A PROCESS IMPLEMENTATION EVALUATION OF

the Vista Centre Brain Injury Services (VCBIS) Personal Support/ Independence Training (PSIT) Program

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Prepared for
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Main Messages

Vista Centre Brain Injury Services (VCBIS) provides a variety of community-based services to adults with acquired brain injury (ABI) in the Ottawa and Cornwall areas. This page highlights the main messages that emerged from an implementation evaluation of the Personal Support/Independence Training (PSIT) program that was conducted from September 2018 – April 2019.

PSIT workers prioritize client goals when developing Individual Support Plans. They also address the clinical assessment protocols (CAPs) identified from the implementation of the InterRAI – Community Health Assessment (CHA) with clients. However, some challenges the PSIT workers face when using the CHA with clientele have been noted.

Clients feel that they have a say in determining their goals and service delivery. Clients who are able to formulate personal goals are provided with the opportunity to state their goals; however, some ABI clients face challenges with self-awareness making it difficult to identify their needs.

The primary assessment tool has weaknesses for use with ABI clients. PSIT workers have described several aspects of the CHA that make it challenging to use when they develop a client's Individual Support Plan (ISP). For example, the CHA was not created to be implemented specifically with individuals suffering with ABI and it may not be sensitive enough to measure changes relevant to the implementation of the PSIT program.

Rubrics developed to assess on-going client progress have potential. The on-going progress in specific areas of independent living and functioning of clients in the PSIT program is assessed by their PSIT workers using rubrics. The PSIT workers have identified areas where these rubrics are most helpful, as well as suggestions of how to improve their design.

Client progress is reviewed on a regular basis. However, progress can take time with ABI clients which can be a source of frustration.

Executive Summary

Background

ABI currently affects about 1.5 million Canadians, and each year an additional 165,000 people sustain an ABI (Brain Injury Canada, 2014). Survival rates of persons experiencing ABI have increased with advanced trauma services and improved treatment options. However, support programs for those with ABI have not kept pace with those rates. Over the 30 years of Vista Centre Brain Injury Services' (VCBIS) existence, there has been a growing demand for access to the VCBIS services from new clients seeking services and existing clients who often need long-term services and rely on these same resources.

In 2014, the Ontario Ministry of Health and Long-Term Care mandated VCBIS to administer the International Resident Assessment Instrument (InterRAI) – Community Health Assessment (CHA) with its PSIT clients annually and after significant change in health. In 2016, PSIT workers initiated the use of a variety of rubrics developed in-house to assess clients' on-going progress with their goals. Rubric levels were meant to be updated each visit with the client and reviewed along with the client Individual Support Plan (ISP) every 3 months. These assessment procedures were implemented to collect information on changes in client status and progress.

Management from VCBIS sought the assistance of graduate students from the University of Ottawa Program Evaluation diploma program to conduct an evaluation of the Personal Support/Independence Program (PSIT) from Sept. 2018 to April 2019. The purpose of this evaluation is to examine specific PSIT program service delivery methods, and to identify strengths and/or weaknesses in how the program is currently being implemented. The PSIT program is a core service for the VCBIS.

The evaluation approach was a process evaluation, wherein the focus was the activities and output portions of the PSIT program. There was a participatory approach in the evaluation where stakeholders were involved in the evaluation design, data collection, and an opportunity to comment on the interpretation of the evaluation analysis.

Evaluation Questions

The following evaluation questions were developed to assess the implementation of the PSIT program:

1) To what extent is information from the assessment tool (CHA) being appropriately used to develop client Individual Support Plans (ISP) and assess on-going needs?
2) In what ways is there good alignment between the expectations outlined in the client's ISP and the reality of the PSIT service delivery method?

Methods

A mixed-methods approach was used, synthesizing both quantitative and qualitative data collected from multiple data sources of information to answer the evaluation questions. The following sources of data were used:

- Historical agency documents stored on the Sharepoint™ database were used to collect quantitative information on client demographics, results from client CHA and rubric scores, and client ISPs.
- An 18-item PSIT client feedback survey was developed and administered to collect quantitative and qualitative information regarding clients' experiences with the PSIT program.
- A brief multiple-choice PSIT worker survey was developed and conducted to gather quantitative and qualitative information regarding workers' experiences with using the CHA and rubrics in developing client ISPs.
- A focus group interview with 10 PSIT workers was conducted to gather qualitative information regarding workers' experiences with the PSIT program.

Conclusions

After collecting and analyzing the data, and verifying the findings with VCBIS management, the evaluators formulated the following conclusions.

When developing client ISPs, the PSIT workers incorporate both client goals and specific clinical assessment protocols (CAPS) that are identified from implementing the CHA with clients, however the PSIT workers prioritize client goals. The majority of clients feel that their goals are incorporated into their ISP. The PSIT workers feel that rubrics are useful for measuring on-going progress in client's functional levels in well-defined tasks, but they identified problems with the number of different rubrics in use and the lack of standardization of rubric design and scoring among PSIT workers.

The PSIT workers have identified that the CHA has several weaknesses when implemented with this ABI population that limit how useful it is to assist in developing client ISP and measure outcomes. They feel that the CHA does not seem to be sensitive enough to measure changes in areas such as cognitive loss, which is key to ABI rehabilitation. The PSIT workers also expressed confusion regarding how certain CAPs "triggered" from the CHA, such as communication and cognitive loss, are to be addressed in clients' ISPs.

During the past two years, PSIT workers had been directed by management to review ISPs with clients every 3 months. The workers find that this is too short a time period to sufficiently measure progress with rubrics, especially when some clients receive visits once a month. The clients themselves do not feel the need to review their ISP this frequently either. This seems to be in part due to minimal progress apparent in this short time period. It would be more motivating for the client to see progress when reviewing their ISP, however

this tends to take more time in this population.

The intensity of service delivery (i.e., number of hours per week or month) allocation does not seem to have a consistent and goal-orientated method. Factors such as client's severity of injury or time since injury could be considered when determining service delivery.

Suggestions for Improvement

The following suggestions for areas that could be useful to examine further are based on the results of the evaluation and the evaluators' interactions with management and staff of VCBIS:

1) Consider additional training of PSIT workers on using the CHA in more effective ways for their clients. There may be additional measures from the CHA that would be useful in determining service delivery intensity and reassessment frequency, such as MAPLe and CHESS scores.
2) Review the CAPs commonly triggered by clients and provide more clarification and training among all PSIT workers on how they can most effectively address the CAPs in the client ISPs.
3) Form a small working group of PSIT workers to reduce the number of rubrics, standardize the level descriptions, and standardize scoring between workers to increase consistency and reliability.
4) Consider offering support groups for certain areas that show a frequent need for the PSIT clients and may be better addressed in a group setting, such as cooking.
5) Review ISP with client every 6 months. Report rubrics levels using most frequent and most recent observations.
6) Allocate hours of service in a consistent and goal oriented way. Clients on a path of independence maintenance meet less frequently with PSIT workers, while clients motivated to improve functional skills receive more hours more frequently.
7) Pilot test an alternative outcome measurement tool that has been developed for ABI population and is more sensitive to measuring critical areas such as cognitive loss. Ontario Neurotrauma Foundation has a list of recommendations in their document: *Clinical Practical Guideline for the Rehabilitation of Adults with Moderate to Severe TBI* (Ontario Neurotrauma Foundation, 2017).

List of Abbreviations

ABI	Acquired Brain Injury
ADL	Activities of Daily Living
CAP	Clinical Assessment Protocol
CHA	Community Health Assessment
CHESS	Changes in Heath, End-stage disease and Signs and Symptoms
ED	Executive Director
IADL	Instrumental Activities of Daily Living
InterRAI	International Resident Assessment Instrument
ISP	Individual Support Plan
LHIN	Local Health Integration Network
MAPLe	Method of Assigning Priority Levels
PM	Program Manager
PSIT	Personal Support / Independence Training
SIL	Supported Independent Program
TBI	Traumatic Brain Injury
VCBIS	Vista Centre Brain Injury Services

Evaluation Context

Vista Centre Brain Injury Services (VCBIS) is a non-profit agency funded through the Champlain Local Health Integration Network (LHIN) which has provided community-based services to individuals with acquired brain injuries (ABI) for more than 30 years. As shown in Table 1, VCBIS currently offers a variety of community-based programs and services for adults with ABI in Ottawa and Cornwall. Potential clients must meet specific eligibility criteria to receive services for each program.

Table 1
VCBIS Community-Based Programs and Services

Program Type	Description
Personal Support/Independence Training (PSIT)	Physical, social, or emotional supports to individuals living with the effects of a traumatic brain injury.
Assisted Living Services	Full-time residence with five rooms.
Day Programs	Social and recreation activities.
Support Groups	Group support in specific areas: adjustment group, healing through visual arts, anger management.

Services are provided on a subsidized or fee-for-service basis. VCBIS provides continual support to persons living with the effects of ABI through a Participant and Family Centered Care (PFCC) framework (Guion, Mishoe, Passmore & Witter, 2010). On an outreach basis, VCBIS offers individuals with the opportunity to fully participate in their community, by providing support in their own environment. Participants receive individualized support in the planning and achievement of their goals in relation to activities of daily living, employment, health, education, home organization, recreational activities and maintenance of independence. VCBIS encourages participants to establish and direct their own services.

Acquired Brain Injury Background and Treatment

Definition of Acquired Brain Injury

Acquired brain injury (AB I) is defined as damage to the brain which occurs after birth, is not caused by congenital or regenerative factors, and can result from either a traumatic brain injury (e.g., physical trauma due to accident, motor vehicle incident, fall, assault, neurosurgery, etc.), or a non-traumatic injury derived from either an internal or external source (e.g., stroke, brain tumor, infection, poisoning, hypoxia, ischemia, encephalopathy or substance abuse) (Brain Injury Canada, 2014). ABIs may result in significant physical (headaches, fatigue), cognitive (concentration, decision-making) (Malojcic et al., 2008), and emotional (anger, depression) difficulties (Koponen et al., 2002; Kreutzer, Seel, & Gourley, 2001; Hoofien, Gilboa, & Donovick, 2001).

Background on Brain Injury and Treatment

ABI currently affects about 1.5 million Canadians, and each year an additional 165,000 people sustain an ABI (Brain Injury Canada, 2014). Furthermore, ABI is a leading cause of death and disability in North America and worldwide (Chen et al.,2012). ABI is a pressing public health problem and imposes a significant financial burden on health systems (Hyder, Wunderlich, Puvanachandra, Gururaj & Kobusingye, 2007). ABI rehabilitation is complex due to the vast differences in cause, severity, location, duration, and progression of ABIs, (van Heugten, Wolters Gregório & Wade, 2012). There are also a wide range of demographics of individuals injured and their access to care which affect treatment options and rehabilitation results. The effectiveness of rehabilitation depends on a variety of factors, such as treatment setting, provider expertise, treatment type and intensity, and measurement tool (Cioe & Seale, 2018; Cioe et al.,2017; Smeets, Ponds, Verhey & van Heugten, 2012).

According to Teasell et al. (2005), treatment settings in Canada follow on a continuum of:

(1) Acute care (e.g., emergency department, intensive care, surgical, neurotrauma care),
(2) Post-acute care (e.g., inpatient rehabilitation, transitional residential care), and
(3) Community-based services (e.g., home and community-based, outpatient).

Not all individuals with ABI require treatment in each component of the continuum, and progress across the continuum is not necessarily linear (Teasell, Cullen & Bayley, 2005). Some individuals move from lower acuity to higher acuity care settings depending on medical complications (Cioe et al., 2017).

Community-based ABI Health Care in Ontario

There are numerous models of community-based ABI care in Ontario. Some centres offer services from an occupational therapist, physiotherapist, speech language pathologist, social worker, physiatrist, neuropsychologist, and neuropsychiatrist. Other centres have more limited services.

Eicher (2012) described an outpatient, community-based program for ABI clients with focused goals and accurate self-awareness of their disabilities. Progress shown by clients depended on the intensity of rehabilitation, where those receiving more intense treatment showed higher levels of progress. Initial levels of disability and chronicity (time since injury) are significant factors in determining progress. There is evidence in research that individuals receiving non-intensive long-term community-based supported living programs can successfully reach the goal of stabilizing functional status and help keep individuals live independently. In these types of programs, the goal is “no change,” keeping clients in independent living situations.

Individuals with ABI can access community-based care through regional LHIN organizations. In the Champlain LHIN region (Ottawa and Cornwall area), a person with ABI moves through their recovery process and their health care team, a family member or themselves will contact the ABI System Navigator. The ABI

Navigator's goal is to ensure that clients are directed to services that will meet their specific needs (Champlain LIHN, 2019).

Personal Support/ Independence Training (PSIT) Program Description

The PSIT program began in 1992 as the Supported Independent Program (SIL) and was created in response to the specific need of residential clients identified as no longer needing the 24-hour residential program, but could live in the community with some support. In 2001 additional funding was provided after the Acquired Brain Injury Coalition identified over 60 individuals with an ABI requiring SIL services. In 2013, additional funding was provided to create another position to address the growing waitlist, and in 2013 VCBIS was given funding to provide PSIT in the Cornwall area, for 8 additional clients.

PSIT Program Eligibility

The PSIT program is available for individuals with a diagnosis of an ABI who are 18 years and older, and who have completed post injury rehabilitation. To be eligible for the program, potential participants must also have the willingness to increase their independence and express interest in participating in a program to accomplish their goals and be living in, or about to be living in Ottawa or Cornwall.

PSIT Worker Duties and Program Activities

The PSIT program has been operating at full capacity (117 clients) with each of the 10 PSIT workers providing 26.5 hours of one-on-one personal support to clients per week. There is a waitlist of approximately 50 people, and the average wait time to start the program is 195 days. PSIT workers hold certification through college or university programs in social work or social services.

The training provided to clients in the PSIT program includes strategies to improve independent living skills, behavioural management, physical development and health, sensory-motor development, communications and social skills, and emotional and spiritual development. This program is provided for clients living with their families, those living in health care facilities and for clients living independently in the community. PSIT workers provide personal support and independence training services at the client's residence and training may be on a long-term basis.

Program Intake and Assessment Tools

Clients initiate the intake process in the PSIT program through the Champlain ABI System Navigator and they are placed on a waiting list until space becomes available. Initial meetings between client and PSIT worker involve completing the standardized assessment tool mandated by the Ontario Ministry of Health and Long-Term Care, the International Resident Assessment Instrument (InterRAI) – Community Health Assessment (CHA) (presented in Appendix A) (Morris et al., 2010). This assessment instrument has been designed to be used in a range of health care sectors (InterRAI, 2019). The CHA allows for the assessment of individuals living in a range of settings (e.g., independent living through ass

isted residence), and health care providers can track clients as they move along the continuum of care, while requiring staff to learn only one assessment system of the multitude of assessment tools available. Items on the CHA are designed to identify or "trigger" specific clinical assessment protocols (CAPs), which then allow the health care provider to focus on key issues so that decisions as to whether and how to intervene can be explored with the client. PSIT workers are all trained in the proper use and interpretation of the CHA instrument.

Outcome Measurement and Individual Support Plans (ISPs)

After completing the CHA assessment, the PSIT worker reviews the results with the client and they work together to develop an Individual Support Plan (ISP), which includes identifying supports and goals, and assigning appropriate rubrics to be used to measure progress. A set of rubrics have been developed by PSIT workers based on similar rating scales used in the CHA to measure on-going progress in specific areas such as activities of daily living (ADL), cognitive performance, instrumental ADL (IADL), aggressive behavior, social engagement, and self-care. Review of client progress is done on a quarterly basis with the rubrics, and re-assessment with the CHA is done on an annual basis or if clients experience significant change in their health condition. Adjustments are made as necessary and documented in the client ISP. An example of a client ISP can be found in Appendix B.

Program Logic Model

The evaluators developed a logic model (presented in Appendix C) of the PSIT program to outline the program needs, inputs, activities, outputs and outcomes. The program **need** is to provide personal support and independence training to help clients achieve and maintain independent living. The **inputs** of the program include funding sources, personnel, facilities and participants (i.e., clients, their family members and/or significant others).

Program **activities** include the intake process, service delivery method development, re-assessment process, and discharge process. Program **outputs** include the number of clients involved in the various stages of the program, including those individuals initiating the intake process and currently on the waitlist to receive services. Additional outputs include the assessment tools used and client discharges completed.

Program **outcomes** are divided into:

- Immediate outcomes: Clients reached or re-evaluated their personal goals, reducing the need for services by long-term clients, and more new clients receiving PSIT services.
- Intermediate outcomes: Reduced wait time for ABI services, and maintained client independence and autonomy.
- Long-term outcomes: Contributed to local health system sustainability, and improved quality of life of clients and their families.

Contributing factors identified are the complexity of ABI injuries which affect rehabilitation, client demographics, and funding agency capacity and priorities.

Development of Evaluation Plan

The organization submitted a request to the University of Ottawa in 2018 for an evaluation of their current services to determine if they are meeting the needs of their clients. This request for a program evaluation followed the agency's recent development of a Strategic Plan in 2016.

The evaluators met with the program manager (PM) at VCBIS, who provided information about the agency in order to determine the evaluation needs, evaluation questions, and to develop the logic model of the PSIT program. The PM verbally described the agency and its programs, answered questions and provided documents regarding its services, strategic plan, accreditation, assessments, and the number of clients involved in the programs. The evaluators supplemented this with information from the VCBIS, LHIN and InterRAI websites, as well as documents found on the VCBIS' Sharepoint™ web-based information portal.

Over the course of several weeks in October 2018, feedback from the PM on drafts of the program description, logic model, evaluation needs and questions to verify the information and to stimulate further discussion was sought by the evaluators. Evaluators also met with the agency's Executive Director (ED), PSIT workers and LHIN representatives to better understand the evaluation needs.

Intended Audience

This evaluation plan has been developed to inform the VCBIS Program Manager (PM), Executive Director (ED), the PSIT workers, and LHIN representatives. The evaluation plan has been presented by the evaluators to all these audience members through two different interactive presentations in November and December 2018.

Evaluation Purpose and Approach

The PSIT program the PSIT program is a core service for the VCBIS. The purpose of this evaluation was to examine specific PSIT program service delivery methods implemented by VCBIS, and to identify strengths and/or weaknesses in how the program is currently being implemented.

The evaluation approach was a process evaluation where the focus was the activities and output portions of the PSIT program. There was a participatory approach in the evaluation where stakeholders were involved in the evaluation design, data collection, and an opportunity to comment on the interpretation of the evaluation analysis.

Evaluation Questions

The following evaluation questions were developed to guide the assessment of the implementation of the PSIT program:

1) **To what extent is information from the assessment tool CHA being appropriately used to develop client ISP and assess on-going needs?**
   - Sub question 1*: Is all the appropriate information from the CHA assessment tool being used in the ISP?*
   - Sub question 2*: Is information from the assessment tool being transformed appropriately into rubrics?*
   - Sub question 3*: Are changes in client behavior indicated in rubric levels consistent with changes in CHA levels?*

2) **In what ways is there good alignment between the expectations outlined in the client's ISP and the reality of the PSIT service delivery method?**
   - Sub question 1*: How are client goals incorporated into the ISP and PSIT service delivery?*
   - Sub question 2: *What is the intensity of PSIT services and how are services allocated?*
   - Sub question 3: *Are PSIT workers reviewing ISPs with clients regularly?*

Program Evaluability

In assessing the evaluability of the PSIT program, *Evaluation Essentials*, by Alkin (2018), was helpful in providing a number of issues to consider: 1) the nature and relevance of the questions, 2) the nature and stage of the program, 3) the resources available, and 4) technical issues such as whether the evaluation question is measurable with the available data. These items have been examined in relation to the PSIT program at VCBIS, and are discussed below.

1) The evaluation questions are relevant to the program staff and managers, as they need their program to be delivered as intended, since their funding and resources are limited, yet they wish to meet the increasing demands for the services they provide. The evaluation questions have been sufficiently focused so that they are measurable. In addition, the evaluators and stakeholders have a high level of confidence that the evaluation questions can be answered.

2) The PSIT program has been implemented at VCBIS for many years in its current form, by PSIT counsellors who have been working at VCBIS for many years. There are well documented procedures on file. Substantial written and anecdotal information is also available regarding all aspects of the program delivery. New intake and discharge procedures were recently mandated (Nov. 2018) by the funding agency, so there will be limited information on how they function by the time the evaluation data collection period begins in January 2019. This may have an impact on the evaluation, though the evaluation focus will primarily be on the delivery of services. There are also a number of ABI clients who have been receiving PSIT services who are willing and able to provide information from the perspective of program participants.

3) The PM and ED are both very motivated to have an evaluation of the PSIT program completed and are putting their own time and staffing resources toward supporting the evaluation process. Staff are also interested in examining the service delivery methods so that they can ensure that they are delivering the services, as intended. While management and staff are new to participating in a program evaluation, they do not appear to be overly resistant.

4) Technical issues regarding available, measurable data to address the evaluation question have been assessed by the evaluators. There is existing quantitative data accessible to the evaluators, as well as sufficient documentation describing the program. This will be supplemented with quantitative and qualitative information gathered through a survey, questionnaire and focus group interview, to provide detailed information that addresses the evaluation questions.

Evaluation Methods

A mixed-methods approach was used, collecting and synthesizing both quantitative and qualitative data via multiple sources of information to answer the evaluation questions. This approach was developed in close collaboration between VCBIS program manager (PM) and the evaluators, with advice provided by university course instructors Dr. Cobigo and Dr. Aubry.

Quantitative information relating to our evaluation questions and indicators was gathered from several sources:

(1) **Historical agency documents** are stored on the Sharepoint™ database and were reviewed to compile information on specific program descriptions, client demographics, client charts with records of ISPs and InterRAI-CHA results, assessment tools, rubrics and service delivery intensity related to the evaluation questions. Relevant data was accessed by the evaluators directly from files on the Sharepoint database or provided by the PM.
(2) **An 18-item PSIT client feedback survey** was created to gather information on client involvement in determining services delivered (See Appendix D). The 2019 survey was created using some items from a client satisfaction survey conducted by VCBIS in 2016, and additional questions were included to gather specific information for the evaluation. This survey provided information both to the current evaluation, as well as to the VCBIS management on client feedback and satisfaction. The survey was administered to all PSIT clients using SurveyMonkey™. The VCBIS program manager (PM) created the survey and distributed it to all current clients. PSIT workers reminded their clients to complete the survey, and offered support to clients, as needed.
(3) **A PSIT worker survey** was created to gather information on how PSIT workers implement services and use the assessment tools (See Appendix E). This questionnaire was administered by SurveyMonkey™ in January, prior to qualitative data collection, to assist in designing appropriate focus group discussion guidelines. The PM also assisted in creating and distributing this via SurveyMonkey™.

Qualitative data collection sources to collect detail-rich information on the service delivery practices conducted in the PSIT program were also utilized by the evaluators.

(1) **Written comments from the PSIT client feedback survey and the PSIT worker survey** were used to gather information on client and worker perceptions regarding the implementation of services and use of assessment tools (See Appendices D and E).
(2) **A focus group interview** was conducted with all the PSIT workers during a staff meeting in February. The PM offered a two-hour time slot where all the PSIT workers were available to attend, as well as meeting space and lunch for participants. One evaluator led the discussion and a second evaluator took notes and managed the audio recording of the discussion. (See Appendix F for the focus group outline).

Data Analysis

To conduct the quantitative analysis of the current and archived VCBIS data was downloaded into Excel © documents. Results from the PSIT client feedback survey and the PSIT worker questionnaire were entered into Excel © spreadsheet. Frequency (percentages) of responses was calculated for all PSIT worker survey and PSIT client survey questions. Client demographics (i.e., client age, gender, years since head injury, years in the PSIT program) collected from the PSIT client feedback survey and from historical agency documents were analyzed using Excel © to calculate frequencies (percentages) and averages.

Chart reviews were conducted on the results from 25 randomly selected clients' CHA assessments for 2017 and 2018 to determine the percentage of CAPs triggered incorporated into client ISPs, as well as to determine changes in CAPs scores.

Chart reviews of 63 client, provided by 7 PSIT workers, rubric scores and service delivery intensity (i.e., number of hours per week, bi-week or month) for 2017 and 2018 was conducted. Frequency of rubrics used for all clients as well as individual clients was determined. Changes in recorded rubric levels for individual clients over various time periods was determined and summarized. SPSS was used to compare service delivery intensity to PSIT worker. Descriptive statistics for the data were computed, and correlational and linear regression analysis were used to explore the relationship between service delivery intensity and the PSIT workers.

Qualitative analysis of the focus group interview audio recording and notes was completed independently by both evaluators. Audio recording was used to facilitate coding processes and identify quotes that were relevant to evaluation questions. A thematic analysis was conducted, wherein the focus group interview transcript was coded to extract important themes and ideas from PSIT workers. We define themes as units of meaning derived from participants' descriptions of their thoughts, feelings and experiences. Our analysis followed the interpretive practices of constant comparison and attempted to uncover patterns within the focus group. Our themes bring together components of participants' descriptions which may not be meaningful if viewed in isolation and further, our themes taken together provide a comprehensive picture of participants' collective descriptions.

Open-ended comments from the PSIT Client Feedback Survey were coded to extract important themes and ideas from clients in similar fashion to the focus group. Survey comments were extracted to uncover

pertinent themes and ideas from both the PSIT client survey and the PSIT worker survey to provide a comprehensive picture of participants' collective responses.

Finally, document reviews were conducted to compare the assessment scales and descriptions of the CAPs in the CHA and the rubrics. Data analysis was completed from March -early April 2019, and the final report was completed by late April (2019) (See Appendix G).

Ethical Considerations

The evaluators signed confidentiality agreements and agreed to handle private and sensitive agency data and documents carefully following agency guidelines and protocol (See Appendix H). Informed, written consent was obtained from individuals completing interviews (See Appendix I) and questionnaires (See Appendix J and K). No names from the survey, questionnaire and focus interview notes will be disclosed. Participation in the survey, questionnaire and interview was voluntary. Participants were not be required to answer all of the questions and are able to withdraw consent at any time.

Storage and Backup, Retention, Preservation and Data Sharing

Following VCBIS agency guidelines and protocol outlined in the confidentiality agreement, historical data (i.e., client ISPs, InterRAI-CHA scores and rubrics) was only stored and accessed via the VCBIS Sharepoint™ password protected database. PSIT workers, VCBIS staff and program evaluators had sole access to the Sharepoint™. During data collection and data analysis, client names were replaced with codes so that relevant data pertaining to the same client could be compared. A master list of client names and codes was be stored on Sharepoint™ and destroyed after the data analysis was complete. This evaluation report will not include any direct or indirect identifying information about individual clients' personal or medical history.

The PSIT worker survey and the PSIT client feedback survey was collected using Survey Monkey. Access to survey responses is password protected, and access is granted to both program evaluators and the PM. Responses from both surveys are anonymous.

All raw data (i.e., audio recording and transcriptions) of information collected in the focus group interview was stored in secure cabinets during the analysis process, then destroyed after the analysis summaries were complete. Any names mentioned in the interview were removed during the transcription process. The summaries and reports from the evaluation have become the property of VCBIS, upon completion of the program evaluation.

Responsibilities and resources

Clients were offered support from VCBIS staff in completing the PSIT client feedback survey. For the focus group interview with the PSIT workers, VCBIS management provided time to conduct the interview during a regularly scheduled staff meeting, a meeting room, lunch, and office materials. VCBIS management was responsible for storage and management of historical data (reports from SSO, client ISPs, InterRAI-CHA scores and rubrics) stored on the VCBIS Sharepoint™ and for the survey responses collected via Survey

Monkey. Program evaluators were held responsible for the management and recording of the focus group interview.

Limitations to data collection and analysis

It is important to describe any limitations related to the data collection and analysis. As we were using a large portion of our data from historical documents, such as client charts and ISPs, we had no control over exactly what data was collected and in what form it was documented. In addition, there was some fluctuation of clients withdrawing from or starting PSIT services throughout the 7 months the evaluation was being conducted. These factors had an impact on the client data that was available, resulting in different numbers of clients included in the various data analysis, particularly client demographics.

Another limitation of the data collection and analysis was missing data from client charts. PSIT workers did not always document client ISPs and rubrics completely and consistently for every client. In some cases there was no up-to-date client ISPs from specific PSIT workers.

Finally, the evaluators had planned to include data from the InterRAI – CHA results of all PSIT clients for the past 5 years, and were told by a LHIN staff that this data was readily available. Unfortunately, we were never provided this data and we collected data from a random sample of 25 clients for the past 2 years. While this information was somewhat informative, it would be interesting to see the results of a larger sample of clients over a longer period of time.

Client Demographics

PSIT Client Demographics

PSIT client ages and gender are presented in Figure 1. The clients ranged in age from 26 to 80 years. The mean age was 53 years. 17% of the clients were 65 years or older. There were 62% male and 38% female clients.

There are implications of clients ages when we look at the CHA assessment tool that was mandated for use at VCBIS. The CHA was developed primarily for use with senior populations (InterRAI, 2019). Looking at the PSIT clients, 83% are under 65 years.

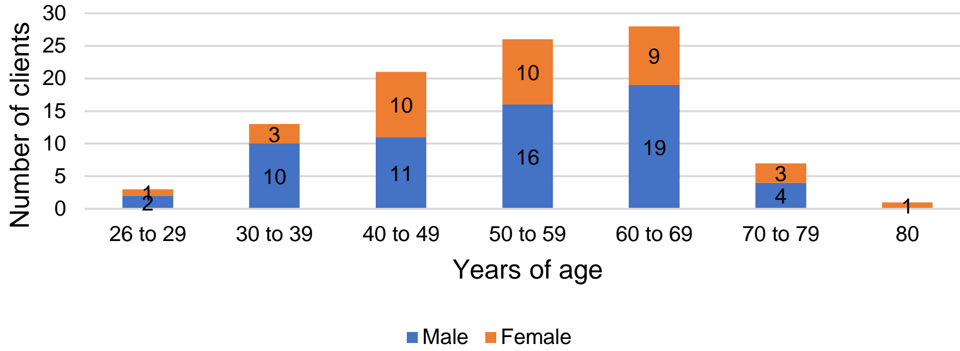

Figure 1. PSIT Client Age and Gender (n = 90)

The number of years between when the clients sustained their initial brain injury and when they began receiving services at VCBIS was calculated by subtracting the number of years since they started receiving VCBIS services from the number of years since brain injury. The results are represented in Figure 2, and show that 57% of the clients began services within 1 to 4 years of their brain injury, 13% of clients began services 5 to 9 years after their brain injury. The remaining 30% of clients began services over a range of 10 to 46 years after their brain injury.

This shows that the majority of the clients at VCBIS receive relatively early intervention, where research has shown that rehabilitation, especially intensive post-hospital, results in greater improvements (Eicher et al, 2012).

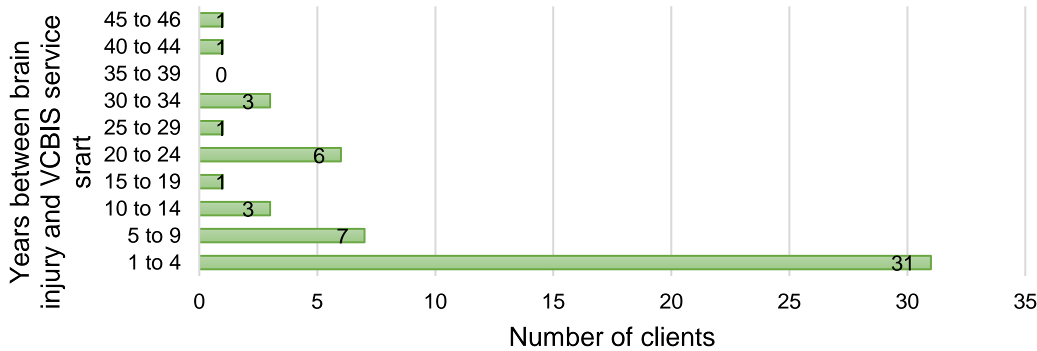

Figure 2. Years between client's brain injury and VCBIS services start (n=54)

Evaluation Findings – Question 1

To what extent is information form the assessment tool: The InterRAI-CHA being appropriately used to develop client ISPs and assess ongoing needs?

The methodology for the first evaluation question included: (1) A chart review of CAPs triggered for individual clients and individual client ISPs with rubrics and notes from a randomized sample of 25 PSIT clients, (2) Administration of the PSIT worker survey via SurveyMonkey e-mail link to all PSIT workers (n=10), (3) Organization and facilitation of the PSIT worker focus group interview among PSIT workers (n=10), (4) Analysis and comparison of rubrics and scale descriptors versus the InterRAI-CHA scale descriptions, (5) A chart review of triggered CAPs levels on the annual CHA assessment over a 2 year period from a randomized sample of 25 PSIT clients, and (6) A chart review of 70 client rubrics (convenience sample).

Appendix L provides an overview of the evaluation plan (indicators, data collection sources, data collection methods and analysis) for the first question of the evaluation, including the methodology identified to answer each of the sub-questions. While the methodology is grouped by evaluation question and sub-question for simplicity of presentation, it is important to note that each of the methods yielded information that informed the evaluation results, and that the findings and answers to each evaluation question is based on the evaluation as a whole. Each data collection source and corresponding data analysis is explained in greater detail in the Evaluation Methods section above.

Sub question 1: Is all the appropriate information from the CHA assessment tool being used in the ISP?

Percentage of triggered Clinical Assessment Protocols (CAPs) incorporated in client ISPs

A chart review of 25 randomly selected clients showed that 100% of CAPs triggered on the CHA were incorporated into client ISPs. A template of the ISP can be seen in Appendix A. CAPs are organized into four categories: (1) Cognition and Mental Health, (2) Functional Performance, (3) Social Life, and (4) Clinical Issues. Within the functional performance category are the activities of daily living (ADL) and instrumental activities of daily living (IADL). This information was then used by PSIT workers to:

(1) Choose areas to work on with the client where program would be assessed using a specific rubric,

(2) Make recommendations for the client to follow-up with specific medical care, and

(3) Make a note in the ISP indicating that the client chose not to work on the CAP (e.g., tobacco use).

