10
Case Management in the Neuro-Rehabilitation Setting

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Introduction

Case management, as defined by the Case Management Society of America, is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes (Ahrendt, 2006). The case management profession was initiated in North America in the early 1900s within the field of community mental health. Case management providers were public health nurses who coordinated patient services. After World War II, case managers were employed to help coordinate care for servicemen who required multiple medical specialties to optimize their recovery. In the private sector, insurance companies began to employ nurses to manage health insurance claims for complex cases. As the practice of case management grew, other professionals were brought in to provide neuro-rehabilitation case management (Fitzsimmons, 2003).

Neuro-rehabilitation services grew in demand in the late 1970s and early 1980s, as improved medical care led to increased chances that a patient would survive a catastrophic injury. Neuro-rehabilitation programs responded to this demand by offering a variety of services. The most comprehensive programs offered case management services, also known as service coordination.

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The Brain Injury Association of America states that there is an annual occurrence of 1.4 million traumatic brain injuries (TBI) a year (www.biausa.org). Thurman et al. (1999) estimated that 80,000 to 90,000 of those brain injuries result in long-term disability. The National Institutes of Health (1998) issued recommendations regarding rehabilitation practices for persons with TBI, which included case management as a component of the extended care and rehabilitation available to TBI survivors. Because survivors of brain injury often have complex needs, including physical, cognitive, and emotional challenges, many of which can be life-long,

there can be many professionals involved in the rehabilitation and recovery process. It is essential to coordinate the care and services provided, and to have a "point person" who can act as a liaison between the various providers, family members and insurance company representatives. The key staff member responsible for this care coordination is the rehabilitation case manager.

The Difference between Rehabilitation Case Management and Insurance Case Management

Rehabilitation case management differs from insurance case management in a number of ways. Insurance case managers are employed either directly by the insurance company or indirectly through a private case management firm that contracts with the insurance company. For survivors with moderate to severe injuries, families are encouraged to request the assignment of an insurance case manager to monitor care and help ensure the survivor gets all the services he/she is entitled to. It has been demonstrated that individuals whose insurance case managers are able to provide financial assistance and independently authorize rehabilitation treatment will fare better than those whose insurance case managers are not able to autonomously authorize treatment (Ashley et al., 1994). While some insurance case managers are able to visit survivors in their home or at the rehabilitation program, most are dependent upon written and verbal reports to monitor progress.

Rehabilitation case managers are employed by the rehabilitation facility and are the liaison with the insurance company case manager. They are able to interact with and observe the survivor on a daily basis and have the important responsibility of providing as comprehensive a clinical description to the insurance case manager as possible, usually by telephone or written correspondence.

Ideally, both insurance and rehabilitation case managers will work together with the survivor and family to monitor medical needs and utilization of benefits. The goal is to maximize the individual's benefits, by structuring services so that the benefits are utilized over the greatest length of time at the lowest frequency of use (Cesta, 2002).

Qualifications of a Neuro-Rehabilitation Case Manager

Rehabilitation case management is traditionally conducted by certified rehabilitation counselors and certified case managers who hold professional degrees in rehabilitation counseling, nursing or social work. Other professionals such as psychologists, speech/language, and occupational therapists can be trained as case managers. The Commission on Rehabilitation Counselor Certification (www.crccertification.com) is responsible for certification of professional counselors who specialize in rehabilitation. Case management certification is

also available through the Commission for Case Manager Certification (www.ccmcertification.org). Neuro-rehabilitation case managers can also become certified as brain injury specialists, through the Academy of Certification for Brain Injury Specialists (www.aacbis.net).

Rehabilitation case management requires many different types of skills. From an interpersonal perspective, case managers must be able to work in an empathetic and supportive manner with survivors and families and possess excellent communication skills (Goodall, et al., 1993). In addition to strong interpersonal skills, it is important for a case manager to have clinical experience in brain injury rehabilitation and to be appropriately credentialed. Clinical experience provides the case manager with a deeper understanding of the complex needs of brain injury survivors. It is also critical for case managers to be familiar with various advocacy organizations, social service agencies, entitlement programs and legal rights of individuals with disabilities. These include the national and state chapters of associations for individuals with neurological illnesses/injuries (e.g., Brain Injury Association of America, American and National Stroke Associations); benefits available through the social security administration (e.g., social security disability insurance, supplemental security income); workers' compensation; state programs/funding for crime victims; housing options; programs for students with disabilities; vocational rehabilitation agencies; medicare, medicaid, and medicaid waiver programs; para-transit services; recreational programs; companies specializing in environmental modifications; the Americans with Disabilities Act (ADA); the Family Medical Leave Act; Individuals with Disabilities Education Act (IDEA) and other pertinent legislation (Goodall et al., 1993).

Funding for Case Management Services

Funding for case management can be obtained through private or public funding streams. Private funding examples include insurance companies that hire case managers to perform utilization review activities and service coordination, comprehensive rehabilitation programs that employ case managers to coordinate clients' services, and families who hire private case managers to help them better coordinate the multiple needs of the survivor.

Public funding for case management can be obtained through those states that offer medicaid waiver programs with specific Home- and Community-Based Services (HCBS) for individuals with acquired brain injury. Medicaid HCBS waiver programs are designed to help survivors live in the least restrictive setting. Participants agree to waive their right to placement in a nursing home. Case management services, usually referred to as service coordination, are provided so that the waiver participants can access various services and therapies outside of the nursing home setting in their own communities. In 2001, Medicaid HCBS waiver programs were offered in 20 states. The programs are funded by tax dollars and/or dedicated fines such as those levied on individuals who are charged with

driving while intoxicated (Vaughn & King, 2001). A comparison study across various states demonstrated that traumatic brain injury waiver programs saved various states millions of dollars in Medicaid funding that would have previously been spent on nursing home costs (Spearman et al., 2001). As of 2006, there are 48 states and the District of Columbia that offer Medicaid HCBS waiver programs (www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp).

AB was 18 years old when he sustained a traumatic brain injury due to a motor vehicle accident. He was just about to begin college at the time of the injury. Post-injury sequelae included hemi-paralysis, a severe speech impairment, and memory problems. His mother was actively involved in his recovery. She maintained him on her employer's health insurance plan as a disabled adult child. The rehabilitation case manager worked with his mother as relentless advocates when the insurance company frequently denied his treatment. When his insurance was exhausted, she enrolled him in the Medicaid HCBS waiver program, so that he was able to receive structured services that improved his functional status. Over the years of treatment he progressed from using a wheelchair to using a cane for long distances. While his speech remains very difficult to understand, he uses an augmentative communication device. The service coordination of the Medicaid waiver program provided enough structure and support that his mother was able to continue working. Her employer's health insurance also provided AB with the opportunity to access more rehabilitation services than the HCBS waiver program was able to offer. Keeping this young man in the community in the least restrictive setting was clearly beneficial to him. It also saved the taxpayers many thousands of dollars over the course of his lifetime. His mother benefited as well, knowing that her son was receiving excellent treatment in a structured day program as well as the love and care of his home environment each night.

Clinical Case Management Responsibilities

Establishing Rapport, Building Trust, and Empowering Clients

Establishing rapport with survivors and their families is a key component of successful case management. To establish rapport, the case manager should use each point of contact as an opportunity to foster a productive working relationship with the survivor and the family, and reinforce active involvement in the rehabilitation process. Family involvement is an important factor in successful outcomes; although Kreutzer et al. (1997) emphasized that there are many reasons why engaging the family as effective rehabilitation partners is complex and not easily achieved. Challenges in productive family involvement can include cultural differences (Simpson et al., 2000) as well as unstable pre-injury family dynamics magnified post-injury. It is important for the case manager to provide sufficient time, reassurance and resources to overwhelmed families to help them establish trust and reduce tension. It is also helpful to make certain that families receive training on constructive coping skills to deal with the frustration, stress and anger

they may be experiencing. Referral for individual, group, and/or family counseling as needed is critical.

