BURKE
REHABILITATION
MONTEFIORE HEALTH SYSTEM

SPINAL CORD INJURY PROGRAM

Program Description

The mission of Burke Rehabilitation's Spinal Cord Injury (SCI) Program is to provide the most comprehensive, patient centered and effective rehabilitation to maximize recovery from physical, cognitive, and psychological impairments caused by traumatic or acquired spinal cord dysfunction. Led by Dr. Jamie John in inpatient and Dr. Shelly Hsieh in outpatient, the interdisciplinary team collaborates with the individual with the spinal cord injury and the family and/or caregiver to facilitate achievement of the best possible physical and mental recovery. Intensive rehabilitation is provided in a safe, secure, and structured environment to allow the individual to reach his/her full potential and return to an active, productive lifestyle.

The rehabilitation team consists of the individual with the spinal cord injury, his or her family and/or caregivers, and medical, nursing, and other rehabilitation personnel who, by virtue of their education, training, and experience, are qualified to work with this patient population. The inpatient and outpatient rehabilitation professionals on the team are responsible for assessing the individual with a spinal cord injury's medical, behavioral, psychosocial, and rehabilitation needs, establishing individualized goals in consultation with the individual and/or family/caregiver, designing and implementing a treatment program, assessing its outcome, communicating with the team and preparing the individual and family for the next phase in the rehabilitation process, including resuming activities in the individuals' communities.

Scope of Services

Burke's Inpatient Spinal Cord Injury Rehabilitation Program:

- Maximizes recovery from the physical, cognitive, and psychological impairments caused by spinal cord injury.
- Provides the highest quality, patient focused rehabilitation.
- Provides rehabilitation through an interdisciplinary approach that emphasizes communication, collaboration, and cooperation.
- Focuses on the individual's capabilities and use of compensatory strategies and devices to lessen activity limitations.
- Removes or lessens restrictions to participation in life roles and situations to the extent possible, and counsels and educates individuals, families, and caregivers on alternative possibilities for life participation when necessary.

- Prepares the individual with a spinal cord injury, family, and/or caregiver to make the transition to the next stage of the rehabilitative process.

Burke's Outpatient Spinal Cord Injury Program:

- Maximizes recovery from the physical, cognitive, and psychological impairments caused by spinal cord injury.
- Providing the highest quality, patient focused rehabilitation
- Provides rehabilitation through an interdisciplinary approach that emphasizes communication, collaboration, and cooperation.
- Focuses on the individual's capabilities and use of compensatory strategies and devices to lessen activity limitations.
- Removes or lessens restrictions to participation in life roles and situations to the extent possible and counsels and educates individuals and families on alternative possibilities for life participation when necessary.
- Prepares the individual with a spinal cord injury, family, and/or caregiver to make the transition to the next stage of the rehabilitative process.

Burke's intensive and comprehensive Spinal Cord Injury Program focuses on maximizing each person's ability to function, through personalized care and individually designed therapy programs. Preventing secondary complications, improving self-confidence, and optimizing adaptation and education, helps patients achieve the highest level of independence possible.

The Spinal Cord Injury Program serves patient populations from adolescence through geriatric in the inpatient and outpatient setting. In 2024 and 2025, the ages for the persons served have ranged from 16 to 94. The SCI Program admitted two adolescents to the inpatient program and two adolescents were treated in the outpatient department in 2024. In 2025, one adolescent was admitted to the inpatient program and 3 adolescents treated in the outpatient program. The following table outlines the number of adolescents treated by age on the Spinal Cord Injury Program over the past two years.

Year	Adolescent ages (number of adolescents treated)
2024	16 y/o (2 outpatients) 18 y/o (2 inpatients)
2025	17 y/o (1 inpatient, 1 outpatient) 16 y/o (2 outpatient)

Diagnoses of patients served include traumatic spinal cord injury at the cervical through lumbar levels, vascular injuries to the spinal cord including, but not limited to aneurysm and dissection, transverse myelitis of any etiology, spinal tumors, myelopathy at the cervical and thoracic levels, inflammatory and infectious diseases of the spinal cord, and other non-traumatic injuries to the spinal cord. Beginning on the day of admission and continuing through hospital discharge to post-acute care services and the community, the spinal cord injury team works collaboratively to identify and address the needs of each individual. The interdisciplinary assessment is conducted by the medical and rehabilitation professionals on the individual's team, including the physician, rehabilitation nurse, social worker/case manager, clinical neuropsychologist, occupational therapist, physical therapist, speech-language pathologist, recreation therapist, and dietician. Other professionals, such as the orthotist and neurologic music therapist, become part of the team as warranted. These professionals share the information obtained from the assessment via verbal communication and chart documentation so that each team member can understand the individual's strengths, impairments, and limitations to activity, restrictions in participation, and the environmental and personal contextual factors that may influence treatment outcomes and plans for discharge.

