



WELCOME TO BRIDGEPOINT HEALTH

A **GUIDE** for Referring Professionals

BRIDGEPOINT HEALTH IS A PUBLICLY FUNDED HEALTH CARE ORGANIZATION, IN TORONTO, THAT PROVIDES PATIENT CARE, RESEARCH AND TEACHING IN THE SPECIALIZED FIELD OF COMPLEX CHRONIC DISEASE PREVENTION AND MANAGEMENT – THE BIGGEST HEALTH CARE CHALLENGE OF THE 21ST CENTURY. AFFILIATED WITH THE UNIVERSITY OF TORONTO, THE BRIDGEPOINT HEALTH NETWORK INCLUDES BRIDGEPOINT HOSPITAL, BRIDGEPOINT FAMILY HEALTH TEAM, THE BRIDGEPOINT CENTRE FOR RESEARCH, EDUCATION AND POLICY, AND THE BRIDGEPOINT HEALTH FOUNDATION.

WWW.BRIDGEPOINTHEALTH.CA

Dear Referring Partners

At Bridgepoint Health, we are committed to providing our referring partners with excellent service.

This Guide is designed to provide you – our valued referring partner with the information you need to make a referral to our Hospital.

On request, we will also provide you with:

- additional copies of our Referring Guide (also available at www.bridgepointhealth.ca)
- copies of brochures and flyers that you may wish to give to your patients to help them to get to know Bridgepoint
- a virtual tour of our hospital for our patients to see – and hear – what Bridgepoint offers them
- additional supports – just tell us what you need.

We hope to hear from you soon. Contact us today for more information.

E-mail: referrals@bridgepointhealth.ca

Referral Hotline: 416 461 8251 x2414

Referral Fax: 416 461 5499

Frequently Called Numbers

Main Switchboard 416.461.8251

Publications for your patients 416.461.8251 x2177

Bridgepoint Family Health Team Referrals 416.470.6690

BRIDGEPOINT HEALTH REFERRALS

Email referrals@bridgepointhealth.ca

Website
(see referring partner section) www.bridgepointhealth.ca

Referral Hotline 416.461.8251 x2414

Referral Fax Line 416.461.5499

Table of Contents

INTRODUCTION TO BRIDGEPOINT HEALTH	1
QUICK GUIDE TO BRIDGEPOINT HEALTH	2
DIRECTIONS TO BRIDGEPOINT HOSPITAL	3
SNAPSHOTS OF BRIDGEPOINT HOSPITAL	4
PROGRAMS AND SERVICES	
Who We Serve	4
Complex Care Services	5
General	6
Neurological Care and Activation	7
Medical Activation	8
Neuromuscular Support	9
ALC Connect	10
Palliative Care	12
Dialysis	13
Complex Rehabilitation Services	14
Medical Rehabilitation	15
Neuro-Rehabilitation	16
Musculoskeletal Rehabilitation	17
Day Treatment	18
Stepping Up to Rehab	19
SPECIALTY CLINICS AND SERVICES	
Introduction	20
Augmentative Communication and Writing Clinic (ACWC)	21
Lower Extremity Gait Support Services (LEGGs)	21

Seating and Positioning Clinic	22
Dental Clinic	22
Chiropractic Clinic	22
Psychology Services	22
Ophthalmology Clinic	22
Cultural Interpreters	23
Patient Representative Office	23
Therapeutic Recreation	23
Patient Wellness Program	23
Spiritual Care	23

OUR COMMUNITY SERVICES

Bridgepoint Family Health Team	24
--	----

LOOKING AHEAD	25
-------------------------	----

QUICK GUIDE TO ADMISSIONS PROCESSES

Application Requirements	27
Information We Need with Your Application	28
Application Checklist	29

STREAMLINED ADMITTING SERVICES AND CO-PAYMENTS

Direct Admission	31
Complex Care Co-Payment	31

WHAT INFORMATION DO WE NEED PRIOR TO ADMISSION

Transfer Paperwork	32
Transfer Paperwork Checklist	33
Patient Privacy	34
We Want Your Feedback	35

Introduction to Bridgepoint Health

Located on the east side of Toronto, Bridgepoint Health is a University of Toronto community affiliated teaching organization committed to being Canada's Leader for the treatment of Complex Chronic Disease - the most important health care issue of the century.

This bold vision is particularly important today. Consider the following facts:

- 16 million Canadians living with chronic conditions. The numbers regarding this third frontier of health care are staggering:
- 365,000 people in Metropolitan Toronto have been diagnosed with three or more chronic conditions.
- 60,000 of these have complex disorders and disabilities
- Another 18,000 have a complex or severe disability
- Every year about 18,000 people in the Greater Toronto Area require active rehabilitation to address disabilities resulting from illnesses such as stroke, arthritis and osteoporosis or because of injuries such as hip and other fractures, or brain injuries

Comprised of Bridgepoint Hospital and the Bridgepoint Family Health team, Bridgepoint Health is making a difference in patients lives through offering the broad range of programs and services you will read about in this guide.

Through our innovative programs and services, Bridgepoint's team works towards reducing the burden of Complex Chronic Disease on individuals and on society as a whole.

