OUTPATIENT MEDICAL REHABILITATION PROGRAMS

Scope of Service

Program Purpose

To provide evaluation, intervention, education and training to patients, families, and caregivers for people of all ages who demonstrate rehabilitation needs due to a physical, cognitive or developmental impairments.

The program goal is to aid the person served in achieving their highest level of function in self care activities, motor development, mobility, communication, cognition, school and work activities, self-advocacy, emergency preparedness and social and emotional adjustment.

The family/caregiver(s) are integral members of the rehabilitation team. We encourage and support their involvement in developing goals, carrying through home programs and preparing for community integration.

Population(s) Served

People referred for outpatient services demonstrate a variety of rehabilitation needs on admission. They may include, but are not limited to, one or more of the following:

- Communication and/or Cognitive Impairments
- Fine and Gross Motor Impairments
- Feeding Concerns
- Functional / iADL Impairments
- Gait Training
- Mobility Impairments
- Orthopedic Needs
- Sensory Integration Needs
- Vestibular Concerns
- Visual Perceptual and/or Visual Motor Impairments

Children 12 years and under will be admitted to the pediatric program, adolescents between the ages of 13 years and 18 years and attending school will be admitted to the adolescent program and all other ages will be admitted to the adult program.

People who require specialized respiratory care will have verbal consultation of equipment and needs prior to admission. Those requiring a vent will not be admitted to day programming.

Co-morbidities will be assessed on an individual basis and a determination will be made if these can be managed by the rehabilitation team.

Setting/Hours/Frequency Services

Services are offered at our Main Campus, 3011 Baltimore Avenue, Kansas City, MO.

Services are between 7:30 AM – 6 PM, Monday through Thursday and 7:30 – 4 PM on Friday.

Services are determined based on medical need. Frequency of service is determined by evaluation, physician recommendation, and ability to access services. Frequency of services will be discussed and determined after the evaluation.

Funding Sources

Services are funded by a variety of sources which may include but are not limited to:

- Commercial Insurance
- Medicaid / Medicare
- Self-pay – fees can be discussed, at time of referral, with business office
- Other funding options such as Regional Offices, County Boards, Bureau of Special Health Care Needs and other funding sources (First Hand, Falling Forward, Caring Program, Charity)

Program/Services Offered

The Team consists of the child, their family and professionals, as appropriate, from the specialties of:

- Assistive Technology
- Aquatics
- Case Management
- Driver's Evaluation and Training
- Education Specialist
- Neuropsychology/Psychology
- Nursing
- Occupational Therapy
- Patient Representative
- Peer Mentoring
- Physiatry
- Social Work
- Speech Language Pathology
- Therapeutic Recreational Specialist

Health and wellness promotion and prevention of secondary health conditions across the lifespan is encouraged throughout the rehabilitation process including education, therapy involvement and community education.

If a wound is present prior to admission Ability KC's team, under the direction of an external wound care management team, will help monitor healing process, assist with dressing changes and provide education and prevention strategies.

If a wound develops after admission Ability KC's team will monitor healing process and make appropriate referrals to external physician or wound care management as needed. Under direction of external physician will continue to monitor healing process, assist with dressing changes and provide education and prevention strategies.

Referral Procedures

Referrals to the programs may be made directly by family members, physicians, school personnel, and others in the community.

Referrals are initiated by contacting the admissions department, community liaisons or case managers.

A written prescription for treatment from the physician is required. This must come from a M.D. or D.O.

Consulting services are available upon referral in the following areas:

- Adolescent Medicine
- Audiology
- Clinical Trials or Research Opportunities
- Dentistry
- Durable Medical Equipment
- Medical Spasticity Intervention
- Neurology
- Nutrition
- Ophthalmology/Optometry
- Orthotics/Prosthetics
- Pain Management
- Primary Care Physician
- Rehabilitation Engineering
- Resources for Spiritual Needs
- Respiratory Management
- Substance Abuse
- Swallow Assessments
- Urology
- Women's / Men's health
- Wound Care
- Other resources as identified by treatment team

Program Admission Criteria

For admission, the patient must:

- Have a developmental disability or an illness, injury, or intervention resulting in a change in their previous functional daily activity status or decreased acquisition of developmental milestones;
- Have a reasonable expectation for greater functional independence and the ability to achieve goals and show progress;
- Have the potential to comprehend and cooperate with the plan of care; and be medically stable.
- There are no restrictions placed on acceptance to the program, and every attempt is made to meet the needs of the person and their support system in relation to geographic location, age, sex, race, culture, sexual orientation, gender identity or financial status.
- For those who do not live in the greater metropolitan area, assistance to locate housing is available.
- People diagnosed with communicable diseases and/or tuberculosis are not admitted for rehabilitation services.
- Persons are not admitted for psychiatric care.
- Individuals with behavioral issues related to physical or neurological impairment will be admitted if it is determined the program can effectively manage in this environment.

Discharge Planning & Criteria

Discharge planning begins upon admission to the program with child, patient, family, staff and community agency participation as appropriate.

The case manager, with support from social worker, facilitates and coordinates discharge planning and the transfer of information to school, work, physician, other agencies, etc. Family conferences are scheduled as necessary and may be an integral part of discharge planning.

Projected discharge dates are established with person served/family/caregiver and the treatment team in accordance with goal achievement.

Referrals are made, as appropriate, to other community agencies during program and upon completion of the program.

Discharge planning and decisions consider the following:

- Person served, family/caregivers and support system's preferences, needs and resources
- Person served ability to be functional in the home, school and/or community environment
- Progress toward achievement of program goals
- Potential to continue to progress
- Person served or family/caregiver's desire to receive or obtain alternative services
- Compliance with organizational policies
- Need for further health-care intervention

Intended Discharge Environment

The Program prepares the person served, regardless of current living setting, to be more independent in the home, school and community.

Follow-Up Services

At discharge from the program, a follow-up evaluation is scheduled, if indicated, to determine if functional status has been maintained or improved upon.

If an onsite follow-up is not indicated a phone follow-up will be completed

The timeframes for follow-ups are based on what is appropriate for the person served.

If problems are identified at follow-up, recommendations are made to assist the person served/ family/caregivers to resolve the problem or receive necessary support services.

Expected Program Outcome

The person served will transition to home, school and community and continue the process toward maximum independence.