Conference Presentation Abstract

Title:

Tracking Movement of Clients with an ABI Through the System from Acute Care into the Community: What Does It Tell Us and What Else Might We Need to Know?

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Summary:

What happens to clients with an ABI in Ontario, once they leave the hospital system, is generally unknown. Movement and utilization of services within Alternative Level of Care (ALC) beds, the homecare system, in long term and complex continuing care, and in physician offices has not been previously quantified. The ABI Dataset pilot project was developed to address this issue and is the first registry in the world that centralizes information on ABI from both traumatic and non traumatic causes. In Phase 1 of the ABI Dataset pilot project, existing administrative data from the National Ambulatory Care Reporting System (NACRS), Discharge Abstract Dataset (DAD) and National Rehabilitation Reporting System (NRS), was identified as an important source of information that enables mapping the trajectory of individuals with an ABI from acute care to various discharge destinations throughout the continuum of care. In a subsequent phase, the data were analyzed by Local Health Integration Networks (LHINs) comparing regional data to provincial and also examining ALC. The data are made available to improve efficiencies (ALC days) and reduce inequities of access by Local Health Integration Networks province wide. Findings on LHIN variability and ALC utilization will be presented. The second phase is now examining the movement of the ABI cohort into the community specifically tracking ABI clients into home care, long term and complex continuing care, as well as visits to physician offices. The data have been extracted from the Continuing Care Reporting System (CCRS), Home Care Reporting System (HCRS) and Ontario Health Insurance Plan (OHIP) data. Characteristics of ABI cases, frequency of visits, comparison of TBI and non TBI (NTBI) populations and costs associated with each sector will be presented.

Project Outcomes: Persons with NTBI were significantly older and had longer length of acute care stay compared to TBI cases. Approximately 8% resulted in inpatient rehabilitation annually with 11% of hospitalizations incurring alternate level of care (ALC) days signifying delays in placement/referral to community services. In Ontario, for ABI clients who spent time in ALC, the mean ALC days for TBI clients was 17.8 days (SD 26) with a median of 10. For NTBI, the mean was 21.7 (SD=36.8) while the median was 10. Overall, NTBI patients are less likely to have discharge disposition of rehabilitation. On discharge from rehabilitation, TBI clients were more likely to be discharged to the community /home (62%) when compared to NTBI community/home (58%). Results also indicate there is considerable variation across LHINs.

Learning Objectives: This session will focus on the results across LHINs, client movement from acute care, ALC, into rehab, home care, long term and complex continuing care, as well as visits to physician offices. Characteristics of ABI cases, frequency of visits, comparison of TBI and non TBI (NTBI) populations and costs associated with each sector will be presented. This interactive workshop will engage the participants in examining the data and exploring its relevance and utility for system development, policy development, evaluation, practice and address further research questions. Participants will be asked to answer the questions: is this useful information, what else is it we need to know and how do we make the information accessible and relevant to plan and evaluate care.