South East **LHIN**

Community Stroke Rehab Program LHIN FAQs

STROKE NETWORK *of* Southeastern Ontario

1. **What community-based rehab services are available to eligible stroke survivors through the Community Stroke Rehabilitation Program?**
   Physiotherapy (PT), Occupational Therapy (OT), Social Work (SW) and Speech Language Pathology (SLP) services are available to eligible patients discharged to the community or LTC who have experienced a stroke. These services are in addition to regular South East Local Health Integration Network (South East LHIN) Home and Community Care services. These additional rehabilitation services are funded through the South East LHIN and, with the exception of PT in LTC, are provided through the South East LHIN Home and Community Care program.

   Eligible patients are 16 years of age or older, live in South East Ontario, have experienced a recent stroke or diagnosis of stroke and are eligible for South East LHIN Home and Community Care follow up therapy at home or in a residential care facility. The table below describes the therapy visits available through the Community Stroke Rehabilitation Program.

Community Stroke Rehab Program			
	Weeks 1 - 4	**Weeks 5-8**	**Weeks 9-12**
OT	up to 3 visits per week	up to 2 visits per week	up to 2 visits per week
PT	up to 3 visits per week	up to 2 visits per week	up to 2 visits per week
SLP	up to 2 visits per week	up to 1 visits per week	up to 1 visits per week
SW	up to 1 visit per weeks	up to bi-weekly	up to bi-weekly

Ontario
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2. **How is the Community Stroke Rehabilitation Program initiated for stroke survivors?**

   The hospital inter-professional stroke team identifies the need for ongoing therapy and the focus of intervention for each discipline reflecting the goals identified by patient and family. A referral is then made to South East LHIN Home and Community Care by the Hospital Team for the additional therapy services to determine eligibility. It is important to identify "**Community Stroke Rehabilitation Program**" on the referral and include the initial focus of intervention (e.g., PT for upper extremity weakness and coordination, gait and balance training).

3. **How are the goals of treatment/treatment plan communicated between the Hospital and Community Teams?**

   Communication ideally occurs via a Community Rehab Planning Meeting close to the time of the patient's discharge (see Community Rehab Planning Meeting – FAQs). When this is not possible, sharing of the Hospital Team's therapy notes/plans/information is very valuable for the community providers.

4. **When should referrals to SW be considered?**

   Referrals for psychosocial support, counselling and assistance with financial applications can be of significant benefit to both the patient and the family. It should be noted that the patient/family may be reluctant to accept a SW referral immediately following discharge. For this reason, referral to SW should be considered not only prior to discharge but also throughout the patient's stay on the program. Community providers identifying a need for SW services should communicate the recommendation to the Care Coordinator.

5. **How is the 12-week service plan determined?**

   The initial plan is authorized for 4 weeks by the Care Coordinator (CC). The community provider(s) working with the patient/family will then make recommendations to the CC which continue to align with the patient and family goals. The CC will then authorize services for the next 4 weeks. This process is also followed for the final 4 weeks on the program.

6. **Will patients be able continue with therapy after the 12 weeks?**

   In some cases additional therapy visits may be authorized based on patient's needs and progress. However, this will fall under the regular Home and Community Care Program as the Community Stroke Rehabilitation Program will be complete.

7. **If a patient is attending outpatient therapy can they still access the Community Stroke Rehabilitation Program?**
   In some cases a patient may be eligible for both. For example, a patient might be attending outpatient PT but require OT in-home services for a very specific focus of intervention. It is best to discuss individual patient needs with a CC directly at time of referral.

8. **Are patients who have an extended hospital stay entitled to the Community Stroke Rehabilitation Program?**
   Yes. For example patients who are waiting for LTC placement in hospital, are eligible for services once transition to LTC has occurred.

9. **Are there additional services available to patients on the Community Stroke Rehabilitation Program?**
   Additional services are based on patient need and assessed on an individual basis. Such services may include Rapid Response Nurse, dietitian, nursing, Personal Support Worker and referrals to Community Support Service agencies (e.g. meal services, transportation).

10. **Who provides the Community Stroke Rehabilitation Program services in LTC and how are they arranged?**
    Hospital teams can initiate the Community Stroke Rehabilitation Program for patients transitioning to LTC with a Home and Community Care referral for an OT visit. Ideally, this service is arranged by the CC prior to the patient's transition from hospital to LTC. The Community OT will arrange a care plan meeting in the LTC home and make recommendations for Community Stroke Rehabilitation Program services (i.e. OT, SLP, SW) to the CC. The LTC Home provides PT services. A LTC home may also initiate a referral to the Community Stroke Rehabilitation Program if this has not occurred prior to discharge. It is, however, ideal for the patient and LTC care team if it is the hospital team that initiates the referral.

11. **What resources are available to stroke survivors and families?**

    Stroke Survivor & Caregiver Support Groups (including Living with Stroke© programs)
    Stroke Specific Exercise Programs
    South East Healthline – Stroke Resources microsite
    Heart & Stroke Foundation – Various on-line and hard copy resources
    The recommended primary resource for patients and families is the Heart & Stroke publication, *Your Stroke Journey*, which can be accessed on line or a hard copy may be requested through Heart & Stroke.
    The Stroke Network of Southeastern Ontario website also includes a listing of supplemental resources.

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