



**HENNEPIN COUNTY MEDICAL CENTER
MILAND E. KNAPP REHABILITATION CENTER**

Subject: Scope of Service and Assessment: Brain Injury

I. Scope of Service:

The brain injury services provided at the Miland E. Knapp Rehabilitation Center (Knapp) are part of the comprehensive services available at Hennepin County Medical Center (HCMC). The Knapp traumatic brain injury services are included in the HCMC TBI Center of Excellence continuum of care. The Knapp Medical Director and the Nurse Manager/Program Manager provide leadership of the interdisciplinary team and management of the program's resources.

Knapp accepts referrals for patients with traumatic and non traumatic brain injuries from inside HCMC and from outside hospitals or other care facilities.

Knapp provides an individualized rehabilitation program for persons who have experienced brain injuries. The most frequent diagnoses include traumatic brain injury, multiple trauma with traumatic brain injury and non-traumatic brain dysfunction e.g., encephalopathy, tumor. Patients requiring ventilator support and brain injury patients at less than a Rancho Level IV stage of recovery are not admitted.

Miland E. Knapp Rehabilitation Center is located in the Blue Building of Hennepin County Medical Center. Knapp provides interdisciplinary, integrated care for a culturally diverse adolescent and adult population (age range; 13+, with average for traumatic brain injury: 46 years and non-traumatic brain injury: 52 years). Inpatient and outpatient programs are provided. Onsite services include physical medicine and rehab physicians, physical therapy, occupational therapy, speech-language pathology, clinical psychology, neuropsychology, therapeutic recreation, social work, nutrition services, rehabilitation nursing and chaplaincy. Interpreters are available through HCMC Interpreter Services. Reference to the team in this scope of service includes the patient and family.

The 18 bed staffed (27 bed capacity) Knapp nursing unit provides 7 days per week, 24 hours per day medical/surgical and rehabilitative nursing care. Other rehab services are provided 7 days per week as needed: physical therapy, occupational therapy, speech-language pathology and nutrition services: Clinical psychology, neuropsychology, therapeutic recreation, and social work are provided 5 days per week except on major holidays. The HCMC Patient and Family Centered Care philosophy is practiced through a Primary Nurse and Primary Therapist, interdisciplinary rehabilitation model. The nursing staff and therapists assess and define patient needs with each contact. The interdisciplinary practice model at Knapp is supported by the nursing staff as they apply the concepts taught in therapy to functional, daily activities.

The Knapp scope of services is shared with relevant stakeholders through case-by-case management. Information sharing with the stakeholder/s occurs from pre-admission through the service continuum provided at HCMC including Knapp.

The brain injury inpatients meet admission criteria and have physical and/or cognitive impairments that result in activity limitations and community participation restrictions. The patients reside on the inpatient Knapp nursing unit. Their strengths and needs are assessed by the rehabilitation team as described in the Scope of Assessment and are included in the care planning. Decision making capacity is assessed and declared at regular intervals throughout the rehabilitation program to ensure patient safety and preserve patient rights. It is the responsibility of the treatment team to facilitate functional improvement as specified by each discipline's standards and practices. The goal is to prevent complications, minimize impairments, maximize function and facilitate improvements that lead to a safe and timely discharge plan. The intended discharge destination is a home or homelike setting, not an institution or facility.

Patients are referred to the inpatient and outpatient programs through self referral, family referral, physician referral, facility Social Workers and Care Coordinators/Case Managers. A preadmission screen to determine admission eligibility to the inpatient program is conducted by a Physical Medicine and Rehabilitation physician.

Admission criteria include:

- Ranchos Level of Cognitive Functioning Level IV or greater.
- Likelihood that the patient will be discharged to a non institutional setting.
- An ability to participate in at least 3 hours of therapy per day, if not immediately, within the first 3-4 days of admission.
- Patient/family consent to the Knapp Rehab admission.

The Physical Medicine and Rehabilitation physician is the attending provider (attending provider is defined as the designated individual coordinating the provision of care) and the individual patient's program manager during the Knapp inpatient stay. The HCMC neurosurgery, neurology and surgery providers are available for consultation as needed.

Funding sources include but are not limited to Medicare, Medical Assistance, Workmen's Compensation plans, private insurance and managed care plans. Each payer has specific requirements for authorization of an admission to the rehabilitation program. Those requirements are known as part of the preadmission screening process. Patients without funding sources will not be refused admission based solely on the lack of funding. The HCMC Financial Assistance Department and the Disability Evaluation Center staff are contacted to assist the patient and



family with applications for funding. Patients/families are informed of denials by payers before admission so they may make an informed decision about admission to the rehab program.

The Knapp brain injury program and the HCMC TBI Center of Excellence are directly affected by changes in legislation. We work with community providers to ensure our patients receive care consistent with state and federal regulations including service availability, protection of advocacy, and continuum of care. The HCMC TBI Center of Excellence partners with community care providers and agencies especially the Brain Injury Association of Minnesota to advocate for services at the local, state and national levels. Our hospital staff seeks to educate the community about brain injury including prevention and offers input into the legislative rules and policy process.

A. Requirements for Staff:

Registered Nurses and professional team staff:
Current BLS certification and required annual and interval training.
RN licensure or license/certification per job classification.

All interdisciplinary staff members manage the maintenance and renewal of licensure, registration or certification including continued education and job related competencies.

Staff is encouraged and supported to seek educational opportunities that increase professional skills within their scope of practice and/or to specialized skill areas relative to rehabilitation of persons with brain injury.

B. Nursing Unit Staffing Plan:

The Nurse Manager/Program Manager at Knapp provides overall leadership and management of resources for the nursing unit and the inpatient program.

A charge nurse is present on all shifts. Registered nurses and health care assistants provide the direct nursing care. Float staff from the HCMC float and roster staffs, and other hospital nursing units fill core staff vacancies on a day to day basis. Outside agency staff may occasionally fill daily vacancies for increased observation coverage. The unit must be staffed with no less than 50% core rehab RN's on any shift except when multiple unplanned absences occur.

Increased supervision staffing e.g. q 15 minute checks or 1 to 1 is provided as indicated by the brain injured patients' safety needs.

Staffing is determined using the most recent annual budget information of actual staffing needs and the Medicare requirement to provide 3 hours of therapy per day. The nursing staff matrix and types of therapy services provided are adjusted

according to the patient case mix and their rehabilitation needs. The nursing staff matrix provides a guide for staffing direct care hours for the patients. Care, supervision/observation and education time requirements for patients with brain injury are often higher than those needed for others without neurological impairment. These factors are considered when staff assignments are made. Nursing staff adjustments are made by the shift charge nurse according to the patients' needs and the unit activity on a shift to shift basis.

Patient Care Assignments:

The Knapp Primary and Associate nurses are assigned to their selected patients. The remaining assignments will reflect a primary consideration of rehabilitation complexity especially relative to cognitive impairment and behavior management in the brain injury patients. The nurses' skills, strengths and experience will be considered in assignment of patient care. A Knapp core RN resource will be available to provide direction, instruction and support to the non core RN.

In the event of emergency/disaster, the minimum staffing required on the nursing unit is 2 RN and 1 NA. Increase nursing staff is planned and assigned when needed to manage brain injured patients' care regardless of the budgeted matrix ratios of nurse to patient.

II. Subject: Knapp Rehabilitation Brain Injury Scope of Assessment Summary

The individual's brain injury rehabilitation program is established and modified based on an interdisciplinary assessment of the person's strengths, the patient and family preferences and goals, the patient's physical, cognitive, speech language, psychosocial and behavioral status with related functional abilities, activity limitations and community participation restrictions. Potential risk and complications of the patient's brain injury including secondary prevention are considered. Assessment of health and wellness promotion opportunities relative to the patient's overall health status is included. Leisure and recreational interests, employment and educational pursuits, social skills, chemical use and intimacy wants and needs are assessed as life experience factors. Other areas of assessment include cultural, biological, emotional, educational, religious, and environmental factors that may impact the person's lifestyle.

The brain injured patients' safety needs are significant and require interdisciplinary assessment and interventions. The patient and family are included in the safety needs assessment. Clinical Psychology and physician directed behavior plans are developed and implemented as needed for patient and staff safety. HCMC Psychiatry Service may be consulted to assess behavior and provide recommendations to the rehabilitation team as indicated.

