Neurotrauma Care Pathways

CANADIAN CLINICAL PRACTICE GUIDELINE FOR THE REHABILITATION OF ADULTS WITH MODERATE TO SEVERE TBI

Are You Providing Optimal Care for Persons Post-TBI? Discover How Living Clinical Practice Guidelines are an Accessible Way to Elevate Your Clinical Practice.

Thursday, Dec 5, 2024, 2:30-3:15 p.m.

Neurotrauma Care Pathways Team

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UHN Toronto Rehabilitation Institute
The KITE Research Institute

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LIVING CONCUSSION GUIDELINES

Institut national d'excellence en santé et en services sociaux Québec

Land Acknowledgement

We acknowledge that we are on the traditional territory of many Indigenous nations. In Toronto these include the lands of the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. Today, the meeting place of Toronto is still the home to many Indigenous peoples from across Turtle Island and we are grateful to have the opportunity to work and learn on this territory.

In this Land Acknowledgment, we recognize and respect Indigenous Peoples as traditional stewards of this land and the enduring relationship that exists between Indigenous Peoples and their traditional territories. We recognize the importance of reflecting on what occurred in the past as an important step to reconciliation with our Indigenous communities and other communities that have experienced hardship as part of our colonial past.

We also recognize the challenges and discrimination that can exist in the healthcare system towards persons with Indigenous Background. As healthcare providers, system evaluators and planners, it is our responsibility to identify and implement mechanisms to provide equitable and culturally sensitive care.

Disclosures

The Presenting Authors have an employment relationship with UHN-Toronto Rehab - KITE

- *Any data presented here were supported by ICES, which is funded by an annual grant from the Ontario Ministry of Health (MOH) and the Ministry of Long-Term Care (MLTC). This document used data adapted from the Statistics Canada Postal Code Conversion File, which is based on data licensed from Canada Post Corporation, and/or data adapted from the Ontario Ministry of Health Postal Code Conversion File, which contains data copied under license from Canada Post Corporation and Statistics Canada. Parts of this material are based on data and/or information compiled and provided by CIHI. The analyses, conclusions, opinions and statements expressed herein are solely those of the authors and do not reflect those of the funding or data sources; no endorsement is intended or should be inferred*

Presentation Objectives

Key objectives for this presentation are to:

1. Review key clinical actions, strategies and resources (e.g., Living TBI Clinical Practice Guidelines (CPG) and TBI Care Pathways)

2. Describe the KT/KM (*Knowledge Translation/Knowledge Mobilization*) strategy used to support clinicians to use and integrate best practices into their professional practice

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What Is The Problem?

Traumatic Brain Injury (TBI) is a chronic and complex health condition. Unfortunately, its care quality varies due to:

- Limited availability of specialized acute care & rehabilitation
- Poor acknowledgment that it is a chronic and complex health condition
- Lack of navigation to specialized rehab and appropriate community services & supports
- Care model and access is determined by funding (public vs third party)

AND… these variations become magnified GAPS for those who have been traditionally marginalized in the healthcare system

Neurotrauma Care Pathways

Scope Of The Problem

How many people sustain a TBI every year in Ontario?

Concussion: 170,000 - about 20% will have persisting symptoms: 35,000
Complex mild: 2,500
Moderate to severe: 3,500

TOTAL: 175,000 new injuries a year
Approximately 41,000 with ongoing needs

How do people get injured?

Concussion: 30% Fall; 3% MVC; Sport 5%; Unspecified 41%
Complex mild: **66% Fall**; 9% MVC
Moderate to severe: **71% Fall**; 11% MVC

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Scope Of The Problem

How many people with a moderate to severe TBI receive inpatient rehabilitation?

Specialized brain injury rehab: 9%
Mixed Neuro rehab: 4%
General rehab: 5%

TOTAL: 18%

How many people have follow-up with primary care after discharge from acute care and no inpatient rehabilitation?

within 30 days of discharge - 44%
within 90 days of discharge - an additional 16%

How many people get rehab from Ontario Health atHome after discharge from either acute care or inpatient rehab

Physiotherapy - 20%
Occupational Therapy - 21%
SLP or SW - 0.7%

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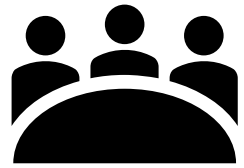
Healthcare Utilization

- Healthcare utilization is high 0-2 and 2-4 years after injury for all severity groups
- Table below shows 0–2-year healthcare utilization compared to the general population
- Mental health (MH) care utilization stays high overtime, suggesting ongoing MH needs for people with TBI

Type of BI	ER visits	MH utilization
Concussion/mild (no admission)	**2.4 X higher**	**1.8 X higher**
Complex mild (1-3 days admission)	**3.6 X higher**	**2.4 X higher**
Moderate to severe (4 or more days admission)	**4.2 X higher**	**2.7 X higher**

Scope Of The Problem



From Persons with lived experience of TBI…..

- Many healthcare **providers are unprepared** to address TBI needs and concerns; they do not understand the ongoing sequelae and chronic nature of the condition that needs are likely to change overtime
- **Who** should be following them in the community? **Who** do they go to for help? **What** is even available to them?

How can we build specialized knowledge and capacity for care management after TBI?

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Gaps In TBI Care

A. General **gap of Equity Considerations** in care; poor overall care documentation and considerations regarding financial status, marginalized groups, comorbidities and geographical location

B. **Poor availability of diagnostic imaging** in rural and remote areas

C. **Inability to provide timely consultation and surgery** for people living in remote areas

D. **Lack of education mechanisms** for healthcare/service providers, persons with lived experience and families

E. **Poor communication and planning** between interprofessional teams during transfers, especially transitions to non-specialized centers

F. **Lack of or inappropriate planning** to link patients to primary care and specialized navigation

G. **13.5%** of moderate to severe traumatic brain injuries receive inpatient rehabilitation in ON; **only 6.5%** receive specialized inpatient rehabilitation

H. **Poor availability of Specialized Outpatient Rehabilitation** services, especially for those living in remote areas or not attending specialized inpatient rehabilitation

I. **Poor availability, limited interprofessional collaborations, and inappropriate funding** models for family doctors and team-based primary care

J. **Access to Community Services and Supports is limited** to personal funds, insurance and/or extended health care benefits

K. **Lack of or inappropriate specialized system navigation support**

L. **Lack of ongoing care, services and supports** for families/friends in the community

M. **Weak mechanisms to re-access rehabilitation** once patient returns to the community

Why Are We Doing What We Are Doing?

- Are there clear Brain Injury Care Pathways that all care providers across the continuum follow? **NO**
- Do care providers know who the providers are who specifically work with persons after brain injury? **SORT OF**
- Are we working together in the most efficient way? **PROBABLY NOT**
- Who is saying '**YES**' to helping people and their families after brain injury? **NOT ENOUGH SERVICE PROVIDERS**

