HELEN HAYES HOSPITAL

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Amputee Program Scope of Services

Our Mission

The mission of the amputee program is to assist our patients in achieving their highest possible level of independence. 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

The amputee program is designed to meet the needs of the individual, ages 18 through the life span, recovering from a traumatic or non-traumatic amputation.

We accept referrals from all over the country, however are top 5 referral sources are Good Samaritan Hospital, Nyack Hospital, Westchester Medical Center, Hospital for Special Surgery and Columbia Presbyterian Medical Center. Helen Hayes Hospital accepts most insurance but if your insurance is not contracted, fees can be negotiated. Helen Hayes Hospital has contracts with most major payer sources but our top five are: Medicare, Blue Cross, Aetna, United Healthcare and Medicaid.

Our Approach & Our Rehabilitation Team

The Helen Hayes Hospital Amputee Program offers a comprehensive continuum of services to its patients. We provide acute rehabilitation, which includes pre-prosthetic and prosthetic training, as well as lifetime follow-up with extensive outpatient services. Educational services, vocational rehabilitation, on-site prosthetic services and community re-entry programs, as well as psychological and psychiatric services are also available to meet the individual needs of our patients.

The program provides unified, interdisciplinary services with a focus on pre-prosthetic and prosthetic training, wound care, pain management, health education and disease prevention, mobility training, strengthening and endurance building, ambulation, maximizing independence in activities of daily living, providing adaptive and durable medical equipment and training for use, medical management, nursing care and nutrition management, smoking cessation, weight control. Our Amputee Program also offers care in preventing, recognizing, assessing and treating conditions related to limb loss and its complications.

The team consists of a physician, registered nurses, physical therapists, occupational therapists, case managers/social workers, prosthetists, mental health specialists and a nutritionist. Pharmacists

in the hospital pharmacy supply all prescribed medications for the patients. Other services of radiology, laboratory, psychology, therapeutic recreation, respiratory, speech and orthotic services are available and are prescribed on as needed basis.

This is a unified, interdisciplinary program offering the culturally diverse amputee population a full range of rehabilitation services. The acute rehabilitation program offers a minimum of 3 hours per day focusing on the return to a maximal functional level. The amount of therapy provided, the number of disciplines involved as well as the amount of time per discipline, is individualized.

Each morning, patients dress in their own clothes and are served breakfast. Patients participate in at least three hours of therapy, following the assigned therapy schedule. Lunch takes place at about 12:00 noon, and therapy generally ends for the day about 4pm. Patients are then free to rest, relax, spend time with visitors or take advantage of any of the amenities or services offered. Dinner is generally served at 5pm.

The medical direction for the Amputee Program is provided by a board-certified physiatrist who is responsible for providing comprehensive medical management for the patients. That physician carefully discusses what to expect as someone now living with an amputation. Complications that may develop, long-term prognosis, as well as the expected outcome are all reviewed with the patient and family. A physician is always available for medical management seven days per week, twenty-four hours per day in the facility.

The amputee patient receives 24 hour nursing care by licensed Registered Nurses with a majority of the nurses being certified in

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rehabilitation (CRRN). In addition we have Health Care Aides (HCAs) to provide assistance with Activities of Daily Living (ADLS) and transfers. The licensed nursing staff administers all medications, provides wound and skin care and diabetic management, if necessary.

The Nurse Manager oversees all (3) shifts of nursing staff seven days/week and is responsible for implementing nursing plans of care and confirming or modifying those plans via interdisciplinary discussions and the weekly team rounds meeting.

Our occupational therapists evaluate the ADL and adaptive equipment needs of our patients. OT also evaluates the patients' 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 community outings, adaptive driving program, transitional living unit and our Smart Apartment allow OT to assist our patients in their transition from hospital to community/ home.

Our physical therapists address lower body function, seating, mobility, respiratory and circulation issues faced by our amputee patients. A therapist with experience in amputee rehabilitation works one-on-one with the patient, 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, mat exercise and upright classes, and hands-on techniques to restore the greatest degree of function and mobility.

The 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 ensures achievement of the predicted outcomes. The 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, comments, concerns, etc.

Case managers assist patients 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 patients and caregivers and facilitate communication between the family and the Amputee Team throughout the continuum of care to insure a smooth transition from hospital to home

Our Prosthetic specialists work to restore mobility to our amputee population by combining an array of state-of-the-art components with our custom designed prosthetic sockets. This is achieved through a consultation and evaluation with diagnostic sockets to provide an intimate fit for control and stability for the amputee during initial fitting of their temporary prostheses and the fitting of their permanent prostheses. Extensive training and education in the proper use and care of the new prosthesis is provided to the patient and family members or caregivers while monitoring the amputee's progress through the continuum of care.

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

Psychosocial issues: Psychiatry, Psychology, physiatry, nursing and our peer mentor all assist the patient and family with issues such as sexuality, substance abuse, depression and the emotional and psychological burden of dealing with limb loss. Individual psychotherapy sessions are provided to patients and families. This support remains present throughout the continuum. 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.