We improve our patients' quality of life by partnering with them to live well and be active players in shaping their own health. And by creating, as well as sharing leading knowledge about complex chronic conditions, we will drive changes in the health care system that make prevention and management of these conditions a fundamental focus.

Quick Guide to Bridgepoint Health

GETTING TO KNOW BRIDGEPOINT HOSPITAL

Ground Level

Executive Offices
Business Office
Library
Gift Shop
Purchasing
X-Ray
Dentist
River Room/Boardroom

First Floor

Parkside Café
Auditorium
Admitting
Meditation Room
Security
Pharmacy
Environmental Services
Utilization Management

Second Floor

Volunteer Office
Day Treatment

Third Floor

3 West: Orthopaedic Rehabilitation
3 East: Neuro Rehab/Musculo-
Skeletal Rehabilitation

Fourth Floor

4 West: Long Term/Short Term
Palliative Care
4 East: Haemodialysis Peritoneal
Dialysis

Fifth Floor

5 West: Medical Rehabilitation
5 East: ALC Connect

Sixth Floor

6 West: Ortho Activation/ Geriatric
Reactivation
6 East: Continuing
Care/Transitional Care

Seventh Floor

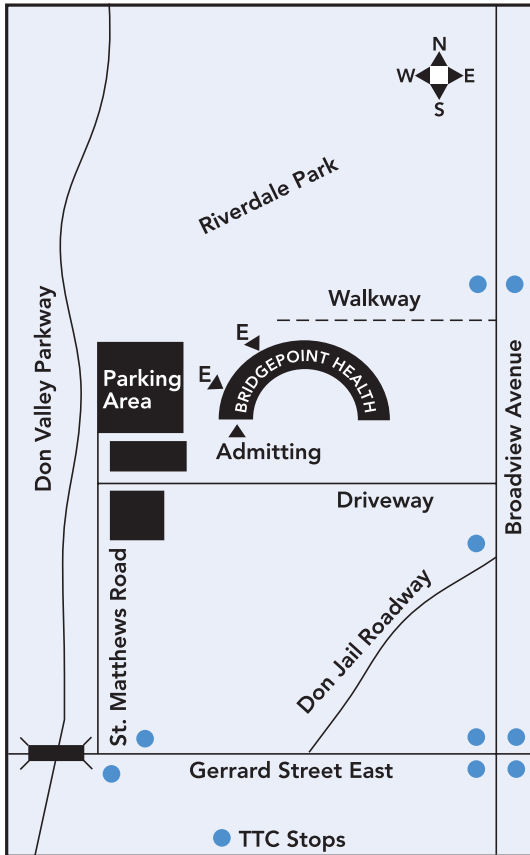
7 West: Neurological Support &
Activation
7 East: Neuro-muscular Support

Eighth Floor

Human Resources
Information Management/Services
Infection Control
Finance
Payroll
Spiritual Care
Occupational Health
Clinical Library
LiveWell!
Dietitians
Recreational Therapy
OD & E



Directions to Bridgepoint Hospital



Bridgepoint Health is located at the intersection of Broadview Avenue and Gerrard Street East. Bridgepoint Hospital overlooks the beautiful Riverdale Park.

The #504 and #505 streetcars run along Broadview Avenue and stop at Bridgepoint Hospital. The #506 streetcar runs along Carlton, turns south onto Parliament and then east onto Gerrard. It also stops at Bridgepoint Hospital at the St. Matthews Road entrance.

Snapshots of Bridgepoint Hospital Services – Who We Serve

Services and Admissions Criteria

Bridgepoint Hospital provides service to young to older adults, primarily to residents of the Greater Toronto Area.

The Hospital currently provides two core clinical programs: Complex Care and Complex Rehabilitation. Within these programs, we have several areas of focus. We also provide a number of outpatient and support services that are offered through clinics located on-site.

We deliver our core services through specialized inpatient and day treatment programs. Our patient populations include individuals recovering from a stroke, heart attack, prolonged hospitalization and intensive care or surgery, or living with the complications and limitations of Parkinson’s disease, advanced diabetes, multiple sclerosis, or HIV/AIDS. Many of our patients also have special needs in the areas of cognitive support, dialysis, and neuro-rehabilitation.

Bridgepoint’s programs and services cover our patient population’s health care needs from head to toe. Our patients’ 18 most frequently reported functional needs are listed to the right of this page.

The following sections describe our programs and services in detail. Listed is the average length of stay, primary diagnosis, admission criteria, contact information and expected wait times between application approval and admission to each of our inpatient services.

Note: wait times listed for each program are estimates based on our experience - they fluctuate from time to time.

Our programs address the 18 core functional needs of our patients:

1. Memory/Cognition
2. Behaviour
3. Mental health/ psychosocial
4. Pain
5. Vision
6. Hearing
7. Eating/swallowing
8. Breathing
9. Speaking/communicating
10. Mobility
11. Falls prevention
12. Spasticity/contractures
13. Dialysis
14. Continence
15. Wounds & ulcers
16. Medication Management
17. ADL improvement
18. IADL/Life skills improvement

Complex Care Services

Bridgepoint Hospital's complex care program serves people living with the effects of severe stroke, advanced dementia, progressive neurological/degenerative diseases, moderate to severe brain injury, advanced diabetes with complications, advanced HIV/AIDS. It also serves complex frail elders and end-stage cancer patients with complications, many of whom may be transitioning from a serious or prolonged stay in an acute care facility.

Complex Care – General

In-patient – located on 6 East

Generally, patients admitted to this service are affected by mild cognitive impairment, brain injury, stroke, neuro-degenerative disease, or other chronic illnesses or have multiple medical conditions. In general, these patients are medically stable, not dependent on technology, nor do they require extensive rehabilitation.

Due to their specific care requirements, or their need for specialized mobility devices, their care needs cannot be met solely with community support or in a long-term care facility.

Anticipated length of stay	> 3 months
Primary Diagnosis	<ul style="list-style-type: none">• cerebral vascular accident, acquired brain injury, mild cognitive impairment, neuro-degenerative disease• (or) geriatric patients with other chronic diseases or multiple medical conditions
Admission Criteria	The patient: <ul style="list-style-type: none">• is non-technology dependent, generally medically stable and requires minimal rehabilitation services• requires assistance with all activities of daily living, and/or behaviours of daily living, medications and treatments related to the medical care• requires care focusing on maximizing social, psychological and physical health• may have mild dementia and requires cognitive support but does not require a secured environment or extensive behaviour management
Estimated wait time between approval and admission	2 - 3 months
Contact Information	Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca

Neurological Care and Activation

In-patient – located on 7 West

Patients in this service have complex, often unstable neurological conditions and require a range of inter-disciplinary diagnostic and therapeutic services. Some patients may have swallowing disorders and are feeding tube dependent and, in some cases, may have the potential to receive nutrition by mouth. The patients on this unit do not have an end stage disease or a severe psychiatric disorder.

The Neuro-Activation service offers a moderately intensive neuro-rehabilitation program. The service is designed for individuals who have received intensive neuro-rehabilitation and are now able to transfer to a neuro-activation program, where they can continue to participate in therapy programs on an ongoing basis, or for individuals who are unable to participate in an intensive neuro-rehab program, but can tolerate a moderately paced service.

Prior to admission, we require demographic information, functional assessment for placement, medical report, social assessment for placement, occupational therapy notes, physiotherapy notes, and current scan or MRI reports.

Complex Care – Medical Activation

In-patient – located on 5 West

Patients admitted to this service have varying diagnoses and no longer need to be in an acute care setting. They require ongoing interdisciplinary assessment and intervention and require varying degrees of activation/rehabilitation. These patients may have had a prolonged and complicated ICU stay following a major medical illness or surgery. Patients are often older or are more deconditioned and require a longer period of moderately intensive rehabilitation. Many have complex wound management issues. Most patients will return to community living or may require a transition to long term care.

Anticipated length of stay	3 - 6 months
Primary Diagnosis	Post-acute medical illness, prolonged ICU stay, ICU neuropathy, cardiac conditions, complex wounds, neurological conditions other than stroke or ABL and MS, post-surgical conditions (transplants or with prolonged, complicated post-op course)
Admission Criteria	<p>The patient:</p> <ul style="list-style-type: none"> • is cognitively, physically, medically, and psychologically able to participate in a rehabilitation program • has the potential for improvement in functional abilities as a result of the rehabilitation and has identified some realistic, attainable functional goals • is not dependent on active medical treatment from an acute care hospital • if receiving dialysis, must pre-arrange their own transportation to dialysis site at another health care facility and be able to transfer independently and travel to outpatient dialysis program
Estimated wait time between approval and admission	2 - 4 weeks
Contact Information	<p>Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca</p>

Neuromuscular Support

In-patient – located on 7 East

Patients admitted to this service have been diagnosed with a progressive neuromuscular condition and require therapeutic as well as emotional and physical care. These patients are not necessarily dependent on active medical treatment but require complex care and assistance with most activities of daily living. Their unstable medical conditions typically necessitates inpatient hospital care, medical management, skilled nursing care and a range of inter-disciplinary diagnostic and therapeutic services based on their individualized requirements. Many of the patients are younger than 50 years of age.

Anticipated length of stay	> 9 months
Primary Diagnosis	Amyotrophic Lateral Sclerosis, Parkinson's Disease, Multiple Sclerosis, Huntington's Disease, other progressive neuromuscular condition
Admission Criteria	<p>The patient:</p> <ul style="list-style-type: none">• has a progressive neuromuscular condition requiring a level of care that cannot be met by long-term care facilities or solely with community support• may be dependent on technology-based continuing or intermittent care• requires a specialized mobility device which will support the natural progression of their condition• may require the support of an augmentative communication device• may require feeding or medication administered through an enterostomy tube and/or intravenous therapy; complex wound care; airway suctioning; continuous oxygen administration and tracheostomy care• requires the assistance of an inter-disciplinary team for most activities of daily living and/or behaviours of daily living, medications, treatments associated with maintaining or enhancing the physical, emotional, social and spiritual well being• has the potential for discharge following a course of rehabilitation therapy• is not dependent on active medical treatment from an acute care hospital
Estimated wait time between approval and admission	10 - 15 days
Contact Information	Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca

ALC Connect Program

In-patient

The ALC Connect/PatientNET program is an interdisciplinary academic teaching service designed to effectively network medically stable patients in acute care to the most appropriate post-acute care environment. The program utilizes an outreach team deployed within St. Michael's Hospital, and potentially other acute care centres, to assess patients who have been designated alternate-level-of-care (ALC).

