



## **Brain Injury Specialty Program Scope of Services**

Gaylord Hospital has more than 65 years of history in providing care to persons affected by Brain Injury and our Brain Injury Program is CARF (Commission on Accreditation of Rehabilitation Facilities) accredited. Rehabilitation after a brain injury is a process that the person and their support system work through together, with the assistance of an interdisciplinary group of professionals. This team approach is essential to maximize the physical, cognitive, linguistic, psychological, emotional, spiritual and social recovery. We work to assist the person with brain injury in setting realistic goals and learning the skills needed to make the most of work, home and life. Our goal is to promote patient functionality through the best clinical services, most advanced and effective treatment protocols, and documented outcomes for our patients. The Brain Injury program follows Gaylord's mission, vision and values statement.

**Our Mission** is to enhance health, maximize function and transform lives.

**Our Vision** to be a recognized and acknowledged destination for rehabilitation and complex medical care providing high-quality, patient-centered, compassionate, team-based healing at every point in the journey from illness or injury to maximum recovery.

**Our Values** are clinical excellence, compassion, integrity, respect, accountability and a commitment to safety.

### **Our Patients/Population Served:**

Gaylord Hospital is dedicated to serving the needs of adult and adolescent persons affected by brain injury. Our inpatient units accept individuals with differing severity level of brain injury and different needs including our early recovery program, rehab program and medically complex program. We have ventilator, telemetry and oxygen capabilities allowing us to serve persons with complex medical needs. We accept patients from Connecticut and surrounding states, sometimes from across the country and other countries, working with various insurance and payer sources. All of our hospital rooms are private rooms and visiting hours are flexible. We have adolescent dedicated suites consisting of private rooms with a parent or support person adjoining the private room, free of charge. Rooms are connected via private bathrooms for each and a shared shower for the suite. Each family suite has a mini fridge. The unit that houses the adolescent suites also has The Loft which is a game room with XBOX ONE and a 42-inch flat-screen TV. Currently Gaylord is undergoing renovation projects and during these renovations, the adolescent suites are occasionally unavailable due to construction.

Our outpatient department provides continued lifelong care working with individuals with brain injury 18 years old and over residing in the community. Patients younger than 18 are approved



on an individual basis. We offer physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), therapeutic recreation (TR), psychology/social work, neuropsychology, concussion services, care management and physician/licensed independent practitioner (LP) services with flexibility of scheduling and frequency. Our TR department has a very active Sports Association with many activities available to community-dwelling persons with brain injury. Our medical services department offers and provides annual follow-up appointments. Gaylord's experienced team works collaboratively to help improve health and function, decrease risk factors and improve overall quality of life.

### **Settings/Locations/Hours of Service:**

Please refer to our website, [Gaylord.org](http://Gaylord.org) for the most up to date hours of service.

#### **Gaylord Inpatient Services**

50 Gaylord Farm Road | Wallingford, CT 06492

#### **Gaylord Outpatient Services**

*(includes **Physiatry, Psychology and Therapy Services**)*

50 Gaylord Farm Road | Wallingford, CT 06492

#### **Gaylord Outpatient Services**

*(providing **neurological PT, OT and SLP and orthopedic PT**)*

8 Devine Street | North Haven, CT 06473

#### **Gaylord Physical Therapy**

*(providing **orthopedic PT**)*

1154 Highland Avenue | Cheshire, CT 06410

50 Berlin Road | Cromwell, CT 06416

28 Durham Road | Madison, CT 06443

### **Frequency of Service:**

Frequency of services is determined on an individual basis after evaluation to meet the needs of each individual.



**Payers and Funding Sources:**

Health insurance benefits are verified prior to initial service. Gaylord Specialty Healthcare participates with most insurance networks.

Accepted managed care plans including but not limited to:

COMMERCIAL	GOVERNMENT	MEDICARE ADVANTAGE
<ul style="list-style-type: none"> <li>▪ Aetna</li> <li>▪ Blue Cross</li> <li>▪ Cigna</li> <li>▪ Connecticare</li> <li>▪ Harvard Pilgrim</li> <li>▪ Multiplan</li> <li>▪ Oxford</li> <li>▪ United Healthcare</li> <li>▪ Yale Health Plan</li> </ul>	<ul style="list-style-type: none"> <li>▪ Medicare</li> <li>▪ State of Connecticut Medicaid</li> <li>▪ VA Community Care Network(managed by Optum)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Aetna Medicare Advantage</li> <li>▪ Blue Cross Medicare Advantage</li> <li>▪ Carepartners of CT</li> <li>▪ Connecticare Medicare Advantage</li> <li>▪ Wellcare Medicare</li> </ul>

**Fees:**

Gaylord Hospital wants to help patients make informed health care decisions. Because that includes having an understanding of your out-of-pocket costs for our services, we make available our charge master on our website, [www.gaylord.org](http://www.gaylord.org).

