PROGRESSIVE ALTERNATIVES SCOPE STATEMENT 2024
HOME AND COMMUNITY SERVICES

Progressive Alternatives offers comprehensive and multifaceted home and community-based services for people with acquired brain injury and/or other catastrophically acquired disability, including spinal cord injury and multiple trauma/orthopedic or mental health conditions. Progressive Alternatives offers home and community-based rehabilitation services, nursing, occupational therapy, counseling and attendant care in the home setting. Home and community-based services are offered when the person served is interested in receiving services in their own home or in a location supported by Progressive Alternatives. The definition of “home” can include an apartment, private home or assisted living residence. Only adults are served. The persons served may participate in a combination of these programs and may also participate in outpatient/day/vocational programs in the community. The intended discharge and transition environments include successful living at home, home with family or other supports, staying with Progressive Alternatives on a long-term basis. Services may be short term or long term. Long term clients will have their program reviewed annually through regularly scheduled team meetings or as needed when there is a change in condition or performance.

The program is administered and monitored by the Senior Team and the Home Managers. The rehabilitation team can include case managers, mental health clinicians, nurse case managers, physical therapists, speech and language pathologists, occupational therapists, and recreational therapists. Personal care and supervision may also be provided by rehabilitation aides. In home therapy is scheduled Monday-Friday between the hours of 9 am to 5 pm. Frequency of rehabilitation therapy ranges in 1-3 days per week to a monitoring status with prn therapy when prescribed. In-home rehab assistant care or nurses are offered up to seven days per week, 24 hours per day, depending on the acuity of the individual served.

Primary payer sources include Michigan Auto No-fault and Community Mental Health Contracts. A fee schedule is published and is available upon request. Referral sources can include discharge planners, physicians, case managers, and family members.

The program provides the person served with the opportunity to progress to their highest functional level and to their greatest degree of independence and community inclusion.

Services:

All services listed in this scope statement are provided directly by Progressive Alternatives or community providers. Treatment is provided in an interdisciplinary manner and the team is individualized to the needs of the client.

Case Management Services: The external case managers coordinate care and assure communication between internal team members, family/guardians, external providers, and the payer source. The PA staff facilitates team and family meetings, provides client/family education, coordinates discharge planning, and prior authorizes services. An RN or LPN is utilized when the client's team includes rehabilitation assistants in the home. In the case of no external case manager the PA nursing team will complete the duties.

Mental Health Services: The internal or external mental health clinician addresses the neuropsychological, behavioral, and psychosocial needs that a client may have. Services include individual counseling, client and family education, and sexuality counseling.

Nursing Services: The nurse will monitor the client's health and the management of medications and other health treatments in the home. The nurse may provide client and family education to achieve the highest level of independence possible regarding pain management, medication management and managing doctor's appointments.

Occupational Therapy: Internal or external Occupational therapists focus on improving skills of basic activities of daily living and skills in the home and community which are important for independent living. Occupational therapy focuses on self- management of a daily schedule, and activities of daily living including basic ADL skills, and instrumental skills including cleaning, laundry, yard work, transportation, and managing finances. Therapy may also be directed toward vocational goals when appropriate. Assessments related to the need for supervision and home assessments are also completed as needed.

Physical Therapy: External Physical therapy focuses on mobility through treatment to manage musculoskeletal function, range of motion, strength, functional mobility, balance, and ambulation. Physical therapists assess the need for home modifications and assistive devices. Services can be provided in the home, community, or at a local gym. These services are coordinated with community resources to best fit the needs of each individual served.

Recreational Activities: Recreational activities are provided in the home, community, or at a local gym and focus on leisure skill development, community participation, and inclusion. These services are coordinated with community resources to best fit the needs of each individual served.

Speech/Language Pathology Services: External Services include evaluation and treatment of communication, swallowing, and cognitive challenges. Speech/language pathologists assess the need for augmentative communication devices and cognitive aids. These services are coordinated with community resources to best fit the needs of each individual served.

Transportation: Internal and external transportation services are provided to assure that the individual can attend necessary appointments and activities in the community.

Assessable Temporary Housing Service or Respite: These services are coordinated on a case-by-case basis and based on the needs of each person served. Services may range from housing only with services provided by an external source or may include other PA services as needed.

Admission criteria:

- The individual has a diagnosis of acquired brain injury, spinal cord injury or other trauma/orthopedic/medical/mental health conditions
- All physical and cognitive levels of functioning will be reviewed for appropriateness and acceptance will depend on an individualized clinical review. The client must be medically stable.
- All levels of spinal cord injury, both complete and incomplete, with all etiologies will be reviewed for appropriateness, and persons with co-morbid conditions will be reviewed for appropriateness. SCI referrals with a significant degree of complexity (i.e., ventilator dependence), if not totally dependent on the ventilator will be individually reviewed and may be accepted with internal and external qualified nurses.
- The client demonstrates the capacity to benefit from specialized home and community services.
- The client demonstrates that he/she can safely be served at home with the assistance of one caregiver.
- The client demonstrates a need for home and community-based services due to the nature of their disability.
- The client desires participation in a home and community program.
- The client's home environment is safe and conducive to receiving home and community services.
- The client is required to have an attending physician or Physical Medicine and Rehabilitation specialist to recommend and authorize treatment.

Discharge/Transition Criteria

- The client has been successful and is ready for the next level of program or independence.
- The physician has recommended a different environment.
- The client needs a more intensive setting due to (medical/behavioral) issues.
- Client/Guardian desires to discontinue program.
- The client's funding has been exhausted.

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