Support Groups, Mentorship & Advocacy: We host a chapter of the United Spinal Association (which serves SCI, amputees, MS, etc.) as well as partner with the Amputee Coalition of America (ACA). We also have a list of former patients from our amputee program, who can serve as a peer mentor. These former patients have been through the programs we offer here and have successfully integrated back into the community and serve as good role models. These services are organized by our Mentorship Coordinator.

Helen Hayes Hospital offers a monthly support group for inpatients, outpatients, and community residents as well as their families and caregivers. These meetings offer opportunities for peer counseling, consultation for accessible travel, self-advocacy, resources for community re-integration, benefits, fitness and exercise strategies, and counseling, emergency preparedness and accessibility rights. The Support Group is led by our Mentorship Coordinator.

Recreational Therapy: These services are designed to help improve leisure function and independence as well as reduce the effects of injury or illness. The program may include adapted leisure activities, leisure education, community reintegration, and community recreation resources. They also offer a daily meditation class. Diversional services offered include: pet therapy; performing arts program; and special events. A monthly calendar of events is posted in each room and announcements are made to inform patients of available activities.

Adaptive Sports and Recreation: Current and former patients, as well as individuals with disabilities living in the community,

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

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, our patients receive a complete medical assessment by a rehabilitation nurse, who will care for the patient during his/her stay, and a board-certified physiatrist. As part of the orientation to our facility, they receive an admission packet that contains information regarding the services provided at the hospital, the services disclosure statement, pertinent phone numbers, contact information, what to expect while here etc… (See admission's binder for more details).

The other members of the interdisciplinary team assess the patient on admission to explore the patients' functional needs. We also utilize a team approach to identify and reduce the risk factors for further amputation and prevent complications.

A treatment plan is then set up for the patient, which addresses his/her medical, physical and psychosocial needs. This plan is reviewed with the patient and family on admission. An individualized therapy program, based on the patient's needs and priorities, will be specifically designed to increase mobility and independence and will be discussed with the patient.

The length of stay is dependent on patient's needs, functional level, and cognitive status and discharge priorities but is typically about 2-3 weeks. Progress is reviewed weekly by the team in interdisciplinary team rounds and discussed with the patient/family member/caregiver or any other pertinent stakeholders after these team rounds. Family conferences are offered to all patients and their families. Progress is measured using the Functional Independence Measurement Instrument (FIM) and Press Ganey survey data.

The interdisciplinary team along with the patient is goal-directed with a focus on functional status in the intended discharge environment. The team and patient work towards minimizing impairments, reducing disability, and achieving predicted outcomes. Durable medical equipment needs are addressed by all team members (i.e., PT, OT, CRT, RN, MD) throughout the continuum. The patient/family is assisted to obtain the recommended equipment for discharge use and trained in the safe use of it.

If necessary, 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, and surgical or rehabilitation physician services. We have lab and radiology services on-site. Therefore staff has the capability to order a diagnostic test STAT and obtain results promptly so that an informed decision can be rendered for the plan of care. Turnaround time is generally one hour for these diagnostic tests.

Education

Our amputee patients are educated by our team on medical complications, equipment, skin care, residual limb care, care of the prosthesis, home exercise program, aging, nutrition, their medications, diabetic care, wellness and preventative care (including foot and limb care). Personal counseling and family training are provided one-on-one and via our amputee informational manual. Each discipline provides educational information through the use of videos, brochures, pamphlets and didactic discussion. Each patient also receives an Amputation educational manual and has access to the educational, TV channel for the amputee population.

Advocacy

The interdisciplinary Amputee Team is at all times advocating for the patient. 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. We work closely with local Independent Living Centers, United Spinal Association, the American Coalition of Amputees and others, and make referrals to their services as appropriate.

Transitional Living Program: This program is designed to promote independence in all functional activities within a hospital

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based home like environment. Patients and their caregivers (who meet the criteria) may be asked to spend a day and night there where they will perform and safely execute all activities necessary to function at home. They are oriented to the area and establish goals with the interdisciplinary team that reflect their ongoing rehabilitation. Following the stay, feedback will be given to the team and any issues identified will be followed up with a resolution.

Continuum of Care (after inpatient): The strength of our program is its extensive range of services, offering a smooth continuum of care. Following intensive inpatient rehabilitation, patients can progress into our Outpatient Rehabilitation Center as well as our on-site Prosthetics and Orthotics department. In addition, Helen Hayes Hospital is one of the only facilities in the region to provide lifelong follow up for common medical conditions associated with limb loss and co-morbidities. The hospital also has a Wellness Center, specially equipped for ambulatory patients as well as wheelchair users, to encourage individuals living with limb loss to stay healthy and prevent future complications.

Admission Criteria

Patients are admitted from acute care as soon as they are medically stable, can participate in at least 3 hours of individual/group therapies per day, and have clear inpatient rehabilitation goals. The team will receive a copy of the patient's medical record including:

- History and physical assessment plus any co-morbidities
- Medication list with date and time of last administration
- Medical, nursing, and therapy progress notes
- Pertinent lab data and diagnostic test results (i.e. x-ray, echo, CAT scans, MRI)
- We do NOT accept renal dialysis patients

Discharge Criteria

Discharge of the patient to the appropriate environment is critical to the success of the Amputee Program. The discharge status is subsequently the foundation of the individualized plan of care.

This plan is set upon the 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 the goals of inpatient rehabilitation
- 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