Toronto abi Network

October 31, 2014

Across the Care Continuum: Community-Based Services & Support for Individuals with an ABI

PeelHaltonDufferin
Acquired Brain Injury Services

PeelHaltonDufferin
Acquired Brain Injury Services

- Services Offered (Mississauga Halton & Central West LHINs)
  - Assisted Living (Residential - MMP Treatment Beds, Life Long Living, Partnerships)
  - Day Services (Social/ Recreational, Clinical Psychosocial Adjustment)
  - Seniors Program (Integration Partnership and Neurobehavioural Support Workers)
  - Supported Independent Living (SIL) & partnership living environments (Thrive/ Able Living, Supportive Housing in Peel)
  - Outreach Program - Case Management
  - Caregiver Support Services
  - Clinical Services – inc. Neuropsychiatry, Psychology

PeelHaltonDufferin
Acquired Brain Injury Services

Assisted Living Services – People Deserve a Home

- 15 treatment beds [PHD ABIS West (9) + TRSL(6)] – MOH Ministry Managed Programs funding - **1 currently unfunded**
- 13 Life Long Living beds across 3 sites (24 hour support)
- 22 clients in Supported Independent Living environments
- Partnership with Thrive/Able Living (24 hour Able Living, Case Management/Programming PHD ABIS)
- Current MH Assisted Living Waitlist 53 – excludes hardest-to-serve HHS Provincial waitlists

PeelHaltonDufferin
Acquired Brain Injury Services

Day Services – Helping People Live, Work and Play!

Purpose: Day services allow opportunities for social and recreational activities in a supportive setting. These activities are designed to build skills, decrease social isolation, provide respite for families and support the 'staying at home' strategy

- Roughly 400 Day Service Recipients
- 6 Full time Day Service Staff
- 2 Full time Recreational Group Leaders
- 1 Full time Psychosocial Group Leader
- Programs take place in-house, in-community and with community partners

Case Management – Helping People Connect

- Assessment
- Life skills support
- Assistance with financial & legal matters
- Vocational & academic placement
- Health maintenance
- Transportation
- Recreation and engagement
- System Coordination
- Crisis management support
- Currently approx. 275 MH/CW Case Management service recipients

PeelHaltonDufferin
Acquired Brain Injury Services

PHDABIS Seniors Program – Helping People Integrate!

Purpose: Developed in response to an aging ABI client and caregiver population, the Ministry's desire to move people from ALC and to keep people with ABI in community/family homes and LTC

Seniors Services Provides:

- Staff Augmentation – Neurobehavioral Support Workers
- Neuropsychiatric, Psychological and Behavioural Consultation
- Extendicare Halton Hills 'Special Unit' Integration Partnership
- Day Services integration and engagement

Family/Caregiver Support Services – Helping People Cope

- Family Support Groups in MH and CW LHIN
- Facilitated by Psycho-social Group Leaders and Case Managers; counselling also provided by Clinical Services, including Neuropsychiatry and Psychology
- Online awareness and education programs, including FABIP (Family ABI Program - software)
- Approx. 90 service recipients year to date

Clinical Services

- Psychological Services
- Neuropsychiatric Consultation
- Psychosocial Group Treatment
- Behavioural Assessment and Consultation
- Access to broader community via Ontario Telemedicine Network (OTN)
- Key partners in LHIN education and development initiatives across the MH

CHIRS
Community Head Injury Resource Services

Community Head Injury Resource Services of Toronto

- Started as the first community-based brain injury rehabilitation program in North America.
- Evolved into a multi-service agency that provides a broad range of supports:
  - Residential Services
  - Community Support Services (CSS) - Outreach
  - Neurobehavioural Intervention
  - Adult Day Services: CHIRS Club and specialized community recreational programs, mentorship program
  - Clinical groups
  - Funded and Fee-For-Service

Community Head Injury Resource Services of Toronto

Residential Services:

- Variety of long-term, supportive housing options ranging from 24-hour supervision, access to staff on a 24 hour basis, and supported independent living.

- Congregate living options in Scarborough, North York, and Etobicoke.

Community Head Injury Resource Services of Toronto

Adult Day Services:

- Offers a variety of social, recreation and skill building programs (e.g., cooking club, swim, bowling, sailing, hobby, etc.)
- At our Finch Street location and in the community.
- More than 25 different programs offered each week.
- Drop-in Center is open 5 days a week from 9-5 (+ some evening programming)

Community Head Injury Resource Services of Toronto

Mentorship Program:

- Designed for clients who have the interest in taking on more of a leadership role.
- Mentorship opportunities include:
  - overseeing the club,
  - preparing lunches,
  - running programs,
  - taking the lead in many CHIRS special events,
  - partnering with other ABI organizations to organize social events

Community Head Injury Resource Services of Toronto

Community Support Services:

- Support is provided to clients who live independently or with family.
- CSS staff work with clients to teach skills such as:
  - money management and budgeting;
  - medical appointments and ongoing management of medical issues
  - activities of household management, such as grocery shopping and meal planning;
  - community orientation, travel training and access to community resources;
  - time management and scheduling;
- Employment Support Services offered through ODSP and WSIB

Community Head Injury Resource Services of Toronto

Community Support Services - Specialized Resources:

Aging at Home Team:

Focuses on those **living with aging caregivers**. Increased focus on respite for families.

Neurobehavioural Intervention Program:

For those with ABI and **Substance Use and/or Mental Health issues.**

Intervention aims to provide:

- client education
- peer support
- prevention messages and harm reduction
- problem solving and coping strategies.

Alcoholics Anonymous open meeting and is held at CHIRS' head office on Thursday evenings from 7:00pm to 8:00pm.

Community Head Injury Resource Services of Toronto

Clinical Resources:

- Neuropsychological and Neurobehavioural Expertise
- Consulting Neuropsychiatry
- Social Work
- Occupational Therapy
- Behavioural Therapists
- Family Support Group
- Clinical Groups

Community Head Injury Resource Services of Toronto

Group	Description
Assertiveness Training	• Designed for participants to deal more effectively with difficult interpersonal situations. • Will also learn to cope better with strong emotions that may arise from difficult interpersonal situations.

Being Social	• Intended to address barriers to having friends or relationships after ABI.
	  • Part 1 focuses on basic social skills for making and maintaining friendships.
	  • Part 2 focuses on dating and relationships.

cTech	• Designed for clients to learn how to use smart phones for cognitive compensation and social participation
Living well with a Brain Injury	• Supports learning about how brain injury affects their lives and how to cope effectively with the changes.
Mindful Art Workshop	• Under the direction of an Occupational Therapist, using art as a medium, clients learn principles of mindfulness, yoga breathing and meditation
Positive Psychology	• Two groups focusing on Positive Psychology (Your Best Self Workshop and Finding Happiness). • Uses PP principles to assist individuals in indentifying harmful thought processes and replace them with compassionate and supportive ones.

Ontario Shores

Centre for Mental Health Sciences

About Us

Ontario Shores Centre is a tertiary level public teaching hospital providing a range of specialized assessment and treatment services to those living with complex and serious mental illness.

Exemplary patient care is delivered through safe and evidence-based approaches where successful outcomes are achieved using best clinical practices and the latest advances in research.

Patients benefit from a recovery-oriented environment of care built on compassion, inspiration and hope.

Ontario Shores
Centre for Mental Health Sciences

Mission, Vision and Values

Mission: We provide leadership and exemplary mental health care through specialized treatment, research, education and advocacy.

