Hospital Report

2007

REHABILITATION

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Ontario

OHA ONTARIO HOSPITAL ASSOCIATION

About This Report

Quality improvement has become an integral part of health care, and hospitals are no exception. In recent years there has been increasing interest in health-system performance measurement in order to provide the information that is required for the effective management of hospitals across Ontario.

Hospitals are faced with many challenges in order to offer the best possible care. This means ensuring that high quality care is provided when and where it is needed, while at the same time effectively managing resources. Measuring quality and efficiency in health care facilities is critical for managing them. Providing comparable information on performance benefits providers of care as well as the public interested in understanding the issues facing Ontario hospitals.

Better information allows hospitals to identify areas where there may be a need for improvement and monitor progress. Sharing this information allows users of the health care system to know which questions to ask, and gives health care providers and decision-makers the evidence that is needed to further improve the quality of health care.

Hospital Report 2007: Rehabilitation is a hospital-specific report that uses a balanced scorecard approach to provide information on the performance of hospitals that provide rehabilitation in designated rehabilitation beds in Ontario. The objectives of this series of reports are to facilitate local quality improvement programs, encourage openness and transparency in reporting and to support hospitals' accountability to the communities they serve.

Who Should Use This Report?

This report is designed for health care providers, managers and others interested in the performance of hospitals in Ontario. The primary audiences for this report series are hospital boards of directors and senior managers and local health integration networks (LHINs). Results should also be shared broadly among hospital staff, patients, families and the public at large.

To ensure optimal use of the scorecard results, board members and senior managers can use the information in this report for strategic planning and priority-setting within their hospitals. By identifying indicators for which their hospital's performance is lower than average, they can direct resources and refine/develop corporate policies to facilitate quality improvement in these areas. Within an environment of competing demands, boards need to ensure that the organization's culture supports an enduring commitment to quality improvement.

Hospitals can use these indicators to describe, evaluate and compare their performance. The results can be used to monitor improvements and outcomes related to specific quality improvement initiatives within hospitals. By comparing hospital-specific results to the provincial average and to peer hospitals' performance, individual hospitals can evaluate their progress in their quality improvement initiatives. These high-level comparisons can also be a first step for hospitals to identify opportunities for improving quality of care. The next step for hospitals would be to examine their own data that support the indicators, to understand the underlying factors contributing to their hospital's results. Finally, hospitals can also use this report to identify other hospitals from which they might seek opportunities to learn.

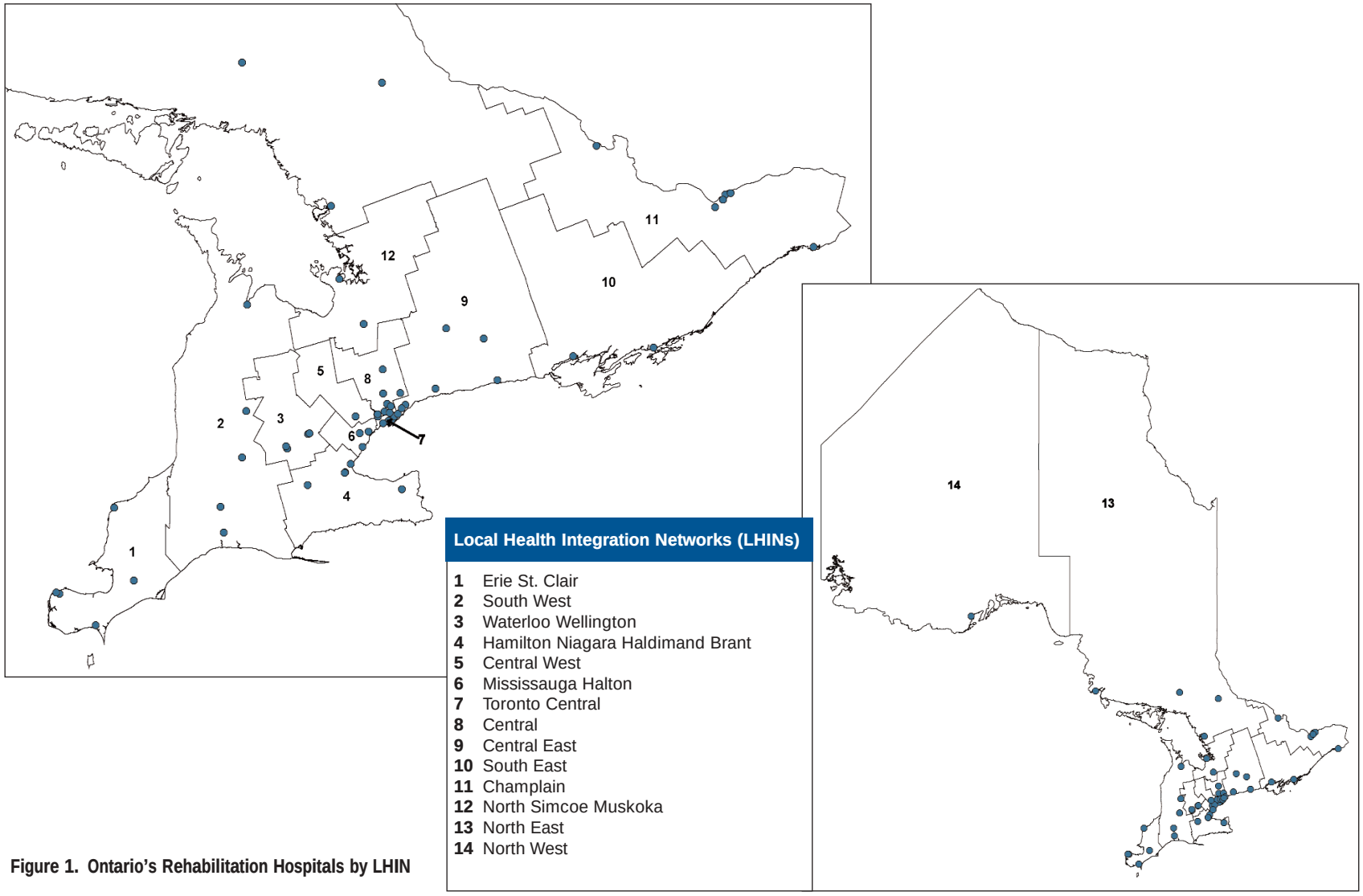
Members of the public can use this report to better understand some of the issues facing the health care system. Public reporting of hospital performance can help to promote a culture of transparency so that Ontarians know that quality care will be available when they need it.

In Ontario, rehabilitation is provided in a variety of settings spanning a continuum of care from acute care to home care. This report focuses only on publicly funded designated adult rehabilitation beds, either in free-standing specialty inpatient rehabilitation hospitals or in designated beds or units designated for rehabilitation purposes that are part of a general hospital. It does not include rehabilitation in acute care, outpatient settings or home-based settings. The facilities or units care for clients with a primary health condition that is physical in nature, for example stroke, orthopedic conditions, brain dysfunction, spinal cord dysfunction or amputation.

Concepts

In this report, the term **hospital** refers to both single-site organizations and multi-site organizations that provide rehabilitation services. The term **facility** refers to specific sites within a hospital corporation (hospitals can have more than one facility).

A Snapshot of Hospital Activity
in Ontario's LHINs



Local Health Integration Networks (LHINs)

1 Erie St. Clair
2 South West
3 Waterloo Wellington
4 Hamilton Niagara Haldimand Brant
5 Central West
6 Mississauga Halton
7 Toronto Central
8 Central
9 Central East
10 South East
11 Champlain
12 North Simcoe Muskoka
13 North East
14 North West

Figure 1. Ontario's Rehabilitation Hospitals by LHIN

This section highlights selected characteristics of local health integration networks (LHINs), providing context for interpretation of the rehabilitation indicator results.

Table 1 shows the proportion of inpatient rehabilitation clients by LHIN and lists the number of hospitals that provide inpatient rehabilitation services by facility type in each LHIN. Facilities participating in the National Rehabilitation Reporting System (NRS) are classified as either *General* or *Specialty*. This classification is specific to the NRS and is intended to facilitate comparative reporting; it is not necessarily consistent with facility classification methods used for ministry reporting in Ontario (that is, the Ministry of Health and Long-term Care Master Number List).

As defined for the NRS, a general rehabilitation facility is a rehabilitation unit or collection of beds designated for rehabilitation purposes that is part of a general hospital offering multiple levels or types of care. A specialty rehabilitation facility is one that provides more extensive and specialized inpatient rehabilitation services and is commonly a free-standing facility or a specialized unit within a hospital. The rehabilitation team at the facility decides which profile most closely represents its rehabilitation program(s) and categorizes itself as general or specialty when beginning submissions to the NRS.

Note that it is possible for a hospital to have more than one facility, and it is also possible for a hospital to have both a specialty rehabilitation facility and a general facility with rehabilitation beds. This is illustrated in the above table under the column “Hospitals With Both Types.”

Table 1. Inpatient Rehabilitation in Ontario

	LHIN	Percent of Inpatient Rehabilitation Clients in Ontario	Specialty Hospitals	General Hospitals	Hospitals With Both Facility Types	Total
1	Erie St. Clair	6.2	1	4	0	5
2	South West	4.8	1	4	0	5
3	Waterloo Wellington	4.6	0	4	0	4
4	Hamilton Niagara Haldimand Brant	8.9	0	4	1	5
5	Central West	0.5	0	1	0	1
6	Mississauga Halton	9.0	0	3	0	3
7	Toronto Central	21.6	3	5	0	8
8	Central	18.1	1	5	0	6
9	Central East	9.0	0	6	0	6
10	South East	1.9	0	1	1	2
11	Champlain	9.9	1	4	1	6
12	North Simcoe Muskoka	1.4	0	2	0	2
13	North East	2.0	1	3	0	4
14	North West	2.3	0	0	1	1
	Ontario	**100**	**8**	**46**	**4**	**58**

Table 2 depicts the total number of stroke, orthopedic and other inpatient rehabilitation clients in Ontario in 2005–2006, by LHIN. Together, the Toronto Central LHIN and the Central LHIN account for almost half (40%) of all inpatient rehabilitation clients. Hospitals in these LHINs had the lowest percentage of stroke clients (10% and 6%, respectively) and were among hospitals with the highest percentage of orthopedic-condition clients (59% and 71%, respectively) when compared with other LHINs. By contrast, hospitals in the North East LHIN had the highest proportion of stroke clients (34%) and the lowest proportion of orthopedic-condition clients (22%).

When making comparisons across LHINs, it is important to consider the varying number of hospitals in each LHIN. Other factors also contribute to differences among LHINs (for example, population density, rural versus urban, hospital type). Where variation in indicator results is observed, further investigation is warranted to explore the opportunities for shared learning and process improvement. The performance allocation tables that follow the summary of results for each section of the report provide LHIN averages for each of the indicators.

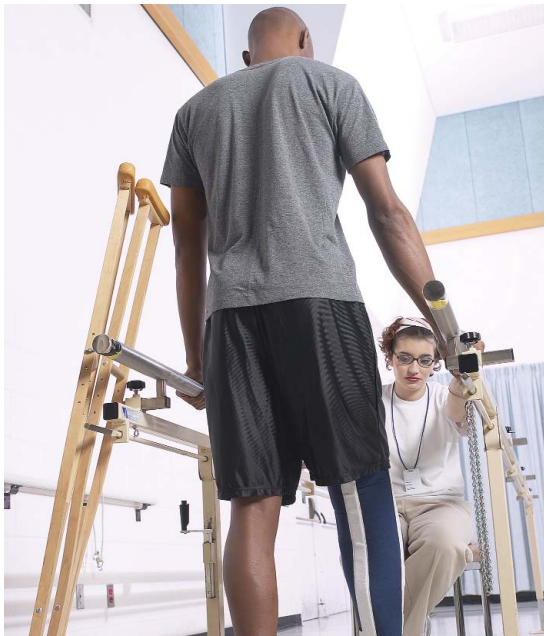


Table 2. Number and Percent of Stroke, Orthopedic Conditions and Other Inpatient Rehabilitation Clients in Ontario by LHIN, 2005–2006

LHIN		Number of Inpatient Rehabilitation Clients in Ontario	Stroke		Orthopedic Conditions		Other RCGs	
			Number	Percent	Number	Percent	Number	Percent
1	Erie St. Clair	1,714	387	22.6	739	43.1	588	34.3
2	South West	1,322	327	24.7	459	34.7	536	40.6
3	Waterloo Wellington	1,268	127	10.0	447	35.3	694	54.7
4	Hamilton Niagara Haldimand Brant	2,457	549	22.3	865	35.2	1,043	42.5
5	Central West	138	17	12.3	114	82.6	7	5.1
6	Mississauga Halton	2,501	297	11.9	1,496	59.8	708	28.3
7	Toronto Central	5,974	565	9.5	3,532	59.1	1,877	31.4
8	Central	5,005	318	6.4	3,552	71.0	1,135	22.6
9	Central East	2,484	374	15.1	1,586	63.8	524	21.1
10	South East	517	133	25.7	226	43.7	158	30.6
11	Champlain	2,741	436	15.9	1,274	46.5	1,031	37.6
12	North Simcoe Muskoka	386	111	28.8	184	47.7	91	23.5
13	North East	542	182	33.6	121	22.3	239	44.1
14	North West	645	74	11.5	402	62.3	169	26.2
Ontario		**27,694**	**3,897**	**14.1**	**14,997**	**54.2**	**8,800**	**31.8**

Source: National Rehabilitation Reporting System, 2005–2006, CIHI.

A Balanced Scorecard

What Is a Balanced Scorecard?

Providing care in a health care facility is a complex activity involving a multitude of skills, experiences and technologies. No single aspect of the system causes poor or excellent hospital performance. For this reason, performance-measurement activities must include measures that provide insights into multiple dimensions of a hospital's performance. The balanced scorecard approach describes performance across four dimensions or quadrants critical to the strategic success of any health care organization. These quadrants include: System Integration and Change, Client Perspectives, Clinical Utilization and Outcomes and Financial Performance and Condition.

Performance measures for each of the four quadrants are provided at the hospital-specific level, along with average scores by LHIN and the province as a whole.

While all hospitals' values are used in calculating average results by LHIN and the province, hospital-specific values are shown for hospitals that had sufficient data and agreed to have their results published for quality improvement purposes. This year, 57 out of 58 (98%) hospitals with designated rehabilitation beds participated in at least one quadrant and 37 (64%) hospitals participated in all four quadrants of the report.

Using a balanced scorecard format, this report provides a summary of performance scores for 23 indicators across four areas of performance.

System Integration and Change

This quadrant focuses on indicators that assess efforts and investments that hospitals need to make in order to improve the delivery of adult inpatient rehabilitation services. It measures the extent to which best practices and the involvement of different players are necessary for making decisions about care, and implementing a client-centred approach to service delivery. [9 indicators]

Client Perspectives

This quadrant describes clients' perceptions of the care they received during inpatient rehabilitation. For participating hospitals, surveys were mailed to clients following their discharge from hospital asking them to rate the care they received related to several components of client-centred rehabilitation, including participation in decision-making and goal-setting, evaluation of outcomes from the client's perspective and family involvement in care. [8 indicators]

Clinical Utilization and Outcomes

This quadrant presents indicators that evaluate hospitals' clinical performance for clients that are cared for in designated adult inpatient rehabilitation beds. The indicators, from the National Rehabilitation Reporting System, describe changes in the Total Function Score[i] as measured by the FIM™ instrument, length of stay and length of stay efficiency. Indicators are reported for the following Rehabilitation Client Groups (RCGs)[ii]: All RCGs, Stroke and Orthopedic Conditions. [3 indicators]

Financial Performance and Condition

This quadrant describes selected measures of efficiency and productivity in hospitals with designated rehabilitation beds. [3 indicators]

i. Total Function Score referenced in this document is based on data collected using the FIM™ instrument. The 18-item FIM™ instrument referenced herein is the property of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

ii. Each of the three indicators are reported for the following Rehabilitation Client Groups (RCGs): All RCGs, Stroke and Orthopedic Conditions. Rehabilitation Client Groups (RCGs) adapted with permission from the UDS$_{MR}$ impairment codes. Copyright 1997 Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc., all rights reserved.

"High-Performing" Hospitals

High-Performing Hospitals Within Quadrants

System Integration and Change

Criteria
Highest score (or 100) on one indicator and above-average rating for at least 4 of 9 indicators and no below-average rating.

High Performing Hospitals
- The Credit Valley Hospital

Client Perspectives

Criteria
Above average on 6 of 8 indicators and no below-average score on any indicator.

High Performing Hospitals
- Providence Continuing Care Centre
- Sisters of Charity of Ottawa (SCO) Health Service
- St. Joseph's Health Care London
- The Ottawa Hospital
- West Park Healthcare Centre

Clinical Utilization and Outcomes

Criteria
Above-average rating on Total Function Change, average or above-average rating on Average Active Rehabilitation Length of Stay and average or above-average rating on Length of Stay Efficiency for at least one of the following RCGs: All RCGs, Stroke, Orthopedic Conditions or the sub-categories within Orthopedic Conditions, Post Hip Fracture or Post Hip and Knee Replacement.

High Performing Hospitals
- Hôtel-Dieu Grace Hospital
- Humber River Regional Hospital
- Joseph Brant Memorial Hospital
- Pembroke Regional Hospital
- St. John's Rehab Hospital
- St. Mary's General Hospital
- The Credit Valley Hospital
- Trillium Health Centre

Financial Performance and Condition

Criteria
There are no high-performing criteria for the Financial Performance and Condition quadrant.

For quality improvement purposes, the Hospital Report series has developed methodologies to identify "high-performing" hospitals within three of the quadrants in rehabilitation care.

It is useful to highlight hospitals that performed well in particular quadrants when compared to their peers, because these hospitals may be able to share useful ideas and best practices with other hospitals within the specific areas of focus. It is interesting to note that no hospitals were identified as high performing across all three quadrants. This illustrates the importance of using a variety of measures, such as a balanced scorecard approach, when looking at hospital performance. Good performance in one quadrant does not necessarily translate into good performance in another quadrant.

In addition, high performance in a given year relates only to how hospitals perform based on the indicators calculated for that particular year. High performance is not necessarily a predictor of high-performing status in future years.

High-performing hospitals are listed in alphabetical order.

Interpreting the Results

Where Can You Find More Information?

Further information is available in the technical summaries, which can be accessed through the Hospital Report website at www.hospitalreport.ca. The technical summaries provide more detailed definitions of the indicators and the statistical methods used to calculate the results.

As there can be competing interests and incentives in the management of hospitals to maximize both quality and efficiency and maintain a balance of resources in the context of limited resources, no single indicator or quadrant should be used to assess a hospital. All aspects of performance are important. One indicator on its own will provide an incomplete picture of overall performance. The indicator results in this report should be viewed as screening tests that can identify potential opportunities for quality improvement. In medicine, screening tests do not provide a definitive diagnosis, but can help to identify patients that require follow-up. Similarly, comparisons of indicator results may not offer a definitive assessment of a hospital's performance. Further investigative work is required by hospitals to better understand the factors underlying their results and identify specific strategies or areas for improvement.

There are many factors that can cause indicator values to vary from hospital to hospital. Some of these factors, such as the diversity in patient characteristics and the populations served are beyond a hospital's control. For this reason, comparisons of indicator scores among hospitals and LHINs should be made with caution. It is also important to exercise caution when examining year-to-year changes in indicator values. This is because the methodology used to calculate indicators is reviewed annually, and in some cases, changes are made to improve the methodology over time. There are certain instances where risk adjustment is not warranted as it does not entirely eliminate the impact of other factors. As in previous years, rehabilitation indicators were presented unadjusted, as it has been shown that there is no significant impact on mean scores.

Interpreting Box Plots

For each quadrant, a summary of the distribution of the hospital values for the indicators is presented graphically using a box plot. Hospitals can use these graphs to determine where their indicator values fall relative to other hospitals', the median value and the provincial average.

Figure 2 is a sample box plot.

The **vertical line** in the shaded box represents the **median value**; this is the value at which half of hospitals' scores are higher and half are lower.

The **shaded box** represents the **interquartile range (IQ)**; the middle 50% of hospital values will be contained in this range.

The **whiskers** or lines beyond the shaded box extend to **the largest and smallest values**, excluding outliers. That is, they contain approximately the top 25% and bottom 25% of hospital values.

Outliers, hospital values that are considerably different from the others, are identified by **circles**, and **extreme outliers** are identified by **stars**.

The **provincial average** (38.3%) is displayed to the right of the graph.

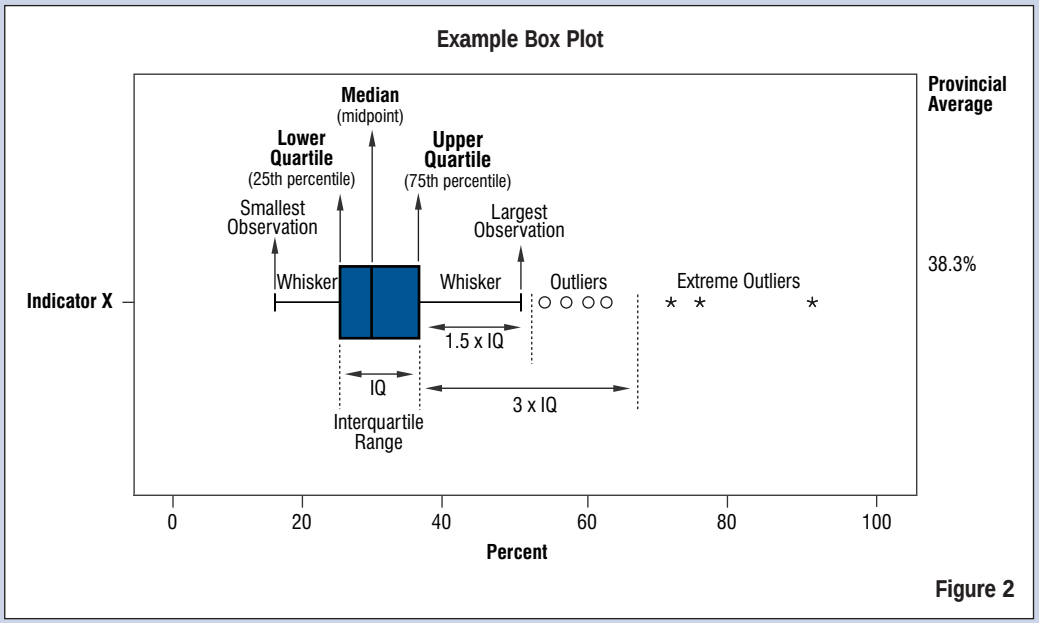


Figure 2

Interpreting Performance Allocation Tables

The performance allocation tables in this report show the indicator values for each hospital participating in that quadrant of the report. Also included is a shaded background that indicates whether the hospital's score on that indicator reflected above-average performance, average performance or below-average performance. For more detailed information on the methodologies used to assign hospital performance, please see the technical summaries provided on the Hospital Report website at www.hospitalreport.ca.

Coloured shading for performance is assigned as follows:

- The hospital's score reflected *above-average* performance.
- The hospital's score reflected *average* performance.
- The hospital's score reflected *below-average* performance.

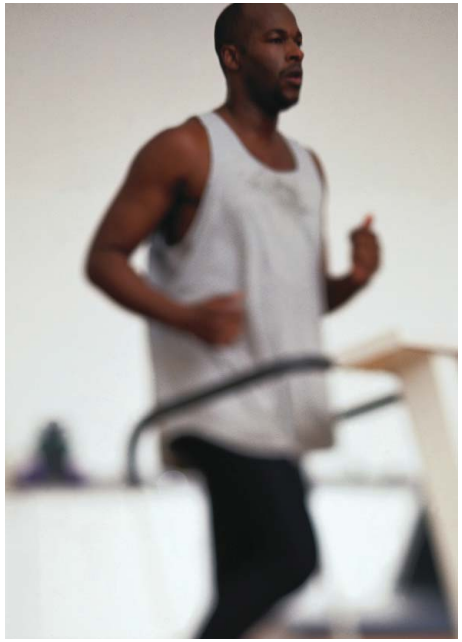
For some indicators, lower values suggest better performance. In these cases, lower values are labeled as *above average.*

Some results are not shown, this is explained by the following symbol.

NR Means non-reportable—some results are not shown to protect patient or physician confidentiality, because the number of events was too low to obtain a reliable estimate or due to a data quality issue.

Performance Allocation

The method of assignment of performance allocation varies based on the quadrant. For Clinical Utilization and Outcomes and System Integration and Change, hospitals' scores were compared to the provincial average for all measures. For Client Perspectives, hospitals' scores were compared to the provincial performance target for all measures (see technical summary for further details). Performance allocations are not calculated for the indicators in the Financial Performance and Condition quadrant.



The System Integration and Change (SIC) quadrant focuses on indicators that assess efforts and investments that hospitals need to make in order to improve the delivery of adult inpatient rehabilitation services. It measures the extent to which best practices and the involvement of different players are necessary for making decisions about care and implementing a client-centred approach to service delivery.

Indicator Definitions

Healthy Work Environment (Revised)

The extent to which hospitals have mechanisms in place to support and promote a healthy work environment, thereby contributing to employees' physical, social, mental and emotional well-being.

Interdisciplinary Integration of Care (Revised)

The amount of interdisciplinary integration that is occurring in the designated rehabilitation beds in Ontario hospitals.

Evidence of Client-Centred Care

The extent to which care, at the level of the individual client, is being provided in a client-centred manner.

Best Practices (Revised)

The extent to which a best practice approach is utilized, involving integrating information from clients and/or family members and individual clinical experience/expertise with the best available evidence in making decisions about the care of individual clients.

Coordination and Continuity of Care Across the Continuum

The degree of coordination and continuity evident for clients who are discharged from inpatient rehabilitation settings.

Evidence of Organizational Client-Centredness (Revised)

The extent to which hospitals implement a client-centred approach to service delivery at the system level.

Organizational Commitment to Staff Development (Revised)

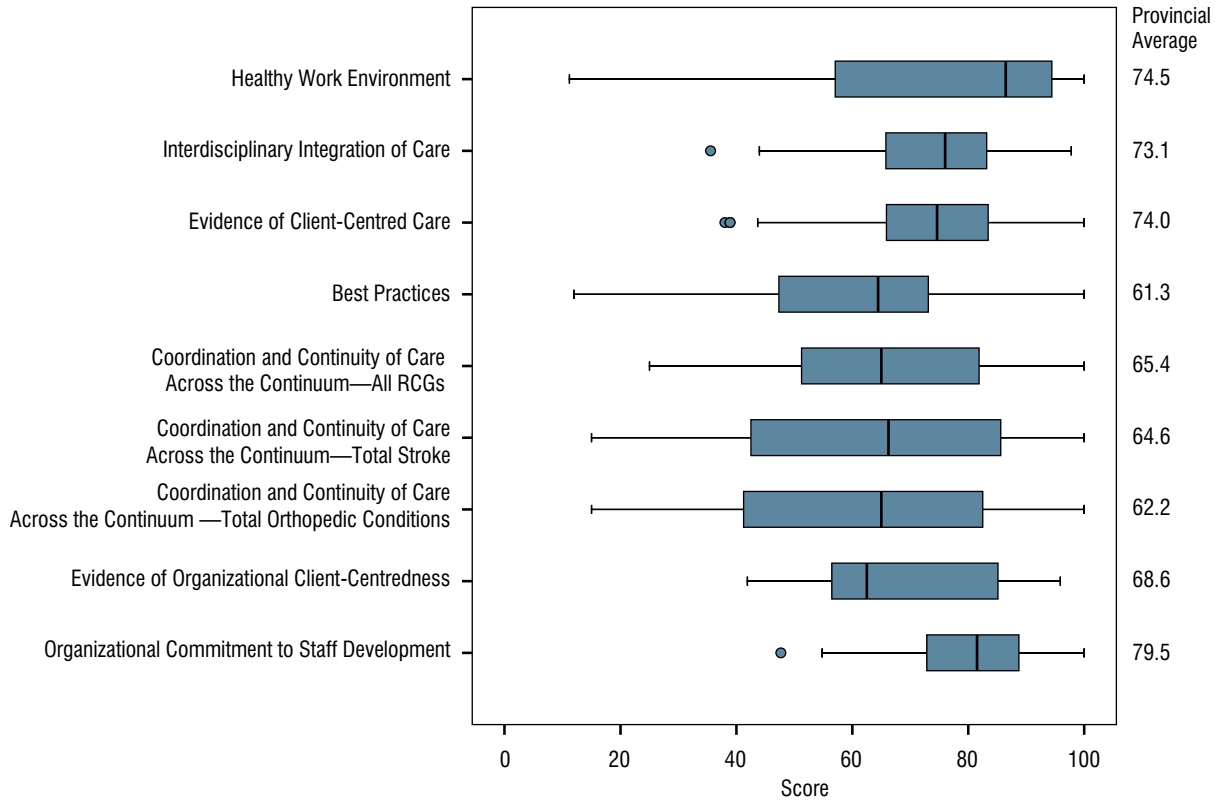
The extent to which there is organizational support for professional development, continuing education activities and performance evaluations for staff allocated to designated rehabilitation beds.

