Waterloo Wellington Rehabilitative Care System

FINAL Report to the WWLHIN
May 2014

Please accept the following document as the final report outlining the accomplishments and work completed as part of the Phase II Rehabilitative Care initiative. This report includes a summary of the final status of the objectives and deliverables of the Phase II Rehabilitative Care Initiative as outlined in the 'Project Charter for the System of Rehabilitative Care'.

The purpose of the Phase II Rehabilitative Care initiative was to:

1. Create a noticeably improved system of rehabilitative care for the residents of Waterloo Wellington that:
   - Raises the quality of care across the entire region by standardizing access to best practice rehabilitative care;
   - Delivers care planned across the continuum of care, creates a better balance of care options and closes system gaps, by identifying opportunities to reallocate resources to ensure patients get the right care in the right place at the right time.
   - Improves access to care, the patient experience, system flow and provides supported transitions through improvement of the system enablers:
     - ✓ standardized referral process,
     - ✓ identification of standardized assessment tools/measures,
     - ✓ identification of opportunities for standardized data collection
     - ✓ a culture of 7-day a week admission, treatment and discharge,
     - ✓ formalized care partnerships, where appropriate
     - ✓ supported care transitions
     - ✓ monitoring and assessment of quality metrics reported by stream lead organizations and reporting of stream performance to providers and WWLHIN

2. Facilitate the creation of a regional program framework and structure that will serve as a template for the development of future regional programs.
   - ✓ Develop a governance and accountability framework and structure that would be applicable and scalable to multiple regional programs;
   - ✓ Develop funding and human resource management strategies to adapt the current system to a regional clinical program model.

This report includes an overview of the activities that have been completed and resulted in successful completion of the stated purposes of the initiative. Additional initiatives to which the Phase II Rehabilitative Care initiative provided support and oversight, above and beyond the stated objectives, are also described.

Please let us know if you require any additional information regarding the completed and/or on-going work within the WW Rehabilitative Care System.

Marianne Walker
President & CEO, St. Joseph's Health Centre Guelph
Executive Sponsor, WW Rehabilitative Care Regional Program

Rehabilitative Care Phase II Initiative Goals, Objectives & Performance Measures – Final Report			
Goals	**Objectives/Deliverables**	**Process Performance Measures**	**Final Status**
1) Implement the recommended stroke integrations	1A. Development of an integration business plan (as required as part of the documentation (s.27) to support the intended stroke integration) to support the transition to an integrated Stroke Program/Stream of Care in WWLHIN (including engagement, sizing and siting and financial analysis to inform the decision making process). 1B. Consolidation and sizing of in-patient stroke beds to dedicated stroke units (acute and in-patient rehabilitative care) 1C. Development of streamlined, equitable access to community services/programs for rehabilitative care system clients with functional goals.	1A. (i) Submission of the required voluntary integration documentation according to project timelines 1B. (i) All acute and in-patient stroke rehabilitative care will be provided in dedicated stroke units. 1C. (i) Development of a measure of community re-integration 1C. (ii) Development of a process to link Rehabilitative Care system clients with community services.	1A. (i) Submitted to LHIN in May 2013 for presentation at June 2013 WWLHIN Board meeting with the final integration decision being made by the WWLHIN Board in August 2013. 1B. (i) As of April 1, 2014, all acute and in-patient stroke rehabilitative care will be provided in dedicated stroke units 1C. (i) Included in Rehabilitative Care Evaluation Framework and Rehabilitative Care System Scorecard (see Appendix I) 1C. (ii) Care Dove was launched for the WW Rehabilitative Care System May 15, 2013. Timebook (appointment sharing) for 22 organizations and Easy Coordinated Access referral process are planned for completion in June 2014. The Council successfully attained one time funding from the WWLHIN to "support the expansion of the Timebook feature within Caredove AND expand the Easy Coordinated Access referral process to include the rehabilitative care system". The project charter including details regarding the final status of deliverables is included in Appendix II. The Rehabilitative Care Council has identified this as 1 of its 4 strategic priorities for 2014 and as such ongoing oversight for this initiative will be completed by the Council through the Community Integration Teams
2) Evaluate and prioritize recommendations from Phase I of	2A. Implementation of a Rehabilitative Care System governance structure 2B. Engagement, sizing &	2A.(i) An established/operational governance structure 2B.(i) A completed financial	2A.(i) A governance/leadership and accountability structure for the Rehabilitative Care System was developed in June 2013 (Appendix III). This structure is applicable and scalable to multiple regional programs.

