MANAGING THE SEAMS: MAKING THE REHABILITATION SYSTEM WORK FOR PEOPLE

The Rehabilitation Reform Initiative

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Please Note:
This paper reflects the discussion of the Provincial Rehabilitation Reference Group. It is not intended to reflect a Ministry position on rehabilitation policy.
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THE REHABILITATION REFORM INITIATIVE
MANAGING THE SEAMS: MAKING THE REHABILITATION SYSTEM WORK FOR PEOPLE

There is an acknowledged need to make changes to the rehabilitation sector, in order to improve the efficacy of rehabilitation services. Working with community partners and other agencies, the Ministry of Health and Long-Term Care (MOHLTC) has the opportunity to improve the quality of these services, as well as the ways in which they are delivered, by developing a new rehabilitation policy framework for use across the province.

By providing such a common framework, the MOHLTC would put in place a standard set of principles and functions – leaving the specifics of the approach to be defined by local and district innovation, responding to local and district needs and resource capacities. Local organizations, comprised of consumers and providers, could thus use the common policy framework to develop detailed service system delivery models and implementation plans that reflect the unique needs of their own communities.

The Rehabilitation Reform Initiative is being undertaken within the context of broader health care system changes, and will complement the MOHLTC’s multi-year rehabilitation reinvestment plan developed in response to the Health Services Restructuring Commission’s directions and recommendations related to rehabilitation. This Initiative is intended to capitalize upon existing innovations and partnerships, and create further momentum by facilitating information sharing with regard to best practices. The policy framework is to be built around a continuum of rehabilitation services that best meets the needs of both clients and providers, while making the most of existing community resources. The aim is to create a more accessible, equitable and
integrated rehabilitation system – one that is more forward looking, and provides services with a minimum of delay, while balancing client goals and service constraints. For this to become a reality, all service providers and other rehabilitation stakeholders must work together to create the necessary alliances and linkages.

The three main purposes of this Initiative are:

1. To improve service to clients by creating a client-centred, coordinated, integrated continuum of services;
2. To provide regions, districts and local areas with a planning framework they can use to develop locally-relevant rehabilitation service delivery plans that reflect the MOHLTC’s overall goals and objectives;
3. To provide the MOHLTC with a planning framework that will facilitate resource allocation decisions, and improve coordination both within the Ministry and with other affected Ministries.

Mission

To effectively and efficiently meet the rehabilitation needs of Ontario residents through the development of collaborative, coordinated, integrated and continuously improving rehabilitation services and community supports. These rehabilitation services and supports are part of, and provide a good 'fit' within, an overall system of health and social services.

Vision

All Ontario residents who require rehabilitation services will receive timely, effective and equitable services aimed at enabling their participation goals.

Principles

Several key principles and goals are at the centre of an integrated rehabilitation system. Such a system would strive to:

1. Achieve a **client-centred** approach that facilitates responsive, individually appropriate, functionally-based goal-setting involving the active and informed participation of the client. Such an approach would respect the client’s autonomy, dignity, values and preferences.
2. Put in place **formal support structures and referral processes** for all clients, with particular attention to those who are without social support from family, friends or other caregivers.

3. Recognize the need for physical, social, psychological, vocational and environmental **service strategies** designed for specific impairments, activity limitations and participation restrictions of individual clients.

4. Understand the importance of environmental, economic, social, cultural, and spiritual factors in determining health outcomes, and take those **determinants of health** into account when developing rehabilitation goals with clients.

5. Recognize the role of prevention through assessing risk and preventing further complications and secondary disorders. Rehabilitation providers have a role to play in educating the public, and other health care providers, in order to change behaviours.

6. Provide a **continuum of services** – addressing the changing needs of the client during the rehabilitation process, and also rehabilitation needs that change over the course of life, from birth through old age.

7. Provide a continuum of services that reflects local and regional resources, and is responsive to **local and regional needs**.

8. Offer a **flexible** approach that provides access to both traditional rehabilitation services and alternative approaches, through a multidisciplinary team.

9. Ensure that multiple, readily-identifiable **access points** into the rehabilitation system exist, and that their existence is clearly communicated and promoted to the public and to health and social service providers. Where feasible, clients could be given a choice of access points.

**NB:** Access to a consistent range of core services may not always mean that services are **present** in each community – especially where services are highly specialized, or when a local population is widely dispersed. Those services, however, should be made **available** to each community, through appropriate support.
10. Ensure that a set of **Core Services** is available to all communities, and that clients have access to a consistent range of services within the publicly-funded rehabilitation system.

11. Provide rehabilitation services in a **timely** manner, so that services are provided when they are needed. Offer a program of quality services that is founded on and contributes to **evidence-based practices**.

12. Offer a program of quality services that supports and is supported by multidisciplinary **research and education**.

13. Make **effective** use of resources.

14. Make **accountable** use of resources.

15. Utilize a set of **data collection and information management tools** that contributes to the effectiveness and efficiency of the system, while protecting the confidentiality of the client.

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**What is Rehabilitation?**

The notion of rehabilitation is an evolving one, the definition of which has shifted markedly in the last few decades. Several principles are at the core of current knowledge about rehabilitation:

- Rehabilitation is about improving the quality of life of people with impairments, activity limitations or participation restrictions resulting from illness or injury, and enabling their participation in society.
- In order to achieve rehabilitation goals related to participation in society, services addressing individuals’ bio-psycho-social needs, as well as their social and environmental contexts, are necessary.
- Client-centred rehabilitation services – in which clients are active participants in goal-setting – are more effective than those which are solely defined and prescribed by professional care providers.
- Rehabilitation is a dynamic process.
- The rehabilitation process happens both within and beyond walls and institutions: rehabilitation services therefore need to be built around “spaces” or “places” within a system, rather than beds.
The definition below is used to define rehabilitation for Ontario residents in this initiative.¹

Rehabilitation is a goal-oriented and often time-limited process, which enables individuals with impairments, activity limitations and participation restrictions to identify and reach their optimal physical, mental and/or social functional level through a client-focused partnership with family, providers and the community. Rehabilitation focuses on abilities and aims to facilitate independence and social integration.²,³

By focusing not only on physical impairments, but also on activity limitations or participation restrictions, it is possible to understand the dynamic nature of the rehabilitation (or habilitation) process and the role of the environment in alleviating barriers to activities or participation. That process will vary from individual to individual; those for whom restoring full function is not an option will be better served by the rehabilitation sector if this focus is adopted.

Depending on the severity of a person’s impairment, activity limitations or participation restrictions, the length and intensity of the rehabilitation process will vary, as will the range of rehabilitation professionals engaged in working with the individual. The client’s need for services may also be episodic, as individuals move through the life cycle and require different types of rehabilitation to facilitate their changing roles (e.g. in employment, child-rearing, as they age, etc.). In order to move to a system that is built around rehabilitation as a dynamic process, it is necessary to shift from a focus on beds within institutions, to spaces or places within/along the continuum. This notion captures the idea that rehabilitation occurs beyond institutional walls, and certainly continues as individuals with permanent disabilities work to integrate into their workplaces and communities.

Another change in our understanding of rehabilitation is reflected in the recent emphasis on client-centred services. Across almost every social service sector, there is a movement toward providing client-centred services – and this is certainly true of rehabilitation services. The movement toward a

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¹ Adapted from the World Health Organization (1983) and the Canadian Institute for Health Information Pilot Project (1999).

² Mental Health services for the purpose of this initiative do not cover acute/chronic diseases such as schizophrenia, personality and bipolar disorders.

³ The process of rehabilitation discussed in this document includes the idea of habilitation for those who were born with an anomaly (or who acquired an impairment at such an early age as to have never had full physical functioning). The goals of habilitation still refer to optimizing the client's ability to function – but the parameters used in assessing habilitation goals may be different from those used for assessing the progress of someone trying to regain previous function through the rehabilitation process.
client-centred approach is largely a result of research that shows that preserving clients’ autonomy and control results in improved health outcomes;\(^4\) at the same time, it also reflects a desire on the part of consumers to be actively involved in their treatment and outcomes.

Finally, those working in health care policy, delivery and research around the world have been gradually moving away from notions and practices which focus on injury or disease, to those which acknowledge that individuals’ needs for health care services cannot be logically separated from the broader determinants of health: those personal, environmental, economic and social factors external to individuals, but which play a large role in affecting – determining – health. Some of these factors are education, employment, income, social networks and social support, food, shelter, culture and race relations, and personal safety (see Appendix 2 for a full list of determinants of health). Research examining the impact of these factors on individual and population health is helping us to truly understand how medical interventions work within the contextual and social structural factors that affect health and well-being.\(^5\)

Thus, rather than relying solely on medical interventions and medicine, the rehabilitation sector is changing its practices, developing a multidisciplinary approach to health that takes into consideration not only the physical, but also the psychological, social and environmental factors that affect health outcomes. Rehabilitation services extend beyond those provided by the acute-care medical system, and include a variety of complementary or alternative practices which are gaining increasing acceptance by providers as increasing numbers of clients are looking for alternative ways of meeting their rehabilitation and health needs (see Appendix 1 for a definition of alternative and complementary rehabilitation services). The functional approach to rehabilitation articulated here is embedded within an understanding of the importance of the bio-psycho-social connection.

**Who Needs Rehabilitation Services?**

Rehabilitation services are used by Ontarians of all ages. The need for rehabilitation can arise at birth; as a result of illness or disease; or following injury at work or play. Though seniors, particularly those over 75, comprise a large component of rehabilitation service users, it is important to remember that virtually all Ontarians can expect to need rehabilitation services at some point in their lifetime – and some may require rehabilitation services during much or all of their lifespan. For some, the rehabilitation

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4 Marmot 1996.
The process may take a matter of months, and serves as the transition between the acute phase of a health condition, and the return to their communities. For others, the rehabilitation process may only be a matter of weeks. The need for rehabilitation services varies widely, and the system must be designed to respond to this variation in need.

**Why a Need for Change?**

During the 1990s, the MOHLTC led a broad-based consultation process aimed at reforming the rehabilitation sector. Much of that work was subsequently overtaken by the broader issues of changes in health care funding, hospital restructuring, and changes to the definition of insurable services under the Automobile Insurance Act. The Workplace Safety and Insurance Board (WSIB) and the insurance industry were part of the process, and in addition conducted consultations and studies of their own.

Most recently the Health Services Restructuring Commission (HSRC) generated two major reports (July 1997; April 1998) that include guidelines for determining the appropriate rehabilitation capacity for and delivery of institution-based services in the province. The reports identify a number of system, delivery and policy issues that need to be addressed if the rehabilitation system is to be effectively reformed.

Several issue areas have emerged from a review of all of the studies:

- the need for a provincial policy framework
- problems of consumer access and service fragmentation
- private-public interface issues
- resourcing of rehabilitation
- problems in rural and northern areas
- the role of technology in rehabilitation
- the need for system-level changes within government

These areas are discussed briefly below.

**Need for a Provincial Policy Framework**

There is no shortage of innovative and interesting work and thinking in the area of rehabilitation; what has been lacking is a standardized, Ministry-supported, framework within which to test and implement these ideas. In essence, there has been no comprehensive vision or method to guide the growth of rehabilitation service delivery in the province. Funding has been
largely program-based, and services have grown as needs have been recognized – for instance, the relatively recent development of services for people with acquired brain injury.

The absence of a clearly articulated policy framework for rehabilitation services may in part be attributable to the evolving concept of rehabilitation – to the shift in recent years from a medical model toward a more holistic one that incorporates clients' psychosocial environments, and by definition involves several government ministries. This most recent philosophical shift has not yet been translated into an overarching rehabilitation policy or delivery model that is sensitive to individual needs, resources and circumstances.

The initiative now underway is intended to address the pressing need for an overarching policy framework.

Rehabilitation Service Delivery: Restricted Access and Fragmentation

Rehabilitation is a highly inter-disciplinary process, which in Ontario is currently delivered through a complex array of public and private programs and services, and by multiple providers. Specifically, rehabilitation is delivered through many types of hospitals (e.g. rehabilitation hospitals, community hospitals with and without ambulatory services, community hospitals with rehabilitation beds) as well as through Children’s Treatment Centres (CTCs), schools, long-term care facilities, community health centres, general practitioners, Community Care Access Centres (CCACs), and private sector providers. It should be noted that as a result of hospital restructuring and changes to the Automobile Insurance Act and the Workplace Safety and Insurance Board, an increasing proportion of rehabilitation services are privately funded.

Public-Private Interface Issues

Partly because the privately funded sector constitutes such a significant proportion of rehabilitation services in Ontario, it is important to understand the interface between publicly and privately funded sectors, and how the different philosophies of the two sectors affect service delivery.

One of the problems relates to a limited and ambiguous definition of publicly funded rehabilitation services. Exactly what qualifies as a 'publicly insured rehabilitation service' is unclear, and the definition seems to cover a diminishing proportion of rehabilitation services. Moreover, anecdotal evidence from clients suggests that the services provided by private insurers
the Workplace Safety and Insurance Board, automobile insurers, and other private entities – appear to have shorter waiting lists, to offer a wider range of services, and to be better coordinated along the service map.

Some argue that this difference is related to clearer outcome goals and accountability for rehabilitation services offered by the private sector largely involving return to employment status – compared to outcome goals for services offered by the publicly funded sector, which deal with a broader range of clients and more complex issues that are not necessarily about return to work. To achieve this accountability, private insurers need to provide services in a timely manner, and long waiting lists are generally not conducive to achieving timely rehabilitation goals. In the privately funded sector, the coordination function is seen as fundamental to the task of moving a client through the system and back to work (or off benefits) efficiently.

Others point out that the clear outcomes and goals within the privately funded rehabilitation sector are set without the client’s participation: the goals are in effect those of the insurer, not of the client. Despite this apparent philosophical difference between the two sectors, there are elements of the privately-funded sector – such as development of service coordination methods, and focus on accountability of service – that could be adapted to the benefit of the publicly-funded sector. Perhaps most importantly, the duplication of rehabilitation services between public and private sector providers, and a lack of coordination across the two sectors, creates problems for clients trying to navigate the system. According to the Health Services Restructuring Commission, “[t]he multiple funding sources that support rehabilitation in this province comprise one of the main barriers that prohibits change in the sector and inhibits analysis”.

Rehabilitation and Resourcing

Rehabilitation is one sector of the health care system in which resource allocation has not been proportional to the need for service, and where resource levels have been significantly reduced. This is in part because of the absence of an overarching policy framework and service delivery mechanism for rehabilitation services and programs. In the past, funding has been largely allocated by program (such as Arthritis, Spinal Cord Injury, Stroke, or Chronic Pain), and has historically reflected Ministry priorities and not necessarily empirically-based need. As knowledge about the rehabilitation needs among some client groups has increased – such as for people with acquired brain injury – programs and services have been added,

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6 HSRC 1997:66
but not within a strategic policy and service delivery framework for rehabilitation. As government moves away from a program- to population-based funding model, it is important that policy-makers be equipped with appropriate data gathering and management tools in order to accurately determine the need for service, and associated funding requirements.

In addition, within general or acute-care hospitals, rehabilitation services and programs as such have had no designated funding: these are funded as part of hospital global budgets. As resources within the whole health care system have been reduced, many hospitals have decided to decrease their rehabilitation funding in order to protect acute care services. Furthermore, resources have been insufficient to support the development and delivery of ambulatory and community-based rehabilitation services.

Health care under-resourcing is compounded by a general lack of understanding concerning the importance of effective rehabilitation services to the overall reduction of health care costs, and the improvement of population health – through the prevention of injuries, primary prevention programs, and the prevention of secondary health conditions. In essence, the rehabilitation sector has a lower public and professional profile compared to acute, life-saving disciplines (such as surgery) and yet without effective rehabilitation services, surgical clients may be unable to resume participation in their workplaces, their communities, or their families. Like many health care disciplines, research in the rehabilitation field has been driven largely by industry (e.g. pharmaceutical companies) because of a lack of other funding sources. This has meant a growth in certain types of rehabilitation approaches – for example, the use of pharmaceuticals – while other approaches remain relatively unstudied – such as the effects of community-based care on client outcomes, and on system resources. As well, the rehabilitation area is not unlike many other health care disciplines, in which the application and incorporation of valid and reliable research is in its infancy. It is not possible to accurately measure or predict the aggregate need for rehabilitation services in general, and certainly it is difficult to do so for specific demographic or geographic sub-groups.

Similarly, other data and information issues – the development of clinical practice and service guidelines, universally accepted outcome measures, a standardized classification system, and accreditation standards – are all negatively affected by under-resourcing in the area. Without accurate and valid information management practices, service providers and payers lack the means to practice objective policy and fiscal decision-making at a systemic level.
Most recently, decreased financial support in the system has resulted in provider shortages and program and service closures (for example, the planned reduction and in some cases closure of many outpatient rehabilitation services across Ontario). Currently, the MOHLTC is moving toward including hospital rehabilitation services in an integrated, population-based funding system. In order to build on current Ministry directions, and to effect funding changes across the rehabilitation process, the rehabilitation sector needs a strong voice and a solid policy base from which to guide the restructuring process. It is necessary to make the link between evidence-based practices, the provision of quality rehabilitation services and supports, and citizen participation – within their families, communities, schools or workplaces.

Rehabilitation in Rural and Northern Ontario

In rural and remote areas of the province, in particular the North, the challenges associated with the rehabilitation system are exacerbated by many factors. These include long distances to major cities, provider reluctance to practice in small or remote communities due to physical isolation from colleagues, and the general practice of concentrating specialized rehabilitation facilities in large urban areas. Problems in the North are intensified due to the exodus of youth seeking employment opportunities in the South, leaving the area with an aging population with potentially high rehabilitation needs. Rural and Northern residents therefore face unique circumstances that affect health maintenance. These circumstances certainly do not target rehabilitation services per se, but they must be taken into account in the design and delivery of those services.

Particular attention needs to be paid to the number of innovative programs and service delivery models that have already been developed in underserviced areas – certainly in the use of Telehealth and Telemedicine, but also in ways that facilitate their delivery to individuals, often in group settings. Rehabilitation services in rural and Northern Ontario need to be considered within the broad context of the 19 Rural and Northern hospital networks recommended by the HSRC. These networks are opportunities for hospitals and community providers to collaborate on strategies for integrated service planning, delivery and access to finite resources. The MOHLTC’s support of the establishment of networks as voluntary and self-sufficient entities will be important to improve client access and service.
Rehabilitation and Technology

Improved technology impacts on rehabilitation needs in different ways. As a result of advances in technology and medicine, people are surviving traumatic incidents, debilitating diseases or health conditions that would have been fatal in the past – many with the support of assistive and adaptive devices. These devices also support a better quality of life: they enable people to go to school, to work, and participate in their communities. Rehabilitation providers are increasingly confronted with clients with more complex rehabilitation needs. Rehabilitation clients' greater expectations for the fulfillment of economic and social participation goals – despite their sometimes complex needs – require us to begin to think of rehabilitation as a process.

Move Beyond Boundaries of Responsibility: Supporting Change within the Government

The diffusion of responsibility for rehabilitation across many government ministries and professional disciplines also impacts service accessibility. At the present time, seven ministries (Health and Long-Term Care; Community and Social Services; Education and Training; Finance; Municipal Affairs and Housing; Transportation; and Citizenship, Culture and Recreation) have some responsibility for rehabilitation, while related programs and policy are being developed at multiple branches within the MOHLTC. Moreover, children's and adult services are coordinated separately, a fact that further complicates decision-making as children become adults and become the responsibility of different ministries. Although significant changes are occurring within the delivery of children’s services, this complex organizational structure makes it difficult to coordinate rehabilitation services.

The problems of coordination are not unique to the area of rehabilitation: the Ministry of Community and Social Services (MCSS) identified similar problems when it launched its “Making Services Work for People” initiative, and is taking steps similar to those proposed here to coordinate and integrate its services. As the lead Ministry on this current rehabilitation Initiative, it is important for the MOHLTC to examine other initiatives underway, and to make the necessary linkages with the appropriate ministries.

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Why a Need for Change Now?

With medical and technological advances saving lives and supporting people with disabilities to live longer, society’s understanding and treatment of people with permanent and short-term disabilities have changed to acknowledge that accessibility in society – in the workplace, the home and the community – is a basic human right, and that governments have a duty to foster this accessibility through appropriate policies and programs. In order to achieve these goals of accessibility, changes are needed within the area of rehabilitation, where services and programs have fallen short of ensuring and supporting full participation and quality of life. Without appropriate supports within the community and the workplace, individuals are not able to fulfill their goals.

Canada’s aging population – the baby boom cohort – is often cited as another compelling reason for reorienting the rehabilitation sector. Though the leading edge of Canada’s baby boom has only just entered its fiftieth year, boomers’ parents are currently facing the challenges of navigating their way around rehabilitation services, as are some children of baby boomers. Through their familial experiences, baby boomers are already forming opinions about the services currently available. To be able to serve the needs of baby boomers in their senior years, program and policy makers need to make systemic changes now, with a view to easing some of the pressures on the system that aging boomers will inevitably create.

Baby boomers represent not merely a potential increase in volume of demand on rehabilitation services, they will also raise questions of service location and delivery. While the majority of services are located in urban settings, as people age, many choose to live in rural areas – a phenomenon already witnessed in European countries with older populations.