Patients covered by private health insurance are encouraged to contact their insurance carrier to understand their financial responsibilities. Contact information for your insurance carrier can be found on the back of your health insurance card or by visiting the carrier’s website. You can also call the Gaylord Hospital Patient Financial Services department at (203) 284-2827 or email [Billinginquiries@gaylord.org](mailto:Billinginquiries@gaylord.org).

**Referral Sources:**

Referrals are made from many sources such as acute care hospitals, rehab hospitals, skilled nursing facilities, home health care, community physicians and self-referral.

**Admission Criteria:**

**Acute Inpatient Program Admission Criteria**

**Gaylord Hospital screens all potential admissions by utilizing nationally recognized admission criteria. Patients must have:**

1. Diagnosis of a brain injury, excluding developmental and degenerative disorders.
2. Must be 18 years of age or older. An exception to this policy would be a patient who is younger and only at the discretion of the Medical Director, Inpatient Rehab or designee. Exclusion may be radiation or chemotherapy.
3. Does not require the capabilities of an acute care hospital.
4. Onset within 3 months (exceptions to be reviewed by the Medical Director, Inpatient Rehab or designee.)
5. Requires 24-hour nursing care and medical coverage.
6. Can benefit from at least two therapies.
7. Able to tolerate and benefit from therapy programs.
8. No preceding comprehensive rehabilitation effort; OR previously unattained but currently feasible rehabilitation goals with the potential to tolerate and benefit from services and attain significant functional goals
9. Ability to comprehend very basic commands.
10. Hospital resources of a scope, duration, frequency or amount that are not provided or do not exist at a lower level of care and/or the patient failed to recover at another level of care.
11. Cultural and spiritual status assessed and determined to be within the scope of resources and interventions available to meet the needs of the persons served.

**Exclusion:**

The following patients are generally excluded from admission, but exceptions can be made in borderline cases if reviewed and accepted by the Director of Psychology or designee:

- Patients whose current inpatient hospital stay is a result of a suicide attempt
- Patients currently residing in an inpatient psych or substance abuse facility
- Patients who have been exhibiting or demonstrating suicidal ideation or have a documented history of inpatient psych admissions
- Patients with severe mental illness with significant behavioral issues
- Patients who are incarcerated and under the care of the Department of Corrections

**Continued Stay Criteria**

1. Continued daily monitoring by a physician-led team of healthcare professionals is required.

2. Coordination and delivery of multidisciplinary care with care team meeting at a minimum every two weeks and verifiably documented progression or regression with plan of care revised accordingly.
3. Hospital resources of a scope, duration, frequency, or amount which are not provided or do not exist at a lower level of care and/or the patient failed to recover at another level of care.
4. Interdisciplinary coordinated team approach to program of care consisting of PT, OT, Respiratory therapy, and/or Speech therapy 5 days per week.

### **Early Recovery Program (ERP) Admission Criteria**

**Gaylord Hospital screens all potential admissions by utilizing nationally recognized admission criteria. Patients must have:**

1. Diagnosis of a brain injury.
2. Onset within three months (exceptions to be reviewed by the Medical Director, Inpatient Rehab or designee.)
3. Does not require the capabilities of an acute care hospital; free of serious co-morbidity that would impact overall prognosis, not vent dependent.
4. Must be 18 years of age or older. An exception to this policy would be a patient who is younger and only at the discretion of the Medical Director, Inpatient Rehab or designee
5. Requires 24 hour nursing care and medical coverage.
6. Neurological impairment requiring intervention of at least 2 therapies.
7. Unable to participate in the acute program secondary to decreased endurance, a decreased level of consciousness, decreased conditioning, and/or multiple co-existing medical issues.
8. Hospital resources of a scope, duration, frequency or amount which are not provided or do not exist at a lower level of care and/or patient failed to recover at another level of care.
9. Patients in a minimally conscious state will be assessed on an individual basis by Medical Director, Inpatient Rehab or designee.
10. Conservatorship process is in progress.
11. Long-term plan has been discussed with the primary caretaker and other appropriate family.
12. Psychological status and behavioral status assessed and determined to be within the scope of resources and interventions available to meet the needs of the persons served.
13. Cultural and spiritual status assessed and determined to be within the scope of resources and interventions available to meet the needs of the persons served.
14. Free from pre-morbid dementia.

### **Exclusion:**

The following patients are generally excluded from admission, but exceptions can be made in borderline cases if reviewed and accepted by the Director of Psychology or designee:

- Patients whose current inpatient hospital stay is a result of a suicide attempt

- Patients currently residing in an inpatient psych or substance abuse facility
- Patients who have been exhibiting or demonstrating suicidal ideation or have a documented history of inpatient psych admissions
- Patients with severe mental illness with significant behavioral issues
- Patients who are incarcerated and under the care of the Department of Corrections

### **Continued Stay Criteria**

1. Continued daily monitoring by a physician-led team of healthcare professionals is required.
2. Coordination and delivery of multidisciplinary care with care team meeting at a minimum of every two weeks and verifiably documented progression or regression with plan of care revised accordingly.
3. Hospital resources of a scope, duration, frequency, or amount which are not provided or do not exist at a lower level of care and/or patient failed to recover at another level of care.
4. Interdisciplinary coordinated team approach to program of care consisting of PT, OT, Respiratory therapy, and/or Speech therapy 5 days per week.

### **Outpatient Admission Criteria:**

#### **Criteria for Provision of Outpatient Therapy Services**

Patients are typically admitted for outpatient services once a prescription is obtained. For PT services, a written prescription is not required based on CT state law. The prescription can be brought by the patient or faxed and/or mailed by the patient or referral source. It should contain the patient's name, date of birth, address, phone number, medical diagnosis, onset date, specific therapy services ordered and insurance information, as well as the physician's dated signature, address and phone number. However, it will be processed with the patient's name, medical diagnosis, specific therapy services ordered and physician's signature while other information is being obtained via communication with the referral source. The patient's insurance will be verified to ensure it is active and the evaluations will be scheduled for each respective order.

In order for therapy to be provided to an individual in the outpatient clinic, therapy services must be considered:

- Restorative in nature and appropriate for the patient's condition
- Require the skill of a licensed clinician to design, implement, and progress a plan of treatment or maintain the current level of function.
- Preventative of further functional decline for degenerative conditions. Of note, skilled intervention is still required during any maintenance therapy.
- Indicated for design of appropriate home exercise program with instruction to patient and/or caregiver.

**Patients will be treated in Outpatient Therapy when:**

- Mobility deficits interfere with daily living, employment, and/or schooling.
- Musculoskeletal, neuromuscular, cardiopulmonary, neurocognitive, visual/perceptual, and other disease processes, or injury deficits interfere with functional mobility, and/or activities of daily living.
- Musculoskeletal, neuromuscular, cardiopulmonary, neurocognitive, visual/perceptual other disease processes, or injury deficits reduce an individual's ability to interact with the environment safely, independently and/or effectively.
- Conditions in which pain or other sensory dysfunction interfere with functional mobility and/or activities of daily living.
- Musculoskeletal, neuromuscular, neurocognitive, visual/perceptual, respiratory and other disease processes or injury deficits reduce an individual's ability to communicate via oral-motor and motor-speech, verbal expression, auditory comprehension, reading comprehension, written expression, pragmatic skills, and other non-verbal communication skills.
- Musculoskeletal, neuromuscular, neurocognitive, respiratory or other conditions such as post-surgical conditions interfere with an individual's ability to achieve normal nutrition via swallowing.
- Special techniques or procedures are required for the patient to achieve functional mobility, communication and increase independence in activities of daily living.
- Special equipment and/or devices are required for the patient to achieve functional mobility, communication and increase independence in activities of daily living.
- Functional mobility and level of ADL independence is below premorbid abilities and the patient desires treatment for these impairments.

**Discharge Criteria**

**Inpatient Discharge Criteria:**

1. Patient has stable vital signs, has returned to either baseline orientation or pre-morbid state, has a satisfactory airway, has stabilized or resolved acute problem, and is able to be cared for in a less acute environment.
2. Patient has met program goals, stabilized or requires physician intervention less than twice weekly.
3. The discharge plan goals have been met. Services are in place for either home or transfer to another facility. These services are deemed safe and appropriate for the patient's care.
4. Patient no longer meets any other screening criteria for continued stay.
5. Patient's progress has plateau or maximum functional gains have been achieved.
6. Patient develops a medical condition/complication that requires intense services in a short term acute care hospital or transfer to the medical division/program at Gaylord.
7. Patient has suffered a complicating medical or psychological condition interfering with his/her ability to participate in his/her program.
8. Patient left against medical advice.

9. Patient and/or caregiver are not cooperative with the discharge plan or have unrealistic goals the patient is unable to achieve.
10. Patient expired.

**Outpatient Discharge Criteria:**

A patient may be discharged from treatment when they:

1. Have received the maximum benefit from the treatment program as documented by no objective changes in mobility, activities of daily living, motor, visual/perceptual, swallow, communication and/or cognitive functioning.
2. Are independent with all prescribed exercises and no longer requires skilled intervention from a clinician.
3. Have achieved the outcome long-term goal(s) as stated and as documented by objective measurements.
4. Are functioning at pre-morbid status.
5. Are functioning at a level that is safe and appropriate for his/her daily needs.
6. Choose to discontinue services.
7. Are deemed to be appropriate to be serviced in another setting- such as home care.
8. Have experienced a change in their condition that requires the patient to cease outpatient therapy for any length of time.
9. Are out of compliance with the hospital's attendance policy.
10. Do not comply with hospital policies regarding safety.
11. Refuse to participate in therapy activities.
12. Are admitted into a hospital.
13. Are discharged from therapy by a referring physician.
14. Are out of compliance with the Inappropriate Patient Behavior Policy (Workplace Violence Prevention).
15. Have expired.

**Program Description:**

Upon admission to the brain injury program, the patient receives thorough evaluations by all team members and an individualized care plan is developed for the patient. Activity limitations, behavioral status, cultural needs, impairments, intended discharge/transition environment, medical acuity, medical stability, participation restrictions, environmental needs and psychological status are all considered. Goals, frequency of therapy and length of stay are individualized to the patient's needs and tolerance as determined through the evaluation process. This is reevaluated continually throughout the patient's stay. For inpatients, this is reevaluated formally at weekly team conferences. Length of stay is individualized, however, average length of stay for inpatients is 25 days for the acute program, 60 days for early recovery, and for outpatient is 17 visits.



**Our Interdisciplinary Rehab Team:**

- **The person served:**

The rehabilitation team centers on the person and their goals. As the most important part of the rehabilitation team, the person served (and their family/support system if desired) collaborates with the other team members in order to learn, understand, provide input and make progress. It is important that the team has the Brain Injury survivor's input on all areas of the treatment plan in order to best serve the person's needs and meet their goals.

- **Physician/LP:**

The physician is the team leader. This professional may be a specialist in physical medicine and rehabilitation/physiatrist or internal medicine. Since most patients have survived a severe and potentially life-threatening injury, continued management of medical complications beyond the acute care hospital is essential. Without medical stability, the person with a brain injury's full participation in a rehabilitation program would be impossible. The physician will assess many aspects of the ongoing healthcare needs of the person with a brain injury. Both pre-existing and new medical problems will be evaluated, monitored, and managed. The medical team may include a physician's assistant (PA) or an advanced practice registered nurse (APRN), who play key roles in managing the brain injury survivor's ongoing healthcare needs. Gaylord has two medical directors who are specialty board-certified in brain injury.

Upon admission, the attending physician will provide a comprehensive evaluation. The physician looks at the unique aspects of care in a person with brain injury such as evaluating for abnormal tone, bladder function, bowel function, dysphagia, aphasia, cognition, behavior, respiration, skin integrity, infection management, medicine management, DVT/PE prevention, men's and women's health issues, neurological changes and nutritional needs. Lab and diagnostic tests are also completed based on patient needs. Based on this evaluation the physician provides orders to the rehab team. Consultants can also be called in to see inpatients, or referrals can be made on an as-needed basis including OB/gyn, pulmonology, critical care, ENT, urology, plastics, neurology, neurosurgery, hematology, infectious disease, neuropsychology, psychiatry, nephrology, cardiology, orthopedics, podiatry, ophthalmology and neuroptometry.

- **Nursing:**

We have 24-hour nursing care provided by licensed registered nurses, licensed practical nurses and certified nursing assistants. We have several Certified Rehabilitation Registered Nurses (CRRN) on staff including the nurse manager for the primary floor for persons with acquired brain injury (ABI).

A registered nurse is responsible for establishing a plan of care based on the needs of the patient as identified by the nurse. The ultimate goal of rehabilitation nursing care is



helping people regain control of and responsibility for their lives. The focus is on the brain injury survivor becoming more independent and less reliant on others as discharge approaches.

The nurse ensures that each person receives adequate nutrition and rest, administers medications and performs treatments ordered by the physician. Monitoring the person to prevent or correct problems such as skin integrity, infection, and weight management is very important. Nursing provides education and training in regard to bowel and bladder management. Physical, cognitive, social and emotional reactions are also observed and recorded.

Rehabilitation nurses work closely with other team members in evaluating and helping the brain injury survivor practice on the unit the functional skills taught in other therapies. Because the family/support system is part of the team, education and participation in their relative's care are necessary. Correct techniques are taught to the family in the therapy departments and in the nursing unit. Once these techniques are learned, the family will be encouraged to help whenever they are present. Adequate family training not only makes the transition from hospital to home possible but often can mean the difference between the brain injury survivor being able to go home or to another facility.

- **Wound Care**

- **Wound Care Specialist:**

- Our team includes APRN-trained wound care specialists, an RN certified in wound and ostomy care and a physician who completed a Fellowship with The American Professional Wound Care Association. A wound care specialist is a clinician who is specially trained and certified to evaluate wounds and determine the appropriate treatment. The wound may be a result of an accident that occurred, surgery, pressure or other causes.

- **Wound Care Team:**

- The wound care team is a group of multidisciplinary clinicians who are specialty-trained to evaluate wounds and determine the appropriate treatment. This team is part of a multidisciplinary group comprised of therapy, LP, nursing, nutrition, psychology/social worker and care management to create a treatment plan. An RN (wound and ostomy certified) was also added to the team this past year to assist with follow-up care and added continuity.

- **Care Management:**

- The care manager (CM) coordinates healthcare services through the collaborative multidisciplinary team approach. The CMs are involved in reviewing the appropriateness of

continued stay, and providing education and support to hospital staff regarding community resources, managed care issues, or payment/payer issues.

