Community Stroke Rehab Program Annual Report 2022-23

November 20, 2023

HOME AND COMMUNITY CARE SUPPORT SERVICES
South East

strokenetwork
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Summary

This annual report provides an overview of the Community Stroke Rehabilitation Program (CSRP) since service inception in 2009 and reflects the most recent fiscal year (FY) data (April 1, 2022 – March 31, 2023).

Eligible stroke survivors following their hospital discharge to either community or long-term care (LTC) receive the appropriate level of therapy to support their ongoing rehabilitation through the provision of: physiotherapy (PT), occupational therapy (OT), speech-language pathology (SLP) and social work (SW), as needed. Home care services are provided through Home and Community Care Support Services South East. Patients may also receive support during transition from hospital through Community Rehabilitation Planning (CoRP) meetings, and/or a Rapid Response Nurse (RRN) or Transition Support Nurse (TSN) visit.

Key Findings in 2022-23

- Total patients decreased 3% while total visits decreased 13% from the previous fiscal year.
- Median total visits per patient also decreased from 11 to 10 visits.
- The median wait time to first home therapy visit was stable at 5 days.
- Rehab Assistants are now providing therapy visits in all areas of the region.

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Home and Community Care Support Services South East
Community Stroke Rehab Program 2022/23

532 admissions to the Community Stroke Rehab Program, a decrease of 3% from the previous fiscal year.

74% of patients received visits from at least two disciplines. 3% of patients received visits from all four disciplines.

Median wait time to first therapy visit remained stable at 5 days.

Rehab Assistants are now providing therapy visits in the Southeast. There were 45 patients that received at least 1 visit from a RA this year.

150 Community Rehab Planning (CoRP) meetings were held. 28% of patients received a CoRP Meeting prior to discharge from hospital.

73% of patients received at least one virtual visit from their therapist:
PT 56% | OT 65% | SLP 38% | SW 7%

HOME AND COMMUNITY CARE SUPPORT SERVICES
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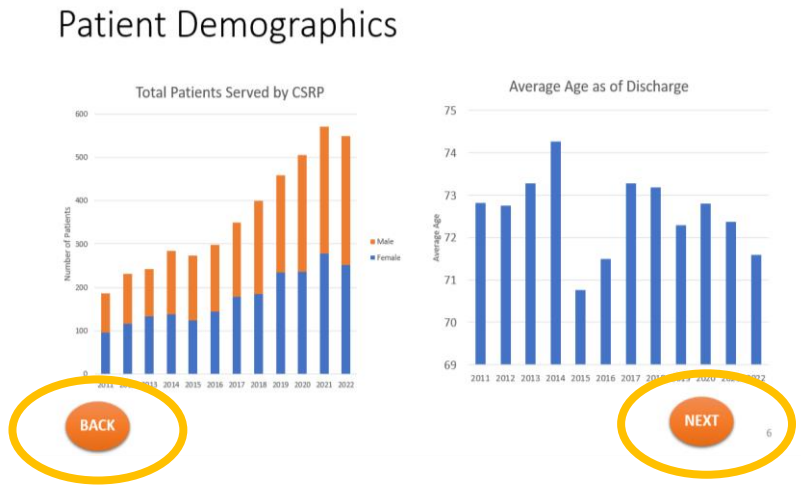
Navigating the report

- Navigating this report can be done through use of the buttons on each page to allow readers the choice in the content they are interested in reviewing or simply by scrolling through each page.
- There is a ‘Home Page’ that allows readers to review information and data specific to six chapters of Community Stroke Rehab in the Southeast.
- Each section page will have a “Back” button that will return readers to the home section and a “Next” button to advance readers through the selected section.

Home Page

Sample Page



Patient Demographics

Program Summary & Resources

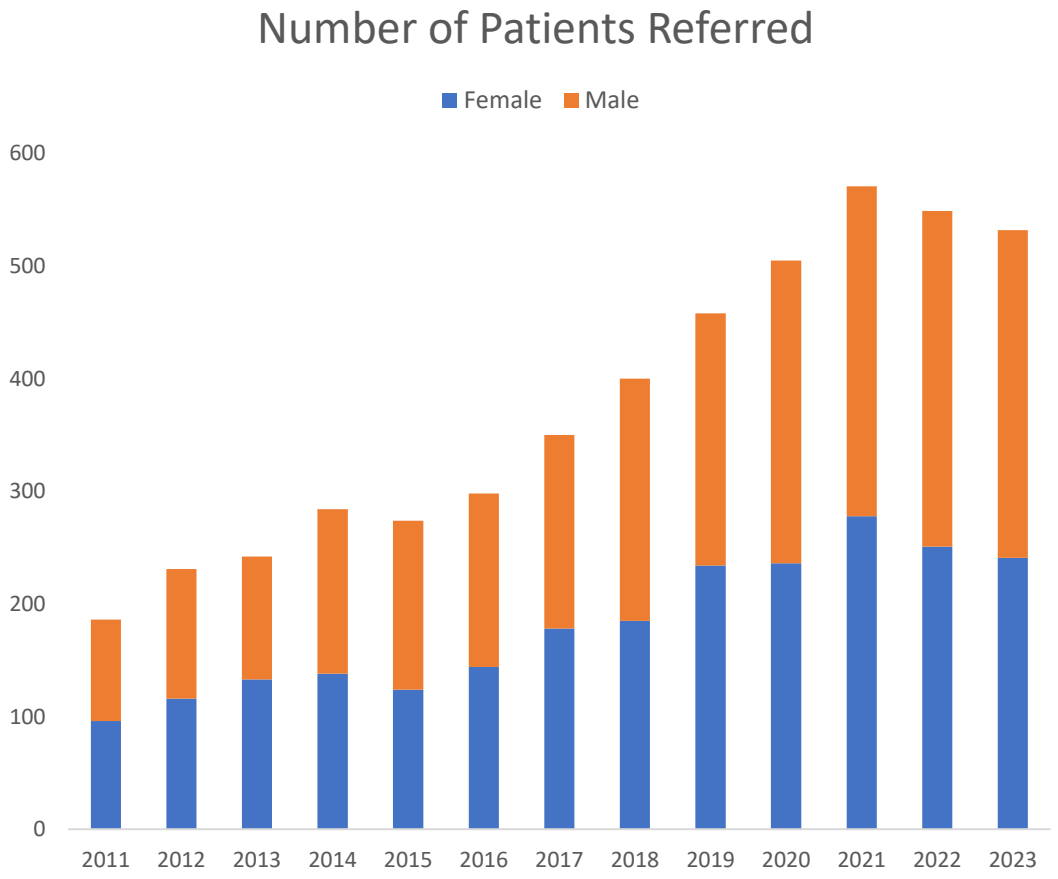
Therapy Visits

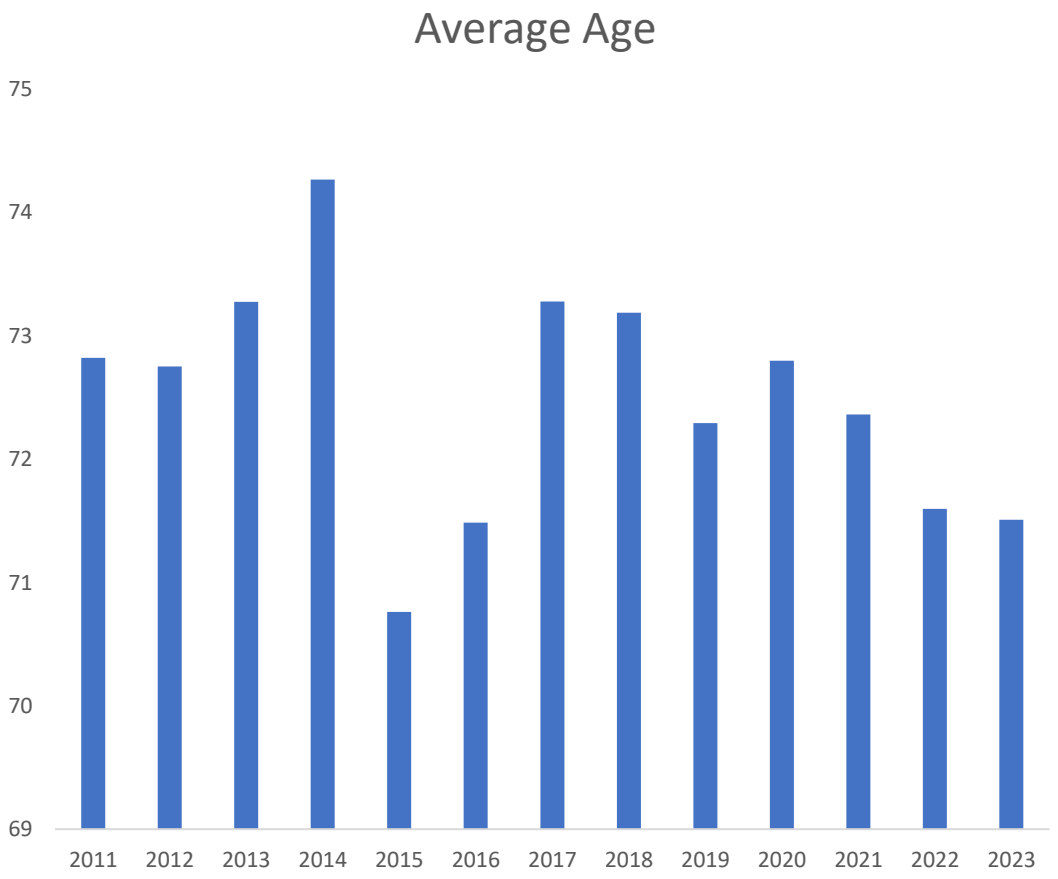
Wait Times

Regional Comparison

Quality Improvement Projects

Patient Demographics





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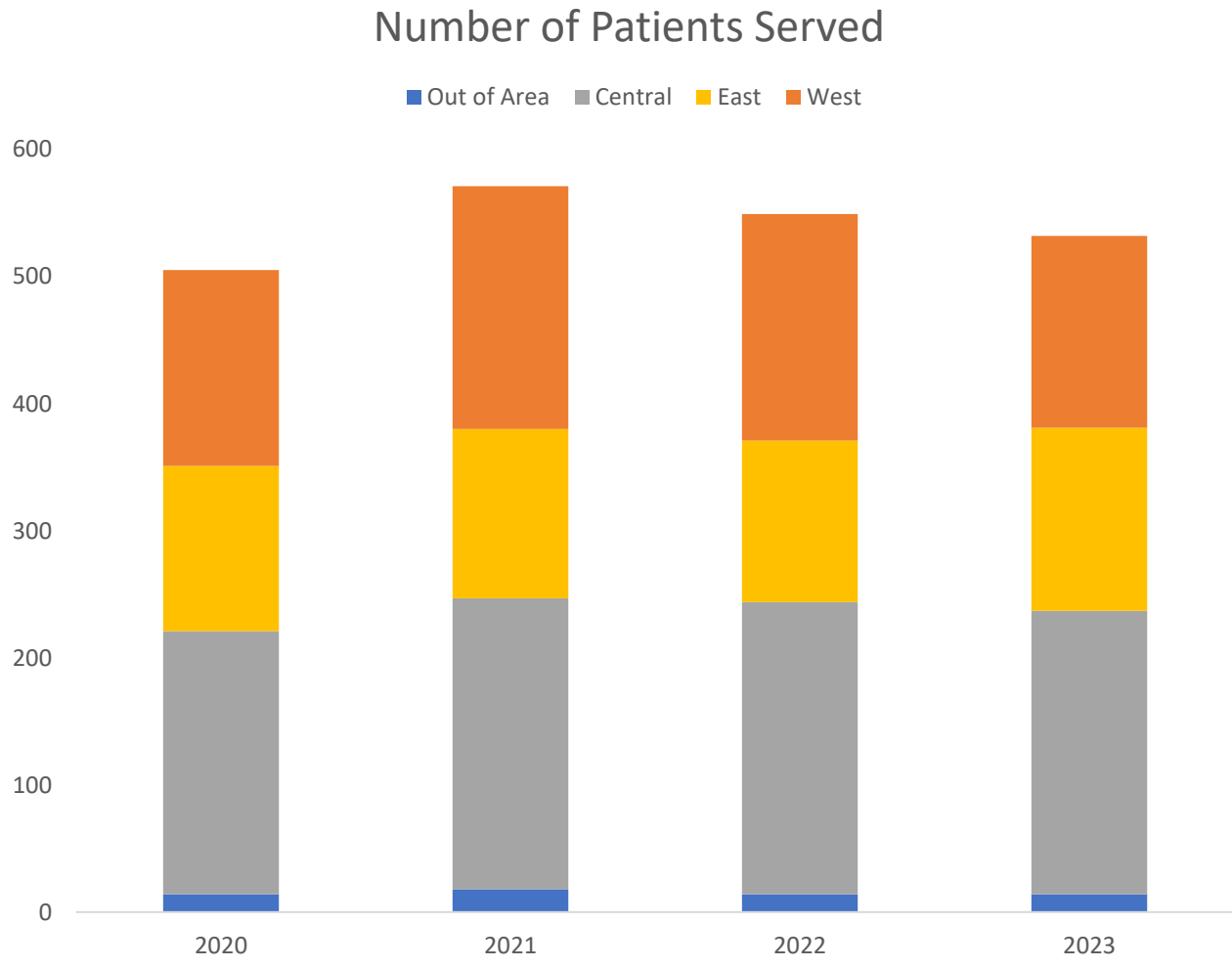
Patient Demographics

The number of patients receiving CSR decreased again in 2023. This decrease was primarily a result of lower referral volumes in the West subregion. The East subregion had an increase in referrals, up to 144 from 127 in 2022.

	2020	2021	2022	2023
Out of Area	14	18	14	14
Central	207	229	230	223
East	130	133	127	144
West	154	191	178	151
Total	**505**	**571**	**549**	**532**



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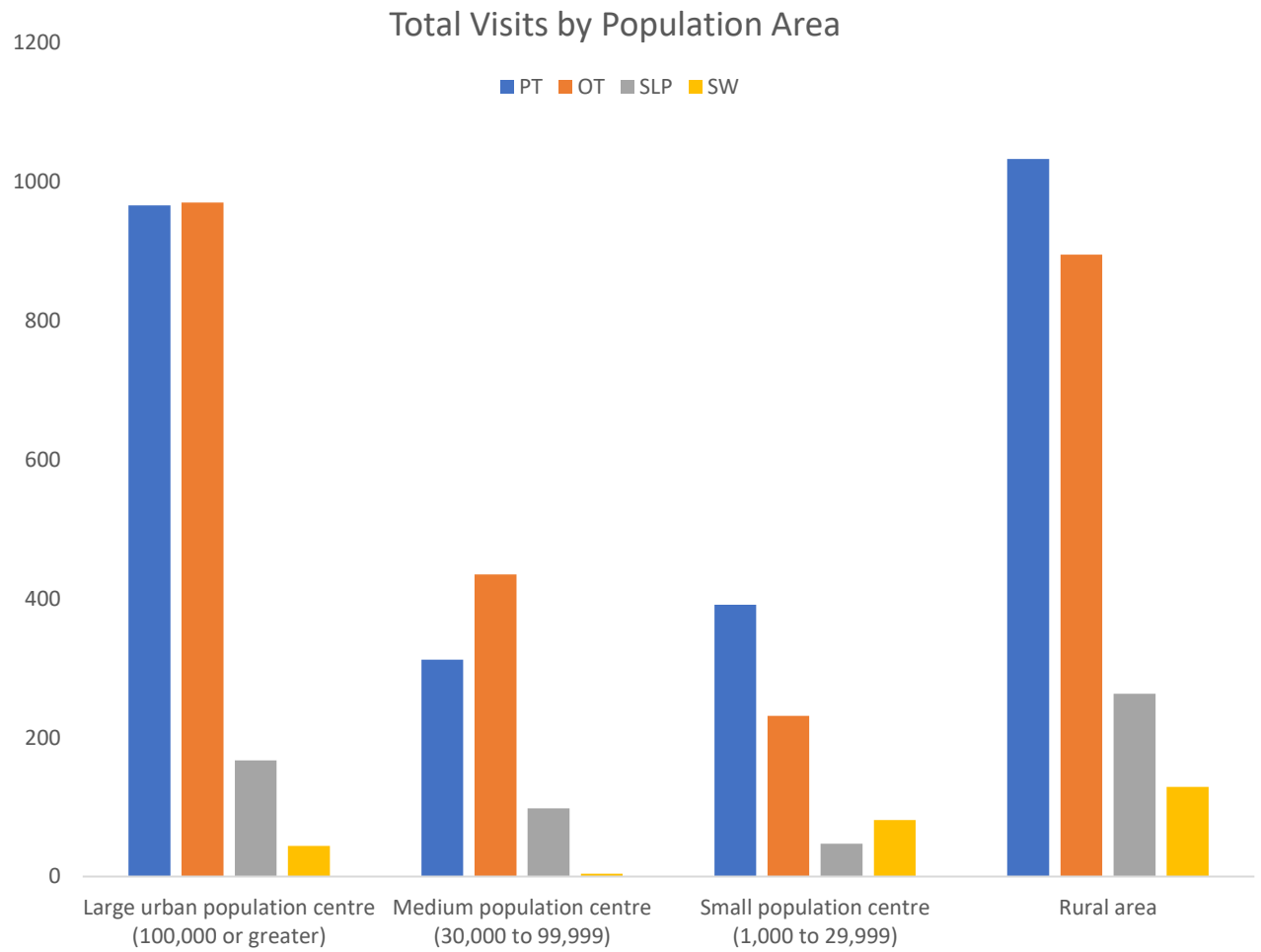
Patient Demographics

Reflective of the population makeup in the Southeast region, the majority of CSR visits took place in a rural area.

The number of visits in large urban centers (Kingston) continues to have a large number of total visits, in part due to the lack of Outpatient Stroke Rehab programming in this area.



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Program Summary and Resources

Community Stroke Rehab Program Description

Eligible stroke survivors following their hospital discharge to either community or long-term care (LTC) receive the appropriate level of therapy to support their ongoing rehabilitation through the provision of: PT, OT, SLP and SW.

Services are provided through Home and Community Care Support Services South East with the exception of PT in the LTC home (LTCH) setting which is provided by the LTCH. Additionally, patients discharged from acute care are referred to the Rapid Response Nurse/Transition Support Nurse (TSN) program. Patients discharged from a rehab setting may also be referred to the RRN/TSN depending on their needs.

For patients leaving hospital and going to the community, rehabilitation care plans focusing on the patient's goals are developed with the patient and their family/caregivers, hospital interprofessional stroke team and the Home and Community Care Support Services South East care coordinator. A Community Rehabilitation Planning (CoRP) meeting may occur between the hospital team, community provider and patient/family prior to the patient leaving hospital.

For patients leaving hospital and going to a LTCH, an interprofessional care planning conference is organized following admission to the LTCH, and involves the patient, their family, community therapist and members of the LTCH care team as determined by the Director of Care or designate.

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Program Summary and Resources

Community Stroke Rehab Program Description

All patients who have experienced a new stroke should be considered for referral to the CSRP prior to discharge including patients transitioning to Long-Term Care. **Hospital teams need to complete the Home and Community Care Support Services South East referral form a minimum of 24-48 hours prior to discharge.** The form should clearly indicate **"**Community Stroke Rehab Program**"** and include a suggested therapy plan with focus of interventions. For all patients discharged from acute, or for more complex patients, a referral to the RRN should be included. The table below outlines CSRP therapy services. Note that for LTC, PT is provided by the LTCH.

Community Stroke Rehab Program		
	Weeks 1-4	Weeks 5-12
OT	Up to 12 visits over 4 weeks	Up to 16 visits over 8 weeks
PT	Up to 12 visits over 4 weeks	Up to 16 visits over 8 weeks
SLP	Up to 8 visits over 4 weeks	Up to 8 visits over 8 weeks
SW	Up to 4 visits over 4 weeks	Up to 4 visits over 8 weeks

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Program Summary and Resources

Reminders

- A Community Rehabilitation Planning (CoRP) meeting should be **considered for all discharges from rehab**. The CoRP meeting ideally occurs within 72 hours of discharge but planning for this meeting could start as early as two weeks prior to discharge. Note that it may take 4-5 days to arrange the CoRP meeting. The hospital OT typically coordinates the CoRP meeting however another therapist may be more appropriate in some circumstances. The most appropriate therapy discipline supports the Care Planning Meeting in the LTCH in lieu of the CoRP meeting.
- **Virtual visits** have been included in the CSRP model in response to COVID. Find virtual resources here: COVID-19 Rehab Resources | Rehab Care Alliance
- An extended stay in hospital (e.g. waiting for LTC) does **NOT** preclude the patient from being eligible for the CSRP.
- Referral to SW should be considered during discharge planning **and throughout the patient's recovery journey.** SW can assist with psychosocial supports, links to vocational support services and assistance with applications for financial support **at any time** post-stroke.

