Community Based Services
Best Practice in MA

PRESENTED BY:

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COMMUNITY REHAB CARE- WATERTOWN

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Overview:

- Community Rehab Care is licensed as an Outpatient Rehabilitation Clinic offering Physical, Occupational and Speech Therapy and Wellness Programs for Neurological and Orthopedic clients in a Community Reintegration Model. Only independent clinic of its kind in MA.
- Providers of Case Management for SHIP, MS Society, Waiver Programs, Private
- 23 years experience as a woman owned business
- Accredited with the Commission for Accreditation of Rehab Facilities (CARF) for Interdisciplinary Medical Rehab Programs: Brain Injury Specialty (Adults, Children and Adolescents)
- Licensed by Massachusetts DPH and Medicare Certified as a Rehab Agency, SDO
- Presented with Community Partner Award at the Annual BIA conference 2019.
- www.brain-injury-rehab.com or like us on Facebook

Model of Care:

- Neurological Model – Acquired Brain Injury from all causes (MVA, gunshot wound, assault, anoxia from drug overdose and cardiac arrest, stroke, brain tumor, aneurysm)
- Real world functional approach to therapy, (PT, OT, SLP)we are not a day program
- Transdisciplinary team with certifications for the Neurological population (NCS, CBIS)
- Community Based
- Contracted with all major Insurance Plans including Medicare and Mass Health Products
- Goal to get back on " the best life's path"

Understanding the Post Acute Journey

- When does recovery of post-traumatic brain injury stop? “Spontaneous recovery is the brain healing itself, this is cited at 6-12 months”. (Nudo,2011) “Functional recovery can be with individuals 2-5 and more years post.”(O’Neil-Pirozzi & Hsu, 2016)
- Over 10 years ago the client came from the ER to Acute Rehab to CRC. We would usually not even see a client for 1-2 years post injury.
- Currently, a client comes from the ER, may or may not go to acute rehab, to home health agency, to a skilled nursing facility or home or a mix of the above and circles back to Community Rehab Care if they find us. Agencies/hospitals are vying to keep their own clients and keep them in their own sometimes limited network
- Transitions of care vary widely and handoffs are not consistently well coordinated

Example: Understanding Post Acute Needs

Past Medical History	Barriers	Modifications	Follow Up Status
37 year old TBI secondary to motorcycle accident vs car Hypertension, LOC>30 minutes and rib and pelvic fractures History of alcohol and cocaine use Attended OP therapy over a 7 month period tapering frequency of visits	Reduced memory and insight Precautions due to NWB, RLE, WBAT LLE Risk for caregiver burnout Risk for homelessness	High frequency care Monthly family team meetings and family education Connected with couple's counseling; support groups Home and community visits and modifications Transition planning within client's community	At discharge (90 SLP/OT; 72 PT visits), Mayo Portland Adaptability Index (MPAI-4) improved from mod-severe to mild limitations Set up volunteering, HICS, Statewide Head Injury Employment Services , SHIP Health status stable and remained sober/clean Able to remain living with longstanding girlfriend and grown children

Example: Understanding Post Acute Needs

Past Medical History	Barriers	Modifications	Follow Up Status
69 year old female s/p R thalamic hemorrhage which Resulted in L sided hemiplegia and dysphagia	Hemiplegia Significantly reduced activity tolerance Insight and coping with adjustments- Focus on 100% “full return” Remedial vs. compensatory	Consistent family team meetings with direct feedback on caregiver education, prognosis, HEP, etc. Home visits and modifications Supported outside consultation with orthotist at CRC Identified appropriate cardiovascular program	84 PT visits, 50 ST visits, 74 OT visits over a 10 month period. Attending wellness programming, support groups, alternative treatments to compliment needs, adaptive yoga, aquatic classes New brace with modifications

Example: Supervision Rating Scale (SRS)

- Measures the level of supervision a client receives>>> helps to decrease caregiver burden
- 2017 Outpatient community based rehab program data revealed 27 improved, 21 maintained status, 1 declined.

