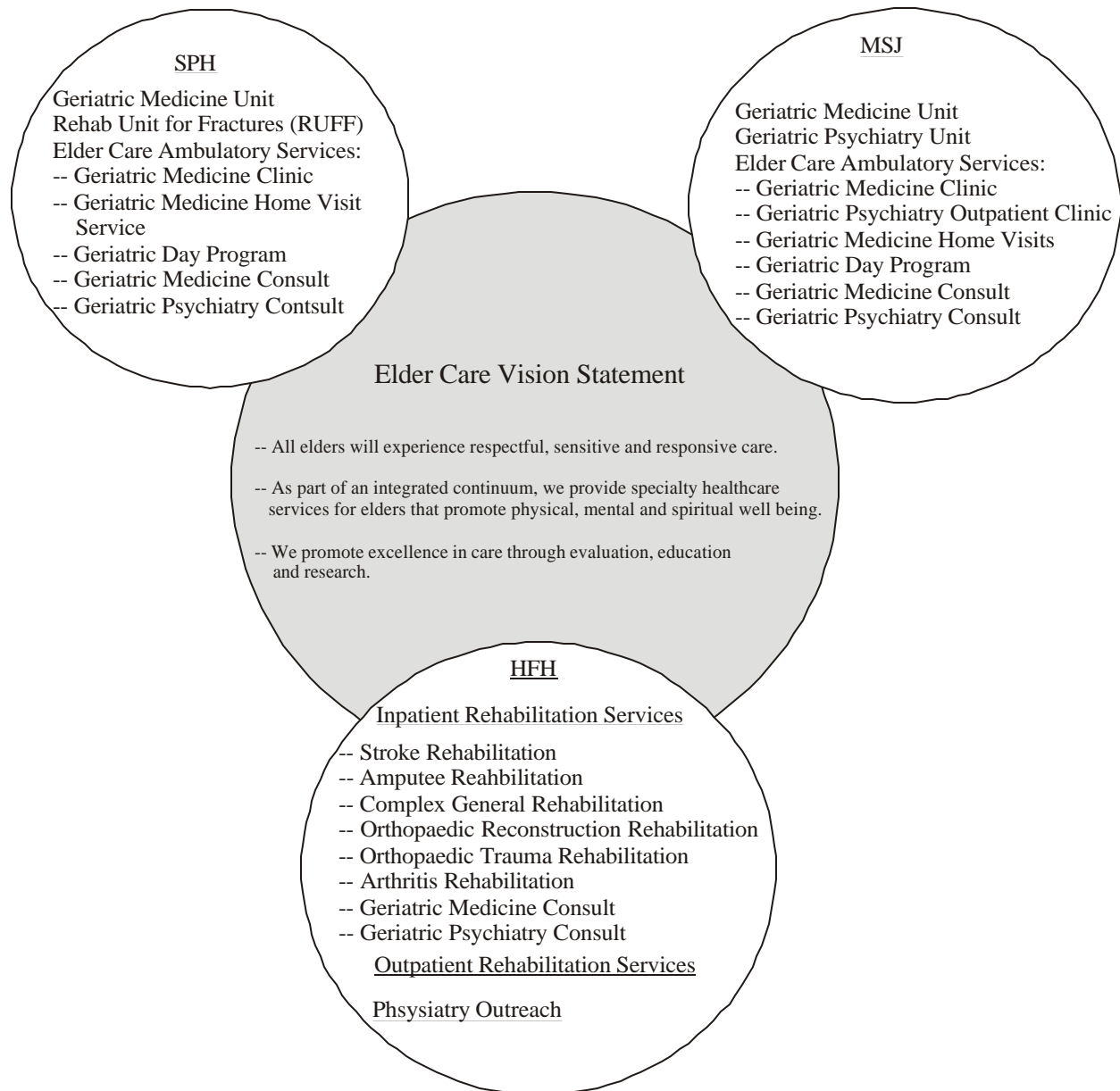


A GUIDE TO ELDER CARE PROGRAM

Providence Health Care provides a continuum of geriatric services delivered from three hospital sites. The following diagram displays the services located at each site.

The information in this guide is intended to assist referral sources and PHC triage/intake workers in determining where a patient might best be served within the PHC Elder Care Program.



GENERAL GUIDELINES

PURPOSE:

To provide interdisciplinary services for assessment, development of management plans and treatment for elderly patients presenting with psycho-social-functional decline, in addition to multiple complex medical problems. The site of the service delivery will vary based on the individual's specific needs, the degree of acuity, previous contact with a component of the Elder Care Program Services, and the actual geographic location of their residence.

GENERAL TARGET POPULATION:

1. Geriatric Medicine and Geriatric Psychiatry

For Elderly individuals who generally are greater than 65 years old and who present with at least **two** of the following:

- Chronic medical problem that is unstable, such as COPD, CHF, diabetes, hepatic or renal failure, chronic pain, neurodegenerative disorders (e.g. Parkinson's)
- Psychiatry complaint such as depression, or behavioural dysfunction such as aggression
- Confusion
- Unexplained weight loss
- Complex wound care
- Polypharmacy
- Recent functional decline
- Decreased mobility with risk of falls
- Caregiver stress
- Tenuous living situation.

2. Holy Family Hospital Rehabilitation Services

For individuals greater than 55 who present with at least two of the following:

- Neurological disorders (e.g. CVA)
- Amputations
- Post-op ortho reconstructions (e.g. total knee replacement)
- Post-op ortho trauma (e.g. hip fractures)
- Musculoskeletal disorders
- Communication disorders
- Dysphagia
- Perceptual deficits
- Functional disabilities

- Specialized needs: seating/splinting/orthotics/hydrotherapy
- Complex psychosocial disorders

ELDER CARE PROGRAM SERVICES CRITERIA GENERAL GUIDELINES

SERVICES:

An interdisciplinary team provides team or discipline-specific services. The team consists of:

- Physicians (Family Physicians, Geriatric Medicine specialists, Geriatric Psychiatrists, Psychiatrists)
 - SLP
- Nurses
- Occupational Therapists
- Dietitians
- Recreation Therapists
- Pastoral Care
- Social Workers
- Physiotherapists
- Pharmacists
- Psychologists

REFERRAL GUIDELINES:

Referral can be initiated by anyone but there should be agreement by the Attending Physician/Family Physician to refer the patient to the PHC Elder Care Program. Collateral info from caregivers, either non-professional or professional, is beneficial to determining the service necessary.

WHO TO CALL:

1) **GERIATRIC MEDICINE AND PSYCHIATRY**

A. **For Patients Residing in the Community:** (glos)

Call the PHC Central Intake number, **604-806-8889**, to access the following services:

- Geriatric Medicine Unit or Geriatric Psychiatry Unit at Mount St. Joseph's.
- The Geriatric Day Programs at MSJ and SPH, and
- The Geriatric Medicine Outpatient Clinic (MSJ & SPH), Geriatric Psychiatry Outpatient Clinic (MSJ) and Home Visit Service.

Initial assessment information will be collated on a Central Intake Form (see Appendix A). This will be reviewed by the Central Intake Nurse in order to allow for triage to the appropriate service (see Appendix B). The Central Intake number should also be called if it is not known to which service the referral should be made. Other contact information:

- Central Intake Fax — **604-806-9340**
- Central Intake Email — **geriservices@providencehealth.bc.ca**

B. **For Patients in MSJ's or SPH Acute Care Settings:**

Mount Saint Joseph Hospital

- Request for Transfer to 4E Geriatric Medicine Unit - **604-877-8324**
- Referrals for Geriatric Medicine inpatient consults - **604-877-8324**
- Referrals for Geriatric Psychiatry inpatient consults - **604-877-8164**

ELDER CARE PROGRAM SERVICES CRITERIA GENERAL GUIDELINES

St. Paul's Hospital

- Referrals for Geriatric Medicine Consults – **604-806-8029**
- Referrals for Geriatric Psychiatry Consults
(Inpatients) -- **604-682-2344 , local 62414**
(Outpatients) **604-806-8004**

2. HOLY FAMILY HOSPITAL REHABILITATION SERVICES

- For Psychiatry Consult, call Dr. Elliott Weiss at 604-806-8973 or Dr. Herman Lau at pager number 604-686-1965.
- For referrals to HFH for both inpatient and ambulatory services, call 604-322-2653 or fax referral to 604-321-6886.

All patients seen in an ambulatory or inpatient setting will be registered within the PHC ADT system and be assigned a medical records chart number. This will enable access to patient information throughout PHC for purposes of continuity and consistency.

EXCLUSION CRITERIA:

- Treatment available at a less acute level of care.
- Patients are high level of acuity requiring extensive treatment not offered within the program.
- There is no demonstrated potential for improvement (i.e. patient has “plateaued”).

GENERAL DISCHARGE CRITERIA:

- Clinical/functional goals have been met or can be met with available community resources.
- Liaison with community services/resources (e.g. LTC, Home Care, Family Physician, Adult Day Care, etc. – see *glos.*) has occurred to ensure these services are available.
- Discharge medications and adherence issues are clarified.
- Necessary aids have been arranged (e.g. wheelchair, walker).
- Patient/primary caregiver has been educated regarding discharge plan.
- Follow-up visits have been arranged with the Family Physician and other specialists as appropriate.
- Post-discharge investigations have been arranged.
- Transport to residence has been arranged (applies only to inpatients).
- Needs transfer to tertiary resource (i.e. Long Stay such as Riverview).

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A. INPATIENT SERVICES

1. Geriatric Medicine Unit St. Paul's Hospital
<p>Target Population:</p> <ul style="list-style-type: none"> Elderly patients from the acute care setting, with multiple/complex medical, functional or psychosocial problems.
<p>Services:</p> <ul style="list-style-type: none"> 22 beds with a full interdisciplinary team
<p>Referral Guidelines:</p> <ul style="list-style-type: none"> Selection via the Geriatric Medicine Consult Service(GMC): (604) 806-8029 during the weekdays and Geriatrician on call for after hrs and weekends. A prioritized waitlist is maintained on the unit (9C).
<p>Attending Physician:</p> <ul style="list-style-type: none"> The Geriatric Medicine specialist assigned as “Attending”, with weekday coverage by clinical associates and <i>On Call</i> coverage by other members of the Division of Geriatric Medicine and the Clinical Associates.
<p>Admission Criteria:</p> <ul style="list-style-type: none"> Current inpatient within PHC, requiring inter-disciplinary assessment, treatment and reactivation in the acute care setting . Treatment plan and goals should be specified. Direct admits from emergency will only occur if the patient has recently (i.e. within 2 weeks) been discharged from this unit. Require daily medical assessment with daily documentation of treatment. Require skilled nursing > 4h/24h e.g. single iv meds > 3x/24h; daily transfusions, vitals q 8h. Requires 1-2 hours of skilled therapy per day at least 5 days per week with weekly documentation of d/c planning/team meetings. Require availability of all pharmacy, diagnostic, consulting, medical, and other services on site such as TPN, dialysis. Responsive to and able to participate in a reactivation milieu as well as potential for functional improvement. Functional impairment requiring at least minimum/limited assistance. (glos) Projected Length of stay: 5 days to 4 weeks.
<p>Discharge Criteria:</p> <ul style="list-style-type: none"> See General Discharge Criteria.
<p>Follow-Up:</p> <ul style="list-style-type: none"> The majority will be seen in follow-up, either through the Elder Care Ambulatory Services or through a home visit by the Geriatric Medicine Specialist, to ensure continuity of care. Most patients will be referred to community resources (<i>glos.</i>). Liaison with Continuing Care and the Family Physician will occur prior to discharge. Discharge summaries will be sent to all involved/appropriate community services/resources.

A. INPATIENT SERVICES

**1. Geriatric Medicine Unit St. Paul's Hospital
continued**

Exclusion Criteria:

- No demonstrated rehab potential (glos) and likely requiring placement in a LTC facility.
- Too medically unstable to participate in reactivation.
- Patients who are medically stable and could be repatriated to their local hospital.

A. INPATIENT SERVICES

2. Geriatric Medicine Unit Mount Saint Joseph's Hospital

Target Population:

- Elderly persons who require the services of a multi-disciplinary, in-patient setting in order to enable them to safely continue living in the community. Access may be directly from the community (including residential care) or, from hospital.

Services:

- 22 beds with full multi-disciplinary team, supported by specialist geriatric consultation as needed, providing assessment, treatment, limited rehabilitation, and triage to appropriate settings and services post-discharge. The Unit is intended to provide sub-acute medical care and/or therapy, generally defined as that requiring regular physician/nursing/allied health attendance, with complex medical/parenteral therapies/investigations provided.

Referral Guidelines:**1. Inpatient Transfers:**

- a) weekday hours – by request for assessment to the 4East unit at 604-877-8324, Unit Coordinator. A receiving physician will assess the appropriateness of the patient transfer and will facilitate physician-to-physician communication as necessary.
- b) after-hours and during code triage - directed through the Leader on-call, who will refer to admission criteria, consult with the on-call physician, and facilitate physician-to-physician communication as necessary.

2. **Urgent Planned Community Admissions:** will be directed through Central Intake at 604-806-8889, who will validate admission criteria, consult with the appropriate receiving physician and facilitate physician-to-physician communication as necessary.

Referrals will be prioritized according to the following, where A. has the highest priority:

- A. Persons in hospitals meeting criteria, during *Code Triage*.
- B. Persons in the community meeting criteria, assessed as likely to require admission/ER within 72 hours should they not be admitted.
- C. Persons in hospitals meeting criteria as determined by Unit Physician.
- D. Persons in the community meeting criteria, assessed as likely to require admission/ER within 30 days, should they not be admitted.

Where demand exceeds capacity, a waiting list (reflecting all above categories) will be maintained.

Attending Physician:

- 2 attending Family Physicians and 1 attending Geriatric Specialist.

A. INPATIENT SERVICES

2. Geriatric Medicine Unit Mount Saint Joseph's Hospital continued

Admission Criteria:

- Functional decline within the last month and can no longer manage with maximum community services. (glos)
- Able to tolerate 1-2 hours of skilled therapy per day at least 5 days per week with weekly documentation of d/c planning/team meetings.
- Requires Physician assessment > 4 times per week
- Functional impairment requiring at least minimum/limited assistance
- Responsive to and willing to participate in a reactivation milieu and potential for functional improvement
- Code Status established where appropriate
- Projected length of stay 2 – 6 weeks

Exclusion Criteria:

- Aggressive behaviour/wandering
- Special needs that cannot be met by the clinical skills of the staff on the unit e.g. PCA, Hemodialysis.

Discharge Criteria:

- See General Discharge Criteria.

Follow-Up:

- Most patients will be referred to community resources (glos.). Liaison will occur prior to discharge with Continuing Care. Family Physicians will be contacted when necessary to discuss cases. All Family Physicians will receive discharge summaries. All discharged patients will be advised when to see their Family Physician post discharge.
- Some patients requiring multidisciplinary follow-up will be referred to the Elder Care Ambulatory Service.

A. INPATIENT SERVICES

3. Geriatric Psychiatry Unit Mount Saint Joseph's Hospital

Target Population:

- Patients generally 65 or older, referred from community (home, long term care facilities, etc.) or from other acute care centres.
- May also include those individuals under age 65 who present with early onset neuropsychiatric illness, e.g. early onset Alzheimer's Disease or Parkinson's Disease.
- It is expected that the patient referred will present with problems primarily with neuropsychiatric etiology but they may also present with co-morbid medical conditions.

Services:

- 20 acute care beds with a full interdisciplinary team, integrated into a fully serviced Acute Care Hospital.
- Other services are available on a consult basis, e.g. Neurology, Anaesthesia, Urology.

Referral Guidelines:

- Referral is through Central Intake.
- Although referral queries are welcomed from all health care personnel, the patient will not be accepted until a referral from a physician is received in writing, along with supporting information/ records/history.

Attending Physician:

- The Geriatric Psychiatrist listed as the Attending Physician is the most responsible physician.
- Referring/Family Physician is invited to attend case conferences.

Admission Criteria:

- The referred patient has exhausted all outpatient avenues for assessment and treatment of the presenting problems and remains at risk due to neuropsychiatric disorder – failed outpatient management. (glos)
- Requires geriatric psychiatry assessment > 4 times per week
- Requires skilled nursing assessment and intervention 24 hours per day.
- May present with one or many behavioural disturbances that put the patient or others at risk such as suicidal gestures, verbal or physical aggression, elopement risk or purposeful wandering, self imposed dietary restriction, obsessive/compulsive activities and/or withdrawal.
- The patient can not be safely treated where they currently reside e.g. home environment not conducive to care or outpatient management contraindicated. (glos)

A. INPATIENT SERVICES

3. Geriatric Psychiatry Unit Mount Saint Joseph's Hospital continued

Prioritization of Referrals

Referrals are reviewed and if the individual meets admission criteria, he or she is added to the waitlist on a priority basis by the Central Intake Team using the following criteria for priority listing:

- The imminence of threat to self or others and is to be certified under the BC Mental Health Act.
- The number and quality of caregivers (professional and non-professional) involved with the patient for ongoing safety planning until admission can occur.
- The length of time waiting for admission and its detrimental effects on the patients well being or potential for recovery.
- Patients from the VCHA take priority over those from outside these boundaries. Referrals from outside VCHA will be directed to Riverview Intake as well but may be accepted for admission if extremely urgent and the other waitlist is long.
- Patients referred from PHC Hospital sites that meet criteria.
- Patients that have left the unit on Extended Leave under the BC Mental Health Act.
- Also taken into consideration is the milieu and patient mix on the in patient unit in relation to the presenting problems of the referred patient. The goal is to retain a safe and therapeutic environment on the unit.

Discharge Criteria:

- See General Discharge Criteria.
- Disposition is addressed for the patient *prior to admission*. It is expected that following the necessary assessment and treatment, the individual will return to their home, i.e. LTC facility or personal home.

Follow-up:

- Follow-up is organized on an individual basis to include Family Physician, Mental Health Team and/or Geriatric Psychiatry/Medicine specialist (outpatient or outreach).

A. INPATIENT SERVICES

4. Elder Care Rehabilitation Services, Holy Family Hospital

Target Population:

- The older adult greater than 55 years of age referred from acute care or the community and requiring rehabilitation to return to independent or assisted living.

Services:

Interdisciplinary team with access to Physiatry, Geriatric Medicine and Geriatric Psychiatry consultation with specific services for the following patient groups:

- 75 inpatient beds.
- 28 neurological program patients.
- 8 amputee patients.
- 14+ post-operative orthopaedic reconstruction patients (hips and knees).
- 10+ post-operative orthopaedic trauma patients (fractured hips).
- 10 arthritis program patients, including two post-operative foot and ankle patients.

Referral Guidelines:

- Initial referral is generally from the acute care physician, the family physician or the community therapist.
- Referral sources will complete an 'Application for Inpatient Rehabilitation Admission' form (see Appendix C) and send it to the Central Intake Assistants (CIAs) at telephone: 604-322-2653 or fax: 604-321-6886.
- Referred patients are screened by the physiatrist.
- The CIAs will notify the referring source when the patient has been accepted for or declined admission.

Attending Physician:

- The physiatrist will either serve as the attending physician or provide consultation/directive care (glos) if one of a hospitalist/Family Physician is the attending.

Admission Criteria:

- Patients who meet the general and specific criteria for each clinical service, and can benefit from the rehabilitation experience within an acceptable timeline will be considered for admission. This process is overseen by the Physician Operations Leader, who is a physiatrist. If the patient does not meet the criteria for admission, a physiatrist consultation may assist in identifying the most appropriate care needs for the patient.

The following are general criteria:

- Medically stable i.e. remains stable during course of rehabilitation, medical needs can be met in short and intermediate term with physician assessment twice per week; lab tests less than twice per week; and no new requirement for continuous oxygen.

A. INPATIENT SERVICES

4. Elder Care Rehabilitation Services, Holy Family Hospital continued

- Nutritional status adequate.
- Discharge to previous home or assisted living is realistic at completion of the rehabilitation program.
- Not a safety risk i.e. elopement, confusion, impulsivity.
- Cognition sufficient to follow instructions either verbally or by gestures and to allow carry-over from one therapy session to another.
- Activity tolerance sufficient for rehabilitation i.e. must be able to sit in a wheelchair for two hours twice per day and able to attend up to three half-hour therapy sessions per day.
- Is capable of safely transferring with one care aide/nurse assist, not a mechanical lift.
- Projected length of stay 2 –8 weeks.
- Nursing care needs can be met within 2.5 Nursing Care Hours.

Specific criteria:

- If for CVA, rehab should ideally be within 1 month of event. Perceptual dysfunction, if present, must not be severe i.e. must be able to attend to affected side with cueing and must be able to sit unsupported with feet on the floor for one minute.
- For MSK patients: the surgical incision must be healing without evidence of infection, recent fractures must be stabilized and movement restrictions must not limit participation in rehab service. Weightbearing status should be “partial” or “full”.
- For Amputees: the incision should be healing, no further limb surgery is planned within two months, able to weightbear through other lower extremity, able to wear footwear, have potential for mobility to improve with a prosthesis.

Exclusion Criteria:

- Isolation requirements e.g. MRSA, active TB.
- Special needs that cannot be met by the clinical skills of the staff on the unit e.g. PIC lines are to be managed by the sending facility. * **Hemodialysis may be accepted under limited circumstances. The decision rests with the treating nephrologists and physiatrist.**

Discharge Criteria:

- See General Discharge Criteria.

Follow-Up:

- Most patients will be referred to our outpatient services or community based resources. Liaison will occur prior to discharge with Continuing Care. Family Physicians will receive discharge summaries.

A. INPATIENT SERVICES

5. Rehabilitation Unit for Falls and Fractures (RUFF), Saint Paul's Hospital
Target Population: <ul style="list-style-type: none">• Post-operative patients with fractured hips
Services: <ul style="list-style-type: none">• 15 beds with full interdisciplinary team.
Referral Guidelines: <ul style="list-style-type: none">• Initial referral is generally from CNL, Orthopedic surgeon or designate of the Ortho unit
Attending Physician: <ul style="list-style-type: none">• FP with On-call orthopedic coverage.
Admission Criteria: <ul style="list-style-type: none">• Post-op Day 5 hip fractures transferred from SPH Orthopedic Unit• Patients with non-operative fractures unable to manage at home/ lower level of care if otherwise medically stable• Functional impairment requiring at least an assist to transfer and mobilize.• Projected length of stay 7-14 days.• Responsive to and willing to participate in reactivation milieu.• MD assessment/oversight greater or equal to 2 x per week.
Exclusion Criteria: <ul style="list-style-type: none">• Medically unstable.• Non-weight bearing patients.• Non-ambulatory prior to admission.
Discharge Criteria: <ul style="list-style-type: none">• See General Discharge Criteria.
Follow-Up: <ul style="list-style-type: none">• Referred back to Community Resources

B. ELDER CARE AMBULATORY SERVICES

1. Geriatric Medicine Outpatient Clinic (SPH, MSJ)
Target Population: <ul style="list-style-type: none">• Patients in the community who have general target population characteristics.• Follow-up after discharge from other services in Geriatric Medicine.
Services: <ul style="list-style-type: none">• Full interdisciplinary team is <u>NOT</u> available.• All referrals are seen initially by the Geriatric Medicine Specialist in consultation, and then may be referred to other services such as physiotherapy, occupational therapy, or nutrition. There is close liaison with community services including the LTC Case Manager, Home Care Service, and Family Primary Care Physician to ensure that action plans are clear and there is no duplication of services.• Follow-up will be provided for the majority of patients discharged from the Geriatric Medicine Unit to ensure effective discharge planning.
Referral Guidelines: <ul style="list-style-type: none">• Referrals are made through Central Intake at 604-806-8889 for New assessments.• Patients to be seen in follow-up will be booked through the local office at 604-806-8029 for SPH or MSJ at local 78371.
Attending Physician: <ul style="list-style-type: none">• The Geriatric Medicine specialist will assume responsibility for initiating changes in medications and treatment plans in consultation and liaison with the Family Physician. The Family Physician will continue to provide the primary care role.
Admission Criteria: <ul style="list-style-type: none">• As per target population.
Exclusion Criteria: <ul style="list-style-type: none">• Patients who cannot be transported to the clinic. These patients will be triaged by Central Intake to either an Inpatient or Homevisit Service.• Patients with a primarily psychiatric diagnosis such as chronic schizophrenia or depression will usually be re-routed to the Geriatric Psychiatry Service or the Mental Health Team.• Patients needing extensive nursing or rehabilitation services will be re-routed to one of the Elder Care/Day Program settings.
Discharge Criteria: <ul style="list-style-type: none">• See General Discharge Criteria

B. ELDER CARE AMBULATORY SERVICES

2. Geriatric Medicine Home Visit Service

Target Population:

- New assessments and follow-up for patients in the community who have general target population characteristics.
- Follow-up visits after discharge from inpatient services in Geriatric Medicine.
- Patients generally more physically frail or cognitively impaired such that travel to a clinic is impossible.

Services:

- Central Intake Nurse review.
- Geriatric Medicine consultation and liaison with community services.

Referral Guidelines:

- Referrals are made through Central Intake at 604-806-8889.

Attending Physician:

- The Family Physician of record will provide the primary care role. Directive care (glos) by the Geriatric Medicine Specialist.

Admission Criteria:

- Patients requiring assessment by a Geriatric Medicine Specialist for acute/chronic functional and medical decline who are unable to attend a clinic or a Geriatric Day Program.
- Patients are unable to attend because of physical frailty limiting mobility to household ambulation. **OR** Patients who reside in a LTC facility benefit from being seen in their home settings with their medical records available.

Exclusion Criteria:

- Patients with predominantly psychiatric diagnoses will be referred to the Mental Health Team unless already seen by and/or referred by the Mental Health Team.
- Patients referred for primary care. This should be provided by Family Physicians in the community.

Follow-Up:

- By other community agencies with the understanding that patients can be readily referred again should the need arise.

B. ELDER CARE AMBULATORY SERVICES

3. Geriatric Day Program (GDP) (MSJ, SPH)

Target Population:

- Patients in the community who have general target population characteristics and require services from more than 2 disciplines in addition to the physician.

Services:

- Full interdisciplinary team with access to Geriatric Medicine and Geriatric Psychiatry consultation.

Referral Guidelines:

- Referral is through Central Intake (604) 806-8889.

Attending Physician:

- Clinical Associates and/or Geriatricians will liaise with Primary Care Physicians to ensure continuity of care.

Admission Criteria:

- Focus on elderly living in the community with decline in function who are willing to participate in reactivation milieu.
- Multicultural needs are considered.
- Follow-up can be provided for patients discharged from inpatient units to help with transition back to the community.
- Length of stay 2-12 weeks.

Discharge Criteria:

- See General Discharge Criteria.

Follow-up:

- A summary of the Assessment and Treatment plan including concerns, recommendations and suggestions is faxed to involved Health Care Providers with description of which community services have been put in place.
- Outpatient Clinic visits may be arranged to continue treatment with specific discipline(s).

B. ELDER CARE AMBULATORY SERVICES

4. Geriatric Psychiatry Outpatient Clinic (MSJ)
Target Population: <ul style="list-style-type: none">• As per inpatient, however, not requiring acute care admission.• Patients receiving outpatient services as their primary treatment source.• Ambulatory patients on drug protocols.• Patients referred for a second opinion or for specialized services.• Follow-up for discharged inpatients.
Services: <ul style="list-style-type: none">• Geriatric Psychiatry.• Limited access to other disciplines (e.g. Neuropsychology, Social Work, Occupational Therapy, Physiotherapy and Nursing).
Referral Guidelines: <ul style="list-style-type: none">• Referrals are reviewed and if the individual meets admission criteria, he or she is added to the waitlist on a priority basis by the Central Intake Team. Although referral queries are welcomed from all health care personnel, the patient will not be accepted until a referral from a physician is received in writing, along with supporting information/records/history.
Attending Physician: <ul style="list-style-type: none">• Family Physician will continue to provide primary care.• Geriatric Psychiatrist will initiate changes in medication and treatment plans in consultation with the Primary Care Physician.
Admission Criteria: <ul style="list-style-type: none">• Dementia, depression and neurodegenerative illnesses such as Parkinson's Disease that can be managed on an ambulatory basis.
Discharge Criteria: <ul style="list-style-type: none">• See General Discharge Criteria.
Follow-up: <ul style="list-style-type: none">• Periodic follow-up visit(s) after initial consult available as clinically indicated (range of timing and quantity).

B. ELDER CARE AMBULATORY SERVICES

5. Geriatric Electroconvulsive Therapy Program (MSJ)

Target Population:

- Patients generally over 65 with a psychiatric disorder amenable to outpatient electroconvulsive therapy (ECT). Exceptions are made to age if there is a concurrent neuropsychiatric disorder (examples being Parkinson's Disease, dementia) or as space permits.
- Patients may be referred from the Geriatric Psychiatry Unit at Mount Saint Joseph Hospital after an inpatient hospitalization, which included the initiation of an ECT course.
- Also, referrals for assessment for Outpatient ECT are also welcome from other hospitals, community mental health resources (Mental Health teams, Venture) or community physicians in the Vancouver coastal Health Authority.

Services:

- We assess suitability for ECT treatments for either:
 - as an acute treatment course to attain remission
 - or
 - maintenance course to maintain wellness.
- Care involves
 - initial and ongoing psychiatric assessment with respect to ECT progress
 - anaesthesia assessment
 - medical investigations
 - other medical/dental/psychiatric consultations as required for the safe delivery of appropriate for ECT
- Delivery of ECT treatments and post anesthetic supervision
- Education about ECT for patients, family and healthcare providers is an integral component of our program.

Referral Guidelines:

- Referral is through the ECT Nurse at Mount Saint Joseph Hospital at 604-877-8142 who will provide a referral package.

