Rehabilitative Care Alliance
System Evaluation Indicator
Technical Specifications

Developed by the System Evaluation Task and Advisory Groups of the Rehabilitative Care Alliance

November 30, 2018

BACKGROUND

In the RCA's first mandate, the RCA *Rehabilitative Care System Evaluation Framework* was developed to support a standardized approach to evaluating system performance across the rehabilitative care continuum. This standardized approach is intended to support evidence-based practice and system-wide improvement, including the prioritization of regional and provincial quality improvement opportunities. Furthermore, it will allow LHINs, HSPs and other stakeholders to demonstrate the contribution of rehabilitative care to overall health care system objectives.

APPROACH

The work of the System Evaluation Task and Advisory Groups focused on the implementation of the framework with the goal of developing a provincial performance report and preliminary scorecard using the indicators from the framework.

PURPOSE OF THE TECHNICAL SPECIFICATIONS

The task and advisory groups reviewed provincial data sources to confirm data availability and reliability for the indicators in the system evaluation framework. Based on this review, it was decided to focus on defining, collecting data and reporting only those indicators for which data is available to feasibly calculate these indicators. The groups reviewed and adapted technical definitions for these indicators, which are included here.

The technical definitions provided in this report were used to collect the data provided in the accompanying scorecard data spreadsheet and are meant to support the understanding and standardized collection of performance data for rehabilitative care in Ontario.

Additional comments and suggested updates on this document are welcome for future iterations. Please send comments to info@rehabcarelliance.ca

November 30, 2018

LIST 1: PRIORITY INDICATORS

Quality Dimension	Ind. #	Rehab. Care System Indicator	Type	Where Indicator is Also Used
Accessible	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	Explanatory	H-SAA/M-SAA
Accessible	A3	Wait time for in-home rehabilitative care services: patient availability date to date of first therapy visit	Explanatory	OHA, QIP
Safe	C3	Repeat ED visits for falls for community-dwelling seniors: annual rate per 100,000 people aged 65 years and older (age standardized)	Explanatory	Integrated Falls Prevention Framework & Toolkit (July 2011) LHIN Collaborative

LIST 2: SUPPLEMENTARY INDICATORS

Quality Dimension	Ind. #	Rehab. Care System Indicator	Type	Where Indicator is Also Used
Accessible	A4	Percent contribution to ALC rate, open and closed cases separately, for patients in acute care waiting for inpatient rehabilitative care	Explanatory	H-SAA
Accessible	A5	Percent contribution to ALC rate, open and closed cases separately, for patients in a rehabilitation bed or complex continuing care bed	Explanatory	
Effective	B5	Average change in functional score by Rehabilitation Client Group (RCG)	Explanatory	
Effective	B6	Average Admission FIM® Scores by Rehabilitation Client Group (RCG)	Explanatory	
Effective	B8	Average active rehabilitation LOS efficiency	Explanatory	
Safe	C2	ED visits for falls for community-dwelling seniors: annual rate per 100,000 people aged 65 years and older (age standardized)	Explanatory	Integrated Falls Prevention Framework & Toolkit (July 2011) LHIN Collaborative
Integrated	F3	ALC designation rate within 2 days for acute care patients discharged to inpatient rehabilitative care	Explanatory	
Appropriately Resourced	H4	Proportion of patients admitted to inpatient rehabilitative care within each RCG	Developmental	

