

ORGANIZATIONAL RECOMMENDATIONS FOR TBI HEALTH SYSTEMS



1. TBI resources should be reorganized to a demand-based model instead of a population-based model to appropriately distribute resources to underserved northern and rural communities struggling with high incidences of TBI.

2. Develop an immediate communication strategy to disseminate existing open-source TBI/ABI clinical support resources to clinicians in rural and remote areas to increase specialized knowledge within general facilities.

3. Ontario Health Teams (OHTs) should mandate and allocate resources to the small rural hospitals to support the uptake of TBI knowledge and expertise using both active (such as webinars, lectures, accreditation programs) and passive (resource sharing) TBI educational tools to help close the gap in TBI knowledge between specialized and general rehabilitation facilities.

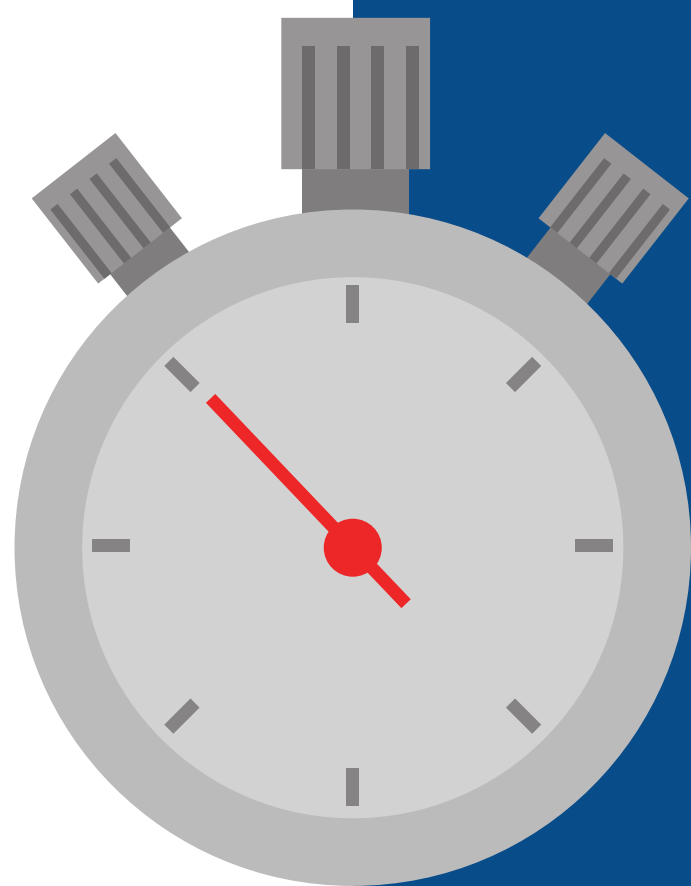
4. To address the inappropriate use of funds and resources caused by 24% of in-hospital time being spent in alternative levels of care, a Community Support Coordinator with links to OHTs should be placed within each in-patient institution to better coordinate efficient transitions from one level of care to the next. This would support the development of integrated care.

5. There should be a clearly identified person (e.g., case or care coordinator, preferably someone who could follow the patient over the continuum of care) who schedules the first follow-up appointment with their patient's GP and remains connected to the patient to ensure effective transition to longer term community-based services. This person should be formally connected to OHTs and would support the provision of integrated care.

6. As long-term outcomes for TBI are significantly influenced by early intervention, financial resources should be used to effectively organize early TBI recovery with the aim of reducing the number of days between TBI onset and inpatient rehabilitation admission. This will lead to reduced care costs and demand in the long-term as well as improve acute care outcomes.

7. Data and trends from this report should be used by Ontario Health and OHTs to prepare for capacity building over the next five years and prepare to meet the demand of those living with TBI. Demands on inpatient, outpatient, and community resources should be considered. Specific evaluation strategies and key performance indicators (such as return to school/work, community independence, social integration, and stable housing) should be agreed upon to assess how systems are responding to changes in demand.

STANDARDS AND THRESHOLD RECOMMENDATIONS



1. Reduce median number of days from discharge to first homecare therapy visit from 9 to no more than 5, as recommended by the Rehabilitative Care Alliance's Best Practice Framework [33]. Shorter times to homecare visits are expected to help maintain functional gains from in-patient rehabilitation and reduce readmission rates and therefore emergency costs associated with ongoing TBI care.

2. Generalized rural facilities should have at least one senior clinician who has completed 200 hours of specialized TBI rehabilitation. If such a clinician is not able to work directly at the institution, then procedures should be in place to support telephone or virtual consultations with such a clinician to enhance the specialization of care.

3. Increase the number of mandated homecare therapy visits within 180 days of first visit from four to at least eight to improve readmission rates, health outcomes, and caregiver burden.

ABI PROVINCIAL NETWORK STAKEHOLDER RECOMMENDATIONS



1. Following the annual release of the TBI Report Card, the provincial stakeholders (e.g., ABI Navigators, Brain Injury Associations, ONF ABI Team, Ministry of Health, Ontario Health Team planners and leadership) should agree upon 3-4 key areas of impact over the next year, self-identify mechanisms of change within their capacity, and collectively develop key performance indicators and outcome goals. It should be recalled that these recommendations come out of TBI data as that is where the evidence is available but should be considered relevant to the broader acquired brain injury sector.

2. As seniors are in the intersection of some of the more concerning observations, such as higher mortality, primarily caused by falls, it is crucial to work with Fall Prevention programs, Public Health and Regional Geriatric Programs to ensure that prevention as well as efficient diagnosis and treatment practices are in place, such as increased frequency and duration of clinical monitoring.

3. As this report card presents individual and average performance of key health and financial TBI indicators of each LHIN; hospital boards of directors, senior hospital managers, and LHIN administrators should reference their relative performance compared to other LHINs when setting priorities and strategic planning to target improvement in areas where they fall below average. As incidence of TBI is increasing in rural and northern communities, specific stakeholders in areas of prevention should utilize this data in determining needs-based prevention education.

4. As healthcare falls under provincial jurisdiction, provincially-focused ABI Conferences (e.g., Toronto ABI Network and OBIA conferences) should incorporate a TBI policy summit to bring together all levels of stakeholders within TBI and set strategic priorities inferred from the annual TBI report card. A systematic meeting process will help hold all stakeholders accountable for participating in evolving the TBI system and allow for regular evaluation and feedback.