During the initial meeting, the rehabilitation case manager should gather a medical, psychosocial and employment history as well as goals for discharge. In addition to information gathering, the case manager should be a provider of information and education to the survivor/family at this time. He/she should educate them about the role of the rehabilitation case manager. In most cases, family members have never worked with a case manager and don't know what to expect (Fitzsimmons, 2003). For families of inpatients, it is important to review program policies, visiting hours, and information about passes. It is also important to provide an overview of what the survivor/family can expect (e.g., estimated length of stay, possible next steps such as homecare or outpatient therapy) over the coming weeks/months. It is always helpful to provide written material, such as an orientation booklet, to supplement verbal information. While it is important to recognize that families will vary on the amount of contact, information, and involvement they expect or desire, it is generally useful to arrange follow-up meetings at regular intervals to discuss progress toward goals, barriers and next steps.

Throughout the entire process of establishing rapport and building trust, a case manager needs to demonstrate effective interpersonal skills. Case managers need to be aware of not only what they say, but also how they say it. Survivors and families need to be treated with respect and dignity, especially as they find themselves in the vulnerable position of requiring the aide of others around them. Mozzoni and Bailey (1996) noted that clinicians who received training on how to effectively give feedback helped to improve the functional outcomes of their clients. Case managers must be attuned to the awareness and motivation levels of survivors. Miller et al. (1999) describe how the transtheoretical model of change (Prochaska et al., 1992), which has been used successfully in the field of addictions, can be applied to the rehabilitation setting. The stages include precontemplation, contemplation, determination, action, maintenance, and relapse. Precontemplation is marked by lack of awareness of deficits. Contemplation is the stage in which the individual has some awareness of difficulties but is ambivalent about making change. The determination stage is when an individual expresses awareness and the desire to change. In the action stage the individual is fully engaged in rehabilitation. Maintenance occurs as the individual attempts to maintain the gains that he or she has made during rehabilitation. Relapse occurs when prior behavior patterns return as the main method of functioning. At this point, the case manager's role is to help the individual move through the early stages of precontemplation, contemplation and determination (Van der Broek, 2005).

It is important to empower survivors and families to become self-advocates versus fostering dependence. Case managers can find themselves involved in performing tasks for survivors and families that they can easily do for themselves. The relationship between the case manager, survivor, and family should be an active partnership. By fostering a mutual partnership, the case manager is assisting the survivor in regaining independence (Fitzsimmons, 2003). One practical way to

empower survivors and families is to work with them to set goals for various tasks that can be accomplished from one appointment to the next and to encourage collaboration. The level of collaboration varies depending on the extent to which the survivor can manage his or her own goals. Active problem solving can help engage the survivor in the process of setting goals (Van der Broek, 2005).

A family's coping style can influence how they handle their loved one's injury. Kosciulek (1994) identified two coping styles that were predictive of family adaptation: positive reappraisal and tension management. Positive reappraisal refers to the ability to redefine stressful events to make them more manageable, while tension management is characterized by a family's belief that the problems that they are encountering can be successfully overcome.

Development of Goals

With feedback and input from all members of the interdisciplinary team, the case manager can work with the survivor and family to set short- and long-term goals. The process of goal-setting involves arriving at an overlap between the needs and wants of all who are actively involved. Survivors who are actively involved in their own goal-setting have a higher level of goal attainment than those who are not as actively involved in the process (Webb & Glueckauf, 1994). Goal-setting can be achieved through a sequence of steps, including problem identification, goal definition, option appraisal, and solution selection. For instance, if after undergoing a neuropsychological evaluation, a survivor identifies that he has a memory problem, he and the rehabilitation team may develop a goal of needing to use an external memory aid/device. Working with his family and therapist(s), the survivor can then appraise the various devices available and select one (e.g., daily planner) that best meets his needs. The clinical team facilitates the movement through these different steps by discussing pros and cons of change, removing barriers, emphasizing personal choice, and clarifying details on the use of the chosen assistive device (Van der Broek, 2005).

