CHAMPLAIN LHIN

Ranked 1 or 2 of 14 LHINs

Ranked 13 or 14 of 14 LHINs

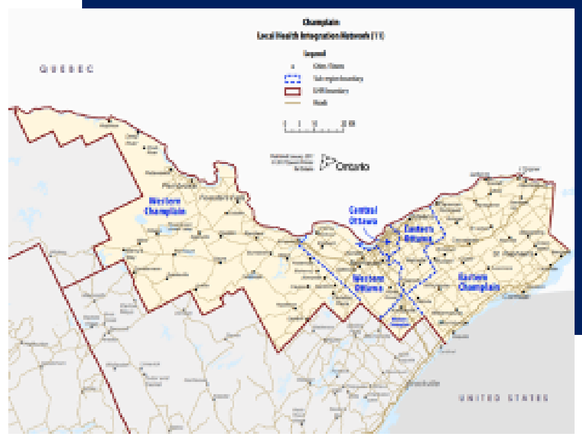
No	Indicator	LHIN 2018/19-2019/20	Ontario 2018/19-2019/20	Rank
1	Annual age- and sex-adjusted incidence rate per 1,000 population for: a) moderate to severe TBI	2.7	2.5	9
	b) concussion/mild TBI	9.7	9.1	8
2	Risk-adjusted TBI mortality rate within 30 days of admission to hospital per 100 patients	13.4	13.7	6
3	Proportion of ALC days to total LOS in acute care (%)	25.1	25.2	8
4	Proportion of acute patients with TBI (%) discharged from acute care and admitted to: a) general inpatient rehabilitation	4.4	6	10
	b) specialized ABI inpatient rehabilitation	11.3	7.5	4
5	Median number of days from TBI onset and admission to: a) general inpatient rehabilitation	11 (7-21)	13 (8-23)	2
	b) specialized ABI inpatient rehabilitation	27 (16.5-42)	25 (12-44)	8
6	Median FIM change of: a) general inpatient rehabilitation	22	25	12
	b) specialized ABI inpatient rehabilitation	14	25	13
	Median FIM efficiency of: c) general inpatient rehabilitation	1	1.1	8
	d) specialized ABI inpatient rehabilitation	0.4	0.8	11**
7	Median time from discharge from acute care/inpatient rehabilitation to first HCC visit for: a) physiotherapy	35 (13-74)	15 (5-59	14
	b) occupational therapy	29 (9-77)	11 (4-46)	14
	c) speech language pathology	101 (62-169)	55 (13-144)	11
	d) social work	-	52 (18-127.5)	NR
8	Median number of HCC visits within 60 days of discharge from acute care/inpatient rehabilitation for: a) physiotherapy	3 (2-4)	4 (2-5)	13
	b) occupational therapy	2 (1-3)	2 (1-3)	4
	c) speech language pathology	-	2 (1-2)	NR
	d) social work	-	2 (1-3)	NR
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)	68.6, 90.5, 95	75.1, 93.1, 95.5	11*
	b) GP/FP (mental health-related reason)	7.6, 21.9, 29	7.2, 21.2, 28.5	7†
	c) Specialist (physical medicine, neurosurgeon, neurology)	35.2, 61.9, 72	36.8, 66.3, 70.9	11†
	d) Specialist (psychiatry)	-, 11.4, 14	4, 12.8, 17	9‡
	e) No GP/FP or specialist follow-up assessment within 30 days	20, NA, NA	16.5, NA, NA	10
10	Proportion of patients with a TBI (%) discharged from acute care to: a) complex continuing care (CCC)	3.3	3.6	9
	b) long-term care (LTC)	1.3	1.6	6
11	Age- and sex-adjusted all-cause readmission rate at 30 days for patients with TBI per 100 patients	3.6	4.1	4
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
**Colour banded due to ties in rank ordering

Regional Context: Champlain

Population: 1,319,900 (9.6% of Ontario population)



Health Services:

