Rehabilitative Care Alliance

Rehabilitative Care System Performance Report 2021/22

Summary Report

APRIL 2023

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INTRODUCTION

The Rehabilitative Care Alliance (RCA) is pleased to share the 2021/22 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:

- The interactive dashboard with all data presented graphically to show regional and organization level data, in addition to trends over time.
- 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 data reported in this summary.

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

- National Rehabilitation Reporting System (NRS)
- Complex Continuing Care Reporting System (CCRS-CCC)
- National Ambulatory Care Reporting System (NACRS)
- 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 presents data collected during the COVID-19 pandemic. Provincially mandated public health measures, postponed surgeries, and health and human resource (HHR) issues have had a significant impact on all areas of the health care system, including rehabilitative care.

A new addition to the summary report is the inclusion of data from the rehab provider experience survey. The survey was launched in September 2022 and provides an initial glimpse into provider experience that is unique to rehab professionals. The indicators for provider experience have not yet been established therefore a summary is shared in this report but the data is not yet included in the dashboard.
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.

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 benchmarked indicators and eleven supplementary indicators. The indicators have been mapped to the Quintuple Aim approach to analytics with the five domains of: Population Health, Patient Experience, Provider Experience, Value/Efficiency and Health Equity.[1] Data for Provider Experience and Health Equity is not yet available but will be included in future reports.

The three benchmarked and eleven supplementary indicators were selected because the data for them is both available and reliable.

Benchmarks were previously established by an expert panel based on evidence and performance across the province.

Highlights from the 2021/22 report

The 2021/22 fiscal year was marked by the ongoing presence of COVID-19, high rates of seasonal flu, respiratory syncytial virus (RSV) and unprecedented workforce shortages. The HHR issues typically noted in rural and remote regions now impact every sector and every region of the province. The stress from the pandemic, coupled with an older workforce retiring and staff choosing to leave health care has placed enormous pressure throughout the health care system. The 2021/22 system performance data provides insight into the state of rehabilitative care across Ontario and a baseline understanding of rehab providers experiences in the wake of the pandemic and the complex issues facing the entire health care system.

Data trends in the 2021/22 reporting year are notably different than previous reporting years. While the data was fairly stable between the 2019/20 and 2020/21 years, there are changes in 2021/22 for wait times for in-home rehab, and the rate of repeat ED visits for falls among older adults living in the community.

- Consistent with previous years, no legacy LHIN reached the three-day benchmark for 90th percentile wait for any inpatient rehab bed type this year. The lowest 90th percentile wait for high-intensity rehab was 9 days in the SW and NW legacy LHINs. While there is regional variability in wait times, there is much more variability in wait times across bed types.
- There was a significant increase in the number of patients admitted to high-intensity and low-intensity rehabilitative care. In 2021/22, there were 57,645 patients admitted to inpatient rehab, an increase of 10,506 from the previous reporting year yet still not at the pre-pandemic level of 60,134 in 2019/20.
- Sixty-six percent of patients were admitted to inpatient rehab without being designated as awaiting an Alternate Level of Care (ALC), i.e., with no recorded wait time. This was consistent with the pre-pandemic rate of 66% noted in the 2019/20 reporting year.
- The largest change in the 2021/22 data was the wait time for in-home rehab.
    - The 90th percentile wait for adult long stay occupational therapy rose to 27 days, up from 15 days the year prior. The 50th percentile wait for this discipline was 7 days, up from 5 days the year prior.
    - Similar trends were noted in adult long stay physiotherapy with the 90th percentile wait time rising to 21 days, up from 15 days in 2020/21. The 50th percentile wait for this discipline was 7 days, up from 5 days the year prior.

- In 2021, the provincial rate of repeat ED visits for falls in community-dwelling older adults per 100,000 was 759 down from 849 the previous calendar year. There is a downward trend noted from 838 in 2018 and 847 in 2019. The benchmark for this indicator was calculated to be 491 this year, the lowest it has ever been.

The 2021/22 year was an especially challenging year with the impact of multiple waves of COVID-19 variants coupled with unprecedented staffing shortages. Although variability in performance is expected from year to year, there were considerable regional and provincial differences observed.

- Four legacy LHINs (CW, TC, ESC, C) reported 90th percentile wait times less than the provincial average of 13 days for high-intensity inpatient rehab, with a range of nine to 12 days. The three-day benchmark for 90th percentile wait time for a high-intensity inpatient rehab bed remains aspirational.
    - However, it should be noted that wait time data is only available for those patients with an alternate level of care designation. As such, wait time data is currently unavailable for those patients without an ALC designation and who may be transitioning to rehab within the benchmark.
- Three legacy LHINs (TC, C, and CE) reported 50th percentile (median) wait times for inpatient rehab that were at or below the provincial average of 4 days for high-intensity rehab**.** The median wait time for high-intensity rehab rose by one day in 2021/22 and an increase from the previous reporting years that were stable at 3 days.
- The provincial average for the 90th percentile wait time for low-intensity rehab was 21 days with NW, HNHB, MH, ESC, CW, C and SE all performing at or below the provincial average.
- Three legacy LHINs CW (465), MH (502), C (506) reported the lowest age standardized repeat ED visits for falls in 2021. These rates were used to form the benchmark for this indicator of 491 and the lowest benchmark calculated to date.
- The following sub regions demonstrated age standardized rates of repeat ED visits for falls below the benchmark for 2021: Bramalea (CW), Scarborough North (CE), North West Mississauga (MH), Bolton-Caledon (CW), Eastern York Region (C), Brampton (CW), North Etobicoke Malton West Woodbridge (CW), East Mississauga (MH), Tecumseh Lakeshore Amherstburg LaSalle (ESC), Eastern Ottawa (CH), South West Mississauga (MH), North York Central (C), Burlington (HNHB), Scarborough South (CE), Western Ottawa (CH), and North York West (C).

While the biggest changes in the 2021/22 reporting year were the increased wait times for in-home rehab, there were also significant improvements noted in the rate of repeat ED visits for falls. The data also highlight how sub-regions, organizations, legacy LHINs and the Ontario Health regions are performing year over year. The performance data in this report and dashboard can be used by regional tables to identify opportunities for improvement.

REHABILITATIVE CARE IN ONTARIO 2021/22

The reporting of health system performance data, specific to rehabilitative care, is essential to improve care delivery, and enhance patient outcomes. The development of the performance report and dashboard was conducted in several stages, with provincial partners engaged in all aspects of the work.

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

- Utilize data derived from existing and reliable data sources
- Share performance data with partners intentionally and sensitively
- Utilize existing targets and benchmarks where available and appropriate
- Be transparent in the methodology used
- Calculate benchmarks for indicators to drive change, when the desired change is both meaningful and the impact of the change is understood
- Include patients and care partners in the benchmarked indicator selection process.

For this reporting period, data is available on the 14 legacy LHINs and the 6 Ontario Health Regions in the dashboard. In this report, only the legacy LHINs are summarized.

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

The following sections provide a summary of the benchmarked indicators and supplementary indicators that have been reported annually by the RCA since 2016. More detail on these indicators and the data sources can be found in the accompanying technical manual.

BENCHMARKED INDICATORS

Wait time for Inpatient Rehabilitative Care

This indicator should be interpreted with caution as 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 complex continuing care beds (CCC-LTLD) and activation/restoration beds such as convalescent care program beds offered in long term care (LTC) facilities (CVC).

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 (CVC) beds. The suspension of the CVC beds resulted in very limited data for the 2020/21 reporting year but volumes started to increase in 2021/22.

Of note, the 90th percentile wait for high-intensity inpatient rehab was 12 days for the last three years. In 2021/22 that number rose to 13 days; this was also associated with a greater volume of patients admitted to high-intensity rehab, 16,559 admitted in 2021/22 and 13,371 admitted the previous year.

Conversely, the 90th percentile wait for low-intensity rehab decreased by one day to 21 days which was also associated with a decrease in the volume of patients admitted 3,589 compared to 4,655 the previous reporting year.

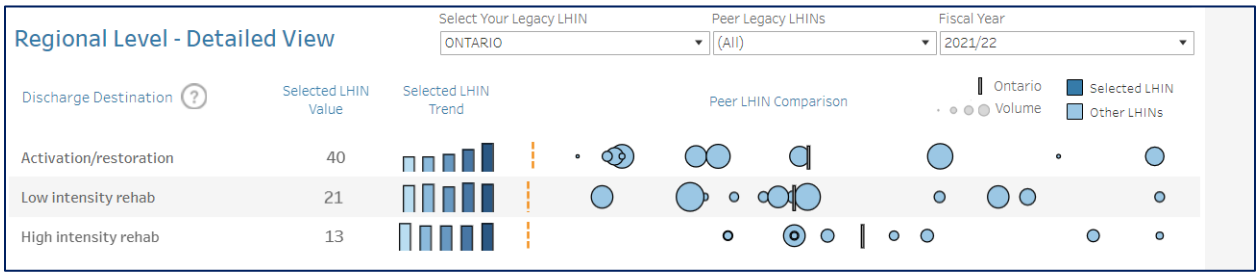

Figure 1: RCA System Performance Dashboard view of 90th% Wait Time for Inpatient Rehab in Ontario for 2021/22

During the first year of the pandemic, the suspension of short-stay convalescent care beds or activation/restoration beds (CVC-reporting beds) resulted in a large reduction in the volume of admissions. Although the suspension is no longer active, the volume of admissions for 2021/22 was at 696, just about double the number from 2020/21 reporting year. There was also a large jump by eight days for the 90th percentile wait for activation/restoration beds (CVC) to 40 days from 32 days in the previous reporting year. This was likely attributed to the delayed re-opening of these beds in some homes.

High performers

The legacy LHINs that achieved a 90th percentile wait below the provincial average for high-intensity inpatient rehab in the 2021/22 year were CW (9 days), TC (11 days), ESC (11 days), and C (12 days).

The legacy LHIN with the shortest 50th percentile wait time for high-intensity rehab was TC (3 days) and C (3 days) which was one day below the provincial median wait time of 4 days. CE matched the provincial average for 50th percentile wait for high-intensity rehab.

Opportunities for improvement

Again, in the 2021/22 reporting year, no legacy LHIN achieved the provincial benchmark of three days for 90th percentile wait and it remains an aspirational benchmark. The 90th percentile wait and median percentile wait time times in the 2021/22 reporting year were longer and more variable in terms of legacy LHINs than previous reporting years. The variable volumes of patients combined with the impact of the pandemic and HHR issues may have contributed to performance across bed types for this reporting year.

ALC

There was a significant increase in the number of patients admitted to inpatient rehabilitative care in this reporting year. There were approximately 57, 645 patients admitted to inpatient rehabilitative care, an increase of 10,506 from the previous reporting year (47,139); however, the admission volumes are still lower than the 2019/20 pre-pandemic year (60,132). There was an ALC designation in acute care for 20,148 or 34% of patients, which is a decrease or improvement from the previous reporting year where 38% of patients waiting for inpatient rehab were deemed ALC. This implies that 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 66% was consistent with the 2019/20 reporting year and the increase noted in 2020/21 may have been attributed to the increased pressures in acute care caused by the pandemic.

Wait time for In-home Rehabilitative Care

The 2021/22 reporting year notes a large jump in the 90th percentile wait for in-home rehabilitative care. The benchmark for this indicator is set at five days for the 90th percentile wait but it is four to five times that across the disciplines. This reporting year, the 90th percentile wait for long stay occupational therapy rose to 27 days from 15 days in 2020/21. Similarly, long stay physiotherapy rose to 22 days from 15 days. The increases were not quite as marked for long stay social work which went from 22 days up to 26 days and long stay speech-language pathology which rose from 17 to 21 days for the 90th percentile wait.

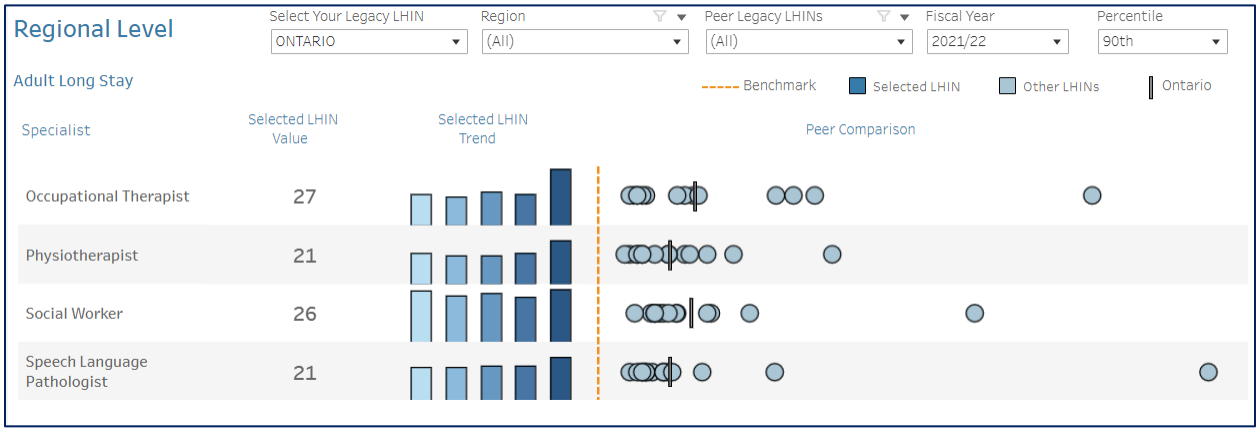

Figure 2: RCA System Performance Dashboard view of Adult Long Stay 90th% Wait Time for In-home Rehab in Ontario for 2021/22

The median wait times for in-home rehabilitative care in Ontario also jumped from five to seven days for long stay occupational therapy and physiotherapy. There was no change for long stay social work and a one day increase to seven days for long stay speech-language pathology. A similar one day increase to eight days was noted for short stay social work and a two day increase for short stay speech-language pathology.

The other notable increase in wait times for in-home rehab was with respect to volumes. In 2020/21 the volume of long stay in-home rehab across the disciplines was 213,238, this rose to 227,170 in 2021/22 with a difference of 13,932. The largest increase in volumes was with long stay physiotherapy with 87,856 an increase of 12,233 from 2020/21. Other increases were noted in speech-language pathology with an increase of 1,491 and social work 1,506 in this reporting cycle. Surprisingly, there was a decrease in the volume of long stay occupational therapy patients by 1,298 in the 2021/22 reporting year which may have been attributed to the longer than usual wait times.

The total volume of short stay in-home rehab was 77,516 for all disciplines up from 70,727 in the previous reporting year. The largest increase in short stay volumes was for physiotherapy with 34,734 up 4,112 from the previous year.

The wait times for short stay in-home rehab also increased across all disciplines. The largest increase was for occupational therapy with a jump from 17 days to 30 days for the 90th percentile wait. The increase was only two days up from five to seven for the median wait time for both occupational therapy and physiotherapy. Physiotherapy also had an increase in 90th percentile wait from 14 to 22 days. Short stay social work had minor increases of one day for median wait and up four days to 28 for 90th percentile wait. Similar smaller waits were noted for short stay speech-language pathology with a two day increase to eight days for the median wait and up two days to 23 days wait for the 90th percentile.

High performers

The 90th percentile wait for long stay in-home rehab had higher than normal wait times across disciplines. While no legacy LHIN or discipline was able to achieve the benchmark of five days for 90th percentile wait, a median wait time of four days was achieved for the NW legacy LHIN for long stay speech-language pathology, and median wait of five days was achieved for the NW with long stay occupational therapy, in ESC and MH in long stay physiotherapy, CW and NE in long stay social work.

For long stay occupational therapy, eight of the legacy LHINs were below the provincial average of 27 days. The legacy LHINs with the lowest 90th percentile wait for long stay occupational therapy were: ESC (12 days), NW (13 days), MH (14 days), C (14 days), CW (15 days), HNHB (16 days), CE (23 days) and SW (25 days).

Similar trends were noted in long stay physiotherapy with seven legacy LHINs having a 90th percentile wait below the provincial average of 21 days. The legacy LHINs below the provincial average were: ESC (11 days), MH (12 days), HNHB (14 days), CW (14 days), C (15 days), NW (15 days), CE (18 days).

Opportunities for improvement

This year it is evident that the historical HHR issues, combined with the system impact from the pandemic, influenced wait times for in-home rehab. The RCA has been publishing the wait times for in-home rehab since the 2017/18 reporting year and never have the 90th percentile wait times been as high as they were reported this year. However, it is noted that practices across legacy LHINs may vary with

respect to how referral to in-home rehab services are prioritized and health professional resources utilized. For example, a patient with a more urgent need for in-home rehab service may be prioritized over other, less urgent referrals. In other words, patients with a higher risk or more urgent need for service may be seen within the five-day benchmark, while patients with a less urgent need may wait longer. The data in this report does not differentiate in the level of urgency between referrals.

It was also noted that the volumes of in-home rehab have grown, especially for long stay physiotherapy. A potential source for the increase in long stay physiotherapy volumes is the recent shift towards same day surgeries for Bundled Care hip and knee arthroplasty. It was voiced in an RCA Bundled Care Task Group that although more patients are being discharged the day of the surgery, more are referred for in-home rehab to optimize recovery and the resources are simply shifting from acute care to community care for these patients.

It is also important to consider the impact of the HHR issues that impact the entire system. Historically, rehab professionals have been less likely to opt for community-based work as hospital-based work has tended to offer higher salaries, mentorship and professional development opportunities. The issues impacting the rehab workforce are being explored in the RCA workforce initiative and plans are underway to further this strategic work in the 2023/24 work plan.

Repeat ED visits due to falls

In the 2021 calendar year, the provincial rate of repeat ED visits for falls among community-dwelling older adults was 759 per 100,000 older adults. This is higher than the targeted benchmark of 445 but lower than the previous provincial average of 849.

A total of 118,328 patients visited the ED for a fall in 2021, with 18,318 or 15% being repeat visits. This represents a decrease of 6% down from 21% in the 2020 year. The improvement in the repeat ED rate may be attributed to less older adults seeking care for falls in the ED during the pandemic due to concerns about contracting COVID-19 from acute care facilities.

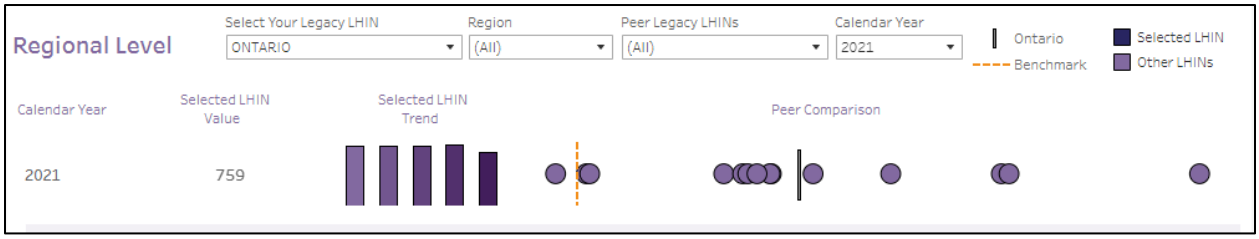

Figure 3: Rate per 100,000 of Fall-Related Repeat ED visits for older adults aged 65 years+ in 2021

High performers

In 2021, the age standardized rate of repeat ED visits for falls among adults 65 years and over by legacy LHIN ranged from 407 to 1040 per 100,000. In 2020, the age standardized rate of repeat ED visits for falls among adults 65 years and over ranged from 606 to 1,143 per 100,000 across sub-regions representing a slightly higher rate than the 2021 reporting year.

Several legacy LHINs demonstrated rates of repeat ED visits for falls among older adults below the provincial benchmark: CW, MH, C, CE, and TC. This is an improved performance for the TC legacy LHIN and CE legacy LHIN as they were above the provincial average in the 2020 reporting year.

A large proportion of the sub-regions scored below the provincial average for the 2021 reporting year. These include: Bramalea (CW), Scarborough North (CE), North West Mississauga (MH), Bolton-Caledon (CW), Eastern York Region (C), Brampton (CW), North Etobicoke Malton West Woodbridge (CW), East Mississauga (MH), Tecumseh Lakeshore Amherstburg LaSalle (ESC), Eastern Ottawa (CH), South West Mississauga (MH), North York Central (C), Burlington (HNHB), Scarborough South (CE), Western Ottawa (CH), North York West (C), South Etobicoke (MH), Western York Region (C), Essex South Shore (ESC), Kitchener-Waterloo-Wellesley-Wilmot-Woolwich (WW), North Toronto (TC), Oakville (MH), Barrie and Area (NSM), Mid-West Toronto (TC), Rural Hastings (SE), Northern York Region (C), South Simcoe (C), Niagara North West (HNHB), Milton (MH), Windsor (ESC), Durham West (CE), South Georgian Bay (NSM), West Toronto (TC).

Opportunities for improvement

A contextual factor to note, the rate of repeat ED visits for falls may be higher in rural and remote regions due to the ED being the only place to receive primary care after hours and on weekends. It was also reported that in some communities in northern Ontario, the ED is the only place to access necessary diagnostic imaging such as x-rays and may be contributing to the higher rates in those regions.

At a provincial level, 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 includes: i) Rehabilitative Care for Older Adults Living With/At Risk of Frailty Best Practice Framework ii) Post-Fall Pathways Pilot Report iii). Emergency Department Post-Fall Pathway iv). Primary Care Post-Fall Pathway.

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.

To reduce functional decline and improve patient outcomes, it is essential to integrate rehabilitative care services into secondary fall prevention pathways for older adults with frailty. The RCA is therefore working collaboratively with partners to implement secondary fall pathways across Ontario and most recently, is preparing for a Paramedic Post-Fall Pathway pilot in partnership with community paramedicine services.

SUPPLEMENTARY INDICATORS

The overall number of patients admitted into a high-intensity rehab (NRS-reporting bed) was up 6% in 2021/22 at 28,484 from 26,861 in 2020/21. This is still lower than the pre-pandemic reporting year of 2019/20 when there were 33,029 admissions.

Similarly, there was an upward trend of 34% in the 2021/22 reporting year with 29,161 admissions to low-intensity rehab and complex continuing care programs (CCRS-reporting beds) versus 19,259 admitted in 2020/2021.

Consistent with previous years, the Resource Utilization Group (RUG) most frequently reported for low-intensity rehab in CCRS-reporting beds was special rehab-medium at 15%, followed by special rehab-low at 4%, special rehab-high at 2%, and special rehab-very high at 1%.

