SKOGLI HELSE- OG REHABILITERINGSSENTER AS

Skogli offers specialized interdisciplinary rehabilitation for patients with disability due to rheumatic diseases, musculoskeletal diseases, chronic pain conditions, fatigue, stroke, cardiovascular diseases, after major orthopedic surgery, lymphedema, disease conditions of internal organs, and rehabilitation after burns and transplant surgery.

As a health centre Skogli has a long tradition in active disease prevention through improved lifestyle and promotion of important health factors: Healthy diet, physical activity, clean water, sunlight, temperance/abstinence, clean air, rest and trust.

Skogli has a contract with Helse Sør-Øst which includes 82 patients in the above categories, 7 patients in "Raskere tilbake" (national initiative aiming at reducing absence from work) and 5 patients in a special agreement with Lillehammer Municipality , which amounts to a patient volume at about 1,300 each year.

Skogli is part of specialized health care, which means that the rehabilitation require special resources and is performed using internationally recognized methods of treatment and performance measures, where interdisciplinarity, patient participation in the rehabilitation process and structured follow-up program after ended program at the rehabilitation center are important elements.

Skogli receive patients mostly from Health Region Sør-Øst, but also from other parts of the country due to the "free choice rule", where patients can choose which hospital or specialized health care institution they prefer. They are referred from their GP via RKE (Regional Coordination Unit, located at Sunnaas hospital), or directly from hospitals or specialist doctors.

The target group is mainly people in their active age (able to work) with the need for specialized and interdisciplinary rehabilitation.

The goal with the rehabilitation process is to help the patients recover their lost functions through exercising their abilities and increase their knowledge about their conditions so they are able to return to a normal life as possible, being active in social life and also work life. The main areas of responsibility are to help the patients experience improved function, independency across life areas, and at the same time protect and promote patient rights. The patients are to all times treated with respect and dignity.
The rehabilitation process is conducted by a interdisciplinary team which includes the patient. The process focuses on clear information, effective treatment, achievement of planned goals and reintegration of the patients in their desired environment.

The duration of the stay varies from 1-2 weeks for orthopedic patients to 3-4 weeks for the remaining group of patients. Sometimes there is a prolonged stay exceeding the initial decided week(s) and is then decided by an interdisciplinary team together with the patient. In certain cases after the stay the patient continues to receive treatment in an outpatient setting.

Admission criteria
Conditions that normally lead to admission:

- The diagnosis/malfunction is in accordance to the performance agreement/contract with Helse Sør-Øst
- Real potential for rehabilitation
- Conditions of short duration (< 1 year) are prioritized
- Danger of dropping out of the labor market
- First-time applicants, and former patients with documented positive effect of previous rehabilitation stays
- Younger patients are normally given a higher priority than older individuals
- Motivated patients who are able to actively involve themselves in the rehabilitation process
- Conditions which require interdisciplinary intervention
- Limited /non-satisfactory local treatment options

Conditions which normally leads to rejection:

- No/weak potential for rehabilitation, together with poor effect of previous stays
- Poor self-reliance/independency
- Predominantly recreational purposes (socially justified applications)
- A high intake of analgesics or addictive medications, and alcohol.
- Predominantly psychiatric conditions or dementia
- High risk patients with unstable medical conditions
- Significant problems food intake (tube feeding)

Discharge/shortened stay: Termination of the stay can happen due to medical and non-medical reasons. Intercurrent disease or increased circulatory instability which hinders participation in the rehabilitation program, which does not require hospitalization, lack of expected progress are examples of valid medical conditions. Dissatisfaction, death of close family members, violation of the patient regulations, deviant behavior, etc., are examples of non-medical causes of termination.

Transmission: Referral and admission for acute hospitalization may happen in cases with acute disease or accident, or if there is deterioration of existing chronic disease that needs further examination and treatment in hospital. The doctor responsible for the patient or the doctor on call provides to the hospital the necessary information (written and by phone) about the ongoing medical condition of the patient. Transmission to the hospital normally happens with an ambulance or taxi.

The rehabilitation program at Skogli is being administered by 7 interdisciplinary rehabilitation teams

- **Red team**: Takes care of patients with rheumatic diseases and osteoporosis
- **Yellow team**: Includes patients with musculoskeletal diseases with general or local pain conditions, sequela after fractures or other accidents, Group-based or individualized approach.
- **Turquoise team**: Includes patients with fatigue
- **Green team**: Includes patients with cardiovascular diseases such as angina pectoris, previously undergone myocardial infarction, coronary artery bypass- and valvular surgery, PCI, patients with sequel after surgery and conditions in internal organs, burns and transplant surgery, and lymphedema.
- **Blue team**: Takes care of patients who needs rehabilitation after major orthopedic surgery (coxarthrosis, gonarthrosis, fractures, neck- and back surgery, rheuma surgery), and patients with lymphedema.
- **Purple**: Takes care of rehabilitation of patients with stroke.
- **STAR**: Skogli has a team focusing on occupational rehabilitation, who admits persons who are referred from the health region which is covered by "Helse Sør-Øst", including persons in the program "Raskere tilbake"

Rehabilitation team: Within the team there is a physician, nurse/LPN, physical therapist, occupational therapist, psychologist, dietitian, socionom, speech therapist, vision therapist, rehabilitation assistant, exercise instructor, in varied composition depending on the need of the team. The team cooperates and works closely together and has the patient at the center. Relatives have the possibility to become involved in the process.

Rehabilitation plan: The patient will meet his team members within 3 days of arrival and there will be established a detailed written rehabilitation plan which describes the goals and expectations of the patient for the rehabilitation stay (short term) and long term goals. In addition will the team together with the patient decide what measures must be taken to reach the desired goals which continuously are being evaluated together with the patient.
In addition, at arrival the patient receives information about who is his/her rehabilitation coordinator/contact, the goal and content of the rehabilitation program in addition to practical information concerning the stay.

Rehabilitation content: The treatment takes place both individually and in group settings depending on the needs and requests. Once a week there is a meeting with the team where all patients are being discussed, the rehabilitation plan is evaluated and sometimes adjusted.

The patient regularly meets his/her physical therapist who evaluates and train muscle strength, endurance, fitness, mobility, balance, walking and movement capability, Training/testing of mobility aids is another area where the physical therapist is involved.

The occupational therapist surveys, guides and facilitates training for patients who face challenges in performing various daily activities (in their home/at work/leisure time). The goal is to recover activity and participation, accept the new life situation and experience a meaningful existence. Potential measures may be hand training, training in personal care, guiding in activities and application for various aids.

Nurses/LPN have as their goal to enhance or maintain the wellbeing and health of the patient through directed measures. They train the patients in daily routines when needed and in cooperation with occupational therapist and physical therapist. They have the responsibility for distribution of medications to the patients who are in need of this. Smoking cessation classes are being conducted by well qualified nurses.

The physicians evaluates the health condition of the patient, disability and rehabilitation needs at arrival and during the stay. In addition the physician are responsible for the quality of the interdisciplinary rehabilitation effort.

The psychologists assesses various mental functions in appropriate patients, provide individual and group based guidance to patients and team members. Psychologists are also actively involved in the rehabilitation of patients with chronic pain, lifestyle diseases by motivating change in behavior. Patients also receive help in managing crisis associated with their ongoing disease or life situation.

The social worker assesses the social situation and needs, guides and provides necessary support in relations which involves the employer, NAV (Norwegian Labour and Welfare Administration), health institutions, etc.

The dietitian plays an important role in the rehabilitation process of patients with lifestyle diseases, rheumatic diseases, etc.

The speech therapist and vision therapist contribute to the rehabilitation process of patients who have stroke that affects language. The vision therapist cooperates with a local optometrist in town.

The rehabilitation assistant, exercise instructor and prosthetist are also important participants in the rehabilitation process among certain patients.

Lectures about various topics are important work in the teams, where the goal is to lead the patients into a better understanding of their health condition and disease and how to better master it, improved quality of life and participation at home and in society in general.

Treatment intensity: Most patients have a daily program where individual and group based activity varies between 3-5 hours. In addition there is soft tissue treatment at the physical therapist 2-3 times a week (30 min) for those who need it. Further there are lectures 2-3 time a week in average, guidance, etc. The duration of the program varies between 2 – 4 weeks, 3 weeks in average.

Relatives are encouraged to participate. There will be arrange a special day with program for relatives for those with CFS / fatigue. There are also meetings in which relatives meet with representatives from the rehabilitation team, the patient and representatives from the Municipatlity. Relatives of stroke patients are offered a free night in connection with the visit of representatives of The Stroke Association. In addition, telephone calls and other contact / collaboration / training of relatives is done when needed.

Interest organizations: We have regular visits from LHL, ME Society and the Stroke Association where patients are given information and connect in order to receive local follow up after the rehabilitation stay. Both patients and relatives are included in the program.

Follow up: This happens usually in cooperation with the referral agency (GP, specialist, hospital). An interdisciplinary discharge summary is created which outlines a plan for further rehabilitation. In addition each patient receives an individualized activity program under supervision of a physical therapist or other professionals in the municipality. We often cooperate with the HMS (Assistive Technology Center), ambulant teams, orthopedic companies, referral for home visits by occupational therapists, nurses, etc. The patients also receive information about IP (Individual Plan) which can be initiated or reported to the coordinating unit in the home municipality or district of the patient

Results: An overview of demographic information and examples of outcome can be found here: http://skogli.no/Prosjekter.htm