



**Rehabilitative
Care Alliance**

**2020/21 Rehabilitative Care
System Performance Report:**
Summary Report

January, 2022

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INTRODUCTION

The Rehabilitative Care Alliance (RCA) is pleased to share the 2020/21 Rehabilitative Care System Performance Report: Summary Report.

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

- [interactive dashboard](#) with all data presented graphically to show site and organization level data, in addition to trends and regional variability.
- [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 data reported in this summary.

Data for the 14 indicators in this report were collected from:

- Complex Continuing Care Reporting System (CCRS-CCC)
- National Ambulatory Care Reporting System (NACRS)
- Ontario Health:
 - IntelliHealth
 - Wait Time Information System (WTIS)
 - Client Health and Related Information System (CHRIS);
- Local Health Integration Network (LHIN) database
- Registered Persons Database files (RPDB)

This report captures data collected during the first year of the COVID-19 pandemic. Provincially mandated public health policies, such as lock downs, delayed surgeries, and health and human resource issues have had a significant impact on rehabilitative care.

Regional leads are encouraged to share this report with health service providers (whose data is reflected) and regional rehabilitative care committees. This report and the data available on the [dashboard](#) should be used as a tool for improvement activities and teams are encouraged to reflect on their organization's performance during this unprecedented time.

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 three priority indicators and eleven supplementary indicators. This year a realignment of the indicators was undertaken to map the indicators to the Quadruple Aim approach to analytics and address the four quadrants of: Population health, Patient Experience, Care-team well-being, and Value/Efficiency.

The three priority and eleven supplementary indicators were selected because the data for them is both available and reliable. Benchmarks were previously established for the three priority indicators by an expert panel based on evidence and current performance across the province.

Highlights from the 2020/21 report

At the time of writing this report, Ontario is facing another wave of the COVID-19 pandemic with the emergence of the Omicron variant. Over the last year, there have been tremendous gains to minimize the impact of COVID-19 with the rollout of vaccines and therapeutics, but pressures remain high as new variants continue to burden the acute care sector and place strain across all aspects of the health care system. Throughout the pandemic, rehabilitative care experienced changes and challenges, which resulted in innovations in how rehabilitative care was delivered. The 2020/21 performance data provide a unique glimpse into the impact the pandemic had, and continues to have, on rehabilitation services across Ontario.

It is interesting to compare the data from 2020/21 to the previous years as many of the trends that were observed over the previous years were consistent in 2020/21. It is acknowledged that the pandemic impacted different regions and sectors disproportionately; however, based on the rehabilitative care data available, wait times, quality of care and patient outcomes were generally consistent with pre-pandemic performance. At a high level, and based on the data available for the 14 rehabilitative care indicators, the largest impact of the pandemic was seen in the data for in-home rehabilitation and falls.

- Wait time for inpatient rehab did not change significantly in 2020/21. In fact, the 90th percentile for NRS beds has stayed the same for the last three years at 12 days.
- There was a slight increase in 90th percentile wait time for low intensity rehab by three days compared to the 2019/20 reporting year (22 days).
- No legacy LHIN 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.
- 59% of patients were admitted to inpatient rehabilitative care without being designated as awaiting an alternate level of care, i.e., no recorded wait time. This is a reduction of 7% from 66% the previous 2019/20 reporting year and similar to what was reported in 2018/19 at 61%.
- The most significant change from 2019/2020 to 2020/2021 was seen in the wait time for in-home rehab, primarily, for OT services. Most patients who waited for in-home OT services waited between five and seven days. The benchmark for this indicator is five days or less.
 - The median wait times for adult long stay in-home OT was at or below the benchmark of five days for Central, Central East. Their 90th percentile waits, while above the benchmark, were still notably lower than other legacy LHINs in the province.
- In 2020, there was a decrease in the number of fall related Emergency Department (ED) visits by 18% compared to the previous year. This is consistent with CIHI's report of an overall decrease of 22% for fall related ED visits¹.
- Of the visits to the ED for a fall in 2020, 21% were repeat visits compared to 17% in 2019. The overall decrease in fall related ED visits but increase in rate of repeat fall related visits may be attributed to provincially mandated public health measures which disproportionately impacted community dwelling seniors most at risk for falls.

