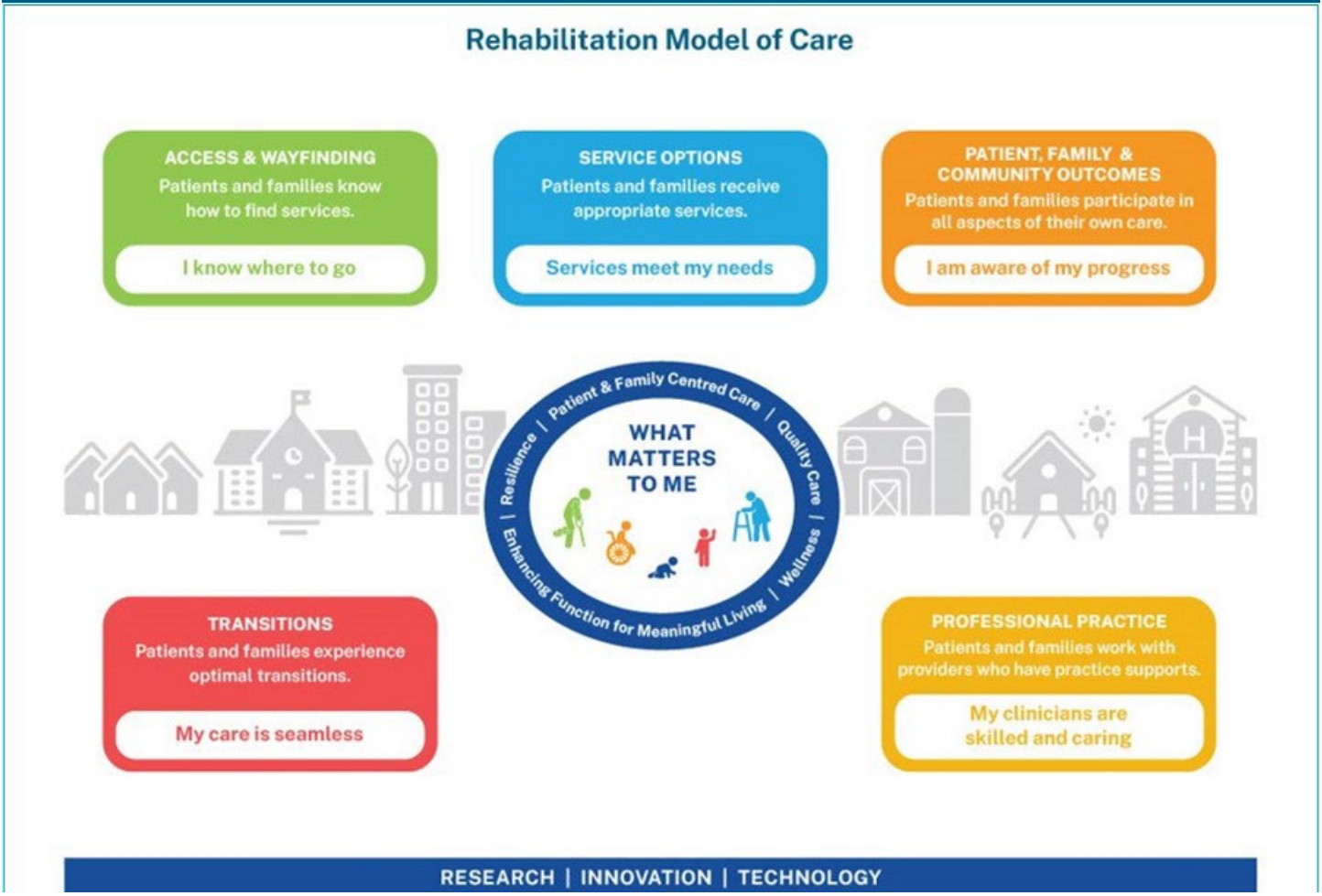
Allied Health Professions

Rehabilitation Model of Care

A guide for clinicians, practice leaders and operational leaders



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Introduction

This guide is for clinicians, leaders and administrative support personnel who are interested in learning about, as well as actively implementing the Rehabilitation Model of Care (R-MoC). It is a reference document that can be used to support service planning and guide program development.

