HELEN HAYES HOSPITAL

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Stroke Program Scope of Services

Our Mission

The mission of our stroke program is to train and assist our patients to achieve 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

Specifically, the stroke program is designed to meet the needs of all individuals, from young adult through the life span, who are recovering from a stroke (cerebral hemorrhage or infarction). This program offers inpatient acute rehabilitation services for a culturally diverse population who have impairments caused by stroke such as; difficulty in walking, impaired motor function, decreased balance, difficulty with swallowing, feeding, grooming, dressing, bathing, and limitations in cognition, perception, communication, emotional control, and social interaction.

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

Our Approach and Our Rehabilitation Team

The stroke program provides unified, interdisciplinary services with a focus on health education, disease prevention, self-care and mobility training, strengthening and exercise regimens, recovery of communication, cognition, and perception, provision of and training with adaptive and durable medical equipment, and nutritional/ transitional feeding management.

The stroke team consists of the primary physician, nurse manager, therapy program director, registered and licensed nurses, case manager, physical, occupational, speech & recreation therapists, and registered dietician. The hospital pharmacy supplies all prescribed medications for the patients.

As needed other professionals may be added to the team for specific services. Available on site adjunctive and/or diagnostic services are: audiology, chemical dependency counseling, diagnostic radiology, driver assessment, driver education, ENT services, prosthetics &/or orthotics, laboratory, ophthalmology consults, respiratory therapy, and the Center for Rehabilitation Technology, and vocational rehabilitation.

Dr. Jason Greenberg MD, a board certified neurologist, provides the medical direction for the team. This physician oversees the team of licensed caregivers and is responsible for a full medical evaluation and treatment plan. Around the clock medical coverage is provided by 24-hour nursing staff and an in-house, on-call hospital physicians.

Our Nurse Manager, oversees all (3) shifts of nursing staff (7) days/week, oversees patient satisfaction surveys, and provides consultation for all patient issues.

The Therapy Program Director oversees and coordinates all therapy programs. The Therapy Program Director ensures that all persons served meet the criteria for admission to the program, receive an appropriate individualized, interdisciplinary treatment program, receive a minimum of (3) hours of comprehensive therapy a day, and ensures achievement of the predicted outcomes. The Therapy 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.

The interdisciplinary team works together to provide a comprehensive program, but each area has a specific focus.

The nursing staff provide the stroke survivor with 24-hour care by licensed nurses with a majority of the nurses being certified in rehabilitation. In addition there are certified CNA's and HCA's to

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provide assistance with ADL'S and transfers. The licensed nursing staff administers all medications, provides wound and skin care and is responsible for bowel and bladder training as needed. In addition, the nursing staff is responsible to educate the patient and family members on all aspects of care as part of the discharge planning.

Occupational therapists evaluate and treat the upper extremities for function and motor control impairments. OT evaluates the ADL (activities of daily living), as well as visual/perceptual deficits, cognition, and memory. The adaptive equipment and assistive technology needs (i.e. adapted call bells, phones, computer access, and TV remotes), for their in-patient stay as well as for discharge, are also addressed by our occupational therapists. OT staff can customize splints as needed for our patients to assist with positioning and function for ADLs. Simulated activities in our Smart Apartment facilitate progress with home and food management and assist our patients in their transition from hospital to the community/ home. Helen Hayes Hospital continues to utilize new, progressive therapeutic equipment such as the Armeo and Saebo, which promote the recovery of upper extremity function.

Physical therapists address lower body function such as walking, balance, stairs, strengthening, flexibility, tone reduction, seating, and mobility. A therapist works one-on-one with the patient, helping to provide opportunities for regaining skills to promote an active life at home, work or community. Our Functional electrical stimulation (FES) Bike is an excellent tool for promoting strength and motor control recovery for both the upper and lower extremities. Complex seating and mobility needs are addressed via our Center for Rehabilitation Technology (CRT). Our Prosthetics and Orthotics department is on site and therefore available any time for consult and or fabrication of custom orthosis.

Speech-Language therapists assist our stroke survivors with swallowing, speech, cognitive and communication difficulties. Bedside swallowing evaluations and a fluoroscopic modified barium swallow (MBSS) are available as well as FEES assessments (fiber optic endoscopic examination of swallowing). Diet advancement and the teaching of protective swallowing techniques are a large part of our programming.

Case Managers assist patients and families/caregivers with discharge planning, insurance issues and the exploration of community resources. They are the primary team member responsible for communication of information regarding discharge planning, coordination of 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 team throughout the continuum of care to ensure a smooth transition from the hospital to the discharge location.

Social Worker/Patient and Family Liasons are available to meet with patients and/or their families/caregivers as needed while here to help support and encourage or advise.

A registered dietitian works with the interdisciplinary team members to provide nutritional support to patients and families. The dietitian develops an individualized nutritional care plan for each patient based on the SLP-recommended diet and the oral diet and/ or enteral nutrition (tube feeding) as ordered by the physician. The dietitian continues to monitor numerous aspects of each patient's nutritional needs throughout the rehabilitation stay. Diet education and food and drug interaction list is provided to the patient and family regarding the prescribed oral diet and/or tube feeding to encourage adherence during the stay and post discharge.

The Center for Rehabilitation Technology (CRT) (CRT) specializes in the application of assistive technology to enable individuals with disabilities to take control of their lives. CRT's goal is to achieve the most integrated assistive technology system for each person it serves, specifically, one that eliminates barriers to independence, improves functioning and quality of life, and makes the home, school, and workplace user-friendly. This program provides a full range of evaluation, testing, training and educational services in the application of assistive technology for people with disabilities. Its ability to custom design and fabricate assistive technology devices on site, while offering personalized attention to individual needs, has earned it a national reputation for excellence in a highly specialized field. The CRT program includes the following specialty service areas:

- Seating and Wheeled Mobility
- Augmentative Communication
- Computer Access/Environmental Controls
- Job Accommodations
- Assistive Devices for Daily Living
- Rehabilitative Engineering

Admission Criteria Admission Criteria

Admissions typically come from the tristate area, but the program considers admissions from local, regional and occasionally nation referral sources/facilities. Considered for the program are patients with a recent stroke, including cerebral infarction and cerebral hemorrhage. HHH accepts Medicare, Medicaid, private insurance and or private funding. Our admissions/referral team will work with potential patients to determine if their insurance will approve admission. Patient Financial Services are also available to discuss & or negotiate other payment options or fees if there are issues with insurance coverage.

Referral to the stroke program is under the direction of the patient's acute care attending physician who deems the patient medically stable to participate in daily therapy.

A referral specialist from Helen Hayes Hospital does a pre-admission assessment in the acute care setting of the medical and rehabilitation status to ascertain the patient's potential benefit from the rehabilitation program. The HHH stroke team is available to admissions for consult on any potential admission that may be in question.

For continuity of care it is necessary that the stroke team receive

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a copy of the patients chart with an acute care discharge summary including:

- History and physical.
- All consults.
- Up to date medical list including date and time of last dose.
- Nurses transfer summary.
- Recent progress notes.
- Lab work.
- Diagnostic test results: (chest x-ray, report, echocardiogram, ultrasound, CAT Scan, MRI, etc.

The HHH neurologist reviews the chart and determines if the patient is an appropriate rehab candidate, using the Medicare regulations as a guideline. Items such as: activity limitations or participation restrictions, behavioral and psychological status, cultural needs, and potential to return home are all considered. If the patient would benefit from inpatient skilled therapy and can tolerate a minimum of 3 hours per day, the admission is medically approved.

Program Description

In the Stroke rehabilitation program, the patient will receive a comprehensive medical, physical, occupational, speech and ancillary therapy program specifically designed to improve safety, mobility and independence.

The stroke service is located on a dedicated 24-bed unit of our acute rehab facility. Typical daily services are for a minimum of (3) hours per day, and include physical, occupational and speech therapies, rehabilitation nursing, patient and family/caregiver education, nutrition services, therapeutic recreation and social services/discharge planning. The number of disciplines involved as well as the amount of time per discipline, is individualized for each patient based on their needs and functional level. The stroke program initiates on day of admission and the therapy day can typically begin around 8 am and ends about 4 pm. The total time in therapy may vary on different days reflective of each patient's tolerance and needs, but overall patients will receive at least three hours of therapy 5 days/week. Sessions are typically 30-60 minutes and 1-2 times per day. Patient tolerance, preferences and fatigue are always considered when schedules are made. The rehabilitation therapy extends beyond the individual sessions throughout the entire 24 hours when the Rehabilitation Nursing staff reinforces the therapeutic techniques during daily activities.

