STROKE NETWORK *of* Southeastern Ontario

Communiqué – June 2017
Enhanced Community-Based LHIN Rehabilitation Services for Stroke Survivors

Background:

Timely, enhanced home-based rehabilitation services have been provided to new stroke survivors in Southeastern Ontario since February 2009 through LHIN-funded (formerly CCAC) services.

Eligible stroke survivors receive **enhanced** Physiotherapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP) and Social Work (SW) services following discharge to the community, including Long-Term Care (LTC). These services are provided through the South East LHIN, with the exception of PT in the LTC home setting where LTC home physiotherapy providers are utilized (funded separately).

Service plans that focus on goals identified by the client and their family are initially developed by the hospital interprofessional stroke team, with the LHIN Care Coordinator. Collaborative care planning occurs across the hospital-community sectors through Discharge Link (DL) meetings for those returning home. For LTC settings, an interprofessional care planning conference is scheduled following the client's admission to the LTC home.

This communiqué provides an overview of services since the program began in 2009. This annual Communiqué is released each June, with data continuing to be reported per fiscal year (April 1 – March 31).

Note: Glossary of acronyms can be found at bottom of Page 7

KEY FINDINGS 2016-17

- Referrals to the program continue to increase (up by 48 referrals from previous fiscal year)
- Proportion of referrals from rehab continue in a slight downward trend while referrals from acute care are trending upwards
- Increase in Discharge Link Meetings for Providence Care Hospital and Quinte Health Care
- Median wait time remains stable at 4 days to first therapy visit
- Significant increase in total number of OT and PT visits as compared to previous fiscal
- Average visits after acute care: OT 4.8, PT 6.7, SLP 3.7 and SW 3.6. Average visits after rehab: OT 8.8, PT 10.1, SLP 6.4, SW 3.2 (OT, PT visits increased over last year)
- Continue to consider **Social Work Services for all clients.** This service is **frequently underutilized**.
- Continue to consider referrals for clients transitioning to LTC. A lengthy wait time to access LTC does **NOT** preclude the client from being eligible for those services**.**

What's next? The Stroke Network of Southeastern Ontario, along with the South East LHIN Home and Community Care teams, will work collaboratively to make improvements to the Enhanced Community-Based Rehabilitation Program for Stroke Survivors. Efforts will focus on responding to feedback from clients, caregivers and providers, and moving towards better alignment with Quality-Based Procedures for Stroke. Opportunities to include patient experiences/outcomes in the annual evaluation process is also being considered. If you are interested in other Home Based-Community Stroke Rehabilitation programs, a provincial report was released in August 2016 and can be accessed here.

Ontario
South East Local Health Integration Network

Annual Review of Enhanced Rehabilitation Services

TABLE 1 - Referrals to Enhanced Therapy Program

FISCAL	n - Participants	n – Referred to community	n – Referred to LTC
Feb. 2009 – March 2010	173	145	28
April 2010 – March 2011	182	153	29
April 2011 – March 2012	236	226	10
April 2012 – March 2013	242*	228	13
April 2013 – March 2014	271	256	15
April 2014 – March 2015	270	260	10
April 2015 – March 2016	281	276	5
April 2016 – March 2017	329	320	9
TOTALS TO DATE	**1984**	**1864**	**119**

*** 1 unknown destination**

There was a significant increase (n=48) in referrals to the Enhanced Rehab Program in fiscal 2016/17.

TABLE 2 - Enhanced Rehab Program Admissions/Total Unique ED Visits for Stroke Admissions

