



NATIONAL ASSOCIATION
OF STATE HEAD INJURY
ADMINISTRATORS

NASHIA

**Brain Injury Resource Facilitation:
A Consensus of Best Practices**

2024

Made possible with funding from:



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BACKGROUND

In 2023, the National Association of State Head Injury Administrators (NASHIA) was awarded a grant from the Moody Foundation to develop consensus related to the practice of resource facilitation. Elements for consideration included the name, core components, principles and approaches, evaluation and measurement, and data collection.

There is scientific support for the efficacy of resource facilitation to significantly improve return to work and school after brain injury, as well as to reduce recidivism among justice-involved individuals with TBI returning to the community. Additional findings also include a correlation between resource facilitation and a decrease in level of disability associated with brain injury, as well as reduction in services needed by individuals upon completion of the resource facilitation process.

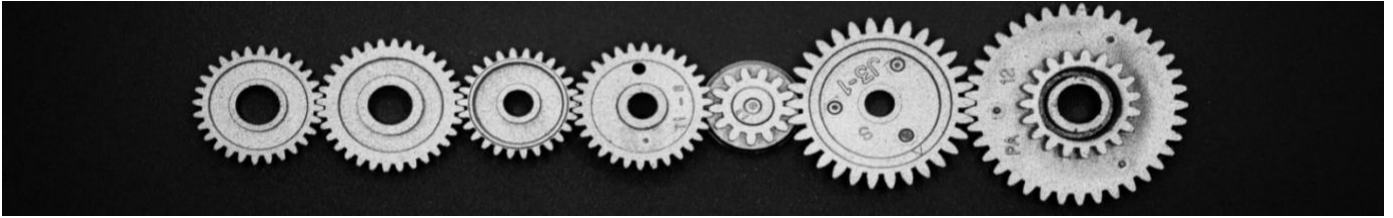
While these research findings are relatively new, resource facilitation is not a new concept. Many states provide some form of resource facilitation for individuals with brain injury. The United States Department of Health and Human Services (DHHS) Health Resources and Services Administration conducted two previous consensus conferences on resource facilitation for individuals with brain injury, the first in 1999 and the other in 2010. However, despite these efforts, a recent survey found significant variability between providers and settings related to a) the definition and structure of services provided, b) funding mechanisms, c) eligibility criteria, and d) metrics used, if any, to describe impact or outcome. This has led states to struggle with how to fund resource facilitation, develop evidence-based models, and build specific outcome measures to ensure the efficacy of these programs. The TBI State Partnership Program administered by the Administration of Community Living within DHHS has put an emphasis on developing or enhancing existing resource facilitation support. As 31 states currently receive a grant from this program, the need to develop a consensus on definition, key elements, and measurement metrics is pressing.

Brain injury is now recognized by experts in the field as a chronic condition. Resource facilitation is seen as an approach to mitigate, or at least manage, brain injury as a chronic condition. As a result, there is a need to establish a consensus on best practices related to:

- a) The components of resource facilitation;
- b) The principles and approaches of resource facilitation; and,
- c) The outcomes, measurements, and common data elements of resource facilitation.

To accomplish these objectives, NASHIA implemented a Delphi Consensus process with brain injury leaders across the country.





METHODS

STEP 1: Identify, Select, and Invite an Expert Panel

NASHIA assembled a Steering Committee consisting of representatives with expertise in resource facilitation, evaluation measures, and common data elements (see appendix A for a complete list of participants). The Steering Committee assisted in all aspects of the Delphi process including the following:

1. Reviewing and developing the set of assumptions to be tested.
2. Assisting in identifying Delphi survey participants.
3. Reviewing and approving the surveys for each Delphi round.
4. Guiding the analysis of each survey round.

