

# Realizing the Potential of Rehabilitative Care for People with Complex Health Conditions: The Time Is Now

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## Abstract

In today's demographic landscape, with its aging population and increasing number of individuals who are living with multiple chronic conditions and comorbidities, the healthcare system is tasked with responding to the needs of medically complex individuals. However, the pressures arising from this emerging demographic are felt not only within the acute care sector at the point of medical crisis but along the entire continuum of the healthcare system. Rehabilitative care plays a key role in that continuum by providing the process through which individuals are engaged in interventions to address their functional (both cognitive and physical) and psychosocial care goals to help them carry on with the business of living.

"Once you set aside the acute phases or crises that mark injury or disease, much of modern health care is indeed rehabilitation in one form or another." Naylor (2009).

This paper outlines the role of rehabilitative care in supporting the oftentimes complex needs of those with multimorbidities. It describes how the themes of rehabilitative care are reflected within recently published system-level reports and how rehabilitative care can be used to support health system directions. This paper also includes a particular focus on the work of the newly established provincial Rehabilitative Care Alliance to promote rehabilitative care across

Ontario in alignment with Ministry of Health and Long-Term Care priorities, including care for those with complex health conditions.

## Rehabilitation within the Ontario Health System

Getting back to living one's life, once the medical crisis is addressed, falls very much within the purview of rehabilitation. Rehabilitation is "instrumental in enabling people with limitations in functioning to remain in or return to their home or community, live independently, and to participate in education, the labour market and civic life" (World Health Organization [WHO] 2016a, 2016b). Rehabilitation provides people with disabilities the structures and supports needed to attain independence and self-determination (WHO 2016a, 2016b).

Despite recognition of its important role, rehabilitation is not a comprehensive part of Canada's national health insurance plan. In Ontario, publicly funded rehabilitative care services are provided in varying degrees. Within hospitals, patients may receive rehabilitation as part of their acute care admission (including within an intensive care unit) if they are admitted to a designated rehabilitation bed or if they are admitted to a Complex Continuing Care (CCC) bed. In Ontario, rehabilitation or CCC beds may be located within an acute care hospital or may be within a free-standing rehab/CCC hospital where no acute care services are provided. In 2015, the Ministry of Health and Long-Term Care (MOHLTC) described complex

continuing care as a program that “provides continuing, medically complex and specialized services to both young and old, sometimes over extended periods of time. CCC is provided in hospitals for people who have long-term illnesses or disabilities typically requiring skilled, technology-based care not available at home or in long-term care facilities.”

Rehabilitative care is also provided in varying degrees to residents of long-term care homes through in-home care or to those seen in hospital-based outpatient/ambulatory rehabilitation programs or community-based physiotherapy programs. Outpatient/ambulatory rehabilitative care is not a universally insured service under the Canada Health Act (Government of Canada 1984), and, in the past few years, there has been an erosion of the number and scope of hospital-based outpatient/ambulatory rehabilitation programs in an effort to achieve cost containment (GTA Rehab Network 2011; Landry et al. 2009; Ontario Physiotherapy Association et al. 2011).

### The Case for Rehabilitative Care

In a recent editorial in the journal *Clinical Rehabilitation*, the editor proposes: “Rehabilitation should be central to all healthcare at all times” (Wade 2015: 1041) and presents a comprehensive summary of evidence within the literature, illustrating “that rehabilitation is beneficial, both for the patient and for society” (Wade 2015: 1043). Similarly, a WHO report (2011: 96) provides a summary of evidence, including various Cochrane reviews, that illustrates the benefits of rehabilitation. “Rehabilitation – provided along a continuum of care ranging from hospital care to rehabilitation in the community can improve health outcomes, reduce costs by shortening hospital stays, reduce disability and improve quality of life. Rehabilitation that begins early produces better functional outcomes for almost all health conditions associated with disability.”

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### Multimorbidity and the Role of Rehabilitative Care

Within Ontario, the prevalence of multimorbidity is high with one in four Ontarians having at least two conditions, and for those aged 75 and older, the prevalence of multimorbidity increases to three in four Ontarians (Koné et al. 2013). Further, the link between multimorbidity and economic burden on Ontario’s healthcare system is significant such that healthcare costs per capita rise exponentially with increased number of health conditions, especially when the number of conditions increases from four to five or more conditions (Thavorn et al. 2013). The need to address the high utilization of healthcare resources and improve the quality and outcomes of care for people with medically complex conditions has been recognized

internationally (Mery et al. 2013) and also within Ontario with recent provincial initiatives such as Health Links and models of bundled funding to enhance the coordination of care for people with complex needs. These initiatives include a focus on patient-reported outcomes.

