Rehabilitative Care Alliance

Rehabilitative Care System Performance Report 2022/23

Summary Report

MARCH 2024

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INTRODUCTION

The Rehabilitative Care Alliance (RCA) is pleased to share the 2022/23 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)
- 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)

There are two additions to the 2022/23 System Performance Summary Report and dashboard, the inclusion of length of stay data and volume data for high-intensity rehab by the Rehab Client Group (RCG). This data was identified as having value to system planning and is in addition to the existing value/efficiency indicator for the average length of stay efficiency for high-intensity rehab.

In 2023, the Rehab Provider Experience Survey was once again circulated. The survey was available during the month of September and shared via the RCA distribution list, professional associations and organizations. The indicators for provider experience have not yet been established therefore a summary is shared in this report and on the RCA website but the data is not 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 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 is both available and reliable for yearly reporting.

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

Highlights from the 2022/23 Report

The 2022/23 fiscal year was marked by unprecedented workforce shortages and ongoing capacity issues. In this reporting cycle, the COVID-19 language shifted from pandemic to recovery, and organizations experienced enormous capacity pressures as they attempted to decrease the backlog of patients waiting for surgery, and put a renewed focus on eliminating the volume of patients in acute care waiting for an alternative level of care (ALC). The system constraints coupled with widespread staffing challenges have strained all parts of the healthcare system, including hospitals, community programs and in-home rehab. The impact of these challenges is reflected in the 2022/23 System Performance data.

Data highlights from the 2022/23 reporting year are as follows:

Inpatient rehab wait-times

- In 2022/23, there were 43,361 patients admitted to inpatient rehab, down from 57,645 the previous reporting year, a difference of 14,284 or 25%. The volume of patients in 2022/23 was similar to the 2020/21 year at 47,139 but it is still much lower than the pre-pandemic reporting year of 60,132 in 2019/20.
- 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.
- Of note, the provincial 90th percentile wait for high-intensity inpatient rehab was 12 days in 2018/19 - 2020/21,13 days in 2021/22 and up to 15 days in 2022/23.

***New* – Average Length of Stay in high-intensity rehab**

- New this reporting year, data on the average length of stay (LOS) by rehab client group (RCG) for inpatient high-intensity rehab is available. The desire to monitor this data stemmed from an increased focus on rehab utilization following hip/knee arthroplasty and initial activities related to specialized rehab capacity planning.
- The longest average length of stay provincially by RCG was for traumatic spinal cord dysfunction (31.9 days), major multiple trauma (31.3 days) and burns (28.8 days). The RCGs with the lowest average length of stay provincially include other disabling impairment (16.9 days), and arthritis (17.9 days). Other RCGs of interest include stroke (28.4 days), pulmonary (20.7 days), and cardiovascular (20.5 days) inpatient rehab.

In-home rehab wait-times

- The number of long-stay in-home rehab visits decreased from 227,170 in 2021/22 to 217,791 in 2022/23, a decrease of 9,379 visits.
- Large differences were noted in the 2022/23 wait time data for in-home rehab. The 90th percentile wait for adult long-stay occupational therapy rose to 40 days, up from 27 days in 2021/22 and 15 days the year prior.

    - The 50th percentile wait for occupational therapy was 7 days, consistent with the year prior.
- The 90th percentile wait for short-stay occupational therapy was 54 days, up from 30 days in 2021/22 with the 50th percentile wait increasing to 8 days.
- Similar trends were noted in adult long-stay physiotherapy with the 90th percentile wait time rising to 30 days, up from 21 days in 2021/22 and 15 days in 2020/21.
    - The 50th percentile wait for this discipline was 7 days, consistent with the year prior.

ALC Trends

There was an ALC designation in acute care for 21,732 of the 43,436 (or 50 %) of patients waiting for high-intensity and low-intensity rehab. This number does not include those waiting for an activation/restoration or convalescent care bed that is typically offered in an LTC facility.

- It is assumed that the other 50 % of patients accessed high-intensity rehab or low-intensity rehab without being designated as waiting for an alternative level of care i.e., with no recorded wait time.
- This is a significant increase in ALC rates from the 35 % reported in 2021/22 and 38% reported in 2020/21.

Falls

- The provincial rate of repeat ED visits for falls decreased from 759 per 100,000 in 2021 for adults aged 65 and over living in the community to 745 in 2022. The benchmark for this indicator went up to 522 based on the performance of the top three legacy LHINs with CW having the lowest rate at 462 per 100,000, followed by MH at 503 and C at a rate of 601. These three legacy LHINs were also the top performing for the rate of repeat visits to ED in 2021.

While a large increase in average provincial wait times was noted for inpatient and in-home rehab in 2022/23, there was also a significant decrease in the volume of patients admitted across all RCGs in high-intensity rehab and patient visits for in-home rehab. Also, there was a significant increase in the ALC rate for patients waiting in acute care for inpatient rehab beds. While the data highlight provincial trends and year-over-year trends, it may not reflect the contextual nuances that impact the data at a sub-regional, organizational, legacy LHIN or an Ontario Health region level.

REHABILITATIVE CARE IN ONTARIO 2022/23

The reporting of health system performance data, specific to rehabilitative care, is essential to improve care delivery and enhance patient outcomes. The performance report and dashboard were 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, wherever possible
- 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 6 Ontario Health Regions, the 14 legacy LHINs 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 Brant: 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 (CVC) program beds offered in long term care (LTC) facilities.

The 90th percentile wait for high-intensity inpatient rehab had been stable at 12 days between 2018/19, 2019/20, and 2020/21. That number rose to 13 in 2021/22 and rose again to 15 days in 2022/23. A similar trend was seen with the 50th percentile wait as it had been stable at six days but rose to seven days in 2022/23.

Similarly, the 90th percentile wait for low-intensity rehab increased from 21 days to 22 days in 2022/23. This was also associated with a slight increase in the volume of patients admitted to low-intensity rehab which was 4,052 compared to 3,589 compared to the previous reporting year.

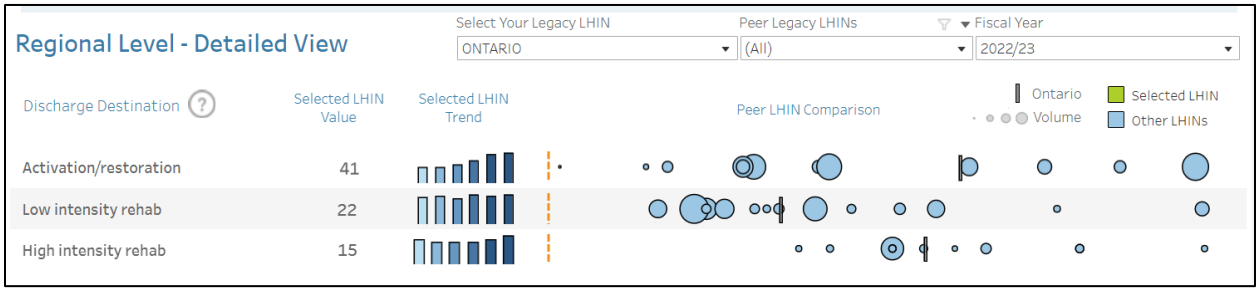

Figure 1: RCA System Performance Dashboard view of 90th Percentile Wait Time for Inpatient Rehab in Ontario for 2022/23

During 2020/21, the suspension of short-stay convalescent care beds (CVC-reporting beds) resulted in a large reduction in the volume of admissions. The suspension was terminated in 2021/22 and there was an increase in the volume of admissions with 1,013 admitted in 2022/23 up from 696 in 2021/22 and 350 in the 2020/21 reporting year. There was also a significant increase in the 90th percentile wait of 41 days for convalescent care beds (CVC) and a 50th percentile wait of 16 days compared to the prior reporting year.

The provincial average for the 90th percentile wait for high-intensity rehab in 2022/23 was 15 days. The following legacy LHINs had a 90th percentile wait below that average and included: ESC (11 days), CW (12 days), SW (14 days), HNHB (14 days), TC (14 days), and C (14 days).

The legacy LHIN with the shortest 50th percentile wait time for high-intensity rehab was ESC (3 days) one day below the provincial median wait time of 4 days. Several legacy LHINs matched the provincial average of 4 days for the 50th percentile wait for high-intensity rehab: CW, HNHB, TC, C, NE, and NW.

In the 2022/32 reporting year, no legacy LHIN achieved the provincial benchmark of three days for a 90th percentile wait and it remains an aspirational benchmark. The 90th percentile wait and median percentile wait time times in the 2022/23 reporting year were higher than the previous reporting year, and more variable in terms of legacy LHINs than in previous reporting years. The increased capacity pressures combined with the impact of the widespread HHR issues may have contributed to the increase in wait times for inpatient rehab across rehab bed types for this reporting year.

Wait time for In-home Rehabilitative Care

The 2022/23 reporting year noted another large jump in the 90th percentile wait for in-home rehabilitative care. The benchmark for this indicator is five days for the 90th percentile wait but it was much higher across the disciplines for both short and long-stay services. This reporting year, the 90th percentile wait for long-stay occupational therapy rose to 40 days up from 27 days in 2021/22 and from

15 days in 2020/21. Similarly, the 90th percentile wait for long-stay physiotherapy rose to 30 days up from 22 days in 2021/22 and from 15 days in 2020/21.

A similar trend was noted for the 90th percentile wait for long-stay social work which went up to 36 days from 26 days in 2021/22 and long-stay speech-language pathology which rose from 21 to 37 days for the 90th percentile wait in 2022/23.

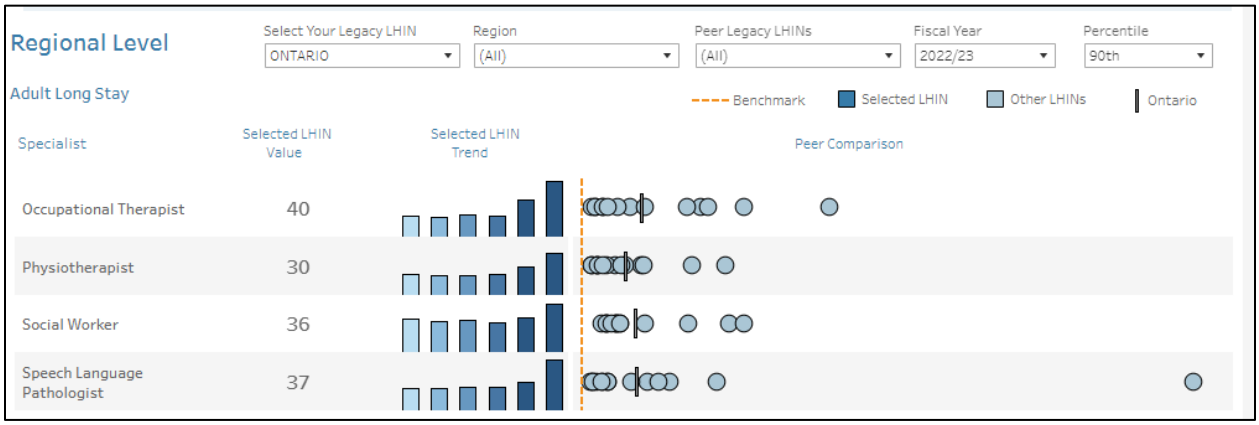

Figure 2: RCA System Performance Dashboard view of Adult Long Stay 90thpercentile Wait Time for In-home Rehab in Ontario for 2022/23

The median wait times for in-home rehabilitative care in Ontario stayed consistent at seven days for long-stay occupational therapy and physiotherapy in 2022/23; however, there was an increase to eight days for long-stay social work and a one-day increase to seven days for long-stay speech-language pathology.

Similar increases were noted across the short-stay programs for all disciplines. 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 largest increase was for occupational therapy with a jump from 30 days to 54 days for the 90th percentile wait. A similar large increase was noted from the previous reporting cycle when the wait rose from 17 days in 2020/21 to 30 days in 2021/22. The median wait time for short-stay occupational therapy rose from seven to eight days.

There was a large increase in the 90th percentile wait for short-stay physiotherapy at 34 days in 2022/23 up from 22 in 2021/22. Whereas, the median wait for short-stay physiotherapy stayed the same at seven days in 2022/23.

Similar to the other disciplines, longer waits were noted for short-stay speech-language pathology with a two-day increase to 10 days for the median wait and from 23 days wait to 57 days for the 90th percentile in 2022/23.

The other notable change for in-home rehab was regarding visits. Long-stay rehab visits decreased from 227,170 in 2021/22 to 217,791 in 2022/23, a decrease of 9,379. This may have been attributed to the impact of persistent HHR issues that have been impacting in-home rehab.

Over the last few years, there has been an increased focus on delivering care in the community and support for older adults to age in place which has been increasing the demand for in-home rehab services. With the increase in demand, coupled with the COVID pandemic, and widespread workforce shortages, in-home rehab providers have struggled to maintain staffing levels. The high level of vacant positions is placing increased pressure on the remaining staff who are already struggling to manage increased caseloads and increased patient complexity.

Long-stay occupational therapy and physiotherapy

There was a significant decrease of 12,086 long-stay occupational therapy visits from 109,237 in 2021/22 to 97,151 in 2022/23. There was a slight increase in long-stay physiotherapy visits with 87,856 in 2021/22 up by 3,398 to 91,254 in 2022/23.

The volumes of long-stay speech-language pathology stayed fairly consistent at 14,089 in 2022/23, down slightly from 15,299 in 2021/22. The opposite trend was noted in social work with an increase in 2022/23 to 15,297 patient visits from 14,778 in 2021/22.

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 by 4,112 from the previous year.

For long-stay occupational therapy, eight of the legacy LHINs were at or below the provincial average of 40 days for the 90th percentile wait. The legacy LHINs with the lowest 90th percentile wait for long-stay occupational therapy were: NW (11 days), ESC (13 days), SW (13 days), CW (18 days), MH (18 days), C (21 days), HNHB (27 days), NE (34 days).

Similar trends were noted in long-stay physiotherapy with nine legacy LHINs having a 90th percentile wait below the provincial average of 30 days. The legacy LHINs below the provincial average were: ESC (11 days), SW (11 days), MH (12 days), NW (14 days), CW (15 days), MH (15 days), C (18 days), HNHB (20 days), NSM (25 days), CE (29 days).

The 90th percentile wait for long-stay in-home rehab had higher than normal wait times across all disciplines**.** While no legacy LHIN or discipline was able to achieve the benchmark of five days for 90th percentile wait, the NW legacy LHIN had the lowest median wait times of three days for short-stay speech-language pathology, four days for long-stay occupational therapy, four days for long stay speech-language pathology and five days for short-stay occupational therapy.

Opportunities for improvement

The 2022/23 reporting year demonstrates significant increases in wait times for in-home rehab across disciplines and legacy LHINs. Large increases were noted in last year's reporting cycle, and even larger

increases are noted in this 2022/23 reporting year. Once again, the in-home rehab sector is facing profound workforce shortages that are impacting wait times for in-home rehab.

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 2024/25 work plan.

It is important to note that practices across legacy LHINs may vary regarding how referrals to in-home rehab services are prioritized and health professional resources utilized. For example, a patient with a more urgent need for an 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 do not differentiate in the level of urgency between referrals.

Falls

Repeat ED visits due to falls

In the 2022 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 522 and higher than the previous provincial average of 745. The benchmark was established by ranking the legacy LHINs in descending order of performance and using the Achievable Benchmarks of Care methodology[2]. There has been a downward trend in the provincial average for repeat ED visits for falls among community-dwelling older adults since 2020 when it was 849.

A total of 126,348 older adults visited the ED for a fall in 2022, with 21,112 or 17% being repeat visits. This represents an increase of 2% from 2021. The slight increase in repeat ED visit rates may reflect more older adults seeking care for falls in the ED than during the pandemic.

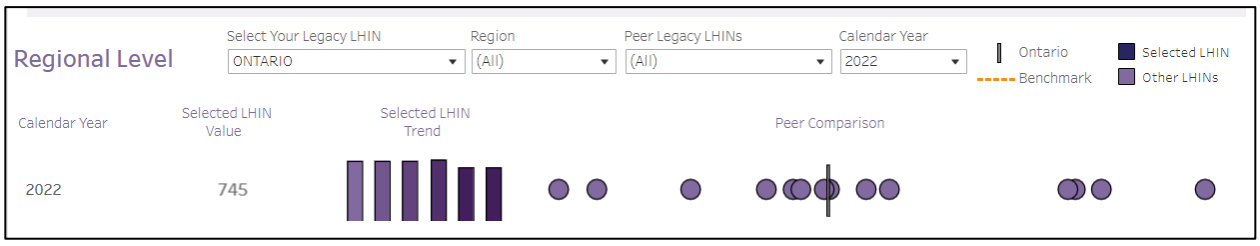

Figure 3: Rate per 100,000 Fall-Related Repeat ED visits for older adults aged 65 years+ in 2022

In 2022, the age-standardized rate of repeat ED visits for falls among adults 65 years and over by legacy LHIN ranged from 462 to 1,145 per 100,000. In 2021, the age-standardized rate of repeat ED visits for falls among adults 65 years and over ranged from 465 to 1,040 per 100,000 representing similar trends among sub-regions with a slightly lower range than the 2022 reporting year.

A large proportion of legacy LHINs demonstrated rates of repeat ED visits for falls among older adults below the provincial benchmark: CW, MH, C, WW, ESC, CE, and CH.

A contextual factor to note, the rate of repeat ED visits for falls may be higher in rural and remote regions due to limited access to primary care, especially after hours and on weekends. For many rural communities, the ED is the only place to receive primary care outside business hours and in some communities, the ED is the only place to access necessary diagnostic imaging such as X-rays. As a result, the lack of access to primary care and diagnostics may be reflected in higher rates of ED visits for falls in some regions.

