
Hospital Report 2003: Rehabilitation Technical Summary
System Integration and Change

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January, 2004

Rehabilitation System Integration and Change Technical Summary

Overview

Hospital Report 2003: Rehabilitation is comprised of four quadrants, including the System Integration and Change Quadrant. This quadrant describes the processes and innovations used by hospitals to support quality improvement and their efforts to integrate care provided in designated adult inpatient rehabilitation beds, with care provided elsewhere in the hospital and in the community. The Rehabilitation Technical Summary presents detailed information on the methodology and results from the System Integration and Change Quadrant of *Hospital Report 2003: Rehabilitation*.

Methodology

Identification of Indicators

The process of identifying indicators for the rehabilitation sector began with the preliminary study conducted for *Hospital Report 2001*.¹ There were three main steps involved in the process of identifying indicators. The initial step was to conduct a literature review. Articles were selected that described or discussed global measures of rehabilitation outcomes or processes; or articles that provided a conceptual review of performance measurement issues specific to rehabilitation. The second step was to conduct interviews with 11 key informants to gather baseline information that was used to define subsequent steps and additional information sources. An Advisory Panel was then constituted to provide input into indicator selection. Panel members were chosen through a nomination process. All hospitals in Ontario were invited to nominate clinicians and/or administrators to the panel according to listed criteria. Fifteen panel members were selected based on related experience and a mix of the following factors: clinicians and administrators, small rehabilitation units and large rehabilitation centres, geographic diversity and experience developing indicators. During the preliminary study and subsequent to it, the panel and the researchers developed a list of indicators to measure System Integration and Change.

Domains and Associated Indicators

The domains, with associated indicators, are listed below.

Domain I - Clinical and Research Activity/Expertise

- a) Evidence-based Practice
- b) Recruitment and Retention of Staff
- c) Evidence of Student Clinical Education
- d) Organizational Commitment to Staff Development

1. Hospital Report 2001: Preliminary Studies – Volume One, Exploring Rehabilitation and Mental Health. Toronto (ON): Hospital Report Research Collaborative; 2002. Available from URL: <http://www.hospitalreport.ca>.

Domain II - Internal Coordination of Care

a) Interdisciplinary Integration of Care

Domain III - System Integration

a) Evidence of Discharge Planning

b) Use of Admission and Discharge Criteria

c) Availability of Information Across the Continuum of Care

d) Coordination and Continuity of Care

Domain IV - Client-centred Rehabilitation

a) Evidence of Client-centred Care

b) Evidence of Organizational Client-centredness

Questionnaire Development

The next stage was to develop a System Integration and Change Questionnaire to operationalize the domains and indicators identified by the Advisory Panel. Several sources were utilized to suggest content for questionnaire items to address each of the indicators selected by the Advisory Panel.

These sources included:

- Consultation with experts for some of the major indicator domains (e.g. Evidence-based Practice)
- Review of the System Integration and Change Questionnaires for *Hospital Report 2001: Acute Care* and *Complex Continuing Care*
- Review of the Canadian Council of Health Services Accreditation's Achieving Improved Measurement (AIM) Accreditation Standards
- Review of the Heart and Stroke Foundation of Ontario's Stroke Rehabilitation Consensus Panel Report (May, 2000)
- Review of the Health Services Restructuring Commission's Legacy Report (March, 2000)
- Consultation with a working group comprised of personnel with research, quality assurance and clinical backgrounds, that addressed measurement of Client-centred Rehabilitation at the program/organizational level; representation on this working group was from The University of Toronto, Toronto Rehabilitation Institute, St. John's Rehabilitation Hospital and Mount Sinai Hospital.

The System Integration and Change survey process addresses issues relevant to rehabilitation, as well as issues of a corporate nature. The Complex Continuing Care sector released its first system-level scorecard in December, 2001. Due to areas of overlap and some similarities between Complex Continuing Care and Rehabilitation, a decision was made to produce an integrated System Integration and Change Questionnaire for these two sectors. As a result, extensive collaboration occurred between researchers from the Complex Continuing Care and Rehabilitation sectors. This included joint meetings and working partnerships to incorporate the questions for both sectors into one questionnaire. To address issues of a corporate nature, there was further integration with all sectors involved in the Hospital Report process. These sectors included Acute Care, Complex Continuing Care,

Mental Health, Nursing and Emergency Department Care. Hospital corporations received these questions in one questionnaire. This process was done to minimize the response burden for hospital staff.

In August of 2002, the questionnaire development was at a stage where further panel advisory input was required. Plans were made to reconvene the Rehabilitation Advisory Panel on September 20, 2002. Prior to the panel meeting, panelists were mailed the questionnaire, as well as a pre-panel feedback form. Panelists were asked to evaluate various questions. Each question was evaluated by five different panelists. Evaluations included rating each question according to the following:

- 1) The clarity of the question/statement;
- 2) The clarity of the response options;
- 3) The ease of obtaining the information; and
- 4) The quality of the data obtained through the question.

Panelists were also encouraged to provide written comments/suggestions with respect to each question. These evaluations were returned to the researchers prior to the September 20, 2002 panel meeting so that an analysis of the data could be completed prior to the panel meeting.

Based on the results of the Pre-panel Feedback form, “Clarity” and “Availability” scores were developed with a minimum of four and a maximum of eight for each score. Questions, that had scores of six or less, were considered by the researchers either for exclusion from the questionnaire or for discussion at the panel meeting on September 20, 2002. A summary of the descriptive data/comments that the researchers received was also taken into consideration when excluding questions or choosing questions to bring before the panel.

The objectives of the September 20, 2002 panel meeting were as follows:

- 1) To clarify wording of problematic questions;
- 2) To rank the questions with respect to “importance”; and
- 3) To reduce the number of questions in the System Integration and Change Questionnaire.

Concepts that were discussed related to definitions for “Formal” and “Informal” Processes; and to scales that included “Very few”, “Some”, “Most”, “All”. Problematic questions that were discussed with the panel included questions that addressed recruitment and retention incentives and strategies, student teaching, National Rehabilitation Reporting System (NRS) data, physician availability, customization of educational activities for clients and senior person responsible for regulated health professionals. Panelists ranked questions according to their level of importance. Rankings were then averaged across panel members.

Consensus was obtained from the panelists for changes and/or exclusion of questions from the questionnaires. The full questionnaire, including the corporate questions, is available on the Hospital Report website: www.hospitalreport.ca.

Survey Process

On November 1, 2002, the Integrated System Integration and Change Questionnaire for Complex Continuing Care and Rehabilitation Services was couriered to 46 of the hospital corporations or partnerships in Ontario that had agreed to participate in this quadrant. Initially, multi-site corporations were provided with separate questionnaires for each site. Some multi-site corporations subsequently chose to complete one questionnaire for all sites, while others completed separate questionnaires for individual sites. Therefore, in this Report, responses specific to rehabilitation are from 47 hospital corporations and/or sites, while responses of a corporate nature are from 45 hospital corporations.

The questionnaires were addressed to a contact person that hospitals had identified during the signup process. To help ensure submission of high quality data, instructions enclosed with the questionnaire asked that individual questionnaire sections be completed by the person in the hospital who possessed the most knowledge about the topic covered in that section. Hospitals were requested to return their completed questionnaires no later than December 6, 2002.

Hospitals were provided with contact information if they had any questions regarding the Integrated System Integration and Change Questionnaire. Queries were fielded from November 4, 2002 to December 20, 2002. On December 20, 2002, follow-up telephone calls to those hospitals that had not returned questionnaires were made to maximize response to the questionnaire. For those few hospitals that had not returned questionnaires, further telephone calls were made during the months of January and February, 2003.

Data Quality

The indicators for the System Integration and Change Quadrant were based on hospital survey data that are subject to a “social desirability bias”. This means that those responding to survey questions may either consciously or unconsciously answer questions in a way that makes their hospital appear favourable. To attempt to minimize this bias, survey questions were constructed to focus on specific activities or behaviours, as opposed to attitudes or beliefs. To maximize data quality, an extensive follow-up procedure was conducted for missing, unclear and contradictory data. This follow-up included telephone calls, with corresponding electronic-mail documentation, with the rehabilitation contact person at the hospital. Based on the follow-up telephone and electronic-mail communications, missing data were entered into the questionnaires. Unclear entries on the questionnaire were clarified as well. Sometimes responses were contradictory to the instructions provided or contradictory to responses provided in previous questions. In such cases, follow-up was made to ensure no contradictory responses existed and the data provided were accurate. Due to this extensive follow-up procedure, members of the research team are very confident that the data are of high quality.

Survey data were then entered into an Access database. To further ensure high quality data, a process of double data entry was undertaken. This process involved entering raw data on at least two occasions and comparing differences in datafiles. Any differences were

subsequently reconciled with the source data. This process continued until there were no discrepancies between databases.

Indicator Development

Development of the indicators for the System Integration and Change Quadrant was ongoing during the research process. In addition to input from the Advisory Panel, researchers from other sectors of the Hospital Report Research Collaborative were also consulted in the development of indicators for rehabilitation. Once the survey process was complete and the data entered into a database, researchers began the work of refining the indicators. At this time, they identified questions for inclusion in or exclusion from indicators for the System Integration and Change Quadrant. These recommendations were based on the following:

- Panel ranking of questions based on importance from the September, 2002 Advisory Panel meeting
- The distribution of responses in each question
- The quality of the data
- The clarity of the questions based on feedback from the hospitals during the follow-up process.

Preliminary recommendations on the composition and calculation of indicators were developed. The researchers recommended that indicators be reported either as an index (score-type) measure or descriptively (the percentage of hospitals that reported specific responses to questions).

In May, 2003, the System Integration and Change Advisory Panel was reconvened. The meeting of the Advisory Panel had three objectives. They were:

1. To review the questions recommended for inclusion in indicators;
2. To review the proposed calculation of questions within indicators; and
3. To weight all of the questions represented in indicators that received an index or score-type measure.

The Advisory Panel discussed the inclusion of questions in indicators and the calculation of indicators and came to a group consensus for each indicator. The decisions for weighting of questions were arrived at by one of two methods:

1. Visual Analogue Scale – Advisory Panel members were asked to elicit a weight for questions comprising the indicators on a visual analogue scale; or
2. Consensus – After a facilitated discussion, members of the Advisory Panel were asked to come to a group consensus for the weighting of each indicator.

Where weighting was determined by visual analogue scale, the mean weights for each question were calculated. In an effort to develop a more concise report with fewer indicators, some changes were made by the researchers following the Advisory Panel meeting. Changes to the indicators made by the researchers were communicated to the Advisory Panel via electronic-mail.

Peer Groups

The indicator results for this quadrant are reported provincially, by Ontario Hospital Association (OHA) region and by specialty and general peer groups. Appendix C of *Hospital Report 2003: Rehabilitation* includes the geographical allocation of the OHA regions and hospital corporations within each region. The reader is cautioned when interpreting regional variations as some regions, particularly OHA Region 1 (North), have relatively small sample sizes.

Specialty and general designations are equivalent to the specialty and general peer groups used in the NRS by the Canadian Institute for Health Information (CIHI). A general rehabilitation hospital is defined as one that provides inpatient rehabilitation in general (acute care) hospitals with rehabilitation units, programs or designated physical rehabilitation beds. A specialty rehabilitation hospital is one that provides comprehensive inpatient rehabilitation and specialized programs in a freestanding rehabilitation/complex continuing care hospital or a specialized unit within a hospital designated for physical rehabilitation. For detailed definitions of general and specialty peer groups please refer to Appendix B of *Hospital Report 2003: Rehabilitation*.

Detailed Description of the Indicators for System Integration and Change

The System Integration and Change Quadrant is comprised of 11 indicators derived from the System Integration and Change Questionnaire. Since this is the second stage in a series of reports for rehabilitation and is system-level, indicators are at varying stages of development. Five (5) of the 11 indicators are sufficiently developed to receive an index or score-type measure. The remaining six indicators are at early stages of development and index measures have not been developed. Therefore, the percentage of hospitals that identified specific responses to the questions that comprise each of these six indicators is reported.

A detailed description of each indicator in *Hospital Report 2003: Rehabilitation* is provided below. This includes a description of each item that comprises each indicator as well as the calculations performed on each indicator. For indicators that received an index measure, the point allocation for each item included in the indicator is presented. In order to calculate the indicator score, each question must be multiplied by the specific weighting. For example:

Question 3: A hospital received 20 points out of a possible 25 points. To calculate the contribution of this question to the indicator score divide the hospital's score (20) by the maximum point allocation (25) and multiply by the weighting for the question (30.0%). In this example, the hospital received 24.0% of the total indicator score for this question.

All hospitals that participated in the System Integration and Change Quadrant completed one of two versions of the *Hospital Report 2003: Integrated System Integration and Change Survey*. Freestanding rehabilitation hospitals completed Version One of the questionnaire. This version includes questions specific to rehabilitation as well as questions of a corporate nature. Acute care hospitals with designated inpatient rehabilitation beds completed Version

Two of the *Hospital Report 2003: Integrated System Integration and Change Survey*. This version of the questionnaire contains only those questions specific to rehabilitation. All hospitals that responded to Version Two of the questionnaire also completed the *Corporate – System Integration and Change Survey*, which contains all the questions of a corporate nature. All three questionnaires are available at www.hospitalreport.ca.

Preceding each question detailed in this section, the corresponding number from each questionnaire is provided. The questionnaires will be referred to by the abbreviation indicated in brackets:

- *Hospital Report 2003: Integrated System Integration and Change Survey - Version One (V1)*
- *Hospital Report 2003: Integrated System Integration and Change Survey - Version Two (V2)*
- *Corporate – System Integration and Change Survey (C)*

For example, Question 29 (V1), Question 22 (V2), indicates that this question is located in the *Hospital Report 2003: Integrated System Integration and Change Survey - Version One* as number 29 and in the *Hospital Report 2003: Integrated System Integration and Change Survey - Version Two* as number 22.

Indicator 1: Evidence-based Practice

The Evidence-based Practice indicator was designed to measure the extent to which hospitals are providing support for evidence-based practice in rehabilitation. This indicator is comprised of components of six questions from the System Integration and Change Questionnaire. Responses to these questions were reported descriptively. That is, the percentage of hospitals to indicate certain responses to the following questions were described.

Question 3 (V1), Question 3 (V2)

Hospitals were asked to indicate if they had any practice protocols/guidelines developed or in the development stage between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded affirmatively was calculated.

Question 4 (V1), Question 4 (V2)

Hospitals were asked to report on which practice protocols/guidelines were developed or under development between April 1, 2001 and March 31, 2002. This included the name of the clinical issue with protocol, the patient group for whom the protocol was developed and the extent of use for each protocol. Practice protocols were grouped by common clinical issues and the number of hospitals that reported each protocol was calculated. Further, the extent of use of the most common protocols was ascertained by calculating the number of hospitals to report each of the five listed options:

- Protocol was in the early stage of development between April 1, 2001 and March 31, 2002
- Protocol was developed since March 31, 2002 and has been implemented

- Protocol was developed by March 31, 2002 and no eligible patients were cared for using this protocol
- Protocol was developed by March 31, 2002 and some (1-74%) eligible patients were cared for using this protocol
- Protocol developed by March 2002 and most (75%+) eligible patients were cared for using this protocol.

Question 8 (VI), Question 21 (C)

Hospital corporations were asked to indicate which resources were available for and accessible by their staff for the development and use of practice protocols/guidelines between April 1, 2001 and March 31, 2002. The items included:

- Allowance for dedicated clinician time for practice protocol or guideline development
- Financial resources/support staff necessary to support development of practice protocols or guidelines
- Structure/process for identifying clinical experts around best practice issues needed to develop or validate practice protocols/guidelines
- Evidence of championship by management for the development and use of practice protocols/guidelines
- Evidence of championship by clinical/professional leadership for the development and use of practice protocols/guidelines
- Structure/process in place for the collection and dissemination of outcome data demonstrating the advantages of using practice protocols/guidelines
- On-the-job training and staff education regarding the development and use of practice protocols/guidelines
- Availability and access to electronic resources to help facilitate the use of practice protocols/guidelines
- Structure/process in place to assist with the integration of practice protocols/guidelines with hospital documentation
- Process for monitoring and re-evaluating practice protocol/guideline use.

The percentage of hospitals to report each of the above items was calculated.

Question 43 (VI), Question 11 (C)

Hospital corporations were asked to indicate the percentage of staff (<25%, 25-74%, or 75%+) that participated in formal in-service programs, courses and off-site conferences for research activities/skills supported by the organization between April 1, 2001 and March 31, 2002. Descriptive results were calculated for physicians, nursing staff, other regulated health professionals, unregulated patient-care staff and other hospital staff.

Question 61 (VI), Question 35 (V2)

Hospitals were asked to report which other service providers were involved in the joint initiative of developing standardized protocols that span patient care in the hospital and the community between April 1, 2001 and March 31, 2002. The percentage of hospitals that reported this joint initiative with external service providers (acute care hospitals, CCACs, community support service agencies, mental health agencies, LTC facilities, cancer centres,

other CCC/Rehab providers) was calculated.

Question 63a (VI), Question 20a (C)

Hospital corporations were asked to indicate if patient-care staff could access literature search databases and other library resources and/or education materials “on-line” in real time between April 1, 2001 and March 31, 2002. The percentage of hospitals that reported that staff had access to perform these functions was calculated.

Indicator 2: Recruitment and Retention of Staff

The Recruitment and Retention of Staff indicator was constructed to reflect the extent to which hospitals are implementing recruitment and retention strategies for their staff. This indicator is comprised of three questions from the System Integration and Change Questionnaire. This indicator did not receive any scoring. Rather, the percentage of hospitals that indicated certain responses to these questions were described within the Report.

Question 30 (VI), Question 1 (C)

Hospital corporations were asked to indicate which recruitment and retention incentives and strategies were implemented for nurses, other regulated health professionals on staff, unregulated patient care staff and other hospital staff between April 1, 2001 and March 31, 2002. The listed strategies included:

- Flexible work arrangements
- Employee referral bonuses
- Relocation assistance
- Competitive salaries
- Parking/transportation subsidies
- Signing bonuses
- Use of recruitment agencies
- Committee designated to address issues of recruitment and retention
- Committee designated to address quality of work life, including scheduling and workload issues
- A hospital website that offers information about opportunities at the hospital
- Availability/use of employee assistance programs
- Recognition programs such as special awards for excellence or accomplishment (not just long service)
- Representation at job fairs
- General cost of living increases
- Other additional increases in non-union salaries for all positions
- Other additional increases in non-union salaries for specific positions
- Opportunities for advanced education supported by the hospital and/or hospital foundation
- Daycare program
- Eldercare programs
- 24-hour cafeteria services
- Counseling and other resources for career planning

- Staff lounge on each unit.

The percentage of hospitals to report each strategy listed was calculated.

Question 31 (VI), Question 2 (C)

This question focused on recruitment/retention incentives or strategies for physicians. Hospital corporations were asked to indicate which strategies were implemented for physicians between April 1, 2001 and March 31, 2002. The strategies included:

- Relocation assistance
- Committee/ task force designated to address physician recruitment and retention
- Full-time staff responsible for physician recruitment and retention
- Retirement/retention plans
- Retention bonuses
- Parking/transportation subsidies
- Paid accommodation and travel expenses for site/community visits
- Hospital website that offers information regarding employment opportunities for physicians at the hospital
- Hosting events for physicians through the hospital and/or local medical community to raise awareness of healthcare facilities in the area
- Long service leaves (sabbaticals)
- Practice overhead support
- Spousal support
- Supplemental financial incentives (e.g. non-fee-for-service)

The percentage of hospitals that reported each strategy was calculated.

Question 34a (VI), Question 3a (C)

Hospital corporations were asked if they tracked staff turnover rates between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded affirmatively was calculated.

Indicator 3: Evidence of Student Clinical Education

The Evidence of Student Clinical Evaluation indicator measure was constructed to illustrate the amount of student clinical education occurring in rehabilitation. This indicator is comprised of one question from the System Integration and Change Questionnaire.

Question 48 (VI), Question 24 (C)

Hospitals were asked to report the following for regulated health professionals:

- The number of hours of clinical supervision
- The number of hours of in-house student teaching
- The number of FTEs working in Rehabilitation Services
- The number of FTEs involved in student teaching

The regulated health professionals included were audiologists, dietitians, occupational therapists, pharmacists, physiotherapists, psychologists, RNs, RPNs, social workers and speech language pathologists. The mean number of hours of clinical education by profession, the percentage of FTEs involved in student teaching and the mean number of hours of clinical education per FTE were calculated. For *Hospital Report 2003: Rehabilitation*, only the data for occupational therapists and physiotherapists were presented due to data quality issues for other professional groups.

Indicator 4: Organizational Commitment to Staff Development

The Organizational Commitment to Staff Development indicator was developed to reflect the extent to which there is organizational support for professional development, continuing education activities and performance evaluations for all hospital staff. This indicator is comprised of five questions from the System Integration and Change Survey. Three of these five questions were included in the calculation of an index measure. Two further questions were not included in the index measure, but were reported descriptively in this indicator.

Question 42 (VI), Question 10 (C)

Hospital corporations were asked to indicate which groups (physicians, nurses, other regulated health professionals on staff and unregulated patient care staff) were provided with various continuing education or professional development support within their organization between April 1, 2001 and March 31, 2002. Hospitals were awarded one point for their responses for each professional group for the following items: reimbursement of continuing education courses (partial or full); reimbursement of advanced education (partial or full); bursaries/scholarships; paid time off to take courses; unpaid time off to take courses; financial reward upon completion of an educational program; on-site courses provided by hospital staff; and on-site courses provided by external organizations or experts. The maximum score for this question was 32 points. This question was weighted 41.25% of the final indicator score.

Question 43 (VI), Question 11 (C)

Hospital corporations were asked to indicate the extent of investment in various continuing education activities for physicians, nursing staff, other regulated health professionals, unregulated patient care staff and other hospital staff between April 1, 2001 and March 31, 2002. Hospitals were awarded points based on whether few (1 point), some (2 points) or most (3 points) of their staff participated in the training. The continuing educational activities included in the question were: team building; conflict management; ethical issues; quality improvement; cultural diversity; domestic violence and/or abuse; availability of community services for patients; clinical management; leadership development; and research activities/skills. The item with the highest score for each professional group was included in the indicator score. The maximum score for this question was 15 points. This question was weighted 33.75% of the final indicator score.

Question 44 (VI), Question 12 (C)

Hospital corporations were asked to indicate if they tracked formal performance evaluations for their staff between April 1, 2001 and March 31, 2002. One point was awarded to

hospitals that responded affirmatively. This question was weighted 25.0% of the final indicator score.

Question 45 (V1), Question 13 (C)

Hospital corporations were asked to report how frequently they conducted formal performance evaluations (yearly, every two years or every three years or less frequently). The percentage of hospitals that responded yearly, every two years and every three years or less frequently was calculated.

Question 47 (V1), Question 15 (C)

Hospital corporations were asked to indicate which groups (physicians, nurses, other regulated health professionals, unregulated patient care staff and other hospital staff) had formal performance evaluations between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded that physicians, nurses, other regulated health professionals, unregulated patient care staff and other hospital staff received formal performance evaluations was calculated.

Table 1 summarizes the possible points and weighting for the Organizational Commitment to Staff Development indicator.

Table 1. Organizational Commitment to Staff Development Indicator

Question Number	Possible Points	Weighting
Question 42 (V1), 10 (C)	32	41.25%
Question 43 (V1), 11 (C)	15	33.75%
Question 44 (V1), 12 (C)	1	25.0%
Question 45 (V1), 13 (C)	*	*
Question 47 (V1), 15 (C)	*	*
		Total 100.0%

*Question was not included in the calculation of the index measure.

Indicator 5: Interdisciplinary Integration of Care

The Interdisciplinary Integration of Care indicator was designed to reflect the amount of interdisciplinary integration that is occurring in rehabilitation in Ontario hospitals. This indicator is comprised of seven questions. These questions were not scored. However, the percentage of hospitals that responded to each item within the questions was calculated.

Question 19 (V1), Question 12 (V2)

Hospitals were asked to indicate if they had a process (formal or informal) to incorporate patient input into decision-making between April 1, 2001 and March 31, 2002. The item - evaluation by the multidisciplinary team of progress toward goal achievement - was selected to contribute to this indicator. The percentage of hospitals that reported formal or informal processes was calculated.

Question 43 (V1), Question 11 (C)

Hospital corporations were asked to indicate the percentage of staff that participated in

formal inservice programs, courses, and off-site conferences for teambuilding and conflict management between April 1, 2001 and March 31, 2002. Staff groups included in this question were: physicians, nursing staff, other regulated health professionals on staff, unregulated patient care staff and other hospital staff. The percentage (<25%, 25-74% or 75%+) of each group that participated in teambuilding training and conflict management training was calculated.

