the Whole Story

REHABILITATION THAT FOCUSES ON THE WHOLE PERSON

NYU Rusk Institute of Rehabilitation Medicine
NYU LANGONE MEDICAL CENTER

LETTER FROM THE CHAIRMAN

By Steven R. Flanagan, MD
Chairman of Rehabilitation Medicine and Medical Director of the Rusk Institute

This is an exciting time for the Rusk Institute of Rehabilitation Medicine and one of the most important in our history. Since it was established, Rusk has been recognized as one of the preeminent rehabilitation programs in the world, ranked among the top 10 in the country and the best in New York State by *US News* and *World Report* every year for over 20 consecutive years. We've achieved this through:

- The pioneering work of Howard Rusk and those he brought to NYU Langone Medical Center to establish the first university-based rehabilitation program in the world;
- The rehabilitation professionals at Rusk who pioneered what is now the standard of care in rehabilitation medicine – to treat the entire person by addressing not only their physical needs, but emotional, vocational and social needs as well; and
- Most importantly, by providing the highest quality of care anywhere in the world

With a venerable history that began during World War II, Rusk has occupied its current facility at 400 East 34th Street since the 1950s. But I am sure everyone would agree that it isn't the building that accounts for Rusk's success; rather it is the tireless, dedicated and interdisciplinary work of the physicians, nurses, therapists, aides and every other member of the hospital staff. Rusk is defined by what our clinicians and staff collectively do for people with disabilities every day and not the building within which they provide these critical and often life-changing services.

"Since it was established, Rusk has been recognized as one of the preeminent rehabilitation programs in the world, ranked among the top 10 in the country and the best in New York State by *US News* and *World Report* every year for over 20 consecutive years."

The building at 400 East 34th Street, a dated physical plant that does little justice to what we accomplish there every day, will come down at the end of 2012 to make room for a new clinical pavilion. It is important to note, however, that Rusk will continue to be the centerpiece of rehabilitation medicine at NYU Langone Medical Center and that any rehabilitation service provided by the Department of Rehabilitation Medicine across the medical center will be provided by the skilled rehabilitation professionals from Rusk. Moving forward, instead of our patients primarily receiving care at 34th Street, we will be going to our patients across the medical center, including on the main campus in Tisch Hospital, at our Hospital for Joint Diseases on 17th Street, and at a variety of outpatient facilities.

Rusk has also been working on several very important strategic initiatives intended to ensure we continue to lead the way for physical medicine and rehabilitation well into the 21st century. First, we will consolidate our non-musculoskeletal outpatient services, administration, education and research programs to newly acquired and soon-to-be renovated space at 240 East 38th Street, which will be a very short distance from the new Musculoskeletal Institute (MSI). MSI, a state-of-the-art center for clinical care, research and education and a joint effort with the Department of Orthopaedic Surgery and the Divisions of Rheumatology and Pain Medicine, will open later this year with a strong Rusk presence, both in therapy and physician services.
We are also implementing and expanding our research program including new research collaborations with many School of Medicine departments as well as with NYU's Steinhardt School of Culture, Education and Human Development. Rusk will also have an important clinical presence in the Kimmel Pavilion, slated for completion in 2017. This state-of-the-art inpatient unit, which is being designed with input from Rusk staff members, will be strategically situated close to other neuroscience departments.

As mentioned, this is an exciting and important time for Rusk. Our future is bright. By acting strategically and proactively, our future is brighter than it ever was before. I am encouraged by the commitment and dedication of everyone at Rusk who delivers the best rehabilitation care in the world. Soon, this care will be provided in modern, state-of-the-art environments more worthy of their service, which will enable us to elevate the care that Rusk provides to an even higher level.

PLANTS AND PAIN IN THE PT CLINIC: WORKING TOWARDS AN OPTIMAL HEALING ENVIRONMENT

By Matthew Wichrowski, MSW, HTR

Having a surgical procedure can often be a painful and anxiety-inducing experience. Pain control in medical settings is challenging because patients need relief not only from aversive situation but also from accompanying emotional stress. Thus, pain can limit the rehabilitation process and slow progress towards regaining independence. While surrounded by plants in the greenhouse during horticultural therapy treatment, many patients have commented that they didn't think about their pain. They also reported reduced stress and a positive shift in mood. We decided to explore this effect and consider other treatment areas where plants might be helpful.

Upon reviewing the literature, we found a few others thinking along the same lines: Ron Melzack, an emeritus researcher from McGill University, has proposed the Gate-Control Theory of pain. This theory states that there are cognitive, emotional and sensory inputs which contribute to a person's experience of pain. Pain perception can be influenced by one's mood and level of stress and anxiety as well as through focus on or distraction from the painful condition. Other researchers have found that subjects can hold their hands in a pail of uncomfortably cold water for longer periods of time when surrounded by plants in a lab experiment. Patients having their gall bladder removed more often requested Tylenol as compared to narcotic analgesics, when they had a view of a group of trees from their hospital window. Recently in Korea patients reported lower pain, anxiety and fatigue, and positive impressions of employee caring when their hospital room had a number of plants installed.

So, in a performance improvement project we looked at the effects of plants on pain and anxiety in early stages of inpatient orthopaedic rehabilitation in the physical therapy clinic. The first stage of the project involved patient treatment, as usual. During the second phase we added privacy screens to surround the treatment space. In the third phase we added plants to the treatment space with the privacy screens in place.

Although this was a pilot study and there weren't enough patients to make any solid statistical conclusions, there were many positive comments from patients and staff regarding the plant room. In a follow up questionnaire many patients rated the quality of the treatment space as excellent and stated that they would recommend it to others. Some of the treating physical therapists noted that patients appeared more relaxed and enjoyed the quieter space as it gave them something else to focus on during treatment. We also learned that patients enjoy a degree of privacy during treatment as long as there is adequate space to engage in therapy. After the study some of the plants were kept in the clinic to help 'green up' the space.

Small scale studies such as this allow us to explore ways to enhance the healing environment. As we come to a better understanding of the complex mechanisms of healing including the effects of the immediate environment on a person's well-being, we can fine tune the healthcare environment to provide improved outcomes for our patients.

IN THIS ISSUE. . .

UPDATE ON THE AMPUTEE SUPPORT PROGRAM AT NYU LANGONE MEDICAL CENTER

By Jeffrey Heckman, DO, *Clinical Instructor, Department of Rehabilitation Medicine*
By Jeffrey Cohen, MD, *Clinical Professor, Department of Rehabilitation Medicine*

As physicians, we come across patients with incredible stories on a daily basis. In Physical Medicine and Rehabilitation (PM&R), those stories seem to take on a special significance. In a specialty little known to most patients, and even many physicians, we encounter patients who find themselves in positions they did not expect to be in and which they are rarely prepared to face. These patients are usually not alone; most have families,

friends, and/or caregivers. When we started the NYU Langone Medical Center Amputee Support Program (NASP) in August of 2008, the goal was clear: to provide help, support, information, and other resources to those in need. Our efforts augment the incredible strength and courage that clearly exists in this patient population.

Since the inception of NASP, we have taken numerous steps to ensure that our members maximize their abilities in all realms of their lives. NASP was founded to mirror the outstanding multidisciplinary care that patients receive at the Rusk Institute of Rehabilitation Medicine. We constantly strive to provide our members with innovative methods to reintegrate into their communities. To do this, we engage members in monthly support group meetings, community-based activities, and patient advocacy opportunities. In this format, physicians, therapists, nurses, psychologists, social workers, amputees, families, and friends are brought together to achieve a common goal and work together to enhance lives.

CREATING A COMMUNITY

It is well-documented in medicine that support groups allow patients to achieve results that many are unable to accomplish alone. Participants in the support group are welcome to speak or listen, and are encouraged to learn and connect with others. They share personal thoughts and emotions and support one another through a collective growth process. NASP extends the value of this dynamic by introducing participants to individuals that are qualified to assist in unique ways. Our multidisciplinary approach includes not only physicians and patients, but staff from various relevant fields such as social work and psychology. These meetings are often very powerful and quite emotional, as members share stories of triumph and despair. Whether it be about a member completing a marathon on a hand crank bicycle, trials and tribulations of Access-a-Ride, or simply the pain and discomfort associated with wearing a prosthesis every day, members share and learn from each other in a comfortable setting with trained professionals to lend guidance and resources when necessary.

Individuals with limb loss in the community learn about these meetings through our website and via email from our group leaders. In addition, all amputees admitted to Rusk are enrolled in an inpatient education program and given information about NASP prior to discharge.

SOCIALIZING AND ACTIVITY

Return to leisure and recreational activities can be a huge step in the recovery process following amputation. NASP leaders have therefore worked closely with the NYULMC Auxiliary to obtain funding to host many activities in the New York City community. NASP members have participated in a number of social engagements in the community including bowling events at Chelsea Piers 300 Bowling Club, Dinner at Patsy's Pizzeria on 3rd Avenue and Movies at Kips Bay AMC Loews Theatre. In addition, NASP has organized trips to Citifield for New York Mets games and arranged for participants to attend concerts at New World Stages and Lincoln Center at Alice Tully Hall. NASP is also affiliated with organizations like the Achilles Track Club, Challenged Athletes Foundation, and the Orthotic and Prosthetic Assistance Fund to create more opportunities for our members to reintegrate into the community. These organizations allow amputees to enjoy activities such as running and swimming clinics, the Achilles Hope and Possibilities 5K in Central Park, and McKeever's First Ride Equine Assisted Horse Therapies in Warwick, NY, among others.

NEW OPPORTUNITIES

NASP recently teamed up with Victor Calise of the NYC Department of Parks and Recreation to organize a free indoor amputee mobility clinic at Recreation Center 54. This is the first clinic of its kind in Manhattan; amputees are able to get together at the center and learn new exercises and techniques to improve their exercise tolerance and walking ability. The popularity and quality of the clinics has grown since its inception in February 2010: during the summer of 2010, the mobility clinics were held in Central Park at 90th Street and Fifth Avenue every Monday night from 7-8 pm and the same schedule is in place for summer 2011.

EXPANSION OF SERVICES

In July 2010 Dr. Heckman received the full support from the Medical Director and Chairman of the Rusk Institute of Rehabilitation Medicine, Steven Flanagan, MD, to develop a unique and comprehensive outpatient amputee clinic. This event marked another significant milestone in establishing NYULMC as the place of choice for comprehensive care of amputees. The program will serve to complement the Rusk inpatient amputee specialty program directed by Dr. Cohen. Like the inpatient program, the clinic will utilize a team approach where physicians, prosthetists, physical therapists and case managers work with patients to achieve their individual goals. This will serve as a model program for outpatient amputee care.

A LITTLE HELP FROM OUR FRIENDS

Our success has been extraordinary and the ability of NASP to generate excitement and participation in the community continues to accelerate. These accomplishments can be directly attributed to the generous funding from the NYULMC Auxiliary along with educational grants and funding from other organizations to support the program. NASP continues its expansion in the NYULMC community and its surrounding neighborhoods, and will continue to work towards a seamless transition for amputees from the hospital through rehabilitation and back into the community.

JOIN US

We are happy to say that we continue to grow and assume a greater presence in the community as our services are noticed and generate excitement. We are always ready to embrace new members however, and invite all who live with the loss of a limb, their families, friends, and caregivers to join us for a meeting, event, or to simply visit our website. Our meetings are held the last Thursday of every month at the Rusk Institute of Rehabilitation Medicine, 400 E. 34th Street, New York, NY 10016 on the first floor in room 111-112 from 6-7:30 p.m.

