

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

**Subject: Scope of Service and Assessment: Comprehensive Program**

**I. Scope of Service:**

Miland E. Knapp Rehabilitation Center (Knapp) is located in the Blue Building of Hennepin County Medical Center (HCMC). Knapp provides interdisciplinary, integrated care for a culturally diverse adolescent and adult population (age range; 13+, with average: 49 years). Inpatient and outpatient programs are provided. Services include physical medicine and rehabilitation 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. The Knapp Medical Director and the Nurse Manager/Program Manager provide leadership of the interdisciplinary care team and management of the comprehensive program resources.

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

Knapp's 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.

The Knapp inpatients meet admission criteria and have physical and/or cognitive impairments that result in daily activity limitations and community participation restrictions. They reside on the inpatient Knapp nursing unit. Their strengths and needs are assessed by the rehabilitation team as described in the following Scope of Assessment and are included in the care planning. The goal is to facilitate improvements that lead to a safe and timely discharge plan by preventing complications, minimizing impairments, and maximizing function. The intended discharge destination is a home or homelike setting, not an institution or facility.

The most frequent diagnoses include; traumatic brain injury, multiple trauma, spinal cord injury/disorder, stroke, non traumatic brain dysfunction, neuropathy related to metabolic or endocrine conditions and cardiovascular/respiratory deconditioned.

Patients requiring ventilator support, those with complete spinal cord injuries proximal to C7 and patients whose Ranchos Level of Cognitive Function are below level IV are not admitted to Knapp.

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:

- A 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.
- 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 individual patient's program manager during the Knapp inpatient stay. Exception: Transplant Service patients will have the Transplant Surgery physician as the attending provider. The Physical Medicine and Rehabilitation physician serves as the program manager/ordering provider for the rehabilitation aspects of care.

Funding sources include but are not limited to Medicare, Medical Assistance, Workmen's Compensation plans, private insurance and managed care plans. Patients without funding sources will not be refused admission based solely on the lack of funding. HCMC Financial Assistance and Disability Evaluation Department staff are contacted to assist the patient and family with applications for funding. Each payer may have different requirements for admission to the rehabilitation program. Those requirements are known as part of the preadmission screening process before admission. Patients/families are informed of denials by payers before admission so they may make an informed decision about admission to the rehab program.

#### **A. Requirements for Staff:**

Registered Nurses and professional team staff:

Current BLS certification and HCMC required annual and interval training

RN licensure or license/certification per job classification.

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

Staff is encouraged to seek educational opportunities that increase their professional skills within their scope of practice and/or to specialized skills relative to rehabilitation diagnoses.

#### **B. 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 one to one sitter coverage. The unit must be staffed with no less than 50% core rehab RN's on any shift except when multiple unplanned absences occur.

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. Nursing staff adjustments are made by the shift Charge Nurse according to the patients' needs and unit activity on a shift by shift basis. The nursing staff matrix provides a guide for staffing direct care hours for the Knapp patients.

**C. Patient Care Assignments:**

Patient care assignments on the nursing unit are completed by the oncoming shift Charge Nurse to maximize the skills of scheduled and float staff. The Knapp Primary and Associate nurses are assigned to their selected patients. The remaining assignments are made to reflect a primary consideration of rehabilitation complexity. 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.

<u>Nursing Unit Staffing</u>			
	Care Shift: % of Staff	RN / # of Patients	Health Care Assistant / # of Patients
Days	40%	1 / 4 or 5	1 / 12
Evenings	40%	1 / 4 or 5	1 / 12
Nights	20%	1 / 6	0

In the event of emergency/disaster, minimum required staffing is 2 RN's.

**II. Subject: Knapp Rehabilitation Scope of Assessment**

**Summary:**

The individual's rehabilitation program is established and modified based on interdisciplinary assessment of the person's strengths, the patient and family preferences/goals and the physical, cognitive, speech language, psychosocial and behavioral impairments with related activity limitations and community participation restrictions. Potential risk factors, safety needs and complications of the patient's diagnosis including co-morbidities are considered. Health and wellness promotion especially relative to the patient's condition is included. Other areas of assessment that may impact lifestyle include cultural, biological, emotional, educational, religious and environmental factors. Leisure and recreational interests, employment and educational

pursuits, social skills, substance use/abuse and intimacy wants and needs are assessed as important life experience factors. Decision making capacity is assessed throughout the patient's program and is documented at regular intervals in the medical record. The patient and family are included in the rehabilitation process including the assessment and planning phases.