The goal of the PatientNet activities is to ensure smooth transitioning and integrated movement of the patient to the most appropriate services at Bridgepoint Health, and integrated movement across the continuum to the most appropriate level of care.

Additionally, this program has a 36-bed inpatient assessment unit, the PatientHUB, to receive patients with complex performance trajectories who have been assessed by the ALC Connect Team. These patients require detailed and specialized assessments that will facilitate care plan development, treatment and triaging. Anticipated length of stay is 8 to 12 weeks.

As indicated by its name, the ALC Connect/PatientNET program is targeted at building bridges for patients in acute hospitals designated as "Alternate Level of Care" (ALC).

The Bridgepoint ALC Connect Program responds to this need through two program components:

- **The ALC Connect Mobile Team.** This is an assessment team, which will be deployed in acute care hospitals to assess patients who are deemed ALC. A Physician and a Clinical Nurse Specialist/Nurse Practitioner lead the assessment team.
- **The ALC Connect Unit** is a 36-bed assessment unit at Bridgepoint Hospital to which patients will be admitted who require a period of intensive inpatient assessment in order to determine their goals for treatment and to link the patients with the most appropriate care program.

Palliative Care

In-patient – located on 4 West

The Palliative Care service provides care to individuals in the end stages of terminal illness. Care is extended not only to the patients, but also to their families and friends.

We believe in a holistic approach to care where a skilled inter-disciplinary team meets the patient's physical, psychosocial, spiritual and cultural needs. The level of care required cannot be met by long-term care facilities or through community support.

For patients who wish to remain at home for as long as possible, applications go on a waiting list and are activated only when they are ready for admission.

Anticipated length of stay	48 hours - 2 months
Primary Diagnosis	End stage disease, cancer, HIV/AIDS
Admission Criteria	The patient: <ul style="list-style-type: none">• is in the terminal stage of the disease process• has complex, often unstable clinical conditions• requires inpatient hospital care, medical management, skilled nursing care and a range of inter-disciplinary diagnostic and therapeutic services• has provided, or the substitute decision maker has provided, consent for Do Not Resuscitate (DNR)• requires pain management, family support, other symptom management, terminal admission• is not dependent on active medical treatment from an acute care hospital
Estimated wait time between approval and admission	1 - 7 days
Contact Information	Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca

Dialysis

In-patient – Hemodialysis and Peritoneal Dialysis located on 4 East

The Dialysis service provides inpatient peritoneal dialysis and, in partnership with The Scarborough Hospital, inpatient hemodialysis. Patients typically have other medical problems requiring inpatient treatment in a facility, preventing them from receiving dialysis in the community or in their own home. The level of care required cannot be met by long-term care facilities or community support but can be met in a complex care facility.

For those clients who wish to remain at home for as long as possible, applications will go on a waiting list and will only be activated when they are ready for admission.

Anticipated length of stay	> 6 months
Primary Diagnosis	Renal failure requiring dialysis
Admission Criteria	<p>The patient:</p> <ul style="list-style-type: none">• has end stage renal disease• has complex, often unstable clinical conditions• requires inpatient hospital care, medical management, skilled nursing care and a range of inter-disciplinary diagnostic and therapeutic services• is dependent on technology based continuing or intermittent care• may require feeding or medication administered through an enterostomy tube and/or intravenous therapy; complex wound care; airway suctioning; continuous oxygen administration; and tracheostomy care• requires the assistance of an inter-disciplinary team for all activities of daily living and/or behaviours of daily living, medications, treatments associated with maintaining or enhancing the physical, emotional, social, and spiritual well-being• is not dependent on active medical treatment from an acute care hospital
Estimated wait time between approval and admission	3 - 9 months
Contact Information	Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca

Complex Rehabilitation Services

Bridgepoint Hospital serves stroke survivors with moderate function loss; patients with acquired brain injury; elderly patients with hip fractures; patients with multiple, severe fractures and patients who have gone through a long-term, debilitating treatment; or major surgery with complications. We provide our rehabilitative care through three primary inpatient areas and one multi-service outpatient clinic within the Hospital.

We also provide home care rehabilitation services, which can be accessed through Bridgepoint Community Rehab.



Medical Rehabilitation

In-patient – located on 5 West

A wide range of services is provided to individuals with varying diagnoses who no longer need to be in an acute care setting, yet require interdisciplinary assessment and intervention. These individuals may have had an injury or other surgery, with a prolonged, complicated post-op course.

Anticipated length of stay	1 - 3 months
Primary Diagnosis	Post acute medical illness, prolonged ICU neuropathy, cardiac conditions, post-surgical conditions (with a prolonged, complicated post-op course) transplants, neurological conditions other than stroke, head injury or neuromuscular conditions.
Admission Criteria	The patient: <ul style="list-style-type: none">• is cognitively, physically, medically and psychologically able to participate in a rehabilitation program• has the potential for improvement in functional abilities as a result of the rehabilitation• is not dependent on active medical treatment from an acute care hospital• has identified some realistic attainable functional goals.• must be able to travel and transfer to an outpatient dialysis program if receiving dialysis. Transportation must be pre-arranged.
Estimated wait time between approval and admission	10 - 15 days
Contact Information	Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca

Neuro-Rehabilitation

In-patient – located on 3 East

Patients in this service have suffered a recent (within the past 12 months) neurological illness or injury, a stroke, or acquired brain injury excluding spinal cord injuries.

Short-term and slow stream intensive rehabilitation is available. Short-term rehabilitation has an anticipated length of stay of 1-3 months. Slow to recover rehabilitation has an anticipated length of stay of less than 6 months.

Anticipated length of stay	1 - 6 months
Primary Diagnosis	Recent neurological illness/injury excluding spinal cord injury, neuro-surgical, cerebral vascular accident, acquired brain injury, Guillain Barré syndrome
Admission Criteria	The patient: <ul style="list-style-type: none">• requires intensive neuro-rehabilitation from the inter-disciplinary team as a result of injury/surgery which will enable the patient to attain an optimal level of function• requires nursing care to meet activities of daily living on a 24-hour-a-day basis• must be medically stable, cognitively able to participate in an intensive rehabilitative program, and scores at least at the V-VII level on Rancho Los Amigos Cognitive Scale• has active rehabilitation goals• has an application submitted to the Acquired Brain Injury Network, who will forward it to Bridgepoint Hospital for consideration
Estimated wait time between approval and admission	2 - 10 days
Contact Information	Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca

Musculoskeletal Rehabilitation

In-patient – located on the 3rd Floor

The Musculoskeletal service provides rehabilitation following multiple trauma, or orthopedic surgery (primarily lower extremity). A full range of rehabilitation services is provided to these patients by the inter-disciplinary team. Patients who require extended intravenous therapy by peripheral or central lines are also accepted.

Anticipated length of stay	1 - 3 months
Primary Diagnosis	Musculoskeletal surgery/injury
Admission Criteria	<p>The patient:</p> <ul style="list-style-type: none">• requires intensive orthopedic rehabilitation therapy from the inter-disciplinary team as a result of an injury/surgery which will enable the patient to attain/ maintain optimal level of function• must be medically stable, and cognitively and physically able to participate in an intensive rehabilitation program• requires nursing care to meet activities of daily living (ADLs) on a 24-hour-a-day basis
Estimated wait time between approval and admission	1 - 2 days
Contact Information	<p>Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca</p>

Day Treatment

Outpatient – located on the 2nd Floor of the Hospital

Inter-disciplinary outpatient rehabilitation is provided to patients who require musculoskeletal or neurological services on an outpatient basis.

The Musculoskeletal Rehabilitation Service is appropriate for clients who have had an orthopedic injury or surgery, multiple traumas, complex soft tissue injuries or have rheumatic disease.

The Neuro-Rehabilitation Service offers treatment for clients with an ABI of traumatic, vascular, neoplastic, hypoxic or infectious origin, and who have the potential to improve with an intensive rehabilitation program.

The Neuromuscular Rehabilitation Service offers short term intervention to a variety of patients who have the potential to attain specific goals.

Note: Rehabilitative outpatient support services include medicine, nursing, occupational therapy, physiotherapy, social work, speech language pathology, chiropody, vocational rehabilitation, augmentative communication, seating, neuropsychology (on a consultation basis) and dietary (on a consultation basis). More information on these services is provided in the following section.

Anticipated length of treatment	< 3 months
Primary Diagnosis	Cerebral vascular accident, acquired brain injury, neuromuscular condition, musculoskeletal injury/surgery, rheumatic disease
Admission Criteria	The patient: <ul style="list-style-type: none">• is 18 years of age or older• has regular transportation available• is able to participate in active rehabilitation• is referred by a physician• is actively followed by a physician• is medically stable• is independent in continence care/management• is able to achieve rehabilitation goals in a short-term period• is accompanied by someone if there are significant cognitive impairments, behavioural problems or physical care needs
Contact Information	Referral Questions Online: referrals@bridgepointhealth.ca Referral Hotline: 416.461.8251 x2414 Referral Fax: 416.461.5499 Client Services Concerns: 416.461.8251 x2218 Website: www.bridgepointhealth.ca

Stepping Up to Rehab

In-patient – located on 6 West

Patients admitted to this service are primarily over the age of 65, have experienced a musculoskeletal injury and/or surgery and require a period of minimal or no weight-bearing prior to their participation in an active rehabilitation program.

The focus of care is a low intensity therapy program to assist these patients in maintaining their existing function and preventing further deconditioning in preparation for participation in an active rehabilitation program.

The anticipated length of stay on this unit is 4 to 6 weeks and the ultimate discharge destination is to independent living in the community.

