

Chapter 4

Section 4.08

Ministry of Health and Long-Term Care

Rehabilitative Services at Hospitals

Follow-up to VFM Section 3.08, 2013 Annual Report

RECOMMENDATION STATUS OVERVIEW					
	# of Actions Recommended	Status of Actions Recommended			
		Fully Implemented	In Process of Being Implemented	Little or No Progress	Will Not Be Implemented
Recommendation 1	3	1	2		
Recommendation 2	6	2 2/3	1	1 1/3	1*
Recommendation 3	5	2 2/3	1 1/3	1	
Recommendation 4	1		1		
Recommendation 5	3	2/3	1 2/3	2/3	
Total	18	7	7	3	1
%	100	39	39	17	5

Note: The fractions in some cells result from recommended actions being implemented to different degrees by the three hospitals we audited.

* One recommendation was not applicable to one hospital.

Background

In coming years, the demand for rehabilitation services, such as physiotherapy and occupational therapy, in Ontario is expected to increase significantly, especially after 2021 when the first baby boomers turn 75. In 2014/15, about half of regular rehabilitation inpatients were over 75 years of age.

The Ministry of Health and Long-Term Care (Ministry) funds inpatient rehabilitation services in about 60 hospitals through 14 Local Health Integration Networks (LHINs). There are two kinds of

inpatient rehabilitation: regular (frequent sessions for a short term) and restorative (slower-paced and over a longer term). In 2014/15, the approximately 60 hospitals had more than 2,500 regular rehabilitation beds (they had almost 2,500 in 2012/13), to which more than 31,000 patients (it was more than 30,000 in 2012/13) were admitted. Orthopedic conditions (including hip and knee replacements) and stroke were the most common reasons people were admitted to regular rehabilitation inpatient programs.

The Ministry funds rehabilitation services for eligible Ontarians. This includes hospital

rehabilitation inpatients and hospital-registered outpatients. The Ministry also funds community-based services for qualified people, including those 19 and under and 65 and over; people who require physiotherapy at home or in long-term-care homes; and people who are eligible for social or disability assistance from the province.

In our *2013 Annual Report*, we found that the Ministry did not have information available on the total public funding spent on rehabilitation services or on the number of patients who used hospital-run outpatient programs.

There is no co-ordinated rehabilitation system in Ontario. Instead, individual hospitals—some with input from their LHIN—generally determine which inpatient and/or outpatient rehabilitation services they will offer, if any. This means that each hospital establishes its own policies and procedures for determining patient eligibility for its services, prioritizing patients and providing care. As a result, a patient deemed eligible for services at one hospital might not be eligible for similar services at another. Many stakeholder associations have called for better provincial co-ordination of rehabilitation programs to help transition people from acute care to rehabilitation and to ensure patients receive rehabilitation when needed.

Some of our other significant observations included the following:

- There was wide variation in the supply of regular rehabilitation inpatient beds across the province, which could mean that patients had to travel outside their LHIN for services. The number of beds ranged from 57 per 100,000 people in the Toronto Central LHIN to only six per 100,000 in the Central West LHIN. The provincial average is 18 beds per 100,000.
- The lack of information on the use or outcomes of restorative inpatient rehabilitation or on outpatient rehabilitation meant the Ministry did not know if those services were effective.

- Approximately a third of patients admitted to inpatient rehabilitation at the two hospitals we visited with stroke programs had been assessed by an acute-care hospital as having mild functional impairment. This suggested they might have been better served in outpatient programs if these less costly services were available.
- Patients who no longer required hospital care may be occupying beds needed by other patients. The Ontario Hospital Association reported that, as of March 2013, about 2,300 alternate-level-of-care patients who were ready to be discharged were waiting in acute-care hospital beds for arrangements to be made. Of these, 25% were waiting for a regular rehabilitation bed or a complex continuing care (which includes restorative rehabilitation) bed.
- With the exception of stroke, for most conditions requiring rehabilitation, there were few best-practice standards in Ontario for such matters as when therapy should start and frequency of treatment. Practices varied at the hospitals we visited.