PRIORITY INDICATORS

INDICATOR A1: Wait time for inpatient rehabilitative care

Indicator Description	**Indicator Name**	**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**
	Indicator Description	This indicator measures the time a patient is waiting in acute care for an inpatient rehabilitative care bed by measuring the time from the most recent discharge destination determined date to discharge date
	Relevance	Timely access to inpatient rehabilitative care
	Level of analysis	• Single admission • Facility based analysis (i.e. the location of the facility is used to report regional performance)
	Data Source(s)	Access to Care Wait Time Information System
Numerator	**Calculation (define the numerator)**	Discharge Date – Discharge Destination Determination Date in days calculated at median and 90th percentile Volumes are also reported
	Exclusion/Inclusion Criteria	Inclusion: • All patients ≥18 years with a discharge destination indicated as a either Rehab (NRS-reporting bed), Complex Continuing Care (CCRS-reporting bed) or Convalescent Care (CCP) • Discharged from acute care during the fiscal year (allocated based on discharge date) • Valid HCN number (not null or 0 and must be 10 digits - all numeric) Exclude: • Missing discharge date • Missing ALC discharge destination determination date • Missing ALC discharge destination detail
Denominator	**Calculation (define the denominator)**	n/a
	Exclusion/Inclusion Criteria	n/a

Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	Provincial (wait times are calculated for the 10th, 25th, 50th, 75th and 90th percentiles) LHIN (50th and 90th percentiles) Discharge Destination Detail Discharge Destination rollup (NRS, CCP, CCRS-LTLC, CCRS-non-LTLD)
	Trending (what year are data available)	FY2012/13 to FY2017/18
	Limitations	The current data only captures those patients who have a waitlist entry (those patients waiting for rehabilitative care who have been designated ALC). A waitlist entry/update and determination of a discharge destination do not indicate acceptance by the receiving organization. The reported data is reflective of the intended rehab discharge destination from acute care and may be modified by the rehab program upon admission
Additional Information	**References**	• Alternative Level of Care (ALC) Reference Manual, version 2, January 2017
	Comments/Interpretation	This indicator should be interpreted as the time a patient in acute care waits for a rehabilitative care bed, where that patient was designated ALC for that level of care. A lower wait time is preferred. Wait times where calculated volumes are less than 10 are suppressed and given a NV designation. Wait times for CCC non-LTLD beds are excluded from the benchmark calculation. The ALC discharge destination determination date is used as a proxy for the referral date, as it is defined as "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." Using this method, only time spent waiting specifically for the inpatient rehabilitative care bed will be included in the wait time. If a patient has had

		his/her discharge destination changed multiple times, for various clinical reasons, this method may decrease the presented wait time in certain scenarios. While this approach helps to focus the calculated wait for a specific service, it may not be deemed the most reflective of the entire patient experience, i.e., it is not inclusive of the total ALC wait time.
	Alignment	Access
	Improvement suggestions	Move to a wait time definition that captures time from the date of rehab referral to date of admission to inpatient rehabilitative care. Reported in alignment with the Rehab Care Alliance definitions framework – with discharge destinations aligned to the RCA definitions of bedded levels of rehabilitative care.

INDICATOR A3: Wait time for in-home rehabilitative care

Indicator Description	**Indicator Name**	**Wait time for in-home rehabilitative care services: patient availability date to date of first therapy visit**
	Indicator Description	This indicator measures the time from the patient available date following service authorization to the date of the first in-home therapy visit.
	Relevance	Timely access to in-home rehabilitative services
	Level of analysis	• Single episode of care per service • Population based analysis by LHIN (i.e. the location of the patient's residence is used to report regional performance)
	Data Source(s)	Health Shared Services Ontario Client Health & Related Information System
Numerator	**Calculation (define the numerator)**	Date of first visit - Patient Available Date (PAD) in days calculated at median and 90th percentile Volumes are also reported
	Exclusion/Inclusion Criteria	Exclude: • Patients who were on hold for any reason between patient availability date and date of first therapy visit
Denominator	**Calculation (define the denominator)**	• All patients with a patient availability or service authorization date
	Exclusion/Inclusion Criteria	Include: • In-Home care referrals • Patients who received their first visit during the fiscal year noted (April 1 to March 31st) • Adult Short Stay (Adult Short Stay-Acute, Adult Short Stay-Wound, Adult Short Stay-Oncology, Adult Short Stay-Rehab or SRC 91, 92 if no CCM population assigned) • Adult Long stay (CCM population of Adult Chronic, Adult Complex or Adult Community Independence or SRC of 93 or 94 if no CCM population assigned) • Age >=18 years at time of patient available date • Valid OHIP number

Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	• Provincial (wait times are calculated for the 10th, 25th, 50th, 75th and 90th percentiles) • LHIN (50th and 90th percentiles) • Service by Regulated Health Professional (Physiotherapy, Occupational Therapy, Speech Language Pathology, Social Work) • CCM Category (Adult Long Stay / Adult Short Stay) • Referral Source (Community / Hospital)
	Trending (what year are data available)	FY2014/15 to FY2017/18
Additional Information	**Limitations**	None specified
	References	None
	Comments/Interpretation	This indicator should be interpreted as the time a patient is waiting for in-home rehabilitative care services. A lower number is preferred. Services are categorized using the following functional centre ID's: Physiotherapy (1300, 2100, 2700, 4700, 6114) Occupational Therapy (1400, 2200, 2800, 4800), Speech Language Pathology (1500, 2300, 2900, 4900) Social Work (1600, 5000) Single episode of care per service means that if there is more than one service authorization for the same service, the earliest Patient Availability Day (PAD) before the first visit is used for the wait time start. In the event a negative wait time is produced, the wait time is set to 0 days.
	Alignment	Accessibility
	Improvement suggestions	None currently

INDICATOR C3: Repeat ED visits for falls for community-dwelling seniors

Indicator Description	**Indicator Name**	**Repeat ED visits for falls for community-dwelling seniors: annual rate per 100,000 people aged 65 years and older (age standardized)**
	Indicator Description	This indicator measures the annual rate of repeat visits for falls among seniors living in the community, expressed as the age standardized rate per 100,000 people
	Relevance	A measure of the effectiveness of fall prevention efforts across the province
	Level of analysis	• Unique patient • Population based analysis (i.e. the location of the patient's residence is used to report regional performance)
	Data Source(s)	National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information
Numerator	**Calculation (define the numerator)**	Total number of repeat visits (above 1) to the ED with "fall" indicated, where is "fall" = ICD-10 code WW00-WW19
	Exclusion/Inclusion Criteria	**Include** • All patients >=65 years • Valid OHIP number **Exclusions** • Visits from non-participating ED's • Scheduled ED visits are excluded, where scheduled ED visit indicator = "Y" or ED visit indicator = "0" (as of 2011–2012). • Index case • Transfers from type: home for the aged, interim long term care, nursing home and temporary long term care home. Also exclude transfers from hospital: other hospitals, rehab hospitals, acute hosp with psych, acute hosp without psych, community psych hospital, chronic care treatment hospital, gen rehab hosp, misc psych hosp, ontario psych hosp, spec rehab hosp

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Denominator	Calculation (define the denominator)	Total number of people aged 65 years and older / 100,000 Adjustment (age standardization) This measure is age-standardized to LHIN specific fiscal year population for the crude rate and the Statistics Canada 2011 Canadian population for the expected rate for seniors 65+ calculated in 5 year age increments: 65-69, 70-74, 75-79, 80-85, 85-89, 90+ The standardized rates for re-visits per 100,000 is calculated as follows: Age Standardized Rates for re-visits per 100,000= Sum of all expected events (#re-visits) x 100,000 Total Standard population
	Data Source(s)	Ontario Ministry of Health and Long-Term Care (MOHLTC): IntelliHEALTH ONTARIO (IntelliHEALTH)
	Exclusion/Inclusion Criteria	Include: • All patients >=65 years • Valid OHIP number
Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	Provincial LHIN By age cohort, 5 year increments, regrouped
	Trending (what year are data available)	CY2013-CY2017
Additional Information	**Limitations**	Documentation of falls in NACRS-ED has been noted as generally unreliable/inconsistent across reporting organizations Does not include falls in the community that are not referred to the ED but are treated in the community

	References	Integrated Provincial Falls Prevention Framework and Toolkit, July 2011
	Comments/Interpretation	This indicator should be interpreted as the rate of repeat visits made to the ED for fall among those 65 years and older per 100,000 people A lower number is better
	Alignment	Safety
	Improvement suggestions	Consider alternate data sources to capture falls that are treated in the community and outside of ED as well as the methodology for recording falls in the ED

SUPPLEMENTARY INDICATORS

INDICATOR A4: ALC rate in acute care to inpatient rehab (modified)

Indicator Description	**Indicator Name**	**Percent contribution to ALC rate, open and closed cases separately, for patients in acute care waiting for inpatient rehabilitative care**
	Indicator Description	This indicator measures the usage of acute care beds for patients awaiting inpatient rehabilitative care by measuring the total number of ALC days contributed (open and closed cases) over the total number of acute inpatient days, expressed as a percentage
	Relevance	This indicator measures the usage of acute care beds for patients awaiting inpatient rehabilitative care by measuring the total number of ALC days contributed (open and closed cases) over the total number of acute inpatient days, expressed as a percentage
	Level of analysis	• Single discharge • Facility based analysis (i.e. the location of the facility is used to report regional performance)
Numerator	**Calculation (define the numerator)**	The total number of days that patients spent designated ALC in an acute bed (non-surgical, surgical, and intensive/critical care beds) where the discharge destination is inpatient rehab (NRS-reporting bed), Complex Continuing Care (CCRS-reporting bed), or Convalescent Care. This includes all active patients (open and closed) during that time period.
	Data Source(s)	Access to Care, Wait Time Information System WTIS
	Exclusion/Inclusion Criteria	Inclusions: ALC days for Acute Inpatient Services (NS + SU + IC) Exclusions: 1. ALC cases discontinued due to 'Data entry error' 2. ALC Days are excluded for the portion of the time when Inpatient Service = Discharge Destination for Post-Acute Care 3. ALC cases identified by the facility for exclusion
Denominator	**Calculation (define the denominator)**	[July 2017 onwards]: Daily Bed Census Summary Acute Patient days = the total number of patient days occupying Acute (AT) beds (includes Mental Health Children/Adolescent) [May 2017 and prior]: Bed Census Summary Acute Patient days = the total number of patient days contributed by inpatients in Medical (MED)

		+ Surgical (SURG) + Combined Medical & Surgical (CMS) + Intensive Care and Coronary Care (ICU) + Obstetrics (OBS) + Paediatric (PAE) + Child/Adolescent Mental Health (Children MH) + Acute Addiction (Addiction) + Pediatrics in Nursery (Paed Days in Nursery) + Newborns (Level 1 - General + Level 2 - Intermediate + Level 3 - ICU Neonatal + Not in Regular)
	Data Source(s)	Daily Bed Census Summary (July 2017 onwards) and Bed Census Summary (BCS) May 2017 and prior
	Exclusion/Inclusion Criteria	Exclusions: [Bed Census Summary] Patient days contributed by inpatients in the emergency department (Bed Type = Emergency (Emerg + PARR, Emergency + PARR)).
Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	Provincial LHIN Discharge Destination rollup (NRS, CCP, CCRS)
	Trending (what year are data available)	FY2013/14 to FY2017/18 reported quarterly
Additional Information	**Limitations**	Please note that only those facilities (Acute & Post-Acute) submitting both ALC data (to the WTIS) and BCS data (through the HDB Web Portal) are included in ALC Rate calculation. Any master number that does not have inpatient days reported to the BCS for a given month/quarter will be excluded from reporting for that month/quarter. As of June 2017, Bed Census Summary (BCS) data has been updated according to the new Daily Census Summary (DCS) format. As a result, June 2017 data is not reported. Additional notes regarding ALC days: - The day of ALC designation is counted as an ALC day but the date of discharge or discontinuation is not counted as an ALC day. - For cases with an ALC designation date on the last day of a reporting period and no discharge/discontinuation date, then ALC days = 1.

