

**Partners in Transformation**  
**GTA Rehab Network Strategic Plan**  
**2005-2008**

**June 2005**



**GTA REHAB  
NETWORK**

GTA Rehab Network  
Strategic Plan 2005 - 2008

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## EXECUTIVE SUMMARY

In January 2005 the GTA Rehab Network initiated a strategic planning process with the intent to create a vision for rehabilitation in the Greater Toronto Area (GTA) and to identify strategic priorities for the Network that would guide its actions over the next three years. The initiation of the strategic planning process was prompted by the desire to reflect on the progress of the first five years of the Network and by the emergence of Ontario's Health Transformation Agenda and the resulting potential opportunities for the Network.

### A Vision for Rehabilitation in the GTA

An in-depth articulation of the future vision for rehab was expressed in *Rehabilitation in the Greater Toronto Area: A Vision for the Future*, a supplementary document which was commissioned at the start of the planning process<sup>1</sup>.

The report examined the current state of rehabilitation in the GTA and key drivers and trends that impact the need for, access to, and delivery of, rehab services for clients and their families. Specifically, major population forces, scientific developments, human resources and clinical and program shifts, as well as the absence of a policy framework for rehabilitation in Ontario, provide the backdrop for creating the following vision for rehabilitation in the GTA:

#### Vision

**Rehabilitation is an integral and essential component of the continuum of health care, reinforcing positive health behaviours, rebuilding lives and reintegrating individuals into the community.**

The Network's vision for rehabilitation services in the GTA embodies several defining principles, key characteristics and enabling processes, the *highlights* of which are summarized below:

#### Principles

- Equitable access to rehabilitation services that is characterised by affordability, adequate service capacity and timely transitions.
- Family-centred and consumer driven initiatives
- Evidence-based wherever possible and focussed on improved client and population outcomes at all times.

#### Characteristics

- Rehabilitation services and programs are arrayed across the continuum in three major groupings:
  - High volume, high intensity
  - Low volume, high intensity
  - Across the continuum, outside of designated programs or units.

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<sup>1</sup> *Rehabilitation in the Greater Toronto Area: A Vision for the Future* is available as a supplementary report on the GTA Rehab Network website – [www.gtarehabnetwork.ca](http://www.gtarehabnetwork.ca)

**Characteristics**

	<b>High Volume – High Intensity</b>	<b>Low Volume – High Intensity</b>	<b>Across the continuum, outside of designated programs or units</b>
<b>Setting</b>	<ul style="list-style-type: none"> <li>delivered in <i>designated rehabilitation hospitals</i> or <i>designated programs/units</i> in acute care and community hospitals</li> <li>inpatient, ambulatory and in-home settings</li> </ul>	<ul style="list-style-type: none"> <li>delivered in <i>designated rehabilitation hospitals</i> or <i>designated programs/units</i> in acute care hospitals</li> <li>inpatient, ambulatory and in-home settings</li> </ul>	<ul style="list-style-type: none"> <li>delivered across the continuum of care in a variety of settings <i>outside</i> of designated programs or units</li> </ul>
<b>Population</b>	<ul style="list-style-type: none"> <li>targeted to clients who require high intensity of rehabilitation and/or highly specialized expertise</li> </ul>	<ul style="list-style-type: none"> <li>targeted to clients who require high intensity of rehabilitation and/or highly specialized expertise/technology</li> </ul>	<ul style="list-style-type: none"> <li>targeted to clients who require rehab in order to transition to another level of care or to a higher level of independence</li> </ul>
<b>Access</b>	<ul style="list-style-type: none"> <li>available in <i>multiple sites</i> across the GTA and located as <i>close to home as possible</i></li> </ul>	<ul style="list-style-type: none"> <li>available in <i>fewer targeted sites</i> in the GTA</li> <li>lower volumes and the requirement for critical mass (in addition to specialized expertise/technology) require these programs to be concentrated in fewer sites</li> </ul>	<ul style="list-style-type: none"> <li>available in a variety of settings (acute, post-acute, CCC, LTC, ambulatory, in-home)</li> <li>facilitates the flow of patients in the continuum ( e.g., transition care in CCC or services in acute care prior to high intensity rehab or discharge home)</li> </ul>
<b>Examples</b>	<ul style="list-style-type: none"> <li>stroke; musculoskeletal; geriatric rehab; cardiac; and vocational rehab programs</li> </ul>	<ul style="list-style-type: none"> <li>trauma; spinal cord; complex ABI; complex wound; amputee; post-SARS; West Nile recovery; burns; and post transplantation rehab programs</li> </ul>	<ul style="list-style-type: none"> <li>low intensity-long duration rehab in CCC units; physiotherapy services in the ICU; OT consultations for ADL in acute programs; SLP consultations for swallowing in a variety of settings; rehab professionals in stroke prevention clinics</li> </ul>

- *Focused integration* of rehabilitation programs and services *across the continuum of care* will build on the success of existing disease management models (e.g., stroke) and system-oriented models such as the Regional Geriatric Program.
- Collaborative participation across the GTA in new and emerging *chronic disease management strategies*, with renewed emphasis on client education and support for self-management, will complement the existing rehabilitation and secondary prevention strategies in place for the highest incidence diseases.
- Service delivery will be enabled by an adequate supply of appropriately educated and credentialed *rehabilitation human resources*.

## **Enabling Processes**

- Quality improvement, outcome evaluation and performance measurement strategies
- Research, teaching and innovation
- Knowledge translation and exchange strategies
- Accountability frameworks
- Advocacy
- Policy development

This vision for rehabilitation in the GTA provides guiding parameters for the GTA Rehab Network's future work. It is clear that achievement of this vision is beyond the scope of the Network alone, particularly given its current membership and structure. However, the Network can refocus its activities to advance the key elements described above.

## **Network Strategic Priorities**

The strategic planning process established four strategic priorities to guide the Network over the next three years:

### ***1. Align with and influence Ontario's Health Transformation***

Ontario's Health Transformation Plan includes several key initiatives that, together, are designed to create a system, changing how we do business and how parts of the system relate to one another. The newly developed vision for rehabilitation in the GTA speaks in very parallel terms. The role of the Network will shift to supporting and assisting members in evolving or transforming in new directions and in achieving the vision for rehabilitation as an integral component in the transformed system.

### ***2. Improve service delivery and access***

Strengthening rehabilitation services delivery, coordination and access continues to be a high priority for the Network. Early activities of the Network focused on addressing key foundational work for achieving improved coordination, access and service delivery. Further attention to this priority over the next several years will build on the foundational work to achieve significant improvements in service and access across the continuum.

### ***3. Inform planning and performance measurement***

As a network of provider organizations, the GTA Rehab Network must come to consensus on how activities, services and utilization are tracked, measured and used for improvement or performance comparison. The Network must continue to explore indicators and measures that assess the current performance of rehabilitation's contribution to patient and system outcomes. With the development of Local Health Integration Networks (LHINs), the Network has an opportunity to recommend the most appropriate data for use in planning and performance measurement in rehabilitation by leveraging the experience and expertise of its members.

### ***4. Share best practices and enhance knowledge exchange***

The GTA Rehab Network members have reported very high value in the Network's initiatives related to best practices. The major efforts related to best practices have been focused on Best Practices Day, an annual forum for the rehabilitation community to profile their work and share

information across the research-practice boundary, promoting knowledge transfer and exchange. Further attention is required in clarifying the definition and scope of *best practice* in relation to *evidence-based practice*, broadening the focus beyond clinical practice, leveraging best practice information for advocacy purposes, supporting the members in the adoption and implementation of best practices and extending the target audience for best practices beyond the current membership.

The goals for each of the four strategic priorities are summarized below. More detailed actions to advance these goals are outlined in the main text of the strategic plan.

<b>Strategic Priorities</b>	<b>Goals</b>
<b>1. Align with and influence Ontario's Health Transformation</b>	<ol style="list-style-type: none"> <li>1. Provide expert rehabilitation leadership and resources in relevant transformation priorities, including LHINs</li> <li>2. Revisit membership of the Network to align with the LHINs and new vision for rehab</li> <li>3. Promote and demonstrate the value of the GTA Rehab Network in an integrated health system.</li> </ol>
<b>2. Improve service delivery and access</b>	<ol style="list-style-type: none"> <li>1. Standardize rehabilitation definitions and clarify rehabilitation services across the continuum.</li> <li>2. Develop tools that support access and coordination across the continuum</li> <li>3. Strengthen understanding and commitment to outpatient, ambulatory and in-home parts of the rehab continuum</li> <li>4. Establish an electronic centralized referral system for target rehab populations</li> </ol>
<b>3. Inform Planning and Performance Measurement</b>	<ol style="list-style-type: none"> <li>1. Establish indicators and benchmarks for performance, using existing data and tools</li> <li>2. Define and standardize service and transition classification terminology that can be utilized across the continuum</li> <li>3. Select and recommend the best of the existing tools/indicators that are sensitive to change across the continuum</li> <li>4. Identify gaps in services and complex/hard to serve populations</li> </ol>
<b>4. Share best practices and enhance knowledge exchange</b>	<ol style="list-style-type: none"> <li>1. Expand current mechanisms for identifying, sharing and implementing best practices across the continuum of care</li> <li>2. Develop processes to track or monitor the adoption of best practices</li> <li>3. Identify target audiences and strategies for knowledge exchange, between and among the membership and external groups</li> <li>4. Collaborate with researchers to disseminate evidence-based practice and outcome measures</li> </ol>

### **Enablers to Support the Strategic Priorities**

In addition to identifying four strategic priorities, the strategic planning process recognized several enabling competencies and capabilities as essential supports to achieving the Network's priorities:

- **Network Partnerships and Alliances**
- **Communication, Promotion and Advocacy**
- **Infrastructure Support and Funding**

Of these enabling competencies, it is critical that the Network be responsive and proactive to initiatives throughout the continuum of care and seek the partnerships and alliances that will further the advancement of rehabilitation as a key contributor. Further, the Network must leverage its communications to promote and advocate for the important role of rehabilitation as an integral part across the continuum.

As the Network looks to implementing its priorities and actions, infrastructure support and funding are critical to success.

