ADULT OUTPATIENT MEDICAL REHABILITATION PROGRAM

Scope of Service

Program Purpose

To assist individuals with physical or neurological impairments to function within home and community at their highest level of independence through the provision of comprehensive and coordinated multidisciplinary evaluation and restoration services addressing prevention, minimizing impairments, reducing activity limitations, maximizing participation, and educational and psychological needs; and referral to other community services.

Individuals may require service from one or more disciplines. Duration, intensity, and frequency of a service will vary depending on the needs of the person served and by progress towards functional goals.

The individual may be admitted to the appropriate program listed below and may be transitioned from one program to another based on their needs. This overview describes all three programs.

- Day Hospital: a full or partial day program
- SAILS: a full or partial day program
- Adult Outpatient

Services are provided Monday–Friday from 8:00–4:00 for Day Hospital, SAILS and the Adult Outpatient Program.

The program promotes the goals set forth in the facility's mission and vision statement

Intended Discharge Environment

The program prepares the person served who is already living at home or in a residential setting with the support to become more independent in that environment and progress to independence in other appropriate environments.

Conditions of Persons Served

Individuals referred for outpatient rehabilitation demonstrate a variety of rehabilitation problems on admission. Examples of such problems may include, but are not limited to, one or more of the following:

- Limited ability to perform self-care
- Limited ability to manage the home
- Impaired cognition
- Problems in school/work performance

- Mobility impairments
- Disability adjustment problems
- Limited knowledge of community resources
- Impaired physical ability
- Impaired vision
- Limitations in community reintegration skills
- Limited knowledge of recreational opportunities

Services Offered

The program is provided at a freestanding outpatient rehabilitation facility. Services are provided in designated areas utilizing equipment and materials that are appropriate to the age and specific needs of the persons served. The program offers comprehensive coordinated rehabilitative services provided by an assigned team of medical rehabilitation professionals, who consistently treat their assigned caseload. The following professionals provide the service:

- Case Manager – employed by Ability KC
- Occupational Therapist – employed by Ability KC or agency
- Physiatrist – Medical Director under contract
- Physical Therapist – employed by Ability KC or agency
- Psychologist/Neuropsychologist – employed by Ability KC
- RN, LPN, and CNA – employed by Ability KC or agency
- Return to Work Navigator – employed by Ability KC
- Social Worker – employed by Ability KC
- Speech/Language Pathologist – employed by Ability KC or agency
- Swallow studies are contracted services
- Therapeutic Recreation Specialist – employed by Ability KC

Services are provided on an outpatient basis. Available services may include but are not limited to the following: case management, discharge planning, medical evaluation and treatment, bowel and bladder/training and management, skin care management, patient/family education, evaluation and treatment/training in self care, transfers, ambulation, wheelchair mobility, use of splints and orthotics, home/work/school evaluation and modification recommendations, work simplification, wheelchair assessment and maintenance, community integration, modalities, therapeutic exercises, speech and cognition language assessment and intervention, recreational activities, socioeconomic assessment, counseling, advocacy, psychological testing, support groups and pre-vocational assessment. When implicated, specialty services (ACCT and psychology) may be provided via telehealth.

Referrals to other appropriate agencies or professionals may be made for additional support and/or rehabilitation services such as prosthetics, orthotics, rehabilitation engineering, vocational/educational requirements, wound care other than assessment and dressing management, or mental health/chemical use/abuse/dependency counseling.

Program Admission Criteria

The Adult Medical Rehabilitation Programs accepts for services those persons 18 years of age and older with a physical or neurological disability resulting in a change in functional status. These individuals may be limited by their disability in activities at home, post secondary education, or on the job, and are reasonably expected to achieve greater functional independence as a result of the services received. These individuals may have experienced a recent onset, recent regression, and recent progression or may have had no prior exposure to rehabilitation services.

There is no restriction placed on acceptance of patients, and every attempt is made to meet the needs of the person served and their family in relation to geographic location, sex, creed, race, culture or financial conditions. Patients admitted to the Adult Medical Rehabilitation Program are typically over the age of eighteen. Individuals under the age of 18 and/or who are in primary or secondary school are referred to the Pediatric/Adolescent Program.

Prior to the admission, the individual must have a plan to be discharged to the same or a less restricted environment.

Individuals must be medically stable. Those diagnosed with childhood communicable diseases and/or tuberculosis are not admitted for rehabilitation services. Persons are not admitted for psychiatric care or for treatment of alcohol or drug dependency. Individuals with behavioral issues related to the physical or neurological impairment will be admitted if it is determined that this issue can be appropriately managed in this environment.

Referral & Screening Procedures

Referrals to the program may be made directly by the individual seeking service, their family or caregiver, physicians and others in the community. Referrals are initiated by contacting the Admissions department.At the time of referral, the admissions staff will obtain preliminary information necessary to determine the patient's eligibility for program admission. Medical and payer information and prescription will be requested at this time. The initial visit will be scheduled at this time or after needed information is received. Explanation of financial arrangements is provided prior to admission to the person served and/or family/caregiver.

**Individuals requiring a ventilator are told during screening and upon admission that they must bring their own competent, trained caregiver each day to monitor, control and provide care for the ventilator equipment at all times while in the building and during treatment.

As appropriate and requested, a staff member may screen referrals for appropriateness at the referring facility. Prospective patients and/or their family/caregiver are encouraged to visit the facility. Arrangements can be made to tour the facility and talk with staff about program services. The patient and family/caregiver are given written orientation material before or at admission.

Funding Sources

Services are funded by a variety of sources which may include but are not limited to: Medicare, Medicaid, commercial insurance, workers compensation, self-pay or State Department of Vocational Rehabilitation.

Assessment & Program Planning

Based on the diagnosis and rehabilitation problems identified in referral and pre-admission information, the appropriate team members are identified and scheduled to see the patient.

An individual assessment is provided by each team member to address level of function, needs, and strengths of the person served and their family/caregiver, taking into consideration developmental, cultural, spiritual and age related issues. Assessment results, treatment recommendations, rationale for treatment/treatment activities and the needs of the person served and family/support system are discussed with the patient and/or family/support system and common functional goals are identified.

Individualized program planning takes place within each service and the overall program plan is designed by the entire treatment team and is coordinated by the case manager. The person served and family/caregiver are recognized as important members of the rehabilitation team and are actively involved throughout the evaluation, goal setting and program planning process. Patient and family/caregiver education is an integral part of the rehabilitation process and the education provided is designed to meet the specific needs of the person served and their family/support system. This is achieved through various means including during treatment sessions, group sessions, informational handouts, counseling sessions, and providing information regarding support and/or advocacy groups, services and resources available from the program and in the community.

Case Management System

All patients are assigned a case manager and/or social worker during their program. The case manager is responsible for ensuring that the person receives a coordinated program of appropriate and integrated services which is geared toward the accomplishment of the goals specified in the person's overall program plan. The case manager/social worker/therapist communicates any changes in the treatment plan to the person served/caregiver and other involved parties. The case manager facilitates and coordinates discharge through early and ongoing involvement with and input from the person served, family/caregiver, staff and relevant community agencies to maximize independent functioning in the post-discharge environment. The case manager will provide ongoing communication with payor and person served/family/caregiver service to assist in monitoring and reserving resources. The case manager will help identify community resources and communicate progress and treatment recommendations to the payer.

Conferences

Team Conferences are held biweekly for SAILS and Day Hospital patients and monthly for Neuro Rehab outpatients. They will be held more frequently if indicated by patient or payer need. During this conference assessment/reassessment results are shared, the overall program plan is established and revised, progress/status and areas of concern are discussed, and discharge, recheck and/or follow-up plans are established. Evaluation reports, progress notes and team conference notes are sent to appropriate physicians, referral sources, and other involved agencies/representatives. Family conferences are conducted as appropriate.

Input from patient and families/caregivers is encouraged and is recognized as an essential component. Physicians, representatives of referring agencies and insurance case managers may attend meetings. Evaluation reports and/or progress notes are routinely sent to them and to the referring physician. Numerous informal staff, patient and family meetings take place to further insure a coordinated effort.

Patient Discharge Planning & Criteria

Discharge planning begins upon admission to a program with person served, family, staff and appropriate community agency participation. Family conferences and home/work visits may be conducted.Projected discharge dates from each service are discussed with and agreed upon by the person served and/or family/caregiver. Discharge planning and decisions consider the following:

- The patient's ability to re-enter home and/or community environment.
- Progress toward achievement of program goals.
- Lack of goal achievement or potential.
- Refusal to receive or obtain further services.
- Non-compliance with organizational policies
- Need for further health care intervention.
- Need for referral to outside agencies.

Follow-Up Services

Follow-ups are conducted as appropriate, either on-site, by phone or by mail or by the physicians. If problems are identified at follow-up, recommendations are made to assist the individual and/or family to resolve the problem or receive necessary support services. Time frames for follow-up vary according to discharge dates from each service and patient need.

Input From Individuals Served

The Program strives to provide high quality services. Staff seek ongoing input from the person served and family throughout the program. Input from those served is also solicited at follow-up in accordance with Program Outcome Management Procedures.

Day Hospital

The assessment of program quality for the person served is accomplished through a network of review systems including:

Quality Assessment and Improvement: Focuses on maintaining and improving the quality and appropriateness of care provided by medical and professional staff. It identifies problems in patient care systems and processes, designs activities to overcome those problems and performs follow-up monitoring to ensure corrective steps have been effective.

Utilization Review: Assesses and monitors appropriate utilization and delivery of services, including adequate progress toward goal achievement and justification for continued length of stay (intensity, duration and frequency of service).

Program Outcome Management: Assesses and monitors the overall effectiveness and efficiency of medical department programs. Data is collected as patients begin and complete programs. Patient evaluation of the programs and services provided is also monitored. Program outcome management reports are produced on a regular basis and results are reviewed by administration and appropriate staff and shared with all staff.

Risk Management: Provides risk identification and risk prevention techniques in order to reduce risks for persons served and, in turn, provide higher quality of care.

SAILS (Successful Adult Independent Living Skills)

To provide a structured environment along with an intensive, comprehensive medical rehabilitation program on an outpatient day treatment basis primarily for individuals with brain injury. The focus of the SAILS Program is to build on existing skills and abilities to assist the individual to integrate as functionally as possible back in to the home, community and school or work settings. The SAILS Program promotes the goals put forth in The Institute's mission and vision statements.

The program admits individuals for brain injury services who may be injured as a result of trauma or disease and may include, but not be limited to the following:

- Anoxic Brain Injury
- Brain Aneurysm
- Brain Injury (traumatic and non-traumatic)
- Brain Tumor
- Cerebral Vascular Accident
- Encephalopathy