For information regarding the inpatient amputee specialty program please contact Dr. Cohen's office at 212-263-6338.

For information regarding the outpatient amputee specialty program please contact Dr. Heckman's office at 212-263-6098.

For information regarding the NYULMC Amputee Support Program (NASP) please visit our website at http://amputee-support.med.nyu.edu.

THE COMMUNICATION COMMUNITY GROUP PROGRAM

By Karen Riedel, PhD, CCC-SLP, *Director, Speech-Language Pathology Department*

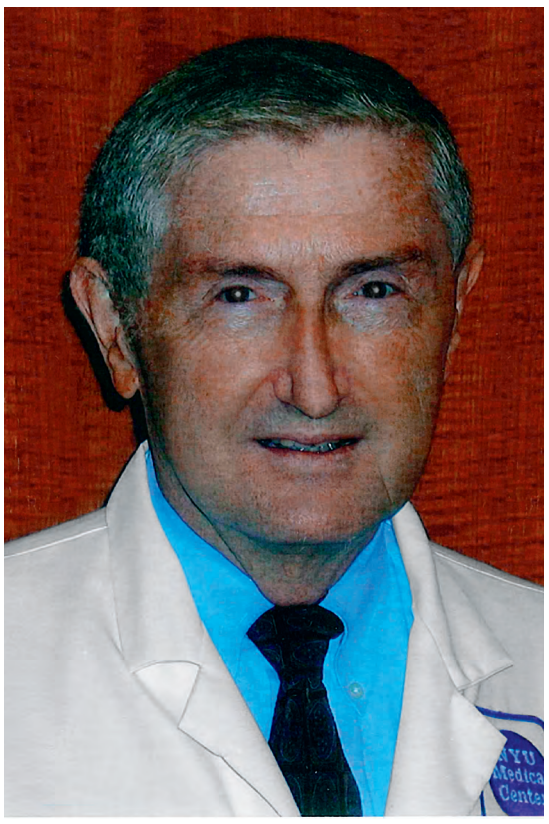
The Communication Community Group Program (CCGP) has a long and unique history at the Rusk Institute. In the mid 1950's, Dr. Howard Rusk encouraged the then Rusk Institute Auxiliary to become involved in a variety of different activities at the newly established Institute of Rehabilitation Medicine. Emmy Beard, President of the Rusk Auxiliary, in partnership with Dr. Martha Sarno, the former Director of the Speech Pathology Department, established a social program for individuals with aphasia. Together they set up an apartment-like facility on the second floor of the Rusk building. There, people were free to drop in, have lunch, and participate in a program designed to reduce the social isolation of individuals with aphasia. With the help of volunteers, former patients with aphasia came every day to talk, play board games, and even catch up on the stock market.

The collaboration of the NYU Langone Medical Center Auxiliary and the Speech-Language Pathology Department continued through the decades. In 2008, when Elyse Riley, an Executive Board Member of the Auxiliary, and coordinator of the Aphasia Community group for over twenty years, stepped down because of failing health, the NYULMC Auxiliary awarded a donation to the Speech-Language Pathology Department in her honor. Their gift has enabled the hiring of a coordinator and subsequent expansion of the program. The mission of the program continues by providing a setting for former Rusk patients to get together for socialization and the program assists in the reintegration of individuals in the community. Today, four groups per week are offered for persons with aphasia, and one newly formed group is specifically designed for persons with communication difficulties associated with Parkinson's disease. In 2009, a total of 758 visits were recorded for approximately 40 persons with aphasia. In 2010, 1071 visits to our expanded program were recorded.

In addition to meeting at Rusk Institute, the groups have participated in many outside activities. The volunteer facilitators have organized trips to the Museum of Modern Art where the CCGP forged a relationship with MOMA's disability program. The facilitators have encouraged and fostered relationships among members that go beyond the weekly meetings. On June 16, 2010, the collaboration of the NYULMC Auxiliary and the Speech-Language Pathology Department was highlighted at the 31st Annual Aphasia Luncheon. For further information, please contact the coordinator of the Communication Community Group Program, Dr. Linda Carozza, CCC-SLP, who can be reached at 212-263-6027.

DEVELOPMENT CORNER: DR. HOWARD THISTLE'S EDUCATION FUND

By Melissa Halbridge, *Associate Director of Development*



Dr. Howard Thistle has spent his entire illustrious career in the halls of The Rusk Institute of Rehabilitation Medicine. Since moving here from his native Canada in 1964, he has spent over 45 years at NYU Langone Medical Center and served 22 years as the Director of Education for the Rusk Institute. In this time, he has been an integral part of making Rusk the best rehabilitation hospital in New York and one of the top ten in the country.

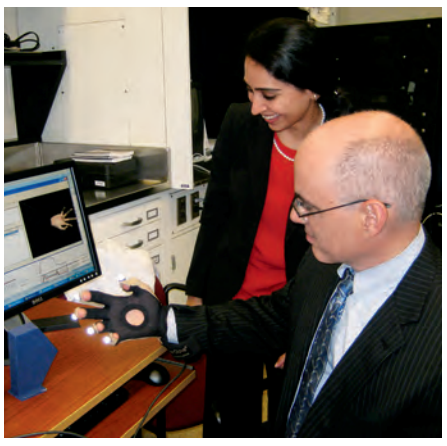
Dr. Thistle has always been extremely passionate about the training and education of the future young minds of rehabilitation medicine and has recently donated $50,000 to create an Education Fund to provide support for young academics striving to become our next generation of leading physicians. According to Dr. Thistle, "When one has spent so much time in a positive, uplifting environment like NYU Langone Medical Center and Rusk and has profited as a person while honing their medical skills and learning about life, the least one can do is to make certain that it continues into the next generation".