Specialty Clinics and Services

In addition to the care provided to patients by our program care teams, Bridgepoint offers the following specialty services provided through on-site clinics.



Augmentative Communication & Writing Clinic (ACWC)

In-patient and Outpatient – located on the 2nd Floor

ACWC is a specialized service addressing the communication needs of individuals with severe speech and physical impairments through the provision of augmentative and alternative communication (AAC). ACWC believes that every person has the fundamental right to communication; the right to share in decisions of care; the right to develop and maintain social relationships; and the right to improve their quality of life.

Upon assessment, clients are provided with a face-to-face and/or written communication system that is appropriate, given their environment and their communication partners.

The ACWC clinic is comprised of a Speech-Language Pathologist, Occupational Therapist, Communicative Disorders Assistant and Technologist. The Assistive Devices Program (ADP) of the Ontario Ministry of Health and Long-Term Care has designated ACWC an Expanded Level AAC clinic.

Contact Information	Director 416.461.8252 x2334 Speech-Language Pathologist 416.461.8252 x2854 Occupational Therapist 416.461.8252 x2149
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LEGSS (Lower Extremity Gait Support Services)

Located on the 2nd Floor

This clinic provides inter-disciplinary assessments for lower extremity orthotics (braces) for inpatients and patients admitted to Day Treatment who have difficulty walking.

Contact Information	Outpatient referrals through the Case Manager 416.461.8252 x2371. Admitting information 416.461.8252 x2064
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Seating and Positioning Clinic (In-patient and Outpatient)

Located on the 2nd Floor

This well-equipped clinic addresses basic and complex seating needs. The clinic provides services based on individual patient needs following a comprehensive assessment. These services are comprised of mat assessments, a computerized pressure mapping system, as well as the prescription, dispensing and follow-up review of trial equipment. Clinic staff have Assistive Devices Program authorization status.

Contact Information	In-patient Clinic Coordinator 416.461.8252 x2230 Outpatient Coordinator 416.461.8252 x2012 For referral forms for outpatients: 416.461.8251 x2381
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NOTE: application forms need to be completed but do not require a physician's signature for consideration

Dental Clinic – located on the Ground Floor

This service provides inpatients with convenient access to routine dental care. Some services are not covered by OHIP, and patients may be required to pay dental fees.

Contact Information	416.461.8252 x2061
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Chiropody Clinic – located on the 2nd Floor

In-patients and Day Treatment patients experiencing foot problems of any kind are referred to the Chiropody Clinic for treatment. Services span preventative education and routine chiropody to the management and treatment of the high-risk foot (persons afflicted with diabetes and/or lower limb vascular problems).

Contact Information	416.461.8252 x2060
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Psychology Services

Neuro-psychological assessment service is available on a consultation basis.

Ophthalmology Clinic

Available on a referral basis, this service provides inpatients and Day Treatment patients with convenient access to eye examinations and prescriptions.

Cultural Interpreters Program

A comprehensive service delivery model has been developed to address the needs of non-English speaking patients and family members. The office has also developed a dedicated resource to Cantonese and Mandarin speakers. Bilingual staff and volunteers are screened and trained to provide interpreter services, and freelance interpreter services are purchased as required. After-hours and emergency issues are addressed through Language Line Services.

Patient Representative Office

Contributing to the delivery of high quality care and services, this office provides formal avenues for patients and family members to express their comments, concerns, and suggestions.

Therapeutic Recreation

The goal of Therapeutic Recreation is to enhance the quality of life, functioning and health status of patients. Trained professionals individually use leisure interest assessments to develop treatment plans and implement specifically designed recreation and leisure activities that respond to each patient's individual needs.

Patient Wellness Program

The Patient Wellness Program recognizes that the physical, emotional, intellectual and social aspects of life all contribute to an overall sense of well-being. The Program is designed to be accessible to all patients, and there are activities available specifically to benefit those with reduced mobility. Some of the activities include Tai Chi, the Fitness Centre, Meditation, as well as many special events.

Spiritual Care

Bridgepoint's care philosophy includes care for the whole person – body, mind and spirit. Through the Spiritual Care Service, Bridgepoint provides access to chaplains representing all denominations, as well as regularly scheduled non-denominational spiritual services.

Our Community Services

The Bridgepoint Family Health Team

The Bridgepoint Family Health Team serves patients within our immediate geographic area as well as across the Greater Toronto Area.

The Bridgepoint Family Health team offers:

- Access to comprehensive primary care services
- A LiveWell! program
- Specialized primary care for members of people living with Complex Chronic Disease and disability
- Palliative care.

Looking Ahead

Over the last several years, the leadership of Bridgepoint Health has been working with the Province of Ontario, City of Toronto and the community to create a Master Plan for redevelopment of the current site and the creation of an integrated “campus of care”. The new site plan includes the building of a new, leading Toronto hospital for individuals living with Complex Chronic Disease, the relocation of the operating Don Jail, the refurbishing of the historic Don Jail – to be adapted and reused, new research and teaching facilities, parklands and new mixed use buildings.

The overall vision of the design of the new site is to create a campus that is architecturally significant for Toronto and that also promotes the healing and wellness of Bridgepoint Health patients and the community. This commitment to leading city design and wellness is being reflected in all aspects of the redevelopment project – from the architecture, to the establishment of new parklands and gardens on the site – to the Bridgepoint culture, to the services offered to patients, to the design and operation of a new wellness centre; the new Bridgepoint Health campus will be wholly dedicated to health and well-being.

The new Bridgepoint Hospital funded by the Province of Ontario will be the cornerstone of the redevelopment project. The state-of-the-art hospital will be expressly built for complex, chronic patients and their families, and will offer cutting edge treatment.

The new hospital will keep 1,200 jobs in this community and create hundreds of new construction jobs. It will revitalize this significant corner of the City, bringing more people into the East End of the City.

The project also involves renovating the currently vacant historic Toronto jail for research purposes and for health promotion.

A new park will be created to ensure that green space is more readily available to the community. It will showcase the lush Don Valley and provide access to some of the City’s best views.

The advancement of the Bridgepoint Centre for Research, Education, and Policy is another key aspect of the redevelopment plan. The Centre will become a national meeting place where leading researchers come together to conduct clinical trials and share their knowledge of Complex Chronic Disease and disability treatments and innovations. The Centre will also play an important role as a teaching facility to mentor the next generation of complex care providers through Bridgepoint’s emerging affiliation with the University of Toronto.

During the consultation process, a number of principles have directed and shaped the Master Plan that received approval from both the City of Toronto (2006) and the Province of Ontario (2005). These principles are summarized as follows:

- Building a natural, green and healing community of caring
- Building new relationships between the campus, Riverdale Park, the Don Valley, and the vibrant Riverdale neighbourhood
- Make the most of the site's unique features and heritage buildings; and
- Introduce compatible new uses, including community spaces, public parks, and multiuse buildings that serve patients and the community.

Quick Guide to Admission Processes

Admissions Process

Bridgepoint Hospital services over 50 different health care organizations. Our goal is to review all complete applications within two business days.

To help facilitate an efficient admission for all of our referring facilities, we have developed one admission process for all Hospital services. There are four steps in the admission process:

STEP ONE

Please refer to the description of services in this guide to determine which service area of the Hospital to apply to.

STEP TWO

Fax your complete application to our Admitting Department at 416.461.5499.

An application checklist is provided in the next section of this guide for your convenience.

STEP THREE

The appropriate program care team will review your complete application. You will be notified within 2 business days of the application's acceptance or rejection.

STEP FOUR

Once the application is approved and a bed is available, we will call you to arrange admission.

STEP FIVE

If the application is not accepted by the unit to which it was directed, we will redirect the application, as appropriate for the review and consideration of another, more appropriate unit.

FYI:

- Please do not hesitate to call our Admissions Director for assistance:
416.461.8252 x2218
- All applications and supporting information can be faxed to the Admitting Department:
416.461.5499
- We receive approximately 250 applications for review each month.
- For the status of an application, call Admitting:
416.461.8252, x2064

A bed offer will only be made upon receiving assurance that the required admission information will be delivered to Bridgepoint Hospital prior to or at the time of admission (please see the required *Transfer Paperwork* in the following section). If no bed is available, you will be informed of an approximate wait period.

While we will accept any type of patient application that you send us, we cannot emphasize enough the importance of a complete application. A complete application will allow us to determine quickly if we are able to deliver the care your client needs.

Please use the checklist provided in the following section to ensure your application is complete.

Information We Need With Your Application

An application that contains all of the necessary information with appropriate clarity contributes to the quality of care provided to the transferring patient because it helps us to prepare in advance for the continuity of their care.

A complete application also takes us less time to review for approval.

To ensure your application is processed as efficiently as possible and that all possible means to promptly admit and care for your patient are considered, we recommend using the following checklist to complete your application form.

FYI:

- Please ensure your applications are legible and in black ink.
- Only applications that are complete, legible, and contain all required information are reviewed for potential admission.
- Referring facilities with "Direct Admission" privileges must provide us with this information prior to the patient's admission to the facility via fax to Admitting (information regarding Direct Admission is provided in the following section).

Application Checklist ✓

EXPECTATION FOR ADMISSION

- Program or area of focus you are applying for
- Bed type (complex continuing care or rehabilitation)
- If complex continuing care; would patient benefit from activation? If yes, attach goals and rehabilitation notes from all disciplines
- If rehabilitation, attach rehabilitation notes from all disciplines

DEMOGRAPHIC SHEET

- Name, address, gender, age (must be 18 years or older)
- Include the health card version code, if applicable

MEDICAL REPORT

- Include the admitting medical assessment
- Describe your goals for admission
- Include current and all past diagnoses
- Include all current medication and dosage with respective diagnosis
- Include current and past MRSA, VRE status
- Include prognosis, if palliative care application
- Include Do Not Resuscitate status, if palliative care application
- Include the type of dialysis
- Oxygen details (saturation level, concentration)
- If psychiatric history, detail current status and treatment

FUNCTIONAL ASSESSMENT *(this section preferably completed by a nurse)*

- Include weight bearing status, if applicable and related details
- Provide full details of pressure ulcers, include stage, diagram and present skin care routine
- Include behavioural assessment (indicate behaviour frequency and intensity), if applying for Cognitive Support Program
- Estimate hours of nursing care required to provide care