STEP 2: Identify a Set of Assumptions to Be Tested Through a Delphi Survey Process

NASHIA collaborated with Mt. Sinai Brain Injury Research Center's Rehabilitation Neuropsychology Fellows to conduct a literature review related to resource facilitation components used within the brain injury community and associated evaluation methods. Thirty-six papers were identified. Several of the articles focused on the use of resource facilitation as an intervention for improving outcomes. Three papers were found that described resource facilitation and focused on defining the common components of resource facilitation. Therefore, these three papers were used to develop the first set of assumptions to be tested. The following were the papers used to develop the set of assumptions:

- Resource Facilitation: A Consensus of Principles and Best Practices to Guide Program Development and Operations in Brain Injury, Connors, S., 2001.
- Health Resources Services Administration, Resource Facilitation Survey Results, 2009.
- Summer Ibarra, Devan Parrott, Wendy Waldman, Flora M. Hammond, Christina Dillahunt-Aspillaga & Lance Trexler: Provision of resource facilitation services for individuals with acquired brain injury across the United States: results of a 2018 resource facilitator provider survey, Brain Injury, 2020.

The Steering Committee reviewed and debated the set of assumptions until they came to consensus on the final set of assumptions for inclusion in the round one survey. This set of assumptions follows in the Survey Delphi Participants section (*Please note that in the first round the term "neuro-resource facilitation" was used within survey questions. The first round results indicated a need to determine what the services should be called. Therefore, in round two the more general term "resource facilitation" was used in the survey questions*).



STEP 3: Survey Delphi Participants

The Steering Committee provided names for survey participants who currently fund or provide resource facilitation, as well as researchers who have conducted research in the area of resource facilitation. Additionally, current resource facilitation providers assisted in identifying individuals with lived experience, including family members and caregivers. A total of 45 survey participants completed the survey each round of the Delphi survey process (it is important to note that one individual completed the majority of the survey each round but not the entire survey). Twenty-five of these individuals were providers, thirteen were researchers, and eight were individuals with lived experience or family members/caregivers.

The final set of assumptions included in the round one survey and survey results were as follows:

1. It is important to have uniformity across the country related to the term used to describe neuro-resource facilitation (NRF) for the following purposes of funding (93%), policy (91%), research (89%), and program improvement (85%).
2. Calling the services “neuro-resource” facilitation (NRF) helps to set this support apart from resource navigation/service coordination etc. provided to individuals experiencing other conditions or disabilities (76%).
3. Calling the services NRF helps programs to obtain funding for people with brain injury (61%).
4. Individuals with brain injury have unique needs and therefore require specific strategies and support (100%).
5. Individuals with brain injury require NRF providers with knowledge of brain injury to access needed resources and services (96%).
6. The following are components of NRF:
 - a. Connecting individuals to community resources (100%)
 - b. Discovery of an individual’s strengths and challenges (89%)
 - c. Identification of needs (100%)
 - d. Goal setting and planning (89%)
 - e. Plan implementation (87%)
 - f. Arrangement and coordination of supports (89%)
 - g. Monitoring (83%)
 - h. Re-assessment (e.g., set new goals as applicable) (76%)
 - i. Community outreach to increase awareness of brain injury (74%)
 - j. Community outreach to create awareness of available brain injury services (79%)
 - k. Brain injury education and training for individuals (87%)
 - l. Brain injury education and training for families and caregivers (89%)
 - m. Building capacity through brain injury education and training for organizations to teach about brain injury (76%)
 - n. Emotional support (85%)
 - o. Advocacy on behalf of individuals (89%)
 - p. Advocacy for systems change (83%)
7. Basic principles of NRF should include the following:
 - a. Facilitation is available to anyone with brain injury or their family and others supporting an individual (96%).
 - b. Facilitation is available to anyone regardless of their abilities (87%).
 - c. Facilitation considers the wants and needs of individuals with brain injury to be the priority (96%).
 - d. Facilitation adapts to the needs of individuals and the opportunities for meeting those needs (89%).
 - e. Facilitation builds community partnerships (91%).
 - f. Facilitation outcomes are measured (93%).
 - g. Once connected, follow-up activities lead to more proactive services (98%).



- h. NRF should be provided to individuals with brain injury (100%), family members and caregivers (98%), providers and agencies (67%).
 - i. NRF services can be provided either in-person or virtually (email, text, video conferencing) (93%).
 - j. The duration of NRF support should be flexible to balance an individual's needs and the resources and funding available (94%).
 - k. NRF should focus on assisting individuals to live happy and healthy lives in the community (91%).
 - l. Individuals should be able to access NRF throughout their lifetime, as needed (96%).
 - m. Building capacity (strengthening awareness, understanding, knowledge, tools, and skills) should be an integral part of NRF among individuals with brain injury (96%), family and caregivers (100%), community professionals and service providers (87%), and policymakers (76%).
 - n. NRF is shaped by a variety of personal and professional perspectives. There are specific areas of expertise or unique knowledge required within NRF programs as a whole (note: not all staff need to have all of these attributes) that include understanding the causes, course, and consequences of brain injury (93%), the community and its associated resources (96%), diverse systems of high intersectionality of brain injury (93%), diversity and inclusion (83%), what it means to have "lived experience" or to provide support as a family member or caregiver (91%).
8. Measurements, outcomes, and data collection:
- a. It is important to have a common definition of data categories used by all NRF programs across the country (80%), for funding (82%), policy (84%), research (89%), and program improvement (93%).
 - b. It is important to have common outcome measures implemented by all NRF programs across the US (87%), for funding (80%), policy (82%), research (80%), program improvement (84%).
 - c. It is important to have a database for common data and outcomes to be reported (71%), for funding (73%), policy (73%), research (82%), program improvement (80%).
 - d. NRF programs should measure an individual's satisfaction with their service delivery (96%), improvement in quality of life (80%), and impact for individuals served, the program, and the community (80%).
 - e. Evaluation measures should be flexible to meet program needs (80%).
 - f. There may be unique program outcome measure considerations in addition to core outcome measures (96%).

Once the round one surveys were completed, NASHIA collaborated with the Fellows from Mt. Sinai to analyze the results. These results were then presented to the Steering Committee. Based on the results and feedback obtained by the survey participants, the Steering Committee worked with NASHIA to revise the assumptions and to develop the second round Delphi survey. Additionally, the Steering Committee determined that in order for consensus to be reached on an assumption, there had to be 80% of respondents agreeing with the statement.

Based on the 80% consensus criteria, all but the following assumptions and subcomponents reached consensus in the round one survey. These assumptions necessary to move to round two included:

1. Calling the services "neuro-resource" facilitation (NRF) helps to set this support apart from resource navigation, service coordination etc. provided to individuals experiencing other conditions or disabilities (76%).
2. Calling the services NRF helps programs to obtain funding for people with brain injury (61%).
3. There were four components for which consensus was not reached including:
 - A. Re-assessment (76%)
 - B. Community outreach to raise awareness of brain injury (74%)
 - C. Community outreach to create awareness of available brain injury services (79%)
 - D. Building capacity through brain injury education and training for organizations to teach about brain injury (76%).
4. The following principles did not reach consensus:
 - A. NRF should be provided to providers/agencies (67%).



- B. Building capacity should be an integral part of NRF among policymakers (76%).
5. There was one question related to outcome measures and common data elements that did not reach consensus. “How important is it to have a common database for data and outcomes to be reported for funding (73%) and for policy (73%)?”

Through a careful look at the comments associated with the assumptions that did not reach consensus, it was clear that the original wording of the assumptions did not clearly convey meaning. Therefore, these assumptions were restructured for the second-round survey. Additionally, the second-round survey included a question that allowed participants to rank potential names. Participants could also write in an alternative name.

The following reworded assumptions were tested in round two of the Delphi process.

1. When thinking about an ideal, future state, it would be beneficial to move from using a variety of names such as neuro-resource facilitation, resource facilitation, brain injury resource facilitation or resource navigation to one universal, uniform name to describe the services (96%).
2. Regardless of if you feel a universal name is beneficial, please rank order which name best describes the service:
Brain injury resource facilitation
Brain injury resource navigation
Neuro-resource facilitation
Neuro-resource navigation
Resource facilitation
Other

Fifty-one percent of respondents chose Brain Injury Resource Facilitation as their first choice, with 91% having Brain Injury Resource Facilitation in their top two choices and finally, 95% chose Brain Injury Resource Facilitation as one of their top three choices.