Question 76 (VI), Question 48 (V2)

Hospitals were asked to indicate which groups attended at least 75% of multidisciplinary rounds between April 1, 2001 and March 31, 2002. Staff groups included in this question were: family physicians; physician specialists; registered nurses (RNs, RPNs); social workers; physiotherapists; occupational therapists; speech language pathologists; pharmacists; audiologists; dietitians; psychologists; personal support workers; and patients/families. For each group listed, the percentage of hospitals that indicated that the group attended rounds at least 75% of the time was calculated.

Client Perspectives of Rehabilitation Services Questionnaire

The following questions from the Client Perspectives of Rehabilitation Services Questionnaire were included in this indicator (The Client Perspectives of Rehabilitation Services Questionnaire is available at www.hospitalreport.ca):

Clients were asked to respond to the following statements on a 5-point scale including Strongly Agree, Agree, Neutral, Disagree and Strongly Disagree:

- I had to repeat the same information to the different program staff
- My therapists, nurses and doctors worked well together
- There was one person in charge of coordinating my care among the therapists, nurses and doctors
- Most things were done in the hospital within a reasonable amount of time.

The percentage of respondents that indicated each response option was calculated.

Indicator 6: Evidence of Discharge Planning

The Evidence of Discharge Planning indicator was designed to ascertain the prevalence of key staff roles involved in discharge planning and the extent of hospital collaboration with external service providers with respect to discharge planning. This indicator is comprised of two questions, for which the results are reported descriptively.

Question 33 (VI), Question 4 (C)

Hospital corporations were asked to report if various staff roles existed between April 1, 2001 and March 31 or were introduced during this period. The staff roles of discharge planner and social worker were selected for inclusion in this indicator. The percentage of hospitals that indicated that a discharge planner and social worker existed in the hospital was calculated.

Question 61 (V1), Question 35 (V2)

Hospitals were asked to indicate if they participated in the following joint initiatives with other service providers between April 1, 2001 and March 31, 2002: looking at care planning in the hospital and determining appropriate patient discharge criteria; and evaluating appropriateness of discharge. The percentage of hospitals that indicated they had participated in these joint initiatives was calculated for each service provider. Service providers included:

- Acute care hospitals
- Community care access centres
- Community support service agencies
- Mental health agencies
- Long-term care facilities
- Cancer centres
- Other complex continuing care/rehabilitation providers.

Indicator 7: Use of Admission and Discharge Criteria

The Use of Admission and Discharge Criteria indicator was constructed to evaluate the development of admission and discharge criteria for rehabilitation in Ontario. This indicator is comprised of four questions from the System Integration and Change Survey, which all received various weights in the calculation of a final indicator score.

Question 22 (V1), Question 15 (V2)

Hospitals were asked to report the extent to which standardized admission criteria were used within programs. The response options included: standardized admission criteria did not exist for this program (0 points); standardized admission criteria were under development between April 1, 2001 and March 31, 2002 and implemented after March 31, 2002 (0.5 points); standardized admission criteria were applied to some (1-74%) patients admitted to this program (1 point); and standardized admission criteria were applied to most (75%+) patients admitted to this program (2 points). Hospitals were asked to report for each program. However, the program with the highest score was retained for inclusion in the indicator score. The maximum point allocation was two points. This question was weighted 29.4% of the final indicator score.

Question 23 (V1), Question 16 (V2)

Hospitals were asked to report which stakeholders were consulted in the development of standardized admission criteria between April 1, 2001 and March 31, 2002. The response options included: representatives of other levels of care within our organization (0.5 points); other organizations that refer patients to our CCC/Rehab Services (1 point); other rehabilitation providers in the catchment area (1 point); and patients and families (1 point). Hospitals responded to this question by program. However, the program with the highest score was retained for inclusion in the indicator score. The maximum point allocation was 3.5 points. This question was weighted 20.6% of the final indicator score.

Question 24 (V1), Question 17 (V2)

Hospitals were asked to indicate the extent to which standardized discharge criteria were used for each program or patient type between April 1, 2001 and March 31, 2002. The response options included: standardized discharge criteria did not exist for this program (0 points); standardized discharge criteria were under development between April 1, 2001 and March 31, 2002 and implemented after March 31, 2002 (0.5 points); standardized discharge criteria were applied to some (1-74%) patients discharged from this program (1 point); and standardized discharge criteria were applied to most (75%+) patients discharged from this program (2 points). Hospitals responded to this question by program. However, the program with the highest score was retained for inclusion in the indicator score. The maximum point allocation was two points. This question was weighted 29.4% of the final indicator score.

Question 25 (V1), Question 18 (V2)

Hospitals were asked to report which stakeholders were formally consulted in the development of standardized discharge criteria between April 1, 2001 and March 31, 2002. The response options included: representatives of other levels of care within our organization (0.5 points); other organizations that refer/discharge patients to our CCC/Rehab Services (1 point), other CCC/Rehab providers in the catchment area (1 point); and patients and families (1 point). Hospitals responded to this question by program. However, the program with the highest score was retained for inclusion in the indicator score. The maximum point allocation was 3.5 points. This question was weighted 20.6% of the final indicator score.

Table 2 summarizes the possible points and weighting for the Use of Admission and Discharge Criteria indicator

Table 2. Use of Admission and Discharge Criteria

Question	Possible Points	Weighting
Question 22 (V1), 15 (V2)	2	29.4%
Question 23 (V1), 16 (V2)	3.5	20.6%
Question 24 (V1), 17 (V2)	2	29.4%
Question 25 (V1), 18 (V2)	3.5	20.6%
		Total 100.0%

Indicator 8: Availability of Information Across the Continuum of Care

The Availability of Information across the Continuum of Care indicator was developed to measure the amount of information-sharing preadmission and postdischarge from rehabilitation in Ontario hospitals. This indicator is comprised of two questions from the System Integration and Change Questionnaire. Both questions were weighted into a final indicator score.

Question 52 (V1), Question 27 (V2)

Hospitals were asked to indicate which processes were in place for sharing information about Rehabilitation Services for patients pre-admission to inpatient rehabilitation between April 1,

2001 and March 31, 2002. Hospitals received 0 points for indicating the response option “never”, 1 point for “sometimes” and 2 points for “always” for the following items:

- Written materials about the Rehab program were handed out to patients awaiting admission
OR
Patients were referred to our website for information about the Rehab program
- Rehab staff/physician spoke directly with patients before admission to discuss the Rehab program
- Rehab staff/physician completed pre-admission assessments or screening assessments.

Although hospitals responded to this question for each program, only the program with the highest score was retained for inclusion in the indicator score. The maximum point allocation was six points. This question was weighted 41.25% of the final indicator score.

Question 53 (V1), Question 28 (V2)

Hospitals were asked to report on information transfer postdischarge from Rehabilitation Services between April 1, 2001 and March 31, 2002. Hospitals were allocated points for indicating that the following information was transferred upon discharge from rehabilitation: medical notes (1 point); summaries from other health professionals (1 point); and other (e.g. lab reports, diagnostic imaging) (1 point). Points were allocated for indicating that family physician (1 point) and other relevant health care professionals/agencies (1 point) received the information. Hospitals that reported that information was sent within two days of discharge received one point and those that reported that information was sent greater than two days postdischarge received 0.5 points. The maximum point allocation was six points. Hospitals responded to this question for each program. However, the program with the highest score was retained for inclusion in the indicator score. This question was weighted 58.75% of the final indicator score.

Table 3 summarizes the possible points and weighting for the Availability of Information Across the Continuum of Care indicator.

Table 3. Availability of Information Across the Continuum of Care

Question	Possible Points	Weighting
Question 52 (V1), 27 (V2)	6	41.25%
Question 53 (V1), 28 (V2)	6	58.75%
		Total 100.0%

Indicator 9: Coordination and Continuity of Care

The Coordination and Continuity of Care indicator was designed to reflect the degree of coordination and continuity evident in rehabilitation programs for patients after discharge from inpatient rehabilitation services. This indicator is comprised of five questions and their components. This indicator was not scored. The results for all questions in this indicator were reported descriptively.

Question 54a (V1), Question 29a (V2)

Hospitals were asked to indicate if there was a process in place by which patients could contact program staff after discharge from inpatient rehabilitation between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded affirmatively to this question was calculated.

Question 54b (V1), Question 29b (V2)

Hospitals were asked if they had formal processes to contact program staff after discharge from inpatient rehabilitation between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded affirmatively to this question was calculated.

Question 55a (V1), Question 30a (V2)

Hospitals were asked to indicate whether staff made follow-up telephone contact with patients discharged from inpatient rehabilitation between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded affirmatively to this question was calculated.

Question 55b (V1), Question 30b (V2)

Hospitals were asked to indicate if they had a formal process for making follow-up telephone contact with patients discharged from inpatient rehabilitation between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded affirmatively to this question was calculated.

Question 55c (V1), Question 30c (V2)

Hospitals were asked to indicate the percentage of all rehabilitation patients discharged from inpatient rehabilitation that received follow-up telephone calls between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded: few patients (<25%), some patients (25-74%) or most patients (75%+) was calculated.

Question 55d (V1), Question 30d (V2)

Hospitals were asked to indicate how long program staff continued to make follow-up telephone calls for patients after discharge from inpatient rehabilitation between April 1, 2001 and March 31, 2002. The percentage of hospitals that responded: up to 1 month post-discharge, up to 3 months post-discharge, up to 6 months post-discharge and up to 1 year post-discharge was calculated.

Question 56a (V1), Question 31a (V2)

Hospitals were asked if they had a process in place to arrange follow-up assessment visits for patients discharged from inpatient rehabilitation between April 1, 2001 and March 31, 2002. The percentage of hospitals that reported such processes was calculated.

Question 56b (V1), Question 31b (V2)

Hospitals were asked to indicate if they had a formal process to contact program staff after discharge from inpatient rehabilitation between April 1, 2001 and March 31, 2002. The percentage of hospitals that reported formal processes was calculated.

Question 56c (V1), Question 31c (V2)

Hospitals were asked to indicate the percentage of rehabilitation patients discharged from inpatient rehabilitation to attend follow-up assessment visits between April 1, 2001 and March 31, 2002. The response options were: few patients (<25%), some patients (25-74%) or most patients (75%+). The percentage of hospitals that reported these responses was calculated.

Question 56d (V1), Question 31d (V2)

Hospitals were asked to report the services available to rehabilitation patients at follow-up visits for each program/patient type between April 1, 2001 and March 31, 2002. These services included physician services, nursing services, therapy services and other professional services. The percentage of hospitals that reported the existence of each service for at least one program in rehabilitation was calculated.

Question 57a (V1), Question 32a (V2)

Hospitals were asked to report if they had a process in place to arrange outpatient therapy or day hospital visits for patients discharged from inpatient rehabilitation services between April 1, 2001 and March 31, 2002. The percentage of hospitals that reported a process was calculated.

Question 57b (V1), Question 32b (V2)

Hospitals were asked to report if they had a formal process to arrange outpatient therapy or day hospital visits at their organization for patients discharged from inpatient rehabilitation services between April 1, 2001 and March 31, 2002. The percentage of hospitals that reported a formal process was calculated.

Question 57c (V1), Question 32c (V2)

Hospitals were asked to indicate the percentage of all rehabilitation patients discharged from rehabilitation who accessed outpatient/day hospital at their organization. The response options were: few patients (<25%), some patients (25-74%), and most patients (75%+). The percentage of hospitals that reported these options was calculated.

Question 58a (V1), Question 33a (V2)

Hospitals were asked if they had a process in place to enable periodic readmissions of patients back into inpatient rehabilitation after they completed their inpatient rehabilitation program between April 1, 2001 and March 31, 2002. The percentage of hospitals that reported a process was calculated.

Question 58c (V1), Question 33c (V2)

Hospitals were asked to indicate the types of services provided for patients readmitted back into inpatient rehabilitation: medical assessment/intervention; nursing assessment/intervention; multidisciplinary assessment; and therapy interventions. The percentage of hospitals that reported each service was calculated.

Indicator 10: Evidence of Client-centred Care

The Evidence of Client-centred Care indicator was designed to reflect the extent to which care at the individual level is being provided in a client-centred approach. This indicator is comprised of seven questions, which all received various weights in the calculation of a final indicator score.

Question 15 (V1), Question 8 (V2)

Hospitals were asked to report if they provided printed information to patients and families regarding the availability of services through the following mechanisms: a) as part of the admission package; and b) readily accessible within our CCC and/or Rehab Services. The services or opportunities listed were:

- Services that support wellness, improvement, and quality of life (e.g. recreation)
- Social, spiritual and community activities
- Patient advocate/ombudsperson
- Taking part or refusing to take part in research or clinical trials
- Services within the hospital that are relevant to their condition
- Services in the community that are relevant to their condition
- How to report a complaint or commendation.

