CENTRAL EAST LHIN

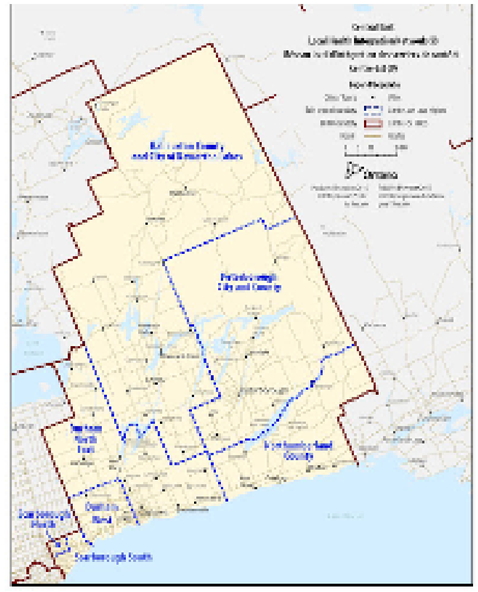
Ranked 1 or 2 of 14 LHINs
Ranked 13 or 14 of 14 LHINs

No	Indicator	LHIN 2018/19-2019/20	Ontario 2018/19-2019/20	Rank
1	Annual age- and sex-adjusted incidence rate per 1,000 population for: a) moderate to severe TBI	2.3	2.5	5
	b) concussion/mild TBI	8.9	9.1	6
2	Risk-adjusted TBI mortality rate within 30 days of admission to hospital per 100 patients	13.2	13.7	4
3	Proportion of ALC days to total LOS in acute care (%)	31.6	25.2	13
4	Proportion of acute patients with TBI (%) discharged from acute care and admitted to: a) general inpatient rehabilitation	7	6	6
	b) specialized ABI inpatient rehabilitation	6.9	7.5	9
5	Median number of days from TBI onset and admission to: a) general inpatient rehabilitation	11 (5-24)	13 (8-23)	2
	b) specialized ABI inpatient rehabilitation	24 (11-45.5)	25 (12-44)	6
6	Median FIM change of: a) general inpatient rehabilitation	29.5	25	3
	b) specialized ABI inpatient rehabilitation	32	25	2
	Median FIM efficiency of: c) general inpatient rehabilitation	1.3	1.1	2
	d) specialized ABI inpatient rehabilitation	1.1	0.8	2
7	Median time from discharge from acute care/inpatient rehabilitation to first HCC visit for: a) physiotherapy	18.5 (5-82)	15 (5-59	9
	b) occupational therapy	11 (4-34)	11 (4-46)	8
	c) speech language pathology	60 (10-128)	55 (13-144)	7
	d) social work	81 (23-111)	52 (18-127.5)	10
8	Median number of HCC visits within 60 days of discharge from acute care/inpatient rehabilitation for: a) physiotherapy	4.5 (3-6)	4 (2-5)	4
	b) occupational therapy	2 (1-3)	2 (1-3)	2
	c) speech language pathology	2 (1-2)	2 (1-2)	5
	d) social work	1 (1-2)	2 (1-3)	6
9	Proportion of patients with TBI (%) discharged from inpatient rehabilitation with a follow-up assessment within 30 days, 180 days, 365 days by a: a) GP/FP (any reason)	80, 96.7, 97.1	75.1, 93.1, 95.5	2*
	b) GP/FP (mental health-related reason)	5.3, 19.3, 25.2	7.2, 21.2, 28.5	9†
	c) Specialist (physical medicine, neurosurgeon, neurology)	34.7, 67.3, 72.7	36.8, 66.3, 70.9	5†
	d) Specialist (psychiatry)	4.7, 14, 18.7	4, 12.8, 17	4‡
	e) No GP/FP or specialist follow-up assessment within 30 days	14.7, NA, NA	16.5, NA, NA	5
10	Proportion of patients with a TBI (%) discharged from acute care to: a) complex continuing care (CCC)	2.9	3.6	5
	b) long-term care (LTC)	1.9	1.6	10
11	Age- and sex-adjusted all-cause readmission rate at 30 days for patients with TBI per 100 patients	4.5	4.1	10
12	Total number of patients with TBI discharged from inpatient rehabilitation: a) complex continuing care (CCC)	NA	23	NR
	b) long-term care (LTC)	NA	16	NR

