Community Stroke Rehab Program Annual Report 2021-22

October 31, 2022

HOME AND COMMUNITY CARE SUPPORT SERVICES
South East

strokenetwork
SOUTHEASTERN ONTARIO

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, 2021 – March 31, 2022).

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). 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) visit.

Key Findings in 2021-22

- Total patients and visits were both down 4% from last fiscal year.
- Median total visits remained stable at 11 visits.
- The median wait time to first home therapy visit increased from 4 to 5 days.
- 78% of patients received at least one virtual visit

Need additional information? Please contact: Catherine Nicol, Home and Community Care Support Services South East at 613-544-8200 ext. 4156 or catherine.nicol@hccontario.ca **OR** Travis Wing (Stroke Network of Southeastern Ontario) at 613-549-6666 ext. 6841 or travis.wing@kingstonhsc.ca

Home and Community Care Support Services South East
Community Stroke Rehab Program 2021/2022

549 admissions to the Community Stroke Rehab Program, a decrease of 4% from the previous fiscal year.

81% of patients received visits from at least two disciplines. 7% of patients received visits from all four disciplines.

Median time to first therapy visit increased from 4 to 5 days.

Individuals in rural settings had lower average of PT & OT visits.

158 Community Rehab Planning Meetings. 29% of CSRP Patients received a CoRP Meeting.

78% of patients received at least one virtual visit from their therapist:
PT 58% | OT 70% | SLP 41% | SW 42%

HOME AND COMMUNITY CARE SUPPORT SERVICES
South East

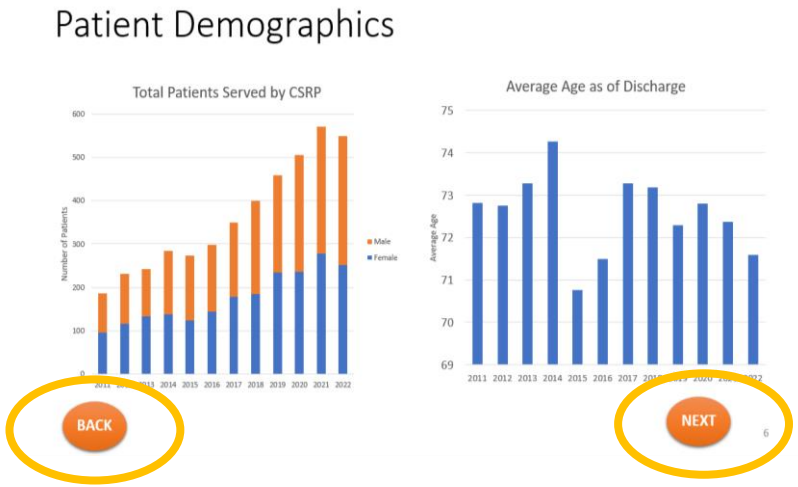
strokenetwork SOUTHEASTERN ONTARIO

Navigation

- 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 the 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

