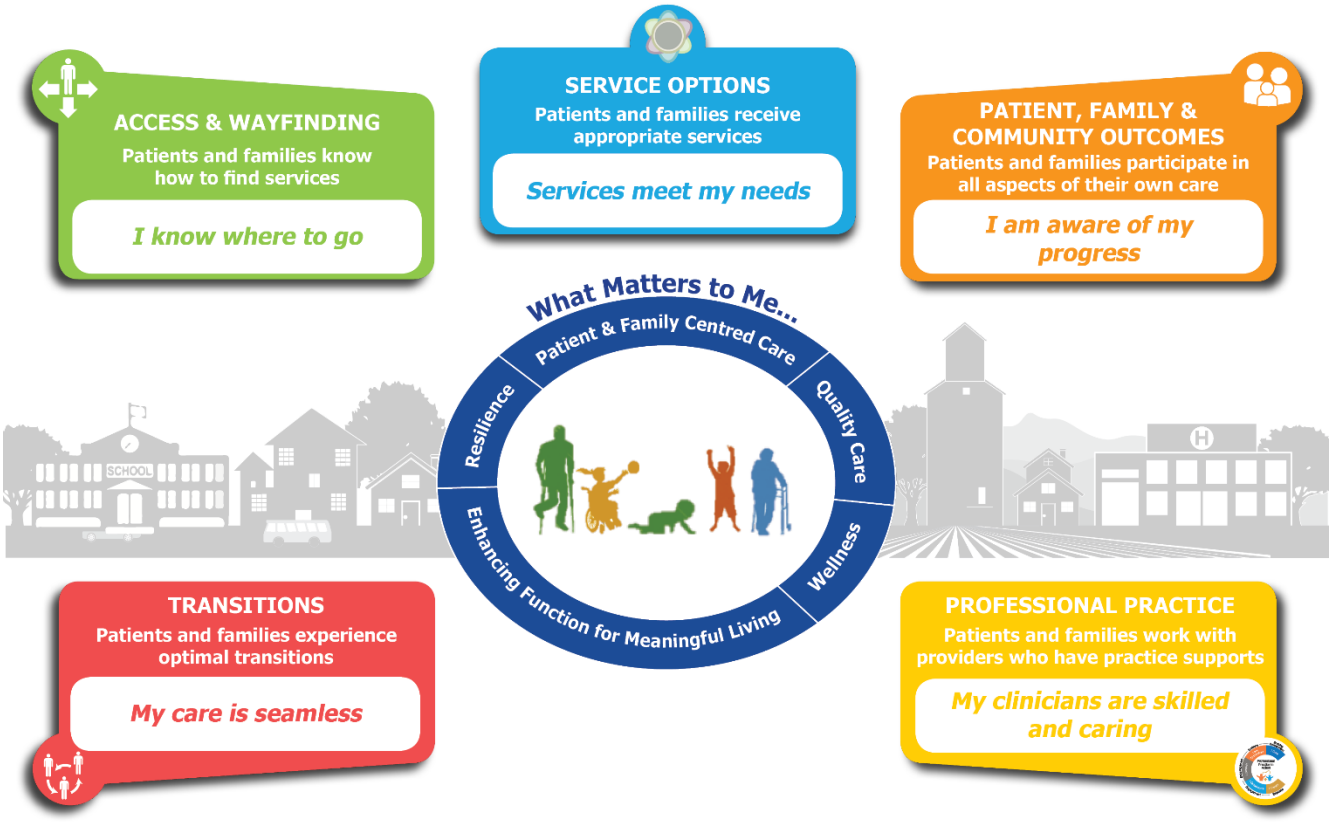
Rehabilitation Model of Care

A discussion guide for clinicians, practice leaders and operational leaders



RESEARCH | INNOVATION | TECHNOLOGY

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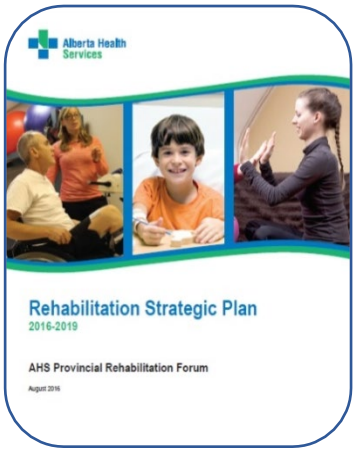
Background

Rehabilitation improves patient/client outcomes, health system efficiency, medical and surgical intervention effectiveness, and the health, quality of life, and productivity of a community. Rehabilitation services partner with the patient/client, family, other service providers and communities to address health needs from being healthy and getting better, to living well with illness or disability and end of life.

The Rehabilitation Conceptual Framework (RCF; AHS, 2018) guides the conceptualizing, designing, and delivery of rehabilitation services in AHS. The philosophy of rehabilitation in AHS is centred on **enhancing function for meaningful living** and on enabling people to identify, reach and maintain cognitive, communication, emotional, physical, psychological, social, and spiritual health goals. By focusing on abilities and facilitating resourcefulness, rehabilitation aims to: maintain, prevent, slow, improve, restore, or compensate for lost function in order to improve inclusion and participation (WHO, 2012).



In 2016, AHS developed a three year provincial Rehabilitation Strategic Plan. Among five, an important strategy in the plan centred on building a unified, sustainable provincial blueprint for rehabilitation. A key action under this strategy involved developing a Model of Care for rehabilitation in the province.

A Model of Care guides service planning and broadly defines the way in which health care is delivered. Standardization of elements within a model of care creates and reinforces a consistent implementation that in turn yields accessible, appropriate, effective, efficient and safe rehabilitation experiences and outcomes for clients/patients, families, and communities.

The Rehabilitation Model of Care (R-MoC) was developed to be foundational to planning and delivering rehabilitation services across sectors in AHS and approved by the Provincial Rehabilitation Steering Committee in 2018.

This guide is offered to facilitate discussion and advance implementation of the R-MoC and its universal elements.

Rehabilitation Model of Care (R-MoC)

R-MoC Philosophy & Concepts

People are at the centre of rehabilitation in AHS, demonstrated in the R-MoC graphic. The centr e of the model asks 'What Matters' to patients/ clients, their families and communities.

"What matters to you matters to us."
(Patient First Strategy, AHS)

Understanding what matters leads to quality care that is focused on enhancing function for meaningful living.

Integral to the R-MoC is a wellness approach – a holistic understanding of health that includes cognitive, psychological, social, emotional, spiritual, and environmental factors.

Through leadership and a shared commitment to implementing a provincial Rehabilitation Model of Care, **Patients/Clients & Families will say…**

"I have the ability to function and live well in my community."

• • •

"I know where to go - access points are clear and coordinated."

• • •

"The services meet my needs."

• • •

"I am progressing and there is a plan to help me achieve my goals. "

• • •

"I have caring and skilled providers."

The R-MoC encourages clients/patients to be active participants in their rehabilitation and in the process, build self-efficacy. The way that people think and feel about their condition has a significant impact on the ability to manage one's health behaviours and outcomes. Self-efficacy and wellness contribute to feelings of having control, which in turn creates motivation and capability to take on and persist with new and difficult tasks.

Another important concept within the R-MoC is resiliency - for patients/clients, families *and* providers. It calls on all to reflect upon and pursue opportunities that support and enhance personal resilience and wellness. A number of resources are available on Insite to help clinicians to build their own resiliency as well as to support the resiliency of those receiving rehabilitation services.

The six dimensions of quality described by the Health Quality Council of Alberta (HQCA) are foundational to the MOC and reflected in the evaluation of experience and outcomes.

R-MoC Components

Surrounding the patient/client and family are five core components described below. These components should be conceived of as non-linear and interactive. They are strongly interlinked, tied together by a commitment to helping patients/clients maintain wellness, develop or restore function, and get back to work, school, and life sooner after an injury or illness.

Access & Wayfinding structures and processes guide clients/patients, families, communities, and referral sources to access points for timely and appropriate rehabilitation programs and services.

The aim is to create system structures that enable clear and coordinated access to the right rehabilitation service at the right time. Web-based directories help to navigate AHS programs and services confidently. Path to Care and the Alberta Referral Directory support equitable access by standardizing referral processes and by monitoring wait times. Connect Care will further integrate and transform how providers and patients/clients find and access healthcare.

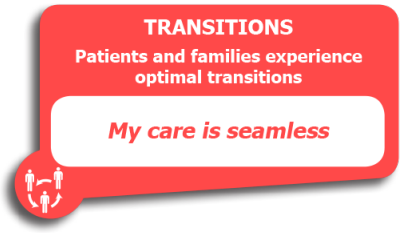
Service Options optimize the match between the specific needs of a patient/client, group or community through a variety of evidence-informed rehabilitation services. Rehabilitation providers meet those diverse needs by offering a variety of evidence-informed rehabilitation services. Work to standardize rehabilitation services across AHS will promote patient safety, experience, outcomes and system efficiency by providing quality services that are reproduced over time and in various locations.

When selecting among Service Options, consideration is given to the required type and level of service, amount, frequency, duration and intensity, settings, providers, and resources. Service types include prevention, health promotion, education, intervention, and case management.

Key Enablers

- Rehabilitation Conceptual Framework
- Professional Practice in Action
- Provincial Rehabilitation Strategic Plan
- Practice & Operational Leadership
- Workforce Planning
- Rehabilitation Client/ Patient & Family Advisory
- Population Needs Analytics
- Funding Models
- Data Performance
- Measurement
- IT Supports

Clients/patients are encouraged to be active participants in their rehabilitation through shared decision-making and collaborative goal setting. This is essential to facilitating their engagement with, and measuring meaningful progress from, the hard work that is required in the rehabilitation process. The aim is for clinicians to use a collaborative process to set functional goals that MATTER to clients. Clients are made aware of their progress through the consistent use of standardized tools and outcome measures. Tracking and monitoring of client outcomes and experience ensures that improvements are made both at the individual client and service level.



Transitions refer to the movement of clients and families' care between services, sectors, community and home. Transitions are planned from the outset of care based on current and future patient/client needs, co-created with patients, families and care teams, and evolve as needed. Seamless, well-coordinated care relies on many factors. From the initial visit, healthcare providers proactively plan with and support patients & families through treatment and points of transition to ensure continuity of care. Warm handovers ensure the continuation of patient-centered service delivery through well-planned conversations with clients/patients and their families to identify next appropriate services and to coordinate safe, timely, streamlined, and successful transitions within the healthcare system and into the community.

AHS has endorsed *Professional Practice in Action* (PPA) as a blueprint for optimizing professional practice. Professional practice is defined as "practice that reflects the commitment to caring relationships with patients and families and strong ethical values; utilization of specialized knowledge, critical inquiry and evidence-informed decision making; continuous development of self and others; accountability and responsibility for insightful competent practice; and, demonstration of a spirit of collaboration and flexibility to optimize service. PPA speaks to the need to recognize the roles of individuals (the 5 Cs) and of the organization (the 5 Es) in co-creating excellence in professional practice, which in turn enables quality, patient and family centred care.

Adopting the Model of Care will require health care providers, managers and leaders to consolidate existing and/or develop new competencies related to implementing and integrating each of the model components toward quality improvement and patient centered care.

Clinical guides and resources will support implementation of standardized services and, when needed, specialty orientation education will be developed.

A key resource underpinning the implementation of the R-MoC is HealthChange® methodology. This methodology provides an evidence based systematic framework and approach to support the development and maintenance of a variety of competencies required for the MoC which asks clinicians to engage in person centred conversations that promote client self-efficacy and self-management, shared decision making, client readiness, and collaborative goal setting.

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Research, innovation and technology are the building blocks for service provision within the MoC providing clinicians with the evidence and tools to inform their practice and implement both large and small scale improvements in processes, documentation and care. Ongoing research and the application of new technologies are essential to solving clinical problems and improving rehabilitation services and outcomes.

Implementing the Rehabilitation Model of Care

Cross-sector partnerships, along with engagement with community partners are crucial to creating collaborative and integrated rehabilitation services. As implementation progresses within and across sectors, and with provincial data to support improved decision making, the six dimensions of quality described by the Health Quality Council of Alberta (HQCA), will become a closer reality - yielding positive outcomes that increase client well-being and independence, improve client and family experiences - meeting the rehabilitation needs of Albertans in the community.

	**Acceptability**	Health Services are respectful and responsive to user needs, preferences and expectations
	Accessibility	Health services are obtained in the most suitable setting in a reasonable time and distance
	Appropriateness	Health services are relevant to user needs and are based on accepted or evidence-based practice
	Effectiveness	Health services are provided based on scientific knowledge to achieve desired outcomes
	Efficiency	Resources are optimally used in achieving desired outcomes
	Safety	Mitigate risks to avoid unintended or harmful results