## **Moving to Implementation**

Given the close alignment with the new strategic priorities and the current directions of the Network, completion of ongoing work remains a year one priority and will position the Network well for implementation of new strategic initiatives.

### **The Year 1 implementation priorities include:**

- Fully understand the Transformation Plan and develop information material that articulates rehab and the Network's potential role in achieving and influencing direction of this agenda
- Establish a Membership and Governance Task Force to reconsider membership in light of the LHIN boundaries and the vision of rehab as integral to the full continuum of care
- Sponsor a 1-2 day workshop with representation from acute, rehab, CCC and LTC outpatient/ambulatory and CCACs, to identify common definitions and clarify key areas of future work to define and standardize processes
- Facilitate and develop mechanisms to support system wide implementation projects (e.g., client transitions from acute care/rehab/home as part of Toronto Joint Network project)
- Identify partnership and sponsorship opportunities to develop web-based centralized referral system for targeted populations (e.g., Script Project)
- Develop a process to achieve consensus on key data elements and indicators for performance measurement
- Expand and evaluate strategies to facilitate sharing and implementing best practices by clinical leaders and clinicians at the front-line
- Establish the Network as a resource centre/clearinghouse for strategies that assist members in implementing best practices in their unique environment; identify champions and expert/opinion leaders.

The strategic planning process has confirmed a strong member commitment to the GTA Rehab Network, substantiated the value placed on the work undertaken by the Network and articulated priorities for the next several years. The Ontario Transformation Plan and the new vision for rehabilitation set the context for an exciting future for the Network, as it assists members and works in partnership to *“reinforce positive health behaviours, rebuild lives and reintegrate individuals into the community.”*

## BACKGROUND AND INTRODUCTION

The GTA Rehab Network is comprised of 42 publicly funded hospital- and community-based organizations and others from across the Greater Toronto Area (GTA) that are involved in the planning and provision of rehabilitation services.<sup>2</sup> The Network was established in 1999, on the recommendation of the Health Services Restructuring Commission (HSRC). Toronto/GTA is unique in Canada in having a large number of freestanding rehabilitation hospitals along with multiple acute care hospitals also providing specific inpatient and outpatient rehabilitation programs. This multiplicity drives the need for coordination and collaboration in delivery of both specialized and general rehabilitation services.

The Network's current vision is 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. Through the Network, members aim to:

- coordinate rehab services throughout the GTA
- improve access to service
- address gaps in service and reduce duplication where it exists
- increase research and education
- measure overall performance.

The Network is a planning, coordinating and advisory body. By sharing information and working together, Network members identify issues that impede access and delivery and generate solutions to improve rehab services for the residents of the GTA. It communicates the interests of the rehabilitation sector to the Ontario Ministry of Health and Long-Term Care (MOHLTC) and advocates on behalf of its members for changes to improve the rehabilitation system.

In its first five years, the Network has been guided by four strategic priorities:

- System-wide improvements
- Best practices
- Access and coordination
- Information and education.

Through the committed work of the volunteer members, supported by a small secretariat, the Network takes pride in its many significant accomplishments over its initial years.

### **GTA Rehab Network (1999)**

#### **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.

<sup>2</sup> With the formal disbanding of district health councils on March 31, 2005, the GTA Rehab Network membership decreased to 38.

**GTA Rehab Network Accomplishments 1999 – 2005**

<b>Musculoskeletal Strategy</b>	Development of a strategy and action plans to address access, demand and sustainability for MSK patients using data from the National Rehabilitation Reporting System (NRS), CIHI's discharge abstract database, CCACs and the Network's <i>Rehab Finder</i> . This blueprint to guide future initiatives is one of the first known attempts to combine an analysis of these various data sources to paint a picture of the continuum.
<b>Online Resource and Forum for Joint Replacement Patients</b>	Creation of an evidence-based patient education website on joint replacements based on a review of the literature and consultations with patients, surgeons, physiatrists and allied health providers across the continuum. Funded by a two-year grant of \$100,000 from The Change Foundation, this project also aids in dissemination of best practices in joint replacement.
<b>Best Practices Day</b>	Hosting of an annual showcase of research, best practice and innovation in rehabilitation that facilitates development and promotion of best practices and facilitates knowledge transfer/exchange between clinicians, researchers and policy/management professionals. The event has hosted more than 1,000 delegates and 300 initiatives in the past five years.
<b>Rehab Finder</b>	Creation of a comprehensive, searchable, website providing easy access to standardized listings of rehab programs and admission criteria across the GTA. In addition to allowing providers to find appropriate programs for patients, it also improves the transparency of the referral process. <i>Rehab Finder</i> data on program capacity and distribution allows identification of gaps and aids system planning. User surveys indicate a high satisfaction rate with the tool.
<b>Standardized Referral and Response Forms</b>	Development, testing and implementation of common readmission, referral and response forms for MSK referrals to facilitate inter-organizational referrals. Increases transparency of the referral process and allows tracking of patients declined for rehab. Part of the infrastructure required to develop an electronic referral system that can monitor access issues.
<b>Stroke Information Card</b>	A resource for physicians and other healthcare providers in the GTA to help stroke survivors make a successful transition to the community following stroke. Developed in consultation with physicians, providers, stroke survivors and caregivers, the card raises awareness of the key determinants of successful community re-engagement and provides information on stroke services for use with stroke survivors post-rehab.
<b>Low Intensity Long Duration (LTLD) Stroke Triage/Assessment Tool and Demonstration Project</b>	Development of a common definition and triage/assessment tool for LTLD stroke rehab to help standardize referral process and gain consensus on LTLD program components. A collaborative demonstration project will identify characteristics, outcomes and resource needs for LTLD stroke patients in various settings and result in a business case to the MOHLTC to increase recognition of and funding for LTLD stroke rehab programs.
<b>Inpatient Rehab Referral Guidelines</b>	Development of inpatient rehab referral guidelines for use with multiple populations to increase consistency in use of definitions for medical stability, rehab readiness and ALC, standardize processes to optimize timing of rehab referrals and responses and improve communication between facilities.
<b>Data and Informatics Products</b>	Publishing of more than 15 reports on the rehabilitation system in areas such as: inventories, needs assessments, bed counts, stroke rehab, musculoskeletal rehab, waiting lists, etc.
<b>Grants and Awards</b>	Leveraging of over \$500,000 in grant funding and receipt of a National Best Practices Award.

With considerable achievements marking the first five years, the Network agreed that this was an appropriate time to reflect on its initial developmental years and consider its future direction. The members appreciate the complex nature of networks in general and the challenges of meeting the needs of its diverse constituents many of whom have:

- differing views on the scope of rehabilitation, the delivery and funding of services
- varied levels of participation in the Network and awareness of the range of its activities
- diverse views on the role, structure, functions and priorities of the Network.

The timing for the strategic planning initiative coincides very well with the developments of the MOHLTC Transformation Plan. The planned introduction of Local Health Integration Networks (LHINs) and the closure of district health councils compel the GTA Rehab Network to reconsider its membership and role in view of the proposed mandate and priorities of the impending LHINs.

In the fall of 2004, the GTA Rehab Network Coordinating Council, agreed to launch a formal strategic planning process to develop a future vision for rehabilitation and articulate the Network's role in facilitating achievement of that vision, including outlining specific strategic priorities for the Network for the next three years. A Strategic Planning Committee (Appendix I) was established to oversee and guide the strategic planning process.

## STRATEGIC PLANNING PROCESS

The Strategic Planning Committee initiated the planning process in January 2005, approving a work plan that included planning principles, extensive consultations, a member survey and a multi-stakeholder planning retreat.

The consultation process involved over 40 individual or group interviews with members, external stakeholders and key contacts in rehabilitation and network organizations within the GTA, throughout Ontario and across the country. A member survey was undertaken in which each member entity was requested to provide input on a range of Network activities and potential future activities. A total of 29 of 42 organizations responded to the survey.<sup>3</sup>

The Strategic Planning Committee engaged in the development of a vision document that included an environmental scan and recommendations for what the rehabilitation system should look like for the Greater Toronto Area. This vision was intended to fill a void that exists with the lack of a policy framework for rehabilitation in Ontario and provide a broader context for the development of strategic priorities for the GTA Rehab Network for the next three years. The vision document, *Rehabilitation in the Greater Toronto Area: A Vision for the Future*, was approved by the Strategic Planning Committee and Coordinating Council and has been published as a stand-alone document.<sup>4</sup>

A planning retreat was held on March 31, 2005 with over 80 participants, including representation from across the membership and key external stakeholders. Attendees provided considerable input on both the draft vision for rehabilitation and the strategic priorities and goals for the Network. (Appendix II and III: Retreat Agenda and Participants)

The draft strategic plan was finalized through the Strategic Planning Committee and was presented to the Coordinating Council in May 2005.

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<sup>3</sup> Results of the Member Survey are available as a supplementary report on the GTA Rehab Network website - [www.gtarehabnetwork.ca](http://www.gtarehabnetwork.ca)

<sup>4</sup> *Rehabilitation in the Greater Toronto Area: A Vision for the Future* is available as a supplementary report on the GTA Rehab Network website - [www.gtarehabnetwork.ca](http://www.gtarehabnetwork.ca)

## SETTING THE CONTEXT

Rehabilitation providers see both enormous opportunities and significant challenges in meeting the changing needs of patients and their families as they look to the future. The GTA Rehab Network, in pursuing its mission to ‘*coordinate service, promote equitable access, address gaps, reduce duplication, increase research and education and measure overall performance*’, must recognize several key environmental drivers that will influence its abilities to fulfill this mandate. The major trends identified during the environmental scanning and consultation process are summarized below<sup>5</sup>.

### **Burden of Chronic Disease**

The demand for rehabilitation is increasing, in part, as the overall burden of chronic disease and disability increases. Population growth and population aging are raising the overall incidence of chronic disease. In Canada, 16 million people live with chronic illness and chronic disease accounts for 87 percent of disability. The growing number of seniors is also increasing both the need for and the complexity of these rehabilitation services. Additional high risk groups are those who belong to vulnerable communities (e.g., aboriginals) and those who are socio-economically disadvantaged.

### **The Changing Nature of Rehabilitation**

Rehabilitation is taking on new meaning and direction in a renewed health care system. Rehabilitation “...is changing as a result of breakthroughs in technology, molecular biology and the human genome, expanding beyond an emphasis on social science in kinesiology and anatomy. More attention is focusing on multifactoral determinants, the influence of genetics, the environment and psychosocial health status as well as knowledge translation. Interventions are changing with more interdisciplinary linkages and the need to work with people who have different skills and knowledge.”<sup>6</sup>

### **Rising Consumer Expectations for Rehab**

Today’s consumer has a much higher expectation of our health system, a higher level of knowledge and information on the benefits of various modalities and a very high expectation for functional performance that, together, set exceedingly high targets for rehabilitation access and performance.

### **Shift to Private Sector Rehabilitation**

Private sector activity has grown significantly with outpatient and ambulatory rehabilitation services shifting away from a largely publicly-funded environment to one predominantly involving private providers and payers. This shift is most pronounced where there have been reductions in publicly-funded outpatient rehabilitation services by

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<sup>5</sup> A more complete description of environmental influences is included in *Rehabilitation in the Greater Toronto Area: A Vision for the Future* Supplementary Documents.

<sup>6</sup> Martha Piper (2001). *The Future of Academic Rehabilitation*. Keynote Address, University of Toronto

local hospitals and where selected services, funded by the MOHLTC and provided by physiotherapists and audiologists, have been either limited or eliminated.

### **Multiplicity of Payers, Providers and Services**

Rehabilitation is characterized by a fragmented patchwork of services and a multiplicity of providers and payers. Rehabilitation is available in varying degrees throughout the continuum of care across sectors and settings (acute, in-home, outpatient clinics, inpatient rehab hospitals, long-term care (LTC), complex continuing care (CCC)). The result is:

- substantial variation in capacity across the province (e.g., out-patient, sub-acute and inpatient rehabilitation)
- variation in service scope, definition, performance measurement and reporting of data (outside of the National Rehabilitation System-mandated facilities)
- challenges for streaming patients to the “right” service, in the “right” location/setting at the “right” time
- limited or inconsistent access to certain inpatient program types (e.g., Low Tolerance, Long Duration (LTLTD), Acquired Brain Injury (ABI), Geriatric) and outpatient program types (e.g., COPD, amputee rehabilitation and developmental pediatrics)
- patients with complex needs experience lengthy delays in access that in some cases amounts to a denial of service (complexity of their rehab requirements makes it difficult to place patients in appropriate programs, adding to the need for more “hybrid” programs)
- inconsistent access to in-home care.

### **Access and Capacity Issues**

Access to rehabilitation services is determined largely by where you live and who pays for the service, as determined by cause or location of injury or disease. While access to inpatient rehabilitation in a hospital setting is guaranteed under the Canada Health Act, no such protection is afforded those whose needs must be met in an ambulatory/clinic setting.

Barriers to access include the inability to pay for services that are available only in the private sector, wait times for limited services provided by the public sector (especially true for outpatient services) and a lack of knowledge by the consumer and potential referral sources (physicians, nurse practitioners) of the availability of services<sup>7</sup>.

Capacity varies across the province and GTA region, both in terms of rehab beds per population (ranging in the GTA from 11 to 24 beds per 100,000 population) and wide variations in capacity for targeted services such as stroke rehab and total knee replacements.<sup>8</sup>

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<sup>7</sup> Cott CA, Devitt R, Falter LB, Soever L, Wong R (2004). *Adult Rehabilitation and Primary Health Care in Ontario: Final Report*.

<sup>8</sup> Mark Rochon (October 2004) Speaker notes to IBC/WSIB Conference, Toronto; GTA Rehab Network 2001 *Clinical Committee Survey Report: Current Status of Rehabilitation in the GTA*, p. 23

## Barriers to Discharge from Acute Care (ALC cases)

Now that long-term care capacity has increased in the system and access is no longer the challenge it was a few years ago, it is suggested that access to rehabilitation services remains a barrier to discharge from acute care. Challenges cited include:

- too many different points of access, requiring multiple referrals using different processes
- wide variation in criteria for admission and in the way organizations process referrals, assess the application and reply to referrals<sup>9</sup>
- the most challenging cases (resource intense) are routinely rejected and are the slowest to transfer from acute care (i.e. largest number of ALC days), with little assistance offered to find the appropriate post-acute care.

## Clinical and Program Shifts

Changes in clinical practice resulting from new and emerging technology and knowledge e.g., the Integrated Stroke Strategy for Ontario has led to the redesign of therapeutic strategies and rehabilitation programs across the province. There are renewed efforts to support the long-awaited shift from acute care to home care by the recent expansion of funds for home care services in the first wave of the government's Transformation Plan.

## Adaptability, Responsiveness and Complexity

While acute care services have shifted tremendously in the past decade to shorter lengths of stay, highly focused discharge planning early on in a patient's acute care stay and aggressive strategies to improve acute care bed management, rehabilitation programs and services have not shifted to the same degree to accept patients earlier in their clinical course. Further, concern is expressed about the adaptability and responsiveness of rehabilitation programs to new and emerging needs, such as rehabilitation for oncology or transplantation patients.

Clients that we see in the community today, are in worse shape than the inpatients of 5 years ago.

*Bob Morton, CCAC of Peel*

For their part, regional and provincial rehabilitation programs for children and adults are challenged to meet the needs of progressively more acute *and* complex patients who have survived multiple trauma and/or a range of co-morbidities not previously seen at this stage in the continuum. In addition, pediatric rehab services are progressively more challenged by the needs of youth with complex genetic and congenital disabilities who are living into adulthood, placing ever-growing pressure on the pediatric-adult interface in rehabilitation services.

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<sup>9</sup> Addressing this issue has been a major focus of the Network, with progress being made through *Rehab Finder*, a common Referral and Response form and the Inpatient Referral guidelines.

As noted above, the growing burden of chronic disease and the increasing number of seniors with complex co-morbidities will place even further pressures on the sector's capacity and ability to respond and adapt innovatively to these increasing and changing demands.

### **Human Resources Pressures**

While there have been positive changes to rehabilitation training including a new graduate degree entry-to-practice standards, there are escalating demands due to new and emerging clinical program and research developments and shortages in key disciplines at a time when significant cohorts of the professional workforce are approaching retirement age. There are major concerns throughout the industry that the supply is not keeping pace with the growing demand for rehabilitation services which threatens to exacerbate an already challenging and competitive retention and recruitment environment.

### **MOHLTC Transformation Plan**

In September 2004, Minister George Smitherman presented Ontario's Health Transformation Plan.<sup>10</sup> Selected elements include an integrated system through creation of Local Health Integration Networks (LHINs), renewal of primary care in parallel to the LHINs and reduced wait times for acute care procedures – many with post-operative rehabilitation implications e.g., some cardiac procedures, cancer care and hip and knee replacements.

LHINs are being implemented 'to better integrate and coordinate health services at the local level – a solution that engages communities in health system transformation by enhancing and supporting local capacity to plan, coordinate, integrate and fund the delivery of health services at the community level. Unlike the integrated models in place in other provinces of Canada, LHINs will not be providers of clinical services, but will coordinate service delivery.'<sup>11</sup>

The emergence of LHINs may have a significant impact on the planning, organization and delivery of rehabilitation services, as the LHINs assume their roles of integrating and coordinating services. The current distribution of specialized rehabilitation services will require inter-LHIN planning to coordinate access to specialized services across LHINs.

### **Absence of a Rehabilitation Policy Framework**

Notwithstanding the newly introduced Transformation Plan, the lack of a provincial policy framework for rehabilitation and the absence of a comprehensive vision or method to guide the growth of rehabilitation services, has resulted in programs and services being developed largely along program, population health or payor demand lines.

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<sup>10</sup> [http://www.health.gov.on.ca/english/media/speeches/archives/sp\\_04/sp\\_090904.pdf](http://www.health.gov.on.ca/english/media/speeches/archives/sp_04/sp_090904.pdf)

<sup>11</sup> Health Results Team (2004). *Local Health Integration Networks: Building a True System*. Bulletin No.1 – Oct 6. Toronto: MOHLTC

The net effect of policy drift has been a series of strong but disjointed programs, multiple access streams associated with overall access deficit and a loss of system client-centredness that is characterized by formidable barriers for clients and families to navigate as they move through the health care continuum.

The above influences and changes in our health system provide the context for creating a vision for rehabilitation in the GTA.

## **VISION FOR REHABILITATION**

The strategic planning process established a new vision for rehabilitation in the GTA, which is summarized below and presented in greater detail in *Rehabilitation in the Greater Toronto Area: A Vision for the Future*.

This vision sets the framework for the GTA Rehab Network to establish its strategic priorities and goals, recognizing that, alone, the Network cannot fully achieve this vision. While the focus of the visioning exercise has largely been on the public component of rehab services, there is an increasing awareness of the need to interface with the privately funded component of the sector. In the coming years, the Network will need to leverage its strengths and resources to achieving targeted areas of this vision and to work in partnership with others to realize a preferred future for rehab clients and their families in the GTA.

Development of this vision was informed through a review of the literature, consultation locally and across the country and the critical feedback by members and external stakeholders at the March 2005 strategic planning retreat. It envisions a flexible and responsive health system where individuals and their families seeking rehab services have equitable access to optimal services in a range of settings and environments.

### **The Promise and Potential of Rehabilitation**

Rehabilitation is an integral part of the health care continuum. In acute care this is evidenced through well-developed interprofessional, program-managed team structures. Similarly, where services and processes are currently well established, rehabilitation facilitates system accessibility through effective transitions across much of the continuum [e.g., to the next level of rehabilitation program, residential care (long-term, complex continuing, home), or independent living] by optimizing the patient's functional level. However, for the health system to be truly accessible, requires that patients move with ease through whatever parts of the continuum they require, so that they can receive the "right care, at the right time, in the right place".<sup>12</sup>

Rehabilitation's multiple roles (clinical and other processes that optimize function, educator of clients, families and professionals, generator of new knowledge through research and innovation and facilitator of effective health system transitions) position rehabilitation as an integral and essential component of an effective and accessible health care system. Our future vision for rehabilitation in the GTA reinforces and highlights the value of these roles.

