



Ontario Health
Toronto

Toronto Region Primary Care Workforce Planning Toolkit Technical Notes

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Introduction

This document contains technical notes regarding the measures presented in the Toronto Region Primary Care Workforce Planning Toolkit. It contains information on data sources, indicator definitions, and analysis details.

For questions, assistance or more information, please contact Ontario Health Toronto, Health Analytics OH-TorontoHealthAnalytics@ontariohealth.ca

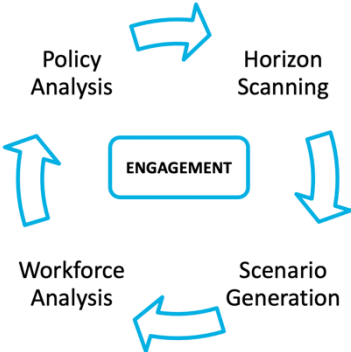
Project Description

The Toronto Region Primary Care Workforce Planning Toolkit is a collection of resources to support integrated primary care workforce planning in the Toronto Region. The toolkit is the result of a collaboration between the Health Analytics team at Ontario Health Toronto and researchers from the Canadian Health Workforce Network. The development of the toolkit was informed by extensive consultation with partners, including the City of Toronto, as well as decision-makers, health system leaders, and primary care providers.

The toolkit provides a body of evidence around the current (and projected future) states of population health needs and primary care service provision at a neighbourhood level within the City of Toronto. The goal of the toolkit is to support providers, planners, Ontario Health Teams (OHTs) and other partners, particularly with regard to deployment of primary care workforce and other health system resources.

Planning Approach

This fit-for-purpose planning process unfolds through four activities: horizon scanning, scenario generation, workforce analysis, and policy analysis. These activities are iterative and engagement with partners is embedded in the process.



Planning Toolkit

The Toronto Region Primary Care Workforce Planning Toolkit is a collection of resources to support integrated primary care workforce planning. The approach addresses population needs and workforce capacity at the neighbourhood, sub-region, and whole city levels, as well as challenges specific to Toronto, such as patient mobility, population growth due to development, and physician retirement.

The interactive dashboard synthesizes data from multiple sources and provides a comprehensive overview of the primary care landscape. In six steps, users can explore community characteristics, primary care service requirements and capacity, alignment, and factors at play before putting it all together and identifying the most pertinent issues for their communities.

The information in the dashboard is a starting point for local stakeholders wishing to better understand the primary care landscape in their communities. Interpretation of these outputs should consider the local context, including factors related to both the community and the local workforce. Engagement and consultation with local stakeholders and frontline healthcare providers are essential parts of the planning process.

- 1 Understand Community Characteristics
- 2 Understand Service Requirements
- 3 Understand Workforce Service Capacity
- 4 Assess Alignment
- 5 Explore the Factors at Play
- 6 Put It All Together

Choosing a Geography

Recognizing that patients should have access to primary care in their communities, our planning approach is built around 158 Toronto neighbourhoods.

Dashboard users can walk through each planning step sequentially for a given neighbourhood, or choose to focus on a single step across multiple neighbourhoods.

The 158 City of Toronto neighbourhoods were built by the Social Development, Finance & Administration department at the City of Toronto using Statistics Canada Census Tracts. More information about neighbourhoods is available at <https://www.toronto.ca/city-government/data-research-maps/neighbourhoods-communities/neighbourhood-profiles/about-toronto-neighbourhoods/>.

Sub-regions are geographic planning regions developed to help better understand and address patient and population needs at the local level. There are 11 sub-regions in the City of Toronto. Two sub-regions (Scarborough North and Scarborough South are usually considered together. One sub-region overlaps with a neighbouring Region and only the part of this sub-region located in Toronto has been included in these analyses. More information about sub-regions is available at <https://geohub.lio.gov.on.ca/documents/b33cedfd7b7648749045b5c4b1e7cea7/about>.

In the “Sub-Region” selector panel, dashboard users can choose the sub-region in which the neighbourhood of interest is located. When a sub-region is selected, only neighbourhoods associated with that sub-region are displayed in the “Neighbourhood” selector panel. Multiple sub-regions may be selected. When “Select all” is chosen, a complete list of Toronto Region neighbourhoods is displayed in alphabetical order.

Note that neighbourhood geographies are not specifically designed for primary care health workforce planning.

Because some neighbourhoods were newly created in 2022 data for some indicators are not available. These will be updated as data become available.

Note that sub-region boundaries in the City of Toronto do not equate to Ontario Health Teams (OHT) boundaries, but are used as a proxy to show the approximate catchment area served by OHTs.

Some neighbourhoods are split between sub-regions. In these cases, neighbourhoods have been assigned to a single subregion as follows:

Neighbourhood Name (Number)	Split Between Sub-Regions	Assigned To
Kingsview Village-The Westway (6)	North Etobicoke Malton West Woodbridge & North York West	North Etobicoke Malton West Woodbridge
Willowridge-Martingrove-Richview (7)	North Etobicoke Malton West Woodbridge & North York West	North Etobicoke Malton West Woodbridge
Victoria Village (43)	North York Central & East Toronto	North York Central
Leaside-Bennington (56)	North Toronto & Mid-East Toronto	North Toronto
South Riverdale (70)	Mid-East Toronto & East Toronto	East Toronto
Yonge-St.Clair (97)	Mid-West Toronto & North Toronto	North Toronto
Clairlea-Birchmount (120)	East Toronto & Scarborough South	East Toronto
Birchcliffe-Cliffside (122)	East Toronto & Scarborough South	East Toronto
St-Lawrence-East Bayfront-The Islands	Mid-West Toronto & Mid-East Toronto	Mid-East Toronto

Step 1: Understand Community Characteristics

Indicators and Data Sources

Data Element	Year(s)	Data Source/Steward	More Information
Population Size	2001-2021	Census/OCHPP*	2021 data were derived from Statistics Canada's 2021 Census of Population (Census), Catalogue #98-401-X2021006-3 Ontario, released October 26, 2022
Age Structure	2021	Community Data Program (CDP), City of Toronto	EO3775 - Ontario 3 - 2021 Target Group Profile cross-tabulated with Age Groups, 2021 Census - 25% Sample Data.
Expected Population Growth	2021-2031	Planning Research and Analytics, Strategic Initiatives, Policy & Analysis, City Planning Division, City of Toronto	The methodology uses population estimates based on the best fit of the 2021 Census Tract geographies to the 158 SDFA Neighbourhood boundaries and the Q2 2023 development pipeline, which is a good indication of near-term development potential, to estimate potential population growth within each neighbourhood. A Medium growth scenario with a 10-year horizon (2021-2031) is presented.
Ontario Marginalization Index Quintiles	2021	MAP Centre for Urban Solutions at St. Michael's Hospital & Public Health Ontario/OCHPP	https://www.publichealthontario.ca/-/media/documents/O/2017/on-marg-userguide.pdf https://www.ontariohealthprofiles.ca/onmarginON.php
2+ Chronic Conditions	2018/19	ICES/OCHPP	Derived from validated disease registries maintained by ICES; Prevalence and age-

Data Element	Year(s)	Data Source/Steward	More Information
			standardized (/100) of 2 or more Chronic Conditions among individuals hospitalized on April 1st, 2019, Ages 20+
Asthma	2018/19	ICES/OCHPP	Derived from validated disease registries maintained by ICES; Prevalence and age-standardized rate (/100) of Asthma on April 1st, 2019, Age 0+
COPD**	2018/19	ICES/OCHPP	Derived from validated disease registries maintained by ICES; Prevalence and age-standardized rate (/100) of Chronic Obstructive Pulmonary Disease (COPD) on April 1st, 2019, Ages 35+
Diabetes	2018/19	ICES/OCHPP	Derived from validated disease registries maintained by ICES; Prevalence and age-standardized rate (/100) of Diabetes on April 1st, 2019, Ages 20+
Hypertension	2018/19	ICES/OCHPP	Derived from validated disease registries maintained by ICES; Prevalence and age-standardized rate (/100) of High Blood Pressure (HBP) on April 1st, 2019, Ages 20+
Mental Health & Addiction	2018/19	ICES/OCHPP	Derived from validated disease registries maintained by ICES; Prevalence and age-standardized rate (/100) of Mental Health and Addiction-related Visits on April 1st, 2019, Ages 20+
ED Visits by Urgency	2018-2020	National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information (CIHI)/OCHPP	All unscheduled ED visits (2018/19 to 2019/20) that are High Urgency (CTAS 1,2,3) and Low Urgency (CTAS 4,5)
ED Visit Rate by Urgency (/1000) (age-standardized)			
Hospitalizations for Ambulatory Care Sensitive Conditions	2021-2023	Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI)/OCHPP	Hospitalization Rates for Ambulatory Care Sensitive Conditions (/100,000 population) 2021/22 to 2022/23, Ages 0-74
Attachment to a primary care provider	2022	ICES PCPOP Dataset/OCHPP	Patients considered to be attached to a primary care provider include those rostered to Primary Care Enrolment Model (PEM), those who visited a Community Health Centre in the last 2 years, those who are virtually rostered with physicians having >=10% continuity, and those virtually rostered children assigned to pediatricians/FP
Over 65 years old	2021	Census/OCHPP	Percent of population who were aged 65 years or older: Derived from Statistics Canada's 2021 Census of Population

Data Element	Year(s)	Data Source/Steward	More Information
			(Census), Catalogue #98-401-X2021006-3 Ontario, released October 26, 2022
No knowledge of English or French	2021	Census/OCHPP	Percent of population who did not know either English or French: Derived from Statistics Canada's 2021 Census of Population (Census), Catalogue #98-401-X2021006-3 Ontario, released October 26, 2022
Recent immigrants (Received Immigration Status Between 2016 – 2021)	2021	Census/OCHPP	Percent of population who received immigration status between 2016 and 2021: Derived from Statistics Canada's 2021 Census of Population (Census), Catalogue #98-401-X2021006-3 Ontario, released October 26, 2022
CHF*** Cases	2023	ICES/OCHPP	Number of CHF cases April 1st, 2023

*Ontario Community Health Profiles Partnership
**Chronic Obstructive Pulmonary Disease
***Congestive Heart Failure

Step 2: Understand Service Requirements

Indicators and Data Sources

Data Element	Year	Data Source
Visits for Residents of the Neighbourhood	2016 (Base Year)	CIHI Population Grouping Methodology
Visits for Residents of the Neighbourhood	2017-2026	Derived (see below)
% of Care Accessed in Home Neighbourhood	2017/18	ICES
Visits for Residents of the Neighbourhood, Adjusted for Patient Mobility	2016-2026	Derived (see below)
Visits for Patients from Outside Toronto	2016-2026	ICES
Visits for Residents of Other Neighbourhoods	2016-2026	Derived (see below)
Total Service Requirements	2016-2026	Derived (see below)

Physician service requirements originate from the CIHI Population Grouping Methodology (CIHI Pop Grouper, <https://www.cihi.ca/en/submit-data-and-view-standards/methodologies-and-decision-support-tools/case-mix/population-grouping-methodology>). The number of visits to a primary care physician predicted based on clinical and demographic profiles is generated by the Pop Grouper for each individual in a given neighbourhood in the base year (2016). These individual estimates are aggregated to a neighbourhood-level estimate (*Visits for Residents of the Neighbourhood, 2016*).

Service requirements are projected forward in time (*Visits for Residents of the Neighbourhood, 2017-2026*) using population growth estimates provided by the City of Toronto (Planning Research and

Analytics, City Planning Division). A Medium population growth scenario and a 10-year horizon are used to adjust service requirement estimates for population growth. We assume linear residential development and population growth between the base year and the horizon year.

Because not all residents of a given neighbourhood access primary care in that neighbourhood, adjustment for spatial patterns of utilization is required. We adjust for population mobility using an Origin-Destination matrix for primary care utilization, reflecting the neighbourhood of residence and the neighbourhood of care for all primary care visits in Toronto, generated by ICES (through an AHRQ request process) using data from FY2017/18. This matrix allows us to identify how much care residents of a given neighbourhood access in their own neighbourhoods (*% of Care Accessed in Home Neighbourhood*) and in every other neighbourhood across the city. It also provides an estimate of the number of visits accessed in the neighbourhood by patients from outside the city (*Visits for Patients from Outside Toronto*). We assume that patterns of care-seeking behaviour are stable over time and apply adjustments based on the matrix to the base year and future year estimates.

Adjustment for spatial patterns of utilization results in an estimate of the number of visits required in the neighbourhood, both for residents of the neighbourhood (*Visits for Residents of the Neighbourhood, Adjusted for Patient Mobility*) and for residents of other neighbourhoods (*Visits for Residents of Other Neighbourhoods*). For neighbourhood residents, the estimate is the product of the estimated service requirements for all residents of the neighbourhood and the percentage of care accessed in home neighbourhood. For residents of other neighbourhoods, service requirements are adjusted for spatial patterns of utilization by definition. The estimate reflects the number of visits needed by residents of other neighbourhoods and the proportion of those visits expected to be accessed in the neighbourhood in question.

Thus, in a given neighbourhood, the number of primary care visits (Total Service Requirements) are a function of the number of visits to a primary care physician required by neighbourhood residents and by residents of other neighbourhoods in the City, adjusted for spatial patterns of utilization and population growth, along with the number of visits utilized by patients from outside the City of Toronto.

In our baseline scenario, we assume that new residents of a neighbourhood will have a similar profile and service requirements to those currently residing within the neighbourhood. We also consider how scenarios related to changing population characteristics impact service requirements (not currently displayed).

Step 3: Understand Workforce Service Capacity

Indicators and Data Sources

Data Element	Year	Data Source
Comprehensive Primary Care Physicians (Annual Visits)	2017-2020	ICES Physician Database (IPDB), ICES
Interprofessional Health Practitioners (Average Weekly Service Hours Available)	2016-2018	Health Professions Database (HPDB) https://data.ontario.ca/dataset/health-professions-database
Physician Service Capacity		
Non-Comprehensive Care	2017-2023	ICES/OCHPP
Safe Comprehensive Care	2017-2023	Derived (see below)

Care At Risk	2017-2023	Derived (see below)
Total Service Capacity	2017-2023	Derived (see below)

Comprehensive Primary Care Physicians

Physicians who provide services more than 44 days per year and who provide more than half of services for core primary care, in at least 7 of 22 activity areas, are defined as providing comprehensive primary care (*Comprehensive Primary Care Physicians*). An algorithm developed at ICES is used to identify these physicians (<https://www.cmajopen.ca/content/5/4/E856>).

Interprofessional Health Practitioners

Interprofessional health practitioners providing services relevant to primary care include: Chiropractors, Dietitians, Midwives, Nurse Practitioners, Optometrists, Occupational Therapists, Pharmacists, Psychologists, Physiotherapists, Registered Nurses, Registered Practical Nurses, Respiratory Therapists, and Speech-Language Pathologists. This list of priority professions was defined through iterative consultations with partners and stakeholders.

Practice settings captured in the HPDB that are deemed relevant to primary care include: Community Health Centre (CHC), Family Health Team (FHT), Nurse Practitioner Led Clinic, Other Group Practice Office, Solo Practice Office, Client's Environment, Board of Health or Public Health Laboratory or Public Health Unit, Community Care Access Centre (CCAC), Diabetes Education Centre, Residential/Long-Term Care Facility, Assisted Living Residence/Supportive Housing, Children Treatment Centres (CTC), Community Pharmacy, Other Community-Based Pharmacist Practice, TeleHealth Ontario and Telephone Health Advisory Services, and Correctional Facility. This list of practice settings was defined through iterative consultations with partners and stakeholders.

Areas of practice activity captured in the HPDB that are identified as relating directly to primary care and that are used to characterize service capacity for interprofessional health practitioners include: General Service Provision, Continuing Care, Comprehensive Primary Care, Chronic Disease Prevention and Management, Public Health, Mental Health and Addiction, Primary Maternity Care, Geriatric Care, Infectious Disease Prevention and Control, and Palliative Care. This list of practice activities was defined through iterative consultations with partners and stakeholders.