Background

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

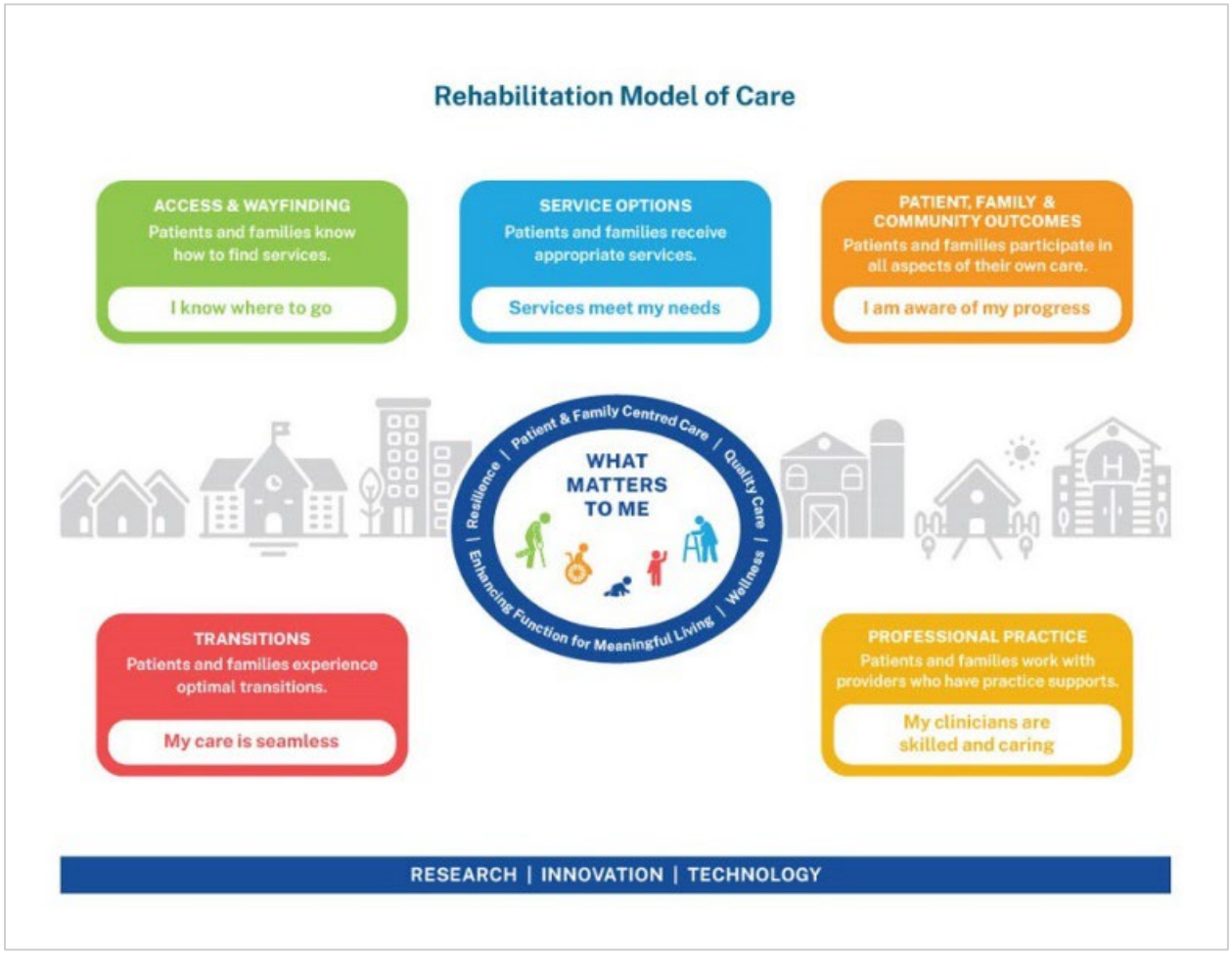
Rehabilitation Conceptual Framework (RCF)

The Rehabilitation Conceptual Framework guides the conceptualizing, designing, and delivery of rehabilitation services in AHS.(1) The philosophy of rehabilitation in AHS is centred on **enhancing function for meaningful living** and on enabling people to identify, reach and maintain cognitive, communication, emotional, physical, psychological, social, and spiritual health goals. By focusing on abilities and facilitating resourcefulness, rehabilitation works with the "person and their family to address underlying health conditions and their symptoms, modifying their environment to better suit their needs, using assistive products, educating to strengthen self-management, and adapting tasks so that they can be performed more safely and independently."(2)

Rehabilitation Model of Care (R-MoC)

A Model of Care guides service planning and broadly defines the way in which health care is delivered. Standardization of elements within a model of care creates and reinforces a consistent approach and implementation that in turn yields timely access, and services that are equitable, effective, efficient and sustainable, integrated and safe. These services are people centered.

The Rehabilitation Model of Care (R-MoC) was launched in 2017 to provide a common language and approach to rehabilitation service delivery.



There are three parts to the Model:

Concepts / Philosophy – at the heart of the Model are the concepts of Patient and Family Centered Care, Enabling Function for Meaningful Living, Wellness and Resiliency, Quality of Life.

The Core Components include Access and Wayfinding, Service Options, Patient, Family & Community Outcomes, Transitions, and Professional Practice.

Underpinning the Model is research, innovation and technology.

R-MoC Philosophy and Concepts

Incorporating the R-MoC into service delivery and client/patient care requires health care providers, managers and leaders to consolidate existing and/or develop new competencies related to implementing and integrating each of the model components toward quality improvement and patient centred care.

What Matters to Me…

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

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

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

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

Another important concept within the R-MoC is resiliency - for patients/clients, families *and* providers. It calls on all to reflect upon and pursue opportunities that support and enhance personal resilience and wellness.

In alignment with Health Quality Alberta's seven dimensions of quality (see below)(3), the aim of the Rehabilitation Model of Care and its implementation is to ensure people-centred accessible, effective, efficient, safe, equitable and integrated rehabilitation experiences and outcomes.

Health Quality Council, Alberta Quality Dimensions for Health	
People Centred	The wholistic preferences, needs, and strengths of people and communities matter.
Accessible and timely	People can readily access services that meet their needs.
Effective	Health services are respectful and responsive to user needs, preferences and expectations.

Efficient and sustainable	Resource use balances individual and other impacts (system, environment, population health) to benefit current and future generations.
Safe	Fostering trust and feelings of security and avoiding all forms of preventable harm.
Equitable	Health care services respond to unique community needs to avoid unfair differences in experiences and in health outcomes.
Integrated	Interconnected people, teams, sectors, organizations, and communities.

To learn more, see Appendix A: Wellness Approach in Rehabilitation

R-MoC Components

Surrounding the patient/client and family are five core components. These components are non-linear and interactive. They are strongly interlinked, tied together by a commitment to helping patients/clients maintain wellness, develop or restore function, and get back to work, school, and life sooner after an injury or illness. The following sections describe the five R-MoC Components in more detail.

Service Options

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

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

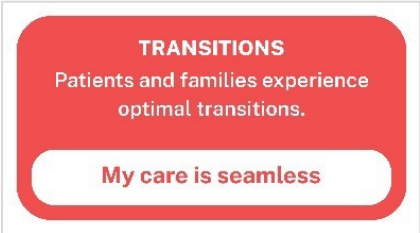
To learn more, see the Rehabilitation Conceptual Framework.

Patient, Family & Community Outcomes

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

To learn more, see the Patient Reported Experience Measures (PREM) and/or Patient Reported Outcome Measures (PROM) guide and Appendix B: Collaborative Goal Setting.

Transitions



- Transitions refer to the movement of client and family care between services, sectors, community and home. Transitions are planned from the outset of care based on current and future patient/client needs, co-created with patients, families and care teams, and evolve as needed. Seamless, well-coordinated care relies on many factors. From the initial visit, healthcare providers proactively plan with and support patients & families through treatment and points of transition to ensure continuity of care. Warm handovers involve direct verbal or face-to-face communication between the sending and receiving care teams and provides a higher level of client/family and receiving care team support during the transition process. It allows for successful transitions within the healthcare system and into the community.