Vision: Recovering Best Health - Nurturing Hope - Inspiring Discovery

Values: Excellence, Innovation, Safety, Respect and Community

Ontario Shores
Centre for Mental Health Sciences

Neuropsychiatry Services (NPS): Inpatient

Population Served: Medically stable individuals 18-65 years of age with an acquired brain injury or brain disorder (e.g. neurodegenerative disease) **AND** a serious mental health concern.

Area Served: Province-wide

Program Model: An inter-professional team consisting of neuropsychiatry (O. Ghaffar), neuropsychology (R. Ip), occupational therapy, rehabilitation/behavioural therapy, psychiatric nursing, therapeutic recreation, and social work use a recovery-oriented approach with patients and families, primarily targeting psychiatric symptoms and associated behavioural problems in a secure, 25 bed inpatient setting of a public psychiatric hospital. We endeavor to partner where possible with individuals' community supports.

Ontario Shores
Centre for Mental Health Sciences

Neuropsychiatry Services (NPS): INPATIENT

Services Include:

- Specialized interprofessional assessments
- Diagnostic clarification
- Medication review
- Behavioural interventions
- Life-skills training
- Individual and group therapy
- Therapeutic recreation
- Vocational planning
- Family support, education and consultation
- Inclusion of community partners in planning and treatment
- Discharge planning and community reintegration support

Neuropsychiatry Services (NPS): OUTPATIENT

The Outpatient Neuropsychiatry and Consultation Service at Ontario Shores provides specialized assessment, consultation, treatment, rehabilitation and behavioural programming to individuals 18 to 65 years old who have a mental health concern, a brain injury or disorder, including Huntington Disease, and who have cognitive and/or behavioural challenges. Educational presentations are available upon request.

Neuropsychiatry Services (NPS): Outpatient

Population Served: Medically stable individuals 18-65 years of age with an acquired brain injury or brain disorder (e.g. neurodegenerative disease) **AND** a serious mental health concern.

Area Served: Province-wide; hospital and or Ontario Telemedicine Network (OTN) neuropsychiatric consultation/assessment. Follow up (in person or OTN) available if deemed appropriate.

Program Model: Outpatient Neuropsychiatrist (O. Ghaffar), and Nurse Clinician deliver psychiatric care, including pharmacologic and psychotherapeutic treatments (including behaviour therapy) as appropriate in collaboration with community partners.

Neuropsychiatry Services (NPS): OUTPATIENT

Services include:

- Assessments
- Consultations
- Behavioural support
- Shared care
- Assistance connecting patients with community resources
- Follow-up to support the patient's journey to recovery and goal attainment as well as counseling, medication and symptom management and support

Neuropsychiatry Services (NPS):

How to Make a Referral

- The centralized referral form can be found at ontarioshores.ca. Please indicated which service you are requesting.

- Additionally, refer to the website for information that needs to be included with the referral i.e. MARS, blood work, diagnostic imaging)

NPS Current Wait Times

- Inpatient referrals are triaged and prioritized based on level of urgency. Admission times are dependent upon availability of inpatient beds. Please note: We are not an emergency or crisis service.

- Outpatient appointments can vary in wait times. Presently outpatient services are provided one day per week by the Neuropsychiatrist and Nurse Clinician.

THANK YOU!

Andrea Spencer, Community Nurse Clinician
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Joanna Holley, Community Behaviour Therapist
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Ontario Shores
Centre for Mental Health Sciences

Presented by: Kate Moore
Manager, Clinical Services

About Cota

Mission Statement

- To support individuals with mental health and cognitive challenges to live well within their communities

Values

- Hope
- Dedication
- Respect
- Accountability
- Collaboration
- Innovation

About Cota's Services

Cota offers a wide range of services to adults living with:

- serious mental illness,
- geriatric mental health conditions,
- acquired brain injuries, and
- developmental disabilities and dual diagnoses.

Our services include:

- case management,
- supportive housing,
- short-term residential beds,
- day programs,
- court and justice related services,
- an assertive community treatment team (ACT), and
- services for individuals who are experiencing homelessness.

Acquired Brain Injury (ABI) Case Management

- Cota's ABI Case Management service provides practical individualized support in the community to adults 16-64 years of age living with an acquired brain injury across the City of Toronto. Services include the collaborative development of and implementation of an individualized recovery/goal plan and direct support in the areas of identified need.

- For more information or to make a referral: Please call the Toronto ABI Network (416) 597-3057 or visit their website at www.abinetwork.ca.

Acquired Brain Injury (ABI) Adult Day Service

- Cota's ABI Adult Day Service program offers a variety of creative group sessions for adults 16-64 years of age living in the City of Toronto. Groups rotate every 12-16 weeks and sessions are available Monday to Friday. The program is located at Providence Healthcare in Scarborough.

- For more information or to make a referral: Please call the Toronto ABI Network (416) 597-3057 or visit their website at www.abinetwork.ca.

Acquired Brain Injury (ABI) Supportive Housing – Collegeview Site

- This program provides rent-geared-to-income accommodation within a Toronto Community Housing building in downtown Toronto and on-site supports are provided to 20 residents with varying levels of ability. The goal of the program is to assist residents with activities of daily living and personal goals so that they can maintain their housing and lead fulfilling lives within the community.

- For more information or to make a referral: Please call the Toronto ABI Network (416) 597-3057 or visit their website at www.abinetwork.ca.

WEST PARK
HEALTHCARE CENTRE

WEST PARK HEALTHCARE CENTRE

- West Park provides specialized rehabilitation, complex continuing and long-term care services for persons with lung disease, diabetes, stroke, brain injury, amputation and musculoskeletal issues arising from a life-changing event or illness.

- Beds
  - Rehabilitation 126 (11? ABI beds)
  - Complex Continuing Care 140

WEST PARK HEALTHCARE CENTRE

- Neurorehabilitation for stroke and ABI (inpatient)
- Outpatient rehabilitation therapy
- Behavioural rehabilitation for severe ABI and severe challenging behaviours (inpatient)
- Outreach behavioural rehabilitation for moderate to severe ABI and challenging behaviours (client's homes, residential facilities, acute care hospitals)
- ABI Day Program and Survivor Support Group run jointly with Cota

WEST PARK HEALTHCARE CENTRE

- Outpatient Rehab

For patients requiring additional therapy post-inpatient rehabilitation

Services available include:

- PT,OT,SLP
- Psychology, Social Work
- Chiropody, Massage, Acupuncture – Fee for Service
- Return to Work Program
- Hydrotherapy/Aquafit

WEST PARK HEALTHCARE CENTRE

- Behavioural Outreach
  - Therapists work directly with clients, and with family, care givers, and staff in home, residential sites, acute care hospitals
  - Weekly visits for 6 – 12 months
  - Clients must be age 18 – 65, medically stable, have family physician.
  - One-month wait list.
- Survivor Support
  - Survivor support group lead by social worker, Cota case manager
  - Open ended. Members share experiences, information, hope.
  - Age 18 and over. No wait list. Maximum 15 members.
  - Professional referral required

WEST PARK HEALTHCARE CENTRE

- Community Supports
  - Behaviour Therapists provide weekly consultation to Cota Collegeview residential program (20 residents), and to Cota Dual Diagnosis service as required.

Baycrest

University of Toronto, Rehabilitation Sciences Sector & Rotman Research Institute, Baycrest

Rehabilitation Sciences Sector
UNIVERSITY OF TORONTO

Baycrest
Enriching Care
Enhancing Knowledge
Enlightening Minds
Rotman Research Institute

Rehabilitation Sciences Sector

- Department of Occupational Science & Occupational Therapy
- Department of Physical Therapy
- Department of Speech-Language Pathology
- Graduate Department of Rehabilitation Sciences

Baycrest

- Rotman Research Institute – Brain Health & Aging

Rehabilitation Sciences Sector
UNIVERSITY OF TORONTO

Baycrest
Enriching Care
Enhancing Knowledge
Enlightening Minds
Rotman Research Institute

Our Aim: achieve optimal participation in everyday life for everyone with an ABI

What we can offer you:

- Access to expertise
- Access to information
- Opportunity to have input to and participate in life-changing research.

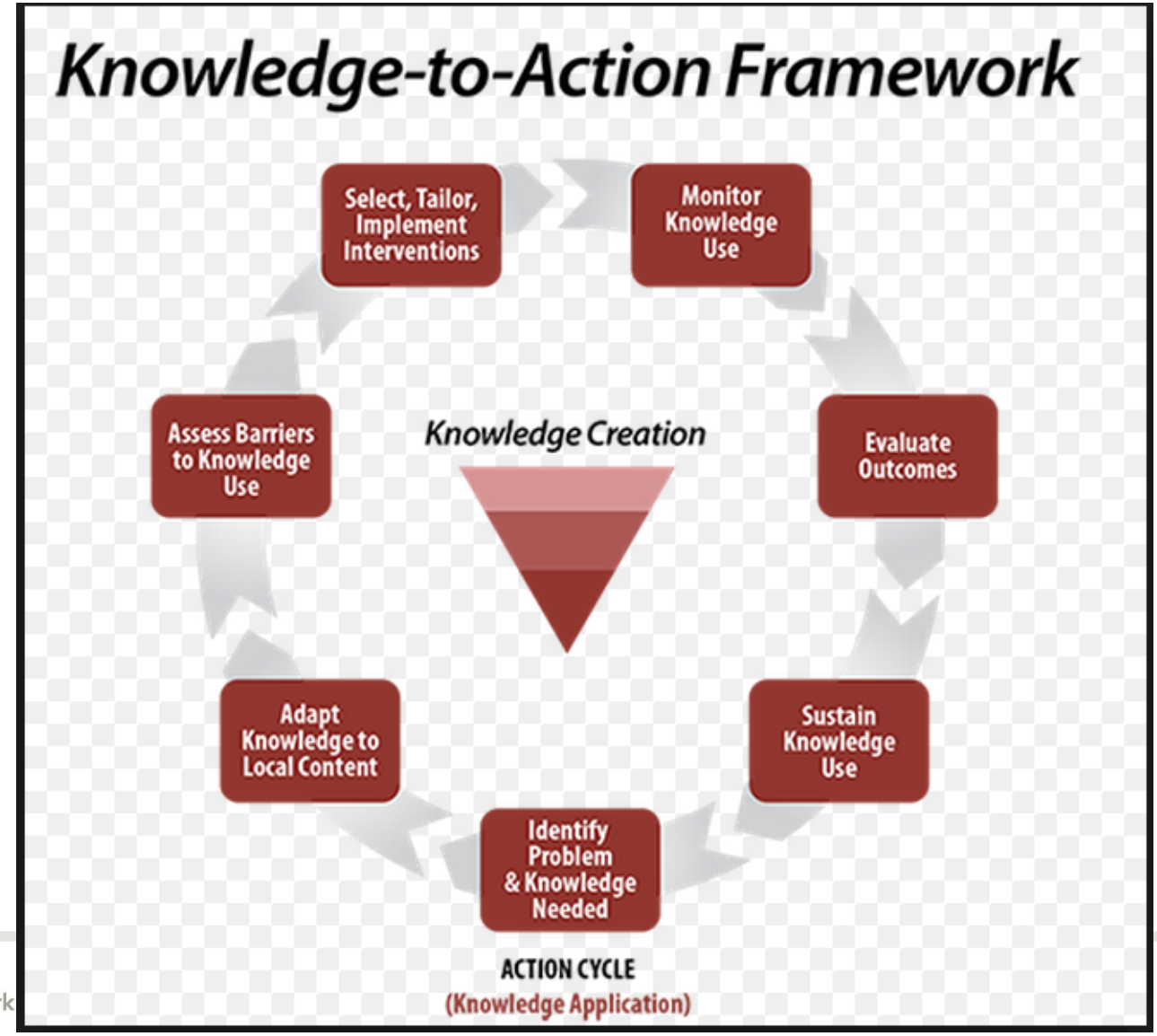
What we ask of you:

- Opportunity to collaborate on research
- Opportunities to invite your clients to participate in our projects.

Rehabilitation Sciences Sector
UNIVERSITY OF TORONTO

Baycrest
Enriching Care
Enhancing Knowledge
Enlightening Minds
Rotman Research Institute

Participate with Us!



Rehabilitation Sciences Sector
UNIVERSITY OF TORONTO

Baycrest
Enriching Care
Enhancing Knowledge
Enlightening Minds
Rotman Research Institute

Some of our Current Opportunities:

1 – Develop tele-rehab opportunities for cognitive rehabilitation

2 – Investigate opportunities to provide appropriate services to people who hare homeless and have ABIs

3 – Discover whether computer brain training helps in everyday life

4 – Be part of a volunteer research pool

Holland Bloorview

Kids Rehabilitation Hospital

Holland Bloorview
Kids Rehabilitation Hospital

Join A World of Possibility

Holland Bloorview
Kids Rehabilitation Hospital

Brain Injury Rehab Team

- The Brain Injury Rehab Team (BIRT) serves clients aged 3 months to 18 years who require rehabilitation following an acquired brain injury.

- An interdisciplinary team provides collaborative assessment and interventions facilitating return of function, development of compensatory skills and assisting reintegration into the family, school and community at the child's optimum level.

Holland Bloorview
Kids Rehabilitation Hospital

Join A World of Possibility

Inpatient Services:

- Rehabilitation Stream
- Restorative Stream
- Burst of Therapy

Day Program Services:

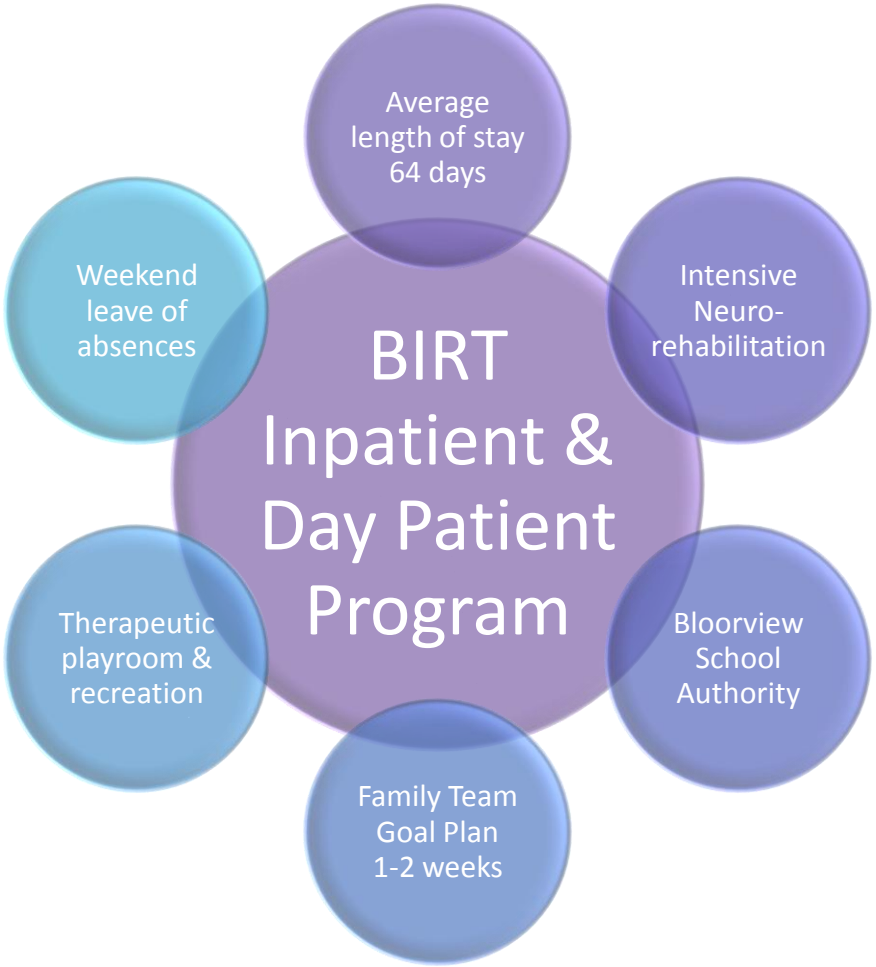
- Ambulatory Care Service
- Transition from hospital to home

Outpatient Services :

- Mild, Moderate and Severe Streams
- Follow Up Medical Clinic

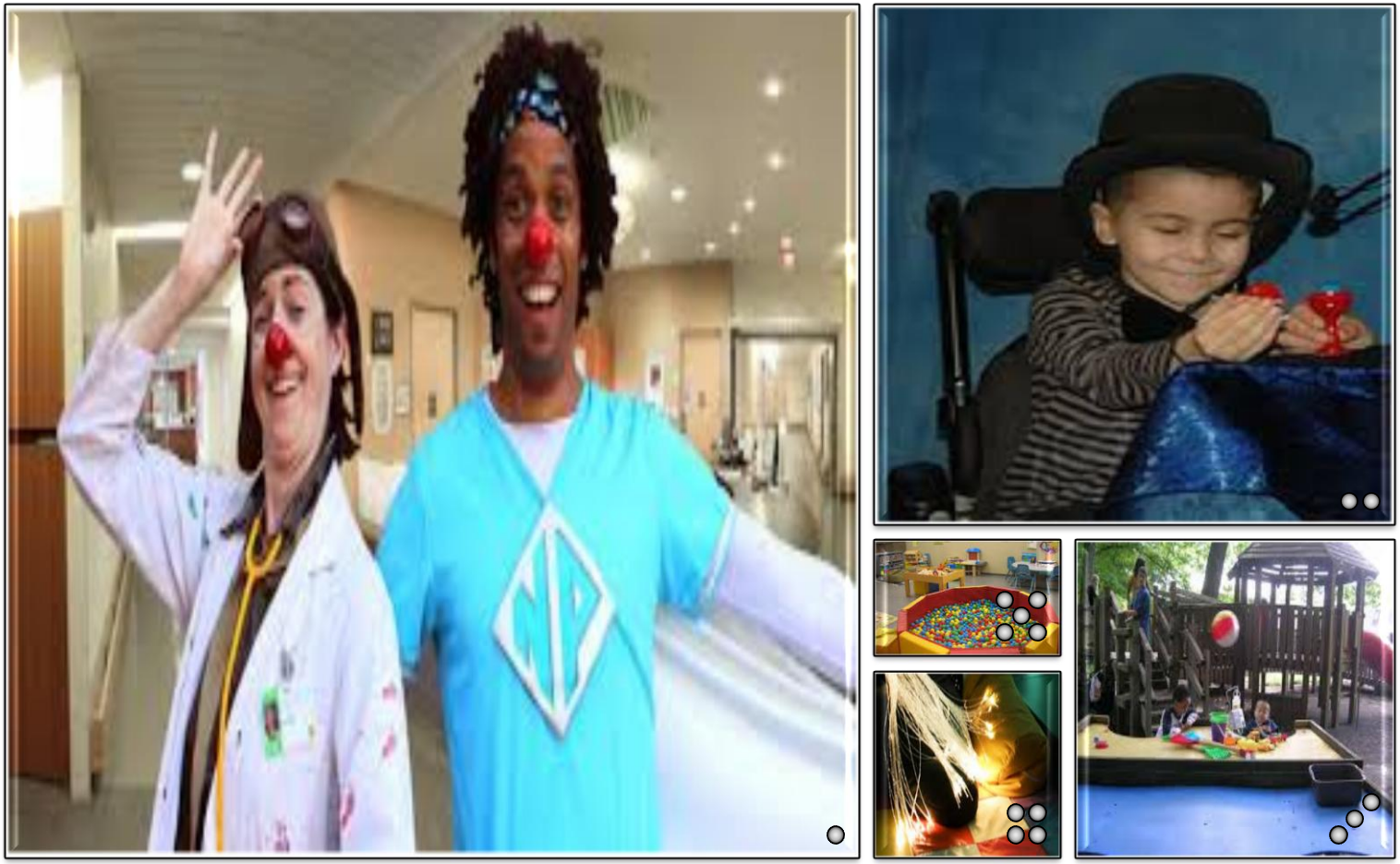
Holland Bloorview
Kids Rehabilitation Hospital

In & Day Patient Programs



Holland Bloorview
Kids Rehabilitation Hospital

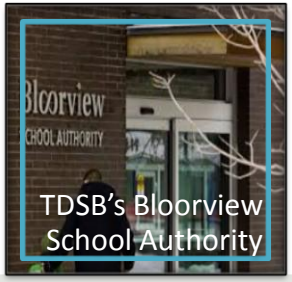
Child & Family Centered



Therapeutic Clowns | Project Magic | Accessible Playgrounds | Snoozelen Rooms | Ronald McDonald Playroom

Holland Bloorview
Kids Rehabilitation Hospital

More Special Features



MARCH
OF DIMES
CANADA

MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

Who are we?

- A Not for Profit organization that has been working for over 60 years to create a society inclusive of persons with disabilities
- A Robust service provider offering a variety of programs and services which include Employment services, Assistive Devices Program, Home and Vehicle Modification program, Conductive Education, Peer Support groups, Recreation programs www.marchofdimes.ca
- Our largest programs and services are through our LHIN funded Independent Living Programs (Attendant Services, Assisted Living and Acquired Brain Injury)
- LHIN funded ABI programs since 1992

MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

Standard Eligibility Criteria for ABI LHIN funded programs:

- Have a documented Acquired Brain Injury
- Be 16 years of age or older
- Require the support of MODC as a result of the ABI
- Have a valid health card
- Not be in receipt of insurance funds

MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

Supportive Housing

- Located in Newmarket
- Supporting 8 individuals – Three 2 bedroom units, Two 1 bedroom units
- Individualized support for activities of daily living, to acquire new skills and develop strategies for community integration
- Collaboration with a range of professionals, including Behavioural consultation and Neuropsychiatrist
- Current waitlist 35.
- Average wait time 1041 days

MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

Outreach Program (MODC and York Simcoe Brain Injury Services YSBIS)

- Community based supports offered throughout York Region, South Simcoe and North Simcoe Muskoka
- Individualized rehabilitation and case management support
- Assist individuals to have a more meaningful role in home and community, gain previous skills and learn new skills to enhance quality of life
- Collaboration with a range of professionals and community providers
- Current waitlist 169 (MODC and YSBIS)
- Average wait time 568 days

MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

Aphasia and Communication Disabilities Program

- Community based programs in Newmarket, Stouffville, Vaughan, Maple, Whitby and Peterborough
- Peer group setting where individuals work with Speech Language Pathologists, Communicative Disorders Assistants and trained volunteers to learn supportive communication strategies and optimize language abilities
- Support for caregivers and families through training and workshops.
- Current waitlist 67
- Average wait time 250 days
- Eligibility – adult living with Aphasia other acquired communication

MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

ABI Groups

- Community based groups throughout York Region, South Simcoe and North Simcoe Muskoka
- Offer a variety of social, recreational and life skills opportunities
- Retreats and Conferences specifically designed for ABI survivors and Caregivers
- Overnight Independent Living programs for youth 16 -25
- No waitlist

MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

Fee for Service Program

- Working with insurance companies and other private revenue sources to support persons with ABI
- Rehabilitation Workers and Attendants working with rehab teams throughout the GTA in supportive housing programs and private homes

Stroke Survivor Peer Support Program

- Information and Support groups for stroke survivors and their families

Conductive Education

- Program combines elements of education and rehabilitation to help survivors gain mobility and self sufficiency.