Data presented are based on results from a survey completed on a voluntary basis by hospital managers in February 2007. Results for the 56 hospitals that completed this year's SIC rehabilitation survey are included in the analysis and illustrated in the performance allocation tables.

The introduction of a web-based SIC survey allowed for a more streamlined process for hospitals to submit their responses. Please note that there have also been significant changes in the indicator weights and methodologies and performance allocation methods. Caution should be taken when trending indicator results from previous years. For a complete listing of all the changes introduced this year, please refer to this year's SIC technical summary (available at www.hospitalreport.ca).

This year, the Healthy Work Environment indicator has been included in all sectors (that is, Emergency Department Care, Complex Continuing Care, Rehabilitation and Acute Care). Hospitals that participated in multiple sectors have the same Healthy Work Environment score across all sectors. However, the provincial average and performance allocation for this indicator is not consistent because it includes only participating hospitals within that sector.

Summary of Results



Source: *Hospital Report 2007*: SIC Survey.

Figure 3

For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

Figure 3 depicts the distribution of scores and the provincial average (mean) for each of the indicators. There is considerable variation in scores for the majority of the indicators. Hospitals can use this figure to see where their scores (found in the performance allocation tables) for each of the indicators fall relative to other hospitals' scores in the province. This figure is not meant to facilitate comparison between indicators.

Summary of Results (cont'd)

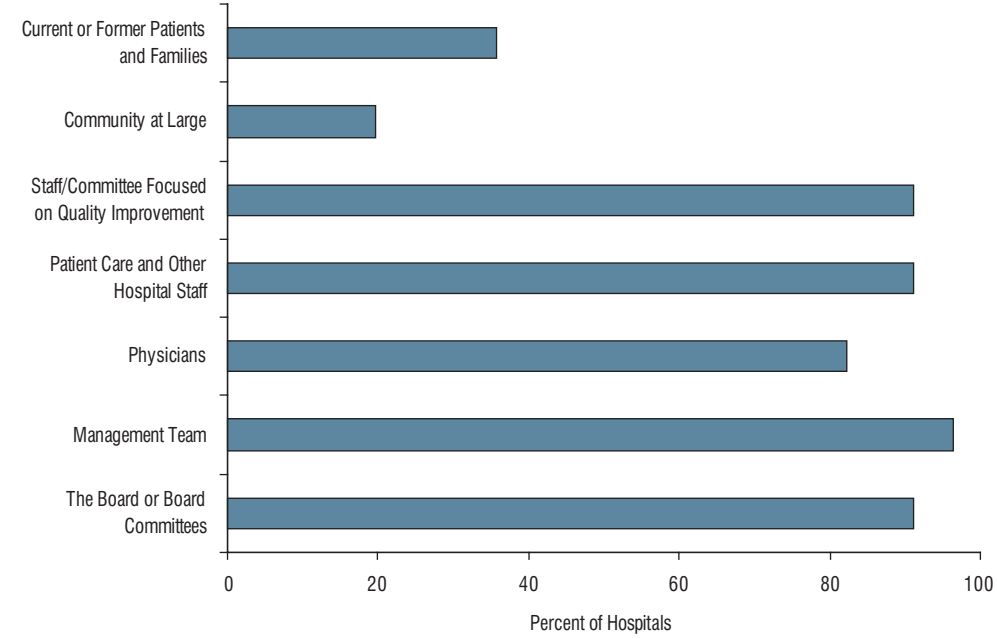
The results from this year's survey on System Integration and Change highlight hospitals' commitment to staff development and quality of care. Hospitals strive to ensure there are designated staff roles in the hospital to provide quality care for patients. This year, approximately 80% of hospitals indicated that they had a formal process to designate someone from the multidisciplinary team to every patient to address questions and concerns about care, goals, treatment and discharge decisions. Although there is considerable variation among hospitals, the results indicate that there are an increasing number of hospitals that are implementing a client-centred approach to service delivery at the system level.

Almost two-thirds (64%) of hospitals surveyed reported that they had a formal process in place to educate staff on the use of models and frameworks to guide best practices within a client-centred context. Best practices involve integrating information from patients, family members and clinical experience/expertise with the best available evidence in making decisions about the care of individual patients. A similar proportion of hospitals (64%) also had a formal process in place for developing and/or adapting clinical practice guidelines. The variation in this indicator suggests that there are still opportunities for hospitals to implement formal processes to support the integration of best practices.

Summary of Results (cont'd)

This year's results indicate that hospitals are frequently implementing a client-centred approach to service delivery at the system level. One of the ways of measuring a client-centred approach is through the use and dissemination of patient/family feedback. Figure 4 illustrates that hospitals are most frequently using and sharing their results with their management team, hospital staff and board committees. The use and dissemination of patient satisfaction data to communities, patients and families is very low compared to the use and dissemination to health professionals. Although hospital scores show a wide variation, hospitals in general can continually improve their levels of sharing and disseminating data with their communities and with current/former patients and families. How they share and use the information are also key aspects in improving quality of patient care.

Use and Dissemination of Patient Satisfaction Data via Verbal Presentation and Discussion of Results



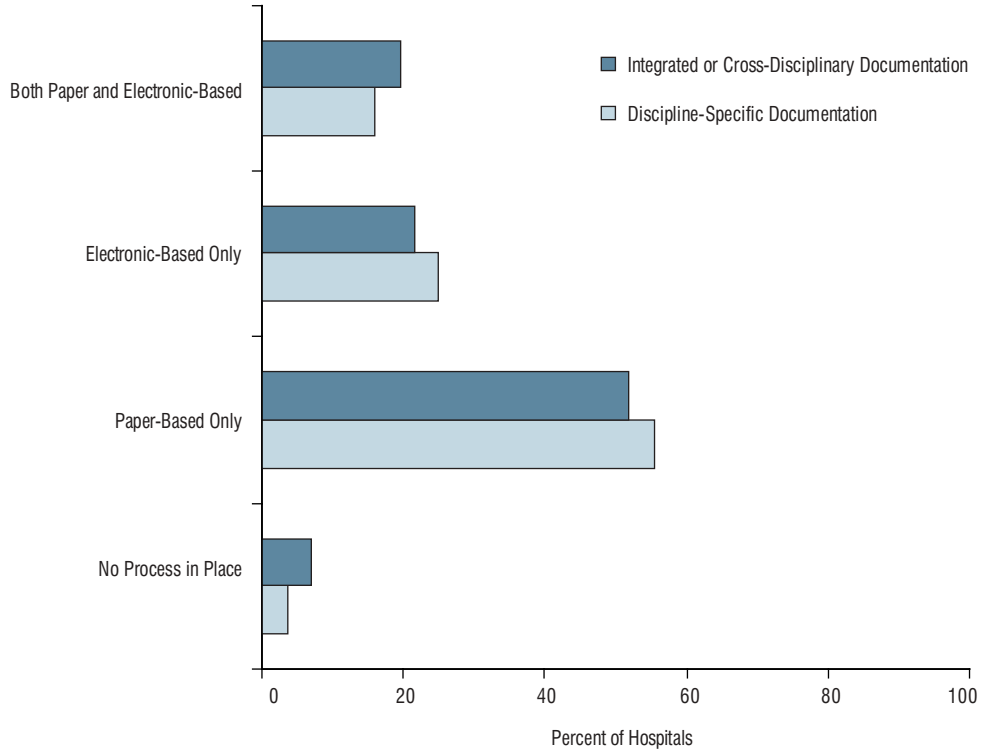
Source: *Hospital Report 2007*: SIC Survey.

Figure 4

Summary of Results (cont'd)

Tracking clinical documentation is a key concept in promoting integration of care within the hospital. This year's results indicate that hospitals' staff are utilizing different methods in their clinical documentation in the clinical record. Figure 5 illustrates that only a small percentage of hospitals do not have a process in place for tracking their clinical documentation in the clinical record. Currently, most hospitals are tracking their clinical documentation via paper-based methods. It is important that hospitals continually find opportunities to standardize their ways of tracking clinical documentation as it promotes continuity, interdisciplinary teamwork within all hospital staff and hospital awareness of increasing access to information.

Processes Currently Utilized for Clinical Documentation in the Clinical Record by Staff Within Rehabilitation Services

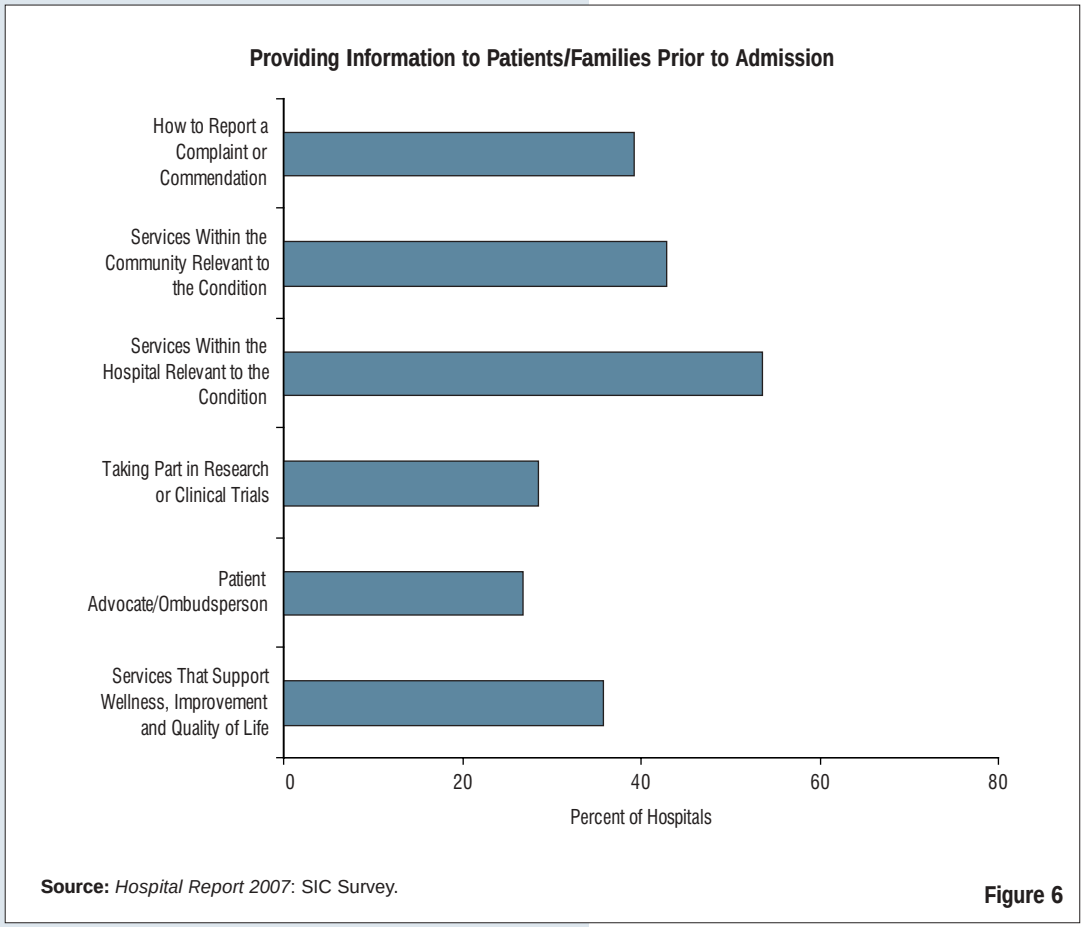


Source: *Hospital Report 2007*: SIC Survey.

Figure 5

Summary of Results (cont'd)

Providing accessible information to patients and families is a key factor in promoting client-centred care. This year's results indicate that the most frequent information available to patients and families prior to admission was regarding services within the hospital relevant to the condition. Although there is information that is readily accessible in most hospitals (for example, printed information on display, available at information desk or posted at bedside) within rehabilitation services at the hospital, hospitals can enhance how they provide information by creating new innovative processes to provide additional information prior to a patient's admission (Figure 6).



Source: *Hospital Report 2007*: SIC Survey.

Figure 6

Performance Allocation Table

The performance allocation table includes results for 56 hospitals that completed the Rehabilitation SIC survey and are participating in this report.

For each indicator, a higher score and above-average performance classification is interpreted as a better result. The maximum score for each indicator is 100. As in the last report, a three-point scale (above average, average, below average) was used to determine performance.

Methodology Changes

In Hospital Report 2005, the method of assigning performance allocation was based on comparing the hospital's indicator score with the 99% confidence interval of the provincial mean for each corresponding indicator. This year, in order to be consistent with other sectors of the System Integration and Change quadrant's performance allocation methods, a new performance allocation method was applied. It sets the upper and lower cut-points at the 95th percentile and the 5th percentile, respectively. This method does not require normality, yet produces an interval similar the one obtained by mean +/- 1.645 standard deviations and should capture roughly 90% of the indicator values.

Hospitals with a score at or higher than the upper cut-point are classified as above average; hospitals with a score at or less than the lower cut-point are classified as below average; and hospitals with a score between the cut points are classified as average. Using this method, approximately 90% of the hospitals would be classified as average.

