BRAIN INJURY SPECIALTY PROGRAM
Scope of Service

Program Purpose

- To provide evaluation, intervention, education and training for persons served and family members of all ages, who demonstrate rehabilitation needs after a brain injury.
- The program goal is to aid the person served in achieving their highest level of function in self care activities, motor development, cognition, executive functioning, communication, vision, life activities, emergency preparedness, self-advocacy and social and emotional adjustment. Furthermore, the program supports and provides education to person served to minimize risk of complications due to brain injury and prevention of recurrent brain injury.
- The family/caregiver(s) are integral members of the persons served rehabilitation team. We seek their involvement in developing goals, carrying through home programs and preparing for community integration.
- The program will explore technology that will help support patients' long-term needs.

Population(s) Served

- People referred for outpatient or day treatment services demonstrate a variety of rehabilitation needs on admission. They may include, but are not limited to, one or more of the following:
  - Mobility impairments
  - Fine and/or motor impairments
  - Visual perceptual and/or visual motor impairments
  - Communication and/or cognitive impairments
  - Functional / iADL impairments
  - Other impairments identified by the team
- Children 12 years and under will be admitted to the pediatric program, adolescents between the ages of 13 years and 18 years (or up to 21 if they are still in high school) will be admitted to the adolescent program and all other ages will be admitted to our adult program.
- People who have had a brain injury and require a vent will not be admitted to the program unless they can benefit from program and have a caregiver who will be responsible for vent management at all times.

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

Setting/Hours/Frequency of Service

- Services are offered at our Main Campus, 3011 Baltimore Ave, Kansas City, MO.
- Day treatment services are between 9 AM – 4 PM with drop off and pick-up 20 minutes before or after your scheduled start and end time. Day program services are offered Monday through Friday.
- Outpatient services are offered 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 sources (Cerner Charitable Foundation, Clay County Children's Services Fund, Falling Forward, Caring Program, Charity) may be available and explored with responsible party.

Program/Services Offered

The Stroke Specialty Team consists of the person served, their family and professionals, as appropriate, from the specialties of:

- Assistive Technology
- Aquatics
- Case Management
- Driver's Evaluation and Training
- Education Specialist
- Employment Services
- Neuropsychology/Psychology
- Nursing
- Occupational Therapy
- Patient Representative
- Peer Mentoring
- Physiatry
- Physical Therapy
- Social Work
- Speech and 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 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 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 the treatment team

Program Admission Criteria

For admission, the patient must:

- Have a brain injury diagnosis resulting in a change in their previous functional daily activity status;
- 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.
- For those who do not live in the greater metropolitan area, assistance to locate housing is available.

- There are no restrictions placed on acceptance, and every attempt is made to meet the needs of the person served and their family in relation to geographic location, age, sex, race, sexual orientation, culture or financial status.
- Persons diagnosed with 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 physical or neurological impairment will be admitted if it is determined the program can effectively manage in this environment. Ongoing assessment of behavior and persons served ability to benefit from program occurs formally and informally throughout length of stay.

Discharge Planning & Criteria

- Discharge planning begins upon admission to the program with persons served, family, staff and community agency participation as appropriate.
- The case manager and/or social worker facilitates and coordinates discharge planning and the transfer of information to community, physician, other agencies, etc.
- Family conferences and home visits 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 upon completion of the program.
- Discharge planning and decisions consider the following:
  - Persons served, family/caregivers and support system's preferences, needs and resources
  - Ability to re-enter 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/services

Intended Discharge Environment

- The program prepares the person served who is already living in a home setting with support to be more independent in the home, school and community.
- The program can support the exploration of transitional living environments.

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 and as determined by the team.
- 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 successfully transition to home, school and/or community and continues the recovery process toward maximum independence.