Monitoring Overall Treatment and Progress

Rehabilitation case managers monitor the survivor's progress through a number of different means. During interdisciplinary meetings, the rehabilitation case manager can gather feedback from the various team members on the survivor's progress. If the individual is making satisfactory progress across all disciplines then the rehabilitation case manager can use the review to help plan for next steps. If the survivor is making less than adequate progress, the case manager and team can discuss ways to overcome obstacles/barriers to progress.

In addition to team meetings, case managers need to review discipline specific progress notes, observe survivors in treatment sessions and communicate regularly with the survivor and family, to obtain information that may not be discussed or available during team meetings. By using all of these tools, the rehabilitation case

manager will be able to obtain the most comprehensive picture of the survivor, provide a projected discharge date from the current level of rehabilitation program, and offer guidance regarding future rehabilitation, medical and psychosocial needs.

Discharge Planning

Discharge planning from an inpatient rehabilitation program aims to prepare the survivor and family for a positive transition to home and the surrounding community. With input from various members of the interdisciplinary team, the case manager must address the amount of assistance or supervision needed, and help the survivor/family determine how this can be provided upon discharge (e.g., by hiring a 24-hour aide, or moving into an assisted living facility). Equipment needs (e.g., walker, augmentative communication device), and environmental modifications (e.g., grab bars, ramp) must be determined and completed prior to discharge. Recommendations for continued rehabilitation (e.g., home-based or outpatient therapies) must be ascertained and referrals made to ensure continuity of care. While usually the primary goal for the brain injury survivor, discharge to home can be an overwhelming prospect to families. They may feel their loved one has not progressed enough and needs more therapy before being discharged, or that they are unprepared to manage the burdens of time and care that many survivors will need upon returning home. It is critical that the case manager communicates openly and works collaboratively with the survivor and family from the outset, in order to minimize shock, upset and crises that can occur close to discharge.

Discharge planning in an outpatient setting typically involves assisting the brain injury survivor to develop and achieve realistic goals in areas such as homemaking, caretaking, employment, school and social/leisure activities. A primary goal upon discharge from outpatient rehabilitation is for the survivor to be actively engaged in regular, productive activities, which promote physical, cognitive, and emotional health, and are pleasurable and meaningful to the individual. The transition from a structured to an unstructured environment can be very challenging for the survivor. Discharge planning must help to replace the structure of rehabilitation with the structure of meaningful activities and daily functional tasks. At this level of care, it becomes crucial for the case manager to work with other agencies, organizations, or providers, to develop a broad community-based network that can support the survivor and family. Survivors and families also benefit from follow-up phone calls or meetings to ensure that they are making a smooth transition to home/community activities, and are demonstrating carry-over of the rehabilitation gains into these naturalistic settings.

Interdisciplinary Team–Family Meetings

It is important to provide feedback to survivors and families, to increase awareness of limitations and strengths, discuss progress, and ensure collaborative goal setting. The survivor is much more likely to be open to feedback if family members validate the concerns and recommendations of the treating therapists. The interdisciplinary

team–family meeting can be an effective forum for providing feedback, as well as gaining valuable insights that can aid in treatment, and establishing a collaborative relationship between the survivor, family and rehabilitation team. It is important that the case manager meet with the team ahead of time to coordinate the information that is to be communicated, and avoid mixed or conflicting messages. A structured agenda can assure increased productivity and efficiency. Case managers need to be sensitive to the possibility that survivors may feel overwhelmed during family/team meetings and should try and create a comfortable, nonthreatening environment (e.g., open circle versus conference table set-up). Abreu et al. (2002) described a survivor-centered approach to interdisciplinary team meetings, emphasizing the value of concise team meetings with active survivor involvement. Team meetings should include written agendas, summary of goals and the survivor should have the option to audiotape or videotape the meeting. Survivors can be encouraged to take notes at the end of meetings to facilitate recall of the main points reviewed. At the conclusion of the meeting, the case manager should schedule a follow up meeting so the survivor and the family understand that they will have on-going opportunities to provide and receive feedback in a formalized manner.

