Resource Facilitation: Indiana Best Practices Manual for Return-to- Work or Return-to-School

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Indiana Vocational Rehabilitation Services

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Many people have contributed to the success of the Indiana Resource Facilitation initiative. As in anything successful, "it takes a village." It feels impossible to rank order the people who made the most contribution, and in no way does the serial order of the people mentioned herein reflect the magnitude or quality of their contribution. I am also sure that I have left out specific individuals who have been important to these efforts and to them I apologize in advance.

Nonetheless, without Sandra Knutson's efforts to promulgate the clinical benefits of Resource Facilitation, not only for the person with brain injury, but their caregivers and families as well, the Indiana Resource Facilitation initiative would not have begun. Mrs. Knutson supported all of us along the way – advocacy not only results in better lives, but also better science. Thank you Sandra!

The success of the Indiana Resource Facilitation initiative would have not been possible without the support of the Health Resources and Services Administration (HRSA) Brain Injury (BI) grant program. The dedicated and committed leadership of HRSA has been consistently supportive and terrific advocates for people with brain injury. We are very grateful for their efforts and commitment.

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The Indiana Brain Injury Leadership Board was also created through the 2009-2013 HRSA grant. This Board, and all of the dedicated clients, have continued to offer new ideas, open doors, provide new funding streams, and promote awareness of brain injury through their respective governmental agencies and non-governmental organizations.

The Brain Injury Association of Indiana (BIAI) has also been an important partner in the development of Resource Facilitation in Indiana. This project would have not been as successful without the enormous number of volunteer hours provided by Kristen Smith, O.T.R. and Alan Neuenschwander, co-leaders of the Fort Wayne BIAI Support Group, Samantha Backhaus, Ph.D. Susie Fitt, and Susan Crane, co-leaders of the Indianapolis BIAI Support Group, as well as Rebecca Eberle, M.A., S.L.P.-C.C.C. and Laura Karcher, M.A., S.L.P.-C.C.C., co-leaders of the Bloomington, Indiana BIAI Support Group. These Support Group

Leaders have helped hundreds of people with brain injury and their families through providing high-quality and professional support groups. Their collaboration in this project has been invaluable.

The Rehabilitation Hospital of Indiana (RHI) and the RHI Foundation have been essential to the management of the grants supporting the Indiana Resource Facilitation initiatives. We are most appreciative of the efforts of Dr. Dan Wolosyzn, CEO and Dr. Jim Malec, RHI Director of Research, Jim Graham, Executive Director of the RHI Foundation, and all of the staff who have managed the many "behind the scenes" administrative processes essential to these efforts.

Any successful initiative requires excellent staff, and this project has been no exception. Wendy Waldman bravely stepped into the role of the HRSA grant coordinator in the 8th inning and has done a terrific job, bringing excellent experience and training that allowed her to hit the ground running. Our Resource Facilitator (RF) for the research trials, Susie Fitt has been a phenomenally devoted and passionate advocate. Susan Crane, Tina Funkhouser, and Pamela Nihiser have also been terrific Resource Facilitators, dedicated to each of their patients and families. I respect and admire their often very practical and experience-driven recommendations and strategies accompanied by the compassion of "having (literally) been there." Our Local Support Network Leader (LSN) Alan Neuenschwander has worked diligently to develop local infrastructure and systems of support that serve our people receiving Resource Facilitation services. I also appreciate and rely on Devan Parrott, M.S. as our data analyst for her attention to and rigor with data management and her design of the Resource Facilitation database. Devan also has played an essential role in the design of our quality assurance and program evaluation system. Our new Executive Program Assistant, Judy Reuter, has hit the ground running and brings excellent professional, administrative and organizational skills to herd this team into cohesion. Dr. Summer Ibarra has also provided expertise and competence beyond her years and has assumed her new role as Associate Director, Department of Resource Facilitation. And with candor, and not obligation, I am most appreciative of the clinical depth and breadth that Laura Trexler, O.T.R. brings to the team. Bringing Resource Facilitation to Indiana was her idea!

I want to sincerely thank all of the people who have contributed to the Indiana Resource Facilitation initiative. It is remarkable what we collectively have been able to accomplish.

Lance E. Trexler, Ph.D.
March 2014

EXECUTIVE SUMMARY

Resource Facilitation services to assist individuals with a brain injury to return to home, community and work is not a new concept. Based on empirical data, several states have implemented various forms of Resource Facilitation—ranging from "telephonic services only" to a case management approach. With funding from two HRA grants (2006-2009; 2009-20013), Indiana began to explore different models for possible implementation. With VRS serving as the lead state agency, it was appropriate that the goal of Resource Facilitation would focus on return-to-work or return-to-school which is also a key strategy for successful rehabilitation and community re-entry as well as prevention of co-morbidities. Secondly, leaders wanted to move from an empirical based model to one that is evidenced-based with opportunity to review clinical outcomes for patients. As Indiana developed its Resource Facilitation initiative, this clinical approach became part of our guiding framework for discovery, development and implementation.

The Best Practices Manual was developed to help guide other providers in the delivery of evidence-based Resource Facilitation services. The first chapter provides a historical overview of how Indiana has been able to move from science to practice and from practice to policy in now providing Resource Facilitation services. The second chapter provides the overall rationale for why people with brain injury and their families need Resource Facilitation services. We address the variety of issues with recovery from brain injury that influence long term outcome and return-to-work or return-to-school as well as gaps in the continuum of care that are driven by system barriers, among others. In the third chapter, we define Resource Facilitation and provide a detailed overview of the organizational structure for the entire Resource Facilitation team and their roles. Chapter 4 presents our research that supports both the clinical efficacy and the clinical effectiveness of the Indiana Resource Facilitation model. Both randomized controlled trials as well as a prospective clinical cohort study have all demonstrated between 64-68% return-to-work or return-to-school, significantly better than the 30-40% that has been demonstrated without a specialized brain injury intervention.

Chapter 5 presents the Service Model developed with VRS to provide Resource Facilitation in Indiana, including the Resource Facilitation Evaluation, Resource Facilitation services, and the Job Placement phase. We are very committed to ensuring treatment fidelity for all providers of Resource Facilitation and promoting evidence-based practice. These commitments are made possible through a rigorous quality assurance and program evaluation methodology that is presented in Chapter 6. To further support evidence-based practice, we provide training and certification criteria for providers and for all of the professionals on the Resource Facilitation Team in Chapter 7. This chapter also includes criteria for programs to become certified to provide Resource Facilitation services and what the need to do to maintain their certification. In Chapter 8, we draw some conclusions from what has been a very active but productive epoch in the development of Resource Facilitation services and make recommendations for future programmatic and research efforts.

Section 8 of the Manual provides a number of supportive appendices that provide particularly operational related forms and report formats so that future providers of Resource Facilitation do not have to, so to speak, re-invent the Resource Facilitation wheel.

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Chapter

1

Introduction: How Did We Get To Where We Are?

2006-2009 HRSA Grant

Indiana got its start with Resource Facilitation through the 2006-2009 Indiana Brain Injury Health Resources and Services Administration (HRSA) Grant. The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

The 2006-2009 Indiana Traumatic Brain Injury Planning, Implementation and Partnership Grant had the following objectives:

- Complete a statewide assessment of needs and resources
- Initiate statewide information and referral
- Provide statewide education (targeted groups included VRS professionals, Indiana educators, providers, clients)
- Establish a Grant Advisory Council
- Initiate statewide systems of support.

The Needs and Resources Survey identified a number of needs, among them was:

Respondents indicated that they had difficulty with the transition from inpatient/ hospital based care to return to home and work. They did not know how to find resources or negotiate the various government programs and reported not being aware of numerous resources and often felt "dumped" once they were no longer met criteria for receiving services.

Resource Facilitation and the HRSA Grant

Based on this finding, and the collaboration between the ever inspiring and resourceful Sandra Knutsen, of the National Association of State Head Injury Administrators – TBI Technical Assistance Center, and early champion for Resource Facilitation services and Laura C. Trexler, O.T.R., the Indiana Resource Facilitation initiative was begun. As always, Sandra opened many doors and Laura became one of the members of the Person and Family Directed Services

Focus Area Work Group, which was formed in 2006 and expanded to include a sub-group on Resource Facilitation that Sandra organized. Based on Laura's extensive clinical background in vocational re-entry following brain injury, she inspired the idea of Indiana's engagement in Resource Facilitation.

Putting Resource Facilitation to the Test

Not by chance, Laura was able to stimulate curiosity in the present author (Lance E. Trexler, Ph.D.), who suggested that we conduct a randomized clinical trial of Resource Facilitation as, while it sounded like potentially a meaningful service, there was no evidence to support Resource Facilitation services. As a result, we embarked on and completed a randomized control trial that provided some initial evidence to support the efficacy of Resource Facilitation. This study demonstrated that 64% of the participants with acquired brain injury who received Resource Facilitation were able to return-to-work or return-to-school as compared to 36% of the control participants. Further, the participants in Resource Facilitation were found to have significantly greater reductions in level of disability as compared to Control participants.

These results provided some very initial support for the efficacy of Resource Facilitation. However, these findings need corroboration and so we successfully applied to the Indiana Spinal Cord and Brain Injury Research Board for a replication randomized controlled trial in 2009. The results of this larger study demonstrated that 67% of the participants who received Resource Facilitation services were able to successfully return-to-work or return-to-school.

From Research to Practice

Leadership of VRS committed, based on these findings, to fund Resource Facilitation services as part of a pilot program to continue to study the benefits of Resource Facilitation services. Resource Facilitation services were provided to clients of VRS from the northeast and central Indiana regions. In this prospective clinical cohort, support for the effectiveness of Resource Facilitation was demonstrated. It was found that 67% of the Resource Facilitation clients were able to successfully return-to-work or return-to-school.