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<sup>12</sup> Minister G. Smitherman (September, 2004). *Ontario's Health Transformation Plan: Purpose and Progress*. Notes for speech delivered in Toronto

## Vision

Rehabilitation is an integral and essential component of the continuum of health care, reinforcing positive health behaviours, rebuilding lives and reintegrating individuals into the community.

The rehab system we envision maximizes the client’s health, function and quality of life and continually reinforces healthy behaviours. Patient flow is maximized and interventions and treatment are based on the best available evidence, measured outcomes and active client and family involvement.

This vision for rehabilitation services in the GTA embodies several *defining principles, key characteristics and enabling processes*:

### Principles

- **Equitable access** to rehabilitation services that is characterised by **adequate service capacity** and **timely transitions**.
- **Family-centred and consumer driven initiatives**: Consumers of rehabilitation have the most up-to date knowledge of where gaps in the health system exist and where they have the most impact. Mechanisms will be implemented to better involve and learn from clients and families in each of the many roles enacted by rehabilitation.
- Rehabilitation services will be **evidence-based** wherever possible and focussed on improved **client and population outcomes** at all times.

### Characteristics

- Rehabilitation services and programs are arrayed across the continuum in three major groupings:
  - High volume, high intensity
  - Low volume, high intensity
  - Across the continuum, outside of designated programs or units.

### Characteristics

	High Volume – High Intensity	Low Volume – High Intensity	Across the continuum, outside of designated programs or units
<b>Setting</b>	<ul style="list-style-type: none"> <li>• delivered in <i>designated rehabilitation hospitals or designated programs/ units</i> in acute care and community hospitals</li> <li>• inpatient, ambulatory and in-home settings</li> </ul>	<ul style="list-style-type: none"> <li>• delivered in <i>designated rehabilitation hospitals or designated programs/ units</i> in acute care hospitals</li> <li>• inpatient, ambulatory and in-home settings</li> </ul>	<ul style="list-style-type: none"> <li>• delivered across the continuum of care in a variety of settings <i>outside</i> of designated programs or units</li> </ul>

Characteristics cont'd

	High Volume – High Intensity	Low Volume – High Intensity	Across the continuum, outside of designated programs or units
<b>Population</b>	<ul style="list-style-type: none"> <li>targeted to clients who require high intensity of rehabilitation and/or highly specialized expertise</li> </ul>	<ul style="list-style-type: none"> <li>targeted to clients who require high intensity of rehabilitation and/or highly specialized expertise/technology</li> </ul>	<ul style="list-style-type: none"> <li>targeted to clients who require rehab in order to transition to another level of care or to a higher level of independence</li> </ul>
<b>Access</b>	<ul style="list-style-type: none"> <li>available in <i>multiple sites</i> across the GTA and located as <i>close to home as possible</i></li> </ul>	<ul style="list-style-type: none"> <li>available in <i>fewer targeted sites</i> in the GTA</li> <li>lower volumes and the requirement for critical mass (in addition to specialized expertise/technology) require these programs to be concentrated in fewer sites</li> </ul>	<ul style="list-style-type: none"> <li>available in a variety of settings (acute, post-acute, CCC, LTC, ambulatory, in-home)</li> <li>facilitates the flow of patients in the continuum (e.g., transition care in CCC or services in acute care prior to high intensity rehab or discharge home)</li> </ul>
<b>Examples</b>	<ul style="list-style-type: none"> <li>stroke; musculoskeletal; geriatric rehab; cardiac; and vocational rehab programs</li> </ul>	<ul style="list-style-type: none"> <li>trauma; spinal cord; complex ABI; complex wound; amputee; post-SARS; West Nile recovery; burns; and post transplantation rehab programs</li> </ul>	<ul style="list-style-type: none"> <li>low intensity-long duration rehab in CCC units; physiotherapy services in the ICU; OT consultations for ADL in acute programs; SLP consultations for swallowing in a variety of settings; rehab professionals in stroke prevention clinics</li> </ul>

- ***Focused integration*** of rehabilitation programs and services ***across the continuum of care*** will build on the success of existing disease management models (e.g., stroke) and system-oriented models such as the Regional Geriatric Program. New and emerging opportunities for integration will be exploited (e.g., in the primary care sector<sup>13</sup>) to strengthen rehabilitation’s contribution to population health and the effectiveness of the system.<sup>14</sup>
- Collaborative participation across the GTA in new and emerging ***chronic disease management strategies***, with renewed emphasis on client education and support for self-management, will complement the existing rehabilitation and secondary prevention strategies in place for the highest incidence diseases e.g., diabetes, congestive heart failure, asthma, COPD and ischemic heart disease.
- Service delivery will be enabled by an adequate supply of appropriately educated and credentialed ***rehabilitation human resources***.

**Enabling Processes**

<sup>13</sup> MOHLTC (November 2004). *Family Health Teams - Advancing Primary Care*. Bulletin. Toronto.

<sup>14</sup> “The ‘rehab approach’ to disability (especially its sensitivity to systemic and upstream causes) is under-utilized by the current health care system”. [John Frank (2004). *Disability, Rehabilitation and Population Health: An Underutilized Research Practice Collaboration*. Keynote Address: GTA Rehab Network Best Practices Day 2004, Toronto.]

- **Quality improvement, outcome evaluation and performance measurement strategies** will gauge the success of a renewed integration effort as well as that of individual programs and clinical processes.
- **Research, teaching and innovation** are the drivers of the “promise and potential of rehabilitation”. Collaborative partnerships between research institutions and **rehabilitation programs** will advance each of these initiatives while supporting the education and expansion of rehabilitation human resource groups in scarce supply.
- **Knowledge translation and exchange strategies** that have a measurable impact on the quality, timeliness, location and “dose” of services provided (evidence-based practice) will be vigorously implemented across the continuum of care providers.
- **Accountability frameworks** that emphasize and foster shared responsibility with funders and providers in other sectors of the health care system will be embraced.
- **Advocacy:** The rehabilitation sector will designate the important task of advocacy to players that can ensure that rehabilitation is included in new and emerging provincial reform efforts, particularly, primary care renewal, chronic disease management and health promotion/illness prevention.
- **Policy** development for a rehabilitation framework, which has cross-LHIN or provincial scope and addresses the role of the public and private sectors in a deliberate and thoughtful way, will accelerate the pace at which rehabilitation can drive the changes necessary to achieve the goals of the Transformation Plan.

This vision for rehabilitation in the GTA provides guiding parameters for the GTA Rehab Network’s future work. It is clear that achievement of this vision is beyond the scope of the Network alone, particularly given its current membership and structure.

However, the Network can refocus its activities to advance many of the key elements outlined above. As a first step, it will require a major commitment to work within its current membership to embrace rehab within and across the full continuum of care as well as pursuing new partnerships and alliances to address this broader view of rehab.

We have created a compelling vision for rehabilitation in the GTA, however it is larger than us alone - it will require a look at our membership, forming new partnerships and alliances and promoting a clear understanding of the impact and implications of this new vision.

Marian Walsh, Strategic Planning Committee

## GTA REHAB NETWORK – ACHIEVING THE VISION: OUR STARTING POINT

The in-depth consultation conducted in the first phase of the strategic planning process was useful in informing the development of the vision of rehab for the GTA, as well as yielding significant input on the strengths, weaknesses, opportunities and threats facing the Network. The resulting “SWOT” analysis (Figure 1.), derived both from the extensive consultations and member survey provides a snapshot of the Network at the early stages of the strategic planning process.

**Figure 1. GTA Rehab Network - Strengths, Weaknesses, Opportunities and Threats (March 2005)**

<p style="text-align: center;"><b>Strengths</b></p> <ul style="list-style-type: none"><li>• Brings providers together to a common table on rehab issues and supports a “common language” for rehab; perceived as “neutral broker”</li><li>• Active participation by membership that has strong representation from the most senior ranks of the rehab sector</li><li>• Strong, professional, highly productive and competent Secretariat</li><li>• Substantial core work accomplished; positive impact in the past two years through <i>Rehab Finder</i>, admissions work, website, MSK strategy, ALC work, leadership in stroke continuum</li><li>• Well attended and highly regarded Best Practices Day</li><li>• Successful in attracting external funding for special projects</li><li>• Effective prioritization of initiatives that are able to be implemented; delivers benefits to front-line care, population specific, addressing rehab across the continuum</li><li>• “Attention to access, patient flow, integration and coordination- very practical, without much money bringing people together to do things that are important.”</li></ul>
<p style="text-align: center;"><b>Weaknesses</b></p> <ul style="list-style-type: none"><li>• Lacks levers to compel all members to participate or implement tools, standards, etc, that are developed by the Network</li><li>• Difficulty in measuring impact and accounting for secondary consequences (e.g., changes following <i>ALC Report</i>)</li><li>• Mixed support from some acute care providers</li><li>• Focus has largely been on institutional rehab with less attention to community or ambulatory rehab</li><li>• Funding derived largely through membership fees; creates some instability in infrastructure and continuous need to market/demonstrate effectiveness to diverse membership group</li><li>• Limited staff and infrastructure to take on breadth of rehab issues that are important to large and varied membership</li><li>• Coordinating Council structure may not be as effective as potentially could be, with possible disconnect of members who are not sitting at the Coordinating Council</li><li>• Communication issues, e.g., information does not always get from all key contacts across the members; lack of effective vehicles to reach acute care clinicians</li></ul>

### **Opportunities**

- Demonstrate the value of the Network as a resource to LHINs in coordinating and integrating rehab services across the care continuum
- Increase the sharing of tools across other organizations in the GTA/905 and throughout the province
- Expand role as a knowledge resource, increasing knowledge exchange and sharing best practices
- Build on previous work, e.g., ALC work to define criteria for designating ALC; LTLD initiative
- Lead in chronic disease management models and implementation strategies
- Lead in advancing work of Toronto Joint Network
- Explore strategies for addressing human resources shortages, e.g., expand involvement of rehab nursing
- Develop infrastructure for more data-driven roles
- Enhance focus on evidence based rehab performance measures
- Enhance advocacy role – either as core function or building capacity (knowledge, data) that could be used for advocacy
- Collaborate with new OHA Rehab Council and other rehab networks; pursue partnerships with other agencies (fostering consumer/public support)
- Leverage champions among specialists to communicate and advocate change among peer specialists across acute care
- Explore relationships with private sector providers re: ambulatory rehab

