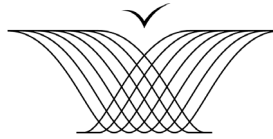


GTA REHAB
NETWORK

*Analysis of Alternate Level of Care
(ALC) Snapshots:*

*Patients Awaiting Rehabilitation in ALC
and
Inpatient Rehabilitation Capacity*

May 2004



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Inpatient Rehabilitation Capacity***

May 2004

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
FULL REPORT	7
1.0 Background and Introduction	7
1.1 Greater Toronto Area Rehabilitation Network.....	7
1.2 Alternative Level of Care (ALC) Task Group.....	7
1.3 The Conceptual Framework.....	7
1.4 ALC Snapshots	8
1.5 Analysis of Findings and Report Format.....	9
2.0 Analysis: Patients Awaiting Rehab Placement in ALC	10
2.1 Prevalent Rehab Groups.....	10
2.2 Referral Status of Patients Awaiting Rehab in ALC.....	10
2.3 Average Number of Days Awaiting Rehabilitation in ALC.....	12
2.4 Time of Rehab Referral Relative to ALC Designation.....	12
2.5 Low Tolerance, Long Duration Rehabilitation (LTLTD)/Slow Stream Rehabilitation.....	13
2.6 Coexisting Conditions.....	14
3.0 Inpatient Rehabilitation Capacity	15
3.1 Pre-SARS Survey and Capacity.....	15
3.2 Patients Accepted and Expected to Transfer into Rehab Facilities.....	15
3.3 Inpatient Rehabilitation Discharges and Admissions.....	15
4.0 Combined Analysis Comparing Patients Awaiting Rehab in ALC and Inpatient Rehab Capacity	17
4.1 Number of Patients Awaiting Rehabilitation in ALC vs. Number of Designated Beds Available at Time of Snapshots	17
4.2 Referral Patterns.....	17
5.0 Summary of Key Findings	19
6.0 Summary of Key Questions Arising from the Data Analysis	20
6.1 Prevalence of Specific Population Groups Awaiting Rehab in ALC.....	20
6.2 Reasons Why Patients are Not Accepted.....	20
6.3 Use of ALC Definition.....	20
6.4 Number of Days Patients are Awaiting Rehab in ALC.....	20
6.5 Access to Available Capacity.....	21

(continued)

7.0	Summary of Recommendations for Consideration.....	22
7.1	Recommendations Pertaining to Communication.....	22
7.2	Recommendations Pertaining to Rehab Readiness, ALC Designation and Referral Process.....	23
7.3	Recommendations Pertaining to the Continuum of Care.....	24
7.4	Recommendations Pertaining to Population Specific Initiatives.....	24
7.5	Overall Recommendation.....	24
8.0	Implications and Next Steps.....	25
8.1	Activities to Improve the Referral Process.....	25
8.2	Activities to Improve Patient Flow.....	25
8.3	Activities to Improve Patient Access.....	26
8.4	Future Surveys/Snapshots.....	26
	TABLES.....	27
	APPENDICES.....	40
A.	GTA Rehab Network ALC Task Group Members.....	40
B.	Sample Surveys.....	41
C.	Organizations that Responded to the Survey for Each of the Snapshots.....	44
D.	Organizations Surveyed According to Regions.....	45
E.	Organizations Surveyed According to Organization Type.....	46
F.	References.....	47

EXECUTIVE SUMMARY

In early 2003, the report of the Greater Toronto Area (GTA) Rehabilitation Network, “*Measuring and Managing Supply and Demand: A Waiting List Information Management Proposal for Musculoskeletal Rehabilitation in the GTA*”, identified challenges in interpreting waiting list information. The report outlined the need to quantify and better identify the types of patients waiting for rehabilitation, the services for which they are waiting and the reasons for waiting. Members of the GTA Rehabilitation Network had similarly noted problems with patients accessing inpatient rehabilitation from acute care. In response to these identified concerns, the GTA Rehab Network incorporated a focus on issues related to alternate level of care (ALC) patients into its operating plan of 2003-2004.

The GTA Rehab Network was subsequently contacted by the Ontario Ministry of Health and Long-Term Care (MOHLTC) with a request to conduct an inventory of patients awaiting inpatient rehabilitation in ALC during the Severe Acute Respiratory Syndrome (SARS I & II) outbreaks in the Spring of 2003. In the spring/summer of 2003, the ALC Task Group was established with representation from acute care, inpatient rehabilitation and community organizations. The objective of the ALC Task Group was to conduct a review of patients waiting in ALC beds in organizations across the Greater Toronto Area (GTA) to enhance understanding of patient flow issues, identify patient populations experiencing difficulty accessing rehabilitation and determine how to improve access.

Accordingly, the Network conducted a series of five snapshots across the GTA between April and September 2003 to capture detailed information about not only the patients awaiting rehabilitation, but also the rehab capacity across all Network member organizations with designated adult inpatient rehab beds. The ALC Task Group convened in July 2003 to begin to review and interpret the data from these snapshots.

The following report includes an analysis of the findings and questions arising from the snapshot data. A series of recommendations and an implementation plan proposed by the ALC Task Group is also included with the report.

The following report provides an account of the data analysis in the following format:

- Patients Awaiting Inpatient Rehabilitation in Alternative Level of Care
- Inpatient Rehabilitation Capacity
- Combined Analysis Comparing Patients Awaiting Rehabilitation in ALC (demand) and Rehabilitation Capacity (supply)
- Summary of Key Findings
- Summary of Key Questions Arising from the Data Analysis
- Summary of Recommendations for Consideration
- Implications and Next Steps
- Tables (*Summary of data where applicable*)
- Appendices

Each data element under each category of the report includes a discussion of the data and an analysis according to overall snapshots, by region and then by organization type. Please note that the data reported in this report is complex and detailed and should not be taken out of context. Any questions for clarification should be directed to the GTA Rehab Network office at (416) 597-3057.

Summary of Key Findings

The analysis of the ALC snapshots led to the identification of several issues that could be addressed to minimize the overall ALC days in the GTA. These issues have been identified with supporting data throughout the report. The following points are a summary of the overall key findings of all five snapshots:

Patients Awaiting Rehab in ALC

- Of all patients awaiting rehab in ALC from the regions surveyed, (Halton, Peel, Durham, York and Toronto) 88% were in the Toronto Region Hospitals.
- Of all patients awaiting rehab in ALC, 53% were in 4 acute teaching hospitals while 47% of patients were spread across 14 community hospitals.
- The most prevalent rehab groups awaiting rehab in ALC were musculoskeletal (28%), stroke/neurology (22%), geriatric (20%) and acquired brain injury (10%).
- Across all five snapshots, 53% of patients awaiting rehab in ALC were referred to only one organization for rehabilitation. It was also noted that referral patterns across some organizations are well established, regardless of bed availability.
- Of the referrals made for patients awaiting rehab in ALC, 23% were made prior to ALC designation, 44% were made on the same day and 33% were made after ALC designation.
- Of all the referrals made for patients awaiting rehab in ALC, 46% of referrals had not received a response at the time of the snapshot. Of these referrals with no responses, 46% of referrals were sent on the day of the snapshot or 1 day prior to the snapshot date; 24% of referrals were sent 2 to 5 days prior to the snapshot date; and 30% of referrals were sent more than 5 days prior to the snapshot date.
- Of the referrals for which program details were provided, 22% of patients awaiting rehab in ALC were in need of low tolerance, long duration (LTLTD) rehabilitation.

Rehab Capacity

- Of all patients occupying inpatient rehabilitation beds, 5.1% were ready for and awaiting discharge; 51% of whom were awaiting long-term care.
- The greatest apparent shortfalls in inpatient rehab capacity in decreasing order existed for respiratory, stroke/neurology, geriatric, musculoskeletal and acquired brain injury populations; the greatest apparent excess of inpatient rehab capacity existed for amputee, cardiac and trauma populations.
- Referrals are often sent to a few organizations with little or no capacity instead of other organizations with more available capacity.

Summary of Key Questions Arising from the Data Analysis

Although the analysis of the data resulted in several key findings, the following additional areas require further exploration:

1. Prevalence of specific population groups awaiting rehab in ALC

The data from the snapshots indicate that certain population groups (i.e. patients in need of MSK, Stroke/Neurology, Geriatric and ABI rehab) comprise the most prevalent groups awaiting rehab in ALC. The data regarding rehab capacity show that the distribution of rehab beds generally matches the demand for rehab beds by the most prevalent rehab populations. The capacity to accommodate Geriatric patients in specifically-designated Geriatric rehab beds is less clear because these patients are often admitted to General as well as Geriatric rehab beds.

Although the distribution of rehab beds generally matches the distribution of the most prevalent rehab populations, patients nevertheless encounter difficulties in accessing rehab beds quickly and additional data is needed to further delineate barriers to accessing inpatient rehabilitation. The GTA Rehab Network's Admission Information Website, which will be launched in the summer of 2004, will provide detailed program descriptions of rehabilitation programs and services across the GTA. An examination of these program details will help to further identify where particular rehab populations can be accommodated and which rehab facilities can accept patients with special needs. The website will also provide information regarding the programs that accept only internal referrals and those that can be more widely accessed by external referral sources.

2. Reasons why patients are not accepted

Although asked in the survey, specific reasons why some patients awaiting rehab in ALC were not accepted by rehab facilities remains unclear. Obtaining more specific and detailed information will help determine whether reasons for non-acceptance are related to discrepancies between referring and rehab facilities in their

understanding of rehab readiness, lack of appropriate resources to accommodate specific patient needs, or reduced capacity relative to demand. The Network's Electronic Referral and Wait List System will include the development of a standard response form and the tracking of reasons for when patients are waitlisted or declined.

3. Use of ALC Definition

The extent to which organizations are aware of and make consistent use of the definition of ALC is unknown. The Toronto District Health Council defines an ALC patient as follows:

A patient who is considered a non-acute treatment patient but occupies an acute care bed. This patient is awaiting placement in a chronic care unit, home for the aged, nursing home, rehabilitation facility, other extended care institution or home care programs etc. The patient is classified as an ALC when the patient's physician gives an order to change the level of care from acute care and requests a transfer to another facility¹.

The analysis of the data from the snapshots revealed that 77% of referrals were made either on the day of or after ALC designation. Although the reasons to account for this may be related to the need for clearer guidelines regarding rehab readiness, it may also be associated with inconsistencies in organizations' understanding and application of the definition of ALC.

4. Number of Days Patients are Awaiting Rehab in ALC

The data from the snapshots do not indicate how long patients are awaiting rehab in ALC. The data captured reflect the length of time patients were waiting in ALC as of the date of the snapshot only and therefore do not capture total length of stay. When considering the number of repeat patients between snapshots (approximately 30 days apart), most patients had a length of stay of less than 30 days in ALC. However, the data do not distinguish whether patients are generally waiting less than five days or more than 20 days. Generally, if a patient is waiting in ALC for less than five days, this could be considered a reasonable wait owing to the time required to review and respond to a referral. However, we cannot determine from the data if patients are waiting longer, which could be an indication of several issues that may need to be addressed. For instance, is there a lack of resources in the system to accommodate these patients resulting in longer wait times in ALC? Are patients who are designated ALC not quite 'ready for rehab' and need more time to convalesce before they are ready for rehab? Is some form of transitional care therefore needed for these patients? Are referrals for these patients being made to the appropriate programs? Are referrals for these patients being made to programs that have available capacity and the ability to accommodate specific special needs?

5. Access to Available Capacity

The survey data indicate that many rehab facilities with available capacity for specific rehab groups were not receiving referrals, while a significant number of patients awaiting rehab in ALC were being referred to facilities with little or no capacity. However, it is unclear from the survey data why rehab facilities with available capacity were not being accessed. Are referring organizations unaware of the services and resources offered by all rehab facilities? Do these rehab facilities that have capacity lack specific resources to accommodate special needs being sought by referring facilities? Are these rehab facilities geographically not preferred? During April and June 2003, some rehab units were vacant but were closed due to SARS I and SARS II. Although there was more excess capacity during these two snapshots, some organizations still had excess capacity and were still not receiving referrals during the other post-SARS snapshots. Further exploration is needed to assess why these facilities with available capacity are not being accessed before any further recommendations can be determined.

¹ Toronto District Health Council, *First Annual Toronto's Health System Report Card* (Toronto, 1999), p. 9

Summary of Recommendations

Based on the analysis of the snapshots throughout the report, the following outlines the key recommendations proposed by the ALC Task Group. The recommendations have been classified into the following five categories:

- Recommendations pertaining to Communication
- Recommendations pertaining to Rehab Readiness, ALC Designation and the Referral Process
- Recommendations pertaining to the Continuum of Care
- Recommendations pertaining to Population Specific Issues
- Overall Recommendation

Recommendations Pertaining to Communication

- a) **Providers should indicate specific reasons as to why patients are not accepted or waitlisted.**
This would assist in the development of more appropriate and efficient referral processes. Also, this detail would indicate which patient populations and special needs are not being met.
- b) **Response times should be standardized even if it means providing a response of “review of application is still in process.” Recommend that responses shall be provided within two business days of application receipt.**
This would help improve accountability, transparency and turnaround times in the patient referral/acceptance processes.
- c) **Develop a system to increase awareness of and transparency around resource availability to accommodate special needs.**
This would increase the efficiency of the referral process by providing information about the types of patient needs that can be accommodated in each facility. This information could also be used to further delineate which patient population needs are not being met.
- d) **A standard referral form should be developed and used to provide information on specific resource needs.**
A standard referral form would encourage more consistency and transparency when communicating the needs required by the patients being referred. Creating a standard form would increase the likelihood of including more appropriate detail on a patient’s status and specific rehab needs. This would increase the efficiency of the overall referral/response process and would prevent response delays due to lack of information.