At a provincial level, to address the individual and systemic effects of a fall among older adults, the RCA has published 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 the 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 implementing a Paramedic Post-Fall Pathway pilot in partnership with community paramedicine services across the province.

SUPPLEMENTARY INDICATORS

VOLUME DATA

The overall number of patients admitted into a high-intensity rehab (NRS-reporting) bed was down by 26% to 21,740 from 28,484 in 2021/22. There has been a downward trend since the pandemic with the pre-pandemic volumes at 33,029 admissions in 2019/20 to high-intensity rehab.

There was also a downward trend with admissions to low-intensity rehab and complex continuing care programs (CCRS-reporting beds) with 21,621 reported in 2022/23 compared to 29,161 in 2021/22 and similar to 19,259 in the 2020/21 reporting year. That's a decrease of 30% or 7,540 admissions in the 2022/23 reporting year compared to the year prior.

The number of patients admitted to an activation/restoration bed (CVC-reporting) was up 37% to 1,013 in 2022/23 from 696 in 2021/22.

Across all legacy LHINs and RCG conditions, the number of patients admitted to high-intensity rehab beds in 2022/23 was down from the previous reporting year in 2021/22, except for brain dysfunction which had a 29% increase from the previous reporting year. All other RCGs had a relative decrease between 17% and 34 %. (Table 1). It is unclear why there was a decrease in the volume of patients across all legacy LHINs and RCGs, except for brain dysfunction. The brain dysfunction RCP is inclusive of sub-categories which include traumatic, non-traumatic, traumatic open injury, traumatic closed injury, and other. The largest proportion of injuries within this RCG are traumatic closed injuries.

New to the Summary Report this 2022/23 reporting year is the inclusion of the average length of stay data by RCG. Interest in length of stay data stems from exploration into rehab utilization of individuals who have undergone hip, knee or shoulder arthroplasty as part of the Ministry of Health Bundled Care program. In addition, initial work is underway for capacity planning for specialized rehabilitative care programs and length of stay data will help to inform the current state of different specialized rehab populations.

Those programs with the longest lengths of stay for high-intensity inpatient rehab include traumatic spinal cord dysfunction (31.9 days), major multiple trauma (31.3 days) and burns (28.8 days). The lowest average length of stay by RCG was for disabling impairment (16.9 days) followed by arthritis (17.9 days).

Table 1: Admission volumes, relative difference in volume and average length of stay by RCG in 2022/23

Rehab Client Group (RCG)	Provincial admission volumes for high-intensity rehab by RCG 2021/22	Provincial admission volumes for high-intensity rehab by RCG 2022/23	Relative Difference in Volume from 2021/22 to 2022/23	Average Length of Stay (days) in 2022/23
Amputation of Limb	811	638	↓ 24%	26.6
Arthritis	102	82	↓22%	17.9
Brain Dysfunction	996	1407	**↑34%***	**27.0**
Burns	59	47	↓23%	28.8
Cardiac	1019	668	↓42%	20.5
Debility	3064	2228	↓32%	24.3

Major Multiple Trauma	495	409	↓19%	31.3
Medically Complex	4682	3244	↓36%	22.5
Neurological Conditions	792	564	↓34%	29.1
Orthopedic Conditions	8139	6357	↓25%	21.0
Other Disabling Impairments	85	68	↓22%	16.9
Pain Syndromes	235	180	↓27%	23.1
Pulmonary	884	544	↓48%	20.7
Spinal Cord Dysfunction	1451	1131	↓25%	31.9
Stroke	5631	4170	↓30%	28.4

* Increases noted across the following Legacy LHINs: MH: 98 in 2021/22 to 160 in 2022/23 (63%); CH: 99 in 2021/22 to 145 in 2022/23 (48%); SE: 32 in 2021/22 to 60 in 2022/23 (61%); TC: 340 in 2021/22 to 661 in 2022/23 (94%); HNHB: 86 in 2021/22 to 103 in 2022/23 (20%).

All legacy LHINs were noted to have a decrease in the volume of admissions to high-intensity rehab beds. This is a change from previous years that demonstrated increases in admission and variability among legacy LHINs.

Table 2: Admissions Differences by Legacy LHINs between 2021/22 and 2022/23

Legacy LHIN	Notable admission findings for high-intensity rehab in 2021/22	Notable admission findings for high-intensity rehab in 2022/23	Relative Difference
C	768	575	↓29 %
CE	2423	1553	↓44 %
CW	768	575	↓29 %
CH	3137	2465	↓24 %
ESC	2125	1626	↓27 %
HNHB	2351	1676	↓29 %
MH	1752	1451	↓19 %
NE	876	619	↓34 %
NSM	452	348	↓26 %
NW	378	303	↓22 %
SE	867	721	↓18 %

SW	2012	1404	↓36 %
TC	9391	7586	↓21 %
WW	935	699	↓29 %

In 2021/22, there was an increase in the number of admissions to high-intensity rehab for orthopedic conditions. This was likely a result of the ramp-up of surgeries following the reduction the year prior due to the postponement of non-urgent surgeries during the pandemic. In the 2022/23 reporting year, there was a 22% decrease in orthopedic admissions which is likely attributed to the stabilization of surgery volumes and the shift towards same-day surgeries for patients undergoing hip and knee arthroplasty across the province.

Alternative Level of Care (ALC)

Only patients who are designated as ALC are included in the WTIS dataset (the data source for the RCA indicator on wait time). There was an ALC designation in acute care for 21,727 or 50% of the 43,426 patients who were admitted into high-intensity and low-intensity rehab. This number does not include those waiting for a reactivation/restoration or convalescent care bed that is typically offered in an LTC facility.

The 50% ALC rate is an increase from the previous reporting year which had 38% of patients waiting for inpatient rehab deemed ALC. The majority of patients deemed ALC were waiting for high-intensity rehab (78%), followed by waiting for a low-intensity rehab bed (18%).

The percentage of patients waiting for a high-intensity rehab bed decreased slightly from 80% in 2021/22 and 89% in 2020/21. The percentage of adults waiting for low-intensity rehab (18%) remained stable from the previous reporting year.

The biggest difference was for activation/restoration beds which had an increase from 3% up to 4% in the 2022/23 reporting year which is still significantly lower than the pre-pandemic 2019/20 reporting year which was at 10% for activation/restoration beds. This is likely 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 50% of patients had no wait time in acute care before being transferred to inpatient rehab which was down significantly from the 68% that had no recorded wait time in 2021/22 and the 62% in the 2020/21 reporting year.

In 2022/23, there were 43,426 patients admitted to high-intensity and low-intensity inpatient rehab, down from 57,645 the previous reporting year, a difference of 14,284. The volume of patients admitted in 2022/23 was similar to the year prior at 47,139 but was still much lower than the pre-pandemic reporting year of 60,132 in 2019/20.

During System Evaluation task group meetings, it was noted that several factors may have impacted the decrease in patient admissions. It was reported that there has been a reduction in the number of in-patient rehab beds across the province as sites had to close or switch rehab beds to transitional care

beds to help address the ALC issues; this may have contributed to the lower number of rehab admissions in 2022/23. Other possible factors identified are the health human resource issues and bed closures due to infection prevention and control measures which may impact bed availability and overall admission volumes.

In 2022/23, there were 21,699 low-intensity rehab admissions to CCRS-reporting beds and 21,727 high-intensity rehab admissions to NRS-reporting beds for a total of 43,426 inpatient rehab admissions which is lower than the 47,139 admitted in the 2021/22 year. The reduction of 3,713 between 2021/22 and 2022/23 or an 8% decrease in the number of patients admitted to high and low-intensity inpatient rehabilitative care.

Inpatient Rehab: Measures of Functional Change

Capacity pressures have been impacting all parts of the health system. Hospitals have been under extreme pressure to transfer patients quickly into the community to relieve pressure in the ED and open up additional beds. 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 2022/23 the average admission FIM® score across all 17 Rehab Client Group (RCG) categories was 71.4, which was similar to the 71.6 reported in 2021/22. This remains lower than the 2020/21 average of 74.4. Prior to the pandemic, the average admission FIM® score was 73.7 in 2018/19 and 72.7 in 2019/20. This suggests that patients continue to be admitted to high-intensity inpatient rehab at lower functional independence levels than in previous years.

Increases to admission FIM® scores were noted for the following RCGs: amputation of a limb, arthritis, burns, cardiac, congenital anomalies, orthopaedic conditions, and pulmonary.

Decreases in admission FIM® scores were noted for the following RCGs: brain dysfunction*, debility, major multiple trauma, medically complex, neurological conditions, pain syndromes, spinal cord dysfunction, and stroke.

**Brain dysfunction was also associated with an increase in the volume of admissions for the 2022/23 reporting year.*

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 before the pandemic. The shift towards the higher change score suggests patients are achieving roughly the same functional gains in rehabilitative care in 2022/23 that they received before the pandemic.

