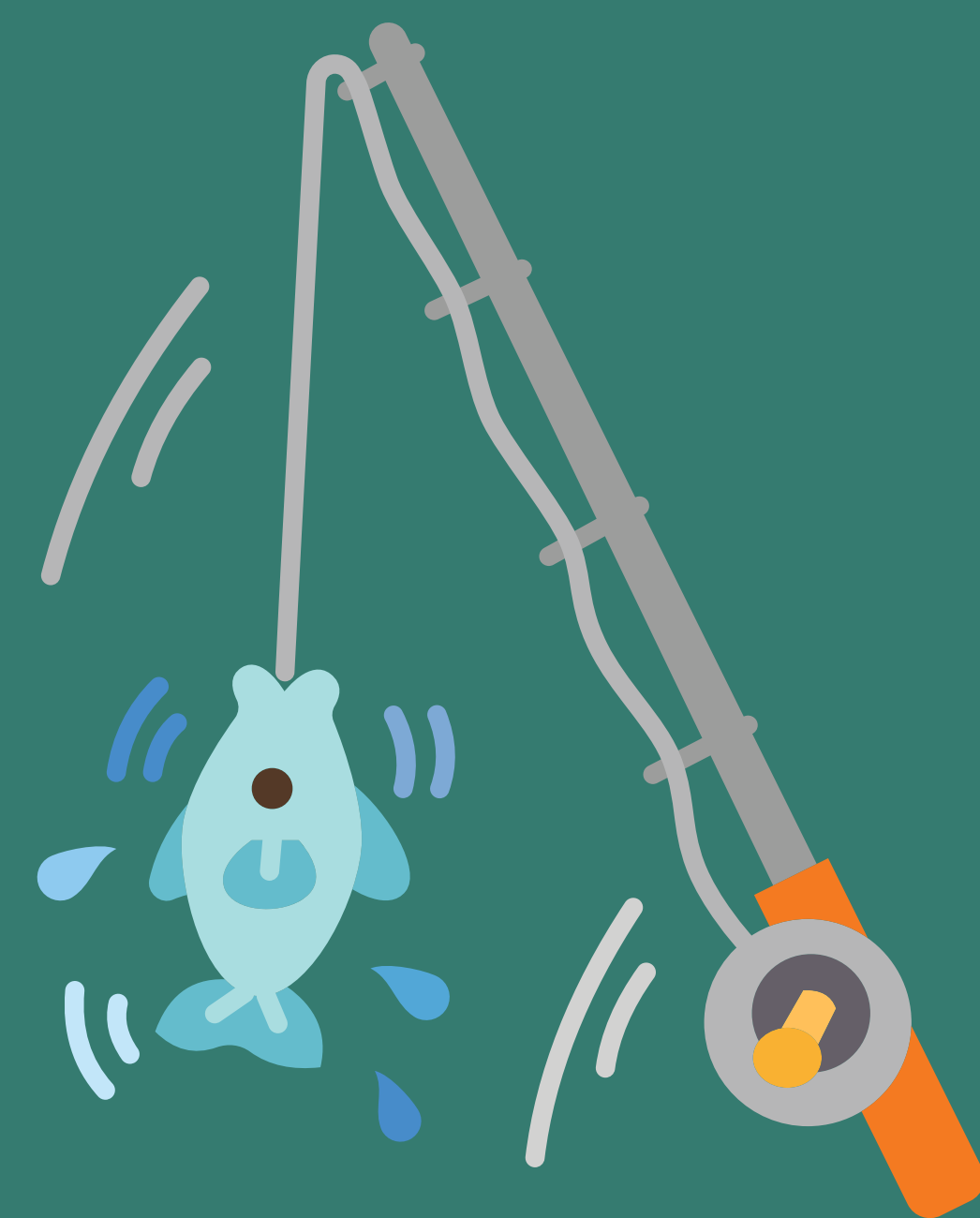


Are you floundering around to find help? Getting hooked on a path in Peel-Halton



Introduction

Ontario lacks an equitable system of care for traumatic brain injury (TBI). Care quality and health outcomes depend on where you live, available funding and severity/type of injury. Less than 18% percent of people with moderate to severe TBI receive inpatient rehabilitation. Less than 10% will have outpatient rehabilitation when they do not have inpatient first. There is poor follow up in the community after discharge. Evidence-based and standardized Neurotrauma Care Pathways with companion quality indicators were co-created with key partners from across Ontario. It is time to implement them.

Objective

Implementation of the Care Pathway and companion Quality Indicators

Methodology

1. **Identify** who is doing what with which clients
 - ABI Navigators were important participants
2. **Invite** from community-based brain injury providers to get into the implementation boat with the ABI Navigators
 - Mind Forward Brain Injury Services in Peel Halton said **YES!**
3. **Be sure** we have identified who is doing what with which clients.
Making sure to include the providers who may not only work with brain injury clients or may not know they are!
4. **Have** an in-person meeting for all the key Pathway partners
5. **Identify** care gaps and opportunities for improved collaboration.
Use administrative data to highlight the current gaps in the care journey and in meaningful data collection.
6. **Develop** an action plan to get to Full implementation of the Ideal Brain Injury Care Pathways and Quality Indicator data collection

Conclusions

1. This implementation work shows how a community-based brain injury provider can spearhead a system level quality improvement project resulting in elevated care for people/families after brain injury.
2. The Peel Halton ABI Care Pathway is relevant for all mechanisms of injury; it is designed to be the foundation for Equitable Care Delivery.
3. This systematic approach with clear documentation allows for spread to other regions and chronic health conditions.

Outcomes

You're invited.....

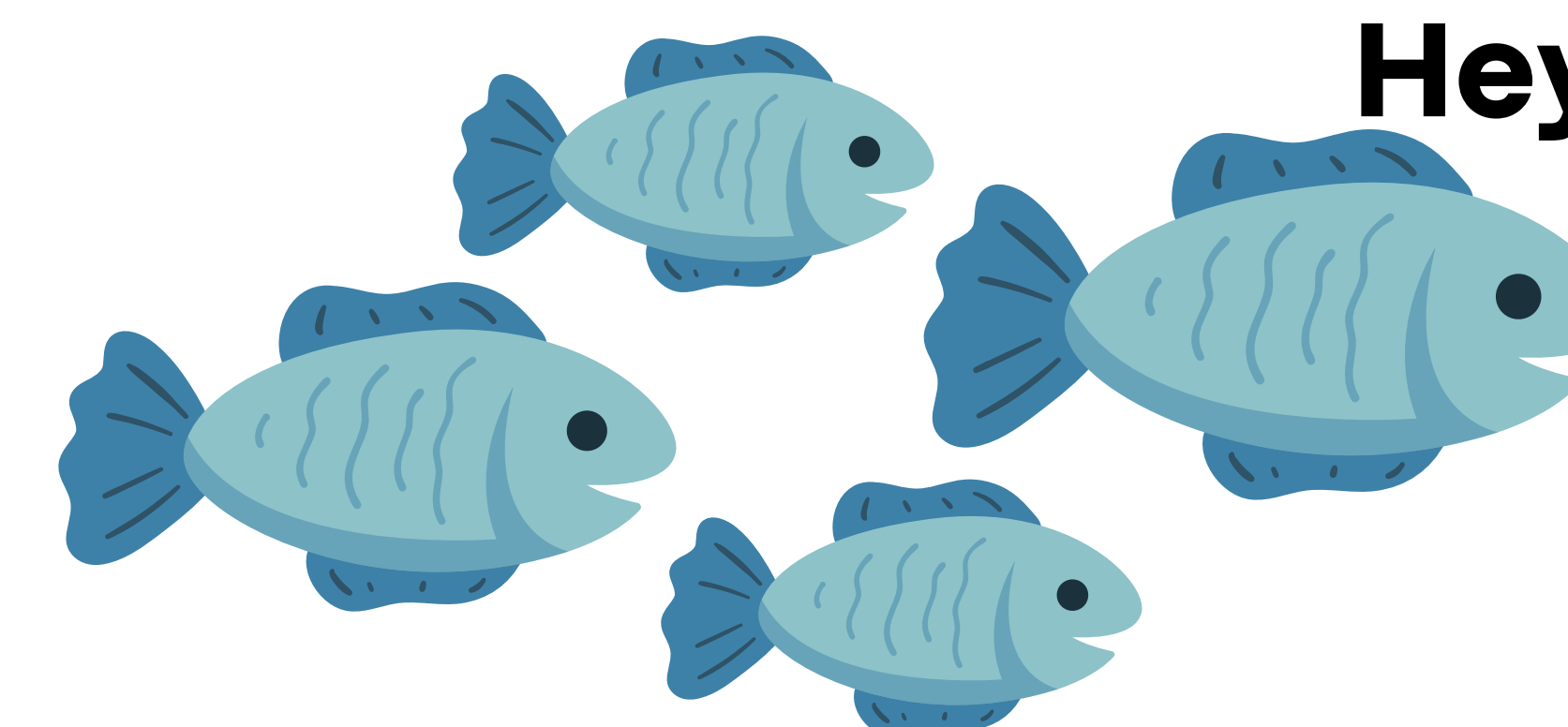
It was easy to get agreement from providers that they need to work better together:

- Local Acute Care (not a Level 1 Trauma Centre; Level 1 centres are out of region)
- Specialized brain injury rehabilitation (out of region but about an hour away)
- Community based brain injury provider: Mind Forward Brain Injury Services
- Regional ABI Navigator
- Supported Housing Program: Peel Living
- Community mental health and addiction services
- Ontario Health West Region and Mississauga OHT

You're also invited.....

At the first meeting, the group felt that others should also be brought into the group

- Family Health Teams (FHTs)
- Community Paramedicine; First responders
- Additional Housing: SHIP, Region of Peel/Halton
- Ontario Works
- Public Health
- Shelters
- Elizabeth Fry/John Howard



Hey, let's get to know each other!

Peel Halton ABI Care Pathway Collaborative is formed to improve the care for people after brain injury.

Key features are:

- timely, comprehensive and appropriate assessment
- access to trained specialized rehabilitation
- navigation into community supports
- follow-up by primary care, and
- ongoing access to education and supports over the lifespan

The voices of persons with lived experience and their families are integral.

There have been some ongoing challenges with implementation of the data quality indicators; supplemental data collection using common operational definitions for the data indicators is being implemented in the short term to allow for reporting on impact.

Is there help to implement the Pathway and the Quality Indicators?
YES, the Neurotrauma Care Pathways Team

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