Brain Injury Scope of Services

The mission of the Brain Injury Program follows within the parameters of the mission of the Patricia Neal Rehabilitation Center, Ft. Sanders Regional Medical Center, and Covenant Health. It is the mission of the Brain Injury Program of the Patricia Neal Rehabilitation Center to be patient focused in all that we do so as to provide excellent care and education necessary to transition a brain injured individual from trauma or point of decline to an optimal discharge setting by improving his/her capacity to function independently. The mission is achieved by a combination of therapeutic and medical interventions and education to provide the most conducive environment for recovery within the resources available. We will do our part to be the first and best choice for brain injury recovery in the East Tennessee region.

It is the Vision of the Brain Injury Program of the Patricia Neal Rehabilitation Center to be recognized as the premier Brain Injury Program through integrity, quality, serving the customer, caring for and developing our customers, and using the community’s resources wisely.

The goal of the Brain Injury Program at PNRC is to become a BI center of excellence that is internationally recognized for quality, comprehensive continuum of patient care, research, and education with an exceptionally qualified staff.

The Brain Injury Program at the Patricia Neal Rehabilitation Center occupies 2 floors of Fort Sanders Regional Medical Center. The patients are primarily treated in the 3 East Spinal Cord Injury/Brain Injury gym and the 3 East outpatient gym with patient rooms located on 4 East and 4 West. The rooftop therapy park and ADL apartment are also utilized as needed. The current physical plant of Patricia Neal Rehabilitation Center is approximately 58,000 square feet of dedicated space.

The Patricia Neal Rehabilitation Center is located within an acute care hospital, which allows our patients access to the medical specialties and services of Fort Sanders Regional Medical Center. Patients are referred to medical specialists and support services within Fort Sanders Regional Medical Center when determined appropriate by the attending physiatrist. These include, but are not limited to, the following services:

1. Neurosurgery
2. Cardiology
2. Pulmonology
3. Pharmacy
4. GI
5. Orthopedic Surgery
6. Neurology
7. Internal Medicine
8. Endocrinology
9. Ophthalmology/Optometry
10. Otorhinolaryngology
11. General Surgery
12. Plastic Surgery
13. Urology
14. Psychiatry
15. Podiatry
16. Diagnostic Services
17. Respiratory Therapy
18. Orthotics/Prosthetics
19. Dietetics/Nutrition
20. Prosthetics/Orthotics

Patricia Neal Rehabilitation Center helps patients regain the greatest amount of independence and enjoy the highest quality of life. Services will include appropriate intervention along a continuum of care that best fits the needs of the patient from inpatient to outpatient with coordination of available community services. Patricia Neal Rehabilitation Center accepts from ages 6 and up.

Patients and families are a vital part of the rehabilitation team and participate with the interdisciplinary team in developing an individualized treatment plan. Progress towards defined goals is reviewed in a weekly team conference. All patients are under the care of trained staff and a physiatrist, who with the case manager will coordinate the highly skilled team of professionals. The environment is designed to address the cognitive, physical, educational, psychosocial, spiritual, and behavioral needs of the patient. Professional staff members are continually updating treatment skills and techniques to incorporate into the most effective treatment for patients.

Primary referrals to the Patricia Neal Rehabilitation Center are received from the following regions: east Tennessee, southeast Kentucky, western North Carolina, northern Alabama, northwest Georgia, and southwest Virginia. The main referral area for the brain injury program is east Tennessee. Referrals are initiated by physicians, case managers and patient/family requests. The Patricia Neal Rehabilitation Center has received patients from across the country and around the world including the continents of Asia, South America, Europe, and Africa.
Upon receipt of the referral, a clinical liaison and rehabilitation physician will review the medical record and determine the most appropriate placement in the continuum of care to best meet the patient’s needs.

Patricia Neal Rehabilitation Center admissions staff will verify insurance coverage prior to admission and are available to discuss any estimated out of pocket expense to the patient. The rehabilitation center accepts multiple payor sources: Medicare, Medicare Advantage Plans, and TNCare, Worker’s Compensation, commercial insurances, and self pay. Patricia Neal Rehabilitation Center establishes its rates for service through a reimbursement analysis established by Covenant Health’s revenue process.

