

Consensus and Collaboration in the Care of Hip Fracture Patients: Towards a Plan for the System

**GTA Rehab Network Hip Fracture Committees
Summary Report**

November 2006

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EXECUTIVE SUMMARY

Background

The care of hip fracture patients in the Greater Toronto Area is currently characterized by a lack of standardization in practice across organizations, inability to address the needs of patients with dementia and medical complexities, and long lengths of stay. Hip fracture patients account for about 20% of inpatient rehabilitation. Their treatment presents significant social, medical, financial and quality of care issues.

In January 2006, the GTA Rehab Network put out a call for leadership from Network member organizations to develop a system wide plan for streamlining and improving the care of hip fracture patients. The initiative was spurred by the recommendations of the GTA Rehab Network's former MSK Best Practices Task Group; reports conducted by researchers; and the leadership interlocks existing between the GTA Rehab Network and the Total Joint Network. Over 17 organizations stepped forward to form a steering committee with two subgroups focussed on advocacy and models of care.

Approach

During the six-month period in which the committees were active, the groups collectively identified key issues and consulted with experts in the field. The objectives were to understand the literature available on discharge options after hip fracture and the practices of the provincial leader in the care of hip fracture patients in Ontario.¹ Following these consultations, the group identified characteristics that could be used to differentiate subgroups within the hip fracture population and differences in potential discharge locations. The group also reviewed and discussed a proposed model of care for hip fracture patients that was being used in a pilot project between Toronto Rehab and Toronto Western Hospitals. The group embraced the proposed model as a good one for the system. A proposal based on the model was developed by the Total Joint Network in collaboration with the GTA Rehab Network hip fracture committees for a funding opportunity arising through the Performance Improvement Fund. Possible implementation issues were flagged for later discussion.

Summary of Key Findings

- *Most prevalent issues in the care of hip fracture patients:* Issues commonly faced by GTA Rehab Network members in the care of hip fracture patients include: getting patients from the emergency department into surgery; dealing with clinical complexity; referral and discharge disposition issues; and human resource/physician remuneration issues.
- *Inconclusive evidence on optimal setting for post fracture care:* The relevant literature does not give conclusive evidence on ideal interventions or differences in outcomes according to discharge destinations. A review of the literature on best practices in hip fracture care was conducted in Australia and put into the format of a clinical pathway.
- *Suitability of the hip fracture model currently identified as the provincial leader:* Hospital Report Card 2005 identified Providence Continuing Care Centre in Kingston as a provincial leader in the care of hip fracture patients based on the clinical utilization and outcomes quadrant of the Hospital Report Card for Rehabilitation 2005. Their model is characterized by long standing relationships between the individuals involved in each part of the continuum; the presence of the traditional

¹ As defined by Hospital Report Card for Rehabilitation 2005 in the clinical utilization and outcomes quadrant.

rehabilitation team including a hospitalist; daily pool and exercise therapy; and consistent messaging to the patient and family. The model however does not take non-weight-bearing patients or patients who are cognitively impaired. It is also operating in the context of a smaller urban centre in which there are fewer organizations involved in the referral process and care of hip fracture patients. These factors were felt to be a limitation for its suitability in the GTA.

- *Salient characteristics in differentiating streams of patients:* By developing case studies describing typical patients, the group identified 12 salient characteristics that may impact the level of care a patient receives. These include: level of social support; extent of supervision available for the patient in the home upon discharge; extent of informal housekeeping assistance available; medical issues; dementia; difficulty understanding instructions; presence of behavioural issues; osteoporosis; depression; or special needs; extent to which the home is accessible from a mobility perspective; and willingness to participate in rehabilitation.
- *A potential model of hip fracture care in the GTA:* A model of care developed and trialed between Toronto Western Hospital and the Toronto Rehabilitation Institute premised on a comprehensive rehabilitation and geriatric assessment for each patient, including those who are traditionally excluded from rehabilitation, was felt to be an appropriate model for the system. The proposed model would provide better use of rehabilitation beds, shorter acute care and rehab lengths of stay, and accommodate more patients with medical complexities, dementia, depression, delirium, and cognitive impairments. It was submitted in June for funding consideration to the Performance Improvement Fund.
- *Issues for future consideration in the implementation of a new model of care:* Implementation issues identified for further discussion on the proposed model of care included the establishment of partnerships so that each organization would optimize its role in the model of care; appropriate training and human resource recruitment; and developing ability to deal with cognitive impairments, dementia and delirium affecting rehab as well as medical complexities.

