2019/20 Rehabilitative Care System Performance Report:

Summary Report

May, 2021

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INTRODUCTION

The Rehabilitative Care Alliance (RCA) is pleased to share the 2019/20 Rehabilitative Care System Performance Report: Summary Report.

This summary report, which provides a high-level overview of performance, is one component of a package of information that includes:

- an interactive scorecard with all data presented graphically to show trends and regional variability
- raw data tables for those who would like a deeper dive into specific data points (available on request from info@rehabcarealliance.ca)
- a technical manual that provides substantial background, glossary of terms, indicator definitions and more.

These documents provide additional context and should be reviewed for further details on the performance reported below.

This is the fourth installment in the annual reporting of rehab indicators by the RCA and marks a new milestone: the inclusion of organizational and sub-regional reporting now allows the demonstration of regional variability across Ontario.

Regional leads are encouraged to share this report with their health service providers (whose data is reflected) and regional rehabilitative care committees.

In addition to reporting on rehab care system performance, the RCA has focused on how to use this data to support quality improvement regionally and provincially. Key change ideas for improving performance were identified through a root cause analysis with provincial stakeholders and subject matter experts in 2019 and in 2020 they identified a direction for improvement related to the indicator of wait time for in-home rehabilitative care services. The RCA will continue to look for and support quality improvement initiatives focused on improving performance against the three benchmarked indicators. These continued efforts will help to optimize rehabilitative care performance both regionally and provincially as an enabler of quality health care overall.

About the Rehabilitative Care System Performance Report

The RCA's Rehabilitative Care System Performance Report is an annual assessment of the current performance of rehabilitative care provided across the province.

The Report is based on the RCA's Rehabilitative Care System Evaluation Framework, which includes indicators to evaluate performance in eight quality dimensions, including accessibility, safety and patient-centred care.

The RCA currently reports on three priority and eleven supplementary indicators, selected because the data for them is both available and reliable. Benchmarks were established for the three priority indicators by an expert panel based on evidence and current performance across the province. These benchmarks are regularly reviewed and recalculated as needed to reflect current performance across the province.

Performance data for this report is provided by Access to Care and Ontario Health – Health System Performance and Support Division .The RCA also uses data from IntelliHEALTH ONTARIO. Technical definitions for the indicators ensure they are measured consistently to allow reliable comparison of data.

HIGHLIGHTS FROM THIS YEAR'S REPORT

At the time of writing this report, Ontario is facing the third wave of the COVID-19 pandemic, which puts the data from 2019/2020 in an interesting context. Given that there were significant changes to rehabilitative care service delivery in 2020/21, this report will serve as the last set of data reported for these indicators in the time before COVID-19; a relative baseline. Given that the data reported in this performance report cover the full fiscal year, the last two weeks of 2019/2020, in which the province entered the first lockdown, are likely to have a minimal impact on the reported data.

That said, it is interesting to note that many of the trends that have been observed over the previous three to five years in the supplementary indicators were reversed in 2019/2020; however, the magnitude of the changes has been relatively small:

- Wait time for inpatient rehab has slightly decreased compared to 2018/19 and more LHINs are reporting median wait times that are below the provincial benchmark for the 90th percentile wait; seven LHINs now have median wait times for NRS and CCRS-nonLTLD beds that are 3 days or less
- 66% of patients were admitted to inpatient rehabilitative care without being designated as awaiting an alternate level of care, i.e., with no recorded wait time. This is an improvement over last year where 61% were admitted without an ALC designation
- Wait time for in-home rehab has increased slightly compared to 2018/19 - the provincial 90th percentile wait time ranged from 11-23 days in 2018/19, which increased to 13-26 days in 2019/20
- In Ontario in 2019, the age-standardized rate of repeat ED visits for falls among community-dwelling older adults was 847 repeat visits per 100,000. This rate has increased slightly from 838 in 2018

The data on these indicators are expected to fluctuate from year to year and as noted above, the changes have not been significant. Despite these minimal year over year changes, there are some regions, sub-regions and organizations that stand out as consistently continuing to improve performance:

- The number of LHINs reporting median wait times for inpatient rehab that are below the 3 day benchmark increased in 2019/20. NW LHIN had the lowest 90th percentile waits for both NRS (7 days) and CCRS-nonLTLD beds (6 days).
- In WW, HNHB, MH, and C LHINs the median wait times for all in-home PT, OT, and SLP rehab services was at or below the benchmark of five days. Their 90th percentile waits, while above the benchmark, were still notably lower than other LHINs in the province.
- From a sub-regional perspective, Tecumseh Lakeshore Amherstburg LaSalle (ESC LHIN), Bramalea (CW LHIN) Eastern York Region (C LHIN), North Etobicoke Malton West Woodbridge

(CW LHIN), and Kitchener-Waterloo-Wellesley-Wilmot-Woolwich (WW LHIN) reported the lowest age standardized repeat ED visits for falls in 2019 and were consistently among the 10 sub-regions that reported the lowest rates, year over year.

