Outpatient rehabilitation services for patients with brain injuries in Bern, Switzerland

Overview

In the early 2000s, providers in the city of Bern, Switzerland grew increasingly concerned by an observed gaps in rehabilitation services for working-age patients recovering from brain injuries; notably a lack of comprehensive and coordinated services targeted to the specific needs of these patients. In response, a group of rehabilitation therapists – specializing in occupational, physical and speech therapy – joined together to open an outpatient rehabilitation centre specifically tailored to the needs of working-age patients recovering from brain injuries. In 2003, planning and preparations for the centre began and start-up costs were self-financed by the leadership team. With no similar model for the delivery of rehabilitation services in Switzerland in place, the leadership team developed care guidelines and protocols based on their own expert knowledge and practical experience, supported with input from other providers. In 2005, after securing a guarantee for reimbursement of services from insurance companies, the centre – coined Rehapunkt, meaning "rehabilitation point" – opened. Initially offering rehabilitation services just one day per week, professional networking helped build patient lists and, by 2008, the centre had expanded to a larger space and was open five days per week. Occupational therapists are employed directly by the centre. All other professionals, including physiotherapists and speech therapists, rent rooms at the centre and are contracted to provide services. Patients enrol for services through referral from inpatient rehabilitation centres and follow a six-month rehabilitation programme tailored to their individual needs and goals. General practitioners receive regular updates on patients throughout the programme to support continuity of care upon completion. Approximately 40% of centre patients have been able to successfully return to work after completing the programme, with an additional 30% of patients able to return to work in some capacity. Presently, the centre continues to grow and is currently seeking a larger space to enable further expansion. Additionally, the integrated multidisciplinary Rehapunkt model has been replicated by two other centres in Switzerland.

Problem definition

During the early 2000s, rehabilitation services for patients with brain injuries in Switzerland were largely focused on the needs of the growing population of geriatric patients. However, this left a gap in services targeted to the specific needs of working-age patients who, following a brain injury, required specialized care designed to facilitate their return to work (Box 1).

Moreover, patients with brain injuries required care from a mix of different specialists - including occupational therapists, physiotherapists and speech therapists - to provide the comprehensive range of services needed to support return to normal functions. However, the various providers needed for the effective rehabilitation of patients with brain injuries were fragmented, leaving patients with the burden of seeking care from multiple providers in different locations. Furthermore, a lack of communication between providers prevented coordinated delivery of care plans, leading to patients' symptoms being treated separately, rather than as part of a complex whole.

Box 1

What problems did the initiative seek to address?

- Rehabilitation for brain injuries largely organized around the needs of geriatric patients, failing to meet specific rehabilitation needs of younger patients.

- Multiple providers needed for effective rehabilitation of patients with brain injuries, but physical separation and a lack of communication between providers resulted in fragmented care delivery.

Health services delivery transformations

Timeline of transformations

In the early 2000s, gaps in available rehabilitation services for working-age patients recovering from brain injuries drew concern from a group of rehabilitation therapists working in Bern, Switzerland. In response, this self-formed leadership team proposed opening a comprehensive rehabilitation centre to provide services specifically targeted to working-age patients (Table 1). In 2005, after two years of planning, the centre – coined Rehapunkt, meaning "rehabilitation point" – was opened. The centre has gradually expanded over time, acquiring additional building space and extending opening hours to help accommodate increasing demand for services. At present, Rehapunkt continues to grow and its model is being replicated by other centres in Switzerland.

Description of transformations

Selecting services. The centre offers a comprehensive package of outpatient rehabilitation services to patients following a brain injury; services offered include occupational therapy, physical therapy, speech therapy and a range of complementary therapies, as well as counselling and coaching. Services are geared towards helping patients return to work and are specifically tailored to needs of patients aged 18-70 years. The centre offers both group-based and individual therapies; group therapy is considered particularly important by the initiative's leaders for supporting successful rehabilitation. Services are organized in a six-month programme and, if necessary, services can be extended following programme completion.

Designing care. The centre works from WHO's International Classification of Functioning, Disability and Health (ICF) framework for measuring health and disability. Centre-specific protocols and processes were developed by the leadership team based on their expert knowledge and many years experience working in this field; experts at a nearby hospital also provided technical input.

Upon discharge from inpatient care, patients referred to the centre enter a six-month care programme and attend the centre two full days per week. Clinical experience of the initiative's leaders indicated six months is the typical amount of time needed for patients to sufficiently regain functioning. During the programme patients receive three evaluations, allowing personalized care plans to be constructed based on individual goals, needs and progress.

Organizing providers. A variety of health professionals have been brought together to work as a multidisciplinary team. Co-location of providers within the centre means patients can now access all the different services they need at one location. "We have all the therapies under one roof. ... We really try to have providers work together to be one process." In addition, each patient is assigned a personal case manager to oversee and coordinate their care. Patients are referred to the centre directly from inpatient rehabilitation facilities, the aim being to have patients enrolled in centre services "the day they come home" to ensure continuity and avoid regression due to a lag in care. In turn, the centre has established a feedback system with general practitioners to ensure continuous care when patients graduate from the centre.

Table 1
What were the chronological milestones for the initiative?

2003	Therapists specializing in rehabilitation of brain injuries conceive idea for Rehapunkt centre to address observed service gaps; first meeting to plan the initiative held.
2003–2005	Planning period for the initiative; building location selected, care pathways developed and negotiations held with insurance companies to secure reimbursement for services.
2005	Rehapunkt opens and begins offering integrated occupational, physical and speech therapy services one day per week.
2005–2008	Demand for services offered by the centre gradually increases and patient lists grow.
2008	Larger building space acquired for centre and opening hours extended to five days per week; additional services added.
Present	Continued delivery of rehabilitation services at Rehapunkt; further expansion of centre planned.

Managing services. Start-up costs for the centre were largely self-funded by leaders of the initiative, with supporting funds donated by a partner's business and a local church. Infrastructural investments included securing a building space for the centre and making necessary renovations to support activities. Management of the centre is overseen by the leadership team, consisting of the head occupational therapist, physiotherapist and speech therapist. Occupational therapists are directly employed by the centre, but physiotherapists and speech therapists rent rooms at the centre and are contracted to deliver services; contracted employees are free to see their own patients in addition to those enrolled at the centre. Other health professionals are contracted on an ad hoc basis to deliver specific services as needed. Regular staff meetings help to facilitate a coordinated system.

Improving performance. The centre offers on-the-job training and ad hoc training courses for qualified individuals needing to improve their skills. Meetings, known as quality circles, are held quarterly between the leadership team to review performance and adjust processes as necessary to improve quality and functioning of centre services. A more comprehensive review is held between all providers at the centre annually.

Engaging and empowering people, families and communities

The centre's goal is to help patients regain the highest possible level of functioning in daily and professional life. There is a strong focus on helping the patient achieve independence through skills-training and patients are actively included in care decisions and encouraged

Table 2
How was the delivery of health services transformed through the initiative?

Before	After
Selecting services	
Lack of integrated rehabilitation services targeted to working-age patients with brain injuries.	Integrated rehabilitation services targeted to working-age patients with brain injuries available within Rehapunkt centre; services offered include occupational, physical and speech therapies.
Designing care	
Lack of guidelines for delivery of integrated rehabilitation services to working-age patients with brain injuries.	Centre works from ICF framework developed by WHO; centre-specific processes and guidelines developed based on knowledge and experience of the leadership team; patients follow a six-month personalized care plan.
Organizing providers	
Health professionals isolated from each other and organized in separate locations; lack of communication between providers results in poor continuity of care for patients.	Health professionals co-located within the centre and work in multidisciplinary teams; case manager assigned to each patient to coordinate care; referral networks established with inpatient facilities; feedback sent to general practitioners.
Managing services	
Centre not yet in operation.	Centre start-up costs primarily self-financed by leaders; necessary building space acquired; centre managed by lead occupational therapist, physiotherapist and speech therapist; occupational therapists employed directly by the centre, but physiotherapists and speech therapists contracted to deliver services.
Improving performance	
Centre not yet in operation.	Training provided to centre staff as needed; meetings held between leadership team every three months to review performance; whole-staff meeting held annually.

to participate in their care. Patients work with a case manager to define goals and establish a personalized care plan. Patients' relatives or other support network members are welcome throughout the care process and, once patients regain sufficient functioning, their employer may also be included. When ready, patients return to work for a trial period and, during this time, an exit plan is developed with strategies to help patients continue making progress beyond the programme.

Health system enabling factors

As a single-centre initiative, formal policy changes to support the new model of services delivery have not yet been required. Instead, the centre has managed to develop within the existing health system structures to effectively provide services (Table 3). A key enabler for the initiative was the guarantee for reimbursement of services from the compulsory health insurance providers and accident insurance companies. Professionals working at the centre bill insurance companies directly for services rendered and the centre is required to complete an annual evaluation of activities for insurers.

Partnerships with universities offering occupational and physical therapy programmes allow university students to complete required practice placements at the centre. As part of their placement, students are provided with data collected by the centre to complete research projects. While data is collected by the centre, the centre itself has not conducted a formal performance evaluation.

Outcomes

While no formal outcomes are available to date, measures to monitor the performance of the centre are in place and research is conducted by university students as part of their practical work placements completed at the centre.

Table 3
How has the health system supported transformations in health services delivery?

System enablers	Example
Accountability	• Centre is required to report to insurance companies who pay for services.
Competencies	• Partnerships with universities allow occupational and physical therapy students to complete required practice placements at the centre.
Information	• University students completing practice placements at the centre conduct research on activities using data collected by the centre.

Approximately 40% of patients have been able to successfully return to work after completing the Rehapunkt six-month rehabilitation programme, with an additional 30% able to return to work in some capacity. Leaders of the initiative attribute a large part of the programme's success to its unique use of group rehabilitation, noting that patients appear to significantly benefit from this type of care. Additionally, the integration of patients' family and employers was reported to be another key influencer of positive patient outcomes.

Change management

Key actors

The idea for Rehapunkt was formed by an entrepreneurial occupational therapist who, already running an occupational therapy practice, was well positioned to observe gaps in services and had the necessary skills to conceive of a new practice to help address these. Going on to become the owner of Rehapunkt, the centre was designed and managed together with a self-formed leadership team composed of colleagues at partner physical and speech therapy practices who were also motivated by the issue. This leadership team first met in 2003 and, together with input from local physicians and experts at a nearby hospital, designed and implemented Rehapunkt. This leadership team continues to oversee and manage the centre today, meeting regularly to coordinate necessary activities and strategize improvements.

Initiating change

With a motivated leadership team in place and the idea for Rehapunkt having been developed, attempts were made to generate necessary start-up funds through fundraising. However, as insufficient funds for necessary investments in infrastructure were raised, eventually the centre had to be largely self-financed by initiative leaders, which meant limiting its scale to control costs. Future financial viability of the centre was secured early on through extensive discussions with insurance companies to guarantee reimbursement for services rendered. Insurance companies were already reimbursing services proposed by the centre when delivered separately, but needed to be convinced to extend reimbursement for integrated services delivery; securing support from insurance companies was described as a crucial step in developing the centre.

Implementation

As Rehapunkt was unique in its approach to the delivery of rehabilation services, management

and clinical processes were adapted as needed based on operational experience, facilitated by quarterly review meetings between the leadership team. While starting out small, the centre gradually grew its patient list through word-of-mouth via leveraging professional networks, including a professional organization for occupational therapy in Bern as well as a national professional organization for rehabilitation. Over time, these networks helped raise awareness of the centre, generate referrals and build demand for services. While the centre has grown significantly from when it first opened, fluctuations and uncertainty in demand are described by the leadership team as a continued challenge requiring careful scheduling and consideration.

Moving forward

The centre plans to continue operations at the local level, gradually expanding to accommodate increasing demand for its services. The leadership team also hopes to widen the targeted population by extending services to patients with conditions such as multiple sclerosis or Parkinson's disease. While initiative leaders plan to continue operating Rehapunkt at the local level, its model has already been replicated by two other centres and there is considerable interest from other parties in establishing similar centres around Switzerland. Rehapunkt will continue to support the proliferation of its model through observation of its practice and providing coaching to interested centres.

Highlights

- Direct clinical experience of the multi-professional leadership team helped draw awareness to gaps in services delivery and aided the design of practical services to address observed needs.
- Co-location of providers within the centre increased coordination of services and ease of access for patients; external professional relationships and networking were important for generating referrals and growing the initiative.
- Gradually building the scale and scope of the initiative allowed time for sufficient resources to be collected and partnerships established; the initiative advanced with steady but sustainable growth.