Recommendations

The work of the hip fracture committees resulted in a number of recommendations endorsing the adoption of a new model of care as proposed from the Toronto Rehabilitation Institute and Toronto Western Pilot Project. These are contained in the proposal that was submitted to the Performance Improvement Fund (Available: <http://gtarehabnetwork.ca/currentproject.asp#hipfractures>)

In addition to those recommendations, the following process-related recommendations were also made:

1. Re-examine the GTA Rehab Network Hip Fracture committee structure in collaboration with the Total Joint Network to ensure that the committee structure is aligned with next steps.
2. Seek external funding to develop patient and family support materials that would complement the new model of care and facilitate knowledge transfer.
3. Develop triage guidelines for hip fracture patients to assist referrers in selecting the most appropriate discharge destination for patients in the new model of care.
4. Support and integrate the work of the GTA Rehab Network Definitions task group which is identifying the minimum requisite components of rehab in different settings.

Conclusions

Over a period of six months, the Hip Fracture committees of the GTA Rehab Network have consulted with industry experts and leaders on the care of hip fracture patients; drafted a typology for hip fracture patients and programs that can be further developed to differentiate streams for this population; and worked with the Total Joint Network in developing a funding proposal for the implementation of a new model of care. The work of these committees demonstrates the ongoing spirit of collaboration and commitment to optimizing access and outcomes for rehabilitation patients and their families in the GTA.

1.0 BACKGROUND

1.1 Purpose

The objectives of this report are to consolidate, for reference, the discussions, consultations, and proposals developed by the GTA Rehab Network hip fracture committees for the care of this patient group. It includes a summary of a funding proposal developed through the Total Joint Network (TJN) in collaboration with the GTA Rehab Network Hip Fracture committees.

1.2 Motivation

Following the recommendations published by GTA Rehab Network member committees and partners², the GTA Rehab Network committed through its 2006-2007 operating plan to collaborate in: 1) the development of a system-wide proposal for improvements in access and quality of care for individuals with hip fractures 2) triage guidelines and 3) the dissemination of best practices in the care of this patient group.

In January 2006, the GTA Rehab Network asked all organizations to consider their interest in providing leadership in a system wide initiative to streamline the care of hip fracture patients across the five Local Health Integrated Networks which span the GTA. Seventeen organizations appointed representatives to sit on the steering committee.

Two additional subcommittees were then formed, the advocacy and models of care task groups. The mandate of the Advocacy Task Group was to explore the social, political, financial and communication elements involved in supporting a system wide change in the care of hip fracture patients. The mandate of the Models of Care Task Group was to explore the operational and clinical elements of possible alternatives to the current organization and delivery of hip fracture services in the GTA. The mandate of the steering committee was to identify key issues of concern; propose possible solutions; and assist in finding the means through which to implement a system change in the care of this population.

1.3 Approach

The approach included the following:

- Identification of key issues experienced by organizations in the care of hip fracture patients
- A review of existing initiatives that can be used as learning models or models for replication
- Consultation with Providence Continuing Care Centre (PCCC) in Kingston³
- Consultation with experts in the field to better understand the available evidence on outcomes of different types of post fracture care.
- Development of a proposal to the Network's Coordinating Council seeking support for the Network's collaboration with the Total Joint Network to replicate the TJN model for hip fracture patients and seek one time implementation funding.
- Review and discussion of a model of care currently being tested for a pilot project through Toronto Rehab and Toronto Western Hospitals and the development of a funding proposal for this model in collaboration with the Total Joint Network.

