

Hospital Report



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REHABILITATION

Produced by the Hospital
Report Research Collaborative

A joint initiative of the Ontario Hospital
Association and the Government of Ontario

FOREWORD

Many Ontarians at some time in their lives will require rehabilitation services for themselves or their families. It is important for them to know that when that time comes, quality rehabilitation care and treatment will be available when and where they need it.

We are very pleased to release this Rehabilitation report as part of the *Hospital Report 2005* series. The 2005 series will also include reports on Acute Care, Emergency Department Care, and Complex Continuing Care.

These reports are an important resource for government, health care providers, and the public. They monitor and report on the performance of hospitals in the province and support continuous quality improvement efforts throughout the system.

Rehabilitation 2005 focuses on adult inpatient rehabilitation care provided by hospitals and is the first-ever hospital-specific scorecard on the performance of Ontario hospitals in providing rehabilitation care. The report describes the status of inpatient rehabilitation performance with respect to quality, efficiency, accessibility, and financial performance. And, we are also pleased to note that a women's health perspective has been integrated into the report to provide a better understanding of issues related to equity.

Overall, the news is good. Hospitals have made gains in each of the areas we are measuring. However, there is still room for improvement in the areas of preparing patients and families for discharge from hospital, and helping patients make the transition from hospital to community.

We believe that patients are the core of our health system and that both the Government of Ontario and health care providers need to be even more accountable to the public we serve.

Together, our thanks go to the researchers from the Hospital Report Research Collaborative based at the University of Toronto, for their dedication, professionalism, and scientific rigor in development of the report and to the many other individuals who have contributed to our common goal of improved Rehabilitation care.

Without the commitment and cooperation by hospitals that voluntarily participate in this project, the reports would not have expanded to include additional areas of study. This report and the others in the series are an important tool in building a stronger healthcare system that responds to the needs of Ontarians.

Acknowledgement

The Hospital Report Research Collaborative would like to acknowledge the funding support and leadership of the Ontario Women's Health Council (OWHC) as they continue to promote and sponsor the integration of the women's health perspective into all sectors of the Hospital Report.



George Smitherman
Minister of Health
and Long-Term Care



Hilary Short
President and CEO
Ontario Hospital Association

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SCORECARD OVERVIEW

Hospital Report 2005: Rehabilitation is a hospital-specific report that uses a balanced scorecard approach to report on the performance of Ontario hospitals that provide rehabilitation in designated rehabilitation beds.



WHAT DOES THE SCORECARD ILLUSTRATE?

In Ontario, rehabilitation is provided in a variety of settings spanning a continuum of care from acute care to home care. This report focuses only on publicly-funded designated adult inpatient rehabilitation beds, thereby excluding portions of the continuum such as rehabilitation in acute care, outpatient settings, and home-based settings.

- For the System Integration and Change quadrant, most hospitals are performing well with respect to Organizational Commitment to Staff Development. However, considerable variation exists for indicators of Best Practices, Coordination and Continuity of Care Across the Continuum, Evidence of Organizational Client-Centredness, and Healthy Work Environment (freestanding rehabilitation/complex continuing care hospitals) suggesting potential for improvement for many facilities in these areas.
- With respect to the Clinical Utilization and Outcomes quadrant, overall, hospitals are able to achieve good gains in function among their clients with stroke, hip fracture, and total joint replacement. There is, however, potential for hospitals to make improvements in Active Rehabilitation Length of Stay and Length of Stay Efficiency for clients with these same conditions, while still maintaining optimal change in function.
- Hospitals are performing well on all the Client Perspectives indicators. However, similar to the results of *Hospital Report 2003: Rehabilitation*, transitions from hospital to the community and, the involvement of clients and their families in care, continue to be two key areas where hospitals with designated rehabilitation beds need to consider improvements. Providing clients with the information that they need to manage their conditions in the community is significantly related to clients' perceived quality of care, and is an area that requires improvement in many hospitals. Involving clients and families is also significantly related to clients' perceived quality of care. For clients with stroke, involvement of families in rehabilitation programs is significantly related to greater improvements in functional outcomes.



- With respect to Financial Performance and Condition, for nurses and therapists combined, over 85% of the hours worked were spent engaged in client care activities. Also noteworthy is the fact that actual dollars expended on direct client care has increased by 42% since 1999/2000.
- The sex disaggregated findings in this Report highlight minimal differences in the average number of days that women and men wait for admission to rehabilitation, an important measure of equity in access to care. However, women in inpatient rehabilitation are significantly more likely than men to have shorter lengths of stay, to live alone after their discharge from inpatient rehabilitation, and to have less favourable perceptions of the information provided to them to manage their conditions after discharge.

Next Steps

In future rehabilitation reports, further development is required to broaden the scope to include rehabilitation occurring in other parts of the continuum such as acute care, outpatient ambulatory care settings, and home-based settings. Other work for the Financial Performance and Condition quadrants will include ongoing research regarding NRS data quality, the grouping methodology, and associated weights.

The 2003/04 year was a particularly challenging year for Ontario hospitals that needed to respond to the operational challenges presented by SARS. Nurses who held positions in more than one hospital, or who worked as agency nurses across a number of facilities, were able to work in only one setting and were restricted from working in multiple hospitals during SARS. Furthermore, infection control policies often limited the ability of direct care providers to report for work. It is impossible to determine the exact impact of these factors on performance values across all quadrants for 2003/04. From a financial perspective, it is possible that the increase in nursing benefit hours during 2003/04 was a result of the inability to share nursing resources across hospitals and the implementation of infection control and isolation measures.

One of the advantages of the balanced scorecard is the ability to present indicators that reflect multiple dimensions of an organization's performance and to identify relationships among these dimensions of performance. For example, the findings in this Report highlight the importance of effective multidisciplinary teamwork for optimal functional outcomes in stroke. Interdisciplinary integration of care is also strongly related to best practices and evidence of client-centred care, suggesting the importance of hospitals investing in structures and processes that support these indicators. These inter-quadrant relationships are detailed in a later section of this Report.



HOW CAN HOSPITALS USE THE RESULTS?



The purpose of hospital-specific results is to enable hospitals to compare their performance with that of other hospitals and to evaluate progress in achieving key strategic priorities in health care. The indicator results should be viewed as screening tests, identifying potential opportunities for quality improvement. Hospitals must “drill down” using their own data both to validate the results and to better understand the specific factors underlying the results. Hospital managers can also use these reports to identify other hospitals from which they might seek opportunities to learn.

The balanced scorecard framework can assist hospitals to balance the trade-offs that must often be made between efficiency and quality, within the context of limited resources. Thus, no single indicator or quadrant should be used to judge a hospital with designated inpatient rehabilitation. Each aspect of performance is important, including equity (i.e., sex differences), and looking at just one quadrant such as Client Perspectives is not advisable. Similarly, ranking of hospitals by any one indicator or by adding up and averaging indicator scores will create misleading and incorrect information about relative hospital performance.

There are many factors that can cause indicator values to vary from hospital to hospital. Some of these factors, such as the type of client treated, are beyond a hospital's control. Where possible, commonly accepted statistical techniques were used to help reduce the impact of these factors on comparability of hospitals. We examined results with and without risk-adjustment for age, sex, and Functional Independence Measure (FIM™) admission scores for the Clinical Utilization and Outcomes quadrant. Since we found no differences, results are presented unadjusted. Likewise, for the Client Perspectives quadrant, risk adjustment was undertaken considering age and sex variables. When each of these variables was considered alone or in combination, they had no significant impact on mean scores or on the scores of individuals. As a result, Client Perspectives results are also presented unadjusted. As risk-adjustment did impact comparisons between women and men, results by sex, and differences between these, were adjusted for such factors as age (Client Perspectives, Clinical Utilization and Outcomes), FIM™ admission score (Clinical Utilization and Outcomes), and length of stay (Client Perspectives).

Risk-adjustment techniques are not perfect and do not entirely eliminate the impact of other factors. For this reason, comparisons of indicator scores, and sex differences, among hospitals must be made with caution. Hospitals that appear to have different scores could actually be quite similar in terms of relative performance. It is also important to exercise caution when examining year-by-year changes in indicator values for a specific hospital. This is because the methodology used to calculate indicators is reviewed annually by expert panels, and in some cases, changes are made to improve the methodology over time.

DO THE SCORECARD RESULTS RELATE TO KEY STRATEGIC PRIORITIES?

A survey on hospitals' key strategic priorities, completed by hospital CEOs in the winter of 2004 and validated in the fall of 2004, highlights the following important strategic priorities:

- Optimizing staff recruitment and retention
- Enhancing client safety
- Implementing decision support systems
- Improving vertical integration.

The scorecard results demonstrate that most hospitals are performing well with respect to investments and commitments to staff development, factors important to staff retention. Another strategy relevant to the goal of optimal staff recruitment and retention is creating a healthy workplace. Adopting strategies to support a healthy workplace was identified in our strategic priorities survey as an ongoing challenge for hospitals. The scorecard results for the Healthy Work Environment indicator for Rehabilitation/Complex Continuing Care facilities reflects considerable variation across facilities, reinforcing the need for improvements in this area.

Integrating evidence-based decision-making into an organization's culture is an important component of a decision support system. The strategic priorities survey demonstrated that hospitals continue to face challenges in terms of implementing desired practices in this area. This challenge is reinforced by the results in this Report which reflect considerable variation across hospitals in implementing the best available evidence to make decisions about the care of individual clients.

Successful reintegration of clients into the community following discharge from hospital is one of the key goals of the rehabilitation process, reinforcing the importance of vertical integration for this sector. The implementation of strategies to enhance the coordination and continuity of care across the continuum remains a challenge for a number of hospitals that provide inpatient rehabilitation, with the transition from hospital to the community being identified as a particularly challenging area. In addition, the sex disaggregated results that found more women than men living alone post-discharge, and more women than men reporting unfavourable perceptions of the continuity of their care, reinforce the need to pay close attention to sex differences in planning targeted and effective strategies for reintegration of clients into the community. The need for hospitals to focus improvement efforts in this area is emphasized by hospital managers and clients, through the results of the system integration and change survey and surveys on client perspectives of care.

To ensure optimal use of the scorecard results, including results by sex, Board members should identify indicators for which their hospital's performance is below average and for which sex differences are significantly different and ensure that sufficient resources are allocated to facilitate quality improvement in these areas. Within an environment of competing demands, Boards need to ensure that the organization's culture supports an enduring commitment to quality. These strategies will optimize the organization's likelihood of achieving its goals.



ARE THERE BENCHMARK HOSPITALS?

For quality improvement purposes, the Hospital Report series identifies benchmark hospitals. Benchmark hospitals are those identified as high performers in more than one quadrant of the balanced scorecard. For purposes of this Report, the algorithm for high performing hospitals includes those hospitals that performed well in at least two of the following three quadrants of the balanced scorecard: System Integration and Change (SIC), Clinical Utilization and Outcomes (CUO), and Client Perspectives (CP).^{*} Five hospitals performed notably well in at least two of either SIC, CUO, or CP quadrants. These hospitals, which represent a range of locations and size of programs, may be able to provide useful ideas and practices to other similar rehabilitation facilities. Of the five high performing hospitals, two did not have any statistically significant sex differences on any indicators in the CP or CUO quadrants. This finding reinforces the notion that in many cases, hospitals with good performance across multiple quadrants generally also have sex/gender equitable performance, reflecting good performance in women's health.

- *Penetanguishene General Hospital Incorporated – North Simcoe Hospital Alliance* performed above average on five SIC indicators and met the criteria for a high performing hospital for one RCG category (Total Stroke) in the CUO quadrant. Located in the south-central region of the province, it has 15 designated rehabilitation beds and no specialized rehabilitation programs.
- *Providence Continuing Care Centre* performed above average on six SIC indicators and met the criteria for a high performing hospital for one RCG category (Post Hip Fracture) in the CUO quadrant. As well, Providence Continuing Care Centre did not have any statistically significant differences between women and men on any indicators in the CP and CUO quadrants across key RCG groups. Located in the east of the province, it has 51 designated rehabilitation beds. Forty-six beds are located at the St. Mary's of the Lake site in Kingston, and include specialized programs for stroke, musculoskeletal, spinal cord injury, amputee, and acquired brain injury. The remaining five beds are located at the St. Vincent de Paul site in Brockville.
- *St. John's Rehabilitation Hospital* performed above average on five SIC indicators and met the criteria for a high performing hospital for one RCG category (All RCGs) in the CUO quadrant. Located in the Greater-Toronto area (GTA), it has 160 designated rehabilitation beds with programs for amputees, transplants, neurological conditions, cardiac conditions, medically complex, major multiple trauma, burns, and orthopaedic conditions.
- *Trillium Health Centre* performed above average on seven SIC indicators and met the criteria for a high performing hospital for three RCG categories (All RCGs, Total Stroke, Post Hip and Knee Replacement) in the CUO quadrant. Trillium Health Centre operates 74 inpatient rehabilitation beds that provide care for short, medium, and long-term rehabilitation clients. Sixty general rehabilitation beds are located at the Mississauga site with the remaining 14 beds located at the Queensway site. The rehabilitation beds are used to care for many different populations including orthopaedics, stroke, medicine, neurology, cardiac, and surgery.
- *West Park Healthcare Centre* performed above average on six SIC and six CP indicators. As well, West Park Healthcare Centre did not have any statistically significant differences between women and men on any indicators in the CP or CUO quadrants, across key RCG groups. Located in the GTA, it has 133 designated rehabilitation beds with specialized rehabilitation programs for neurorehabilitation, amputees, musculoskeletal, respiratory conditions, and transition to independent living, plus a tuberculosis and an acquired brain injury behaviour unit.

^{*} High performing hospitals are defined as above average on at least 5 of 7 SIC indicators, excluding the Healthy Work Environment indicator; for the Coordination and Continuity of Care Across the Continuum and Use of Admission and Discharge Criteria indicators, the best score was considered among all the following Rehabilitation Client Groups (RCGs): All RCGs, Total Stroke, and Total Orthopaedic Conditions; above average on at least 5 of 8 Client Perspectives indicators; and for CUO, a combination of above average on Total Function Change, average or above average on Average Active Rehabilitation Length of Stay and average or above average on Length of Stay Efficiency for at least one of the following RCGs (All RCGs, Total Stroke, Total Orthopaedic Conditions, Post Hip Fracture, Post Hip and Knee Replacement). When hospitals had above average Total Function Change, we considered it acceptable for Active Rehabilitation Length of Stay and Length of Stay Efficiency to be average. These criteria take into account the complexity of some of the RCG groups, as well as the importance placed on achieving optimal total function change. When considering function change and LOS combined, a higher priority was placed on achieving gains in total function. For some of the more complex RCG categories, it may be necessary to accept a longer length of stay to achieve optimal change in function.

BACKGROUND

Hospital Report 2005: Rehabilitation is a hospital-specific report that uses a balanced scorecard to report on the performance of Ontario hospitals that provide rehabilitation in designated rehabilitation beds. These hospitals vary by size, type of condition seen, and the degree to which their programs are specialized. Given this variability in characteristics across hospitals, it is very difficult statistically to group hospitals into meaningful subgroups or peer groups for comparisons. Indicators are therefore compared across all hospitals with designated rehabilitation beds and are presented at provincial, regional, and hospital-specific levels.

The wide variety of conditions seen in these designated beds include total brain dysfunction, arthritis, pain syndromes, neurological conditions, amputations, burns, pulmonary conditions, congenital deformities, other disabling impairments, major multiple trauma, developmental disabilities, medically complex, stroke, cardiac conditions, spinal cord injury, and orthopaedic conditions. It is beyond the scope of this Report to provide information for all of these clinical conditions. Instead, the Report focuses on the most commonly seen conditions which include stroke and orthopaedic conditions, particularly total joint replacement and hip fractures.

This Report includes results for 45 of 54 hospital corporations with designated rehabilitation beds that voluntarily participated in this Report. Health care providers, managers, and researchers chose 22 different indicators to assess performance. These indicators examine four important areas of rehabilitation care that form a balanced scorecard. The four areas include: System Integration and Change (8 indicators),** Clinical Utilization and Outcomes (3 indicators),*** Client Perspectives (8 indicators), and Financial Performance and Condition (3 indicators). In addition to these four quadrants, a women's health perspective is integrated into this Report to provide a better understanding of issues related to equity.

** The Coordination and Continuity of Care Across the Continuum and Use of Admission and Discharge Criteria indicators are reported for the following RCGs: All RCGs, Total Stroke, and Total Orthopaedic Conditions.

*** Indicators are reported for the following RCGs: All RCGs, Total Stroke, and Total Orthopaedic Conditions.

With whom should the results be shared?

The objectives of this Report are to facilitate local quality improvement programs and to support hospitals' accountability to the communities they serve. The primary audiences for this Report are Boards of Directors and senior managers. To achieve the objectives of the Report, these individuals should identify meaningful ways to share the results with middle management, decision support and quality improvement staff, front line staff, clients, families, and communities served.

Where can you find further information?

Further information is available in the E-scorecard and technical summaries. The E-scorecard is a web-based, password-protected electronic application incorporating annual Hospital Report indicators and underlying components. The prime objective of the E-scorecard is to allow interactive comparative analyses by providing predefined and customized reports and graphs.

The E-scorecard and technical summaries can be accessed through the Hospital Report Research Collaborative website: www.hospitalreport.ca



A BALANCED SCORECARD

FOR ONTARIO'S HOSPITALS WITH DESIGNATED REHABILITATION BEDS

System Integration & Change

This quadrant describes the ability of hospitals with designated rehabilitation beds to adapt to a dynamic health care environment. It describes the structures, processes, and innovations used by hospitals to support quality improvement and their efforts to integrate systems and processes within rehabilitation with care provided elsewhere in the hospital and the community. These indicators include data on: how information is used and shared; how services are coordinated within and outside the organization; how clients' perspectives are incorporated into the rehabilitation program; and how staff development occurs.

Client Perspectives

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

Clinical Utilization & Outcomes

This quadrant presents indicators that evaluate hospitals' clinical performance for clients that are cared for in designated rehabilitation beds. The indicators describe changes in function, length of stay, and length of stay efficiency, as measured by the Functional Independence Measure (FIM™) of the National Rehabilitation Reporting System dataset.

Financial Performance & Condition

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

Women's Health Perspective

The women's health perspective reports differences for women and men on indicators of Clinical Utilization and Outcomes and Client Perspectives. This perspective describes the magnitude and significance of these differences, and explores relationships among these differences, as well as in relation to performance on other rehabilitation indicators (e.g., System Integration and Change).



INTERPRETING SCORES

FOR ONTARIO'S HOSPITALS WITH DESIGNATED REHABILITATION BEDS

The tables in this Report show the numeric scores for indicator values on a hospital-by-hospital basis. Also included is a shaded background that indicates whether the hospital's score on that indicator reflected above average performance, average performance, or below average performance. A score of above average performance or below average performance means that the hospital's score was statistically different than the average score for all participating hospitals. There is no coloured shading for the Financial Performance and Condition quadrant because, for financial indicators, a value above the provincial average may not mean better performance.

Coloured shading for performance is assigned as follows:

- the hospital's score reflected *above average* performance
- the hospital's score reflected *average* performance
- the hospital's score reflected *below average* performance

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

NR means non-reportable – some results are not shown because hospitals chose not to report by certain RCGs or because the number of surveys or domains of surveys was too low to obtain a reliable estimate (<30).

RE means reported elsewhere – the Healthy Work Environment indicator is a corporate-level indicator. Only freestanding rehabilitation hospitals' results are presented in this Report. Healthy Work Environment indicator results for hospitals that have designated rehabilitation beds within an acute care hospital are reported in *Hospital Report 2005: Acute Care*.

THE ONTARIO HOSPITAL ASSOCIATION (OHA) REGIONS

Some hospitals have more than one site or serve many communities. In the tables that follow, hospital sites are not listed and only one community is shown. A complete list can be found in a supplementary document for *Hospital Report 2005: Rehabilitation* located on the website (www.hospitalreport.ca). The regional boundaries are based on OHA Regions. Local Health Integration Networks (LHINs) were still being refined during the development of this Report. In future reports, regional results will be based on Ontario's LHINs boundaries.

Region 1 (North) Includes Sudbury, Thunder Bay, and communities from Kenora through to Parry Sound

Region 2 (East) Includes Ottawa, Carleton, Peterborough, and communities from Haliburton through to Stormont

Region 3 (Greater-Toronto Area) Includes Metro Toronto, and communities in Durham, Peel, and York

Region 4 (South-Central) Includes Hamilton-Wentworth, Waterloo, and communities from Simcoe through to Niagara

Region 5 (South-Western) Includes Essex, Oxford, and Grey through to Kent

This quadrant focuses on the changes and investments that hospitals need to make in order to continually improve delivery of adult inpatient rehabilitation. Data presented for this quadrant are from the System Integration and Change Survey, completed by hospital managers. Forty-five (45) of 54 hospital corporations completed the survey.

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

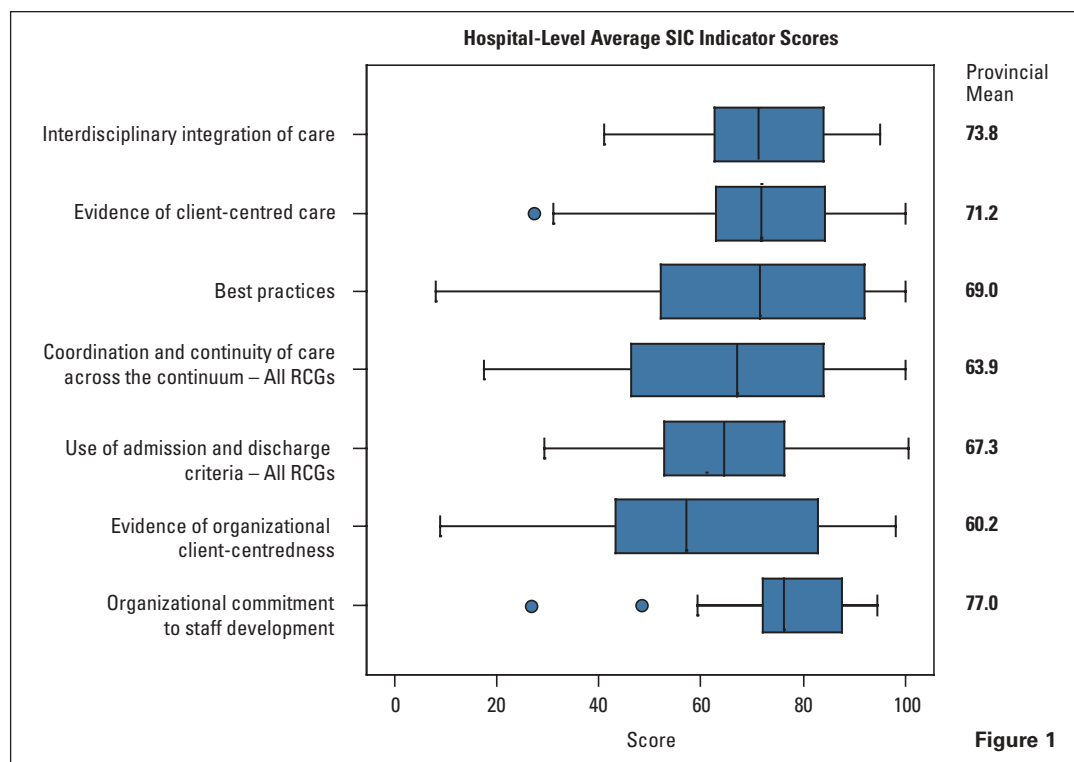
Indicator Definitions

- *Healthy Work Environment**
The extent to which hospitals have mechanisms in place to support and promote a healthy work environment and thereby contribute to employees' physical, social, mental, and emotional well-being.
- *Interdisciplinary Integration of Care*
The amount of interdisciplinary integration that is occurring in designated rehabilitation beds in Ontario hospitals.
- *Evidence of Client-Centred Care*
The extent to which care, at the level of the individual client, is being provided in a client-centred manner.
- *Best Practices*
The extent to which a best practice approach is utilized, involving integrating information from clients and/or family members and individual clinical experience/expertise with the best available evidence in making decisions about the care of individual clients.
- *Coordination and Continuity of Care Across the Continuum***
The degree of coordination and continuity evident for clients who are discharged from inpatient rehabilitation settings.
- *Use of Admission and Discharge Criteria***
Evaluates the development and utilization of admission and discharge criteria for admission to, and discharge from, designated rehabilitation beds in Ontario.
- *Evidence of Organizational Client-Centredness*
The extent to which hospitals implement a client-centred approach to service delivery at the system level.
- *Organizational Commitment to Staff Development*
The extent to which there is organizational support for professional development, continuing education activities, and performance evaluations for staff allocated to designated rehabilitation beds.

* The Healthy Work Environment indicator is a corporate-level indicator. Only freestanding rehabilitation hospitals' results are presented in this Report. Healthy Work Environment indicator results for hospitals that have designated rehabilitation beds within an acute care hospital are reported in *Hospital Report 2005: Acute Care*.

** The Coordination and Continuity of Care Across the Continuum and Use of Admission and Discharge Criteria indicators are reported for the following RCGs: All RCGs, Total Stroke, and Total Orthopaedic Conditions.

PROVINCIAL INDICATOR RESULTS (SIC)



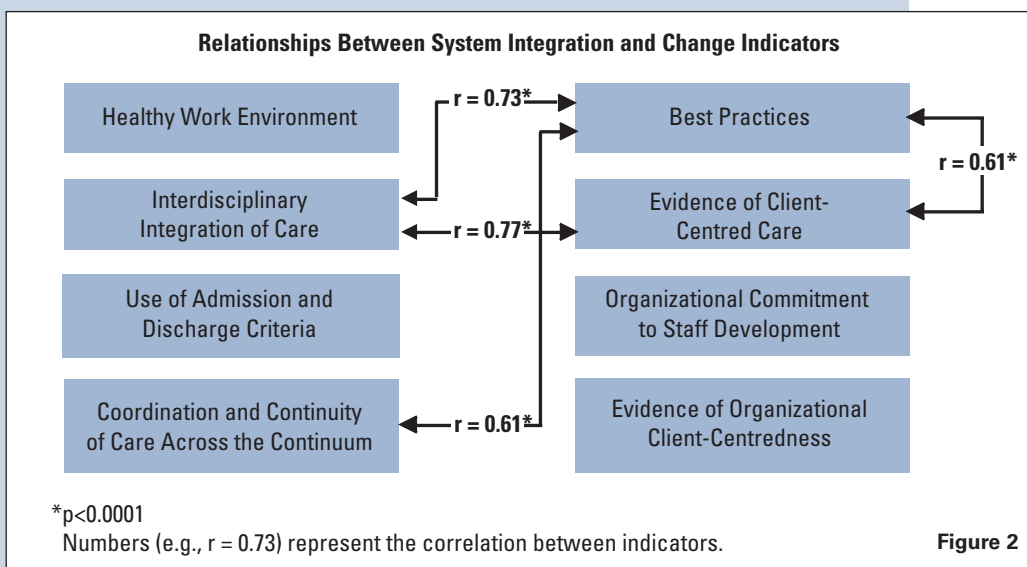
This box and whisker plot displays the distribution of scores for hospitals in Ontario for all indicators in the System Integration and Change quadrant. The black line inside the box reflects the median score, indicating that 50% of hospitals scored higher and 50% of hospitals scored lower. Similarly, the left and right outlines of the box represent the 25th and 75th percentile scores, respectively. Excluding the outliers, the whiskers extending from both ends of the box display the minimum and maximum hospital scores for the indicators. Circles represent the outliers with scores greater than one and one-half box lengths from the edges of the box. To the right of the box plot, the mean score for each indicator is displayed.

Means and medians are two measures of central tendency. Medians, which are the black lines in the centre of the boxplots, are the central values. Means which are used in this Report to evaluate and compare hospital performance, are the arithmetic average of the hospital values. Unlike medians, means are influenced by extreme values. Mean values that are substantially higher or lower than median values for the same indicator, reflect data with a distribution that is highly skewed.

SUMMARY OF RESULTS

- Most hospitals are performing well with respect to the Organizational Commitment to Staff Development indicator. This demonstrates an improvement from *Hospital Report 2003: Rehabilitation*.
- There is considerable variation in performance for indicators of Best Practices, Coordination and Continuity of Care Across the Continuum, and Evidence of Organizational Client-Centredness suggesting that there is potential for improvement for many facilities.
- *Hospital Report 2003: Rehabilitation* identified that the Evidence of Organizational Client-Centredness indicator score (54.8) was low relative to other indicator scores. Although the average indicator score for the Evidence of Organizational Client-Centredness has modestly improved this year (60.2), the increase is not statistically significant. This indicates that there continue to be opportunities for hospitals to focus attention on organizational client-centredness.
- Among the freestanding rehabilitation/complex continuing care hospitals there is considerable variation in performance for the Healthy Work Environment indicator, illustrating that adopting strategies to support a healthy workplace may continue to be a strategic priority for some hospitals.

- As depicted below, hospitals that perform well on the Best Practices indicator are significantly more likely to also perform well on the Interdisciplinary Integration of Care, Evidence of Client-Centred Care, and Coordination and Continuity of Care Across the Continuum indicators. In other words, hospitals that are providing the infrastructure and support to promote the use of research evidence into practice are also more likely to have better supports for effective multidisciplinary team-work; more involvement of families and more education and emotional support for clients and families throughout their inpatient stay; and more follow-up with clients after discharge. Further, hospitals that focus their efforts on improving Best Practices may also see improvement in these other indicators.



Hospital Corporation	Community Served	OHA Region	Healthy Work Environment	Inter-disciplinary Integration of Care	Evidence of Client-Centred Care	Best Practices	All RCGs		Total Stroke		Total Orthopaedic		Evidence of Organizational Client-Centredness	Organizational Commitment to Staff Development
							Coordination & Continuity Across the Continuum	Use of Admission & Discharge Criteria	Coordination & Continuity Across the Continuum	Use of Admission & Discharge Criteria	Coordination & Continuity Across the Continuum	Use of Admission & Discharge Criteria		
Provincial Average			62.9	73.8	71.2	69.0	63.9	67.3	61.9	66.9	60.6	65.8	60.2	77.0
Baycrest Centre for Geriatric Care	Toronto	3	100.0	70.3	72.3	96.0	75.0	39.7	75.0	39.7	75.0	39.7	92.0	91.4
Bluewater Health	Sarnia	5	RE	65.8	62.9	53.3	65.0	76.5	65.0	76.5	65.0	76.5	71.9	76.6
The Brantford General Hospital	Brantford	4	RE	74.8	79.1	81.3	55.0	64.7	55.0	64.7	55.0	64.7	34.8	75.5
Bridgepoint Health	Toronto	3	88.3	93.2	83.0	96.0	78.8	100.0	78.8	100.0	78.8	100.0	97.9	74.3
Chatham-Kent Health Alliance	Chatham	5	RE	71.6	77.1	68.0	73.8	76.5	NR	NR	NR	NR	74.4	77.3
Cornwall Community Hospital	Cornwall	2	RE	41.3	27.3	36.0	51.3	58.8	51.3	58.8	51.3	58.8	57.3	60.7
Grand River Hospital	Kitchener	4	RE	61.8	70.8	55.8	46.4	72.8	46.4	72.8	46.4	72.8	27.7	82.9
Grey Bruce Health Services	Owen Sound	5	RE	63.1	62.9	60.0	95.0	39.7	95.0	39.7	85.0	39.7	45.0	68.3
Halton Healthcare	Oakville	4	RE	60.8	36.1	64.0	32.5	64.7	32.5	64.7	32.5	64.7	41.1	68.3
Hamilton Health Sciences	Hamilton	4	RE	85.3	84.2	96.0	85.0	76.9	75.0	54.4	63.8	53.0	84.7	90.7
Hôpital régional de Sudbury Regional Hospital	Sudbury	1	RE	61.8	51.2	40.0	63.8	29.4	63.8	29.4	63.8	29.4	37.3	60.2
Hotel-Dieu Grace Hospital	Windsor	5	RE	41.2	62.8	32.0	17.5	35.3	13.8	35.3	17.5	35.3	33.6	69.5
Huron Perth Healthcare Alliance	Stratford	5	RE	69.0	59.0	64.0	87.5	64.7	87.5	64.7	87.5	64.7	84.9	73.6
Joseph Brant Memorial Hospital	Burlington	4	RE	71.7	68.0	48.0	25.0	70.6	25.0	70.6	25.0	70.6	8.8	76.2
Lakeridge Health	Oshawa	3	RE	80.3	88.3	92.0	96.3	88.2	86.3	88.2	86.3	88.2	57.7	94.4
Leamington District Memorial Hospital	Leamington	5	RE	60.0	64.1	8.0	32.5	64.7	32.5	64.7	32.5	64.7	40.4	79.2
Niagara Health System	Niagara Falls	4	RE	72.0	66.1	76.0	68.8	32.3	68.8	32.3	68.8	32.3	46.2	59.3
North York General Hospital	Toronto	3	RE	62.7	42.4	72.0	42.5	76.5	42.5	76.5	42.5	76.5	11.4	68.3
Pembroke Regional Hospital	Pembroke	2	RE	74.2	72.2	48.0	46.3	100.0	46.3	100.0	46.3	100.0	76.6	94.0
Penetanguishene General Hospital Inc. (The) – North Simcoe Hospital Alliance	Penetanguishene	4	59.3	92.7	100.0	74.7	67.5	76.5	67.5	76.5	67.5	76.5	86.5	88.4
Peterborough Regional Health Centre	Peterborough	2	RE	50.2	31.0	48.0	77.5	35.3	77.5	35.3	77.5	35.3	39.7	65.5
Providence Continuing Care Centre	Kingston	2	93.8	87.7	89.4	92.0	61.3	100.0	61.3	100.0	61.3	100.0	95.8	94.2
Providence Healthcare	Toronto	3	34.8	72.1	83.3	52.0	32.5	64.7	32.5	64.7	32.5	64.7	41.9	72.2
Quinte Health Care	Belleville	2	RE	87.4	63.4	64.0	86.3	75.0	86.3	75.0	NR	NR	82.8	73.6
Rouge Valley Health System	Scarborough	3	RE	70.0	59.0	64.0	60.0	29.1	60.0	32.2	60.0	32.2	43.2	87.5

* Non-reportable – Some results are not shown because hospitals chose not to report by certain RCGs.

** Reported elsewhere – The Healthy Work Environment Indicator is a corporate-level indicator. Only freestanding rehabilitation hospitals' results are presented in this Report. Healthy Work Environment indicator results for hospitals that have designated rehabilitation beds within an acute care hospital are reported in *Hospital Report 2005: Acute Care*.

Hospital Corporation	Community Served	OHA Region	Healthy Work Environment	Inter-disciplinary Integration of Care	Evidence of Client-Centred Care	Best Practices	All RCGs		Total Stroke		Total Orthopaedic		Evidence of Organizational Client-Centredness	Organizational Commitment to Staff Development
							Coordination & Continuity Across the Continuum	Use of Admission & Discharge Criteria	Coordination & Continuity Across the Continuum	Use of Admission & Discharge Criteria	Coordination & Continuity Across the Continuum	Use of Admission & Discharge Criteria		

Sault Area Hospital	Sault Ste. Marie	1	RE	66.8	76.7	36.0	47.5	52.9	NR	NR	NR	NR	51.4	26.8
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	2	57.4	87.5	87.4	88.0	55.0	44.1	55.0	44.1	55.0	44.1	48.6	75.9
Southlake Regional Health Centre	Newmarket	3	RE	63.5	42.7	52.0	30.0	61.8	NR	NR	30.0	32.3	52.4	72.0
St. John's Rehabilitation Hospital	Toronto	3	91.8	84.8	81.0	72.0	85.0	94.1	85.0	88.2	75.0	88.2	58.4	94.4
St. Joseph's Care Group	Thunder Bay	1	34.6	70.8	81.6	68.0	83.9	88.2	75.0	73.5	57.5	88.2	75.1	65.3
St. Joseph's Health Care London	London	5	RE	91.0	84.3	72.0	68.5	100.0	63.8	100.0	53.8	100.0	58.0	92.6
St. Joseph's Health Centre	Toronto	3	RE	69.8	87.9	96.0	76.3	76.5	NR	NR	76.3	76.5	47.6	88.9
St. Joseph's Healthcare Hamilton	Hamilton	4	RE	84.8	96.4	96.0	96.3	51.5	NR	NR	NR	NR	38.8	73.6
St. Mary's General Hospital	Kitchener	4	RE	81.5	79.1	92.0	42.5	48.5	NR	NR	NR	NR	48.7	81.5
St. Thomas-Elgin General Hospital	St. Thomas	5	RE	54.6	36.2	28.0	25.0	60.3	25.0	60.3	25.0	60.3	90.5	48.3
Sunnybrook & Women's College Health Sciences Centre	Toronto	3	RE	88.5	86.1	100.0	95.0	64.7	NR	NR	95.0	64.7	88.5	86.6
The Credit Valley Hospital	Mississauga	3	RE	93.5	80.3	80.0	85.0	52.9	85.0	52.9	85.0	52.9	63.4	72.2
The Ottawa Hospital	Ottawa	2	RE	79.3	69.1	72.0	80.8	64.7	67.5	64.7	67.5	50.0	87.2	77.8
Toronto East General Hospital	Toronto	3	RE	63.5	49.9	44.0	48.8	76.5	NR	NR	NR	NR	43.8	88.9
Toronto Rehabilitation Institute	Toronto	3	64.7	96.7	97.6	100.0	79.0	96.3	71.3	94.1	81.3	88.2	79.7	80.3
Trillium Health Centre	Mississauga	3	RE	82.0	90.8	100.0	82.5	64.7	82.5	64.7	82.5	64.7	88.5	85.4
West Park Healthcare Centre	Toronto	3	96.6	84.5	69.4	100.0	100.0	88.2	82.5	88.2	90.0	88.2	98.0	94.4
William Osler Health Centre	Brampton	3	RE	87.2	82.5	72.0	85.0	76.5	85.0	76.5	81.3	76.5	57.6	74.8
Windsor Regional Hospital	Windsor	5	RE	75.0	71.3	92.0	50.0	76.5	50.0	76.5	50.0	76.5	59.3	85.2
York Central Hospital	Richmond Hill	3	RE	76.8	97.3	65.3	38.8	76.5	38.8	76.5	38.8	76.5	60.2	79.2

Mean Hospital Results by OHA Region

Region 1 (North)	54.4	75.6	75.5	69.3	67.5	67.8	65.0	65.1	62.7	64.2	64.7	74.0
Region 2 (East)	59.1	68.1	56.3	56.8	63.3	62.6	63.3	62.6	57.5	59.6	61.0	73.9
Region 3 (Greater-Toronto Area)	72.1	78.2	75.8	79.3	70.1	73.4	70.3	74.2	69.2	70.7	64.0	82.5
Region 4 (South-Central)	71.7	76.9	75.0	76.0	55.4	58.4	49.8	61.7	49.8	61.7	43.5	74.7
Region 5 (South-Western)	57.1	65.7	64.5	53.0	57.2	66.0	54.1	64.7	52.0	64.7	62.0	74.5

* Non-reportable – Some results are not shown because hospitals chose not to report by certain RCGs.

** Reported elsewhere – The Healthy Work Environment Indicator is a corporate-level indicator. Only freestanding rehabilitation hospitals' results are presented in this Report. Healthy Work Environment indicator results for hospitals that have designated rehabilitation beds within an acute care hospital are reported in *Hospital Report 2005: Acute Care*.

This quadrant focuses on measures that provide an understanding of the clinical performance for hospitals with designated rehabilitation beds in Ontario. Data are from the 2003/04 National Rehabilitation Reporting System (NRS). These data were mandated for collection for designated rehabilitation beds in October 2002. Data from all 54 Ontario hospital corporations with designated rehabilitation beds in Ontario that contribute to this data set were used to calculate provincial and regional means; hospital-specific data are shown for 45 of 54 hospital corporations that voluntarily agreed to participate in this Report. The primary outcome measure used in the NRS is the Functional Independence Measure (FIM™).

For all of the indicators, an above average performance classification is desirable. For Average Total Function Change and Length of Stay Efficiency a comparatively higher number is desirable, while for Average Active Rehabilitation Length of Stay a comparatively lower number is desirable. Indicator scores and performance classifications are reported for the following Rehabilitation Client Groups (RCGs): All RCGs, Total Stroke, and Total Orthopaedic Conditions. In the box plots, provincial measures of central tendency are also reported for Post Hip Fracture and Post Hip and Knee Replacement.

Indicator Definitions

The key indicators in this quadrant are Average Total Function Change, Average Active Rehabilitation Length of Stay, and Length of Stay Efficiency. Two additional indicators – Average Days Waiting for Admission to Rehabilitation, and Average Cognitive Function Change – are also reported in the Women's Health Perspective section of this Report.

- *Average Total Function Change*
A measure of how much the client's functional status improved from admission to discharge while in inpatient rehabilitation.
- *Average Active Rehabilitation Length of Stay*
A measure of the number of days the client required an inpatient rehabilitation stay to become ready for discharge.
- *Length of Stay Efficiency*
The average change in total function score per day for clients participating in inpatient rehabilitation occurring in designated rehabilitation beds.
- *Average Days Waiting for Admission to Rehabilitation*
A measure of access to the inpatient rehabilitation system. This indicator can be used as a yardstick for the length of time clients are waiting for an inpatient rehabilitation bed and can identify whether wait time is adversely affecting length of stay in acute care.
- *Average Cognitive Function Change*
A measure of the impact of inpatient rehabilitation on cognitive skills.

PROVINCIAL INDICATOR RESULTS (CUO)

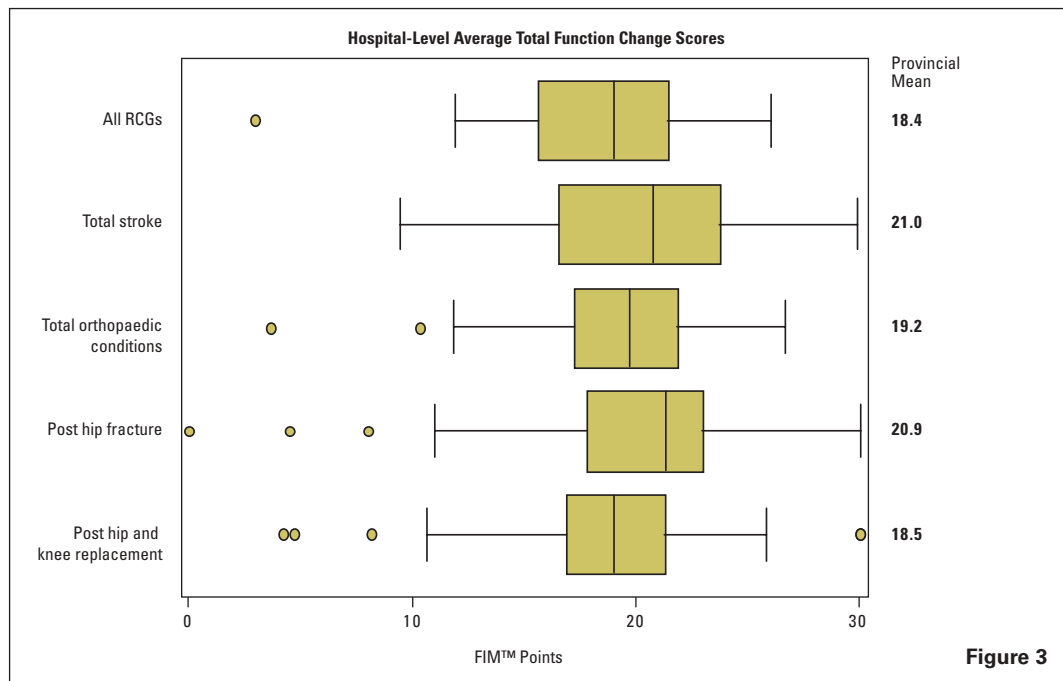


Figure 3

These box and whisker plots display the distribution of hospital scores in Ontario for select indicators in the Clinical Utilization and Outcomes quadrant. The relative contribution of each hospital to the distribution is determined by weighting each hospital by its sample size. The black line inside the box reflects the median hospital score, indicating that 50% of hospitals scored higher and 50% of hospitals scored lower. Similarly, the left and right outlines of the box represent hospitals with 25th and 75th percentile scores, respectively. Excluding the outliers, the whiskers extending from both ends of the box display the minimum and maximum hospital scores for the indicators. Circles represent the outliers with scores greater than one and one-half box lengths from the edges of the box. To the right of the box plot, the mean hospital score for each indicator is displayed.

Means and medians are two measures of central tendency. Medians, which are the black lines in the centre of the boxplots, are the central values. Means, which are also listed to the right of each figure, and are used in this Report to evaluate and compare hospital performance, are the arithmetic average of the hospital values. Unlike medians, means are influenced by extreme values. Mean values that are substantially higher or lower than median values for the same indicator, reflect data with a distribution that is highly skewed.

SUMMARY OF RESULTS

It is important to note that for this quadrant, one outcome measure, the FIM™, is used across a variety of diagnostic groups, rather than using disease-specific measures.

- The improvement in function from admission to discharge is, on average, 20 FIM™ points for clients with stroke or orthopaedic conditions. Overall, hospitals are able to achieve good gains in function among their clients with stroke, hip fracture, and total joint replacement.

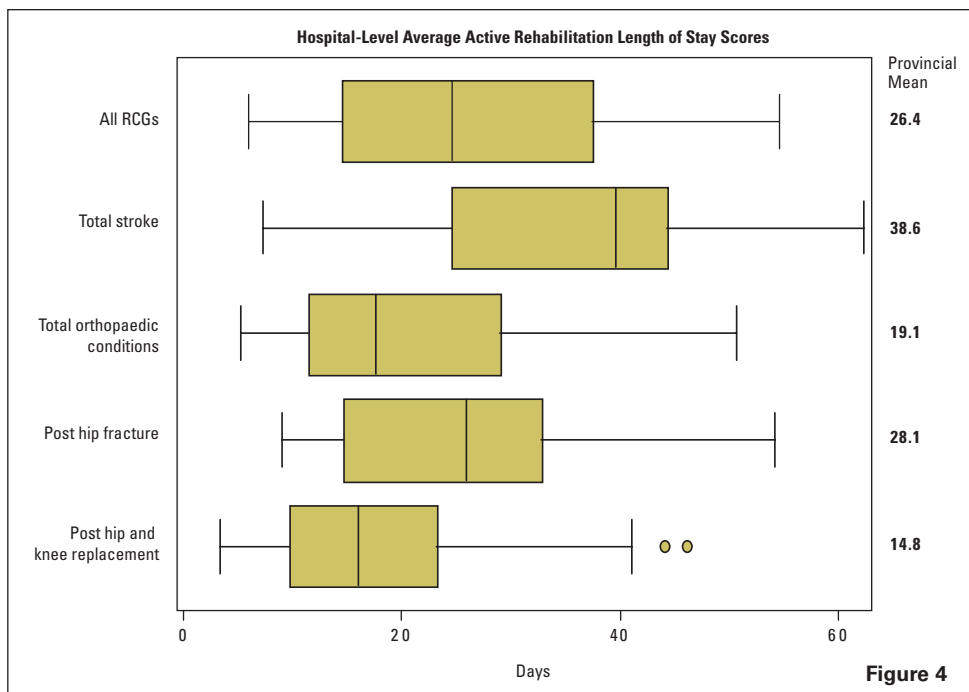


Figure 4

- As expected, the more complex clients – those with stroke or hip fracture – require a longer length of stay to achieve the same gain in function as clients undergoing elective joint replacements. There is, however, potential for hospitals to make improvements in Active Rehabilitation Length of Stay and Length of Stay Efficiency for all of these client groups, while maintaining optimal change in function. This recommendation is based on the variation seen in Active Rehabilitation Length of Stay indicator scores across hospitals. Because Length of Stay Efficiency reflects FIM™ change per day, even small differences in indicator scores reflect substantive variation.

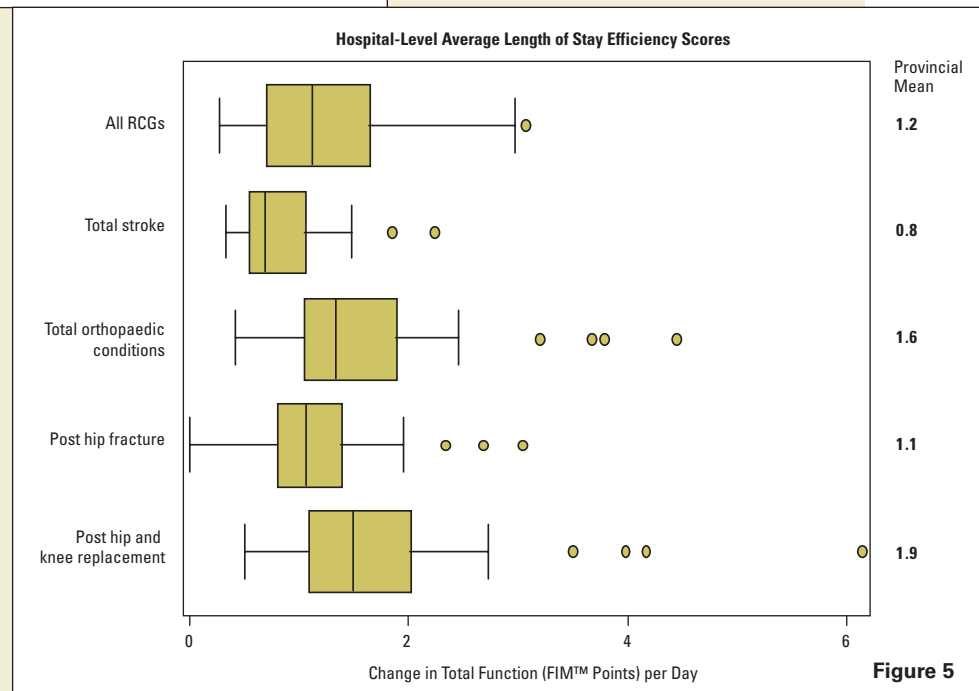


Figure 5

■ Above average performance ■ Average performance ■ Below average performance

Hospital Corporation	Community Served	OHA Region	All RCGs			Total Stroke			Total Orthopaedic Conditions		
			Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency

Provincial Average			18.4	26.4	1.2	21.0	38.6	0.8	19.2	19.1	1.6
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Baycrest Centre for Geriatric Care	Toronto	3	14.7	47.3	0.3	18.6	54.0	0.4	18.3	50.1	0.4
Bluewater Health	Sarnia	5	19.2	24.8	1.4	17.4	42.0	0.5	20.4	15.3	1.9
The Brantford General Hospital	Brantford	4	19.6	21.8	1.1	22.4	29.0	1.0	20.4	17.1	1.4
Bridgepoint Health	Toronto	3	22.8	33.6	1.1	16.6	54.8	0.4	23.9	29.0	1.3
Chatham-Kent Health Alliance	Chatham	5	19.0	28.2	0.9	21.4	42.3	0.7	17.3	20.1	1.1
Cornwall Community Hospital	Cornwall	2	13.6	36.2	0.4	17.9	46.1	0.4	12.9	28.8	0.5
Grand River Hospital	Kitchener	4	15.4	44.3	0.8	19.7	57.4	0.7	11.9	17.0	1.4
Grey Bruce Health Services	Owen Sound	5	12.4	25.1	0.6	10.8	28.2	0.4	15.9	17.1	1.1
Halton Healthcare	Oakville	4	15.7	19.9	1.1	15.7	24.6	0.5	18.0	17.5	1.5
Hamilton Health Sciences	Hamilton	4	18.9	40.5	0.7	19.6	39.7	0.7	20.8	30.8	0.9
Hôpital régional de Sudbury Regional Hospital	Sudbury	1	16.9	39.6	0.3	17.2	38.7	0.4	17.6	32.6	0.5
Hotel-Dieu Grace Hospital	Windsor	5	16.9	8.4	2.7	12.0	10.0	1.5	19.9	6.6	3.7
Huron Perth Healthcare Alliance	Stratford	5	23.1	33.2	1.0	20.9	46.4	0.6	26.7	29.5	1.3
Joseph Brant Memorial Hospital	Burlington	4	22.0	26.9	1.1	24.4	38.7	0.8	23.3	25.6	1.2
Lakeridge Health	Oshawa	3	24.9	37.7	1.2	27.5	54.9	0.7	24.1	25.3	1.7
Leamington District Memorial Hospital	Leamington	5	15.9	10.2	1.6	16.9	10.5	1.8	16.7	11.0	1.5
Niagara Health System	Niagara Falls	4	26.1	33.6	0.9	29.9	33.7	1.0	22.6	26.6	1.0
North York General Hospital	Toronto	3	17.0	16.3	1.3	18.5	21.4	1.0	17.0	15.3	1.5
Pembroke Regional Hospital	Pembroke	2	24.3	33.3	1.1	25.5	41.4	1.0	24.2	28.3	1.3
Penetanguishene General Hospital Inc. (The) – North Simcoe Hospital Alliance	Penetanguishene	4	19.0	22.3	0.9	26.9	33.0	0.8	17.5	18.1	1.1
Peterborough Regional Health Centre	Peterborough	2	21.5	48.3	0.5	24.1	62.2	0.4	22.1	41.7	0.6
Providence Continuing Care Centre	Kingston	2	20.5	38.0	0.8	20.8	47.3	0.5	24.9	27.9	1.2
Providence Healthcare	Toronto	3	22.7	43.8	0.7	27.0	58.8	0.5	22.8	37.6	0.8
Quinte Health Care	Belleville	2	19.3	35.4	0.6	23.9	41.9	0.6	17.8	23.4	0.9
Rouge Valley Health System	Scarborough	3	17.8	14.6	1.7	22.5	31.1	1.0	18.0	11.5	1.9

■ Above average performance ■ Average performance ■ Below average performance

Hospital Corporation	Community Served	OHA Region	All RCGs			Total Stroke			Total Orthopaedic Conditions		
			Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency	Average Total Function Change	Average Active Rehabilitation Length of Stay	Length of Stay Efficiency

Sault Area Hospital	Sault Ste. Marie	1	15.5	25.8	0.9	13.1	32.1	0.6	17.6	27.4	1.1
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	2	22.3	54.5	0.4	23.0	62.3	0.4	23.9	50.6	0.5
Southlake Regional Health Centre	Newmarket	3	15.7	11.0	3.1	22.6	29.7	1.0	16.4	7.2	3.8
St. John's Rehabilitation Hospital	Toronto	3	22.5	24.5	1.2	23.7	44.3	0.6	21.8	19.6	1.3
St. Joseph's Care Group	Thunder Bay	1	12.3	22.9	1.4	16.5	57.5	0.3	15.4	10.7	2.1
St. Joseph's Health Care London	London	5	20.0	40.7	0.6	21.6	45.7	0.5	19.8	32.8	0.7
St. Joseph's Health Centre	Toronto	3	14.6	10.3	1.5	13.1	9.6	1.4	15.3	10.3	1.6
St. Joseph's Healthcare Hamilton	Hamilton	4	18.9	27.7	1.1	19.2	44.5	0.5	20.2	20.5	1.6
St. Mary's General Hospital	Kitchener	4	12.2	10.8	1.4	9.5	9.6	1.0	12.7	10.5	1.6
St. Thomas-Elgin General Hospital	St. Thomas	5	18.9	24.3	1.0	13.6	21.0	0.8	20.1	23.7	1.1
Sunnybrook & Women's College Health Sciences Centre	Toronto	3	11.9	7.1	1.9	10.6	7.3	1.5	12.0	7.1	1.9
The Credit Valley Hospital	Mississauga	3	17.5	32.8	0.7	19.9	39.8	0.7	19.7	30.7	0.9
The Ottawa Hospital	Ottawa	2	15.4	30.9	0.8	18.1	43.6	0.5	18.8	17.5	1.3
Toronto East General Hospital	Toronto	3	14.6	13.2	1.2	9.5	12.5	0.8	14.9	13.3	1.2
Toronto Rehabilitation Institute	Toronto	3	20.5	43.1	0.7	24.5	43.3	0.6	20.1	29.3	0.9
Trillium Health Centre	Mississauga	3	19.9	16.0	2.0	24.9	26.1	1.5	19.7	12.3	2.4
West Park Healthcare Centre	Toronto	3	16.2	38.1	0.6	20.5	39.3	0.5	26.1	28.8	1.0
William Osler Health Centre	Brampton	3	23.9	27.8	1.1	26.4	37.4	0.8	25.0	28.9	1.0
Windsor Regional Hospital	Windsor	5	20.9	37.4	0.6	21.1	39.5	0.6	21.2	33.2	0.7
York Central Hospital	Richmond Hill	3	15.8	16.1	1.1	17.8	23.5	0.8	17.1	15.0	1.2

Mean Hospital Results by OHA Region

Region 1 (North)	14.4	27.4	1.1	18.0	43.2	0.5	15.9	14.8	1.9
Region 2 (East)	16.8	35.2	0.7	21.4	49.6	0.5	20.5	28.8	1.0
Region 3 (Greater-Toronto Area)	18.8	24.0	1.4	22.1	35.7	0.9	19.1	18.0	1.7
Region 4 (South-Central)	18.1	25.3	1.2	21.4	35.8	0.8	18.9	18.4	1.7
Region 5 (South-Western)	18.8	28.2	1.2	18.3	35.2	0.7	19.7	20.5	1.6

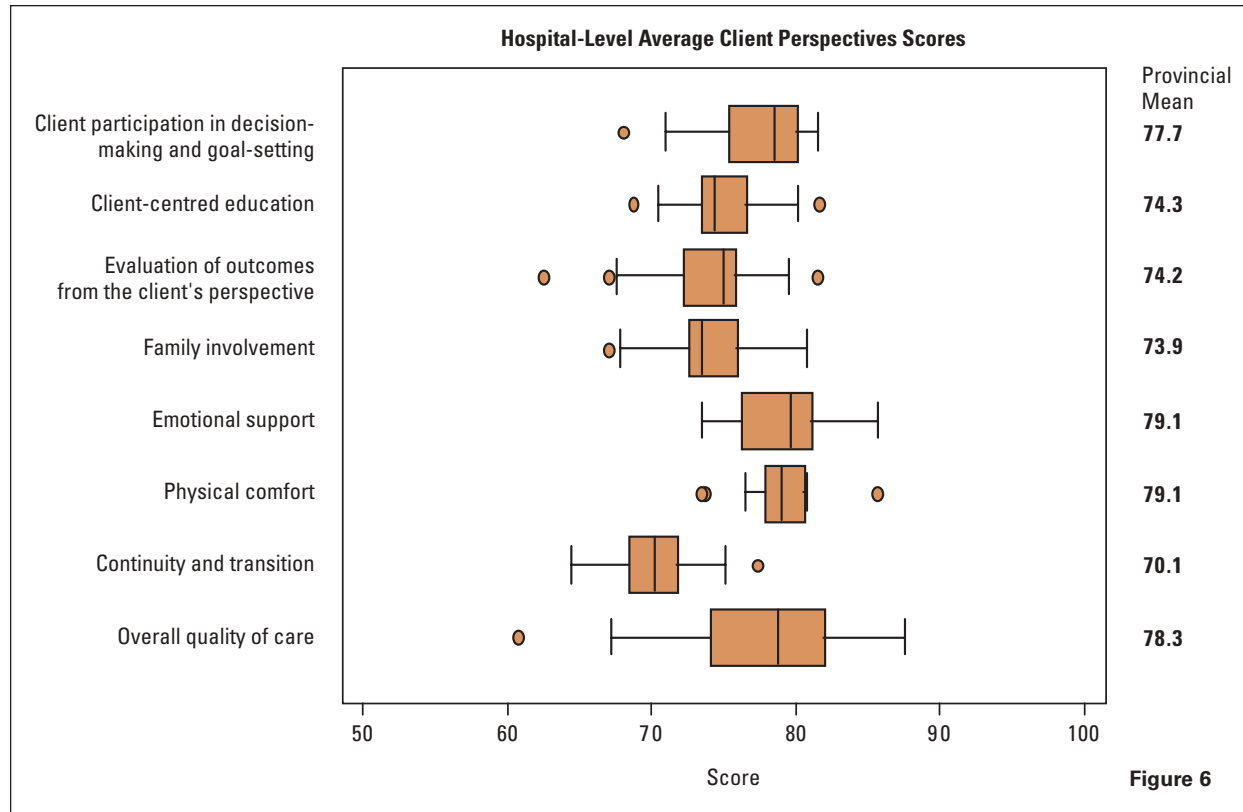
This quadrant describes clients' perceptions of the care they received while in designated rehabilitation beds. The client perspectives survey for rehabilitation, called the Client Perspectives of Rehabilitation Services Questionnaire (CPRSQ), was sent to 11,464 clients from 35 participating hospitals between April 1, 2003 and March 31, 2004. The number of returned, usable questionnaires was 5,272, resulting in an overall response rate of 46%.