Current Initiatives/Related Projects

- GTA Rehab Network Referral and Response Form Task Group (as per recommendations in the GTA Rehab Network’s *Measuring and Managing Supply and Demand Report*):
This Task Group is involved in developing forms for MSK rehab to improve communication and transparency in the referral/response process, which would include standardizing response times to minimize system delays. These forms are being developed with a view to applying the learning to other rehab populations.
Target: All rehab hospitals
- GTA Rehab Network’s Admission Information Website:
This initiative provides information on rehab programs/services offered by member organizations through the use of the web-based template on the Network’s website to enhance knowledge of and access to rehab programs/services in the GTA and the special needs that each program can accommodate.
Target: All rehab hospitals

Recommendations Pertaining to Rehab Readiness, ALC Designation and Referral Process

- a) **A common checklist/guideline should be developed to determine when patients are ready for rehab**
Determining predictors or descriptors for rehab readiness would increase efficiency and transparency of the placement process by encouraging standard and consistent communication and understanding of a patient's status and rehab needs.
- b) **Organizations should strive to submit referrals at least 2 days before ALC designation.**
Encouraging facilities to submit patient referrals at least 2 days before ALC designation when it is anticipated that the patient will benefit from rehab will help to obtain an earlier response from a rehab facility and thus minimize the overall number of days in ALC.
- c) **Organizations should send referrals to more than one rehab program as appropriate.**
This practice would optimize access to rehab by ensuring that rehab referrals are reviewed by more than one facility.
- d) **A centralized routing mechanism for rehab referrals should be considered to increase efficiency of the referral process, ensure referrals are sent to programs offering services to appropriately accommodate the needs of the patient and to better manage the waitlist for multiple referrals.**
This information would encourage a more efficient referral process by centralizing all information on resources and availability of services to accommodate patient needs thereby improving the access and utilization of information for the referral process.

Current Initiatives/Related Projects:

- GTA Rehab Network's Admission Information Website:
This initiative provides information on rehab programs/services offered by member organizations through the use of the web-based template on the Network's website to enhance knowledge of and access to all rehab programs/services in the GTA.
- The Electronic Referral and Wait List System:
This initiative, pending Ministry of Health and Long-Term Care support, will pilot a centralized electronic referral routing system for MSK rehab referrals.
Target: Acute Care Facilities, Rehab Facilities

Recommendations Pertaining to the Continuum of Care

- a) **A review should be conducted to determine why and how long patients in inpatient rehabilitation are waiting for placement.**
Implementation of a system to track patients in inpatient rehab who are ready for discharge but are awaiting placement should be considered. Because delays in discharge from rehab have a direct impact on the movement of patients from acute care to rehab, a tracking system would help to identify and address reasons for delays in discharge of these patients from rehab.
- b) **Organizations should increase flexibility as able and appropriate around the use of available beds in the system to accommodate rehab population groups with higher demand.**

Current Initiatives/Related Projects:

- The GTA Rehab Network's Long Term Care Task Group has made recommendations to the Placement Forum Steering Committee of the Toronto District Health Council to improve the management of the waiting list for long term care referrals and the prioritization policies regarding transfer of patients to long-term care referrals.
Target: GTA Rehab Network, Rehab Facilities

Recommendations Pertaining to Population Specific Initiatives

- a) **Conduct a review of the most prevalent rehab groups (MSK, Stroke/Neurology, Geriatric and ABI) and least prevalent groups (Chronic Pain, Burn and Trauma) with respect to the capacity of rehab services available for each population. Determine if the distribution and quantity of resources is adequate, appropriate and able to meet the needs of patients awaiting rehab in ALC.**
- b) **Conduct a review to determine capacity available to accommodate population specific patients in need of Low Tolerance, Long Duration (LTLTD) rehab**

Current Initiatives/Related Projects:

- To be conducted by the ALC Task Group
Target: GTA Rehab Network, ALC Task Group

Overall Recommendation

A monitoring body should be established to oversee the implementation of these recommendations.

Current Initiatives/Related Projects:

- Establishment of a new ALC Task Group to improve referral processes, optimize patient flow and enhance access to inpatient rehabilitation.
Target: GTA Rehab Network ALC Task Group

Implications and Next Steps

Upon conclusion of the ALC Analysis Report, the current ALC Task Group disbanded with a final recommendation that a Monitoring Body be established to oversee the implementation of the recommendations from the report. Members from the ALC Task Group will be participating on this Monitoring Body.

The recommendations from the report will be used as part of the foundation for future initiatives and operating plans of the GTA Rehab Network and its various projects. A number of the recommendations proposed are currently being addressed by various initiatives within the GTA Rehab Network. The following report will outline the snapshot analysis in more detail, identify the key findings and issues and provide an implementation plan for the recommendations and initiatives proposed.

FULL REPORT

1.0 BACKGROUND AND INTRODUCTION

1.1 Greater Toronto Area Rehabilitation Network

The Greater Toronto Area Rehabilitation Network is a collaboration of organizations in the Greater Toronto Area (GTA) that are involved in the planning and provision of rehabilitation services. It was established in 1999, on the recommendation of the Health Services Restructuring Commission (HSRC).

Vision

The vision of the Greater Toronto Area Rehabilitation Network is to create an integrated rehabilitation system that is responsive to clients and their families and achieves equitable and timely access to quality services at the right time and in the right place.

Mission

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

1.2 Alternate Level of Care (ALC) Task Group

In early 2003, the report of the Greater Toronto Area (GTA) Rehabilitation Network, “*Measuring and Managing Supply and Demand: A Waiting List Information Management Proposal for Musculoskeletal Rehabilitation in the GTA*”, identified challenges in interpreting waiting list information. The report outlined the need to quantify and better identify the types of patients waiting for rehabilitation, the services for which they are waiting and the reasons for waiting. Members of the GTA Rehabilitation Network had similarly noted problems with patients accessing inpatient rehabilitation from acute care.² In response to these identified issues, the GTA Rehab Network incorporated a focus on issues related to alternate level of care (ALC) patients into its Operating Plan of 2003-2004.

The GTA Rehab Network was subsequently contacted by the Ontario Ministry of Health and Long-Term Care (MOHLTC) with a request to conduct an inventory of patients awaiting inpatient rehabilitation in ALC during the Severe Acute Respiratory Syndrome (SARS I & II) outbreaks in the Spring of 2003. In the spring/summer of 2003, the ALC Task Group was established with representation from acute care, inpatient rehabilitation and community organizations. The objective of the ALC Task Group was to conduct a review of patients waiting in ALC beds in organizations across the Greater Toronto Area to enhance understanding of patient flow issues, identify patient populations experiencing difficulty accessing rehabilitation and determine how to improve access.

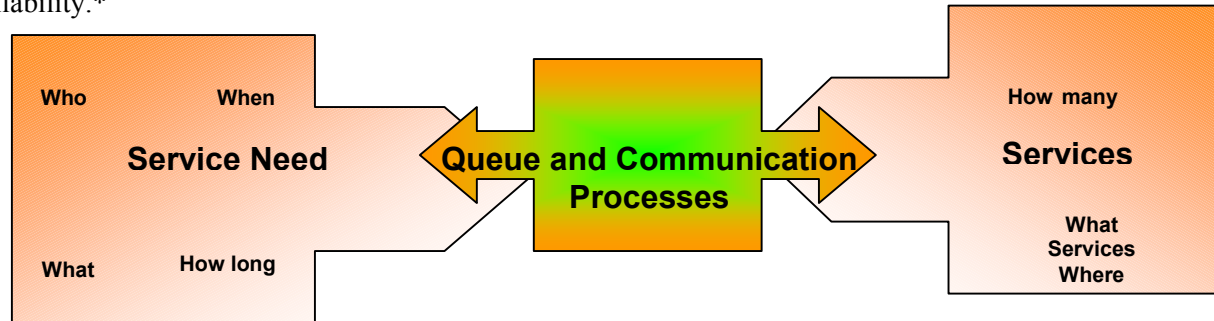
Accordingly, the Network conducted a series of five snapshots across the GTA between April and September 2003 to capture detailed information about not only the patients awaiting rehabilitation, but also the rehab capacity across all Network member organizations with designated adult inpatient rehab beds. The ALC Task Group convened in July 2003 to begin to review and interpret the data from these snapshots.

1.3 The Conceptual Framework

The surveys used to conduct the inventory were based on a conceptual framework adapted from the GTA Rehab Network’s Waiting List Information Management Task Group, (2003). The framework in Figure 1 illustrates the interface between rehab service need and rehab service availability related to the transition of care.

² Rafferty, C., *Presentation to GTA Rehab Network Waiting List Information Management Task Group* (December, 2001)

Figure 1: Framework for the conceptualization of rehab service needs of patients in ALC and rehab service availability.*



*From the Rehab Network's "Measuring and Managing Supply and Demand: A Waiting List Information Management Proposal for Musculoskeletal Rehabilitation in the Greater Toronto Area."
(As adapted from Markel, F. & Rafferty, C., Joint Planning and Policy Committee (Toronto, 2001))

The first component is *service need*. This section of the framework includes:

- Who: The characteristics of the patients awaiting rehab in ALC (i.e. age, gender, diagnosis);
- What: The rehab services needed by those patients awaiting rehab in ALC;
- When: How soon the rehab services are needed by patients awaiting rehab in ALC;
- How long: How long they have been waiting or should wait.

The second component is *services*. This section of the framework includes:

- What: The types of rehab services available;
- Where: The location and relative distribution of these rehab services;
- How many: The capacity and availability of these rehab services and the types of patients that can be accommodated in these programs.

The third and linking component is the *queue and communication processes*. This section of the framework illustrates the process between the transitions of care and includes:

- The referral processes;
- The review of patient applications;
- The matching of service need and availability.

By capturing data on the need for inpatient rehabilitation (as per patients in ALC), relative to the availability of these resources, this initiative has enhanced understanding of patient groups awaiting inpatient rehabilitation in ALC beds, referral processes and patient flow issues. This initiative has also helped to identify areas where further work can occur to improve access to rehabilitation.

1.4 ALC Snapshots

As per the initial request from the MOHLTC, the GTA Rehab Network conducted two surveys at the end of April 2003: one of patients in Toronto Region Hospitals in Alternate Level of Care beds awaiting rehabilitation and one of current rehab capacity across all Network members with designated adult inpatient rehab beds (Appendix B). The surveys were distributed electronically to program leaders in each organization. These surveys were repeated in mid-May and mid-June to collect comparison data and better understand patient flow issues in accessing rehabilitation across the system.

Two additional surveys were conducted in July and September 2003 to reflect the resumption of operations post-SARS and post-summer bed closures respectively. During these periods, the snapshots of patients awaiting rehab in ALC were expanded to include all GTA Rehab Network hospitals, not just those in Toronto Region hospitals as per the first three surveys. In addition, rehab programs were also asked to further differentiate the number of patients who were ready to be discharged to include those awaiting Complex Continuing Care and to specify from where patients were admitted.

The snapshots were conducted on the following dates:

- April 25, 2003
- May 14, 2003
- June 10, 2003
- July 24, 2003
- September 24, 2003

For the rehab capacity survey, organizations were also asked to report expected admissions and discharges five days post snapshot dates and to indicate the number of patients on their waiting list for each program.

Organizations were asked to return the surveys on the day following the snapshot via email or fax. Organizations that responded are listed in Appendix C.

1.5 Analysis of Findings and Report Format

The following report provides an account of the data analysis in the following format:

- Patients Awaiting Inpatient Rehabilitation in Alternative Level of Care
- Inpatient Rehabilitation Capacity
- Combined Analysis Comparing Patients Awaiting Rehabilitation in ALC (demand) and Rehabilitation Capacity (supply)
- Summary of Key Findings
- Summary of Key Questions Arising from the Data Analysis
- Summary of Recommendations for Consideration
- Implications and Next Steps
- Tables (*Summary of data where applicable*)
- Appendices

Each category provides details of the data analysis with supporting figures. ***The data analysis includes: a summary of the data across all five snapshots; a regional breakdown of the data; and further analysis by hospital type (i.e. acute teaching, community, rehabilitation hospital groups).*** This is followed by a discussion of the findings, additional ‘Questions Arising from the Data’, and ‘Additional Points for Consideration’. A more detailed summary of the data is available in the *Tables* section and is referred to throughout this report.

Notes:

Toronto Region Data versus Aggregate Average Data

The data analysis was also conducted from a regional perspective. (See Appendix D for organizations according to regions.) Please note: given the higher volumes of patients awaiting rehab in ALC in the Toronto region, the aggregate data also reflect the data as reported for the Toronto region alone. Of the total number of patients awaiting rehab in ALC across all five snapshots (385), Toronto region had 338 (88%); whereas, Halton/Peel had 30 (8%), Durham had 9 (2%) and York had 8 (2%). As a result, the Toronto region data is strongly reflected in the average of the aggregate data. The data from York, Durham and Halton/Peel regions vary significantly from the this average, but are not apparent in the overall aggregate average due to the relatively higher volumes of the Toronto region data. It should also be noted that because the volume of patients in York, Durham and Halton/Peel regions is small, it is difficult to draw conclusions regarding any trends or patterns of significance.

Acute Teaching Hospital Data versus Community Hospital Data

An analysis of the data has also been conducted from the perspective of organization types (acute teaching, community and rehabilitation). It is important to note that the overall data for acute teaching hospitals reflects only ***four organizations***, all of which are ***limited to the Toronto region***. (Organizations are listed in Appendix E). On the other hand, the overall data for the community hospitals comprises ***14 organizations that have ALC beds and are dispersed across all four regions (Toronto, Durham, Halton/Peel and York)***. Note: the data for the rehabilitation hospitals includes six organizations.

2.0 ANALYSIS: PATIENTS AWAITING INPATIENT REHABILITATION IN ALC

Each snapshot consisted of two surveys. One survey was designed to gather data on patients who were awaiting rehab in ALC. The following analysis provides details of the key findings from the data.

2.1 Prevalent Rehab Groups

The most prevalent rehab groups³ of patients awaiting rehabilitation in ALC across all FIVE snapshots were Musculoskeletal (MSK) (28% or 108/385), Stroke/Neurology (22% or 85/385), Geriatric (20% or 77/385) and Acquired Brain Injury (ABI) (10% or 40/385). Of these, 61-71% were identified as having special needs. Both genders were represented in the MSK, Stroke/Neurology and Geriatric rehab groups with slightly greater representation of females in the MSK (64%) and Geriatric (61%) groups. However, gender representation in the ABI group is predominantly male (95%).

The least prevalent rehab groups were Chronic Pain (0% or 0/385), Burn (0.3% or 1/385) and Trauma (1% or 4/385). Because the number of patients in these groups is low, no significant conclusions regarding patient characteristics and trends can be drawn from the data.

(Refer to Tables 2.1-1 to 2.1-2)

Regional Analysis:

Patients in need of MSK rehab comprised the most prevalent rehab groups in all but one of the regions, York Region. In Toronto, 27% of ALC patients (91/338) required MSK rehab. In both Halton/Peel (10/30) and Durham (3/9), 33% of ALC patients were waiting for MSK rehab. Although the percentage of patients awaiting MSK rehab in Halton/Peel and Durham was higher than in Toronto, the total number of patients in Toronto is far greater than in the other regions. In York Region, patients in need of Geriatric rehab were most prevalent comprising 38% (3/8) of all patients awaiting rehab in ALC in the region. In Toronto, the least prevalent rehab groups were Trauma, 1% (4/338) and Burn, ~0% (1/338). In the other regions, several rehab groups had no patients in ALC awaiting rehab.

(Refer to Table 2.1-3 and Table 2.1-4)

Analysis by Organization Type:

Of the total number of patients awaiting rehab in ALC, 53% or 204/385 were waiting in one of the four acute teaching hospitals, all four of which are located in the Toronto region; whereas 46% or 181/385 were from the 14 community hospitals dispersed across all regions in the GTA.

Of the patients awaiting rehab in ALC in the acute teaching hospitals, the most prevalent rehab groups in decreasing order were patients in need of MSK (27%), ABI (17%), Stroke/Neurology (16%) and Geriatric (15%) rehab services. In the community hospitals, the most prevalent rehab groups were similar: MSK (29%), Stroke/Neurology (29%) and Geriatric (26%). However, there were relatively fewer patients in ALC beds in need of ABI rehab services in the community hospitals than in the acute teaching hospitals. This is likely due to the greater number of neurosurgery and trauma programs located in the acute teaching hospitals.

(Refer to Table 2.1-5)

QUESTIONS ARISING FROM THE DATA

- Why are certain population groups awaiting rehab in ALC more prevalent than others?

2.2 Referral Status of Patients Awaiting Rehab in ALC

The total number of patients awaiting rehabilitation in ALC across all five snapshots was 385. Of these, 348 patients had had referrals made on their behalf at the time of the snapshots.

³ Note: Individual patients awaiting rehab placements were classified into rehab groups based on patient characteristics and programs to which they were referred and not solely based on the diagnosis.

Data analysis of patients accepted and waitlisted reveal that both genders are fairly equally represented with the exception of patients with ABI who were predominantly male (92% or 22/24). This finding for patients with ABI is consistent with overall incident rates for ABI. The analysis also shows that, as expected, the most prevalent rehab population groups in ALC are equivalent to the rehab population groups most commonly waitlisted and accepted for inpatient rehabilitation. This pattern suggests that patients who are waitlisted are not a reflection of population-specific issues. Instead, possible reasons why patients are wait-listed may be related to resource issues (e.g. insufficient rehab bed capacity and/or staffing), placement issues (e.g. the clinical complexity of the patient cannot be accommodated), clinical issues (e.g. a lack of consistent understanding regarding ‘rehab readiness’), or policy issues (e.g. patient chooses to wait for their preferred facility)⁴:

Overall, there were 649 referrals made on behalf of patients awaiting rehab in ALC across the five snapshots. Of these, 74 or 11% of the referrals were not accepted. The most common rehab population groups not accepted for inpatient rehabilitation include: Stroke, MSK, Amputee and ABI. Reasons for patients not being accepted were rarely provided and were often vague. Of the reasons that were provided in the surveys, common ones included: patients are not appropriate for the program; patients are more appropriate for a slow stream program; the sites are not accepting patients (due to SARS-related bed closures); and sites do not have appropriate equipment. A better understanding of the reasons patients are not accepted or waitlisted would help address the issues that prevent access and acceptance to facilities.

(Refer to Tables 2.2-1a to 2.2-1f)

Table 2.2-1g details the number of days since a referral was made for patients who had not received a response at the time of the snapshot. At the time of the snapshots, a total of 649 referrals were made for the 385 patients awaiting rehab in ALC across all five snapshots. Of these, 46% or 296/649 had not yet received a response. However, almost half of these referrals with no responses (46% or 136/296) were made within 0 to 1 day of the snapshot date and it may be that facilities were still in the process of reviewing referral applications. Nevertheless, the majority of the referrals with no response (54% or 160/296) were made more than 2 days before the snapshot and of these 30% (89/296) were made more than 5 days before the snapshot date.

(Refer to Table 2.2-1g)

Regional Analysis:

Of the 649 referrals made for patients awaiting rehab in ALC beds, 637 or 98% of referrals were made to rehab programs in the GTA and the majority were sent to facilities in the Toronto region (93% or 591/637). Halton/Peel region received 4% or 27/637 of all referrals. York Region received 1% or 9/637 referrals and Durham region received 2% or 10/637 referrals. Two per cent of referrals or 12/637 were made to regions outside of the GTA.

Of the 74 referrals that were not accepted, patients in need of Stroke/Neurology rehab were most commonly not accepted by facilities in Toronto (31% or 22/71). Although York and Durham regions each had one referral for Stroke/Neurology not accepted, all other referrals in these regions were accepted. Durham region had no non-acceptances across all snapshots. However, the volume of patients in York and Durham regions is too small to draw any conclusions of significance.

(Refer to Table 2.2-2)

Referrals by Organization Type:

The majority of rehab referrals made to organizations within the GTA (92% or 588/637) were sent to the six rehab facilities in Toronto (See Appendix D & E for distribution of hospitals by region and hospital type). Seven per cent (46/637) were made to community hospitals in Halton/Peel, York and Durham regions.

QUESTIONS ARISING FROM THE DATA

- How can a better understanding be obtained around why patients are not accepted or waitlisted?
- Why are patients deemed not appropriate by the facility to which they were referred?
- How long does it take a response to be received once a referral has been made?

⁴ GTA Rehab Network, *Measuring and Managing Supply and Demand: A Waiting List Information Management Proposal for Musculoskeletal Rehabilitation in the Greater Toronto Area* (Toronto, 2003)

ADDITIONAL POINTS FOR CONSIDERATION:

- Encourage organizations to provide specific reasons for delays in reviewing applications and non-acceptance of referrals. If rehabilitation providers indicated specific reasons as to why patients are not accepted or waitlisted, then more appropriate and efficient referral processes can be proposed. Also, this detail would indicate which patient-population needs are not being met.
- Determine individual response times to referrals and identify specific population groups or characteristics that correlate with longer response times.
- Consider standardizing the referral response process to increase transparency and efficiency in the system.

2.3 Average Number of Days Awaiting Rehabilitation in ALC⁵

The patient data captured by the snapshots indicate that the majority of patients are not waiting for rehab for more than one month⁶. There were nine patients common across the April and May snapshots and eight across May and June. There were three patients that were common across the April, May and June snapshots. No repeat patients were identified across the July and September snapshots. However, in contrast to the April, May and June snapshots, the July and September snapshots represent a 60-day span between snapshots.

As for the types of patients waiting, the data suggest that there are fewer patients in need of respiratory and spinal cord rehab in ALC compared to other populations, but these patients generally wait longer in ALC. These patients typically require specialized equipment and treatment.

(Refer to Tables 2.3-1)

QUESTIONS ARISING FROM THE DATA

- What criteria are used to determine if rehab patients in ALC are waiting too long; is there an acceptable target? What is the length of stay of patients awaiting rehab in ALC?
- Are some populations more likely to wait longer in ALC?

2.4 Time of Rehab Referral Relative to ALC Designation

The data indicate significant variations between the time of referral to inpatient rehabilitation relative to ALC designation. The majority of patients were referred to inpatient rehabilitation on the same day (44% or 154/348) or prior (23% or 79/348) to ALC designation. However, 33% or 114/348 patients were referred to inpatient rehabilitation post ALC designation. Of these, 7% or 26/348 of patients were referred to rehab more than 14 days after ALC designation and one patient was not referred until 53 days after his/her ALC designation. Upon analysis of the characteristics of patients who were referred more than 14 days post-ALC designation, 100% or all 27/27 had complex special needs. Also, 75% or 20/27 of these patients for whom program details were provided were in need of slow stream rehab.

(Refer to Table 2.4-1)

Regional Analysis:

The majority of patients (89% or 308/348) referred to rehab across all five snapshots were referred from hospitals in the Toronto region. Peel referred 8% or 28/348 of all patients to rehab; York referred 2% or 8/339 of all patients to rehab; and Durham referred 2% or 7/339 of all patients referred to rehab. These figures, in conjunction with the finding that the majority of referrals (93%) were sent to facilities in the Toronto region, demonstrate that the movement of ALC patients from acute care to rehab largely occurs within the Toronto region.

Of the 308 patients referred from hospitals in Toronto, the majority (70% or 217/308) were referred either before ALC designation (23% or 72/308) or on the same day as ALC designation (47% or 145/308). The majority of patients in Durham (50% or 2/4) were also referred either before or on the same day as ALC designation.

⁵ Indicates time in ALC as of the day of the snapshot, not total time in ALC.

⁶ When considering the number of repeat patients common across snapshots (approximately 30 days apart), most patients had a length of stay of less than 30 days in ALC.

In contrast, the majority of referrals from Halton/Peel (61% or 17/28) and York (63% or 5/8) were made after ALC designation, generally within 1-7 days post ALC designation.
(Refer to Table 2.4-2)

Analysis by Organization Type:

Of all the patients in ALC who were referred to rehab, 52% or 182/348 were from acute teaching hospitals whereas 48% or 166/348 were from community hospitals. The distribution of when referrals were made relative to ALC designation shows that 75% or 135/183 of referrals by acute teaching hospitals were made either before or on the same day as ALC designation. Almost half (41% or 68/166) of referrals by community hospitals were made after ALC designation.
(Refer to Table 2.4-3)

Note: There are a total of four acute teaching hospitals whereas there are a total of 14 community hospitals that were included in the snapshots. (Indicated in Appendix E)

QUESTIONS ARISING FROM THE DATA

- When should patients be designated ALC? Do we need a consensus panel to develop a standard definition and/or characteristics of rehab readiness?
- When should patients be referred to rehab relative to ALC designation?

ADDITIONAL POINTS FOR CONSIDERATION:

- Convene a consensus panel to develop guidelines as to when patients are appropriate for rehab and when referrals should be made.
- Hospitals need to consider a more standardized discharge planning process to ensure consistency in the designation of ALC and the initiation of referrals for rehab.

2.5 Low Tolerance, Long Duration Rehabilitation (LTLT)/Slow Stream Rehabilitation

Of all referrals for which program details were provided across all five snapshots, 22% or 78/348 of patients who were referred and awaiting rehab in ALC were in need of a low tolerance, long duration rehab program. The data indicate that of the patients awaiting LTLT rehab in ALC, patients in need of Stroke and Geriatric rehab comprised the largest group. Patients in need of Stroke rehab alone comprise 31% or 24/78 of all patients waiting for LTLT rehab; patients in need of Geriatric rehab comprised 28% or 22/78 and all other rehab groupings comprise 41% or 32/78. Because program details specifying the need for LTLT were not provided with each referral, it is unclear if Stroke and Geriatric populations may be more likely to need LTLT rehab compared to other rehab groups.
(Refer to Table 2.5-1a)

Regional Analysis:

Similar to the overall data, referrals for LTLT rehab were predominantly made to Stroke and/or Geriatric rehab programs. In the Toronto Region alone, 28% or 19/68 of all referrals to LTLT rehab were made for Geriatric rehab programs and 26% or 18/68 of all referrals to LTLT rehab were made to Stroke rehab programs. In the Halton/Peel region, 75% or 3/40 of all referrals to LTLT were made to Stroke Rehab programs and 25% or 1/4 were made to Geriatric Rehab programs. In York Region, 100% or 2/2 of all referrals made to LTLT rehab were made to Geriatric Rehab programs. In Durham, 75% or 3/4 of all referrals made to LTLT rehab were made to Stroke rehab programs. No referrals to Geriatric LTLT rehab programs were made in Durham. However, the numbers in the Halton/Peel and Durham regions are too small to illustrate any trends.
(Refer to Table 2.5-1b)

Analysis by Organization Type:

Of all patients referred to LTLT rehab programs, 54% or 42/78 were from the four acute teaching hospitals, all located in the Toronto region, while 46% or 36/78 were from community hospitals across all regions.

QUESTIONS ARISING FROM THE DATA

- What is the availability of LTLD programs for populations in need?
- Are there any barriers to accessing LTLD programs?
- Are patients in need of Stroke and Geriatric rehab reflective of a higher proportion of rehab patients in need of LTLD Rehab?

ADDITIONAL POINTS FOR CONSIDERATION:

- Conduct a review of LTLD program availability and capacity relative to population specific needs and best practices.

2.6 Coexisting Conditions

Seventy-two percent or 277/385 of all patients identified across all five snapshots were reported as having co-existing conditions; however, the acuity of these co-existing conditions was not provided. Those most commonly reported include: hypertension, diabetes, past cerebrovascular accident, mental illness and atrial fibrillation. These co-existing conditions may be common characteristics of patients requiring rehab. Often, the complexity and number of co-existing conditions can have a greater effect on rehab placement.

QUESTIONS ARISING FROM THE DATA

- How do co-existing conditions affect rehabilitation placement? Are there differences among the types of co-existing conditions that have a differential impact on rehabilitation placement?

ADDITIONAL POINTS FOR CONSIDERATION:

- Encourage referring organizations to provide more information regarding the resources needed to accommodate patients with co-existing conditions.
- Encourage receiving organizations to provide more information regarding their ability to accommodate special needs and reasons for non-acceptance into a program.
- Implementation of standardized referral and response forms would facilitate the collection of detailed information regarding co-existing conditions, reasons for non-acceptance and other factors that affect rehab placement.

3.0 INPATIENT REHABILITATION CAPACITY

The Network also surveyed those organizations that provide inpatient rehab in the GTA. The following details the analysis of rehab capacity.

3.1 Pre-SARS Survey and Capacity

According to the GTA Rehab Network's annual surveys of designated inpatient rehab beds staffed and in operation, there were 1261⁷ beds across the GTA in February 2003. The following figures indicate the number of designated rehabilitation beds staffed and in operation across the GTA for each snapshot:

- April 2003 1105 (*SARS I*)
- May 2003 1217
- June 2003 1179 (*SARS II*)
- July 2003 1157
- September 2003 1174

Inpatient rehab capacity was adversely affected by the SARS I and II outbreaks that peaked during April and June 2003. However, the snapshots also reflect less than full capacity during May, July and September. SARS continued to impact capacity in the summer of 2003 such that full rehab capacity was not reached in July and September. Additional factors that likely contributed to reduced capacity during these months were summer bed closures and renovations.

3.2 Patients Accepted and Expected to Transfer into Rehab Facility

Of all the patients accepted and expected to transfer into a rehab facility between the dates of the snapshots and five days post-snapshot, respondents indicated that 93% or 783/838 of patients were being admitted directly from acute care whereas 7% or 55/838 were admitted from other locations.

3.3 Inpatient Rehabilitation Discharges and Admissions

Of the total number of patients occupying designated rehab beds at the time of all snapshots, 5.1% or 249/4841 were ready for discharge but were awaiting placement. Of those, 51% or 128/249 were waiting specifically for Long-Term Care (LTC) and 47% or 117/249 were awaiting other placement. This data is important to note as challenges in discharging patients from inpatient rehab can impact on the availability of resources for ALC patients.

(Refer to Table 3.2-1)

Regional Analysis:

The percentage of patients waiting for discharge from rehab was relatively consistent across all regions: Toronto 5.2% or 180/3430; Halton/Peel 5.1% or 41/797; York 4.7% or 12/254 and Durham 4.4% or 16/360.

However, York Region had a significantly smaller proportion of patients waiting for LTC at 8% or 1/12 as compared with other regions: Toronto 54% or 97/180; Halton/Peel 56% or 23/41; and Durham 44% or 7/16.
(Refer to Table 3.2-2)

Analysis by Organization Type:

A total of 4841 rehab beds were occupied across all five snapshots. Of these, 52% of patients (2535/4841) occupied beds in rehabilitation hospitals and 45% of patients (2201/4841) occupied rehab beds in community hospitals. Of the patients awaiting LTC placements, 68% or 88/128 were waiting in rehabilitation hospitals while 34% or 40/128 were waiting in community hospitals.

(Refer to Table 3.2-3)

⁷ Note: This figure reflects the number of designated rehab beds staffed and in operation as of February 2003.

QUESTIONS ARISING FROM THE DATA

- Why are patients in rehab waiting for placement?
- How long are patients in inpatient rehab beds awaiting discharge?

ADDITIONAL POINTS FOR CONSIDERATION:

- Although patients in inpatient rehab who are awaiting discharge are not designated as ALC patients, these patients nevertheless have an impact on the availability of resources for and movement of ALC patients from acute care into rehab.

4.0 COMBINED ANALYSIS COMPARING PATIENTS AWAITING REHABILITATION IN ALC AND INPATIENT REHABILITATION CAPACITY

The data from the snapshots were further analyzed by comparing patients awaiting rehab in ALC with inpatient rehab capacity. As per the conceptual framework in Figure 1, the combined analysis enables a better understanding of service gaps and access issues from a supply and demand perspective.

4.1 Number of Patients Awaiting Rehabilitation in ALC versus Number of Designated Beds Available at Time of Snapshots

The data indicate that in decreasing order, Respiratory, Stroke/Neurology, Geriatric, Musculoskeletal⁸ and Acquired Brain Injury rehab groupings have the most significant shortfalls in capacity relative to other rehab groups. The rehab groupings of Amputee, Cardiac, Musculoskeletal⁸ and Trauma had the most significant available capacity.

(Refer to Table 4.1)

4.2 Referral Patterns

The data indicate that of all patients in ALC for whom rehab referrals were made:

- 53% (186/348) were referred to one organization
- 22% (76/348) were referred to two organizations
- 17% (59/348) were referred to three organizations
- 8% (27/348) were referred to four or more organizations

This analysis shows that for more than half of the patients (53%), referrals were submitted to only one organization. This figure increases to 75% when combined with referrals that were sent to two organizations. Factors that may account for a lack of widespread submission of referrals may be reflective of issues related to awareness, availability and distribution of services in the system. These issues may include: a lack of awareness among referrers of specific rehab services that are available at various sites; the habitual submissions of referrals by certain organizations to preferred facilities; the existence of preferred provider relationships; the access to in-house rehab beds by some organizations; the availability of specific services or resources at a limited number of sites to accommodate the highly specialized needs of some patients; patient preferences; or SARS-related effects.

(Refer to Table 4.2-1)

Regional Analysis:

The majority of referrals were made to one organization in each of the following regions: Halton/Peel: 96% or 27/28 of all referrals made; York: 75% or 6/8 of all referrals made; and Durham: 100% or 4/4 of all referrals made. In Toronto, however, the referral patterns were more diverse: 48% or 149/308 of all referrals were made to one organization; 24% or 74/308 of all referrals made were to two organizations; 19% or 58/308 of all referrals were made to three organizations; and 9% or 27/308 were made to four or more organizations.

(Refer to Table 4.2-2)

Analysis by Organization Type

The relative distribution of the number of referrals made per patient was similar in both community and acute teaching hospitals. The distribution of the number of referrals made per patient by community hospitals is as follows: 62% or 103/166 to one organization, 21% or 35/166 to two organizations, 13% or 21/166 to three organizations and 4% or 7/166 to four or more organizations. The distribution of the number of referrals made per patient by acute teaching hospitals is as follows: 46% or 83/182 to one organization; 22% or 41/182 to two organizations; 21% or 38/182 to three organizations; and 11 or 21/182 to four or more organizations.

(Refer to Table 4.2-3)

⁸ NOTE: There were significant shortfalls in Musculoskeletal rehabilitation capacity relative to demand in the May, July and September snapshots, whereas there was significant capacity in the April and June snapshots. The fluctuation in the availability of MSK rehab beds was likely owing to SARS-related bed closures.

QUESTIONS ARISING FORM THE DATA

- What are the reasons why patients are not accessing apparently available beds? What are some of the barriers and how can they be addressed?
- Why are referrals sent to only one organization?
- How do we ensure appropriate distribution and accessibility of beds for each rehabilitation population group?
- Why are certain sites more commonly chosen to refer particular population groups, while they may not have the greatest of bed availability compared to other sites?

ADDITIONAL POINTS FOR CONSIDERATION:

- The development of a centralized rehab referral process could increase utilization of available and commonly non-accessed beds.
- Encourage referring organizations to refer to more than one organization.

5.0 SUMMARY OF KEY FINDINGS

The analysis of the ALC snapshots led to the identification of several issues that could be addressed to minimize the overall ALC days in the GTA. These issues have been identified with supporting data throughout the report. The following points are a summary of the overall key findings of all five snapshots:

Patients Awaiting Rehab in ALC

- Of all patients awaiting rehab in ALC from the regions surveyed, (Halton, Peel, Durham, York and Toronto) 88% were in the Toronto Region Hospitals.
- Of all patients awaiting rehab in ALC, 53% were in 4 acute teaching hospitals while 47% of patients were spread across 14 community hospitals.
- The most prevalent rehab groups awaiting rehab in ALC were musculoskeletal (28%), stroke/neurology (22%), geriatric (20%) and acquired brain injury (10%).
- Across all five snapshots, 53% of patients awaiting rehab in ALC were referred to only one organization for rehabilitation. It was also noted that referral patterns across some organizations are well established, regardless of bed availability.
- Of the referrals made for patients awaiting rehab in ALC, 23% were made prior to ALC designation, 44% were made on the same day and 33% were made after ALC designation.
- Of all the referrals made for patients awaiting rehab in ALC, 46% of referrals had not received a response at the time of the snapshot. Of these referrals with no responses, 46% of referrals were sent on the day of the snapshot or 1 day prior to the snapshot date; 24% of referrals were sent 2 to 5 days prior to the snapshot date; and 30% of referrals were sent more than 5 days prior to the snapshot date.
- Of the referrals for which program details were provided, 22% of patients awaiting rehab in ALC were in need of low tolerance, long duration (LTLTD) rehabilitation.

Rehab Capacity

- Of all patients occupying inpatient rehabilitation beds, 5.1% were ready for and awaiting discharge; 51% of whom were awaiting long-term care.
- The greatest apparent shortfalls in inpatient rehab capacity in decreasing order existed for respiratory, stroke/neurology, geriatric, musculoskeletal and acquired brain injury populations; the greatest apparent excess of inpatient rehab capacity existed for amputee, cardiac and trauma populations.
- Referrals are often sent to a few organizations with little or no capacity instead of other organizations with more available capacity.

6.0 SUMMARY OF KEY QUESTIONS ARISING FROM THE DATA ANALYSIS

Although the analysis of the data resulted in several key findings, the following additional areas require further exploration:

6.1 Prevalence of Specific Population Groups Awaiting Rehab in ALC

The data from the snapshots indicate that certain population groups (i.e. patients in need of MSK, Stroke/Neurology, Geriatric and ABI rehab) comprise the most prevalent groups awaiting rehab in ALC. The data regarding rehab capacity show that the distribution of rehab beds generally matches the demand for rehab beds by the most prevalent rehab populations. The capacity to accommodate Geriatric patients in specifically-designated Geriatric rehab beds is less clear because these patients are often admitted to General as well as Geriatric rehab beds.

Although the distribution of rehab beds matches the distribution of the most prevalent rehab populations, patients nevertheless encounter difficulties in accessing rehab beds quickly and additional data is needed to further delineate barriers to accessing inpatient rehabilitation. The GTA Rehab Network's Admission Information Website, which will be launched in the summer of 2004, will provide detailed program descriptions of rehabilitation programs and services across the GTA. An examination of these program details will help to further identify where particular rehab populations can be accommodated and which rehab facilities can accept patients with special needs. The website will also provide information regarding the programs that accept only internal referrals and those that can be more widely accessed from external referral sources.

6.2 Reasons Why Patients are Not Accepted

Although asked in the survey, specific reasons why some patients awaiting rehab in ALC were not accepted by rehab facilities remains unclear. Obtaining more specific and detailed information will help determine whether reasons for non-acceptance are related to discrepancies between referring and rehab facilities in their understanding of rehab readiness, lack of appropriate resources to accommodate specific patient needs, or reduced capacity relative to demand. The Network's Electronic Referral and Wait List System will include the development of a standard response form and the tracking of reasons for when patients are waitlisted or declined.

6.3 Use of ALC Definition

The extent to which organizations are aware of and make consistent use of the definition of ALC is unknown. The Toronto District Health Council defines an ALC patient as follows:

A patient who is considered a non-acute treatment patient but occupies an acute care bed. This patient is awaiting placement in a chronic care unit, home for the aged, nursing home, rehabilitation facility, other extended care institution or home care programs etc. The patient is classified as an ALC when the patient's physician gives an order to change the level of care from acute care and requests a transfer to another facility⁹.

The analysis of the data from the snapshots revealed that 77% of referrals were made either on the day of or after ALC designation. Although the reasons to account for this may be related to the need for clearer guidelines regarding rehab readiness, it may also be associated with inconsistencies in organizations' understanding and application of the definition of ALC.

6.4 Number of Days Patients are Awaiting Rehab in ALC

The data from the snapshots do not indicate how long patients are awaiting rehab in ALC. The data captured reflect the length of time patients were waiting in ALC as of the date of the snapshot only and therefore do not

⁹ Toronto District Health Council, *First Annual Toronto's Health System Report Card* (Toronto, 1999), p.9

capture total length of stay. When considering the number of repeat patients between snapshots (approximately 30 days apart), most patients had a length of stay of less than 30 days in ALC. However, the data do not distinguish whether patients are generally waiting less than five days or more than 20 days. Generally, if a patient is waiting in ALC for less than five days, this could be considered a reasonable wait owing to the time required to review and respond to a referral. However, we cannot determine from the data if patients are waiting longer, which could be an indication of several issues that may need to be addressed. For instance, is there a lack of resources in the system to accommodate these patients resulting in longer wait times in ALC? Are patients who are designated ALC not quite 'ready for rehab' and need more time to convalesce before they are ready for rehab? Is some form of transitional care therefore needed for these patients? Are referrals for these patients being made to the appropriate programs? Are referrals for these patients being made to programs that have available capacity and the ability to accommodate specific special needs?

6.5 Access to Available Capacity

The survey data indicate that many rehab facilities with available capacity for specific rehab groups were not receiving referrals, while a significant number of patients awaiting rehab in ALC were being referred to facilities with little or no capacity. However, it is unclear from the survey data why rehab facilities with available capacity were not being accessed. Are referring organizations unaware of the services and resources available by all rehab facilities? Do these rehab facilities that have capacity lack specific resources to accommodate special needs being sought by referring facilities? Are these rehab facilities geographically not preferred? During April and June 2003, some rehab units were vacant but were closed due to SARS I & II. Although there was more excess capacity during these two snapshots, some organizations still had excess capacity and were still not receiving referrals during the other post-SARS snapshots. Further exploration is needed to assess why these facilities with available capacity are not being accessed before any further recommendations can be determined.

7.0 SUMMARY OF RECOMMENDATIONS FOR CONSIDERATION

Based on the analysis of the snapshots throughout the report, the following outlines the key recommendations proposed by the ALC Task Group. The recommendations have been classified into the following five categories:

- Recommendations pertaining to Communication;
- Recommendations pertaining to Rehab Readiness, ALC Designation and the Referral Process;
- Recommendations pertaining to the Continuum of Care;
- Recommendations pertaining to Population Specific Issues;
- Overall Recommendation

7.1 Recommendations Pertaining to Communication

Recommendations Pertaining to Communication

- a) **Providers should indicate specific reasons as to why patients are not accepted or waitlisted.**
This would assist in the development of more appropriate and efficient referral processes. Also, this detail would indicate which patient populations and special needs are not being met.
- b) **Response times should be standardized even if it means providing a response of “review of application is still in process.” Recommend that responses shall be provided within two business days of application receipt.**
This would help improve accountability, transparency and turnaround times in the patient referral/acceptance processes.
- c) **Develop a system to increase awareness of and transparency around resource availability to accommodate special needs.**
This would increase the efficiency of the referral process by providing information about the types of patient needs that can be accommodated in each facility. This information could also be used to further delineate which patient population needs are not being met.
- d) **A standard referral form should be developed and used to provide information on specific resource needs.**
A standard referral form would encourage more consistency and transparency when communicating the needs required by the patients being referred. Creating a standard form would increase the likelihood of including more appropriate detail on a patient’s status and specific rehab needs. This would increase the efficiency of the overall referral/response process and would prevent response delays due to lack of information.

Current Initiatives/Related Projects

- GTA Rehab Network Referral and Response Form Task Group (as per recommendations in the GTA Rehab Network’s *Measuring and Managing Supply and Demand Report*):
This Task Group is involved in developing forms for MSK rehab to improve communication and transparency in the referral/response process, which would include standardizing response times to minimize system delays. These forms are being developed with a view to applying the learning to other rehab populations.
Target: All rehab hospitals
- GTA Rehab Network’s Admission Information Website:
This initiative provides information on rehab programs/services offered by member organizations through the use of the web-based template on the Network’s website to enhance knowledge of and access to rehab programs/services in the GTA and the special needs that each program can accommodate.
Target: All rehab hospitals

7.2 Recommendations Pertaining to Rehab Readiness, ALC Designation and Referral Process

Recommendations Pertaining to Rehab Readiness, ALC Designation and Referral Process

- a) **A common checklist/guideline should be developed to determine when patients are ready for rehab**
Determining predictors or descriptors for rehab readiness would increase efficiency and transparency of the placement process by encouraging standard and consistent communication and understanding of a patient's status and rehab needs.
- b) **Organizations should strive to submit referrals at least 2 days before ALC designation.**
Encouraging facilities to submit patient referrals at least 2 days before ALC designation when it is anticipated that the patient will benefit from rehab will help to obtain an earlier response from a rehab facility and thus minimize the overall number of days in ALC.
- c) **Organizations should send referrals to more than one rehab program as appropriate.**
This practice would optimize access to rehab by ensuring that rehab referrals are reviewed by more than one facility.
- d) **A centralized routing mechanism for rehab referrals should be considered to increase efficiency of the referral process, ensure referrals are sent to programs offering services to appropriately accommodate the needs of the patient and to better manage the waitlist for multiple referrals.**
This information would encourage a more efficient referral process by centralizing all information on resources and availability of services to accommodate patient needs thereby improving the access and utilization of information for the referral process.

Current Initiatives/Related Projects:

- GTA Rehab Network's Admission Information Website:
This initiative provides information on rehab programs/services offered by member organizations through the use of the web-based template on the Network's website to enhance knowledge of and access to all rehab programs/services in the GTA.
- The Electronic Referral and Wait List System:
This initiative, pending Ministry of Health and Long-Term Care support, will pilot a centralized electronic referral routing system for MSK rehab referrals.
Target: Acute Care Facilities, Rehab Facilities

7.3 Recommendations Pertaining to the Continuum of Care

Recommendations Pertaining to the Continuum of Care
<p>a) A review should be conducted to determine why and how long patients in inpatient rehabilitation are waiting for placement. Implementation of a system to track patients in inpatient rehab who are ready for discharge but are awaiting placement should be considered. Because delays in discharge from rehab have a direct impact on the movement of patients from acute care to rehab, a tracking system would help to identify and address reasons for delays in discharge of these patients from rehab.</p> <p>b) Organizations should increase flexibility as able and appropriate around the use of available beds in the system to accommodate rehab population groups with higher demand.</p>
Current Initiatives/Related Projects:
<ul style="list-style-type: none"> ▪ The GTA Rehab Network’s Long Term Care Task Group has made recommendations to the Placement Forum Steering Committee of the Toronto District Health Council to improve the management of the waiting list for long term care referrals and the prioritization policies regarding transfer of patients to long-term care referrals. <i>Target: GTA Rehab Network, Rehab Facilities</i>

7.4 Recommendations Pertaining to Population Specific Initiatives

Recommendations Pertaining to Population Specific Initiatives
<p>a) Conduct a review of the most prevalent rehab groups (MSK, Stroke/Neurology, Geriatric and ABI) and least prevalent groups (Chronic Pain, Burn and Trauma) with respect to the capacity of rehab services available for each population. Determine if the distribution and quantity of resources is adequate, appropriate and able to meet the needs of patients awaiting rehab in ALC.</p> <p>b) Conduct a review to determine capacity available to accommodate population specific patients in need of Low Tolerance, Long Duration (LTLTD) rehab</p>
Current Initiatives/Related Projects:
<ul style="list-style-type: none"> ▪ To be conducted by the ALC Task Group <i>Target: GTA Rehab Network, ALC Task Group</i>

7.5 Overall Recommendation

Overall Recommendation
A monitoring body should be established to oversee the implementation of these recommendations.
Current Initiatives/Related Projects:
<ul style="list-style-type: none"> ▪ Establishment of a new ALC Task Group to improve referral processes, optimize patient flow and enhance access to inpatient rehabilitation. <i>Target: GTA Rehab Network ALC Task Group</i>

8.0 IMPLICATIONS AND NEXT STEPS

A new ALC Task Group has been struck to oversee the implementation of the recommendations from this report. Based on the findings of this report, the Task Group's objectives are to support and/or implement initiatives that improve referral processes, optimize patient flow through the system and enhance access to inpatient rehabilitation. Currently, a number of the proposed recommendations from this report are already being addressed by various initiatives of the GTA Rehab Network. The recommendations from this report will also serve to inform future initiatives and operating plans of the GTA Rehab Network.

The following discussion outlines an implementation plan for the recommendations proposed in this report based on current initiatives and proposed activities for the ALC Task Group or future working groups. For the purposes of this discussion, these activities have been organized into three distinct categories related to the referral process, patient flow and access; however, in practice, these groupings are not mutually exclusive as many of these activities overlap or exert influence on more than one category.

8.1 Activities to Improve the Referral Process

There are a number of issues that have been identified in this report that are directly related to the process of referral for patients in need of rehabilitation. These issues include inconsistencies, incompleteness and delays in the information that is conveyed between referring and receiving facilities as well as a suboptimal submission of referrals on behalf of patients. These result in delays in the referral process and acceptance of referred patients.

The following activities and/or strategies are directed towards addressing these issues and improving the referral process:

- i) The GTA Rehab Network Referral and Response Form Task Group is currently in the process of developing a standard referral and response form for joint replacement and hip fracture patients to improve and streamline the referral process. Standardized forms will improve communication between referring and receiving facilities regarding specific resource needs of rehab candidates, their current status, the presence of any co-existing conditions, reasons for non-acceptance and other information required to facilitate the referral process.

The ALC Task Group will collaborate with the Referral and Response Form Task Group upon the completion of the development of their standard form for MSK to adapt the single referral and response MSK form for other rehabilitation referrals.

- ii) The Referral and Response Form Task Group, in collaboration with the Wait List Information Management Steering Committee, is in the initial stages of developing a pilot project to implement an electronic referral and wait list system for inter-organizational musculoskeletal referrals. To address inefficiencies in the referral process related to wait list management, the ALC Task Group will review the preliminary results of this pilot study for a single referral process for MSK to determine the applicability and feasibility of a single referral process for other rehab populations.
- iii) The GTA Rehab Network has developed an Admission Information Website that provides information about rehab programs and services offered by member organizations across the GTA. The availability of such comprehensive information regarding rehabilitation services will increase the awareness of these programs among services providers and promote the submission of rehab referrals to *all* available programs that can accommodate the needs of rehab patients. Ongoing monitoring to ensure that information regarding the Admission Information Website is adequately publicized and utilized by service providers is imperative.

8.2 Activities to Improve Patient Flow

A number of issues related to the movement of patients through the system were also identified. For those waiting in acute care, certain rehab population groups are waiting longer than others for inpatient rehab; others are not

accepted into the programs to which they applied. For those waiting in rehab facilities, some are unable to move to the next level of care because of delays in discharge. The following activities, although related to the referral process, can be viewed as having a direct impact on the movement of patients through the system.

- i) The ALC Task Group, in collaboration with the Referral and Response Form Task Group, will work to develop a set of guidelines for the rehabilitation referral process that will be used by both acute care and rehabilitation hospitals to improve communication between referring and receiving facilities and optimize the transfer of patients from one level of care to the next. These guidelines will establish timelines in which referrals are to be submitted, reviewed and responded to. They will also include definitions that can be used consistently across the GTA regarding rehab readiness and ALC designation to ensure that patients are medically stable and referrals are initiated at appropriate times relative to a patient's ability to participate in rehab.
- ii) The ALC Task Group will also explore the development of a common approach to track patients in rehabilitation beds who are awaiting placement. Such a tracking system can then be used to determine reasons for delays in placement and assist in the development of strategies to reduce delays and improve patient flow.

8.3 Activities to Improve Patient Access

In addition to the above strategies and activities that all impact on patient access to inpatient rehabilitation, the following activities also address potential barriers to accessing services.

- i) It remains unclear if the capacity in the rehab system matches the demand for rehab beds relative to the distribution of the most and least prevalent rehab population groups. A comparison of the data from the ALC snapshots with program descriptions in the Admission Information Website will provide information regarding rehab bed availability and the ability to accommodate special needs.
- ii) The Admission Information Website provides information regarding the capacity of rehab facilities and programs to accommodate special needs. The implementation of a standardized referral and response form that reliably and accurately captures information regarding patients' special needs as well as the response to rehab referrals could be used to quantify the number of patients with special needs whose rehab applications are declined or waitlisted. By utilizing both of these sources of information, the GTA Rehab Network is well-positioned to identify service gaps relative to need and develop strategies to minimize these gaps and improve access for patients with specialized needs.

8.4 Future Surveys/Snapshots

The ALC Task Group will consider conducting additional surveys and/or snapshots in future. The benefits of conducting additional surveys/snapshots are twofold. First, because the snapshots were in part conducted to capture information regarding ALC patients during the SARS outbreaks, they are not representative of ALC patients under normal operating conditions. Conducting additional surveys could potentially highlight issues that were not apparent during SARS. Second, this report has identified a number of key questions that require further investigation. Data elements to address these key questions could be incorporated into additional surveys/snapshots in the future.

TABLES

Prevalence of Rehab Groups

Table 2.1-1: Most Prevalent Rehab Groups* Awaiting Rehab in ALC Across all Five Snapshots						
Group	Prevalence	Age		Gender		Special Needs
		Average	Range	Male	Female	
Musculoskeletal	108 / 385 = 28%	72	17 to 98	36%	64%	61%
Stroke/Neurology	85 / 385 = 22%	68	31 to 94	51%	49%	69%
Geriatric	77 / 385 = 20%	80	62 to 98	39%	61%	71%
ABI	40 / 385 = 10%	52	24 to 80	95%	5%	68%

Table 2.1- 2: Least Prevalent Rehab Groups Awaiting Rehab in ALC Across all Five Snapshots						
Group	Prevalence	Age		Gender		Special Needs
		Average	Range	Male	Female	
Chronic Pain	0 / 385 = 0%	-	-	-	-	-
Burn	1 / 385 = 0.3%	36	36	100%	0%	100%
Trauma	4 / 385 = 1%	56	33 to 72	50%	50%	-

Prevalence of Rehab Groups: Regional Analysis (Most Prevalent Rehab Groups)

Table 2.1-3: Most Prevalent Rehab Groups of Patients Awaiting Rehabilitation in ALC Across all Five Snapshots		
Region	Group	Prevalence
Overall Average	Musculoskeletal	108 / 385 = 28%
	Stroke/Neurology	85 / 385 = 22%
	Geriatric	77 / 385 = 20%
	ABI	40 / 385 = 10%
Toronto	Musculoskeletal	88 / 338 = 26%
	Geriatric	67 / 338 = 20%
	Stroke/Neurology	65 / 338 = 19%
	ABI	38 / 338 = 11%
Halton/Peel	Stroke/Neurology	10 / 29 = 34%
	MSK	9 / 29 = 31%
	Geriatric	3 / 29 = 10%
	General	3 / 29 = 10%
York	Geriatric	3 / 8 = 38%
	Stroke/Neurology	2 / 8 = 25%
	Respiratory	1 / 8 = 13%
	Cardiac	1 / 8 = 13%
	General	1 / 8 = 13%
	MSK	0 / 8 = 0%
Durham	ABI	2 / 4 = 50%
	Geriatric	1 / 4 = 25%
	MSK	1 / 4 = 25%

* Note: Individual patients awaiting rehab placements were classified into rehab groups based on patient characteristics and programs to which they were referred and not solely based on the diagnosis. The most prevalent rehab groups listed represent the top 4-5 rehab groups relative to the total number of patients in ALC.

Prevalence of Rehab Groups: Regional Analysis (Least Prevalent Rehab Groups)

Table 2.1-4: Least Prevalent Rehab Groups of Patients Awaiting Rehabilitation in ALC Across all Five Snapshots		
Region	Group	Prevalence
Overall Average	Chronic Pain	0 / 385 = 0%
	Burn	1 / 385 = 0.3%
	Trauma	4 / 385 = 1%
Toronto	Burn	1 / 338 = ~0%
	Trauma	4 / 338 = 1%
Halton/Peel	ABI	0 / 29 = 0%
	Trauma	0 / 29 = 0%
	Burn	0 / 29 = 0%
	Amputee	0 / 29 = 0%
	Spinal	0 / 29 = 0%
York	MSK	0 / 8 = 0%
	ABI	0 / 8 = 0%
	Spinal	0 / 8 = 0%
	Trauma	0 / 8 = 0%
	Burn	0 / 8 = 0%
	Oncology	0 / 8 = 0%
	Amputee	0 / 8 = 0%
Durham	Respiratory	0 / 4 = 0%
	Spinal	0 / 4 = 0%
	Trauma	0 / 4 = 0%
	General	0 / 4 = 0%
	Cardiac	0 / 4 = 0%
	Amputee	0 / 4 = 0%

Prevalence of Rehab Groups: Regional Analysis (Analysis by Organization Type¹⁰)

Table 2.1-5: Prevalence of Rehab Groups by Hospital Type Groups		
Rehab Group	Prevalence in Acute Teaching Hospitals	Prevalence in Community Hospitals
ABI	35 or 17%	5 or 3%
Amputee	6 or 3%	4 or 2%
Burn	1 or 0.5%	0 or 0%
Cardiac	5 or 2%	4 or 2%
Chronic Pain	0 or 0%	0 or 0%
Musculoskeletal	56 or 27%	52 or 29%
Stroke/Neurology	33 or 16%	52 or 29%
Oncology	6 or 3%	4 or 2%
Respiratory	4 or 2%	3 or 2%
Spinal	14 or 7%	1 or 0.5%
Trauma	4 or 2%	0 or 0%
Geriatric	30 or 15%	47 or 26%
General	10 or 5%	9 or 5%
Total Number of Patients Awaiting Rehab in ALC per Hospital Type	204 / 385 = 53%	181/385 = 47%

¹⁰ A list of hospitals according to hospital type is found in Appendix E.

Referral Status of Patients Awaiting Rehab in ALC

The following tables outline the referral status of patients awaiting rehab in ALC *at the time of the snapshot*. Please note: figures indicated do not reflect the LOS patients have been waiting in ALC.

Table 2.2-1a: Referral Status of Patients Awaiting Rehab in ALC - April 2003					
Population	No Referral Made Yet	Referred but No Response	Referred and Waitlisted	Referred and Not Accepted	Reasons for Non-Acceptance
ABI	1	8	4	3	<ul style="list-style-type: none"> ▪ Patient not appropriate ▪ Lack of resources to support special needs
Amputee					
Burn			1		
Cardiac					
Chronic Pain					
MSK	3	5	6	2	<ul style="list-style-type: none"> ▪ Patient requires vac dressing
Neurology		9	1	2	
Oncology					
Respiratory		2	2		
Spinal Cord		4	2		
Stroke	2	15	7	2	<ul style="list-style-type: none"> ▪ Not accepting patients (from Sunnybrook owing to SARS outbreak) ▪ Lack of equipment
Trauma				1	
Geriatric		6	2	4	<ul style="list-style-type: none"> ▪ More appropriate for homecare
Other					
General					

Table 2.2-1b: Referral Status of Patients Awaiting Rehab in ALC - May 2003					
Population	No Referral Made Yet	Referred but No Response	Referred and Waitlisted	Referred and Not Accepted	Reasons for Non-Acceptance
ABI		3	6		
Amputee			1		
Burn					
Cardiac		1			
Chronic Pain					
MSK	2	18	15	2	<ul style="list-style-type: none"> ▪ More appropriate for slow stream rehab ▪ Lack of dialysis equipment
Neurology			1	2	<ul style="list-style-type: none"> ▪ More appropriate for long term care
Oncology					
Respiratory					
Spinal Cord		3	1	2	<ul style="list-style-type: none"> ▪ Requires equipment for larger patient
Stroke		11	5	8	<ul style="list-style-type: none"> ▪ More appropriate for slow stream rehab ▪ Requires longer length of stay ▪ Patient not appropriate
Trauma			10		
Geriatric	2	5	6	1	<ul style="list-style-type: none"> ▪ More appropriate for slow stream rehab
Other					
General		5		3	<ul style="list-style-type: none"> ▪ More appropriate for slow stream rehab

Referral Status of Patients Awaiting Rehab in ALC, Continued

Table 2.2-1c: Referral Status of Patients Awaiting Rehab in ALC - June 2003					
Population	No Referral Made Yet	Referred but No Response	Referred and Waitlisted	Referred and Not Accepted	Reasons for Non-Acceptance
ABI		1	11	1	
Amputee	1	3	1		
Burn					
Cardiac	1				
Chronic Pain					
MSK		13	12	7	▪ Patient not weight-bearing
Neurology		2	10		
Oncology		3	2	1	
Respiratory		1			
Spinal Cord		1	2		
Stroke		9	10	3	
Trauma		1	2		
Geriatric	2	20	8	3	
Other					
General		4	1		

Table 2.2-1d: Referral Status of Patients Awaiting Rehab in ALC - July 2003					
Population	No Referral Made Yet	Referred but No Response	Referred and Waitlisted	Referred and Not Accepted	Reasons for Non-Acceptance
ABI		5	8	1	▪ More appropriate for slow stream
Amputee		3	3	6	▪ Patient not cooperating in therapy; incontinence
Burn					
Cardiac	1	1	1		
Chronic Pain					
MSK	2	10	12		
Neurology	1		7		
Oncology		1			
Respiratory			2		
Spinal Cord			1		
Stroke		8	9	3	▪ More appropriate for long term care ▪ Patient not appropriate
Trauma					
Geriatric	2	25	6		
Other					
General	1	2	5		

Referral Status of Patients Awaiting Rehab in ALC, Continued

Table 2.2-1e: Referral Status of Patients Awaiting Rehab in ALC - September 2003					
Population	No Referral Made Yet	Referred but No Response	Referred and Waitlisted	Referred and Not Accepted	Reasons for Non-Acceptance
ABI		5	4		
Amputee			1		
Burn					
Cardiac		4	2	1	▪ Need more information; patient does not fit program referred to
Chronic Pain					
MSK	4	38	19	4	▪ Need more information; patient has oncology needs that cannot be accommodated
Neurology		7	4		
Oncology	1		2		
Respiratory		3		3	▪ Patient has too many comorbidities; patient doesn't appear fit for active rehab
Spinal Cord		2			
Stroke		17	12	3	
Trauma					
Geriatric	4	11	12	6	▪ Dementia; O2 needs; more appropriate for LTC; patient not stable
Other					
General	1	1	5		

Table 2.2-1f: Most Common Population Groups Not Accepted by Inpatient Rehab and Reasons Not Accepted (Across All Five Snapshots)	
<p>Most common rehabilitation population groups not accepted by inpatient rehabilitation facilities across all five snapshots include:</p>	<ul style="list-style-type: none"> ▪ Stroke ▪ MSK ▪ Amputee ▪ ABI
<p>Reasons for patients not accepted to a rehabilitation facility across all five snapshots include:</p>	<ul style="list-style-type: none"> ▪ Patient not appropriate for facility referred (118) ▪ More appropriate for slow stream program/longer LOS (10) ▪ Needs LTC/CCC (7) ▪ Sites not accepting patients (5) ▪ Do not have appropriate equipment (5) ▪ More appropriate for ABI program (4) ▪ Patient too medically complex (3) ▪ Not weight bearing (2) ▪ Does not reside in catchment (2) ▪ Age (1) ▪ Patient not willing and able to participate in active rehabilitation (1)

Referral Status of Patients Awaiting Rehab in ALC, Continued

Table 2.2-1g: Number of Days Since a Referral was Made for Patients with No Responses (Across all Five Snapshots)							
Population	Total Number of Referrals with No Responses	Referral Sent 0 to 1 day before Snapshot		Referral Sent 2 to 5 days before Snapshot		Referral Sent More than 5 days before Snapshot	
ABI	22	12	54%	1	5%	9	41%
Amputee	6	3	50%	1	17%	2	33%
Burn	0	0	0%	0	0%	0	0%
Cardiac	6	4	66%	1	17%	1	17%
Chronic Pain	0	0	0%	0	0%	0	0%
MSK	84	42	50%	22	26%	20	24%
Neurology	18	13	72%	2	11%	3	17%
Oncology	4	2	50%	2	50%	0	0%
Respiratory	6	1	17%	0	0%	5	83%
Spinal Cord	10	3	30%	2	20%	5	50%
Stroke	60	30	50%	20	33%	10	17%
Trauma	1	0	0%	0	0%	1	100%
Geriatric	67	34	51%	18	27%	15	22%
Other	0	0	0%	0	0%	0	0%
General	12	1	8%	3	25%	8	67%
Totals	296	136	46%	71	24%	89	30%

Regional Analysis:

Table 2.2-2: Referral Status of ALC Patients by Region				
Region	Total Number of Referrals Made to Region*	Percentage of Referrals Not Accepted*	Population Groups Most Commonly Not Accepted	
Toronto	591 or 93%	71 / 591 = 12%	Stroke/Neurology	22 / 71 = 31%
			Musculoskeletal	15 / 71 = 21%
			Geriatric	11 / 71 = 15%
Halton/Peel	27 or 4%	1 / 27 = 4%	Stroke/Neurology	1 / 1 = 100%**
York	9 or 1%	2 / 9 = 22%	Stroke/Neurology	1 / 2 = 50%**
Durham	10 or 2%	0 / 10 = 0%	-	-
Total Number of Referrals	637			

* Taken as a sum of all five snapshots and includes all referrals made for each patient awaiting rehab in ALC.

** A total of 1 not-accepted for each region of Halton/Peel and York is insignificant when drawing conclusions as to the population groups most commonly non-accepted.

Average Number of Days Awaiting Rehabilitation in ALC¹²:

Table 2.3-1: Average Number of Days Patient Rehab Group have been Waiting for Rehab in ALC at time of Snapshot										
Population	SARS I		SARS II		SARS II		SARS II		SARS II	
	April 2003		May 2003		June 2003		July 2003		September 2003	
	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range
ABI	16	1 to 48	9	0 to 66	20	5 to 91	22	7 to 56	8.4	7 to 14
Amputee	-		2	2	16	0 to 47	10	1 to 28	12	12
Burn	1	1	-	-	-	-	-	-	-	-
Cardiac	-	-	1	1	-	-	13	1 to 37	10.2	2 to 34
Chronic Pain	-	-	-	-	-	-	-	-	-	-
MSK	29	1 to 80	24	1 to 75	9	1 to 3, 102	6	1 to 20	3.4	1 to 14
Neurology	10	1 to 34	21	21	17	12 to 27	8	1 to 20	7.5	2 to 20
Oncology	-	-	-	-	15	5 to 32	0	0	11.3	3 to 22
Respiratory	24	22 to 26	36	36	60	60	4	3 to 4	7.7	1 to 13
Spinal Cord	24	1 to 60, 512	25	1 to 74, 531	62	14 to 109	2	2	1.6.	16
Stroke	21	2 to 95	13	1 to 50	24	1 to 56	17	2 to 28	7.3	1 to 19
Trauma	3	3	4	3 to 5	8	8	-	-	-	-
Geriatric	14	1 to 28	11	1 to 28	36	1 to 27	9	1 to 28	8.1	1 to 22
Other	-	-	-	-	18	-	-	-	-	-
General	-	-	17	7 to 37	-	13 to 21	4	1 to 10	2.7	2.7

(Highlighted values indicate the three longest average numbers of days awaiting rehab in ALC for each snapshot.)

Time of Referral Relative to ALC Designation

Table 2.4-1: Time of Referral Relative to ALC Designation					
Referral for Patient Awaiting Rehab in ALC Made...					
Prior to being designated ALC	On the same day as they were designated ALC	1 to 2 days after they were designated ALC	3 to 7 days after they were designated ALC	8 to 14 days after they were designated ALC	More than 14 days after they were designated ALC
79 or 23%	154 or 44%	45 or 13%	33 or 10%	10 or 3%	25 or 7%

¹² Indicates time in ALC up until the day of the snapshot, not total time in ALC.

Time of Referral Relative to ALC Designation: By Region

Table 2.4-2: Time of Referral Relative to ALC Designation by Region (Totals represent a sum of all five snapshots)								
Region	Total Number of Patients Referred	Referral Made...						
		Prior to ALC Designation	On Same Day as ALC Designation	Post ALC Designation				
				Overall Post ALC Designation	1-2 days post ALC Designation	3-7 days post ALC Designation	8-14 days post ALC Designation	> 14 days post ALC Designation
Toronto	308 or 89%	72 or 23%	145 or 47 %	91 or 30%	31 or 10%	25 or 8%	9 or 4%	26 or 8%
Halton/Peel	28 or 8%	4 or 14%	7 or 25%	17 or 61%	11 or 39%	5 or 18%	1 or 4%	0
York	8 or 2%	2 or 25 %	1 or 12%	5 or 63%	2 or 25%	3 or 38%	0	0
Durham	4 or 1%	1 or 25%	1 or 25%	1 or 25%	1 or 25%	0	0	0
Total	348							

Time of Referral Relative to ALC Designation: By Organization Type

Table 2.4-3: Time of Referral Relative to ALC Designation by Organization Type								
Hospital Type	Total Number of Patients Referred	Referral Made...						
		Prior to ALC Designation	On Same Day as ALC Designation	Post ALC Designation				
				Overall Post ALC Designation	1-2 days post ALC Designation	3-7 days post ALC Designation	8-14 days post ALC Designation	> 14 days post ALC Designation
Acute Teaching	182 or 52%	43 or 24%	92 or 51 %	47 or 25%	15 or 8%	13 or 7%	4 or 2%	15 or 8%
Community	166 or 48%	36 or 22%	62 or 37%	68 or 41%	29 or 17%	21 or 13%	6 or 4%	11 or 7%
Total	348							

Low Tolerance, Long Duration Rehabilitation (LTLTD)

The following table indicates the number of referrals to LTLTD rehabilitation by population:

Table 2.5-1a: Low Tolerance, Long Duration Rehabilitation (LTLTD)						
Population	April 2003	May 2003	June 2003	July 2003	Sept. 2003	Total
ABI	1	3	2	2	2	10 / 348 = 3 %
Cardiac	-	1	-	1	1	3 / 348 = 1 %
MSK	6	-	1	-	1	8 / 348 = 2 %
Neurology	1	-	-	1	1	3 / 348 = 1 %
Oncology	-	-	1	-	-	1 / 348 ~ 0 %
Stroke	4	6	6	4	4	24 / 348 = 7 %
Geriatric	1	4	3	9	5	22 / 348 = 6%
General	1	5	1	-	-	7 / 348 = 2 %
Total	14 / 23 = 61%	19 / 29 = 66%	14 / 24 = 58%	17 / 28 = 61%	14 / 26 = 54%	78 / 348 = 22%

Low Tolerance, Long Duration Rehabilitation (LTLTD): By Region

Of all referrals for which program details were provided, 22% (78/348) of patients awaiting rehab in ALC were in need of low tolerance, long duration rehab. The following table indicates the number of patients referred to LTLTD rehabilitation by population and region:

Table 2.5-1b: Number of Patients Awaiting LTLTD Rehab in ALC by Region	
Population	Total
TORONTO	
ABI	9 or 13%
Cardiac	3 or 4%
MSK	8 or 12%
Stroke	18 or 26%
Neurology	3 or 4%
Oncology	1 or 1%
Geriatric	19 or 28%
General	7 or 10%
TOTAL	68 or 87%
HALTON/PEEL	
Stroke	3 or 75%
Geriatric	1 or 25%
TOTAL	4 or 5%
YORK	
Geriatric	2 or 100%
TOTAL	2 or 3%
DURHAM	
ABI	1 or 25%
Stroke	3 or 75%
TOTAL	4 or 5%

Low Tolerance, Long Duration Rehabilitation (LTLTD): By Organization

Table 2.5-1c: Number of Patients Awaiting LTLTD Rehab in ALC by Organization	
Acute Teaching Hospitals	54% or 42/78
Community Hospitals	46% or 36/78

Inpatient Rehabilitation Discharges and Admissions

Table 3.2-1: Inpatient Rehabilitation Discharges and Admissions						
	April 2003	May 2003	June 2003	July 2003	Sept 2003	Overall Snapshots
Total Number of Patients Waiting for Discharge from Inpatient Rehabilitation Relative to Total Number of Rehab Beds Occupied across all GTA Hospitals with Designated Rehab Beds	53/788 = 6.7%	51/1069 = 4.8%	49/887 = 5.5%	57/1019 = 5.6%	39/1078 = 3.6%	249/4841 = 5.1%
Total Number of Patients Waiting for Long-Term Care Placement Relative to Total Number of Rehab Beds Occupied across all GTA Hospitals with Designated Rehab Beds	37/788 = 4.7%	18/1069 = 1.7%	27/887 = 3.0%	26/1019 = 2.6%	20/1078 = 1.9%	128/4841 = 2.6%
Total Number of Patients: Waiting for Long Term Care Relative to Total Number of Patients Waiting for Discharge from Inpatient Rehabilitation	37/53 = 70%	18/51 = 35%	27/49 = 55%	26/57 = 46%	20/39 = 51%	128/249 = 51%
Total Number of Patients: Waiting for Complex Continuing Care Relative to Total Number of Patients Waiting for Discharge from Inpatient Rehabilitation	Not captured	Not captured	Not captured	8/57 = 14%	3/39 = 8%	Not captured for all snapshots
Total Number of Patients: Waiting for Other Relative to Total Number of Patients Waiting for Discharge from Inpatient Rehabilitation	16/53 = 30%	33/51 = 65%	22/49 = 45%	*30/57 = 53%	*16/39 = 41%	117/249 = 47%

* Does not include complex continuing care as it was captured separately for the first time during the July & September 2003 snapshots.

Inpatient Rehabilitation Discharges and Admissions: By Region

The following table indicates the total number of patients ready for discharge per each region. The table further details patients waiting for long term care, complex continuing care and other placements.

Table 3.2-2: Inpatient Rehabilitation Discharges and Admissions by Region (Across all five snapshots)				
	Toronto	Halton/Peel	York	Durham
Total Number of Patients Waiting for Discharge from Inpatient Rehabilitation Relative to Total Number of Rehab Beds Occupied across all Region Specific Hospitals with Designated Rehab Beds	180 / 3430 = 5.2%	41 / 797 = 5.1%	12 / 254 = 4.7%	16 / 360 = 4.4%
Total Number of Patients Waiting for Long Term Care Placement Relative to Total Number of Rehab Beds Occupied across all Region Specific Hospitals with Designated Rehab Beds	97 / 3430 = 2.8%	23 / 797 = 2.9%	1 / 254 = 0.4%	7 / 360 = 1.93%
Total Number of Patients: Waiting for Long Term Care/Waiting for Discharge	97 / 180 = 54%	23 / 41 = 56%	1 / 12 = 8%	7 / 16 = 44%
Total Number of Patients: Waiting for Complex Continuing Care/Waiting for Discharge (during July and September snapshots)	2 / 180 = 1%	0 / 41 = 0%	7 / 12 = 58%	0 / 16 = 0%
Total Number of Patients: Waiting for Other/Waiting for Discharge**	81 / 180 = 45%	8 / 41 = 44%	3 / 12 = 25%	10 / 16 = 63%

** Includes complex continuing care, but not long term care.

Inpatient Rehabilitation Discharges and Admissions: By Organization Type

Table 3.2-3: Inpatient Rehabilitation Discharges and Admissions by Hospital Type (Across all five snapshots)					
Hospital Type	Total Number of Rehab Beds Occupied	Total Number of Patients Occupying Rehab Beds Who Were Awaiting Discharge	Total Number of Patients Awaiting LTC Placement	Total Number of Patients Awaiting CCC Placement	Total Number of Patients Awaiting Other Placement
Acute Teaching*	105 or 2%	0 or 0%	0 or 0%	0 or 0%	0 or 0%
Community	2201 or 45%	119 or 5.4%	40 or 34%	7 or 5.9%	72 or 61%
Rehabilitation	2535 or 52%	130 or 5.1%	88 or 68%	2 or 1.5%	40 or 31%
Total:	4841				

*Of the four acute teaching hospitals, only Sunnybrook and Women's College Health Sciences Centre has designated inpatient rehab beds.

Number of Patients Awaiting Rehabilitation in ALC versus Number of Designated Beds Available at Time of Snapshots

Table 4.1 illustrates:

- The number of patients awaiting rehab in ALC for each rehab group (Column A) with respect to...
- The number of beds vacant on the day of the snapshot (Column B) and...
- The number of beds available five days after the snapshot if all patients accepted and on the waiting list at each organization were to be admitted (Column C).

Table 4.1: Number of Patients Awaiting Rehabilitation in ALC versus Number of Designated Beds Available at Time of Snapshots															
Population	April 2003			May 2003			June 2003			July 2003			September 2003		
	A*	B*	C*	A*	B*	C*	A*	B*	C*	A*	B*	C*	A*	B*	C*
ABI**	10	9	2	8	0	-2	8	11	-8	8	0	-5	6	2	1
Amputee***	0	20	9	1	18	17	3	24	13	6	17	14	1	12	8
Burn	1	1	0	0	0	1	0	4	3	0	4	4	0	5	5
Cardiac	0	10	10	1	6	3	1	12	12	3	6	9	5	3	0
Chronic Pain	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSK	14	95	31	23	41	-33	17	104	29	18	18	-48	36	1	-83
Neurology	7	25	21	1	5	6	5	20	19	4	22	7	4	19	20
Oncology	0	2	2	0	0	0	4	2	1	1	1	0	3	2	1
Respiratory	2	26	-9	2	3	-49	0	8	-9	2	15	-36	3	2	-28
Spinal	6	11	7	6	9	8	2	11	10	1	3	4	1	-1	-10
Stroke	14	14	2	12	-4	-23	8	8	-20	14	-8	-25	16	-11	-21
Trauma	1	8	11	2	12	10	0	16	14	0	15	17	0	11	9
Geriatric	6	66	-12	11	7	-16	19	10	11	22	6	-6	19	9	-34
Other	0	23	7	4	12	3	1	9	4	0	8	-2	0	11	2
General	0	67	58	0	39	47	2	53	-14	4	31	12	6	31	-6

** Negative numbers (bolded in table) indicate overall greater demand than capacity.

*** Highlighted data indicate overall greater capacity than demand.

A* = Indicates the number of patients awaiting rehab in ALC in all Toronto Region hospitals during the April, May and June snapshots and all GTA Rehab Network Hospitals with ALC beds during the July & September snapshots.

B* = Indicates the number of vacant inpatient rehabilitation beds across all GTA hospitals with designated adult inpatient rehab beds as of the dates of the snapshots.

C* = Indicates number of rehabilitation beds available across the GTA five days post the dates of the five snapshots if all patients accepted and on the waiting list at each organization were to be admitted. Negative numbers indicate greater demand than capacity. As patients are often referred to more than one organization, it is likely they are maintained on more than one waiting list, which in reality, results in greater rehabilitation capacity than is reflected in these figures.

Referral Patterns: By Region

The following table indicates the overall distribution of all patients captured across all five snapshots for which the following numbers of referrals were made per region:

Table: 4.2-2: Number of Organizations to which Referrals Were Made per Patient by Region					
Region	Total Number of Patients Referred	Referrals made to:			
		One Organization	Two Organizations	Three Organizations	Four or More Organizations
Toronto	308	149 or 48%	74 or 24%	58 or 19%	27 or 9%
Halton/Peel	28	27 or 96%	1 or 4%	-	-
York	8	6 or 75%	1 or 13%	1 or 13%	-
Durham	4	4 or 100%	-	-	-
Total:	348	186	76	59	27

Referral Patterns: By Organization Type

Table: 4.2-3 Number of Organizations to Which Referrals were Made per Patient by Organization Type					
Hospital Type	Total Number of Patients Referred	Referrals made to:			
		One Organization	Two Organizations	Three Organizations	Four or More Organizations
Community	166 or 48%	103 or 62%	35 or 21%	21 or 13%	7 or 4%
Acute Teaching	182 or 52%	83 or 46%	41 or 22%	38 or 21%	20 or 11%
Total:	348	186	76	59	27

APPENDICES

APPENDIX A: GTA REHAB NETWORK ALC TASK GROUP MEMBERS

Chair

Malcolm Moffat, President and CEO, St. John's Rehabilitation Hospital

Task Group Members

Jocelyn Bennett, Program Director, Nursing – Clinical Specialties, Mount Sinai Hospital

Carol Cober, Director, Continuing Care Programs and Inpatient General Medicine, York Central Hospital

Lynn Douglas, Client Service Manager, Scarborough Community Care Access Centre

Georgia Gerring, Vice-President, Programs, Toronto Rehabilitation Institute

Steve Isaak, Executive Director, Halton-Peel District Health Council

Mary Murphy, Central Emergency Network Coordinator, St. Michael's Hospital

Heather Reid, Program General Manager, Continuing Care and Rehabilitation, Rouge Valley Health System

Diane Savage, Social Work, Mount Sinai Hospital

Fatima Sheriff, Utilization Manager, University Health Network

Dr. Gaetan Tardif, Director, Division of Psychiatry, University of Toronto; and Vice-President, Medicine, Toronto Rehabilitation Institute

Charissa Levy, Executive Director, GTA Rehab Network

Sue Balogh, Project Coordinator/Planner, GTA Rehab Network

Ruquaiyeh Siddiqi, Project Coordinator/Planner, GTA Rehab Network

APPENDIX B: SAMPLE SURVEYS

SNAPSHOT OF CURRENT INPATIENT REHABILITATION CAPACITY AMONG GTA REHAB NETWORK MEMBERS

PLEASE READ INSTRUCTIONS ON PAGE 1 BEFORE PROCEEDING WITH SURVEY ON PAGE 2

**SNAPSHOT IS TO BE TAKEN: WEDNESDAY SEPTEMBER 24TH PLEASE RETURN BY: THURSDAY
SEPTEMBER 25TH**

INSTRUCTIONS: Please note these instructions differ slightly from the previous capacity survey you received in June.

Thank you for participating in this snapshot of inpatient rehabilitation capacity in the Greater Toronto Area. This survey will take approximately 20 minutes to complete. Please read through the instructions in full before completing the survey.

1. Complete this survey **only** for your designated rehabilitation beds
2. You may print this survey and complete it manually or complete it using your mouse and keyboard
3. **Multi-site organizations** need only complete **one survey** for their corporation.
4. If you offer both **pediatric and adult** rehabilitation in your designated rehab beds, please complete a **separate form for each**
5. If you are a **community hospital**, please tell us which populations you serve, by checking **yes or no** for each population in the "type of patient" column **but** indicate the number of general rehab beds you have in the GENERAL REHAB row.
6. If you are a **rehabilitation hospital** with programs for different population groups, please **complete every row and column for each population group that you serve**.
7. If you provide both general rehabilitation and population specific rehabilitation, please ensure that the total reflects this information without double counting.

**SNAPSHOT OF CURRENT INPATIENT REHABILITATION CAPACITY
AMONG GTA REHAB NETWORK MEMBERS**

Name of Organization			
Site (if applicable please complete a separate form for each)			
Name of contact individual			
Telephone and Email Address		Telephone:	Email:
This survey is being completed for: (please check only one)		Adult Populations <input type="checkbox"/>	Pediatric Populations <input type="checkbox"/>

Population Group	Type of patient normally accepted (please check yes or no)		Number of beds currently staffed and in operation	Number of beds currently occupied	Number of patients ready for discharge but who are waiting for:			Total number of discharges expected between September 24 th and September 30 th	Number of patients accepted and expected to transfer to the facility between September 24 th and September 30 th from:		Number of referrals which: (A) Are currently wait listed and who do not have an admission date or who have an admission date after September 30 th ; (B) Have yet to be reviewed	
	Yes	No			(A) LTC	(B) CCC	(C) Other		Acute care	Other location	(A) Are currently wait listed	(B) Have yet to be reviewed
ABI	<input type="checkbox"/>	<input type="checkbox"/>										
Amputee	<input type="checkbox"/>	<input type="checkbox"/>										
Burns	<input type="checkbox"/>	<input type="checkbox"/>										
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>										
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>										
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>										
Neurology	<input type="checkbox"/>	<input type="checkbox"/>										
Oncology	<input type="checkbox"/>	<input type="checkbox"/>										
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>										
Spinal Cord	<input type="checkbox"/>	<input type="checkbox"/>										
Stroke	<input type="checkbox"/>	<input type="checkbox"/>										
Trauma	<input type="checkbox"/>	<input type="checkbox"/>										
Geriatric	<input type="checkbox"/>	<input type="checkbox"/>										
Other*	<input type="checkbox"/>	<input type="checkbox"/>										
GENERAL	<input type="checkbox"/>	<input type="checkbox"/>										
TOTAL NUMBER												

SAMPLE SURVEY OF PATIENTS AWAITING REHAB IN ALC

Snapshot of data to be taken on Wednesday September 24th, 2003				
Please Return this Survey to the GTA Rehab Network on Thursday September 25, 2003				
Contact Information: GTA Rehab Network	Telephone: 416-597-3057 Email: gtarehabnetwork@torontorehab.on.ca Fax: 416-345-7021			
Date Data Collected:				
Hospital Name				
Site				
SARS Category				
CCAC (pick your local CCAC)				
Contact for Clarification				
Phone				
Fax				
Please provide the following information for each patient in Alternate Level of Care awaiting rehabilitation who is ready for transfer today				
1. Patient Medical Record Number				
2. Diagnosis of Patient				
3. Age of Patient				
4. Sex of Patient				
5. List any co-existing conditions or special needs this patient has				
6. Indicate the number of days this patient has been designated ALC awaiting rehab				
7. Indicate the date the patient was designated ALC				
8. Has a referral been made to rehab?				
9. If no, why not?				
10. If yes, for each patient referral indicate:	Date Referral Sent	Organization	Program	Program Details
example:	17-Apr-03	Bridgepoint	Stroke	Inpatient - slow stream
11. In the chart below, list each organization where this patient has been referred and with an 'x' indicate the current status of the referral. If not accepted, please specify why				
Organization	No response to date	Accepted & on wait list	Not accepted	If not accepted, indicate reason provided

APPENDIX C: ORGANIZATIONS THAT RESPONDED TO THE SURVEY FOR EACH OF THE SNAPSHOTS*

*As indicated by checkmark (✓)

Patients Awaiting Rehab in ALC					
Organization	April	May	June	July	September
Humber River Regional	✓	✓	✓	✓	✓
North York General Hospital	✓	✓	✓	✓	✓
Mount Sinai Hospital	✓	✓	✓	✓	✓
Rouge Valley Health System	✓	✓	✓	✓	✓
The Scarborough Hospital	✓	✓	✓	✓	✓
St. Joseph's Health Centre	✓	✓	✓	✓	✓
St. Michael's Hospital	✓	✓	✓	✓	✓
Sunnybrook & Women's College Health Sciences Centre	✓	✓	✓	✓	✓
Toronto East General & Orthopaedic Hospital	✓	✓	✓	✓	✓
University Health Network	✓	✓	✓	✓	✓
**Credit Valley Hospital	n/a	n/a	n/a	✓	✓
**Halton Healthcare Services	n/a	n/a	n/a	✓	✓
**Lakeridge Health	n/a	n/a	n/a	✓	✓
**Markham Stouffville Hospital	n/a	n/a	n/a	✓	✓
**Southlake Regional Health Centre	n/a	n/a	n/a	✓	✓
**William Osler Health Centre	n/a	n/a	n/a	✓	✓
**York Central Hospital	n/a	n/a	n/a	✓	✓
**Trillium Health Centre	n/a	n/a	n/a	✓	----

Rehab Capacity					
Organization	April	May	June	July	September
Humber River Regional	✓	✓	✓	✓	✓
Credit Valley Hospital	✓	✓	✓	✓	✓
North York General Hospital	✓	✓	✓	✓	✓
Rouge Valley Health System	✓	✓	✓	✓	✓
The Scarborough Hospital	✓	✓	✓	✓	✓
St. Joseph's Health Centre	✓	✓	✓	✓	✓
Lakeridge Health	✓	✓	✓	✓	✓
Sunnybrook & Women's College Health Sciences Centre	✓	✓	✓	✓	✓
Toronto East General & Orthopaedic Hospital	✓	✓	✓	✓	✓
Toronto Rehabilitation Institute	✓	✓	✓	✓	✓
Bridgepoint Health	✓	✓	✓	✓	✓
St. John's Rehabilitation Hospital	✓	✓	✓	✓	✓
West Park Healthcare Centre	✓	✓	✓	✓	✓
Baycrest Centre for Geriatric Care	✓	✓	✓	✓	✓
Halton Healthcare Services	✓	✓	✓	✓	✓
Markham Stouffville Hospital	✓	✓	✓	✓	✓
Southlake Regional Health Centre	----	✓	✓	✓	✓
Trillium Health Centre	✓	✓	✓	✓	✓
William Osler Health Centre	✓	✓	✓	✓	✓
York Central Hospital	✓	✓	✓	✓	✓
Providence Healthcare	✓	✓	✓	✓	✓

** These organizations were not surveyed in the April, May and June 2003 snapshots to capture patients awaiting rehab in ALC.

APPENDIX D: ORGANIZATIONS SURVEYED ACCORDING TO REGIONS

Region	Organization
Toronto	<ul style="list-style-type: none"> ▪ Bridgepoint Health ▪ St. John’s Rehabilitation Hospital ▪ Toronto Rehabilitation Institute ▪ West Park Healthcare Centre ▪ St. Michael’s Hospital ▪ Mt. Sinai Hospital ▪ Sunnybrook & Women’s College Health Sciences Centre ▪ University Health Network ▪ Baycrest Centre for Geriatric Care ▪ Humber River Regional Hospital ▪ North York General Hospital ▪ Providence Healthcare ▪ St. Joseph’s Health Centre ▪ The Scarborough Hospital ▪ Toronto East General and Orthopaedic Hospital ▪ Rouge Valley Health System (Centenary Site) ▪ William Osler Health Centre (Etobicoke Site)
Halton/Peel Regions	<ul style="list-style-type: none"> ▪ Credit Valley Hospital ▪ Halton Healthcare Services ▪ Trillium Health Centre ▪ William Osler Health Centre (Brampton and Georgetown Sites)
York Region	<ul style="list-style-type: none"> ▪ Markham Stouffville Hospital ▪ Southlake Regional Health Centre ▪ York Central Hospital
Durham Region	<ul style="list-style-type: none"> ▪ Lakeridge Health ▪ Rouge Valley Health System – (Ajax/Pickering Site)

APPENDIX E: ORGANIZATIONS SURVEYED ACCORDING TO ORGANIZATION TYPE

Organization Type	Organization
Rehabilitation Centres (6)	<ul style="list-style-type: none"> ▪ Baycrest Centre for Geriatric Care ▪ Bridgepoint Health ▪ Providence Healthcare ▪ St. John’s Rehabilitation Hospital ▪ Toronto Rehabilitation Institute ▪ West Park Healthcare Centre
Acute Teaching Hospitals (4)	<ul style="list-style-type: none"> ▪ Mt. Sinai Hospital ▪ St. Michael’s Hospital ▪ Sunnybrook & Women’s College Health Sciences Centre ▪ University Health Network
Community Hospitals (14)	<ul style="list-style-type: none"> ▪ Credit Valley Hospital ▪ Halton Healthcare Services ▪ Humber River Regional Hospital ▪ Lakeridge Health ▪ Markham Stouffville Hospital ▪ North York General Hospital ▪ Rouge Valley Health System ▪ The Scarborough Hospital ▪ Southlake Regional Health Centre ▪ St. Joseph’s Health Centre ▪ Toronto East General & Orthopaedic Hospital ▪ Trillium Health Centre ▪ William Osler Health Centre ▪ York Central Hospital

* For the purposes of data analysis, participating organizations were organized into the above categories to distinguish among Rehabilitation Centres that have designated rehab beds and no ALC beds, Acute Teaching Hospitals that have ALC beds and Community Hospitals that have a combination of ALC and designated rehab beds.

APPENDIX F: REFERENCES

1. Greater Toronto Area Rehabilitation Network, (2003) Waiting List Information Management Task Group. Measuring and Managing Supply and Demand: A Waiting list Information Management Proposal for Musculoskeletal Rehabilitation in the Greater Toronto Area. Toronto, Canada.
2. Rafferty, C., Markel, F., Macmillan, I., Rodgers, J. (2002) How do patients and physicians rate urgency of care? A comparison of urgency ratings for general survey. *Hospital Quarterly*. Spring, 31-40.
3. Rafferty, C. (2001). Presentation to GTA Rehab Network Waiting List Information Management Task Group. December.