Attending Physician

- Geriatric psychiatrists with special training and focus on ECT will supervise each patient.
- Clinical decisions related to ECT will be made in collaboration with community physicians and psychiatrists.

Admission Criteria:

- Patients over 65 years of age who suffer from a psychiatric disorder which have responded, or are likely to respond to outpatient ECT.

B. ELDER CARE AMBULATORY SERVICES

5. Geriatric Electroconvulsive Therapy Program (MSJ) continued

- Patients must have a physician, preferably a psychiatrist, responsible for the overall psychiatric monitoring of the patient's progress, including pharmacological management and psychotherapy, if applicable.
- Patients must have access to transportation, ideally accompanied by an adult, to and from the hospital, although, we are able to assist in this regard.
- Duration of involvement in the program may be limited or indefinite depending on the clinical circumstances.
- Patients themselves or another responsible adult must be able to ensure nothing by mouth is taken the night prior to treatments and that necessary medications are taken the morning of treatments.
- Ideally, the patient should have monitoring for the full day after treatments because of the use of a general anaesthetic.

Discharge Criteria

- Discharge will occur when
 - it is assessed that the patient no longer requires ECT to maintain wellness or
 - if it is believed that the potential risks outweigh the potential benefits for the patient.

Follow-up:

- A summary of treatment outcomes and tolerance are sent to the community physician or psychiatrist upon discharge, with further recommendations regarding ECT or other aspects of psychiatric management as appropriate.

B. ELDER CARE AMBULATORY SERVICES

6. Elder Care Rehabilitation Outpatient Services (HFH)
<p>Target Population:</p> <ul style="list-style-type: none">• Patients in the community, or discharged from the Elder Care Rehabilitation Inpatient Program, who require rehabilitation services from more than two disciplines.• As above who require continence management rehabilitation.• As above who require swallowing and nutrition rehabilitation services.• As above who require <i>Drive Able</i> testing.
<p>Services:</p> <ul style="list-style-type: none">• Interdisciplinary team with access to physiatrist consultation.
<p>Referral Guidelines:</p> <ul style="list-style-type: none">• Referrals are sent to the Central Intake Assistants at phone: 604-322-2653 or fax: 604-321-6886 for processing. The referral forms are available in Appendix C.• The referred therapy team reviews the referral and accepts or declines.
<p>Attending Physician:</p> <ul style="list-style-type: none">• A physiatrist may be consulted to the patient by the referring source or an outpatient therapist. An outpatient is not necessarily attended to by a physician (physiatrist) at Holy Family.
<p>Admission Criteria:</p> <ul style="list-style-type: none">• As for inpatients.• Patients reside in the community or in assisted living.
<p>Discharge Criteria:</p> <ul style="list-style-type: none">• As for inpatients.• When the rehab program is complete and the client has achieved or is unable to achieve their rehabilitation goals.
<p>Follow-up:</p> <ul style="list-style-type: none">• As for inpatients.

C. CONSULTATION AND LIAISON SERVICES

1. Geriatric Medicine Consult Service (MSJ, SPH)

Target Population:

- The Older adult inpatient with a combination of medical, psychosocial and functional problems impeding discharge.
- The older adult in ER at SPH site who has potential for discharge from ER if linked with other Elder Care Services.

Services:

- The service **differs** between the MSJ site and the SPH site. At SPH, there is level III on-call coverage. After hours, the Geriatrician on-call at SPH can be paged to discuss the case but generally the consult will not be done until the next day. At MSJ, there is no after hours or weekend coverage.
- A “flagging” system is in place to notify the Geriatric Medicine Office at SPH of the admission of any patients known to the Program. A team member can then provide information to the patient’s chart. This may precipitate a referral.
- The Geriatric Medicine specialist sees the patients and liaises with other health care professionals assigned to that geographic area, as necessary.
- A consult is not synonymous with transfer to other Geriatric Medicine services. Such transfers within PHC will be arranged based on the appropriateness and bed availability.

Referral Guidelines:

- Referral is by the Family Physician or Attending Physician/Specialist. The reason for referral should be indicated on the consult form. Referrals are processed from 0900-1600 hrs., Monday through Friday at the following numbers: SPH – 604-806-8029, MSJ – (604) 877-8324. Please note the difference in availability noted above.

Referral Criteria:

The frail elderly with multi-system disease with acute or chronic components, and psycho-social/functional problems. Indicators for referral include:

- Age is generally 75 years or older, or known to the Geriatric Service
- Cognitive dysfunction
- Decreased mobility or decreased function
- Caregiver burden, either professional or family based

Follow-Up:

- The Geriatrician will dictate a consult that will be copied to all involved physicians and health care services. The Geriatrician will provide ‘directive care’ (glos) to Attending Physician.
- Some patients may be seen in follow-up through the Elder Care Ambulatory Services
- In all cases, the care will be handed back over to the Primary Care Physician and community resources.
- If the patient meets the criteria for a Geriatric Medicine Unit, a transfer will be arranged if a bed is available in a timely fashion. However, if the patient is to be discharged within 4-5 days, the Geriatrician participates in the development of a discharge plan and may provide follow-up to the patient in the community to ensure that the discharge plan is effective.

C. CONSULTATION AND LIAISON SERVICES

2. Geriatric Psychiatry Consult Service (MSJ, SPH)
Target Population: <ul style="list-style-type: none">• As per inpatient.
Services: <ul style="list-style-type: none">• Geriatric Psychiatry consults to all wards.
Referral Guidelines: <ul style="list-style-type: none">• For MSJ — Program Secretary at (604) 877-8164, local 78164• For SPH —The Consults Pager at 54391, local 62414
Attending Physician: <ul style="list-style-type: none">• Geriatric Psychiatrists will liaise with Attending Physician to ensure continuity of care.
Admission Criteria: <ul style="list-style-type: none">• Frail elderly with behavioural disturbance, or neuropsychiatric illness.
Discharge Criteria: <ul style="list-style-type: none">• Patient is no longer in hospital
Follow-up: <ul style="list-style-type: none">• Patients may be referred to Community Mental Health Team or MSJ Geri Psych Outpatient Day Clinic.

C. CONSULTATION AND LIAISON SERVICES

3. Physiatry Consult Service

- Dr.'s Elliot Weiss and Herman Lau are available to do consults at all PHC sites.
 - The consult service is not limited to patients who fit the general target population for the Elder Care Program.
- Dr. Elliot Weiss: phone: 604-806-8973 or fax: 604-806-9254
Dr. Herman Lau: pager: 604-686-1965

GLOSSARY

1. “Attending” Physician:
 - The physician medico-legally responsible for the patient – the name of the physician under whom the patient is admitted to a hospital bed.

2. “Community” vs. “In-hospital”:
 - Patient in own residence, whether a home or a residential care facility, as opposed to being an inpatient in hospital.

3. Community Services/Resources:
 - The Continuing Care Division of a city or municipality is funded by the Provincial Ministry of Health. Continuing Care provides visiting Home Care Nursing and Rehabilitation Therapy Services, Long Term Care (LTC) Home Support Services and LTC Residential Facility care. An individual assessed by an LTC case manager may be eligible for homemaker services, adult day care services, or be put on the list for a LTC facility. A LTC Case Manager can also help to make sure an individual is aware of other services including Meals on Wheels and the Seniors’ Well Aware Program (SWAP).
 - Mental Health Teams
 - Family Physicians

4. Directive Care:
 - Consultative medical direction usually given by a consultant to the Attending Physician, documented in the patient chart, on a twice weekly basis.

5. Discharge:
 - Refers to discharge from that Geriatric Service, not necessarily to home setting.

6. Emergency Placed:
 - Directly admitted to a LTC facility via a priority waitlist.

7. Failed Outpatient Management:
 - Every effort has been made to provide the required services in an out-patient setting but treatment plan has not been successful, e.g. seen in clinic/GDP, home care services, home support worker.

8. Functional Levels:
 - Independent.
 - Independent with aid.
 - Supervision required.
 - Minimal assist required, e.g. stand-by assist.
 - Moderate assist, e.g. one person assist to mobilize.
 - Maximum assist, e.g. require extensive assistance for functional mobility.
 - Dependent, e.g. unable to perform any ADL’s.

GLOSSARY

9. Home Environment Not Conducive To Care:

- Environment/circumstances prevent adequate care, e.g. no running water, no phone, no elevator.
- Patient suspected to be a victim of abuse, either physical or emotional.

10. Outpatient Management Contraindicated:

- Patient is too fragile to travel to an outpatient clinic.
- Services unavailable for safe delivery in the home setting.
- Services unavailable through Home Care or a clinic.
- Patient/caregiver unable to manage care, either because of language barrier (interpreter not available), cognitive impairment, or physical impairments such as inability to transfer, blindness, or impaired motor dexterity.

11. Patient/Primary Caregiver Education:

- Professional staff have provided training that has been assessed through patient/caregiver demonstration or description. This training, as well as the assessment for competency/capability, should be documented, e.g. medication management, ostomy care, diabetes management, CHF management.

12. Rehabilitation Potential:

- Determined based on patient's prior function, with extent/reversibility of current condition (CHF with deconditioning vs. major CVA), and patient's expressed and/or demonstrated compliance with rehabilitation program.

Ability to Ambulate: > Independent > cane > walker > wheelchair > bed bound

Needs Assist: > to transfer > to walk > on stairs

Services Accessed via Central Intake
Telephone: 604-806-8889 - Fax: 604-806-9340

St. Paul's Hospital:

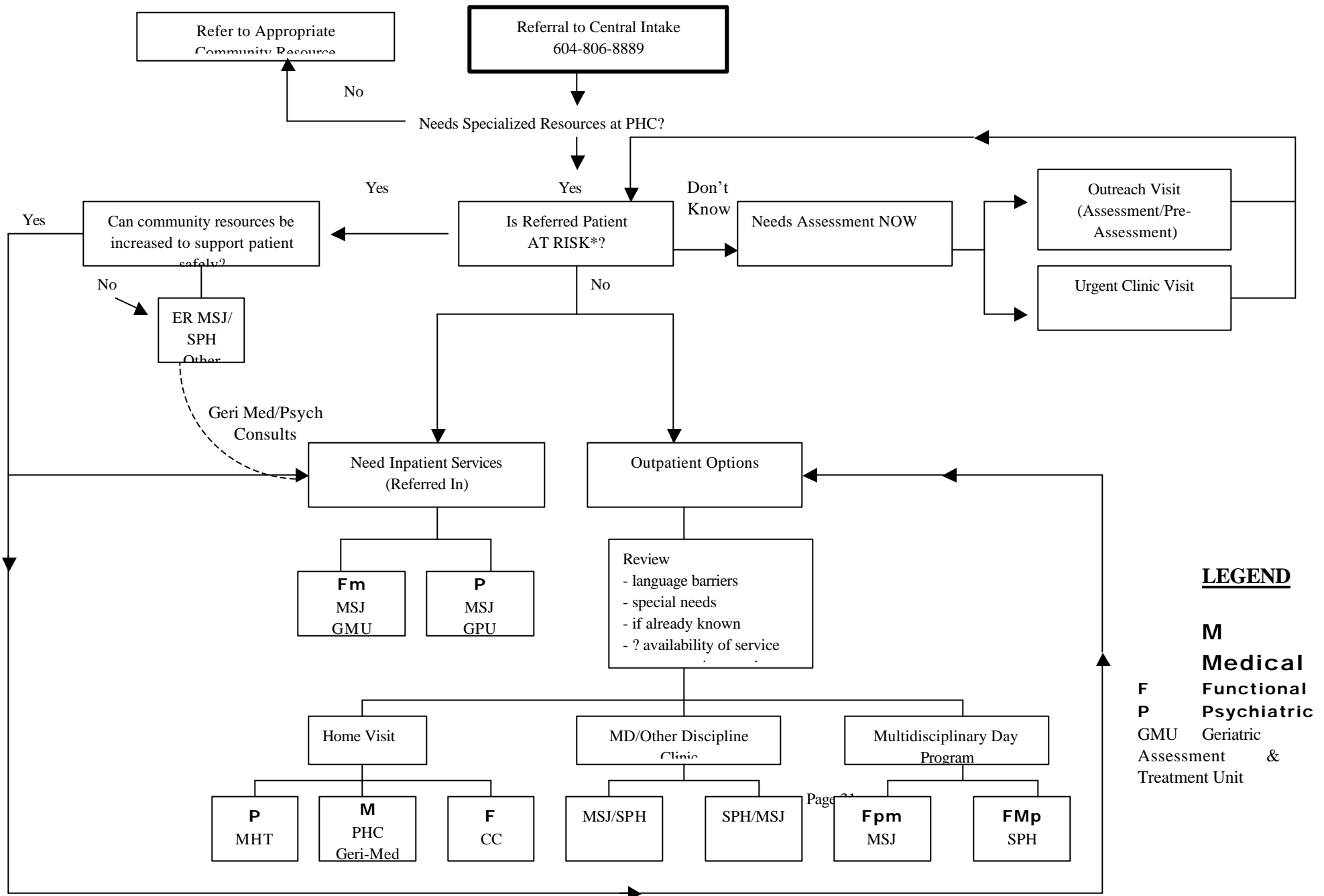
> Geriatric Medicine Outpatient Clinic > Geriatrician Home Visit > Geriatric Day Program