- In 2020, the age-standardized rate of repeat ED visits for falls among community-dwelling older adults was 849 repeat visits per 100,000. The provincial benchmark for this indicator is 624. This rate was not impacted by the pandemic as it has essentially stayed the same as it was with 847 in 2019 and 838 in 2018.

It was anticipated that the pandemic would have a significant impact on the 2020/21 data and although fluctuations from year to year are expected, the changes were not as large as anticipated. Despite the minimal changes, there are some regions, sub-regions and organizations that demonstrate very strong performance:

- Four legacy LHINs (NW, TC, C, CE) reported 90th percentile wait times less than the provincial average for inpatient rehab in the range of six to 11 days. The three day benchmark for 90th percentile wait for an NRS-reporting bed remains aspirational.
- Median wait times for inpatient rehab had three legacy LHINs (NW, TC, CE) reporting 50th percentile wait times for inpatient rehab that are at or below the three day benchmark. This was consistent with the year prior. Even during the pandemic, the NW continues to have the lowest median wait times in the province with two days for inpatient rehab (NRS) and low intensity (CCRS-LTLD) reporting beds.
- At the sub-regional level, Bramalea (CW), North West-Mississauga (MH), Tecumseh Lakeshore Amherstburg LaSalle (ESC), Eastern York Region (C), Eastern Ottawa (CH), South West Mississauga (MH), Niagara North West and Kitchener-Waterloo-Wellesley-Wilmot-Woolwich (WW) reported the lowest age standardized repeat ED visits for falls in 2020.
- Although subtle changes are reflected in the 2020/21 performance data, it is recognized that the entire health care system, including rehabilitative care, made tremendous strides to adapt to the ever changing pandemic landscape. Some of the changes that most impacted rehabilitative care included:
 - Acute care hospitals and outpatient/community clinics shifted human resources to areas of greatest needed, which resulted in rehabilitation staff being deployed to acute care, inpatient rehab and CCC units.
 - Wide spread cancelled or delayed surgeries which impacted community based rehabilitative care. CIHI reported roughly half of a million fewer surgeries were performed during the first 16 months of the pandemic compared to 2019².
 - Virtual care became essential as provincially imposed social distancing mandates limited the ability to provide face to face care.
 - Early in the pandemic, home care services saw a significant decrease in the number of home care screening assessments completed. CIHI reported a decrease of 25% between March and June 2020, regardless of where the assessment was completed. Mirroring this decline, the number of full assessments also declined substantially (44%) during the same reporting period³. By June 2020, CIHI reported that screening assessments had nearly returned to pre-pandemic

levels, but full assessments had not. Similar trends have been reported by provincial rehabilitative care stakeholders, with most identifying that volumes rebounded significantly by fall 2021 with the largest demand being for OT services.

While subtle differences are seen in the 2020/21 reporting year, the RCA will use the information published in this report to support provincial stakeholders to use the data to continue to deliver high value care. The performance report data in this report and the [dashboard](#) can be used to identify best practices and awareness of opportunities for improvement. It also highlights how organizations, legacy LHINs and the newly formed Ontario health regions are performing year over year.

REHABILITATIVE CARE IN ONTARIO 2020-2021

The reporting of health system performance data, specific to rehabilitative care, is essential to improve care delivery, and enhance patient outcomes. The following sections provide a summary of the priority indicators and supplementary indicators that have been reported annually by the RCA since 2016. The RCA currently reports on three priority and 11 supplementary indicators. More detail on these indicators and the data sources can be found in the accompanying [technical manual](#).

PRIORITY INDICATORS

Priority indicators are the three indicators that are benchmarked.

Wait time for Inpatient Rehabilitative Care

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 (NRS), low intensity rehab in CCC beds (CCC-LTLD) and convalescent care program beds (CCP).

One significant pandemic related change was the enactment of the Long-Term Care Homes COVID-19 Emergency Policy effective March 23, 2020. The policy directed the suspension of the short-stay residents in respite care or convalescent care program (CCP) beds. The suspension of the CCP beds resulted in very limited data and the wait time data reported for CCP beds should be interpreted with caution. As of the writing of this report, this COVID-19 Emergency Policy continues to remain in effect.