		- The ALC Rate indicator methodology makes the assumption that the Inpatient Service data element (as defined in the WTIS) is comparable to the Bed Type data element (as defined in the BCS). - The total ALC days by discharge destination represents the number of ALC days contributed by patients designated ALC within the same reporting period as the Bed Census Summary data submitted who have waited for the discharge destination during the patient journey, **irrespective of the current discharge destination** (i.e. a patient may have waited 5 days for rehab but their final discharge destination may have not been rehab).
	References	Alternative Level of Care (ALC) Reference Manual, version 2, January 2017
	Comments/Interpretation	This indicator should be interpreted as the number of days that patients use those beds waiting for a NRS, CCP or CCC bed as a proportion of available days in an acute care bed, over the period of a fiscal year. A lower percentage is preferred. The data source used to calculate the total patient days in the ALC Rate Report is the Daily Bed Census Summary (BCS) [previously the Daily Census Summary (DCS)]. Ontario hospitals make daily (previously monthly) data submissions to the ministry's Health Data Branch (HDB) Web Portal. ATC then takes a data cut from the Web Portal to use for the total patient days in the ALC Rate Report. Please refer to the BCS DQ Notes tab within the ALC Rate Report for more details about the data refresh timelines.
	Alignment	Accessible
	Improvement suggestions	None at this time

INDICATOR A5: ALC rate in rehab and CCC (modified)

Indicator Description	**Indicator Name**	**Percent contribution to ALC Rate, open and closed cases separately, for patients in a rehabilitative care bed or complex continuing care**
	Indicator Description	This indicator represents the rate of ALC in inpatient rehab by measuring the total number of ALC days in Rehab and CCC (open and closed cases), contributed over the total number of inpatient days, expressed as a percentage
	Relevance	Access
	Level of analysis	• Single admission • Facility based analysis (i.e. the location of the facility is used to report regional performance)
Numerator	**Calculation (define the numerator)**	The total number of days that patients spent designated ALC in a rehabilitation bed or complex continuing care bed. This includes all active patients (open and closed) during that time period.
	Data Source(s)	Access to Care, Wait Time Information System
	Exclusion/Inclusion Criteria	Inclusions: ALC days for Inpatient Service CC + RB Exclusions: • ALC cases discontinued due to 'Data entry error' • ALC Days are excluded for the portion of the time when Inpatient Service = Discharge Destination for Post-Acute Care (*Exception: Bloorview Rehab, CCC to CCC) • ALC cases identified by the facility for exclusion
Denominator	**Calculation (define the denominator)**	[July 2017 onwards]: Daily Bed Census Summary CCC Patient days = the total number of patient days occupying Complex Continuing Care (CR) Beds Rehab Patient days = the total number of patient days occupying in General Rehabilitation (GR) + Special Rehabilitation (SR) Beds [May 2017 and prior]: Bed Census Summary The total number of patient days contributed by inpatients in complex continuing care (Chronic) +

		General Rehabilitation (Gen. Rehab) + Special Rehabilitation (Spec. Rehab)
	Data Source(s)	Daily Bed Census Summary and Bed Census Summary (BCS)
	Exclusion/Inclusion Criteria	Exclusions: [Bed Census Summary] • Patient days contributed by inpatients in the emergency department (Bed Type = Emergency (Emerg + PARR, Emergency + PARR)).
Geography & Timing	**Timing/frequency of release**	Annually
	Levels of comparability	Provincial LHIN
	Trending (what year are data available)	FY2013/14 to FY2017/18
Additional Information	**Limitations**	Please note that only those facilities (Acute & Post-Acute) submitting both ALC data (to the WTIS) and BCS data (through the HDB Web Portal) are included in ALC Rate calculation. Any master number that does not have inpatient days reported to the BCS for a given month/quarter will be excluded from reporting for that month/quarter. Additional notes regarding ALC days: • The day of ALC designation is counted as an ALC day but the date of discharge or discontinuation is not counted as an ALC day. • For cases with an ALC designation date on the last day of a reporting period and no discharge/discontinuation date, then ALC days = 1. The ALC Rate indicator methodology makes the assumption that the Inpatient Service data element (as defined in the WTIS) is comparable to the Bed Type data element (as defined in the BCS).
	References	ALC Rate Report Methodology document, Access to Care, Cancer Care Ontario, August 2013

	Comments/Interpretation	This indicator should be interpreted as the number of days that patients use an NRS or CCC reporting beds to wait for another type of bed, as a proportion of the total available days in those NRS or CCC beds, over the period of a fiscal year. A lower number is preferred. The data source used to calculate the total patient days in the ALC Rate Report is the Daily Bed Census Summary (BCS) [previously the Bed Census Summary and Daily Census Summary (DCS)]. Ontario hospitals make daily (previously monthly) data submissions to the ministry's Health Data Branch (HDB) Web Portal. ATC then takes a data cut from the Web Portal to use for the total patient days in the ALC Rate Report. Please refer to the BCS DQ Notes tab within the ALC Rate Report for more details about the data refresh timelines.
	Alignment	Accessible
	Improvement suggestions	None at this time

INDICATOR B5: Average total functional change (FIM®) by RCG

Indicator Description	**Indicator Name**	**Average change in functional score (FIM®) by Rehabilitation Client Group (RCG)**
	Indicator Description	Average change in functional score (FIM®) by Rehabilitation Client Group (RCG) for patients in an NRS reporting bed
	Relevance	Effectiveness of NRS inpatient rehab
	Level of analysis	• Single admission/unique patient • Facility based analysis (i.e. the location of the facility is used to report regional performance)
	Data Source(s)	Canadian Institute for Health Information National Rehabilitation Reporting System
Numerator	**Calculation (define the numerator)**	Mean and median total functional change (FIM® change = discharge total FIM®-admission total FIM®)
	Exclusion/Inclusion Criteria	N/A
Denominator	**Calculation (define the denominator)**	All patients >=18 years admitted into inpatient rehabilitation
	Exclusion/Inclusion Criteria	Include: • Patients admitted to an NRS reporting bed • Discharged alive • ≥18 years • Admitted into inpatient rehab during the fiscal year • Valid OHIP number Exclude: • Hospital transfers within a facility or between facilities within 24 hours • Missing Admission FIM® score • Missing Discharge FIM® score
Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	Provincial LHIN RCG
	Trending (what year are data available)	FY2013/14 to FY2017/18
Additional	**Limitations**	None

Information		
	References	None
	Comments/Interpretation	The indicator should be interpreted as measuring functional change over an inpatient rehab episode of care. A larger number is better
	Alignment	Effective
	Improvement suggestions	None at this time

INDICATOR B6: Average admission FIM® scores by RCG

Indicator Description	**Indicator Name**	**Average admission FIM® Score by Rehabilitation Client Group (RCG)**
	Indicator Description	Mean admission FIM® score by RCG for patients in an NRS reporting bed
	Relevance	Provides context on complexity of patients at admission
	Level of analysis	• Single admission/unique patient • Facility based analysis (i.e. the location of the facility is used to report regional performance)
Numerator	**Calculation (define the numerator)**	Mean admission FIM® score
	Data Source(s)	CIHI NRS
	Exclusion/Inclusion Criteria	N/A
Denominator	**Calculation (define the denominator)**	All patients >=18 years admitted into inpatient rehab
	Data Source(s)	CIHI NRS
	Exclusion/Inclusion Criteria	Include: • Patients admitted to an NRS reporting bed≥ 18 years • Admitted into inpatient rehab during the fiscal year • Valid OHIP number Exclude: • Hospital transfers within a facility or between facilities within 24 hours • Missing discharge date • Missing Admission FIM® score • Missing discharge FIM® score
Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	Provincial LHIN Facility RCG
	Trending (what year are data available)	Annual

Additional Information	**Limitations**	None
	References	FY2013/14 to FY2017/18
	Comments/Interpretation	This indicator should be interpreted as the functional level as measured by the FIM® tool of patients at admission. A higher score denotes the more independent a patient is at completing tasks.
	Alignment	Effective
	Improvement suggestions	None at this time

INDICATOR B8: Average active rehab LOS efficiency

Indicator Description	**Indicator Name**	**Average active rehabilitation LOS efficiency**
	Indicator Description	This indicator measures the average change in Total Function Score per day of client participation in a NRS inpatient rehabilitation program
	Relevance	Effective
	Level of analysis	• Single admission/unique patient • Facility based analysis (i.e. the location of the facility is used to report regional performance)
	Data Source(s)	Canadian Institute for Health Information National Rehabilitation Reporting System
Numerator	**Calculation (define the numerator)**	Mean LOS efficiency (FIM® change (discharge total FIM® – total admission FIM®) /total LOS)
	Exclusion/Inclusion Criteria	Excludes clients with incomplete admission and discharge Function Scores
Denominator	**Calculation (define the denominator)**	All patients admitted to inpatient rehab
	Exclusion/Inclusion Criteria	Include: • All admissions to inpatient rehab (NRS reporting bed) • Discharged alive • ≥18 years • Admitted into inpatient rehab by fiscal year • Valid OHIP number Exclude: • Hospital transfers within a facility or between facilities within 24 hours • Missing discharge date • Missing Admission FIM® score • Missing discharge FIM® score
Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	Provincial LHIN RPG
	Trending (what year are data available)	FY2013/14 to FY2017/18

Additional Information	**Limitations**	
	References	FIM® efficiency is the change in total FIM® score divided by total length of stay; it provides information on the average amount of functional recovery per day of inpatient rehab.
	Comments/Interpretation	This indicator should be interpreted as the mean FIM® efficiency for patients
	Alignment	Effective
	Improvement suggestions	None at this time

INDICATOR C2: ED visits for falls for community-dwelling seniors

Indicator Description	**Indicator Name**	**ED visits for falls for community-dwelling seniors: annual rate per 100,000 people aged 65 years and older (age standardized)**
	Indicator Description	This indicator measures the annual rate of visits for falls among seniors living in the community, expressed as the age standardized rate per 100,000 people
	Relevance	A measure of the effectiveness of fall prevention efforts across the province
	Level of analysis	• Unique patient • Population based analysis (i.e. the location of the patient's residence is used to report regional performance)
Numerator	**Calculation (define the numerator)**	Total number of visits to the ED in the fiscal year where fall is indicated as either main or other problem, where: • "Fall" = ICD-10 code WW00-WW19
	Data Source(s)	CIHI Discharge Abstract Database and National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information
	Exclusion/Inclusion Criteria	Include • All patients >=65 years • Valid OHIP number Exclusions • • Scheduled ED visits, where indicator = "Y" or ED visit indicator = "0" (as of 2011–2012). • Visits from non-participating ED facilities • Transfers from type: home for the aged, interim long term care, nursing home and temporary long term care home. Also exclude transfers from hospital: other hospitals, rehab hospitals, acute hosp with psych, acute hosp without psych, community psych hospital, chronic care treatment hospital, gen rehab hosp, misc psych hosp, ontario psych hosp, spec rehab hosp • Delete Encrypted_HN=7863803113
Denominator	**Calculation (define the denominator)**	Total number of people in the region who are 65 years and older based on the calendar year / 100,000

		Adjustment (age standardization) This measure is age-standardized to LHIN specific fiscal year population for the crude rate and the Statistics Canada 2011 Canadian population for the expected rate for seniors 65+ calculated in 5 year age increments: 65-69, 70-74, 75-79, 80-85, 85-89, 90+
	Data Source(s)	Statistics Canada Distributed by: Ontario Ministry of Health and Long-Term Care (MOHLTC): IntelliHEALTH ONTARIO (IntelliHEALTH)
	Exclusion/Inclusion Criteria	≥ 65 years old No other exclusions
Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	LHIN Province By age cohort, 5 year increments, regrouped
	Trending (what year are data available)	CY2013 to CY2017
Additional Information	**Limitations**	Documentation of falls in NACRS-ED has been noted as generally unreliable/inconsistent across reporting organizations Does not include falls in the community that are not referred to the ED but are treated in the community Population predictions were used and not actual census data
	References	Integrated Provincial Falls Prevention Framework and Toolkit, July 2011
	Comments/Interpretation	This indicator should be interpreted as the rate of total number of visits made to the ED for fall among those 65 years and older per 100,000 people 65 years and older. A lower number is better
	Alignment	Safety

