



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

### **Scope of Service And Disclosure Statement Stroke Program – Inpatient**

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

Roger C. Peace Rehabilitation Hospital Inpatient Stroke Program is designed to provide specialized rehabilitation services, tailored to the unique needs and strengths of each person with stroke. The program utilizes a specialized core of professionals who work together to provide early, aggressive acute inpatient rehabilitation to restore persons with stroke to their highest potential physically, socially, emotionally, and financially. The scope of the Inpatient Stroke 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 stroke program is part of a continuum that includes, as appropriate, Roger C. Peace Rehabilitation Hospital (RCPRH), and outpatient services for both Young Stroke (under 65) and those of more traditional age.

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

<b>Population Served</b>	<b>Settings</b>
Children 2—14 years of age	Children with a stroke are admitted to Roger C. Peace Rehabilitation Hospital.
Adolescents 15—17 years of age	Adolescents with a stroke are admitted to Roger C. Peace Rehabilitation Hospital
Adults 18—65 years of age	Adults with a stroke are admitted to Roger C. Peace Rehabilitation Hospital
Geriatric persons over 65 years of age	Geriatric persons with a stroke 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 patient's 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 medical 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 Compensation, 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:

- Physiatrist
- 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 other specialty services required can be provided 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, communicating, swallowing, breathing, eating, home management)
- **Participation restrictions** (e.g. Restrictions in ability to shop, attend church, drive, sports, work, family roles, 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 occurs 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 this improvement is achieved 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 or safety.
- A suitable discharge disposition has been identified and agreed to.

An integrated admission process assesses level of impairment, activity, and participation for individuals who sustain a stroke or other cerebrovascular disease.

Persons admitted are expected to be medically stable. In order to serve the broadest possible range of individuals, admission will not be denied solely on the basis of feeding tubes, IV medications, cardiac problems, hypertension, or other problems that can be readily and reasonably medically managed in the rehabilitation setting. Medical stability should include:

- Stable or improving medical status
- Lack of communicable disease (unless cleared by Infectious Disease)
- Adequate pulmonary function
- Stable vital signs
- Adequate control of any seizure activity

Co- Morbidities may include but are not limited to:

- Adjustment disorder
- Depression (excluding the patient being an active threat to themselves or others)
- Alcohol or other substance use/dependency
- Cardiovascular issues (stable)

- Metabolic disorders
- Diabetes

**X. Program Description:**

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

- Mobility
- Activities of Daily Living
- Communication
- Dysphagia
- Bowel and/or bladder control
- Cognition
- Behavior
- Safety awareness
- Nutrition
- Perception
- Motor strength
- Spasticity
- Sexual Dysfunction
- Circulation Impairment
- Pain
- Contractures
- Balance
- Sensory functioning
- Adjustment issues
- Psychosocial support
- Aging with a disability
- Secondary stroke prevention
- Lifelong health and wellness

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 Stroke Program is located within Roger C. Peace Rehabilitation Hospital, a 37-bed rehabilitation facility, which adjoins Greenville Memorial Hospital, a large acute care hospital which is certified by the Joint Commission as a Primary Stroke Center. For patients admitted to the Inpatient Stroke Program, nursing care is provided around the clock. 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 their support systems. Our scope of practice directed by the following objectives:

- To provide a comprehensive inpatient rehabilitation program under the direction of an in-house physiatrist working collaboratively with physical therapy, occupational therapy, speech therapy, recreation therapy, psychology, case management and nursing to implement therapeutic interventions based on initial and ongoing assessment of each individual patient
- To provide inpatient interventions directed toward: mobility, self-care, bowel and bladder, swallowing, nutrition, communication, cognitive difficulties, behavioral changes, strength, balance, sensory and perceptual changes, safety, assistive technology, psychological adjustment, leisure skills, sexuality, and community reintegration
- To provide close, ongoing medical supervision during the inpatient rehab stay to manage the needs of persons recovering from stroke, including addressing their comorbidities, managing risk of possible complications and providing secondary stroke prevention



- To provide access to specialty medical services through referrals to specialists available through the Greenville Health System and other providers.
- To provide rapid access to any emergency services in the event such services are needed
- To educate stroke survivors and their support systems about the challenges presented by stroke and to provide them with resources, educational and otherwise, that help promote the health, adjustment, and optimal functioning of the survivor and support system
- To assist stroke survivors in understanding their individual risk factors for stroke and the ways in which they can reduce that risk through ongoing medical support and behavior change
- 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.
- To make recommendations and to assist with acquisition of equipment and assistive devices appropriate at discharge
- To make recommendations and arrangements, in collaboration with the person serviced and his/her support system, for appropriate follow-up rehabilitation services
- To provide patients and families with information regarding personal care assistance, respite care, community long term care, private sitter agencies, and day programs.
- To provide referrals to community resources including support groups (both Stroke Support Group and Aphasia Support Group are offered by RCP), free or low cost medical clinics, Meals on Wheels and other agencies that support stroke recovery and independence
- To use research, networking, and collaboration with national and regional stroke 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
- To work with patients, families, and referral sources in educating them about programs and services available
- To identify program performance improvement initiatives that support the organizational and hospital Performance Improvement Plans, to improve our rehabilitation processes, and patient/family outcomes
- 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.

Access to the Inpatient Stroke Program is initiated with a referral from a physician, health care system, or individual to Admissions. Once obtained, medical 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 and a bed becomes available.

Once admitted, the interdisciplinary team members begin the evaluation process. Mutually defined goals and more detailed discharge planning begin in these early therapy sessions. The whole treatment team meets weekly to review progress and identify any concerns or obstacles to the established plan. More frequent meetings are scheduled as changes arise. Family conferences with the treatment team are scheduled on an as needed basis. Patient and family input is considered throughout the process with coordination provided through nursing, case management and other team members, as appropriate. Referrals to appropriate support agencies are initiated and medical equipment is secured. Post-discharge regimens and medical management are 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
- Continues to evidence measurable benefit of practical value

**XII. Discharge/Transition Criteria:**

A patient will be discharged from the Inpatient Stroke Program when:

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

**XIII. Outcomes (2020):**

- Characteristics of patients served:
  - Average age – 60.10 years
  - Number under age 18 – 8
  - Ratio of male to female – 116 (61.7%) male and 72 (38.3%) female
  - Patient satisfaction – 97.71%
- Number of patients served:
  - 188 discharges
- Length of Stay:
  - 21.02 days on average
- Average hours of therapy
  - 3.4 hours per day
- Disposition at discharge:
  - 76.46% were able to return home
  - 17.11% SNF
  - 5.88% Acute

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

**XV. Signatures Needed:**



\_\_\_\_11/19/2020\_\_\_\_

Chief Operating Officer, Rehabilitation Hospital

Date

**XVI. Policy Responsibility: Chief Operating Officer, Rehabilitation Hospital  
In Coordination with: Stroke Program Coordinators**

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