SOUTH WEST LHIN

Ranked 1 or 2 of 14 LHIN
Ranked 13 or 14 of 14 LHIN

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	3.7	2.5	14
	b) concussion/mild TBI	10.8	9.1	14
2	Risk-adjusted TBI mortality rate within 30 days of admission to hospital per 100 patients	13.1	13.7	3
3	Proportion of ALC days to total LOS in acute care (%)	28.5	25.2	11
4	Proportion of acute patients with TBI (%) discharged from acute care and admitted to: a) general inpatient rehabilitation	4.6	6	8
	b) specialized ABI inpatient rehabilitation	7	7.5	7
5	Median number of days from TBI onset and admission to: a) general inpatient rehabilitation	18 (11-24)	13 (8-23)	13
	b) specialized ABI inpatient rehabilitation	36.5 (27.5-59.5)	25 (12-44)	11
6	Median FIM change of: a) general inpatient rehabilitation	18	25	13
	b) specialized ABI inpatient rehabilitation	17	25	11
	Median FIM efficiency of: c) general inpatient rehabilitation	0.8	1.1	13
	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	8 (4-23)	15 (5-59)	3
	b) occupational therapy	8 (3-25)	11 (4-46)	3
	c) speech language pathology	162 (48-222)	55 (13-144)	13
	d) social work	42 (19-88)	52 (18-127.5)	2
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)	14
	b) occupational therapy	2 (1-3)	2 (1-3)	10
	c) speech language pathology	-	2 (1-2)	NR
	d) social work	1.5 (1-2)	2 (1-3)	7
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)	76.3, 92.5, 97.3	75.1, 93.1, 95.5	7*
	b) GP/FP (mental health-related reason)	7.5, 21.3, 29.3	7.2, 21.2, 28.5	8†
	c) Specialist (physical medicine, neurosurgeon, neurology)	40, 88.8, 92	36.8, 66.3, 70.9	1†
	d) Specialist (psychiatry)	3.5, 12.5, 16	4, 12.8, 17	6‡
	e) No GP/FP or specialist follow-up assessment within 30 days	16.3, NA, NA	16.5, NA, NA	6
10	Proportion of patients with a TBI (%) discharged from acute care to: a) complex continuing care (CCC)	1.6	3.6	3
	b) long-term care (LTC)	1.8	1.6	9
11	Age- and sex-adjusted all-cause readmission rate at 30 days for patients with TBI per 100 patients	3.6	4.1	5
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

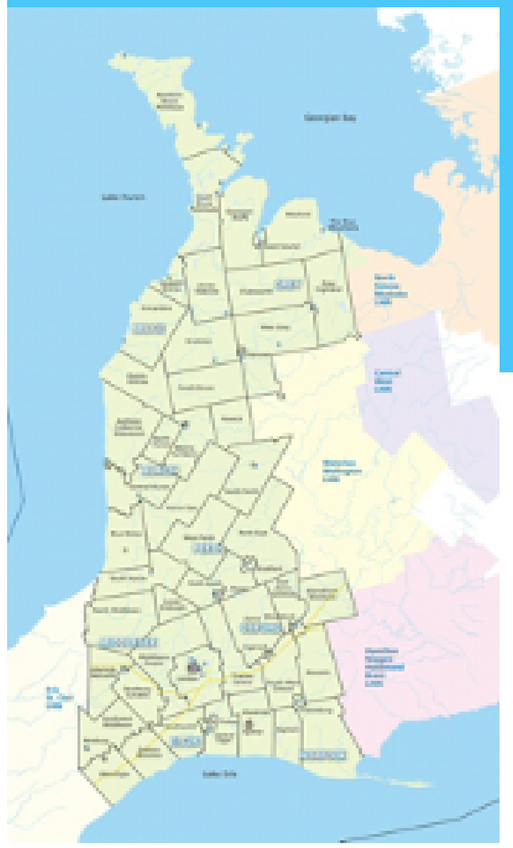
*Ranking determined at 30 days
†Ranking determined at 180 days
‡Ranking determined at 365 days
NR denotes No Ranking
**Colour banded due to ties in rank ordering

Regional Context: SW

Population: 971,5000 (7% of Ontario population)

Health Services:

Acute Care	
Level 1 Trauma Centre	London Health Sciences Centre – Victoria Hospital Campus
Acute Hospitals with Neuro-Capacity	London Health Sciences Centre – University HospitalHuron
Other Acute Hospitals	Perth Health Alliance (Clinton, St. Mary's, Seaforth, Stratford) South Huron Hospital Alliance Alexandra Marine and General Hospital Alexandra Hospital South Bruce Grey Health Centre (Kincardine, Durham, Walkerton, Chesley) Listowel Wingham Hospital Alliance (Listowel Memorial Hospital, Wingham & District Hospital) Middlesex Hospital Alliance (Four Counties Health Services in Newbury and Strathroy Middlesex and General Hospital) Grey Bruce Health Services (Owen Sound Regional Hospital, Lion's Head Hospital, Markdale Hospital, Meaford Hospital, Southhampton Hospital and Wiarton Hospital) St. Thomas Elgin General Hospital Tillsonburg District Memorial Hospital
Inpatient Rehabilitation	
Specialized ABI	St. Joseph's Health Care London, Parkwood Institute
General	Huron Perth Health Alliance Listowel Wingham Hospital Alliance Grey Bruce Health Services St. Thomas Elgin General Hospital Woodstock General Hospital
Outpatient Rehabilitation	
Specialized ABI	St. Joseph's Health Care London, Parkwood Institute
General	Woodstock General Hospital Rehabilitation Grey Bruce Health Services – single therapy services Huron Perth Health Alliance – single therapy services