Administrative Case Management Responsibilities

Case managers are responsible for a wide variety of administrative matters that include obtaining authorizations from funding sources, integrating interdisciplinary progress notes and coordinating treatment. The case manager must ensure early on that the survivor and family understand the benefits and limitations of their particular insurance. In addition to discussing private insurance benefits, case managers must understand and be prepared to talk with survivors and families about accessing public insurance programs such as Medicaid and Medicare very early in the rehabilitation stay, when it is often clear that the survivor may need to access those types of public benefit programs after they exhaust their private benefit plans. The case manager must be able to guide and assist families in taking the necessary steps to apply for the appropriate programs.

In most private insurance plans, primary care physicians play a critical role in helping survivors to access medical benefits of all types. As a result, case managers must work with families to obtain primary care physician (PCP) referrals and inform families when referrals and benefits are about to exhaust. They should encourage families to monitor the referrals and to learn how the appeals process works for their insurance company. The more informed the family, the better advocates they can be.

Insurance Authorizations/Advocacy

One of the most critical administrative tasks for the case manager is to obtain treatment authorization from insurers. It is important for the rehabilitation case manager to learn about policy restrictions and limitations. Whenever possible, the

survivor or family can be asked to provide a copy of the insurance policy benefits booklet for the case manager to review. If the policy book cannot be located, then the family and rehabilitation case manager can call the insurance company jointly to verify the level of benefits available. Survivors who are still employed may be able to use the human resources division of their company to locate information about their insurance benefits. Another important factor to consider when obtaining information about a survivor's policy is whether it is "contractual" or "as medically needed." A policy that has contractual limits (e.g., 30 days maximum of acute rehabilitation) is much more limited than one based on medical necessity.

Each insurance company has its own set of requirements and paperwork that must be submitted in order to obtain authorizations. In general, most insurance companies want progress reports to support each request for authorization. The case manager can generate these progress reports by incorporating key information from each member of the interdisciplinary team, or the case manager can simply send each discipline's individual progress report. In either case, progress reports must reflect the details of progress and continued goals across all disciplines, in order to justify additional treatment. Documentation must indicate the medical necessity of continued treatment, and the expectation for significant functional improvement over a reasonable period of time, as most insurance companies do not provide coverage for "maintenance" therapy. If a survivor has not made significant gains during a given reporting period, it is important to provide the reason for the lack of progress, and plans to overcome the barrier(s). If the insurance company denies an authorization for treatment that the interdisciplinary team feels is justified, family members have the option of filing an appeal with the insurance company. This type of appeal is called an internal appeal. If an internal appeal is denied, the family can then file an external appeal (e.g., with the state insurance department). Additionally, families may decide to utilize attorneys, advocacy organizations or local/state representatives to support them in advocating for the survivor to receive continued services.

Coordination with Other Care Providers

Coordinating treatment between the neuro-rehabilitation team and other care providers (e.g., primary care physicians [PCP]) is another responsibility of the rehabilitation case manager. The PCP can be very supportive of the need for rehabilitation and can help advocate for continued care when indicated. Many health maintenance organization (HMO) plans require that the PCP be a "gate-keeper" and write referrals for treatment. This means that the case manager will need to routinely call the PCP's office to obtain referrals if the family member cannot obtain the referrals for treatment. PCPs also have an active role in referring survivors to other specialty physicians when the need arises. Once consent to release information is obtained, case managers can help survivors by calling the new specialty physician in advance of the appointment to describe the relevant issues and forward appropriate medical information. The case manager needs to follow up with the survivor, family and specialty physician to learn the outcome of the visit. The

PCP will often be the one provider who continues to follow the survivor after rehabilitation ends. Keeping the PCP informed of rehabilitation progress and goals, as well as post-discharge recommendations, can help ensure good continuity of care.

