

GTA REHAB  
NETWORK

CLINICAL  
COMMITTEES'  
SURVEY REPORT:

CURRENT STATUS OF  
REHABILITATION IN THE GTA

Access and Coordination Committee  
Services Inventory and Gaps Committee  
Quality Care Committee

June 2001

**CLINICAL COMMITTEES'  
SURVEY REPORT:**

**CURRENT STATUS OF REHABILITATION IN THE GTA**

**Access and Coordination Committee  
Services Inventory and Gaps Committee  
Quality Care Committee**

**June 2001**

Greater Toronto Area Rehabilitation Network  
550 University Avenue, Room 1114  
Toronto, Ontario M5G 2A2  
Telephone: 416-597-3057 · Fax: 416-591-6812  
[www.gtarehabnetwork.ca](http://www.gtarehabnetwork.ca)

# TABLE OF CONTENTS

<b>Membership and Acknowledgements</b> .....	i
<b>Executive Summary</b> .....	iv
<b>I. Background</b> .....	1
<b>II. Findings</b>	
A. Admission Criteria.....	7
B. Provider Perceptions.....	10
C. Referral Patterns.....	16
D. Coordination and Monitoring Issues.....	18
E. Sizing of Services.....	21
F. Siting of Services.....	25
G. Staffing.....	41
H. Activity.....	44
I. Hours of Operation.....	47
J. Inventory of Care Pathways and Guidelines.....	48
<b>III. Summary of Issues and Recommendations</b> .....	54
<b>IV. Priority Areas</b> .....	61
<b>V. Next Steps</b> .....	65
<b>References</b>	
<b>Appendices</b>	
A: Survey Glossary and Questionnaire	
B: List of Participants	
C: Recommendations from Past Initiatives	
D: Literature Reviews on Access Measures	
E: Definition of Access	

## **CLINICAL COMMITTEES MEMBERSHIP**

Ms. Mimi Lowi-Young                      Chair, Joint Clinical Committees

### ***Access and Coordination Committee***

Ms. Mimi Lowi-Young (Chair)            President & CEO, *St. John's Rehabilitation Hospital*

Ms. Carol Cober                            Director, Continuing Care Program & Inpatient General  
Medicine, *York Central Hospital*

Ms. Rose Edwards                        Vice-President, Programs and Chief Nursing Officer, *St.  
John's Rehabilitation Hospital*

Ms. Gill Firth                              Coordinator of Professional Practice, Physiotherapy, *North  
York General Hospital*

Ms. Louise Gibson-Howcroft            Program Director, Neurology/Musculoskeletal Program, *St.  
Michael's Hospital*

Ms. Cathy Hecimovich                   Director, Client Services, *CCAC of Halton*

Ms. Penny Hubbert                        Health Planner, *Simcoe-York District Health Council*

Ms. Noreen Kay                            Social Work, Trauma Program, *Sunnybrook & Women's  
College Health Science Centre*

Ms. Catherine Kohm                      Clinical Utilization Manager, *University Health Network*

Ms. Anne-Marie Malek                   Vice-President, Programs, *West Park Healthcare Centre*

Dr. Mark Mason                            Physician Leader, Rehabilitation Program, *Lakeridge  
Health Corporation*

Ms. Carol Puri                              Director, Rehabilitation Services, *Trillium Health Centre*

Ms. Gelda Pymar                          Program General Manager, Continuing Care and Rehab,  
*Rouge Valley Health System*

Ms. Rika Vander Laan                    Executive Director, *GTA Rehab Network*

### ***Services Inventory and Gaps Committee***

Ms. Rika Vander Laan (Chair)            Executive Director, *GTA Rehab Network*

Ms. Angela Chan                          Transition Associate, *St. Michael's Hospital*

Ms. Tina Demmers	Clinical Leader, <i>Allied Health/Professional Services, Lakeridge Health Corporation</i>
Ms. Joan Ferguson	Vice-President, Programs and Services, <i>Bloorview MacMillan Centre</i>
Ms. Georgia Gerring	Vice-President, Programs, <i>Toronto Rehabilitation Institute</i>
Ms. Evelyn Maurice	Director, Rehabilitation, <i>Humber River Regional Hospital</i>
Ms. Helen McKay	Manager, Acute Rehabilitation, <i>Halton Healthcare Services Corporation</i>
Ms. Heather Reid	Program General Manager, Continuing Care and Rehabilitation, <i>Rouge Valley Health System</i>
Ms. Jennifer Scott	Manager, Client Services, <i>North York Community Care Access Centre</i>
Ms. Carol Smith-Romeril	Senior Planner, <i>Durham, Haliburton, Kawartha &amp; Pine Ridge District Health Council</i>
Ms. Fern Teplitsky	Senior Health Planner, <i>Toronto District Health Council</i>
Ms. Jan Walker	Director, Clinical Evaluation & Research Unit, <i>West Park Healthcare Centre</i>

### **Quality Care Committee**

Dr. John Flannery (Chair)	Director of Physiatry and Marketed Services, <i>St. John's Rehabilitation Hospital</i>
Ms. Barbara Bell	Manager, Performance Measurement, Clinical Evaluation and Research Unit, <i>West Park Healthcare Centre</i>
Ms. Lynn Budgell	Clinical Pathways Clinician, <i>Halton Healthcare Services Corporation</i>
Ms. Linda Dignem	Care Process Consultant, <i>Lakeridge Health Corporation</i>
Ms. Shari Hughes	Physiotherapist and Professional Practice Leader, Trauma, <i>Sunnybrook and Women's College Health Centre</i>
Ms. Kim Lenahan	Operations Director, Neurorehabilitation Program, <i>Toronto Rehabilitation Institute</i>

Ms. Karyn Lumsden	Director Rehabilitation Services, <i>Credit Valley Hospital</i>
Ms. Annette Marcuzzi	Acting Professional Practice Leader Physiotherapy, <i>St. John's Rehabilitation Hospital</i>
Ms. Janet Rajroop	Director, Client Services, <i>Scarborough Community Care Access Centre</i>
Ms. Judy Ritchie	Project Manager, Continuous Improvement, <i>Southlake Regional Health Centre</i>
Ms. Kathy Romas	Business Manager, Outpatient Rehabilitation Services, <i>Markham Stouffville Hospital</i>
Ms. Rika Vander Laan	Executive Director, <i>GTA Rehab Network</i>

### ***Project Coordinator***

Ms. Tina Saryeddine	Project Coordinator/Planner, <i>GTA Rehab Network</i>
---------------------	---

## **ADDITIONAL ACKNOWLEDGEMENTS**

The Clinical Committees also gratefully acknowledge the following individuals for their advice and expertise in helping to complete this project:

- *Ms. Stephanie Elgie* for her work in preparing the population maps on pages 27-40.
- *Ms. Brenda McGovern* for her expertise in creating an electronic version of the Clinical Committee survey.
- *Mr. Robert Jessop* for facilitating Clinical Committee updates through communication in the *Bulletin* and for his expertise in editing and formatting the document.
- *Ms. Charissa Courtney* for her advice and her assistance in verifying data and editing on various occasions.
- *Ms. Samantha Slemko and Ms. Corrine Whittle of St. John's Rehabilitation Hospital and Ms. Fran Jackson of Bloorview MacMillan Centre* for arranging the meeting venues for the committees.

The Clinical Committees also graciously acknowledge each of the individuals at the participating organizations who responded to the survey and provided perspectives and information on their organizations' rehabilitation services and experiences.

In addition, the following former members of the committees also contributed to this initiative: Karen Atkin, Peter Biasucci, Alexis Dishaw, Barb Kendrick, Nancy Kula, Natalie Pawlenko, Kate Reed, Susan Roher, Catherine Wang.

## EXECUTIVE SUMMARY

The Clinical Committee Survey Initiative is an effort driven by nearly forty rehabilitation providers from organizations within the Greater Toronto Area. The project was designed to identify rehabilitation issues at the service delivery level that need to be addressed in order to achieve a vision of an integrated rehabilitation system.

In order to do so, a survey was designed and conducted by the Access and Coordination, Services Inventory and Gaps, and Quality Care Committees of the GTA Rehab Network and administered to all facilities offering acute care, regional rehabilitation, complex continuing care with rehab, and community care access centres.

The survey examined admission criteria, referral patterns, patient flow, waiting list management, the siting and sizing of rehabilitation services, staffing, activity, hours of operation, care pathways, and guidelines for pathway development and selection.

Upon completion of the analysis of these sections, the committees identified 36 rehabilitation issues. A joint session was then held on May 2<sup>nd</sup>, 2001 to come to consensus on the areas which upon resolution would be most effective in moving towards a vision of an integrated rehabilitation system. It was determined that addressing these areas would lead to the resolution of nearly 25 of the 36 issues identified through the survey.

These areas and the actions required are as follows (in no particular order):

Area	Potential Impact/Outcome at Resolution
<p>Many quality improvement/care pathway activities are occurring in silos with no connectivity across the continuum of care.</p> <p><b>Action Required:</b> Examine variation in care pathways by population group and communicate best practice for population(s).</p>	<ul style="list-style-type: none"> <li>• Reduction in duplication in pathway development and use</li> <li>• Consensus on best practice</li> <li>• Coordination along the continuum of care</li> <li>• Better transition for patients as they move across the continuum</li> </ul>
<p>Most rehabilitation is occurring 5 days/week. HSRC recommendation for 7 day/week rehabilitation.</p> <p><b>Action Required:</b> Initiate a research project to examine the benefits and drawbacks of 7 day per week rehabilitation for inpatients and outpatient rehabilitation which looks at all factors.</p>	<p>Examining the impact of 7 day/week rehabilitation will provide clarity around:</p> <ul style="list-style-type: none"> <li>• Business/planning implications of moving to a 7 day model i.e. staffing, capacity, etc.</li> <li>• Clinical/outcome advantages and disadvantages</li> <li>• Direct and indirect costs and benefits for the patient and the community</li> </ul>

Area	Potential Impact/Outcome at Resolution
<p>Admission criteria: Form and function of admission criteria vary, causing lack of clarity about who is getting access and who is not, the use of subjective terms, inability to match a patient with a service, etc.</p> <p><b>Action Required:</b> Identify and implement measures which improve the patient's ability to gain access or the program's ability to admit the patient.</p>	<ul style="list-style-type: none"> <li>• Openness and transparency in the admission process</li> <li>• Integration and problem solving across organization</li> <li>• Objectivity around subjective admission requirements</li> <li>• Matching patient's needs to facility abilities</li> <li>• Making the business case for needs not sufficiently addressed</li> <li>• Potential to incorporate work of OHA, Provincial Rehab Working Group and triage tool into provider practice</li> </ul>
<p>Framework for capacity in relation to need: Crude estimate of overall capacity constructed by assessing location of services, populations served by region, beds/100 000, staffing ratios and numbers, and activity measures. However there is a lack of demand information and no agreed upon methodology for projecting future need.</p> <p><b>Action Required:</b> In consultation with the District Health Councils, use current data to develop the assumptions and model needed for a statistically valid and reliable demand projection for rehabilitation in the GTA.</p>	<ul style="list-style-type: none"> <li>• Benchmarks to use in planning</li> <li>• Standardized assumptions to use in projecting future need across the system.</li> </ul>
<p>Organization specific waiting lists and manual waiting list management may cause prioritization issues and do not take advantage of cross organizational problem solving.</p> <p><b>Action Required:</b> Explore the feasibility of a waiting list management system for rehabilitation in the GTA. Determine an infrastructure for communicating capacity between organizations</p>	<ul style="list-style-type: none"> <li>• Means of sharing capacity information</li> <li>• Cross-organizational problem solving</li> <li>• Increased efficiency</li> <li>• Shortened waiting lists</li> <li>• Reduced duplication</li> <li>• Consensus on waiting list management approach</li> <li>• Transparency and openness about the issues</li> <li>• Discovery of other possibilities for dealing with capacity</li> </ul>

Area	Potential Impact/Outcome at Resolution
<p>Needs of particular population groups (i.e. wandering patients, patients with cognitive/behavioural issues, medically complex patients) may not be sufficiently addressed as these populations often fail to meet admission requirements.</p> <p><b>Action Required:</b> Develop a more systematic means of quantifying the problem in order to determine the type and quantity of resources/measures needed.</p>	<ul style="list-style-type: none"> <li>• Improvement in access, scope, and quality of services available to meet these particular needs.</li> </ul>
<p>Variations in how rehabilitation programs collect information, how indicators are measured and why they are collected (i.e. especially outpatient information).</p> <p><b>Action Required:</b> Support timely and consistent use of the proposed minimum data set and where additional data is required, build around the minimum data set (JPPC Recommendation).</p>	<ul style="list-style-type: none"> <li>• Conceptual framework for measuring and managing outpatient rehabilitation</li> <li>• Streamlining of the number of data indicators collected across the system</li> <li>• Improved coordination and management as a result of more commensurable indicators</li> </ul>
<p>Proximity vs. critical mass: Maps of where populations are receiving services vary for each population group. Concerns exist about the balance of critical mass and proximity and the “correct” location to treat a patient.</p> <p><b>Action Required:</b> Develop criteria for articulating the appropriate level of care and medical capabilities for regional rehabilitation centres, acute care hospitals by urging the MOHLTC and the OHA to clarify the roles of regional and non-regional centres in rehabilitation; use of ambulatory care and home care; and use of specialized vs. general rehabilitation beds</p>	<ul style="list-style-type: none"> <li>• Equitable access for patients within Toronto and in the 905 region.</li> <li>• Ensuring quality in all regions of the GTA.</li> <li>• Proper consideration of patient needs and preferences</li> <li>• Once principles are determined, it will be possible to put the enablers in place such as transportation, satellite clinics etc to address the problems that arise.</li> </ul>

Area	Potential Impact/Outcome at Resolution
<p>Use of non-designated beds for MSK, Stroke and Geriatrics, some organizations also report referral to non-designated beds for rehabilitation.</p> <p><b>Action Required:</b> Conduct further investigation into why and how non-designated beds are being used.</p>	<ul style="list-style-type: none"> <li>• Ensuring that non-designated rehab beds are sufficiently equipped</li> <li>• Better understanding about “right sizing the rehab system”</li> </ul>
<p>Rehabilitation in the home: Need for a greater understanding of in home rehabilitation and outpatient rehabilitation Need for a greater understanding of outpatient rehabilitation: appropriateness of inpatient to outpatient ratios, location of outpatient services, impact of transportation in accessing outpatient services, understanding of outpatient services provided by private providers.</p> <p><b>Action Required:</b></p> <ul style="list-style-type: none"> <li>• Consult with CCACs to better understand what data is available and what we need to collect/draw on to complete the inventory picture.</li> <li>• Examine the appropriateness of the number of inpatient to outpatient programs by population and explore opportunities for improving the delivery model.</li> <li>• Develop a framework for outpatient rehabilitation, which allows for a better understanding of how much outpatient rehabilitation occurs outside of the Network.</li> <li>• Conduct a study on the impact of transportation issues on access in rehabilitation including: impact on the distribution of inpatient, outpatient, and home care services; review of existing initiatives; and non emergent transportation between facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Better understanding of in home rehabilitation and its linkages to outpatient rehabilitation</li> <li>• Better understanding of transportation requirements and outpatient services required</li> <li>• More complete picture of rehabilitation</li> </ul>

***Next Steps:***

In order to address these areas, as well as to achieve resolution of the 36 rehabilitation issues identified, the Network will engage in various approaches. First, where it is appropriate and feasible for the Network to do so, some of the priority areas will be incorporated directly into the GTA Rehab Network Operating Plan. Second, the Network will seek opportunities to raise awareness and collaborate with other organizations in order to address each of the issues. Finally, the status of the issues identified will be revisited to determine if there are new opportunities to address them and as a source from which to draw future initiatives and activities.

***Acknowledgement:***

The Network would again like to acknowledge each of the committee members as well as the organizations and individuals that participated in this initiative. The dedication shown in the identification of the noted issues and action plans speaks to the collective commitment to achieving an integrated rehabilitation system for the patients, families and rehabilitation providers of the Greater Toronto Area.

## **I. BACKGROUND**

This document summarizes the issues and findings from the clinical committee survey initiative. The first section of the report describes the mandate, objectives and approach of each of the three clinical committees. The second section of the report lists the findings and the issues that arise from each section of the survey. It contains the findings and deliberations of all three committees and the supporting data for the 36 issues identified. The third section of the report summarizes the issues and recommendations of each of the committees. The fourth section provides the outcomes of a consensus session held to select priority areas from the 36 issues, which may have the greatest impact in moving us towards the vision of an integrated rehabilitation system.

### ***Mandate:***

The mission of the GTA Rehab Network is to provide a forum for collaboration, communication, and consensus building that enables its members, the providers of rehabilitation services, to work towards the vision of an integrated rehabilitation system coordinate services, promote equitable access, address gaps, reduce duplication, increase research and education, and measure overall performance.

As part of enabling this mission, the Clinical Committees conducted a survey designed to identify rehabilitation issues experienced by public rehabilitation providers in the GTA. The issues are those that must be addressed in order to improve coordination and integration across the system.

### ***Objectives:***

1. Analyze admission criteria, referral patterns, provider perceptions, and coordination issues in order to better understand access issues at the points of entry to and coordination of the rehabilitation system.
2. Create an inventory of rehabilitation services which builds on the work of the January 2000 Services Inventory Working Group with a view to further our understanding of capacity issues and gaps.
3. Inventory care pathways that are known to exist among GTA Rehab Network member organizations for the purpose of creating an inventory of care pathways that will support providers and in order to examine the number, type and variation among care pathways by population group.

### ***Approach:***

- Three clinical subcommittees — Access and Coordination Committee, Services Inventory and Gaps Committee, and Quality Care Committee— were formed in April 2000.
- Membership on the committees was appointed by Network member organizations and included nearly 40 representatives with clinical or administrative backgrounds from the acute, rehabilitation, and community sectors, as well as from the District Health Councils.

- Committee members participated directly in developing the questionnaire, determining the parameters and definitions (Appendix A), analyzing the findings, and identifying the issues and recommendations.
- All publicly-funded acute care, complex continuing care with rehabilitation, regional rehabilitation centres, and Community Care Access Centres in the GTA participated by completing the survey and assisting the Network in understanding their services (Appendix B).
- The response rate was 100%.
- In some cases the results were analyzed for the GTA as a whole and in other cases the results were analyzed by “cluster” which refers to a grouping of organizations within the same geographic location, e.g. the CCACs and hospitals in Durham, or the CCACs and hospitals in Halton-Peel. The cluster groups are explained in Appendix B.
- Once the issues and recommendations were identified at the subcommittee level, a joint meeting was held to obtain consensus on priority areas.
- The survey is intended to describe the system in its current state from the provider perspective and to identify the issues that Network members wish to have addressed. For this reason, the survey and the report do not examine issues such as outcomes, appropriateness, effectiveness, financial issues, ethics and patient or provider satisfaction.
- For the purpose of the survey, a modification of the MOHLTC definition of rehabilitation was used (Appendix A).
- Providers were asked to report on the rehabilitation services in their organizations that met the definition as well as the following five criteria: time-limited; goal-oriented; involve multidisciplinary/multiple providers; responsive, dynamic; directed by a regulated health professional.
- Private/insured services/clinics, WSIB, physician offices, children’s treatment centres, and services that are consultative as opposed to treatment-based were beyond the scope of the study.
- This initiative was intended to build on the work previously completed by the Provincial Rehabilitation Reference Group, the Health Services Restructuring Commission (HSRC), and the January 2000 Services Inventory Working Group (Appendix C).

## **Committees:**

### **Access and Coordination Committee:**

One of the key responsibilities of the Network is to ensure and promote equitable access to rehabilitation services. In keeping with this mission and mandate, the Access and Coordination Committee surveyed all of its members in November 2000 to determine access issues related to the points of entry to and coordination of the rehabilitation system.

Assessing access to healthcare services is complex because it is value-laden and because there is no consensus on a conceptual understanding of the definition of access. Appendix D provides a summary of the literature review on the definitions, measurements, and issues with measuring access. Appendix E provides the definition of access that was developed and used by the Access and Coordination Committee for this initiative.

The Access and Coordination Committee of the GTA Rehab Network chose to examine access issues that occur at the points of entry to and points of coordination to the rehabilitation system, with the view that by addressing one component at a time, we can eventually advance our overall understanding while making positive improvements in the short term.

The approach taken to address points of entry and coordination included:

- Inventorying and analyzing admission criteria
- Assessing referral patterns to determine geographic themes and variations in accessing rehabilitation services
- Analyzing coordination issues to determine if there are process issues which may help to improve access and patient flow
- Determining provider perceptions of the important barriers to access and the most disadvantaged population groups in order to determine which areas need attention and if it is feasible to create action plans in these areas.

Issues such as quality, timeliness, and choice were beyond the scope of the study.

### **Services Inventory and Gaps Committee:**

Previous initiatives have identified the lack of basic planning information as a barrier to improving rehabilitation services. The Provincial Rehabilitation Reference Group, the HSRC, and the January 2000 Services Inventory Working Group also identified the need to understand the rehabilitation system's current capacity.

Specifically, *Managing the Seams* describes the need for an environmental scan of the current rehabilitation system pg.30

*“While it is important to consider the broader information requirements of the rehabilitation sector, the goal of the initial environmental scan would be more modest; it would be based on data that is currently available. Specifically... the capacity of providers to meet service and support needs would be required for each area”*

*Managing the Seams* then goes on to describe how capacity should be assessed, specifically identifying the following questions which need to be answered:

- What is the nature of the service provided?
- Who provides the services?
- Where is service provided?
- What services are needed but not provided/gap analysis?

In addition to answering these capacity questions posed by the Provincial Rehabilitation Reference Group, the Services Inventory Group also looked at:

- Staffing FTEs
- Volumes
- Hours of Operation

The inventory focuses on the supply side of the service delivery equation. It describes the system as it is at a snapshot in time (April 1, 1999 to March 31, 2000 or as at November 2000). The analysis of this supply information allows us to draw some conclusions about supply in relation to demand and potential access issues related to the siting and sizing of services. It is important to note that the inventory is simply intended to describe what is currently in the system and does not purport to show what should or should not be.

Consequently, the layout of the service inventory is intended to show differences by region. A decision was made not to show organization specific data due to concerns about confidentiality and potential use of the data as benchmarks or comparators.

### **Quality Care Committee:**

As per the Terms of Reference of the GTA Rehab Network, it is part of the Network's responsibility to support members and clinicians as they improve processes and protocols for rehabilitation in the GTA.

As a starting point towards meeting this responsibility, the Quality Care Committee inventoried the care pathways known to exist in the GTA, with the view that by informing professionals of the care pathway work done by their colleagues, we can begin to promote information sharing across the system, minimize the duplication of efforts, and begin to integrate quality initiatives across the system and the continuum of care.

The care pathways inventoried are those that relate to the OHA Rehabilitation Population Groups for acute care, rehabilitation and home care. The committee felt that this would help provide a better perspective of the potential rehabilitation experience across the continuum of care.

The committee has included a list of guidelines for the development and selection of care pathways based on the literature and Network member experiences with the use of care pathways at their own organizations.

From a system's perspective, the number and variation of pathways provides an indication of the level of coordination that is currently occurring in rehabilitation system and points to possible areas where there is potential for consolidating the pathways.

The inventory will prove useful to organizations that are interested in creating care pathways. However, it should not be interpreted as the committee's endorsement or lack thereof, of the use of care pathways.

### ***Limitations:***

As a first attempt to formally identify rehabilitation issues in the GTA, this report has limitations. Some of the limitations are related to the way the questions were asked and will serve as learning for the future. Other limitations are related to the specificity of information submitted. Any errors or admissions were unintentional.

Perhaps one of the most pervasive issues identified in previous initiatives by the Provincial Rehabilitation Reference Group, the HSRC, and the Services Inventory Group of January 2000 was the lack of common language and frameworks amenable to describing rehabilitation in the GTA. While progress has been made in this area, the following limitations are still present in this initiative:

- **Outpatient Services:** Data in this report is limited in two respects. First, in comparison to inpatient services that are easier to quantify and describe, we do not have consistent outpatient descriptors. Secondly, it is possible that considerable outpatient activity is being offered by non-Network member providers and therefore, are not captured in the survey.
- **Children and Youth:** This initiative does not paint a complete picture of rehabilitation services for children and youth in the GTA because a good deal of rehabilitation for children is offered by children's treatment centres who are not Network members and therefore were not surveyed as part of the initiative.
- **CCACs and Home Care:** The CCACs are unique in the manner in which they offer rehabilitation. All CCACs serve all population groups and therefore an analysis of the siting of services did not produce any meaningful information. Furthermore, much of the volume and staffing data is conceptually different because of the contracted activity and nature of the services. Further study of the CCACs will be required to properly understand rehabilitation in the home.
- **Population Groupings (Appendix A):** The OHA population groups were very helpful tools for creating the inventory. Most organizations were able to identify the population groups and report some data using these categories and their definitions. However, due to differences in organization-specific approaches to rehabilitation and to program design, the population group definitions sometimes could not be matched with the actual program structure, causing difficulty in comparing data.

The following items were noted:

- Neurology: Many organizations group Stroke and ABI under Neurology and have difficulty distinguishing between them for reporting purposes;
  - Trauma: In some cases, burn programs are incorporated into trauma programs;
  - Oncology: Rehabilitation for this population group is often distributed among the programs for other population groups;
  - Musculoskeletal (MSK): The MSK population group is broad and may need to be broken down further in order to get a better understanding of the group;
  - Multiple diagnoses: In many cases, patients may not fit neatly into one of these categories due to multiple diagnoses. More work needs to be done in developing common language for services geared to these patients.
- 
- **Subjective reporting:** Some of the sections rely on the providers' perspective and experiences and are therefore subjective.
  - **General rehabilitation:** This initiative has been successful in beginning to understand what is happening in general rehabilitation beds. The analysis has given some indication that general rehabilitation beds are actually used in population specific ways. However, even where organizations have allocated their beds to specific population groups, the decision is organization-specific and may be implemented with different degrees of formality. Therefore, the area of general rehabilitation must still be examined further.
  - **Areas beyond the scope of the study** included a detailed analysis of services offered in "shadow" rehabilitation beds/spaces; physician/medical resources; contracted services, support staff, and other participants in the delivery of rehabilitation services; and intensity of services.
  - **Analyses beyond the scope of the study:** The clinical committees initiative was intended to describe, rather than evaluate, the current rehabilitation system. For this reason, the committees did not examine in depth issues around financials, ethics, best practice, appropriateness, patient choice or satisfaction.

## II. FINDINGS

### A. ADMISSION CRITERIA

This section summarizes the findings from the analysis of the admission criteria of each institutional rehabilitation program in the GTA. The purpose of analyzing the admission criteria was to examine the form, function and key factors noted in the criteria which cause a patient to be admitted to or excluded from admission to a rehabilitation program in the GTA. It is important to note that this section does not purport to describe who is actually being admitted but describes the admission criteria as they are reported.

Admission criteria can be considered as a gate-keeping mechanism. The more clearly and explicitly they are written, the less subjective the criteria, and the more clearly gaps and access issues can be identified in order to coordinate a more equitable and fair system. However, from a patient services perspective, admission criteria must also be flexible enough to accommodate the uniqueness of each patient's situation.

This analysis of admission criteria looks at a balance of these perspectives. First, the form of the criteria is assessed against common descriptors of the admission criteria format such as whether it contains inclusion criteria, exclusion criteria, reference to age, diagnoses, medical conditions, etc. Second, the admission criteria are analyzed for common themes that may act as indicators or contra-indicators for admission.

#### ***Summary of Issues Identified:***

*(see Tables 1 and 2)*

- Form and function of the admission criteria vary, causing a lack of clarity around who is/is not being admitted and the capabilities of the receiving organization to accept patients with particular needs.
- Patients with particular needs (i.e. patients who wander, have cognitive impairments or psychiatric disorders) are often excluded by the admission criteria.
- Appropriateness and use of the concept of “medically stable”, a term specified in all criteria but which may be a subjective and debatable term from a clinical standpoint.
- Subjective requirements such as “willing to participate” or “potential for improvement” are required by most programs.
- Process requirements that pose a barrier to admission include failure to provide a letter of return, failure to secure a discharge plan.
- Admission criteria are seldom specific to diagnostic groups. The only diagnostic groups specifically excluded from any of the criteria are ABI and Spinal Cord.
- Transportation arrangements are required for access to many outpatient rehab programs.

**TABLE 1: Commonly occurring statements in inclusion and exclusion criteria for admission to a non-regional rehabilitation program in the GTA**

<b>Category</b>	<b>Most commonly occurring statements</b>	<b>Number (n=14)</b>
Age	>18	10
	>55	2
	<18	2
Diagnosis	Given as a component of the criteria	12
	Diagnoses given match bed allocations	6
Medical Issues	Given as a component of the criteria	12
	Medical stability	12
	Weight bearing	4
Inclusions	Given as a component of the criteria	10
	Cognitive ability	10
	Goals identified	5
	Physical stamina for >90 min	5
	Potential for improvement	5
	Physician on staff	4
	Discharge plans	4
	Ability to get to program	2
Exclusions	Given as a component of the criteria	11
	Behavioural issue	7
	Wandering issue	7
	Complexity/medical issue	6
	Cognitive ability	6
	By diagnosis (ABI and Spinal Cord)	3

**TABLE 2: Written requirements for admission to a regional rehabilitation centre program by population group**

✓ = a program has requirement as a condition for admission

X = a program is designed to address this requirement but may not require patients to have it in order to be admitted

Requirement	ABI	AMP	BUR	CAR	GER	MSK	NEU	RES	SPC	STR
Cognitive abilities		✓		✓	✓ X		✓ X	✓ X	✓	✓
No dementia/progressive neuro.	✓	✓			X					
Non violent/aggressive/behavioural	✓	✓	✓						✓	
No psychiatric diagnosis			✓	✓						
Medically stable	✓	✓	✓	✓	✓		✓	✓		✓
Goals identified									✓	✓
Potential for improvement	✓	✓								✓
Withstands <= 30 min of therapy		✓	✓	✓			✓			
Incontinence addressed						✓ X	✓			
Not requiring a secure space				✓	✓		✓			
Weight bearing						✓ X				
Willingness to participate		✓								
Not requiring enteral feeding			✓		✓					
Discharge plan in place	✓	✓	✓							
Send back provision	✓	✓	✓							
Transportation	✓		✓	✓	✓					
No criminal charges	✓									
Non smoking								✓		
Safe swallowing and breathing			✓	✓				✓		
No infectious/comm diseases									✓	
Physician on staff										
Has a family physician	✓									
Demonstrates complex needs	✓	✓	✓	✓						

Note: Two symbols appear where there is more than one program for the population with different admission requirements

## B. PROVIDER PERCEPTIONS

Respondents were asked to rate the extent to which they experienced a number of access issues when trying to move a patient from their facility to the next level of care. The categories were left open-ended and respondents were asked for comments alongside each of the issues.

The scores that each organization assigned to the barrier were then totalled and the issues were ordered from most to least frequently experienced issue. The issues were also examined by cluster, by inpatient and outpatient responses, for child and adult services, for general rehabilitation and population specific groups, and by institutional and community care access centres.

All respondents were also asked to identify the three rehabilitation population groups whose needs are least addressed in rehabilitation.

### **Summary of Issues Identified:**

*(See Tables 3,4 and Figure 1)*

- **Barriers to moving a patient to the next level of care in order of extent experienced by respondents for both inpatient and outpatient**

*(1 is the most frequently experienced issue; 14 the least frequently experienced)*

1. Provider availability (waiting lists)
2. Availability of expertise (i.e. OT, PT, palliative care)
3. Transportation
4. Availability of specialty programs (i.e. complex medical needs)
5. Needs of special populations (homeless, wandering, aggressive patients)
6. Language barriers
7. Availability of prosthesis, AAC, seating and supportive devices
8. Out of country/uninsured
9. Physical facility issues
10. Out of province/uninsured
11. Availability of medical equipment
12. Driving assessment
13. Physician availability
14. Availability of patient information

- **Top five issues are consistent when results are examined by:**
  - inpatient and outpatient
  - adult and paediatric
  - CCACs, regional centres, acute care with rehabilitation
  
- **Cluster specific issues include:**
  - Language: Toronto Community Hospitals and CCACs
  - Uninsured and Out of Country: Toronto Acute Teaching Hospitals
  - Driving Assessment: Halton-Peel and York Region Community Hospitals
  - Physical facility issues: Regional Centres, Durham Region and Halton-Peel Community Hospitals
  - Prosthesis and other devices: Toronto Community Hospitals and Regional Centres
  
- **Most disadvantaged population groups (Figure 1):**
  - Geriatric
  - Chronic Pain
  - ABI
  - Oncology
  - Respiratory/Stroke

**TABLE 3: The top five access issues and the verbatim qualifying statements identified by clinical committee survey respondents**

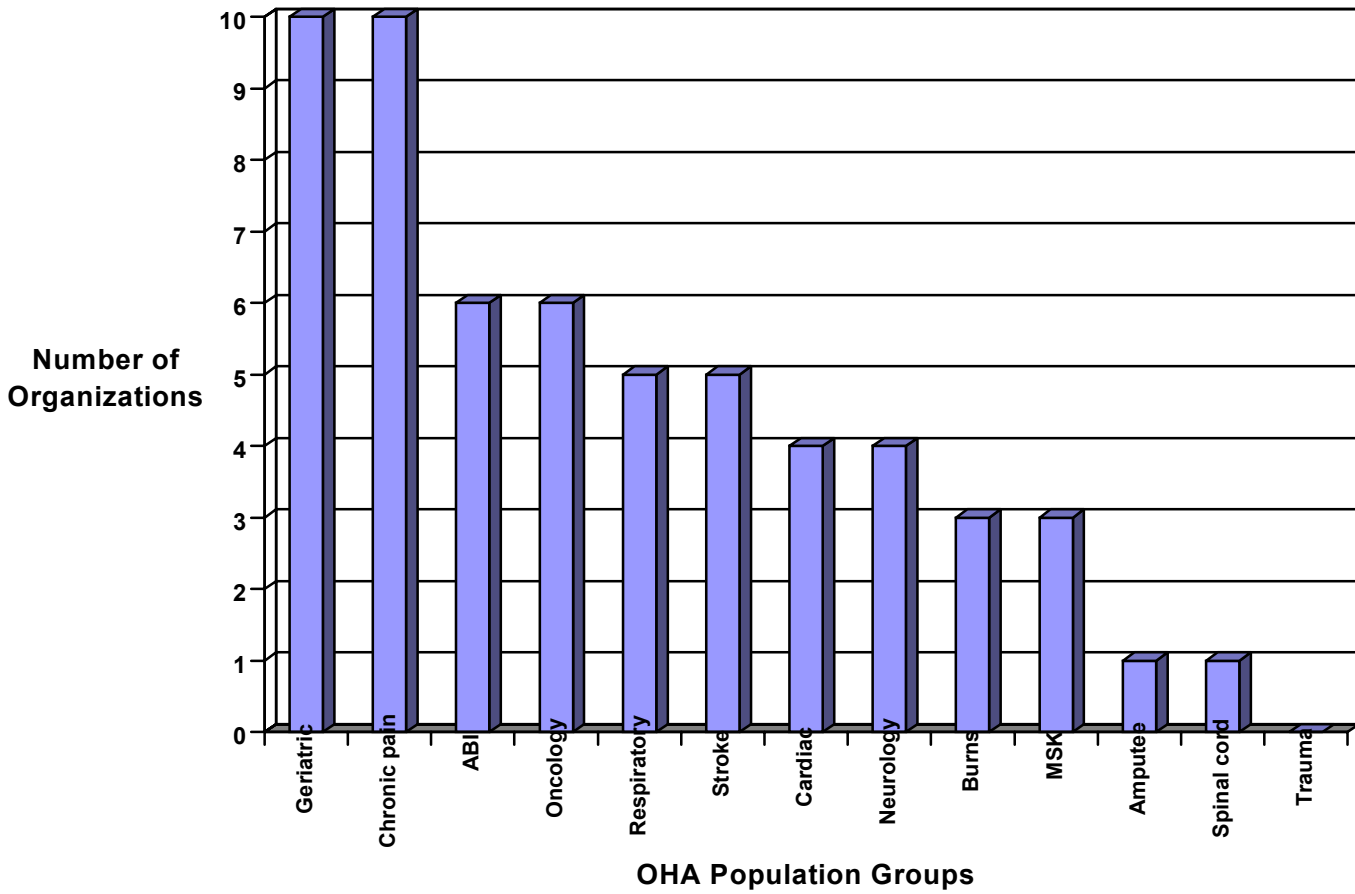
Issue	Provider Comments
Provider availability	<ul style="list-style-type: none"> <li>• “Especially Speech Language Pathologists”</li> <li>• “For low functioning patients”</li> <li>• “Scarcity of home care nursing services”</li> <li>• “Waiting lists”</li> <li>• “Waiting time for CCAC services”</li> <li>• “Waiting list for ambulatory care programs”</li> <li>• “Waiting lists [caused by] availability of rehabilitation and vacancies”</li> <li>• “Long wait for stroke rehab and neuro rehab, lack of facilities for patients with palliative diagnosis, lack of slow stream rehab”</li> <li>• “Funding and Volumes”</li> <li>• “Nursing shortage”</li> <li>• “CCAC shortage of nurses, PT, OT”</li> <li>• “Home ventilator”</li> <li>• “OHIP Clinics within the community”</li> <li>• “Outpatient Rehabilitation”</li> </ul>
Availability of expertise	<ul style="list-style-type: none"> <li>• “...will not accept patients with IV or who require IM categorization for inpatient ad community; management of complex patient care needs (i.e. trach, TPN, PIC lines, expertise in management of complex neurological disorders, NMS, GBS Huntington’s) access to inpatients psychiatric services for patient in inpatient rehab is very problematic”</li> <li>• “Lack of Speech and RT”</li> <li>• “Lack of expertise in death and dying and for palliative patients”</li> <li>• “Neuropsych”</li> <li>• “access to surgeons”</li> <li>• “behavioural problems”</li> <li>• “CCACs”</li> <li>• “Decreased ABI services, no functional testing available, vocational expertise unavailable”</li> <li>• “Post paediatric developmental”</li> </ul>
Transportation	<ul style="list-style-type: none"> <li>• Availability of ambulances during admission hours for patient transfers Community WheelTrans to transport to outpatient services</li> <li>• “Hours [when] no TTC accessible”</li> <li>• “No TTC stops, patients need to walk uphill”</li> <li>• “Lack of reciprocity between WheelTrans &amp; Trans-Help brokers”</li> <li>• “Some difficulty in timing TTC for discharge”</li> <li>• “Many elderly people are alone and financially limited ... difficult for them to get around”</li> </ul>

Issue	Provider Comments
Availability of specialty programs	<ul style="list-style-type: none"> <li>• “Insufficient programs to meet needs for cognitive, behavioural therapy, slow stream rehabilitation, severe brain injury, complex respiratory care, chronic ventilated care”</li> <li>• “ABI program, child and family”</li> <li>• “specialized teaching programs have long lists for patient with multiple diagnosis”</li> <li>• “Geriatric, mental health, and pediatrics”</li> <li>• “Neuro-rehabilitation/ABI”</li> <li>• “Criteria for admission seem to change, patients who are heavy care are at a disadvantage, as are patients who are non weight bearing or take two to transfer, dual diagnosis is a barrier, limited services for swallowing disorders, patient on dialysis and patients with cancer (undergoing radiation) ”</li> </ul>
Needs of special populations	<ul style="list-style-type: none"> <li>• “for populations listed and also on dialysis, MRSA, IV antibiotics, require tube feeding, require neuro-psychological services”</li> <li>• “insufficient programs to meet needs for cognitive behavioural, therapy, slow stream rehab, severe brain injury, complex respiratory care chronic ventilated”</li> <li>• “ABI child and family”</li> <li>• “this is a large barrier for those who are mentally ill, have dual diagnoses, are developmentally challenged or in homes,, in addition, elderly patients often do not have the same access to rehab as younger clients”</li> </ul>

**TABLE 4: Most commonly experienced access issues by cluster**

<b>Group</b>	<b>Barriers to Inpatient Care</b>	<b>Barriers to Outpatient Care</b>
All organizations	Provider availability	Provider availability
	Needs of special populations	Needs of special populations
	Availability of Expertise	Transportation
	Transportation	Availability of expertise
	Specialty programs	Specialty Programs
Regional Rehab Centres	Needs of special populations	Transportation
	Provider availability	Needs of special populations
	Availability of expertise	Specialty programs
	Specialty programs	Prosthesis and other devices
	Transport/physical facility	Availability of expertise
Acute Teaching Hospitals	Provider availability	Transportation
	Needs of special populations	Provider
	Out of country	Out of province/uninsured
	Specialty programs	Out of country
	Availability of expertise	Needs of special populations
Toronto Community Hospitals	Provider availability	Provider availability
	Language	Specialty programs
	Needs of special populations	Language
	Prosthesis	Availability of expertise
	Special programs/Transp.	Transportation
Durham Community Hospitals	Language	Specialty programs
	Needs of special populations	Provider availability
	Specialty programs	Availability of expertise
	Provider availability	Transportation
	Expertise/physical facility	Patient information
Halton-Peel Community Hospitals	Needs of special populations	Provider availability
	Provider availability	Transportation
	Specialty programs	Needs of special populations
	Physical facility	Availability of expertise
	Transportation	Specialty programs
York Region Community Hospitals	Specialty programs	Driving assessment
	Transportation	Transportation
	Provider availability	Specialty programs
	Driving assessment	Patient information
	Availability of expertise	Availability of expertise
CCACs	Provider availability	
	Availability of expertise	
	Language	
	Needs of special populations, Transportation	

**FIGURE 1: Number of non-regional centres (n=14) and CCACs (n=10) ranking population groups as most disadvantaged**



## C. REFERRAL PATTERNS

Organizations were asked to identify the top five organizations to which they referred for rehabilitation and where appropriate, the top five organizations from which they accepted rehabilitation referrals. The organizations were then asked to identify whether formal agreements or memorandums of understandings existed for their referrals.

The responses were analyzed by cluster in order to determine if there is variation by region within the GTA and if patients in each region have similar access to regional centres. They were also analyzed to determine if organizations are referring back and forth in any predictable fashion. Variations by cluster give an indication of access to regional centres by region and the referral patterns give an idea of capacity and coordination mechanisms.

### **Summary of Issues Identified:**

(See Figure 1 and Tables 5 and 6)

- **Question of information or capacity:** Some organizations report that they are referring to places where there are no designated rehabilitation beds. This could mean
  - lack of awareness about changes in organizations' services/roles
  - provider decisions that non-designated beds are sufficiently equipped
  - lack of capacity at centres with designated rehabilitation beds
- **Referrals to CCACs:** nearly all Network members are referring to the CCACs for community rehabilitation services.
- **Outpatient referral outside of public hospitals and CCACs:** For outpatient services, many referrals are to non-Network members, such as private clinics and treatment centres.
- **Most 905 hospitals refer only to their own outpatient rehabilitation programs:** Possible reasons include
  - outpatient facilities are sufficient to deal with the volume and complexity
  - transportation is a barrier to patients accessing other programs/patient choice
- **Variations in referral patterns between Metro hospitals and 905 Community Hospitals.** Patients of 905 hospitals are referred to both regional and non-regional centres. Patients at the acute care teaching hospitals are mostly referred to regional centres. Possible issues include (Table 5):
 

<ul style="list-style-type: none"> <li>• discrepancies in access</li> <li>• severity of cases going to acute teaching hospitals</li> <li>• provider awareness of alternatives</li> </ul>	<ul style="list-style-type: none"> <li>• lack of capacity</li> <li>• geographical proximity</li> </ul>
--	--
- **Memorandums of understanding (MOUs):** Aside from the agreements that exist with the formal Networks (ie ABI, RGP), only five organizations reported having formal agreements with other Network member organizations.

**TABLE 5: Referral patterns by cluster group for inpatient and outpatient/community\* rehabilitation**

<b>Cluster Group (see Appendix B)</b>	<b>Organizations to which cluster groups refer patients most frequently or from which referrals are received*</b>
Toronto Acute Care Teaching Hospitals	<ul style="list-style-type: none"> <li>To adult Regional Centres, Baycrest or Providence, and Riverdale</li> <li>Southlake and Rouge Valley also receive referrals from these organizations for inpatient services only</li> </ul>
Toronto Complex Continuing Care facilities offering rehabilitation	<ul style="list-style-type: none"> <li>To Humber River Regional and Riverdale for Inpatient Services</li> <li>To the Regional Centres for Outpatient Services</li> <li>To Toronto East General and the Scarborough Hospital for Outpatient Rehabilitation by formal agreement</li> </ul>
Toronto Community Hospitals	<ul style="list-style-type: none"> <li>To Toronto Rehab, St. John's, Riverdale and West Park</li> <li>Baycrest and Providence receive referrals from these organizations for inpatient rehabilitation.</li> </ul>
Halton Peel Hospitals	<ul style="list-style-type: none"> <li>To the Regional Centres and to Riverdale for inpatient services only</li> <li>No referral between cluster member organizations in Halton Peel. Only self referral occurs.</li> </ul>
Durham Region Hospitals	<ul style="list-style-type: none"> <li>To private clinics and children treatment centres for outpatient rehabilitation</li> <li>To organizations within the cluster for inpatient programs that do not have designated beds.</li> </ul>
York Region Hospitals	<ul style="list-style-type: none"> <li>Refer to Regional Centres for inpatients</li> <li>Some referral between Cluster members</li> </ul>

\* All organizations report referring to CCACs for outpatient/community rehabilitation

**TABLE 6: Regional centres: Top five organizations from which referrals are received at the regional centres (no variation by population group)**

<b>St. John's</b>	<b>West Park</b>	<b>Toronto Rehab</b>
<ul style="list-style-type: none"> <li>Sunnybrook &amp; Women's College HSC</li> <li>North York General Hospital</li> <li>St. Michael's Hospital</li> <li>University Health Network - Toronto General</li> <li>William Osler Health Centre - Brampton Site</li> </ul>	<ul style="list-style-type: none"> <li>Humber River Regional Hospital</li> <li>St. Joseph's Health Centre</li> <li>St. Michael's Hospital</li> <li>Sunnybrook &amp; Women's College HSC</li> <li>Trillium Health Centre</li> </ul>	<ul style="list-style-type: none"> <li>University Health Network</li> <li>St. Michael's Hospital</li> <li>St. Joseph's Health Centre</li> <li>Sunnybrook &amp; Women's College HSC</li> <li>Baycrest Centre for Geriatric Care and Providence Centre</li> </ul>

## D. COORDINATION AND MONITORING ISSUES

This section looks at process issues in order to identify potential bottlenecks in the patient flow process and to determine if there are areas that may be consolidated across the GTA that will result in better access to rehabilitation.

The analysis looks at the similarities and difference in:

- the process of referring and admitting patients (i.e. the presence of an admissions committee, the frequency of admissions, hours admissions occur)
- the manner in which waiting list are managed (i.e. manually/automated, internally/externally)
- the indicators collected for monitoring access

### **Summary of Issues Identified:**

(See Figures 2,3 and Table 7)

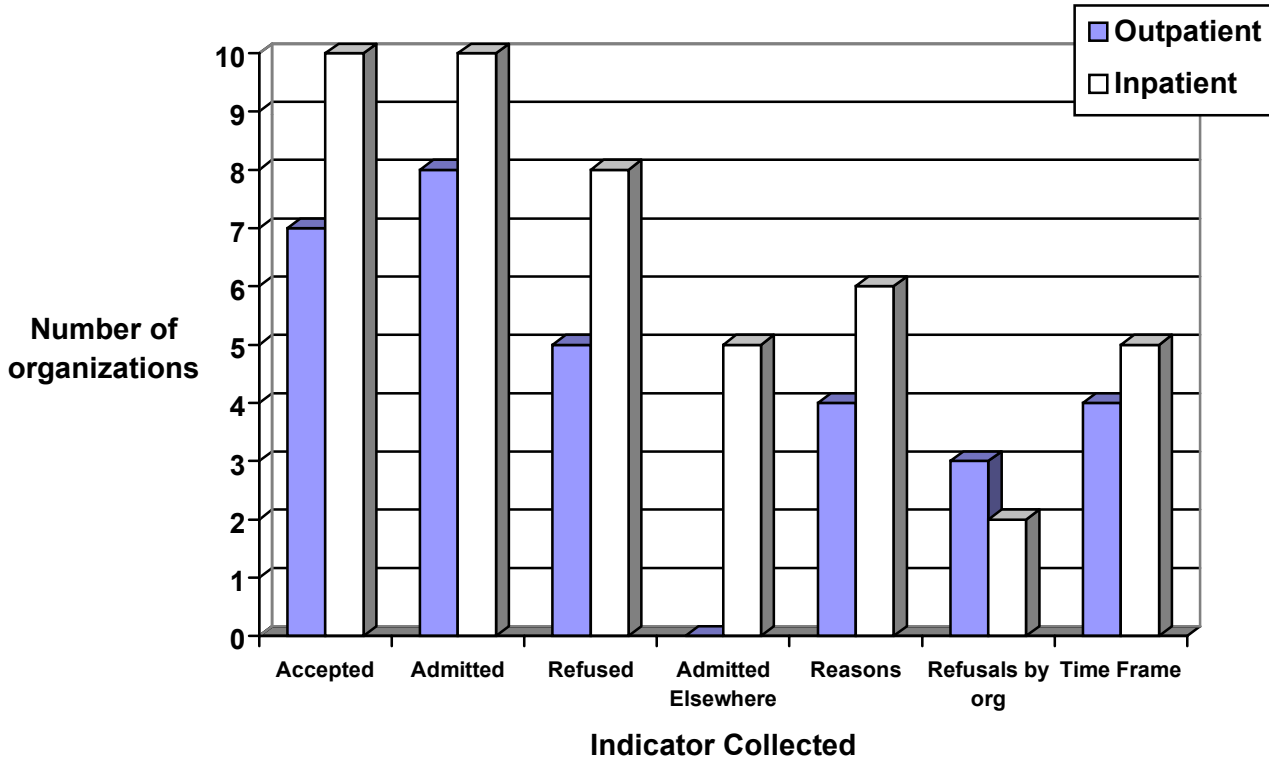
#### **Similarities:**

- Referrals are currently:
  - originated at hospitals, community, and long term care facilities. No other sources were identified.
  - initiated by a member of the multidisciplinary team after consultation, i.e. a psychiatrist, physician, occupational therapist, physiotherapist, social worker.
  - made in writing by either a physician or by another health care provider as opposed to by telephone
  - nearly always followed up and sent by a social worker.
- Most organizations track the number of admissions and acceptances (Figure 2).
- Most waiting lists are managed manually and by program. There is little management of rehabilitation waiting lists by discipline. With the exception of the Toronto ABI Network, no externally managed waiting lists for rehabilitation were identified. In most cases, the waiting list is managed by organization and where there are multiple sites, the waiting list is also managed by the site (Figure 3).

#### **Variations:**

- Admission committees are used by some organizations to admit patients and not by others.
- Admission times are not clearly linked to hours of operation or to the frequency of the admission committee meeting times.
- Turn around time from application to admission varies from 24 hours to 6 weeks for both inpatient and outpatient admissions.
- Indicators monitored: Not all organizations monitor the number of patients refused, the reasons for refusal, where the patient is actually admitted, and the time frame from application to admission (Figure 2) (Table 7)

**FIGURE 2: Number of non-regional organizations (n=14) collecting information on the number of patients accepted, admitted, refused, admitted elsewhere, reasons for refusal, refusing organization, and time frame for admission**

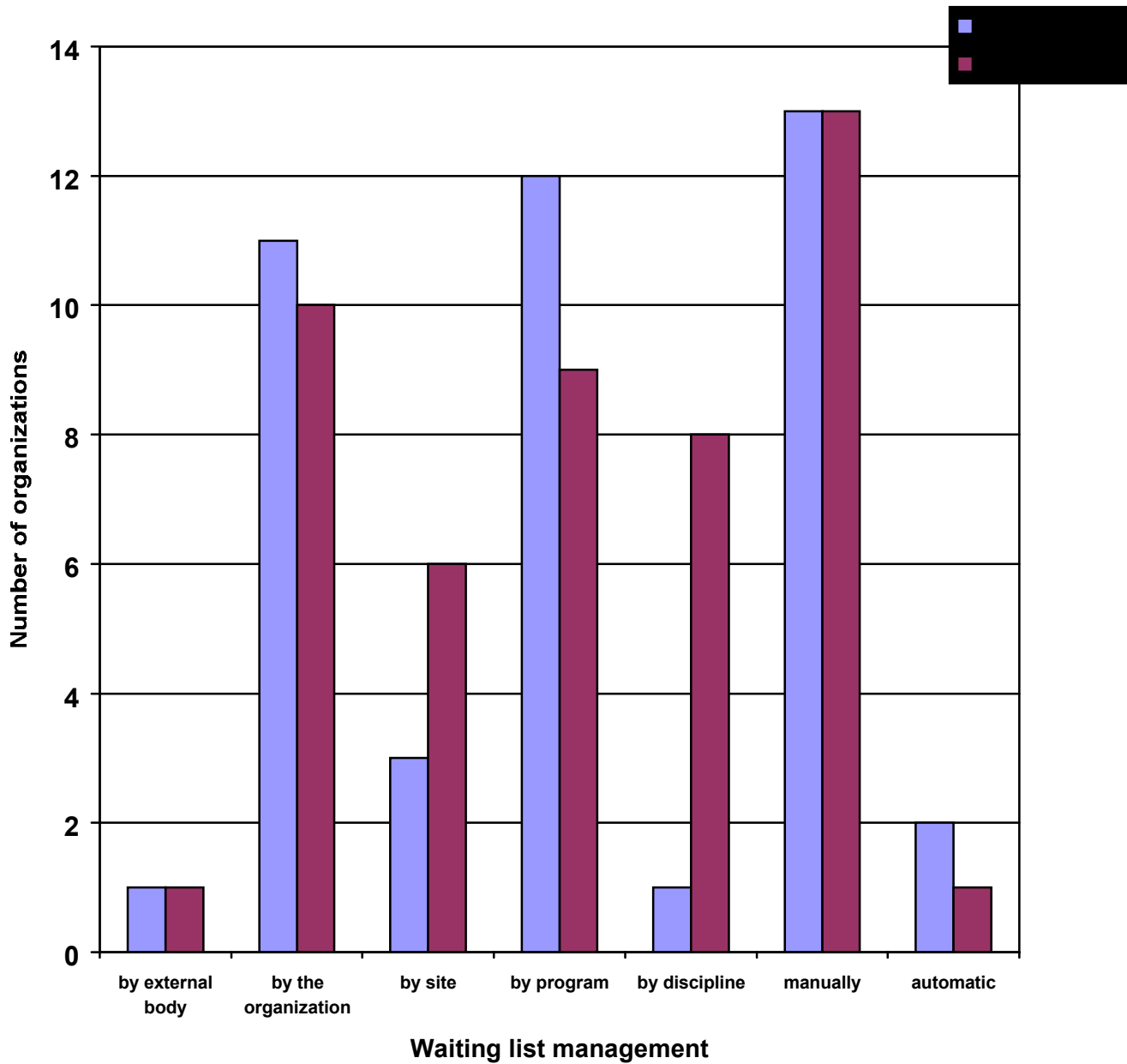


**TABLE 7: Data collected by population groups by the regional centres regarding admissions and refusals**

	Accept	Admitted	Refused	Reasons	Refusal by organization	Rate of refusal	Time Frame
ABI	✓	✓	✓	✓	✓	✓	✓
AMP	✓	✓	✓	✓	✓	✓	✓
CARD	✓	✓	✓	✓	✓	✓	✓
GER	✓	✓	✓	✓	✓	NA	✓
MSK	✓	✓	✓	✓	✓	✓	✓
NEUR	✓	✓	✓	✓	✓	✓	✓
RESP	✓	✓	✓	✓	✓	✓	✓
SPINAL CORD	✓	✓	✓	✓	✓	✓	✓
STROKE	✓	✓	✓	✓	✓	NA	✓

(✓=collected, NA=Not Applicable)

**FIGURE 3: Number of organizations indicating how their waiting lists are managed**



## E. SIZING OF SERVICES

This section reports the number of designated and non-designated rehabilitation beds in the GTA by population group. The numbers shown in this section are not necessarily reflective of all of the population specific rehabilitation in the GTA, as much population specific rehabilitation occurs in beds which are designated general rehabilitation. Furthermore, in most cases, even where population specific beds exist, the decision to allocate them by population group is an organization specific decisions rather than an MOHLTC driven decision. Section F will paint a more realistic picture of rehabilitation in the GTA by identifying where patients are receiving inpatient services in population specific beds, in general beds, and in outpatient programs.

### **Summary of Issues Identified:**

(See Figures 4,5 and Tables 8-11)

- There were 1, 178 rehabilitation beds in the GTA in November 2000, 52% of which were at the regional rehabilitation centres.
- MSK, Geriatric and Stroke beds account for 49% of all rehabilitation beds
- General rehabilitation beds account for another 23% of beds , leaving only 28% of beds specifically allocated to ABI, Spinal Cord, Respiratory, Cardiac, Chronic Pain, Burns, and Trauma.
- Currently there are approximately 22.7 rehabilitation beds/100 000 population for the GTA using an estimated population figure of 5,284,000.
- When examined by cluster group and region however, there are at most 14.9 non-regional beds/100 000 and 11.5 regional rehabilitation beds/100 000
- Non-designated rehabilitation beds reported account for an additional 13% over the number of beds. Not all organizations who report offering rehabilitation in non-designated beds were able to quantify how many non designated beds are used for rehabilitation.
- Non-designated beds reported are used for Stroke, Geriatric, MSK and Neurology.
- Non-designated beds are complex continuing care (CCC) or alternate level of care (ALC) beds in community hospitals or acute and ALC beds in acute care teaching hospitals.
- Projections of total bed numbers/100 000 are also offered in Table 9. Projected bed numbers are drawn from “HSRC Directions Report, April 1998.”
- **Limitations:**
  - The number of beds reported may be in flux as changes occur frequently.
  - Not all organizations are able to identify the number of beds allocated to population groups, although they may be definitely serving the population groups.

- Allocating a bed to a population group may have different implications at different organizations and should not be interpreted as a statement of intensity or comprehensiveness of services.
  - Not all organizations are able to identify the number of non-designated rehabilitation beds being used for rehabilitation and therefore the figure is likely under-reported.
  - The population figures used for the bed/100 000 population ratios have not been adjusted for any factors, including age or morbidity
- **Questions for further investigation:**
- Why and how are general rehabilitation beds allocated to population groups?
  - What is the incidence and prevalence of the population groups in the GTA?
  - Is the number of beds appropriate, specifically for MSK, Neurology, and Geriatrics?
  - What intensity of rehabilitation is occurring in non-designated rehabilitation beds?
  - What are the reasons for use of non-designated beds?

**TABLE 8: Total number and location of designated inpatient rehabilitation beds by population group and cluster**

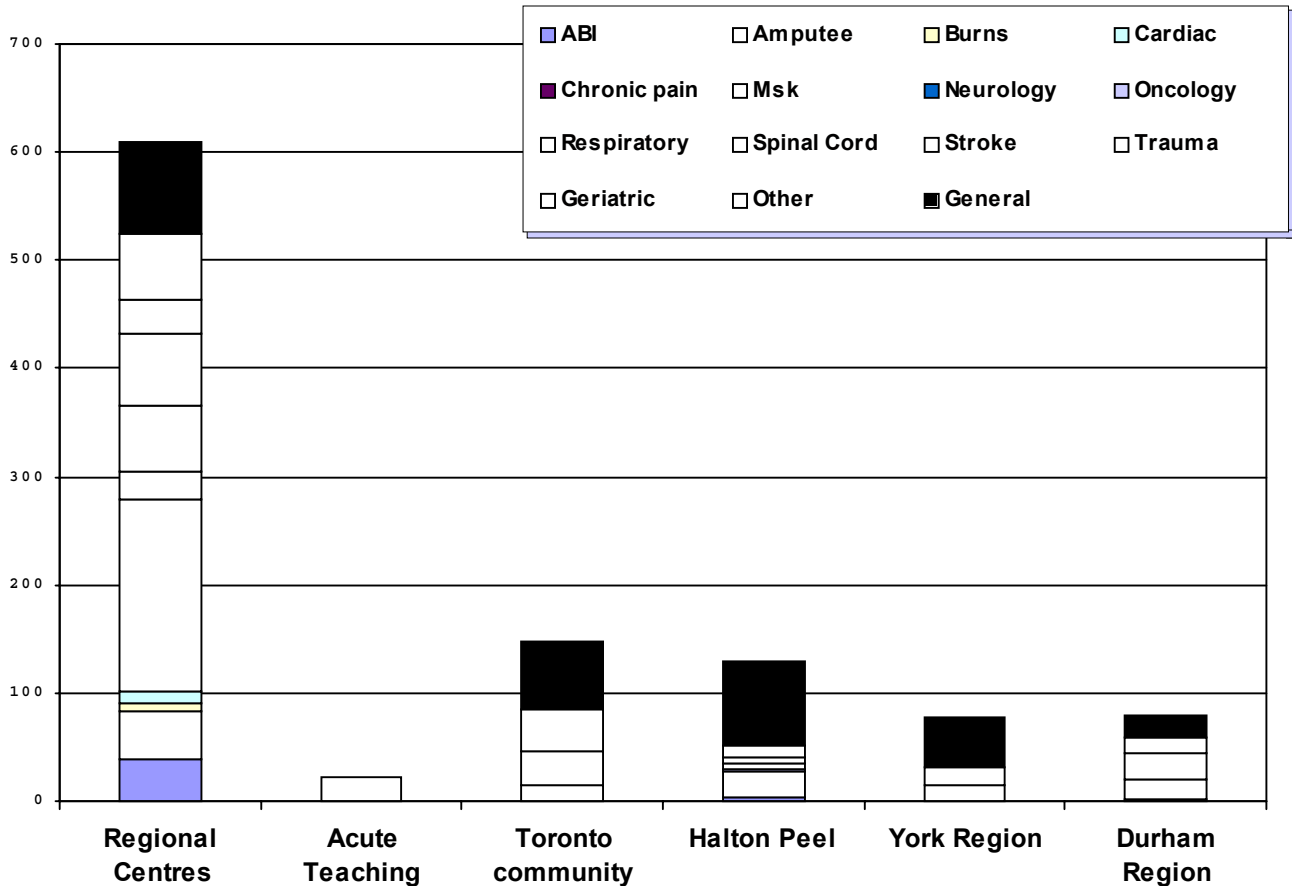
	Regional Rehab Centres	Acute Care Teaching	Toronto Community and CCC Hospitals with Rehabilitation	Halton-Peel Community Hospitals	York Region Community Hospitals	Durham Region Community Hospitals	Total
ABI	43	0	9	3	0	0	55
Amputee	46	0	0	0	0	0	46
Burns	6	0	0	0	0	0	6
Cardiac	12	0	0	1	0	0	13
Chronic pain	0	0	0	0	0	0	0
MSK	177	22	96	23	14	20	352
Neurology	0	0	9	1	0	0	10
Oncology	0	0	0	1	0	0	1
Respiratory	26	0	0	1	0	0	27
Spinal Cord	60	0	0	0	0	0	60
Stroke	68	0	5	17	0	23	113
Trauma	31	0	0	0	0	0	31
Geriatric	60	0	32	5	0	16	113
Other	26	0	39	11	0	0	76
General	55	0	75	79	46	20	275
<b>TOTAL</b>	<b>610</b>	<b>22</b>	<b>265</b>	<b>142</b>	<b>60</b>	<b>79</b>	<b>1178</b>

**TABLE 9: Designated rehabilitation beds per 100,000 people**

Year	Measure	Total for GTA	Regional Centres	Toronto Hospitals <sup>(3)</sup>	Halton-Peel Hospitals	York Region Hospitals	Durham Region Hospitals
<b>2000</b>	<b>Beds Nov. 2000</b>	<b>1178</b>	<b>610</b>	<b>287</b>	<b>142</b>	<b>60</b>	<b>79</b>
	Population <sup>(1)</sup>	5,284,000	5,284,000	2,594,000	1,400,000	760,000	530,000
	Beds/100 000	22.3 <sup>(2)</sup>	11.5	11.1	10.1	7.9	14.9
<b>2003</b>	<b>Beds in 2003 <sup>(4)</sup></b>	<b>1334</b>	<b>590</b>	<b>299 <sup>(4)</sup></b>	<b>251</b>	<b>95</b>	<b>99</b>
	Population <sup>(1)</sup>	5,479,000	5,479,000	2,646,200	1,847,000	810,000	566,000
	Beds/100 000	24.3	10.8	11.3	13.6	11.7	17.5

- 1) population figures are taken from “GTA Population and Employment Projections to 2031”, City of Toronto Urban Development Services. Population figures have not been adjusted for any factors including age or morbidity.
- 2) Population of the GTA is used for the regional centre beds/100 000
- 3) Includes Riverdale, Baycrest, and Providence, and Acute Care Teaching Hospitals
- 4) Numbers for the 2003 bed projections come from the HSRC Directions Report April 1998 (did not include Riverdale).

**FIGURE 4: Breakdown of designated rehabilitation beds by region and population group in November 2000**



**TABLE 10: Number of non-regional organizations offering rehabilitation in non-designated rehabilitation beds (each organization may use more than one option)**

	Regional Centres	Acute Teaching	Toronto Hospitals*	Halton Peel	York Region	Durham Region	Total
Total # of organizations	4	4	8	4	3	2	25
# using non des. beds	2	3	6	3	3	2	19
CCC	2	0	2	2	3	2	11
ALC	0	2	1	1	1	1	6
Acute	0	3	2	2	3	1	11
Other	0	0	0	Mental Health	0	Dialysis	2
Org. able to report # of non-designated beds	0	1	5	0	1	0	7

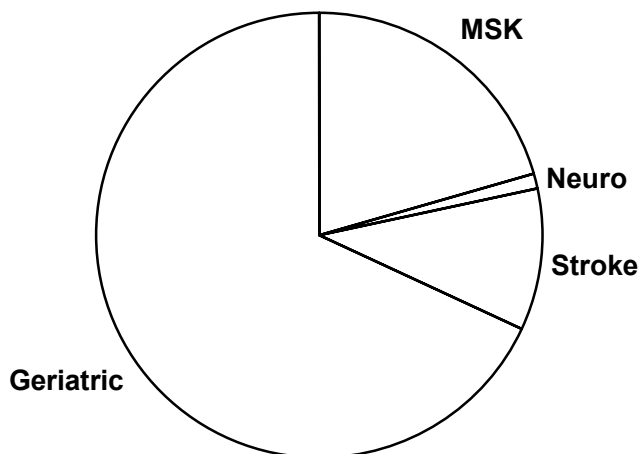
Includes Riverdale, Baycrest, and Providence

**TABLE 11: Distribution of non-designated beds by region and by population group**

	Regional Centres	Acute Teaching	Toronto Hospitals	Halton Peel	York Region	Durham Region	Total
MSK	0	0	32	*	13	*	45
Neurology	0	0	2	*	*	*	2
Stroke	0	0	16	*	*	*	16
Geriatric	5	12	89	*	*	11	117
General	*	*	*	*	*	4	4
<b>TOTAL</b>	<b>5</b>	<b>12</b>	<b>139</b>	<b>*</b>	<b>13</b>	<b>15</b>	<b>184</b>

\* = non-designated beds are used but could not be clearly quantified

**FIGURE 5: Distribution of identified non-designated beds by population**



## F. SITING OF SERVICES

This section looks at where populations go to receive inpatient and outpatient services. Organizations were asked to identify the population groups that they served in general inpatient beds, in beds specifically allocated to the population and in their outpatient programs and even non-designated beds. The organizations serving each population are indicated on the maps shown on pages 27-40.

The purpose of the section is to understand the activity in general and non-designated rehabilitation beds, potential access issues relating to the proximity of services, and what services are occurring beyond those identified by the designated bed data.

### **Summary of Issues Identified:**

(See Table 12 and pages 27-40)

- Population groups served by the largest number of organizations in general rehabilitation beds include MSK, Neurology, Stroke, and Geriatric. This is in addition to:
  - 588 designated rehabilitation beds, specifically allocated to these population groups
  - 156 non-designated rehabilitation beds used for these population groups.
- Populations served by the largest number of outpatient programs are MSK, Neurology, and Stroke, followed by Respiratory and Cardiac.
- Population groups served by the least number of organizations include Spinal Cord, Amputee, Burns, Chronic Pain, and Respiratory.
- **Limitations:**
  - Differentiating between population specific beds and general rehabilitation may or may not be a useful distinction. In most cases, organizations determine if the beds will be population specific or not and therefore may do so with varying degrees of formality.
  - Lack of information about the comprehensiveness or appropriateness of the services.
  - In using the maps for analysis, consideration must be given to the differences in population density across the regions.
- **Questions for further investigation:**
  - Is the distribution of population groups across the GTA appropriate in terms of critical mass and proximity?
  - For populations such as ABI, Spinal Cord, Amputee, Burns, Chronic Pain are there transportation issues for patients who live far from the program?
  - For the MSK, Neurology, and Stroke populations, examine why such a large proportion of resources is allocated and yet undesignated beds are still used.
  - For each population, assess the advantages and disadvantages of increased outpatient services and make recommendations where appropriate.
  - Does the distribution of services match the population demand/need incidence and prevalence in the region?

**TABLE 12: Number of organizations (n=14) serving each population group in designated rehab beds allocated by population, general (gen) designated or non designated beds, and outpatient programs by population group and region**

	Pop spec. desig. beds	General des. or non desig. beds	Total org. offering inpatient rehab	Total org. offering outpatient rehab
<b>ABI</b>	3	6	9	5
<b>AMP</b>	2	7	9	7
<b>Burns</b>	1	1	2	5
<b>Cardiac</b>	4	6	10	11
<b>Chronic pain</b>	0	3	3	6
<b>MSK</b>	8	14	22	18
<b>Neurological</b>	1	15	16	15
<b>Oncology</b>	0	7	7	8
<b>Respiratory</b>	2	9	11	14
<b>Spinal cord</b>	2	4	6	8
<b>Stroke</b>	7	14	21	17
<b>Trauma</b>	1	6	7	8
<b>Geriatric</b>	3	14	17	8

### Population Service Maps (pages 27-40)

As discussed in Sections E and F, painting a true picture of rehabilitation services requires examination of where patients go to receive rehabilitation services as opposed to simply looking at the number of designated beds or where a formalized program or service exists.

The maps displayed on pages 27-40 show where population groups are receiving services in the GTA. In order to show what type of structure exists to serve the population group, the following symbols are used:

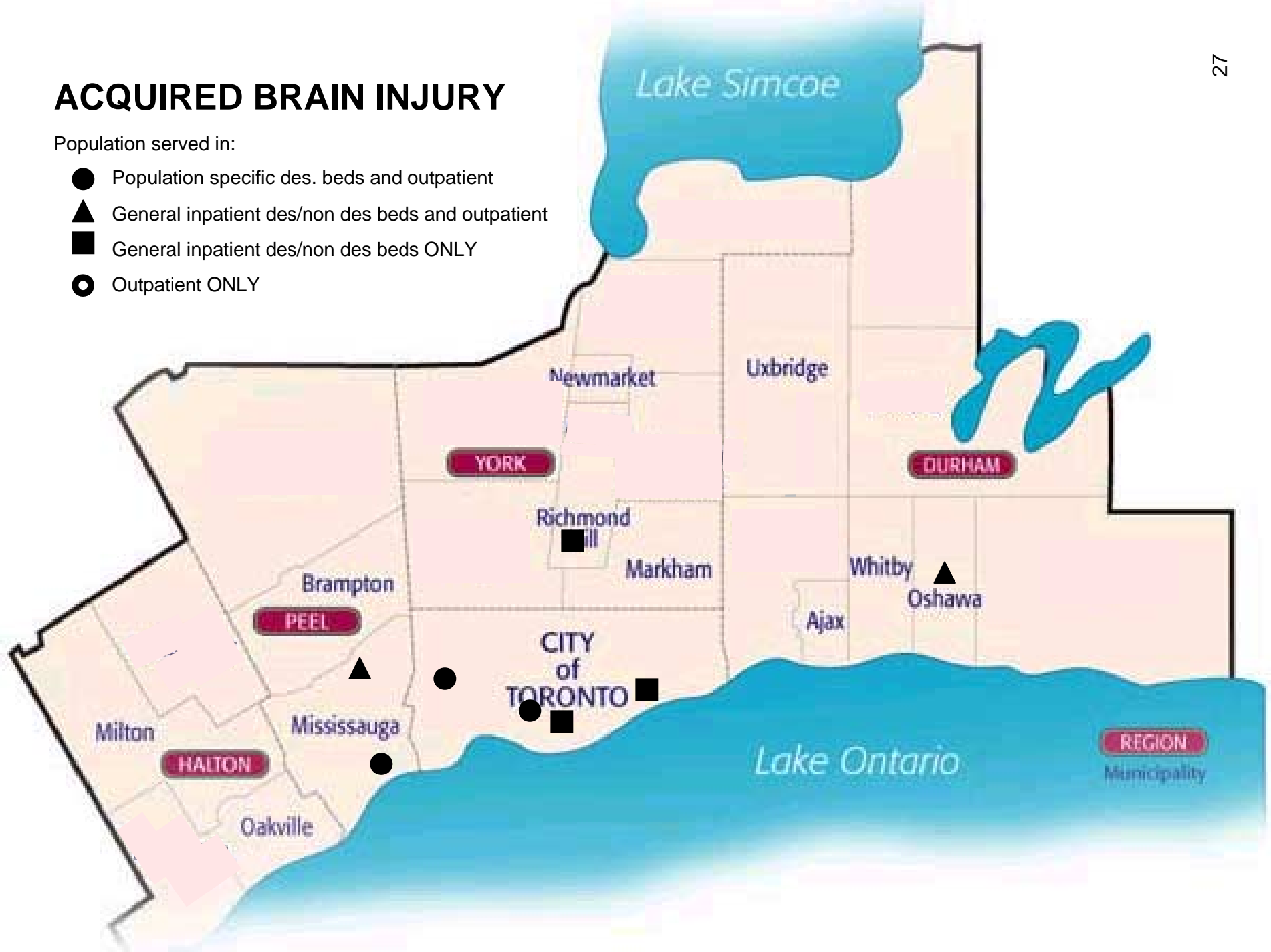
- : designated rehabilitation beds allocated by the organization to the population group and outpatient program
- ▲: designated and non-designated general rehabilitation beds and outpatient
- : designated rehabilitation beds
- : outpatient only

The maps displayed on pages 27-40 are used with permission from the Greater Toronto Marketing Alliance Website. The approximate locations of the organizations were mapped using a template kindly provided by the Toronto District Health Council.

# ACQUIRED BRAIN INJURY

Population served in:

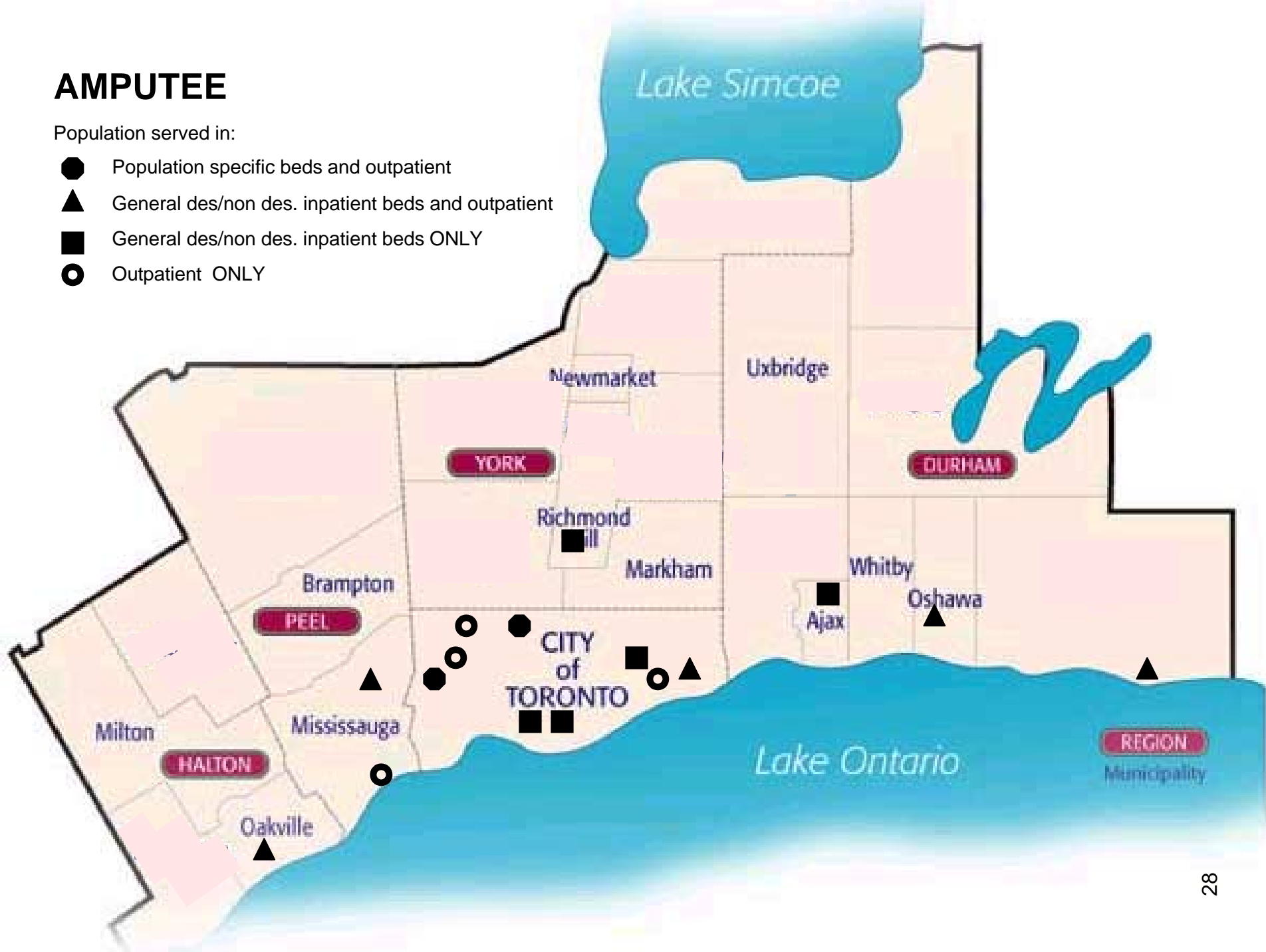
- Population specific des. beds and outpatient
- ▲ General inpatient des/non des beds and outpatient
- General inpatient des/non des beds ONLY
- Outpatient ONLY



# AMPUTEE

Population served in:

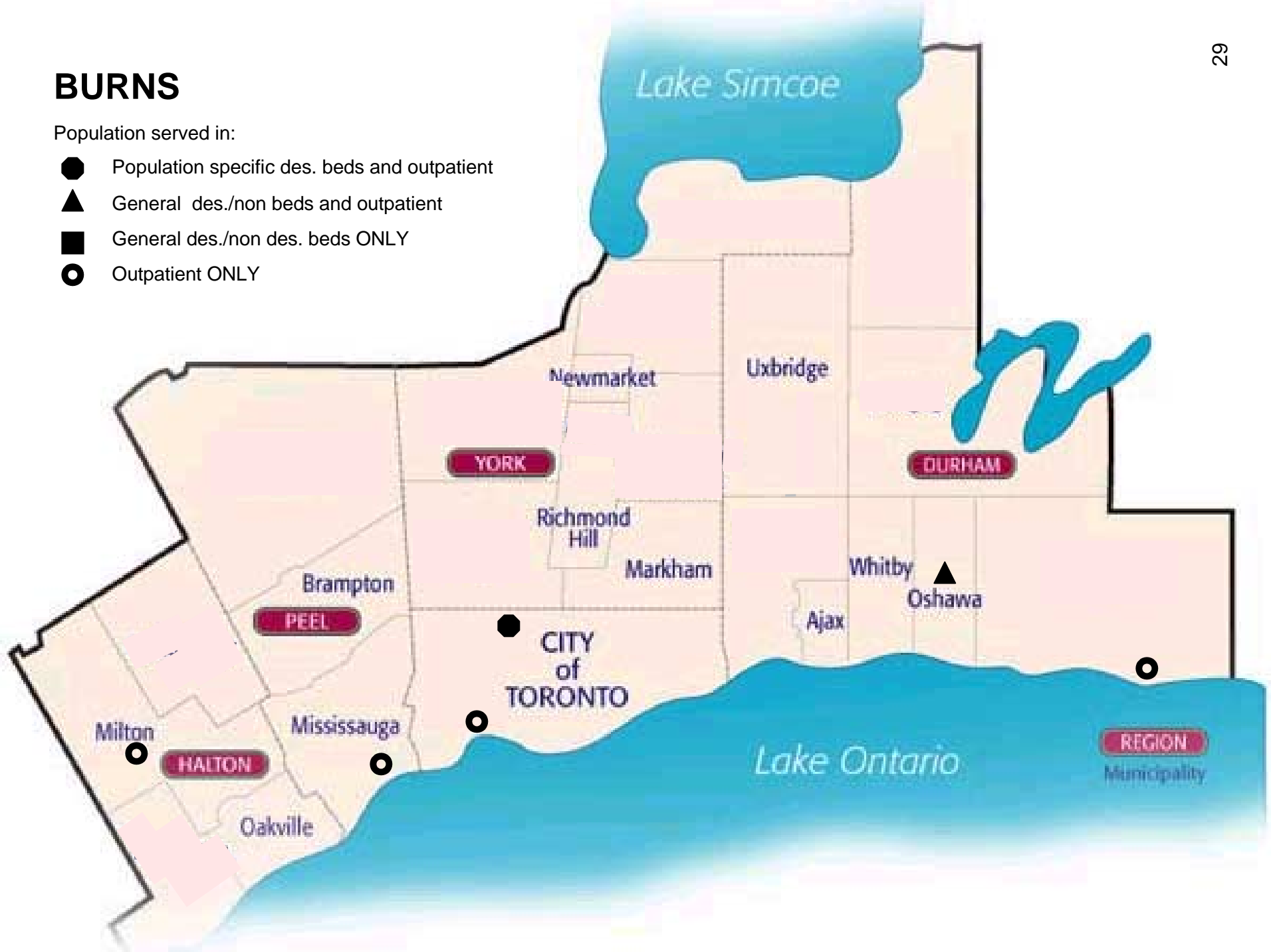
- Population specific beds and outpatient
- ▲ General des/non des. inpatient beds and outpatient
- General des/non des. inpatient beds ONLY
- Outpatient ONLY



# BURNS

Population served in:

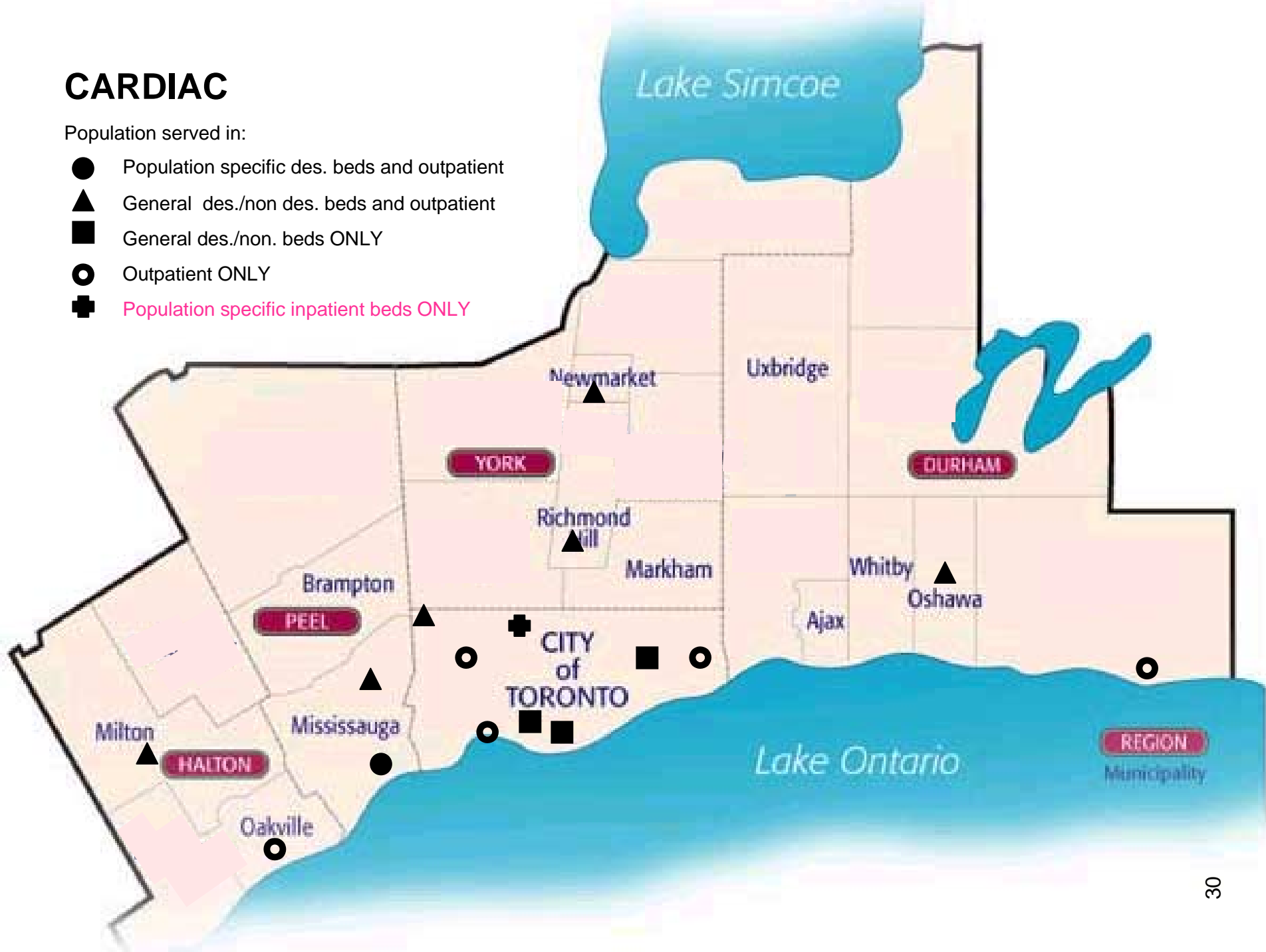
- Population specific des. beds and outpatient
- ▲ General des./non beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



# CARDIAC

Population served in:

- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non. beds ONLY
- Outpatient ONLY
- ⊕ Population specific inpatient beds ONLY



# CHRONIC PAIN

Population served in:

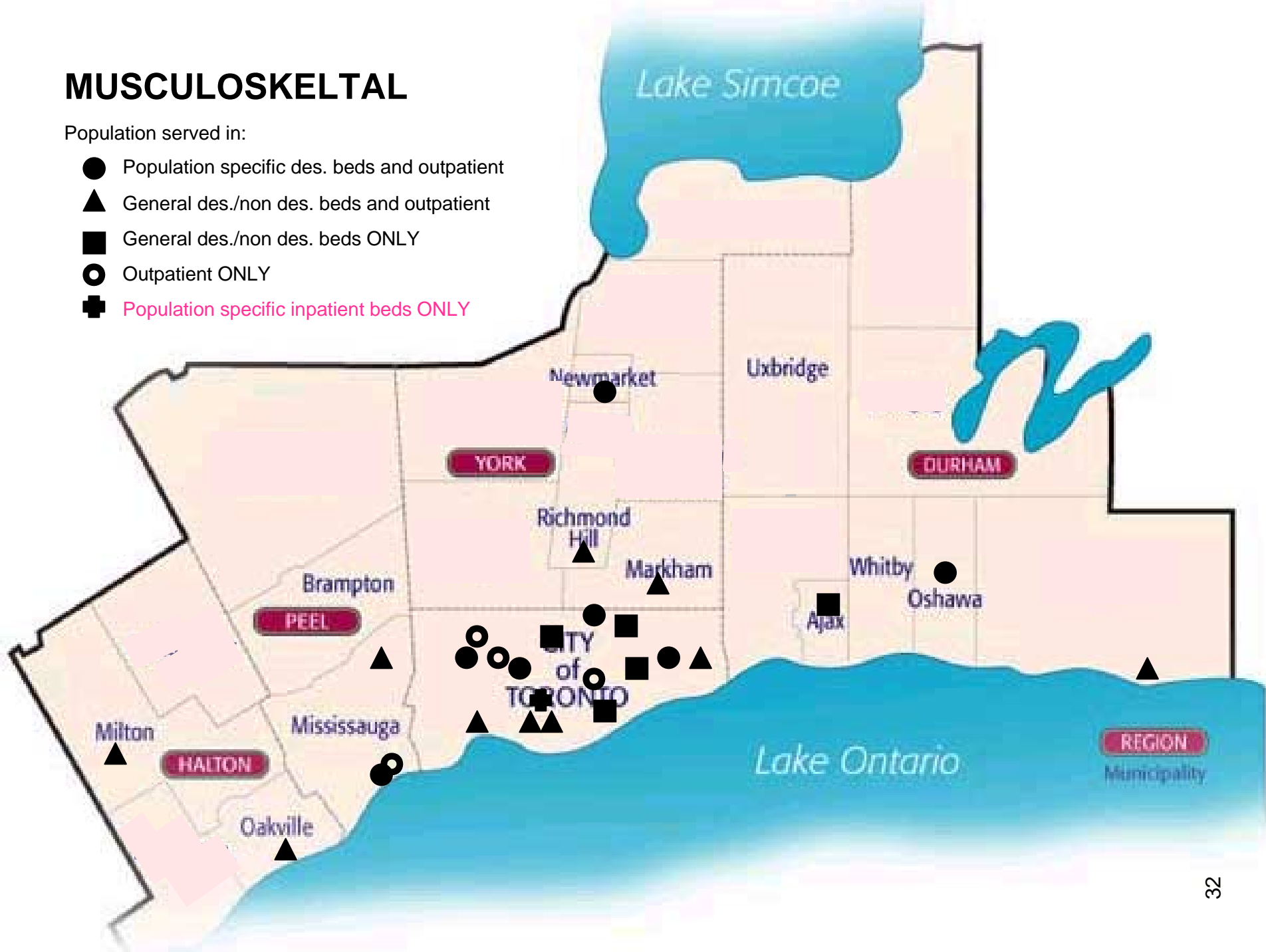
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



# MUSCULOSKELTAL

Population served in:

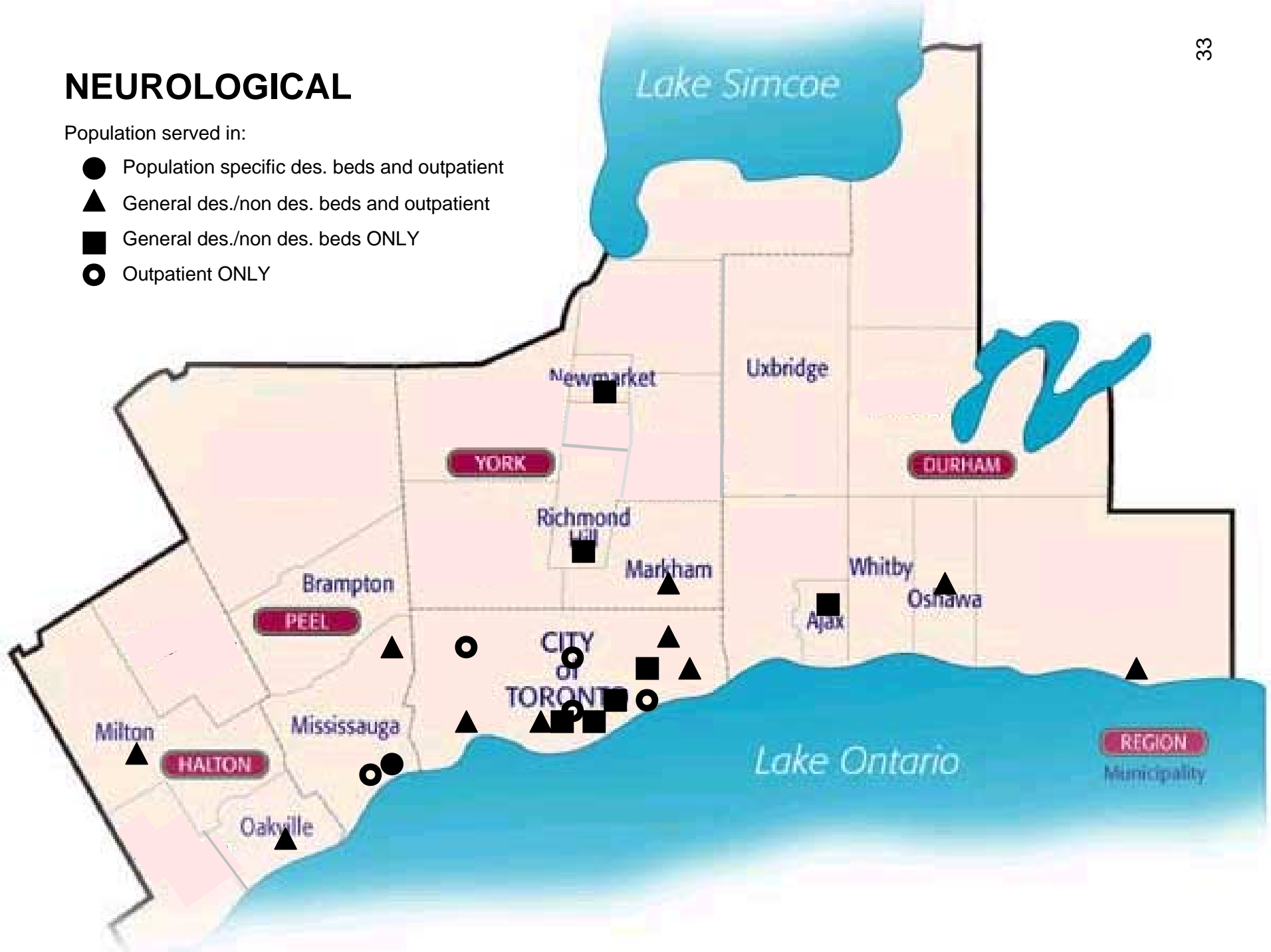
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY
- ⊕ Population specific inpatient beds ONLY



# NEUROLOGICAL

Population served in:

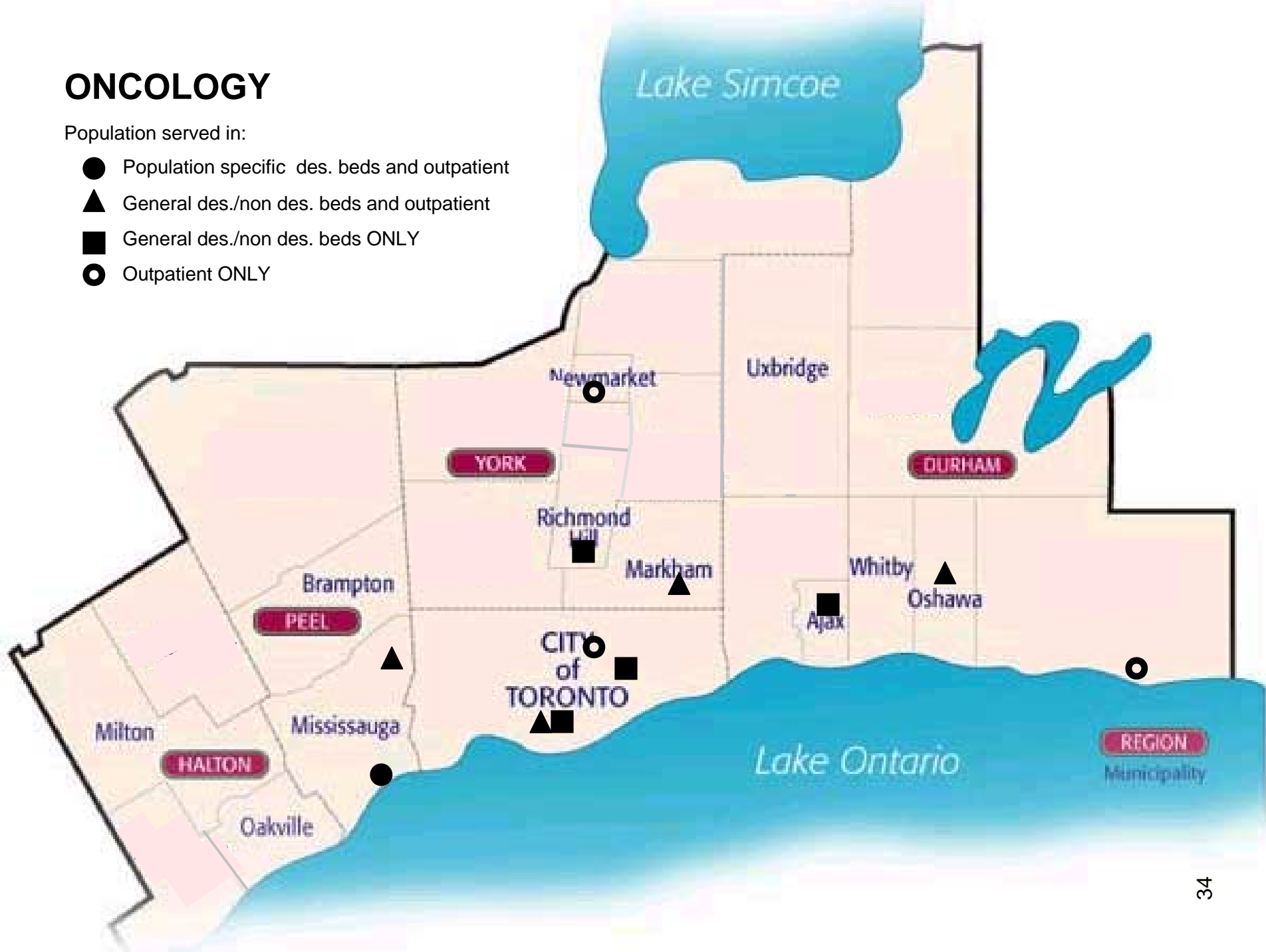
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



# ONCOLOGY

Population served in:

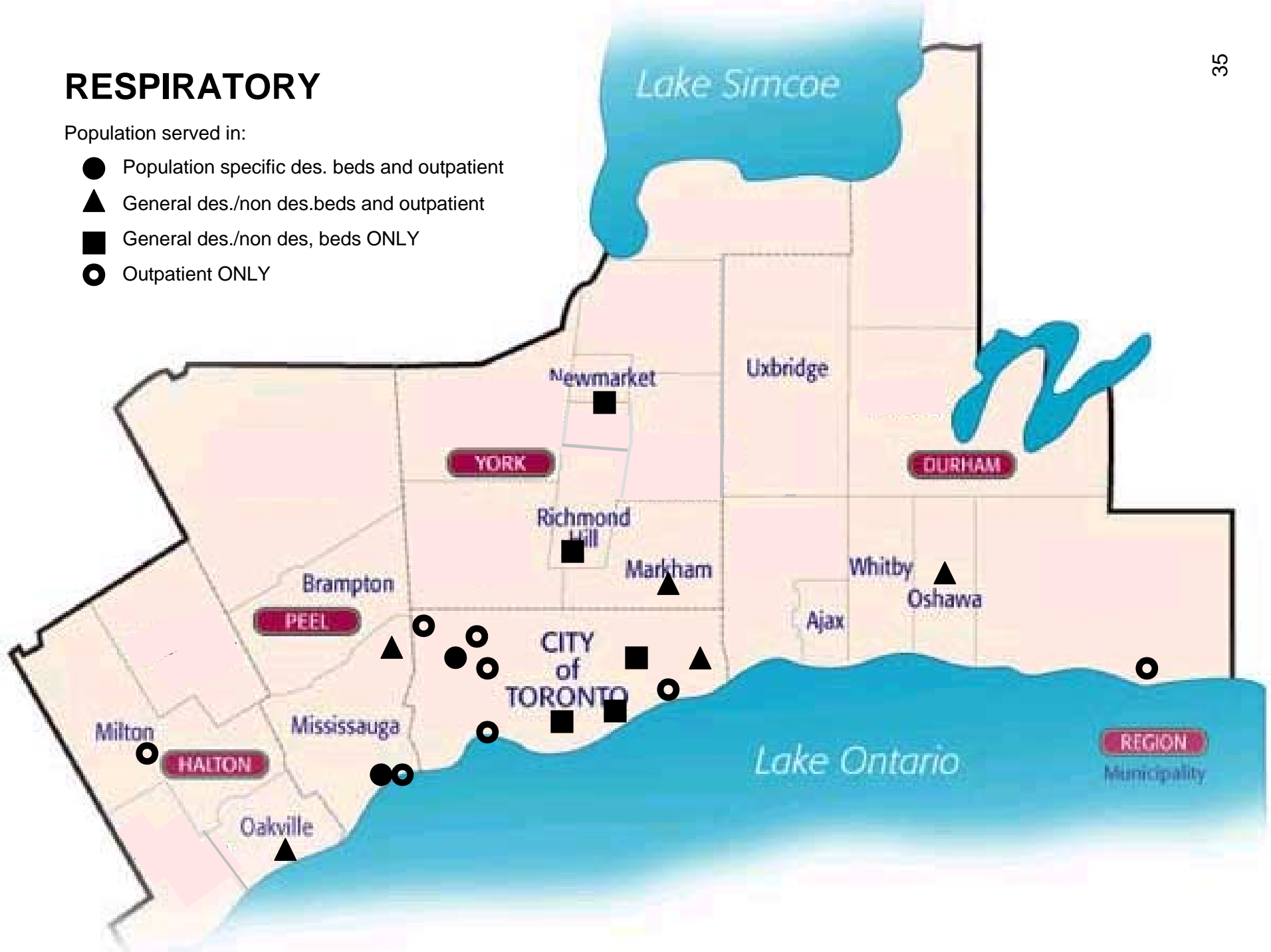
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



# RESPIRATORY

Population served in:

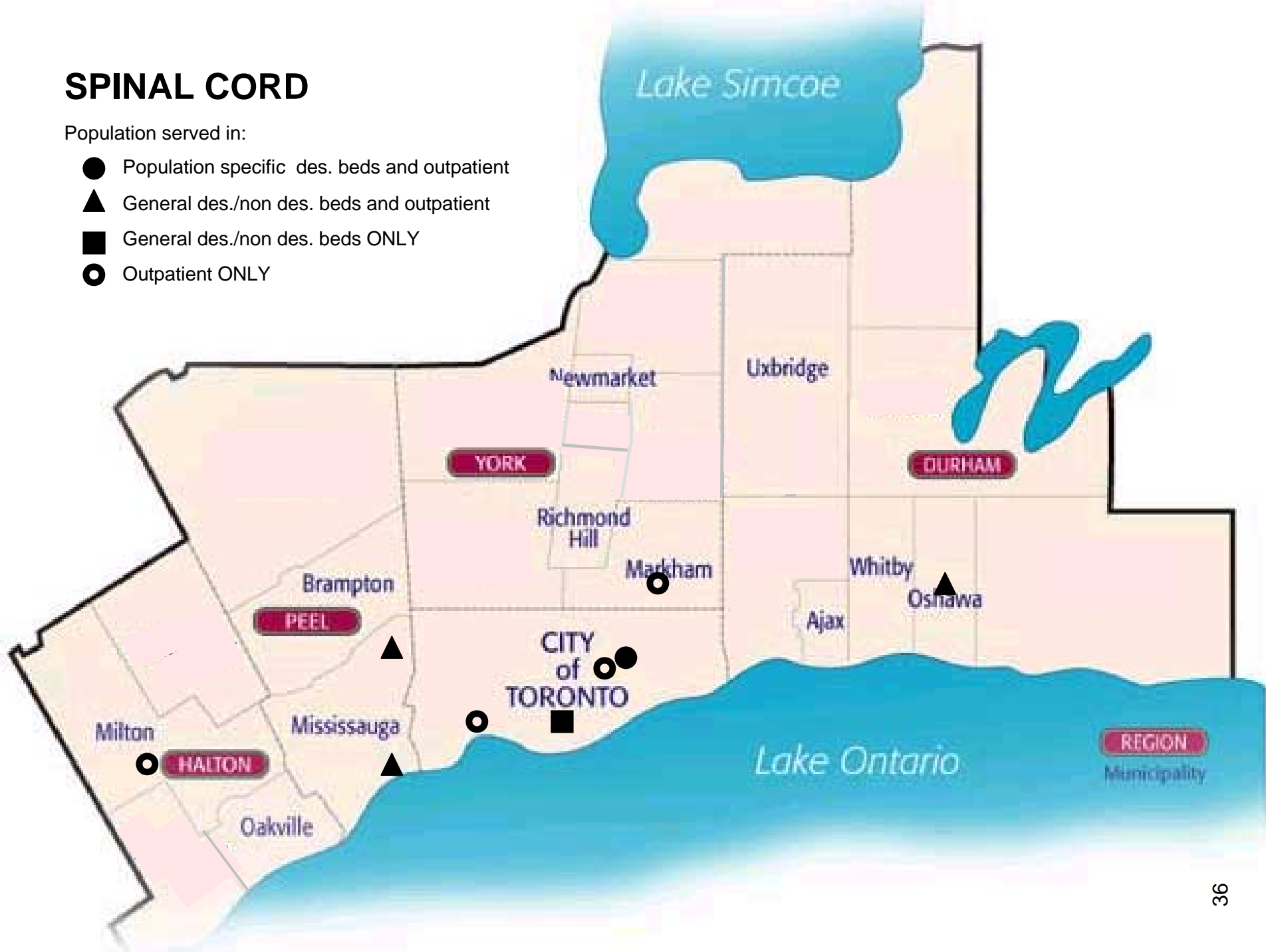
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des, beds ONLY
- Outpatient ONLY



# SPINAL CORD

Population served in:

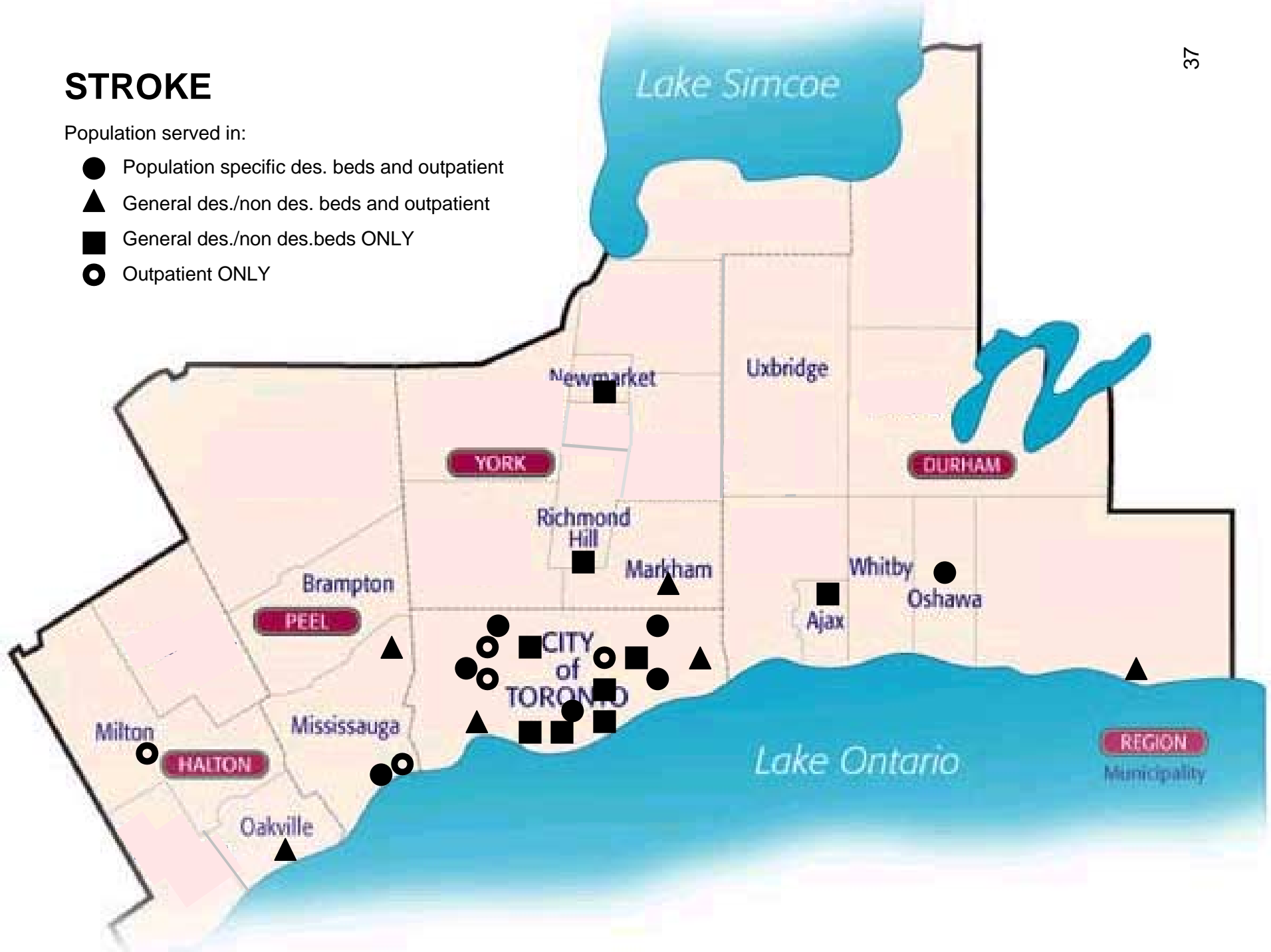
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



# STROKE

Population served in:

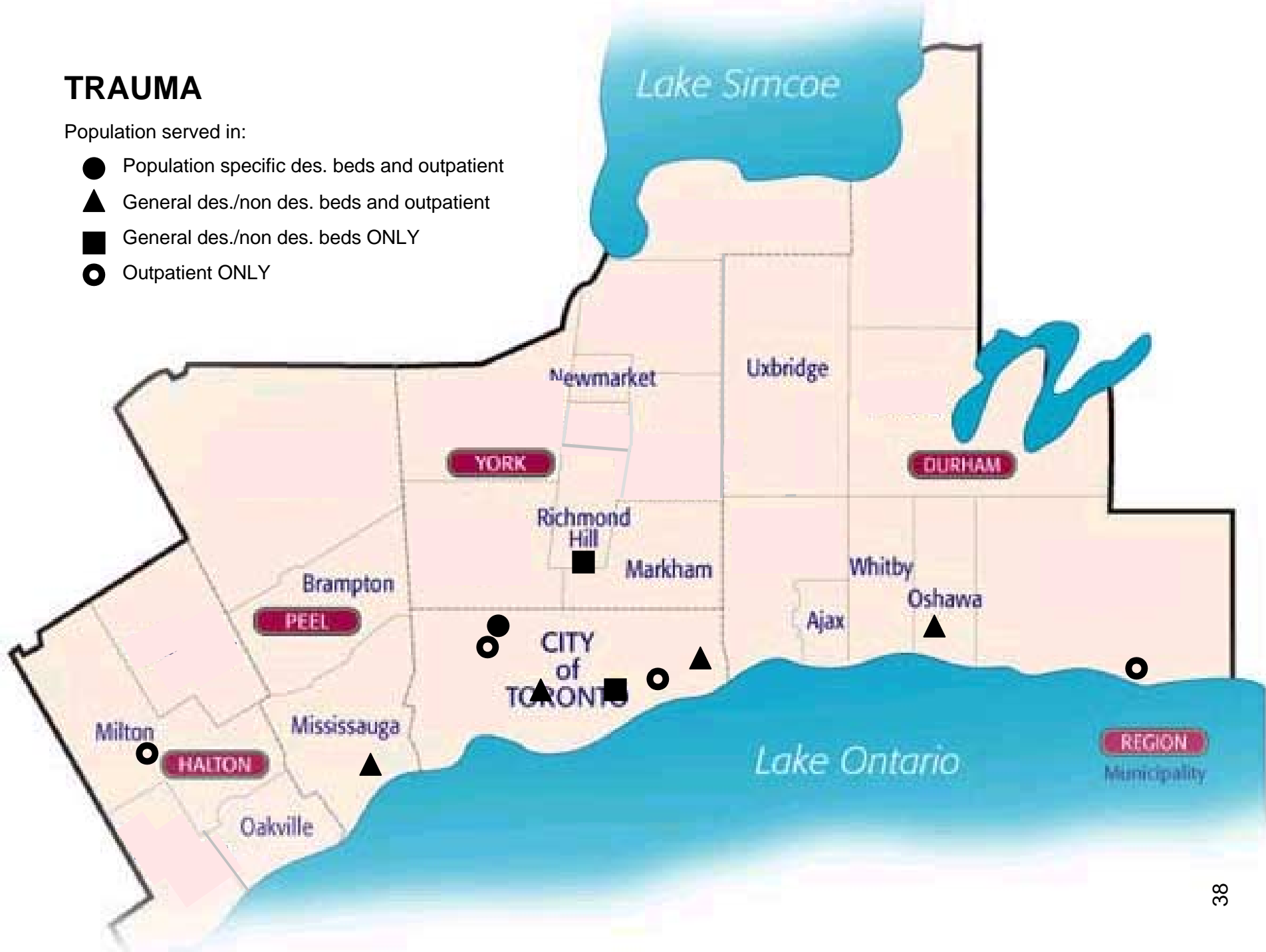
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des.beds ONLY
- Outpatient ONLY



# TRAUMA

Population served in:

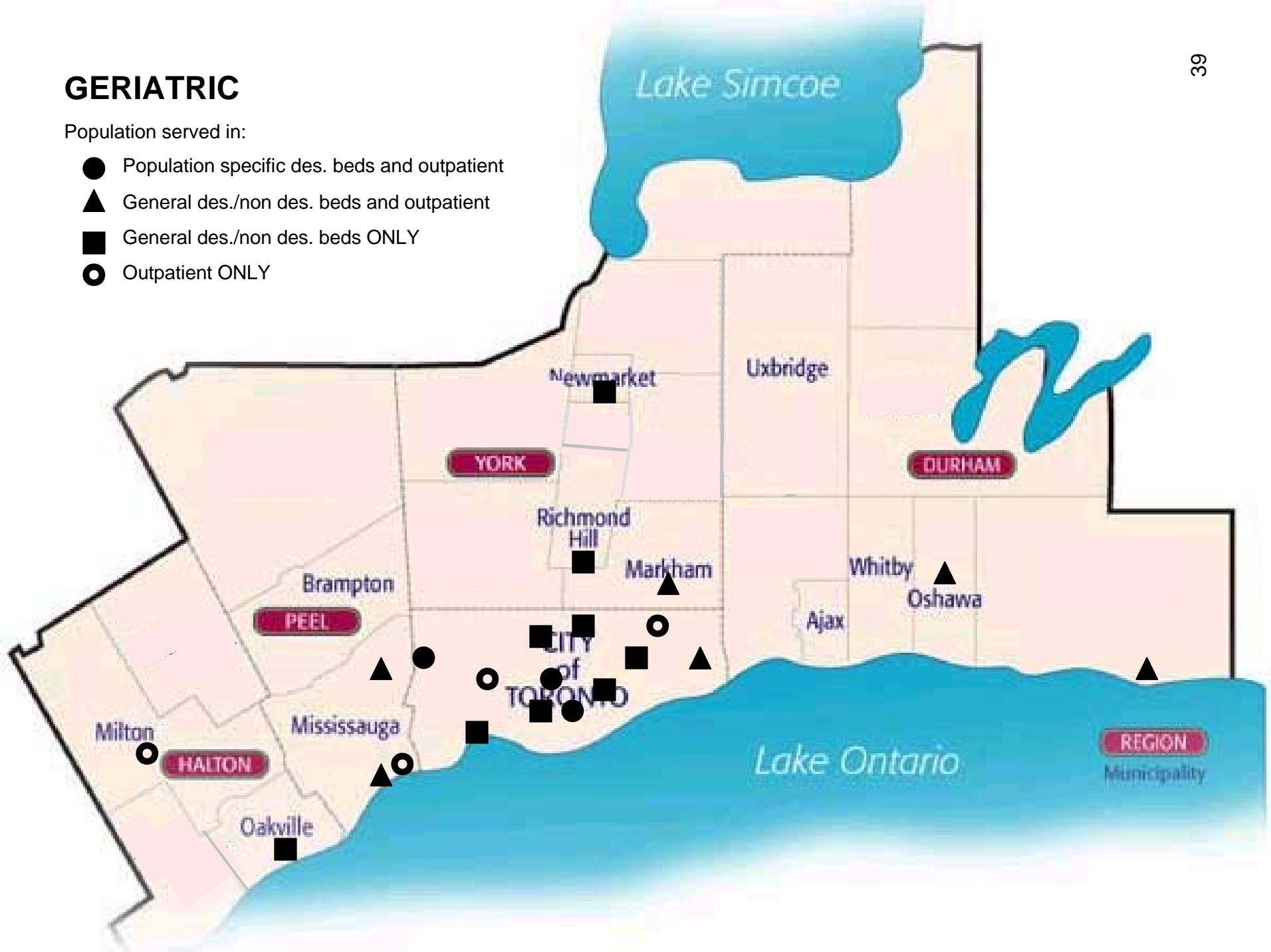
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



# GERIATRIC

Population served in:

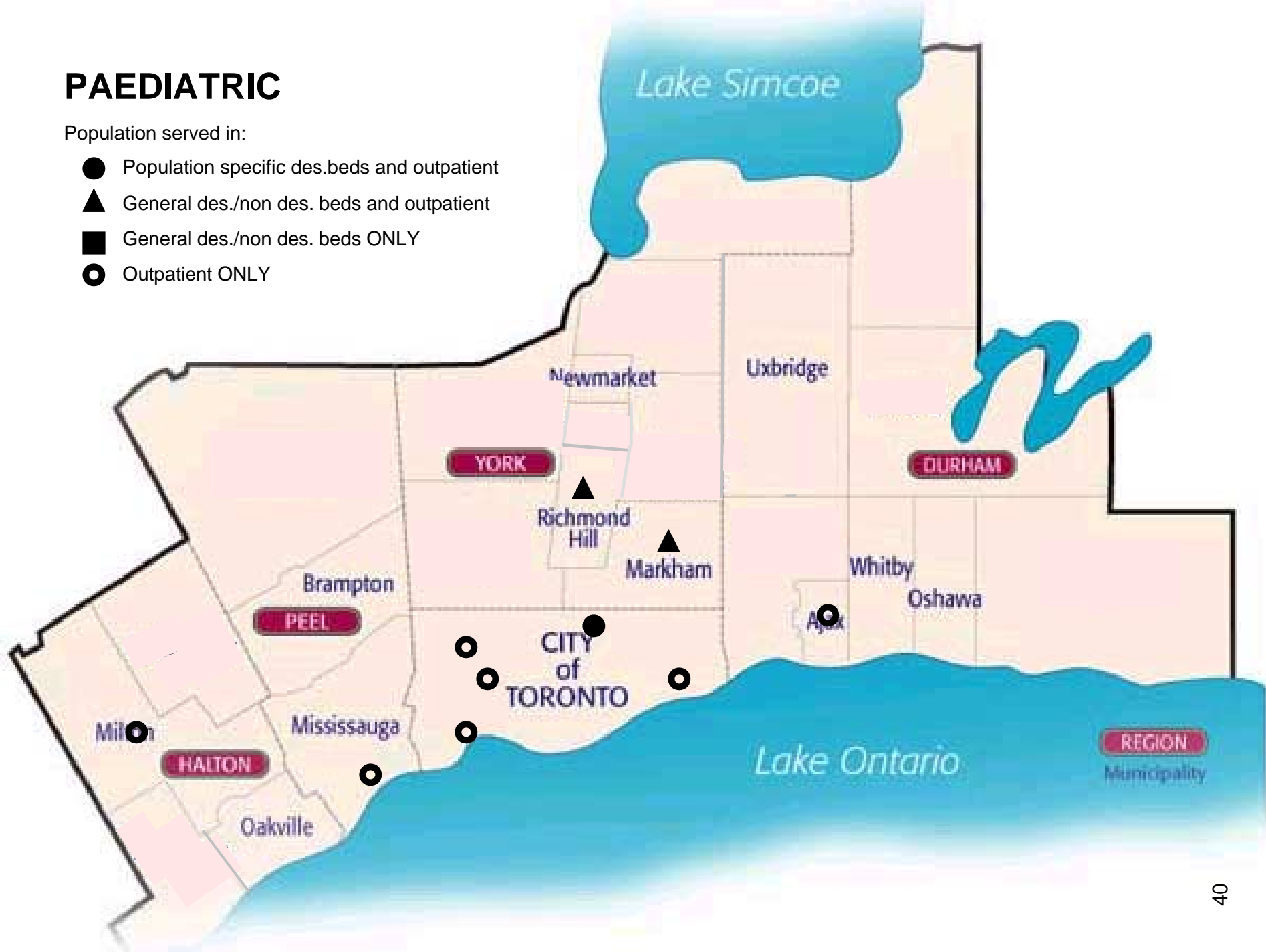
- Population specific des. beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



# PAEDIATRIC

Population served in:

- Population specific des.beds and outpatient
- ▲ General des./non des. beds and outpatient
- General des./non des. beds ONLY
- Outpatient ONLY



## G. STAFFING

This section follows the recommendation from the January 2000 Services Inventory Working Group to understand staffing by organization and to get a better idea of intensity. While workload measurement was beyond the scope of this inventory, the committee examined some FTE/bed ratios as well as nursing to bed ratios by population group and by region. The section focuses on the budgeted FTEs for April 1, 2000-March 31, 2001 and budgeted FTEs for the same period in 1999-2000.

### **Summary of Issues Identified:**

(See Figure 6 and Tables 13-15)

- There has been an overall increase in the number of budgeted FTEs in rehabilitation for April 1, 2000 to March 31, 2001 compared to the previous fiscal year. However, the number of beds also increased.
- Approximately half of all FTEs budgeted for rehabilitation in the chosen groups are at regional centres and half are at the acute care facilities offering rehabilitation.
- When examined as a percentage of the total staffing complement for rehab, the breakdown of RN, RPN, OT, OTA, PT, PTA, SLP, SW, and Clinical Nutritionists are fairly consistent between clusters.
- At non-regional centres, Nursing FTEs/bed range from 0.18 to 0.45, with the majority between 0.24 and 0.30.
- Compared to the regional centres, psychologists are the only group of professionals that are not generally included in the rehab staffing complement of the non-regional centres.
- Nursing FTEs/bed by population group at the regional centres range from 0.22 to 0.56. With the exception of spinal cord, stroke, and ABI most of the population groups have a nursing FTE/bed ratio of 0.2-0.3.

### **Limitations:**

- While the FTEs/bed may be constant the actual practice may vary considerably since the FTEs/bed does not measure workload intensity.
- Most organizations were not able to provide vacancy information, thus while the number of budgeted staff has increased, there could be a decrease in the actual number of staff in the system.

### **Questions for discussion and next steps:**

- Why are the staffing ratios consistent across regions and organizations?
- How are staffing ratios determined?
- How is workload measured?

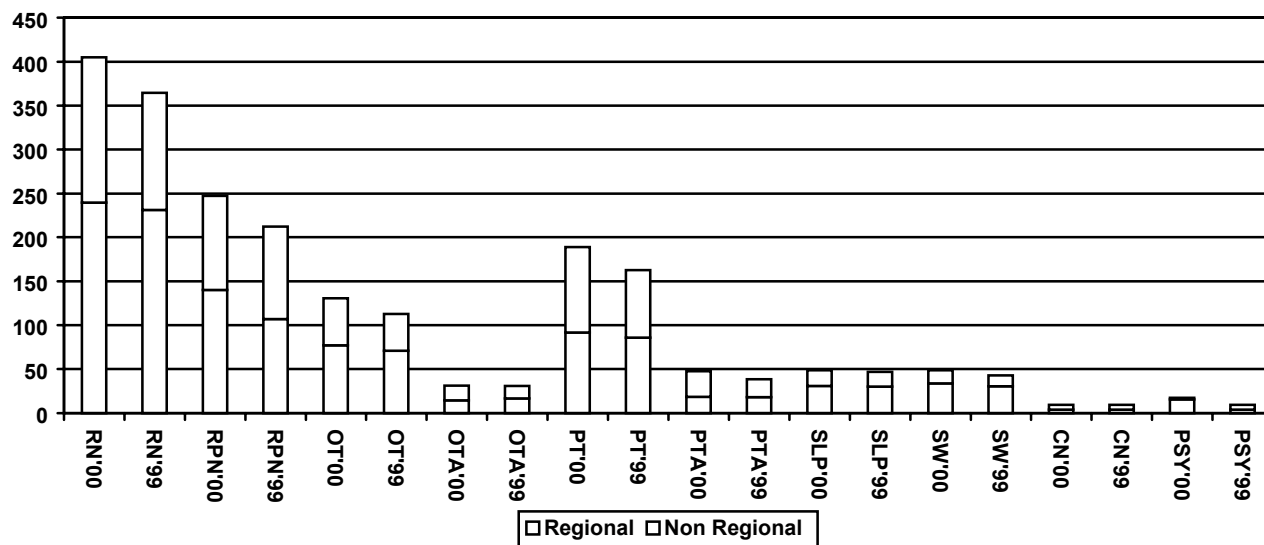
**TABLE 13: Total FTEs in selected rehab professionals groups in the GTA budgeted for 2000/2001**

	RN	RPN	OT	OTA	PT	PTA	SLP	SW	CN	PSY	Total
<b>Regional</b>	<b>239.8</b>	<b>140.2</b>	<b>76.9</b>	<b>14.6</b>	<b>91.4</b>	<b>18.7</b>	<b>31</b>	<b>33.8</b>	<b>3.9</b>	<b>15.5</b>	<b>665.8</b>
<b>CCC with Rehab</b>	16.4	21.4	5.4	0.8	7.1	0.9	1.3	2.2	1	0	56.5
<b>Metro Comm.</b>	16.6	10.7	8.6	1.7	21.7	5.7	1.6	2.0	0.8	0	69.3
<b>Halton-Peel</b>	79.9	34.8	20.2	8.7	38.3	11.0	8.9	7.1	2.2	0.9	211.9
<b>York Region</b>	17.6	15.0	9.3	2.3	17.3	6.9	0.5	0.4	0.3	0	69.6
<b>Durham Region</b>	34.6	25.3	10.3	3.3	13.1	4.5	5.3	3	1.2	1	101.5
<b>Non-regional</b>	<b>165.1</b>	<b>107.2</b>	<b>53.8</b>	<b>16.8</b>	<b>97.5</b>	<b>29</b>	<b>17.6</b>	<b>14.7</b>	<b>5.5</b>	<b>1.9</b>	<b>508.8</b>
<b>Total</b>	<b>404.9</b>	<b>247.4</b>	<b>130.7</b>	<b>31.4</b>	<b>188.9</b>	<b>47.7</b>	<b>48.6</b>	<b>48.5</b>	<b>9.4</b>	<b>17.4</b>	<b>1174.6</b>

**TABLE 14: Total FTEs in selected rehab professional groups in the GTA budgeted for 1999/2000**

	RN	RPN	OT	OTA	PT	PTA	SLP	SW	CN	PSY	Total
<b>Regional</b>	<b>231.3</b>	<b>152</b>	<b>70.7</b>	<b>16.7</b>	<b>85.8</b>	<b>18.1</b>	<b>30.3</b>	<b>30.5</b>	<b>3.9</b>	<b>14.4</b>	<b>653.8</b>
<b>CCC with Rehab</b>	7.2	12.6	2.0	0.5	3.0	0.3	0.8	1.0	0.5	0	27.9
<b>Metro Comm.</b>	26.5	33.2	12.4	1.9	26.3	5.4	2.5	3.5	1.8	0	113.6
<b>Halton-Peel</b>	67.3	29.4	18.2	8.0	35.9	10.7	8.6	6.2	1.9	0.9	187.1
<b>York Region</b>	6.7	9.2	1.0	1.0	1.0	0	0	0	0.2	0	20.0
<b>Durham Region</b>	25.7	21.1	8.6	2.8	10.8	4.0	4.8	1.5	1.0	1.0	81.3
<b>Non-regional</b>	<b>133.4</b>	<b>105.5</b>	<b>42.2</b>	<b>14.2</b>	<b>77</b>	<b>20.4</b>	<b>16.7</b>	<b>12.2</b>	<b>5.4</b>	<b>1.9</b>	<b>429.9</b>
<b>Total</b>	<b>364.7</b>	<b>257.5</b>	<b>112.9</b>	<b>30.9</b>	<b>162.8</b>	<b>38.5</b>	<b>47</b>	<b>42.7</b>	<b>9.3</b>	<b>16.3</b>	<b>1083.7</b>

**FIGURE 6: Total FTEs in selected rehabilitation professional groups by regional and non-regional centre in the GTA budgeted for 2000/2001 vs. 1999/2000**



**TABLE 15: Breakdown of professionals budgeted for GTA rehabilitation programs in 2000/2001 as percentage of total by region**

	RN	RPN	OT	OTA	PT	PTA	SLP	SW	CN	PSY
<b>Regional</b>	36%	21%	12%	2%	14%	3%	5%	5%	1%	2%
<b>CCC with rehab</b>	29%	38%	10%	1%	13%	2%	4%	4%	0	0%
<b>Metro Comm.</b>	24%	15%	12%	2%	31%	8%	3%	3%	2%	0%
<b>Halton-Peel</b>	38%	16%	10%	4%	18%	5%	3%	3%	1%	0%
<b>York Region</b>	25%	21%	10%	3%	25%	10%	1%	1%	1%	0%
<b>Durham Region</b>	34%	25%	13%	3%	13%	4%	3%	3%	1%	1%
<b>Total</b>	34%	21%	11%	3%	16%	4%	4%	4%	1%	1%

**TABLE 16: Nursing FTEs per population specific bed at the regional centres**

Population Group	Number of FTEs/Bed
<b>ABI</b>	0.38
<b>AMP</b>	0.22
<b>Burns</b>	0.28
<b>Cardiac</b>	0.22
<b>MSK</b>	0.23 to 0.30 (more than one program reported)
<b>Respiratory</b>	0.28
<b>Spinal cord</b>	0.56
<b>Stroke</b>	0.40
<b>Trauma</b>	0.28
<b>Geriatric</b>	0.22

## H. ACTIVITY

Each organization was asked to report actual utilization measures for the period of March 31, 1999 to March 31, 2000. The objective of the question was not only to monitor the activity but also to understand the language and the data that Network members use when collecting utilization information for rehabilitation. Regional centres were asked to provide information by population group.

As there are no established benchmarks for rehabilitation utilization, this section looks only at what is and makes no allusion to the appropriateness or best practice. The components examined are:

- Percentage occupancy
- Average and expected length of stay
- Number of inpatient separations
- Number of outpatient visits

### **Summary of Issues Identified:**

*(See Tables 17 and 18)*

**At non-regional centres:** Two outliers were omitted since they reflected exceptional circumstances at the organizations. Not all organizations were able to report data.

- Inpatient: Total number of beds for which utilization data is reported is 352, total separations is 2,974, and total days is 116,034.
- Percentage occupancy for the non-regional centre beds is 82% with a high of 101%, a low of 76% and a median of 94%.
- Average Length of Stay (ALOS) from the data submitted, is 39.1 days for all non-regional rehabilitation beds with a median of 41 and a range of 24 to 153 days.
- Outpatient programs: Total of 201,521 visits. This figure is under-reported because of the large number of organizations using attendances instead of visits.

**At regional centres:**

- Inpatient: There were 4, 862 separations. Length of stay ranged by population group with ALOS highest for ABI, Geriatric, Spinal Cord. The other population groups ranged between 15 and 52 days.
- For outpatient services, most organizations could give volumes but spaces and new referrals were not possible.

**Limitations:**

- We don't have a sense of whether these volumes are sufficient or appropriate.
- For outpatient services, there is a lack of standardized measures for describing activity across organizations which confounds totals for the system.

**Questions for further analysis:**

- To what extent does this volume meet need?
- What are the planning assumptions that need to be made in order to develop a projection methodology for predicting future need?
- What is the best way to conceptualize, measure and manage outpatient services?

**TABLE 17: Summary of reported utilization data for Network member non-regional centres as at March 31, 2000**

Inpatient separations <sup>(1)</sup>	2974
ALOS	
Overall	49 days
Median	41 days
High	153 days
Low	24 days
% Occupancy (inpatient) <sup>(1)</sup>	
Overall <sup>(2)</sup>	82 %
Median	94 %
High	101 %
Low	76 %
Outpatient Visits <sup>(1)</sup>	201,521

(1) Figure is under-reported because several organizations could not report data

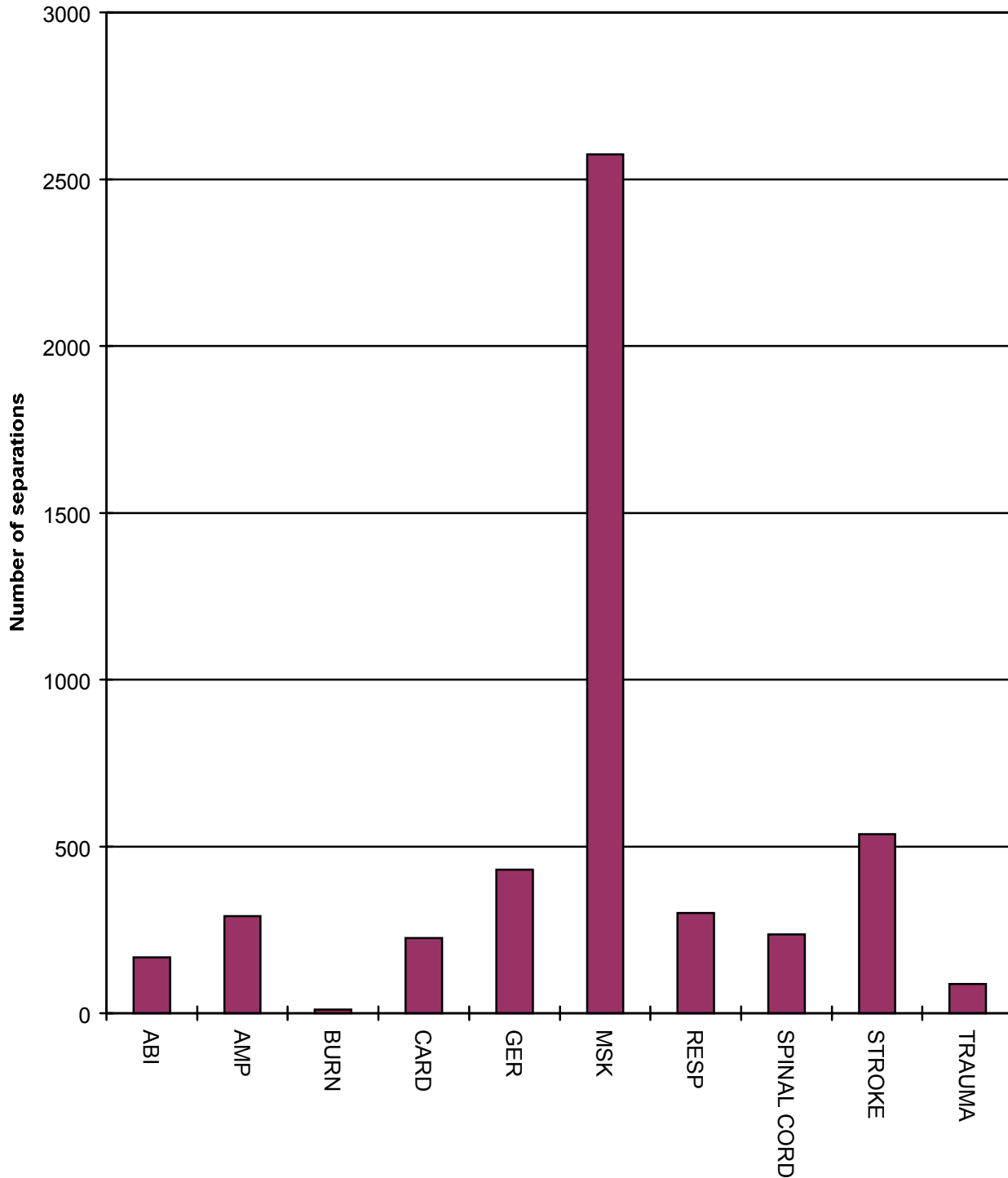
(2) Based on patient days available 365 days a year, does not include data from organizations who could not submit both bed and patient day data

**TABLE 18: Summary of data relating to the OHA population groups reported by the regional centres**

Population	Inpatient Separations	Days	ALOS	%Occupancy	Visits
ABI	167	11,940	71	71-90	21,400
AMP	291	8,212	28	76	1,771
BURN	11	328	44	*	*
CARD	226	4,130	18	93	39,939
GER	431	20,713	48	90	12,270
MSK	2574	48,219	19	86	498
RESP	301	7,451	25	*	3,067
SPINAL CORD	237	20,929	88	83-96	4,750
STROKE	537	21,387	40	*	2,995
TRAUMA	87	4,723	52	*	*

\*No data reported

**FIGURE 7: Number of inpatient separations at regional rehabilitation centres by population group (April 1, 1999- March 31, 2000)**



## **I. HOURS OF OPERATION**

One of the recommendations of the HSRC was to increase rehabilitation service delivery to a seven day per week model. The survey therefore asked organizations to report their hours of operation and whether or not they offered services on weekends.

The finding was that most organizations offered rehabilitation, both inpatient and outpatient, five days a week during regular business hours (weekdays 9-5) which did not extend into the late evening. There were four organizations who offered extended hours on weekdays and some organizations did provide single service rehabilitation on weekends.

### ***Summary of Issues Identified:***

- Most organizations offering rehabilitation, both inpatient and outpatient, did so five days a week during regular business hours (weekdays 9-5)
- Four organizations offered extended hours on weekdays. Several offered single service rehabilitation on weekends.

### **Questions for further investigation:**

- What is the economic cost/indirect burden of illness associated with rehabilitation offered only during business hours (i.e., the indirect cost to the patient of lost work, lost time, transportation costs, babysitting costs, lost school hours)?
- What additional reasons other than those associated with resources may impede movement to a 7 day per week model?
- What are the advantages, drawbacks, feasibility of a 7 day service delivery model for both inpatient and outpatient rehabilitation?

## J. INVENTORY OF CARE PATHWAYS AND GUIDELINES

**Care pathways** (clinical pathways, care paths and care guides) are tools developed by multi-disciplinary teams which describe the optimal sequencing and timing of interventions for patients with specific diagnoses and conditions. Within these populations, care pathways are used where there is high volume of patients and/or a high degree of uniformity among the specific population.

Care pathways focus on outcomes to be achieved during a specific time frame and may serve as a framework for measuring resource utilization and evaluating outcomes. (See Appendix A for related terminology).

This inventory of care pathways was collated using three methods:

- Committee members brought forward care pathways that they knew to exist in their own organizations.
- Committee members conducted scans for each of the population groups to bring forward care pathways from other organizations.
- Through the Clinical Committee survey administered in November 2000, all organizations were polled to determine if care pathways were in use.

The care pathways in this inventory are categorized into those that are known to exist at the regional rehabilitation centres, the community care access centres, and those at the acute care centres. They are then categorized by OHA population group, organizations, whether the intended user is the provider, the patient or both, and where appropriate, if the care pathway relates to the acute or rehabilitation phase of care.

The Quality Care Committee has reviewed many of the care pathways but has not evaluated the care pathways listed in this inventory. Instead, the committee has chosen to provide suggested guidelines, based on the literature, which organizations may use in selecting or evaluating care pathways for their own use (Table 22).

### **Summary of Issues Identified:**

*(See Tables 19-22 and Figure 8)*

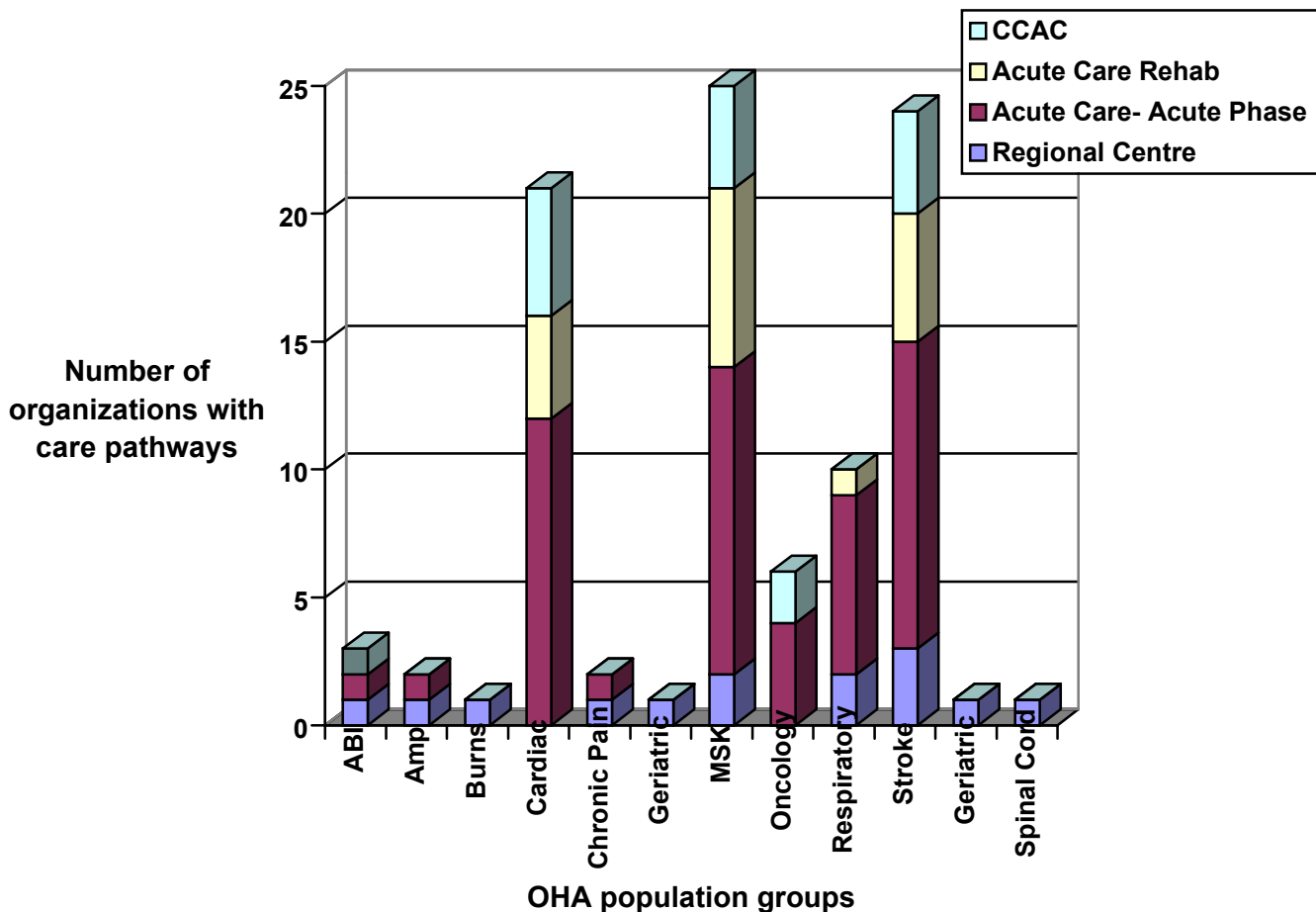
- Many quality improvement/care pathway activities occurring in silos with no connection across continuum of care.
- Variation in the number of care pathways and possible opportunities/benefits in consolidation (number in brackets indicates the number of organizations with care pathways for that population group):
 

MSK	(25)	Respiratory	(10)	Amputee	(2)
Stroke	(24)	Neurology	(3)	ABI	(3)
Cardiac	(21)	Spinal Cord	(1)	Burns	(1)
- Lack of clarity around the boundaries between acute care and rehabilitation resulting in problems categorizing and conceptualizing care pathways.

**Questions for further investigation:**

- Use care pathways to examine the transition points that patients experience as they cross the continuum of care and understand coordination issues.
- Where there are a large number of different care pathways in the care pathways for a specific population, further examination of the variation should be pursued.
- For populations for which there are few care pathways but a large volume of patients and a high degree of uniformity, further examination of the opportunities or benefits of developing care pathways should be pursued.
- What is the feasibility of maintaining access to current information to care pathways in other organizations in order to improve coordination along the continuum of care.

**FIGURE 8: Number of organizations with care pathways in each of the OHA rehabilitation population groups**



**TABLE 19: CCACs with care pathways related to the OHA population groups**

POPULATION GROUP (OHA)	NAME OF ORGANIZATION	USER ✓=Yes ✗=No	
		Patient	Provider
ABI	North York CCAC	✗	✓
Cardiac	Durham Access To Care	✗	✓
Cardiac	East York CCAC		✓
Cardiac	North York CCAC	✗	✓
Cardiac	Scarborough CCAC		✓
Cardiac	York CCAC		✓
MSK	Durham Access To Care	✗	✓
MSK	Halton CCAC	✓	✓
MSK	North York CCAC	✗	✓
MSK	Toronto CCAC	✗	✓
Neurology	East York Access Centre		✓
Neurology	North York CCAC	✗	✓
Oncology	Durham Access To Care	✗	✓
Oncology	East York CCAC		✓
Stroke	Durham Access/ Lakeridge	✓	✓
Stroke	North York CCAC	✗	✓
Stroke	York CCAC		✓
Stroke	Toronto CCAC	✗	✓

**TABLE 20: Regional rehabilitation centres with care pathways related to the OHA population groups**

OHA POPULATION GROUP	NAME OF ORGANIZATION	USER ✓=Yes ✗=No	
		Patient	Provider
ABI (Mild/Sev)	Toronto Rehabilitation Institute	✗	✓
Amputee	West Park Health Centre	✗	✓
Burns	St. John's Rehabilitation Hospital	✗	✓
MSK	St. John's Rehabilitation Hospital	✗	✓
MSK	Toronto Rehabilitation Institute	✗	✓
Chronic Pain	Toronto Rehabilitation Institute	✗	✓
Geriatric	West Park Healthcare Centre	✗	✓
Respiratory	Toronto Rehabilitation Institute	✗	✓
Respiratory	West Park Healthcare Centre	✗	✓
Spinal Cord	Toronto Rehabilitation Institute	✗	✓
Stroke	West Park Healthcare Centre	✗	✓
Stroke	St. John's Rehabilitation Hospital	✗	✓
Stroke	Toronto Rehabilitation Institute	✗	✓

**TABLE 21: Acute care centres with care pathways related to the OHA population groups for both the acute and rehabilitation phases of care**

OHA POPULATION GROUP	NAME OF ORGANIZATION	Type of Care Pathways ✓=Yes ✗=No		USER ✓=Yes ✗=No	
		Acute	Rehab	Patient	Provider
		ABI	University Health Network	✓	✗
Amputee	Sunnybrook and Women's College	✓	✗	✗	✓
Cardiac	Credit Valley	✓	✗	✓	✓
Cardiac	Halton Healthcare Services	✓	✗	✓	✓
Cardiac	Humber River Regional	✓	✓	✓	✓
Cardiac	Lakeridge Health	✓	✓	✓	✓
Cardiac	Rouge Valley Health System	✓	✓	✗	✓
Cardiac	Southlake Regional Health Centre	✓	✓		✓
Cardiac	St. Joseph's Health Centre	✓	✗		✓
Cardiac	Sunnybrook and Women's	✓	✗	✗	✓
Cardiac	Toronto East General	✓	In dev	✗	✓
Cardiac	Trillium Health Centre	✓	In dev		✓
Cardiac	University Health Network	✓	In dev	✗	✓
Cardiac	York Central Hospital	✓	✗	✗	✓
Chronic Pain	University Health Network	✓	✗	✗	✓
MSK	Credit Valley	✗	✓	✓	✓
MSK	Halton Health Care Services	✓	✗	✓	✓
MSK	Lakeridge Health	✓	✓	✓	✓
MSK	Markham Stouffville	✓	✓	✗	✓
MSK	Mt. Sinai Hospital	✓	✗	✗	✓
MSK	Orthopaedic and Arthritic Institute	✓	✓	✓	✓
MSK	Rouge Valley Health System	✓	✓	✗	✓
MSK	Southlake Regional Health Centre	✓	✓	✓	✓
MSK	St. Michael's Hospital	✓	✗	✗	✓
MSK	Sunnybrook and Women's	✓	✗	✗	✓
MSK	Toronto East General	✓	In dev	✗	✓
MSK	University Health Network	✓	✗	✗	✓
MSK	York Central Hospital	✓	✓	✗	✓
Neurology	University Health Network	✓	✗	✗	✓
Oncology	Credit Valley	✓	✗	✓	✓
Oncology	Lakeridge Health	✓	✗	✗	✓
Oncology	University Health Network	✓	✗	✗	✓
Oncology	York Central Hospital	✓	✗	✗	✓
Respiratory	Credit Valley	✓	✗	✓	✓
Respiratory	Halton Healthcare Services	✓	✗	✓	✓
Respiratory	Southlake Regional Health Centre	✓	✓	✗	✓

OHA POPULATION GROUP	NAME OF ORGANIZATION	Type of Care Pathways ✓=Yes ✗=No		USER ✓=Yes ✗=No	
		Acute	Rehab	Patient	Provider
		Respiratory	Toronto East General	✓	✗
Respiratory	Trillium Health Centre	✓	✗	✗	✓
Respiratory	University Health Network	✓	✗	✗	✓
Respiratory	York Central Hospital	✓	✗	✗	✓
Spinal Cord	University Health Network	✓	✗	✗	✓
Stroke	Halton Healthcare Services	✓	✗	✓	✓
Stroke	Lakeridge Health	✓	✓	✓	✓
Stroke	Rouge Valley Health System	✓	✓	✓	✓
Stroke	The Scarborough Hospital	✓	✓	✓	✓
Stroke	Southlake Regional Health Centre	✓	✓	✓	✓
Stroke	St. Joseph's Hospital	✓	✗	✗	✓
Stroke	St. Michael's Hospital	✓	✗	✗	✓
Stroke	Sunnybrook and Women's College	✓	✗	✗	✓
Stroke	Toronto East General	✓	✗	✗	✓
Stroke	Trillium Health Centre	✓	In dev	✗	✓
Stroke	University Health Network	✓	✗	✓	✓
Stroke	York Central Hospital	✓	✓	✗	✓

### Access to Care Pathways:

The care pathways listed in this inventory are the property of the organizations listed. They cannot be distributed through the Network office. However, further information on how to obtain some of these pathways is available through the Network office. For further information please call the GTA Rehab Network at (416) 597-3057.

**TABLE 22: Suggested guidelines for the development and selection of care pathways based on a review of the literature and existing tools\***

<p><b>PURPOSE:</b> (CHA and CMA, 1994), (Graham, 2000), (Ellis and Johnson, 1997)</p> <ul style="list-style-type: none"> <li>• Clearly stated (e.g., improve patient outcomes, reduce length of stay)</li> <li>• Sufficient clarity about the “who, what, where, when, and why”</li> <li>• Reflected in format (e.g., outcomes, target dates)</li> <li>• Designed for population specific events which are likely to occur 75-80% of the time</li> <li>• Designed for high volume patients, high resource intensity patients or patient population groups with a fair degree of uniformity.</li> </ul>
<p><b>EVIDENCE-BASED:</b> (CHA and CMA, 1994)</p> <ul style="list-style-type: none"> <li>• References from current literature (e.g., Randomized Controlled Trials)</li> <li>• Consensus from experts (internal &amp; external)</li> <li>• Institutional data (e.g., Length of stay reports, patient satisfaction surveys)</li> </ul>
<p><b>MULTIDISCIPLINARY:</b> (Ellis and Johnson, 1997), (Graham, 2000), (Weinstein and Hockley, 2000)</p> <ul style="list-style-type: none"> <li>• All relevant professionals included in development</li> <li>• “Buy-in” from staff and physicians, client input</li> </ul>
<p><b>OUTCOME FOCUSED:</b> (Ellis and Johnson, 1997)</p> <ul style="list-style-type: none"> <li>• Goals and outcomes are realistic and measurable</li> <li>• Expected outcomes are expressed clearly and concisely</li> </ul>
<p><b>PATIENT FOCUSED:</b> (Graham, 2000), (Toronto Hospital, 1996)</p> <ul style="list-style-type: none"> <li>• Inclusion/exclusion criteria to specify patient group</li> <li>• Goals are client focused.</li> <li>• Outcomes are based on both client and provider considerations</li> <li>• Patient version of the pathway is available</li> </ul>
<p><b>APPROPRIATELY INTEGRATED WITH OTHER SYSTEMS:</b> (Weinstein and Hockley, 2000)</p> <ul style="list-style-type: none"> <li>• Clinical Practice Guidelines</li> <li>• Routine orders</li> <li>• Algorithms</li> <li>• Standards of Care</li> <li>• Documentation system and other institutional processes</li> </ul>
<p><b>LINKED:</b> (Toronto Hospital, 1996)</p> <ul style="list-style-type: none"> <li>• With other agencies within the continuum of care (acute, rehab, chronic, community)</li> </ul>
<p><b>MULTIFUNCTIONAL USE:</b> (Weinstein and Hockley, 2000)</p> <ul style="list-style-type: none"> <li>• Planning daily patient care</li> <li>• Communication between professionals</li> <li>• Collecting data to facilitate decision making (variances)</li> <li>• User-friendly format</li> </ul>
<p><b>REVIEWED/EVALUATED REGULARLY:</b> (Ellis and Johnson, 1997), (Weinstein and Hockley, 2000)</p> <ul style="list-style-type: none"> <li>• After pilot to make necessary changes</li> <li>• Annually or as needed after implementation to ensure quality.</li> </ul>

\*based on initial work done by the Best Practices Committee at Lakeridge Health

### III. SUMMARY OF ISSUES AND RECOMMENDATIONS

This initiative has resulted in the identification of 36 rehabilitation issues which require further investigation or resolution. These issues are numbered and listed below and are matched with a potential recommendation or strategy for addressing the issue. The section of the survey from which the issue is drawn is indicated at the top of each section.

#### **ADMISSION CRITERIA**

ISSUE/QUESTION	RECOMMENDATION/OPTION
1. Form and function of the admission criteria vary, causing a lack of clarity around who is/isn't being admitted and the capabilities of the receiving organization to accept patients with particular needs	1. Develop principles for the standardization of admission criteria that will be flexible enough to accommodate patients with unique situations or needs but uniform enough to indicate which patients are not being admitted.
2. Patients with particular needs (i.e. wandering, cognitive impairment, psychiatric disorders) are often excluded by the admission criteria.	2. Identify and implement measures that improve the patient's ability to gain access or the program's ability to admit the patient. 3. Collect data on the number of refusals and the reasons for refusals using a standardized template for a trial period to quantify the problem.
3. Appropriateness and use of the concept of medically stable: medically stable is specified in all criteria but is subjective and not particularly meaningful from a clinical standpoint.	4. Establish a methodology and common language for documenting and communicating the capabilities of each organization for dealing with medical complexities. 5. Develop standard descriptors that help to ensure that facilities understand medical issues of patients prior to patient arrival. 6. Develop criteria for articulating the appropriate level of care and medical capabilities for regional rehabilitation centres, the acute care hospitals, ambulatory care, and home care by urging the OHA and the Ministry of Health and Long Term Care to clarify the roles of regional and non-regional centres in rehabilitation. 7. Develop a triage tool which appropriately matches patients to rehabilitation services and that is standardized across organizations.

ISSUE/QUESTION	RECOMMENDATION/OPTION
4. Subjective requirements such as willing to participate or potential for improvement are required by most programs	8. Develop parameters and principles for becoming more objective about the subjective requirements in admission criteria.
5. Process requirements that pose as a barrier to access include failure to provide a letter of return, failure to secure a discharge plan.	9. Examine parameters for the appropriateness of patient return to referring facility in order to better comprehend the letter of return issue and examine the interface between CCAC and facilities to better understand discharge issues.
6. Admission criteria are seldom specific to diagnostic groups. The only diagnostic groups specifically excluded from any of the criteria are ABI and Spinal Cord.	Recommendation #6
7. Transportation arrangements are required for access to many outpatient rehab programs.	10. Conduct a study on the impact of transportation issues on access to rehabilitation, including in the examination: <ul style="list-style-type: none"> <li>• Review of existing initiatives</li> <li>• Impact on the distribution of inpatient, outpatient, and home care patients</li> <li>• Non emergent transportation of patients between facilities</li> </ul>

### REFERRAL PATTERNS

ISSUES/QUESTIONS	RECOMMENDATIONS/OPTIONS
8. Metro hospitals cite the regional centres more frequently as one of the top 5 locations to which they refer patients than do the 905 hospitals.	11. Explore capacity question and referral patterns for 905 regions to ensure that there is equitable access in the 905 regions to the regional centres.  Recommendation #6
9. Outpatient rehabilitation referrals go to a large number of private clinics, so the outpatient picture is incomplete.	12. Develop a framework for outpatient rehabilitation which allows for a better understanding of how much outpatient rehabilitation occurs outside of the Network
10. Some organizations are reporting inpatient referrals to organizations with no designated rehab beds.	13. Maintain a publicly available and up to date listing of organizations with designated rehabilitation beds  14. Explore reasons for referrals to non-designated beds, i.e. awareness, capacity, patient choice, etc.

### **COORDINATION MECHANISMS AND INDICATORS**

<b>ISSUES/QUESTIONS</b>	<b>RECOMMENDATIONS/OPTIONS</b>
11. No common standards for admission and referral process (varying admission and referral times). Does the process cause bottlenecks?	15. Coordinate admission and referral times across the system and within each region  16. Determine best practice in terms of use of an admissions committee and the feasibility/benefits of an committees by region.
12. Organization specific waiting lists and manual waiting list management may cause prioritization issues and do not take advantage of cross-organizational problem solving.	17. Explore the feasibility of a waiting list management system for rehabilitation in the GTA  18. Determine an infrastructure for communicating capacity between organizations.
13. Lack of data about patients refused and reasons for refusal means we know there's a problem but there is insufficient data to prove it.	Recommendation #3

### **PROVIDER PERCEPTIONS**

<b>ISSUES/QUESTIONS</b>	<b>RECOMMENDATIONS/OPTIONS</b>
14. Provider availability (waiting lists as a result of availability of SLP, PT, OT, Home Care)	19. Support and consult with the District Health Council Health Human Resource initiative to develop a model which allows consistent identification of vacancies and human resource projections.  Recommendation #17
15. Availability of specialty programs, expertise, and the needs of particular populations poses as a barrier when trying to move a patient to the next level of care.	Recommendation #2  Recommendation #3
16. Transportation (availability of WheelTrans, timing of TTC relative to discharge)	Recommendation #10
17. ABI, Geriatric, Chronic Pain, and Oncology identified as populations whose needs for rehabilitation are least addressed.	20. Conduct an environmental scan to determine what information is available for these population groups.

