

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. Services are provided on the nursing units in the Rehab Hospital at WakeMed, in the therapy gyms, the Health Park and other WakeMed public areas and, as appropriate, within the community. Medical and nursing services are available twenty-four hours per day, seven days per week. Therapy services are offered daily. Case Management services are available six days per week.

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

- Recognizing, assessing, and treating conditions related to stroke and its complications
- Preventing of conditions related to stroke and its complications
- Identifying and reducing risk factors for recurrent stroke
- Promoting lifestyle changes that reduce modifiable risk factors for stroke recurrence
- Expediting best functional independence and performance
- Facilitating psychological wellbeing, coping, and adjustment and adaptation skills
- Facilitating community inclusion and participating in life roles
- Providing services for families and support systems
- Promoting use of assistive technology where appropriate

WakeMed Rehab receives referrals from many sources, including, but not limited to, private physicians, acute care 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.

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, 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 years old and up, though younger children may be accepted after discussion and approval of Medical Director, Director of the Rehab Hospital, Therapy Manager and Nurse Manager of 3C 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 potentially 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 private and semi-private rooms, as well as updating 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 Individualized 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 Program is medically supervised by a physiatrist who has expertise in the medical management and rehabilitation of people recovering from stroke. Services are provided by highly qualified professional staff designated for the inpatient stroke rehabilitation program. Treatment space, team assignment, bed assignment and equipment are also appropriate to the stroke rehabilitation program. WakeMed Rehab services and equipment offered that are specialized for the Stroke Program include: Ekso with variable assist, Bioness, Lite Gait (bodyweight support with coordinating treadmill), FEES, modified barium swallow studies, mirror therapy, and Pet Assisted Therapy.

The interdisciplinary teams for the Stroke Rehabilitation Program are comprised of person served, family members/caregivers/support system members as appropriate and of consistently assigned staff from the following professional disciplines depending upon patient need:

Rehabilitation Medicine	Neuropsychology
Rehabilitation Nursing	Therapeutic Recreation
Occupational Therapy	Clinical Case Management
Physical Therapy	Clinical Dietician
Speech-Language Pathology	

Based on the individual needs of each patient the Stroke Program provides or arranges for services. If services not available within the Rehabilitation Hospital or the WakeMed system are needed, referrals, contracts or consultations will be made to provide persons served with appropriate services, which may include, but are not limited to:

- All medical, diagnostic and laboratory services offered at WakeMed Raleigh campus
- Pediatric services
- Orthotics and Prosthetics
- Department of Social Services
- Social Security Administration
- Community Support Agencies, Advocacy Groups, Peer Support Groups
- Durable Medical Equipment
- Vocational Rehabilitation
- Audiology
- Optometry
- Dysphagia Management
- Spiritual Care Services
- Palliative Care
- Family/support system counseling
- Caregiver/Family Services
- Substance Use Counseling/Addiction Specialist
- Environmental modifications/ Rehab Engineering/ Assistive Technology
- Driver Assessment Education and Rehabilitation
- Behavioral Health and Psychiatry
- Medical Interpreter Services
- Sexual Counseling
- Sexual Function and Reproductive Assessment and Management
- Dialysis
- Spasticity Management
- Specialty Consultants

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. Pediatric patients are appropriate for stroke programming with special attention given to developmental needs and age-appropriate assessment/interventions. 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 rehab 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 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, at a minimum. 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's/family's goals and to facilitate appropriate and safe discharge to the community. 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 at regular intervals 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 and family/support system education focus on promoting the independence of the person served in the functional areas of:

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| 1. Health/Medical Stability | Prevention/recognition/assessment/treatment of conditions related to stroke and its complications; swallowing, bowel function, bladder function, 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, dysphagia management as needed, and 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, balance, environmental barrier management |
| 6. Self-care | Activities of daily living including feeding, grooming, bathing, dressing, toileting, managing hygiene as well as home management and visual or perceptual deficits |
| 7. Communication | Auditory comprehension, verbal/nonverbal expression, speech |

	intelligibility, reading, writing, hearing
8. Cognition	Orientation, attention, memory, reasoning/problem solving, visual/spatial
9. Recreation & Leisure	Leisure skills, community integration, leisure/recreation participation, resource awareness, adaptive leisure
10. Environment	Level of stimulation, safety, fall risk reduction, accommodations, compensatory aids
11. Pain Management	Management of pain at a level that allows participation in daily life Activities
12. Social	Social interaction, social skills, peer involvement
13. Vocational	Preparation to return to the workforce, or addressing skills required when contemplating eventual return to the workforce
14. Spiritual	Access to spiritual resources and support, as indicated and desired

The Stroke Rehabilitation Program identifies services and programs, dependent upon the needs of the persons served, that it may provide or link with including: 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, hospice and long term care. 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 individuals and family/caregiver
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 and/ or prosthetic agencies

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

The Stroke Program provides an organized and reinforced education program about stroke that fosters self-management for persons served and their family/support systems that includes education covering:

1. Financial resources and benefits systems including, but not limited to, vocational rehabilitation, Social Security, Medicaid, etc.
2. Medical and rehabilitation management
3. Related anatomy and physiology
4. Recognition of signs and symptoms of recurring stroke (FAST, call 911, importance of and how to access emergency care quickly)
5. Primary prevention related to preventing recurrence of stroke
6. Secondary risks and complications due to impairment
7. Adaptation to deficits resulting from stroke
8. Aging with a disability
9. Medication management including administration, effects, indications, contraindications
10. Importance of personal health profile development
11. Continence management
12. Skin care
13. Nutrition and hydration
14. Fall risk reduction
15. Swallowing

16. Communication and speech, including aphasia
17. Cognition and competency
18. Behavioral changes
19. Psychosocial issues
 - Adjustment to disability
 - Self-advocacy
 - Life roles and changes
 - Mental health needs
 - Cultural impact
 - Social perceptions
20. Mobility
21. Assistive devices
22. Orthotic use, fit, and training
23. Equipment /compensatory aid use
24. Activities of daily living
25. Home safety and suggested home modifications
26. Visual and perceptual skills and deficits
27. Sexuality and intimacy
28. Substance use, including smoking cessation
29. Use of leisure time, accessing the community
30. Need for follow up care and how to access it
31. Community resources
32. Community re-entry
33. Caregiver support
34. Information on personal care assistants

Need for continued treatment at this level of care 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, 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, patient and family are adequately prepared, and discharge destinations are finalized. The Stroke Program identifies the skill sets necessary to be successful in the next environments of care for both the person served and the family/support system. After participation in family training session(s), the patient and/or the family are asked to provide return demonstration of skills prior to discharge.

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. For each person served, a follow-up plan is developed with input from patient/ family and treatment team members prior to discharge. Upon discharge, each patient and family receives discharge instructions that details much of the follow-up plan including recommendations for the following as needed:

1. Medical/physiological issues and contact information with phone numbers
2. Details of plan to manage: stroke prophylaxis, deconditioning, diabetes, hyperlipidemia, hypertension, physical inactivity.
3. List of medications, dosage and directions for use combined with resources to obtain and adhere to prescribed administration
4. Dietary instructions
5. Functional issues including therapy prescriptions, activity/ participation levels
6. Psychosocial support agencies

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