WakeMed Rehab Amputee Scope of Service

The WakeMed Rehab Continuum provides an integrated, comprehensive delivery of rehabilitation services utilizing evidenced based practices directed toward a population of individuals who have limb loss as a result of illness, injury, or disease process. This continuum includes acute care services at both the WakeMed Raleigh and Cary campuses, the CARF accredited WakeMed Rehabilitation Hospital, Outpatient Rehab at various locations, and WakeMed Home Health. Admission to the WakeMed Rehab Continuum would benefit these individuals in ways not otherwise possible by developing and restoring skills toward independence and decreasing the dependency effect on their families and communities.

WakeMed Rehab receives referrals from many sources, including, but not limited to, private physicians, physiatrists, 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. 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. The Amputee program, specifically, receives referrals directly from Vascular Surgeons, Orthopedic Surgeons and Prosthetic providers.

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.

Annually, WakeMed reviews market comparisons and establishes reasonable rates for single and double-occupancy 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. Ongoing 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, Director of the Rehab Hospital 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.

The amputee program in the WakeMed Rehab Continuum is medically supervised by a physiatrist who has expertise in the medical management and rehabilitation of people with limb loss. Highly qualified

professional staff designated specifically for the inpatient and outpatient rehabilitation program provide services that are up to date with current research standards. Treatment space, bed assignment and equipment are also specifically identified for provision within the amputee rehabilitation program.

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 and support systems 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
Therapeutic Recreation	Directly
Clinical Dietician/Nutritional Counseling	Directly
Speech-Language Pathology	Directly
Wound Care	Directly/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

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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	Referral
Durable Medical Equipment	Referral
Vocational Rehabilitation	Referral
Audiology	Referral
Spiritual Care Services	Referral
Palliative Care	Referral
Caregiver/Family Services	Directly/Referral
Sexuality and Intimacy Counseling	Directly
Substance Abuse Counseling/Addiction Specialist	Directly/Referral
Rehab Engineering	Directly/Referral
Drivers Assessment and Education	Referral
Specialty Wheelchairs	Contract
Medical Interpreter Services	Directly/Conctract
Enrironmental Modifications/Assistive Technology	Directly/Referral
Peer Support	Referral

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

Upon admission to amputee program, each individual receives a comprehensive assessment and evaluation by each team member initially involved in the provision of his/her direct care. 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.

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 for an initial team conference 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 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.

The outpatient treatment 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 8am-5:30pm.

Patient and family involvement in the amputee 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 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 specific family training sessions. Every effort is made to meet patient/family needs and goals through participation in the decision making process.

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

1. Health/Medical Stability	Bowel function, Bladder function, Skin integrity, Sleep/wake cycles, Medication management, Wellness Promotion, Prevention of complications, contraindications, stump care and management
2. Nutrition/Diet	Nutritional status, Nutritional intake, Assessment and interpretation of lab values, Diet education
3. Psychosocial	Support system, Education, Vocation, Patient/family understanding of illness, Patient/family coping/adjustment/insight, Community and financial resources, Discharge planning
4. Behavior	Behavior management, social interaction, self-control
5. Mobility	Bed mobility, Transfers, Gait, Wheelchair mobility, Environmental barrier management
6. Self-care	Feeding, Grooming, Bathing, Dressing, Toileting, Home management, Visual perception
7. Communication	Auditory comprehension, Verbal/nonverbal expression, Speech intelligibility, Reading, Writing, Hearing, Swallowing
8. Cognition	Orientation, Attention, Memory, Reasoning/problem solving, Visual/spatial
9. Leisure	Leisure skills, social skills, Leisure/recreation participation, Resource awareness, Adaptive leisure
10. Environment	Level of stimulation, safety, accommodations, compensatory aids

Continued Care Planning occurs throughout the patient's admission and includes, as needed:

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 and wellness.
9. Referral to equipment, orthotic or prosthetic agencies.

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

1. Medical/physical problems..
2. Continued progress toward stated goals.
3. Expected improvement in function and independence.
4. Availability of alternative treatment or programming.

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The program provides an organized education program about amputation for persons served and their family/support system that includes education on:

1. Financial resources and benefits systems including, but not limited to, Vocational Rehabilitation, Social Security, Medicaid, etc.
2. Management of secondary complications
3. Skin Care and prevention of pressure ulcers
4. Cardiovascular management
5. Substance misuse
6. Aging with a disability
7. Psychosocial issues
   - Adjustment to disability
   - Role changes
   - Mental health needs
   - Cultural impact
   - Adjustment issues
   - Delineation of roles
   – Social perceptions
8. Foot/Limb/Wound care
9. Nutrition
10. Diabetes management

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.

Upon discharge, each patient and family receive a follow-up plan including 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, doses and directions for use.
4. Therapy prescriptions.
5. Recommendations for activity/participation levels.
6. Dietary instructions.
7. Contacts with Home Health Care or Outpatient rehabilitation, as needed.
8. Contacts with referred financial and vocational assistance agencies.
9. Contacts with DME, orthotics or prosthetic agencies.
10. Educational service contacts.
11. Referral for psychosocial adjustment counseling (family counseling, individual counseling, parent support groups, sibling support groups).
12. Substance Use Disorder support/treatment referrals
13. Community support groups and/or advocacy groups

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