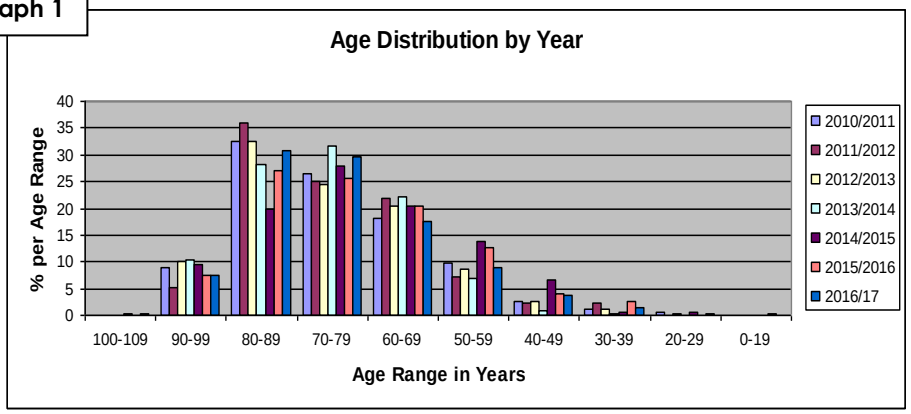
Fiscal	Total unique ED visits with Stroke	# Admitted to Enhanced Rehab	% Admitted to Enhanced Rehab
2009/2010	921	173	**18.8**
2010/2011	887	182	**20.5**
2011/2012	887	236	**26.6**
2012/2013	918	242	**26.4**
2013/2014	1143	271	**23.7**
2014/2015	1232	270	**21.9**
2015/2016	1282	281	**21.9**

Using the most recently available data from the Canadian Institute of Health Information (CIHI) 2015/16, the total reported number of individuals with stroke has continued to increase since 2011/12. Referrals to the Enhanced Rehab Program as a percentage of the total unique ED visits for people experiencing a stroke remained stable as compared to the previous fiscal. Note: This data is up to 2015/16 only. (Table 2)

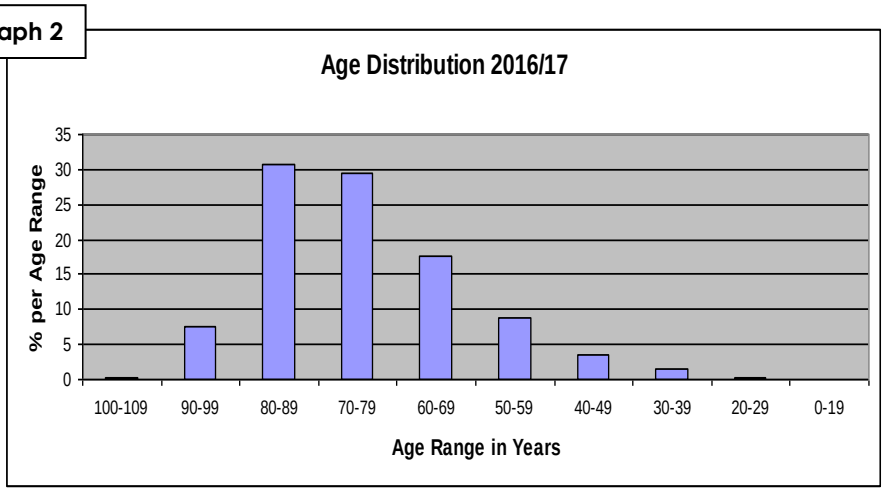
TABLE 3 - Average & Median Ages of Clients Referred to Enhanced Therapy Program

	Fiscal 10/11	Fiscal 11/12	Fiscal 12/13	Fiscal 13/14	Fiscal 14/15	Fiscal 15/16	Fiscal 16/17
Average Age (years)	74	74	74.5	75.5	70.7	71.6	73.6
Median Age (years)	76	77	77	76	72	73	76