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Program Summary and Resources

Reminders

- Consider referral to **Stroke Survivor and Caregiver Support Groups**, **Stroke Specific Exercise Programs** and **Aphasia Supportive Conversation Groups** and to other community exercise programs and supports when appropriate. A community rehab visit may be used by the community provider to connect the patient with any community support/program prior to discharge from the CSRP.
- Information on various community programs is available through the Stroke Network of Southeastern Ontario's website under Community Supports and through the South East Healthline under Stroke Resources**.** A Patient Journey Map co-developed by stroke survivors and caregivers is a recommended education and navigation resource**.** Additional resources include Driving After Stroke, Return to Work and Navigation and Transition Toolkits.
- Funding for education is available through the Stroke Network of Southeastern Ontario in the form of Shared Work Days to link with stroke experts and through a new Professional Development Fund.

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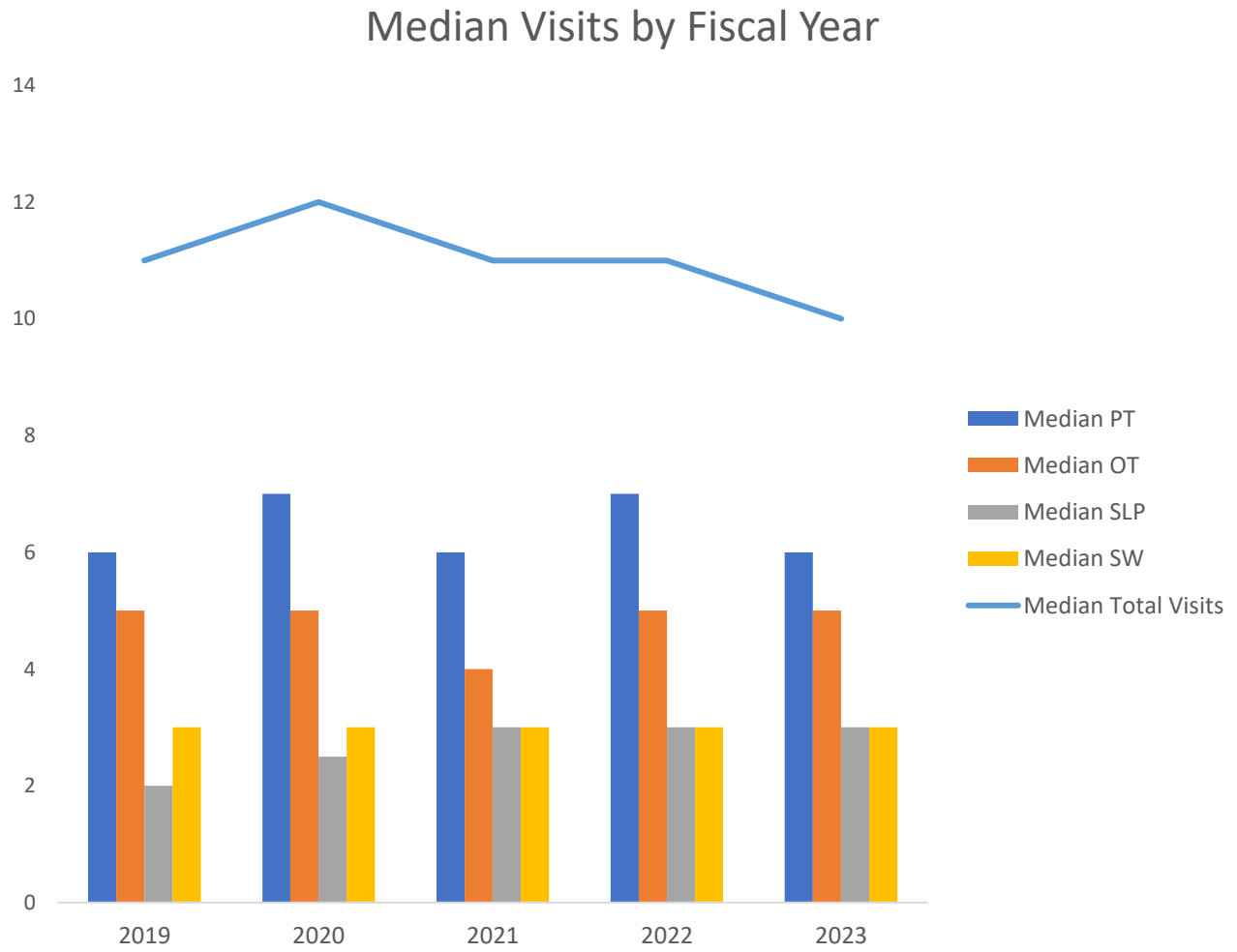
Therapy Visits

The median number of total therapy visits per patient decreased in 2022/23. Physiotherapy provided the largest median visit volume in the Southeast.

Both in-person and virtual visits are included in this calculation.

Visits delivered by both therapists and therapy assistants are included in 2023. For example, PT and PTA visits are included together in calculating the median Physiotherapy visits.



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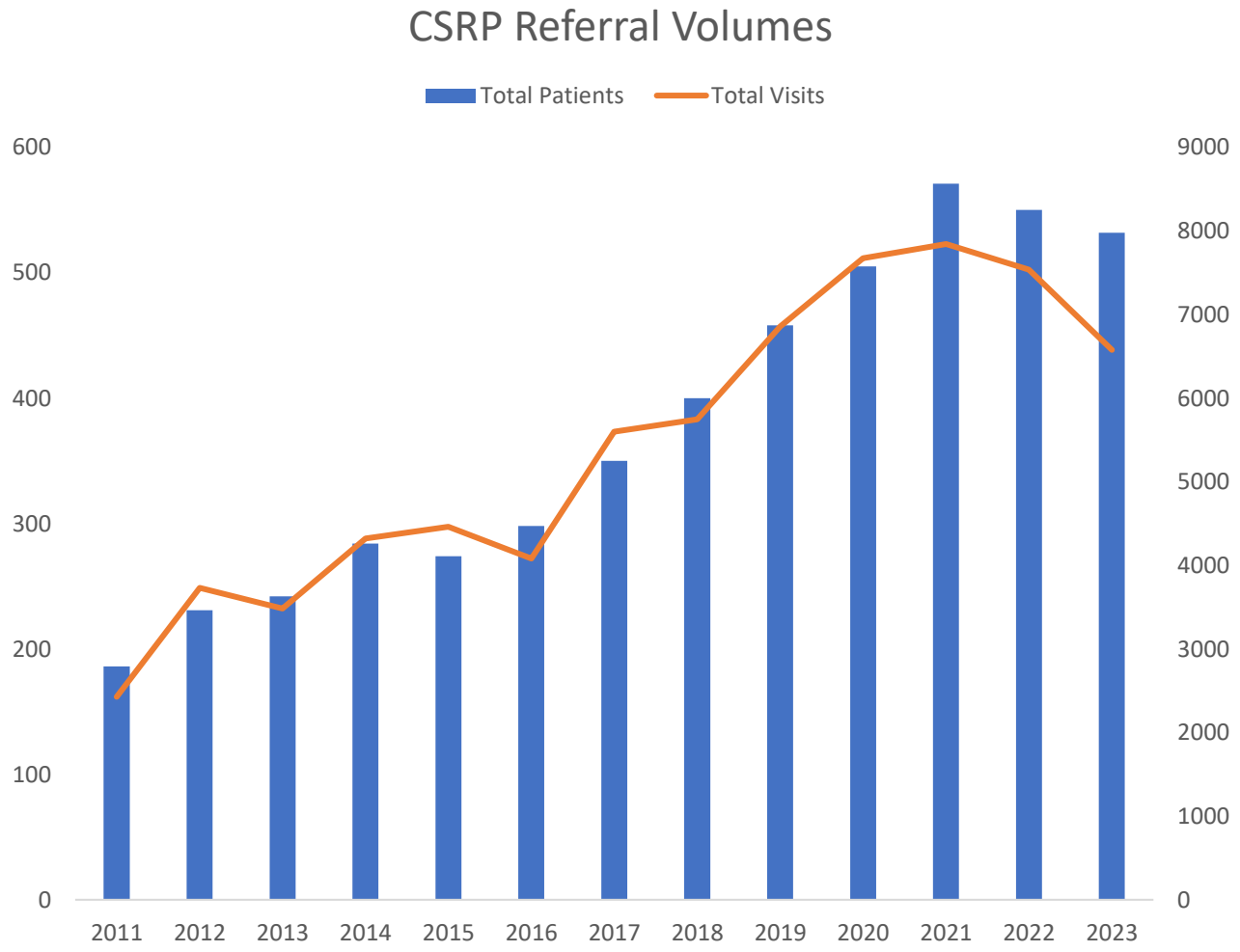
Therapy Visits

The number of patients and total visits were both down in 2022-23

- Total Visits: 6576.5
- Total Patients: 532

A decrease in patient volumes and total visits has created a concerning trend. The number of strokes in the region has increased year over year which would suggest an increased need for community rehabilitation for this population. Factors that may be contributing to a decrease in services may include staffing challenges or patients accessing outpatient services.



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Therapist and Therapy Assistant Visits

Rehab Assistants (RA) – Physiotherapy Assistant (PTA), Occupational Therapy Assistant (OTA), and Communicative disorders assistants (CDA) – visits have been included in the report for the first time as CSRP providers are now able to include assistant visits in their program model. RA visits can be scheduled alongside a therapist or individually, depending on the treatment plan. RA visits are funded in addition to therapist visits in the CSRP and are necessarily not scheduled in place of a therapist.

Hiring into RA positions has varied in each subregion and recruitment continues for all providers. In the first year of this new staffing model, there were 45 patients that received at least one visit from a therapy assistant as a part of their therapy program.

