SCOPE OF SERVICE
ORLANDO HEALTH INSTITUTE FOR ADVANCED REHABILITATION
OUTPATIENT BRAIN INJURY PROGRAM
2020-21

MISSION STATEMENT/PHILOSOPHY

The mission of Orlando Health and Orlando Health Institute for Advanced Rehabilitation is to improve the health and quality of life of the individuals and communities we serve. Our vision is to be a trusted leader inspiring hope through the advancement of health.
Orlando Health Institute for Advanced Rehabilitation's Purpose Statement is *"Through interdisciplinary rehabilitation we will relieve, restore and reintegrate."*

DEPARTMENT ORGANIZATION AND REPORTING PATHS

The Manager of Orlando Health Institute for Advanced Rehabilitation Institute oversees the daily operational activities at Orlando Health Rehabilitation Outpatient Services, including staff supervision, scheduling, budgeting of resources, maintenance of a safe, therapeutic environment, and compiling and distributing pertinent information to the department's stakeholders. Orlando Health Institute for Advanced Rehabilitation management reports to the Orlando Health Institute for Advanced Rehabilitation management reports to the Administrator of Allied Health and Support Services at ORMC. The Orlando Health Institute for Advanced Rehabilitation Director is responsible for directing the medical and rehabilitation management of the programs outpatients, and reviewing performance improvement initiatives for all programs in the outpatient setting.

Performance Improvement

Staff identifies performance improvement initiatives daily through the use of GEMBA boards. Specific performance improvement initiatives are developed for outpatient services based on needs identified through GEMBA, outcomes management, patient satisfaction surveys, and other stakeholder input. Performance Improvement and outcomes management information indicators and focus studies are compiled by Orlando Health Rehabilitation Institute management or designees and reported to community stakeholders, and the Orlando Health Rehabilitation Institute Leadership Committee. Performance Improvement and outcome information is provided to staff at GEMBA meetings and is posted on departmental GEMBA boards. Outcomes are shared with various stakeholders annually via multiple means of communication.
GEMBA meetings are held weekly and more frequently if required.

Compliance

The manager of Orlando Health Institute for Advanced Rehabilitation participates in a Therapeutic Council. It is the purpose of this council to ensure the coordination of the delivery of rehabilitation services, maintenance of the highest quality of care and compliance with Standards of Practice and Policies and Procedures. The Therapeutic Council meets monthly, more frequently if needed. The Orlando Health Rehabilitation Institute Leadership Committee meets monthly to review financial performance, efficiency and effectiveness of the program, access, customer service, outcome studies and patient satisfaction. Financial statements and monthly operation review systems are used to evaluate trends and assist in the budgeting process.

Staffing

Therapy staffing is determined by outpatient census. Staff members are assigned to each patient by team to maintain consistency for the patient. Staffing deficits are addressed by using pool

therapy staff, deploying therapy staff from other Orlando Health, Inc. facilities, or authorizing overtime. Staffing overage is addressed by canceling pool staff, floating core staff to another Orlando Health, Inc. facility or unit, or allowing use of paid time off (PTO). Staffing standards will allow for participation in in-services, committees, meetings, and educational opportunities.

SERVICES PROVIDED

Orlando Health Rehabilitation Outpatient Services is located at 100 West Gore Street, Suite 104 in the Lucerne Medical Plaza. The program provides rehabilitation care for outpatients 8 a.m. to 5:00 p.m., Monday through Friday. A patient first philosophy is the foundation of all of our programs. Therapists and the nurse case manager/patient care coordinator (when applicable) work closely with other members of the rehabilitation team in developing and implementing the plan of care for each patient. Foremost in planning is the patient's stated goals. These are established during the evaluation period and are integral to planning and establishing outcomes. The Nurse Case Manager plays a key role as the coordinator of care for the multiservice patient (patients receiving more than one type of therapy) by facilitating team conferences, meeting with and providing program-orientation to patients and their families, and assisting the team in providing ongoing education regarding the patient's diagnosis and related healthcare topics. The Nurse Case Manager may also assist by making referrals to necessary community services and by communicating with insurance companies. For patients receiving one type of therapy, their therapist will provide orientation, education, and make referrals to necessary community services. Front desk staff and/or the Nurse Case Manager assist single service patient care by communicating with insurance companies.

Fiscal Responsibility/ Financial Accessibility

Monthly financial statements and monthly operation review systems are used to evaluate trends and assist in the budgeting process.
Outpatient services do not discriminate based on socioeconomic status, race, religion, or disability.
We accept a variety of funding sources, including private insurance, self-pay, and state programs. The charges and fees are specific to payor source and are available upon request. As rates are negotiated with payors on a global basis for Orlando Health and patient's needs are unique to each admission, this is provided on a case by case basis. For those not using a third party payor, we will provide our self-pay policy and access to our patient business representatives for assistance.
Our fees will vary depending on the services actually received during the admission.

Discharge support/community benefits for those who qualify.

- Discharge support is an OH administered program in which patients are pre-approved for financial assistances prior to being discharged from the hospital.
- Patients may be approved for financial assistance on a case by case basis as per Orlando Health's Financial Assistance Program (FAP)
- Patients will be seen who have previously been approved for uncompensated care by OH.

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Patient financial records are audited quarterly for financial integrity. 10% of the total new admissions are reviewed to insure that the bills accurately reflect the services that were

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TYPES OF PATIENT/POPULATION SERVED

Patients served are ages 13 and above who have been diagnosed with a brain injury (traumatic, anoxic, closed head injury, open head injury) or a neurological impairment.
The patients must demonstrate a potential for rehabilitation and a need for an interdisciplinary team approach. They must also have a past medical history and present medical and psychological condition that can tolerate a comprehensive rehabilitation program.

The therapist or nurse reserves the right to refuse treatment if they deem the patient to be impaired due to any reason, to include but not limited to suspected influence of alcohol or medications (prescription drugs or otherwise), where safety would be compromised for that session. With repeat occurrences, the therapist/nurse reserves the right to refer the patient back to their physician to reassess the appropriateness of therapy and will require a new prescription for the patient to return to outpatient rehabilitation.

Admissions and Referral Process

Referral Process

Patients may be referred by physicians, discharge planners, allied health professionals, third party payers, family members or other patients.
Physical Therapy Services may be obtained via physician referral or direct access as per the Florida State Physical Therapy Practice Act and the Orlando Health medical staff rules and regulations.
A physician's referral is required for Occupational Therapy or Speech and Language Pathology services.
Some patients require all three disciplines, while others may require only one or two. Specific orders may be required for certain types of evaluations (i.e. Rehab Swallow Study, Wheelchair Evaluation, etc.). Therapists will evaluate persons referred to the program to determine their potential to participate in and benefit from a comprehensive outpatient rehabilitation program.

Admission Process

Admission Criteria
Standards for admission include:

1. The patient is at least 13 years of age and has a history of brain injury or a neurological impairment. The cause of the brain injury may be traumatic, or as result of a brain tumor or anoxia (lack of oxygen) and may be a close or open head injury.
2. The patient is in need of therapeutic intervention for the improvement of physical, cognitive, communicative, behavioral, social, and/or emotional functioning.
3. The patient can benefit from rehabilitation.
4. The patient is medically stable. Each patient's co-morbidities (conditions associated with the diagnosis of TBI) will be assessed and addressed at time of initial evaluation. Co-morbidities that allow the patient to benefit from an outpatient rehabilitation program will be permitted and addressed. If co-morbidities present a barrier to therapy, the patient will be referred to appropriate specialists/resources to address needs such as wound care, urology, psychology, pain management, rehab physiatrist, etc.

