ARTHRITIS COMMUNITY RESEARCH & EVALUATION UNIT (ACREU)

University Health Network

ONTARIO COMMUNITY REHABILITATION: A PROFILE OF DEMAND AND PROVISION

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The opinions, results and conclusion are those of the authors and no endorsement by the Ministry of Health and Long-Term Care is intended or should be inferred.

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home care which is covered by OHIP and coordinated through Community Care Access Centres.

METHODS

Please refer to the Technical Summary accompanying this profile for a description of the methodologies used to produce this profile and their limitations.

KEY FINDINGS

Current demand for community rehabilitation in Ontario (All findings are from the Canadian Community Health Survey, Cycle 2.1, 2003 and are age and sex adjusted):

- OT and PT Utilisation[*]: 7.6% of the Ontario population reported at least one consultation with a PT; 1.3% reported at least one consultation with an OT, Speech Language Pathologist or Audiologist.

- Chronic Conditions: 69.4% of the Ontario population reported having at least one chronic condition. This finding is consistent across the LHINs.

- Arthritis: 17.6% of the Ontario population reported having arthritis/rheumatism. These findings vary across the LHINs with Central West LHIN having the lowest reported prevalence of arthritis/rheumatism (11.4%) and Hamilton Niagara Haldimand Brant LHIN having the highest (21.7%).

- Back problems: 20.3% of the Ontario population reported having back problems (excluding arthritis and fibromyalgia). Toronto Central LHIN has the lowest prevalence of back problems (14.6%) and North Simcoe Muskoka LHIN the highest (21.5%).

- Repetitive Strain Injury: 11.3% of the Ontario population reported having repetitive strain injury. The Central West LHIN has the lowest prevalence of repetitive strain injury (7.2%) and the North West LHIN has the highest (16.1%).

- Injuries that could be attended to by a rehabilitation professional: 8.7% of the Ontario population reported suffering an injury that could potentially require services of a rehabilitation professional. Central West LHIN had the lowest prevalence (6.9%) and North Simcoe Muskoka LHIN the highest (13.3%).

- Activity and/or Participation Limitation: 31.8% of the Ontario population reported having activity and/or participation limitations. The Central LHIN had the lowest prevalence of activity and/or participation limitation (25.6%) and North West had the greatest proportion of the population with an activity and/or participation limitation (36.1%).

[*] It is not possible to differentiate between consultations occurring in institutional or community settings.

Current provision and access for community rehabilitation in Ontario:

- Number of OTs and PTs registered for independent practice in 2006[†]:
  - 4 000 OTs
  - 5 500 PTs

- Rate of OTs and PTs per 100,000 population[†]:
  - 31.5 OTs per 100,000 population for the province of Ontario
    - Toronto Central LHIN has the highest rate of OTs (57.5 OTs per 100,000) and Central West LHIN the lowest (14 OTs per 100,000).
  - 43.4 PTs per 100,000 population for the province of Ontario
    - Toronto Central has the highest rate of PTs (77.2 PTs per 100,000) and Central West the lowest (22.4 PTs per 100,000).

- The majority of community rehabilitation settings are privately funded.
  - There are over twice as many (2.2 to 1) privately funded community OT clinics as publicly funded
  - There are almost 3 times as many (2.9 to 1) privately funded community PT clinics as there are publicly funded settings
  - Most publicly funded community rehabilitation services are in hospital outpatient departments, which have long wait lists
  - Very few Community Health Centres offer community rehabilitation services

- The highest concentration of community rehabilitation is found in the more populated LHINs in the southern region of the province.

- There is no relationship evident between utilisation and provision of OT and PT.
  - LHINs with the highest proportions of OT or PT utilisation did not have the highest number of OTs or PTs per 100 000 population.

- Wait Times
  - In December 2005, the median wait time for publicly funded OT or PT services was 15 days.
  - Approximately 70% of all publicly funded clinics in Ontario providing community rehabilitation report having a wait time that range between 1 and 360 days, with the longest waits being at hospital outpatient departments for patients with chronic musculoskeletal conditions.

[†] It is not possible to determine the proportion of either OTs or PTs working exclusively in community settings due to current data collection processes by their respective regulatory bodies. Therefore provision for community rehabilitation services represents OTs and PTs working in all settings (institutional and community).

CONCLUSIONS

- Demand and provision for community rehabilitation vary within and across LHINs. There is a higher concentration and provision of services in the southern and more populated LHINs that does not correlate with demand.
- Wait times and access to rehabilitation services are an issue for publicly funded settings.
- High quality data for community rehabilitation services is lacking

RECOMMENDATIONS

1. Timely dissemination of these profiles to each of the LHIN's health planning boards to inform and enhance further planning, implementation and evaluation.
2. Explore Community Health Centres and other community interdisciplinary care delivery models as potential cost-effective options to expand publicly funded community rehabilitation services
3. Develop reliable and valid quality indicators of community rehabilitation services
4. Develop and harmonize reliable and valid community rehabilitation provision data in order to track community rehabilitation services

1 INTERPRETATION AND STRUCTURE OF THIS REPORT

1.1 INTERPRETATION

This working report is the first of its kind to profile demand and provision for community rehabilitation services in Ontario. It consists of 16 individual reports that include: a Technical Summary outlining the methods used to create the profiles; a general overview of demand and provision for community rehabilitation for the province of Ontario, and 14 individual community rehabilitation profiles for each LHIN in Ontario (ACREU Working Reports 2007-01-A to 2007-01-P). This compilation is meant to be used in conjunction with existing data on the status of health care services in order to provide a comprehensive overview of community rehabilitation services in Ontario. The profiles are intended to assist health planners make informed decisions about community rehabilitation service in terms of demand, provision, access and geographic location. It is anticipated that these profiles will augment and enhance information already produced by the LHINs and the Ministry of Health and Long Term Care (The Health Systems Intelligence Project) regarding the status of local health service demand and provision across Ontario.

The data used to produce the community rehabilitation profiles are not exhaustive. Community Care Access Centres, community rehabilitation services provided through mental health institutes or institutes that provide rehabilitation to children and/or adolescents, and, specialty ambulatory programs (such as amputee programs or hand clinics) were excluded from this profile as inclusion of these settings was beyond the scope of this project. Furthermore, some information may be missing due to inadequate data quality and reasons pertaining to information privacy. The information presented in this document is meant to assist in decision making and health services planning and is not intended to be used in isolation of other data sources.

Please refer to the Technical Summary accompanying this profile for a description of the methodologies used to produce this profile and its limitations.

1.2 STRUCTURE

This report is organised into **ten** sections:

INTRODUCTION: This section provides a brief background of the LHINs in the province of Ontario. It also provides a general introduction to the delivery of community rehabilitation throughout the province of Ontario and explains why it is important to provide a snapshot of community rehabilitation for the province. The purpose and objectives of this report are presented.

SETTING THE CONTEXT: COMMUNITY REHABILITATION IN ONTARIO: This section sets the context of community rehabilitation delivery in the province of Ontario.

WHAT IS THE CURRENT DEMAND FOR COMMUNITY REHABILITATION IN ONTARIO?: This section describes the demand for rehabilitation services for the province. For the purpose of this project, *demand* will be defined as the potential need or desire for community rehabilitation services and is based on the general population distribution (all

ages), the population distribution age 65 years and over, average annual household income, OT and PT utilisation, activity and participation limitation, as well as key health variables that may be indicative of demand for community rehabilitation services.

WHAT IS THE CURRENT PROVISION FOR COMMUNITY REHABILITATION IN ONTARIO?: This section describes the current provision for rehabilitation services for Ontario. For the purposes of this profile *provision* is defined as the availability of community OT services and PT services and is based on: 1) the number of therapists for every 100,000 people living in the LHIN; 2) the number of clinical settings providing community rehabilitation services and 3) the full time equivalent staff allocation at community rehabilitation settings.

RELATIONSHIP OF DEMAND AND PROVISION FOR COMMUNITY REHABILITATION IN ONTARIO: This section examines the relationship between community rehabilitation demand and provision for OT and PT services across Ontario.

COMMUNITY REHABILITATION ACCESS IN ONTARIO: This section describes access to rehabilitation services and is based on geographic location, method of funding (publicly vs. privately funded services), hours of operation and wait times for service.

COMPEDIUM OF MAPS: All maps discussed in the preceding sections are presented as a collection in this section of the report.

CONCLUSIONS and RECOMMENDATIONS: This section provides conclusions and recommendations regarding the status of community rehabilitation demand and provision across the province of Ontario.

GLOSSARY

REFERENCES

2 INTRODUCTION

The means by which Ontario residents receive health services has been significantly restructured over the last several years. The most significant change in provincial healthcare delivery occurred in March of 2006, when the Local Health System Integration Act received royal ascent from the Ontario legislature. This called for appointed health planning boards to plan, co-ordinate and fund health services within 14 defined geographic boundaries within Ontario. These geographic regions are referred to as Local Health Integration Networks (LHINs). Map 1 shows the geographic boundaries for each LHIN (refer to the compendium of maps, section 8 of this report).

LHINs operate as not-for-profit organisations that oversee health services including hospitals, community care access centres, home care, long-term care, mental health, community health centres as well as addiction and community support services. The LHIN structure aims to bring together providers in order to identify local priorities, plan local health services, and deliver them in an integrated and coordinated fashion[1]. The Ministry of Health and Long Term Care outlines the principles, goals and requirements for the LHINs to ensure that all Ontarians have access to a consistent set of health care services.

With the newly established LHINs now operating throughout the province of Ontario, added attention is being given to the delivery of care occurring at the institutional level and at the community level. A better understanding of the availability of institutional care has become established with the recent focus on the Hospital Reports that examine the performance of hospitals throughout the province[2]. However, assessment of the demand and provision of community services is more problematic due to inadequate data collection and the heterogeneity of community service provision. One such area is community rehabilitation services.

Rehabilitation is a goal-oriented process that enables individuals with impairment, activity limitations and participation restrictions identify and reach their optimal physical, mental and/or social functional level through client-focused partnership with family, providers and the community[3]. Rehabilitation focuses on abilities and aims to facilitate independence and social integration. It involves many different health care professionals of which include occupational therapists and physiotherapists.

Occupational therapists (OTs) are first contact autonomous, client focused health care professionals who help people of all ages assume or reassume the skills they need for meaningful occupations - the day to day skills, activities, interactions and experiences with the environment and community around us[4]. Physiotherapists (PTs) are also first contact, autonomous, client-focused health professionals trained to improve and maintain functional independence and physical performance, as well as, prevent and manage pain, physical impairments, disabilities and limits to participation[5]. Both professionals play an important role in health promotion, disease prevention, and management of a variety of health conditions throughout the life course and along the continuum of care.