To roughly paraphrase from Ontario Health Quality's *Measuring Up 2019: A yearly report on how Ontario's health system is performing*, parts of the system are working well or improving, yet there are still many opportunities for improvement.

The Rehabilitative Care Alliance will use the information published in this report as one tool to identify areas where rehabilitative care service delivery continues to improve, and where there are opportunities for improvement. The ongoing work of the RCA will include developing initiatives that target improvement on these indicators and will be guided by the Quadruple Aim Framework.

REHABILITATIVE CARE IN ONTARIO 2019/20

Ongoing reporting of health system performance indicators specifically focused on rehabilitative care supports a standardized approach to evaluating performance across the rehabilitative care continuum and implementation of improved care delivery. The following sections provide a summary of the priority indicators and supplementary indicators that have been reported annually by the Rehabilitative Care Alliance since 2016. The RCA currently reports on three priority and 11 supplementary indicators. More detail on these can be found in the accompanying technical manual.

PRIORITY INDICATORS

Priority indicators are those three indicators in the System Evaluation Performance Report that are benchmarked.

Wait time for Inpatient Rehabilitative Care

The time spent waiting for inpatient rehabilitative care has not substantially changed over the previous five years. For this indicator, rehabilitative care includes data reported by the Wait Time Information System (WTIS) for patients with an ALC designation who were discharged to high intensity NRS-reporting rehab beds, low intensity rehab in CCC beds (CCC-LTLD) and convalescent care program beds (CCP). The 90th percentile wait time for inpatient rehabilitative care benchmark is three days. In 2019/20 the 90th percentile wait time was 12 days for NRS beds, 16 days for CCC-LTLD beds, and 25 days for CCP beds. No LHINs reached the three-day benchmark for 90th percentile wait for any bed type this year. And while there is regional variability in wait times, there is much more variability in wait times across bed types.

Note: For brevity, this report uses the following abbreviations to refer to the LHINs:

Erie St. Clair LHIN – ESC LHIN
Southwest LHIN – SW LHIN
Waterloo Wellington LHIN – WW LHIN
Hamilton Niagara Haldimand Norfolk LHIN – HNHB LHIN
Central West – CW LHIN
Mississauga Halton LHIN – MH LHIN
Toronto Central LHIN – TC LHIN
Central LHIN – C LHIN
Central East LHIN – CE LHIN
South East LHIN – SE LHIN
Champlain LHIN – CH
North Simcoe Muskoka LHIN – NSM LHIN
North East LHIN – NE LHIN
North West LHIN - NW LHIN

Focusing on NRS-reporting beds, the 90th percentile wait time has consistently been reported between 12 and 14 days, provincially and that trend is consistent in 2019/20. Since 2012/13, the median wait time for an NRS-reporting bed has consistently been four days, but dropped to 3 days in 2019/20. No LHINs achieved the three-day benchmark for 90th percentile wait for an NRS-reporting bed, but all LHINs had a median wait time of six days or less.

While the benchmark of three days for the 90th percentile wait remains aspirational, seven LHINs have been able to achieve a three-day wait or less for 50% of their patients who are ALC waiting for inpatient rehab, which signals an improvement over last year. This reduction in median wait time for rehab may

be signaling a trend toward overall improvements in wait times but more data will be needed to know with any certainty.

As discussed above, only patients who are designated as ALC are included in the WTIS dataset. In 2019/2020, 18 441 patients were admitted to a CCRS reporting bed and 21 158 patients were admitted to an NRS reporting bed without an ALC designation. This year, 66% of patients total were admitted to inpatient rehabilitative care without being designated as awaiting an alternate level of care, i.e., with no recorded wait time. This is also an improvement over last year where 61% were admitted without an ALC designation, though it is still too early to determine if this is a trend.

