BCBIA Showcase & Celebration for Brain Injury

Showcasing Excellent ABI Services in British Columbia

Summary of 10 Programs/Services Included in the ABI Provincial Services Evaluation Initiative

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www.brainstreams.ca

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Acquired Brain Injury Provincial Services Evaluation Initiative: Phase 1 Report

EXECUTIVE SUMMARY

With generous support from the Rick Hansen Foundation, the British Columbia Brain Injury Association (BCBIA) launched an initiative called *Acquired Brain Injury (ABI) Provincial Services Evaluation Initiative.* The purpose of this initiative was to answer the following question: "What excellent programs and services for people with ABI[i] exist in BC?" The focus was on quality programs and services that demonstrate excellence in the area of transitioning people living with acquired brain injury to be active participants in their communities. Rather than identifying areas of deficiency or weakness, BCBIA wanted to identify areas of strength and opportunities to expand on those strengths.

The project was guided by a Steering Team consisting of ABI Leads and Stroke Leads from each of the regional Health Authorities, Provincial Stroke Leads from the Provincial Health Services Authority, and representatives from BCBIA. The health authority representatives each identified two programs/services for inclusion in the evaluation. In making their selection, they considered the following four criteria: 1) *Community engagement* (helps individuals transition successfully to community); 2*) Peoples' experiences* (displays high levels of satisfaction for clients and families); 3) *Quality outcomes* (demonstrates positive individual goal attainment and functional outcomes); and, 4) *Economic value* (shows positive return on investment).

Scope of the Evaluation

Selection of Services for Inclusion in Evaluation - It was recognized that there would be limitations inherent in asking the Steering Team members to identify the services, most notably that they would likely put forward services with which they were most familiar, and that others might be missed in the process. It was agreed, however, that in the absence of a comprehensive overview of all existing ABI services in BC, it would serve as a good place to start.

Collection and Availability of Data - During the data collection process, 1-2 hour conversations were had with eighteen key service contacts/key informants. There was great variation in the size, budgets and nature of the 10 programs and services evaluated. All of the 10 programs/services had information and statistics to share, although there was great variability in quantity and quality of the available data.

Success Factors

The most common success factors identified through the evaluation include the following values/approaches:

- **Recovery-oriented** – Is goal based, not just focused on clinical outcomes
- **Client-centered** – Meets people where they are at
- **Based on best practices** – Engages in continuous improvement based on best practices and client feedback
- **Flexible** – Is flexible and does "whatever it takes" in order to meet the unique needs of clients
- **Coordinated, collaborative approach** – Works closely with all appropriate service providers
- **Dedicated program management or project support -** Invests in and/or allocates a program manager, program coordinator or project manager to lead and/or support the initiative
- **Links to other services** – Makes links to other community services essential to supporting clients upon discharge
- **Marketing** – Educates other parts of the system about its purpose and services
- **Group education sessions** – Offers group education sessions as a means to provide information & support
- **Value-add** – Offers something complementary to other parts of the system
- **Evaluation** – Provides dedicated resources for data collection, analysis, evaluation and reporting where possible
- **Supportive leadership** – Has support from organizational leaders and decision-makers (especially those in health authorities), demonstrated through words and actions

[i] This project adopted the World Health Organization's definition of ABI: "Damage to the brain, which occurs after birth and is not related to a congenital or a degenerative disease. These impairments may be temporary or permanent and cause partial or functional disability or psychosocial maladjustment" (Geneva 1996).

Programs/Services Included in the ABI Provincial Services Evaluation Initiative

Fraser Health: Community Rehab Early Discharge Initiative (REDi)	
Lead	Fraser Health
Service Location	Outpatient Clinics (attached to hospitals) in six FHA communities
Population Served	Eligible clients (includes ABI)
Contact	Joanne Spooner (joanne.spooner@fraserhealth.ca)

Program/Service Brief Description

- An outpatient service designed to provide coordinated rehabilitation to clients who have realistic, achievable functional goals, who no longer need to stay in hospital and are able to be supported at home.
- The program includes three components:
  1) Central intake process that coordinates services across the region an defines a clients' unique care plan
  2) Outpatient clinics delivering interdisciplinary rehabilitation; and,
  3) Community reintegration program such as TIME (Together in Movement and Exercise) classes and Stroke Education classes.

Program Strengths/Success Factors

- The program offers the ability to customize the type, frequency and duration of outpatient services to what each patient needs, including allowing for service interruption and program re-entry as required. The model is transferable to other populations and communities.
- Sitting in rounds on the Inpatient Rehab units allows for timely identification and action for those appropriate for Early Supported Discharge.
- Developing functioning partnerships and successfully linking people with a wide range of community centres, services and organizations has supported clients' recovery and community integration.
- A comprehensive Health Record Documentation Framework and Program Standards support quality of care.

Fraser Health: Concussion Clinic	
Lead	Fraser Health
Service Location	Concussion Clinic office in Coquitlam; group education sessions provided in various communities within health region
Population Served	Traumatic Brain Injury – concussion clients
Contact	Deanna Yells, OT (deanna.yells@fraserhealth.ca), Heather MacNeil, OT (heather.macneil@fraserhealth.ca) Tracy Lindberg, Neuropsychologist (tracy.lindberg@fraserhealth.ca), Program Telephone: 604-528-5387
Website	http://www.fraserhealth.ca/your-health/health-topics/concussion/concussion-clinic/

Program/Service Brief Description

- An early intervention and follow-up service for clients living with the effects of a recent concussion/mild traumatic brain injury.
- It is based on best practices which suggest that one of the best ways to help in the recovery process is to ensure the client has a good understanding about concussions in the early stage of recovery, and that they learn how to effectively manage the symptoms.
- Health care professionals make a referral and the Clinic mails the client an informational package that invites them to call the clinic to schedule a time to attend an information session. Individuals call the clinic and, if they meet the eligibility criteria, they are booked into a group session. Group education sessions are 1.5-2 hours in length and are conducted by two facilitators. Each session averages 15-30 participants, and are conducted in a number of communities across the health region. If there are factors that make the group session impractical (e.g., language fluency, social anxiety), the same educational information is delivered via 1:1 session.
- Individual follow-up appointments may be booked with clinicians after the information session, on a case by case basis.

Program Strengths/Success Factors

- The Clinic is a small, flexible program that is ever-evolving their methods of providing client services and staff have the capacity to tailor service delivery based on a client's individual needs.
- Given the "invisible" nature of the injury, staff at the Clinic recognize that validation and reassurance are critical elements of the service they provide, in addition to the education and liaison function with rehab services.
- Development of a Concussion Awareness Training Tool has been instrumental in supporting stakeholder education and improving quality and consistency of clinical practice across BC.

CONNECT Lake Country Specialized ABI Transitional Rehabilitation Program and Residential Services	
Lead	CONNECT Communities
Service Location	CONNECT Lake Country Condominium Development
Population Served	ABI
Contact	Karen Tims, Director Culture, People and Services (karent@connectcommunities.ca)
Website	http://www.connectcommunities.ca/

Program/Service Brief Description

- Complex and specialized short-term transitional rehab through to long-term residential placement services for people living with brain injury and stroke provided in a nurturing, innovative and empowering community environment.
- The condominium development in Lake Country is home to transitional rehab and individualized services for up to 42 people living with brain injuries in six distinct homes with seven people in each.
- Residents are expected to contribute to the running of the home they are living in with support, supervision or assistance being given on a "doing with, not for" basis.

Program Strengths/Success Factors

- Whether long-term or transitional, all of CONNECT's programs address the physical, cognitive, emotional and behavioural needs of its clients.
- CONNECT prevents institutionalization and dependence at every step by creating a powerful new pathway for individuals with ABI. CONNECT believes every individual impacted by brain injury, stroke and other complex cognitive disabilities deserves the best chance at redesigning their life.
- CONNECT makes lives better because of its Life Redesign Model. Its innovative "doing with" coaching culture of flexibility, creativity and personal accountability leverages neuroplasticity and equitable relationships for better outcomes.

