RESIDENTIAL REHABILITATION ASSESSMENTS in the Development of a Life Care Plan

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Residential rehabilitation assessments come in all shapes and sizes based upon the specifics of the program as well as the expertise and level of cohesiveness of the treatment team. Ideally, residential programming should occur in a community-based program that has a relevant therapeutic milieu in terms of evaluating “real life” performance in an ecologically valid manner. Programs that are geographically isolated and not “in community” often have insurmountable challenges facing them in terms of performing ecologically valid community-based assessments. In comparison to what might be accomplished in an outpatient clinic setting, life care planners can gain more valuable information from an assessment that occurs over a longer period of time and in a real-world environment.

Residential Brain Injury Programs

There are several types of brain injury rehabilitation formats available to persons with acquired brain injuries (ABI) and their families. Hospital-based rehabilitation programs are primarily utilized for acute care soon after the initial brain injury has occurred. The client may transition to a post-acute residential rehabilitation program, outpatient or day treatment program, and eventually either to home or to some type of extended rehabilitation or supported living program. The course of recovery will vary with each individual and depend on factors such as the neuropathology type, the presence and extent of secondary brain injury, and the duration of loss of consciousness. Additional recovery may occur over a number of years post-injury as the individual adjusts to his or her impairments and develops functional compensation for related deficits.

Spontaneous neurological recovery was traditionally believed to occur up through 18 - 24 months post-injury; however, more recent research has demonstrated that neurological recovery timeframes may vary from months to many years depending on variables such as the primary neuropathology, extent of secondary brain injury, and acute prognostic parameters. At the same time, it is generally accepted that improvement of function through adaptation and compensation for deficits can occur for many years post-injury and clearly beyond the time of neurological plateau.

Consensus would dictate that it is reasonable to consider the development of a life care plan (LCP) to project current and future needs once the claimant/patient has reached at least a neurological plateau (although there are certainly situations where an LCP would be appropriate earlier post-injury). Because the ultimate outcome level may be a moving target early in recovery, the life care planner may need to use published literature on ABI outcomes in addition to specific clinical projections in order to project future needs. The life care planner may also need to specify that the plan should be revised as changes in patient/claimant status occur.

An admission to a residential post-acute rehabilitation program can be extremely helpful in determining the capacity of the injured person to safely live independently. In addition to basic physical and cognitive functioning, such assessments can provide insight into complex living skills such as self-medication, time management, social skills, and stability of mental health over time. Many residential brain injury facilities are set up as a home-like atmosphere or similar to a small community college with a campus and several buildings in an urban or sub-urban setting. These programs often have 24-hour direct support staff such as life skills trainers (LSTs); clinical case managers; a nurse; licensed physical therapists, occupational therapists, speech-language pathologists and psychologists. Part of the treatment team may include at least one physician, usually a psychiatrist, neurologist, or neuropsychiatrist.

A typical supported living program may be a single-family home able to accommodate three to eight clients with LSTs providing 24-hour direct care, a clinical case manager, and access to therapists and medical specialists as needed. Another version available in the post-acute continuum is the supported apartment program, which provides an apartment in the community with daily staffing and support. In each of these living environments, the clients are provided with a daily schedule of therapies and activities that are designed to help the client improve skills needed to reintegrate into the community. Access to recreational and productive activities or vocational programs is typically part of the weekly client schedule. For each activity or therapy, staff is provided to assist the client and observe and document the client's progress toward rehabilitation or behavioral goals.

Medical care is provided by weekly and monthly nursing assessments, regular visits by a psychiatrist or other physician, and by any needed specialist in the local community that may be required, e.g., an ophthalmologist, neurologist, or psychiatrist. The facility case manager will usually be the professional who coordinates the medical appointments and ensures that their client is receiving the services that are required and that all parties are communicating effectively.

An activities coordinator, typically an occupational or recreational therapist, organizes daily goal-oriented therapeutic activities and works with LSTs to coordinate extension activities. These latter activities are designed to work on particular therapy goals such as improving range of motion, strength or motor control in the upper extremities, or remembering the sequence of steps...
in preparing a meal or planning a shopping trip. Productive activities may be organized in the program so that the client assists with certain tasks in daily operations, such as vehicle maintenance, clerical tasks, or kitchen duties. Access to community programs such as horticulture, art, and music therapy may be provided. "Affirmative Industry" programs provide clients a chance to help operate a company that produces products or crafts sold in the community (Fraser 1990).

All of these components of residential brain injury programs provide opportunities for understanding how the individual with the brain injury functions in the real world and the degree of his or her true abilities and deficits. Sometimes the person with brain injury does not have access to a comprehensive residential program because he or she cannot afford it and does not have insurance coverage for the treatment/assessment. The client, due to the aforementioned restrictions, may end up placed in a group home for individuals with developmental disabilities or even in a nursing home, often placed with geriatric patients and sometimes even on an Alzheimer's unit. Obtaining comprehensive assessments of function in these types of facilities will be more challenging, and the information obtained typically will be more limited. The life care planner may need to make recommendations for additional evaluations by medical specialists such as neuropsychiatrists, neurologists, physiatrists, or therapists in order to obtain information helpful to the planning process.

