Hamilton Health Sciences
Acquired Brain Injury Program
Overview of Program

The Acquired Brain Injury (ABI) Program at the Hamilton Health Sciences – Regional Rehabilitation Centre, Hamilton General Hospital serve the rehabilitation needs of adults with acquired brain injuries and their families. These individuals are from anywhere in the Province of Ontario. Our ABI program consists of inpatient units, an outpatient clinic, community outreach and consultative services.

ABI Program Philosophy

We are committed to facilitating comprehensive services for individuals with acquired brain injuries that reflect:

- Innovative client-centered service
- Treatment plans based on individualized functional goals
- Treatment within a rehabilitative setting or within the individual’s natural environment whenever possible
- Treatment that includes behavioural, cognitive, communication, medical, physical, psychological, psychosocial and psychiatric components as necessary

Vision

Our vision for the ABI Program is one of leadership and innovation in providing a continuum of opportunity for individuals with acquired brain injuries and their families, and to advance the field of acquired brain injury rehabilitation by:

- Providing the highest level of quality services possible that will meet the expectations of the individual, family and community
- Using our resources responsibly to balance quality, hope and cost in meeting functional goals
- Facilitating access to life long living opportunities
- Optimizing community re-integration
- Optimizing the outcomes of the rehabilitation process through data-driven, evidence-based practice
- Promoting research and continuous education and development for health professionals in the field of acquired brain injury.
Service Delivery Model

The model of service delivery revolves around the goals of the individual with the acquired brain injury and his/her family. These goals are defined in very specific terms and measured with a comprehensive system of data collection and analysis. Working together with the individual and his/her family towards the achievement of the rehabilitation program goals is a team of health care professionals consisting of:

- Multi-skilled rehabilitation therapists and advanced rehabilitation therapists, behaviour therapists, psychologists, psychometrists, nurses, physicians, physiotherapists, occupational therapists, speech-language pathologists, social workers, nutritionists, therapeutic recreationists and pharmacists
- Clinical coordinators, community intervention coordinators and clinical specialists

The staff team is supported by specialists in education, evaluation and research to ensure:

- Comprehensive, consistent and ongoing education and Development of staff across the ABI program
- Outcome evaluation
- Evidence-based practice
- Advancement of ABI rehabilitation research

Intake Process

A comprehensive referral process determines admission to the ABI Program. The intake process begins when the completed intake package and medical referral are received at the ABI Program office. All referrals are reviewed within one week of receipt. In most cases, following a review of this preliminary information, a Community Intervention Coordinator will visit the individual in his/her local community to conduct a Functional Intake Assessment. This assessment is designed to determine the individualized and functional rehabilitation needs of the individual and to develop an intervention strategy based on the collection and analysis of the clinical data.

The Intake Committee, in conjunction with the Community Intervention Coordinator, completes a review of the assessment information to determine the appropriateness of the individual for admission to one of the inpatient units. The following criteria are considered in this review:

- Previous history
- Current status - physical, psychosocial, behavioural, cognitive, communicative and psychiatric
- Adjustment issues
Intake Process (cont’d)

- Human and financial* resources available to the client
- Identification and availability of a discharge environment
- Urgency of admission in terms of suffering, potential danger and the probable prognosis with or without proper intervention

*Financial resources are not a factor for eligibility for an inpatient admission (which is covered by OHIP) but rather for future planning

The needs of the individual may also be met in his/her home community through community intervention, through referral to the ABIP outpatient clinic or outreach services.

A. **ABI Inpatient Programs**

**ABI Rehabilitation (3 South)**

**Community Re-integration**

This sub-program assists individuals with acquired brain injury to develop a level of independence sufficient for re-integration into the community. Functional life skills training are provided for 8 individuals with moderate acquired brain injuries. *(There are two (2) Provincial beds and six (6) Regional beds.)* The environment in this program aims to build a home-like routine with a focus on community and group living. All therapeutic activities are developed with regard to the discharge environment, whether it be home or another facility based setting. Group and individual activities are designed to promote “living” and “doing”.

**Slow To Recover**

The Slow to Recover program accommodates 6 individuals with severe brain injuries. Patients who receive services through the Slow to Recover program meet all or most of the following criteria:

* Intermittently or minimally responsive (Ranch Los Amigos level II-III)
* Significant physical need (SIRUS III - total care)
* Six (6) months or longer post injury
* Need for regular nursing intervention
* Medically stable

Rehabilitation is provided by specialists in neurology, nursing, respiratory therapy, occupational therapy, physiotherapy, speech-language pathology, therapeutic recreation, social work, nutrition and rehabilitation therapy. Consultation is provided by physiatry, behaviour therapy, neuropsychology and pharmacy. Individual and family education is a strong component of the program. Slow to Recover individuals may be discharged home or to another hospital, nursing home or complex
continuing care and future care providers are trained to deliver the appropriate care and programming. The Slow to Recover team also provides community consultations and assistance in the development of community-based programs.

**Neurobehavioural Unit (3 North)**

In November 2010, St. Joseph’s Healthcare ABI Mental Health Program divested with Hamilton Health Sciences, Centre for Behavioural Rehabilitation to form an integrated Neurobehavioural Program.

The Neurobehavioural Program is an 11-bed unit responding to the needs of individuals with acquired brain injuries and mental health issues who display challenging, socially unacceptable behaviours that prevent their participation in conventional rehabilitation programs. For these individuals, management of their physical and cognitive disabilities is not possible without concurrent management of the compliance problems or behaviours of excess. The significant behavioural difficulties of these individuals may also prevent them from successfully living in the community without ongoing supports. The program will consider these necessary supports and advocate for them as well as train future care providers prior to discharge from the program.

The focus of the Neurobehavioural Program is on functional rehabilitation in a structured engaging environment to achieve behavioural self-regulation that can be generalized to a community environment. The client to staff ratio is 1:1 during the majority of waking hours.

**B. Outreach Service**

The Outreach Service is provided to individuals with acquired brain injuries after their discharge from inpatient units. This service is designed to facilitate a smooth transition to the community and is essential to the individual's ability to maintain the gains made while in the hospital. The Outreach Service also serves individuals who have been referred directly from the community who have not had a hospital admission. Frequency of direct contact with staff varies depending on the individual’s needs and identified goals. The staff assist the patient to return to community living in social, vocational and recreational areas.

The team consists of Clinical Coordinator, Advanced Rehabilitation Therapists, Social Work, and Psychology.

**C. ABI Out Patient Clinic**

The ABI Outpatient Clinic typically sees individuals with moderate/mild brain injury. These individuals usually live at home or in community facilities. The focus of the clinic is on assessment and problem solving for individuals with known or suspected brain injuries. Some typical individual and family needs that are addressed in the clinic include:

* Assistance in accessing existing community resources (such as occupational therapy, physiotherapy, counseling, life skills programs, recreational programs, substance treatment services, vocational re-entry services, driving assessment services)
ABI Out Patient Clinic (cont’d)

* Education about brain injury and the impact on functional abilities (such as mobility, self care, communication)

* Awareness of symptoms and issues that may emerge but are easily missed or misinterpreted (such as emotional lability, daytime fatigue, sleep disturbance, reduced concentration or attention, lack of insight, headaches, psychosocial adjustment)

* Pain management

* Rehabilitation medical management

* Medication management

* Social work services (such as individual and family counseling, anger management, group therapy - relaxation)

* Neuropsychological assessment to evaluate the impact of the brain injury

D. Community Crisis Management Team

The ABI Crisis Management Team provides a quick response to ABI survivors and their families who are in severe difficulty or at high risk of danger to themselves or others. This team facilitates the coordination of individualized crisis services for people in their own communities. Members of the crisis team liaise closely with family members, community programs and local emergency and law enforcement agencies to minimize risk to ABI individuals living in the community who have significant behavioural problems. Individualized program plans will outline strategies for crisis prevention and management in the short term while delineating community resources required for long-term supports.

E. ABI Community Services - (Third Party Funded)

ABI Community Services provides community-based rehabilitation and consultative services for individuals with acquired brain injuries who are 16 years of age and older.

All clients referred to ABI Community Services require third party funding which may include the Workplace Safety and Insurance Board, insurance companies or other collaborative agencies. This fee-for-service program brings together a team of rehabilitation specialists who are highly skilled at dealing with functional issues relative to community re-integration.

This functional rehabilitation program occurs in the client’s community and home to ensure that practical skills are developed which can be applied within the individual’s living and working environment.
For More Information

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