Michigan Brain Injury Provider Council's White Paper on Attendant Care

Executive Summary

The purpose of this paper is to establish standards for attendant care provided in the home setting. This paper provides an informational overview of in-home attendant care funded through the Michigan auto no-fault system, advocates for continued coverage under the Michigan Auto No-Fault Act, and makes recommendations for monitoring in-home care situations to assure high quality care and ethical treatment.

Based on numerous Michigan appellate court decisions, in-home attendant care is permitted under the current Michigan Auto No-Fault Law as a "reasonably necessary" service, or "allowable expense benefit," for the injured person's "care, recovery or rehabilitation." In addition to being a desirable alternative to an institutional setting, the U.S. Supreme Court in the Olmstead decision asserted the right of a disabled person to live and receive treatment in the least restrictive setting.

In-home attendant care for persons with catastrophic injuries can be a desirable alternative to long-term placement in an institution such as a nursing home or group home, and can enhance the rehabilitation outcomes and quality of life for the injured person. The care may be provided by family members, commercial providers, or a combination of both. In either case, a "reasonable" reimbursement charge, based on the "reasonably necessary" hours of attendant care provided, should be made to the care provider.

Decisions regarding the appropriateness of in-home attendant care, as well as the type, intensity, frequency, level of care, and supervision required, are made by the treating physician in concert with other clinicians and family members following a comprehensive assessment of the individual's care needs. Hourly costs for in-home attendant care may vary depending on level of care required, number of hours provided, skill level required of providers, geographic location, and market conditions. All attendant care situations should have In-Home Care Plans, and at least annual reviews of the plan and the caregiver competence to provide the care needed. In-home situations with higher risk for a conflict of interest, such as where a family member is financially dependent on the provision of attendant care, need special attention and monitoring.

Proposed legislation that would impose severe limitations on the rate of reimbursement and a maximum number of hours per week for attendant care is not reasonable for many catastrophically injured individuals dealing with spinal cord or traumatic brain injuries. Such limits will likely result in an increase of persons forced to live in institutional settings. Instead of setting legal limitations on the amount of care that can be provided, annual reviews by qualified treating physicians should determine the reasonable amount of attendant care for injured individuals and market rates should determine reimbursement amounts.

"In-Home Care" or "Attendant Care" Coverage under the Michigan No-Fault Act

The terms "attendant care" or "in-home care" appear nowhere in the Michigan No-Fault Automobile Insurance Act. However, the concept of attendant care has been indisputably established pursuant to case law interpretation by our Michigan appellate courts interpreting the "allowable expense benefit" under §3107(1)(a) of the No-Fault statute which broadly defines the types of benefits payable to persons injured in motor vehicle accidents to include:

"All reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation."

The fact that the No-Fault Act does not specifically mention "in-home care" or "attendant care" is typical of the allowable expense provisions of that Act and how they have been interpreted by our Courts. Over the nearly 40 years since enactment of the statute, the simple language of §3107(1)(a) quoted above has been interpreted by our appellate courts to include entitlement to specially equipped vehicles such as handicapped vans[1], home accommodations[2], medical mileage[3], vocational rehabilitation[4], guardian and conservatorship expenses[5], not to mention medical expenses for inpatient hospital-based treatment or outpatient treatment and related therapies[6].

The in-home care or attendant care benefit is no different than all of the other types of benefits which our Courts have held without question arise from the broad language of the allowable expense benefit provisions of the No-Fault statute.

Definition of "In-Home Care" or "Attendant Care"

Since the No-Fault statute does not specifically refer to "in-home care" or "attendant care," it is not surprising that the statute does not define that term either. Rather, over the 38 year history of the No-Fault statute, determination of the types of services that might fall into the category of "in-home care" or "attendant care" has been made by appellate courts only. Over that time period, Courts have ruled approvingly in favor of the compensability of a number of services that can come under the umbrella of the terms "in-home care" or "attendant care," including commercially provided in-home health and medical care services such as nursing provided by RNs and LPNs, highly-trained and general-level home health aides, as well as non-licensed family-provided care services.

In the absence of a statutory definition of "in-home care" or "attendant care," it is necessary to rely upon Court decisions interpreting the allowable expense benefit and its relation to services provided in a home setting to elicit the parameters of this benefit. It is clear from the cases interpreting the allowable expense benefit provisions of the No-Fault statute in the context of

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[1] Davis v Citizens Ins Co, 195 Mich App 323 (1992)
[2] Kitchen v State Farm, 202 Mich App 55 (1993)
[3] Swantek v ACIA, 118 Mich App 807 (1982)
[4] Tennant v State Farm, 143 Mich App 419 (1985)
[5] Heinz v ACIA, 214 Mich App 195 (1995)
[6] Nasser v ACIA, 435 Mich 33 (1990)

home-based care, that attendant care includes at least the following (See Appendix A for more detail):

(1) Medically related services including licensed care
(2) Personal care services
(3) Supervision and monitoring
(4) On-call availability

Importance of In-Home Care

Of the many decisions from our appellate courts which have addressed the issue of in-home care, none have questioned the importance of in-home care as a benefit that can improve overall outcomes, enhance a patient's recovery, and potentially reduce the expense that otherwise would be associated with inpatient continuing care. Because many patients cannot be safely left alone, an in-home care plan must also address the issue of patient safety and well being. Many people recovering from their injuries are able to be provided excellent care within their homes. Further, many patients are not able to be provided appropriate care in an institutionalized setting, or do not require care at that level, but can be cared for within their home by either commercial providers of such care or by family providers.

In-home care supports the expression of the right for self-determination in care, a principle sanctioned by the Michigan Mental Health Code that mandates least-restrictive environments. In-home care also supports people with disabilities in exercising their choice to live in the community as protected by Olmstead v. L.C., 527 U.S. 581 (1999) (See Appendix B), a United States Supreme Court case regarding discrimination of people with disabilities in institutions as well as the Americans with Disabilities Act (1990), which prohibits discrimination of persons on the basis of disability.

Coverage Level and Care Complexity Issues

In-home attendant care and nursing services are provided to individuals with qualifying care needs by family members, private arrangements, or commercial agencies. In-home care provides the option for an injured person to live in an environment that is as close to "normal" as possible. Qualifying care needs may include supervision and behavior management, personal care, and transportation. Sometimes complex skilled nursing treatment and oversight are met by caregivers qualified to carry out the tasks under the direction of a physician with special knowledge of injury-related care needs.

The "In-Home Care Plan"

An "In-Home Care Plan" is an assessment of needs and an identified strategy to meet the needs of the injured individual in their own home. It should identify the hours of care needed by the patient per day and the level of complexity of care need. Ideally, an In-Home Care Plan is developed by a rehabilitation professional with input from other rehabilitation professionals around goals identified by the patient and family, and approved by the patient's treating physician.

An In-Home Care Plan should restore a person with a disability to their fullest capacity in roles with family and community relationships, as well as leisure and work activities in a setting that least impinges on their freedom, self-control, and direction. Rehabilitation involves re-learning once-familiar tasks. Providing in-home care allows people to recover and rehabilitate in an environment that is familiar and relevant to them. If attendant care is needed, the patient and family must also determine if the care will be provided by family members, private arrangement, a commercial home care agency, or a combination of agency and family or private care.

Patient's Right to Choose Service Providers

As a part of the Michigan No-Fault Law it is the prerogative of an injured individual and their family to choose service providers. Therefore families may elect to be caregivers and be paid directly by insurance companies. The involved treatment team should determine if the family or providers of in-home care are able to safely meet the needs of the individual. While the needs of the injured individual are paramount, safety and interests of the caregivers is also an important consideration in this judgment.

Coverage: Number of Hours of Care Needed Per Day

An injured person may require continuous or intermittent care. The required number of hours of care is determined by a qualified physician in collaboration with pertinent professionals that may include a physical therapist, occupational therapist, speech-language pathologist, neuropsychologist, behavior analyst, social worker, and/or rehabilitation nurse.

For physical needs, such as spinal cord injury or orthopedic disability, professionals such as physical and occupational therapists are often consulted. Cognitive and behavioral issues are best addressed collaboratively with a neuropsychological evaluation in consultation with other professionals (See Appendix C).

Special Considerations for Children

Care by parents of minor children is a pre-existent commitment of family resources. The number of hours paid to family caregivers for children and adolescents is addressed by comparing the current care needs of the patient to his or her parenting needs had the child not been injured.

Complexity: Level of Care

The two main levels of care an individual with an injury might require are "non-skilled" care and "skilled" care. Skilled care includes tasks that require ongoing clinical reassessment of the patient's condition. Within each level are sub-levels of care requiring varying training, skills, oversight, and experience. This is represented in Table A below.

In the case of physical limitations by the patient, care needs are more obvious and are often easier to classify. For instance, a ventilator-dependant patient requires skilled nursing. A patient with a spinal cord injury who is not ventilator-dependent often still requires complex or advanced attendant care for bowel and bladder care.

In the case of traumatic brain injury, the patient may have no visible limitations, but may have cognitive/behavioral issues jeopardizing safety. For example, a detailed behavior plan is often implemented by an attendant providing advanced or complex care requiring specific training and professional oversight.

TABLE A

LEVEL OF CARE	DESCRIPTION OF PROVIDER	QUALIFICATIONS	DESCRIPTION OF CARE
"Non-skilled" care	Sitter or companion	Adult with basic knowledge and required skills	Orienting, safety monitoring, generally no hands-on care.
	Basic	Adult with basic knowledge and required skills including additional training	Personal care and support
	Advanced care attendant	Adult with advanced knowledge and required skills, demonstrated competencies, and experience with regular oversight by a qualified rehabilitation professional	Demonstrated competence in complex care tasks
	Complex care attendant	Adult with advanced knowledge and required skills, demonstrated competencies, specialized training, and experience with regular oversight by a qualified rehabilitation professional	Demonstrated competence with complex care including elements of skilled nursing care
"Skilled" care	Skilled nursing LPN/RN	LPN/RN	Standard training for nursing
	Advanced skilled nursing LPN/RN	LPN/RN	Specialized training for nursing (ie: ventilator management)

The Process of Determining and Structuring Care

The process of establishing a home care arrangement starts with a qualified physician or other medical professionals who are fully knowledgeable of the specifics of the patient's medical condition and needs. Following consultation with other professionals as needed, the physician or other medical professional writes a formal prescription for the number of hours and level of care needed by the patient.

As with all allowable expenses, the compensability under the No-Fault statute always comes down to physician verification that the service involved is "reasonably necessary" for the care of the injured person.

With care needs stipulated in this manner, families and individuals then must decide how to meet care needs. Several options are available to structure care. These options and their advantages and disadvantages are available in Table B.

Special Considerations for Families

Families often become providers of in-home care. The requirements on families can be extensive and detract from other productive roles. A family member may forego roles of employment, homemaking, and other responsibilities in order to provide this care, making appropriate compensation reasonable and necessary.

TABLE B

TYPE OF CARE	DESCRIPTION	WHEN APPROPRIATE	ADVANTAGES	DISADVANTAGES
Family/ Family hired	Independent caregiver All caregivers are family or privately arranged relationships	Family demonstrates competency and interest Family has no record of abuse or criminal record	Care within familiar structures Financial support for families Immediate acceptance of caregivers	Family may become dependent on income Financially dependent families may have difficulty supporting transition to independence May have altered relationship roles May have limited experience or no formal training/ education Limited access to continuing education No worker compensation protection or other formal employment benefits Difficult to measure outcomes or establish standards of care

(Table B Continued on next page…)

TABLE B (continued from page 6)

TYPE OF CARE	DESCRIPTION	WHEN APPROPRIATE	ADVANTAGES	DISADVANTAGES
Agency	Commercial agency employed caregivers	Family preference No family availability Family not qualified Complexity of care requirements Family prefers to maintain other employment	Rehabilitation professional oversight Establishment of a formal care plan Pool of screened and trained caregivers Accountability procedures and policies for needs Formal accreditation and standards of practice/ adherence to ethical standards, outcome measures, and standards of care Formal procedures for complaints and rights protection	Loss of family privacy from a home open to caregivers If living within a family, loss of family autonomy
Hybrid attendant care	Mixed arrangement of family/private and agency care-givers including agency-hired family members	Needs exceed family skills or preferences	Flexibility for family members as caregivers Structured respite support Skills sets available beyond family capacity	If living within a family, loss of privacy If living within a family, some loss of autonomy Integration of care styles between family and agency can be difficult

SPECIFIC CONCERNS AND RECOMMENDATIONS

Person-Centered Approach and Quality of Life

In-home care services, regardless of provider, should be provided in the context of a person-centered approach. The preferences and needs of the individual receiving care should be a primary consideration when structuring care arrangements. Many factors influence decisions regarding in-home care, such as the availability of appropriately skilled providers and a safe and appropriate home environment. These factors may influence the options for in-home care, residential placement, or selection of providers, but the preferences of the recipient of care should be given high consideration in the formulation of the arrangements.

Continuing Rehabilitation and Treatment

In-home care arrangements should support a person's expression of personal choice, access to opportunities for continuing rehabilitation and treatment, and where possible, the restoration of community independence. In-home care is not a substitute for rehabilitative treatment, but serves as an extension of well-structured intervention strategies.

Conflicts of Interest between Recipients of Care and Care Providers

Concerns emerge when family or caregivers become financially or otherwise dependent on the insurance benefits provided to the care recipient (wages for providing care, accessible housing, and other benefits). The care situation should always allow for progress of levels of independence, appropriate developmental transitions, and competent personal choice. Circumstances of a recipient of care having no access to external clinical supervision and oversight of any sort should be avoided as it risks a range of consequences that can include neglect or exploitation.

Safeguards should allow for support to transition to reduced levels of care where recovery or developmental changes support such progress. There are several avenues to safeguard the individual against conflicts of interest family caregivers or agencies might have including:

- A comprehensive In-Home Care Plan developed by an experienced and qualified rehabilitation professional is an established strategy to determine care needs, appropriate interventions, and define caregiver competence.
- At minimum, annual reevaluations of the In-Home Care Plan by an experienced and qualified rehabilitation professional should be conducted to identify changes in care needs due to progress, complications, resources, or personal choice.
- The reevaluation of the plan of care should include reevaluation of caregiver competence and performance if they are not overseen by an agency.
- A treating physician should conduct periodic assessments of the individual receiving care, including an exploration of the individual's developmental needs and preferences. Even in long-term care situations, physician review of the care plan should occur at least annually.
- Regular involvement with a broad network of community and medical supports.
- Required documentation and affidavit of the care provided with recourse if fraudulent billing occurs.

Changing Needs of Care

The intensity of care needs is expected to change over the course of recovery and adjustment to disability. Some persons may only have temporary needs for in-home care, while others may require such care indefinitely. Intervals of reevaluation will vary based on rates of change in function and medical status. At least annual review is recommended even in long-term care situations. Catastrophic injury is not a single event. It is a condition that results in dynamic ongoing care needs and interacts with other health conditions. As a result, attendant care needs may increase or decrease throughout an injured individual's life.

Cost Determination

The attendant care benefit is no different than any other allowable expense compensable under §3107(1)(a). Proof of its compensability as a No-Fault benefit depends upon proof of (1) the reasonableness of the amount of the charge; (2) the reasonable necessity of the service; (3) the causal connection of the need for service to injuries sustained in a motor vehicle accident.

The cost of in-home care is most often based on an hourly rate. This rate is determined by the complexity of the care to be provided. As with most employment, market conditions should determine the reasonable reimbursement for the care level provided. For example, the employment market would support that the cost of care for a ventilator-dependent patient provided by registered nurses and licensed practical nurses will be significantly greater than that provided for a less medically complex patient by an attendant, home health aide, or non-licensed or certified provider. The hourly rate for care, factored for complexity, times the number of hours per day prescribed by a qualified physician determines the overall costs of in-home care.

CONCLUSION

Since the Michigan Auto No-Fault Law was passed approximately 38 years ago, in-home care has offered catastrophically injured persons and their families the opportunity to remain together while allowing the injured person to realize maximum rehabilitation benefits and a desirable quality of life in the least-restrictive environment.

Recently, in-home attendant care has been the focus of some controversy including the perception of excessively high rates of reimbursement and excessive hours of care provided to individuals. Because of this perception, legislation has been promoted that would effectively eliminate opportunities for injured persons to receive in-home services by imposing levels of reimbursement below Medicaid rates, as well as limitations on the number of in-home care hours that could be provided on a weekly basis. These arbitrary limitations would undermine the care of some of the most injured individuals in Michigan. Instead, consideration should be given to providing the most appropriate level and coverage of care by completing a regular review of attendant care arrangements, and reducing the conflict of interests that can exist in care situations. Additionally, market conditions in different geographical areas should set the reimbursement rate for the varying levels of in-home care that is provided.

APPENDIX A

MAJOR PRINCIPLES OF THE ATTENDANT CARE BENEFIT

Based upon the analysis of the concept of in-home care or attendant care as an allowable expense benefit by our Courts, at least eight important principles have developed over the years. Those principles are as follows:

- Commercial Agency Care: Care which most often includes licensed registered nurses, licensed practical nurses, high tech aides or nurses' aides who provide medically related services, but which also includes personal care services, supervision, and monitoring is compensable as an allowable expense[1].
- Family Provided Care: Family provided care, which resembles in-home nursing care, is compensable as an allowable expense even though the family member providing the care has no formal medical training[2].
- Care for Minor Children: Parents of an injured child are entitled to be compensated for in-home attendant care services rendered to their child and are not precluded from recovering payment for such services merely by reason of the fact that they might be legally obligated to support their minor child[3].
- Supervisory and On-Call Care: Payment of reasonable charges for in-home attendant care services is not restricted to the provision of "hands on" or active care, but rather, can include reimbursement of such providers for "on-call" time or "supervision" or other ad hoc activities such as "cueing," where such services are reasonably necessary and the injured person is in need of such supervision or monitoring because they cannot be left alone safely [4]. For example, some patients will require on-call availability of a caretaker during the non-waking hours of the patient for the patient's safety and well-being.
- Reasonable Necessity: By definition, the attendant care being provided by either family or commercial providers must be "reasonably necessary" for the injured person's care, recovery, or rehabilitation[5].
- Reasonable Charge: The amount of compensation for an allowable expense, including attendant care payments, is based upon an evaluation of the nature of the service provided. Michigan is a fee-for-service system. There exist no fee schedules establishing what is or is not a "reasonable charge" within the definition of the allowable expense benefit. In the case of family-provided attendant care, determination of the appropriate rate depends on a number of factors including actual pay plus consideration of benefits an agency would typically pay. Our Courts have held that comparison to institutions provides a valid method for determining whether the amount of an expense was reasonable and for placing a value on comparable services[6].
- Incurred Expense: By definition, an allowable expense must be "incurred" to be compensable. This means that those providing the service must do so with the expectation of being compensated. However, the requirement that an expense be "incurred" does not require that the insurer be actually billed by family members who provide attendant care services[7].

- Fee Schedules Not Applicable: The Michigan No-Fault system is a fee-for-service system. Previous efforts by insurance companies to impose a managed care/fee schedule system were defeated in 1992 (Proposal D) and 1994 (Proposal C) by large voting margins. Efforts by insurers to impose third party fee schedules from the Workers' Compensation system or systems such as Medicare, Medicaid, Blue Cross/Blue Shield, HMOs, or PPOs have also been rejected by the Court of Appeals[8].

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[1] Green v Federal Kemper Insurance Company, 88 Mich App 364 (1979) and Manley v DAIIE, 425 Mich 140 (1986)
[2] VanMarter v American Fidelity, 114 Mich App 171 (1982)
[3] Manley v DAIIE, 425 Mich 140 (1986)
[4] Mase v Auto Owners, Court of Appeals Docket No 132002 (1992)
[5] Nasser v ACIA, 435 Mich 33 (1990)
[6] Manley v DAIIE, 127 Mich App 444 (1983)
[7] Booth v Auto Owners, 224 Mich App 724 (1997)
[8] Munson Hospital v ACIA, 218 Mich App 375 (1996) and Mercy Mount Clemens Corporation v ACIA, 219 Mich App 46 (1996)

APPENDIX B

Olmstead v. L.C., 527 U.S. 581 (1999)

The Supreme Court held that individuals with disabilities have the right to live in the community rather than in institutions if (1) their treatment professionals determine that they are able to live in the community; (2) the individuals do not object to living in the community; and (3) provision of services in the community can be provided without fundamentally altering the way in which the state serves similar people with disabilities.

APPENDIX C – Definition of Terms

NEUROPSYCHOLOGICAL EVALUATION – A comprehensive neuropsychological evaluation consists of a record review, interview with the patient and/or family, psychometric assessment, and the generation of a report that integrates all available information. A neuropsychological evaluation determines: (a) the pre-injury level of abilities of the individual, (b) the presence of any post-injury behavioral or cognitive deficits that warrant novel or additional attendant care services, and (c) the degree to which the latter need is related to traumatic brain injury or other pre-existing (e.g., mental retardation) or co-morbid (e.g., post-traumatic stress disorder) factors. It has been well-established that neuropsychological evaluation has incremental validity in the determination of the long-term outcomes of both pediatric[1] and adult[2] traumatic brain injury. Neuropsychologists also appreciate that there are several variables that may influence a person's performance and functioning (e.g., mood, pain, financial or personal incentives), and they have the opportunity to use objective symptom validity measures to determine if the patient's effort is sufficiently credible. It should be realized that the symptoms and needs of patients with traumatic brain injury may change over time; therefore, periodic neuropsychological reevaluations may be needed to update attendant care needs.