Understanding the distribution of these services across the province is important given the recent shift from institutional based care to community care. This shift has become evident with a greater proportion of patient populations such as total joint arthroplasty patients encountering early discharge from acute care institutions to the community[6]. Patients who typically received

rehabilitation in an inpatient facility, are now receiving rehabilitation within their home through publicly funded services provided by Community Care Access Centres or are required to seek care from outpatient clinics operating within their community such as hospital outpatient clinics, Designated Physiotherapy Clinics, Community Health Centres or The Arthritis Society's Arthritis Rehabilitation and Education Program. Those who have supplemental insurance, or who are willing and able to pay out of pocket, can also access rehabilitation services through the private sector. However, there is no coordination of community rehabilitation services and nowhere can one find an overview of public and privately funded services for the province of Ontario.

Creating a profile of community rehabilitation for Ontario and each of its LHINs will assist in the identification of health human resource allocation, spatial organisation of services, and the determination of rehabilitation planning needs in terms of service coordination, funding allocation and accountable management. This will also provide a tool for the identification of needs and gaps in service planning and will help to reveal areas in need of further research.

2.1 PURPOSE AND OBJECTIVES

The purpose of this project is to integrate existing data sources and evidenced based findings for Ontario community rehabilitation services in order to provide a snapshot of current service demand and provision for community rehabilitation services within each LHIN.

The primary objectives of this report are to:

1. Examine the demand for existing community rehabilitation services, including the geospatial distribution, within Ontario and each LHIN. ***Demand*** **is defined as the potential need or desire for community OT services and PT services and is based on the general population distribution (all ages), the population distribution age 65 years and over, average annual household income, OT and PT utilisation, activity and participation limitation, as well as key health variables that may be indicative of demand for community rehabilitation services.**
2. Examine existing community rehabilitation provision, including the geospatial distribution, within Ontario and each LHIN. ***Provision*** **is defined as the availability of community OT services and PT services based on geographic location, method of funding (public vs. privately funded services), health human resource allocation, hours of operation and the presence of waiting lists.**
3. Integrate the above information to establish a profile for community rehabilitation services for Ontario and each LHIN.

3 SETTING THE CONTEXT: COMMUNITY REHABILITATION IN ONTARIO

Community rehabilitation services are available throughout the province of Ontario, in both the public and private health care sectors. Services can be provided through home care, community clinics, schools, private practice clinics and primary care networks, The majority of physiotherapy services available in the community, as well as an increasing number of OT services are delivered through private clinics. Individuals seeking private OT or PT services in the community either self-pay or may have coverage through insurance plans. Insurers include the Workplace Safety and Insurance Board; insurance coverage through employer-provided or private extended health benefits plans, and, motor vehicle accident coverage through automobile insurers. The majority of publicly funded community rehabilitation services are provided in hospital outpatient departments and are covered under the hospitals global operating budget; however, there are a number of hospital outpatient clinics that operate as private revenue generating entities within the hospital corporation. Other publicly funded settings for rehabilitation services include a limited number of Community Health Centres located throughout the province and the Arthritis Society Arthritis Rehabilitation and Education Program. Seniors, youth and other categories of patients may obtain PT services that are covered by the Ontario Health Insurance Plan (OHIP) at Designated Physiotherapy Clinics; however, there are no community OHIP funded clinics that provide OT services in the province. Lastly, those who are unable to access care at outpatient facilities can access community care services through home care which is covered by OHIP and coordinated through Community Care Access Centres.

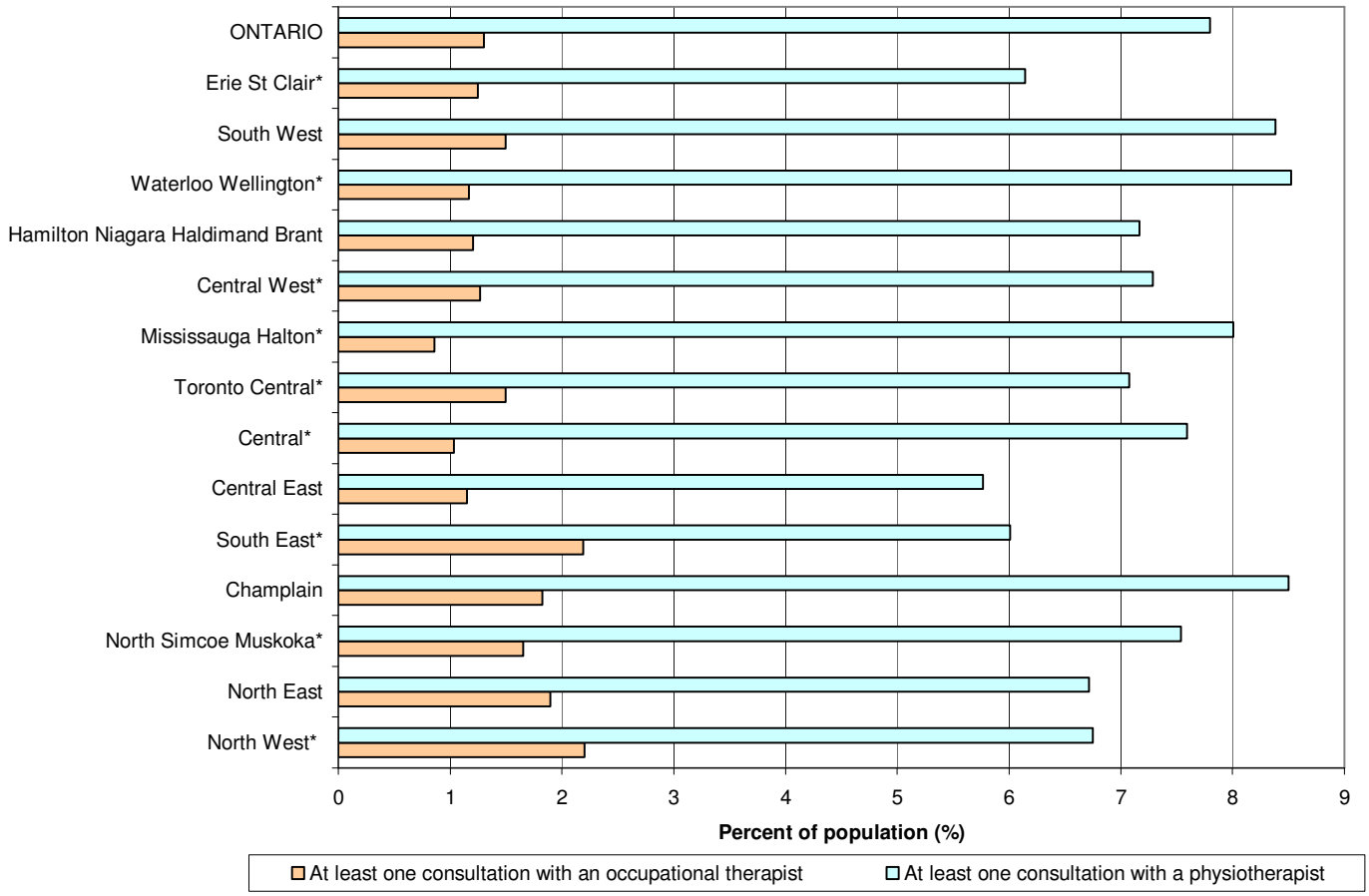
4 WHAT IS THE CURRENT DEMAND FOR COMMUNITY REHABILITATION IN ONTARIO?

Indicators of potential demand for Ontario community rehabilitation services included:

- OT and PT utilisation
- Chronic condition
- Arthritis
- Back problems
- Repetitive strain injury
- Injuries that could be attended by a rehabilitation professional
- Activity and/or participation limitation

Each of the above variables was examined by LHIN, and for Ontario, and is presented in the following figures.

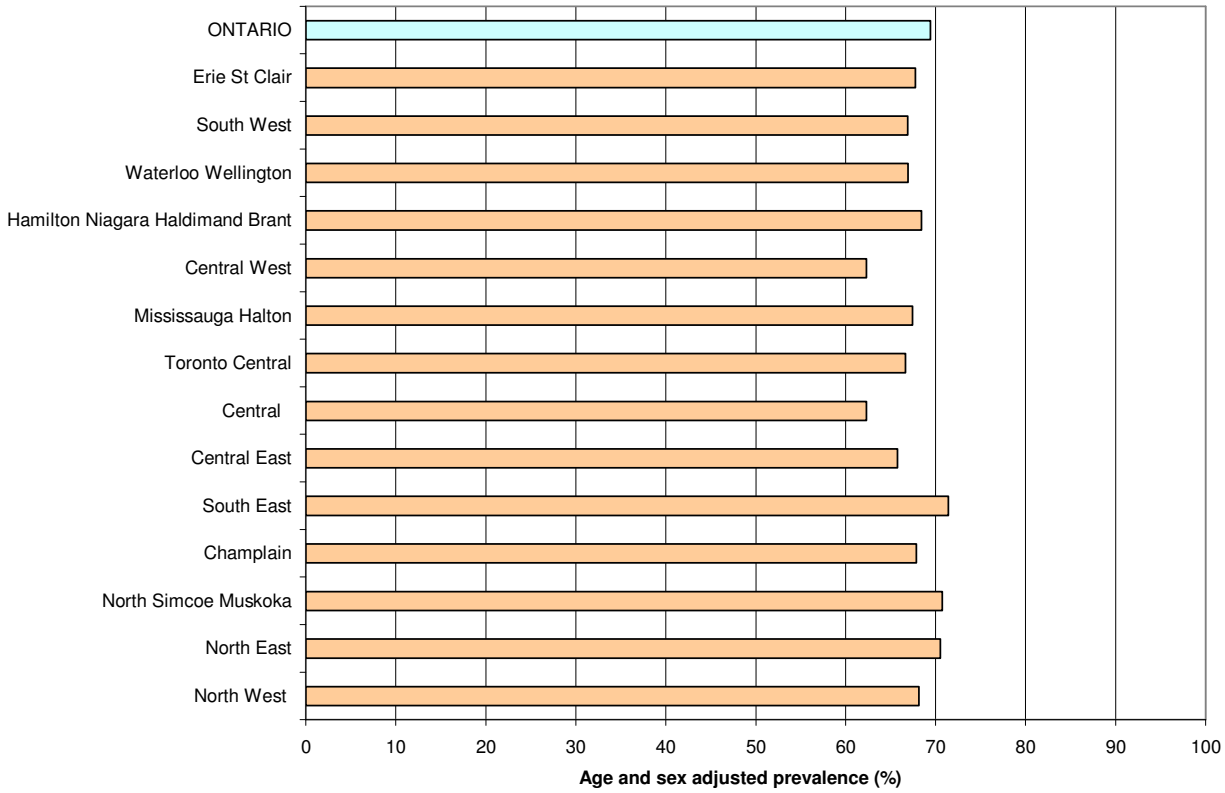
Figure 1: Utilisation of occupational therapy and physiotherapy services by Ontario and Local Health Integration Networks, 2003



Note: "at least one consultation with an occupational therapist" and "at least one consultation with a physiotherapist" are age and sex adjusted.
* Coefficient of variation for "at least one consultation for occupational therapy" ranges from 16.6% to 33.3% and should be interpreted with caution.
Data Sources: Canadian Community Health Survey, cycle 2.1 [2003], Statistics Canada, Master File, Research Data Centre, University of Toronto

Figure 1 compares at least one consultation with an OT and at least one consultation with a PT in the year 2003, by LHIN and for the province of Ontario. Values by LHIN have been age and sex adjusted. It is important to note that occupational therapy utilisation also includes consultation with a speech language pathologist or audiologist. It was not possible to extract only OT utilization based on data source limitations for this variable. Furthermore, these variables do not differentiate between consultations occurring in institutional or community settings. The overall utilisation for OT is 1.3% of the provincial population. The overall utilisation for PT is 7.6% of the provincial population. Across LHINs there is less OT utilisation compared to PT utilisation.

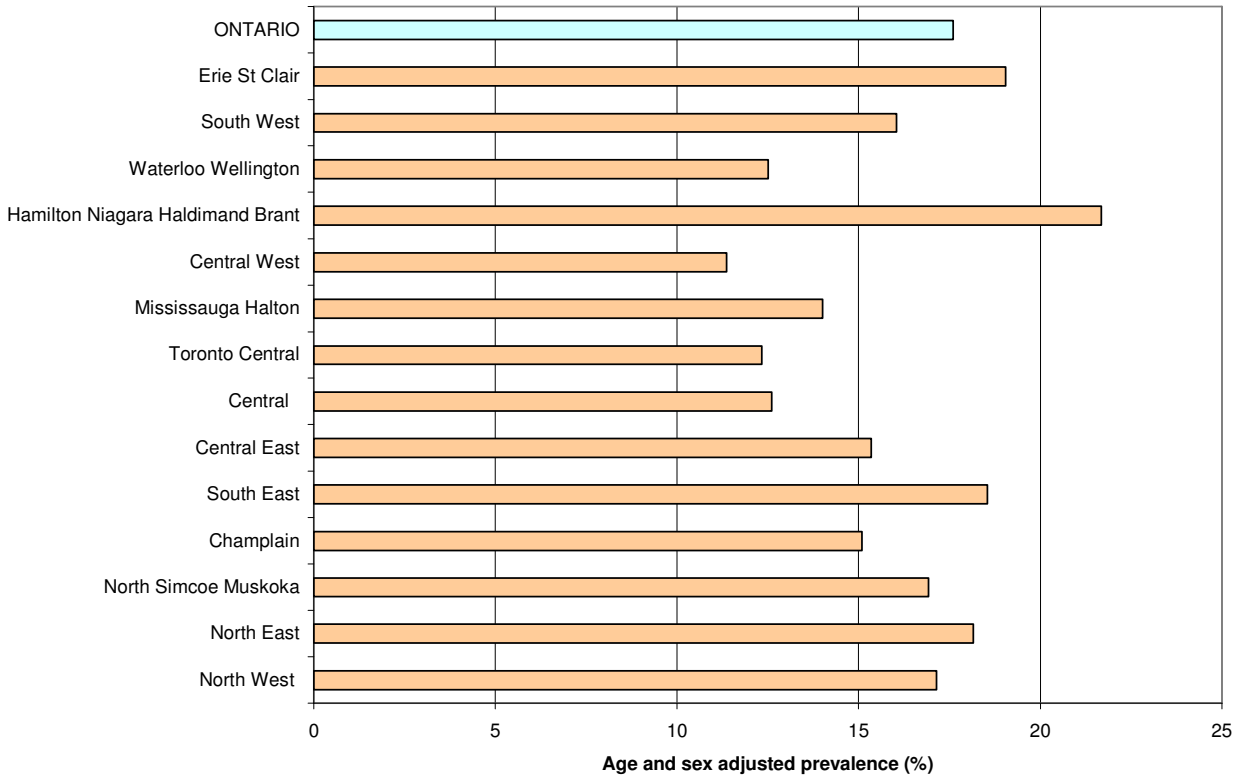
Figure 2: Prevalence of having at least one chronic condition by Ontario and Local Health Integration Networks, 2003



Data Sources: Canadian Community Health Survey, cycle 2.1 [2003], Statistics Canada, Master File, Research Data Centre, University of Toronto

Figure 2 presents the age and sex adjusted prevalence of having at least one chronic condition by LHIN and for Ontario. There is a uniform distribution across Ontario. For the province overall, 69.4% of the population report having at least one chronic condition. This ranges from 62.3% of the Central and Central West LHIN populations up to 71.4% of the South East LHIN population.

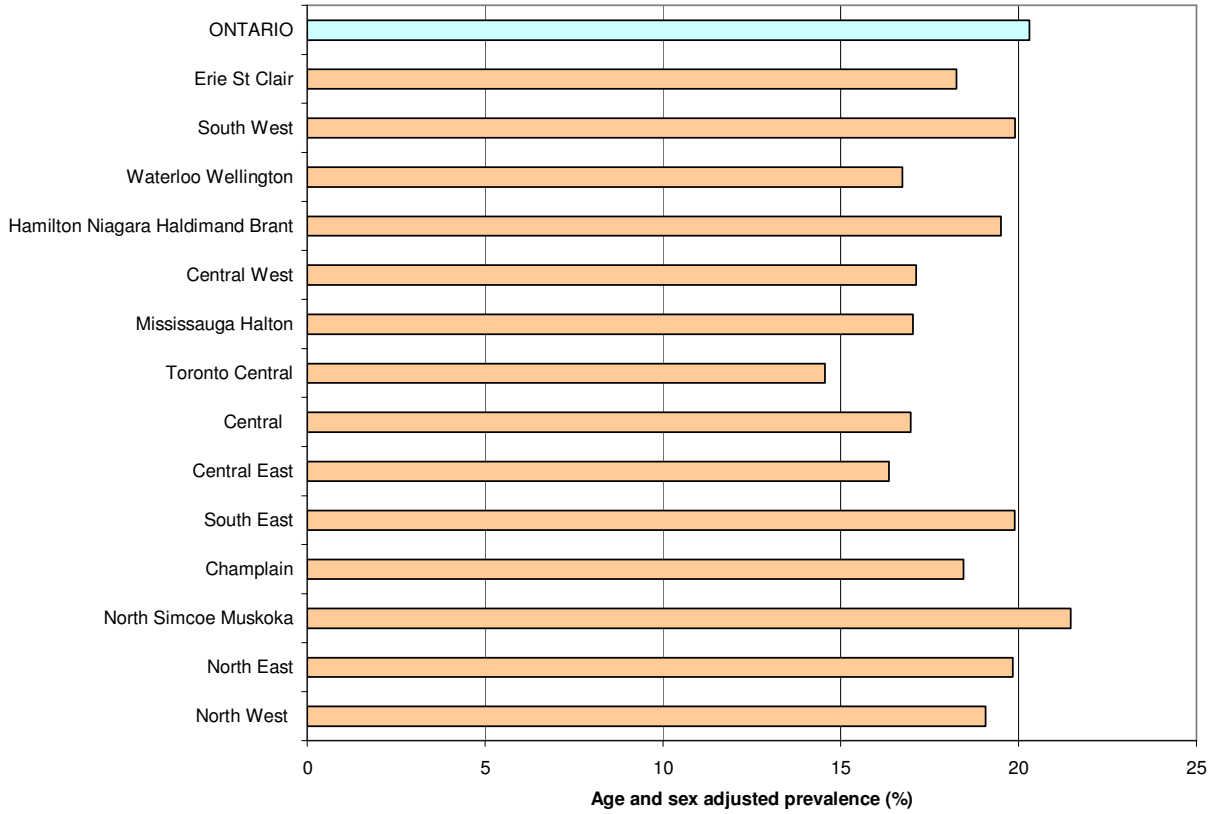
Figure 3: Prevalence of arthritis/rheumatism by Ontario and Local Health Integration Networks, 2003



Data Sources: Canadian Community Health Survey, cycle 2.1 [2003], Statistics Canada, Master File, Research Data Centre, University of Toronto

The age and sex adjusted prevalence of arthritis/rheumatism is presented in figure 3. The Ontario prevalence is 17.6% of the population. There is variability observed across LHINs with Central West LHIN having the lowest prevalence (11.4%) and Hamilton Niagara Haldimand Brant having the highest (21.7%).

