.g., musculoskeletal, stroke, cardiac or COPD²⁶ rehabilitation) to chronic disease management and self-management programs (e.g., arthritis, multiple sclerosis or COPD) and illness/disease prevention and wellness education in the community at-large. Ultimately, rehabilitation is a process focused on abilities.

Rehabilitation is an integral part of the health care continuum. In acute care this is evidenced through well developed inter-professional program managed team structures. Similarly, where services and processes are currently well established, they facilitate system accessibility through effective transitions across much of the continuum [e.g., to the next level of rehabilitation program, residential care (long-term, complex continuing, home), or independent living] by optimizing the patient's functional level. However, for the health system to be truly accessible, requires that patients move with ease through whatever parts of the continuum they need, so that they can receive the “right care, at the right time, in the right place.”²⁷

The Promise and Potential of Rehabilitation

Rehabilitation's multiple roles (clinical and other processes that optimize function, educator of clients, families and professionals, generator of new knowledge through research and innovation and facilitator of effective health system transitions) position rehabilitation as an *integral and essential component* of an effective and accessible health care system. Our future vision for rehabilitation in the GTA reinforces and highlights the value of these roles.

²⁵ Activities of Daily Living

²⁶ Chronic Obstructive Pulmonary Disease

²⁷ Minister G. Smitherman (September, 2004). *Ontario's Health Transformation Plan: Purpose and Progress*. Notes for speech delivered in Toronto.

Vision

Rehabilitation is an integral and essential component of the continuum of health care, reinforcing positive health behaviours, rebuilding lives and reintegrating individuals into the community.

The rehab system we envision maximizes the client's health, function and quality of life and continually reinforces healthy behaviours. Patient flow is maximized and interventions and treatment are based on the best available evidence, measured outcomes and active client and family involvement.

The GTA Rehab Network's vision aligns rehabilitation services in the GTA with the principles and priorities of Ontario's Transformation Plan and the emerging LHINs by outlining rehabilitation's defining *principles*, its essential *characteristics* and *enabling processes*:

Principles:

- ***Equitable access*** to rehabilitation services that is characterised by ***adequate service capacity*** and ***timely transitions***.
 - It is essential that there are sufficient core rehabilitation services in place, to support the same level of access across the GTA, regardless of where people live. In addition, specialized services will be distributed across the GTA so that transportation barriers are minimized for families.
 - Patients will move across the health system continuum to access the right type of rehab in the right setting (out-patient clinic, inpatient rehab, long-term care, complex-continuing care, private home/residence) for their needs with little or no waiting time.
- ***Family-centred and consumer driven initiatives***: Consumers of rehabilitation have the most up-to date knowledge of where gaps in the health system exist, and where they have the most impact. Mechanisms will be implemented to better involve and learn from clients and families in each of the many roles enacted by rehabilitation. Consumer driven initiatives will be the hallmark of the new rehabilitation environment where individuals and families partner with providers to “drive” innovation in each of these roles.
- Notwithstanding the dearth of evidence in many areas, rehabilitation services will be ***evidence-based*** wherever possible and focussed on improved ***client and population outcomes*** at all times. Best practice mechanisms that target the transfer, uptake and implementation of new and underutilized, existing knowledge will be rigorously pursued and implemented.

Characteristics:

- Rehabilitation services and programs are arrayed across the continuum in three major groupings:
 - High volume, high intensity
 - Low volume, high intensity
 - Across the continuum, outside of designated programs or units.

Characteristics

	High Volume – High Intensity	Low Volume – High Intensity	Across the continuum, outside of designated programs or units
Setting	<ul style="list-style-type: none"> delivered in <i>designated rehabilitation hospitals</i> or <i>designated programs/units</i> in acute care and community hospitals inpatient, ambulatory and in-home settings 	<ul style="list-style-type: none"> delivered in <i>designated rehabilitation hospitals</i> or <i>designated programs/units</i> in acute care hospitals inpatient, ambulatory and in-home settings 	<ul style="list-style-type: none"> delivered across the continuum of care in a variety of settings <i>outside</i> of designated programs or units
Population	<ul style="list-style-type: none"> targeted to clients who require high intensity of rehabilitation and/or highly specialized expertise 	<ul style="list-style-type: none"> targeted to clients who require high intensity of rehabilitation and/or highly specialized expertise/technology 	<ul style="list-style-type: none"> targeted to clients who require rehab in order to transition to another level of care or to a higher level of independence
Access	<ul style="list-style-type: none"> available in <i>multiple sites</i> across the GTA and located as <i>close to home as possible</i> 	<ul style="list-style-type: none"> available in <i>fewer targeted sites</i> in the GTA lower volumes and the requirement for critical mass (in addition to specialized expertise/technology) require these programs to be concentrated in fewer sites 	<ul style="list-style-type: none"> available in a variety of settings (acute, post-acute, CCC, LTC, ambulatory, in-home) facilitates the flow of patients in the continuum (e.g., transition care in CCC or services in acute care prior to high intensity rehab or discharge home)
Examples	<ul style="list-style-type: none"> stroke; musculoskeletal; geriatric rehab; cardiac; and vocational rehab programs 	<ul style="list-style-type: none"> trauma; spinal cord; complex ABI; complex wound; amputee; post-SARS; West Nile recovery; burns; and post transplantation rehab programs 	<ul style="list-style-type: none"> low intensity-long duration rehab in CCC units; physiotherapy services in the ICU; OT consultations for ADL in acute programs; SLP consultations for swallowing in a variety of settings; rehab professionals in stroke prevention clinics