Funding is provided through a number of resources for specialized residential rehabilitation programs. Many residential programs receive funding for clients with brain injuries through workers' compensation insurance, accident and health insurance, and funds from liability claims or settlements. Some states have Medicaid waiver programs that allow for limited public funding. Most often the life care planner is involved in cases with pending liability funds. In some of these cases, residential rehabilitation programs may be able to work with the attorneys to provide services on a lien basis so that the client can receive services prior to any settlement from liability. In most of these cases, external catastrophic case managers are involved to ensure that the client receives the proper services and that funds are being used appropriately for the client's best interest.

**Life Care Planner Needs**

Life care planners need the best information available to project future care needs. Often treating physicians and therapists can offer only best-guess responses to the life care planner about how a person with ABI may behave in real-world situations over an extended period of time. Without information from a residential facility, the family report is often the best data source for information regarding changes or problems with cognitive skills and behaviors in various community settings. Independent medical examiners may have even less access to such data even though they may be asked to give opinions about the effect of behavior on future independent living and/or vocational functioning.

In order to improve the accuracy of projections for cognitive, behavioral, and social functioning and the need for particular types of community or facility supports, a residential rehabilitation evaluation (RRE) should be considered. Such evaluations take several weeks to complete. The authors have found that a three to six week assessment is usually the minimum recommended period of time required to answer many of the typical questions posed by a life care planner. (These recommendations are guidelines only, based on the experience of the authors and do not necessarily reflect the opinions of other brain injury providers.)

As discussed below under "Medical Aspects of the RRE," longer lengths of stay typically provide more information about complex community functioning, as well as a better understanding of emotional and behavioral stability. Because not all residential programs provide time-limited evaluations or separate evaluation services, life care planners should become aware of the resources in their region. Advocacy and educational associations such as the Brain Injury Association of America (BIAA) and state chapters, the North American Brain Injury Society (NABIS) and the International Brain Injury Association (IBIA), as well as professional case management organizations such as the International Association of Rehabilitation Professionals (IARP) and Case Management Society of America (CMSA), can provide both resource directories and valuable professional experience helpful in selecting such programs.

The life care planner may be involved directly in making a referral to the facility or they may be able to recommend referral by the attorney or insurance company. Either way, it is important that the life care planner be involved prior to or close to admission so that specific referral questions can be posed. It is helpful if the rehabilitation program is provided with the referral questions prior to or at the time of admission so that the assessment can be done in a timely manner.

Questions that the life care planner may have that an RRE should be able to answer or provide some information about include:

- Can the client perform his or her own activities of daily living (ADLs) safely and successfully?
- What effect do cognitive deficits have on the client's daily and weekly function?
- Is the client able to safely manage his or her own medication administration?
- How do a client's emotional issues affect his or her daily function?
- Can the client accurately follow a schedule and how does he or she manage unstructured time?
- How well does the client get along with peers, staff, and people in the community? What are behavioral triggers that aggravate the client and what is the best environment to minimize behavioral outbreaks?
- Can the client benefit from neuropsychiatric pharmacological interventions?
- How much future physical therapy, occupational therapy, speech therapy and psychology services should be projected?
- Can the client access the community safely? Can he or she use public transportation and successfully shop, and plan and make meals? Can the client manage his or her money effectively?
- How much family support is available? What is the best long-term living environment for the client? How much and which type of home or facility support will he or she need?
- What is the client's degree of safety awareness and can the client effectively protect himself or herself in society?
- What is the amount of support needed?
- What type of lay, paraprofessional and/or professional must provide the help in question?

The life care planner also should stay in touch with the facility clinical case manager and be prepared to attend facility team meetings so that issues can be discussed and additional questions asked to further clarify current and future needs.

In addition, the authors propose that long-term follow-up of a client in a residential brain injury facility for whom an LCP has been prepared can provide a foundation for establishing the validity of LCP recommendations for individuals with acquired brain injury. Further research in this area certainly seems to be warranted.

**Medical Aspects of the RRE**

For medicolegal purposes, the bottom-line question is: What is more probable than not? It is our opinion that the shorter evaluation will generally allow an experienced and cohesive treatment team to develop a comprehensive list of medically necessary recommendations. Longer evaluations are indicated when there are concerns regarding the efficacy of prior rehabilitation efforts and/or the true rehabilitation/functional potential of the client.

We often find that even clients who have been through extensive rehabilitation programs can benefit from longer-term transitional neurorehabilitation services if there is an aggressive interdisciplinary and transdisciplinary approach using a biopsychosocial model (e.g. an approach incorporating biological/medical, psychological and social aspects of the disease process and how it impacts the patient in question), as opposed to simply a psychosocial or purely medical model. Certainly the information garnered is more detailed, accurate, and specific when the period of evaluation is longer. The involved professionals can also speak with greater levels of assuredness regarding the likelihood that interventions will be necessary if they have had a longer period of exposure to and experience with the client. Part of the process in determining how long an evaluative period is necessary needs to be driven by economics of scale, and as previously noted, the purpose of the evaluation.

A comprehensive program will provide for on-site physician involvement by a specialist experienced in ABI, e.g., a physiatrist, neurologist, or psychiatrist. A comprehensive physical examination by the program physician can be crucial in revealing ongoing neuromedical issues, as well as delineating impairments consequential to accident-related sequelae, whether secondary to brain injury or peripheral injuries. The assessment should be comprehensive and include evaluation of physical, cognitive, and behavioral impairments. A thorough evaluation should also take into account common problems seen in...