SOUTH EAST LHIN HOME & COMMUNITY CARE

COMMUNITY STROKE REHAB PROGRAM 2018/19

447 referrals to the Community Stroke Rehab Program. An increase of **19%** from previous fiscal.

53% were referred from an **acute** care setting, **40%** were referred from a **rehab** setting and 7% were referred from other settings.

Median time to first therapy visit stable at **4 days**

+1

Patients in rural and small population centres averaged **one additional wait day** for services.

Median age for male patients was **71** and for females was **77**.

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

PT

Average **PT** Visits
Acute **5.9**
Rehab **9.1**

OT

Average **OT** Visits
Acute **5.0**
Rehab **8.6**

SLP

Average **SLP** Visits
Acute **3.6**
Rehab **5.6**

SW

Average **SW** Visits
Acute **3.5**
Rehab **3.5**

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. Note that patients discharged from acute stroke units should also receive a Rapid Response Nurse referral.

Community Stroke Rehab Program		
	Weeks 1-4	Weeks 5-12
Occupational Therapy (OT)	**Up to 12** visits over 4 weeks	**Up to 16** visits over 8 weeks
Physiotherapy (PT)	**Up to 12** visits over 4 weeks	**Up to 16** visits over 8 weeks
Speech Language Pathology (SLP)	**Up to 8** visits over 4 weeks	**Up to 8** visits over 8 weeks
Social Work (SW)	**Up to 4** visits over 4 weeks	**Up to 4** visits over 8 weeks

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 at any time post-stroke.
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?

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