## **SIZING OF SERVICES**

<b>ISSUE/QUESTION</b>	<b>RECOMMENDATION/OPTIONS</b>
<p>18. Distribution of rehabilitation beds per 100 000</p> <ul style="list-style-type: none"> <li>• 52% at regional centres</li> <li>• 48% at non-regional centres</li> <li>• 49% Geriatric, MSK, Stroke</li> <li>• 23% general beds</li> <li>• 28% all other population groups</li> </ul>	<p>21. Identify/clarify appropriate balance of specialized/general inpatient and outpatient services for specific populations which take into account proximity and critical mass.</p> <p>Recommendation #6</p>
<p>19. Distribution of beds by region per 100 000</p> <ul style="list-style-type: none"> <li>• Overall: 22.7</li> <li>• Regional beds: 11.5</li> <li>• Toronto Hospitals (all): 11.1</li> <li>• Halton Peel: 10.1</li> <li>• York Region: 7.9</li> <li>• Durham: 14.9</li> </ul>	<p>22. Examine distribution of beds by region against the age and morbidity adjusted figures for each region and against estimates of the incidence and prevalence of the condition.</p>
<p>20. Projection for 2003 per 100 000</p> <ul style="list-style-type: none"> <li>• Overall: 26.6</li> <li>• Regional Beds: 10.8</li> <li>• Toronto Community: 15.5</li> <li>• Halton Peel: 10.1</li> <li>• York Region: 7.9</li> <li>• Durham: 14.9</li> </ul>	<p>Recommendation #22</p>
<p>21. Use of Non-designated beds:</p> <ul style="list-style-type: none"> <li>• MSK, Stroke, Neurology, and Geriatrics</li> <li>• Complex continuing care and ALC beds at acute care centres and CCC and acute care beds at the teaching hospitals.</li> </ul>	<p>23. Conduct further investigation into why and how non-designated beds are currently being used.</p>

## **SITING OF SERVICES**

<b>ISSUE/QUESTION</b>	<b>RECOMMENDATION/OPTIONS</b>
<p>22. Number of organizations offering inpatient services to each population:</p> <ul style="list-style-type: none"> <li>• MSK (22), Stroke (21), Geriatric (17)</li> <li>• Neuro (16), Respiratory (11)</li> <li>• Oncology (7), Amputee (9)</li> <li>• Trauma (7), ABI (9)</li> </ul>	<p>24. Explore opportunities to support coordinated models of service delivery for large health populations i.e.</p> <ul style="list-style-type: none"> <li>• Stroke (Coordinated Stroke Strategy)</li> <li>• Geriatric (Regional Geriatric Program)</li> <li>• Neurology (ABI Network)</li> <li>• MSK</li> </ul>

ISSUE/QUESTION	RECOMMENDATION/OPTIONS
<p>23. Population Groups served by the largest number of outpatient programs:</p> <ul style="list-style-type: none"> <li>• MSK (18)</li> <li>• Neurology (15)</li> <li>• Stroke (17)</li> <li>• Respiratory (14)</li> </ul>	<p>25. Initiate a task force to examine the appropriateness of inpatient to outpatient program ratio and explore opportunities for improving the delivery model.</p>
<p>24. Distribution of Outpatient Programs:</p> <ul style="list-style-type: none"> <li>• Ratio of inpatient to outpatient programs by population group varies</li> <li>• Lesser number of outpatient programs east than west of Central Toronto</li> </ul>	<p>Recommendation #25</p>
<p>25. Child and Paediatric Services: Incomplete picture due to non-Network members providing children’s rehabilitation</p>	<p>26. Consult Bloorview MacMillan Centre regarding the feasibility and usefulness of conducting a separate inventory for child and adolescent rehabilitation in the GTA.</p>
<p>26. CCAC specific rehabilitation data required to better understand home care in rehabilitation.</p>	<p>27. Consult with CCACs to better understand what data is available and what we need to collect/draw on to complete the inventory picture.</p>
<p>27. Proximity and Critical Mass</p> <ul style="list-style-type: none"> <li>• Maps of where population groups are receiving services vary for each population</li> <li>• Concerns about the balance of critical mass and proximity</li> </ul>	<p>Recommendation #21, #6</p> <p>28. In consultation with the District Health Councils, use current data to develop the assumptions and model needed for a statistically valid and reliable demand projection methodology for rehabilitation in the GTA.</p>

**STAFFING**

ISSUE/QUESTION	RECOMMENDATION/OPTION
<p>28. Total numbers of budgeted FTEs by rehabilitation professional group have increased. Difficulty in collecting vacancy data</p>	<p>29. Support and consult with the District Health Council Health Human Resource initiative to develop a model which allows consistent identification of vacancies and human resource projections</p>

ISSUE/QUESTION	RECOMMENDATION/OPTION
<p>29. Across all regions and organizations the percentage of each professional group of the total rehab staffing is consistent:                      RN: 24-36%;RPN: 15-38%                      OT: 10%-13%; OTA: 1-4%                      PT: 13-31%; PTA: 3-9%                      SLP: 1-5%; SW: 1-5%                      CN: 0-2%; PSY: 0-2%                      Nursing staff per bed:                      0.21-0.45 FTEs/bed</p>	<p>30. Initiate benchmarking activity for the skill complement and staffing ratio required for rehabilitation and begin by examining other regions in Canada.</p>

**ACTIVITY MEASURES AND HOURS OF OPERATION**

ISSUE/QUESTION	RECOMMENDATION/OPTION
<p>30. No current or projected demand information or assumptions that can be used to assess the activity measures collected : ALOS, Separations, Visits, New Referrals, Patient Days, % Utilization</p>	<p>Recommendation # 22  Recommendation # 28</p>
<p>31. Crude estimate of overall capacity constructed by:</p> <ul style="list-style-type: none"> <li>• Location of services</li> <li>• Population served by region</li> <li>• Staffing ratios and numbers</li> <li>• Activity Measures</li> </ul>	<p>Recommendation #28  31. Further the dialogue on the value and importance of understanding capacity for rehabilitation in the GTA and match capacity data elements to those for population need.</p>
<p>32. Organizations vary in their data collection abilities and interpretations, specifically around outpatient rehabilitation.</p>	<p>32. Support timely and consistent use of the proposed minimum data set and where additional data is required build around the minimum data set.  33. For outpatient rehabilitation, develop a conceptual framework Recommendation #12</p>
<p>33. Most organizations operating on a 5 day a week model</p>	<p>34. Initiate a research project to examine the benefits and drawbacks of 7 day per week rehab for inpatients and outpatient rehabilitation that looks at all factors.</p>

**CARE PATHWAYS**

<b>ISSUE/QUESTION</b>	<b>RECOMMENDATION/OPTIONS</b>
34. Many quality improvement/care pathway activities occurring in silos with no connection across continuum of care.	35. Maintain access to current information on care pathways and quality tools in other organizations by encouraging organizations to post care pathways on their web sites.
35. Variation in the number of care pathways and possible opportunities/ benefits in consolidation: MSK (25) Stroke (24) Cardiac (21) Respiratory (10) Neurology (3) Spinal Cord (1) Amputee (2) ABI (3) Burns (1)	36. Examine variation and determine and communicate best practice for populations for which there are a large number of care pathways (MKS, Stroke, Cardiac) OR support initiatives which already exist to determine best practice.  37. Communicate guidelines for development of pathways to facilitate development and sharing of expertise across the system.  Recommendation #24
36. Lack of clarity around the boundaries between acute care and rehabilitation resulting in problems categorizing and conceptualizing care pathways.	38. Develop and promote clear and consistent parameters for defining the boundaries between acute care and rehabilitation  39. Establish a framework for conceptualizing outpatient/ambulatory care services that can be consistently used across the system.

## IV. PRIORITY AREAS

Recognizing the scope, number of issues and the subsequent recommendations that have arisen from the clinical committees' initiatives, the GTA Rehab Network held a joint meeting with each of the three committees (Access and Coordination, Services Inventory and Gaps, and Quality Care) to examine the issues and priorities.

The joint meeting held on May 2, 2001 leveraged the relationships between the issues resulting in the identification a few high level areas which the committees felt would be most effective in moving towards a vision of an integrated rehabilitation system. Addressing these areas will lead to the resolution of nearly 25 of the 36 issues identified through the survey.

Area (issue numbers are included in brackets)	Potential Impact/Outcome at Resolution
<p>Many quality improvement/care pathway activities are occurring in silos with no connectivity across the continuum of care. (#34)</p> <p><b>Action Required:</b> Examine variation in care pathways by population group and communicate best practice for population(s).</p>	<ul style="list-style-type: none"> <li>• Reduction in duplication in pathway development and use</li> <li>• Consensus on best practice</li> <li>• Coordination along the continuum of care</li> <li>• Better transition for patients as they move across the continuum</li> </ul>
<p>Most rehabilitation is occurring 5 days/week. HSRC recommendation for 7 day/week rehabilitation. (#33)</p> <p><b>Action Required:</b> Initiate a research project to examine the benefits and drawbacks of 7 day per week rehabilitation for inpatients and outpatient rehabilitation which looks at all factors.</p>	<p>Examining the impact of 7 day/week rehabilitation will provide clarity around:</p> <ul style="list-style-type: none"> <li>• Business/planning implications of moving to a 7 day model i.e. staffing, capacity etc.</li> <li>• Clinical/outcome advantages and disadvantages</li> <li>• Direct and indirect costs and benefits for the patient and the community</li> </ul>
<p>Admission criteria: Form and function of admission criteria vary, causing lack of clarity about who is getting access and who is not, the use of subjective terms, inability to match a patient with a service, etc. (#1-#11)</p> <p><b>Action Required:</b> Identify and implement measures which improve the patient's ability to gain access or the program's ability to admit the patient.</p>	<ul style="list-style-type: none"> <li>• Openness and transparency in the admission process</li> <li>• Integration and problem solving across organization</li> <li>• Objectivity around subjective admission requirements</li> <li>• Matching patient's needs to facility abilities</li> <li>• Making the business case for needs not sufficiently addressed</li> <li>• Potential to incorporate work of OHA, Provincial Rehab Working Group and triage tool into provider practice</li> </ul>

Area (issue numbers are included in brackets)	Potential Impact/Outcome at Resolution
<p>Framework for capacity in relation to need: Crude estimate of overall capacity constructed by assessing: location of services, populations served by region, beds/100 000, staffing ratios and numbers; activity measures. However there is a lack of demand information and no agreed upon methodology for projecting future need. (#31)</p> <p><b>Action Required:</b> In consultation with the District Health Councils, use current data to develop the assumptions and model needed for a statistically valid and reliable demand projection for rehabilitation in the GTA.</p>	<ul style="list-style-type: none"> <li>• Benchmarks to use in planning</li> <li>• Standardized assumptions to use in projecting future need across the system</li> </ul>
<p>Organization specific waiting lists and manual waiting list management may cause prioritization issues and do not take advantage of cross organizational problem solving. (#12, #14)</p> <p><b>Action Required:</b> Explore the feasibility of a waiting list management system for rehabilitation in the GTA. Determine an infrastructure for communicating capacity between organizations</p>	<ul style="list-style-type: none"> <li>• Means of sharing capacity information</li> <li>• Cross-organizational problem solving</li> <li>• Increased efficiency</li> <li>• Shortened waiting lists</li> <li>• Reduced duplication</li> <li>• Consensus on waiting list management approach</li> <li>• Transparency and openness about the issues</li> <li>• Discovery of other possibilities for dealing with capacity.</li> </ul>
<p>Needs of particular population groups (i.e. wandering patients, patients with cognitive/behavioural issues, medically complex patients) may not be sufficiently addressed as these populations often fail to meet admission requirements. (#2, #3, #6, #14, #15, #17)</p> <p><b>Action Required:</b> Develop a more systematic means of quantifying the problem in order to determine the type and quantity of resources/measures needed.</p>	<ul style="list-style-type: none"> <li>• Improvement in access, scope, and quality of services available to meet these particular needs.</li> </ul>

Area (issue numbers are included in brackets)	Potential Impact/Outcome at Resolution
<p>Variations in how rehabilitation programs collect information, how indicators are measured and why they are collected (i.e. especially outpatient information). (#32)</p> <p><b>Action Required:</b> Support timely and consistent use of the proposed minimum data set and where additional data is required, build around the minimum data set (JPPC Recommendation).</p>	<ul style="list-style-type: none"> <li>• Conceptual framework for measuring and managing outpatient rehabilitation</li> <li>• Streamlining of the number of data indicators collected across the system</li> <li>• Improved coordination and management as a result of more commensurable indicators</li> </ul>
<p>Proximity vs. critical mass: Maps of where populations are receiving services vary for each population group. Concerns exist about the balance of critical mass and proximity and the “correct” location to treat a patient (#18, #27)</p> <p><b>Action Required:</b> Develop criteria for articulating the appropriate level of care and medical capabilities for regional rehabilitation centres, acute care hospitals by urging the MOH-LTC and the OHA to clarify the roles of regional and non-regional centres in rehabilitation; use of ambulatory care and home care; use of specialized vs. general rehabilitation beds</p>	<ul style="list-style-type: none"> <li>• Equitable access for patients within Metro and in the 905 region.</li> <li>• Ensuring quality in all regions of the GTA.</li> <li>• Proper consideration of patient needs and preferences</li> <li>• Once principles are determined, it will be possible to put the enablers in place such as transportation, satellite clinics etc to address the problems that arise.</li> </ul>
<p>Use of non-designated beds for MSK, Stroke and Geriatrics, some organizations also report referral to non-designated beds for rehabilitation (#10, #21)</p> <p><b>Action Required:</b> Conduct further investigation into why and how non-designated beds are being used</p>	<ul style="list-style-type: none"> <li>• Ensuring that non-designated rehab beds are sufficiently equipped</li> <li>• Better understanding about “right sizing the rehab system”</li> </ul>

Area (issue numbers are included in brackets)	Potential Impact/Outcome at Resolution
<p>Rehabilitation in the home: Need for a greater understanding of in home rehabilitation (# 26) and outpatient rehabilitation Need for a greater understanding of outpatient rehabilitation: appropriateness of inpatient to outpatient ratios, location of outpatient services, impact of transportation in accessing outpatient services, understanding of outpatient services provided by private providers.(#23, #32, #9, #24)</p> <p><b>Action Required:</b></p> <ul style="list-style-type: none"> <li>• Consult with CCACs to better understand what data is available and what we need to collect/draw on to complete the inventory picture</li> <li>• Examine the appropriateness of the number of inpatient to outpatient programs by population and explore opportunities for improving the delivery model.</li> <li>• Develop a framework for outpatient rehabilitation, which allows for a better understanding of how much outpatient rehabilitation occurs outside of the Network.</li> <li>• Conduct a study on the impact of transportation issues on access in rehabilitation including: impact on the distribution of inpatient, outpatient, and home care services; review of existing initiatives; non emergent transportation between facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Better understanding of in home rehabilitation and its linkages to outpatient rehabilitation</li> <li>• Better understanding of transportation requirements and outpatient services required</li> <li>• More complete picture of rehabilitation</li> </ul>

## **V. NEXT STEPS**

The clinical committee initiative has met its objectives of identifying rehabilitation issues that need to be addressed in order to move towards the vision of an integrated rehabilitation system.

In order to move forward on resolving these issues, the Network will use three approaches. First, where it is appropriate and feasible to do so, both in terms of membership interest and resources, the Network will select some of these areas to address directly in its upcoming operating plan.

Secondly, for issues that are better addressed by forums outside of the GTA Rehab Network, action will be taken to raise awareness of the issues and to seek opportunities to collaborate in those forums with a view to having the issues resolved.

Finally, all of the issues identified will serve as a baseline for monitoring progress and selecting future activities that will assist in achieving a vision of an integrated, client-centred rehabilitation system for the patients and families of the Greater Toronto Area.

## REFERENCES

ARA Consulting Group and Carnaross Consulting Inc., Environmental Scan and Analysis of the Public and Private Rehabilitation Sectors, July 1998.

The Change Foundation, CIBC Oppenheimer, and Arthur Andersen Consulting, Making Restructuring Work: the Current Path: Hospital Restructuring at the Mid-Point, Part 1 and 2, 1999.

Greater Toronto Area Rehabilitation Network, Rehabilitation Inventory Working Group. An Inventory of Rehabilitation Services in Toronto, York, Peel, Halton and Durham, January 2000

Greater Toronto Area Rehabilitation Network, Report of Survey: Implementation Status of HSRC Directions, May 2000.

Greater Toronto Area Rehabilitation Network, Terms of Reference, 1-11.

Health Services Restructuring Commission, Change and Transition, April 1998, 8-72.

Health Services Restructuring Commission, Rebuilding Ontario's Health System, July 1997, 58-65.

Health Services Restructuring Commission, Toronto Health Services Restructuring Report, April 1998, 6-22.

OHA Rehabilitation Working Group, Rehabilitation Program Definitions, March 1999.

Provincial Rehabilitation Reference Group, Managing the Seams: Making the Rehabilitation System Work for People, March 2000.

### ***Access Indicators and Measurement:***

Berk, Marc L. and Shur, Claudia L., Access to Care: How much difference does Medicaid Make?, Health Affairs, 1998, 17(3), 169-180.

Berk, Marc L. and Shur, Claudia L., Measuring Access to Care: Improving Information for Policy Makers, Health Affairs, 1998, 17(1), 180-186.

Daniels, Norman and Sabin, James, Limits to Healthcare: Fair Procedures, Democratic Deliberation and the Legitimacy Problem for Insurers, Philosophy and Public Affairs, 304-348.

Daniels, Norman and Sabin, James, The Ethics of Accountability in Managed Care Reform, Health Affairs, 1998, 17(5), 50-64.

Fisher, Elliott S. Weinberger, John E., Stukel, Therese A., Skinner, Sandra M., Freeman, Jean L., Littlesohn, Alan M., Associations Among Hospital Capacity, Utilization, and Mortality of US Medicare Beneficiaries, Controlling for Sociodemographic Factors, 2000, 34:6

Gabbott, Mark and Hogg, Gillian, Grounds for Discriminating: Establishing Criteria for Evaluating Health Services, The Services Industries Journal, 1995, 15(1), 90-101.

Gamble, John E., Icenogle, Marjorie L., Bryan, Norman B., Rickert, Daniel A., The Effects of Open Access on Member Satisfaction and Intentions to Remain in an HMO, Healthcare Management Review, 2000 25(4), 34-47.

Gold, Marsha and Stevens, Beth, Synopsis and Priorities for Future Efforts, HSR: Health Services Research, 1998, 33(3), 611-713.

Mackay, Niccie L. and Coventry, John A., Access Implications of Rural Hospital Closures and Conversions, Hospital and Health Services Administration, 1995, 40(2), 227-261.

Mummalaneni, Venkatapparao and Gopalknistran Pradeep, Access, Resource, and Cost Impacts on Consumer Satisfaction with Healthcare: A comparison across alternative health care models and times, Journal of Business Research, 1997, 39, 173-186.

Weinberger, Morri, Oddone, Eugene Z., Henderson, William G., Does Increased Access to Primary Care Reduce Hospital Readmissions?, The New England Journal of Medicine, 1996, 334 (22), 1441-1447

### ***Care Pathways:***

Canadian Healthcare Association (CHA) and Canadian Medical Association (CMA), Integrating Clinical Practice Guidelines into Canadian Healthcare Facilities, Ottawa, 1996.

Clinical Indicator Data Collection Forms, 1996, 1-13.

Ellis, Brian W. and Johnson, Sue., A clinical view of pathways of care in disease management, International Journal of Health Care Quality Assurance, 1997, 10 (2), 61-66.

Graham, Ian., Appraisal Instrument for Canadian Clinical Practice Guidelines, Loeb Health Research Institute, March 2000.

Lakeridge Health Corporation and Hamilton Health Sciences Centre, Markers of Quality in Paths, March 2000.

The Toronto Hospital, Handbook for the development of Care Guides and Clinical Indicator Data Collection Forms, January 1996.

Weinstein, Judith and Hockley, Jennifer, Paths for System Improvement.

## APPENDIX A: GLOSSARY

---

### SURVEY OBJECTIVES

1. To determine admission, discharge, and exclusion criteria across the GTA Rehabilitation Network for Ministry of Health and Long Term Care designated beds, ambulatory care spaces, and home-based rehabilitation.
2. To identify issues related to access and coordination
3. To describe the current state of rehabilitation
4. To determine the system's capacity for rehabilitation in the GTA.

### SCOPE OF THE SURVEY

**The survey uses the following definition of rehabilitation:** Rehabilitation is a highly multidisciplinary process offered through a complex array of public and private programs and services through multiple providers at different settings, to individuals with impairments, activity limitations and participation restrictions in order to identify and reach their optimal mental physical and or social functional level through a client focused partnership with family, providers and the community. Rehabilitation focuses on abilities and aims to facilitate social interaction and independence (*modified from MOH Policy Draft, 1999*).

**This survey will focus on publicly funded rehabilitation programs and services. For the purpose of this survey, we will not include rehabilitation services which are:**

- WSIB, automobile insurance, and private
- Short Term Disability/Long Term Disability Insurance
- Physician offices as funded by OHIP
- Long Term Care- Physiotherapy, Occupational Therapy, not funded through CCAC
- private clinics, providers
- geriatric activation and reactivation
- offered by children's treatment centres
- consultative as opposed to treatment-based

**For the purpose of this survey, rehabilitation program must meet the following criteria**

- Time-limited
- Goal oriented
- Involve multidisciplinary/multiple providers
- Responsive, dynamic, potential for functional improvement/independence
- Directed by a regulated health professional

### PROGRAMS

For the purpose of this survey, a rehabilitation program exists when designated rehabilitation beds are further designated by population group as per the categories outlined by the OHA Working Group. Where designated rehabilitation beds and spaces are not further designated by population group, the service is referred to as "general rehabilitation".

**APPENDIX A: GLOSSARY****POPULATION GROUPS**

Source: OHA Rehabilitation Working Group, Rehabilitation Program Definitions March 1999

<b>Acquired Brain Injury (ABI)</b>	A program designed to maximize function in individuals with acquired brain injuries. An ABI is defined as damage to the brain which occurs after birth and is not related to a congenital disorder or a degenerative disease. The brain damage may be due to a traumatic injury to the head or by conditions such as anoxia or infection.
<b>Amputee</b>	A program designed to assist patients with upper and/or lower extremity amputation. Specialized rehabilitation services, including assessment, preventative measures, treatment, and discharge planning are provided to amputees, promoting their optimal level of function.
<b>Burns</b>	A program designed to provide rehabilitation to burn patients with full to partial thickness burns including upper and lower extremity quadrants. Burn patients suffering from multiple trauma, amputations and musculoskeletal injuries are also admitted to the program. These patients are admitted from acute care institutions for wound and scar management, pain management, physical rehabilitation, voice therapy, customized garment service, hydrotherapy, IV therapy and psychosocial support.
<b>Cardiac</b>	A program designed to limit the physiologic and psychological effects of cardiac illness; reduce risk for sudden death or re-infarction; control cardiac symptoms; stabilize or reverse the arteriosclerotic process and enhance the psychosocial and vocational status of selected patients.
<b>Chronic Pain</b>	A program designed to help patients manage chronic non-malignant pain by minimizing the impact of pain, increase the physical function and activity levels, improve psychological well being and community integration, while reducing reliance on health care providers, services and pain related medications.
<b>Geriatric</b>	A program designed to optimize the elderly and often pre-morbidly frail individual who has experienced a loss of independence due to an acute illness/injury. This is often superimposed on chronic medical and functional problems. Treatment interventions are tailored to meet the needs of those elderly patients who are less appropriate for traditional rehabilitation programs due to limited tolerance, diminished pre-morbid functional capacity, complicated medical problems, or impaired cognition.
<b>Musculoskeletal</b>	A program designed to provide rehabilitation to patients with an injury or disorder/disease of bone, joint or muscle and/or other systemic diseases whose course or complication result in musculoskeletal impairments.
<b>Neurology</b>	A program designed to provide rehabilitation to patients exhibiting functional deficits of neurogenic origin other than stroke, including Multiple Sclerosis, Parkinson's, Guillain-Barre Syndrome, Amyotrophic Lateral Sclerosis (ALS), dystrophies, palsies, brain tumors, encephalopathies and other neurological conditions.

**APPENDIX A: GLOSSARY**

<b>Oncology</b>	A program designed for patients suffering from loss of function caused by a malignant process or associated with the surgical pharmacological or radiation treatment of a tumour. The principal impairments include weakness due to nerve dysfunction, de-conditioning, circulatory problems such as lymphadenopathies, joint contractures and disabling pain.
<b>Respiratory</b>	A program for patients with a variety of problems affecting the respiratory system including Chronic Obstructive Pulmonary Disease (COPD) (asthma, emphysema, chronic bronchitis), cystic fibrosis, restrictive pulmonary syndromes, (thoracic resections, lung transplant, pulmonary fibrosis), and neuromuscular diseases (ALS, muscular dystrophy, polio).
<b>Spinal Cord</b>	A program designed to provide services for patients with disabling diseases or injury of the spinal cord. Those diseases or injuries may be static (trauma, vascular, congenital, infectious, inflammatory, extramedullary tumours) or degenerative (multiple sclerosis, syringomyelia, spinal stenosis, autoimmune, genetic, intra-medullary tumours).
<b>Stroke</b>	A program designed to provide rehabilitation to patients exhibiting rapid development of clinical signs of local disturbance in blood supply to the brain secondary to a thrombotic, embolytic or haemorrhagic event(e.g. Acute Brain Attack).
<b>Trauma</b>	A program designed to provide rehabilitation using a systems approach to patients suffering from serious traumatic injuries or major trauma in which there is multi-system derangement.

**TYPICAL NEEDS ADDRESSED**

Sources: CIHI, National Pilot Project, Minimum Data Set, February 1999

Functional Independence Measures (FIM)

McDowell, I. and Newell, C. Measuring Health. A guide in scales and questionnaires. (2<sup>nd</sup> ed.) New York: Oxford University Press, p., 523.

<b>Transfers</b>	All aspects of transferring to and from a bed, chair and wheelchair or coming to a standing position, if walking is the typical mode of locomotion. Also includes getting on and off a toilet and getting into and out of a tub or shower stall (FIM)
<b>Swallowing/ Nutrition</b>	Nutritional activities assist a client achieve or maintain a level of functional ability in the nutritional domain. Examples include counseling, diet and nutrition teaching, meal planning, special diet planning/monitoring (CIHI)
<b>Wound Care</b>	Includes caring for <ul style="list-style-type: none"> <li>• Chronic ulcer of the skin (decubitous ulcer and pressure sore)</li> <li>• Other skin and other subcutaneous tissue conditions (CIHI)</li> </ul>
<b>Locomotion</b>	Includes walking once in a standing position or if using a wheelchair, once in a seated position on a level surface. Also includes going up and down 12 to 14 stairs without any type of handrail or support. (FIM)

**APPENDIX A: GLOSSARY**

<b>ADL (bathing, eating, dressing)</b>	Activities of Daily Living (ADL) are concerned with more severe levels of disability relevant mainly to institutionalized patients and to the elderly. Activities included under the heading of ADLs are bathing, dressing, toileting, and eating. (McDowell, I. and Newell, C.)
<b>IADL (shopping, cleaning)</b>	Instrumental Activities of Daily Living (IADL) extend the ADL theme to cover tasks that require a finer level of motor co-ordination than is necessary for the relatively gross activities covered in ADL scales. IADL cover activities needed for continued community residence. (McDowell, I. and Newell,C.)
<b>Cognition</b>	Activities that assist a client achieve or maintain a level of functional ability in the cognitive domain. Examples include: memory skills training, problem solving skills training, decision making skill training, counseling. Comprehension includes understanding of either auditory or visual communication.
<b>Speech</b>	Expression includes clear vocal or non-vocal expression of language. This item includes either intelligible speech or clear expression of language using a writing or a communication device (FIM)
<b>Bowel and Bladder Management</b>	<p>Bladder management includes complete and intentional control of the urinary bladder and if necessary use of equipment or agendas to bladder control. The Functional goal is to open the urinary sphincter only when that is needed and to keep it closed the rest of the time This may require devices, drugs, or assistance in some individuals.</p> <p>Bowel management includes complete and intentional control of the anal sphincter. The functional goal of bowel management is to open the anal sphincter only when that is needed and to keep it closed the rest of the time. This may require devices, drugs, or assistance in some individuals. (FIM)</p>
<b>Psychosocial</b>	Activities that assist a client achieve or maintain a level of functional ability in the psycho-social domain. examples: life skills training, psychotherapy, coping skills, counseling (CIHI)

## APPENDIX A: Survey

### INSTRUCTIONS

Thank you for your participation in the GTA Rehabilitation Network's Access/Coordination, Service Inventory and Gaps, and Quality Care Survey. Your input is integral to the success of this project. Attached, you will find a glossary which outlines the survey's scope and objectives and provides clarification on some of the terms used.

Please complete the survey by following the instructions below:

1. **Only complete sections relevant to your organization by noting the instructions at the top of each page.**
2. Note the specific definitions used when describing your rehabilitation programs, services, and population groups (see glossary).
3. **For pages 2 and 3**, please complete by site if you are a multi-site organization. If on the other pages, there are site specific issues you would like to highlight, please use the margins or attach a separate page.
4. **For pages 4-15**, please note the following.
  - *If you have designated rehabilitation beds or spaces which are further designated by population group (programs)* as defined by the OHA Working Group (see glossary), **please photocopy pages 5-15 and complete a separate set for each program.**
  - *If your designated rehabilitation beds or spaces are not divided by program*, please use the term "general rehabilitation" to describe your service and complete only one set of questions.
  - *If you have non-designated rehabilitation beds or no rehabilitation beds*, **please complete pg. 2,3,4,10, and 15 only.**
5. **Should you require assistance in completing this survey, please call Tina Saryeddine at the GTA Rehabilitation Network Tel. (416) 597- 3422 x. 3924**
6. For your convenience, this survey will be provided to you as both an electronic file and as a paper copy. Complete only one.
7. Return your completed survey via email or post by **Monday December 4, 2000** to  
Tina Saryeddine, Project Coordinator/Planner, GTA Rehabilitation Network  
550 University Avenue, 11<sup>th</sup> floor, Toronto, M5G 2A2  
Email: Saryeddine.Tina@torontorehab.on.ca

**PART I: THIS PAGE IS TO BE COMPLETED BY ALL ORGANIZATIONS. MULTI SITE ORGANIZATIONS SHOULD PHOTOCOPY THIS PAGE AND COMPLETE BY SITE .**

**Name and Telephone of Contact person**

**Organization**

**Site (if applicable)**

To which of the following **population groups** do you offer inpatient (specify the number of designated (**#DRB**) and non designated beds (**#NDRB**), ambulatory care, and community **rehabilitation** services (please mark with an (X)) See glossary for definitions.

	Adult								Paediatric **							
	Inpatient				Amb Care *		Comm		Inpatient				Amb care *		Comm	
	Yes	No	#DRB	#NDRB	Yes	No	Yes	No	Yes	No	#DRB	#NDRB	Yes	No	Yes	No
Acquired Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amputee	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burns	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurology	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oncology	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(\*) Must be institution-based, includes day hospital (\*\*) Children and youth under the age of 18.

**THIS PAGE IS TO BE COMPLETED BY ALL ORGANIZATIONS. MULTI SITE ORGANIZATIONS SHOULD PHOTOCOPIY THIS PAGE AND COMPLETE ONE FOR EACH SITE.**

**ORGANIZATION**

**SITE (if applicable)**

<i>Please indicate Yes or No ( with an (X)) to each of the following questions:</i>		<b>Yes</b>	<b>No</b>	<b>Comments (if any)</b>
<b>Do you provide rehabilitation in non-designated rehabilitation:</b>	Beds	<input type="checkbox"/>	<input type="checkbox"/>	
	Spaces	<input type="checkbox"/>	<input type="checkbox"/>	
<u>If yes</u> , are these non-designated beds/spaces	Acute care beds	<input type="checkbox"/>	<input type="checkbox"/>	
	Alternate level of care beds	<input type="checkbox"/>	<input type="checkbox"/>	
	Complex Continuing Care beds	<input type="checkbox"/>	<input type="checkbox"/>	
	Community	<input type="checkbox"/>	<input type="checkbox"/>	
	Ambulatory Care Spaces	<input type="checkbox"/>	<input type="checkbox"/>	
	Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	
	Available to external clients	<input type="checkbox"/>	<input type="checkbox"/>	
	Used for internal transfers	<input type="checkbox"/>	<input type="checkbox"/>	

<i>Please indicate Yes or No ( with an (X)) to each of the following questions:</i>	<b>Inpatient</b>		<b>Ambulatory</b>		<b>Community</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>Do you provide single service/discipline rehabilitation?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you provide rehabilitation programs or services for third party payers (e.g. WSIB)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART II: THIS PAGE IS TO BE COMPLETED BY ALL ORGANIZATIONS**  
**ORGANIZATION**

POPULATION GROUP	Care Pathway Use: For each population, please indicate with an (X) the phase(s), if any, in which care pathways are used at your organization.			Patient Satisfaction: For each population, please indicate with an (X) the phases in which patient satisfaction is formally monitored (i.e. You may need to check all if you survey all patients)			Survey Tools: For populations in which patient satisfaction is formally monitored, indicate with an (I) if the survey tool was developed in-house or an (E) if the survey tool was developed by an external vendor			Provider Perception: Please indicate with an (X) the three (3) populations in each phase of care whose needs you feel are <b>least</b> addressed		
	<i>phase of care</i>	<i>Acute</i>	<i>Rehab</i>	<i>Comm</i>	<i>Acute</i>	<i>Rehab</i>	<i>Comm</i>	<i>Acute</i>	<i>Rehab</i>	<i>Comm</i>	<i>Acute</i>	<i>Rehab</i>
Acquired Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amputee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	I <input type="checkbox"/> E <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART III: FOR DESIGNATED REHABILITATION BEDS AND SPACES ONLY**

***IF YOU DO NOT HAVE DESIGNATED BEDS OR SPACES PROCEED TO PAGE 10***

**Rehabilitation Programs:** For the purpose of this survey, a "program" exists when designated rehabilitation beds or spaces are further designated by population group as identified by the OHA Working Group.

If your designated rehabilitation beds are further designated by population group, please photocopy pages 5-15 and complete one set of questions for each program.

If you have designated rehabilitation beds which are not further designated by population group, please use the term "general rehabilitation" and complete only one questionnaire.

**Name of person completing survey**

**Telephone**

**Email Address**

**Organization**

**Program (or general rehabilitation):**

***PART IV: FOR DESIGNATED REHABILITATION BEDS AND SPACES ONLY. IF YOU HAVE DESIGNATED BEDS OR SPACES FURTHER DESIGNATED BY POPULATION GROUP (PROGRAM) BUT ARE NOT ABLE TO DIFFERENTIATE YOUR STAFFING BY PROGRAM, PLEASE INDICATE "ALL PROGRAMS" AND COMPLETE AS A TOTAL.***

<b>ORGANIZATION</b>	<b>PROGRAM</b> (or general rehab)
---------------------	-----------------------------------

Are you able to distinguish inpatient and outpatient staffing (if no, complete only the table for "TOTAL" ( below)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you have designated beds by population group, can you provide staffing by program?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**INPATIENT Rehabilitation Staffing** *please complete/validate attached data from GTA Rehab Network's HSRC survey 04/00*

FTEs	RN	RPN	OT	OTA	PT	PTA	SLP	SW	Clin. Nutr.	Psych.
budget 00/01										
budget 99/00										
vacant 10/31/00										

**OUTPATIENT Rehabilitation Staffing** *please complete/ validate attached data from GTA Rehab Network's HSRC survey 04/00*

FTEs	RN	RPN	OT	OTA	PT	PTA	SLP	SW	Clin. Nutr.	Psych.
budget 00/01										
budget 99/00										
vacant 10/30/00										

**TOTAL Rehabilitation Staffing** *please complete/ validate attached data from GTA Rehab Network's HSRC survey 04/00*

FTEs	RN	RPN	OT	OTA	PT	PTA	SLP	SW	Clin. Nutr.	Psych.
budget 00/01										
budget 99/00										
vacant 10/30/00										

**Please specify the professionals captured in "OTHER"**

**FOR DESIGNATED REHABILITATION BEDS AND SPACES ONLY**

<b>ORGANIZATION</b>	<b>PROGRAM</b> (general rehab)
---------------------	--------------------------------

	Inpatient		Ambulatory		Community	
	Yes	No	Yes	No	Yes	No
Can you provide the # of separations/ discharges by program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Activity:** Please state whether or not the following measures are available and provide data where possible.

For designated rehabilitation beds/spaces only	Availability of Information			Amount	Comments
	YES	NO	N/A	actual Apr.1'99-Mar.31'00	
<b>INPATIENT</b>					
Number of beds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Number of separations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Patient days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Percentage occupancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>AMB CARE/COMM</b>					
Number of visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Number of new referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Number of spaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

	Inpatient		Ambulatory		Community	
How many days per week do you offer therapy?						
What are your hours of operation						
Do you offer therapy on week-ends	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

*FOR DESIGNATED REHABILITATION BEDS ONLY*  
**ORGANIZATION** **PROGRAM** (or general rehab)

**Typical Needs Addressed INPATIENTS** (please refer to the glossary for definitions and complete for each column

<b>(check or answer those which apply)</b>	<b>Transfers</b>	<b>Swallowing /Nutrition</b>	<b>Wound Care</b>	<b>Loco-motio</b>	<b>ADL</b> (bathing, eat, dress)	<b>IADL</b> (shopping/ cleaning )	<b>Cognition</b>	<b>Speech</b>	<b>Bowel and bladder mgmt</b>	<b>Psycho-social</b>
We provide this service independently										
We do not provide this service <u>but we refer to (specify):</u>										
Our patients do not have these needs										
There is no suitable program to address the needs of our patients										

**FOR DESIGNATED REHABILITATION SPACES ONLY**  
**ORGANIZATION** **PROGRAM** (or general rehab)

**Typical Needs Addressed: OUTPATIENT (please see attached definitions and complete for each column)**

Clinical Committees Survey Report: Current Status of Rehabilitation in the GTA

<b>(check or answer those which apply)</b>	<b>Transfers</b>	<b>Swallowing /Nutrition</b>	<b>Wound Care</b>	<b>Loco-motio</b>	<b>ADL</b> (bathing, eat, dress.)	<b>IADL</b> (shopping/ cleaning )	<b>Cognition</b>	<b>Speech</b>	<b>Bowel and bladder mgmt</b>	<b>Psycho-social</b>
We provide this service independently										
We do not provide this service <u>but we refer to (specify):</u>										
Our patients do not have these needs										
There is no suitable program to address the needs of our patients										

*FOR ALL ORGANIZATIONS UNLESS YOU DO NOT REFER PATIENTS TO OTHER ORGANIZATIONS FOR REHABILITATION*  
**ORGANIZATION** **PROGRAM** (or general rehab)

**FOR ORGANIZATIONS THAT REFER** **TO INPATIENT PROGRAMS** **TO COMMUNITY/**

<b>PATIENTS OUT FOR REHABILITATION</b>			<b>AMBULATORY CARE</b>	
Name the five (5) organizations to which you refer most frequently for rehabilitation	1.		1.	
	2.		2.	
	3.		3.	
	4.		4.	
	5.		5.	
Name the organizations with which there are <b>formal</b> agreements/ Memorandums of Understanding	Organization's Name	Program/Population Group	Organization's name	Program/Population Group
How many facilities do you refer to for each referral?				
Who initiates the referral:				
Who sends the referral:				
Who does the follow-up:				
<i>Please describe or attach your policy on the choice of facilities to which you apply.</i>				
<p><b>FOR DESIGNATED REHABILITATION BEDS AND SPACES ONLY</b>  <b>IF YOU DO NOT HAVE DESIGNATED REHABILITATION BEDS OR SPACES PROCEED TO PAGE 15</b>  <b>ORGANIZATION</b> <span style="float: right;"><b>PROGRAM</b> (or general rehab)</span></p>				

<b>FOR ORGANIZATIONS THAT ACCEPT REFERRALS FOR REHABILITATION</b>	INPATIENT		COMMUNITY/AMBULATORY	
Name the five (5) organizations that refer to you most frequently	1.		1.	
	2.		2.	
	3.		3.	
	4.		4.	
	5.		5.	
Name the organizations with which there are <b>formal</b> agreements or Memorandums of Understanding	Organization's Name	Program/Population Group	Organization's Name	Program/Population Group
Number of days of the week that admission occurs				
Hours of the day during which admissions take place				
Maximum number of patients admitted per day				

<b><i>FOR DESIGNATED REHABILITATION BEDS AND SPACES ONLY</i></b>	<b>ORGANIZATION</b>
	<b>PROGRAM</b> (general rehab)

<b>ADMISSION CRITERIA</b> (Please attach your written criteria if available. If written criteria do not	INPATIENT (indicate if criteria is attached)	COMMUNITY/AMBULATORY (indicate if criteria is attached)
---	---	--

Clinical Committees Survey Report: Current Status of Rehabilitation in the GTA

<b>address specific questions, please complete).</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
From where do your referrals originate (check all that apply or specify which others):	hospital <input type="checkbox"/> community <input type="checkbox"/> LTC <input type="checkbox"/> other (specify)	hospital <input type="checkbox"/> community <input type="checkbox"/> LTC <input type="checkbox"/> other (specify)
Age (please give the range)		
Diagnosis		
Medical issues: i.e. weight bearing, medical stability		
Exclusion criteria (please specify/attach)		
Which patients are not suitable for your beds/spaces (e.g. those that need a secure space)		
Please describe your catchment area if available <i>(omit this question if you are a regional program)</i>		
Under what circumstances if any do you admit patients outside that area ?		
What is the average <u>expected</u> length of stay for the program/service?		
<b>FOR DESIGNATED REHABILITATION BEDS AND SPACES ONLY</b>		
<b>ORGANIZATION</b>	<b>PROGRAM</b> (or general rehab)	

<b>COORDINATION</b> Indicate yes or no (with an X) to each question	<b>INPATIENT</b>		<b>COMMUNITY/AMBULATORY</b>	
<b>Is your program accessed through :</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>

Written application from a health provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone referral from a health provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written application from a physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone referral from a physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have written material describing the admission process? (if yes, please attach)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you have a pre admission program?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you have an admissions committee?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how often does it meet?				
What is the turn around time for an application? (i.e. receipt, review, decision)				

<b>Waiting Lists for Rehabilitation Beds/Spaces:</b>	<b>INPATIENT</b>	<b>COMMUNITY/AMBULATORY</b>
Is your waiting list managed externally or by your organization	externally <input type="checkbox"/> by the organization <input type="checkbox"/> by site <input type="checkbox"/>	externally <input type="checkbox"/> by the organization <input type="checkbox"/> by site <input type="checkbox"/>
Is your waiting list managed by program or discipline	program <input type="checkbox"/> discipline <input type="checkbox"/>	program <input type="checkbox"/> discipline <input type="checkbox"/>
Is your waiting list managed manually or is it automated	manually <input type="checkbox"/> automated <input type="checkbox"/>	manually <input type="checkbox"/> automated <input type="checkbox"/>
What are the three most commonly experienced problems with respect to the management of your waiting lists? ( <i>i.e. patients on multiple lists, current information regarding patient status, availability of beds etc.</i> )		

<b>FOR DESIGNATED REHABILITATION BEDS AND SPACES ONLY</b>	
<b>ORGANIZATION</b>	<b>PROGRAM</b> (or general rehab)

Do you currently collect the following information on rehabilitation patients? (please mark yes or no with an X)	Inpatient		Ambulatory Care		Community	
	YES	NO	YES	NO	YES	NO
Number of people accepted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of people admitted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of people refused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of people admitted elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reasons for refusal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People accepted or refused by organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you currently collect the following performance indicators to monitor access?</b>						
Rate of refusal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time frame for review of applications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)						

<b>DISCHARGE CRITERIA:</b> Please attach (if available) or specify below	<b>INPATIENT</b> Discharge criteria attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>COMMUNITY/AMBULATORY</b> Discharge criteria attached? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Criteria</b>		
<b>In your opinion which three factors most influence discharge. i.e. policies or issues</b>		

**TO BE COMPLETED BY ALL ORGANIZATIONS**  
**ORGANIZATION** \_\_\_\_\_ **PROGRAM** (or general rehab)

**ACCESS&COORDINATION** To what extent do you experience the following barriers to access to the NEXT LEVEL OF CARE. (5 is very often; 1 is never)

BARRIER	INPATIENT						COMM/ AMB CARE						COMMENTS
	5	4	3	2	1	N/A	5	4	3	2	1	N/A	

Clinical Committees Survey Report: Current Status of Rehabilitation in the GTA

---

Provider availability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physician availability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Availability of expertise/specialties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical facility issues (ex. secure facilities)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Availability of medical equipment (ex. O <sub>2</sub> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Availability of prosthesis, AAC, seating, and supportive devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Language barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs of special populations (e.g. behavioural, homeless, mentally ill.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uninsured/Out of Province	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Out of country	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Availability specialty programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Availability of patient information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please specify)														
<b>Are there interpretation services?</b>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>					<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>		
<b>Do you offer services in French?</b>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>					<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>		

## **APPENDIX B: List of Survey Participants**

### **Regional Rehabilitation Centres**

- Bloorview MacMillan Centre
- St. John's Rehabilitation Hospital
- Toronto Rehabilitation Institute
- West Park Healthcare Centre

### **Acute Teaching Hospitals**

- Mt. Sinai Hospital
- St. Michael's Hospital
- Sunnybrook & Women's College Health Sciences Centre
- University Health Network

### **Community Hospitals**

#### **Durham Region Community Hospitals**

- Lakeridge Health Corporation
- Rouge Valley Health System - Ajax Site

#### **Halton Peel Community Hospitals**

- Credit Valley Hospital
- Halton Healthcare Services Corporation
- Trillium Health Centre
- William Osler Health Centre

#### **Toronto Community Hospitals**

- Humber River Regional Hospital
- St. Joseph's Health Centre
- The Scarborough Hospital
- Toronto East General and Orthopaedic Hospital
- North York General Hospital
- Rouge Valley Health System - Centenary Site

#### **York Region Community Hospitals**

- Markham Stouffville Hospital
- Southlake Regional Health Centre
- York Central Hospital

### **Complex Continuing Care with Rehabilitation**

- Baycrest Centre for Geriatric Care
- Providence Centre
- The Riverdale Hospital

### **Community Care Access Centres**

- Community Care Access Centre of Halton
- Community Care Access Centre of Peel
- Community Care Access Centre of York Region
- Durham Access To Care
- East York Access Centre for Community Services
- Etobicoke Community Care Access Centre
- North York Community Care Access Centre
- Scarborough Community Care Access Centre
- Toronto Community Care Access Centre
- York Community Care Access Centre

## **APPENDIX B: List of Member Organizations in the GTA Rehab Network**

- Baycrest Centre for Geriatric Care
- Bloorview MacMillan Centre
- Community Care Access Centre of Halton
- Community Care Access Centre of Peel
- Community Care Access Centre of York Region
- Credit Valley Hospital
- Durham Access To Care
- Durham, Haliburton, Kawartha and Pine Ridge District Health Council\*
- East York Access Centre for Community Services
- Etobicoke Community Care Access Centre
- Halton Healthcare Services Corporation
- Halton-Peel District Health Council\*
- Humber River Regional Hospital
- Lakeridge Health Corporation
- Markham Stouffville Hospital
- Ministry of Health and Long-Term Care\*
- Mt. Sinai Hospital
- North York Community Care Access Centre
- North York General Hospital
- Providence Centre
- Regional Geriatric Program of Toronto\*
- Rouge Valley Health System
- Scarborough Community Care Access Centre
- The Scarborough Hospital
- Simcoe-York District Health Council\*
- Southlake Regional Health Centre
- St. John's Rehabilitation Hospital
- St. Joseph's Health Centre
- St. Michael's Hospital
- Sunnybrook & Women's College Health Sciences Centre
- Toronto Acquired Brain Injury Network\*
- Toronto Community Care Access Centre
- Toronto District Health Council\*
- Toronto East General & Orthopaedic Hospital
- Toronto Rehabilitation Institute
- Trillium Health Centre
- University Health Network
- University of Toronto\*
- West Park Healthcare Centre
- William Osler Health Centre
- York Central Hospital
- York Community Care Access Centre

\* *ex-officio member*

## APPENDIX C: Recommendations from Past Initiatives

The Clinical Committee survey was developed with a view to build on the work of past initiatives and move forward in the direction of an integrated rehabilitation system. To ensure that the initiative build on the outcomes and recommendations of previous initiatives were reviewed and considered the following in the development process (Table 2).

Common recommendations for next steps made by each of the documents reviewed included:

- lack of common terminology as an impeding factor in the collection and subsequent use of valid information in planning for rehabilitation services.
- need for a description of the current rehabilitation service delivery system and the system's capacity. A list of the full range of providers, including CCACs, rehabilitation and acute care hospitals, as well data tracking tools and databases currently utilized was recommended.
- a more detailed review of the accessibility, waiting list, and admission issues faced by patients and providers.

**TABLE 2: Review of past initiatives relating to the Clinical Committee Survey**

<b>Report/Initiative</b>	<b>Objectives</b>	<b>Requirements Identified/ Next Steps</b>
<i>Rebuilding Ontario's Health System</i> , July 1997, pp. 58-64.  <i>Change and Transition</i> , April 1998.  <b>Health Service Restructuring Commission</b>	To identify issues, planning parameters, and recommendations for the organization and delivery of rehabilitation services.	<ul style="list-style-type: none"> <li>• A classification system that is relevant for inpatient, outpatient, and in-home rehabilitation</li> <li>• Standardized data collection and analysis.</li> <li>• Information/data on utilization of in-home and outpatient rehabilitation and outcome data</li> <li>• Mechanisms to promote linkages between inpatient, outpatient, and in-home providers or rehabilitation services, as well as mechanisms to facilitate integration across the sectors</li> <li>• Develop definitions for the full range of institution and community-based services</li> <li>• Study the case mix of rehabilitation patients</li> </ul>
<i>Environmental Scan and Analysis of the Public and Private Rehabilitation Sectors</i> , July 1998.  <b>ARA Consulting Group</b>	Identification of issues and trends in adult outpatient rehabilitation	<ul style="list-style-type: none"> <li>• Information on patient flow</li> <li>• Methodology for determining need</li> <li>• Need for increase in quantitative data</li> </ul>
<i>Rehabilitation Program Definitions</i> , March 1999.  <b>OHA- Rehabilitation Working Group</b>	Examine and further clarify rehabilitation programs identified by the HSRC in April' 98 .	Recommends four planning considerations for future initiatives: <ul style="list-style-type: none"> <li>• Resource limitations</li> <li>• Flexibility</li> <li>• Critical Mass</li> <li>• Proximity</li> </ul>

<b>Report/Initiative</b>	<b>Objectives</b>	<b>Requirements Identified/ Next Steps</b>
<p><i>An Inventory of Rehabilitation Services in Toronto, York, Peel, Halton and Durham</i>, January 2000</p> <p><b>GTA Rehab Network</b></p>	<p>Prepare an inventory describing publicly funded rehabilitation services provided by hospitals, community service agencies, and CCACs in the GTA/905 region.</p>	<ul style="list-style-type: none"> <li>• More intensive investigation into hospital and community program could ensure that there are accessible and comprehensive programs for all Toronto Regions</li> <li>• Examine eligibility criteria</li> <li>• Investigation of human resource capabilities by individual organization and by hospital would ensure that benchmarks on number of professional per clients are appropriate.</li> </ul>
<p><i>Managing the Seams: Making the Rehabilitation System work for People</i>, March 2000</p> <p><b>Provincial Rehabilitation Reference Group</b></p>	<p>To provide a planning framework to develop locally relevant rehabilitation service delivery plans</p> <p>To provide the MOHLTC with a planning framework that will facilitate resource allocation decisions and improve coordination</p>	<ul style="list-style-type: none"> <li>• Identify and describe client groups</li> <li>• Account for individual with multiple diagnosis</li> <li>• Describe who provides which services by location, client group</li> <li>• Needs Assessment mechanisms</li> <li>• A description of current system</li> <li>• A description of system capacity</li> <li>• Identify data tracking tools and mechanisms currently collected.</li> </ul>

**APPENDIX D: Literature Review on Access Measures**

<b>USER</b>	<b>DEFINITION</b>
<b>Canada Health Act</b>	“By virtue of section 12 [the five tenets of the Canada Health Act] the health care insurance plan of a province must provide for: a. insured health services on uniform terms and conditions and reasonable access by insured persons to insured health services un-precluded or unimpeded either directly or indirectly by charges or other means”
<b>Canadian Council for Health Services Accreditation</b>	Access to a consistent range of core services may not always mean that services are present in each community, especially where services are highly specialized or when a local population is widely dispersed. Those services however should be made available to each community through appropriate support measures.
<b>Change Foundation, CIBC, Andersen Consulting</b>	Defined by population need, proximity of service, and patient transfer.
<b>Provincial Rehabilitation Reference Working Group “Managing the Seams”</b>	Access to a consistent range of core services may not always mean that services are present in each community, especially where services are highly specialized or when a local population is widely dispersed. Those services however, should be made available to each community through appropriate support measures.
<b>National Library of Medicine</b>	The degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system. Factors influencing this availability include geographic, architectural, transportation, and financial considerations among others

<b>Article Reviewed</b>	<b>Relevant Findings to Committee Initiative</b>
<b>Measuring access to care: Improving Information for Policymakers</b>	<p>Commentary on issues with measuring access</p> <p>“two of the most important problems underlying our effort to provide consistent and meaningful information are the lack of agreement about standards for measuring access from an operational point of view and lack of consensus about the conceptual definition of access”</p> <p>“the future of health policy would be well served by reconciling the different perspectives of the research and policy making communities”</p> <p>Measures identified:</p> <ul style="list-style-type: none"> <li>• Inability to obtain care</li> <li>• Insurance coverage</li> </ul>
<b>Archives of Physical Rehabilitation v.76, 1995</b>	Availability of information providers, follow up service, location and choice
<b>Access, Resource and Cost Impacts on Consumer Satisfaction with Health Care</b>	Identified 5 access related aspects of the delivery system and three resource based variable of care. Convenient location, emergency care, office hours for non emergency care, parking facilities and waiting time

Article Reviewed	Relevant Findings to Committee Initiative
	<p>Identified 3 related resource variables</p> <ul style="list-style-type: none"> <li>• Availability of hospitals</li> <li>• Availability of family doctors</li> <li>• Availability of medical specialists</li> </ul>
<p><b>Grounds for Discrimination: Establishing Criteria for Evaluating Health Services</b></p>	<p>Physical accessibility: transportation, parking, Treatment accessibility: hours of operation and range of specialty clinics</p>
<p><b>Synopsis and Priorities for Future efforts</b></p>	<p>Highlights key points and themes from the Robert Wood Johnson Symposium on Access</p> <ul style="list-style-type: none"> <li>• Access to care is a multidimensional concept that continues to evolve over time</li> <li>• Patients and clinicians differ in their views of access. Patients value outcomes but focus on convenience, timeliness, and other service aspects. Providers tend to focus on outcomes, quality etc.</li> <li>• Concept of Access and its measurements are value laden. Different access definitions have different imply different view points and cost implications</li> <li>• Access definitions blur with concepts like quality, satisfaction, effectiveness, and outcomes.</li> </ul>
<p><b>Measuring access to care through population based surveys: where are we now?</b></p>	<ul style="list-style-type: none"> <li>• Reviewed 9 National American Access Surveys for whether or not they contained the following categories of questions to measure access. The number of surveys that included the category is shown in brackets.</li> <li>• Encouragement of preventive care (2)</li> <li>• Well child care (4)</li> <li>• Immunization (4)</li> <li>• Attitude toward source of care (6)</li> <li>• Quality of overall medical care (7)</li> <li>• Availability of medical care (7)</li> <li>• Ease if getting to physician (7)</li> <li>• Costs (3)</li> <li>• Influence of insurance plan (1)</li> <li>• Overall satisfaction (4)</li> <li>• Choice of providers (5)</li> <li>• Referrals to specialists (4)</li> </ul>

## **APPENDIX E: Definition of Access**

For the purpose of this report, the Access and Coordination committee is using the following **definition of access**:

The degree to which individuals are inhibited or facilitated in the ability to gain entry to and to receive care and services (1) from insured health services on uniform terms and conditions (2) to a consistent range of required core services (3) in the most appropriate setting and at the right time based on their respective needs (4). This may not always mean that services are present in each community, especially where services are highly specialized (3). *(1) National Library of Medicine 2) Canada Health Act (3) Managing the Seams (4) AIMS Standards.*

The definition of access chosen by the committee is based on definitions which are used by:

- the National Library of Medicine
- the Canada Health Act
- Managing the Seams
- Canadian Council of Health Services Accreditation.

(Appendix D)