We made a number of recommendations for improvement and received commitments from the Ministry and hospitals that they would take action to address our recommendations.

Status of Actions Taken on Recommendations

The Ministry and hospitals provided us with information in the spring and summer of 2015 on the current status of our recommendations, indicating that they had made some progress in implementing several of the recommendations we made in our *2013 Annual Report*. The Ministry and the hospitals have fully implemented close to 40% of the recommendations. For example, all hospitals that we audited in 2013 now prioritize patients based on

need and track the amount of therapy provided to patients. As well, the Ministry and the hospitals are in the process of implementing about another 40% of the recommendations as they are waiting for the completion of work being led by the province's Rehabilitative Care Alliance (Alliance) on a standardized data collection and reporting system. The Ministry is also working toward establishing a province-wide co-ordinated system for rehabilitation by setting out a Definitions Framework and standardized eligibility. The remaining recommendations have shown little or no progress or will not be implemented, including one recommendation which is inapplicable at one hospital. For example, at the time of our follow-up review, none of the hospitals had performed a formal assessment to determine the need for and costs of evening and weekend therapy services.

The status of actions taken on each of our recommendations is described in the following sections.

System Co-ordination and Capacity

Recommendation 1

To better ensure that Ontarians requiring rehabilitation have equitable access to services, the Ministry of Health and Long-term Care (Ministry) should work with the Local Health Integration Networks to:

- *establish a province-wide co-ordinated system for rehabilitation, including both regular (shorter-term) and restorative (longer-term) inpatient services and all community-based outpatient services;*

Status: In the process of being implemented by March 2017.

Details

At the time of our 2013 audit, we found that each hospital generally established its own policies and procedures for admitting rehabilitation patients, determining patient eligibility, prioritizing patients for services, managing patient wait lists and

providing patient care. This approach resulted in differences in the types and levels of inpatient and outpatient services provided by hospitals across the province.

The Rehabilitative Care Alliance (Alliance), which was established by Ontario's 14 LHINs, includes representatives from the Ministry, health-service providers in the hospitals and community sectors, and clinical experts. The Alliance has developed, validated and shared a provincial Definitions Framework for inpatient and community-based rehabilitative services. The objectives of the Definitions Framework are to establish provincial standards for rehabilitative levels of care and provide clarity to patients, families and referring professionals. It also aims to provide a foundation for determining the number and location of rehabilitation beds and services to be offered in the province. The Definitions Framework defines rehabilitative care, and standardizes eligibility criteria and intensity of therapy for each level of care (e.g., short-term, long-term, etc.). Over the next two years, the Alliance plans to support the LHINs' implementation of the tools, frameworks and processes that have been developed to establish a province-wide co-ordinated system for rehabilitation.

- *provide the public with detailed information on programs available, eligibility and how to apply, such as through a public website.*

Status: Fully implemented.

Details

In 2013, we found that there was no listing, such as a website, that patients and their families could access to see all publicly funded rehabilitation services available in the province, by LHINs or otherwise.

Each of the three hospitals that we followed up with has its own website, and each of the 14 Community Care Access Centres (CCACs) across the province has also maintained a website through **thehealthline.ca** that directs patients and their

families on how to seek the rehabilitation services they need. Eligibility requirements and how to apply are either posted on **thehealthline.ca** or linked to each hospital's respective website.

Since our last audit, the Ministry has established a centralized Ontario government website, **Ontario.ca**, which contains over 10,000 location listings for rehabilitation programs and over 60 other types of services.

In order to have good information for current and future decision-making, the Ministry should establish, in conjunction with its shareholders, what information should be collected on restorative inpatient and outpatient services and how best to collect the data.

Status: In the process of being implemented by March 2017.

