

GTA Rehab Network Strategic Planning – Member Survey

Summary of Findings

Response to Survey : 29 responses from 42 members

Toronto Acute Teaching Hospital (3 of 4)

Rehabilitation hospital (7 of 7)

Toronto Community Hospital (4 of 7)

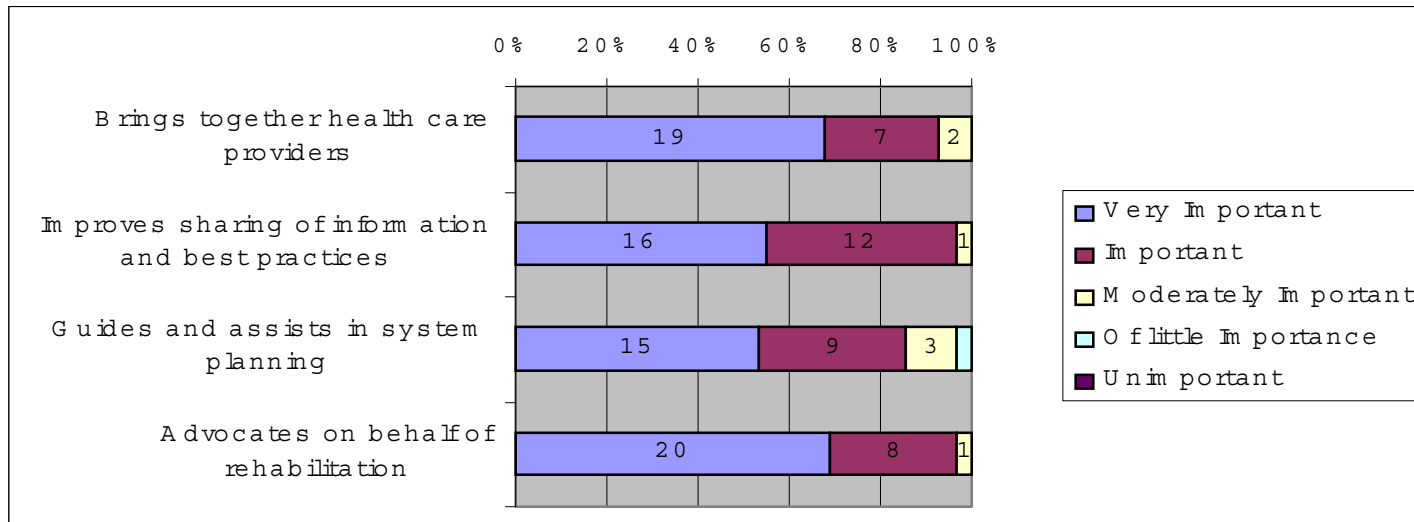
416 CCAC (2 of 5)

905 Community Hospital (7 of 8)

905 CCAC (4 of 4)

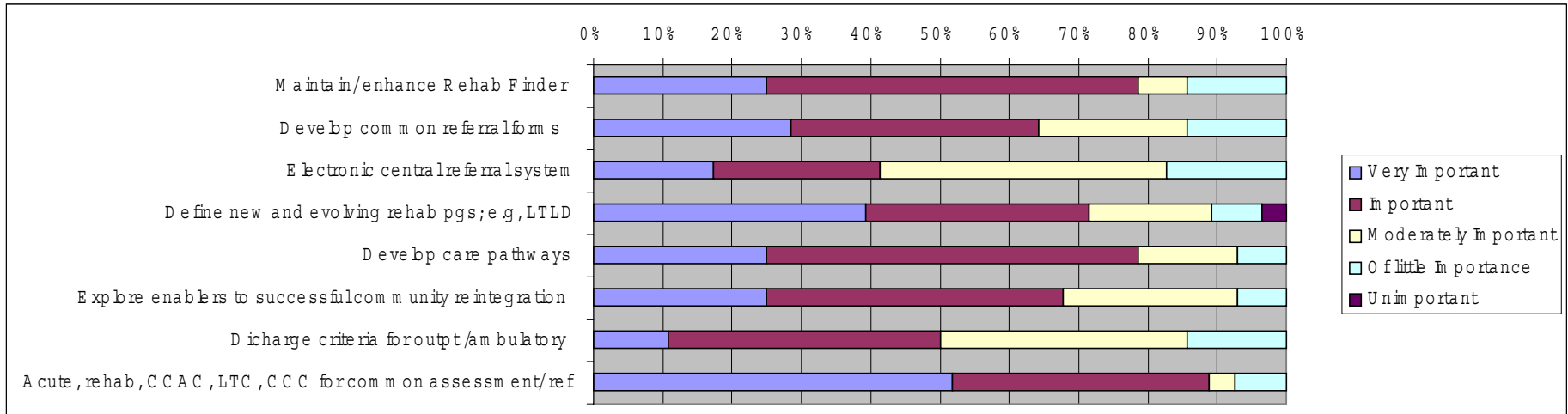
Ex-officio (2)

