Rehabilitative Care System Evaluation

2017/2018 Performance Report

Improving Quality of Rehabilitative Care through Standardized Evaluation

November 30, 2018

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Executive Summary

The RCA is pleased to share this 2017/18 report - the first full iteration of the Rehabilitative Care System Performance Report that includes, in addition to this document, a *scorecard* and set of supporting *indicator definitions*. This report follows the 2016 and 2017 releases of the RCA System Evaluation Performance Data. Release of this report marks a significant milestone in the implementation of a standardized approach to evaluating system performance across the rehabilitative care continuum.

Data is reported for 11 indicators (three priority and eight supplementary) for the three years including 2015/16 to 2017/18 fiscal years. Data support and expertise was provided by Access to Care (ATC), Health Shared Services Ontario (HSSO) and Erie St. Clair LHIN and HNHB LHIN decision support teams. The RCA also used data from the Ontario Ministry of Health and Long-Term Care: IntelliHEALTH Ontario.

HIGHLIGHTS FROM THIS YEAR'S REPORT (2017-2018)

- There were approximately 32,790 patients admitted to **high intensity rehab** (NRS-reporting bed) and 24,410 to **complex continuing care** (CCC).
- Of the 21,080 patients who were designated as ALC for inpatient rehabilitative care, 71% were discharged to an NRS-reporting bed, 18% to a CCC-LTLD bed and 10% to a Convalescent Care bed.
- 294,446 patients received **in-home rehabilitative care services** with the largest volume receiving Occupational Therapy (OT) (145,789), followed by Physiotherapy (PT) (118,759), Speech Language Pathology (SLP) (17, 644) and Social Work (SW) (11,965) (combined long and short stay patients).
- 132,063 **ED visits for falls** were reported among seniors in Ontario, and of those, 12-18% were **repeat visits**.
- Although the 3 day benchmark for the 90th percentile wait time (the number of days, or less, that 90% of patients waited) for inpatient rehabilitative care was not met this year by any LHIN, many patients in acute care hospitals deemed ready for inpatient rehabilitative care did wait for 3 days or less. Six LHINs had median wait times for inpatient rehabilitative care that were 3 days or less and all LHINs had median wait times under 6 days. The Ontario 90th percentile wait time for inpatient rehab is 13 days for NRS beds, 17 for CCC-LTLD and 22 for CCP.
- Similarly, many patients who waited for in-home rehabilitative care services in Ontario waited less than the benchmark of 5 days. Median wait times ranged from 2 to 14 days. The 90th percentile wait time for patients referred to in-home rehabilitation care in Ontario varied across LHINs from as short as 7 days to as long as 50 days. Median and 90th percentile wait time was largely dependent on the health professional for whom patients were waiting. In 2017/18, the 90th percentile wait for in-home rehab (combined short and long stay) was 13 days for OT/PT, 15 days for SLP, and 22 days for SW.

- In 2017, the age standardized rate of repeat ED visits for falls among adults 65 years and over ranged from 515 to 1,081 per 100,000 across the province.

This 2017/2018 report is being made available to RCA stakeholders only, including RCA committees, LHINs, the MOHLTC and other provincial organizations. LHINs are encouraged to share the report with their health service providers (whose data is reflected) and regional rehabilitative care committees.

Introduction

Publication of this report marks a significant milestone in the implementation of a standardized approach to evaluating system performance across the rehabilitative care continuum. It addresses a gap in the availability of comparable, standardized, rehabilitative services data in Ontario. This standardized data is intended to support provincial quality improvement opportunities by enabling health services providers (HSPs) and Local Health Integration Networks (LHINs) to evaluate, report and benchmark the performance of the rehabilitative care system in Ontario. Standardized data will assist planners in making system wide improvements to ensure that people have access to the needed rehabilitative care resources across the province. Furthermore, it will allow LHINs, HSPs and other stakeholders to demonstrate the contribution of rehabilitative care to overall health care system objectives.

REHABILITATIVE CARE ALLIANCE

The Rehabilitative Care Alliance (RCA) was established by Ontario's 14 LHINs in the spring of 2013 in response to a recognized need for greater standardization across rehabilitative care programs. Over the past few years, the RCA has made significant progress in its efforts to strengthen and standardize rehabilitative care through better planning, improved performance management and evaluation and the integration of best practices across the care continuum.

The work of the RCA is guided by available evidence and data and informed by regular engagement and consultation with subject matter experts and key stakeholders.

For more information about the Rehabilitative Care Alliance, please visit *www.rehabcarealliance.ca*.

Rehabilitative Care Alliance Vision

Patient and system outcomes are optimized through the integration of rehabilitative care at all levels of health services policy, planning and delivery.

DEVELOPMENT OF THE REPORT

In 2015, the RCA released the *Rehabilitative Care System Evaluation Framework* and has been working to support implementation of this standardized framework. The work of the System Evaluation Task and Advisory Groups has been to focus on the implementation of the framework with the goal of developing a provincial performance report and scorecard using the indicators from the framework. The development of the performance report and scorecard was conducted in several stages, with provincial stakeholders engaged in all aspects of this work.

Below are the key principles that have guided, and continue to guide, the group's work:

- Utilize data derived from existing and reliable data sources

- Performance data is shared with stakeholders intentionally and sensitively
- Utilize existing targets and benchmarks where available and appropriate
- Methodology is transparent
- Benchmarks are calculated for indicators to drive change, when the desired change is both meaningful and the impact of the change is understood
- Patient and caregivers are included in the priority indicator selection process

For more information, see *RCA Mandate II Final Report*

WHO SHOULD USE THIS REPORT

This 2017/18 report is designed for health care planners, health care providers, administrators and others interested in the delivery and performance of rehabilitative care services in Ontario.

To ensure optimal use of the scorecard results, LHINs can use the information in this report for strategic planning and priority-setting within their regions. By identifying indicators for which their region's performance is lower than the provincial average, they can consider the need to direct resources and refine/develop initiatives to facilitate quality improvement in these areas.

Results should be shared among LHIN staff and LHIN health care service providers who are involved with the planning of rehabilitative care services. At this time, the report is not intended for broad public circulation.

The report is intended to be reviewed in conjunction with the interactive performance scorecard to be accessed here: *www.rehabcarealliance.ca/scorecard*. Technical definitions for the indicators presented in this report are available on the *Rehabilitative Care Alliance website*.

Performance Indicators

The 11 rehabilitative care system indicators (Table 1) cross the care continuum and cover the quality domains established by Health Quality Ontario (HQO) in 2013[1]; ***access, safety, effectiveness, appropriately resourced* and *integration*[2].**

The accompanying technical definitions provide the calculations and data sources for all the indicators, including the age standardization calculation for indicators C2 and C3. The indicators included are those from the System Evaluation Framework that are feasible to calculate and for which data is available. Three of these 11 indicators have accompanying benchmarks. The remaining 8 supplementary indicators provide information on the quality of rehabilitative care services overall and context for interpretation of the performance against benchmarks.

Table 1: Rehabilitative care system indicators

Indicator Ref #	Rehab. Care System Indicator	Quality Domain
Priority Indicators		
A1	Wait time for inpatient rehabilitative care: time from most recent discharge destination determined date from acute care to discharge date, where the discharge destination is inpatient rehabilitative care	**Accessible**
A3	Wait time for in-home rehabilitative care: patient availability date to date of first therapy visit	**Accessible**
C3	Repeat ED visits for falls for community-dwelling seniors: annual rate per 100,000 people aged 65 years and older (age standardized)	**Safe**
Supplementary Indicators		
A4	Percent contribution to ALC Rate in acute care by patients waiting for inpatient rehabilitative care	**Accessible**
A5	Percent contribution to ALC Rate in a rehabilitation bed or complex continuing care bed	**Accessible**
B5	Average change in functional score by Rehabilitation Client Group (RCG)	**Effective**
B6	Average Admission FIM Scores by Rehabilitation Client Group (RCG)	**Effective**
B8	Active rehabilitation LOS efficiency	**Effective**
C2	ED visits for falls for community-dwelling seniors: annual rate per 100,000 people aged 65 years and older (age standardized)	**Safe**
F3	ALC designation rate within 2 days for acute care patients discharged to an inpatient rehabilitative bed	**Integrated**
H4	Proportion of patients admitted to inpatient rehabilitation within each RCG	**Appropriately Resourced**

[1] Health Quality Ontario (2013) What is Quality Improvement? Attributes of a High-Quality Health System. Retrieved from http://www.hqontario.ca/quality-improvement on July 8, 2014.

[2] Note: HQO has further refined the quality domains to be *safe, effective, patient-centred, efficient, timely and equitable* and as such, the System Evaluation Task Group will work towards aligning the existing indicators as well as any future indicators that are reported on with these refined quality domains.

Methodology

Data Sources

Data for the 11 indicators in this report were collected from the Canadian Institute for Health Information (CIHI) National Rehab Reporting System (NRS); the Complex Continuing Care Reporting System (CCRS-CCC); NACRS-ED provincial data sets via the Ontario Ministry of Health and Long-Term Care: IntelliHEALTH Ontario; Access to Care (ATC) Wait Time Information System (WTIS); Health Shared Services Ontario (HSSO) Client Health and Related Information System (CHRIS); MOHLTC Health Data Branch Portal and the Ministry of Finance Population Projections.

Indicators are reported for the 2017/2018 fiscal year (April 1 – Mar 31) for all facility-based indicators and for the 2017 calendar year for all population-based indicators.

Facility-based indicators

Nine indicators are calculated at the facility level and therefore report on performance for the facilities in a given LHIN for the fiscal year 2017/18 (discharged April 1, 2017 to March 31, 2018). The median and 90th percentile are reported for the two wait time indicators. All indicators are reported at the LHIN and Provincial Level. As per privacy best practices, where appropriate, some values may be suppressed or not reported to protect the privacy interests of individuals.

Population-based indicators

The fall indicators (C2 and C3) are reported by calendar year and are based on the LHIN population who are over age 65. Direct standardized rates were calculated using the 2017 Ontario adult population estimates from the 2011 census and administrative data from the Ministry of Finance, using 5 year increments from age 65 to 85 and 85 years and older.

Provincial Benchmarks

Three of the 11 rehabilitative care system indicators have accompanying benchmarks. A modified Delphi approach was used to select which indicators would have benchmarks. The criteria for selecting a benchmark included: attainable, agreeable to major stakeholders and reflective of top performance. The benchmarks were endorsed by the RCA System Evaluation Task and Advisory Groups and the Patient and Family Caregiver Advisory Group in 2016.

Two of the indicators with a benchmark address wait times for rehabilitative services. One, time to inpatient rehabilitation (A1) and the other time to in-home rehabilitation (A3). These benchmarks were calculated through consensus after reviewing data on current and past performance and alignment with other provincial wait time benchmarks.

The third indicator selected for benchmarking (C3) was the rate of repeat Emergency Department (ED) visits for falls among community-dwelling seniors. This indicator focuses on safety and speaks to the multi-faceted approach needed to change performance in this area. The benchmark is calculated using the Achievable Benchmarks of Care (ABC) methodology[3]**.** The principle of the ABC methodology is that the benchmark is based on data from the top performers. To calculate a benchmark using the ABC methodology, the average is calculated from the results of the top performing LHINs (representing the top 20% of the total population included in this indicator). The benchmark will be re-calculated annually (see Table 2).

The benchmark of **652** was calculated by:

- Ranking LHINs in descending order of performance on the indicator.
- Beginning with the highest-performing LHIN, the LHINs were added until at least 20% of the total number of patients were represented (in the denominator). In this case, 20% of the total population was 473,950
- The benchmark was calculated using only the providers selected in step two (20%), by dividing the total number of patients who received appropriate care by the total number of patients eligible for that care in the subset. This included Central West, Mississauga Halton and Central LHINs.

Table 2 – 2017 benchmark calculation for repeat ED visits

LHIN	Repeat ED Visit for Falls (est. rate per 100,000)	Population
(05) Central West	515	130,651
(06) Mississauga Halton	720	176,229
(08) Central	723	293,169
(03) Waterloo Wellington	730	119,444
(07) Toronto Central	738	198,156
(09) Central East	822	279,520
(01) Erie St. Clair	833	124,057
(12) North Simcoe Muskoka	899	93,885
(13) North-East	1013	116,989
(04) Hamilton Niagara Haldimand Brand (HNHB)	1027	271,492
(11) Champlain	1039	226,799
(02) South-West	1074	187,267
(14) North-West	1081	42,859
(10) South-East	1094	109,235
Total Population		2,369,752
Avg. Top Performers	652	

[3]Kiefe et al, *International J in Health Care* 1998;10(5):443-447

Defining Inpatient Rehabilitative Care

When referring to inpatient rehabilitative care throughout this report, it is the rehabilitative care services provided in any NRS or CCRS-CCC reporting bed and where data is available, Convalescent Care.

However, the following caveats apply:

- Data obtained from the WTIS (indicators A1, A4, A5, F3) distinguish CCRS-CCC bed types by program using the 'discharge destination detail' data element. Patients waiting for low intensity rehab services are noted as waiting for CCC-LTLD beds. CCC-non-LTLD beds are excluded from 'inpatient rehabilitative care'.
- Indicators A1, A4, F3 include data related to Convalescent Care.
- Indicators B5, B6, B8 and H4 include of data from NRS-reporting beds only.

Wait time for inpatient rehabilitative care (A1)

OVERVIEW

This indicator measures the time a patient is waiting in acute care for inpatient rehabilitative care. It is a measure of the number of days from the patient's most recent discharge destination determined date to the actual discharge date to inpatient rehabilitative care.

This indicator measures wait times for 'inpatient rehabilitative care' in the following bed types:

- NRS-Reporting Beds
- Complex Continuing Care Low Tolerance Long Duration Beds (CCC-LTLD)
- Convalescent Care Beds (CCP) in LTC Homes

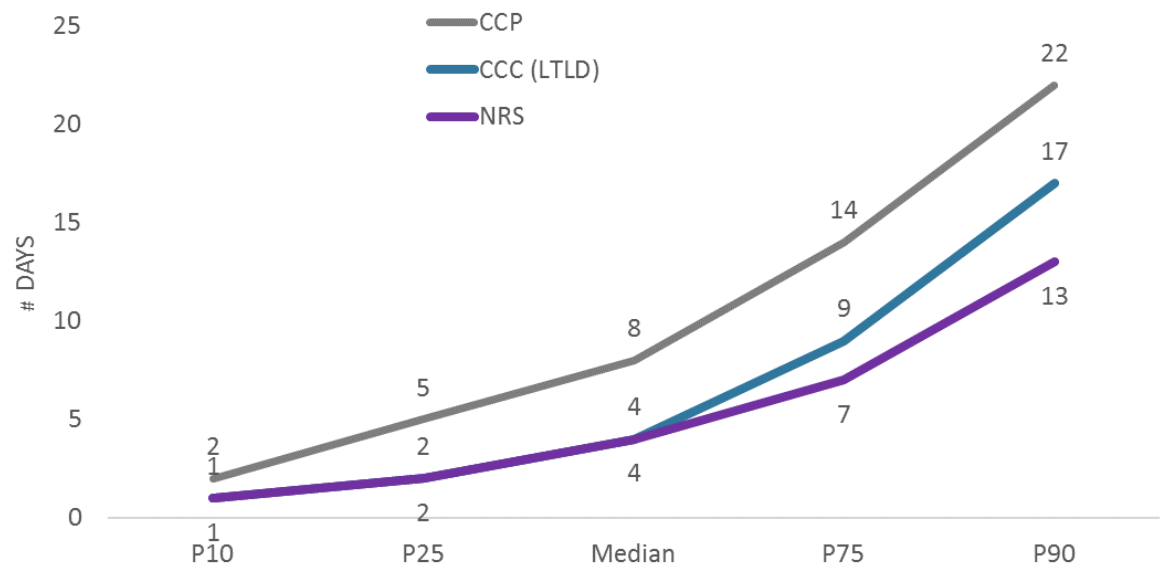
Why is it important to measure?
Patients who are waiting for inpatient rehabilitative care are not getting the care that they need when they need it. Long wait times may indicate that the current number of inpatient rehab beds is not meeting demand or that there are issues with bed utilization. It is a measure of timely access to care.

Data Sources
Wait Time Information System (WTIS)

Benchmark
A benchmark of **3 days** for the 90th percentile wait for inpatient rehabilitative care was arrived at through consensus as it approximated the 25th percentile of wait times in Ontario in 2015/16, indicating an achievable benchmark that represents high quality care. CCC-non-LTLD beds are excluded from the calculation for wait times for inpatient rehabilitative care as this patient population is medically complex and in need of a variety of programs including long stay CCC, behavior management, palliative care and other programs.

RESULTS AND KEY FINDINGS

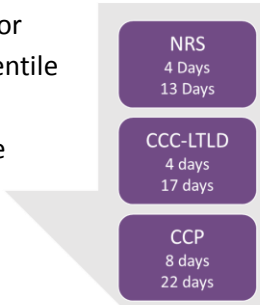
Figure 1 – Provincial wait time for inpatient rehabilitative care (FY2017/18)



	Total Patient Volumes	P10	P25	Median	P75	P90
NRS	15,008	1	2	4	7	13
CCC (LTLD)	3,882	1	2	4	9	17
CCP	2,190	2	5	8	14	22

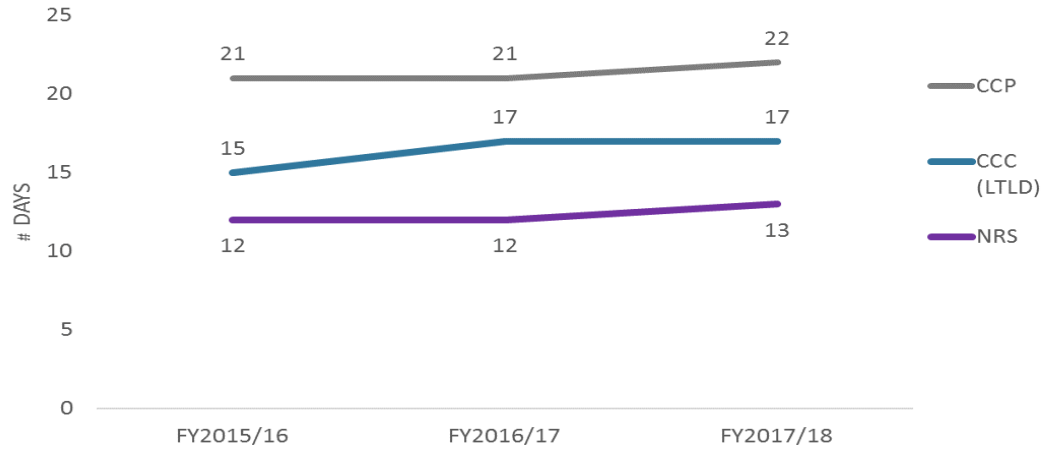
The time spent waiting for inpatient rehabilitative care is dependent on the discharge destination for which the patient is waiting (*see Figure 1*).

- Shortest wait times among patients waiting for inpatient rehabilitative care are for patients going to NRS reporting beds a median wait time of **4 days** and 90th percentile wait time of **13 days.**
- Patients waiting for rehabilitative care in CCC-LTLD beds have a median wait time of **4 days** and a 90th percentile wait time of **17 days.**
- Patients waiting for rehabilitative care in CCP beds wait the longest, with a median wait time of **8 days** and a 90th percentile wait time of **22 days.**



Trends over time

Figure 2 - Provincial wait time for inpatient rehabilitative care, 90th percentile (FY2015-2018)

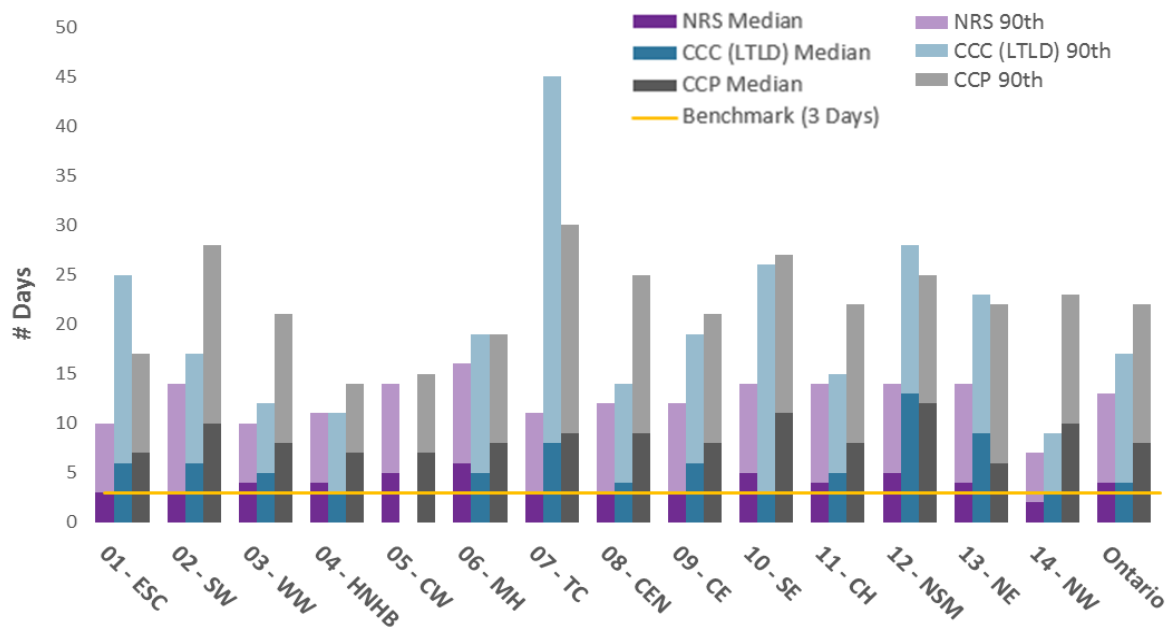


	2015/16		2016/17		2017/18	
Bed Type	**Median**	**90th**	**Median**	**90th**	**Median**	**90th**
NRS	4	12	4	12	4	13
CCC (LTLD)	4	15	5	17	4	17
CCP	8	21	8	21	8	22

Figure 2 demonstrates that, in general, wait times for inpatient rehabilitative care have not significantly changed over the past three years.

Variation across LHINs

Figure 3 – Wait time for inpatient rehabilitative care, median and 90th percentile (FY2017/18)



	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
NRS															
Median	3	3	4	4	5	6	3	3	3	5	4	5	4	2	4
90th	10	14	10	11	14	16	11	12	12	14	14	14	14	7	13
Complex Continuing Care (LTLD)															
Median	6	6	5	3	NV	5	8	4	6	3	5	13	9	3	4
90th	25	17	12	11	NV	19	45	14	19	26	15	28	23	9	17
Convalescent Care Program (CCP)															
Median	7	10	8	7	7	8	9	9	8	11	8	12	6	10	8
90th	17	28	21	14	15	19	30	25	21	27	22	25	22	23	22

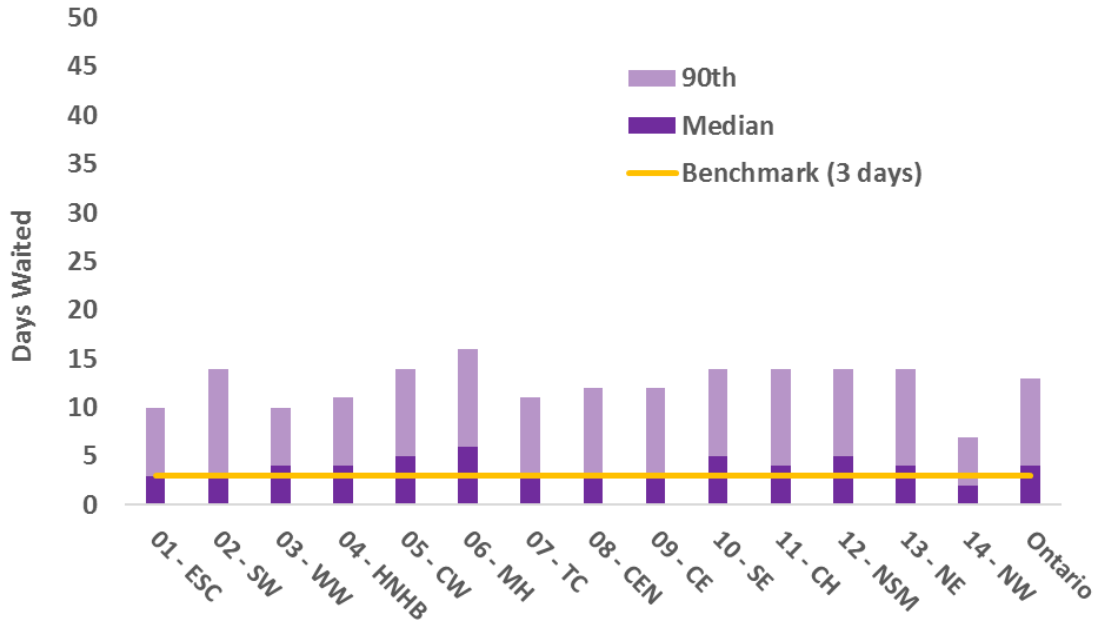
Highlighted cells =< 3 days

Figure 3 above shows the overall picture for wait times for inpatient rehabilitative care by LHIN for each type of bed, at the median and 90th percentile level of reporting. A more detailed breakdown is provided for each bed type in the following sections.

- Wait times for inpatient rehabilitative care are the longest when waiting for Convalescent Care in LTC Homes compared to NRS or CCC-LTLD.
- There is less variability across LHINs when waiting for NRS-reporting beds (standard deviation (SD) of 2.4) compared to wait times for CCC-LTLD (9.6SD) or Convalescent Care (SD 4.7)

NRS

Figure 4 - Wait time for an NRS-reporting bed, median and 90th percentile, (FY2017/18)



	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
Median	3	3	4	4	5	6	3	3	3	5	4	5	4	2	4
90th	10	14	10	11	14	16	11	12	12	14	14	14	14	7	13

Highlighted cells =< 3 days
N=15,008 patients

- For the 2017/18 reporting year, the 3 day benchmark for the 90th percentile wait for an NRS-reporting bed was not achieved by any LHIN. The NW LHIN is the best performer with a 90th percentile wait time of 7 days followed by ESC and WW with 90th percentile wait times of 10 days *(see Figure 4)*.
- 50% of the patient population with an ALC designation who were discharged to an NRS-reporting bed waited 3 days or less in 6 LHINs (NW, ESC, SW, TC, CEN, CE) and 6 days or less in the remaining LHINs. Understanding that these 6 LHINs are achieving median wait times of 3 days or less suggests that great work is already underway in the province to provide timely access to rehab in Ontario.

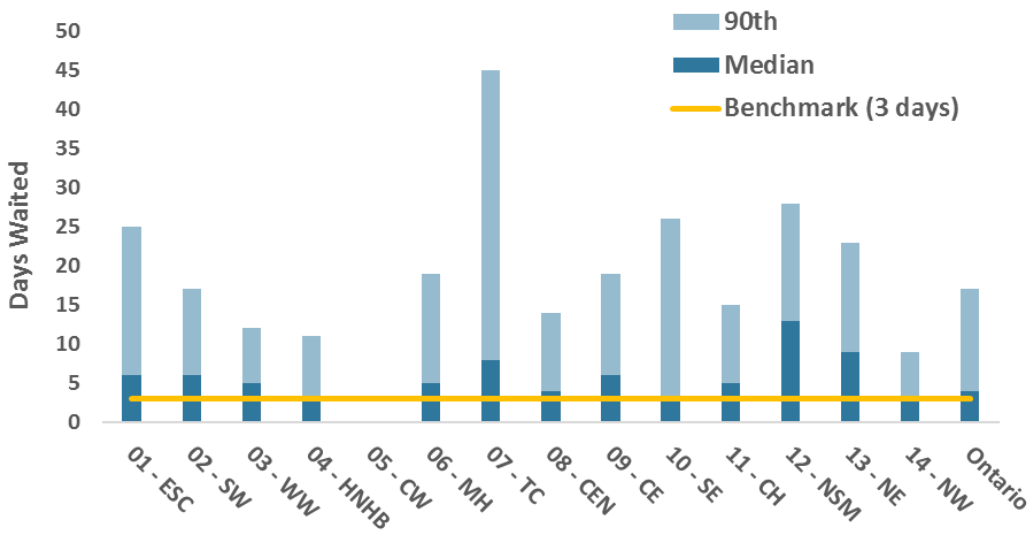
Variations within NRS-Reporting Beds

Within the WTIS database, program specific detail associated with the facility type or service required by the patient at the point of discharge or transfer is captured as 'discharge destination detail'. For NRS discharge destinations, the rehab programs that can be further specified are cardiac, geriatric, LTLD, MSK, neuro, or other. Data on wait time by program specific detail is not shown here, but is available in the accompanying *interactive performance scorecard*.

There is a larger variation in the 90th percentile wait times across programs in NRS reporting beds (SD 4.4) compared to the 90th percentile wait time for all NRS-reporting beds across LHINs (SD 2.4). Patients admitted to inpatient cardiac rehab programs had the shortest 90th percentile wait time at 6 days and LTLD program patients the longest, with a 90th percentile wait time of 19 days.

COMPLEX CONTINUING CARE (CCRS-CCC-LTLD)

Figure 5 – Wait time for CCC-LTLD bed (low intensity rehab), median and 90th percentile (FY2017/18)



	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
Median	6	6	5	3	NV	5	8	4	6	3	5	13	9	3	4
90th	25	17	12	11	NV	19	45	14	19	26	15	28	23	9	17

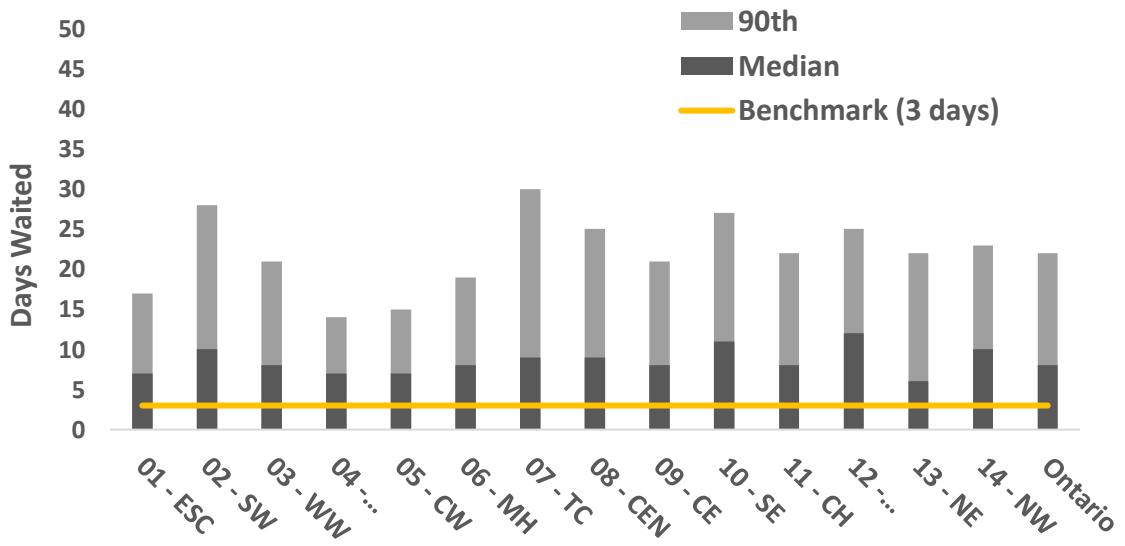
Highlighted cells =< 3 days
N=3,882 patients

- For the 2017/18 reporting year, the benchmark of 3 days for the 90th percentile wait for inpatient rehabilitative care was not achieved by any LHIN for patients waiting for CCC-LTLD beds[4]. The NW LHIN is the top performer with a 90th percentile wait time of 9 days followed by HNHB with a 90th percentile wait time of 11 days *(see Figure 5)*.
- 50% of the patient population with an ALC designation who were discharged to a CCC-LTLD bed waited 3 days or less in 3 LHINs (HNHB, SE, NW) and 13 days or less in the remaining LHINs. Again, understanding that these 3 LHINs are achieving median wait times of 3 days or less suggests that great work is already underway in the province to provide timely access to rehab in Ontario.

[4] CCC-non-LTLD beds are excluded from the wait time calculation for Complex Continuing Care as the population group waiting for these beds are usually more medically complex and do not meet the eligibility criteria for low intensity rehabilitation

CONVALESCENT CARE BEDS

Figure 6 – Wait time for convalescent care (CCP), median and 90th percentile (FY2017/18)



	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
Median	7	10	8	7	7	8	9	9	8	11	8	12	6	10	8
90th	17	28	21	14	15	19	30	25	21	27	22	25	22	23	22

Highlighted cells =< 3 days
N=2,190 patients

- For the 2017/18 reporting year, the benchmark of 3 days for 90th percentile wait for CCP beds was not achieved by any LHIN (*see Figure 6)*.
- 90th percentile wait times range from 14 days (HNHB) to 30 days (TC) while median wait times range from 6 days (NE LHIN) to 12 days (NSM LHIN).
- HNHB, CW and ESC have the lowest wait times for CCP beds, although NE LHIN has the lowest median wait time of six days.

CONTEXT AND ANALYSIS – WAIT TIME FOR INPATIENT REHABILITATIVE CARE

Table 3 – Number of patients designated as ALC who waited in acute care for inpatient rehabilitative care

	FY2015/16	FY2016/17	FY2017/18
NRS	14,323	14,828	15,008 (66%)
CCC (LTLD)	3,944	3,879	3,882 (17%)
CCC (non-LTLD)	2188	1989	1,816 (8%)
CCP	2,606	2,452	2,190 (10%)
Total	**23,061**	**23,148**	**22,896**

In 2017/18, there were a total of 22,896 adult acute care patients who were designated as ALC while waiting for inpatient rehabilitative care. The majority of these patients (66%) were waiting for an NRS bed, followed by 17% for CCC-LTLD, 8% CCC non-LTLD, and 10% for CCP (*see Table 3*).

In 2017/18, there were approximately 32,790 patients admitted to an NRS bed, which means that the wait time data presented represents approximately half of all patients who were admitted to an NRS bed. This is because only patients who were designated as ALC will be included in the WTIS dataset. The remaining patients will have accessed the rehab bed through another pathway or did not have any wait (and hence, no ALC data reported) in acute care.

CONSIDERATIONS – INDICATOR INTERPRETATION

The A1 indicator calculation utilizes the *Most Recent Discharge Destination Detail Determination Date* as the 'start' date for counting the wait time to the final discharge date. The accuracy of the discharge destination bed type and discharge destination detail is dependent on acute care providers' knowledge of rehab programs and the patient's rehab needs. There may be some variation in how accurately bed types and program details are documented in the WTIS.

The discharge destination detail field may be updated more than once after a patient is designated as ALC. By using the 'most recent' discharge destination, the data should reflect the time from when a final destination has been determined to the date the patient is discharged to that destination. However, the data will not include the full time that the patient waited in the acute care bed, if the discharge destination field is changed after the patient is designated as ALC. As a result, the reported wait times may appear to be shorter than the patient experience would reflect.

It is also important to note for the interpretation of this wait time data that only patients with an ALC designation who are documented in the WTIS have their wait time reported in this indicator. Because of

this, a mathematical effect could occur where, as ALC rates[5] and ALC volumes[6] decrease, median and 90th percentile wait times may appear longer. As fewer patients are waiting in ALC, only those with longer wait times will remain in the sample. With a smaller sample size, the distribution of the wait times will have a tendency to skew relative to previous data reports. This both moves the median of the population higher and because of the inevitable tailing, the 90th percentile wait time can also be elevated. In summary, successes in reducing the number of patients designated ALC for rehab may reflect longer wait times as it is often the most complex patients who have the longest wait times and present the greatest challenges in moving to an appropriate rehabilitative care bed.

To support interpretation of this data, an analysis of ALC rates and volumes is provided in the *Supplementary Indicators* section of this document and the accompanying data for these indicators is provided in the *data set.* As always additional information on ALC rates and volumes is available from Access to Care.

[5] The proportion of inpatient days in Acute and Post-Acute care settings that are spent designated ALC in a specific period of time. See glossary of terms for reference.
[6] ALC volumes refer to the number of ALC cases (i.e. patients designated ALC) that meet a select criteria. They may be presented/reported as a number or a percentage/proportion of cases. See glossary of terms for reference.

Wait time for in-home rehabilitative care services (A3)

OVERVIEW

This indicator measures the number of days a patient is waiting for in-home rehabilitative care from the patient availability date following service authorization to the date of the first therapy visit.

It includes the following services: Physiotherapy, Occupational Therapy, Speech Language Pathology and Social Work**.**

Data is calculated at the median and 90th percentile, provincially and for each LHIN and includes data for both short and long stay patients.

Why is it important to measure?

Long wait times for this indicator may indicate that the level of services available in the community is not meeting demand. It is a measure of *Timely Access to Care.*

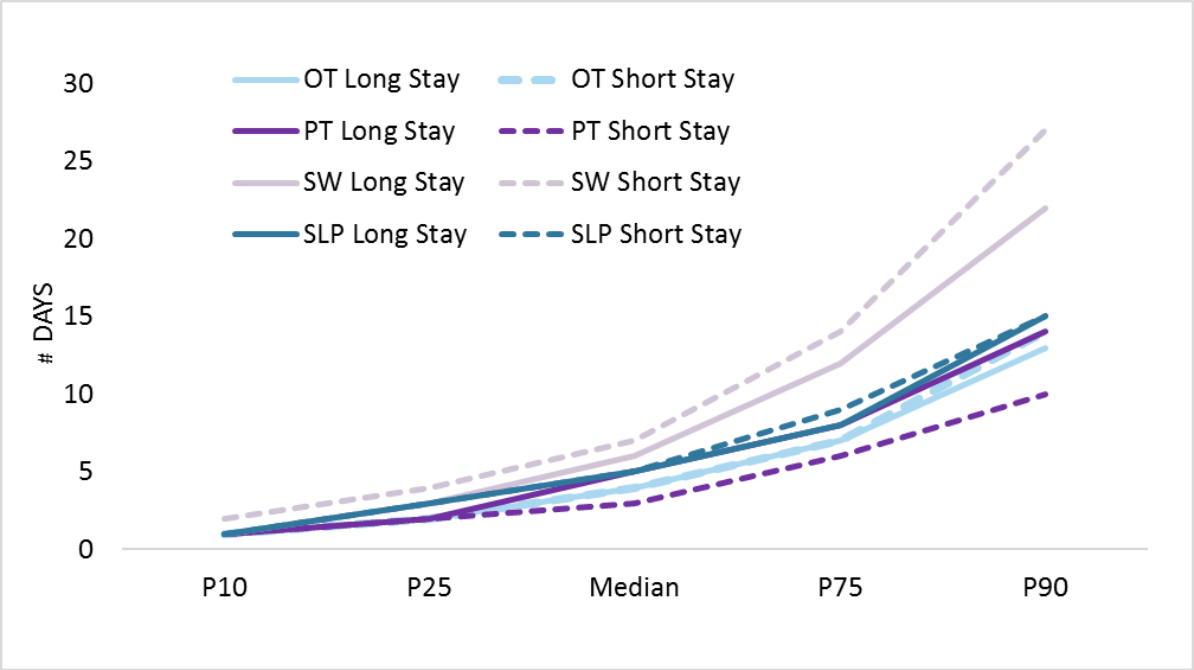
Data Sources

Client Health & Related Information System (CHRIS), Health Shared Services Ontario

Benchmark calculation

A benchmark of **5 days** was selected for the 90th percentile wait time for in-home rehab to align with the current MOHLTC benchmark for wait time for in-home nursing and personal support.

Figure 8 – Provincial wait time for in-home rehabilitative care services (FY2017/18)



Rehab Service	# Patients	P10	P25	Median	P75	P90
PT Long Stay	75,485	1	2	5	8	14
PT Short Stay	43,274	1	2	3	6	10
PT (Long and Short)	118,759	1	2	4	7	13
OT Long Stay	111,577	1	2	4	7	13
OT Short Stay	34,212	1	2	4	7	14
OT (Long and Short)	145,789	1	2	4	7	13
SLP Long Stay	10,895	1	3	5	8	15
SLP Short Stay	6,148	1	3	5	9	15
SLP (Long and Short)	17,043	1	3	5	9	15
SW Long Stay	11,990	1	3	6	12	22
SW Short Stay	865	2	4	7	14	27
SW (Long and Short)	12,855	1	3	6	12	22

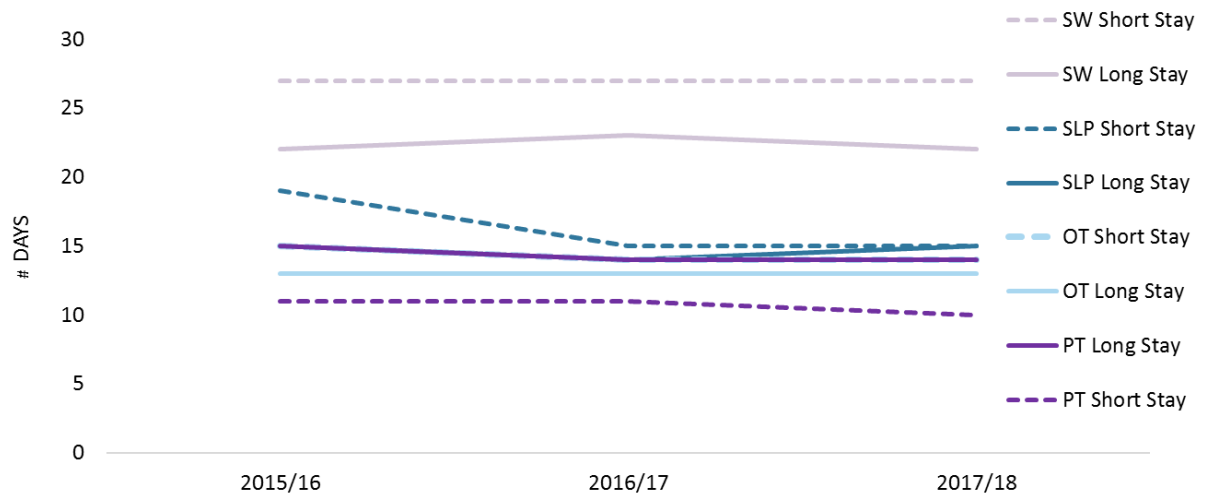
- Time spent waiting for in-home rehabilitation services is dependent on the Regulated Health Professional (RHP) services for which the patient is waiting. When data for short stay and long stay patient wait times are combined (*Figure 8)*:
    - Wait times for OT and PT services are the lowest, with a 90th percentile wait time of **13 days** and a median wait time of **4 days**.

- Patients waiting for SLP services have a 90th percentile wait time of **15 days** and a median wait of **5 days**

- Patients waiting for SW services typically wait the longest, with a 90th percentile wait time of **22 days** and a median wait time of **6 days**
- In some cases, long stay patients have a longer wait time compared to short stay patients. For example, for Physiotherapy, the 90th percentile wait times were 4 days longer for long stay patients compared to short stay patients. For Social Work, the 90th percentile wait times were 5 days longer for long stay compared to short stay patients. Variation in wait times between short stay and long stay patients is most notably at the 90th percentile wait, as would be expected. Even then, this variation seems to only be present when waiting for physiotherapy or social work services.

Trends over time

Figure 9 – Provincial wait time for in-home rehabilitative care services, 90th percentile, (FY2015-2018)

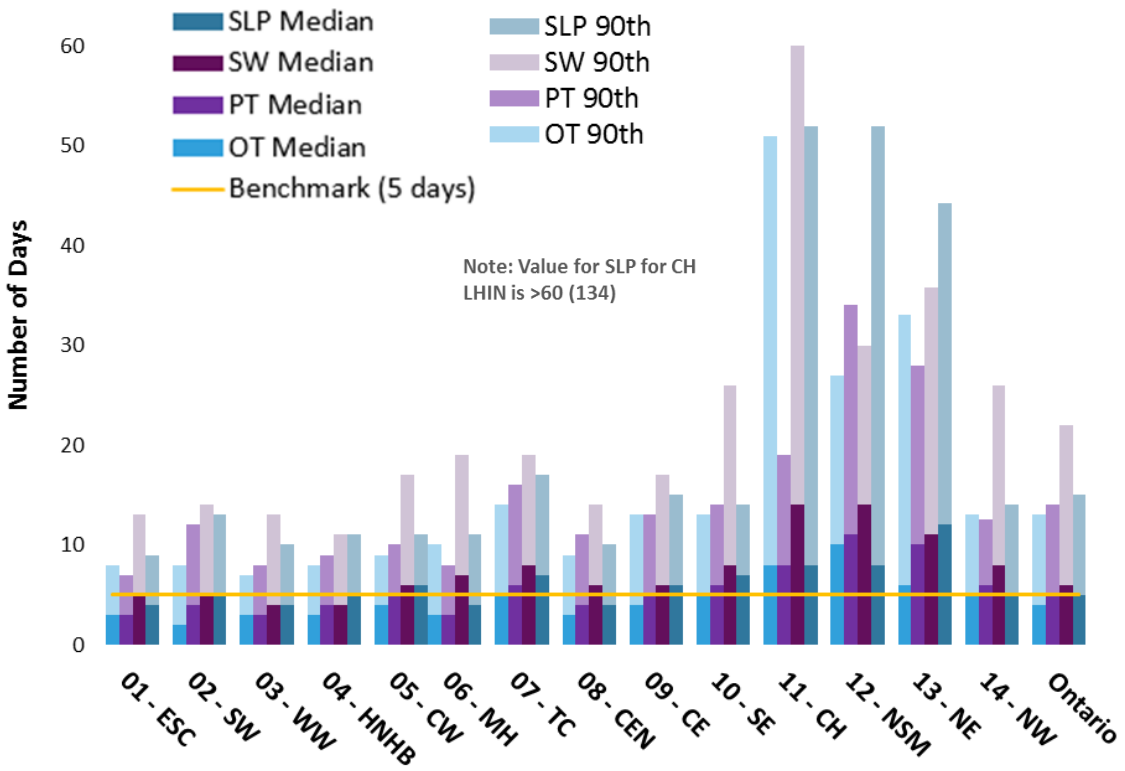


	2015/16		2016/17		2017/18	
RHP	Short Stay	Long Stay	Short Stay	Long Stay	Short Stay	Long Stay
OT	15	13	14	13	14	13
PT	11	15	11	14	10	14
SLP	19	15	15	14	15	15
SW	27	22	27	23	27	22

- Generally speaking, wait times for in-home rehabilitative care services have been fairly consistent over the last three reporting cycles. The only period of time where there was greater than a one day change between years was for Speech Language Pathology services. In 2015/16 SLP short stay patients waited 19 days. The wait time improved (dropped) to 15 days in both 2016/17 and 2017/18 *(see Figure 9 above)*.

Variation across LHINs

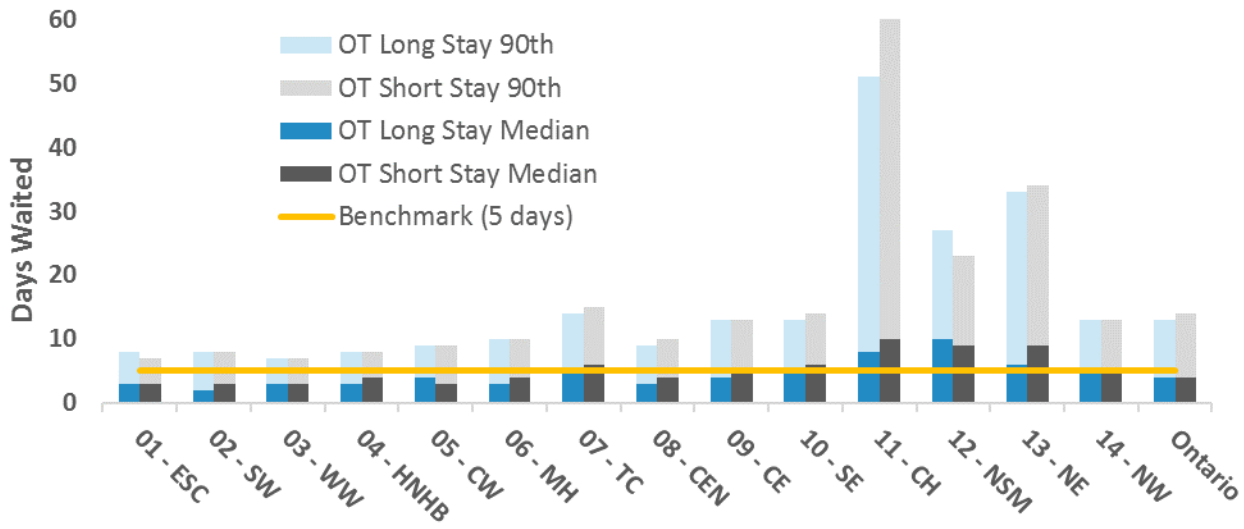
Figure 10 – Wait time for in-home rehabilitation, long stay, median and 90th percentile (FY2017/18)



LHIN	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
OT															
Median	3.0	2.0	3.0	3.0	4.0	3.0	5.0	3.0	4.0	5.0	8.0	10.0	6.0	5.0	4.0
90th	8.0	8.0	7.0	8.0	9.0	10.0	14.0	9.0	13.0	13.0	51.0	27.0	33.0	13.0	13.0
PT															
Median	3.0	4.0	3.0	4.0	5.0	3.0	6.0	4.0	5.0	6.0	8.0	11.0	10.0	6.0	5.0
90th	7.0	12.0	8.0	9.0	10.0	8.0	16.0	11.0	13.0	14.0	19.0	34.0	28.0	12.5	14.0
SLP															
Median	4.0	5.0	4.0	5.0	6.0	4.0	7.0	4.0	6.0	7.0	8.0	8.0	12.0	5.0	5.0
90th	9.0	13.0	10.0	11.0	11.0	11.0	17.0	10.0	15.0	14.0	52.0	52.0	44.2	14.0	15.0
SW															
Median	5.0	5.0	4.0	4.0	6.0	7.0	8.0	6.0	6.0	8.0	14.0	14.0	11.0	8.0	6.0
90th	13.0	14.0	13.0	11.0	17.0	19.0	19.0	14.0	17.0	26.0	133.9	30.0	35.8	26.0	22.0

Occupational Therapy Services (OT)

Figure 11 – Wait for in-home OT (Long and short stay), median and 90th percentile (FY2017/18)



LHIN	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
LS-Median	3	2	3	3	4	3	5	3	4	5	8	10	6	5	4
SS-Median	3	3	3	4	3	4	6	4	5	6	10	9	9	5	4
LS-90th	8	8	7	8	9	10	14	9	13	13	51	27	33	13	13
SS-90th	7	8	7	8	9	10	15	10	13	14	144	23	34	13	14

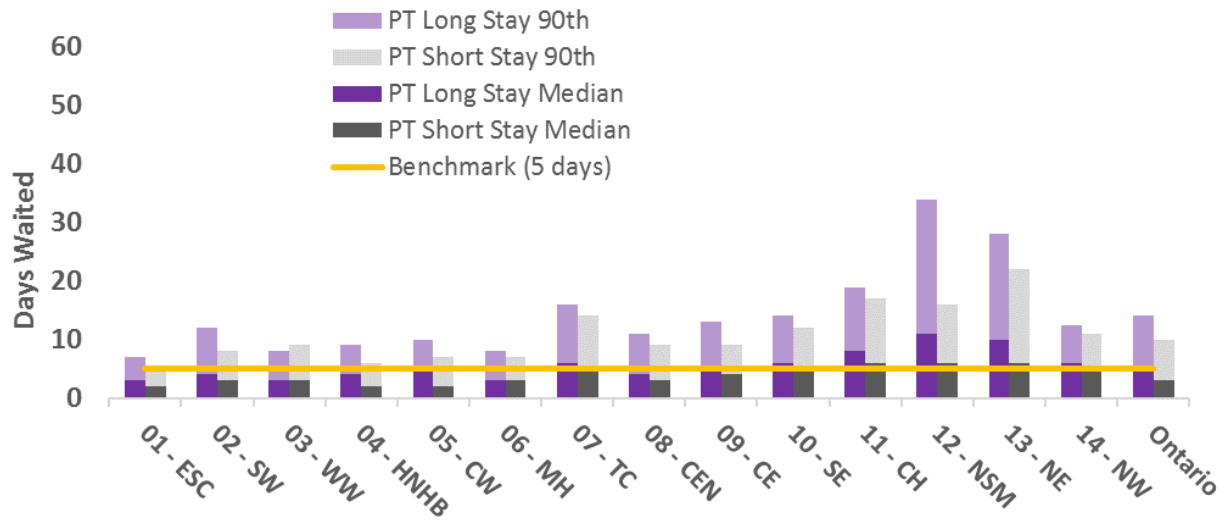
LS = Long stay, SS= Short stay

N= 145,789 patients (Occupational Therapy)

- For the 2017/18 reporting year, the benchmark of 5 days for 90th percentile wait for in-home rehab care was not achieved by any LHIN for Occupational Therapy services *(see Figure 11 above*). The variation in the 90th percentile wait times for long stay patients ranged from 8 to 51 days and 7 to 144 for short stay patients.
- The WW LHIN had the shortest 90th percentile wait time of 7 days.
- Most LHINs (11) had median wait times of 5 days or less for long-stay patients and 9 LHINs had a median wait time of 5 days for short-stay patients. In other words, when waiting for in-home rehab services, many LHINs are able to provide services to half of their clients in 5 days or less.

Physiotherapy Services (PT)

Figure 12 – Wait for in-home PT (long and short stay), median and 90th percentile (FY2017/18)



LHIN	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
LS-Median	3	4	3	4	5	3	6	4	5	6	8	11	10	6	5
SS-Median	2	3	3	2	2	3	5	3	4	5	6	6	6	5	3
LS-90th	7	12	8	9	10	8	16	11	13	14	19	34	28	13	14
SS-90th	5	8	9	6	7	7	14	9	9	12	17	16	22	11	10

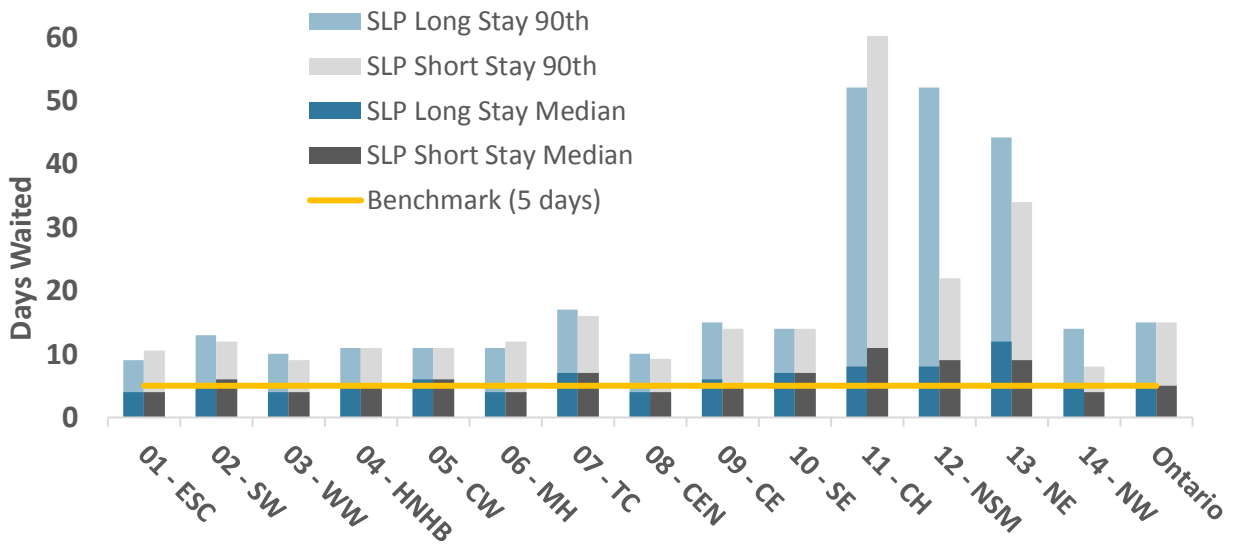
LS = Long stay, SS= Short stay

N= 118,759 patients (physiotherapy)

- For the 2017/18 reporting year, ESC met the benchmark of 5 days for 90th percentile wait for in-home PT services for short stay patients. In general, 90th percentile wait times for long stay patients ranged from 7 to 34 days and from 5 to 22 for short stay patients *(see Figure 12 above)*.
- The LHIN with the shortest wait time is ESC with a 90th percentile wait time for long stay patients of 7 days followed by WW and MH with wait times of 8 days.
- 8 LHINs have median wait times of 5 days or less for long stay patients and 11 LHINs for short stay patients. There is no difference in median wait times for long stay and short stay patients.
- When waiting for PT services, there was variation in the wait time between short stay and long stay patients unlike when waiting for other rehab services.

Speech Language Pathology (SLP) Services

Figure 13 – Wait or in-home SLP (long and short stay), median and 90th percentile (FY2017/18)



LHIN	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
LS-Median	4	5	4	5	6	4	7	4	6	7	8	8	12	5	5
SS-Median	4	6	4	5	6	4	7	4	5	7	11	9	9	4	5
LS-90th	9	13	10	11	11	11	17	10	15	14	52	52	44	14	15
SS-90th	11	12	9	11	11	12	16	9	14	14	190	22	34	8	15

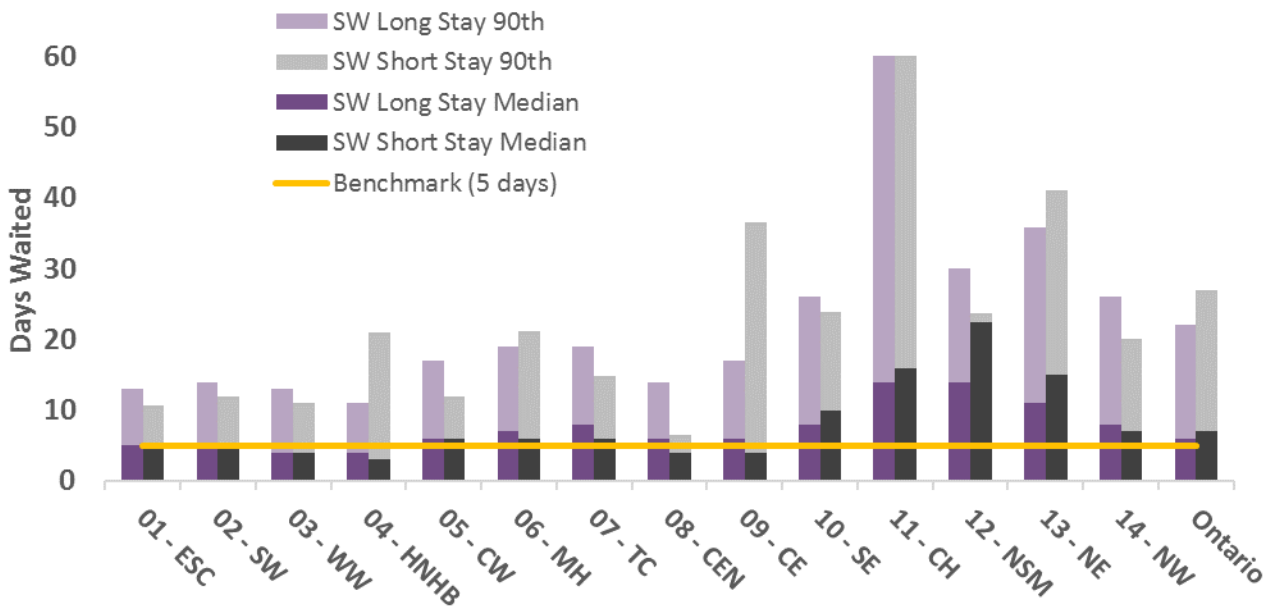
LS = Long stay, SS= Short stay

N = 17,043

- For the 2017/18 reporting year, the benchmark of 5 days for 90th percentile wait time was not achieved by any LHIN for Speech Language Pathology Services (*see Figure 13 above)*.
- 90th percentile wait times for long stay patients ranged from 9 to 52 days and from 9 to 190 days for short stay patients, although if data is excluded for the CH LHIN then the range is from 9 to 34 days.
- The LHIN with the shortest wait time is ESC with a wait time of 9 days for long stay and 11 days for short stay patients followed by WW and CEN LHINs.
- 7 LHINs have median wait times of 5 days or less for both long stay and short stay patients.

