<table>
<tr><td>Service Name</td><td colspan="2">Alfred Health Community Rehabilitation Program</td></tr>
<tr><td>Brief Description of Service</td><td colspan="2">Alfred Health Community Rehabilitation Program provides goal directed rehabilitation for clients following a change in their functional status. The primary focus is an interdisciplinary team approach towards agreed treatment goals.

Sessions may be in the client's home, local community or in our rehabilitation centre located at Caulfield Hospital. Group and/or individual sessions may be offered depending on clients' clinical need. Groups offered encompass: hip and knee rehabilitation, upper limb rehabilitation, aquatic physiotherapy, community access, public transport, balance/mobility, Memory, Stroke Wise, Fatigue and communication training.

Community Rehabilitation operates with 4 teams: Caulfield Home-based, Caulfield Centre-based, South Melbourne Home-based, South Melbourne Centre-based. The Community rehabilitation team is determined from the client's geographical location and predominant need for clinical setting (i.e. home vs centre) at the time of referral.</td></tr>
<tr><td>Location of Service</td><td colspan="2">Based within the Ashley Ricketson Centre at Caulfield Hospital</td></tr>
<tr><td>Service Hours</td><td colspan="2">Monday to Friday between 8:30am – 5:00pm.</td></tr>
<tr><td rowspan="2">Catchment Area
Refer to catchment maps</td><td>Caulfield catchment (LGA's)
-Glen Eira
-Stonnington (eastern side)
-Bayside (north of South Rd)</td><td>South Melbourne catchment (LGA's)
-Melbourne (southern area)
-Port Phillip
-Stonnington (western side)</td></tr>
<tr><td colspan="2">*Out of catchment referrals from Alfred Health to facilitate discharge from hospital to be discussed with the Operations Lead</td></tr>
<tr><td>Referral Sources</td><td colspan="2">☑ GP / Medical
☑ Health Professional (e.g. nurse, physiotherapist)
Referrals from external hospitals (e.g. Monash) require a medical discharge summary</td></tr>
<tr><td>Compensable Clients</td><td colspan="2">☑ TAC – in consultation with the manager
☑ Workcover – in consultation with the manager
☑ DVA – in consultation with the manager
Note that private health insurance rebates are not available
☑ NDIS – Check with relevant Team Leader
☑ Level 3 and 4 Home Care Packages – Check with relevant Team Leader</td></tr>
<tr><td>RACF's</td><td colspan="2">• RACF's – to be discussed with the Operations Lead</td></tr>
<tr><td>Client Age</td><td colspan="2">18 years and over</td></tr>
<tr><td>Eligibility Criteria</td><td colspan="2">OVERALL
• Must have had an acute illness, injury, surgery, or an exacerbation of a chronic condition resulting in a change in function that is expected to benefit from an episode of rehabilitation.
• Goals for realistic functional improvement with rehabilitation episodes should be able to be identified.
• Must be willing and able to actively participate in rehabilitation (medically, physically, cognitively, and psychosocially).
• Must be medically stable and should have a GP willing to provide medical support.
• Individuals living independently with care supports (Home care packages)
• Individuals being discharged from Alfred Health rehabilitation wards identified by the treating team as requiring further rehabilitation (>4 sessions).</td></tr>
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	• Will accept cardiac or pulmonary diagnoses as appropriate however should be offered cardiac or pulmonary rehabilitation by preference if appropriate.
	• ***Please complete "Safety Assessment for Community Visit" form to determine if home visits can be completed, otherwise only centre based appointments can be provided.***
	
	HOME BASED SERVICES:
	• ***Must have identified rehabilitation needs which are best or can only be achieved with management predominantly provided in the client's home environment***
	  • E.g. The client needs to be in their own environment / local community / specific context to learn and implement skills / strategies (communication / cognitive / physical) that will improve participation in their daily life.
	  • The client will have difficulty transferring skills / strategies learnt in other contexts into function.
	• Must have suitable home environment for the provision of therapy (e.g. completion of OT home assessment where indicated, risks including behaviours of concern, violence/aggression, history of drug /alcohol use of client/family/support persons, manual handling risk to staff and accommodation risks must be satisfactorily managed).
	• Unable to access the centre due to health, physical and / or environmental limitations (e.g. fatigue, goals of accessing the community to allow attendance at the centre).
	
	CENTRE BASED SERVICES:
	• Must have rehabilitation needs which are best achieved with management predominantly provided in a centre based facility.
	• Must be willing and safe to travel into the centre and are able to mobilise (includes wheelchair mobility) sufficiently to access the centre (50 metres).
	• Clients are required to provide their own transport however assistance with taxi costs can be negotiated on an individual basis if there are no other transport options.

Exclusion Criteria Alternative service options for referral are specified	• Clients who are on inpatient programs need to be discussed with the Manager (including those supporting clients in their homes such as HITH, Transition Care Programs and Better at Home). • Referrals requiring **monitoring** or **maintenance** (consider referral onto community health services including activity groups). • Individuals who require an occasional session of therapy (<4 sessions) post hospital discharge to check safety concerns or equipment (consider referring to PAC or Alfred MATS allied health). • Referrals for home modifications or equipment prescription in isolation (consider referring to Community Health Services). • Referrals for return to work without associated rehabilitation needs. • Individuals presenting with single issues with little activity limitations who likely require one on one, cubicle based treatment **only** i.e. no gym based management (consider community health services). ❖ e.g. 33 y.o. with # or soft tissue injury (such as wrist/shoulder/ankle) or isolated voice impairment **and** no other issues or disciplines required. versus individuals with more complex co-morbidities and multiple conditions **with goals for intervention** who may benefit from Community Rehab. e.g. 32 y.o. with # wrist/shoulder/ankle with a history of falls post stroke with mobility, personal care, cognitive and language goals.

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<tr><td>Priority of Access
Urgent Referrals
Routine Referrals
• Response Time
• Criteria</td><td>
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<tr><th></th><th>Urgent</th><th>Routine</th></tr>
<tr><td>Target response time</td><td>Initial assessment completed within 24-48 business hours</td><td>Initial assessment completed within 7 business days</td></tr>
<tr><td>Criteria</td><td>At risk of readmission or deterioration if not seen promptly</td><td>All other clients</td></tr>
<tr><td colspan="3">Note: Alfred Health hospital discharges are to be prioritised</td></tr>
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<tr><td>Fees</td><td>Home Based sessions: There are no fees for these sessions
Centre Based sessions: $10.00 for all individual and group sessions, capped at $20/week
There is the possibility of waiving fees if this will facilitate a client accessing the service</td></tr>
<tr><td>Contact Person
For queries</td><td>Caulfield Centre Based Team Leader ext: 66119 or mobile 0429 694 021
South Melbourne Centre Based Team Leader ext: 67230 or mobile 0409 436 379
Caulfield Home Based Team Leader ext: 66477 or mobile 0499 856 562
South Melbourne Home Based Team Leader ext: 66231 or mobile 0410 346 509
Alfred Health Community Rehabilitation Program Manager ext: 66223 or mob: 0419 577 123
Operations Lead: 0419 770 237</td></tr>
<tr><td>Appointment Process</td><td>Appointments are booked by the service.</td></tr>
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