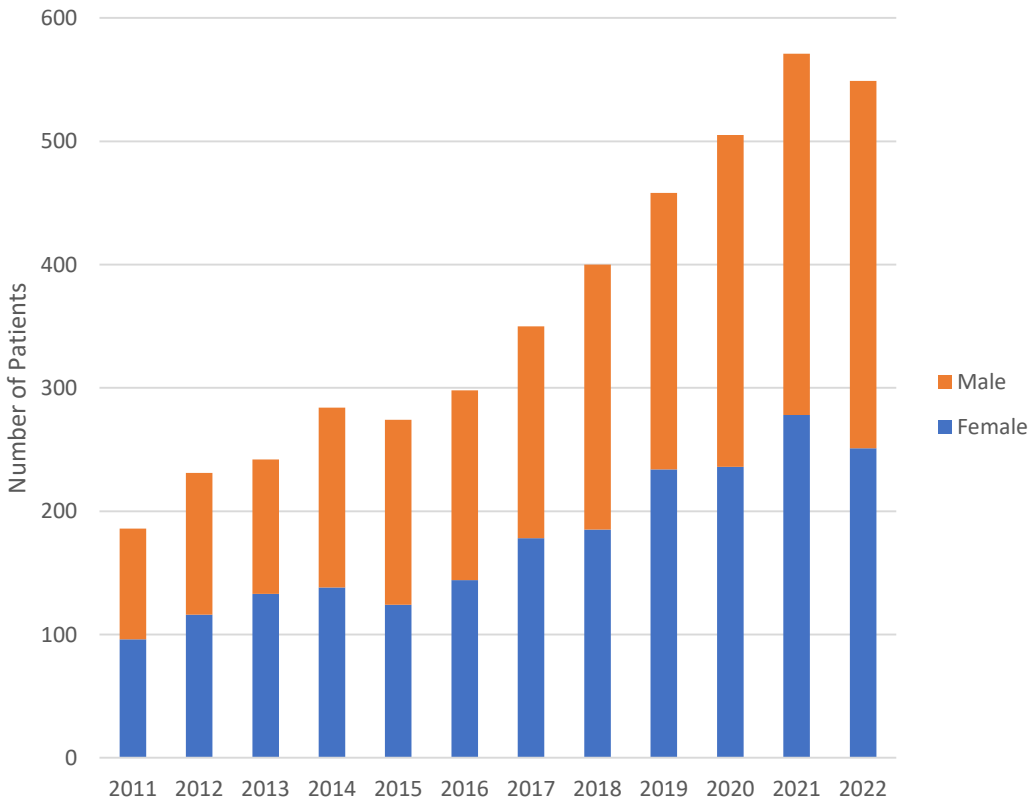
Therapy Visits

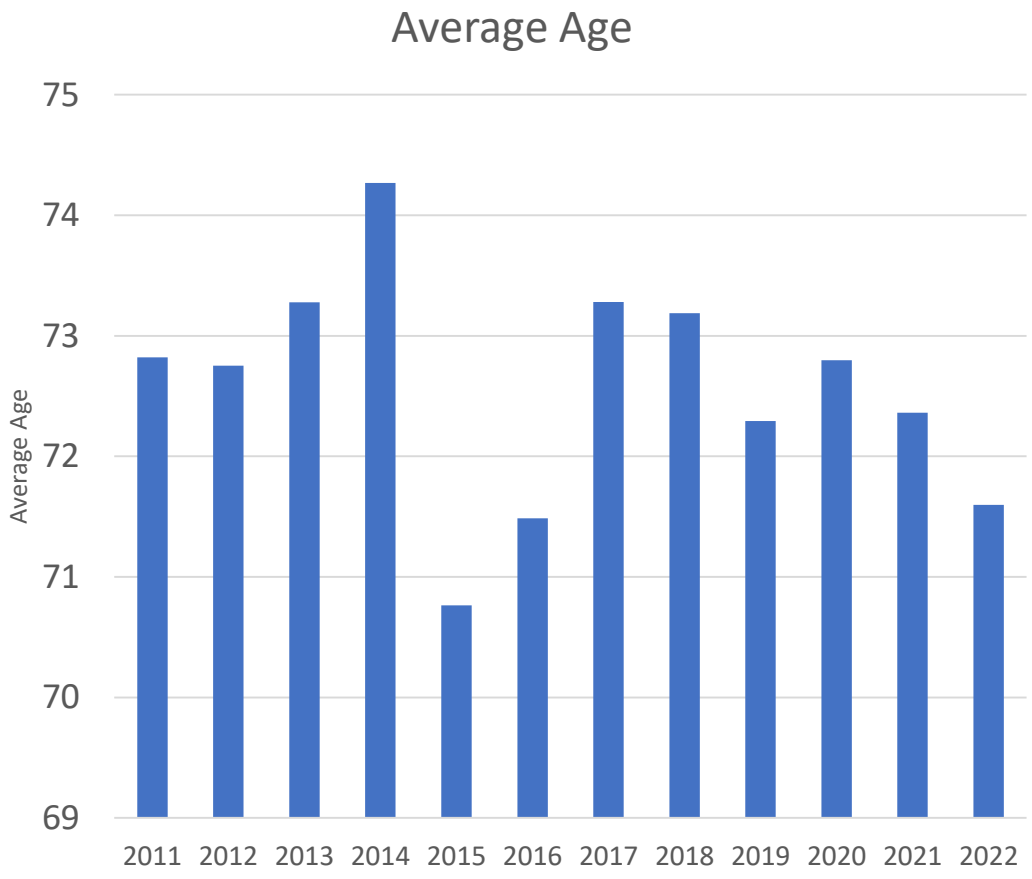
Wait Times

Regional Comparison

Quality Improvement Projects

Patient Demographics





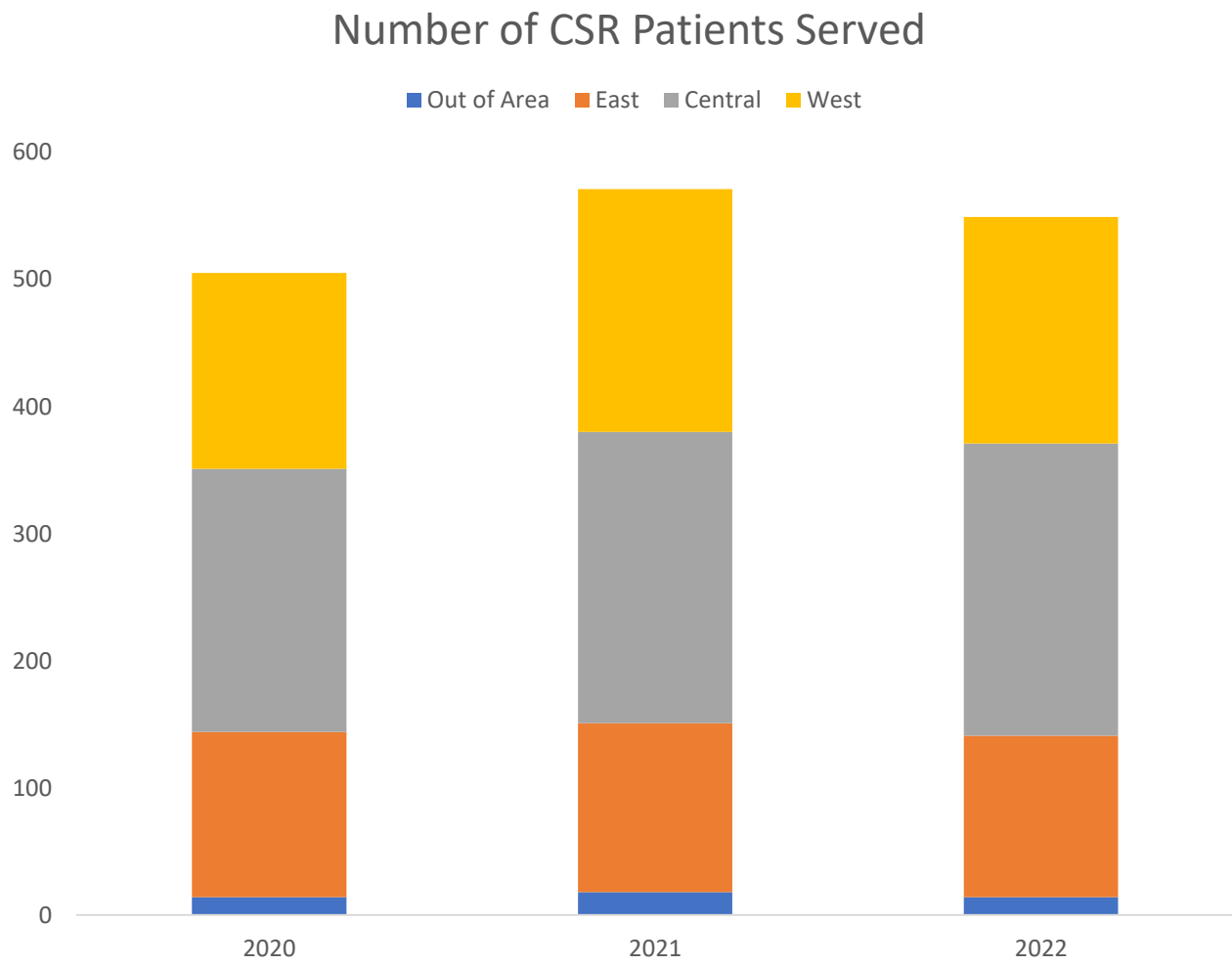
BACK

NEXT

Patient Demographics

The number of patients receiving CSR in 2022 decreased from the previous year from 571 to 549. The largest decrease in patients was seen in the West region.

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



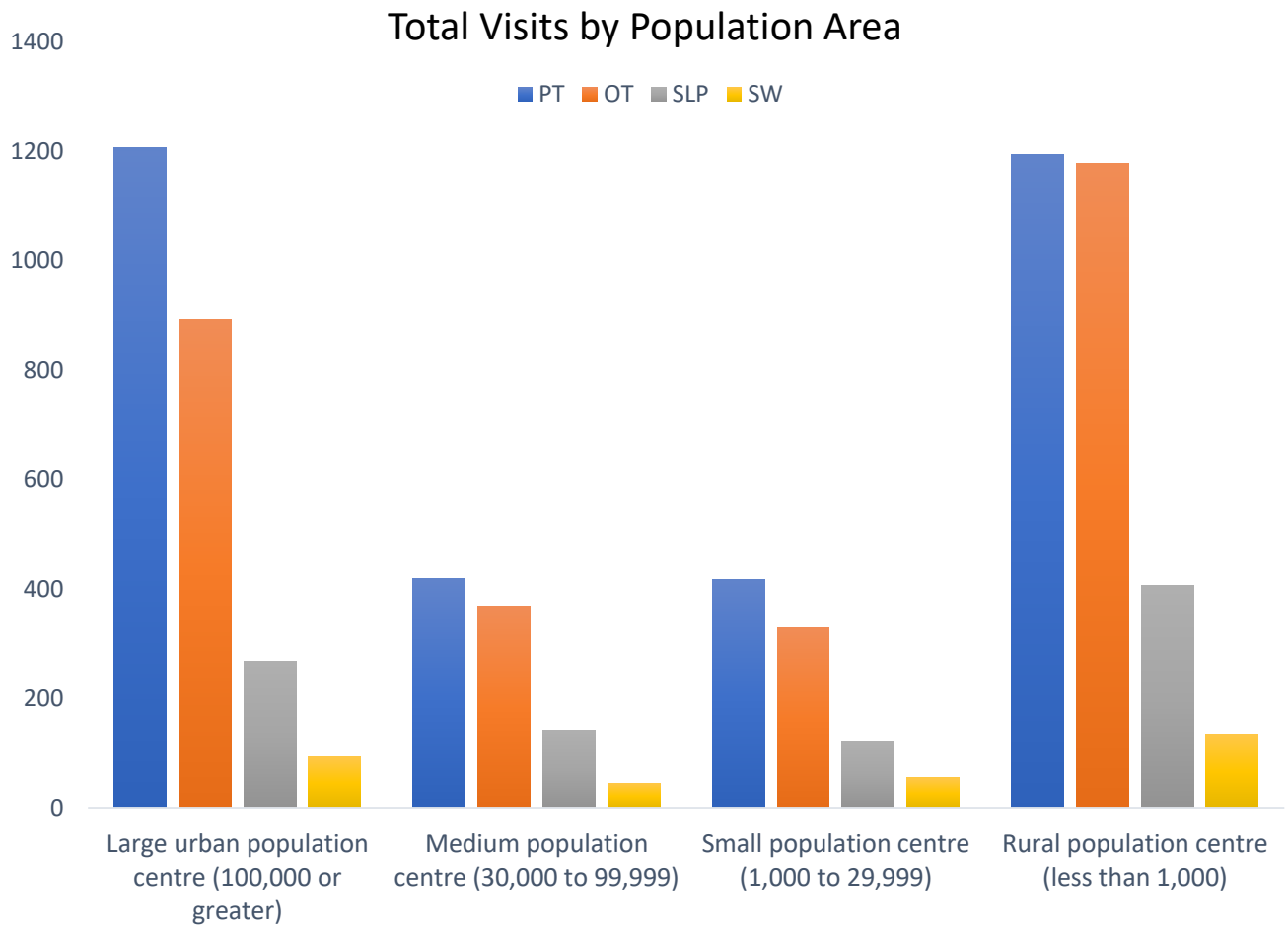
BACK

NEXT

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 region.



BACK

NEXT

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 program. Patients discharged from a rehab setting may also be referred to the RRN 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.

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

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.

BACK

NEXT

Program Summary and Resources

Reminders

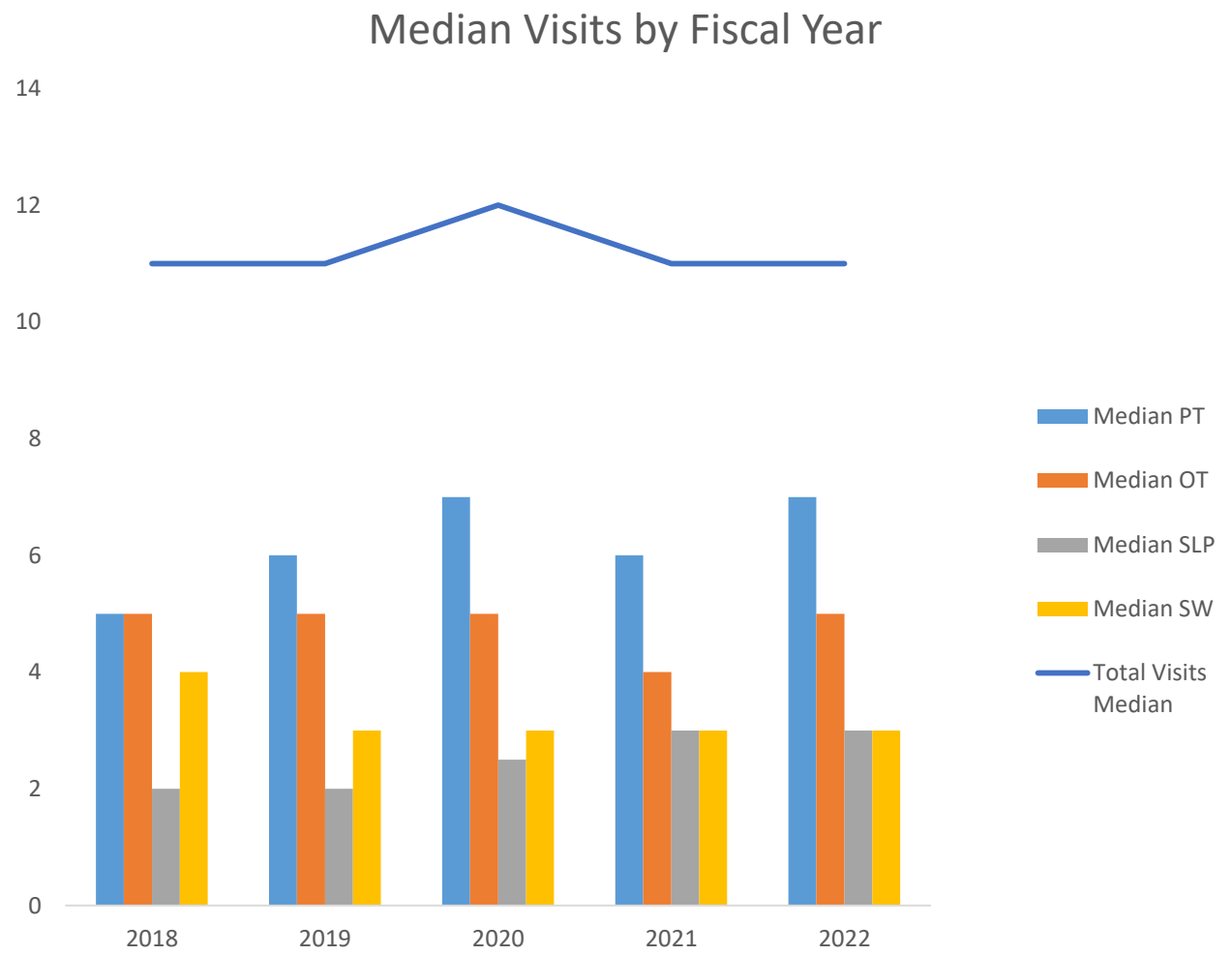
- Consider referral to **Stroke Survivor and Caregiver Support Groups**, **Stroke Specific Exercise Programs** and **Aphasia Supportive Conversation Groups** and to other community exercise programs and supports when appropriate. A community rehab visit may be used by the community provider to connect 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.

BACK

Therapy Visits

The median number of total therapy visits remained stable over this year, with physiotherapy providing the largest median visit volume in the Southeast.

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



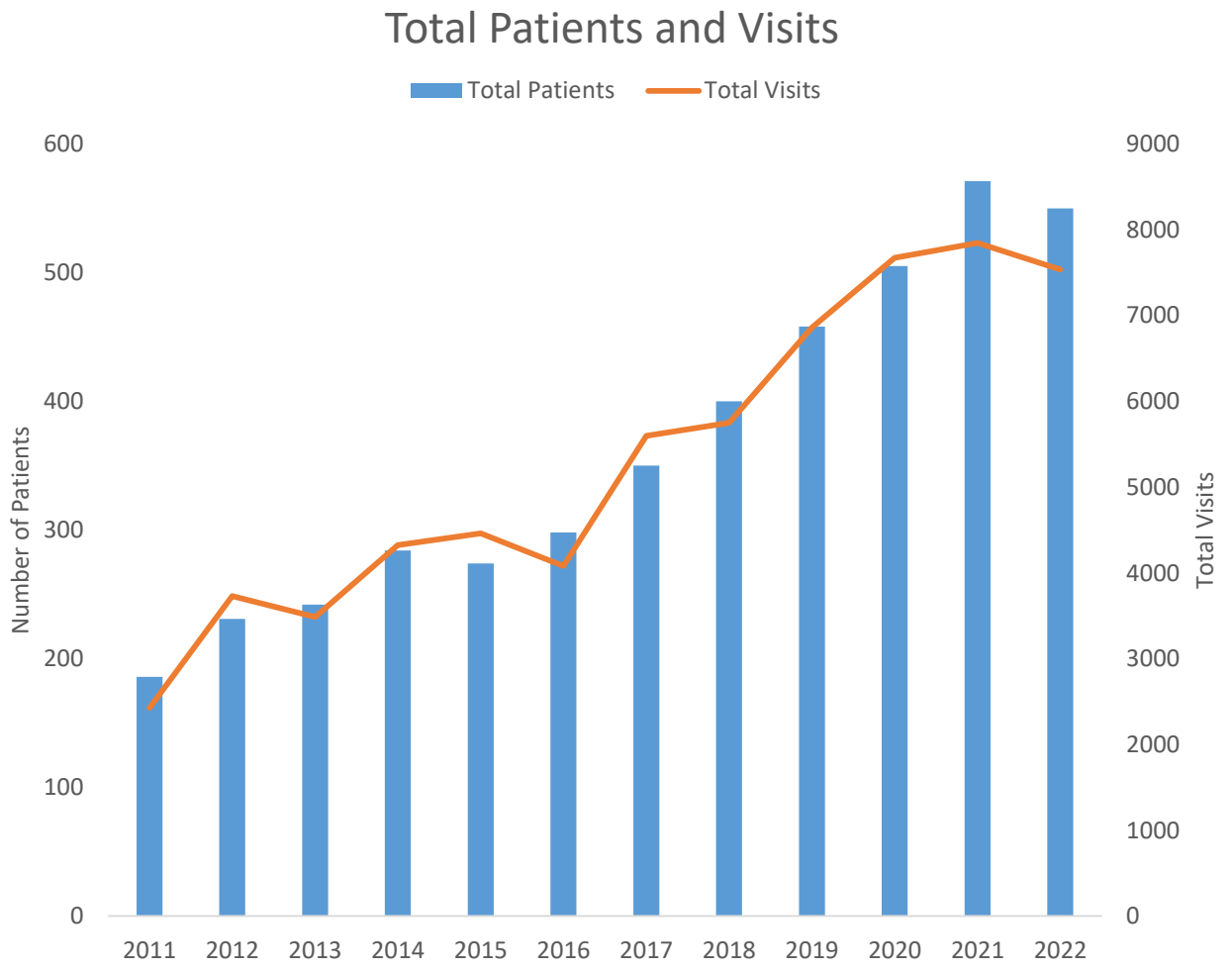
BACK

NEXT

Therapy Visits

The number of patients and total visits were both down slightly in 2021-22.

