

Specialized Burn Rehabilitation

BACKGROUND:

As Ontario's health care system transitions to an integrated care model, Ontario Health Teams (OHTs) will be responsible for providing a full and coordinated continuum of care for all but the most specialized conditions and procedures, which will be delivered by existing specialized providers.

The provision of rehabilitation occurs at different points in the continuum of care and may require a general or a specialized approach depending on the patient population requiring treatment. The University of Toronto's Physical Medicine and Rehabilitation group alongside the GTA Rehab Network identified the following rehabilitation populations that require a specialized approach. These populations include acquired brain injury (ABI), amputee, burn, cardiovascular, complex trauma, oncology, pediatric, pulmonary, spinal cord injury and stroke. These specialized rehabilitation programs should continue to be provided regionally and/or provincially and be part of system-level planning and capacity building.

The need for specialized expertise and the lower volumes of patients for some populations may preclude the provision of rehabilitation close to home. However, rehabilitation for high volume populations (e.g., older adults with frailty, patients with progressive neurological conditions, musculoskeletal issues, or with injuries from minor trauma) should be provided as part of care that is close to home across all OHTs.

This document provides rehabilitative care best practice guidance for Ontario Health Teams to assist in determining when the expertise of a specially trained interprofessional team with a focused skill set is necessary to provide safe, effective and efficient care. It was developed by the GTA Rehab Network's Specialized Rehab Advisory Group and local rehabilitation expert working groups.

PURPOSE:

The purpose of this document is to provide a guide that:

- delineates what services and resources are required to provide specialized rehabilitation
- differentiates when specialized rehabilitation services are needed to support one of the ten rehabilitation populations (acquired brain injury, amputee, burn, cardiovascular, complex trauma, oncology, pediatric, pulmonary, spinal cord injury and stroke)

GUIDING PRINCIPLES:

There are a few guiding principles of specialized rehabilitation service provision that are common across all ten populations addressed in this document:

- Service is provided by a specially trained interprofessional team with a focused skill set. Rehabilitation professionals include audiologists, dietitians, kinesiologists, occupational therapists, physical medicine and rehabilitation specialists (physiatrists), physiotherapists, psychologists, rehabilitation nurses, respiratory therapists, social workers and speech-language pathologists, as well as other regulated health professionals.¹

¹ Rehabilitative Care Alliance. (Nov 2020). [Patient and System-Level Benefits of Rehabilitative Care: A primer to support planning by OHTs and Ontario Health.](#)

Note: The Ontario Ministry of Health provides [additional information](#) on other regulated health providers.

- Expertise is demonstrated in programs that see higher volumes of patients. A critical mass of patients must be seen to maintain expertise and clinical efficiency and effectiveness.
 - Critical mass is a threshold for the volume of cases that must be seen by a rehabilitation program to maintain expertise.
- Service provision requires clinical coherence with other programs or services across the continuum of care.
 - Clinical coherence is a relationship between specialized rehabilitation program/service and a complementary service(s) across the continuum that support comprehensive integrated patient care. For example, inpatient ABI rehabilitation has clinical coherence with acute neuro/neurosurgery, outpatient ABI clinics and community care.
- Service provision requires specialized resources including extensive capital and/or operating resources.
- Specialized rehabilitation programs should be funded equitably across the province to ensure there is sufficient capacity to meet evidence-based requirements for rehabilitative care.

HOW TO USE THIS RESOURCE:

The tables that follow provide a description of what specialized rehabilitation provides for the population (Table A) and a description of the patient profile to facilitate determining the optimal rehabilitation sector/location (Table B). This resource will be used for the following rehabilitation populations:

- Acquired brain injury (ABI)
- Amputee
- Burn
- Cardiovascular
- Complex trauma
- Oncology
- Pediatric
- Pulmonary
- Spinal Cord Injury (SCI)
- Stroke

To find specialized rehabilitation programs, see [Rehab Finder](#).

KEY ASPECTS OF SPECIALIZED REHABILITATION PROGRAMS FOR PATIENTS FOLLOWING BURN INJURY

Table A

The following section describes four guiding principles for specialized rehabilitation programs. In order to be considered a specialized rehabilitation program, all aspects of these principles need to be in place and should not be considered in isolation.

| Guiding Principles for Specialized Services | REHABILITATION PROGRAM: BURN REHABILITATION |
|--|---|
| <p>Requires team expertise and competency</p> | <ul style="list-style-type: none"> • Knowledgeable in:^{2 3 4 5} <ul style="list-style-type: none"> – Wound care (e.g., open wounds, dressings, donor and graft sites) and edema management – Managing contractures, hypertrophic scar, heterotopic ossification – Assessment and treatment of nerve injuries, electrical injuries and co-existing trauma – Addressing mental health and psychosocial issues related to burn injuries – Assessment and treatment of cognitive impairments (e.g., delirium, mild brain injury) – Supporting identification of goals towards return to work and pre-morbid function. • Burn Rehabilitation Therapist Competency Tool (BRTCT) for long term rehabilitation & outpatient care⁶ <ul style="list-style-type: none"> – The competency tool outlines basic knowledge and skill sets (or level 1 domains of care) central to burn rehabilitation therapists’ practice. These domains of care include the following: burn rehabilitation evaluation/treatment and discharge planning, wound care and assessment, critical management, edema, pain/anxiety management, positioning, splinting, range of motion, post-operative management, functional mobility and gait, activities of daily living, physical agents/modalities, scar assessment and management, |

² European Burns Association. (2017). European practice guideline for burn care. Minimum level of burn care provision in Europe. Available from www.euroburn.org

³ International Society for Burn Injury (ISBI). (2016). ISBI Practice Guideline for Burn Care. Burns, 42, 953-1021. <http://dx.doi.org/10.1016/j.burns.2016.05.013>

⁴ NSW Agency for Clinical Innovation. (2017). Clinical Guideline: Burn Physiotherapy and Occupational Therapy Guidelines (1st Ed.). Chatswood: Agency for Clinical Innovation. Available from: https://www.aci.health.nsw.gov.au/data/assets/pdf_file/0018/236151/Burns-PT-OT-Guidelines.pdf

⁵ NSW Agency for Clinical innovation. (2011). *Clinical Practice Guidelines Speech Pathology Burn Patient Management* (3rd Ed.). Chatswood: Agency for Clinical Innovation. Available from: https://www.aci.health.nsw.gov.au/data/assets/pdf_file/0020/162641/SBIS_Speech_Path_CPG_2011.pdf

⁶ Parry, I., Forbes, L., Lorello, D., Benavides, L., Calvert, C. Hsu, S., Choinard, A., Godleski, M. et al. (2017). Burn Rehabilitation Therapists Competency Tool- Version 2: An expansion to include long-term rehabilitation and outpatient care. Journal of Burn Care Research, 38 (1), e261-e268. <https://doi.org/10.1097/BCR.0000000000000364>

| Guiding Principles for Specialized Services | REHABILITATION PROGRAM: BURN REHABILITATION |
|---|---|
| | <p>management of cutaneous impairment, endurance and muscular strength, community reintegration and health/wellness.</p> <ul style="list-style-type: none"> • The interprofessional team utilizes skills and training from respective professions/roles and applies evidence-based practices to augment the recovery of patients with burn injury through experience, communication and ongoing professional development. Interprofessional team members may include but not limited to the following: physicians (including physical medicine and rehabilitation specialist and psychiatrist), nurses, physical therapists, occupational therapists, occupational therapist assistants/physical therapist assistants, speech-language pathologists, social workers, dietitians, pharmacists, vocational therapists, recreational therapists, massage therapists, behavioural specialists, and spiritual care practitioners. |
| <p>Provides services to a critical mass</p> | <ul style="list-style-type: none"> • To be considered experts, rehabilitation clinicians should carry a caseload of patients requiring burn rehabilitation on a regular basis to develop/maintain clinical skills to address patients' needs. • The volume of patients seen in specialized inpatient and/or outpatient rehabilitation programs should be inclusive of all burn-related levels of complexity and needs to be sufficient to maintain expertise in the burn rehabilitation population, resulting in effective and efficient care. • Specialized burn rehabilitation has the capacity to offer specialized services across multiple sectors/locations of care (e.g., inpatient rehabilitation and community-based/outpatient rehabilitation). |
| <p>Services require clinical coherence with other programs</p> | <ul style="list-style-type: none"> • Pain control services including neuropathic pain • Pruritus management • Wound care • Surgery/Plastics • Trauma/Orthopaedics • Geriatric medicine • Mental health services including psychosocial/psychiatry supporting body image, sexuality, quality of life and return to pre-morbid activities. This may include consults and treatment with psychiatrist, clinical/neuropsychologists. |

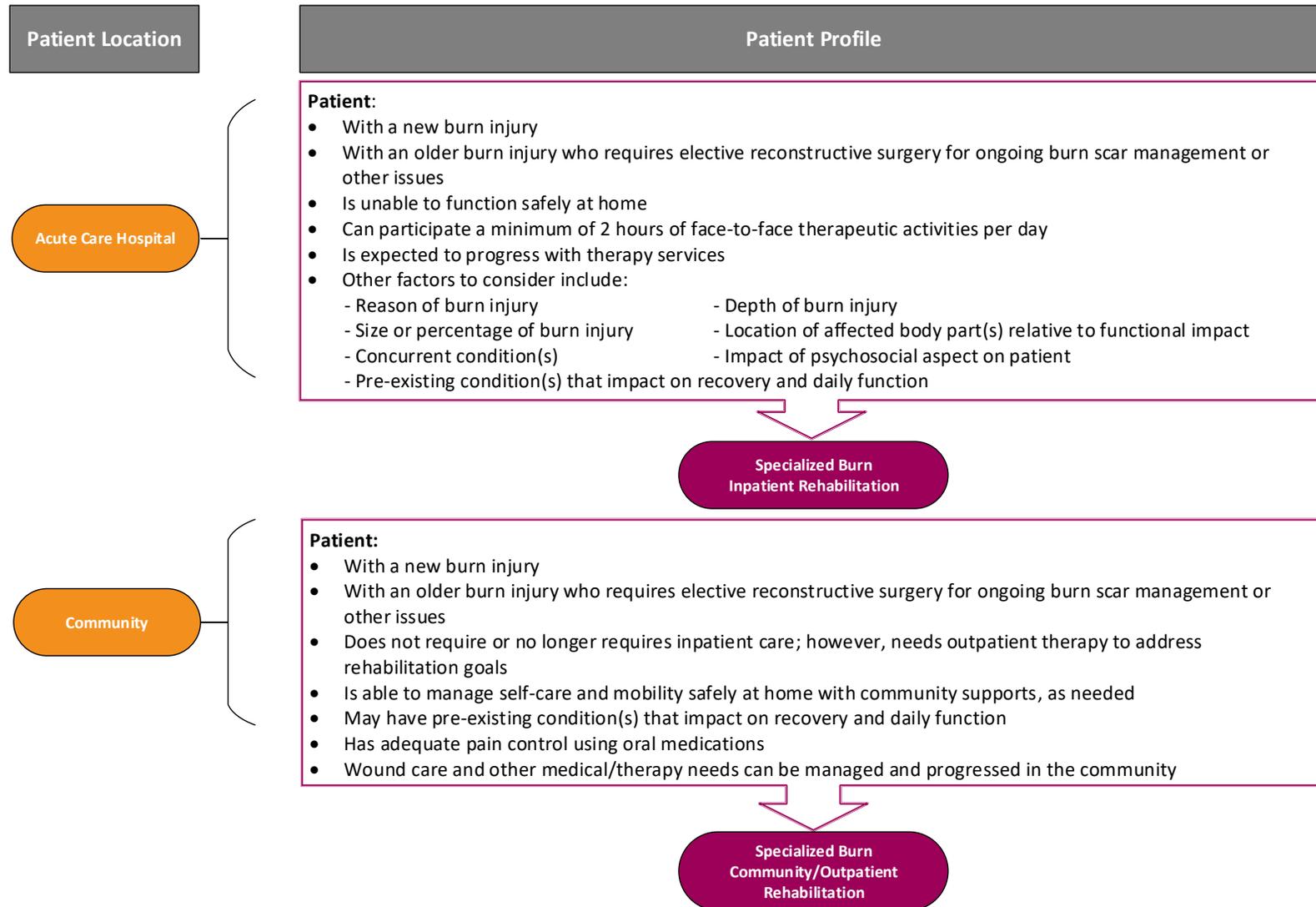
| Guiding Principles for Specialized Services | REHABILITATION PROGRAM: BURN REHABILITATION |
|--|--|
| | <ul style="list-style-type: none"> • Vocational rehabilitation services • Orthotics/Prosthetics' services |
| <p>Services require specialized resources</p> | <ul style="list-style-type: none"> • Orthoses (including face masks, microstomia management) and prosthetic devices • Scar prevention modalities (e.g., pressure garments, silicone products) • Social supports for patients including peer support networks • Interprofessional specialized burn rehab team <ul style="list-style-type: none"> – The burn rehabilitation therapists should have basic knowledge and skill set of level 1 competencies, outlined in the Burn Rehabilitation Therapist Competency Tool-version 2.⁷ – The domains of care include the following: burn rehabilitation evaluation/treatment and discharge planning, wound care and assessment, critical management, edema, pain/anxiety management, positioning, splinting, range of motion, post-operative management, functional mobility and gait, activities of daily living, physical agents/modalities, scar assessment and management, management of cutaneous impairment, endurance and muscular strength, community reintegration and health/wellness. • Exercise equipment and assistive devices appropriate for the setting • Funding for ongoing professional development of team members, which may include travel for sub-specialized topics |

⁷ Parry, I., Forbes, L., Lorello, D., Benavides, L., Calvert, C. Hsu, S., Choinard, A., Godleski, M. et al. (2017). Burn Rehabilitation Therapists Competency Tool-Version 2: An expansion to include long-term rehabilitation and outpatient care. *Journal of Burn Care Research*, 38 (1), e261-e268.

<https://doi.org/10.1097/BCR.0000000000000364>

DETERMINING THE OPTIMAL SPECIALIZED REHABILITATION LOCATION BASED ON PATIENT PROFILE: BURN INJURY

Overview - Burn Injury Rehabilitation (see Table B for details)



PATIENT PROFILE FOR THOSE REQUIRING SPECIALIZED BURN REHABILITATION

Table B

The following section describes the patient profile for those who require specialized rehabilitation. It is not meant to reflect comprehensive admission criteria.

To achieve optimal functional outcomes, burn rehabilitation requires a coordinated and collaborative interprofessional team approach that should be holistic and person-centred addressing the specific needs of the patient. Patients and families are viewed as partners in service delivery and the interprofessional team works in collaboration with them to deliver care.

| LOCATION OF REHABILITATION | PATIENT PROFILE: BURN REHABILITATION |
|----------------------------|---|
| Inpatient Rehabilitation | <p>Patient profile:</p> <ul style="list-style-type: none"> • Patient with a new burn injury from acute care requiring inpatient rehabilitative care due to inability to function safely at home • Patient with an older burn injury who requires elective reconstructive surgery for ongoing burn scar management or other issues • Factors to consider if a patient requires inpatient rehabilitation include the following: <ul style="list-style-type: none"> – Reason of burn injury (e.g., self-inflicted) – Location of affected body part(s) relative to functional impact (e.g., bilateral burn injuries in hands) – Depth of burn injury (e.g., partial/full thickness burns) – Size or percentage of the skin that is burned (e.g., higher total body surface area [TBSA] percentage burn) – Impact of psychosocial aspect on patient (e.g., disfigurement of face, loss of residential home or family, addiction supports needed). – Concurrent condition(s) such as an amputation injury, heterotopic ossification – Pre-existing conditions (e.g., substance use disorder and other mental health issues, neurological issues) in addition to the burn injury, that impact on patients’ recovery and daily function. <ul style="list-style-type: none"> ▪ The prevalence of having a mental health diagnosis prior to a burn injury was 57% - 64%.^{8 9} |

⁸ Palmu, R., Suominen, K, Vuola, J. & Isometsa, E. (2010). Mental disorders among acute burn patients. *Burns*, 36(7), 1072-1079. <https://doi.org/10.1016/j.burns.2010.04.004>

⁹ Oster, C. & Sveen, J. (2014). The psychiatric sequelae of burn injury. *General Hospital Psychiatry*, 36(5), 516-522. <https://doi.org/10.1016/j.genhosppsy.2014.05.003>

| LOCATION OF REHABILITATION | PATIENT PROFILE: BURN REHABILITATION |
|---|---|
| | <ul style="list-style-type: none"> • Medically appropriate for the level of care provided in a rehabilitation hospital (as opposed to needing burn intensive care unit, step-down or acute medical care) • Patient can participate a minimum of 2 hours of face-to-face therapeutic activities per day • Patient is expected to make progress with therapy services. <p>Other Considerations:</p> <ul style="list-style-type: none"> • Patients with burn injuries should receive 6 to 7 days of treatment per week in the inpatient rehabilitation program to prevent detrimental functional loss and support their recovery. • Inpatient rehabilitation admission or a longer inpatient rehabilitation stay is dependent on the “community setting” resources for burn-specific care of patient’s residential region. Access to burn-specific care varies significantly in the province based on availability of resources including skillset of health professionals. • Patients with complex burns may have other disabling conditions including a traumatic amputation injury, brain injury, or peripheral nerve injury that requires inpatient rehabilitation admission and consultation with other specialized services.¹⁰ • Identification and early access to mental health services (e.g., psychiatrist and/or other health professional support with expertise in addressing post-traumatic stress disorder) are critical aspects of care based on high prevalence of mental health diagnoses post-burn injury and high utilization of mental health services among survivors of major burn injury.^{11 12} |
| <p>Community-Based/ Outpatient Rehabilitation Specialized burn rehabilitation can be</p> | <p>Patient profile:</p> <ul style="list-style-type: none"> • Patient with a new burn injury who does not require or no longer requires inpatient rehabilitative care • Patient with an older burn injury who requires elective reconstructive surgery for ongoing burn scar management or other issues |

¹⁰ Thananopavarn, P. & Hill, J. (2017). Rehabilitation of the complex burn patients with multiple injuries or comorbidities. *Clinics in Plastic Surgery*, 44(4), 695-701. <http://dx.doi.org/10.1016/j.cps.2017.05.002>

¹¹ Palmu, R., Suominen, K, Vuola, J. & Isometsa, E. (2010). Mental disorders among acute burn patients. *Burns*, 36(7), 1072-1079. <https://doi.org/10.1016/j.burns.2010.04.004>

¹² Mason, S., Nathens, A., Byrne, J., Ellis, J., Fowler, R., Gonzalez, A., Karanicolas, P., Moineddin, R & Jeschke, M. (2017). Association between burn injury and mental illness among burn survivors: A population-based, self-matched, longitudinal cohort study. *Journal of American College of Surgeons*, 225(4), 516-524. <http://dx.doi.org/10.1016/j.jamcollsurg.2017.06.004>

| LOCATION OF REHABILITATION | PATIENT PROFILE: BURN REHABILITATION |
|---|--|
| <p>provided in-person or as a hybrid of both in-person and virtual check-in.¹³</p> | <ul style="list-style-type: none"> • Patient needs outpatient therapy to address deficits in function, range of motion, ongoing management of burn-associated complications (hypertrophy, etc.), and/or has remaining home, community living and/or vocational skill goals impacted by the injury (e.g., return to work).¹⁴ • Patient can manage self-care and mobility safely at home with community supports, as needed. • Pre-existing conditions (e.g., substance abuse/mental health issues, neurological issues) in addition to the burn injury, that impact on patients' recovery and daily function <ul style="list-style-type: none"> – The prevalence of having a mental health diagnosis prior to a burn injury was 57% - 64%.^{15 16} • Pain control is adequate using oral medications and without opiates or with a planned opiate wean. • Wound care can be managed in community setting. • Ongoing medical, therapy, social work and nursing needs can be managed in the community setting. • Patient can independently progress through scheduled face-to-face onsite therapy visits in an ambulatory rehabilitation setting. In addition, care may also include a home exercise program and/or virtual rehabilitation check-in's (e.g., through online videoconferencing) with therapist(s) or health care provider to ensure the needs of the patients are met. <p>Other Considerations:</p> <ul style="list-style-type: none"> • As a specialized regional burn rehabilitation program, team members must be accessible to community therapists or other clinicians for consultation regarding complex burn cases or burn specific issues (e.g., electrical injuries, splinting and scar management, provision of an Assistive Devices Program [ADP] authorization clinic for pressure garments which includes the MD prescriber and Occupational Therapist or |

¹³ See Appendix A for key considerations for virtual rehabilitation

¹⁴ Hundeshagen, G., Suman, O. & Branski, L. (2017). Rehabilitation in the acute versus outpatient setting. *Clinics in Plastic Surgery*, 44(4), 729-735.
<http://dx.doi.org/10.1016/j.cps.2017.05.004>

¹⁵ Palmu, R., Suominen, K, Vuola, J. & Isometsa, E. (2010). Mental disorders among acute burn patients. *Burns*, 36(7), 1072-1079.
<https://doi.org/10.1016/j.burns.2010.04.004>

¹⁶ Oster, C. & Sveen, J. (2014). The psychiatric sequelae of burn injury. *General Hospital Psychiatry*, 36(5), 516-522.
<https://doi.org/10.1016/j.genhosppsych.2014.05.003>

| LOCATION OF REHABILITATION | PATIENT PROFILE: BURN REHABILITATION |
|----------------------------|--|
| | <p>Physical Therapist authorizer, re-integration issues, peer support linking, contracture management, functional return, and body image issues).^{17 18}</p> <ul style="list-style-type: none"> • For communities without local burn expertise, specialized regional burn centres provide short-term monitoring and/or consultation through virtual care, working in collaboration with local health care providers. • While it might be expected that larger burn injuries (i.e., 10% TBSA or more) or burn injuries involving hands/face or electrical mechanism will often require specialized rehabilitation, patients with smaller burn injuries should have access to a burn rehabilitation team for interprofessional assessment/consultation to guide their recovery. Patients with small burn injuries may not be admitted to a burn unit or referred to outpatient rehabilitation program; thus, delayed presentation from the community can affect their functional recovery which the specialized burn rehabilitation team can effectively address. • Treatment plan including frequency of treatment should be flexible based on needs of the patient. • Identification and early access to mental health services (e.g., psychiatrist and/or other health professional support with expertise in addressing post-traumatic stress disorder) are critical aspects of care based on high prevalence of mental health diagnoses post-burn injury, and high utilization of mental health services among survivors of major burn injury.^{19 20} |

¹⁷ Edgar, D. & Brereton, M. (2004). ABC of burns: Rehabilitation after burn injury. *British Medical Journal*, 329, 343-345.

<https://doi.org/10.1136/bmj.329.7461.343>

¹⁸ Dodd, H., Fletchall, S., Starnes, C. & Jacobson, K. Current concepts burn rehabilitation, Part 2 Long-term recovery. *Clinics in Plastic Surgery*, 44(4), 713-728.

<http://dx.doi.org/10.1016/j.cps.2017.05.013>

¹⁹ Palmu, R., Suominen, K, Vuola, J. & Isometsa, E. (2010). Mental disorders among acute burn patients. *Burns*, 36(7), 1072-1079.

<https://doi.org/10.1016/j.burns.2010.04.004>

²⁰ Mason, S., Nathens, A., Byrne, J., Ellis, J., Fowler, R., Gonzalez, A., Karanicolas, P., Moineddin, R & Jeschke, M. (2017). Association between burn injury and mental illness among burn survivors: A population-based, self-matched, longitudinal cohort study. *Journal of American College of Surgeons*, 225(4), 516-524.

<http://dx.doi.org/10.1016/j.jamcollsurg.2017.06.004>

APPENDIX A: KEY CONSIDERATIONS ON VIRTUAL REHABILITATION

There are several benefits of providing virtual rehabilitation for patients and clinicians. These include: reducing travel time for patients and increasing the ability to reach patients in more remote communities.¹ There are also challenges with providing virtual rehabilitation. These may include the lack of equipment and/or comfort with using technology, the absence of contextual factors that are more available during in-person sessions, limitations around safety (e.g., hands on assistance with exercises), and limitations in the ability to conduct some assessments and interventions.^{1, 2, 3} The following are key considerations for conducting virtual rehabilitation:

- Select patients carefully. Not every patient or every patient's goals are suitable and the decision to use a virtual format should be considered on a case-by-case basis using professional clinical judgment.⁴
- Confirm that the patient has the required technology and the needed support/assistance for virtual rehabilitation and that the patient's setting is in a safe, secure and confidential environment.⁵
- Follow professional regulatory college guidelines about obtaining consent; the collection, use and retention of personal health information; safety considerations and emergency planning, and having the proper skills and training to provide virtual rehabilitation.^{2, 4, 5}
- Use the most effective and secure virtual platform to provide high quality and confidential virtual rehabilitation (e.g., use high speed internet, a confidential setting, and a platform that is compliant with the [Personal Information Protection and Electronics Document Act \(PIPEDA\)](#)).⁵
- Have support processes in place to provide technical support and address technical issues for both the patient and provider and to address language, communication or other accessibility issues.⁴
- Consider use of virtual, in-person or a mix of the two formats (e.g., hybrid model) depending on the patient's resources, needs, and goals.
- Use indicators to evaluate the impact, effectiveness, quality and safety of virtual rehabilitation.⁴

References:

¹ Bland, K., Bigaran, A., Campbell, K., Trevaskis, M., & Zopf, E. (2020). Exercising in isolation? The role of telehealth in exercise oncology during the COVID-19 pandemic and beyond. *Physical Therapy, 100* (10), 1713-1716. <https://doi.org/10.1093/ptj/pzaa141>

² McGuff, R., Cotie, L., Harris, J., Baer, C., Brisco, K., Chipperfield, D., Moran, B., Pike, R., Ross, M., Yeung, C., Blacquiére, D., Mountain, A., Gierman, N., Lindsay, P. (Eds.), on behalf of Heart and Stroke Foundation of Canada in collaboration with the Canadian Association of Cardiovascular Prevention and Rehabilitation. (2021). *Virtual Cardiovascular Prevention and Rehabilitation Implementation Toolkit*. Heart and Stroke Foundation of Canada. Available from <https://www.heartandstroke.ca/-/media/1-stroke-best-practices/vcr-toolkit-final-2021.ashx?rev=e2d73b476e6e4ef1abc09624992566d0>

³ Turolla, A., Rossetini, G., Viceconti, A., Palese, A., & Geri, T. (2020). Musculoskeletal physical therapy during the COVID-19 pandemic: Is telerehabilitation the answer? *Physical Therapy, 100* (8), 1260-1264. <https://doi.org/10.1093/ptj/pzaa093>

⁴ Rakover, J., Laderman, M., & Anderson, A. (2020). [Telemedicine: Centre Quality and Safety](#). *Healthcare Executive, 35*(5), 48-49.

⁵ O'Neil, J. (n.d.) [Tele-Rehabilitation in times of COVID-19](#). Canadian Physiotherapy Association. <https://physiotherapy.ca/times-covid-19>

APPENDIX B: STAKEHOLDER ENGAGEMENT

| UNIVERSITY OF TORONTO, TEMERTY FACULTY OF MEDICINE, DIVISION OF PHYSICAL MEDICINE & REHABILITATION ^a | | |
|--|---|-------------------------------------|
| PM&R Specialist | Job Title and Affiliation | Specialized Rehab Population |
| Dr. Mark Bayley | Medical Director and Psychiatrist-in-Chief, University Health Network/Toronto Rehab and Altum Health Professor, University of Toronto ^a Vice-Chair, Coordinating Council, GTA Rehab Network Adjunct Scientist, Institute of Clinical and Evaluative Sciences, Sunnybrook Health Sciences Centre | All Populations |
| Dr. Larry Robinson | Program Chief, Rehabilitation Services, Sunnybrook Health Sciences Centre Director and Professor, Division of Physical Medicine and Rehabilitation, University of Toronto ^a Senior Scientist, Evaluative Clinical Sciences, St. John’s Rehab Research Program, Sunnybrook Research Institute | All Populations |
| Dr. Matthew Godleski | Physician (Physical Medicine and Rehabilitation Specialist), Sunnybrook Health Sciences Centre Assistant Professor, University of Toronto ^a | Burn Rehab |

| SPECIALIZED REHAB ADVISORY GROUP | |
|---|--|
| Organization | Member |
| Holland Bloorview Kids Rehabilitation Hospital | Joanne Maxwell |
| Sinai Health System/Hennick Bridgepoint Hospital | Wendy Cameron |
| Sunnybrook Health Sciences Centre/St John’s Rehab | Dr. Larry Robinson (Co-Chair) Siobhan Donaghy |
| Unity Health Toronto/ Providence Healthcare | Anna Marie Sneath |

| SPECIALIZED REHAB WORKING GROUP – ABI REHAB | |
|--|---|
| Organization | Member |
| Sunnybrook Health Sciences Centre/St John’s Rehab | Billie Alagas Mila Bishev Aly Kassam Michelle Kroesen Gary Siu Karl Wong |
| GTA Rehab Network | Charissa Levy Sharon Ocampo-Chan |

| SPECIALIZED REHAB ADVISORY GROUP | |
|---|--|
| Organization | Member |
| University Health Network/ Toronto Rehab | Dr. Mark Bayley (Co-Chair) Joanne Kwong |
| West Park Healthcare Centre | Angela Dowd |
| GTA Rehab Network | Charissa Levy Sue Balogh Sanja Milicic lafrate Sharon Ocampo-Chan |