TORONTO
HEALTH SERVICES
RESTRUCTURING REPORT

REHABILITATION,
LONG-TERM CARE AND
SUB-ACUTE CARE

APRIL 1998
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INTRODUCTION

Background

This is the third report issued for Toronto by the Health Services Restructuring Commission (HSRC). It includes the HSRC’s directions for hospital restructuring for Toronto’s rehabilitation, long-term care and sub-acute care services following the notices of intention issued on March 6 and July 23, 1997. The HSRC has made changes in response to new information obtained, input received from the community and further analysis. This report should be read in conjunction with the first two Toronto restructuring reports.

The HSRC is an independent body operating at arm’s-length from government. Its role is to make decisions about hospital restructuring and to advise the Minister of Health on restructuring other aspects of Ontario’s health services system. The HSRC’s four-year mandate consists of three specific and closely related components:

- to work with communities and district health councils, and make decisions about restructuring hospitals to make them more effective and efficient;
- to make recommendations to the Minister of Health about which health services will require funding reinvestment as a result of changes to the hospital system and changing needs of the population; and
- to make recommendations to the Minister on restructuring other components of the health care system to improve overall quality of care, outcomes and efficiency.

The HSRC’s approach to restructuring in Toronto is consistent with that in every other community reviewed. Factors relating to the delivery of health services are analyzed, the particular characteristics of the community and the future needs of the population are assessed, and decisions are made about the most appropriate mix of health services, their location and their governance. The HSRC used as its starting point the Metropolitan Toronto District Health Council’s hospital restructuring project completed in November 1995. The MTDHC strongly supported a significant planned reconfiguration of hospital services in Toronto.

Since the release of the two HSRC reports for Toronto and over the course of reviewing public representations, the HSRC has once again been reminded of the size and complexity of health care delivery in Toronto. There is a vast array of institution- and community-based services, as well as

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1 On January 1, 1998, Metropolitan Toronto became known as the City of Toronto with the amalgamation of Scarborough, East York, North York, Toronto, Etobicoke and York.
significant inter-relationships between Toronto and the surrounding regions of the Greater Toronto Area (GTA). The HSRC’s deliberations for Toronto go beyond its boundaries and take into account options for health service restructuring for the entire GTA. Similarly, the HSRC’s deliberations for the GTA/905 took this broad perspective. The Toronto boundary is essentially irrelevant for health care planning and patient utilization purposes. People cross municipal boundaries within the GTA for their care to the point that the GTA functions as a single community for health services.

The HSRC recognizes that there are inter-dependencies and linkages between health care providers throughout the GTA and Central East region of Ontario. In the HSRC’s decisions, capital expenditures are minimized with the maximum use of the good inventory of hospital buildings and organizations in Toronto for rehabilitation and long-term care services. Access to services is maintained for GTA/905 residents since they will continue to access Toronto hospitals for selected secondary and highly specialized services. It is recognized, however, that more specialized services will increasingly be provided in the GTA outside Toronto to meet the needs of the growing population.

The HSRC takes a long-term view of the system. Its directions and advice are intended to set in motion an ongoing process to achieve improvements in system quality, accessibility and affordability. Restructuring is an evolving process, not an endpoint. Furthermore, it is obvious that the change process is not a simple one. It involves organization cultures, people and physical resources. The HSRC recognizes the importance of putting in place appropriate strategies and structures to facilitate the change process. It also appreciates that in the short term, these changes will have a profound impact on the communities affected.

The HSRC fully appreciates that organizations possess distinct cultures and may have different approaches to the delivery of health care services. Integrating services requires fostering new cultures, appreciating organization histories, and nurturing the positive attributes of each organization. It is necessary to ensure that the traditions of excellence of individual organizations become inherent components of the culture of newly created organizations. The common link in health services is a commitment to provide the best possible service to those who need it.

The HSRC believes that the status quo is not an option. Although individual hospitals and other health care services have responded positively to the challenges facing them, there are limitations to what individual organizations can accomplish. Without a system approach, the future will be characterized by further fragmentation of hospital and other health services, reduced accessibility, and compromised quality of care at a high cost to the public. This is clearly evident when rehabilitation and long-term care services are examined.

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3 These regions include Durham, Halton, Peel and York, and are referred to as the GTA/905. In 1995, the GTA/905 population was about 2.2 million compared to 2.4 million in Toronto.
The system of rehabilitation and long-term care envisioned by the HSRC rebalances the services that are available in Toronto and the rest of the GTA. Expertise and resources are consolidated to achieve the benefits of critical mass, excess capacity is minimized to achieve financial savings and administrative efficiencies, and resources are redistributed to ensure services are closer to the people who need them. The HSRC’s initial planning benchmarks for rehabilitation and long-term care were presented in its discussion paper *Rebuilding Ontario’s Health System: Interim Planning Guidelines and Implementation Strategies* (July 1997). The revised planning benchmarks, on which the following final directions are based, are presented in the HSRC’s paper *Change and Transition* (April 1998).

In Toronto, the HSRC’s vision for rehabilitation consolidates highly specialized regional services in designated facilities. Generally, long-term local rehabilitation services are sited in regional facilities where these exist. Otherwise, long-term rehabilitation programs are located in chronic care facilities or are co-located with short-term local programs in acute care facilities. Rebalancing rehabilitation services results in services being located closer to the population that needs them.

Long-term care services cover a broad range, including chronic care hospitals, chronic units in acute care hospitals, nursing homes, homes for the aged, supportive housing, long-term home care, attendant care and adult day care. Complex continuing care beds are decreased and consolidated in fewer facilities. Other long-term care resources are increased to meet the needs of the population for these services. In the GTA/905, all long-term care services are increased with the greatest increases in nursing homes, homes for the aged and community-based services. The result is improved access within and beyond Toronto, rehabilitation and long-term care sectors structured to provide the right services in the right settings and well-positioned to meet increasing demands of population growth and changing demographics, and a more affordable system that facilitates additional investments in other areas of health care, such as community-based services.

It is critically important to recognize that the HSRC’s goal of creating a vigorous health services system is achievable only with reinvestments in community-based health services and high quality, accessible hospitals. Appropriate community structures and support services must be put in place before beds are closed. The HSRC has identified areas of reinvestment in community-based services that are needed to support the restructuring of local hospital services. In addition, it has identified the need to upgrade or expand hospital buildings to ensure that the infrastructure is in place for the future. Through its recommendations to the Minister of Health, the HSRC is fostering an unprecedented capital renewal program across the province to put in place the necessary physical structures to support the restructured system. The magnitude and impact of these reinvestments will contribute to developing a vigorous health services system.

**Representations to the HSRC**
In response to its second report on Toronto, the HSRC received 71 representations from hospitals, health agencies and organizations, labour, other groups and individuals. The representations provided additional data and information for consideration. Their number and the obvious time and thought that went into their development are indicative of the keen interest in health services restructuring in Toronto.

The following is a summary of the principal issues and topics raised in the representations:

- proposed planning targets and sizing for rehabilitation and complex continuing care;
- costing for rehabilitation (especially specialized programs and seven-day-a-week rehabilitation), complex continuing care, palliative care and sub-acute care;
- funding for ambulatory care, in-home services, program transfers and teaching activities;
- operating cost methodology, especially for administrative efficiencies, and capital cost estimates for rehabilitation and complex continuing care;
- definition and siting of short-term rehabilitation and sub-acute care;
- distribution of rehabilitation services in Toronto and the GTA/905, especially long-term and regional programs;
- siting of a regional rehabilitation provider in east Toronto and the GTA/905, and the role of designated regional facilities beyond Toronto;
- recognition of other regional and provincial rehabilitation programs, and the academic role of regional rehabilitation facilities;
- siting of complex continuing care and palliative care;
- admission criteria for complex continuing care;
- recognition for specialized geriatric services, including definition and siting of geriatric rehabilitation and geriatric inpatient units;
- roles of Runnymede Chronic Care Hospital, Salvation Army Toronto Grace Hospital and Riverdale Hospital;
- amalgamation of Lyndhurst Hospital, the Rehabilitation Institute of Toronto and the Toronto Rehabilitation Centre;
- re-investments for home care and community-based long-term care services;
- HSRC submission and planning process;
- human resource strategy across the GTA;
- networks: rehabilitation networks in Toronto and the GTA/905, provincial children’s rehabilitation and developmental network, provincial and local specialized geriatric networks, geriatric medicine and psychiatric services network, palliative care providers network;
- implementation issues: timing of reinvestments and the transfer of current hospital-based services to the community, the roles of the Metropolitan Toronto District Health Council and Community Care Access Centres.

Overview of the Report
The second HSRC report for Toronto presented intended directions and advice for rehabilitation and long-term care, and welcomed input on the most appropriate location for sub-acute programs. This report presents the highlights of those intentions, a summary of principal issues raised in the representations, the HSRC’s deliberations, and its final directions and advice. Sections IV and V address other issues, and the financial impact of restructuring rehabilitation, long-term care and sub-acute care. The reader is advised to refer to the HSRC’s first two Toronto reports released in March and July 1997 for additional information.

The lead commissioner of this review was Dr. Duncan Sinclair; the accompanying commissioners were Shelly Jamieson and Hartland M. MacDougall.
SECTION I: REHABILITATION

The HSRC received representations on a wide range of rehabilitation issues. Its deliberations and final directions are presented for the following:

- planning assumptions;
- regional and long-term rehabilitation services within geographic clusters;
- short-term rehabilitation services;
- paediatric rehabilitation services; and
- implementation of changes in rehabilitation services.

PLANNING ASSUMPTIONS

Highlights of the Notices - July 1997

- ‘Short-term local’ rehabilitation services (average length of stay less than 10 days) to be provided in acute care facilities.
- ‘Long-term local’ rehabilitation services (average length of stay more than 10 days) and ‘regional’ rehabilitation (highly specialized programs) to be provided in regional facilities, where these are designated.
- Principal planning region for short- and long-term local services to be Toronto and its nine boundary forward sortation areas (FSAs) and the principal planning region for regional rehabilitation to be Central East and Halton regions.\(^5\)
- Planning for short-term, long-term and transition to independent living services to be 16 beds per 100,000; planning for regional services to be four beds per 100,000 population.

Principal Issues in the Representations

Representations concerning the planning guidelines noted that the HSRC’s bed target rates were too aggressive and under-estimated current and future rehabilitation needs. Concerns were expressed that acute care efficiencies would actually result in a greater need for rehabilitation services. The appropriateness of certain assumptions was also questioned. For example, seven-day-a-week rehabilitation was regarded as inappropriate for some client groups. As well, representations suggested that short-term rehabilitation should be longer than 10 days and include more complex cases.

Including the population of the nine forward sortation areas (FSAs) bordering Toronto to site rehabilitation services in Toronto was questioned. This was seen as limiting the client’s choice of where to go for services and keeping specialized rehabilitation in Toronto rather than developing these services in the GTA/905. It was also suggested that Halton be included in the Hamilton review of regional rehabilitation. Overall, support was expressed for redistributing rehabilitation beds throughout the GTA, although some concerns were expressed with what was viewed as an inconsistent approach to siting long-term rehabilitation beds.

\(^5\) The nine boundary FSAs are: L1V (Durham); L3R, L3S, L3T, L4J, L4K, L4L (York); and L4T, L4V (Peel). Central East region includes Toronto, Durham, York, Peel, Northumberland, Haliburton, Peterborough, Victoria and Simcoe.
In terms of funding, capital cost allocations for ambulatory care activity were regarded as too low. As well, day hospital and respite volumes and costs needed to be recognized in the HSRC’s final calculations.

The HSRC’s Deliberations

Since the July 1997 release of the second Toronto restructuring report and a discussion paper, *Rebuilding Ontario’s Health System: Interim Planning Guidelines and Implementation Strategies*, the HSRC has continued to refine its planning guidelines for determining the appropriate level of institution-based rehabilitation services to meet the needs of the population. The HSRC’s report *Change and Transition* (April 1998) presents the results of the HSRC’s additional analyses and the revised planning benchmarks on which the final directions are based. The following should be read in conjunction with the rehabilitation chapter in *Change and Transition*.