Interior Health: Acute ABI Coordinator Role	
Lead	Interior Health
Service Location	Kelowna General Hospital (KGH)
Population Served	ABI
Contact	Cathryn Goodman, Acute ABI Coordinator (Cathryn.goodman@interiorhealth.ca)

Program/Service Brief Description

- A role that serves as one point of contact for patients and families. The Coordinator provides education and orientation to the system within acute care and community to support maximum independence.
- The ABI Acute Coordinator provides:
  - Case management to ensure connections for patients to resources post-discharge and to assist in ensuring needs are met in acute.
  - Initial contact with patient and family to provide orientation to the acute care system, recovery and resources in community.
  - Liaise with medical team, patient and families to ensure issues related to complex care needs and complex discharge planning are managed and addressed.
  - Education to families on: brain injury, resources, acute processes and roles, post hospital discharge, approach to support.
  - Education about brain injury to staff providing care to patient.
  - Effort to ensure KGH clients are linked to ABI services throughout Interior Health.

Program Strengths/Success Factors

- Proximity to clients in acute care is key to the role's success.
- The Coordinator is able to connect with families as early as possible and follows them through different wards in the hospital. This is unique in that all other patients have their care providers change when they move.
- Serving as a liaison between family, clients and staff facilitates the communication required for effective care across the continuum.
- The Coordinator brings a community lens to the discharge plan and liaises regularly with the community team.
- The program's approach is to look for creative solutions by using generic services as much as possible and individualizing them.

SRABC: Community Stroke Recovery Navigator (CSRN)	
Lead	Stroke Recovery Association of BC (SRABC)
Service Location	Nanaimo Regional General Hospital
Population Served	Stroke
Contact	Wendy Johnstone, CSRN Program Consultant (vancouverislandsrabc@gmail.com) and Tim Readman, ED SRABC (execdir@strokerecoverybc.ca)
Website	http://strokerecoverybc.ca/about-us/current-projects/

Program/Service Brief Description

- A post-hospital, community-based stroke recovery navigation service that links stroke survivors and caregivers with community resources based on co-created goals, and provides educational sessions.
- Services provided by the Community Stroke Recovery Navigator (CSRN) include:
  - Client assessment and service-action planning (including Caregiver Reaction Assessment Instrument, Hospital Anxiety and Depressions Score, intake questionnaire and Reintegration to Normal Living Index);
  - Follow-up phone support/availability;
  - Information and referral to other services;
  - Client and caregiver education on self-management; and,
  - Collaboration and linkages with other community and health care providers.

Program Strengths/Success Factors

- The program does a good job of using eligibility criteria to identify who would be a good fit for the program.
- Following up with people 30-60 days post-discharge is critical.
- Community-based education sessions are an effective way to reach a significant number of people.
- It is important to note that some people do not require action plans. Sometimes people just needed to receive validation that they are doing everything right – that in and of itself proves to be valuable and appreciated.
- Monthly emails to those providing referrals helps encourage ongoing buy-in and participation.

Island Health: Hospital to Homes (H2H) Committee	
Lead	Island Health
Service Location	Multi-Hospital Sites Island Wide
Population Served	Complex clients (includes ABI)
Contact	Judith Armstrong, Regional Program Coordinator, Brain Injury Program (judith.armstrong@viha.ca) and Kelly Reid, Director Operations Mental Health & Substance Use (kelly.reid@viha.ca)

Program/Service Name & Brief Description

- A multidisciplinary Island Health committee that collaborates to find community placements for clients with complex needs and often co-occurring disorders who have long hospital stays (e.g., brain injury and mental health or substance use issues).
- The Committee meets once a week for approximately 1 hour. Additional follow-up meetings are often arranged to discuss certain clients in a more in-depth way.
- The Committee brings in different services (either to a Committee meeting or to a follow-up meetings) to manage the unique and varied needs of clients. The Committee does whatever it takes to find long-term community placements for clients. For example, it generates referrals, addresses barriers and influences programs regarding denials for service.

Program Strengths/Success Factors

- Many similar committees have come and gone, demonstrating limited success and no lasting power. The H2H Committee has existed for over three years and continues to experience high levels of participation because of its proven track record of success in finding community placements for clients.
- High level of leadership involvement, authority and decision-making power is required.
- Flexibility regarding intake processes and willingness to address concurrent disorders. Strong relationships built on trust and collaboration have been fostered.
- Short wait time between referral and H2H meetings. Effective tracking of events, decisions and agreed actions.
- Strong client and family engagement is key.

