Acquired Brain Injury Services – Inpatient Telephone Follow Up

Tip Sheet

**Purpose/Goal:** Guide, NOT Solve. We are promoting self-management

“Self-management is a person-centered approach in which the individual is empowered and has ownership over the management of their life and conditions” - Long-Term Conditions Alliance Scotland (2008) and self-efficacy.

### Setting Up the Call:

| Set parameters for time and content | ➢ About 15 minutes  
➢ Focus on reviewing areas you & team had concerns about prior to discharge and how things have been going since leaving rehab |
| Reiterate purpose | ➢ Guide them in addressing any issues that arose from team’s recommendations  
➢ Guide in self-managing new issues that arose after leaving TRI  
➢ Redirect to resources in the community to help manage issues |

**SCRIPT:**

- This is a quick check-in call that will take about 15 minutes or so.
- We will talk about how things are going with areas you and your rehab team at TRI had concerns about at discharge.
- My role here will be to celebrate things that are going well.
- And if need be, to help you problem solve on how to self-manage any issues that did arise – this would include: ways you can work on dealing with the resources you have available at home and in your community, including guiding you on how to connect to those resources.

### Ending the Call: How to close this loop

- Give brief summary of what was discussed & have patient teach-back
- Review what patient will need to follow-up on in community & have patient teach back
- If patient has issue with team recommendations: connect with core team & set estimated time frame for when will reconnect with patient (if necessary)

**SCRIPT:**

- Today you said things are going well with A, B & C.
- But were having a problem a new problem with E, and F is a problem you’ve been having with a recommendation we made.
- Use teach-back to have the patient recite back the plan to deal with any issues discussed.

### How to Help Self-Manage

**C - Current Plan:**

- What are you **Planning** to do to remedy this problem/issue?

**P - Support People:**

- What **Supports/Support People** can you call in to help you with this? (E.g., family, CCAC/case mangers etc...)
- **Who** has information that would be help you create a plan to solve the problem? (E.g., pharmacist/doctor would have information to help address concern with side-effect of medication)

**R - Resources:**

- Link to **Resources/Information** that may offer additional help with problem solving Information.
Community Resources

- **211:**
  - Free helpline that connects you to community and social services in your area 24 hours a day, 365 days a year, in over 150 languages.
  - Phone: Dial ‘2-1-1’, Web: [www.211ontario.ca](http://www.211ontario.ca)

- **CNAP**
  - The Community Navigation and Access Program: A network of 30+ community support service (CSS) agencies in the Toronto area who are collaborating to improve access and coordination of support services for older adults, their care providers and health care stakeholders.
  - Contact: **1-877-621-2077** – or - **416-217-2077**

- **Telehealth**
  - Telehealth Ontario is a free, confidential service you can call to get health advice or information. A Registered Nurse will take your call 24 hours a day, seven days a week.
  - Contact: **1-866-797-0000**

- **www.healthline.ca**
  - Search by postal code/region/topic area to find local health & community services in Ontario.

- **Brain Injury Society of Toronto (BIST):**
  - Non-Profit organization seeking to provide education, awareness, support and advocacy to people with ABI. Different programs including support groups and social gatherings, etc.
  - Contact: 416-830-1485, web: [www.bist.ca](http://www.bist.ca)

### Common Scenarios

1. **Patient complaining of new onset headaches/dizziness/side effects of medications/pain/changes in sleep**
   - *You can advise the patient to see their family doctor.*

2. **Patient was referred for ongoing therapy, and has not received a call from the outpatient facility**
   - *Encourage patient to look in their discharge binder for the contact information for the outpatient facility, encourage them to reach out to follow up on status of application.*

3. **Patient reports issues with equipment**
   - *Encourage patient to reach out to vendor (contact information should be in the discharge binder) or liaise with their outpatient team if appropriate.*

4. **Patient had a fall, and is experiencing new symptoms**
   - *Encourage patient to reach out to family doctor, or to go to emergency.*

5. **Patient hasn't received a response from CPP (or any financial aids)**
   - *Encourage patient to speak with outpatient SW if available. If this was initiated in inpatient, encourage patient to look at the discharge summary from SW/Francine for contact information.*
     - CPP (Retirement and Disability): **1-800-277-9914**
     - E.I. (all types): **1-800-206-7218**
     - OW/ODSP office locator: [www.ontario.ca/socialassistance](http://www.ontario.ca/socialassistance), or contact your social worker or community resource worker.

6. **Recommended supervision not able to be provided, for whatever reason**
   - *Encourage patient to speak with their therapy team if available regarding gaps in available support at home.*
   - *If patient feels that additional support is needed at home, encourage them to contact Home and Community Care (previously CCAC).*

7. **Patient is reporting new psychiatric symptoms (i.e. hallucinations, delusions)**
   - *Contact family doctor or go to Emergency*

*It is important to note that if you do not feel comfortable addressing an issue in the moment, you can always consult with the team and call the patient back.*

*If you are anticipating that the call will bring up issues that may be difficult to address, you can make the call with another team member present for support.*