The Rusk Institute of Rehabilitation Medicine is one of the largest centers of its kind for the treatment of adults and children with disabilities and home to innovations and advances that have set the standard in rehabilitation care for every stage of life and every phase of recovery. Dr. Thistle believes that the field of rehabilitation medicine has never been more necessary and hopes that his fund will inspire medical students to go into this incredibly rewarding line of work in which he has spent his career. This fund honors Dr. Thistle's commitment to education and the field of rehabilitation medicine.

Anyone who would like to honor Dr. Thistle's commitment to education and the field of rehabilitation medicine, please reach out to Christopher Sickels in the Development Office at 212-404-3646.

RESEARCH ON MOTOR RECOVERY

By Ann Thaler-Shore, MPT, MPA, *Manager, Office of Continuing Care*



The Rusk Institute of Rehabilitation Medicine is now home to the Motor Recovery Research Laboratory, which is directed by Preeti Raghavan MD, an NIH-funded physician-scientist. The lab had its first open house on July 29, 2010. The mission of the motor recovery lab is to understand how people recover and regain movement after brain injury and to develop effective therapeutic strategies.

Dr. Raghavan has focused her efforts on studying the recovery of hand function after stroke by examining fingertip forces and finger movements during functional tasks. The idea is to try to understand the way that stroke affects people in greater detail and to figure out what it would take to restore hand function. She and her colleagues previously found that patients with weakness on one side of the body after a stroke (hemiparesis) who could grasp and lift objects, did not easily learn the relationship between an object's weight and the amount of fingertip force they needed to use, despite repeated practice with the affected hand. However, they did so more readily if they practiced with their unaffected hand first.[1] These interesting results suggest that one approach to treating functional deficits in patients with hemiparesis may be to use the unaffected (strong) hand to teach the affected (weaker) hand. Current studies are examining how such practice must be structured to get the best results. Another recently published study examined how people who have had a stroke shape their hands around objects.[2] It was found that patients shaped their hand to the object using a different set of joints, and did not plan their grasp strategy in advance compared to healthy individuals. The results help us understand the reasons behind the physical difficulties that some people have after a stroke, and provide some ideas for treatment.

It is important to understand that no two patients who have had a stroke are exactly alike. Any given patient may have a number of factors that affect his or her ability to function. How, then, is a therapist to know which strategies would be most effective for that individual patient? These decisions are typically up to therapists' experience, and are difficult to understand scientifically. To aid in such decisions, Dr. Raghavan and her colleagues have developed a new rating scale called the Upper Extremity-Impairment Function Rating Scale (UE-IFRS) that analyzes the relationship between movement problems and ability to function in any given patient.[3] The patient performs specific functional tasks that are videotaped and scored by trained raters. The raters score each part of a patient's movement during the tasks. The scores are then compiled to provide a snapshot of problems relevant to function that need to be addressed by the therapist. The UE-IFRS could allow a clinician or researcher to understand how specific problems affect functional ability. This information may then be used to guide treatment selection and may help researchers examine the effectiveness of different treatments.

There are several new studies underway as well. One is investigating the effects of music on mood and on patients' ability to control movement (motor control) with the affected hand, and another exciting study is looking at how overuse injury may be prevented in musicians.

We are very excited about all of the amazing work that Dr. Raghavan is doing in the Motor Recovery Research Laboratory. We look forward to learning more!

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1. Raghavan P, Krakauer JW, Gordon AM (2006) Impaired anticipatory control of fingertip forces in patients with a pure motor or sensorimotor lacunar syndrome. Brain 129: 1415-1425.

2. Raghavan P, Santello M, Gordon AM, Krakauer JW (2010) Compensatory motor control after stroke: an alternative joint strategy for object-dependent shaping of hand posture. J Neurophysiol 103: 3034-3043.

3. Armstrong G, Hirsch R, Dijkers M, Raghavan P. The Upper Extremity Impairment Function Rating Scale (UE-IFRS): Linking Upper Extremity Impairment to Function Post-Stroke; Annual conference of the Association of Academic Physiatrists 2010; Bonita Springs, FL.

RUSK WITHOUT WALLS

MARIANNE HARDART'S JOURNEY TO SOUTH AFRICA

By Ana Mola, MA, RN, ANP-BC, *Program Director, Rusk Cardiopulmonary Rehabilitation*

As health care professionals we are enriched and humbled through our patient experiences. Marianne Hardart, Director of Therapeutic Recreation, Child Life & Creative Arts Therapies, requested and was granted a ten week clinical sabbatical from the NYULMC leadership, to share best practices of child life studies and clinical practice at the Red Cross War Memorial Children's Hospital (RCWMCH) in Cape Town, South Africa. The main goal of the sabbatical was to explore and understand the interdisciplinary challenges of children with burns and cancer as a member of the hospital's pain management team. Marianne discovered this opportunity through the Wheelock College alumni newsletter.

In March and April 2010, through the organization Connect-123, Marianne became part of the interdisciplinary professional pain management team at RCWMCH which was composed of an anesthesiologist, an art therapist, a mental health specialist, a palliative care specialist, child life specialist and a registered nurse with a specialty in pain management. The hospital is dependent on the global volunteerism of specialized professionals in the child life arena, because the hospital does not have this specialty program nor does the local University of Capetown. Marianne elected to bridge the "Rusk Without Walls" philosophy which can be interpreted as a diverse caring community whose professionals honor and respect differences among people, their ideas, and their ways of coping and healing in the world. Global immersion through community engagement at a national and local level through experiential learning actualizes the understanding of diversity and acceptance of cultural mores.

Marianne's unique opportunity in South Africa, combined with her extensive clinical expertise bridged the capacity of analyzing the social, cultural, political and economic contexts of the death and dying experience for children, parents and staff. In addition, traditional child life interventions such as distraction, guided imagery and play therapy were used during painful dressing changes on the burn unit and general procedures on the oncology unit. The children were helped to integrate age appropriate and creative adaptive pain relief skills that might be perceived as integral to their lifelong learning of resilience and coping strategies in response to other challenging experiences.

> "The children were helped to integrate age appropriate and creative adaptive pain relief skills that might be perceived as integral to their lifelong learning of resilience."

Marianne's South Africa experience has given her a new lens to incorporate and understand the broad social, cultural, political and economic contexts that influence the lives of all children and families at the local, national, and international levels. Her immersion in Cape Town, South Africa has made her reflect on possible interventions that can be incorporated in a pediatric pain program at NYULMC.

MARIANNE HARDART'S JOURNEY TO SOUTH AFRICA, PICTURED ON THIS PAGE:
Marianne with two pediatric patients at the Red Cross War Memorial Children's Hospital; images of the beauty of Cape Town - Table Mountain and Cape Town Coastline

REFLECTIONS ON HAITI, PICTURED ON FOLLOWING PAGE:
Nandita and Antoine, an interpreter, working together to train rehabilitation aides; a young Haitian boy studying for school outside his tent in the camp; day-to-day life in Haiti - woman transporting a bag of rice on her head.

REFLECTIONS ON HAITI

By Nandita Singh, MPH, OTR/L, *Program Manager, Occupational Therapy*

Although it's been several months since returning from my second trip to Haiti, the images of smiling faces are quite vivid, the smell of burning coal continues to linger, and I often catch myself tapping my fingers to an upbeat Haitian rhythm. I continue to reflect on my emotions and process all of the experiences I had volunteering as an occupational therapist in Haiti.

Like many people watching the human suffering on television in January 2010, I wanted to help. I joined forces with two other occupational therapists and four dedicated staff from the Afya Foundation in Yonkers, New York. In collaboration with a hospital in Port au Prince, our goal was to train hospital staff to care for patients with disabilities. Our team would introduce concepts of rehabilitation care to Haitian healthcare workers in hopes of assisting patients in their physical recovery. At the time, the plan seemed very ambitious.

> "Our team would introduce concepts of rehabilitation care to Haitian healthcare workers in hopes of assisting patients in their physical recovery."

On March 16, 2010, I boarded a plane to Port au Prince, and upon landing I was immediately thrown into navigating the complexities of the relief effort. Surprisingly, my first reaction was quite calm. I was able to remain focused despite seeing patients solemnly laying in their hospital beds under white tents in the hospital courtyard. The injuries and surgeries were unlike any I had ever seen including a woman with both her upper arm and lower leg amputated. People were not embarrassed to express their fear of entering concrete buildings and were impressively eager to share their stories about their ordeals surrounding the earthquake. Equally striking, two months after the earthquake many patients had not walked or attempted to perform basic activities of daily living since their surgery or injury. Although patients had received some level of medical and surgical care, it did not appear that they had received any education about the recovery process or rehabilitative care.

Our team of occupational therapists, who had never worked together, quickly created a curriculum which included transfer training, basic self care, scar massage, conditioning exercises, wheelchair training and documentation. With the use of interpreters, we were able to teach the hospital staff many of these core skills in order to mobilize patients and assist them in performing their daily life skills again. One of our goals was to teach the hospital staff to focus on a client-centered approach, specifically asking all patients to identify their therapy goals.

When simply given the permission to move and instructed in strategies, patients pushed their own limits and carried on with their day to day tasks such bathing, dressing, cooking and doing their laundry. On my follow up visit to Haiti in April, although the rebuilding process seemed frustratingly slow, many earthquake survivors remained active and determined to rebuild their lives and make sense of their drastically altered world. After learning key fundamentals, I was impressed with the level of innovation to adapt and create new routines to engage in daily tasks. Working in the tent camps, I witnessed many examples of perseverance. Some people set up store fronts and children studied for school and kicked around soccer balls outside their new homes–a make shift tent.

Although the devastation continues to linger in Haiti, with recent flooding and an outbreak of cholera, the resilience of the Haitians is quite apparent. I returned from both trips emotionally, mentally and physically drained. I found myself easily distracted with memories of the chaos and people's stories of strength and survival. I also battled a stomach bug for several months. I am often asked if I feel sorry for those affected by the earthquake. I am quick to respond, "How can I feel sorry for people who do not feel sorry for themselves?". A common Haitian phrase, "deye monn gin monn" loosely translates to "behind this mountain is another mountain".

Like most volunteer experiences, you often gain much more than you offer. I met a young woman, Sarah, working at the hotel I stayed at. Her grandmother died and both her nursing school and hotel where she worked part-time crumbled on the day of the earthquake. She told me she was not sure why she survived but was determined to find her purpose in life. My purpose and resolve to pursue my own personal and professional goals are now much more powerful. A little generosity and compassion truly does go along way.

STAFF HIGHLIGHT: JUDY ZLOTNICK AT THE MS COMPREHENSIVE CARE CENTER

By J. Tamar Kalina, MS, OTR/L, CCRC, MSCS, *Director of Rehabilitation, MS Care Center*

The NYU Langone Medical Center (NYULMC) Comprehensive Multiple Sclerosis Care Center was established in 1994 by Dr. Joseph Herbert to provide state-of-the-art diagnostic evaluations and multidisciplinary follow-up care to patients diagnosed with MS. Over the past decade the Center has flourished and presently sees over 3,000 patients and has more than 12,000 patient visits annually. In 2008, our Center became an integral component of the NYULMC Center of Excellence on Multiple Sclerosis, a designation awarded to only six programs campus wide. A dedicated team of professionals, including neurologists, nurses, a social worker, occupational and physical therapists, psychologists, a patient advocate, and administrative staff are committed to the MS Care Center's four-fold mission: providing the finest patient care and rehabilitation, researching the cause and cure for MS, educating tomorrow's healthcare professionals, and improving the quality of life of the patients we serve.

In April 2008, Judy Zlotnick, OTR/L, joined the occupational therapy (OT) team at the MS Care Center. Judy is a native of Montreal who graduated from McGill University, where she obtained her degree in OT. She was trained in specialized aspects of MS Care and has been instrumental in expanding the OT programs and services at the Center. As an occupational therapist, she works to improve the functional performance and quality of life of individuals with MS so they retain or regain independence, maintain their role in their family and in society, and enjoy a rich and rewarding life.

Last year, Judy initiated a wheelchair clinic for individuals with MS who require powered mobility and complex seating systems. At that time, the waiting time for such an evaluation at other New York City centers was over six months, with another six-month delay for wheelchair deliveries. This endeavor has been extremely successful in significantly decreasing the wait time for a powered chair and, to date, over a dozen individuals with MS have acquired new wheelchairs through Judy's intervention.

Judy's pleasant demeanor and flexibility have made her a true asset to our team. When she is not engaged in individual treatments at the MS Care Center, she may be found providing care in the inpatient, outpatient, or acute OT departments, performing neurological and orthopaedic evaluations, helping patients improve independence in activities of daily living, assessing for adaptive equipment, fashioning splints, and taking care of other patient needs.

To quote Judy, "working at the NYULMC MS Care Center for the past two years has not only been a truly rewarding professional experience, but has expanded my growth and knowledge as a clinician and as a member of a multidisciplinary team."

DIVERSITY IN NYULMC: PRIORITIZING CULTURALLY-SENSITIVE CARE

By Jody Gill, MS, CI, *Director, Language, Cultural and Disability Services*

"So, tell me your story!" This is a good way for any clinician or therapist to begin a partnership of care with their patient. We all have a story and by encouraging our patients to tell us theirs, we learn about who they are, what their beliefs, expectations and needs are. Truly understanding our patients can be crucial to the delivery of healthcare and optimal outcomes.

The Language, Cultural & Disability Services department works to ensure that every patient's cultural needs and practices are being respected and recognize that effective communication is a right, not a privilege. By providing free medical interpreting services to patients/families and staff, we help patients maintain their dignity, their independence, and support them in making informed decisions. With a staff of three full-time Chinese interpreters, two full-time Spanish interpreters, myself, a certified sign language interpreter and an extensive list of agency and freelance interpreters, we build bridges. We not only witness but have the unique honor of facilitating communication so connections can be made. What could be more gratifying!

Of course, it's not just about language–it is about each person's story. There is an individual story, a family story and often a community or collective story. How amazingly lucky we are to be in an institution where there is so much diversity, celebration of culture, languages spoken, and stories told!

Did you know that many traditional Chinese people believe that the soul is in the blood so that when vials of blood are taken for tests, this is understandably a great concern for the patient and the family?

Or did you know that for many of our Russian patients, nutrition is often seen as one of the most important ways to stay healthy? If a patient is able to eat, they might see themselves as being well or healed.

And for many of our Spanish speaking patients (who may come from many different places), we have learned that they tend to have many visitors with extended family members visiting day and night. It is expected that the community cares for the patient's personal needs both out of respect and obligation.

The importance of understanding and respecting that many Orthodox Jews believe there should be no physical contact with someone of the opposite sex (this may include handshaking or sitting next to someone) is so important when providing care.

What is YOUR story? What would you like us to know about you? What questions AREN'T we asking? What questions do YOU have? Teach us – educate us – tell us your story.

If you would like to contact us for more information please call Jody Gill at (212) 263-0101 or Janet Huege at (212) 263-2151.

VOCATIONAL REHABILITATION: A SUCCESS STORY

Robert Lindsey, CRC, LMHC, *Director of Vocational Services*

In 1984 Jackie was diagnosed with Neurofibromatosis Type 2 (NF2), a genetic disorder that causes tumors to grow. That year she had a tumor removed from her left ear and lost hearing on that side. Twelve years later, in January of 1997, she became profoundly deaf in her right ear as well, after surgery to remove a similar tumor. In addition to her deafness, Jackie has paralysis in her face and problems with balance caused by other tumors.

Totally deaf, Jackie had to abandon her college major of early childhood education and her goal of teaching young children. No longer able to perform her duties as a supermarket cashier and bookkeeper, she also lost her job. The following years were marked by frustrating attempts to find employment. Working with vocational counselors she was sent on job interviews only to find out the position required verbal communication skills and telephone work. Jackie attempted to learn American Sign Language in order to teach deaf children but was unable to form the facial expressions used in signing due to her weakened muscles. After many disappointments and no job offers Jackie returned to college and switched her major to English with the goal of finding a career in writing and/or research. While in school she obtained a temporary research intern position at the Lexington School for the Deaf, a positive experience and her first job since losing her hearing.

In 1998 Jackie became a patient of J. Thomas Roland, Jr., MD, Chairman of the Department of Otolaryngology & Associate Professor of Otolaryngology and Neurosurgery, NYU School of Medicine, who performed auditory brainstem implant (ABI) surgery. The ABI has assisted Jackie to distinguish between sounds and to communicate via lip reading. To address her problems with balance, Jackie received vestibular rehabilitation therapy at the Rusk Institute.

