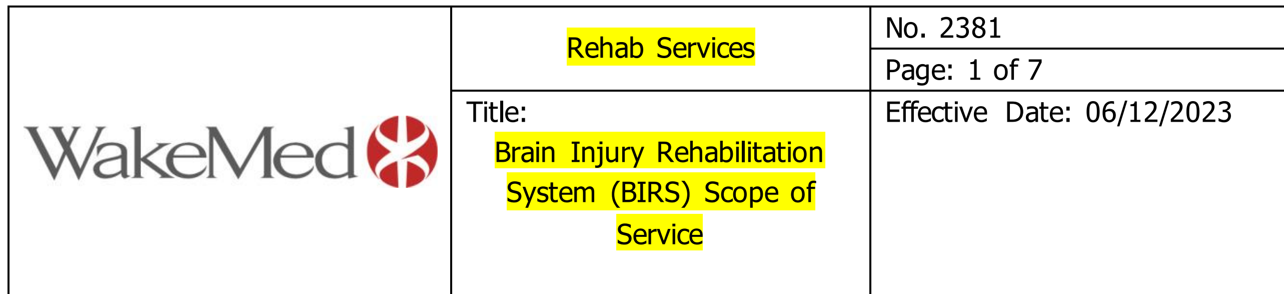


WakeMed	Rehab Services	No. 2381 Page: 1 of 7
	Title: Brain Injury Rehabilitation System (BIRS) Scope of Service	Effective Date: 06/12/2023

WakeMed Rehab Brain Injury Rehabilitation System (BIRS) Scope of Service

WakeMed Rehab provides an integrated, comprehensive delivery of rehabilitation services directed toward a population of individuals who have sustained an acquired brain injury as a result of illness, injury, or disease process. These services are provided across a continuum of care, which includes WakeMed' s acute care services at both the WakeMed Raleigh and Cary campuses, the CARF accredited WakeMed Rehabilitation Hospital, the Outpatient Intensive Neuro Rehabilitation programs in Raleigh, Clayton and Cary, Outpatient Rehab at various other locations, and WakeMed Home Health. Specific program details are described in the BIRS manual. Involvement in the BIRS program would benefit these individuals in ways not otherwise possible by developing and restoring skills toward independence and decreasing dependency on their families and communities.

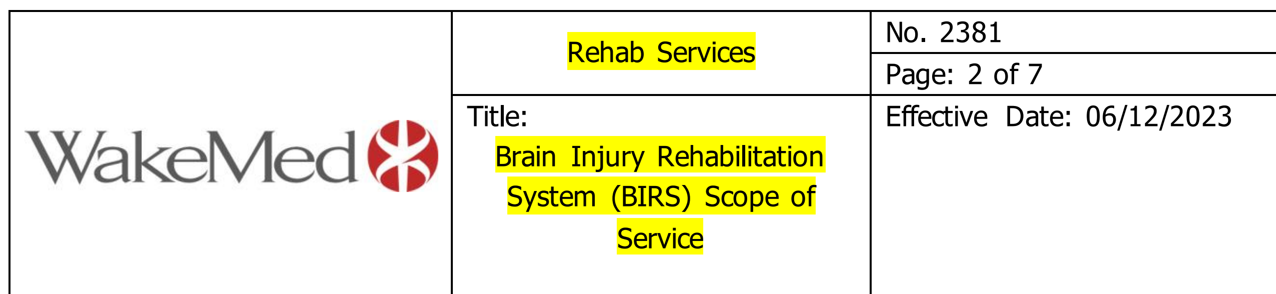
The scope of the BIRS program addresses the unique aspects of delivering care to the person served according to their level of impairment, activity level and participation in the following areas:

- Prevention of brain injury
- Recognizing, assessing, and treating conditions related to brain injury
- Prevention of complications and co-morbidities
- Identifying and reducing risk factors for recurrent brain injury
- Facilitating functional independence and performance
- Facilitating psychological well- being, coping and social adjustment
- Facilitating community inclusion and participating in life roles
- Promoting use of assistive technology
- Providing services for families/support systems

WakeMed Rehab receives referrals from many sources, including, but not limited to, private physicians, physiatrists, acute care hospitals, rehab hospitals, nursing facilities, Wake County Health Department, home health agencies, WakeMed Emergency Departments, local urgent care centers and follow-up appointments from former inpatients and outpatients. The majority of Rehab Hospital patients served are from central and eastern North Carolina, however all referrals from outside the primary catchment area are considered for admission.

Payer sources for WakeMed Rehab include state and federal public payers (Medicare, Medicare Advantage Plans and Medicaid), commercial insurances, worker's compensation, and self-pay. Any payer requirements that potentially affect the provision of services are identified and communicated to the treatment team, including the person served.

Annually, WakeMed reviews market comparisons and establishes reasonable rates for private and semi-private rooms, as well as updating the Charge Description Master for all provided services. Program fees are defined, and anticipated liability related to services are discussed with patients individually prior to admission and provided in writing via the Written Disclosure Form. On-going discussion regarding the financial impact of



hospitalization and services post-discharge is the responsibility of the case manager.