For more information www.marchofdimes.ca

PACE
Independent Living
Setting the pace in Independent Living

PACE is a community based support service organization established in 1981 to provide support services to adults with physical disabilities.

PACE's services to Consumers/Members are provided in a manner that is consistent with the **Philosophy of Independent Living**.

Area(s) served: GTA area

PACE's Brain Injury services are currently located in Etobicoke.

- Edwards Manor: 24 hours Supportive Housing
- Learning Network (Adult Day Services)

- PACE provide support services to approximately 180 Consumer/Members, who have a variety of physical disabilities (Multiple Sclerosis, Cerebral Palsy, Spinal Cord injuries, Acquired Brain Injury, Muscular Dystrophy and Huntington's disease).

- PACE provides services to Consumers/Members in five Supportive Housing sites and through Attendant Outreach Program and Day Programming.

Admission criteria

- You have sustained a brain injury resulting in the need for a long-term supported living environment
- You do not have any “severe” behavioural challenges which may prevent them from working towards their long term goals, safe community access or which present an imminent risk of harm to self and to others
- You do not have any high risk physical conditions that may require on site intensive medical/nursing services
- Must be willing to actively participate and work collaboratively with staff on the goal(s) they set for him/herself
- Willing to accept support from Co-op/ Learning Network staff and partners

Waitlist

PACE does have a waitlist for the Edwards Manor Co-Op and The Learning Network. Applicants are not put on the waitlist until they are prescreened.

We have a pre-membership list where referrals are tracked. If a vacancy is determined, background information is gathered then reviewed, a vision meeting is held with the applicant to further understand their needs. The vision meeting is used to develop a Collaborative Action Plan that would inform our Members Service Agreement.

Edwards Manor Co-Op

- The Project provides 24 hour support to individuals with an abi
- designed to encourage a “co-operative community” for 10 individuals to live in a private studio apartment with support individualized to their needs

The Learning Network (Adult Day Service)

- The Learning Network operates Tuesday to Saturday
- Offers Learning and Educational workshops (i.e.. Cooking/healthy eating, gardening, communication …) and also social activities
- We do not offer one to one support
- PACE partners with ESS (Etobicoke Senior Services) on Thursday to provide ABI Service support to seniors (with an ABI) at the ESS (ADS)

PACE Independent Living
Setting the pace in Independent Living

Professional Resources ********

- 2 Consulting Neuro Psychologists
- Consulting Kinesiologist

Survivor & Caregiver Support

- Workshops available through the Learning Network
- Included in annual Feedback and Service Quality Questionnaire
- Information with regards to Health and Safety (ie. Home pest) are shared with family members and caregivers

Thank You

If you have any questions please contact us.
Shirley Rokos, Director of Enhanced Services
416-789-7806 Ext 235

York-Simcoe Brain Injury Services

York-Simcoe Brain Injury Services

Mackenzie Health

- A partnership between Mackenzie Health, Centre for Behaviour Health Sciences and March of Dimes Canada
- We provide community based clinical services to individuals 16 years and older living with an acquired brain injury and those who support them
- Service Area: York Region, Simcoe County and Muskoka Region
- Referrals can be made by: individuals with ABI, family members, health professionals, community organizations
- Goal-focused, individualized treatment plans are developed collaboratively to maximize client adjustment, quality of life and community reintegration after an ABI

York-Simcoe Brain Injury Services

Mackenzie Health

What we offer:

- Individualized neurobehavioural support to assist clients and families adjust to the effects of ABI
- Access to specialists to assist in assessment of ABI
- Education for clients, families and community relating to ABI
- Connection to community resources such as housing, legal, transportation and income support
- 1 to 1 support with client rehab goals in home and community
- Problem Solving Group, Caregiver Support Group, Surviving and Thriving with Youth After ABI, Social Skills Group

York-Simcoe Brain Injury Services

Mackenzie Health

Waitlist:

- Triage system
- Intake interview conducted by program co-ordinators, assess and determine priority
- Wait time can be up to 18 months, but activation can be sooner based on individual need
- During the intake, individual is provided with resources and linkages to other community services as needed

York-Simcoe Brain Injury Services

Mackenzie Health

Our Team:

Through Mackenzie Health:

- Behaviour Consultants: Developed a Case Conceptualization Model, whereby we provide comprehensive functional and behavioural assessments, treatment and support/training; utilize cognitive-behaviour therapy and applied behaviour analysis; access to neuropsychological and neuropsychiatric assessments as needed

Partnership with March of Dimes:

- Case Manager : provide coordinated community resources
- Rehabilitation Support Workers: promote independent living and learning essential skills for community integration and socialization.

Framework for Behavioural Consultants:

Case Conceptualization Model (CCM)

- Identify developmental, precipitating and maintaining factors that contribute to behaviours
- Identify risk and protective factors: developmental, familial, contextual
- Collaborative goal setting – short and long-term
- Identify, anticipate, and address potential barriers to treatment effectiveness
- Assess client progress on regular basis
- Holistic approach to understanding client: culturally, socially, ethnically sensitive

York-Simcoe Brain Injury Services

Mackenzie Health

Groups Facilitated by Behaviour Consultants:

- Problem Solving Group: This group explores client's difficult situations, thinking patterns, emotional and behavioural responses and coping strategies.
- Caregiver Support Group: Created to support caregivers with managing stress, addressing feelings of loss and finding a way to move forward in a meaningful way.
- ABI Social Skills Group - Pilot Project: Created to help individuals with ABI to facilitate the use of social skills.
- Surviving and Thriving with Youth After ABI – Pilot Project in Partnership with Bloorview Kids: Resilience skills for parents of youth who have sustained a brain injury.

York-Simcoe Brain Injury Services

Mackenzie Health

Mackenzie Health ABI Adult Day Program

- Opportunity for social, recreational and skill building activities in a therapeutic environment
- Activities range from physical health, cognitive activities, social interactions fostering connections with peers
- Respite for families and caregivers
- Program staff include behaviour consultant, recreation therapist and client care assistant providing personal care as needed
- 3 locations: Vaughan, Maple and Newmarket
- Program is available to individuals 18 years and older, within York Region and South Simcoe County

Central & Toronto Central CCAC

About CCAC

Who we are

- Local point of access to in-home and community-based health care services
- Part of Ontario wide community care network, coordinate services for residents living anywhere in Ontario
- Funded by the Ministry of Health and Long-Term Care Central LHIN

What we do

- Care and services based on patient's individual care needs
- Professional care coordination to wrap care around patient
- Information and access to health and community resources to help people and families get the care they need

How we help

CCAC makes it possible for patients to:

- Leave the hospital and recover at home
- Remain safely at home
- Attend school
- Transition to long-term care or supportive housing
- Find a family doctor or nurse practitioner
- Avoid the emergency department, when possible
- Find services in the community that support health and independence
- Die with dignity, in the setting of choice