The evaluators noted that there was some information from the CHA that was not included in client ISPs, such as the Method of Assigning Priority Levels (MAPLe) scores and the Changes in Heath, End-stage disease and Signs and Symptoms (CHESS) scores. According to the document, “Best Practice Guidelines for the interRAI CHA Reassessment” (Community Care Information Management, 2011) the MAPLe is used to categorize clients into five levels of risk for adverse outcomes and is a decision-making support tool that can be used to inform choices related to allocation of home care resources. The CHESS measures medical complexity and health

instability. Together the MAPLe and CHESS scores can be used as predictors to help inform reassessment frequency.

PSIT worker perceptions of incorporating all triggered CAPs in client ISPs

Although a chart review revealed that 100% of CAPs triggered by the CHA were incorporated into the ISP, responses in the PSIT worker survey showed that five of the ten PSIT worker felt that they always incorporate all CAPs triggered into the ISP, while 3 of ten workers (30%) felt that they usually incorporate them. Two of the PSIT workers responded that they sometimes incorporate all CAPs triggered into the ISP. This perception may be attributed to a misinterpretation of the question, as it is possible that PSIT workers assumed that the incorporation of triggered CAPs into the ISP involved choosing areas to work on with clients and assess on-going progress using rubrics. However, themes that emerged from the focus group reveal that the PSIT workers have several concerns with the CHA that have a direct impact on how they develop ISPs with clients.

ISP Development. Based on themes that emerged from the focus group interview involving all PSIT workers (n= 10), the PSIT workers develop client ISPs based on:

(1) ***Clients' observed and expressed needs***. Information about clients' needs take precedence over the triggered CAPs. PSIT workers determine client needs by asking clients or being told by clients which specific activities or strategies they would like to work on, and by simply being in the client's environment and observing areas in which they are struggling to remain independent.
(2) ***Individual factors***. Severity of brain injury, previous consumption of alcohol and/drugs, and inherent ability (level of cognitive capacity) related to client's capability of interacting with tasks to improve their ability to function independently also affect whether PSIT workers choose to address a CAP that is triggered.
(3) ***Accuracy of triggered CAPs***. PSIT workers found that the triggered CAPs are problematic, as sometimes the CAPs that are triggered are surprising, inaccurate in rating, or there is a disconnect between what the client would like to work on and the CAP that was triggered. The triggered CAP may not accurately describe the client's area of struggle. A PSIT worker stated that:

> *Even when I do [the CHA assessment] now, [after I have received training to administer it], I'm surprised sometimes by what comes up as a CAP, what's triggered because it's like an aspect of…their life that we've never needed to work on or do anything with.*

PSIT workers administer the CHA, which triggers certain CAPs. While a CAP may be triggered, PSIT workers felt that the CHA does not trigger CAPs that are aligned with clients' expectations of the PSIT services that are provided. PSIT workers also indicated that it is common to see clients speak of needs that they have that would help them remain independent, while these areas of struggle are not identified by the CHA.

Difficulties with the CHA. PSIT workers identified the following challenges:

(1) **It takes a long time to administer** during the primary interview and assessment (ranging from 40 minutes to 3 hours), reducing time that is dedicated to maintaining and improving clients' independence.

(2) **Clients' self-assessment limits the accuracy of CHA scores:**

When we do the CHA, sometimes you're going to see that the client is going to respond in a way that they, the mood that they have at the moment. Sometimes… that presents bias because you know the client. If the client responded [in a certain way], it might trigger a different outcome.

Moreover, conflicting opinions are sometimes given by clients' caregivers, indicating that the clients' self-report on a certain scale may be inaccurate.

(3) **The CHA is not specific to ABI clients** and does not lend to maintenance and improvement of independence for individuals with ABI. PSIT workers reported that the CHA does not address compounded issues, and that a more personal interaction is needed to evaluate the antecedents to pertinent issues that should be addressed.

This assessment is not geared toward ABI whatsoever. It's great if you have a client in a long-term care facility but it is not geared towards ABI at all.

(4) **PSIT workers also expressed that their level of training** limits their ability to address specific problem areas identified by the CHA. CAPs commonly triggered by clients are cognitive loss and communication, and not all PSIT workers feel confident in how these should be address. There seems to be confusion around whether PSIT workers need to explore clinical issues as some felt that clinical issues are simply part of the population they reach, while others indicated that they provided appropriate referrals and followed up on these issues.

Sub question 2: Is information from the assessment tool being transformed appropriately into rubrics?

Consistency of scale levels and descriptions in rubrics with CHA scale levels and descriptions

There is very little consistency between the CHA scale levels and rubric scale levels. The scales for the CAPs are very limited in number, using 0 to equal "not triggered," 1 to equal "triggered to monitor for risk of decline," and sometimes 2 to equal "prevent decline." There are several different scales in the CHA for specific outcome measures, each scale indicating 0 as the highest level of functioning with increasing numbers indicating decreased functioning. The number of levels in these outcome measure scales vary from two to seven. The descriptions of the various scale levels are not consistent other than level 0 always representing the highest level of functioning. The CHA is presented in regular format in Appendix A.

The rubric scales that the PSIT workers developed range from either 1 – 4 or 1 – 5, with level 1 indicating the lowest level of functioning and 4 or 5 indicating the highest level of functioning. Table 2 shows the scale and descriptions of a commonly triggered CAP, Cognitive Loss, compared to the scale and description of a typical rubric, Cognitive Skills for Daily Decision Making.

Table 2
Scale and Description from CHA and Rubric

Cognitive Loss CAP (from CHA)	Cognitive Skills for Daily Decision Making (from rubric)
2 = Triggered to prevent decline 1 = Triggered to monitor for risk of cognitive decline 0 = Not triggered	1 = Severely impaired; rarely makes decisions 2 = Moderately impaired; decisions are poor 3 = Minimally impaired in some situations, decisions are poor 4 = Modified independence 5 = Independent

Another noteworthy factor with the rubrics is that from a sample 7 PSIT workers, they used over 20 different rubrics with each rubric having slightly different descriptions. Some of the rubrics were designed to assess very similar areas of functionality. (Represented in Appendix N)

The consequences of the PSIT workers developing rubrics using information from the CHA, where scales and descriptions vary so drastically across outcome measures, is that there has been difficulty designing rubrics that are standardized and scoring is consistent across PSIT workers.

The PSIT workers expressed frustration with creating and using the rubrics, and identified several problems with the rubric design that hindered their usefulness in providing on-going assessment of client progress:

(1) Subjective and inconsistent rating across PSIT workers,
(2) Non-standardized levels and descriptions across rubrics,
(3) Not sensitive enough to measure changes in ABI population.

There's an element of inaccuracy in the way… the rubrics are formulated because the counts are subjective [when you are] measur[ing] performance. What could be for some counsellors a level 3, could be 2 for another. It all depends, and also the performance of the client themselves might lack that objectivity because of the way that it's measured.

Sub question 3*: Are changes in client behavior indicated in rubric levels consistent with changes in CHA levels?*

Ratio of changes in rubric levels compared to changes in CHA levels over time

A chart review of 25 randomly selected clients showed that 100% of clients triggered the CAP Cognitive Loss in the years 2017 and 2018 (annual assessment). The level triggered did not change over time for any of the clients. It is expected with this ABI population that cognitive loss would be triggered, but it is unexpected that there is no improvement or decline shown for any of the clients over time. Across the 25 client charts there were several other CAPs triggered that did show changes over time in both the level of the same CAP

and the type of CAP triggered. There seems to be a lack of sensitivity for the CHA to measure small increments of change that tend to occur in ABI populations.

A sample of rubrics for 70 clients showed that rubric levels were measured over a variety of different durations, ranging from 6 months to 2 years. Examining the levels over these time periods showed that the most common results were that the levels stayed the same (54%) or improved 1 level (41%). A few clients increased 2 levels, and a couple clients decreased one level.

It is difficult to compare the level of the CAPs triggered to the rubric level for individual clients as often a client will be working on more than one rubric, and some clients work on up to 4 rubrics at a time, or a rubric may not be used for several of the triggered CAPs. However, the PSIT workers include detailed notes in the ISPs that describe factors in the client's life that may be having an impact on CAPs triggered and rubric levels. Specific information on the type of training the PSIT worker is implementing with the client and client progress is also included in the ISP.

Perceptions of consistency of change measured between rubrics and CHA

The difficulty in comparing changes in CHA levels and rubric levels over time experienced in the chart reviews is also seen in the perceptions of the PSIT workers. In the PSIT worker survey, five PSIT workers (50%) stated that they sometimes notice a consistency between changes in CHA scores compared to rubric scores when doing re-assessments, while one reported that they usually notice a change, and one reported that they never notice a consistency between changes in CHA scores compared to rubric scores when conducting re-assessments. Three PSIT workers provided comments to the question, explaining that they rarely see consistency between changes in CHA scores compared to rubric scores when doing re-assessments as the CHA triggers are almost identical year after year. Another PSIT worker stated that the level of consistency depends on the client's level of stability and effort demonstrated in the achievement of agreed upon goals.

In the focus group interview, PSIT workers did not find that rubrics were helpful in providing and monitoring on-going progress in independence functioning with their clients, with the exception of rubrics outlining short, well defined, concrete tasks that are objectively measured. Reasons for this were:

(1) It is difficult to see improvement with rubric levels over a short period of time (3-month intervals). Additionally, client improvement on rubric scales may be affected by the fact that clients are sick and unavailable, and PSIT workers may only see clients once every two or four weeks.

> *Unless it's a specific goal or…[a goal that requires] a short time [to achieve] like bus training, making muffins, learning how to do laundry when you've moved in somewhere new, [using a rubric is not helpful].*

(2) There are problems with the rubric design that lead to subjective and inconsistent measurements.
(3) The rubrics are not sensitive enough to measure small changes in functioning for the ABI population.
(4) PSIT workers have difficulty in justifying client care to management when the assessment tools used do not demonstrate change.

How are you going to justify the fact that [PSIT care] is just maintenance?

PSIT workers recognize the challenges in measuring small changes in function levels over short periods of time with their ABI clients, and the difficulties in justifying continued services to management and funding agencies when there seem to be no progress for some clients. There is increasing pressure to move clients through the PSIT program as the waitlist and wait times continues to grow for individuals waiting to receive PSIT services.

Evaluation Findings – Question 2

In what ways is there good alignment between the expectations outlined in the client's ISP and the reality of the PSIT service delivery method?

The methodology for the second evaluation question included: (1) Administration of the client feedback survey via SurveyMonkey™ e-mail link to all PSIT clients (n= 57), (2) Administration of the PSIT worker survey via SurveyMonkey™ e-mail link to all PSIT workers (n=10), the (3) Organization and direction of the PSIT worker focus group interview among PSIT workers (n=10) and (4) Collection and analysis of historical data comparing PSIT service delivery intensity to PSIT worker, client age and gender.

Appendix M provides an overview of the evaluation plan (indicators, data collection sources, data collection methods and analysis) for the second question of the evaluation, including the methodology identified to answer each of the sub-questions.

Sub question 1: How are client goals incorporated into the ISP and PSIT service delivery?