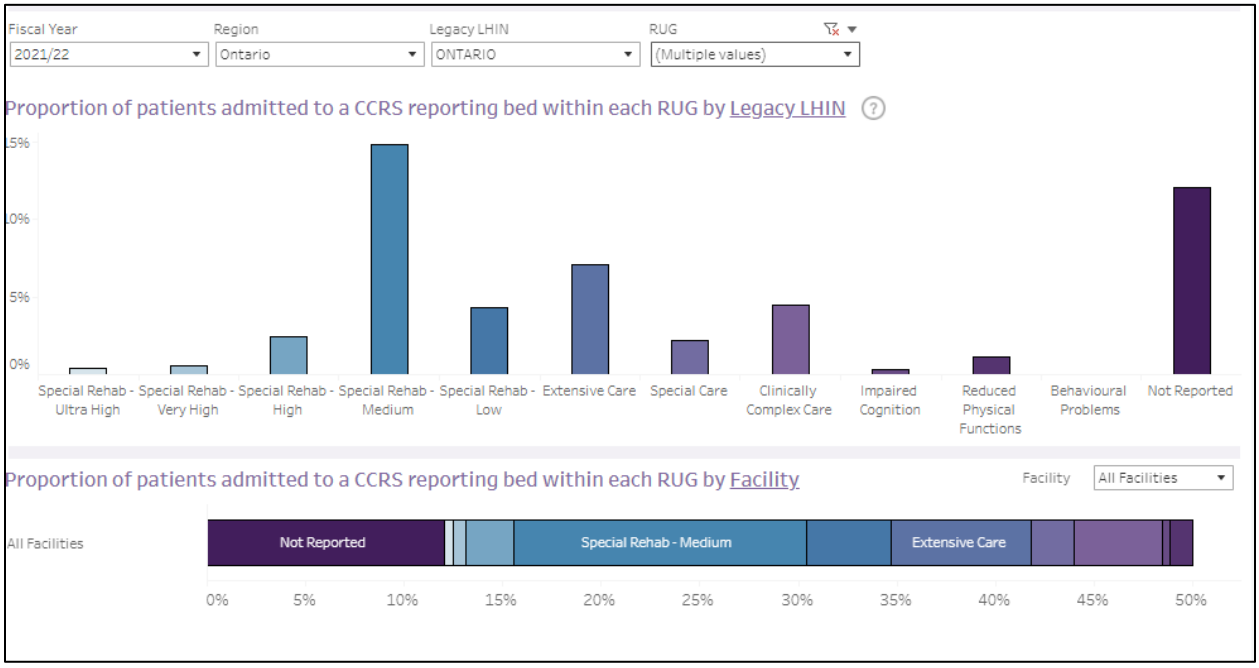

Figure 4: The proportion of patients admitted to a CCRS-reporting bed by RUG

Across all legacy LHINs, the number of patients admitted to high-intensity rehab beds in 2021/22 was up slightly from 2020/21; however, there remains significant variation within the legacy LHINs.

The CW legacy LHIN reported the greatest increase in admissions with a 57% increase in overall admissions; whereas most of the other LHINs saw less dramatic changes from the previous reporting year. Several legacy LHINs (CE, CH, HNHB, MH, NE, NW, SE, TC, and WW) had relatively stable volumes (within 8%) of the previous 2020/21 reporting year.

Legacy LHIN	Notable admission findings for high-intensity rehab
C	• 15% increase in overall admissions with largest increase noted in 26% more stroke admissions in 2021/22
CE	• 4% reduction in overall admissions with a reduction in stroke by 10%, a reduction in medically complex by 22%, and an increase in orthopedic admissions of 10% and debility by 13%
CW	• 57% increase in overall admissions, with the largest increases noted in medically complex 58%, orthopedic conditions 59%, and stroke 30%
CH	• 6% increase in admissions, with largest increases in debility with the number of admissions doubled, a 16% in orthopedic conditions

ESC	• 10% increase in overall admissions with the largest increase noted at a 21% increase in orthopedic conditions
HNHB	• admission rates were consistent with very minimal changes across the RCG categories
MH	• overall admission rates were consistent with the previous year, there was a 22% increase in the rate of admission for medically complex
NE	• 4% reduction in overall patient volumes, with the largest reduction being 10% in stroke
NSM	• 11% increase in patient volumes with the largest increase noted in debility
NW	• overall admission volumes were consistent with a decrease noted in brain dysfunction 42% and an increase neurological condition
SE	• overall stable admission volumes with a large increase of 81% in debility, 36% with spinal cord dysfunction and a decrease of 15% in orthopedic conditions
SW	• 13% increase in overall admissions with a large increase in the volume of admissions for amputation of limb at 227% and 16% increase for stroke
TC	• 8% increase in overall patient volumes with an 86% increase in pulmonary admission, 48% for cardiac and a 57% decrease in brain dysfunction
WW	• overall admissions were stable but a significant decrease of 103% in admissions for brain dysfunction, 39% increase in debility, and 12% decrease in admissions for orthopedic conditions

Interestingly, over the last few years there have been a notable reduction in admissions for orthopedic conditions. This year, there was an 8% overall increase in the number of orthopedic admissions to high-intensity rehab at 8,139 compared to 7,554 in 2020/21. This was likely due to the increase in arthroplasty surgeries related to the postponement of scheduled surgeries in 2020/21. This is an interesting finding as there was also a large shift towards same day surgeries for hip and knee arthroplasty in the 2021/22 reporting year.