Admission decision-making occurs within a team process by evaluating the patient's impairments, activity, and participation limitations, determining rehab needs and potential for functional improvement. Additionally, a review of the program's ability to meet the patient's needs and recognize community resource alternatives and availability is assessed. WakeMed Rehab serves patients ages 4 and up, though younger children may be accepted after discussion and approval of Medical Director, Director of the Rehab Hospital and Director of Rehab Nursing on a case-by-case basis. Appropriate placement of each person served is also addressed through the admission and discharge/transition criteria for each component of care, the resources available, resources previously used, ongoing assessment and the person's potential to benefit.

A physiatrist medically supervises WakeMed Rehab's BIRS program. Services are provided by highly qualified professional staff designated specifically for the brain injury rehabilitation program. Treatment space, bed assignment and equipment are also specifically identified for provision within the brain injury rehabilitation program. The person served, family members, caregivers and support systems are an integral part of the interdisciplinary treatment team at WakeMed. The majority of rehab services are delivered with the patient and the care provider together in the same space. Services delivered via information and communication technologies might include participation in support and education groups and virtual monitoring for falls prevention. Platforms used to deliver services via information and communication technologies include video conferencing (Zoom, Webex, Microsoft Teams, etc.) and platforms such as remote video monitoring. Patients participating in services being delivered via information and communication technologies have no geographical exclusions during the Rehab Hospital episode of care.

In addition, as appropriate, and based on need, the following professional disciplines and services are arranged either directly, by referral or by contract:

SERVICE OFFERED	PROVIDED BY
Clinical Case Management	Directly
Rehabilitation Medicine	Directly
Rehabilitation Nursing	Directly
Occupational Therapy	Directly
Physical Therapy	Directly
Rehab Psychology/Neuropsychology	Directly
Therapeutic Recreation	Directly
Clinical Dietician	Directly

Speech-Language Pathology	Directly
Wound Care	Directly/Referral
Diabetic Educator	Directly
All medical, diagnostic and laboratory	Directly/Referral
Pediatric Services: • Pediatrician • Pediatric Hospitalist • Child Life Specialist	Directly/Referral Directly/Referral Directly Directly
Orthotics and Prosthetics: • Del Bianco • Beacon Prosthetic • Hanger • Limbionics • Bio Tech	Referral Contract Contract Contract Contract Contract
Department of Social Services	Referral
Social Security Administration	Referral
Community Support Agencies, Advocacy Groups, Support Groups	Referral
Mental Health and Wellbeing	Referral
Optometry/Ophthalmology/Neuro-ophthalmology	Referral
Durable Medical Equipment	Referral
Vocational Rehabilitation	Referral
Audiology	Referral
Spiritual Care Services	Referral
Palliative Care	Referral
Caregiver/Family Services	Directly/Referral
Substance Abuse Counseling/Addiction Specialist	Directly/Referral

Rehab Engineering	Directly/Referral
Drivers Assessment and Education	Referral
Specialty Wheelchairs	Contract
Elopement Prevention System	Contract
Sexuality and Intimacy Counseling	Directly
Environmental Modification/Assistive Technology	Directly/Referral
Peer Support / Referral	Directly/Referral
Medical Interpreter Services	Directly/Contract

Provision is made to include all consulting services and external case managers as members of the interdisciplinary team.

Upon admission to the BIRS Program, each individual receives a comprehensive assessment and evaluation by each team member initially involved in provision of direct treatment. Appropriate assessments are provided based on the ages, cognitive levels, interests, concerns, and cultural and developmental needs of the person served. Designated space, equipment, furniture, materials, and private areas for family/peer visits are provided as appropriate. Pediatric patients are appropriate for BIRS programming with special attention given to developmental needs and age-appropriate assessment/interventions.

For patients served in the Rehab Hospital, with input from all team members, the physician develops an Individualized Plan of Care for each patient within four days of admission. In both inpatient and outpatient settings, the treatment team will meet to update the Plan of Care based on realistic, achievable, functional goals and planned interventions necessary for goal achievement in a realistic time frame. Treatment planning includes a minimum standard of intensive rehab programming of either three hours of therapy per day, five days per week or fifteen hours of therapy over a seven-day period. In the inpatient setting, weekend therapy is routinely provided as recommended by the team and as part of the treatment plan.

The Care Plan is structured to include the patient/family goals and discharge planning issues. An estimated length of stay and assessment of discharge needs are identified within the parameters of the long-term goals. Through the case management process, the Plan of Care is shared with the patient/family and, when appropriate, the individual's insurer to facilitate communication, reimbursement, and a collaborative discharge plan.

Patient and family involvement in the brain injury program begins during the pre-admission and assessment phases and continues throughout the program. The comprehensive Plan of Care, progress and goals are formally discussed with the patient/family at least weekly in inpatient settings by the Clinical Case Manager. Discipline specific goals focused on fostering self-management are discussed during treatment sessions and include the family during specific family training sessions. Every effort is made to meet patient/family needs and goals through participation in the decision-making process. Goal conflicts are addressed primarily through the Case Management process or Family Conferences, but may also be addressed during family training sessions, individual treatment sessions, or other contacts with person served and/or family. The BIRS program provides or arranges for family/support system advocacy training, support services, education, family support, and peer/sibling support as appropriate

Each patient's program includes Orientation, Assessment, Treatment, Discharge Planning and Follow Up. Evaluation, treatment, programming and focus on the functional areas of:

1. Health/Medical Stability	Bowel function, Bladder function, Skin integrity, Sleep/wake cycles, Medication management, Wellness Promotion, Prevention of complications, contraindications
2. Nutrition/Diet	Nutritional status, Nutritional intake, Assessment and Interpretation of lab values, Diet education
3. Psychosocial	Support system, Education, Vocation, Patient/family understanding of illness, Patient/family coping/adjustment/insight, Community and financial resources, Discharge planning.
4. Behavior	Behavior management, social interaction, self-control
5. Mobility	Bed mobility, Transfers, Gait, Wheelchair mobility, Environmental barrier management.
6. Self-care	Feeding, Grooming, Bathing, Dressing, Toileting, Home management, Visual perception.
7. Communication	Auditory comprehension, Verbal/nonverbal expression, Speech intelligibility, Reading, Writing, Hearing, Swallowing.
8. Cognition	Orientation, Attention, Memory, Reasoning/problem solving, Visual/spatial.
9. Leisure	Leisure skills, social skills, Leisure/recreation participation, Resource awareness, Adaptive leisure.
10. Environment	Level of stimulation, safety, accommodations, compensatory aids.

The program provides an organized education program about brain injury for persons served and their family/support systems that includes education on:

- Neuroanatomy
- Etiology and epidemiology of acquired brain injury
- Communication with providers
- Active involvement in the service delivery process
- Behavioral supports

- Cognitive and communication interventions
- Developmental/life transitions
- Community resources
- Recognizing and reporting suspected abuse and neglect
- Professional Boundaries
- Sexuality and Reproductive Issues
- Medical complications
- Risks associated with brain injury
- Self-advocacy for patient and family
- Psychosocial and Psychological issues following brain injury, including but not limited to:
  - Adjustment to disability
  - Role changes
  - Mental health needs
  - Cultural impact
  - Adjustment issues
  - Delineation of roles
  - Social perceptions
- Substance misuse

Continued Care Planning occurs throughout the patient's admission and includes, as needed:

1. Contact with the patient's primary or referring physician and/or hospital.
2. Early identification of a realistic discharge destination.
3. Assessment of accessibility and characteristics of the discharge environment and community.
4. Identification of family/primary caregivers.
5. Identification of and referral to community support resources, including but not limited to advocacy services, counseling/support resources for individual, family, parent, sibling, etc. and the Brain Injury Association of NC.
6. Referral for continued rehabilitation therapy on an outpatient or home care basis.
7. Referral to medical specialists for follow-up after discharge.
8. Education regarding prognosis, prevention, and wellness.
9. Referral to equipment, orthotic or prosthetic agencies.

Need for continued admission is decided upon by all team members during team and family conferences and is based on:

1. Medical/physical problems which can best be treated within the rehabilitation hospitalization
2. Continued progress toward stated goals.
3. Expected improvement in function and independence.
4. Availability of alternative treatment or programming.

Origination date: *Not Set*
Prepared by: *Exec Dir, Rehab Services*
Approved by: *Rehab Administration*
Reviewed: *06/12/2023*
Revised: *06/10/2023*

Discharge dates are planned or set when continued admission is no longer necessary, patient and family are adequately prepared, and discharge destinations are finalized.

Upon discharge, each patient and family receive a follow-up plan including the following, as needed:

1. Follow up medical appointments with the primary physician and/or physiatrist and any other medical specialist determined by the discharging physiatrist.
2. Telephone number for Clinical Case Manager for questions or problems after discharge.
3. List of medications, doses, and directions for use.
4. Therapy prescriptions.
5. Recommendations for activity/participation levels and supervision needs.
6. Dietary instructions.
7. Contacts with Home Health Care or Outpatient rehabilitation, as needed.
8. Contacts with referred financial and vocational assistance agencies.
9. Contacts with DME, orthotics or prosthetic agencies.
10. Educational service contacts.
11. Referral for psychosocial adjustment counseling (family counseling, individual counseling, parent support groups, sibling support groups).
12. Substance Use Disorder Support/Treatment Referrals
13. Community support groups and/or advocacy groups (specifically Brain Injury Association of NC).

Origination date: *Not Set*
Prepared by: *Exec Dir, Rehab Services*
Approved by: *Rehab Administration*
Reviewed: *06/12/2023*
Revised: *06/10/2023*