Ontario
South East Local Health Integration Network

STROKE NETWORK of Southeastern Ontario

Community Stroke Rehabilitation Program
Information Sheet for Health Care Providers

> *A critical concept within stroke rehabilitation is that 'rehabilitation' does not refer to a specific place or time where care is received. Rather, stroke rehabilitation is a goal-oriented set of therapies and activities as part of patient care post-stroke. Rehabilitation starts shortly after the stroke event occurs and continues as long as required for each individual to achieve their maximum potential recovery.*
> - Canadian Stroke Best Practice Recommendations (2016)

The South East Local Health Integration Networks (LHIN) *Stroke Rehabilitation Program* provides increased intensity of OT, PT, SLP and SW for up to 12 weeks to patients living in the SE region who have experienced a new stroke. Eligible patients are considered for **enhanced Physiotherapy (PT), Occupational Therapy (OT), Social Work (SW) and Speech Language Pathology (SLP)** services through the Home & Community Care offices of the South East LHIN following discharge home. For patients discharged to Long Term Care (LTC), PT will be provided by the LTC Home with enhanced OT, SLP and SW being provided through Home & Community Care. To qualify for the program, patients must be over 16 years of age, have had a recent stroke, and be eligible for therapy from Home & Community Care.

Service Objectives for patients and families include:

- timely access to enhanced community and LTC rehabilitation services;
- improved function;
- the provision of emotional support; and
- improved satisfaction and experience with the transition to home.

The program also supports improved information flow across the continuum of care and enhanced stroke care expertise in the community for health care providers.

> *Many patients who have completed a course of inpatient rehabilitation will still require ongoing therapy provided in the community to achieve their desired goals once discharged from hospital.*
> - Canadian Stroke Best Practice Recommendations (2016)

Acute care hospitals, complex continuing care and rehabilitation facilities discharge patients to the Community Stroke Rehabilitation Program in community and LTC settings through Home & Community Care. The hospital teams will identify potential participants, coordinate referral to Home and Community Care and host the Community Rehabilitation Planning Meeting where applicable.

Whenever possible a Community Rehabilitation Planning Meeting occurs between the patient/family, hospital Occupational Therapist (OT) and the community OT prior to discharge to communicate and coordinate treatment plans and objectives. For LTC residents, a collaborative care plan meeting is arranged by the community OT, and may include the LTC Director of Care, or designate, LTC Physiotherapist, direct care providers, patient and family whenever possible. To ensure a patient focus, the goals of patients and their families help to drive the initial and ongoing rehabilitation planning.

If you have a stroke patient that you believe should be receiving these services, please contact a Home & Community Care Support Services South office **at 310-2222**.

If you require additional assistance, please contact:

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