As well, members of the baby boom generation are accustomed to a retail economy that responds promptly to consumer demands. Highly knowledgeable about the services they need, baby boomers are likely to be demanding about receiving rehabilitation services when and as they want them. If their needs are not met, it is unlikely that members of this generation will be prepared to sit on a waiting list: rather, they will apply their considerable wealth to obtain the services they want privately – in Canada or elsewhere. Following this scenario, the public system could be deprived of the necessary critical mass of clients. That in turn would erode the system's ability to care for those who cannot afford to use private

8 Foot 1998.
services, who must rely on the public system – and would exacerbate problems of access and inequity.

Persons aged 65 and older are heavy users of the health care system – health expenditures in that age group are more than four times those for people aged 45 to 64. The boomer generation is aging, the number of seniors in Canada is expected to double in the next 15 to 20 years. Because of the relationship between aging and heart disease (which currently accounts for 20 percent of acute care hospital costs and 15 percent of home care costs), the aging-related need for cardiac care alone will create a significant increase in the need for health care services, including rehabilitation.

Finally, because people are living longer, more seniors are surviving with a greater complexity of health conditions and co-morbidities – another challenge to the rehabilitation sector’s resources. According to one expert, “The aging of the boomers is the most critical demographic issue facing the health care system at the millennium.”

**Summary**

The preceding sections provide numerous reasons for making changes to the rehabilitation service system in Ontario. To summarize:

It is necessary to make changes in order to improve the quality and level of service to clients who are not being well served by the present array of largely disconnected services.

The demands on rehabilitation services are changing, as a result of: changing philosophical notions about what constitutes rehabilitation; technological changes; population demographic shifts; and associated shifts in the level and volume of need for rehabilitation services.

Changes are necessary in order to benefit the rehabilitation system: it is necessary for the system to be efficient, effective and accountable to the public that it serves.

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THE COMPONENTS OF THE REHABILITATION SYSTEM:

What Should the Rehabilitation System Look Like?

In order to create an integrated continuum of services and meet the goals enunciated in the Vision and Mission statements and Principles detailed in this report, it is important to build on the current strengths of the rehabilitation sector, while discarding those practices which no longer work. People's rehabilitation goals reach beyond a focus on physical needs, and address quality of life issues such as return to work, to education, and to community living. Clear linkages must therefore be made between the rehabilitation sector and other health and social policies and programs, so that rehabilitation services are integrated into the overall health and social services system.

Figure 1 identifies the necessary components of a client-centred, integrated and coordinated system that serves clients at every stage of the rehabilitation process. These are the components of the system that ought to be in place. Describing the components of the rehabilitation in this way also captures the data and information requirements of the rehabilitation field.
Begin with the Client

Who Does the Rehabilitation System Serve?

The first step in designing a system of rehabilitation services is to identify rehabilitation client groups. *Who does the rehabilitation system serve?* The answer to this question gives some indication of the organizational complexity of the rehabilitation field: rehabilitation services cross into other areas of the health care system (including long term care, acute care, home care, and children’s services) and also interface with programs managed through other government ministries. The framework illustrated in Figure 1 acts at both the individual and the population levels; the term “client” refers to both individuals and to populations or groups of individuals (client groups) with similar needs.

The Canadian Institute for Health Information has developed a classification tool (as part of its 1999 Pilot Project) that begins to describe who receives rehabilitation services. Examples of client groups receiving rehabilitation services are people with the following health conditions:
- stroke
- joint replacement
- brain injury
- fracture/dislocation
- arthritis
- cardiac problems
- pulmonary conditions
- vascular disturbances
- amputations
- spinal cord injuries
- debility
- neurological diseases
- injury/trauma

By understanding the composition and size of the rehabilitation client groups, and how these vary by geographic area or region, we can begin to lay out the components of an integrated rehabilitation system.

Measuring Client Need

In response to current thinking, an improved rehabilitation system would be organized around level of client function.

In this model, (ICIDH-2 World Health Organization 1999) individuals are described as experiencing three kinds of 'disablement' as a result of health conditions: impairments, activity limitations and participation restrictions. There is a complex, dynamic, and bi-directional relationship among these three components of an individual’s health condition, and environmental and personal contextual factors – also referred to as determinants of health (see Appendix 2).

Rehabilitation services address one or more of the three components of a health condition. What matters is the individual’s functioning, and the ways in which rehabilitation services can be used to improve the individual’s physical well-being, reduce activity limitations and overcome participation restrictions so that rehabilitation clients can lead more satisfying lives.

A new method is needed to replace current program-funding models in order to be able to do system-wide planning; a system based on spaces or places rather than beds still needs to be rationalized from a funding perspective. Several jurisdictions have begun to develop a framework for classifying spaces within the system according to different levels of client need.
(including the HSRC 1998). Based on this work, spaces would be grouped according to several criteria:

- the type of impairment, activity limitation or participation restriction;
- the severity of impairment, activity limitation and/or participation restriction; and,
- the expected duration of the rehabilitation process during which services will be needed. (See Appendix 1).  

Using these criteria, client need for rehabilitation services can be grouped into three broad categories: Acute, Continuing and Episodic (See Appendix 1). Levels of service coordination would in turn correspond to each of these three types of need (see Managing the Seams: Making the Rehabilitation System Work for People below).

What is a Client-Centred System?

At the centre of a transformed rehabilitation system are its users, these include clients and their support networks (which are comprised of their families, friends), and other caregivers. In designing a client-centred system, the components of the system incorporate clients’ needs for service, instead of a system in which clients’ needs are simply fit into available programs and services. The challenge in designing such a system is to balance client needs with the system’s ability to provide services and successfully address jurisdictional issues.

From the client perspective, a client-centred system is one within which clients are actively involved in managing their health care and their rehabilitation process, and in setting individually-appropriate goals in partnership with service providers. Research shows that there is an important relationship between clients’ involvement in goal-setting, their sense of control over the overall process, and health outcomes. In essence, the client-centred approach helps to preserve the client’s dignity, autonomy, individuality, choice and independence. For those clients with a reduced capacity for independent decision-making, or who are without social support from family, friends or other sources, formal support structures and referral processes must be put in place from within the system.

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10 Detailed protocols would be required in order to clearly set out the guidelines for inclusion into each type of space within the system, specific to each client group.

11 Marmot 1996.
From the system perspective, a client-centred system must recognize that the system is not unlimited, it is constrained by finite financial and human resources that are unequally allocated across the province. Together, providers and clients must manage resources so as to maximize their benefit across the entire system. Building a rehabilitation system around individual and system needs and capacities evokes mutuality, or a sharing of responsibilities.

A client-centred system, therefore, represents informed and supported decision-making by the client in partnership with their families and health care professionals, within the constraints of the overall health care system.

**What are the Services that Rehabilitation Provides?**

A second component of the rehabilitation system comprises the services that are provided to individuals throughout the course of the rehabilitation process, and across the continuum of institution-based to community-based services. A comprehensive list of services has been developed by the Canadian Institute for Health Information (CIHI), and is being adapted for the purposes of this Initiative. This list of services can be grouped under the following categories (see Appendix 4 for information on how these categories were defined, and what they include):

- Assessment: Screening, Initial, Re-assessment
- Service Planning and Coordination
- Direct Therapies and Services: Cognitive, Communication/Linguistics, Physical, Nutritional, Psycho-social, Vocational
- Social Participation
- Equipment and Assistive Technology
- Education
- Consultation

All rehabilitation services are captured within these categories: those that enable clients to move toward their participation goals, and those that are essential in supporting individuals to achieve and maintain their maximal independence and quality of life. Rehabilitation services must aim to meet the needs of individuals at the three levels of client need (impairment, activity limitation and participation restriction). Without such essential

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12 These services are called “interventions” within the CIHI material. The more neutral word “services” was chosen because of the need to capture the importance of community-based rehabilitation services and supports within the full continuum that extends beyond medical services.
support services as attendant care, supportive and adaptive housing and transportation, and assistive devices, many individuals will continue to experience disablement. With such essential services in place, individuals are more likely to experience an enhanced quality of life, and participate in their communities.

**Who Provides Rehabilitation Services?**

Rehabilitation services are provided by a range of professionals and peer mentors working within the publicly- and privately-funded sectors: medical doctors, surgeons, therapists (occupational, physio, speech-language), social workers, vocational counselors, psychiatrists, nurses, chiropractors and audiologists, to name a few. Many, but not all, of these providers are regulated under the Regulated Health Professions Act, 1991 (for a list of professions that are regulated, see Appendix 5). Increasingly, providers may be solo practitioners in private practice, but many continue to be employed by institutions such as hospitals or Children’s Treatment Centres (CTCs), or are part of a network of professionals working out of medical centres.

For many years, service partners such as the Canadian Paraplegic Association, the Arthritis Society, and the Heart and Stroke Foundation have played pivotal roles within the rehabilitation system (providing peer support and counseling, information and service coordination) but their roles have not been recognized as being integral to the larger system. As the rehabilitation system is redefined and partnerships are forged, it will be important to recognize and work with such organizations throughout the rehabilitation process. For the purposes of this Initiative, the list of rehabilitation providers compiled by the Canadian Institute for Health Information (CIHI) is used to describe regulated and unregulated professions involved in providing rehabilitation services (see Appendix 6 for the full list of providers).

**Where Are Rehabilitation Services Delivered?**

Rehabilitation services are provided at a variety of physical sites: in institutions (e.g. hospitals, publicly- and privately-funded offices or clinics, Children’s Treatment Centres) at home, at work, in schools and at recreational centres (e.g. aquatic or fitness facilities). These sites can then be grouped according to whether the services they provide are delivered regionally or locally (see Appendix 1, under Specialization). It is clear from many studies that not all services can be delivered locally, and there are compelling arguments for aggregating some services regionally or
provincially (HSRC 1998). In particular, clients with complex needs, who require highly specialized professional expertise and equipment and who do not form a critical mass, would benefit from a pooling of resources in a specialized environment (e.g. Regional Rehabilitation Hospitals). Such client groups include: people with acquired brain injuries; people with complex burns; people with severe spinal cord injuries who require ventilators; and people with severe trauma and other complex conditions.

Notwithstanding this need to aggregate some services, which are essentially institutional in nature, specialized support services must be locally available to people when they return to their communities. This is especially critical with decreased length of stay (LOS). People need specialized expertise in their communities as they continue their rehabilitation after a shortened hospital stay.

**Who Receives Funding for Rehabilitation Services?**

A very diverse group of individuals, organizations and institutions presently receives funding for rehabilitation services. Funded organizations include, but are not limited to:

- Institutions
  - such as general hospitals (with and without rehabilitation beds);
- Rehabilitation hospitals;
- Community Care Access Centres;
- Children’s Treatment Centres;
- Clinics; and,
- Community-based organizations
  - such as the Canadian Paraplegic Association; the Heart and Stroke Foundation; the Arthritis Society.