Proportion Assistant to Therapist visits when Assistant involved in therapy plan	
PT	63%
OT	51%
SLP	58%

Number of Visits by Therapy Assistants by Region

Therapy Assistant	East	Central	West	Total
PTA	56	89	-	145
OTA	1	282	10	293
CDA	21	-	-	21

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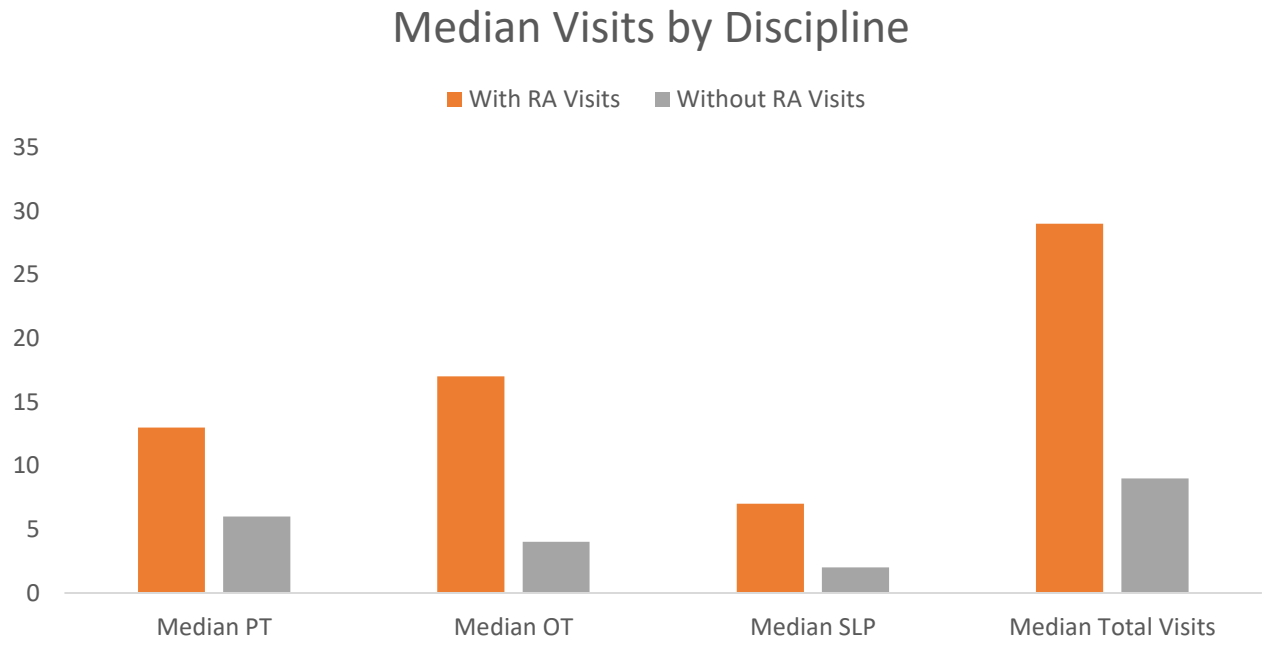
Rehab Assistants

Patients that received therapy visits from Rehab Assistants (RA) received significantly more visits as a part of their rehabilitation in the community.

The median number of therapy visits for patients with at least one RA providing visits was 29, compared to 9 total visits for those without a RA visits during their CSR program.



Discipline	Number of Patients	Median Visits by Discipline with RA	Median Visits by Discipline without RA
PT/PTA	14	13	6
OT/OTA	31	17	4
SLP/CDA	5	7	2

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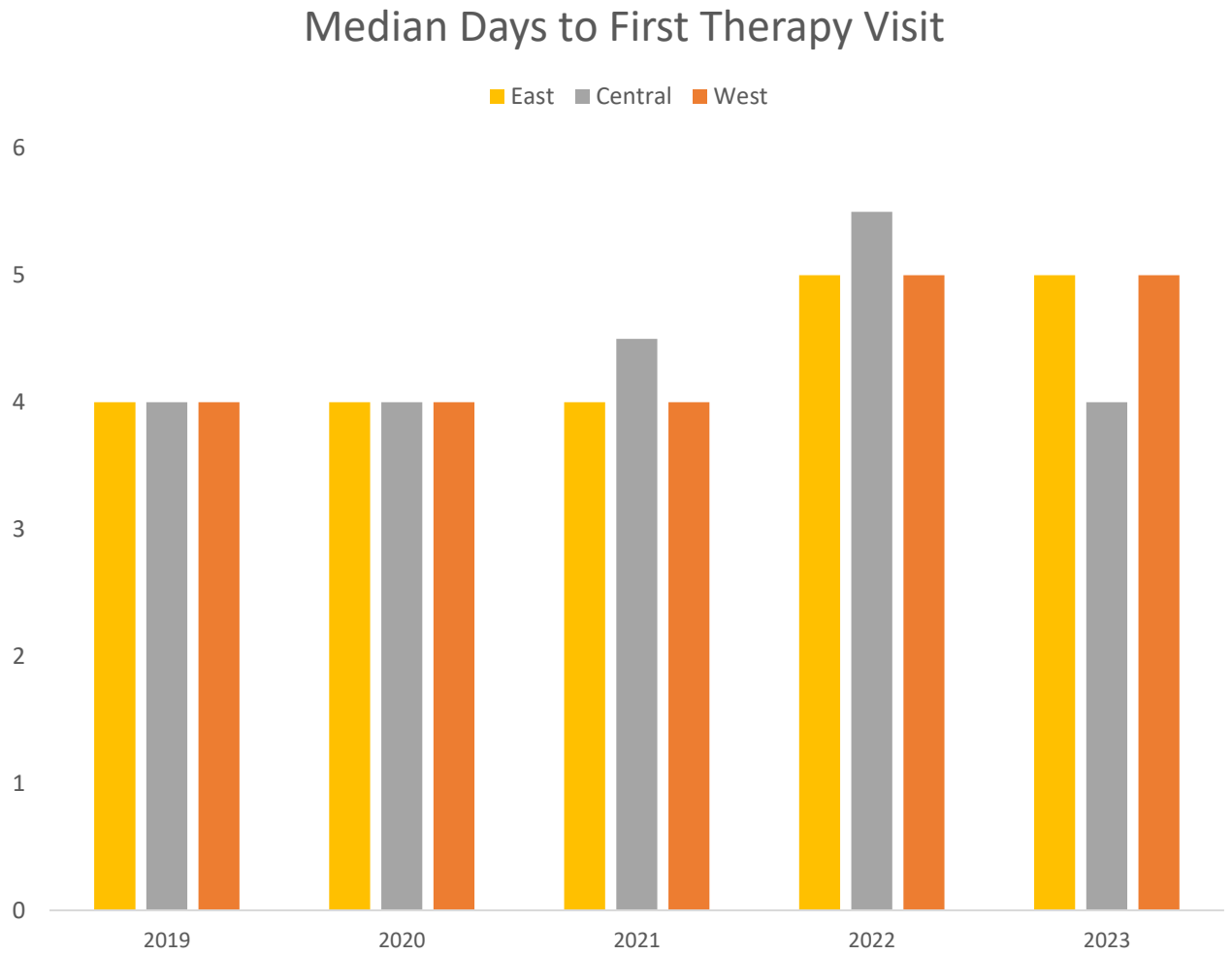
Wait Times

Appropriate and timely rehabilitation can significantly improve outcomes for people who have experienced a stroke, increasing their level of independence and opportunity for community re-engagement, and overall quality of life.

Median wait times to first visit have increased in the East and West subregions, while the Central subregion returned to a median wait time to first therapy visit of 4 days in 2023.



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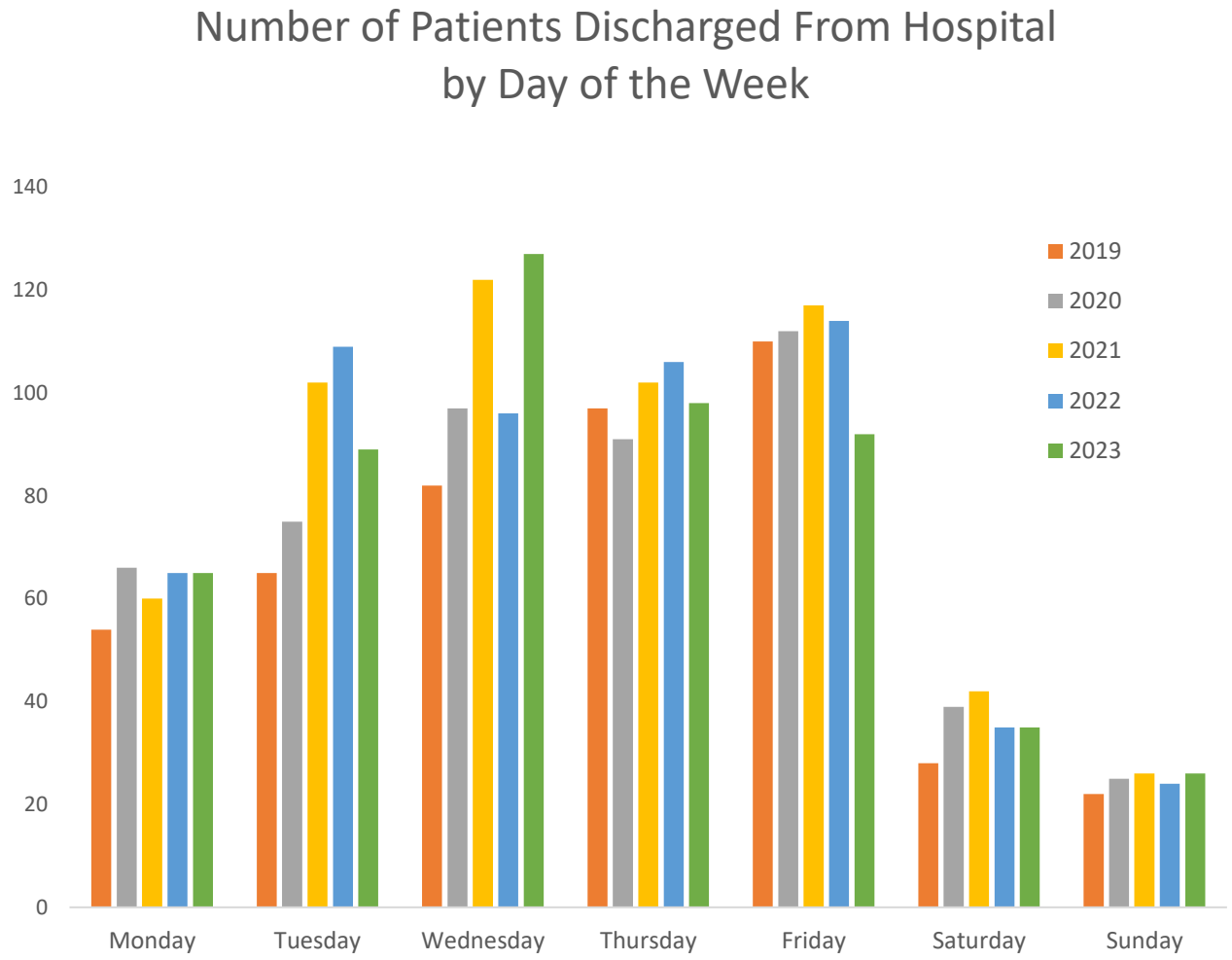
Wait Times

In 2023, the median wait time for first therapy visit was 5 days. Wait times can be influenced by the day of the week patients are discharged from hospital.

The *new* OH-CorHealth CSR Model of Care target for first visit is 48 hours from Acute Care and 72 hours from Rehabilitation.

Median Days to First Therapy Visit by Hospital Discharge Day

	M	T	W	T	F	S	S
2020	3	2	5	5	4	4	4
2021	2.5	3	5	5	4	4	3
2022	4	6	5	5	5	5	4.5
2023	3.5	3	5	4	5	4	5



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EAST
LLG

CENTRAL
KFLA

WEST
HPE

ALL

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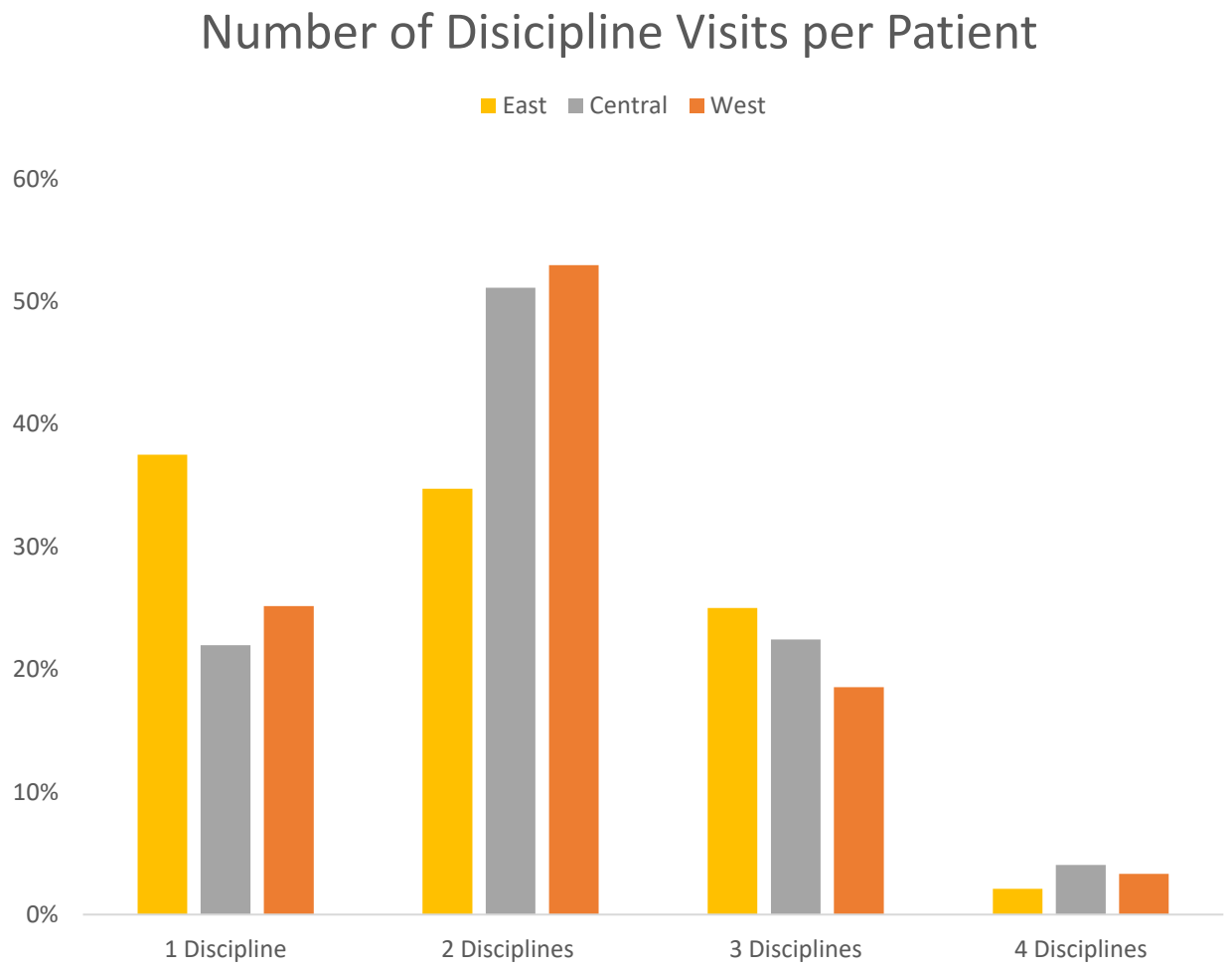
Regional Comparison – All Regions

Patients referred to the Community Stroke Rehab program may see:

- Physiotherapy
- Occupational Therapy
- Speech Language Pathology
- Social Work

This graph outlines the proportion of patient therapy visits from multiple disciplines in the region.



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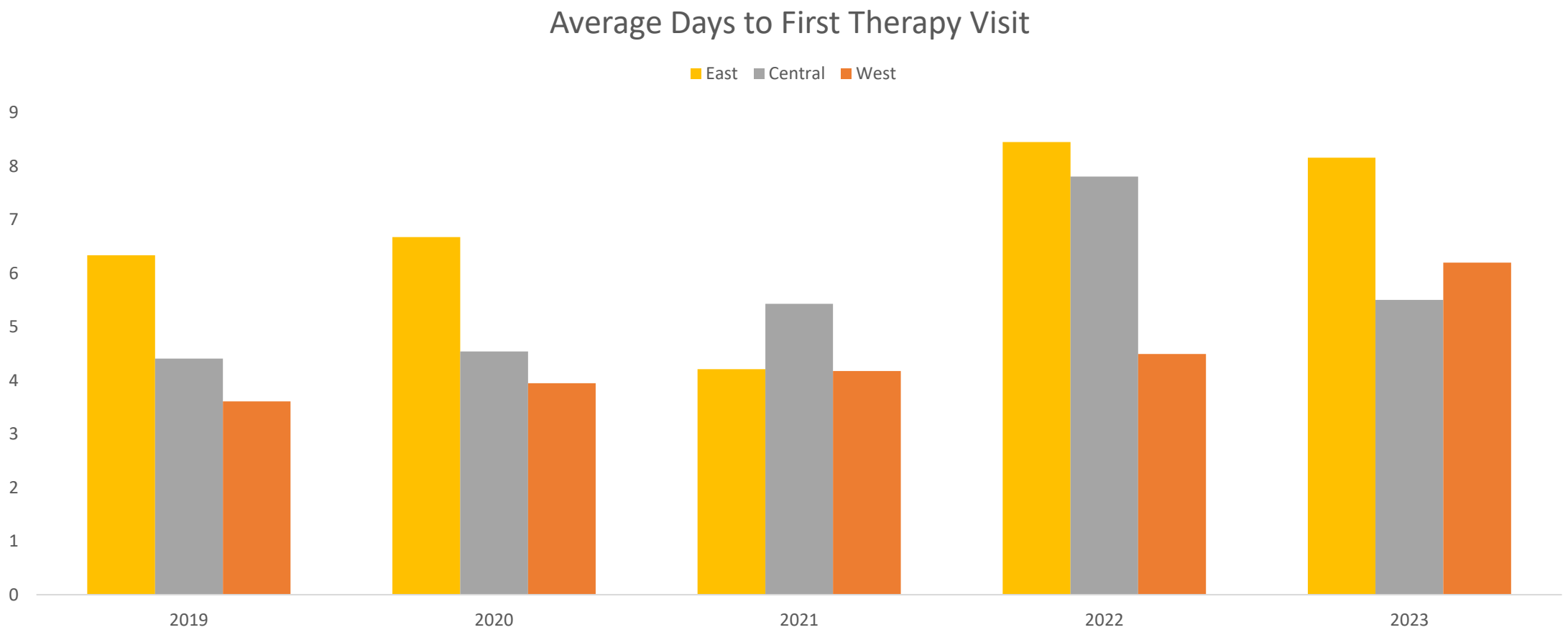
Regional Comparison – All Regions



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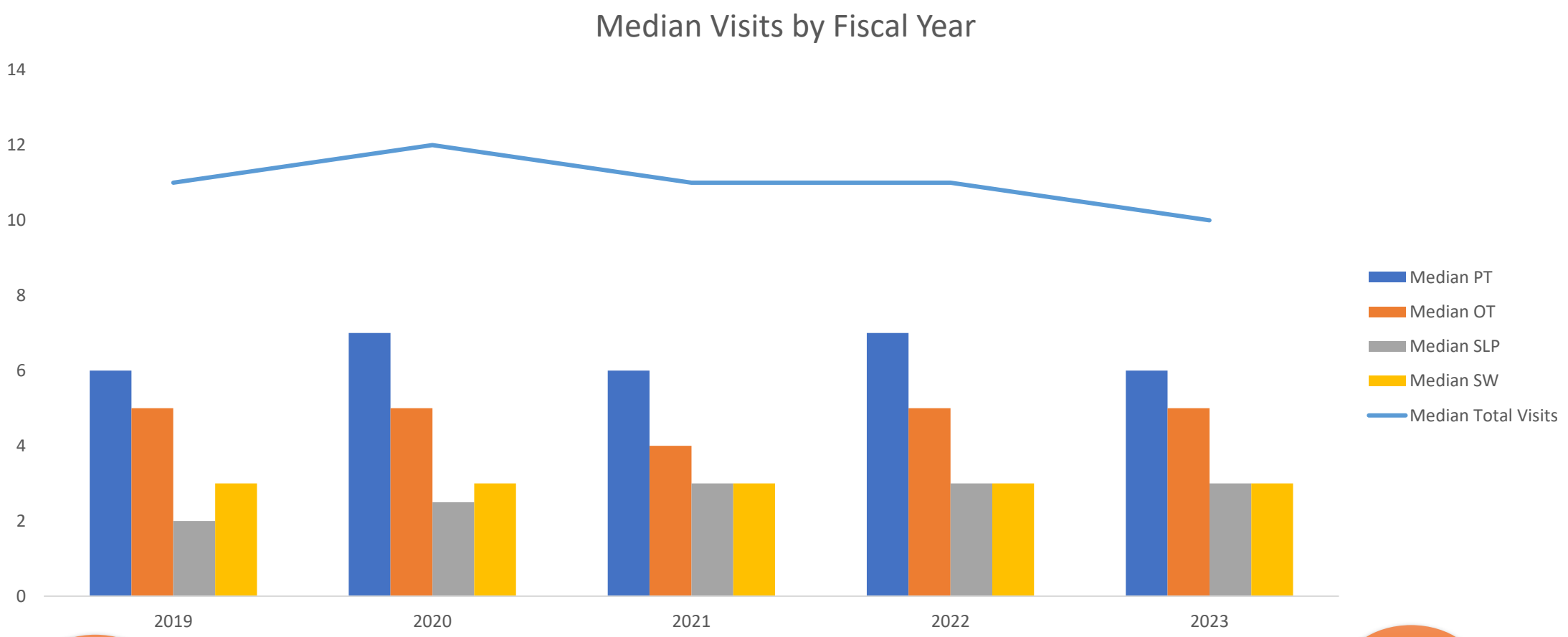
Regional Comparison – All Regions



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Regional Comparison – All Regions

Number of Referrals by Region

	2019	2020	2021	2022	2023
KLFA	167	207	229	230	223
LLG	119	130	133	127	144
HPE	153	154	191	178	151

Median Days to First Visit by Region

	2019	2020	2021	2022	2023
KLFA	4	4	4.5	5.5	4
LLG	4	4	4	5	5
HPE	4	4	4	5	5

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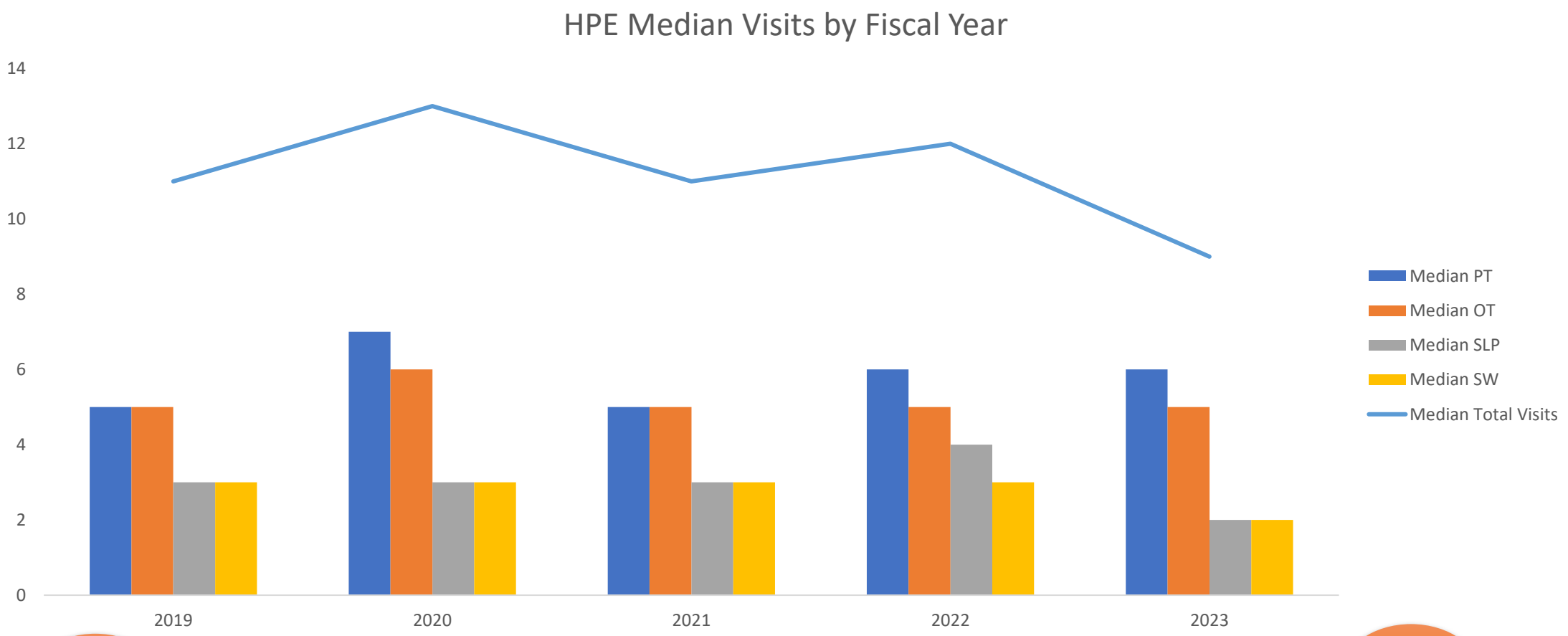
Regional Comparison – HPE



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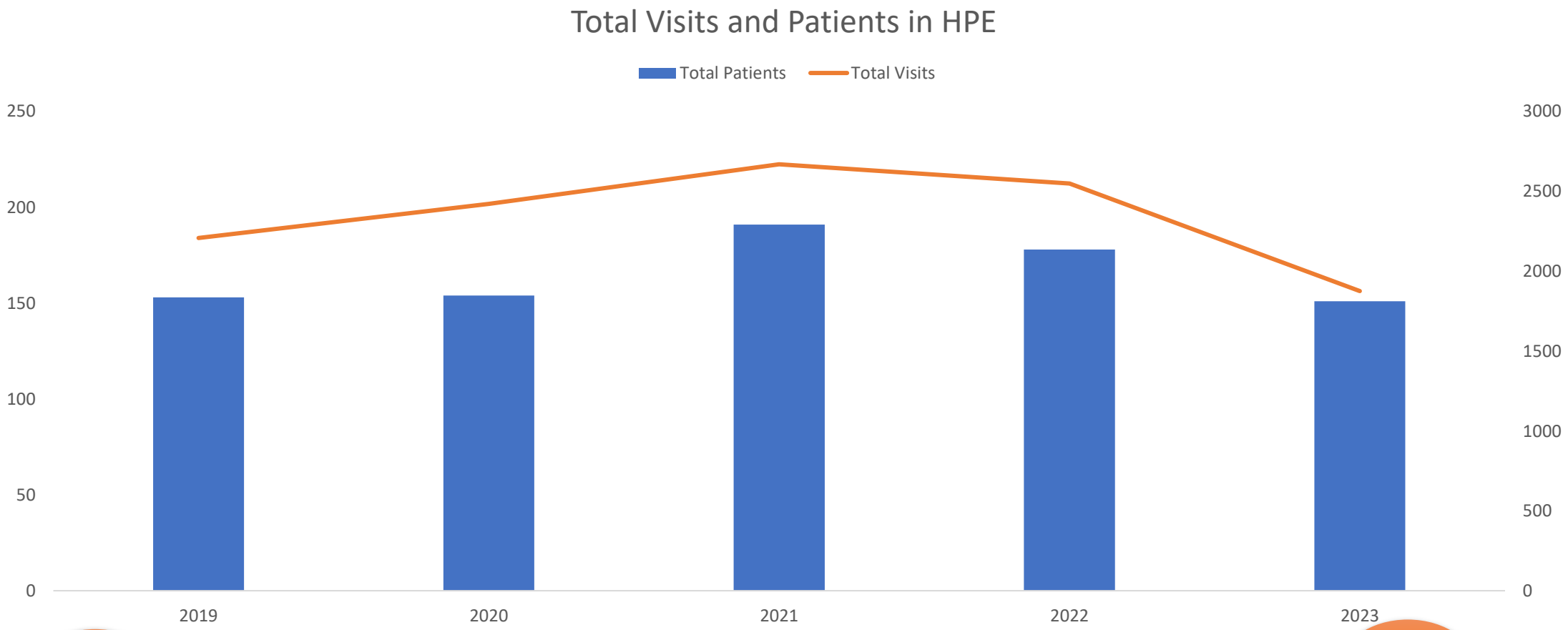
Regional Comparison – HPE



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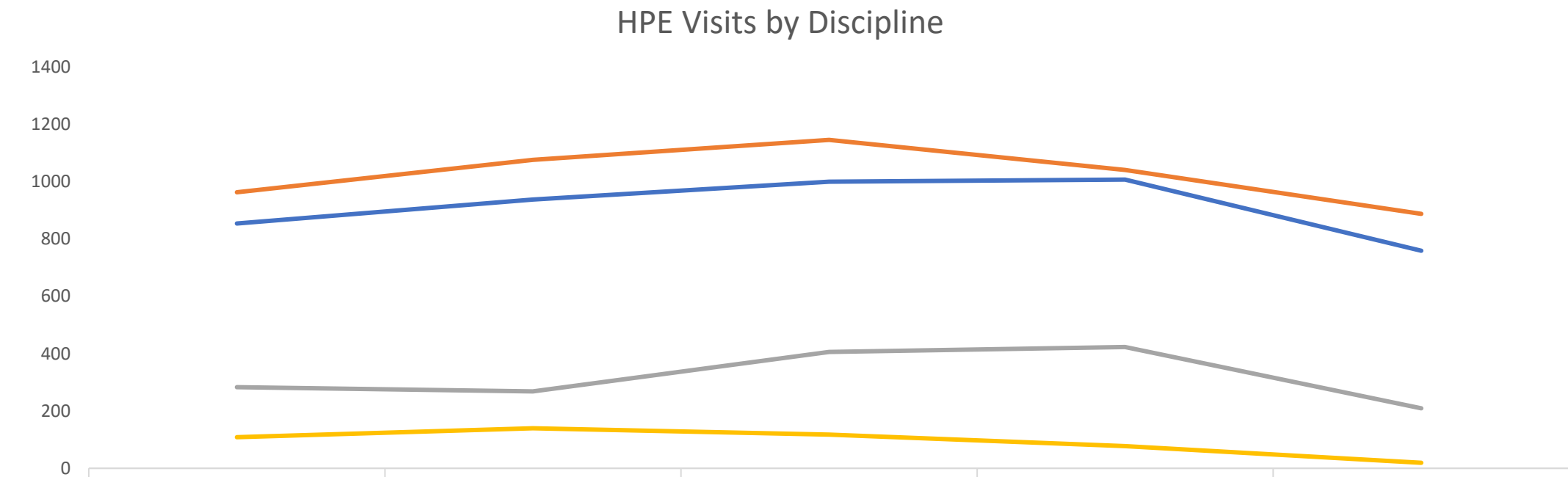
Regional Comparison - HPE



	2019	2020	2021	2022	2023
PT	854	938	1000.25	1007	759
OT	963	1076	1146	1041	888
SLP	283	268	406	423	209
SW	108	139	117	77	19

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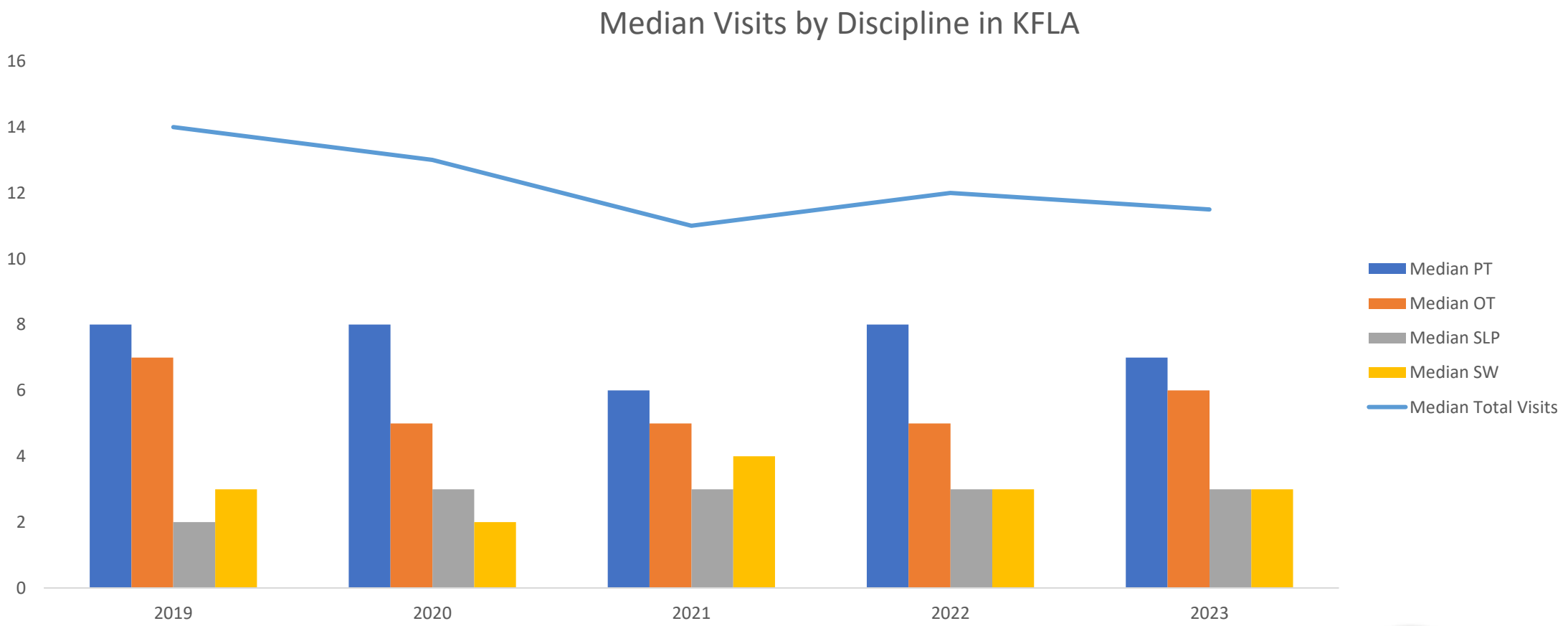
Regional Comparison – KFLA



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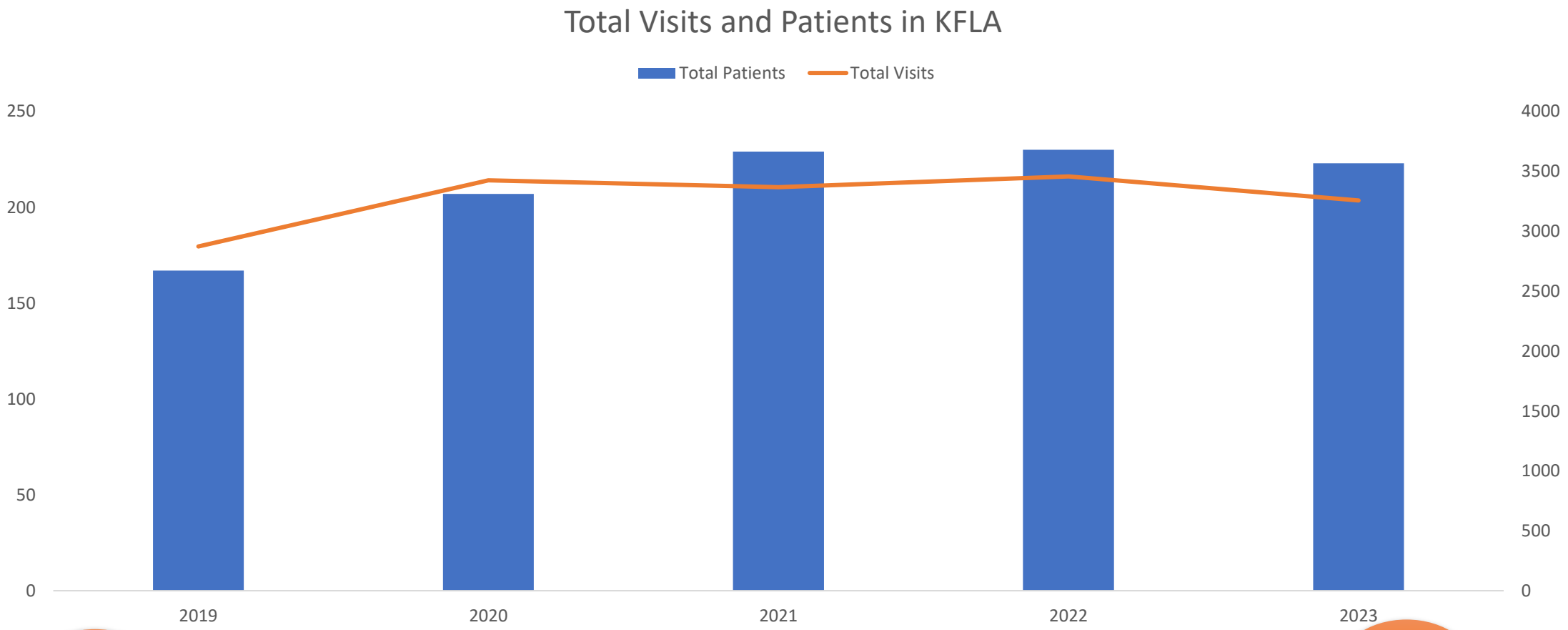
Regional Comparison – KFLA



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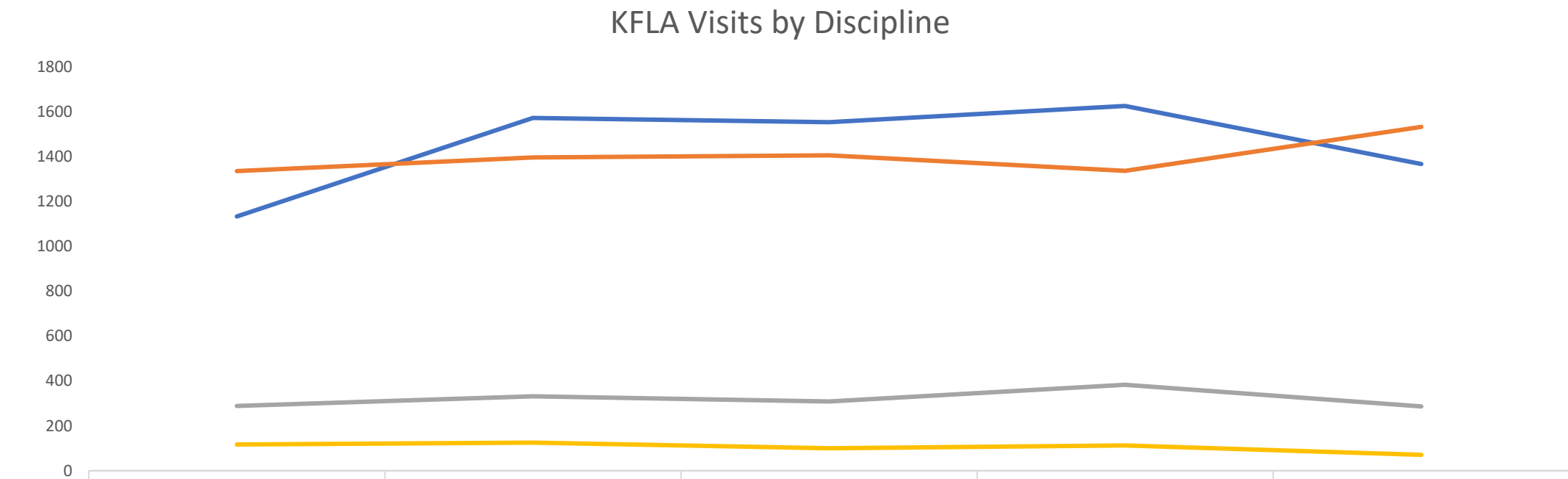
Regional Comparison – KFLA



	2019	2020	2021	2022	2023
PT	1133	1572	1553.25	1625.5	1367.5
OT	1336	1396	1406	1337	1533
SLP	288	331	308	383	286
SW	116	125	100	112	70

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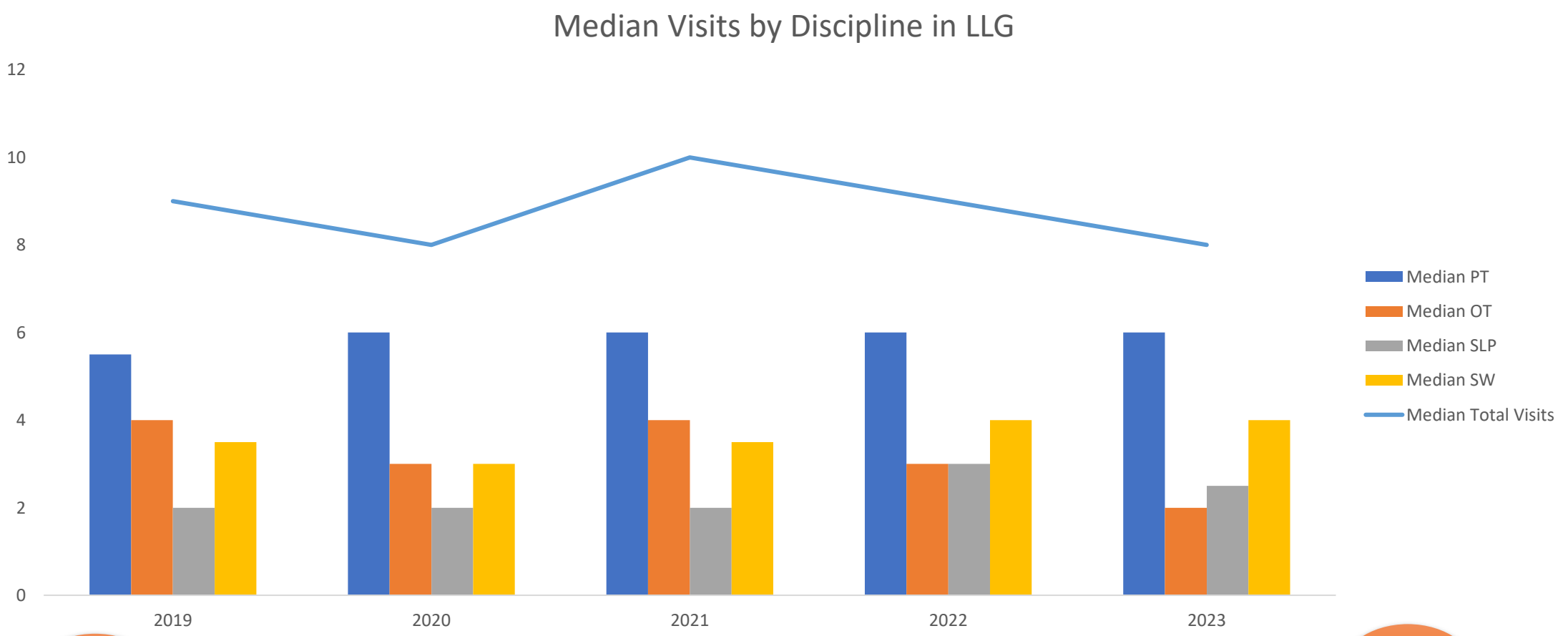
Regional Comparison – LLG



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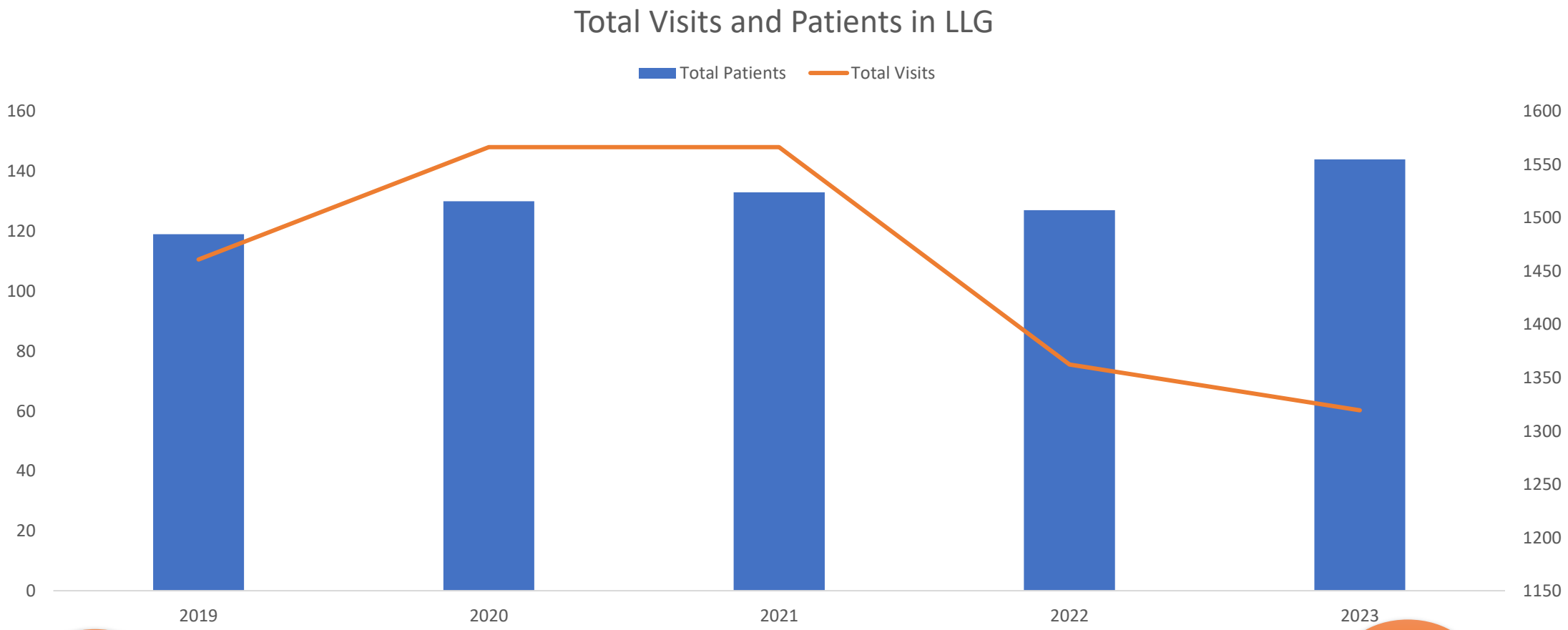
Regional Comparison – LLG



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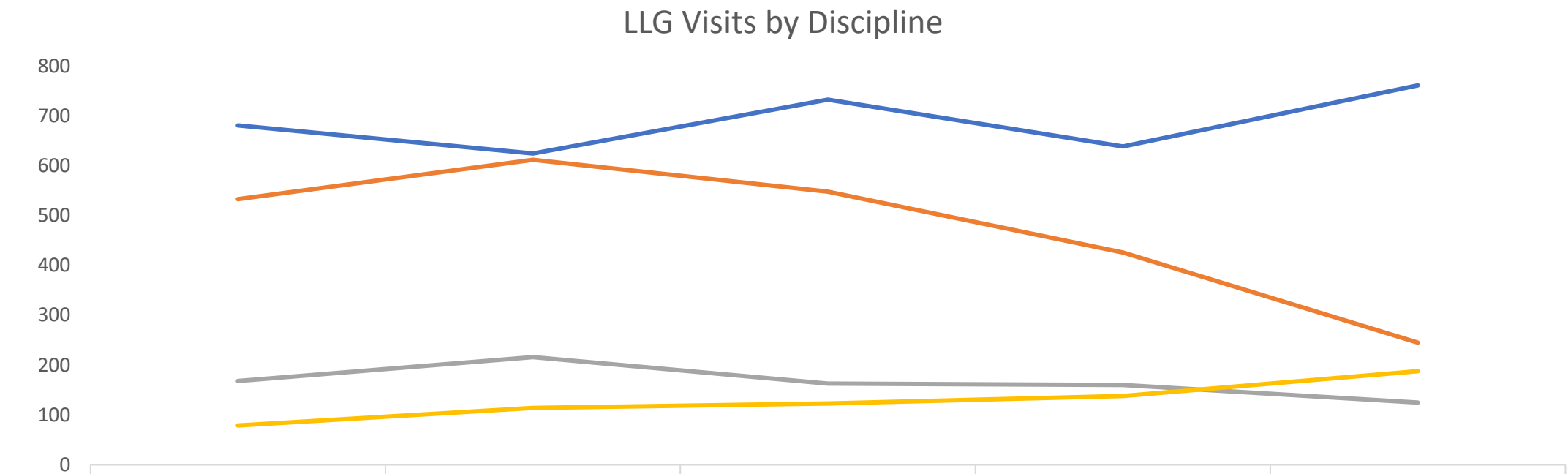
Regional Comparison – LLG



	2019	2020	2021	2022	2023
PT	681	624.5	732.5	638.5	761.5
OT	533	612	548	426	245
SLP	168	216	163	160	125
SW	79	114	123	138	188

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Quality Improvement Projects

COMMUNITY REHABILITATION PLANNING (CoRP) MEETINGS

The program can now, by exception, permit two or more additional community therapists to participate in a Community Rehabilitation Planning meeting, where warranted and with manager approval. It is well known that there are some patient circumstances for which enhanced support at this transition time is essential. These visits can either occur at once or staggered as per patient/family tolerance and availability, hospital team availability, and community therapy scheduling.

	Providence Care Hospital	Kingston Health Sciences Centre	Brockville General Hospital	Perth & Smiths Falls District Hospital	Quinte Health
2020	75	5	10	0	55
2021	94	2	7	5	63
2022	95	0	12	3	48
2023	91	1	9	5	44

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Quality Improvement Projects

PATIENT OUTCOME MEASURE – PILOT PROJECT

- HCCSS, Kaymar and the SNSEO established a pilot project to create a process for home care providers in the southeast region to administer and document a clinical outcome measure at the beginning and end of a patient's therapy program. The adoption of a common clinical outcome measure is defined in the CorHealth Ontario CSR Model of Care
- In June 2023, Kaymar began piloting a patient outcome measure with stroke patients in their therapy program. Patients were assessed on admission and discharge from the program using the Reintegration to Normal Living Index (RNLI) by a member of their therapy team. The RNLI is a common assessment tool used by CSR programs in Ontario.
- Between June and October 2023, more than 65 patients have had the RNLI completed on admission to the program.
- Staff feedback on the use of the RNLI has been collected during staff meetings and via survey.
- Next steps will include refining the process for completing the assessment and sharing lessons learned with other providers in the region.

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Quality Improvement Projects

REHAB ASSISTANT VISITS

- HCCSS SE enabled contracted providers to include Rehabilitation Assistants (RAs) in their therapy care plans. Onboarding of RAs has been ongoing in each region throughout the fiscal year.
- Providers in the Southeast began including RAs in their therapy visits in 2022/23. There were 45 patients that had RAs providing therapy visits as a part their therapy program.
- RA visits can be scheduled alongside a therapist or individually, depending on the treatment plan. RA visits are funded in addition to therapist visits in the CSRP and are necessarily not scheduled in place of a therapist.
- SNSEO has assisted by assembling a Table of Learning Opportunities for therapists and assistants shared to all CSRP Providers in the Southeast region.
- Rehab Assistant visits are also included in the visit counts for the respective discipline they are working under during a visit. Data on visits with Rehab Assistants is included in this report here.

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Quality Improvement Projects

CorHealth Community Stroke Rehab Provincial Project

Model of Care – released September 2022

- The Ministry of Health announced an investment to establish a new, comprehensive community post-stroke rehabilitation program on April 12, 2022.
- This initiative is envisioned as **a multi-year project** to enable an equitable, integrated and patient-centered system of care that supports recovery of patients after stroke. The purpose of this initiative is the planning, development, and implementation of a comprehensive post-stroke publicly funded community rehabilitation program to provide post-stroke community-based care in a consistent and equitable way.
- A current state gap analysis was completed in 2023. Results from the gap analysis showed that patients across the province had varied access to CSR, with some regions currently not offering a CSR program or only offering CSR in one setting (only in-home or outpatient clinic). Detailed results of the gap analysis were shared in August 2023 with partners and providers in the Southeast region.
- Planning meetings within each sub-region in the Southeast aimed at further aligning services to the model of care have been scheduled for November 2023.

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