NORTH SIMCOE MUSKOKA 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	3.4	2.5	11
	b) concussion/mild TBI	10.3	9.1	10
2	Risk-adjusted TBI mortality rate within 30 days of admission to hospital per 100 patients	13.5	13.7	7
3	Proportion of ALC days to total LOS in acute care (%)	23.3	25.2	7
4	Proportion of acute patients with TBI (%) discharged from acute care and admitted to: a) general inpatient rehabilitation	2.3	6	14
	b) specialized ABI inpatient rehabilitation	6.3	7.5	11
5	Median number of days from TBI onset and admission to: a) general inpatient rehabilitation	14.5 (10.5-29)	13 (8-23)	8
	b) specialized ABI inpatient rehabilitation	31 (12-55)	25 (12-44)	9
6	Median FIM change of: a) general inpatient rehabilitation	23	25	11
	b) specialized ABI inpatient rehabilitation	29.5	25	5
	Median FIM efficiency of: c) general inpatient rehabilitation	1.1	1.1	5
	d) specialized ABI inpatient rehabilitation	0.9	0.8	7
7	Median time from discharge from acute care/inpatient rehabilitation to first HCC visit for: a) physiotherapy	18.5 (8-74.5)	15 (5-59	9
	b) occupational therapy	25 (10-87.5)	11 (4-46)	12
	c) speech language pathology	59 (14-117.5)	55 (13-144)	6
	d) social work	82 (57-85)	52 (18-127.5)	12
8	Median number of HCC visits within 60 days of discharge from acute care/inpatient rehabilitation for: a) physiotherapy	4 (3-5)	4 (2-5)	8
	b) occupational therapy	2 (1-3)	2 (1-3)	9
	c) speech language pathology	1.5 (1-3)	2 (1-2)	5
	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)	78.8, 97, 100	75.1, 93.1, 95.5	3*
	b) GP/FP (mental health-related reason)	-, 24.2, 37.5	7.2, 21.2, 28.5	4†
	c) Specialist (physical medicine, neurosurgeon, neurology)	33.3, 63.6, 65.6	36.8, 66.3, 70.9	8†
	d) Specialist (psychiatry)	-, -, -	4, 12.8, 17	NR‡
	e) No GP/FP or specialist follow-up assessment within 30 days	-, NA, NA	16.5, NA, NA	NR
10	Proportion of patients with a TBI (%) discharged from acute care to: a) complex continuing care (CCC)	0.8	3.6	1
	b) long-term care (LTC)	2.4	1.6	13
11	Age- and sex-adjusted all-cause readmission rate at 30 days for patients with TBI per 100 patients	4.5	4.1	11
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: NSM

Population: 475,500 (3.4% of Ontario population)

Health Services:

Acute Care

Level 1 Trauma Centre	No
Acute Hospitals with Neuro-Capacity	No
Other Acute Hospitals	Royal Victoria Hospital Orillia Soldiers Memorial Hospital Georgian Bay General Hospital Collingwood General Marine Hospital Muskoka Algonquin Health Care Waypoint Centre

Inpatient Rehabilitation

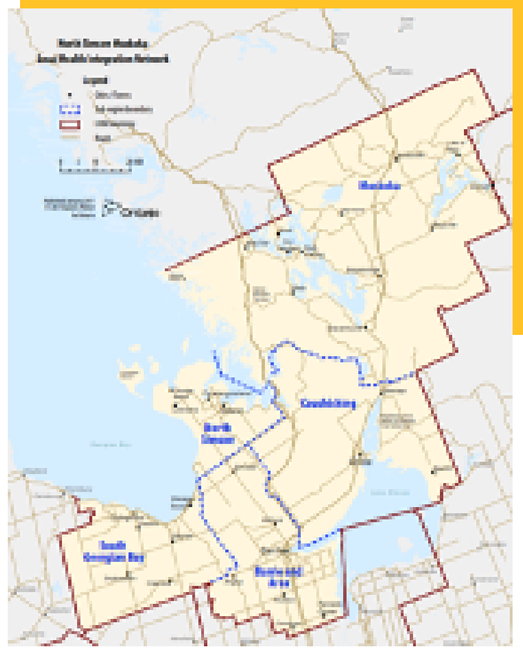
Specialized ABI	No
General	Royal Victoria Hospital (general rehabilitation, integrated Stroke Care unit) Orillia Soldiers Memorial (general rehabilitation, integrated Stroke Care unit) Georgian Bay General (general rehabilitation)