A focus on rehabilitative care in supporting individuals with multimorbidity is “softly” being acknowledged within the literature. However, most evidence in rehabilitative care is based on single conditions and specific functional elements. It is not necessarily applicable to individuals with multiple health issues requiring personalized care plans designed with an interdisciplinary team. In an effort to help inform health system changes to improve care for patients with chronic conditions, Boult et al. (2009: 2331) conducted a literature review and summarized high-quality studies with a variety of designs. The authors identified 15 models of comprehensive healthcare that have shown the potential to improve the quality, efficiency or health-related outcomes of care for older persons with chronic conditions. One of these was “proactive rehabilitation.” Boult et al. (2009: 2332) indicate that studies on “proactive rehabilitation” have demonstrated beneficial effects on physical function, with reductions in hospital, emergency department or home care use also being reported, albeit less frequently. The authors also indicate: “in a quasi-experimental study, subjects receiving restorative care had a significantly greater likelihood of remaining at home.” Yet, despite this review, there is still much to learn in terms of effective rehabilitative care practice for people with multiple health issues.

In a 2011 study, Fried et al. sought to elicit the health outcome priorities of older persons. In consideration of four universal outcomes, including staying alive, pain relief, maintaining independence and symptom relief, the health outcome that was ranked as most important by the largest proportion of participants (76%) was maintaining independence. While the terminology in this study does not explicitly reflect rehabilitative care, interventions provided by rehabilitative care providers have a direct role in helping people enhance and/or maintain independence and optimize societal roles within the context of their environment. Unfortunately, the lack of a clear and fully formed policy framework and integrated funding mechanisms for rehabilitative care services currently limit the extent to which the role of rehabilitative care can support these outcomes within community ambulatory-based settings.

### A Focus on Rehabilitative Care Supports Health System Priorities

The 2011 Walker Report, commissioned to provide recommendations to the MOHLTC regarding Alternate Level of Care (ALC) in Ontario, outlined the importance of understanding ALC pressures because this issue is very much related to complex care for all ages. “Alternate Level of Care

is the designation given by a physician to a patient who is occupying a bed in a hospital while not requiring the intensity of resources or services provided in that particular care setting" (Access to Care 2016). The Walker report (2011: 19) acknowledges that challenges in enhancing access and flow across services are not limited to ALC issues alone and that broader health system changes are required to meet the needs of Ontario's aging population. A primary message of the Walker report is that an "Assess and Restore" philosophy and function should be considered central to the care delivery for seniors, regardless of their point of entry into the healthcare system. Dr. Walker described potential pathways where direct access to such programs offered within rehabilitation or complex continuing care (CCC) beds would be beneficial in preventing further decline and enhancing individuals' level of functioning. Further, in addition to the role of bedded levels of rehabilitative care, best-practice rehabilitative care pathways and community rehab services were highlighted as key enablers to improve patient flow across the system. As described later in this paper, work of Ontario's Rehabilitative Care Alliance has started to build on this alternate pathway in support of direct access to rehabilitative care for individuals with medically complex needs.

The 2012 Commission on the Reform of Ontario's Public Services, also known as the Drummond (2012) Report, endorsed the recommendations of the Walker Report and, in particular, recommended that the government prioritize six of the recommendations from the Walker Report (2011). Of these, one recommendation was to enhance programs aimed at restoring and "reactivating" the functional level of older adults with opportunities to enhance community-based care and ongoing supports, the focus of which directly aligns with the objectives of rehabilitative care.

The need to integrate more comprehensive and robust rehabilitative care services across the continuum, specifically for persons with complex, multiple morbidities, as a key enabler to health system changes is not unique to Ontario or even to Canada. It is a direction that has also been highlighted internationally. In a 2011 report from The King's Fund and Nuffield Trust, Goodwin et al. (2011: 15) outline the position that care for people with complex healthcare and social care needs must be made a priority for both the government and health service providers, pointing to the need to "... develop capacity in primary and community care, to prioritise investment in social care to support rehabilitation and re-ablement, and to take forward the subsequent downsizing of activity undertaken in acute hospitals."

Despite rehabilitative care's recognized contribution to supporting health system priorities and improving patient outcomes, there has been a lack of standardization in rehabilitative care across Ontario. This lack of standardization across

the province has resulted in variability in the use of system resources and patient outcomes and continues to undermine the ability of rehabilitative care providers to address the complex needs of patients with multimorbidities. There is significant variation in the availability and type of rehabilitative care services provided across the province, which affects people's access to these services (Auditor General of Ontario 2013). Whether patients are able to access the type of rehabilitative care that is needed should not depend on where patients live, how many health conditions they have or how complex their conditions may be. "There is a need for a provincially co-ordinated rehabilitation system. Ontario's population is aging, so there will be an even greater need for rehabilitation services in the future." (Auditor General of Ontario 2013: 223).

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### **The Provincial Rehabilitative Care Alliance**

The Rehabilitative Care Alliance was established in 2013 with a focus on improving and standardizing rehabilitative care services at the system level across age spans and populations. Given the pressures on the system to address the needs of people with medical complexity and frailty, along with concurrent political and healthcare sector attention to the recommendations of the Walker Report (2011), Senior Friendly Hospital Report (Wong et al. 2011) and Sinha Report (2012), a provincial-wide focus on rehabilitative care emerged, including an emphasis on medically complex, frail seniors.

The Rehabilitative Care Alliance (RCA), funded by Ontario's 14 Local Health Integration Networks (LHINs), is a provincial task-oriented, collaborative group created to effect positive change in rehabilitative care across Ontario. It was initially established with a two-year mandate.

At the outset, the RCA laid a path for success by building on the strong foundation and leadership of the GTA Rehab Network and recommendations of the Rehabilitation and Complex Continuing Care (CCC) Expert Panel (2011). The Rehab Care Alliance engaged a small but highly productive secretariat, strong executive leadership and a diverse, provincial roster of clinicians, administrators and policy makers to advance the work. It further reinforced its efforts through a commitment to broad stakeholder engagement to help inform the development of key deliverables.

The following overview of select RCA initiatives includes highlights of specific areas where the RCA's work addresses care delivery and service planning for persons with complex care needs. To address key system gaps and issues within

rehabilitative care, the RCA developed an initial two-year work plan (April 2013–March 2015) focused on four key priorities:

1. Definitions Framework for Rehabilitative Care
2. Capacity Planning & System Evaluation
3. Frail Senior/Medically Complex
4. Outpatient/Ambulatory Rehabilitative Care Data

Each priority was supported by both a Task and Advisory group with cross-province representation. This work has led to an unprecedented level of engagement across the province, which has continued into the second two-year mandate (April 2015–March 2017) of the Alliance, ensuring that deliverables truly reflect a provincial lens.

In its first mandate, the RCA developed standardized definitions frameworks for bedded and community levels of rehabilitative care. While the rehabilitation and CCC sectors have developed considerable expertise to manage the care of patients with complex needs (Ontario Hospital Association 2006), the frameworks, for the first time, establish provincial standards for the comprehensive scope of rehabilitative care. They provide clarity for patients, families and referring professionals regarding the focus and clinical components within each level of rehabilitative care and describe expected service levels to guide capacity planning – in conjunction with the RCA's Capacity Planning Framework.

In short, the RCA Definitions Frameworks for Rehabilitative Care are the standards by which the provincial rehabilitative care system can begin to ensure equitable access to consistent, high-quality rehabilitative care services. The frameworks support a common understanding and expectations of rehabilitative care services, including the inherent features that, when delivered in a reliable and predictable way, ideally position the rehabilitative care system to support the functional needs and goals of persons with complex and multiple morbidities. Although the frameworks are not population-specific (i.e., provide standards for each and every rehab population group), the Definitions Framework for Bedded Levels of Rehabilitative Care includes two levels of rehabilitative care specific to patients who require short- and long-term complex medical management. Inclusion of these two levels acknowledges that medical complexity, in and of itself, should not serve as a barrier to receiving rehabilitative care. The frameworks go even further by making explicit statements in their eligibility criteria and definition of restorative potential that patients requiring short- or long-term complex medical management may benefit from rehabilitative care and that the presence of cognitive impairment, depression or delirium should not be used in isolation to determine the restorative potential of the patient. This perspective provides an opportunity to standardize the approach to supporting the rehabilitative care needs for all patients with multimorbidities across the province of Ontario.