Best-Practice TBI Care

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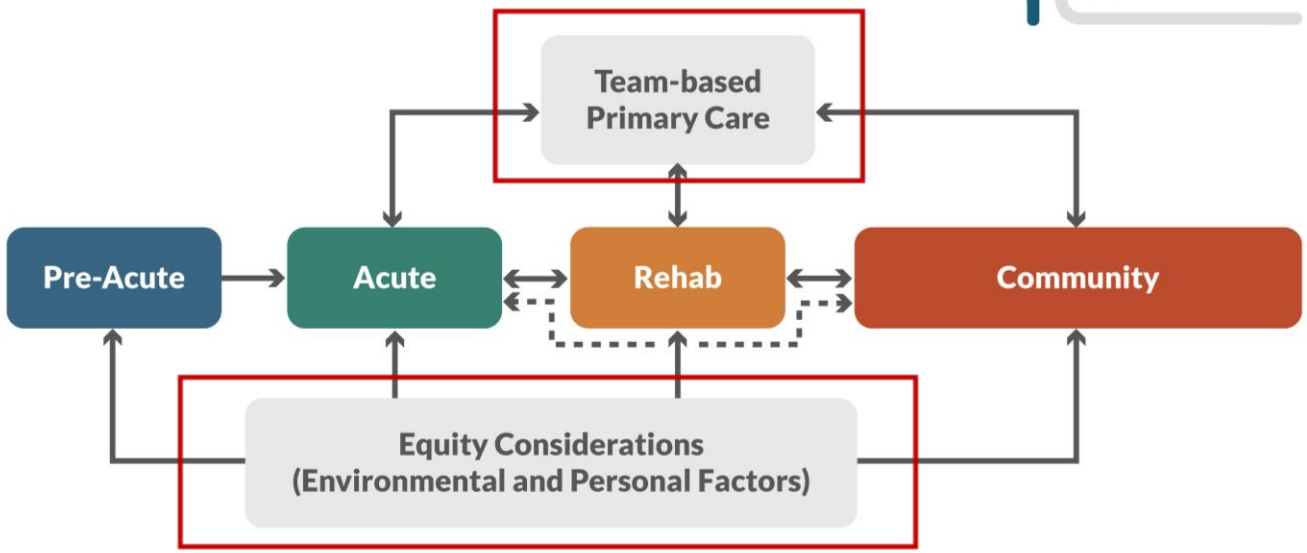


Neurotrauma Care Pathways Interactive Website:
https://www.neurotraumapathways.ca

The process involved co-creation with key partners across the province, particularly persons with lived experience

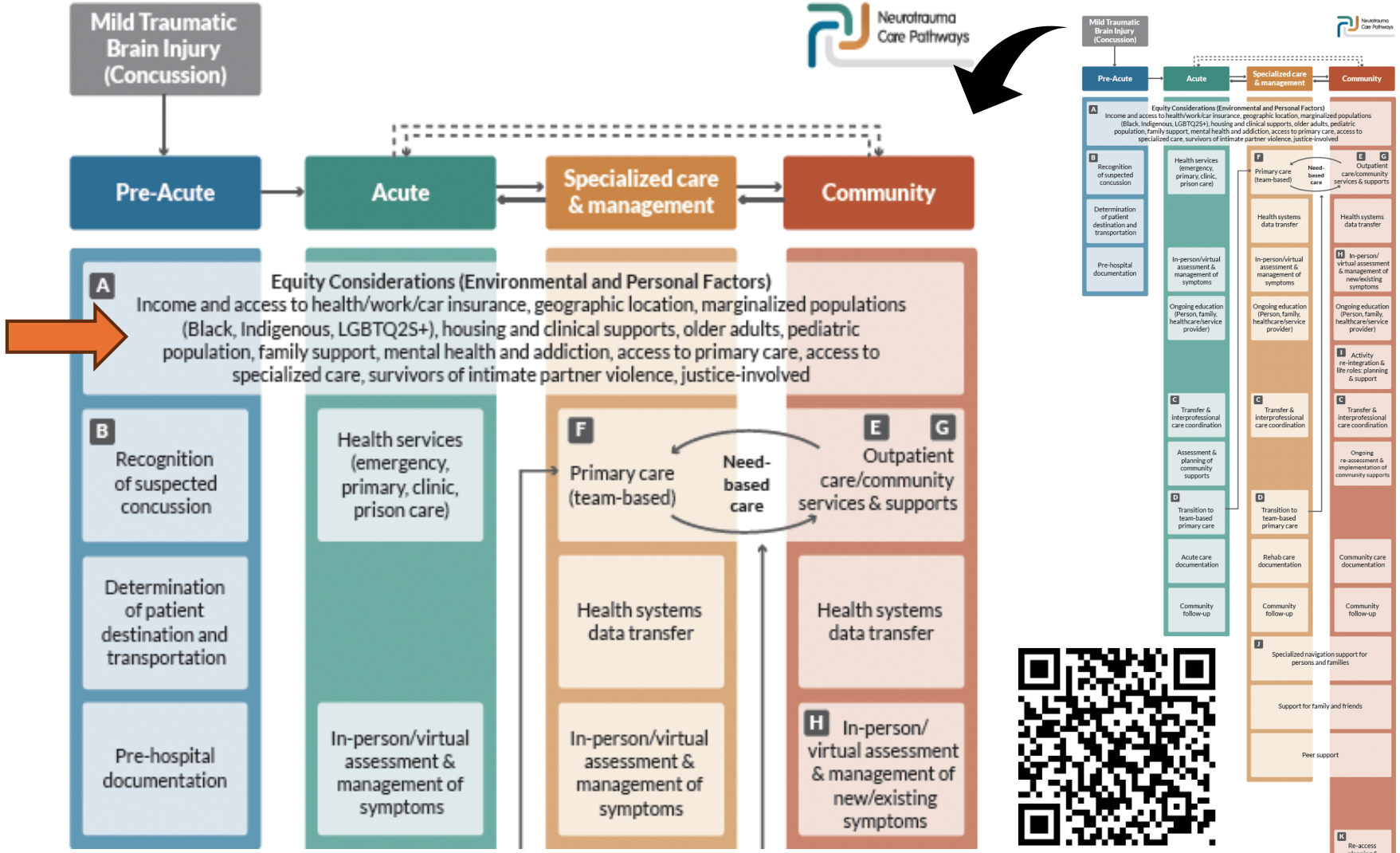
Each care stage contains building blocks (key elements of care), which are linked to existing evidence-based CPGs

Neurotrauma
Care Pathways

Ideal Care Pathways

Current Gaps in current care are addressed by the Ideal Care Pathways

Implementation of the building blocks can be measured by **companion quality indicators** to facilitate uptake by health care providers and system planners.



Important Living Website Links

LIVING CONCUSSION GUIDELINES

Living Concussion Guidelines for Adults

PedsConcussion
LIVING GUIDELINE FOR
PEDIATRIC CONCUSSION CARE

Peds Concussion Guideline

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Adults Moderate to Severe TBI Guideline

Let's Navigate To the Guideline

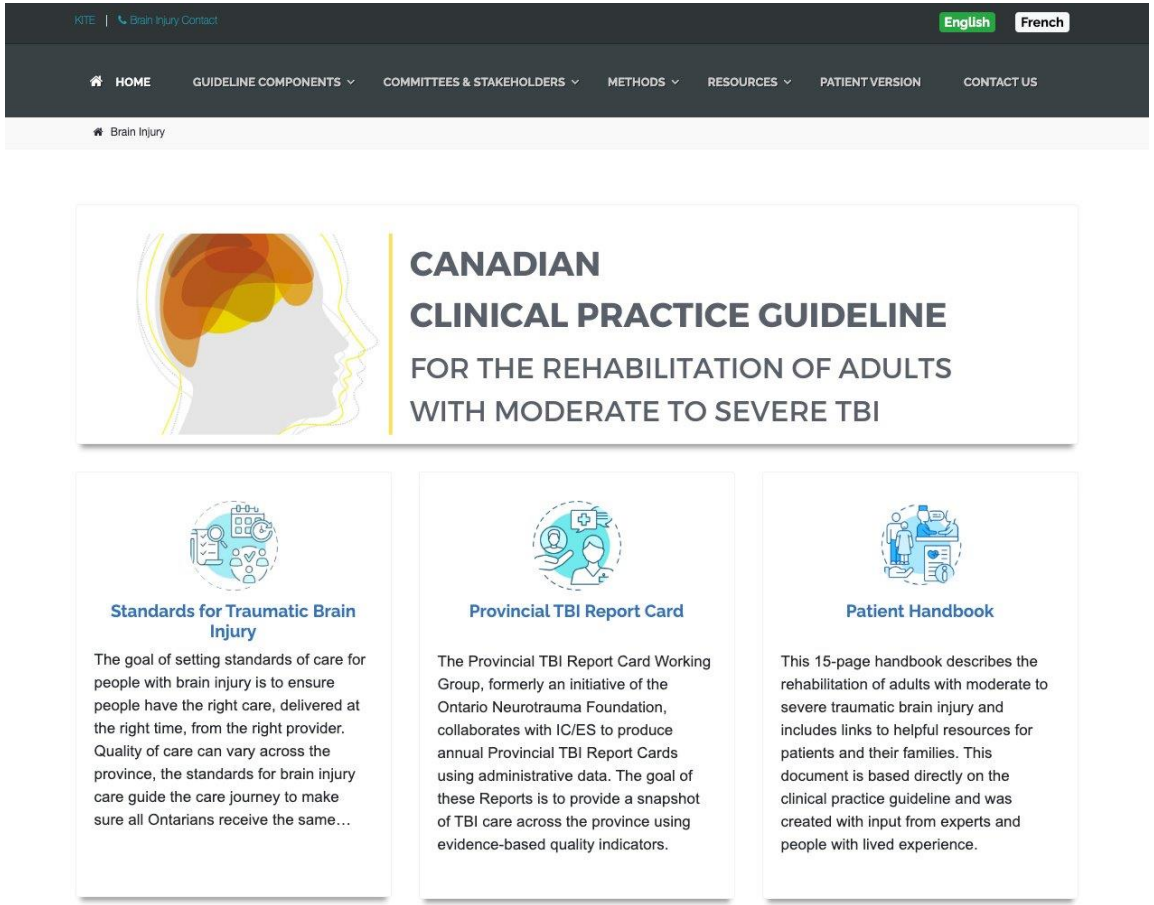
The Canadian TBI Guideline Website:
https://kite-uhn.com/brain-injury/en