5. The patient requires minimal nursing care and is living in the community with family or other support system.
6. No medications will be administered via nursing in the outpatient setting.
7. The patient is manageable within the staffing limitations.
8. The patient and must not exhibit uncontrollable behaviors that are harmful to themselves or others.
9. The patient's past medical history and present medical and psychological condition are favorable for a comprehensive rehabilitation program and will not preclude attendance and/or participation in the program.
10. The patient has an available family/other support system.
11. Pertinent medical, educational, and vocational records have been formally requested with patient/guardian consent.
12. The patient has insurance coverage, other funding or meets criteria for uncompensated care.
13. The patient agrees to adhere to the attendance policy.

Multi Service Patients

Patients who are candidates for the Orlando Health Rehabilitation Institute (OHRI) outpatient program are reviewed and approved by the Medical Director or his designee, the Manager of Rehabilitation or their designee, and / or the Nurse Case Manager/Patient Care Coordinator with input from the rehabilitation team as appropriate. Funding sources often require authorization and include Medicare, Florida Worker's Compensation, Medicaid, Florida Brain and Spinal Cord Injury Program, insurance and other payers.

Upon admission, patients and families who receive more than one type of therapy are offered a program orientation to become more familiar with services offered and to receive important information and education regarding their health, diagnosis, and prevention of injuries or other complications. A family conference is automatically offered upon completion of the initial evaluation. However, family conferences may be scheduled more frequently upon request or as recommended by the rehabilitation team throughout the course of outpatient rehabilitation.

Single Service

Patient referred for one type of therapy receive an evaluation based on the information provided by the referral source or on the doctor's prescription. The therapist will provide program orientation to assist the patient in becoming more familiar with services offered. Important information and education regarding their health, diagnosis, and prevention of injuries or other complications is also provided. Patient progress is reassessed at least weekly, with goals reassessed at least monthly, or at the prescription's duration, or more often if goals are met prior to month's end. The therapist is responsible for coordinating the care of patient including referring to community resources, orientation to start and finish times of treatment sessions, intake of patient goals, and review of the cancellation policy and overall plan of care. The nurse case manager may assist with referrals to community resources.

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THE PROGRAMS

An inclusive evaluation /assessment is conducted by each of the involved licensed team members. The initial evaluation is completed and a formal report indicating the results of the evaluation is filed within 3 clinical visits. If the nurse evaluates the patient, results of that assessment are documented and filed within 24 hours. Services provided are based on the assessed needs of the patient including their level of function before illness, developmental considerations, cultural and religious needs. The evaluation will assess impairments, assess and recommend activity limitations such as activities of daily living, and assess and recommend participation restrictions such as driving or return to work. Patient progress is assessed on an ongoing basis and changes in the treatment plan are discussed and agreed upon in treatment sessions at least weekly and in team and family conferences when applicable. Educational needs, if applicable, are addressed by the team with the school's integration coordinator. Neuropsychology, Psychology, and/or Mental Health Counseling Services may be recommended and referrals made as appropriate.

Treatment plans are based on input provided from the evaluations of all the professional team members involved and by the patient and family/support system. The frequency of therapy needed to help patients meet their goals is determined by the therapist, but will take into account the personal needs of the patient and their family. All team members are responsible for carrying out the interdisciplinary treatment plan. The patients and their families assist in the development and implementation of a person-centered treatment plan which is unique to the patient based on the individual's goals, including the environmental factors that impact their lives in their day to day routines. Treatment aims at restoring the highest level of function to allow patients to resume activities they were involved prior to disability when possible and/or to establish new routines within their capability that maximize quality of life and community integration.

The program conforms to a series of rigorous and internationally recognized standards developed by the Commission on Accreditation of Rehabilitation Facilities (CARF). Currently, accredited programs include our brain injury, spinal cord injury, stroke, multiple service, and single service rehabilitation programs.