### **Challenges/Threats**

- LHINs are creating uncertainty for immediate future for all Networks, with respect to service coordination and integration roles
- Network's original mandate derived from HSRC – membership agreements committed until 2007
- Rehab is also part of a much larger privately funded system over which Network has little influence
- Increasing need to address/advocate for system wide issues, equity of access, public/private interface, funding for rehabilitation services and growing human resources challenges
- Tensions in balancing diverse membership interests
  - across continuum (acute to community)
  - by program or population (neuro vs. MSK)
  - geographic (905, Toronto)
  - pediatric – adult
  - CEO, Clinicians, other providers
- Rehab is present across all provider groups – acute, CCC, LTC, rehab, community – a challenge to consider the rehab interests across all
- Inability to adequately solve the ALC problem, for some members, challenges the effectiveness of the Network
- Heavy reliance on volunteers; issue of Network commitments balanced with organizational commitments
- Low profile of rehab and lack of policy framework, make rehab vulnerable to delisting continual cuts; keeping rehabilitation on the MOHLTC radar screen with no rehab policy framework and shrinking MOHLTC resources dedicated to rehab

The member survey results confirmed the important role of the Network in:

- Advocating on behalf of rehabilitation system, providers and the unmet needs of identified patient groups (*97% rated as very important or important*)
- Improving the sharing of information and best practices (*97% rated as very important or important*)
- Bringing together health care providers on behalf of the consumer (*90% rated as very important or important*)
- Guiding and assisting in system planning (*83% rated as very important or important*).

The strategic plan that follows is intended to build on current strengths, address critical weaknesses, leverage key opportunities in the environment and balance the threats and challenges that create tensions for the Network and its members. The SWOT analysis also provides a benchmark against which the Network can measure its performance as it proceeds with implementation of the strategic plan.

## STRATEGIC PRIORITIES FOR THE NETWORK

The strategic priorities for the Network evolve from several inputs:

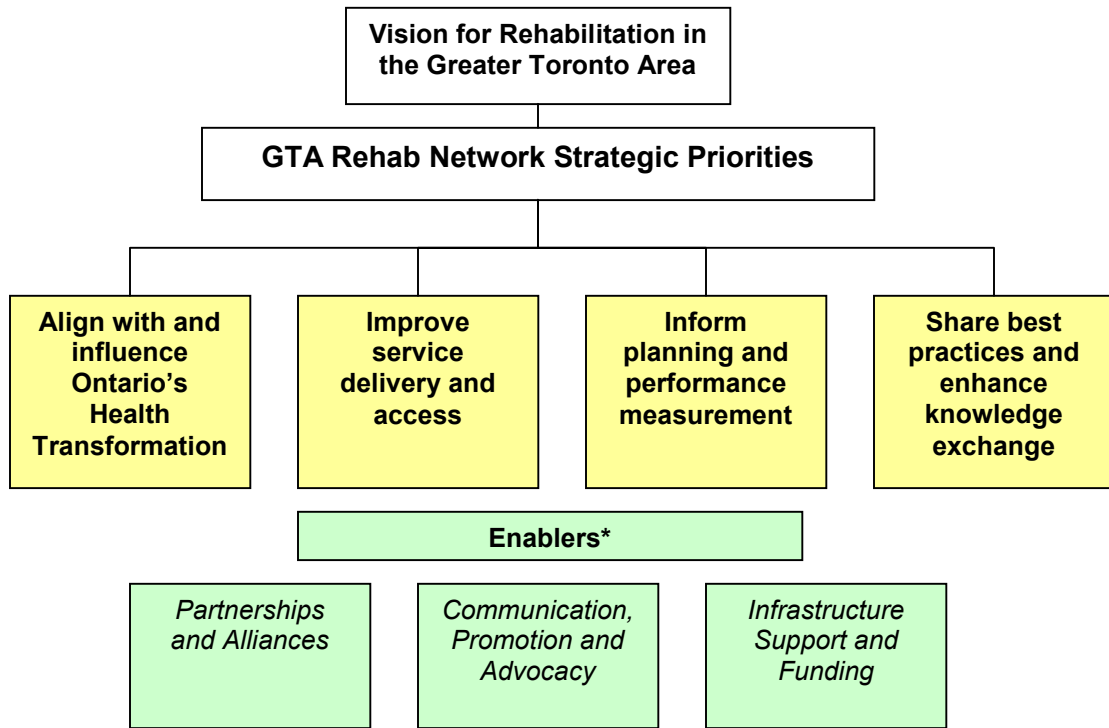
- the context of the newly developed vision for rehabilitation, *Rehabilitation in the GTA: A Vision for the Future*
- key areas of importance and priority identified through the strategic planning consultations, member survey and planning retreat; and
- reflection on the Network's strengths, weaknesses, opportunities and challenges.

Network members have strongly confirmed support for the Network's focus over its first five years, which included productive and meaningful activities in the areas of:

- System-wide improvements
- Best practices
- Access and coordination
- Information and education.

The member survey confirmed a high level of support for continued work in each of the above areas. With the recent thrust of the MOHLTC's Transformation Plan, there is also unanimous support for a Network priority strategy in this area, both to align with and influence the government's agenda and to revisit the Network membership in light of the new LHIN boundaries.

The newly developed vision for rehabilitation in the GTA clearly articulates a view of rehabilitation as integral across the full continuum of care. This expanded landscape of rehabilitation further compels the Network to revisit its membership and partnerships and to consider a broader scope of the continuum in addressing its strategic priorities. This vision challenges the Network to actively engage with acute care, rehabilitation, complex continuing care, long-term care, outpatient/ambulatory and in-home services to ensure the voice and contributions of rehabilitation to achieve patient and program goals across the continuum. The Network must consider its role in facilitating and championing this outreach and connectivity throughout the continuum, as it pursues each of the four strategic priorities that are outlined below:



\* In identifying goals and actions for each of the four strategic priorities, it was clear that there were several shared and critical enabling strategies that would be important for facilitating successful action in each of these priority areas. Developing strengths and depth in these competencies and capabilities will be important for the Network.

**Strategic Priority #1: Align with and Influence Ontario’s Health Transformation**

Ontario's Transformation Agenda that includes the creation of LHINs and a wait-list initiative in five areas (including cardiac, cancer and joint replacements), along with Family Health Teams and information management, provides enormous opportunities to advance rehabilitation, through

- new visions; new questions
- creative responses to new needs
- new conversations and relationships
- new sense of accountability (less blame and more commitment)

*Sheila Jarvis, President and CEO, Bloorview McMillan  
GTA Rehab Network Retreat, March 31, 2005*

The Ontario Government Health Transformation Plan focuses on goals of improved access, structural and system change and measurement of outcomes. The Transformation Plan includes several key initiatives that, together, are designed to create a system changing how we do business and how parts of the system relate to one another.

Collectively the priorities of the Transformation Plan:

- Articulate a series of **expectations** for how the transformed system will work
- Establish/strengthen/redefine a series of networks and **relationships** among health care partners
- Hold health care partners **accountable** for performance within a context of redefined relationships
- Is informed by the **evidence** for new and improved practices and processes.

Organizations within the health system will begin realigning priorities and relationships with one another to advance the Transformation Agenda. The newly developed vision for rehabilitation in the GTA speaks in very parallel and synergistic terms to expectations, relationships, accountability and evidence. The role of the Network will shift to supporting and assisting members in advancing the transformation agenda and in achieving the vision for rehabilitation as an integral and essential component of the transformed system.

Several of the individual Transformation initiatives provide specific opportunities for rehabilitation providers and the Network:

- **LHINs** – opportunity for health care providers to plan, coordinate and integrate rehab services locally, with the Network providing guidelines, standardized tools, best practices information and other resources
- **Wait list strategies** – areas of priority including cardiac, oncology and joint replacements are of key interest and relevance to rehabilitation
- **Family Health Teams** – opportunity for rehabilitation to provide guidelines and resources with respect to key population groups, such as post-stroke community reintegration and chronic disease self-management
- **Chronic disease prevention and management** – opportunity to advance client education and support for self management, complementing existing rehabilitation and secondary prevention strategies in place for highest incidence diseases (e.g., diabetes, congestive heart failure, asthma)
- **Information management strategy** – opportunity to influence the range of data collected and the use and analysis of data in performance measurement.

The task for the Network is to assess where and how it may influence the transformation through one or more of these targeted areas.

It will be critical that the GTA Rehab Network position its role to offer guidance and resources in planning and coordinating services with respect to rehabilitation in the LHINs. Experience in other jurisdictions across Canada with regional health authorities has confirmed the value of networks in bringing together communities of

Networks will evolve within and across LHINs to:

- develop and strengthen communities of practice
- focus on cross sectoral linkages - social services, shared care models with primary care

This presents an important opportunity for the GTA Rehab Network to demonstrate its value to multiple LHINs.

*Hume Martin, CEO, Rouge Valley Health System*

practice, informing guidelines and facilitating access and coordination for targeted populations. This presents an important opportunity for the GTA Rehab Network to establish itself as the “go to resource for rehab” for system access initiatives, evidence-based practice and outcomes (for standards and evaluations), professional education and applied research across multiple LHINs.<sup>15</sup>

The Transformation Agenda is setting the direction for structural changes (i.e., LHINs) and new relationships among organizations (e.g., addressing wait list strategies). The GTA Rehab Network is experiencing the immediate impact with the district health councils having been recently disbanded and the CCACs proposing restructuring and realignment within the new LHIN framework. With the proposed LHINs in the GTA area, the Network hospital members will be distributed across five LHINs – Toronto Central, Central, Central East, Mississauga Halton and Central West. Within several of these LHINs, there are rehabilitation providers (hospitals and CCACs) who are not currently members. The response to the member survey clearly supported (24 of 29 responses) the expansion of the Network membership to include all MOHLTC-funded rehabilitation providers in those LHINs most closely aligned with the current membership. The change and expansion of the membership and the structure of the Network governance will need immediate attention in moving forward. Further considerations include the potential for LHIN membership in the Network, similar to the (former) DHC membership and evolving the name of the Network to more accurately reflect these changes. A review of the membership will also provide the opportunity to explore an improved interface with other parts of the rehab continuum, community, voluntary health organizations and the private sector.

