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INTEGRATED COMMUNITY BASED REHAB

BUILDING SYSTEM CAPACITY FOR ABI

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ABI PROGRAM

The Ottawa Hospital | L'Hôpital d'Ottawa

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Report to Champlain LHIN Board 2017 :Overview

- Acquired brain injury (ABI) is the leading cause of death and disability in Canadians under the age of 45.
- Limited integrated services and resources are available to meet the long term needs of ABI citizens in Champlain.
- How can we enhance ABI community based rehabilitation services through integration, improved accessibility and sustainability?
- Can capacity be increased to enhance health outcomes?

REPORT FINDINGS: OPPORTUNITIES FOR IMPROVEMENT

- Reduce wait lists for residential settings (currently > 10 years).
- Reduce placement in inappropriate settings
- Reduce resource inequities between LHINs

CURRENT ACTIONS AND NEXT STEPS

- Short Term Pilot project: Transition from high support residential setting towards supported independent living incorporating technology.
- Long term service enhancement: Create an enhanced level of residential care to allow transition from hospital ALC to a residential setting
- Ongoing process: Engage stakeholders to explore further integration and improvements along the continuum of community rehabilitative care

DELIVERABLES – ALC TO COMMUNITY

- Assess all current ALC patients with ABI and high priority community clients, and develop Community Care Plans where appropriate;
- Engage with community ABI housing providers to implement the Community Care Plans;
- and
- Establish partnerships through purchase of service agreements with ABI housing providers to sustain clients within the community.

ALC TO COMMUNITY

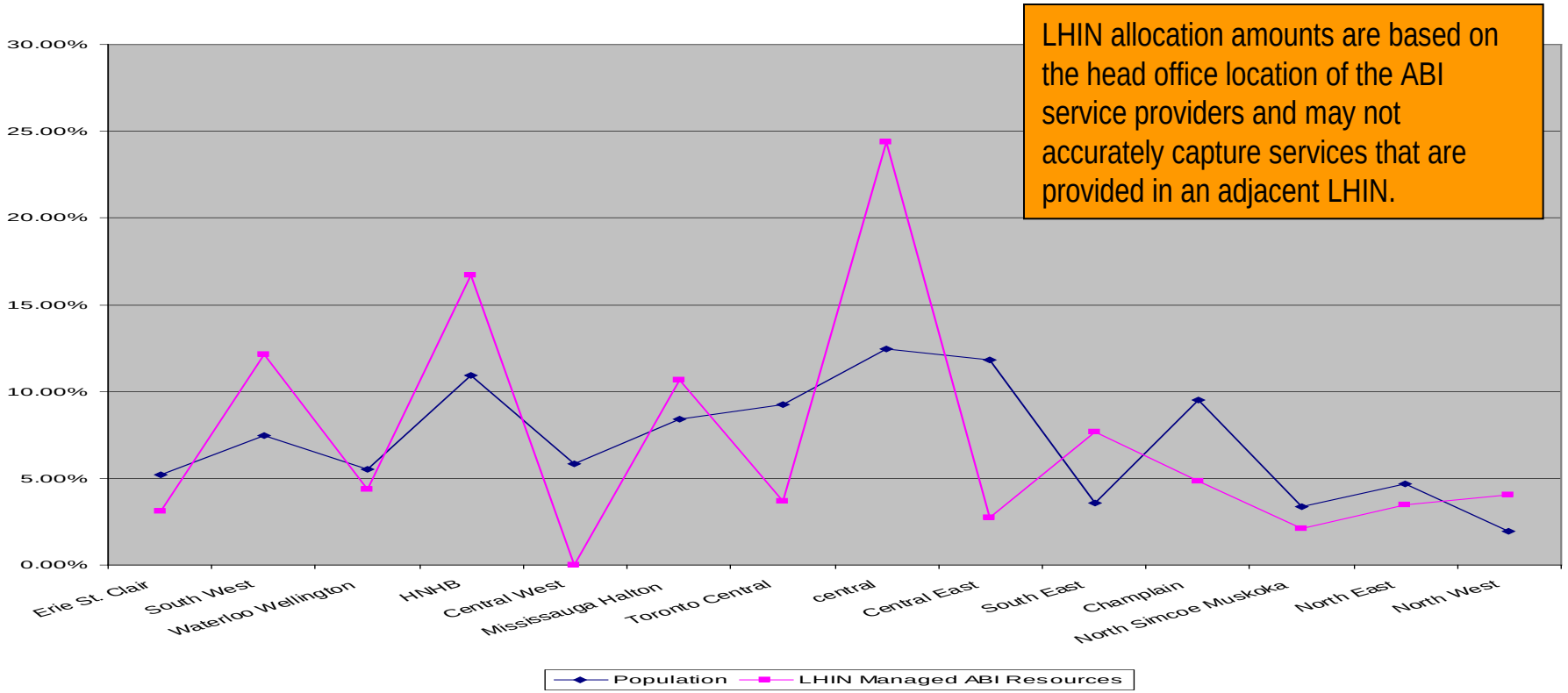
- Phase 2 a)
  - the “transition from ALC to community” project . In this phase the team assessed 5 individuals in ALC beds . One **(1)successfully transitioned to community** residential care (pathways) (March 2018)

ALC/AT RISK TO COMMUNITY

- Phase 2 b
  - expanded the criteria to ALC , Complex Continuing care and high risk community clients. In this current phase , the team has completed 7 assessments , deeming 4 clients eligible. Of this group , 1 individual has completed a stay at Robin Easey and has **successfully transition to a retirement level** care(March 2018) . One other client will be admitted from ALC bed to REC in near future .
  - 14 assessments completed. Three (3) individuals have transitioned to lower cost and more appropriate level of care. We expect to be able to transition at least 2 more to meet our current target

NEXT STEPS

ABI RESOURCES BY LHIN VS POPULATION (%)



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