North Greenville Long Term Acute Care

Scope of Service and Disclosure Statement
Spinal Cord Injury Program – Long Term Acute Care

I. Introduction:
North Greenville Hospital – Long Term Acute Care Spinal Cord Specialty Program (SCSP) is an integrated system of care that recognizes that each person with a Spinal Cord Injury (SCI) 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 rehabilitation to restore persons with SCI to their highest potential physically, socially, emotionally, and financially and to liberate persons from the ventilator. The scope of the SCI 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 Long Term Acute Care Hospital (LTACH), Roger C. Peace Rehabilitation Hospital (RCPBH), and outpatient.

II. Populations Served:

<table>
<thead>
<tr>
<th>Population Served</th>
<th>Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults 18—65 years of age</td>
<td>Adults with a spinal cord injury are admitted to LTACH at North Greenville Hospital with or without ventilator dependency</td>
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<tr>
<td>Geriatric persons over 65 years of age</td>
<td>Geriatric persons with a spinal cord injury are admitted to LTACH at North Greenville Hospital with or without ventilator dependency</td>
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<tr>
<td>Ventilator Dependent with or without venting capabilities</td>
<td>Persons with a spinal cord injury who are ventilator dependent are treated at the long term acute care hospital (LTACH) at North Greenville Hospital (NGH)</td>
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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 2-5 times per week, Monday through...
Friday. Therapy services are provided 5 days a week. Nursing is also provided 24 hours a day, 7 days a week.

IV. **Payer Sources:**
Range from Medicare, Medicaid Programs, Private Pay, Hospital Sponsorship

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 North Greenville Hospital – Long Term Acute Care.

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
- Physical Therapy
- Occupational Therapy
- Respiratory Therapy
- Speech Therapy
- Prosthetics and Orthotics
- Nutritional Services
- Chaplain
- Wound care
- Telemetry
- Ultrasound
- Ventilator Assistance
- Imaging
- Lab
- Internal Medicine
- Assistive Technology
- Nephrology
- Pulmonology
- Infectious diseases
- Podiatry
- Emergent Care - Patients are transferred to an acute care facility as appropriate
- Any specialty services required will be offered through referrals off site

North Greenville Hospital is located in Travelers Rest, South Carolina. This location is approximately a 20 minute drive from the Greenville Health System University Medical Center. NGH offers diagnostic imaging, laboratory services, specialty consults and pharmacy services. Hospitalist, residents, and ED physicians are on-site 24 hours a
day for patient care and emergencies. If emergent care exceeds our facilities capabilities, patients will be transferred to GMH for further care.

VIII. **Goal/Practice Guidelines:**
The goal of the program is to wean from the ventilator and/or trach, if applicable, and enable each individual to achieve maximum potential in self-care behaviors and functional capabilities through a patient-centered care model. An interdisciplinary team consisting of a hospitalist, physician's assistant or nurse practitioner, case manager, licensed nurse, physical therapist, occupational therapist, respiratory care therapist, speech-language pathologist, 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:

- Build strength and endurance to assist in weaning from the ventilator and/or tracheostomy tube
- 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 North Greenville Hospital – Long Term Acute Care:

- LOS: >25 days
- Discharge to home; community setting or to a lower level of care
- Admission for:
  - Medically complex
  - Complex wound care
  - Vent weaning
  - Complex respiratory needs
- Criteria: must be within the guidelines of InterQual
- **Exceptions:** facility is unable to admit Endotracheal tubed patients on vents
An integrated admission process assesses levels of impairment, activity, and participation for individuals who sustain a SCI or develop spinal cord pathology secondary to the following medical etiologies:

1. Traumatic:
   - Vehicular accidents
   - Sports sustained
   - Acts of violence
   - Falls
   - Accidental

2. Non-Traumatic due to:
   - Spinal Stenosis/compression
   - Spinal cord infarct
   - Cancer
   - Disease process
   - Degenerative disorders