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

Indicator Definitions

- *Client Participation in Decision-Making and Goal-Setting*
The extent to which clients are included in decision-making and goal-setting.
- *Client-Centred Education*
The extent to which the education and information that clients receive is client-centred.
- *Evaluation of Outcomes from the Client's Perspective*
The extent to which clients are involved in evaluating the outcomes of treatment.
- *Family Involvement*
The extent to which families are involved in the rehabilitation process.
- *Emotional Support*
The extent to which clients feel they are receiving emotional support from staff.
- *Physical Comfort*
The extent to which clients feel that their physical comfort needs have been addressed.
- *Continuity and Transition*
The extent to which clients feel that there was continuity and transition evident in rehabilitation programs for clients following discharge from inpatient rehabilitation.
- *Overall Quality of Care*
Ascertain client perceptions of the overall quality of rehabilitation care.

PROVINCIAL INDICATOR RESULTS (CP)



This box and whisker plot displays the distribution of hospital scores in Ontario for all indicators in the Client Perspectives quadrant. The relative contribution of each hospital to the distribution is determined by weighting each hospital by its sample size. The black line inside the box reflects the median hospital score, indicating that 50% of hospitals scored higher and 50% of hospitals scored lower. Similarly, the left and right outlines of the box represent hospitals with 25th and 75th percentile scores, respectively. Excluding the outliers, the whiskers extending from both ends of the box display the minimum and maximum hospital scores for the indicators. Circles represent the outliers with scores greater than one and one-half box lengths from the edges of the box. To the right of the box plot, the mean hospital score for each indicator is displayed.

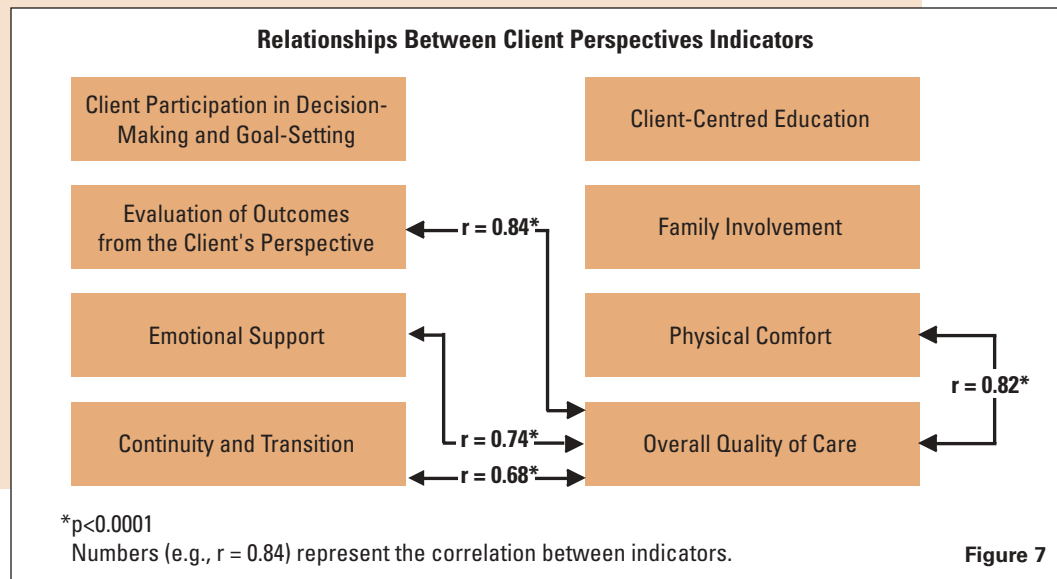
SUMMARY OF RESULTS

- Hospitals are performing well on all of the Client Perspectives indicators. However, the scores on the Continuity and Transition indicator are significantly lower than for the other indicators. Hospitals could be performing better with respect to providing clients with the information that they need to manage their conditions after discharge.

Means and medians are two measures of central tendency. Medians, which are the black lines in the centre of the boxplots, are the central values. Means, which are listed to the right of the figure, and are used in this Report to evaluate and compare hospital performance, are the arithmetic average of the hospital values. Unlike medians, means are influenced by extreme values. Mean values that are substantially higher or lower than median values for the same indicator, reflect data with a distribution that is highly skewed.

- As depicted below, Overall Quality of Care is strongly related to Evaluation of Outcomes from the Client's Perspective, Physical Comfort, Emotional Support, and Continuity and Transition indicators. In other words, Overall Quality of Care for clients is strongly related to:

- 1) the extent to which clients feel they are involved in determining their progress in rehabilitation (Evaluation of Outcomes from the Client's Perspective);
- 2) the degree to which clients feel their physical comfort needs are being recognized and handled by the staff (Physical Comfort);
- 3) the extent to which clients feel they are treated with respect and dignity (Emotional Support); and
- 4) whether clients feel that they have been given the information that they need to manage their conditions in the community (Continuity and Transition).



■ Above average performance ■ Average performance ■ Below average performance NR Non-reportable*

Hospital Corporation	Community Served	OHA Region	Client Participation in Decision-Making & Goal-Setting	Client-Centred Education	Evaluation of Outcomes from the Client's Perspective	Family Involvement	Emotional Support	Physical Comfort	Continuity & Transition	Overall Quality of Care
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Provincial Average			77.7	74.3	74.2	73.9	79.1	79.1	70.1	78.3
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Baycrest Centre for Geriatric Care	Toronto	3	78.8	74.6	74.3	73.6	78.5	78.6	67.7	74.1
Bluewater Health	Sarnia	5	74.5	74.1	71.4	68.8	75.4	77.1	66.2	71.1
The Brantford General Hospital	Brantford	4	NR	NR	NR	NR	NR	NR	NR	NR
Bridgepoint Health	Toronto	3	75.1	68.7	71.7	67.8	76.0	77.9	66.7	74.1
Chatham-Kent Health Alliance	Chatham	5	74.4	73.4	71.4	69.2	75.2	76.6	68.9	74.0
Cornwall Community Hospital	Cornwall	2	77.8	78.0	78.5	76.2	81.1	80.7	70.7	79.0
Grand River Hospital	Kitchener	4	74.6	70.4	67.6	68.3	75.0	76.5	67.0	67.2
Grey Bruce Health Services	Owen Sound	5	78.2	76.7	70.8	75.4	79.9	79.6	NR	78.7
Halton Healthcare	Oakville	4	74.9	75.1	72.8	74.9	77.5	78.0	66.0	73.8
Hamilton Health Sciences	Hamilton	4	77.4	74.5	73.0	74.5	78.1	78.1	69.0	75.9
Hôpital régional de Sudbury Regional Hospital	Sudbury	1	75.6	74.5	71.4	73.5	75.0	77.4	73.6	74.1
North York General Hospital	Toronto	3	NR	NR	NR	NR	NR	NR	NR	NR
Pembroke Regional Hospital	Pembroke	2	NR	NR	NR	NR	NR	NR	NR	NR
Penetanguishene General Hospital Inc. (The) – North Simcoe Hospital Alliance	Penetanguishene	4	NR	NR	NR	NR	NR	NR	NR	NR
Peterborough Regional Health Centre	Peterborough	2	NR	NR	NR	NR	NR	NR	NR	75.8
Providence Continuing Care Centre	Kingston	2	80.1	75.8	75.4	74.7	82.1	80.0	72.3	81.7
Providence Healthcare	Toronto	3	75.4	72.9	73.3	72.1	75.8	77.4	68.5	75.5
Quinte Health Care	Belleville	2	75.0	71.9	71.1	74.5	77.7	73.7	NR	75.6

* Non-reportable – Some results are not shown because the number of surveys or domains of surveys was too low to obtain a reliable estimate (<30).

■ Above average performance ■ Average performance ■ Below average performance NR Non-reportable*

Hospital Corporation	Community Served	OHA Region	Client Participation in Decision-Making & Goal-Setting	Client-Centred Education	Evaluation of Outcomes from the Client's Perspective	Family Involvement	Emotional Support	Physical Comfort	Continuity & Transition	Overall Quality of Care
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Sault Area Hospital	Sault Ste. Marie	1	73.4	71.1	70.6	67.1	73.5	77.2	69.5	69.1
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	2	80.7	77.3	76.0	80.1	81.0	80.3	73.6	82.5
Southlake Regional Health Centre	Newmarket	3	76.5	73.6	72.3	72.2	75.7	79.0	69.5	81.8
St. John's Rehabilitation Hospital	Toronto	3	78.5	73.4	75.8	73.4	80.4	80.8	69.6	81.0
St. Joseph's Care Group	Thunder Bay	1	79.8	74.7	75.4	73.3	80.9	79.8	71.7	82.3
St. Joseph's Health Care London	London	5	80.2	76.4	74.4	76.9	81.7	80.0	71.4	81.9
St. Mary's General Hospital	Kitchener	4	73.8	76.7	69.9	76.4	74.2	77.2	64.5	72.0
St. Thomas-Elgin General Hospital	St. Thomas	5	NR	NR	NR	NR	NR	NR	NR	NR
Sunnybrook & Women's College Health Sciences Centre	Toronto	3	70.9	70.9	69.6	68.3	75.4	79.1	69.1	75.5
The Credit Valley Hospital	Mississauga	3	75.2	74.3	72.7	73.5	76.0	77.1	67.6	72.7
The Ottawa Hospital	Ottawa	2	80.0	77.3	76.5	76.0	82.6	80.5	72.4	82.7
Toronto East General Hospital	Toronto	3	79.4	73.2	75.2	70.0	80.5	78.2	71.8	74.2
Toronto Rehabilitation Institute	Toronto	3	78.9	74.4	75.0	75.6	79.5	79.0	71.1	77.1
Trillium Health Centre	Mississauga	3	74.1	72.3	70.7	73.5	76.6	77.6	66.8	73.1
West Park Healthcare Centre	Toronto	3	81.3	77.3	78.1	75.9	81.7	80.7	73.7	83.3
William Osler Health Centre	Brampton	3	76.7	74.1	72.3	72.4	79.7	78.6	64.4	76.6
York Central Hospital	Richmond Hill	3	75.4	71.7	73.2	72.7	77.5	78.3	68.8	79.2

Mean Hospital Results by OHA Region

Region 1 (North)	78.4	74.2	74.2	72.5	79.0	79.2	71.7	79.6
Region 2 (East)	79.5	76.7	75.7	76.9	81.5	79.9	72.2	81.3
Region 3 (Greater-Toronto Area)	77.3	73.3	74.1	73.1	78.6	79.1	69.5	77.7
Region 4 (South-Central)	76.1	74.9	72.5	74.1	77.4	78.2	67.9	74.4
Region 5 (South-Western)	77.7	75.3	73.0	73.6	79.0	78.7	70.0	77.7

* Non-reportable – Some results are not shown because the number of surveys or domains of surveys was too low to obtain a reliable estimate (<30).

This quadrant focuses on indicators of Financial Performance and Condition that are specific to designated rehabilitation beds. Developing indicators of Financial Performance and Condition for this sector is challenging largely because of data collection limitations. First, rehabilitation programs are often located in hospitals that have other service mandates, such as complex continuing care or acute care. This makes it difficult to isolate revenues and expenditures that relate solely to rehabilitation services. Second, many performance indicators require a method to classify and group similar clients. These case mix groups usually have weights that reflect relative differences in resource demands. Methods and systems that can be used to address these data shortcomings are not yet fully implemented for this sector.

In the absence of isolated cost data, case mix groups and associated weights, only three measures related to Financial Performance and Condition for rehabilitation services were recommended for use by the advisory panel supporting the research team.

The financial data included in this Report are for the 2003/04 fiscal year, which was the most recent data available during the research. The data are submitted annually to the Ontario Ministry of Health and Long-Term Care (MOHLTC) using formats specified by the Ontario Hospital Reporting System (OHRS). Data from all 54 hospital corporations with designated rehabilitation beds in Ontario were used to calculate provincial and regional means; hospital-specific data are shown for 45 of 54 hospital corporations that voluntarily agreed to participate in this Report.

Indicator Definitions

- *Percent Direct Rehabilitation Cost*
Measures the direct costs of providing nursing, diagnostic and therapeutic services, and food services, to rehabilitation clients as a proportion of the total costs associated with these clients.
- *Nursing Worked Hours*
Measures the proportion of time nurses spend working in the hospital on activities such as direct client care, charting, and in-service education, as a proportion of the total hours earned. The hours being measured are for those nurses who normally engage in activities related to client care, and excludes hours worked by nurses who fill management and administrative roles.
- *Percent Unit-Producing Personnel (UPP) Nursing and Therapy Worked and Purchased Service Hours*
Measures the proportion of time nurses and therapists spend working in the hospital on activities such as direct client care, charting, and in-service education, as a proportion of the total hours earned. Unit-producing personnel (UPP) or unit-producing nurses/therapists are nurses/therapists who normally engage in activities related to client care, and excludes nurses/therapists who fill management and administrative roles.

PROVINCIAL INDICATOR RESULTS (FINANCE)

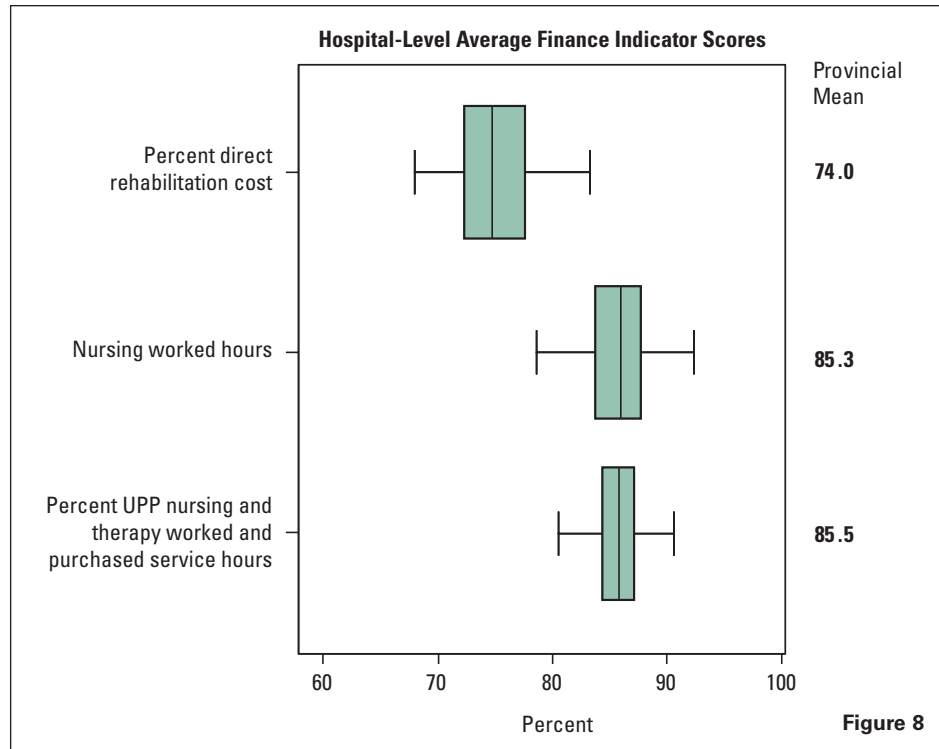


Figure 8

This box and whisker plot displays the distribution of scores for hospitals in Ontario for all indicators in the Financial Performance and Condition quadrant. The black line inside the box reflects the median score, indicating that 50% of hospitals scored higher and 50% of hospitals scored lower. Similarly, the left and right outlines of the box represent the 25th and 75th percentile scores, respectively. The whiskers extending from both ends of the box display the minimum and maximum scores for the indicators. To the right of the box plot, the mean score for each indicator is displayed.

Means and medians are two measures of central tendency. Medians, which are the black lines in the centre of the box-plots, are the central values. Means, which are listed to the right of the figure, are the arithmetic average of the hospital values. Unlike medians, means are influenced by extreme values. Mean values that are substantially higher or lower than median values for the same indicator, reflect data with a distribution that is highly skewed.

SUMMARY OF RESULTS

- Almost three quarters of the expenses incurred by hospitals providing rehabilitation services are related to providing direct client care. While this proportion has remained relatively steady over the past four years (hovering closely around an average of 74%), the actual dollars expended on direct client care has increased significantly – by over \$99 million (42%) since 1999/2000.
- Over 85% of the hours worked by nurses were spent engaged in client care activities. The remaining time is accounted for by vacation time, orientation, and other benefit hours. Similar to the situation noted above, although the proportion of hours worked by nurses has remained somewhat steady (a slight decline of 1.4% has occurred over five years), there has been a noticeable increase in the actual number of worked and purchased service hours in this same period. Worked hours have increased by almost 941,000 hours. The fact that a small decline in this indicator is observed during this same period suggests that a slight increase in the number of benefit hours (such as sick time) also occurred.
- For nurses and therapists combined, over 85% of the hours worked were spent engaged in client care activities.

In future years it is hoped that the implementation of a common rehabilitation dataset, case-mix classification system, and case-mix weights will allow the introduction of additional indicators of the Financial Performance and Condition of inpatient rehabilitation in Ontario's hospitals. The Committee advising the Financial Performance and Condition quadrant has identified a number of potentially valuable indicators that could be included after the necessary data are routinely collected. Among the recommended indicators that cannot be reported due to data limitations are Total Cost per FIM™ -FRG Weighted Case, Direct Cost per FIM™ -FRG Weighted Case, Direct Client Care Hours per FIM™ -FRG Weighted Case, and Total UPP Worked Hours per FIM™ -FRG Weighted Case.

To move toward a more comprehensive set of financial indicators for rehabilitation, two issues need to be addressed. These issues are:

- A nationally accepted method for grouping clients into case mix groups must be adopted
- A methodology for calculating weighted cases must be adopted.

Future work in the Financial Performance and Condition quadrant includes ongoing research on NRS data quality, the grouping methodology, and the associated weights. We strongly support Canadian Institute for Health Information (CIHI) initiatives to develop the grouping methodology for inpatient rehabilitation clients and the associated weights. Future reports will also benefit from introduction of FIM™ -FRG methods, which will better adjust for case-mix differences among rehabilitation clients.

Hospital Corporation	Community Served	OHA Region	Percent Direct Rehabilitation Cost (%)	Nursing Worked Hours (%)	Percent UPP Nursing and Therapy Worked and Purchased Service Hours (%)
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Provincial Average			74.0	85.3	85.5
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Baycrest Centre for Geriatric Care	Toronto	3	70.2	87.7	86.1
Bluewater Health	Sarnia	5	78.0	83.8	83.8
The Brantford General Hospital	Brantford	4	75.9	86.6	88.5
Bridgepoint Health	Toronto	3	71.8	86.8	86.7
Chatham-Kent Health Alliance	Chatham	5	64.0	89.7	88.9
Cornwall Community Hospital	Cornwall	2	76.8	86.0	85.8
Grand River Hospital	Kitchener	4	74.8	83.2	84.2
Grey Bruce Health Services	Owen Sound	5	76.2	84.2	84.3
Halton Healthcare	Oakville	4	79.6	87.9	88.5
Hamilton Health Sciences	Hamilton	4	73.8	81.8	82.1
Hôpital régional de Sudbury Regional Hospital	Sudbury	1	76.4	87.0	86.7
Hotel-Dieu Grace Hospital	Windsor	5	76.5	99.9	96.9
Huron Perth Healthcare Alliance	Stratford	5	76.0	87.4	86.4
Joseph Brant Memorial Hospital	Burlington	4	80.1	86.1	85.4
Lakeridge Health	Oshawa	3	73.8	84.7	84.9
Leamington District Memorial Hospital	Leamington	5	69.8	93.9	92.9
Niagara Health System	Niagara Falls	4	74.9	87.3	87.6
North York General Hospital	Toronto	3	70.3	85.6	85.2
Pembroke Regional Hospital	Pembroke	2	77.3	86.1	85.9
Penetanguishene General Hospital Inc. (The) – North Simcoe Hospital Alliance	Penetanguishene	4	72.7	78.9	81.5
Peterborough Regional Health Centre	Peterborough	2	78.1	82.3	83.3
Providence Continuing Care Centre	Kingston	2	70.7	86.9	85.9
Providence Healthcare	Toronto	3	73.6	84.8	85.0
Quinte Health Care	Belleville	2	73.7	92.4	90.7
Rouge Valley Health System	Scarborough	3	72.8	81.8	83.3

Hospital Corporation	Community Served	OHA Region	Percent Direct Rehabilitation Cost (%)	Nursing Worked Hours (%)	Percent UPP Nursing and Therapy Worked and Purchased Service Hours (%)
Sault Area Hospital	Sault Ste. Marie	1	79.2	89.6	89.0
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	2	70.2	85.9	86.3
Southlake Regional Health Centre	Newmarket	3	77.5	84.6	86.4
St. John's Rehabilitation Hospital	Toronto	3	74.3	79.3	80.4
St. Joseph's Care Group	Thunder Bay	1	83.2	86.3	86.1
St. Joseph's Health Care London	London	5	79.6	85.4	85.1
St. Joseph's Health Centre	Toronto	3	78.2	86.5	86.6
St. Joseph's Healthcare Hamilton	Hamilton	4	77.2	83.8	85.1
St. Mary's General Hospital	Kitchener	4	79.1	88.9	88.9
St. Thomas-Elgin General Hospital	St. Thomas	5	73.7	83.7	87.4
Sunnybrook & Women's College Health Sciences Centre	Toronto	3	73.4	83.6	84.4
The Credit Valley Hospital	Mississauga	3	79.1	86.1	87.0
The Ottawa Hospital	Ottawa	2	73.5	87.6	86.0
Toronto East General Hospital	Toronto	3	70.6	85.9	85.2
Toronto Rehabilitation Institute	Toronto	3	71.3	86.1	86.1
Trillium Health Centre	Mississauga	3	74.3	88.6	89.1
West Park Healthcare Centre	Toronto	3	67.9	85.1	85.0
William Osler Health Centre	Brampton	3	78.1	77.2	80.5
Windsor Regional Hospital	Windsor	5	72.2	78.6	81.4
York Central Hospital	Richmond Hill	3	76.3	88.6	91.3

Mean Hospital Results by OHA Region

Region 1 (North)	80.2	87.2	86.7
Region 2 (East)	72.7	86.3	86.0
Region 3 (Greater-Toronto Area)	72.9	85.0	85.4
Region 4 (South-Central)	75.5	84.6	84.9
Region 5 (South-Western)	75.6	85.7	85.5

Inter-Quadrant Relationships

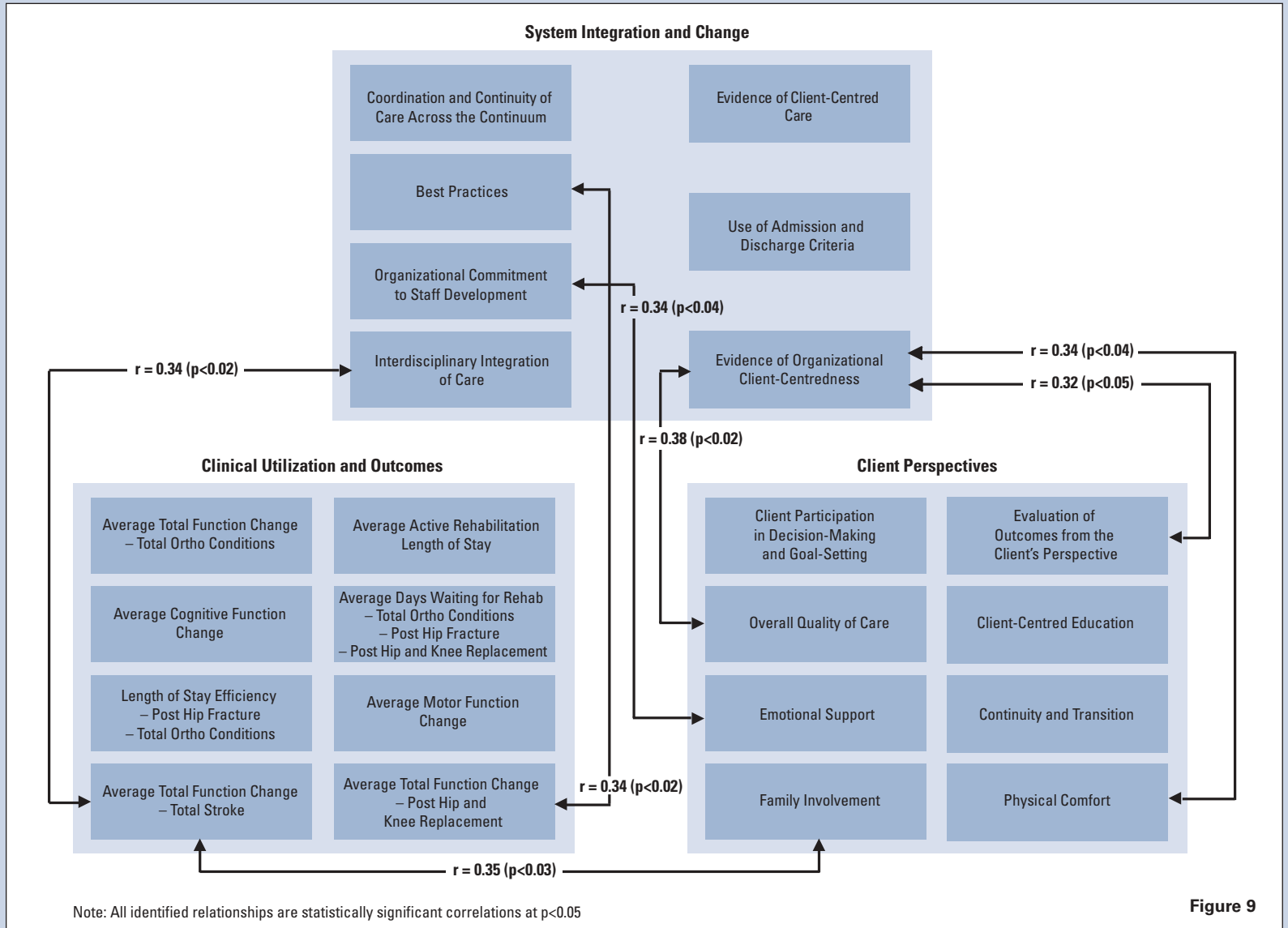


Figure 9

When utilizing a balanced scorecard approach to performance measurement, it is valuable to investigate relationships among indicators across quadrants. These relationships can begin to highlight the impact on outcomes by investing or focusing on various care processes.

Figure 9 illustrates the key relationships among indicators within System Integration and Change, Clinical Utilization and Outcomes, and Client Perspectives quadrants. These relationships were identified by examining correlation matrices containing the indicators from the three quadrants. In general, the correlations are low to moderate with significance values less than $p=0.05$. When interpreting these results, both the strength of the correlation and the level of statistical significance should be considered. These results represent trends that could potentially provide direction for hospitals with respect to quality improvement efforts. Future research exploring more complex statistical modelling will be conducted to further explore these inter-quadrant relationships.

As was noted in the section describing Financial Performance and Condition, for the years covered by this Report, case mix groups and associated weight data are not available, nor is it possible to easily separate costs associated with rehabilitation services from overall hospital operating costs. The result is that the Advisory Panel recommended using only three measures of Financial Performance and Condition from a pool of potential indicators. All three of these indicators relate to labour availability, and two of the indicators (Nursing Worked Hours and Percent UPP Nursing and Therapy Worked and Purchased Service Hours) are highly correlated. Although the indicators provide valuable insights into a narrow dimension of rehabilitation performance, in themselves they are not sufficient to provide an overall picture of the Financial Performance and Condition of rehabilitation hospitals. As a result there is limited scientific merit in identifying relationships between these indicators and the more comprehensive range of indicators presented for other quadrants in this Report. More meaningful inter-quadrant comparisons will be possible after the FIM™ -FRG weighted case data become available, which will allow a much broader range of indicators related to Financial Performance and Condition.

System Integration and Change <—> Client Perspectives

- Hospitals that actively involve clients and families within the organization (Evidence of Organizational Client-Centredness) are perceived by clients to provide higher quality of care (Overall Quality of Care); to involve clients more in determining their progress in rehabilitation (Evaluation of Outcomes from the Client's Perspective); and to recognize and manage clients' physical comfort needs (Physical Comfort).
- Clients in hospitals that support staff development (Organizational Commitment to Staff Development) are more likely to report that they are treated with respect and dignity by staff and not seen as just another case (Emotional Support).

Client Perspectives <—> Clinical Utilization and Outcomes

- Hospitals that perform well on the Family Involvement indicator are more likely to perform well on the Total Function Change indicator for stroke.

System Integration and Change <—> Clinical Utilization and Outcomes

- Clients undergoing total joint replacement in hospitals with higher scores in Best Practices have greater overall improvement in function scores. That is, clients undergoing total joint replacement in hospitals with greater support for integration of research findings into practice demonstrate greater overall improvement in function.
- Clients who have had a stroke and receive rehabilitation in hospitals with higher scores on Interdisciplinary Integration of Care have greater overall improvement in function scores. That is, clients that receive stroke rehabilitation in hospitals that provide greater support for multidisciplinary teamwork have greater overall improvement in function.

These findings highlight the importance of effective multidisciplinary teamwork and best practices for clinical outcomes.

All of these findings warrant further study to better understand these relationships.

Understanding how women use, benefit from, and perceive the quality of rehabilitation care in Ontario and how this differs from men, is important. More women than men use inpatient rehabilitation care in Ontario. More specifically, half of stroke clients in Ontario's rehabilitation beds are women and 70% of orthopaedic clients are women. Women in rehabilitation beds across Ontario are also, on average, five years older than men (i.e., 73 years vs. 68 years).

Not only is inpatient rehabilitation care more prevalent for women, and particularly older women, but the quality of rehabilitation care in Ontario may have different implications for women, given the unique contexts of their lives. Regaining functional status and ensuring readiness for discharge and adequate follow-up may be particularly important as women often return home to situations in which they are the primary informal caregivers, and/or live alone.

In addition, for some time, research in other jurisdictions has identified sex inequities in access to and quality of rehabilitation care.¹ This work has stimulated opportunities for improvements in equitable rehabilitation care, including automatic referral systems for (cardiac) rehabilitation.² Ongoing research on the differential impact of arthritis in Ontario and care gaps, including in rehabilitation services, is reinforcing the importance of targeted strategies for women.^{3,4}

Examining sex differences more closely is an important starting point to understanding the nature and significance of these differences, and identifying and defining valuable opportunities for improvement in equitable care. Systems for collecting, disaggregating, monitoring, and understanding data by sex in the short-term, and by gender[†] in the long-term, should be part of addressing decision support as a strategic priority for Ontario hospitals.

This section of the Report highlights, at a system level, the nature and significance of the sex differences in rehabilitation care across two quadrants: Client Perspectives (CP) and Clinical Utilization and Outcomes (CUO).

† Gender is made up of multiple dimensions, and reflects the interaction of sex with other economic, cultural, environmental, social characteristics and roles ascribed to and relations between the sexes (e.g., income, ethnicity, social support).

1 Ades PA, Waldmann ML, Polk DM, Coflesky JT. (1992). Referral patterns and exercise response in the rehabilitation of women coronary patients aged greater than or equal to 62 years. *American Journal of Cardiology*, 69(17):1422-1425.

2 Grace SL, Evindar A, Kung TN, Scholey PE, Stewart DE. (2004). Increasing access to cardiac rehabilitation: automatic referral to the program nearest home. *Journal of Cardiopulmonary Rehabilitation*, 24(3):171-174.

3 Badley E, Glazier R. (2004). Arthritis and related conditions in Ontario. ICES Research Atlas. Available at: www.ices.on.ca

4 Moss P. (1997). Negotiating spaces in home environments: older women living with arthritis. *Social Science and Medicine*, 45(1):23-33.

Differences for Women and Men on Client Perspectives

- Women receiving inpatient rehabilitation in Ontario generally have more unfavourable perceptions of the quality of care they receive than men. Although these differences appear to be small, they are statistically significant across six of the eight indicators of Client Perspectives. Within the Client Perspectives quadrant, sex differences in Overall Quality of Care are most strongly related to sex differences in Family Involvement and Client-Centred Education.

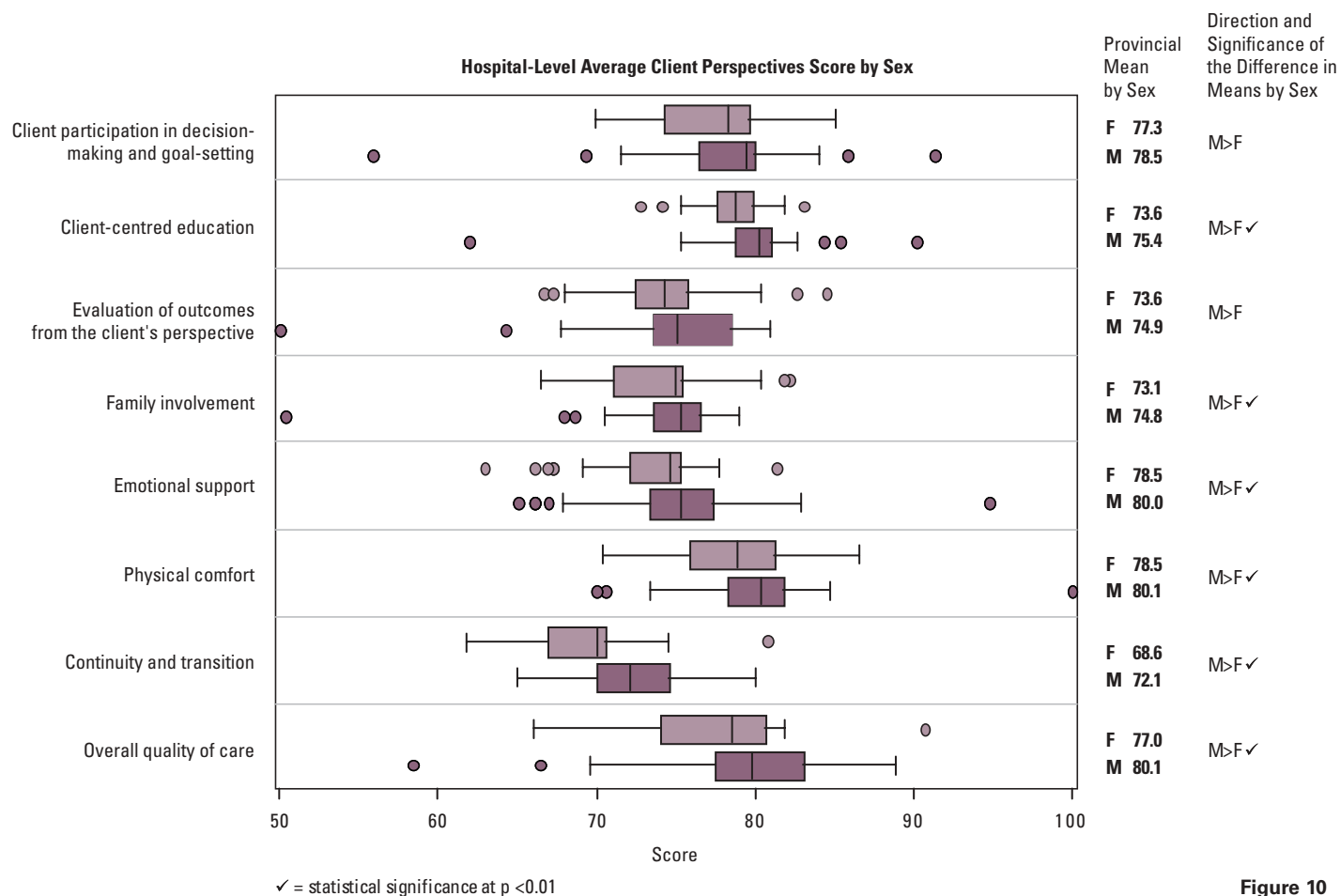
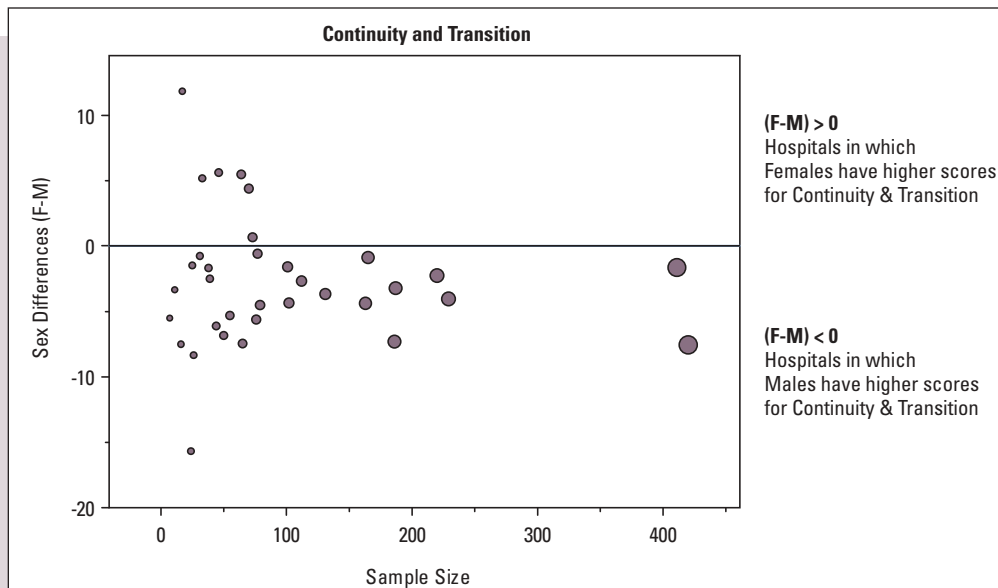


Figure 10

These box and whisker plots display the distribution of hospital scores in Ontario for select indicators by sex. The relative contribution of each hospital to the distribution is determined by weighting each hospital by its sample size. The black line inside the box reflects the median hospital score, indicating that 50% of hospitals scored higher and 50% of hospitals scored lower. Similarly, the left and right outlines of the box represent hospitals with 25th and 75th percentile scores, respectively. Excluding the outliers, the whiskers extending from both ends of the box display the minimum and maximum hospital scores for the indicators. Circles represent the outliers with scores greater than one and one-half box lengths from the edges of the box. To the right of the box plot, the mean hospital score for each indicator is displayed.

Means and medians are two measures of central tendency. Medians, which are the black lines in the centre of the boxplots, are the central values. Means, which are listed to the right of the figure, and are used in this Report to evaluate and compare sex differences, and hospital performance, are the arithmetic average of the hospital values. Unlike medians, means are influenced by extreme values. Mean values that are substantially higher or lower than median values for the same indicator, reflect data with a distribution that is highly skewed.

- In addition to listing the overall average means for women and men, Figure 10 shows the wide variation in Client Perspectives scores by sex across Ontario hospitals, particularly for Overall Quality of Care. Hospital-level Client Perspectives scores for women and men are adjusted for age and length of stay. Both women and men report less favourable perceptions with the continuity of their care, and their care transition post-rehabilitation; and the differences between women and men are also greatest on this indicator. In fact, as shown in Figure 11, regardless of the number of clients surveyed, in five times more Ontario hospitals with rehabilitation beds, men report more favourable perceptions of the continuity of their care and their transition post-discharge than women. This means that a large proportion of women in Ontario perceive that they are not getting the information they need to manage their conditions in the community.



All circles in this graph are hospitals with designated rehabilitation beds in Ontario (the size of each circle is proportional to the number of clients sampled in each hospital for the Client Perspectives Survey).

Figure 11

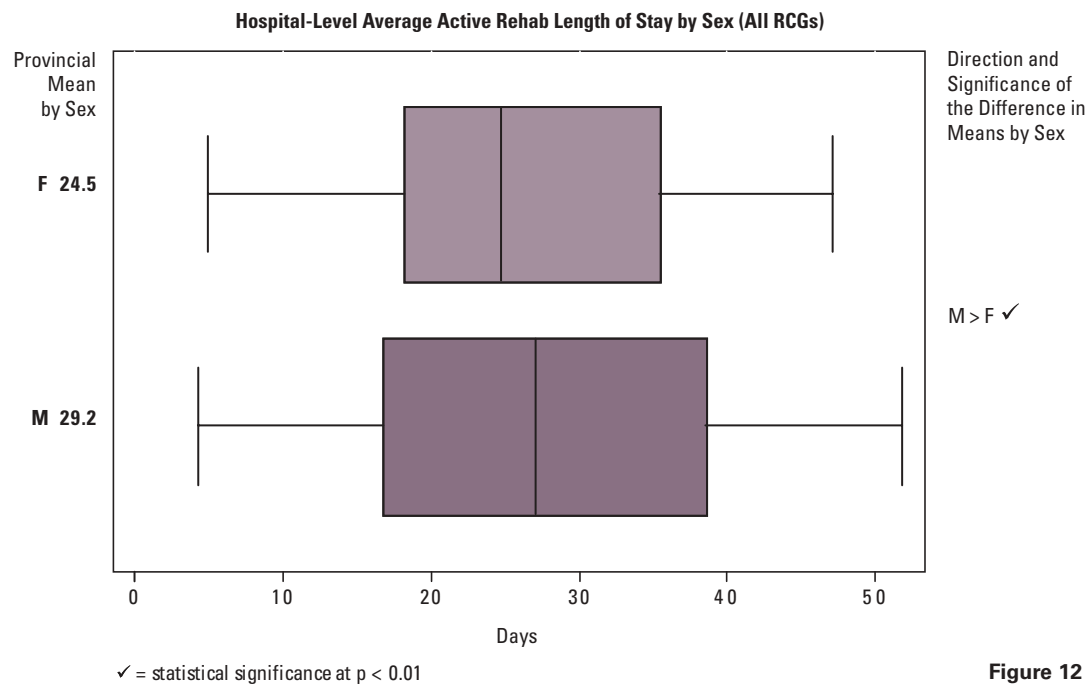


Figure 12

Differences for Women and Men on Clinical Utilization and Outcomes

- The most notable difference for women and men on indicators of clinical quality and access in inpatient rehabilitation is the number of days required to be ready for discharge (i.e., Active Rehabilitation Length of Stay). The active length of stay in inpatient rehabilitation for men (in the All RCGs group) is, on average, five days longer than that of women (see Figure 12). Women receiving inpatient rehabilitation for stroke and hip and knee replacement also tend to have shorter stays than men. Hospital-level values for Clinical Utilization and Outcomes indicators for women and men are adjusted for age and functional status at admission.

