SOUTH EAST LHIN HOME & COMMUNITY CARE

COMMUNITY STROKE REHAB PROGRAM 2017/18

376 new stroke survivors received timely, in-home rehabilitation in the **Community Stroke Rehab Program** (CSRP)

52% were referred from an **acute** care setting, **40%** were referred from a **rehab** setting and 8% were referred from other settings. **11** patients transitioning to LTC were referred to the CSRP.

Increase of **47** referrals from last fiscal (↑ **14.3%)**

Median time to first therapy visit stable at **4 days** (program target is 5 days)

Age range of patients receiving CSRP services was **27 to 98 years**

Average number of therapy visits received by patients was **15**

PT

Average **PT** Visits
Acute **5.8** | Rehab **8.9**

OT

Average **OT** Visits
Acute **6.3** | Rehab **9.9**

SLP

Average **SLP** Visits
Acute **3.5** | Rehab **4**

SW

Average **SW** Visits
Acute **3.6** | Rehab **5**

STROKE NETWORK *of* Southeastern Ontario

Ontario
Local Health Integration Network

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 Southeast 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 LTC Home.

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 LTC Homes** 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 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 Southeast Healthine under Stroke Resources.
7. Funding is available through the Stroke Network of Southeastern Ontario (SNSEO) 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

Need additional information?

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