The HSRC confirms its vision of rehabilitation services as one of:
- consolidating specialized regional services to fewer sites;
- co-locating long-term local services with regional services, where possible; and
- siting short-term local services in acute care facilities.

Designating regional facilities and co-locating long-term rehabilitation with regional services builds on existing programs and specialty strengths, and enhances critical mass. It ensures clinical coherence of more specialized services and optimizes use of excess capacity in regional facilities. It also supports high quality undergraduate and postgraduate medical education and the education of other health professionals. Long-term local rehabilitation services are sited in regional facilities where these exist. Otherwise, long-term rehabilitation programs are located in chronic care facilities or co-located with short-term local programs in acute care facilities. This helps to ensure sufficient critical mass for high quality rehabilitation care.

Siting short-term rehabilitation in acute care facilities reduces disruptions to patients and service providers because of fewer patient transfers, makes early intervention possible, and strengthens the focus on community integration. It would be unreasonable to site all long-term rehabilitation programs for the GTA in the designated regional facilities located in Toronto. This would compromise access to services for the communities in the GTA/905.

The HSRC reassessed its planning methodology and benchmarks for rehabilitation. Additional rehabilitation cases were identified, the initial methodology was adjusted in selected program clusters, a growth factor was applied to rehabilitation, and a five-day-a-week rehabilitation model was accepted as the general service benchmark. (It was concluded that although a patient-focused continuous service delivery model is appropriate, seven-day-a-week rehabilitation is not suitable for all patients.) As a result of these analyses, the revised planning guideline for the population projected to 2003 for
rehabilitation services is 25 beds or spaces/100,000 to be allocated as 4 regional and 21 local (which includes transition to independent living spaces).

The HSRC conducted further analysis on its definitions of short- and long-term rehabilitation. An analysis of the Canadian Institute for Health Information (CIHI) rehabilitation data determined that 25% of rehabilitation cases in 1995/96 had an average length of stay of 14 days or less. Based on these data, the HSRC determined that, in general, 25% of local beds should be allocated to short-term rehabilitation, defined as having an average length of stay (ALOS) of 14 days or less. This percentage may be adjusted in each region depending on the impact of patient volumes, critical mass, facility capacity and proximity of regional rehabilitation providers. An analysis of these factors determined that in Toronto, 33% of local beds will be allocated to short-term rehabilitation. The remaining local beds will be long-term rehabilitation, having an expected ALOS of more than 14 days.

The HSRC reassessed whether the nine boundary FSAs should continue to be used to site local rehabilitation services in Toronto. In its review of the GTA/905, the HSRC concluded that the GTA functions as a continuous urban system. Boundaries within the GTA do not determine where residents seek their care. In large urban areas, residents and their physicians tend to choose among a number of nearby hospitals, all of which may be regarded as “close to home” but in fact be located in another municipality. Patient referral patterns for rehabilitation are expected to be similar to those for acute care services. The HSRC confirms that using the nine boundary FSAs to determine local rehabilitation services in Toronto is appropriate.

Since the July 1997 Toronto report, the HSRC has analyzed rehabilitation referral patterns in a number of communities in southern Ontario. These analyses indicate that Toronto’s specialty rehabilitation programs serve residents from a broader area than originally thought. As well, only part of Halton is served by Toronto. Based on current utilization patterns, the HSRC concludes that the principal planning region for Toronto’s specialty rehabilitation programs should be expanded to include not only Central East region but all of Dufferin county, and 50% of Wellington and Waterloo counties. As well, 60% of Halton is in Toronto’s principal planning region. (The remaining parts of Wellington, Waterloo and Halton are served by Hamilton.) The HSRC confirms that a broader population base is required for planning regional rehabilitation programs because of the highly specialized nature of the treatment and skills of the health care providers, and the need to achieve an optimal critical mass of patients and beds. Designated facilities that offer these programs will not only serve the local Toronto population but will have a broader role as regional rehabilitation providers.

As a result of revisions to the planning methodology and benchmarks for rehabilitation, local short-term beds in Toronto will increase from 104 to 200 beds by 2003. (The HSRC’s July 1997 report had proposed an increase to 176 beds based on the previous methodology.) Local long-term and regional beds will decrease in Toronto from 963 to 705 beds. (The HSRC’s July 1997 report had proposed a decrease to 480 beds based on the previous methodology.) Twenty additional transition to independent living beds will also be sited in Toronto.
The issue of determining costs for outpatient rehabilitation is addressed in Section V.

REGIONAL AND LONG-TERM REHABILITATION SERVICES

Highlights of the Notices - July 1997

- The Rehabilitation Institute of Toronto, St. John’s Rehabilitation Hospital and West Park Hospital to provide designated regional and long-term local rehabilitation programs.
- The Rehabilitation Institute of Toronto to cease operations at the Austin Terrace site (formerly Hillcrest Hospital).
- The Lyndhurst Hospital, the Rehabilitation Institute of Toronto and the Toronto Rehabilitation Centre to amalgamate into one corporation (‘Tri-Hospital Rehabilitation Corporation’ - Note: this is a working title only).
- The Rehabilitation Institute to participate in the Joint University Avenue Task Force in discussions relating to rehabilitation.
- Baycrest Centre for Geriatric Care to transfer selected programs to West Park Hospital, and the Riverdale Hospital to transfer selected programs to the Tri-Hospital Rehabilitation Corporation and St. John’s Rehabilitation Hospital.
- St. Bernard’s Hospital to transfer its operations and management to St. John’s Rehabilitation Hospital, with St. Bernard’s Hospital to manage its patient care services until the transfer is complete.

Principal Issues in the Representations

The representations concerning long-term and regional rehabilitation services addressed siting, service configurations, program designations and funding. The view was expressed that there is sufficient critical mass in Durham Region, and in the east and north-east GTA/905 to warrant siting some regional services such as paediatric and amputee rehabilitation. It was suggested that these could be set up as satellite operations of regional providers. Representations suggested that regional centres be designated for east Toronto, York, Durham, Peel and the west GTA. Suggested sites include Centenary Health Centre, Providence Centre, St. John’s Rehabilitation Hospital, West Park Hospital and York Central Hospital.

Representations from Lyndhurst Hospital and the Rehabilitation Institute of Toronto supported the creation of the Tri-Hospital Rehabilitation Corporation. Key issues related to the preservation of spinal cord as a priority program, disposition of the resources of hospital foundations, preservation of organizational cultures, and the most appropriate governance and management model. An amalgamation proposal was submitted jointly by the Toronto Rehabilitation Centre and Sunnybrook Health Science Centre.

A number of representations opposed the closing of St. Bernard’s Hospital. In particular, it was suggested that St. Bernard’s could play an important role providing sub-acute care. Transferring the

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6 The siting of rehabilitation services in east Toronto was addressed in the HSRC’s GTA/905 report released in November 1997. Short- and long-term local rehabilitation beds were sited in acute care facilities.
inpatient rehabilitation program from Baycrest Centre for Geriatric Care was felt to compromise research and teaching opportunities as well as continuity of care. Riverdale Hospital supported a role change for the facility.

Issues of program designations were raised by the three proposed regional rehabilitation providers. Representations suggested that trauma rehabilitation should be recognized as a regional program in both the Rehabilitation Institute of Toronto and St. John’s Rehabilitation Hospital; geriatric psychiatry rehabilitation should be recognized at the Rehabilitation Institute of Toronto; musculoskeletal, inpatient respiratory and transition to independent living programs should be recognized as regional programs, and the mycobacterial lung disease service should be recognized as a provincial program at West Park Hospital. Representations also noted that the academic role of the three regional providers, especially that of the Tri-Hospital Rehabilitation Corporation, should be formally recognized and funded. Finally, representations noted that the transfer of patients to regional centres should be coordinated and open to all users.

A number of submissions noted that the HSRC’s cost allocations for program transfers, specialized rehabilitation and teaching were too low. As well, capital funds were deemed to be insufficient to cover increased outpatient services. Issues were also raised about the HSRC’s bed calculations, and planning guidelines and average length of stay for spinal cord injury.

The HSRC’s Deliberations

The HSRC addressed the designation of regional facilities in four geographic clusters, the redistribution of long-term and regional programs to designated sites, and academic activities.

Designation of Regional Facilities

The HSRC confirms its intent to designate regional rehabilitation facilities in Toronto, and co-locate regional and long-term programs on these sites where possible. Regional programs are highly specialized and targeted to clients with complex rehabilitation needs. Since these services have low volumes, distributing these volumes among many local providers would result in fragmentation of specialized skills and expertise, and inefficiencies in the investment of resources for diagnostic and therapeutic technologies. Co-locating long-term services with regional programs further enhances critical mass and specialty strengths, and supports strong education programs for health care professionals.

It must be noted that although the designated regional rehabilitation providers are located in Toronto, they are not designated providers of regional services for Toronto alone. As noted previously, the specialty rehabilitation programs of these facilities serve the complex rehabilitation needs of residents
from a broad area that includes Central East region, Dufferin County, part of Halton region, and part of Wellington and Waterloo counties.

In its July 1997 report, the HSRC identified regional and long-term local rehabilitation programs that would be provided at the designated regional sites. The HSRC considered the requests for additional program designations. The impact of these revised designations is reflected in bed and costing reallocations where the HSRC has determined that additional resources are necessary to support these services. Funding allocations for rehabilitation are presented in Section V.

The HSRC’s deliberations on regional sites located in north, south-central, west and east Toronto are presented below.

**North Toronto**

The HSRC confirms its intent to designate St. John’s Rehabilitation Hospital as the regional rehabilitation facility located in north Toronto. In its deliberations on program designations, the HSRC concluded that trauma rehabilitation will continue to be provided as a regional program at St. John’s Rehabilitation Hospital.

The HSRC directs St. John’s Rehabilitation Hospital to provide designated regional and long-term local rehabilitation programs. These include amputee, long-term geriatric, stroke and neurology, cardiac, oncology, orthopaedic and trauma.

**South-Central Toronto**

The HSRC confirms its intent to designate the Rehabilitation Institute of Toronto as the regional rehabilitation facility located in south-central Toronto. In its deliberations on program designations, the HSRC concluded that trauma rehabilitation will be recognized as a regional program at the Rehabilitation Institute of Toronto. As well, geriatric psychiatry rehabilitation will be recognized as a regional program at the Rehabilitation Institute of Toronto. However, the hospital in conjunction with the Addiction and Mental Health Services Corporation will assess the suitability of maintaining this program as a rehabilitation program.

In its July 1997 report, the HSRC gave notice of its intent to direct the amalgamation of Lyndhurst Hospital, the Rehabilitation Institute of Toronto and the Toronto Rehabilitation Centre into the “Tri-Hospital Rehabilitation Corporation”. The HSRC later received a proposal from the Toronto Rehabilitation Centre to amalgamate with Sunnybrook Health Science Centre. The HSRC confirms the amalgamation of the Toronto Rehabilitation Centre, the Rehabilitation Institute of Toronto and the

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7 The name, “Tri-Hospital Rehabilitation Corporation” is a working title only.
transfer of assets of Lyndhurst Hospital to form the Tri-Hospital Rehabilitation Corporation based on the following.