Discharge planning is initiated early on during the inpatient stay. The CM develops and revises individualized discharge plans as indicated by the team's assessment, and the patient's response to treatment. Many factors including the psychosocial, physical, educational and cultural aspects are considered when developing a plan. It is the role of the Care Manager to ensure that the ABI survivor's plan of care promotes a safe and timely discharge and to evaluate the overall plan for effectiveness. The CM involves both the ABI survivor and family in the formulation of goals for a safe discharge. The CM provides the link between provider and payer organizations, physicians and the community in transitioning a person through the healthcare continuum.

- **Occupational Therapist:**

The occupational therapist (OT) evaluates and treats areas that affect a person's ability to care for themselves and does so by assisting the person in achieving the highest level of independence possible in activities of daily living (ADLs). This may include areas such as feeding, grooming, dressing, bathing, ability to get to and from the bathroom, and preparing meals. A brain injury may cause temporary or permanent weakness or paralysis on one side of the body. A person may need to re-learn how to perform these activities with the use of one arm or leg, and to compensate for visual, perceptual, and cognitive deficits. The OT may recommend adaptive equipment or modify the environment to assist the brain injury survivor with their ability to perform these tasks more independently. Recommendations for assistive technology, DME, splints and home modifications will be explored by the occupational therapist.

Family education and training is very important piece of the brain injury recovery process. The occupational therapist will provide demonstrations and training to family members in the areas of self-care and mobility in preparation for a safe discharge home.

Many of our OTs have attended advanced training such as the ABI Specialist Course and other ABI-focused continuing education courses.

- **Physical Therapist:**

The role of physical therapy (PT) is to assist brain injury survivors in attaining the highest level of mobility possible following a brain injury. The physical therapist will conduct an evaluation of movement in both legs comparing strength, sensation, tone and coordination, which often may be impacted following a brain injury. The therapist will also evaluate endurance, balance, as well as important mobility skills necessary for getting out of bed to walk, move from/to a bed or wheelchair ("transfer"), or use stairs. Gaylord has services available to evaluate for custom braces and wheelchairs.

Family education and training is an essential component to a brain injury survivor's recovery following a brain injury. In consideration of an ABI survivor/family goal for a discharge to home, it may be advised for the appropriate family members to attend treatment sessions for training to assist the patient with safe mobility in the home environment. Recommendations for necessary assistive equipment and continued therapy services are made by the physical therapist prior to discharge.

Our physical therapy team includes board-certified neurologic clinical specialists and many in the physical therapy staff have attended specialty ABI education programs such as the ABI Specialist Course.

- **Speech-Language Pathology:**

The role of the speech-language pathologist is to improve your swallowing, communication and cognition. If appropriate, brain injury survivors are evaluated by a speech-language pathologist (SLP). The doctor will order an evaluation of swallowing, communication and/or cognition. Following the evaluation(s), an individualized treatment plan is developed. Goals are set by the brain injury survivor, family members and therapist, to assist with returning to the highest level of function. Examples of speech therapy goals include returning a patient to eating the least restrictive diet if the person is on a nothing by mouth (NPO) or modified diet, using a speaking valve if a tracheostomy is in place, or remembering newly learned information. Treatment is given in individual speech therapy sessions and group therapy if appropriate. Families are encouraged to participate in treatment sessions to promote the implementation of all skills/strategies learned.

To assist with the goal of improving swallowing, the speech pathology department has the capability to provide bedside swallow evaluations, modified barium swallow evaluations and fiber optic endoscopic evaluations of swallow (FEES). To assist with the recovery of speech and verbal expression speaking valves and alternative means of communication are available. The speech therapy department has specialists trained in assistive technology and swallowing.

- **Therapeutic Recreation:**

Therapeutic Recreation (TR) uses leisure and recreation programs to improve an individual's quality of life and physical, cognitive, social and emotional function. TR helps to improve abilities, enhance independence and make participation in recreation possible. TR offers activities that address the physical, cognitive, social, emotional and creative needs through engaging in activities of interest to each individual. Some examples of activities may include board games, cards, Wii or video games, arts and crafts, iPad use, sports and community re-integration. Leisure education teaches or enhances recreation skills and attitudes that will be used throughout life. It can help one

to discover new and exciting activities through interest exploration and to re-familiarize one with their community. Leisure Education also helps an individual continue participating in activities of interest through adaptive equipment.

- **Respiratory Therapy:**

The respiratory care practitioners at Gaylord Hospital are available 24 hours a day, seven days a week. The Respiratory Therapist (RT) plays a key role in the management of the brain injury patient. The RT will initially assess for any and all respiratory needs including oxygen, medication therapies, airway clearance modalities and airway interventions. The RT works with the interdisciplinary team to best coordinate all aspects of the brain injury survivor's care. The RT works with members of the interdisciplinary team to monitor respiration and oxygen needs to help facilitate speech, ambulation and return to everyday activities. The RT staff provides education on breathing interventions to maintain optimal respiratory function.

