Toronto abi Network

Descriptions of Programs/Services of Member Organizations

	BRIDGEPOINT SINAI HEALTH SYSTEM 14 St. Matthews Road Toronto, Ontario M4M 2B5
Program or Service:	**Inpatient ABI and Neurological Care Unit**
Contact:	Utilization Specialist, ABI, Stroke and Neurological Care (416) 461-8252 ext. 2298
Capacity:	**Number of spaces:** 31 bed unit located on 4 South -- 19 High Intensity beds and 22 Reconditioning beds
Definition of ABI:	CHI, CVA and other acquired brain injuries of traumatic, vascular, neoplastic, hypoxic or infectious origin.
Program Description:	• program provides assessment, treatment, and coordination with community based services • coordinates with patients, family members, case managers, family physicians, and others who can contribute to promoting a successful outcome following an ABI • integrated approach to the rehabilitation process • expected outcome is that the client will have attained realistic short term goals mutually set with the team, and that the client is functioning at an optimal level required for their proposed discharge environment
Admission Criteria:	• age 18 and above • must have rehabilitation potential • need for intensive rehab following a neurological insult • disability may range from mild to severe • medically stable and able to participate in therapy for several hours per day • psychologically ready to participate in active rehabilitation • must be functioning at Rancho Los Amigos Scale of at least Level V • attainable goals should be outlined in the application • discharge destination must be included on the application
Exclusion Criteria:	• severe behavioural problems unless accompanied by privately funded behaviour specialist • medically unstable such that participation not possible • presence of severe cognitive deficits, significant neglect inattention or judgement that impedes progress with rehabilitation • brain injury event is not recent (greater than 1 year) • restraints/constant care provider in use
Admission Process:	**Referral within the Network:** • completion of application • application to ABI Network Office • application forwarded to program • review of application by program staff **Other Referrals:** • pre-admission assessment completed/compiled by referring agency • could suggest a pre-admission tour for family if time permits
Discharge Criteria:	• safe and appropriate discharge plans
Funding:	Ministry of Health and Long-Term Care, Institutional Division

Program details subject to change. Last reviewed: April 2019

Toronto abi Network

Descriptions of Programs/Services of Member Organizations

	BRIDGEPOINT SINAI HEALTH SYSTEM 14 St. Matthews Road Toronto, Ontario M4M 2B5
Program or Service:	**Outpatient Neurological Rehabilitation Program**
Contact:	Kim Meighan, Case Manager (416) 461-8252 ext. 2278 Ambulatory Care Reception, Extension: 2371
Capacity:	Based on services required. Waitlist is used.
Definition of ABI:	• CHI, CVA and other acquired brain injury of traumatic, vascular, neoplastic, hypoxic or infectious origin.
Program Description:	• Short-term intensive outpatient neuro-rehab services offered by an inter-professional team of health professionals. Services available include Physiotherapy, Occupational Therapy (including Vocational Rehabilitation Services), Speech Language Pathology, Social Work, Nursing, and Physiatry. Access to Neuropsychology is available as per internal team request. • Therapeutic groups and 1:1 rehab options available
Admission Criteria:	Client must: • be 18 years of age or older • be medically stable • have a 'recent' (usually within 12 months) diagnosis of CHI, CVA and other acquired brain injury of traumatic, vascular, neoplastic, hypoxic or infectious origin. • have active and realistic rehab goals (documented on referral form) • be able to participate in an active rehab program, and attend regularly scheduled appointments • have the potential to improve with a short-term intensive program • have regular transportation to/from the hospital, which has been arranged prior to the first visit • be continent or able to manage incontinence • be followed by a physician (i.e., referring physician or family physician) • be accompanied by a family member, friend or attendant, if there are significant cognitive and/or behavioural concerns
Exclusion Criteria:	• Client is medically unstable such that participation is not possible • Client is unable to manage incontinence • Client has severe behaviour problems (i.e., physical / verbal aggression, substance abuse, unstable psychiatric disorders) and who are unaccompanied • Client is unable to attend regularly scheduled appointments at least x2 weekly. • Clients requires a general maintenance rehab program • Client has already participated in an outpatient ABI program for the same injury
Admission Process:	**Referral within the Network:** • Completion of ABI Client Community Profile • Profile to ABI Network Office • Referral forwarded to program • Program reviews referral and screens for suitability. Eligible referrals are triaged to waiting list. **Other Referrals**: • Completion of the GTA Rehab Network – Outpatient/Ambulatory Care Referral Form http://www.gtarehabnetwork.ca/outpatient-ambulatory
Discharge Criteria:	• Client has achieved/near completion of short-term goals (as per referral/admission criteria) • Client has reached maximum potential within the active rehab program • Client has repeated absences from scheduled appointments and/or not willing to participate

	• Client admitted to another facility (e.g. inpatient/acute care or outpatient program) • Community services able to address ongoing needs of client and family
Funding:	Ministry of Health and Long-Term Care

Program details subject to change. Last reviewed: April 2019

Toronto abi Network

Descriptions of Programs/Services of Member Organizations

	CENTRAL LHIN HOME AND COMMUNITY CARE, ABI PROGRAM 1100 Gorham Street Unit 1, Newmarket ON L3Y 8Y8
Program or Service:	**ABI Program**
Phone:	905-895-1240 or 416- 222-2241
Contact:	ABI Care Coordinator, North of Steeles at Ext. # 5121 ABI Care Coordinator, South of Steeles at Ext. # 5181 Manager, Home and Community Care at Ext. # 4232
Capacity:	Central Adult ABI caseload is approx. 80 patients across 2 caseloads
Definition of ABI:	Damage to the brain which occurs after birth and is not related to a congenital disorder or a degenerative disease. A **traumatic brain injury** is caused by a motor vehicle accident, a fall, an assault or a sports injury. A **non-traumatic brain injury** could be caused by medical conditions such as anoxia, aneurysm, infection, brain tumour or a stroke. (Ontario Brain Injury Association)
Program Description:	• Active rehabilitative program provided by an interdisciplinary team including Occupational Therapy, Physiotherapy, Speech and Language Therapy and Social Work. • Rehabilitation Therapists are speciality trained in ABI Cognitive Retraining. • Behavioural Therapy and Psychological Therapy are available. • ABI trained Personal Support Workers provide personal care in addition to facilitating client's independence in self-care and activities of daily living. • Dedicated ABI caseload for adults 16 years of age and over**.** • ABI Care Coordinator works in consultative model with external partners including community agencies, school boards, hospitals and outpatient programs/adult day programs. Consultation is also provided to Central LHIN in house staff by ABI Care Coordinator for patients with brain injury receiving services on community, palliative support, mental health and paediatric caseloads. • ABI patients are eligible to receive all other non-ABI speciality services provided by Central LHIN Home and Community Care including Nursing, Dietician, therapies and Personal Support Services • Partnering with ABI and non-ABI community agencies to re-integrate client into community and vocational services. Included but not limited to York Simcoe Brain Injury services (YSBIS), Brain Injury Services Simcoe (BISS), CHIRS, Cota, Day Programs, Vocational Counselling (Seneca) Ontario March of Dimes, Housing Programs, and Hospital Partners (Holland Bloorview, West Park Hospital, St. Michaels Hospital, Toronto Rehab/UHN, Hospital for Sick Children, Hamilton Health Science ABI Program) • Participate with advisory boards including Toronto ABI Network Advisory Committee and Central LHINs ABI Collaborative • ABI Care Coordinators coordinate and chair bimonthly meetings with interdisciplinary service provider team to conduct patient case reviews, coordinate service planning and facilitate knowledge transfer. ABI Care Coordinator has membership on Head Injury Support Group and other community partners as required.
Admission Criteria:	• Resides in Central LHIN boundaries • Primary diagnosis of Acquired Brain Injury • Up to 5 years post diagnosis/injury. Over 5 years, assessed on an individual client basis. • Birth to 16 years of age assigned to Paediatric Caseload, over 16 years of age, assigned to Adult ABI Caseload. Central LHIN ABI services are available for clients up to the age of 64 years of age. • Functionally able to participate in an active rehabilitation program where severe behavioural issues are managed • Patient/family participate and consent to goal directed care planning to maximize patient independence and re-integrate into the community through cognitive and functional retraining

Descriptions of Programs/Services of Member Organizations

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- Patients with dual diagnosis and substance abuse are assessed for services on an individual case by case basis
- Primary location of service provision is client's home residence. Service requests for locations other than client's home, such as Group Homes, Long-term Care Facilities, Day Programs, Schools, are assesses in consultation with ABI Care Coordinator

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<tr><td>Exclusion Criteria:</td><td colspan="2">

- Patients behaviour that prevent or compromise their ability to attain rehabilitation goals (substance abuse, dual diagnosis)
- Acquired brain injury caused by degenerative neurological diagnosis (Alzheimer's Disease, Parkinson's Disease, Multiple Sclerosis) or developmental delay (Cerebral Palsy) and/or progressive brain tumours/lesions where ABI rehab is not the focus of treatment/intervention

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<tr><td>Admission Process:</td><td>

Referral within the ABI Network:

- All hospital referrals require in-hospital Rehab Therapists Reports including ABI Profile, Neuropsychologist report if available
- Central LHIN receives Profile from ABI Network
- Chart opened in Central LHIN, identifying client as ABI
- Patient assigned to ABI caseload and services ordered requesting ABI providers as appropriate
- Patient identified as ABI are not waitlisted for ABI services
- ABI Care Coordinator completes home visit to client within 14 days to assess status (completes RAI-HC), realign service plan with treatment goals
- ABI providers visit frequency established to meet clients needs, usually once weekly in consultation with ABI Case manager, client and family
- Joint interdisciplinary case conference completed in-home within 3 months of admission includes ABI Care Coordinator, ABI Service Providers and patient/family to assess progress, adjust service plan/goals

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Other Referrals (outside the ABI Network):

<u>Referrals from hospitals:</u>

- an in-hospital Care Coordinator completes patient eligibility assessment, establishes service plan and sets up services prior to patients discharge home from hospital

<u>Referrals from the community:</u>

- Referral made by patients, family, and physicians to Central LHIN Contact Centre, via telephone or fax. Office Care Coordinators opens a client file requesting assessment by ABI Care Coordinator
- ABI Care Coordinator completes a home visit to patient to complete assessment for eligibility, establish service plan and orders services
- Patients identified as ABI are not waitlisted for ABI services
- Service plans established with patients/family/substitute decision makers in consultation with physician and referral source
- patient referred and linked to community ABI programs (i.e. CHIRS, YSBIS, vocational rehabilitation) and non-ABI programs as appropriate
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<tr><td>Discharge Criteria:</td><td colspan="2">

- When patient has met therapeutic rehabilitation goals
- Patient may be transferred to regular Central LHIN caseload if ABI rehabilitation goals have been met and has remaining goals that can be addressed on regular caseload

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<tr><td>Funding:</td><td colspan="2">Ministry of Health and Long-Term Care</td></tr>
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Program details subject to change. Last reviewed: June 2019

Toronto abi Network

Descriptions of Programs/Services of Member Organizations

	COMMUNITY HEAD INJURY RESOURCE SERVICES OF TORONTO (CHIRS) 62 Finch Avenue West Toronto, Ontario M2N 7G1
Program or Service:	**Community Support Services, Residential Services, Adult Day Services, Neurobehavioural Intervention, Clinical Groups, and Neuropsychological Assessment**
Contact:	Intake Team: (416) 240-8000 Fax: (416) 240-1149 E-mail: intake@chirs.com Website: www.chirs.com
Definition of ABI:	Brain injury is non-degenerative and non-congenital in nature.
Program Description:	**Community Support Services:** ► **Ashby Community Support Services:** case management and individualized community support services geared to the needs & goals of the individual: • support with activities of daily living and community living skills • Support to engage with community and develop a structured schedule of productive activity • education support in partnership with special needs department of schools • neuropsychiatric assessment and consultation • neuropsychological assessment and consultation • vocational services including development of job readiness skills, job preparation, job search and job coaching. • social work services • individual and family counselling • educational and therapeutic groups • family support group ►**Clinical groups** cTech (use of technology), Living Well with a Brain Injury, Men's group, Positive Psychology, Skills for Emotional Well Being. ► **Aging at Home Program** Offers same supports as above to individuals living with an aging care giver with an enhanced focus on respite for the family. **Specific Program Eligibility:** Client must be living with an aging care giver (age 55 or older) ►**Neurobehavioural Intervention Program:** Specialized service through Community Support Services that focuses on individuals with co-occurring ABI and addictions and/or mental health issues. **Services Include:** • comprehensive functional assessment in the home and the community **Adult Day Services:** **Hours of operation**: 9:00 a.m. to 9:00 p.m. Monday to Thursday and 8:30 a.m. to 4:30 p.m. on Friday • social/recreation programs at CHIRS Head Office and in the community • various special events, including one weekend event/month, theme weeks and workshops • Drop-in available Monday to Friday 8:30 a.m. to 4:30 p.m. • lunch offered daily at a minimal cost • Peer mentorship program: clients help run the Drop-in, lunch program and recreation programs **Specific Program Eligibility:** Client must be able to participate with group support only, and be independent for personal care/ travel OR arrange their own 1:1 support as needed. **Residential Services:** • based on variable support model ranging from 24-hour on-site support to 24 hour access to support • 3 sites - a fully accessible bungalow in Etobicoke (St. George's) (7 participants); supported living apartments in Scarborough (Aldebrain Towers) with 22 participants in 1-, 2- and 4-bedroom units; and Finch residence with 5 apartments.

Descriptions of Programs/Services of Member Organizations

	• Intensive case management and individualized community support services geared to the expressed needs & goals of the individual • 1:1 addiction counselling related to substance use if required • Access to SUBI (substance use and brain injury) group	**Neuropsychological Assessment Services:** Assessments are designed to identify possible challenges with brain functioning, define strengths and weaknesses and help guide treatment and service delivery. **This service is directed towards individuals who:** • have a history of trauma sufficient to suspect complicated mild to severe brain injury. • have had no neuropsychological testing in the past 2 years.
Admission Criteria:	• Have a moderate to severe brain injury • Be between the ages of 18 and 60 on the date that services commence (Note: Neuropsychological Assessment Services accepts individuals who are 18 years of age and older) • Reside in Toronto or York Region (Aging at Home Program only), but may waive this criterion if individual is able to travel to CHIRS programs and comparable services are not offered in their area • individual is expected to benefit from services Please also see specific program eligibility criteria	
Exclusion Criteria:	None where admission criteria are met.	
Admission Process:	• referral by self or other • completion of ABI Community Profile referral form through the Toronto ABI Network • review of documentation, screening interview, then review by intake committee	
Discharge Criteria:	CHIRS provides long term support as long as the individual's needs can be adequately met by available resources and the individual continues to benefit from services.	
Funding:	Subsidized services: Ministry of Health and Long-Term Care through the Local Health Integration Network Fee-for-Service: Funding arranged through third party payer	

Program details subject to change. Last reviewed: April 2019

Toronto abi Network

Descriptions of Programs/Services of Member Organizations

	COTA 550 Queen Street East, Suite 201 Toronto, Ontario M5A 1V2
Program or Service:	**ABI Case Management Services; ABI Behaviour Supports Program; ABI Supportive Housing; ABI Adult Day Services**
Contact:	Venky Rao (416) 785-9230 ext. *8766*
Definition of ABI:	Major interruption of brain function occurring after birth, unrelated to a congenital disorder or degenerative disease; the injury typically results from an external trauma or an internal occurrence (i.e., tumour, stroke or aneurysm).
Program Description:	**ABI Case Management Services:** The Acquired Brain Injury (ABI) Case Management program provides individual support services to clients with acquired brain injuries in the city of Toronto and the southern portion of York Region. Our ABI Case Managers work collaboratively with their clients by providing client-centred supports which help them to access community resources/services and to assist them to live fulfilling lives in the community. **Behaviour Supports Program**- Behavioural Supports are available to clients that apply for services less than 5 years post injury if they have an ABI and challenging behaviours. Eligible individuals will be supported by an ABI Case Manager who will be responsible for coordinating their care. The Behavioural Supports will be individualized for each client, but the service plan may include 1) a psychological assessment, 2) brief interventions from a psychologist, and 3) in-home support from a behaviour therapist and/or individual support worker. The services will be goal based. As necessary, clients will also be referred to Home and Community Care for ABI rehab services such as Occupational Therapy, Physiotherapy and Speech-Language Therapy. **ABI Supportive Housing:** Cota's Acquired Brain Injury services include a supportive housing program located near the intersection of Yonge Street and College Street in downtown Toronto. This program provides rent-geared-to-income accommodation and supports. The program can accommodate up to 20 residents. Each resident lives in a bachelor apartment and shares a communal kitchen with other residents. The goal of the program is to assist residents with activities of daily living and other individualized goals so that they can maintain their housing and optimize their quality of life. **ABI Adult Day Services:** The ABI Adult Day Services program offers supportive and creative group environments for people with an ABI to engage in meaningful day-time activities, explore strengths, and develop new/diverse skills. ABI Adult Day Services is designed to act as a stepping stone to personal recovery and community inclusion. As such, we encourage members to define their goals and help shape activities to meet those goals.
Admission Criteria:	• Must have an acquired brain injury • 16 years of age and older • For the ABI Case Management Services, individuals must live within the city of Toronto (North York, Scarborough, Etobicoke, downtown Toronto) or the southern portion of York Region. • For the Behaviour Supports Program, individuals must be less than 5 years post injury and they must live within the boundaries of Toronto Central LHIN.
Exclusion Criteria:	• Individuals that are under the age of 16 years. • Individuals whose primary diagnosis is a congenital disorder, a neurodegenerative disorder or a concussion.

Descriptions of Programs/Services of Member Organizations

Admission Process:	**Referral within the Network:** • Completion of ABI Client Community Profile • Send Profile to ABI Network Office • Profile forwarded to program • Review of Profile by program staff • Screening assessment to determine eligibility and client's interest in our services Please note that the ABI Supportive Housing Program only holds a small waitlist due to the limited number of vacancies that become available over time. Thus, we do not accept new referrals on an ongoing basis.
Discharge Criteria:	• Dependent upon client's goals
Funding:	• Ministry of Health and Long-Term Care, Toronto Central LHIN and Central LHIN.

Program details subject to change. Last reviewed: April 2019

Descriptions of Programs/Services of Member Organizations

	HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL 150 Kilgour Road Toronto, On Canada M4G 1R8
Program or Service:	**Brain Injury Rehabilitation Team (BIRT), Inpatient or Day Program Service**
Contact:	Cindy Ruelens, Intake/ Coordinator 416-425-6220 ext. 6030 Inpatient/Day Program Referral Form
Capacity:	**Number of spaces:** 18 inpatient/day patient
Definition of ABI:	Any brain injury as a result of traumatic or non-traumatic causes
Program Description:	The Brain Injury Rehab team serves clients aged 3 months to 18 years who require rehabilitation following an acquired brain injury. An interdisciplinary team provides collaborative assessment and intervention for children and adolescents by facilitating return of function, development of compensatory skills and assisting reintegration into the family, school and community at the child's optimum level. Rehabilitation following a brain injury is a complex multifactorial process and the inpatient stay is only one stage of the journey to recovery. Clients can continue to make gains as they transition into the community. There are two streams of acquired brain injury (ABI) inpatient rehabilitation programs: Rehabilitation Stream and Restorative Stream. Children who are admitted into the Restorative Rehabilitation Stream can transition to the Rehabilitation Stream when able to participate in active rehabilitation and/or transition to home. See Admission Criteria for more information on each stream.
Admission Criteria:	• Rehabilitation Stream • Presents at Level lV and higher on Rancho Los Amigos Scale: Confused and agitated without targeted aggression. The client is confused and does not make sense in conversation but may be able to follow simple directions. Stressful situations may provoke some upset, but again agitation is no longer a major problem. Clients may experience some frustration as elements of memory return. • Presents with new moderate to severe functional deficits (physical and/or cognitive) • Requires two or more professional services (OT/PT/SLP) • Requires medical and nursing care • Medically stable with a plan in place for discharge post rehab (i.e. stable vital signs, stable tracheostomy); an onsite or OTN review maybe required • Expected participation in a school program and therapeutic playroom activities • Appropriate services are not available closer to home • Need to be off tube feeds and IV's for at least 4 hours a day so they can participate in rehabilitation • No longer ventilator dependent • Not a danger to themselves or others • No drug or alcohol dependency • • Restorative Stream • Presents at Level lll on Rancho Los Amigos Scale: demonstrate a localized response but which may be inappropriate or early Level IV: demonstrates confusion, disorientation and may present with agitated, aggressive or inappropriate behaviour • An onsite or OTN review will be required. • Presents with complex cognitive, physical and nursing needs • Has attention and responsiveness for a minimum of a 30 minute session, twice per day • Demonstrates meaningful responses to their environment • Expected participation in a school program and therapeutic playroom activities • Medically stable with a plan in place for discharge post rehab (i.e. stable vital signs, stable tracheostomy) • Appropriate services are not available closer to home

	• Need to be off tube feeds and IV's for at least 4 hours a day so they can participate in rehabilitation • No longer ventilator dependent • Not a danger to themselves or others • No drug or alcohol dependency
Exclusion Criteria:	
Admission Process:	**Referral within Network:** • Submit Holland Bloorview Kids Rehab referral • Copy of profile to Toronto ABI Network office • Decision within 48 hours (2 working days) **Other Referrals:** • Complete and submit Holland Bloorview Kids Rehabilitation Hospital referral • Decision within 48 hours (2 working days)
Discharge Criteria:	• Achievement of target goals • Plateau in areas of concern • Community services able to address ongoing needs of client and family
Funding:	Ministry of Health and Long-Term Care

Program details subject to change. Last reviewed: March 2014

	HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL 150 Kilgour Road Toronto, On Canada M4G 1R8
Program or Service:	**Brain Injury Rehabilitation Team (BIRT) Out Patient Services**
Contact:	Central Registration (416 425-6220 ext. 6460) Outpatient Referral Form
Capacity:	Based on services required on intake and FTE attached to this service. Waitlist may be utilized.
Definition of ABI:	Any brain injury as a result of traumatic or non-traumatic causes
Program Description:	• Comprehensive medical follow up and out patient services for clients recovering from a brain injury at home. Services may be offered individually or in a group/workshop format • Holland Bloorview Kids Rehabilitation Hospital is a paediatric treatment centre for Metro Toronto and a provincial resource for community consultation, education and development
Admission Criteria:	• Must be 3 months to 18 years • Medically stable • Presents with moderate to severe functional deficits (physical and/or cognitive) • Medical referral to Follow Up Clinic is required prior to accessing any BIRT outpatient services • Have rehabilitation goals and willingness to participate in rehabilitation programs • Live within the Toronto Area • Need to be off tube feeds and IV's for at least 4 hours a day so they can participate in rehabilitation • No longer ventilator dependent • Not a danger to themselves or others • No drug or alcohol dependency
Exclusion Criteria:	
Admission Process:	Fax medical referral to Registration Services, (416) 422-7036

Discharge Criteria:	• Achievement of target goals • Plateau in areas of concern • Community services able to address ongoing needs of client and family
Funding:	Ministry of Health and Long-Term Care

Program details subject to change. Last reviewed: March 2014

	HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL 150 Kilgour Road Toronto, On Canada M4G 1R8
Program or Service:	**Persistent Concussion Clinic**
Contact:	Intake Coordinator (416 425-6220 ext.3239) Central Registration (416 425-6220 ext. 6460) Outpatient Referral Form
Capacity:	Based on services required on intake and FTE attached to this service. Waitlist may be utilized.
Definition of ABI:	Any concussion or mild brain injury as a result of traumatic causes
Program Description:	Comprehensive medical follow up and outpatient services for clients recovering from a concussion at home. Services may be offered individually or in a group/workshop format Concussion and You Education Sessions are offered on a regular basis, and open to clients and families Registration for Concussion and You Education Holland Bloorview Kids Rehabilitation Hospital is a paediatric treatment centre for Metro Toronto and a provincial resource for community consultation, education and development.
Admission Criteria:	• Must be 3 months to 18 years • Medically stable • At least four weeks post-concussion • Symptoms related to the concussion persist • Unable to return to school activities or sport • Medical referral to BIRT Outpatient Services is required • Have rehabilitation goals and willingness to participate in rehabilitation programs • Not a danger to themselves or others • No drug or alcohol dependency
Exclusion Criteria:	
Admission Process:	Fax medical referral to Registration Services (416) 422-7036
Discharge Criteria:	• Achievement of target goals • Plateau in areas of concern • Community services able to address ongoing needs of client and family
Funding:	Ministry of Health and Long-Term Care

Program details subject to change. Last reviewed: January 2016

Descriptions of Programs/Services of Member Organizations

	MARCH OF DIMES CANADA – REGIONAL OFFICE 13311 Yonge Street, Ste 202 Richmond Hill, ON L4E 3L6
Program or Service:	**Community Support Services – Supportive Housing (Toronto & Newmarket), Group/Day programs (York region), Case Management and Outreach Rehab Support (York region)**
Contact:	Joanne Dick , Independent Living Resource Worker (905) 773-7758 ext 6216 or jdick@marchofdimes.ca
Capacity:	**Supportive Housing** Newmarket 9 spaces shared and single occupancy **Supportive Housing** Toronto 5 spaces single occupancy **Group/Day programs** York Region and Simcoe County – group size varies **Case Management and Outreach Rehab** York Region – case load varies based on need
Definition of ABI:	Damage to the brain which occurs after birth as a result of a traumatic or non-traumatic event and is not related to a congenital or a degenerative disease.
Program Description:	**Supportive Housing** Individualized support within a 24 hour program model, with activities of daily living, community orientation and recreation activities. Clients are supported to acquire new skills and develop strategies for community integration in consultation with a range of professionals including Behaviour Consultant and Neuropsychiatrist. **Peer Groups** Provides a safe and supportive atmosphere in which to learn coping strategies with peers, explore ABI education and opportunities to participate in social/recreational events. *Participants are responsible for travel and any personal support required **Day program – Aphasia and Communication Disabilities** The program is supported by Speech Language pathologists, Communicative Disorders Assistants and trained volunteers who encourage learning and use of supportive communication strategies (written key words, interactive drawings, gestures) to optimize language abilities. **Case Management (Partnership with Mackenzie Health) & Outreach Rehab Support** The program incorporates comprehensive functional behaviour assessments to evaluate the effects of brain injury and an individualized plan is developed with recommendations for community support to promote acquisition of skill and strategies for re-integration. Program team includes Behaviour Consultant and Neuropsychiatrist.
Admission Criteria:	Basic criteria for ABI programs - 16 years or older, Ontario Resident insured under OHIP & Documented ABI. Aphasia and Communication Disabilities program – 18 years or age or older living with Aphasia or other acquired communication disabilities due to stroke or brain injury. More details Re: Admission criteria– please contact Joanne Dick @ jdick@marchofdimes.ca
Exclusion Criteria:	None where admission criteria are met.
Admission Process:	Referral by self or other. Completion of ABI Client Community Profile if a referral made through the TO ABI Network Completion of MODC ABI Application for services if referral made directly to MODC. Contact Joanne Dick at (905) 773-7758 ext 6216 or jdick@marchofdimes.ca or visit our website for application www.marchofdimes.ca Review of documentation, Applicant Interview and review by Internal Intake Committee.
Discharge Criteria:	MODC may discharge if the individual no longer meets the eligibility criteria, if needs change to the extent that available resources are no longer adequate or if the individual discontinues service
Funding:	Central and Toronto Central LHIN & Fee for Service options

Descriptions of Programs/Services of Member Organizations

	Mind forward Brain injury services – Previously Peel Halton Dufferin Acquired Brain Injury Services (PHDABIS) 176 Robert Speck Parkway Mississauga ON, L4Z 3G1 www.PHABIS.com
Program or Service:	Rehabilitation and support services for adults with ABI
Contact:	Ashley Budd, Interim Clinical Services Manager: (905) 949-4411 ext. 240 Fax: (905) 949-4019 Mariana Ljuljdjuraj, Clinical Services Coordinator (Intake): (905) 949-4411 e Keitha McNeil, Interim CEO (905) 949-4411 ext. 232
Capacity:	Assisted Living Services - 25 clients Day Programming (Mississauga, Oakville, Orangeville) – 200+ clients ABI Seniors Services – approximately 50 clients (in home, LTC and hospital) Supported Independent Living – 35-40 clients Caregiver Services – 100+ caregivers
Definition of ABI:	Brain injury that is non-degenerative and non-congenital in nature.
Program Description:	**I.** Mind Forward Clinical Services include neuro-psychiatric and psychological assessment and support. **II.** The Mind Forward programme currently comprises 5 service streams: 1. **Assisted Living Services** - supportive housing in: Transitional Residence for Specialised Learning (TRSL), PHD West, Conover, Britannia Place, Windsor Hill (24 hour staffing) 2. **Day Programme Services** – (Mississauga, Oakville, Orangeville) open concept environments, individuated programmes and group/ modular activities addressing therapeutic recreation, life skills, vocational and psychosocial issues 3. **Community Services –** SIL (Supported Independent Living), Senior's Services 4. **Outreach Services** - Case Management/ co-ordination and community crisis support 5. **Clinical Services** – Neuro-psychiatric/ psychological support and assessment, Psychosocial Support Groups (CBT, Anger Management ect.)
Admission Criteria:	To receive service an individual must: • Have a primary diagnosis of an Acquired Brain Injury (ABI) • Be 16 years of age and over • Live or choose to travel to the region of Peel, Halton, or Dufferin County • Be an active participant in achieving mutually agreed-upon goals • Be medically stable • Be free of psychiatric or behavioural symptoms of an order that would preclude the individual from being able to participate in mutually agreed upon goals.
Exclusion Criteria:	If an individual does not coincide with Admission Criteria
Admission Process:	Download an application at www.PHABIS.com
Discharge Criteria:	
Funding:	MH LHIN, CW LHIN thorough MH LHIN, Ministry of Health and Long Term Care

Program details subject to change. Last reviewed: March 2019

Descriptions of Programs/Services of Member Organizations

	PACE INDEPENDENT LIVING 970 Lawrence Ave. West #210 Toronto, Ontario M6A 3B6
Program or Service:	ABI Supportive Housing–(Edwards Manor: 24 hours, 7 days a week), Adult Day Services(The Paula Cassin Learning Center: Tuesday-Saturday 9:00 am-4:00 pm) Community Program: Monday-Friday 9:00 am-5:00 pm
Contact/Phone:	Jackie Wilson (Program Manager) 416 789-7806 ext. 314 JLWilson@pace-il.ca
Capacity:	Supportive Housing: 10 individual studio apartments Adult Day Services: based on services required Community Program: based on services required
Definition of ABI:	Brain injury that is non–degenerative and non-congenital in nature
Program Description:	The **Edwards Manor** project is our Supportive Housing project for adults living with the effects of an acquired brain injury (ABI). This is an integrated community apartment complex in south Etobicoke where PACE provides 24 hour support to these individuals living in their own studio apartment, Support services include personal, general and wellness assistance. Specific to ABI support, enhanced services are provided that are customized to address individual life skill, cognitive and behaviour needs We work with each individual to set goals that determine the scope of the individual supports to be provided. Individuals learn or relearn ways to live independently again. **The Paula Cassin Learning** Center is our Adult Day Program * Social and educational, goal-oriented activities for people living with the effect of an acquired brain injury in a group setting for part of the day* helps to support family/caregiver who provide day–to-day care. Workshops vary but mostly focus on development of learning skills- computer, social interaction, cooking and health and wellness* program sessions of 10-12 weeks **Community Program**: We work with our client to develop tailored supports and strategies to facilitate their success in reaching their goal(s). Following the assessment process, recommendations and a plan for specific individualized service needs and goals are developed. Depending on the goals that have been established, the length of the program could e 6-12 weeks long. Further assessments maybe conducted on an as-needed basis. Service is provided in the home, community, school or workplace once or twice a week (depending on the needs)
Admission Criteria:	PACE ABI Programs offers short and long term community-based support services to adults 18 years of age and over living with the effects of an acquired brain injury (ABI). We work with individuals to support their lives in the community Supportive Housing (Edwards Manor): • persons who have sustained a mild or moderate brain injury (must provide medical documentation confirming diagnosis) and in need of a long term supported living environment • Are able to interact safely when out in the community • age 45 and up as required by the landlord, Toronto Community Housing • must be medically stable and not present a risk of harm to themselves and others • must be able and willing to identify and participate in short and/or long term goals and make a commitment to the program Adult Day Services: • person must have sustained a brain injury • age 18 years and up • be able to learn in a group environment • must be able to identify learning goals and work towards using learned skills in their home environment

	• must be independent for personal care including incontinence **Community Program**: • must be at least 18 years old • be able to work on short and/or long term goals and to make a commitment to the program • Not present a risk of harm to themselves or others • Be ble to interact safely when out in the community
Exclusion Criteria:	• Client has severe behavioural challenges (physical, verbal, aggression, substance abuse, wander) which precludes their participation in the program and integration into the community and may present imminent harm to self and others. • Client is medically unstable • Client has a progressive or degenerative disease • Client is not able or willing to participate in goals • Client has high-risk physical conditions which would require on-site, intensive medical/nursing observation and treatment
Admission Process:	**Referral within the Network**: Completion of ABI Client Community Profile application **Referral by self or other** Intake interview to establish appropriateness of program for the client
Discharge Criteria:	Noncompliance with Client Service Agreement Client decides to discontinue the Program Client no longer meets the eligibility criteria, if clients needs change to the extent that available resources are no longer adequate.
Funding:	Ministry of Health and Long Term Care through the Toronto Central LHIN

Program details subject to change. Last reviewed: April 2019

Descriptions of Programs/Services of Member Organizations

	ST. MICHAEL'S HOSPITAL 30 Bond Street Toronto, Ontario M5B 1W8
Program or Service:	**Trauma and Neurosurgery Program – Regional Trauma Centre**
Contact:	Mary Copeland, Clinical Leader Manager (416) 864-6060 x. 5113
Definition of ABI:	TBI, non-traumatic ABI (includes aneurysms, tumours, AVMs)
Program Description:	• Provides care to acutely ill patients with multisystem traumatic injuries and those requiring neurosurgical management • Includes an intensive care unit and an inpatient unit • Patients fall within two services – trauma or neurosurgery – depending on injury classification • Full complement of health disciplines staff (PT, OT, SLP, SW, RD, Pharm, Chaplaincy); includes Case Managers and NPs • Access to other internal specialized care teams as required • Daily rounds to discuss patient care plan • Affiliated internal Head Injury Clinic for outpatient follow up as required
Admission Criteria:	• Most trauma patients are admitted through Emergency Department • Large number of trauma patients being referred from across the province (provincially designated trauma centre) • Neurosurgical admissions through Emergency Department, direct from neurosurgeons, and from other agencies; direct admission to ICU also possible
Exclusion Criteria:	None
Admission Process:	• Usually through emergency department, or through elective surgical admission • Head injury diagnosis is made together by team, to facilitate referral to appropriate services
Discharge Criteria:	• Ultimate goal to is to ensure patients are receiving appropriate treatment in most appropriate setting; once medically stable, and no longer requiring specialized trauma/neurosurgery care, patients are repatriated back to sending/home hospital or alternate level of care is pursued based on each patient's needs • Potential discharge destinations include: other tertiary centre if indicated, home or referring hospital, home (with or without home care supports), outpatient rehabilitation, inpatient rehabilitation, complex continuing care, long term care, palliative care and respite care. • Please note that these discharge destinations will be determined through discussion between the health care team and the patient and their family, and will be based on the patient's goals and care needs.
Funding:	Ministry of Health and Long-Term Care, Institutional Division

Program details subject to change. Last reviewed: May 2016

Descriptions of Programs/Services of Member Organizations

	ST. MICHAEL'S HOSPITAL 30 Bond Street Toronto, Ontario M5B 1W8
Program or Service:	**Trauma and Neurosurgery - Head Injury Clinic (HIC)**
Contact:	Alicja Michalak - Clinical Coordinator (416) 864-5520 Head Injury Clinic Office: (416)-864-6060 Ext.4639 Office Hours: Monday, Wednesday to Friday: 8:00 AM to 4:00 pm Clinic Location: 3rd Floor Donnelly Wing South
Capacity:	The St. Michael's Hospital Head Injury Clinic (SMH HIC) was established in 1987 to assess and treat patients who suffered a traumatic brain injury. The Head Injury Clinic is the largest of its kind in Ontario, over 2000 patient visits per year
Definition of ABI:	Acquired traumatic brain injury
Program Description:	• The HIC aims to provide consultation, management, and treatment to patients who have sustained mild and moderate Traumatic Brain Injury (TBI) • The clinic ensures patients receive appropriate access to services, as well as accurate information related to mild and moderate (TBI) management to guide them in their recovery • The clinic is run by a multidisciplinary team including physiatrists, neuropsychiatrist, neuro-otolaryngologist, clinical coordinator, social worker, cognitive speech-language pathologist, research associate, and student research volunteers Goals of the Head Injury Clinic: o Early intervention for patients who have sustained mild and moderate (TBI) to prevent patients from developing chronic post-concussive symptoms o To provide consultation, management, and treatment for patients who have sustained mild and moderate (TBI) o To ensure patients receive appropriate information and access to services o To collaborate with other providers across the system to best meet patient's needs
Admission Criteria:	• The mandate of the clinic is to provide follow up treatment and care to St. Michael's Hospital's patients who have suffered mild and moderate (TBI) • Patients are referred directly from the Emergency Department, Trauma- Neurosurgery Department or from Family Practice at St Michael's Hospital
Exclusion Criteria:	• Non -traumatic brain injuries • Injuries that occurred more than 1 year ago • Inpatients of Toronto Rehabilitation Institute (TRI), Bridgepoint Health and West Park Health Centres
Admission Process:	• Through the SMH Trauma & Neurosurgery Program, the SMH Emergency Department & the SMH Family Practice
Discharge Criteria:	• When the patient has reached maximum recovery and /or has a treatment team in place and/or back to pre-morbid activity level whenever possible • At the discretion of the treating physician and HIC team
Funding:	Ministry of Health and Long-Term Care

Program details subject to change. Last reviewed: June 2019

Descriptions of Programs/Services of Member Organizations

	SUNNYBROOK HEALTH SCIENCES CENTRE 2075 Bayview Avenue North York, Ontario M4N 3M5
Program or Service:	**Trauma Program/Regional Trauma Centre**
Contact:	Elise Goldberg, Occupational Therapist (416) 480-6100 ext. 4187 (C5 ward unit)
Definition of ABI:	Traumatic brain injury, intracranial hemorrhage
Program Description:	As an integral part of Sunnybrook Trauma, Emergency and Critical Care Program, the Trauma unit cares for acutely ill patients with multisystem, traumatic injuries. These injuries can result from falls, motor vehicle crashes, assaults, work related and sports injuries. Many teams of physicians may care for a single patient depending on the complexity of their injuries. Patients requiring neurosurgical intervention such as those with traumatic brain injury may be cared for on two levels of intensive care units and the ward, C5. The primary focus of care on C5 includes assessment of functional status, intervention, discharge planning, and communication within a patient-centered environment. The interprofessional team on C5 supports the philosophy and principles of patient-centered care, and the mission and values of Sunnybrook Health Sciences Centre – excellence, collaboration, accountability, respect, and empowerment. Typically patients on C5 are prepared for discharge home, inpatient rehabilitation, complex continuing care facility or another community care setting.
Admission Criteria:	• ☐ clients with ISS score of 16 or greater • ☐ any referrals by acute care hospitals • any admissions via the Emergency Room as per provincial trauma triage guidelines
Exclusion Criteria:	None
Admission Process:	• usually through emergency department, or by referral
Discharge Criteria:	• ☐ goal is to discharge when client is medically stable • ☐ if discharge to a facility (including inpatient rehab), generally Rancho Los Amigos Level III–VI, depending on admission criteria of receiving facility • generally, patient cannot have 1:1 care (ex. observer)
Funding:	Ministry of Health and Long-Term Care, Institutional Division

Program details subject to change. Last reviewed: June 2018

Descriptions of Programs/Services of Member Organizations

	SUNNYBROOK HEALTH SCIENCES CENTRE 2075 Bayview Avenue North York, Ontario M4N 3M5
Program or Service:	**Mild to Moderate Traumatic Brain Injury Clinic ~ Outpatient, Follow-up Clinic**
Contact:	Elke McLellan, TBI Clinic Coordinator Phone: (416) 480-4095 Fax: (416) 480-4613
Definition of ABI:	Traumatic brain injury, sustained through trauma – MVC, fall, sports, assault, etc.
Program Description:	Interdisciplinary team including a neuropsychiatrist, youth psychiatrist, physiatrist, neurologist and occupational therapist; with timely access to other SHSC physician specialists, clinics, adjunctive services and medical/diagnostic tests. The clinic utilizes an evidenced-based approach for the early assessment, diagnosis and management of physical emotional, behavioural, cognitive, and psychological symptoms following mild to moderate traumatic brain injury. Persistent symptoms that extend beyond the typical acute recovery period are managed. Our team provides the following range of services: • Assessment, diagnosis and management (pharmacological and non-pharmacological) of TBI and related sequelae • Early detection and management of factors that may impact recovery • Coordination of community supports and rehab services (OHIP and third party-funded) • Reintegration support for patients returning to work/school • Collaborative care with the primary care physician/team • Patient and family education • Follow up every 3 months, for up to one year .
Admission Criteria:	• Mild to moderate TBI • Age range 26– 65 for Adult Clinic, 14 – 25 for Adolescent /Young Adult Clinic • No geographical limits • Referrals must be received within 3 months of injury Referral to clinic is applicable if there is any period of loss of consciousness or alteration in mental state at the time of injury; loss of memory for events immediately before or after the injury; and persistent concussion symptoms with functional impairments in areas of occupational, academic or social functioning Due to the high demand for appointments, external referrals (patients who were not admitted or seen in SHSC emergency department) to the adult clinic must also have at least one of the following: positive findings on neuro-imaging studies; presenting GCS of equal or less than 14; skull, facial bone or cervical fracture The following documentation must be provided: • Referral letter/consult note with reason for referral • EMS, Emergency Room, Hospital Admission/Discharge reports, if available • Neuro-imaging reports, if applicable • Any other clinical notes, reports or relevant tests related to the subject injury
Exclusion Criteria:	• Referral more than 3 months post injury Severe TBI • Non-traumatic brain injuries • To avoid duplication of services individuals who receive inpatient ABI rehabilitation or who have been referred to other brain injury clinics or hospital ABI outpatient rehab

	programs will not be seen in the clinic. Those with individual symptoms that can be served by single services (e.g. headache, pain, eye, dizzy clinic, etc.) will not be seen in the TBI Clinic •
Admission Process:	• Physician referral is required. • Referrals received internally through trauma and emergency program, family and community medicine, other ambulatory clinics • The clinic also accepts external referrals from community physicians. Completion of ABI Community Profile referral form through the Toronto ABI Network. • Referral reviewed upon receipt, may also include telephone screening interview. Patients given appointment if above referral criteria and requirements are met Referring physician is notified of appointment.
Discharge Criteria:	Patients are generally followed in the TBI Clinic for up to one year, at which point reasonable and necessary community services should be well established, and care is then transferred to the community physician.
Funding:	Ministry of Health and Long-Term Care
Other:	The TBI Clinic also has a mandate to conduct on-going research in the assessment and treatment of mild to moderate TBI.

Program details subject to change. Last reviewed: April 2019

Descriptions of Programs/Services of Member Organizations

	TORONTO REHABILITATION INSTITUTE - UHN **University Centre** 550 University Avenue Toronto, Ontario M5G 2A2
Program or Service:	**Inpatient ABI Rehabilitation**
Contact:	Carmen Volpe, Service Coordinator, Neuro Cognitive Stream: (416) 597-3422 ext. 3593 Miranda Hong, Service Coordinator, Neuro Physical Stream: (416) 597-3422 ext. 3441
Capacity:	**Number of spaces:** 33 inpatient beds: 5 "slow stream" & 28 regular rehab
Definition of ABI:	• brain injury not progressive in nature, having occurred within 1 year of injury
Program Description:	• • Toronto Rehab continues to be a provincial leader in specialized ABI rehabilitation services. Our inpatient service is the only program within the GTA that aligns with ABI Best Practice Standards. We offer intensive rehabilitation on secured units across two floors and 33 beds. The *Neuro Cognitive* stream offers specialized care to patients whose primary needs relate to cognition and behaviour. The *Neuro Physical* stream provides care to patients who have experienced a significant reduction in their physical function, and who may also have cognitive and/or behavioural changes. Five beds are designated slow-to-recover for patients with particularly complex needs. Patients are placed into the appropriate stream dependent on functional presentation at time of referral by the service coordinators. • Note: the program also provides inpatient rehab services to patients with MS who have cerebral involvement (recent diagnosis or following a relapse/MS flare) • .
Admission Criteria:	• Primary diagnosis is traumatic and non-traumatic brain injuries (this may include benign tumours, infections, aneurysms and anoxic brain injuries). • Acquired brain injury has occurred within the first year of application for admission • Note: also accepts patients with a recent diagnosis of MS who have cerebral involvement or following a relapse/flare • Accepts referrals regionally, out-of-province and out-of-country, but the majority of referrals come from the Greater Toronto Area • Patient must demonstrate insight and potential for participating in the rehabilitation process and is expected to participate in all components of the program • Age range is generally 18 years of age and older. Younger referrals may be considered depending on patients goals. • Patient must be medically and psychiatrically stable in order to participate in an intensive rehabilitation program • If a patient has complex issues, a trial assessment may be required to determine if continuation in the program is recommended • Patients applying to slow stream should exhibit purposeful responses to the environment and be able to actively participate in a rehab session for a minimum of 30 minutes, 2-3 times/ day, 5-6 days/week • All patients must be oriented x 2 and demonstrate carry-over of new learning • For the Regular Stream, a minimum Rancho Los Amigo Scale level = 4-5 is required. for the Slow to Recover Stream, a minimum Rancho Los Amigo Scale level = 4 is required • admissions are determined on an individual basis
Exclusion Criteria:	• patients who do not participate in or agree to the inpatient rehabilitation process • patients with a progressive neurological condition as primary diagnosis (other than MS) • patients with severe behavioural disturbances such as aggression or severe anti-social behaviour which precludes their participation in the program and their integration into the unit • other behaviours which limit rehabilitation potential and participation, e.g. concurrent alcohol and/or drug misuse

	• patients not able to participate in intensive rehab due to medical or psychiatric conditions (unstable/active/acute psychiatric illness) requiring medical care/special needs/frequent medical appointments
Admission Process:	• Completed referral forms are submitted through Strata eReferral (RM&R). If no access to Strata eReferral (RM&R), please submit a completed GTA Rehab Network Integrated Acute Care to Bedded/ CCC Referral form via fax to the Toronto ABI Network • Toronto ABI Network forwards faxed applications to ABI program service coordinator for review • ABI program staff review faxed applications and referrals submitted via Strata eReferral (RM&R)
Discharge Criteria:	• upon completion or near completion of inpatient rehab goals • continued rehab goals are appropriate to be addressed in an outpatient setting • patient presents with any of the exclusionary criteria described above • patients who are inconsistently participating or who do not want to participate in active inpatient rehabilitation • if patient does not have a discharge location, he/she might be returned to the referring facility or to the care of his/her family
Funding:	Ministry of Health and Long-Term Care, Institutional Division

Program details subject to change. Last reviewed: April 2019

	TORONTO REHABILITATION INSTITUTE (2 SITES) **1. University Centre (UC)** 550 University Avenue Toronto, Ontario M5G 2A2 (University & Dundas) **2. Rumsey Centre (RC)** 345 Rumsey Road Toronto, Ontario, M4G 1R7 (Bayview & Eglinton)
Program or Service:	**Day Hospital/Outpatient Rehabilitation**
Contact	Vivien Poon, Outpatient ABI Service Coordinator Tel: (416) 597-3422 ext. 5321
Capacity:	18 – 22 at UC and RC
Definition of ABI:	• brain injury not progressive in nature, having occurred within 24 months of injury
Program Description:	• short term active outpatient rehabilitation for individuals requiring an interdisciplinary, goal-oriented approach addressing impairments in physical, perceptual, cognitive, communicative, and social domains

Admission Criteria:	• diagnosis of an acquired brain injury within 24 months of post onset with positive imaging findings on MRI and/or CT head
	• clients must require the intervention of at least 2 different therapy services (e.g., PT, OT, SLP, and/or SW)
	• clients must be clinically stable (mentally, physically and medically) to enable regular attendance and full participation in therapies (attend approximately 2 x/week for 1 – 3 hours per visit)
	• clients must have the capacity to benefit from a goal oriented, therapeutic program and demonstrate potential to improve through program participation
	• Clients require accompaniment if they:
	  • require assistance to safely arrive to the centre and/or to navigate the building
	  • require assistance with toileting,

Exclusion Criteria:	• medically unstable

Descriptions of Programs/Services of Member Organizations

	• uncontrolled alcohol/substance abuse which interferes with participation in an active outpatient rehab program • severe behavioural issues (i.e. physical/verbal aggression, substance abuse, unstable psychiatric disorders) • client requires a general maintenance rehab program • has already participated in an outpatient ABI program for the same injury • concussion/mild TBI if imaging results are negative
Admission Process:	• Toronto ABI Network Community Form must be completed and faxed to the network • Toronto ABI Network forwards the application to the program's Service Coordinator • The Service Coordinator reviews the referral and if appropriate will contact the client directly to discuss eligibility for the program and next steps
Discharge Criteria:	• upon completion or near completion of rehab goals • • client's ongoing goals can be appropriately addressed in a community setting • client presents with any of the exclusionary criteria described above • • clients who are inconsistently participating or who do not want to participate in active outpatient rehabilitation • clients who are not following the attendance policy • client is admitted to another facility (e.g. acute care or inpatient program)
Funding:	Ministry of Health and Long-Term Care, Institutional Division

Program details subject to change. Last reviewed: April 2019

Descriptions of Programs/Services of Member Organizations

	UNIVERSITY HEALTH NETWORK **Toronto Western Hospital** 399 Bathurst Street Toronto, Ontario M5T 2S8
Program or Service:	**Acute Care Institution**
Contact:	Neuroscience Social Workers: The 5A pager is 416-719-1557 and 5B pager is 416-719-1076
Definition of ABI:	Damage to the brain and its functions secondary to injury or illness.
Program Description:	Interdisciplinary team approach for establishing and implementing a comprehensive treatment program.
Admission Criteria:	• clients who require medical assessment and/or intervention • not a trauma unit… neurovascular specialization (AVM, aneurysm, stroke, tumour, SAH due to falls)
Exclusion Criteria:	None
Admission Process:	• either elective (planned) or emergency-based • Patients come from all over Ontario through Criti-Call.
Discharge Criteria:	• once medically stable, team decides on appropriate discharge plan • When possible, medical prognosis is discussed with client/family and preparation initiated for post-rehab care.
Funding:	Ministry of Health and Long-Term Care, Institutional Division

Program details subject to change. Last reviewed: November 2013

Toronto abi Network

Descriptions of Programs/Services of Member Organizations

	WEST PARK HEALTHCARE CENTRE 82 Buttonwood Avenue Toronto, Ontario M6M 2J5
Program or Service:	**Service:** **Inpatient Neurological Rehabilitation** **Contact:** Pamela Madan-Sharma, Manager, Neuro-Rehabilitation Services (416) 243-3600 ext. 4135, fax (416) 243-3654 pamela.madan-sharma@westpark.org OR Michelle Latchana, (416) 243-3600 ext. 2622 OR Mary Simone, Care Co-ordinator, (416) 243-3600 ext. 4125
Capacity:	**Number of spaces:** 7 inpatient beds
Definition of ABI:	• Individual who has sustained (acquired) brain dysfunction secondary to a traumatic event, or illness/event requiring neurosurgery and deficits include cognitive and or behavioural issues
Program Description:	• rehabilitation services to patients with an ABI • patient focused, interdisciplinary approach to assist patients in working toward their goals • focus is on education of the patient and the families to allow patients to maximize their abilities for discharge into their community • discharge medical follow up as needed
Admission Criteria:	• clients (individual) who has sustained a recent ABI, who can show improvement in functional independence through a comprehensive rehabilitation program • medically stable • Rancho Los Amigos Level V or above • 18 years old or older • where appropriate, clients (patients) under the age of 18 can be admitted • motivated to improve and willing to participate in program
Exclusion Criteria:	• This program cannot accommodate patients with psychiatric disorders that could interfere with the rehabilitation program • This program cannot accommodate patients who may wander
Admission Process:	• completion of Inpatient Rehab/CCC Referral Form, completed application submitted via the Toronto Central LHIN electronic Resource Matching and Referral (RM&R) system or faxed directly to West Park Healthcare Centre • .
Discharge Criteria:	• Client is able to safely cope within his/her home environment and to access services, if needed, in the community • Patient no longer requires an in-patient setting for his/her rehabilitation • Patient is able to continue therapy in the community, either through out-patient therapy, home care or private services. • Patient and family have been educated regarding the patient's needs and is able to carry them out safely • The client is demonstrating no further benefit from the in-patient therapy program and/or there are no further goals
Funding:	Ministry of Health and Long-Term Care, Institutional Division

Program details subject to change. Last reviewed: April 2019

Toronto abi Network

Descriptions of Programs/Services of Member Organizations

	WEST PARK HEALTHCARE CENTRE 82 Buttonwood Avenue Toronto, Ontario M6M 2J5	
Program or Service:	**ABI Behaviour Service: Inpatient Services**	
Contact:	Karl Gunnarson (416) 243-3600 ext. 2615 Karl.gunnarson@westpark.org	
Capacity:	**Number of spaces:** 5 inpatient beds	
Definition of ABI:	Broadly defined with focus on challenging behaviours.	
Program Description:	• service focuses on individual client's goals and needs • service uses a behavioural approach to treatment of challenging behaviours that are the result of ABI • goal is to enable clients with ABI and associated challenging behaviours to lead purposeful and meaningful lives • assist clients to learn skills necessary to live in community settings.	**Service Principles:** • services based on Positive Behaviour Interventions and Support and Applied Behaviour Analysis. • help families adapt to the needs of the person with brain injury • work closely with other service providers to coordinate a full spectrum of client services.
Admission Criteria:	• adults, age 18 to 65 years, who have an ABI and associated behavioural challenges that prevent them from accessing other needed services, or from returning to their communities • identified discharge destination	
Exclusion Criteria:	• medically unstable • requiring hospitalization for medical or psychiatric reasons • facing criminal charges	
Admission Process:	via Toronto ABI Network	
Discharge Criteria:	successful achievement of client goals	
Funding:	Ministry of Health and Long-Term Care, Institutional Health Branch	

Program details subject to change. Last reviewed: April 2019

	WEST PARK HEALTHCARE CENTRE 82 Buttonwood Avenue Toronto, Ontario M6M 2J5	
Program or Service:	**ABI Behaviour Service: Outreach Program**	
Contact:	Rayna Pinto (416) 243-3600 ext. 2611	
Capacity:	Flexible	
Definition of ABI:	Broadly defined with focus on challenging behaviours.	
Program Description:	• provide consultation, and in-community behaviour rehabilitation services for clients, family members, and caregivers to help	**Service Principles:** • service focus is on the goals and behavioural needs of individual clients, family members, and other caregivers

	manage challenging behaviours following ABI. • goal directed clinical assessments and interventions using principles of Positive Behavioural Intervention and Supports, Cognitive Behaviour Therapy, and Applied Behaviour Analysis. • assist clients and family members learn skills and provide education and training to family members, care providers, and organizations on coping with behavioural changes following ABI. • Neuropsychological/neurobehavioural assessments are provided to specific clients if indicated to enhance client care.	• work closely with other service providers to coordinate a full spectrum of client services
Admission Criteria:	• adults who have an ABI and associated behavioural challenges, who are living in their own or their family home, in a residential facility, or are in a hospital • age 18 to 65 years	
Exclusion Criteria:	• medically unstable (for clients living at home) • pre-injury history of serious mental illness or significant substance abuse • requiring hospitalization for medical or psychiatric reasons • facing criminal charges	
Admission Process:	via Toronto ABI Network	
Discharge Criteria:	Normally term of intervention does not exceed 6 months.	
Funding:	Ministry of Health and Long-Term Care, Institutional Health Branch	

Program details subject to change. Last reviewed: April 2019

	WEST PARK HEALTHCARE CENTRE 82 Buttonwood Avenue Toronto, Ontario M6M 2J5	
Program or Service:	**ABI Adult Day Program**	
Contact:	Janet Grange, Manager, Neuro-Rehabilitation Services (416) 243-3600 ext. 2601, fax (416) 243-3654 janet.grange@westpark.org	
Capacity:	Flexible	
Definition of ABI:	See ABI Network definition.	
Program Description:	• The program provides recreational, social, and educational activities, and community outings. • In partnership with Cota, we offer community case management to clients and families. We link caregivers to community services, and provide education on managing challenging behaviours. • Neuropsychological/neurobehavioural assessments are provided to specific clients if indicated to enhance client care.	**Service Principles:** • Program activities enhance participants' strengths, and foster learning new skills. • Educational groups address issues that challenge ABI clients and their families. • Activities focus on recreational activities, social support, and skills training. **Transportation:** • West Park Healthcare Centre may be able to provide some transportation assistance on an individual basis.

	• Overnight respite and consultation with a physiatrist available to participants. • The program operates 5 days per week from 10:00am to 2:30pm; each client attends 1-2 days per week for about 6 months; some registered programs are available with the curriculum changing quarterly. • Participants bring their lunch Monday - Thursday, and the program provides light snacks.	
Admission Criteria:	Program participants are at least 18 years old; have moderate to severe acquired brain injury; are medically stable; currently living in, or preparing to return to the community; have a family physician. They may also have challenging behaviours and/or physical disabilities. We do not provide physical assistance with care needs (i.e. feeding, toileting)	
Exclusion Criteria:	Clients must reside in the community or will be residing in the community. We do not take clients residing in long-term care homes.	
Admission Process:	via Toronto ABI Network	
Discharge Criteria:	Enrolment period about 6 months.	
Funding:	Clients must have a valid OHIP card. Program costs are covered by OHIP. There may be costs associated with some outings.	

Program details subject to change. Last reviewed: April 2019

Descriptions of Programs/Services of Member Organizations

	YORK-SIMCOE BRAIN INJURY SERVICES (YSBIS) ***A partnership between Mackenzie Health-Centre for Behaviour Health Sciences and March of Dimes Canada*** **RICHMOND HILL OFFICE** 13311 Yonge Street, Suite 202 Richmond Hill, ON L4C 3L6 Tel: 905-773-3038 Toll free: 1-800-362-7793 Fax: 905-773-5176 **BARRIE OFFICE** 570 Bryne Drive, Unit H Barrie, ON L4N 9P6 Tel: 705-721-7793 Fax: 705-728-7456
Program or Service:	**Community Support Services – Behaviour Consultant, Case Manager and Rehabilitation Worker** **Areas Served: York Region, Simcoe County and Muskoka Region**
Contact Person:	Susy Farramenta 905-773-3038 ext. 6200 Email ysbis@mackenziehealth.ca www.mackenziehealth.ca
Definition of ABI:	Damage to the brain which occurs after birth as a result of a traumatic or non-traumatic event and is not related to a congenital or a degenerative disease.
Admission Criteria:	• 16 years of age or older with an Acquired Brain Injury • Resident of York Region, Simcoe County or Muskoka Region • Have a valid Health Card
Admission Process:	• Referrals by self or others with client consent ➢ Completion of ABI Community Profile Form via Toronto ABI Network -or- ➢ If referring directly to YSBIS, contact office 905 773 3038 for Request for Service form -or- ➢ For patients residing in the North Simcoe Muskoka Area a YSBIS NSM Collaborative Referral form is available via www.abicollaborative.ca • Review of referral Form upon receipt • Patient contacted by office to schedule an in-home Intake Interview to determine eligibility followed by review of further documents obtained upon consent.
Program Description:	• York-Simcoe Brain Injury Services provides behavioural community based ABI clinical assessment, treatment and follow-up to individuals 16 years and older. This may include neuropsychological and/or neuropsychiatric assessments • Case Management and individualized rehabilitation support is provided in collaboration with behaviour consultant • Individualized goals are developed with patient to improve quality of life and ability to engage meaningfully with their community • Problem Solving Group • Caregiver Workshops • Brain Injury Education • ABI Adult Day Programs – See Individual Description of Program via Toronto ABI Network

Program details subject to change. Last reviewed: June 2019

Descriptions of Programs/Services of Member Organizations

YORK-SIMCOE BRAIN INJURY SERVICES (YSBIS) ABI ADULT DAY PROGRAM *A department of Mackenzie Health-Centre for Behaviour Health Sciences*			
3 LOCATIONS:	**York-Simcoe Brain Injury Services** **Maple Health Centre** 10424 Keele Street Maple, ON L6A 2L1	**York-Simcoe Brain Injury Services** **Newmarket Health Centre** 194 Eagle Street Newmarket, ON L3Y 1J6	**York-Simcoe Brain Injury Services** **CHATS - Vaughan-Jane** 9401 Jane Street, Suite 328 Vaughan, ON L6A 4H7
Program or Service:	**ABI Adult Day Program**		
Contact Person:	Susy Farramenta 905-773-3038 ext. 6200 Email ysbis@mackenziehealth.ca		
Hours of Operation:	9:00 am to 3:30 pm		
Admission Criteria:	• 18 years of age or older with an Acquired Brain Injury • Participants must be medically stable • Resident of York Region, Simcoe County • Have a valid Health Card		
Admission Process:	• Referrals by self or others with client consent • Completion of ABI Community Profile Form via Toronto ABI Network -or- • Completion of YSBIS Request for Service Form (Contact office 905 773 3038 for form) -or- • Contact the Local Health Integration Network – Home and Community Care • Review of referral Form upon receipt • Patient contacted by office to schedule an in-home Intake Interview to determine eligibility followed by review of further documents obtained upon consent.		
Fees:	$22.09 **Sliding Scale based on income. Subsidy Available**	$20.00 **Sliding Scale based on income. Subsidy Available**	$26.15 - $11.25 **Sliding Scale based on income. Subsidy Available**
Services Provided:	• Arts & Crafts • Social Skills • Peer Support • Brain Injury Education • Cognitive Activities • Cooking Program • Discussion Groups • Fitness & Exercise • Health and Wellness Workshops • Monthly Outings		
Service Description:	A Specialty Day program for individuals with a brain injury resulting from trauma or non-progressive disease. This program provides an opportunity to interact with peers in a stimulating and therapeutic environment. It offers a wide variety of opportunities for social and recreation activities while providing caregiver respite. Provide Caregiver Stress Management Workshops. A calendar of events is available on a monthly basis.		

Program details subject to change. Last reviewed: June 2019

Toronto abi Network

Descriptions of Programs/Services of Member Organizations

YORK REGION ABI ADULT DAY PROGRAM A DEPARMENT OF MACKENZIE HEALTH			
3 LOCATIONS:	**Maple Health Centre** 10424 Keele Street Maple, ON L6A 2L1	**Newmarket Health Centre** 194 Eagle Street Newmarket, ON L3Y 1J6	**Mackenzie Health Jane Street** 9401 Jane Street, Suite 328 Vaughan, ON L6A 4H7
Contact Person:	Client Services Associate: Make referral by calling 905-773-3038 ext. 6200 or Email ysbis@bellnet.ca		
Service Area:	York Region & South Simcoe		
Ages Serviced:	• 18 and over		
Languages:	• English, French • Interpreters are provided when possible as needed.		
Wheelchair Access:	Yes		
Method of Referral:	• Self, professional (consent required for referral)		
Method of Payment	A daily minimal fee will be charged. Can apply for subsidy.		
Services Provided:	• Computer Activities • Socialize with Peers • Leisure Activities (Bocce, bowling, Mini-putt, shuffleboard) • Arts & Crafts • Cooking Program • Theme Days • Fitness & Exercise • Woodworking • Discussion Group • Brain Injury Education		
Service Description:	Mackenzie Health through York-Simcoe Brain Injury Services offers adult day services to individuals with a brain injury resulting from trauma or non-progressive disease. Participants must be medically stable. This program provides an opportunity to interact with peers in a stimulating and therapeutic environment. It offers a wide variety of opportunities for social and recreation activities while providing caregiver respite. Provide Caregiver Stress Management Workshops. A calendar of events is available on a monthly basis.		

Program details subject to change. Last reviewed: November 2013