SOUTH 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	3.4	2.5	10
	b) concussion/mild TBI	10.6	9.1	12
2	Risk-adjusted TBI mortality rate within 30 days of admission to hospital per 100 patients	13.8	13.7	9
3	Proportion of ALC days to total LOS in acute care (%)	28	25.2	10
4	Proportion of acute patients with TBI (%) discharged from acute care and admitted to: a) general inpatient rehabilitation	4.3	6	11
	b) specialized ABI inpatient rehabilitation	11.9	7.5	3
5	Median number of days from TBI onset and admission to: a) general inpatient rehabilitation	12 (3-33)	13 (8-23)	4
	b) specialized ABI inpatient rehabilitation	32 (24-63)	25 (12-44)	10
6	Median FIM change of: a) general inpatient rehabilitation	25	25	5
	b) specialized ABI inpatient rehabilitation	25	25	8
	Median FIM efficiency of: c) general inpatient rehabilitation	1	1.1	8
	d) specialized ABI inpatient rehabilitation	0.7	0.8	8
7	Median time from discharge from acute care/inpatient rehabilitation to first HCC visit for: a) physiotherapy	14 (4-45)	15 (5-59	6
	b) occupational therapy	14 (5-46)	11 (4-46)	10
	c) speech language pathology	62 (13-116)	55 (13-144)	9
	d) social work	46.5 (13-116)	52 (18-127.5)	3
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)	10
	b) occupational therapy	2 (1-3)	2 (1-3)	4
	c) speech language pathology	1.5 (1-3)	2 (1-2)	3
	d) social work	2 (1-3)	2 (1-3)	2
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)	66, 90, 89.6	75.1, 93.1, 95.5	13*
	b) GP/FP (mental health-related reason)	-, 14, 20.8	7.2, 21.2, 28.5	13†
	c) Specialist (physical medicine, neurosurgeon, neurology)	32, 72, 81.3	36.8, 66.3, 70.9	3†
	d) Specialist (psychiatry)	-, -, 14.6	4, 12.8, 17	7‡
	e) No GP/FP or specialist follow-up assessment within 30 days	30, NA, NA	16.5, NA, NA	13
10	Proportion of patients with a TBI (%) discharged from acute care to: a) complex continuing care (CCC)	3.0	3.6	6
	b) long-term care (LTC)	3.0	1.6	14
11	Age- and sex-adjusted all-cause readmission rate at 30 days for patients with TBI per 100 patients	3.3	4.1	2
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: SE

Population: 469,400 (3.6% of Ontario population)

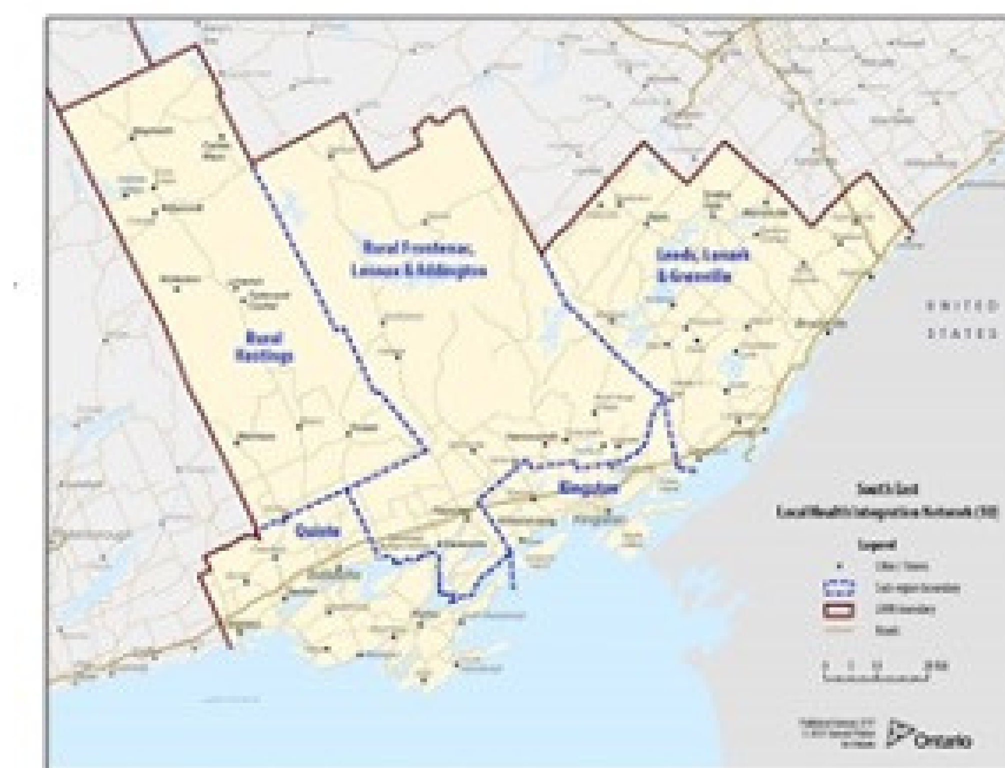
Health Services:

Acute Care	
Level 1 Trauma Centre	Kingston Health Sciences Centre – Kingston General Hospital site
Acute Hospitals with Neuro-Capacity	Kingston Health Sciences Centre – Kingston General Hospital site
Other Acute Hospitals	The QHC Belleville General Hospital Northumberland Hills Hospital Brockville General Hospital Perth / Smiths Falls District Hospital