High performers

A few LHINs have made significant progress in reducing wait times for inpatient rehabilitative care this year. Generally speaking, HNHB, Champlain and Northwest LHINs have been ongoing high performers with respect to both 90th percentile and median wait times across all three bed types. This year, while NW LHIN continues to have some of the lowest wait times in the province, other LHINs have reduced wait times and are now among the top performers. LHINs with median wait times for both CCRS-LTLD and NRS reporting beds that are 3 days or less include Erie-St. Clair, Southwest, Toronto Central, Central East, South East, and North West LHINs. NW LHIN also has the lowest 90th percentile wait for NRS-reporting beds and CCC beds – six days ad eight days, respectively.

Opportunities for improvement

Overall, the 90th percentile wait times for Convalescent Care Program (CCP) beds (25 days) and many of the CCC-nonLTLD beds (29 days) are long and have significant regional variability. Wait times for CCC beds are significantly impacted by patients awaiting placement in long-term care. Generally speaking, the wait time for CCC-nonLTLD beds is much longer than for other bed types (NRS or CCC-LTLD).

Wait time for In-home Rehabilitative Care

In 2019/20, 300,288 patients received in-home rehabilitative care services with most patients receiving occupational therapy (OT) (153,329) services, followed by physiotherapy (PT) (112,848), speech language pathology (SLP) (19,498) and social work (SW) (14,613) (combined long and short stay patients). There were some volume fluctuations this year over last year (fewer patients seen by OTs, more patients seen by PTs, for example) but compared to last year (where 302 903 total patients received in-home rehabilitation) this year fewer patients received in-home rehabilitative care. That said, the decrease was minimal and the number of patients receiving in-home rehabilitative care is still broadly trending up from 5 years ago.

Many patients who waited for in-home rehabilitative care services in Ontario waited for 5 days or less – which is the benchmark for this indicator. Median wait times ranged from three to 20 days across LHINs and sub-regions in the province. Overall, the provincial 90th percentile waits for 2019/20 have increased compared to the 2018/19 year across all regulated health professionals in both the adult long stay and

adult short stay populations. The provincial 90th percentile wait time ranged from 11-23 days in 2018/19, which increased to 13-26 days in 2019/20.

The 90th percentile wait time in 2019/20 for patients referred to in-home rehabilitative care in Ontario exhibited wide variation across LHINs, from as short as six days in WW LHIN (for OT) and seven days in ESC LHIN (for PT) to as long as 85 days in Champlain LHIN (for SW). There was significant regional variation and variation dependent on the health professional for whom patients were waiting. Wait times for PT and OT were lower and closer to the benchmark, while wait times for SLP and SW were often longer. There is recognition that there are health human resource pressures for SW and SLP care, which is often cited to explain the longer wait times for this care.

High performers

In WW, HNHB, MH, and C LHINs the median wait times for all PT, OT, and SLP services was at or below the benchmark of five days. Their 90th percentile waits, while above the benchmark, were still notably lower than the other LHINs in the province. In WW LHIN the median wait times for all types of in-home rehab was four days or less.

Opportunities for improvement

Consistently across the province, the wait time for in-home social work and speech language pathology services has been longer, relative to the wait for occupational therapy or physiotherapy. The longer wait times for these regulated health professionals have been attributed to shortages in human resources. This year, a group of subject matter experts undertook a root cause analysis to identify opportunities for improvement on wait time for in-home rehabilitative care. A number of quality improvement ideas were identified, with one being prioritized for further development. In the coming year, the RCA, with stakeholders and subject matter experts, will work toward improving communication processes with rehab care providers when patients are discharged from inpatient care with in-home rehab care services.

Repeat ED visits due to Falls

This system level indicator was identified in the 2011 Integrated Falls Prevention Framework and Toolkit[1] 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 increase[2]. 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.

In 2019, 127,059 ED visits for falls were reported among community-dwelling seniors in Ontario, representing an increase of 8,908 ED visits over 2018. Of the visits to the ED for a fall in 2019, 21,874

[1] Integrated Provincial Falls Prevention Framework & Toolkit, LHIN Collaborative July 2011
[2] Access to Care (2014) Orthopaedic Quality Scorecard. Released quarterly by Ministry of Health and Long Term Care through Access to Care at Cancer Care Ontario.

(17%) were repeat visits, meaning the patient had already had an initial ED visit due to a fall in 2018 or earlier in the 2019 year.

In Ontario in 2019, the rate of repeat ED visits for falls among community-dwelling seniors was 847 repeat visits per 100,000 seniors. Stating this another way, for every five community-dwelling seniors who had an unscheduled visit to the ED related to a fall, one would have had a repeat ED visit again in the reported year. This rate has increased slightly from 838 in 2018, but over the past five years, the rate fluctuated between 746 (2013) and 847 (2019) repeat ED visits for falls per 100,000 seniors. Looking over the past seven years of data it does appear that there may be an increasing trend in the rate of repeat ED visits for falls.

High performers

In 2019, the age standardized rate of repeat ED visits for falls among adults 65 years and over by LHIN ranged from 601 to 1202 per 100,000 across LHINs with very little change year over year. In 2018, it was noted that in Champlain LHIN the rate for repeat ED visits for falls among older adults has been steadily decreasing, from 1,008 in 2013 to 798 in 2018. Unfortunately, the rate increased in 2019 to 816 repeat ED visits for falls but this still represents an overall decreasing trend in that region from 2013.

Several sub-regions - Eastern York Region (C LHIN), Bramalea (CW LHIN) and North Etobicoke Malton West Woodbridge (CW LHIN) - are consistently performing well on all three of the falls indicators: ED visits for falls, repeat ED visits for falls, and inpatient admissions resulting from an ED visit for a fall. The age standardized rates of all three of these indicators do seem to be linked; as ED visits for falls increase so too will the other two indicators.

There is significant variability among the sub-regions in performance on these indicators. In 2019, the age standardized rate of repeat ED visits for falls among adults 65 years and over ranged from 476 to 1955 per 100,000 across sub-regions with very little change year over year. The sub-regions with the lowest age standardized rates for repeat ED visits for falls were: Tecumseh Lakeshore Amherstburg LaSalle (ESC LHIN), Bramalea (CW LHIN) Eastern York Region (C LHIN), North Etobicoke Malton West Woodbridge (CW LHIN), and Kitchener-Waterloo-Wellesley-Wilmot-Woolwich (WW LHIN). Not surprisingly these same sub-regions are all in the lowest five reporting regions for ED visits for falls (age standardized rates). The highest age standardized rates for repeat ED visits for falls were reported in District of Thunder Bay (NW LHIN), Elgin (SW LHIN), Northern (NW LHIN) and Cochrane (NE LHIN) sub-regions.

Opportunities for improvement

Northern and rural regions face significant challenges in supporting their patients close to home and in their communities due to extreme geographical distances. Given this, it is perhaps not surprising that sub-regions in these areas reported higher rates of repeat ED visits for falls than others. Lower-population rural sub-regions such as Cochrane or Northern may see greater numbers of ED visits due to falls as patients often access primary care through the ED, especially on evenings and weekends. For

example, in the NW LHIN, there are no urgent care centres or centres other than the ED to have an x-ray completed to rule out fracture or get primary needs met, which likely results in higher rates of reported ED visits for falls.

A stronger focus on primary and secondary fall prevention and rehab in the community to support community-dwelling older adults with frailty would help to reduce the burden on emergency services, hospital emergency departments and acute care.

In addition to considering underlying reasons like rurality to reduce regional and sub-regional variability on this indicator, there is room for improvement across the province generally. The RCA is working collaboratively with stakeholders across the province to identify and implement secondary fall prevention strategies.

SUPPLEMENTARY INDICATORS

Rehabilitation hospitals, like much of Ontario's health care system, are seeing increasing volumes and are admitting increasingly complex patients. In 2019/20, there were approximately 33,029 patients admitted to high intensity rehab (NRS-reporting bed) and 27,103 to complex continuing care (CCC).

Across all LHINs, the number of patients admitted to NRS-reporting beds has been fluctuating with a slow increasing trend. Since 2013/14 the number of patients admitted to inpatient rehab has increased 7%, from 30,900 in 2013/14 to 33,029 admissions in 2019/20. In the recent three years; however, total admissions to a NRS reporting beds across the province have been relatively stable. Changes in total admissions to NRS reporting beds have varied broadly across the LHINs, with CW LHIN seeing a 26% decrease since 2016/17, North East LHIN seeing a 37% increase and Toronto Central LHIN seeing a 13% increase in the same timeframe.