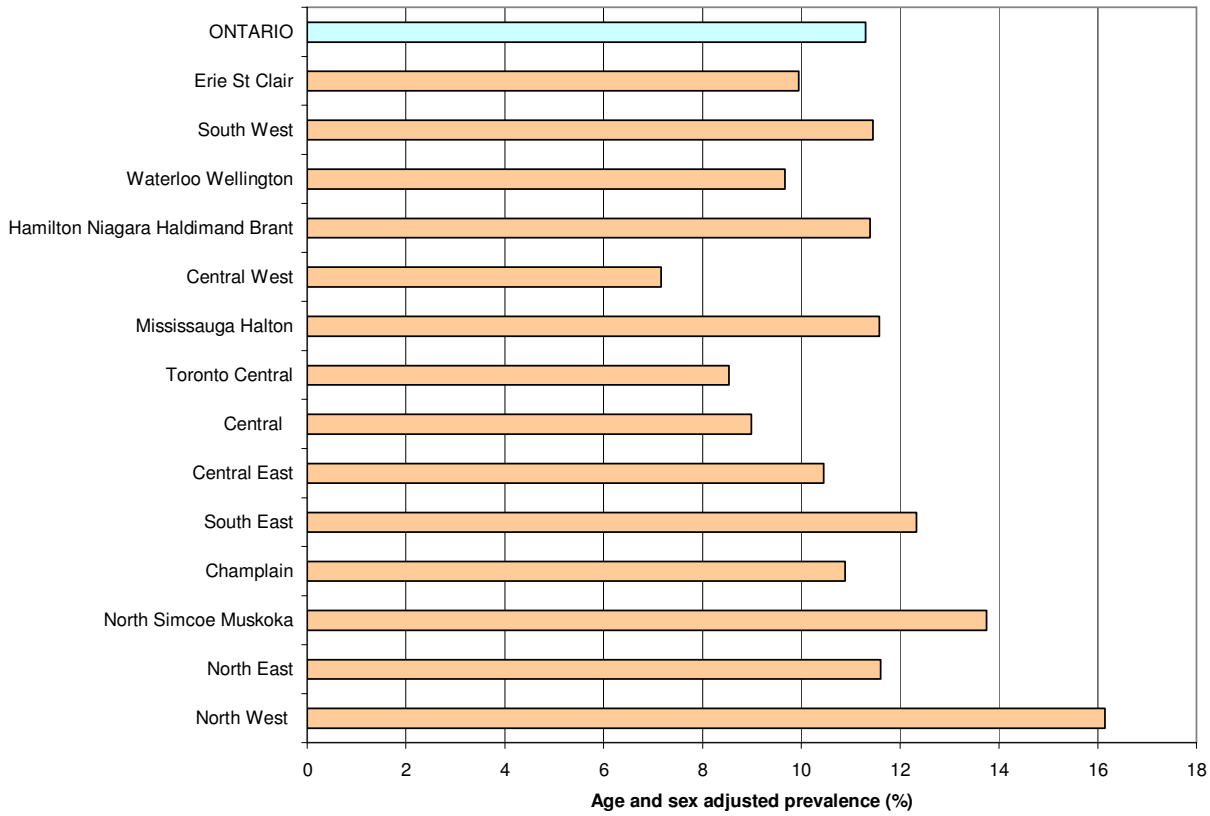
Figure 4: Prevalence of back problems (excluding arthritis and fibromyalgia) by Ontario and Local Health Integration Networks, 2003



Data Sources: Canadian Community Health Survey, cycle 2.1 [2003], Statistics Canada, Master File, Research Data Centre, University of Toronto

Figure 4 shows the age and sex adjusted prevalence of back problems (excluding arthritis and fibromyalgia). The Ontario prevalence is 20.3% of the provincial population. Toronto Central LHIN has the lowest prevalence of back problems at 14.6% and North Simcoe Muskoka LHIN has the highest prevalence at 21.5% of LHIN population.

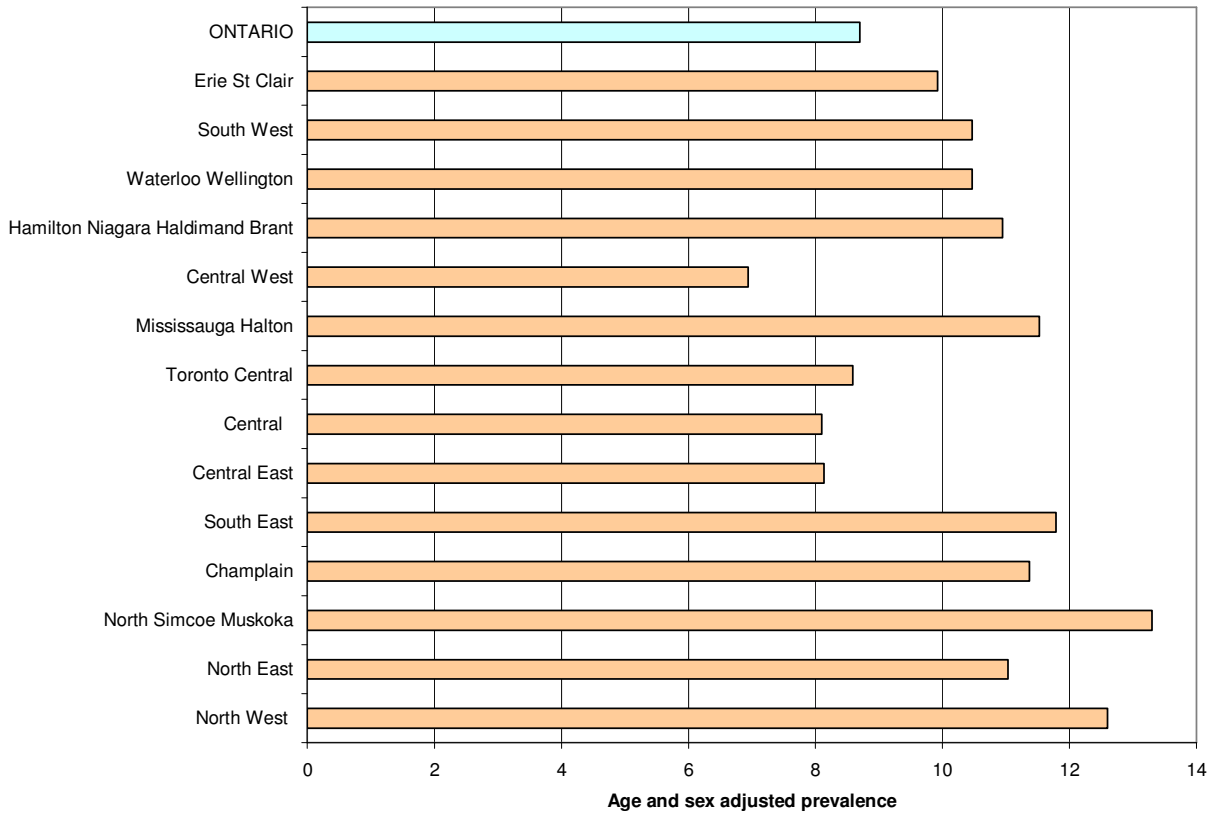
Figure 5: Prevalence of repetitive strain injury by Ontario and Local Health Integration Networks, 2003



Data Sources: Canadian Community Health Survey, cycle 2.1 [2003], Statistics Canada, Master File, Research Data Centre, University of Toronto

Figure 5 displays the age and sex adjusted prevalence of repetitive strain injury for Ontario and each LHIN. Just over 11 % (11.3%) of the provincial population reported having a repetitive strain injury in 2003. Variation across LHINs is observed with only 7.2% of the Central West LHIN population reporting repetitive strain injury and 16.1% of the North West LHIN reporting repetitive strain injury.

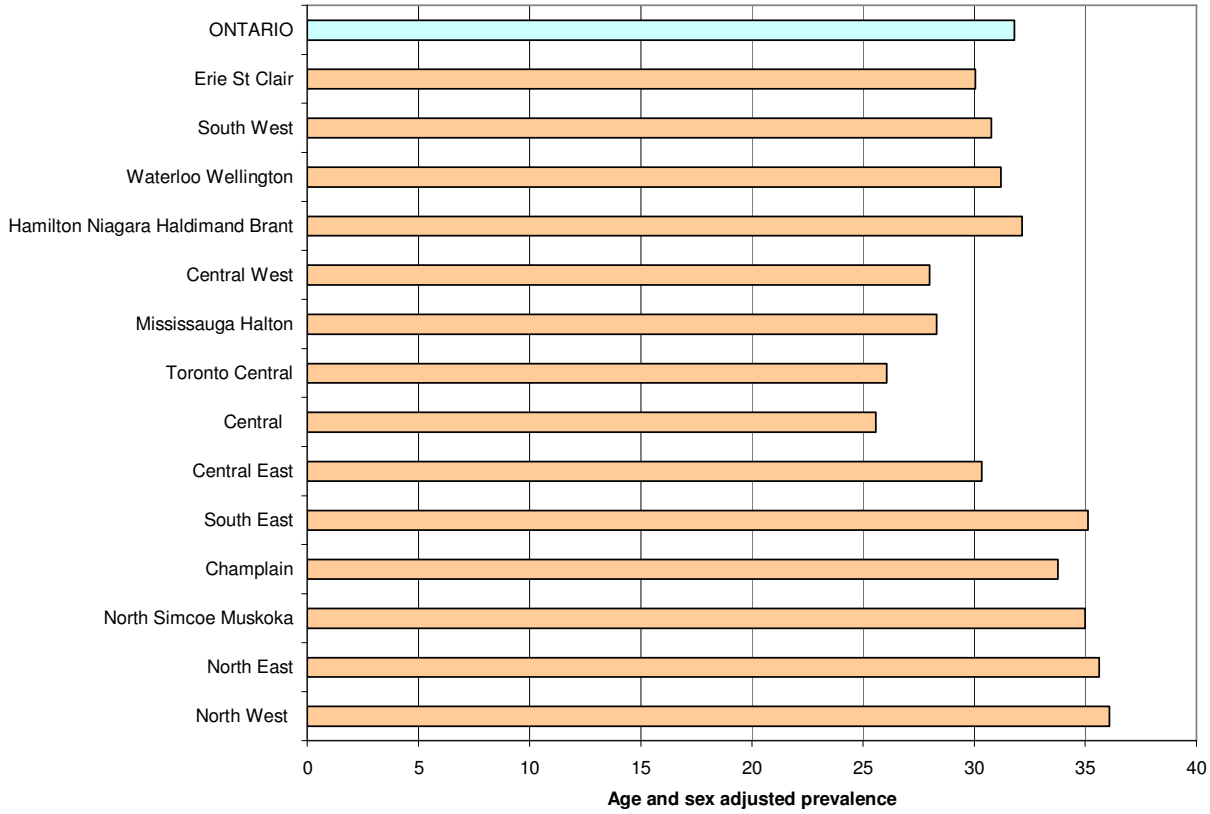
Figure 6: Prevalence of injury that may be attended to by a rehabilitation professional by Ontario and Local Health Integration Networks, 2003



Data Sources: Canadian Community Health Survey, cycle 2.1 [2003], Statistics Canada, Master File, Research Data Centre, University of Toronto

Figure 6 presents the age and sex adjusted prevalence of suffering an injury in 2003 that may be attended to by a rehabilitation professional. Almost 9% (8.7%) of the Ontario population reported such an injury. Central West had the lowest prevalence (6.9%) and North Simcoe Muskoka had the highest prevalence (13.3%).

Figure 7: Prevalence of activity and/or participation limitation by Ontario and Local Health Integration Networks, 2003



Data Sources: Canadian Community Health Survey, cycle 2.1 [2003], Statistics Canada, Master File, Research Data Centre, University of Toronto

Figure 7 presents the age and sex adjusted prevalence for activity and/or participation limitation by LHIN and for Ontario. Overall, 31.8% of the Ontario population reported having activity and/or participation limitations in 2003. The Central LHIN had the lowest prevalence of activity and participation limitation (25.6%) and North West had the greatest proportion of the population have an activity and participation limitation (36.1%).