Program Structure

- The **Nurse Case Manager/ Care Coordinator** is responsible for coordinating the care for multiservice patients and assists in communicating with the team, physicians, and insurance companies regarding patient care and progress. Front Desk Staff also assist in verifying insurance benefits and obtaining authorization.
- **Team conferences** are held for multiservice patients and led by the Nurse Case Manager. Treatment changes are decided by the entire treatment team and discussed with patient/family during treatment sessions or in family conferences.
- **Family conferences** are offered to patients receiving more than one therapy service upon completion of the initial evaluation. Otherwise, family conferences are held as frequently as requested by the team and / or the patient and family. Patients/families receiving one therapy

usually communicate directly with that therapist during sessions and as needed. However, family conferences will be arranged upon request.

- Formal **orientation** to rehabilitation is initiated by the Nurse Case Manager and/or the treating therapist. All team members are responsible for orientation.
- **Schedules** are created on a weekly basis and take into account patient/family preferences and times of availability whenever possible. Multiple therapies may be scheduled on the same day for scheduling and transportation convenience.
- **Translation Services** are available as needed and provided free of charge to patients and family members who speak a language other than English.
- Patients are **reassessed by the treatment team at least monthly** to evaluate progress. Input from the team will be utilized to update the Goals and Outcomes and Plan of Care and to establish and / or confirm the anticipated discharge date based on a person-centered philosophy.
- In order for patients, families, and caregivers to be capable of providing the necessary support, they must have an understanding of the disease process, the patient's functional disabilities, the rehabilitation process / goals and knowledge of resources available to them after discharge. **Training and support for patients and others** may occur on a one-on-one basis or in formalized groups and is the responsibility of every member of the team. Successful reintegration of the patient into the community requires the support of family members and / or significant others.
- **Discharge planning** begins during the admissions phases and continues throughout the program. Responsibility for discharge planning is shared by all members of the treatment team, including the patient and their family as appropriate. Referrals are made as indicated and follow up contacts are made by the designated person (sometimes the patient or family member) to facilitate successful integration into the community.

Discharge Criteria

Patients and family members are given as much notice as possible before discharge from outpatient services. Discharge planning starts upon admission to the program and continues throughout the course of rehabilitation. Patients and families are trained on the use of compensatory strategies and home exercise programs, as applicable, to assist with the transition to life without formal intervention, as the goal is for patients to become independent with their therapy program or for family members to assist with exercises at home. Prior to the discharge process, the patient may be referred to appropriate community resources (i.e. vocational rehabilitation, Office of Students with Disabilities, Sheltered Workshops, etc.) and assisted in attaining necessary equipment to promote safety and independence.

Patients may be discharged from the program when:

1. The patient has received maximum benefit from the program by achieving all of the rehabilitation goals.

2. After comprehensive evaluation, the patient is determined to have no potential to benefit from and / or ability to tolerate our comprehensive outpatient rehabilitation program. Patients may be referred to another resource or program that will better meet their needs, such as a transitional living, Long Term Acute Care, Skilled Nursing, or inpatient rehabilitation facility.
3. The patient is unable to make further progress toward rehabilitation goals.
4. The patient no longer requires skilled rehabilitation services to achieve rehabilitation goals.
5. The patient is admitted to the hospital or experiences a major intervening surgical, medical or psychological problem that precludes benefit from a continued intensive rehabilitation program.
6. The patient and / or the family are no longer willing to be active participants in the program.
7. The patient / family exercises legal rights and declines the services offered.
8. The patient's needs demonstrate the ability to benefit from an extension or continuation of services through community resources not offered directly by the outpatient program (i.e. vocational rehabilitation, school based intervention, etc.).
9. The Prescription/plan of care has expired (per physician specified order or insurance provider criteria)
10. The patient's insurance coverage is exhausted and the patient refuses the option of continuing treatment under self-pay status.
11. Lack of patient attendance/compliance (3 unexcused absences from appointments, the individual is unwilling to participate in treatment or treatment attendance has been inconsistent and efforts to address these factors have not been successful.)
12. The individual is transferred or discharged to another location where ongoing service from the current provider is not reasonably available. Efforts will be made to refer for continuation of services in the new locale.