Since her ABI implant she has undergone three additional surgeries at NYU Langone Medical Center. With all of her follow up visits for treatment, she became very familiar with NYULMC and felt it would be a good place to work. She shared her aspirations with Jody Gill, the Director of Language, Cultural and Disability Services, who had accompanied Jackie to a pre-surgical testing appointment to facilitate communication. Jody referred Jackie to the Rusk Institute's Vocational Services Department to meet with a rehabilitation counselor and establish a vocational goal and rehabilitation plan.

Jackie's counselor recommended an administrative support career. Jackie committed herself enthusiastically to the plan, enrolled in the Rusk Institute's computer skills training program and with the assistance of note takers, successfully completed the course with high marks. Equipped with the requisite office skills, her counselor placed her in an internship in the Medical Center's Department of Nursing Education where she gained hands-on experience performing data entry and general office work.

According to her supervisor in Nursing Education, Jackie performed "wonderfully" during her 10-week program. She learned new tasks quickly and her work product was "excellent". Jackie used a TTY (text telephone) when receiving directions or asking questions; that was the only job accommodation that she required. She loved working in Nursing Education and when her internship ended she stayed on as a volunteer. The department director was so impressed by Jackie's abilities and motivation that she contacted colleagues throughout the Medical Center to inquire about job opportunities. She was able to get Jackie an interview with Marianne Brassil, the senior clinical research analyst in Clinical Quality & Effectiveness, and Dr. Martha Radford, the department director and the Medical Center's Chief Quality Officer. Jody Gill accompanied Jackie to type the questions using the TTY.

Jackie was hired as a part-time casual employee, to work under Marianne, who relates that Jackie impressed her as bright, enthusiastic, and eager to learn. When she started, Jackie was performing data entry work but Marianne felt that she clearly needed and wanted more of a challenge. "I took a leap of faith," says Marianne, and Jackie was trained to be a clinical abstractor, which requires learning treatment protocols and memorizing medical terminology. Much of the work that she performs is typically done by RN's. Marianne is delighted with her decision and feels that Jackie, now a full time permanent employee is "amazing."

"I consider myself very fortunate to be working at NYULMC and I truly enjoy the work that I am doing," says Jackie. She finds the work environment congenial and her co-workers considerate of her hearing loss. They communicate with her by speaking more slowly so she can lip read, by gesturing, or by writing and emailing. Marianne relates that staff members welcomed Jackie with open arms and that communication has not been an issue. Jackie is very grateful for the opportunity she was given and says "All I wanted was for a potential employer to judge me based on my work ethic and ability, rather than on my disability. Just because a person has a disability does not necessarily mean that they are unable to do some jobs that non-disabled employees are able to do." We agree!

STRIVING FOR THE BEST: THE RUSK OUTCOMES MANAGEMENT SYSTEM

By Ora Ezrachi, PhD, *Manager, Rusk Outcomes Management System*

At the Rusk Institute we use a patient-centered method to measure the effectiveness and efficiency of our inpatient treatment programs. Our programs are effective if our patients learn to function more independently and are able to return to the community after discharge. We measure how efficient our programs are by tracking how long it takes to accomplish these results.

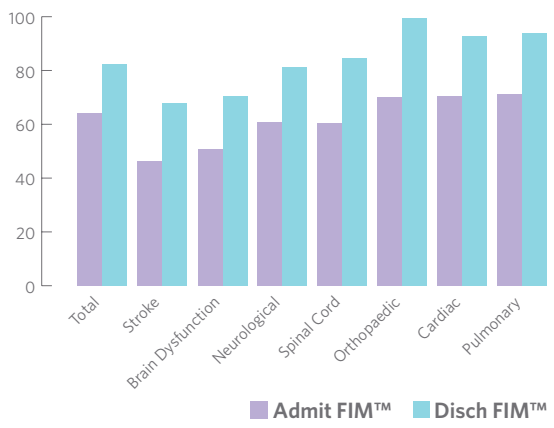
PERIODIC MONITORING

On admission all patients are evaluated by the team, their physician, nurses, and therapists. Treatment goals are developed jointly with the patient and the team. During the stay, this team of professionals monitors and continually documents patient progress in all areas. To measure how independently patients function, we also use a rehabilitation-focused instrument called the FIM™, or Functional Independence Measure.

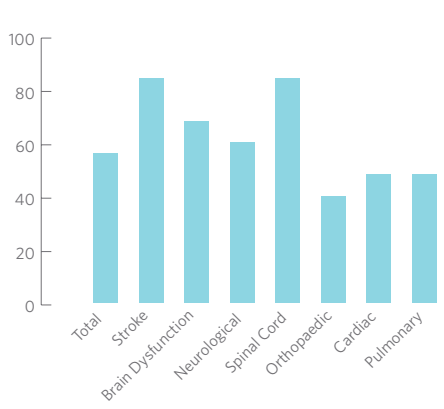
MEASURING FUNCTIONAL IMPROVEMENT, LENGTH OF STAY, AND DISCHARGE STATUS

The Rusk Institute strives to provide rehabilitation services that will help our patients function more independently. The charts summarize this information for patients with various impairments who received treatment between July 1, 2009 and June 30, 2010. Increase in ability to function independently is measured using the FIM™. The rehab team rates patients' performance in 18 activities covering self-care, locomotion, mobility, sphincter control, and cognition. The FIM™ score is the total of the ratings on these 18 items. The higher the score, the more independently an individual is able to function. The changes in the FIM™ scores between admission and discharge show that, as a result of inpatient treatment, patients show higher overall levels of independence in functioning at discharge. Length of stay usually depends on the how much progress a patient is making and varies depending on the impairment. Most patients are able to return home after their treatment at Rusk.