Based on the results of the assessment, goals are determined with the individual and/or family/caregiver(s) and a treatment plan is implemented. The goal of the intensive rehabilitation program at Burke is to help each patient return to as active and productive life as possible despite physical disability. Team consultation and collaboration occur throughout the course of rehabilitation. For hospital inpatients, the individual's progress is discussed formally once per week at a team meeting; for outpatients, once a month. Family members and/or caregiver(s) are encouraged to attend and participate in treatment sessions and patient care as appropriate. Educational presentations, videos, handouts, and discussions for patients and their family members/caregivers on assorted topics related to spinal cord injury is provided by team members. In the inpatient setting, individualized family meetings are scheduled to facilitate communication between the team and patient as well as their family/caregivers as appropriate. The focus of family meetings is individualized to the needs of the patient and may include discussion regarding discharge planning, functional progress achieved, review of short and long term goals, medical status, as well as discussing the needs of the individual during their length of stay, at time of discharge, and for the future.

Within a safe, secure and structured environment in the inpatient setting, each individual is scheduled for a minimum of three hours of intensive therapy Monday through Friday and one to two hours of therapy during the weekend. Therapy services are scheduled between the hours of 7:30 a.m. to 6:30 p.m. and are primarily provided in the SCI/Neuro gym on the ground floor of the main hospital in addition to other specialized areas within the main hospital as appropriate (i.e. other therapy gyms , patient room, ADL room). Rehabilitation nursing and access to a physician are available twenty-four hours a day, seven days a week. The medical team can address the patients' medical management, however if the patients'

medical status changes, patients are transferred to an acute care hospital for emergent care until they are deemed medically stable enough to participate in rehabilitation. The medical team will also consult with the referring hospital medical team or other medical providers in the community as necessary during the length of stay to ensure continuity and coordination of care.

In the Outpatient therapy setting, assessments and interventions are scheduled at the individual's convenience, typically 3 times a week for 45- or 60-minutes sessions each. Therapy is provided at the main campus outpatient facility between the hours of 7:00 a.m. and 7:00 p.m.

Within the scope of the Spinal Cord Injury Program, patient evaluation and care planning are designed around the World Health Organization definitions. The model assesses levels of dysfunction which stem from the patients' admitting diagnosis regarding impairments, activity limitations, and participation restrictions.

Impairments: Weakening, damage, or deterioration of function within a specific component of the neurological system, due to injury or disease.

Examples: Decreases in strength, active range of motion, passive range of motion, cognition, balance, and / or activity tolerance along with increases in pain.

Activity Limitations: The inability to perform a specific task as a consequence of the aforementioned impairments.

Examples: Difficulty with mobility, ambulation, stair negotiation, eating, or self-care.

Participation Restrictions: The cumulative effect of impairments and activity limitations on the ability of a person to participate in life roles.

Examples: Inability to perform duties as a parent, caregiver, employee, or participant in social and leisure activities.

Cultural and religious needs are respected for each patient by the entire team. Accommodation to the patient's schedule, dietary needs and requests, and the provision of appropriate equipment are provided to enhance the patient's experience and support full participation in the rehabilitation program. All staff members participate in annual cultural diversity and sensitivity training. Patients' preferences are shared throughout the team to ensure that patients receive individualized care.

Inpatient Admission Criteria

Every potential patient who may benefit from our care is discussed with the screening staff and a physician. The Program Director may also be included in the discussion to review

rehabilitation needs. The rehabilitation potential for every patient is evaluated prior to admission.

Screening Process

Referrals to Burke are usually made by physicians, social workers, discharge planners or case managers. A reasonable medical and functional profile must be provided and appropriate sections of the medical record from the acute care process are included. A rehabilitation nurse or member of the screening team may also perform a detailed evaluation at the referring institution. Recommendations are then made to the appropriate member of the medical staff who renders a final decision regarding admission.