Levels of Spinal Cord Injury:

a. Persons with a SCI Asia Impairment Scale of A, B, C, and D if the patient meets LTACH criteria.

b. Will accept all levels of SCI

c. Incomplete injuries can be inclusive of the following clinical syndromes:
   - Central Cord
   - Brown Sequard
   - Anterior Cord
   - Conus Medullaris
   - Cauda Equina

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:

- Autonomic dysreflexia
- Pain
- Neurogenic bowel
- Neurogenic bladder
- Respiratory compromise
• Circulation impairment
• Sexual dysfunction
• Spasticity
• Loss of skin integrity
• Dysphagia
• Infertility
• 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 alterations in these problems.

The SCI Program located within North Greenville Hospital is a 45 bed long term acute care hospital, providing daily 24 hour nursing care, and therapy 1-5 days a week. There are 10 ICU beds that are designed for ventilator use, high oxygen use, and medically complex patient. The remaining beds are part of medical surgical unit. Respiratory therapy is on staff 24 hours; therapists (PT, OT, ST) are on the floor M-F from 7-5. Other disciplines are integrated into the 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 healthcare delivery system. Our scope of practice is directed by the following objectives:

1. To provide a comprehensive rehabilitation program under the direction of an in-house hospitalist who works collaboratively with RCP physiatrist, ST, PT, OT, Respiratory, Case Management and Nursing to establish therapeutic protocols based on evaluative data. 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 ventilator weaning, if appropriate, with coordination of the hospitalist, pulmonologist, and respiratory therapy. A pulmonologist is in-house M-F and on-call over the weekend to assist in directing care.
3. To facilitate community reintegration through education and consulting Recreational Therapist via RCP.
4. To coordinate lifetime medical and rehabilitation needs through follow-up with a physiatrist and/or case manager.
5. To assist with setting up support services, such as public transportation, attendant care, wheelchair prescription, wheelchair maintenance, and access to health care network.
6. To monitor system integrity through specialty consultations.
7. To support adjustment and adaptable 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. The Spinal Cord Support Groups meet monthly at the Rehabilitation Hospital. Peer counselors are available on an inpatient and outpatient basis.
8. To use research, networking, collaboration with national and regional SCI centers, and standards of care from ASCIP and CARF to direct the clinical practice of the team and standards of care specific to each discipline.
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, use current models to facilitate program change, improve processes, and patient/family outcomes.
11. 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.
12. To work with patient, families, and referral sources in educating them about programs and services available.
13. To explore and refer patients to appropriate discharge environments such as home, community based providers, SNF, assisted living and other environments as appropriate.
14. 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 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 a long term acute care program that cannot be provided at an alternative level of care.

XII. Discharge/Transition Criteria:
A patient will be discharged from the long term acute care SCI program when:

  a. When the patient is successful liberated from the ventilator and/or deemed ventilator dependent and appropriate education with patient and family has been completed.
  b. The patient no longer meets the criteria to stay in a long term acute care setting and all education has been completed for the next level of care.

XIII. Outcomes: (2018)
- Characteristics of patients served:
  o Average age – 51
  o Ratio of male to female – 5:2
  o Patient satisfaction – Patient Surveys provided, but not returned
- Number of patients served:
  o 7 – all successfully weaned from vent
- Length of Stay: 46.14 days
- Average hours of therapy
  o 1 hour of therapy per day-5 days a week
- Disposition at discharge:
  o 4 patients discharged to RCP
  o 2 patient discharged to SNF secondary to families inability to provide 24 hour assistance
  o 1 back to GMH for continued medical care

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

XIV. Signatures Needed:

[Signature]
Administrator, Rehabilitation Hospital

[Signature]  2/4/19
Date

XV. Policy Responsibility: Administrator, Rehabilitation Hospital
In Coordination with: Spinal Cord Injury Program Coordinators

XVI. References: CARF Standards Manual Medical Rehabilitation, July 1, 2018

XVII. Dates: