Government of **Western Australia**
North Metropolitan Health Service
Mental Health, Public Health and Dental Services

State Head Injury Unit: A client-centred community rehabilitation pathway

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Introduction

The State Head Injury Unit (SHIU) provides a comprehensive community-based case coordination and rehabilitation service for patients with an acquired brain injury (ABI) aged 16-65 years. This is based on the Comprehensive Enhancement Practice: An Implementation Model Reference: Rothman J and Sager JS, Case Management: Integrating Individual and Community Practice, 2nd Ed, 1998[1]. (refer Fig. 1)
In updating the SHIU model of care (MoC), national and international specialised brain injury rehabilitation service model literature was reviewed. The evidence outlined in these reviews consistently reported that effective brain injury rehabilitation models have the following key characteristics:

- Individualised, goal-based approach with early and ongoing assessment for needs identification. ABI rehabilitation should be holistic to match the strengths and needs of patient and modified over time.
- Flexible entry and exit points with patients needing access services at different times as they progress through their rehabilitation and recovery.
- Rehabilitation model is non-linear with patients needing to re-visit rehabilitation along the continuum of care as recovery progresses and new challenges emerge. Clear communication / information sharing between services supports this process.
- Delivered by a collaborative interdisciplinary team with care coordinated to match the individual and complex needs of patients.
- Effective evidence-based rehabilitation interventions commenced early and deliver continuous tailored care of the right intensity.
- Ensuring support and education to caregivers and family members.

The SHIU MoC incorporates these characteristics through the case coordination and interdisciplinary rehabilitation model. Case coordination is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. Patients are referred for interdisciplinary rehabilitation as needed along the care continuum.

Case coordination involves a phased and systematic process with sequential and overlapping functions to enable the provision of seamless, integrated care and improved patient outcomes across the continuum. A comprehensive case coordination approach provides appropriate, flexible, and coordinated support.

The SHIU MoC allows flexibility of service delivery through the referral pathways and re-referral to the service following discharge. Linkages with key stakeholders prior to referral and during SHIU program promote information sharing and timely access to services. The SHIU registration streams allow for flexibility of service delivery to best meet patient needs in a timely and cost-effective manner.

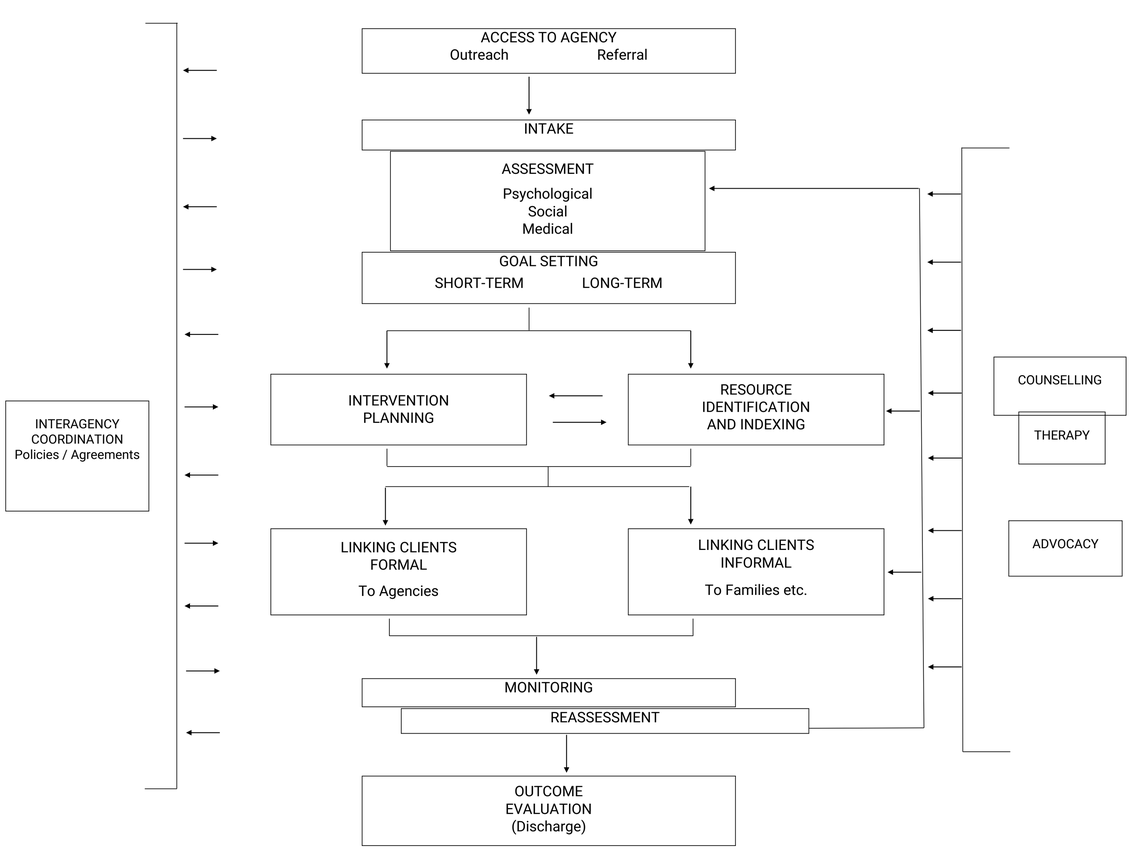

Fig. 1: Comprehensive Enhancement Practice: An Implementation Model
Reference: *Rothman J and Sager JS, Case Management: Integrating Individual and Community Practice, 2nd Ed, 1998.*

References:
1.Comprehensive Enhancement Practice: An Implementation Model Reference: Rothman J and Sager JS, Case Management: Integrating Individual and Community Practice, 2nd Ed, 1998.
2.Rehabilitation Models: A scoping review. Dr Beth Costa/ Dr Kate Gibson. April 2017 Evidence Review. Institute for Safety, Compensation and Recovery Research Victoria.
3.State-wide adult brain injury rehabilitation health service plan 2016-2026. System, Policy and Planning Division Queensland Health. November 2016.
4.British Society of Rehabilitation Medicine. Rehabilitation following acquired brain injury, National Clinical Guidelines. 2003. Royal College of Surgeons: London.
5.Interdisciplinary Approaches to Facilitate Return to Driving and Return to Work in Mild Stroke: A Position Paper. Suzanne Perea Burns, Jaclyn K Schwartz, Shannon L Scott, Hannes Devos,
Mark Kovic, Ickpyo Hong, Abiodun Akinwuntan. American Congress of Rehabilitation Medicine. Archives of Physical Medicine and Rehabilitation. 2018; 99;2378-88

SHIU Model of Care

The SHIU, as an interdisciplinary team, have adapted Rothman and Sager's model to include the assessment and rehabilitation pathways the client undertakes upon referral to the SHIU (refer Fig. 2).

This adapted model includes the principles and pathways of Rothman and Sager's model, adding processes undertaken at each stage and Goal Completion prior to Outcome Evaluation.

Referrals to the SHIU are accepted from acute and subacute services (including inpatient, rehabilitation in the home and outpatient), general practitioner (GP) or self-referral from patient, family or carer (refer Fig. 3).

Clients are allocated a case coordinator on admission and therapy services are accessed on an as needs basis as identified by case coordination, client and / or family as part of a collaborative process. Clients have access to:
1) Group education through the Understanding ABI sessions;
2) Therapy services: Clinical Psychology, Neuropsychology, Occupational Therapy, Physiotherapy, Social Work, Speech Pathology, Welfare Officer and Allied Health Assistant;
3) Rehabilitation Medicine specialist;
4) Culturally appropriate services through Aboriginal Health Liaison

As SHIU is a community-based rehabilitation service, therapies are provided in the home, workplace, and community or at the Unit, when indicated. The SHIU has access to Telehealth services for rural / country-based clients, and with WACHS as a consultancy service.

Length of program is determined by the clients' identified needs and goals related to their ABI recovery, and progress towards these. Goals are reviewed on a regular basis through the Client Review Meeting and programs revised as needed. Nearing completion of their SHIU program, if long term supports are identified, referrals to appropriate services are made with clinical handover provided. Treating medical practitioners are also advised of the discharge plan (refer Fig. 3).

If issues related to ABI arise following discharge from the service, the SHIU will continue to be available as a resource to clients, family and community supports. This could include provision of information, referral on to other relevant agencies or targeted, time limited therapy services.

Additionally, SHIU functions as an ABI resource service for the wider community.

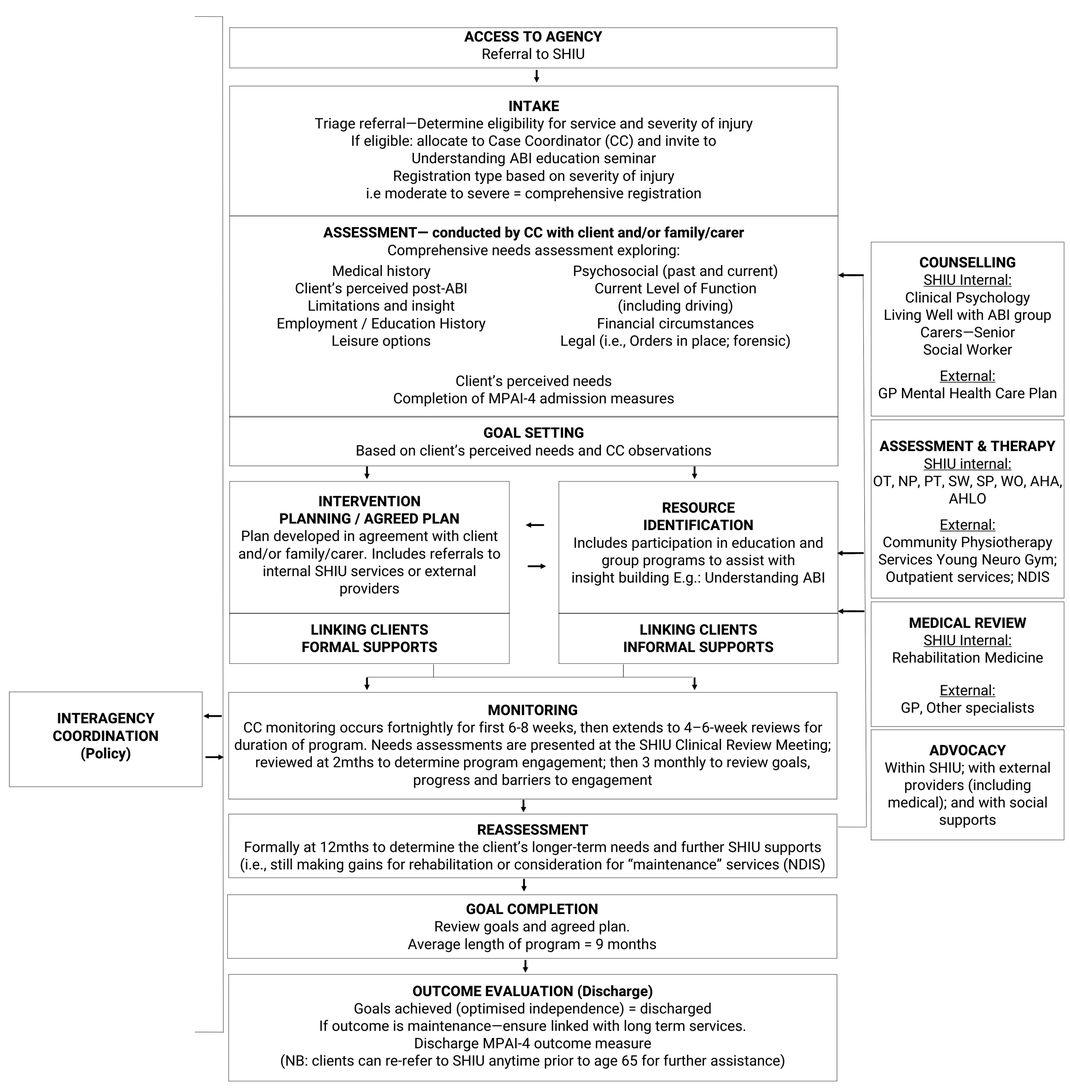

Figure 2. SHIU Model of Care Adapted from "Comprehensive Enhancement Practice: An implementation Model"

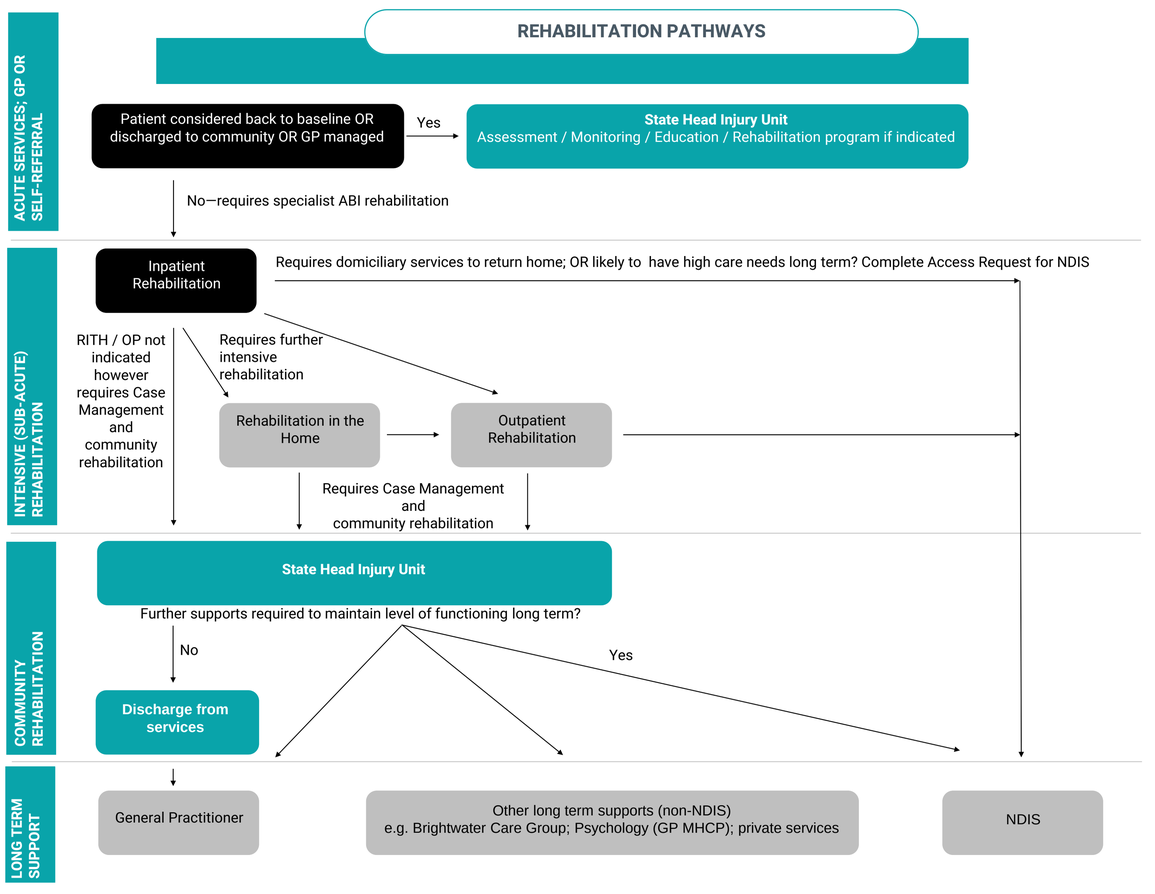

Figure 3. Rehabilitation Pathway.

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