Community Stroke Care Service and Priority Home Service COVID-19 Response Planning Visit Priority Codes

Purpose of Document

To outline visit priority codes in an effort to prioritize service delivery in response to COVID-19.

Therapy Priority Codes for Specialty Programs: Community Stroke Care Service and Priority Home Service			
	PRIORITY 1	**PRIORITY 2**	**PRIORITY 3**
OCCUPATIONAL THERAPY	- High risk for falls per Home Care guidelines and has fallen since discharge home - Family requires transfer training ASAP - Skin integrity issues or concerns - Issues with equipment placing client, caregivers or staff at risk of injury - Issues with transfers placing client, caregivers or staff at risk of injury - Suicidal ideation or other mental health concerns - Lives alone; limited social supports; new living environment - Main support/caregiver planned at discharge no longer available (vital support to maintain client at home) - Will facilitate a discharge from acute care hospital or prevent presentation to hospital	- Non-urgent equipment needs - Caregiver burnout or potential caregiver burnout - Upper extremity priorities: painful shoulder, uses SAEBO, developing contractures, significant tightness - Failure to cope since discharge home - Requires 24 hour supervision (which is being provided) - Cognitive, perceptual and/or affective impairment placing client at risk - Was/is caregiver for spouse or other person - High risk for falls per Home Care guidelines; no falls since discharge - Deconditioning, environmental risks, cognitive impairments, or risk taking behavior affecting client safety and increasing risk of falls	- Requires functional assessment and follow-up post hospitalization
PHYSIOTHERAPY	- High risk for falls per Home Care guidelines and has fallen since discharge home - Client lives alone and/or has limited or no social supports - Will facilitate a discharge from acute care hospital or prevent presentation to hospital	- Acute and/or new complaints of pain identified - High risk for falls per Home Care guidelines; no falls since discharge - Deconditioning, environmental risks, cognitive impairments, or risk taking behavior affecting client safety and increasing risk of falls - Client is developing loss of ROM, excessive stiffness or contractures as identified by a healthcare provider - Failure to cope since discharge	- Requires functional assessment and follow-up post hospitalization

		home	
SOCIAL WORK	- Experiencing mental health crisis including but not limited to: Suicidal Ideation, addictions etc. requiring immediate intervention and referral to services - Unsafe family situation with potential need for safety planning or criminal justice intervention - Uncertain or undetermined housing situation requiring immediate housing placement - Suspect abuse including: financial, sexual, neglect, physical, self-harm	- Caregiver burnout or potential caregiver burnout - Failure to cope since discharge home, including post-stroke adjustment, mental health supports and referrals where concern for client overall mental health and ability to rehab is recognized - Housing concerns where client needs new housing within 1-3 month time - Income related concerns such as: Applying for EI, EIA, Applying for CPP disability, STD/LTD navigation - Advocacy with a timeline attached requiring more urgent support	- Caregiver support - Non-urgent housing where client has stable housing currently but needs assistance with applications/assistance for personal preference - Family and client support relating to navigation of systems such as POA, health care directives, tax credits - Non-urgent referrals and resources, including non-urgent mental health support with coping, post-stroke adjustment and referrals where overall client wellbeing is stable - Advocacy with no timeline attached requiring overall support
SPEECH LANGUAGE PATHOLOGY	- Client at risk for aspiration as identified at time of hospital discharge - Significant communication impairment and client lives alone and/or has limited social supports - Will facilitate a discharge from acute care hospital or prevent presentation to hospital	- Lives with family or other and has significant communication impairment - Communication impairment has significant impact on mood and ability to socialize - Follow-up for dysphagia management	- Requires assessment and follow-up post hospitalization