

# Community Stroke Rehabilitation Workshop

October 24, 2025





# Agenda

- CSR Self-Assessment, Regional/Provincial Updates, and Resources
- Assessing Driving within Stroke Care
- Beyond the Berg: High-Level Balance
- Embracing the CSR Model of Care – Sudbury Team Fireside Chat
- Regional CSR “Brag and Steal” Presentations
- Closing Remarks



# Community Stroke Rehabilitation (CSR) Self-Assessment

Prepared by: Natalie Aitken, MSW/RSW  
Regional Rehabilitation Coordinator

# Setting the stage

Ontario Health Business Plan – *Develop, advance and sustain strategies to reduce variation in community stroke rehabilitation services that promote standardized programming and align with the model of care*



**Enhance Clinical  
Care and Service  
Excellence**

*(OH Business Plan 2024/25)*



### Community Stroke Rehabilitation

Current State and Gap Analysis Summary

Released April 2023

# Provincial Model of Care (MOC) Released 2022





# Background & Purpose

- Priority from SNSEO 2025–2027 Workplan: “Create and sustain access to best practice community/outpatient stroke rehab.”
- Objective: Evaluate alignment with the Ontario Health–CorHealth CSR Model of Care (2022)
- Purpose: Assess current practice, identify strengths & opportunities, and guide quality improvement planning.



# Methodology

- Electronic self-assessment survey (May–June 2025) based on CSR Model of Care
- 33 items across six key care components
- Completed by: Quinte Health (QH), Providence Care Hospital (PCH), and Perth & Smiths Falls District Hospital (PSFDH) initially
- Follow-up in-person meetings (June–July 2025) validated responses.
- Community Providers (Quinty Rehab, Kaymar, and Communicare) Completed late summer.

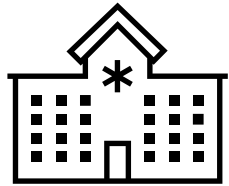
# Community Stroke Rehabilitation

Model of Care

July 20, 2022

1. Population
2. Team Members
3. Referral Process
4. Care Settings
5. Duration of Care
6. Clinical Delivery

# Overall alignment with CSR MOC



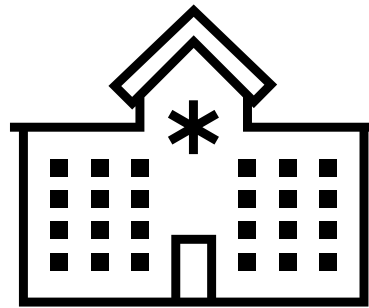
Total Summary of the <b>33 Elements</b>	PSFDH	PCH	QHC
C Completely Meets	20	22	21
P - Partially Meets	6	4	0
N - No does not meet	7	7	12



Total Summary of the <b>33 Elements</b>	HPE	KFLA	LLG
C Completely Meets	21	25	21
P - Partially Meets	4	4	3
N - No does not meet	7	4	8
N/A	1	0	1

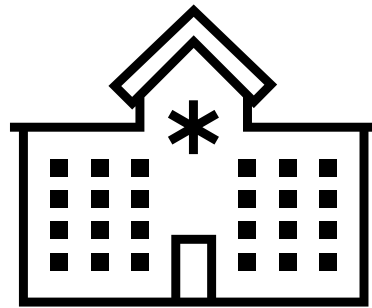
# Hospital Based CSR Strengths

- Strong consistent clinical delivery
- Active patient & caregiver involvement during care and transitions
- Emphasis on self-management and practice between sessions
- Proactive transition planning with clear discharge processes
- Use of standardized assessments and aphasia-friendly tools.



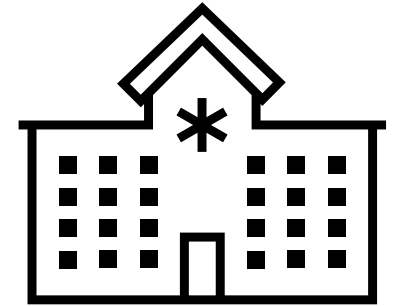
# Hospital Based: Opportunities

- All visits currently in hospital outpatient clinics – limited in-home/community care
- No programs offer routine follow-up visits (PSFDH piloted subset)
- Teams not yet fully trained in Supportive Conversations for Adults with Aphasia (SCA)
- Group therapy and technology integration vary across sites.



# Hospital Based-QI Initiatives

- Quinte Health: Team rounds, Trial mid-point patient/family meetings
- Providence Care Hospital: Integrate virtual sessions; standard education program; explore in-home/community visits
- Perth & Smiths Falls DH: Link to stroke exercise groups; track re-entry & SW referrals



# Community CSR Strengths

- Strong adherence to population criteria; clear referral pathways from all sources
- Team Composition: All regions have therapy assistants supporting care delivery
- Patient & Caregiver Involvement: Stroke survivors and caregivers are informed and engaged in their care transitions.
- Self-Management Focus: Programs promote independent practice and self-learning between therapy sessions.
- Collaboration & Community Links: Programs maintain strong connections with community agencies to support social needs and resource navigation.



# Community CSR Opportunities

- Team Processes: Programs are not yet functioning as interdisciplinary teams, e.g. no team meetings/structured communication among therapists
- Navigation Role: No formal navigator roles identified  
OHaH Care Coordinators provide some navigation, but alignment with the **CSR Navigation Guidance Document** is needed for consistency
- Nursing Expertise: Patients lack access to nurses with stroke expertise
- Follow-up Services: no structured 6-month or 1 year follow up visits by therapy team
- Post-Stroke Depression: Education on post-stroke depression not routinely provided





# Summary

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Overall Southeast CSR programs are striving to deliver high-quality, patient-centered care.

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Hospital Based Programs have identified Quality Improvement Initiatives aligned with the MOC and are engaged in preparing for the Provincial Data Strategy.

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Community Based Providers continue to make strong use of therapy assistants alongside therapists, while maintaining strong connections with community resources'.

\*The provincial CSR OHaH planning may support future opportunities to align with the MOC



# Provincial CSR Updates

- **Data Reporting Initiative**
  - Aim data submissions beginning May 2026
  - RCA is supporting implementation
  - OHaH CSR not initially apart of data reporting
- **CSR Waitlist Mgt. Guidance Document**
- **CSR Community of Practice (SW CoP)**
- **OHaH CSR Provincial Program Planning**

# Quorum

<https://quorum.hqontario.ca/en>



## Community Stroke Rehabilitation CoP

The Community Stroke Rehabilitation Community of Practice (CoP) is for Regional Stroke Network staff, Ontario Health regional staff, and clinical and administrative staff involved in implementing the new Model of Care for Community Stroke Rehabilitation across Ontario. Through this CoP members will increase their awareness of leading practices and gain access to resources, tools and strategies that can be used to improve the quality of care provided within existing CSR programs and in standing up new programs. Members will work together to identify solutions to common challenges, share lessons learned, and collaborate towards future sustainability of programs.



## CSR Data Reporting Initiative CoP

This Community of Practice (CoP) brings together data and project leads involved in the development and implementation of the Community Stroke Rehab (CSR) Data Reporting Initiative. Our shared purpose is to strengthen data collection and reporting practices across Ontario, driving quality improvement and enhancing care for people with stroke.



# Southeast Impact

- Lumeo implementation means Hospital Based CSR programs can support each other with the Data Reporting Initiative
  - **Southeast CSR/Lumeo Regional Working Group** – first met **Aug 11, 2025**. This working group will help build solutions for the data strategy.
- Hospital Based CSR Team members can expect to be engaged in pilot testing in early 2026

# Resources

- Return to Driving
- Emotional Well-Being and Counselling Resource
- Community Stroke Support Services



Fewer strokes. Better outcomes.

HOME ABOUT NEWS BEST PRACTICE & EDUCATION COMMUNITY SUPPORTS CONTACT

## Smart Tips for Stroke Care

Now Available! Check out this new resource that highlights common changes due to stroke and strategies for managing these changes.

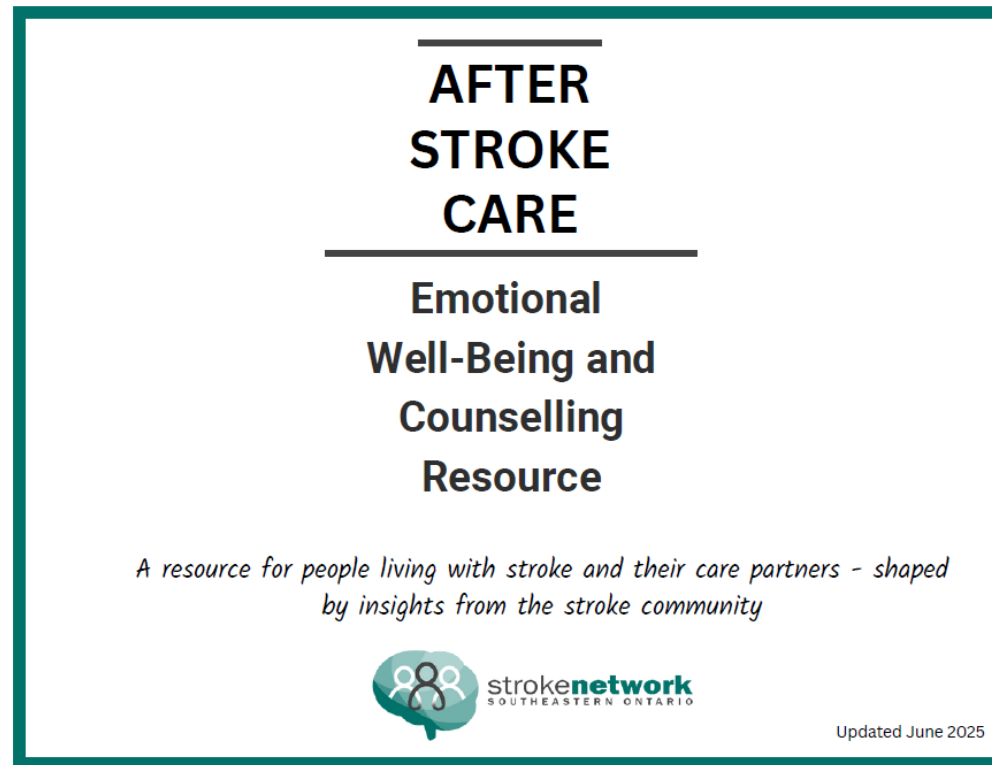


[Learn More](#)





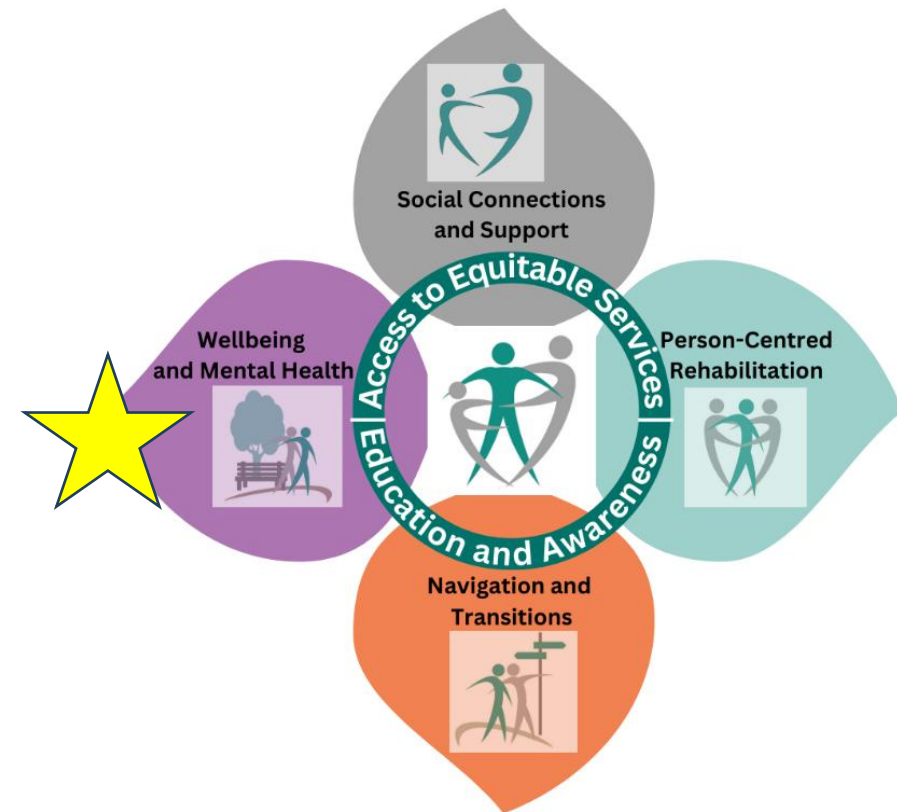
# Supporting Post-Stroke Well-Being: The Development of a Mental Health Resource



Sandra Liu, Regional Stroke Community and LTC Coordinator, [Sandra.liu@kingstonhsc.ca](mailto:Sandra.liu@kingstonhsc.ca) – October 2025

# Background and Rationale

- Informed by the [2023 Community Consultation, “What We Heard: Enhancing Individualized Community Stroke Services”](#)
- One of the **4 key themes** that emerged was ***Well-Being and Mental Health***
- One of **top 5 recommendations** being the need for greater support in this area
- Particularly the **need for accessible counselling related to *grief, loss and disability following a stroke***



# Project Goals and Guiding Principles

- Move from a list to a supportive navigation tool
- Meet an unmet need and voiced priority
- Help initiate important discussions and support people on their journey of recovery
- **Collaborative co-design** – designer, interest holders, and end-users work together to foster a solution
- **Several feedback loops** – included PWLE

“When I look back, things so much changed for me”  
~ Stroke Survivor

“The loss and grief that comes with it”  
~Stroke Survivor

“Was lost in a way, that’s the way it is, do what I have to do, times of crying too as well”  
~Stroke Survivor

“I’m thinking now that a virtual meeting with a social worker, someone, once month or something would have been useful”  
~Caregiver



# Community Stroke Support Services



StrokeUnderstood

## Referral to Community Stroke Support Services

*Please check which area the referral is being made for:*

**Lanark, Leeds & Grenville**

Jennifer Godkin Rec Therapist  
Senior Support Services (CPHC)  
[jgodkin@cphcare.ca](mailto:jgodkin@cphcare.ca)  
1-800-465-7646 x2043  
Fax: 613-342-6788

**Kingston Frontenac Lennox & Addington**

Emilia Leslie MSW, RSW  
Greater Kingston Victorian Order of Nurses  
[emilia.leslie@von.ca](mailto:emilia.leslie@von.ca)  
613-634-0130 x3469  
Fax: 613-634-0125

**Hastings & Prince Edward Counties**

Lorraine Pyle RSSW  
Community Care for South Hastings  
[lorrainep@ccsh.ca](mailto:lorrainep@ccsh.ca)  
613-969-0130 x5207  
Fax: 613-969-1719



**Senior Support Services-LLG**  
*Supporting Seniors Independence  
at Home and in the Community.*