- The HSRC expects that the Tri-Hospital Rehabilitation Corporation will provide leadership in cardiac and outpatient rehabilitation as part of a fully-affiliated University of Toronto teaching and research centre devoted to rehabilitation.
- The creation of the Tri-Hospital Rehabilitation Corporation supports the HSRC’s vision of establishing regional rehabilitation centres with a strong base of expertise and specialized services upon which to build programs that include inpatient and outpatient care, education and research.
- Cardiac rehabilitation services will be accessible to patients from a broad range of acute hospitals, including all three regional cardiac centres in Toronto (St. Michael’s Hospital, The Toronto Hospital and Sunnybrook Health Science Centre).
- The Tri-Hospital Rehabilitation Corporation will result in greater critical mass and less duplication of services between the Toronto Rehabilitation Centre and the Rehabilitation Institute of Toronto in such areas as acquired brain injury, stroke and neurology, and cardiac rehabilitation.
- The Tri-Hospital Rehabilitation Corporation will enhance clinical service delivery by strengthening critical mass, and concentrating skills and expertise under one governance and management structure. This will create a strong foundation upon which to build a regional centre that collaborates with the other regional rehabilitation centres, and other facilities in the Central East region and beyond.

Lyndhurst Hospital has indicated its support for bringing together the three organizations. However, because it operates as a division of the Canadian Paraplegic Association, an amalgamation of all three organizations would be complicated. Lyndhurst has suggested that the properties and assets of the hospital be transferred to the Tri-Hospital Rehabilitation Corporation, formed by the amalgamation of the Rehabilitation Institute of Toronto and the Toronto Rehabilitation Centre.

As noted in the HSRC’s July report, the process of creating the new hospital does not mean assimilating one organization into another. Rather, it means developing a new culture supported by a new board. The board of the new organization will determine leadership and management structures. It will be incumbent upon the new board to ensure that the traditions of excellence in all three organizations become an inherent part of the new corporation.

In its July report, the HSRC gave notice of its intent to direct the Rehabilitation Institute of Toronto to participate in the Joint University Avenue Task Force discussions about minimizing duplication and maximizing coordinated patient care delivery, education and research as these relate to rehabilitation. Representatives of the Tri-Hospital Rehabilitation Corporation were to take over this task once the board of the new corporation was created.

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8 The other members of the Joint University Avenue Hospitals Task Force are The Toronto Hospital (which includes the former Princess Margaret Hospital) and Mount Sinai Hospital.
On November 17, 1997, the *Report of the University Avenue Hospitals Task Force* on clinical service integration was submitted to the HSRC. The report recommends one joint chief of rehabilitation medicine based at the Rehabilitation Institute of Toronto and cross appointed at Mount Sinai Hospital and The Toronto Hospital. The report notes that the joint chief would have authority for rehabilitation resources within the three organizations with funds to remain within each organizations’ budget, would be the University of Toronto’s division director for physiatry, and would develop the overall plan for rehabilitation services on University Avenue. In March 1998, the HSRC issued notices of intention for the University Avenue hospitals to implement a plan for clinical consolidations, and further consolidation and integration of administrative and support services.

The HSRC directs the Rehabilitation Institute of Toronto to provide designated regional and long-term rehabilitation programs. These include acquired brain injury, spinal cord injury, long-term geriatric, geriatric psychiatry, stroke and neurology, cardiac, oncology, orthopaedic and trauma.

The HSRC further directs the Rehabilitation Institute of Toronto to determine, in conjunction with the Addiction and Mental Health Services Corporation, the appropriateness of maintaining a rehabilitation designation for the geriatric psychiatry program.

The HSRC directs the Lyndhurst Hospital, the Toronto Rehabilitation Centre and the Rehabilitation Institute of Toronto, with the assistance of an HSRC-appointed facilitator, to develop one corporation – the “Tri-Hospital Rehabilitation Corporation – through the amalgamation of the Toronto Rehabilitation Centre and the Rehabilitation Institute of Toronto, and the transfer of properties and assets of the Lyndhurst Hospital.

The HSRC directs the Rehabilitation Institute of Toronto to cease operations at the Austin Terrace site (formerly Hillcrest Hospital).

**West Toronto**

The HSRC confirms its intent to designate West Park Hospital as the regional rehabilitation facility located in west Toronto. In its deliberations on program designations, the HSRC concluded that musculoskeletal rehabilitation will be recognized as a local long-term program at West Park Hospital. The transition to independent living program will continue to be designated as local long-term rehabilitation. The HSRC recognizes, however, that inpatient respiratory includes a broad range of

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9 The report was submitted by the HSRC-appointed facilitator, Michael Decter.
10 Metropolitan Toronto Health Services Restructuring: Supplemental Report & Notices of Intention to Issue Directions; Service Integration Among the University Avenue Hospitals. March 1998.
conditions, some of which require highly specialized services. The specialized regional component of
inpatient respiratory will continue to be provided at West Park Hospital. As well, the HSRC recognizes
that the mycobacterial lung disease program at West Park Hospital goes well beyond meeting the needs
of the facility’s regional catchment area.

| The HSRC directs West Park Hospital to provide designated regional and long-term rehabilitation programs. These include acquired brain injury, amputee, musculoskeletal, specialized respiratory (including the mycobacterial lung disease program), respiratory, long-term geriatric, stroke and neurology, and transition to independent living. |

**East Toronto**

In its July report, the HSRC deferred its decision on siting a regional rehabilitation provider in east Toronto pending the review of the GTA/905. It was concluded that this review would determine the best option for locating long-term and regional rehabilitation services for east Toronto, York and Durham regions, and parts of Central East region. In its report on the GTA/905 released in November, the HSRC determined that there was insufficient critical and optimal mass to support designating a fourth regional rehabilitation provider. The HSRC further determined that the residents of east Toronto should access long-term rehabilitation services in local acute hospitals that offer short-term rehabilitation services. These services were to be sited at Centenary Health Centre, Salvation Army Scarborough Grace Hospital, Scarborough General Hospital, and Toronto East General and Orthopaedic Hospital.

The HSRC received submissions that supported designating a regional rehabilitation provider in east Toronto. Suggested sites included Centenary Health Centre, Providence Centre and various sites in the GTA/905.

The HSRC reconsidered the issue of designating a fourth rehabilitation facility that would offer both long-term and regional programs. Currently, regional rehabilitation programs are not provided in hospitals in east Toronto and the GTA/905. The HSRC concludes that designating a fourth regional provider would fragment regional services and reduce critical mass at all the regional sites. Designated regional facilities must have sufficient critical mass to support highly specialized programs, and specialized skills and expertise. They also require a substantial investment of both human and financial resources. The HSRC concludes that the three designated facilities – St. John’s Rehabilitation Hospital, the Tri-Hospital Rehabilitation Corporation and West Park Hospital – will meet the specialized rehabilitation needs of the population in east Toronto, the GTA/905 and beyond.

The HSRC reassessed its decision to site both short- and long-term local beds in acute care facilities in east Toronto. The current role of Providence Centre in long-term rehabilitation was re-examined.

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1 GTA/905 Health Services Restructuring Report, November 1997.
Providence Centre currently offers general and geriatric rehabilitation services, and is a facility of the Toronto Regional Geriatric Program. These services are integrated with long-term care programs, including complex continuing care, offered by Providence Centre. In assessing the siting of local long-term rehabilitation, the HSRC considered the expertise and scope of services of Providence Centre. The HSRC concludes that Providence Centre should continue to provide long-term local rehabilitation services in east Toronto.

Redistribution of Long-Term and Regional Programs to Designated Sites

The HSRC reviewed the concerns raised in the representations about transferring programs from the Baycrest Centre for Geriatric Care, the Riverdale Hospital and St. Bernard’s Hospital to the designated regional rehabilitation facilities. The HSRC’s deliberations were grounded in its vision for rehabilitation services. There are sufficient rehabilitation resources to meet the needs of Toronto and the rest of the GTA. However, beds are concentrated in Toronto and need to be redistributed across the GTA. Rebalancing the distribution of rehabilitation resources will result in smaller programs in Toronto. The HSRC reiterates the importance of consolidating programs where possible to achieve sufficient critical mass to ensure high quality care, support for specialized care providers and improved teaching opportunities in rehabilitation.

The HSRC reassessed its decision to redistribute long-term and regional programs currently offered at the Baycrest Centre for Geriatric Care, the Riverdale Hospital and St. Bernard’s Hospital to the designated regional facilities.

Baycrest Centre for Geriatric Care plays a leading role in research into cognitive neuro-rehabilitation through the hospital’s Rotman Research Institute, and provides teaching opportunities in rehabilitation. The HSRC recognizes the importance of the specialized rehabilitation research being conducted at Baycrest Centre. The facility also offers neurologic and geriatric rehabilitation, a long-term local program. This rehabilitation program is integrated with a broad range of programs at Baycrest Centre including complex continuing care, long-term care and seniors’ programs. Baycrest is also a facility of the Toronto Regional Geriatric Program. For these reasons, the HSRC concludes that Baycrest will continue to provide neurologic and geriatric rehabilitation as a long-term local program.

The HSRC encourages Baycrest Centre to share the results of its research with other rehabilitation providers through the Rehabilitation Network, and to engage in collaborative research with these providers, especially the designated regional hospitals. This information sharing and collaborative research efforts must be used to impact positively on clinical rehabilitation practice locally, regionally and provincially.

The Riverdale Hospital offers both local and regional programs including neurologic (acquired brain injury/stroke), amputee, orthopaedic and geriatric rehabilitation. When Riverdale’s regional programs
are sited at the designated regional facilities and its short-term orthopaedic cases at acute care facilities, an insufficient critical mass of rehabilitation programs remains at the facility. The HSRC, therefore, confirms its intent to transfer Riverdale Hospital’s long-term and regional rehabilitation programs to the Tri-Hospital Rehabilitation Corporation and St. John’s Rehabilitation Hospital.

St. Bernard’s Hospital offers orthopaedic, cardiac and trauma rehabilitation. When regional programs are sited at the designated regional facilities and short-term programs at acute care facilities, an insufficient critical mass of rehabilitation programs remains at St. Bernard’s Hospital. The HSRC, therefore, confirms its intent to transfer St. Bernard’s long-term and regional rehabilitation programs to St. John’s Rehabilitation Hospital. As a result of these program transfers, the HSRC confirms that St. Bernard’s should cease operating as a hospital. St. Bernard’s and St. John’s should jointly develop a plan whereby St. John’s Rehabilitation Hospital contracts with St. Bernard’s Hospital to manage St. Bernard’s patient care services until the transfer of these services to St. John’s is complete.

The HSRC directs the Riverdale Hospital to transfer its neurologic, orthopaedic and geriatric rehabilitation and reactivation programs to the Tri-Hospital Rehabilitation Corporation, and its amputee program to St. John’s Rehabilitation Hospital.

The HSRC directs St. Bernard’s Hospital to transfer its operations and management, including its programs and services, to St. John’s Rehabilitation Hospital.

The HSRC further directs St. Bernard’s Hospital, in conjunction with St. John’s Rehabilitation Hospital, to develop and implement a plan whereby St. John’s Rehabilitation Hospital contracts with St. Bernard’s Hospital or its owners to manage the patient care services of St. Bernard’s Hospital until the completion of the transfer of rehabilitation services to St. John’s Rehabilitation Hospital.

**Academic Activities**

The HSRC believes that education and research must be preserved and enhanced in the restructured hospital sector. Not only must these activities be supported where clinical services have been moved from one site to another, but new learning opportunities must be developed as well. Indeed, one of the HSRC’s key objectives of designating regional rehabilitation sites is to ensure sufficient critical mass to support specialized skills and expertise, and enhance the opportunities for education and research activities.

Currently the three designated regional rehabilitation sites are engaged in academic activities which include education and research.
• In south-central Toronto, the Rehabilitation Institute of Toronto (RIT) has recently become a fully affiliated University of Toronto rehabilitation teaching hospital. RIT has a research institute that has funded studies in such areas as treatment methods for osteoporosis, sleep research, oncology rehabilitation and post-traumatic head injury rehabilitation. Lyndhurst Hospital is also affiliated with the University of Toronto and has a board research committee. Its primary research focus is clinical outcomes for spinal cord rehabilitation, including determining indicators of success after spinal cord injury. The Toronto Rehabilitation Centre is affiliated with the University of Toronto and has conducted extensive applied research in cardiac rehabilitation, including the effects of exercise training on patients with various heart conditions.

• In west Toronto, West Park Hospital is affiliated with the University of Toronto. It has a Clinical Evaluation and Research Unit that emphasizes applied research on the therapies and services directly affecting the hospital’s clients, families and caregivers. Extensive research has been conducted in respiratory rehabilitation as well as in post-traumatic brain injury rehabilitation, stroke and amputee rehabilitation, and community living.

• In north Toronto, St. John’s Rehabilitation Hospital is in the process of affiliating with the University of Toronto. It has conducted research in such areas as the minimum data set for rehabilitation, clinical pathways for total hip rehabilitation and clinical outcome measures.

Baycrest Centre for Geriatric Care and Providence Centre also have linkages with the University of Toronto, and conduct rehabilitation research.

The HSRC is aware that acute care teaching hospitals receive a funding adjustment that recognizes and supports their contributions to teaching and research. The three regional rehabilitation centres have requested that the HSRC allocate funds to support the costs of expanded academic activities. The HSRC supports the principle of providing appropriate funding for academic activities in rehabilitation and will advise the Minister to address this issue.

The HSRC advises the Minister of Health to evaluate and develop a policy on funding academic activities in rehabilitation facilities.
SHORT-TERM REHABILITATION SERVICES

Highlights of the Notices - July 1997

- The Toronto Hospital, Mount Sinai Hospital, St. Michael’s Hospital, Bayview Hospital Corporation, St. Joseph’s Health Centre, Mississauga-Queensway Hospital Corporation, Etobicoke General Hospital, Humber River Regional Hospital, North York General Hospital, Scarborough General Hospital, Salvation Army Scarborough Grace Hospital, Centenary Health Centre, and the Toronto East General and Orthopaedic Hospital to implement a service plan for the provision of short-term rehabilitation services.

Principal Issues in the Representations

Representations generally expressed support for siting short-term rehabilitation beds in acute care facilities. Some representations expressed the view that patients who need more than a few days of rehabilitation should go to designated rehabilitation facilities. Others suggested that short-term rehabilitation beds should be located in free-standing rehabilitation facilities when they are adjacent to an acute care site. A few acute care hospitals proposed higher short-term bed allocations. Funding issues raised in the representations noted that support for outpatient activity was inadequate, and that one-time funding should be provided for rehabilitation program development costs in acute care facilities.

The HSRC’s Deliberations

The HSRC confirms that its objective for short-term rehabilitation is to support early intervention following an acute care episode, and to reduce the transfer of patients from acute to rehabilitation hospitals for short-term stays. The HSRC, therefore, confirms its intent to site short-term rehabilitation beds in acute care facilities throughout Toronto. This will lead to an increased focus in acute care facilities on reintegration of the patient into the community. It will also enable the designated regional facilities in Toronto to concentrate their efforts on the delivery of specialized care, and advance the development of specialized skills and expertise. The short-term rehabilitation beds sited on University Avenue will remain in the acute care facilities. However, the management of these rehabilitation resources will be determined by the University Avenue Hospitals Task Force.

The HSRC confirms its intent to designate 13 acute care facilities in Toronto to provide short-term rehabilitation; the total number of designated local short-term beds will be 200.
## Current and Proposed Local (Short- & Long-Term) and Regional Rehabilitation Beds

<table>
<thead>
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<td><strong>963</strong></td>
<td><strong>176</strong></td>
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* Ministry of Health, Inventory of Beds, 1996

** These rehabilitation beds are associated with the catchment area of the Queensway site. They will be located at the Mississauga site. The short-term bed allocation for the Mississauga site is presented in the HSRC’s report on the GTA/905 (April 1998).

+ Current beds as of July 1996. Includes 10 transition to independent living beds.

++ Includes 10 transition to independent living beds and 20 tuberculosis beds (mycobacterial lung disease).

^ An additional 20 transition to independent living beds will be sited in Toronto.

**PAEDIATRIC REHABILITATION SERVICES**
The HSRC’s Deliberations

Bloorview MacMillan Centre is a regional and provincial facility that provides children’s inpatient and outpatient rehabilitation, and complex continuing care. The centre is a leader in children’s rehabilitation and development.

Bloorview MacMillan Centre evaluated the appropriateness of 14 sites in Toronto for the future consolidation of its programs and services. Its analysis, which included consultation with clients, families and staff, determined that the site of the Workplace Safety and Insurance Board in Toronto ensures accessibility, and is the most suitable and cost effective alternative to meet future needs. The HSRC accepts Bloorview MacMillan Centre’s evaluation of alternative sites. The HSRC is aware that Bloorview Macmillan is negotiating with the Workplace Safety and Insurance Board to purchase its site. The HSRC will issue directions once these discussions are complete. The capital costs and the costs of consolidating these services on the alternative site are presented in Section V.

IMPLEMENTATION OF CHANGES IN REHABILITATION SERVICES

Representations expressed support for the Toronto Rehabilitation Network, although a number of issues were raised regarding membership. It was suggested that the network link with rehabilitation service providers in the GTA/905, either informally or by formally including the GTA/905 as network members. It was also suggested that acute care providers were over-represented in the network: a more appropriate membership would either be 50% of members from rehabilitation facilities or proportional representation based on patient volumes. It was also suggested that mental health providers be formally linked to the network. Concerns were expressed that a network with too many members would be unfocused and ineffective. A number of representations requested financial support to ensure success for the network. Finally, it was suggested that implementation of changes in rehabilitation should include monitoring the changes in service and funding to assess the impact of acuity on case mix, bed distribution and funding.
Support was expressed for a provincial rehabilitation network. It was also suggested that other networks be established, such as a provincial children’s rehabilitation and developmental network with links to the provincial rehabilitation network and the provincial paediatric task force, a local and provincial specialized geriatric medicine network, and an integrated network for geriatric medicine and psychiatric services.

The HSRC’s Deliberations

The HSRC confirms its intent to direct the establishment of the Rehabilitation Network under the leadership of the corporation resulting from the formation of the Tri-Hospital Rehabilitation Corporation which includes Lyndhurst Hospital, the Rehabilitation Institute of Toronto and the Toronto Rehabilitation Centre. Although this facility will provide leadership, it is expected that the three designated regional rehabilitation providers and the Bloorview Macmillan Centre will jointly guide the activities of the network. Acute hospitals that provide rehabilitation services will participate in the network, as will a representative of the Toronto Community Care Access Centres (CCACs).

The HSRC believes it is important for the network to have formal links with the rehabilitation service providers in the GTA/905 because rehabilitation services will be rebalanced across the whole GTA. In its November 1997 report on the GTA/905, the HSRC recommended that providers of hospital-based rehabilitation services in each region together with the relevant district health council (DHC), develop a mechanism to achieve coordination of rehabilitation services. The HSRC concludes that these groups will be represented on the Rehabilitation Network. In addition, there will be one representative of the GTA/905 CCACs.

Active participation of the GTA/905 rehabilitation providers expands the scope of the network beyond Toronto to the broader GTA. The GTA/905 groups will be expected to continue working with their DHCs to develop mechanisms to achieve coordination of rehabilitation services within their regions.

The HSRC is supportive of having a broad range of stakeholders in the network but is sensitive to it becoming too large and unfocused. The HSRC believes that the responsibilities of the network should be considered when determining an appropriate balance of representatives. Its membership does not preclude the network from establishing sub-committees or working groups to address certain tasks in more depth or to address related issues. Some of these may include children’s rehabilitation and development issues, geriatric medicine and psychogeriatrics, and mental health rehabilitation.

The HSRC concludes that the membership of the Rehabilitation Network will, at a minimum, be made up of representatives from the following areas:

- 1 representative from each of the three regional rehabilitation providers;
- 1 representative from Bloorview MacMillan Centre;
- 1 representative of acute teaching hospitals in Toronto that provide local rehabilitation services;
- 2 representatives of community hospitals in Toronto that provide local rehabilitation services;
The HSRC confirms that the responsibilities of the network will be to:

- ensure coordination of and equitable access to rehabilitation services;
- establish linkages among the institution- and community-based rehabilitation providers;
- develop a performance evaluation mechanism for regional rehabilitation services with respect to quality and access indicators for the regional rehabilitation planning region;
- examine opportunities to reduce duplication and administrative overhead, increase research, and improve direct service delivery;
- recommend improvements to transportation access for rehabilitation; and
- in conjunction with community-based providers, recommend siting of the additional transition to independent living spaces in Toronto as identified by the HSRC.

The HSRC has no mechanism to assess the request to fund the rehabilitation network. Members of the network are encouraged to determine the extent to which the network can be supported with existing staff and financial resources in hospitals and the DHCs.

The HSRC directs the Rehabilitation Institute of Toronto to lead the development and ongoing work of the Rehabilitation Network until the Tri-Hospital Rehabilitation Corporation is created.

The HSRC directs the hospital providers of local and regional rehabilitation services in Toronto and the GTA/905, the Community Care Access Centres in Toronto and the GTA/905, and the District Health Councils in Toronto and the GTA/905, to appoint representatives to the Rehabilitation Network as determined by the HSRC’s membership criteria by June 30, 1998.

The HSRC recognizes that implementation of the rehabilitation planning guidelines requires a re-balancing of rehabilitation resources across the GTA. Rehabilitation beds in Toronto will decrease as the number of beds in the GTA/905 will increase. It is recognized that the 2003 targets must be achieved using reasonable and manageable implementation processes.
The HSRC believes that each phase of implementation requires careful monitoring to ensure that quality and access objectives are met. The Ministry of Health should set up a process to monitor the progress of the rebalancing of rehabilitation services in partnership with the DHCs in the GTA. In turn, the DHCs should coordinate the rebalancing of services and evaluate the implementation of these changes. It should be the responsibility of the DHCs in the GTA to keep the Ministry of Health informed of the progress being made to rebalance services, and to make recommendations to the Ministry that ensure accessibility to quality services is maintained.
SECTION II: LONG-TERM CARE

The HSRC considers long-term care to include chronic care hospitals, chronic units in acute care hospitals, nursing homes, homes for the aged, supportive housing, long-term home care, attendant care and adult day care. This section should be read in conjunction with the HSRC’s discussion paper on long-term care services, which includes HSRC’s policy and planning guidelines.\(^{12}\)

The HSRC received representations on a wide range of long-term care issues in Toronto. Its deliberations and final directions are presented for the following:

- planning assumptions;
- complex continuing care;
- palliative and respite care; and
- implementation of changes in long-term care services.

PLANNING ASSUMPTIONS

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**Highlights of the Notices - July 1997**

- Principal planning region for long-term care services to be Toronto and its nine boundary forward sortation areas (FSAs).
- Planning for ‘complex continuing care’ (care received by a chronic patient who requires hospitalization) to be seven beds per 1,000 population 75 years of age and older (includes respite and palliative care in a complex continuing care setting).
- Planning range for ‘long-term care places’ (long-term care beds in nursing homes and homes for the aged, supportive housing, long-term home care, attendant care and adult day care) to be 206.0 to 243.1.

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**Principal Issues in the Representations**

Representations on complex continuing care noted that the planning ratios are too low and the bed targets unrealistic for the needs of those 75 and older. As well, the target was regarded as inadequately reflecting the growing complex continuing care needs of adults aged 19-74. This is especially pertinent to Toronto with its larger proportion of persons with HIV/AIDS who require higher levels of care. Finally, a number of representations suggested that one classification system, MDS/RUGS III, should be used for both hospital and long-term care sectors.

**The HSRC’s Deliberations**

Since the release of its July report on Toronto and the discussion paper *Rebuilding Ontario’s Health System: Interim Planning Guidelines and Implementation Strategies*, the HSRC has continued to assess the adequacy of its planning guidelines for long-term care. The report *Change and Transition*...
presents the results of the HSRC’s additional analyses and the revised guidelines on which the final directions and advice are based. The following should be read in conjunction with the long-term care chapter in *Change and Transition*.