#### **A. Preadmission Assessment**

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

#### **B. Information sharing of the Knapp Rehabilitation Center scope of services and assessment** with prospective patients is done through:

- HCMC Knapp Rehabilitation Center website.
- Verbal information shared by the preadmission screening physician.
- Admission information provided by the rehab team members and materials including patient and family guides.
- 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:

- Psychiatric assessment (24 hours): admission H&P including a statement of the patient's decision making capacity and daily rehab and medical care requirements.
- Review of patient information from the referring source.
- Patient and family's input.
- Social Work assessment including family involvement to insure the disclosure of accurate information of the person served (completed within 5 days).
- Initial assessments 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 ordered by the rehab physician as part of the care plan.
- Therapeutic Recreation Leisure Assessment (completed within 72 hours).
- Rehabilitation nursing admission assessment (24 hours).

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

- Patient's response to assessment and treatment.
- Patient's strengths, impairments, safety needs, decision making capacity, activity limitations and anticipated participation restrictions.
- Patient's current functional status (including FIM data).
- Whether the inpatient acute rehab level of service is appropriate/required.
- Modifications to the rehab program for the person served.
- Expected outcomes/discharge goals.
- Patient and family learning and support services needs.
- Anticipated length of stay.
- Expectations of the person served and family to accomplish the goals.
- Anticipated discharge and community reintegration plan.

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

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

#### **D. Re-Assessment**

Reassessment is done by team members with each patient contact.

Where the initial interdisciplinary assessment period supports the intense inpatient acute rehab 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 needed. The patient and family will be included in the discussions and decisions. Based on the treatment provided and ongoing assessment, collaboration of the team members at the progress conference includes:

- An expressed agreement by the patient/family to participate in the rehab plan.
- Review of the progress toward the discharge goals.
- Determination of the patient's functional status, continued 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.
- 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.
- Reassessment of the anticipated length of stay.
- Review of the discharge and community reintegration plans.
- Review of community resources/services that are available for the patient / family / stakeholder to facilitate access for continued rehabilitation and to resume pre-hospitalization lifestyle activities.

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

Weekly team rounds are held to discuss patient progress between interdisciplinary patient/family conferences. Documentation is included in the individual patient's medical record.

The Interdisciplinary Conference and Rounds documentation is communicated to others e.g., payers or the referring physician as appropriate with consent from the patient or designated decision maker for the patient.

**E. Discharge and transition planning:**

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

When discharged, the patient receives a folder that contains portable medical information for them and their family. Included is the information about HCMC "My Chart", an online access to the patient's electronic medical record. The diagnosis specific Knapp Patient and Family Guide to Rehabilitation is sent with the patient as it contains risk and identification of symptoms information as well as illness prevention and health and wellness recommendations. With consent from the patient or alternate decision maker, electronic or paper medical records are made available to their stakeholders including other providers such as primary care physicians. Follow up appointments are scheduled for providers including PM&R, other specialists and primary care providers after discharge unless opposed by the patient or decision maker. Patients and families are advised to discuss return to work, school, driving and other life experience concerns with their providers during their clinic appointments.

Discharge planning may be influenced but not solely determined by funding. The patient will be informed about resource funding so they can make decisions about their care and discharge arrangements. Alternative funding resources are explored with the patient.

When discharge is not possible due to lack of funding for a facility and/or denial of admission to facilities, the rehabilitation program is uninterrupted while discharge planning continues. When therapeutic goals are achieved, interdisciplinary collaboration includes reduction of some therapies and increase in frequency of others as the anticipated discharge destination changes.

**F. Discharge and transition to an appropriate service level occurs;**

- When the responsibility for coordination of the follow-up recommendations 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 rehabilitation nursing needs are minimal to absent.
- When the discharge goals are achieved or when progress has plateaued without goals achieved and/or progress toward goals can be achieved in a less intense (acute) level of care.
- When discharge arrangements are completed based on the recommendations of the rehabilitation team and the patient/family input. Physicians, social services, nursing, and therapists communicate (through notes, discharge summary, online or phone) with prospective discharge locations (transitional facilities, treatment programs, long-term care facility) as well as other community care providers and financial/care provider stakeholders as applicable.