Service capacity is defined as the amount of time (hours) spent in direct professional services on practice activities related to primary care in practice settings relevant to primary care. The service capacity of interprofessional health practitioners is estimated for each individual and then aggregated to the neighbourhood level.

In other words, the equation describing the primary care service capacity of a single registered professional in a given year (y) in a given neighbourhood (x) is as follows:

$$SC_{yx} = \frac{\text{\# of weeks worked} \times \text{\# of hours worked per week} \times \% \text{ of time in direct professional services}}{52} \times \text{number of settings in neighbourhood x associated with a primary care activity}$$

The service capacity generated by an entire occupational group in a given year (y) in a given neighbourhood (x) that can be allocated to primary care activities is the sum of service capacities (SC_{yx}) of all of its constituent professionals.

Note that interprofessional health practitioner service capacity is reported as “**Average Weekly Hours Available**” and reflects the average weekly hours of direct professional services in activities identified as relating directly to primary care, estimated based on past hours worked. Note that this estimate represents normal hours of service that the workforce undertook, not "potential" or "extra" available hours. These are descriptive estimates, not projections, and may not represent future workforce service capacity.

Physician Service Capacity

Physician service capacity is decomposed into three separate components:

1. *Non-Comprehensive Care*: Primary care services (visits) provided by physicians who practise less than 44 days per year or who otherwise do not meet the criteria to be characterized as providing comprehensive primary care according to the algorithm developed at ICES (<https://www.cmajopen.ca/content/5/4/E856>). These services are likely delivered in walk-in clinics and other episodic care settings.
2. *Safe Comprehensive Care*: Primary care services (visits) provided by comprehensive primary care physicians who are not expected to exit the workforce (those whose age-based risk of retirement is less than 20%) in the year in question. Service capacity for these physicians is estimated on an individual level for the base year (2017) (based on the total number of visits provided (from IPDB)) and projected forward (2018 to 2023) with adjustment for age-based changes in workload. Retirement probabilities and average age-based changes in workload are derived from a study of comprehensive primary care physicians practicing in Ontario between 1992 and 2013 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6516703/>). Individual estimates of physician service capacity are aggregated to generate a neighbourhood-level estimate.
3. *Care at Risk*: Primary care services (visits) provided by comprehensive primary care physicians who are at risk of retirement (those whose age-based retirement risk is at least 20%) in the year in question. Service capacity for these physicians is estimated on an individual level for the base year (2017) and projected forward (2018 to 2023) with adjustment for age-based changes in workload. Individual physician service capacity estimates are aggregated to generate a neighbourhood-level estimate.

Thus, total neighbourhood-level service capacity is a function of the estimated number of visits provided by non-comprehensive care physicians, plus the estimated number of visits provided by comprehensive care physicians who are not expected to exit the workforce, plus the estimated number of visits provided by comprehensive care physicians who are considered to be at risk of retirement.

Note that we assume that providers’ retirement probabilities and age-based changes in workload will be consistent with those observed in comprehensive primary care physicians practicing in Ontario between 1992 and 2013 (from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6516703/>).

Step 4: Assess Alignment

Indicators and Data Sources

Data Element	Year	Data Source
Service Requirements (Visits)	2017-2023	Derived (see below and Step 2 for details)
Service Capacity (Visits)	2017-2023	Derived (see below and Step 3 for details)
Gap	2017-2023	Derived (see below)

Total service requirements are a function of the number of visits to a primary care physician required by neighbourhood residents and by residents of other neighbourhoods in the City, adjusted for spatial patterns of utilization and population growth, along with the number of visits utilized by patients from outside the City of Toronto.

Total service capacity is a function of the estimated number of visits provided by comprehensive care physicians who are not expected to exit the workforce, plus the estimated number of visits provided by comprehensive care physicians who are considered to be at risk of retirement, plus the estimated number of visits provided by non-comprehensive care physicians.

The gap is the difference between Total Service Requirements and Total Service Capacity.

Step 5: Explore the Factors at Play

Growth

Population growth is a key driver of service requirements.

The choropleth map shows estimated 10-year population growth (in percent) by neighbourhood in the Toronto Region (2022-2032) under a Medium growth scenario.