The HSRC confirms that the reduction of complex continuing care beds must be viewed in the context of rebalancing the long-term care system, with appropriate increases in other areas of the sector. These include facility-based settings such as nursing homes and homes for the aged, and community-based settings such as supportive housing, long-term home care, attendant care and adult day care.

The HSRC supports the gradual restructuring of long-term care services over the next three to five years to allow sufficient time for appropriate alternative services to be put in place to meet the care needs of the population. Successfully achieving this goal is contingent upon reinvestments in community-based services and appropriate facility-based services.

The HSRC reassessed the use of the nine boundary FSAs to plan long-term care services in Toronto. Representations, especially from hospitals in York Region, requested that the nine FSAs be used to size services in the GTA/905. An analysis of utilization patterns for 1995/96 determined that 57% of York Region residents who live in York’s six boundary FSAs obtain their complex continuing care in the region; the other 43% in Toronto. A total of 60 complex continuing care beds are required to meet the needs of York’s six boundary FSAs by 2003; 60% of these will be sited in York Region and 40% in Toronto. This ensures that capacity is available in York Region to meet the needs of these residents, and that the use of existing capacity in Toronto is maximized. The HSRC’s analysis further determined that the nine FSAs will be used to plan long-term care spaces in the municipalities in which they are located.

As a result of additional analysis, the revised planning targets for in-hospital long-term care are 8.23 beds per 1,000 population 75 years and older, to be allocated as follows: 7.62 beds for complex continuing care, .20 for respite and .41 for palliative care. It must be noted that, although the HSRC guideline is described as the number of beds per 1,000 population 75 and older, this target in fact incorporates the long-term care needs of the population aged 19-74 as well.

Based on the HSRC revised targets, 1,350 complex continuing care beds, 35 respite beds and 73 palliative beds will be required in Toronto by 2003 for a total of 1,458 beds. (The HSRC had proposed 1,379 beds in its July 1997 Toronto report using the previous methodology.) In both instances, the total does not include 20 complex continuing care beds sited at Bloorview MacMillan Centre. Palliative and respite beds will not be specifically allocated to selected facilities. Rather, it is expected that all hospitals that provide complex continuing care services will also provide respite and palliative care services according to the planning targets.

When analyzing long-term care spaces, the HSRC conducted further research on guidelines for
beds in nursing homes and homes for the aged, and spaces in supportive housing, long-term home care, attendant care and adult day care. Initially, the guideline was based on maintaining resources between the 25th and 75th percentile of actual utilization. In the revised methodology, the guideline is based on average utilization. As a result, Toronto will need an additional 10,997 spaces by 2003. These are distributed as follows:
- 5,634 long-term care beds in nursing homes or homes for the aged; and
- 5,363 places in supportive housing, long-term home care, attendant care and adult day care.

**COMPLEX CONTINUING CARE**

**Highlights of the Notices - July 1997**
- Centenary Health Centre, Salvation Army Scarborough Grace Hospital, Toronto East General and Orthopaedic Hospital, Bayview Hospital Corporation, Mississauga Queensway Hospital Corporation (Queensway site), Providence Centre, Tri-Hospital Rehabilitation Corporation (Dunn Avenue site), Baycrest Centre for Geriatric Care and West Park Hospital each to implement a plan for their respective hospitals that includes the operation of designated complex continuing care beds.
- Runnymede Chronic Hospital, the Salvation Army Toronto Grace Hospital and the Riverdale Hospital to cease operating as public hospitals, and consider making application to the Minister of Health for the development of long-term care services.
- Advise the Minister of Health to revoke the licence of Dewson Hospital.
- Scarborough General Hospital to cease operating chronic care beds, and St. Joseph’s Health Centre to cease operating Our Lady of Mercy Pavilion.
- Advise the Minister of Health to consider proposals or applications for the development of long-term care services by Runnymede Hospital, the Salvation Army Toronto Grace Hospital, Riverdale Hospital and Dewson Hospital within the policy framework of the long-term care system.

**Principal Issues in the Representations**

The representations on complex continuing care addressed the definition and siting of services, the proposed closure of facilities, and funding. Representations noted that defining ‘complex continuing care’ works against an integrated continuum of services because patients who require this level of care have to be transferred to another facility. Some representations noted that complex continuing care should not be provided in acute care hospitals; the opinion was that these patients are better served in non-acute settings. Some acute facilities proposed increasing the number of designated complex continuing care beds, and a non-acute facility requested flexibility to use day spaces for both rehabilitation and complex continuing care, as well as more time to implement reductions in complex continuing care beds.

Some representations expressed concern about the closure of Riverdale Hospital. It was noted that the facility has the culture and skill to provide complex continuing care, and that its closure leaves south-east Toronto underserved. Concerns were also expressed about the future of Riverdale Hospital’s end stage renal disease program and access to complex continuing care for persons with HIV/AIDS.
Representations on Runnymede Chronic Care Hospital, the Salvation Army Toronto Grace Hospital and Riverdale Hospital proposed models of enriched, multi-level, long-term care that includes maintaining current complex continuing care patients. Runnymede Hospital requested that current funding be maintained, that a cross-funding formula be developed, and that changes be phased in gradually with extended time frames and ongoing evaluation.

A number of representations noted that the long-term care model proposed by the HSRC will require additional investments in rehabilitation, clinical specialty resources, equipment and capital.

The HSRC’s Deliberations

The HSRC confirms its conclusion that complex continuing care patients must have access to hospital-based supports, technical resources and multi-disciplinary expertise. This places complex continuing care patients in the setting most appropriate for their needs, and consolidates the expertise necessary to meet their high care requirements. The HSRC confirms that complex continuing care will be sited in acute care facilities or in facilities with expertise in complex continuing care with strong links to acute hospitals. The HSRC recognizes that research is inconclusive as to whether the best setting is in specialized units of acute care hospitals or in free-standing facilities. It confirms its intent to site complex continuing care beds using excess capacity in acute care hospitals, where appropriate, and good capital stock in freestanding complex continuing care facilities. These beds are consolidated and geographically distributed in ten sites throughout Toronto to meet the needs of the population.

The HSRC directs the following facilities to implement a plan for their respective hospitals that includes the operation of complex continuing care beds as designated by the HSRC:

- Centenary Health Centre, Salvation Army Scarborough Grace Hospital, Toronto East General and Orthopaedic Hospital, Bayview Hospital Corporation, Mississauga Queensway Hospital Corporation (Queensway site), Providence Centre, Tri-Hospital Rehabilitation Corporation (Dunn Avenue site), Baycrest Centre for Geriatric Care and West Park Hospital.

The HSRC directs Scarborough General Hospital to cease operating chronic care beds by December 31, 1999.

The HSRC directs the St. Joseph’s Health Centre to cease operating Our Lady of Mercy Pavilion by December 31, 1999.

The table shows the current and proposed distribution of complex continuing care beds in Toronto.

Current and Proposed Complex Continuing Care Beds in Toronto
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<th>Proposed Distribution by 2003</th>
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<tr>
<td><strong>Total</strong></td>
<td><strong>2,241</strong></td>
<td><strong>1,399</strong></td>
</tr>
</tbody>
</table>


** Excludes the 340 veterans’ beds.

The HSRC confirms its intent to direct the Runnymede Chronic Hospital, the Salvation Army Toronto Grace Hospital and Riverdale Hospital to cease operating as public hospitals, and to consider making application to the Minister of Health for the development of residential long-term care services. The HSRC also confirms its intent to advise the Minister of Health to revoke the licence of Dewson Hospital and to consider an application for residential long-term care services. The closure of these hospitals and their programs and services will be coordinated with the increased availability of suitable long-term care alternatives. The HSRC reiterates that these applications should be within the policy framework of the long-term care system, and should include the building of suitable physical plants. These facilities should also provide programs and services that are appropriate to their status as residential long-term care facilities within the Ministry’s policy framework.

Excellent opportunities exist for innovative programs in residential long-term care facilities. For example, the Salvation Army Toronto Grace Hospital has proposed a palliative care unit in the non-hospital, low-technology atmosphere of long-term care. The residential and social focus of this environment contributes positively to quality of life issues that are central to palliative care. While the HSRC recognizes that palliative care is provided in a number of facility- and community-based settings, the Salvation Army Toronto Grace has made a compelling case to use its expertise for a specially
designed palliative care unit. Best practices for palliative care can be developed, evaluated and shared with other providers of palliative care services. The HSRC commends Salvation Army Toronto Grace Hospital on this initiative and encourages it to pursue this worthwhile endeavour in its application to the Minister of Health.

The HSRC directs the Runnymede Chronic Hospital, the Salvation Army Toronto Grace Hospital and Riverdale Hospital to cease to operate as public hospitals at their current sites no later than March 31, 2000, and to consider making application to the Minister of Health for the development of long-term care services.

The HSRC advises the Minister of Health to revoke the licence of Dewson Hospital no later than March 31, 2000.

The HSRC advises the Minister of Health to consider proposals or applications from Runnymede Hospital, the Salvation Army Toronto Grace Hospital, Riverdale Hospital and Dewson Hospital for the development of residential long-term care services to be provided in appropriate facilities, and within the policy framework of the long-term care system.

Closure of Riverdale Hospital - Dialysis Services and Complex Continuing Care for Persons with HIV/AIDS

In its July report, the HSRC advised the Minister of Health that the resources for the chronic dialysis program sited at Riverdale Hospital should remain with the dialysis program at St. Michael’s Hospital. The closure of Riverdale Hospital has raised concerns about the future of this facility’s end stage renal disease program. Representations suggested that responsibility for relocating this program be given to the Toronto Region Dialysis Committee and the Kidney Foundation.

In response to the HSRC’s directions on dialysis services, the Toronto Region Dialysis Committee, the GTA hospitals providing dialysis services and the Central Ontario Branch of the Kidney Foundation of Canada developed the Plan for Implementation of HSRC Directives: Dialysis Patient Movement from Wellesley Central and Other Hospitals (January 1998). This report recommended that the Riverdale dialysis program, which was provided in partnership with Wellesley Central Hospital, be transferred to Scarborough General Hospital. The HSRC supports this transfer and directs Scarborough General to offer this program in partnership with a facility that offers complex continuing or other long-term care services in east Toronto.

The HSRC directs Scarborough General Hospital to offer the dialysis program previously offered by Riverdale Hospital, in partnership with a facility that offers complex continuing care or other long-term care services in east Toronto.
The closure of Riverdale Hospital was seen to affect a joint proposal between Riverdale and Casey House Hospice for enhanced access to complex continuing care for persons with HIV/AIDS. Representations suggested that Casey House be expanded by five beds to compensate for the loss of access to these services at Riverdale.

The HSRC believes that the closure of Riverdale Hospital should not compromise access to complex continuing care for persons with HIV/AIDS. The HSRC directs the Toronto East General and Orthopaedic Hospital to work collaboratively with Casey House, St. Michael’s Hospital and the Toronto Community Care Access Centres to meet this need. The HSRC recognizes that care for persons with HIV/AIDS is provided in a number of facility- and community-based settings.

The HSRC directs the Toronto East General and Orthopaedic Hospital to ensure access to complex continuing care for persons with HIV/AIDS, in collaboration with Casey House Hospice, St. Michael’s Hospital and the Toronto Community Care Access Centres.

PALLIATIVE AND RESPITE CARE

Principal Issues in the Representations

A number of representations requested clearer directions on palliative care services, including the siting of these services and the disposition of these services in the facilities that are directed to close. The need for expanded palliative care services was identified in west Toronto and the west GTA, as well as by Etobicoke General Hospital, The Toronto Hospital, North York General Hospital, Salvation Army Scarborough Grace Hospital and Scarborough General Hospital. It was also suggested that respite care be funded at Casey House in keeping with the recommendation of the Metro Toronto District Health Council.