In addition, individuals can currently be funded for self-directed attendant care.

**Who is Responsible for the Big Picture?**

Finally, a web of institutions, organizations and associations responsible for the “Big Picture” guides the system: policy, planning, evaluation, management, research, education, and training. Currently, the web is made up of all government ministries that have links with rehabilitation services, professional associations, regulatory colleges, non-governmental organizations and other service partners; colleges and universities; and
other payers (Workplace Safety and Insurance Board – WSIB; Auto Insurance; Other Insurance) and other groups.

These vital system-level tasks must be carried out in an integrated, coordinated, effective and efficient manner. If they are not, the client will continue to experience the rehabilitation system as extremely difficult to access and navigate.

MANAGING THE SEAMS: MAKING THE REHABILITATION SYSTEM WORK FOR PEOPLE

It is clear that in order to create a system out of the existing set of disconnected services, efforts need to be focused on better management of the "seams" between services and sectors. It is important to maintain, and build on, the current strengths of the rehabilitation sector, while correcting its areas of weakness. In effect, what is necessary is not a 'seamless system', but a 'well-tailored' one.

In order to better describe the rehabilitation process at the level of service delivery, Figure 2 maps the relationship of the components of the rehabilitation system, highlighting the coordination and integration activities that must be initiated (or enhanced where they already exist). There are a number of components in the system:

1. Multiple, identified access points
2. Universal screening and referral mechanisms (within the rehabilitation system, or to other appropriate services)
3. Universal assessment of client-need tools (based on the ICIDH-2 framework)
4. Service coordination function
5. Monitoring, Evaluation and Follow-up (client and system levels)
6. Transition out of rehabilitation services
7. Information Production and development of Management Tools and Practices
Model of Client-Centered Rehabilitation Service Delivery

CLIENT NEED IDENTIFIED ➔ Screening/Referral (Broker Function) ➔ MULTIPLE/IDENTIFIED ACCESS POINTS ➔ Referral to/Linkages with Appropriate Health/Education/Social Services

Assessment of Client Needs
- ACUTE/SHORT TERM
- EPIDEMIC CONTINUING/ONGOING
- Diagnosis/Health Condition
- Impairment
- Activity Limitation
- Participation Restriction
- Determinants of Health

Service Coordination
- Level and Form
- Identified
- Negotiation of Roles
- Collaborative Goal Setting (Ongoing)
- Client/Support Network and Providers
- Implementation of Services and Supports
- Monitoring Evaluation Follow-up: Client and System

SYSTEM COORDINATION - Linkages with Health and Social Systems
- Prevention/Promotion, Information, Communication, Education, Research, Evaluation

EXIT

Fig. 2
Multiple, Identified Access Points

There is an acknowledged need for multiple, clearly identifiable access points into the rehabilitation system that are clearly communicated to clients, referral sources, and providers. Where appropriate and possible, clients would be able to choose an entry point into the system that best fits their needs. Currently, access to the system is typically through: physicians (either within a hospital setting or through general practice); hospital discharge coordinators; Community Care Access Centre (CCAC) case managers; nursing stations (in the North); schools; or privately-funded provider offices or clinics. Though these entry points serve some clients well, there are rehabilitation clients with less serious, or non-life threatening impairments, who would be better served by other means of access to the system.

Two additional access points that could be implemented are a 1-800 number, and a specialized website that could refer individuals to appropriate service locations. Similarly, a specialized website could provide information that would assist clients in deciding on an appropriate course of action, based on detailed algorithms. Unquestionably, the implementation of multiple access points would have to be preceded by intensive provider and public education.

Universal Screening and Referral Mechanism

A universal screening and referral mechanism is an important tool for a system with multiple access points. The screening and referral mechanism would play a ‘broker’ role, ensuring that individuals are correctly identified as rehabilitation clients, and are matched with services in a timely manner.

Universal screening tools would need to be developed and implemented within each of the access points; for example, individuals using the 1-800 number and needing to see a physician could be provided with the names of the closest General Practitioners with expertise in rehabilitation. Clear guidelines would be necessary to ensure that this system ‘broker’ function did not become a barrier to service.

Universal Assessment and Classification System Tools

The use of universal assessment and classification tools appropriate to each client group, based upon the ICIDH-2 framework, would be necessary in order to assess client need in four different areas: impairment, activity limitation, participation restriction and determinants of health (see Appendix 1).
Service Coordination Function

Following the determination of a client's need for rehabilitation services (Acute or Short-Term; Continuing or On-going; or Episodic), a level of service coordination appropriate to facilitation of the rehabilitation process would be initiated. For example, an individual experiencing an acute incident, and who was expected to regain full functioning, would likely receive service coordination throughout the duration of the rehabilitation process. However, the expectation would be that regardless of how lengthy the process, this individual would ultimately leave the system.

Another individual, with a life-long need for rehabilitation services of some nature, might typically fall within the Continuing category and may receive more intensive and more extensively coordinated services.

Yet another individual, who has a life-long impairment that is generally stable when environmental and technical supports are in place, could be considered to have Episodic needs for rehabilitation. That person's service coordination would typically be less intensive, but she or he would have an on-going relationship with the system, or an ‘active’ file that could be reactivated quickly and easily when services such as seating adjustments were needed.

Finally, yet another individual might experience a temporary, relatively mild impairment such as an ankle sprain that nevertheless requires some timely attention in order to prevent secondary impairment. Such an individual would probably deal with a small number of professionals (or just one), and would be unlikely to need any kind of service coordination at all. Services would be provided for a short period, after which the person would leave the system altogether.

The form of service provided, and the complexity of service coordination, would need to reflect the Principles, Mission and Vision statements developed for this Initiative. It is important that service coordination reflect goals collaboratively developed by clients, their support network and service providers; and that system supports be activated when clients or their support networks do not have the necessary information or skills to take part in goal-development. Clients and rehabilitation professionals would need access to a range of information services (e.g. websites) so that outcome goals could be set with the client and mutually agreed upon. Since accountability is a responsibility shared by clients, their service coordinators and service providers, service opportunities and constraints would need to be clearly defined.

Service coordination might take various forms, depending on the client's situation. Individual clients could self-manage, coordination could be delivered using a team approach; clients could choose as a service
coordinator one of their rehabilitation providers with whom they had developed a good working relationship; and so on. Protocols around these details would have to be developed; those protocols would also cover ways of coordinating with other service partners who may also have assigned a case manager to a client.

Key components of service coordination would include the use of: teams; service plans and care maps; and service partner coordination (e.g. between the privately and publicly funded sectors, where each partner has provided a case manager). Service Partners – organizations such as the Heart and Stroke Foundation, Canadian Paraplegic Association, and the Arthritis Society; as well as Independent Living Resource Centres; Vocational Rehabilitation providers, and private sector providers and clinics – could act as facilitators, or provide services directly.

**Monitoring, Evaluation and Follow-up**

Monitoring, Evaluation and Follow-up (at both client and system levels) represent one of the final stages of the rehabilitation process. It is particularly important to conduct these activities as clients are traversing the “seams” of the system: that is, move from service to service, or from site to site. These aspects of rehabilitation are currently performed with varying levels of success.

Service coordinators and clients should routinely re-evaluate goals on an on-going basis. Adjustments of services and strategies are made as needed (indicated in Figure 2 by the arrows coming out of the Monitoring, Evaluation, Follow-up Box, and leading to “Adjustments to Client Services”, and above, to "Referral to/Linkages with Appropriate Health/Education/ Social services"). In the monitoring, evaluation and follow-up phase of the process, individuals and their rehabilitation providers can decide whether they have reached their goals for rehabilitation, and so achieved their desired outcomes. If so, the client may be transitioned out of the system (Transition Out). Alternatively, it might be decided that further services are required, with the rehabilitation process continuing (On-going). This might mean that an individual continues to receive direct therapy, or that on-going support is given through the adaptation and reintegration phase of their rehabilitation. In either case, the individual remains “in” the system, and is seen as receiving on-going services.

From the system perspective, monitoring, evaluation and follow-up must occur in order to ensure that rehabilitation services are achieving the desired outcomes. Indicators of system efficiencies (such as those developed by the Canadian Institute for Health Information) are an important part of this evaluation process. Where necessary, “Changes to the System” may emerge from evaluation activities. These may be required within the rehabilitation system, or within the larger health and social services systems (these
possibilities are indicated in Figure 2). Gaps in service coordination are largest as individuals move from one sector of the system to another. Monitoring and evaluation during these “transition spaces” would help ensure continuity of service coordination.

**Transition Out of the System**

Service providers should ensure that individuals leaving the rehabilitation system experience their exits as smooth transitions. Particularly for individuals with an on-going disability or health condition. During exit planning individuals should always be put in touch with services within their communities through which they can acquire information, maintain and promote health and re-connect with the rehabilitation system in a timely fashion should the need arise. Those individuals leaving the system who require rehabilitation services on an episodic basis should be able to re-enter the system directly through their service coordinator, without having to re-enter the system at the point of screening and referral. For some clients of the rehabilitation system, a “transition out“ may be considered unnecessary, these clients may determine that their need or goal has been met and will exit the system entirely.

**Development of System Coordination and Integration Tools and Practices**

The system-level coordination and integration functions described above must be supported by several system-level structures: prevention of diseases/injuries likely to require rehabilitation; health promotion; universal, shared information systems; comprehensive, valid data collection and management practices; public and provider education; communication strategies; and evaluation of rehabilitation outcomes. Nor is it enough to develop evidence-based practices, because the translation of these best practices into clinical practice is a significant challenge. It is therefore important that supports to the development and implementation of evidence-based practices be provided.

The final piece shown in Figure 2 highlights the importance of these “System Coordination” structures, shown by the arrow running underneath the boxes. These largely information-related functions form the foundation upon which an integrated and coordinated rehabilitation system can be built. Without these functions, the rational planning and implementation of such a new system cannot be accomplished. Further, these functions are important if individuals are to be tracked between the publicly and privately funded spheres of the system, and if the system is to achieve integration and coordination across multiple service partners.
Creating the System

This initiative is being carried out under the auspices of the MOHLTC, and within an overall health services reorganization. In some places in Ontario, networks or affiliations of rehabilitation practitioners have formed to begin to address many of the issues of access and coordination present in the system. These groups have come together largely without guidance from the Ministry, and represent largely, if not entirely, institutional perspectives on rehabilitation. If these bodies are to be leaders in reforming the system, it is important that membership include community-based rehabilitation perspectives.

The purpose of the current initiative is to provide those areas where such bodies have formed, as well as those where they have not, with a framework that will allow them to develop a rehabilitation system and service delivery
model that reflects the needs and available rehabilitation services of their particular region. By using a common framework and procedure, regional/district organizations would be able to create an integrated service delivery system for the public rehabilitation sector. The policy framework would assist communities in utilizing their local strengths and skills, and is not intended to supplant those efforts already under way.

**Implementation of the Initiative**

**Environmental Scan and Needs Assessment**

Each region/district’s service delivery model would need to be constructed based on an environmental scan of rehabilitation services as defined here in their own area. Ideally, that scan would look at rehabilitation information at both the client (outcome) and system/process levels. Several organizations (the Canadian Council on Health Services Accreditation - CCHSA; Canadian Institute on Health Information - CIHI) are currently involved in developing indicators at each of these levels, which can assist in quality monitoring and the evaluation of rehabilitation services. For example, the CCHSA has developed indicators that are linked to standards of service, and to one of four dimensions of service quality. For example, the indicator 'waiting time' relates to the qualitative goal 'responsiveness', and can be measured against a standard of 'access' as they define it. Other service quality and evaluation criteria might include:

- Managing Services (process-oriented, e.g. safety, communication)
- Quality of Service (outcomes-oriented, e.g. quality of life)
- Effectiveness (outcomes-oriented, e.g. of services)
- System Efficiencies (process-oriented, e.g. timeliness of services)
- Achieving Participation of Client (e.g. process-oriented)

The lack of good, comprehensive data in the rehabilitation area is one of the most significant hurdles that those working in the sector currently face. While it is important to consider the broader information requirements of the rehabilitation sector, the goal for the initial environmental scan would be more modest; it would be based on data that is currently available. Specifically, an analysis of the *current needs for rehabilitation*, and the *capacity of providers* to meet service and support needs, would be required for each area in which a system is being developed. These analyses would provide a basis for understanding the needs and strengths of each region, and any disparities between regions. Data provided should also include demographic information for the francophone population, and service system data for services in French. The following table is intended for use as a model to assist in determining the data requirements for the environmental scan.
## Data Requirements

<table>
<thead>
<tr>
<th>Information Required</th>
<th>Indicators</th>
<th>Source</th>
<th>Strengths/Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessing Service Need</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General population (contextual) information</td>
<td>Local population estimated by demographic characteristics (e.g. sex; by age category - children as defined by Children’s services=0-18? 21? - ; 22-35; 36-45; 46-55; 56-65; 66-75; 76-85; 85+), SES</td>
<td>Canadian Census</td>
<td>Good data</td>
</tr>
<tr>
<td>Who are Rehab's Client Groups</td>
<td>Client group by impairment-related characteristics (e.g. people with arthritis; heart and stroke problems; ABI; etc.); by demographic characteristics Needs to account for people with dual or multiple diagnoses</td>
<td>- CIHI &lt;br&gt; - provider data (e.g. hospital, CCAC, privately funded provider) &lt;br&gt; - data from other Provinces &lt;br&gt; - Proxy measures (MS Society, CPA, Arthritis Society)</td>
<td>Proxy measures very partial</td>
</tr>
<tr>
<td><strong>Assessing Service Capacity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is Nature of Service Provided: Services</td>
<td>Rates of service by client group by demographics</td>
<td>- CIHI &lt;br&gt; - CCAC database &lt;br&gt; - data from other Provinces &lt;br&gt; - provider data (e.g. hospital, CCAC, privately funded provider) &lt;br&gt; - HALS/ StatsCan</td>
<td></td>
</tr>
<tr>
<td>Who Provides Services ?</td>
<td>% Providers by client group, by demographics &lt;br&gt;% Providers by services, by client group, by demographics</td>
<td>- CIHI &lt;br&gt; - provider data (e.g. hospital, CCAC, privately funded provider) &lt;br&gt; - data from other Provinces &lt;br&gt; - professional associations &lt;br&gt; - HALS/ StatsCan</td>
<td></td>
</tr>
<tr>
<td>Information Required</td>
<td>Indicators</td>
<td>Source</td>
<td>Strengths/Weaknesses</td>
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<tr>
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<tr>
<td>Where is Service Provided – location (e.g. home, office, school, institution, privately-funded provider’s office or clinic, recreational centre etc.)</td>
<td>% Service location, by service</td>
<td>- CIHI</td>
<td>Information only as good as those collecting – unstandardized, not universal</td>
</tr>
<tr>
<td>% Service location, by service, by client group, by demographics</td>
<td>- provider data (e.g. hospital, CCAC, privately funded provider)</td>
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<td></td>
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<tr>
<td></td>
<td>- data from other Provinces</td>
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<tr>
<td></td>
<td>- professional associations</td>
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<tr>
<td></td>
<td>- HALS/ StatsCan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gap Analysis (Current Waiting Lists)</td>
<td>%/rates of client group, by service needed</td>
<td>- provider data (e.g. hospital, CCAC, privately funded provider)</td>
<td>- Limited use because people self-regulate (people stop referring if the wait is too long); there is no waiting list if there is no expectation for service</td>
</tr>
<tr>
<td></td>
<td>%/rates of client group, by service needed, by location</td>
<td>- Proxy measures (MS Society, CPA, Arthritis Society)</td>
<td></td>
</tr>
<tr>
<td>Analysis of Services Needed, Not provided (services that do not exist but should)</td>
<td>%/rates of client group, by service needed; this could include some health promotion services</td>
<td>- Service Partners (e.g. Heart and Stroke, Arthritis Society)</td>
<td>- Difficult to determine if this information is currently being collected; unlikely that it is collected systematically</td>
</tr>
<tr>
<td></td>
<td>- case managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- program evaluations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predicting Future Use</td>
<td>Based on population projections and other information about the rehabilitation system, Projected service system usage patterns by client group; by demographics; by component of system to be used</td>
<td>- HALS</td>
<td>- Difficult to accurately determine with present information sources -proxies</td>
</tr>
<tr>
<td></td>
<td>- StatsCan</td>
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<td></td>
<td>- advocacy/ NGO groups</td>
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</table>
Developing Service Delivery Models and Implementation Plans

Service delivery models and implementation plans will differ from one region to another because of varying local needs and capacities. However, certain common expectations would guide all plans; in particular, plans would have to reflect the principles and definitions outlined earlier in this document.

Using the service delivery framework, plans would reflect the new vision for service delivery, and would propose the essential changes and on-going elements required in order to obtain the vision. All plans would include:

1. A description of the current rehabilitation service delivery system:
   - Describe the current rehabilitation services system. The description should include all components and current linkages within the system (e.g. hospitals, CCACs, community organizations).

2. A description of the system capacity:
   - Provide an assessment of the capacity of each system to meet local needs and list necessary service components. The assessment would be based on the essential data to be collected (as outlined above). The assessment should list the full range of providers, including CCACs, Rehabilitation and other hospitals, and other service delivery agencies.
   - Identify data-tracking tools and databases currently utilized, where appropriate.
3. Service and delivery plans:

- Describe the vision and goals for service delivery in your region, including projected client, family and community impacts.
- Based on the service delivery framework, provide plans for meeting service gaps by building on existing resources, by realigning existing resources, by redefining program/service mandates, or by reallocating resources.
- Based on the service delivery framework, provide plans for conducting on-going quality assurance tasks (e.g. service evaluations).
- Identify existing or intended “Best Practice” or pilot initiatives that allow for new and innovative approaches and that further the service delivery vision.
- Identify existing coordination or networking initiatives, or plans to put them into place.
- Identify community resources that may be provided at no cost (donated, borrowed or loaned), including operating resources such as space, supplies, equipment and administrative systems.
- Provide a cost analysis of the planned system, showing current and proposed resources.
- State the ratio of administration costs to service system component costs.
- Identify shortfall based on the cost analysis.

4. Priorities for the Rehabilitation System:

- Identify system components, or additions to components, that are a priority, and give the rationale for that priority. (These initiatives would also need to reflect MOHLTC priorities).

5. Implementation Timetable:

- Provide a timetable for the phasing-in of the plan, covering the service components and the realignment or redefinition of existing resources and funding enhancements.

Incentives

Currently, the MOHLTC has a multi-year plan for rehabilitation reinvestment that contemplates the approval of 179 new local rehabilitation beds in
1999/2000. That plan derives from HSRC recommendations, not Ministry policy, and is limited to hospital-based, in-patient rehabilitation services.

As stated above, the current Initiative is aimed at moving beyond hospital-based rehabilitation and beds, to planning for "spaces" or places that can accommodate the full continuum of rehabilitation services and supports. No funding has been allocated for the Initiative.

Within the overall setting of fiscal responsibility and resource management, it is important to evaluate the effectiveness of current spending, and where necessary, supporting organizations to spend existing funds better. It is expected that with resource reallocation there will be more resources in the system to support the implementation of system service delivery models. In the interim, the MOHLTC and MHRRB need to explore other incentives that would encourage and support the development of systems to accomplish those goals. These may include:

- Highlighting best practices on a website; and/or
- Providing support to local and district alliances through information sharing (workshops on team building, etc.).

**Human Resource Planning**

A description of the current and projected shortfall for the major rehabilitation professionals (including OT, PT, SLPT, etc.) will be provided, and a strategy developed to address any identified inadequacies.

**Monitoring and Evaluation**

The implementation of the rehabilitation system and planning process would be monitored. Regular feedback from stakeholders would be obtained in order to gauge progress. The feedback process will include factors like improving access, reducing waiting lists, increasing coordination, consumer satisfaction, and facilitating progress to independent living and productivity.

**Review of the System Plans**

The MOHLTC, through its regional offices, will review system plans. Those plans would likely be modeled on the following criteria, but they will also need to build on the service delivery models once they have been finalized.

- Systems are designed locally, using existing resources;
- Systems are multi-sectoral and utilize resources from the broader community;
- Priorities for system enhancement are clear and achievable;
The rehabilitation system described is likely to achieve the following:

1. Reduced duplication of service
2. Clear, accessible, access points
3. Timely service
4. Improved transitions to independent living
5. Increased participation of rehabilitation clients

**Communication of the Initiative**

Each plan would include a local communication strategy for ensuring that the broader community, in particular consumers, is aware of the initiative.
Recommendations

Recommendations for the Rehabilitation System

1. Test the new service delivery model/components

It is recommended that the MOHLTC pilot the service delivery model in 2-4 locations across Ontario. The pilots would need a thorough evaluation component and the results could form the basis for long-term policy and program changes for the delivery of rehabilitation services within the province.

2. Accelerate coordination/linkages work within the MOHLTC with regard to rehabilitation, including links with the Integrated Services for Children Initiative and Mental Health policy and programs

There are many change initiatives underway within the MOHLTC, including the implementation of the HSRC directives. Many of these directives will have consequences for the delivery of rehabilitation service delivery. It is recommended that the newly created departmental rehabilitation coordinating group be given a clearer mandate to ensure that any changes as result of hospital restructuring and other initiatives take into consideration new directions for rehabilitation.

