



Enhancing Function for Meaningful Living



Rehabilitation Conceptual Framework

2018

About this Document

In February 2012, AHS released the *Rehabilitation Conceptual Framework* as a guide to assist AHS service providers, managers and service planners in improving access to quality sustainable rehabilitation services.

This 2018 version reflects updated knowledge and context. It provides guidance to reflect current evidence and the following significant changes in Alberta Health Services the past 4 years:

- Development of a single provincial approach to Rehabilitation Services via AHS' [Rehabilitation Strategic Plan](#)
- AHS current Values
- [2017-2020 AHS Health Plan and Business Plan](#)
- [Four Foundational Strategies](#) and
- [Professional Practice in Action](#)

Throughout this document, terms requiring explanation are defined in a separate appendix. Terms are hyperlinked to [Appendix A - Glossary of Rehabilitation Terms](#) the first time the word or phrase appears in the document. In addition to the extensive glossary of terms, additional supplemental content exists as appendices to maintain a more concise main document.

Appendices to the Framework provide further description of concepts and terms, as well as examples and practical resources to support implementation. References for the Appendix A are cited within the Framework's main document.

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EXECUTIVE SUMMARY



PURPOSE

The Rehabilitation Conceptual Framework (the Framework) guides Alberta Health Services (AHS) to conceptualize, design and deliver rehabilitation services. It provides the basis to move rehabilitation services into the future and offers a foundation to:

- Apply the AHS philosophy for rehabilitation - *enhancing function for meaningful living* - across services, settings and the continuum of health
- Achieve rehabilitation goals for capacity building, prevention, fostering resourcefulness and enhancing or restoring function
- Understand the needs of clients, communities and the organization – seeking a dynamic balance in striving for quality
- Learn about the concepts AHS considers essential to rehabilitation
- Embrace innovation, evidence-informed practice, change and growth through a solution-focused cyclical process of learning and improving

FOUNDATIONS OF REHABILITATION IN AHS

Rehabilitation is a set of interventions that reduce disability and optimize function in individuals, with attention to their environments (WHO, 2017c).

Rehabilitation is further defined by the NHS England (2016, p.37) as *a personalised, interactive and collaborative process, reflecting the whole person. It enables an individual to maximise their potential to live a full and active life within their family, social networks, education/training and the workplace where appropriate. Rehabilitation can take place at any time across a life course or in a continuum and may include habilitation, reablement and recovery* (NHS England, 2016, p.37)

Rehabilitation services contribute to quality of life, productivity in society, effectiveness of medical and surgical interventions, and the efficiency of the health system. Rehabilitation helps people maintain wellness, develop or restore function, and get back to work, school, and life sooner after an injury or illness (AHS, 2017b; WHO, 2017c, 2017d).

Rehabilitation in AHS is guided by

... our philosophy

- Enhancing function for meaningful living

... our principles and beliefs

- People are at the centre of all we do.
- Rehabilitation is part of every life, active and inclusive, focused on function, embedded across health care and communities, and informed by evidence.
- Rehabilitation is everyone's responsibility. Individual providers, and AHS as a whole, collaborate to create quality outcomes and positive health care experiences.

... client experience

- We strive to provide experiences where people know that they matter. They are valuable partners in their own health care.

Clients, communities, providers, planners, and our organization all have essential roles in rehabilitation.

PLANNING & PROVIDING REHABILITATION SERVICES

Planning and providing rehabilitation is highly complex and not easily prescribed. In striving for quality we must engage with users and partners to:

- Balance needs, evidence and resources
- Move knowledge to action
- Apply the Rehabilitation Process
- Consider and employ a variety of Service Options

We create future-oriented, results-driven service using needs, resources, and evidence to inform decision making. The principles of evaluation and learning are embedded when providers and planners follow an iterative knowledge to action cycle, use a participatory problem solving approach, and value and learn from people's experiences. We share and use outcome measures, data and analytics to support dynamic, timely and continuous learning, improvement and innovation.

The Rehabilitation Process guides planners and providers to identify a client, group, or community's needs; relate problems to relevant factors of the person and the environment; define rehabilitation goals; plan and implement measures; and assess the effects through a continuous learning process (WHO & World Bank, 2011). It relies on evidence and is responsive to preferences, values and circumstances of clients & families. Using a biopsychosocial model, the process is strength-based, solution-focused and cyclical.

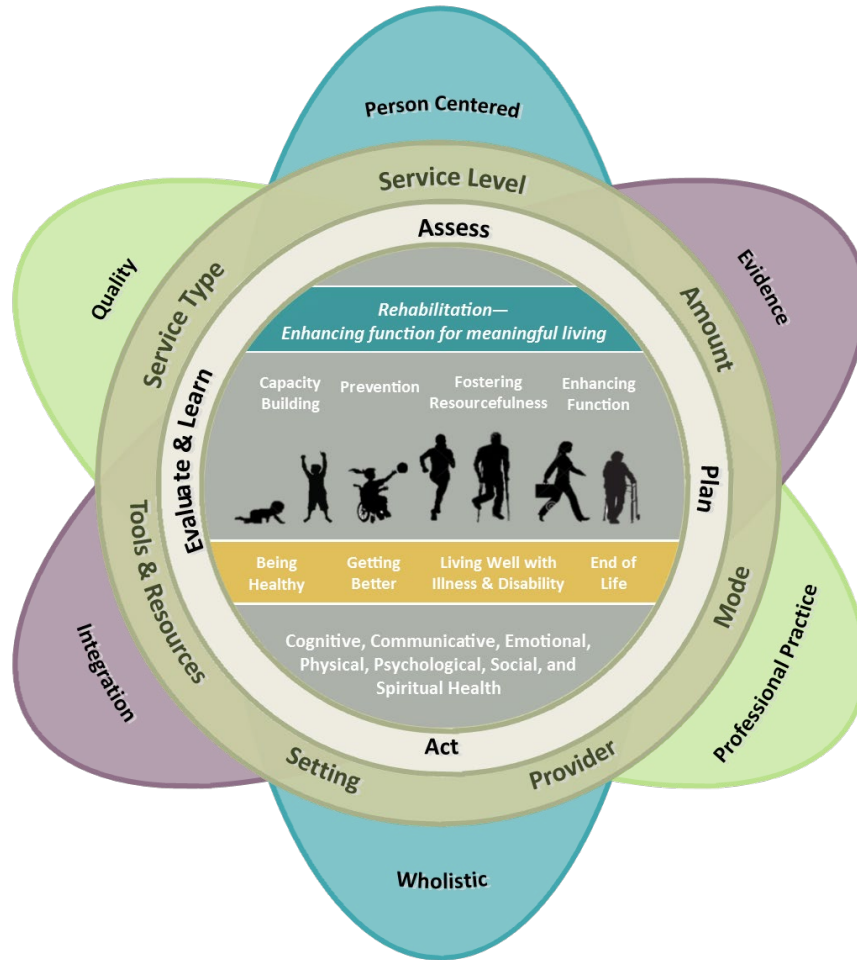
We aim to meet diverse rehabilitation needs by creating and offering a variety of services. Service Options allow for the creation and use of a variety of interventions that match needs, optimize resources and act on available evidence. The type, level, amount, mode, provider, setting, tools and resources are considered in relation to the unique needs of the client or group.

Appendices to the Framework provide further description of concepts and terms, and practical resources to support implementation.

For further information contact practice.consultation@ahs.ca.

THE FRAMEWORK

The AHS Rehabilitation Conceptual Framework



- Our philosophy is *enhancing function for meaningful living*
 - People are at the centre of rehabilitation in AHS
- Services focus on ability - through capacity building, prevention, fostering resourcefulness, and enhancing or restoring function
 - Rehabilitation contributes to wellness across the continuum of health, the lifespan and generations - impacting the health and wellbeing of the whole person and their community
 - Rehabilitation enables and encourages people to identify, reach and maintain their cognitive, communicative, emotional, physical, psychological, social and spiritual health goals
 - Rehabilitation services are planned and provided using a continuous learning process
 - People are matched to service options based on their needs at different times of life
- Quality rehabilitation comes from professional practice that is person centred, wholistic, integrated and guided by evidence

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INTRODUCTION

The Rehabilitation Conceptual Framework (the Framework) guides Alberta Health Services (AHS) to conceptualize, design and deliver rehabilitation services. It provides the basis to move rehabilitation services into the future and offers a foundation to:

- Apply the AHS rehabilitation philosophy – *Enhancing function for meaningful living* - across services, settings and the continuum of health
- Achieve rehabilitation goals for capacity building, prevention, fostering resourcefulness and enhancing or restoring function
- Understand the needs of clients, communities and the organization – seeking a dynamic balance in striving for quality
- Learn about the concepts AHS considers essential to rehabilitation
- Embrace innovation, evidence-informed practice, change and growth through a solution-focused cyclical process of learning and improving.

Appendices to the Framework provide definitions of terms, further description of concepts, and practical resources to support implementation.

This Framework presents the ideals that AHS strives for in developing evidence, resources, strategies and services. Each section may be applied to the health system, programs, teams and individual rehabilitation service providers. For support in applying this document to your context, please contact practice.consultation@ahs.ca.

Within this document, “rehabilitation” may be used to name or describe an activity or service.



FOUNDATIONS OF REHABILITATION

A foundation is the base underlying the reasoning and justification for an activity. This section outlines what we do, the difference it makes, what guides us and who is involved.

WHAT WE DO

Rehabilitation Defined

Rehabilitation is a set of interventions that reduce disability and optimize function in individuals with health conditions, with attention to their environments (WHO, 2017c).

Rehabilitation is a personalised, interactive and collaborative process, reflecting the whole person. It enables an individual to maximise their potential to live a full and active life within their family, social networks, education/training and the workplace where appropriate. Rehabilitation can take place at any time across a life course or in a continuum and may include habilitation, reablement and recovery.

NHS England, 2016, p.37

Rehabilitation focuses on abilities - facilitating resourcefulness, self-care, inclusion and participation. It aims to prevent or slow loss of function, improve or restore function, compensate for lost function, and maintain current function (WHO, 2012). Rehabilitation enables people to identify, reach and maintain cognitive, communication, emotional, physical, psychological, social, and spiritual health goals.



The goals of rehabilitation services for individuals, groups and broad populations are:

Capacity Building...

- Enriching community and system ability to support function and to facilitate health and wellness
- Partnering to change public awareness, acceptance and expectations about health, wellness and disability
- Influencing societal norms, policies and physical environments

Prevention...

- Preventing and deterring complications, developmental delay, disease, disability, illness and functional decline at an individual, group and population level

Fostering Resourcefulness...

- Partnering with people who are adapting to life with a health condition that impacts their function; helping them acquire knowledge, skills and strategies to overcome functional impairments
- Nurturing self-care and healthy behaviour
- Facilitating engagement and achievement of health goals
- Enhancing ability of individuals, families and caregivers to modify environments and support inclusion

Enhancing Function...

- Enabling people to actively participate in roles, relationships and activities important to them.
- Minimizing impairment; maximizing activity in daily life; restoring function; and enriching participation in societal roles through a focus on ability (adapted from WHO, 2002, WHO 2017c)

Impact of Rehabilitation

It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.

NHS England, 2016, p.5

Rehabilitation equips people “to live their lives, fulfill their maximum potential and optimize their contribution to family life, their community and society as a whole” (NHS England, 2016, p.5).

Rehabilitation has impact across the continuum of health, the lifespan, and generations. It impacts the health system and other sectors such as education and social services (WHO, 2017c).

Services contribute to quality of life, productivity in society, effectiveness of medical and surgical interventions, and the efficiency of the health system. Rehabilitation helps people maintain wellness, develop or restore function, and get back to work, school, and life sooner after an injury or illness (AHS, 2017b). For infants and children, rehabilitation optimizes development to facilitate participation in education, community activities and work in later years. It can also improve quality of life and reduce functional difficulties associated with aging (WHO, 2017c). Clients who receive restorative care early in their health trajectory reportedly access fewer personal care services and their need for higher levels of care is reduced (AHS, 2015a).



WHAT GUIDES US

Rehabilitation in AHS is guided by our philosophy, our principles and beliefs, and client experience.

Our Philosophy

Rehabilitation - enhancing function for meaningful living

Our Principles and Beliefs

People are at the centre of all we do

- People have voice and choice in co-designing services and determining their own care
- Services are for the whole person - acknowledging their inherent worth and personal preferences; encouraging their strength and resourcefulness
- We treat the person not their disease - considering an individual's context, personal factors, and how their health condition impacts participation in life

Rehabilitation is

...part of every life

- Rehabilitation plays a role in every person's life at various times
- We support and restore health, function, well-being, quality and involvement in life

...active and inclusive

- People actively participate in all aspects of their own care - planning, practice, feedback and learning
- We encourage people to be connected, learning from and with others



...focused on function and ability

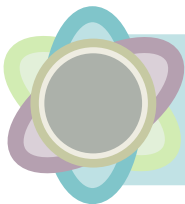
- Emphasis is on fostering potential, ability and participation in everyday life
- We promote adaptation to enhance or restore function
- Services are flexible rather than prescriptive

...embedded across health care and communities

- Rehabilitation is everyone's responsibility. Individual providers and AHS as a whole collaborate to create quality outcomes and positive health care experiences
- Within AHS, the necessity for rehabilitation is present in all health care settings
- Integration across services and sectors is essential to quality and best supports people in their life journey
- Partnership and coordination help us respond to individual and community context, needs and goals
- Clients, families, communities and providers all benefit from knowledge, prevention and health promotion. All have the ability to facilitate a person's rehabilitation journey.

...informed by evidence

- Evidence-informed decision making and continuous improvement create future-oriented, results-driven quality services



For Providers

See [Appendix B - Concepts and Resources Supporting the Framework](#) to learn more about the foundational elements underpinning our philosophy and beliefs.

Client Experience

Rehabilitation considers how services are received: what matters to clients and families.

We strive to provide experiences where people say,

...about the health system and their community,

- *I have input and help to design services*
 - *I am part of a community that supports my health and wellbeing*
 - *I have easy access to a range of services depending on what I need*
- ✓ ***My opinion matters***

...about their rehabilitation service and providers,

- *I have someone to turn to that helps me to make the most of available services*
 - *I receive caring service based on my unique needs*
 - *I am confident in the quality of my care*
 - *I participate in team discussions that are about me*
- ✓ ***My care matters***

...about themselves,

- *I am a partner in creating my own plan of care*
 - *I am confident in my ability to impact my own health*
 - *I have shared ownership in my health experience*
 - *I access and use my own health information*
- ✓ ***I matter***



For Providers

A checklist for Client Experience in Practice is included in [Appendix C](#).

OUR ROLES IN REHABILITATION

Our Clients

Rehabilitation services benefit people who are healthy, recovering from acute illness or injury, living with chronic conditions that impact their function, or reaching end of life.

Clients, their families, and communities have active roles in rehabilitation planning and provision. They choose and work to achieve their own personal rehabilitation goals, actively participating in a process of learning and practice (Wade, 2015b).

Individuals and communities collaborate with providers and planners in co-designing rehabilitation services. Consult the [Engagement and Patient Experience Team](#) for information on engaging Patient and Family Advisors.

Our Providers and Planners

All health care providers and sectors have a part to play in facilitating function through a holistic, integrated approach to wellness and care (WHO, 2017c).

Person-centred partnerships between clients, families, providers and communities facilitate health promotion, treatment, care and prevention of injury and illness, and of recurrence and secondary conditions (adapted from WHO, 2015a).



The World Health Organization (2017c, 2017d) advocates for a multidisciplinary rehabilitation workforce, where rehabilitation service providers work across all aspects of health care and partner with other sectors. Strong communication and liaison between all involved are necessary for effective and efficient rehabilitation (Wade, 2015b).

Our Organization

AHS plays a role in strengthening professional practice and in integrating rehabilitation services and the rehabilitation philosophy. Rehabilitation is essential to achieving the AHS vision:

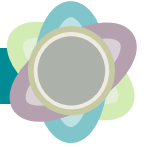
Rehabilitation is also foundational to the AHS Mission: To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Rehabilitation service planners and providers strive for alignment and integration across AHS departments and service settings, such as Acute Care, Addiction and Mental Health, CancerControl Alberta, Primary Health Care, Chronic Disease Management, Seniors Health, and Population, Public and Indigenous Health. Partnership is essential to quality rehabilitation services for clients and communities. Coordination across the continuum of rehabilitation services (primary, secondary and tertiary) is also essential.

We constantly seek to uphold the AHS Vision, Mission, Values and Strategies, and to comply with relevant policy, regulation and legislation. We are also guided by the provincial Rehabilitation Strategic Plan (AHS, 2016e).

Healthy Albertans.
Healthy Communities.
Together.

PLANNING & PROVIDING REHABILITATION SERVICES



Planning and providing rehabilitation is highly complex and not easily prescribed. In striving for quality we must engage with clients and partners to:

- Seek a Dynamic Balance
- Move Knowledge to Action
- Apply the Rehabilitation Process (Wade, 2015b; WHO & World Bank, 2011)
- Consider and employ a variety of Service Options

SEEK A DYNAMIC BALANCE

To provide quality rehabilitation, planners and providers consider needs, evidence and resources.

- **Needs** – individual and community wellness, health needs, expectations and context; the preferences and perspectives of clients, providers and the system
- **Evidence** - available evidence which includes research, outcomes, service evaluations, demographics, and population data as well as context and clinical and organizational knowledge
- **Resources** – available service options, staffing, facilities, tools, technology, equipment, stakeholders and strategic partnerships.

Maximizing this dynamic balance requires rehabilitation to be fully integrated into the model of health care service delivery (WHO, 2017d).



MOVE KNOWLEDGE TO ACTION

To create future-oriented, results-driven service, rehabilitation planners and providers use evidence to inform decision making, embed evaluation and learning into service planning and provision, and move knowledge to action.

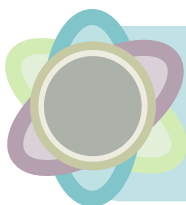
As recommended by the World Health Organization (2017d), AHS uses individual, program and population data to inform decision making related to clinical care, management and policy. We seek, share and act on relevant evidence, including clinical judgment, expertise and organizational knowledge. Evidence-informed decision making follows a cycle of:

- asking questions
- acquiring and assessing evidence
- adapting and applying knowledge to the local context, and
- evaluating, in a continuous iterative loop

Continuous improvement embeds evaluation and learning in service planning and contributes to professional practice. Strategic partnerships across AHS create opportunities for learning, evaluation and applying evidence that are paramount to positive rehabilitation outcomes.

Approaches and processes that support AHS rehabilitation to move knowledge to action include:

- AHS Improvement Way - an organization-wide approach for solving problems and implementing system improvements
- The Knowledge Cycle – an iterative process followed to plan, manage, deliver, and use health services effectively (AHS Knowledge Resource Service, 2013b)
- The Rehabilitation Process – a client-centred process for planning and providing rehabilitation services for clients and communities (Wade, 2015b; WHO & World Bank, 2011)



For Providers

Each of the above facilitate and require collaboration, sharing, learning and change leadership. Appendix D – Models for Moving Knowledge to Action provides further information.

FOLLOW THE REHABILITATION PROCESS

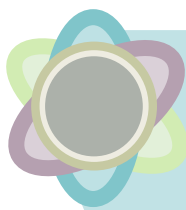
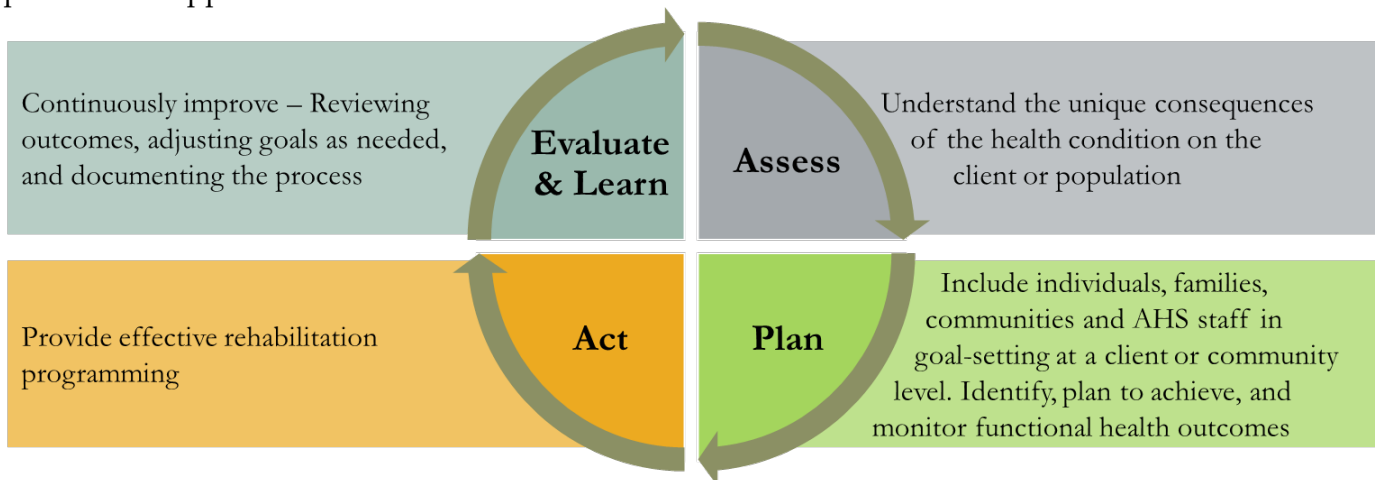
Rehabilitation providers and planners in AHS follow the Rehabilitation Process in applying a biopsychosocial model (Wade, 2015b; WHO & World Bank, 2011). Wade (2015b) compares and contrasts the Rehabilitation Process with the *health care process* which uses a biomedical model. Both follow a similar problem-solving approach comprised of four phases: assessment, planning, action, and evaluation and learning. Both aim to “preserve life and safety, and to minimize pain and distress” (Wade, 2015b, p.1148). The difference is that in a biomedical model, focus is on managing the disease itself and patients are passive recipients of health care. In a biopsychosocial model, focus is on managing the consequences of disease, and active client participation is fundamental. See Wade (2015a-b; 2016a-b) and Wade & Halligan (2017) for further discussion.

The Rehabilitation Process is described by Wade (2015b, p.1042) as a “problem-solving educational process model”. It guides planners and providers to identify a client, group, or community’s problems and needs; relate problems to relevant factors of the person and the environment; define rehabilitation goals; plan and implement measures; and assess the effects (WHO & World Bank, 2011).

The Rehabilitation Process relies on evidence and is responsive to preferences, values and circumstances of clients & families. The process is strength-based, solution-focused, ongoing and cyclical.

Accountability for the Rehabilitation Process is shared and everyone endeavors to understand their role in achieving desired results. All phases of the process integrate available evidence, input from clients and families and clinical decision making. Components of Clinical Decision Making (AHS, 2016b) applied by providers are described in Appendix E - Components of Clinical Decision Making.

An overview of goals for each of the four phases is outlined below with further application and examples provided in Appendix F.



For Providers

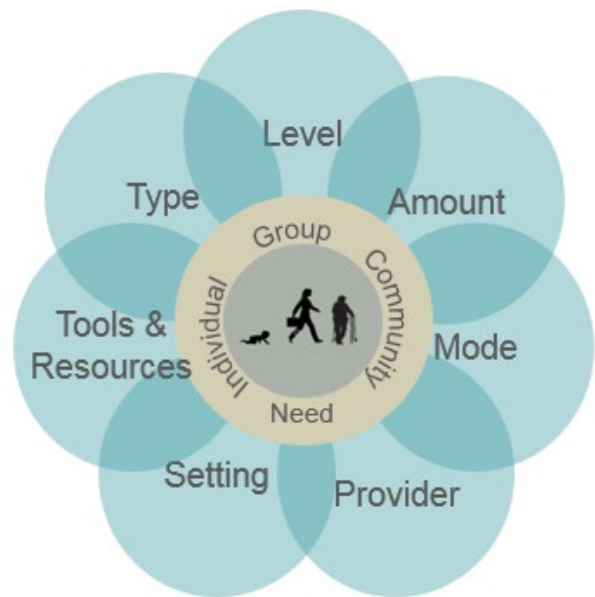
A guide to applying the Rehabilitation Process including further description of the four phases, examples of the process in action and checklists for planners and providers is provided in Appendix F – Guide to the Rehabilitation Process in AHS.

CONSIDER SERVICE OPTIONS

Rehabilitation planners and providers aim to meet diverse rehabilitation needs by creating and offering a variety of services. Service options allow for customization to match needs, act on available evidence and optimize resources.

This section outlines key considerations to:

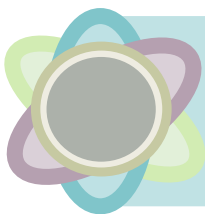
- create integrated and flexible approaches
- match the unique needs of individuals, groups, and communities with varied services
- balance priorities with resource demands
- facilitate application of the [Alberta Quality Matrix for Health](#) (HQCA, 2005).



To the greatest extent possible, service decisions are based upon:

- Impact on individuals and communities (e.g., safety, prevention, burden of disease, caregiver distress, ability to enhance or restore function, support during transitions, expressed needs, prevalence and population demographics)
- Evidence (e.g., available data, analytics, outcome measures, standards, standardized services or [clinical care pathways](#), literature, innovation, expert consensus, complexity or rate of change and the amount of clinical decision making required)
- Achievability (e.g., staffing and resources, context, partnership opportunities, feasibility, sustainability, system knowledge and capacity)
- Alignment (e.g., organizational priorities, current initiatives, context, timing, potential for the person or group to participate in and benefit from service, external drivers and potential dependencies or barriers)

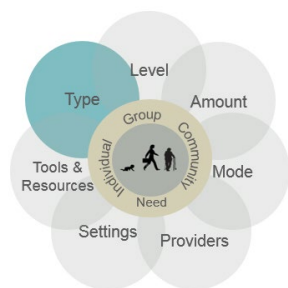
Access and coordination are important aspects of integrated care. Service eligibility may be based on parameters such as diagnosis, age or functional ability. To meet client needs, providers strive to facilitate connections with other services as required. Collaboration across the continuum of rehabilitation services is essential to person-centred, quality care. The World Health Organization (2017c) notes that coordinated mechanisms, including referral pathways, are essential for people who require multiple services or prolonged care.



For Providers

Service Options are integrated to wrap around the needs of an individual, group or community. See Figure 4: Considerations for Service Options and [Appendix G – Guide to Service Options](#) for a table outlining options.

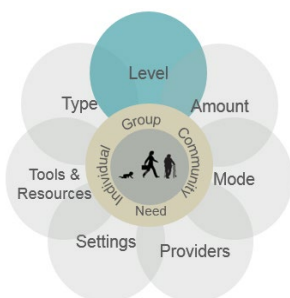
Service Type



The service types are health promotion, habilitation, intervention, care and case management. All require integration, coordination and may be delivered with varying degrees of intensity and personalization to address changing and diverse needs. A client or community's rehabilitation goals determine whether one or a combination of the service types is most appropriate. See [Appendix G](#) for further explanation of Service Types.

Restorative care is a type of rehabilitation, an approach to care, and a health service setting. It enables clients to regain or retain their independence following the debilitating effects of acute illness, injury, or prolonged hospitalization. See [Appendix I](#) for further information.

Service Level



Matching individualization to need facilitates acceptability, accessibility, appropriateness, effectiveness, efficiency, and safety. Service level reflects the degree of customization. Understanding the complexity and uniqueness of a health condition or need and associated personal and environmental factors guides service level decisions.

Three distinct levels of service are integrated and overlap to sufficiently meet varied needs. Universal and targeted services can lead to self-efficacy, healthy behaviour or environmental modifications that impact the success of personalized services. People may access and benefit from more than one level of service at the same time, and may enter and exit at any level.

Service levels listed below are described further in [Appendix G](#).

Personalized services

- designed to meet the unique needs of a particular person

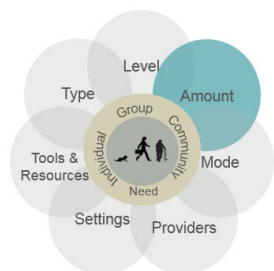
Targeted services

- designed for groups of people with a common need

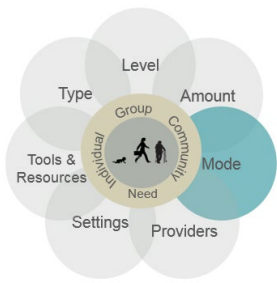
Universal services

- designed to meet the needs of broad populations and available to all Albertans

Amount

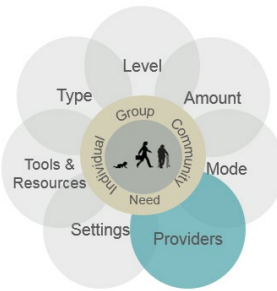


Flexibility in the frequency, duration and timing of a service helps providers to tailor the amount of services to the health needs of individuals, groups and communities. It is important to consider the amount of service in relation to functional need, rate of change and other contextual factors (Adapted from Durham Reder, 2008).



Mode

Mode refers to how services are delivered (e.g., consultation to family or other providers, information sharing, telephone, web-based, interactive learning to clients, caregivers or partners, modalities, structured practice, group facilitation, peer support, environmental modifications, etc.).



Providers

Who is involved with a particular service varies depending on the health condition, environmental and personal context, individual provider competencies, roles and skill mix of the team. Collaborative services may be single-, multi-, inter-, or trans-disciplinary in approach and different providers may have the ability to meet the same need. In determining team composition the important roles of family members, service partners and community members are considered. Some needs are better served by a health care provider and others by individuals who interact more regularly and in more natural environments with the client and family (adapted from AHS, 2011c).

Rehabilitation providers contribute to functional health outcomes and facilitate smooth transitions, continuity of care, system navigation and flow through the system. They bring a unique lens to system planning and to establishing an individual Integrated Plan of Care.

Competencies and learning needs of rehabilitation providers are often shared across health disciplines and are grounded in the concepts supporting this Framework (Appendix B). They emphasize but are not limited to:

- Understanding the International Classification of Functioning, Disability and Health and its impacts on service delivery at system and policy, program, community and individual client levels. Integrating personal and environmental factors such as cultural identities, family function, physical settings and social policy in a whole person approach (WHO, 2001. See Appendix H)
- Championing interprofessional collaboration through person centred care, team functioning, communication, role clarity, collaborative leadership and conflict resolution (CIHC, 2010).
- Integrating wholistic health practices with mainstream practices (AHS, 2015a)
- Applying a wellness and a life course approach
- Providing case management and system navigation: Assessing and supporting capability for self-management and knowing how to access available resources and system linkages

- Building client and community partnership and engagement. Leading teams across traditional and extended internal and external partnerships. Understanding and promoting engagement with the health system and with health behaviour change
- Creating evidence and contributing to quality improvement
- Applying specialized rehabilitation skills (e.g., advanced practice, use of technology)
- Integrating professional practice competencies in individual actions and in contributing to organizational practice
- Using the Rehabilitation process in striving for quality

Settings

All health service settings have a unique purpose that may be facilitated through attention to rehabilitation needs (Wade, 2016a). Various types of rehabilitation will occur within a setting.

The setting in which rehabilitation is provided has implications not only for access but also factors such as efficiency, cost-effectiveness and patient satisfaction.

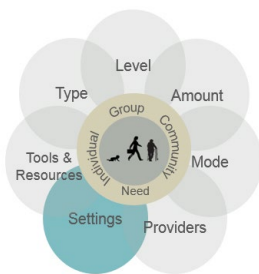
WHO, 2017c, p17

According to the World Health Organization (2017c), the setting where rehabilitation is provided impacts access as well as efficiency, cost-effectiveness and patient satisfaction. To the greatest extent possible, services are provided where they have the most impact, facilitate capacity building, best support generalization of skills and are least disruptive. For example, services may be provided in a home, work environment or community recreation centre. When it is not feasible for services to be conducted in natural contexts, settings and activities are adapted to be as realistic as possible. Broadly, health service settings include home, community, and inpatient or facility.

Tools & Resources

Rehabilitation recognizes the need for staffing, facilities, tools, technology, equipment and other resources to provide standards driven, evidence-informed practice. Stakeholders and service partners are also valued resources that contribute to planning and service delivery.

AHS seeks to allocate resources sufficient to achieve program goals; committing to focusing resources on the highest priorities to achieve high quality patient and population outcomes and to continuing to increase operational efficiency (see AHS Health Plan and Business Plan, 2017-2020, AHS 2017a). Service planners and providers access, develop and give input to policies, procedures,

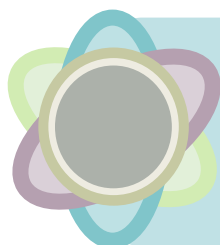


evidence, decision making tools, and practice consultation in accordance with legislation, regulation, and standards.



Advances in technology have a significant impact on results in rehabilitation services. Use of communication technology can increase the impact of rehabilitation interventions (AHS, 2016a). Rehabilitation service providers and planners seek to access and integrate technology to support quality and achievement of program goals.

Access to quality assistive technology is fundamental to improving people's function, independence and participation. Rehabilitation service providers ensure assistive products are suitable for the person and their environment. They train users and facilitate adaptations as needs evolve (WHO, 2017c, 2017d).



For Providers

Knowledge Management connects people to resources, processes, and people that can help them apply evidence-informed best practices for better client outcomes and organizational effectiveness. For associated tools and resources, see Appendix D – Models for Moving Knowledge to Action.

SUMMARY

The AHS Rehabilitation Conceptual Framework outlines the guiding concepts and details the considerations required to plan and provide rehabilitation services. The Framework serves as a basis for moving rehabilitation services into the future in support of our AHS rehabilitation philosophy – *enhancing function for meaningful living*.

For further information contact practice.consultation@ahs.ca.



Promoting understanding among health workers of the principles of rehabilitation and its role in different contexts is imperative for high-quality care, appropriate referral and optimal use of services.

WHO, 2017c, p.13

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Appendix A – AHS Glossary of Rehabilitation Terms

Glossary Term	Description
Adherence	<p>Any behaviour to maintain or improve health (e.g., seeking advice, taking medication appropriately, practicing new skills, attending follow-up appointments, and executing behavioural modifications). According to the WHO, increasing adherence may have a greater impact on population health than improvements in treatments and adherence is largely impacted by self-efficacy (WHO, 2003).</p> <p>The literature has identified the quality of the therapeutic relationship as being an important determinant of adherence (WHO, 2003).</p>
Assessment	<p>Assessment is initiated when there are questions about an individual’s health needs and how best to meet these needs. It includes both formal and informal measures ranging from administering standardized assessment tools to observing an individual in a specific setting or listening to family concerns. Assessment is ongoing. It is important in adjusting plans and determining effectiveness of interventions. Assessment considers: All aspects of the International Classification of Functioning, Disability & Health; integration of data in order to understand an individual’s condition in relation to functioning in their unique personal and environmental context; and supports individual care planning and service decisions.</p>
Care	<p>Assistive, supportive, and facilitative actions to improve or to maintain a person’s health and wellness (Armstrong & Armstrong, 2003). A caring approach is used to improve the quality of life for clients and their families. It can positively influence the course of illness and recovery. Care may include listening to the client, building a therapeutic relationship, preserving dignity, and providing encouragement, assistance, comfort, and advocacy. It requires skills and desire to connect with an individual, group, or community (Registered Nurses Association of Ontario, 2006).</p>
Case Manager	<p>A specific role that is responsible for providing case management services. The Case Manager provides leadership in collaborating with the interdisciplinary team, ensuring continuity of care and overseeing the Continuing Care Coordinated Access process, including intake & screening, assessment, service needs determination, service delivery, reassessment, transitions, and discharge (adapted from AHS Continuing Care Case Management Framework & Guidelines, January, 2011a). Rehabilitation providers may take on or support the role of the case manager.</p>
Chronic Disease Management	<p>A combination of health promotion and intervention delivered through a combination of <u>primary care</u>, specialized clinics and community-based health services. Chronic diseases are long-lasting, persistent, and often require therapy, education and training for the individual with the chronic disease to maintain health. People with chronic health conditions may need support to improve their confidence, skills, knowledge, and motivation to manage the physical, social, and emotional impacts of their disease. Rehabilitation providers play a vital role in educating and supporting individuals in the management of chronic condition (AHS, Chronic Disease Management Resource Centre, 2015b).</p>

Glossary Term	Description
Client	An individual or group requesting or receiving rehabilitation services, their family, caregivers or others that they identify as supporting them in their rehabilitation journey. The term client generally applies to individuals receiving rehabilitation services in a community or outpatient setting. However, in this document it may include patients and their families, groups, communities or populations.
Clinical Care Pathway	<p>An evidence-informed description of the route an individual or group takes through the health journey, for a defined health condition. It outlines the care provided to a specific population across a progressive series of interventions (e.g., screening, assessment, treatment, coaching and transition); identifies professional roles and competencies; and guides collaborative integrated service delivery to reach optimal outcomes (Adapted from: WHO, 2004; AHS, 2013a).</p> <p>Care pathways provide agreed-upon expectations for the care journey developed by key stakeholders through integration of evidence, expert-consensus, quality indicators, and context.</p>
Co-Design	A process that involves the team and the client and family working in collaboration to plan and design services or improve the experience with services. Co-design recognizes that the experience of and input from the client and family is as important as the expertise of the team in understanding and improving a system or process (AHS, 2017a).
Collaborative Practice	<p>Collaborative practice involves respecting clients, patients, families, caregivers, and members of each health discipline for their unique skills and ideas. When a specific skill set is combined with those of the rest of the team, the quality of care increases.</p> <p>As a health care organization, Alberta Health Services (AHS) is dedicated to providing the highest quality care. To truly provide the best care, health care providers need to collaborate with clients and patients, families and caregivers, and with all providers both within and outside of AHS.</p> <p>AHS and Alberta Health share a vision of collaborative practice: <i>“Health care providers in Alberta deliver the highest quality of safe, person-centred care by collaborating with each other and with individuals, their families and caregivers”</i> (Alberta Health cited in AHS, 2015d).</p> <p>These collaborative practice principles serve to inspire all AHS health care providers to renew their focus on how they work with each other, clients and patients, families and caregivers.</p> <p>When teams work collaboratively, it is found that people are more satisfied and feel they have better access to the health system. Health care providers are more satisfied with their jobs and workplace (AHS, 2015d). Teams are defined by the health needs of the individual receiving care.</p>
Community Integration	Services for an individual entering a new community when their current living situation is no longer suitable, creating a need for transition to the new community (Passmore, 2012).
Community Reintegration	Intervention targeted to an individual re-entering their community or resuming their life style after experiencing “a disruption to their functional abilities” (Passmore, 2012).

Glossary Term	Description
Competence	A person’s knowledge, skills, judgment and way they approach their work (adapted from CIHC, 2010).
Continuum of Rehabilitation Services	<p>Primary Rehabilitation Services Rehabilitation services that are broadly available and typically include interventions such as prevention, education, screening, risk stratification, assessment, coaching, treatment, and referral. Access to these services is through self-, family- or primary care provider- referral.</p> <p>Secondary Rehabilitation Services Rehabilitation services provided to people with needs requiring specialized equipment, provider expertise and skill mix not available in primary rehabilitation. Access to these services is typically through referral from a primary care provider.</p> <p>Tertiary Rehabilitation Rehabilitation services provided to people with need for highly specialized expertise and highly resourced technology and equipment. These rehabilitation services are generally only one component of the patient’s comprehensive treatment plan. Services integrate leading innovation and clinical research. Access to these services is through physician specialists and other rehabilitation service providers. The location of these services is not limited to Tertiary Rehabilitation Centers or Hospitals.</p>
Evidence	“Evidence is information derived from a range of sources (e.g., experience, evaluation, research, context) that has been subjected to testing and is found to be credible” (AHS, 2013 in <i>About KRS: Knowledge Resource Service</i>).
Evidence-Informed Decision Making	“The collection, evaluation and integration of valid research evidence, combined with clinical expertise, and an understanding of patient and family values and expertise to inform clinical decision-making” (Sackett et al, 2000 in <i>Knowledge Management Glossary</i>).
Habilitation	Services which traditionally involve helping individuals acquire abilities and skills associated with normal development (Shank & Coyle, 2002).
Health Condition	An acute or chronic disease, disorder, injury of trauma. A health condition may also include status or events such as pregnancy, ageing, stress, congenital anomaly or genetic predisposition (WHO, 2017c).
Health Needs	Objectively determined individual, group or community health concerns that require care, from health promotion to palliation (WHO, 2017a; 2017b). It includes the perceived need for health services as experienced by the individual. Professionally defined health needs are recognized by health professionals from the point of view of the benefit obtainable from advice, preventive measures, management or specific therapy. Scientifically confirmed health needs are the need confirmed by objective measures of biological, anthropometric or psychological factors, expert opinion or the passage of time; it is generally considered to correspond to those conditions that can be classified in accordance with the International Classification of Diseases. Professionally defined and perceived needs may or may not coincide with scientifically confirmed need (WHO, 2016).

Glossary Term	Description
<p>Health Promotion</p>	<p>Services directed to enabling people to manage and improve their health. Activities encourage healthy development, healthy lifestyles, healthy aging, self-care, self-efficacy, and self-management or advanced care planning. Health goes beyond the absence of disease, and considers the wellness of individuals, populations, organization and communities. Promoting health requires community participation and strategic partnerships beyond health services.</p> <p>As defined by the World Health Organization (2017a), health promotion is “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.”</p> <p>Health promotion is mostly provided through targeted or universal services that support people in “Being Healthy.”</p>
<p>Health Service Settings</p>	<p>Acute Care is delivered in rural and community hospitals, regional hospitals, metropolitan hospitals and tertiary hospitals as well as urgent care centres.</p> <p>Community Rehabilitation supports people in their own context. People living in their communities access a variety of services throughout their lives. Services are provided by AHS clinicians or contracted service providers in outpatient departments, community health centres, schools, family care centres or other community locations.</p> <p>Continuing Care refers to health, personal care and accommodation services for individuals requiring support for independence and quality of life. In AHS, there are three settings in which continuing care services provide individuals, with different health needs, with a broad range of health and personal care, accommodation and hospitality services: Home Living, Designated Supportive Living, Facility Living (Long Term Care) (Alberta Health, 2016).</p> <p>Facility Living is a subset of continuing care that includes those living in long-term care facilities like nursing homes and auxiliary hospitals. Care and accommodation services are provided for people with complex health needs who are unable to remain at home or in a supportive living setting (Alberta Health, 2016).</p> <p>Home Living enables independence and quality of life support for those who live in their own home, apartment, condominium or another independent living option and require continuing care. Individuals are responsible for arranging any home-based care and support services required. Home living can provide in-home professional support services such as nursing and rehabilitation, and personal support services like homemaking, bathing or grooming assistance (Alberta Health, 2016).</p> <p>Inpatient Care includes acute-, sub-acute-, cancer-care and transition services. Pre-hospital care supports rapid recognition, management and transport of individuals with acute health conditions that occur outside of the hospital setting. Examples include emergency services, hospital inpatient care, urgent care, medical and short-term rehabilitation services.</p> <p>Primary Care refers to the activities within <u>primary health care</u> that are provided in the community and that address the everyday health needs of individuals and their families through health promotion, and the prevention, diagnosis and treatment of illness and injury (AHS, 2011d).</p>

Glossary Term	Description
	<p>Rehabilitation Unit is a dedicated hospital unit that provide assessment, treatment and management for individuals whose immediate health care need is intensive rehabilitation in an inpatient setting.</p> <p>Restorative Care (Bedded Restorative Care and Restorative Home Care) is operated by Senior’s Health. Restorative Care can be provided by AHS and contracted providers in an individual’s home or in specialized units in Continuing Care centres and hospitals. Individuals are supported to remain home or return home, wherever home may be (AHS, 2018). Restorative care can also refer to a type of rehabilitation (see description below).</p> <p>Supportive Living combines accommodation services with other supports and care. It meets the needs of a wide-range of people, but not those with highly complex and serious health care needs. In addition to providing a place to live, accommodation services in supportive living accommodations can include meals, housekeeping and social activities. Supportive living residents can also receive professional and personal support services through home care.</p> <p>Residents pay an accommodation fee to cover the costs of providing accommodations and services like meals, housekeeping and building maintenance (Alberta Health, 2016).</p> <p>Tertiary Rehabilitation Centre/Hospital is a purpose built facility for a defined population of individuals whose immediate health care need is intensive, specialized assessment and rehabilitation services from a dedicated interdisciplinary team including physician specialists. Providers have advanced clinical and research expertise and access to significant levels of specialized and highly resourced technology and equipment. Tertiary rehabilitation hospitals provide both inpatient and outpatient tertiary rehabilitation and are limited to a few sites in Alberta.</p> <p>Urgent Care Centre provides a health service option for unscheduled patients with urgent but not life-threatening needs. It includes triage, assessment and management of patients presenting with illness, injury or psychosocial needs (AHS, 2016g).</p>
Integrated Plan of Care (IPOC)	<p><i>A single care plan for a patient based on interprofessional assessments. The IPoC becomes a single source of truth for documenting and communicating within and amongst care teams (AHS, 2015c CoACT Glossary np).</i></p>
Integration	<p><i>Integration in the health system involves the management and delivery of rehabilitation in conjunction with other health services so that people receive timely, comprehensive and well-coordinated care, according to their needs and across different levels of the health system (WHO in WHO, 2017c, p10).</i></p> <p>Integration refers to services managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course (WHO, 2015b).</p>
Interprofessional Teams	<p>Interprofessional teams are groups of providers who work together with a common goal, using <u>Interprofessional Collaborative Practice Competencies</u>. The team includes the individual, group or community receiving service and is defined by their unique needs. Teams may be described as:</p>

Glossary Term	Description
	<p>Interdiscipline/Interdisciplinary/ Multidiscipline/Multidisciplinary A team of two or more disciplines working together</p> <p>Transdiscipline/Transdisciplinary Crossing disciplinary boundaries to provide a broader scope of practice (WHO, 2017c).</p>
Intervention	<p>In rehabilitation, intervention refers to actions for the <i>prevention of impairment and deterioration in the acute phase of care as well as for optimization and maintenance of functioning in the post-acute and long-term phases of care</i> (WHO, 2017c p5) delivered within the context of a need, health condition or impairment.</p>
Life Course Approach	<p>An approach that encourages focus on critical periods of growth and development, transition, and integration of health services to impact quality of life through the life course or life journey.</p> <p>Acknowledgement that aging is impacted by genetics, physical and social environments, and personal characteristics across generations. Biological, personal and social impacts on health are integrated from before birth through to end of life and across generations (Sulmasy, 2002).</p> <p>A Life Course Approach acknowledges that different rehabilitation services become important to people at different stages in their life and individuals will come and go from health services as they need. Interactions with individuals are not viewed as discreet events but as integrated parts of the whole of a person’s life journey (WHO, 2000).</p>
Partners	<p>Those who may be involved in supporting the Client and family including physicians, other health care providers, community agencies, schools, funding agencies and other ministry services such as Human Services.</p>
Person Centred/ Person and Family Centred Care (PFCC)	<p>Clients, patients and families are integral members of the health-care team, and their active participation is encouraged in all aspects of care; including as Partners in planning, implementation and evaluation of existing and future care and services (AHS, 2015f).</p> <p>A person-centred approach aligns with the emerging body of evidence on the determinants of health suggesting a need to consider the factors in the environment that contribute to a person’s health and well-being, or conversely, to their illness and lack of well-being.</p>
Population Health Needs	<p>The multiple and varied characteristics of individuals that create the demand for preventative and curative health services. Health needs are influenced by social, cultural, political, contextual, geographical, environmental and financial factors (Government of Canada, 2006).</p>
Prevention, Primary & Secondary Prevention	<p>Services aim to prevent delays in development, disease, disability, chronic conditions, illness and functional decline in individuals, groups and populations. Activities identify and deter concerns in early stages, before complications arise.</p> <p>Primary Prevention is directed towards preventing the initial occurrence of a delay or concern, disease, injury or condition. Services emphasizes capacity building, screening, risk stratification, surveillance and control of risk factors</p>

Glossary Term	Description
	<p>Secondary Prevention is focused on those with chronic illness and a history of acute exacerbation in order to prevent or delay further functional decline and future disease, complications, exacerbation or injury. It seeks to maintain quality of life. Activities include early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions (adapted from WHO, 1998).</p>
<p>Primary Health Care</p>	<p>Refers to activities, provided in partnership with individuals, families, communities, and populations, that extend beyond primary care to include the determinants of health (for example: education, housing, income, and environment (AHS, 2011d).</p>
<p>Professional Practice</p>	<p>Professional Practice is defined as practice which 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; demonstrating a spirit of collaboration and flexibility to optimize service (AHS, 2016d).</p>
<p>Quality</p>	<p>Quality encompasses the six dimensions described by the HQCA (2005): acceptability, accessibility, appropriateness, effectiveness, efficiency, and safety. See Appendix B for further description.</p>
<p>Rehabilitation Service Providers/ Rehabilitation Providers</p>	<p>All health care providers have a part to play in facilitating function through a wholistic approach to wellness and health care.</p> <p>Some disciplines have specialized training in the area of rehabilitation. These include but are not limited to: audiologists, occupational therapists, psychiatrists, physiotherapists, recreation therapists, rehabilitation nurses, speech-language pathologists, therapist aides and therapy assistants.</p>
<p>Restorative Care</p>	<p>A type of rehabilitation that enables clients to regain or retain their independence following the debilitating effects of acute illness, injury, or prolonged hospitalization. It is a time-limited, multi-disciplinary, goal oriented and client-centered approach. Restorative care helps clients, across the continuum of care, return to home and remain at home as long as possible. It mitigates the risk or need for higher levels of health care or premature admission to a Continuing Care living option. Restorative care helps medically stable clients learn or re-learn the necessary skills required to complete their daily living activities. Restorative care can also refer to a health service setting (see above description).</p>
<p>Risk Stratification</p>	<p>Risk stratification and associated tools assist with identification and screening for the potential of disability, delay or functional decline. It is particularly important to identifying and proactively managing high-risk, high-cost users. Risk stratification tools help providers to determine modifiable issues and identify appropriate intensity and frequency of care required (adapted from AHS, 2015a).</p>
<p>Screening</p>	<p>A high level needs identification process that gathers salient pieces of information that are sufficient to guide service recommendations to the individual or for the population.</p> <p>A variety of screening options are available such as: developmental screening, healthy living screening, risk screening and dialogue, among others. Screening is offered through multiple</p>

Glossary Term	Description
	<p>approaches, including but not limited to, individual self-selection for Universal and Targeted Services, formal processes for Targeted community programs, health provider referral or self-referral for Clinical Services and dialogue.</p> <p>Developmental screening identifies children with possible developmental delays early, ensuring appropriate timely assessment and early intervention as required. Early identification ensures that children can access and benefit from a range of services early in life and be well supported through their development (Alberta Health and Wellness, 2006).</p> <p>Healthy living and risk screening empowers individuals to consider the effects that diet, level of exercise, balance of activities and habits like smoking and drinking have on their health. Screening enables individuals to detect health risks, supporting early identification and Treatment.</p> <p>Screening dialogue between a health provider and an individual requesting help includes a discussion of the individual’s concerns and goals and available resources or services that might assist.</p> <p>Coaching services partnering to screen or otherwise identify individuals or groups who would benefit from rehabilitation assessment or programs is often appropriate.</p> <p>Population screening is the systematic application of specific tests, examinations, validated questionnaires, or other procedures to whole or targeted (higher risk) population groups.</p> <p>Opportunistic screening or case finding occurs when a test is offered to an individual without symptoms of the disease when they present to a health care practitioner for reasons unrelated to that disease (AHS, 2011b).</p> <p>Screening may be required at multiple points in the course of helping the client or community meet goals - determining effectiveness of chosen interventions and potential need for adjustments in planning.</p>
Self-Care	<p>What people do for themselves to establish and maintain health, prevent and deal with illness. It is a broad concept encompassing:</p> <ul style="list-style-type: none"> • hygiene (general and personal) • nutrition (type and quality of food eaten) • lifestyle (sporting activities, leisure, etc.) • environmental factors (living conditions, social habits, etc.) • socioeconomic factors (income, cultural beliefs, etc.) • self-medication <p>(WHO, 2016)</p>
Self-efficacy	<p>Confidence in the ability to perform a behavior. In the context of health behavior change, self-efficacy is one’s knowledge, beliefs, confidence and motivation in relation to their health, self-care and ability to manage it, to health goals and to engage in healthy behaviours. Self-efficacy is one factor associated with change in behaviour (Linke et. al., 2014; Bandura, 1997; Euromed Info, 2016).</p>
Self-Management	<p>Self-management is what people with do (their action and behaviour) to cope with the effects of their disease. This includes working with their caregivers and other health providers so</p>