Rehabilitative Care Phase II Initiative Goals, Objectives & Performance Measures – Final Report			
Goals	**Objectives/Deliverables**	**Process Performance Measures**	**Final Status**
the Rehabilitation Review and implement as appropriate.	siting and financial analysis of the future state to inform the implementation process. 2C. Care organized around four condition specific streams of care, led by "Stream Lead Organizations" with clinical care paths supporting the delivery of evidence based best practices across the care continuum. 2D. Prioritization of recommendations from Phase I of the Rehabilitation Services Review 2E. Development of systems and process to support improved data collection, use and availability to demonstrate patient outcomes, patient satisfaction and system performance. 2F. Development of streamlined, equitable access to community services/programs for rehabilitative care system clients with functional goals.	analysis and established financial structure 2B. (ii) Recommendations re: sizing and siting for the future state 2C.(i) Identification of Stream Lead Organizations 2C. (ii) Development, implementation and processes for on-going monitoring and evaluation of clinical care pathways to support standardized, evidence based care within each stream of care 2D.(i) A prioritized list of Phase I recommendations and development of a work breakdown structure for each recommendation to be implemented. 2E.(i) Development of processes to collect, report and improve patient outcomes, patient satisfaction and system performance. 2E. (ii) Development of accountabilities to support patient outcomes, patient satisfaction and system performance	2B. (i)and (ii) Financial analysis of recommended stroke services was included in the Stroke Integration Business Case. The Finance sub-group (CFOs) developed to support the stroke integration developed over arching guiding principles for the transfer of services between organizations. The human resources group (HR VPs) developed guiding principles for the movement of staff. These funding and human resource management guiding principles and frameworks that were developed to support the integration of stroke services can be adapted to support other regional program integrations. An 'In-patient Sizing Report' was submitted to the WWLHIN in December 2013 (revised version submitted in February 2014). 2C. (i) Completed in June 2012 2C. (ii) and 2E. (i) 6/7 integrated rehabilitative care best practice pathways were introduced in March-June 2013. The 7th care pathway was introduced in May 2014. Implementation of the best practices that are contained within the care paths is one of the Rehabilitative Care Council's 4 strategic priorities for 2014. The Council will monitor the system and patient level outcomes through quarterly review of the WW Rehabilitative Care Council Scorecard. Stream Lead Steering Committee scorecards are also being developed to monitor patient outcomes by organization as a mechanism to support continuous quality improvement across the system. 2D. (i) See Implementation Work Plan (Appendix IV) 2F. (i) See Evaluation Framework and Rehabilitative Care System Scorecard (Appendix I). 2F. (ii) Care Dove was launched for the WW

Rehabilitative Care Phase II Initiative Goals, Objectives & Performance Measures – Final Report			
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		2F. (i) Development of a measure of community re-integration 2F. (ii) Development of a process to link Rehabilitative Care system clients with community services.	Rehabilitative Care System May 15, 2013. Timebook (appointment sharing) for 22 organizations and Easy Coordinated Access referral process (to support Primary Care referral to rehabilitative care community services) are planned for completion in June 2014. The Rehabilitative Care Council has identified this as 1 of its 4 strategic priorities for 2014 and as such ongoing oversight for this initiative will be completed by the Council through the Community Integration Teams
3) Promote transparency and support stakeholder engagement through an effective communication and engagement strategy	3A. Development of a broad-based communications plan. 3B. Development of a stakeholder engagement strategy	3A.(i) Ongoing, concise key messages developed and delivered promptly to stakeholders throughout project 3B.(i) Evidence of a process to monitor stakeholder satisfaction with communication and engagement throughout project	3A. (i) Key messages were published after each Rehabilitative Care Council meeting. Rehabilitative Care newsletters were published as required throughout the 2-year project. 3B. (i) Survey of stakeholder satisfaction with communication and change management was conducted in February 2013.
4) Manage change effectively	4A. Project Coordinator appointed to lead the project using project management and business planning tools 4B. Coordinate with enabler projects – OTN, HELP, CCAC Expanded Role, RM&R 4C. Collaboration with provincial partners to align/streamline processes	4A.(i) Recruitment of a project coordinator 4A. (ii) Key milestones completed on time 4A. (iii) Development and implementation of a change management strategy to support the implementation of the WWLHIN Rehabilitative Care System 4A. (iv) Evidence of a process to monitor	4A. (i) Completed in June 2012 4A. (ii) See Implementation Work Plan (Appendix IV) 4A. (iii) Change management activities were completed as required to support system stakeholders in their implementation efforts including monthly webinars, face to face team meetings, development of a rehabilitative care system website, distribution of materials to support reporting, sustainability planning, community engagement sessions, media messaging and patient stories etc. 4A. (iv) Survey of stakeholder satisfaction with communication and change management was conducted in February 2013.

Rehabilitative Care Phase II Initiative Goals, Objectives & Performance Measures – Final Report			
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		stakeholder satisfaction with the approach to change management 4B. (i) Evidence of inclusion of enabler projects in the re-designed system. 4C. (i) Evidence of alignment with regional and provincial initiatives	4B. (i) On-going linkages/collaboration with Caredove, CCAC Expanded Role, CCAC Coordinated Access, SGS re-design, IDEAs program etc. 4C. (i) On-going alignment with the Rehabilitative Care Alliance, RM & R, Assess and Restore policy development and funding etc.

Additional Activities/Tasks Completed as Part of the Phase II Rehabilitative Care Initiative

In addition to the stated deliverables and objectives of the initiative, the Rehabilitative Care Council has also taken a leadership role in:

- Development of an Integrated Falls Prevention Strategy
- Coordination and communication regarding changes to publically funded physiotherapy services in Summer 2013 to maximize opportunities to leverage new funding mechanisms including a gap analysis and capacity planning that informed report to the Ministry through the WWLHIN.
- Coordination of Assess and Restore funding to ensure alignment and integration with existing opportunities/directions within the local system. Specifically, over $300,000 was spent supporting the implementation of education opportunities, capacity building initiatives and information sharing.
- The adoption of standardized, evidence based acute stroke order sets and active involvement in the development of inpatient rehab evidence based stroke order sets.
- Development of a regional programs website to house information related to regional programs (www.regionalhealthprogramsww.com)
- A literature review of patient experience measures across the continuum of rehabilitative care
- Undertaking a process to identify a solution for an electronic bed board management system
- Development of a Decision Making Framework to support clinicians to refer to the most appropriate, efficient rehabilitative care setting (Appendix V)
- Development of standardized patient education material to support each integrated care pathways for use by all organizations across the LHIN
- Development of a framework to support the evaluation of the integrated stroke program (as per the integration directives).
- Identification of standardized clinical outcome measures for use by rehabilitative care providers across the continuum to evaluate changes in patient functional outcomes

Lessons Learned Throughout the Rehabilitative Care Phase II Initiative

Leadership

- Leadership commitment is paramount to success to both engage other system leaders to provide support for directions and provide opportunity to provide input for change as well as to identify and mitigate risks, mange issues and to facilitate agreement
- Focused efforts are required to enhance relationships across all organizations, not just hospitals.
- Focused effort and resources affect change at a greater pace (ie. stroke, which had dedicated integrated director) than those that require current staff to conduct new program planning and care pathway implementation in addition to their 'regular day jobs'.
- Need diverse organizational and sectorial representation on Councils to ensure the unique needs of each organization and sector is represented

Change Management

- Create a burning platform for change upfront
- Evolve and repeat the message regarding the need for change throughout the implementation process
- Successful transformational change requires readiness/acceptance and active involvement of all stakeholders
- Assessment of capacity for change is critical
- When planning implementation, ensure sufficient time and resources/support for change management and engagement with HSPs.

- Need to consider the capacity of senior clinical leaders and front line staff to implement best practices in different clinical areas of focus in a finite amount of time. Smaller sectors in particular have significant challenges as may require same staff to participate in numerous change management and implementation initiatives.
- Sponsor organizations need to be supported in order to provide the significant leadership and support that is required for successful implementation and coordination of a regional program.

Patient/Family Engagement

- Require ongoing patient and family engagement and taking action on appropriate recommendations.
- Consider patient/caregiver representation on Councils, patient/caregiver advisory groups, leveraging existing community groups, patient/caregiver interviews and measurement of patient experience.

Decision Support, Finance & Human Resources

- Address financial and decision support issues early on in the process
- Important to have decision support and finance at the table for sizing and siting discussions
- Access to and analysis of data and evidence is critical to making informed decisions and to monitor progress towards goals.
- If the movement of services is required/proposed, consider opportunities to offset volume/service transfers with other volume/service transfers to minimize overall impact to organizations within the system.

