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WakeMed Rehab Spinal Cord Injury Scope of Service


The WakeMed Rehab Continuum provides an integrated, comprehensive delivery of rehabilitation services utilizing evidence-based practice directed toward a population of individuals who have sustained a spinal cord injury as a result of illness, injury, or disease process. This continuum includes WakeMed’s acute care services at both the WakeMed Raleigh and Cary campuses, the CARF accredited WakeMed Rehabilitation Hospital, the Outpatient Intensive Neuro Rehabilitation programs in Raleigh, Clayton and Cary, Outpatient Rehab at various other locations, and WakeMed Home Health, and continues post-discharge from the medical programs, with care in the Spinal Cord Injury Fitness Program, the Spinal Cord Injury Support Group and involvement with the North Carolina Spinal Cord Injury Association(NCSCIA). Admission to the WakeMed Rehab Continuum would benefit these individuals in ways not otherwise possible by developing and restoring skills toward independence, facilitating self-management, and decreasing the dependency effect on their families and communities.

WakeMed Rehab receives referrals from many sources, including, but not limited to, private physicians, psychiatrists, acute care hospitals, rehab hospitals, nursing facilities, Wake County Health Department, home health agencies, WakeMed Emergency Departments, local urgent care centers and follow-up appointments from former inpatients and outpatients. Payer sources for WakeMed Rehab include both state and federal public payers (Medicare, Medicare Advantage Plans and Medicaid), commercial insurances, worker’s compensation, and self pay. Any payer requirements that affect the provision of services are identified and communicated to the treatment team, including the person served. 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.

Annually, WakeMed reviews market comparisons and establishes reasonable rates for private and semi-private rooms, as well as updating the Charge Description Master for all provided 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, outpatient services and services post-discharge is the responsibility of the case manager.

Admission decision-making occurs by evaluating the patient’s impairments, activity and participation limitations and determining rehab needs and potential for functional improvement. Additionally, a review of the program’s ability to meet the patient’s needs and recognize community resource alternatives and availability is assessed. WakeMed Rehab serves patients ages 4 and up, though younger children may be accepted after discussion and approval of Medical Director, Rehab Hospital Director and Director of Rehab Nursing, or Outpatient Rehab Director 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, and resources previously used, ongoing reassessment, and the person’s potential to benefit.

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The spinal cord injury treatment program in the WakeMed Rehab Continuum is medically supervised by a physiatrist who has expertise in the medical management and rehabilitation of people with a spinal cord injury. Highly qualified professional staff designated specifically for the inpatient and outpatient spinal cord injury rehabilitation program provides evidence based services that are up to date with current research standards. Treatment space, bed assignment and equipment are also specifically identified for provision within the spinal cord injury rehabilitation program. WakeMed Rehab services offers specialty equipment aligned with evidence based practice for the SCI population including the Vector Gait and Safety System, Bioness upper and lower extremity, Xcite, Lite Gait with body weight support with treadmill, FES cycles,,Ekso NR, pressure mapping, SEMG, and IOPI.

The majority of rehab services are delivered with the patient and the care provider together 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 systems are an integral part of the interdisciplinary team at WakeMed. In addition, as appropriate, and based on need, the following professional disciplines, resources, services, supports and/or interventions are arranged either directly, by referral or by contract:

SERVICE OFFERED	PROVIDED BY
Clinical Case Management	Directly
Rehabilitation Medicine	Directly
Rehabilitation Nursing	Directly
Clinical Nurse Specialist	Directly
Occupational Therapy	Directly
Physical Therapy	Directly
Rehab Psychology/Neuropsychology	Directly
Therapeutic Recreation	Directly
Clinical Dietician	Directly
Speech-Language Pathology	Directly


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Wound Care	Directly/Referral
Diabetic Educator	Directly
Sexual Function/Reproduction	Directly/Referral
All medical, diagnostic and laboratory, including Respiratory Care	Directly/Referral
Pediatic Services: <ul style="list-style-type: none"> • Pediatrician • Pediatric Hospitalist • Child Life Specialist 	Directly/Referral Directly/Referral Directly Directly
Orthotics and Prosthetics: <ul style="list-style-type: none"> • 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,	Directly/Referral
Mental Health and Wellbeing and Psychiatry	Directly/Referral
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
Rehab Engineering	Directly/Referral

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Drivers Assessment and Education	Referral
Specialty Wheelchairs	Contract
Environmental Modification/Assistive Technology	Referral
Medical Interpreter Services	Directly/Contract

The spinal cord injury rehabilitation program coordinates services to meet individual needs. Integration of services is provided through interaction and feedback within the WakeMed system and with other service providers/systems. Provision is made to include all consulting services and external case managers as members of the interdisciplinary team.