### **Supporting Direct Access to Rehabilitative Care Beds for Community-Based “At Risk” Adults**

In alignment with the provincial reports “Living Longer, Living Well” (2012) and “Ontario’s Action Plan for Seniors” (MOHLTC 2013) and in direct support of operationalization of the Assess and Restore Guideline (MOHLTC 2014), RCA stakeholders prioritized the development of a “Provincial Priority Process to Support Direct Admissions to Bedded Levels of Rehabilitative Care from the Community/ED.” This process supports access to bedded levels of rehabilitative care for high-risk older and/or medically complex adults in the community who are at imminent risk of institutionalization due to recent functional decline. The “Priority Process” is not intended to replace community-based options that are available to support achievement of the client’s/patient’s functional goals. Rather, it serves as a mechanism to remove acute care as the sole point of access to rehabilitative care beds for frail, complex individuals in the community with potentially reversible functional decline for whom community-based rehabilitative care options are either not available or appropriate (Rehabilitative Care Alliance 2015).

**The frameworks support** a common understanding and expectations of rehabilitative care services ...

### **Assessment and Treatment of Geriatric Syndromes by Rehabilitative Care Providers**

Additionally, a “Compendium of Rehabilitative Care Best Practices to Support the Assessment and Treatment of the Geriatric Syndromes” was created to support an “Assess and Restore” approach to care across the rehabilitative care continuum. It was intended to support an increased awareness of the geriatric syndromes that contribute to frailty, as well as increased capability amongst rehabilitative care professionals to assess and treat geriatric syndromes.

The “Compendium” is a concise summary of existing best practices from gold-standard literature that describes tools, measures, practices and interventions that are within the scope of rehabilitative care providers and which enable comprehensive assessment and treatment of the geriatric syndromes that may contribute to frailty amongst persons with complex, multiple morbidities (Rehabilitative Care Alliance 2015).

### **Standardized Data Collection in the Outpatient/Ambulatory Rehabilitative Care Setting**

Opportunities to provide high-quality, cost-effective ambulatory-based care to a variety of populations, including those with multimorbidity, are the basis for the RCA’s initiative to develop a minimum data set (MDS) for MOHLTC-funded, outpatient/ambulatory (OP/AMB) rehabilitative care programs. In a recently published three-year study, Wodchis et al. (2016) found that use

of healthcare services by high-cost users was sustained over time and that most spending for high-cost users was for institutional care, while among low-cost users, spending was predominantly for ambulatory care services. The OP/AMB MDS was developed by the Rehabilitative Care Alliance to address the long-acknowledged lack of standardized data reporting from publically funded ambulatory rehabilitative care services and highlights the role that outpatient/ambulatory rehabilitative care can play to inform development of new community-based, cost-effective models of care. Elements within the data set include evaluation of not only patients' presenting issue but also other issues that may impact functional recovery and engagement within the context of their environment (e.g., participation in paid work; voluntary or other social activities; the extent to which a fear of falling impacts on activity participation; and engagement in instrumental activities of daily living). The OP/AMB MDS will inform the planning of sufficient rehabilitative care capacity to enable the system to respond to the needs of all populations, including, as a priority, those with complex, multiple morbidities. This capacity is required, as part of the MOHLTC's focus on bundled funding models of care, Health Links and other chronic disease management strategies, to ensure the system is able to effectively support the functional challenges encountered by persons with complex, multiple morbidities in the community. The OP/AMB MDS is currently being piloted by multiple health service provider organizations across Ontario and can be accessed through the Rehabilitative Care Alliance.

### **Assess and Restore**

In addition to the initiatives described above, the RCA is also supporting the LHINs as they operationalize the MOHLTC's Assess and Restore Guideline through focused Ministry funding of initiatives targeted at high-risk frail seniors and others with restorative potential. The RCA is playing a key role in supporting the evaluation of the impact of the "Assess and Restore" funding on key outcomes for the frail senior/medically complex population.

In summary, the described RCA deliverables serve to standardize and enhance the approach to rehabilitative care for persons with complex, multiple comorbidities. Work of the Rehabilitative Care Alliance was recognized in the 2013 report of the Auditor General of Ontario as "focusing on system accessibility and quality" and "in defining best practices in rehabilitation that are expected to help standardize the definitions of regular and restorative rehabilitation to better track services and costs" (p. 226). Implementation of these quality-focused, standardized approaches to care will optimize system resources and ideally position rehabilitative care to contribute to optimal outcomes. As Oliver (2016), consultant in geriatrics and acute general medicine, commented in the online "Views & Reviews" section of the *BMJ*, "Rehabilitation is part of medicine ... That's the way of modern healthcare." **HQ**

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