



VIHA - South Island Adult Rehabilitation, Geriatric, Activation and Specialized Complex Care Program Referral Criteria and Processes

INPATIENT ADULT REHABILITATION

- ❑ Geriatric Assessment and Rehabilitation, **7 North, VGH**
- ❑ Inpatient Neuro Rehabilitation, **5 North, VGH**
- ❑ Inpatient Complex Musculo-Skeletal Rehabilitation, **RP2, RJH**
- ❑ Inpatient Sub-Acute Rehabilitation, **5B, VGH**

Activation and Specialized Complex Care Programs

- ❑ Landsdowne Activation Program (LAP) Aberdeen Site (4-12 weeks LOS)
- ❑ Functional Enhancement Program (FEP), Aberdeen Site (6-36 weeks LOS)
- ❑ Interim Supportive Care Option (ISCO) Gorge Road Hospital Site (up to 3 weeks LOS)

NON-BED SERVICES

- ❑ Outpatient Neuro-Rehabilitation Program, VGH
- ❑ Outpatient Musculo-Skeletal Rehabilitation Program, RJH
- ❑ Geriatric Evaluation & Management (GEM) Teams (RJH, VGH all wards)
- ❑ Geriatric Outpatient Clinic, Main Floor Memorial Pavilion

Specialized Complex Care Programs

FACILITY	Landsdowne Activation Program Aberdeen Hospital	Functional Enhancement Program Aberdeen Hospital	Interim Supportive Care Option (ISCO) Gorge Road Hospital
GOAL	<ul style="list-style-type: none"> <input type="checkbox"/> To provide comprehensive, slow-stream activation program for patients in transition between acute care and home or assisted living 	<ul style="list-style-type: none"> <input type="checkbox"/> A goal oriented, time-limited program aimed at improving the functional ability and quality of life of complex clients assessed as requiring Complex Care placement. <input type="checkbox"/> To help client's transition to a lesser level of care, meet the criteria for further rehabilitation or relocate to a residential care facility. 	<ul style="list-style-type: none"> <input type="checkbox"/> To provide interim supportive care to people who are being discharged from hospital or live in the community and have a need for temporary home support that exceeds availability.
OVERVIEW	<ul style="list-style-type: none"> <input type="checkbox"/> 30 Beds <input type="checkbox"/> Private, semi private and 4-bed rooms <input type="checkbox"/> Interdisciplinary care team includes: physician, nursing, physiotherapy, occupational therapy, social work, nutrition, recreation therapy, rehab assistants, speech and language pathology <input type="checkbox"/> Activation includes engaging patients in normal everyday activities to increase their functioning to ensure a successful transfer home <input type="checkbox"/> No fee applied <input type="checkbox"/> Length of Stay: 4-12 weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> 5 Beds <input type="checkbox"/> Interdisciplinary services including: Medical Coordinator, Physiotherapy, Occupational Therapy, Recreational Therapy, Social Work, Speech Language Pathology, Respiratory Technician, Dietitian, Nursing, Clinical Resource Nurse, consulting Pharmacist, and Volunteer Coordinator <input type="checkbox"/> Residential care rate applies <input type="checkbox"/> Length of stay: 6-36 weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> 22 beds <input type="checkbox"/> Interdisciplinary services including: nursing, therapy services, nutrition services and social work. <input type="checkbox"/> Clients pay their daily respite rate. <input type="checkbox"/> Length of stay: up to 3 weeks
CRITERIA	<ul style="list-style-type: none"> <input type="checkbox"/> 19 Years or older <input type="checkbox"/> Medically stable <input type="checkbox"/> <input type="checkbox"/> Clinical lab findings improving or unchanged at time of referral <input type="checkbox"/> Cognitive ability and motivation to participate in functional program <input type="checkbox"/> Client goals are identified and agreed to prior to admission <input type="checkbox"/> Potential to reach a level of function sufficient to live at home 	<ul style="list-style-type: none"> <input type="checkbox"/> 19 Years or older <input type="checkbox"/> Assessed as Complex Care(RAI) with neurological or respiratory diagnosis <input type="checkbox"/> Medically stable <input type="checkbox"/> Cognitive ability and motivation to attain desired goals <input type="checkbox"/> Able to tolerate 30 minutes of therapy, 5 days/week <input type="checkbox"/> Potential to attain functional goals that will positively influence level of independence, quality of life and discharge to alternate level of care. <input type="checkbox"/> Client goals can be met within the program. <input type="checkbox"/> Client goals are identified and agreed to prior to admission. 	<ul style="list-style-type: none"> <input type="checkbox"/> 55 years plus <input type="checkbox"/> Current with or eligible for HCC case management service <input type="checkbox"/> Medically/psychiatrically stable <input type="checkbox"/> Must be able to return home <input type="checkbox"/> Has a family physician <input type="checkbox"/> Need for home support exceeds available resources
PROCESS	<ul style="list-style-type: none"> <input type="checkbox"/> Referrals made through Hospital Liaison/Case manager. <input type="checkbox"/> Patient must sign a letter of understanding 	<ul style="list-style-type: none"> <input type="checkbox"/> Referral made to LTC Facility Coordinator @ 388-2273 <input type="checkbox"/> Referral reviewed by FEP Team and applicant visited by a team member prior to decision. 	<ul style="list-style-type: none"> <input type="checkbox"/> Referral made through Liaison Case Managers, if client in hospital, or Community Case Management.
CONTACT	<ul style="list-style-type: none"> <input type="checkbox"/> Social Worker, Lansdowne Unit, Aberdeen Hospital <input type="checkbox"/> 250 370-5688 Local 4625 (Office) <input type="checkbox"/> 250 3705610 (Fax) 	<ul style="list-style-type: none"> <input type="checkbox"/> Social Worker, Hillside Unit, Aberdeen Hospital <input type="checkbox"/> 370-5624 (Office) <input type="checkbox"/> 370-5658 (Fax) 	<ul style="list-style-type: none"> <input type="checkbox"/> ISCO Case Manager 250-995-4743