Even during the COVID-19 pandemic, wait times for inpatient rehabilitative care did not change significantly from previous years. In 2020/21 the 90th percentile wait time was **12 days for NRS beds, 22 days for CCC-LTLD beds, and 32 days for CCP beds.**

The 90th percentile for NRS beds stayed the same for the last three years, while the CCC-LTLD wait time increased by three days and by seven days for CCP.

No legacy 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 greater variability in wait times across bed types.

In 2019, it was announced that the 14 LHINs would be reorganized into 5 interim geographical regions. For this reporting period, data is available on the 14 legacy LHINs and the 5 interim regions in the dashboard. In this report, only the legacy LHINs are summarized but regional data is available via the Dashboard.

Note: this report uses the following abbreviations to refer to the legacy LHINs:

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

Focusing on NRS-reporting beds, the 90th percentile wait time has been reported to be 12 days for the last three years. Since 2012/13, the median wait time for an NRS-reporting bed has consistently been four days, but it dropped to three days in 2019/20, and stayed at three days for 2020/21.

While no legacy LHIN achieved the three-day benchmark for 90th percentile wait for an NRS-reporting bed; four legacy LHINs (NW, TC, C, CE) had wait times less than the provincial average in the range of six to 11 days and Ontario had an average wait time of three days for 50% of patients waiting for inpatient rehab.

Consistent with last year (2019/20) seven legacy LHINs (NW, C, CE, CW, ESC, SW and TC) achieved a three-day wait or less for 50% of their patients who were ALC waiting for inpatient rehab.

As previously mentioned, the suspension of short stay CCP beds operated within long term care homes was reflected in the admission of 350 patients provincially for 2020/21. This is down from 2048 reported the previous 2020/19 year. The change was also reflected in the wait time with a decrease from 10 days down to eight days. It was anticipated that the number of patients admitted to CCP beds would have been less than 350 due to the provincial Long-Term Care Homes COVID-19 Emergency Policy. It is suspected that the volume of patients admitted to CCP was attributable to patients being transferred to other transitional care facilities that were not located in long term care homes but were coded as such.

There was also a decrease of 22% in the volume of patients admitted to low intensity rehab (CCC-LTLD). The volume for 2020/21 was 4,655 compared to 5,946 in the previous year. There was a slight increase in the wait time for median low intensity rehabilitative care. The median wait time increased to five days up from four days in 2018/19 and 2019/20.

High performers

Consistent with the 2019/20 reporting period, the following legacy LHINs were high performers with respect to both 90th percentile and median wait times across all three bed types: HNHB, C, CE and MH.

The legacy LHIN with the shortest median wait time was NW with a two day wait; while, C, CE, CW, ESC, SW, and TC had a three day median wait time. Legacy LHINs with a four day median wait time included MH, HNHB, and SE while WW and CH had median wait times of five and six days respectfully.

Even during the pandemic, the NW continues to have the lowest wait time in the province of two days for NRS and CCRS-LTLD reporting beds. As well, the C legacy LHIN had a median wait time for NRS of three days and CCRS-LTLD beds of two days.

Opportunities for improvement

Overall, no legacy LHIN achieved the provincial benchmark of three days for 90th percentile wait; however, considering the increased complexity of transitioning acute care patients into inpatient rehabilitative care, the consistent wait times for both NRS reporting beds and CCC-LTLD should be considered an accomplishment.

ALC

This year, approximately 47,139 patients were admitted to inpatient rehabilitative care, either an NRS reporting bed or CCRS reporting bed. There was an ALC designation in acute care for 18,026 or 38% of those patients. This implies that 62% 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 a slight decrease from the previous year where 66% were admitted without an ALC designation, though it is still too early to determine if this is a trend, it is evident that patients were rapidly discharged from acute care into rehab to accommodate bed demands by COVID-19 related admissions and the need for surge capacity in acute care.

Wait time for In-home Rehabilitative Care

There were slight reductions in the number of OT and PT visits whereas SLP and SW stayed roughly the same. Most patients (median) who waited for in-home rehabilitative care services in Ontario waited between five and seven days. Median wait times ranged from the shortest being three days for physiotherapy (long and short stay) to 14 days for social work (long stay). The 90th percentile benchmark for this indicator is five days or less.