² (GTA Rehab Network, 2006) [Exploring the Hip Fracture and Joint Replacement Landscape in a Changing Context: Implications and Recommendations](#), and (ACRUE, 2006) [Current Status and Future Opportunities for Inpatient Musculoskeletal Rehabilitation: An Analysis of Supply Data and Provider Viewpoints on Future Needs](#) available: www.gtarehabnetwork.ca/publications.asp

³ Ontario's highest performer³ in clinical utilization and outcomes for the hip fracture RCG

- Identification of the potential differentiating characteristics of hip fracture patients and programs through draft case studies and an analysis of MSK program objectives.

2.0 FINDINGS

2.1 What key issues do organizations face in caring for hip fracture patients?

Each organization was asked to identify priority issues in the care of hip fracture patients from the organizational perspective. The following themes emerged:

Accessing surgery from the emergency department:

- Availability of operating room time
- Flow of patients from the emergency department to an acute care bed

Determining appropriate discharge destination:

- Absence of a screening mechanism to assist in discharge destination selection
- Understanding the differences across various discharge destinations
- Caring for patients who are sent back to acute care due to inappropriate referral, change in patient status, or co-morbidities (especially cardio-respiratory issues).

Clinical management and operational issues:

- Addressing the needs of individuals with: cognitive issues, medical complexities, pain, delirium, medical stability, and weight bearing status
- Moving patients out of rehabilitation within the 14-day period designated for some rehabilitation units and maintaining a shorter length of stay in acute care.

Human resource issues:

- Physician remuneration policies preclude remuneration of a geriatrician for coordinating the care of a patient, leaving the coordination aspect to other physicians or professionals.
- Availability of training resources to ensure that staff know how to work with patients who have issues related to cognition, dementia or delirium.

2.2 What hip fracture initiatives are already occurring across the continuum in the GTA?

Each organization was asked to identify key initiatives in the care of hip fracture patients that could be shared with the committee for learning or modeling purposes. These are described very briefly below. It should be noted that these initiatives were identified in January 2006 and may or may not be still current. The initiatives are also not intended to represent all of the hip fracture activities of the organization, but rather to record activities that were discussed at the January 2006 meeting in the context of information sharing and possible learning opportunities. Please contact the organization directly for further information on any organization specific program.

Rouge Valley Health System, Ajax-Pickering Site:

- Plans to split unit at the Ajax site in order to create a transitional care unit so that patients can develop tolerance until they are ready to participate in a full rehabilitation program

York Central Hospital:

- Uses complex continuing care beds for this population and is working to address delirium and pain management in the post operative period. A focussed effort is being made to reduce wait time for these patients in the emergency department.

Etobicoke-York Community Care Access Centre and St. Hilda's Home for the Aged:

- Both maintain hip fracture patients in their care as long as necessary until the patient is safe on his or her own. A well developed falls prevention program also exists.

West Park Healthcare Centre:

- The Functional Enhancement Service (FES) was created due to an identified need to provide rehabilitation for patients who are unable to tolerate the intensity of the present rehab programs (Neuron and MSK), and who would require a longer length of stay to achieve established functional goals (90-120 days average). The population on the FES unit is mixed: neurological (ABE, CVA, other) and MSK. The MSK rehabilitation unit also accepts patients who are non-weight-bearing.

Providence Healthcare:

- Providence Healthcare has 43 beds dedicated to orthopedic amputee rehabilitation. To support this busy rehab unit, four years ago Providence opened a pre-rehab service in the complex continuing care program to link the patient's post-surgical journey from the acute care hospital to the active ortho rehab service within Providence. In addition, Providence has a specialized geriatric service that supports the older frail adult who has had a fracture and can benefit from rehab in order to return home to the community or return to a long term care facility at a higher functional level.

Toronto Rehab/Toronto Western Hospital:

- This partnership initiative is looking at a new model of care for hip fracture through a pilot study. The model explores the potential of rapidly transitioning patients from acute care to rehab and the care of patients who do not traditionally fit the eligibility criteria for rehab. It also involves consideration of CCC and geriatric programs to serve this population.

Mt. Sinai Hospital:

- Mt. Sinai Hospital has developed care pathways to guide patient triage from the emergency department to the next phase or type of care.

St. Michael's Hospital:

- Designated Osteoporosis screening clinic designed to help prevent second fractures which are common for individuals who have an initial hip fracture.

Bridgepoint Health:

- At Bridgepoint Health, patients who have sustained a hip fracture are admitted to either Ortho Rehab or Ortho Activation based on their weight bearing status, cognitive abilities and their tolerance for therapy. Patients are admitted from emergency or other acute care inpatient units. We are currently reviewing the proposed Hip Fracture Model of Care to enhance the services that we currently provide to patients with hip fractures.

2.3 What does the literature say on rehabilitation options following hip fracture?

As per the Network's commitment to utilizing the best available evidence to inform system change initiatives, the committees consulted with Dr. Susan Jaglal, Toronto Rehabilitation Institute Research

Chair at the University of Toronto, to provide the committee with a review of the evidence on rehabilitation options following hip fracture.

Dr. Jaglal's review included six randomized control trials (RCTs) from the UK, Australia, Sweden, Finland and Canada comparing different interventions for patients with similar age and inclusion criteria. While the literature could not provide conclusive evidence as to the outcomes of each intervention, it did allow the committee to identify the types of discharge options, interventions, and outcome measures being used in the care of hip fracture patients. These are summarized in the sections below:

Post surgical discharge options for hip fracture patients.

- Orthopedic unit (acute and post acute care in same location)
- Geriatric orthopedic rehabilitation units: mixed assessment and rehab unit (acute and post acute care are separate)
- Geriatric hip fracture program (usually operates within an orthopedic unit to offer multi-disciplinary care as well as care from a geriatrician)
- Early supported discharge program (transfer of selected patients after early identification in orthopedic unit)

Types of interventions used in the care of hip fracture patients:

- Geriatric-orthopedic care in a designated unit and weekly case conferences with allied health
- Multi-disciplinary care by a general practitioner or geriatrician in orthopedic unit
- Early mobilization, comprehensive rehabilitation, early discharge, family contact
- Transfer to geriatric hospital and weekly visit by orthopedic surgeon
- Multi-disciplinary geriatric team and intensive rehabilitation based in geriatric ward
- Ortho-geriatric hip fracture unit with two interdisciplinary meetings/week

Types of outcomes of post fracture rehabilitation commonly identified in studies:

- Regaining mobility especially re walking and self care
- Improvement in geriatric depression scale
- Improvements in pain, vitality, mental health, and physical function.

2.4 What can we learn from other models for the care of hip fracture patients?

Hospital Report Card Rehabilitation 2005 identified Providence Continuing Care Centre (PCCC) in Kingston as a high performance hospital in the hip fracture Rehabilitation Client Group (RCG).

Measures used and outcomes achieved at Providence Continuing Care Centre, Kingston:

- Higher than average performance in clients reporting improved health status, improvement in pain and ability to achieve goals.
- Clients and families are involved in the decision and goal setting process and receive a high level of emotional support.
- LOS efficiency is 1.2 FIM points/day⁴. This compares to 0.8 FIM points/day average in Ont.
- A majority (83%) of patients who were living in their homes prior to the acute care admission return to the community. Nearly 50% of these patients receive home care services or assisted living services. The remaining 20% of patients admitted from their homes, either are discharged back to acute care (5%) or to long term care (14%).

⁴ Change in FIM score divided by the length of stay

Model Characteristics:

- A team which includes: physical medicine and rehab specialist, hospitalist, nursing, physiotherapy, occupational therapy, discharge planning, CCAC case management, social work, psychology, nutrition
- Stable team, strong relationships, consistent staffing, good communication, strong linkages with acute care, CCAC, outpatient rehab, community services
- Daily rehab PT/OT and pool therapy, and medical management. Emphasis on pain management to enable patient to fully participate in rehab
- Consistent information given to patients and families by the team; well established protocol
- Weekly revisiting of discharge plans and goal achievement
- Approach to discharge involves team and family discussions within the first week to determine location, timelines, and family support for discharge.

The group felt that this consultation was very informative. While the protocols for admission, discharge, and decision making are not available in a formalized format, the long standing interpersonal relationships between the providers along the continuum of care in Kingston appear to be a critical success factor. Some concern however was noted that a model for the GTA needed to include the ability to accept and care for patients with cognition issues, dementia and medical complexities. It would also need to consider the unique context of the GTA as a large urban centre with multiple organizations involved in the referral and provision of care of hip fracture patients.

