



INTENSIVE CASE MANAGEMENT

WWLHIN

Abstract

A 12-week project to provide intensive case management services to the moderate to severely brain injured clients in the Region of Waterloo and the County of Wellington

INTRODUCTION

The Waterloo Wellington LHIN graciously provided one time funding in the fourth quarter of the 2017/18 fiscal year to provide intensive case management services to those who had suffered a moderate to severe brain injury.

This report represents the outcomes of this work over a 12-week period because of that funding.

OVERVIEW

Traverse Independence offers supports and services to individuals with an acquired brain injury. The mission is to maximize the client's ability to live independently by providing support services for adults with an acquired brain injury (ABI). These support services are available through a variety of programs including the transitional living program, group home, supportive housing, two different day programs, and an outreach program.

The outreach program currently supports the greatest number of clients. There are 70 active clients receiving outreach services at an average of 2 hours/week. We have an extensive waitlist for outreach clients at 128 clients with an approximate wait time of 22-24 months.

There is a comprehensive intake process, which reviews the goals, strengths, and challenges, the clients face. We have found that a significant number of the clients in the intake process identify that they require immediate support and case management. Many clients require support to be connected to other resources, navigate specialized resources, the mental health, and addictions system and there is a small requirement for a connection with primary care. A number of caregivers were identified during this project as requiring support and education.

Individuals who have sustained an acquired brain injury require an individualized approach to their health care. Many describe difficulties with memory, initiation, motivation, feelings of being overwhelmed easily, difficulty with communication and poor problem solving skills. The changes to the brain associated with an acquired brain injury make it increasingly difficult for an individual to access and coordinate services without support. During the intake process, three key groups of clients have been identified requiring support.

1. Supports to navigate the health care system including primary care, mental health, and addictions, manage the symptoms from the acquired brain injury, and refer to community supports for both the client and the caregiver.
2. Discharge planning from hospital, which includes a comprehensive care coordination with the hospital, community organizations, and the client and their caregiver.
3. Stabilization for those clients requiring quick access services to resolve a crisis, which includes support for both the client and the caregiver. This can be a short-term support or a long-term support.

INTENSIVE CASE MANAGEMENT

Intensive case management is for clients who have complex needs. The model currently being used looks at the client in a holistic way, addressing the current problems and challenges at hand.

It also looks at why the client is facing these challenges. "The main service that a case manager provides directly to a client is a plan based on the assessment of the problems and a determination of what other assistance is needed to overcome the client's difficulty in using other helpers." (Ballew and Mink, 1996)

Traverse Independence uses the following case management model: (Ballew and Mink, 1996)

1. **Engagement** - building trust, clarifying roles, negotiating expectations
2. **Assessment** - finding client's strengths, needs/resource balance, identifying barriers
3. **Planning** - identifying goals, specifying goals, developing action plan
4. **Accessing resources** - connecting client to resources, negotiating, advocating, developing internal resources, and overcoming barriers
5. **Coordination** - organizing helping efforts, gaining agreement to common goals, monitoring, supporting helping efforts
6. **Disengagement** - evaluating results, identifying signs of disengagement, sequencing disengagement, determining ongoing responsibility

The engagement and assessment phase were already occurring in the Traverse Independence intake process. This allows for a coordinated plan for the client starting at the initial referral to Traverse Independence.

Many of the clients who require the support of intensive case management have significant and complex barriers. This requires the intensive case manager to re-engage with the client, reassess their needs, and engage in ongoing planning and ongoing implantation of plans. This case management model requires a worker who is highly skilled in system navigation from an acquired brain injury perspective. It requires that each client have a personalized, flexible, and individualized approach and plan.

One of the observations of this pilot project was that Traverse Independence offers Outreach services, which has an approximate waitlist of 22-24 months. Intensive case management can address many of the more immediate needs and resources, which are identified in the intake and assessment process at Traverse Independence for the client at the point of intake. If these are addressed following the intake process, many of the clients may not need outreach services, or will require fewer outreach visits. Intensive case management was completed with the client, family members, caregivers, and including strong integration with other community supports. It worked regularly work with the hospitals to ensure smooth hospital discharges for complex clients with an acquired brain injury.

An acquired brain injury is an injury to the head, which has occurred after birth. This means that many individuals who now have an acquired brain injury, are in their adult years. Many have never been connected to any community and health care resources. Prior to their acquired brain injury, they did not require these supports. For example, two of the clients who received intensive case management supports had never been connected to any other health care provider or community resource other than their family doctor. Prior to their acquired brain injury, they were living successfully in their home and community. Having an acquired brain injury can immediately change a person's overall health. When we consider a person's social determinants of health, the

onset of an acquired brain injury can immediately place employment in jeopardy, which can lead to income displacement, which then leads to housing and food insecurity, which can ultimately lead to social exclusion (Raphael, 2009). We see this repeatedly with clients who sustain a brain injury. This project was able to support these clients from the onset of the acquired brain injury and eliminated some of the erosion of social determinants of health for the client and/or their caregiver.

The supports offered to the clients who received the intensive case management were incredibly diverse. They ranged from

- assistance with application for community housing
- referrals to Stonehenge Specialized Addiction Services
- referrals to Healthlinks
- assistance with Extraordinary Needs funding applications
- acquired brain injury education for client, caregivers and community
- referrals to Hamilton Health Sciences' ABI program, coordination of services with Hamilton Health Sciences ABI program
- referrals to acquired brain injury services out of WWLHIN (for client who is moving out of the LHIN)
- referrals for private group homes in the community
- referrals to CMHA (support coordination, FACT, service resolution)
- connecting with community resources such as YMCA reduced fee, the working center reduced fare bus pass, community support connections, housekeeping, mobility plus
- ODSP appeals and ODSP applications
- referrals to Legal Aid Ontario
- referrals to Developmental Services Ontario
- coordination for hospital discharge planning with the hospital, and other involved community organizations
- Case coordination and ABI education between community organizations (Rural Wellington Community Outreach Team, Healthlinks, CMHA, Spinal Cord Injury Ontario, Stonehenge Therapeutic Community, LHIN Home and Community Care).

The case management services supported fifteen clients, seven of which were patients in a local WW hospital, (the majority had been ALC in the hospital for several weeks/months). Two of the case management clients who were supported in this project, have resided in hospital for several months. These two clients required a complex coordinated plan with several community resources before a coordinated discharge could occur.

Nine of the fifteen case management clients required support with accessing long-term affordable housing. Three clients resided in hospital and required appropriate housing with staffing supports in place. Five of the case management clients who received services need affordable housing. Two are currently without a fixed address and in need of urgent housing. One is residing in a subsidized retirement home, which cannot continue to support this client and his complex needs and is threatening eviction for the client.

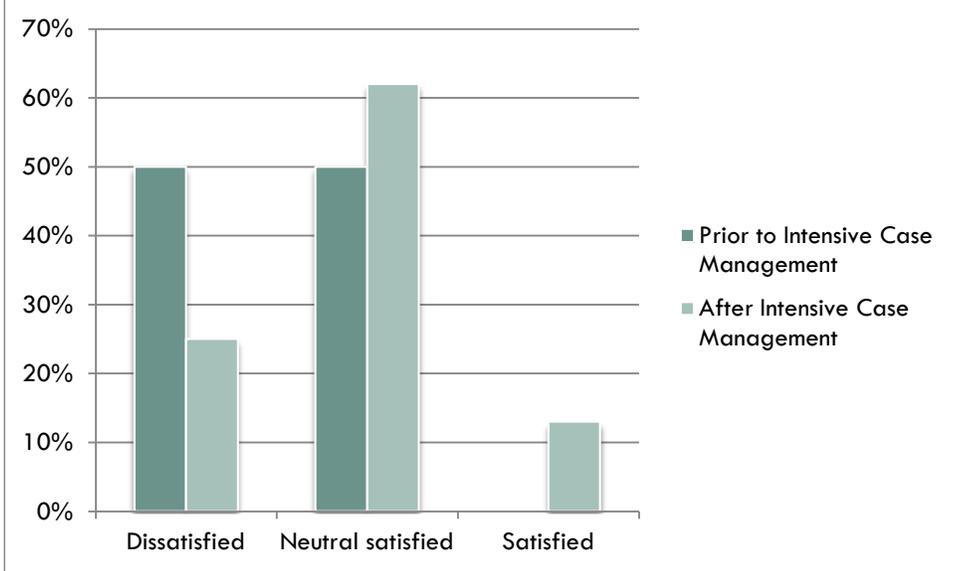
OUTCOMES OF INTENSIVE CASE MANAGEMENT AND DATA COLLECTION

Pre- and post-questionnaires were completed for 70% of the intensive case management clients and their caregivers (as available). From the pre- and post-measures, we did see a decrease in their stress and anxiety, which indicates that the services were helpful to the client, their family, and/or caregiver. Despite the short period (approx. one month) for most clients who received case management service, it was seen as beneficial.

Many of the caregivers completed the ZARIT burden interview. This is a self-inventory, which measures the physical, emotional, and financial burden on support persons or their caregivers. The scale is designed to examine the burden as it relates to supporting the client with an acquired brain injury with their functional and/or behavioural needs in a non-clinical setting. Within the time frame which they received intensive case management support, their caregiver burden score typically decreased slightly yet remained in the same category as when they started. For the majority of the caregivers, their burden level scored in the severe range.

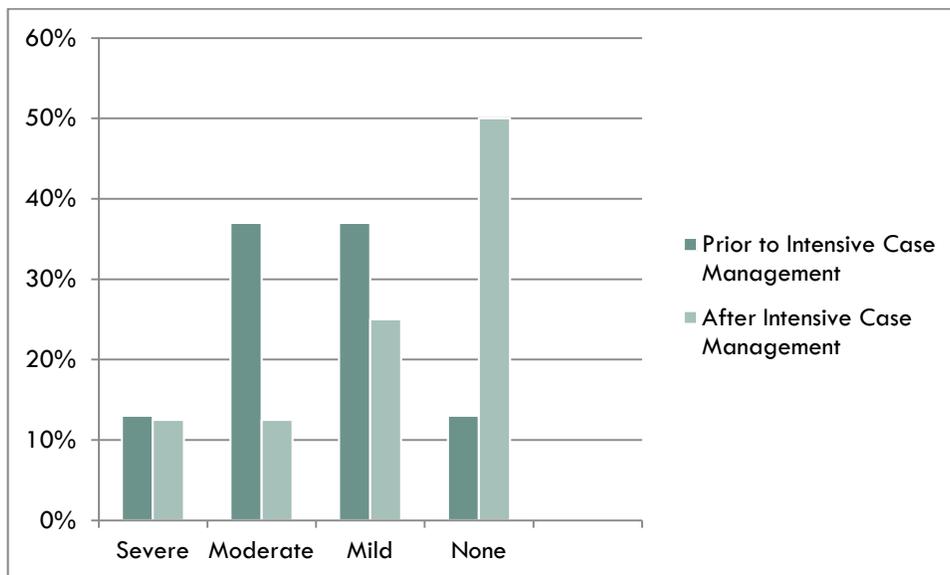
(Dis) satisfaction with service accessibility

Many of the clients completed the Service Obstacle Scale. This test measures the client’s dissatisfaction with service accessibility out of a score of 42. Higher scores indicate greater dissatisfaction and obstacles to service. Overall, initially the clients scored high in this test.



Level of depression

Many of the clients completed the Patient Health Questionnaire (PHQ-9). This is a self-assessment where the scores may be indicative of barriers to service provision. Higher scores on this test may be suggestive of a depressive episode and additional community supports, such as counselling, day programs, and self-help groups may be helpful.



CONCLUSION

The intensive case management pilot proved to make a difference and meet the objectives of the Patients First mandate, the WWLHIN's Integrated Health Services Plan and the Annual Plan. It has provided a high level of care that is focused on significantly improving the experience and health of the residents of Waterloo and Wellington. Its intense focus on the social determinants of health and all other reasons around health inequity is a collaborative process with primary care and all other health care providers.

RECOMMENDATIONS FOR THE FUTURE

1. Consider the intensive case management model of service as a permanent service for the brain injury clients.
2. Ensure the service provides support to both short term and long-term clients
3. Integrate the service within already exiting ABI programs to ensure efficiencies of care and integration
4. Ensure the case management services are fully integrated with primary care, mental health and addictions.

References

Ballew, J. R., & Mink, G. (1996). *Case management in social work: Developing the professional skills needed for work with multi problem clients*. Springfield, IL: C.C. Thomas.

Raphael, D. (2009). *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholars Press.

Addendum 1

A 53 year old single male, who sustained an acquired brain injury from a series of assaults, accidents, and concussions. Initially, he was without a fixed address and did not have any monthly income when beginning Intensive Case Management support. He has a history of alcohol and substance use, at the time of receiving support he has been sober. He has been diagnosed with anxiety, depression, Crohn's and colitis, vision difficulties, chronic pain and vertigo. His goals with the Intensive Case Management process were to find stable housing, access financial support, eat an affordable and healthy diet, regain his physical strength, and to organize his life.

His quote:

"My experience with Intensive Case Management with Traverse Independence has given me a chance to reflected new and prosperous plans for my future. When I first started working with [her], there was a void in my life, which would translate to more depression and feelings like those that I cannot survive. Through working with Traverse Independence, they are helping me in my life plans, and are helping me to fulfill my direction in life. My family is happier for me now, since being introduced to Traverse Independence, my doctor has been on board and suggests that I continue and I will follow their direction. To this date, my conversations with my Intensive Case Manager have been ultimately great. Being able to see, meet and know that I have this support makes me more confident in my next steps of my recovery. My plans are to navigate good health, maintain good thinking, and begin to volunteer and give back my time. This support has brought me back to writing more, brought me out of depression, and allowed me to think about myself more. I now believe that I can get back on my feet, and be on my own again"

Addendum 2

A 53 year old single woman, who has an Acquired Brain Injury due to severe post-concussion syndrome. At the time of beginning Intensive Case Management, she was without any monthly income and was not working due to her injury. She has been diagnosed with anxiety and depression, chronic pain, daily headaches, and has sensitivity to light and noise. At the time of intake, she was scheduled for a hernia surgery, which would limit her physical abilities for a short time. She was having difficulty with household organization, and impulsive decisions surrounding her finances, which was placing her current housing at risk.

She described her intensive case management experience as:

“When I first met with the Intensive Case Manager, I was desperate, overwhelmed, fearful, and uncertain of the future, almost without hope. The Intensive Case Manager walked alongside me as I got my life back on track. [She] helped me to prioritize, organize, and bite off small chunks in my to-do list. She made it manageable, attainable and has been helping me to build confidence in my abilities. She has been helping me to maximize on my strengths. She has helped me sort out my finances, incorporate the use of technology, connected me to existing resources in my community, and has directed me when to use these resources. Things that used to once overwhelm me and would have previously caused significant error, have turned into things that are now are understandable and manageable. I have developed skills to staying on task, stay focused and I have become grounded. I am coming to a place where the storm in my life is starting to calm, I can see the light in the horizon, and I now know that the darkness no longer has to surround me. I can now look to the future.”