Home and Community Care Support Services South East

COMMUNITY STROKE REHAB PROGRAM 2020/21

568 admissions to the Community Stroke Rehab Program. An increase of **11%** from previous fiscal.

54% were referred from an **acute** care setting, **38%** were referred from a **rehab** setting and 8% were referred from other settings.

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

Individuals in **rural** settings had **lower** average of **PT & OT** visits

145 Community Rehab Planning Meetings (↑23% from previous fiscal)

Received **at least one** virtual visit: PT 25%, OT 26.5%, SLP 25.6%, SW 56.9%

Average number of **total therapy visits** received by patients was **13** (↓ by 1 from last FY)

PT

Average Visits: 7
Post-Acute
Average **7.2**
Post- Rehab
Average **7.4**

19% received **≥12 visits**

OT

Average Visits: 6
Post-Acute
Average **6.5**
Post-Rehab
Average **6.0**

15% received **≥12 visits**

SLP

Average Visits: 3.9
Post-Acute
Average **4.1**
Post-Rehab
Average **4**

7% received **≥12 visits**

SW

Average Visits: 3.5
Post-Acute
Average **3.4**
Post-Rehab
Average **3.7**

18% received SW services

Compared to last fiscal:

- average visits ↑acute & rehab for SLP & SW; ↑ acute OT; ↓rehab PT; stable PT acute & OT rehab
- percent ≥ 12 visits ↓ for PT, OT and ↑ for SLP; ↓ percent receiving SW services

RESOURCES & 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 Home and Community Care Support Services South East 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 interventions. For all patients discharged from acute, or for more complex patients, a referral to the RRN should be included. 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 5-12
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. A **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 Hospital OT typically coordinates the CoRP meeting however another therapist may be more appropriate in some circumstances. The most appropriate therapy discipline supports the **Care Planning Meeting in LTCH** in lieu of the CoRP meeting.
3. **Virtual visits** have been included in the CSRP model. Find virtual resources here www.rehabcarealliance.ca/tele-rehab-and-covid-19.
4. An extended stay in hospital (e.g. waiting for LTC) does **NOT** preclude the patient from being eligible for the CSRP.
5. Referral to SW should be considered during discharge planning **and throughout the patient's recovery journey.** SW can assist with psychosocial supports, links to vocational support services & assistance with applications for financial support any time post-stroke.
6. Consider referral to **Stroke Survivor and Caregiver Support Groups**, **Stroke Specific Exercise Programs** and **Aphasia Supportive Conversation Groups** where available and to other community exercise programs and supports when appropriate. A community visit may be used by the community provider to connect the patient with any community support/program prior to discharge from the CSRP.
7. Information on various community programs is available through the Stroke Network of Southeastern Ontario's website under Community Supports and through the South East Health Line under Stroke Resources. A Patient Journey Map co-developed by stroke survivors and caregivers is a recommended education and navigation resource. Additional resources include Driving After Stroke, Return to Work and Navigation and Transition Toolkits.
8. 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 and through a new Professional Development Fund.

Need additional information?

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