2009-2013 HRSA Grant

Indiana needed to develop a state-wide model and infrastructure to support Resource Facilitation services, and we successfully applied for our second HRSA grant. In this grant, we were able to establish the Indiana Brain Injury Leadership Board, comprised of representatives from multiple state agencies as well as other non-for-profit and provider organizations, with the goal of promoting awareness and engagement to support Resource Facilitation services. Local Support Networks were developed in northeastern Indiana and Central Indiana to provide for local awareness and coordination of services for utilization by the Resource Facilitators to address individual client needs.

Economic Impact of Resource Facilitation

Also through the 2009-2013 HRSA grant, we were able to engage researchers at the Ball State University Center for Business and Economic Research to study the impact of Resource Facilitation services. These investigators found that if Indiana provided Resource Facilitation services to all applicable people (meeting the same criteria as were utilized in the research trials) with brain injury in Indiana:

- 1003 people with brain injury would return-to-work each year,
- $31,017,775 in lost wages would be avoided each year,
- $10,000,000 in lost business taxes would be avoided each year,
- $4,800,000 in lost personal tax revenues would be avoided each year, and
- These savings did not include expenses associated with other state agencies, disability or Medicaid/Medicare.

2014 HRSA Grant Funding

Indiana was granted a fifth year of funding by HRSA, and with these funds we were also able to develop training and certification criteria for providers of RF services and complete a capacity assessment to determine potential providers of Resource Facilitation services in southern and northwest Indiana to ensure state-wide access.

From Practice to Policy

In 2014, the VRS committed to a sustainable model of providing Resource Facilitation services that was independent of grant funding. The clinical services model for Resource Facilitation are presented in Chapter 5 of this Best Practices Manual.

Chapter

2

Rationale: Why Resource Facilitation is Needed?

A. Scope of the Problem

One million people in the United States experience a brain injury (BI) each year. Based on population, these data would suggest that 20,735 people in Indiana experience a BI each year and the Indiana State Board of Health has reported that approximately 5,146 will require hospitalization. Other studies of outcome would suggest that of these 5,146 patients, 1,660 will have long term disabilities related to their injury. The estimated annual acute health care costs for the patients admitted to Indiana hospitals were $1,001,500,500 not including post-acute medical care, rehabilitation, public or private sector disability, lost productivity, VRS, among others. These data only describe the incidence and cost of traumatic brain injury, and do not include data for other types of acquired brain injury, such as various types of stroke, brain tumors, infections or other types of brain injury.

In the Indiana 2006-2009 HRSA BI grant, the Indiana Statewide Needs and Resource Assessment was completed based on responses from people with brain injury, their families, and professionals. Some of the most significant findings from the needs assessment include:

- The most prevailing issue that surfaced was the lack of awareness around brain injury. This included how to recognize BI in medical or non-medical settings, how to locate and utilize available resources for survivors and families, and the general public's awareness of BI.

- The top five services that survey respondents indicated they needed, but did not receive were: Behavioral Supports, Support Groups, Assistive Technology, Cognitive Rehabilitation, Brain Injury Residential Programs and Recreational Opportunities.

- Respondents indicated that they had difficulty with the transition from inpatient/ hospital based care to return to home and work. They did not know how to find

resources or negotiate the various government programs and reported not being aware of numerous resources and often felt "dumped" once they were no longer met criteria for receiving services.

B. "Recovery" following Brain Injury is Highly Variable

There are several different stages of recovery following a brain injury and the attendant resources needed are different. Advances in our emergency medical system and neurosurgery have resulted in many more people surviving moderate-to-severe traumatic brain injury. After acute hospitalization and transfer to the acute rehabilitation hospital, services are then directed at self-care. At this point the patient and family are still being largely directed by the health care system.

Many of the long term cognitive, behavioral, and psychosocial consequences of brain injury emerge following acute rehabilitation or discharge from acute hospitalization. It is at this post-acute phase when the effects of cognitive and neurobehavioral problems become apparent. Many of the psychosocial difficulties that accompany brain injury, affecting the person with the injury, as well as their families, emerge within the first 6-12 months after injury. It is at that time when they are confronted with everyday challenges such as solving once simple or automatic problems or having to multitask between competing demands. This is the stage where the medical and health care systems are frequently the least able to address these difficulties.

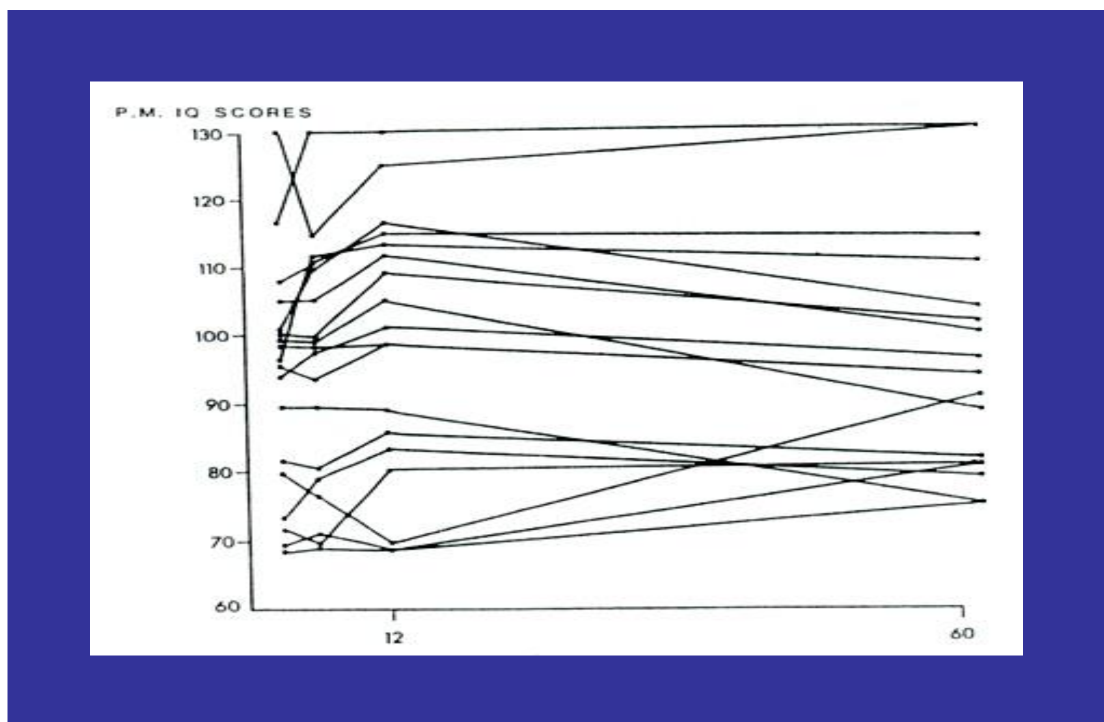
In some environments, sophisticated post-acute brain injury rehabilitation programs are available to address these problems; other programs may be limited due to geographic reasons or limited reimbursement. Assuming that the person has some access to outpatient services, they are often limited to 1 or 2 months following discharge which may sufficiently address the cognitive, behavioral, emotional or social and family struggles that accompany brain injury. Residual cognitive, behavioral and psychosocial difficulties are the most frequent barriers to returning to work following brain injury. Without rehabilitation, the patient with brain injury has limited opportunity to become a candidate for VRS. These different stages of "recovery" are continuous; the different facilities and services are provided in different settings (e.g., hospital, clinic, supported employment setting) and typically funded by different sources.

Brain injuries vary in severity and trajectory of recovery. Severity of injury can vary from quite mild with transient cognitive and neurobehavioral impairments to death or persistent vegetative states. However, initial severity of injury is not a good predictor of long-term level of disability. Pre-injury cognitive resources, medical factors, substance abuse, family support, and psychiatric status, among others, affect recovery. Post-injury factors include family and social support, access to rehabilitation, substance abuse, pharmacological

mismanagement, and psychiatric co-morbidities after injury. The influence of these diverse factors results in significant heterogeneity in a) the clinical presentation after brain injury and b) the trajectory of recovery.

Figure 1 exemplifies this heterogeneity. These data were gathered for BI subjects at immediately after injury and at 6, 12 and 60 months post-BI on a measure of executive functioning (planning and sequencing). Each line on the figure represents one person's performance on this measure of executive functioning at these 4 observations over time. These subjects received at most acute rehabilitation, and some of the mild BI subjects were discharged home after acute inpatient admission. The number of subjects who either did not make much recovery and/or declined over time is notable. The declines were most likely associated with biopsychosocial factors that affect the functional expression of the injury, such as substance abuse, environmental and social withdrawal, or depression.

Figure 1
Heterogeneity of "Recovery" after Brain Injury



C. Resources are Limited and Fragmented

There are few health care or clinical providers that specialize in brain injury. These professionals are often spread across multiple disciplines, including neuropsychologists, rehabilitation therapists, physiatrists or vocational specialists. People with brain injury and their families may not know what kind of professional to access for different problems, and not all professionals within a given profession may be experts in acquired brain injury.

Further, there are multiple gaps between the health care system and other social supports, such as vocational services. Many patients are unfortunately discharged from acute care or acute rehabilitation hospitals without a long-term plan or without specialized brain injury follow-up. Additionally, the reimbursement for these services is obtained through different systems. Patients may have access to-- but be unaware of--multiple payment systems, including private health insurance, public health insurance, VRS or waivers. Overwhelmed families are typically challenged by complex funding guidelines according to their policies that includes, types of services covered, eligibility criteria, and waiting lists.

These gaps leave the person with a brain injury and their stressed families to navigate an “ocean” with no compass; exacerbating the effects of the emotional and psychosocial consequences of their injury. This can detrimentally impact their recovery gains while setting the stage for further deterioration through the development of comorbidities such as depression, substance abuse, family breakdown, and all too often incarceration.

Resource Facilitation provides for a brain injury specialized proactive navigator for the person with brain injury and their family.

Chapter

3

What is Resource Facilitation?

A. Resource Facilitation Defined

"Resource facilitation is a partnership that helps individuals and communities choose, get and Keep information, services and supports to make informed choices and meet their goals[1]." The collaborative process involves clients (individuals with brain injury and their personal support systems) working in partnership with facilitators (individuals who provide assistance in navigating systems) to achieve agreed upon goals.