Graph 1

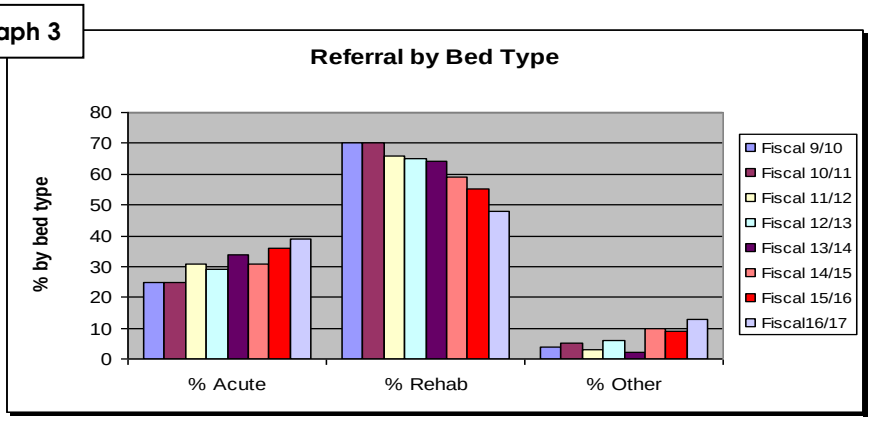


Graph 2



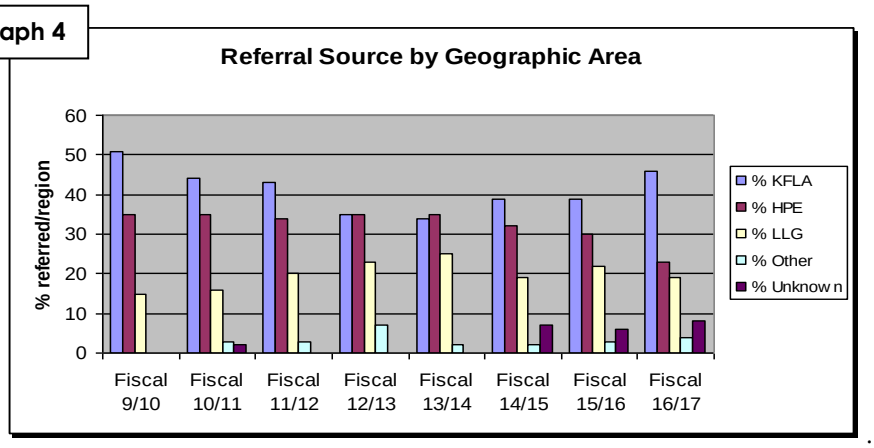
Both the average and median ages increased during this reporting period compared to the two previous fiscals – the oldest client admitted to the program was 101 and the youngest was 23. Increases were seen in the 70 to 89 age range.

Graph 3



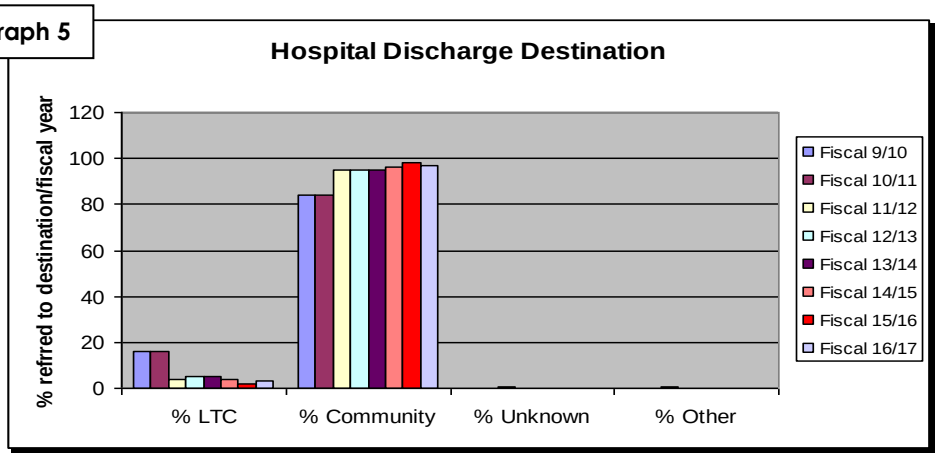
Referrals are primarily received from rehabilitation and acute care hospitals, with a smaller number of referrals originating from other sources such as other LHINs, LTC, private dwellings and out-of-region hospitals (n=14) (Graph 3). The sources of the remaining referrals are unknown (n=27). Referral rates from rehabilitation beds continue to constitute the majority of referrals at about 48 per cent, however the percentage has continued on a downward trend. Referrals originating from acute constituted about 39 per cent continuing an upward trend from last fiscal. Referrals from other sources saw an increase to about 13 per cent (n=41). Of those, almost 66 per cent had no documented referral source.