- Total Visits: 7,537
- Total Patients: 549

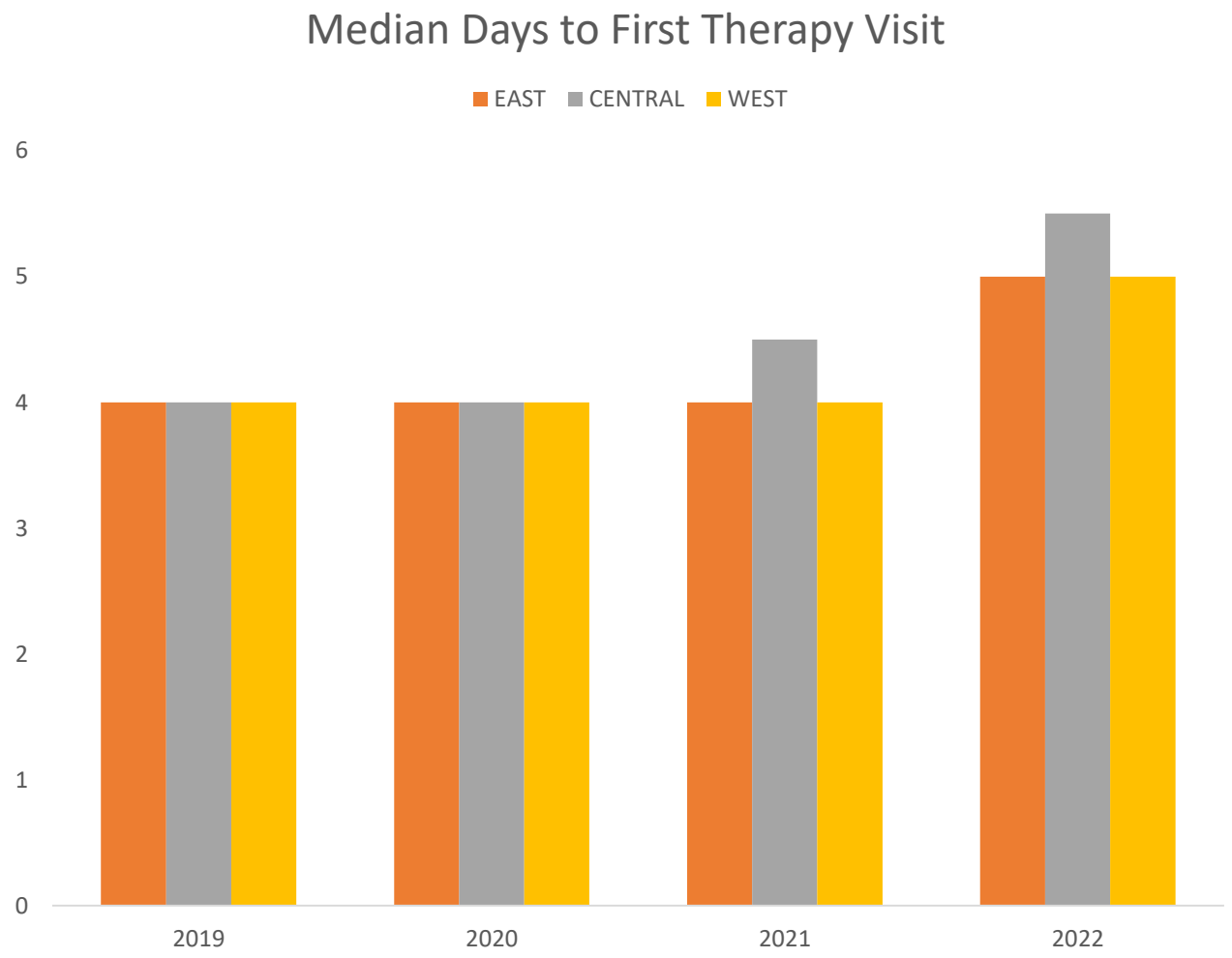


BACK

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 all regions of the Southeast over the past fiscal year.



BACK

NEXT

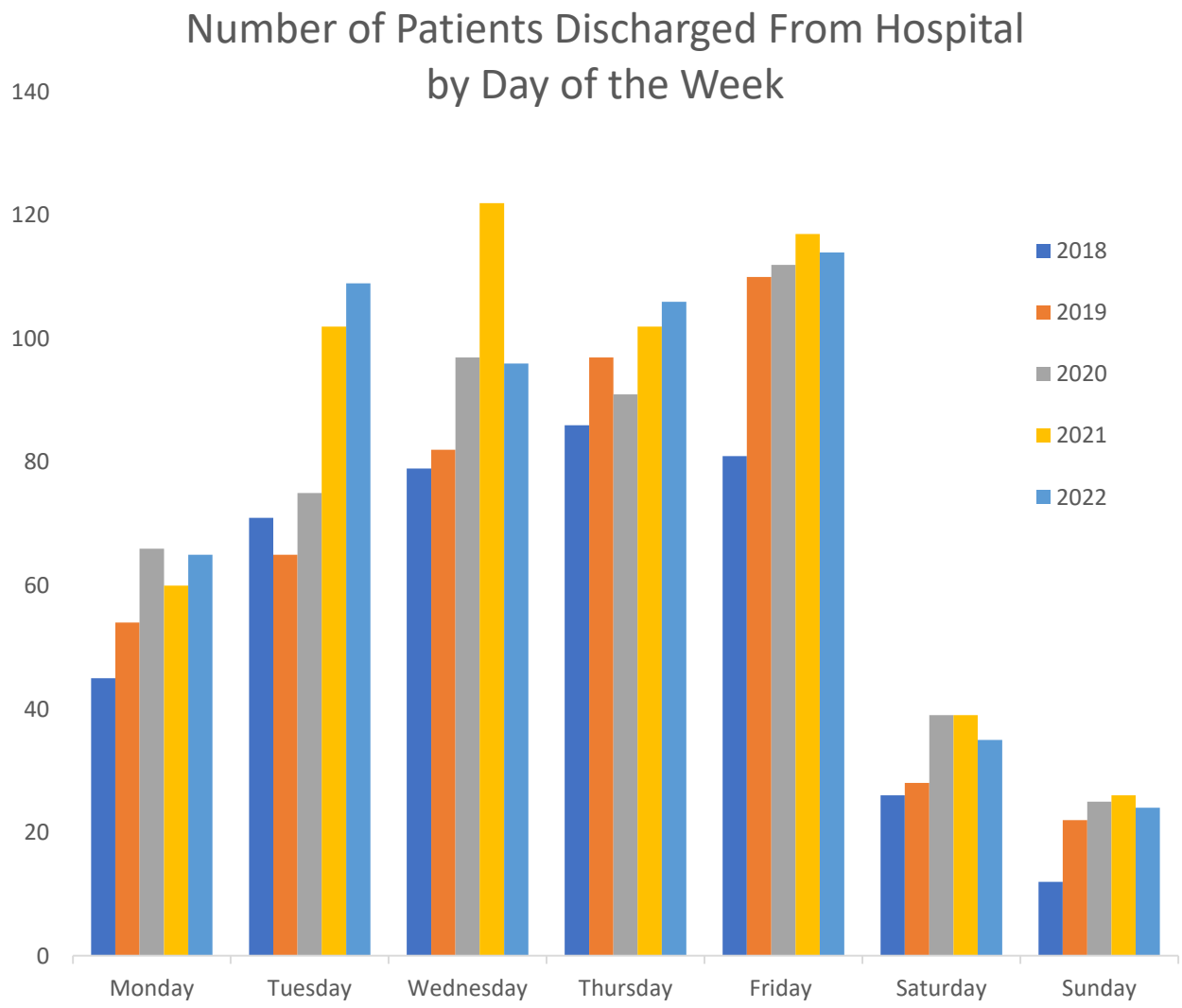
Wait Times

In 2022, the median wait time for first therapy visit increased to 5 days. Wait times for can be influenced by hospital discharge day of the week.

