



## **Roger C. Peace Rehabilitation Hospital**

### **Scope of Service and Disclosure Statement Brain Injury Program –Inpatient**

#### **I. Introduction:**

The Brain Injury Program of Roger C. Peace Rehabilitation Hospital is designed to offer specialized rehabilitation treatment to individuals with acquired brain dysfunction.. The program utilizes a specialized core of professionals who work together to provide early, aggressive acute inpatient rehabilitation to restore persons with TBI to their highest potential physically, socially, emotionally, and financially. The scope of the TBI program supports the hospital plan for the provision of patient care services and works collaboratively with other department services or programs to enhance patient care outcomes 24 hours a day, 7 days a week. Therapies are generally done between 7 am to 5 pm, however, accommodations can be made to meet the patient's individualized needs. The CARF accredited system of care includes as appropriate Roger C. Peace Rehabilitation Hospital (RCPRH), and outpatient.

#### **II. Populations Served:**

<b>Population Served</b>	<b>Settings</b>
Children 2—14 years of age	Children with a brain injury are admitted to Roger C. Peace Rehabilitation Hospital
Adolescents 15—17 years of age	Adolescents with a brain injury are admitted to Roger C. Peace Rehabilitation Hospital
Adults 18—65 years of age	Adults with a brain injury are admitted to Roger C. Peace Rehabilitation Hospital
Geriatric persons over 65 years of age	Geriatric persons with a brain injury are admitted to Roger C. Peace Rehabilitation Hospital

#### **III. Hours of Service/Days of Services/Frequency of services:**

The amount and type of therapy that patients receive is determined by the patients needs and physician order. Patients will receive an average of at least 3 hours of therapy per day for 5 days per consecutive 7 day week. This equates to a minimum of 15 hours per week which is provided daily Monday through Saturday. Patients may receive more or less therapy according to their individual needs and change in status. Therapy services are provided 6 days a week. Rehab Nursing is also provided 24 hours a day, 7 days a week.

#### **IV. Payor Sources:**

Range from Medicare, Managed care, Workers Comp, Medicaid Programs, Auto, Private Pay, Commercial Insurance, Department of Disability and Special Needs (DDSN) or Uncompensated Care.

V. **Fees:**  
Patients and families may call (864) 455-7000 and ask for the Patient Accounts Department for a good faith estimate of the fees and out-of-pocket expenses that they may expect to pay for the services received at Roger C. Peace Rehabilitation Hospital.

VI. **Referral Sources:**  
Referrals are typically made from an acute care hospital. Other referrals are considered on a case by case basis, dependent on medical necessity.

VII. **Specific Services Offered:**  
Direct and consult services offered include:

- Physiatry
- Case Management
- Rehab Nursing
- Physical Therapy
- Occupational Therapy
- Respiratory Therapy
- Speech Therapy
- Recreational Therapy
- Prosthetics and Orthotics
- Psychology
- Pain Management
- Nutritional Services
- Chaplain
- Wound care
- Ultrasound
- Imaging
- Urodynamics
- Lab
- Internal Medicine
- Assistive Technology
- Vocational/Educational Counseling and Rehab
- Cardiology
- Podiatry
- Pulmonology
- Infectious diseases
- Emergent Care - Patients are transferred to an acute care facility as appropriate
- Any specialty services required will be offered through referrals off site

VIII. **Goal/Practice Guidelines:**  
The goal of the program is to enable each individual to achieve maximum potential in self-care behaviors and functional capabilities through a patient-centered care model; thereby making it possible for the individual to pursue meaningful avocational or vocational goals. An interdisciplinary team consisting of a physiatrist, case manager, rehabilitation certified nurse and/or licensed nurse, physical therapist, occupational therapist, respiratory care therapist, speech-language pathologist, neuropsychologist, recreational therapist, nutritionist, and chaplain work collaboratively to meet the patient/family goals within a program model that supports the mission, vision and core values of the organization.

The overall rehabilitation goals of the Program:

- Focus on effectiveness and efficiency in assisting the individual to achieve their highest level of functioning and independence
- Place equal emphasis on education and preparation of the persons served and key stakeholders

The scope and intensity of services is related to each person's unique:

- **Medical care needs**
- **Cultural needs**
- **Impairments**
- **Activity limitations** (e.g. Functional problems with walking, dressing, toileting, speaking, swallowing, breathing, eating, home management)
- **Participation restrictions** (e.g. Restrictions in ability to shop, attend church, drive, sports, work, family role, school)
- Services provided include screening, evaluation, goal setting, treatment, education, counseling, and follow-up.

#### **IX. Admission Criteria:**

The patient must meet all of the following criteria at the time of admission to the Rehabilitation Hospital:

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be a physical or occupational therapy.
- The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the hospital. Significant benefit is when the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement as a result of the rehabilitation treatment and in a prescribed period of time. Such improvement must be of practical value to improve the patient's functional capacity and/or adaptation to their impairments.
- The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. Rehabilitation physician supervision includes face-to-face visits with the patient at least 3 days per week throughout the patient's stay at the hospital in order to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
- The patient must evidence a primary problem in self-care, mobility, safety or pain.
- A suitable discharge disposition has been identified and agreed to.

An integrated admission process assesses levels of impairment, activity, and participation for individuals who sustain a TBI or develop brain injury secondary to the following medical etiologies:

1. Traumatic:
  - Vehicular accidents
  - Sports sustained
  - Acts of violence
  - Falls
  - Accidental
  - Penetrating or open head injury
2. Non-Traumatic due to:
  - Brain Aneurysm
  - Brain Tumor
  - Hypoxia
  - Anoxia
  - Metabolic Injury
  - Drug/ Alcohol abuse

Patients referred with a dual diagnosis of brain injury and spinal cord are evaluated to determine the appropriate nursing unit.

- a. When cognitive deficits are the primary concern, the patient is referred to the Brain Injury Unit.
- b. If the patient has the cognitive ability to participate in the rehabilitation program, a referral is made to the Spinal Cord program.

Co- Morbidities may include but are not limited to:

- a. Psychiatric adjustment disorder if a psychiatrist has deemed a patient no longer a threat to themselves or others before they are admitted
- b. Depression
- c. Alcohol dependency
- d. Self destructive behaviors
- e. Pressure ulcers
- f. Cardiovascular, as long as they are stable
- g. Metabolic disorders
- h. Diabetes

**X. Program Description:**

The rehabilitation process is designed to assess physiological alterations and institute medical and/or therapeutic interventions to manage the following conditions:

- Mobility
- Activities of Daily Living
- Communication
- Pain
- Respiratory compromise
- Circulation impairment
- Sexual dysfunction
- Spasticity
- Loss of skin integrity
- Dysphagia
- Visual Perceptual deficits
- Nutritional deficits
- Contractures
- Motor weakness
- Sensory impairment
- Adjustment issues
- Psychosocial support
- Aging with a disability
- Lifelong health and wellness
- Wheelchair seating and positioning

The overall focus of treatment becomes one of promoting functional capabilities and preventing secondary medical and musculoskeletal complications from the deficits in these areas.

The inpatient TBI Program is located within Roger C. Peace Rehabilitation Hospital, a 37-bed rehabilitation facility, which adjoins Greenville Memorial Hospital. TBI Unit is a locked unit located on 3rd floor Roger C. Peace Rehabilitation Hospital. Providing daily 24 hour nursing care. Therapy is typically provided 6 days a week. Interdisciplinary care coordination meetings are held regularly several times a week, and as needed to monitor progress, identify obstacles and provide ongoing coordination of rehab services for each person served.

An interdisciplinary team is responsible for developing, expanding, evaluating and restructuring the program to meet the changing needs of our patients and the health care delivery system. Our scope of practice is directed by the following objectives:

1. To provide a comprehensive inpatient rehabilitation program under the direction of an in-house physiatrist who works collaboratively with Speech Therapy, Physical Therapy, Occupational Therapy, Recreational Therapy, Psychology, Respiratory Therapy, Case Management and nursing to implement therapeutic interventions based on initial and ongoing assessment of each individual patient.  
These include mobility/safety, self-care, leisure skills, management of bowel and bladder issues, psychological adjustment, nutrition, spasticity management, medical issues (such as circulatory, respiratory, musculoskeletal), assistive technology services, maintenance programs, wheelchair clinic, adapted driving program, pain, sexuality and the patient's environment in the home and community, outside referral agencies and any other needs both in-house and through referral resources that a patient may require.
2. To facilitate community reintegration through patient-directed outings where life care skills and accessibility needs are evaluated.
3. To educate brain injury survivors and their support systems about the challenges presented by brain injury and to provide them with resources, educational and otherwise, that help promote the health, adjustment and optimal functioning of the survivor and support system.
4. To explore and refer patients to appropriate discharge environments such as home, community based providers, skilled nursing facilities, assisted living and other environments as appropriate.
5. To coordinate lifetime medical and rehabilitation needs through follow-up with a physiatrist and/or case manager.
6. To assist with setting up support services, such as public transportation, attendant care, wheelchair prescription, wheelchair maintenance, and access to health care network.
7. To monitor system integrity through specialty consultations.
8. To provide referrals to community resources including support groups.
9. To use individual patient/family teaching sessions to enable the patient/family to resume direction and management of life care needs.
10. To identify program performance improvement initiatives that support the organizational and hospital PI Plans and use the defined PDSA model to facilitate program change, improve process and patient/family outcomes.
11. To use research, networking and collaboration with national and regional brain injury and rehabilitation entities to ensure that our interventions are consistent with the most up-to-date evidence-based standards of care and best practices at the level of each individual discipline as well as the overall program level.
12. To maintain active communication with third party payors and work together on maximizing funding in an efficient manner which will benefit the patient on a life-long basis.
13. To work with patient, families, and referral sources in educating them about programs and services available.
14. To explore and refer patients to appropriate discharge environments such as home, community based providers, SNF, assisted living and other environments as appropriate.
15. To provide patients and families with information regarding personal care assistance, respite care, and day programs.

Entry into the system begins with a referral from a physician, health care system or individual to admissions. Once pertinent data is obtained, the records are evaluated by personnel in patient access, the medical director and/or a nurse liaison to determine if entry criteria are met. Admissions occur as soon as the individual is medically stable.

When a patient presents for assessment, the interdisciplinary team members are mobilized to begin the evaluation process. Mutually defined goals and discharge planning begin at these introductory therapeutic sessions. The team convenes weekly to collaborate and coordinate the goals and assess concerns or obstacles to the established plan. Family team conferences are scheduled on an as needed basis. The patient/family's input is provided through the nurse and case manager, as well as any member of the team. Referrals to appropriate support agencies are initiated and medical equipment is secured. Post-discharge

regimes and medical management is established through a collaborative relationship with community services, the family physician and the follow-up physician visits. Continued therapy needs are discussed and arranged.

**XI. Continuing Stay Criteria:**

- Continues to meet admission criteria and evidences a confirmed medical necessity for an intensive rehabilitation inpatient program that cannot be provided at an alternative level of care
- Has and continues to evidence measurable benefit of practical value

**XII. Discharge/Transition Criteria:**

A patient will be discharged from the acute inpatient rehabilitation TBI program when:

- a. Comprehensive inpatient rehabilitation goals have been met and patient is ready to transition to another level of care
- b. The patient reaches their expected functional outcomes/goals for their level of injury needed to return to their pre-morbid living situation
- b. Patient's progress plateaus
- c. Patient becomes medically or behaviorally unstable requiring a different level or program of care
- d. The patient is unable to consistently tolerate 3 hours of therapy a day or 15 hours across a 7 day period
- e. Patient remains non-compliant with plan of care despite coaching, counseling and education.

**XIII. Outcomes: (2020)**

- Characteristics of patients served:
  - Average age – 50.92 years
  - Number under age 18 – 1
  - Ratio of male to female – 96 male to 35 female
  - Patient satisfaction – 97.16%
- Number of patients served:
  - 131 discharges
- Length of Stay: 17.66 days on average
- Average hours of therapy
  - 3.29 hours per day
- Disposition at discharge:
  - 87.69% were able to return home
  - 4.62% were discharged to a SNF
  - 7.69% were discharged to Acute Care

**XIV. Approval(s) Needed: Chief Operating Officer, Rehabilitation Hospital**

**XIII. Signatures Needed:**

  
Chief Operating Officer, Rehabilitation Hospital

— 11/19/2020 —  
Date

**XV. Policy Responsibility: Chief Operating Officer, Rehabilitation Hospital  
In Coordination with: Brain Injury Program Coordinators**

**XVI. References: CARF Standards Manual Medical Rehabilitation, July 1, 2020**