

The Rehabilitative Care System supports high quality patient experiences through the utilization of best practices to enhance outcomes for individuals with functional goals. This evaluation framework has been developed to support the identification of opportunities for quality improvement and evaluation of rehabilitative care system performance against provincial targets/thresholds (where they exist). This framework has been developed by provincial rehabilitative care system stakeholders and key subject matter experts through a collaborative process that has identified existing indicators that support quality improvement and demonstrate the contribution of the rehabilitative care system to overall health system goals and directions.

Note 1: No single measure should be used in isolation to evaluate a system’s performance but rather as a collection of indicators to support prioritization of quality improvement initiatives.

Note 2: For all indicators with benchmarks that are time sensitive, the most current year of data should be used.

Developmental /Category III
Explanatory/Category II – Not Defined
Explanatory/Category II – Defined
Proposed Priority

Quality Dimension <sup>1</sup>	Health System Outcome Objectives <sup>2</sup>	Existing Indicator and Reference	Rehabilitative Care System Indicators	Benchmark	Target
<b>Accessible</b> <i>People should be able to receive the right care at the right time in the right setting by the right health care provider.</i>	To Reduce Wait Times for Defined Services	Acute to rehabilitative care bed ALC days by RPG (OHA, QIP, CIHI NRS)	A1. Time from referral to admission to a bedded level of rehabilitative care (by referral source i.e. acute, community)		
		n/a	A2. Time from referral to first outpatient rehabilitation therapy appointment (by referral source i.e. acute, bedded levels of rehabilitative care or community)		
		90th Percentile Wait Time for CCAC In-Home Services ((P) MLPA)	A3. Wait Time for CCAC In-Home Rehabilitative Care Services-Application from Community Setting to First CCAC Rehabilitative Care Service (excl case mgmt.)		
	To Reduce Total Alternative Level of Care Days	Percentage of Acute Alternate Level of Care (ALC) Days (Closed Cases) (H-SAA/M-SAA)	A4. ALC Rate in Acute Care Acute to Rehab (Closed Cases) (H-SAA/M-SAA)		
		ALC Rate (H-SAA/M-SAA)	A5. ALC Rate in rehabilitative care, by level of care <sup>3</sup>		

<sup>1</sup> Health Quality Ontario (2013) What is Quality Improvement? Attributes of a High-Quality Health System. Retrieved from <http://www.hqontario.ca/quality-improvement> on July 8, 2014.

<sup>2</sup> LHIN Provincial Logic Model

<sup>3</sup> Rehabilitative Care Alliance Definitions Framework

<p><b>Effective</b>  <i>People should receive care that works and that is based on the best available scientific information.</i></p>	To Reduce Readmission Rates for Defined Populations	Readmissions Within 30 Days for Selected Case Mix Groups (CMGs) (H-SAA/MLPA)	B1. Readmissions Within 30 Days for Selected Case Mix Groups (CMGs) after receipt of bedded, in-home or outpatient/ambulatory rehabilitative care service		
		30-Day Readmission of Patients with Stroke or Transient Ischemic Attack (TIA) to Acute Care for All Diagnoses (H-SAA)	B2. 30-Day Readmission of Patients with Stroke or Transient Ischemic Attack (TIA) to Acute Care for All Diagnoses (H-SAA)		
	To Delay/Prevent LTC Admission	Clients discharged home who were home prior to admission (OHA, QIP)	B3. Clients discharged home from bedded levels of rehabilitative care who were home prior to admission		
		% patients admitted into LTC within one-year following hospital discharge for select conditions or select index hospitalizations (ICES)	B4. % patients admitted into LTC within one-year following discharge from a bedded level of rehabilitative care hospital		
	To Optimize Utilization of Resources and Reduce Unnecessary Variation	Average Total Functional Change (by RCGs) (Hospital Reports)	B5. Average Total Functional Change (by RCG)		
		Average Admission Function Scores (CIHI NRS)	B6. Average Admission FIM Scores (by RCG)		
		Intensity of Therapy	B7. # of minutes patient spends in goal directed face to face therapy (PT, OT and SLP only)		
		Active LOS Efficiency by RPG (OHA, QIP)	B8. Active LOS Efficiency by RPG		
		n/a	B9. Proportion of programs/services that align with Definitions Framework		
	To Reduce Hospitalizations for Ambulatory Care Sensitive Conditions	Appropriate admission rates for select conditions that are sensitive to outpatient/ambulatory care delivery (QBP, HQO Quality Agenda)	B10. Inpatient rehabilitative care admission rates for conditions that are sensitive to ambulatory care (e.g. Stroke 1160)		
	To Improve Cost Efficiency for Service Delivery	% Direct Inpatient Rehabilitative Care Cost (Hospital Reports)	B11. % Direct Inpatient Rehabilitative Care Cost		
	To Optimize Value for Money (QBPs)	Direct Cost per Case of Select Conditions	B12. Direct inpatient rehabilitative care cost per case for QBP conditions		

<p style="text-align: center;"><b>Safe</b></p> <p style="text-align: center;"><i>People should not be harmed by an accident or mistakes when they receive care.</i></p>	To Reduce Falls	Fall-related admission to hospitals from ED per 100,000 for seniors aged 65 years and older <sup>4</sup>	C1. Fall-related admission to hospitals from ED per 100,000 for people aged 65 years and older <sup>3</sup>		
		Number of falls-related ED visits per 100,000 seniors aged 65 and older <sup>3</sup>	C2. Number of falls-related ED visits per 100,000 people aged 65 and older <sup>3</sup>		
		Repeat ED visits for falls in the past 12 months at the beginning of the rolling 12 month period per 100,00 people aged 65 years and older <sup>3</sup>	C3. Repeat ED visits for falls in the past 12 months at the beginning of the rolling 12 month period per 100,00 people aged 65 years and older <sup>3</sup>		
	To Improve Patient Safety in Defined Care Settings	% of LTC residents in daily physical restraints (OHA, CCRS QIs & LTC)	C4. % of LTC residents in daily physical restraints	3% <sup>4</sup>	11% <sup>4</sup> (Prov. Avg.)
		% of LTC residents whose pain worsened (OHA, CCRS QIs)	C5. % of LTC residents whose pain worsened	n/a	11.3 <sup>4</sup> (Prov. Avg.)
<p style="text-align: center;"><b>Patient-Centered</b></p> <p style="text-align: center;"><i>Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.</i></p>	To Improve Patient Experience	Cross-Continuum Patient Experience (HQO Quality Agenda)	D1. Rehabilitative Care System Cross Continuum Patient Experience		
	To Prevent Cognitive and Functional Decline	Rate of no decline in ADL function (Sr. Friendly Hospital, CCRS QIs)	D2.a Percentage of patients (65 and older) with no decline in ADL function from (acute) hospital admission to hospital discharge as measured by a validated tool		
			D2.b Percentage of patients (65 and older) with no decline in ADL function while receiving in-home rehabilitative care as measured by a validated tool		
		Rate of hospital acquired delirium (RGP)	D3.a Incidence of delirium in patients (65 and older) acquired over the course of acute hospital admission D3.b Incidence of delirium in patients (65 and older) acquired over the course of rehabilitative care admission		

<sup>4</sup> Integrated Falls Prevention Framework & Toolkit (July 2011) LHINCollaborative

<b>Equitable</b> <i>People should receive the same quality of care regardless of who they are and where they live.</i>	Improve equitable access to standardized, best practice services across the region/province	n/a	E1. To support measurement of equity and to illustrate potential differences across population groups, measures from other dimensions may be considered through an equity lens/filter e.g. Age, Sex, Education, Language, Regional Variations, Income etc.		
<b>Integrated</b> <i>All parts of the health system should be organized, connected and work with one another to provide high-quality care.</i>	To Ensure High Need Users Have Integrated Care Plans	Primary care visit within 7 days following hospital discharge for CHF or COPD (HQO CQA)	F1.a Primary care visit within 7 days following acute care hospital discharge for CHF or COPD		
	To Improve Transitions Across Systems To Improve System Navigation for High Need Users	# of patients with evidence of discharge documentation sent to primary care physician (OHA)	F1.b Primary care visit within 7 days following discharge from bedded rehabilitative care for CHF or COPD F2. # of patients with evidence of discharge documentation available to primary care provider and/or next rehabilitative care provider		
	To Reduce Avoidable Patient Days in Hospitals or Other Alternative care Settings	% of Acute ALC Designations to CCC & In-Patient Rehab within 2 Days of Admission	F3. % of Acute ALC Designations to CCC & In-Patient Rehab within 2 Days of Admission		
	<b>Population Health Focused</b> <i>The health system should work to prevent sickness and improve the health of the people of Ontario.</i>	Improve Access to Population-Focused Networks of Care	Percent of Stroke Patients Discharged to Inpatient Rehabilitation Following an Acute Stroke Hospitalization (H-SAA)	G2. Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation.	44.3% <sup>5</sup>
		% of Stroke Patients Admitted to Stroke Unit During Their Inpatient Stay (HSAA)	G3. Proportion of stroke/TIA patients treated on a stroke unit at any time during their inpatient stay	89.7% <sup>6</sup>	48.1% <sup>6</sup> (Prov. Avg.)
Access to regional/provincial programs is available if		n/a	G5. Average Acute ALC days to specialized rehabilitative care programs (i.e. ABI, SCI, stroke, burns, amputee)		