- **Focused integration** of rehabilitation programs and services **across the continuum of care** will build on the success of existing disease management models (e.g., Stroke), and system-oriented models such as the Regional Geriatric Program. New and emerging opportunities for integration will be exploited (e.g., in the primary care sector²⁸) to strengthen rehabilitation’s contribution to population health and the effectiveness of the system.²⁹ Similarly, new and innovative linkages within the broader rehabilitation sector

²⁸ MOHLTC (November 2004). *Family Health Teams - Advancing Primary Care*. Bulletin. Toronto.

²⁹ “The ‘rehab approach’ to disability (especially its sensitivity to systemic and upstream causes) is under-utilized by the current health care system”. [John Frank (2004). *Disability, Rehabilitation and Population*

will be fostered e.g., with the Worker's Safety Insurance Board and the burgeoning, "private"³⁰ outpatient sub-acute sector.

- Collaborative participation across the GTA in new and emerging **chronic disease management strategies**, with renewed emphasis on client education and support for self-management, will complement the existing rehabilitation and secondary prevention strategies in place for the highest incidence diseases e.g., diabetes, congestive heart failure, asthma, COPD and ischaemic heart disease.
- Service delivery will be enabled by an adequate supply of appropriately educated and credentialed **rehabilitation human resources**. A comprehensive, GTA, collaborative human resource strategy will be essential to align complex supply and demand challenges e.g., enrolment to entry-to-practice education programs, the emerging crisis in nursing and other professions that is associated with large retirement cohorts and the workforce shifts associated with highly variable salary/remuneration practices between sectors (hospital versus community, private versus public).

Enabling Processes:

- **Quality improvement**, outcome **evaluation and performance measurement strategies** will gauge the success of a renewed integration effort as well as that of individual programs and clinical processes. Standardized tools and shared assessment strategies will build on the NRS³¹ experience (e.g., by incorporating other databases such as the RAI³² that capture rehabilitation service utilization and patient outcomes data), while information technologies that "talk" to one another across the system will be essential enablers for success.
- **Research, teaching and innovation** are the drivers of the "promise and potential of rehabilitation." Collaborative partnerships between research institutions and **rehabilitation programs** will advance each of these initiatives while supporting the education and expansion of rehabilitation human resource groups in scarce supply. Technology will further support these initiatives through advances in the bio-medical engineering and other fields as well as in the information and communications arena (knowledge transfer, chronic disease management, tele-rehabilitation, data warehousing and decision support).
- **Knowledge translation and exchange strategies** that have a measurable impact on the quality, timeliness, location and "dose" of services provided (evidence-based practice) will be vigorously implemented across the continuum of care providers.

Health: An Underutilized Research Practice Collaboration. Keynote Address: GTA Rehab Network Best Practices Day 2004, Toronto.]

³⁰ Refers to services that are either privately-funded and/or delivered through for-profit organizations.

³¹ *National Rehabilitation Reporting System* (NRS) and minimum data set captures only adult inpatient rehabilitation services from across Canada

³² one component is currently being used by CCACs in long-term care

- **Accountability frameworks** that emphasise and foster shared responsibility with funders and providers in other sectors of the health care system will be embraced. When the goal is to maximize the efficiency of the overall health care system **and** the funds (incentives) follow the patient, new forms of **partnering** and service delivery models will emerge. In particular, linkages with other rehabilitation networks (e.g., in other LHINs) and providers (e.g., in the “private” sector) have the potential to quickly leverage resources to address otherwise unachievable goals and unserviceable needs.
- **Advocacy:** The rehabilitation sector will designate the important task of advocacy to players that can ensure that rehabilitation is included in new and emerging provincial reform efforts, particularly, primary care renewal, chronic disease management and health promotion/illness prevention. In addition, the powerful potential associated with “the very high functional performance expectations of the aging baby boomers”³³ will be harnessed to exploit research and development opportunities and to address inequities in service access and a potentially damaging policy vacuum.
- **Policy** development for a rehabilitation framework, which has cross-LHIN or provincial scope and addresses the role of the public and private sectors in a deliberate and thoughtful way, will accelerate the pace at which rehabilitation can drive the changes necessary to achieve the goals of the Transformation Plan.

Conclusion

This Vision for Rehabilitation in the GTA is expected to provide guiding parameters for the GTA Rehab Network’s future work. It is clear that achievement of this vision is beyond the scope of the Network alone, particularly given its current membership and structure. However, the Network can refocus its own activities to advance many of the elements outlined above. As the Network identifies its strategic priorities for the next three years, it will look for “partners in transformation” to achieve this compelling new vision for rehabilitation in the GTA.

³³ University of Toronto, Faculty of Medicine Academic Plan, 2004-2010.

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