Upon admission to WakeMed Rehab Spinal Cord Injury 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.

For patients served in the Rehab Hospital, with input from all team members the physician develops an Individualized Plan of Care for each patient within four days of admission. The treatment team will meet to update the Plan of Care based on realistic, 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 a 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.

The Outpatient Program team completes individualized assessments and develops a Plan of Care based on realistic, achievable, functional goals and planned interventions necessary for goal achievement in a realistic time frame. The interdisciplinary team establishes a frequency of treatment based upon the individual rehab needs of the person served, short and long term goals and discharge needs. The Outpatient Program operates Monday through Friday from 8:00am-5:30pm based on patient need.

Patient and family involvement in the spinal cord injury 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


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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 persons served and/or family. The system of care provides, or arranges for, advocacy training, support services, education, family support, and sibling/peer support as appropriate.

Patient and family involvement continues into the outpatient program. A comprehensive Plan of Care is established, assuring continuous service from inpatient into outpatient. Informal team meetings are held. Discipline-specific goals are discussed during treatment sessions and include the family, as needed, during specify family training sessions. Every effort is made to meet patient/family needs and goals through participation in the decision making process.

The scope of the spinal cord system of care includes Orientation, Assessment, Patient/Family Education, Treatment, Evaluation, Programing, Discharge and Transition Planning and Follow Up. The WakeMed Rehab Spinal Cord Injury Specialty Program serves patients recovering from injury or illness affecting all levels of the spinal cord, whether complete or incomplete, as long as ventilatory support is not required. Patients with spinal cord dysfunction resulting from any etiology are served and no patients are excluded based on comorbid conditions as long as WakeMed Rehab Admission Criteria is met.

The system of care addresses the unique aspects of delivering care to the person served by activity and participation in the following areas:

1. Medical/Physiological Sequelae: Auto-immune disorders and immune suppression, autonomic dysfunction, abnormal tone, body composition, bowel and bladder function, circulation, demyelinating disorders, dysphagia, fertility, infection management, medications, musculoskeletal complications, neurological change, nutrition, pain, respiration and support,, sexual function, Men's health issues, skin integrity, spasticity, vision, and Womens health.
2. Psychosocial: Behavioral health, Substance use, family/support system counseling, mental health, advocacy, coping/adjustment/insight to disability, peer support services, and sexual adjustment.
3. Functional: Activities of daily living, assistive technology, behavior, cognition, communication, community integration, driving, durable medical equipment, emergency preparedness, environmental modifications, leisure and recreation, medication, mobility, orthoses, personal care assistants, prostheses, seating and occupation.
4. Education and Training for the persons served and their family/support system, the community, and the professional community.
5. Aging including aging with a disability and spinal cord injury and dysfunction in an aging population.
6. Case Management
7. Resource management
8. Transitions across the lifespan
9. Prevention related to potential risks and complications due to impairments, secondary health


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- conditions due to impairments, activity limitations, participation restrictions, and the environment.
10. Safety for the persons served and the environments in which they participate.
 11. Research capability
 12. Follow up
 13. Health promotion and wellness
 14. Resources for independent living and community integration

The Spinal Cord System of Care provides or arranges for diagnostic services to screen for and assess the status of bladder function, bowel function, cardiac function, cognitive function, depression, metabolic function, musculoskeletal function, neurological function, psychological function, respiratory function, sexual function, skin integrity, swallowing, thromboembolic disease and other common secondary conditions.

The spinal cord system of care identifies services/programs that dependent upon the needs of the persons served it will provide or link with: emergent care, acute hospitalization, other inpatient programs, skilled nursing care, long-term care hospitals, behavioral health, home care, other outpatient programs, community based services, independent living centers, residential services, vocational services, primary care, specialty consultants, clinical research centers, consumer advocacy organizations, driver rehabilitation and long term care. The system of care also defines its relationships with the services/programs, defines the responsibilities of the spinal cord system of care and the services/programs with which it links. The system of care identifies key communication contacts within the services/programs and acts as a resource in establishing personnel competencies for the services/programs identified for each person served. The system of care will involve, as appropriate, the payer, the referral source, treating physicians, health care professionals, the person served, the family or support system, and the employer/employer designee. 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 individual, family, parent, sibling, etc.
6. Referral for continued rehabilitation therapy on an outpatient or home care basis.
7. Referral to medical specialists for follow-up after discharge.
8. Education regarding prognosis, prevention, wellness, intimacy and sexual health issues
9. Referral to equipment, orthotic or prosthetic agencies.

The system of care also assists the person served to access community resources, uses community systems, obtains appropriate equipment and supplies and provides referrals for expertise when appropriate. The program provides information to patient and families/support systems about laws and regulations pertaining to accessibility, education, employment, health, rights and social supports as appropriate.

Need for continued treatment is decided upon by all team members throughout the treatment process during


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team and family conferences, as well as informal daily 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. The patient and/or the family are asked to demonstrate these skills required prior to discharge.

The system provides an organized education program about spinal cord injury for the persons served and the family/support systems regarding:

1. Access to financial resources and benefits systems such as education, vocational rehabilitation, Social Security, Medicaid, workers' compensation, etc.
2. Activities of daily living
3. Autonomic dysfunction
4. Assistive technology
5. Behavior
6. Cognition
7. Communication
8. Bladderfunction
9. Bowel function
10. Body composition
11. Cardiovascular risk factors
12. Circulation
13. Substance use
14. Consumer advocacy organizations
15. Depression
16. Driving
17. Dysphagia
18. Durable medical equipment
19. Diabetes prevention
20. Edema management
21. Emergency preparedness
22. Environmental modification
23. Fall prevention
24. Follow-up medical care, including the need for such care and how to access it
25. Independent living
26. Community integration


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27. Infection Management
28. Life care planning
29. Aging with a disability
30. Medical nutrition therapy
31. Medications
32. Mobility
33. Nutrition
34. Musculoskeletal Complications
35. Neurological changes
36. Occupation
37. Orthoses
38. Pain management
39. Personal care assistants
40. Prostheses
41. Psychosocial issues
 - a. adjustment to disability,
 - b. behavior health
 - c. family/support system counseling
 - d. role changes,
 - e. mental health needs,
 - f. cultural
 - g. adjustment issues,
 - h. delineation of roles,
 - i. social perceptions
 - j. peer support services
42. Pulmonary care and management
43. Advocacy and consumer competency
44. Self-management of health
45. Setting
46. Sexual counseling and education, including information about fertility, sexual function and adjustment
47. Skin integrity care and prevention of pressure ulcers
48. Transitions across the life span
49. Abnormal tone and tone management
50. Spinal cord injury research, including access to current research
51. Respiration and support
52. Use of leisure and recreation
53. Weight management
54. Men's and Women's Health Issues
55. Health promotion and wellness

The System of Care provides for the transition of the persons served to other levels of care including


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immediate access to emergency medical services as needed. Upon discharge, each patient and family will receive a written follow-up plan including recommendations for the following as needed:

1. Follow up medical appointments with the primary care 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, and recommended activity/participation levels
6. Psychosocial issues
7. Aging issues
8. Education and training
9. Resource management
10. Transition planning
11. Primary prevention
12. Secondary prevention
13. Community integration services
14. Equipment checks
15. Level of supervision recommended
16. Life-long follow-up including, the durability of the outcomes achieved, issues of impairment, issues of activity, issues of participation, issues of quality of life, the environment, and personal preferences.
17. Contacts with Home Health Care or Outpatient rehabilitation.
18. Contacts with referred financial and vocational assistance agencies
19. Contacts with DME, orthotics or prosthetic agencies.
20. Educational service contacts.
21. Referral for psychosocial adjustment counseling (family counseling, individual counseling, parent support groups, sibling support groups).
22. Substance Use Disorder support/treatment referrals
23. Community support groups and/or advocacy groups

The scope of the spinal cord system of care recognizes the importance peer relationships can have on the long-term outcomes for those with a spinal cord injury. Efforts are made to maintain relationships with current social networks and also establish new relationships with persons living in the community with a spinal cord injury. The peer support program assures that patients with newly acquired spinal cord injuries have an opportunity to establish a relationship with another person of like characteristics with a spinal cord injury. Often these relationships can serve as a source of ‘real life’ information, shared experiences and support in adjusting to the challenges of living with spinal cord injury. Referrals to peer supporters are made with the patient’s permission by the treatment team to trained previous patients or active members within the network of those with Spinal Cord Injury. Referral to spinal cord injury support groups, NCSCIA, and adaptive sports further enhance the opportunity for integration with new social, recreational and peer networks.

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