All 3 Guidelines have a similar format, but we will just walk through one of them today

Guideline For TBI Rehabilitation

The Canadian CPG for the Rehabilitation of Adults with Moderate-Severe TBI:

- Is based on ongoing and comprehensive review of international research, clinical evidence and lived experience
- Helps inform TBI care across jurisdictions
- Provides best-practice recommendations, resources, and tools to make clinical decisions that will improve the quality and consistency of TBI care



How To Use The TBI Guideline

Section 1 - Components of the Optimal TBI Rehabilitation System

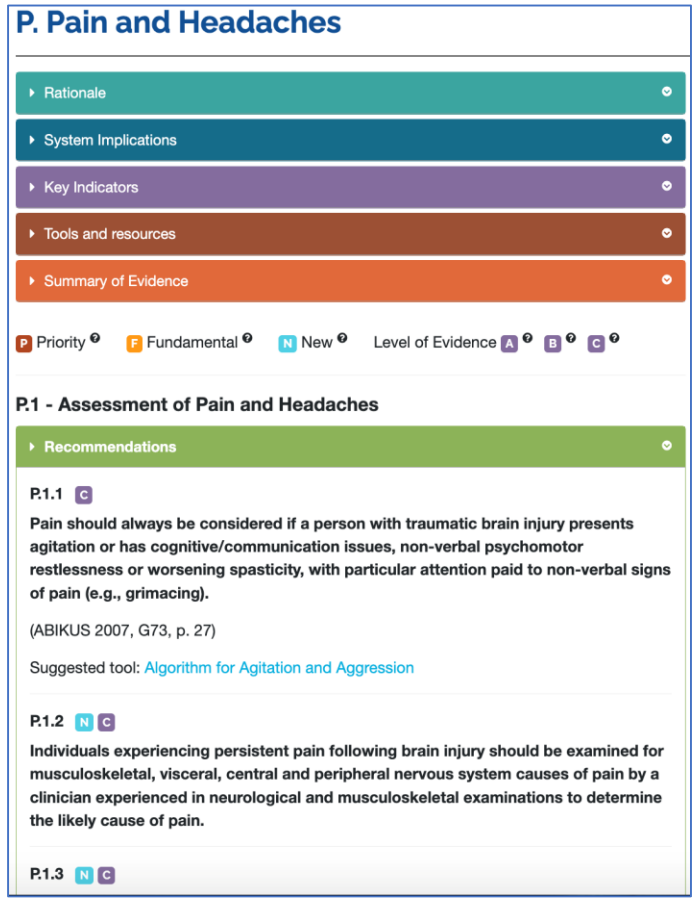
- A - Key Components of TBI Rehabilitation
- B - Telehealth
- C - Subacute Rehabilitation
- D - Promoting Reintegration and Participation
- E - Caregivers and Families
- F - Brain Injury Education and Awareness
- G - Capacity and Consent

Target Audience: Health system leaders and planners

Section 2 - Assessment and Rehabilitation of Brain Injury Sequelae

- H - Comprehensive Assessment of the Person with TBI
- I - Disorders of Consciousness
- J - Cognitive Functions
- K - Cognitive Communication
- L - Dysphagia and Nutrition
- M - Motor Function and Control
- N - Sensory Impairment
- O - Fatigue and Sleep Disorders
- P - Pain and Headaches
- Q - Psychosocial / Adaptation Issues
- R - Neurobehaviour and Mental Health
- S - Substance Use Disorders
- T - Medical / Nursing Management
- U - Intimacy and Sexuality

Target Audience: Clinicians



https://kite-uhn.com/brain-injury/en/guidelines

Why Keep Coming Back to the Guideline?

The Guideline is living with regular updates to:

- ✓Recommendations
- ✓Summary of Evidence
- ✓Tools and Resources
  - Infographics, decision trees and algorithms
  - Links to evidence-based tools and resources
- ✓New topics added to respond to demand and evidence

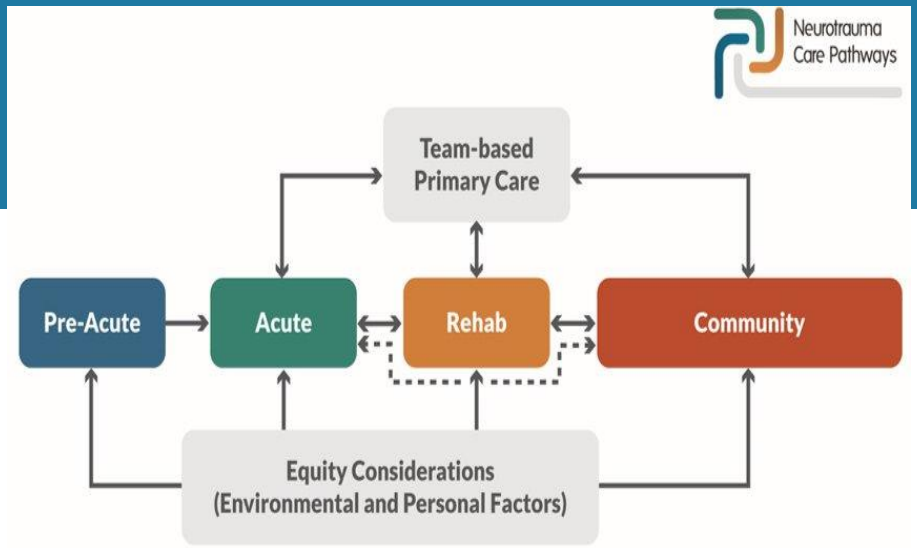
All updates* *are made to both the* ***French and English* *versions*

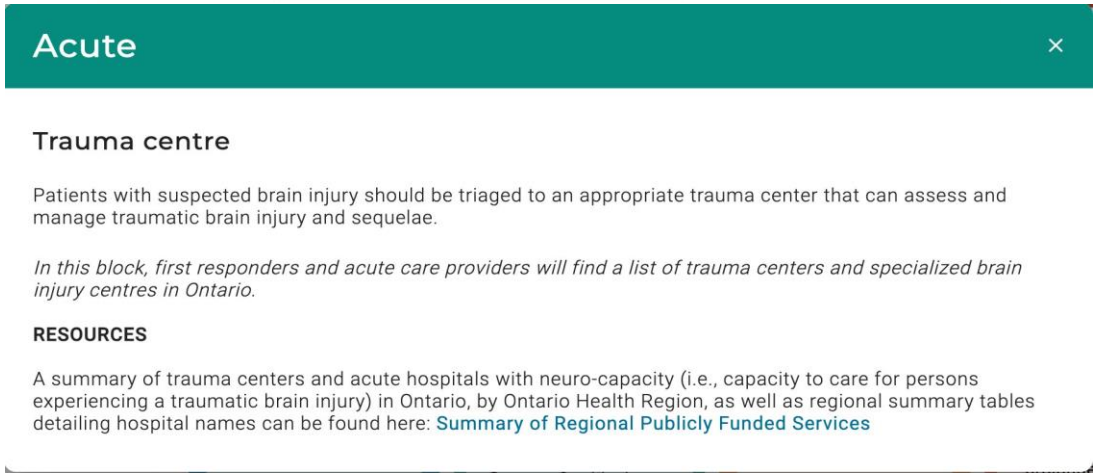
Case Example

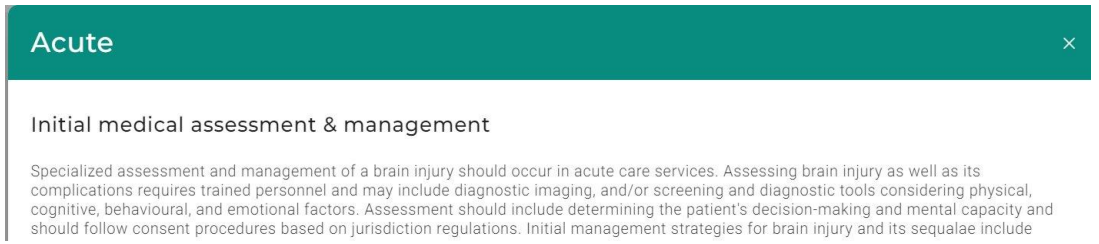
Ross is a 45-year-old man who sustained a **severe brain injury** and had to have craniectomy and partial resection of the left temporal lobe due to severe elevated ICP.

What are the Key Clinical Practice Points?

- Documentation of GCS, SDH that are likely to influence care decisions
- Evaluation for rehabilitation
- Documentation of screeners and assessments completed
- INFORMATION!
- Robust discharge planning for next stage in the Care Pathway; Peer Support?

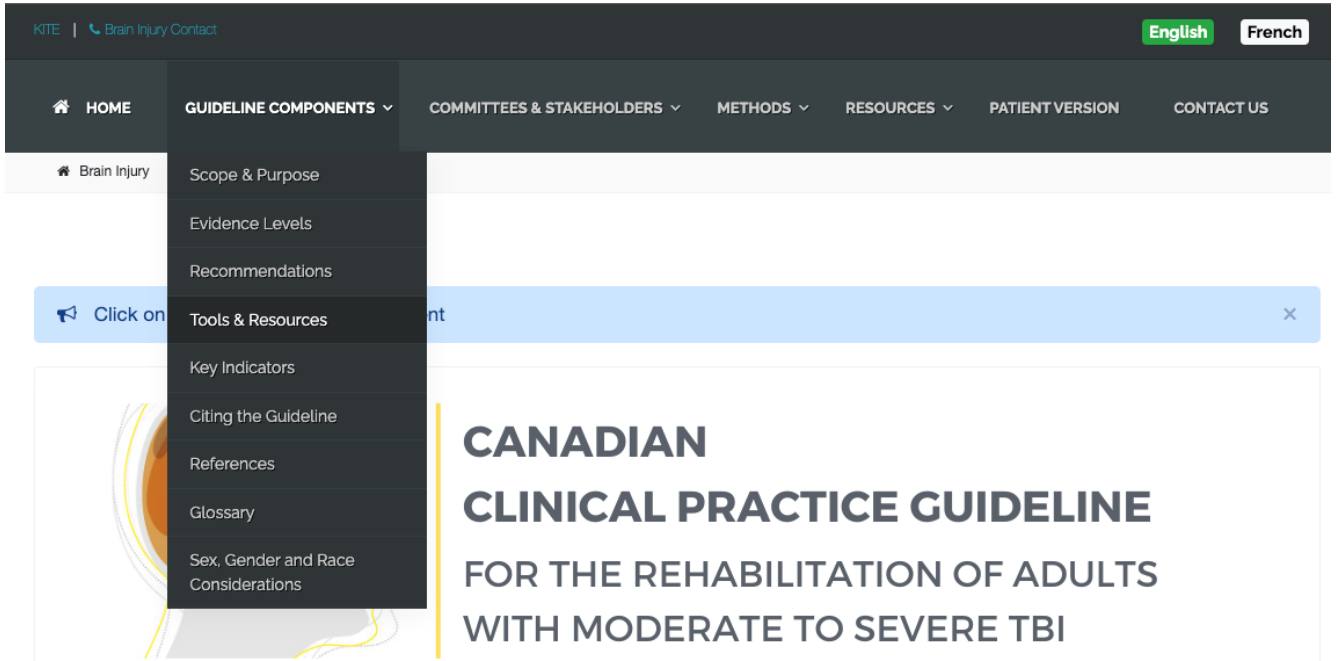


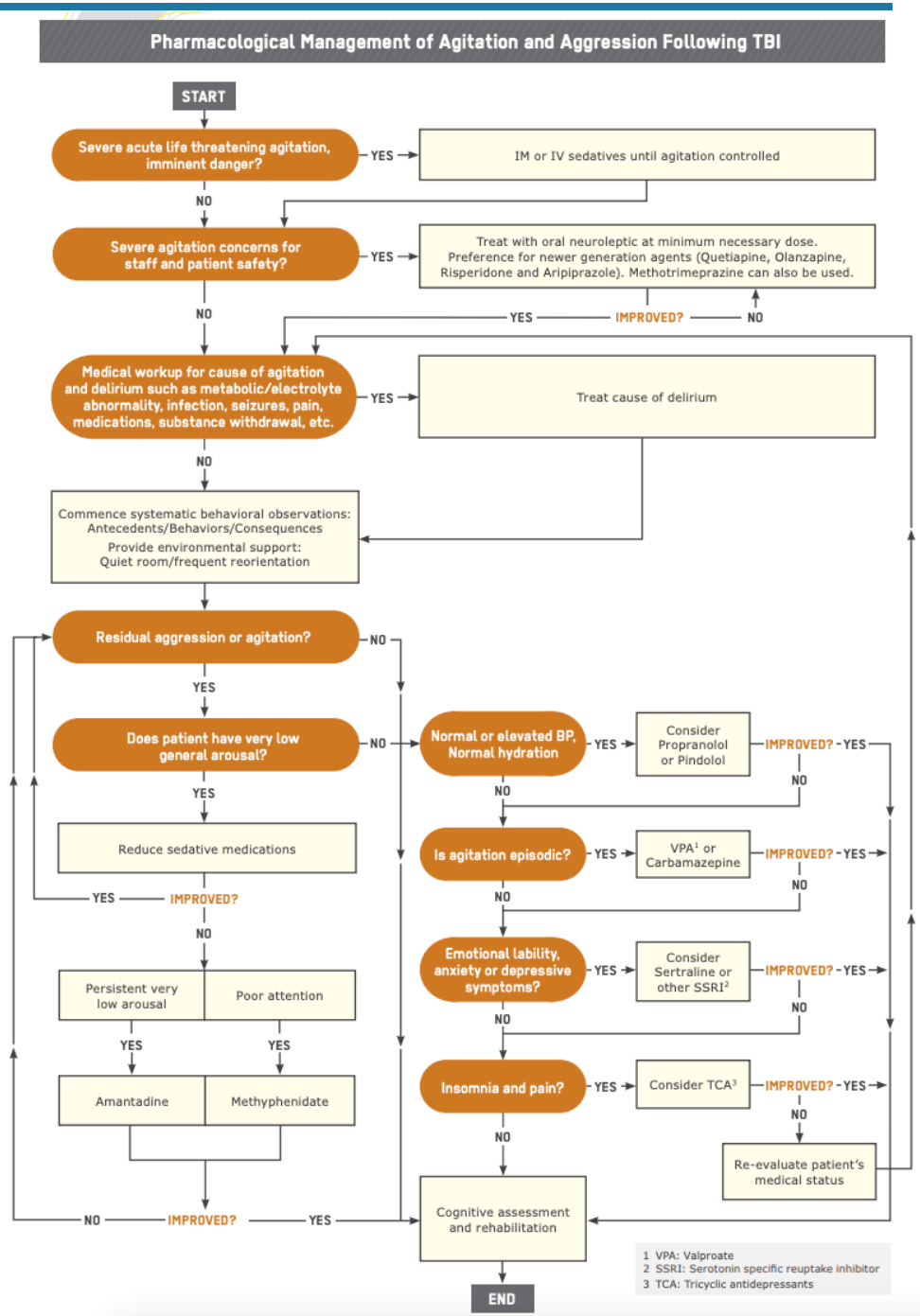




Case Example

- Ross has just arrived on the floor from the ICU and is **very agitated**
- He is swinging at the nurses when they enter the room and yelling loudly.





Case Example

- With treatment with IM neuroleptics followed by oral neuroleptics, **Ross settles down but is still very concerned**
- His blood work shows he has low sodium which is corrected
- He is more alert and has a decreased need for sedative medications

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» T. Medical / Nursing Management

» T.9. Principles of Medication Management (Neuropharmacology)

Recommendations

T.9.9 C

Pharmacological treatment of neurobehavioural / mental health or other symptoms following traumatic brain injury should be used with caution and with the knowledge that studies suggest that many medications, including neuroleptics, anxiolytics, and anticonvulsants are associated with slowed recovery after brain injury.

(Adapted from ABIKUS 2007, G15, p. 19)

Suggested tool: Health Canada Indications of Use

Case Example

- Ross settles down but has gradually developed increased yelling when the nurses walk in the room
- **Antecedent Behaviour Consequence** charting is completed, and the yelling occurs only when a nurse walks in the room & not others
- **Cause of yelling = pain**
- Reassurance reduces the frequency, but the behaviour persists

R. Neurobehaviour and Mental Health

- Rationale
- System Implications
- Key Indicators
- Tools and resources
- Summary of Evidence

P Priority F Fundamental N New Level of Evidence A B C

R.1 - Neurobehavioral Assessment

- Recommendations

R.2 - Neurobehavioral Interventions

- Recommendations

Case Example

- Ross improves but the **subacute rehab team** feels they could improve the efficiency of the care they provide to people like him
- ***What are some of the key practices? (HINT: This is a system question)***

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C. Subacute Rehabilitation

Save PDF

- Rationale
- System Implications
- Key Indicators
- Tools and resources
- Summary of Evidence

P Priority F Fundamental N New Level of Evidence A B C

C.1 - TBI Inpatient Rehabilitation Models

- Recommendations

C.2 - Duration, Intensity and Other Attributes

- Recommendations

C.2.1 P C

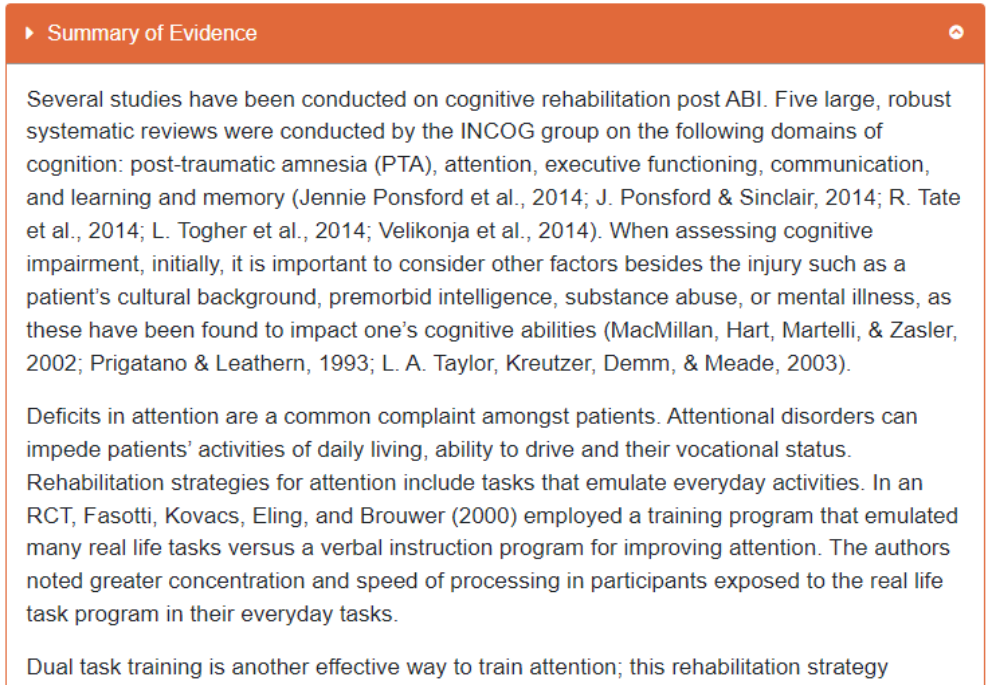
A target length of stay should be established with input from persons with traumatic brain injury (TBI) and their families/caregivers as soon as possible after admission to

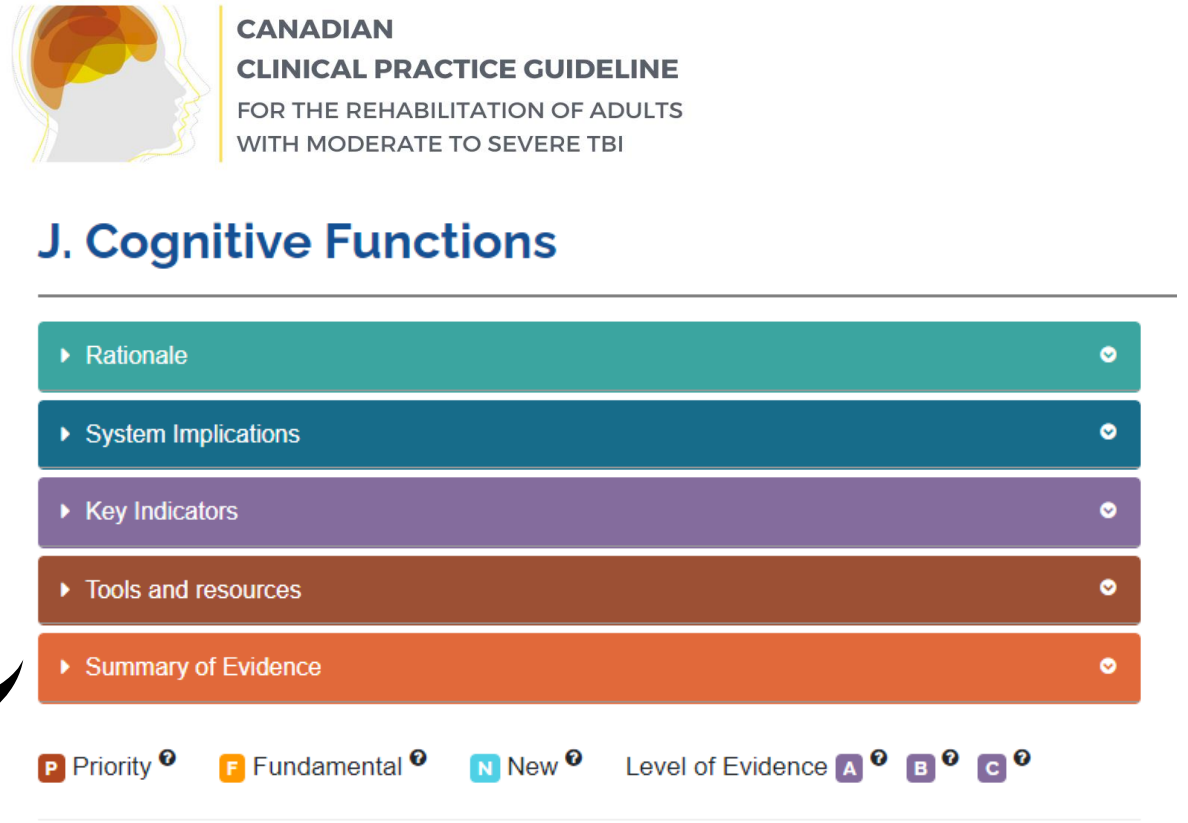
Guidelines Index

- A - Key Components of TBI Rehabilitation
- B - Telehealth
- **C - Subacute Rehabilitation**
- D - Promoting Reintegration and Participation
- E - Caregivers and Families
- F - Brain Injury Education and Awareness
- G - Capacity and Consent
- H - Comprehensive Assessment of the Person with TBI

Case Example

- A new doctor comes on the service and asks why the patient needs more intense **cognitive rehabilitation**
- “Where’s the evidence?”





Case Example

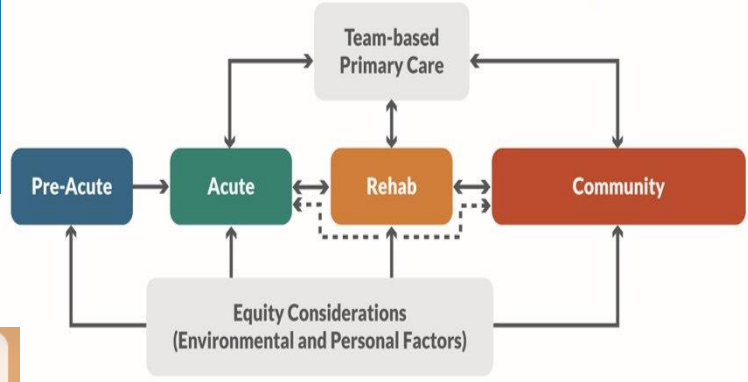
Ross has been lucky to get access to inpatient rehab. **What should the rehabilitation phase address?**

What are the Key Clinical Practice Points?

- Multidisciplinary team assessment, in the context of SDH
- Meaningful goals
- Promotion of resilience and agency
- Documentation of structure, process, outcome
- INFORMATION!
- Families need support
- Robust discharge planning for next stage in the Care Pathway; Peer Support?

Interprofessional Specialized Rehab

- Equity Considerations (Environmental and Personal Factors)
- Specialized inpatient
- Specialized outpatient
- Health systems data transfer
- In-person / virtual assessment & management of symptoms
- Ongoing education (Person, family, healthcare/service provider)
- Plan re-integration & life roles
- Transfer & interprofessional care coordination



- Assessment & planning of community supports (cont. from Acute)
- Transition planning (cont. from Acute)
- Rehab care documentation
- Community follow-up
- Specialized navigation support for persons and families
- Support for family and friends
- Peer support

Case Example

- Discharge planning needs to be patient-centered
- Integral role of Team-Based Primary Care

D. Promoting Reintegration and Participation

Save PDF

- Rationale
- System Implications
- Key Indicators
- Tools and resources
- Summary of Evidence

P Priority F Fundamental N New Level of Evidence A B C

D.1 - Postdischarge Follow-Up and Support

Recommendations

D.1.1 P B

All persons with traumatic brain injury (TBI) discharged from a specialized TBI rehabilitation program (inpatient, outpatient, residential) should have access to scheduled telephone, virtual or in person follow-up contact with a professional trained in working with persons after brain injury. It is preferable that this professional have skills in promotion of self-management skills, motivational interviewing, and goal setting, in order to adequately provide reassurance and problem-solving support.

(Adapted from INESSS-ONF, 2015)

Guidelines Index

- A - Key Components of TBI Rehabilitation
- B - Telehealth
- C - Subacute Rehabilitation
- **D - Promoting Reintegration and Participation**
- E - Caregivers and Families
- F - Brain Injury Education and Awareness
- G - Capacity and Consent
- H - Comprehensive Assessment of the Person with TBI
- I - Disorders of Consciousness

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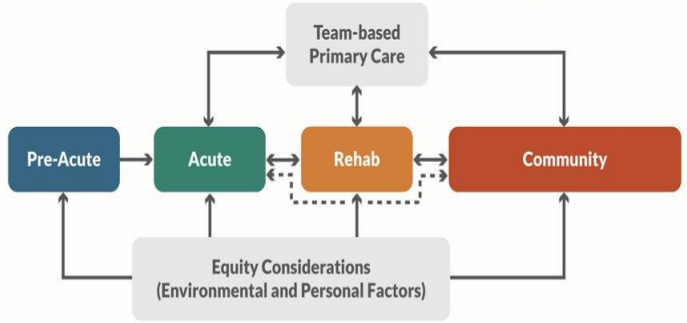


Community follow-up

Re-access planning & coordination

Community

Re-access planning & coordination

As a person with brain injury's needs change over time and in relation to ageing, mechanisms to facilitate their re-access to the healthcare system are essential. The person with brain injury's primary care provider should be prioritized as the first access point to plan and coordinate re-access needs. Persons with brain injury may require re-entry to acute care or rehabilitation, depending on the severity of the change in outcome.

In this block, community service providers and system planners can find links to recommendations on establishing mechanisms to allow persons with TBI to easily re-access the healthcare system.

GUIDELINE LINKS

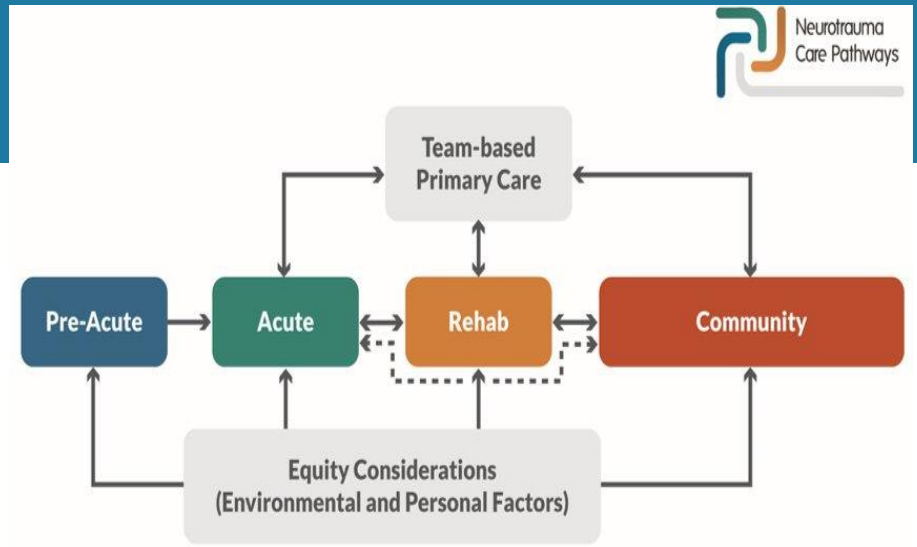
- Clinical Practice Guideline for the Rehabilitation of Adults with Moderate to Severe TBI
  - Section C: Subacute Rehabilitation - C.1: TBI Inpatient Rehabilitation Models (Subsection: 1.4)
  - Section D: Promoting Reintegration and Participation- D.2: Community Rehabilitation (Subsection: 2.3)

Case Example

Ross has better chance of succeeding in the community because he had rehab and he is ‘connected’.

What are the Key Clinical Practice Points?