2.5 Can we differentiate streams of hip fracture patients and hip fracture programs?

The committee felt that a critical success factor in a new model of care for hip fracture patients would be the recognition of diversity within this patient group and within the current complement of services offered to hip fracture patients. It was felt to be important to find a way to more appropriately match patient characteristics with those of the program or service.

As such, the committee developed 7 case studies⁵ that could serve as typical prototypes of hip fracture patients based on a combination of 12 factors which we have listed below. In addition, the types of discharge destinations available to hip fracture patients and the types of program objectives articulated in Rehab Finder⁶ were also analyzed and listed.

Factors potentially differentiating patient cases or situations:

- Level of social support
- Extent of supervision available for the patient in the home upon discharge
- Extent of informal housekeeping assistance available
- Extent to which home is accessible from a mobility perspective
- Presence of complex medical issues
- Presence of osteoporosis
- Presence of special needs
- Presence of dementia
- Difficulty understanding instructions
- Presence of behavioural issues
- Presence of depression
- Willing to participate in the rehabilitation process

⁵ It should be noted that the case studies were not developed using commonly accepted qualitative case study research methodology. They are therefore intended to serve as a starting point only.

⁶ Rehab Finder is the GTA Rehab Network's database of publicly-funded rehabilitation programs and service admission criteria and descriptions.

Potential types of discharge destinations based on committee discussions:

- Home with rehabilitation support (PT/OT)
- Home with nursing support
- Home with personal support services
- Home without additional publicly funded support
- Home with outpatient or follow up appointment
- Inpatient care in a geriatric rehabilitation program
- Inpatient care in a general rehabilitation setting
- Inpatient care in a low tolerance long duration bed through complex continuing care or rehab
- Inpatient care in a complex continuing care bed
- Inpatient care in a convalescent care bed
- Inpatient and residential support through a long term care bed

Types of program objectives which may be used to differentiate hip fracture programs:

- Meeting needs of patients who are aggressive or uncooperative
- Meeting needs of patients who have delirium, dementia, or cognition issues
- Providing multi-system rehabilitation due to complex rehab needs
- Focussing on doing what is necessary to get the patient home safely
- Providing pre rehab or an opportunity to transition after acute care
- Providing ongoing complex medical or nursing support to the patient
- Increasing strength and range of motion
- Accommodating the needs of patients who require low tolerance long duration rehabilitation

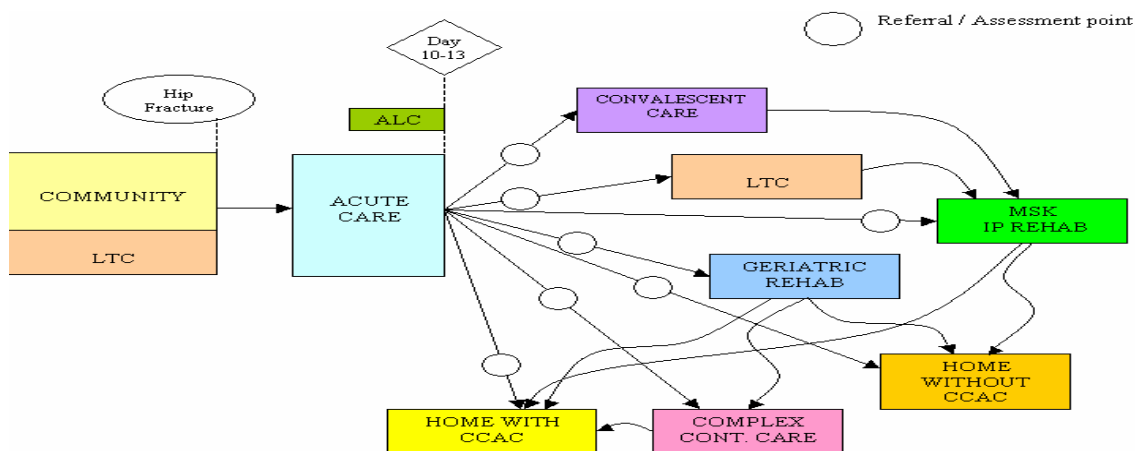
2.6 What is a potential model of care and what are the considerations for implementation?^{7 8}

The Models of Care task group began with the intent of proposing a new model of care by surveying existing programs and patient characteristics and using the survey information to begin a series of guidelines for selecting a discharge destination for the patient from acute care. Given the status of the current system, which is characterized by the absence of a set pathway, multiple referral and assessment points, and a lack of clarity on discharge destinations (depicted in figure 1), the group felt that studying the current situation without giving individuals a proposed ideal model to respond to would not be fruitful.

⁷ These items were raised as relevant question in a survey which was not administered due to timing issues.

⁸ It should be noted that some of this text and material was developed by the Total Joint Network in collaboration with the GTA Rehab Network hip fracture committees for the Performance Improvement Fund Application that was submitted in June 2006.

Figure 1: Depiction of current situation in care of hip fracture patients (developed by TJN and the GTA Rehab Network Hip Fracture Committees for a submission to the Performance Improvement Fund).

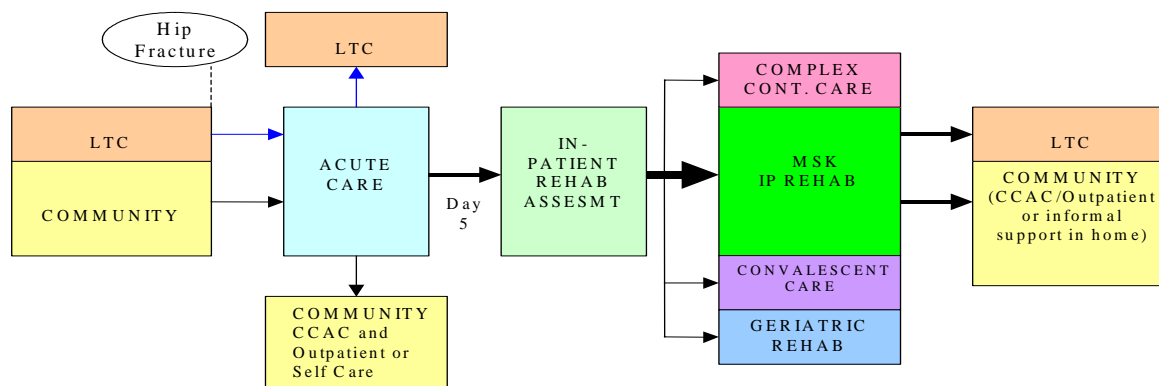


As such, a model of care used for a pilot project by Toronto Rehab and the University Health Network was presented to the committee (depicted in figure 2).

The tenets of the model are as follows:

- All hip fracture patients will be admitted to acute care hospitals and receive surgical care in a timely fashion (ideally within 48 hours).
- Patients from the community who are progressing well after surgery and are able to be discharged home will be encouraged to do so with appropriate CCAC services.
- Patients living in a long term care facility prior to their fracture will be transferred back to their respective facility on day 5 post surgery if medically stable with CCAC services if necessary.
- All medically stable patients who came from the community and require further rehab will be transferred to an appropriate inpatient rehab unit on day 5 post surgery regardless of fracture type, weight bearing status or cognitive function.
- During the first 7 days in inpatient rehab, patients will begin rehabilitation and undergo a multidisciplinary evaluation to determine the most appropriate setting for continued rehabilitation. The majority will remain in an active rehab unit, others may require complex continuing care, geriatric rehab or convalescent care.
- An integrated model of care will facilitate seamless transfer of patients to the most appropriate setting at the appropriate time to ensure best possible care.
- The model is currently being implemented as a pilot initiative between University Health Network, Mt. Sinai Hospital, Toronto Rehab and Toronto CCAC.

Figure 2: Proposed Framework for care of patients with hip fractures⁹



The group reviewed the model and felt it would achieve:

- Improved system efficiency for hip fracture patients resulting in reduced wait times for surgery, length of stay in acute care hospitals and improved access to rehabilitation.
- A seamless model of care that will increase access to appropriate rehabilitation for patients, especially those with issues restricted weight bearing status, altered cognition or dementia.
- Patient centered care that will empower patients and their families to better manage the challenges of the hip fracture journey.
- An integrated, evidence-based clinical pathway, which will help to reduce errors and ensure that all patients receive optimized care. This will increase efficiency by reducing pressures on each phase of the care continuum.
- Alignment with LHIN, Ontario Ministry of Health and Long-Term Care wait time strategies to promote integration and to help achieve benchmarks for timely delivery of care.

The model was unanimously endorsed. The Total Joint Network, in partnership with the GTA Rehab Network Hip Fracture Committees, developed a proposal for a funding opportunity with the Performance Improvement Fund. The signatures of all GTA Rehab Network member organization CEOs/EDs as well as leaders for Osteoporosis Canada and the Ontario branch of the Arthritis Society, provided their signatures in support for the initiative.

In the early examination of the model, the committee developed a series of questions designed to help assess the gap between the current and proposed states and to help identify what elements would need to be put in place in order to achieve it. Although the items below were not validated, they are recorded for future consideration at the implementation stages.

- How to address the transition/transfer of patients with any of the following: oxygen, catheters, urinary tract infections, pneumonia, pressure sores or wound care issues.
- How to ensure that the necessary assessments related to pre-morbid functioning, fracture, care assessments, past medical history, living arrangements and social supports occur.
- How to determine what the most appropriate expected outcomes are at each stage of treatment and which outcome measurement tools will be used.

⁹ This framework was adapted from the TRI/Western pilot project model and modified for submission in the Performance Improvement Fund Application by the Total Joint Network in collaboration with the GTA Rehab Network Hip Fracture Committees.

- How and with whom to develop necessary partnerships to facilitate optimal resource utilization for each organization while ensuring equitable and effective care for patients.
- How to identify where medical staff need to be recruited with specializations in geriatrics and psychiatry.
- How to differentiate or identify the parameters used to determine the optimal care setting for the patient after the initial stages of care.
- How to identify patients who can be discharged safely home immediately after acute care.
- How to identify the educational needs of staff in dealing with issues related.

While the committees' discussions about the model to date have focussed primarily on the transition of patients after acute care, the committee felt it would be important to give further consideration to the resources needed to ensure successful community reintegration following hip fracture.

3.0 RECOMMENDATIONS AND NEXT STEPS

The work of the hip fracture committees resulted in a number of recommendations endorsing the adoption of a new model of care as proposed from the Toronto Rehabilitation Institute and Toronto Western Pilot Project. These are contained in the proposal that was submitted to the Performance Improvement Fund (Available: <http://gtarehabnetwork.ca/currentproject.asp#hipfractures>).

In addition to those recommendations, the following process-related recommendations were also made:

1. Re-examine the GTA Rehab Network Hip Fracture committee structure in collaboration with the Total Joint Network to ensure that it is aligned with next steps.
2. Seek external funding to develop patient and family support materials that would complement the new model of care and facilitate knowledge transfer.
3. Develop triage guidelines for hip fracture patients to assist referrers in selecting the most appropriate discharge destination for patients in the new model of care.
4. Support and integrate the work of the GTA Rehab Network Definitions task group which is identifying the minimum requisite components of rehab in different settings.

4.0 CONCLUSION

Over a period of six months the Hip Fracture Advocacy, Models of Care and Steering Committees of the GTA Rehab Network have come to consensus on a new approach for caring for hip fracture patients, identified key implementation issues, proposed a draft typology that can be further developed to differentiate streams of patients and programs and worked with the Total Joint Network in developing a funding proposal for the implementation of a new model of care. The work of these committees demonstrates the ongoing spirit of collaboration and commitment to optimizing access and outcomes for rehabilitation patients and families in the GTA.

5.0 COMMITTEE MEMBERS AND ACKNOWLEDGEMENTS

The GTA Rehab Network would like to acknowledge the members of the Hip Fracture Steering Committee and the Advocacy and Models of Care Task Groups. Special thanks are also extended to the Total Joint Network.

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Ms. Carol Cober	York Central Hospital
Ms. Tatiana Diamond	York Central Hospital
Ms. Charissa Levy	GTA Rehab Network
Ms. Tina Saryeddine	GTA Rehab Network

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