SCOPE OF SERVICES

N7 Inpatient Rehab

Effective Date: 12/11/2024

The Inpatient Rehabilitation Unit at North Memorial is an 18-bed Medicare-certified and CARF-accredited post-acute provider of intensive rehabilitation services located within a 353-bed community hospital with a Level 1 trauma center in the Twin Cities suburb of Robbinsdale, MN.

Mission

Empowering our patients to achieve their best health.

Values

To provide the best care for our patients, their loved ones and each other, we will:

PERSON-CENTERED CARE:

We believe that each person we serve:

- Is the key participant in their own health planning along with their chosen support system.
- Has distinct needs, wants and expectations.
- Has the right to live as independently as possible.
- May need support as they adjust to their new body image and capabilities.
- Has the right of freedom from abuse, retaliation, neglect, humiliation, financial or other exploitation.
- Has the right to timely and informed medical decision making.

PATIENT POPULATIONS SERVED:

The Inpatient Rehabilitation Unit provides services for individuals ages 14 and older recovering from.

- Stroke
- Multi-trauma
- Amputation
- Traumatic and non-traumatic brain injury
- Neurological disorders
- Complex orthopedic conditions
- Complex cardiac-related impairments
- Oncology-related activity limitations
- Medically complex diagnoses
- Traumatic and non-traumatic spinal cord injury

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SETTINGS:

Program services are provided on the 7th floor nursing unit and in the Plaza-level therapy gym. An outdoor healing garden and mobility courtyard are also available for use.

HOURS OF SERVICE:

The Inpatient Rehabilitation Unit operates 24 hours a day, seven days a week, 365 days per year. There are no posted visiting hours.

FREQUENCY OF SERVICES:

- Rehabilitation nursing is provided 24/7.
- Therapy services are available 7 days per week.
- Rehabilitation provider visits provided no less than 3 face-to-face visits per week.
- Hospitalist services available 24/7.

PAYORS AND FUNDING SOURCES:

North Memorial Health accepts payment from Medicare, Minnesota Medical Assistance, commercial insurance companies, workers compensation, auto no-fault, self-pay, and other sources by arrangement. Some insurance companies require prior authorization prior to admission. If the patient doesn't have the ability to pay, they can meet with a financial counselor and make arrangements to pay. Fees are discussed prior to services being rendered.

REFERRAL SOURCES:

Patients can be referred by physicians/providers, case managers, discharge planners, home health agencies, or can self-refer. Referrals can be made by calling 763-581-8711 to speak to a Clinical Liaison

SERVICES OFFERED:

The program is organized around an interdisciplinary program model of post-acute care that includes:

- Patient and their support system
- Rehabilitation physician
- Rehabilitation physician assistant
- Medical specialists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Medical social worker / case manager (contract Lifepoint)
- Rehabilitation techs / transporters
- Registered Dietitian (on-site)
- Clinical psychologist (on-site)
- Pharmacy (on-site)
- Laboratory services (contract/on-site)
- Radiology (on-site)
- Respiratory therapy (on-site)
- Wound/ostomy specialists (on-site)
- Clinical liaison (contract Lifepoint)
- IRF-PAI coordinator (contract Lifepoint)
- Orthotists/prosthetists (community)
- Education specialists (community)
- Interpreter services (contract/off-site)
- Food services (contract/on-site)

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SPINAL CORD DYSFUNCTION SCOPE :

As a Level 1 Trauma Center with 24-hour neurosurgery and orthopedic surgery capabilities, North Memorial receives frequent acute injuries involving the spinal cord. When a patient with spinal cord dysfunction is referred for inpatient acute rehabilitation, clinical liaison specialists evaluate the patient and confer with the rehabilitation provider and therapy team. Decisions are made on a case-by-case basis with the following general parameters:

Etiology: impairments that are generally recent traumatic or non-traumatic in nature. Decisions based on etiology are related to the degree to which the team can impact the patient's medical condition, functional activity limitations and participation restrictions.

Level of Spinal Cord Injury: All spinal cord injury levels will be considered, however patients requiring ventilatory support or continuous CPAP or Bi-PAP support cannot be served by this program. Patients who do not meet our criteria are often referred to outside full-service spinal cord injury specialty programs such as those at Courage/Kenny, the VA, Craig Rehabilitation, Shepherd Center.