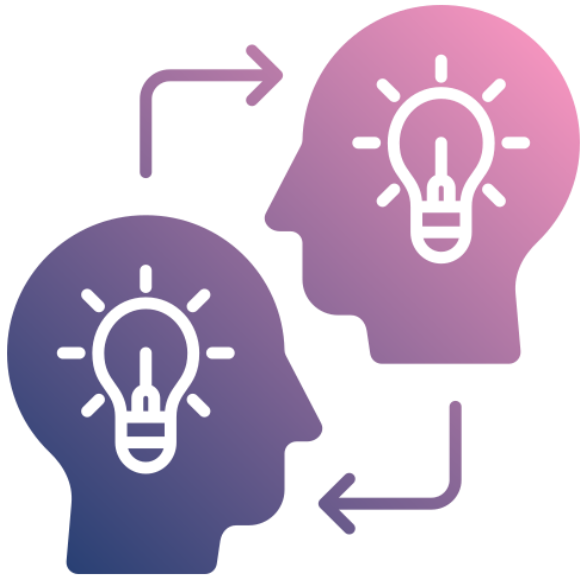
- Who are the key community-based providers? Do we know about each other? Are we working together?
- Meaningful goals and focus on life goals
- Promotion of resilience and agency
- Documentation of structure, process, outcome
- INFORMATION!
- Peer Support: PWLE and Families
- Future planning and chronic condition management; things will change over time; in the context of SDH



- Follow-up can be provided by acute care, primary care, family health teams, and community service providers
- Follow-up must be needs-based and integrated across providers so that there are no gaps or unnecessary delays in care

KT/KM Objective

The Care Pathway and Guideline are excellent resources. However, **their benefits are contingent on the successful knowledge translation of the Guidelines and Care Pathways into professional practice.**



Our Objective:

To show clinicians how to use and integrate online CPGs and associated Care Pathways using principles of adults learning.

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Principles of Adult Learning

Readiness to learn: *Adults learn best when the subject matter helps them solve a real-world problem.*

Self-concept: *An adult learner's self-concept and individuality are important to the learning process.*

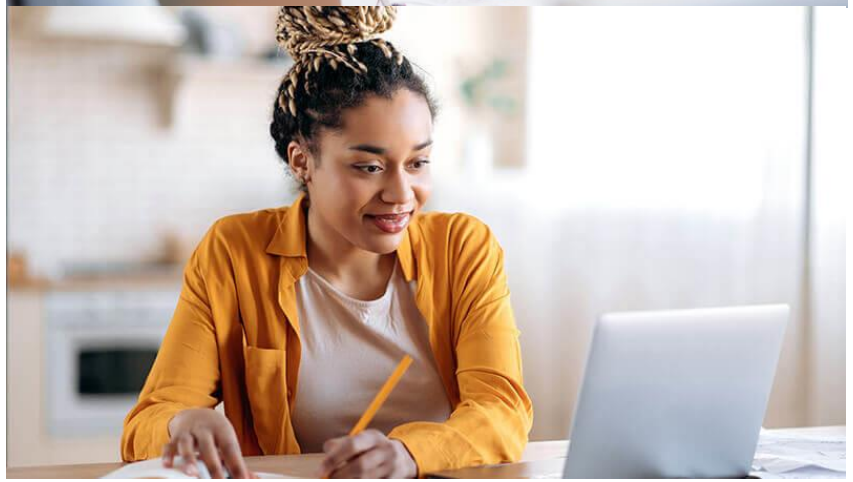
Internally motivated and self-directed: *Adults prefer to feel in control of their own learning. They resist learning when they feel others are imposing information on them.*

Experience: *Adults prefer to learn from their own experiences. They are more likely to be engaged if they can see how the material relates to their lives.*

Orientation to learning: *This principle gives meaning or direction to the learning process.*

Adults learn by doing: *Adults learn best through active participation and practicing what they are learning. They learn best through experience, feeling, and doing a new task with support and feedback from others.*

Motivation: *Motivation is key with adult learners. You can motivate them by offering them a reason for every activity they need to complete.*



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Methods

Regulated Healthcare Professional Associations (RHPA) were approached to co-develop targeted KT activities that promote the relevance of the CPGs and Care Pathways by addressing their areas of need.

How were the CPGs and Care Pathways promoted?

- Using clinical administrative data
- Partnering with practicing clinicians
- Addressing current issues in care as identified by the RHPAs

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Target Audience

Target Audience:

Healthcare professionals who do not commonly treat persons with TBI or are not current on TBI best practices.

Secondarily those who commonly treat TBI/ABI to tune up their knowledge

Neurotrauma Care Pathways

Who Worked With Us?

Collaboration occurred with many RHPA and other organizations, including:

AT•ON® ATHLETIC THERAPY ONTARIO

ONTARIO PSYCHOLOGICAL ASSOCIATION

Sunnybrook HEALTH SCIENCES CENTRE

npac NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

Ontario Chiropractic Association

Ontario Society of Occupational Therapists

afhto association of family health teams of ontario

Elder Abuse Prevention Ontario

ONTARIO PHYSIOTHERAPY ASSOCIATION

What Did We Do?

KT activities were co-developed with the RHPA and tailored to their preference to suit diverse audiences.

Common KT Activities:

- **"Lunch and Learn" Interactive Webinars** (*recorded and had their slide decks made available for asynchronous learning*)
- Newsletter Articles
- Blog Posts
- All-Member Email Blasts
- Website Links
- Conference Presentations
- Peer-Reviewed Manuscripts
- Social Media Posts

In most cases, multiple KT methods were used.

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Outcomes

"Lunch and Learn" Interactive Webinars - Examples

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CANADIAN CLINICAL PRACTICE GUIDELINE FOR THE REHABILITATION OF ADULTS WITH MODERATE TO SEVERE TBI

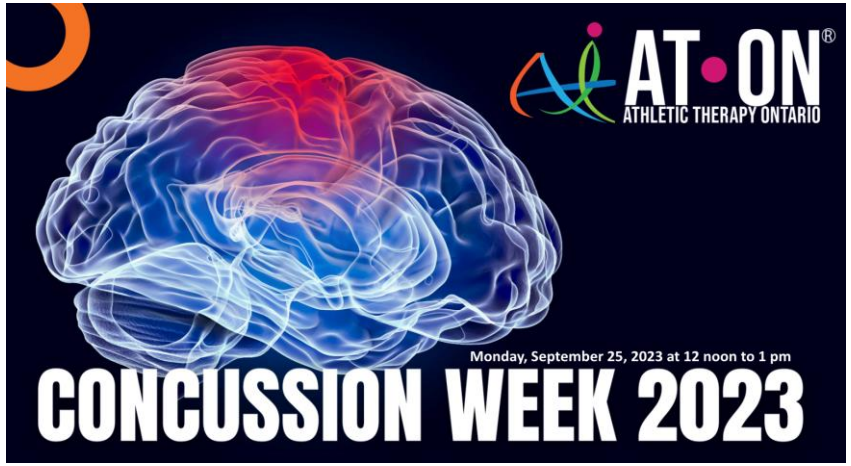
What does it take to care for a person after a Traumatic Brain Injury? The essential role of Primary Care

Thursday, Oct 5, 2023, 12-1pm

Dr. Mark Bayley
Judith Gargaro

Research Analysts: Aishwarya Nair, Parwana Akbari

afhto association of family health teams of ontario | UHN Toronto Rehabilitation Institute The KITE Research Institute | Institut national d'excellence en santé et en services sociaux Québec | Ontario Ministry of Health & Long Term Care



Neurotrauma Care Pathways | Ontario Chiropractic Association

Supporting Individuals with Traumatic Brain Injury: Concussion, Mild or Moderate to Severe Injury

Tuesday, September 24, 2024 | 12-1pm

UHN Toronto Rehabilitation Institute The KITE Research Institute | PedsConcussion LIVING GUIDELINE FOR PEDIATRIC CONCUSSION CARE | LIVING CONCUSSION GUIDELINES

Neurotrauma Care Pathways | CANADIAN CLINICAL PRACTICE GUIDELINE FOR THE REHABILITATION OF ADULTS WITH MODERATE TO SEVERE TBI | ONTARIO PHYSIOTHERAPY ASSOCIATION

Where do Physiotherapists fit into the Care Pathway after TBI? Making it relevant

Wednesday, Dec 6, 2023, 12-1pm

Neurotrauma Care Pathways Team
Manager: **Judith Gargaro**
Research Analysts: **Aishwarya Nair, Parwana Akbari**
Project Lead: **Mark Bayley**

Clinician Presenter
Shannon McGuire – Registered Physiotherapist, St. Joseph's Health Care London – Parkwood Institute

UHN Toronto Rehabilitation Institute The KITE Research Institute | PedsConcussion LIVING GUIDELINE FOR PEDIATRIC CONCUSSION CARE | LIVING CONCUSSION GUIDELINES | Institut national d'excellence en santé et en services sociaux Québec | Ontario Ministry of Health & Long Term Care

Were We Successful?