Outpatient Rehabilitation

Specialized ABI	No
General	Royal Victoria Hospital Orillia Soldiers Memorial

Community-based Services

Rehabilitation by registered professionals	Home and Community Care Private services
Brain Injury Organizations	York Simcoe Brain Injury Services (specialized clinical services, community reintegration supports, in-home clinical services, functional and behavioural assessments, neuropsychological and neuropsychiatric assessments, care management supports, rehabilitation supports, problem solving group, caregiver stress management workshops) Brain Injury Services Muskoka Simcoe (independence and community integration supports, community programs, rehabilitation supports, ABI workshops, in-home and community supports, adult day services, opportunities for socialization, recreation and maintenance of functional living skills) March of Dimes Canada (peer support and socialization opportunities, peer support group, retreats for ABI survivors)



Access to Specialist:	
Physiatrist	✓
Psychiatrist	✓
Neuropsychiatrist	✓
Behavioural psychologist	✓
Speech-language pathologist	x
Paediatric specialist	x

Regional Context: NSM

What works well in NSM LHIN

- The NSM ABI Collaborative, composed of the 4 LHIN funded agencies delivering community integration ABI services in NSM, operates within a shared service framework, creating a single coordinated system and to facilitate seamless transitions for survivors across the continuum of care through increased education and awareness of community-based ABI services. It has created a shared application process with shared data base, and the ABI Pathway with NSM LHIN Home and Community Care.
- The ABI Pathway provides a template for the coordination of interdisciplinary services that will enhance the functional and social outcomes of ABI clients in the community. The ABI Pathway provides suggestions as to the number of visits and weeks on service for LHIN provided Professional Services. The partner agencies such as YSBIS and BIS provide timely access to Rehabilitation Worker to support the work of the Professional therapies and maximize those resources by providing functional opportunities to engage in rehabilitation goals.

What are some gaps, opportunities or drivers in NSM LHIN

- Lack of infrastructure for patients to be discharged to (e.g. insufficient community and caregiver supports to allow patients to be supported at home, no ABI-specific supportive housing, reluctancy of LTC homes to admit clients with ABI and behavioural needs and/or young individuals who may exhibit behaviours due to inappropriate placement).
- The vast physical geography makes transportation a challenge (e.g., lack of transportation, poor travel hours, long commutes, traveling to the Greater Toronto Area to access specialized services).
- Lack of specialized care in region.

Client Vignette

- A 28-year-old female sustained an ABI through a sporting injury. The client attempted to return to work shortly after being released from hospital rehabilitation and was unsuccessful due to the continued symptoms of her ABI. Due to these ongoing difficulties, the client received support services through the NSM LHIN Home and Community Care Services ABI PATHWAY, which was a direct offer of OT and SLP services. In addition, she was given a direct offer of the services of a Rehabilitation Worker from one of the NSM ABI Collaborative agencies to work alongside the OT and SLP. This process is defined and coordinated as a specific pathway for ABI clients receiving NSM LHIN Home and Community Care Services.

- The Rehabilitation Worker was able to meet the client weekly and the Professional Services were able to visit monthly. This model maximizes the professional Rehabilitation Services by both extending the time of involvement while not increasing visits and allowing more time for the client to practice and acquire the skills in a functional environment promoting generalized acquisition of skills. The functional areas and skills acquired are described below:
    - The client defined the following goal areas with the OT: scheduling, routine, and pacing.
    - The client defined the following goal areas with the SLP: verbal and written communication skills.

- The Rehabilitation Worker addressed the above goal areas by supporting the client with learning how to use her phone to set reminders and create a daily schedule while creating and maintaining a structured routine to learn how to pace and set herself up for a successful day. The Rehabilitation Worker was also able to support the client with her goal of verbal and written communication. The Rehabilitation Worker and the client worked on written communication through the client's online business. The client was able to write content about her products and verbally share them with the Rehabilitation Worker. The client continues to sell her products online successfully.

- The client successfully learned how to maintain a routine and pace herself. She is now confident with her verbal and written communication skills. She is working on a presentation for her peers and writing an article for a magazine to teach others about pacing following an ABI.

- The client was assessed using the Quality of Life Questionnaire and demonstrated improvements across all domains. The client continues to access various services through BIS (Adult day program, education groups, urban pole walking, meditation, and mindfulness). She is currently taking a language course independently to continue to challenge herself. The client has gained enough confidence to be able to live independently and continues to work hard to learn and grow everyday.