Completeness of spinal cord dysfunction: The program can serve both complete and incomplete injury and will depend on the potential for functional improvement.

Co-morbidities: all conditions that accompany the spinal cord injury will be considered in the context the program's ability meet the patient's overall medical, functional and psycho-social needs during the program and at discharge.

CONTINUUM OF CARE:

Together with acute care and outpatient services, we provide or connect to a full continuum of care from initial injury through return to the community. North Memorial provides outpatient therapy services in Robbinsdale and Maple Grove but does not provide home health or SNF-based transitional care services.

SCOPE SHARING:

Scope of service information is shared to persons served, families/support systems, referral sources, payers and funding sources, other relevant stakeholders and the general public in a variety of ways, including:

- This document provided at admission in admission packet
- North Memorial website: Inpatient Rehabilitation - North Memorial Health
- Clinical liaison marketing efforts – referral sources, providers
- North Memorial intranet
- Community marketing events
- Bulletin boards

TELEMEDICINE / COMMUNICATION TECHNOLOGIES:

The Inpatient Rehabilitation program does not at this time provide information or communication technologies (telemedicine, telerehabilitation, telehealth, tele-speech) to deliver services to patients.

REVIEW AND UPDATING:

The scope of services document is reviewed annually by the NMHH Rehab Operations Council (ROC) and is updated as necessary.

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ADMISSION CRITERIA:

1. The patient must require active and ongoing intervention of multiple therapy disciplines (Physical Therapy, Occupational Therapy, Speech-language Pathology, or prosthetics/orthotics), at least one of which must be physical therapy or occupational therapy.
2. The patient must require an intensive rehabilitation therapy program. The program generally consists of at least 3 hours of therapy per day at least 5 days per week.
3. The patient must be reasonably expected to actively participate in and benefit from the intensive rehabilitation therapy program at the time of admission to the inpatient rehab facility. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time.
4. The patient must require physician supervision by a rehabilitation provider defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the inpatient rehab facility 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.
5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.
6. The patient should have an identified discharge disposition plan.

EXCLUSION CRITERIA:

While all cases are evaluated on a case-by-case basis, the program generally does not offer admission to patients with the following conditions:

- Patients requiring mechanical ventilatory support, continuous CPAP or Bi-PAP;
- Tracheostomies than cannot tolerate having their trachs capped or cannot tolerate a Passy-Muir valve without the need for nursing or RT supervision during daytime hours for therapy needs;
- Patients who require trach dome during the daytime hours;
- Patients requiring trach suctioning more than once per 8-hour shift;
- Traumatic brain injuries who score at level 4 or lower on the Rancho Los Amigos Scale of Cognitive Functioning.
- IV drip that requires constant monitoring
- Patients requiring telemetric monitoring
- Active psychosis with violent tendencies
- Patients on suicide watch

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TRANSITION CRITERIA:

Patients may transition to a different level of care when:

- Discharge criteria are met (see below)
- Acute medical event requires the patient be discharged to an acute hospital unit
- Patient chooses to transition to a different rehabilitation program or service
- Patient leaves on their own volition against medical advice
- Patient expires

DISCHARGE CRITERIA:

Discharge to HOME when:

- Medically stable
- All or most goals have been met
- Family /patient education complete
- Home environment judged to be safe
- Patient independent in mobility and ADLs or help is available
- Equipment needs identified
- Home care agency choice complete (if needed)
- Follow-up care arranged for therapy and professional services
- D/C transportation and clinic visits arranged
- Team determines that additional days are unlikely to improve functional status

Discharge to **SKILLED NURSING** or **TRANSITIONAL CARE** when:

- There is a change in medical status and no longer meeting IRF criteria
- Patient is unable to tolerate 3 hours of therapy a day
- Family support insufficient for care needs or unable to provide 24 hr care
- Slow progress and needs slow pace for further recovery
- Care needs too extensive for care to be delivered at home
- Patient needs extra time/therapy to achieve needed level of function to live at home
- Patient preference to reduce burden on family
- Patient is a safety risk and unable to live at home
- Patient's bowel and bladder needs cannot be met by the care giver at home
- Patient/family and team agree that other discharge options are not appropriate

REHABILITATION PROCESS:

Rehabilitation Services provides interdisciplinary rehabilitation under the direction of a rehabilitation physician. The interdisciplinary team includes the patient and their support system, and representatives from the following services: physicians, advance practice providers, rehabilitation nurses, occupational therapists, physical therapists, speech language pathologists, social workers, dietitians, and chaplains. Consultation services are available from psychologists, orthotists and prosthetists, interpreter services, and other medical providers and various specialties throughout the hospital based on symptomatology.

Each discipline (OT, PT, SLP, Rehabilitation Nursing, Social Services) provides the following services dependent upon the individual and cultural needs of each individual: assessment, treatment, ongoing evaluation, functional goal development, customer and family/chosen support system education and training, team consultation and reporting, outpatient programming, home program development and follow-up services. The rehabilitation team incorporates cultural considerations in treatment plans and provides services to meet the customers' needs in the areas of mobility, nutrition, swallowing, activities of daily living (ADL), communication, cognition, behavior, participation restrictions, home management, and community integration.

CORE STAFFING – Methods for determining/modifying staffing to meet patient needs:

Nursing: There are three shifts: Day (07-15:30), Evening (15:00 -23:30), and Night (23-07:30). Nursing ratios are generally 4:1. Staffing per shift is based on a flexible core staffing pattern and is adjusted on customer census, acuity, and specific customer needs.

Therapy: Assignment of therapists is through a "geo-rounding" model designed to balance the needs of both the rehab and acute care patients while giving therapists experience with a broad range of diagnoses and approaches to care

PHYSICIAN SERVICES:

Patients on the ARU are under the care of the ARU Medical Director with supplemental specialist services provided as needed. Rehabilitation management is provided by the Medical Director and medical care is shared between the Medical Director and hospital specialists. The ARU Medical Director is a rehabilitation physician with training and experience in medical rehabilitation and makes final admission decisions.

Assessment And Resassessment Practices

Assessments and reassessments on the Inpatient Rehabilitation Unit are done through:

- daily documentation by team members
- daily clinical huddle with MD, PA, primary nurse, social worker, therapy leads
- daily real-time compliance review with STR checklist by Program Manager and/or IRF-PAI Coordinator
- weekly interdisciplinary team conference
- Continuous Quality Improvement (CQI) Committee, which meets quarterly
- Rehab Operations Council (ROC) Steering Committee, which meets monthly
- reviewing action plans periodically
- monthly team meetings (Unit Council, leadership meetings, etc.)
- reviewing Safety Event Reports
- Patient Satisfaction Surveys
- quarterly partnership review (QPR)

INPUT FROM PERSONS SERVED:

As a program that believes deeply in person-centered care we continually focus on the expectations of the persons we serve and other stakeholders. We seek, solicit, collect, analyze and use input from all stakeholders to create services that meet or exceed the expectations of the patients, their support systems, the community, and other stakeholders. We use a variety of mechanisms to collect information throughout the year, including but not limited to:

- Patient/family satisfaction surveys
- Follow-up phone calls shortly after admission and several months after admission
- Daily check-in with each patient
- Family conference input
- Comment cards
- Formal grievance reports
- Referral source satisfaction survey
- Physician/provider satisfaction survey
- Performance improvement reports
- Patient communal dining discussions
- Discharge meeting with physician/nursing
- Reports to Medical Education Committee (MEC)
- Quarterly Partnership Reviews with administration

INFORMATION AND COMMUNICATION TECHNOLOGIES:

To promote effective communication with patients, families and other stakeholders within our service area, the program may occasionally deliver services utilizing communication technologies, including but not limited to iPad, Facetime, Zoom, Teams, etc. Instructions and training for using the equipment will be provided as needed, including identification, emergency and privacy procedures.

STANDARDS AND GUIDELINES:

2024 is the 34th consecutive year that Rehabilitation Services has submitted outcome data to the Uniform Data Service for Medical Rehabilitation in Buffalo, New York. By subscribing to UDSmr, Rehabilitation Services can compare key objectives of the rehabilitation program to both regional and national standards. On an annual basis, Rehabilitation Services establishes goals based on regional and/or national data and compares its outcomes to those goals on a quarterly basis. Analysis of this data by Rehabilitation Services management team and the Rehabilitation Operations Council allows for program changes as needed to achieve optimal outcomes for patients. The Program Evaluation Model (PEM) provides a composite score of weighted quality metrics which allows comparison with all other inpatient acute rehabilitation unit in the national database.

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