Acute Care	
Level 1 Trauma Centre	The Ottawa Hospital
Acute Hospitals with Neuro-Capacity	The Ottawa Hospital
Other Acute Hospitals	Hospital Montfort
Inpatient Rehabilitation	
Specialized ABI	Robin Easey Centre
General	No
Outpatient Rehabilitation	
Specialized ABI	Robin Easey Centre
General	No
Community-based Services	
Rehabilitation by registered professionals	Home and Community Care Private
Brain Injury Organizations	Pathways to Independence - Brain Injury Services Vista Brain Injury Services

Access to Specialist:

Physiatrist	x
Psychiatrist	x
Neuropsychiatrist	✓
Behavioural psychologist	✓
Speech-language pathologist	x
Paediatric specialist	x

What works well in Champlain LHIN

- There are two community agencies that offer services to both urban and rural clients.
- A unique and effective transitional program operated through the Ottawa Hospital, the Robin Easey Centre and two community brain injury service providers. Both the rehab centre and the community agencies have counsellors who work side-by-side to offer the needed service and to decrease length of stay in a transitional unit. Clients are seamlessly transferred from a hospital setting to a community setting (community agencies specializing in the care of those with a brain injury).
- Clients have an opportunity to participate in three distinct day programs for those with an ABI. The clients participate in the planning of activities and the programs provide respite to caregivers.

What are some gaps, opportunities or drivers in Champlain LHIN

- Lack of proper housing: There are only 11 dedicated and funded residential setting places within this region, which relative to the need, is practically nonexistent. Unfortunately, as a result, many ABI clients are housed in inappropriate settings and are thus at risk of re-injury as well as declines in their physical, cognitive and mental health. Indeed, as health care providers, we are often faced with the ethical dilemma of discharging clients to unsafe environments (i.e., residential services with limited supports) versus to a long-term home where their physical needs may be met, but where their mental health is most likely to deteriorate given the lack of opportunity to connect with others experiencing similar disability
- Long waiting lists for residence (20 years).
- ABI services are underfunded.
- Limited access to services; persons with physical restrictions do not qualify for existing community-based specialized rehab or supportive services
- Difficulty in locating appropriate services.
- Limited number of beds.

Regional Context: Champlain

Client Vignette

- A 35-year-old woman suffered a severe traumatic brain injury in the context of a fall. Her mother, who lives in Calgary, alerted her landlord when she did not hear from her, and the patient was found unconscious. She was transported to the Ottawa Hospital where she was resuscitated and medically stabilized. As a result of her injury, she showed cognitive impairment as well as reduced mobility (requiring a walker for balance difficulties). She was subsequently transferred to the Ottawa Hospital Rehabilitation Centre where she underwent inpatient brain injury rehabilitation for 6 weeks. Her medical history also includes alcohol use disorder, a complicating factor to her recovery. Except for her 6-year daughter (living with her father), she has no other social contacts or supports in the region.

- Following her inpatient rehabilitation, she was transferred to the Robin Easey Centre transitional program to help her with life skills and community reintegration. She benefitted from the structure and daily reminders of this residential program, however, despite her motivation to turn her life around and increase her functioning, she continued to struggle with distractibility, poor judgement and an inability to follow-through on tasks. An application was made for the ABI navigator to access ABI services in the region, and she is awaiting services. Given her functioning and risk factors (substance reuse), a supportive environment was recommended following her admission. She declined to move to Calgary to live with her parents as she did not want to be far away from her daughter. It was not felt that a nursing home would be appropriate, and she preferred an environment where she can come and go more freely. It was agreed that she move to a domiciliary hostel (residential services) and that the ABI transition program (Ottawa Hospital and Vista Centre) provide supports for this transition. Staff worked closely with the residence and her parents to provide the daily prompting and the supports needed. Despite the supports, however she remains at risk for making poor decisions and forgetting her mealtimes. It remains an ongoing challenge to ensure her safety and wellbeing.

For more stories: http://champlainabicoalition.com/stories-of-hope/