Board Support and Commitment

- Focus on improvements to patient outcomes and experiences
- Support work that advances the local system towards becoming a high quality system of care
- Engage in Board to Board discussion among organizations
- Provide constructive feedback about plans and opportunities for improvement
- Once plan is agreed upon, hold leadership accountable for implementing

LHIN Support

- Clarify roles of the LHIN and the Sponsor Organization are required from the outset
- Provide clear direction about the “what” rather than the “how”
- Provide project support to complete major work of the Council and HSPs
- Meet regularly with Sponsor CEO to discuss barriers, challenges and to identify where LHIN can assist
- Participate as active members of program Councils to fulfill role in integrating and aligning system activities

Physician Engagement and Leadership

- Engage physicians to develop support for the change and for the implementation of best practices
- Develop a targeted and concise formal communication and engagement plan to optimize physician involvement and support
- Identify a physician lead for each integrated clinical program (Chief’s to MACs, LHIN physician leads to respective sector physicians)

Communication

- Identify stakeholders and their preferred mode to receive communication
- Engage key clinical champions in each organization and each sector that will assist in disseminating the message
- Leverage formal communicators in each organization to support the communications plan

  - Develop and implement a comprehensive communication plan to manage the message including concise, multi-modal communications
  - Repeat critical messages
  - If services are being moved, include a plan for media releases, meetings with community members, patients/families

The Role of Council Moving Forward in Sustaining the Gains and Advancing the Success of the WW Rehabilitative Care System

The role of the Rehabilitative Care Council moving forward is to provide oversight and support coordination within the WW Rehabilitative Care System. Specifically, to provide support to

- Organizations that deliver rehabilitative care to deliver coordinated, best-practice rehabilitative care services. The top priorities for the Council in 2014 are:
  - Embedding best practices within existing care delivery mechanisms;
  - Ensuring all patients know the name, date and time of their next appointment prior to moving to the next level of care;
  - Development of standard education materials and a common approach to patient education and self-management;
  - Utilization of standard patient outcome measures across the continuum of care

- Stream Lead Organizations to identify and implement quality improvements within each respective stream of care that are aligned with the overall rehabilitative care system strategic goals. Based on the key priority outcomes that have been identified by each Stream Lead Steering Committee, and included on the Rehabilitative Care Council Scorecard, Stream Lead Steering Committees will be working to identify 1-2 priority quality improvement initiatives (activities) to influence the overall system priority outcomes and support care pathway best practices

In summary, the Rehabilitative Care Phase II initiative has achieved its stated objectives and deliverables. The initiative has also provided significant benefit to the system by completing additional tasks and activities in support of system quality and integration efforts. The following figures demonstrate the impact that the initiative has had on access to rehabilitative care best practices in Waterloo Wellington:

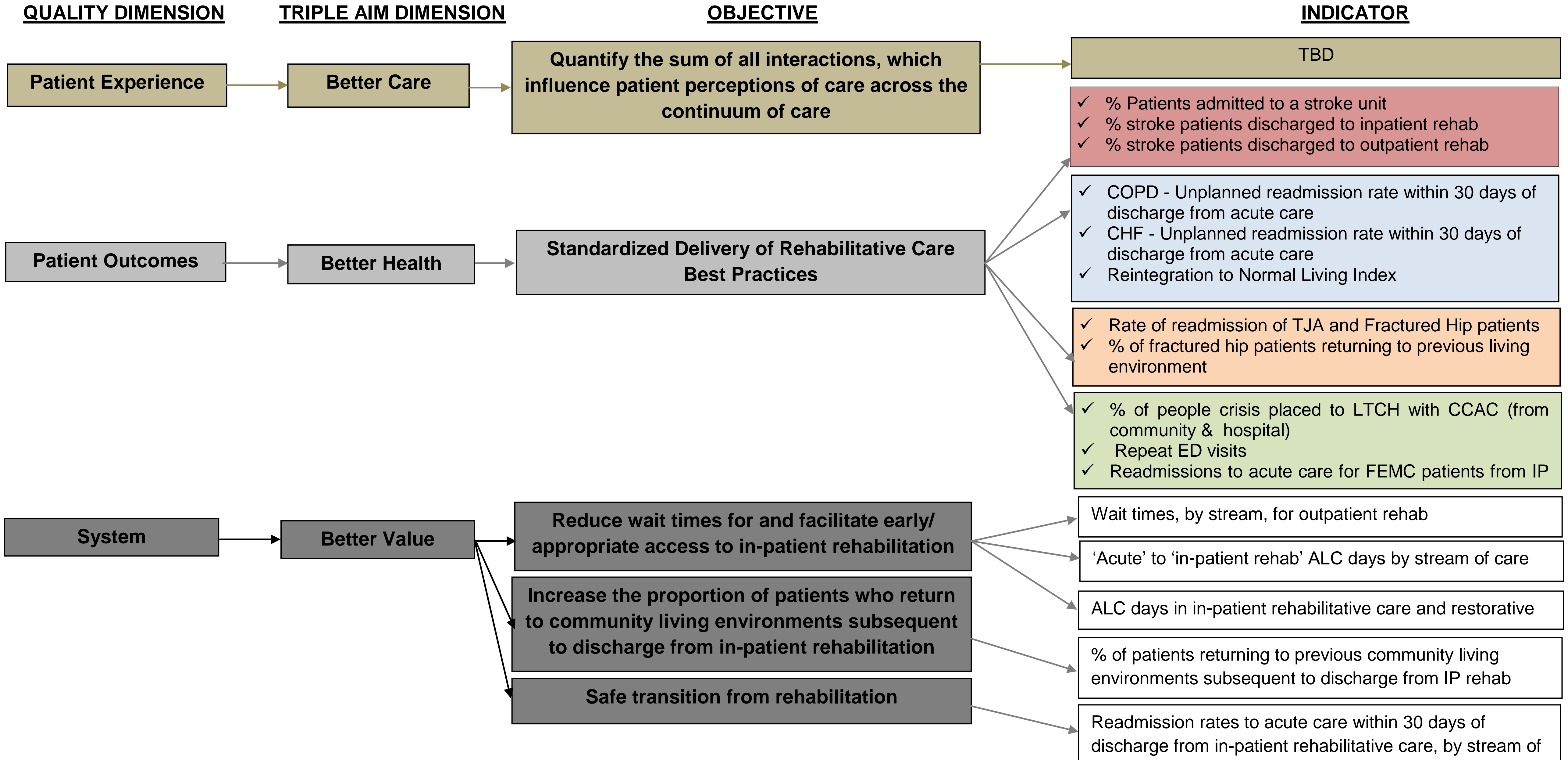
Figure I - The status of Rehabilitative Care Best Practices in WWLHIN in 2011 – The RehabServices Review revealed significant practice variartion within the WW Rehabilitative Care System. The following select rehabilitation best practices were not fully implemented across Waterloo Wellington LHIN:

	Best Practice	Implementation in WWLHIN?
Fractured Hip	7 day a week rehabilitation	Variable
	Referral to rehab on post-op day #3 if not progressing	Not Measured
	Transfer to rehab on post-op day #5 if required	No
Total Joint Arthroplasty	7 day a week rehabilitation in acute	Variable
	Orthopedic Quality Scorecard - 90% (+/- 10%) discharge rate to home from acute care hospitals.	Yes
Stroke	ALPHA FIM completed on day #3	No
	Onset to rehab - Day 5 (Ischemic Strokes) or Day 7 (Hemorrhagic)	No
	7 day a week admission process to rehabilitation	No
	45% of patients admitted to inpatient rehabilitation w severe strokes (RPG= 1100, 1110)	No
	7 day a week rehabilitation	No
Elder Care	Comprehensive Geriatric Assessment (CGA) is required for frail older persons with rehabilitation needs	No
	Geriatric rehabilitation should be managed by a physician and interdisciplinary team trained in care of the elderly	No
	Frail older rehabilitation candidates with mild to moderate dementia should not be excluded from rehabilitation	No
	A common rehabilitation/activation framework is required to reduce the functional and cognitive decline of hospitalized elderly patients	No

Figure II - The status of Rehabilitative Care Best Practices in WWLHIN in 2014 – As a result of the Phase II Rehabilitative Care System Initiative, residents of Waterloo Wellington now have more equitable access to rehabilitative care best practices and there is reduced variation in both process and patient outcomes across the system:

	Best Practice	Status in WWLHIN
Fractured Hip	7 day a week rehabilitation	Processes to support achievement of these targets are embedded in the MSK care paths and expected outcomes are being monitored by the Rehabilitative Care Council
	Referral to rehab on post-op day #3 if not progressing	
	Transfer to rehab on post-op day #5 if required	
Total Joint Arthroplasty	7 day a week rehabilitation in acute	
	Orthopedic Quality Scorecard - 90% (+/- 10%) discharge rate to home from acute care hospitals.	
Stroke	ALPHA FIM completed on day #3	As a result of the integration of stroke services and the development of a WW Regional Stroke Program (Apr'14), access to these best practices will be standardized across the system and the associated patient outcomes will be monitored
	Onset to rehab - Day 5 (Ischemic Strokes) or Day 7 (Hemorrhagic)	
	7 day a week admission process to rehabilitation	
	45% of patients admitted to inpatient rehabilitation with severe strokes (RPG= 1100 or 1110)	
	7 day a week rehabilitation	
Elder Care	Comprehensive Geriatric Assessment (CGA) is required for frail older persons with rehabilitation needs	As a result of local planning and in alignment with provincial directions related to Assess and Restore, the Rehabilitative Care Council has made recommendations regarding the development of a regional inpatient specialized geriatric rehabilitation program. Approval and implementation of these recommendations would support the delivery of these best practices. Also, The Frail Senior and Medically Complex Stream Steering Committee is developing a 'care map', in alignment with the provincial Assess and Restore Framework
	Geriatric rehabilitation should be managed by a physician and interdisciplinary team trained in care of the elderly	
	Frail older rehabilitation candidates with mild to moderate dementia should not be excluded from rehabilitation	
	A common rehabilitation/activation framework is required to reduce the functional and cognitive decline of hospitalized elderly patients	