Inpatient Rehabilitation	
Specialized ABI	Providence Care Hospital
General	Providence Care Hospital

Outpatient Rehabilitation	
Specialized ABI	No
General	No

Community-based Services	
Rehabilitation by registered professionals	Home and Community Care Private
Brain Injury Organizations	Community Brain Injury Services (CBIS) – Rehabilitation and Specialized Support services (e.g., outreach, group, limited psychological, and assisted living services) Brain Injury Association Quinte Brain Injury Association District (social/recreation programs, peer mentoring, resources, special events) March of Dimes Canada Pathways for Independence (supported living and day programs/services)



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

Regional Context: SE

What works well in SE LHIN

- Range of community brain injury services for individuals with moderate to severe brain injuries.
- Post Concussion Action Group is a program, based on ONF recommendations, available for individuals in South East Ontario with post-concussion symptoms 3 months or more after their injury.
- The Southeastern Ontario (SEO) ABI (Acquired Brain Injury) and Addictions/Mental Health Collaborative, a "situation table" for addressing the needs of people with moderate to severe ABI and a complicated by addictions and/or mental illness, who are believed to be at risk.
- Revved Up Exercise Program is a community-based exercise program for individuals in the greater Kingston community who are living with a disability. A partnership bridging the gap between community and research. Developed by health professionals sensitive to and educated about the fitness and lifestyle considerations for people with disability and/or chronic disease.
- Brain Injury sector has representation on local HSJCC and Situation Table
- Through the Local Acquired Brain Injury Network (SEO ABI Network), there is communication and relationships between the hospital and community support services for community reintegration (i.e., Home and Community Care Support Services and VON).
- Community ABI Service Provider representation at ABI Inpatient Rounds (PCH) to help coordinate/facilitate discharge planning.
- Access to Neuropsychiatry
- Group program designed specifically for individuals with an ABI who have difficulties with handling crises, unstable emotional reactions and impulsivity.

What are some gaps, opportunities or drivers in SE LHIN

- Issues surrounding wait times for LTC, supervised/assisted living, and for patients with a social requirement as a barrier.
- Barriers in post-acute settings such as social, mental health, behavioral, and neurological.
- The movement of ALC patients from KHSC to create capacity in acute care, resulting in increased rate of ALC at Providence Care (partly).
- The slow transition to LTC, limited resources to complete needed renovations and access equipment, and limited supportive living / accessible housing impacting ALC numbers and ALC days.
- Barriers to discharge are social (lack of supports, lack of finances) and behaviors.
- Issues in securing PSW resources to safely discharge patients to home, which impacts the ability to use the home first approach.
- Issues with access to allied professionals during the pandemic.
- Issues with access to LTC due to pandemic directives, resulting in decreased number of beds.
- The impact of the lack of outpatient services for ambulatory patients who do not need nursing care (e.g. admission to inpatient rehabilitation beds when not needed, receiving less intensive services than needed).
- Lack of ABI specialized LHIN funded therapists for OT/PT through Home and Community Care.
- Lack of funded vocational rehabilitation services.
- Insufficient ABI-specific behaviour or mental health supports for children available in the community through the mental health agencies.

Regional Context: SE

Client Vignette

- Young adult male sustained a TBI as a result of an assault. At the time of the assault, he had just graduated from Culinary Arts Program and was beginning an apprenticeship. Client received acute care services (underwent craniotomy and evacuation of right subdural haematoma) then moved to inpatient ABI Rehabilitation Unit where he remained for approximately 4 months. Discharge plans included referral to Community Brain Injury Services (CBIS) and Home and Community Care for OT, PT, SLP and Dietician. Client was connected to Physiatry. Client returned to live with parents as he was not able to live independently.

- Client noted physical recovery as main goal of rehabilitation and identified community rehabilitation roles of being employed in the Food Industry and being a productive community member. Cognitive challenges included processing speed, divided attention, visual memory and visuo-spatial comprehension.

- Caregiver Support made available to family through CBIS Caregiver Support Group.

- Client worked one to one with Community Rehabilitation Counsellor. He participated in CBIS cooking group, used a variety of adaptive devices for cooking and became self-sufficient in the kitchen. The client cooked items for local church to donate and mentored in the CBIS cooking group. He was connected with ODSP Employment Supports. Client volunteered at Community and Primary Health Care helping with activities and cooking and was later employed 2-3 days per week in the kitchen at a local Convention Centre.

- Client took part in a one-week assessment within CBIS Assisted Living Program to experience living outside the family home. Client demonstrated independence in many areas (e.g., personal care, meal planning and preparation). Main challenges continued to be around quick decision-making, distraction, and over-thinking. He was assisted with reviewing Future Needs Assessment through the Victim Assistance Program to explore the possibility of transitioning to more independent living. Although client was not at a point of wanting to move out of family home, he is seen as a good candidate for MOH Transitional Funding. A draft Transitional Funding proposal was completed for future consideration.

- Client became self-sufficient in family home and community. He regularly participated in activities at the local YMCA and various social/community events. Client presented motivational speech about the effects of violence to numerous schools and community agencies. He was awarded the Queen Elizabeth II Diamond Jubilee Award for making a difference in the lives of students, young offenders and at-risk youth. Client has transitioned to group only status within CBIS. He participates in special events and group activities. Although he is not currently employed due to a recent surgery and the pandemic, he plans to return to work once he's fully recovered and there is a suitable position for him.