Decision making capacity is assessed throughout the program and documented at regular intervals in the medical record. The patient and family/decision maker are included in the rehabilitation process including the assessment and planning phases.

When the brain injured patient's safety needs exceed Knapp's capabilities, a referral is made to another community program to meet those needs. When the patient's behavior is of danger to others including staff and/or other patients in the program, discharge arrangements to another setting are initiated.

A. Preadmission Assessment

Preadmission assessment of prospective rehabilitation candidates and of patients seeking readmission after recent discharge is completed by the rehabilitation physician (Physiatrist). Preadmission identification of a payer source with authorization as needed is part of the Preadmission Assessment. Reference: Knapp Policy – Pre-Admission Assessment.

B. Information sharing with prospective patients/families

Information about the Knapp Rehabilitation Center scope of services and assessment is shared through:

- HCMC Knapp Rehabilitation Center website
- verbal information shared by the admitting physician
- admission information provided by the rehab and acute team members and materials including the Knapp Patient and Family Guide to Brain Injury Rehabilitation
- preadmission tours

C. Admission Assessment

An interdisciplinary assessment/evaluation period begins when the patient is admitted to Knapp. During that period, normally 4-5 working days, an assessment is made of the areas described in the summary. The assessment is documented. Reference: Knapp Policy – Interdisciplinary Documentation Requirements.

Activities that help to accomplish this assessment are:

- **Physiatric assessment (24 hours):** admission H&P including a statement of the patient's decision making capacity and daily rehab and medical care requirements.
- The patient and family's input.
- A Social Work assessment including family involvement to insure the disclosure of accurate information for the person served (completed within 5 days).
- Assessments initiated by Physical and Occupational Therapy (24 hours), and completed within 72 hours of admission, Speech-Language Pathology (24 hours with report within 5 days), Neuropsychology and

Clinical Psychology (48 hours initial interview), all as prescribed by the rehab physician as part of the overall care plan.

- A Therapeutic Recreation Leisure Assessment (completed within 72 hours)
- A rehabilitation nursing assessment (24 hours)
- Review of the documentation in the electronic medical chart or documentation faxed from the outside source relative to brain injury factors (i.e., swallowing precautions, falls, elopement and other safety risks) to establish the care plan and prevent complications.

An interdisciplinary Rehab Conference is held under the direction of the patient's Program Manager (physiatrist) after the assessment period. The patient and/or family are included in the decision making process at this conference to insure disclosure of accurate information and to gain informed consent for the rehabilitation and discharge plan. Based on the assessments, the discussions and decisions include:

- the patient's response to assessment and treatment.
- the patient's strengths, impairments, behavioral and safety needs, decision making capacity, activity limitations and anticipated participation restrictions.
- the patient's current functional status (including FIM data).
- whether the inpatient level of service is appropriate/required.
- recommended changes in the rehab program for the person served.
- the expected outcomes/discharge goals.
- the patient and family learning and support services needs.
- the anticipated length of stay.
- the expectations of the person served and family to accomplish the goals.
- the anticipated discharge and community reintegration plan.

Documentation of the participants and content of this conference is included in the patient's medical record.

When the initial assessment period has resulted in a decision that the inpatient level of service is not appropriate to meet the patient's needs or is not acceptable to the patient or decision maker, transition to a different level or care/service will be facilitated in a timely manner.

D. Re-Assessment

Reassessment occurs with each patient contact.

Where the initial interdisciplinary assessment period supports the intense inpatient level of service and the patient or decision maker consents to continued participation, subsequent interdisciplinary conferences are held. The frequency of the Progress Conferences is determined on an individual patient basis according to the program decisions indicated. The patient and family are included in the discussions and decisions. Based on the treatment provided and ongoing assessment, collaboration of the team members at the progress conference includes:

