Sub-acute Rehabilitation Program
Scope of Services

Our Mission

The mission of the Sub-acute Rehabilitation Program is to assist residents in achieving their highest possible level of independence. This mission is consistent with the Helen Hayes mission to promote independence and health through high quality, cost effective medical rehabilitation care with dignity and respect for all.

Our Residents

The Sub acute Program at Helen Hayes Hospital offers an expanded level of service to individuals in need of short-term rehabilitation care before returning home. This program is designed to meet the needs of individuals, ages 18 through the life span.

This program is well suited for individuals who may not be medically able to participate in a full day, intensive therapy, such as those with orthopaedic injuries, who are not yet weight-bearing. Sub-acute services may also be recommended for those who have progressed well in acute rehabilitation and have met most of their goals. These individuals may be functioning at a relatively high level, but require training to master certain tasks, such as stair climbing, before returning home.

Sub acute rehabilitation is ideally suited for individuals recovering from hip or knee surgery, fractures and other orthopaedic conditions.

Generally, individuals in need of short term rehabilitation, who are medically stable, motivated to participate and who show reasonable potential to achieve their rehabilitation goals within a relatively short time are candidates for this program.

Our Approach and Our Rehabilitation Team

The flexibility of the program in caring for individuals at different stages of the rehabilitation process makes it ideal for those either beginning or continuing their rehabilitation treatment. The Sub acute Program is a less intense level of rehabilitation care, developed to meet a broad range of patient needs.

The program provides unified interdisciplinary services on mobility training, activities of daily living training, strengthening, ambulation, equipment acquisition and training for use, physical endurance building, medical management, nursing care and nutritional management.

The primary team consists of physicians, a physician assistant, registered and licensed nurses, psychologist/mental health specialists, physical therapists, occupational therapists, case managers/social workers and recreational therapists. Pharmacists in the hospital pharmacy supply all prescribed medications for the patients. Other services of radiology, laboratory, chaplainry, respiratory, nutritionist, respiratory, speech and orthotic/prosthetic services are available.

The Attending Medical Director, Dr. Mary Guarracini, a board certified physiatrist, oversees the unit administratively. This physician along with the physician assistant provides comprehensive medical management. Around the clock medical coverage is provided by 24 hour nursing staff and an in-house on call hospital physician.

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, receive appropriate amount of comprehensive therapy a day, follows the MDS regulation and reviews achievement of the predicted outcomes. The Clinical Program Director is available to meet with residents as well as families/caregivers as needed, to explain or discuss the program or address any questions, comments, concerns etc.

The Nurse Manager oversees all 3 shifts of nursing staff seven days/week. Often coordinates and oversees resident satisfaction surveys and provides consult for all resident issues.
The MDS Coordinator establishes and manages a system for the coordination, completion and submission of the MDS and while maintaining compliance with federal and state regulations with regards to the MDS.

The resident receives 24 hour skilled nursing care by licensed nurses. The licensed nursing staff administers all medications, provides wound and skin care and is the primary discipline for bowel and bladder training. In addition the nursing staff is responsible to educate the resident and family members on all aspects of care as part of the discharge planning.

Our occupational therapists evaluate the ADL and adaptive equipment needs of our residents. Assistive technology needs -- both immediate (i.e. adapted call bells, phones and TV remotes), as well as long-term requirements are addressed. OT also evaluates the residents’ cognitive status, and can set up a cognitive remediation program. Our OT staff addresses any physical impairments and functional limitations to provide for optimal individualized exercise programs. Upper body orthoses are made and set up by OT to assist positioning and function for ADL’s. Our home and food management center allow OT to assist our residents in their transition from hospital to community/home.

Our physical therapists address lower body function, seating, mobility, respiratory and circulation issues faced by our residents. A therapist works one-on-one with the resident, helping to provide opportunities for regaining skills and the tools to promote an active life at home, work or school. Physical therapists, who address physical impairments and functional limitations, will assess strength and flexibility and utilize individualized exercises and hands-on techniques to restore the greatest degree of function and mobility.

Case managers assist residents and families with entitlement programs, insurance issues and the exploration of community resources. They disseminate information regarding discharge planning, and arrange for home care, outpatient therapy and nursing home services where appropriate. They are available for guidance to both residents and caregivers and facilitate communication between the family and the rehab team, throughout the continuum of care to insure a smooth transition from hospital to home.

Mental Health: Psychosocial issues are managed in an interdisciplinary manner. Psychiatry, Psychology, mental health specialists and nursing all assist the resident and family with issues such as substance abuse, and any emotional and psychological issues. Individual psychotherapy sessions are provided to residents and families. Medication and psychotherapy are used to help treat the psychiatric diagnoses that may challenge a particular resident. This support remains present throughout the continuum. For those individuals with cognitive impairments interfering with rehabilitation or thought to potentially impact return to function in the community may be referred for comprehensive neuropsychological assessment. Results of these evaluations are incorporated into cognitive remediation strategies utilized by the team and specifically the Speech and OT staff providing the cognitive therapies.

Certified Vocational Rehabilitation Counselors assess and assist our residents throughout the continuum and make referrals to VESID and job retraining programs. They also serve as a liaison between the resident and their employers, and assist in job modifications that may be necessary.

The therapeutic recreation therapists introduce residents to computer skills that can be used for leisure or professionally. In addition, they introduce residents to adaptive gardening, golf, tennis, and basketball, as well as a Wellness Center Program that includes an adaptive gym. They also offer a daily meditation class. Information is also provided to residents on other facilities in the community, which provide a myriad of leisure activities (i.e. horseback riding, etc.). Our recreational therapist also runs a “wheelchair/seated” aerobic exercise video on the weekends to enable our resident to exercise while promoting socialization.

Adaptive Sports and Recreation: current and former residents, as well as individuals with disabilities living in the community, are given opportunities to participate in a range of recreational activities. Equipment can be adapted as necessary and patients are encouraged to utilize newly developed skills and techniques acquired through rehabilitation. We have an Adapted Sports Coordinator who organizes the program. Activities include the following:

- Aquatics
- Gardening
- Kayaking
- Rowing
- Basketball
- Sailing
- Waterskiing
- Hand cycling
- Snow skiing
- Softball
- Glider Planes
- Bowling
- Archery
- Rock climbing
- Fishing
- Golf
- Yoga
- Paintball

The Center for Rehabilitation Technology (CRT) is a nationally recognized center dedicated to the innovative and interdisciplinary application of technology to assist people with physical disabilities to increase their independence. CRT’s team members are specialists in a wide range of assistive technologies and excel in working with clients who may have multiple and/or severe disabilities that may need an integrated approach to best meet multiple technology needs.

- Our clinical services include:
- Seating and Wheeled Mobility
- Augmentative/Alternative Communications
- Job, Environmental & Ergonomic Accommodations
- Electronic Aids to Daily Living (EADL’s)
- Computer & Tablet Access
- Special Apparatus Services: Rehab Engineering, Fabrication & Custom Solutions
The department’s Arnold Goldman Center and Smart Apartment are showcases for the assistive technology being used to help individuals of all abilities, from people with mobility limitations to those with communication impairments.

Program Description

Upon admission to the sub-acute rehabilitation program, the resident will receive an evaluation and an assessment by team members including physician &/or physician assistant, nurse, physical and occupational therapist and case manager. The sub-acute rehabilitation program, discharge planning and resources available are discussed with the resident during this interview.

Other services may be requested as needed.

The amount of therapy provided, both the number of disciplines involved as well as the amount of time per discipline, is individualized. Every resident will have an interdisciplinary MDS assessment performed on him or her. While the total time may vary on different days relative to each patient’s tolerance and needs, it is common for residents to receive anywhere from 30 min to 2.5 hours of therapy including Occupational, Physical and Speech Therapies. The amount of therapy they receive is determined on each individual’s needs.

Durable medical equipment needs are addressed by all team members throughout the continuum. Our facility and its staff deal with reputable and responsible vendors that put our resident’s needs first.

The practice of therapy extends beyond the individual sessions throughout the entire 24 hours when nursing staff reinforce the therapeutic techniques during daily activities. We also provide those residents, who are appropriate, to participate in our weekend walking program which is run by our CNAs (Certified Nursing Assistants).

Length of stay is discussed with resident/family at interdisciplinary care plan meetings or via the case manager. Length of stay is individually based with an average of 15 days. Functional Independence Measure Instrument (FIM) is utilized to measure the progress by the team, as well as the MDS scoring system. All team members are trained in the scoring of the FIM and the MDS.

As needed other professionals may be added to the team for consultant services. Available adjunctive and/or diagnostic services are; psychological services, nutritional services, urology, diagnostic radiology, orthotic/prosthetic services, laboratory services, respiratory therapy, cardiac and pulmonary diagnostic services, genitourinary/ gynecological services, podiatry, consultative medical, neurological, surgical or rehabilitation physician services.

Continuum of Care (after inpatient): The strength of our program is its extensive range of services, offering a smooth continuum of care. Following inpatient sub-acute rehabilitation, patients can progress into our Outpatient Rehabilitation Center. The hospital also has a Wellness Center, specially equipped for ambulatory patients as well as wheelchair users, to encourage individuals living to stay healthy and prevent future complications.

Education

Resident and family education is an ongoing process. Each discipline provides education information through the use of videos, brochures, pamphlets, didactic discussion and formal classes.

Advocacy

The interdisciplinary team is at all times advocating for the residents. This can take many forms and may include educating family and friends about access to programs and services with activity limitations and participation restrictions; arranging for appropriate counseling and support services. We offer all of our residents an opportunity to voice any concerns or questions they may have at our Resident Forum. This is run by our patient/resident relation’s representative.

Admission Criteria

Patients must meet medical necessity guidelines as defined by their payor.

General Guidelines:

- All patients must have a realistic discharge plan and family involvement.
- Patients that are unable to sign their admission consent due to physical or cognitive problems must have consents signed by an accompanying family member or via phone consent with a family member prior to admission.
- We accept patients with all types of IV access devices, but need documentation as to insertion date, length and type.
- Patients who weigh over three hundred fifty pounds must be discussed with the Nursing department and Program Director to determine if required equipment is available.
- IV antibiotics will be accepted as long as the frequency of administration does not interfere with therapy.
- Patients requiring long-term antibiotic treatment should have a venous access device (VAD) prior to admission.
- Patients requiring chemotherapy and/or radiation therapy should receive same prior to admission or after discharge.
- The Respiratory Department must be informed of patient requiring BiPap, CPAP in order to verify availability of equipment.
- Minimum age is 18.

Rehabilitation Guidelines for The SNF

- The patient must require the active and ongoing therapeutic interventions of at least one therapy discipline (PT, OT or SLP).
- The rehabilitation program is defined as ½ hour to 2 ½ hours

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per day, at least five days per week.

- The patient must reasonably be expected to actively participate in, and significantly benefit from, the subacute rehabilitation program. The goal of the program is return home.

**Exclusionary Criteria for The SNF**

- VAC dressing
- Tracheostomy
- 1:1 supervision
- Dementia that interferes with day-to-day learning
- Peritoneal and hemo dialysis
- Telemetry
- Ongoing chemo or radiation therapy
- Hyperalimentation
- Pressure ulcers Stage III and IV
- Psychiatric issues which would interfere with progress in therapy

**Issues Requiring Case-by-Case Evaluation Prior to Admission**

- Transfer requiring assist of more than one person
- Medical complexity requiring visits to multiple physician consultants
- Surgical drains
- Central IV access
- All medically complex patients
- Patients with severe or end stage chronic disease

**Discharge Criteria**

Discharge of the resident to the appropriate environment is critical to the success of the sub acute rehab program. The Hospital offers a continuum of care through the Outpatient Center and Outpatient Clinics and/or home service referrals. Follow up care is based upon the functional status at the time of discharge and the individualized plan of care.

This plan is set upon the day of admission and an intended discharge date is projected. Within the framework of four possible paths actual discharge occurs. With safety as the bottom line, discharge occurs when the team, resident, and/or family determines that:

- The resident/family has accomplished their goals
- the resident no longer requires a sub acute rehabilitation setting
- the resident could be safely managed in an alternative environment
- the resident has an acute medical need which prohibits participation in the sub acute rehabilitation program
- maximized their optimal level of independence