Social Work (SW) Services

Figure 14 – Wait for in-home SW (long and short stay), median and 90th percentile (FY2017/18)



LHIN	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
LS-Median	5	5	4	4	6	7	8	6	6	8	14	14	11	8	6
SS-Median	6	5	4	3	6	6	6	4	4	10	16	23	15	7	7
LS-90th	13	14	13	11	17	19	19	14	17	26	134	30	36	26	22
SS-90th	11	12	11	21	12	21	15	7	37	24	80	24	41	20	27

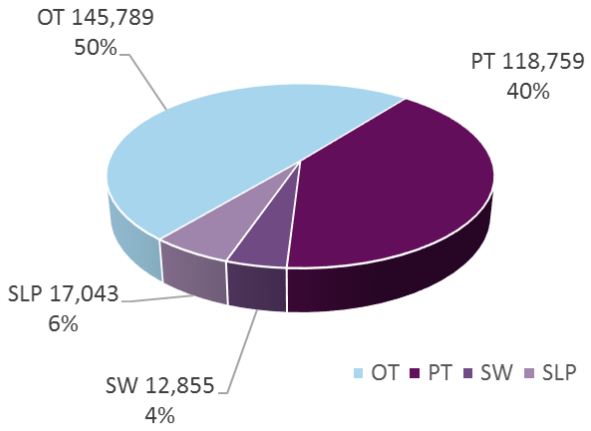
LS = Long stay, SS= Short stay

N = 12,855

- For the 2017/18 reporting year, the benchmark of 5 days for 90th percentile wait time was not achieved by any LHIN for Social Work Services.
- 90th percentile wait times for long stay patients ranged from 11 to 134 days and from 7 to 80 days for short stay patients, although if data is excluded for the CH LHIN then the range is smaller, from 11 to 36 for long stay and 7 to 37 days for short stay.
- The LHINs with the shortest wait time are HNHB, WW and ESC.
- 4 LHINs have median wait times of 5 days or less for long stay patients. For short stay patients, 5 LHINs have median wait times of 5 days or less (*see Figure 14 above)*.

CONTEXT AND ANALYSIS – WAIT TIME FOR IN-HOME REHABILITATIVE CARE

Figure 15 – Number of patients (short and long stay) who waited for in-home rehabilitative care, by RHP (FY2017/18)



In 2017/18 FY, there were 294,446 patients who waited for in-home rehabilitative services. These patients are grouped into either short stay (84,499) or long stay (209,947).

Of these patients, the highest volume (combined short and long stay) were waiting for OT (145,789) followed by PT (118,759), SLP (17, 644) and Social Work (11,965) (*see Figure 15)*.

CONSIDERATIONS - REGIONAL CONTEXT

Wait times in the Champlain LHIN for in-home rehab services appear to have significantly increased this reporting cycle. For example, when looking at changes from 2016/17 to 2017/18, wait times for OT services for long stay patients jumped from 27 to 51 days; OT short stay jumped from 34 to 144 days; SLP long stay jumped from 39 to 190 days and SW long stay jumped from 35 to 134 days. These changes are as a result of adjustments to the wait list procedures used in the CH LHIN. The Champlain LHIN has advised that actual service in the LHIN has improved and will continue to do so as more resources are being invested for in-home services.

Generally, in Northern Ontario there has been some expectation or understanding that wait times for in-home services would be longer, as the geography of these LHINs, with vast land and disparate populations, make serving many communities challenging. However, when comparing wait times between the NW, NE and NSM LHINs, wait times for in-home rehab services are much shorter in the NW LHIN compared to its other Northern counterparts. For example, wait times for OT services (long stay) for 2017/18 in NSM are 27 days, 33 days in NE and 13 days in NW which is comparable to the 13 day provincial average. In fact, wait times for in-home rehab care services in NW LHIN are shorter than in CH LHIN for the 17/18 year. And while there may be compounding factors as already noted, it would be worth investigating whether there are practices that have been adopted by the NW LHIN that enable these shorter wait times.

In general, practices across LHINs may vary with respect to how referral to in-home rehab services are prioritized and health professional resources utilized. For example, a patient with a more urgent need

for in-home rehab service may be prioritized over other, less urgent referrals. In other words, patients with a higher risk or more urgent need for service may be seen within the 5 day benchmark, while patients with a less urgent need may wait longer. The data reported here did not account for this triage methodology.

Repeat ED visits for falls (C3)

OVERVIEW

This indicator measures the annual rate of repeat visits to the ED for falls among seniors living in the community, expressed as the age standardized rate per 100,000 people. This indicator includes seniors (≥65 years old) who are living in the community who were not transferred from another hospital or a long-term care home. Only unscheduled visits were included in the indicator definition.

Why is it important to measure?

Repeat ED visits for falls is a measure of the effectiveness of secondary fall prevention and ED diversion efforts across the province. Low rates of repeat ED visits for falls is desirable. Age standardization of the data using the 2011 population estimates for the current year, controls for variation in expected increases in falls with variation in age of LHIN populations and allows comparison between LHINs. Meeting the benchmark for this indicator is one way to ensure community-dwelling frail seniors are receiving appropriate community-based interventions to maintain and optimize their functional status.

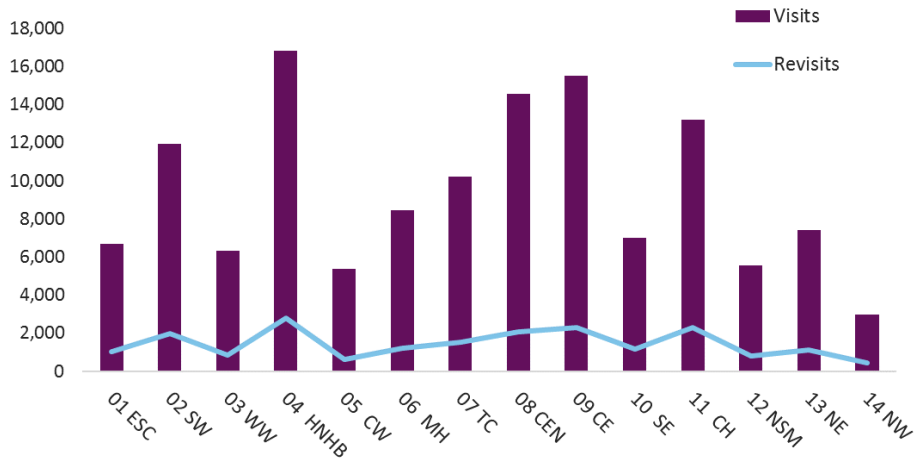
Data Sources

Ontario Ministry of Health and Long-Term Care: IntelliHEALTH ONTARIO (NACRS-ED)

RESULTS AND KEY FINDINGS

In 2017, there were **132,063** visits to the ED related to falls for seniors 65 years and older in the community (falls among seniors who are institutionalized are excluded from the reporting and calculations)**.** Out of these visits for falls **20,322 (15%)** were repeat visits, meaning the patient had already had an initial ED visit due to a fall in 2016 or earlier in the 2017 year. Therefore, for every **20** community-dwelling seniors who had a visit the ED related to a fall in 2016 or 2017, **3** will have visited the ED, unscheduled, again in the reported year.

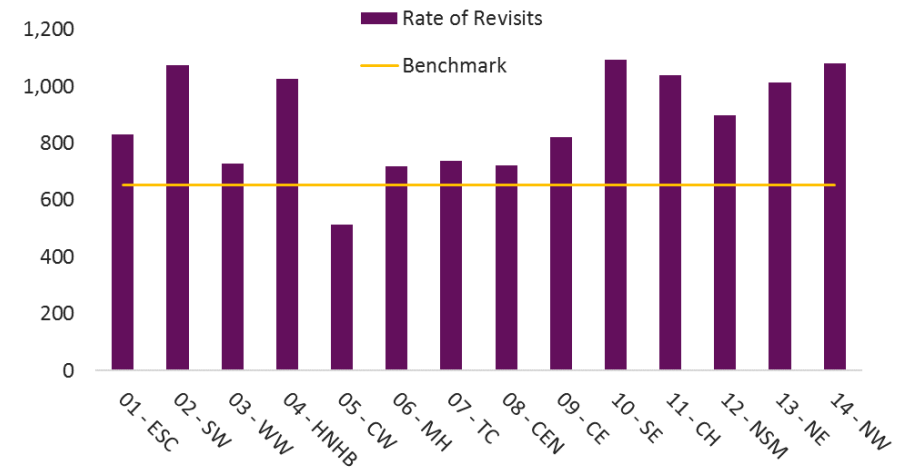
Figure 16 – Total ED visits for falls vs revisits (2017)*



LHIN	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW
Visits	6,701	11,931	6,340	16,838	5,366	8,458	10,229	14,547	15,513	6,993	13,190	5,572	7,402	2,983
Revisits	1,022	2,001	845	2,822	630	1,201	1,537	2,082	2,310	1,168	2,306	816	1,148	456

**Figure 16 represents actual numbers of ED Visits and is not age standardized*

Figure 17 – Repeat ED Visits for falls for community-dwelling seniors (2017 age-standardized rate per 100,000)



LHIN	ESC	SW	WW	HNHB	CW	MH	TC	CEN	CE	SE	CH	NSM	NE	NW
Rate of Revisits	833	1,074	730	1,027	515	720	738	723	822	1,094	1,039	899	1,013	1,081
Rate of Visits	5,444	6,412	5,458	6,158	4,310	5,026	4,952	5,035	5,538	6,514	5,923	6,084	6,478	7,108
Proportion of Revisits	15%	17%	13%	17%	12%	14%	15%	14%	15%	17%	18%	15%	16%	15%

- Repeat ED visits for falls represent 12-18% of the total ED visits for falls across LHINs.
- The three LHINs with the highest rate of repeat ED visits for falls are SW (1,074), NW (1,081) and SE (1,094).
- The age standardized rate of ED visits for falls varied from 4,310 per 100,000 seniors in the CW LHIN to o 7,108 per 100,000 in the NW LHIN.
- The range for age standardized rate of Repeat ED visits for falls is from 515 per 100,000 in CW compared to 1,081 per 100,000 in NW LHIN.
- This indicator is a system level indicator that was identified in the 2011 Integrated Falls Prevention Framework and Toolkit as one of three indicators to measure the effectiveness of fall prevention efforts for community-dwelling seniors across the province. Certainly, if the needs of community-dwelling seniors are not being met, the rate of repeat ED visits for falls may be increased. The overall goal is to decrease not only repeat ED visits due to falls, but also the rate of ED visits for falls, along with fall-related admissions to hospital.

CONSIDERATIONS – INDICATOR INTERPRETATION

It has been noted throughout provincial consultation on this indicator and in discussion with experts that coding for falls related visits in the ED can be inconsistent and variable. In accordance with the NACRS-ED and ICD-10 methodology for coding problem codes and cause codes, a fall cannot be coded as the 'primary reason' for an ED visit, and is always coded as a 'secondary' problem or potential cause. For example, a head injury or other injury may be coded as the primary reason for the ED visit as a result of a secondary problem, the fall. As a result, the fall may not be consistently or accurately documented in the patient record. This can make it challenging from a data reporting perspective but also for identifying the ongoing support needed for fall prevention for those who visit the ED who have had a fall.

Further, the definition for this indicator excludes visits to the ED that are scheduled in advance, as these visits are not considered emergency visits. However, there are some concerns around the accuracy of how these visits are coded. If a scheduled visit is not coded as such, the overall number of ED visits for falls may appear higher than the actual number.

Supplementary Indicators

In addition to the three priority indicators, data are reported on 8 supplementary indicators that provide context for a deeper understanding of the priority indicators and their associated benchmarks. A summary of the data with some analysis on these indicators is provided below. More detail on these can be found in the accompanying *scorecard.*

ONTARIO'S REHAB POPULATION

A total of 57,200 patients were admitted to inpatient rehabilitative care in Ontario in 2017/2018. Figures 19 and 20 provide further detail on the patients admitted to NRS-reporting beds and CCRS-reporting beds, respectively.

As illustrated in Figure 18, the proportion of patients admitted to an NRS-reporting bed within each Rehab Client Group (RCG) provides information on the population of patients who received inpatient rehabilitative care services in a high intensity rehab program. In 2017/18, 32,790 patients were admitted to an NRS-reporting bed. Seventy percent of the patients admitted to high intensity inpatient rehabilitation are either Orthopaedic Conditions (33%), Stroke (20%) or considered Medically Complex (17%).

Figure 18 – Proportion of Ontario patients admitted to NRS reporting beds within each RCG (FY2017/18)

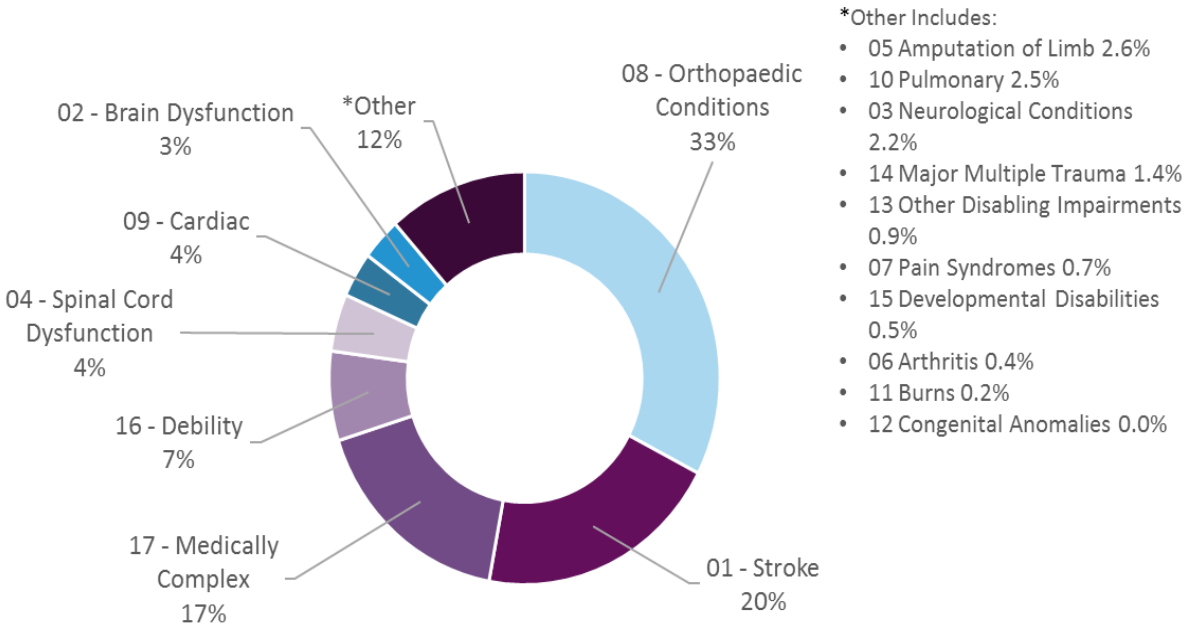
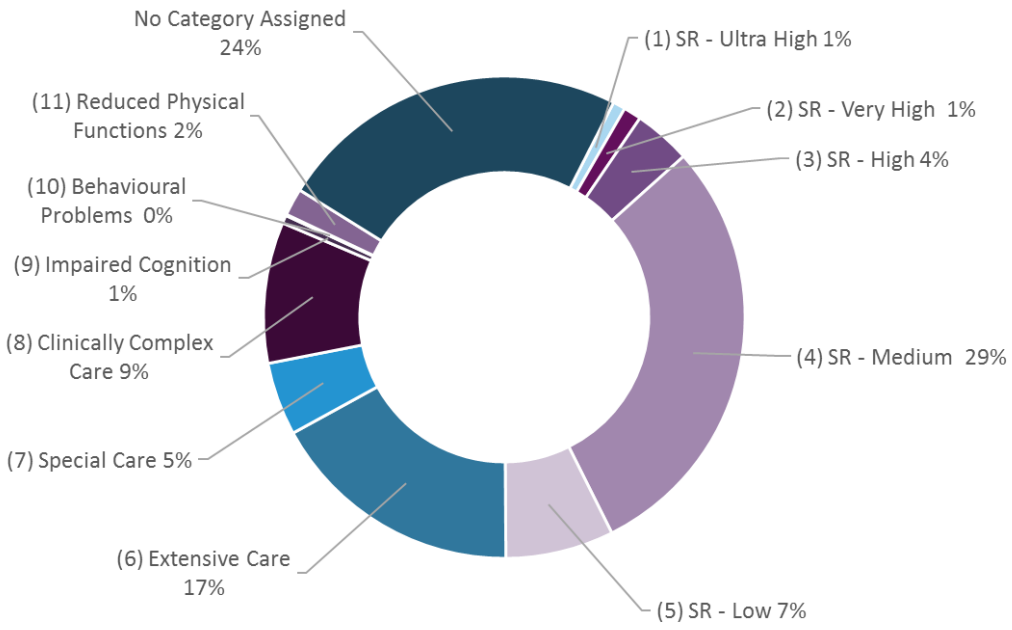


Figure 19 – Proportion of Ontario patients admitted to CCRS reporting beds by RUG (FY2017/18)



Note: SR = Special Rehabilitation

In 2017/18, there were 24,410 patients admitted to a CCRS-CCC reporting bed. As illustrated in Figure 19, the largest proportion of patients were admitted to the RUG category Special Rehabilitation - Medium (29%). Patients in all of the Special Rehabilitation RUG categories comprise a total of 42% of admissions to CCRS-CCC reporting beds.

ADMISSION FIM®, TOTAL FUNCTIONAL CHANGE, AND LOS EFFICIENCY

The average admission FIM® scores of patients provides context on the complexity of patients at admission and provides further description of patients admitted to NRS-reporting beds. FIM® scores are only calculated for patients admitted to an NRS-reporting bed. A higher score denotes the more independent a patient is at completing tasks. It is noted that there are limitations to the FIM® score to reflect functional impairment related to communication and cognition. The average FIM® admission score in Ontario in 2017/18 was 73.6 (*Table 4*). This ranged from 62.2 in the MH LHIN to 79 in the HNHB LHIN *(Table 4*). Over the past 3 years, the average admission FIM® score has decreased across the province by 1.5 points.

Figure 20 compares admission FIM® to average change in FIM® by RCG in Ontario. In 2017/18 the average admission FIM® by RCG ranged from 69.9 (stroke) to 91.5 (burns). The highest volume of patients in NRS-reporting beds are admitted with orthopedic conditions, stroke or are medically

complex (figure 18). The average admission FIM® scores for these patients groups were 74.3, 69.9, and 72.9 for respectively.

Table 4 – Average Admission FIM® Scores by LHIN

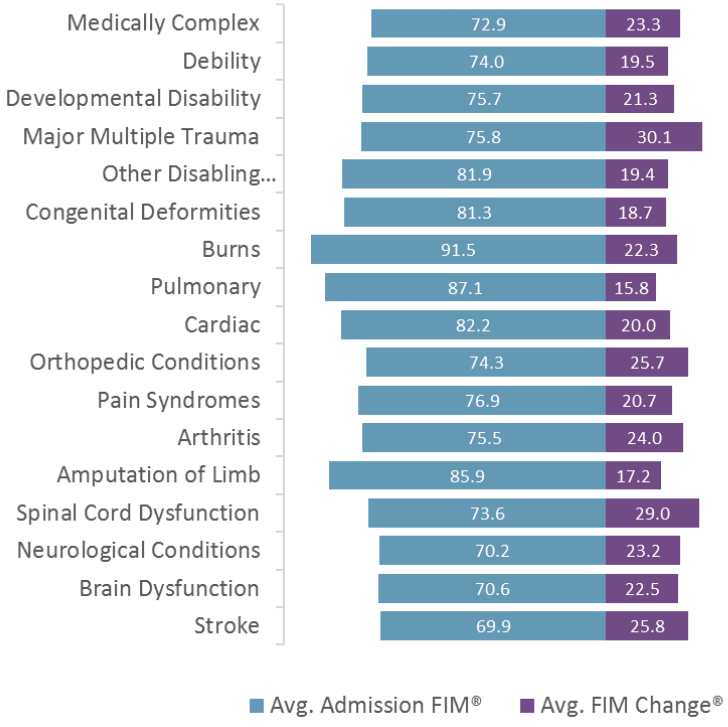
	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
FY15/16	71.5	75.9	70.6	79.4	75.1	64.4	78.2	73.1	70.7	74.1	78.6	75.1	78.6	75.4	75.1
FY16/17	69.4	76.5	70.8	79.4	69.8	63.6	75.3	74.0	71.3	72.2	76.5	72.5	77.4	72.0	74.1
FY17/18	69.8	76.3	72.0	79.0	71.0	62.2	73.8	77.5	71.5	70.8	76.9	71.5	77.2	71.7	73.6

The average change in functional score by Rehabilitation Client Group (RCG) for patients in NRS-reporting beds provides information on the functional change for patients discharged from inpatient rehab based on the patient population. Higher values represent greater improvement.

In FY2017/18, the average change in functional score provincially was 24.0 and represents a slight increase over previous years (22.3 in FY2015/16 and 22.7 in FY2016/17).

Some Rehabilitation Client Groups appeared to have greater changes than others. The RCG's for Major Multiple Trauma, Stroke and Non-Traumatic/Traumatic Spinal Cord Dysfunction had the largest changes in function scores (see Figure 20).

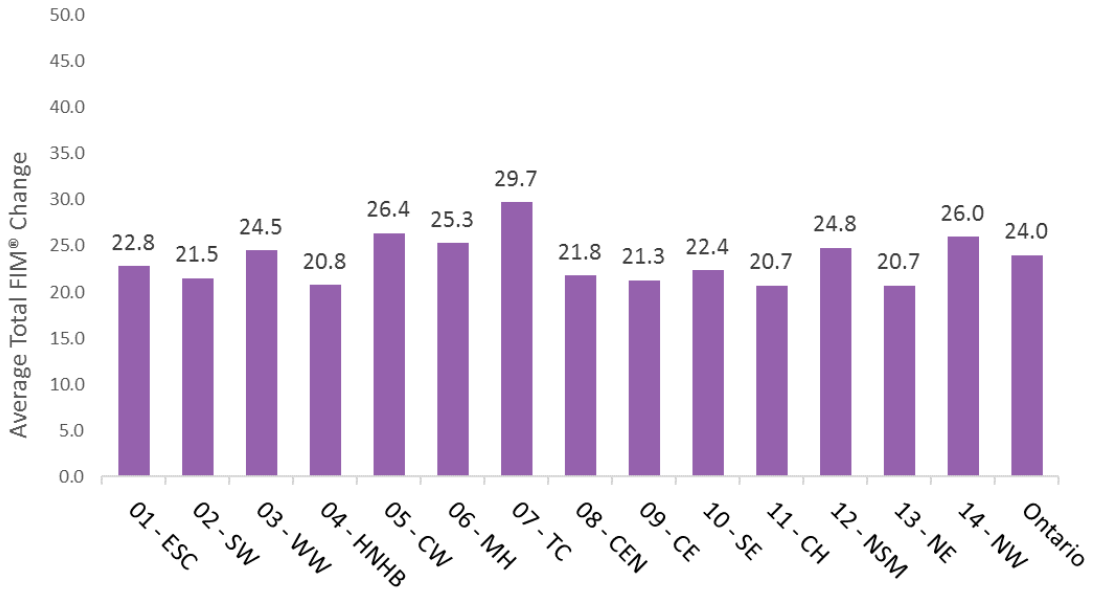
Figure 20 – Average change in FIM compared to average admission FIM®, by RCG for 2017/18 patients discharged from NRS reporting beds



By LHIN, the total change in function scores range from 20.7 in NE LHIN to 29.7 in TC LHIN (see Figure 21).

The average active rehabilitation LOS efficiency measures the average amount of functional change *per day* of inpatient rehabilitation. In Ontario, the average active rehabilitation LOS efficiency is 1.3 and has not changed significantly from previous years (*see interactive data scorecard for more detailed results by LHIN).*

Figure 21 – Average total functional (FIM®) change (FY2017/18)



ALC RATES

Throughout this report and the supporting data tables, technical definitions, etc., the ALC rates for open and closed cases are reported separately. Because of this the data in this report does not currently align with reporting of ALC rates by Access to Care which includes open and closed cases combined. Even though the definitions vary slightly, the data reported here, can be interpreted similarly to ALC rates reported by Access to Care. To avoid confusion with the definitions of ALC rates by ATC the technical definitions for these indicators are labeled as “Proportion of total bed days that were utilized by patients designated as ALC, open and closed cases reported separately” but for ease of reading, we will use “ALC rate” as the term interchangeably.

The ALC rate data has been provided for this report by Access to Care via the WTIS. Please note that there may be variance in reported ALC rates when compared to rates reported from iPort™ Access as methodologies vary. iPort™ Access counts ALC days using the starting designation date which is a different methodology than used on the ATC information site, and in calculations for indicator A5. The methodology for indicator A5 calculates ALC days only during the reporting period. Take the following example of a case where the ALC designation date = April 1, 2015, and discharged date = April 5, 2017.

- iPA validation would count the total number of days for that case (from April 1, 2015 to April 5, 2017)
- The methodology used for A5 would only count the active dates within FY 17/18 (from April 1, 2017 to April 5, 2017)

Therefore, differences in indicator results could be substantial, particularly for patients who are waiting a long time.

A decline in ALC rate indicates that more patients are getting access to the care they need when they need it. As noted in the discussion of the wait time for inpatient rehabilitative care, it is important to understand the context of the number of patients who are designated ALC for rehab as well as the ALC rates in order to understand changes in wait time.

ALC rate, the total sum of bed days used for patients who were designated ALC, over the total available bed days, can be impacted in two ways: by reducing the number of patients designated ALC for rehabilitative care and the number of days waiting for inpatient rehabilitative care services. This holds true for how ALC rates are documented in this report with open and closed cases reported separately, as the calculations are the same. In this way ALC rates and wait times are linked. What is critical to note, however, is that a decrease in ALC rate could potentially result in longer median and 90th percentile wait times for inpatient rehab if the rate is lower because fewer patients are designated ALC. For example, if wait times are decreasing disproportionally where patients with shorter waits are no longer designated ALC, the ALC rate would decrease but the median and 90th percentile waits would appear to increase (the shape of the distribution curve of 'wait time' would no longer be symmetrical).

ALC rates were examined both for patients in acute care designated ALC for inpatient rehabilitative care (see Figures 24 and 25) and for those in an inpatient rehabilitative care bed designated ALC for any other destination (see Figures 26 and 27).

In acute care in Ontario in 2017/2018, 21,080 patients were designated ALC for inpatient rehabilitative care (to NRS, CCC-LTLD, CCP) which accounted for 228,172 total bed days used for patients in acute care (open and closed cases). Provincially, the ALC rate for patients who were in acute care waiting for inpatient rehabilitative care was 3.4% (closed cases) and 0.64% (open cases). There has been little change with these provincial numbers over the last three reporting cycles (see Figure 24). Across LHINs in 2017/18, the ALC rate for patients who were waiting for inpatient rehabilitative care ranged from 2% in ESC to 4.6% in NSM (Figure 25, closed cases).

In inpatient rehabilitative care in Ontario in 2017/2018, patients that were designated ALC in rehab and CCC accounted for 383,695 patient days (226,295 closed cases and 157,400 open cases). Provincially, the ALC rate for patients who were in inpatient rehabilitative care waiting for another type of bed was 10.1% (closed cases) and 7.0% (open cases) (see Figure 26). There has been little change with these provincial numbers over the last three reporting cycles. Across LHINs in 2017/18, the ALC rate for patients who were waiting for another type of bed in rehab and CCC ranged from 0% in CW to 20.6% in NW LHIN for open cases and 0.5% in CW to 23.3% in CE for closed cases (see Figure 27). Where ALC

rates are higher, wait times will be impacted as patients designated ALC will be occupying a bed that could otherwise be used for patients waiting for inpatient rehabilitative care.

Figure 22 – Proportion of total bed days that were utilized by patients designated as ALC waiting for inpatient rehabilitative care

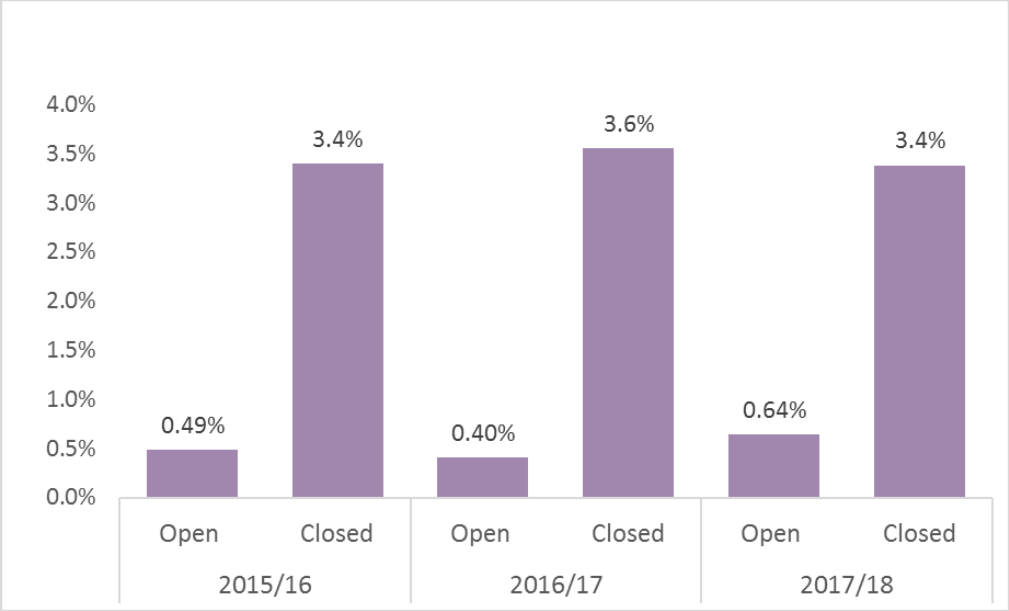


Table 5 – Proportion of total bed days that were utilized by patients designated as ALC waiting in acute care for inpatient rehabilitative care, by LHIN, open and closed cases (FY2017/18)

LHIN	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
Closed Cases (%)	2.0	2.1	3.9	4.5	4.0	4.0	3.3	3.4	3.3	2.7	2.5	4.6	4.4	3.3	3.4
Open Cases (%)	0.3	0.2	0.4	0.9	0.9	0.8	0.8	0.5	0.7	0.2	0.5	0.7	0.7	1.5	0.6

Figure 23 – Proportion of total bed days that were utilized by patients designated as ALC in rehab and CCC

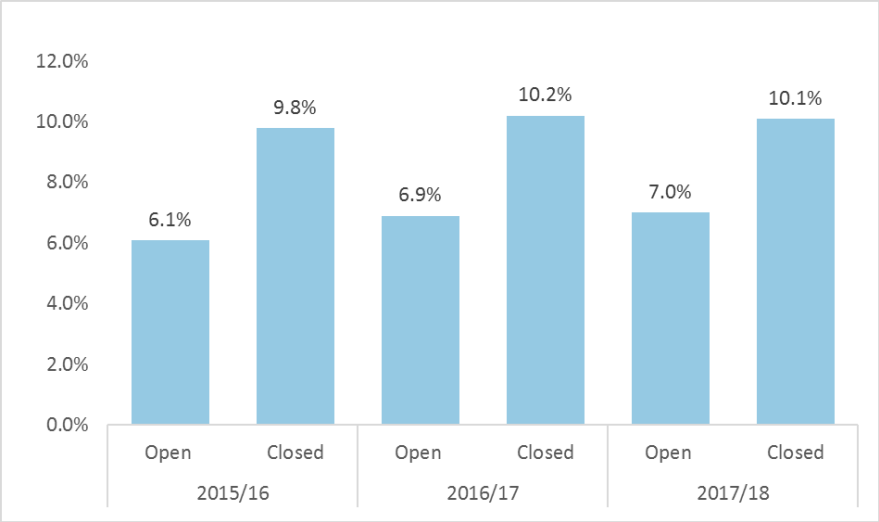


Table 6 – Proportion of total bed days that were utilized by patients designated as ALC in rehab and CCC, by LHIN, open and closed cases (FY2017/18)

	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
Open Cases (%)	8.6	7.9	4.5	4.8	0.0	2.1	5.6	2.4	10.2	6.3	9.5	1.9	17.2	20.6	7.0
Closed Cases (%)	15.6	13.5	12.5	10.7*	0.5	6.5	5.2	10.4	23.3	13.2	7.9	3.5	19.2	21.6	10.1

**Note, a larger than usual discrepancy in A5 closed cases for 2017/2018 in HNHB LHIN has been noted between data pulled in iPort compared to data provided from the WTIS. Rationale for this variance is described on page 37, specifically regarding differences in methodology of the two systems.*

In addition to ALC rates overall and wait times for inpatient rehabilitative care, data have been provided on the number of patients who are designated ALC for inpatient rehabilitative care within 2 days of their admission to acute care. The underlying question for this data is *"How many patients who were admitted to acute care might have been more appropriately admitted directly to inpatient rehabilitative care*?" If a patient is designated as ALC within 2 days of admission to acute care, this may indicate a missed opportunity for direct admission to inpatient rehabilitative care. Provincially in 2017/18, of all patients who were designated ALC for inpatient rehabilitative care, 7 to 8% of those patients were designated within 2 days of their acute care admission. More specifically, 7.4% of patients with a discharge destination of CCC-LTLD, 7.6% of those with discharge destination of Convalescent Care and

8.3% of those with discharge destination of an NRS-reporting bed were designated ALC within 2 days of their acute care admission.

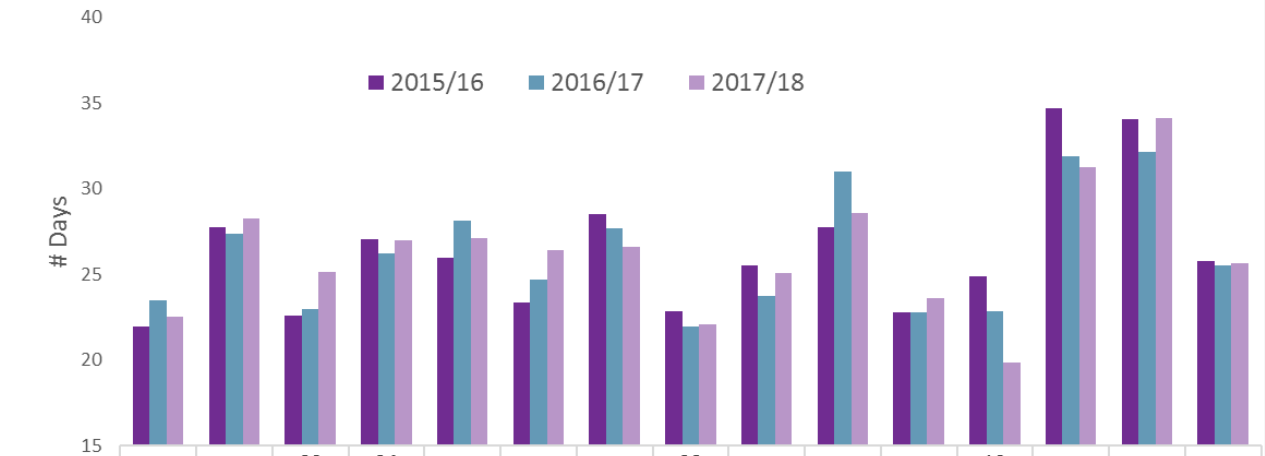
Further details on ALC rates in acute care for inpatient rehabilitative care, ALC rates in inpatient rehabilitative care, and the rate of patients designated ALC for inpatient rehabilitative care within 2 days of their acute care admission are included in the accompanying *scorecard* and data files.

LENGTH OF STAY

The average length of stay (LOS) in different bed types can be a contributing factor to wait times. For example, in 2017/18 the average length of stay across all complex continuing care is 72 days, ranging from 26 days (Central LHIN) to 102 days (Toronto Central LHIN) *(see Figure 28a).* Comparatively, average LOS in NRS-reporting beds was 25.6 days, ranging from 19.9 days in the North Simcoe Muskoka LHIN to 34.1 days in North West LHIN (see Figure 28a). When grouped by Rehabilitation Client Group (RCG), LOS in NRS-reporting beds ranged from 14.2 days for patients in the 'Other Disabling Impairments' group to 38.7 days for patients in the 'Spinal Cord Dysfunction' group (*see Figure 28b*).

Length of stay is an important factor when planning for capacity, as bed types where the LOS is longer will be able to serve fewer patients. If there is not enough capacity, patients may wait in acute care longer.

Figure 28a - Average length of stay (LOS) in NRS reporting beds by LHIN (FY2015-2018)



	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
2015/16	21.9	27.7	22.6	27.0	26.0	23.4	28.5	22.8	25.5	27.8	22.8	24.9	34.7	34.0	25.8
2016/17	23.5	27.4	23.0	26.2	28.1	24.7	27.7	22.0	23.8	31.0	22.8	22.8	31.9	32.1	25.5
2017/18	22.5	28.3	25.1	27.0	27.1	26.4	26.6	22.1	25.0	28.6	23.6	19.9	31.3	34.1	25.6

Figure 28b – Average length of stay (LOS) in NRS reporting beds by RCG (2017/18)

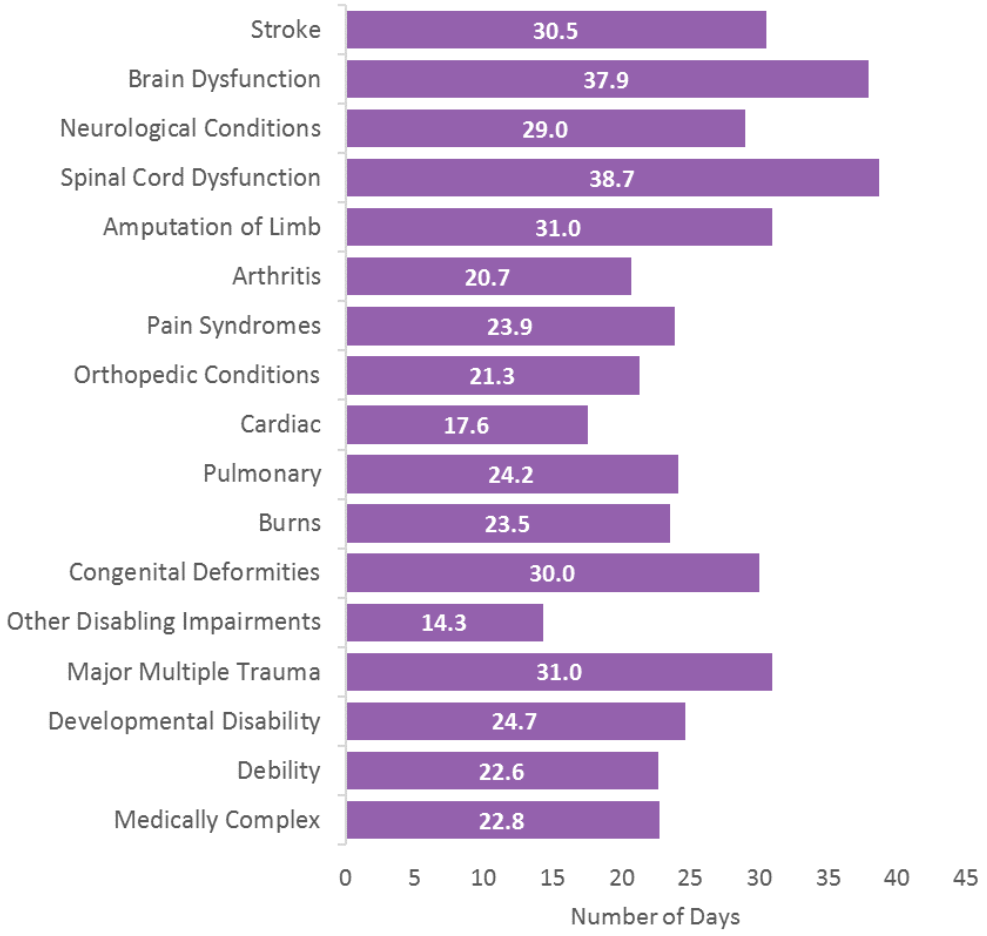
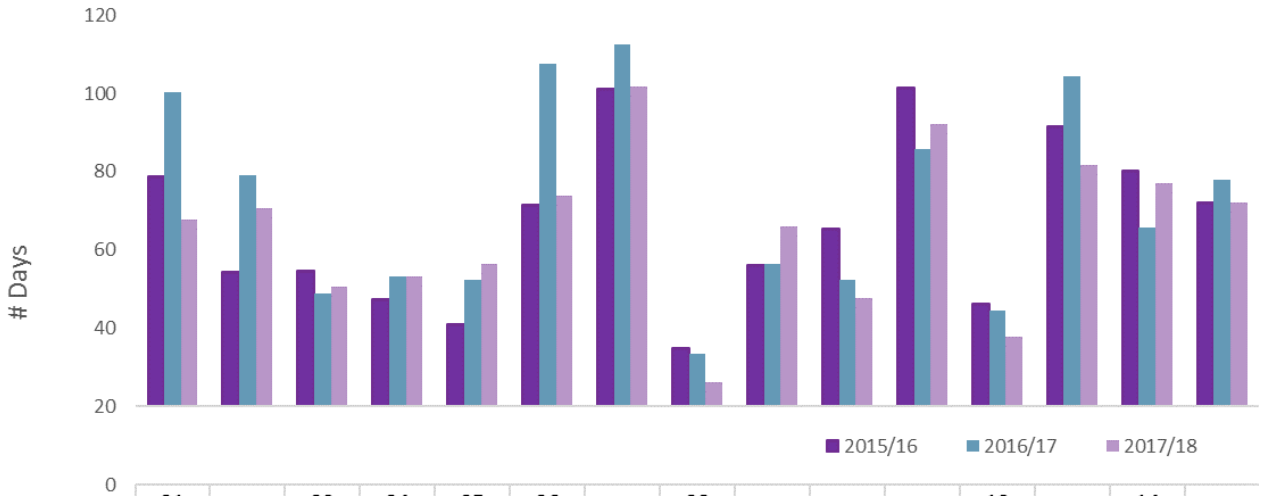


Figure 29a) Average length of stay (LOS) in complex continuing care(includes all CCC patients in palliative and behavioral beds) by LHIN (FY2015-2018)



	01 ESC	02 SW	03 WW	04 HNHB	05 CW	06 MH	07 TC	08 CEN	09 CE	10 SE	11 CH	12 NSM	13 NE	14 NW	ON
2015/16	79	54	55	47	41	72	101	35	56	65	102	46	92	80	72
2016/17	100	79	49	53	52	108	113	33	56	52	86	45	104	66	78
2017/18	68	71	50	53	56	74	102	26	66	48	92	38	82	77	72

Looking ahead – Quality Improvement Opportunities

NEXT STEPS: PERFORMANCE REPORT

As noted, this RCA System Evaluation 2017/18 performance report is the first comprehensive report of Rehabilitative Care System indicators and analysis. Previously, only performance data had been circulated. This 2017/18 report will be available to RCA stakeholders only, including RCA committees, LHINs, the MOHLTC and other provincial organizations. While LHINs are encouraged to share the report with their health service providers (whose data is reflected) and regional rehabilitation committees, at this time the performance report has limited circulation.

The RCA is committed to transparency and continuous improvement. The RCA will continue to work with stakeholders to improve the reporting process, indicator definitions, and data reported in alignment with the needs of LHINs. Looking ahead, reporting at the organizational level, including indicators that capture outpatient services and measurement of equity in rehab service delivery have been identified as opportunities for improvement in reporting. At the moment there are no immediate plans to develop more benchmarks. The RCA plans to post future reports on the RCA website and make them more publicly available.

NEXT STEPS: QUALITY IMPROVEMENT

As the RCA System Evaluation Task group continues to refine the data collection and indicator reporting process, the group is also focusing on the strategic work of considering how to use this data for quality improvement. The task group has drafted a quality improvement approach utilizing root cause analysis to better understand how the RCA can support change and the sharing of change ideas and what policy or resource issues need to be addressed.

RCA partners will continue to be engaged including:

- **Provincial performance data publishers (OHA, HQO, CorHealth)**: to elevate the awareness of key rehab system performance indicators and benchmarks
- **LHINs**: to monitor performance against the three priority rehabilitative care indicators and interpretation of their data. Identify opportunities to help LHINs improve quality with respect to their regional performance against provincial benchmarks
- **Fall prevention collaborative working group:** implementation of LHIN level quality improvement initiatives as it pertains to the indicator for repeat ED visits due to falls
- **Access to Care ALC Advisory committee:** quality improvement initiatives for inpatient rehab access as it pertains to the indicator for wait time to access inpatient rehab from acute care
- **Health Shared Services Ontario:** quality improvement initiatives for in-home wait times for rehabilitative care

Appendices

APPENDIX A—GLOSSARY OF TERMS

ALC	When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care [CCC], Mental Health or Rehabilitation), the patient must be designated ALC at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).[i]
Acute Care	Acute care beds are categorized as follows: **Non-surgical**: A designated bed providing care to patients who are receiving acute medical care but who are not waiting for or have not had surgical procedures. **Surgical**: A designated bed providing care to patients who are waiting for or have already undergone surgical procedures. **Intensive / Critical Care**: A designated bed providing care to patients with acute or potentially life -threatening conditions requiring advanced medical care and support.[ii]
ALC Discharge Destination	The location determined by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient is to be discharged or transferred. ALC Discharge Destination is composed of two elements: – Discharge Destination Type & Discharge Destination Detail.[iii]
ALC Discharge Destination Detail	Program specific detail associated with the facility type or service required by the patient at the point of discharge or transfer.[iv]
ALC Discharge Destination Determination Date	The date when the decision is made by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient is to be discharged or transferred.[v]
ALC Designation Date	The date when a physician or delegate determines that a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting.[vi]

ALC Volumes	ALC volumes refer to the number of ALC cases (i.e. patients designated ALC) that meet a select criteria. They may be presented/reported as a number or a percentage/proportion of cases. [vii]
ALC Rate	The proportion of inpatient days in Acute and Post-Acute care settings that are spent designated ALC in a specific period of time.[viii]
Open ALC Cases	Patients who have been designated/re-designated ALC and are still open (i.e., still waiting) as of a specified date (e.g., end of a reporting period).[ix]
Closed ALC Cases	Patients who have been discharged or discontinued within a specified period of time (inclusive of start and end dates) *(definition adapted from the ALC Volume definition of closed cases)* **Discharged:** Patients who have been designated/re-designated ALC and were discharged to an ALC Discharge Destination within a specified period of time (e.g., within reporting month). **Discontinued:** Patients who have been designated/re-designated ALC and have had their ALC designation discontinued within a specified period of time (e.g., within reporting month). ALC cases may be discontinued due to one of the following reasons: change in destination invalidates ALC designation, change in medical status, data entry error, death, discharge against medical advice, transfer to acute care, unplanned repatriation. Note: only ALC cases discontinued due to change in medical status may be re-designated ALC.[x]
Bedded levels of Rehabilitative Care	Bedded levels of rehabilitative care refer to hospital-based designated inpatient rehab beds and complex continuing care beds as well as convalescent care/restorative care beds within LTCH (Rehabilitative Care Alliance, Definitions Framework for Bedded Levels of Rehabilitative Care)[xi]
The Canadian Institute for Health Information (CIHI)	The Canadian Institute for Health Information (CIHI) is an independent, not-for-profit organization that provides essential information on Canada's health systems and the health of Canadians.
Continuing Care	Hospital-based continuing care serves individuals who may not be ready for discharge from hospital but who no longer need acute care services. Also known as extended care, chronic care or complex continuing care, it provides ongoing professional services to a diverse population with complex

	health needs. Facilities may be free-standing or co-located with acute and/or rehabilitation services within one hospital.[xii]
Continuing Care Reporting System (CCRS)	The Continuing Care Reporting System (CCRS), launched in 2003–2004, contains demographic, clinical, functional and resource utilization information on individuals receiving continuing care services in hospitals or long-term care homes in Canada.[xiii]
Client Health & Related Information System (CHRIS)	CHRIS (Client Health and Related Information System) supports the delivery of care at home and in the community for 670,000 patients in Ontario. Patients get the right care at the right time and place because of features in CHRIS. • The home and community care patient health record and secure Document Management System • Clinical assessment and decision-support • Includes integration of the interRAI Home Care assessment instrument • Care planning and coordination • Includes Coordinated Care Plans and the standardized Care Coordination Dashboard • Direct-to-provider ordering and oversight of home care services • Direct-to-vendor ordering and delivery of medical supplies and equipment • Patient referrals and placements across the continuum of care • Caseload and workforce management[xiv]
Complex Continuing Care (CCC)	A designated bed providing specialized care to patients who are medically complex, require hospital stays, regular onsite physician care and assessment, and active management over extended periods of time. CCC – Low Tolerance Long Duration (LTLD) Specialized inpatient rehabilitation suitable for individuals in need of a slower-paced program over a longer period of time than is offered in other programs. LTLD is used interchangeably with “slow stream rehab.” CCC – Non Low Tolerance Long Duration (NonLTLD) This category would include all patients in complex continuing care beds who are not in an LTLD bed.[xv]
Convalescent Care Bed (CCP)	Provision of care to support the gradual recovery of health and strength after illness or surgery. Convalescent Care programs provide 24-hour care to people who require specific medical and therapeutic services in supportive environments for defined periods of time.[xvi]

Discharge Date	The date when the decision is made by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient is to be discharged or transferred.[xvii]
Discharge Destination	The location determined by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient is to be discharged or transferred. In the WTIS, the ALC Discharge Destination data element is composed of two elements: 1. ALC Discharge Destination Type: The facility type or service required by the patient at the point of discharge or transfer. 2. ALC Discharge Destination Detail: Program specific detail associated with the facility type or service required by the patient at the point of discharge or transfer.[xviii]
FIM®	The functional assessment instrument included in the Uniform Data Set for Medical Rehabilitation (UDSMR). It is composed of 18 items (13 motor items and 5 cognitive items) that are rated on a 7-level scale representing gradations from independent (7) to dependent (1) function. The FIM® instrument is a measure of disability and looks at the caregiver burden associated with the level of disability. Admission FIM® instrument Assessment — The baseline functional assessment that is done using the FIM® instrument at the time of admission to the rehabilitation program. The FIM® instrument should be administered within 72 hours of admission. Discharge FIM® instrument Assessment — The assessment of the client's functional ability using the FIM® instrument at discharge. The FIM® instrument should be administered within 72 hours before discharge from the rehabilitation program.[xix]
Health Shared Services Ontario (HSSO)	Health Shared Services Ontario (HSSOntario) is an agency of the Government of Ontario that supports Ontario's 14 Local Health Integration Networks in meeting the health care needs of their local communities. Through the continuous development and delivery of province-wide digital health platforms, quality improvement initiatives, and other business and IT supports, HSSOntario uses leading-edge technology and best practices to enable health system integration and better patient care.[xx]

IntelliHEALTH ONTARIO	IntelliHealth is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario healthcare system. IntelliHEALTH enables users to create queries and run reports through easy web-based access to high quality, well organized, integrated data.[xxi]
Long Term Care (LTC) Bed	A designated bed providing care to meet both the medical and nonmedical needs of people with chronic illnesses or disabilities who require care that is not available in the community[xxii]
LOS efficiency	The change in Total Function Score (see Total Function Score) per day of client participation in the rehabilitation program. Calculated as change in Total Function Score from admission to discharge divided by length of stay (see Length of Stay).[xxiii]
National Ambulatory Care Reporting System (NACRS)	The National Ambulatory Care Reporting System (NACRS) contains data for all hospital-based and community-based ambulatory care: • Day surgery • Outpatient and community-based clinics • Emergency departments
National Rehabilitation Reporting System (NRS)	A primarily voluntary national health information system for adult inpatient rehabilitation services. The province of Ontario has mandated its use for all designated rehabilitation beds in that province. The NRS contains client data collected from participating adult inpatient rehabilitation facilities and programs across Canada. The NRS data elements contain information related to socio-demographic information, administrative data, health characteristics, activities and participation and therapeutic interventions. These elements are used to estimate a variety of indicators including wait times and client outcomes.[xxiv]
Cardiac	Specialized inpatient rehabilitation program for patients with cardiac issues designed to maximize their overall function through interprofessional clinical expertise. *(NRS-Reporting beds, WTIS)*[xxv]
Geriatric	Specialized inpatient rehabilitation program for geriatric patients (age as defined by the specific program) designed to maximize their overall function through interprofessional clinical expertise. *(NRS-Reporting beds, WTIS)*[xxvi]

Low Tolerance Long Duration (LTLD)	Specialized inpatient rehabilitation suitable for individuals in need of slower-paced programs over longer periods of time than are offered in other programs. LTLD is often used interchangeably with "slow stream rehab." [xxvii]
MSK	Specialized inpatient rehabilitation program for patients with musculoskeletal issues, designed to maximize their overall function through interprofessional clinical expertise. This may include, but is not limited to, arthritis, osteoporosis, and bone cancer. (*NRS-Reporting beds, WTIS*)[xxviii]
Neuro	Specialized inpatient rehabilitation program for patients with neurologically related impairments, designed to maximize their overall function through interprofessional clinical expertise. This may include, but is not limited to, acquired brain injury (ABI), stroke, spinal cord injury and generalized neurological rehabilitation (e.g., degenerative neurological conditions such as Parkinson's and Multiple Sclerosis). (*NRS-Reporting beds, WTIS*)[xxix]
Other Rehabilitation	Non-specialized inpatient rehabilitation program for patients not captured in the above categories, designed to maximize their overall function through interprofessional clinical expertise. *(NRS-Reporting beds, WTIS*)[xxx]
Patient Days	The number of days that a client is present in an inpatient rehabilitation bed or facility in a given time period. Calculated for both open and closed episodes of care.[xxxi]
Rehabilitation Client Group (RCG)	Within the NRS, a client is categorized into 1 of 17 health condition groups known as Rehabilitation Client Groups (RCGs). The RCG selected for a particular client is based on the condition that best describes the primary reason for his or her admission to the inpatient rehabilitation unit or facility, such as a stroke or limb amputation.[xxxii]
Rehabilitation Group (RG)	A type of categorization representing the highest level of diagnostic classification for clinically similar patients and used in the RPG case mix grouping methodology for the NRS. The RPG methodology was developed by Ontario's Joint Policy and Planning Committee using data from the NRS and other sources for Ontario facilities. Assignment to any of the 21 RGs is based on the Rehabilitation Client Group (RCG) code selected for each NRS record. Each patient is assigned to an RG, based on their RCG, which is combined with other variables to assign each patient to an RPG.[xxxiii]
Rehabilitation Patient Group (RPG)	A sub-classification of Rehabilitation Groups (RGs) in inpatient rehabilitation case mix grouping methodology developed by Ontario's Joint Policy and

	Planning Committee using NRS data for Ontario facilities. Patients are assigned to 1 of the 83 specific RPGs based on a combination of RG, Admission Motor Function Score and/or Admission Cognitive Function Score (derived from data collected using the FIM® instrument) and/or age. Each RPG is associated with a typical cost weight, which is intended to be updated annually.[xxxiv]
RUG-III Categories [xxxv]	**Special Rehabilitation** All special rehabilitation will have 150 or more minutes of therapy AND 1 or more therapies on 5 or more days OR 45 or more minutes of therapy AND 1 or more therapies on 3 or more days AND 2 or more nursing rehab techniques on 6 or 7 of last 7 days. Amount of therapy time ranges from 45 minutes or more (low) to 720 minutes or more (ultra high) Special Rehabilitation – Ultra High Special Rehabilitation – Very High Special Rehabilitation – High Special Rehabilitation – Medium Special Rehabilitation – Low **Extensive Services** - High ADL Impairment score (7 to 18) AND tracheostomy care OR ventilator/respirator OR antibiotic-resistant infection OR Clostridium difficile infection **Special Care** - Tracheostomy care OR ventilator/respirator OR antibiotic-resistant infection OR Clostridium difficile infection OR High ADL Impairment score (7 to 18) AND any Special Care items **Clinically Complex** - Tracheostomy care OR ventilator/respirator OR antibiotic-resistant infection OR Clostridium difficile infection OR Any Special Care items OR Any Clinically Complex items **Behaviour Problems** - RUG_III_ADL score of 4 to 10 AND troubling behaviours **Impaired Cognition** - RUG_III_ADL score of 4 to 10 AND high Cognitive Performance Scale (CPS) score of 3 to 6 **Reduced Physical Functions** - All assessments qualify
Total Function Score	The sum of the scores for all 18 elements on the FIM® instrument, ranging from 18 to 126. A higher Total Function Score suggests a higher level of independent functioning in activities of daily living and communication.[xxxvi]
WTIS (Wait Times Information System)[1]	The WTIS is a web-based application that collects surgery, diagnostic imaging (CT/MRI), ALC, and Cardiac Care Network wait time data to inform our understanding of the patient journey. The system provides clinicians and

other healthcare professionals with the tools they need to effectively assess patient waits in a standardized manner.

Access to Care (ATC), within CCO, is the service delivery agent for the Wait Time and ER/ALC Information Strategies on behalf of the Ministry of Health and Long-Term Care[xxxvii]

APPENDIX C – ACKNOWLEDGEMENTS

Expert support

The work of the RCA is dependent on the expertise and support of a great many individuals. Many served on the RCA's System Evaluation Task and Advisory Groups as well as other sub-committees and are listed in the appendices. In addition, the RCA would like to thank the following:

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- Candice Tam, ALC and Mental Health

Communications: Linda Huestis

ESC LHIN:
- Helen Johnson, Strategy and Health System Planner
- Clifford Ekwempe, Epidemiologist/Data Analyst

Health Shared Services Ontario:
- Heather Binkle, Director, Client Services
- Cheryl Bostock, Manager Information Management & Funding
- Jay Callowhill, Analyst

HNHB LHIN:
- Kim Young, Advisor Planning
- Lia Salam-White, Manager Decision Support

PowerBI Scorecard Development: Melissa Chang

System Evaluation Task and Advisory Group Chair: Imtiaz Daniel, Ontario Hospital Association

RCA TASK AND ADVISORY GROUPS

The RCA is funded by the 14 LHINs. Its governance model engages provincial stakeholders and rehabilitative care providers from across the continuum and reports to the LHIN CEOs through a Steering Committee and Task and Advisory Groups including the System Evaluation Task and Advisory Groups.

For a complete listing of all RCA Task and Advisory Groups and their members, please refer to *RCA Governance and Working Group Members*.

System Evaluation Advisory Group (*as of September 30, 2018*)

Chair: Imtiaz Daniel, Ontario Hospital Association

Shahin Ansari	University Health Network
Heather Arthur	Cornwall Community Hospital
Daniel Ball	Halton Healthcare
Tabatha Bowers	Scarborough and Rouge Hospital
Sylvia Brachvogel	Sunnybrook Health Sciences Centre - St. John's Rehab
Jennifer Buccino	Dietitians of Canada
Bonnie Camm	William Osler Health System
David Ceglie	Hotel Dieu Shaver Health and Rehabilitation Centre
Robert Craft	CareWorx
Sylvia Davidson	Baycrest Health Sciences
Angela Dye	Pickering Sports Medicine & Wellness Centre
Laura Forma	West Park Healthcare Centre
Rhonda Galbraith	West Park Healthcare Centre
Laera Gattoni	Toronto Central LHIN
Marie Graham	Bayshore HealthCare Ltd.
Vinita Haroun	Ontario Long Term Care Association
Cindy Harrison	CommuniCare Therapy
David Heaton	Closing the Gap Healthcare
Shelley Huffman	Stroke Network of Southeastern Ontario/Kingston Health Sciences Centre
Maureen Hutley	Hamilton Health Sciences
Helen Johnson	ESC LHIN
Debbie Junk-Lloyd	West Parry Sound Health Centre
Amy Khan	Mississauga Halton LHIN
Jennifer Kodis	Hamilton Health Sciences
Caryn Langstaff	Providence Care
Kathryn Leblanc	Hamilton Health Sciences
Patrice Lindsay	Heart & Stroke Foundation
Grace Liu	York University
Anne Marie MacLeod	Sunnybrook Health Sciences Centre
Rhona McGlasson	Bone and Joint Canada
Ryan Miller	Orillia Soldiers' Memorial Hospital
Kelly Milne	Regional Geriatric Program of Eastern Ontario, The Ottawa Hospital
Karen Pontello	Partners In Rehab
Sherry Roberts	Winchester District Memorial Hospital
John Spirou	Centres for Active Rehabilitation Excellence
Sarah Tam Lee	Saint Elizabeth Health Care
Gaétan Tardif	University Health Network - Toronto Rehab
Denise Taylor	St. Joseph's Care Group - Thunder Bay
Nicole Thomson	Sinai Health System - Bridgepoint
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Susan Veltri	Thunder Bay Regional Health Sciences Centre
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Zach Weston	Waterloo Wellington LHIN
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System Evaluation Task Group (as of September 30, 2018)

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