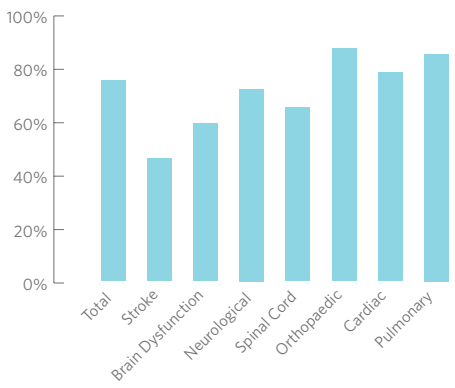
Admission and Discharge FIM™ Scores — July 1, 2009 – June 30, 2010



Average Length of Stay (Days) — July 1, 2009 – June 30, 2010



% Discharged to Community — July 1, 2009 – June 30, 2010

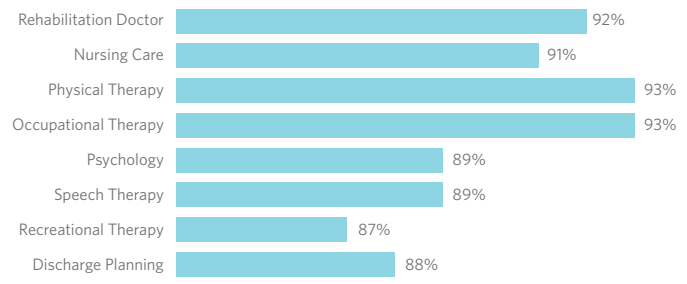


OVERALL PATIENT SATISFACTION REMAINS HIGH

All patients receive a survey in the mail within 1-2 weeks after discharge, in which they are asked to rate how satisfied they were with the services received while they were at Rusk. All patients discharged between July 1, 2009 and June 30, 2010 were mailed surveys and 28% responded. Most of the patients who answered told us they were highly satisfied with their Rusk inpatient stay. (Charts below show the percentage of patients who rated a specific area or service as either "Good" or "Very Good.")

Satisfaction with Services — July 1, 2009 – June 30, 2010

Overall Satisfaction — July 1, 2009 – June 30, 2010



COMMENTS FROM OUR PATIENTS

"Nursing care from top down was absolutely fabulous."

"The staff from cleaners to experienced nurses was always excellent."

"Excellent nurses – compassionate and competent."

"The PT people were outstanding. I was amazed by the progress made under their supervision."

"Therapists gave me confidence to work hard."

"My OT was excellent. She extended herself to make sure I met my goals."

"[OT was] very good in assisting me in learning what I needed to take care of myself."

"I LOVED going to horticultural therapy. It was so good to get away from the whole hospital routine and just relax and enjoy. I also learned a lot. I also did some beading and enjoyed the music events."

"My psychologist was so helpful in helping me deal with the trauma of my illness."

"The doctors that worked with me were excellent and made sure I understood what was said."

"Each day I was updated on my conditions, and all my concerns were addressed."

"Social Work [was] excellent in discharge arrangement[s] and very helpful to patient[s] and family."

"I was extremely impressed with the care I received. All staff were unfailingly kind and professional."

WOMEN'S HEALTH REHABILITATION AND THE ART OF MEDICINE

By Jaclyn H. Bonder, MD, *Director – Women's Health Rehabilitation*

The Hippocratic Oath, the sacred document that all physicians swear to uphold upon becoming a doctor, includes the following clause: "I will remember that there is art to medicine as well as science." Perhaps in no field in medicine are these words more closely adhered to than in rehabilitation. And increasingly, this prescient statement is applicable to a rapidly growing component of rehabilitation: women's health.

Women are different than men. While we all know this fact to be true, the notion has taken some time to be fully accepted in medical practice. We are proud that Rusk is one of the first rehabilitation hospitals in the country to have a dedicated women's health program.

Among the many diagnoses that are specific to women, three of the most common that can substantially impact quality of life are back pain during or after pregnancy, stress urinary incontinence, and chronic pelvic pain. The fact is, for all three of these diagnoses and many others there are rehabilitative services available to help, and by participating, women can dramatically improve their quality of life. At Rusk, we are lucky to have physicians and physical therapists trained in and devoted to women's health rehabilitation. As a multidisciplinary team, physicians and therapists work with patients to diagnose, treat, and educate those affected by these and many other conditions unique to women.

Through the generous funding of the NYU Langone Medical Center Auxiliary Fund, the women's health program will be growing its services to include activities that will help women in the community understand these issues even more. Through events such as neighborhood lectures, support groups, prenatal yoga classes, and anatomy courses, we aim to educate women on prevention and not just treatment of these conditions. Recently, as part of National Rehabilitation Medicine Awareness Week, the director of the women's health program, Dr. Jaclyn H. Bonder, gave a lecture, "Your Physical Health from Head to Toe: What Makes Women Special?," in which she talked about musculoskeletal health from adolescence to post-menopause.

The women's health program at Rusk is also dedicated to promoting this topic among physicians. Dr. Bonder and others recently held a continuing medical education course to further elucidate the importance of women's health conditions to department faculty and to explore innovative approaches to disseminate this critical information. In addition, Dr. Bonder has published her research findings on women's health and rehabilitation in peer-reviewed journals and has delivered platform presentations at national conferences.

Medicine is built on science. That fact is indisputable. But there is another side to it, one that relies on intuition, passion, and most importantly, a dedication to looking beyond what is plainly there to understand the fundamentals of what makes humans who they are and how they differ from one another. Sometimes it is as simple as understanding what makes us unique. The faculty and staff at Rusk and the women's health rehabilitation program embrace this concept and use it to provide the best care possible.

If you have any questions about the Women's Health Rehabilitation Program or to schedule an appointment, please call Dr. Bonder's Rusk office at 212-263-3029.

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the Whole Story

REHABILITATION THAT FOCUSES ON THE WHOLE PERSON

Readers of "The Whole Story" are invited to submit comments, feedback, or questions to Gwen Treharne at gwen.treharne@nyumc.org or 212 263-8830.

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