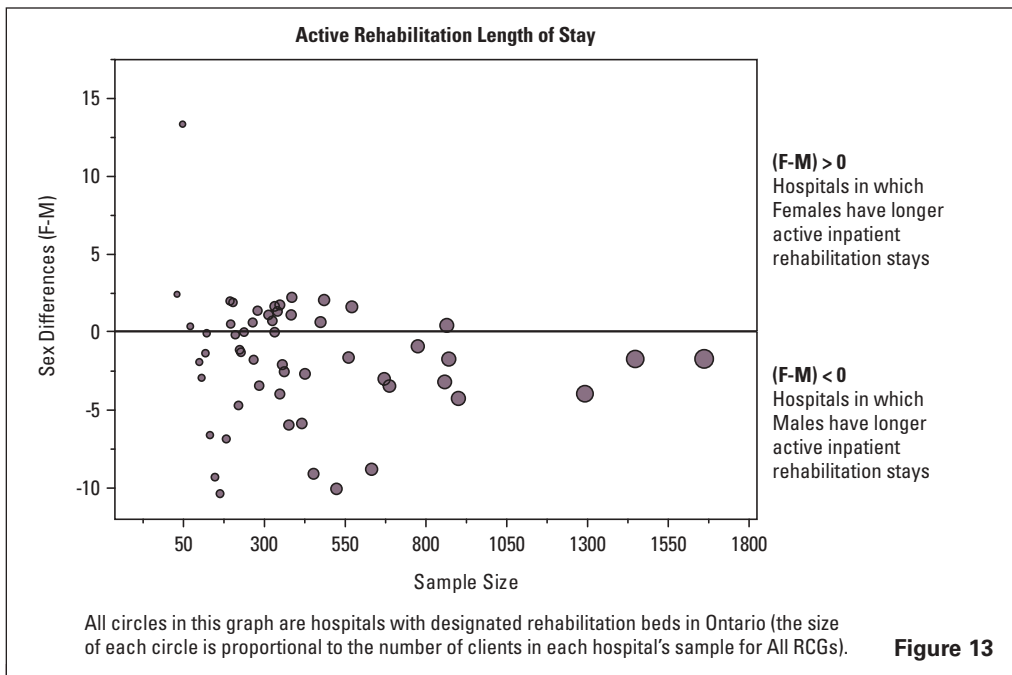


Figure 13

- As shown in Figure 13, about twice as many hospitals (with both small and large sample sizes) had males with longer active rehabilitation lengths of stay.

- Given that, overall, women have shorter stays in inpatient rehabilitation, have less favourable perceptions of the information they are provided at discharge for their transition into the community, and are more likely than men to live alone post-rehabilitation (see Figure 14), targeted strategies for discharge planning for women are imperative. Addressing this issue will require hospitals to improve current and develop further partnerships, particularly in the community. These improvements will help to advance hospital leaders' strategic priority of enhancing vertical integration.

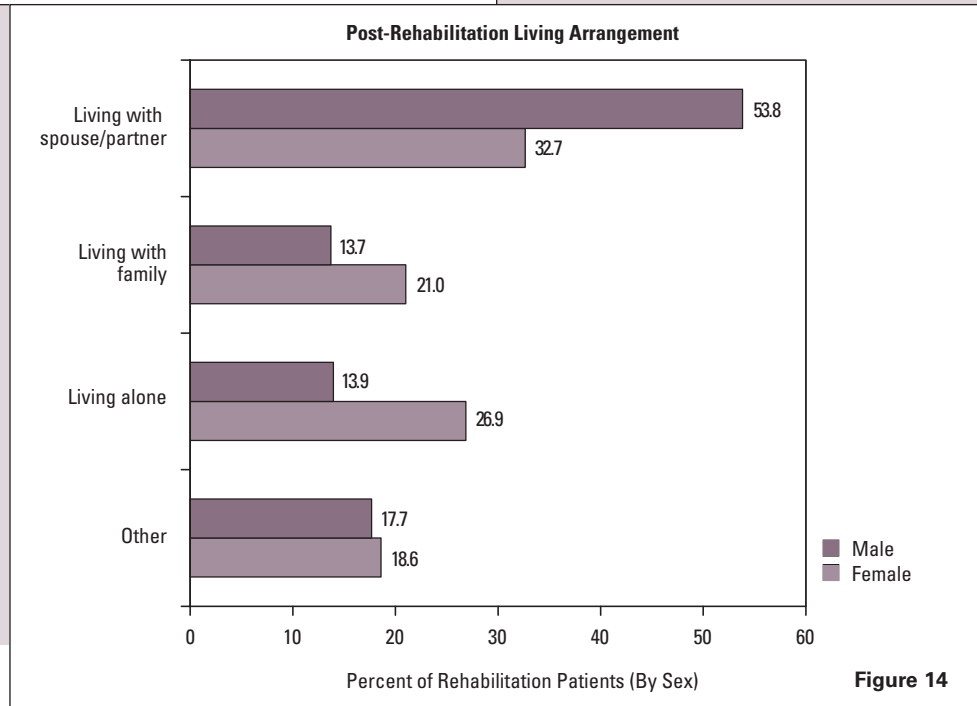


Figure 14

- Overall, women in Ontario experience a slightly greater average improvement in total function (as measured by the FIM™) from admission to discharge, and change in function per day (as measured by the Length of Stay Efficiency indicator). In contrast, men experience a slightly greater average improvement in cognitive function from admission to discharge. These differences are statistically significant (see Figure 15). As shown in Figure 16, regardless of sample size, there are at least twice as many hospitals with rehabilitation beds in which women experienced a greater total function improvement than men.
- Generally, women and men experience similar waiting times for admission to the inpatient rehabilitation system in Ontario (i.e., less than one day to three days). This is evidence of increasingly equitable access to rehabilitation care in Ontario.

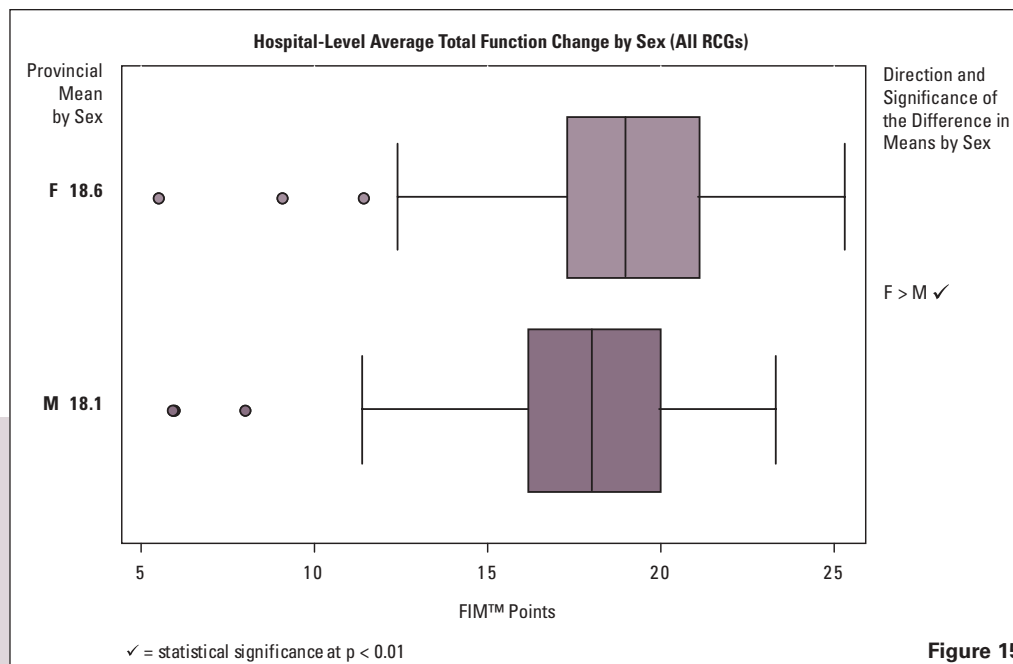


Figure 15

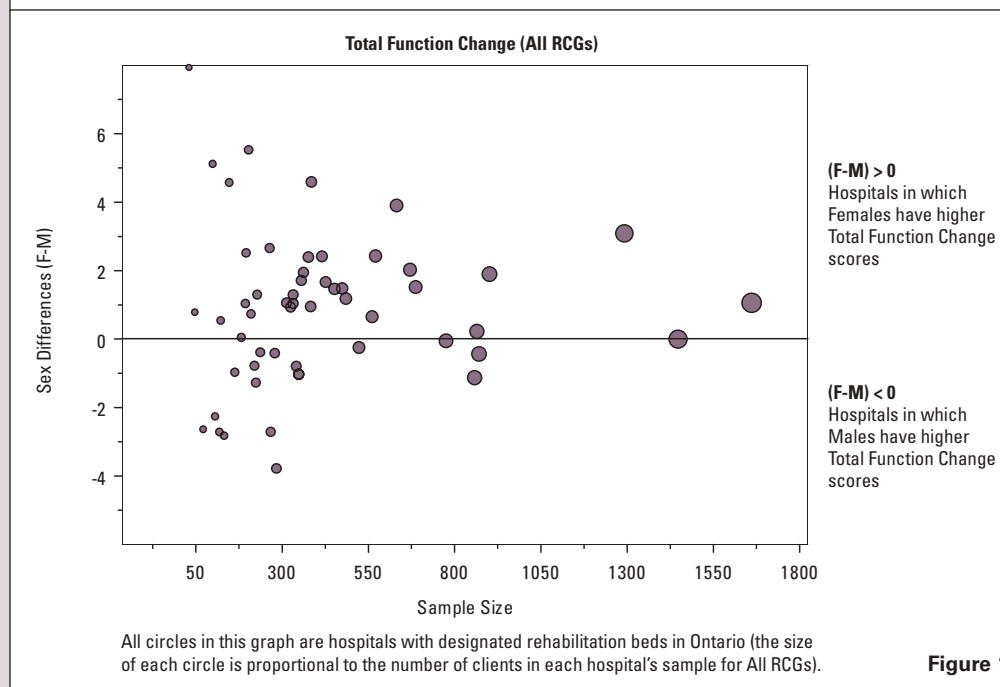


Figure 16

Inter-quadrant Relationships: Differences for Women and Men

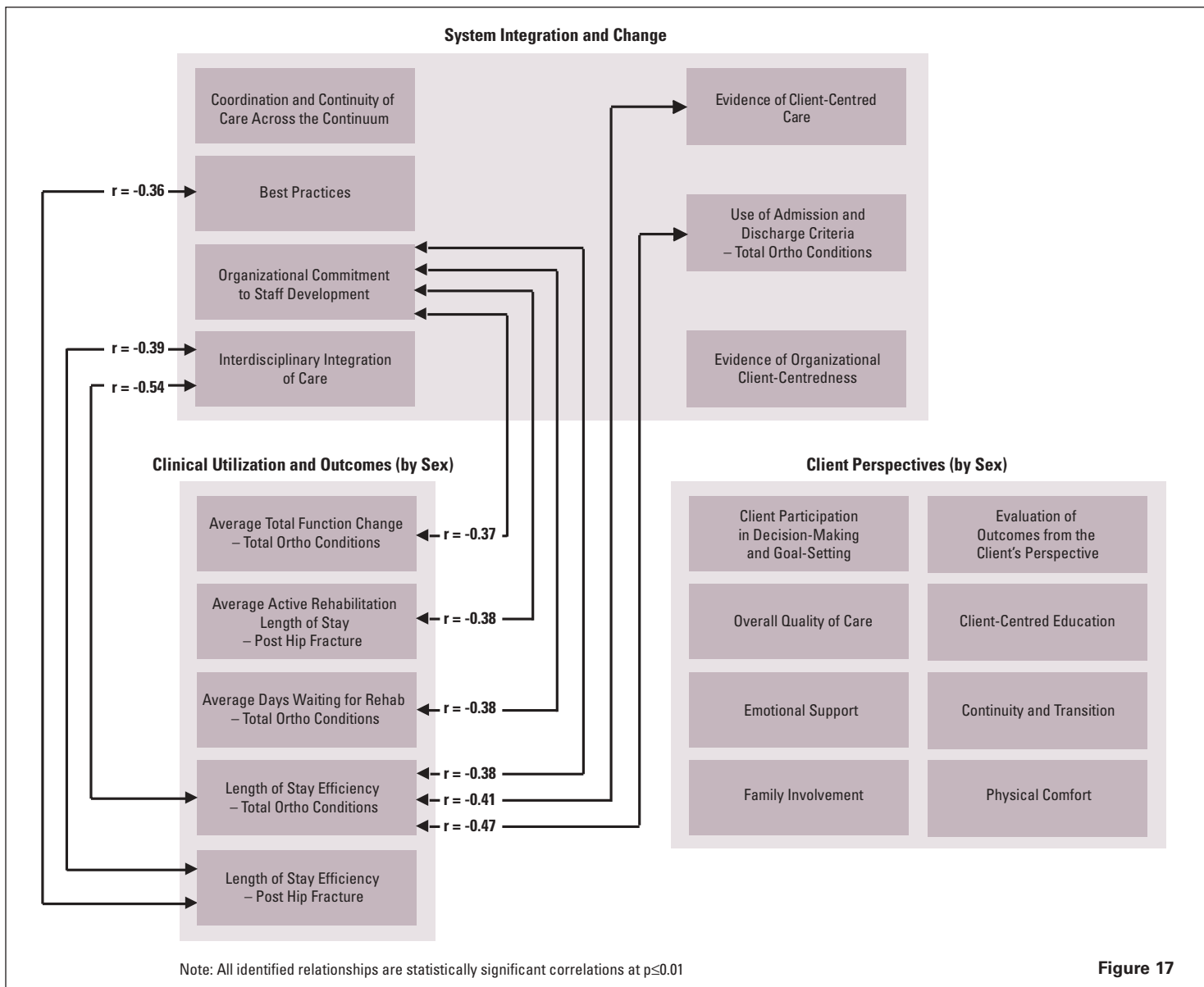


Figure 17

- In terms of correlates of differences for women and men on clinical indicators, there are no statistically significant correlations between sex differences for Client Perspectives indicator scores and System Integration and Change indicator scores. However, hospitals with higher scores on Best Practices, Use of Admission and

Discharge Criteria, Organizational Commitment to Staff Development, Evidence of Client-Centred Care, and Interdisciplinary Integration of Care (as evaluated by the SIC survey), have smaller sex differences on several clinical indicators, including Average Total Function Change, Average Days Waiting for Admission to Rehabilitation, Average Active Rehabilitation Length of Stay, and Length of Stay Efficiency. As shown in Figure 17, these relationships were supported by statistically significant, low to moderate negative correlations. This means that hospitals that use strategies to involve clients in decision-making, and to support them emotionally, and that integrate information from clients and/or their families and individual clinical experience/expertise with the best available evidence to make decisions about care, may be more likely to provide more sex equitable rehabilitation care. In addition, hospitals that report using standardized admission and discharge criteria, particularly for their orthopaedic clients, have clients with more equitable total function change per day (Length of Stay Efficiency), regardless of sex. Furthermore, hospitals with rehabilitation beds that invest in professional development, engage in continuing education activities, and performance evaluations for their staff, as well as foster the interdisciplinary integration of their staff, may be providing more sex equitable care to their clients. In fact, hospitals with higher scores on Organizational Commitment to Staff Development were more likely to have smaller disparities between women and men on all four clinical indicators featured in Figure 17. This finding highlights the opportunity to improve the delivery of equitable care by advancing the strategic priority of staff recruitment and retention through learning about and implementing effective human resource practices that are already adopted in some organizations.

- These inter-quadrant findings further reinforce the relationship between good performance overall and good performance in women's health. They also highlight the importance of paying attention to sex and gender in the organization and delivery of care for clients in rehabilitation beds.



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The Hospital Report Research Collaborative

University of Toronto
150 College Street, Fitzgerald Building, Room 147
Toronto, Ontario M5S 1A8

Telephone 416 946-5023

Fax 416 978-1466

www.hospitalreport.ca

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