



Assumption
University

Digital Commons @ Assumption University

Human Services and Rehabilitation Studies
Department Faculty Works

Human Services and Rehabilitation Studies
Department

2018

What Families, Clinicians and Payors Need to Know About Transitional Rehabilitation

Gary S. Seale
Centre for Neuro Skills

Nicholas J. Cioe
Assumption College, nj.cioe@assumption.edu

Susan H. Connors
Brain Injury Association of America

Follow this and additional works at: <https://digitalcommons.assumption.edu/hsrs-faculty>



Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Seale, G. S.; Cioe, N. J.; and Connors, S. H. (2018). What Families, Clinicians and Payors Need to Know About Transitional Rehabilitation. *Brain Injury Professional* 15(1): 20-22.
<https://braininjuryprofessional.com/>.

This Article is brought to you for free and open access by the Human Services and Rehabilitation Studies Department at Digital Commons @ Assumption University. It has been accepted for inclusion in Human Services and Rehabilitation Studies Department Faculty Works by an authorized administrator of Digital Commons @ Assumption University. For more information, please contact digitalcommons@assumption.edu.

What Families, Clinicians and Payors Need to Know About Transitional Rehabilitation

Gary S. Seale, PhD, Nicholas J. Cioe, PhD, Susan H. Connors, Brain Injury Professional

When a person sustains a traumatic brain injury (TBI), he and his family are thrust into a health care system that is unfamiliar and difficult to navigate. Too often, patients do not have access to the full continuum of treatment – especially transitional rehabilitation (TR). This article addresses why that is so and ways to change it.

Transitional Rehabilitation Defined

TR is a program of comprehensive, residential treatment that includes intensive physical, cognitive, and behavioral therapies plus counseling, education, and medical care as needed (Chua et al., 2007). TR encompasses remediation techniques to restore function along with compensatory strategies, assistive technology, and environmental modifications to improve function. TR is sometimes called residential rehabilitation or transitional living because patients may reside in structured facilities that mimic real-world settings. TR is appropriate for individuals who have completed acute hospital-based rehabilitation, are medically stable, and able to participate in intensive therapy. TR is also suitable for patients who may not have received acute rehabilitation or cannot safely transition from hospital to home due to increased risk for medical complications or re-injury. TR patients may have moderate to severe brain injuries and accompanying decrements in strength, poor balance, or decreased ability to perform basic activities of daily living (ADLs). Individuals who demonstrate post-traumatic amnesia, behavioral dysregulation, impulsivity, and poor self- and safety awareness are appropriate for TR programs, as are those who experience a change in life circumstances, such as the loss of a family

caregiver or emergence of a secondary health condition. TR may also benefit patients with milder injuries or post-concussive disorders that do not respond to established treatment regimens.

TR Differs from Other Treatment

Unlike acute hospital-based rehabilitation, TR programs are community-based. Skills and strategies taught in the clinic are practiced in community venues to encourage self-awareness and self-reliance. Therapy, which can last up to eight hours per day, focuses on resuming former social roles and on mastering advanced ADLs. With proper safety measures in place, patients are allowed to make mistakes based on poor judgement, poor self-awareness, or poor impulse control to gain insight, refine goals, and enhance collaboration with the treatment team.

TR programs address the individual's ongoing medical needs, such as seizures, endocrine dysfunction, sleep disorders, pain, or swallowing disorders prior to discharge home. Ideally, the physician providing medical care is a specialist in brain injury medicine, such as a physiatrist. With the assistance of therapists or nurses, patients learn to arrange medical appointments, manage co-morbidities and medications, and practice the use and care of durable medical equipment. TR programs also guide families in making home modifications and learning behavior management techniques prior to discharge.

Challenges in Accessing TR

About 52% of individuals age 15 and older with moderate to severe traumatic brain injury (TBI) are discharged directly home from an acute hospital with no further treatment (Cuthbert et al., 2011). Research suggests up to 20% of those with a severe injury return to pre-injury functioning within one year post-injury. Therefore, it is reasonable to believe there are several factors beyond spontaneous recovery that explain a premature departure from treatment.

Families simply do not know TR exists or how to advocate for admission to a TR program. TR programs may not be available in a particular geographic region. Clinicians do not refer patients because they misjudge the patient's ability to make further gains or are unaware of the provider expertise, treatment intensity, and outcomes achieved at the post-acute level. Sometimes clinicians are pressured to discharge patients to less intensive placements, such as skilled nursing facilities, or are prohibited from discussing discharge options without prior clearance from payors. Additionally, some referrals are not made because the TR program is not in network, either a hospital network or payor network of providers.

Payors control patient access to TR based on their coverage philosophies and payment policies. Those with long-term responsibility for the patient – such as workers compensation carriers – tend to invest in rehabilitation that maximizes a person's health and independence. Payors with short-term responsibility – such as group health plan insurers – tend to stint on care, thereby shifting costs to families and public programs. Even payors that cover TR may deny admission based on medical necessity or may discontinue treatment due to lack of measurable progress. This short-sighted strategy may save money initially but can result in higher long-term costs due to re-hospitalization or the development of medical or psychosocial complications requiring treatment.

Clinicians Fight for Patients

Clinicians can stop the harmful 'delay, deny, discontinue, and discharge to daytime TV' spiral that patients experience by clearly describing their patient's on-going medical conditions and the physical and cognitive impairments that prevent a safe transition to home. Clinicians can articulate the benefits of appropriate treatment intensity and duration to ensure successful reintegration into the community (Tsaousides and Gordon, 2009). They can describe for payors the role of cognitive rehabilitation therapies in reducing activity limitations and participation restrictions (Malec and Basford, 1996) and the cost efficiencies and improved health outcomes achieved through comprehensive rehabilitation of sufficient scope, duration, timing, and intensity (Ashley and Cervelli, 2010).

Best Practices for Payors

Payors benefit when they comprehend the differences in focus and philosophy across the TBI treatment continuum and the necessary variations in therapy intensity and duration to ensure successful return to the community. Similarly, payors benefit when they acknowledge that comprehensive-holistic treatment is the standard of care following TBI (Tsaousides

and Gordon, 2009) because it reduces psychosocial problems and promotes community re-integration and return to work (Geurtsen et al., 2010), and can reduce lifetime costs. TR programs are particularly effective when therapies are implemented by an interdisciplinary team, using community-based rehearsal, cognitive rehabilitation therapy, and family involvement (Turner-Stokes, 2008).

Payors benefit when they appreciate the difference between progress and outcome measurement at the acute and post-acute levels of care. Most hospital-based programs use the Functional Independence Measure (FIM) as the primary outcome measure. The FIM, has ceiling effects and is not appropriate for patients in TR programs (Hall et al., 2001). TR programs are focused on the overall functioning of the individual in real-world settings, and a larger range of outcomes are possible, such as return to productive activities, driving, and quality of life.

Therefore, most TR programs employ measures of global function, such as the Mayo-Portland Adaptability Inventory, and other measures important at the post-acute level of care, such as life satisfaction, mood, and supervisory need.

Finally, payors benefit most when they embrace the substantial lifetime cost savings associated with participation in TR programs (Ashley et al., 1990 & 1993; Khan et al., 2002). These savings are most salient with regard to attendant care, development of medical and psychosocial complications, and avoidance of re-hospitalization.

Selecting a TR Program

One of the most important decisions families make is where to obtain treatment for their loved ones. Regrettably, families often make decisions about placement based on marketing brochures rather than outcomes data. Choosing a TR program based on proximity to the family can be a mistake. Similarly, focusing only on the environment without asking questions about the program itself can lead to bad decisions.

When selecting a TR program, families should determine how the facility is licensed and if the program uses best practices and evidenced-based clinical guidelines, or has earned accreditation (e.g., CARF, Joint Commission). They should investigate staff qualifications, organizational training culture, and staff to patient ratios. Top TR programs provide coordinated, interdisciplinary treatment by licensed physical, occupational, speech, music, and recreation therapists as well as neuropsychologists, counselors, and case managers. Medical and nursing services are integrated into TR treatment and generally involve physiatrists, neurologists, and registered nurses. Residential programs provide up to 24/7 supervision by qualified staff, such as a certified medication assistant, certified nursing assistant, or certified brain injury specialist. Also available in top TR programs is around the clock access to a physician and neuropsychologist to avert medical or psychological crises.

TR programs incorporate person-centered principles into treatment plans, and the family is integrated into the treatment team (e.g., involved with goal-setting, participate in therapy sessions, regularly visit the patient). Families will want to inquire about the balance between individual and group therapies, the number of therapy hours per day, and how free time is used. They should ask about the availability of peer support, family training, and help with transition planning, including vocational options and day programs. Above all else, families will want to know how patients with brain injuries of similar type and severity performed in the TR program.

Conclusion

While hospital-based surgical and medical treatment saves a person's life, transitional rehabilitation often places an important role in making that life worth living. The evidence for TR's efficiency and long-term cost savings is substantial (Ashley & Cervelli, 2010), but too often payors dictate access to care, length of stay, and clinical services provided. We urge families and clinicians to advocate for improved insurance coverage of TR because it maximizes health outcomes and personal independence.

Authors Note: We use the term "patient" throughout this article to reflect our opinion that transitional rehabilitation is a type of medically necessary treatment that should be paid by health insurance carriers.

References

Ashley MJ and Cervelli L. Maximizing rehabilitation outcomes and cost efficiency following acquired brain injury. *Brain Injury Source*. 7: 10-21, 2010.

Ashley MJ, Krych DK, Lehr RP. Cost-benefit analysis for post-acute rehabilitation of the traumatically brain injured patient. *Journal of Insurance Medicine*. 22: 156-161, 1990.

Ashley MJ, Persel CS, Krych DK. Changes in reimbursement climate: Relationship among outcome, cost, and payor type in the post-acute rehabilitation environment. *Journal of Head Trauma Rehabilitation*. 8: 30-47, 1993.

Chua KSG, Ng YS, Yap SGM, et al. A brief review of traumatic brain injury rehabilitation. *Annals Academy of Medicine*. 36: 31-42, 2007.

Cuthbert JP, Corrigan JD, Harrison-Felix C, et al. Factors that predict acute hospitalization discharge disposition for adults with moderate to severe traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*. 92:721-730, 2011.

Geurtsen GJ, van Heugten CM, Martina JD, et al. Comprehensive rehabilitation programmes in the chronic phase after severe brain injury: A systematic review. *Journal of Rehabilitation Medicine*. 42: 97-110, 2010.

Hall KM, Bushnik T, Lakisic-Kazazic B, et al. Assessing traumatic brain injury outcome measures for long-term follow-up of community-based individuals. *Archives of Physical Medicine and Rehabilitation*. 82: 367-74, 2001.

Katz DI, Polyak M, Coughlan D, et al. Natural history of recovery from brain injury after prolonged disorders of consciousness: outcome of patients admitted to inpatient rehabilitation with 1-4 year follow-up. *Prog Brain Res*. 177:73-88, 2009.

Khan S, Khan A, Feyz, M. Decreased length of stay, cost savings and descriptive findings of enhanced patient care resulting from an integrated brain injury programme. *Brain Injury*. 16: 537-554, 2002.

Malec JF, and Basford JS. Postacute brain injury rehabilitation. *Archives of Physical Medicine and Rehabilitation*. 77: 198-207, 1996.

Nakase-Richardson R, Whyte J, Giacino JT, et al. Longitudinal outcome of patients with disordered consciousness in the NIDRR TBI Model Systems Programs. *J Neurotrauma*. 29: 59-65, 2012.

Tsaousides T, and Gordon WA. Cognitive rehabilitation following traumatic brain injury: Assessment to treatment. *Mount Sinai Journal of Medicine*. 76: 173-181, 2009.

Turner-Stokes L. Evidence for the effectiveness of multidisciplinary rehabilitation following acquired brain injury: a synthesis of two approaches. *Journal of Rehabilitation Medicine*. 40: 691-701, 2008.

About the Authors

Gary S. Seale, PhD, is Regional Director of Clinical Services for the Centre for Neuro Skills. He received his doctoral degree in Rehabilitation Science from the University of Texas Medical Branch (UTMB) in Galveston. He is licensed in Texas as a Psychological Associate and Chemical Dependency Counselor and holds a clinical appointment at UTMB in the School of Health Professions – Department of Rehabilitation Science. He has worked exclusively in post-acute brain injury rehabilitation for over 27 years and has conducted research and published peer-reviewed articles on rehabilitation outcomes, the relationship between positive emotion and recovery of functional status following stroke, and emergency preparedness for disabled populations.

Nicholas J. Cioe, PhD, is the Director of Rehabilitation Counseling at Assumption College in Worcester, MA. He is a graduate from the College of the Holy Cross and received his Masters and Doctoral degrees from Southern Illinois University – Carbondale. He is a Certified Rehabilitation Counselor and Certified Brain Injury Specialist Trainer. Dr. Cioe has worked at all levels in TR programs and continues to provide staff training and individual rehabilitation plan development in the post-acute sector. His research and publications focus on response to disability following brain injury, impaired self-awareness, rehabilitation issues, and brain injury outcomes.

Susan H. Connors is president and chief executive officer of the Brain Injury Association of America (BIAA). She was executive director of the National Association of State Head Injury Administrators from 2001 to 2005 and BIAA's national director of state affairs from 1995 to 2001. She has served in advisory capacities and on expert panels for several federal agencies, universities, and nonprofit organizations and has authored numerous publications, position statements and articles. She has a bachelor's degree in public communication from George Mason University.