- **Food and Nutrition Services:**

A registered dietitian (RD), upon nutrition consultation, will evaluate and monitor the nutritional status of ABI survivors and provide guidance for the person, family and team. Interventions may include education about healthy food choices to help manage chronic health conditions and assistance with managing poor appetite or addition of nutrition supplementation. The dietitian also assesses and may modify a tube feeding regimen as needed. The RD works closely with the speech-language pathologist (SLP) when a modified consistency diet is needed due to swallowing problems. A representative from the Food & Nutrition department meets with inpatients daily for individual menu selections.

Nutrition education may be provided in both group and individual sessions. Continued nutrition support and counseling may be recommended after discharge on an outpatient basis.

- **Psychology:**

The role of psychology for patients and their families/support system is to provide an evaluation of current functioning, including emotional, personality, cognitive and behavioral. In addition, the clinician will assess one's adjustment to illness. Recommendations are offered to guide treatment. Psychological treatment may include individual, family and/ or group therapies to aid in adjustment issues and coping for the brain injury survivor and family members. Treatment would include collaboration with other care providers to ensure continuity of care. A brief neuropsychological evaluation may also be conducted based upon need with the goal of helping to inform treatment as well as to assist the brain injury survivor and family in gaining an understanding of the cognitive and emotional changes. Upon discharge, resource information may be

provided for follow-up as necessary. After discharge, the role of Psychology for brain injury survivors may continue to the outpatient rehabilitation program and include an assessment by a neuropsychologist or other clinician. This is done to guide treatment and collaborate with outpatient doctors, physical, occupational and/or speech therapists to ensure continuity of care and to ensure the person's needs are met. Psychology facilitates outpatient individual and group therapies. Neuropsychological evaluations may also be conducted based upon individual need, to further inform treatment, especially as individuals begin to resume premorbid life roles (e.g. academia, employment) or seek additional services in the home. Resource information is also provided to help the brain injury survivor reconnect with his/her community and bolster his/her support network.

- **Pastoral Care:**

Hospital chaplains have specialized training and have been authorized by a formal religious body to minister to brain injury survivors, families and staff in a healthcare setting. The goal of the chaplain is to help facilitate a person's use of his/her own faith, belief system, religious experience, or heritage during a crisis. The chaplain can help provide religious resources, act as a helpful liaison with various religious bodies or communities, or assist the brain injury survivor and family to use faith and spiritual values to gain emotional support or spiritual strength. Our Chaplains meet with our patients and/or their families at their request and at times provide structured services.

## **Clinics and Services**

### **Wheelchair Assessment Services:**

Our wheelchair clinic is directed by a certified Assistive Technology Practitioner in collaboration with contracted equipment vendor(s) with a goal to maximize a person's seating positioning and mobility from a wheelchair level. We have lightweight wheelchairs, power wheelchairs and specialty cushions available for persons served to trial during their stay as an inpatient or for an outpatient to trial when attending a wheelchair clinic appointment.

### **Orthotics and Prosthetics Clinic:**

Gaylord has an orthotics and prosthetic services available for inpatients and outpatients. Inpatient has a scheduled weekly service which utilizes a team of a physiatrist, physical therapist and contracted Certified Prosthetists/Orthotists (CPO). Evaluation, fabrication and follow-up services are available. Outpatient schedules or refers on an as needed basis.

**Aquatic Therapy:**

Gaylord's 75-by-25-foot therapeutic pool is specially designed for people with disabilities. The water is maintained at a temperature between 88 and 90 degrees F. Pool features include:

- 2-foot wide ledge for easy wheelchair access
- Hydraulic lift
- Ceiling lift
- Stairs with rails
- Adaptive exercise and swimming equipment
- Bench in the water for those who need to sit while exercising
- Accessible locker rooms and showers

The pool has an aquatic therapy staff that consists of PTs, OTs, exercise physiologists, rehab aides and lifeguards who have received training in aquatic therapy. Individual session, group session, community aquacize groups and recreational opportunities are available to inpatients, outpatient and community members.

**Community Reentry:**

Community Reentry is a group session provided at Gaylord Hospital. The purpose of community reentry is to provide an opportunity for exposure to community barriers, increase knowledge of leisure resources in the community, increase skill building through on-site therapy intervention, provide opportunities for social interaction and increase physical and/or cognitive functioning. Criteria for participating in the group include but not limited to being medically stable and cleared by the physician to leave the hospital for 1 ½ hours for community trips.

**Transitional Living:**

The Louis D. Traurig House is the only transitional living center for people with acquired brain injuries in Connecticut. Located in Wallingford on the campus of Gaylord Hospital, Traurig House is an 8-bed, co-ed facility. Typically, residents come to Traurig House after they have completed their inpatient rehabilitation but are not quite ready to go home because of difficulty with language, physical or cognitive functioning. Traurig House provides the necessary transition to ease the patient from hospital to home. Insurances are accepted with a contract for transitional living, including Blue Cross of Connecticut and Connecticare. Unfortunately, some insurance providers like Medicare, United and Cigna do not have a benefit. The average length of stay for residents is four weeks.