Details

In our 2013 audit, the Ministry did not have detailed information on restorative patients, such as the number of admissions and related rehabilitation beds, the number of rehabilitation visits to hospital physiotherapists or occupational therapists, the number of patients and the types of hospital-based and outpatient rehabilitation services available. Without complete information, it is difficult for the Ministry or the LHINs to determine the capacity of the system and how it is used.

Working with the Alliance, the LHINs will use the Definitions Framework, Capacity Planning and System Evaluation task groups to manage rehabilitative care planning for restorative patients and develop a reporting system that tracks information such as the number of patients served in each level of rehabilitative care, intensity of services provided, occupancy rates, rates and reasons for patients being denied services, and patient outcomes.

Inpatient Services

Recommendation 2

To better ensure that inpatient rehabilitation meets patients' needs as efficiently and equitably as possible, hospitals should:

- *implement systems for accepting patient referrals electronically;*

Status: Hospital 1: Fully implemented.

Hospital 2: Little or no progress.

Hospital 3: In the process of being implemented by June 2017.

Details

The hospitals we visited varied in how they received patient referrals for inpatient services. For example, one hospital received most of its patient referrals via an electronic system. Another hospital received only internal referrals electronically, while the third hospital could only receive referrals through phone or fax. As well, two of the hospitals we visited were already able to access internal patient information electronically but external patient information had to be entered manually.

A provincial standardized referral form was initiated by the Toronto Central LHIN and was in place at the time of our 2013 audit. The Ministry expects all health-service providers across the province to implement the form by the end of fiscal year 2015/16. The Ministry told us that, as of March 2015, the form is already being implemented by over 70% of health-service providers. However, it is up to the health-service providers to incorporate the use of the standardized form through their own electronic systems. We found that the referral processes used by each of the three hospitals still varied.

Already in place during our audit in 2013, the LHIN of Hospital 1 implemented an electronic Resource Matching and Referral system. This hospital receives referrals electronically from its own and another LHIN.

Hospital 2 modified the provincial referral form and developed a decision algorithm and a new

process to accept clients to its acute-care inpatient units. This hospital plans to expand the use of the modified form to accept referrals from all other hospitals within the same LHIN by March 2017, and this model will also be used by the two next largest hospitals in the LHIN. Although Hospital 2 uses a standardized referral form, the process for referrals from outside of this hospital is still paper-based. Hospital 2 will not be able to accept patient referrals electronically until an electronic system is developed by the LHIN. This hospital's LHIN is currently piloting an electronic form at a few of the smaller hospitals in the LHIN.

Hospital 3 accepts internal patient referrals electronically; however, referrals from outside this hospital are still paper-based. Since our last audit, the hospital has worked with the province and its Regional Rehabilitation Network to develop a standardized referral form containing all necessary data elements, and has adopted this standardized referral form for all its internal and external referrals. Hospital 3 indicated that it is ready to implement an electronic referral system as soon as it is developed by the LHIN. The expected date of the implementation is June 2017.

- *implement systems for uploading associated patient data electronically;*

Status: Hospital 1 and 2: Little or no progress.

Hospital 3: In the process of being implemented by June 2017.

Details

Although Hospital 1 receives referrals electronically, it still has to manually re-enter all patient information into its own information system—an inefficient process that increases the risk of data entry errors. The hospital explored the opportunity to upload health record information electronically and decided that, due to the high cost and ongoing maintenance fees, it will wait for the LHIN to take action in regards to interfacing its electronic referral system with its information system.

Hospital 2's patient information is electronically accessible on its systems so health information for internal referrals does not have to be re-entered. This was in place at the time of our last audit. However, for referrals from outside the hospital, staff must still enter patient information manually. In the next few years, this hospital plans to implement a new electronic health record system that will electronically upload patient referrals into its system but it does not yet have a date for when it will be implemented.

Hospital 3 has an electronic system to track health information from its acute-care site, which was in place at the time of our audit. However, as Hospital 3's external referrals are still paper-based, each referral must be manually entered into this system. This hospital indicated that once the LHIN-level electronic referral system is implemented during fiscal year 2015/16, its electronic health record system will be integrated with the LHIN system.

- *in conjunction with the Ministry of Health and Long-term Care (Ministry) and the Local Health Integration Networks (LHINs), develop standardized practices regarding patient eligibility for similar programs, prioritization of patients based on patient need, and the frequency and duration of therapy;*

Status: Hospital 1: Fully implemented.

Hospital 2: Little or no progress.

Hospital 3: In the process of being implemented by June 2016.

Details

Our 2013 audit found that the hospitals we visited varied in how they determined eligibility for similar programs. In addition, neither the province nor the LHINs established a standardized prioritization policy for hospitals to follow, so each hospital decided how to prioritize its own patients. With the exception of standards for people who suffered a stroke, we found that there were few best-practice standards in Ontario for the amount, type and

frequency of inpatient therapy that patients should receive for specific conditions. At the hospitals we visited, the amount and type of therapy that each patient received was based on the professional judgement of his or her therapist and the resources available.

In fiscal year 2013/14, Hospital 1 worked with the LHIN Task Force to develop standards for the frequency and duration of therapy for the hip/knee rehabilitation populations. This hospital told us it had followed these best practice standards for rehabilitation admissions, including eligibility and prioritization for total joint replacement and fractured hips.

Hospital 2 uses its own eligibility and prioritization criteria for accepting patients into its programs because there are no standardized criteria established in its region. Also, there are no region-wide standardized practices regarding the frequency and duration of therapy. Hospital 2 indicated that the amount and type of therapies provided is based on a clinical assessment by a physiatrist and an interprofessional rehabilitation team. This hospital considers the patient's previous and current levels of functioning as well as their expected recovery when creating outcome goals. Hospital 2 expects that a patient accepted into its inpatient rehabilitation program will receive, on average, three hours or more of therapy each weekday from the interprofessional team.

Hospital 3 informed us that it is in the process of reviewing the criteria (such as for patient eligibility, prioritization of patients and frequency and duration of therapy) established by the Alliance in the Spring of 2015, and that it would adopt these criteria in collaboration with its Regional Rehabilitation Network, which includes all hospitals in the region as well as the region's CCAC and LHIN, by June 2016.

- *track and monitor information on the amount of therapy actually provided to patients, the*

number of patients declined and the associated reasons;

Status: Hospital 1, 2 and 3: Fully implemented.

Details

Our 2013 audit identified that the hospitals did not track all key information. For example, none of the hospitals documented all rehabilitation provided to an individual patient, so it was difficult to determine how much therapy was actually provided. In addition, only one hospital we visited tracked the number of patients who were declined and why.

Hospital 1 now tracks the amount of therapy delivered by each therapist to individual patients receiving rehabilitation services. The hospital reviews the summary reports every month to ensure each patient receives an equitable amount of therapy. Also, it now tracks the rates and reasons for being declined.

Hospital 2 has an electronic system that tracks and reports on therapy time received by each patient. The report shows the date therapy was provided, which therapist provided the therapy, and the length of the therapy session. This hospital monitors the number of patients accepted and declined, as well as how long the patient waited from being admitted to being provided a rehabilitation bed. The triage nurses also document in an electronic log the reasons patients were denied therapy services.

Hospital 3 has an electronic workload system that measures the amount of therapy given to each patient by all members of the health-care team. This hospital has been tracking wait times, decline rates and reasons for refusals since our audit in 2013.

- *track and monitor information on the time it takes to fill a bed after a patient is discharged;*

Status: Hospital 1 and 2: Will not implement. Our position is that this is appropriate given the short turnaround time.

Hospital 3: Fully implemented.