In these same three years, there has also been significant variability in admissions by Rehab Client Group (RCG). Since 2016/17 the number of admissions for 'debility' has increased by 667 patients per year or 28%. There has also been an increase in admissions of stroke patients by 135 patients per year (2%) compared to 2016/17. Admissions due to burns has increased by 67% since 2016/17 though due to low volumes that only amounts to an additional 28 patients per year. Conversely, admissions to inpatient rehab for patients with orthopedic conditions have been decreasing across the province, likely due to the implementation of bundled care and the recommendation made by the provincial Orthopedic Expert panel that 90% of patients should be discharged home post total joint replacement.[3,4] In 2019/20, there

[3] Access to Care (2014) Orthopaedic Quality Scorecard. Released quarterly by Ministry of Health and Long Term Care through Access to Care at Cancer Care Ontario.
[4] Health Quality Ontario & Ministry of Health and Long-Term Care. (2013). Quality-Based Procedures: Clinical Handbook for Primary Hip and Knee Replacement. Accessed: http://www.hqontario.ca/Portals/0/Documents/evidence/clinical-handbooks/hip-knee-140227-en.pdf

were 9887 patients admitted for orthopedic conditions, which is 836 per year (8%) fewer than in 2016/17.

Alternate Level of Care (ALC)

- Of the approximate 60,053 patients admitted to inpatient rehabilitative care — either an NRS reporting bed or CCRS reporting bed —there was an ALC designation in acute care for 20,454 or 34% of those patients. Only patients who are designated as ALC are included in the WTIS dataset (the data source for the RCA indicator on wait time). This means that the wait time data presented represents approximately 34% of all patients who were admitted to inpatient rehabilitative care. The remaining patients (66%) would have accessed inpatient rehabilitative care without having been designated as awaiting an alternate level of care, i.e., with no recorded wait time.
- In 2019/20, there were a total of 20,454 adult acute care patients who were designated as ALC waiting for inpatient rehabilitative care. The majority of these patients (70%) were waiting for an NRS bed, followed by 21% waiting for a Complex Continuing Care-low tolerance long duration (CCC-LTLD) bed, 7% waiting for a Complex Continuing Care-non-low tolerance long duration (CCC-non-LTLD) bed, and 10% waiting for a Convalescent Care Program (CCP) bed.
    - ALC rates in acute care for patients waiting for an NRS-reporting bed are relatively low compared to other discharge destinations, such as mental health or long-term care.
    - In *Measuring Up 2019*, Ontario Health (Quality) reported a provincial ALC rate of 15.5% for all destinations and trending upward.[5] In contrast, the acute ALC rate for those waiting for inpatient rehabilitative care was only 3.8% in 2019/20.
    - ALC rates within inpatient rehabilitative care are relatively low compared to acute care, the exception being those patients in CCC waiting for long-term care. As noted above, while the COVID-19 pandemic started in Ontario in mid-March 2020, the impact of ALC transfers from acute care to rehab/CCC were not seen in in the 2019/20 fiscal year but are expected to be notable in the 2020/21 report.

Inpatient Rehab: Measures of Functional Change

Along with the fluctuating volumes that hospitals are facing, admitted patients have also had fluctuating levels of function. Since 2013/14 there has been an overall decrease in admission FIM® score (indicating patients are being admitted at lower functional independence), though the average admission FIM® score did increase provincially in 2019/20 over 2018/19. In fact, the provincial average admission FIM® score in 2019/20 was the highest it has been since 2013/2014. The rate of change across the LHINs in average admission FIM® score was highly variable, with the greatest decrease in admission FIM® scores

[5] Measuring Up 2019: A yearly report on how Ontario's health system is performing, Ontario Health. 2019.

noted in patients admitted to NRS beds in the TC LHIN and C LHIN and the greatest increase in admission FIM® scores for patients admitted to NRS beds in the WW LHIN.

If admission FIM® scores are compared by RCG, the variability between groups remains, but the rate at which admission FIM® scores are decreasing is consistent. A review of the provincial admission FIM® scores shows that most rehab client groups had less than 2% variability in admission FIM® scores over the past 5 years. Outliers in this review are patients in the congenital deformities and developmental disability rehab client group who have had a dramatic decrease in admission FIM® (30%) over the past 5 years – possibly because the volumes in these groups are significantly lower than in other client groups.

this report also considered how has patient functional independence has changed over the inpatient stay but looking at total functional change (the difference in FIM score at discharge vs admission) as well as active length of stay efficiency which is a measure of the total FIM change over the patient's active length of stay. Generally speaking, while patients are being admitted at a lower level of function (as demonstrated through lower admission FIM® scores), over the past 5 reporting years, they have been making greater gains during their stay and are being discharged at similar levels of function. However, in 2019/20, the total change in FIM® scores was 21.3 at the provincial level, which is a 2.6 point decrease over the previous year. Active length of stay (aLOS) efficiency has also been increasing over the past few years, from 1.1 in 2014/15 to 1.3 in 2018/19, but in 2019/20 aLOS efficiency dropped to 1.2 compared to 1.3 in 2018/19. There has been some regional variability in the degree of total FIM® change and average aLOS efficiency, making it difficult to identify any particular trends at the sub-region level.