In providing and discontinuing services, Orlando Health Rehabilitation Institute staff supports and adheres to:

1. The State of Florida Practice Standards
2. Professional organization's practice standards and code of ethics
3. Orlando Health, Inc. Code of Conduct and Standards of Care / Practice

***Special Needs Addressed by our Program*:**

- Autoimmune disorders, (conditions that occurs when the immune system, the body's protection system, mistakenly attacks and destroys healthy body tissue), infectious disorders and immune suppression (a slowing or stopping of natural immune responses) are addressed through our corporate policies for infection control. Infectious disease physicians are available in our system of care for consultation as appropriate and upon referral.
- Dysphagia, swallowing difficulty, is addressed by the team and specifically by the speech language pathologist through swallow studies, modified diets, therapeutic strategies to

improve function, and adaptive techniques. The team, patients and families are educated in the needs of the patients to ensure proper carryover of the strategies.

- Skin integrity and any breakdown of the skin are addressed through regular skin checks performed by the team. We also address this issue through the care and education plans for our patients. The team addresses any issues that are identified and provides education to the patient to promote healing, prevention of further issues and to increase their level of independence. We also have wound care nurses, plastic surgeons and wound care specialist physicians available in our system of care to address any alterations in skin integrity.
- Visual dysfunction is evaluated by Occupational Therapy, addressed by the treatment team/physician and ophthalmologists are available by referral for consultation as needed.

Medical

- Circulation issues are identified in the nursing assessments and addressed as needed. Deep vein thrombosis, DVT, is a clot of blood formed within a blood vessel that remains attached to the place it originated. Medications, training and preventative measures are sometimes helpful to avoid the occurrence of DVTs as they can be common when people become inactive after injuries or surgeries. Education regarding these interventions is provided in our program.
- Medications are reviewed by the nurse case manager and/or therapist. Patients are referred back to their physician when questions arise. Education in indications, contraindications, precautions, and complications is provided for each patient.
- Musculoskeletal (involving muscles and bones) complications are addressed by the treating team and, if needed, orthopedic physicians are available by referral.
- Education regarding nutritional needs is provided to the patient. Patients may be referred to their physician or to a dietician as individually needed.
- Pain management is team focused with a goal of addressing causes and symptoms to meet expected outcomes.
- Respiratory issues must be stable to allow for the outpatient rehabilitation process.
- Spasticity (increased tone in muscles) management is addressed through medications as directed by patient's physician, education and therapeutic techniques.

Neurological: Involving the Nervous System

- Neurologists and neurosurgeons are available through referral. Ongoing assessment of this is performed by the team to monitor the patient's progress and intervene if complications occur.
- Demyelinating disorders cause interruptions and/or slowing of the messages that are sent through the spinal cord. Educational resources, training and instructions for care are provided for patients and their caregivers.

Household Management

- Skills required to carry out functional tasks to manage a household are addressed by the team and focused on by the occupational therapist. These tasks include laundry, kitchen

- Recommendations for environmental modifications are provided by the therapists and care coordinators and the patient is to meet expected outcomes with the discharge environment in mind. Assistance is provided to plan and coordinate the necessary modifications to ensure a safe and accessible discharge environment.

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Personal

- Bowel and bladder needs are addressed through our education program and in our care plans if there is difficulty managing these issues. Training in the use of adaptive equipment occurs when needed to promote independence.
- Fertility needs are addressed through education with the team as well as by referral to specialty physicians such as Obstetrics/Gynecology and Urologists.
- Sexual function is addressed by interventions and education from our nurse case manager and occupational therapists. We have available reference materials and equipment to educate our patients and significant others.

Mobility

- Mobility (ability to move in an environment such as in bed or in the community) is addressed by the treating team and focused on by the physical therapist. The goals are focused on training and equipment prescriptions that are designed to meet the set goals to improve the patient's level of independence.
- Equipment needs are assessed by the treating team and communicated to vendors providing this equipment.
- Specific wheelchair evaluations are provided to each patient as needed.
- Seating needs are addressed by the treating team and focused on by the physical therapist. Seating assessments are included as a part of the wheelchair evaluation.

Social/Emotional/Intellectual

- Cognitive and behavioral issues are addressed by the treating team and focused on by the speech language pathologist, occupational therapist, physician, and neuropsychologist, depending on the needs of the patient.
- Communication issues are addressed by the treating team and focused on by the speech language pathologist.
- Psychosocial (involving social and mental aspects) and behavioral health needs are addressed by the interdisciplinary team including a neuropsychologist, and physician. Referrals to appropriate resources are made. These counseling and support services are extended to the families of our patients as well.
- Leisure and recreation needs are addressed by the treating team. Recreational therapists are available for the outpatient program as needed.

Specialty

- Assistive technology needs are addressed by the treating team. If rehabilitation engineering or customized equipment is indicated, these services are available through referral to several state and private providers.
- Driving assessments are completed by the Occupational Therapist (CDRS). Vehicle modifications are addressed through referral to community resources.

- Durable medical equipment (DME) is provided by home health coordinators based on the needs of the patient. The needs are communicated by the treatment team and the care coordinator. DME resources are established for patients with a wide range of resource availability.
- Emergency preparedness is addressed through patient and family/caregiver education.
- Orthotic and prosthetic (artificial device designed to provide support such as a brace or artificial limb) needs are addressed by the treating team. Devices are provided by Orlando Health Rehabilitation Institute staff, orthotists/prosthetists, or approved providers depending on the nature of the recommended device.
- Counseling for aging is provided by our care coordinators, therapists, and physicians.
- Transition planning is managed by our professional team. We assist the patient in planning the transition between the different stages of the continuum of care.

Prevention

- Our team addresses prevention with education and training in both the outpatient and inpatient settings. Primary prevention topics include reducing personal risk factors, body mechanics, orthotic/prosthetic instructions, instruction and recommendations for transportation options for community mobility safety, options for safety devices, etc.
- Secondary complication prevention is provided through team intervention as well as our education process to instruct patients in common secondary complications and how to prevent them from occurring. This includes prevention related to potential risks and complications due to impairments, activity limitations, participation restrictions and the environment.

Self-Care

- Activities of daily living (bathing, toileting, dressing, grooming, etc.) are addressed by the entire team and focused on by the occupational therapists. The goals are to provide the highest level of independence possible in performing or directing care. Caregiver education and identification of needed adaptive equipment are included. The goals are developed based on the assessment of each patient, expected results, the resources, and the discharge environment.

Community

- Community integration is addressed by the treating team including community outings, functional community tasks, peer support groups, group outings and functions depending on the needs of the patient.
- Orlando Health Rehabilitation Institute staff participates in peer support groups and facilitates functions in the community to encourage the integration of leisure and recreation activities into the lives of the patient.
- Resources for independent living and community integration include close association with the Brain and Spinal Cord Injury Program (BSCIP), BSCIP Med Waiver Program, Vocational Rehabilitation, and Access Lynx.

- Vocational rehabilitation is provided through specialists in our state vocational rehabilitation program. Prevocational and preparatory strategies for return to work are included in plans of care depending on the needs of the patient.
- Substance abuse, counseling, and mental health needs are addressed via external referral and by our staff neuropsychologists, depending on the needs of the patient. These resources are also available via community referral depending on patient need.
- Case management is provided within the rehabilitation program as well as from the community. Our team works with our insurance case managers and other programs as necessary to coordinate resources to meet the life-long needs of the patient.

Education

- Education and family training are a main component of our program. The treatment team educates the patients and their families in person continuously throughout their recovery. On admission they are provided with a comprehensive manual covering topics such as orientation to the program, wellness, aging, prevention, community resources, caregiver information, and much more. It is taken home with them for their future reference.
- The outpatient facility also has an extensive resource library of information available to patients and their family/support system.
- Orlando Health Rehabilitation Institute seeks opportunities to provide education and training to the general and professional communities to promote awareness, prevention and knowledge of stroke. The medical director pursues research prospects for our program to participate in as well.

