ARU (ACUTE REHAB UNIT)= Located on 2 East A/D. Used for patients with short term acute rehab needs (typically ~ 2 weeks and patient should be able to do 3-4 hours of therapy/day). If patient requires long term rehab, consider other placement options. Post surgical patients, e.g. s/p BKA's, are most appropriate. Patients need to be evaluated and accepted by PMR resident to transfer to the ARU. There is a specific Acute Rehab consult for potential transfers (different from standard PMR consult). Patient should not have active medical issues and be residing on a non-monitored med-surg bed.

TCU (TRANSITIONAL CARE UNIT) = Located on 2 East B/C. Used for patients with primary transitional needs or difficult placement, i.e. long term abx, radiation, chemo, complex wound care, or sometimes rehab. Nursing is a step down from med surg and patients are not rounded on over the weekend (must be VERY stable). Nursing restrictions: no daily labs, no IV pain meds, no IV diuretics, no heparin gtt. A TCU consult must be placed and the patient needs to be evaluated and accepted by TCU hospitalist attending prior to transfer. If the veteran is receiving IV abx, there must be an ID consult with duration of IV abx and if appropriate, a PICC line placed or at least ordered.

2 NORTH = Essentially older patients with dementia/psychosis that should not be placed around younger more aggressive patients on other psych wards. This is a locked ward. An ideal patient for this ward is an 80yo male with dementia and no significant medical problems, who wanders and is awaiting placement. If patient does not wander and does not need sitter, likely does not need locked facility. If the patient is awaiting conservatorship, team social worker must submit conservatorship paperwork prior to transfer. To place this consult, you place a "tcu" consult but indicate consult is for 2N in your patient description.

DOM (Domiciliary) = Substance abuse treatment program. No age requirement. Must be independent with ADLs including medication management, no recent suicide ideation/attempts. Must have recent Suicide Risk Assessment. Must have TB clearance. No narcotics authorized. If on Methadone, must be connected with outpatient clinic. Consult must be placed to DOM. DOM screening team determines admission. Medical cases are considered case by case, these are done MD to MD call. Discuss first with Social worker. For returns to the DOM, the MD calls Dr. Levin for authorization (x43101).

Exodus Lodge (Building 207) = <65 y/o. Transitional housing for up to 30 days. Must be independent with ADLS (will accept independent vets in wheelchairs). Must have TB clearance. Must have recent Suicide Risk Assessment.

GPD (Grant and Per Diem) =Substance Abuse & Homeless program similar to the DOM. Offers transitional housing and employment, and residential drug and alcohol treatment. Must be independent with ADLs, no recent suicide ideation/attempts. Must have recent Suicide Risk Assessment. Must have TB clearance. No narcotics authorized. No methadone. Social worker must make referral.

HAVEN 1 = >65 y/o, under Grant and Per diem. Social worker must make referral. Must be independent with ADLs. Patients do receive homeless & substance abuse treatment. Must have TB clearance. Must have recent Suicide Risk Assessment.

HAVEN 2 = No age requirement. Can provide transitional housing < 1 week. Must have concrete discharge plan. Must have recent TB clearance. Must be independent with ADLs. Social worker must make referral.

Haven Detox = No age requirement. Must be on Librium. Independent with ADLs, medically stable with no active psychiatric issues. Must have recent Suicide Risk Assessment. Must have TB clearance. Priority given to Homeless. Social worker will refer.

New Directions Detox = Offers 21-day opiate detox for veterans. Social worker will refer.

RECUPERATIVE CARE = Located in Haven II. Short term placement with concrete discharge plan for Veterans requiring additional medical care like wound care. Must have TB clearance. Must have recent Suicide Risk Assessment. Application to be completed by MD, provided by social worker. Social worker will make referral.

BOARD AND CARE = Permanent housing for those who need assistance with IADLs (like medication management and meal preparation). No age requirement. Must be independent with ADLS. Must have recent Suicide Risk Assessment. Must have TB clearance. Bariatric Veterans more difficult to be placed. Must have income. *THIS IS NOT COVERED BY INSURANCE.* Veteran is required to pay out of pocket for placement. A discharge summary will be requested by facility prior to acceptance. Social

worker will place consult and submit documentation to placement coordinator. Veterans must be at least 3 months clean and sober.

HOME HEALTH = No age requirement. Provided by contracted Agencies. MD submits Home Care Service Consult via CPRS for patients requiring: IV Abx (no more than twice a day), wound care (supplies must be provided), Home PT/OT, medications , Foley care, PICC line care, follow up on feeding tubes, home safety evaluation, SW, bloodwork, etc. Should discuss with case manager prior to placing consult.

SNF/CNH (SKILLED NURSING HOME/COMMUNITY NURSING HOME) = No age requirement, but more difficult to place younger veterans. Skilled nursing homes require a SKILLED need such as IV abx, wound care, skilled physical therapy. If there are none, discuss further with social worker as they made need long-term custodial care at a Community Nursing Home. Veterans with dementia, Bariatric (>300lbs) or those with recent ETOH/Drug abuse are more difficult to be placed. CNH consult to be placed by MD when Veteran is medically stable for discharge. Discuss with Social worker. PMR consult is often very helpful and sometimes required to document that patient has skilled nursing needs. Certain CNH long term residents may return on weekends.

NHCU (Nursing Home Care Unit)/CLC (Community Living Center) = On campus nursing home. No age requirement. Priority given to Veterans that are 70% or higher service connected. Also for veterans undergoing chemo/XRT who cannot come in from home. Discuss with social worker and hospitalist **prior** to placing consult, unless patient came from CLC and his/her bed is still being saved. Patient cannot receive rehab more than 3 x week at CLC. Veterans must be at least 2 months clean and sober. Patients on methadone for pain control will be accepted. Long term residents may return on the weekend.

VASH (Veterans Affairs Supportive Housing) =VA Section 8 program (subsidized housing). Discuss with social worker as this is an outpatient program. *THIS IS NOT AN IMMEDIATE RESOLUTION TO HOMELESSNESS*. Veterans must APPLY for this program.

STATE VETERANS HOME = On campus. *THIS IS NOT AN IMMEDICATE RESOLUTION TO HOMELESSNESS*. Veterans must APPLY for this program. No age requirement. State owned & operated. Must discuss with social worker.

Palliative Care Service = Located on 2EB/C. Used for patients with prognosis less than <2 weeks. Palliative care team should be consulted as they will make determination for referral.

HUGS (Inpatient Hospice) = Located at the Sepulveda VA. It is overseen by the Palliative Care team. Veterans should have prognosis of <6 months. Palliative Care team should be consulted as they will make determination for referral. No age requirement.

FISHER HOUSE = On campus housing for FAMILIES of our hospitalized Veterans. Family must reside >50 miles from WLA VA Campus. CANNOT BE HOMELESS. Some patients can be lodged at Fisher house while receiving care at hospital (Chemo, XRT, etc) but MUST have a caregiver with them at ALL times. Consult placed by social worker.

PATRIOT HOUSE = On campus housing for Veterans who require short-stay housing (<24-48 hours) while they receive care at the hospital (ie. surgery, appointments). Must reside >50 miles from the WLA VA Campus.

SERVICE CONNECTION = The Veteran has an illness, ailment, and/or disability directly caused by their military service or diagnosed during time of service. They have submitted a claim to VA BENEFITS (a separate department) & it has been approved by this department. The VA hospital has no involvement in submitting their claims or determining percentage. The higher % service connected, the more $ received. VA-contracted CNH are fully paid for.

If they need…

Rehab: Acute Rehab, CNH or Home Care with PT/OT.

Wound Care: TCU, Home Care with Wound Care* or Recuperative Care.

IV ABx: TCU, Home Care*, CNH or CLC (limited).

Opt PCP appointment: PCP office will automatically make an appointment upon discharge.
If appointment needed within 2 weeks for a patient with no phone: Ask Case Manager.

Subspecialty Appointment*:* place subspecialty consult and in comments section write the name of the approving fellow for

overbooking. Please also write up-to-date patient phone number. If the patient has no phone, please have case manager make appointment prior to discharge.

In regards to Insurance, PLEASE consult with social worker as this REALLY is case by case.

Equipment: Please consult Case managers, not social workers for any equipment (wheelchairs, canes, etc) needed.

Transportation= Do not offer ANY transportation to Veterans or their families without first discussing with social worker. Taxi & Meal vouchers are not provided.

***** For home care, home services consult will need to be placed.