Graph 4



In reviewing the data for referral rates **by percentage** and by geographic area, referral distribution has experienced a significant shift with an increased percentage from the KFLA area, and a corresponding decrease from the HPE area. LLG has remained relatively stable. In looking at **actual numbers**, the shift is a response to an increase in actual referrals from both KGH (up by 26 referrals from last fiscal) and Providence Care (also up by 26 referrals from last fiscal) rather than a decrease in referrals from HPE (78 last year and 74 this year). LLG has also had an increase in numbers; up by 12 from last fiscal. Referrals from unknown sources have increased this fiscal.

Graph 5



Graph 5 – Hospital Discharge Destination

Hospital discharge destination has remained relatively stable over the previous 6 fiscal years with referrals to LTC constituting a very low proportion of the total (n=9). (Graph 5)

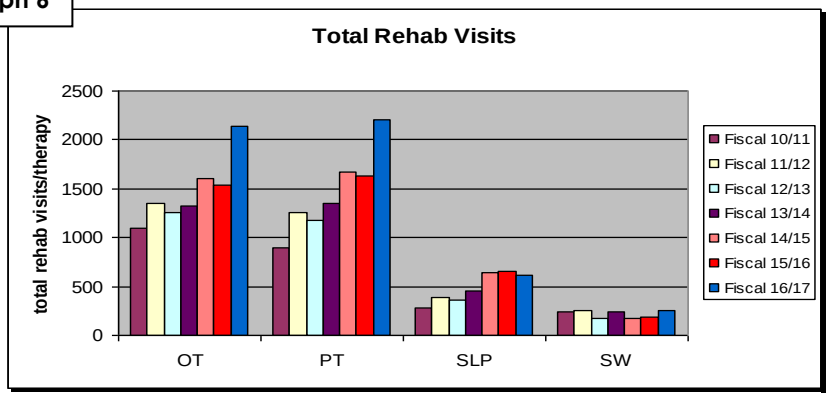
TABLE 4

Average & Median Days Waiting to First Scheduled Rehabilitation Visit

Time – Hospital Discharge to First Scheduled Rehabilitation Therapy Visit (days)	Fiscal 10/11	Fiscal 11/12	Fiscal 12/13	Fiscal 13/14	Fiscal 14/15	Fiscal 15/16	Fiscal 16/17
Average Days Waiting	4.9	4.6	4.4	4.3	4.3	4.5	4.1
Median Days Waiting	5	4	4	4	4	4	4

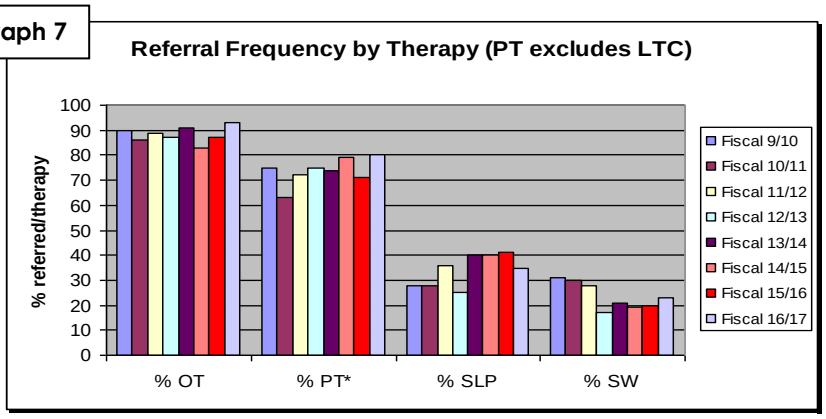
The goal of the Enhanced Rehab Program is to maintain wait times at less than five days. This fiscal, the average has experienced a decrease in comparison to all previous fiscals, while the median remained stable. The shortest time to first scheduled visit for this fiscal is same day service (the highest outlier wait time was 47 days). Prior to implementation of the enhanced program in 2009, the average time to first scheduled rehabilitation therapy visit was 44 days.

Graph 6



Total rehabilitation visits for OT and PT have experienced a **significant increase** from last year (increase of 598 visits for OT and 568 visits for PT). This may be partly explained by the increase of 48 referrals to the program. Of note is the fact that this increase in referrals did not produce an increase in SLP visits; in fact the number of visits decreased slightly. SW did experience a slight increase in visits equal to some earlier fiscal years but this service appears to be underutilized. (Graph 6) In looking at the average number of visits per client, the total is 15.9.

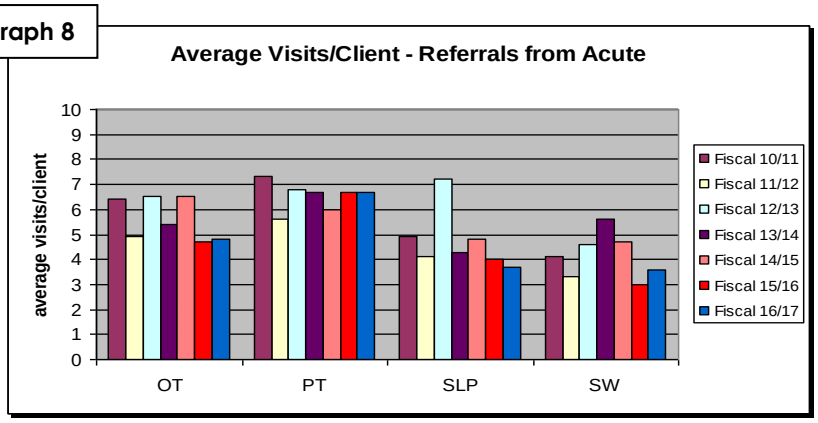
Graph 7



Corresponding to the previous graph which illustrated an increase in the actual number of PT and OT visits, the **<u>percentage</u>** of individuals referred to these two disciplines also increased. (Graph 7)

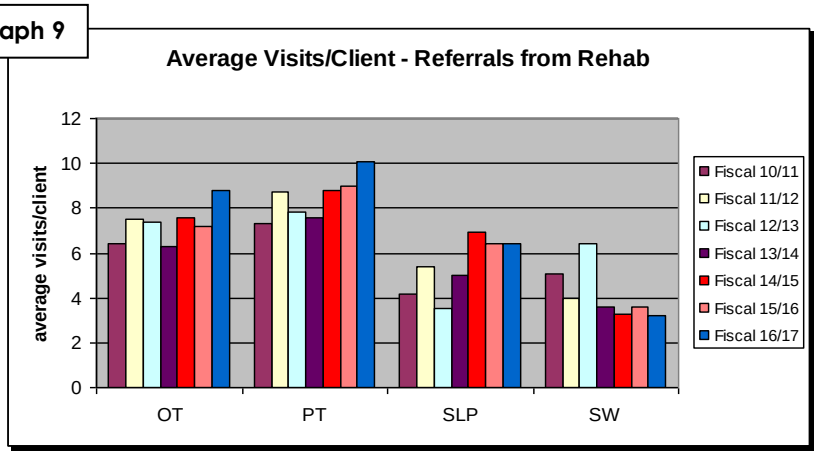
<u>REFERRALS TO THE COMMUNITY</u>

Graph 8



Average visits/client for discharges from acute beds has remained relatively stable with a slight increase in SW and slight decrease in SLP. (Graph 8)

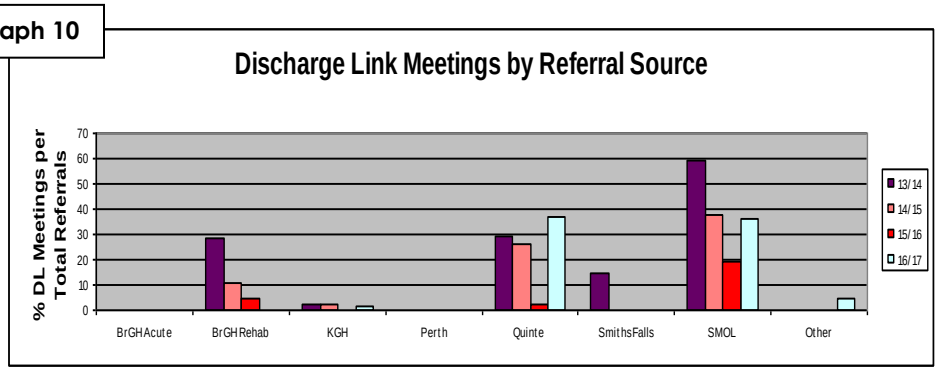
Graph 9



Graph 9 – Average Visits/Client – Referrals from Rehab

The visit average for clients discharged from rehab settings again reflects the findings in Graphs 6 and 7 with **increases in PT and OT** average numbers of visits. (Graph 9)

Graph 10



The DL Meeting is an integral component of the Enhanced Rehab Program, particularly for more complex patients transitioning to the community. Graph 10 provides information on the percent of DL meetings per total number of referrals. Quinte Health Care and Providence Care demonstrate significant increases in the number of DL Meetings. Brockville had no DL meetings documented. Two DL meetings fall under the category of other – one from an unknown referral source. Table 5 provides this same information in absolute numbers (versus percentage).

TABLE 5 - Total DL Meetings/Total Referrals by Geographic Region

	Total Referred 13/14	# DL Meetings 13/14	Total Referred 14/15	# DL Meetings 14/15	Total Referred 15/16	# DL Meetings 15/16	Total Referred 16/17	# DL Meetings 16/17
BrGH Acute	17	0	16	1	22	0	44	0
BrGH Rehab	21	6	19	2	19	1	12	0
Perth	11	0	10	0	10	0	5	0
Smiths Falls	7	1	6	0	9	0	2	0
Quinte	103	30	87	23	83	3	75	29
KGH	41	1	46	1	49	0	72	1
PCH	49	29	56	21	59	11	78	28

LONG TERM CARE (LTC) RFERRALS

TABLE 6 - Total Referrals to LTC by Fiscal Year

Fiscal 10/11	Fiscal 11/12	Fiscal 12/13	Fiscal 13/14	Fiscal 14/15	Fiscal 15/16	Fiscal 16/17
23	8	12	15	10	5	9

Given that the numbers of referrals to LTC remain very low, data analysis is very limited.

TABLE 6 - Referrals to Enhanced Rehab program for Clients Transitioning to LTC

Organization	# Clients Referred	# Visits OT	# Visits SLP	# Visits SW
Quinte	4	24	8	0
Brockville	2	4	4	0
Providence Care	2	5	0	0
Other	1	8	0	5

Note that PT is provided by the LTC Home so data is not available for this service.

GLOSSARY OF ACRONYMS

ALC	Alternate Level of Care
BrGH	Brockville General Hospital
CC	Care Coordinator
DL Meeting	Discharge Link Meeting
ED	Emergency Department
HPE	Hastings & Prince Edward
KFLA	Kingston, Frontenac, Lennox & Addington
KGH	Kingston General Hospital
LHIN	Local Health Integration Network
LLG	Lanark, Leeds & Grenville
LTC	Long Term Care
OT	Occupational Therapy
PCH	Providence Care Hospital
PT	Physiotherapy
SLP	Speech Language Pathology
SW	Social Work

The following page provides a quick 'reminders' reference tool.

REMINDERS

1. Hospital Team Members and Care Coordinators should share discharge planning information as early as possible and arrange for **critical Discharge Link (DL) Meeting**. The planning/organizing for this meeting could start as early as two weeks prior to discharge with the DL meeting ideally occurring within 72 hrs of discharge. Note: it may take 4-5 days to arrange the DL meeting. Community OTs should continue to support the **Care Planning Meeting** in LTC Homes. To make referrals to the Enhanced Program**, hospital teams need to complete the LHIN Referral Form a minimum of 24-48 hours prior to discharge and indicate clearly on the form "*Enhanced Stroke Rehabilitation Services*"** and include suggested therapy plan with focus of intervention. A Care Coordinator will process the referral and provide confirmation of services arranged. Note that information sheets supporting both processes may be found by clicking here.

2. Table 7 outlines the additional rehab services available through the Enhanced Rehab Program. These services should be considered for all clients discharged to **community or LTC** who have newly experienced a stroke in addition to regular Home & Community Care therapy services (e.g., OT can be authorized up to 3x/week for the first 4 weeks and up to 2x/week for the next 4 weeks). **Note that an extended stay in hospital (e.g., waiting for LTC placement, designated as ALC) does NOT preclude the client from being eligible for those services once the transition to LTC has been made.**

TABLE 7 - Enhanced Rehab Therapy Services

	Baseline Services	Enhanced Services Initial 4 Weeks	Enhanced Services Second 4 Weeks
OT	Weekly for 8 weeks	Up to: 2 extra visits/wk of OT *CC could therefore authorize in the service plan up to 3 visits per week for the first 4 weeks*	Up to: 1 extra visit/wk of OT *CC could therefore authorize in the service plan up to 2 visits per week for the next 4 weeks*
PT	Weekly for 8 weeks	Up to: 2 extra visits/wk of PT *CC could therefore authorize in the service plan up to 3 visits per week for the first 4 weeks*	Up to: 1 extra visit/wk of PT *CC could therefore authorize in the service plan up to 2 visits per week for the next 4 weeks*
SW	Social Work is normally as required	Up to: 1 extra visit/wk of SW *CC could therefore authorize in the service plan up to weekly visits for the first 4 weeks*	Up to: 1 extra visit/2wks of SW *CC could therefore authorize in the service plan up to bi-weekly for the next 4 weeks*
		SW NOTE: * On a case-by-case basis if deemed appropriate, the service plan can be extended over 12 weeks (rather than 8) for Social Work services.	
SLP	Weekly for the first 4 weeks and bi-weekly for the next 4 weeks	Up to: 1 extra visit/wk of SLP *CC could therefore authorize in the service plan up to 2 visits per week for the first 4 weeks*	Up to: Up to: 1 extra visit/2wks of SLP *CC could therefore authorize in the service plan up to weekly for the next 4 weeks*

3. All Hospital Teams/Community Providers/Care Coordinators should consider recommending **Social Work** (SW) for psychosocial support and counseling for both Community and LTC home discharges. Note that clients/families may not be receptive to a SW referral immediately following discharge. Community Providers should assess the need for a SW referral at a later point in the recovery and communicate this recommendation to the Care Coordinator (CC). The CC should also consider the value of a SW referral and/or mood assessment prior to discharge from services. It may be of benefit for Community Providers and CCs to encourage acceptance of SW services through the offer of help with applications for financial support such as disability tax credits in addition to emotional support as there may be some reluctance on the part of clients and/or families to recognize the need for and benefits of emotional and psychosocial supports. Younger clients may benefit from SW to link with vocational support services.

4. Consider making use of the funding available through the Stroke Network of Southeastern Ontario for education in the form of **Shared Work Days** to link with stroke experts. For shared work day applications visit http://strokenetworkseo.ca/events-registration

5. Consider referring clients to **Stroke Survivor and Caregiver Support Groups** and **Stroke Specific Exercise Programs** where available and to other community exercise programs when appropriate. Consider coordinating a visit with the client to an exercise program to support transitioning. Information on programs is available through the Southeast HealthLine under Stroke Resources or under Community Supports on the Stroke Network website at or by contacting Gwen Brown.

Contacts:

Patti Dixon-Medora
Manager, Client Services South East LHIN
Phone 613-544-8200 x 8210
patti.dixon-medora@se.ccac-ont.ca
Fax 613-549-2098

Gwen Brown
Regional Stroke Community & LTC Coordinator, SNSEO
Phone 613-549-6666 x 6867
browng2@kgh.kari.net
Fax 613-548-2454