In 2001, an estimated 6,250 individuals in the United States participated in one of 16 resource facilitation programs for people with brain injury[2]. That number has now increased drastically. Depending on the program, resources are acquired through referral, purchase or direct provision of services and supports. Based on program descriptions collected by the Brain Injury Association (BIA), the estimated annual cost of resource facilitation was $1,200 per person in 1999. State government agencies, nonprofit organizations and for-profit entities offer the program, often at no charge or on a sliding scale fee basis, to the clients. Facilitation may begin at the onset of the injury, following acute rehabilitation or during community re-entry. Programs may last for weeks, months or years.

B. The Organizational Structure for Resource Facilitation

The Indiana Brain Injury Leadership Board

Through the Indiana HRSA grants, the Indiana Brain Injury Leadership Board was developed and was co-chaired by the lead agency, VRS and the Lead Contractor, the Rehabilitation Hospital of Indiana. The over-riding goal for the Board was to sustain Resource Facilitation services, but also to promote interagency awareness, coordination of services, and continually re-assess needs and resources for people with brain injury. The Indiana HRSA Brain Injury Leadership Board will also serve as the Professional Advisory Council for the Indiana

[1] Connors, S.H., (2001). Resource Facilitation: A Consensus of Principles and Best Practices to Guide Program Development and Operation in Brain Injury. http://nashia.org/pdf/biaaresfacilconsensus.pdf

[2] HRSA's MCHB Federal TBI Program's TBI Technical Assistance Center ; National Opinion Research Center (NORC) at the University of Chicago, Resource Facilitation: A Summary of Programs in the United States, 2009. https://tbitac.hrsa.gov/download/ResourceFacilitationGuide-508.pdf

University/Rehabilitation Hospital of Indiana Traumatic Brain Injury Model Systems (TBIMS) grant awarded in November of 2012. The receipt of the TBIMS grant, and it's linkage to the Indiana HRSA Brain Injury Leadership Board provides for a unique synergy of research, clinical service and policy as related to brain injury in Indiana.

The Board is composed of representatives from the following state agencies and organizations:

- VRS – Family and Social Services Administration (FSSA)
- Rehabilitation Hospital of Indiana
- Indiana University School of Medicine, Department of Physical Medicine and Rehabilitation
- Maternal & Child Health - Indiana State Department of Health
- Office of Primary Care - Indiana State Department of Health
- Indiana Protection and Advocacy Services
- Brain Injury Association of Indiana
- Department of Veterans Affairs
- Office of Medicaid Policy and Planning Coverage & Benefits - FSSA
- Division of Aging – FSSA
- Department of Mental Health and Addiction - FSSA
- Indiana University School of Health & Rehabilitation Sciences
- The Mentor Network
- Center on Community Living and Careers; Indiana Institute On Disability and Community – Indiana University
- Indiana Senate
- Indiana House of Representatives
- Indianapolis Medical Society
- Indiana Department of Correction
- Indiana Veterans Behavioral Health Network (IVBHN)
- INDATA - Indiana Assistive Technology Act/Easter Seals Crossroads

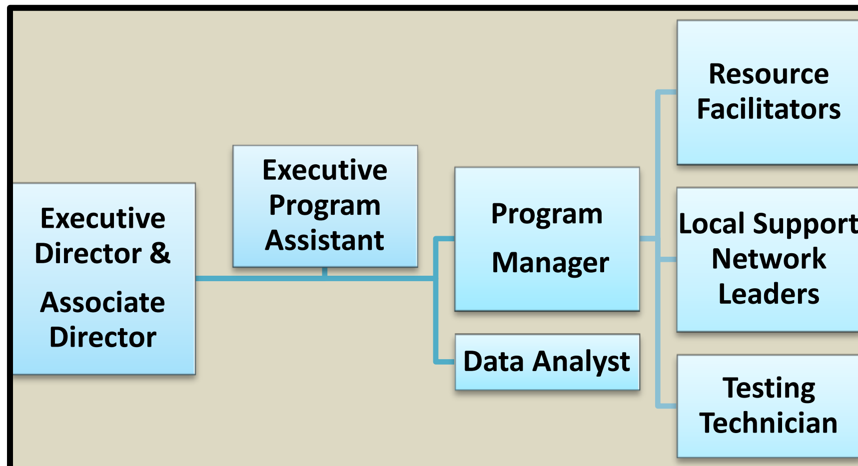
The Leadership Board, and in particular VRS were successful in sustaining Resource Facilitation services, so starting in 2014 the Leadership Board will address other applications of resource facilitation as well as other priorities for brain injury services in Indiana.

The Resource Facilitation Team

The Rehabilitation Hospital of Indiana (RHI) Department of Resource Facilitation has led the research initiatives and clinical development and is comprised of the positions identified in the figure below. The team is clinically led by the Executive and Associate Director, as well as the Program Manager. These positions are filled by a Rehabilitation Neuropsychologist and Rehabilitation Psychologist as well as an Occupational Therapist with considerable

brain injury and vocational re-entry experience, respectively. Training and experiential criteria for all positions in the Resource Facilitation team are provided in Chapter 6.

The following figure illustrates the overall organization of the Resource Facilitation Department. The table thereafter provides a summary of responsibilities for each position.



Resource Facilitation Team: Roles and Responsibilities

Title	Reports to	Responsibilities
Director	CEO	a. Oversees Grant & Clinical Resource Facilitation Program's operations, services and programs; liaison with administration as appropriate. b. Researches, develops, guides implementation of programs and services; evaluates for quality and outcome c. Provides NeuroVocational Evaluation (NVE) services, including the development and implementation of treatment plans for individual patients as it relates to return-to-work and return-to-school d. Provides clinical guidance, staff education, in-services, opportunities for professional growth and mentorship to team
Associate Director	Director	a. Provides NeuroVocational Evaluation services, including the development and implementation of treatment plans for individual patients as it relates to return-to-work. b. Provides clinical guidance, staff education, in-services, opportunities for professional growth and mentorship to team c. Assists Director in developing, overseeing implementation, and evaluation of programs and services d. Develops and implements RF related research activities and assists in dissemination and presentation of results.
Data Analyst	Director	a. Analyzes data from Resource Facilitation procedures and evaluations

		b. Delivers data products in report, presentation or verbal communication c. Maintains accurate and reliable data entry d. Conducts data integrity audits e. Collects data from Resource Facilitators and RF staff f. Participates in continuous quality improvement/ program evaluation activities and observes measures to ensure that quality standards are met.
HRSA Grant Project Coordinator	Director	a. Spearheads the development of certification criteria for Neuropsychologists (NY) and Resource Facilitators (RF) b. Spearheads the development of education component for certification of NY and RF c. Develops competency criteria for NY and RF d. Assists with Certified Brain Injury Specialist (CBIS) training of RHI RF staff, as needed e. Coordinates Employment Specialist Training with Dr. Bob Fraser f. Monitors BIAI e-learning website development for HRSA e-learning goals g. Oversees BIAI Resource Directory and modifies resources for LSN regions h. Works with LSN leaders to market services
Program Manager	Associate Director	a. Oversees and manages RF referrals; tracks referral trends related to regions b. Oversees and manages internal deliverables related to work flow, time lines w/referral management & service delivery c. Oversees budget including liaison w/Patient Financial Services regarding coding, billing (when sent, status w/payment) d. Updates and audits Medical record/Electronic Medical Records, charts e. Monitors customer satisfaction including client/family, VRS, employer f. Monitors internal team workmanship g. Provides team leadership, direct staff supervision, staff support, serves as liaison with RHI management team and offers education regarding leadership agenda h. Assists director and associate director in program development as needed
LSN Leaders	Program Manager	a. Guides a core team-BIAI support group leaders, VRS Counselor - in Local Support Network Leader (LSN) development and sustainability b. Informs and guides LSN regional advisory board c. Builds a consortium of regional resources: providers, state agencies, employers, etc. d. Participates in client specific assessment, identifies community resources and natural supports appropriate to support the needs, and assists in development of a written plan for patient and family.

		e. Completes a vocational stabilization plan which includes initiation of a monthly team review of plan, methods to monitor employment/academic adjustment, employer satisfaction/academic success and ongoing education regarding accommodations, etc., with placement of client f. Documents regional resources and acts as a liaison with BIAI to update regional Resource Directory g. Performs marketing calls to LSN/RF referral sources focusing on recruitment of clients, stakeholder guidance to training/education h. Supports regional RF by offering resource contacts i. Assists with data collection and reporting such as client case conversion to VRS and then to RF authorization, employer site development, employer satisfaction
Resource Facilitator	Program Manager	a. Identifies, facilitates, and procures resources to assist client in achievement of optimal levels of independence and community re-entry related to return-to-work or return-to-school b. Serves as the communication linkage between client/family, VRS Counselor, RHI team, providers, state agency, BIAI support group, and more c. Serves as a BI educator to stakeholders involved in client's care d. Serves as an advocate and models positive advocacy for client and family e. Offers training and education to clients in specific areas of need to complement provider care f. Offers ongoing support to client/family g. Completes assessments, daily activity logs, support service application assistance and other written documentation as needed h. Collects data to support program evaluation including measures of orientation, activities of daily living, satisfaction surveys
Executive Program Assistant	Direct Report – Director Indirect Report - Program Manager	a. Liaisons with VRS – accept referrals, track updated VRS office staff directory and disseminate to staff, log data related to authorizations (type, amount, etc.) b. Sends evaluation & service reports at each stage of completion to RHI internal billing and tracks dates sent c. Schedules evaluation and monthly team conferences

Chapter

4

Indiana Outcomes for Resource Facilitation

Returning someone to work with a brain injury is a plan that is established as soon as possible in their course of rehabilitation. Unfortunately, multiple studies have demonstrated that the return-to-work rate following brain injury is quite low, particularly when the patients do not have access to specialized post-acute brain injury rehabilitation. While the range in the percent that return-to-work ranges considerably, the vast majority of studies indicated that approximately 30% of people return-to-work within one year following moderate to severe acquired brain injury.

Randomized Control Trials of Resource Facilitation

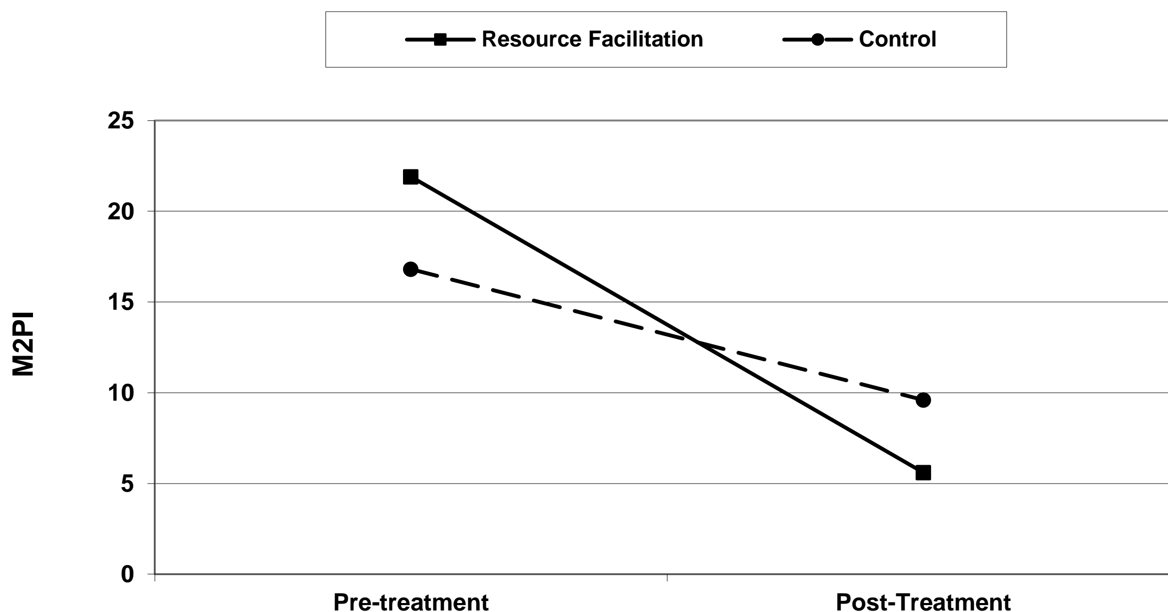
In our first randomized controlled trial, participants were 23 people were recruited from the Rehabilitation Hospital of Indiana Brain Injury Rehabilitation Unit. These people were randomly assigned to either the Resource Facilitation group, or control group (with regular follow-up). Those patients that were randomized into the Resource Facilitation group (N=12) received six months of Resource Facilitation services. These participants had a variety of acquired brain injuries, including traumatic brain injury, intracranial hemorrhage, and stroke.

Statistical analyses demonstrated that there were no differences between the two groups in terms of age, sex, education or diagnosis. At enrollment, each patient was assessed regarding their overall cognitive impairment. Both groups were found to be equivalent in terms of their initial severity of cognitive impairment. The Resource Facilitation group was found to be 52 days post injury as compared to 85 days for the Control subjects, although this difference was not found to be statistically significant.

At the conclusion of six months of Resource Facilitation, 64% of the patients who had received Resource Facilitation were employed at follow-up as compared to 36% of the control group. Statistically, this was found to be very significant ($p \leq 0.0001$). The Mayo Portland Adaptability

Inventory-4 (MPAI-4) Participation Index was also administered at enrollment and at follow-up (see Figure 4). This Index contains items that measure degree of independence with activities at home and in the community, transportation and return-to-work.

While both groups improved significantly, (less is better on the MPAI-4 as it is a measure of disability), the group that received Resource Facilitation demonstrated significantly greater improvement relative to the control group. This was also very statistically significant (p=less than 0.0007) despite the fact that the Resource Facilitation group was a little more disabled (although not significant statistically) than the control group at enrollment. These findings indicate that patients who received Resource Facilitation services returned to work much more often and were more independent in their home and in their community. These findings were published in the Journal of Head Trauma Rehabilitation (see **Appendix A**).



Based on our first randomized controlled trial, we applied to and received funding from the Indiana Spinal Cord and Brain Injury Research Fund for a replication trial with a larger sample size. In this study, we recruited 44 participants from the Rehabilitation Hospital of Indiana with acquired brain injury and randomized them into Resource Facilitation and Control groups. The randomization was performed by a research associate that was blinded to their follow-up condition. The Resource Facilitation participants received 15 months of Resource Facilitation while the Control participants received regular follow-up. The participants were on average 64 days post injury, 37 years of age, were 62% male, and had 13.62 years of education. No significant differences between the two conditions were found for age, education, sex, initial severity of cognitive impairment or time since injury.

Sixty-eight percent of the participants who received Resource Facilitation services were found to return-to-work or return-to-school as compared to 55% of the controls. The outcomes for the Control group revealed a significantly better outcome than most studies of return-to-work following brain injury. Further inspection of the data revealed that 9 of the Control group participants and two of the Resource Facilitation group returned to work or school within one month of being recruited into the study. When these participants were removed from the analyses, it was found that 67% of the Resource Facilitation group participants versus 44% of the Control group participants successfully returned to work or school after 15 months. It was also found that for those participants that who returned to work or school, they had significantly lower levels of psychological distress. It was also found that decreased time since injury predicted success (employment or school) ($\chi 2$=6.5, p=.011). While the numbers of participants in the control group that were able to return-to-work or return-to-school was found to be considerably better than in other studies, these findings continued to demonstrate better outcome for participants who received Resource Facilitation.

A. A Prospective Clinical Cohort Trial of Resource Facilitation

A total of 161 clients were referred by VRS and enrolled in Resource Facilitation services between March 8th 2010 and October 30, 2013. Of these 161 referrals, 25 clients never started Resource Facilitation services. An additional 10 did not finish Resource Facilitation services secondary to a variety of factors including moving out of state, death and no longer having a return-to-work goal. At the time of these analyses, 57 cases were still active. Only the 69 clients with closed cases were therefore included in the present analyses.

Results from the prospective clinical cohort revealed that this group was on average 9.28 <u>years</u> post injury, in stark contrast to the participants in the randomized controlled trials, which were 52 <u>days</u> and 64 <u>days</u> post injury, respectively. The average age was 38 and 54% had greater than a high school education. Seventy-eight percent of the clients were male.

The results demonstrated that 67% of the clients who received Resource Facilitation were able to return-to-work or return-to-school, certainly consistent with findings derived through the randomized clinical trials which revealed that 64% and 68%, respectively. These findings taken together provide strong evidence to support the efficacy as well as effectiveness of Resource Facilitation services following both acute and chronic acquired brain injury in terms of promoting return-to-work or return-to-school.

B. Economic Impact of Resource Facilitation

The Center for Business and Economic Research (Ball State University) studied the potential economic impact of providing Resource Facilitation to all Indiana people who sustained a brain injury (moderate to severe) comparable to those studied in our first randomized controlled trial (see **Appendix A**). They simulated the economic impact of this intervention on the estimated population of brain injury patients in Indiana per year and provided estimates of the earnings losses associated with BI and the resultant long-term disability (compared to "return-to-work").

Utilizing incidence rates, Indiana's share of BI related long-term disability is 6,181 persons per year. With the RF intervention showing 64% employed post-treatment, an average of 1,003 Indiana residents would return-to-work with RF. The average earnings for those employed in Indiana and who are 25 years old or older is $30,925. Therefore, the average economic impact of RF treatment is $31,017,775 annually in avoided lost wages. If further adjusted by age, percent employed, and educational attainment, this recaptures an additional $22.5 million in additional earnings on an annual basis.

The researchers suggest that the estimates of $31 million and $22.5 million are very conservative. For example, they do not reflect annual losses to business tax revenue ($10million) or personal tax revenue ($4.8 million) that results from work force loss. Fringe benefits and Medicare/Medicaid costs are other example not reflected in these amounts.

C. Customer Satisfaction

As evidenced, the data illustrates that Resource Facilitation is effective in returning clients with brain injury to work and school. However, there is also a human element that defines success of the service. This includes personal perception and reaction to the services provided for all engaged clients: the client, VRS Counselors and Resource Facilitators. When reviewing anecdotal evidence from correspondence, surveys and other forms of feedback, several key themes arise regarding each of the key clients. The following is some of the qualitative feedback we have received from various constituencies.

Feedback from our Clients:

- *I would have never gone to a support group meeting if my RFer did not go with me. I was nervous to go by myself.*
- *She is my "angel." I would not be here without her.*
- *She consistently goes above and beyond for her clients.*
- *She thinks outside the box; does work she does not need to. She is a pleasure to work with and to talk to.*

- *My experience has been positive, educational and rewarding. Our every need was met.*
- *I am very lucky to have her as my RFer. She is very knowledgeable of my injury and very knowledgeable of services offered to individuals with my condition.*
- *Without her I would have had no direction. I am very thankful to have her guidance and help.*
- *After being my lifeline for the past year, I am a little afraid of not being able to do this myself. She has been heaven sent and I will miss her sooooo (sic) much.*
- *She was always there to answer any of my questions and I feel she really cared about my family. Knowing I could call her with any question really helped me feel better.*
- *"As much as this new life I was forced into is hard to understand, I am so glad you were brought into our life. You truly are GOD sent and a real Blessing to both of us. Thank you for putting your heart into all you do."*
- *I am glad that I was offered the chance to participate in RF. Even though my recovery was fairly simple and I did not require much help it was great to know that I had access to these resources. My RFer helped me with several requests, such as sending medical records from NRC to the FAA and TSA, It was excellent to have someone available all the time whom I trusted and could provide any help I needed during my return to education. Now I am involved in a career search and continue to receive help.*
- *From my experience I would say that the program is extremely helpful, and can be even more so for those who need more assistance than I did.*

Feedback from VRS Counselors:

- *Has the time and the specific knowledge base of the resources beyond the purview of VRS*
- *Can be creative in identifying the formal and informal supports needed to effectively utilize the services we provide*
- *Coordinate records to expedite processing*
- *Is the "lifeline" for the client once they leave our office*
- *Can identify potential issues early in "patient reviews" with the team to ensure appropriate interventions*
- *They can follow-up with case details that often time the client can't manage*
- *The client is not alone—they help provide consistency once they leave our office*
- *With the additional client contact that RF provides, the RFers have a better understanding of clients needs*
- *Since the RFers have "been there" clients are more at ease to share*
- *They have ability/flexibility to collaborate with professionals and government agencies for resources and assistance*
- *They are able to advocate for the services the client needs*

- *The RFer is the go between client and team members*
- Assist with education, support and involvement of family
- They can make client accountable for her part in the success of her recovery and outcome
- We have started to include the RFer in our staffing. This has made us more effective and efficient; and a learning experience for all.

The following testimonial is lengthy, but it illustrates the range of supports and services that Resource Facilitation provides the VRS Counselor.

I have been a vocational rehabilitation counselor for the past five years, most of which occurred in another state.

The state I previously worked in did not have Resource Facilitation. I had a number of clients with TBI who consequently "fell through the cracks" because they could not keep up with appointments or follow through with services. In addition, I did not have the time or knowledge to connect them with resources that were available to them outside of vocational rehabilitation that very well could have made the difference for them being able to obtain and maintain work.

I have been extremely impressed with the Resource Facilitation services provided by RHI, and I know that these services have made the difference in clients' lives. For example, the Resource Facilitator for one of the clients I work with has been working with a judge to ensure that he does not go back to prison. She was able to provide medical documentation to the judge and explain how his behavior is related to TBI and that he is working hard toward his vocational goal. Obviously this one example is a powerful testament to the Resource Facilitation program.

In another case, the Resource Facilitator worked with a client to assist her with adjustment to a technical position that was initially quite stressful. This client is maintaining a high paying full-time position with benefits, in large part due to the Resource Facilitation that was provided.

The Brain Injury Coping Skills group is another example of how Resource Facilitation has helped clients on my caseload understand their disability, learn coping mechanisms, and receive support from others who have the same disability. I believe that while I could refer someone to this group, the likelihood of them being able to follow through with the group is much higher with the Resource Facilitator assisting with transportation coordination, which can be very difficult or next to impossible for someone with a brain injury.

In summary, based on my experience of doing voc rehab for this population both with and without Resource Facilitation, I believe that Resource Facilitation is a

necessary service for clients who have TBI. If it were not in existence, many, if not all these clients would not be able to be served by voc rehab, because they would not be able to follow through to obtain the services that we provide. It is the connecting glue that makes everything work.

Chapter

5

Indiana Resource Facilitation Service Model

A. Eligibility Criteria for the Resource Facilitation Program

The eligibility criteria are based on our previous research and clinical experience in returning people to work following brain injury. Eligibility criteria include:

- Return-to-work goal, and
- A diagnosis of a non-progressive impairment of brain function (e.g., traumatic brain injury, stroke, brain infection, hypoxia, among others).

The operational management of the entire Resource Facilitation services is provided in the Resource Facilitation Program Management Timeline found in Appendix B. Further, the Resource Facilitation Authorization Timeline can be found in Appendix C. This document provides for information regarding the stages of service provision and payment points from VRS (VRS).

B. Referral to Resource Facilitation

Each of the 25 VRS offices in the state of Indiana has established a VRS Brain Injury Counselor. These individuals are primarily responsible for tracking newly eligible clients with an acquired brain injury, and establishing an Individualized Plan for Employment (IPE). In addition, the VRS Brain Injury Counselor serves as a consultant to other counselors who have an established plan for an individual with brain injury.

A referral for Resource Facilitation services may occur before or after VRS eligibility determination as appropriate to each individual. The VRS Counselor will contact the Executive Program Assistant (EPA) of the Resource Facilitation Program to make the referral by filling out a Referral Form/ Face Sheet for RF Services and sending it to the RF Office.

The EPA receives the Referral Form/ Face Sheet (see **Appendix D**) and the authorization for RF services and enters the data into the Resource Facilitation Database. The EPA then sends the referral information to the assigned RF and RF Program Manager. EPA also contacts the client and schedules their NeuroVocational Evaluation (NVE) as well as the Initial Team Conference for the RF team. EPA also mails a 'Welcome to RF' Packet (see **Appendix E**) to the client.

C. Resource Facilitation Evaluation

The evaluation therefore has four components, as follows.
Resource Facilitation Evaluation

1) Resource Facilitation Initial Intake
2) Local Support Network Community Resource Assessment
3) NeuroVocational Evaluation (NVE) for Resource Facilitation
4) Initial Team Conference

1. **Resource Facilitation Initial Intake** (see **Appendix F** for the Intake Form)
Within three business days, the Resource Facilitator (RF) contacts the prospective client and arranges the date, location, and participants for the Initial Intake. The Resource Facilitation Initial Intake includes scheduling, travel time, face to face evaluation with the client and family, consultation with other team members as required, and documentation on the Intake Form.

The Initial Intake is designed to establish needs, review goals related to return-to-work or return-to-school, identify existing and make an initial determination of needed resources, including funding, services and partnerships. A release of information will also be signed to give the RF permission to contact the client's current service providers and other necessary parties. Some areas addressed include: demographics, residential information, marital status, methods of transportation, educational history, hospitalization and rehabilitation care, employment history, affiliations and memberships and current benefit information. The Resource Facilitation Client Agreement (see **Appendix G**) and the Client's Rights and Responsibilities will be reviewed and signed with the client and their caregiver/ supports. Resource Facilitators also administer the Cognitive Log (C-Log) (Novack, 2004). The C-Log is a very basic measure of severity of cognitive impairment based on ten items that involve attention, memory and cognitive flexibility. The Resource Facilitator will also complete an Activities of Daily Living Questionnaire (ADLQ) and a Survey of Unmet Needs and Service Use (SUNSU). The C-Log, ADLQ and SUNSU are also used for the Program Evaluation process for Resource Facilitation.

A critical component of Resource Facilitation is education about brain injury, for the client, their family, their employer and co-workers. Education begins at the time of the initial intake.

2. **Local Support Network (LSN) Community Resource Assessment** (see **Appendix H** for the corresponding form)

The LSN Leader will participate in this part of the Resource Facilitation process by determining the client's community resource needs. In contrast to the Resource Facilitator, who collects information about the person and their family/caregiver, the LSN leader will identify community resources and natural supports that are appropriate to access these needs. The LSN leader is responsible for asking, from the very beginning, what will be needed to reach vocational placement and vocational retention, and what community resources may be needed including therapeutic and physician services, mental health and/or substance abuse centers, transportation, potential employers, brain injury support groups, family supports among many others. The LSN leader also ensures that these supports remain in place for the client after Job Placement and thereafter as determined appropriate by the clinical team.

3. **NeuroVocational Evaluation for Resource Facilitation**

The NeuroVocational Evaluation for Resource Facilitation is a day-long evaluation conducted by a Neuropsychologist or Rehabilitation Psychologist and includes the following components:

- Review of the medical and Resource Facilitation records by the Neuropsychologist,
- One hour consultation with the Client and Family and the Neuropsychologist,
- Determination of the specific tests needed by the Neuropsychologist,
- 8 hours of testing and scoring of all tests administered by a trained psychometrician,
- NeuroVocational Evaluation Report for Resource Facilitation, that includes:
  - Determination and certification of need for Resource Facilitation (if the client is appropriate for resource facilitation services), and
  - Determination of the specific needs, goals and treatment plan for Resource Facilitation.

Please see **Appendix I** for forms and outcome measures that are used in the NeuroVocational Evaluation including the timeline for the evaluation, the clinical interview, the Mayo- Portland Adaptability Inventory-4 (MPAI-4), the Vocational Independence Scale-Revised (VIS-R) and the RF NVE- Data Entry Form.

The NeuroVocational Evaluation for Resource Facilitation includes evaluation of the following domains:

- Cognitive functions (e.g., learning and memory, executive functions, language)
- Neurobehavioral functioning (awareness, impulsivity, behavioral self-regulation)
- Medical and Psychological History
- Medications
- Vocational preferences and barriers
- Level of disability associated with the injury, including abilities, adjustment, and participation
- Assessable transportation
- Substance abuse history
- Coping styles and skills
- Family support
- Extensive pre-injury vocational and educational history

The NeuroVocational Evaluation for Resource Facilitation was designed to answer the following types of questions:

- What are their vocational options given their cognitive, behavioral and social resources and limitations?
- What are the best strategies help them resume a vocational role?
- What are their vocational preferences?
- What types of rehabilitation may they need to achieve and maintain their vocational potential?
- What other resources may they need to obtain or retain employment?

4. Initial Team Conference (see **Appendix J** for the corresponding form)
Each case is reviewed by the Team after the Resource Facilitation Initial Intake, LSN Community Resource Assessment and NeuroVocational Evaluation for Resource Facilitation have been completed to obtain the perspective from the entire team in developing a plan and goals for resource facilitation. Clinical and vocational perspectives merge into a client-centered approach derived through team collaboration that is monitored over time in subsequent team conferences.

Documentation Requirement – A report will be prepared by the Neuro/Rehabilitation Psychologist for the entire Resource Facilitation Evaluation that reviews the findings from all of the components of the evaluation, which is submitted to the VRS Counselor along with billing for the service.

D. Resource Facilitation Services

In the Indiana Resource Facilitation model, the Resource Facilitator initiates follow-up with the client at a minimum of every 2 weeks. This contact serves to offer support, encouragement, education and provide new information, review previous assignments, and/or establish new assignments. Contact with family, other service providers, potential funding sources, state agencies, and more are ongoing as well.

1. Resource Facilitation Services Initial Report (see **Appendix K**)
Following the assessment phase, Resource Facilitation Services cannot begin until services have been authorized by a VRS Counselor. If deemed necessary within the evaluation process, this service is billable after 1 month of Resource Facilitation service and with at least two contacts with the client.