The following goals are recommended for this Strategic Priority. Discussion at the planning retreat generated several proposed actions:

<b>Goals</b>	<b>Proposed Actions</b>
<ol style="list-style-type: none"> <li>1. Provide expert rehabilitation leadership and resources in relevant Transformation priorities, including LHINs</li> <li>2. Revisit membership of the Network to align with the LHINs and new vision for rehab</li> <li>3. Promote and demonstrate the value of the GTA Rehab Network in an integrated health system.</li> </ol>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>• Form a consultant team to advise LHINs on rehabilitation programs and priorities; bring together rehab experts and communities of practice as required</li> <li>• Prepare information packages, tool kit for LHINs on rehab topics and priorities</li> <li>• Establish a Membership and Governance Task Force to review and align membership and governing processes</li> </ul> <p>Future Years:</p> <ul style="list-style-type: none"> <li>• Assess opportunities for Network to interface with or inform strategies related to Family Health Teams and key wait list initiatives</li> <li>• Explore Network’s role in advancing Chronic Disease Prevention &amp; Management Framework</li> </ul>

<sup>15</sup> Consultations with Brian Schmidt, B.C. Provincial Health Services Authority and Susan Muirwood, Capital Health Authority, Edmonton, February 2005.

## Strategic Priority #2: Improve Service Delivery and Access

Strengthening rehabilitation services delivery, coordination and access continues to be a high priority for the Network. Many of the early activities of the Network focused on addressing key foundational work for achieving improved coordination, access and service delivery, i.e., developing *Rehab Finder*, standard terms and definitions, standard referral forms and assessment tools. The Network's major initiatives in the areas of alternate level of care snapshots, low tolerance long duration (LTLTD) stroke rehabilitation and musculoskeletal rehabilitation have explored the scope and size of the access and service delivery issues in these respective areas.

The consultation with member hospitals identified diverse experiences with access issues. The 905 and Toronto community hospitals reported relatively few problems with accessing general short-term rehabilitation services, noting that many of the community hospitals have rehabilitation beds. Problems with access tended to focus on patients requiring LTLTD rehabilitation, or on patients with behavioural or complex needs. Several of the acute care teaching hospitals in Toronto (without rehabilitation beds), reported ongoing access problems for most patients needing inpatient rehabilitation, with the exception of joint replacement cases. Accessing rehabilitation at the community level varied by area and type of professional service required.

Challenges with respect to access and service delivery include:

- multiple points of entry, requiring multiple referrals using different processes
- lack of clarity regarding rehabilitation services provided in individual rehab hospitals, CCC and LTC facilities
- differing assessments of “rehab ready” by referring organizations and receiving organizations
- variation in criteria for admission, requirements for referrals and referral processing
- difficult and resource-intensive cases experience long, unexplained waits, that in some cases amount to a denial of service
- longer than expected wait times for selected referrals from acute care to rehab hospitals, e.g., complicated neuro, ABI, LTLTD cases

The GTA Rehab Network has defined “rehab ready” and will release this material in spring 2005. The Network is currently defining the needs of patients who require LTLTD and identifying program components for LTLTD.

The member survey confirmed the importance of several initiatives of the Network to strengthen access and coordination:

- Collaborate with acute care, rehab, CCAC, LTC and CCC for common assessment and referral approaches (83% rate as very important or important)
- Develop care pathways (76% rate as very important or important)

Solving the issues of access, integration and coordination requires good measures for:

- defining rehabilitation needs - objective data to quantify needs of the population
- determining available services and system capacity

*Dr. Mark Bayley, Psychiatrist  
Toronto Rehab Institute*

- Maintain and enhance the *Rehab Finder* (76% rate as very important or important)
- Define new and evolving programs, e.g., LTLTD (70% rate as very important or important).

In the survey, fewer members rated an electronic central referral system as very important or important (41%). However, the concept of an electronic central referral system received much stronger endorsement at the planning retreat. It has been suggested by some as an extremely effective mechanism to streamline the referral process to rehabilitation programs, thereby improving patient prioritization and reducing wait times. Others have pointed out the advantages of an electronic central referral system in providing objective data on wait times and access issues including the ability to quantify underserved patient populations and other barriers to access. The planning for an electronic central referral system must also include attention to funding and sponsorship.

The Network must continue to address issues of access and service delivery. An example of a current multi-stakeholder initiative to improve access and service delivery is the Total Joint Network (TJN) Project (funded by the MOHLTC). It is intended to address wait list and capacity issues for primary joint replacement. Participants include representatives from across the continuum, working together to address definitions, referral processes and streamline transfer points to facilitate smooth and efficient flow of patients through the continuum. Over the next two years, the GTA Rehab Network can play an important role in advancing the work of the TJN.

The following goals provide the overall direction and proposed actions have been outlined as suggested implementation strategies.

Goals	Proposed Actions
<ol style="list-style-type: none"> <li>1. Standardize rehabilitation definitions and clarify rehabilitation services across the continuum.</li> <li>2. Develop tools that support access and coordination across the continuum</li> <li>3. Strengthen understanding and commitment to outpatient and ambulatory parts of the rehab continuum</li> <li>4. Establish an electronic centralized referral system for target rehab populations</li> </ol>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>• Sponsor a 1-2 day workshop with representation from acute, rehab, CCC and LTC, outpatient/ambulatory and in-home services to identify common definitions and clarify key areas of future work to define and standardize</li> <li>• As lead player in the Toronto Joint Network, facilitate and develop mechanisms to support effective, timely client transitions from acute care/rehab/home</li> <li>• Identify partnership and sponsorship opportunities to develop an electronic centralized referral system for targeted populations (e.g., Script Project)</li> </ul> <p>Future years:</p> <ul style="list-style-type: none"> <li>• Gain consensus and common understanding of admission, referral and transfer processes across the continuum, focusing on populations of importance to the majority of</li> </ul>

Goals	Proposed Actions
	the membership (e.g., LTLD) <ul style="list-style-type: none"> <li>• Facilitate development and implementation of care pathways (e.g., stroke, joint replacement )</li> <li>• Track/monitor changes in outpatient services and assess impact on access to care</li> </ul>

**Strategic Priority #3: Inform Planning and Performance Measurement**

The Vision for Rehabilitation in the GTA describes the many characteristics and elements of a highly functioning and responsive rehabilitation system that meets patient and family need. The Network must continue to access the appropriate data, tools and mechanisms to accurately assess the current performance of the rehabilitation system and inform the planning for system improvement. The Network has undertaken specific initiatives that inform planning, e.g., *Analysis of Alternate Level of Care (ALC) Snapshots: Patients Awaiting Rehab in ALC and Inpatient Rehabilitation Capacity*.

This priority is very much linked to the priority on improving service delivery and access. The data, tools and mechanisms to track performance in the system will highlight concerns or issues of service delivery and access. The collaborative work across the continuum in addressing access and service delivery will yield common data elements, set performance targets and monitor performance.

Further work that exploits existing data to develop performance measures and inform system planning is critical to the Network.

The member survey identified strong support in several areas:

- Undertake studies/projects to identify and quantify gaps in targeted rehabilitation services (79% responses rated as very important or important)
- Develop outcome measures and benchmarks/indicators for performance measurement (76% responses rated as very important or important).

Community hospital members have further identified the need for Network support in “system planning –in determining what kind of beds we need in rehab, whether or not specific community hospitals should further specialize their services, how to deal with repatriated patients and community referrals.”<sup>16</sup>

Providers in rehabilitation and across the continuum hold differing views on the family of instruments that should be used to track patient-based data. For example, the National Rehabilitation System (NRS) by CIHI, is in use and the outcome measurement tool as directed by the MOHLTC for in hospital rehabilitation is the Functional Independence Measure (FIM). There are other tools that will meet the needs of stakeholders that intersect with the rehab continuum. For example, Dr. Katherine Berg, University of

<sup>16</sup> Karen Lumsden, Credit Valley Hospital, Strategic Planning Retreat, March 31, 2005.

Toronto Chair of Physical Therapy, advocates for the use of the interRai family of instruments as the foundation for patient based data.<sup>17</sup> The use of such data would:

- Support both clinical trials and health services research
- Consider the effect of strategies across the targeted service and the health care continuum
- Support an integrated, common assessment framework across the entire system (not just rehab providers)
- Facilitate evidence-based policy decisions
- Permit linking of clinical and health service use, (e.g., hospitalizations) to evaluate the longer term effects on function and cost.

The foundation for setting benchmark measures and informing system planning is reliable and proven data. It is proposed that the Network consider more closely the various data and measurement choices available when

**Performance must be**

- assessed according to valid, relevant measures...
- calculated by an objective authoritative source...
- based upon high quality, timely data.

*Dr. Adalsteinn Brown  
Lead Information Management  
Health Results Team*

recommending tools for providers to use. With the development of LHINs, the Network has an opportunity to recommend the most appropriate data for use in planning and performance measurement in rehabilitation by leveraging the experience and expertise of its members.

The following goals and proposed actions are recommended to support Informing Planning and Performance Measurement:

<b>Goals</b>	<b>Proposed Actions</b>
<ol style="list-style-type: none"> <li>1. Establish indicators and benchmarks for performance, using existing data and tools</li> <li>2. Define and standardize service and transition classification terminology that can be utilized across the continuum</li> <li>3. Select and recommend the best<sup>18</sup> of the existing tools/indicators that are sensitive to change across the continuum</li> <li>4. Identify gaps in services and complex/hard to serve populations</li> </ol>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>• In partnership with interested parties and experts in this field, identify/review existing data sets to come to consensus on which to implement/eliminate (in a small continuum sample or larger continuum sample). Promote this consensus to the LHINs and broader constituencies.</li> </ul> <p>Future Years:</p> <ul style="list-style-type: none"> <li>• Select tools which align with perceived system benefits; consider outcome indicators of health care utilization that might be impacted by positive rehabilitation service/program outcomes</li> </ul>

<sup>17</sup> Katherine Berg, presentation to GTA Rehab Network Strategic Planning Retreat, March 31, 2005

<sup>18</sup> Refers to the best psychometric properties (reliability, validity) as well as the best clinical utility of the tool(s) for the target population including stage of illness/condition/recovery, setting, rehabilitation service/provider/profession.

Goals	Proposed Actions
	<ul style="list-style-type: none"> <li>• Coordinate a task force to standardize definitions and terminology</li> <li>• Lead a consensus conference/workshop to resolve serious differences of opinion on the “best” or most appropriate tool(s) to recommend</li> <li>• Design an implementation support strategy, including education, training, data collection</li> <li>• Analyse data/indicators (with stakeholders) to identify recommendations in rehabilitation performance improvement and planning</li> </ul>

**Strategic Priority #4: Share Best Practices and Enhance Knowledge Exchange**

The GTA Rehab Network members have reported very high value in the Network’s initiatives related to best practices. The major efforts related to best practices have been focused on Best Practices Day, an annual forum for the rehabilitation community to profile their work and share information across the research-practice boundary, promoting knowledge transfer and exchange. Best Practices Day has been held five times, featuring 287 poster and podium presentations and over 30 plenary speakers. A total of 1,160 delegates have attended over the five years and the event has been supported by \$66,000 in sponsorship.

The member survey reinforced the importance of the Network’s role in promoting best practice:

- Organize an annual best practices day to promote knowledge exchange among rehabilitation clinicians, researchers and administrators *(86% rated as very important or important)*
- Organize regular forums for front-line staff on new models of care, best practices, sharing new approaches to care *(83% rated as very important or important)*
- Transfer knowledge and skills to family practitioners and others to support as much care as possible occurring in the community *(76% rated as very important or important)*
- Maintain a web-based library of materials and references for specific rehabilitation topics and materials/contacts for best practices or care models *(70% rated as very important or important)*.

It is evident that the sharing of best practices is a primary role for the Network and very highly valued by the members. Areas that require further work include:

- clarifying the definition and scope of *best practice* in relation to *evidence-based practice*,

Many hospital members have adopted new practices and instituted new protocols based on learning of best practices at our Annual Best Practices Day. We need to find ways to better share new findings and model approaches more frequently through the year.  
*Heather Reid, Rouge Valley Health System*

including the implementation of evidence-based practice in distinct practice settings and monitoring/evaluating the application in different practice settings

- establishing two to three best practice guidelines annually
- broadening the focus beyond clinical practice to include system design, integration and change practices
- supporting members in adopting and implementing best practices
- leveraging best practice information for advocacy purposes, linking with other strategic priorities of the Network
- extending the target audience for best practices beyond the membership through linkages with other networks or communities of interest.

Network activities in the area of best practices/evidence-based practice should be undertaken through collaboration with other groups/networks that are working in this area (e.g., West Toronto Regional Stroke Network’s Best Practice Guidelines for CCACs for stroke patients). The Network may wish to examine the successful work of the Registered Nurses Association of Ontario in best practices. The opportunity exists for reaching out more broadly across the continuum and to other communities of similar interest to leverage the exemplary work of the Network in the area of best practices.

The following goals provide the overall direction for this strategic priority and proposed actions have been outlined for further consideration.

Goals	Proposed Actions
<ol style="list-style-type: none"> <li>1. Expand current mechanisms for identifying, sharing and implementing best practices across the continuum of care</li> <li>2. Develop processes to track or monitor the adoption of best practices</li> <li>3. Identify target audiences and strategies for knowledge exchange, between and among the membership and external groups</li> <li>4. Collaborate with researchers to disseminate evidence-based practice and outcome measures</li> </ol>	<p>Year 1:</p> <ul style="list-style-type: none"> <li>• Expand and evaluate strategies to facilitate sharing and implementing best practices by clinical leaders and clinicians at the front-line</li> <li>• Establish the Network as a resource centre/clearinghouse for strategies that assist members in implementing best practices in their unique environment and evaluating their uptake; identify champions and expert/opinion leaders</li> </ul> <p>Future Years:</p> <ul style="list-style-type: none"> <li>• Develop relationships/partnerships with academic institutions, networks and other groups with shared interests in rehabilitation</li> <li>• Leverage Telehealth or other initiatives to reach beyond the GTA to both learn and disseminate knowledge</li> <li>• Communicate the value of best practices over time, particularly as and when they change as a result of new knowledge</li> </ul>

## **ENABLERS TO SUPPORT THE STRATEGIC PRIORITIES**

In addition to identifying four strategic priorities, the strategic planning process recognized several enabling competencies and capabilities as essential supports to achieving the Network's priorities. These underpin the four areas and require immediate attention by the Network.

1. Partnerships and Alliances
2. Communication, Promotion and Advocacy
3. Infrastructure Support and Funding

### **Partnerships and Alliances**

The Vision for Rehabilitation in the GTA and the Network's strategic priorities are highly dependent on collaboration and alliances. An immediate priority as noted above will be to revisit its membership to align more closely with LHIN boundaries and catchment areas.

However, in addition to formal membership relationships, the Network will need to reach out strategically to old and new partners in addressing its priorities and pursuing its new vision. This includes establishing effective mechanisms to interface with academic and research organizations, voluntary health organizations, the private sector and other key stakeholders. The Network must foster strong partnerships in areas of collaborative work, e.g., Stroke and Total Joint Replacement. It must also look beyond rehabilitation to changes in other sectors, such as acute care or complex continuing care and be prepared to support the rehab components of those sectors' transformation efforts.

There will be a need to:

- Target key partners to advance each of the Network's strategic priorities and its new vision for rehab.
- Explore new models of advisory panels, forums or multi-stakeholder workshops to engage diverse constituents.
- Collaborate with other regional rehabilitation networks to address shared priorities and to influence public policy and key decision-makers.
- Leverage the newly created OHA Complex Continuing Care and Rehabilitation Council.

### **Communication, Promotion and Advocacy**

The Network is a virtual organization. It is currently comprised of 42 membership organizations (now 38 with dissolution of DHCs) with hundreds of point-of-care providers, health professionals, administrators, researchers and other key stakeholders who have an interest in the products, recommendations and activities of the Network. Further, the Network relies heavily on its volunteers to provide the expert knowledge and insights to inform its products and recommendations. It will need members to buy-in, promote and advocate for its shared vision for rehabilitation in the GTA. Communicating

effectively with members within and across organizations is an ongoing challenge and priority for the Network.

As a membership organization, promoting ongoing value to its current members is essential as well as promoting its value to potential members. With the advent of LHINs, an immediate priority will be to showcase the accomplishments of the Network and to demonstrate its value as a “go to resource” for rehabilitation.

In both the member survey and at the planning retreat, there was strong endorsement for promoting a clear message that rehab is integral to an integrated health system and to improved patient care and health outcomes. Members fully support the Network’s role in advocating on behalf of rehab to influence public policy (*97% of responses in Member Survey identify advocacy as very important or important*). However, they also believe that advocacy must be based on evidence and fact, building on the rigorous work of the Network and its partners. Members have expressed a preference for stretching further in the advocacy arena, building on Network products and learnings, as well as on the partnerships and linkages across rehabilitation communities.

It may seem simplistic, but the first and most adamant point of feedback I heard from my colleagues was **ADVOCACY**. Those of us who have passionately worked in the field of rehab services for many years, have been witness to the more recent erosion of services in the hospitals.  
*Karen Lumsden, Credit Valley Hospital*

There is a need to:

- Promote a shared vision for rehabilitation in the GTA
- Strengthen communications across the Network using diverse mechanisms and media
- Enhance the profile of the Network by marketing its achievements and sharing its tools, processes and products more broadly
- Use evidence-based information arising from the Network’s initiatives/products to influence implementation of new approaches and policy changes, including addressing equity of access and service gaps
- Identify and collaborate with champions who can promote the “case for rehab”

### **Infrastructure Support and Funding**

The Network is supported by a highly productive but very small Secretariat. The core functions of the Network are supported by annual membership fees. (The GTA Rehab Network is currently the largest membership network in Canada that is fully funded by membership fees).<sup>19</sup> Support for an ambitious strategic plan is critical but must be contextualized within the reality of limited resources, both fiscal and human resources.

At a minimum, achievement of the four strategic priorities will require the following:

- Planning support for strategy development, research and communications
- Administrative coordination and support for workshops, task forces, consensus panels
- Information systems development to compile data, performance measurements

<sup>19</sup> Barry Monaghan, SPC Committee member, May 2005.

- Support for implementation of tools – education, training, data collection software, hardware; IT support (by both Network and providers)
- Technology and staffing support for an electronic referral system.

The Network has been successful in the past in obtaining external funding for specific initiatives and should be encouraged to continue to seek special funding in the future.

The pace and aggressiveness which the Network chooses to embrace its new vision for rehab will have a fundamental impact on its infrastructure resource requirements and the organization of these resources.

## **MOVING TO IMPLEMENTATION**

This strategic plan provides a framework to advance the new vision for rehabilitation in the GTA. It confirms four strategic priorities and three key enabling strategies for the Network.

Given the close alignment with the new strategic priorities and the current directions of the Network, completion of ongoing work remains a year one priority and will position Network well for implementation of new strategic initiatives.

Year 1 implementation priorities for each area include:

- Fully understand the Transformation Plan and develop information material that articulates rehab and the Network's potential role in achieving and influencing direction of this agenda
- Establish a Membership and Governance Task Force to reconsider membership in light of the LHIN boundaries and the vision of rehab as integral to the full continuum of care
- Sponsor a 1-2 day workshop with representation from acute, rehab, CCC and LTC outpatient/ambulatory and CCACs to identify common definitions and clarify key areas of future work to define and standardize processes
- Facilitate and develop mechanisms to support system wide implementation projects (e.g., client transitions from acute care/rehab/home as part of Toronto Joint Network project)
- Identify partnership and sponsorship opportunities to develop an electronic centralized referral system for targeted populations (e.g., Script Project)
- Develop a process to achieve consensus on key data elements and indicators for performance measurement
- Expand and evaluate strategies to facilitate sharing and implementing best practices by clinical leaders and clinicians at the front-line
- Establish the Network as a resource centre/clearinghouse for strategies that assist members in implementing best practices in their unique environment; identify champions and expert/opinion leaders.

The GTA Rehab Network has a well developed annual operating plan process. The above priorities should be integrated into the 2005-2006 operating plan. Further, all of the goals and proposed actions should be considered with a view to short-, mid- and long-term timelines.

Given the culture of accountability, indicators and performance measures will need to be identified to track the Network's performance against its stated goals and timelines.

## **CONCLUSION**

The strategic planning process has confirmed a strong member commitment to the GTA Rehab Network, substantiated the value placed on the work undertaken by the Network and articulated priorities for the next several years.

This process has identified major changes in the external environment that will provide opportunities and challenges to rehab providers and to the patients and families whom they serve. The Ontario Health Transformation directions and the new vision document, *Rehabilitation in the GTA: A Vision of the Future*, present exciting opportunities for the Network and its partners to gain momentum around a new vision for rehabilitation and a preferred future when “*rehabilitation is an integral and essential component of the continuum of care, reinforcing positive health behaviours, rebuilding lives and reintegrating individuals into the community.*”

## **Appendix I: Strategic Planning Committee**

Tina Smith, Chair	<i>Program Director, Department of Health Policy, Management and Evaluation, University of Toronto</i>
Malcolm Moffat	<i>President and CEO, St. Johns Rehab Hospital</i>
Barry Monaghan	<i>President and CEO, West Park Healthcare Centre</i>
Mary Beth Montcalm	<i>President and CEO, Providence Healthcare</i>
Heather Reid	<i>Program General Manager, Continuing Care and Rehabilitation, Rouge Valley Health System</i>
Mark Rochon	<i>President and CEO, Toronto Rehab</i>
Cathy Szabo	<i>Executive Director, Etobicoke and York CCAC</i>
Marian Walsh	<i>President and CEO, Bridgepoint Health</i>
Heather Brien	<i>Acting Executive Director, GTA Rehab Network</i>
Linda Huestis	<i>Communications Consultant, GTA Rehab Network</i>
Strategy Consultants	
<i>Helena Axler &amp; Associates Inc.</i>	
Helena Axler	
Margaret Duffy	
Susan Tremblay	

## Appendix II: Retreat Agenda

**GTA Rehab Network Strategic Planning Retreat  
March 31, 2005  
Vaughan Estate, Estates of Sunnybrook  
Courtyard Ballroom  
AGENDA**

- 7:30 a.m.      **Continental Breakfast**
- 8:00            **Welcome and objectives of the meeting**      Tina Smith, Chair
- 8:10            **Setting the Context**  
*The first five years, a view to the future*      Mark Rochon, Vice-Chair
- 8:30            **Drivers of Change**  
*Moderator: Barry Monaghan*
- The changing system environment: implications for  
rehabilitation and networks*  
Sheila Jarvis, Chair Ontario Hospital Association  
President & CEO Bloorview MacMillan Children's Centre
- The changing role of rehabilitation: implications  
for practice, research and policy*  
Katherine Berg, Chair Physical Therapy, University of Toronto
- Rehab in a regionalized environment:  
Lessons Learned- Future Opportunities*  
Hume Martin, President & CEO, Rouge Valley Health Centre
- Questions and panel discussion*
- 9:40            **System-wide improvements and accountability:  
a view from the Ontario Health Results Team**  
Adalsteinn Brown, Lead Information Management,  
Health Results Team
- 10:10           **Break**
- 10:30           **Our future vision for Rehabilitation in the GTA**
- Presentation of Model      Margaret Duffy
- Roundtable discussion
- Report back to Plenary      Helena Axler
- 11:45           **Lunch**
- 12:30           **Realizing our Vision**  
**The members speak out: what do we need/want from the Network  
for the next 3 - 5 years?**  
*Moderator: Malcolm Moffat*
- Specialized rehab/physiatrist (Mark Bayley)
  - 905 Hospital – provider (Karyn Lumsden)
  - Community/CCAC (Robert Morton)
  - Acute care/teaching hospital (Heather McPherson)
- Presenters will speak for 5 minutes and address the top 3 priority needs for their  
constituency. Panel discussion to follow*

1:10	<b>Confirmation of the Network's strategic priorities Feedback on consultation &amp; members' survey</b>	Helena Axler Susan Tremblay
1:30	<b>Testing the strategic priorities: Developing goals and actions</b> <ul style="list-style-type: none"><li>• <i>Align Network with Transformation Agenda &amp; LHIN mandate &amp; membership</i></li><li>• <i>Improve service delivery and access</i></li><li>• <i>Share best practices and undertake knowledge exchange</i></li><li>• <i>Inform planning and performance measurement</i></li><li>• <i>Advocate and influence public policy</i></li></ul>	Breakout groups
2:45	<b>Break</b>	
3:00	<b>Report Back to Plenary</b>	All
3:45	<b>Reinforcing our infrastructure to enhance effectiveness to members</b> <i>Plenary discussion</i>	Helena Axler
4:10	<b>Wrap Up and Next Steps</b>	Tina Smith
4:15	<b>Planning Retreat Adjourns</b>	
4:15	<b>Wine &amp; Cheese Reception: <i>All members/participants invited to attend</i></b>	

## **Appendix III: GTA Rehab Network Strategic Planning Retreat List of Participants**

<b>Last Name</b>	<b>First Name</b>	<b>Organization Name</b>
Adie	Clare	Baycrest Centre for Geriatric Care
Anderson	Carol	Lakeridge Health Corporation
Andrachuk	Brenda	CCAC of York Region
Barker	Donna	St. John's Rehab Hospital
Bassett-Spiers	Kent	Ontario Neurotrauma Foundation
Bayley	Mark	Toronto Rehab
Belza	Tish	St. Michael's Hospital
Berg	Katherine	University of Toronto
Bisaillon	Susan	Trillium Health Centre
Brown	Adalsteinn	Ministry of Health and Long-Term Care
Brown	Barry	Ministry of Health and Long-Term Care
Brown	Dennis	Toronto Grace Health Centre
Buckner	Carol	Humber River Regional Hospital
Catton	Kathi	Toronto Grace Health Centre
Copplestone	Christina	Mt. Sinai Hospital
Cotton	Catherine	The Scarborough Hospital
Cripps-McMartin	Paula	University Health Network
Currie	Sharon	Mt. Sinai Hospital
Danbrook	Cathy	The Ottawa Hospital
Ferguson	Joan	Bloorview MacMillan Children's Centre
Ferro	Enza	Ontario Hospital Association
Gillani	Asmita	York Central Hospital
Graveline	Chantal	COTA Health
Grossi	Mary-Grace	St. John's Rehab Hospital
Hall	Stephen	Bridgepoint Health
Hardenne	Denise	Halton Healthcare Services
Harris	Janet	Durham Access To Care
Hartford	Anne	Sunnybrook & Women's College Health Sciences Centre
Hladin	Nadia	Trillium Health Centre
Hovey	Brock	Lakeridge Health
Huijbregts	Maria	Baycrest Centre for Geriatric Care
Hurley	Laurie	The Arthritis Society
Jarvis	Sheila	Bloorview MacMillan Children's Centre
Konigshaus	Gregory	North York General Hospital
Likwormik	Betty	St. Joseph's Health Centre
Lumsden	Karyn	Credit Valley Hospital
MacLeod	Anne Marie	Sunnybrook & Women's College Health Sciences Centre
Mallia	Vija	Castleview Wychwood Towers
Martin	Hume	Rouge Valley Health System
McPherson	Heather	Sunnybrook & Women's College Health Sciences Centre
Miller	Dale	Etobicoke and York CCAC

<b>Last Name</b>	<b>First Name</b>	<b>Organization Name</b>
Moffat*	Malcolm	St. John's Rehab Hospital
Monaghan*	Barry	West Park Healthcare Centre
Montcalm*	Mary Beth	Providence Healthcare
Moore	Sharon	Markham Stouffville Hospital
Morton	Robert	CCAC of Peel
Murphy	Mary	St. Michael's Hospital
Norman	Pat	Southlake Regional Health Centre
Pierce	Cathy	Markham Stouffville Hospital
Prentice	Dawn	Halton Healthcare Services
Reid	Heather	Rouge Valley Health System
Reidel	Lou	Ontario Hospital Association
Rochon*	Mark	Toronto Rehab
Ross	Carol	Toronto East General Hospital
Ryan	Gary	Southlake Regional Health Centre
Scott	Hugh	The Scarborough Hospital
Scott	Jennifer	North York CCAC
Sheriff	Fatima	University Health Network
Soric	Rajka	West Park Healthcare Centre
Streiner	David	Baycrest Centre for Geriatric Care
Szabo*	Cathy	Etobicoke and York CCAC
Tardif	Gaetan	Toronto Rehab
Walker	Jan	West Park Healthcare Centre
Walsh	Gaye	Bridgepoint Health
Walsh	Josie	Providence Healthcare
White	Ken	Trillium Health Centre
Wisniewski	Larissa	Bridgepoint Health
Wolfson	Laurence	William Osler Health Centre
Young	Michael	Humber River Regional Hospital

**Strategic Planning Consultants**

Axler*	Helena	Helena Axler & Associates
Duffy*	Margaret	Helena Axler & Associates
Tremblay*	Susan	Helena Axler & Associates

**GTA Rehab Network Secretariat**

Aird	Patty	GTA Rehab Network
Balogh	Sue	GTA Rehab Network
Brien*	Heather	GTA Rehab Network
Huestis*	Linda	GTA Rehab Network
Jessop	Robert	GTA Rehab Network
Moir	Judy	GTA Rehab Network
Saryeddine	Tina	GTA Rehab Network
Smith*	Tina	GTA Rehab Network

\* *Member of Strategic Planning Committee*

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