Of course, where there was a provincial decrease in aLOS efficiency, some LHINs stood out as continuing to make improvements in these indicators. HNHB LHIN had an increase in aLOS efficiency this year to 1.6 over 1.2 in 2018/19 and Central LHIN increased to 1.6 over 1.3 from last year. Champlain, North Simcoe Muskoka, and North East and North West LHINs all saw increased aLOS efficiency in 2019/2020. No LHINs had an increase in Total Functional Change in 2019/20 over 2018/19.

Secondary Fall Prevention

In 2019, the provincial age standardized rate of ED visits for falls among community-dwelling older adults decreased slightly to 4,873 per 100,000 from 5,445 in 2014. This decrease over the 5 years was consistent across 13 LHINs – Toronto Central LHIN increased to 5153 ED visits for falls per 100,000 in 2019. Since last year, however, almost all LHINs saw an increased age standardized rate in ED visits for falls among community-dwelling older adults with only Champlain, North East and North West LHINs reporting a decreased rate compared to last year. When comparing rates over the past three years, two LHINs stand out as having had a more substantial reduction of roughly 1,000 visits per 100,000 older adults:

- CH LHIN, rate of 6,068 in 2014 decreased to 4611 in 2019 (difference of 1457)
- MH LHIN, rate of 5,144 in 2014 decreased to 4,100 in 2018 (difference of 1044)

ED visits due to falls has been decreasing since 2016 though there was a slight increase in 2019. As one would expect, generally, as rates of ED visits due to falls is decreasing so would the rates at which these visits result in inpatient admissions. This was true in the data set from where the rates of inpatient admissions after and ED visit due to fall was decreasing with decreasing falls related ED visits, until this year where the rate slightly increased. While both the rate of ED visits due to falls and the related inpatient admissions did increase this year, the rates are still lower than they were in 2016.

LOOKING AHEAD – QUALITY IMPROVEMENT OPPORTUNITIES

The vision of the Rehabilitative Care Alliance is that patient and system outcomes are optimized through the integration of rehabilitative care at all levels of health services policy, planning and delivery. Continued standardized collection and reporting of rehabilitative care indicators can support rehabilitative care stakeholders across the province in reaching these goals, for the benefit of patients, their family and caregivers, and the health care professionals working in the system.

In 2020/21, the RCA System Evaluation Indicator Task Group began a process of reviewing and refreshing performance indicators. The goal is to identify indicators from the framework that are no longer serving the purpose of measuring toward strategic quality improvement and to identify any accountability or monitoring indicators that should be included to continue to drive performance toward high quality rehabilitative care for the province. As a first step, this task group considered wait time for and utilization of outpatient rehabilitation for the 2019/20 report. Unfortunately, as the data collection for NACRS Clinic Lite has been limited to Bundled Care program and only been operational for 2 fiscal years, there are concerns that early reporting of this data before any data quality issues could be addressed would be premature. Further, as of the writing of this report, it is acknowledged the data for the 2020/2021 report will need to be reviewed in the context of the significant changes to health care delivery due to the pandemic.

Over the coming years, the RCA, in collaboration with regional and provincial partners, plans to undertake work on one provincial level quality improvement initiative. Key change ideas for improving performance were identified through a root cause analysis with provincial stakeholders and subject matter experts in 2019 and in 2020 they identified a direction for improvement related to the indicator of wait time for in-home rehabilitative care services as the first step, with a goal to developing plans for a pilot by the end of 2021/22.

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- Jay Callowhill, Senior Data Analyst

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

Indicator Development Task Group Chairs:
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The analyses, conclusions, opinions and statements expressed are those of the RCA and are independent from the funding source or data providers. No endorsement by Ontario Health, ICES, CIHI, Intellihealth or the Ontario MOHLTC is intended or should be inferred

Rehabilitative Care Alliance
700 Bay Street, Suite 601
Toronto, ON M5G 1Z6

E: info@rehabcarealliance.ca
P: 416-597-3057