Details

At the time of our audit, none of the hospitals tracked how long it took to fill vacated rehabilitation beds. This information could help prevent long waits for patients in acute-care beds who need rehabilitation beds.

Hospital 1 informed us that because its turnaround time is less than two hours due to advance planning of admissions and discharges taking place on the same day, it was not necessary to track the time it takes to fill a bed after a patient is discharged.

Hospital 2 indicated that because it plans in advance when patients are admitted and discharged, its turnaround time is less than a day. Therefore, it said it would not be implementing this recommendation.

Hospital 3 is currently tracking and monitoring the time to fill an inpatient bed through an electronic system. This hospital tracks wait times for beds on a monthly basis, and if the occupancy rate drops below its target of 95%, it will look at the time taken to fill beds. The hospital indicated that its turnaround time is generally the same or next day.

- *consistent with the Health Insurance Act, charge a co-payment only to restorative rehabilitation patients who are not expected to return home.*

Status: Hospital 1: Fully implemented.

Hospital 2: Will not implement. Our position is that this is appropriate because this recommendation is not applicable to this hospital.

Hospital 3: Fully implemented.

Details

In 2013, one of the two hospitals we visited with complex continuing care (CCC) beds charged the co-payment to all of its CCC patients, including restorative rehabilitation patients, regardless of whether they were expected to return home,

something that is not allowed under the *Health Insurance Act*.

During our 2013 audit, Hospital 1 was already in compliance with the *Health Insurance Act* in charging co-payment only to restorative rehabilitation patients who are not expected to return home.

Hospital 2 does not have restorative rehabilitation in-patient beds, so this recommendation is not applicable.

Effective April 1, 2014, Hospital 3 indicated that it had complied with the *Health Insurance Act* by no longer charging the co-payment to restorative rehabilitation patients who are expected to return home.

Outpatient Services

Recommendation 3

To better ensure that patients have timely access to required outpatient services, hospitals should:

- *prioritize eligible patients based on need, rather than on other factors such as whether they were referred from the hospital's inpatient program or externally;*

Status: Hospital 1, 2 and 3: Fully implemented.

Details

Our 2013 audit found that there was no provincial or LHIN-wide policy for prioritizing patients on wait lists; each hospital followed its own procedures. The policy at two of the hospitals we visited was to prioritize on the basis of who had been waiting the longest. The third hospital told us that the policy was also to consider factors such as the patient's medical issues and risk of falling.

In 2014, Hospital 1 hired a dedicated Patient Flow Co-ordinator, who is an occupational therapist, to ensure appropriate prioritization by client need and urgency. This hospital told us that since fiscal year 2013/14, only five referrals have been declined, and this was because the hospital did not offer the services that were required by the patients.

Hospital 2 informed us that all referrals to its outpatient rehabilitation programs are prioritized based on need, such as their safety risks, the amount of time since injury, and potential for improvement. In addition, this hospital has an orthopedic rehabilitation clinic that deals exclusively with patients who have had surgery at this hospital. All other hospitals in this LHIN that offer surgery and have outpatient rehabilitation services operate in a similar fashion. Within this closed referral system, patients are also prioritized according to need.

Hospital 3 told us it prioritizes patients based on clinical need, and matches them to the program that best suits their needs. In addition, this hospital told us that the patient must have functional goals and a reasonable expectation of meeting those goals in order to be accepted for rehabilitation.

- *assess the need for, and the costs and benefits of, providing evening and weekend services;*

Status: Hospital 1, 2 and 3: Little or no progress.

Details

In 2013, we found that one of the reasons it can be hard for patients to attend outpatient services was because there are few or no evening/weekend services for clients who cannot attend programs on weekdays.

Hospital 1 told us that its outpatient rehabilitation clinics are meeting demand with their Monday-to-Friday “business-hours” scheduling, and that the clinics’ wait times are short. However, the hospital has not done any formal analysis on this, and it said it will add a question to its outpatient survey to find out whether patients want extended hours. It did not provide a specific time frame to fully implement this recommendation.