3. Keeping in mind that use of the same name would not be mandatory for any state, a universal, uniform name helps with seeking program funding (87%).
4. A component of a program that offers this type of service should include re-assessment (review needs on an ongoing basis) (98%).
5. A component of a program that offers this type of service should provide outreach/awareness of brain injury (91%).
6. A component of a program that offers this type of service should also provide outreach/awareness of services (96%).
7. A component of a program that offers this type of service should be able to build capacity through brain injury education and training for organizations to teach about brain injury (89%).
8. These types of programs should support other providers/professionals in the community who serve individuals with brain injury through approaches such as training/education, capacity building, technical assistance, and consultation (89%).
9. These types of programs should educate policy makers (e.g., agency decision makers, legislators) as to the benefits of this service (84%).
10. Assuming that a funding option existed and that participant data would be secure, it is important to have a database for common data and outcomes to be reported (98%), for the purposes of funding (91%) and policy (84%).

Each assumption tested in the second-round survey met the minimum of 80% consensus threshold set by the Steering Committee. Therefore, there was no need for a third-round survey.





SUMMARY OF RESULTS

As was indicated previously, consensus was reached in two rounds of surveys. The conscientious work and consideration of each assumption by the Steering Committee led to the original set of assumptions being very sound, even before the first survey went out. This likely explains why only two rounds were required. The information gained from the first survey sent to the 45 respondents provided guidance and direction for the second survey. Each of these iterative processes led to meeting the minimum threshold of 80% of all the assumptions by the round two survey.

Through the survey process, and with input from the Steering Committee, it is important to note that while the Delphi consensus results reflect an agreed upon set of best practices as it relates to resource facilitation, these are not mandates for states. However, the findings could potentially be built into future policy or grant requirements should a funder choose to use them.

The following reflect the consensus on best practices as it relates to resource facilitation:

1. A universal name would be helpful for funding, research, program improvement, and policy. The consensus on the name that best describes this work is **Brain Injury Resource Facilitation**.
2. There are several **core components** that should be included for a program to be considered a Brain Injury Resource Facilitation program:
 - A. Connecting individuals to community resources
 - B. Discovery of an individual's strengths and challenges
 - C. Identification of needs
 - D. Goal setting and planning
 - E. Plan implementation
 - F. Arrangement and coordination of supports
 - G. Monitoring
 - H. Re-assessment (review needs on an ongoing basis)
 - I. Outreach and awareness of brain injury
 - J. Outreach and awareness of brain injury services
 - K. Brain injury education and training for individuals
 - L. Brain injury education and training for families/caregivers
 - M. Build capacity through brain injury education and training for organizations to teach about brain injury
 - N. Provide education about brain injury to policy makers (e.g., agency decision makers, legislators)
 - O. emotional support



- P. advocacy on behalf of individuals
 - Q. advocacy for systems change
3. The following **principles and approaches** are important when considering implementation of a Brain Injury Resource Facilitation program.
 - A. Facilitation is available to anyone with brain injury or their family and others supporting an individual.
 - B. Facilitation is available to anyone regardless of their abilities.
 - C. Facilitation considers the wants and needs of the individual with the brain injury to be the priority.
 - D. Facilitation adapts to the needs of individuals and the opportunities for meeting those needs.
 - E. Facilitation builds community partnerships.
 - F. Facilitation outcomes are measured.
 - G. Once connected, follow-up activities lead to more proactive services.
 - H. Resource facilitation programs support other providers/professionals in the community who serve individuals with brain injury through approaches such as training/education, capacity building, technical assistance, and consultation.
 - I. Individuals with brain injury have unique needs and therefore require special strategies and support.
 - J. Resource facilitation should be provided to individuals with brain injury, family members, and caregivers with technical assistance and consultation for providers/agencies.
 - K. Resource Facilitation can be provided either virtually or in person.
 - L. The duration of Resource Facilitation should be flexible to balance an individual's needs and the resources and funding available.
 - M. Building capacity (strengthening awareness, understand, knowledge, tools, and skills) should be an integral part of resource facilitation among people with brain injury, family members and caregivers, and community professionals/service providers
 - N. Resource facilitation should help people live happy and healthy lives in the community.
 - O. Resource facilitation can be accessed throughout a lifetime.
 4. While it is recognized that not every staff member of a Brain Injury Resource Facilitation program will possess all of the following knowledge, this **knowledge** should exist among the program collectively:
 - a. Causes, course, and consequences of brain injury
 - b. The community and its associated resources
 - c. Diverse systems of intersectionality of brain injury
 - d. Diversity and inclusion
 - e. What it means to have lived experience as an individual with brain injury or to provide support as a family member/caregiver
 5. This consensus process identified the importance of measuring the effectiveness of Brain Injury Resource Facilitation programs through **measurements and common data elements**. The following are recommendations related to measurements, outcomes and data.
 - A. It is important to have a common definition of data categories used by all resource facilitation programs across the country for funding, policy, research, and program improvement.
 - B. It is important to have a set of common outcome measures implemented by all resource facilitation programs across the country for funding, policy, research, and program improvement.
 - C. It is important to have a database for common data and outcomes to be reported for funding, policy, research, and program improvement.



