Recommendations from the 2021 Ontario Traumatic Brain Injury (TBI) Report Card

RECOMMENDATIONS DIRECTED TO CLINICAL SERVICE PROVISION

1 A formal collaboration and information-sharing mechanism should be developed between acute care providers and specialized ABI inpatient rehabilitation programs **to ensure that every person with a TBI who could benefit from specialized brain injury inpatient care receives it.**

2 Every person with TBI should receive the same **quality-based and consistent specialized brain injury rehabilitation care across the continuum (inpatient, outpatient and outreach).**

3 A system-wide effort should be implemented to build capacity for **access (in-person or virtually) to neurobehavioural services** across the continuum of care for assessment, treatment and evaluation or persons with behavioural challenges after TBI.

4 Formal collaboration mechanisms involving assessment, collaborative concurrent and coordinated treatment, and discharge planning should be initiated and supported to provide **brain injury expertise to mental health and substance use** treatment and support programs, and **mental health and substance use** expertise to brain injury treatment and support programs.

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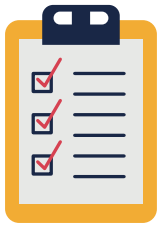
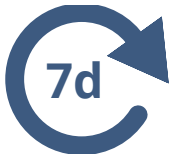


5 To minimize use of Alternative Level of Care (ALC) days and ensure that all persons with moderate to severe TBI are assessed for rehabilitation appropriateness, standard **referrals to Occupational Therapy, Physiotherapy and Speech-Language Pathology** should be implemented for every patient with moderate to severe TBI in **acute care** (including centers receiving repatriated patients from other acute centers). This will ensure timely, comprehensive, interdisciplinary assessment and initiation of early rehabilitative care interventions.

6 Every person with TBI discharged from an inpatient rehabilitation program should have a **follow up appointment with a Primary Care Provider scheduled within 30 days.**



7 Every person with TBI discharged from specialized inpatient brain injury rehabilitation should have a referral **to specialized outpatient or home care/community-based rehabilitation that results in a first visit within 7 days.**

RECOMMENDATIONS TO ADDRESS IDENTIFIED GAPS IN AVAILABLE DATA

An integrated data system with mandated data collection should be developed and implemented that allows for integration of data collection across the continuum of care to characterize the full trajectory of care received by persons after TBI.

Suggested Data Elements

	A Inpatient	B Outpatient	C Community
1. Wait time from readiness for next stage of rehabilitation to when the service is initiated	✓	✓	✓
2. Type and frequency of rehabilitation services received (e.g., PT, OT, SLP, SW, Clinical Psychologist, Nurse, and Physician/Physiatrist)	✓	✓	✓
3. Direct access to professionals trained in assessment and treatment of Mental Health and Substance Use/Misuse and Neurobehavioural Issues	✓	✓	✓
4. Length of Stay and/or Service Duration	✓	✓	✓
5. Detail in discharge options to identify the specific type of post-discharge care that patients are referred to (e.g., community 3rd party rehab, HCC, only family care, family care while waiting for a different level of care, etc.)	✓	✓	
6. Percentage of clients discharged from service compared to total number of active clients and reason for discharge			✓

PT - Physiotherapy; OT - Occupational Therapy; SLP - Speech Language Pathology; SW - Social Work; HCC - Home and Community Care

