WakeMed Rehab Hospital Stroke Rehabilitation Scope of Service

WakeMed Rehab Hospital provides an integrated, comprehensive delivery of rehabilitation services utilizing evidenced-based practice directed toward a population of individuals who have sustained a stroke. Admission to WakeMed Rehab Hospital benefits these individuals in ways not otherwise possible by developing and restoring skills toward independence and decreasing the dependency effect on their families and communities.

The scope of the Stroke Program addresses the unique aspects of delivering care to the person served according to their individual needs regarding impairment, activity level, and participation in the following areas:

- Recognizing, assessing, and treating conditions related to stroke and its complications
- Prevention of conditions related to stroke and its complications
- Identifying and reducing risk factors for recurrent stroke
- Promoting lifestyle changes that focus on reducing modifiable risk factors for stroke recurrence
- Facilitating functional independence and performance
- Facilitating psychological and social coping
- Facilitating adaptation skills
- Facilitating community integration and participating in life roles
- Providing services for families and support systems
- Promoting use of assistive technology

WakeMed Rehab receives referrals from many sources, including, but not limited to, private physicians, acute care hospitals, nursing facilities, Wake County Health Department, WakeMed Home Health, WakeMed Emergency Departments, local urgent care centers, and follow-up appointments from former inpatients and outpatients. The majority of Rehab Hospital patients served are from central and eastern North Carolina, however all referrals from outside the primary catchment area are considered for admission.

Admission decision-making occurs within a team process by evaluating the patient's impairments, activity, and participation limitations and determining rehab needs and potential for functional improvement. Additionally, the program's ability to meet the patient's needs and recognize community resource alternatives and availability is assessed. WakeMed Rehab serves patients ages four and up, though younger children may be accepted after discussion and approval of the Medical Director, Director of Rehab Hospital, and Director of Rehab Nursing on a case-by-case basis. Appropriate placement of each person served is also addressed through the admission and discharge/transition criteria for each

component of care, the resources available, resources previously used, ongoing reassessment, and the person's potential to benefit.
Payer sources for WakeMed Rehab include state and federal public payers (Medicare, Medicare Advantage Plans and Medicaid), commercial insurances, worker's compensation, and self-pay. Any payer requirements that would potentially affect the provision of services are identified and communicated to the treatment team, including the person served.

Annually, WakeMed reviews market comparisons, establishes reasonable rates for private and semi-private rooms, and updates the Charge Description Master for all services. Program fees are defined, and anticipated liability related to services are discussed with patients individually prior to admission and provided in writing via the Written Disclosure Form. On-going discussion of the financial impact of hospitalization and services post-discharge is the responsibility of the case manager.

The WakeMed Rehab Hospital Stroke Rehabilitation Program is medically supervised by a physiatrist who has expertise in the medical management and rehabilitation of people with a stroke. Services are provided by highly qualified professional staff designated specifically for the inpatient stroke rehabilitation program. Treatment space, team assignment, bed assignment, and equipment are also appropriate to the stroke rehabilitation program. WakeMed Rehab Hospital offers specialty equipment and modalities for rehabilitation that are aligned with evidence-based optimal stroke recovery, including FES cycles, x-cite, Bioness UE & LE, Lite Gait (bodyweight support with coordinating treadmill), Vector Safety System, MBSS, FEES, EksoNR, InMotion Arm, IOPI, sEMG, and Pet Assisted Therapy.

The majority of rehab services are delivered with the patient and the caregiver in the same space. Services delivered via information and communication technologies might include participation in support and education groups and virtual monitoring for falls prevention. Platforms used to deliver services via information and communication technologies include video conferencing (Zoom, Webex, Microsoft Teams, etc.) and platforms such as remote video monitoring. Patients participating in services being delivered via information and communication technologies have no geographical exclusions during the Rehab Hospital episode of care.

The person served, family members, caregivers, and support system are an integral part of the interdisciplinary treatment team at WakeMed. In addition, as appropriate, and based on need, the following professional disciplines and services are arranged either directly, by referral, or by contract:

SERVICE OFFERED	PROVIDED BY
Clinical Case Management	Directly
Rehabilitation Medicine	Directly
Rehabilitation Nursing	Directly
Occupational Therapy	Directly
Physical Therapy	Directly
Rehab Psychology/Neuropsychology	Directly

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Therapeutic Recreation	Directly
Clinical Dietician/Nutritional Counseling	Directly
Speech-Language Pathology	Directly
Wound Care	Directly/ Referral
Dialysis	Referral
Diabetic Educator	Directly
All medical, diagnostic, and laboratory	Directly/ Referral
Pediatric Services: • Pediatrician • Pediatric Hospitalist • Child Life Specialist	Directly/Referral Directly/Referral Directly Directly
Orthotics and Prosthetics: • Del Bianco • Beacon Prosthetic • Hanger • Limbionics • Bio Tech	Referral Contract Contract Contract Contract Contract
Department of Social Services	Referral
Social Security Administration	Referral
Community Support Agencies, Advocacy Groups, Support Groups	Referral
Mental Health and Wellbeing	Directly/ Referral
Optometry/ Neuro-ophthalmology/ Neuro-optometry	Referral
Durable Medical Equipment	Referral
Vocational Rehabilitation	Referral
Audiology	Referral
Spiritual Care Services	Referral
Palliative Care	Referral
Caregiver/Family Services	Directly/ Referral
Substance Abuse Counseling/Addiction Specialist	Directly/Referral
Sexual Function/Counseling	Directly/ Referral
Rehab Engineering	Directly /Referral
Drivers Assessment and Education	Directly/ Referral
Specialty Wheelchairs	Contract
Medical Interpreter Services	Directly/ Contract
Environmental Modifications/Assistive Technology	Directly /Referral
Aphasia Services	Directly/ Referral
Peer Support	Directly/ Referral

Provision is made to include all consulting services and external case managers as members of the

interdisciplinary team.

Upon admission to WakeMed's stroke rehabilitation program, each individual receives a comprehensive assessment and evaluation by each team member initially involved in provision of his/her direct treatment. Appropriate assessments are provided based on the ages, cognitive levels, interests, concerns, and cultural and developmental needs of the persons served. Designated space, equipment, furniture, materials, and a private area for family/peer visits are provided as appropriate. The stroke program is applicable to pediatric patients with special attention given to developmental needs and age-appropriate assessment/interventions.

With input from all team members, the physician develops an Individualized Plan of Care for each patient within four days of admission. The rehab treatment team will meet for an initial team conference to update the Plan of Care based on appropriate, achievable, functional goals and planned interventions necessary for goal achievement in a realistic time frame. Treatment planning includes a minimum standard of intensive rehab programming of either three hours of therapy per day, five days per week or fifteen hours of therapy over each seven-day period. Weekend therapy is routinely provided as recommended by the team and as part of the treatment plan. The Plan of Care is structured to include the patient/family's goals and discharge planning issues. An estimated length of stay and assessment of discharge needs are identified within the parameters of the long-term goals. Through the case management process, the Plan of Care is shared with the patient/family and, when appropriate, the individual's insurer to facilitate communication, reimbursement, and a collaborative discharge plan.

Patient and family involvement in the stroke rehabilitation program begins during the pre-admission and assessment phases and continues throughout the program. The inpatient rehab clinical case manager formally discusses the comprehensive plan of care, progress, and goals, with the patient/family, at least weekly. Discipline-specific goals focused on fostering self-management are discussed during treatment sessions and include the family during specific family training sessions as needed. Every effort is made to meet patient/family needs and goals through participation in the decision-making process. Goal conflicts are addressed primarily through the case management process or family conferences, but may also be addressed during family training sessions, individual treatment sessions, or other contacts with person served and/or family.

The Stroke Program provides or arranges for family/support system advocacy training, support services, education, family support, and sibling/peer support as appropriate.

Each patient's program includes Orientation, Assessment, Education, Treatment, Discharge Planning, and Follow Up. Evaluation, treatment, programming, and patient/family education focus on promoting the independence of the person served in the functional areas of:

1.Health/Medical Stability Prevention/recognition/assessment/treatment of conditions related to stroke and its complications bowel function/ continence, bladder

	function/continence, skin integrity, sleep/wake cycles, cardiovascular status, medication management, wellness promotion, contraindications.
2.Nutrition/Diet	Nutritional status, nutritional intake, hydration, assessment and interpretation of lab values, diet education.
3.Psychosocial	Support system, education, vocation, participation in life roles, patient/family understanding of illness, patient/family coping/adjustment/adaptation skills, insight, community and financial resources, discharge planning.
4.Behavior	Behavior management, social interaction, self-control, mood disturbances, anxiety
5.Mobility	Motor function, bed mobility, transfers, gait, wheelchair mobility, environmental barrier management
6. Self-care	Feeding, grooming, bathing, dressing, toileting, home management, visual or perceptual deficits.
7. Swallowing	Dysphagia assessment/intervention, objective swallow studies, modified diets, swallowing strategies.
8. Communication	Auditory comprehension, verbal/nonverbal expression, aphasia, speech intelligibility, reading, writing, hearing, other communication disorders
9. Cognition	Orientation, attention, memory, reasoning/problem-solving, visual/spatial.
10. Leisure	Leisure skills, social skills, community integration, community participation, leisure/recreation participation, resource awareness, adaptive leisure.
11. Environment	Level of stimulation, safety, fall risk reduction, accommodations, compensatory aids.

The stroke rehabilitation program identifies and provides or links with services and programs that, dependent upon the needs of the persons served, may include: emergent care, acute hospitalization, other inpatient programs, skilled nursing care, home care, other outpatient medical rehab programs, community-based services, residential services, vocational services, primary care, specialty consultants and long term care. Care planning also includes:

1. Contact with the patient's primary or referring physician and/or hospital.
2. Early identification of a realistic discharge destination.
3. Assessment of accessibility and characteristics of the discharge environment and community.
4. Identification of family/primary caregivers.
5. Identification of and referral to community support resources, including but not limited to advocacy services, counseling/support resources for individuals, family/caregivers.
6. Referral for continued rehabilitation therapy on an outpatient or home care basis.

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7. Referral to medical specialists for follow-up after discharge.
8. Education regarding prognosis, prevention, and wellness.
9. Referral to equipment, orthotic or prosthetic agencies.

The Stroke Program assists the person served to access community resources, use community systems, obtain appropriate equipment/supplies, and does provide referrals for expertise when appropriate.

Need for continued treatment is decided upon by all team members throughout the treatment process during team and family conferences, as well as informal treatment team conversations, and is based on:

1. Medical/physical problems, which can best be treated within the rehabilitation hospitalization.
2. Continued progress toward stated goals.
3. Expected improvement in function and independence.
4. Availability of alternative treatment or programming.

Discharge dates are planned or set when continued hospitalization is no longer necessary and/or the patient and family are adequately prepared and discharge destinations are finalized. The system of care identifies the skill sets necessary to be successful in the next environments of care for both the person served and the family/support system. The patient and/or the family are asked to demonstrate the skills required prior to discharge.

The Stroke Program provides an organized, coordinated, multi-modal education program about stroke for persons served and their family/support systems that includes education on:

1. Medical and rehabilitation management
2. Financial resources and benefits systems including, but not limited to, vocational rehabilitation, Social Security, Medicaid, etc.
3. Anatomy and physiology
4. Bowel and bladder management
5. Medication management including identification, purpose, administration, side effects, indications, contraindications, storage, errors/ emergency actions, obtaining, implications of abrupt discontinuation
6. Need for follow-up care and how to access it
7. Advanced Directives
8. Community resources
9. Accessing emergency care
10. Caregiver support, including information on personal care assistants
11. Nutrition and hydration
12. Swallowing issues
13. Communication and speech, including aphasia
14. Cognition and capacity

15. Psychosocial issues
    - Adjustment to disability
    - Self-advocacy
    - Life roles and changes
    - Social perceptions/ cultural impact
    - Mental health needs
    - Supported self-management
16. Adaptation to the stroke and its complications
17. Aging with a disability
18. Primary prevention related to preventing recurrence, complications, and new or worsening conditions
19. Signs and symptoms of stroke/ recurring stroke and appropriate response
20. Secondary health risks and complications due to impairment including falls risk reduction
21. Intimacy, sexuality, sexual functioning
22. Skin care and protection
23. Mobility
24. Assistive devices, orthotics, durable medical equipment, and compensatory aides
25. Activities of daily living
26. Visual and perceptual skills and deficits
27. Home safety and suggested home modifications
28. Behavioral issues or changes
29. Substance use, misuse, dependency, including smoking cessation
30. Use of leisure time, accessing the community
31. Specific healthcare procedures and techniques

The Stroke Program provides for the transition of the persons served to other levels of care including immediate access to emergency medical services as needed. Upon discharge, each patient and family will receive a follow-up plan including recommendations for the following as needed:

1. Follow-up medical appointments with the primary physician and/or physiatrist and any other medical specialist determined by the discharging physiatrist.
2. Telephone number for case manager for questions or problems after discharge
3. List of medications, dosage, and directions for use
4. Dietary instructions
5. Functional issues including therapy prescriptions, activity levels
6. Psychosocial support agencies
7. Resources to address aging issues
8. Education and training
9. Resource management
10. Transition planning
11. Primary prevention

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12. Secondary prevention
13. Community integration services including education regarding laws and regulations related to patient rights
14. Equipment checks
15. Follow-up including, the durability of the outcomes achieved, issues of impairment, activity, participation, and quality of life
16. Contacts with home health care or outpatient rehabilitation
17. Contacts with referred financial and vocational assistance agencies
18. Educational service contacts
19. Referral for psychosocial adjustment counseling (family counseling, individual counseling, parent support groups, sibling support groups)
20. Community support groups and/or advocacy groups
21. Level of supervision recommended