Clients' perceptions of being able to communicate goals, expectations, how services are provided to them, and knowledge of what is in their ISP

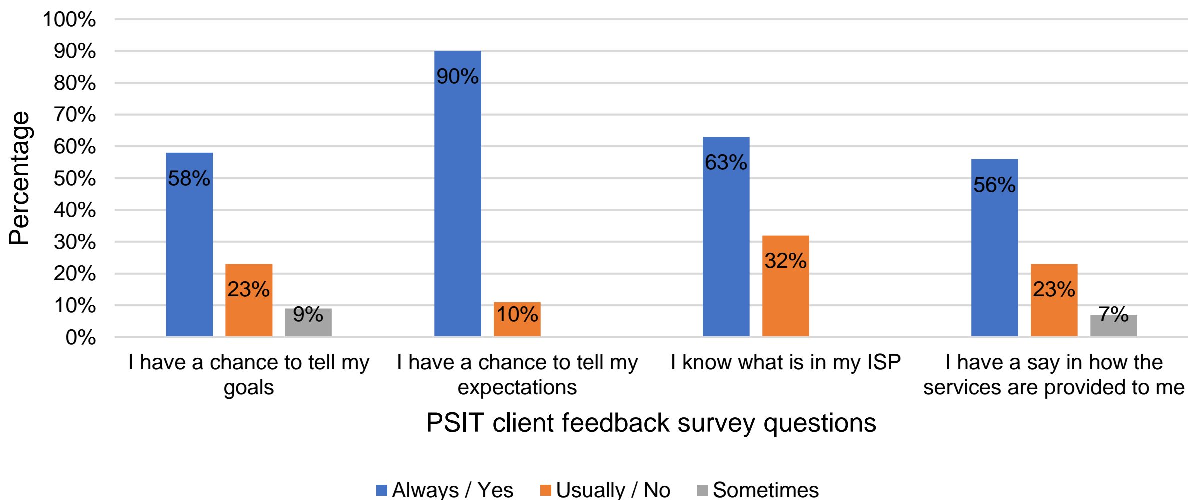

Figure 3. Client's incorporations of how goals are incorporated into their ISP and PSIT service delivery(n = 57). Answers from the PSIT client feedback survey are represented as percentages (%).

Overall, based on questions 4, 5, 7 and 11 from the PSIT client feedback survey, most PSIT clients felt that they had a chance to tell their PSIT worker their goals and expectations. Most PSIT clients also knew what was in their ISP and felt that they had a say in how PSIT services are provided to them.

Some clients did not answer the survey question and opted to provide comments for clarification. Overall, four respondents indicated that they either do not have any goals established for themselves or that not being able to share their goals is their own challenge and not the PSIT workers fault. Four of eighteen respondents that commented that their brain injury hinders their ability to remember what is in their ISP. These comments are not unexpected in ABI individuals, where memory and lack of self-awareness in common.

PSIT client feedback survey: If you have been dissatisfied with PSIT services, do you feel you are able to tell your PSIT worker or management? (Q12)

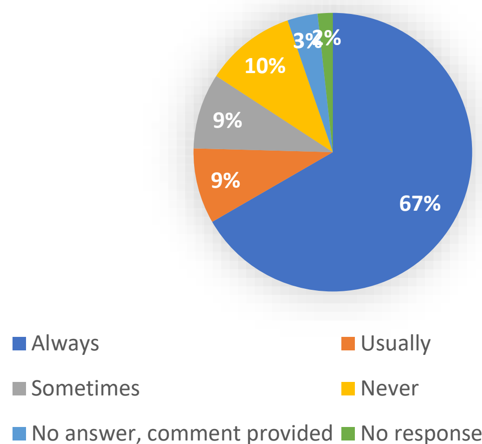

Figure 4. Clients' ability to tell their PSIT worker or management they are dissatisfied with services.

Most clients (67%) stated that they always feel that they are able to tell PSIT workers or management if they have been dissatisfied with PSIT services. One client commented on a miscommunication between a PSIT worker and themselves over lack of attention.

Perceptions of how PSIT workers incorporate client goals in their ISPs and PSIT service delivery

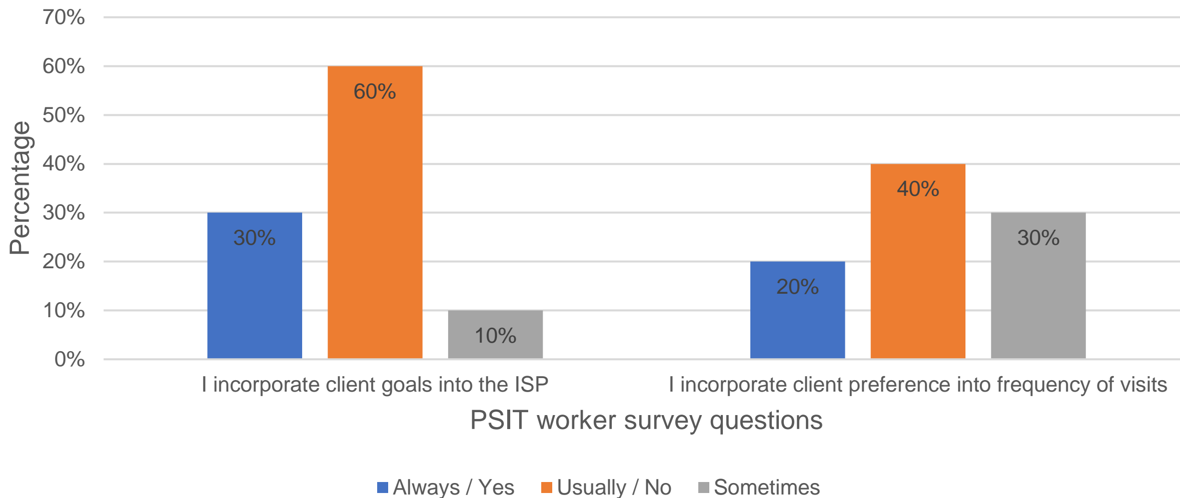

Figure 5. PSIT workers perception of how they incorporate client goals in ISPS and PSIT service delivery (n = 10).

Based on questions 6 and 7 from the PSIT worker survey, PSIT workers stated that they always (30%) or usually (60%) incorporated client goals into their ISP. One (10%) PSIT worker did not answer and provided a comment with regard to the question, stating that this is an area of discussion among staff as CAPs triggered are not necessarily congruent with the client's view of their situation.

Regarding the incorporation of client preference into frequency of visits, two PSIT workers stated that they always incorporated client preference into the frequency of visits, four stated that they usually did, while three stated that they sometimes did.

Focus group interview: *How are client goals incorporated into the ISP and how do you balance incorporating client goals and triggered CAPs into ISPs?*

As described in detail previously in this report, PSIT workers expressed that they have difficulty prioritizing client goals/needs while still incorporating all the triggered CAPs into the client ISPs. They explained that some client goals may not clearly be measured by the assessment tools, and it is difficult to outline client goals in ISPs and address these with PSIT training:

> Some things are not going to change. Like if a client were to say "I can't see, and I can't hear and I need help at the grocery store to read things so that I don't buy expired milk and I don't buy expired bread."

PSIT workers highlighted that they are there to support maintenance of client independence and that they are not trained to provide skills or address difficulties related to cognitive decline or ABI-related cognitive symptoms. Prior to the introduction of the mandated CHA and rubric use, PSIT workers felt that they provided more client-centered care in establishing and addressing client goals. PSIT workers explained that client-focused care does not seem to be as important as correctly implementing the assessment tools, and that this has introduced a disconnect between client goals and triggered CAPs being incorporated into the ISPs:

It used to feel like a more supportive process. Asking them what areas of their life they need help with, as opposed to us presenting them their scores on the CHA that then highlights their problem areas.

Sub question 2: What is the intensity of PSIT services and how are services allocated?

Service delivery intensity

Quantitative analysis was done to explore service delivery intensity with respect to PSIT worker, using data from 63 client charts. Service delivery intensity (defined by hours per week, bi-weekly, or month) was organized into 5 categories: 1 = 4 hours/week; 2 = 1 – 3 hours/week; 3 = 2 hours bi-weekly; 4 = 2 – 3 hours/month; 5 = phone call. Table 3 presents the percentage of clients receiving each intensity level.

Table 3:
Percentage of Clients and Service Delivery Intensity levels (n = 63)

Category	Service Delivery Intensity	Percentage of Clients
1	4 hours/week	11%
2	1 – 3 hours/week	52%
3	2 hours bi-weekly	24%
4	2 – 3 hours/month	11%
5	Phone call	2%

The most common intensity of service delivery is 1 – 3 hours/week, with 52% of clients receiving this intensity. The next most frequent intensity is 2 – 3 hours/bi-weekly, for 24% of clients. Eleven percent of clients receive services at the intensity 4 hours/week and 2 – 3 hours/month, and one client receives services by phone.

The correlation between Worker and Intensity is 0.325 - this is significant at the 0.05 level, and indicates that roughly 10% of the variance is shared between these two variables. Based on this information, we tested for an explanatory relationship between Worker and Intensity (of Service Delivery); the regression results for predicting Worker from Intensity show that we can predict Worker from Intensity level to some extent (the fitted model is **Worker** = 1.86 + 0.72***Intensity**; the SEM (Standard Error of Estimate) for this analysis is 1.88).

This difference in service delivery intensity between PSIT workers was explained by the VCBIS PM as being due to an influx of new clients for one PSIT worker at the time the data was collected, where new clients were allotted the highest level of intensity initially but would be reduced in intensity once assessments were completed and ISPs were developed with the clients.

PSIT worker perceptions of how PSIT service delivery intensity is allocated

In the focus group interview, PSIT workers stated that the frequency and number of hours of service is affected by:

(1) **Program budget.** Whether the program budget allows for service delivery frequency/length

(2) **Exchanges between PSIT worker and management.** Whether PSIT workers justify PSIT service to management

(3) **Client's expressed need for service**

(4) **PSIT worker experience.** PSIT worker's judgement of frequency and intensity of the program based on prior experience

Sub question 3: Are PSIT workers reviewing ISPs with clients regularly?

Client Perceptions. In response to question 8 of the PSIT client feedback survey, clients' perceptions were that they always (7%) or usually (25%) reviewed their ISP with their PSIT worker every 3 months. A little less than half (42%) stated that they sometimes review their ISP, while 16% responded that they never did.

Based on question 9 from the PSIT client feedback survey, 26% of clients stated that they always made changes to their ISP with PSIT workers when needed, 12% reported that they usually did, 26% responded that they sometimes did, and 15.8% perceived that they never made changes to their ISP when needed. One respondent commented that they did not feel the need to change what is in their ISP.

PSIT worker Perceptions. The PSIT worker survey revealed that the regular review of ISPs greatly varies across PSIT workers. Two of ten PSIT workers stated that they usually review the ISP with each client every 3 months, three stated that they sometimes do, while two stated that they never review ISPs with clients every 3 months. One PSIT worker commented that they always review the ISP informally, whether it be in a discussion or over the phone, while another PSIT worker indicated that most ISPs are emailed and reviewed upon request unless there is a significant increase or decline in health that the worker felt must be addressed.

Based on thematic coding of the focus group interview involving all 10 PSIT workers, in line with findings from the PSIT worker survey and client survey, PSIT workers stated that the frequency they review ISP with clients varied due to several factors, such as:

(1) Client disinterest stemming from the fact that the clients no longer work with the PSIT worker to reach their goal,

(2) Client anxieties towards allocation of services based on rubric and CHA outcomes outlined in the ISP, and

(3) Requests from caregivers who expected them to review ISPs regularly.

Evaluation Conclusions

After collecting and analyzing the data, and verifying the findings with VCBIS management, the evaluators formulated the following conclusions with respect to the evaluation questions.

Evaluation Question 1: To what extent is information from the assessment tool: CHA being appropriately used to develop client Individual Support Plan (ISP) and assess on-going needs?

We conclude from the findings that PSIT workers include all triggered CAPs from the CHA into the client ISPs, and then consult with the client to determine which goals to address and work on using rubrics for on-going assessment. Though the quantitative findings show that 100% of the triggered CAPs are incorporated into client ISPs, only 50% the PSIT workers perceive that they always include all CAPs triggered. This discrepancy may be explained by a confusion PSIT workers perceive in clarifying the methods of how they should address the various CAPs in the ISP. PSIT workers have been directed by VCBIS management to include all triggered CAPs in the ISPs, though there are several CAPs that PSIT workers are supposed to simply make recommendations for the client to follow-up with care from other health professionals (e.g., physician, mental health professional, speech therapist). Currently at VCBIS, the PSIT workers, who are trained in social work or social services, are not part of an inter-disciplinary team of health professionals who could provide guidance in determining methods of addressing certain triggered CAPs.

The PSIT workers have identified that the CHA has several weaknesses when implemented with their ABI clientele that limit how useful it is to assist in developing client ISPs that will help clients maintain and improve independence. They feel that there is a disconnect between the information that the CHA provides and the clients' expressed and observed needs and expectations. The PSIT workers state that while developing the ISP, clients' needs take precedent over the triggered CAPs.

The PSIT workers have created several rubrics that have been useful for measuring client progress in well-defined tasks, but there have been some challenges. The rubric scales and descriptions have been derived partially from scales and descriptions in the CHA, though these scales and descriptions vary across outcome measures. The PSIT workers themselves suggest that the rubric scales and descriptions need to be standardized for use by all PSIT workers. In addition, the total number of rubrics in use should be reduced, grouping similar rubrics together.

Changes in client behaviour indicated by rubric levels and CHA levels are somewhat consistent, though there are some challenges in assessing changes. The PSIT workers state that there is often no change in CAPs triggered between annual assessments. Similarly, rubric levels show very little change in level over a range of 6 months to 2 year time periods. The goal of the PSIT program is to assist clients in maintaining their independent living capacity, which may mean that "no change" in behaviour could be seen as success. However, the lack of change measured could also be the result of assessment tools being not sensitive enough to measure subtle changes in ABI client behaviour, problems with the assessment tool design, or problems with assessment implementation.

Evaluation Question 2: In what ways is there good alignment between the expectations outlined in the client's ISP and the reality of the PSIT service delivery method?

We conclude that the majority of clients feel that they have an opportunity to tell their PSIT worker what their goals are and how the PSIT services are provided to them. A portion of the clients state that they have difficulty identifying their goals due to their brain injury. The PSIT workers state that they do include client goals in ISPs and try to include client preferences in service delivery methods. Some of the challenges PSIT workers face in aligning client goals with the reality of PSIT services is the lack of self-awareness ABI clients have regarding their capabilities and needs.

Currently, PSIT workers are expected to review ISPs with clients every 3 months. The workers find that this is too short a time period to sufficiently measure progress with rubrics, especially when some clients receive visits once a month. The clients themselves do not feel the need to review their ISP this frequently either. This seems to be in part due to minimal progress apparent in this short time period. It would be more motivating for the client to see progress when reviewing their ISP, however this tends to take more time in this population.

The intensity of service delivery (i.e., number of hours per week or month) allocation does not seem to have a consistent and goal-oriented method. Factors such as client's severity of injury or time since injury could be considered when determining service delivery.

Suggestions to Consider

The following suggestions for areas that could be useful to examine further are based on the results of the evaluation and the evaluators' interactions with management and staff of VCBIS:

1) Consider additional training of PSIT workers on using the InterRAI – CHA in more effective ways for their clients. There may be additional measures from the CHA that would be useful in determining service delivery intensity and reassessment frequency, such as MAPLe and CHESS scores.
2) Review the CAPs commonly triggered by clients and provide more clarification and training among all PSIT workers on how they can most effectively address the CAPs in the client ISPs.
3) Form a small working group of PSIT workers to reduce the number of rubrics, standardize the level descriptions, and standardize scoring between workers to increase consistency and reliability.
4) Consider offering support group for certain areas that show a frequent need for the PSIT clients and may be better addressed in a group setting, such as cooking.
5) Review ISP with client every 6 months. Report rubrics levels using most frequent and most recent observations.
6) Allocate hours of service in a consistent and goal orientated way. Clients on a path of independence maintenance meet less frequently with PSIT workers, while clients motivated to improve functional skills receive more hours more frequently.
7) Pilot test an alternative outcome measurement tool that has been developed for ABI population and is more sensitive to measuring critical areas such as cognitive loss. Ontario Neurotrauma Foundation has a list of recommendations in their document: Clinical Practical Guideline for the Rehabilitation of Adults with Moderate to Severe TBI (Ontario Neurotrama Foundation, 2017).

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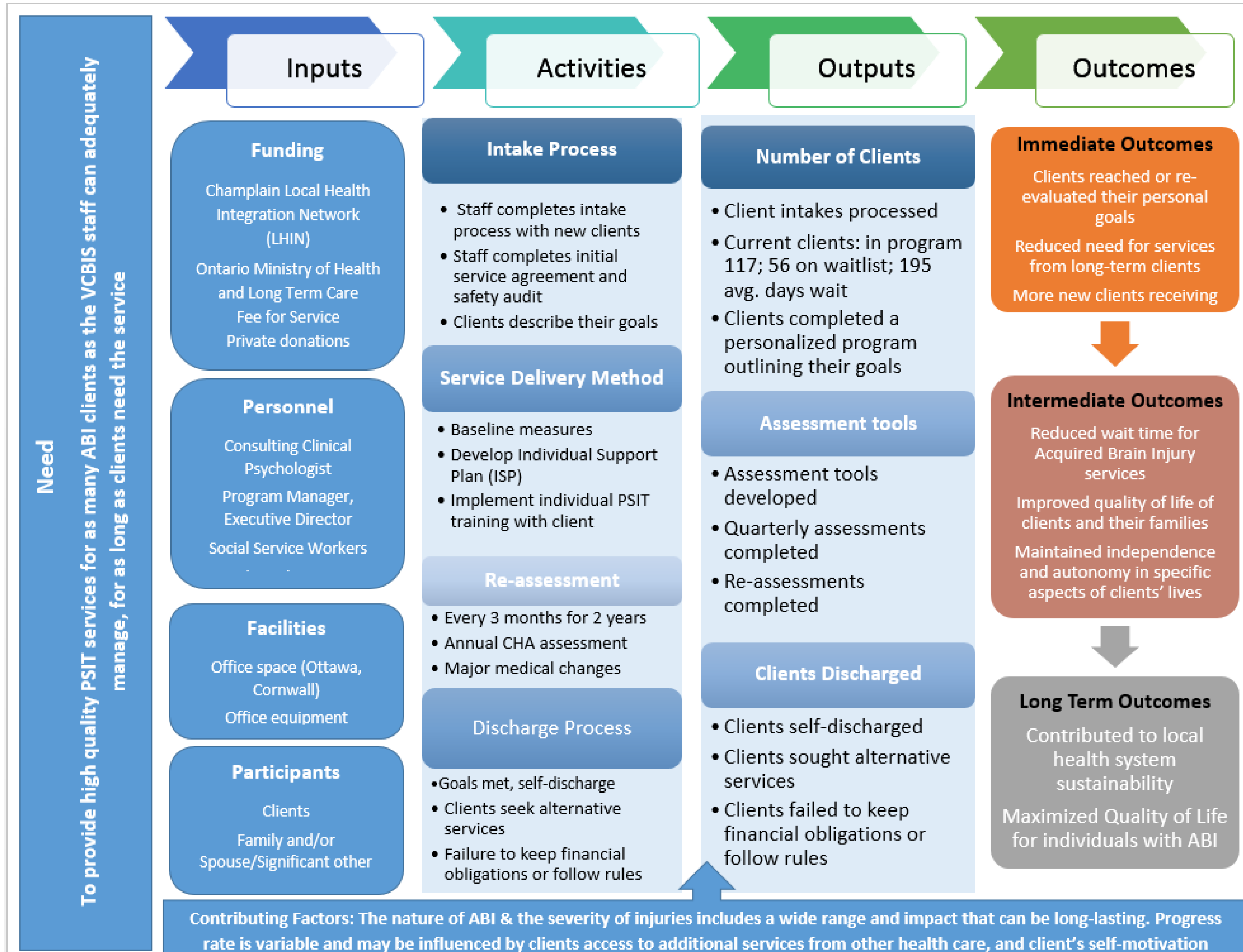
Appendix B

PSIT Client ISP Example

CAP's	Category	Overall Goals of Care	Method	Progress
Cognition	Cognitive Loss Communication	Drop-down menu to choose common goals based on the CAPs triggered	Discuss with client specific independence training and choose rubric to measure on-going level	Make notes of progress through description and rubric levels
Functional Performance	Physical Activity IADL ADL			
Social Life	Informal Support			
Clinical Issues	Cardio Falls Pain			

Appendix C

Logic Model : Vista Centre Brain Injury Services Personal Support/ Independence Training



Appendix D

PSIT Client Feedback Survey 2019

Demographic Information:					
Q1 How long have you been with Vista Centre Brain Injury Services (VCBIS)?	# years				
Q2 How long ago was your initial brain injury?	# years				
Q3 Are you male or female?	Male	Female			
ISP related:					
Q4 Do you have a chance to tell your Personal Support/Independence Training (PSIT) worker what you your goals are?	Always	Usually	Sometimes	Never	Comment
Q5 Do you have a chance to tell your Personal Support/Independence Training (PSIT) worker what you expect from the PSIT services?	Yes	No	Comment		
Q6 Do you have an Individual Support Plan (ISP)?	Yes	No	I don't know	Comment	
Q7 Do you know what is in your ISP?	Yes	No	Comment		
Q8 Do you review your ISP with your worker on a regular basis (every 3 months)?	Always	Usually	Sometimes	Never	Comment
Q9 Do you and your PSIT worker make changes to your ISP when needed?	Always	Usually	Sometimes	Never	Comment
Q10 What goals has the PSIT worker helped you with in the last 3 months?	Comment				
Q11 Do you feel you have a say in how the PSIT services are provided to you?	Always	Usually	Sometimes	Never	Comment
PSIT services related:					
Q12 If you have been dissatisfied with the PSIT services, do you feel you are able to tell your PSIT worker(s) or the management?	Always	Usually	Sometimes	Never	Comment
Q13 Does your PSIT worker answer your questions clearly?	Always	Usually	Sometimes	Never	Comment
Q14 Does your PSIT worker treat you with respect?	Always	Usually	Sometimes	Never	Comment

Q15 Are you satisfied with the independence training the PSIT worker gives you?	Always	Usually	Sometimes	Never	Comment
Q16 What independence training has been the most useful in the past 3 months?	Comment				
Q17 Has the independence training helped you to understand and cope more effectively with your brain injury? If so, how?	Yes	No	Comment		
Q18 Would you recommend VCBIS to others who are living with the effects of a brain injury?	Yes	No	Comment		

Appendix E

PSIT Worker Survey 2019

Demographic Information:					
Q1 Related education: What level of education have you attained and when?	Education level				
Q2 How many years have you worked with PSIT services?	# years				
Assessment Tools related/ Client Input related: **On average for your clients,**					
Q3 Do you incorporate all CAPs triggered in client ISP?	Always	Usually	Sometimes	Never	Comment
Q4 Do you record levels on each rubric for every client?	Always	Usually	Sometimes	Never	Comment
Q5 Do you review the ISP with each client every 3 months?	Always	Usually	Sometimes	Never	Comment
Q6 Do you incorporate client goals into their ISP?	Always	Usually	Sometimes	Never	Comment
Q7 Do you incorporate client preference into the frequency of visits?	Always	Usually	Sometimes	Never	Comment
Q8 When doing re-assessments, do you notice a consistency between changes in the CHA scores compared to rubric scores?	Always	Usually	Sometimes	Never	Comment

Appendix F

PSIT Worker Focus Group Outline

Welcome

- Introduce moderator and assistant:
  Good morning and welcome to our session.