Each of seven listed services or opportunities was allocated one point. However, hospitals were awarded a maximum of five points for responses to both “provided as part of the admission package” and “readily accessible within our CCC and/or Rehab Services.” The maximum point allocation for this question was ten points. This question was weighted 5% of the total indicator score.

Question 16 (V1), Question 9 (V2)

Hospitals were asked to indicate how they customized their educational activities to the individual needs of the patient/family between April 1, 2001 and March 31, 2002. Hospitals were awarded one point for indicating that they had an informal process and two points for a formal process for the following: assessment of each patient/family to determine their information needs; assessment of each patient/family to identify when they are ready for education (readiness-to-learn); reassessment of information needs and readiness-to-learn over time; and evaluation of the outcome of patient/family education (patient/family learning was evaluated after information was provided). The maximum point allocation for this question was eight points. This question was weighed 15.0% of the total indicator score.

Question 17 (V1), Question 10 (V2)

Hospitals were asked if they had processes to involve families in patient care within rehabilitation between April 1, 2001 and March 31, 2002. Hospitals were awarded one point for indicating that they had an informal process and two points for a formal process for the following: patients to direct the degree of family involvement or non-involvement in the care process; and to assess family expectations and capacity to be involved in the patient’s care in hospital and after discharge (if discharge is applicable). The maximum point allocation for this question was four points. This question was weighted 10.0% of the total indicator score.

Question 18 (V1), Question 11 (V2)

Hospitals were asked how families were involved in each of the following processes within rehabilitation between April 1, 2001 and March 31, 2002. For each process, hospitals were allocated points for indicating the existence of one-to-one meetings with any member of the health care team (1 point), designated staff person to meet with families (1 point) and team meetings (1 point). Three processes were included: setting of patient goals; patient care planning and therapy planning; and discharge planning. The maximum point allocation for this question was nine points. This question was weighted 10.0% of the total indicator score.

Question 19 (V1), Question 12 (V2)

Hospitals were asked to indicate which processes were in place in rehabilitation to incorporate patient input into decision-making about care, goals, treatment and discharge plans between April 1, 2001 and March 31, 2002. Hospitals received one point for indicating that an informal process existed and two points for a formal process for the following processes: one-to-one meetings between professionals from the multidisciplinary team and the patient to elicit patient input into care, goals, treatment and discharge decisions; team meetings between professionals from the multidisciplinary team and the patient to elicit patient input into care, goals, treatment and discharge decisions; choice routinely provided to patients regarding multidisciplinary meetings (one-to-one or with the team); goal-setting for each patient based on agreement between the patient and the multidisciplinary team; designation of contact person from the multidisciplinary team for each patient to address patients' questions and concerns about care, goals, treatment and discharge decisions; establishment of discharge date involves patient input; and process for resolution of disagreements between the patient and the multidisciplinary team regarding care, goals, treatment and discharge decisions. Hospitals were awarded two points for indicating an informal process was in place and four points for a formal process for evaluation by the patient of progress towards goal achievement. The maximum point allocation for this question was 18 points. This question was weighted 30.0% of the total indicator score.

Question 20 (V1), Question 13 (V2)

Hospitals were asked whether rehabilitation had a formal process to assess and document patients'/families' emotional support needs and what emotional support mechanisms were in place for rehabilitation patients/families between April 1, 2001 and March 31, 2002. Hospitals received points for indicating that there was a formal process for assessing and documenting emotional support needs for patients (4 points) and families (2 points). Points were awarded for indicating the following mechanisms existed for patients: professionals trained in emotional support counseling provided one-to-one counseling (2 points); professionals trained in emotional support counseling provided group counseling OR patients/families linked with a peer support network and/or a formal buddy system (2 points); and printed information on how to access emotional support services was readily available (1 point). If hospitals indicated the same mechanisms were in place for families, they received the following points: professionals trained in emotional support counseling provided one-to-one counseling (1 point); professionals trained in emotional support counseling provided group counseling OR patients/families linked with a peer support network and/or a formal buddy system (1 point); and printed information on how to access emotional support services

was readily available (0.5 points). The maximum point allocation for this question was 13.5 points. This question was weighted 20.0% of the total indicator score.

Question 32 (V1), Question 9 (C)

Hospitals were asked which of a list of emotional support mechanisms for staff existed in their organization between April 1, 2001 and March 31, 2002. The emotional support mechanisms included: printed information on how to access emotional support services available to staff; staff linked with peer support network and/or formal buddy system; trained professionals provided group counseling at the hospital; trained professionals provided one-to-one counseling at the hospital; and Employee Assistance Program (EAP) is available to staff. Hospitals received one point for each emotional support mechanism they indicated up to a maximum of three points. This question was weighted 10.0% of the total indicator score. Table 4 summarizes the possible points and weighting for the Evidence of Client-centred Care indicator.

Table 4. Evidence of Client-centred Care Indicator Summary

Question	Possible Points	Weighting
Question 15 (V1), 8 (V2)	10	5.0%
Question 16 (V1), 9 (V2)	8	15.0%
Question 17 (V1), 10 (V2)	4	10.0%
Question 18 (V1), 11 (V2)	9	10.0%
Question 19 (V1), 12 (V2)	18	30.0%
Question 20 (V1), 13 (V2)	13.5	20.0%
Question 32 (V1), 9 (C)	3	10.0%
		Total 100.0%

Indicator 11: Evidence of Organizational Client-centredness

The Evidence of Organizational Client-centredness indicator was developed to reflect the extent to which hospitals implement a client-centred approach to service delivery at the system level. This indicator is comprised of four questions, in which all questions were given various weights for a final indicator score.

Question 27 (V1), Question 20 (V2)

Hospitals were asked which mechanisms were in place between April 1, 2001 and March 31, 2002 to elicit patient/family feedback about rehabilitation by rehabilitation program/patient type. Two points were awarded to hospitals for indicating that either patient/family satisfaction surveys OR focus groups with patients/families were in place in at least one program in rehabilitation. Hospitals received three points for indicating that patient/family councils OR patient/family involvement in services planning existed in at least one program in rehabilitation. The program with the highest score was used as the final score for this question. A maximum of five points was allocated for this question. This question was weighted 50.0% of the total indicator score.