Hospital 2 said it will complete an assessment of the costs and benefits, including the consideration of quality indicators and available resources, of extending services to evenings and weekends by March 31, 2016. Evening services in this hospital’s

orthopedic post-surgical outpatient department have been available at the time of our audit in 2013.

Hospital 3 said it will develop a methodology to determine the cost of providing expanded access for outpatient services in fiscal year 2015/16. The hospital indicated that implementing this recommendation would either require funding that recognizes the additional cost of expanding service hours, or it would have to reduce its Monday-to-Friday day-time services.

- *in conjunction with the Ministry of Health and Long-Term Care (Ministry) and Local Health Integration Networks (LHINs), develop standardized practices for common patient conditions, such as total joint replacements, regarding when to begin outpatient therapy, as well as the type and duration of therapy.*

Status: Hospital 1: Fully implemented.

Hospital 2: In the process of being implemented by March 2017.

Hospital 3: Fully implemented.

Details

In our 2013 audit, we reported that, other than for stroke programs, there are few best practices in Ontario for outpatient therapy such as when therapy should start, how much therapy should be provided, what type of therapy should be provided, the length of therapy sessions and the number of weeks therapy should be provided.

Hospital 1 informed us that it follows the Ministry’s Quality Based Procedures’ best practices for outpatient rehabilitation of total knee and total hip replacements which include standardized practices for when to begin outpatient therapy as well as the type and duration of therapy. This hospital is also a member of several working groups to develop best practice standards for rehabilitation of knee and hip fractures and total joint replacements.

Hospital 2 informed us that it is part of a Regional Rehabilitation Network that meets monthly to standardize rehabilitation practices

for common orthopedic procedures. This hospital indicated that, since September 2014, it has been following the Ministry's Quality Based Procedures' standardized protocols for total hip replacements, total knee replacements and hip fractures, which include specific timeframes on when to start rehabilitation, how many sessions to provide as well as the duration and format of services. However, Hospital 2 also has other patient populations, such as patients with an acquired brain injury or a spinal cord injury, where regional or provincial standardized practices do not exist. Hospital 2 indicated that this will likely be fully implemented by March 2017, as it is waiting for further recommendations by the Alliance's subgroup on outpatient quality based procedures.

Hospital 3 indicated that it has adopted the Ministry's Quality Based Procedures' best practices with respect to common patient conditions such as outpatient total knee and total hip replacements.

Further, hospitals should collect information to better ensure that available outpatient resources are utilized efficiently and effectively, such as information on the number of appointment cancellations and patient no-shows.

Status: Hospital 1, 2 and 3: Fully implemented.

Details

In 2013, only one hospital tracked information, at one of its two clinics, on whether each therapist was fully booked, how many appointments were cancelled by patients, and the extent of patient no-shows. The other two hospitals did not track this information. Hospital 1 developed a report to monitor outpatient targets, including patient volumes, wait times, admissions and discharges. This report is reviewed on a daily basis by hospital staff and on a weekly basis by senior management. Information on cancellations and no-shows is currently being collected manually. The hospital is in the process of standardizing these definitions to that it can be compared across all units. Hospital 1 informed us

that it is on track to acquire and implement a new scheduling system by March 2016.

Hospital 2 captures the number of appointments each day, the number of cancellations and the number of no-shows in all outpatient areas.

Hospital 3 collects data on use by outpatients, including new visits, follow-ups, cancellations and no-shows. During our last audit in 2013, this hospital monitored wait times and length of stays in outpatient programs using its electronic wait-list system. Hospital 3 told us that it has since refined this system, and it uses this system actively to report wait times.

Hospitals should collect information to better ensure that available outpatient resources are utilized efficiently and effectively, such as on the change in patient functionality between when outpatients start and when they complete outpatient rehabilitation.