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. The provincial average aLOS efficiency had 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 is again back down to 1.1 in the 2022/23 reporting year. This indicates that the functional gains achieved during

the high-intensity inpatient rehab were not as significant as in previous reporting years. This could be attributed to patients with higher medical acuity being admitted into inpatient rehab programs as indicated by the admission FIM® scores.

Secondary Fall Prevention

In the 2022/23 reporting year, the Ontario government identified a new way of organizing and delivering care through Ontario Health Teams (OHTs). In previous reporting years, the falls data were reported at the sub-regional level but the collection and reporting has shifted to the OHT level. There are currently 58 OHTs in the province, but the data from 2022/23 represents only the 52 OHTs that were in place at the time of data collection. There have also been changes to the OHT names when the data was collected. As a result, comparisons are not made to previous sub-regional level data but comparisons at the former legacy LHIN level are used.

Rate of ED visits

The provincial age-standardized rate of ED visits for falls among community-dwelling older adults was 4,468 per 100,00 which was very similar to what was reported in 2021 and below the pre-pandemic rate of 4,873 per 100,000 in 2019. In 2022, the rate of ED visits for community-dwelling older adults for falls was below the provincial average of 4,468 for eight (MH, CW, C, CH, WW, CE, ESC, TC) of the 14 legacy LHINs.

Rate of Admissions from Falls

The provincial rate of admission from ED for falls among community-dwelling older adults was 1,022, just below the 1,045 rate in 2021. In 2022, the rate of admission for falls ranged from 730 to 1,464. There were five legacy LHINs with a rate below the provincial average (HNHB, CW, TC, SE, and C).

At a provincial level, the falls data has stayed fairly stable over the last two reporting years. It will be important to understand the Ontario Health regional and OHT level differences. Ongoing work by the RCA will continue to focus on the integration of rehabilitative care into secondary fall prevention pathways and through the implementation of best practice frameworks that support the overall reduction of functional decline among older adults and the improvement of patient outcomes.

Rehab Provider Experience Survey

In the fall of 2023, the RCA launched its second annual rehab provider experience survey. The purpose of the survey was to better understand the current experience of rehab providers and include provider experience data as part of the RCA's Quintuple Aim approach to System Evaluation. The summary of the previous 2022 rehab provider experience survey summary is available on the RCA website.

The 2023 survey was updated based on feedback from the first survey and in consultation with professional rehab associations (Ontario Kinesiology Association, Ontario Society of Occupational Therapists, Ontario Physiotherapy Association and Speech-Language & Audiology Canada). The survey

was distributed through RCA distribution lists, professional associations and via snowball sampling. Respondents were asked how they received the survey and 58% (256) received it through a colleague or the organization where they worked. Another 24% (105) received it through their respective professional association (OKA, OSOT, OPA or SAC).

The survey elements included:

- demographic information
- employment profile
- equity and inclusion
- stress, burnout and moral distress

Five hundred and fifty-six respondents completed the survey in 2023, which is fewer than the 641 respondents in 2022. The distribution of responses was consistent with the year prior, primarily representing the southern parts of the province.

- North West: 8% (42)
- North East: 10% (37)
- East: 20% (104)
- Toronto: 23% (119)
- West: 25% (129)
- Central: 13% (67)
- Provincial: 3% (13)

Due to snowball sampling, it is difficult to calculate the response rate for the survey. As such, **the survey results should be interpreted with caution as they do not represent the entire rehab workforce population.**

Respondent Demographics

Of the respondents:

- 49% reported working in an acute or rehab/complex care hospital setting
- 90% identified as female
- 44% reported being 45 years or older
- 36% reported working in the rehab sector for 20 years or more

The majority of respondents were occupational therapists (25%), physiotherapists (22%) and speech-language pathologists (16%), followed by rehabilitation assistants [OTA/PTA/CDA] (9%), kinesiologists (7%) and nurses (7%). There were a large number of “other” disciplines identified which included roles in pharmacy, therapeutic recreation, and other specialties.

Demographics/Representation

The RCA included questions about equity and inclusion to help inform future workforce planning initiatives and help facilitate a dialogue about representation within the rehab professional community.

Two percent of respondents (9) identified as being First Nation, Métis or Inuk/Inuit and 9% (50) identified as Francophone.

Seventy-six percent of respondents (419) were between the ages of 25 – 54 and 21% (121) were 55 years and older. Ninety percent (556) were trained in Canada and 80% (511) reported working in clinical roles while 14% (71) reported working in non-clinical roles such as leadership, quality improvement or education.

Employment Profile

Survey respondents primarily work at rehabilitation/complex continuing care hospitals 34% (175), acute care hospitals 22% (114), hospital-based/community clinics 19% (87), home care 8% (41) and other settings 9% (44). A small proportion of 4% (18) work remotely.

The majority of survey respondents 31% (157) have been in their current role for 1-5 years, with the second largest group 24% (123) having been in their role for > 20 years. Ten percent of respondents (50) have been in their role for less than a year.

Greater than 50% (259) reported that they plan to stay in their current role for more than five years while 32% (149) reported that they would leave for a different position in their profession. Ten percent (47) indicated they plan to leave their profession entirely.

The top reasons (respondents were asked to pick the top 3) that would prompt them to leave their job was stress/burnout 45% (231), followed by retirement 35% (178), and better career opportunities 28% (143).

Stress and Burnout

Stress and burnout continue to be serious issues in the rehabilitative care workforce. Forty-four percent (204) reported their work life as a bit stressful, 40% (186) reported 'quite a bit stressful' and 6% (26) reported their work life to be 'extremely stressful'. These levels of stress are higher than what was reported in 2022 when 28% (181) reported 'quite a bit stressful' and 3% (18) reported 'extremely stressful'. Overall, in 2022, 76% of respondents reported stress in their work life versus 90% of respondents who reported some level of stress in their work life in 2023.

Respondents were also asked to report on burnout, 35% (161) reported one or more symptoms of burnout compared to 40% (187) who reported being under stress but not feeling burned out. These responses are also higher than last year's survey responses but there was a downward trend of 4% (17)

in 2023 from 6% (36) in 2022 in the number of individuals who reported being completely burned out and needing to seek changes or help.

Based on feedback from the 2022 survey, a question about moral distress was added to the survey. The moral distress thermometer was used to calculate respondents' level of moral distress which ranges from zero – no moral distress to 10 which is the worst possible moral distress. It was found that of the 496 respondents, the average level of moral distress was 3/10, which is just below "uncomfortable" on the moral distress thermometer.

Themes from Open-Ended Questions

The 2023 survey also included an open-ended question which allowed respondents to provide any additional information they felt was relevant to their experience. A total of 128 comments were collected. The comments were themed and these are some of the most commonly reported themes:

- Insufficient compensation for continually expanding demands/caseloads
- Need for work-life balance
- Lack of career advancement opportunities
- Lack of support for professional development paid education days
- Need a system that supports providers working to their full scope – trust from colleagues to work at expanded scopes of practice
- Lack of support/engagement from leadership, organizations and government

We need more innovation of part-time roles, shared roles, and flexible hours for patients/staff to receive/deliver care. We need more transdisciplinary models and less multidisciplinary models where care is delivered in silos, under the same roof.

I am immensely satisfied in my current role. One of the things that I greatly value is having flexibility and autonomy over my scheduling. I also appreciate a hybrid model of some work in the clinic and some work from home. I really value the ability to find new passions and help shape/create my role and the services I provide.

Next Steps

The second rehab provider experience survey has highlighted some of the ongoing issues that are impacting the experience of rehabilitative care providers. Although this survey is not representative of all rehab providers in the province, it provides a glimpse into the levels of stress, burnout and moral distress that continue to be present.

As workforce issues continue to dominate conversations across provincial tables, the RCA Workforce Task Group continues to identify, prioritize and outline strategies to highlight the need for action from government, professional associations, organizations and decision-makers.

LOOKING AHEAD – QUALITY IMPROVEMENT OPPORTUNITIES

The ongoing work of the System Evaluation Task group will continue to advance the collection of system performance indicators and explore opportunities for the inclusion of new indicators and available data. An ongoing desire to advance the collection of community-based clinics, and hospital outpatient programs was clearly articulated and will be prioritized for 2024/25.

In 2023, the RCA embarked on a strategy development process to create a strategic framework and intent to guide the work. Four key pillars were identified, one focused on "Use of Evidence to Drive Change". The objective of this pillar is to leverage knowledge and data to inform decision-making, promote innovative models of care, identify and address improvement opportunities, advance workforce planning and demonstrate the value of rehab for patient and system outcomes. The specific deliverables attached to this pillar are yet to be identified but with many improvement activities underway across the RCA task groups, such as the Rehab Transitions Self-Assessment tool, there will be ample opportunities to continue to use data to improve rehabilitative care and overall system performance.

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- Ali Sadri, Senior Business Intelligence Specialist
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rehabcarealliance.ca

For more information, contact:
info@rehabcarealliance.ca

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