Brain Injury Program Scope of Services

Our Mission
The mission of the Brain Injury Program is to assist our patients in achieving their highest possible level of independence. This is consistent with Helen Hayes Hospital’s core values and mission in that it promotes independence and health through high quality, cost effective medical rehabilitation care with dignity and respect for all.

Our Patients
The Brain Injury Program is designed to meet the needs of individuals from young adult through the life span, with a focus on traumatic brain injury, aneurysm, subdural hematoma, and brain tumor. The Brain Injury Program of Helen Hayes Hospital offers the entire continuum of rehabilitation services from coma recovery, acute rehabilitation, outpatient services, wellness and Transitional Rehabilitation Center Day Program.

Our Approach and Our Rehabilitation Team
Helen Hayes Hospital’s Brain Injury Program is an individualized combination of medical and therapeutic interventions. The program offers patients the opportunity to be placed in the Neuro Recovery Program and or progress into the Acute Rehabilitation Program. The determination is made through information gathered from the pre admission and admission process and most importantly from the initial evaluations and team consultation. The acute program offers an intensive interdisciplinary approach, designed specifically for each patient based on needs and goals. The focus is most typically on improving activities of daily living (bathing, grooming, eating, dressing), adaptive equipment assessment and use, upper and lower motor function mobility training, custom seating, cognition and memory, exercise and strengthening, physical endurance, health and nutrition management, mobility in the home and in the community, perceptual/cognitive skills, speech/language difficulties, swallowing problems, emotional control, social skills and behavioral management.

For patients who are not yet ready for acute rehabilitation the inclusion of our Neuro Recovery Program serves to provide a more complete continuum of care and service for brain injury patients who are in a coma or emerging from coma. The Neuro Recovery Program was developed in 1993 and is specifically designed to prevent or minimize secondary complications of traumatic brain injury, which are commonly observed in comatose head injury survivors. Complications can include muscle contractures, skin breakdown, pulmonary issues and blood clots. The program provides unified, interdisciplinary services with a focus on Coma stimulation vent weaning, swallow management, mobility training, strengthening and exercise regimens, specialized seating, physical endurance and health and nutrition management. The goal is to minimize the chances of secondary complications when the head injured survivor transfers to the next phase of their rehabilitation. This program also offers access to cognitive testing and counseling from our team psychologist.

Our Attending Physician is Dr. Glenn Seliger MD, a board certified neurologist, and he coordinates the Brain Injury Comprehensive Inpatient Programs. 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 oversees the interdisciplinary treatment team. A physician is available for medical management 7 days per week, 24 hours per day.

**The Clinical Program Director** oversees and coordinates all therapy programs. The Program Director ensures that all persons served meet the criteria for admission to the program, receive an appropriate individualized, interdisciplinary treatment program, and receive a minimum of 3 hrs. of comprehensive therapy a day and ensures achievement of the predicted outcomes. The Clinical Program Director is available to meet with patients as well as families/caregivers as needed, to explain or discuss the program or address any questions or concerns.

**The Nurse Manager** oversees all 3 shifts of nursing staff seven days/week. Often coordinates and oversees patient satisfaction surveys and provides consult for all patient issues.

**The interdisciplinary Brain Injury treatment team** consists of a Neurologist, Nurse Practitioner, Clinical Program Director, Case Manager, Psychiatrist, Neuro-psychologist, licensed Clinical Social Worker, Occupational, Physical, Speech-language and Recreation therapists, Registered nurses, Respiratory therapists, and Dietician, all working in conjunction with the patient.

The team meets at weekly rounds, and huddles on all non-rounds days or informally as needed. All are venues to identify and discuss physical, cognitive, and social progress or issues amongst the interdisciplinary team. Treatment plans, goals and progress is documented on the interdisciplinary rounds forms, and are discussed at weekly rounds. The length of stay is an interdisciplinary team decision formalized and modified as needed at formal rounds.

**Our Admission Criteria**

All traumatic brain injuries, aneurysms, subdural hematomas, sub-arachnoid hemorrhages and brain tumors, anoxic brain injuries that are less than four months post injury are the customary candidates for inpatient programs. The patient’s attending physician, (typically from an acute care setting) deems the patient medically clear to participate in individual/group therapy daily.

A Helen Hayes Hospital Referral Specialist does a pre-admission assessment of medical and rehabilitation needs to assure potential benefit from the program. All levels of the Rancho Los Amigos Cognitive Scale will be screened and reviewed with consideration given as to the time of injury and age of patient.

For continuity of care it is necessary that the Brain Injury team receive a copy of the patients chart with a discharge summary including:

- History and physical
- All consults
- Recent medication list including date and time of last dose
- Nurses transfer summary
- Recent progress notes
- Lab work (last several days)
- Any diagnostic test results: (chest x-ray, report, echocardiogram, ultrasound, CAT Scan, MRI, etc.
- The most recent CT, MRI or MRA

**Program Description**

Upon admission to the service, the team evaluates the patient and a plan of care established in the first 24 hours. Typical services include rehabilitation nursing, incontinence training, physical, occupational, speech and recreational therapies, ventilator weaning, psychiatric services, cognitive retraining, neuro-psychology, patient family/caregiver education, nutrition services, home/food management training, and social services/ discharge planning.

As said earlier, Helen Hayes Hospital offers an acute rehab program, or for patients who have sustained a recent, severe brain injury and are in or emerging from coma, we offer the option for the **Neuro Recovery Program**. The determination for which program is made through information gathered from the pre-admission and admission process and most importantly from the initial evaluations and team consultation.

In the first 30 days of the Neuro Recovery Program, each patient receives intensive coma stimulation as well as therapy care to prevent the secondary complications that often accompany coma. Case management is available to assist the family with discharge planning upon admission into the program and throughout the stay. Social work/patient family liaison works closely with families/caregivers at this time as well.

Continued participation beyond the initial 30 days is dependent upon significant measurable gains. This gain is measured though use of the JFK Coma Scale. The JFK Coma scale is a tool used to measure degrees of coma recovery. At the end of the 30 day evaluation period, a 6 point gain in the scoring system will be considered evidence that the patient is making gains and may benefit from continued participation in the Neuro Recovery Program.

If the patient is eligible to continue, they will enter a 2nd 30-day coma stimulation period, which is again evaluated with use of the JFK scale. At the completion of the second 30-day period the patient must be eligible for acute rehabilitation as evidenced by FIM score improvements, to qualify for continued hospital stay. If at the end of this period, the patient is unable to participate in acute rehabilitation, the case manager will assist the family/caregivers in instituting the discharge plan. Patients who are discharged and show improvement at a later date may be evaluated for re-admission into the active rehabilitation program.

**The Acute Rehabilitation Program** offers an intensive interdisciplinary program, designed specifically for each patient based on functional needs and goals. The focus is most typically on mobility training, custom seating, activities of daily living, cognition and memory, exercise and strengthening, adaptive equipment, physical endurance, health and nutrition management. Our programs also offer vent-weaning and swallow management as well as access to cognitive testing and counseling from our team psychologist and or patient/family liaison.
Brain Injury Program Scope of Services continued

In either program, the amount of therapy provided, the number of disciplines involved as well as the amount of time per discipline, is individualized. While the total time may vary on different days relative to each patient’s tolerance and needs, the minimum patients receive in the acute program is 3 hours of therapy at least 5 days per week.

The therapy day begins at approximately 8:00 am and ends around 4 pm. Each patient is provided with an individualized schedule of a therapy program and this schedule is updated and or modified as needed with regard to patient tolerance, preferences and fatigue. Modifications are always made for cultural or religious preferences/needs. The practice of therapy extends beyond the individual sessions throughout the entire 24 hours when the rehabilitation nursing staff reinforces the therapeutic techniques during daily activities. The average length of stay in the acute rehabilitation program is about 27 days.

Patient progress is formally reviewed on a weekly basis by the team. Progress is measured using the Functional Independence Measure Instrument (FIM). All team members are required to be certified in the use of the tool.

As needed other professionals may be added to the team for specific services. Available on site adjunctive and/or diagnostic services are: Audiology, Chaplaintry, Chemical Dependency Counseling, Diagnostic Radiology, Driver Assessment, Driver Education, ENT Services, Orthotics & or Prosthetic Services, Laboratory Services, Ophthalmology Consults, Respiratory Therapy, The Center for Rehabilitation Technology, and Vocational Rehabilitation.

The interdisciplinary team along with the patient is goal directed with a focus on maximizing the patient’s functional status in the intended discharge environment. This destination is ideally the home, with either home services or referral for out-patient neurological services, but sub-acute or long-term facility discharges are also common options.

The Helen Hayes Hospital the Out-Patient Neurological Program provides an innovative option to shortened hospital stays, bridging the gap between traditional inpatient, homecare and outpatient rehabilitation programs. HHH OPN is located on our main floor and offers a smooth continuum of comprehensive and intensive therapeutic services focusing on promoting maximal independence and well-being. The HHH OP Neuro area is generally open Monday – Friday from 7:30am to 6:00pm, but often hrs. will vary based on patient’s needs. The Brain Injury Cognitive Program provides an individualized outpatient rehabilitation program designed to work on the problems that impact on how the patient functions in everyday life. These activities may include dressing, planning a meal, balancing a checkbook, driving etc. The Brain Injury Cognitive Program is offered during the hours the OPN center is open.

The Day Program at the Transitional Rehabilitation Center located on our campus allows individuals recovering from brain injury the opportunity to practice and be accountable for their daily living skills in a supervised and supportive environment. Following inpatient rehabilitation, most individuals with TBI need ongoing supportive services to help them adjust to their new limitations and become as independent as possible.

The Transitional Rehabilitation Program provides service coordination, counseling, life skills training, behavioral programming and social and recreational opportunities, along with “Whatever It Takes”, to help participants begin the next phase of their life.

Education

Patient and family/caregiver education is an ongoing individualized process. Each discipline provides educational information through the use of videos, brochures, pamphlets and didactic discussion. Community education is done through various modalities, i.e. Internet, radio, programming, adaptive sports etc. The Head Injury Support Group meets monthly at Helen Hayes Hospital. Guest speakers provide important information discussion and support to Head Injury survivors, families and caregivers.

Advocacy

The interdisciplinary Brain Injury Team is at all times advocating for the person served. This can take many forms and may include educating family, 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.

Discharge Criteria

Discharge of the patient to the appropriate environment is critical to the success of the Brain Injury Program. Following inpatient rehabilitation, patients can be discharged to home, OP Neurological Rehab, sub-acute or long-term care programs. HHH also offers the day program at the TRC, where patients with higher levels of function can refine their interpersonal and organizational skills. The Day Program at the Transitional Rehabilitation Center serves as an important final step in transitioning back to the community.

A tentative plan is set upon day of admission and an intended discharge date is projected. With safety as the bottom line, discharge occurs when the patient and/or family:

- Have accomplished their goals that were established with therapy
- No longer require an intensive rehabilitation setting
- Could be safely managed in an alternative environment
- Have an acute medical need, which prohibits participation in the rehabilitation program.