



GREENVILLE HEALTH SYSTEM

Roger C. Peace Rehabilitation Hospital

Scope of Service and Disclosure Statement Comprehensive Integrated Inpatient Rehabilitation Program

I. Introduction:

Roger C. Peace Rehabilitation Hospital Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP) is an integrated system of care that recognizes that each person with rehabilitative needs has a unique set of capabilities, which must be identified and developed to the fullest, thus promoting optimal wellness. The program utilizes a specialized core of professionals who work together to provide early, aggressive acute inpatient rehabilitation to restore patients to their highest potential physically, socially, emotionally, and financially. The scope of CIIRP 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 days a week. The CARF accredited system of care includes as appropriate, Long Term Acute Care Hospital (LTACH), Roger C. Peace Rehabilitation Hospital (RCPRH), and outpatient.

II. Populations Served:

Population Served	Settings
Children 2—14 years of age	Children with comprehensive rehabilitation needs may be considered on an individual basis to Roger C. Peace Rehabilitation Hospital.
Adolescents 15—17 years of age	Adolescents with comprehensive rehabilitation needs may be considered on an individual basis to Roger C. Peace Rehabilitation Hospital
Adults 18—65 years of age	Adults with an comprehensive rehabilitation needs are admitted to Roger C. Peace Rehabilitation Hospital
Geriatric persons over 65 years of age	Geriatric persons with comprehensive rehabilitation needs are admitted to Roger C. Peace Rehabilitation Hospital
Ventilator Dependent with or without weaning capabilities	Persons with rehabilitation needs who are ventilator dependent are treated at Long Term Acute Care Hospital (LTACH) at North Greenville Hospital (NGH)

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 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
- Nurse Practitioner
- Rehab Nursing
- Physical Therapy
- Occupational Therapy
- Respiratory Therapy
- Speech Therapy
- Recreational Therapy
- Prosthetics and Orthotics
- Psychology
- Pain Management
- Nutritional Services
- Chaplain
- Wound care
- Telemetry
- Ultrasound
- Ventilatory Assistance
- 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 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 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 agreed to

An integrated admission process assesses levels of impairment, activity, and participation for individuals who require rehabilitation intervention due to, but not limited to the following medical etiologies:

1. Multi fractures
2. Debility
3. Cancer
4. Neurological Impairment
5. Cardiac

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
- i. Peripheral Vascular Disease
- j. Renal Disease

X. Program Description:

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

- Pain
- Respiratory compromise
- Circulation impairment
- Sexual Dysfunction
- Spasticity
- Loss of skin integrity
- Dysphagia
- Nutritional deficits
- Contractures
- Motor weakness
- Sensory impairment
- Adjustment issues (comprehensively and specifically related to limb loss)
- Psychosocial support
- Aging with a disability
- Lifelong health and wellness
- Wheelchair seating and positioning
- Smoking Cessation
- Weight Management

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

The Comprehensive Integrated Inpatient Rehabilitation Program is located within Roger C. Peace Rehabilitation Hospital, a 37 bed rehabilitation facility which adjoins Greenville Memorial Hospital, providing daily 24 hour nursing care, and therapy 7 days a week. There are 10 private rooms designated for persons with the most acute medical complications and semi-private rooms to accommodate the census. There are designated therapists (PT, OT, RT or Respiratory) on the unit daily. Other disciplines are integrated into the rehabilitation program based on the individual assessment and patient/family/team goals to facilitate the desired outcomes.

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 ST, PT, OT, RT, TR, Psychology, Case Management and Nursing to establish therapeutic protocols based on evaluative data. These include mobility/safety, self-care, leisure skills, psychological adjustment, nutrition, spasticity management, medical issues

(such as circulatory, respiratory, musculoskeletal), assistive technology services, maintenance programs, wheelchair clinic, adapted driving program, pain, sexuality, 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 coordinate lifetime medical and rehabilitation needs through follow-up with a physiatrist and/or case manager.
4. To assist with setting up support services, such as public transportation, attendant care, wheelchair prescription, wheelchair maintenance, and access to health care network.
5. To monitor system integrity through specialty consultations.
6. To support adjustment and adaptive skills through psychological and peer support in group and individual endeavors. The services include patient/family counseling, sexuality counseling, and education regarding the dynamics of chemical dependence and disability. Peer counselors are available on an inpatient and outpatient basis.
7. To use research, networking, collaboration with national and regional rehabilitation centers, professional rehabilitation based organizations, and CARF to direct the clinical practice of the team and standards of care specific to each discipline.
8. To use individual patient/family teaching sessions to enable the patient/family to resume direction and management of life care needs.
9. To identify program performance improvement initiatives that support the organizational and hospital PI Plans use current model to facilitate program change, improve process and patient/family outcomes.
10. 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.
11. To work with patient and families, and referral sources in educating them about programs and services available.
12. To explore and refer patients to appropriate discharge environments such as home, community based providers, SC Vocational Rehab, SNF, assisted living and other environments as appropriate.
13. To provide patients and families with information regarding personal care assistance, respite care, community long term care, private sitter agencies, 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 Roger C. Peace Rehabilitation Hospital 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
- c. Patient's progress plateaus
- d. Patient becomes medically or behaviorly unstable requiring a different level or program of care
- e. The patient is unable to consistently tolerate 3 hours of therapy a day or 15 hours across a 7 day period
- f. Patient remains non-compliant with plan of care despite coaching, counseling, and education.

XIII. Outcomes: (2017)

- Characteristics of patients served:
 - Average Age: 53.3 years
 - Number under 18- 0
 - Ratio Male to Female: 51.4%male to 48.6% female
 - Patient Satisfaction: 93.6%
- Number of patients served: 70
- Average Length of Stay: 18 days
- Average hour of therapy
 - 3.25 hours per day
- Disposition at discharge:
 - Home 88.5%
 - SNF 5.7%
 - Acute 5.7%

XIV. Approval(s) Needed: Administrator, Rehabilitation Hospital

XV. Signatures Needed:

Adrienne Talbert
Administrator, Rehabilitation Hospital

1/5/2018
Date

**XV. Policy Responsibility: Administrator, Rehabilitation Hospital
In Coordination with: Amputee Program Coordinators**

XVI. References: CARF Standards Manual Medical Rehabilitation, July 1, 2017

XVII. Dates: