

Systems Analysis of Health and Community Services for Acquired Brain Injury in Ontario

Synopsis - Alternate Level of Care and Wait Lists

The Systems Analysis of Health and Community Services for ABI in Ontario was initiated to describe the scope and nature of health and community services, the linkages that exist at the various points of the continuum, as well as linkages across transitions from children to adult services. Specifically, the project team conducted a literature review, extensive *key informant interviews* with a sample of organizations from across the ABI continuum and across the province, including:

- ABI-specific and other community-based organizations (OACBABIS¹ and non-OACBABIS)
- community care access centres (CCACs)
- community brain injury associations
- rehabilitation hospitals

In addition, *on-line surveys* with acute care hospitals/trauma centres and children's treatment centres (CTCs) were conducted. A total of 79 interviews and surveys were conducted.

The project was designed to capture the majority of publicly-funded services, but was not an inventory of ABI services that are accessed by the population. It was limited to include only those general services where there was an identifiable critical mass or a cluster of services identified by stakeholders.

Research Team

Dr. Susan Jaglal – Principal Investigator
Professor, University of Toronto
Senior Research Scientist, Toronto Rehabilitation Institute

Rika Vander Laan, *Consultant*
Daria Parsons, *Consultant*
Charissa Levy, Executive Director, Toronto Acquired Brain Injury Network
Sarah Munce, Research Assistant

¹ Ontario Association of Community Based Boards for Acquired Brain Injury Services is a not for profit unincorporated association of not for profit charitable providers of rehabilitation services to persons living with the effects of an acquired brain injury residing in the province of Ontario.

Alternate Level of Care and Wait Lists

This fact sheet provides highlights from the report related to Alternate Level of Care (ALC) for people with ABI in the province. Some key results regarding wait lists are also provided here as they are often connected to the ALC challenge. The results reflect issues that have been known for some time. Following results and recommendations, implications are briefly discussed.

What the ABI Systems Analysis found

Across all stakeholder groups, a higher proportion of organizations reported a wait time for accessing services as opposed to wait time for intake.

Across all of the stakeholder groups, a high proportion of organizations maintained a waiting list. Across all the LHINs, the most dominant reasons for the wait list were not enough staff and not enough funding for services to meet demand. A higher proportion of organizations reported offering some support to those on a wait list (especially OACBABIS and non-OACBABIS community-based organizations).

ABI patients have difficulty **transitioning out of ALC** acute care beds because of psychiatric issues, behavioural needs, medical /nursing needs, and substance use (rank ordered).

Survey results indicate that this is due to:

- ▶ Long wait lists for services reflecting gaps or unmet needs for:
 - Psychological/mental health
 - Drug and alcohol abuse
 - Emotional supports/counseling
 - Social and cognitive needs
 - Job skills/vocational support
 - Rehabilitation

- ▶ No suitable discharge destination
 - Services are often not available in the individual's home region
 - Inadequate access to ongoing services in the community to address the complexities and long-term needs such as behaviour, substance use, mental health, cognition and continuing rehabilitation

Recommendations from respondents in regards to ALC and implications for system planners and providers

There is a high prevalence of ABI and mental health and/or substance abuse and behavioural issues, making this population particularly vulnerable to being designated ALC.

Fourteen percent of individuals with ABI have ALC days. The reported mean number of ALC days in acute care is 22. (*Ontario ABI Dataset, Colantonio et al, in press*). Furthermore, ABI has the longest inpatient rehabilitation ALC days. (*Utilization of Adult Inpatient Rehabilitation Services in Ontario Hospitals 2003/04 – 2007/08, April 2010, Ontario Ministry of Long Term Care*)

ALC Solutions

- ▶ **Skills and training** in generalist services for managing ABI are needed
 - Provision of enhanced ABI services on acute care units to assist with behavioural issues, impulsivity control, safety risks, family support

- ▶ **Programs**
 - The system does not need more adult inpatient rehab beds but rather **enhanced inpatient rehab services**
 - **Enhanced ambulatory rehabilitation** programs
 - Planning for **more pediatric ABI** inpatient beds and centres outside of the GTA
 - Increased **behaviour support** programs/services

- ▶ **Linkages and collaboration** between hospitals and community based organizations to enable transitions
 - A particularly compelling solution/area of investment for the high number of ALC days in the ABI population is the need for more community-based programs. This enables individuals to live at home in a familiar, comfortable environment, leading a greater likelihood of engagement in daily activities . Active collaboration between hospitals and community-based services is needed to allow for this transition of care, with follow-up support and outreach teams.
 - LHIN-designated ABI funds could be used to support strengthening of the linkages between hospitals and community-based services, with a focus on coordinating care and improving service flow.

▶ **System Flexibility**

- Increased flexibility is needed in **service criteria**, rules about eligibility, and number of hours of service.
- In some cases, a **few additional hours/week** from CCACs could enable individuals of **all ages** to return home to the community and remain there, thus alleviating ALC, providing appropriate care for the individual, and avoiding inappropriate admission to long-term care facilities.

▶ Increased provision of a **range of housing and support** for individuals with an ABI on a continuum to serve variable needs and to enable people with ABI to be in the community rather than in a more costly institutional setting

- In-home living supports at variable service hours
- Funding unpaid caregivers, i.e., parents, partners, and family members to provide support
- Accessible (physically) and affordable housing provided in a variety of different models
- Outreach – from direct phone call, to variable in-person service hours to 24-hour virtual hotline

▶ **Track innovative models** currently being tested and share results across LHINs:

- Toronto Central CCAC's population-based service model
- Waterloo Wellington LHIN - transition beds
- travelling outreach teams
- short stay beds specifically for ABI