Roger C. Peace Rehabilitation Hospital

Scope of Service and Disclosure Statement
Spinal Cord Injury Program -- Outpatient

I. Introduction:
Roger C. Peace Rehabilitation Hospital Spinal Cord Injury System of Care (SCSC) 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 inpatient and outpatient rehabilitation to restore persons with SCI to their highest potential physically, socially, emotionally, and financially. 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. The CARF accredited system of care includes as appropriate Long Term Acute Care Hospital (LTACH), Roger C. Peace Rehabilitation Hospital (RCPRH), and outpatient.

The Outpatient Spinal Cord Injury Program of Roger C. Peace Rehabilitation Hospital is provided as part of the continuum of care available through the Greenville Health System. Being on the main Greenville Hospital System campus allows us easy access to the emergency department and our own Physiatrists for consultation if medical emergencies develop related to spinal cord injury complications, i.e.: autonomic dysreflexia, low blood pressure skin breakdown, bowel/bladder issues, neurological changes, pain, circulation and spasticity.

II. Populations Served:

<table>
<thead>
<tr>
<th>Population Served</th>
<th>Settings</th>
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</thead>
<tbody>
<tr>
<td>Children 2—14 years of age</td>
<td>Children with a spinal cord injury under the age of 12 will be considered for treatment on an individual basis but are usually not treated by the outpatient spinal cord team</td>
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<tr>
<td>Adolescents 15—17 years of age</td>
<td>Adolescents with a spinal cord injury are treated at Roger C. Peace Outpatient</td>
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<tr>
<td>Adults 18—65 years of age</td>
<td>Adults with a spinal cord injury are treated at Roger C. Peace Outpatient</td>
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<tr>
<td>Geriatric persons over 65 years of age</td>
<td>Geriatric persons with a spinal cord injury are treated at Roger C. Peace Outpatient</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 Roger C. Peace Outpatient if they have an attendant to manage the ventilator.</td>
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III. **Hours of Service/Days of Services/Frequency of services:**
The outpatient program is located on the campus of GMH on the first floor of Roger C. Peace Rehabilitation hospital. The outpatient therapy gym is open Monday through Friday 8 – 5:30. Each therapy session is one hour long. Frequency is based on the individual need of the patient as established at the initiation of the individual plan of care by the evaluating clinician.

IV. **Payor Sources:**
Range from Medicare, Managed care, Workers Comp, Medicaid Programs, Auto, Private Pay, Commercial Insurance, Department of Disability and Special Needs (DDS) 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 often made from the discharging physician at the conclusion of a patients inpatient hospitalization for outpatient therapy. Referrals are also received from physicians, nurse practitioners and doctors of osteopathy at outpatient clinics.

VII. **Specific Services Offered:**
- Physiatry
- Social Work/Case Management
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Recreational Therapy
- Wound care
- Seating clinic
- Driver training

The Roger C. Peace Rehabilitation Hospital's specialized outpatient team addresses the primary impairments and activity restrictions that result from spinal cord injuries and disease (traumatic injury or non traumatic). Depending on the patient's needs, treatment may include
physical therapy, occupational therapy, neuropsychology, recreational therapy, social work/case management and speech and language pathology.

Durable medical equipment needs are identified and equipment is available for onsite demonstration. This can include specialized wheelchairs (manual, power and custom wheelchairs), cushions, and power lifts, etc. Roger C. Peace outpatient therapy offers a wheelchair seating clinic for assessment and fitting of custom manual and power wheelchair seating systems.

Roger C. Peace offers a Driver’s Rehabilitation Program with certified driving instructors/Occupational Therapists and a modified car with adaptive equipment (hand controls, brake controls, etc).

The outpatient team has a close working relationship with local orthotic and prosthetic providers to help with patient training regarding fitting and use of these specialized devices. They are available for consultation during therapy appointments and often have sample equipment to trial.

Referrals for vocational Rehabilitation services and other local support agencies are made by the case manager. Those needing personal care attendants or assistance are referred to local agencies and the Spinal Cord Injury Program staff offer training to personal care assistants and attendants before discharge.

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 social work/case manager, physical therapist, occupational therapist, speech-language pathologist, neuropsychologist, recreational therapist 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:

- **Cultural needs**
- **Impairments**
- **Activity limitations** (e.g. Functional problems with mobility, 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:**
Entry into the system begins with a referral from a physician, health care system or individual to admissions. When a patient presents for assessment, the interdisciplinary team members are mobilized to begin the evaluation process, the services the patient receives depends on the referrals made to the therapy department based on the patients needs. The team convenes monthly 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 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 are established through a collaborative relationship with the patient/family, community services, the family physician, and the follow-up physician visits.

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

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

a. When cognitive deficits are the primary concern, the patient is referred to the Brain Injury Program.

b. If the patient has the cognitive ability to participate in the rehabilitation program, a referral is made to the Spinal Cord program.

c. Safety awareness and the cognitive ability to comply with the recommended standards will be considered prior to the recommendation.

Levels of Spinal Cord Injury:

a. Will accept all levels of SCI as long as the patient is appropriate for outpatient therapies

b. 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 therapeutic interventions to educate and/or manage the following conditions, with referrals made to appropriate provider for medical needs:

- Abnormal Tone
- Autonomic dysreflexia
- Body Composition
- Pain
- Neurogenic bowel
- Neurogenic bladder
- Respiratory compromise
- Circulation impairment
- Sexual dysfunction
- Abnormal tone
- 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.

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 outpatient rehabilitation program the team which may consist of ST, PT, OT, RT, Psychology, and social work/Case Management establish therapeutic protocols based on evaluative data, under the referral and plan of care confirmed by the referring physician. These include mobility/safety, self-care, leisure skills, management of bowel and bladder issues, psychological adjustment, nutrition, spasticity management, education on 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 through referral resources that a patient may require.

2. To facilitate community reintegration through community based recreational therapy referral 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 primary care provider.

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. Peer counselors are available on an inpatient and outpatient basis. The SC Spinal Cord Injury Association (SCSCIA) Greenville Area Breeze group meets monthly in the Greenville area.

7. 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.

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 models to facilitate program change, improve processes, 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 lifelong basis.

11. To work with patient, families, and referral sources in educating them about programs and services available.

12. To explore and refer patients to appropriate agencies during or after discharge such as vocational rehabilitation.
13. To provide patients and families with information regarding personal care assistance, respite care, community long term care, private sitter agencies, and day programs.

XI. Continuing Stay Criteria:
   - Has and continues to evidence measurable benefit of practical value in a meaningful period of time
   - Abides by the departmental cancellation/no show policy

XII. Discharge/Transition Criteria:
A patient will be discharged from the outpatient rehabilitation SCI program when:
   a. Comprehensive outpatient rehabilitation goals have been met
   b. The patient reaches their expected functional outcomes/goals for their level of injury
   c. Patient's progress plateaus
   d. Patient becomes medically or behaviorally unstable requiring a different level or program of care
   e. Patient remains non-compliant with plan of care despite coaching, counseling and education.
   e. Patient does not abide by cancellation/No show policy

XIII. Outcomes: (2018)
   - Characteristics of patients served:
     o Average age – 47
     o Number under age 18 – 1 patient served
     o Ratio of male to female – 35 male / 19 female
     o Patient satisfaction – 98.9% of our patients were satisfied with the care they received.
   - Number of patients served:
     o 54
   - Number of Visits:
     o Average number PT visits – 24.6
     o Average number OT visits – 8.5
     o Average number of Wound Care PT visits - 16
   - Disposition at discharge: All remained in their homes.

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

XIV. Signatures Needed:

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: