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Rehabilitation System Strategic Plan for the Erie St. Clair Region

Prepared by the Erie St Clair Rehabilitation Advisory Network
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Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

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Foreward

Message from the Rehabilitation Advisory Network

In its second Integrated Health Services Plan (IHSP 2), the ESC LHIN identified rehabilitation services as a key priority area and critical enabler to lowering hospital length of stay, improving patient flow, and maintaining or improving a patient's strength and tolerance for activities of daily living. The current rehabilitation system in the Erie St Clair region is fragmented and both residents and providers struggle with knowing how to access and best utilize the system. In addition, stakeholders recognize that the need for change is driven by growing care demands from an aging population, heightening fiscal concerns, ongoing acute care pressures related to ER wait times and Alternate Level of Care, and the reality of health human resource challenges. These challenges underscore the urgency for our LHIN to develop a clear, pragmatic and inspiring rehabilitation system plan.

With the support of the ESC Rehabilitation Advisory Network, stakeholders across the LHIN came together to develop a rehabilitation strategy that identifies approaches to ensure timely and appropriate access to care, support for prevention and self-management and sharing expertise and knowledge across providers. Our strategy recognizes that rehabilitation is as a key enabler to assist in moving people effectively through the health care system, improving the care outcomes and experiences and ultimately optimizing the abilities, health and quality of life for our residents.

Our strategy recognizes that right-sizing our rehabilitation resources, implementing and adhering to best practices and supporting self-management will build system capacity to deliver excellent rehabilitation services in our hospitals and community. We will leverage our strengths and collaborative approaches to support better integration of services and a more systemic approach to care delivery.

Our Plan lays out our strategic themes and goals which support an ambitious Vision and Mission of our rehabilitation system. As we developed our Strategic Plan, we challenged our stakeholders to develop stretch goals that reflect our collective vision of the future. The goals were developed based on an analysis of our strengths, weaknesses, opportunities and threats (SWOT) to address the gaps between our current state and desired future state.

We are pleased to share this plan with you and encourage you to review our highest priority rehabilitation system goals and how we intend to move forward together. With the right leadership, support, collaboration and person-centred care approach, we will collectively focus on the residents we serve to provide them with outstanding care.

Nancy Snobelen
Rehabilitation Advisory Network Co-Chair

Alec Anderson
Rehabilitation Advisory Network Co-Chair

Executive Summary

The ESC LHIN tasked the Rehabilitation Advisory Network with developing a rehabilitation strategy and plan for the region to provide a shared vision for system improvement, identify key measures for monitoring success and establish an action plan for moving forward. Once approved and implemented, the strategy will help to lower hospital length of stay, lead to improved patient flow, and ultimately help to maintain or improve a patient's ability to care for themself and participate in meaningful activities.

Through a series of focus groups and strategic planning workshops, stakeholders from across the LHIN collaboratively developed the following rehabilitation system vision and mission to reflect the collective aspirations of how the system can best meet the needs of our community today and in the future.

> **Our Vision:** Erie St. Clair LHIN's integrated system of rehabilitation services optimizes abilities, health and quality of life for its residents.
>
> **Our Mission:** Through regional partnerships, we provide a coordinated and sustainable system of high quality, person-centred rehabilitative care that maximizes independence and supports active living.

The stakeholders also described a desired future state that reflects how the new rehabilitation system Vision and Mission can be translated into practice.

In assessing how far the current state is from the desired future state, participants reflected on the SWOT analysis developed through focus groups and identified and assessed the magnitude of existing gaps in the system. Five areas were identified as having the largest gaps, specifically: agreement on and adoption of best practices; equitable, timely access to care; appropriate allocation of rehabilitation resources; shared cost model; and early interventions. While the group identified a number of gaps to be addressed, it was also evident that there were pockets of strengths and successes to build upon, including: excellent collaboration and teamwork; strong clinical expertise; good adherence to best practices where they have been adopted; and well established inter-organizational partnerships.

In planning the strategies and goals to close the gaps, stakeholders focused on a population and best practices-driven approach. The resulting strategy prioritizes goals that will impact the experiences and clinical outcomes of the highest volume rehabilitation patient populations (patients with stroke, orthopaedic conditions and geriatrics). The rehabilitation strategic plan identifies 9 strategic goals supported by 5 enablers that have been grouped into the three Strategic Themes:

Strategic Themes	Strategic Goals
Theme 1: Providing the Best Care in the Right Location	1. Identify and implement Best Practices for the top three rehabilitation clinical conditions across the continuum 2. Facilitate the appropriate use of inpatient rehab beds 3. Ensure adequate access to funded outpatient and community-based rehabilitation services
Theme 2: Supporting Prevention, Activation and Self-Management	4. Roll-out the ESC-wide collaborative seniors falls prevention strategy 5. Expand rehabilitation for the complex inpatient population (activation on medical units). 6. Integrate self-management philosophy with residents & families in each program
Theme 3: Developing Expertise and Sharing Knowledge	7. Develop standards for rehabilitation expertise and a LHIN wide strategy for professional development 8. Increase public/health care professional understanding of rehab and the resources available through formal education and marketing 9. Develop regional centres of excellence for the top clinical conditions

Many of the strategic goals are interrelated and in some cases are directly enabled by other, more tactical activities. As such, it was identified that the achievement of the highest priority strategic goals depends on the successful completion of the work identified in the following five enabling activities:

1. Standardized tools;
2. Standardized staffing models;
3. Predictive models;
4. A system map; and
5. A LHIN-wide Rehabilitation Coordinator.

Workshop participants are eager to see changes happen at the local level and the LHIN has indicated the need to begin implementing quality and cost-saving changes as soon as possible. There was general agreement that the goals in strategy theme 1 will be prioritized and ideally implemented within 12-18 months following the approval of the plan. However, this plan is ambitious and given the current fiscal environment, there are limited funds with which to invest in the implementation work. As such, implementation and resourcing options have been identified that reflect the prioritization of the goals along with logical dependencies. In particular, it will be necessary to determine how to invest in a Rehabilitation Coordinator role to conduct the extensive research and analysis to support the goals in strategy theme 1. Finally, to successfully implement the plan within the 1-3 year timeframe, it will be critical to sequence the goals to build on the early analysis and leverage the pockets of strength that exist across the LHIN.

Context

Background

Rehabilitation services focus on restoring reduced function or adapting to the changed function of physical systems within the body. It also has an important role to play in prevention of functional loss, with evidence indicating that the earlier the rehabilitation intervention occurs, the better. It is a philosophy that must be embedded throughout the continuum of care, not just within a bed based program.

Patients may experience reduced function in one or more body systems following an acute illness or event such as stroke or trauma; following chronic disease such as arthritis or COPD; or with multiple system involvement resulting in frailty or debility. There is strong evidence that the processes used by rehabilitation services are effective at reducing both mortality and morbidity. These processes include early mobilization and intensive therapeutic intervention with specialized expertise. Highlights from this vast body of evidence have been compiled into an addendum describing the outcomes of recommended rehabilitation practices for a broad range of prevalent conditions (see Appendix A).

> *"It is an exciting time to be involved in stroke rehabilitation with a strong and growing research evidence-based.*
>
> *Evidence-based guidelines in clinical practice have been shown to be associated with improved patient outcomes in stroke rehabilitation.*
>
> *Translating research evidence and guidelines into clinical practice is the next big challenge in stroke rehabilitation.*
>
> *The recent Drummond Report to the Ontario government emphasized the need for 'researched-based clinical guidelines'."*
>
> *Robert W. Teasell, MD FRCPC*
> *Professor, Schulich School of Medicine*
> *Department of Physical Medicine & Rehabilitation,*
> *Parkwood Hospital, St. Joseph's Health Care London*
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The aging population, increasing health care costs, availability of research evidence and changes in modes of delivery are driving the need to review the way rehabilitation services are designed and delivered in ESC. The demand for rehabilitation resources is on the rise in Ontario and the current rehabilitation system in the ESC LHIN region is fragmented, resulting in less than ideal care for key patient populations. Implementing best practices for specific patient populations and ensuring appropriate and timely access results in a variety of benefits for the patients, their families, their communities, and for the health system.

The ESC LHIN tasked the Rehabilitation Advisory Network with developing a rehabilitation strategy and plan for the region. The specific objectives of the strategic planning process are to:

1. Develop a shared vision for system improvement
2. Identify key measures for monitoring success
3. Establish an action plan for moving forward

Once approved and implemented, the strategy will help to lower hospital length of stay, lead to improved ALC flow, and ultimately help to maintain or improve a patient's ability to care for themself and participate in meaningful activities.

Planning Influences

There are a number of planning activities and reports that have and will continue to influence the rehabilitation strategy. In 2009, the ESC LHIN identified rehabilitation services as a key priority in its Integrated Health Services Plan (IHSP). The LHIN's IHSP identified priority rehabilitation populations including:

- Frail individuals over the age of 65 with multiple chronic conditions
- Patients with stroke
- Individuals with chronic respiratory diseases, and heart failure; and
- Patient populations with other neurological, vascular and orthopedic conditions.

The IHSP also identified a number of system specific rehabilitation goals that were included as part of the strategic planning process.

In December 2010, the Ministry of Health and Long-Term Care established an Expert Panel on Rehabilitation and Complex Continuing Care as a sub-committee of the ER/ALC Expert Panel. The purpose of the Rehabilitation and CCC Expert Panel is 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.

In June 2011, the Expert Panel issued its phase 1 report focused on providing advice and guidance to the ER/ALC Expert Panel on how best to reduce ALC lengths of stay throughout the system by properly utilizing the resource capacity, role and expertise available in Rehabilitation and Complex Continuing Care. The phase 1 report identified patients with stroke and orthopedic conditions as priority populations and best practices were collected and catalogued for total joint replacement, hip fracture and stroke. In addition, the report addressed:

- System capacity and patient flow;
- Obtaining value for money;
- Accountability;
- Data availability and use; and
- The need to establish common definitions (processes, categories of care and locations of care).

In June 2011, the Ministry issued a report on "Caring For Our Aging Population and Addressing Alternate Level of Care", authored by Dr. David Walker, the Province's Alternate Care Level (ALC) Lead. The "Walker report" recommended that the Ministry must fundamentally change the way it funds and delivers physiotherapy to ensure effective and appropriate care is provided and that providers are held accountable. Walker points out that reducing system reliance on in-patient rehabilitation and optimizing opportunities for rehabilitation in community settings will help to realign capacity to patient needs (pp. 21-22). The report specifically recommends:

- Creating opportunities for "Assess and Restore" for the seniors population

- Ensuring hospitals adopt best practice rehabilitation care pathways for joint replacement, hip fractures and stroke; and
- Standardizing admission criteria and assessment tools for rehab beds and CCC programs.

Finally, a summary report and recommendations for Senior Friendly Hospital Care in Ontario was released in August 2011. This report, commissioned by Ontario's 14 LHIN's, outlines senior friendly hospital care strategies with the vision to enable hospitalized seniors to maintain optimal function while they are hospitalized so that they can make successful transitions home or to the next appropriate level of care.

Throughout the implementation of the rehabilitation strategy, we will continue to monitor progress and new developments coming from the Ministry and the Rehab and CCC Expert panel to ensure we are aligned with and leveraging the provincial expertise and emerging recommendations.

Strategic Planning Process

Working with ESC LHIN staff, the ESC LHIN Rehabilitation Advisory Network through the Lead Organization, the Windsor Regional Hospital (WRH), initiated a strategic planning process to identify how to optimize and integrate the future ideal state for rehabilitation services across the Erie St. Clair health care system to support improved outcomes and efficiencies. The rehabilitation services strategic planning process included an analysis of the current state (through an inventory of current services, and a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis with current system stakeholders), a future-state visioning exercise, a gap analysis, the identification and prioritization of strategic goals to bring the system closer to the desired future state and the development of a specific action plan to achieve those goals.

To support the planning work, WRH seconded two part-time resources as Project Coordinators and secured the services of a strategic planning facilitator to plan and facilitate three working sessions with a broad group of rehabilitation system stakeholders. To ensure the resultant strategic plan was reflective of the needs and perspectives from across the LHIN and the continuum of care, the Project Coordinators ensured that the focus groups and strategy workshop participants included representatives from hospitals, various rehabilitation clinics, primary care, contracted providers and publicly-funded community services organizations. The full participant list is included in Appendix A.

Rehabilitation Services Inventory

The Project Coordinators developed a rehabilitation services inventory by collecting data directly from the ESC LHIN hospital, community, clinic and outpatient rehab sectors using a survey methodology. Surveys were emailed out to contacts and returned by email, or were reviewed by telephone for completion. One survey was designed for hospitals and a second simpler survey for the community sector. The inventory did not include rehab services being provided in retirement homes or long-term care homes in the LHIN due to time constraints. It is important to note that rehabilitation services in Complex Continuing Care beds were difficult to sort out from the hospital information – this is an area which may need further research in the future. The resultant draft inventory of rehabilitation services in Appendix B was populated with information received from the survey and workshop participants. Further updates will be required as part of the implementation of the action plan.

Strategic Planning Workshops

Three full-day Strategic Planning Workshops were hosted on March 8th, March 21st, and April 4th with participants from across the spectrum of care. In advance of the workshops, the Project Coordinators conducted a preliminary SWOT analysis of the current rehabilitation system in the LHIN. A total of 125 rehabilitation health care providers participated. The preliminary SWOT data was collected through focus groups and/or return of a questionnaire and was further developed in the facilitated workshops. The planning workshops covered the following topics:

- **Workshop #1** - Develop the "ideal" future-state for rehab services in the region
  - Review Current State
  - Conduct SWOT analysis
  - Develop Future State and Draft Vision and Mission statements

- **Workshop #2** - Identify and prioritize goals to reach the future-state
  - Gap analysis
  - Review goal submissions
  - Identify prioritization criteria and considerations
  - Prioritize goals

- **Workshop #3 –** Plan for the Implementation and Measuring Success
  - Confirm prioritization of goals
  - Implementation considerations (opportunities and barriers)
  - Performance measures and metrics
  - Develop the structure for the Action Plan including key milestones, roles and responsibilities

In addition to the workshops, participants were asked to complete 'homework' assignments between workshops to build on the input and feedback obtained in each of the workshops and to provide an opportunity for participants to include other colleagues in the work.

Strategic Planning Report

Following the completion of the final workshop, the facilitator collaborated with the Project Coordinators, the Advisory Network representatives and the LHIN to develop the draft Strategic Planning report and Action Plan that outlines the steps and resources required to achieve the ideal future state. The draft report was circulated to all participants for review and edits prior to final approval for consideration by the ESC LHIN Board.

Rehabilitation System Vision and Mission

ESC LHIN's rehabilitation system vision and mission statements were collaboratively developed and refined by a broad group of stakeholders to reflect the collective aspirations of how the ESC LHIN rehabilitation system can best meet the needs of our community today and in the future.

> **Our Vision:** Erie St. Clair LHIN's integrated system of rehabilitation services optimizes abilities, health and quality of life for its residents.
>
> **Our Mission:** Through regional partnerships, we provide a coordinated and sustainable system of high quality, person-centred rehabilitative care that maximizes independence and supports active living.

The vision and mission represent what we intend to accomplish and how we will meet those objectives. This vision statement supports the aspirations of what rehabilitations services can and should be in the ESC LHIN in the near future.

Future State

When we asked stakeholders to consider the ideal future state of the rehabilitation system, we conceptualized their vision in three dimensions of care:

1. Improving the health of the population;
2. Enhancing the patient experience; and
3. Reducing, or at least controlling, the per capita cost of care.

The three dimensions above are based on the Institute for Healthcare Improvement's Triple Aim Initiative, which is the planning framework that is used by the ESC LHIN and a number of other LHINs to develop their IHSP. The Triple Aim approach is very appropriate for cross-sector planning as it encourages community partnerships, the involvement of multiple health care organizations, community groups, patients and their families in a co-ordinated effort to achieve shared goals. More information on the Triple Aim approach can be found in Appendix C.

The future state aspirations reflect how the new rehabilitation system Vision and Mission is translated into practice. This vision must be 'lived' across the continuum of care and reflected in the ways that we collectively deliver care to our communities. Through strong regional partnerships, the system will be well integrated and coordinated across the continuum to support a more person-centred approach to care. That care will be high quality, using best practices to optimize abilities, health and independence. Care in the right place at the right time will improve residents' quality of life and ultimately ensure the long-term sustainability of the system.

Table 1 below provides a summary of the future state aspirations for the rehabilitation system as articulated by the strategic planning workshop participants in each of the three Triple Aim categories. Further detail on the Future State Aspirations, the Current State SWOT Analysis and Gaps can be found in Appendix D.

Table 1: Description of Future State Aspirations

Future Aspirations	Future State Descriptions
Improving the Health of the Population	
1. Service Providers have Specialized Expertise	Service providers (clinicians) have dedicated population and condition-specific expertise and are working to their full scope of practice at all stages of care.
2. Best Practices to Optimize Recovery	Service providers use population and condition-specific best practice interventions for all populations to optimize function at all stages of recovery.
3. Focus on Prevention and Risk Reduction	Service providers across the spectrum of care understand the causes of disability, proactively screen populations for risk factors and provide education and support for preventive measures.
Enhancing the patient experience	
1. Equitable, Timely Access	Urban and rural residents have cost effective, equitable access to the appropriate general and specialized rehabilitation services through innovative methods to optimize their functioning.
2. Smooth Care Transitions	An integrated system of care supports timely, effective and population-appropriate communication to support smooth care transitions and minimize duplication of effort and unnecessary waiting across the continuum of care.
3. Standard Pathways and Planning for return to function	Patients and clients across the LHIN receive the same level of care through cross-continuum standard care pathways in environments that are conducive to recovery.
4. Teaching patient self-management	Patients and clients are informed of their care options, are involved in goal setting, co-ordinating their own care and are taught to self-manage within their capabilities.
Reducing, or at least controlling, the per capita cost of care	
1. Appropriate Allocation of Resources	The rehabilitation system is sized with the appropriate volume of inpatient, outpatient/ambulatory and community-based services to efficiently and sustainably support the best practices to meet population needs.
2. Shared Cost Model	Creative and flexible funding models support and reflect the flow of patients across the continuum into the most appropriate care settings to receive cost-effective services.
3. Early Intervention	Patients and clients are assessed to identify the earliest rehabilitation intervention opportunity to restore functioning and reduce length of stay across the continuum.
4. Decreased costs to access education specialists	Providers proactively build relationships and access education and specialists in other regions through the use of innovative and cost-effective tools such as OTN.

Current State Gap Analysis

In assessing how far the current state is from the future state aspirations, we asked participants to reflect on the SWOT analysis and identify where the gaps exist. Table 2 below summarizes the current state gaps by Triple Aim category and a sense of the magnitude of those gaps. Workshop participants

assessed the gaps at a high level (through a voting system) against a range of progress made towards the desired future state, specifically:

- **Very Large Gap:** Little to no progress (0-20%)
- **Large Gap:** Some initiatives started (21-50%)
- **Medium Gap:** Most initiatives underway (51-75%)
- **Small Gap:** Almost all initiatives are in place (76-100%)

Table 2: Gap Analysis

Future Aspirations	Current State Gap Description	Gap Size
Improving the Health of the Population		
1. Service Providers have Specialized Expertise	• Expertise and specialization shortage – specifically the right mix of providers and expertise with certain patient populations. • General lack of gerontologists in the LHIN and minimal 'specialized' community support.	**Large Gap**
2. Best Practices to Optimize Recovery	• There is a need to obtain consensus across the LHIN on standard language, clinical pathways, metrics and targets. • Difficult to maintain best practices when staff is spread too thinly without adequate coverage or standard staffing models.	**Very Large Gap**
3. Focus on Prevention and Risk Reduction	• There are prevention programs throughout the LHIN (stroke, falls, COPD etc…), but awareness is low, the programs exist in silos and interventions are not standardized across the continuum of care.	**Medium-Large Gap**
Enhancing the patient experience		
4. Equitable, Timely Access	• There is limited use of technology to leverage expertise. • Transportation is an issue in the rural communities. • Outpatient resources are limited and wait list criteria is not standardized across the LHIN.	**Very Large Gap**
5. Smooth Care Transitions	• Partnerships and collaboration are strong across the LHIN however communications could be improved. • Eligibility criteria is not clear or consistent across the continuum and lacks standard assessment tools • Quality and satisfaction measures are different across the LHIN	**Large Gap**
6. Standard Pathways and Planning for return to function	• Some standard pathways exists, however there is no consistency in pathway availability • Lack of consensus on standard pathways and inconsistent use of pathways and standards	**Large Gap**
7. Teaching patient self-management	• There are opportunities to start health promotion earlier and be less reactive • System navigation is complex and layered with barriers • Need to train staff to care for the geriatric population (senior-friendly)	**Large Gap**

Future Aspirations	Current State Gap Description	Gap Size
Reducing, or at least controlling, the per capita cost of care		
8. Appropriate Allocation of Resources	• We need to leverage more community resources • Lack of LHIN-wide data on outcomes, costs and services to support predictive modeling and resource planning • General lack of understanding about how rehabilitation services can relieve system pressures • Face common misconceptions: Rehabilitation is a service not a location; and function is not a disease	**Very Large Gap**
9. Shared Cost Model	• Funding incentives do not align with desired patient outcomes (ie. funding to keep beds full) • Need to identify cost-effective non-bedded solutions • Funding should follow the patient into the community • Increase the use of lower-cost resources in the community • Lack targets for re-admits and length of stay etc… • Lack of collaborative, cross-continuum budgeting	**Very Large Gap**
10. Early Intervention	• Need to increase the degree of interprofessional collaboration in the acute and community setting • Do not have recommended targeted staffing per sector to ensure early intervention (i.e. ER, ICU/PCU)	**Large – Very Large Gap**
11. Cost effective access to education and specialists	• Education gets cut when budgets are tight • Not leveraging OTN enough for training, attending grand rounds • Need to leverage opportunities to create partnerships • Do not have an inventory and forecasted need of trained health human resources	**Large Gap**

Building on Strengths

There is no question that there are a number of gaps to address, however as illustrated in the SWOT and gap analysis, there are pockets of strengths and successes to build on. Specifically:

- Collaboration and Teamwork with integrated interprofessional teams that enable good communication and informed decision-making;
- Clinical expertise in select areas across the regions that is recognized, appreciated and helps drive quality and efficiency;
- Adherence to best practices where they are implemented – e.g. Order sets, hip # pathways, GEM program, delirium and fall management, and mobilization early in course of admission; and
- Excellent partnerships between providers like the hospitals CCAC, LTC, ABI and Day Programs / Day Hospital and integration within Bluewater Health , CCAC and CHC in COPD program.

Strategy Approach, Themes and Goals

Strategic goals are identified to enable us to build on strengths and close the gap between the current state and the desired future state. The strategic plan and associated goals cover a 1-3-year horizon. To be effective, the goals must be specific, measureable, attainable, realistic and timely (SMART). The goals specify what we endeavor to do over the next three years and what outcomes we expect to achieve. We have also identified goal-specific measures and metrics to enable us to track our progress.

Regional, system-level planning relies on ongoing cross-sector consultation, collaboration and the recognition of multiple levels of interdependency. As such, to reflect the interrelated nature of our system, the goals have been grouped into related key strategic themes to support a fluid, flexible and creative approach to implementing the strategic plan. Collectively, the achievement of the goals will enable us to move much closer to the desired future state.

A Population-Driven Approach

The Rehabilitation Strategy workshop participants chose to focus on a population and best practices-driven approach to the ESC Rehabilitation Strategy. This approach ensures that the strategy will have broad reach across the LHIN and will impact the experiences and clinical outcomes of the highest volume rehabilitation patient populations. To ensure that the strategic directions are ones that can be acted on sooner, rather than later, the group recommended focusing on conditions and diagnoses that have known and accepted best practices. This focus will significantly reduce the amount of additional analysis and negotiation required to establish agreement on the best practice interventions and clinical approaches to support these populations. In addition, as the Provincial Rehab and CCC Expert Panel continue to move forward with their work, additional best practices will be endorsed at a provincial level that can be adopted by the LHIN at a later date. The top three populations identified by the group, based on volume and clarity of best practice interventions, are:

- Patients with stroke
- Patients with orthopaedic conditions – specifically hip fractures
- Geriatric patient population

Development of Strategic Themes

The strategic goals that were submitted, reviewed and updated by the workshop participants have been further refined and complementary goals and enablers have been grouped into appropriate thematic categories. In total, there are 9 strategic goals and 5 enablers that have been grouped into the following three Strategic Themes:

- **Theme 1:** Providing the Best Care in the Right Location
- **Theme 2:** Supporting Prevention, Activation and Self-Management
- **Theme 3:** Developing Expertise and Sharing Knowledge

It is important to note that the order of the themes is a reflection of the prioritization and desired timing of the implementation of the strategic goals. The prioritization process and criteria are detailed in Appendix E. As illustrated in Table 3 below, theme 1 contains the highest priority goals and enablers, followed by theme 2 and the lowest priority strategic goals are in theme 3.

Table 3 – ESC Rehabilitation Strategic Themes and Goals

Strategic Themes	Strategic Goals
Theme 1: Providing the Best Care in the Right Location	1. Identify and implement Best Practices for the top three rehabilitation clinical conditions across the continuum 2. Facilitate the appropriate use of inpatient rehab beds 3. Ensure adequate access to funded outpatient and community-based rehabilitation services
Theme 2: Supporting Prevention, Activation and Self-Management	4. Roll-out the ESC-wide collaborative seniors falls prevention strategy 5. Expand rehabilitation for the complex inpatient population (activation on medical units). 6. Integrate self-management philosophy with residents & families in each program
Theme 3: Developing Expertise and Sharing Knowledge	7. Develop standards for rehabilitation expertise and a LHIN wide strategy for professional development 8. Increase public/health care professional understanding of rehab and the resources available through formal education and marketing 9. Develop regional centres of excellence for the top clinical conditions

Priority Strategic Goals and Enablers

Many of the goals identified by the Rehabilitation Strategy Workshop participants are interrelated and in some cases are directly enabled by other, more tactical activities. In the third workshop, it was determined that the highest priority strategic goals were tightly related to each other and were further supported by four enablers. The top three priority strategic goals identified by the workshop participants are:

1. Identify and implement **Best Practices** for the top three clinical conditions across the rehab continuum
2. Facilitate the appropriate use of **Inpatient Rehab Beds**
3. Ensure adequate access to funded hospital and community-based **Outpatient Rehab Services**

The achievement of the three top priority strategic goals depends on the successful completion of the work identified in the five enabling activities. For example, to implement best practices, the LHIN and service providers need to address a number of key service components including but not limited to consistent clinical interventions and care processes, appropriate locations of care, and standardization of tools and staffing models. These components become key dependencies for the successful implementation of best practices. In addition, to facilitate the appropriate use and access to inpatient rehab beds and outpatient rehab services today and in the future, it is critical that the LHIN develop a

predictive model for rehabilitation services utilization for the highest priority populations and diagnoses. And finally, inpatient beds and outpatient service requirements will need to be designed based on a full understanding of how the highest priority patients will flow through the continuum of care while receiving leading practice care. To summarize, the three top priority goals are further supported by the following five enablers:

1. Identify and implement **standardized tools** for application in assessment, communication and measurement of patient and program outcomes
2. Standardize the **staffing models** (staff mix & skill sets) in rehab programs across the LHIN
3. Develop **predictive models** for rehab utilization and growth for sustainability of programs for the top three populations/diagnoses over the next ten years
4. Develop a **system map** that streamlines the services to meet the varied rehab needs of ESC residents across the continuum of care
5. A dedicated **LHIN-wide Rehabilitation Coordinator**

Strategy Theme 1: Providing the Best Care in the Right Location

In the first year of the ESC Rehabilitation Strategy, the focus will be on the three highest priority strategic goals and their supporting enablers. Collectively this group of Goals and Enablers support the ***Strategic Theme: Providing the Best Care in the Right Location***. The high priority goals and the goal enablers are summarized in Table 4 below and further explained in the following sections.

Table 4: Theme 1 Goals and Enablers

Theme 1: High Priority Strategic Goals	Goal Enablers
1. Identify and implement Best Practices for the top three rehabilitation clinical conditions across the continuum	• Standardized tools for application in assessment, communication and measurement of outcomes • Standardized staffing models (staff mix & skill sets) in rehab programs across the LHIN • Predictive models for rehab utilization and growth for sustainability of programs for the top three populations/diagnoses over the next ten years • A system map that streamlines services to meet the needs of residents across the continuum of care • A dedicated LHIN-wide Rehabilitation Coordinator
2. Facilitate the appropriate use of inpatient rehab beds	
3. Ensure adequate access to publicly-funded outpatient/ambulatory and community-based rehabilitation services	

Goal #1 - Identify and implement Best Practices for the top three rehabilitation clinical conditions across the continuum.

The top three rehabilitation clinical conditions for which best practices will be applied are stroke, hip fracture and geriatrics. Various best practices have been identified for these clinical conditions, however, there will be some variation and debate regarding what is the right best practice for a given organization and/or program to adopt. Clinical best practices include at a minimum:

- Standardized levels (intensity and frequency) of therapy for patients (across ESC LHIN) based on best practice; and

- Standardized pathways for specific diagnostic categories across the LHIN based on best practice (where appropriate for the patient).

What We Hope to Achieve	How We Will Measure Success
- Improved consistency of programs and care across the LHIN for the top three patient populations - Improved patient flow as a result of the adoption and adherence to best practice care pathways - Improved outcomes for populations where clinical best practices have been adopted and adhered to	- Pathways in place across settings - Meet best practice stroke strategy and hip# strategy admission to Rehab targets, acute LOS targets and discharge to home targets - Clinical outcome measures associated with specific populations (stroke, orthopedic and geriatrics) - Patient experience/satisfaction measures

Steps to Achieve the Goal:

- Establish a LHIN-wide health care providers working group
- Identify and obtain agreement on the best practices to be adopted and adhered to for each of the top three clinical conditions at a sufficient level of detail to be able to assess compliance.
- Assess current best practices compliance across all relevant service providers/programs.
- Describe the magnitude of the gaps for non-compliant service providers/programs and prioritize a plan for the adoption of specific best practices.
- Create a business plan identifying the changes and funding implications
- Establish a 'change schedule' and 'change management processes for health service providers/programs.
- The following strategic goal enablers will be addressed in the later implementation stages once the changes have been identified and a change management process has been established:
  - ***Enabler:*** Identifying and implementing standardized tools for application in assessment, communication and measurement of patient and program outcomes
  - ***Enabler:*** Standardizing the staffing models (staff mix & skill sets) in programs across the LHIN

Goal #2 - Facilitate the appropriate use of inpatient rehab beds

Facilitating the appropriate use of inpatient rehabilitation beds requires a solid understanding of the current use of inpatient beds along with a projection of the future demand. The review of the current use of beds would include all types of beds being used for to deliver rehabilitation services – this includes for example: REACT, Assess and Restore, Transitional Care and rehabilitation beds at all facilities across the ESC LHIN. The future demand of inpatient rehabilitation must be aligned with the best practices for the top three clinical conditions. As such, to determine the appropriate use, it will be necessary to map the ideal (best practice) cross-continuum care paths of each of the three clinical conditions including identifying the location of care, services delivered and length of stay (LOS) at each major stage of care for all of the relevant beds.

What We Hope to Achieve	How We Will Measure Success
- Inpatient beds are used for the appropriate patient - Right patient, right bed/service, right time - Sufficient capacity to meet the current and projected inpatient care need	- Decrease ALC for rehab in acute care - Decrease service interruption days - Meet best practice stroke strategy and hip# strategy admission to Rehab targets, acute LOS targets and discharge to home targets - Patient experience/satisfaction measures

Steps to Achieve the Goal:

- Identify and describe (by program, services and LOS) when and how each clinical condition would benefit from an inpatient rehabilitation stay (based on best practices and emerging innovations).
- ***Enabler:*** Develop a system map that streamlines the services (inpatient, outpatient and community) to meet the varied rehab needs for the top three populations/conditions of ESC residents across the continuum of care.
- Obtain agreement from all service providers with inpatient rehab beds on the expected use of and patient flow through inpatient beds (all types including but not limited to: REACT, Assess and Restore, Transitional Care and rehabilitation beds at all facilities) for each of the top three clinical conditions – noting the range of clinical acuity variations between patients.
- Identify and assess gaps, barriers and enablers to meet the appropriate inpatient bed use targets.
- ***Enabler:*** Develop predictive models for rehab utilization and growth for sustainability of inpatient bed demand for the top three populations/conditions over the next ten years
- Quantify the current volume of inpatient beds (all types) by region against the demand projection (assuming best practice bed use and LOS) and assessing the gap/excess of beds to meet the needs of those populations.

Goal #3 - Ensure adequate access to funded outpatient/ambulatory and community-based rehabilitation services

Facilitating the appropriate capacity and access to outpatient/ambulatory and community-based rehabilitation services also requires a solid understanding of the current service capacity and a projection of the future demand. The future demand of outpatient and community rehabilitation services must also be aligned with the best practices for the top three clinical conditions. As such, in conjunction with the analysis conducted in Goal #2, this goal will benefit from a mapping of the ideal (best practice) cross-continuum care paths for each of the three clinical conditions including identifying the location of care, services and length of stay (LOS) for outpatient and community services at each major stage of care.

What We Hope to Achieve	How We Will Measure Success
- Decrease inpatient LOS, increase patient flow, reduce/eliminate wait times, appropriate patient in appropriate level of service at appropriate time - Improved patient flow throughout the system - Improved patient outcomes - Improve access to care closer to home, convenience and re-integration into community; improved patient abilities - Access to improved outpatient/ambulatory and community-based service data	- Decreased inpatient rehab LOS, decreased wait times for inpatient rehab admission, decreased ALC days in acute and rehab - Reduced readmissions to acute care - Patient satisfaction / quality of life measures - Follow up functional measures at 3 and 6 months post d/c - For long stay CCAC clients, RAI measures should show functional improvement - Outpatient/ambulatory database linked to IP database for analysis of resource use and outcomes

Steps to Achieve the Goal:

- Identify and describe (by program, services and LOS) when and how each clinical condition would benefit from outpatient /ambulatory and/or community-based rehabilitation services (based on best practices and emerging innovations).

- ***Enabler:*** Develop a system map that streamlines the services (inpatient, outpatient/ambulatory and community) to meet the varied rehab needs of ESC residents across the continuum of care.
- Obtain agreement from all service providers on the range of services required in outpatient/ambulatory and community settings to meet the requirements for each of the top three clinical conditions – noting the range of clinical acuity variations between patients.
- ***Enabler:*** Develop predictive models for rehabilitation utilization and growth for sustainability for outpatient/ambulatory and community services capacity for the top three populations/conditions over the next ten years
- Quantify the current outpatient/ambulatory and community services capacity by region against the demand projection (assuming best practice bed use and LOS) and assess the gap/excess to meet the needs of those populations.
- Create a business case that outlines the changes to be made and funding sources
- Identify the requirements and options to establish a standardized data collection process for outpatient and community rehabilitation services. This would enable capturing, analyzing and sharing data from outpatient clinics, FHTs, OHIP funded clinics CHCs, community care etc.
- Research and review alternative service and funding models for outpatient/ambulatory rehabilitation services.

Strategy Theme 2: Supporting Prevention, Activation and Self-Management

One of the most successful strategies to keeping a population healthy is by focusing on and investing in prevention and self-management strategies. In anticipation of growing demand for rehabilitation services that will inevitably exceed the inpatient, outpatient/ambulatory and community services supply, the onus is on all service providers to include a focus on prevention, activation and self-management to reduce the need for down-stream rehabilitation services. We have identified three strategic goals that support the ***Strategic Theme: Supporting Prevention, Activation and Self-Management***. The goals and their respective enablers are summarized in Table 5 below and further explained in the following sections.

Table 5: Theme 2 Goals and Enablers

Theme 2: Strategic Goals	Goal Enablers
4. Develop an ESC-wide collaborative seniors fall prevention strategy	• Resources (ie. LHIN-wide Rehabilitation Coordinator) to conduct the research and analysis • Establishment of working groups to identify existing best practices and program strengths • A system map that streamlines services and identifies where prevention and self-management programs and interventions should be delivered
5. Expand rehabilitation for complex inpatient populations (activation)	
6. Integrate the self-management philosophy with residents and families in each program	

Goal #4 – Roll-Out the ESC-wide collaborative seniors falls prevention strategy

ESC LHIN has a number of falls preventions strategies currently operating in various pockets around the LHIN, however awareness is low and the programs operate in silos. There has recently been a push across the province to develop LHIN-wide Falls Prevention strategies. ESC LHIN has initiated the work to

establish an ESC-wide collaborative falls prevention strategy and intends to continue to work in earnest. This strategy will apply a best-practices approach to developing consistent and proven falls prevention program materials for use across the continuum of care.

What We Hope to Achieve	How We Will Measure Success
- Common, LHIN-wide falls prevention program objectives, strategies, interventions, materials and branding - Increased resident awareness of falls prevention strategies - All health service providers (primary, care, acute, post-acute and community) trained on delivering falls prevention support	- Reduced number of fractures, subdural hematomas and other severe injuries and/or hospital admissions due to falls - % of target population receiving consistent falls prevention and management information

Steps to Achieve the Goal:

- Establish a LHIN-wide Falls Prevention Working Group
- Inventory the existing falls prevention programs and materials
- Research effective falls prevention and management programs and assess the gaps in the current ESC programs
- Identify and confirm target populations and program information and education improvements.
- Identify desired falls prevention and management program improvements and develop materials and processes to pilot and spread the improvements
- Review data collection, tracking and reporting for falls and associated injuries and make recommendations for improvements

Goal #5 - Expand rehabilitation for the complex inpatient population (activation on medical units).

Early access to rehabilitation resources, to restore and reactivate an elderly patient's level of functioning particularly following an acute episode, can improve outcomes for patients and lead to lower lengths of stay on inpatient units. This strategy supports patients and clients being assessed to identify the earliest rehabilitation intervention opportunity during the 'upstream' part of their care – ie. in the emergency department and/or in the acute care unit to minimize the risk of deconditioning and deterioration in a hospital bed.

What We Hope to Achieve	How We Will Measure Success
- Clear 'early intervention' opportunities identified for stroke, orthopedic and geriatric populations - Interprofessional collaboration in the acute and community setting - Achieving recommended targeted staffing per sector to ensure early intervention	- LOS – acute and inpatient rehabilitation units - Functional improvement status at point of discharge - % discharge home or rest home

Steps to Achieve the Goal:

- Inventory activation programs in the LHIN and identify gaps in service

- Review existing activation programs and identify strengths and best practices to be considered for spread to other organizations (dedicated bedded programs as well as interprofessional teams)
- Develop business cases to assess the cost, benefits and locations for the introduction of additional activation programs and services across the LHIN

Goal #6 - Integrate self management philosophy with residents & families in each program

Supporting patient and client self-management through strategies can contribute to cost-effective methods of sustaining function and health at home. There are a number of emerging best practices related to supporting patient self-management of chronic conditions. It will be important for ESC LHIN to identify programs which already utilize self-management principles and assess outcomes for specific populations to potentially spread to other programs across the LHIN.

What We Hope to Achieve	How We Will Measure Success
- Consistency in information and patient self-management education across settings - Improved capacity for patient and family caregivers in chronic disease management - Potential to reduce incidence of serious complications of chronic disease	- Number of programs delivering rehabilitation services that have self-management program initiatives and services in place by a specific date. - Reduced readmissions, potential reduced length of stay - Patient experience and engagement in their health

Steps to Achieve the Goal:

- Identify programs that already utilize self-management principles and assess outcomes
- Identify best practices in patient self-management of chronic conditions
- Select models from best practices and existing high performing programs to leverage and spread across other ESC rehabilitation programs and services
- Develop a reporting process to track 'teach and discharge' program outcomes.
- Develop a patient experience and engagement measurement tool to assess self-efficacy

Strategy Theme 3: Developing Expertise and Sharing Knowledge

To support and sustain the goals outlined in the first two strategic themes, it will be important that health service providers across the LHIN are available and have access to rehabilitation knowledge, information and opportunities to enhance their expertise. We have identified three strategic goals that support the ***Strategic Theme: Developing Expertise and Sharing Knowledge***. The goals and their respective enablers are summarized in Table 6 below and further explained in the following sections.

Table 6: Theme 3 Goals and Enablers

Theme 3: Strategic Goals	Goal Enablers
7. Develop standards for rehabilitation expertise and a professional development strategy	• Resources (ie. LHIN-wide Rehabilitation Coordinator) to conduct the research and analysis

Theme 3: Strategic Goals	Goal Enablers
8. Increase public/health care professional understanding of rehab and the resources available through formal education and marketing	• Establishment of working groups to identify where pockets of specific expertise exist and can be leveraged across the LHIN • Access to a centralized rehabilitation services information directory (leveraging an existing resource or building a new resource)
9. Develop regional centres of excellence for the top clinical conditions	

Goal #7 - Develop standards for rehabilitation expertise and a supporting professional development strategy

The adoption and spread of clinical best practices will in some cases require updating the skills and expertise of health service providers in the LHIN. In particular, as programs become increasingly specialized, the standards for expertise at all levels will change. A review of expertise across the LHIN and identification of required standards for expertise will need to support the best practices goal. A LHIN-wide rehabilitation-focused professional strategy would identify cost-effective professional development options and partnership opportunities.

What We Hope to Achieve	How We Will Measure Success
- Establish agreed upon standards for rehabilitation roles that reflect the full scope of practice at all levels - Attract and retain the required expertise to fully adhere to best practice care delivery - Increase expertise in professional care providers	- 100% of rehabilitation nurses have completed the rehabilitation nursing certification - Number of vacant positions requiring specialized rehabilitation and population-specific expertise across the LHIN - Quarterly Education Sessions LHIN wide

Steps to Achieve the Goal:

- Develop core competencies for the top three diagnostic groups (stroke is already available)
- Conduct an analysis to identify gaps in expertise relative to current & anticipated program needs
- Perform a LHIN-wide education/professional development needs assessment (90 days).
- Prioritize needs based on priority populations of stroke, hip fractures and medically complex/geriatric.
- Identify and pursue opportunities to partner with academic resources
- First education session offered 90 days after completion of the needs assessment
- Quarterly education sessions offered across the LHIN (OTN).

Goal # 8 - Increase public/health care professional understanding of rehabilitation and the resources available through formal education and marketing

The benefits and range of rehabilitation services are not always known and understood by residents and health service providers, resulting in missed opportunities to maximize ability and function. In particular, system navigators do not always have access to comprehensive, current and accurate information about appropriate services and supports. Increasing the public and health service providers' understanding of rehabilitation will support access to early intervention and ongoing adherence to therapy regimes.

What We Hope to Achieve	How We Will Measure Success
- Improved understanding of rehabilitation and its contributions to relieving system pressure - Reduced tendency to cut services in rehabilitation due to funding pressures - Smoother transitions for patients and families - Improved navigation and access to appropriate services	- Short LOS in inpatient units - Funding that is aligned to population needs - Improved patient/client satisfaction scores - Increased % of patients with Rehabilitation discharge goals

Steps to Achieve the Goal:

- Develop an inventory of rehabilitation resources (or connect with and build on the emerging healthline database)
- Establish or strengthen (through the CCAC) the system navigator role for rehabilitation services
- Develop a marketing and communications plan to inform all health service provides of one-stop access to rehabilitation information and resources
- Identify opportunities to document and publish clinical and financial outcomes
- Present LHIN and regional decision-makers with research and operational evidence that demonstrates the clinical and cost benefits of providing early rehabilitation for the ALC population
- Develop a research forum to publicize impact of Rehabilitation services

Goal #9 - Develop regional centres of excellence for the top clinical conditions

With the support of regional partners, we will identify opportunities to regionally or virtually cluster specialized care for the top clinical conditions and highest priority populations. We will leverage regional partner capabilities and contributions in both the identification of the specialized care needs and the development of regional centres of excellence. Expertise will be made broadly accessible through networks of local champions/leads and virtual channels such as OTN.

What We Hope to Achieve	How We Will Measure Success
- Develop population and condition-specific specialized expertise - Develop knowledge sharing networks - Establish cross-region and cross-LHIN training and mentorship programs - Cost efficiencies by providing LHIN wide specialized expertise in designated locations	- Improve access to specialized expertise - Improved clinical outcomes for specific populations and conditions - Participation in program and clinical trials and studies

Steps to Achieve the Goal:

- Proactively identify regional specialized care needs and collaborate with LHIN-wide partners to address those needs
- Build upon established models of care for selected specialized areas recognized for their outstanding quality, continuous improvement and innovation
- Develop linkage to academic centres and other centres of excellence in other LHINs (ie. Regional Geriatric Program / Specialized Geriatric Services)

Summary of Strategic Themes, Goals and Enablers

Table 7 – Summary of Strategic Themes, Goals and Enablers

Strategic Themes	Strategic Goals	Goal Enablers
Theme 1: Providing the Best Care in the Right Location	1. Identify and implement Best Practices for the top three clinical conditions across the rehab continuum 2. Facilitate the appropriate use of inpatient rehab beds 3. Ensure adequate access to funded outpatient and community-based rehabilitation services	• Standardized tools for application in assessment, communication and measurement of patient and program outcomes • Standardized staffing models (staff mix & skill sets) in rehab programs across the LHIN • Predictive models for rehab utilization and growth for sustainability of programs for the top three populations/diagnoses over the next ten years • A system map that streamlines the services to meet the varied rehab needs of ESC residents across the continuum of care • A dedicated LHIN-wide Rehabilitation Coordinator to support the research, analysis and process improvement initiatives across the LHIN
Theme 2: Supporting Prevention, Activation and Self-Management	4. Roll-out the ESC-wide collaborative seniors fall prevention strategy 5. Expand rehabilitation for the complex inpatient population (activation on medical units). 6. Integrate self-management philosophy with residents & families in each program	
Theme 3: Developing Expertise and Sharing Knowledge	7. Develop standards for rehabilitation expertise and LHIN wide strategy for professional development 8. Increase public/health care professional understanding of rehab and the resources available through formal education and marketing 9. Develop regional centres of excellence for the top clinical conditions	

Strategy Options and Recommendations

The rehabilitation strategy workshop participants have come to agreement on the need for and prioritization of the strategic goals (refer to Appendix E for the detailed prioritization process and criteria). However, this plan is ambitious and given the current fiscal environment, there are limited funds with which to invest in the implementation work.

Implementation Options

The implementation of the identified goals should reflect the prioritization of the goals along with logical dependencies. The following outlines some implementation options for consideration:

1. All high priority goals in Strategic Theme #1 are implemented within 12-18 months of the plan being approved.
2. Implement only those goals and initiatives that demonstrate a clear return on investment (health system savings versus the implementation and change management costs) of less than three years. This option requires further analysis to conduct the return on investment for the goals being considered.
3. Wait until the provincial Rehabilitation and Complex Continuing Care Expert Panel completes its work and implement the Panel recommendations that align with the highest priority ESC strategic goals with the support of the Panel's data and analysis (assuming they have completed LHIN-level and sub-region level analysis).

Resourcing Options

The dependencies identify the need for a dedicated LHIN-wide Rehabilitation Coordinator to support the research, analysis and process improvement initiatives across the LHIN. There are a number of options that the LHIN could consider to resource the implementation of the plan:

1. Hire a full-time Rehabilitation Coordinator at the LHIN
2. Identify a lead health service provider organization to fund a LHIN-wide Rehabilitation Coordinator position
3. Second a full-time resource from a health service provider partner
4. Identify which pieces of research, analysis and process improvement support can be conducted in short project cycles that can be resourced using short-term contractors or consultants

Recommendations

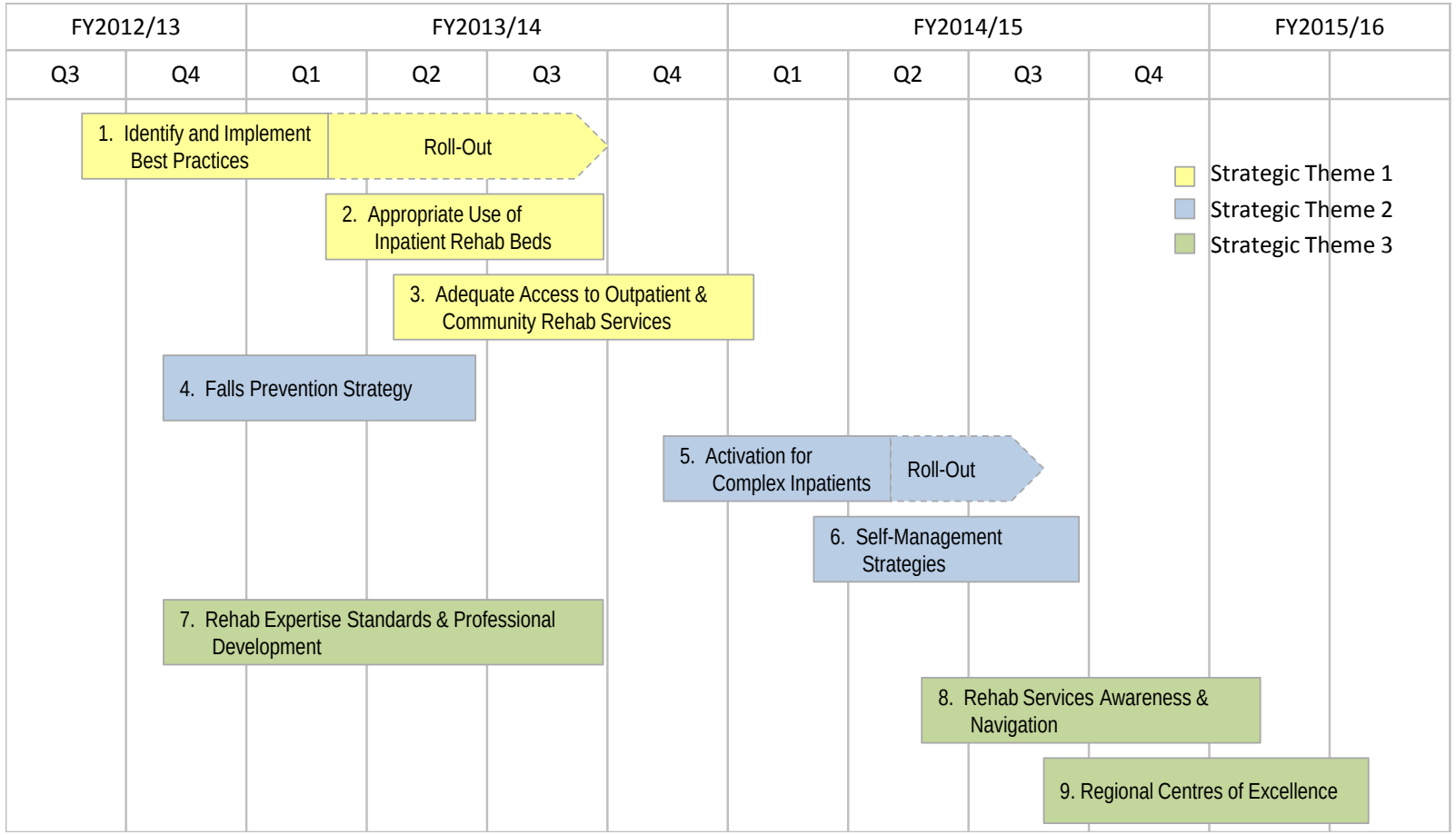
Workshop participants are eager to see changes happen at the local level and the LHIN has indicated the need to begin implementing quality and cost-saving changes as soon as possible. As such, it is recommended that the LHIN begin implementing the highest priority goals as soon as the strategic plan is approved, specifically:

1. All high priority goals in Strategic Theme #1 are implemented within 12-18 months of the plan being approved; and
2. Hire a part or full-time Rehabilitation Coordinator at the LHIN to support the research, analysis and process improvement initiatives across the LHIN.

Rehabilitation Strategy Action Plan

Proposed Implementation Timelines

The following chart illustrates the proposed timeline to implement each of the nine strategic goals. It is recommended that the highest priority strategic goals from Strategic Theme 1 be implemented within the first 12-18 months following approval of this plan. To successfully implement the plan within the 1-3 year timeframe, it will be critical to secure adequate resourcing and sequence the goals to build on successes.



The following charts illustrate the estimated timelines to complete the main steps to achieve each of the strategic goals.

Strategic Theme 1: Providing the Best Care in the Right Location

The work to implement the best practices for the top three clinical conditions can begin in June 2012 with the process work completed by January 2013. The ongoing implementation and spread will occur between January and June 2013.

Goal #1 - Identify and implement Best Practices for top three clinical conditions across the rehab continuum.	1-Dec-12	1-Jan-13	1-Feb-13	1-Mar-13	1-Apr-13	1-May-13	1-Jun-13	1-Jul-13	1-Aug-13	1-Sep-13	1-Oct-13	1-Nov-13	1-Dec-13	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14
Identify and obtain agreement on the best practices to be adopted and adhered to for each of the top three clinical conditions at a sufficient level of detail to be able to assess compliance.																		
Assess current best practices compliance across all relevant service providers.																		
Characterize the magnitude of the gaps for non-compliant service providers and prioritize the adoption of specific best practices.																		
Establish a 'change schedule' and 'change management process' for health service providers.																		
Identify and implement standardized tools for application in assessment, communication and measurement of patient and program outcomes																		
Standardize the staffing models (staff mix & skill sets) in rehab programs across the LHIN																		
Implement the changes at all organizations where gaps appear																		

The work to facilitate the appropriate use of inpatient rehabilitation beds (goal #2) and ensure adequate access to funded outpatient and community-based rehabilitation services (goal #3) is very similar work that relies on the same data sets and analysis. The work can begin in earnest in January 2013 after the best practices work has been well underway as that will significantly influence the requirements. The inpatient work will be complete September 2013, followed by the outpatient and community-based work in December 2013 as illustrated on the workplans below.

Goal #2 - Facilitate the appropriate use of inpatient rehab beds	1-Dec-12	1-Jan-13	1-Feb-13	1-Mar-13	1-Apr-13	1-May-13	1-Jun-13	1-Jul-13	1-Aug-13	1-Sep-13	1-Oct-13	1-Nov-13	1-Dec-13	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14
Identify and characterize (by program, services and LOS) when and how each clinical condition would benefit from an inpatient rehabilitation stay (based on best practices and emerging innovations).																		
Develop a system map that streamlines the services (inpatient, outpatient and community) to meet the varied rehab needs for the top three populations/conditions of ESC residents across the continuum of care.																		
Obtain agreement from all service providers with inpatient rehab beds on the expected use of and patient flow through inpatient beds for each of the top three clinical conditions – noting the range of clinical acuity variations between patients.																		
Identify and assess gaps, barriers and enablers to meeting appropriate inpatient bed use targets.																		
Develop predictive models for rehab utilization and growth for sustainability of inpatient bed demand for top three populations/conditions over the next ten years																		
Quantify the current volume of inpatient beds by region against the demand projection (assuming best practice bed use and LOS) and assessing the gap/excess of beds to meet the needs of those populations.																		

Goal #3 - Ensure adequate access to funded outpatient and community-based rehabilitation services	1-Dec-12	1-Jan-13	1-Feb-13	1-Mar-13	1-Apr-13	1-May-13	1-Jun-13	1-Jul-13	1-Aug-13	1-Sep-13	1-Oct-13	1-Nov-13	1-Dec-13	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14
Identify and characterize (by program, services and LOS) when and how each clinical condition would benefit from outpatient and/or community rehabilitation services (based on best practices and emerging innovations).																		
Obtain agreement from all service providers on the range of services required in outpatient and community settings to meet the requirements for each of the top three clinical conditions – noting the range of clinical acuity variations between patients.																		
Quantify the current outpatient and community services capacity by region against the demand projection (assuming best practice bed use and LOS) and assess the gap/excess to meet the needs of those populations.																		
Create a business case that outlines the changes to be made and funding sources																		
Identify the requirements and options to establish a standardized data collection process for outpatient and community rehabilitation services. This would enable capturing, analyzing and sharing data from outpatient clinics, FHTs, OHIP funded clinics CHCs, community care etc.																		
Research and review alternative funding models for outpatient rehabilitation services.																		

Strategic Theme 2: Supporting Prevention, Activation and Self-Management

As there are many Falls Prevention programs currently up and running, and the LHIN has already committed to implementing a LHIN-Wide program, building on the work done to-date, it should be relatively simple to ramp up the process of collaborating to support a consistent, LHIN-wide approach. The acceleration of this work can begin in the fall of 2012 and will be materially completed by March 2013.

Goal #4 - Roll-out the ESC-wide collaborative seniors fall prevention strategy	1-Dec-12	1-Jan-13	1-Feb-13	1-Mar-13	1-Apr-13	1-May-13	1-Jun-13	1-Jul-13	1-Aug-13	1-Sep-13	1-Oct-13	1-Nov-13	1-Dec-13	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14
Establish a LHIN-wide Falls Prevention Working Group																		
Inventory the existing falls prevention programs and materials																		
Research effective falls prevention and management programs and assess the gaps in the current ESC programs																		
Identify and confirm target populations and program information and education improvements.																		
Identify desired falls prevention and management program improvements and develop materials and processes to pilot and spread the improvements																		
Review data collection, tracking and report for falls and associated injuries and make recommendations for improvements																		

Expanding rehabilitation for the complex inpatient population can be a quick win if it is included as a geriatric best practice to support activation and an enabler that reduces the need for rehabilitation beds in support of the work in strategic theme 1. As such, it is proposed to begin in January 2013 when the best practices work is materially complete and is anticipated to be complete by September 2013.

Goal #5 - Expand activation for the complex inpatient population (on medical units).	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14	1-Jun-14	1-Jul-14	1-Aug-14	1-Sep-14	1-Oct-14	1-Nov-14	1-Dec-14	1-Jan-15	1-Feb-15	1-Mar-15	1-Apr-15	1-May-15	1-Jun-15	1-Jul-15
Inventory activation programs in the LHIN and identify gaps in service																			
Review existing activation programs and identify strengths and best practices to be considered for spread to other organizations (dedicated bedded programs as well as interprofessional teams)																			
Develop business cases to assess the cost, benefits and locations for the introduction of additional activation programs and services across the LHIN																			
Roll-out additional activation programs																			

Similar to the Falls Prevention programs, there are a number of self-management approaches and programs that could be better coordinated and spread LHIN-wide. However, given limited resources and a relative lower prioritization score, this work is anticipated to begin January 2014 and be complete by August 2014.

Goal #6 - Integrate self management philosophy with residents & families in each program	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14	1-Jun-14	1-Jul-14	1-Aug-14	1-Sep-14	1-Oct-14	1-Nov-14	1-Dec-14	1-Jan-15	1-Feb-15	1-Mar-15	1-Apr-15	1-May-15	1-Jun-15	1-Jul-15
Identify programs that already utilize self-management principles and assess outcomes																			
Identify best practices in patient self-management of chronic conditions																			
Select models from best practices and existing high performing programs to leverage and spread across other ESC rehabilitation programs and services																			
Develop a reporting process to track 'teach and discharge' program outcomes.																			

Strategic Theme 3: Developing Expertise and Sharing Knowledge

The developing standards for rehabilitation expertise and a professional development strategy must follow the best practices work to ensure that the appropriately trained resources can support the best practices. This work is scheduled to commence in April 2013 and be materially complete by January 2014.

Goal #7 - Develop standards for rehabilitation expertise and a supporting professional development strategy	1-Dec-12	1-Jan-13	1-Feb-13	1-Mar-13	1-Apr-13	1-May-13	1-Jun-13	1-Jul-13	1-Aug-13	1-Sep-13	1-Oct-13	1-Nov-13	1-Dec-13	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14	1-Jun-14
Develop care competencies for the top 4 diagnostic groups (stroke is already available)																			
Conduct an analysis to identify gaps in expertise relative to current and anticipated program needs																			
Perform a LHIN-wide education/professional development needs assessment																			
Prioritize needs based on priority populations of stroke, hip fractures and medically complex/geriatric.																			
Identify and pursue opportunities to partner with academic resources																			
First Education session offered 90 days after completion of the needs assessment																			

The implementation work associated with the two lowest priority goals (building awareness of rehabilitation and developing centres of excellence) is schedule to begin no earlier than fiscal year 2014/15.

Goal # 8 - Increase public/health care professional understanding of rehab and the resources available through formal education and marketing	1-Jan-14	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14	1-Jun-14	1-Jul-14	1-Aug-14	1-Sep-14	1-Oct-14	1-Nov-14	1-Dec-14	1-Jan-15	1-Feb-15	1-Mar-15	1-Apr-15	1-May-15	1-Jun-15	1-Jul-15
Develop an inventory of rehabilitation resources (or connect with and build on the emerging healthline database)																			
Establish or strengthen (through the CCAC) the system navigator role for rehabilitation services																			
Develop a marketing and communications plan to inform all health service provides of one-stop access to rehabilitation information and resources																			
Identify opportunities to document and publish clinical and financial outcomes																			

Goal #9 - Develop regional centres of excellence (cluster patient groups)	1-Feb-14	1-Mar-14	1-Apr-14	1-May-14	1-Jun-14	1-Jul-14	1-Aug-14	1-Sep-14	1-Oct-14	1-Nov-14	1-Dec-14	1-Jan-15	1-Feb-15	1-Mar-15	1-Apr-15	1-May-15	1-Jun-15	1-Jul-15	1-Aug-15
Proactively identify regional specialized care needs and collaborate with LHIN-wide partners to address those needs																			
Build upon established models of care for selected specialized areas recognized for their outstanding quality, continuous improvement and innovation																			
Develop linkage to academic centres and other centres of excellence in other LHINs (ie. Regional Geriatric Program / Specialized Geriatric Services)																			

Concluding Thoughts

Throughout the planning process, it has been clear that that a 'one size fits all' general approach to building an effective rehabilitation system is not sufficient to meet our communities' needs. We have unique pockets of strengths to leverage, regions that require further support and distinct populations with specific needs. To be effective at implementing positive changes for our residents, we are taking a population-specific and best practices approach that will drive better clinical outcomes and experiences for the highest volume of rehabilitation patient populations. Our programming and care will be specific to the needs and requirements of the populations being served. As a LHIN, we will coordinate and standardize what we do to deliver high quality care in the most effective and efficient manner.

Over the next three-years, we anticipate growing and learning as we implement this plan and we will be in an excellent position to apply that knowledge to changes that will impact even broader rehabilitation populations. The LHIN, the Rehabilitation Advisory Network and our stakeholders are looking forward to implementing this plan and bringing us closer to our desired future state.

Appendices

Appendix A: Literature Review

Appendix B: Workshop Participant List

Appendix C: Inventory of Rehabilitation Services

Appendix D: Overview of IHI's Triple Aim Framework

Appendix E: Current State SWOT and Gap Analysis

Appendix F: Prioritization Process and Criteria

Appendix A: Literature Review – Best Practices, Targets and Outcomes

Population	Document	Process	Practice Detail	Target	Outcomes
Stroke	Ontario Stroke Report Card, 2009/10	Access to Rehab	Acute stroke patients access inpatient rehab; admit to rehab post onset Day 7	41%	Improved access to rehab
		Access to Rehab	Admit severe stroke (RPG=1100 or 1110) to inpatient rehab	50%	Fewer admits to LTC; discharged to home
		Access to intense, specialized rehab in the community	Mild stroke (FIM>100) d/c to community with specialized/intense therapy	All except those who live alone	Save IP days; achieve max recovery
		Efficient inpatient rehabilitation program	Median FIM Efficiency for moderate stroke in inpatient rehab	1.2	Optimal recovery obtained in shortest LOS
	Canadian Best Practice Recommendations for Stroke Care: Update 2010 Ontario Stroke Network Stroke Reference Panel Recommendations 2011	Admit to acute stroke unit	ALOS 5 days	100%	Reduced mortality and morbidity
		Admit to stroke rehab unit	7 day/wk admissions 7 day/wk therapy 3 hours/day therapy	41% of all stroke	Reduced mortality and morbidity; shortened LOS; fewer adm to LTC
		Access to intense, specialized rehab in the community	2-3 visits/wk x12 weeks	13% of all stroke	
	Life After Stroke Making It Happen; Community Stroke Rehabilitation Teams Improve Quality of Life and Ability to Stay at Home for Stroke Survivors; Stroke 2011	Access to intense, specialized rehab in the community	Specialized team providing intensive rehabilitation and community reintegration	28% (87pts/yr served in population of 316 stroke adm/yr in HuronPerth)	Shortened hospital LOS (acute and rehab); improved recovery (FIM); reduced depression (HADS) and caregiver burden

Population	Document	Process	Practice Detail	Target	Outcomes
Hip Fracture	Osteoporosis: Towards a Fracture Free Future; March 2011	Identification and prevention of fracture	Everyone who has sustained an osteoporotic fracture: receive pain control, preventive medication, fall risk assessment, education	100%	
	National Hip Fracture Toolkit, Bone and Joint Decade Canada; June 2011	Access to surgery	Surgery in <48 hours	100%	
		Acute care	IDT; mobilize within 12-24 hours of surgery; WB status should be 'as tolerated' only 5% non-weight-bearing; 7 day/wk OT & PT.	95% WBAT, mobilize within 12-24 hours, 7day/wk therapy	More patients d/c home; fewer require long term care
	Functional Recovery of Hip Fracture patients; Bone and Joint Canada Toolkit Resource July 2011	Access to rehabilitation (all pts who were ambulatory prior to fracture regardless of cognitive / medical status Those with impaired cognition and/or complex medical/social needs may require longer stays with more prolonged rehabilitation prior to transitioning back to pre-fracture living arrangements)	Admit to active inpatient rehabilitation Day 5 postop	70% (10% directly home; 20% to LTC)	
			Fast-Stream – Home within 5-14 days with appropriate home support at discharge.		
			Usual Stream – Home within 14-28 days with appropriate home support at discharge.		
			Slow Stream – Home within 28-90 days with appropriate home support at discharge.	15%	
		Discharge	Return to pre-living status	75%	Greater number returned to previous living status

Population	Document	Process	Practice Detail	Target	Outcomes
Joint Replacement	GTA Rehab Network Guideline for Pre-Admission Processes: Primary, Elective, Unilateral Total Joint Replacement; September 2011	Pre-op education rehab-specific	Offer 6-8 weeks before sx date ideally; pts. can begin to excs and improve fitness in advance of sx		Supports shorter LOS and faster recovery
		Pre-op medical workup	2 weeks prior to sx		Shorter LOS
		Discharge destination triage	Explore every opportunity for discharge to home post-sx; ideally rehab, social work or nursing to discuss with pt.	80% d/c home	Greater cost effectiveness with care provided in community
		Referral to post-acute rehab	Initiate referral in pre-adm phase; schedule 1st appt. for 2-3 days and no more than one week post-d/c from acute care or CCAC; use of standardized referral forms		Maximize number of patients supported to discharge home; improve communication on care transitions
	Hip and Knee Replacement Toolkit, Bone and Joint Canada, March 2011	Standardize referral processes for rehab	Majority can rehab with home or outpatient care; comorbidities or postoperative complications may necessitate inpatient rehab – individualized care plan with care map that measures the pt. against their required activities of daily living; referral to outpatient or home care after inpt. Rehab		Greater cost effectiveness with care provided in community
	Orthopedic Quality Scorecard	Length of stay	Acute ALOS	4.4 days	
		Discharge planning	Proportion of patients d/c home	90+%	

Population	Document	Process	Practice Detail	Target	Outcomes
Geriatric	Senior Friendly Hospital Care Across Ontario: Summary Report and Recommendations August 2011	Therapy targeted at functional decline	Screen all older patients early in admission for risk of functional decline Implement evidence-based protocols to mobilize patients adapted to local context.	100%	Reduce complications, reduce adverse outcomes, reduce LOS, reduce ALC, reduce cost of care
		Management of Delirium	Implement interprofessional delirium screening, prevention and management protocols across all departments	100%	Reduce adverse outcomes, reduce LOS, reduce ALC, reduce costs
		Management of Care Transitions	Early needs assessment, identification of transition issues, and engagement/goal setting with patients and families	100%	Reduce adverse outcomes, reduce readmission rates, improve continuity of care
	Health System Use By Frail Ontario Seniors; ICES November 2011	Risk assessment	Use LACE to reduce hospital readmissions. Use MAPLe for LTC		
	Organization Design for Geriatrics: An Evidence Based Approach; Regional Geriatric Programs of Ontario July 2008	Inpatient consultation and comprehensive geriatric assessment and treatment for reversible/remediable disabilities	Target patients most likely to benefit (over age 75; problems with falls, gait, balance problems; functional limitations; confusion; depression; incontinence; potentially reversible/remediable disabilities; pts. in transition) Use on-line system to flag pts.; use trained staff member to further screen; ensure capacity to respond within 24 hrs.; provide written recommendations; follow-up bi-weekly at minimum; track outcomes		

		Geriatric assessment and rehab units	Admission screening for rehab potential; CGA including nutritional assessm't, screen for depression and cognitive impairment; Close medical supervision & concomitant treatment for intercurrent co-morbidities; inter-disciplinary team trained in care of elderly / managed by MD; MD and pharmacist complete medication review		Increase number of individuals discharged home, reduce institutionalization	
		Geriatric Day Hospital	Screen and target frail pts. with complex conditions at risk of inpatient admission and/or institutionalization; control LOS to 90 days or less		Help avoid inpatient admissions; maintain independent living in community	
		Geriatric outpatient care / specialized geriatric outreach services	carefully target only those patients who are likely to benefit – by frailty rather than age, combine assessment with sustained treatment and follow-up; multidisciplinary teams have better outcomes than single discipline services;		Link between hospital and community care; Reduce ED visits, maintain indep.; reduce institutional admissions	
	State of the Art in Geriatric Rehabilitation. Part I: Review of Frailty and Comprehensive Geriatric Assessment, Wells et al., 2003	Geriatric rehabilitation	Frail elderly patients should be screened for rehab potential. Standardized tools are recommended to aid Dx, Ax, and outcome measurement. Team approach to geriatric rehab should be interdisciplinary and utilize comprehensive geriatric assessment, medication review and self-medication programs.		Increase number of individuals discharged home, reduce institutionalization; Increased survival; Improved functional status.	

	State of the Art in Geriatric Rehabilitation. Part II: Clinical Challenges. Wells et al., 2003	Geriatric rehabilitation	Outlines evidence based practices for hip fracture, stroke, nutritional status, depression, and cognitive impairment in frail elderly patients undergoing rehabilitation.		Refer to article for more details.
	Because this is the rainy day: a discussion paper on home care and informal caregiving for seniors with chronic health conditions February, 2011	Caregiver support	increasing services and supports: home care, day and respite programs, caregiver support programs and supportive housing units, tax credits		Keep people supported in their homes with informal caregivers; avoid unnecessary and costly hospitalization or long-term-care placement
Population	**Document**	**Process**	**Practice Detail**	**Target**	**Outcomes**
Cardiac	Canadian Guidelines for Cardiac Rehabilitation and Cardiovascular Disease Prevention: *Translating Knowledge into Action* 3rd Edition, Canadian Association of Cardiac Rehabilitation, 2011	Cardiac rehabilitation Integrated into the cardiovascular care continuum Standard of care for: MI Percutaneous coronary interventions (PCI) CABG Other such as CHF, valve replacement, Heart transplant	Referral best accomplished by automatic referrals integrated into care pathways Programs tailored to meet individual patient needs Core components include pt. assessment, risk stratification, health behavior interventions, risk factor modification, psychosocial counseling, vocational counseling, exercise training, patient education and performance measures Guidelines outline suggested best practices for exercise and physical activity, management of diabetes, hypertension, lipids and meds.		Reduce ED visits, hospital readmissions Promote chronic disease self-management

	Emerging practices	Cardiac rehabilitation	Incorporating cardiac rehabilitation practices to other populations with vascular pathologies – diabetes, stroke, etc.		Could leverage existing programs to enhance chronic disease management of related conditions like diabetes, and stroke
	Comprehensive Cardiac Rehabilitation for Secondary Prevention After Transient Ischemic Attack or Mild Stroke I: Feasibility and Risk Factors. PL Prior et al. Stroke Nov 2011	Cardiac rehabilitation, risk factor education and medication review following TIA or mild stroke	Exercise 4days/week Nurse led risk factor management Medication based on BPG		Significantly reduced risk factors
	Cardiac Rehabilitation A Contemporary Review. Braverman DL. Am J Phys Med Rehabil 2011;90:599Y611	Cardiac rehabilitation			reduced recurrent myocardial infarction by 17% at 12 mos and reduced mortality by 47% at 2 yrs.35
Pulmonary	Canadian Thoracic Society recommendations for management of chronic obstructive pulmonary disease – 2007 update	Pulmonary rehabilitation	• Clinically stable patients who remain dyspneic and limited in their exercise capacity despite optimal pharmacotherapy should be referred for supervised pulmonary rehabilitation (level of evidence: 1A). • An urgent need exists to increase access to pulmonary rehabilitation programs across Canada (level of evidence: 2A).		
	Optimizing pulmonary rehabilitation in chronic obstructive pulmonary disease – practical issues: A Canadian Thoracic Society Clinical Practice Guideline. Can	Pulmonary rehabilitation care by team; recommended to include physician; must have access to oxygen and	Aerobic Training +Resistance Training is more effective than AT alone in improving endurance and functional ability. While AT is the foundation of PR, it is recommended that both AT and RT		

	Respir J 2010;17(4):159-168.	resuscitation equipment	be prescribed to COPD patients. (GRADE: 2B) It is recommended that longer PR programs, beyond six to eight weeks duration, be provided for COPD patients. (GRADE: 2B) It is strongly recommended that patients with moderate, severe and very severe COPD participate in PR.(GRADE: 1C) It is strongly recommended that COPD patients undergo PR within one month following an AECOPD due to evidence supporting improved dyspnea, exercise tolerance and HRQL compared with usual care. (GRADE: 1B) PR within one month following AECOPD is also recommended due to evidence supporting reduced hospital admissions and mortality compared with usual care.(GRADE: 2C)		
	A clinical practice guideline for physiotherapists treating patients with chronic obstructive pulmonary disease based on a systematic review of available evidence; Clin Rehabil 2009; 23; 445	Pulmonary rehabilitation	Supervised endurance training either on a treadmill or on a cycle ergometer (or a combination of both) is recommended for patients in all stages of the disease who are able to perform endurance training of at least moderate intensity. Training frequency should be three times weekly in the first weeks of an exercise program.		

Complex Continuing Care	Optimizing the role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System; OHA May 2006		Complex continuing care is a specialized program of care providing programs for medically complex patients whose condition requires a hospital stay, regular onsite physician care and assessment, and active care management by specialized staff.		
Restorative care	No literature identified				
Population	**Document**	**Process**	**Practice Detail**	**Target**	**Outcomes**
SCI	Spinal Cord Injury Rehabilitation Evidence www.scireproject.com	Access to inpatient rehab	•Earlier admission to specialized, interdisciplinary SCI care		• reduced length of total hospital stay and greater and faster rehabilitation gains with fewer medical secondary complications
		Outpatient and Follow-up Care	•Routine, comprehensive, specialist follow-up services •Regular and accessible interdisciplinary follow-up and outpatient care. •Telehealth applications such as telemedicine for follow-up		• improved health •improved functional goal attainment •enhance patient satisfaction with follow-up services and may improve functional outcomes.

Population	Document	Process	Practice Detail	Target	Outcomes
ABI	Evidence Based Review of Moderate to Severe Acquired Brain Injury http://www.abiebr.com	Access to inpatient rehab	Earlier time from injury onset to rehabilitation admission results in improved functional outcomes.		Inpatient rehabilitation improves self-care and mobility and significantly improves functional outcome, social cognition and return to work in patients with TBI and non-TBI.
		Therapy Intensity	High-intensity rehabilitation is associated with improved outcomes at discharge and at two and three months post-injury. Therapy intensity may predict motor functioning at discharge.		
		Multidisciplinary team care	Multidisciplinary inpatient rehabilitation more effective.		
		Transitional living setting	Transitional living setting during the last weeks of inpatient rehabilitation is associated with greater independence than inpatient rehabilitation alone.		
		Outpatient therapy	Neurobehavioural or neurorehabilitative programs improve behavioural and cognitive functioning post ABI.		
		Community based programs	Community-based programs for ABI patients are associated with greater independence, higher social activity levels, and less need for care support when they can be sustained for at least six months. There remains a need to provide ongoing outpatient or community care and rehabilitation years post injury.		

Appendix B: ESC LHIN Rehab Network Strategic Planning – Participant List

Totals = 36 31 27

Facility	Title	Email	Name	Phone Number	Mar 8	Mar 21	Apr 4
Chatham Kent							
Chatham-Kent HealthAlliance Box 2030 Chatham, Ontario N7M 5L9	Program Director Rehabilitation and Continuing Care Program	**nsnobelen@ckha.on.ca**	Nancy Snobelen		☑	☑	☑
	Coordinator, OT, SLP, Therapeutic Recreation	**kdehaan@ckha.on.ca**	Kim deHaan		☑	☑	☑
	Coordinator, Physiotherapy, EMG, Chiropody, Cardiac Clinic, Cardiac Rehab	**gking@ckha.on.ca**	Gail King	519-352-6401	☑	☑	☑
	Clinical Manager, In-Patient Rehab. Services	**dgreen@ckha.on.ca**	Dave Green		☑	☑	☐
Home Care	Pace Homecare Sarnia-Lambton and Chatham-Kent	**ahovey@pacehealth.com**	Angela Hovey, VP Services and Operations	1-866-904-9904 ext. 8404	☑	☑	☑
Chatham Family Health Team	Thamesview FHT – ED Occupational Therapist	**denise.waddick@thamesviewfht.ca** **jennifer.kreiger@thamesviewfht.ca**	Denise Waddick Jennifer Kreiger	519-354-0070	☑	☑	☐ ☑
Windsor Essex							
Hotel-Dieu Grace Hospital 1030 Ouellette Windsor, Ont. N9E-1A1	Coordinator District Stroke Centre Windsor-Essex Trauma Coordinator Assess/Restore Mgr	**andrea.drummond@hdgh.org** **elsie.galbraith@hdgh.org** **stephanie.malec@hdgh.org**	Andrea Drummond Elsie Galbraith Stephanie Malec	519-973-4411 ext.	☑ ☐	☑ ☑	☑ ☐ ☑
Windsor Regional Hospital Western Campus 1453 Prince Road Windsor, Ontario N9C 3Z4	Director Rehab and Allied Health	**John_Norton@wrh.on.ca**	John Norton		☑	☑	☑
	Physiatrists	**Nathania_Liem@wrh.on.ca**	Dr. Nathania Liem		☑	☑	☑
	Charge Nurse and Intake Liaison	**Denean_Kristolovich@wrh.on.ca**	Denean Kristolovich		☑	☑	☑
	Manager Allied Health	**Christine_Edwards@wrh.on.ca**	Chris Edwards	519-257-5230	☑	☑	☑

Facility	Title	Email	Name	Phone Number	Mar 8	Mar 21	Apr 4
	Social Work	**Carla_Milevski@wrh.on.ca**	Carla Milevski		☑	☑	☑
Leamington District Memorial Hospital	Clinical Director of Inpatient Services Critical Care Director	**Cheryl.Deter@ldmh.org** **Rita.Taillefer@ldmh.org**	Cheryl Deter Rita Taillefer	519-326-2373	☑ ☑	☑ ☑	☑ ☐
Windsor Essex CHC	Director Clinical Services	**tconte@wechc.org**	Teresa Conte	519-253-8481 ext. 256	☑	☐	☑
Family Health Teams representative	Harrow Health Centre Inc. Executive Director	**bgray@harrowfht.ca**	Brian Gray	519-738-2000	☐	☐	☐
Home Care	Bayshore Therapy and Rehab	**basmith@bayshore.ca**	Brenda Smith, Clinical Manager	519-974-5953 ext. 329	☐	☑	☑
OHIP funded Physiotherapy Clinics	Advanced Rehabilitation Centre Windsor	**johnspirou@gmail.com**	John Spirou	519-254-2222	☑	☐	☐
Sarnia Lambton							
Grand Bend CHC 99 Victoria St. Thedford, ON NOM 2NO	Physiotherapist COPD Rapid Response Team	**npasut@gbchc.com**	Nicole Pasut	519-296-0117	☑	☑	☑
Bluewater Health Norman Site 89 Norman Street Sarnia, Ontario N7T 6S3	Manager Ambulatory, Rehabilitation and Allied Health	**jmackey@bluewaterhealth.ca**	Jenn Mackey	519-464-4400 ext. 8270	☑	☑	☐
	Director of Surgery and Rehabilitation	**vlucas@bluewaterhealth.ca**	Vicky Lukas	519-464-4400 ext. 5506	☑	☐	☐
	District Stroke Coordinator	**ldykes@bluewaterhealth.ca**	Linda Dykes	519-464-4400 ext. 4465	☑	☑	☑
LHIN Wide							
ESC CCAC 750 Richmond St. Chatham, ON N7M 5K4	Senior Director Client Services	**Tricia.Khan@esc.ccac-ont.ca** **Lucy.Coppola@esc.ccac-ont.ca**	Tricia Khan designate: Lucy Coppola	519-436-2222 ext. 2703	½ ☑	☐ ☑	☐ ☐
	Senior Manager Client Services	**Diane.Mulcaster@esc.ccac-ont.ca**	Diane Mulcaster	519-258-1088 ext. 5239	☑	☑	☑
	Senior Director Project	**Kelley.Ilisevic@esc.ccac-ont.ca**	Kelley Ilisevic	519-337-1000	☑	☑	☐

Facility	Title	Email	Name	Phone Number	Mar 8	Mar 21	Apr 4
	Management, HR and Organizational Development						
Geriatric Services Regional Geriatric Program Parkwood Hospital, St. Joseph's Health Care, London	Geriatrician, ESC LHIN ALC Lead Designate – Director, Specialized Geriatric Services	**Michael.Borrie@sjhc.london.on.ca** **Elizabeth.McCarthy@sjhc.london.on.ca** (designate)	Dr. Michael Borrie Elizabeth McCarthy	519-685-4021	☐ ☑	☐ ☐	☐ ☑
	Geriatrician, WE – Designate – Director, Rehabilitation Services	**Jennie.Wells@sjhc.london.on.ca** (designate) **Sharon.Jankowski@sjhc.london.on.ca**	Dr. Jennie Wells Sharon Jankowski	519-685-4021	☐ ☑	☐ ☑	☐ ☐
Assisted Living Southwestern Ontario (ALSO) (formerly APPD)	Executive Director	**LynnCalder@alsogroup.org**	Lynn Calder	519-969-8188	☑	☐	☐
The Arthritis Society	Southwestern Ontario Regional Director	**Nancy.Ambrogio@arthritis.on.ca**	Nancy Ambrogio	519-433-2191	☑	☐	☑
Head injury associations	New Beginnings, Executive Director	**lgall@biack.com**	Lori Gall	519-351-0297	☑	☑	☐
ESC LHIN	Quality and Performance Manager	**Pete.Crvenkovski@lhins.on.ca**	Pete Crvenkovski	1-866-231-5446 ext. 3217	☑	☐	☑
	Health Systems Design Manager	**Alec.Anderson@lhins.on.ca**	Alec Anderson	1-866-231-5446 ext. 3212	☑	☐	☑
	Sr. Director, Health System Design	**Ralph.Ganter@lhins.on.ca**	Ralph Ganter	1-866-231-5446 ext. 3205	☐	☐	☑
	ESC LHIN ALC Lead	**Laurie.Zimmer@lhins.on.ca**	Laurie Zimmer	1-866-231-5446 ext. 3216	☑	☑	☐
	Sr. Director, Delivery and Implementation	**Brad.Keeler@lhins.on.ca**	Brad Keeler	1-866-231-5446, ext. 3206	☐	☐	☐
		Paul.Brown@lhins.on.ca	Paul Brown		☑	☑	☐
		Frank.Chalmers@lhins.on.ca	Frank Chalmers		☐	☐	☐

Facility	Title	Email	Name	Phone Number	Mar 8	Mar 21	Apr 4
Project	Coordinator	**hjohnson99@cogeco.ca**	Helen Johnson		☑	☑	☑
Coordinators	Coordinator	**Deb.Willems@LHSC.ON.CA**	Deborah Willems		☑	☑	☑
Project Facilitator	RWS Advisory	**fiona.mcdougall@rwsadvisory.com**	Fiona McDougall		☑	☑	☑
Guest	Program Manager, Inpatient Rehabilitation WRH		Kari-Lynn Malec			☑	☑
Guest	Student Application Developer, ESC CCAC		Alex Lee			☑	

Appendix C: Current State Services Inventory

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
ALL							
POPULATION SERVED	2006 LHIN data: 393,400			2006 data: 108,590	2006 data: 128,205		
EMERGENCY CARE							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
ACUTE CARE							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)	all admitted inpatients by referral from hospital physician	all admitted inpatients by referral from hospital physician	all admitted inpatients by referral from hospital physician	all admitted inpatients by referral from hospital physician	all admitted inpatients by referral from hospital physician		
Geography Served	Windsor-Essex: Trauma unit is regional for LHIN	Windsor-Essex and LHIN region	Windsor-Essex and LHIN region				
ACTIVATION/AMBULATION	ACTIVATION/ AMBULATION	ACTIVATION/ AMBULATION	ACTIVATION/ AMBULATION	ACTIVATION/ AMBULATION	ACTIVATION/ AMBULATION		
Capacity (Beds, FTE, Funding etc.)	FTE: 4 Beds covered: Medicine	FTE: 3.2 Beds covered:	FTE: 1 Beds covered:	FTE: Beds covered: Medicine	FTE: 2.2 Beds covered: 76		
Eligibility (Patient Population)	Medicine			Medicine	Medicine		
REHABILITATION	SHORT TERM REHAB	GENERAL AND SPECIAL REHABILITATION		GENERAL REHABILITATION	GENERAL REHABILITATION		
Capacity (Beds, FTE, Admissions etc.)	20 beds 2010 NRS Admissions: 181	52 beds; increasing to 60 beds in ?; FTE: 20.5	none	22 beds FTE: 9.3 2010 NRS Admissions: 361	27 beds FTE: 9 2010 NRS Admissions: 295		

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
		2010 NRS Admissions: 479					
Eligibility (Patient Population)	anticipated LOS < 2 weeks	medically stable; has rehabilitation goals requiring inpatient admission that can be addressed by an interdisciplinary team; ability to learn and participate		medically stable; has rehabilitation goals requiring inpatient admission that can be addressed by an interdisciplinary team; ability to learn and participate	medically stable; has rehabilitation goals requiring inpatient admission that can be addressed by an interdisciplinary team; ability to learn and participate		
Geography Served		Provides rehabilitation for MOH designated 'special' populations which include ABI, amputee, SCI for ESC.					
ASSESS-RESTORE	ASSESS-RESTORE	REACT	ASSESS-RESTORE	ASSESS-RESTORE			
Capacity (Beds, FTE, Funding etc.)	15 beds FTE: 4 Annual admissions: 525	6 beds FTE: 2.2	10 beds FTE: 2.47 Annual admissions: 431 (projected)	10 beds FTE: 3.06	none		
Eligibility (Patient Population)	>65 years of age Potential d/c to home or rest home Able to direct own care 90% of time One person assist or better No restraints,						

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
	wounds, IV/IM narcotics						
COMMUNITY REHABILITATION							
HOSPITAL OUTPATIENT		WRH	Leamington	CKHA	Bluewater	Bluewater-CEEH	
Capacity **FTE: combined PT, OT, SLP, SW , Recreation Therapy and Therapy assistants*		FTE*: 10.3 Visits: 18,561	FTE*: 0.24 Visits: 1,024	FTE*: 6.79 Visits: 12,506	Day Hospital: FTE*: 2.1 1100 served Outpatient: FTE: 1.85 Visits: 4,014	FTE*: 2.3 Visits: 5,947	
Eligibility (Patient Population)							
CCAC							
Capacity (Beds, FTE, Funding etc.)	Total Clients receiving Rehab services: 8752 Total visits OT: 12864 PT: 18535 SLP: 2646 SW: 1303						
Eligibility (Patient Population)							
Geography Served							
CHC	Windsor Essex CHC			Chatham Kent CHC	Grand Bend CHC	North Lambton CHC	
Capacity (Beds, FTE, Funding etc.)	FTE:14.5 + 2 med secretaries			FTE: 1.0 OT for COPD and Falls 0.5 PT serving clients in Wallaceburg	FTE:10	FTE: 3.4 (OT, SW, Resp, PT)	
Eligibility (Patient Population)				COPD and Fall Prevention team (OT, RN) plus PT at	COPD and Outpatient musculoskeletal and neuro	COPD and Fall Prevention	

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
				Wallaceburg			
OHIP Designated Physio Clinics	Advanced Rehabilitation Centre	Wardle's Physiotherapy Clinic	none	none	Sarnia Community Care Physiotherapy	Sam Shuqauir Physiotherapy	
Capacity (Beds, FTE, Funding etc.)	FTE: 2.5 PT / 6 PTA	FTE: 7 PT/PTA			FTE: 1 PT		
Eligibility (Patient Population)							
CARDIAC REHABILITATION		Windsor Essex Cardiac Wellness	Windsor Essex Cardiac Wellness	CKHA Cardiac Rehab Program			
Capacity (Beds, FTE, Funding etc.)		420 clients/year	80 clients/year	128 clients/year FTE: 0.84 (Kin, Dietitian, RN)			
Eligibility (Patient Population)							
THE ARTHRITIS SOCIETY							
Capacity (Beds, FTE, Funding etc.)	FTE: 2.5 Clients on service: 200						
Eligibility (Patient Population)	ESC LHIN						
OTHER	Aquired Brain Injury Consult Team	WRH Pulmonary Rehab Program					
Capacity (Beds, FTE, Funding etc.)	1.9 (SW/Psychol/OT) + Psychiatry 1/2 day/month	$63,000 annual funding; FTE: 0.3 PT, 0.3 RT; can see 72 pts/yr					
Eligibility (Patient Population)	Windsor-Essex						
COMMUNITY SUPPORT							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
DAY PROGRAMS	CHRYSALIS			NEW BEGINNINGS CLUBHOUSEAND STROKE RECOVERY ASSOCIATION			
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)	ABI			ABI and Stroke			
ASSISTED LIVING SW ON							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
PRIMARY CARE							
PRIMARY CARE				Thamesview FHT			
Capacity (Beds, FTE, Funding etc.)				1 FTE OT			
Eligibility (Patient Population)				rostered patients only			
Specialized Geriatric Services	Windsor-Essex Geriatric Assessment / Consultation Program						
Capacity (Beds, FTE, Funding etc.)	4.5 FTE (RN/PT/OT) + Team physician + 2 part-time geriatricians, and support from SWOGAN						
Eligibility (Patient Population)	Individuals 55 and over, meeting specific referral criteria						

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
HIP FRACTURE							
POPULATION SERVED							
ACUTE CARE							
Capacity (Beds, FTE, Funding etc.)	Hip Fracture*: 528 *Number of hospitalizations for seniors (65+ years) for all hip fractures 2009/10 Hip fractures due to falls in WE in 2010: 412			Hip fractures due to falls 2010: 152	Hip fractures due to falls 2010: 161		Hip Fracture: 605 We are 21% over the provincial per 1,000 rate for seniors with a hip fracture
Eligibility (Patient Population)							
REHABILITATION	SHORT TERM REHAB	GENERAL AND SPECIAL REHABILITATION		GENERAL REHABILITATION	GENERAL REHABILITATION		
Capacity (Beds, FTE, Admissions etc.)	2010-11 NRS Admissions: 7	2010-11 NRS Admissions: 20 Hip Replacement: 44		2010-11 NRS Admissions: 39 Hip Replacement: 58	2010-11 NRS Admissions: 41 Hip Replacement: 22		
Eligibility (Patient Population)	anticipated LOS < 2 weeks						
COMMUNITY REHABILITATION							
HOSPITAL OUTPATIENT		WRH	Leamington	CKHA	Bluewater	Bluewater-CEEH	
Capacity **FTE: combined PT, OT, SLP, SW , Recreation Therapy and Therapy assistants*		FTE*: 10.3 Visits: 18,561	FTE*: 0.24 Visits: 1,024	FTE*: 6.79 Visits: 12,506	Day Hospital: FTE*: 2.1 1100 served Outpatient: FTE: 1.85 Visits: 4,014	FTE*: 2.3 Visits: 5,947	

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Eligibility (Patient Population)							
CCAC							
Capacity (Beds, FTE, Funding etc.)	Total Clients receiving Rehab services: 8752 Total visits OT: 12864 PT: 18535 SLP: 2646 SW: 1303						
Eligibility (Patient Population)							
CHC	Windsor Essex CHC			Chatham Kent CHC	Grand Bend CHC	North Lambton CHC	
Capacity (Beds, FTE, Funding etc.)	FTE:			FTE:	FTE:	FTE: 3.4	
Eligibility (Patient Population)				COPD and Fall Prevention	COPD and Outpatient musculoskeletal and neuro	COPD and Fall Prevention	
OHIP Designated Physio Clinics	Advanced Rehabilitation Centre	Wardle's Physiotherapy Clinic	none	none	Sarnia Community Care Physiotherapy	Sam Shuqauir Physiotherapy	
Capacity (Beds, FTE, Funding etc.)	FTE: 2.5 PT / 6 PTA	FTE: 7 PT/PTA			FTE: 1 PT		
Eligibility (Patient Population)							
THE ARTHRITIS SOCIETY							
Capacity (Beds, FTE, Funding etc.)	FTE: 2.5 Clients on service: 200						
Eligibility (Patient Population)	ESC LHIN						
COMMUNITY SUPPORT							
DAY PROGRAMS							
Capacity (Beds, FTE, Funding etc.)							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Eligibility (Patient Population)							
ASSISTED LIVING SW ON							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
PRIMARY CARE							
PRIMARY CARE				Thamesview FHT			
Capacity (Beds, FTE, Funding etc.)				1 FTE OT			
Eligibility (Patient Population)				Rostered patients			
ORTHO							
POPULATION SERVED							
EMERGENCY CARE							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
ACUTE CARE							
Capacity (Beds, FTE, Funding etc.)	Hip Replacement: 362 Knee Replacement: 364 Other Ortho:	Hip Replacement: 122 Knee Replacement: 266 Other Ortho:		Hip Replacement: 179 Knee Replacement: 230 Other Ortho:	Hip Replacement: 133 Knee Replacement: 219 Other Ortho:		
Eligibility (Patient Population)							
REHABILITATION	SHORT TERM REHAB	GENERAL AND SPECIAL REHABILITATION		GENERAL REHABILITATION	GENERAL REHABILITATION		

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Capacity (Beds, FTE, Admissions etc.)	TKR: 3 Other Ortho: 10	Hip Replacement or Revision: 53 TKR: 6 Other Ortho: 57		Hip Replacement or Revision: 65 TKR: 7 Other Ortho: 27	Hip Replacement or Revision: 25 TKR: 7 Other Ortho: 33		
Eligibility (Patient Population)	anticipated LOS < 2 weeks						
ASSESS-RESTORE	ASSESS-RESTORE	REACT	ASSESS-RESTORE	ASSESS-RESTORE			
Capacity (Beds, FTE, Funding etc.)	15 beds FTE: 4 Annual admissions:	6 beds FTE: 2.2	10 beds FTE: 2.47 Annual admissions:	10 beds FTE: 3.06	none		
Eligibility (Patient Population)	>65 years of age Potential d/c to home or rest home Able to direct own care 90% of time One person assist or better No restraints, wounds, IV/IM narcotics						
COMMUNITY REHABILITATION							
HOSPITAL OUTPATIENT		WRH	Leamington	CKHA	Bluewater	Bluewater-CEEH	
Capacity **FTE: combined PT, OT, SLP, SW , Recreation Therapy and Therapy assistants*		FTE*: 10.3 Visits: 18,561	FTE*: 0.24 Visits: 1,024	FTE*: 6.79 Visits: 12,506	Day Hospital: FTE*: 2.1 1100 served Outpatient: FTE: 1.85 Visits: 4,014	FTE*: 2.3 Visits: 5,947	
Eligibility (Patient Population)							
CCAC							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Capacity (Beds, FTE, Funding etc.)	Total Clients receiving Rehab services: 8752 Total visits OT: 12864 PT: 18535 SLP: 2646 SW: 1303						
Eligibility (Patient Population)							
CHC	Windsor Essex CHC			Chatham Kent CHC	Grand Bend CHC	North Lambton CHC	
Capacity (Beds, FTE, Funding etc.)	FTE:			FTE:	FTE:	FTE: 3.4	
Eligibility (Patient Population)				COPD and Fall Prevention	COPD and Outpatient musculoskeletal and neuro	COPD and Fall Prevention	
OHIP Designated Physio Clinics	Advanced Rehabilitation Centre	Wardle's Physiotherapy Clinic	none	none	Sarnia Community Care Physiotherapy	Sam Shuqauir Physiotherapy	
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
THE ARTHRITIS SOCIETY							
Capacity (Beds, FTE, Funding etc.)	FTE: 2.5 Clients on service: 200						
Eligibility (Patient Population)							
COMMUNITY SUPPORT							
DAY PROGRAMS							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
ASSISTED LIVING SW ON							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
PRIMARY CARE							
PRIMARY CARE				Thamesview FHT			
Capacity (Beds, FTE, Funding etc.)				1 FTE OT			
Eligibility (Patient Population)							
STROKE							
POPULATION SERVED							
EMERGENCY CARE							
Capacity (Beds, FTE, Funding etc.)	Stroke Report Card: 442	Stroke Report Card: 68	Stroke Report Card: 29	Stroke Report Card: 249	Stroke Report Card: 228	Stroke Report Card: 9	NACRS 2010: 2,079
Eligibility (Patient Population)	Includes stroke and TIA						
ACUTE CARE							
Capacity (Beds, FTE, Funding etc.)	2011 Admissions: 380				Annual admissions: 200		Annual Admissions: 678
Eligibility (Patient Population)							
ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION		
Capacity (Beds, FTE, Funding etc.)		FTE: 3.2 Beds covered:	FTE: 1 Beds covered:	FTE: Beds covered:	FTE: 2.2 Beds covered: 76		
Eligibility (Patient Population)				Medicine	Medicine		

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
REHABILITATION	SHORT TERM REHAB	GENERAL AND SPECIAL REHABILITATION		GENERAL REHABILITATION	GENERAL REHABILITATION		
Capacity (Beds, FTE, Admissions etc.)	2010-11 NRS Admissions: 15	2010-11 NRS Admissions: 165		2010-11 NRS Admissions: 90	2010-11 NRS Admissions: 60		
Eligibility (Patient Population)	anticpated LOS < 2 weeks	Severe (RPG 1100-1110): 42% Moderate (RPG 1120-1140): 37% Mild (RPG 1150-1160): 20%		Severe (RPG 1100-1110): 37% Moderate (RPG 1120-1140): 38% Mild (RPG 1150-1160): 26%	Severe (RPG 1100-1110): 40% Moderate (RPG 1120-1140): 43% Mild (RPG 1150-1160): 16%		
ASSESS-RESTORE	ASSESS-RESTORE	REACT	ASSESS-RESTORE	ASSESS-RESTORE			
Capacity (Beds, FTE, Funding etc.)	15 beds FTE: 4 Annual admissions:	6 beds FTE: 2.2	10 beds FTE: 2.47 Annual admissions:	10 beds FTE: 3.06	none		
Eligibility (Patient Population)	>65 years of age Potential d/c to home or rest home Able to direct own care 90% of time One person assist or better No restraints, wounds, IV/IM narcotics						
COMMUNITY REHABILITATION							
HOSPITAL OUTPATIENT		WRH	Leamington	CKHA	Bluewater	Bluewater-CEEH	
Capacity **FTE: combined PT, OT, SLP, SW , Recreation Therapy and Therapy*		FTE*: 10.3 Visits: 18,561	FTE*: 0.24 Visits: 1,024	FTE*: 6.79 Visits: 12,506	Day Hospital: FTE*: 2.1 1100 served Outpatient: FTE: 1.85 Stroke Admissions: 35	FTE*: 2.3 Visits: 5,947	

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
assistants							
Eligibility (Patient Population)							
CCAC							
Capacity (Beds, FTE, Funding etc.)	CIHI 08/09 Total Stroke Clients receiving Rehab services in ESC LHIN: 376 Mean Total Rehab visits (OT, PT, SLP, SW combined): 4.5						
Eligibility (Patient Population)							
CHC	Windsor Essex CHC			Chatham Kent CHC	Grand Bend CHC	North Lambton CHC	
Capacity (Beds, FTE, Funding etc.)	FTE:14.5 + 2 med secretaries			FTE: 1.0 OT for COPD and Falls 0.5 PT serving clients in Wallaceburg	FTE:10	FTE: 3.4	
Eligibility (Patient Population)				COPD and Fall Prevention	COPD and Outpatient musculoskeletal and neuro	COPD and Fall Prevention	
OHIP Designated Physio Clinics	Advanced Rehabilitation Centre	Wardle's Physiotherapy Clinic	none	none	Sarnia Community Care Physiotherapy	Sam Shuqauir Physiotherapy	
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
CARDIAC REHABILITATION	Windsor Essex Cardiac Wellness		Windsor Essex Cardiac Wellness				
Capacity (Beds, FTE, Funding etc.)	420 clients/year		80 clients/year				
Eligibility (Patient Population)							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
COMMUNITY SUPPORT							
DAY PROGRAMS	CHRYSALIS			NEW BEGINNINGS CLUBHOUSEAND STROKE RECOVERY ASSOCIATION			
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)	ABI			ABI and Stroke			
ASSISTED LIVING SOUTHWEST ON							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
PRIMARY CARE							
PRIMARY CARE				Thamesview FHT			
Capacity (Beds, FTE, Funding etc.)				1 FTE OT			
Eligibility (Patient Population)							
GERIATRIC							
POPULATION SERVED	58% of ESC LHIN seniors live in W/E: 2012 = 58759, projected increase by 2017 = 67262			18% live in C/K: 2012 = 18236, projected increase by 2017 = 20874	24% live in S/L: 2012 = 24314, projected increase by 2017 = 27833		population over age 65: 2012 - 101,309 projected increase by 2017 - 115,969
EMERGENCY CARE	GEM Nurse Program	GEM Nurse Program	GEM Nurse Program	GEM Nurse Program	GEM Nurse Program		
Capacity (Beds, FTE, Funding etc.)							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Eligibility (Patient Population)							
ACUTE CARE							
Capacity (Beds, FTE, Funding etc.)							Medically Complex (Convalescence, Debility): 1,123
Eligibility (Patient Population)							In ESC LHIN seniors 65+ account for: 66% of hospital days, 86% ALC days, 20% ED visits, 59% of readmits within 30 days (from ESC LHIN SFH report)
ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION		
Capacity (Beds, FTE, Funding etc.)	FTE: 4 Beds covered:	FTE: 3.2 Beds covered:	FTE: 1 Beds covered:	FTE: Beds covered:	FTE: 2.2 Beds covered: 76		
Eligibility (Patient Population)	Medicine			Medicine	Medicine		
REHABILITATION	SHORT TERM REHAB	GENERAL AND SPECIAL REHABILITATION		GENERAL REHABILITATION	GENERAL REHABILITATION		
Capacity (Beds, FTE, Admissions etc.)	NRS 10/11 Medically Complex and Debility: 38	NRS 10/11 Medically Complex and Debility: 96		NRS 10/11 Medically Complex and Debility: 61	NRS 10/11 Medically Complex and Debility: 49		

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Eligibility (Patient Population)	anticpated LOS < 2 weeks						
ASSESS-RESTORE	ASSESS-RESTORE	REACT	ASSESS-RESTORE	ASSESS-RESTORE			
Capacity (Beds, FTE, Funding etc.)	15 beds FTE: 4 Annual admissions: 525	6 beds FTE: 2.2	10 beds FTE: 2.47 Annual admissions: 431 (projected)	10 beds FTE: 3.06	none		
Eligibility (Patient Population)	>65 years of age Potential d/c to home or rest home Able to direct own care 90% of time One person assist or better No restraints, wounds, IV/IM narcotics						
COMMUNITY REHABILITATION							
HOSPITAL OUTPATIENT		WRH	Leamington	CKHA	Bluewater	Bluewater-CEEH	
Capacity **FTE: combined PT, OT, SLP, SW , Recreation Therapy and Therapy assistants*		FTE*: 10.3 Visits: 18,561	FTE*: 0.24 Visits: 1,024	FTE*: 6.79 Visits: 12,506	Day Hospital: FTE*: 2.1 1100 served Outpatient: FTE: 1.85 Visits: 4,014	FTE*: 2.3 Visits: 5,947	
Eligibility (Patient Population)							
CCAC							
Capacity (Beds, FTE, Funding etc.)	Total Clients receiving Rehab services: 8752 Total visits OT: 12864 PT: 18535 SLP: 2646 SW: 1303						
Eligibility (Patient Population)							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
CHC	Windsor Essex CHC			Chatham Kent CHC	Grand Bend CHC	North Lambton CHC	
Capacity (Beds, FTE, Funding etc.)	FTE:14.5 + 2 med secretaries			FTE: 1.0 OT for COPD and Falls 0.5 PT serving clients in Wallaceburg	FTE:10	FTE: 3.4 (OT, SW, Resp, PT)	
Eligibility (Patient Population)				COPD and Fall Prevention	COPD and Outpatient musculoskeletal and neuro	COPD and Fall Prevention	
OHIP Designated Physio Clinics	Advanced Rehabilitation Centre	Wardle's Physiotherapy Clinic	none	none	Sarnia Community Care Physiotherapy	Sam Shuqauir Physiotherapy	
Capacity (Beds, FTE, Funding etc.)	FTE: 2.5 PT / 6 PTA	FTE: 7 PT/PTA			FTE: 1 PT		
Eligibility (Patient Population)							
CARDIAC REHABILITATION	Windsor Essex Cardiac Wellness		Windsor Essex Cardiac Wellness				
Capacity (Beds, FTE, Funding etc.)	420 clients/year		80 clients/year				
Eligibility (Patient Population)							
COMMUNITY SUPPORT							
DAY PROGRAMS				NEW BEGINNINGS CLUBHOUSEAND STROKE RECOVERY ASSOCIATION			
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)				ABI and Stroke			
ASSISTED LIVING SW ON							
Capacity (Beds, FTE, Funding etc.)							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Eligibility (Patient Population)							
PRIMARY CARE							
PRIMARY CARE				Thamesview FHT			
Capacity (Beds, FTE, Funding etc.)				1 FTE OT			
Eligibility (Patient Population)							
Specialized Geriatric Services	Windsor-Essex Geriatric Assessment / Consultation Program						
Capacity (Beds, FTE, Funding etc.)	4.5 FTE (RN/PT/OT) + Team physician + 2 part-time geriatricians, and support from SWOGAN						
Eligibility (Patient Population)	Individuals 55 and over, meeting specific referral criteria						
CARDIORESP							
POPULATION SERVED							
EMERGENCY CARE							
Capacity (Beds, FTE, Funding etc.)	120 ED visits /month CHF & Pulmonary; plus 160 ED visits/month COPD			45 ED visits/month + 80 visits/month	40 ED visits/month + 70 visits/month		
Eligibility (Patient Population)							
ACUTE CARE							
Capacity (Beds, FTE, Funding etc.)							CHF/COPD: 2,474
Eligibility (Patient Population)							
ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION	ACTIVATION/AMBULATION		
Capacity (Beds, FTE, Funding etc.)	FTE: 4 Beds covered:	FTE: 3.2 Beds covered:	FTE: 1 Beds covered:	FTE: Beds covered:	FTE: 2.2 Beds covered: 76		
Eligibility (Patient Population)	Medicine			Medicine	Medicine		

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
REHABILITATION	SHORT TERM REHAB	GENERAL AND SPECIAL REHABILITATION		GENERAL REHABILITATION	GENERAL REHABILITATION		
Capacity (Beds, FTE, Admissions etc.)	2010 NRS Admissions: 15	2010 NRS Admissions: 2		2010 NRS Admissions: 24	2010 NRS Admissions: 22		
Eligibility (Patient Population)							
ASSESS-RESTORE	ASSESS-RESTORE	REACT	ASSESS-RESTORE	ASSESS-RESTORE			
Capacity (Beds, FTE, Funding etc.)	15 beds FTE: 4 Annual admissions:	6 beds FTE: 2.2	10 beds FTE: 2.47 Annual admissions:	10 beds FTE: 3.06	none		
Eligibility (Patient Population)	>65 years of age Potential d/c to home or rest home Able to direct own care 90% of time One person assist or better No restraints, wounds, IV/IM narcotics						
COMMUNITY REHABILITATION							
HOSPITAL OUTPATIENT		WRH	Leamington	CKHA	Bluewater	Bluewater-CEEH	
Capacity **FTE: combined PT, OT, SLP, SW , Recreation Therapy and Therapy assistants*		FTE*: 10.3 Visits:	FTE*: 0.24 Visits:	FTE*: 6.79 Visits:	Day Hospital: FTE*: 2.1 1100 served Outpatient: FTE: 1.85 Visits:	FTE*: 2.3 Visits:	
Eligibility (Patient Population)							

	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
CCAC							
Capacity (Beds, FTE, Funding etc.)	Total Clients receiving Rehab services: 8752 Total visits OT: 12864 PT: 18535 SLP: 2646 SW: 1303						
Eligibility (Patient Population)							
CHC	Windsor Essex CHC			Chatham Kent CHC	Grand Bend CHC	North Lambton CHC	
Capacity (Beds, FTE, Funding etc.)	FTE:14.5 + 2 med secretaries			FTE: 1.0 OT for COPD and Falls 0.5 PT serving clients in Wallaceburg	FTE:10	FTE: 3.4 (OT, SW, Resp, PT)	
Eligibility (Patient Population)				COPD and Fall Prevention	COPD and Outpatient musculoskeletal and neuro	COPD and Fall Prevention	
OHIP Designated Physio Clinics	Advanced Rehabilitation Centre	Wardle's Physiotherapy Clinic	none	none	Sarnia Community Care Physiotherapy	Sam Shuqauir Physiotherapy	
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
CARDIAC REHABILITATION		Windsor Essex Cardiac Wellness	Windsor Essex Cardiac Wellness	CKHA Cardiac Rehab Program	Cardiac Rehab Program (private)		
Capacity (Beds, FTE, Funding etc.)		420 clients/year over 23,000 visits/year	80 clients/year	128 clients/year FTE: 0.84 (Kin, Dietitian, RN)			
Eligibility (Patient Population)							
COMMUNITY SUPPORT							
DAY PROGRAMS							
Capacity (Beds, FTE, Funding etc.)							

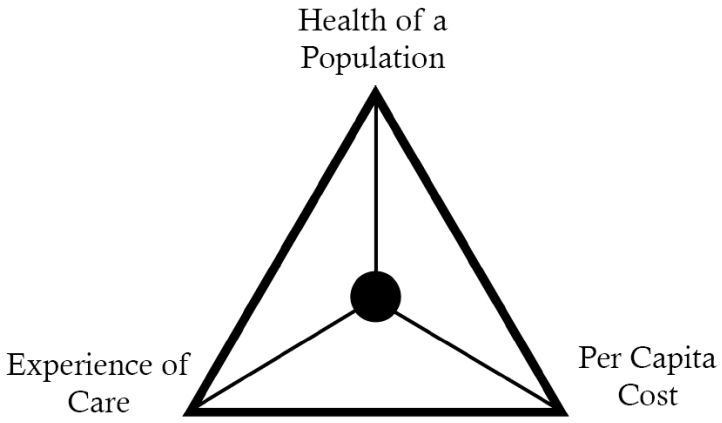
	WINDSOR-ESSEX			CHATHAM-KENT	SARNIA-LAMBTON		ESC LHIN
HOSPITAL	**Hotel-Dieu Grace Hospital**	**Windsor Regional Hospital**	**Leamington District Memorial Hospital**	**Chatham-Kent Health Alliance**	**Bluewater Health**	**Charlotte Englehart Hospital**	**LHIN TOTAL ADMITS DAD 10/11**
Eligibility (Patient Population)							
ASSISTED LIVING SW ON							
Capacity (Beds, FTE, Funding etc.)							
Eligibility (Patient Population)							
PRIMARY CARE							
PRIMARY CARE				Thamesview FHT			
Capacity (Beds, FTE, Funding etc.)				1 FTE OT			
Eligibility (Patient Population)				rostered patients			
OTHER		WRH Pulmonary Rehab Program					
Capacity (Beds, FTE, Funding etc.)		$63,000 annual funding; FTE: 0.3 PT, 0.3 RT; can see 72 pts/yr					
Eligibility (Patient Population)							

Appendix D: IHI's Triple Aim Framework

The Institute for Healthcare Improvement's (IHI) Triple Aim framework provides the LHIN with a tool to evaluate its progress and success across a variety of areas relevant to the overall aims of the initiative. The ESC LHIN will apply the Triple Aim concept and processes in it three-year planning horizon.

About the Triple Aim

- Triple Aim is a strategic concept developed by the IHI, an independent not-for-profit organization based in Cambridge, Massachusetts.
- The Triple Aim approach fits well with the provincial mandate of the LHINs.
  - Defines 'quality' from the perspective or experience of the individual.
  - Encourages organizations to develop partnerships in their communities and to involve other health care and non-health care providers, community groups, patients and their families in a coordinated effort to reach their goals.



- "Better care for individuals, better health for populations, and lower per-capita costs." These three interdependent goals are the basis for the Institute for Healthcare Improvement's (IHI's) Triple Aim Initiative and have become a unifying vision for health system design.

The Triple Aim framework has been used across the globe to improve the coordination and delivery of care, remove waste, and redirect resources toward activities that have the greatest impact on health.

Appendix E: ESC Rehab System Current and Future State Gap Analysis

A. Support Optimal Health Outcomes			
Future State Statements	**GAPS**	**Current State SWOT Analysis**	
1. Service Providers have Specialized Expertise - Specialty resources for specific patients - Comprehensive Geriatric Assessment (CGA); Hospital Elder Life Program (HELP) - All health care providers accountable for health education and risk assessment - Evidenced based program (ie. HELP) in every hospital in ESC LHIN - Dedicated community stroke rehab teams - Geriatric specialty resources - Geriatric rehab delivered by qualified multidisciplinary staff working to scope	**Strength: Need methods to build on expertise and collaboration** - Inventory and standardize the expertise in the LHIN, and then strategically place it within regions - Standardize assessment tools and management strategies - Create centres of excellence that integrate rehab into daily activities to achieve three hours of therapy per day **Opportunity:** • Geriatrician (London) available for consults • Physiatry available in Windsor • Parkwood specialty centre for Sarnia	**Weakness: Health Human Resources** - There is an expertise and specialization shortage - Do not always have the right mix of people with the right expertise to provide the care - Need expertise with certain patient populations to achieve the best outcomes - Lack of geriatricians in LHIN - Need Physiatry coverage in areas other than Windsor - Lack of specialized community resources for patients being discharged from specialty centers (e.g. day rehab)	
Little or no progress (0-20%): **9**	Some initiatives started (21-50%): **14**	Most initiatives underway (51-75%): **0**	Almost all is in place (76-100%): **0**
2. Best Practices to Optimize Recovery - Environment conducive to recovery - Appropriate intensity for patients' tolerance - 6 to 7 day a week therapy (if best practice) for all populations - Optimize patient function at all stages of recovery	**Opportunity: Best Practices** - Select relevant best practices - Consensus on standard language, pathways, metrics and targets - Integrate rehab into regular, daily functions to meet intensity targets - Capitalize on the activation model in	**Weakness: Health Human Resources** - There is no coverage for vacations, illness for rehab resources - Staff are spread too thin - Key services staff are missing (ie. SLP) - Need to explore other staffing models - Units staffed based on funding (not pt	

A. Support Optimal Health Outcomes			
Future State Statements	**GAPS**	**Current State SWOT Analysis**	
- Post stroke depression, spasticity follow up - Reintegrated patients back into community - CHF COPD support in home to prevent readmissions (ER) - Prevent deconditioning; loss of independence; complications	acute care for all >65 **Opportunity: Staffing Models** - Standardize staffing norms/rations across the LHIN - Practitioners should be practicing in full scope (right time, right place)	need) 1:5 - Unaware of staffing "best practice" models for stroke ortho (hip #) geriatric medically complex patients	
Little or no progress (0-20%): **17**	Some initiatives started (21-50%): **6**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):
3. Focus on Prevention & Risk Reduction - Reduce falls - Reduce cognitive (delirium) challenges - Decrease medical event - Decrease re-occurrence and readmission - For recurrence of stroke - Management of risk factors - Preventative measures FHT, CHC - Understand cause of disability or fracture figure out prevention and apply in FHT/CHC - Primary care to offer mental/physical wellness education - Trends of "stroke" – causes & prevention - Education re: stroke symptom recognition - Seniors health screening for risk factors - More robust public health programs focused	**From flip charts (Blend with A4):** - Stroke prevention clinics available Sarnia/Chatham/Windsor - Stroke prevention (secondary) in acute care	**From flip charts (Blend with A4):** - Lack of coordinated system for falls prevention - Lack of pharmacists participating in care - Lack of activation – prevention of deconditioning not high enough priority in acute care - Current state related to falls is silo'd - Lack of awareness of prevention programs for stroke, falls, COPD cardiac - Lack of standardized pathway for falls and fall prevention (throughout continuum (acute to community)) - Combination of lack of resources and training with RN/RPN	

A. Support Optimal Health Outcomes			
Future State Statements	**GAPS**	**Current State SWOT Analysis**	
on Musculoskeletal health reducing the need for surgical interventions and rehab.			
Little or no progress (0-20%):	Some initiatives started (21-50%): **19**	Most initiatives underway (51-75%): **4**	Almost all is in place (76-100%):

B. Provide the Best Patient Experience			
Future State Statements	**GAPS**	**Current State SWOT Analysis**	
1. Equitable, Timely Access - Access to Specialists via OTN local clinic visits - Equitable access & choice (rural or urban) - Freedom of choice regarding access to the right program or service - Cost-effective, convenient transportation - Availability to rural/remote areas to come to rehab centre - No wait times - Access to primary care - Access to outpatient and community rehab	**Opportunity: Use of Technology for Access and Leveraging Expertise** - Use technology to leverage expertise where we can (i.e. to access centres of excellence and specialized care) **From flip charts:** - Improve transportation and access to a concrete(?) location - Understanding who and what is funded amongst the providers across the continuum and the criteria	**Weakness: Access to Community and Home Care** - Outpatient resources are limited with long wait lists that mean patient stay as inpatients longer - Inequity of access based on referral source - Too many waiting lists - Travel for staff is not preferable **From flip charts:** - No standardization to wait list criteria - Lack of OHIP funded providers in the communities	
Little or no progress (0-20%): **19**	Some initiatives started (21-50%): **4**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):
2. Smooth Care Transitions - Well informed, smooth transitions (need to know contact for info “go to person”) - Only tell story once – EPR one patient, one	**From flip charts:** - Clarification across continuum eligibility - Standardize ass. and communication tools amongst the providers	**Strength: Spirit of Collaboration is Strong** - Partnerships and collaboration are strong throughout the LHIN - Could improve communications	

B. Provide the Best Patient Experience			
Future State Statements	**GAPS**	**Current State SWOT Analysis**	
record - Involve my family – keep informed - Clear, efficient communication - Building trust in relationships with clients across the continuum - No wait at each transition across the continuum	- Who is measuring quality in each area of transition and standardize the measures	- LHIN representatives are supportive and value rehab services - Organizations have learned to become lean and resourceful in the care delivered across the sector **From flip charts:** - Each organization uses a different satisfaction survey method (some can afford NRC Pickard etc)	
Little or no progress (0-20%): **5**	Some initiatives started (21-50%): **15**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):
3. Standard Pathways and Planning for return to function - Need standardized pathways - Standardized flow and no waiting - An environment conducive to recovery - Adequate post op follow up therapy - A plan that includes a return to work - LHIN wide pathway for TJR from pre-surgical to full recovery (to plan for episode of care)	**From flip charts:** - Decision making – how do we convince them (doc/team) with the data	**From flip charts:** - No consistency in pathway availability - Inconsistent use of pathways/standards - Barriers to pathway: • urban vs. rural • Doc preference varies • B.P. not followed by all • Lack of consensus by ply.	
Little or no progress (0-20%): **3**	Some initiatives started (21-50%): **20**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):
4. Teaching patient self-management - Patient involvement in goal setting and co-ordinating care - Patients be provided with/taught easy to	**Opportunity: Best Practices** - Patients take on increased responsibility in their ongoing management and care **From flip charts:**	**From flip charts:** - Reactive system in everything!! i.e. falls, chronic disease mgmt - System navigation is complex and	

B. Provide the Best Patient Experience			
Future State Statements	**GAPS**	**Current State SWOT Analysis**	
understand, accurate information - Allowing patients to live at risk **5. Other** - Affordable/accessible housing - Hospital experience is individualized, Senior friendly - Knowledgeable staff work together, timely, responsive - Pharmacy visits to seniors in home	- Rights to live at risk vs. (6) a system that imposes our beliefs of risk - Health promotion earlier i.e., 50 year olds FHTs - Chronic disease support with incentives to attend and source benefits - Senior friendly - Train staff how to care for geriatric population	layered with barriers	
Little or no progress (0-20%): **4**	Some initiatives started (21-50%): **19**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):

C. Ensure Effective Cost Management		
Future State Statements (Comments)	**GAPS**	**Current State SWOT Analysis**
1. Appropriate Allocation of Resources - "Sizing" the system with right number of beds (i.e. community rehab is less costly than in patients) - Community centred groups (i.e. CDM) more established and utilized (i.e. Stanford Model)	**Opportunity: Clarify Role of Rehab** - Need a paradigm shift in thinking: rehab is not a "location" and function not as a "disease" - Demonstrate the contribution of rehab services to relieving system pressures - Need an evidence-based marketing/ PR campaign to demonstrate rehab tangible contributions to relieving system problems (ALC, LOS) **From Flip Charts:** - Linking services available – methods,	**Weakness: Allocation of Resources** - Resources are not always where the care is needed - Need to leverage more of the community resources **Threat: Lack of Understanding of Rehab** - Lack of understanding of rehab and its contributions to relieving system pressures leads to service cuts **From Flip Charts** - Decisions about funding is not system based vs. individual agencies

C. Ensure Effective Cost Management			
Future State Statements (Comments)	**GAPS**	**Current State SWOT Analysis**	
	knowledge, forum, marketing (social)	- Decisions based on cost - Lack of prediction model (with probabilities) - Lack of access to data (transparency) - Lack of common data collection tools - Lack of data on outcomes linked to cost and service - Patient record fragmented esp. ambulatory journey - Lack of program inventory - Lack of data on costs - Lack of outcome data on specific services	
Little or no progress (0-20%): **19**	Some initiatives started (21-50%): **5**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):
2. Shared Cost Model - Shared cost model - Health spending account - Transportation available at low cost to patients in rural/remote area to come to rehab centre (also applies to Patient Experience)	**Opportunity: New Funding Model/Solutions** - Need to change the funding model - Need to identify what can be done with current funding to reallocate resources to enhance rehab - Look for cost-effective non-bedded solutions **Opportunity:** - Funding should follow the patient into the community	**Weakness: Funding Pressures** - Need incentives to change the system that make sense for patient outcomes (ie. hospitals are funded to keep beds full, need to do more work on discharge/admits) **From flip charts:** - RM&R - Lack of remote/mobile access to PT/specialty e.g. northern service	

C. Ensure Effective Cost Management			
Future State Statements (Comments)	**GAPS**	**Current State SWOT Analysis**	
	- We need to increase use of lower cost, non-regulated workers to assist in the community - Continuous improvement using lean principles and philosophies to achieve right provider at right time - Incentives and pay for performance **From Flip Charts:** - PT navigator for all Dx. - System (rehab) coordinator e.g. end-of-life (B. Lambie) - ABI CCAC Team and other specialized community based teams - ABI/Private insurers have navigators (some)	providers - Lack of PT-specific funding - Lack of outcome or service knowledge for PT or provider to develop service plan - Lack targets for e.g. re-admits; LOS; ER Visits; LOS-OP; "slinky model" (decrease service as self-mgmt increases) - Lack of decision making forums entering into budget cycles (including lack of knowledge on impact downstream) - ABI CCAC Team in CK	
Little or no progress (0-20%): **17**	Some initiatives started (21-50%): **6**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):
3. Decrease cost to education/specialists by using variety of methodologies - Partnership with Parkwood geriatric - Grand rounds - Geriatric Refresher day - RGP/RPP	**Opportunity: Education** - Regular grand rounds philosophy – regular times & topics attended by all rehab staff in the LHIN - Use of OTN for training - Create connections and partnerships with centres of expertise (Parkwood and GTA rehab network) **From flip charts:**	**Weakness: Education** • Education is the first thing to get cut when budgets are tight **From flip charts:** • OTN • AHPPD fund	

C. Ensure Effective Cost Management			
Future State Statements (Comments)	**GAPS**	**Current State SWOT Analysis**	
	- Equipment funding for remote connections and remuneration - Robotics/simulators - Prioritization mechanism for service need, funding, PT need - Inventory of HHR and project need - Specialization (lack of) and access to the service - Need more work on IPC practice		
Little or no progress (0-20%): **10**	Some initiatives started (21-50%): **11**	Most initiatives underway (51-75%): **1**	Almost all is in place (76-100%):
4. Early Intervention - Early access to the right resources (front-load) to reduce LOS, referrals to rehab unit - Geriatric "rehab" starts in Emergency/ admission and follows through to discharge - Assign target LOS (I.P/O.P) across the continuum by RCG - Maximize access to TPA LHIN wide (stroke)	**From flip charts:** - Service goes to PT/family in community services – for ED and prevention - IPC team – knowledge float between sectors - Recommend target staffing per sector e.g. ER, ICU/PCU - Simulation exercise for each population (case study) - CHC and FHT standard staffing and chronic	**From flip charts:** - New beginnings "clinic" space used for e.g. SLP	
Little or no progress (0-20%): **12**	Some initiatives started (21-50%): **11**	Most initiatives underway (51-75%):	Almost all is in place (76-100%):

Comments on Other Populations	
Category	**Comments (not already captured above)**
Health Outcomes	• Rehab services provided for individuals with lower income who are not eligible for services that are ministry funded • Identify diagnosis with prescription medication to pharmacy • Hospital discharge connected to FHT pharmacist (community) in a timely manner
Patient Experience	• One stop shop such as Day Hospital model when patients need increased level of intensity/range of services • Patient navigator for each patient e.g. SW
Cost Management	• Provide full continuum of care to enable the provision of needed service in the most cost effective location e.g. day rehab, out patients • Use of OTN for physiatrist support across the LHIN
Other	• Shared/centralized professional development strategy • Future state for ABI • Rec. Used to reintegrate to community for ABIs. OTs as well • CCAC availability on weekend passes for inpatient rehab

Summary of Future State Results

- Decrease LOS
- Decrease ALC
- Decrease Falls, Wounds
- Increased Patient Satisfaction
- Decreased Delirium
- Increased % of patients return home

Appendix F: Goals Prioritization Criteria and Process

Goals (Short)	Goals – Full Text
1. Falls Prevention	1. Develop an ESC-wide collaborative seniors fall prevention strategy
2. Understanding Rehab	2. Increase public/health care professional understanding of rehab and the resources available. Reinforce the philosophy of rehabilitation through formal education and marketing.
3. Inpatient Activation	3. Expand activation for the complex inpatient population (on medical units).
4. Best Practices	4. Develop & implement Best Practice for top 3 clinical conditions across the rehab continuum
5. Standards for Expertise	5. Develop standards for rehabilitation expertise
6. Centres of Excellence	6. Develop regional centres of excellence (cluster patient groups)
7. Continuum System Map	7. Develop a system map that streamlines the services to meet the varied rehab needs of ESC residents across the continuum of care.
8. System Navigator	8. Develop a system navigator role (transition coach) for rehabilitation resources
9 & 13. Access to Out-Patient	9. Improve access to funded out-patient rehab services (outreach/allied health/day programs). (13) Adequate Outpatient Rehab Services (hospital & community) to support patient flow.
10. Self-Management	10. Integrate self management philosophy with residents & families in each program
11. Standardized Tools	11. Identify and implement standardized tools for application in assessment, communication (e.g. transitions), measurement of patient and program outcomes, etc.
12. Standard Staffing Model	12. Standardize the staffing models (staff mix & skill sets) in rehab programs across the LHIN
14. Inpatient Bed Use	14. Facilitate the appropriate use of inpatient rehab beds
15 Professional Developmt.	15. LHIN wide strategy for professional development
16. Predictive Models	16. Develop predictive models for rehab utilization and growth for sustainability of programs for top five diagnoses over the next ten years

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2. Goal Prioritization

- Prioritization was based on three dimensions:
  1. Weighted & unweighted criteria
  2. Relative ranking
  3. Ease of implementation vs. impact

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3. Criteria For Ranking of Goals

Weighted

1. Addresses a legislated requirement that is not already in place
2. Is an identified MOHLTC and/or LHIN priority or Rehab CCC Expert Panel priority
3. Addresses a very large gap in current programs and services
4. Will improve the results of a Publicly Reported Quality Indicator

Not Weighted

1. Is very easy and quick to implement
2. Has a sustainable positive impact on: Quality of care (with measurable outcome indicators)
3. Has a sustainable positive impact on: Client experience (as measured through surveys)
4. Has a sustainable positive impact on: Health system costs (direct and upstream/downstream)
5. Addresses the needs of patients with high health system utilization costs
6. Requires very little investment and has an ROI of less than 2 years
7. Does not requires any additional human resources to be implemented
8. Responds to a specific and significant client risk issue
9. Results in a much more efficient use of resources
10. Addresses the needs of a high volume population
11. Has been identified as a priority by patients

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4. Results of Criteria Ranking of Goals

Ranking	Goals
1	14. Appropriate Inpatient Bed Use
2	4. Best Practices
3	13. Access to Out-Patient Services
4	9. Access to Out-Patient Services
5	11. Standardized tools
6	7. Continuum System Map
7	16. Predictive Utilization Models
8	1. Falls Prevention
9	12. Standard Staffing Model
10	3. Inpatient Activation (Medicine)
11	15. Professional Development
12	10. Self-Management
13	8. System Navigator
14	5. Standards for Expertise
15	2. Understanding Rehab
16	6. Centres of Excellence

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5. Results of Relative Ranking of Goals

Ranking	Goals
1	7. Continuum System Map
2	4. Best Practices
3	14. Appropriate Inpatient Bed Use
4	9. Access to Out-Patient
5	3. Inpatient Activation (Medicine)
6	13. Access to Out-patient
7	1. Falls Prevention
8	16. Predictive Utilization Models
9	5. Develop standards for rehabilitation expertise
10	12. Standard Staffing Model
11	10. Self-Management
12	11. Standardized Tools
13	2. Understanding Rehab
14	15. Professional Development
15	8. System Navigator
16	6. Centres of excellence (cluster patient groups)

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6. Variance Analysis

Relative Ranking	Relative Difference	Criteria Ranking
1. Continuum System Map	5	1. Inpatient Bed Use
2. Best Practices	0	2. Best Practices
3. Inpatient Bed Use	-2	3. Access to Out-Patient (13)
4. Access to Out-Patient (9)	0	4. Access to Out-Patient (9)
5. Inpatient Activation	5	5. Standardized Tools
6. Access to Out-Patient (13)	-3	6. Continuum System Map
7. Falls Prevention	1	7. Predictive Models
8. Predictive Models	-1	8. Fall Prevention
9. Standards for Expertise	5	9. Standard Staffing Model
10. Standardized Tools	-5	10. Inpatient Activation
11. Standard Staffing Model	-2	11. Professional Development
12. Self-Management	0	12. Self-Management
13. Understanding Rehab	2	13. System Navigator
14. Professional Development	-3	14. Standards of Expertise
15. System Navigator	-2	15. Understanding Rehab
16. Centres of Excellence	0	16. Centres of Excellence

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7. Reconciling the Variances

- Goals with 5 point variances will be discussed to determine if there was a common understanding of the goal and/or if the goal is seen more as an enabler or dependency for another goal.
- Goals to Discuss:
  1. Develop a **system map** that streamlines the services to meet the varied rehab needs of ESC residents across the continuum of care. (ranked 1 & 6)
  2. Expand **activation** for the complex inpatient population (on medical units). (ranked 5 & 10)
  3. Identify and implement **standardized tools** for application in assessment, communication (e.g. transitions), measurement of patient and program outcomes, etc. (ranked 5 & 10)
  4. Develop standards for **rehabilitation expertise** (ranked 9 & 14)

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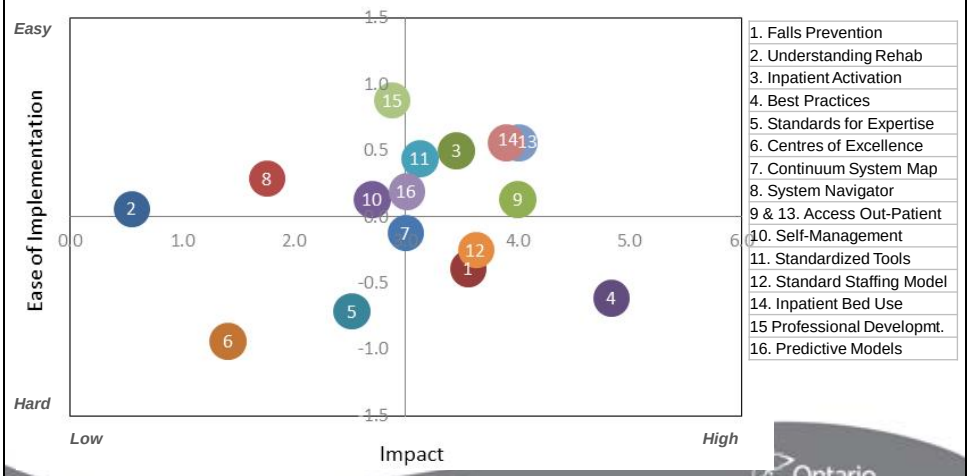
8. Impact vs. Ease of Implementation



1. Falls Prevention
2. Understanding Rehab
3. Inpatient Activation
4. Best Practices
5. Standards for Expertise
6. Centres of Excellence
7. Continuum System Map
8. System Navigator
9 & 13. Access Out-Patient
10. Self-Management
11. Standardized Tools
12. Standard Staffing Model
14. Inpatient Bed Use
15 Professional Developmt.
16. Predictive Models

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9. Summary of Goal Prioritization

Confirm the top priority goals:

1. Inpatient Bed Use (high impact, easier to implement)
2. Best Practices (very high impact, not easy to implement)
3. Access to Out-Patient Services (high impact, medium difficulty to implement)
4. Inpatient Activation (medium impact, easier to implement)
5. Standardized Tools (medium impact, easier to implement)
6. Continuum System Map (medium impact, medium difficulty to implement)

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