Introduction of Topic

- Thank you for agreeing to partake in the focus group today. My name is Chelsea Noël and assisting me is Deanne Donohue. The results of the focus group will be used to review aspects of the Personal Support/Independence Training (PSIT) program service delivery. The objectives of the evaluation are to examine the use of the InterRAI Community Health Assessment (InterRAI-CHA) tool in developing client Individual Support Plans (ISPs) and rubrics, as well as to examine how client input is incorporated into ISPs.
- You were selected because as a PSIT worker, you are directly involved in administering the InteRAI-CHA and rubrics, as well as developing Individual Support Plans (ISPs) for clients.

Guidelines

- I just wanted to share with you a few guidelines before we get started:
- ✓ Please keep in mind that we are recording and transcribing the focus group, so only one person speaking at a time. We will be on a first name basis today, but we won't use any names in our reports. You may be assured of complete confidentiality.
- ✓ The focus group will last an hour and a half. Please make sure that you are brief, clear and complete in answering our questions so that we may get around to all 7 questions.
- ✓ There are no right or wrong answers, only differing points of view. Feel free to share your point of view even if it differs from what others have said. We are interested in both negative and positive comments and sometimes negative comments are the most helpful
- ✓ There is no need to agree with others, but you must listen respectfully as others share their views.
- ✓ We ask that you turn off any mobile devices. If you cannot and must respond to a call, please do so as quietly as possible and rejoin us as quickly as you can.
- ✓ My role as a moderator will be to guide the discussion.

Questions

We have passed around name tags to help us remember each other's names. Let's find out more about each other by going around the table. Tell us your name and where you live.

Our discussion will revolve around the two evaluation questions:

1. Is information from the assessment tool Inter-RAI CHA being appropriately used to develop client ISPs and assess on-going needs?

2. Is there good alignment between the expectations outlined in the client's ISP and the reality of PSIT service delivery method?

Let’s start with discussion around the first evaluation question.

1. How do you incorporate information from the InterRAI-CHA and/or triggered CAPs in client ISP?
2. How useful is the information from the InterRAI-CHA assessment in developing your client ISP?
3. How do you determine when to use a rubric or more than one rubric in an ISP?
4. How useful are the rubrics useful in providing and monitoring Personal Support/Independence training with your clients?
5. How do you record levels on the rubrics for your clients?
6. When doing re-assessments, how do changes in CAPs scores compare to changes in rubric levels?

Now for discussion around the second evaluation question.

1. How are client goals incorporated into their ISP?
2. How do you balance incorporating client goals and triggered CAPs into ISPs?
3. How do you determine how frequent you deliver services with clients? (weekly, bi-weekly, monthly)
4. How often do you review ISPs with clients? Do you show them their ISP?

Ideas for improvement:

1. If you could make one change to the way rubrics are used, what would it be?
2. If you could make one change to the program to improve the development of ISPs for clients, what would it be?

Appendix G

Evaluation Workplan and Timelines

Actions	Responsible			Timelines			
	Evaluator 1	Evaluator 2	VCBIS	Jan	Feb	Mar	Apr
Client Chart Review							
Request specific reports from SSO: InterRAI-CHA triggered CAPs	x		x				
Request client ISPs with rubrics from PSIT workers			x				
Recoding data	x	x					
Data analysis and reporting	x	x					
PSIT Client Feedback Survey							
Develop questions and response scales	x						
Put survey on-line using SurveyMonkey			x				
Disseminate survey to current clients			x				
Collect survey responses	x	x					
Compile survey results	x	x					
Data analysis and reporting: quantitative data	x	x					
Data analysis and reporting: qualitative data (comments)	x	x					
PSIT Worker Questionnaire							
Develop questions and response scales	x						
Put survey on-line using SurveyMonkey			x				
Disseminate survey to PSIT workers			x				
Collect survey responses	x	x					
Compile survey results	x	x					
Focus Group Interview							
Develop discussion questions using results from questionnaire	x						
Test discussion questions	x	x					
Confirm participation from PSIT workers			x				
Conduct group interview	x						
Transcribe audio recording of interview	x	x					
Analyze and code transcriptions	x	x					

Presentation of Evaluation							
Present initial findings and conclusions to stakeholders	x	x					
Present evaluation to professor and class	X	x					
Complete final report	x	x					

Appendix H

Letter of Agreement

Letter of Agreement
PSY 7102: Field Research in Social and Community Interventions

This is a letter of agreement between *Vista Centre Brain Injury Services (VCBIS)* (“*the Sponsor”*), *Deanne Donohue and Chelsea Noël* (“*The Students”)* regarding evaluation work to be performed as part of a course offered at the University of Ottawa entitled *PSY7102A: Field Research in Social and Community Interventions*.

Description of the Course

This is a graduate level course on program evaluation practice, given by Tim Aubry, PhD (“*the Instructor”)*. The objectives of the course are:

- To broaden and deepen students’ knowledge of evaluation theory and practice through weekly readings from the required textbook, from other assigned electronic sources, and from in class discussions and sharing of field-based experiences; and
- To give students the opportunity to acquire supervised experience in program evaluation through the conduct of a small-scale evaluation.

Description of the Work

The Sponsor and The Students have agreed that The Students will conduct an evaluation of the Personal Support/Independence Training (PSIT) program offered by VCBIS.

Goal of the Evaluation:
The goal of the evaluation is to review aspects of the PSIT program service delivery.

Evaluation Objectives:
The objectives of the evaluation are to examine the use of the InterRAI Community Health Assessment (InterRAI-CHA) tool in developing client Individual Support Plans (ISPs) and rubrics, as well as to examine how client input is incorporated into ISPs.

Evaluation Activities:
To accomplish these objectives, The Students will: collect data from client charts provided via VCBIS agency files and Health Shared Services Ontario (SSO), design and administer a client survey and a PSIT worker questionnaire, and design and conduct a focus group interview with PSIT workers.

Schedule:
The timeline for the accomplishment of the work is January to April 2019. A detailed workplan will be shared with the Sponsor.

This timeline is subject to review by both parties depending on unforeseen events during the course of the evaluation.

Resources:
A VCBIS volunteer, recently graduated from the the Carleton University program evaluation graduate diploma program, will be involved in retrieving data from SSO and transferring it to Excel documents. Clients will also be offered support from staff in completing the client survey.

Deliverables

The Students will deliver to the Sponsor a written technical report and executive summary by April 26, 2019. The Students will also work with the Sponsor to create a presentation of the evaluation for the Brain Injury Awareness Day event in June 2019. The Students will work with the Sponsor to submit an abstract for a presentation of the evaluation for the Ontario Brain Injury Association conference in October 2019.

Responsibilities of The Students

The Students agree to conduct the evaluation according to Program Evaluation Standards outlined by the Canadian Evaluation Society (http://www.evaluationcanada.ca/site.cgi?s=6&ss=10&_lang=en)

The Students agree to follow the ethical guidelines of the *Tri-Agency Policy Statement: Integrity in Research and Scholarship.*
http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/
.
The Students also agrees to (identify other relevant responsibilities pertinent to the organization, program, or project, such as maintaining confidentiality, regular updates, etc.)

Responsibilities of the Sponsor

To support the evaluation, the Sponsor agrees that Tammy Kuchynski will act on behalf of the organization to:

- Support access to participants and VCBIS agency files and SSO data, review reports, facilitate communication within the organization, facilitate distribution of client and PSIT worker surveys to both clients and PSIT workers, respectively, schedule and inform the PSIT workers of the intended focus group attend scheduled meetings with program evaluators,

Responsibilities of the Instructor

The Instructor agrees to provide regular supervision to The Studenst to complete the evaluation project. This supervision will be in the form of classroom lectures and discussions, individual consultation, and feedback and evaluation of course-related assignments.

Final Report

On completion of the project The Students shall provide to Sponsor a report describing the project and the results together with any conclusions, opinions or recommendations. On delivery of the report, all right and title to the report shall pass to Sponsor.

Publication

The Sponsor acknowledges that the report will be used by the Instructor for evaluating the academic performance of The Students.

The Sponsor also acknowledges that under some circumstances The Students may present or publish evaluation findings in academic forums or journals. The Sponsor's staff participating in the project will be invited to collaborate as authors on any of these publications. To merit a co-authorship, a substantive contribution to the development and/or conduct of the project and to the write-up of such publications will be expected, and must be in accordance with prevailing ethical guidelines regarding authorship on scientific papers. Other contributions of lesser nature will be recognized through acknowledgements. The Sponsor may, after consultation with The Students, request that its identity be concealed in any communication of evaluation results.

Signatures

Signature for sponsoring organization:

_______________________________ Date:___________________

Name and sponsoring organization:

____

Signature of students:

_______________________________ Date:__________________

Name of student:

____

_______________________________ Date:__________________

Name of student:

____

Signature of course instructor:

_______________________________ Date:__________________

Tim Aubry, Ph.D.
Professor, School of Psychology
University of Ottawa

Appendix I

Letter of Consent for PSIT Worker Focus Group Interview

Personal Support/Independence Program (PSIT) Evaluation

Consent for PSIT Workers

Introduction

You are being asked to participate in a study examining the PSIT Program managed by graduate students from the Evaluation Diploma graduate program at the University of Ottawa. Before agreeing to participate in this study, it is important that you read and understand this consent form. It includes details that we think you need to know in order to decide if you wish to participate in this study. If you have any questions you can direct them to any member of the evaluation team.

Evaluation Team

Co-Investigator
Deanne Donohue
ddono096@uottawa.ca
(613) 290-7414

Co-Investigator
Chelsea Noel
cnoel1075@uottawa.ca

Purpose of the Study

The overarching objective of this evaluation is to examine current services to determine if they are meeting the needs of their clients following the agency's development of their strategic plan. Specifically, we will gather information on how PSIT workers implement services and use assessment tools.

Focus Group Interview Procedure

With your consent, an interviewer will ask the group a series of questions about the implementation of the PSIT program services. The interview will be audio-recorded and transcribed. No names or identifiable information will be collected. If you choose not to consent to the audio recording, you will not be able to participate in the interview. The interview will last a maximum of 90 minutes.

Participating in this focus group interview is voluntary and you have the right to decide that you do not want to take part at any time without giving a reason. Your decision to take part or not take part in the study will

not affect your employment situation. If you withdraw from the study, we will not transcribe any of your responses.

Potential Benefits and Inconveniences

You will not receive any personal benefit from your participation in this evaluation. However, the results of this study will provide a better understanding of how to improve the PSIT service delivery.