1. Importance of the following with respect to the role of the GTA Rehab Network:

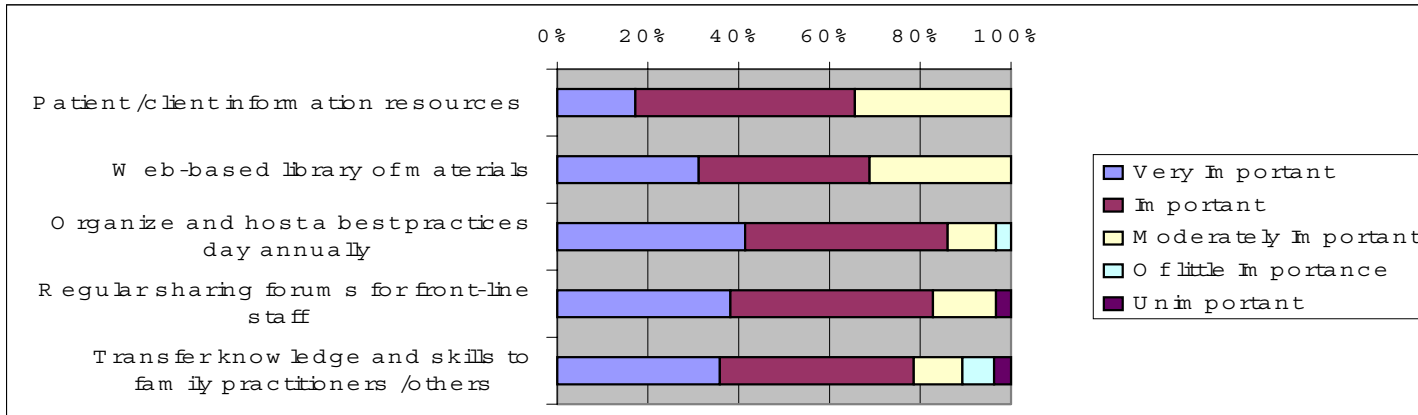


2. Importance to initiatives, both current initiatives that are underway by the Network and potential additional initiatives that have arisen during the early consultations in the strategic planning process.