Participants in the Transitional Living Program receive services in our Cognitive or Aphasia Day Treatment Program, at Gaylord Hospital; such as cognitive retraining, communication skills, community re-entry, psychosocial skills, independent living skills, psychological support as well as individual Physical Therapy, Occupational Therapy and Speech Therapy. The setting is that of a home with bedrooms, sitting areas, a computer station with internet access, a kitchen and dining room.





The residents have weekly goals in the house to progress their functional skills toward independent living and maximize their potential under the supervision and assistance of staff. The Traurig House allows the patient and their family to “practice” what it will be like for when the person returns home.

#### **Concussion Services:**

Gaylord’s comprehensive concussion care is a program featuring specialty-trained experts who provide an individualized concussion management program for teens and adults. Gaylord’s interdisciplinary team draws upon a long and successful history of treating brain injuries. Our collaborative center consists of physiatrists, neuropsychologists, sports medicine physical therapists, vestibular/balance physical therapists and certified athletic trainers. In some cases, specialty treatment options may include audiologists, occupational or speech therapists, all with advanced training in neurological disorders to maximize recovery.

#### **Day Treatment Programs:**

Gaylord offers two unique day treatment programs, the Aphasia Day Treatment Program and the Cognitive Day Treatment Program. Both are intensive full-day, individualized programs that include a mix of group and individual therapies provided on an outpatient basis. Our specialists will design a treatment plan based on a patient’s specific needs. Areas addressed include but are not limited to, communication, cognition, education, nutrition, psychosocial factors, chemical usage, and a community reentry trip. All therapies aim to provide patients with the techniques needed to maximize skills and increase independence.

#### **Care Across the Lifespan:**

We offer and encourage annual follow-up visits with a physiatrist, a doctor of physical medicine and rehabilitation. They can be sooner as needed. The doctor monitors function and medications and provides a resource assessment to maximize a person’s quality of life post-brain injury. Outpatient therapy services are also available on an as-needed basis. Gaylord is committed to serving brain injury survivors throughout their lifespan, from adolescence through the aging process.

### **Support and Advocacy**

#### **Acquired Brain Injury (ABI) Peer Mentor Program:**

Gaylord has developed a very strong ABI peer mentor program. ABI survivors volunteer and are trained by the hospital to be peer mentors. They can meet with patients privately to provide encouragement or answer questions regarding stroke recovery.



**Caregiver Support Group of Acquired Brain Injury Patients:**

Gaylord Hospital is the sponsor and host of a caregivers support group. It is a source of education and support for caregivers of persons with acquired brain injury. It is the only caregivers support group in Connecticut.

**Adaptive Sports Program:**

Gaylord Hospital's Sports Association is dedicated to improving the lives of persons with physical disabilities through adaptive sports and recreation. The program is known throughout New England for providing exceptional opportunities for people with brain injury. We offer the most diverse adaptive sports program in the state of Connecticut, with 16 different sports, ranging from introductory recreation activities to highly competitive sports teams. Sports include:

- Archery
- Cycling
- Boccia
- Veteran's Fishing
- Golf
- Kayaking
- Wheelchair Rugby
- Skiing and Snowboarding
- Sled Hockey
- Wheelchair Tennis
- Rock Climbing
- Paratriathlon
- Water Skiing
- Yoga
- Pickleball
- Virtual Adaptive Boxing

**Technology**

**Augmentative and alternative communication (AAC)** incorporates the communication methods used to supplement or replace speech or writing for those with difficulty producing or understanding language. AAC is used by those with a wide range of speech and language impairments. AAC can be a permanent addition to a person's communication or a temporary aid.

The purpose of AAC is to facilitate meaningful participation in daily life activities. Special augmentative aids, such as picture and symbol communication boards and electronic devices, are available to help people express themselves. This may increase social interaction, performance, and feelings of self-worth. AAC should be used when communication needs are not being met, and to express his or her own feelings, thoughts, wants and needs.

A team approach is utilized when providing AAC services. A Speech-Language Pathologist will identify the need for AAC and perform an assessment to determine the most appropriate AAC techniques and equipment. The SLP then develops material, programs a device, and trains the



patient, family, and other team members regarding use. An occupational therapist may assist in determining the most effective ways to access communication aides and a physical therapist to determine the most effective positioning for the patient.

**Assistive technology (AT)** is any item, piece of equipment, or product system used to increase, maintain, or improve functional capabilities. Assistive technology can be off the shelf, modified or customized. Assistive technology enables a brain injury survivor to fully participate in meaningful activities and fulfill life roles. Trained therapists work collaboratively with individuals to determine the most effective and efficient assistive technology to meet individual needs. Therapists may recommend devices to help people be more independent with feeding, bathing, dressing, communicating, cooking and/or accessing their home environment. Assistive technology also includes devices that increase your mobility, computer access and communication. Assistive technology may be considered 'low tech' or 'high tech'. Low-tech equipment may include a long-handled reacher or elastic shoelaces. High-tech equipment may include an environmental control unit that can control lights and simple appliances in your home.

Some examples of technology that Gaylord utilizes are:

- FEES
- Visi-Pitch
- Functional Electrical Stimulation (FES)
- Bioness
- Saebomas
- Positioning Equipment
- Braces
- GWalk
- SmartWheel
- Pressure Mapping
- Vestibular Technology (VORTEQ, DVA-T, VHIT and binocular video goggles)
- Environmental Control Units
- iPads
- Dragon Dictate
- Ekso
- Zero G
- Alter G
- BURT
- Synchrony
- Smartboard

## Education

### Patient Education:

The Brain Injury Committee at Gaylord Hospital created a unique brain injury education manual that answers many common questions, highlights important issues and addresses return to important life activities. We also offer a brain injury education series. Issues addressed in the education manual and education series are expansive and include anatomy, what is a brain injury, how the brain works, medical complications, predictors of recovery, memory, communication, fatigue, equipment and technology, sexuality, leisure and community



resources. The education manual is also available to the community on our website. These resources are used to educate persons served and their family/support system. Education is also provided by the clinical team during individual sessions and group sessions. Persons served are educated on how to direct their own care and in regards to self-advocacy. As desired by the person served and as appropriate family, support system and hired caregivers are educated and trained in providing the care needed to the person served.

#### **Staff Education:**

Gaylord is also committed to the education of its staff. We have a staff-designed 14-week ABI Specialist Course which is an educational series covering a wide range of ABI topics. We also have many in-house in-service opportunities and encourage staff to attend outside educational opportunities and seminars.

#### **Community and Professional Education:**

Gaylord is involved and dedicated to educating the general community and professional community. Many of our staff have presented at outside conferences and to community groups. Our ABI support group which is open to the community arranges for guest lectures. Our ABI Specialist Course is open to the community, not just to Gaylord staff. We have provided Wallingford Emergency Services with a presentation on the unique needs of serving a persons with brain injury.

Gaylord is also invested in prevention through community lectures on various topics. Specifically, Gaylord Hospital's ThinkFirst program, the first in the state, educates Connecticut's youth about risk-taking behaviors and injury prevention. We have also provided public service announcements in the form of billboards and digital advertising/information in regards to helmet-wearing while riding motorcycles and use social media as a forum for education and sharing of resources.

#### **Research**

Gaylord has a long history of research dating back to its time as a TB sanitarium. In 2020, those research efforts were advanced through the generosity of George and Carol Milne and the creation of the Milne Institute for Healthcare Innovation.

The Milne Institute focuses on three areas: Research, Applied Technology, and Product Development.

In research, the Milne Institute collaborates with internal and national experts to progress the rehabilitation field in various specialties, including gait and balance, cognitive screening, and dysphasia. With the Milne Institute, Gaylord can provide additional support for practical bedside rehabilitation research, and share its expertise and research findings with clinicians and



patients nationwide. The Milne Institute also seeks out new rehabilitation technologies that can improve the outcomes and experiences of Gaylord’s patient-clinician teams. Over \$1M has been invested in new technologies since the inception of the Milne Institute. The Milne Institute sees product development as an intersection of these other two areas. Working with early commercialization and startup companies to test their products and evaluate their market viability, the Milne Institute ensures Gaylord clinicians have access to cutting-edge technology while giving companies access to expert rehabilitation clinicians. The Milne Institute has been successful including several peer-reviewed articles, presenting numerous posters at national and international conferences, and the development of hundreds of research projects. We continue to grow and expand.

Research involvement specific to brain injury over the past 3 years has included: COT-cog study, Does Bioness Integrated Therapy System (BITS) Touch Screen Technology Improve Field Awareness to Inpatients with Neurological Visual Field Deficits?, Clinical utility of the TOMME10 scoring criteria for detecting suboptimal effort in an mTBI veteran sample. Anthony Rinaldi, Jada J Stewart-Wallis, David Scarisbrick, and Zoe Proctor-Weber. Published August 2020 in Applied Neuropsychology: Adults and a Case report on a patient with presumed Lance-Adams Syndrome; Abstract to be submitted to ACRM 3/17/23; potential for m/s in the future.

## Future

The Gaylord Hospital Brain Injury Specialty Program continually works to improve its programs and services -in expertise, innovation, and dedication to those who have sustained a brain injury. Our goal is to continually expand our services and our footprint, becoming a nationally and internationally known neuro destination center for the care of persons with brain injury. Gaylord is proud of the investment in staff, technology, education, research, and expert clinical care. We acknowledge the broad spectrum of care required by people throughout their lifetime and are committed to the continued provision of services from prevention, to inpatient care, to long term follow- up as an outpatient. At Gaylord, we ***Think Possible.***

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