STROKE NETWORK *of* Southeastern Ontario

Community Stroke Rehabilitation Program
Annual Report – June 2018

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

Background: With this program, eligible stroke survivors following their hospital discharge to either community or Long Term Care receive the appropriate level of therapy to support their ongoing rehabilitation specifically through the provision of: Physiotherapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP) and Social Work (SW). Services are provided through the South East Local Health Integration Network (LHIN) Home and Community Care, with the exception of PT in the LTC home setting. LTC Home physiotherapy providers are part of the stroke rehab team and are contracted by the LTC home.

For patients leaving hospital and going to the community, rehabilitation care plans that focus on the patient's goals are developed with the patient and their family/caregivers, hospital interprofessional stroke team and the South East LHIN Care Coordinator. A Community Rehabilitation Planning meeting may occur between hospital team, community provider and patient/family prior to patient leaving hospital.

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

KEY FINDINGS 2017-18

- ✓ Increased referrals (up by 47 from previous fiscal year)
- ✓ Referrals from acute care comprised the majority at 52% with 40% coming from rehab sites
- ✓ Increased number of Community Rehab Planning Meetings at Providence Care Hospital and Quinte Health Care
- ✓ Average number of days to first therapy visit stable at 4 days; below the program target of 5 days
- ✓ Average number of visits after acute care: OT 4.7, PT 4.2, SLP 2.3 and SW 2.4.
- ✓ Average number of visits after rehab: OT 8, PT 9.1, SLP 4.6, and SW 3.8
- **Social Work Services are frequently underutilized.**
- **Referrals for patients transitioning to LTC are lower than expected.**
- **A decrease in referrals from Brockville General Hospital (BrGH) is of concern**, especially given significant increase in stroke admissions to BrGH and BrGH's role as the acute stroke unit for the LLG area.

What's New? At the end of FY 2017-18 changes were implemented to the Community Stroke Rehab Program (CSRP) to respond to stroke survivor, family and provider input requesting increased flexibility in the service delivery. This included changes in the names of both the Program and the in-hospital discharge planning meeting (formerly the Discharge Link meeting, now called the Community Rehab Planning (CoRP) Meeting). The program duration has been **extended to 12 weeks for all therapies** and there is an option to conduct the CoRP meeting by phone provided the client is in attendance. This change to the CoRP model was in recognition of the travel challenges for those community therapists working in rural and remote locations.

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

Ontario
South East Local Health Integration Network

Annual Review of Community Stroke Rehabilitation Program

TABLE 1 - Referrals to Community Stroke Rehabilitation 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
April 2017 – March 2018	376*	364	11
TOTALS TO DATE	**2360**	**2228**	**130**

*** 1 unknown destination**

There was an increase (n=47) in referrals to the Community Stroke Rehab Program in FY 2017/18.

TABLE 2 – Community Stroke Rehab Program Admissions/Total Unique ED Visits for Stroke Admissions

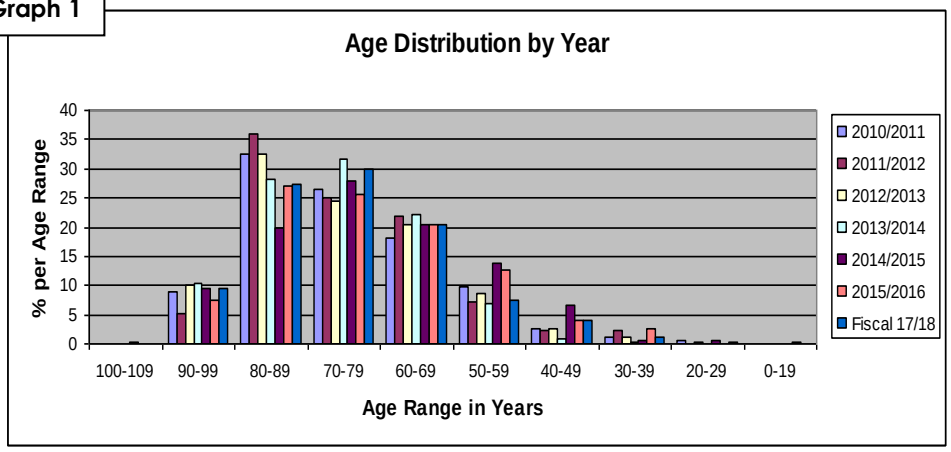
Fiscal	Total unique ED visits with Stroke	# Admitted to CSRP	% Admitted to CSRP
2009/2010	921	173	**18.8**
2010/2011	887	182	**20.5**
2011/2012	887	236	**26.6**
2012/2013	918	242	**26.4**
2013/2014	1143	271	**23.7**
2014/2015	1232	270	**21.9**
2015/2016	1282	281	**21.9**
2016/2017	1167	329	**28.2**