Status: Hospital 1: In the process of being implemented by March 2017.

Hospital 2: In the process of being implemented by January 2018.

Hospital 3: In the process of being implemented by June 2017.

Details

Our 2013 audit found that outpatients who received rehabilitation services were not assessed using a standardized measure for determining their functional improvement; therefore, there is little information on whether outpatient programs are effective.

All three hospitals are waiting for the Alliance to finalize specific outcome measures to be included in a standardized reporting system for all hospitals across the province. All three hospitals plan to implement the Alliance's recommendations, which are expected by March 2017.

Hospital 1 is working with the Alliance and its Regional Rehabilitation Network outpatient working group to determine the most appropriate tool to measure functional improvement.

One of Hospital 2's sites uses outcome measures at the beginning and the end of rehabilitation treatment for all patients. This hospital currently does not have a central reporting function for change in patient functionality, except for its physiotherapy clinic.

Although Hospital 3 measures patient functionality individually, there is no standardized tool and no central reporting function used across all outpatient rehabilitation settings to determine whether outpatient therapy is effective.

Common Conditions Requiring Rehabilitation

Recommendation 4

To better ensure that stroke patients receive rehabilitation services that address their needs and that rehabilitation resources are used efficiently, the Ministry of Health and Long-term Care (Ministry) should work with the Local Health Integration Networks (LHINs) to implement, at least on a pilot basis, the stroke-rehabilitation and patient-flow best practices, including those relating to timely access and the extent of therapy, accepted by the Ministry's Rehabilitation and Complex Continuing Care Expert Panel.

Status: In the process of being implemented by March 2017.

Details

In our 2013 audit, none of the hospitals we visited that had a stroke program tracked how much therapy each patient received. The amount and type of stroke therapy that each patient receives was based on the professional judgment of his or her therapists.

After our 2013 audit, the Ministry, in collaboration with Health Quality Ontario, developed a Quality Based Procedures (QBP) Clinical Handbook. The QBP Clinical Handbook offers evidence-based best practice recommendations for selected disease areas or procedures. As of March 2015, the QBP Clinical Handbook for stroke had been updated to include post-acute care, and work was

underway to develop a post-hospital medical QBP. There is no mandated time frame by which a QBP must be implemented by hospitals, but the Ministry indicated that it will work with the LHINs and hospitals to assist in timely implementation of best practice recommendations. The QBP Clinical Handbook includes timely access to rehabilitation within five to seven days, and this metric, along with rehabilitation intensity and time spent in therapy, has been included on the Ontario Stroke Network annual report card. This will allow the Ministry to monitor whether stroke patients receive timely access to rehabilitation.

In addition, each LHIN associated with the hospitals that we visited implemented best practices in stroke rehabilitation:

- The Toronto Central LHIN has implemented the Clinical Service Performance Improvement for Stroke to ensure stroke patients receive rehabilitation services that address their needs and that rehabilitation services are used efficiently. The Toronto Central LHIN Stroke Implementation Group developed standardized approaches to program planning and identified performance indicators and processes for outpatient rehabilitation to monitor and measure program performance.
- In the Champlain LHIN, the Champlain Regional Stroke Network (CRSN) has an established Stroke Rehabilitation committee, which is focused on improving patient flow and performance related to stroke rehabilitation across the region. A Pilot Community Stroke Rehabilitation System is under development. This multi-sector working group is developing a model for community-based stroke rehabilitation.
- Hamilton Niagara Haldimand Brant (HNHB) LHIN is collaborating with the Central South Regional Stroke Network and Regional/District Stroke Centre to establish an integrated acute stroke recovery system that provides standardized, evidence-based stroke care, improves client outcomes, facilitates system

sustainability and improves the co-ordination of stroke care. A plan is being developed for an integrated stroke recovery system for the Niagara Health System.