Overall, the provincial 90th percentile waits for 2020/21 have been comparable with the 2019/20 reporting year. OT long stay went down from 16 to 15 days, PT went up from 14 to 15 days, SW went down from 24 to 22 days, and SLP remained the same at 17 days.

In 2020/21 there was a slight reduction in the number of visits for in home rehabilitation with 283,965 compared to 300,288 in the 2019/20 reporting year. Most patient visits were for OT (144,080), followed by PT (106,246), SLP (18,702) and SW (14,938) (combined long and short stay patients).

High performers

The OT and PT long stay provincial average for median wait was at the benchmark of five days or less. Legacy LHINS with PT and OT services at or below the provincial average included: C, CE, ESC, MH, and CW. Their 90th percentile waits, while above the benchmark, were still notably lower than the other legacy LHINS in the province. In the WW legacy LHIN, the median wait times for all types of in-home rehab was four days or less.

Opportunities for improvement

Historical health human resource (HHR) pressures for SW and SLP for in-home rehabilitation have often been cited to explain the longer wait times in previous years. This year, the pandemic placed even greater HHR pressure on all health care disciplines. The HHR demands are projected to persist beyond the 2022/23 reporting year and will require comprehensive strategies to attempt to address staffing concerns and minimize the impact on patient outcomes.

Recognizing the seriousness of the HHR issue, the RCA will be working with provincial stakeholders, academic institutions and professional associations to explore the development of a provincial rehabilitative care workforce strategy to support local and regional stakeholders with planning for the recruitment and retention of rehabilitation providers.

Repeat ED visits due to falls

In the 2020 calendar year, the provincial rate of repeat ED visits for falls among community-dwelling seniors was 849 repeat visits per 100,000 seniors. This is higher than the targeted benchmark of 624. 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.

A total of 104,660 visits to the ED for a fall were reported in 2020 with 22,154 or 21% being repeat visits. This represents a slight increase over the 2019 year. This is not surprising as community dwelling seniors were disproportionately impacted by provincial lockdowns and social distancing mandates that impacted their ability to maintain their physical, social and mental health which may have increased the rate of falls.

High performers

In 2020, the age standardized rate of repeat ED visits for falls among adults 65 years and over by legacy LHIN ranged from 606 to 1,143 per 100,000 with slight variations between year to year but overall, there was minor change. In 2019, the age standardized rate of repeat ED visits for falls among adults 65 years and over ranged from 468 to 1,711 per 100,000 across sub-regions with very little change year over year.

Several sub-regions Bramalea (CW), Eastern York Region (C), Kitchener Waterloo Wellesley Wilmot Woolwich, Niagara North West, North Etobicoke Malton West Woodbridge (CW) and Tecumseh Lakeshore Amherstburg LaSalle demonstrated fall rates below the 2020 benchmark for repeat ED visits for falls for community dwelling seniors.

Opportunities for improvement

Northern and rural regions face significant challenges to support 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.

To address the individual and systemic effects of a fall and recurrent falls among older adults, the RCA released a series of documents to prevent functional decline and secondary falls among older adults living with frailty. The document series include: i) [The Best Practice Framework for Older Adults Living with Frailty](#) ii) Implementing post fall rehabilitative care pathways. iii). [The Post Fall Pathway for Emergency Department & Primary Care](#).

In addition, a quick reference to [Post Falls Pathway for Older Adults](#) document was released along with robust implementation tools and project management support to assist sites that wish to take this on as a quality improvement initiative.

In addition to considering the underlying reasons for falls, there is room for improvement across the province. The RCA is working collaboratively with stakeholders across to identify and implement secondary fall prevention strategies.

SUPPLEMENTARY INDICATORS

The pandemic placed increased pressure on acute care which resulted in the rapid decanting of patients into rehabilitation, and community based care. In the 2020/21 reporting year, there were 27,880 patients admitted to high intensity rehab (NRS-reporting bed) down 16% from 33,029 in the 2019/20 reporting year. Similarly, there was a downward trend with the number of admissions to low intensity rehab in CCC with 19,259 admitted in 2020/21 compared to 27,103 admitted in 2019/20.

Across all legacy LHINs, the number of patients admitted to NRS-reporting beds in 2020/21 was lower than in previous years; however, variation within the legacy LHINs was noted. The C legacy LHIN reported the greatest decrease in admissions with a 79% reduction compared to 2019/20. In contrast, other legacy LHINs (TC, WW, CE, SE) had relatively stable volumes (within 8%) of the previous 2019/20 reporting year.

Legacy LHIN	Notable admission findings
C	<ul style="list-style-type: none"> 79% reduction in patient volumes with a 60% reduction in medically complex, 42% reduction in orthopedic conditions and 30% reduction in the number of patients admitted for stroke
CE	<ul style="list-style-type: none"> 4% reduction overall with a 30% decrease for stroke, 47% decrease for brain dysfunction and 32% decrease for medical complexity
CW	<ul style="list-style-type: none"> 44% reduction in overall volume with a notable 34% reduction in patients admitted for orthopedic conditions
CH	<ul style="list-style-type: none"> Overall decrease of 12% and a 41% reduction in patients admitted with pulmonary conditions
ESC	<ul style="list-style-type: none"> 20% reduction in overall admissions but 25% increase in patients admitted for debility
HNHB	<ul style="list-style-type: none"> 24% reduction in overall admissions but 20% increase in patients admitted with medically complexity
MH	<ul style="list-style-type: none"> 14% reduction in overall volume with 34% increase in patients admitted for debility and a notable 47% decrease in patients admitted for medical complexity
NE	<ul style="list-style-type: none"> 32% reduction in overall patient volumes, 38% decrease in neurological conditions, 67% increase in spinal cord dysfunction, 53% reduction in cardiac, 79% reduction in debility
NSM	<ul style="list-style-type: none"> Overall 14% reduction in patient volumes with a 32% increase in the volume of patients admitted for debility

NW:	<ul style="list-style-type: none"> • 14% reduction in overall volume, with 20% reduction in stroke volume
SE	<ul style="list-style-type: none"> • Overall relatively stable volumes with a slight decrease of 2%; a notable decrease in brain dysfunction by 41% and a significant change in medically complex patients with an increase of 271%
SW	<ul style="list-style-type: none"> • 13% reduction in overall admissions but 67% increase in patients admitted for debility
TC	<ul style="list-style-type: none"> • Overall relatively stable admission rate with 2% increase in volumes
WW:	<ul style="list-style-type: none"> • 8% reduction in overall admissions but 63% increase in patients admitted for cardiac

Interestingly, over the last few years there have been notable reductions in admissions for orthopedic conditions with the roll out of bundled care. In 2020/21, there was a 24% reduction in admissions for orthopedic conditions. This was likely attributable to the pandemic related postponement and cancellation of elective surgeries to assist with capacity planning in acute care facilities. Another noteworthy mention is the 13% increase in the volume of patients admitted for debility. Anecdotal reports from provincial stakeholders suggested that patients were discharged from acute care into inpatient rehabilitation rapidly and this could explain this provincial increase in patient volumes for debility.

Alternate Level of Care (ALC)

- Of the approximate 47,139 patients admitted to inpatient rehabilitative care — either an NRS reporting bed or CCRS reporting bed — there was an ALC designation in acute care for 18,026 or 38% of those patients. The number is up slightly from the year prior which was at 34%. The remaining patients (62%) accessed inpatient rehab without being designated as waiting an alternative level of care i.e., with no recorded wait time. This is a slight decrease from the year prior which was 66% in the previous year.
- 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 38% of all patients who were admitted to inpatient rehabilitative care.
- In 2020/21, there were a total of 18,376 adult acute care patients who were designated as ALC waiting for inpatient rehabilitative care. The majority of these patients (73%) were waiting for an NRS bed, followed by 17% waiting for a low intensity rehab bed (CCC-LTLD), 9% waiting for a non low intensity bed (CCC-non-LTLD) bed, and 2% waiting for a convalescent care program (CCP) bed.
 - The percentage of patients waiting for an NRS bed, and a CCC-LTLD or CCC-non-LTLD bed have not changed significantly from the year prior.