We do not believe that you will experience any significant risks to your well-being by participating in the focus group interview. It is possible that you may experience some level of discomfort in discussing personal information, such as how you deliver services to your clients. You may refuse to answer any question if you become uncomfortable or for any reason. Additionally, you can let the interviewer know if you would like to take a break or withdraw from the interview at any time.

Anonymity and Confidentiality

During your participation in the research project, the co-investigators will collect information from you and store it in a secured data file. Only information needed for answering the research questions will be collected. Only the co-investigators will have access to the data. Consent forms and other identifying information you give us will be kept in a locked filing cabinet, only the co-investigators will have access to the information.

Confidentiality will be respected and no information that discloses your identity will be released or published without consent, such as disclosing abuse or acute risk of harm to yourself or others. Your name will not be associated with anything you say during the interview and your responses to the questions will be kept strictly confidential and private. All files of audio recorded interviews will be stored on a secure (password protected) server until transcription, which will only be accessible by the co-investigators. A transcript of the interview will be identified by a code and stored in a locked filing cabinet. This data will be destroyed after the data analysis and summaries have been completed.

You are encouraged not to reveal any information that could identify yourself or other individuals. Should you reveal any identifiable information during the discussion, the information will not be transcribed but rather paraphrased to capture the idea expressed. Any names mentioned in the recordings will not be transcribed. Should you consent to the use of quotations from the interview, they may be used in write-ups and presentations on this study. However, the quotations will not contain any information that allows you to be identified.

Audio-recordings from the interviews will be stored on a password protected computer in the research office. Anonymous notes taken during the interviews or from audio-recordings may also be stored on the

researchers' encrypted and password protected laptop(s). Data bases created for the study and all records containing personal information whether in electronic or paper format such as consent forms will be destroyed after the completion of the study.

Data Utilization and Storage

Data from this study will be used for research purposes and may be published in scientific journals and presented in conferences. If you choose to withdraw from the study, you can choose whether or not to withdraw your data. In the event that the results of this study are published or presented, no individual information or information that could identify you will be released. As well, the data collected in the project can be used for other analyses related to the project and to develop future research projects.

Questions and Request for Information

If you have questions at any time about the study or the procedures, you may contact the Co-Investigators, Deanne Donohue or Chelsea Noel by phone or e-mail at the coordinates listed above.

Informed Consent

I acknowledge that the evaluation described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the evaluation. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the evaluation. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the evaluation or the research procedures. I have been assured that information relating to me and my clients will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission. I have been given sufficient time to read and understand the above information.

By signing this consent, I agree to participate in this evaluation. I will be given a copy of the signed and dated consent form.

I agree to participate in a focus group interview for this evaluation.

Yes ☐ No ☐

I agree to have the focus group interview audio-recorded and field notes recorded.

Yes ☐ No ☐

I agree that the research team can collect my personal information from the VCBIS administrative database.

Yes ☐ No ☐

I understand and agree that my anonymized quotations may appear in published reports.

Yes ☐ No ☐

X_____________________ _____________________________ _____________
Participant's Signature Name, Printed Date (dd/mm/yy)

X_____________________ _____________________________ _____________
Interviewer's Signature Name, Printed Date (dd/mm/yy)

Appendix J

Informed Consent Introduction : PSIT Worker Survey

Dear Personal Support/Independence Training (PSIT) Workers,

Thank you for agreeing to complete this questionnaire for the program evaluation of the Vista Centre Brain Injury Services (VCBIS) for PSIT. VCBIS management requested the University of Ottawa to assist in the evaluation of their current services to determine if they are meeting the needs of their clients following the agency's development of their strategic plan.

The goal of this questionnaire is to collect information relating to the evaluation questions. We will collect your responses and comments to gather information on how PSIT workers implement services and use assessment tools.

We ask you to answer each question honestly. Participation is entirely voluntary and strictly confidential and your responses will remain anonymous. You can withdraw from this evaluation at any time. Only summaries of responses will be shared and used during this evaluation.

By completing this questionnaire, you are consenting to participate in this program evaluation. If you have any questions regarding this questionnaire, please direct them to Deanne Donohue (613) 290-7414 (ddono096@uottawa.ca) or Chelsea Noel (cnoel075@uottawa.ca) via e-mail or phone, program evaluators for PSIT.

Appendix K

Informed Consent Introduction : Personal Support/ Independent Living Program Client Feedback Survey

Dear Personal Support/Independence Training (PSIT) clients,

Thank you for agreeing to complete this survey for the program evaluation of the Vista Centre Brain Injury Services (VCBIS) for PSIT. VCBIS management asked the University of Ottawa to assist in evaluating their PSIT.

We are collecting your responses and comments to gather information on how services are delivered to you.

We ask you to answer each question honestly. Participation is entirely voluntary and strictly confidential and your responses will remain anonymous. You can withdraw from this evaluation at any time. Only summaries of responses will be shared and used during this evaluation.

By completing this survey, you are consenting to participate in this program evaluation. If you have any questions regarding this survey, please direct them to Deanne Donohue (613) 290-7414 (ddono096@uottawa.ca) or Chelsea Noel (cnoel075@uottawa.ca) via e-mail, program evaluators for PSIT.

Appendix L

Question 1 Data collection, Methods and Analysis

Sub question 1: Is all the appropriate information from the CHA assessment tool being used in the ISP?			
Indicators/Measures	**Data Collection Sources**	**Data Collection Methods**	**Analysis**
Percentage of triggered Clinical Assessment Protocols (CAPs) incorporated in client ISPs	(1) Historical agency files: CAPs triggered for individual clients (2) Historical agency files: Individual client ISPs with rubrics and notes	• Chart review of CAPs triggered for individual clients and individual client ISPs, with rubrics and notes from a randomized sample of PSIT clients (n= 25)	• Descriptive statistics (percentages) using Excel to determine proportion of triggered CAPs used in individual client ISP as rubric or recommendation
Perceptions of incorporating all triggered CAPs in client ISPs	(1) PSIT worker survey: question 3 (2) Focus group discussion: question 1, evaluation question 1	• PSIT worker survey administered via SurveyMonkey e-mail link to all PSIT workers (n= 10) • Focus group interview among PSIT workers (n= 10) facilitated by program evaluators	• Descriptive statistics (percentages) using Excel to determine proportion of responses • Thematic analysis of group discussion
Sub question 2: Is information from the assessment tool being transformed appropriately into rubrics?			
Indicators/Measures	**Data Collection Sources**	**Data Collection Methods**	**Analysis**
Consistency of scale levels and descriptions in rubrics with CHA scale levels and descriptions	(1) Historical agency files: Specific rubrics levels and scale descriptions (2) Historical agency files: CHA scale descriptions for corresponding CAPS	• Analysis and comparison of rubrics and scale descriptors versus the InterRAI-CHA scale descriptions	• Descriptive comparison of scale numbers and descriptions of rubrics and CHA

Ratio of changes in rubric levels compared to changes in CHA levels over time	(1) Historical agency files: Changes in triggered CAPs levels each year for individual clients (2) Historical agency files: Rubrics levels each assessment period for individual clients	• Chart review of randomized sample of PSIT clients triggered CAPs levels on annual CHA assessment results over a 2 year period (n= 25) • Chart review of 70 client rubrics (convenience sample)	• Descriptive comparison of changes in CAPs triggered compared to changes in rubric levels
Sub question 3: Are changes in client behavior indicated in rubric levels consistent with changes in CHA levels?			
Indicators/Measures	**Data Collection Sources**	**Data Collection Methods**	**Analysis**
Perceptions of consistency of change measured between rubrics and CHA	(1) PSIT worker survey: question 8	• PSIT worker survey administered via SurveyMonkey e-mail link to all PSIT workers (n= 10)	• Descriptive statistics (percentages) using Excel to determine proportion of responses
Perceptions of the usefulness of the information from the CHA in developing the client ISP and of the rubrics in providing and monitoring PSIT with clients	(2) Focus group discussion question 2 and 4, evaluation question 1	• Focus group interview among PSIT workers (n= 10) facilitated by program evaluators	• Thematic analysis of group discussion

Appendix M

Question 2 Data collection, Methods and Analysis

Sub question 1: How are client goals incorporated into the ISP and PSIT service delivery?			
Indicators/Measures	**Data Collection Sources**	**Data Collection Methods**	**Analysis**
Perceptions that clients had an opportunity to state their goals to the PSIT worker	(1) PSIT Client Feedback Survey: questions 4, 5, 7, 11, 12	• PSIT Client Feedback Survey administered via SurveyMonkey e-mail link (n=57) to all PSIT clients.	• Descriptive statistics (percentages) using Excel to determine proportion of responses
Score on questions regarding incorporating client goals in ISP, preference regarding frequency of visits	(1) PSIT worker questionnaire: question 6, 7	• PSIT worker questionnaire administered via SurveyMonkey e-mail link (n=10) to all PSIT workers	• Descriptive statistics (percentages) using Excel to determine proportion of responses
Perceptions of how PSIT workers incorporate client goals in their ISPs, preference regarding frequency of visits	(1) Focus group discussion question 1 and 2, evaluation question 2, 4	• Focus group among PSIT workers (n=10)	• Thematic analysis of group discussion
Sub question 2: What is the intensity of PSIT services and how are services allocated?			
Indicators/Measures	**Data Collection Sources**	**Data Collection Methods**	**Analysis**
Intensity of PSIT service delivery	(1) Historical agency data pertaining to client demographics, assigned worker and service intensity	• Chart review of 63 clients (convenience sample)	Quantitative analysis (T-tests and linear regression) of service delivery intensity compared to three different variables: (a) client age, (b) client gender, and (c) PSIT worker conducted using data from 63 client charts
Perception of how PSIT workers allocate services	(1) Focus group discussion question 2	• Focus group interview among PSIT workers (n=	• Thematic analysis of group discussion

		10) facilitated by program evaluators	
Sub question 3: Are PSIT workers reviewing ISPs with clients regularly?			
Indicators/Measures	**Data Collection Sources**	**Data Collection Methods**	**Analysis**
Score on question regarding perceptions of clients that they reviewed their ISP regularly with their PSIT worker	(1) PSIT Client Feedback Survey: question 8, 9	• PSIT Client Feedback Survey administered via SurveyMonkey e-mail link (n=57) to all PSIT clients.	• Descriptive statistics (percentages) using Excel to determine proportion of responses
Score on questions regarding whether PSIT workers review ISPs with clients every 3 months	(1) PSIT worker questionnaire: question 5	• PSIT worker questionnaire administered via SurveyMonkey e-mail link (n=10) to all PSIT workers	• Descriptive statistics (percentages) using Excel to determine proportion of responses
Perception of whether PSIT workers review ISPs with clients regularly	(2) Focus group discussion question 4, evaluation question 2	• Focus group interview among PSIT workers (n= 10) facilitated by program evaluators	• Thematic analysis of group discussion

Appendix N

List of Rubrics

	Rubric	Number clients (n=70)	# Workers Use
1	Home organization	14	5
2	Problem solving	14	4
3	Cooking / meal prep	13	5
4	Cognitive skills (for decision making)	13	5
5	Communication	10	5
6	Informal Support	10	3
7	Budgeting	8	4
8	Scheduling	8	3
9	Physical fitness/activity	7	4
10	Mood monitoring	7	3
11	E-mail/Smartphone/Computer	7	3
12	Pain	5	2
13	Community awareness	4	3
14	Falls	4	1
15	Medication management	3	2
16	Groceries	3	3
17	Preventative clinical measure	2	1
18	Paper organization	2	1
19	Socialization	2	1

20	Cleaning	2	2