Glossary Term	Description
	that they become more confident and skilled in managing their chronic disease (adapted from AHS, 2016f).
Skill Mastery	<p>Skills mastery refers to the technique of breaking down skills to be learned into small, manageable tasks in order to increase success. People are more likely to adopt a health behaviour if they think they will be successful in doing it. Thus, interventions increase confidence by giving people many little “successes” in the process of behaviour change (Euromed Info, 2016).</p> <p>Learning and practicing skills is required for an active and emotionally satisfying life in the face of a health condition (Lorig, 1993).</p> <p>Skill mastery and practice are important to successful rehabilitation. If the person feels overwhelmed by the amount of material to be learned or the complexity of tasks involved, he or she will be less likely to be willing to try new skills (Euromed Info, 2016).</p>
Specialization	Differentiation or concentration of focus and expertise within a limited scope or for a particular purpose (adapted from Merriam-Webster, 2016).
Spiritual/ Spirituality	The experience of relationship with self, (intra-personal), with others, (inter-personal), and with what one considers ultimate/Other (trans-personal). Central to spirituality are the beliefs, practices, and communities of belonging that shape a person’s spiritual identity (authentic self), the expression of that identity through a particular work or way of life, and the core values and beliefs that inform one’s sense of meaning and purpose (Pritchard, 2014).
Standardized Rehabilitation Service	<p>An evidence informed description of how a service is delivered across AHS. A standardized service applies to a defined health condition or a specific population and may be part of a care pathway.</p> <p>Standardized services provide agreed upon expectations for practice and service delivery developed by key stakeholders through integration of evidence, expert-consensus, quality indicators, and context.</p>
Strategic Partnerships	<p>Strategic alliances and collaborative efforts to work with other teams, other organizations, ministries, institutions, community groups, to identify and cultivate optimized integrated services, both internal and external to AHS.</p> <p>The aim of forming Strategic Partnerships is to provide services which are not disjointed for the user and which the user can easily navigate. Integration is best seen as a continuum rather than as two extremes of integrated/not integrated. It involves discussions about the organization of various tasks that need to be performed in order to provide a population with good quality health services. Integrated service can look different for systems, programs and individual providers. There are many possible permutations.</p> <p>These partnerships strengthen systems and processes and facilitate greater integration and seamlessness, especially for those with long-term or life course rehabilitation needs.</p>
Strength-Based	A manner of doing things rooted in the beliefs that people (and groups of people, such as organizations, neighborhoods, communities):

Glossary Term	Description
	<ul style="list-style-type: none"> • have existing competencies, resources and are capable of learning new skills, preventing and solving problems • can use existing skills to identify and address their own concerns • can be involved in the process of discovery and learning • are capable of making their own choices as related to their health care needs <p>Using this approach recognizes and builds on client, family and community strengths and involves them in the process of discovery, learning and coping with the challenges.</p> <p>In the Framework, “Strength-Based Approach” may be considered an umbrella term for many approaches such as capacity building, appreciative inquiry, resiliency, community development, solution - focused, etc. These approaches focus on personal relationships, acknowledge contribution, attend to the context and systems, invite meaningful Participation, provide opportunities for skill-building and learning, recognize interrelationships, and concentrate on solutions and potential (Alliance for Children & Youth of Waterloo Region, 2009).</p>
System Navigation	Establishing required linkages and partnerships across health service settings, government sectors and programs with attention to understanding other services, provider roles and potential referrals. The goal is to integrate services and to efficiently direct those with needs that cannot be met by their particular program to connect with more appropriate services.
Treatment	The act of providing service to remediate a health concern related to a developmental delay or following an injury, illness or disability. This includes advice, coaching, support and guidance to facilitate Self-Management. Within the Framework, treatment is considered one aspect of the Rehabilitation Process (Wade, 2015b; WHO & World Bank, 2011).
Voice and Choice	<u>Voice and Choice: Team and Self Reflection in Person and Family Centred Care</u> is a professional practice resource intended to help clinicians assess their current application of person and family centred care (PFCC) practices and to set goals for growth. This resource was developed by Health Professional Strategy and Practice with the support of Engagement and Patient Experience – in consultation with clinicians throughout AHS. It is to be considered a “living” document – please provide questions or suggestions to patient.engagement@ahs.ca . (AHS, 2015g)
Wellness	Wellness is multidimensional and dynamic. The <u>National Wellness Institute</u> identifies six dimensions of wellness: social, emotional, intellectual, spiritual, physical and occupational. Each dimension is interconnected. Wellness is grounded in the concept of health promotion. <p>The definition within the AHS Community Rehabilitation – Model of Care indicates that wellness:</p> <ul style="list-style-type: none"> • is an active, multidimensional and dynamic concept, defined by the individual • acknowledges the biopsychosocial context of the individual and determinants of health • is about increasing awareness and capacity to make choices and building a sense of autonomy <p>(AHS, 2017c)</p>

REFERENCES FOR APPENDIX A

All references for Appendix A are included within the Rehabilitation Conceptual Framework main document.

Appendix B – Concepts & Resources Supporting the Framework

Foundational elements, concepts and resources underpinning the Framework explained here include:

- Patient & Family Centred Care
- A Whole-Person Approach
- The Life Course Approach
- Professional Practice
- Collaboration & Partnership
- Alberta Quality Matrix for Health – Continuum of Health & Dimensions of Quality
- Our Values – AHS Cares

Patient & Family Centred Care	
<u>AHS Patient First Strategy (AHS, 2015b)</u>	
Key Information	Application to the Framework
<p>Patients and families at the centre of everything we do and every decision we make. AHS Principles of Patient & Family Centred Care are:</p> <p>Dignity & Respect – honouring patient and family perspectives, culture and choices</p> <p>Participation – facilitating optimal involvement in care and decision making</p> <p>Information Sharing – sharing complete unbiased information in ways that are affirming and useful</p> <p>Collaboration – partnering to develop, implement and evaluate services</p> <p>Self-Care & Attunement – mindfulness of the impact of provider wellness on interactions and empathy</p>	<p>Services are provided with compassion. Diversity is honored and valued.</p> <p>Patients and families are integral to rehabilitation teams and providers constantly strive to promote respect, enhance communications, facilitate involvement, support a team-based approach and improve transitions in care.</p> <p>We work to facilitate wellness and team work. We look to patients to define who is involved with their care.</p> <p>Patients and families are active partners in planning, implementing, developing learning and evaluating rehabilitation services.</p>
A Whole-Person Approach	
<p>International Classification of Functioning, Disability and Health, World Health Organization (2001) Further description of the ICF is provided in Appendix H. The Rehabilitation Process (Wade, 2015a,b; 2016a,b; WHO & World Bank, 2011)</p>	
Key Information	Application to the Framework

<p>Mind, body and spirit come together to create health.</p> <p>A whole-person approach considers health conditions in the context of personal and environmental factors and how these come together to impact body structure and function, activity and participation.</p> <p>A biopsychosocial model describes the dynamic interaction between an individual’s health condition and context. Spirituality is considered in a whole-person view of health.</p> <p>Function is delineated as different from disability and disease. Focus shifts from cause to impact.</p> <p>People are seen as having an essential active role in rehabilitation, health and wellbeing (rather than seeing a person as “sick” with an external cause leading to external treatment and the need for care).</p>	<p>Facilitates understanding that connectedness and relationship with self, with others, and with what one considers ultimate are essential to wellbeing.</p> <p>Supports strength-based approaches, facilitating recognition of the impact of personal and environmental factors (i.e., culture and contextual factors) on health.</p> <p>Consideration is given to complex inter-related factors that support health and wellbeing, drawing attention to factors that influence behaviour and require system wide collaborative approaches.</p> <p>Encourages a broad understanding of health and alignment with the WHO.</p> <p>Supports advocacy for policy and environmental change.</p>
<p>Life Course Approach (WHO, 2000; 2016)</p>	
<p>Key Information</p>	<p>Application to the Framework</p>
<p>Aging begins before birth and continues through life. Healthy aging is impacted by genetics, physical and social environments, and personal characteristics across generations. Biological, personal and social impacts on health are integrated.</p>	<p>Encourages focus on critical periods of growth and development, transition, and integration of health services to impact quality of life through the life course.</p>
<p>Professional Practice <u>Professional Practice in Action</u> (AHS, 2016b)</p>	
<p>Key Information</p>	<p>Application to the Framework</p>
<p>Professional practice that results from specific individual and collective actions is required to create quality outcomes and positive health care experiences.</p> <p>Individual actions are: creating, caring, <u>competence</u>, commitment, and collaboration.</p> <p>Organizational actions are developing structures and processes to support: an enabling environment, evidence, encouragement, engagement, and evaluation.</p>	<p>Professional Practice in Action outlines how AHS supports professional practice. It illustrates the expectation of how people work to provide patient-centred, evidence-informed, quality care to Albertans.</p> <p>The elements of professional practice facilitate all aspects of rehabilitation service planning, delivery, continuous learning and evaluation.</p>
<p>Collaboration & Partnership Adapted from National Interprofessional Competency Framework - Collaborative Practice Competencies, Canadian Interprofessional Health Collaborative (2010) AHS Collaborative Practice Principles Supporting Patient Centred Care (2015a)</p>	

Key Information	Application to the Framework
<p>Interprofessional Practice Competencies are:</p> <p>Patient and Family Centred Care - Providers seek out, work with, and value the patient, their family and caregivers as Partners in designing and carrying out care services.</p> <p>Role clarifications – Providers understand their own role and the roles of others, and apply this knowledge to support patients in setting and achieving their goals.</p> <p>Team functioning – Providers have a solid understanding of the principles of team work. They know and support processes to foster collaboration among all team members.</p> <p>Collaborative leadership – Providers understand and apply a leadership style that supports <u>Collaborative Practice</u>.</p> <p>Communication – Providers talk with clients and each other and work together in a collaborative, open and responsible way.</p> <p>Conflict resolution – Providers work to engage those involved, including the patient and family, if disputes arise. This is done in a positive and proactive manner.</p>	<p>Patients, family members, providers and other partners are appropriately supported, informed and consulted to perform their roles. Each is aware of their own and others’ responsibilities and accountabilities.</p> <p>Rehabilitation providers are inspired to renew their focus on how they work with one another, patients, families and caregivers, drawing on the abilities of all those involved.</p> <p>Rehabilitation providers are oriented to the impacts of collaborative care on patients’ satisfaction and self-efficacy, efficiency and on role optimization and job satisfaction. They work to establish partnerships among patients/clients and providers, facilitating a participatory, collaborative and coordinated approach to decisions making about health, social and system issues.</p>
<p>Alberta Quality Matrix for Health – Continuum of Health & Dimensions of Quality <u>Alberta Quality Matrix for Health</u> Health Quality Council of Alberta (2005)</p>	
Key Information	Application to the Framework
<p>The Alberta Quality Matrix for Health provides a way of organizing information and thinking around the complexity of the health system.</p> <p>The matrix has two components:</p> <ol style="list-style-type: none"> 1) Dimensions of quality, which focus on aspects of the patient/client experience 2) Areas of need, which divides the range of services provided by the health system into four distinct, but related, categories. 	<p>The Quality Matrix enables the public, clients, patients, providers, and organizations to see how levels of quality and areas of need might intersect. It has been used in numerous ways, including policy development, strategic and service planning, and as a way to educate the public about quality in health care.</p> <p>See Continuum of Health (Areas of Need) and Dimensions of Quality below.</p>
<p>Continuum of Health (Areas of Need)</p> <p>The matrix describes areas of distinct but interrelated health needs:</p>	<p>Rehabilitation contributes to wellbeing across a person’s life.</p> <p>Rehabilitation is integrated in all of these areas and a person may move between them as needed. Thus</p>

<p>Being Healthy - Achieving health and preventing occurrence of injuries, risk factors, illness, chronic conditions and resulting disabilities.</p> <p>Getting Better - Care related to acute illness or injury.</p> <p>Living Well with Illness/Disability - Care and support related to chronic or recurrent illness or disability.</p> <p>End of Life - Care and support to relieve suffering and improve quality of living with or dying from advanced illness or bereavement.</p>	<p>integration and coordination across the areas of need is essential.</p> <p>Rehabilitation has an important role to play in promoting health across the life journey. Services encourage wellness, facilitate healthy development, support recovery and reduce functional decline and acceleration of aging.</p> <p>Services facilitate dying with comfort and dignity. End of life care may encompass capacity building (such as creating environmental supports), preventing secondary concerns and enhancing function.</p>
<p>Dimensions of Quality</p> <p>Acceptability - Services are respectful and responsive to user needs, preferences and expectations.</p> <p>Accessibility - Services are obtained in the most suitable setting in a reasonable time and distance.</p> <p>Appropriateness - Services are relevant to user needs and are based on accepted or evidence-based practice.</p> <p>Effectiveness - Services are provided based on scientific knowledge to achieve desired outcomes.</p> <p>Efficiency - Resources are optimally used in achieving desired outcomes.</p> <p>Safety - Risks are mitigated to avoid unintended or harmful results.</p>	<p>Rehabilitation services strive to apply each of these interrelated quality dimensions in providing future oriented, innovative, outcomes driven services.</p>
<p><u>Our Values - AHS Cares</u> AHS (2016a)</p>	
<p>Key Information</p>	<p>Application to the Framework</p>
<p>Compassion - We show kindness and empathy for all in our care, and for each other.</p> <p>Accountability - We are honest, principled and transparent.</p> <p>Respect - We treat others with respect and dignity.</p> <p>Excellence - We strive to be our best and give our best.</p> <p>Safety - We place safety and quality improvement at the centre of all our decisions.</p>	<p>The AHS core values guide how we work together with patients, clients, families and each other.</p> <p>They provide a common understanding of what's important and guide our actions and interactions in support of providing health care that is truly person- and family-centred.</p>

REFERENCES FOR APPENDIX B

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Appendix C – Client Experience in Practice

Below is a checklist to help providers reflect on their person centered practices in alignment with the AHS (2015a) Patient First Strategy.

We strive to provide experiences where people say,

...about the health system and their community,

- *I have input and help to design services*
- *I am part of a community that supports my health and wellbeing*
- *I have easy access to a range of services depending on what I need*

✓ **My opinion matters**

...about their rehabilitation service and providers,

- *I have someone to turn to that helps me to make the most of available services*
- *I receive caring service based on my unique needs*
- *I am confident in the quality of my care*
- *I participate in team discussions that are about me*

✓ **My care matters**

...about themselves,

- *I am a partner in creating my own plan of care*
- *I am confident in my ability to impact my own health*
- *I have shared ownership in my health experience*
- *I access and use my own health information*

✓ **I matter**

In practice this means:

- Albertans are involved in designing and evaluating rehabilitation health services.
- People's health and wellness are supported by family and friends, physical and social environments, and information and opportunities.
- Clients can see that agencies, facilities and public policies impact wellness.
- Clients can directly access services in locations where they make the most sense and through a variety of options (e.g., telephone and web-based information or intake, self-referral, community based service, embedded in continuing care).
- Albertans know what to expect and how to navigate smoothly through services as their health needs and life situations change.
- Teams provide the support that clients need to make the most of available services.
- Clients experience intensity, frequency and timeliness of service responsive to individual needs.