*Ranking determined at 30 days
†Ranking determined at 180 days
‡Ranking determined at 365 days
NR denotes No Ranking

Regional Context: CE

Population: 1,603,200 (11.6% of Ontario population)



Health Services:

Acute Care

Level 1 Trauma Centre	No
Acute Hospitals with Neuro-Capacity	Lakeridge Health Peterborough Regional Health Centre
Other Acute Hospitals	Northumberland Hills Hospital Haliburton Highlands Health Services Ross Memorial Hospital (Lindsay) Campbellford Memorial Hospital

Inpatient Rehabilitation

Specialized ABI	No
General	Northumberland Hills Hospital Haliburton Highlands Health Services Ross Memorial Hospital (Lindsay) Campbellford Memorial Hospital

Outpatient Rehabilitation

Specialized ABI	Home and Community Care ABIRT Ambulatory Rehabilitation Centre at Lakeridge Health Whitby
General	Northumberland Hills Hospital Haliburton Highlands Health Services Ross Memorial Hospital (Lindsay) Campbellford Memorial Hospital

Community-based Services

Rehabilitation by registered professionals	Home and Community Care Private services
Brain Injury Organizations	Mindworks Providence Care

Access to Specialist:

Physiatrist	**Unsure**
Psychiatrist	✓ (Durham)
Neuropsychiatrist	✓
Behavioural psychologist	**x**
Speech-language pathologist	✓ (Durham)
Paediatric specialist	**x**
Other: Occupational Therapy	✓ (Durham)

Regional Context: CE

What works well in CE LHIN

- ABIRT – team of clinicians that understand brain injury that work in an interdisciplinary team support the individuals, gap is that only in available in Home and Community Case Services, Peterborough County.
- Central East the excellent collaboration that occurs between Fourcast, CMHA and BIAPR meeting works well in meeting the needs of complex clients. Durham collaboration with Lakeridge Health, John Howard Society, DMHS, private providers, long term care facilities and the Region of Durham
- Clinical Practice Guidelines – the ONF guidelines are referred to frequently and utilized well in Central East, by community support agencies, primary care and other clinicians.

What are some gaps, opportunities or drivers in CE LHIN

- Significant shortage of any type of supportive and affordable housing in CE LHIN. Access to ABI housing opportunities requires that individuals move out of their communities, away from families and service providers.
- Referrals are often made by Toronto Rehab programs. These rehab programs assumes that the Central East Region has similar capacity to the programs available in Metropolitan Toronto. This assumption of way more capacity than we have when clients are discharged home puts significant pressure on the system that is already faced with gaps and barriers.
- Home and Community Care representative has been working on the development of an ABI Pathway for the last few years.
- Through the Central East ABI Network there is opportunity to have improved communication between hospital and community supports. The hospital has expectations of community to provide program and services for patients upon discharge, however there is a disconnect of funding allocations and respect for the work that is done in the community.
- There are opportunities to expand capacity, to create new innovative and integrated programming and to leverage what has worked well in public and private service

Client Vignette

- BIAPR has one client story that has been an illustration of the success that can be achieved when specialized service providers work together. This example involves MOH Transitional Funding (BIAPR increased supports Year 1 & 2), hospital mental health (psychiatrist and outreach nurse), Dr. Hamilton (Neuropsychologist) Community Living and BIAPR (case management and Client Support).

- The individual living with ABI, Mental Health and addictions at times, and DSO identified, had never lived independently (they had always lived with family and could no longer) and was being discharged from an extended stay in the mental health ward. The team spent time working together to develop a discharge plan that provided the necessary high intensity supports upfront. Assisted living supports were in put in place to provide daily supports (morning and night – Community Living and BIAPR) to ensure that independent living would be successful. Mental health hospital outreach support continued in the community for 1 year. Daily communication as needed, and a weekly care conference have ensured that the care team were informed of challenges and successes in real time.

- Four years later the individual is still living independently with minimal family supports and community team supports (Mon-Fri). Their capacity to maintain their ADLs and apartment have improved. The variability of the individual's mental health still fluctuates, and they will call the Crisis Line however they are now able to determine if they can wait to discuss how they are feeling with their team in either the morning or evening shift. Daily Team updates are more positive as the individual is building independence and is proud of their work and accomplishments. This is communicated regularly to the individual of how proud the Team is of them. A strong cohesive community staff team has assisted this individual to live as fully and independently as possible while providing the structure to support their needs.