5 WHAT IS THE CURRENT PROVISION FOR COMMUNITY REHABILITATION IN ONTARIO?

In 2006 there were approximately 4,000 occupational therapists registered for independent practice[7]. Map 2 shows the distribution of the rate of occupational therapy provision per 100,000 population by LHIN. The Ontario rate of provision is 31.5 OTs per 100,000. LHINs with higher than the provincial average include North West, Champlain, Hamilton Niagara Haldimand Brant, South West, Central and Toronto Central with the highest provision rate of 57.5 per 100,000. The lowest provision rate is found in the Central West LHIN with 14.0 OTs per 100,000. It is not possible to determine the proportion of OTs working in community settings due to current data collection processes by the OT regulatory college.

In 2006, there were approximately 5,500 PT registered for independent practice and working in the province of Ontario[8]. Map 3 illustrates the distribution of the rate of PT provision per 100,000 population by LHIN. The Ontario rate of provision is 43.4 PTs per 100,000 population. LHINs with a higher provision rate than the provincial average include South East, North Simcoe Muskoka, Waterloo Wellington, Hamilton Niagara Haldimand Brant, South West, North West, Champlain and Toronto Central, with the highest provision of 77.2 per 100,000. The lowest provision rate for PT is found in the Central West LHIN with 22.4 PTs per 100 000. It is not possible to determine the proportion of PTs working in community settings due to current data collection process by the PT regulatory college. Table 1 provides a summary of OT and PT availability by LHIN and for the province for the year 2006.

Table 1: Availability of occupational therapist and physiotherapists in Ontario, 2006

Local Health Integration Network	Population	Number of occupational therapists per 100,000 population	Number of physiotherapists per 100,000 population
Erie St Clair	643,205	18.8	26.5
South West	919,962	38	45.6
Waterloo Wellington	677,887	29	42.6
Hamilton Niagara Haldimand Brant	1,343,403	36.4	45.2
Central West	699,631	14	22.4
Mississauga Halton	100,8121	20.7	36
Toronto Central	1,150,938	57.5	77.2
Central	1,504,817	38.2	38.5
Central East	1,436,769	17.6	29.7
South East	478,892	33	44.7
Champlain	1,170,172	33.6	58.2
North Simcoe Muskoka	408,731	28.3	41
North East	570,777	24.8	35.6
North West	243,340	31.8	52
ONTARIO	**12,256,645**	**31.5**	**43.4**

Data Sources: 2003/04 Population Projects, Statistics Canada; College of Occupational Therapists of Ontario, 2006; College of Physiotherapists of Ontario, 2006

Table 2 provides a summary of community rehabilitation provision for the province of Ontario and each LHIN. The greatest number of community rehabilitation settings is found in the private sector with over twice as many (2.2 to 1) privately funded community OT clinics as publicly funded clinics. There is almost three times (2.9 to 1) the number of privately funded community PT clinical settings as there are publicly funded settings. The greatest number of publicly funded community rehabilitation services is found at hospital outpatient departments. It is evident that there are very few Community Health Centres offering community rehabilitation services across the province.

Table 2: Summary of Community Rehabilitation Settings in Ontario

Local Health Integration Network	Publicly Funded Settings						Privately Funded Settings	
	Community Health Centres		Hospital Outpatient Departments		Designated Physiotherapy Clinics	The Arthritis Society's AREP	Private Clinics	
Rehabilitation Discipline	**OT**	**PT**	**OT**	**PT**	**PT**	**OT or PT***	**OT**	**PT**
Erie St Clair	0	1	5	2	5	1	13	39
South West	0	0	14	25	4	12	28	66
Waterloo Wellington	0	0	2	8	3	4	21	56
Hamilton Niagara Haldimand Brant	1	1	9	13	17	4	50	97
Central West	0	0	2	4	3	2	7	52
Mississauga Halton	0	0	4	4	4	4	34	84
Toronto Central	1	1	13	13	18	3	59	112
Central	0	0	6	7	16	9	94	119
Central East	0	0	7	12	10	13	23	102
South East	1	1	4	6	2	10	16	34
Champlain	0	1	7	14	7	4	40	120
North Simcoe Muskoka	0	1	3	6	3	4	17	38
North East	0	0	18	25	2	6	12	33
North West	0	0	8	11	0	6	4	17
ONTARIO	**3**	**6**	**102**	**150**	**94**	**82**	**418**	**969**

* Based on the primary therapists model of care

Data Sources: ACREU, 2006; The Arthritis Society-Ontario, 2006; College of Occupational Therapists of Ontario, 2006; College of Physiotherapists of Ontario, 2006; Ontario Ministry of Long-Term Care (2005, 2006); Association of Ontario Health Centres, 2006

Map 3 illustrates the location of public and private community OT service location throughout the province of Ontario Map 4 illustrates the location of public and private community PT service location throughout the province of Ontario. The higher concentration of community rehabilitation is found in the more populated LHINs located in the southern region of the province.

6 RELATIONSHIP OF DEMAND AND PROVISION FOR COMMUNITY REHABILITATION IN ONTARIO

Figures 8 and 9 illustrate OT provision by utilisation and PT provision by utilistation respectively. Correlation analyses indicated a relationship between demand and provision across the province is not evident. LHINs with the highest proportions of OT or PT utilisation did not have the highest provision rates (i.e. number of OT/PT per 100 000 population). Similarly, the LHINs with the lowest utilisation did not have the lowest provision rates.

Figure 8: Ontario occupational therapy utilisation by OT provision rate for each LHIN

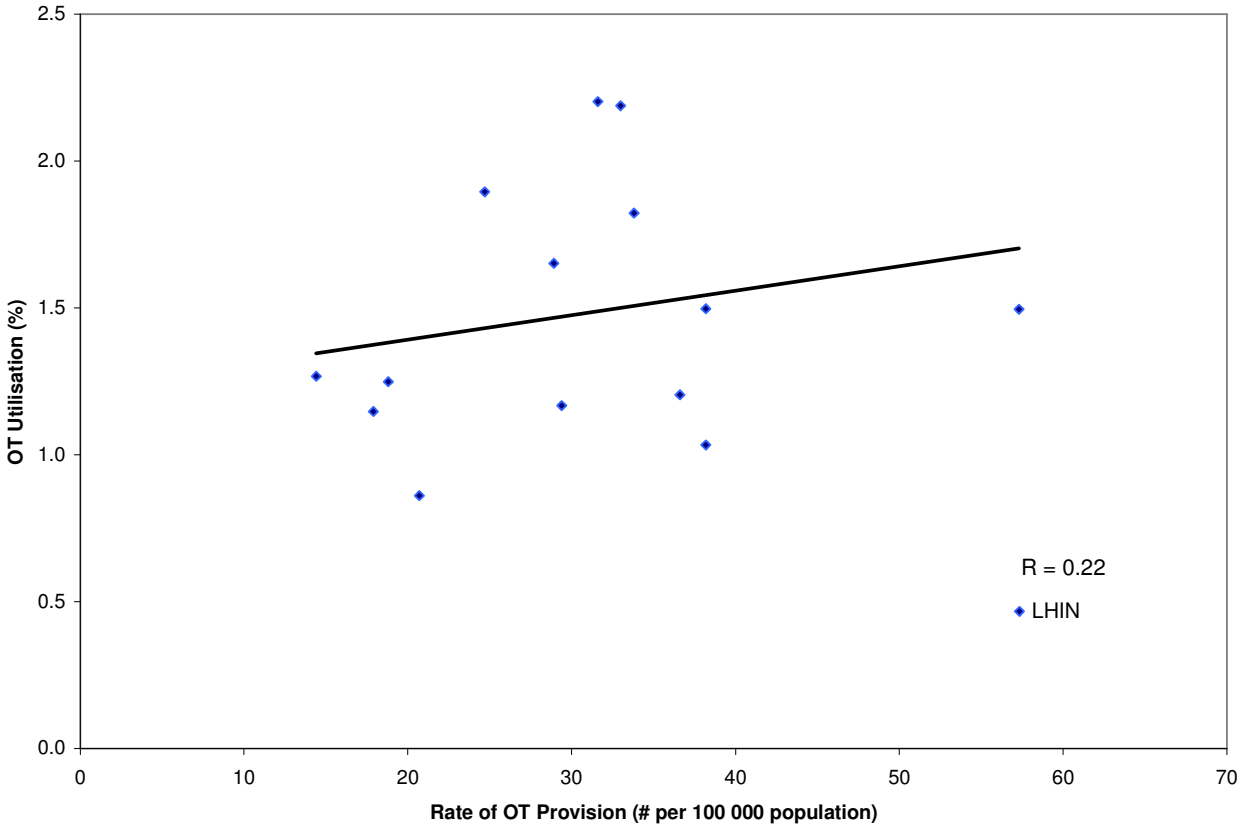
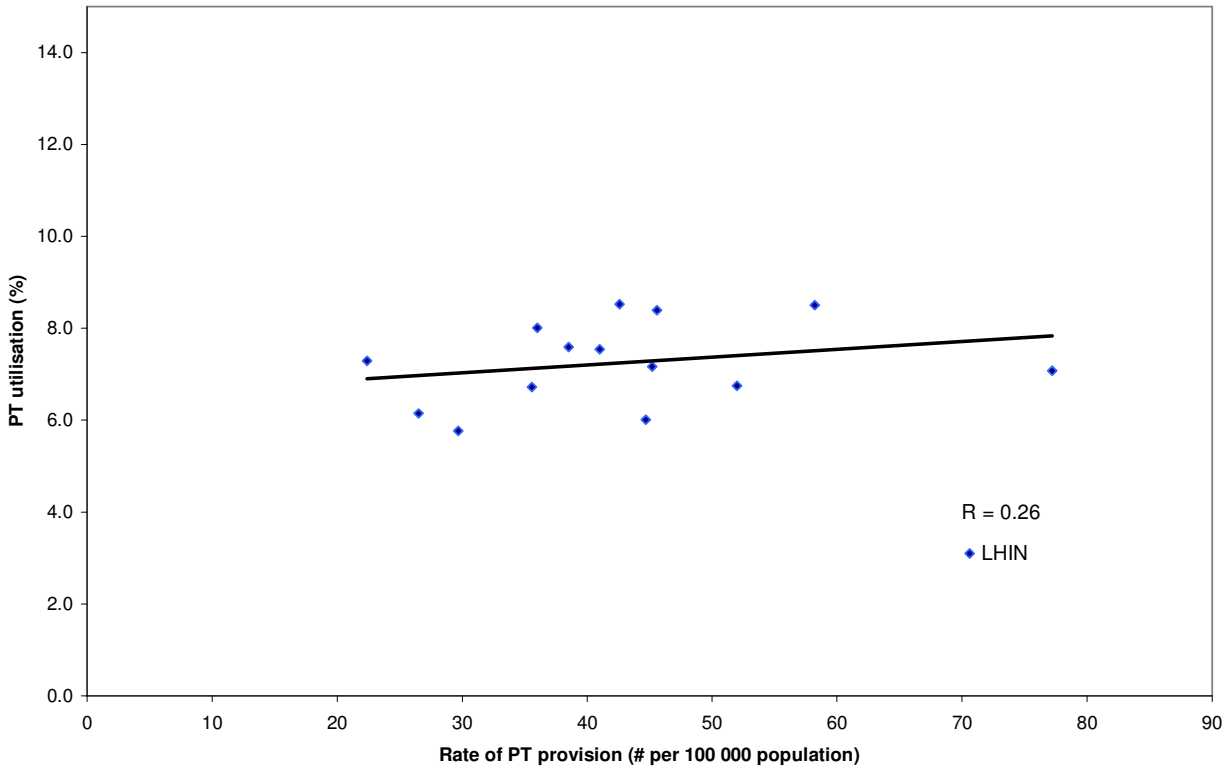


Figure 9: Ontario physiotherapy utilisation by PT provision rate for each LHIN

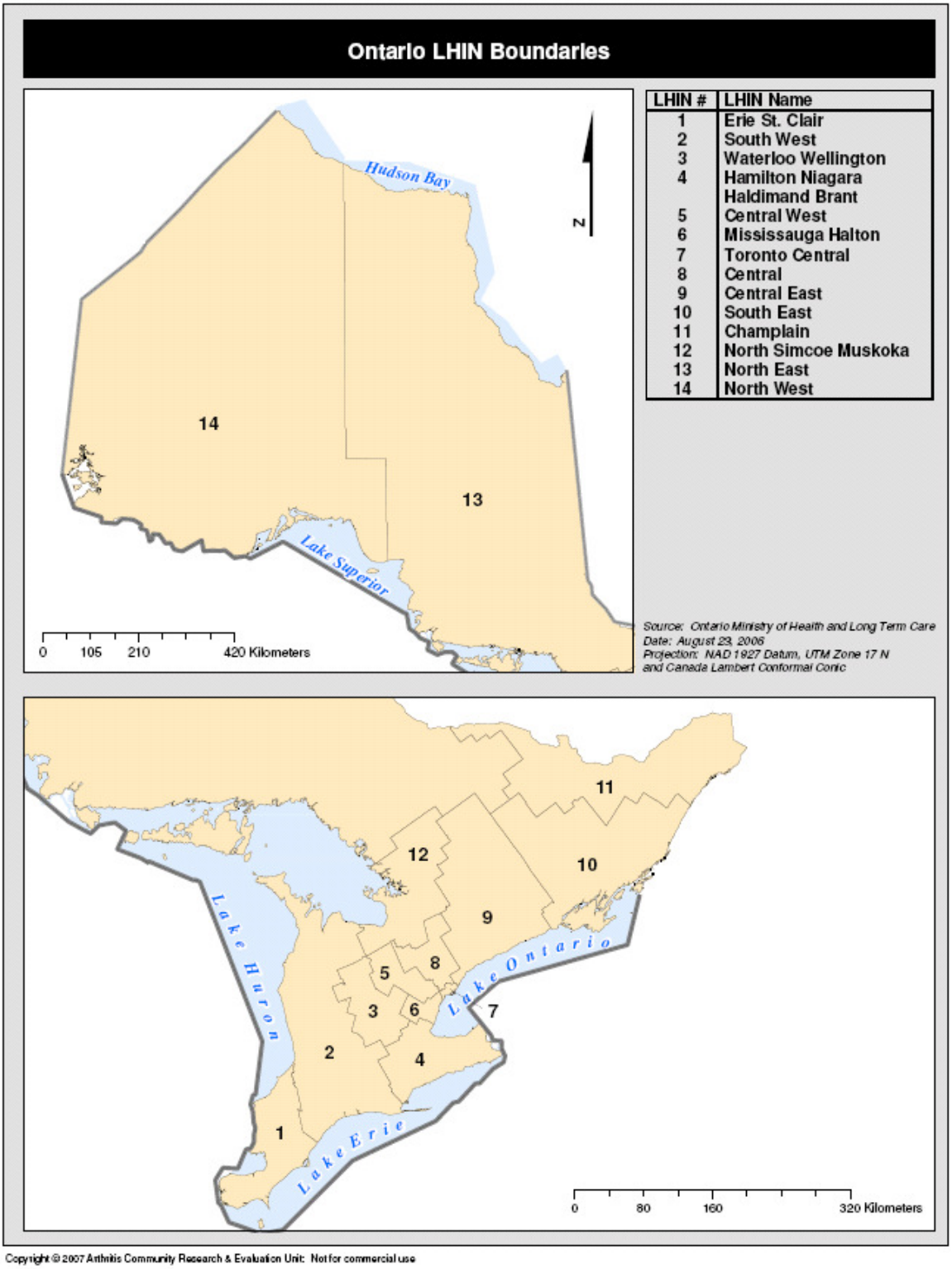


7 COMMUNITY REHABILITATION ACCESS IN ONTARIO

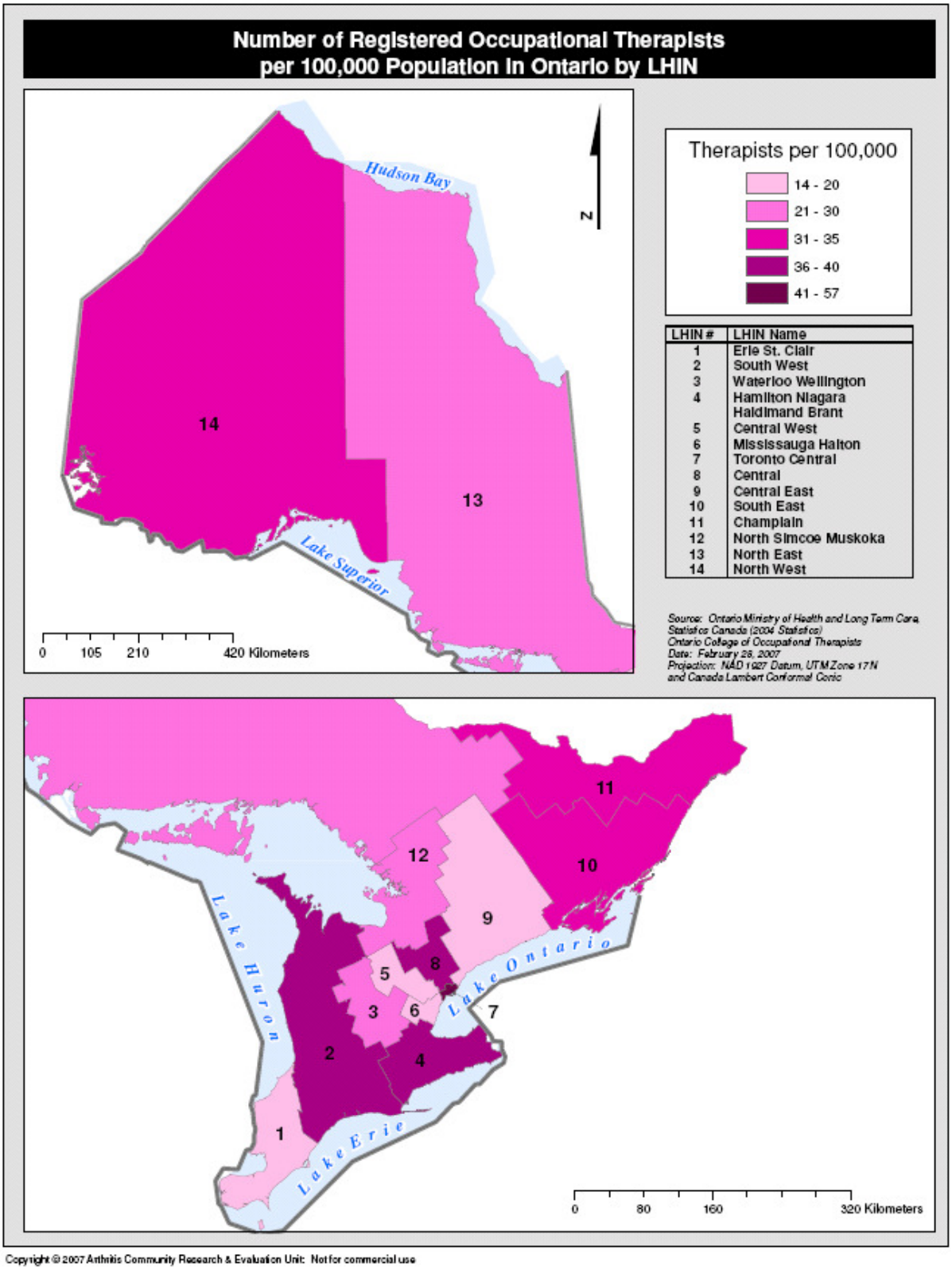
Access is a defining element of Canadian health care and is dependent on the availability of appropriate service that is delivered in a timely manner. Access to rehabilitation services across the province was examined based on wait times, hours of operation and the ratio of private to public clinics that provide community service. In December of 2005, the median wait time for publicly funded OT or PT services was 15 days. Approximately 70% of all clinics in Ontario providing community rehabilitation report having a wait time that ranges between 1 and 360 days, with the longest waits being at hospital outpatient PT departments for patients with a chronic musculoskeletal condition. Approximately 30% of all publicly funded community rehabilitation operate outside of typical business hours (Monday to Friday between 7am and 5pm). Lastly, for each publicly funded community clinic operating in the province of Ontario, there are 2.2 private community clinics offering OT and 2.9 private clinics offer PT services.

8 COMPENDIUM OF MAPS

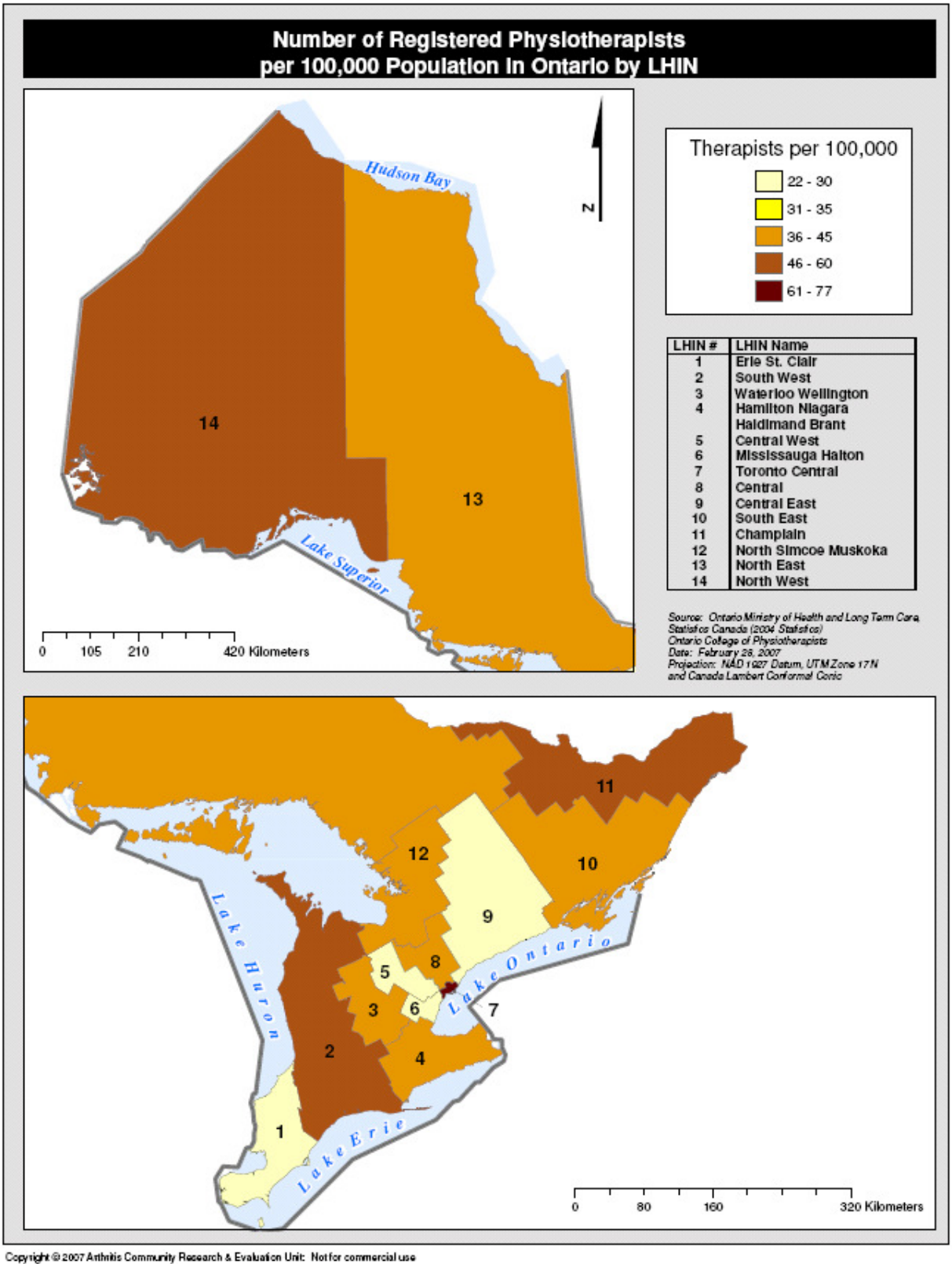
Map 1: Ontario LHIN boundaries.



Map 2: Number of registered occupational therapists in Ontario, 2006

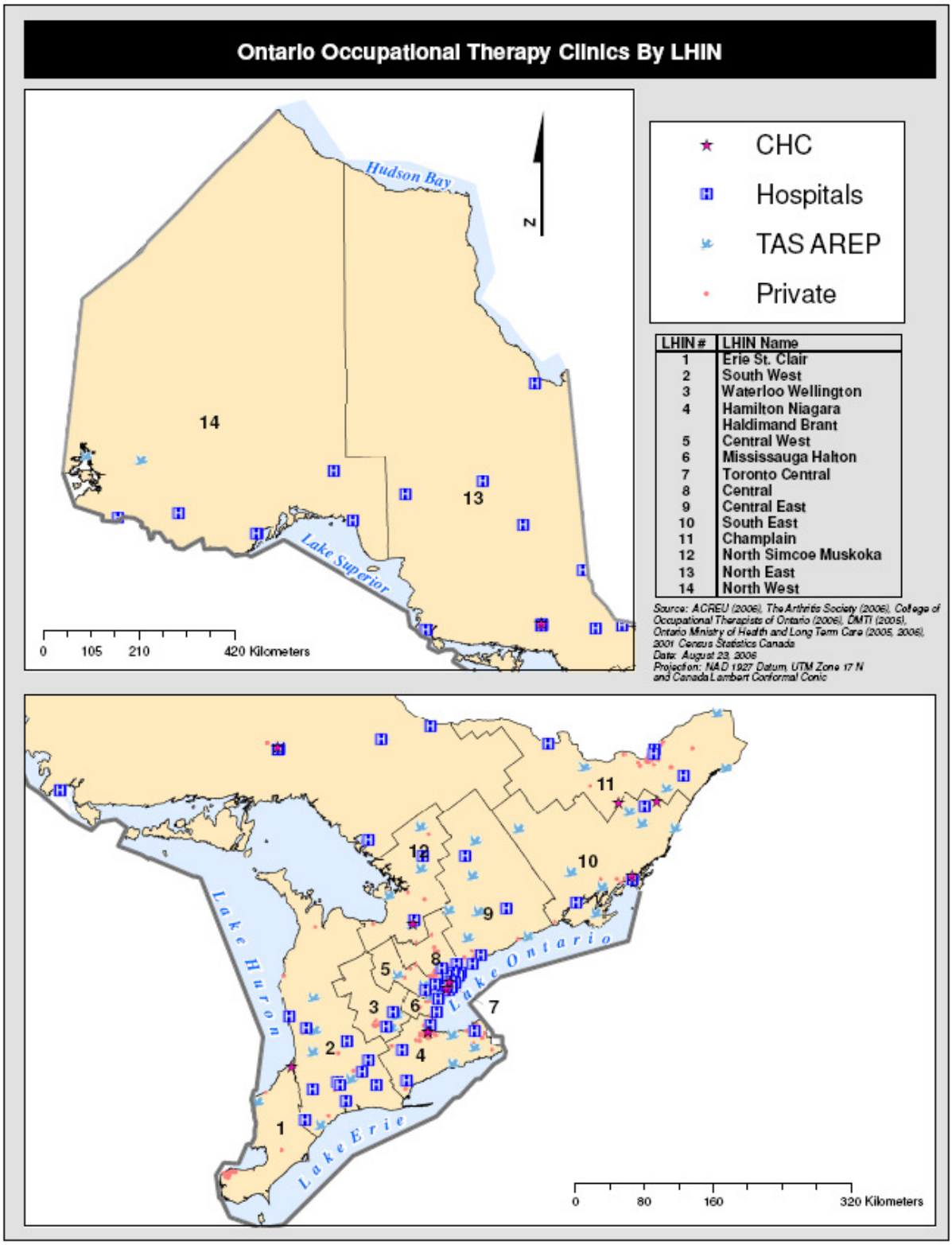


Map 3: Number of registered physiotherapists in Ontario, 2006



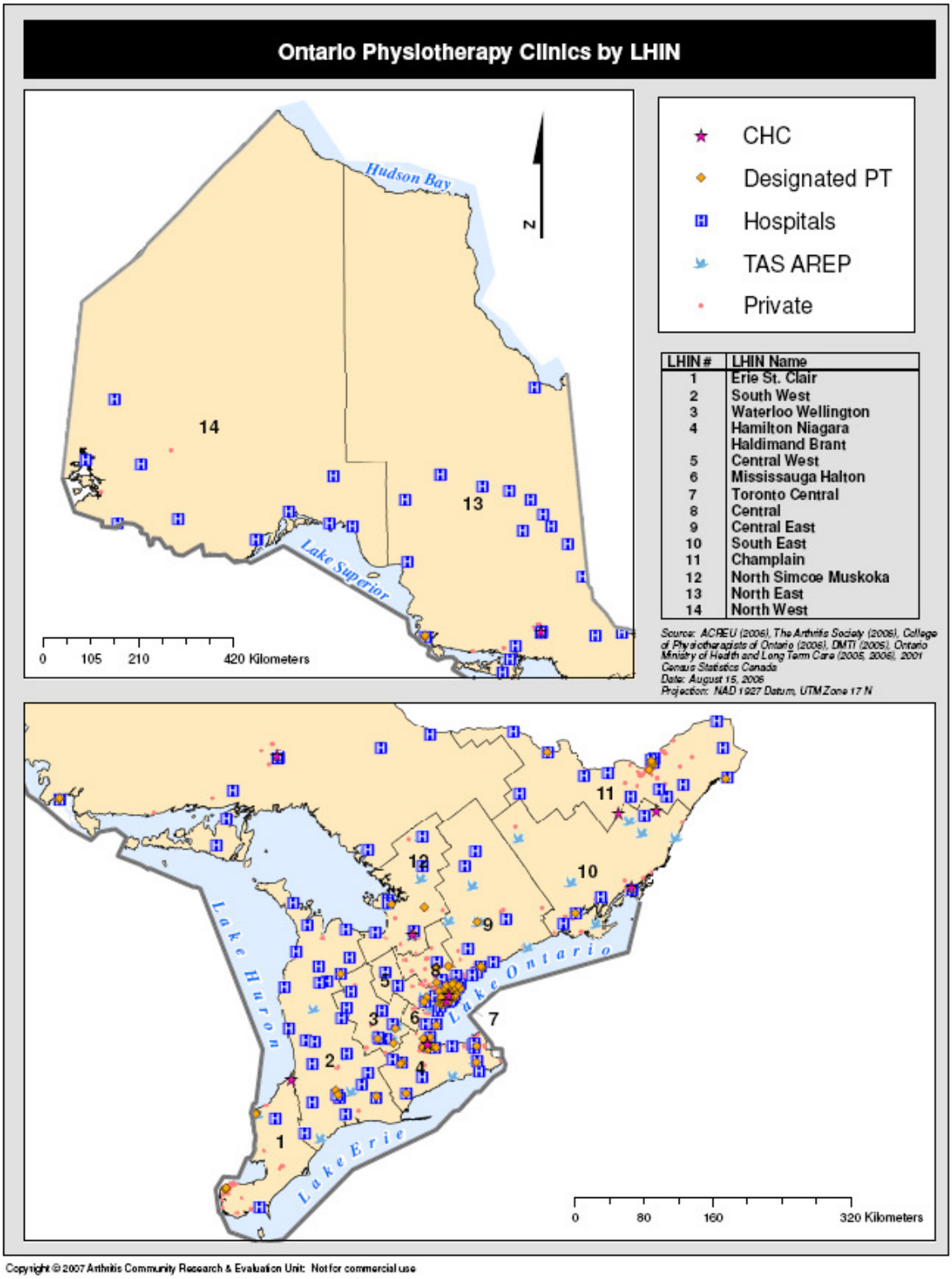
Map 4: Ontario community occupational therapy clinic location by LHIN

(Note for map interpretation: “CHC” refers to Community Health Centres; “TAS AREP” refers to the Arthritis Society Arthritis Rehabilitation and Education Program).



Map 5: Ontario community physiotherapy clinic location by LHIN

(Note for map interpretation: "CHC" refers to Community Health Centres; "TAS AREP" refers to the Arthritis Society Arthritis Rehabilitation and Education Program and "Designated PT" refers to Designated Physiotherapy Clinics).



9 CONCLUSIONS AND RECOMMENDATIONS

1. Demand and provision for community rehabilitation vary within and across LHINs. There is a higher concentration and provision of services in the southern and more populated LHINs that does not correlate with demand.

This report identified that there is no correlation between demand and provision across LHINs, indicating that demand for services does not necessarily reflect provision. This is problematic as demand for service is likely to grow, given the increasing shift of care from institutional based rehabilitation to rehabilitation occurring within the community. Furthermore, over 60% of the population report having at least one chronic condition across the province. Chronic disease places a significant demand on the health care system with diseases such as cardiovascular disease, diabetes, cancer, obesity and respiratory conditions accounting for 46% of the global burden of disease[9]. Some chronic conditions are more likely than others to be associated with disability (e.g. arthritis, musculoskeletal disorders, stroke) and therefore are more likely to require ongoing rehabilitation intervention to optimise a person's ability to function in the community. As care is increasingly shifted to the community in an attempt to reduce the pressure on hospitals by decreasing hospital lengths of stay, additional demand on community rehabilitation services has resulted[10]. Given the increasing prevalence of individuals with chronic diseases requiring rehabilitation and the progressive shift toward community care, it is foreseeable that an already overburdened health care system will be further challenged.

2. Wait times for rehabilitation and access to PT and OT are an issue for publicly funded settings

There are twice as many private OT clinics and almost three times as many private PT clinics than there are publicly funded OT and PT clinics. Wait times are an issue for publicly funded settings, especially hospital outpatient departments and especially for those with chronic musculoskeletal problems[11]. Furthermore, there are 54 Community Health Centers (CHCs) located throughout the province of Ontario[12], with only a small fraction of these offering any form of rehabilitation services. CHCs are a distinct model of primary health care delivery that incorporate the socioeconomic environment of the community, using a comprehensive approach to care that includes interdisciplinary teams and integration of services to meet the needs of clients[13]. The under-utilisation of these settings presents an opportunity to expand community rehabilitation and increase capacity. The CHC model offers a systems approach to organised primary health care, disease prevention and health promotion that is ideal for chronic disease management of which greater than 60% of Ontario and LHIN populations report having. This makes CHCs well positioned to take on a portion of existing demand for community rehabilitation. Since CHCs have been providing primary care for more than 30 years, the model is well established to meet the needs of the community and can adapt its services accordingly[14]. It is encouraging that the Ontario government recently announced its Community Health Centres Expansion Plan which will support 22 new CHCs and 17 new satellite CHCs in 39 Ontario communities by 2007-08[15]. However, it is currently unknown what services will be provided out of these new clinics and if there are plans to expand services in existing CHCs.

3. High quality data for community rehabilitation is lacking

Outlined in the Technical Summary accompanying this report are the many limitations associated with the data used to produce the community rehabilitation profiles. However in addition to issues pertaining to data quality, is the fact that much of the data to describe community rehabilitation in Ontario does not exist. As such, arbitrary decisions regarding data indicators had to be made when creating the profiles. For example, variables used to indicate demand in this report were chosen based on data sources that could be used to represent community rehabilitation demand at the LHIN level. This restricted variables to those collected in the Canadian Community Health Survey. Another example of the issues pertaining to data quality centres around the fact that current data collection processes for community rehabilitation provision do not differentiate between inpatient and community rehabilitation settings. Furthermore, reliable data for wait times, hours of operation and staffing allocation at the LHIN level is lacking.

The reorganisation of health care delivery across Ontario has created a new role for the Ministry of Health and Long Term Care. The LHINs will be responsible for integration and implementation of health care delivery and the Ministry's role will focus on "stewardship, planning and guiding resources to bring value to the health care system" [16]. The Ministry will have four new divisions which include Health System Information Management; Health System Strategy; Health System Investment and Funding; and Health System Accountability and Performance. Critical to the establishments of quality data management will be Health System Information Management that is organized to collect research and evidence for development of health system strategies[17]. The stewardship role for the Ministry of Health and Long Term Care could allow for the collection of inclusive high quality data regarding community rehabilitation that is standardized across LHINs.

9.1 RECOMMENDATIONS

In order to better understand demand and provision for community rehabilitation services in Ontario, and the relationship between the two, the following is recommended:

1) Timely dissemination of these profiles to each LHIN's health planning boards in order to inform and enhance further planning, implementation and evaluation for health system integration priorities that have been established across all Ontario LHINs. This will help the LHINs to achieve an integrated health care system and improved health for the LHIN population and the province overall.

2) Explore Community Health Centres and other community interdisciplinary care delivery models as potential cost-effective options to expand publicly funded community rehabilitation services

3) Development of reliable and valid indicators of demand for community rehabilitation services is required if we are to understand the health care needs of Ontario residents.

4) Development and harmonization of reliable and valid community rehabilitation provision data is required in order to establish an accurate reflection of the status of community rehabilitation across the province.

In conclusion, this compilation of profiles provides one of the first overviews of demand and provision for community rehabilitation in the province of Ontario and each of its LHINs. It also provides baseline data upon which to build an accurate reflection of community rehabilitation services. As the Ontario population evolves, it is important that health systems also evolve, in order to ensure accessible and appropriate care by the right health professional, in the right place and at the right time.

10 GLOSSARY OF TERMS

Choropleth map
A thematic map that displays a quantitative attribute using ordinal classes. Areas are shaded according to their value and a range of shading classes[18].

Community-Based Rehabilitation
In this report, community-based rehabilitation settings include publicly and privately funded settings where rehabilitation can be accessed by community dwelling individuals. Included are private clinics, Designated Physiotherapy Clinics (formerly known as Schedule 5 Physiotherapy Clinics), Community Care Access Centres, Community Health Centres, Hospital Outpatient Rehabilitation Departments and The Arthritis Society Consultation and Rehabilitation Services.

Community Health Centres (CHC)
Community Health Centres are delivered through publicly funded (MOH-LTC), community governed, not for profit organisations that provide primary health care, health promotion and community development services, using multi-disciplinary teams of health providers. These teams sometimes include occupational therapists and physiotherapists. Services are designed to meet the specific needs of the community surrounding the CHC. In many communities, CHCs provide their programs and services for people with difficulties accessing the full range of primary health-care services[12].

Demand
The potential need or desire for community rehabilitation services and is based on the general population distribution (all ages), the population distribution age 65 years and older, average annual household income, occupational therapy and physiotherapy utilisation, activity and participation limitation, as well as key health variables that may be indicative of demand for community rehabilitation services.

Designated Physiotherapy Clinics
Formerly known as Schedule 5 Ontario Health Insurance Plan (OHIP) Physiotherapy Clinics, these clinics are funded by the Ontario Ministry of Health and Long-Term Care through OHIP. In order to be eligible for this service, one must meet at least one of the following conditions: 1) be either under the age of 20 or age 65 and over; 2) a resident of a long-term care home at any age; 3) requiring physiotherapy services in home or after being hospitalised at any age, or, 4) a participant of the Ontario Disability Support Program, receiving Family Benefits and Ontario Works at any age[19].

Dissemination Area (DA)
A dissemination area is a small, relatively stable geographic unit composed of one or more blocks. It is the smallest standard geographic area for which all census data are disseminated. DAs cover all the territory of Canada. Small area composed of one or more neighbouring blocks, with a population of 400 to 700 persons. All of Canada is divided into DAs[20].

Hospital Outpatient Rehabilitation Departments
Many hospitals offer outpatient occupational therapy and/or physiotherapy services. These services are usually funded through the hospital's global budget. However a few clinics

throughout Ontario hospitals exist as for-profit business entities or have contracted services to external providers.

Local Health Integration Network (LHINs)
LHINs are 14 local entities designed to plan, integrate and fund local health services, including hospitals, community care access centres, home care, long-term care and mental health within specific geographic areas[21].

Occupational Therapy (OT)
OTs are health professionals who help people or groups of people of all ages assume or reassume the skills they need for the job of living. OTs work with clients to help identify barriers to meaningful occupations (self care, work and leisure). While enabling clients to change these barriers, occupational therapists fulfill the roles of therapist, educator, counsellor, case manager, resource developer, policy analyst and advocate[4].

Physiotherapy or Physical Therapy (PT)
PTs are first contact, autonomous, client-focused health professionals trained to: improve and maintain functional independence and physical performance; prevent and manage pain, physical impairments, disabilities and limits to participation; and promote fitness, health and wellness[5].

Private Funding
Private funding is derived purely from private sources and are not regulated by the provincial government. Some examples are private third party insurance such as casualty or extended health coverage and out-of-pocket payments directly from the client or their family. In some cases programs are funded through private sources, but the fee structure is regulated in some way by the provincial government. Examples are the Workplace Safety & Insurance Board (WSIB) and the Motor Vehicle Accident (MVA) insurance.

Provision
The availability of community occupational therapy services or physiotherapy services and is based on: 1) the number of therapists for every 100, 000 people living in the LHIN; 2) the number of clinical settings providing community rehabilitation services, and, 3) the full time equivalent staff allocation at community rehabilitation settings.

Public Funding
Public sources of funding are finances derived purely from federal, provincial or municipal governments. In Ontario, public sources for funding rehabilitation services include (but are not limited to) global budgets provided to hospitals and institutions, Community Care Access Centres (CCAC), and direct funding from the Ministry of Health and Long-Term Care.

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

The Arthritis Society Arthritis Rehabilitation and Education Program

The Arthritis Society Arthritis Rehabilitation and Education Program is a specialised program of The Arthritis Society where occupational therapists, physical therapists and social workers, who work throughout the province of Ontario and have advanced training in the assessment and management of arthritis. Patients may self-refer or be referred by a physician. Service is provided through clinics or if indicated, home visits can be arranged. This program is covered by the Ontario Health Insurance Plan[22].

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