Using the most recently available data from the Canadian Institute of Health Information (CIHI) 2016/17, the total reported number of individuals with stroke for fiscal 2016/17 was 1167 and the percentage of patients referred to the CSRP was 28.2 (an increase from the previous fiscal of 2015/16). Note: This data is up to 2016/17 only. Stroke volumes have increased in 2017/18. (Table 2)

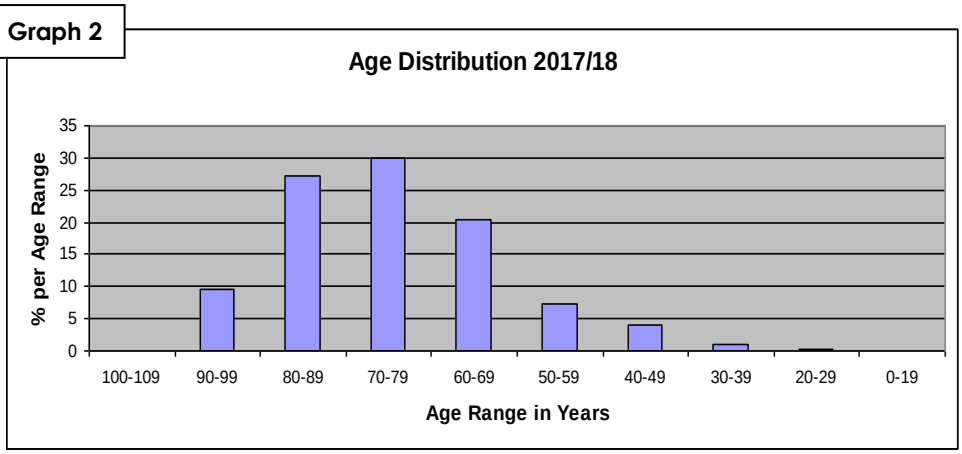
TABLE 3 - Average & Median Ages of Patients Referred to CSRP

	Fiscal 10/11	Fiscal 11/12	Fiscal 12/13	Fiscal 13/14	Fiscal 14/15	Fiscal 15/16	Fiscal 16/17	Fiscal 17/18
Average Age (years)	74	74	74.5	75.5	70.7	71.6	73.6	73.8
Median Age (years)	76	77	77	76	72	73	76	75

Graph 1

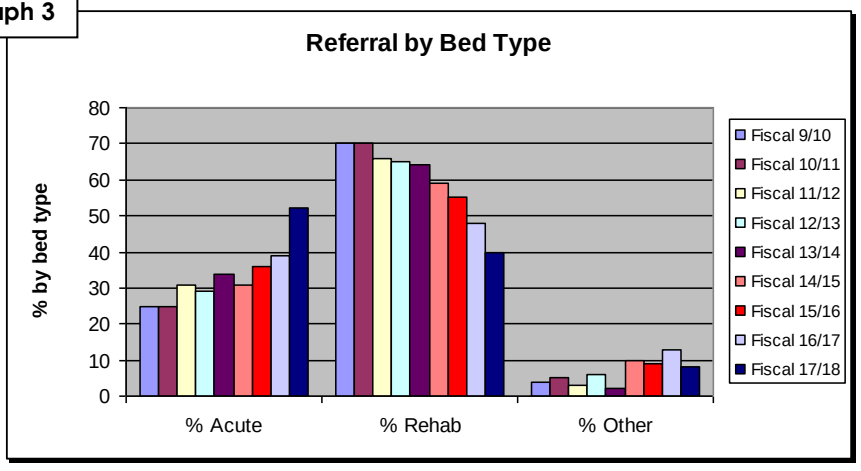


Graph 2



The average and median ages remained relatively stable during this reporting period compared to the two previous fiscals – the oldest patient admitted to the program was 98 years old, and the youngest was 27. Increases were seen in the 70 to 79 age range.

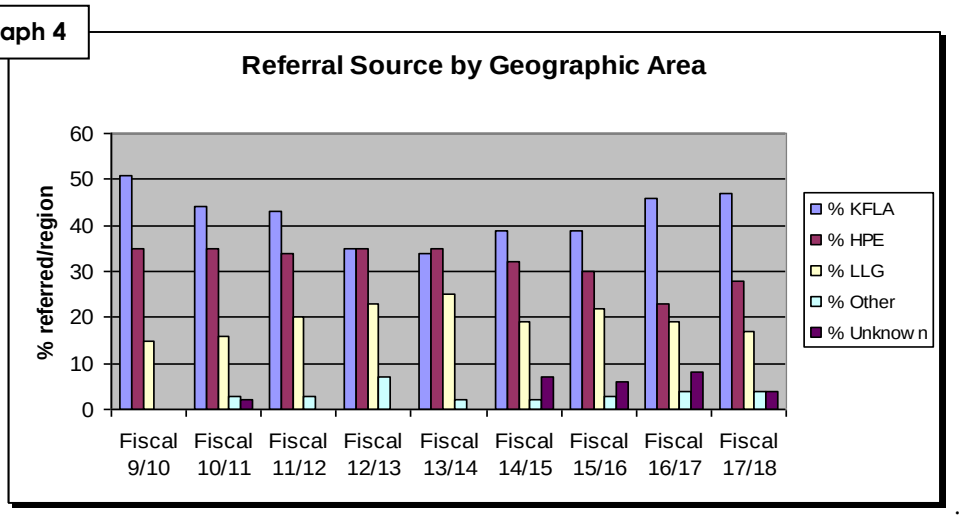
Graph 3



For the first time, referral rates from acute care beds constituted the majority at 52% with 40% coming from rehab. Referrals from other sources* were down from last fiscal at 8%. (Graph 3)

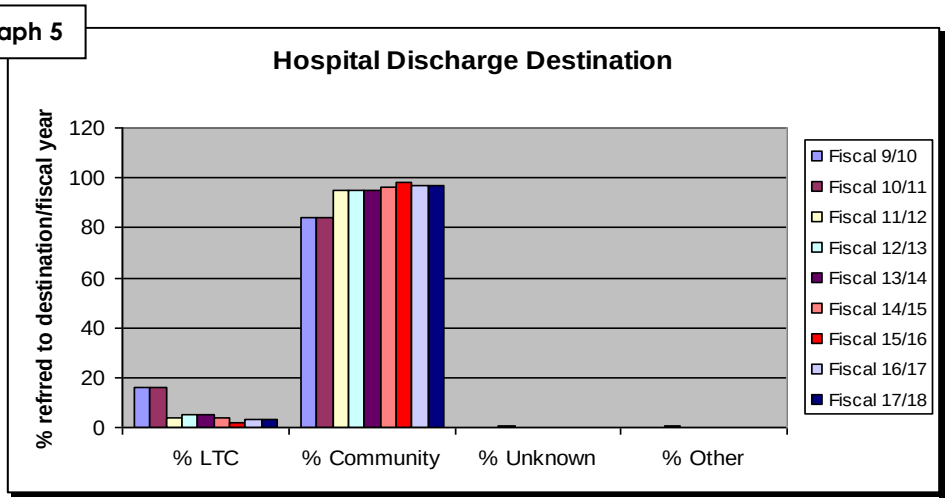
** Other sources include LHINs, LTC, private dwellings and out-of-region hospitals*

Graph 4



Distribution of referrals by geographic area indicates an increase from HPE and KFLA and a decrease from LLG. With respect to **actual numbers**, KHSC was up by 11 referrals from last fiscal, PCH up by 10 referrals and QHC up by 25 referrals. BrGH decreased by 6 referrals.

Graph 5



Graph 5 – Hospital Discharge Destination

Hospital discharge destination has remained relatively stable over the previous seven fiscal years with referrals to LTC constituting a very low proportion of the total (n=11). (Graph 5)

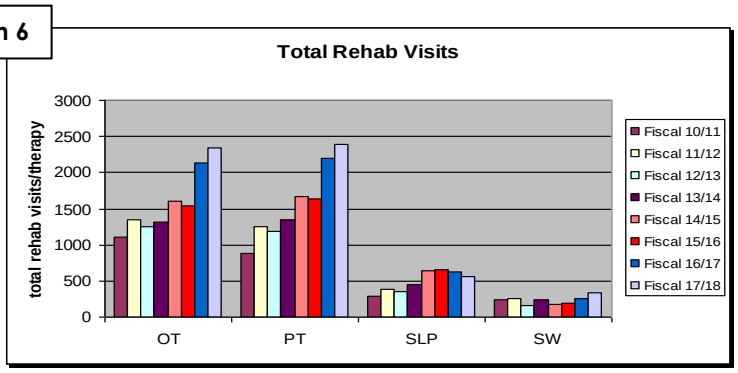
TABLE 4

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	Fiscal 17/18
Average Days Waiting	4.9	4.6	4.4	4.3	4.3	4.5	4.1	4.7
Median Days Waiting	5	4	4	4	4	4	4	4

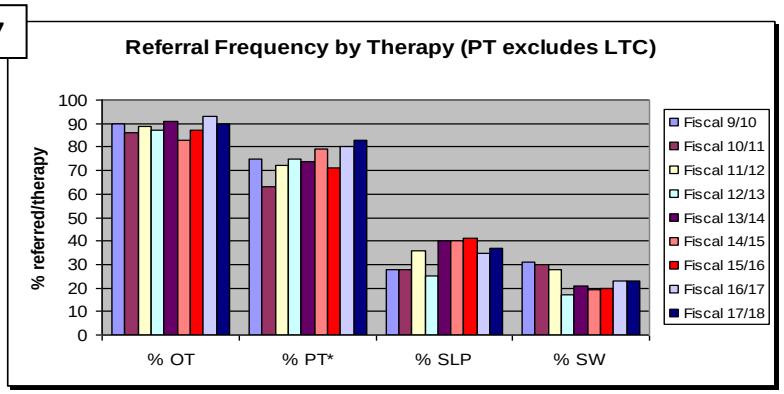
A target of the Community Stroke Rehab Program is to maintain wait times at less than five days. This fiscal, the median has remained stable with an increase in the average. The shortest time to first scheduled visit for this fiscal is same day service (the highest outlier wait time was 73 days).

Graph 6



Total rehabilitation visits for OT and PT have continued the increase noted last fiscal. This may be partly explained by the increase of 47 referrals to the program. Total SW visits also increased and SLP visits decreased. The average number of visits per client is 15, down from last fiscal year at 15.9.

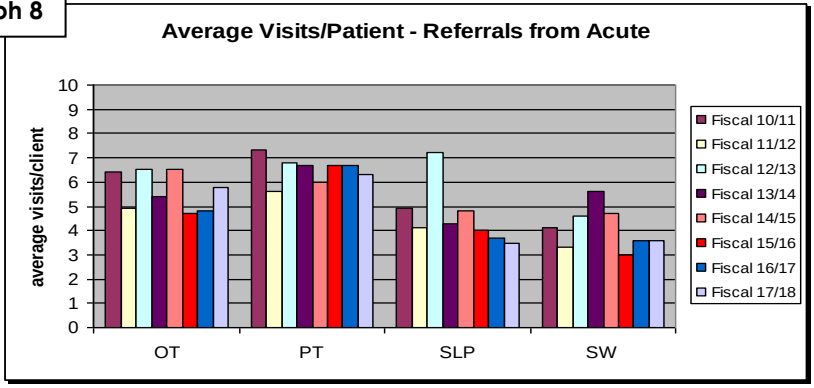
Graph 7



The **percentage** of individuals referred to each of the disciplines remained relatively stable as compared to last fiscal. (Graph 7)

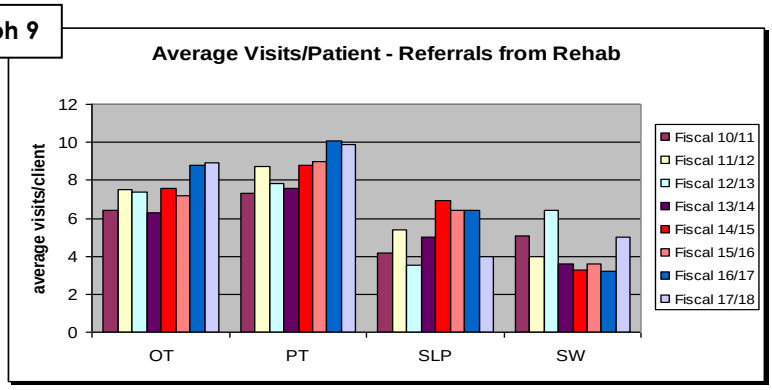
REFERRALS TO THE COMMUNITY

Graph 8



The average visit rate per patient for those discharged from acute beds increased for OT, decreased for PT and SLP and remained stable for SW. (Graph 8)

Graph 9



Graph 9 – Average Visits/Patient – Referrals from Rehab

The average visit rate per patient for those discharged from rehabilitation settings has increased for SW services, decreased for SLP and remained stable for OT and PT. (Graph 9)

TABLE 5 - Total Community Rehab Planning Meetings/Total Referrals by Geographic Region

	Total Referred 13/14	# CoRP Meetings 13/14	Total Referred 14/15	# CoRP Meetings 14/15	Total Referred 15/16	# CoRP Meetings 15/16	Total Referred 16/17	# CoRP Meetings 16/17	Total Referred 17/18	# CoRP Meetings 17/18
BrGH Acute	17	0	16	1	22	0	44	0	39	1
BrGH Rehab	21	6	19	2	19	1	12	0	11	2
Perth	11	0	10	0	10	0	5	0	12	1
Smiths Falls	7	1	6	0	9	0	2	0	3	0
Quinte Rehab	103	30	87	23	83	3	75	29	40	33
Quinte Acute									60	0
KHSC	41	1	46	1	49	0	72	1	83	2
PCH	49	29	56	21	59	11	78	28	88	41

The Community Rehab Planning Meeting is an integral component of the Community Stroke Rehab Program, particularly for more complex patients transitioning to the community. Table 5 above provides information in absolute numbers (versus percentages). Note that beginning this year, QHC has been divided out between acute and rehab.

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	Fiscal 17/18
23	8	12	15	10	5	9	11

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

TABLE 7 - Referrals to Enhanced Rehab program for Patients Transitioning to LTC

Organization	# Patients Referred	# Visits OT	# Visits SLP	# Visits SW
Quinte Acute	3	28	6	0
Brockville Garden	1	7	0	0
Brockville Acute	1	3	0	0
PSFDH – Perth	1	18	0	0
PSFDH – Smiths Falls	1	2	2	0
KHSC	2	3	4	0
L & A	1	9	2	0
Other	1	10	7	1

Note that PT is provided by the LTCH, so data are not available for this service.

GLOSSARY OF ACRONYMS

ALC	Alternate Level of Care
BrGH	Brockville General Hospital
CC	Care Coordinator
CIHI	Canadian Institute of Health Information
CoRP	Community Rehab Planning Meeting (formerly Discharge Link Meeting)
CSRP	Community Stroke Rehabilitation (Rehab) Program
ED	Emergency Department
HPE	Hastings & Prince Edward
KFLA	Kingston, Frontenac, Lennox & Addington
KHSC	Kingston Health Sciences Centre
L&A	Lennox & Addington
LHIN	Local Health Integration Network
LLG	Lanark, Leeds & Grenville
LTC / LTCH	Long-Term Care / Long-Term Care Home
OT	Occupational Therapy
PCH	Providence Care Hospital
PSFDH	Perth Smith Falls District Hospital
PT	Physiotherapy
SLP	Speech Language Pathology
SW	Social Work

REMINDERS

1. All patients who have experienced a new stroke should be considered for referral to the CSRP prior to discharge including patients transitioning to LTC. **Hospital teams need to complete the South East LHIN Referral Form a minimum of 24-48 hours prior to discharge.** The form should clearly indicate **"**Community Stroke Rehab Program**"** and include suggested therapy plan with focus of intervention. 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 5-8**	**Weeks 9-12**
OT	Up to 3 visits/week	Up to 2 visits/week	Up to 2 visits/week
PT	Up to 3 visits/week	Up to 2 visits/week	Up to 2 visits/week
SLP	Up to 2 visits/week	Up to 1 visit/week	Up to 1 visit/week
SW	Up to 1 visit/week	Up to 1 visit bi-weekly	Up to 1 visit bi-weekly

2. **Community Rehab Planning (CoRP) meeting** should be considered for all discharges from rehab. The CoRP 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 OT typically coordinates the CoRP meeting however another therapist may be more appropriate in some circumstances as determined by the Access Care Coordinator and based on recommendations from the hospital team. The most appropriate therapy discipline supports the **Care Planning Meeting in LTCH** in lieu of the CoRP meeting.

3. An extended stay in hospital (e.g. waiting for LTC) does **NOT** preclude the patient from being eligible for the CSRP.

4. Referral to Social Work (SW) should be considered during discharge planning **and throughout the patient's stay on the CSRP**. SW can assist with psychosocial supports, links to vocational support services and assistance with applications for financial support.

5. Consider referral to **Stroke Survivor and Caregiver Support Groups** and **Stroke Specific Exercise Programs** where available and to other community exercise programs and supports when appropriate. A community visit may be used by the community provider to visit an exercise program with the patient prior to discharge from the CSRP.

6. Information on various community programs is available through the South East Health Line under Stroke Resources.

7. Funding for education is available through the Stroke Network of Southeastern Ontario (SNSEO) in the form of **Shared Work Days** to link with stroke experts. For shared work day applications visit http://strokenetworkseo.ca/events-registration

Need additional information? Please contact:

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