- Collaborative care is based on the best available evidence and complete client information. Care teams are positive, caring, knowledgeable and committed.
- Teams are supported by a system that helps them deliver quality care.
- Individuals play an active role in their own health and wellness.
- They receive respectful, comprehensive, consistent and timely information in language that makes sense.
- Their needs, choices, goals and values are heard, respected and addressed in their integrated plan of care.
- They have shared ownership in their health experiences.
- The client experience is supported by the Rehabilitation Process and Service Options.

Voice & Choice: Team and Self-Reflection in Person & Family Centred Care (AHS, 2015) is a professional practice resource to help assess application of person and family centred care practices and to set goals for growth.

REFERENCES FOR APPENDIX C

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Appendix D – Models for Moving Knowledge to Action

Knowledge Cycle

Alberta Health Services, Knowledge Resource Service uses the knowledge cycle in the belief that effective health services planning, management, delivery and use, involve iterative processes to:

- Ask questions that clearly articulate issues and opportunities
- Acquire and assess all types of relevant evidence, including research, evaluation, experience and context
- Adapt evidence as needed
- Apply evidence in context
- Evaluate outcomes
- Create opportunities for linkage and exchange throughout the knowledge cycle



Knowledge Cycle (KRS, 2013)

Knowledge to Action Cycle

Ian Graham et al. (2006) created a conceptual framework to outline the process of moving knowledge to action, integrating the roles of knowledge creation and knowledge application. See the Canadian Institute for Health Research *Moving into action: We know what practices we want to change, now what? An implementation guide for health care practitioners* for more information.

Tools and Resources for Moving Knowledge to Action

AHS Knowledge Management connects people to resources, processes, and people that can help them apply evidence-informed best practices for better client outcomes and organizational effectiveness. Their Knowledge Resource Service (KRS) connects providers and planners with evidence resources and support in using them effectively (access KRS at <http://krs.albertahealthservices.ca>). Also refer to the AHS Improvement Way (AIW) webpage for tools and resources.

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Appendix E – Components of Clinical Decision Making

Across rehabilitation disciplines there are 10 consistent elements essential to clinical decision making (AHS, 2016). These components are embedded in each of the four aspects of moving knowledge to action. They were determined based on a collation of regulatory guidelines, AHS guidelines and clinical input. Dynamic integration of all elements based on critical thinking and collaboration is required. They are as follows:

- **Screening:** Critical clinical appraisal of available initial information to identify individual, family and community needs
- **Consent:** Obtain informed consent to assess, treat or disclose information
- **Assessment:** Get to know the person through critical inquiry with a variety of assessment methods and analysis to further identify and validate individual and group needs/diagnosis
- **Critical Evaluation and Risk Identification/Stratification:** Reflection on risk/condition/environment and one's own knowledge and skill and determination of next steps and/or referral
- **Evidence-informed Approach:** Seek and evaluate relevant evidence, adapt to context, apply and evaluate to ensure evidence-informed decision making across all elements
- **Goal Setting and Care Planning:** Collaboratively establish goals, integrated plan of care, assignment of tasks/activities and discussion of expected outcomes with the individual, family, community and other care providers
- **Implementation:** Implement evidence-informed integrated plan of care that is supportive of individual, family and community goals
- **Transition Support:** Collaborate to support transition planning to enable service access within/across streams of care, giving consideration of individual, family and community needs, supports, and environmental context
- **Evaluation:** Ongoing critical clinical evaluation of relevant information and measures, including individual, family and community perspective, to adjust integrated plan of care as needed
- **Capacity Building:** Information sharing to enhance the skills and abilities of the client, family, their community and care providers to support successful health outcomes

REFERENCES FOR APPENDIX E

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Appendix F – Guide to the Rehabilitation Process in AHS

The Rehabilitation Process is a client-centred process for planning and providing rehabilitation services for clients and communities (Wade, 2015b; WHO & World Bank, 2011). Following the process guides planners and providers to identify a client, group, or community's problems and needs; relate problems to relevant factors of the person and the environment; define rehabilitation goals; plan and implement measures; and assess the effects. The process aims to support application of the biopsychosocial model to engage in continuous learning while managing the consequences of disease. Active client participation is fundamental to the process. See bibliography at the end of this appendix for sources used to inform development of this document.

The Rehabilitation Process - Phases and Goals

Assess

Understand health needs to determine where rehabilitation can deliver benefit. Providers and service planners determine needs of individuals, groups and communities in relation to their context. Decisions are based on client, community and professional perceptions as well as scientifically confirmed needs (Wade, 2015b). Clarifying questions and setting priorities are essential components of assessment.

- The aim of the Assess phase is to understand the unique consequences of the disease or diagnosis on the client/population.

Activities include clarifying questions, screening, clinical assessment, risk stratification, wellness conversations and analysis of population data.

Plan

Establish relevant, meaningful goals together with clients, communities and programs to support behavior change. Plan actions. Support access and integration for required services where and when they will have the greatest impact.

Plans address capacity building, resourcefulness, prevention, and enhancing or restoring function. Well laid plans support smooth transitions, system navigation and case management.

- The goal of the Plan phase is to include individuals, families, communities and AHS staff in goal-setting at a client or community level, and in co-designing services at a system-level. This includes planning to identify, achieve and monitor functional health outcomes.

Activities include goal setting, exploring service options, community consultation, determining required partnerships or referrals and determining needs for programs or standards.

Act

Adaptations to the environment along with specific interventions can greatly improve a person's function (WHO, 2000). Actions may include any or all of the rehabilitation service types outlined in Appendix G.

The roles of the client and service provider in this phase of the Rehabilitation Process are paramount.

- The client is a learner - active participation in goal setting, learning and practice is essential to health behaviour change
- The service provider is a liaison - collaboration is fundamental to the integration of multiple primary interventions across service sectors in AHS. Good communication is essential to client's learning, practice, and understanding feedback

- The goal of the Act phase is to provide effective rehabilitation interventions.

Activities include environmental modifications, coaching, modelling, education, therapeutic practice, treatment modalities, aligning resources to meet population needs, or developing evidence-informed standardized services.

Evaluate & Learn

Through quality improvement initiatives, clinical research and testing innovations, rehabilitation service planners and providers acquire the expertise, practice resources and skills needed to raise the standard of care. Evaluation and learning is part of every client service. Measures range from system wide information and analytics to collections of client stories. Rigor and resources are required to test ideas that benefit all Albertans (AHS, 2015).

- The aim of the Evaluate and Learn phase of the Rehabilitation Process is to continuously improve – Reviewing outcomes, adjusting goals and plans as needed, and documenting the process.

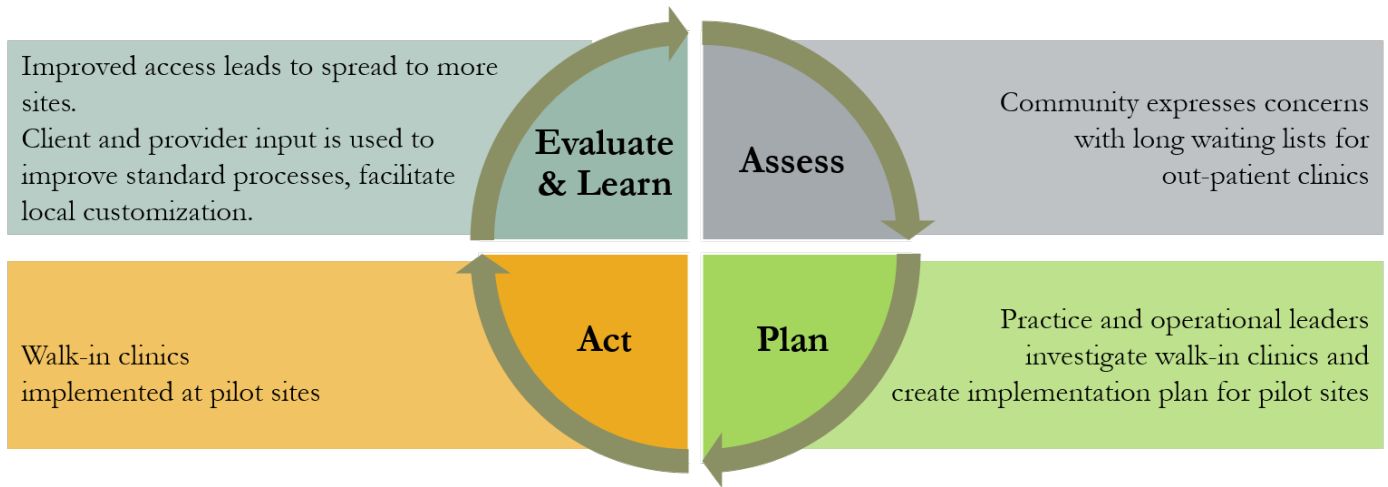
Activities focus on continuous quality improvement and include modifying treatment approaches based on client feedback or outcomes data, anticipating and responding to emerging trends, applying workforce data to program development, or reporting and learning from client concerns.

The principles of evaluation and learning are embedded in rehabilitation services when providers and planners:

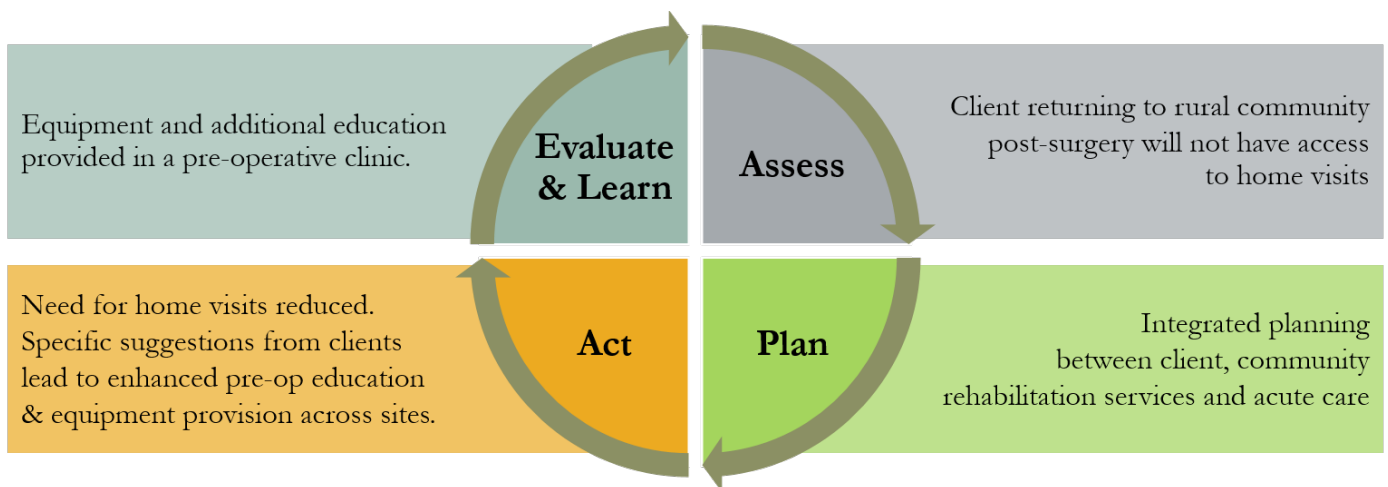
- Follow an iterative knowledge to action cycle for evidence-informed practice (See [Appendix D](#))
- Use a participatory approach; collaborate with service recipients, providers across sectors, evaluators and other stakeholders
- Value and learn from people’s experiences to plan and deliver services that are dynamic and iterative
- Respond to questions and concerns as they arise using problem solving approaches
- Act on learning in a timely manner
- Use consistent data collection methods, information systems, evaluation and analytics to improve quality
- Identify, monitor, document, report, and use clinically relevant outcome measures and decision making processes to inform ongoing improvements and to support system, team and provider learning
- Share and use innovation and evidence to develop and support continuing competence, standardized services, clinical care pathways, care models, decision tools, procedures, programs and policies
- Use both successes and challenges to inform future service delivery. Consider mistakes and failures an important source of learning
- Use provincial professional practice councils to facilitate leadership and learning

The Rehabilitation Process in Use - Examples

The Rehabilitation Process used in service planning



The Rehabilitation Process at a provider level



Rehabilitation Process - Service Planner & Provider Checklists

ASSESSING IN REHABILITATION SERVICES	
Service Planner's role	Provider's role
<ul style="list-style-type: none"> ✓ Assess needs in collaboration with providers, partners, communities and service recipients and in relation to organizational strategies ✓ Determine population needs within the changing context of population demographics, health conditions and environmental or technological factors and standards of care ✓ Facilitate shared understanding of <u>population health</u> needs, expectations and needs across the health continuum ✓ Gather and analyze available data based on the International Classification of Functioning, Disability and Health (WHO, 2001) ✓ Support risk stratification ✓ Consider the <u>Alberta Quality Matrix for Health</u> (HQCA, 2005) and potential for services to create positive health outcomes 	<ul style="list-style-type: none"> ✓ Respond to questions about health, wellness and how to best meet individual or group needs ✓ Facilitate shared understanding of expectations and needs ✓ Assess structure and function, activity, and participation in relation to personal and environmental factors and impacts of risk factors ✓ Consider individual/family wellness, distress and social or occupational disruption ✓ Assess impact of services on prevention, health promotion, function, burden to individuals and families, and available resources ✓ Gather and analyze data to support Risk Stratification, priority setting and program development ✓ Monitor and adapt to the needs of the community in a changing context ✓ Assess impact of services to inform planning and continuous improvement
PLANNING IN REHABILITATION SERVICES	
Service Planner's role	Provider's role
<ul style="list-style-type: none"> ✓ Facilitate strategic partnerships - cooperation between health and social care organizations to impact the efficacy of rehabilitation services across settings and at multiple points of access ✓ Identify required linkages across health service settings to promote ease of access, service integration and smooth transitions of care ✓ Integrate perspectives of individuals, groups or communities and various providers through co-design ✓ Define and use standard criteria for eligibility, priority access or urgency, service intensity, frequency and required degree of <u>specialization</u> 	<ul style="list-style-type: none"> ✓ Seek to understand other services, provider roles, referral processes, available standardized services, clinical care pathways and Service Options ✓ Provide system navigation, linkages, collaboration, and partnership ✓ Explore options and employ evidence through Components of Clinical Decision Making (AHS, 2016) ✓ Develop therapeutic relationships to co-design Integrated Plans of Care that <ul style="list-style-type: none"> ○ outline activities, accountabilities and expected outcomes ○ articulate the roles of each team member ○ include transition plans and potential for <u>community integration</u> or <u>reintegration</u> ○ monitor outcomes, and

<ul style="list-style-type: none"> ✓ Develop processes and infrastructure based on standards and evidence 	<ul style="list-style-type: none"> ○ continuously evaluate required changes, updating the plan at every care transition ✓ Determine ongoing means of communication, interaction and participation
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ACTIONS IN REHABILITATION SERVICES

Service Planner's role:	Provider's role:
<ul style="list-style-type: none"> ✓ Lead the development of effective and efficient, evidence-informed programs ✓ Implement client-centred processes ✓ Align resources to address population need or changing context ✓ Implement walk-in clinics ✓ Inform the Clinical Information System of rehabilitation data needs ✓ Support a shift in focus from treatment to increased prevention and health promotion ✓ Facilitate environmental modifications to support participation of people with unique needs ✓ Meet with community groups to develop long term plans for creating inclusive recreation 	<ul style="list-style-type: none"> ✓ Show kindness, compassion and empathy ✓ Facilitate self-management ✓ Promote well-being and safety ✓ Provide strategies to minimize or reduce the impact of disability or disease ✓ Facilitate participation in therapeutic practice ✓ Provide ongoing feedback ✓ Coordinate with internal and external partners ✓ Provide coaching and therapy to improve function ✓ Provide learning opportunities for patients, clients, families, communities partners and other providers

EVALUATION AND LEARNING IN REHABILITATION SERVICES

Service Planner's role:	Provider's role:
<ul style="list-style-type: none"> ✓ Anticipate and respond to emerging trends ✓ Analyze referrals to inform resource allocation ✓ Apply client survey information to program development ✓ Establish a client advisory ✓ Implement a short term data collection process to gather information about a specific question ✓ Promote a culture that sees concerns as learning opportunities 	<ul style="list-style-type: none"> ✓ Modify treatment approaches based on outcomes data ✓ Identify the need for and participate in continuous quality improvement ✓ Reflect on and report clinical and operational successes and challenges ✓ Report and learn from client concerns ✓ Ask for input and feedback from clients and peers

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Appendix G – Guide to Service Options

Service Options are integrated to wrap around the needs of an individual, group or community.

Considerations for Service Options		
Consideration	Description	Relevant factors
Type	Health promotion Habilitation Intervention Care Case management	<ul style="list-style-type: none"> ✓ Goals of service ✓ Available partnerships ✓ Potential for alignment and integration
Level	Universal Targeted Personalized	<ul style="list-style-type: none"> ✓ Degree to which the need is unique to an individual or common to a group ✓ Required individualization within a population
Amount	Frequency of service Duration of service (session length and over a time span) Time sensitivity (Adapted from Duram-Reder, 2008)	<ul style="list-style-type: none"> ✓ Potential risk or need for rapid real time problem solving ✓ Rate of change or goal attainment ✓ Required amount of repetition ✓ Attention to onset, duration and transition
Mode	Type of interaction or how the service is delivered	<ul style="list-style-type: none"> ✓ Need for direct versus indirect interactions ✓ Potential to leverage capacity and build consistency across environments
Provider	Single or multi-discipline Therapist, therapy assistant, therapy aide or other health care provider Family, community member or service partner Acting as a consultant, coach or direct provider	<ul style="list-style-type: none"> ✓ Potential need for specialization and collaboration ✓ Available staff mix and community resources ✓ Competence and working to full scope
Setting	Where the service is provided including: Home Community/Outpatient Inpatient Facility	<ul style="list-style-type: none"> ✓ Potential for impact within the setting, feasibility, capacity building, generalization of skills and preference of the person ✓ Impact of the environment on functional success

Considerations for Service Options		
Consideration	Description	Relevant factors
		✓ Need for environmental adaptations
Tools & Resources	Policies, procedures, evidence, decision making tools, legislation, regulation, standards, practice consultation, space, tools and technology	✓ Potential need for access to guidance, evidence, technology, clinical tools and information ✓ Sufficient resource allocation to achieve program goals

Service Type

All service types require integration - weaving across settings and following the Rehabilitation Process (Wade 2015a,b: WHO & World Bank, 2011).

A client or community's rehabilitation goals determine whether health promotion, habilitation, intervention, care, case management or a combination of these is most appropriate. Each of these service types may be delivered with varying degrees of intensity and personalization to address changing and diverse needs.

Health promotion

Prevention and health promotion may occur at universal, targeted or personalized levels, supporting being healthy and living well with illness, disability, and disease (WHO, 2017a).

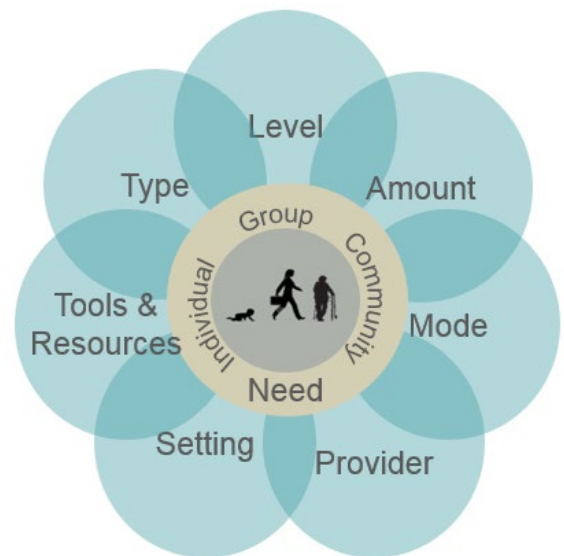
Intervention

Intervention is actions for the *prevention of impairment and deterioration in the acute phase of care as well as for optimization and maintenance of functioning in the post-acute and long-term phases of care* (WHO, 2017c p5). It is delivered within the context of a need, health condition or impairment. Intervention is goal oriented, person- and family-centred and outcome focused. Activities such as consultation, information sharing, coaching, modelling, training, environmental modifications, therapeutic practice and treatment modalities all follow the Rehabilitation Process(Wade, 2015a; WHO, 2016).

A comprehensive range of home or community based, inpatient, and facility services enable people's skill mastery and participation in activities, roles and relationships that are meaningful to them;

- minimizing the experience of impairment
- maximizing activity in daily life
- facilitating participation in societal roles
- building self-care

Intervention is provided in the context of a life course approach, considering opportunities and needs for enduring care. Some individuals benefit from short term, acute or episodic intervention. Others may



require a therapeutic relationship with a given service over a number of years - with periods of intensified need or anticipated progression to restore or maximize functional ability & periods of maintenance to prevent functional decline or prevent secondary conditions. For example, restorative care supports frail, elderly, complex and/or at risk individuals to retain their independence following the debilitating effects of acute illness, injury or prolonged hospitalization. Rehabilitation in palliative care seeks to relieve, rather than cure symptoms, and improve quality of life for individuals and their families (WHO, 2017b). Intervention supports getting better, living well with illness, disability and disease and end of life.

Care

Care requires a connection between the rehabilitation provider and client; it is based on the principles of person and family centred care. Actions include listening to the client, building a therapeutic relationship, and providing assistance, support comfort and advocacy. In providing care, attention is given to preserving dignity and providing encouragement. Care includes interactions that are verbal and nonverbal (i.e., gaze, posture, tone of voice and demeanor); care is purposeful and constructive; there is a sincere desire to connect or engage with others; the intent is to enable others to be leaders of their journey. (Registered Nurses' Association of Ontario, 2006).

Therapeutic care requires that clinicians do three things: Practice with competence, both technically and relationally 2. Establish authentic connections 3. Convey compassion, empathy, and an understanding of the meaning and magnitude of the patients illness or injury to the patient and family. (Koloroutis & Trout, 2012 p. 16).

Case Management

Through the health needs identification process clients determine whether they will manage their own care or require more structured Case Management (adapted from AHS, 2011a; 2011b). Case management is a collaborative process to assist clients in accessing appropriate services across settings. It includes assessing needs, planning for care, assisting the client in navigating the health care system and accessing services, coordinating the various services a client may require, and monitoring and evaluating the options and outcomes (Alberta Health, 2013). Case management facilitates service integration and a common understanding of service goals.

Individuals with illness or disability who need assistance to find services may benefit from a case manager. Other terms that may be used to refer to case management are care coordination, case coordination, integrated case management and program case management. The role of the case manager and who provides this service will vary depending on client need and service setting.

Service Level

Service level reflects degree of customization. Understanding the complexity and uniqueness of a health condition or need and associated personal and environmental factors guides service level decisions.

Three distinct levels of service are integrated and overlap to sufficiently meet varied needs. Universal and targeted services may lead to self-efficacy, healthy behaviour or environmental modifications that impact on the success of personalized services. People may access and benefit from more than one level of services at the same time, and may enter and exit at any level.

Service levels are defined below.

Personalized services

Personalized services are designed to meet the unique needs of a particular person.

Assessment, planning and monitoring is provided on an individual basis. Services may be offered one-to-one or in a group, via direct service, environmental adaptations or consultation to another provider. They may be highly specialized and offered only in tertiary centres or may be broadly available across settings.

Where personalized services are required, targeted and universal approaches are integrated to build supports that wrap around the individual.

Personalized services generally require the most time per individual served. Informed consent is required and documentation is included in the health record.

Targeted services

Targeted services are designed for groups of people with a common need.

Providers employ standard approaches to meet the collective needs of the specified group (such as individuals in a particular setting, those living with a specific health condition or a provider group with a shared learning goal or functional need). Targeted services often address prevention and capacity building for those who are at risk for or are experiencing a similar concern.

People may participate in targeted services without person specific assessment and documentation, adding efficiency where individualized approaches are not required. Targeted services generally take less time per person than personalized and more time per person than universal services.

Universal services

Universal services intend to meet the needs of broad populations and are available to all.

Universal services reach large audiences through information, education, influencing environments of social norms and public policy. They may address broad groups within a community, such as all parents of preschoolers, people who are at increased risk for diabetes or all seniors. By reaching large audiences, they require less staff time per person.

Notes regarding Service Levels:

- Recipients of Universal and Targeted Services *may or may not* be registered (i.e., receiving Personalized Services).
- Some regulatory colleges require that a record is kept of all consultative/coaching services, which may include targeted services. These records are not kept in the health record unless they relate to a specific individual's care.
- Universal and targeted rehabilitation services are sometimes provided effectively without the need for screening.
- Consider the importance of family and caregiver involvement in cases where a concern is identified in a person accessing Universal or Targeted Services.

- Exercise caution in attending to the ease with which Targeted Services become blurred with Personalized Services. When concerns are noted and personalization begins to occur, it is important to initiate an informed consent process.
- Other sectors, such as education services may use these terms in different ways. The definitions within the RCF and applicable in Alberta Health Services are based on broad population health concepts.
- The Informed Consent Process includes information exchange between the most responsible health professional and the client or alternate decision maker. It is documented in the health record as described by the AHS Policy.

Service Levels describe the degree of individualization within a service. Examples and detail of the defining factors of the three levels are provided below:

	Universal	Targeted	Personalized
Examples	Public messaging on particular benefits of regular physical activity for people with diabetes Information to all continuing care facilities on impacts of hearing loss on functioning in elderly populations	Community exercise groups for people with arthritis Workshops for teachers regarding strategies to support learning	Teaching family members about safe transfer prior to a person being discharged to home Developing an individual plan that supports a person to be involved in recreation again after a traumatic brain injury
Base features	Available or distributed to the population as a whole	Designed to meet the collective needs of a specified group Standardized, preset approaches not impacted by person specific assessment	Includes screening or assessment to clarify the needs of recipients Strategies are personalized to meet the needs of unique individuals, though the services may be provided in group or community settings
Recipient	The general population	Groups of individuals, family members and care providers identified as being at risk or as having common needs Service partners and provider groups	An individual, family or their care provider(s): ✓ receiving observation or screening outside of a mass screening campaign ✓ requiring rehabilitation assessment ✓ with therapeutic needs requiring personalized plans and Intervention

	Universal	Targeted	Personalized
Focus	<p>Health promotion</p> <p>Primary & secondary prevention</p> <p>Influencing public awareness, acceptance, norms, expectations, policies and environments</p> <p>Addressing system issues</p>	<p>Promotion and primary or secondary prevention for those at risk</p> <p>Enhancing capacity related to a common concern, risk, health condition or within a defined setting</p> <p>Influencing specific or defined physical and social environments</p>	<p>Personalization of strategies to meet specific needs and context in relation to</p> <p>Secondary and Tertiary Prevention</p> <p>Minimizing Impairment</p> <p>Maximizing Activity</p> <p>Facilitating Participation</p>
Process	<p>Information and education</p> <p>Public messaging</p> <p>No unique Individual identifiers are captured and there is no health record</p>	<p>Partnership models strengthen informed, activated groups and create or improve supportive environments</p> <p>Group goals, routine programs, standardized approaches that accommodate a common need</p>	<p>Person specific clinical impressions and advice. Personalized screening, assessment, care planning and clinical activities. Capacity building, specialized training, coaching, case management, therapeutic activities tailored to address a unique person's needs. Services may be delivered one to one or in a group</p>
Informed Consent Process	<p>Not required</p>	<p>Not required - Information about the service is provided to facilitate choice in participation</p>	<p>Required and documented in the Health Record</p>
Recording & Evaluation	<p>Individual health records not kept</p> <p>Activities, audiences and outcomes may be tracked</p> <p>Program based quality improvement processes are followed</p>	<p>Individual health records are not kept, if an individual is also receiving personalized services it may be appropriate to document participation. Activities, audiences and outcomes may be tracked. Program based quality improvement processes are followed</p> <p>Therapist keeps a copy of communications with other agencies</p>	<p>Documentation for all personalized services is kept in the health record - Individuals are registered with a Unique Lifetime Identifier. Specific outcome and workload information are captured according to program guidelines</p> <p>Program based quality improvement processes are followed</p>

Amount

Flexibility in the frequency and duration of a service also helps providers to tailor the amount of services to the health needs of individuals, groups and communities. It is important to consider the amount of service in relation to functional need, rate of change and other contextual factors (Durham Reder, 2008).

The activity may or may not be time sensitive. Acute intervention is of abrupt onset, relatively short duration, rapidly progressive, time-sensitive or requiring urgent care. Individuals may be best served through an opportunity to come and go from a service during times of transition or intensified need.

Frequency

Frequency refers to how often a service is provided (i.e., a single information session, twice-weekly appointments or the option to attend monthly drop-in clinics over a period of years).

Duration

Duration varies in relation to the length of an interaction and the time span over which a therapeutic relationship is maintained.

Though clinical activities may be short term (episodic) or targeted towards critical periods of development or transition, cumulative effects are considered and there is attention to continuity in service and integration of services across the lifespan and environments (WHO, 2000).

Following are examples of how the amount of service may vary within other considerations for Service Options:

- At a universal level, a strategy to impact healthy behaviour or environmental modifications may need to be sustained over a number of years to create lasting change, or it may be effective after a single activity.
- At a personalized level, intervention for people with chronic illness, complex medical conditions, developmental delays or a longer trajectory for recovery may occur over extended periods and is often intensified during times of transition or windows of opportunity. For some clients, short-term or episodic intervention is adequate.

Mode

Mode refers to how services are delivered (e.g., consultation to family or other providers, information sharing, telephone, web-based, interactive learning to clients, caregivers or partners, modalities, structured practice, group facilitation, peer support, environmental modifications, etc.).

Providers

Rehabilitation providers contribute to functional health outcomes and facilitate smooth transitions, continuity of care, system navigation and flow through the system. They bring a unique lens to system planning and to establishing an individual Integrated Plan of Care.

Who is involved with a particular service varies depending on the health condition, environmental and personal context, individual provider roles and skill mix of the team. Collaborative services may be single-, multi-, inter-, or trans-disciplinary in approach and different providers may have the ability to meet the same need. Multi-disciplinary service provision facilitates a range of rehabilitation to meet varied functional needs (WHO, 2017c).

Integration of rehabilitation into and between different levels of the health systems calls for a capable workforce, and consideration should be given to the capacity of the workforce to function at primary, secondary and tertiary levels, including the number of rehabilitation personnel available, their distribution, skills and competence (WHO, 2017c, p13).

Collaborative working relationships among all team members, clients and key supporters result in better outcomes. In determining team composition the important roles of family members, service partners and community members are considered. Some needs are better served by a health care provider and others by individuals who interact more regularly and in more natural environments with the client and family (adapted from AHS, 2011c).

The unique roles of rehabilitation providers are supported and examined in establishing staff and skill mix across services and in addressing the needs of each individual client, patient or community. When considering staffing requirements, attention is given to ever-changing population demographics, health conditions, impacts of innovation and required standards of care (Birch, et al., 2007). Rehabilitation service planners recognize the need for sustainable health human resources that facilitate quality services.

Professional practice competencies and learning needs of rehabilitation providers are often shared across all health disciplines. They emphasize but are not limited to:

- Championing interprofessional collaboration through person centred care, team functioning, communication, role clarity, collaborative leadership and conflict resolution (CIHC, 2010)
- Applying a wellness approach
- Understanding the International Classification of Functioning, Disability and Health and its impacts on service delivery at system and policy, program, community and individual client levels (WHO, 2001. See [Appendix H](#))
- Integrating personal and environmental factors such as cultural identities, family function, physical settings and social policy
- Building client and community partnership and engagement. Leading teams across traditional and extended internal and external partnerships
- Understanding and promoting engagement with the health system and with health behaviour change
- Creating evidence and contributing to quality improvement
- Providing case management and system navigation: Assessing and supporting capability for self-management and knowing how to access available resources and system linkages
- Integrating wholistic health practices with mainstream practices (AHS, 2015)
- Applying specialized rehabilitation skills in many settings (e.g., advanced practice, use of technology)

Settings

All health service settings have a unique purpose that may be facilitated through attention to rehabilitation needs (Wade, 2015a). Various types of rehabilitation will occur within a setting and are not necessarily defined by client complexity or required specialization.

To the greatest extent possible, services are provided where they have the most impact, facilitate capacity building, best support generalization of skills and are least disruptive. For example, service may be provided in a home, work environment or community recreation centre. When it is not feasible for services to be conducted in natural contexts, settings and activities are adapted to be as realistic as possible. Broadly, health service settings include home, community or outpatient, inpatient, and facility. A description of specific health service settings that may support administrative processes is included in [Appendix A](#).

Tools & Resources

Rehabilitation recognizes the need for tools, technology and resources to provide standards driven, evidence-informed practice and seeks to allocate resources sufficient to achieve program goals. AHS is committed to focusing resources on the highest priorities to achieve high quality patient and population outcomes and to continue to increase operational efficiency (see [AHS Health Plan and Business Plan, 2017-2020](#)). Service planners and providers access, develop and give input to policies, procedures, evidence, decision making tools, and practice consultation in accordance with legislation, regulation, and standards.

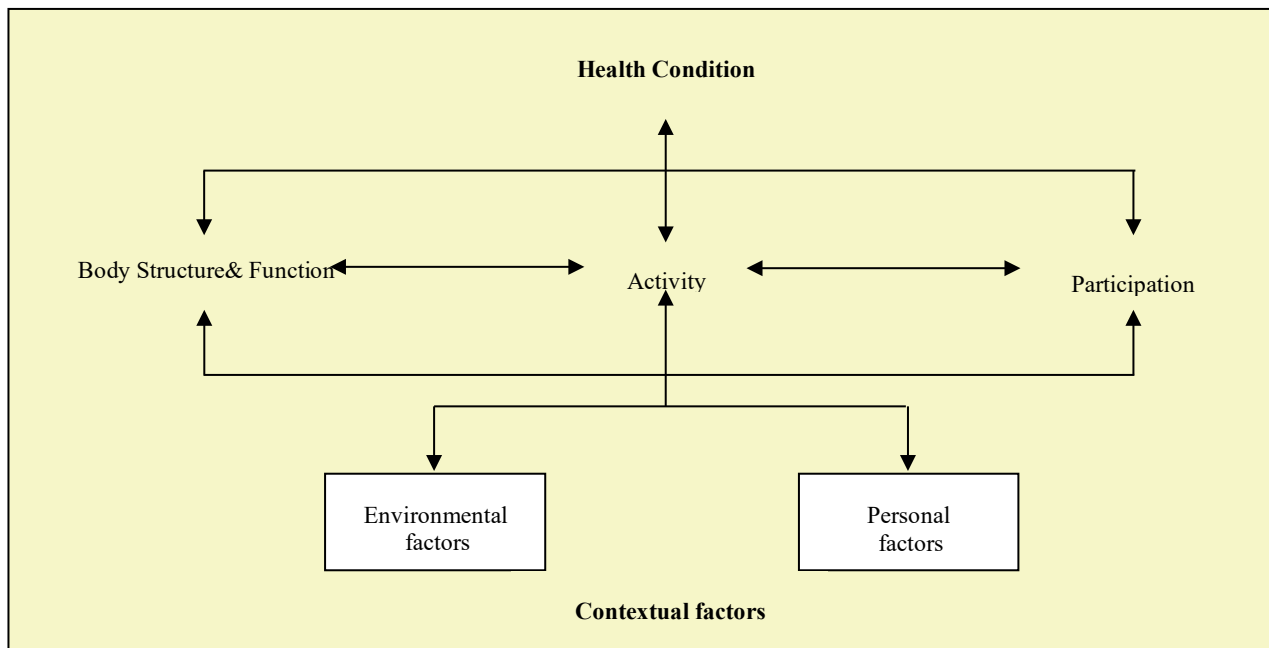
Advances in technology have a significant impact on results in rehabilitation services. Use of communication technology can increase the impact of rehabilitation interventions (AHS, 2016, Benchmarking and Future State in Ambulatory Community Rehabilitation). Rehabilitation service providers and planners seek to access and integrate technology to support quality and achievement of program goals.

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Appendix H – International Classification of Functioning, Disability & Health (ICF)



Model of Functioning & Disability (WHO, 2001)

Using the ICF, health conditions can be described by impact of a disorder or disease on body functions, structure, activity and participation; within the context of the individual's environmental and personal factors. Identifying function in life experiences and environments meaningful to the individual and addressing associated barriers is essential to adopting the Framework. According to the World Health Organization (2002), "every human being can experience a decrement in health and thereby experience some disability" (p.3). Recognizing the experience of disability as a natural part of every life journey helps to focus on participation in life roles, desired activities and relationships as measures of overall health.

The ICF describes the interaction between components that influence functioning and disability. Health conditions (diseases, disorders and injuries) and contextual factors both have impact on:

- Body functions & structure - Body functions are physiological functions of body systems, including psychological functions. Body structures are anatomical parts of the body such as organs, limbs and their components.
- Activity - the execution of a task or action by an individual
- Participation – involvement in life roles and situations meaningful to the individual with consideration of client and caregiver distress

Contextual Factors are barriers or facilitators of wellbeing associated with:

- Personal Factors – the internal attributes of an individual that influence how disability is experienced such as a person's assets and talents, values, spirituality, culture or ethnicity, genetics, age and coping styles

- Environmental Factors – the external physical, social and cultural environment in which people live (e.g., social attitudes; legal and social structures; supports and relationships; communities of belonging) that influence functioning with the health condition (WHO, 2002)

For example, due to a stroke (functional limitation) a person may be unable to drive (activity), restricting his ability to shop and socialize (participate). They may have a spiritual desire (personal factor) to experience connection with others in their community (participate) and be able to access a ride from a neighbor (environmental factor).

For further information see: [Towards a Common Language for Functioning, Disability and Health- A guide for beginners learning to use the ICF.](#)

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Appendix I – Restorative Care

In Alberta Health Services (AHS), restorative care is a type of rehabilitation that enables clients to regain or retain their independence following the debilitating effects of acute illness, injury, or prolonged hospitalization. It is a time-limited, multi-disciplinary, goal oriented, and client-centered approach. Restorative care helps clients, across the continuum of care, return to and remain at home as long as possible. It mitigates the risk or need for higher levels of health care or premature admission to a Continuing Care living option (AHS, 2018b).

Through a focus on function and enablement, the goal of restorative care is to foster resourcefulness, promoting wellness and independence. Grounded in the Rehabilitation Process (Wade, 2015a-b; WHO & World Bank, 2011), restorative care focuses on ability rather than disability and involves a shift from a medical model to a biopsychosocial model. Clients actively participate in their own care. A key component of restorative care is replacing a “do for you” approach with a “work with you” approach to care - promoting independence and knowledge transfer for clients and families. It helps medically stable clients learn or re-learn the necessary skills required to complete their daily living activities

Peer reviewed literature indicates that restorative care improves client and service outcomes. Clients who receive restorative care early in their health trajectory reportedly access fewer personal care services and their need for higher levels of care is reduced (AHS, 2015).

Through effective partnerships, services work towards the overarching goal of integrated and coordinated health services (AHS, 2016). In AHS, Restorative Care Services are operated by Zone Senior’s Health. Restorative Care can be provided by AHS and contracted providers in an individual’s home or in specialized units in Continuing Care centres and hospitals. Individuals are supported to remain home or return home, wherever home may be. Care supports frail, elderly, complex or at risk individuals with disability, chronic disease, or degenerative conditions to retain or maintain their independence (AHS, 2018b).

Restorative potential determines who is admitted to Restorative Care Services. Cognitive impairment, depression, delirium nor discharge destination alone determine restorative potential (Rehabilitative Care Alliance, 2014).

Restorative care follows the rehabilitation philosophy, “*enhancing function for meaningful living.*” Services align with the AHS Rehabilitation Conceptual Framework (2018) goals, guiding concepts, beliefs, and foundational elements such as the Rehabilitation Process and service considerations.

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