Stroke Program
Scope of Services

The Stroke Program of the Patricia Neal Rehabilitation Center (PNRC) is located within Fort Sanders Regional Medical Center and is a member of Covenant Health. The rehabilitation center adheres to the Mission Statement of Covenant Health which is to serve the community by improving the quality of life through better health. In the quest to fulfill this mission, Covenant Health is committed to its vision of being the region's premier healthcare network by providing patient-centered care that inspires clinical and service excellence, making us the first and best choice for our patients, employees, physicians, volunteers, employers and communities. This mission is based on three values:

1. The patient always comes first
2. Excellence in everything we do
3. We will do our part to be the first and best choice

It is the vision of the Stroke program to be a comprehensive rehabilitation center which is regionally and nationally recognized for improving the quality of life. We are the center of choice for recovery, re-integration into the community and promotion of wellness.

The Stroke program at PNRC occupies the 5East wing of Fort Sanders Regional Medical Center. The gym is designed and dedicated to the needs of the patient. The architectural layout of the Center is designed to be entirely accessible for convenient use by physically disabled persons with severe mobility limitations. Accessibility features conform to the American National Standards Institute (ANSI) regulations in addition to recommendations and suggestions from physically disabled persons, family members, and associated consumers. There are occasions when a patient may require treatment to simulate other environments such as community reintegration which requires off campus setting changes or use of the Rooftop Therapy Park or ADL Apartment. The current physical plant dedicated to PNRC is approximately 58,000 square feet.

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
3. Pulmonology
4. Pharmacy
5. GI
6. Orthopedic Surgery
7. Neurology

8. Internal Medicine
9. Ophthalmology
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

The Stroke Program at PNRC is dedicated to providing services to persons who have suffered a loss of physical and/or cognitive impairment due to stroke. 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 age 18 and up. Patients less than 18 years of age will be reviewed on a case by case basis.

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, 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.

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 rehabilitation center is the Knoxville area and surrounding 32 counties. 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.

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
Internal Medicine
Rehabilitation Nursing
Physical Therapy
Occupational Therapy
Recreation Therapy
Speech Language Pathology
Behavioral Medicine/Rehabilitation Psychology
Case Management
Social Work

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. Support is available in the form of a Stroke support group. This group is supported by PNRC, where members have the opportunity to be trained as Peer Visitors. Peer visitation is available to newly diagnosed individuals and their caregivers and help address emotional, physical, social needs, and adaptation to the change resulting from their diagnosis.

Nursing services are available 24/7. Therapy services are available 8:00am – 3:30pm, 7 days a week. A typical day for patients 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. Support Groups
12. Post-Acute services (i.e. Tennessee NeuroRestorative, Gallatin, TN or CCS, Carbondale, IL)
13. TBI Program, Tennessee Department of Health
14. Community Case Management Services
15. Adaptive Driving Evaluation/Training
16. Adaptive Aquatics
17. Community Support 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 within approximately two weeks after discharge as well as a follow up phone survey in 3-6 months.