Submissions noted that palliative care funding is not protected, and rates are inconsistent. It was suggested that rates be set according to patient need or minimally at the current acute care rate, and that there be a consistent co-payment charge for palliative patients. It was noted that there should be alternative payment funding for physicians who provide palliative care. Finally, it was suggested that a palliative care providers network be established.

The HSRC’s Deliberations

As noted in the planning assumptions above, the HSRC determined planning targets for in-hospital long-term care that allocated .20 beds for respite care and .41 beds for palliative care. Based on these targets, 35 respite beds and 73 palliative beds will be required in Toronto hospitals in 2003. The
HSRC has determined that palliative and respite beds will not be specifically allocated to selected facilities. Rather, it is expected that the hospitals providing complex continuing care services will also provide respite and palliative care services according to these planning targets.

The HSRC recognizes that palliative and respite care are also provided in acute care hospitals and in other facility- and community-based settings. At this point in the development of the methodology, however, targets have been determined only for the chronic hospital component of these services.

For a discussion of costing for these services, see the HSRC’s July 1997 Toronto report.

**IMPLEMENTATION OF CHANGES IN LONG-TERM CARE SERVICES**

**Highlights of the Notices - July 1997**

- Advise the Minister of Health to request the six Community Care Access Centres in Toronto to coordinate the implementation of the re-balancing and expansion of long-term care beds and spaces in Toronto.

**Principal Issues in the Representations**

Representations on the implementation of long-term care changes questioned the role of CCACs in admitting clients to complex continuing care. Some representations noted that CCACs should coordinate a complex continuing care regional bed registry but hospitals should have direct access to beds on their sites. It was suggested that one CCAC be designated as the single access point for Toronto for specialized HIV/AIDS complex continuing care services. It was also suggested that CCACs be funded for outcome effectiveness research and to purchase geriatric services. Finally, it was proposed that the Metro Toronto District Health Council take the lead in planning the development of new long-term care facility beds and long-term care community spaces in Toronto.

Representations commenting on implementation time frames noted that more time is needed to negotiate funding and community options for clients, develop additional facility- and community-based long-term care, and develop consistent admission criteria for complex continuing care. As well, it was noted that chronic bed reductions need to be monitored vis-à-vis alternative level of care and long-term care waiting lists.

**The HSRC’s Deliberations**

Implementation of the HSRC’s directions in long-term care represents significant changes and a careful rebalancing of services. Implementation will require careful monitoring to ensure that quality and access objectives are met. This is particularly critical in the first two years when reductions in complex continuing care beds will be offset by increases in long-term care beds and community-based services.
The Ministry of Health should set up a process, in partnership with CCACs and the Toronto District Health Council, to coordinate and monitor the implementation process.

The HSRC deliberated the role of CCACs in admitting clients to complex continuing care. It concludes that the role of CCACs should be expanded to include coordinating placements to complex continuing care beds in addition to their current role of coordinating placement of residents in long-term care facilities and/or access to other long-term care services. The inclusion of complex continuing care in a single placement and admissions process is predicated on a team of professionals, including physicians, participating in the review of admissions to these beds, as well as hospitals being actively involved in determining how the beds are used. The HSRC agrees that one CCAC should be designated as the single access point for Toronto for specialized HIV/AIDS complex continuing care services, and will advise the Minister of Health accordingly.

The HSRC advises the Minister of Health to set up a process, in partnership with the Community Care Access Centres in Toronto and the Toronto District Health Council, to coordinate the implementation of changes in long-term care.

The HSRC further advises the Minister of Health to designate one Community Care Access Centre as the single access point for Toronto for specialized HIV/AIDS complex continuing care services.
SECTION III: SUB-ACUTE CARE

Principal Issues in the Representations

A number of representations questioned whether sub-acute was a discrete level of care. It was noted that the term was neither clearly defined nor well delineated from rehabilitation, especially short-term rehabilitation and geriatric rehabilitation. One representation assumed a link between sub-acute care and geriatrics by suggesting that all patients for sub-acute care be assessed by a geriatrician. Another representation suggested that the definition of sub-acute should reflect cost effective in-home alternatives that could be provided by CCACs.

Opinions varied on where sub-acute resources should be sited: acute care, rehabilitation or complex continuing care facilities. Some facilities suggested a role in the provision of sub-acute care, including St. Bernard’s Hospital, Providence Centre, St. John’s Rehabilitation Hospital and Centenary Health Centre.

The HSRC’s Deliberations

In its July 1997 Toronto report, the HSRC determined that a planning guideline of 14 beds per 100,000 population should be used for sub-acute care. Toronto would, therefore, require 493 sub-acute beds by the year 2003. The HSRC welcomed advice on the most appropriate location of sub-acute programs.

In its deliberations on the definition of and the planning guidelines for sub-acute care, the HSRC concluded that the most appropriate location for sub-acute care is in acute care hospitals. The HSRC refined its definition of sub-acute care to be a ‘distinct’ form of hospital-based inpatient care provided on a supervised inpatient unit of a hospital for individuals in need of slower paced recovery following surgery or short-term medical treatment and convalescence following an acute medical episode. Patients receiving sub-acute care suffer from a loss of function as a result of an acute care episode or extended stay in hospital, are deemed likely to regain functioning following a course of treatment, are focused on reactivation and restoration, and cannot receive conventional home-based services to manage their care requirements. Sub-acute is regarded as a program of acute care.

Cases were removed from sub-acute that were more appropriately classified as short-term rehabilitation. This resulted in a lower planning guideline of 13 beds per 100,000 population.

The HSRC determined sub-acute care sizing for all of the GTA based on the projected population to 2003 adjusted for age. The GTA requires 708 beds, 432 of which are sited in Toronto hospitals. These beds are distributed proportionately by the medical-surgical activity at the following hospitals.

13 See the HSRC’s report Change and Transition for these deliberations.
## Proposed Distribution of Sub-Acute Beds in Toronto

<table>
<thead>
<tr>
<th>Facility</th>
<th>Proposed Distribution by 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centenary Health Centre</td>
<td>27</td>
</tr>
<tr>
<td>Etobicoke General Hospital</td>
<td>21</td>
</tr>
<tr>
<td>North York General</td>
<td>31</td>
</tr>
<tr>
<td>Humber River Regional Hospital</td>
<td></td>
</tr>
<tr>
<td>Finch site</td>
<td>23</td>
</tr>
<tr>
<td>Humber site</td>
<td>25</td>
</tr>
<tr>
<td>Mount Sinai Hospital</td>
<td>23</td>
</tr>
<tr>
<td>St. Joseph’s Health Centre</td>
<td>28</td>
</tr>
<tr>
<td>St. Michael’s Hospital</td>
<td>50</td>
</tr>
<tr>
<td>The Toronto Hospital</td>
<td>81</td>
</tr>
<tr>
<td>Salvation Army Scarborough Grace Hospital</td>
<td>14</td>
</tr>
<tr>
<td>Toronto East General and Orthopaedic Hospital</td>
<td>25</td>
</tr>
<tr>
<td>Bayview Hospital Corp.</td>
<td>51</td>
</tr>
<tr>
<td>Mississauga Queensway Hospital Corp.</td>
<td>*</td>
</tr>
<tr>
<td>Scarborough General Hospital</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>432</strong></td>
</tr>
</tbody>
</table>

* As reported in the HSRC’s April 1998 report on the GTA/905, 42 sub-acute beds will be located at the Mississauga site of this hospital.

The capital estimates for Toronto hospitals have been reassessed to include sub-acute capacity. Capital and operating reinvestments for sub-acute care are presented in Section V.
SECTION IV: OTHER ISSUES

SPECIALIZED GERIATRICS

Representations to the HSRC noted that specialized geriatrics was not acknowledged in the deliberations on rehabilitation and long-term care. This included the role of geriatricians and the Toronto Regional Geriatric Program. Representations noted that geriatric services will become increasingly important because the frail elderly have multiple care needs. It was suggested that specialized geriatric inpatient units be established in all acute hospitals as recommended by the Metropolitan Toronto District Health Council. It was also suggested that the HSRC determine whether specialized geriatrics should be categorized as rehabilitation or long-term care. The designation will affect hospitals that wish to retain their specialized geriatric services but do not have rehabilitation or complex continuing care beds.

The HSRC recognizes that hospitals will provide care for an increasing number of elderly patients. An aging population and longer life expectancies have resulted in a higher incidence and prevalence of chronic and multiple ailments, conditions that are more common in the elderly. Consequently, older people use disproportionately more health care resources than the young. Specialized geriatrics focuses on the elderly with more complex problems, including the frail elderly who are at greatest risk of losing their independence. Geriatricians have specialized expertise in the assessment, care and treatment of the elderly. There are approximately 30 geriatricians practising in the Greater Toronto Area.

The HSRC is aware that the Ministry of Health is in the process of evaluating Regional Geriatric Programs (RGPs) and services for the elderly. RGPs were established by the Ministry in 1987. They are located in each of the five health science centres (Toronto, Hamilton, London, Kingston and Ottawa). RGPs have four broad functions: clinical service, teaching and education, clinical research and consultation. Each RGP has inpatient geriatric assessment beds, outpatient clinics, a day hospital and an outreach multi-disciplinary team. There is inconsistency in the categorization and siting of beds in the geriatric assessment units.

RGPs assess the elderly with more complex problems. They provide more accurate medical diagnoses and more aggressive assessment of rehabilitation potential, followed by short-term rehabilitation and referral to community services where possible. The Toronto RGP provides services in the north (Sunnybrook Health Science Centre, North York General Hospital and Baycrest Centre for Geriatric Care), the east (St. Michael’s Hospital and Providence Centre) and central Toronto (The Toronto Hospital and the Rehabilitation Institute of Toronto).

The HSRC defers further comment on the RGPs and services for the elderly in light of the ongoing evaluation by the Ministry of Health.
HUMAN RESOURCES

In its July report, the HSRC directed hospitals to develop, in conjunction with employee representatives, a Toronto-wide human resource plan to address the impact of the HSRC’s directions on hospital employees. In January 1998, the Labour Adjustment Framework Agreement was completed. The HSRC believes that this agreement provides a firm foundation for addressing the impact of restructuring on hospital employees. Since the agreement has been ratified, no further directions are being issued.

In August 1997, the HSRC announced a medical human resource fact-finding team to identify restructuring issues that affect hospital-associated physicians, and to make recommendations to address these issues. The HSRC received the fact finders’ report in January 1998. It includes recommendations that address a number of areas, including physicians in receiving and amalgamating hospitals, variations in hospital bylaws and changes in clinical demands. In April 1998, the HSRC issued notices to hospitals in Toronto outlining a process for addressing the impact of restructuring on physicians.

SECTION V: FINANCIAL IMPACT OF RESTRUCTURING

The financial impact of restructuring includes a review of the costs and savings associated with restructuring, and reinvestments for home care, long-term care spaces and sub-acute care.

COSTS AND SAVINGS ASSOCIATED WITH RESTRUCTURING

The HSRC methodology for identifying costs and savings associated with restructuring options was developed to:

- determine the extent of savings associated with clinical efficiencies, restructuring savings (program/transfers), consolidation of support services, administrative overhead, and costs of site operations;
- use an approach consistent with industry practices and methodologies currently in place; and
- develop advice for the Minister of Health on the estimated expenses and savings associated with HSRC’s directions and recommendations.

Representations noted that the HSRC’s funding allocations for operating and capital costs of rehabilitation and complex continuing care were too low. As well, estimates were too low for palliative care, sub-acute care, seven-day-a-week rehabilitation, ambulatory rehabilitation and in-home services. Many representations suggested that the HSRC’s assumptions about administrative efficiencies were too aggressive. As well, questions were raised about expected administrative efficiencies, other selected expenses and overhead allocations.

The HSRC costing methodology is included in the July 1997 Toronto report. Actual expenses and savings will require further development during the implementation of the directions by the hospitals in conjunction with the HSRC and the Ministry of Health. The HSRC strives to use the most accurate and consistent information possible in developing the estimates.

Operating Costs And Savings

Rehabilitation

The reconfigured system for rehabilitation services is outlined in Section I. While the cost of this reconfigured system has decreased by 6.8% in Toronto, a high proportion of rehabilitation services will be relocated to the rest of the GTA. The siting of these transferred services is outlined in the HSRC’s final report on the GTA/905 (April 1998).

The costing model for rehabilitation data was based on 1995/96 Ontario Cost Distribution Methodology (OCDM). The model approximates the cost of providing care to a rehabilitation patient on any given day. One limitation of the data is that patient-specific information does not exist for
rehabilitation patients, therefore, costs can not be adjusted for patient acuity. As well, since hospitals have re-defined many of their beds since 95/96, OCDM data may not provide an accurate reflection of a specific hospital's expenses. As a result of these limitations, a very conservative costing model is used to predict resources required for new beds. Clinical efficiencies are not applied to rehabilitation activity since little or no accurate information exists to benchmark hospitals.

A number of representations suggested that reinvestments for rehabilitation services were limited to inpatient activity, which is only one component of the broad spectrum of services offered by designated rehabilitation facilities. To address this concern, the HSRC examined the proportion of funding allocations devoted to outpatient services at existing centres (as a proxy for outpatient activity). Unfortunately, due to the lack of consistency in the proportion of rehabilitation funding for outpatient services, the HSRC is unable to provide estimates for reinvestments related to outpatient rehabilitation activity. Additional work is required to determine the most appropriate funding level for outpatient rehabilitation services.

A number of submissions also raised concerns that the direct cost per diem used in the rehabilitation costing methodology does not accurately reflect differences in case mix or acuity. It was suggested that adjustment factors be incorporated into the costing methodology to reflect intensity of care. At this time, the HSRC is unable to provide estimates of adjustment factors for acuity or case mix for rehabilitation services. The HSRC recognizes that further work needs to be undertaken to determine the need for these adjustments and suggests that this work be undertaken by the Ministry of Health as it monitors and evaluates the re-balancing of rehabilitation resources across the GTA.

The HSRC’s revised planning guidelines assume five-day-a-week rehabilitation service rather than seven-day-a-week service. Although the HSRC supports the need for a more continuous delivery system for rehabilitation, the LOS targets used to establish the revised rehabilitation planning guidelines are based on five-day-a-week service. Since the HSRC is not directing that service be delivered seven days-a-week, an allied health adjustment associated with increased service delivery is no longer required. In the revised costing methodology for rehabilitation, the allied health adjustment has been removed.

The summary of total rehabilitation costs and savings is presented below.

<table>
<thead>
<tr>
<th>SUMMARY OF TOTAL REHABILITATION COSTS AND SAVINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET EXPENSES</td>
</tr>
<tr>
<td>Program reductions</td>
</tr>
<tr>
<td>Administrative efficiencies</td>
</tr>
<tr>
<td>Change in selected expenses</td>
</tr>
<tr>
<td>Site closure expenses</td>
</tr>
<tr>
<td>COST OF RECONFIGURED SYSTEM</td>
</tr>
<tr>
<td>TOTAL SAVINGS</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Complex Continuing Care

In the July 1997 report, the HSRC’s notices included recommendations that several chronic care facilities cease operations: Runnymede Chronic Care Hospital, Salvation Army Toronto Grace Hospital, Dewson Private Hospital and Our Lady of Mercy wing of the St. Joseph’s Health Centre. Since then, the HSRC has determined population planning targets that would result in further restructuring of complex continuing care services and additional savings by the year 2003. The details of the complex continuing care (chronic and palliative care) costing methodology are outlined in the HSRC’s July 1997 Toronto report. The summary of total complex continuing care costs and savings is presented below.

<table>
<thead>
<tr>
<th>Summary of Total Complex Continuing Care Costs and Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET EXPENSES</td>
</tr>
<tr>
<td>Program reductions</td>
</tr>
<tr>
<td>Resource intensity adjustment</td>
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<tr>
<td>Administrative efficiencies</td>
</tr>
<tr>
<td>Change in selected expenses</td>
</tr>
<tr>
<td>Site closure expenses</td>
</tr>
<tr>
<td>COST OF RECONFIGURED SYSTEM</td>
</tr>
<tr>
<td>TOTAL SAVINGS</td>
</tr>
</tbody>
</table>

The HSRC has advised the Minister of Health to reinvest these savings and to provide additional funding for long-term care spaces in Toronto.

Summary of Total Costs and Savings

The 1995/96 net expenses for rehabilitation and complex continuing care total $361.2 million. The total savings as a result of restructuring rehabilitation and complex continuing care are $72.8 million, which represents savings of 20.2%.

Capital Costs (Reinvestments)

The HSRC’s July notices outlined the capital costs required to achieve hospital restructuring in Toronto. Representations from hospitals identified issues regarding space allocation and related funding. The capital requirements for restructuring rehabilitation, chronic care and sub-acute have been estimated.

The HSRC applied the following approach to developing capital cost estimates.
Based on the analysis of each facility’s information and the TDHC analysis, each of the current sites is assessed to determine its functionality, physical state of the buildings and services, and expansion potential;

- Each site is assessed based on the HSRC’s sizing analysis to determine its potential to accommodate the required number of beds and related patient activity; and
- Renovation and new construction costs, as well as related ancillary, site development and furnishings and equipment requirements, are assessed using current industry standards.

The July 1997 Toronto report included capital reinvestments for acute care hospitals based on preliminary sizing for rehabilitation and complex continuing care services. Sizing guidelines have been finalized and capital reinvestments have been recalculated, to reflect the revised guidelines and additional capacity for sub-acute care services.

Capital costs (reinvestments) for rehabilitation, complex continuing care and sub-acute care are outlined in the table on the next page.

**REINVESTMENTS FOR HOME CARE, LONG-TERM CARE AND SUB-ACUTE CARE**

In its July 1997 report, the HSRC recommended that $151 to $157 million be reinvested as additional annual funding for home care, long-term care and sub-acute care.

Representations noted that reinvestments in home care and long-term care were insufficient and did not reflect increased demand for these services. It was suggested that when home care reinvestments are determined, the cost of a comprehensive medical assessment of the frail elderly should be included. It was recommended that reinvestments flow quickly, especially for community-based services such as nursing homes.

It was suggested that the HSRC develop financial targets for non-institutional long-term care investment and capital requirements for new long-term care beds. It was noted that the HSRC should move away from a fragmented funding approach and endorse a seamless approach to population needs-based care.

The HSRC conducted additional analysis on planning guidelines, implementation strategies and investments for home care, long-term care and sub-acute care. These are presented in the HSRC’s report *Change and Transition*. The HSRC’s recommendations for reinvestments in these three areas are presented.
### Capital Reinvestments for Toronto Hospitals*

<table>
<thead>
<tr>
<th>Hospital</th>
<th>July 1997 HSRC Report</th>
<th>April 1998 HSRC Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Toronto Hospital: Western Division</td>
<td>$8.0 million</td>
<td>$8.0 million</td>
</tr>
<tr>
<td>St. Michael’s Hospital</td>
<td>$23.5 mil</td>
<td>$34.0 mil</td>
</tr>
<tr>
<td>Bayview Hospital Corporation</td>
<td>$43.0 mil</td>
<td>$46.7 mil**</td>
</tr>
<tr>
<td>St. Joseph’s Health Centre</td>
<td>$7.0 mil</td>
<td>$7.0 mil</td>
</tr>
<tr>
<td>The Queensway Mississauga Hospital Corporation:</td>
<td></td>
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</tr>
<tr>
<td>Queensway site</td>
<td>$3.8 mil</td>
<td></td>
</tr>
<tr>
<td>Mississauga site</td>
<td>TBD**</td>
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<tr>
<td>Humber River Regional:</td>
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<tr>
<td>Finch site</td>
<td>$37.9 mil</td>
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<td>Humber site</td>
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</tr>
<tr>
<td>North York Branson Hospital site</td>
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<tr>
<td>North York General Hospital</td>
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<tr>
<td>Centenary Health Centre</td>
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</tr>
<tr>
<td>Scarborough General Hospital</td>
<td>$2.6 mil</td>
<td>$2.6 mil</td>
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<tr>
<td>Toronto East General and Orthopaedic Hospital</td>
<td>$12.6 mil</td>
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<td>West Park Hospital</td>
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<td>$2.5 mil</td>
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<tr>
<td>Rehabilitation Institute of Toronto:</td>
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<td>$6.4 mil</td>
</tr>
<tr>
<td>University Ave. site</td>
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<td>$3.5 mil</td>
</tr>
<tr>
<td>Providence Centre</td>
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</tr>
<tr>
<td>Bloorview MacMillan Centre</td>
<td>TBD</td>
<td>$31.4 mil++</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$183.0 million</td>
<td>$265.9 million</td>
</tr>
</tbody>
</table>

* These reinvestments include ancillary and site development costs, and cover the capital costs for sub-acute services.

** The HSRC is further reviewing capital estimates for the Bayview site and the ambulatory care centre of the amalgamated Sunnybrook Health Science Centre, Women’s College Hospital, and the Orthopaedic and Arthritic Hospital.

+ Capital costs for the Mississauga site are included in the HSRC’s review of the GTA/905. See the report of the GTA/905 (April 1998).

++ The capital investment for Bloorview MacMillan is conditional upon negotiating the purchase of the Workplace Safety and Insurance Board of Toronto site in Downsview.

### Home Care

The HSRC defines home care as health care services provided in patients’ homes within 30 days following an acute inpatient or same day surgery discharge. In the July 1997 Toronto report, the methodology for home care reinvestments was based on the following: home care programs were ranked based on utilization rates using 1993/94 to 1995/96 data, a minimum access benchmark was set at the 25th percentile and was used to compare relative use between home care programs across the
province, and the level of reinvestments required to bring “under serviced” home care programs up to the benchmark rate was determined.

The HSRC reassessed and revised its initial methodology based on comments from the field and additional analyses. The revised methodology is as follows: adjustments are made for expected population growth and changes in the age structure in the regions; the benchmark home care utilization rate (75th percentile) for each major clinical category (MCC) and day procedure group (DPG) is multiplied by the corresponding estimated number of hospitalizations for each region including growth to 2003; the mean cost per home care episode for each MCC and DPG is factored into the calculation; home care costs for all MCCs and DPGs are summed to derive the overall financial allocation for each home care program. As with the initial methodology, service intensity, travel costs, and case management and equipment costs are included.

Based on the revised methodology, it was determined that Toronto requires an investment of $42.5 million for home care following acute inpatient and same day surgery procedures.

Long-Term Care Spaces

The term, ‘long-term care spaces’ includes long-term care beds in nursing homes and homes for the aged, and places in supportive housing, long-term home care, attendant care and adult day care. The HSRC conducted further analysis on benchmarks for long-term care spaces. Initially, the benchmark was based on maintaining resources between the 25th and 75th percentile of actual utilization. In the revised methodology, the benchmark is based on average utilization.

Although the HSRC has established a guideline for long-term care beds in nursing homes and homes for the aged, the guideline does not estimate the exact proportion of each service. Similarly, the HSRC guideline for long-term care places does not specify the exact proportion of supportive housing, long-term home care, attendant care and adult day care. The HSRC believes that the appropriate mix of beds and places should be sensitive to local circumstances in each community.

As a result of modifications to the planning guidelines, the HSRC concludes that Toronto will need an additional 10,997 spaces by 2003. These are distributed as follows:
- 5,634 long-term care beds in nursing homes or homes for the aged; and
- 5,363 places in supportive housing, long-term home care, attendant care and adult day care.