About our services

- **Care Coordination**
  - Hospital, community, intake
- **In-home services**
  - Professional Nursing, Rehab Therapies (Occupational Therapy, Physiotherapy, Speech-Language), Personal Support and Homemaking, Nutritional Counseling
- **Community nursing clinics**
  - Seven clinics offering specialized nursing for mobile patients
- **Information and referral**
  - Care Connectors, Centralhealthline.ca
- **Long-term care placement**
  - Long stay, short-stay respite, convalescent care
- **Eligibility, assessment and waitlist management**
  - Adult Day Programs, Assisted Living
- **Specialized Caseloads**
  - Child and Family , School Support, Mental Health, Oncology and End of Life Care, ABI

More about our services

- **Direct Services**
  - Adult Rapid Response Nurses
  - Paediatric Rapid Response Nurses
  - Mental Health and Addictions Nurses
  - Palliative Nurse Practitioners
  - Falls Prevention Coordinators
- **Telehomecare**
  - Self-management and electronic distance monitoring of CHF and COPD patients
- **Home First**
  - Bringing people home from hospital - with enhanced level of services - instead of LTC
- **Primary Care Initiative**
- **Health Links**

ABI at Central CCAC

- **ABI adult caseload** of 80-100 patients (< 18 on child & family caseload)
- **Eligibility**:
  - Traumatic and non-traumatic ABI within 1-2 years post-injury
  - Assess individually > 65 years of age, time post-injury
  - Discharge from acute rehab/neuro rehab unit
- **Dedicated care coordinator** with expert knowledge re ABI and associated community services and supports
- **Rehabilitation focus** with ABI-trained service providers
  - OT, physiotherapy, speech language
- **Eligible for all CCAC services** (e.g. personal support, nursing, dietitian)
- **Consultation and education** to contact centre, general community caseloads, mental health, palliative/EOL
- **ABI Transitional Classroom Program**
  - York Region District School Board, Children's Treatment Network, Mackenzie Health

At a glance

	< 18 year	18 - 65				
CASELOAD	Child and Family	Short Stay	ABI	Senior Chronic-Complex	Mental Health	Palliative
	• Traumatic and non-traumatic • OT/PT/SLP active rehab • Links to community rehab, school, funding	• Mild impairment • 90 days • Single service • Rehab	• Traumatic and non-traumatic • Acute rehab • ABI-trained service provider • LOS 6 mths – 2 years (> 2 years short-stay transfer)	• Traumatic and non-traumatic • >65 years, CVA • BR> 1 year • Active rehab completed • PSW to maintain • Spot OT/PT/SLP • Long stay	• Dual diagnosis • Homeless • Addictions • Mental health nursing • Long stay	• Non-traumatic • BT • PT/OT/SLP • PSW, nursing • LOS up to 1 year
DISCHARGE DESTINATION	• CCAC adult caseload (at age 21)	• Self care • Resume ADL • Employment • YDAS	• York Simcoe Brain Injury Services • Behavioural Services • ABI Adult Day Program • Supportive housing • Case management	• Long-stay CCAC • Private insurance • Retirement home or long-term care	• Housing • COTA • Ontario March of Dimes	• CCAC services • Palliative care unit

Toronto Central Community Care Access Centre

Acquired Brain Injury Program

◆◆◆

Toronto Central CCAC Acquired Brain Injury Program

The TC-CCAC ABI program is focused on **cognitive rehabilitation** and provides the following services:

- Care Coordination
- Psychology Assessment and Behaviour Therapy
- Occupational Therapy
- Social Work
- Speech Language Therapy
- Rehab Support Workers

Toronto Central CCAC Acquired Brain Injury Program

Eligibility Criteria:

- Client meets eligibility criteria for TC-CCAC
- has a primary diagnosis of ABI
- ABI within the past 5 years
- Between 18 and 65 (individual cases reviewed)
- Medically and psychologically stable.
- Able to participate in rehab-focused care
- Services can be delivered in a safe environment

Exclusion Criteria

- Diagnosis - congenital disorder or progressive disorder (e.g., Multiple Sclerosis or dementia, Cerebral Palsy, Alzheimer's Disease, Parkinson's Disease).

Toronto Central CCAC Acquired Brain Injury Program Referrals

The appropriate ABI Network referral forms must be completed and faxed to the ABI Network.

- Client registered at Toronto Central CCAC
- Collateral Information Required with Referral:
  - i. Neuropsychological assessments
  - ii. MRI reports/CT scans
  - iii. Psychiatry/psychological assessments
  - iv. Discharge summaries related to acute episode leading to hospitalization

How to Contact The TC-CCAC ABI Program: 416-217-3820

Coordinators:

R1 Alison Golob Ext. 3969

R2 Lauren Peires Ext. 3410

BRIDGEPOINT
active healthcare

Bridgepoint Active Healthcare

- *Bridgepoint Active Healthcare* is transforming care for patients living with complex health conditions so they can live better.
- Our four pillars support us in diagnosing, treating, managing, researching and teaching, leading healthcare practices for patients with multiple health conditions.
- **HOSPITAL -** our purpose built hospital was designed to enable patients to be active in their care. Our highly skilled care teams work across disciplines to build one central care plan for patients.
- **RESEARCH** – our pioneering research is finding new ways to treat people that will immediately improve health outcomes, performance and system sustainability.
- **COMMUNITY-** we focus on transitioning patients back home and connect with primary care, home care and other community services to ensure that people can safely return to their homes and communities.
- **FOUNDATION** – the generosity of donors, sponsors and the Government of Ontario helps fund our vision of helping people with complex health conditions live better.

Bridgepoint Active Healthcare

The Christine Sinclair Ambulatory Care Centre

- The Christine Sinclair Ambulatory Care Centre helps clients with complex health conditions that may be met in an outpatient setting.
- The centre includes state-of- the-art facilities, a gym with large windows, clinical suites, and a therapeutic pool overlooking Riverdale Park.

Bridgepoint Active Healthcare

Neurological rehabilitation program

- We offer outpatient services for patients with complex neurological rehabilitation needs with a short-term intensive program.
- Appropriate patients include those with a recent acquired brain injury, stroke or neurovascular impairment or a neuromuscular disorder.
- Patients in this program have access to vocational rehabilitation, neuropsychology services and a neurological peer support group for younger adults.
- Program duration: Approximately 8 -10 weeks.

Bridgepoint Active Healthcare

Specialty Outpatient Services:

- Seating Clinic
- Vocational Rehabilitation
- Augmentative Communication and Writing Aids Clinic
- Therapy pool
- Neuropsychology

Bridgepoint Active Healthcare

Musculoskeletal rehabilitation program

- We offer outpatient services for patients with complex musculoskeletal rehabilitation needs with a short-term intensive program.
- Appropriate patients include those who have had orthopaedic surgery for complex fracture, multiple trauma, rheumatic disease or complex soft tissue injuries.
- Program duration: Approximately 6 weeks.

Bridgepoint Active Healthcare

Total joint replacement rehabilitation program

- Our rehabilitation program is for patients who have undergone elective knee and hip replacement surgery.
- T**otal knee replacement program** includes: individualized and detailed home exercise programs with access to the aquatic program as needed; participation in a group rehab program, offering therapy twice a week; and evaluation and recommendations for mobility aids and home equipment.
- Program duration: 5-6 weeks or 10-12 visits.
- **Total hip replacement program** includes: a one-time assessment and education session with a physiotherapist with follow-up as needed

Bridgepoint Active Healthcare

Pain management program

- This 10-week program uses a cognitive-behavioural approach and physical activity to provide coping strategies.
- Available to people with a medically stable chronic pain condition, which has been present for longer than 6 months and has not been responsive to traditional medical intervention.
- There is a small fee associated with this program

Bridgepoint Active Healthcare

Mindfulness based stress reduction program

- This program combines eastern practices of meditation and exercise, with western understanding of stress and its effect on physical and mental health.
- Patients meet weekly over the course of 9 weeks. They learn a variety of meditation practices focused on developing skills in moment-to-moment, non-judgmental awareness of their experiences in life.
- There is a small fee associated with this program.