Hospital	Community Served	LHIN	Healthy Work Environment	Interdisciplinary Integration of Care	Evidence of Client-Centred Care	Best Practices	Coordination and Continuity of Care Across the Continuum —All RCGs	Coordination and Continuity of Care Across the Continuum —Total Stroke	Coordination and Continuity of Care Across the Continuum —Total Ortho	Evidence of Organizational Client-Centredness	Organizational Commitment to Staff Development
PROVINCIAL AVERAGE			74.5	73.1	74.0	61.3	65.4	64.6	62.2	68.6	79.5
Baycrest Centre for Geriatric Care	Toronto	7	59.7	83.3	79.6	80.0	50.0	67.5	67.5	95.9	85.0
Bluewater Health	Sarnia	1	87.9	52.8	60.2	40.9	55.0	55.0	55.0	57.7	47.7
Bridgepoint Health	Toronto	7	94.5	82.8	100.0	64.9	68.8	68.8	68.8	67.9	81.6
Chatham-Kent Health Alliance	Chatham	1	75.6	47.9	38.9	73.8	55.0	55.0	55.0	84.1	69.1
Cornwall Community Hospital	Cornwall	11	79.5	69.7	70.4	48.4	82.5	100.0	100.0	81.3	81.6
Grand River Hospital	Kitchener	3	44.9	81.9	69.8	91.1	63.8	72.5	72.5	45.4	72.7
Grey Bruce Health Services	Owen Sound	2	89.6	78.0	38.0	40.0	91.3	91.3	32.5	53.4	87.5
Guelph General Hospital	Guelph	3	92.7	83.1	96.3	70.7	37.5	37.5	37.5	58.3	85.0
Halton Healthcare	Oakville	6	100.0	89.4	71.6	83.6	65.0	65.0	65.0	89.3	74.3
Hamilton Health Sciences Corporation	Hamilton	4	84.0	89.9	85.0	96.0	91.3	100.0	100.0	94.1	73.8
Hôpital Montfort Hospital	Ottawa	11	90.0	71.1	82.2	57.3	72.5	55.0	55.0	58.2	69.1
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	38.2	84.4	87.1	66.7	81.3	90.0	90.0	55.9	73.0
Hôtel-Dieu Grace Hospital	Windsor	1	96.7	69.5	69.9	64.0	92.5	92.5	92.5	56.8	100.0
Humber River Regional Hospital	Toronto	8	96.4	62.6	83.4	48.0	56.3	23.8	17.5	66.3	92.9
Huron Perth Healthcare Alliance	Stratford	2	53.5	77.1	80.6	53.3	60.0	68.8	68.8	54.9	62.0
Joseph Brant Memorial Hospital	Burlington	4	64.3	73.9	73.7	70.7	30.0	30.0	30.0	61.4	77.9
Lakeridge Health	Oshawa	9	36.4	70.8	78.3	64.0	41.3	41.3	37.5	57.7	88.8
Leamington District Memorial Hospital	Leamington	1	62.3	59.9	69.9	24.0	30.0	30.0	30.0	61.6	60.7
Listowel and Wingham Hospitals Alliance	Listowel	2	33.5	44.0	55.1	72.0	51.3	60.0	60.0	41.9	54.8
Markham Stouffville Hospital	Markham	8	83.2	84.6	66.4	46.7	68.8	68.8	68.8	52.9	82.2
North Bay General Hospital	North Bay	13	18.0	35.6	43.7	16.0	63.8	63.8	63.8	47.9	69.1
North York General Hospital	Toronto	8	95.8	85.8	56.9	45.8	30.0	30.0	30.0	58.5	92.9
Northumberland Hills Hospital	Cobourg	9	95.9	85.1	83.3	72.4	65.0	82.5	82.5	70.2	76.3
Pembroke Regional Hospital	Pembroke	11	89.3	75.8	75.2	48.4	60.0	68.8	68.8	88.4	85.2
Penetanguishene General Hospital Inc. (The)— North Simcoe Hospital Alliance	Penetanguishene	12	97.1	70.8	75.0	68.0	56.3	65.0	65.0	85.0	69.1
Peterborough Regional Health Centre	Peterborough	9	68.9	50.8	68.4	44.0	67.5	42.5	50.0	71.6	73.2
Providence Continuing Care Centre	Kingston	10	96.6	95.3	77.8	82.7	72.5	81.3	63.8	95.9	85.0
Providence Healthcare	Toronto	7	74.7	91.9	79.2	39.1	51.3	60.0	27.5	85.3	83.9

Above-Average Performance Average Performance Below-Average Performance

Hospital	Community Served	LHIN	Healthy Work Environment	Interdisciplinary Integration of Care	Evidence of Client-Centred Care	Best Practices	Coordination and Continuity of Care Across the Continuum —All RCGs	Coordination and Continuity of Care Across the Continuum —Total Stroke	Coordination and Continuity of Care Across the Continuum —Total Ortho	Evidence of Organizational Client-Centredness	Organizational Commitment to Staff Development
Queensway Carleton Hospital	Nepean	11	92.0	83.3	98.2	74.7	96.3	96.3	96.3	91.9	67.9
Quinte Health Care	Belleville	10	35.6	51.7	49.2	12.0	55.0	63.8	63.8	49.9	82.1
Ross Memorial Hospital	Lindsay	9	54.4	56.7	68.2	50.2	35.0	43.8	26.3	86.0	88.8
Rouge Valley Health System	Scarborough	9	70.4	71.4	57.1	32.0	63.8	63.8	63.8	83.4	88.8
Royal Victoria Hospital	Barrie	12	97.2	54.2	68.0	40.0	42.5	42.5	42.5	51.9	87.5
Sault Area Hospital	Sault Ste. Marie	13	38.3	55.6	83.2	50.7	88.8	88.8	78.8	43.1	73.2
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	11.2	58.5	58.2	40.0	80.0	80.0	45.0	62.6	77.9
Southlake Regional Health Centre	Newmarket	8	34.8	68.4	68.4	61.8	50.0	25.0	67.5	54.0	88.8
St. John's Rehab Hospital	Toronto	8	91.0	76.3	83.5	70.7	75.0	75.0	65.0	89.5	75.0
St. Joseph's Care Group	Thunder Bay	14	39.2	81.7	98.1	76.0	91.3	100.0	96.3	46.0	77.9
St. Joseph's Health Care London	London	2	97.2	85.3	87.2	92.0	100.0	100.0	82.5	94.7	88.8
St. Joseph's Health Centre Toronto	Toronto	7	96.7	71.4	59.5	42.7	25.0	25.0	25.0	58.7	100.0
St. Joseph's Health Centre, Guelph	Guelph	3	83.8	73.3	81.2	56.0	40.0	40.0	40.0	51.0	65.5
St. Joseph's Healthcare Hamilton	Hamilton	4	98.5	79.3	82.3	79.1	82.5	82.5	82.5	59.3	85.0
St. Mary's General Hospital	Kitchener	3	85.5	74.7	64.4	64.0	70.0	15.0	15.0	90.0	81.4
St. Thomas-Elgin General Hospital	St. Thomas	2	83.9	80.8	91.0	66.7	65.0	65.0	65.0	84.2	76.8
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	88.6	76.8	80.6	100.0	100.0	15.0	15.0	59.9	85.9
The Brantford General Hospital	Brantford	4	91.9	61.4	73.3	28.0	51.3	68.8	68.8	56.2	77.9
The Credit Valley Hospital	Mississauga	6	86.7	97.8	100.0	70.7	91.3	100.0	100.0	62.8	69.1
The Ottawa Hospital	Ottawa	11	94.3	76.4	92.5	93.3	87.5	96.3	96.3	89.5	88.8
The Scarborough Hospital	Scarborough	9	87.3	63.4	38.9	54.7	60.0	37.5	60.0	62.6	92.9
Toronto East General Hospital	Toronto	7	98.0	81.9	94.7	70.7	57.5	75.0	75.0	62.4	89.1
Toronto Rehabilitation Institute	Toronto	7	93.8	83.6	74.2	85.8	92.5	92.5	75.0	93.3	76.7
Trillium Health Centre	Mississauga	6	94.3	88.0	90.7	70.7	92.5	92.5	82.5	61.9	96.3
West Park Healthcare Centre	Toronto	7	86.2	72.2	56.0	69.3	73.8	56.3	91.3	63.1	88.8
William Osler Health Centre	Brampton	5	24.8	68.2	65.4	70.7	37.5	37.5	37.5	57.3	65.5
Windsor Regional Hospital	Windsor	1	100.0	76.4	97.3	83.6	81.3	90.0	90.0	93.0	92.9
York Central Hospital	Richmond Hill	8	18.0	77.5	68.9	54.7	65.0	82.5	82.5	83.4	69.1

Above-Average Performance Average Performance Below-Average Performance

LHIN	Healthy Work Environment	Interdisciplinary Integration of Care	Evidence of Client-Centred Care	Best Practices	Coordination and Continuity of Care Across the Continuum—All RCGs	Coordination and Continuity of Care Across the Continuum—Total Stroke	Coordination and Continuity of Care Across the Continuum—Total Ortho	Evidence of Organizational Client-Centredness	Organizational Commitment to Staff Development
RESULTS BY LOCAL HEALTH INTEGRATION NETWORK									
LHIN 1 (Erie St. Clair)	84.5	61.3	67.3	57.2	62.8	64.5	64.5	70.6	74.1
LHIN 2 (South West)	71.5	73.1	70.4	64.8	73.5	77.0	61.8	65.8	74.0
LHIN 3 (Waterloo Wellington)	76.7	78.2	78.0	70.4	52.8	41.3	41.3	61.2	76.2
LHIN 4 (Hamilton Niagara Haldimand Brant)	84.7	76.1	78.6	68.4	63.8	70.3	70.3	67.8	78.6
LHIN 5 (Central West)	24.8	68.2	65.4	70.7	37.5	37.5	37.5	57.3	65.5
LHIN 6 (Mississauga Halton)	93.7	91.7	87.4	75.0	82.9	85.8	82.5	71.3	79.9
LHIN 7 (Toronto Central)	86.5	80.5	78.0	69.1	64.8	57.5	55.6	73.3	86.4
LHIN 8 (Central)	69.9	75.9	71.3	54.6	57.5	50.8	55.2	67.4	83.5
LHIN 9 (Central East)	68.9	66.4	65.7	52.9	55.4	51.9	53.3	71.9	84.8
LHIN 10 (South East)	66.1	73.5	63.5	47.3	63.8	72.5	63.8	72.9	83.6
LHIN 11 (Champlain)	76.0	72.5	79.4	60.4	79.8	82.7	76.9	78.6	78.4
LHIN 12 (North Simcoe Muskoka)	97.2	62.5	71.5	54.0	49.4	53.8	53.8	68.4	78.3
LHIN 13 (North East)	31.5	58.5	71.3	44.4	77.9	80.8	77.5	49.0	71.8
LHIN 14 (North West)	39.2	81.7	98.1	76.0	91.3	100.0	96.3	46.0	77.9

This quadrant describes clients' perceptions of the care they received while in designated adult inpatient rehabilitation beds.

The analysis reflects perceptions of clients while in designated rehabilitation beds between April 2005 and March 2006.

For each of the indicators, a higher score is desirable, as is an above-average performance classification. The maximum score for each indicator is 100.

Indicator Definitions

The indicators in this quadrant are made up of individual questionnaire items that reflect different areas of client perspectives.

Client Participation in Decision-Making and Goal-Setting

The extent to which clients are included in decision-making and goal-setting.

Client-Centred Education

The extent to which the education and information that clients receive is client-centred.

Evaluation of Outcomes From the Client's Perspective

The extent to which clients are involved in evaluating the outcomes of treatment.

Family Involvement

The extent to which families are involved in the rehabilitation process.

Emotional Support

The extent to which clients feel they are receiving emotional support from staff.

Physical Comfort

The extent to which clients feel that their physical comfort needs have been addressed.

Continuity and Transition

The extent to which clients feel that there was continuity and transition evident in rehabilitation programs for clients following discharge from inpatient rehabilitation.

Overall Quality of Care

Ascertains client perceptions of the overall quality of rehabilitation care.

Results for the 37 hospitals that voluntarily participated in the rehabilitation client perspectives survey process in 2005–2006 are included in the analysis and illustrated in the performance allocation tables.

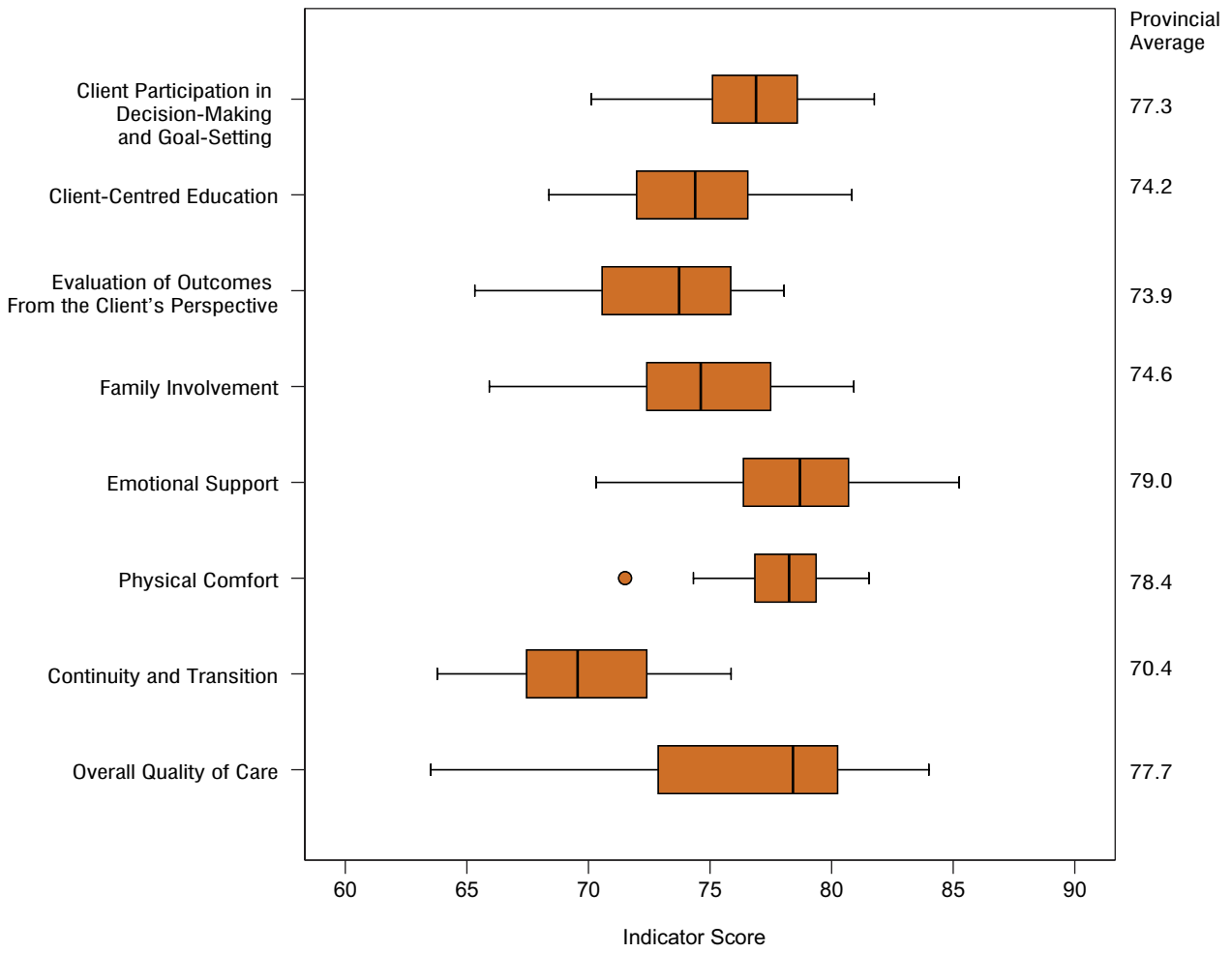
Response Rates

The Client Perspectives of Rehabilitation Services Questionnaire (CPRSQ) was sent to 13,874 clients from 37 participating hospitals between April 1, 2005, and March 31, 2006. In total, 6,901 usable questionnaires were returned, resulting in an overall response rate of 50%. The response rate between the sexes was very similar—females had a response rate of 50% while males had a response rate of 49%.