Alternate Level of Care (ALC)

Of the 57, 645 patients admitted to inpatient rehabilitative care, there was an increase of 22% compared to the 47,139 patients admitted to inpatient rehabilitative care in 2020/21.

There was an ALC designation in acute care for 20,148 or 35% of patients waiting for high- intensity, low-intensity rehab and complex continuing care programs. This number does not include those waiting for an activation/restoration bed that is typically offered as convalescent care in a LTC home. This is a decrease from 38% reported last year and more in line with the 34% reported in the 2019/20 pre-pandemic year. It is assumed that the remaining 65% of patients accessed high-intensity, low-intensity inpatient rehab or complex continuing care without being designated as waiting an alternative level of care i.e., with no recorded wait time.

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 35% of all patients who were admitted to inpatient rehabilitative care.

In 2021/22, there were a total of 20,844 adult acute care patients who were designated as ALC waiting for high-intensity, low-intensity inpatient rehab, complex continuing care or waiting for an

activation/restoration bed in a convalescent care program. The majority of these patients (80%) were waiting for high-intensity rehab, followed by 17% waiting for a low-intensity rehab bed or complex continuing care and 3% activation/restoration beds delivered as short stay convalescent care program beds in LTC.

- The percentage of patients waiting for a high-intensity rehab bed decreased from 89% to 80% in 2021/22 and there was an increase of 8% in the percentage of patients waiting for a low-intensity rehab or complex continuing care bed (17%) in 2020/21. The number waiting for an activation/restoration bed has been relatively stable at 3% up from 2% last year.
- The percentage of individuals admitted into the different rehab programs was consistently lower: other rehab 24% (down from 29%), musculoskeletal 18% (down from 23%), geriatric 15% (down from 18%), neurologic 13% (down from 17%), followed by low-intensity rehab 9% (down from 12%).
- The biggest difference was for activation/restoration beds which had an increase from 2% up to 3% in the 2021/22 reporting year which is still significantly lower than the 2019/20 reporting year was at 10% of activation/restoration beds. This is the result of the lifting of the provincial policy in 2020/21 that suspended short stay convalescent care program beds in LTC homes during the pandemic.
- Approximately 64% of patients had a wait time in acute care prior to being transferred to inpatient rehab which was up slightly from 62% in the 2020/21 reporting year but lower than the 2019/20 reporting year (66%).

Inpatient Rehab: Measures of Functional Change

Hospitals have been under extreme pressure to transfer patients quickly through the health system. It was reported in various task group meetings that patients with higher medical acuity and greater complexity were being admitted into inpatient rehabilitative care.

In 2021/22 the average admission FIM™ score across all 17 Rehab Client Group (RCG) categories was 71.6 down from 74.4 in 2020/21. This indicates that patients were being admitted at lower functional independence than in the previous year. Seven out of the 17 RCGs categories admitted patients with lower admission FIM™ scores, compared to 2020/21 (arthritis, major medical trauma, medical complexity, neurological conditions, orthopaedic conditions, pulmonary and spinal cord dysfunction).

It was also noted that the average total FIM™ change score that dipped last year to 21.8 has risen again to 24.4. The average total FIM™ change score had been consistent at 24.0 for the three years prior to the pandemic. The shift towards the higher change score suggests patients are achieving roughly the same functional gains in rehabilitative care in 2021/22 that they received prior to the pandemic. The decrease last year was likely due to the pandemic creating capacity pressures and the push to move 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 and continues to be stable in 2021/22 at 1.3 for all RCG categories at the provincial level.

Secondary Fall Prevention

The provincial age standardized rate of ED visits for falls among community-dwelling older adults was 4,691 per 100,00 which was an increase from 3,934 in 2020/21 and closer to the pre-pandemic rate of 4,873 per 100,000 in 2019. The rate of ED visits for community dwelling older adults for falls was demonstrated with nine (CW, MH, C, TC, ESC, CH, WW, CE HNHB) of the 14 legacy LHINs having rates below the provincial rate. That is three more legacy LHINs than last reporting cycle for 2020. There was a notable trend this year with the rate of ED visits for older adults being higher across the legacy LHINs than in 2020.

It is important to note that historically, ED visits and hospital admissions for community-dwelling older adults have been historically decreasing since 2016 though the significant increase this year for both ED visits and admissions may be a carryover effect from the pandemic as many community-dwelling older adults experienced a decline in functioning due to the lockdown mandates put in place for the pandemic, specifically the 2020 calendar year, and as such, these results should be monitored over time.

Rehab Provider Experience Survey

In the fall of 2022, the RCA launched the first ever rehab provider experience survey. The survey was developed to address a gap in data for the RCA's System Evaluation Performance Report. It was noted that none of the other provider experience surveys captured elements or disciplines specific to rehabilitative care. The RCA rehab provider experience survey was developed based on learnings from the existing surveys and through consultation with the professional associations (OT, PT, SLP and Kin) and with engagement from Dr. Ivy Bourgeault, Research Chair in Gender, Diversity and Professions at the University of Ottawa. The survey was available for one month and invitations to participate were sent out through the RCA distribution lists with snowball sampling.

The survey elements included:

- demographic information
- employment profile
- equity and inclusion
- stress and burnout

Rehab Provider Survey Results

For the first rehab provider experience survey, there were a total of 641 responses. The highest proportion or respondents were from the Ontario Health West (27%), Toronto (20%), East (19%), Central

(19%) regions. The North East (10%) and North West (7%) also had respondents. The snowball sampling technique made it difficult to calculate the response rate for the survey. As such, **the survey results should be interpreted with caution as the results do not represent the entire rehab workforce population.**

Demographics

Of the respondents, half (49%) reported working in an acute or post-acute hospital setting. The majority of respondents (90%) identified as female and just under half (44%) are 45 years or older and a third (36%) reported working in the rehab sector for 20 years or more.

The majority of respondents were from occupational therapy (32%), physiotherapy (21%), speech-language pathology (12%) followed by nursing (9%) and rehabilitation assistants (95). There were a large number of "other" disciplines identified (75) which included roles such as pharmacy, therapeutic recreation among others.

Equity and Inclusion Indicators

The RCA included questions about equity and inclusion to help inform future workforce planning initiatives and help bring awareness to the representation of rehab professionals. None of the questions in this section were mandatory and respondents could answer as many or as few as they were comfortable.

A few highlights to note were that 2% of respondents identified as being First Nations, Métis or Inuk/Inuit. Fifteen percent of the respondents identified as being born outside of Canada and seven percent identified as being Francophone.

Stress and Burnout

Stress and burnout of health care providers has been in the spotlight over the last two years with the added pressures of the pandemic now coupled with the unprecedented workforce shortages. Seventy-six percent of respondents reported feeling stress in their work life with 15% reporting high levels of burnout. Respondents were asked to compare the stress in their work life now to before the pandemic and 62% reported feeling that it was somewhat or much worse now. In addition, 75% of respondents reported that they were satisfied with their job overall and 54% reported that they are planning to stay in their role for 5 years or longer.

Respondents were also asked to provide any additional comments in an open-ended text box. Many respondents chose to leave additional comments and the most common theme from the comments was centred around moral distress. Many rehab providers identified enjoying their job and their work team but felt the amount of work, lack of resources or funding cuts was making it difficult for them to do their job well.

As this was the first iteration of the rehab provider experience survey, it provides an initial glimpse into the experience of rehab providers and will thoughtfully use this data to inform future RCA workforce

efforts. Planning efforts are underway to make ongoing improvements to the survey for its annual release in September 2023.

LOOKING AHEAD – QUALITY IMPROVEMENT OPPORTUNITIES

The vision of the RCA 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 partners 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 2022/23, the RCA System Evaluation Task Group reviewed the current indicators and explored gaps in data which led to the development of the rehab provider experience survey. It also identified the need for further exploration into the value/efficiency indicator and the potential use of patient reported outcome measures (PROMs) to serve this purpose. Preliminary work is underway to identify the collection of PROMs in rehabilitative care but a reliable data source has not yet been identified.

In addition, there is a continued commitment to explore implementing a health equity lens to the System Evaluation Framework. The RCA will be using a Quintuple Aim which includes the domain of Health Equity to the existing Quadruple Aim[1]. As well, the Ontario Health Toronto region released Measuring Health Equity Updated Core Questions in November 2022. The RCA will explore how to integrate this data set into the indicators and dashboard so that a health equity lens can be applied to rehabilitative care and interventions can be prioritized for the unique needs of equity-deserving population.

[1] Reference: Nundy, S., Cooper, L.A., Mate, K.S. (2022). The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. JAMA.327(6):521–522. doi:10.1001/jama.2021.25181

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