- List any special needs - include all relevant information (e.g., I.V. - reason why, portacath device, feeding tube or any other special devices)
- Provide personal data - complete height, weight, B/P range, and heart rate
- Indicate secure unit requirements

SOCIAL ASSESSMENT

- Indicate reason for application
- Indicate program(s) being applied for, if possible
- Indicate discharge plan and if long term care applications have been submitted
- Indicate Powers of Attorney (type with names and phone numbers)

OTHER

- Attach recent occupational and physiotherapy, and speech language pathology notes if applying for rehabilitation or activation
- State if co-payment has been discussed with patient and attach co-payment calculation form if applying for Complex Continuing Care bed types

FYI:

- Bridgepoint Hospital does not provide care to patients who require the following supportive care interventions:
 - mechanical ventilation
 - total parenteral nutrition
 - nasogastric feeding
- Patients requiring primary psychiatric treatment must have these conditions stabilized prior to acceptance.

Streamlined Admitting Services and Co-payments

Direct Admission

Bridgepoint Hospital offers a streamlined admitting process to referring facilities that admit large volumes of patients to specific services on a regular basis. These partnerships involve the referring facility developing a good understanding of the types of patients who will benefit from admission to Bridgepoint. They also depend on an agreement to send complete information with the transferring patient.

We place considerable importance on these direct admission relationships. This type of streamlined arrangement is based on mutual trust and requires that care teams from both the referring facility and Bridgepoint meet on a regular basis to become familiar with, and understand each other's needs.

Please contact our Admissions Director at 416.461.8252 x2218 to discuss your interest in setting up this type of arrangement.

Complex Care Co-payment

In accordance with provincial legislation, patients who are admitted for complex care and require a prolonged stay are required to pay a co-payment. This payment is the patient's contribution towards accommodation and meals.

The co-payment generally applies from the date of admission. Co-payment status is evaluated monthly.

Patients in certain activation programs may be exempt from these fees, depending on their circumstances. Patients in palliative care are exempt for 60 days.

Please advise your patient/client of possible co-payment charges, and contact our Business Office at 416.461.8251, x2181 if you have questions or need a co-payment calculation form.

What Information Do We Need Prior to Admission?

Transfer Paperwork

When a patient has been approved for admission to Bridgepoint Hospital, additional information is required to ensure appropriate care can be delivered. This information is required prior to, or upon admission.

In most cases, we will not confirm a bed offer without assurance that the transfer paperwork will arrive. The following transfer paperwork checklist outlines the information we need.



Transfer Paperwork Checklist ✓

- Transfer Sheet
- Allergies
- List of current medications (copy of MAR/pharmacy profile)
- Peritoneal Dialysis patients - include dry weight & dialysis prescription
- G-Tube Feedings - include rate/type and amount and tube/size/change date
- Rate and route - oxygen
- Wounds - stage and current treatment
- Special needs - e.g. pressure relief mattress, portacath
- Patient Care Plan - copy of plan
- EKG/EEG results (most recent copy)
- Lab results (most recent copy)
- X-ray results (most recent copy)
- Other test results (include Mantoux test)
- Mobility Status - e.g. weight bearing, equipment
- Summary of clinical course during hospitalization (discharge summary)
- Consults and names and phone numbers of physicians
- Physician's admitting note
- Physician's problem list (if available)
- Behavioural assessment/management form (for cognitive support)

Patient Privacy

Bridgepoint Health is committed to protecting the privacy, confidentiality and security of all personal health information to which we are entrusted. We have a corporate Privacy Policy which outlines rules for the collection, use, disclosure, and retention of personal health information.

Bridgepoint Health uses personal health information for the delivery of direct patient care, administration of the health care system, research, program evaluation and improvement, fundraising, and to meet legal and regulatory requirements.

If the patient's religious affiliation is provided, Bridgepoint's Spiritual Care staff will assist with the patient's spiritual needs. The patient may opt not to provide this information, or may request to be excluded from spiritual care programming.

The patient may request that information not be used for purposes of fundraising.

For more information about privacy of personal health information or to request a copy of the Privacy Policy, please contact the Bridgepoint Health Privacy Officer at 416.461.8251 x1321.

We Want Your Feedback

Your comments and feedback regarding our admission process and/or our Guide for Referring Professionals is welcome and appreciated.

Please fax your comments to Admitting at 416.461.5499 or e-mail info@bridgepointhealth.ca

The intent of this Guide is to provide you, the referring professional, with an overview of the care and services provided by Bridgepoint. We would be happy to discuss with you, the unique care requirements of your patient/client, and we will work with you to ensure that a personal care program is developed to meet individual needs.

This guide is also available on our website at www.bridgepointhealth.ca. We will update the web version on a regular basis, so please be sure to check back for any new information.

In addition to the information contained in this Guide, you can access a virtual tour of Bridgepoint Hospital on our website at www.bridgepointhealth.ca to assist you in working with patients/clients and their families so that they too can see all that Bridgepoint has to offer.

Thank you.



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HEALTH

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