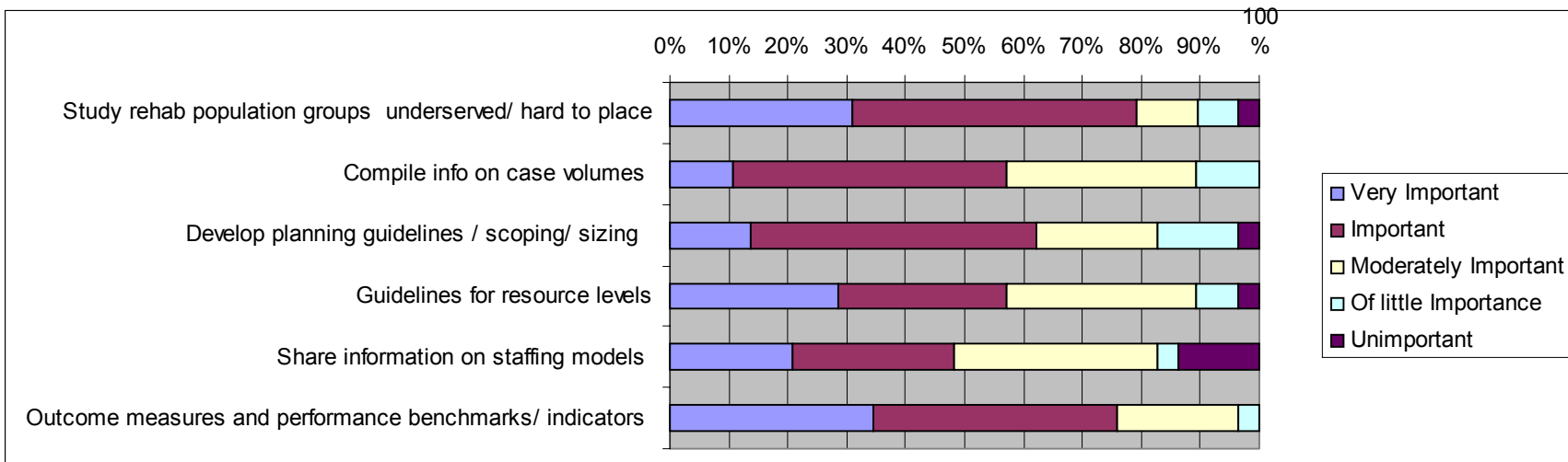
Access and Coordination



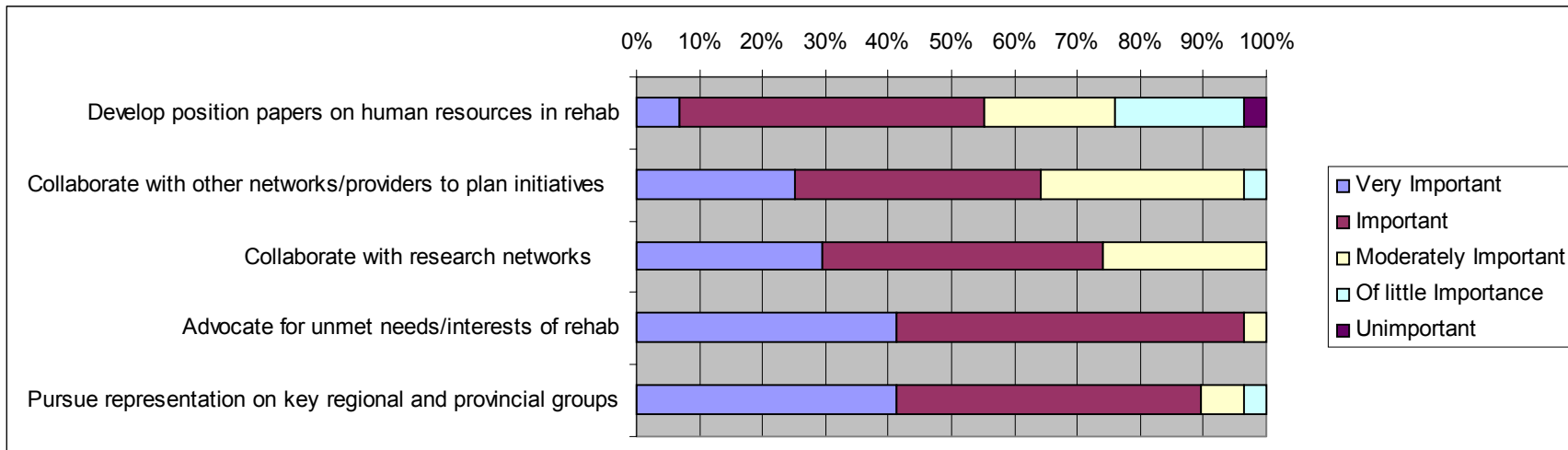
Information and Education; Knowledge Transfer and Exchange



Inform System Planning and Performance Measurement



Other



3. Top three priorities for the Network over the next 2 to 3 years.

Align Network with Transformation Agenda & LHIN mandate and membership

- provide a strong voice/ role for rehab within the LHIN structure (2)
- develop strategies to ensure that rehab benefits from opportunities with the new LHIN model; ensure support for planning and addressing gaps when service is shifted to community
- develop a process for consumer input

Improve service delivery and access

- provide a section on network, identifying where the vacant beds are and the waiting times for each program in each rehab facility; maintain and enhance the wait-list system
- On-line referral service; make available referral forms on-line; individual maps to each facility on-line
- best practices approach for low tolerance population
- continue to lead coordinated efforts for the improvement of rehab services for pts in GTA i.e., LTLTD stroke
- collaborate with acute care and community providers to identify current barriers to access
- greater standardization of admission criteria, referral forms and process, greater consistency and

- transparency in the application and admission process
 - collaborate with acute care re common assessments, share knowledge and outcomes
 - develop common referral forms and guidelines for patients (2)
 - explore enablers to successful community reintegration; current gaps in this area
 - single central intake (2)
 - develop care pathways
 - availability and scope of outpatient facilities, day programs to meet acute and longer term rehab needs not provided by CCACs
 - focus on family practitioners
 - development of systems that will help coordinate provision of rehab services; e.g., extending the brokering role of the ABI network to other areas of referral
 - ensure coordination of services within a system of changes with respect to supportive care beds, delisting of services
 - continue to standardize tools, guidelines, to promote fair and equitable access
- Inform planning, performance measurement and accountability
- move from process and planning to outcomes-based strategies e.g., committee to address reduction of wait times for rehab admission
 - defining new and evolving rehab programs (e.g., LTLD) (2)
 - undertake projects to identify underserved/ hard to place rehab groups (2)
 - continue to update Network members as to all changes within rehab programs
 - develop outcome indicators and benchmark indicators (3)
 - develop resource funding models and address fee for service in community
 - framework and funding model for rehab to advise Government
 - guidelines for resource levels (funding, HR)
 - explore relationship or rehab and complex continuing care
 - develop quality management benchmarks
- Share best practices and undertake knowledge transfer and exchange
- continue annual best practices day; networking
 - research for best practices
 - continue to facilitate knowledge transfer or rehab research and best practices (6)
 - development of best practice throughout and across the continuum
- Advocate and influence public policy for rehabilitation services
- advocacy for Rehab role through the continuum; including acute care, outpatient care
 - advocacy for unmet needs of patients; e.g., those who require LTLD rehab
 - greater advocacy and action based initiatives toward measurable change
 - advocacy for outpatient services (uninsured clients to have access to service)
 - Advocating for rehab services in Primary Health Care Reform – Network can and should provide a strong voice at govt level
 - Advocacy – continue to collect data required for system planning and to profile unmet needs. The value of rehab to enhancing patient outcomes must be more prominently communicated, so that the Ministry will better understand why rehab needs more appropriate funding
 - identify trends and be an advocate for providers
 - ensure voice at planning tables of MOHLTC and LHINs
 - collaborate with other Rehab Networks provincially and nationally

4. Examples of changes made due to the implementation or adoption of Network products, study results, best practice, or other Network deliverables:

- increased awareness and profiling of internal rehab programs (2)
- website reference for patients and families
- consult Rehab Finder (12)
- promotion / adoption of best practices (3); e.g., MSK
- promotion of internet use for resource allocation and community options
- networking for service information and benchmarking re allocation and program care paths
- care pathways info
- SCRIPT project; stroke best practices shared
- link with other organizations to look at length of stay for inpatient rehab programs
- Physio has made changes based on MSK focus group discussions, waitlist discussions and best practices discussions
- SLP implementing new strategies inspired by Best Practices Day
- invested in clearly defining LTLD rehab and need for it in region; invaluable information from Network
- involvement in developing care pathways
- total joint replacement project and MSK rehab – implementation of changes (11)
- strategies for reducing length of stay
- utilized network data to build case to meet needs in service (e.g., LTLD)
- establishment of an inpatient rehab unit (based on best practices)
- establishing partnerships with other facilities in follow-up to LTLD report and ALC snapshots
- reviewing revising sizing of rehab services in response to Network work on stroke
- implementing LTLD rehab program in CCC
- increasing awareness of rehab services across the organization

5. Membership: GTA Rehab Network should be pursuing:

- 24 Expand Network membership to include all MOHLTC-funded rehabilitation providers (hospitals and CCACs) in the LHINs that are most closely aligned with the current GTA Rehab Network
- 2 Leave the membership as is currently
- 2 Other: Perhaps there are already too many players spread too far and maybe Network could become a resource across LHINs; eventually all networks will be adapted to structures/ boundaries of LHINs

6. Overall comments regarding the GTA Rehab Network and its future

- The Network is doing excellent work; however, will be challenged in the future to continually prove its value, especially to the members whose prime focus is not rehab
- GTA Rehab Network has done an excellent job to date. It needs to better integrate geriatric rehab. Future of the Network will be dramatically affected by the LHINs but exactly how is hard to predict.