Northern Health: Two stroke workshops: 1) "Understanding Stroke"; and, 2) "Building Community Connections"	
Lead	Northern Health
Service Location	Prince George Health Unit Auditorium
Population Served	Stroke
Contact	Mary Sluggett, Home & Community Care PT (Mary.Sluggett@northernhealth.ca) Jennifer Amell, Home & Community Care OT (Jennifer.Amell@northernhealth.ca) Shannon Grunerud, Home & Community Care PT (Shannon.Grunerud@northernhealth.ca)

Program/Service Brief Description

- Workshop #1 offers a chance for survivors, families and friends to learn about:
  i. how the brain works and the many changes that happen after a stroke
  ii. practical rehabilitation strategies to help with recovery
  iii. life after a stroke and some resources to help in the recovery journey
- Workshop #2 is an opportunity for the same target audience to learn:
  iv. about existing regional, provincial and national resources and how to access them
  v. from 2-3 stroke survivors and/or caregivers who share their personal journeys
- Both workshops are offered twice per year - in the spring and fall. Both workshops' format is interactive, informal and offers a chance to ask questions and learn from others whose lives are changed by stroke.
- The workshops are1 free to attend and are available to stroke survivors, their family and friends as well as health care providers.

Program Strengths/Success Factors

- In an acute care setting, there is too much information for people to try to absorb all at once. These workshops provide an opportunity for individuals to come back later once they have had a chance to deal with their reality and then can really hear the information, ask their questions and have them answered. The workshops also provide an opportunity to meet other stroke survivors and share their personal stories.

PG BIG: Two group programs: 1) "Rebuilding After Brain Injury"; and 2), "Connect, Learn and Grow" (CLG)	
Lead	Prince George Brain Injured Group Society (PG BIG)
Service Location	PG BIG
Population Served	ABI
Contact	Alison Hagreen, Executive Director (alison.hagreen@pgbig.ca)
Website	http://www.pgbig.ca/

Program/Service Brief Description

- Program #1 is a 24-week, 1.5 hour in-depth course. It looks at strategies of daily living and dealing with the effects of brain injury.
- Program #2 is a weekly 1.5 hour session that provides education and tools, and develops skills and personal connections necessary for personal growth following brain injury.

Program Strengths/Success Factors

"Rebuilding After Brain Injury"

- The program offers a combination of factual, practical information and strategies, as well as opportunities to develop personal connections.
- Having resources (books and handouts) for participants to follow-along with and take home for review reinforces the information and supports learning.
- A skilled facilitator guides interaction amongst survivors, and creates a safe environment for equal sharing of ideas, stories, challenges and successes.

"Connect, Learn and Grow (CLG)"

- The program has an open curriculum with topics chosen by both survivors and facilitators. It provides a discussion forum to share successes and frustrations, and to obtain honest feedback about personal behaviours with the goal of engaging in personal growth needed to rebuild self-identity. Providing both the education and tools needed to develop the personal skill required for that task is key.
- Provides more of an opportunity than "Rebuilding" does to develop meaningful personal connections.

Vancouver Coastal Health: Intensive Rehabilitation Day Program (IRDP)	
Lead	Vancouver Coastal Health (VCH)
Service Location	GF Strong Rehabilitation Centre
Population Served	Eligible clients (includes ABI)
Contact	Kelly Sharp, Community Intervention Coordinator ABI & IRDP (kelly.sharp@vch.ca) and Chris Palmer, Manager IRDP (chris.palmer@vch.ca)

Program/Service Brief Description

- An intensive, 4-5 days/week, 4-6 week, team-oriented outpatient program that offers an alternative to inpatient care.
- PT, OT, rehab assistance, social work, speech language pathology, physiatry and transition support coordination is provided through the program.
- The Program Coordinator works on an ongoing basis with the team, clients and their families to identify the appropriate length of care. Clients may be referred to other less intense outpatient programs, private therapy or back to programs in their communities at the end of IRDP If they have additional goals to address.

Program Strengths/Success Factors

- Over the years the program has refined the admission criteria so that it is bringing in clients most appropriate for this type of rehab program.
- Having an individual to triage and coordinate admissions allows clinicians to focus on the provision of therapies vs. indirect care issues. The Program Coordinator also plays a role in facilitating discussions regarding discharge and the timeliness of transitioning clients to other appropriate supports or services.
- Realistic client to staffing ratios (1 to 5 – consistent with inpatient models) is key to program effectiveness.
- Effective communication and referral processes with acute, rehab and community partners is paramount.
- Consistent evaluation and outcome measures are completed upon admission, discharge and at 3 months post IRDP. These measures demonstrate the value of the program through the clients' achievements and functional gains in their recoveries.

Vancouver Coastal Health: Intensive Rehab Outpatient Program (IROP)	
Lead	Vancouver Coastal Health (VCH)
Service Location	Lions Gate Hospital
Population Served	Eligible clients (includes ABI)
Contact	Barb Ferreira, Manager IROP (barb.ferreira@vch.ca), Susan Bittel, OT (susan.bittel@vch.ca), Catalina Sanchez, PT (catalina.sanchez@vch.ca) and Julia Baylis, SLP (julia.baylis@vch.ca)

Program/Service Brief Description

- A coordinated early discharge service that helps clients transition from hospital to home sooner. Clients attend one-to-one therapy (and group activities when appropriate) as outpatients.
- The program provides a period of intense outpatient rehabilitation and help clients recover and be as independent as possible.
- The program is for any patient that has rehabilitation potential and is able to manage at home and attend appointments at the hospital. Patients benefit from living at home while participating in therapy, rather than staying in the hospital.
- The program accepts all diagnoses.

Program Strengths/Success Factors

- Diagnosis has never been a barrier – the program has always taken people who meet the criteria, and who could benefit from its services. Managers and Senior Leadership in the health authority support the team's efforts to be flexible and adapt the program as required to meet the needs of patients.
- IROP screens its own patients and the team has developed a solid set of eligibility criteria that has been effective in identifying who would benefit most from its services. IROP is constantly reviewing and improving all its processes, including intake assessment forms, to improve patient care.
- The program being hospital-based has facilitated collaboration with referral sources and smooth transitions home.
- The interdisciplinary nature of the team and strong communication between team members have contributed to IROP being able to truly provide holistic treatment.
- IROP does not have a waitlist. Patients begin the program within a week of discharge from hospital.

Everyone Has a Role to Play

The evaluation report provides stakeholders with a snapshot of some of BC's excellent programs/services, offers learnings from the experience and expertise of those programs/services, and serves as a solid foundation on which to build. It identifies areas of promising practices and others that are showing early signs of success but merit further exploration. Embracing the challenge of strengthening the network of ABI services and supports in BC can feel overwhelming – there are many steps that need to be taken. The report is intended to provide a foundation to help readers start to identify and implement manageable steps specific to their context. Everyone has a role to play...at a micro level, readers are encouraged to view this document through the lens of their own role in the system and think about what they can do within their circle of influence. There may be some small changes they can make immediately in their day-to-day work, as well as some big changes they would like to try to encourage in the long-term. At a macro level, readers are encouraged to think about how this document could be used to inform strategic planning at a provincial level. A structure, process and plan will need to be developed to operationalize the actions in this report going forward.

NEXT STEPS: MOVING FORWARD FROM THE REPORT

A strategy was developed to address the priorities for moving forward identified by the Steering Team, including:

1) Establishing a formal partnership with Stroke Services BC (Provincial Health Services Authority);
2) Continuing to work closely with our partners at the Rick Hansen Foundation, each of the 5 regional Health Authorities and with the non-profit and private service providers in our province;
3) Showcasing the 10 programs/services identified as excellent through this initiative; and,
4) Anchoring the ABI Provincial Services Evaluation Initiative to best practice.

Comments or Questions?

If you have comments or questions about this initiative or would like a copy of the full report, there are three ways to contact the BCBIA:

- Call us at 604-984-1212
- Email us at info@brainstreams.ca
- Send us a message via the contact form located at www.brainstreams.ca/contact

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