Performance Monitoring

Recommendation 5

In order to enhance the performance of hospitals providing rehabilitation services, hospitals should:

- *in conjunction with the Ministry of Health and Long-term Care (Ministry), develop standardized performance measures that will provide hospitals with useful and comparative information, such that they can benchmark their performance against other hospitals and better identify areas, if any, requiring improvement;*

Status: Hospital 1: In the process of being implemented by March 2017.

Hospital 2: In the process of being implemented by January 2018.

Hospital 3: In the process of being implemented by June 2017.

Details

Our 2013 audit found that the performance measures tracked at each hospital varied, which limits the ability of hospitals, the LHINs and the Ministry to compare performance and thereby identify better rehabilitation practices.

The Alliance is developing standardized performance indicators and outcome measures. Targets and performance reports are expected to be developed by March 2017, at which time, all three hospitals have committed to implementing these recommendations.

During this follow-up, Hospital 1 informed us that it submits data, including outpatient and fractured hip information, to its Regional Rehabilitation Network, and beginning fiscal year 2015/16 will submit its admission and discharge volumes, number of visits and attendances to its LHIN.

Hospital 2's specialized rehabilitation unit is benchmarked against a specific rehabilitation

organization that provides rehabilitation care to a similar patient population through the National Rehabilitation Reporting System (NRS). The NRS, run by the Canadian Institute for Health Information (CIHI), collects information on the characteristics and effectiveness of rehabilitation services in more than 2,000 adult rehabilitation clients in six provinces. Hospital 2 submits data to the NRS and information is extracted from the NRS database by hospital staff to monitor Hospital 2's activity and performance on a quarterly basis. This hospital is already using all of the outcome measures for orthopedic rehabilitation; however, there is no platform or forum for reporting these.

Hospital 3's Regional Rehabilitative Network compares data across the LHIN for inpatient rehabilitation beds in the areas of stroke, orthopedics and frail seniors. Benchmarks for performance are set for orthopedics by Health Quality Ontario and the Ministry's Quality Based Procedures Clinical Handbook, and for stroke by the Ontario Stroke Network Scorecard.

- *survey patient caregivers, as required under the Excellent Care for All Act, 2010 (Act),*

Status: Hospital 1: In the process of being implemented by March 2016.

Hospital 2: Little or no progress.

Hospital 3: Little or no progress.

Details

In our 2013 audit, we reported that according to the *Excellent Care for All Act*, every health care organization should survey patients and their caregivers at least once every fiscal year. Our audit found that none of the hospitals we visited surveyed caregivers and only two hospitals conducted surveys of outpatients.

Hospital 1 initiated a pilot caregiver survey on one inpatient unit as of March 2015. The pilot has been completed and has been implemented to all inpatient units except for palliative care. This hospital is currently designing a caregiver survey for the caregivers of palliative care patients.

Hospital 2 said it does not have a caregiver survey because most rehabilitation patients are independent and in control of their own decisions. It told us that, for the subset of patients that are not independent, caregivers can fill out the survey on the patient's behalf. The survey also allows patients to provide feedback on caregiver burden, and Hospital 2 encourages caregivers to fill out the survey with the patients. Hospital 2 informed us that it will look into creating a caregiver survey in the spring of 2016.

Hospital 3 has made little progress in implementing our recommendation, but stated that it will be reviewing the feasibility of caregiver surveys by June 2016.

- *conduct outpatient satisfaction surveys.*

Status: Hospital 1 and 3: Fully implemented.

Hospital 2: In the process of being implemented by March 2017.

Details

Hospital 1 has already implemented outpatient satisfaction surveys and this process is ongoing.

Hospital 2 has surveyed patient satisfaction in some of its outpatient areas. This hospital informed us that outpatient surveys in specialized rehabilitation have yet to be developed and will likely be implemented by fiscal year 2016/17.

Hospital 3 has been conducting outpatient satisfaction surveys since our audit in 2013.