On site ancillary services can include the Center for Rehab Technology/Augmentative communication services, P&O and Aquatic Therapy. Also available are psychologists, psychiatrists and neuro-psych services.

The team has formal rounds once a week and mini-rounds once a week. All are open venues to identify and discuss physical, cognitive, and social progress or care issues amongst the interdisciplinary team. Treatment plans are finalized in the first 72 hours of admission on the interdisciplinary plan of care, and any modifications are discussed at weekly rounds. The length of stay and anticipated discharge destination (home, sub-acute, long term care etc.) is formalized at formal rounds and also modified as needed based on what is reported in rounds.

The length of stay is based upon patient need; attainment of goals, functional level, cognitive status and discharge priorities but is usually between 10-23 days and with recognition of Medicare guidelines. Patient progress is reviewed on a weekly basis by the team and this information is reviewed with the patient and family/caregivers. Progress is objectively measured using the Functional Independence Measure Instrument (FIM).

The interdisciplinary team, which includes the patient, establishes goals with a focus on functional status in the intended discharge environment. The team works toward minimizing impairments, reducing disability, achieving predicted outcomes and maximizing independence.

As needed other professionals may be added to the team for specific services. Available adjunctive and/or diagnostic services are: Audiology, Chaplainry, Chemical Dependency Counseling, Diagnostic Radiology, Driver Assessment, Driver Education, Laboratory Services, Pharmacy, Respiratory Therapy, Vocational Rehabilitation, and Rehabilitation Engineering.

Durable medical equipment (DME) needs, are addressed by all team members (i.e. PT, OT, CRT, RN, MD) throughout the continuum. Our facility and its staff deal with reputable and responsible vendors that put our patient's needs first.

Education

Patient and family/caregiver education is an ongoing and individualized comprehensive process. Each discipline provides educational information through the use of videos, brochures, pamphlets and didactic discussion.

Upon admission each patient receives an information booklet to read and take home for reference. If the patient cannot read, case management is available to assist them with the book. Therapy may give the patient additional handouts that can be placed in this reference book, and can also modify the documents based on the patient's vision or reading abilities.

Community education is done through various methods, but our most popular and successful method has been via our YouTube instructional videos found on YouTube.com and helenhayeshospital.org. The Stroke Support Group meets monthly at Helen Hayes Hospital. Guest speakers provide important information discussion and support to stroke survivors, families and caregivers. Information is posted in public common areas and given to the patient at admission.

Discharge Criteria

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

The plan is set during the admission process and a discharge

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date/destination is projected at the first formal rounds. The date and the anticipated plan is discussed with the patient and family/caregivers after rounds. With safety as the bottom line, discharge occurs when the patient and/or family:

- Have attained the goals that were set up in the therapy treatment plans
- No longer require an intensive, acute rehabilitation setting
- Could be safely managed in an alternative environment
- Have an acute medical need which prohibits participation in the rehabilitation program

Prior to discharge, the team works with the patient and family/caregiver to assure referral to the appropriate setting and to provide sufficient hands-on training. Case Management is available to provide assistance or information to help with the transition to the next location after discharge. All necessary adaptive and durable medical equipment is ordered and provided. Training is conducted to assure safety and competence for the patient and family/caregivers. Home exercise programs are created and given by therapy staff as appropriate. Nursing provides individualized medication teaching to the patient and or family/caregiver. A copy of the discharge summary with all pertinent information of medications, equipment, care, and recommended follow up is given at discharge. The case manager will review all the discharge arrangements with the patient and family/caregivers.

Discharge of a patient may also occur for reasons unrelated to their medical treatment when a patient represents a potential danger to himself and or others. Each case in which a discharge for administrative reasons is considered shall be reviewed carefully.

A patient's rights shall not be violated, however they are responsible for their actions.

The following patient violations could result in a recommendation to the Administrator to consider a patient for administrative discharge:

- Illegal use or possession of drugs or drug paraphernalia
- Physical or verbal abuse to others
- Continued inappropriate use of alcohol resulting in disruption on the unit
- Continued violation of hospital rules and regulations
- Unauthorized absences
- Theft, damage, destruction, loss or misuse of hospital property or the property of other patients, employees or other persons
- Interference in the treatment or comfort of other patients

Advocacy

The interdisciplinary Stroke 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.