Based on the revised methodology, it was determined that Toronto requires an investment of $122.8 million for long-term care beds in nursing homes and homes for the aged, using a calculation of $59.72 per diem. (This is the Ministry allocation and does not include co-payment expenses.) A methodology has been developed to estimate the costs of the long-term care places that are not facility-based at $11,972 per place. Using this costing approach, Toronto requires $64.2 million in reinvestments for long-term care places.
Sub-Acute Care

The planning guideline for sub-acute care was modified with cases removed that were more appropriately classified as short-term rehabilitation. This resulted in a lower planning guideline for Toronto of 13 beds per 100,000 population. This means that Toronto would need 432 sub-acute beds by 2003. These beds were distributed proportionately based on the medical-surgical activity of a hospital. Revisions were made to the costing methodology for sub-acute with the conclusion that a small program and unit would incur costs of approximately $211 per day to provide sub-acute care. Based on this cost, the additional annual investment required in Toronto is $33.3 million.

### Reinvestment Summary

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>$28 mil</td>
<td>$42.5 mil</td>
</tr>
<tr>
<td>Long-Term Care Beds in Nursing Homes and Homes for the Aged</td>
<td>$97 mil</td>
<td>$122.8 mil</td>
</tr>
<tr>
<td>Long-Term Care Places (supportive housing, long-term home care, attendant care and adult day care)</td>
<td>TBD</td>
<td>$64.2 mil</td>
</tr>
<tr>
<td>Sub-Acute Care</td>
<td>$26 to $32 mil</td>
<td>$33.3 mil</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$151 to $157 mil</strong></td>
<td><strong>$262.8 mil</strong></td>
</tr>
</tbody>
</table>
SECTION VI: SUMMARY

SUMMARY OF CHANGES IN REHABILITATION, LONG-TERM CARE AND SUB-ACUTE CARE (TORONTO)

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation</td>
<td>1,013</td>
<td>721</td>
<td>905*</td>
<td>108 (- 11%)</td>
</tr>
<tr>
<td>Complex Continuing Care</td>
<td>2,241</td>
<td>1,399</td>
<td>1,478</td>
<td>763 (- 34%)</td>
</tr>
<tr>
<td>Sub-Acute Care</td>
<td>0</td>
<td>493</td>
<td>432</td>
<td>432</td>
</tr>
<tr>
<td>Long-Term Care Beds</td>
<td>11,674</td>
<td>16,881</td>
<td>17,308</td>
<td>5,634 (+ 48%)</td>
</tr>
<tr>
<td>Long-Term Care Places</td>
<td>12,629</td>
<td>16,811</td>
<td>17,992</td>
<td>5,363 (+ 43%)</td>
</tr>
</tbody>
</table>

* 20 transition to independent beds to be sited for 2003.

IMPACT ON SYSTEM SIZING: REHABILITATION CARE, COMPLEX CONTINUING CARE, LONG-TERM CARE AND SUB-ACUTE CARE

**Current**

- 1,013 rehabilitation beds
- 2,241 complex continuing care beds
- 11,674 beds in nursing homes and homes for the aged
- 12,629 places in supportive housing, long-term home care, attendant care and adult day care

**Post Restructuring**

- 905 rehabilitation beds
  - 200 in acute care hospitals
  - 705 in rehabilitation facilities
- 1,478 complex continuing care beds
  - 411 in acute care hospitals
  - 1,067 in complex continuing care facilities
- 5,634 additional beds in nursing homes and homes for the aged for a total of 17,308 beds
- 5,363 additional places in supportive housing, long-term home care, attendant care and adult day care for a total of 17,992 places
- 432 sub-acute beds (42 additional beds are at the Mississauga site of the Mississauga Queensway Hospital Corporation)

*Total does not reflect 340 veterans’ beds located at Sunnybrook Health Science Centre (Bayview Hospital Corporation).
## SUMMARY OF RESTRUCTURING DIRECTIONS: REHABILITATION AND COMPLEX CONTINUING CARE, BY REHABILITATION AND COMPLEX CONTINUING CARE HOSPITALS

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Facility Status</th>
<th>HSRC Directions</th>
<th>Corporate/Governance Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baycrest Centre for Geriatric Care</td>
<td>Retain</td>
<td>• Provide local long-term rehabilitation&lt;br&gt;• Continue complex continuing care role</td>
<td>Retain corporate status.</td>
</tr>
<tr>
<td>Bloorview MacMillan Centre</td>
<td>Retain Site relocation</td>
<td>• Provide local long-term and regional rehabilitation programs&lt;br&gt;• Continue paediatric complex continuing care role</td>
<td>Retain corporate status.</td>
</tr>
<tr>
<td>Dewson Hospital</td>
<td>Close</td>
<td>• Discontinue complex continuing care role&lt;br&gt;• Advised to apply to Ministry of Health to provide long-term care services in a new facility</td>
<td>Advise Minister to revoke licence as private hospital and consider an application to provide long-term care services in a new facility.</td>
</tr>
<tr>
<td>Lyndhurst Hospital</td>
<td>Retain</td>
<td>• Provide local long-term and regional rehabilitation programs&lt;br&gt;• Continue role in spinal cord rehabilitation</td>
<td>Form a new hospital corporation – “Tri-Hospital Rehabilitation Corporation – with the Rehabilitation Institute of Toronto and The Toronto Rehabilitation Centre.</td>
</tr>
<tr>
<td>Providence Centre</td>
<td>Retain</td>
<td>• Provide local long-term rehabilitation&lt;br&gt;• Continue complex continuing care role</td>
<td>Retain corporate status.</td>
</tr>
<tr>
<td>Rehabilitation Institute of Toronto ( RIT)</td>
<td>Close Austin Terrace site Retain University Ave. site</td>
<td>• Designated as a regional rehabilitation provider&lt;br&gt;• Provide local long-term and regional rehabilitation programs&lt;br&gt;• University Ave site to absorb rehabilitation programs from Austin Terrace and Riverdale Hospital&lt;br&gt;• Continue to provide complex continuing care on the Dunn Ave site only&lt;br&gt;• Provide leadership for the Rehabilitation Network</td>
<td>Form a new hospital corporation – “Tri-Hospital Rehabilitation Corporation – with Lyndhurst Hospital and The Toronto Rehabilitation Centre.</td>
</tr>
<tr>
<td>Hospital</td>
<td>Facility Status</td>
<td>HSRC Directions</td>
<td>Corporate/Governance Changes</td>
</tr>
<tr>
<td>------------------------------</td>
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</tr>
</tbody>
</table>
| Riverdale Hospital           | Close          | • Discontinue rehabilitation and complex continuing care role                    | Cease to operate as a public hospital.  
                               |                | • Transfer programs to Tri-Hospital Rehab Corporation and to St. John’s Rehab Hospital | Advise Minister to consider an application to provide long-term care services in a new facility. |
|                              |                | • Advised to apply to Ministry of Health to provide long-term care services in a new facility |                              |
| Runnymede Chronic Care Hospital | Close         | • Discontinue complex continuing care role                                      | Cease to operate as a public hospital.  
                               |                | • Advised to apply to Ministry of Health to provide long-term care services in a new facility | Advise Minister to consider an application to provide long-term care services in a new facility. |
| Salvation Army Toronto Grace Hospital | Close | • Discontinue complex continuing care role                                      | Cease to operate as a public hospital.  
<pre><code>                           |                | • Advised to apply to Ministry of Health to provide long-term care services in a new facility | Advise Minister to consider an application to provide long-term care services in a new facility. |
</code></pre>
<p>| St. Bernard’s Hospital       | Close          | • Discontinue rehabilitation role                                                | Cease to operate as a public hospital but enter into a contractual arrangement with St. John’s Rehabilitation Hospital to continue to operate the programs and services at that site until they are transferred. |
|                              |                | • Transfer programs to St. John’s Rehabilitation Hospital                       |                              |
|                              |                | • Contract with St. John’s to provide services on St. Bernard’s site             |                              |
| St. John’s Rehabilitation Hospital | Retain    | • Designated as a regional rehabilitation provider                               | Retain corporate status.        |
|                              |                | • Provide local long-term and regional rehabilitation programs                  |                              |
|                              |                | • Receive programs from St. Bernard’s Hospital and from Riverdale Hospital       |                              |
| St. Joseph’s Infirmary       | Retain         | • Continue complex continuing care role                                         | Retain corporate status.        |
| Toronto Rehabilitation Centre | Retain         | • Continue outpatient rehabilitation role                                       | Form a new hospital corporation – “Tri-Hospital Rehabilitation Corporation – with Lyndhurst Hospital and the Rehabilitation Institute of Toronto. |</p>
<table>
<thead>
<tr>
<th>Hospital</th>
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</tr>
</thead>
</table>
| West Park Hospital               | Retain          | • Designated as a regional rehabilitation provider  
• Provide local long-term and regional rehabilitation programs  
• Continue complex continuing care role  | Retain corporate status                                                    |

### SUMMARY OF RESTRUCTURING DIRECTIONS: REHABILITATION, COMPLEX CONTINUING CARE AND SUB-ACUTE CARE, BY ACUTE HOSPITALS

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Facility Status</th>
<th>HSRC Directions</th>
<th>Corporate/ Governance Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE CARE HOSPITALS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Bayview Hospital Corporation                  | Retain          | • Provide local short-term rehabilitation  
• Continue to provide complex continuing care beds  
• Provide sub-acute care beds  | Retain corporate status.                                                       |
| Centenary Health Centre                       | Retain          | • Continue to provide local short-term rehabilitation  
• Continue to provide complex continuing care beds  
• Provide sub-acute care beds  | Amalgamate with Ajax and Pickering General Hospital.* |
| Salvation Army Scarborough Grace              | Retain          | • Continue to provide local short-term rehabilitation  
• Continue to provide complex continuing care beds  
• Provide sub-acute care beds  | Retain corporate status.                                                       |
| The Mississauga Queensway Hospital Corporation| Retain McCall wing of the Queensway site for complex continuing care  | • Provide local short-term rehabilitation  
• Continue to provide complex continuing care beds at the McCall wing of the Queensway site  
• Provide sub-acute care beds  | Retain corporate status.                                                       |
| Mount Sinai Hospital                          | Retain          | • Continue to provide local short-term rehabilitation  
• Provide sub-acute care beds  | Retain corporate status.                                                       |
| St. Joseph’s Health Centre                    | Retain          | • Provide local short-term rehabilitation  
• Discontinue complex continuing care role at Our Lady of Mercy  
• Provide sub-acute care beds  | Retain corporate status.                                                       |
<table>
<thead>
<tr>
<th>Hospital</th>
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<th>HSRC Directions</th>
<th>Corporate/ Governance Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarborough General Hospital</td>
<td>Retain</td>
<td>• Continue to provide local short-term rehabilitation&lt;br&gt;• Discontinue complex continuing care beds&lt;br&gt;• Provide sub-acute care beds</td>
<td>Retain corporate status.</td>
</tr>
<tr>
<td>Toronto East General and Orthopaedic Hospital</td>
<td>Retain</td>
<td>• Provide local short-term rehabilitation&lt;br&gt;• Provide complex continuing care beds&lt;br&gt;• Provide sub-acute care beds</td>
<td>Retain corporate status.</td>
</tr>
<tr>
<td>North York General Hospital</td>
<td>Retain</td>
<td>• Provide local short-term rehabilitation&lt;br&gt;• Provide sub-acute care beds</td>
<td>Retain corporate status.</td>
</tr>
<tr>
<td>The Toronto Hospital</td>
<td></td>
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<tr>
<td>St. Michael's Hospital</td>
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<td></td>
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<tr>
<td>Humber River Regional Hospital</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Etobicoke General Hospital</td>
<td>Retain</td>
<td>• Provide local short-term rehabilitation&lt;br&gt;• Provide sub-acute care beds</td>
<td>Amalgamate with Peel Memorial Hospital and Georgetown and District Memorial Hospital.*</td>
</tr>
</tbody>
</table>

* As directed in the HSRC’s report on the GTA/905, April 1998.