INPATIENT ADULT REHABILITATION GROUP

FACILITY	7 North Geriatric Assessment and Rehabilitation Unit VGH	5 North Adult Neuro Rehabilitation Unit VGH	RP2 (Richmond Pavilion) Adult Complex Musculo-Skeletal Rehabilitation Unit RJH	5B Adult Sub-Acute Rehabilitation Unit VGH
GOAL	<ul style="list-style-type: none"> <input type="checkbox"/> To provide assessment and rehabilitation to patients with multiple medical & complex functional problems and complicated discharge planning needs 	<ul style="list-style-type: none"> <input type="checkbox"/> To provide comprehensive interdisciplinary rehabilitation services for patients with a neurological/neuromuscular diagnosis e.g. Stroke or Head Injury <input type="checkbox"/> To assist patients and families to reach a level of independence where they can return to the community they came from 	<ul style="list-style-type: none"> <input type="checkbox"/> To provide comprehensive interdisciplinary rehabilitation services for patients with complex musculoskeletal/neuromuscular conditions or amputations who have community discharge as an expectation <input type="checkbox"/> To actively engage and teach patients all functional aspects of mobility and activities of daily living 	<ul style="list-style-type: none"> <input type="checkbox"/> To provide goal-oriented rehabilitation services to adults who have neurological or general medical impairments
OVERVIEW	<ul style="list-style-type: none"> <input type="checkbox"/> 36 Beds <input type="checkbox"/> Private, semi private and 4 bed units. <input type="checkbox"/> Interdisciplinary care including: Geriatrician, Physiotherapy, Occupational Therapy, Social Work, Nutrition and Recreational Therapy. <input type="checkbox"/> Patients will be up and dressed for daily therapy and meals in the dining room. <input type="checkbox"/> 7days / 24 hour unit <input type="checkbox"/> Average Length of Stay 3 weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> 20 Beds <input type="checkbox"/> Goal based treatment programs with an interdisciplinary team including: Rehab Medicine, Nursing, Physiotherapy, Occupational Therapy, Speech & Language Pathology, Social Work, Nutrition, Neuropsychology and Psychiatry <input type="checkbox"/> Patient's schedule includes individual and group therapy and meals in dining room <input type="checkbox"/> Estimated Length of Stay: 6-8 weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> 25 Beds <input type="checkbox"/> Psychiatrist consults available. <input type="checkbox"/> Nursing Rehab philosophy <input type="checkbox"/> 7 day Rehabilitation Program <input type="checkbox"/> Daily Social Work Services <input type="checkbox"/> Emphasis on active participation in daily exercise routines and practice in activities of daily living <input type="checkbox"/> Length of Stay: 2-8 weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> 16 Beds (8 neuro rehab and 8 medical sub-acute) <input type="checkbox"/> Interdisciplinary care including: Nursing, Physiotherapy, Occupational Therapy, Social Work, Speech & Language Pathology, Rehab Assistants and Nutrition <input type="checkbox"/> Estimated Length of Stay: 2-8 weeks
CRITERIA	<ul style="list-style-type: none"> <input type="checkbox"/> 75 Years or older <input type="checkbox"/> Medically and surgically stable. <input type="checkbox"/> Has had cognitive assessment including a Folstein <input type="checkbox"/> Patient previously independent in ADLs <input type="checkbox"/> Potential for functional improvement. 	<ul style="list-style-type: none"> <input type="checkbox"/> 17 Years or older <input type="checkbox"/> Medically stable <input type="checkbox"/> Must be able to learn and is capable of significant therapeutic change <input type="checkbox"/> Tolerates sitting for 2 hours consecutively and treatment for minimum of 30 minutes a day <input type="checkbox"/> Requires nursing and 2 other services <input type="checkbox"/> Motivated to participate in rehabilitation <input type="checkbox"/> Premorbid level of function supports potential to return to safe, independent living with/without assistance <input type="checkbox"/> Has physical/cognitive/behavioural deficits that require specialized inpatient rehab treatment 	<ul style="list-style-type: none"> <input type="checkbox"/> 17 Years or older <input type="checkbox"/> Intensive diagnostic testing is complete. <input type="checkbox"/> Will have achieved some stability in the management of their acute and/or chronic disease. <input type="checkbox"/> Able to tolerate and participate in daily rehabilitation activities (minimum 30 minutes) <input type="checkbox"/> Have potential to improve their functional status to enable discharge home or special housing. <input type="checkbox"/> Sufficient mental alertness so that verbal instructions can be followed and learning is possible. 	<ul style="list-style-type: none"> <input type="checkbox"/> 17 Years or older <input type="checkbox"/> Must be on a VGH Medical Unit –4A/B, 6C/D, 6A/B (some exceptions may be made at the discretion of the 5B Manager) <input type="checkbox"/> Medically stable <input type="checkbox"/> Must be willing and able to actively participate in daily treatment program <input type="checkbox"/> Have potential to improve <input type="checkbox"/> Would benefit from the services of physiotherapy, occupational therapy and/or speech and language pathology <input type="checkbox"/> Must have a realistic discharge plan in place (can be to 5N)
PROCESS	<ul style="list-style-type: none"> <input type="checkbox"/> Referrals made to Geriatric Medicine through Geriatric Access Link (GAL) <input type="checkbox"/> Geriatricians remain MRP 	<ul style="list-style-type: none"> <input type="checkbox"/> Referrals to rehab services can be sent electronically on the VIHA Intranet. Go to -> 'Clinical Resources' -> 'Referrals and Forms' -> 'Inpatient Rehabilitation Referral Form' and complete the required information. <input type="checkbox"/> Rehab Medicine (a physiatrist) must assess the patient to determine appropriateness for rehab 	<ul style="list-style-type: none"> <input type="checkbox"/> Referrals to rehab services can be sent electronically on the VIHA Intranet. Go to -> 'Clinical Resources' -> 'Referrals and Forms' -> 'Inpatient Rehabilitation Referral Form' and complete the required information. <input type="checkbox"/> Rehab Medicine (a physiatrist) must assess the patient to determine appropriateness for rehab. <input type="checkbox"/> Note: Patient must have MRP who will assume daily medical care 	<ul style="list-style-type: none"> <input type="checkbox"/> Referrals to rehab services can be sent electronically on the VIHA Intranet. Go to -> 'Clinical Resources' -> 'Referrals and Forms' -> 'Inpatient Rehabilitation Referral Form' and complete the required information. <input type="checkbox"/> Any team member in collaboration with their unit CNL can refer patients to 5B
CONTACT	<ul style="list-style-type: none"> <input type="checkbox"/> Geriatric Access Link (GAL) @ 370-8565 	<ul style="list-style-type: none"> <input type="checkbox"/> 5 North Rehabilitation Unit @ 727-4035 <input type="checkbox"/> Rehabilitation Medicine @ 727-4221 	<ul style="list-style-type: none"> <input type="checkbox"/> RP2 Rehabilitation Unit @ 370-8399 	<ul style="list-style-type: none"> <input type="checkbox"/> 5B Sub-Acute Rehabilitation Unit @ 727-4144