Admission Criteria: Spinal Cord Injury Program

Diagnoses for admission include but are not limited to traumatic spinal cord injury, non-traumatic spinal cord injury such as aneurysm, dissection with spinal cord infarction, transverse myelitis of any etiology, spinal tumors, as well as disease processes effecting the central and/or peripheral nervous system.

Additionally, the following is a brief, but not inclusive, list of admission criteria:

- Individuals presenting with an acute injury who are medically stable, cleared to participate in a minimum of 3 hours of therapy, and do not meet other general exclusion criteria listed in the Admission Policy.
- The patient is not a danger to him/herself or other patients on the unit.
- Individuals presenting with chronic spinal cord injury with recent changes in medical or functional status requiring re-evaluation or treatment by an interdisciplinary team.
- Any patient with complete or incomplete tetraplegia can be admitted except those who require continuous ventilatory support and/or those who are in a coma or vegetative state.
- If any one or combination of criteria is not met, the patient may still be considered for admission to Burke, but the program physician must review the screen.

Patient Financial Services/Fees

Burke's Patient Financial Services Department representatives can answer any questions about insurance coverage, expenses, and hospital charges. Once a patient has been medically accepted into a Burke program and insurance benefits have been verified, a patient can be admitted to Burke. Upon discharge, a bill for physicians' and hospital services will be sent to the patient or the patient's insurance carrier. If there are other fees that are not covered by an insurance company for items such as medications and supplies, a bill will be sent to the party responsible for direct payment to the hospital. To understand what, if any, services are not covered by the patient's insurance carrier, the Patient

Financial Services Department at Burke can be contacted for additional information. An inpatient representative may be reached at (914) 597-2329. An outpatient representative may be reached at (914)-597-2206.

Financial Assistance

If the patient does not have health insurance, or has limited coverage, Burke may be able to help. Burke staff are trained to assist patients in identifying options for paying their medical bills. Burke provides financial aid to patients based on their income, assets, and needs. If necessary, Burke will assist the patient, family member, etc. with applying for Medicaid or help to arrange a manageable payment plan. Burke will work with the patient, family member, etc. to determine if the patient is eligible for any of the following payment programs and will help with the completion of the application process:

- Government sponsored programs like Medicaid
- Hospital-Sponsored Financial Assistance
- State Assistance Programs
- Charity Care
- No Interest Payment Plans

Insurance and Managed Care

Burke Rehabilitation Hospital participates in numerous health insurance plans. Discover our list of health insurance plans [https://www.burke.org/patients-visitors/insurance-accepted/] to see if we participate with your insurance.

Insurance carriers offer multiple insurance plans with differing coverage levels. It is important to check whether Burke's rehabilitation programs and services are included in the patient's insurance plan's covered medical benefits. Also, it is common for insurance plans to carry deductible and co-insurance obligations which are the financial responsibility of the patient. Financial representatives from Burke are available to assist in determining whether our rehabilitation services are covered by the patient's insurance plan and in calculating the patient's personal financial obligations as a result of the deductible and co-insurance terms of the insurance plan. Burke Rehabilitation Hospital's Patient Financial Services Office can be contacted at (914) 597-2329 between the hours of 9:00 AM and 4:00 PM, Monday through Friday. For outpatient therapy, call (914) 597-2206.

The Centers for Medicare & Medicaid Services require hospitals to share a list of standard pricing rates for services. See Burke's pricing and cost estimates.

[https://www.burke.org/patients-visitors/pricing-cost-estimates/]

For inpatient services, financial representatives from Burke are available between the hours of 9:00 AM and 4:00 pm, Monday through Friday to assist in determining gross charges for the patient's particular diagnosis. For questions concerning inpatient services, the Financial Assistance Office can be contacted at (914) 597-2329.

Discharge Criteria

Patients are discharged from the inpatient rehabilitation program when any of the following occur:

- The patient has achieved maximal levels of functional improvement or has gained the ability to independently direct his or her own care.
- The patient shows no functional improvement despite alteration of treatment techniques.
- The patient is discharged to an acute care hospital for medical reasons. Acute Care Transfer (ACT) is indicated when the status of the patient changes in such a way that they may not be safely cared for at Burke and require acute hospital level of care determined by medical staff.
- The patient is unable to participate in treatment due to medical, psychological, or cognitive reasons.