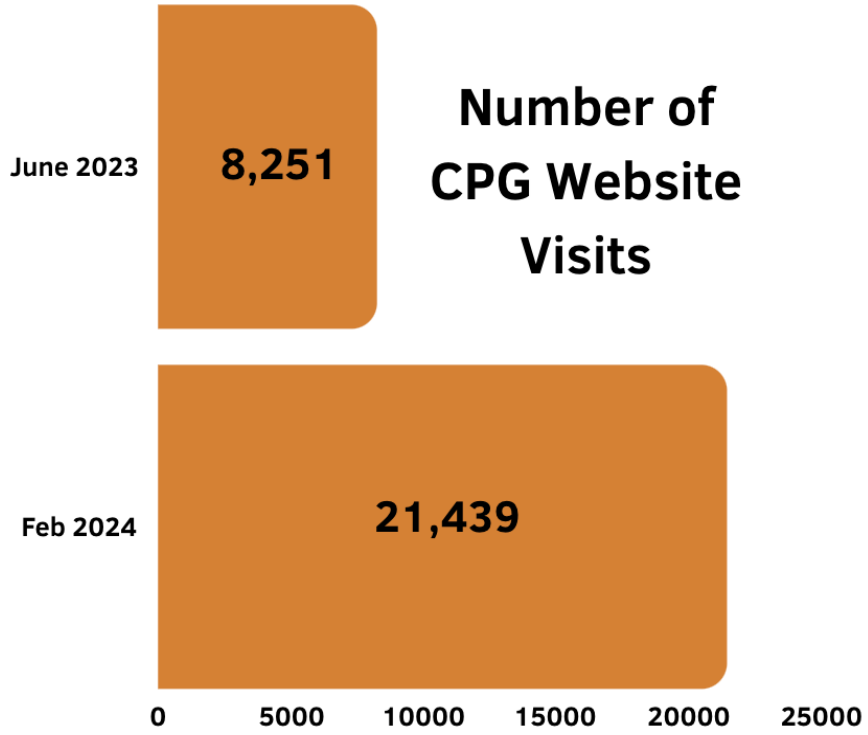
All KT activities were rooted in the principles of adult learning.

- **Self-concept**; *we embodied a self-directed, asynchronous learning model*
- **Adult learner experience, readiness to learn, orientation to learning, and motivation to learn**; *we encouraged voluntary attendance and focused on current challenges/issues*
- **Active learning**; *we presented real-life case examples and clinical data, and helped learners navigate the CPG and Care Pathways*

Neurotrauma Care Pathways

Outcomes: Engagement

These KT activities have been ongoing since June 2023 with **excellent engagement** as evidenced in the increase to the CPG website visitors



The excellent engagement was also highlighted in the **audiences' interactive discussions and interest to return and attend future webinar sessions.**

*The peak of our KM activities was in Oct – Dec 2023; the activities proved to be successful **(Jan: 23,587 users to the website; Feb: 21,439 users)**.

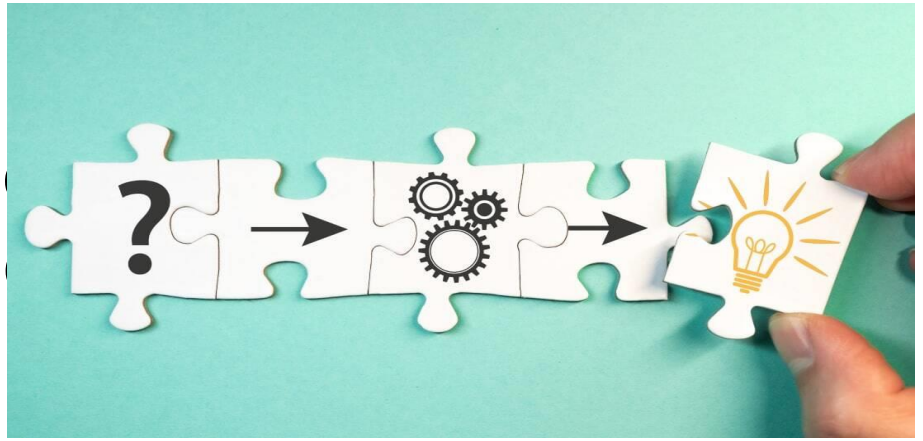
*Our KM activities have slowed down since then, but website usage continues to remain higher than baseline

Neurotrauma Care Pathways

What We Learned

We learned that:

- Healthcare professionals welcome evidence-base practical support to help them make informed an up-to-date TBI clinical care decisions



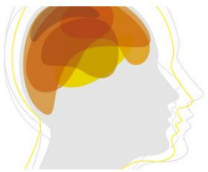
- Awareness of the resources and assumptions about what the CPG and Care Pathways provide are barriers to providing best-practice care

- A multi-faceted and collaborative Knowledge Mobilization strategy is necessary

POP QUIZ

Question One

What is the first recommendation of Section U of the TBI Guideline?



CANADIAN
CLINICAL PRACTICE GUIDELINE
FOR THE REHABILITATION OF ADULTS
WITH MODERATE TO SEVERE TBI

Question One: ANSWER

U. Intimacy and Sexuality

- Rationale
- System Implications
- Key Indicators
- Tools and resources
- Summary of Evidence

P Priority F Fundamental N New Level of Evidence A B C

U.1 - Intimacy and Sexuality Considerations

Recommendations

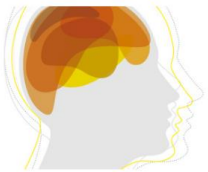
U.1.1 N C

Designated team members: Interprofessional teams should identify members of the team who will always initiate a discussion about intimacy and sexuality with the patient and their partner. The team member should be appropriately trained to initiate this discussion.

Last Updated June 2023

Question Two

Does the TBI Guideline discuss recommendations for assessment and management of sleep disorders?



CANADIAN
CLINICAL PRACTICE GUIDELINE
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WITH MODERATE TO SEVERE TBI

Question Two: ANSWER

O. Fatigue and Sleep Disorders

- Rationale
- System Implications
- Key Indicators
- Tools and resources
- Summary of Evidence

P Priority F Fundamental N New Level of Evidence A B C

O.1 - Assessment of Fatigue and Sleep

- Recommendations

O.2 - Management of Fatigue and Sleep

- Recommendations

Yes

Question Three

Which stage of care does the Neurotrauma Care Pathways <u>NOT</u> provide building blocks of ideal care for?

1. *Acute Care*
2. *Community*
3. *Pre-Acute*
4. *Interprofessional Specialized Rehab*
5. *None of the Above*

Question Three: ANSWER

Which stage of care does the Neurotrauma Care Pathways NOT provide building blocks of ideal care for?

1. *Acute Care*
2. *Community*
3. *Pre-Acute*
4. *Interprofessional Specialized Rehab*
5. *None of the Above*

Question Four

How are you going to use the Care Pathway and Guideline in your work?

Question Four: ANSWER

Implementation Projects

Peel Halton ABI Care Pathway

CE ABI Collaborative

Toronto ABI Network

NEON/acute care/rehabilitation discharge infographics

Peterborough multidisciplinary acute concussion clinic

Scarborough East GTA FHT multidisciplinary ABI Primary care team

Central Link expansion

Concussion Navigator expansion

HSN Acute Care Pathway

And **YOUR** project!

Neurotrauma Care Pathways

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PEDIATRIC CONCUSSION CARE

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THANK YOU

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Ontario
Ministry of Health & Long Term Care