Outpatient Neurology Therapy Scope of Services

Our Mission
The mission of Outpatient Neurology Therapy Services is to enable patients to achieve their highest possible level of independence after suffering a brain injury, stroke, spinal cord injury, or other neurological condition. This is consistent with the core values and mission of Helen Hayes Hospital in that it promotes independence and health through high quality, cost effective medical rehabilitation care with dignity and respect for all.

Our Patients
Specifically, Outpatient Neurology Therapy Services is designed to meet the needs of individuals, starting at infancy through the life span, who are recovering from a brain injury, spinal cord injury, stroke, general deconditioning, and other neurological conditions. This program offers integrated rehabilitation services for a culturally diverse population. Hours of operation are 7:30 a.m. to 5:30 p.m. Monday through Friday. A majority of patients are being seen twice a week.

Our Approach and Our Rehabilitation Team
Based upon the patient’s needs, the program provides single discipline or multiple interdisciplinary services of which Occupational Therapy, Physical Therapy, Speech and Language Therapy are the core services. Also available are the following adjunct services: Nursing, Cardiac Rehab, Neuro-Psychology, Prosthetic and Orthotic, Center for Rehabilitation Technology, Therapeutic Pool and Vocational Rehabilitation. The main focus of the program is ambulation/balance, strengthening and endurance building, upper and lower motor function, maximizing independence in activities of daily living (bathing, grooming, eating, dressing), perceptual/cognitive skills, speech and language difficulties, swallowing problems, social skills, behavioral management, mobility in the home and community, pain management, and health education/disease prevention. The program also makes available services for the provision of adapted technology, prosthetic/orthotic devices, specialized seating, etc. and training in their use.

The Medical Program Director, Glenn Seliger, MD, a board certified neurologist coordinates Outpatient Neurology Therapy Services. He is a member of the New York State Head Injury Association, Editor of Journal of Brain Injury, and participates annually in the New York State Head Injury Association Conference. He has an active clinical practice and participates in quality assessment activities. He consults the interdisciplinary treatment program on an as needed basis.

The Clinical Program Manager oversees and coordinates all therapy programs. The Clinical Program Director is available to meet with patients as well as family/significant other/caregivers as needed, to explain or discuss the program or address any questions, comments, concerns, etc.

Admission Criteria
Patients considered for admission to Outpatient Neurology Therapy Services have sustained a recent stroke (including cerebral infarction and cerebral hemorrhage), traumatic brain injury (i.e. aneurysm, subdural hematomas, brain tumors, anoxic brain injury). Also seen by Therapy Services are patients with traumatic or non-traumatic spinal cord injury, Guillain-Barre Syndrome, peripheral nervous disorders, myopathies, muscular dystrophies, as well as other demylineating and neurological disorders.

The patient’s attending physician (community or Helen Hayes Hospital) deems a patient medically clear to participate in such an outpatient therapy program and initiates the process with a medical order.

The amount of therapy provided, both the number of disciplines to be involved, as well as the amount of time per discipline is individualized. It is based on the patient’s tolerance to therapy and his/her specific treatment needs.

Helen Hayes Hospital is affiliated with NewYork-Prebyterian Healthcare System.
Each referral will be screened by the insurance financial staff for its appropriateness and potential benefit from the program. If the patient is an inpatient at Helen Hayes Hospital, the appropriate Program Case Manager will contact the Ambulatory Outpatient Scheduling Department for available times.

**Program Description**

Upon admission to Outpatient Therapy Services, the patient will receive a comprehensive assessment by the appropriate discipline (OT, PT, Speech). Based on the findings of the assessments, an individualized therapy program will be specifically designed to address the patient’s needs. Findings of the assessment, goals, and the therapy treatment program will be discussed with patient and family/significant other.

As indicated earlier, the therapy program typically address ambulation/balance, strengthening and endurance building, upper and lower motor function, activities of daily living, perceptual/cognitive skills, speech and language difficulties, swallowing problems, pain management, social skills, behavioral management, mobility in the home and community and health education/disease prevention. When specifically identified, adjunct services (i.e. Prosthetic and Orthotic, referral to support groups, Center for Rehabilitation Technology, Therapeutic Pool, peer mentorship, etc.) will be recommended.

The average length of stay is determined by the patient’s diagnosis (refer to section on program protocol by diagnosis) and their specific goals/treatment program. A Patient’s progress is reviewed on an ongoing basis and revised accordingly by the clinician. Updates of the patient progress are communicated to the referring attending physician.

Ongoing communication/dialogue are key to the success of each patient’s program. This can occur at all levels with the family/significant others, other therapy services, adjunct services staff, equipment vendors, insurance case managers, etc.

The plan of care, along with the discussion with patient/family/significant other, are goal directed with a focus on functional status. The discussion centers on preventing and minimizing impairments, reducing disability and achieving predicted outcomes.

**Discharge Criteria/Plans**

Discharge planning and resources available are discussed with the patient/family/significant other during his/her initial assessment. It is critical that this planning start from day one. Home exercise/activity programs are explained to the patient and patient is encouraged to follow through with the exercise/activity program.

The length of stay is dependent upon the patient’s needs, functional level, cognitive status and referring physician’s order. The therapist and patient/family/significant other work together to achieve common goals.

**The Day Program at the Transitional Rehabilitation Center** serves as an important final step for brain injured individuals in transitioning back to the community.

A tentative treatment plan is set-up after the completion of the team’s assessments and an intended discharge date is projected, with safety as the bottom line. Discharge occurs when the patient and/or family/significant other:

- Have accomplished their goals that were established with therapy
- No longer require multiple therapy outpatient services.
- Could be safely managed in an alternative environment
- Have an acute medical need which prohibits participation in the outpatient rehabilitation program
- Are unable to comply with missed appointment policy

Patients may also utilize the Hospital’s Wellness Center, Adaptive Sports Program, and Participant Pool Program upon discharge.

**Education**

Patient and family education is an ongoing individualized process. Each discipline provides information through the use of home exercise programs, brochures, pamphlets, didactic discussion, etc. As appropriate, family/significant other will be asked to attend therapy session to review and practice with the patient in preparation for discharge.

Community education is done through many different mediums, i.e. Internet, radio, newspaper, marketing mailings. A variety of support groups hold their meetings at Helen Hayes Hospital and patients/families are strongly encouraged to participate. Information is posted in public areas of the hospital.

**Advocacy**

The clinical therapy members at all times, advocates for the patient. This can take many forms and may include educating family/significant other, friends, and siblings about access to programs and services with activity limitations and participation restrictions; arranging for appropriate counseling and support services, enabling sibling/peer support, etc.