N=45	Initial	Discharge
Level 1 or 2: Independent	14	24
Level 3: Overnight Supervision	0	1
Level 4,5,6 or 7: Part Time Supervision	10	17
Level 8 or 9: Full Time Indirect Supervision	12	3
Level 10: Full Time Direct Supervision	13	4

Addressing Long Term Life Needs: Chronicity of ABI

- Current research at CRC with Speech, concluded that, “Regardless of time post-injury, individuals with TBI are able to make SLP facilitated functional progress” Data collected from our research shows improvements in function and independence by patients receiving cognitive-communicative therapy in a post-acute community rehabilitation setting. Our conclusion is that patients with chronic TBI may be able to make similar therapy improvement/functional outcomes in comparison to clients with acute TBI.” (Gilbert, O’Neil-Pirozzi, Karas, 2018)
- Social Determinants of Care

Long Term Outcomes

Functional Outcomes of a Physical Therapy Program in Individuals with Chronic ABI

Current evidence suggests that survivors of ABI can continue to make functional gains given ongoing skilled PT intervention. In a sample within our clinic, 21 individuals > 2 years post ABI who participated in maintenance PT services over a 3 year period. Over 50% of these individuals demonstrated reduced fall risk and functional improvements (improvements in walking speed, increased independence, etc). This data supports the hypothesis that individuals with chronic acquired brain injury can continue to make functional change even years after their injury, particularly in terms of balance and reduced fall risk, when provided with appropriate supports and services. It also provides support for the ABI waiver model employed in Massachusetts which includes maintenance level PT services. (Hatas,2018)

Example: Reality of Care

Past Medical History	Barriers	Modifications	Follow Up Status
47 year old female who sustained R CVA with hemiparesis Lengthy course of treatment secondary to medical issues and a subsequent fall- 12+ transitions- 2 SNF admissions; initiated OP 1 year post CVA Prior to stroke: depression, anxiety, smoker, estranged relationship with mother	Homeless- Change of living Mental health Cognitive and physical impairments Minimal family supports Fall risk	Waiver based programming for supportive community living with PCA, service coordination, counseling, adaptive sports, etc. Home/personal safety changes: Lifeline, accessible housing, splinting, etc. High intensity care 4x/wk for prevention and progression	Currently receiving wellness based services 4x week Has not been re-hospitalized, however fell and broke patella- able to triage and manage needs through consistent services and recovered Attends wellness programming (i.e. therapeutic exercise, chair yoga, coping,

Current Insurance, Facility and Licensure Trends

- Limited benefit plans
- High co-pays, deductibles and co-insurance
- Combined plan of care (combined with other disciplines)
- Documentation demands for reimbursement
- Authorization process
- Medical necessity guidelines, no allowances for “cognitive” goals
- Coordination of benefits
- State requirements for an out-patient rehab clinic are outdated and demanding for architectural/space demands and financial obligations

Example: Insurance Impact

Past Medical History	Barriers	Modifications	Follow Up Status
Chronic TBI (1/1993) Complex medical history Maladaptive behaviors	Mental health Substance abuse Behavioral history Medication noncompliance Unstable living setting Medicare insurance	Re-establishing contact with long term supports Behavior plan development Medication management Advocating for AFC for stable living Narrow Plan of Care	Received 20 SLP/OT visits and 3 PT visits over 3 months) Stable living environment with family Follow through with resources, including SHIP contracted CM Ongoing behavioral needs requiring daily nursing for managing medications High level of involvement from family to ensure safety levels Kept deinstitutionalized

Perspectives on Running an Outpatient Clinic and Providing Services to Individuals with ABI:

- The rewards of impacting the lives of thousands of lives is priceless
- All of the staff we have launched to treat neurological people in numerous settings across the country
- Reimbursement rates hardly change for any payer. MassHealth has not increased rates in many years and are our lowest rates which do not attract businesses to open clinics
- Site neutrality issues… small independent clinics are paid far less than large hospital based outpatient services. CMS is working on this over the next 2 years
- Provision of Neuropsychological and Social Work Services is limited
- See attachments #1 Spotlights of Positive Out-patient Rehab Clinic services

Perspectives on Community Based Services – Impact on Individuals in the Community

NEED FOR CASE MANAGEMENT & RESOURCES AND SUPPORT (Formal and Informal)

- Need for CM for ABI not just TBI and most services are not just temporary but may be lifelong
- Short money for keeping clients in the community and out of institutional settings
- Assistance with navigating systems: from health care, financial, MRC, SHIP, rep payees, guardianship, legal systems, housing
- Lack of programs for young ABI to middle age who do not fit in to other programs for work and school and day programming.
- Transportation, transportation, transportation
- ASAPS/ Council on Aging are not well versed in this area and their hands are tied if one does not have Mass Health

Case Management Best Practices & Perspectives

SHIP/MRC, PRIVATE, MASSHEALTH, WORKER'S COMP

- See attachment # 2 for Examples of Accomplishments as a result of Case Management or Community Service Worker involvement.

Comments/ Questions?

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