- D. Examining the impact for individuals served, the program, and the community is essential in the evaluation process.
- E. Individuals' satisfaction with their services delivery should be measured.
- F. Individuals' improvement in quality of life should be measured.
- G. Impact for individuals served, the program, and community is essential in the evaluation process.
- H. Evaluation approaches should be flexible to meet program needs.
- I. There may be unique program outcome measure considerations in addition to core outcome measures.

NEXT STEPS

NASHIA will be working to disseminate the results of this Delphi Consensus on Brain Injury Resource Facilitation in an accessible format to ensure there is awareness of this effort. It is hoped that existing Brain Injury Resource Facilitation programs will use this information to evaluate and modify their programs to ensure the core components, principles and approaches, and methods for outcome measures and data are included in their programs. Additionally, it is hoped programs that are currently developing a Brain Injury Resource Facilitation Program will incorporate these consensus-based best practices into their program design.

In addition to program development, NASHIA will work to use this information to promote policy development and funding to ensure Brain Injury Resource Facilitation is available in every state across the country. NASHIA will also use this information to begin the exploration of developing a mechanism to collect common data elements across Brain Injury Resource Facilitation programs.

Finally, it is also recognized that while understanding the consensus-based best practices related to Brain Injury Resource Facilitation is an important first step; important next steps include developing tools for intake, assessment, monitoring, outcomes measurements and data collection. As a result of this need, NASHIA is partnering with the Moody Endowment to develop the Moody Center for Brain Injury Best Practices. The Center will bring together subject matter experts to advance the field of brain injury. The Center will operate in two, two-year cohorts. The first two-year cohort will focus on developing a Brain Injury Resource Facilitation best practices implementation toolkit.

ACKNOWLEDGEMENTS

NASHIA would like to acknowledge and thank the Moody Endowment for funding the Brain Injury Resource Facilitation Consensus effort and for allowing the focus of the first cohort of the Moody Center for Brain Injury Best Practices to focus on the toolkit development.

NASHIA would also like to thank members of the Steering Committee for their guidance and dedication to this important effort.



APPENDIX A

Steering Committee Members

1. Gavin Attwood: CEO, United States Brain Injury Alliance
2. John Corrigan: Professor, Department of Physical Medicine and Rehabilitation at Ohio State University & Director of the Ohio Brain Injury Program
3. Maggie Ferguson: Disability & Injury Prevention Project Director, Public Health Division, Iowa Department of Health and Human Services
4. Liz Gerdeman: Former Director, MINDSOURCE-Brain Injury Network, Colorado Department of Human Services
5. Nicole Godaire: CEO, Brain Injury Association of Massachusetts
6. Flora Hammond: Professor & Chair of Physical Medicine and Rehabilitation at Indiana University School of Medicine; Chief of Medical Affairs and Brain Injury Co-Medical Director at the Rehabilitation Hospital of Indiana
7. Kate Kerkmans: CEO, Brain Injury Alliance of Colorado
8. Peggy Reisher: CEO, Brain Injury Alliance of Nebraska
9. Lance Trexler: Rehabilitation Neuropsychologist, Clinical Assistant Professor, Department of Physical Medicine and Rehabilitation, Indiana University School of Medicine
10. Steve Wade: Executive Director, Brain Injury Association of New Hampshire and Consulting Executive Director, Brain Injury Association of America-Maine Chapter



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