BURKE
REHABILITATION
MONTEFIORE HEALTH SYSTEM

BRAIN INJURY PROGRAM

Program Description

The mission of Burke Rehabilitation's Brain Injury Program is to provide the most comprehensive, patient-centered, and effective rehabilitation to maximize recovery from physical, cognitive, and psychological impairments resulting from traumatic and acquired brain injuries. Led by Dr Jaskiran Ghuman, Dr Orkhan Mammadov, and Dr Rory Siegel, the interdisciplinary team works collaboratively with the individual with the brain injury and the family and/or caregiver to facilitate achievement of the best possible functional 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 and productive lifestyle.

The rehabilitation team consists of the individual with a brain 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 medical and rehabilitation professionals on the team are responsible for assessing the individual with a brain injury's medical, behavioral, psychosocial, and rehabilitation needs. They establish individualized goals in consultation with the individual and/or family/caregiver. The team designs and implements a treatment program and assesses the outcome. The team communicates with the individual and family/caregiver to plan for the next phase in the rehabilitation process.

Scope of Services

Burke's Brain Injury Program:

- Maximizes recovery from the physical, cognitive, and psychological impairments caused by brain 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 and caregivers on alternative possibilities for life participation when necessary.
- Prepares the individual with a brain injury, family and/or caregiver to make the transition to the next stage of the rehabilitative process.

Burke's intensive and comprehensive Brain 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 Brain Injury Program serves patient populations from adolescence through geriatric. In 2024 and 2025, the ages for the persons served has ranged from 16 to 96. The Brain Injury program admitted no adolescents in 2024 and two adolescents in 2025.

Year	Adolescent Ages (number of adolescents treated
2024	(0 patients)
2025	16 (1 patient) 17 (1 patient)

Diagnoses of patients served include subarachnoid hemorrhage, subdural hematoma, epidural hematoma, diffuse axonal injury, skull fracture, cerebral contusion, intracerebral hemorrhage, anoxic encephalopathy, brain tumor, meningitis, hydrocephalus, encephalitis, brain abscess, delirium and stroke etc.

Beginning on the day of admission and continuing throughout the individual's stay, the Brain 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, nurse, social worker/case manager, clinical neuropsychologist, occupational therapist, physical therapist, speech-language pathologist, behavior management training director, recreation therapist, and dietician. Other professionals, such as the orthotist, psychiatrist, and optometrist, 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 a life as possible. Team consultation and collaboration occur throughout the length of stay. The individual's progress is discussed formally four-five times per week at a team meeting. Family members and/or caregiver(s) are encouraged to attend and participate in treatment sessions and patient care as appropriate. Education is continuously provided to the individual with a brain injury and their caregivers. Individualized family meetings are scheduled as appropriate to facilitate communication between the team and patient as well as the family/caregivers. 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, 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. Rehabilitation nursing and access to a physician are available twenty-four hours a day, seven days a week. The medical team is able to 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 as necessary during the length of stay to ensure continuity of care and coordination of care.

Within the scope of the Brain 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, as a result of 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, reading, 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. Accommodations 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.

Admission Criteria

Every potential patient who may benefit from our care is discussed with the screening staff, physician, and/or program director. 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 with the appropriate sections of the medical record from the acute care process 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 with regard to admission.

Admission Criteria: Brain Injury Program

Candidates for admission include patients who have suffered a brain injury, are medically stable and able to participate in 3 hours of therapy per day.

Exclusions:

- Patients who are in a coma or vegetative state.
- Patients who require ventilator support.
- Other general exclusion criteria are listed in the Admission Policy.

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 to 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 responsible party for direct payment to the hospital. In order 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.

Financial Assistance

If the patient does not have health insurance, or has limited coverage, Burke may be able to help. Burke staff is 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 with numerous health insurance plans. Discover our list of health insurance plans https://www.burke.org/patients-visitors/insurance-accepted/

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. 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.

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/

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 social worker/case manager assumes a leadership role in planning and preparing for the individual's discharge from the inpatient brain injury program. This planning and preparation

begins 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. Information is shared with the family or caregiver(s) in a forum that best meets the family's needs. It can be a formal meeting with the team, observation of therapy sessions, and/or a phone call update or phone conference. Communication with the family or caregiver(s) occurs throughout the duration of the individual's stay at Burke. For adolescents, the social worker/case manager is responsible for communicating with the school when necessary to anticipate, plan and address the patient's educational needs. Neuropsychology performs neuro-psychological testing to facilitate return to school with academic supports when appropriate.

Based on the individual's functional, cognitive and behavioral status, family support, insurance and pre-morbid living situation/environment, the brain injury team makes recommendations for the most appropriate and suitable discharge plan for the individual. This includes recommendations for equipment and continued services. A safe discharge is the main priority when considering possible options. Recommendations may include, but are not limited to:

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

In 2024, three hundred and eighty-six individuals were discharged from Burke Rehabilitation Hospital with a brain injury diagnosis to the following settings:

- 68.39% (264) of the patients returned home to the community
- 15.03% (58) of the patients continued therapy at a subacute rehab facility
- 16.06% (62) of the patients returned to the acute care hospital
- 0.0% of the patients continued therapy at an acute rehab facility
- 0.0% of the patients entered a long term care hospital or hospice

In 2025, three hundred and sixty-five individuals were discharged from Burke Rehabilitation Hospital with a brain injury diagnosis to the following settings:

- 70.96% (259) of the patients returned home to the community
- 10.96% (40) of the patients continued therapy at a subacute rehab facility
- 17.26% (63) of the patients returned to the acute care hospital
- 0.0% of the patients continued therapy at an acute rehab facility
- 0.0% 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 recommendation 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.

In order to ascertain long-term outcome data for individuals discharged, Burke contracts with a company to conduct follow-up interviews via phone at 3-months post discharge.

Three-months post-discharge from Burke in 2025, the individuals living with a brain injury reported the following outcomes:

- Percent of patients living in the community= 88% (benchmark 92.7%)
- Overall, how satisfied were you with the services you received during your rehab stay? = 3.8/4 satisfied (benchmark 3.7)
- My social activity level is similar to or better than before my rehabilitation stay = 2.69/4 satisfied (benchmark 2.92)
- I was involved with decision making during my rehabilitation program = 3.58/4 satisfied (benchmark 3.35)
- The rehabilitation program prepared me for going home = 3.62/4 satisfied (benchmark 3.452)
- The progress I made in rehabilitation met my expectations = 3.57/4 satisfied (benchmark 3.36)
- The rehabilitation program improved my quality of life = 3.58/4 satisfied (benchmark 3.37)

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).

Brain Injury Team Description

The philosophy of the Brain 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 brain injury
- Individual's family and/or caregiver(s)
- Physician
- Medical Residents/ Brain Injury Fellow

- Neuropsychology
- Rehabilitation Nursing
- 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:

- Wound Care by Certified Wound and Ostomy Nurse(s)
- Medical consultations (Hospitalist, Psychiatry, Podiatry, Pain, Urology, Plastics, ENT, Ophthalmology, Optometry, Dermatology, etc.)
- Pastoral Care
- Orthotic/Prosthetic Services
- Pharmacy
- Radiology
- Dialysis
- Laboratory Services
- Complimentary Therapy
- Wheelchair seating/positioning
- Brain injury support groups

From admission through the discharge planning process, team members work collaboratively with each other, the individual with the brain 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. The individual's progress is discussed formally once per week at team conference and four other days per week at the interdisciplinary team rounds. 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. A Burke Binder may be provided to patients to assist with retaining and reinforcing the information learned during the rehabilitation stay. The Burke Binder incorporates information to assist with orientation, therapy goals, brain injury education and home exercise programs.

The Burke Brain Injury Program Offers:

Medical Management

The interdisciplinary team is led by physiatrists, Jaskiran Ghuman, Dr Orkhan Mammadov, and Dr Rory Siegel, who all have experience caring for patients with brain injury. As the leader of the interdisciplinary team, the physicians are responsible for directing the medical care of the individual and monitoring the overall team process and outcome. At Burke, 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 brain injury including, but not limited to behavioral management, abnormal tone, changes in bowel/bladder function, respiratory function, changes in circulation, musculoskeletal complications (i.e. bone density), pain, etc. Medical consultations (Psychiatry, Ophthalmology, Podiatry, Pain, Urology, Plastics, ENT, Dermatology, etc.) are available to address the patient's needs while at Burke.

Clinical Neuropsychology

The Burke Rehabilitation Hospital has long recognized that coping with a brain injury is difficult for patients and families. Burke's clinical neuropsychologists, led by Dr. Julieanne Shulman, specialize 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 behavioral and cognitive impairments brought on by brain injury.

To this aim, a number of psychological services are offered to brain injured individuals and their families. Formal psychological evaluations are conducted to assess the patient's psychological functioning, as needed, typically in the setting of concerns regarding adjustment problems or in the event of a significant premorbid psychiatric history. Neuro-cognitive evaluations, are performed at the request of the team to inform complex differential diagnoses and/or to assist with care and discharge planning. Assessments comprise widely used neuropsychological measures of attention, memory, visual-spatial skills, language abilities, and executive functioning. Interventions may consist of education about brain injury, and its effects on cognition. Consultation with the team to enhance learning strategies to effectively compensate for cognitive deficits for our patients is also common. Moreover, behavioral and other coping strategies to address psychological barriers to progress are also discussed. Family therapy to provide education and optimize adjustment to a loved one's medical condition is also provided, as-needed, in conjunction with services offered by the Caregiver Center.

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, perceptual 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 are 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. When appropriate, patients are taken out in the community to address community re-integration skills.

Physical Therapy

Physical therapists 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. Burke integrates specialized body weight support equipment, functional electrical stimulation, and bracing when appropriate.

Speech-Language Therapy

Speech-language pathologists evaluate and treat adults with communication disorders, such as speech, language, voice and cognitive difficulties, and swallowing disorders. Patients are evaluated by a speech-language pathologist when it is recommended by the team. Following a thorough and comprehensive evaluation, the speech-language pathologist determines appropriate therapeutic interventions, and work with patients to help regain communication skills as well as assisting patients with swallowing disorders to safely drink liquids and eat foods. Swallowing assessments such as Modified Barium Swallow (MBS) studies and Fiberoptic Endoscopic Evaluation of Swallowing test (FEES) are completed when appropriate. Speech therapy incorporates assistive technology to promote assistive and augmentative communication as appropriate.

Rehabilitation Nursing and Wound Care/Ostomy Nursing

Rehabilitation nursing is a specialty of professional nursing and is available 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. The 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. The social worker/case manager ensures that information regarding available funding for the individual is documented and considered during the intake, assessment, and treatment planning so that the individual's funds are used appropriately at this stage of the rehabilitation process and the lifelong needs of the individual are considered. Information regarding sources of funding, such as the TBI waiver, charity care, Medicaid etc., is provided as appropriate to assist the patient, family and/or caregiver(s). 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.

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 work 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.

Behavioral Management

The team specializes in managing behaviors that occur following a brain injury. These include irritability, agitation, lack of awareness and judgement, restlessness, distraction, impulsivity etc. The team discusses behaviors four-five times per week during interdisciplinary team rounds. Modifications to patients' care are made daily to ensure the safety of the patient, family and visitors while trying to provide the least restrictive environment. Staff work with family members to teach them how to recognize brain injury related behaviors and how to deal with them. To ensure that staff are equipped to manage challenging behaviors, our Behavior Management Training Director provides annual training, in-service training and co-treatment sessions when appropriate. Consultations and team huddles are arranged on a case-by-case basis to facilitate a consistent interdisciplinary approach and to maintain safety for all.

Nutrition Education

A registered dietitian visits patients in need of assistance in understanding their dietary modifications or other nutritional concerns in order 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 brain 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 various religious needs. Patients may arrange for visits from clergy from other religious traditions. Holiday services for various faiths are held.

The chaplains respect each patient's personal beliefs and individual ideas. The goal of the Pastoral Care Department is to help renew each patient's sense of hope and offer a spiritual home away from home.

Use of Technology

Below is a list of some of the technology that is incorporated into the patient's rehabilitation care as appropriate:

- Restorative Therapies Xcite
- RTI FES Bike (RT300, 200)
- Bioness Integrated Therapy System (BITS)
- Bioness H200
- Bioness L300+ and L300Go
- Bioness Vector
- LiteGait
- Biodex
- Walkbot

- Rifton Tram
- Saebo- glove, MAS, and micro stim
- Motomed FES
- iPad applications to assist with communication

Outcome Management

The Brain Injury Program 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 brain injury
- Establish an optimal model for patient centered, cost effective, interdisciplinary rehabilitation care of the individual with a brain 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 will be measured 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
- Compliance with the "Three Hour Rule"
- Percent of patients screened versus patients admitted
- Patient satisfaction
- Length of stay
- Wounds
- Post discharge community involvement and satisfaction

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

https://www.burke.org/patients-visitors/your-inpatient-rehabilitation-stay/inpatient-rehabilitation-outcomes/

Additional outcomes measured include:

- Falls
- Agitated behavior scale scores
- Behavioral management approaches

Education

Patient and Family/Caregiver

Ongoing education of the individual with a brain injury and the family and/or caregiver is essential in order 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 brain injury will receive ongoing education from each discipline throughout his/her stay in order to maximize achievement of each individual's goals. Some of the 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. Education also incorporates strategies to prevent future brain injuries by identifying and reducing risk factors for recurrent brain injuries.

Team Members

In house education via inservices 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 brain injury 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 Brain 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 the area of brain injury rehabilitation is a priority to team members. The Burke team provide numerous 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 brain injury to improve the care that individuals receive across the spectrum of healthcare. Burke staff regularly presents at the Brain Injury Association of New York State annual conference and publish articles about brain injury.

Certification training in Non-Violent Crisis Intervention (NVCI) is provided for team members to ensure a safe, least restrictive and consistent approach to managing challenging behaviors. Annual re-certification training is provided to reinforce and build on individual and team interventions.

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

In conclusion, the Brain Injury Team takes pride in the excellent care that they provide for patients after a brain injury, caregivers, and the community. If you have any questions about the program or brain injury rehabilitation, please contact the Brain Injury Program Director, Rachel Feld-Glazman (OT) at 914-597-2586.