NEUROPSYCHOLOGIST – Clinical neuropsychology is a specialty profession that focuses on brain functioning. A clinical neuropsychologist is a licensed psychologist with expertise in how behavior and skills are related to brain structures and systems. In clinical neuropsychology, brain function is evaluated by objectively testing memory and thinking skills. A very detailed assessment of abilities is done, and the pattern of strengths and weaknesses is used in important health care areas such as diagnosis and treatment planning. The clinical neuropsychologist conducts the evaluation and makes recommendations. He or she may also provide treatment, such as cognitive rehabilitation, behavior management, or psychotherapy[3].

REHABILITATION PROFESSIONAL – A rehabilitation professional is a healthcare provider such as a registered nurse, case manager, life care planner, occupational therapist, physical therapist, speech language pathologist, vocational counselor, psychologist, behavior analyst, physician, or nurse case manager who has specialty training in rehabilitation of injuries specific to their discipline expertise and general knowledge of rehabilitation as part of an interdisciplinary team. Certified Brain Injury Specialist (CBIS) is a credential that is recognized by the Brain Injury Association as indicating a level of expert knowledge in brain injury and rehabilitation.

TREATING PHYSICIAN – A treating physician is defined as someone who provides the patient, or has provided the patient, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with the patient. Generally, the patient has an ongoing treatment

relationship with a physician when the medical evidence establishes that the patient sees, or has seen, the physician with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for the treated medical condition(s)[4].

[1] Miller, L.J., & Donders, J. (2003). Prediction of Educational Outcome after Pediatric Traumatic Brain Injury. *Rehabilitation Psychology*, 48, 237-241.

[2] Hanks, R. A., Millis, S. R., Ricker, J. H., Giacino, J. T., Nakese-Richardson, R., Frol, A.B., …& Gordon, W.A. (2008). The Predictive Validity of a Brief Inpatient Neuropsychologic Battery for Persons with Traumatic Brain Injury. *Archives of Physical Medicine Rehabilitation*, 89, 950-957.

[3] Clinical Neuropsychology: A Guide for Patients and Their Families. Public Interest Advisory Committee, Division 40 (Clinical Neuropsychology), American Psychological Association.

[4] McTaggart v. Astrue, 2009 U.S. App. LEXIS 18463 10th Cir. Okla. Aug. 17, 2009.

APPENDIX D – About MBIPC

The Michigan Brain Injury Provider Council's (MBIPC) purpose is to enhance the ability of its members to provide high quality, ethical rehabilitation, health care, and related services to people with brain injury. This is accomplished through resource sharing and information exchange, professional development and education, promotion of beneficial legislation, advocacy for brain injury services, and support of the Brain Injury Association of Michigan.

MBIPC members provide services to people who have sustained an acquired brain injury, including their families, throughout the state of Michigan. Members include organizations or individual professionals that provide direct products and services to people with brain injuries and/or their families, including but not limited to: hospitals, acute and post-acute programs, case management agencies, outpatient clinics, home-care agencies, private practitioners, legal representatives, advocates, and transportation providers. The Council is incorporated as a 501(c)6 organization.

Please visit www.MBIPC.org for more information.

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Nanci Steinebach, RN, BSN, CRRN, CCM has been a rehabilitation nurse for 19 years and is certified in rehabilitation and in case management. Ms. Steinebach directly manages a program that provides rehabilitation nursing and therapy services to neuro-trauma clients in their own homes. She works directly with nurses, physical therapists, occupational therapists, speech-language pathologists, therapeutic recreation specialists, social workers, case managers, physicians, and other allied professionals to provide care for the clients with brain injuries and as well as many other rehab diagnoses.

Cindy Stowe, RN, BSN, CRRN, CCM, CBIT, CLCP, has been specializing in catastrophic case management services for over 25 years and is the founder/owner of Ridgemoor Case Management Services. Cindy is widely recognized for her expertise in the area of home care needs, performing "Home Care Needs Evaluations" on a consultation basis. Her professional

experience also includes providing expert testimony in legal cases involving home care needs in a number of varied and complex cases.

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