- patient and family willingness to continue participation in the rehab plan.
- review of the progress toward the discharge goals.
- determination of the patient's functional status, impairments, decision making capacity, activity limitations and participation restrictions.
- evaluation of the effectiveness of the treatment plan, and safety interventions, discussion of problem areas that result in decreased patient or family participation and determination of the need for initiation or termination of specific rehab services.
- identification of risk factors for recurrent brain injury with a plan for patient/family education. Examples include alcohol/substance use brain injury prevention and return to exertion.
- plans for safe use of needed equipment/assistive technology.
- review/adjustment of the treatment plan including patient/family learning style, educational needs, cultural provisions, medical and rehab management.
- review of options for primary care and assist patient/family to connect with those resources.
- reassessment of the anticipated length of stay.
- review and modification of the discharge and community reintegration plan as indicated.
- review of community resources/services that are available for patient/family/stakeholder that allow patient access to continue rehabilitation and resume pre-hospitalization lifestyle activities.
- review assessed conditions/risks related to brain injury (i.e. swallowing precautions, falls, elopement) to prevent complications.

Documentation of the participants and content of these Progress Conferences is included in the patient's medical record.

Weekly interdisciplinary team rounds are held to discuss patient progress between patient/family conferences. A variety of staff as well as methods are used to

communicate this to the person served, family and other stakeholders. Documentation is included in the individual patient's medical record.

The Interdisciplinary Patient/Family Conference and Rounds documentation is communicated to stakeholders e.g., payers or referring physicians as appropriate with consent from the patient or designated decision maker.

E. Discharge Planning

For the brain injured patient, discharge and transition planning discussions often begins when the patient is admitted to the acute part of the hospital. The anticipated discharge destination is included in the rehabilitation preadmission screening assessment. These discussions and plans continue throughout the brain injured patients stay. During variable stages of recovery the team addresses whether the anticipated discharge plan is realistic and safe. The patient and family/significant persons are included in the discussions and the planning for discharge. Contingency plans are often discussed as alternatives to the original anticipated discharge plan.

When discharged the patient receives a folder that contains portable medical information. Included is the information about HCMC "My Chart", an online access to the patient's electronic medical record. The Knapp Patient and Family Guide to Brain Injury Rehabilitation is sent with the patient as it contains secondary prevention and health/wellness information.

With consent from the patient or alternate decision maker, electronic or paper medical records are made available to their stakeholders including other providers and financial resources. A referral to the Resource Facilitation program of the Minnesota Brain Injury Association is made with consent for follow up contact after discharge. A HCMC TBI Clinic or PM&R Clinic appointment is scheduled at an interval as recommended by the attending physiatrist at Knapp. Patients and families are advised to discuss return to work, school, driving and other life experience concerns during these appointments. In addition, brain injured patients are scheduled for appointments with neurosurgery, surgery, neurology and/or other providers as indicated by their follow up needs. Appointments are scheduled at HCMC or another clinic as desired by the patient and family.

HCMC provides emergency care, acute hospitalization, inpatient/outpatient rehabilitation, and ambulatory services. For other needed services the patient is referred or linked. This may include but is not limited to: Long-term care hospital, skilled nursing facility, home care, hospice, chemical dependency programs, adult care programs, residential/vocational services and community recreational programs and services.

Discharge and transition to an appropriate service level occurs

- When the responsibility for coordination of care and the follow-up plan transitions to the patient/decision maker and the involved parties agree with the plan.
- When medical care or direction of the rehabilitation care team by a physician on a frequent basis is not required and the patient's rehabilitation nursing needs are reduced to minimal or absent. Generally, patients' Rancho Cognitive level is VI or above if discharged to a home setting.
- When the discharge goals are achieved or
- When progress has reached plateau without goals achieved and/or progress toward goals can be achieved in a less intense (acute) level of care.
- When the discharge arrangements are completed based on the recommendations of the rehabilitation team and the patient/family input. Physicians, social services, nursing, therapists, and other relevant clinicians communicate through notes, discharge summaries, online or by phone with discharge locations (transitional or sub acute facilities, treatment programs), as well as other community care providers and financial stakeholders as applicable. Nursing and other therapies coordinate needed supplies and equipment needed at discharge.
When changes to funding sources occur or funding for desired services are not available, the patient will be notified so they may make an informed decision about care and follow up. Alternative funding resources will be explored with the patient.
- When the patient/family has been educated about the follow-up necessary to address assessed conditions related to brain injury (i.e., falls, seizures, elopement and other risks) to prevent complications.