Bridgepoint Active Healthcare

Specialty Clinics(MD only Clinics):

Individuals with complex health care presentations often have specific needs for clarity of diagnosis and management. For such cases, outpatient appointments are available in the following medical specialties:

- Endocrinology
- General Internal Medicine
- Geriatric Psychiatry
- Physiatry

Bridgepoint Active Healthcare

COMPLEXITY SERVICES – Opening in 2015

Our outpatient complexity clinics and programs focus on providing comprehensive care for people in the community with multiple medical conditions, who may also be burdened with emerging cognitive impairment, mental health problems, social isolation, and frailty. These clinics serve people residing within the Don Valley Greenwood and the East Toronto Health Links

Bridgepoint Active Health Care

COMPLEXITY SERVICES – Opening in 2015

- **CARE Clinic:** Staffed by a geriatrician and a comprehensive interprofessional team of healthcare professionals. The aim of the CARE Clinic is to support and strengthen primary care for patients living with multiple chronic conditions by co-managing them with their family doctors.

- **Polypharmacy Clinic:** The goal of this clinic is to optimize prescribing by working closely with patients, their families, and their healthcare teams in order to simplify complex drug regimens and improve overall quality of life.

BRIDGEPOINT active healthcare

Bridgepoint Active Healthcare

Admission Criteria for Ambulatory Care Outpatient Therapy:

- Recent diagnosis (within the last 6 months) and/or recent hospitalization
- Must be able to actively participate in an outpatient therapy program (can tolerate at least 1 hour of therapy)
- Must be able to ambulate and/or require minimal assist to transfer
- Must be independent in self care or have own support/assistance
- Must provide own transportation

Wait times:

- All external referrals are screened by a physician
- General wait times for external referrals can range from 2 – 4 weeks

UHN
Toronto
Rehabilitation
Institute

Toronto Rehab

University Health Network comprised of 4 Hospitals:

- Toronto General
- Toronto Western
- Princess Margaret
- Toronto Rehab (has 5 sites)

Toronto Rehab

Toronto Rehab offers the following programs:

- Cardiac Rehab (Rumsey)
- Complex Continuing Care Program (Bickle)
- Geriatric Rehab (University Centre)
- Long Term Care - (Lakeside)
- Musculoskeletal Rehab (University)
- Brain and Spinal Cord Rehab (University, Lyndhurst, Rumsey)

Toronto Rehab

Brain and Spinal Cord Rehab (University, Lyndhurst, Rumsey)

- Inpatient & Outpatient ABI Rehab
- Inpatient & Outpatient Stroke Rehab
- Inpatient & Outpatient Spinal Cord Rehab
- Complex Injury Outpatient Rehab Services (CIOR- fee for service)
- Neurology (WSIB – fee for service)
- Balance, Mobility and Falls Clinic
- Augmentative and Alternative Clinic (AAC)
- Rocket Upper Extremity Clinic (fee for service)
- Spasticity Clinic

What does Toronto Rehab's Outpatient Acquired Brain Injury Program Offer?

- **Outpatient Rehab (Day Hospitals)☑**
- **Survivor & Caregiver Support ☑**
  - **ONLY as part of social work intervention. NOT as a stand alone program**
- **Neuropsychiatry Services☒**
  - **Only available to inpatient clients. For outpatients we refer out for these services**
- **Behavioural Outreach and Support Services ☒**
- **Residential and Ongoing Community Supports ☒**

Toronto Rehab

Where are we located (2 sites):

University Centre

- Downtown Toronto at University and Elm Street (north of Dundas)
- 10th floor

Rumsey Neuro

- Bayview & Eglinton - just south of Sunnybrook Hospital

Toronto Rehab

Who to refer:

- RECENT acquired brain injury that is not degenerative/progressive in nature
- Those 18 years of age or older
- Medically, psychiatrically / behaviourally stable
- Client must have clearly defined rehab goals and the potential to achieve them – we address physical, perceptual, cognitive, communicative and social issues
- Require two therapies (we do not provide single services)
- Able and willing to participate
- Ability to learn and carryover information taught
- Able to get to our centre independently or have family member / friend assist
- Able to toilet on their own or have a family member/friend assist them

How to refer & what to include:

- Referrals must come via the Toronto ABI Network either on the *community form* or the *form for physicians* and should include the following:
  - MD signature – please ensure that the name of the MD making the referral is clearly on the form so that we know who to reply back to
  - Hospital Admission / Discharge notes
  - MRI/CT scan results
  - Allied health notes
  - Consultant notes (e.g. Neuropsychiatrist, ENT)
- By including as much information as is available it ensures more timely review of referrals
- If in doubt please call outpatient ABI service coordinator:

  ☎Raghad Zaiyouna at 416-597-3422x 5321

Toronto Rehab

What services are available:

We work in inter-professional teams in a client centred and goal based manner. Our team is made up of:

- Occupational Therapy
- Physiotherapy
- Speech Therapy
- Social Work
- Community Resource Worker
- Neuropsychologist & Psychometry
- Physiatrist

Toronto Rehab

Admission Process:

- Service Coordinator reviews the referral
- Service Coordinator calls client/family and/or referral source
- If client meets admission criteria will attend an intake assessment
- Intake assessment is with two members of the team +/- physiatrist
- If appropriate placed on waitlist for services required

Waitlists:

- Wait for service from referral to start is approximately 7 weeks
- University Centre usually has a longer waitlist
- Waitlists are very variable ← if in doubt refer!

How should I prepare my clients for rehab:

- Inform them of the above process
- Ensure they have reliable transportation
- Let them know that if accepted they will attend twice per week (same day and time) during the hours of 9 am – 4pm
- Ask them (or a family member) to start thinking about rehab goals and to write down things they are finding difficult
- Some time at home is often beneficial to build insight / awareness
- LOS is between 2 – 12 weeks depending on client goals and how much they are benefiting from the program

What can clients expect:

- First two weeks the team will assess the client and help to develop client goals
- At the end of the two weeks we meet with the client / family at a family conference
- Client sets their goals based on feedback from the team with the help of their goal coordinator
- A tentative discharge date is set at the family conference
- Client continues to be seen twice per week by the team as necessary until discharge
- Telephone follow up call made approximately 2 months post discharge
- Therapy can be provided either all in one block or be broken up to best meet the clients needs

Trillium
Health Partners
Mississauga
Hospital

Trillium Health Partners
Mississauga Hospital

Outpatient Neuro Rehab Services

Did you know we merged?

Trillium Health Partners encompasses three main sites:

- *Credit Valley Hospital*
- *Mississauga Hospital*
- *Queensway Health Centre*

The latter two were formerly Trillium Health Centre

THP offers the full range of acute care hospital services, as well as a variety of community-based, specialized programs.

Trillium Health Partners
Mississauga Hospital

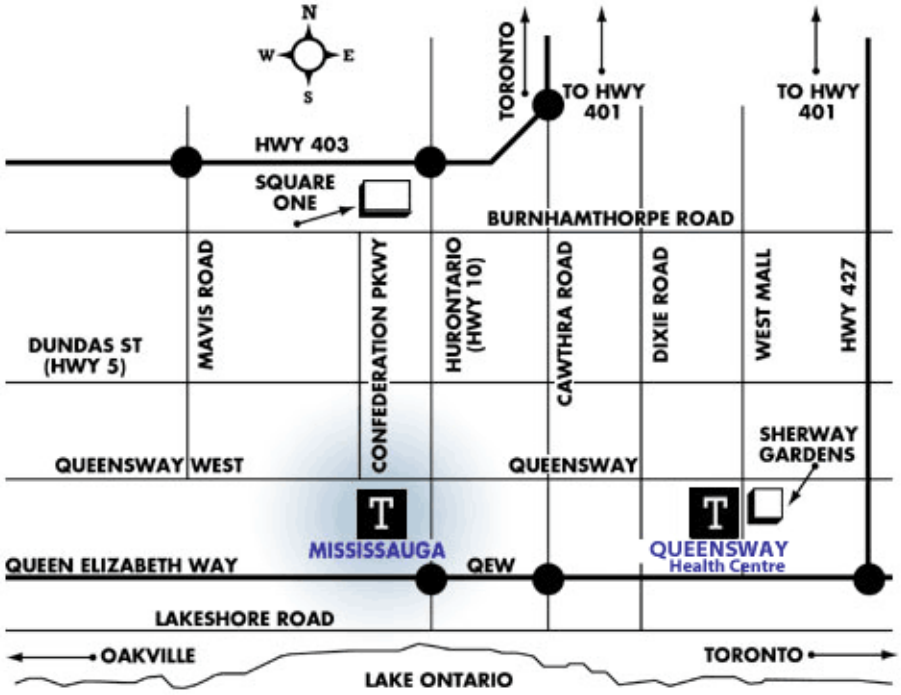
Outpatient Neuro Rehab Services

Where to Find Us:

Trillium Health Partners

Mississauga Hospital

Queensway & Hurontario (Hwy 10)



Trillium Health Partners
Mississauga Hospital

Outpatient Neuro Rehab Services

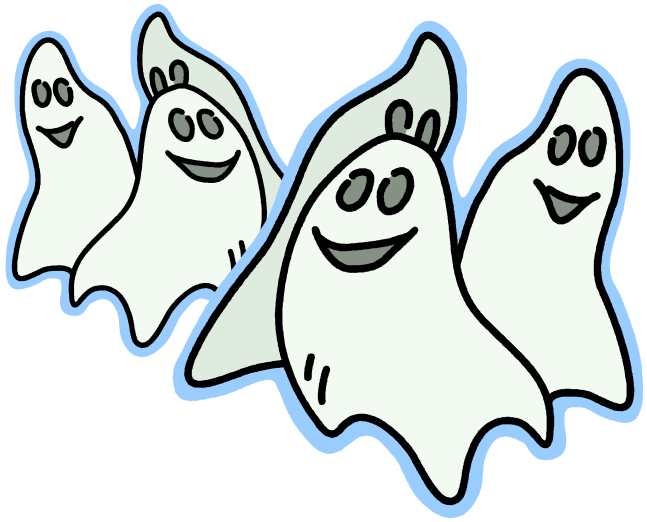
We offer:

Occupational Therapy

Physiotherapy

Speech-Language Pathology

Social Work



OHIP-funded services only (i.e., not WSIB or motor vehicle insurance)

Trillium Health Partners
Mississauga Hospital

Outpatient Neuro Rehab Services

Eligibility criteria:

- A recent stroke within the past 9 months

OR

- An acquired brain injury (e.g. aneurysm) within the past 12 months

OR

- A neurological condition (i.e. multiple sclerosis, degenerative conditions) with recent exacerbation

Trillium Health Partners
Mississauga Hospital

Outpatient Neuro Rehab Services

Eligibility criteria:

- Over 18 years old
- Medically stable
- Have shown recent progress in your recovery and have clear rehab goals
- Able to tolerate at least a 3 hour program plus transportation time
- Live within Trillium's service area (Mississauga and South Etobicoke)
- Commit to attend regular sessions and complete recommended home activities and/or exercises
- Be under the care of a family physician
- Not be under the influence of drugs/alcohol

Outpatient Neuro Rehab Services

Current wait time:

Approx. 6-12 weeks

longer for patients requiring only OT (12-16 weeks)

Target length of stay:

Stroke/ABI: 12 weeks

Neurological conditions: 6 weeks

Length of stay may be shorter – patient's progress is evaluated after 4-6 weeks.

Trillium Health Partners
Mississauga Hospital

Outpatient Neuro Rehab Services

How to Refer to Us

- GTA Rehab Network's Outpatient/Ambulatory Rehab Referral Form (www.gtarehabnetwork.ca)
- Make sure you send medical consultation reports and most recent therapist's reports and discharge summaries

Fax: (905) 848 7537

Phone: (905) 848 7280

BIST
Brain Injury Society of Toronto

Brain Injury Society of Toronto

- Mission - Enhance the quality of life for people in the City of Toronto, living with the effects of acquired brain injury through education, awareness, support and advocacy.
- Our members are survivors, families, caregivers, health professionals and lawyers.
- Membership (dual with Ontario Brain Injury Assoc)
    - $5 Survivor
    - $30 Individual/Professional
    - $50 Family

- Membership is open to anyone and no wait times
- www.bist.ca

Brain Injury Society of Toronto

Support

- Peer Support Mentoring Program – on-going
- Family Support Program - Sept –June
- Social Drop-In – on-going
- Survivor Support Group – Winter 2015
- Concussion Support Program – Spring 2015
- Social Recreation Events – on-going
  - Monthly Bowling
  - Monthly Community Meetings
  - Field Trips – Winter Fair, AGO, ROM, Brickworks
  - Dances/Parties

Brain Injury Society of Toronto

Education

- Family and Survivor Retreats
  - Caring for the Caregiver – Dr. J. Kreutzer and Caron Gan (Nov 22, 2014)
  - Aging and Brain Injury – Feb 2015
  - Brain Fitness – May 2015
- Speaker Forums
  - Educating the Educators—Strategies for teaching children with brain injury
  - Advances in ABI research and therapy – Focus on Toronto
  - Culture and Acquired Brain Injury – Role of religion and culture in recovery
  - A Family Approach to Brain Injury
- ABI Handbook for Hospitals (available June 2015)

Brain Injury Society of Toronto

Advocacy

- Wheel Trans
- Auto Insurance
- Self-Advocacy Tools (2015)

Awareness

- www.areyouaware.ca #areyouaware
- Website devoted to raising awareness about the prevalence of ABI, as well as the effects on individuals and families.
- Winter Social Media Campaign – Feb 2015
- TTC campaign – June 2015

areyouaware.ca

Brain Injury Association of Durham Region

Brain Injury Association of Durham Region

- Charitable, non-profit, funded by Ministry of Long-Term Health Care & Community Services and the Central East LHIN
- Serve individuals who have experienced a brain injury, their families, and caregivers
- Age range is 18 +
- Client Directed Services

Brain Injury Association of Durham Region

- Community Support & Advocacy–
  - Transitional Support Coordinator
  - Community Support Coordinators
  - Supported Independent Living (SILs)
- Social / Recreation Program
  - BIAD Happenings
- Information and Referral to and link with other agencies
- ABI Presentations
- Support Groups
- Entertainment Nights
- Other:
  - Summer Picnic
  - Christmas Party
  - Newsletter
  - Library

Brain Injury Association of Durham Region

- Client Directed Services
- Admission Criteria:
  - Client initiated
  - Declare they have experienced an ABI
- Wait Times
  - Return calls within 24 hours
  - Attend Day Services as desired
  - Meet with CSC worker within 2 weeks

Brain Injury Association of Durham Region

Contact Information:

Mr. Frank Murphy, Executive Director
Brain Injury Association of Durham Region
Unit 24 – 850 King St. W.
Oshawa ON L1J 8N5
T: 905-723-2732; 1-866-354-4464
E: information@biad.ca
W: www.biad.ca

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