The discharge planning process begins when the patient is first admitted to the program. The social worker/case manager leads the planning process, coordinating information from all members of the interdisciplinary team, the patient, and the caregivers/family. Based on the individual's functional status, family support, pre-morbid living situation, level of function, and available resources (i.e., health insurance), the team makes recommendations for the most appropriate and feasible discharge plan for the patient. At the team or family's request, a formal meeting with the team and patient/family is scheduled to discuss appropriate options. A safe discharge is a primary consideration when options are considered.
Recommendations for discharge may include:

- Home with home care services
- Home with outpatient services
- Sub acute rehabilitation services
- Long-term care services

In 2024 and 2025, four hundred eighty-two individuals were discharged from the inpatient at Burke Rehabilitation Hospital with a Spinal Cord Injury diagnosis to the following settings:

- 60.0% (289) of the patients returned home to the community
- 25.5% (123) of the patients continued therapy at a subacute rehab facility
- 14.5% (70) of the patients returned to the acute care hospital
- 0% of the patients continued therapy at an acute rehab facility
- 0% of the patients entered a long-term care hospital or hospice

At the time of discharge, the patient is provided with a summary of all recommendations for continued care and follow-up services including, but not limited to, therapy services, assistance required, medical appointments, summary of applications for transportation or parking permits, etc.

To ascertain long-term outcome data for individuals discharged from inpatient hospital, Burke contracts with a company to conduct follow-up interviews via phone at 3-months post discharge. Outpatients will receive a follow up call from a licensed social worker about 3 months after discharge, to check in on their status in their communities.

Three-months post inpatient discharge from Burke in 2025, individuals living with spinal cord injury reported the following outcomes:

- Percent of patients living in the community: 80.8% (benchmark 91.8%)
- Overall, how satisfied were you with the services you received during your rehab stay? : 3.71/4 satisfied (benchmark 3.71)
- My social activity level is similar to or better than before my rehabilitation Stay: 2.83/4 satisfied (benchmark 2.82)
- I was involved with decision making during my rehabilitation program: 3.67/4 satisfied (benchmark 3.38)
- The rehabilitation program prepared me for going home: 3.64/4 satisfied (benchmark 3.44)
- The progress I made in rehabilitation met my expectations: 3.53/4 satisfied (benchmark 3.34)
- The rehabilitation program improved my quality of life: 3.58/4 satisfied (benchmark 3.40)

Continuing Stay Criteria

Decisions to continue a patient's stay are made by the patient's physician. Changes in a patient's medical status at the time of the planned discharge may precipitate the need to lengthen the patient's stay at Burke. If the discharge is deemed unsafe for any reason, the patient's stay is extended until an appropriate and safe discharge plan can be organized and coordinated. Reasons and subsequent decision to extend a patient's length of stay are communicated to the patient, family and/or caregiver(s).

Spinal Cord Injury Rehabilitation Team Description

The philosophy of the Spinal Cord Injury Program is that the program's mission can best be accomplished by providing rehabilitative care through an interdisciplinary team approach.

The team consists of the following:

- Individual with spinal cord injury
- Individual's family and/or caregiver(s)
- Physician
- Medical Residents
- Rehabilitation Nursing
- Neuropsychology
- Speech and Language Therapy
- Occupational Therapy
- Physical Therapy
- Therapeutic Recreation
- Social Work/Case Management
- Nutrition
- Respiratory Therapy

Additional services available to meet the needs of each individual patient include:

- On-site wound Care by Certified Wound and Ostomy Nurse(s)
- On-site Medical Consultations for Internal Medicine, ENT, Podiatry, Pain, Orthopedics/Sports Medicine
- Outside Medical Consultation for (Urology, Plastics, Dermatology, etc.)
- Pastoral Care
- Neurologic Music Therapy
- Orthotic/Prosthetic Services
- Electrodiagnostic Testing
- Pharmacy
- Psychiatry
- On-site radiology (CT scan, Xray, Ultrasound)
- Laboratory Services
- Complimentary Therapy
- Wheelchair seating/positioning
- Peer support

From admission through the discharge planning process, team members work collaboratively with each other, the individual with the spinal cord injury and the family and/or caregiver(s) to ensure that the specific needs of each individual are addressed. Patient and family and/or caregiver involvement and participation is strongly encouraged throughout the entire rehabilitation process.