	Improvement suggestions	Consider alternate data sources to capture falls that are treated in the community and outside of ED as well as the methodology for recording falls in the ED

INDICATOR F3: Acute ALC Designations for rehab within 2 days

Indicator Description	**Indicator Name**	ALC designation rate within 2 days for acute care patients discharged to inpatient rehabilitative care
	Indicator Description	ALC designation rate within 2 days for acute care patients discharged to an inpatient rehabilitative care bed, expressed as a percentage.
	Relevance	A measure of effective referrals for appropriate resource use
	Level of analysis	• Single admission/unique patient • Facility based analysis (i.e. the location of the facility is used to report regional performance)
Numerator	**Calculation (define the numerator)**	Rate of ALC designations per 100 discharges: numerator/denominator x 100 Number of acute care discharges who were designated as ALC with discharge to an NRS or CCRS reporting bed or CCP within 2 days of admission to that acute care bed
	Data Source(s)	Access to Care, Wait Time Information System
	Exclusion/Inclusion Criteria	Include: • All inpatient acute patients ≥18 years with a discharge destination indicated as either rehab (NRS-reporting bed), CCC (CCRS-reporting bed), or Convalescent Care • Discharged from acute care during the fiscal year • Valid HCN number (not null or 0 and must be 10 digits - all numeric) • ALC designation date within 2 days of admission Exclude: • Missing discharge destination determination
Denominator	**Calculation (define the denominator)**	Number of acute care discharges Note: allocated to year patient was discharged
	Data Source(s)	Access to Care, Wait Time Information System
	Exclusion/Inclusion Criteria	Include: • All patients ≥18 years designated ALC with a discharge destination indicated as a either a rehab bed (NRS-reporting bed), CCRS-reporting bed, or Convalescent Care bed • Discharged from acute care during the fiscal year • Valid HCN number (not null or 0 and must be 10 digits - all numeric

Geography & Timing		Exclude: • Missing discharge destination determination
	Timing/frequency of release	Annual
	Levels of comparability	Provincial LHIN Discharge Destination detail
	Trending (what year are data available)	FY2013/14 to FY2017/18
Additional Information	**Limitations**	• A waitlist entry/update and determination of a discharge destination do not indicate acceptance to that destination or approval by the receiving organization. • The reported data is reflective of the intended rehab discharge destination from acute care and may be modified by the rehab program upon admission.
	References	Alternative Level of Care (ALC) Reference Manual, version 2, January 2017
	Comments/ Interpretation	This indicator is a measure of the number of patients who are designated as ALC for rehab within 48 hours of their admission date to acute care as a proportion of all patients designated ALC. A lower number is better.
	Alignment	Integrated
	Improvement suggestions	None at this time

INDICATOR H4: Proportion of patients admitted to inpatient rehabilitative care within each RCG

Indicator Description	**Indicator Name**	Proportion of patients admitted to inpatient rehabilitative care within each RCG
	Indicator Description	Proportion of patients admitted to a NRS reporting bed within each RCG expressed as a percentage
	Relevance	Provides context to other indicators
	Level of analysis	• Single admission/unique patient • Facility based analysis (i.e. the location of the facility is used to report regional performance)
	Data Source(s)	Canadian Institute for Health Information National Rehabilitation Reporting System
Numerator	**Calculation (define the numerator)**	Number of admissions into each of the RCG groupings (RCG-1 to RCG-17) Numerator/denominator x 100%
	Exclusion/Inclusion Criteria	N/A
Denominator	**Calculation (define the denominator)**	All admissions to an NRS reporting bed
	Exclusion/Inclusion Criteria	• ≥18 years • Admitted into inpatient rehabilitative care during the fiscal year • Valid OHIP number
Geography & Timing	**Timing/frequency of release**	Annual
	Levels of comparability	• Facility • LHIN • Province
	Trending (what year are data available)	FY2013/14 to FY2017/18
Additional Information	**Limitations**	None
	References	None
	Comments/ Interpretation	None
	Alignment	Appropriately resourced
	Improvement suggestions	None at this time