Mt. Saint Joseph's Hospital:

Outpatient: > Geriatric Day Program > Geriatric Medicine Clinic > Geriatric Psychiatry Clinic
> Geriatrician Home Visit

Inpatient: > Geriatric Medicine > Geriatric Psychiatry

Appendix B - DECISION-MAKING PROCESS FOR CENTRAL INTAKE FOR GERIATRIC MEDICINE & PSYCHIATRY SERVICES



LEGEND

M Medical
F Functional
P Psychiatric
 GMU Geriatric Assessment & Treatment Unit



Holy Family Hospital
7801 Argyle Street, Vancouver, B.C. V5P 2L6

**APPLICATION FOR INPATIENT
REHABILITATION ADMISSION**

PLEASE FAX THIS APPLICATION TO: 604-321-6886 (phone: 604-322-2653)
Holy Family Hospital – Central Intake

A. REHABILITATION NEED:

- Arthritis Foot and Ankle Ortho Reconstruct Ortho Trauma
- Neuro Amputee General Other: _____

B. INFORMATION TO BE INCLUDED WITH APPLICATION (please check if sent):

Record of Admission , Recent List of Medications (MAR) , Recent Medical Consultations and Assessments , Major Medical Exams (e.g. Head CT) , Recent Lab Results , Recent PT and OT Assessments , Progress Notes (from the last five days) , SW Notes , and SLP Notes .

C. DEMOGRAPHICS:

Name:	M <input type="checkbox"/> F <input type="checkbox"/>	DOB:	MSP #:
Current Location:	Phone:	Single <input type="checkbox"/> <input type="checkbox"/>	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
Home Address:	Phone:		
Primary Family Contact:	Phone:	Work / Cell:	
Languages Understood:	Intended Discharge Destination:		
Current Specialists (e.g. surgeon, rheumatologist, prosthetist, cardiologist, etc.):	Phone:		
1.	Phone:		
2.	Phone:		
Family Physician:	Billing Number:	Phone:	
Referring Physician:	Billing Number:	Phone:	
*Referring Physician's Signature: X _____	*As part of the application process, a consultation by a physiatrist may be carried out.		

D. MEDICAL INFORMATION:

Primary Diagnosis (including date of surgery / event):

1. _____

Secondary Diagnoses (and duration):

1. _____
2. _____

Major Surgeries (and dates):

1. _____
2. _____

3. _____
4. _____

3. _____
4. _____



Holy Family Hospital
7801 Argyle Street, Vancouver, B.C. V5P 2L6

APPENDIX C

APPLICATION FOR INPATIENT REHABILITATION ADMISSION

E. GENERAL ADMISSION GUIDELINES:

1. Medically stable and nutritional status adequate.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Discharge to one of the following is realistic: Home: Yes <input type="checkbox"/> No <input type="checkbox"/> Assisted Living: Yes <input type="checkbox"/> No <input type="checkbox"/> Intermediate Care: Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. Motivated for specialized rehabilitation.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Not a safety risk.	Yes <input type="checkbox"/>	Risk <input type="checkbox"/>
5. Cognition sufficient to follow instructions either verbally or by gestures and to allow carry-over from one therapy session to another.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Activity tolerance sufficient for rehabilitation (i.e. must be able to sit in a wheelchair for two hours twice per day and able to attend up to three half-hour therapy sessions per day).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Transfers safely with one or two person assist, not a mechanical lift, with nursing staff.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

F. ADDITIONAL GUIDELINES:

For Neurological Conditions:		
1. Recent CVA (as soon as medically stable but preferably within one month).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Perceptual dysfunction, if present, not severe (i.e. must be able to attend to affected side with cueing).	Yes <input type="checkbox"/>	Severe <input type="checkbox"/>
3. Balance in sitting (i.e. must be able to sit unsupported with feet on the floor for one minute).	Yes <input type="checkbox"/>	No <input type="checkbox"/>

For Musculoskeletal Conditions:		
1. Surgical incision healing without evidence of infection.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Recent fracture stabilized surgically or casted.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Joint restrictions (if any) do not impact participation in rehabilitation.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Weightbearing through affected limb.	Non <input type="checkbox"/> Full <input type="checkbox"/>	Partial <input type="checkbox"/> Feather <input type="checkbox"/>

For Limb Loss Conditions:		
1. Stump incision healing and approximated with no evidence of infection.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Further limb surgery is not planned to occur within the next 2 months.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Able to weightbear through other lower extremity and wear shoe.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

4. Potential for mobility (including transfers) to improve with prosthesis.	Yes <input type="checkbox"/> <input type="checkbox"/> No
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Medical Exclusions: I.V. therapy, lab tests more than twice per week, isolation, continuous oxygen (unless previously established in the community) . . .

Comments: _____

Questions (e.g. regarding the status of your application)?

Please contact the Central Intake Assistants @ 604-322-2653