Question 28 (V1), Question 21 (V2)

Hospitals were asked to indicate which strategies were used within rehabilitation between April 1, 2001 and March 31, 2002 to disseminate patient/family feedback results to stakeholders. Responses included: written reports were circulated but not presented to this group (0.5 points); results were presented and discussed with this group (and written reports made available) (1 point); and specific and relevant results were reviewed beyond the initial presentation (1 point). However, hospitals were not expected to use all strategies for each staff group. The maximum number of points per staff group was 1.5 points. Groups included: the board; senior management team; physicians with hospital privileges; managers at the patient care/unit level; nurses (RNs, RPNs) at the program/department/patient care unit level; other patient care staff at the program/department/patient care unit level; staff/committee/task force focused on quality; other hospital staff; community at large; and current or former patients and their families. The total point allocation for the question was 16.5 points. This question was weighted 20.0% of the final indicator score.

Question 29 (V1), Question 22 (V2)

Hospitals were asked to indicate which additional strategies were used to disseminate patient/family feedback results within rehabilitation between April 1, 2001 and March 31, 2002. The point allocation for this question was a maximum of one point for a positive response in at least one of the following strategies: results posted on hospital website; results posted on bulletin board in hospital; or results posted in newsletter/electronic mail. The maximum point allocation was one point. This question was weighted 10.0% of the total indicator score.

Question 33 (V1), Question 4 (C)

Hospitals were asked to indicate if the following staff roles existed between April 1, 2001 and March 31, 2002 or the roles were introduced after March 31, 2002: designated staff who addresses equity issues (eg. gender, religion, language) relevant to patients and families; designated contact person assigned to each patient and family; and patient advocate/ombudsperson. Hospitals were awarded one point for indicating the staff roles were introduced after March 31, 2002 and two points for indicating the staff roles existed between April 1, 2001 and March 31, 2002. Hospitals received points for their responses for each of the three staff roles up to a maximum point allocation of four points. This question was weighted 20.0% of the final indicator score.

Table 5. Evidence of Organizational Client-centredness Indicator

Question	Possible Points	Weighting
Question 27 (V1), 20 (V2)	5	50.0%
Question 28 (V1), 21 (V2)	16.5	20.0%
Question 29 (V1), 22 (V2)	1	10.0%
Question 33 (V1), 4 (C)	4	20.0%
		Total 100.0%

System-Level Findings

This section provides findings for the five indicators of System Integration and Change that received an index or score-type measure. Data are presented provincially and for specialty and general hospitals. The following statistics will be presented for each indicator: the valid N (the number of hospitals that received a score for this indicator), mean, standard deviation, minimum score, 25th percentile, median, 75th percentile and the maximum score. The 25th percentile is the value that is greater than or equal to 25.0% of the hospital scores and less than or equal to the other 75.0%. The median is the value that is greater than or equal to 50.0% of the scores and less than or equal to the other half. The 75th percentile is the value that is greater than or equal to 75.0% of the of the hospital scores.

Peer Groups

In *Hospital Report 2003: Rehabilitation*, results are presented for specialty and general hospitals. It should be noted that only two of the five indicators, which received index measures, demonstrated statistically significant differences between these peer groups. These two indicators are Availability of Information across the Continuum of Care and Evidence of Client-centred Care. In this section of the technical summary, detailed information on the results for each peer group are presented in Tables 6 to 10. These data are presented to allow hospitals to situate themselves among other hospitals and to assist hospitals to support quality improvement initiatives.

Table 6. Indicator: Organizational Commitment to Staff Development

	All Hospitals	General Hospitals	Specialty Hospitals
N	45	33	12
Mean	69.3	71.0	64.7
Std Deviation	15.8	15.8	15.6
Minimum	20.0	20.0	37.7
25 th Percentile	58.5	65.9	53.5
Median	73.9	74.9	65.8
75 th Percentile	80.7	81.0	79.7
Maximum	91.3	91.3	85.8

Table 7. Indicator: Use of Admission and Discharge Criteria

	All Hospitals	General Hospitals	Specialty Hospitals
N	47	35	12
Mean	66.6	63.7	75.2
Std Deviation	22.5	22.4	21.4
Minimum	26.5	26.5	44.1
25 th Percentile	44.1	38.2	55.9
Median	67.6	67.6	77.9
75 th Percentile	88.2	82.3	94.1
Maximum	100	100	100

Table 8. Indicator: Availability of Information Across the Continuum of Care

	All Hospitals	General Hospitals	Specialty Hospitals
N	47	35	12
Mean	83.9	82.2	88.9
Std Deviation	12.5	13.4	8.07
Minimum	48.0	48.0	75.5
25 th Percentile	78.4	74.5	80.9
Median	86.3	83.3	93.1
75 th Percentile	93.1	93.1	95.1
Maximum	100	100	100

Table 9. Indicator: Evidence of Client-centred Care

	All Hospitals	General Hospitals	Specialty Hospitals
N	47	35	12
Mean	73.1	70.5	80.6
Std Deviation	13.0	12.9	10.5
Minimum	47.4	47.3	61.9
25 th Percentile	63.9	62.1	75.4
Median	75.1	71.4	81.7
75 th Percentile	82.9	81.2	89.4
Maximum	99.5	99.5	95.5

Table 10. Indicator: Evidence of Organizational Client-centredness

	All Hospitals	General Hospitals	Specialty Hospitals
N	47	35	12
Mean	54.8	51.6	64.3
Std Deviation	25.5	26.2	21.2
Minimum	0	0	14.2
25 th Percentile	37.3	37.3	57.1
Median	55.2	49.1	68.8
75 th Percentile	78.2	77.3	81.5
Maximum	100	100	83.9

Summary and Next Steps

Hospital Report 2003: Rehabilitation is the second in a series of reports for rehabilitation in the Province in Ontario. The System Integration and Change Quadrant describes processes and innovations used in hospitals to support quality improvement. Future directions for this quadrant will include initiatives to improve the question format and reduce the number of questions in the System Integration and Change Questionnaire. Work to further develop the indicators for the System Integration and Change Quadrant is ongoing. In this iteration of the Report, only five (5) of the 11 indicators received an index or score-type measure. As the next stage of *Hospital Report: Rehabilitation* will report both system-level and hospital-specific data, further development of index measures for the remaining indicators is required.