

WakeMed Rehabilitation Hospital Scope of Service

WakeMed Rehabilitation Hospital provides an integrated, comprehensive delivery of physical rehabilitation services utilizing evidenced-based practice directed toward a population of individuals who have incurred loss of physical and/or cognitive function through illness, injury or disease process. Admission to the Rehabilitation Hospital 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. 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.

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, Open Door Medical Clinic, Alliance Medical Ministries, WakeMed Emergency Departments, local urgent care centers and follow-up appointments from former inpatient and outpatients.

Admission decision-making occurs within a team process by evaluating the patient's needs, including health status, and potential for improvement, the program's capabilities in meeting the patient's needs and community resource alternatives and availability. 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, 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 level of care, the resources needed, available, and those resources previously used, ongoing reassessment, and the person's potential to benefit.

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 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.

Treatment in the Rehabilitation Hospital is medically supervised by a physiatrist and is provided by a highly qualified professional staff designated specifically for the inpatient rehabilitation program. Treatment space, bed assignment and equipment are also specifically identified for provision of the rehabilitation program.

Interdisciplinary teams include the person served, family members/caregivers/and support system, as appropriate, and the following consistently assigned professional disciplines dependent on patient need:

Clinical Case Management
Rehabilitation Medicine
Rehabilitation Nursing

Psychology/Neuropsychology
Therapeutic Recreation
Clinical Dietician

If services not available within the Rehabilitation Hospital or the WakeMed system are needed, referrals, contracts or consultations are 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, Support Groups
- Behavioral Health and Psychiatry
- Optometry
- Durable Medical Equipment
- Vocational Rehabilitation
- Audiology
- Spiritual Care Services
- Palliative Care
- Caregiver/Family Services
- Substance Use Counseling/Addiction Specialist
- Rehab Engineering
- Drivers Assessment and Education

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

Upon admission to the Rehabilitation Hospital each individual receives a comprehensive assessment and evaluation by each team member initially involved in provision of his/her direct treatment.

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 achievement of predicted outcomes in a realistic time frame. Treatment planning includes a minimum standard of intensive rehab programming of either three hours of therapy per day, five of every seven 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 goals, program 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 with the individual's insurer to facilitate communication, reimbursement and collaborative discharge planning.

Patient and family involvement in the rehabilitation program begins during the preadmission and assessment phases and continues throughout the program. The comprehensive plan of care, progress and goals are formally discussed with the patient/family at least weekly by the Clinical Case Manager. Discipline specific goals focused on fostering self-management are discussed during treatment sessions and include the family during specific family training sessions. Every effort is made to meet patient and 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.

Each patient's rehabilitation program includes Orientation, Assessment, Treatment, Discharge Planning and Follow Up. Evaluation, treatment and programming focus on facilitating the achievement of predicted outcomes in the following areas:

1. Health/Medical Stability Bowel function, bladder function, skin integrity, sleep/wake cycles, medication management, wellness promotion, prevention of complications, contraindications, management of chronic conditions.
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 Social interaction, self-control.
5. Function & 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. Recreation & Leisure Leisure skills, leisure/recreation participation, resource awareness, adaptive leisure.
10. Functional Activities of daily living, including mobility, dressing, bathing, managing equipment and clothing, managing hygiene.
11. Pain Management Management of pain at a level that allows participation in daily life activities
12. Social Social interaction, social skills.
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.

Continued Care Planning occurs throughout the patient's hospitalization 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 the 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 hospitalization is decided upon by all team members throughout the treatment process, during team and family conferences, and as part of 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 and predicted outcomes.
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.

Upon discharge, each patient/ family receives a discharge 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 numbers for the nursing unit and doctor's offices for questions or problems after discharge.
3. List of medications, doses and directions for use.
4. Recommendations for activity levels and participation restrictions.
5. Level of supervision recommended.
6. Dietary instructions.
7. Contacts with home health care or outpatient rehabilitation.
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.
12. Community support groups/advocacy groups.