WATERLOO WELLINGTON 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	2.5	2.5	8
	b) concussion/mild TBI	8.9	9.1	5
2	Risk-adjusted TBI mortality rate within 30 days of admission to hospital per 100 patients	15.1	13.7	13
3	Proportion of ALC days to total LOS in acute care (%)	14.2	25.2	4
4	Proportion of acute patients with TBI (%) discharged from acute care and admitted to: a) general inpatient rehabilitation	3.9	6	12
	b) specialized ABI inpatient rehabilitation	3.4	7.5	12
5	Median number of days from TBI onset and admission to: a) general inpatient rehabilitation	19 (11-39)	13 (8-23)	14
	b) specialized ABI inpatient rehabilitation	42 (15-88)	25 (12-44)	13
6	Median FIM change of: a) general inpatient rehabilitation	25.5	25	5
	b) specialized ABI inpatient rehabilitation	15.5	25	12
	Median FIM efficiency of: c) general inpatient rehabilitation	1.5	1.1	1
	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	16 (5.5-53.5)	15 (5-59	7
	b) occupational therapy	7 (3-30)	11 (4-46)	2
	c) speech language pathology	60.5 (4-130.5)	55 (13-144)	8
	d) social work	68.5 (32.5-140.5)	52 (18-127.5)	8
8	Median number of HCC visits within 60 days of discharge from acute care/inpatient rehabilitation for: a) physiotherapy	4 (2-5)	4 (2-5)	6
	b) occupational therapy	3 (2-3)	2 (1-3)	1
	c) speech language pathology	2 (1-4)	2 (1-2)	2
	d) social work	2 (1-3)	2 (1-3)	3
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, 85.7, 90.9	75.1, 93.1, 95.5	11*
	b) GP/FP (mental health-related reason)	-, -, 27.3	7.2, 21.2, 28.5	NR†
	c) Specialist (physical medicine, neurosurgeon, neurology)	40, 51.4, 54.6	36.8, 66.3, 70.9	13†
	d) Specialist (psychiatry)	-, -, -	4, 12.8, 17	NR‡
	e) No GP/FP or specialist follow-up assessment within 30 days	17.1, NA, NA	16.5, NA, NA	7
10	Proportion of patients with a TBI (%) discharged from acute care to: a) complex continuing care (CCC)	1.84	3.6	4
	b) long-term care (LTC)	0.58	1.6	2
11	Age- and sex-adjusted all-cause readmission rate at 30 days for patients with TBI per 100 patients	3.2	4.1	1
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: WW

Population: 778,700 (5.6% of Ontario population)

Health Services:

Acute Care

Level 1 Trauma Centre	No
Acute Hospitals with Neuro-Capacity	No
Other Acute Hospitals	Grand River Hospital St. Mary's Hospital Groves Memorial Hospital Guelph General Hospital Cambridge Memorial Hospital

Inpatient Rehabilitation

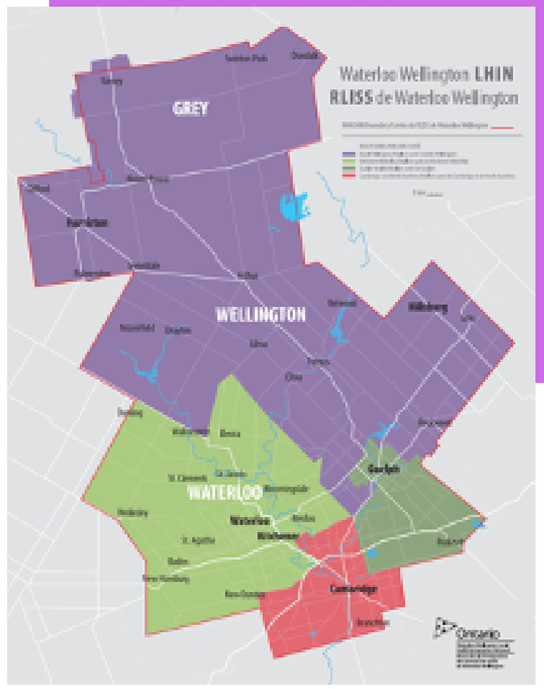
Specialized ABI	No
General	Grand River Hospital St. Joseph's Health Center Groves Memorial Hospital St. Joseph's Health Centre Guelph

Outpatient Rehabilitation

Specialized ABI	No
General	Grand River Hospital – Freeport Campus

Community-based Services

Rehabilitation by registered professionals	Private services Home and Community Care Traverse Independence Case Coordination Program (limited funding for Occupational Therapy, Social Work, Speech Language Pathology, Psychiatry, and Vision Assessments by Neuro Ophthalmology)
Brain Injury Organizations	Traverse Independence (ABI Transitional Living Program, Group Home, Outreach Program, Day Program, ABI Specialized Case Coordination, Behavioural Supports, Caregiver Education) St. Joseph's Health Center – ABI Community Day Program



Access to Specialist:

Physiatrist	**x**
Psychiatrist	✓ (limited)
Neuropsychiatrist	**x**
Behavioural psychologist	**x**
Speech-language pathologist	✓ (limited)
Paediatric specialist	**x**
Other: Occupational therapy, social work	✓

Regional Context: WW

What works well in WW LHIN

- Ontario Health Teams (Guelph, Cambridge, KW4) are including brain injury assessment (HELPS Screening Tool) as part of their intake and assessment in New OH Mental Health and Addictions OHT processes.
- Community Agencies are aware of the programs at Traverse Independence and are consistently providing referrals.
- Local hospital mental health and addiction services are providing referrals and are aware of programs.
- Open communication and client planning between various LHIN agencies.
- There is some movement of clients out of ALC beds into Traverse Independence beds.

What are some gaps, opportunities or drivers in WW LHIN

- Lack of appropriate housing (e.g., housing with ABI specific supports or supportive housing, discharging patients to inappropriate settings).
- ABI housing with supports could occur in the form of ABI specific supportive housing, affordable housing and permanent housing.
- Need for combining services to ensure all client needs are met (e.g., addressing comorbidities).
- Increased risk of caregiver support burnout due to COVID-19 / closure of day programs and community drop-in programs.
- Increased vulnerability and harm to clients who cannot access traditional supports (e.g., harm reduction sites, reliable sourcing) due to COVID-19 / closure of addiction supports.
- Lack of neurology services in the region, requiring travel to Hamilton.

Client Vignette

- A 48-year-old man living with his wife and children experienced a traumatic brain injury from an alcohol related altercation/assault, which resulted in an intracranial and subarachnoid hemorrhage. He was assessed at an acute level hospital following the altercation and was admitted to the ICU. While in hospital, a CT scan was completed, and he received a consultation with the hospital neurosurgeon. He had no premorbid mental health concerns at the time of his TBI.
- Upon discharge home from the hospital, services were arranged for an ABI neurology clinic, outpatient neurosurgery follow-up, and a referral was made at Traverse Independence. Persistent TBI symptoms present at hospital discharge included significant memory loss, attention difficulties, medication support, and prompting and cueing from his partner for the completion of daily tasks. Once home, he experienced significant headaches, and attended the nearby hospital Emergency Department for assistance with pain management several times over the next month.

- A few weeks later, the client's wife reported that she was experiencing high levels of stress and caregiver burnout. A referral to the Care to Share ABI Caregiver Support Group was made.

- At this point in time, no TBI specific supports were available to the client. The client had been referred to Traverse Independence, but the waitlist for services from the Outreach program and Transitional Living program was approximately 2 years at the time.

- A few weeks later, the client developed a significant change in his demeanor that concerned his family and the Outpatient. He was admitted to the mental health floor of the local hospital for management of anger disturbances, post-traumatic stress related to the altercation that caused the TBI, hallucinations, and depression due to significant life changes and loss of employment. There was increasing concern for anger, verbal and physical outburst, and threats of harm.

- The patient was then being followed by a psychiatrist. After a course of assessment and treatment in the inpatient psychiatry unit, he was discharged home. Following discharge, he was referred for outpatient psychiatry services and counselling through a local counselling organization.

- The client commenced outpatient rehabilitation shortly after his discharge from the psychiatry unit, where he received services from the Neuro Outpatient Clinic at Grand River Hospital, which included occupational therapy, speech language pathology and social work services. The rehabilitation team noted the significant functional difficulties that the client was experiencing after his TBI and decided that further inpatient rehabilitation would be of benefit to the client to work on functional goals. Referrals were made to both the Homewood PTSD program and Hamilton Health Sciences ABI Program. Homewood declined the admission. The client was then assessed by the HHS ABI program and was approved for the neurobehavioral program. The client is currently waiting at home to attend this program as the waitlist is several months.