A PROFILE OF COMMUNITY REHABILITATION

HAMILTON NIAGARA HALDIMAND BRANT LOCAL HEALTH INTEGRATION NETWORK

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FACT SHEET

OCCUPATIONAL THERAPY

• Occupational therapy\(^1\) (OT) utilisation was reported by 1.3% of the LHIN population in 2003 for either inpatient or community OT services.
• In 2006, there were 36.4 registered OTs for every 100,000 people living in the Hamilton Niagara Haldimand Brant LHIN. This provision is 17% greater than the overall provincial rate.
• The highest concentration of publicly and privately funded community occupational therapy is located in Burlington, Hamilton and St. Catherines.
• There are 50 private community OT clinics located throughout the Hamilton Niagara Haldimand Brant LHIN.

PHYSIOTHERAPY

• 7.8% of the LHIN population consulted at least once with a physiotherapist (PT) in 2003 for either inpatient or community PT services.
• The availability of PTs in 2006 was approximately 45 PTs per 100,000 population, which is slightly greater than the Ontario provision rate.
• The greatest number of staff allocation for community rehabilitation services is at hospital outpatient departments (PT) and at Designated Physiotherapy Clinics.
• The highest concentration of publicly and privately funded PT service is located in Hamilton, Burlington, and St. Catherines.
• There are 97 private community PT clinics located throughout the Hamilton Niagara Haldimand Brant LHIN.

COMMUNITY REHABILITATION ACCESS

• Median wait times for publicly funded community OT or PT is 0 days, which is less than the median wait time for the province.
• There is over three times the number of private OT clinics for every public OT clinic.
• The ratio of private to public clinic availability for PT is about the same as that for the province, with approximately twice the availability of private clinics than that of publicly funded clinics.
• There are no community OT services in the town of Grimbsy.
• There are limited publicly funded options for community rehabilitation in the south west region of the LHIN for those who do not qualify for home based care.

\(^1\) This value includes at least one consultation with a speech language pathologist, audiologist or occupational therapist.
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 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 Local Health Integrated Networks and the Ministry of Health and Long Term Care regarding the status of local health service provision and demand 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, as well as, 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 the profiles and its limitations.

1.2 STRUCTURE

This report is organised into five sections:

- **INTRODUCTION:** This section provides a brief background of the Local Health Integration Network 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 Hamilton Niagara Haldimand Brant LHIN. The purpose and objectives of this report are presented.

- **THE PROFILE:** The second section presents the profile for community rehabilitation in the Hamilton Niagara Haldimand Brant LHIN and is divided into the following subsections:
  - **Health System Integration Priorities:** The Health System Integration Priorities for the Hamilton Niagara Haldimand Brant LHIN are presented in this section in order to provide context in which community rehabilitation initiatives may be relevant to health planning initiatives specific to the region.

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2 The boundaries of the 14 LHINs are presented in Map 1.
• **Demand:** This subsection describes the demand for rehabilitation services for the LHIN. 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 aged 65 years and older, average annual household income, occupational therapy (OT) and physiotherapy (PT) utilisation, activity and participation limitation, as well as key health variables that may be indicative of demand for community rehabilitation services.

• **Provision:** This subsection describes the current provision for rehabilitation services for the LHIN. For the purpose 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 Hamilton Niagara Haldimand Brant LHIN; 2) the number of clinical settings providing community rehabilitation services, and, 3) the full time equivalent staff allocation at community rehabilitation settings.

• **Access:** This subsection describes access to rehabilitation services and is based on geographic location, method of funding (public vs. privately funded services), hours of operation and the wait times for service.

• **Geographic distribution of community occupational therapy:** This subsection consists of three maps that pertain to *community occupational therapy services* of which clinic location is overlayed with population distribution (Map 2); distribution of the population age 65 years and older (Map 3); and, distribution of average annual household income (Map 4). *Please note that “TAS Rehab Clinics” refers to The Arthritis Society Rehabilitation and Education Program clinic location, and “CHC” refers to Community Health Centres”*

• **Geographic distribution of community physiotherapy:** The final subsection consists of three maps that pertain to *community physiotherapy services* of which clinic location is overlayed with population distribution (Map 5); distribution of the population age 65 years and older (Map 6); and, distribution of average annual household income (Map 7). *Please note that “TAS Rehab Clinics” refers to The Arthritis Society Rehabilitation and Education Program clinic location; “CHC” refers to Community Health Centres”, and, “DPC” refers to Designated Physiotherapy Clinics.*

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

**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. 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. 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. 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. 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. 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. 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 pertaining to 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 occupational therapy (OT) services and physiotherapy (PT) services and is based on the general population distribution (all ages), the population distribution aged 65 years and older, 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  THE PROFILE

3.1 HEALTH SYSTEM INTEGRATION PRIORITIES

Through the process of community engagement and information integration, the following health integration system priorities were established for the Hamilton Niagara Haldimand Brant LHIN in the fall of 2006:

1. Engage and learn from the community.
2. Promote healthy lifestyles.
3. Enhance access to child and youth services.
4. Assist seniors and persons with disabilities to live independently.
5. Provide support for persons with mental health and addiction issues.
6. Enhance care and support for elderly persons.
7. Improve quality of care at the end of life.
8. Develop an electronic health information system.
9. Encourage collaboration among policy makers to promote healthy communities.
10. Continually monitor and improve health services.
11. Promote accountability among community and service providers.

Community rehabilitation is integral to all of the above planning priorities. It is anticipated that the following community rehabilitation profile will inform and enhance further planning, implementation and evaluation for the above priorities. This will help to achieve an integrated health care system and improved health for the residents of the Hamilton Niagara Haldimand Brant LHIN.

3.2 WHAT IS THE CURRENT DEMAND FOR COMMUNITY REHABILITATION IN THE HAMILTON NIAGARA HALDIMAND BRANT LHIN?

Hamilton Niagara Haldimand Brant LHIN is home to approximately 1.3 million residents, accounting for 11% of the provincial population. According to 2004 census estimates, 14.6% of the Hamilton Niagara Haldimand Brant population is 65 years and older, representing a higher proportion of seniors living in this LHIN compared to the province.
Figure 1 presents OT and PT utilisation for the Hamilton Niagara Haldimand Brant LHIN. OT utilisation was reported by 1.3% of the LHIN population in 2003, compared to 7.8% of the LHIN population having consulted at least once with a PT in 2003. When these figures are compared to the province, the Hamilton Niagara Haldimand Brant LHIN has the same proportion of community rehabilitation utilisation as Ontario.

**Figure 1: Occupational Therapy* and Physiotherapy Utilisation for the Hamilton Niagara Haldimand Brant LHIN**

* This value includes at least one consultation with a speech language pathologist, audiologist or occupational therapist.
Figure 2 presents selected conditions that may indicate demand for rehabilitation services. Hamilton Niagara Haldimand Brant has significantly greater prevalence than the province for a number of conditions that include: having at least one chronic condition, back problems (excluding arthritis and fibromyalgia), arthritis/rheumatism, and, having activity and/or participation limitations.

Figure 2: Community Rehabilitation Demand for the Hamilton Niagara Haldimand Brant LHIN

* Significantly different from provincial average based on assessment of 95% confidence intervals
3.3 WHAT IS THE CURRENT PROVISION FOR COMMUNITY REHABILITATION IN THE HAMILTON NIAGARA HADILMAND BRANT LHIN?

Table 1 compares health human resource rates for community OT and PT between the Hamilton Niagara Haldimand Brant LHIN and Ontario. In 2006, there were 36.4 registered OTs for every 100,000 people living in the Hamilton Niagara Haldimand Brant LHIN. This provision is 17% greater than the overall provincial rate. The availability of physiotherapists in 2006 was approximately 45 PTs per 100,000 population, which is slightly greater than the Ontario provision rate. It is not possible to determine the proportion of either OTs or PTs working in community settings due to current data collection processes by their respective regulatory colleges.

Table 1: Hamilton Niagara Haldimand Brant LHIN community rehabilitation human health resource provision

<table>
<thead>
<tr>
<th>Health Human Resources</th>
<th>LHIN 4 – Hamilton Niagara Haldimand Brant</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># per 100 000 population§</td>
<td>Provision Ratio*</td>
</tr>
<tr>
<td>Occupational therapists†</td>
<td>36.4</td>
<td>1.17</td>
</tr>
<tr>
<td>Physiotherapists‡</td>
<td>45.2</td>
<td>1.04</td>
</tr>
</tbody>
</table>

*Provision Ratio=# per 100,000 population in each LHIN/# of per 100,000 population in Ontario
Data Sources: †The College of Occupational Therapists of Ontario; ‡The College of Physiotherapists of Ontario; § 2001 Census (Statistics Canada)

Table 2 describes the number of community rehabilitation settings and the average number of full time equivalent (FTE) OT and PT staff per clinic in the Hamilton Niagara Haldimand Brant LHIN. Based on the available data, the greatest staff allocation for community rehabilitation services is at hospital outpatient departments (PT) and at Designated Physiotherapy Clinics. Average FTE allocation for OT service provision offered out of hospital outpatient departments and private community OT and PT clinics cannot be assessed due to insufficient and unavailable data.

Table 2: Hamilton Niagara Haldimand Brant LHIN community rehabilitation provision

<table>
<thead>
<tr>
<th>Community Rehabilitation Settings</th>
<th>Occupational Therapy</th>
<th>Physiotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of clinics</td>
<td>Average number of FTEs/clinic</td>
</tr>
<tr>
<td>Arthritis Rehabilitation and Education Program Clinics (TAS AREP)†</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td>Community Health Centres (CHC)‡</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Designated Physiotherapy Clinics (DPC)*</td>
<td>Not Applicable</td>
<td>17</td>
</tr>
<tr>
<td>Hospital Outpatient Department (OPD)*</td>
<td>9</td>
<td>…</td>
</tr>
<tr>
<td>Private Clinics</td>
<td>50</td>
<td>…</td>
</tr>
</tbody>
</table>

*Estimates derived from the Ontario Community Rehabilitation Wait Time Survey (ACREU)
Data Sources: †The Ontario Arthritis Society; ‡Association of Ontario Health Centres and key informants§
3.4 HOW DOES ACCESS TO COMMUNITY REHABILITATION IN THE HAMILTON NIAGARA HALDIMAND BRANT LHIN COMPARE TO ONTARIO?

Indicators of access to OT and PT services provided in the Hamilton Niagara Haldimand Brant LHIN are presented in Table 3. Median wait times for publicly funded community OT or PT is 0 days, which is less than the median wait time for the province. Hours of operation cannot be determined due to insufficient data. There is over three times the number of private OT clinics for every public OT clinic. This represents a greater ratio than that found in the province, suggesting less availability of publicly funded community OT services in Hamilton Niagara Haldimand Brant, compared to the provincial average. The ratio of private to public clinic availability for PT is about the same as that for the province, with approximately twice the availability of private clinics than that of publicly funded clinics.

Table 3: Hamilton Niagara Haldimand Brant LHIN community rehabilitation access

<table>
<thead>
<tr>
<th>Access</th>
<th>LHIN 4 – Hamilton Niagara Haldimand Brant</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median wait time for publicly funded OT or PT (in days)*</td>
<td>0</td>
<td>15*</td>
</tr>
<tr>
<td>Percent of publicly funded OT or PT clinics with hours of operation outside normal business hours†</td>
<td>…</td>
<td>31.0*</td>
</tr>
<tr>
<td>Ratio of private to public clinics providing OT services1</td>
<td>3.6</td>
<td>2.2</td>
</tr>
<tr>
<td>Ratio of private to public clinics providing PT services2</td>
<td>2.8</td>
<td>2.9</td>
</tr>
</tbody>
</table>

*Estimates derived from the Ontario Community Rehabilitation Wait Time Survey (ACREU)
†Normal business hours refers to service provision available Monday to Friday between 7:00am to 5:00pm
…Data unavailable/insufficient cell size
1Ratio of private to public clinics = # of private clinics / Σ (TAS AREP+CHC+OPD)
2Ratio of private to public clinics = # of private clinics / Σ (TAS AREP+CHC+DPC+OPD)

3.5 WHAT IS THE GEOGRAPHIC DISTRIBUTION OF DEMAND AND PROVISION FOR COMMUNITY OCCUPATIONAL THERAPY SERVICES?

Map 2: Distribution of privately and publicly funded community occupational therapy clinics. The highest concentration of publicly and privately funded community OT is located in Burlington, Hamilton and St. Catherines. There are no community OT services in the town of Grimbsy. Residents who do not qualify for home based OT or Arthritis Society AREP services in the Grimbsy area would need to travel to access community OT services in the Hamilton or St. Catherines areas. There are no Arthritis Society AREP clinics in Burlington, Hamilton and St. Catherines. Further, there are no Community Health Centres (CHC) that provide OT services within the Hamilton Niagara Haldimand Brant LHIN.

Map 3: Distribution of privately and publicly funded community occupational therapy clinics and the distribution of Hamilton Niagara Haldimand Brant residents age 65 and over. The major urban areas within the Hamilton Niagara Haldimand Brant LHIN have moderate
to high proportions (18-33%) of people 65 years and older. There appears to be both publicly and privately funded OT services located adjacent to dissemination areas with a higher proportion of seniors, with the exception of Grimbsy.

Map 4: Distribution of privately and publicly funded community occupational therapy clinics and the distribution of Hamilton Niagara Haldimand Brant average annual household income. The distribution of publicly and privately funded clinical settings is well dispersed within most urban areas of the LHIN, with a number of publicly funded settings located adjacent to low income dissemination areas (≤$32,556.00). Hamilton is an exception, which has a number of private clinics situated in lower income dissemination areas, with only one publicly funded (i.e., hospital) OT clinic available to residents living in this area. Other low income dissemination areas with limited access to public community OT include the areas east of Simcoe and south of Hamilton.

3.6 WHAT IS THE GEOGRAPHIC DISTRIBUTION OF DEMAND AND PROVISION FOR COMMUNITY PHYSIOTHERAPY SERVICES?

Map 5: Distribution of privately and publicly funded community physiotherapy clinics. The highest concentration of both publicly and privately funded PT service is located in Hamilton, Burlington and St. Catherines. It is worth noting that Simcoe, Dunnville, Welland and Grimsby are the only urban areas with Arthritis Society Rehabilitation Clinics (AREP). Hamilton is the only area with a Community Health Centre that provides PT services within the Hamilton Niagara Haldimand Brant LHIN. The Hamilton area also has the highest concentration of Designated Physiotherapy Clinics (DPC) and private clinics.

Map 6: Distribution of privately and publicly funded community physiotherapy clinics and the distribution Hamilton Niagara Haldimand Brant residents age 65 and over. Similar to the geographic distribution of occupational therapy, there appears to be both publicly and privately-funded physiotherapy services located adjacent to major urban areas with moderate to high proportions (18-33%) of people aged 65 years and older.

Map 7: Distribution of privately and publicly funded community physiotherapy clinics and the distribution of Hamilton Niagara Haldimand Brant average annual household income. The distribution of publicly and privately funded clinical settings appears to be evenly distributed within most urban areas of the LHIN, with a number of publicly funded settings located near low income dissemination areas (≤$32,556.00). Within the Hamilton area, there are several Designated Physiotherapy Clinics (DPCs), and one Community Health Centre (CHC), closely situated to dissemination areas with lower average annual household incomes. However, lower income areas in the south region of the LHIN along the border of Lake Erie, in the west region of the LHIN along the South West LHIN border, and along the east border of the LHIN have limited publicly funded options for community PT for those who do not qualify for home based care.
4 COMPENDIUM OF MAPS

Map 1: Ontario LHIN Boundaries.
Map 2: Distribution of privately and publicly funded community occupational therapy clinics.
Map 3: Distribution of privately and publicly funded community occupational therapy clinics and the distribution of Hamilton Niagara Haldimand Brant residents age 65 and over.
Map 4: Distribution of privately and publicly funded community occupational therapy clinics and the distribution of Hamilton Niagara Haldimand Brant average annual household income.

LHN 4 - Hamilton Niagara Haldimand Brant
Average Annual Household Income by Dissemination Area and
Distribution of Public and Private Occupational Therapy Clinics


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Map 5: Distribution of privately and publicly funded community physiotherapy clinics.
Map 6: Distribution of privately and publicly funded community physiotherapy clinics and the distribution Hamilton Niagara Haldimand Brant residents age 65 and over.
Map 7: Distribution of privately and publicly funded community physiotherapy clinics and the distribution of Hamilton Niagara Haldimand Brant average annual household income.

![Map of Distribution of privately and publicly funded community physiotherapy clinics](image)

Legend:
- CHC (1)
- DPC (17)
- Hospital (13)
- TAS Rehab Clinics (4)
- Private (97)

Average Annual Household Income:
- $0.00 - $32,555.09
- $32,555.01 - $58,131.00
- $58,131.01 - $89,521.00
- $89,521.01 - $119,752.00
- Data Unavailable


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5 GLOSSARY

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.

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.

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.

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.

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. 14

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 advocate4.

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 wellness5.

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\textsuperscript{15}.
6 REFERENCES