<sup>5</sup> <http://www.ices.on.ca/~media/Files/Atlases-Reports/2014/Stroke-Evaluation-Report/Report-Cards.ashx> (2012/13)

	critical mass does not exist locally				
<p><b><u>Appropriately Resourced</u></b> <i>The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people’s health needs.</i></p>	Resources are available to support & inform education /research/ innovation Increase Adoption of Evidence-Based Care	Evidence of each organization’s involvement with research/ innovation activities and/or utilization of available research to provide best evidence care.	H1. Evidence of each organization’s involvement with research/innovation activities		
	Predictive Modelling/Capacity Planning completed for rehabilitative care services	n/a	H2. Evidence of rehabilitative care system capacity planning every 3-5 years		
	Required rehabilitative care services are available to address patient needs	Service distance from home to Outpatient/Ambulatory Rehabilitative Care Service	H3. Average service distance from home to outpatient/ambulatory rehabilitative care service (by service - PT/OT/SLP/Nursing)		
		Distribution of severity among patients in rehabilitative care beds (MOHLTC/QBPs)	H4. Proportion of patients admitted to rehabilitation within each RPG		



**Appendix A** - QBP Indicators (with rehabilitative care system implications/influences) as of November 1, 2014

NOTE: Additional QBP Indicators to be added/considered as introduced by HQO QBP Expert Panels.

STROKE QBP Indicators <sup>6</sup>
Percentage of stroke/TIA patients admitted to a LTC facility within 1 year of stroke /TIA inpatient hospitalization
30-day stroke/TIA risk-adjusted mortality
90 day stroke/TIA readmission rate following hospitalization for stroke/TIA
Proportion of patients with an AlphaFIM® (target completion day 3) function score of 40–80 discharged to inpatient rehabilitation and > 80 discharged to outpatient / community rehabilitation
Discharge disposition of TIA/stroke patients from acute care: home w/out services, home w/ services, IP rehabilitation; CCC / LTC
Percentage of RPG 1150, 1160 (mild) and moderate & severe stroke patients (RPG 1120,30,40 & RPG 1100,1110) receiving inpatient rehabilitation
Hours of rehabilitation therapy provided in inpatient rehabilitation
Percentage of inpatient rehabilitation patients achieving target RPG LOS
Percentage of TIA / stroke patients treated on a stroke unit (including neuro/ICU) for at least 80% of their LOS
Percentage of stroke / TIA ALC days to total LOS
Percentage of stroke/TIA patients admitted to a LTC facility within 1 year of stroke /TIA inpatient hospitalization
30-day stroke/TIA risk-adjusted mortality
90 day stroke/TIA readmission rate following hospitalization for stroke/TIA
Proportion of patients with an AlphaFIM® (target completion day 3) function score of 40–80 discharged to inpatient rehabilitation and > 80 discharged to outpatient / community rehabilitation
COPD QBP Indicators <sup>7</sup>
Access to pulmonary rehabilitation: Patient referral to and receipt of pulmonary rehabilitation (To be developed)

<sup>6</sup> Quality-Based Procedures: Clinical Handbook for Stroke. Health Quality Ontario & Ministry of Health and Long-Term Care March 2013 (Updated September 2013)

<sup>7</sup> Quality-Based Procedures: Clinical Handbook for Chronic Obstructive Pulmonary Disease. Health Quality Ontario & Ministry of Health and Long-Term Care (January 2013)