Upon VRS approval, the Resource Facilitator will initiate services by having an initial meeting with the client, documenting this meeting and any other contact. After the initial contact, the contact with the client will be on a regular basis.

The Resource Facilitation Services Initial Report will then be completed and will consist of the following activities documented within the report:

- 2 meetings with the client to review the results and recommendations from the evaluation and update information
- Information on the goals identified for Goal Attainment Scaling
- A case conference with the Resource Facilitation Team to discuss immediate needs and actions within the case.

Following the RF Services Initial Report, the team will conduct the following activities:

- Resource Facilitation provision by coordination between VRS, service providers, employers and other resources.
- Resource Facilitation services to address the immediate needs as identified within the NVE Team Conference.
- Monthly Case Conferences with the Resource Facilitation Team including the Neuropsychologist, Resource Facilitator, Program Manager, LSN Leader, and others.
- Resource Facilitation Activity Logs documenting activities, events and goals.
- Travel Time and Mileage
- Ongoing Quality Assurance and Program Evaluation

Goal Attainment Scaling (GAS) provides a method for setting and measuring goal attainment. It helps the client to foster self-awareness and to build the capacity for goal setting. It also allows the Resource Facilitation team to monitor progress in treatment and in setting treatment priorities, especially when looking into work readiness. Goals will be

reviewed and scored from the beginning of Resource Facilitation Services all the way to discharge from the Resource Facilitation program. The scores and progress made will be documented on monthly RF Activity Logs, RF Initial Report, RF Final Report, Vocational Placement Report and the 90 Day Employment Report.
Resource Facilitation Activity Logs (see **Appendix L**) are utilized throughout the course of treatment, allowing the Resource Facilitator to catalogue content and date of each contact with clients, family, resources, and more. In addition, the historical overview assists in monthly internal client progress reviews, monitoring activities as they relate to the original plan, allows for plan modification with historical support, supports staff and patient accountability, illustrates the proactive approach and serves as an additional vehicle for data collection for later research projects. These Activity logs are sent to the VRS Counselor on a monthly basis.

During treatment, all Resource Facilitation time is tracked and coded based on activity type. All activities are also coded based on who the Resource Facilitator was interacting with (the client, a family member, or VRS Counselor), and the method of contact (phone, email, or in-person). At least for our project, we feel that it is very important for the Resource Facilitators to all code the quantity of time by the specific type of activity in a consistent manner. Aggregating and coding the data in consistent manner allows for subsequent analyses, particularly as related to guiding resource utilization and by types of activity that may be associated with optimal outcome (see **Appendix M**).

2. Monthly Client Progress Team Conference and Team Collaboration
Each month the Resource Facilitation team, led by the Neuropsychologist/Rehabilitation Psychologist, and attended by Resource Facilitators, the Program Manager, and the Local Support Network Leaders all meet to review, problem solve, and plan cases. Each Resource Facilitator completes a client progress review form prior to the staff meeting, to focus the team on critical historical features and identify challenges to be discussed by the group. Action steps are determined and discussed in subsequent staff meetings. **Appendix N** provides the form used for the monthly client team conferences. VRS Counselors are also encouraged to personally or telephonically to attend the case conference.

In some situations, the Resource Facilitator meets with the VRS Counselors monthly as well to provide in-person updates, problem solve, and more. Additionally, the Resource Facilitators have daily access to the clinical and neuropsychology staff on the project for clinical problem-solving.

Performance feedback forms are individually tailored and client approved. Feedback offers the employee education, an opportunity to modify current strategies, an opportunity to explore additional job modifications, modifications to the level of supervision, opportunities to restructure the environment and to proactively identify strengths and weakness to facilitate success.

3. Discharge and Resource Facilitation Services Final Report (see **Appendix O**)
Discharge from Resource Facilitation Services may occur under a variety of circumstances, such as:

a. The Client achieves 5 days employment.
b. The Client has met all of their established goals for Resource Facilitation.
c. *Unexpected termination of services at the request of the Client.
d. *Unexpected discharge determined by the RF team or the VRS Counselor.
e. Resource Facilitation services have lasted more than 12months without adequate progress towards goals and vocational placement

**If Resource Facilitation services end due to termination or discharge (items c. and d. above) prior to achievement of treatment goals and/or employment, the Resource Facilitation Services Final Report payment will only be made if a minimum of 3-months of service provision occurred with at least 15 hours of services provided (RHI will track hours).*

Upon discharge, Resource Facilitators complete another MPAI-4 and complete discharge demographics. Discharge demographics include:

- Length of service
- Successful vs. unsuccessful close
- Client returned to work/school
- Returned to work full-time or part-time
- Goal Attainment Scale and Progress made

The Resource Facilitation Services Final Report serves as a transition piece by giving Resource Facilitation Services comprehensive information surrounding progress made, continuing barriers needing addressing, possible gaps in services, strengths, and possible recommendations for the Vocational Placement Program.

The final report will also provide documentation necessary pertaining to the end of RF services, such as information on the job offer, information pertaining to successful completion of services, information on goals met or unmet, details around discharge, or documentation that services were provided for 12 months as applicable.

E. Vocational Placement Program

The Vocational Placement program is designed to build and sustain the natural supports and community connections within the local community necessary for long term stabilization and success as led by the Local Support Network Leader. The Local Support Network Leader will also follow-up with the client's employer to ensure successful adaptation in the workplace. The client's Resource Facilitator will also follow the client as appropriate to address any individual needs.

If justified within the evaluation or resource facilitation phase, the VRS Counselor can request Vocational Placement Services which will be provided for 90 days after initial placement into a competitive job. The service is billable when the Client achieves 5 days employment. The initial report will provide the goals (using a goal attainment scaling methodology) and the expected needs of the client.

Vocational Placement Report (see **Appendix P)**
Once the recommendation is made for Vocational Placement Services and the VRS Counselor approves, the Vocational Placement Program activates and the **Vocational Placement Report** is developed and billed. The Vocational Placement Initial Report examines the continued needs of the client based upon the domains of the placement program.

Following the initial report, the LSN Leader, and Resource Facilitator as necessary, will

- Participate in monthly case conferences with the RF Team,
- Build community networks of support
- Complete ongoing Quality Assurance and Program Evaluation

When the client is employed:

- Monitoring of Employment Adjustment
  - Contact with the employer every 2 weeks to monitor work performance and employer satisfaction.
- Employer Education and Consultation
  - Ongoing employer education and consultation to address job accommodations,
  - Strategies to maintain or improve work performance,
  - Peer consultation, and more to be conducted by the Resource Facilitator and the team as needed.

Please note, if there is a VRS employment services provider involved in the case, these activities must occur in coordination with the employment consultant.

90 Day Employment Final Report (see **Appendix Q)**
After supporting the individual for at least 90 days after initial placement in an employment position and upon preparation for VRS Closure, the **90 Day Employment Final Report** is generated. This report documents the successful completion of the program and identifying the supports verified for the long-term success of the client. The MPAI-4 and VIS-R will be completed as well, and all services utilized during the process will be documented.

Chapter

6

Resource Facilitation Quality Assurance and Program Evaluation

Through the fifth year of HRSA grant funding for 2013, we were able to expand our program evaluation methods and metrics. A new Access database was specially developed for Resource Facilitation that will significantly enhance the efficiency of data acquisition and reporting. All metrics for quality assurance and program evaluation will be collected prospectively for all referrals so as provide for a comprehensive evaluation of both process and outcome as well as to ensure rigorous data collection that will serve future studies on the effectiveness of Resource Facilitation, among other related research questions.

Quality assurance provides data to ensure that the process of managing each case is efficient and effective. Through program evaluation, outcomes are aggregated over multiple prospective clients to measure outcome. Further, program evaluation ensures treatment fidelity, that is, outcomes are at least consistent with previous research and clinical trials, and hopefully in the future even better.

A. Quality Assurance

The quality assurance process contains both qualitative and quantitative data. Qualitative data are derived from satisfaction surveys.

At the closure of RF services, determined by successful, 90-day placement in a paid position, or as determination by the RF Team, satisfaction surveys are sent to the client, the VRS Counselor, and the employer after placement. Copies of these surveys can be found in **Appendix R**. Survey results serve as a method of service quality review and facilitate future program enhancements or modifications.

Quantitative data are collected at different time points in order to track efficiency and effectiveness at every point in the resource facilitation process. These time points are outlined in the table below.

QA data points		
QA item	**Data point(s)**	**How often is this data point reviewed?**
Average time to process authorization	Date authorization requested Date authorization received	Weekly
Average duration of authorization	Duration of authorization	Quarterly
Time from referral to welcome letter	Referral date Welcome letter mailing date	Quarterly
Time from authorization to initial intake	Authorization date Initial Intake	Quarterly
Time from initial intake to NVE	Initial intake date NVE date	Quarterly
Time from NVE to initial team conference	NVE date Initial team conference date	Quarterly
Time from initial team conference to final report and bill sent to RHI	Initial team conference date Date final report and bill sent to RHI	Quarterly
Time between RF billing sent to RHI and RHI sending bill to VRS	Date final report and bill sent to RHI Date RHI sends bill to VRS	Quarterly
Time for VRS to pay RHI	Date RHI sends bill to VRS Date VRS sends payment to RHI	Quarterly
Patient staffing frequency	Patient staffing dates	Weekly
Time to authorize Phase II	Date authorization request sent to VRS Date VRS sends authorization to RF	Quarterly
Time between RF billing sent to RHI and RHI sending bill to VRS (Phase II)	Date report and bill sent to RHI Date RHI sends bill to VRS	Quarterly
Time for VRS to pay RHI (phase II)	Date RHI sends bill to VRS Date VRS sends payment to RHI	Quarterly
Time between RF billing sent to RHI and RHI sending bill to VRS (Phase III)	Date final report and bill sent to RHI Date RHI sends bill to VRS	Quarterly
Time for VRS to pay RHI (Phase III)	Date RHI sends bill to VRS Date VRS sends payment to RHI	Quarterly
Time between RF billing sent	Date final report and bill sent	Quarterly

to RHI and RHI sending bill to VRS (Phase IV)	to RHI Date RHI sends bill to VRS	
Time for VRS to pay RHI (Phase IV)	Date RHI sends bill to VRS Date VRS sends payment to RHI	Quarterly
Time between RF billing sent to RHI and RHI sending bill to VRS (Phase V)	Date final report and bill sent to RHI Date RHI sends bill to VRS	Quarterly
Time for VRS to pay RHI (Phase V)	Date RHI sends bill to VRS Date VRS sends payment to RHI	Quarterly
RF productivity	Time spent per category	Monthly
LSN Productivity	Time spent per category	Monthly
Satisfaction	Satisfaction per category	Quarterly
Market Share	Total number RF clients by region Total number of BI patients per region	Quarterly

B. Program Evaluation

Program evaluation procedures were designed to track treatment outcomes for Resource Facilitation clients and ensure that outcomes are consistent with previous research. Program evaluation measures are collected at various time points throughout the Resource Facilitation process. These time points are outlined in the table below.

Program Evaluation	
Measures	How/when is this data point collected?
MPAI-4	NVE End of RF services End of VS (if appropriate)
VIS-R	NVE End of RF services End of VS (if appropriate)
ADLQ	RF initial intake End of RF services End of VS (if appropriate)
SUNSU	RF initial intake End of RF service End of RF services End of VS (if appropriate)
C-Log	RF initial intake only

Measures employed in the program evaluation metrics include instruments for which psychometric properties have been previously researched that provided reliability and validity for their utility in measuring outcomes relevant to the goals of Resource Facilitation. These measures include the following:

- **Mayo-Portland Adaptability Inventory-4 Participation Index (MPAI-4)**
  The MPAI-4 was developed to determine level of disability for people with brain injury. The MPAI-4 has three subscales (Ability Index, Adjustment Index, Participation Index) designed to measure physical, cognitive, emotional, behavioral, and social problems that survivors may encounter after brain injury. Utilization of the MPAI-4 allows for benchmarking with other brain injury rehabilitation outcomes cited in the research literature.
- **Vocational Independence Scale-Revised (VIS-R)**
  The VIS-R was developed specifically to measure levels of independence in work for people with brain injury. Levels of independence include for example supported employment, full and part-time competitive employment, among others. Utilization of the VIS-R allows for benchmarking to specifically vocational outcomes in the research literature.
- **Activities of Daily Living Questionnaire (ADLQ)**
  The ADLQ will be completed by the Resource Facilitator at the initial intake. It is recommended to have an informant facilitate in completion if a caregiver is available. The ADLQ provides a percentage score representing the percent of impairment.
- **Survey of Unmet Needs and Service Use** (**SUNSU)**
  The (SUNSU) provides the Resource Facilitator with an overall idea of the number of perceived unmet needs. This is completed by the Resource Facilitator and the client at the initial intake.
- **Cognitive Log (C-Log)**
  The C-Log is a brief measure of cognitive abilities designed for rehabilitation patients. The items cover orientation, memory, and attention. The C-Log will be used to provide a snapshot of cognitive capacity at time of initial intake.

Each January, the RHI Resource Facilitation Department will analyze and report to the VRS data for all clients receiving Resource Facilitation services to ensure optimal outcomes and treatment fidelity.

The new Resource Facilitation Access database has also been constructed to generate the following reports.

Reports		
Report Name	Variables within the report	When reviewed
Client IDs	Lists all current client names by corresponding ID number	EPA can print this when she wants to see a list of current clients in the RF system by ID number
Client by Phase	Lists all current clients within a specific phase	EPA can print a report showing all participants split by RF Phase Include start dates (authorization date for this phase) Include authorization expiration date as well (EPA)
Client by VRS Counselor	Lists all current clients split by VRS Counselor name	As needed
Clients by RF	Lists all current clients by Resource Facilitator	As needed
Clients by LSN	Lists all current clients by LSN leader	As needed
Clients by NY	Lists all current clients by Neuropsychologist	As needed
Client Schedule	Displays client name and date of initial intake, NVE, and initial staffing	Schedules can be printed for clients or reviewed as needed by staff
Number of clients per region, RF, LSN, NY, VRS Counselor	A snapshot that lists each VRS region, Resource Facilitator, LSN leader, Neuropsychologist, and VRS Counselor and the total number of clients associated with each one.	Monthly
Client names by region	Lists all current clients split by VRS region	As needed
Clients waiting for payment at all payment points	Lists all payment points and the list of clients with outstanding bills	EPA will print this as needed to audit the payment system and follow up with RHI accounting as needed.
Staffing dates by client	Lists the next four staffing conferences and all clients to be staffed each date.	Weekly as staffing dates are updated
Executive Meeting Report	Financials Outcome data Total number of clients Number of referrals for the month	Attached to Executive Director outlook. Executive Director will receive a notification prompting him to print the report
Weekly Manager Meeting Report	Total Number of clients Number clients by Referral source Total number in each phase Total number of referrals for the week	Weekly
Productivity	RF LSN	Review monthly
Referral Report	Total number of referrals by VRS office	Program Manager wants monthly
Quality Assurance (QA) summary	All QA data points	Data Analyst will print quarterly and bring to management meeting
Program Evaluation (PE) summary	All PE data points	Data Analyst will print bi-annually and bring to management meeting.
Market Share	Total number of clients in RF by region Total number of BI clients in VRS by region Market Share percent	Data Analyst will print quarterly (if VRS can produce this quarterly) and bring to management meeting.

Chapter

7

Resource Facilitation Training and Certification Criteria

A. Goals

The goals of the Resource Facilitation Training and Certification Criteria are as follows:

- Ensure that providers of Resource Facilitation have minimum competencies in both Brain Injury and Resource Facilitation through certification, and
- Ensure that treatment fidelity is maintained through re-certification.

B. Initial Training and Experiential Guidelines

Resource Facilitation is a service that is based on both academic and professional training and experience as well as personal experience, particularly for Resource Facilitators that have personal experience with brain injury, either through experiencing brain injury themselves or through caregiving for a person with brain injury. With respect to the latter, the Rehabilitation Hospital of Indiana Resource Facilitation Department has historically hired caregivers for people with brain injury because they have experience serving as an advocate and navigating systems and resources and because they enjoy immediate acceptance from their clients and their families/caregivers. We have also however recently hired a Resource Facilitator with a Bachelor's degree in a related field. Other members of the Resource Facilitation Department have extensive experience in brain injury rehabilitation. The collective academic, professional and experiential dimensions of the team represent a diversity of perspectives that has brought some challenges but overall has brought a successful approach to Resource Facilitation.

Guidelines for previous training and/or experiences for the different Resource Facilitation team members are presented in the following table. These guidelines should be considered as flexible and many individual factors beyond these guidelines are relevant. Critical individual factors include:

- Works well within a team,
- Good verbal and written communication,
- Positive and constructive approach to stress and problem-solving,

- Adaptive, flexible and creative, and
- A passion for as well as curiosity about people with brain injury.

Guidelines for Previous Training and/or Experience

Position	**Required Training and/or Experience**
Resource Facilitator	• Caregiver of or person with brain injury or • Bachelor's degree in related field • Knowledgeable/experience with brain injury
Local Support Network Leader	• Bachelor's or greater in a related field • Experience with organizational leadership • Good communication skills • Knowledgeable/experience with brain injury
Program Manager	• Occupational or Speech Therapist • 5+ years' experience in brain injury rehabilitation • Good leadership and operational skills
Rehabilitation Neuropsychologist	• PhD or equivalent in Clinical Psychology • Sub-specialization in Rehabilitation or Neuropsychology • 5+ years' experience in brain injury rehabilitation • Experience with program and team management

C. Brain Injury and Resource Facilitation Training Criteria

Providing Resource Facilitation Services requires training specific to brain injury and the methods and process of Resource Facilitation. The initial training criteria provide an introduction to brain injury specific competencies, but after provisional certification as a Resource Facilitation provider, Resource Facilitation personnel become certified through the Academy of Certified Brain Injury Specialists (ACBIS). So as to successfully pass the Resource Facilitation Competency Examination, the training for all Resource Facilitation team members has four components:

1) Read required materials,
2) On-site training at the Department of Resource Facilitation, Rehabilitation Hospital of Indiana, and

3) Successfully pass (80% accurate) the Resource Facilitation Competency Examination.

Providers who successfully complete these three components become provisionally certified to provide Resource Facilitation services and be eligible for reimbursement through the VRS.

1) Required Reading: The following materials should be read by all Resource Facilitation staff as part of their initial training, except those with an "*" at the end of the reference which are suggested readings for the Rehabilitation Neuropsychologist and Program Manager so as to assist them with completing the Case Studies component in the initial training.