Based on the results of the initial assessment, goals are determined with the individual and/or family, and a treatment plan is implemented. For hospital inpatients, the individual's progress is discussed formally once per week at team conference and on at least three additional days during the interdisciplinary team huddle; for outpatients,

progress is reviewed by the team once a month. Team consultation and collaboration occur throughout the treatment program. In addition to speaking directly with members of the team regarding the patient's medical condition, progress, functional status, participation in therapy, achievement of established goals, Family members and/or caregivers are strongly encouraged to attend and participate in treatment sessions and patient care as appropriate.

The Burke Spinal Cord Injury Rehabilitation Program Offers:

Medical Management

As the leader of the interdisciplinary team, Dr. John is responsible for directing the medical care of the individual and monitoring the overall team process and outcome. For Burke inpatients, a physician is available 24 hours a day, seven days a week. The medical staff create a plan of medical care to address the primary medical/physiological needs and changes associated with spinal cord injury including, but not limited to abnormal tone, changes in bowel/bladder function, respiratory function, changes in circulation, musculoskeletal complications (i.e. heterotropic ossification, bone density), pain, autonomic dysfunction, sexual dysfunction, men's and women's health issues, fertility, etc. Medical consultations (Podiatry, Pain, Urology, Plastics, ENT, Dermatology, etc.) are available to address all patient needs while at Burke. After discharge from the inpatient hospital, patients can follow up with Burke outpatient physicians for their ongoing rehabilitation needs. Physician appointments can be made at (914) 597-2332.

Clinical Neuropsychology

The Burke Rehabilitation Hospital has long recognized that coping with a neurological illness or injury is difficult for patients and families. Burke's team of clinical neuropsychologists, Julieanne Shulman, Psy.D., Jaime Twaite Ph.D., ABPP-CN, Stephanie Leung, Ph.D., and Lauren Berrill, Psy.D who are specialists in the evaluation and treatment of brain-behavior relationships, work with patients to monitor recovery progress and develop treatment goals and objectives for patients with cognitive impairments and behavioral impairments such as personality changes, brought on by the injury or difficulty with adjustment to the disability. They assist in communicating with the interdisciplinary team as well as psychiatry as needed to ensure the needs of individuals with pre-morbid behavioral health needs and/or history of substance use are being met after injury and during their inpatient stay.

Occupational Therapy

Occupational therapists assist patients in becoming as independent as possible with daily activities, including dressing, bathing, personal hygiene, feeding, getting around in the home and community, pursuing household, work related or leisure activities, and all other activities that occupy one's day. Following a thorough and comprehensive evaluation, the occupational therapist designs an individualized treatment program tailored to address each patient's individual needs.

Occupational therapists are responsible for teaching patients the skills necessary for wheelchair mobility as well as determining the appropriate equipment for each patient (e.g., wheelchair, bathroom equipment, adaptive equipment, assistive technology). In addition, occupational therapists evaluate visual skills, perception skills, and cognitive skills related to functional activities. Occupational therapists complete home evaluation assessments, community skills evaluations, and wheelchair seating recommendations during the length of stay to help facilitate a home discharge as appropriate. Education for vocational training and driving is available.

The Occupational Therapy team assists patients and family members and/or caregivers in learning how to do familiar tasks in a new way and help to make the transition to home and into the community as smooth as possible.

Physical Therapy

Physical therapists and physical therapy assistants assist patients in becoming as functionally independent as possible and maximize recovery following trauma or illness. Physical therapy may consist of muscle strengthening, endurance training, breathing retraining and pulmonary hygiene interventions, improving flexibility, balance training, and functional mobility skills training. Functional mobility skills training includes getting in and out of bed, transferring to and from a wheelchair, mat, and bed, walking and going up and down stairs (as appropriate). Following a thorough and comprehensive evaluation, the physical therapist designs an individualized treatment program tailored to address each patient's individual needs.

Speech-Language Therapy

Speech-language pathologists evaluate and treat adults with communication disorders, such as speech, language, voice and cognitive difficulties, and swallowing disorders. A speech-language pathologist evaluates patients when it is recommended by the team. Following a thorough and comprehensive evaluation, the speech-language pathologist determines appropriate therapeutic interventions, and works with patients to help regain communication skills as well as assisting patients with swallowing disorders to safely drink liquids and eat foods.

Rehabilitation Nursing and Wound Care/Ostomy Nursing

Rehabilitation nursing is a specialty of professional nursing and is available for inpatients at Burke Rehabilitation Hospital 24 hours a day, seven days a week. Nurses at Burke function as care coordinators as they work with patients, family members and/or caregivers and as part of the rehabilitation team to solve problems and promote each patient's maximum independence. The nursing team consists of a nurse manager, registered nurses, nursing assistants, and nursing attendants. In addition, certified wound care and ostomy nurses are available on staff to provide assessment and assist in caring for pressure wounds or other wounds as well as assist with the ostomy needs of the patient during their length of stay. Wound care nurses communicate recommendations to the interdisciplinary team and collaborate in the care of the patient as needed. Nurses are actively involved in the

education of patients and caregivers in injury prevention and care of wounds. Throughout a patient's stay, the nursing team provides education to the patient, family and/or caregiver in areas including, but not limited to administering medications, care for wounds, prevention of secondary complications, and the management of personal care needs.

Social Work/Case Management

The social worker/case manager assumes a leadership role in planning and preparing for the individual's discharge from the inpatient program. Social workers/case managers help patients and family members deal with social, financial, and emotional aspects of the patient's condition. This planning and preparation begin when the individual is admitted to the inpatient program, continues during the inpatient stay and culminates when the team determines that the individual is ready to move to the next step in the rehabilitation process. The social worker/case manager is also responsible for arranging individual tutoring for adolescents when necessary to address the patient's educational needs. In addition, social workers assist individuals in completing documentation (i.e., employment, insurance, and transportation) that may be necessary for long-term support in the community as well as providing education for hiring personal care assistants as needed post discharge. Social workers organize formal meetings with the family or caregiver(s) when appropriate and communicate with the family or caregiver(s) throughout the duration of the individual's stay at Burke. In addition, social workers/case managers serve as hospital liaisons with the patient's insurance case manager.

Neurological Music Therapy

Neurologic Music Therapists use standardized interventions grounded in applied music neuroscience to assist patients with cognitive, sensory, and motor dysfunction due to neurologic disease or injury. They assist the interdisciplinary team to help patients achieve their goals through the clinical application of musical properties as well as music engagement. Decades of research demonstrate that music engages interconnected brain networks involved in movement, speech and language, attention, memory, and emotion. Neurologic Music Therapists leverage this ability to aid in the recovery process, and support patient's functional goals through music's ability to engage and motivate.

Neurologic Music Therapy is offered in a variety of ways: individual session, in cotreatment with members of the interdisciplinary team, and in group settings. In each session, interventions are tailored to best support the patient as they work toward their goals.

Therapeutic Recreation

Recreation therapists use a wide range of interventions to help patients make improvements in the physical, cognitive, emotional, social, and leisure areas of their lives. They assist patients develop skills, knowledge and behaviors for daily living and community involvement. Recreation therapists collaborate with the patient to incorporate specific interests into therapy to achieve optimal outcomes that transfer to real life situations. Research supports the concept that people with satisfying lifestyles will be happier and

healthier. Therapeutic Recreation interventions for patients include individualized therapy sessions, humor therapy, relaxation therapy, adapted leisure and sports activities, and complementary therapy. Computers, games, crafts, adapted sports, and other activities are incorporated. Leisure education and leisure resources are offered, in addition to entertainment and social programs.

Nutrition Education

A registered dietitian visits patients in need of assistance in understanding their dietary modifications or other nutritional concerns to provide patients and family members with the knowledge and skills to make informed choices about healthful diets. Body composition and factors affecting nutritional health after spinal cord injury are addressed.

Pastoral Care

Hospital chaplains representing the Jewish, Catholic, and Protestant faiths are available to visit patients and families. Chaplains offer pastoral care and provide for various religious needs. Patients may arrange for visits from clergy from other religious traditions. Holiday services for various faiths are hosted on site. The chaplains respect each patient's personal beliefs and individual ideas. The goal of Pastoral Care services is to help renew each patient's sense of hope and offer a spiritual home away from home.

Use of Technology

RTI FES Bike (RT300, 200)	Restorative Therapies Xcite
Bioness H200	Saebo- glove, MAS, myotrac and micro stim
Bioness L300+ and L300Go	Bioness Vector
WalkAide	Tyromotion Tymo Balance Platform
LiteGait	AutomoME Go/REACH Environmental Control
WalkBOT	Bioness Integrated Therapy System (BITS)
Rifton Tram	iPad applications to assist with communication

Outcome Management

The Spinal Cord Injury is actively involved in performance improvement initiatives. As part of the hospital's strategic plan, the goals of collecting and analyzing data on a continuous basis include:

- Improve operational efficiency in caring for patients with spinal cord/neurological injury
- Establish an optimal model for patient centered, cost effective, interdisciplinary rehabilitation care of the individual with a spinal cord injury/neurological injury
- Develop a data collection system to document and provide information to monitor and evaluate the clinical effectiveness of the program

- Utilize outcome information to establish standardization of care and evaluation guidelines.

Outcomes that are utilized will address effectiveness, quality, efficiency, access, and satisfaction. They include:

- GG gain by RIC
- Discharge disposition
- Achievement of GG Scores for mobility and self care tasks
- GG efficiency
- Percent of patients screened versus patients admitted
- Patient satisfaction
- Length of stay
- Wounds
- Post discharge community involvement

See information on Burke's inpatient rehabilitation outcomes and quality measures. [https://www.burke.org/about/quality/]

Additional outcomes measured include:

- Gait Speed
- Falls
- Balance

Education

Patient and Family/Caregiver

Ongoing education of the individual with a spinal cord injury and the family and/or caregiver is essential to maximize recovery from the physical, cognitive, and psychological impairments caused by the condition and effectively prepare the individual and family and/or caregiver for the transition to the next stage in the rehabilitation process.

Individuals with a spinal cord injury will receive ongoing education from each discipline throughout his/her stay to maximize achievement of their goals. Some education focuses on the fact that, for many patients, their injuries and resulting conditions are life-changing and lifelong. Coping, resources, and the need for lifelong follow up to deal with changing needs are provided.

Family members and/or caregivers are encouraged to attend and participate in treatment sessions and patient care activities as appropriate. Providing education and training for the family and/or caregivers is an essential component of the patient's rehabilitation stay and provides an opportunity to successfully transition the patient to the next phase of rehabilitation and prevent secondary complications after spinal cord injury.

Resources continue to be available post discharge including a monthly support group held at Burke for individuals with spinal cord injuries and ongoing recreation, leisure, and education programs are offered at Burke for individuals to participate in. Opportunities to participate in the SCI Support Group as well as some recreation and leisure activities are available. Additional resources and information available to caregivers and patients can be found on Burke's Spinal Cord Injury Medicine & Rehabilitation website. [https://www.burke.org/medical-services/spinal-cord-injury-medicine-rehabilitation/]

Team Members

In-house education via in-services provided by Burke staff, research staff, as well as outside speakers, including vendors, is provided to team members.

Team members are supported in attending professional conferences, continuing education courses and seminars throughout the year. Clinical learning workshops that address current trends in the treatment of spinal cord injury and neurological conditions are provided regularly.

The program's goal is to provide evidence-based, state of the art treatment. All staff education initiatives and opportunities will attempt to support this goal. Opportunities are available for education for advanced degrees and clinical specialty certifications. Participation in research initiatives and presentations of poster/platform presentations at seminars and conferences is encouraged and embraced by team members.

Team members are actively involved in community events, hosting events at Burke such as Spinal Cord Injury Awareness Month, Burke Technology and Ability Expo, and within the community such as participating in activities of the White Plains Chapter of the ThinkFirst Program, a nationally based spinal cord and brain injury prevention program. Team members actively assist in the coordination and sponsoring of adapted sports programs and community education events.

Education of the healthcare professional community in spinal cord injury is a priority to team members. The Burke team provide multiple educational opportunities every year by offering observations for future students in the field of healthcare, serving as clinical instructors at academic institutions, and hosting student internships for physical therapy, occupational therapy, speech therapy, and social work/case management. Team members have provided in-service training to other institutions with emphasis on the treatment and care for individuals post spinal cord injury or other neurologic diseases to improve the care that individuals receive across the spectrum of healthcare.

Documentation Requirements

All appropriate information will be maintained in each patient's Electronic Medical Record (EMR) for the duration of the patient's stay. All other documents will be maintained in the

patient's medical chart. At discharge, these documents will be scanned to be included as part of the patient's EMR.

Each discipline will be responsible for completing all appropriate documentation and abiding by timeframes established by the hospital.
Discipline specific documentation requirements include:

- Pre-admission screening information
- Admission screens
- Initial evaluations
- Daily charting
- Re-evaluations
- Discharge evaluations
- Equipment request/justification forms