The *new* 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



BACK

EAST
LLG

CENTRAL
KFLA

WEST
HPE

ALL

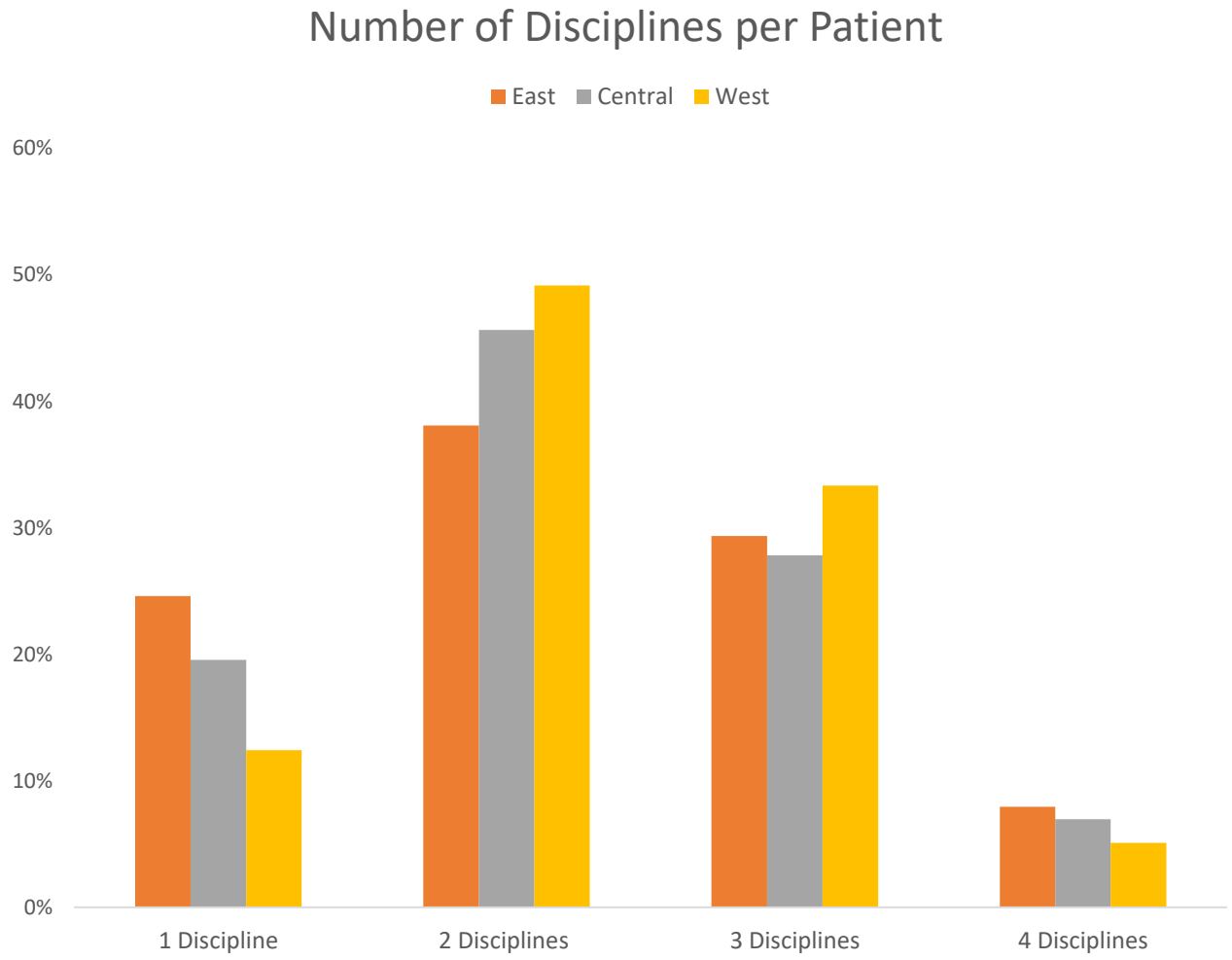
BACK

Regional Comparison – All Regions

Patients referred to the Community Stroke Rehab program receive may see:

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

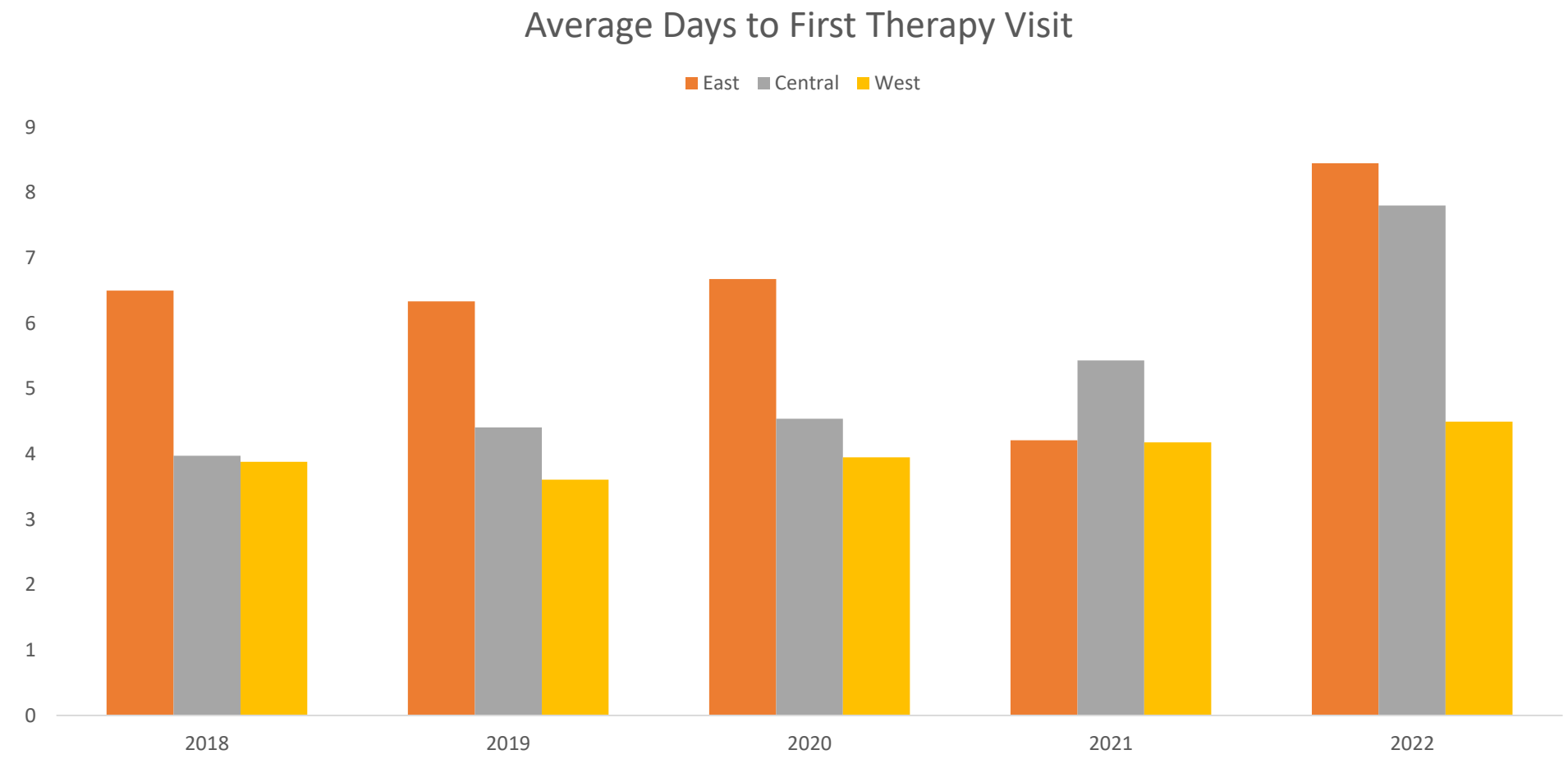
This graph outlines the proportion of patients therapy visits from multiple disciplines in the Southeast.



BACK

NEXT

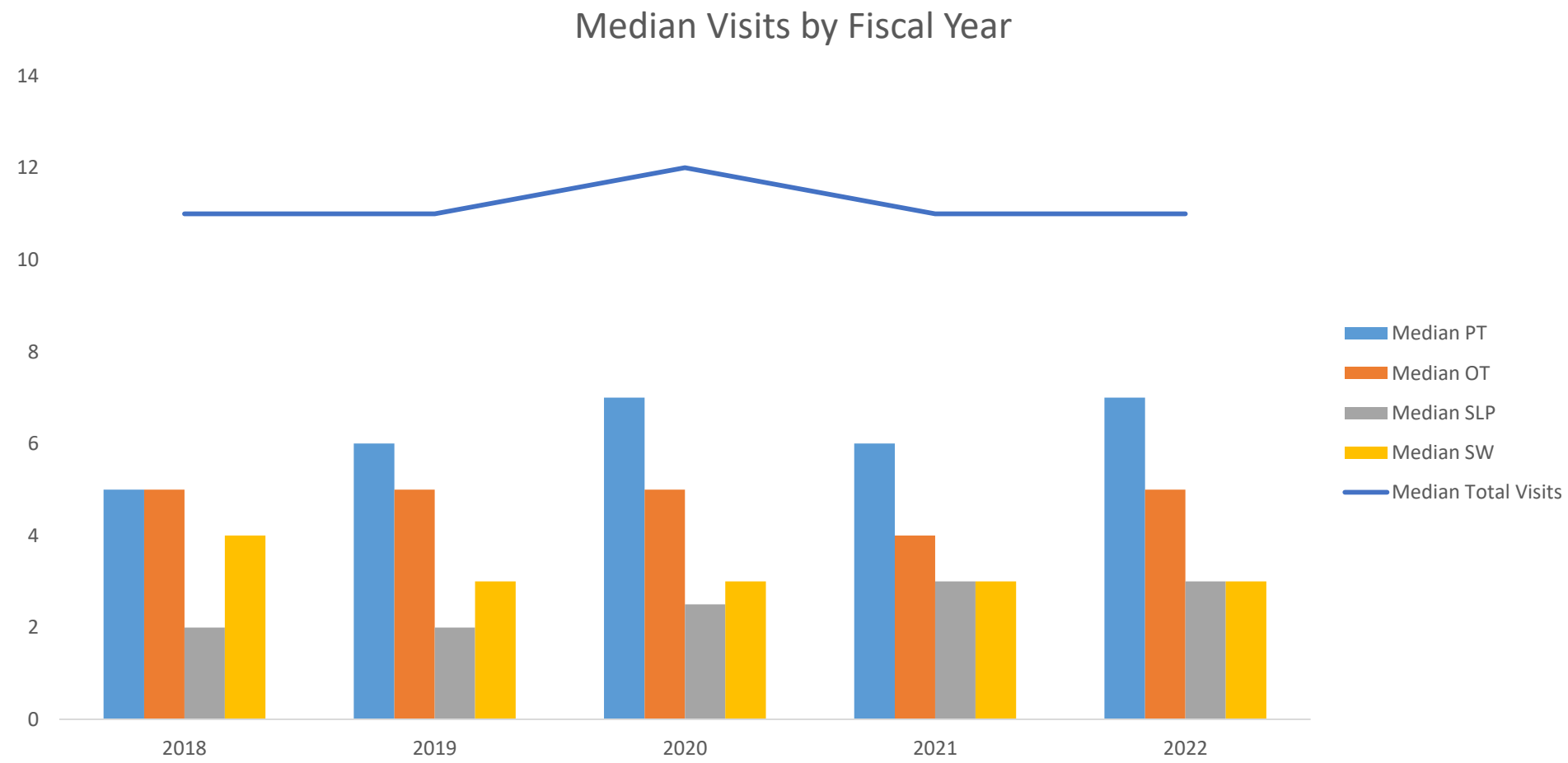
Regional Comparison – All Regions



BACK

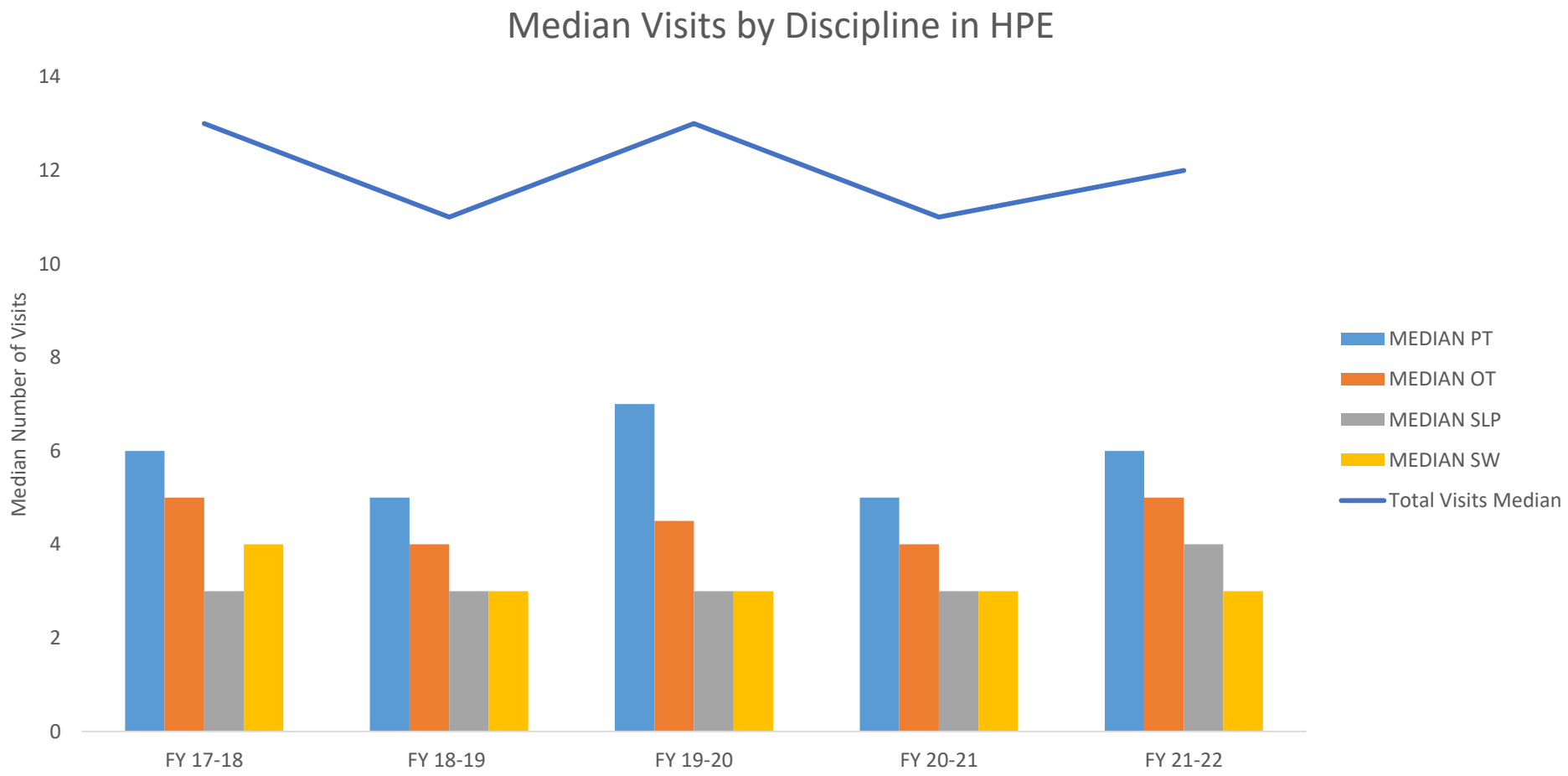
NEXT

Regional Comparison – All Regions



BACK

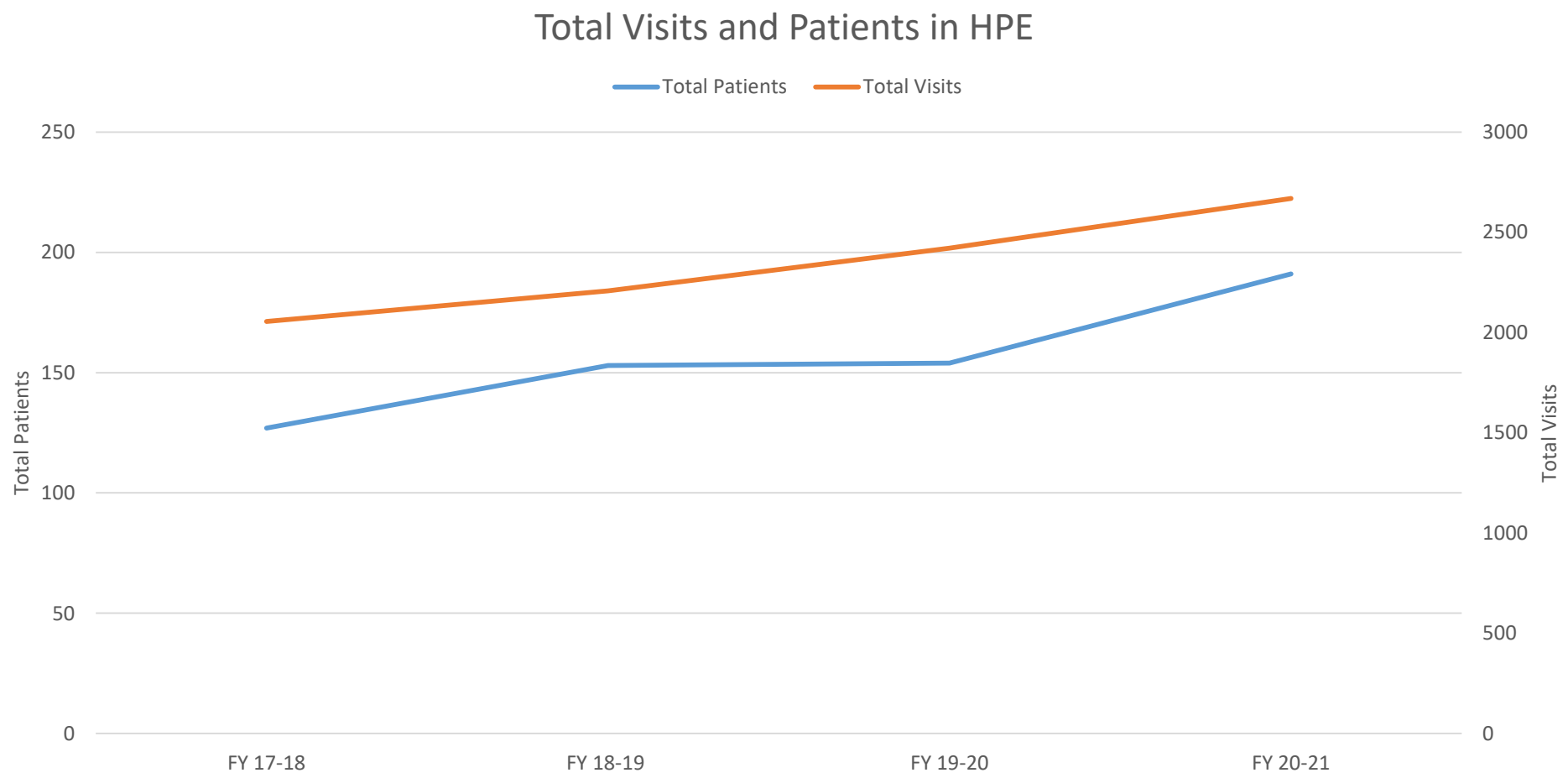
Regional Comparison – HPE



BACK

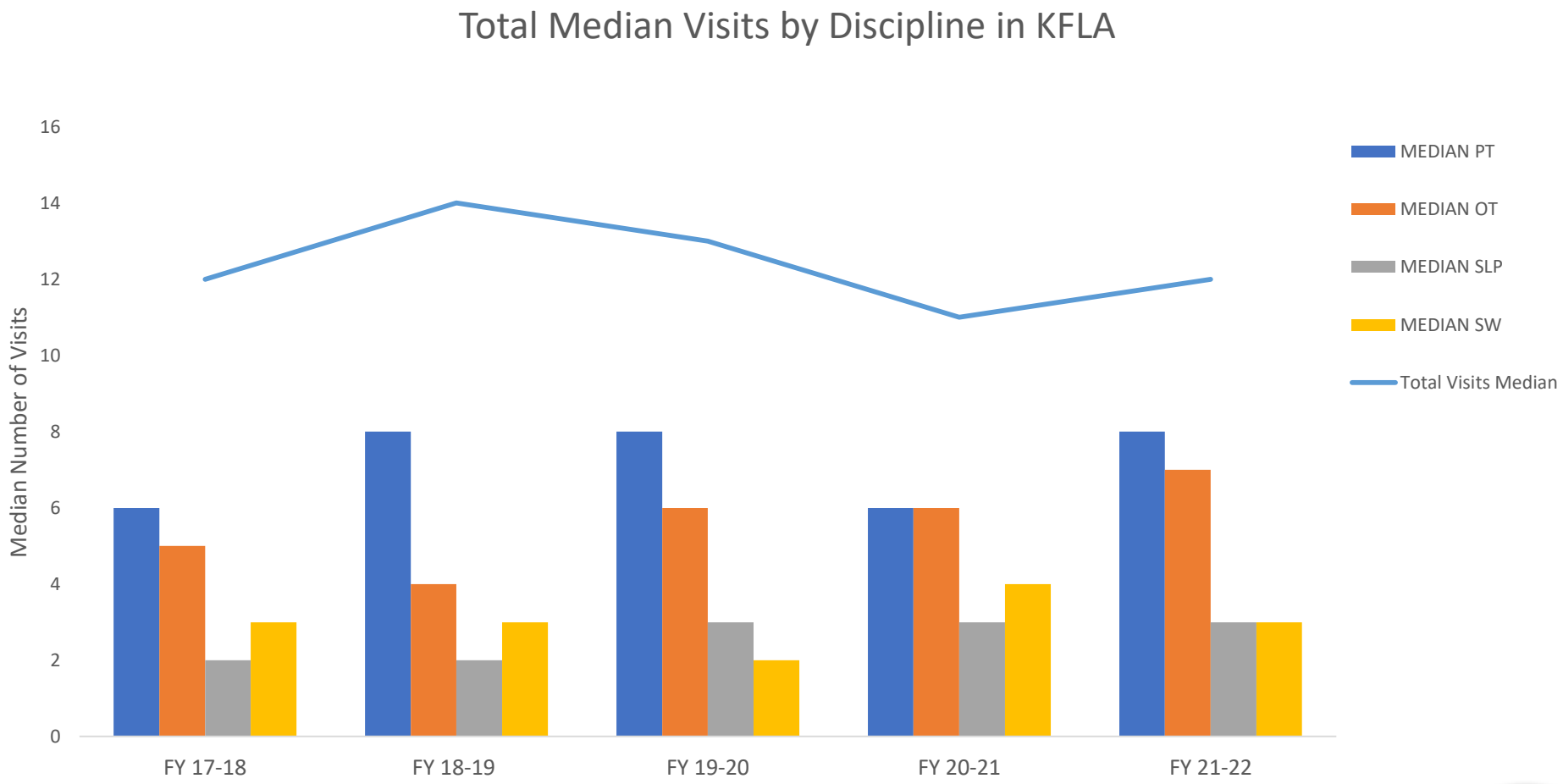
NEXT

Regional Comparison – HPE



BACK

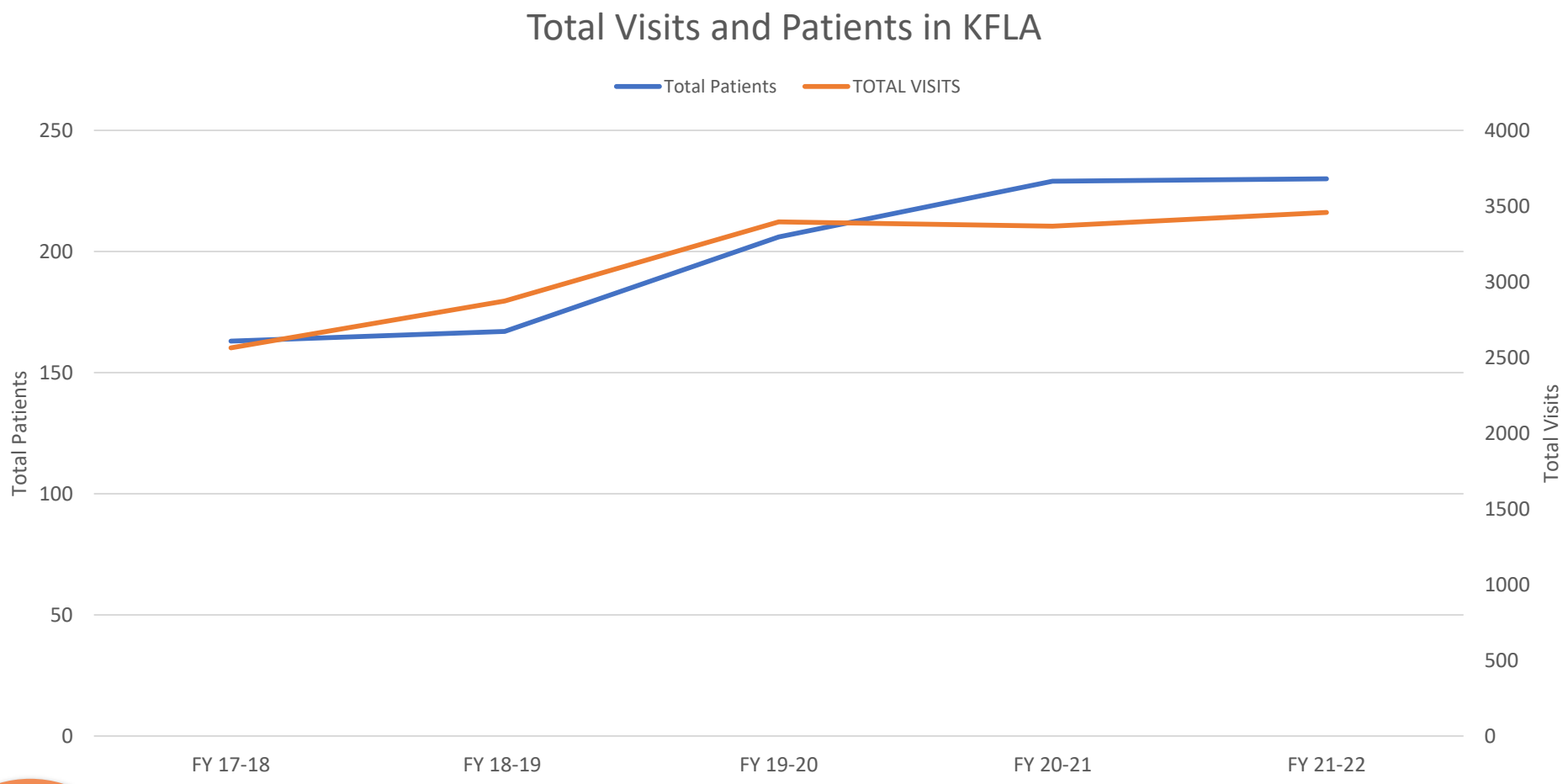
Regional Comparison – KFLA



BACK

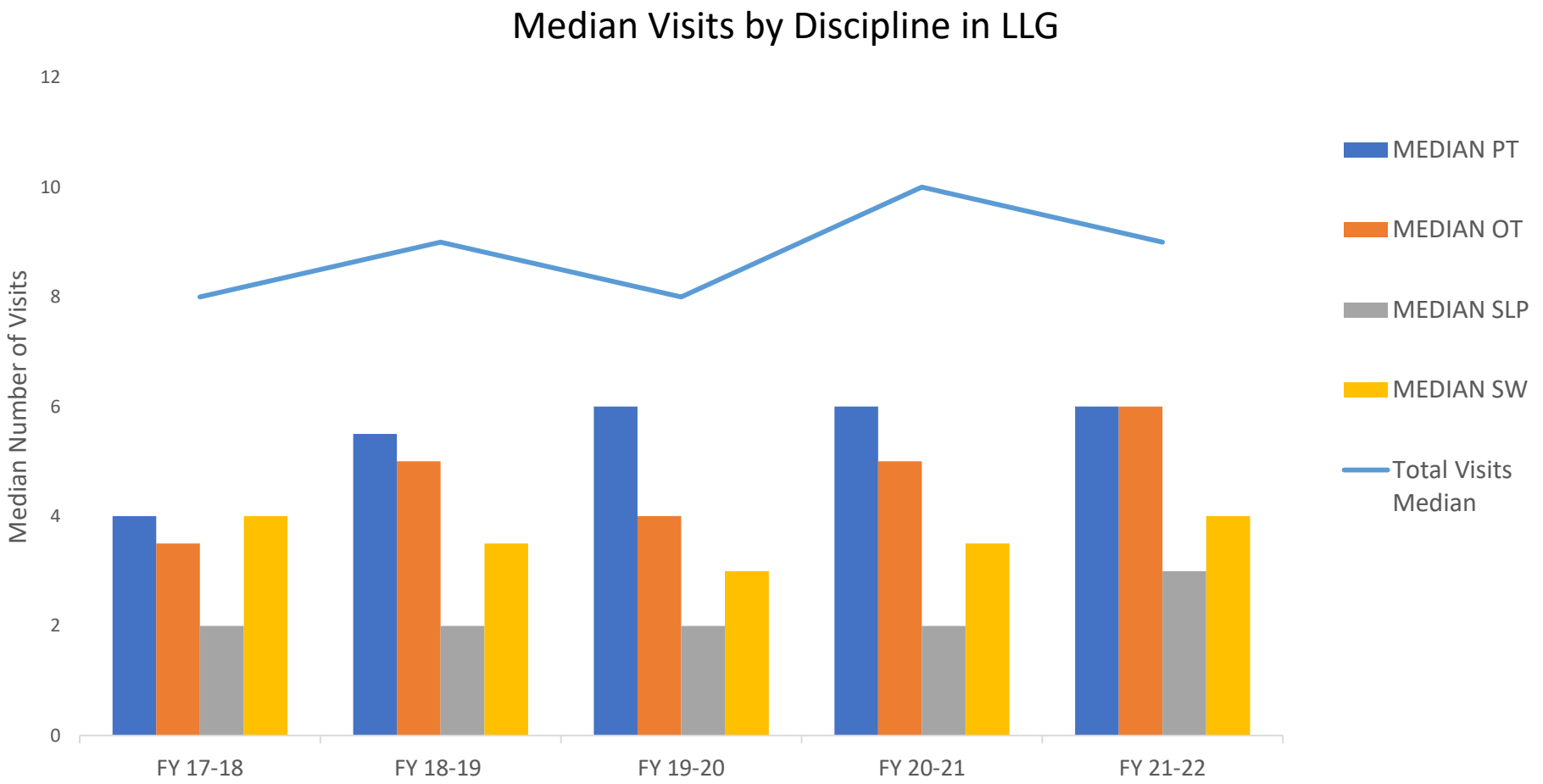
NEXT

Regional Comparison – KFLA



BACK

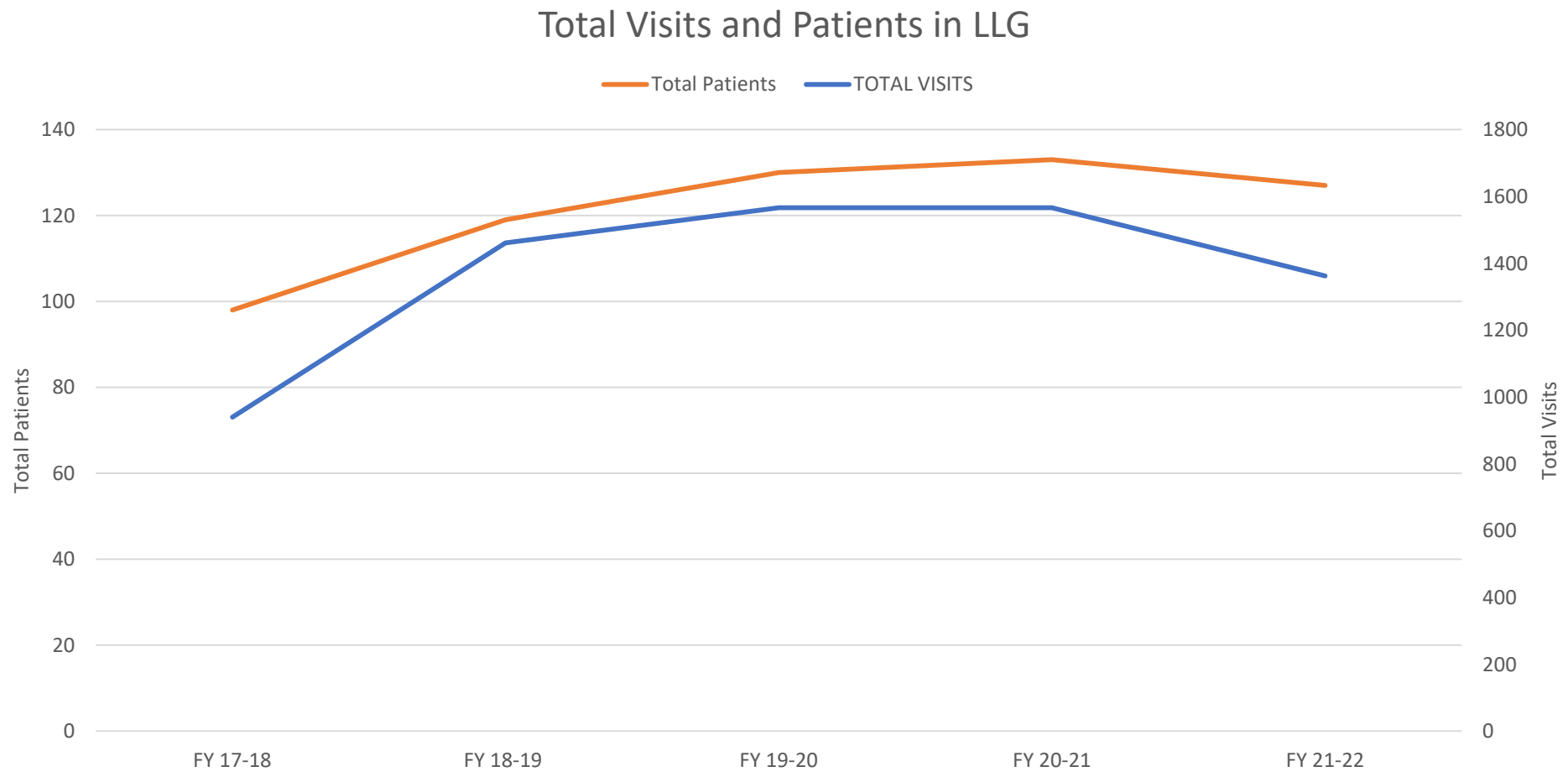
Regional Comparison – LLG



BACK

NEXT

Regional Comparison – LLG



BACK

Quality Improvement Projects

COMMUNITY REHABILITATION PLANNING (CoRP) MEETING UPDATE FALL 2022

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.

For example:

- Complex stroke patient with significant impacts in two or more domains (e.g. physical, cognitive and/or communication/swallowing),
- Patients with no or little supports (e.g., live alone, have access to little or no family/informal caregiver support)
- Patients living with significant functional co-morbidities, and/or
- Patients requiring unique intervention strategies (e.g., have a mental health or dementia diagnosis, are at higher risk for developing comorbidities, or who experience failure to cope).

These visits can either occur at once or staggered as per patient/family tolerance and availability, hospital team availability, and community therapy scheduling.

BACK

NEXT

Quality Improvement Projects

REHAB ASSISTANT VISITS

- Home and Community Care Support Services South East enabled contracted providers to include Rehabilitation Assistants (RAs) in their therapy care plans.
- RAs have participated in additional education and training supported by the SNSEO
- SNSEO has assisted by assembling a Table of Learning Opportunities for therapists and assistants shared to all CSRP Providers in the Southeast region.
- Future SE CSRP reports will include RAs in summarizing the number and frequency of therapy visits patients received.

BACK

NEXT

Quality Improvement Projects

CorHealth Community Stroke Rehab Provincial Project

Model of Care – 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.
- CorHealth, with engagement from over 70 experts, has released a CSR Model of Care document.

Provincial Project Next steps:

- Inventory and Gap Analysis
- Development of Minimum Data Set
- Complete Ideal State of Access to CSR
- Early fund distribution to CSR Providers
- Multi-year plan budget submissions for FY 23/24

BACK