- Academy of Brain Injury Specialists- ACBIS (2007). The Essential Brain Injury Guide (4th edition). https://secure.biausa.org/detail.aspx?ID=344
- Blanchard, M. (2006). TBI Model Systems: Return to Work following Traumatic Brain Injury. (Click on reference to get article)
- Connors, S.H., (2001). Resource Facilitation: A Consensus of Principles and Best Practices to Guide Program Development and Operation in Brain Injury. http://nashia.org/pdf/biaaresfacilconsensus.pdf
- Eslinger, Paul J., (2002). Neuropsychological Interventions: Clinical Research and Practice. New York: Guildford Press *
- Fraser, R.T., Clemmons, D.C., (Eds.), (2000) Traumatic Brain Injury Rehabilitation- Practical Vocational, Neuropsychological, and Psychotherapy Interventions. New York: CRC Press *
- Gordon, WA & Flanagan, S. (2007), "Return to Work after Traumatic Brain Injury", TBI Research Review- Policy and Practice, Number 3. http://www.brainline.org/content/2008/10/tbi-research-review-return-work-after-traumatic-brain-injury_pageall.html *
- HRSA's MCHB Federal TBI Program's TBI Technical Assistance Center ; National Opinion Research Center (NORC) at the University of Chicago, Resource Facilitation: A Summary of Programs in the United States, 2009. https://tbitac.hrsa.gov/download/ResourceFacilitationGuide-508.pdf

- Johnstone, B. & Stonnington, H.H., (2009). Rehabilitation of Neuropsychological Disorders – A Practical Guide for Rehabilitation Professionals, 2nd Edition. New York: Psychology Press *

- Malec, J, Moessner, AM, Kragness, M, Lezak, M. (2000) Refining a Measure of Brain Injury Sequelae to Predict Postacute Rehabilitation Outcome: Rating Scale Analysis of the Mayo-Portland Adaptability Inventory. *Journal of Head Trauma Rehabilitation* 5:1, 670-682

- Malec, J. (2011). Understanding Brain Injury. A Guide for Employers. Mayo Clinic http://www.mayo.edu/pmts/mc1200-mc1299/mc1298.pdf

- Novac, T. (2004) The Cognitive Log. The Center for Outcome Measurement in Brain Injury. http://www.tbims.org/combi/coglog/index.html

- Reid, I., McGeary, KA, Hicks, MJ (2011) Potential Economic Impact of Resource Facilitation for Post-Traumatic Brain Injury Workforce Re-Assimilation. *Research Note. Center for Business and Economic Research, Miller College of Business, Ball State University. (available at lance.trexler@rhin.com)*

- Senelick, Richard & Dougherty, Karla; (2001) Living with Brain Injury – A Guide for Families (2nd edition). Alabama: HealthSouth Press

- Trexler, LE, Trexler, LC, Malec, JD, Parrott, D. (2010). Prospective randomized controlled trial of resource facilitation on community participation and vocational outcome following brain injury. Journal of Head Trauma Rehabilitation, 25 (6), 440-446.

- Trexler, LE and Waldman, W. (2014) Indiana Resource Facilitation Best Practices Manual. Unpublished document available from the authors at lance.trexler@rhin.com

2) On-site training at the Department of Resource Facilitation, Rehabilitation Hospital of Indiana: After completing required readings and identifying the Resource Facilitation personnel, the team will participate in a week-long training program at the Department of Resource Facilitation at the Rehabilitation Hospital of Indiana. The training will have the following schedule:

Day/Time	Content	Present
Monday		
8-9:00	Welcome and Introductions	RHI & training teams
9-12:00	Background and Overview of the Resource Facilitation Department	RHI & training teams
1-5:00	Shadowing for each Resource Facilitation staff member with their counterpart staff member at RHI	One on one
Tuesday		
8-3:30	Shadowing for each Resource Facilitation staff member with their counterpart staff member at RHI	One on one
3-5:00	Team discussion with the RHI team	RHI & training teams
Wednesday		
8-12:00	Shadowing for each Resource Facilitation staff member with their counterpart staff member at RHI	One on one
1-3:00	Shadowing for each Resource Facilitation staff member with other Resource Facilitation team members	One on one
3-5:00	Team discussion with the RHI team	RHI & training teams
Thursday		
8-12:00	Shadowing for each Resource Facilitation staff member with other Resource Facilitation team members	One on one
1-3:00	Presentation of materials for Case Studies	RHI Directors and training team
3-5:00	Overview of the Quality Assurance and Program Evaluation process and metrics	RHI Program Manager and Data Analyst with training team
Friday		
8-11:00	Overview and discussion of the items on the Resource Facilitation Competency Examination	RHI Associate Director with training team
11-12:00	Study time	Training Team
1-3:00	Complete written examination	Training Team with proctor
3-4:00	Team Discussion and Wrap-up	RHI & training teams

The activities that will be shadowed will cover all aspects and phases of the Resource Facilitation Service Model, including the Resource Facilitation Evaluation, Resource Facilitation Services, and the Job Placement Program.

D. Resource Facilitation Examination and Provisional Certification

At the end of the on-site training, the Resource Facilitation Competency Examination will be proctored (Please see **Appendix S** for a copy of this examination). If the majority of the staff in training pass the examination with 80% accuracy, the program will obtain a one-year Provisional Certification status that will allow them to provide Resource Facilitation services and be eligible for reimbursement for those services from the VRS. For those trainees who do not pass the examination, they will have an opportunity to re-take the examination within a month of the training. It is the expectation that all staff will pass the examination, but if not all staff do pass the examination, they will be given an opportunity to pass an oral examination demonstrating their competency.

E. Certification Maintenance

After obtaining Provisional Certification status, Resource Facilitation providers must obtain ACBIS certification for their staff within the one-year Provisional status to further demonstrate their competency in brain injury. Provider staff are expected to maintain their ACBIS certification to maintain the program certification status. ACBIS requires that each person receive 20 hours of continuing education per year which can be obtained through the Brain Injury Association of Indiana.

Within three months of Provisional Certification, providers will submit two case studies to RHI. These case studies will be comprised of the results of their Resource Facilitation Evaluation for two clients that include their assessment findings and recommendations for Resource Facilitation services and demonstrate competency for the Rehabilitation Neuropsychologist in Resource Facilitation. After submitting these case studies, a conference call with the respective Rehabilitation Neuropsychologists will be scheduled for the Rehabilitation Neuropsychologist presenting the cases to review and discuss them. These case studies will demonstrate clinical competency. Based on the written case studies and their presentation, they will be scored by the RHI Executive/Associate Director for adequacy. Should these cases not be judged to be adequate, providers will be given recommendations as to how to improve their case studies and asked to re-submit them.

Programs with a Provisional Certification will also submit their quality assurance and program evaluation data on a quarterly basis to RHI. These data will be separately aggregated into our Resource Facilitation database and the program will receive reports on their outcomes.

After one year of Provisional Certification the program demonstrates ongoing competency by 1) obtaining ACBIS certification for their staff, 2) successfully demonstrating clinical

competency on the case studies, 3) submitting quality assurance and program evaluation data that demonstrate outcomes consistent with previous experimental and clinical research, and 4) participating in a one day annual conference to review their quality assurance and program evaluation data, then they will be awarded a three year Certification to provide Resource Facilitation services. The annual conference will also serve as a method to obtain continuing education credits for ACBIS certification as well as to learn about advances in Resource Facilitation research or practice or other new developments related to brain injury rehabilitation.

This three year Certification status will be maintained by sustaining ACBIS certification for their staff, continuing to submit quality assurance data that demonstrate treatment fidelity, and participating in the annual conference. Should a program not achieve these outcomes, their certification will revert to a one-year Provisional Certification status. The program will be expected to complete all of the requirements specified above during this one-year Provisional Certification, and if they are successful and achieving these benchmarks, then the program will again be re-certified. Should the program not be successful in achieving these benchmarks, the program may lose its certification status.

The VRS and the Rehabilitation Hospital of Indiana will review annually program certification status and assist in resolving any disputes or discrepancies in program certification status.

Chapter

8

Conclusions and Recommendations

Since 2009, Indiana - with key partners in place -has been developing its Resource Facilitation model. The VRS has demonstrated phenomenal commitment to better serve people with brain injury through their support of the HRSA grants and the development of the Resource Facilitation services. With their support, we have been able to move from science to evidence-based practice and from practice to policy. The impact on future survivors of brain injury will benefit significantly and the State of Indiana will benefit economically.

In summary, multiple previous studies have that only about 30% of people with moderate to severe brain injury ultimately return–to-work. Our research with now at total of 136 participants has demonstrated that with Resource Facilitation, return-to-work rates range from 64% to 68% in both randomized controlled trials and in a prospective clinical cohort study providing evidence to support both clinical efficacy and the clinical effectiveness. The qualitative feedback from the person served and their families/caregivers has been remarkable. Satisfaction surveys have also been very positive from counselors of the VRS.

Why Resource Facilitation has been so effective in helping people with brain injury get back to work or school has yet to be researched – all we know is that it is. We can speculate however and it seems likely that factors may include:

- Having a multidisciplinary team of brain injury specialists,
- Collaboration and coordination of services within the Resource Facilitation team and with other service providers,
- A combination of health care professionals and experienced and committed caregivers,
- Resource Facilitation promotes access to need services and supports, and
- A proactive rather than a reactive clinical approach.

We are also committed to continuing our research efforts to ensure the clinical validity of our efforts. We encourage other researchers interested in brain injury rehabilitation and return-to-work goals to engage in research initiatives to:

- Examine other potential eligibility criteria or predictors of response to Resource Facilitation,

- Study effects of Resource Facilitation for different outcomes (e.g., family stability, health outcomes),
- Study effects of Resource Facilitation for different populations (e.g., DOC, children),
- Determine what are the essential ingredients (why is it effective) in Resource Facilitation (e.g., education, access to services), and
- Identify appropriate study treatment methods (e.g., telephonic vs. in-person).

For other providers or states who may be interested in providing Resource Facilitation services, we hope that this information will be of service.

Abbreviations and Acronyms Used in this Manual

ACBIS: Academy of Certified Brain Injury Specialists
ADLQ: Activities of Daily Living Questionnaire
BI: Brain Injury
BIA: Brain Injury Association
BIAI: Brain Injury Association of Indiana
C-Log: Cognitive Log
CBIS: Certified Brain Injury Specialist
EPA: Executive Program Assistant
FSSA: Family and Social Services Administration
GAS: Goal Attainment Scaling
HRSA: Health Resources and Services Administration
IPE: Individualized Plan for Employment
IVBHN: Indiana Veterans Behavioral Health Network
LSN: Local Support Network
MPAI-4: Mayo-Portland Adaptability Inventory-4 Participation Index
NVE: NeuroVocational Evaluation
NY: Neuropsychologist
RHI: Rehabilitation Hospital of Indiana
PE: Program Evaluation
QA: Quality Assurance
RF: Resource Facilitator
SUNSU: Survey of Unmet Needs and Service Use
TBI: Traumatic Brain Injury
TBIMS: Indiana Traumatic Brain Injury Model Systems
VIS-R: Vocational Independence Scale-Revised
VRS: Indiana Vocational Rehabilitation Services

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Appendices 9

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Appendix S: Resource Facilitation Competency Examination