Estimates of neighbourhood-level population growth are prepared by the City of Toronto City Planning Division (Planning Research and Analytics, Strategic Initiatives, Policy & Analysis). The base year for population estimates is 2021 and development pipeline data are current to Q2 2023. Three scenarios (High, Medium and Low) are generated, based on the likelihood that all projects currently in the development pipeline were completed and were occupied at various person per unit ratios. Whether development proposals will be completed and built is unpredictable, but as a whole, the development pipeline has been found generally to be realized in a period of about 10 to 15 years beyond the base year.

Mobility – coming soon!

Retirement

The interactive retirement scenario dashboard allows users to explore different physician retirement scenarios that are relevant to primary care planning and decision-making. Scenarios take into account

the age structure of the physician workforce, age-related retirement probabilities, and age-related changes in service capacity. Once neighbourhoods with populations at risk of being underserved due to physician retirement have been identified, planning can take place to mitigate the impact of retirement.

Compare – coming soon!

Community Trends – coming soon!

Step 6: Put It All Together

Indicators and Data Sources

Data Element	Year	Data Source/Steward
Population Size	2021	Census/OCHPP
Estimated Population Growth	2021 -2031	City of Toronto
% Care Accessed in Home Neighbourhood	2017/18	ICES
Attachment	2022	ICES PCPOP Dataset/OCHPP
Health Status	2018/19	ICES/OCHPP
Comprehensive Primary Care Physicians	2020	ICES Physician Database (IPDB), ICES
Interprofessional Health Practitioners	2016-2018	Health Professions Database (HPDB)
Ontario Marginalization Index	2021	MAP Centre for Urban Solutions at St. Michael's Hospital & Public Health Ontario/OCHPP
Primary Care Needs, Capacity & Alignment	2017, 2020, 2023	Derived

This step compiles data presented in Steps 1-5 in order to help dashboard users better understand key trends and their drivers. This step, supplemented with local knowledge, is a starting point for building a picture of the primary care landscape, identifying key issues, and developing innovative solutions.

Limitations

There are several limitations that have to be taken into consideration when using and interpreting data from the dashboard:

- Unmet need is currently not accounted for in the estimate of Service Requirements. A process to define quantitative estimates of unmet need through engagement with local stakeholders is in development.
- Estimates of service capacity for physicians are in *visits*, while estimates of service capacity for interprofessional health practitioners are in *hours per week*.

- The information in the HPDB was provided on an "as-is" basis. The data were originally obtained by the Ministry of Health directly from health regulatory Colleges. The Ministry therefore cannot and does not warrant or represent that the information is accurate, complete, reliable or current.
- Spatial patterns of utilization and the primary care workforce are not independent; there is an interaction and observed patterns can change over time. For more information about the neighbourhood- and sub-region-level spatial patterns of utilization methodology, results, and visualizations, please contact Ontario Health Toronto.
- Due to the data lags associated with the use of administrative data for planning, emerging trends may not be reflected in our analyses.
- Our workforce model projects forward current capacity available within the system and does not model the impact of entry of new health care providers into the workforce. The neighbourhood-level gaps between service capacity and service requirements illustrated in our outputs can be used to identify neighbourhoods where additional resources are required to meet primary care needs.

Abbreviations

ACSC – Ambulatory Care Sensitive Condition

AHRQ – Applied Health Research Question

CHF – Congestive Heart Failure

CIHI – Canadian Institute for Health Information

COPD – Chronic Obstructive Pulmonary Disease

CTAS – Canadian Triage Acuity Scale

DAD – Discharge Abstract Database

ED – Emergency Department

FY – Fiscal Year

IPDB - ICES Physician Database

NACRS – National Ambulatory Care Reporting System

NP – Nurse Practitioner

OCHPP – Ontario Community Health Profiles Partnership

OHT – Ontario Health Teams

OT – Occupational Therapist

PEM – Patient Enrolment Model

PT – Physiotherapist

RN – Registered Nurse

RPN – Registered Practical Nurse

RT – Respiratory Therapist

SLP – Speech & Language Pathologist

Contact

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