NRC + Picker

The client perspectives results in this quadrant of the report are based on data collected by NRC + Picker Canada. NRC + Picker Canada is a Canadian research company specializing in promoting patient-centred care in the Canadian health care setting. NRC + Picker Canada has over 13 years' experience nationally, and over 26 years' internationally, conducting survey research designed to uncover what is most important to patients.

Summary of Results



Source: Client Perspectives of Rehabilitation Services Questionnaire, 2005–2006

Figure 7

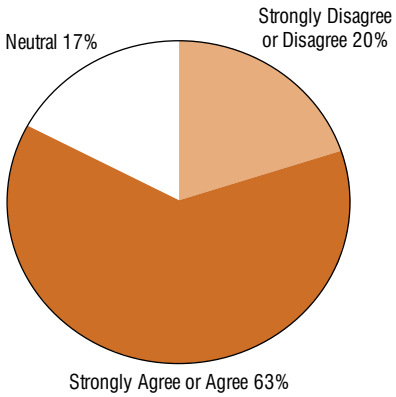
For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

Summary of Results (cont'd)

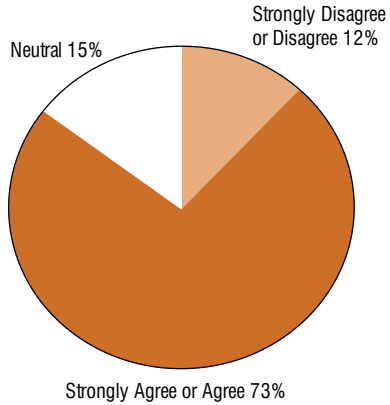
Over three-quarters of rehabilitation clients rated their overall quality of care positively. However, similar to the past two years, rehabilitation clients' perceptions of the continuity of their care and their transition to the community were the least favourable of all the dimensions considered. This suggests that clients perceive that they are not receiving the adequate information they need to continue managing their condition post-discharge. Figure 8 highlights provincial responses to three questionnaire items relating to continuity of care in the community. Although about three-quarters of clients feel that they are getting the information they need, there remains a fairly large percentage (ranging from 12% to 20%) who do not feel that they are receiving information on what to expect after discharge (for example, how to monitor their conditions and how to progress their abilities once they are at home). These are very important issues for continuity and transition when clients return to the community from inpatient rehabilitation. Often they still have a residual physical disability that they need to manage at least in the short term, and often in the long term. This suggests that hospitals could invest in activities that enhance continuity and transition, particularly with respect to providing clients with the information they need to manage their (often) chronic condition after discharge.

Three "Continuity and Transition" Questionnaire Items

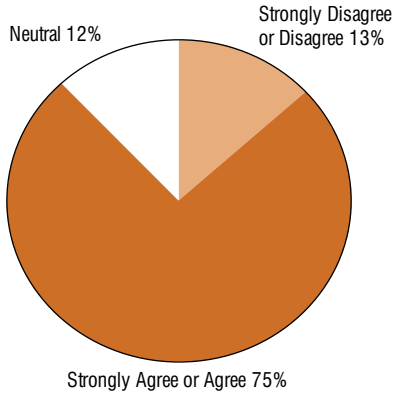
Before leaving the hospital, I was given adequate information about how to monitor my condition for problems and danger signals.



Hospital staff told me what to expect about how I might progress at home in regaining my abilities.



Hospital staff told me about which activities I could and could not do on my own at home.



Source: Client Perspectives of Rehabilitation Services Questionnaire, 2005–2006.

Figure 8

Summary of Results (cont'd)

Men receiving inpatient rehabilitation care were significantly more likely to report positive perceptions of quality of care than women. Inpatient rehabilitation care is more prevalent for women, particularly older women. Regaining functional status and ensuring readiness for discharge and adequate follow-up may be particularly important as women often return home to situations in which they are the primary informal caregivers and/or live alone. Examining differences between women and men may be important in identifying and defining valuable opportunities for improvements in perceived quality of care.

The Overall Quality of Care indicator has the highest number of hospitals assigned a "below-average" performance allocation. It is important to recognize that this indicator consists of only one questionnaire item, while the other indicators are more robust in that they consist of four or more items. Therefore, there is a greater opportunity for lower single-item perceptions to be diluted by higher perceptions on other items within the same indicator. This still highlights the need for hospitals to take a closer look at all components of client-centred rehabilitation they are providing. Although hospitals are generally performing well on all of the indicators, further investigation into the individual components could lead to improved client perceptions on the overall quality of care they receive during their rehabilitation.

Performance allocation table

The table that follows provides indicator results for the hospitals that participated in the Client Perspectives of Rehabilitation Services Questionnaire and passed the 30-case volume screen.

Hospital	Community Served	LHIN	Client Participation in Decision-Making and Goal-Setting	Client-Centred Education	Evaluation of Outcomes From the Client's Perspective	Family Involvement	Emotional Support	Physical Comfort	Continuity and Transition	Overall Quality of Care
PROVINCIAL AVERAGE			77.3	74.2	73.9	74.6	79.0	78.4	70.4	77.7
PROVINCIAL PERFORMANCE TARGET*			76.7	74.1	73.0	74.6	78.4	78.0	69.8	76.6
Baycrest Centre for Geriatric Care	Toronto	7	74.5	72.5	69.5	77.3	77.1	77.1	71.5	71.6
Bluewater Health	Sarnia	1	75.5	75.7	71.5	72.5	76.4	77.4	68.0	75.7
Bridgepoint Health	Toronto	7	73.3	68.5	70.6	67.9	73.8	75.7	66.1	70.8
Chatham-Kent Health Alliance	Chatham	1	80.8	77.9	76.2	80.9	81.0	79.7	73.3	78.4
Grand River Hospital	Kitchener	3	76.8	76.9	72.1	78.2	78.2	77.5	71.5	74.4
Grey Bruce Health Services	Owen Sound	2	75.6	72.3	68.8	71.3	77.1	78.7	69.6	80.3
Halton Healthcare	Oakville	6	74.2	73.1	71.7	73.5	74.5	75.8	65.7	71.7
Hamilton Health Sciences Corporation	Hamilton	4	78.4	78.2	75.9	77.5	81.6	80.0	72.9	81.8
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	72.2	72.1	70.9	71.2	73.9	76.8	68.3	69.0
Lakeridge Health	Oshawa	9	77.7	73.3	74.6	73.2	78.7	77.4	68.4	76.3
Pembroke Regional Hospital	Pembroke	11	NR	NR	NR	NR	NR	NR	NR	NR
Penetanguishene General Hospital Inc. (The)—North Simcoe Hospital Alliance	Penetanguishene	12	75.6	73.5	72.9	72.7	79.1	81.3	68.1	79.4
Peterborough Regional Health Centre	Peterborough	9	78.6	77.1	75.7	77.4	81.8	80.8	69.3	80.3
Providence Continuing Care Centre	Kingston	10	81.8	78.2	77.6	78.8	85.3	80.5	75.9	83.2
Providence Healthcare	Toronto	7	78.1	74.6	74.9	75.0	80.2	77.8	72.1	78.5
Queensway Carleton Hospital	Nepean	11	76.9	75.3	75.0	73.1	80.5	79.1	71.9	79.9
Quinte Health Care	Belleville	10	79.5	75.9	77.0	78.7	82.1	78.3	72.6	77.5
Sault Area Hospital	Sault Ste. Marie	13	75.6	70.0	70.2	72.2	77.2	76.2	67.0	65.7
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	79.2	75.8	76.5	79.5	82.4	79.4	75.5	80.2
Southlake Regional Health Centre	Newmarket	8	78.9	77.8	75.4	77.9	81.0	78.8	72.5	80.5
St. John's Rehab Hospital	Toronto	8	76.1	72.8	74.3	71.3	76.7	79.1	67.7	78.7
St. Joseph's Care Group	Thunder Bay	14	78.2	76.2	75.3	74.6	80.4	77.7	72.6	80.1
St. Joseph's Health Care London	London	2	80.5	77.1	76.4	78.0	82.2	79.6	72.7	84.0
St. Joseph's Health Centre Toronto	Toronto	7	75.6	70.2	68.6	70.9	77.3	78.0	67.5	76.5

* Indicates the average of hospital scores. This is used for performance allocations. For further details, please refer to this year's technical summary.

Above-Average Performance Average Performance Below-Average Performance

Hospital	Community Served	LHIN	Client Participation in Decision-Making and Goal-Setting	Client-Centred Education	Evaluation of Outcomes From the Client's Perspective	Family Involvement	Emotional Support	Physical Comfort	Continuity and Transition	Overall Quality of Care
St. Joseph's Healthcare Hamilton	Hamilton	4	78.9	74.4	73.7	74.4	79.8	78.3	65.4	77.2
St. Mary's General Hospital	Kitchener	3	75.1	71.1	68.8	73.6	74.9	76.1	66.7	78.7
St. Thomas-Elgin General Hospital	St. Thomas	2	75.9	69.9	65.3	73.8	75.9	76.6	63.8	67.0
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	73.9	72.8	70.6	75.9	77.3	78.6	72.4	78.0
The Brantford General Hospital	Brantford	4	77.1	76.2	76.6	79.2	80.1	78.4	68.1	78.4
The Credit Valley Hospital	Mississauga	6	73.3	72.0	68.2	71.7	72.8	74.3	68.5	68.1
The Ottawa Hospital	Ottawa	11	80.9	77.4	77.5	76.6	83.6	80.6	71.9	82.0
Toronto East General Hospital	Toronto	7	73.4	71.0	69.4	68.4	74.4	76.0	67.4	72.9
Toronto Rehabilitation Institute	Toronto	7	77.3	71.5	72.9	75.0	78.8	79.1	70.2	76.0
Trillium Health Centre	Mississauga	6	75.1	70.3	70.9	72.4	75.5	75.9	67.4	71.7
West Park Healthcare Centre	Toronto	7	79.8	76.6	78.0	75.1	80.7	80.4	74.9	82.5
William Osler Health Centre	Brampton	5	70.1	68.4	65.8	NR	70.3	71.5	63.9	63.5
York Central Hospital	Richmond Hill	8	77.1	74.7	75.0	74.9	78.0	77.9	70.7	78.6

* Indicates the average of hospital scores. This is used for performance allocations. For further details, please refer to this year's technical summary.

Above-Average Performance Average Performance Below-Average Performance

	Client Participation in Decision-Making and Goal-Setting	Client-Centred Education	Evaluation of Outcomes From the Client's Perspective	Family Involvement	Emotional Support	Physical Comfort	Continuity and Transition	Overall Quality of Care
RESULTS BY LOCAL HEALTH INTEGRATION NETWORK								
LHIN 1 (Erie St.Clair)	78.1	76.8	73.8	76.9	78.6	78.5	70.6	77.0
LHIN 2 (South West)	79.6	76.0	74.6	76.9	81.1	79.2	71.7	82.1
LHIN 3 (Waterloo Wellington)	75.9	73.8	70.5	75.8	76.6	76.8	69.0	76.6
LHIN 4 (Hamilton Niagara Haldimand Brant)	78.3	76.1	75.1	76.5	80.5	78.9	68.7	79.1
LHIN 5 (Central West)	70.1	68.4	65.8	65.9	70.3	71.5	63.9	63.5
LHIN 6 (Mississauga Halton)	74.2	71.9	70.4	72.6	74.3	75.4	67.1	70.7
LHIN 7 (Toronto Central)	76.4	72.1	72.7	73.4	77.8	78.1	70.1	75.9
LHIN 8 (Central)	76.6	73.8	74.6	73.0	77.5	78.8	69.0	78.9
LHIN 9 (Central East)	78.0	74.6	75.0	74.8	79.7	78.5	68.7	77.5
LHIN 10 (South East)	81.2	77.7	77.5	78.8	84.5	80.0	75.1	81.8
LHIN 11 (Champlain)	78.9	76.3	76.3	76.0	82.0	79.7	72.7	80.8
LHIN 12 (North Simcoe Muskoka)	75.6	73.5	72.9	72.7	79.1	81.3	68.1	79.4
LHIN 13 (North East)	74.1	70.9	70.5	71.7	75.8	76.4	67.6	67.1
LHIN 14 (North West)	78.2	76.2	75.3	74.6	80.4	77.7	72.6	80.1

Note: LHIN-level results are based only on those hospitals that participated in the client perspectives survey. See Table 1 "Inpatient Rehabilitation in Ontario" on page 2 for further details on the breakdown of hospitals within the LHINs.

Data from all 58 Ontario hospitals with designated rehabilitation beds in Ontario that contribute to this reporting system were used to calculate provincial and local health integration network (LHIN) averages; hospital-specific data are shown for 57 hospitals that voluntarily agreed to participate in this report.

Inpatient rehabilitation clients receive services provided by health professionals such as nurses, physiotherapists, occupational therapists and physicians specializing in physical medicine and rehabilitation. These professionals assist clients in maximizing their physical and cognitive function through training and education, and prepare them to return to the community following illness or injury.

This quadrant focuses on the clinical performance of Ontario hospitals in providing adult inpatient rehabilitation care. Data are from the National Rehabilitation Reporting System (NRS) and reflect inpatient rehabilitation activity in Ontario in 2005–2006. NRS data have been mandated for collection for designated rehabilitation beds since October 2002. Clients reported in the NRS include only those with a primary health condition that is physical in nature.

A cornerstone of the NRS is the concept of human function and the focus of rehabilitation in assisting individuals to achieve maximum independence in daily living, be it at home or in an assisted-living facility. The primary measure of physical function in the NRS is the FIM™ instrument, from which a Total Function Score[iii] can be calculated. The FIM™ instrument is a measure of disability and caregiver burden associated with the level of disability.

Indicator scores and performance classifications are reported for the following Rehabilitation Client Groups (RCGs)[iv]: All RCGs, Stroke and Orthopedic Conditions. (Note that "All RCGs" refers to all Rehabilitation Client Groups and thus reflects the total number of inpatient rehabilitation clients within each hospital.) Stroke and Orthopedic Conditions have been highlighted in this section as these two RCGs comprise the majority (16% for Stroke and 49% for Orthopedic Conditions) of all inpatient rehabilitation activity represented in NRS data. For greater specificity, information on the post hip fractures and post hip and knee replacement sub-categories of the Orthopedic Conditions RCG is presented.

Indicator Definitions

There are three key indicators in this quadrant: Average Total Function Score Change, Average Active Rehabilitation Length of Stay and Length of Stay Efficiency.

Average Total Function Score Change

The Total Function Score Change indicator is defined as the Total Function Score at discharge minus the Total Function Score at admission. This is a quality outcome measure of how much the clients' functional status changed, on average, between admission to and discharge from inpatient rehabilitation. A comparatively higher number is desirable. Variations across hospitals, such as the average functional level of clients on admission to the rehabilitation program, the length of time since onset of the condition for which the client is receiving inpatient rehabilitation and the length of stay in inpatient rehabilitation, should be considered when interpreting this indicator.

iii. Total Function Scores referenced in this document are based on data collected using the FIM™ instrument. The 18-item FIM™ instrument referenced herein is the property of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

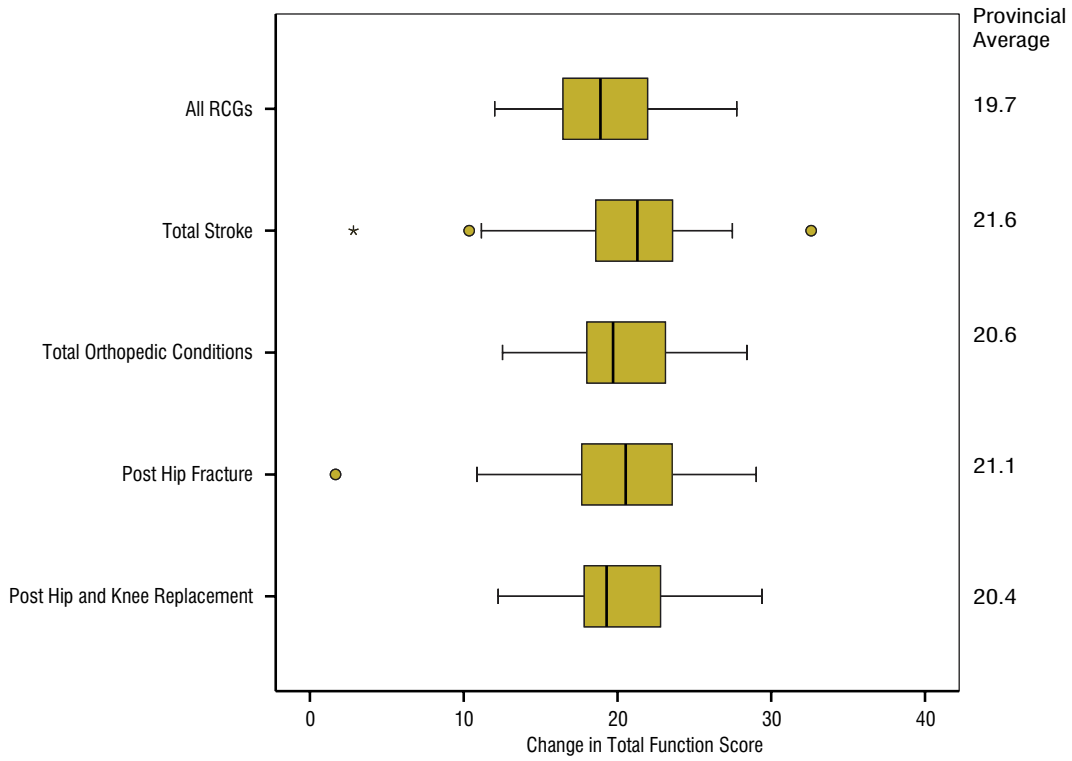
iv. Rehabilitation Client Groups (RCGs) adapted with permission from the UDS$_{MR}$ impairment codes. Copyright 1997 Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc., all rights reserved.

Average Active Rehabilitation Length of Stay

The Active Rehabilitation Length of Stay indicator is defined as the average number of days between clients' admission to and discharge from the rehabilitation facility, excluding any service interruptions. This is a quality measure of the number of days, on average, clients required in an inpatient rehabilitation stay to become ready for discharge. A comparatively lower number is desirable. Variations across hospitals, such as the average functional level of clients on admission to the rehabilitation program, overall client needs and the length of time since onset of the condition for which the client is receiving inpatient rehabilitation, should be considered when interpreting this indicator.

Average Length of Stay Efficiency

The Length of Stay Efficiency indicator is defined as the average change in Total Function Score per day of client participation in the rehabilitation program, excluding service interruptions. This is a quality measure of the functional progress made by clients in relation to how long they stayed in rehabilitation. A comparatively higher number is desirable. Variations across hospitals, such as clients' functional levels and the services provided to the client while in inpatient rehabilitation, should be considered when interpreting this indicator.



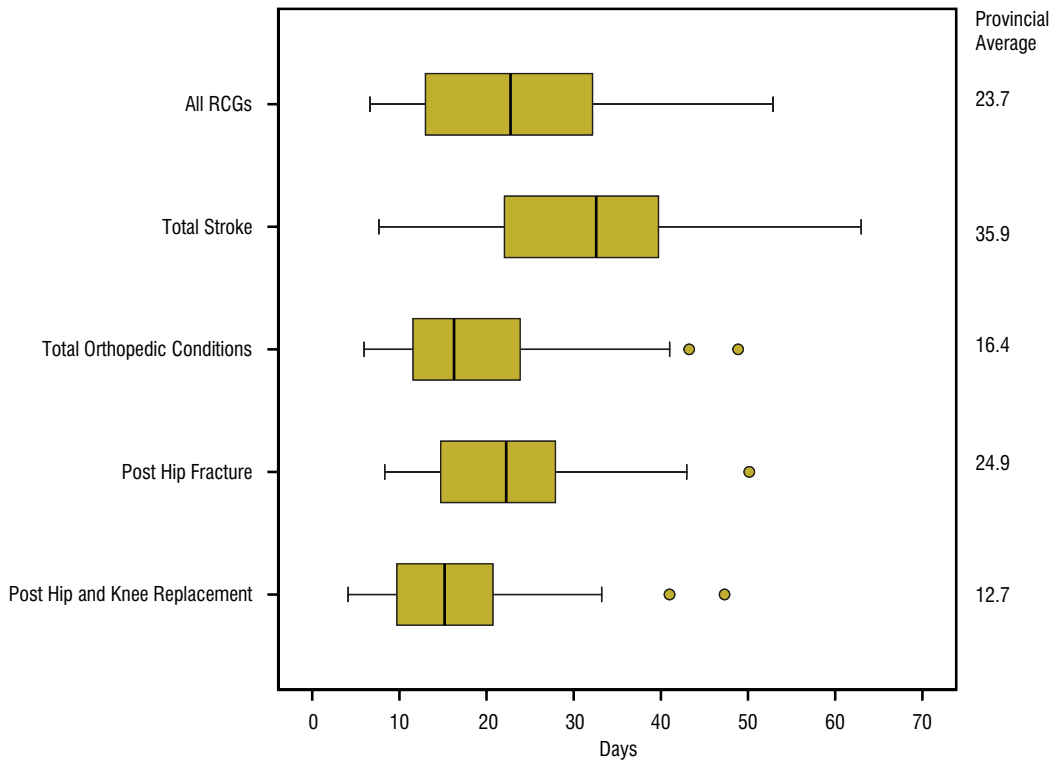
Source: National Rehabilitation Reporting System, 2005–2006, CIHI.

Figure 9

For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

Figures 9, 10 and 11 depict the distribution of hospital-level average Total Function Score changes from admission to discharge, average Active Rehabilitation Length of Stay and average Length of Stay Efficiency scores for all RCGs, the stroke and orthopedic condition RCGs and the two sub-categories within the orthopedic condition RCG. Hospitals can use these figures to determine where their indicator scores (as found in the performance allocation table) fit in relation to the overall distribution of scores for each of the clinical indicators.

Summary of Results (cont'd)



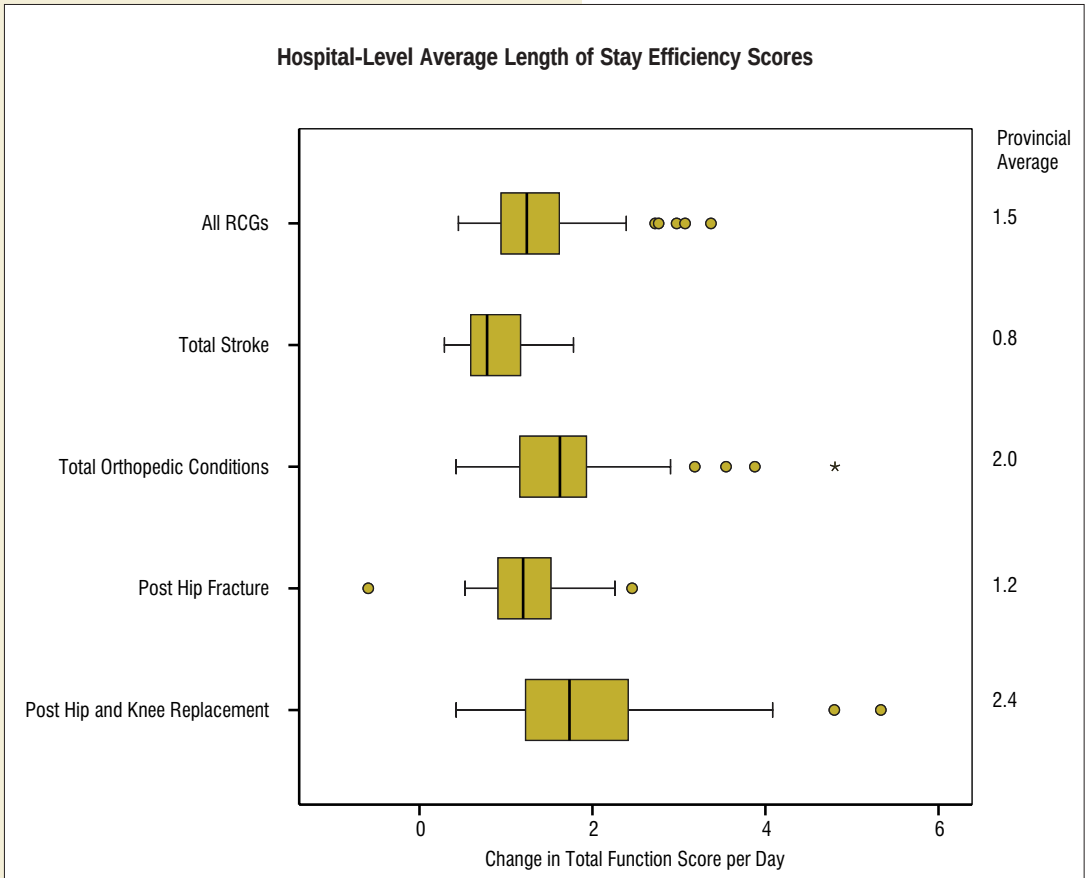
Source: National Rehabilitation Reporting System, 2005–2006, CIHI.

Figure 10

Summary of Results (cont'd)

In 2005–2006, the average Total Function Score Change from admission to discharge, as a measure of functional improvement, for all clients was just under 20. Stroke and orthopedic clients, on average, demonstrated Total Function Score changes that were slightly larger than the average for all clients. The possible values for Total Function Score Change range from -108 to 108. A Total Function Score Change of 0 indicates that there was no change in the client's functional ability between admission and discharge, while a negative value indicates that the client's functional abilities deteriorated following admission to inpatient rehabilitation.

For clients who enter inpatient rehabilitation with greater comparable functional abilities, a lower Total Function Score Change is anticipated, due to the nature of the instrument properties. For example, if a client enters inpatient rehabilitation with a Total Function Score of 110, the potential for improvement, as measured using the FIM™ instrument, is limited to 16 (that is, to reach the maximum possible score of 126).



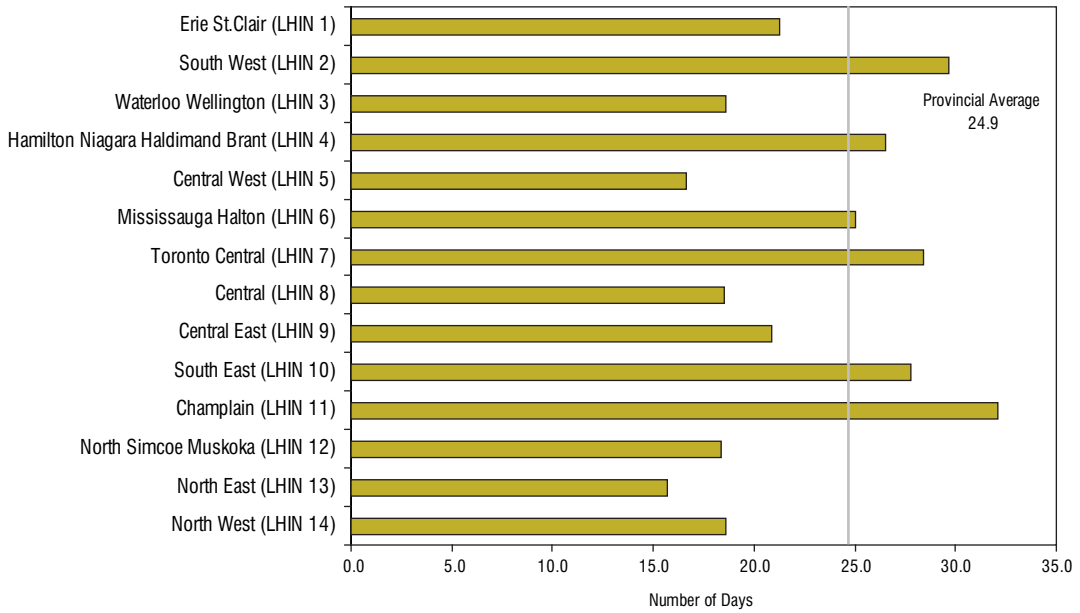
Source: National Rehabilitation Reporting System, 2005–2006, CIHI.

Figure 11

Some clients, such as those receiving rehabilitation following a stroke or a hip fracture, required a longer length of stay to achieve gains in function that were similar, on average, to those clients who participated in rehabilitation following elective joint replacements. Stroke clients stayed, on average, more than twice as long as clients with orthopedic conditions (36 days versus 16 days).

The indicator results for this quadrant suggest variation across hospitals relating to change in functional status and length of stay for inpatient rehabilitation clients. This variation may exist for a number of potential reasons, including variation in client characteristics on admission to the rehabilitation program, the length of time waiting for admission to rehabilitation and the scope and extent of services provided in each hospital.

Summary of Results (cont'd)

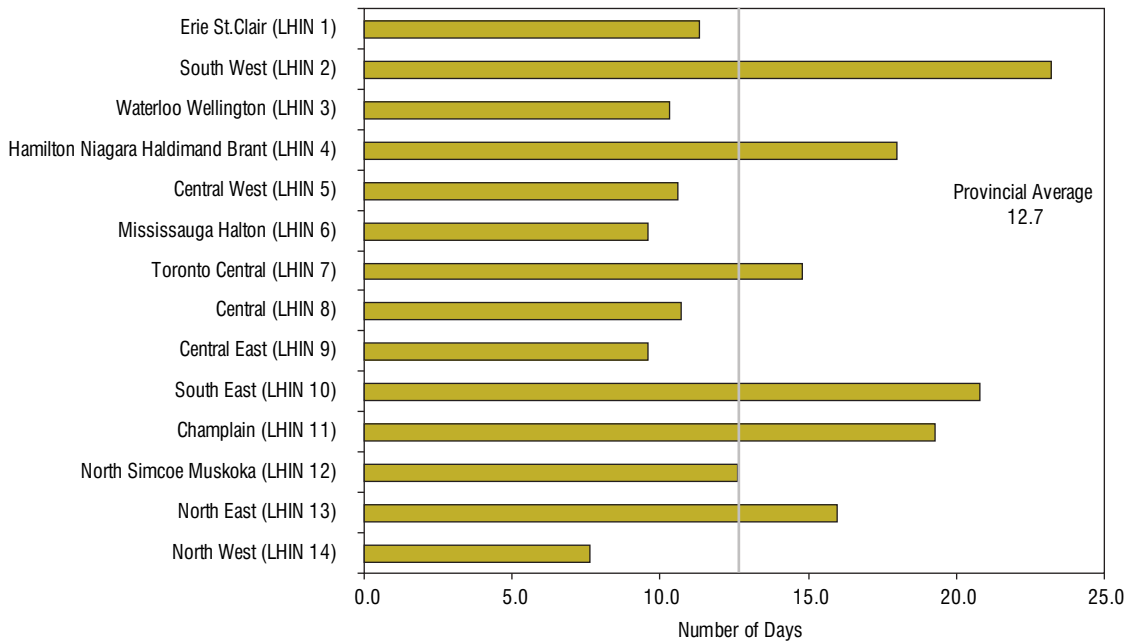


Source: National Rehabilitation Reporting System, 2005–2006, CIHI.

Figure 12

Summary of Results (cont'd)

Figures 12 and 13 show the wide variation in Average Active Rehabilitation Length of Stay for hip fracture and hip and knee replacement clients at the LHIN level. Note that the provincial average Active Rehabilitation Length of Stay for hip fractures (25 days) is twice as long as that for hip and knee replacements (13 days). This may be attributable, in part, to the different levels of care required for these groups. For example, many joint replacement clients undergo a standard, elective procedure and may show functional improvement in a shorter period of time.



Source: National Rehabilitation Reporting System, CIHI, 2005–2006.

Figure 13

In both groups, there are variations in average length of stay among LHINs. For example, the highest average length of stay for clients with hip fractures is found in the Champlain LHIN, at 32 days, and the lowest average length of stay for this group is found in the North East LHIN, at 16 days. In contrast, the highest average length of stay for clients with hip and knee replacements is found in the South West LHIN, at 23 days, and the lowest average length of stay for this group is found in the North West LHIN, at 8 days.

The length of stay in a rehabilitation program can potentially be influenced by many factors, such as age, the presence of comorbid conditions, the number of beds in a facility, the number of transfers, staffing and the availability of needed post-discharge care resources.

It should be noted that LHINs may vary considerably in the number of hospitals within their boundaries, the populations they serve and the services they provide. While these differences must be considered in the interpretation of indicator results, they do not necessarily explain the findings. Where variation in indicator results is observed, further investigation is warranted to explore the opportunities for shared learning and process improvement.

Performance Allocation Table

Hospital	Community Served	LHIN	All Rehabilitation Client Groups: Average Total Function Change	All Rehabilitation Client Groups: Average Active Rehabilitation Length of Stay	All Rehabilitation Client Groups: Length of Stay Efficiency	Stroke: Average Total Function Change	Stroke: Average Active Rehabilitation Length of Stay	Stroke: Length of Stay Efficiency	Orthopedic Conditions: Average Total Function Change	Orthopedic Conditions: Average Active Rehabilitation Length of Stay	Orthopedic Conditions: Length of Stay Efficiency
PROVINCIAL AVERAGE			19.7	23.7	1.5	21.6	35.9	0.8	20.6	16.4	2.0
Baycrest Centre for Geriatric Care	Toronto	7	17.7	37.7	0.5	24.5	45.6	0.6	21.7	36.8	0.7
Bluewater Health	Sarnia	1	20.5	25.9	1.3	20.4	37.0	0.7	21.0	16.0	2.0
Bridgepoint Health	Toronto	7	25.4	31.3	1.3	23.0	52.4	0.5	26.4	24.5	1.5
Chatham-Kent Health Alliance	Chatham	1	18.9	21.4	1.2	18.6	33.7	0.9	20.7	17.4	1.4
Cornwall Community Hospital	Cornwall	11	16.2	36.3	0.5	17.6	48.3	0.4	16.2	31.8	0.5
Grand River Hospital	Kitchener	3	16.5	21.1	1.5	22.8	36.1	1.2	15.5	15.3	1.7
Grey Bruce Health Services	Owen Sound	2	22.4	29.9	0.9	25.0	36.5	0.8	19.6	15.2	1.5
Guelph General Hospital	Guelph	3	12.0	8.9	1.5	10.4	8.1	1.4	13.5	8.7	1.7
Halton Healthcare	Oakville	6	19.3	15.7	1.7	16.6	26.7	0.9	19.6	12.9	2.0
Hamilton Health Sciences Corporation	Hamilton	4	21.2	32.2	1.1	22.8	34.3	0.8	24.5	22.9	1.8
Hôpital Montfort Hospital	Ottawa	11	12.9	13.0	1.1	12.4	13.9	0.8	14.7	12.8	1.2
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	17.0	40.0	0.5	17.9	37.3	0.5	17.5	41.0	0.4
Hôtel-Dieu Grace Hospital	Windsor	1	19.4	7.5	3.4	11.9	8.2	1.6	24.2	6.0	4.8
Humber River Regional Hospital	Toronto	8	25.1	10.2	3.0	18.5	12.0	1.8	25.7	9.3	3.2
Huron Perth Healthcare Alliance	Stratford	2	22.6	32.4	1.2	22.0	46.5	0.8	25.7	22.5	1.7
Joseph Brant Memorial Hospital	Burlington	4	22.0	21.7	1.4	25.2	31.0	1.1	23.1	19.6	1.6
Lakeridge Health	Oshawa	9	27.8	33.1	1.5	32.6	52.6	0.8	27.7	21.7	2.2
Leamington District Memorial Hospital	Leamington	1	16.1	9.7	1.6	12.6	7.6	1.6	18.8	11.6	1.7
Listowel and Wingham Hospitals Alliance	Listowel	2	19.3	16.6	1.6	25.2	19.8	1.7	17.6	15.2	1.7
Markham Stouffville Hospital	Markham	8	15.3	12.4	1.6	19.6	22.0	1.2	14.1	9.5	1.7
North Bay General Hospital	North Bay	13	23.6	30.0	1.3	27.5	40.4	1.2	20.6	19.1	2.1
North York General Hospital	Toronto	8	16.8	15.6	1.2	12.8	11.5	1.2	18.7	14.6	1.5
Northumberland Hills Hospital	Cobourg	9	22.2	27.6	1.2	19.2	42.1	0.5	25.2	22.5	1.6
Pembroke Regional Hospital	Pembroke	11	24.2	26.1	1.4	24.9	30.5	1.1	24.1	23.9	1.8
Penetanguishene General Hospital Inc. (The)—North Simcoe Hospital Alliance	Penetangui-shene	12	15.4	18.6	0.9	21.0	31.5	0.6	13.4	13.9	0.9
Peterborough Regional Health Centre	Peterborough	9	18.4	36.5	0.7	22.7	42.5	0.8	19.1	36.7	0.7
Providence Continuing Care Centre	Kingston	10	22.6	37.0	1.0	21.3	49.5	0.5	25.9	23.3	1.4

Above-Average Performance Average Performance Below-Average Performance

Hospital	Community Served	LHIN	All Rehabilitation Client Groups			Stroke			Orthopedic Conditions		
			Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency
Providence Healthcare	Toronto	7	18.5	35.2	0.7	17.8	51.9	0.4	18.8	27.5	0.8
Queensway Carleton Hospital	Nepean	11	14.1	18.7	1.0	11.1	22.1	0.6	14.7	16.3	1.3
Quinte Health Care	Belleville	10	18.5	29.0	0.7	22.6	35.0	0.7	18.6	26.6	0.7
Ross Memorial Hospital	Lindsay	9	21.0	22.8	1.1	19.4	29.9	0.7	23.1	20.5	1.2
Rouge Valley Health System	Scarborough	9	18.2	11.1	2.4	23.2	23.7	1.4	18.4	8.7	2.7
Royal Victoria Hospital	Barrie	12	19.5	22.2	1.2	24.6	25.9	1.2	21.3	15.1	1.9
Sault Area Hospital	Sault Ste. Marie	13	17.6	22.8	1.0	22.1	32.6	0.9	18.1	19.8	1.1
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	25.2	52.9	0.5	23.6	63.0	0.4	28.4	48.9	0.6
Southlake Regional Health Centre	Newmarket	8	13.9	11.2	3.1	23.7	36.1	0.7	12.5	6.4	3.9
St. John's Rehab Hospital	Toronto	8	22.2	19.9	1.6	23.1	36.8	0.8	21.3	14.9	1.8
St. Joseph's Care Group	Thunder Bay	14	15.8	20.0	1.8	19.8	36.2	0.7	19.1	10.4	2.7
St. Joseph's Health Care London	London	2	21.3	36.8	0.7	22.3	39.7	0.6	21.0	30.8	0.8
St. Joseph's Health Centre Toronto	Toronto	7	16.9	9.2	2.2	12.7	9.6	1.5	18.0	8.7	2.4
St. Joseph's Health Centre, Guelph	Guelph	3	18.5	43.9	0.5	18.7	44.6	0.5	20.0	43.3	0.6
St. Joseph's Healthcare Hamilton	Hamilton	4	17.2	24.9	0.9	19.0	26.2	0.8	19.6	20.7	1.3
St. Mary's General Hospital	Kitchener	3	14.1	12.9	1.3	22.0	13.0	1.7	13.1	15.0	0.8
St. Thomas-Elgin General Hospital	St. Thomas	2	21.8	25.1	1.0	27.4	32.8	0.9	21.5	26.6	1.0
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	15.9	6.6	2.8	2.8	10.8	0.3	16.4	6.2	2.9
The Brantford General Hospital	Brantford	4	19.9	25.7	0.9	20.3	31.2	0.8	21.0	21.9	1.2
The Credit Valley Hospital	Mississauga	6	22.5	23.7	1.4	26.8	31.1	1.0	23.6	21.5	1.9
The Ottawa Hospital	Ottawa	11	16.3	27.5	0.9	18.8	35.4	0.5	18.0	16.1	1.3
The Scarborough Hospital	Scarborough	9	12.8	10.0	1.8	11.6	15.5	0.9	12.8	8.8	1.9
Toronto East General Hospital	Toronto	7	19.2	10.3	2.2	22.0	17.5	1.3	20.2	9.3	2.4
Toronto Rehabilitation Institute	Toronto	7	22.0	39.0	0.9	24.2	43.6	0.7	23.3	23.9	1.5
Trillium Health Centre	Mississauga	6	22.9	14.5	2.7	24.6	24.1	1.5	24.0	10.5	3.5
West Park Healthcare Centre	Toronto	7	16.3	41.6	0.6	19.1	39.5	0.5	26.6	28.9	1.2
West Parry Sound Health Centre	Parry Sound	13	19.3	12.8	1.6	22.6	17.6	1.4	18.5	9.8	1.8
William Osler Health Centre	Brampton	5	19.9	18.8	1.5	23.9	32.5	1.1	19.1	15.2	1.6
Windsor Regional Hospital	Windsor	1	18.2	36.3	0.6	19.5	41.9	0.5	19.7	29.7	0.7
York Central Hospital	Richmond Hill	8	18.4	12.4	1.8	20.8	24.0	1.0	19.7	11.0	2.0

Above-Average Performance Average Performance Below-Average Performance

	All Rehabilitation Client Groups			Stroke			Orthopedic Conditions		
	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency
RESULTS BY LOCAL HEALTH INTEGRATION NETWORK									
LHIN 1 (Erie St.Clair)	18.8	21.3	1.7	17.7	31.3	0.9	21.6	14.9	2.6
LHIN 2 (South West)	21.6	34.3	0.8	23.1	39.3	0.7	21.3	27.4	1.0
LHIN 3 (Waterloo Wellington)	14.8	17.6	1.4	20.5	34.8	1.0	15.1	15.5	1.6
LHIN 4 (Hamilton Niagara Haldimand Brant)	21.1	29.0	1.1	24.2	33.8	0.8	22.9	22.0	1.6
LHIN 5 (Central West)	23.2	13.4	2.1	29.6	22.8	1.7	22.2	11.5	2.3
LHIN 6 (Mississauga Halton)	21.9	16.7	2.3	23.9	27.1	1.3	22.5	12.6	2.9
LHIN 7 (Toronto Central)	19.8	29.0	1.3	20.9	44.7	0.6	21.4	19.1	1.8
LHIN 8 (Central)	20.2	15.7	2.0	21.7	30.6	0.9	20.1	12.0	2.3
LHIN 9 (Central East)	19.7	19.6	1.8	22.2	34.5	0.9	19.2	13.3	2.2
LHIN 10 (South East)	21.4	34.6	0.9	21.9	43.2	0.6	24.8	23.8	1.3
LHIN 11 (Champlain)	18.0	30.0	0.9	19.5	40.1	0.6	19.9	24.4	1.2
LHIN 12 (North Simcoe Muskoka)	17.1	20.0	1.0	23.1	28.3	1.0	15.1	14.1	1.1
LHIN 13 (North East)	18.3	27.8	0.9	21.2	35.7	0.8	18.4	18.4	1.3
LHIN 14 (North West)	15.8	20.0	1.8	19.8	36.2	0.7	19.1	10.4	2.7

In Ontario, rehabilitation is provided in both a hospital and non-hospital setting, spanning a continuum of care from acute care to home care. One part of this continuum of care is inpatient rehabilitation services provided in Ministry of Health and Long-Term Care designated inpatient rehabilitation beds. This quadrant focuses on indicators of Financial Performance and Condition that are specific to designated rehabilitation beds or units in free-standing hospitals (that provided rehabilitation service and/or complex continuing care) or in acute care hospitals.

Three measures of financial performance and condition related to inpatient rehabilitation activities were recommended for use by an advisory panel, focusing on efficiency and human resource use. The indicators presented are based on data from 2005–2006. The data are submitted annually to the Ontario Ministry of Health and Long-Term Care using formats specified by the Ontario Healthcare Reporting Standards (OHRS). To enable informed decisions using relevant management information, the OHRS undergoes annual changes. For example, as of April 2005, hospitals are now required to submit earned hours by occupational class. This change allows for a more detailed reporting of the earned hours of hospital staff by the type of health provider. As hospitals increase their familiarity with these new reporting standards, it is expected that the data collected will provide a clearer depiction of the earned hours for the various health providers employed within Ontario's hospitals.

Developing indicators of Financial Performance and Condition for this sector is challenging, largely because of data collection limitations. First, rehabilitation programs are often located in hospitals that have other service mandates, such as complex continuing care or acute care. This makes it difficult to isolate revenues and expenditures that relate solely to rehabilitation services. Second, many performance indicators require a method to classify and group similar clients. These case mix groups usually have weights that reflect relative differences in resource demands. An adult inpatient rehabilitation grouper and its associated weights have recently been developed by the Ontario Joint Policy and Planning Committee (JPPC). However, some data quality issues are currently being investigated and the grouper and weights should not be used until 2008–2009. In the absence of isolated cost data, case mix groups and associated weights, only three measures related to Financial Performance and Condition for rehabilitation services were recommended for use by the advisory panel.

Data from all 58 hospitals with designated inpatient rehabilitation beds in Ontario were used to calculate provincial and LHIN means; hospital-specific data are shown for 57 hospitals that voluntarily agreed to participate in this report.

Indicator Definitions

% Direct Rehabilitation Cost

This indicator measures the direct costs of providing nursing, diagnostic and therapeutic services, and food services to rehabilitation clients as a proportion of the total costs associated with these clients. Values much higher or lower than the mean and significant changes from previous years may require investigation.

% Nursing Worked Hours

This indicator measures the proportion of time nursing personnel working in the hospital inpatient rehabilitation program spend on activities such as direct patient care, charting and in-service education, as a proportion of the total hours earned. The hours being measured are for those nursing personnel who normally engage in activities related to patient care, and excludes nurses who fill management and administrative roles. Values much higher or lower than the mean and significant changes from previous years may require investigation.

% Nursing and Therapy Worked Hours

This indicator measures the proportion of time nurses and therapists working in the hospital inpatient rehabilitation program spend on activities such as direct client care, charting and in-service education, as a proportion of the total hours earned. This indicator measures the activity of unit-producing personnel (UPP) only; this category of hospital personnel includes nurses/therapists who normally engage in activities related to client care, and excludes nurses/therapists who fill management and administrative roles. Values much higher or lower than the mean and significant changes from previous years may require investigation.

Summary of Results

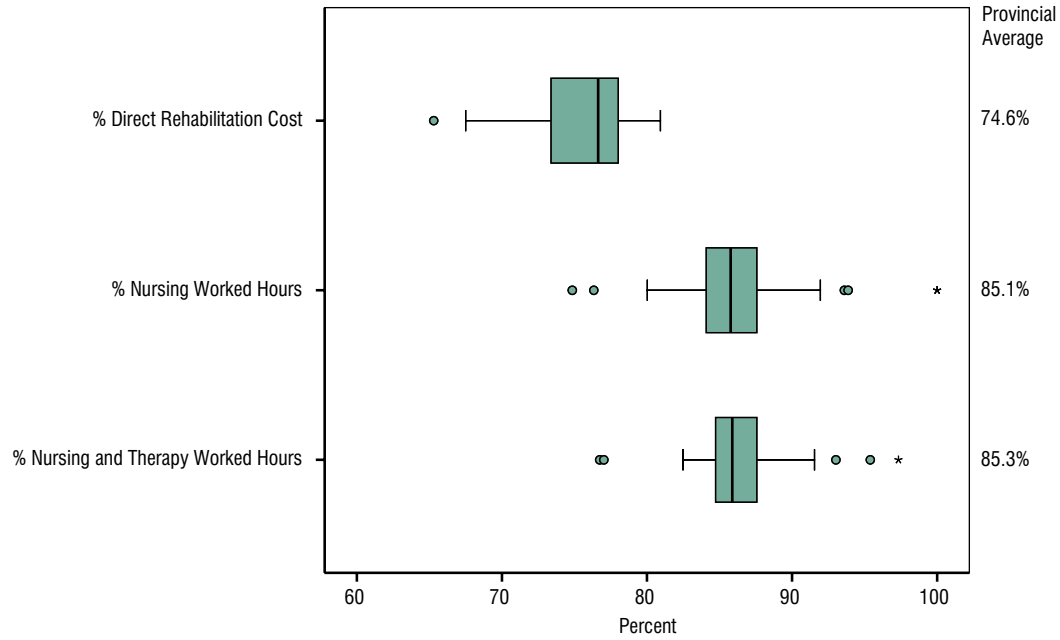
Almost three-quarters of the expenses incurred in the provision of rehabilitation services by Ontario hospitals are related to providing direct client care. While this proportion has remained relatively steady over six years (hovering closely around an average of 74.6%), the actual dollars expended on direct client care increased significantly—by over $92 million (42%) from 2000–2001 to 2005–2006.

In 2005–2006, over 85.1% of the hours earned by nurses working in hospital inpatient rehabilitation programs were spent engaged in activities related to client care. The remaining time is accounted for by vacation time, orientation and other benefit hours. Although the proportion of hours worked by nurses remained somewhat steady (a slight decline of 1.7% occurred over five years), there was a noticeable increase in the actual number of worked hours in this same period. Worked hours increased by approximately 85,000. The fact that a small decline in this indicator is observed during this same period suggests that a slight increase in the number of benefit hours (such as sick time) also occurred during this period.

For nurses and therapists, over 85.3% of their combined worked hours were spent engaged in client care activities related to inpatient rehabilitative services. The therapy worked hours represented approximately one-third of total nursing and therapy worked hours for inpatient rehabilitation. Nursing and Therapy Worked Hours values were also calculated at the level of the LHIN. The LHIN values are weighted averages of all hospitals within a given LHIN (see LHIN table, below).

For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

Distribution of Indicator Scores for Financial Performance and Condition Indicators



Source: Ontario Healthcare Reporting Standards, 2005–2006.

Figure 14

Performance Allocation Table

Hospital	Community Served	LHIN	% Direct Rehabilitation Cost	% Nursing Worked Hours	% Nursing and Therapy Worked Hours
PROVINCIAL AVERAGE			74.6	85.1	85.3
AVERAGE RESULTS BY REHABILITATION SITE					
Baycrest Centre for Geriatric Care	Toronto	7	67.5	87.8	86.2
Bluewater Health	Sarnia	1	78.0	83.9	83.5
Bridgepoint Health	Toronto	7	71.7	85.2	85.9
Chatham-Kent Health Alliance	Chatham	1	78.4	88.3	87.0
Cornwall Community Hospital	Cornwall	11	76.8	85.0	85.8
Grand River Hospital	Kitchener	3	76.9	86.6	86.6
Grey Bruce Health Services	Owen Sound	2	73.9	85.1	84.7
Guelph General Hospital	Guelph	3	76.7	87.6	86.5
Halton Healthcare	Oakville	6	80.9	84.9	87.1
Hamilton Health Sciences Corporation	Hamilton	4	74.3	84.1	84.1
Humber River Regional Hospital	Toronto	8	79.0	86.5	85.9
Huron Perth Healthcare Alliance	Stratford	2	76.6	90.1	88.9
Hôpital Montfort Hospital	Ottawa	11	73.4	87.5	88.4
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	78.6	90.2	88.1
Hôtel-Dieu Grace Hospital	Windsor	1	77.4	100.0	97.3
Joseph Brant Memorial Hospital	Burlington	4	79.3	84.1	85.2
Lakeridge Health	Oshawa	9	76.5	84.5	85.0
Leamington District Memorial Hospital	Leamington	1	72.2	93.9	93.0
Listowel and Wingham Hospitals Alliance	Listowel	2	73.6	92.0	90.7
Markham Stouffville Hospital	Markham	8	77.5	81.0	83.7
North Bay General Hospital	North Bay	13	75.0	85.8	85.3
North York General Hospital	Toronto	8	72.2	76.3	76.7
Northumberland Hills Hospital	Cobourg	9	76.9	85.7	85.7
Pembroke Regional Hospital	Pembroke	11	69.7	89.5	88.9
Penetanguishene General Hospital Inc. (The)—North Simcoe Hospital Alliance	Penetanguishene	12	72.2	83.5	86.4
Peterborough Regional Health Centre	Peterborough	9	78.6	83.3	83.7

Hospital	Community Served	LHIN	% Direct Rehabilitation Cost	% Nursing Worked Hours	% Nursing and Therapy Worked Hours
Providence Continuing Care Centre	Kingston	10	71.6	88.5	85.2
Providence Healthcare	Toronto	7	74.5	82.5	82.8
Queensway Carleton Hospital	Nepean	11	77.3	86.2	86.8
Quinte Health Care	Belleville	10	74.2	91.2	88.9
Ross Memorial Hospital	Lindsay	9	74.0	93.6	91.6
Rouge Valley Health System	Scarborough	9	76.6	85.2	85.4
Royal Victoria Hospital	Barrie	12	78.9	84.5	84.9
Sault Area Hospital	Sault Ste. Marie	13	80.8	84.1	84.7
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	68.4	86.4	87.2
Southlake Regional Health Centre	Newmarket	8	80.0	86.1	87.8
St. John's Rehab Hospital	Toronto	8	71.9	82.7	82.6
St. Joseph's Care Group	Thunder Bay	14	77.5	81.5	82.5
St. Joseph's Health Care London	London	2	77.3	82.2	83.0
St. Joseph's Health Centre Toronto	Toronto	7	78.2	85.0	85.5
St. Joseph's Health Centre, Guelph	Guelph	3	65.3	100.0	95.4
St. Joseph's Healthcare Hamilton	Hamilton	4	77.6	84.4	85.1
St. Mary's General Hospital	Kitchener	3	80.3	87.1	88.1
St. Thomas-Elgin General Hospital	St. Thomas	2	70.6	82.5	83.5
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	76.3	82.3	83.2
The Brantford General Hospital	Brantford	4	75.2	87.6	89.5
The Credit Valley Hospital	Mississauga	6	79.0	85.3	85.8
The Ottawa Hospital	Ottawa	11	74.8	87.0	86.1
The Scarborough Hospital	Scarborough	9	79.1	86.2	86.1
Toronto East General Hospital	Toronto	7	73.3	80.0	82.7
Toronto Rehabilitation Institute	Toronto	7	71.7	86.3	86.2
Trillium Health Centre	Mississauga	6	73.5	86.9	87.6
West Park Healthcare Centre	Toronto	7	73.6	86.6	86.0
West Parry Sound Health Centre	Parry Sound	13	70.3	89.9	89.3
William Osler Health Centre	Brampton	5	77.7	81.4	83.2
Windsor Regional Hospital	Windsor	1	78.2	74.9	77.0
York Central Hospital	Richmond Hill	8	76.9	85.5	85.5

LHIN	% Direct Rehabilitation Cost	% Nursing Worked Hours	% Nursing and Therapy Worked Hours
RESULTS BY LOCAL HEALTH INTEGRATION NETWORK			
LHIN 1 (Erie St. Clair)	77.8	84.1	83.8
LHIN 2 (South West)	76.4	83.2	83.7
LHIN 3 (Waterloo Wellington)	75.8	89.0	88.5
LHIN 4 (Hamilton Niagara Haldimand Brant)	75.4	84.6	84.9
LHIN 5 (Central West)	77.7	81.4	83.2
LHIN 6 (Mississauga Halton)	76.8	86.0	87.0
LHIN 7 (Toronto Central)	72.5	85.4	85.4
LHIN 8 (Central)	74.0	83.0	83.3
LHIN 9 (Central East)	77.1	85.3	85.5
LHIN 10 (South East)	72.2	89.3	86.0
LHIN 11 (Champlain)	72.3	86.8	86.8
LHIN 12 (North Simcoe Muskoka)	75.4	84.0	85.6
LHIN 13 (North East)	78.6	86.5	86.3
LHIN 14 (North West)	77.5	81.5	82.5

Appendix A: Data Sources

The following table provides a list of the data sources used in each of the four sections of this report.

Quadrant	Data Source	Year*
System Integration and Change	System Integration and Change (SIC) Survey	2007
Client Perspectives	Client Perspectives of Rehabilitation Services Questionnaire (CPRSQ)	2005–2006
Clinical Utilization and Outcomes	National Rehabilitation Reporting System (NRS)	2005–2006
Financial Performance and Condition	Ontario Healthcare Reporting Standards (OHRS)	2005–2006
***Note:** Previous years may also have been used in this report for trending purposes.		

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