- The percentage of individuals admitted into the different rehab programs was as follows: other rehab 29%, musculoskeletal 23%, geriatric 18%, neurologic 17%, followed by LTLD 12%.
- The biggest difference was for CCP beds which had a reduction from 10% to 2% in this reporting year. This is the result of the provincial policy that suspended short stay CCP beds in LTC homes.
- More patients had a wait time in acute care prior to being transferred to inpatient rehab or CCC than the previous year as demonstrated by the 4% decrease (66% to 62%) from the 2019/20 to 2020/21.

Inpatient Rehab: Measures of Functional Change

Hospitals have been under extraordinary pressure to transfer patients quickly through the health system which resulted in patients with higher medical acuity and complexity being admitted into rehabilitative care. In 2020/21, nine out of the 17 RCG categories admitted patients with lower admission FIM™ scores, (indicating patients are being admitted at lower functional independence) compared to the 2019/20 year; however, when calculated together the provincial average admission FIM™ score was slightly higher (74.4) than it was in 2019/20 (72.7). This is a surprising trend but it was notably higher in the categories of spinal cord dysfunction, amputation of limb, major multiple trauma, and medically complex patients.

It was also noted that the average total FIM™ change score has been consistent for the last three years at 24.0 but had a marked decrease in 2020/21 to 21.8. This reduction in change score represents patients being discharged from inpatient rehabilitation programs at a lower functional level than they had in previous years likely due to pressures with moving patients quickly through the system.

The other indicator that looks at functional independence over time is the active length of stay (aLOS) efficiency. This indicator is a measure of the total FIM™ change over the patient's active length of stay. Active length of stay (aLOS) efficiency has been stable at 1.3 from 2014/15 to 2018/19. There was a slight decrease in aLOS efficiency in 2019/20 to 1.2, but it was back up to 1.3 in 2020/21. 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.

Secondary Fall Prevention

The provincial age standardized rate of ED visits for falls among community-dwelling older adults was 3,934 per 100,000 which is a decrease from 4,873 per 100,000 in 2019. The lower rate of ED visits for community dwelling older adults for falls was demonstrated with six (WW, CE, TC, C, MH, CW) of the 14 legacy LHINs having rates below the provincial rate. The downward trend was consistent across all legacy LHINs demonstrating the lowest rates since the RCA started reporting on this indicator. As previously stated, the downward trend in fall related ED visits can likely be attributed to the provincially

mandated public health measures during the pandemic and the likelihood that less individuals engaged in social or recreational activities that could be attributed to falls.

It is important to note that historically, ED visits due to falls has been decreasing since 2016 though this significant decrease is a direct result of the pandemic and should be monitored over time.

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 reviewed the current indicators and realigned them with the Quadruple Aim approach to analytics. As additional indicators have been proposed for the framework, ongoing work is needed to identify indicators that are no longer serving the purpose of measuring for strategic quality improvement or being used to identify opportunities that will drive high value rehabilitative care. In addition, a health equity lens will be used to further develop the Evaluation Framework and data collection strategies. Collecting and examining social, environmental and access to care indicators will help identify and reduce unnecessary and avoidable differences in access and outcomes associated with rehabilitative care.

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- Linda Huestis

Institute of Clinical Evaluative Sciences

- Ruth Hall, Adjunct Scientist
- Haley Golding, Epidemiologist

Indicator Development Task Group Chair:

- Marie Disotto-Monastero, Sunnybrook Health Sciences Centre

Ontario Health, Health System Performance and Support

- Candice Tam, Group Manager, ALC and Mental Health

Ontario Health, Health System Performance and Support Division

- Cheryl Bostock, Manager Information Management
- Leicester Fung, Health Data Analyst

Ontario Hospital Association – Performance Dashboard Development:

- Maggie Fung – Director, Data and Analytics
- Ali Sadri – Senior Business Intelligence Specialist
- Yilin Xie - Business Intelligence Specialist

System Evaluation Advisory Group Chair:

- Imtiaz Daniel, Ontario Hospital Association

University Health Network - Decision Support

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Rehabilitative Care Alliance

E: info@rehabcarealliance.ca

700 Bay Street, Suite 601

P: 416-597-3057

Toronto, ON M5G 1Z6