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

Regional Context: SW

Community-based Services	
Rehabilitation by registered professionals	Home and Community Care Private – Parkwood Hospital also has private ABI services St. Joseph's Health Care London, Parkwood Institute–ABI Outreach Program Fowler Kennedy Sports Clinic – must be sport-related injury Dale Brain Injury Services - psychology
Brain Injury Organizations	Dale Brain Injury Services (Assisted Living, Supported Independent Living, Residential Transitional Living, Community Transitional Living, Intensive Community Transitional Living, Stroke Day Program, Group Services, Counseling, Short-Term Case Management, Consultation and Training, Respite Services) Participation Lodge (Residential Care, Respite Services, Outreach Services)

What works well in SW LHIN

- Availability of specialized ABI services with high levels of expertise and physiatrists with expertise in brain injury.
- Access to a neuro-behavioural rehabilitation inpatient program (and small neuro-behavioural Outreach component) with expertise in development and implementation of behavioural programs for individuals with ABI.
- Strong, well developed interdisciplinary outpatient program of PT, OT, SLP, social work and nursing for concussion/mTBI and moderate to severe ABI at Parkwood Main Building, St. Joseph's Health Care London.
- Strong hospital-based Outreach program with ABI expertise serving all of LHIN 2 and much of LHIN 1.
- Strong partnerships between hospital and community ABI services
- Range of community brain injury services for individuals with moderate to severe brain injuries.
- South West brain injury network representing a variety of sectors including mental health and addictions, justice, home and community care.
- Strong Brain Injury Association of London and Region which provides community awareness as well as a variety of services and support groups to survivors of brain injuries and their caregivers.
- Brain Injury sector has representation on local HSJCC.
- Private sector (rehabilitation companies and legal) has expertise in brain injury rehabilitation.

What are some gaps, opportunities or drivers in SW LHIN

- Lack of appropriate housing, discharge destination, and/or adequate long-term home supports for clients with ABI and/or behavioural challenges within or close to their community. preventing access to some ABI services (e.g., inpatient rehab, residential transitional services).
- Long wait times for LTC, rehabilitation beds, assisted living, publicly funded specialized ABI outpatient services, and specialized community services.
- Lack of coordinated services for patients with complex needs who require services from several sectors and specialists, and limited access to psychology, neuropsychology, psychiatry, neuropsychiatry, and publicly funded lifelong services.
- Lack of awareness of intimate partner violence (IPV) related TBI and lack of partnerships between ABI and IPV sectors.
- Potential for acute care patients to be "missed" and have no follow up post-discharge.
- Lack of structure for navigation between 3rd party and publicly funded systems and most appropriate referral destination.
- Insufficient information to the public about ALC and programs to help transition care out of acute care settings.
- Home First is a good program but has limited resources. Insufficient nursing or PSW support to help patients achieve home first option.
- Increased investments in funded education programs (e.g. PSW, RPN) may help enrollment

Regional Context: SW

Client Vignette

- A young person under the age of 25 years old sustained a severe traumatic brain injury, after which they were admitted to a Trauma Centre and underwent several neurosurgeries. Once the patient was medically stable, they were transferred from acute care to inpatient specialized ABI rehabilitation. Fortunately, wait time for rehabilitation bed was not an issue, however, the mechanism of injury and circumstances surrounding injury did not allow for any access to third party funded services. Prior to their injury, the patient was living independently, but after over one year of inpatient rehab, they remained at a low functional level and required maximal assistance with all personal care and transfers, resulting in a need for 24-hour care. While the patient's behaviours improved with a structured and consistent behavioural management program, they remain a challenge and require 1:1 staffing to maintain consistency

- At the time of their injury, patient did not have significant contact with family/friends who could potentially provide support and/or caregiving. Patient remained in hospital well beyond the point when their progress plateaued and no longer required intensive daily therapy (although intensive supports continued to be required due to low level of function and challenging behaviours). This was because there was no feasible discharge destination and a lack of patient finances as they had not been receiving any source of income while in hospital. Housing specifically for clients with ABI does exist in this LHIN (mostly in one city) through community brain injury rehab services, however, the patient was not eligible for any housing/assisted living specifically for clients with ABI due to the level of care required in combination with their challenging behaviours. Other options, such as transitional funding for ABI as well as LTC were explored but ultimately not an option given the level of care needed and behavioural issues. Eventually a family member/friend who is willing to be caregiver emerged and discharge to this person's home with maximal supports through LHIN services as well as ongoing rehab and behavioural services through community brain injury services occurred. The long-term plan remains to explore ABI community beds outside of LHIN which can manage this particular patient's level of care and behaviours, given caregiver is ageing.