Appendix I - WWLHIN REHABILITATIVE CARE SYSTEM EVALUATION FRAMEWORK and KEY PERFORMANCE INDICATORS (KPIs)



Better Health
Better Care
Better Value
A Better Rehabilitative Care System

Waterloo Wellington Rehabilitative Care System: Rehab Scorecard

Produced on: Apr 24, 2014

Stream of Care	Better Care	Current	Target	Status[1]	Baseline[2]	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	Last Update	LHIN Rank	Better[3]

Stream of Care	Better Health	Current	Target	Status[1]	Baseline[2]	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	Last Update	LHIN Rank	Better[3]
	Stroke Patients Admitted to a Stroke Unit	43.9%			43.9%									Q4 2010-11	-	↑
	Stroke Patients Discharged to Inpatient Rehab from Acute	17.9%			19.3%	17.9								Q1 2013-14	-	
	Stroke Patients Discharged to Outpatient Rehab from Acute															
	Stroke Patients Discharged to CCC from Acute	1.3%			4.3%	1.3								Q1 2013-14	-	
	Readmissions to Hospital for Chronic Obstructive Pulmonary Disease (COPD)	17.9%			17.9%*									Q4 2012-13	8	↓
	Readmissions to Hospital for Congestive Heart Failure (CHF)	20.3%			19.3%*									Q4 2012-13	5	↓
	Reintegration to Normal Living Index															
	Readmissions to Hospital after Hip Replacement Surgery	0.6%			-									Q4 2012-13	2	↓
	Readmissions to Hospital after Knee Replacement Surgery	1.0%			-									Q4 2012-13	3	↓
	In-Patient Rehab Fractured Hip Patients Discharged Home[4]	70.6%			81.7%	84.38	70.6							Q2 2013-14	13	↑

Stream of Care	Better Value	Current	Target	Status[1]	Baseline[2]	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	Last Update	LHIN Rank	Better[3]
	Wait Times for Outpatient Rehab															
	Average Acute ALC Days to In-Patient Rehab	6.1			6.9	6.1								Q1 2013-14	2	↓
	Average In-Patient Rehabilitation ALC Days	1.8			1.4	1.9	1.8							Q2 2013-14	11	↓
	In-Patient Rehab Patients Discharged Home[4]	71.3%			78.5%	79.3	71.3							Q2 2013-14	13	↑
	Readmissions to Acute Care from Rehab (within 30 days of discharge)															
	Readmissions to Acute Care from Cardio Pulmonary In-Patient Rehab															
	Readmissions to Acute Care from Musculoskeletal/Orthopaedic In-Patient Rehab															
	Readmissions to Acute Care from Stroke/Neurological In-Patient Rehab															
	Readmissions to Acute Care from Medically Complex/Frail Elderly In-Patient Rehab															