To learn more about Transition conversations, see Appendix C: Transitions.

Professional Practice

Professional practice is defined as practice that reflects:

- the commitment to caring relationships with patients and families
- use of specialized knowledge, critical inquiry and evidence-informed decision making
- continual development of ourselves and others
- accountability and responsibility for insightful

competent practice; and,
- demonstration of a spirit of collaboration and flexibility to optimize service.

Professional Practice in Action (PPA) is a blueprint for optimizing professional practice. It speaks about the need to recognize the roles of individuals (the 3 Cs) and of the organization (the 3 Es) in co-creating excellence in professional practice, which in turn enables quality, and patient and family centred care.

To learn more, see Professional Practice in Action | Insite

Access & Wayfinding

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

The aim is to create system structures that enable clear and coordinated access to the right rehabilitation service at the right time. Web-based directories help people navigate to allied health programs and services. Path to Care and the Alberta Referral Directory support equitable access by standardizing referral processes and by monitoring wait times. Connect Care (electronic charting system) further integrates and transforms how providers and patients/clients find and access health care.

For a list of directories, see Appendix D: Alberta Services Directories & Online Platforms for Health Information.

Research | Innovation | Technology

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

To learn more, see Research Challenge | Insite.

Implementation & Sustainability

Cross-sector partnerships, along with engagement with community partners are crucial to creating collaborative and integrated rehabilitation services. Since the R-MoC launched, the concepts and philosophies have been integrated into the development and approach to rehabilitation services across the province. The primary area of focus has been on the community and outpatient sector. There are opportunities for further expansion into other sectors as the concepts are universal and are relevant within and across all sectors. Provincial Rehabilitation outcome and experience data collection and reporting on a Provincial Tableau dashboard continues with ongoing optimization.

Version History

Version #	Date	Updates
1	February 2019	First release
2	November 2025	Content and format updates

Appendix A: Wellness Approach in Rehabilitation

A wellness conversation supports a whole person approach through engaging with the client about what is important to them. In a wellness conversation, the client and family (*as defined by the client*) feel they are truly listened to when:

- perspectives and concerns are elicited
- values, beliefs and goals are respected
- emotional, social, diversity, cultural and spiritual needs are identified and responded to
- kindness and compassion are conveyed

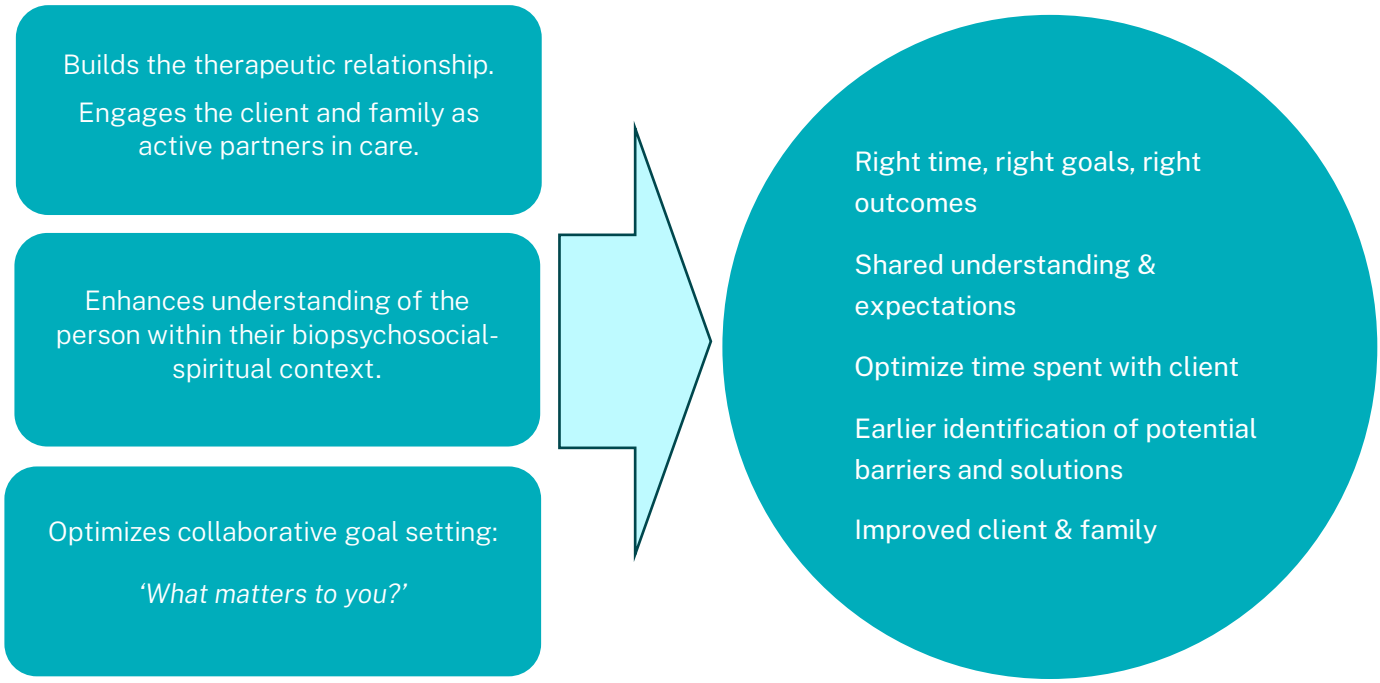
Wellness is:

- an active and holistic process
- multidimensional and interrelated
- defined uniquely by each person
- becoming aware of self, resources and choices
- increasing capacity and success

In the context of rehabilitation, wellness encompasses the person's:

- cultural, socio-economic, environmental, psychological, and spiritual context that influences meaning of wellness
- sense of self-efficacy to manage their health
- sense of social and community engagement that promotes health
- perception of autonomy and choice in health decisions
- experience with coping and resiliency

What is the impact of a wellness conversation?



Wellness resources:

- Engagement & Patient Experience – Insite
- HealthChange Methodology® – available through MyLearningLink
- Social Determinants of Health and Health Inequalities - Government of Canada,
- The Six Dimensions of Wellness - National Wellness Institute

Appendix B: Collaborative Goal Setting

What is collaborative goal setting?

Clinicians and teams intentionally engage clients and families in a shared decision-making process resulting in functional client-centred goals. The client and family are the expert on their values, preferences, and motivations and the provider is the expert on the condition and the rehabilitation process. Collaborative goal setting is an ongoing part of the rehabilitation process and is responsive to evolving priorities over time.

Why collaborative goal setting?

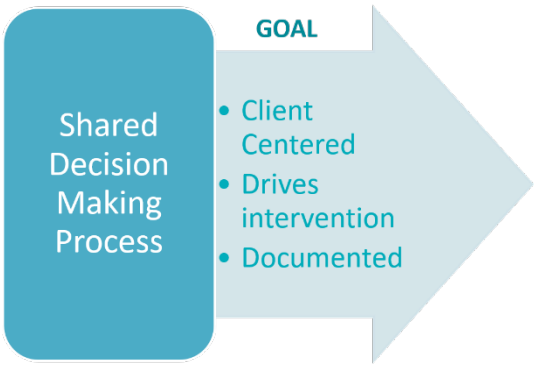
Collaborative goal setting improves client outcomes.(4, 5) When clients and families are actively involved in making decisions about their goals, their engagement, satisfaction, and motivation improves.(4-6) From a service provision perspective, collaborative goal setting may also improve access and equity.(7) In practice, this translates to improved clinical outcomes, greater client commitment in rehabilitation, improved self-management, fewer no shows or cancellations, and fewer readmissions to rehabilitation after discharge.(5, 8-11)

> There is perhaps no greater expression of respect, understanding, hope and empathy by the provider than the ability to elicit, acknowledge, and accept the individual's and family's goals"
>
> ~Adams & Grieder, 2005

How do you collaboratively set goals?

Clinicians need to engage clients in shared decision making to set functional goals that MATTER to the client. Standardized tools and outcome measures to consistently capture client progress and experience are used.

Providing high quality care in rehabilitation begins with understanding what matters to our clients, their families, and their communities. Clinicians engage clients in a shared decision-making process to identify their client's values, needs, and perspectives, and to establish a plan to meet their goals. Clinicians, teams and clients and families partner to identify, reach, and maintain the client's cognitive, communication, emotional, physical, psychological, social, and spiritual health goals.



Rehabilitation centers on ***enhancing function for meaningful living*** - enhancing ability to actively participate in the roles, relationships and activities important to our clients.(6)

Shared Decision Making

Shared Decision Making	Why it Matters
In shared decision making, the client and clinician are both actively involved in the discussion. • The client shares what matters to them. They are experts on their needs and how their condition impacts things that are important to them. • The clinician shares information about clinical issues and treatment options. They are experts on the rehabilitation process. • Everyone asks questions and evaluates the options needed. • Everyone agrees on the goal and how outcomes will be measured.	Engaged clients are committed to the rehabilitation process and understand roles. • A shared decision-making process can help link interventions and communications to the client's goals and builds the client's understanding and expectations of care. Aligning expectations rather than focusing on client buy-in and can help to reduce conflict between clinicians and families.(12) • It balances the clinician's duty of care with the client's right to make a fully informed decision.(13) Engaged clients are committed to the rehabilitation process and understand their role.

Nico and his family own a small restaurant downtown. Since his recent stroke, his wife and 3 teenagers have been attempting to manage the restaurant without him. Nico's new motor impairment affects his speech, and his left arm and leg, and he is very worried about resuming his role in the family business.

Allyah is a competitive swimmer on a para-swim team. After breaking her arm at summer camp, she has been struggling with her front crawl. Her dad brought videos of a swimming practice so that Allyah could show her therapist what she is having a hard time doing. Swimming is what was most important to Allyah. Allyah and her therapist decided to focus on front crawl as her primary goal.

Client & Family Centred

Client & Family Centred	Why it Matters
In alignment with patient and family centred care: • Goals reflect what matters to the client and family, incorporating their values, needs and perspectives. • Goals belong to the client and family, not to the provider. • Goals are written in a way that reflects how the client and family can actively participate in roles, relationships and activities important to them.	• Goals belong to the client, not to the provider. • When goals reflect what matters to the client and family, incorporating their values, needs and perspectives, they have ownership of their rehabilitation goals.(10, 13-15) **Feeling ownership of the goal promotes self-efficacy and self-determination.**

Nico strongly feels that he needs to be with his family and supporting the family business as soon as possible. Supporting him in being able to start with simpler tasks in the restaurant supports his values, passions, and sense of community.

Allyah's therapy goal was to get her left arm out of the water during the front crawl so that she could compete in a freestyle race.

Goal-Driven Intervention

Goal-Driven Intervention	Why it Matters
• Intervention is focused on strategies and behaviors that directly relate to the client and family's stated goals. • Clinicians clearly communicate how the interventions will support achievement of the goals. • Clinicians measure therapy effectiveness by goals through, measure and adjust treatment approach throughout the process.	• Goals belong to the client, not to the provider. • Goals reflect what matters to the client. • Feeling ownership of the goal promotes self-efficacy and self-determination

Nico's PT, OT and SLP have helped him look at different restaurant tasks and how he could return to work. Nico set a goal of being able to help in the front of the restaurant. He will start with greeting and seating people, before progressing to serving. Whis his therapists' help, he is working to steady his gait and speak more clearly. He has started practicing carrying empty trays to work on his left arm strength and coordination.

Allyah's therapist developed a plan to address the problems that were limiting her left arm during swimming and to modify her front crawl to make it a little easier. Each therapy was connected to Allyah's goal of improving her front crawl. When Allyah didn't understand why she was doing some of the exercise, her therapist explains why and how each exercise would help her reach her goal.

Documented

Documented	Why it Matters
Client-centered clinical documentation is a guiding principle of AHS's Clinical Documentation Directive (#1173). In collaborative goal setting this means that goals are: • Written from the family's perspective using language that is meaningful to them. • Recorded/charted in a way that all care providers can see what's important to the patient and family. • The patient has their own copy.	• Clearly documenting client's goals ensures that all involved health providers are working towards the same thing, enhancing ongoing coordination and continuity of care. • When goals are documented, the client and family, and clinicians are better able to track and monitor progress towards the goal, further building motivation.(15, 16) **Everyone is working towards the same purpose and monitoring progress.**

Nico's therapists document his goals, treatment plan and progress in the online documentation system. Because everything is charted, they are aware of each other's goals and can better work together to support Nico's goal of return to work.

Allyah's goal and treatment plan were documented in her chart where her other rehab team members could see it. Allyah had a copy of her goal and treatment plan. She shared it with her swim coaches so that they could also be involved in helping her reach her goal.

Collaborative goal setting resources and tools:

- Connect Care: Documenting a Care Plan
- Canadian Occupational Performance Measure (COPM) – available in Connect Care
- A Guide to Having Conversations About What Matters BCPSQC
- Patient Specific Functional Scale (PSFS)
- Goal Attainment Scale (GAS)

Appendix C: Transitions

Top 5 Tips from Clients & Families for Successful Next Steps

These tips were created with the Provincial Rehabilitation Client and Family Advisory. They are written in the client's voice.

1. Let's talk about next steps from the beginning.

2. Ask me about me:
    - Ask about my journey so far. How far have I come?
    - Ask what is important to me, including my interests, what motivates me, and my daily schedule.
    - Ask me about potential challenges and barriers I think I may face (e.g. transportation, time commitment, finances, support system).

3. Ask me about my support network:
    - Ask me if I have a contact person - who I want to involve and to receive information.
    - What does my support person need to know or access to be able to help me?
    - Leave me with a contact person I can go to during my program and after my program is completed.

Things to consider. Would I like:

- ❑ My family / friend to come with me to discuss my next steps?
- ❑ Follow up phone calls or emails?
- ❑ To know where my information about my rehab needs to go?
- ❑ The program to make a connection / referral somewhere if needed?
- ❑ The information I need written down?

4. My transitions and next steps are different than everyone else's:
    - I need to know what is available in my community.

- Provide me with a list of resources.

Other services in my community:

- ❑ Community programs
- ❑ 811 Health Link (health advice)
- ❑ Home Care locate services)
- ❑ MyChart (access own health Information)
- ❑ Primary Care Networks
- ❑ Recreation programs
- ❑ Self-management
- ❑ Other

5. Ask me where I see myself in 1, 3 or 6 months:
    - Encourage me to write this down.
    - Follow up with a phone call.

My Plan:

- ❑ Steps to take
- ❑ Activities to do
- ❑ Making activities part of my daily life
- ❑ Emotional supports put in place

Appendix D: Alberta Service Directories & Online Platforms for Health Information

Description and purpose of existing service directories and online platforms used by allied health.

Inform Alberta 	• public-facing website • provincial on-line directory of publicly funded and/or not-for-profit community, health, social, and government organizations and services • maintained by the Inform Alberta Partners – health zones, organizations and community information & referral services across Alberta • provincial database from which service profiles are connected to the ARD, MHA, Health Link and Rehab directories listed below • source of truth for all Alberta health service listings and locations
Alberta Referral Directory 	• an internal facing database that is searchable • designated system of record for referral information for AHS • an access point for health professionals, allowing them to look up eligibility criteria and referral information, service and consultant demographics, referral guidelines, referral forms and detailed instructions to facitilate referral acceptance without delay • will be the decision support resource for referral navigation when a referring provider is unsure of options available for their patient/client • Connect Care Referral Orders hyperlinks to the ARD • operational ownership remains with Path to Care and IT Clinical services
Adult Community Rehabilitation Pediatric Rehabilitation Services 	Adult & Pediatric Rehabilitation Directories • public facing directories found on AHS.ca • provides a searchable list of AHS funded rehabilitation services • search the listing by location, provider type and by client and family friendly key words

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