STAFF ORIENTATION, EDUCATION AND COMPETENCIES

Orlando Health Rehabilitation Institute team members participate in hospital new employee orientation and educational activities. Department orientation is completed during the new employee's Introductory Appraisal period under the guidance and direction of an assigned preceptor / mentor and the Rehabilitation Manager. Annual competencies are also assigned and completed each year to address high risk, low volume, or other important skills or concepts for team members.

Orientation is comprehensive and individualized according to employee's specific needs. New employees are assigned to a preceptor who is skilled in the specialized care required for the agreed upon orientation period.

Staff Education is provided on an ongoing basis to include new equipment, new policies and procedures and other topics according to periodic needs assessments. Licensed therapy staff and nurses are granted educational reimbursements based on the specific needs of the department. Information provided on an ongoing basis includes but is not limited to:

- Annual Mandatory Education:
  - Patient's Rights
  - Fire Safety
  - Patient, employee and guest security

  - Infection Control
  - Bloodborne Pathogens- Occupational Safety and Health Administration (O.S.H.A.) In-service
  - Risk Management
  - Cardiopulmonary Resuscitation (CPR) Certification; bi-annually
  - Maladaptive Behavior Policies & Procedures
  - Nonviolent Crisis Intervention education and training for all rehabilitation staff
  - HIPPA standards
  - IT security
- In-services to include products, equipment, procedures, patient care issues, hospital policies and procedures

Staff Competency: Staff members are required to maintain competencies specific to the level of practice required at Orlando Health Rehabilitation Institute as part of Orlando Health, Inc., policy as demonstrated by current licenses and / or certifications, and competency assessments. All therapists are required to pass an annual clinical review, with an 84% grade, which assesses their skills
Coaching plans or performance evaluations are completed twice a year providing an opportunity to assess the competencies and skills of the team members.

TYPES AND SKILLS OF STAFF

The staff or team members employed by the outpatient rehabilitation department are competent, qualified, ethical, and licensed and / or certified where required. The rehabilitation teams are maintained on a constant basis with therapists assigned to patients. When it is necessary for another therapist to work with a patient, the primary therapist has established the plan of care to be followed and provides any necessary information to the treating therapist. This level of teamwork and communication allows the patient to receive seamless, necessary care even when their primary therapist is unavailable. An interdisciplinary, (meaning involving multiple specialty areas), approach is used for providing care to the patients at the Orlando Health Rehabilitation Institute.

The rehabilitation interdisciplinary team consists of the following members:

- Physiatrist
- Registered Nurse Case Manager / Certified Rehabilitation Registered Nurse
- Spinal Cord Injury Network Coordinator
- Physical Therapists
- Physical Therapist Assistants
- Occupational Therapists
  - Certified Driving Rehabilitation Specialist
- Speech Language Pathologists
- Neuropsychologist
- Rehabilitation Aide

Available as needed

- Respiratory Therapists
- Clinical Psychologist
- Clinical Social Worker (LCSW)
- Chaplain
- Dietician
- External Case Managers

INTERACTION WITH ALLIED HEALTH/SUPPORT DEPARTMENTS

- ***Biomedical Engineering:*** performs routine equipment evaluation and appropriate documentation. Maintains and repairs electronic equipment and obtains outside assistance as necessary. Each location in conjunction with Biomedical ensures all electrical patient care items have current maintenance label.
- ***Central Supply:*** orders supplies and maintains them on a par level system.
- ***Corporate Quality & Patient Safety:*** Facilities task forces regarding process improvement initiatives.
- ***Engineering*** provides minor maintenance to the department upon verbal request. Provides, supervises, or coordinates major maintenance or projects to the department upon written request. The outpatient clinic is a leased space. Conducts periodic mandatory fire drills.
- ***Environmental Services:*** can be contacted to provide special services. The outpatient clinic is a leased space, and is cleaned by the facility's management.
- ***Finance Department:*** provides written budget management and expenditure reports on a monthly basis and assists with annual budget requests. Payroll is prepared through this department and they serve as a resource to address payroll issues.
- ***Human Resources*****:**
    - Recruits new employees into the system
    - Maintains list of available positions
    - Processes hired employees into the system
    - Maintains personnel files
    - Generates 90-day and semi-annual coaching plan forms
    - Resource for manager in event of disciplinary action, suspension, termination, or employee grievances.
    - Resource for employee benefits
- ***Health Information Management:*** maintains the official patient record after discharge. It is responsible for fulfilling any outside written request for a copy of the medical record. It will make charts available, after written notification, for retrospective analysis.
- ***Infection Prevention &Control:*** provides routine surveillance activities and serves as a resource regarding infection control issues.

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- ***Information Services***
  - Provides continuous, efficient computerized data processing and other systems related services.
  - Provides education regarding use of various systems within Orlando Health.
  - Provides quotes for the capital purchase of computer hardware.
  - Provides and monitors security access codes for the various systems within Orlando Health.
- ***Clinical Learning*** Provides corporate education and staff development.
- ***Marketing:*** provides direction of the marketing plan, marketing collateral, competitive analysis and an advertising program. They maintain the content of all Orlando Health digital and social media. The marketing department operates under the ethical standards of the American Marketing Association and Orlando Health.
- ***Supply Chain:*** provides certain patient care equipment and purchases authorized on non-stock and capital equipment items. It issues a monthly supply and utilization report.
- ***Outpatient Manager:*** oversees the daily operational activities including financial and clinical activities, budgeting of resources, maintenance of a safe therapeutic environment, departmental growth and development and compiling and distributing pertinent information to the department's stakeholders.
- ***Outpatient Clinical Supervisor:*** provides clinic guidance and support during regular hours of operation. The clinical supervisor is responsible for the appropriate scheduling and supervision of staff and patients, day to day operational activities, maintaining accurate departmental statistics and assisting the manager in the overall operation of the department.
- ***Outpatient Clinical Specialist:*** provides clinic support during regular clinic hours of operation. The clinical specialist assists the supervisor in coordinating scheduling of patients and therapists activities and is the clinical liaison between Inpatient and Outpatient Rehabilitation.
- ***Office/support staff:*** obtains insurance authorization, registers patients and provides admission paperwork to department.
- ***Orlando Health Institute for Learning***
  - Conducts initial orientation for new employees
  - Conducts classes for personnel, professional and CTE development
  - Provides for the continuum of professional development
- ***Outside/Contract Services:*** Will be utilized if cost effective and appropriate. Services must be coordinated through the appropriate departments in order to ensure compliance to Orlando Health and State/Federal guidelines.
- ***Patient Business Services:*** Provides support to the business operations of the department
- ***Registered Dietician:*** is available for consultation.

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- ***Regulatory Department:*** Serves as resource for The Joint Commission and other regulatory standards compliance.
- ***Respiratory Therapist:*** Is available to assess and monitor the patient's respiratory status as needed. In the event of an emergency, 911 will be called.
- ***Revenue Integrity:*** Assures the ethical implementation of all aspects of patient billing.
- ***Risk Management:*** Processes incident reports regarding variances and provides feedback to department.
- ***Safety Department:*** Conducts Environment of Care and Life Safety surveillance inspections. Coordinates Disaster Response Procedures.
- ***Security:***
    - Provides escort upon request for any employee entering or leaving the building.
    - Upon proper identification of the requesting person, will unlock department doors.
    - Provides and maintains employee identification badges.
    - Is notified if any person that could pose a threat or hazard to any employee, patient or visitor is called to their attention.
- ***Spiritual Care Services:*** is available on request.