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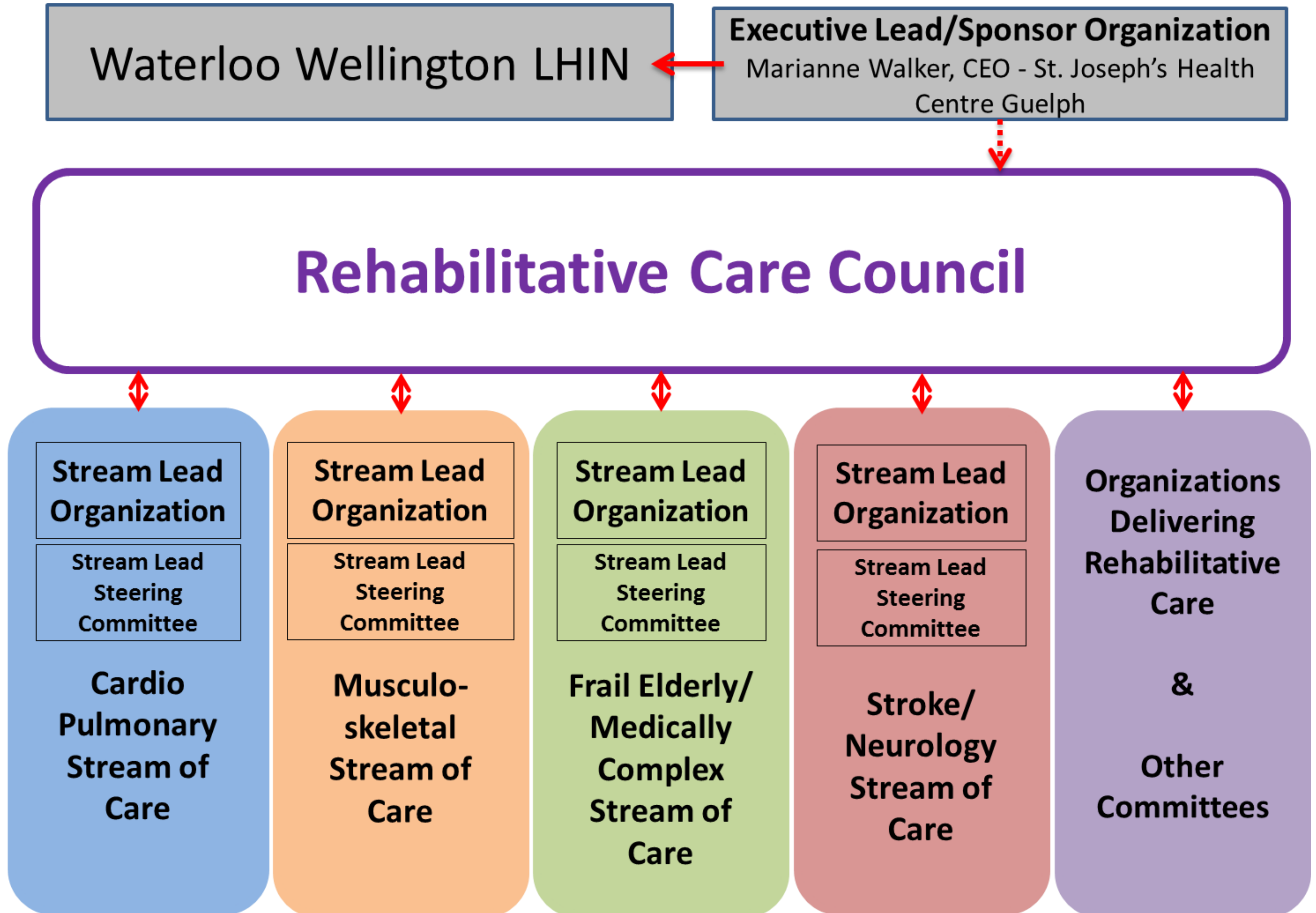
Appendix III – WW Regional Rehabilitative Care Program Leadership Structure



Appendix IV - Implementation Work Plan to Support a Transition to a System of Rehabilitative Care in WWLHIN

Year 1 ACTIVITIES	Accountability	May /12	Jun/ 12	July/ 12	Aug/ 12	Sept/ 12	Oct/ 12	Nov /12	Dec /12	Jan /13	Feb /13	Mar/ 13	
Identify Sponsor Organization	WWLHIN	X											
Develop Phase II Project Charter	Sponsor Organization	X											
Recruitment of System Coordinator	Sponsor Organization	X											
Recruitment of Regional Stroke Director	GRH and SJHC			X	X								
Identify Rehabilitative Care Council Co-Chairs	WWLHIN & Sponsor Organization	X											
Identify Stream Lead Organizations	Sponsor Organization	X											
Operationalize Rehabilitative Care Council	Sponsor Organization		X										
Develop, System Performance Measures & Evaluation Criteria for the Streams of Care	Rehabilitative Care Council					X							
Development of a regional model for Physiatry services (including specialist recruitment and retention).	Rehabilitative Care Council						X						
CITs to complete analysis of community services (Phase I)	CCAC						X						
Stream Lead Organizations to develop Stream Steering Committees	Stream Lead Organizations						X						
Stroke Stream Steering Committee to organize sub-committees to initiate activities & documentation required for integration	Stroke Stream Lead Organization						X						
Complete Sizing & Siting of each Stream of Care (3)	Stream Lead Organizations(3)												~~**Report Presented to WWLHIN November 1, 2013**~~
Stream Lead Organizations (3) develop clinical care pathways (incl. Implementation plans)	Stream Lead Organizations(3)											X	**Pathways introduced in Spring 2013**

Develop Process for Centralized Management of Clinical Care Pathways	Rehabilitative Care Council WWLHIN									X			
Year 1 ACTIVITIES	Accountability	May /12	Jun/ 12	July/ 12	Aug/ 12	Sept/ 12	Oct/ 12	Nov /12	Dec /12	Jan /13	Feb /13	Mar/ 13	
Stroke Stream Subcommittees to plan for full implementation of stroke recommendations	Stroke Stream Lead Organization											X	
Complete required integration documentation	Stroke Stream Lead Organization											X	
Develop Centralized Intake Process for In-patient Rehabilitative Care Beds	CCAC												~~May 2013~~
Determine Process for Clinical Flow/Navigation within Stroke Stream of Care (in consideration of Stroke Navigator included in Stroke Priority Recommendations)	Stroke Stream Lead Organization											X	
Develop standardized intake criteria for out-patient rehabilitative care programs/services	Rehabilitative Care Council & Stream Lead Organizations												In - Progress
Regional Finance and HR Groups to develop guiding principles and framework to support integrations	Rehabilitative Care Council						X	X					
Guiding principles and framework to support integrations presented to CEOs	Rehabilitative Care Council								X				
Stroke Finance and HR Groups to apply regional framework to funding and HR implications of integration to inform business case and required integration documentation	Stroke Stream Lead Organization									X			
Stroke Integration Documentation to Stroke Steering Subcommittee for Approval	Stroke Stream Lead Organization										X		
Stroke Integration Documentation to Rehabilitative Care Council for Approval	Stroke Stream Lead Organization										X		

Stroke Integration Documentation to CEO group for Approval	Executive Sponsor												**~~Mar/ Apr 2013~~**
Stroke Stream Lead Organization submit "Notice of Intended Integration" to HSP Board of Directors	Stroke Stream Lead Organization												
Stroke Stream Lead Organization submit "Notice of Intended Integration" to LHIN Board of Directors	Executive Sponsor												**~~May 2013~~**
Determine role of Rehab Leadership & CCC Networks	Rehabilitative Care Council							X					
SLP • Review SLP services in consideration of a regional approach, required investments, maximizing scopes of practice • Benchmark Barium Swallow Resources • Develop Regional Aphasia program	Rehabilitative Care Council & Stroke Stream Lead Organization												**~~Dec 2013~~**
Develop & Implement Specialized Case Management processes	CCAC												~~Stroke Apr 2014~~
CITs - Phase II	CCAC and Stream Lead Organizations									X			
CITs - Phase III	CCAC												On-Going

Note: Highlighted items are to be completed and are included on the Rehabilitative Care Councils work plan or 2014/15

Year 2 Activities	Accountability	Apr/ 13	May/ 13	Jun/ 13	July/ 13	Aug/ 13	Sept /13	Oct/ 13	Nov/ 13	Dec/ 13	Jan/ 14	Feb/ 14	Mar/ 14	Apr/ 14	May/ 14	Date Completed
Union Notifications	Stroke Stream Lead Organization															None Required
Prepare for Acute Stroke Services Integration (including education, communication/marketing etc)	Stroke Stream Lead Organization										X					
Phased implementation of Acute Stroke Services Integration	Stroke Stream Lead Organization													X		
Develop/Implement Processes to Measure, Collect & Report Key Outcome Measures for the Continuum of Care	Rehabilitative Care Council & Stream									X						

	Lead Organizations															
Stream Lead Organizations Provide Education for Stakeholders re: Implementation of Integrated Care Pathways	Stream Lead Organizations		X													
Implementation of Integrated Care Pathways	Stream Lead Organizations														X	
Re-Alignment/Integration of In-Patient Rehab Beds	Rehabilitative Care Council in partnership with CCAC (Expanded Role)															~~Report Presented to WWLHIN November 1, 2013~~
Implement Centralized Intake Process for In-patient Rehabilitative Care Beds	CCAC		X													
Oncology • Review of the rehabilitative care needs of oncology patients	Rehabilitative Care Council Regional Cancer Centre															TBD
Out-flow • Clarify access processes to out-of-LHIN specialized programs • Establish processes to leverage community agencies to patients awaiting admission to specialized programs	Rehabilitative Care Council & Stream Lead Organizations															TBD
Establish Partnership with Academic Institutions Related to Potential Research and Knowledge Translation Opportunities	Rehabilitative Care Council															**On-Going**
Evaluation of Program Implementation	Rehabilitative Care Council															To be completed Sept 2015
Develop a System to Support On-going Monitoring and Evaluation of System and Stream Level Indicators/Outcomes	Rehabilitative Care Council											X				

Note: Highlighted items are to be completed and are included on the Rehabilitative Care Councils work plan or 2014/15

Appendix V - WW Rehabilitative Care Transition Decision Making Framework