

Orthopedic/Musculoskeletal Program Scope of Services

Our Mission

The mission of the Musculoskeletal Rehabilitation Program is to assist our patients to achieve their highest possible level of independence after orthopedic surgery, arthritis, other orthopedic related conditions, multiple traumas and deconditioning due to accident or illness. 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 the Musculoskeletal program is designed to meet the needs of individuals, ages 20 and through the life span, who are recovering from orthopedic surgeries, resulting from either an osteoarthritis condition or from a fracture, multiple traumas and or deconditioning. This program offers rehabilitation services for a culturally diverse population who are seeking independence after a joint replacement or fracture. The majority of patients are treated and admitted to the 2nd and 3rd floors.

Patients' impairments may be compounded by deconditioning, weakness, pain, and wound care issues that would interfere with upright and functional mobility.

Services to treat comorbidities such as chronic pain, parkinsons disease, neurological conditions and cardiac disease, which may complicate rehabilitation, are also offered.

We accept referrals from all over the country, however our top 5 referral sources are Hospital for Special Surgery, Nyack Hospital, Valley Hospital, Englewood Hospital. 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 which include but are not limited to Medicare, Blue Cross, Aetna, United Health Care and Medicaid.

Our Approach and Our Rehabilitation Team

The program provides unified, interdisciplinary services with an individualized treatment program that incorporates the patients' medical conditions, prior living situation, activity limitations that interfere with functional abilities and cultural and behavioral needs that could interfere with goal achievement and discharge plans. The overall program is focused on 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. The rehabilitation program provides 3 hours per day of both individual and group therapy 5 out of 7 days/week.

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 of the day at about 4pm. Patients are then free to rest, relax and spend time with visitors. Dinner is generally served at 5:00pm.

The team consists of physicians, nurse practitioner, registered nurses, physical therapists, occupational therapists, case managers/ social workers and nutritionist. Pharmacists in the hospital pharmacy supply all prescribed medications for the patients. Other services including radiology, laboratory, psychology, therapeutic recreation, G.U., respiratory, speech and orthotic/prosthetic services are available and are prescribed on an as needed basis.

The Attending Physician is assigned by the Medical Director and is either a Board certified Psychiatrist or Internist who oversees the Orthopedic/Musculoskeletal program and is the patients' primary physician.

The physician will perform a physical examination upon admission and a comprehensive review of all medical systems. This review allows the Attending Physician to discover the patient's general state of health, comorbidities and the status of the patient's joint replacement or fracture and overall level of pain and discomfort. Laboratory and diagnostic tests are completed based on the needs of the patient. Consultants are called as indicated and include cardiologists, pulmonologists, neurologists and mental health counselors.

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Around the clock medical coverage is provided by 24 hour nursing staff and an in-house on call hospital physician. Consultations for other aspects of medical management such as Cardiac, Pulmonary, Infectious Disease, Urology and Radiology, are requested on a need basis.

All findings are discussed with the patient. The physician carefully discusses any complications that may develop and management of the short and long-term outcomes. Pain management and management of side effects is a major focus so that patient can progress through the rehabilitation process and receive maximum benefit from the therapy intervention.

An individualized treatment plan is developed with each patient and this plan includes the patient's and family goals as well as the rehabilitation team's knowledge and experience in guiding patients towards realistic goals. Current medications are reviewed and adjusted as our physician and patient feel is warranted. The treatment plan addresses each patient's medical, physical, psychosocial, behavioral and cultural needs. This plan is reviewed with the patient and/or family shortly after admission and is modified as necessary based upon the degree of progress seen over time.

The orthopedic patient receives 24 hour nursing care by licensed, Registered Nurses (R.N.'s). In addition we have HCA's (Health Care Assistants) to provide assistance with Activities of Daily Living (ADLs) and transfers. The licensed nursing staff administers all medications and provides wound and skin care and monitors your pain.

Our occupational therapists evaluate the ADL (Activities of Daily Living) and adaptive equipment needs of our patients. OT also evaluates the patients' overall endurance, standing tolerance, cognitive status, and safety needs for current environment as well as for discharge setting. Our OT staff assesses physical impairments and functional limitations of the upper body and postsurgical precautions that may interfere with ADL allowing for the development of optimal individualized treatment programs.

Our physical therapists address lower body function, upright and functional mobility and endurance, range of motion and strength of the surgical limb and pain management and works one-on-one with the patient, providing therapeutic interventions designed to regain strength, endurance, address physical impairments and functional limitations, to restore the greatest degree of function and mobility. PT makes recommendations for DME and orders equipment as necessary.

In conjunction with Occupational Therapy, PT will also assess any issues associated with the aging process. PT and OT also help patients and their family members evaluate the home for necessary home modifications for safe discharge.

Case managers assist patients and families with insurance issues and the exploration of follow-up care. 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 especially for transition, discharge and long term planning. They facilitate communication between the family and the Orthopedic/Musculoskeletal team throughout the continuum of care to insure a smooth transition from hospital to home.

Admission Criteria

Patients considered for the admission to the program have recently undergone unilateral or bilateral hip/knee replacements, hemi-arthroplasty, other orthopedic surgeries, fractures, arthritis, multiple traumas and other related conditions. Patients are surgically and medically cleared to participate in individual/group therapies. Patients are assigned to a unit depending upon the complexity of the patient and the bed availability.

The amount of therapy provided, both 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, restrictions, activity limitations, cultural and behavioral needs, patients will receive three hours of therapy 5-6 days/week. The services provided include Occupational and Physical Therapy and Nursing. Additional services available as needed include Speech, Mental Health Specialist, and Therapeutic recreation. The practice of therapy extends beyond individual sessions throughout the entire 24 hours when the rehabilitation nursing staff reinforces the therapeutic techniques during daily activities. Patients are admitted directly from acute care hospitals or home.

A referral specialist from Helen Hayes Hospital does a pre-admission assessment of medical and rehabilitation needs to ascertain the patient's potential benefit from an intensive rehabilitation program.

For continuity of care it is necessary that the orthopedic/musculoskeletal team receive from the acute care hospital a copy of patient's medical records inclusive of:

- History and physical
- Co-morbidities
- Medication list with date and time of last administration, nursing discharge summary with weight bearing status, orthotic devices, recent pertinent laboratory results
- Physical therapy and occupational therapy information if any

Program Description

Upon admission to the Orthopedic/Musculoskeletal program, the patient will receive a comprehensive medical assessment completed by the physician, nurse practitioner, nurse, physical and occupational therapists and case manager. 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. When specifically identified, ancillary therapy programs (ie: Speech Therapy or Recreational Therapy) will be incorporated.

Typical services include rehabilitation nursing services, wound care, pain management physical, occupational therapy, patient/

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family education, home/food management training, case managers and social services/discharge planning.

Discharge planning and resources available are discussed with patient during this initial assessment. A Patient/family information booklet is explained and given to patient at this time.

The average length of stay is dependent on patient's medical needs, functional level, cognitive status and discharge priorities and destination but is usually between 5-7 days. Progress is reviewed weekly by the team in interdisciplinary team rounds and discussed with the patient. Progress is measured using the Functional Independence Measurement Instrument (FIM).

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, preventing falls, managing pain and achieving predicted outcomes. Equipment needs are discussed during the team meeting and with patient/family. The patient/ family is assisted in obtaining the recommended equipment for discharge and trained in the safe use of this equipment.

As needed other professionals may be added to the team for consultant services. Available adjunctive and/or diagnostic services are; psychological services, nutritional services, 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.

Discharge Criteria

Discharge of the patient to the appropriate environment is critical to the success of the Musculoskeletal program. The Hospital offers a continuum of care through the Sub Acute Unit, Outpatient Orthopedic Programs and Outpatient Clinics. The projected discharge status is the foundation of the individualized plan of care.

Discharge date is set during the first team meeting and is discussed with the patient/family. Equipment needs are assessed, obtained and training provided by the team. Prior to discharge, the team works with the patient and family to assure referral to appropriate outpatient services or home services and issued a HEP as needed. With safety as the bottom line, discharge occurs when the patient and /or family have:

- Have accomplished their goals
- 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.

Patient/family discharge information is given to patient/family upon discharge. All necessary adaptive and durable medical equipment is ordered and provided and as appropriate referrals for continued outpatient/home therapy are issued to the patient.

Education

Patient and family education is an ongoing individualized process. Each discipline provides educational information through the use

of brochures, pamphlets and didactic discussion.

Upon admission each patient receives an information booklet to read and take home for reference. As therapy participation increases, various educational handouts regarding post- surgical precautions, falls prevention, pain management and joint protection are given to patients. Home exercise information is given before discharge to help continuation of therapies.

Individual teaching about medication is provided by the nurse. A copy of discharge summary with all pertinent information of medications, equipment, care, medical/surgical follow up is given at the time of discharge. Prescriptions for the medication will be given by the physician.

The case manager will review with patient/family the arrangements for any needed care after discharge.

Advocacy

The interdisciplinary 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; enabling sibling/peer support.