Coordination with Attorneys

Rehabilitation case managers must often provide information to attorneys, with the survivor's consent/request. In the field of brain injury rehabilitation there can be multiple attorneys working with one survivor. The most common types of attorneys for this population are personal injury and workers' compensation attorneys. Some survivors may also retain attorneys for social security or for disability insurance matters. In any case, attorneys may call upon the rehabilitation case manager to solicit verbal feedback regarding a survivor's progress, and obtain updated progress/evaluation reports, especially if a court appearance is approaching. Attorneys may ask rehabilitation case managers to project a list of the survivor's current and future needs so as to put a dollar cost on the amount of care that will be needed during the individual's lifetime. While rehabilitation case managers are not expected to be life care planners, it is important to be able to provide estimates of current and future needs.

Coordination with Schools, Vocational, and Social Service Agencies

As discharge approaches, there is often a need to refer survivors to other agencies for supportive services and programs. Generally, each of these services or programs requires an application or exchange of information regarding the survivor's abilities or difficulties. To complete most referrals, rehabilitation case managers must fill out paperwork, submit progress reports, schedule evaluations, and/or medical appointments that will document the survivor's medical condition and level of functioning.

For school-age survivors and those entering or returning to college, there are various considerations that must be addressed. Each student's unique needs must be taken into consideration. Depending on how severe the brain injury, some students may benefit from classification as special education students. This classification process entitles the student to a variety of services and accommodations that are mandated by federal law and documented in an individualized education plan (IEP). Some of these accommodations are as follows: longer time for tests and projects, assigned note-takers, permission to use a tape recorder during lectures, private tutoring, and alternate forms of testing. Rehabilitation case managers can help guide students and their families through the classification process, and work closely with school personnel to provide information regarding the student's cognitive, emotional, and physical strengths and limitations.

For adults who need vocational services, each state runs its own vocational services office. This office helps individuals with disabilities by sponsoring vocational

evaluations, training and placement, and sometimes funding academic-related needs such as books, personal computers, and tape recorders. When referring brain injury survivors for vocational services, the rehabilitation case manager must work with the survivor and vocational counselor to ensure adequate follow-through. The rehabilitation facility will be asked to supply a copy of the records for each survivor. The case manager can assist the survivor in making sure that they are ready for the initial interview and that they understand the various steps in the process. The case manager should monitor the intake and evaluation process for problems. Survivors can get confused during the evaluation process, as it usually occurs over a several-week period. They may require much support and encouragement to persevere and complete the evaluation.

For survivors who are near retirement age or who are not going to be returning to work, it is critical for the case manager to help them establish a daily structure so they can maintain their functional skills and prevent regression. This can include referrals to social service agencies that offer leisure/recreational programs. Unfortunately, actual options can be limited due to barriers such as transportation, cost, or level of independence required. Nevertheless, case managers should acquaint themselves with various programs in the community. Alternative options such as adult education classes at local colleges or volunteer work may be more suitable for some survivors. Provision of information about local support groups for survivors and caregivers is essential.

Conclusion

Case management in the neuro-rehabilitation setting can be challenging and demanding. To be an effective rehabilitation case manager, a clinician must have excellent clinical, administrative and interpersonal skills. Knowledge of brain-injury-specific community resources, laws, and public benefit programs is vital. Rehabilitation case managers assist the survivor and family in navigating the different aspects of the neuro-rehabilitation program and help integrate the various components into a treatment plan that is well coordinated, collaborative and survivor-centered.