NON-BED SERVICES

FACILITY	Outpatient Neuro-Rehabilitation Program VGH	Outpatient Musculo-Skeletal Rehabilitation Adanac Bldg, RJ H	Geriatric and Assessment Management Teams (GEM) RJH and VGH	Geriatric Outpatient Clinic Memorial Pavilion, RJH
GOAL	<ul style="list-style-type: none"> <input type="checkbox"/> To provide short-term outpatient services for adults who have acquired significant neurological impairments that impact their ability to function. 	<ul style="list-style-type: none"> <input type="checkbox"/> To provide an outpatient program designed to improve physiotherapy access for patients who have had recent orthopaedic or breast cancer surgeries 	<ul style="list-style-type: none"> <input type="checkbox"/> To provide an enhanced assessment and therapy service for seniors in acute care <input type="checkbox"/> The GEM Team works to assess and enhance client functional potential. It is not a substitute for ward therapy. The role is to engage in support and consultation with ward staff 	<ul style="list-style-type: none"> <input type="checkbox"/> To provide assessment and treatment of seniors who have complex medical issues in the community by a geriatrician and interdisciplinary team. <input type="checkbox"/> Program includes two month balance and strengthening physiotherapy exercise class, primarily aimed at the frail clients who are falling.
OVERVIEW	<ul style="list-style-type: none"> <input type="checkbox"/> The program provides both single discipline and multidisciplinary rehabilitation services including Physiotherapy, Occupational Therapy, Speech Therapy, Recreational Therapy, Social Work and Neuropsychology <input type="checkbox"/> Length of stay up to 10 weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> The program is geared to expedite quick follow up after hip, knee, shoulder and ankle surgery <input type="checkbox"/> This program also serves amputee patients and post surgical breast cancer patients <input type="checkbox"/> The program is located at the Adanac Building at the Royal Jubilee Hospital <input type="checkbox"/> Length of Stay: 2 to 6 weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> An interdisciplinary team specializing in enhanced assessment and evaluation of seniors in acute care. <input type="checkbox"/> Team includes Geriatrician, Nursing, Physiotherapy, Occupational Therapy, and Rehabilitation Assistants. <input type="checkbox"/> 5 days / week – Monday to Friday (closed on Statutory Holidays) 	<ul style="list-style-type: none"> <input type="checkbox"/> An inter-disciplinary team (OT, PT, Nursing, Social Work, Nurse Practitioner and Nurse Continence Advisor) specializing in assessment and treatment of seniors in the community. <input type="checkbox"/> 5 days / week – Monday to Friday (closed on Statutory Holidays)
CRITERIA	<ul style="list-style-type: none"> <input type="checkbox"/> Adults with a neurological impairment who have had a significant change in their functional status <input type="checkbox"/> Example diagnoses include: <ul style="list-style-type: none"> <input type="checkbox"/> Recent stroke, <input type="checkbox"/> Brain injury, <input type="checkbox"/> Brain tumor, <input type="checkbox"/> Aneurysm, <input type="checkbox"/> Parkinson's Disease, <input type="checkbox"/> Gillian Barre Disease 		<ul style="list-style-type: none"> <input type="checkbox"/> Frail elderly patients already being seen by a geriatrician requiring additional assessment, evaluation and/or rehabilitation through a consultation team. <input type="checkbox"/> 75 years or older 	<ul style="list-style-type: none"> <input type="checkbox"/> Frail elderly patients already being seen by a geriatrician requiring additional assessment, evaluation and/or rehabilitation through a consultation team. <input type="checkbox"/> 75 years or older
PROCESS	<ul style="list-style-type: none"> <input type="checkbox"/> A physician's referral is required <input type="checkbox"/> Referrals can be sent electronically to the Outpatient scheduler via the VIHA Intranet. Go to -> 'Clinical Resources' -> 'Referrals and Forms' -> 'Outpatient Rehabilitation Referral Form' and complete the required information 	<ul style="list-style-type: none"> <input type="checkbox"/> A physician's referral is required <input type="checkbox"/> Referrals can be sent electronically to OP program, Adanac Building via the VIHA Intranet. Go to -> 'Clinical Resources' -> 'Referrals and Forms' -> 'Outpatient Rehabilitation Referral Form' and complete the required information 	<ul style="list-style-type: none"> <input type="checkbox"/> A physician's referral is required and must be documented in the patient's chart <input type="checkbox"/> The referral is made to Geriatric Services through the Geriatric Access Link 	<ul style="list-style-type: none"> <input type="checkbox"/> Referrals are screened as to priority to be seen in the clinic by the geriatrician. The RN makes initial contact and assessment. Patients are seen as needed by other inter-disciplinary team members. <input type="checkbox"/> Referrals to Geriatric Services are made by the patient's MRP through Geriatric Access Link
CONTACT	<ul style="list-style-type: none"> <input type="checkbox"/> 727-4070 (Phone) <input type="checkbox"/> 727 4075 (Fax) 	<ul style="list-style-type: none"> <input type="checkbox"/> 370-8264 (Tel) <input type="checkbox"/> 370-8030 (Fax) 	<ul style="list-style-type: none"> <input type="checkbox"/> Geriatric Access Link (GAL) 370-8565 <input type="checkbox"/> GEM Main Office 370-8700 (RJH) & 727-4463 (VGH) <input type="checkbox"/> RJH 388-1454 (RN Pager) <input type="checkbox"/> VGH 995-0820 (RN Pager) 	<ul style="list-style-type: none"> <input type="checkbox"/> Geriatric Access Link (GAL) at 370-8565