Patients will not be eliminated from consideration solely due to lack of funding. It is recognized that the center can only support a limited number of charity cases, yet assure its own economic viability.

Upon admission to Patricia Neal, each patient will undergo comprehensive assessments by the rehabilitation team. As these assessments are completed, a plan of care will be established by the rehabilitation physician that is individualized to each patient’s specific needs.

The staff of the rehabilitation center is its most valued resource. Patricia Neal Rehabilitation Center is comprised of highly qualified individuals with specialty training designed to address the needs of the rehabilitation patient. PNRC staff work in a team approach consisting of:

- Rehabilitation Medicine/Physiatry
- Rehabilitation Nursing
- Physical Therapy
- Occupational Therapy
- Recreation Therapy
- Speech Language Pathology
- Behavioral Medicine/Rehabilitation Psychology
- Case Management.

Patient treatment is implemented after team members have completed initial assessments. Patients will participate in individualized treatment plans during their stay at the Patricia Neal Rehabilitation Center. These treatment plans will include 1:1 sessions with therapy staff, but may also include treatment in group settings. Specific treatments and techniques are discussed with family / significant others during scheduled training sessions. Education and psychosocial supportive services for patients and families are an integral part of the rehabilitation process. Education provided is individualized depending upon the patient and family needs.

Nursing services are available 24/7. Therapy services are available 8:00am – 3:30pm, 7 days a week. A typical day for patients Monday through Friday includes 3 hours per day of therapy, consisting of a combination of physical, occupational, and speech therapy.
Weekend therapy is scheduled dependent upon patient need. Behavioral medicine, recreation therapy, and case management see patients on an as needed based. All patients are followed by the rehabilitation physician.

The discharge planning process begins during the initial admission interview with the patient and family. The case manager works with the team to make a plan in consideration of the patient’s goals. The case manager completes a psychosocial assessment with the patient and the family to determine strengths, weaknesses, and coping skills and makes an effective plan that utilizes the patient’s resources most effectively. The discharge plan is reassessed throughout the patient’s stay with plans and goals changed as necessary.

The patient’s individual plan is reassessed throughout the patient’s stay with plans and goals being revised, as necessary. The case manager works with the team to develop a plan in consideration of the patient’s goals. The case manager completes a psychosocial assessment with the patient and the family to determine strengths, weaknesses, and coping skills. The case manager develops a plan that utilizes the patient’s resources most effectively. Referrals are made to community agencies when deemed necessary by the team members. At discharge, the case manager, along with the treatment team will:

- Finalize discharge plans with the patient and significant other(s).
- Refer patients to services along the continuum of care such as Outpatient services, Home Health, Post-Acute services, or integration into appropriate community services.
- Coordinate needed equipment and services such as medication, transportation, and DME.

Patients receive important information in preparation for discharge which will include: medications and prescriptions list, follow-up appointments, community resource contacts, and educational information.

Referrals to agencies and services within the community are made when appropriate and available at discharge from PNRC so that patients may continue their recovery. These include, but are not limited to the following:

1. Home Health Agencies
2. Public Health Agencies
3. Public / Private Schools
4. Sheltered Workshops
5. Independent Living Centers
6. Health Care Centers
7. Vocational Rehabilitation Services
8. Community Mental Health Services
9. Nursing Homes
10. Outpatient Therapy Services
11. Post-Acute services (i.e. Tennessee NeuroRestorative, Gallatin, TN or CCS, Carbondale, IL)
12. TBI Program, Tennessee Department of Health

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13. Community Case Management Services
15. Adaptive Aquatics
16. Community Support Agencies
17. Veterans Services
18. Patricia Neal Innovative Recreation Cooperative
19. Brain Injury Association of Tennessee and BIAA
20. Knoxville Area Brain Injury Support Group
21. East Tennessee Technology Access Center
22. Joni and Friends Ministry or similar spiritual support systems
23. Parks & Recreation Programs with accommodations
24. Disability Rights Tennessee
25. Project Brain
26. Service Animal Agencies

Case management staff will attempt to call/contact patients/families within a week of discharge to address follow up needs including recommended home equipment was obtained, prescriptions were filled, and other needs are addressed. Patients/families may also receive a patient satisfaction survey via phone call within approximately two weeks after discharge as well as a follow up phone survey in 3-6 months.