References and Resources

Abreu, B.C., Zhang, l., Seale, G., Primeau, L., Jones, J.S. (2002) Interdisciplinary meetings: Investigating the collaboration between persons with brain injury and treatment teams. *Brain Injury* 16(8):691–704.

Ahrendt, L. (2006) What is a case manager? http://birf.info/home/library/records/reccase_whatcase.html)

American Academy for the Certification of Brain Injury Specialists, www.aacbis.net.

Ashley, M.J., Lehr, R.P., Krych, D.K., Persel, C.S., Fledman, B. (1994) Postacute rehabilitation outcome: Relationship to case-management techniques and strategy. *Journal of Insurance Medicine* 26(3):348–354.

Brain Injury Association of America, www.biausa.org, 8201 Greensboro Drive, Suite 611, McLean VA 22102, Tel. 703-761-0750

Centers for Medicare and Medicaid Services. www.cms.hhs.gov/MedicaidStWaivProg DemoPGI/05_HCBSWaivers-Section1915(c).asp

Cesta, T.G. (2002) Close Up and Personal. *Case Management* 8(2):46.

Commission for Case Management Certification, www.ccmcertification.org

Commission on Rehabilitation Counselor Certification, http://www.crccertification.com/

Fitzsimmons, R.D. (2003) Brain injury case management: The potential and limitations of late stage intervention-a pilot study. *Brain Injury* 17(11):947–971.

Goodall, P., Dedrick, D., Zasler, N.D., Kreutzer, J.S. (1993, Sept–Oct) Survey of case manager training needs in traumatic brain injury. *Brain Injury* 7(5):455–461.

Kosciulek, J.F. (1994) Relationship of family coping with head injury to family adaptation. *Rehabilitation Psychology* 39:215–230.

Kreutzer, J.S., Sander, A.M., Fernendez, C.C. (1997) Misperceptions, mishaps, and pitfalls in working with families after traumatic brain injury. *Journal of Head Trauma Rehabilitation* 12(6):63–73.

Miller, W.R., Zweben, A., DiClemente, C.C., Rychtarik, R.G. (1999) *Motivational Enhancement Therapy Manual*, National Institute on Alcohol Abuse and Alcoholism, US Department of Health and Human Services.

Mozzoni, M.P., Bailey, J.S. (1996, 2) Improving training methods in brain injury rehabilitation. *Journal of Head Trauma Rehabilitation* 11(1):1–17.

National Institutes of Health (1998, October 26–28). Rehabilitation of persons with traumatic brain injury. *National Institutes of Health Consensus Statement* 16(1):1–41.

Prochaska J.O., DiClemente, C.C. Norcross, J.C. (1992) In search of how people change: Applications to addictive behaviors. *American Psychologist* 47(9):1102–1114.

Simpson, G., Mohr, R., Redman, A. (2000) Cultural variations in the understanding of traumatic brain injury and brain injury rehabilitation. *Brain Injury* 14(2):125–140.

Spearman, R.C., Stamm, B.H., Rosen, B.H., Kaylala, D.E., Zillinger, M., Breese, P., Wargo, L.M. (2001) The use of Medicaid waivers and their impact on services. *Journal of Head Trauma Rehabilitation* 16(1):47–60.

Thurman, O.J., Alverson, C., Dunn, K.A., Guerrero, J., Sneizek, J.E. (1999) Traumatic brain injury in the United States: A public health perspective. *Journal of Head Trauma Rehabilitation* 14(6):602–615.

Van der Broek, M.D. (2005) Why does neuro-rehabilitation fail? *Journal of Head Trauma Rehabilitation* 20(5):464–473.

Vaughn, S.L., King, A. (2001) A survey of state programs to finance rehabilitation and community services for individuals with brain injury. *Journal of Head trauma Rehabilitation* 16(1):20–33.

Webb, P.M., Glueckauf, R.L. (1994) The effects of direct involvement in goal setting on rehabilitation outcome for persons with traumatic brain injuries. *Rehabilitation Psychology* 39(3):185.