3. Address public/private sector interface issues; coordination, data/information and outcome measures

It is recommended that a Payers’ Forum comprised of representatives of the insurance industry, WSIB and the MOHLTC be formed in order to address the coordination, data management and research issues that they share in common.

4. Develop strategies to encourage and support the implementation of evidence based “best practices” across both public and private sectors of the system

There are many areas in the province that are supporting innovation in the areas of research, service delivery and data and information management. It is recommended that ways and means be developed to ensure that new and informative approaches are shared across the province. These could include a website and provincial conferences or forums.
5. Develop and support a standardized methodology for gathering client and service data across the system

There are some areas of the province – notably the GTA and Newmarket – that have developed methodologies for, and recently concluded, data gathering exercises. It is recommended that the MHRRB provide strategic support to the development of a common data-gathering tool to be used at the local and regional levels. This would need to be done in co-operation with the District Health Councils and the 8 Health System Linked Research Units (HSLRUs).

6. Provide strategic support to emerging coordination initiatives at the provincial, regional and local levels (e.g. Networks)

There are several coordinating and networking bodies developing across the province. It is recommended that the MHRRB host a meeting of these groups with a view to sharing information and addressing emerging issues in a more cohesive fashion. This initiative should be linked to the pilots.

7. Provide strategic support to education of health care practitioners regarding the role of rehabilitation in the health care continuum

It is recommended that the MHRRB work with current initiatives in the province aimed at educating health care practitioners in order to develop and support similar initiatives in the province.

8. Support the development, dissemination and implementation of client assessment and client and system outcome measurement tools

There are several initiatives currently underway to develop client assessment and client and system outcome measurement tools (e.g. the tool developed by CIHI; the MDS-PAC tool being piloted by a number of hospitals). It is recommended that the MHRRB support initiatives, such as the on-going JPPC work, to select a comprehensive tool that could be used across the rehabilitation sector (within institutional and community settings, for example). Further, it is recommended that the MHRRB provide strategic support to the implementation of these tools across the rehabilitation sector. This work should be linked with the establishment of a Research Forum, as well as with the pilots.

9. Develop linkages with Health Canada for related programs and services on First Nations reserves
Health Canada supports the delivery of health and rehabilitation services on First Nations reserves. In the north, there is a particular need to coordinate the delivery of services between the two levels of government. It is recommended that the MHRRB approach the MOHLTC regional Manager responsible for Northern Health issues in order to address shared issues with the federal Ministry of Health in a coordinated manner.

10. Develop linkages with Human Resources Development Canada, Canada Pension Plan Disability (CPPD)

The CPPD program has begun a re-orientation toward a more client centered service delivery model. They have embarked on several pilot projects aimed at supporting people to return to work. It is recommended that the MOHLTC approach the CPPD with a view to partnering with them on a pilot initiative.

11. Address unique issues regarding access to rehabilitation services for northern, rural and remote residents – i.e. identify a set of “core programs and services”

It is recommended that the MHRRB approach the MOHLTC regional Manager responsible for Northern Health issues in order to address the issues with the federal Ministry of Health in a coordinated manner.

**Recommendations for the Ministry**

1. Analyze previous cuts to rehabilitation services and programs based on data collected from District Health Councils and other sources, and their impact on the current system. Make appropriate adjustments upon completion of the analysis

Hospital restructuring and associated decreases in hospital budgets have led to broad cuts in the rehabilitation sector. There has been no systematic approach to date to determine the extent of the operating dollar loss to the sector.

2. Secure current funding levels for rehabilitation linked to hospital operating plans

The delivery of rehabilitation services is covered within the global operating budgets of hospitals. Continued restructuring may erode services further. It is recommended that the current funding for the sector be identified and secured as a priority, subject to no further cuts.
3. Identify the set of “core rehabilitation programs and services” and appropriate funding requirements

There has been no work done to date to identify a “core” set of rehabilitation programs and services for the publicly funded system. This needs to be done as part of the pilot initiatives.

4. Identify and implement designated funding for rehabilitation services and programs required for implementing proposed policy and service delivery model(s)

It is recommended that the MOHLTC develop a long-term global budget specifically allocated to rehabilitation programs and services. This work would need to build upon the previous three recommendations and the results of the pilots.

5. Develop and implement inter-ministerial linkages to ensure coherent policy and program development

The community-based, citizen-centered model of rehabilitation service delivery put forth in this document is broad. In order for it to be implemented fully, a similar inter-ministerial approach to that of the Children’s Initiative will need to be undertaken.

6. Address privacy and confidentiality issues with regard to information sharing

The issues of data and confidentiality are impeding the development of information sharing that is required for service coordination in the rehabilitation sector. The issue needs to be brought to the attention of the ministerial working group convened to address this issue for the ministry as a whole.

7. Develop ways and means for addressing accountability issues at the local level in the private and publicly-funded sectors of the system

A community-based model of rehabilitation service delivery will need to address and take into consideration the issues of shared accountability and authorities at the local level. Organizations requested to coordinate their services will need incentives for adjusting their mandates and ways of working.
8. Assess issues with regard to Northern Health travel grants and access to rehabilitation services

Current criteria and allocations of Northern Health travel grants are very restrictive with regard to rehabilitation services. This issue needs to be addressed within the ministry in order to ensure equitable access to services for northern and remote residents.

9. Develop and coordinate human resource planning for rehabilitation professionals

There has been no planning done in the recent past with regard to the human resource requirements for rehabilitation professionals. There are shortages of trained personnel across the province. This is a long-term issue that will need to be addressed in conjunction with long-term planning around a set of core services and dedicated program and services funding for rehabilitation.
APPENDIX 1: Working Definitions (Draft)

Alternative, Non-Traditional, Complementary Services
"Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed."


"A generic term for a diverse range of therapies, models and philosophies which fall outside conventional, Western medical practices and which are used for the assessment, treatment, alleviation or prevention of disease, disorder, dysfunction or pain. Complimentary care modalities are commonly used to augment conventional Western biomedical treatment. Complimentary care modalities used instead of conventional Western biomedical treatment are often called alternative therapies. Taken together, the phrase complimentary care and alternative therapies covers the whole range of modalities available outside of or in addition to conventional Western medical interventions."


Client: 'Client' refers to the individual who has a need for rehabilitation services, associated with a health condition, at the impairment, activity limitation, or participation restriction level. Where applicable, 'client' also refers to an individual’s designated decision-maker(s). This definition acknowledges that the individual client requiring rehabilitation is located within a social network, and that where possible the needs of this social network also should be taken into account. However, rehabilitation providers first and foremost serve the individual requiring rehabilitation services.

Client-Centred: A system that is 'client-centred' takes the client as an active member of the treatment team, involved in identifying needs and goals. Programs are defined, focused, and designed around client needs, abilities and goals. (Definition developed by the Auto Insurance Task Force on Accreditation)
Dimensions of Client Need for Rehabilitation

1. NEED (Nature of Client’s Need for Rehab)\(^{13}\)

The need for rehabilitation services can occur as a result of injury or disease, or at birth, and can occur at one, two or all of the following levels:

**Impairment:** a loss or abnormality of body structure of a physiological or psychological nature, *e.g.* loss of limb, loss of vision...

**Activity Limitation:** the nature and extent of functioning at the level of the person. Activities may be limited in nature, duration and quality, *e.g.* taking care of oneself, maintaining a job...

**Participation Restriction:** the nature and extent of a person’s involvement in life situations in relationship to impairments, activities, health conditions and contextual factors. Participation may be restricted in nature, duration and quality, *e.g.* participation in community activities, obtaining a driving license...

**Determinants of Health:** those personal, environmental, economic and social factors external to individuals, but which play a large role in affecting and determining health. Some of these factors are education, employment, income, social networks and social support, food, shelter, culture and race relations, and personal safety.

2. SEVERITY (Of Impairment, Activity Limitation, Participation Restriction; analysis of Determinants of Health)

*Definition:* **The severity of an individual’s impairment, activity limitations or participation restrictions.** Each of these levels of need may vary independently in their severity, with no linear relationship existing between level of impairment, and limitations and restrictions. Without adequate and appropriate technical, environmental and community supports, as impairments increase in severity, they can lead to more severe activity limitations or participation restrictions. Determinants of health at the societal and personal levels are as important as severity of impairment in understanding activity limitations and participation restrictions.

The intensity of the services required is linked to the severity of an individual’s impairment, activity limitation and/or participation restriction. Individuals with more severe impairments, activity limitations and/or participation restrictions will be expected to require more sophisticated, complex services, expertise and technology associated with stabilizing their

\(^{13}\)From the International Classification of Disease and Impairment (ICDH) –2, beta 1 version 1997.
health condition, preventing secondary impairment, and achieving participation. For some clients, the severity of their impairments, activity limitations or participation restrictions will also affect the duration of their rehabilitation process (see below).

3. **TIME** (Length of Time Service is Needed)

*Definition*: The length (duration) of the rehabilitation process that is required to enable a client to meet activity and participation goals. Time is an important factor in the allocation of rehabilitation resources. Some impairments will require a ‘time-limited’ period of rehabilitation in order for clients to meet their activity and participation goals. For other impairments, rehabilitation may be long-term or even life-long in order for these goals to be reached. For yet another group, the need for rehabilitation may be only periodic or intermittent. There is no direct correspondence between the cause of an individual’s impairment (e.g. stroke) and the expected duration of the rehabilitation process. Rather, the relationship lies with the complexity and severity of all aspects of client need (see above), their determinants of health and the rehabilitation service provided.

Depending on the nature of an individual’s rehabilitation needs, a variety of service delivery configurations can be put in place. For example, the best means of ensuring timely access to rehabilitation services will vary, depending on whether a client’s needs are acute, continuing or episodic in nature, as well as the severity of impairment involved. Similarly, the intensity of the case management system used to follow an individual through the rehabilitation process would vary according to whether the client's needs were acute, continuing or episodic.

**Acute**: Need for rehabilitation services associated with a new onset of impairment, due to an acute incident, disease or birth. In an acute situation, the primary goal is to stabilize the client and prevent secondary impairment. Clients with acute rehabilitation needs are also more likely to require intensive services than are people who have chronic conditions.

**Continuing**: Need for rehabilitation services associated with a permanent or aging-related health condition or disease. Those needing continuing rehabilitation include clients with: complex impairments (such as Acquired Brain Injury - ABI), multiple health conditions, health conditions that are progressive in nature (such as MS or MD), and conditions that require on-going rehabilitation services in order to enable the client to meet activity and participation goals. Clients with continuing rehabilitation needs may or may not require intensive services, depending on the complexity of their impairment; however, services for those with continuing rehabilitation needs are generally less intensive than those used to address acute rehabilitation needs. Within an on-going health condition, individuals may experience acute
episodes, or an exacerbation of their chronic condition. Again, as the complexity of individuals’ needs increase, so too should the level of service coordination being offered or provided.

**Episodic:** Need for rehabilitation services as a result of an exacerbation of a generally stable, on-going, chronic or life-long impairment. Episodic services could include the need for equipment/technological alterations/maintenance in order for clients to meet their activity and participation goals; or the need for rehabilitation services related to a non-acute injury that is neither life-threatening nor seriously restrictive of an individual’s activities or participation, but which nevertheless needs attention in order to prevent further injury. For example, individuals with recurring back conditions may need episodic services, so would an individual with a spinal cord injury whose condition is stable when technological supports are in place, but who may need periodic adjustment to their wheelchair.

Dimensions of Rehabilitation Services

1. **SERVICE STRATEGIES**

   **Definition:** the kind and level of service appropriate to each individual’s needs.

   **Impairment services:** medical services to deal with the impairment, and preventive services to avoid activity limitation.

   **Activity limitation services:** rehabilitation services and provision of assistive devices or other environmental adaptations, and personal assistance to mitigate an activity limitation; preventive services to avoid participation restrictions.

   **Participation restriction services:** public education, equalization of opportunities, social reform and legislation, architectural ‘universal design’ applications and other ways of accommodating activity limitations in major life areas.

2. **SPECIALIZATION** (Of Services)

   **Definition:** The degree to which rehabilitation services require the application of specialized professional and technological knowledge and expertise. Rehabilitation services vary in their degree of specialization. Some draw on more generalized expertise and can be provided at the local level, while others require more specialized expertise provided in a specialized environment (i.e. Regional Rehabilitation Hospitals). Despite an absence of

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14 Adapted from the WHO website: www.who.int/
hard data, it is suggested by many that aggregation of specialized services at the regional level is the most cost-effective way of delivering such services.

**General to Moderately Specialized**: These services are delivered at the local level to clients with varying rehabilitation needs who do not require the specialized services offered at a regional rehabilitation facility.

**Highly Specialized**: These services are highly specialized and deliver services to clients with complex rehabilitation needs through regional rehabilitation facilities. Examples of such aggregated facilities include those serving people with acquired brain injury, burns, spinal cord injury, complex amputation, catastrophic trauma, and specialized respiratory and complex pediatric care needs. Regional programs create the necessary critical mass of clients and provide the clinical expertise and cohesion in order to provide the most effective service possible.

Currently, expertise does not exist within many community settings to provide services for people with acquired brain injury, spinal cord injury (SCI), etc. who are exiting the institutional sector. Where they do not already exist, such services must be developed to enable individuals to return to their communities once they no longer require services through a regional rehabilitation facility.

3. **TIME** (Length of time Service is Provided)

*Definition*: The length of time that rehabilitation services are provided for a given episode of care. While a client may have an acute, continuing or episodic need for rehabilitation services, within each of these categories the services can be grouped as either short or long-term. Short and long-term are relative terms; service delivery times vary from client to client, and according to impairment type and severity.

**Short Term Rehabilitation**: Suitable primarily for those patients who have suffered an acute incident without the complications of multiple diagnoses, advancing age, or other impairments. Also includes care for people who have rehabilitation needs of a preventive nature. These patients require relatively short-term intensive rehabilitation in order to return to home and work environments.

**Long-Term Rehabilitation**: Suitable for those who have suffered an acute incident, or who have a chronic or disabling condition, and require long term, intensive rehabilitation to respond to their complex, highly technological needs, multiple diagnoses, or advancing age.

(A classification tool would be necessary to translate these ideas into more tightly defined categories for policy and planning purposes.)
4. **SITING** (Of Services)

*Definition:* **The physical location of the rehabilitation service provider.** Where rehabilitation services are provided has implications both for their accessibility to the client, and for their cost to the payer. Rehabilitation services can be facility-based, and within hospitals, provided through in-patient or ambulatory programs; delivered through private practice providers’ offices; or delivered to the client within the client’s home or residence, place of work, school, or local recreational centre.

**Facility-Based In-Patient:** Services that are provided within a facility (e.g. rehabilitation hospital; community hospital with rehabilitation beds; community hospital without rehabilitation beds; CTCs).

**Facility-Based Ambulatory:** These services are provided at a facility (such as a hospital or rehabilitation facility) on an ambulatory basis.

**Private Practice Provider’s Office:** These services are provided in the private practice provider’s office (e.g. within the provider’s own home, at a medical clinic or medical centre).

**In-Home/Residence/Workplace/School/Recreational Centre:** These services are delivered at the client's home, residence, workplace, school, or local recreational centre (e.g. through a CCAC; Arthritis Society, CPA; Independent Living Resource Centres, etc.).
APPENDIX 2: Determinants of Health

What Makes Some People Healthy: Determinants of Health\textsuperscript{15}

The ideas emanating from the various sources have been formulated in a document \textit{Strategies for Population Health: Investing in the Health of Canadians} which was approved by the Federal/Provincial/Territorial Ministers of Health in 1994. This document presented the following framework for population health.

![Framework for Population Health](image)

The document \textit{Strategies for Population Health} identifies health determinants as:

**Income and Social Status:** It is not the amount of wealth but its relative distribution that is the key factor that determines health status. Likewise, social status affects health by determining the degree of control people have over life circumstances and, hence, their capacity to take action.

**Social Support Networks:** Support from families, friends and communities is important in helping people deal with difficult situations and maintaining a sense of mastery over life circumstances.

**Education:** Education, that is meaningful and relevant, equips people with knowledge and skills for daily living, enables them to participate in their community, and increases opportunities for employment.

a) **Employment and Working Conditions:** Meaningful employment, economic stability, and a healthy work environment are associated with good health.

\textsuperscript{15} The material in this Appendix is quoted from the paper \textit{Population Health Promotion: An integrated Model of Population Health Promotion} on the Health Canada website: http://www.hc-sc.gc.ca/hppb/healthpromotiondevelopment/pube/php/php2.htm#Healthy
b) **Physical Environment:** Factors such as air and water quality, the type of housing and the safety of our communities have a major impact on health.

c) **Biology and Genetic Endowment:** Recent research in the biological sciences has shed new light on "physiological make-up" as an important health determinant.

d) **Personal Health Practices and Coping Skills:** Personal health practices are key in preventing diseases and promoting self-care. Just as important, are peoples' coping skills. Effective coping skills enable people to be self-reliant, solve problems and make choices that enhance health.

e) **Healthy Child Development:** Positive prenatal and early childhood experiences have a significant effect on subsequent health.

f) **Health Services:** There is a relationship between the availability of preventive and primary care services and improved health (e.g., well baby and immunization clinics, education programs about healthy choices).
APPENDIX 3: Rehabilitation Interventions
(Source: CIHI, National Prototype Reporting System- Adult Inpatient rehabilitation Services, Rehabilitation Minimum Data Set Education Material, August 2000, pp 118-125)

Definition
Rehabilitation interventions are defined as activities that are provided to a person/family or groups of persons, that are aimed at improving/maintaining health status and minimizing the impact of impairments and disabilities on the quality of life.

Intervention categories have been developed for adult rehabilitation services (including habilitation) provided to a variety of person(s) across the continuum including community/home based and facility based services by one or multiple service providers. Although the interventions are intended for use in physical rehabilitation services, they include interventions for psycho-social, emotional, cognitive and physical health conditions that are consequences of disease, injury and other changes in health status.

Coding
Record all types of interventions that were delivered to the person from the time of admission to the time of discharge.

Service Type (setting):
Record whether the intervention was provided to the person on:
• an individual basis
• in a group
• both.

Service Discipline:
Record whether the intervention was provided to the person by:
• a single service provider*
• an interdisciplinary team**
• both.

* intervention is provided by one service provider independently of other service providers even though the service goals may be similar; this may occur in a multi-disciplinary service setting and it may result in one or more service providers recording the same intervention for the same client such as initial assessment or service planning/coordination.

** intervention is provided by a group of service providers (two or more disciplines) in a coordinated and integrated team approach; the service providers have varying competencies/skills and the intervention is dependent on each service provider’s component; the service providers share common health goals/objectives for the client/family.

Notes:
• Interventions are provided to or on behalf of a person/family requiring the services. Interventions may be provided in the presence or absence of the person/family and may be provided to a third party such as a therapy assistant, home care provider or payer who provides the person/family with resources. Examples of these interventions are found in the following categories - Service Planning and Coordination, Education and Consultation.

• Interventions do not include activities directed toward administration of the facility/agency providing service (e.g. budget planning, human resource planning).

• Interventions are recorded using the ‘80/20 rule’. For example, if an initial assessment is conducted for more than 80% of the time and the remaining time is categorized as Service Planning and Coordination, record Initial Assessment only. If it is less than 80%, record both intervention categories.

• Clinical documentation or ‘charting’ (person-specific information) recorded during or following intervention is considered part of the intervention; other documentation on behalf of the person/family such as funding applications, locating resources, third party payer letters, etc., should be coded as ‘Service Planning and Coordination’.

• Education is an integral part of several intervention categories and like clinical documentation is considered part of these categories; when the main purpose of the intervention is education of a person/family or third party, it is considered ‘Education’.

• Obtaining person/family consent is considered a part of each intervention.

**Intervention Categories**

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| Service Planning and Coordination* |

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<td>Injections and Aspirations*</td>
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| Social Participation* |
Recording Rehabilitation Interventions

Using the above categories (definitions on following pages), check off each category of intervention provided to the client between admission and discharge. Interventions provided to an individual client or group of clients should be identified. In addition, interventions delivered by a single service provider or an interdisciplinary team should also be identified.

Definitions

1. **Assessment**

**Screening Assessment**

A screening assessment is conducted when a person and/or family present themselves in person, by telephone or by other means for the purpose of initiating rehabilitation services. The person may be self-referred or referred by others such as service provider(s), agencies, family members. A preliminary review of a person’s status/health condition is conducted using a variety of methods (e.g. chart review, client interview, questionnaires, observation, telephone, testing). Screening assessments may be conducted for various purposes, including but not limited to:

- identification of risk factors;
- stability of health condition;
- readiness/compliance for participation;
- rehabilitation potential;
- triage of referrals;
- redirection of referral if inappropriate;
- provision of immediate assistance;
- determination of suitability for individual/group participation;
- selecting, prioritizing, scheduling services; and
- determining need and appropriateness of referrals.

Includes: review of relevant information provided by the person/family or other sources, screening clinics for specific client groups.

**Initial Assessment**

The initial assessment is conducted when a person/family is accepted, registered or enrolled for rehabilitation services. This assessment may be conducted during one visit or may take place over a period of time/several visits, and may be conducted by one or more service providers. The purpose of the initial assessment includes but is not limited to:
• assessment of person’s physical, psycho-social, emotional and cognitive health status;
• identification of rehabilitation goals and expected outcomes;
• identification of a rehabilitation plan;
• identification of additional information needed (e.g. test results, reports);
• identification of diagnoses and consequences of the health condition(s); and
• collection of information about a client (baseline data).

The initial assessment may be conducted with the person and their family and may include observations, interviews/verbal reporting, the administration of standardized and/or non-standardized tests and completion of questionnaires. Rehabilitation goals, priorities and the amount and type of services required are mutually agreed to with the person/family.

Includes: review of relevant information provided by the person or other sources, assessment clinics for specific client groups.

**Re-assessment**

A re-assessment is a subsequent assessment or discharge assessment for the purpose of re-evaluating and updating goals and expected outcomes or documenting health status at time of discharge. Re-assessment may require administration of standardized or non-standardized tests, structured interviews, observation and/or other assessment protocols.

Includes: review of relevant information provided by the person or other sources, re-assessment clinics for specific client groups.

Excludes: the re-assessment and ongoing monitoring of a person’s status that is conducted on a regular basis during the delivery of other rehabilitation interventions.

2. **Service Planning and Coordination**

Service planning and coordination activities are conducted with and on behalf of the person/family to locate, establish and maintain resources, services and supports necessary to meet the identified rehabilitation goals and expected outcomes. It includes but is not limited to:

• coordinating—locating, coordinating and maintaining links with formal and informal resources, services and support in the person’s environment/community necessary to meet rehabilitation goals. These may include formal and informal service providers/agencies, family members, friends, neighbors, church and community.

• planning—designing, organizing, reviewing strategies, activities, resources and services to meet individual’s rehabilitation goals
Includes transfer and discharge planning, written and verbal contact with third party payers, employers and claims adjusters

- referring—directing person/family to resources, services and supports necessary to meet rehabilitation goals

- monitoring and evaluation—communication with person/family, service providers, payers, for the purpose of tracking delivery of services, evaluating extent to which services meet client’s needs and goals, adjusting services as required; includes consultation with formal and informal service provider(s), person/family and others in interdisciplinary team meetings, conferences, rounds, clinics, etc.

- advocating—influencing systems, decision makers and other community resources on behalf of the person/family; participating in efforts to strengthen and improve services for client/family.

Includes: monitoring of delegated activities to support personnel, writing letters, submitting funding requests, completing applications, etc. with or on behalf of the person/family.

3. Therapeutic Interventions

Functional Activities
These interventions assist a person/family to achieve or maintain an optimal level of functional ability in the physical, cognitive, psycho-social, communication, and vocational domains. The interventions are individually designed and supervised by the service provider(s) for a client or a group of clients. It includes selection, prescription, frequency and intensity of activity, according to client’s physical and psychological impairments or disabilities, his/her physical and psychological limitations, and his/her requirements for equipment or assistive technology. It includes revision and/or progression of activity/programs based on client’s responses.

Cognitive—Activities that assist a client(s) achieve or maintain a level of functional ability in the cognitive domain.

Examples of these interventions include but are not limited to:

- memory skills training
- problem solving skill training
- decision making skill training
- counseling

Communication/Linguistics—Activities that assist a client achieve or maintain a level of functional ability in the communication/linguistic domain.
Examples of these interventions include but are not limited to:

- *language retraining*
- skill training in responding to conversational cues
- skill training in expressing needs/making requests
- skill training in writing or reading messages, letters, reports

*Physical*—Activities that assist a client achieve or maintain a level of functional ability in the physical domain.

Examples of these interventions include but are not limited to:

- *mobility training*
- balance training
- self-care training skills
- counseling
- exercise
- strength and endurance training

*Nutritional*—Activities that assist a client achieve or maintain a level of functional ability in the nutritional domain.

Examples of these interventions include but are not limited to:

- counseling
- diet and nutrition teaching
- meal planning
- special diet planning/monitoring

*Psycho-social*—Activities that assist a client achieve or maintain a level of functional ability in the psycho-social domain.

Examples of these interventions include but are not limited to:

- *life skills training*
- psychotherapy
- coping skills
- counseling

*Vocational*—Activities that assist a client achieve or maintain a level of functional ability in the vocational domain.

Examples of these interventions include but are not limited to:

- *job skills retraining*
• work hardening
• counseling
• vocational planning

**Manual Techniques**
Manual techniques are interventions applied to a person by a service provider using his/her hands to achieve a specific rehabilitation goal(s), such as increased mobility, decreased pain and swelling, improved muscle strength, circulation, balance. These techniques are commonly applied to the muscles, joints, skin and connective tissues of the body of persons with physical impairments and disabilities.

Manual techniques include but are not limited to: all grades of mobilization and manipulation, acupressure, massage, debridement, cranio-sacral technique, compression, stretching, percussion, neuro-stimulation and facilitation, oral stimulation, therapeutic touch, etc.

**Physical Modalities**
This intervention involves applying a physical and/or electrical therapeutic agent to a person with an impairment or disability by a service provider. Physical modalities include but are not limited to: thermal and cryotherapy (heat/cold), compression therapy, mechanical traction, TENS, acutens, muscle stimulation, interferential, therapeutic laser, therapeutic ultrasound, biofeedback, vibrators/percussers, hydrotherapy/whirlpool baths, acupuncture, etc.

**Injections and Aspirations**
These interventions involve the injection of therapeutic agents into muscles, joints, nerves and other soft tissue structures by the service provider, for the purpose of treatment. Injections include but are not limited to injection of corticosteroids or other drugs into joints or bursa, motor point blocks and trigger point injections. Aspirations include aspiration of fluids from joints such as arthrocentesis.

**4. Social Participation Interventions**
Social participation refers to the nature and level of a person’s involvement in life situations such as interpersonal relationships, the community, communication, recreation and employment. The purpose of these interventions is to assist the person/family in achieving an optimal level of social participation in their physical, social, cultural and economic environments. Social participation include:

• the performance of activities for oneself and/or family in ones daily environment (e.g. home, work, school, residence)

• achievement of an optimal level of independent living, social support and a valued role in the community.
Social participation interventions include but are not limited to:

- ergonomic interventions
- leisure training
- recreation counseling
- household management/care of others
- travel with public transportation
- modification/removal of environmental barriers (e.g. physical, social, cultural, economic)

5. Equipment/Assistive Technology
Interventions related to the provision of equipment and/or assistive technology that enable a person to achieve or maintain an optimal level of function in his/her physical, social and cultural environment. These interventions may include but are not limited to:

- measurement and prescription of equipment;
- equipment fabrication/assembling/modifications/fitting;
- instruction in the use of equipment/assistive technology; and
- environmental modifications and controls.

Equipment/assistive technology may be required to assist a person with activities of daily living (e.g. eating, dressing, communication, bathing); mobility (e.g. walkers, wheelchairs, scooters, lifts); environmental adaptations (e.g. workstations, ramps, hearing devices).

6. Education
Education refers to providing information and/or training to develop and enhance the knowledge and/or skills of a person/family or a third party that directly or indirectly assists the person/family in understanding and managing their health condition/disability. The intervention is initiated by the service provider(s). Education may be provided in a structured or non-structured format, with or without the support of educational materials such as pamphlets, tapes, videos, etc. Examples of education include but are not limited to:

- education classes for person/family or groups that assist in understanding the nature of a chronic health condition and how to prevent deterioration;
- evaluation of the level of knowledge of a person/family and informal care providers to determine educational needs;
- education provided to a home support worker who will assist a person with self-care activities in the home after discharge; and
- education provided to an employer on the nature and management of a health condition of one of their employees who has received rehabilitation services.
Includes: educational activities that make up at least 80% of the time and purpose of the contact with the person/family or third party receiving the education intervention, training and delegation of activities to support staff. Excludes: education component that is a part of other interventions such as ability and social participation, therapeutic activity, assistive technology, etc.

7. Consultation
Consultation is a form of service provision in which the service provider is using his or her expertise to enable another provider, organization or company to address issues, needs and desired outcomes. The consultation process is initiated by another provider, organization or company. The consultee rather than the service provider is responsible for the outcomes of the client in the consultation model. The purpose of the consultation may be focused on the needs of a person/family or on improving the effectiveness of a system/environment. Examples of consultation include but are not limited to:

- an agency requests a service provider to help make their workplace accessible to individuals with physical disabilities. One of their employees is a client of the service provider. The information provided was tailored to meet the needs of the employee.
- a local industry requests a rehabilitation agency/service to conduct a workplace safety and ergonomic assessment to facilitate the reintegration of the injured worker back to his work setting.

Excludes: interdisciplinary consultation, team conferences, rounds, etc. which are related to the delivery, monitoring, evaluation and updating of rehabilitation plans for a person/family receiving rehabilitation services. These are included under ‘Service Planning and Coordination’.

*The intervention list and definitions have been adapted in part from:*
APPENDIX 4: List of Regulated Health Professionals in Ontario

The following is a list of the 23 professions, and their associated colleges, governed by the Regulated Health Professions Act, 1991:

Audiology / Speech-Language Pathology
College of Audiologists & Speech-Language Pathologists of Ontario

Chiropody / Podiatry
College of Chiropodists of Ontario

Chiropractors
College of Chiropractors of Ontario

Dental Hygiene
College of Dental Hygienists of Ontario

Dental Technology
College of Dental Technologists

Dentistry
Royal College of Dental Surgeons of Ontario

Denturism
College of Denturists

Dietetetics
College of Dietitians of Ontario

Massage Therapy
College of Massage Therapists

Medical Laboratory Technology
College of Medical Laboratory Technologists of Ontario

Medical Radiation Technology
College of Medical Radiation Technologists

Medicine
College of Physicians & Surgeons of Ontario

Midwifery
College of Midwives of Ontario

Nursing
College of Nurses of Ontario

Occupational Therapy
College of Occupational Therapists of Ontario

Opticianry
College of Opticians of Ontario

Optometry
College of Optometrists of Ontario

Pharmacy
Ontario College of Pharmacists

Physiotherapy
College of Physiotherapists of Ontario

Podiatry
see Chiropody

Psychology
College of Psychologists of Ontario

Respiratory Therapy
College of Respiratory Therapists of Ontario

Speech-Language Pathology
see Audiology
APPENDIX 5: Rehabilitation Providers Types

Provider type(s)

Definition
The type(s) of service provider(s) who delivered rehabilitation interventions (refer to data element #71) to the person between the time of admission and discharge and contributed to clients rehabilitation goals/plans. A maximum of twenty provider types can be recorded. (See table below).

Coding
Record at final assessment.

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