Discharge Link Meeting – FAQ

What is a Discharge Link (DL) Meeting?
A DL meeting is a face to face meeting between therapists, usually OTs, to support continuity of care when clients are transitioning from hospital/inpatient rehabilitation to the community setting. The meeting is intended to support the development of an ongoing rehab plan. It does not replace the Home Assessment. Suggested topics to be discussed at the DL meeting include client's goals in the inpatient setting and for the community, client's progress, treatment techniques, client's response to treatment, role of caregivers, family support, equipment and adaptations.

Who should be considered for a DL meeting?
DL meetings should be considered for all clients being discharged to a community setting from hospital/rehabilitation who have experienced a stroke. Typically, meetings would occur when clients are being transitioned within the same geographical area as the Community Provider.

How is a referral made for a DL meeting?
The referring hospital/rehabilitation unit completes a CCAC referral requesting a DL meeting. The intake Care Coordinator (CC) triages the referral and assigns a CC to the case. The CC assesses the client for eligibility and will then authorize the DL meeting giving the Inpatient OT's contact information to the Community OT via a service offer. The Community OT will be given 4-5 days to schedule the DL meeting.

Who coordinates the DL meeting?
The Community OT contacts the Inpatient OT and coordinates the DL meeting, just prior to the client's discharge from inpatient setting.

When does the DL meeting occur?
Ideally the DL meeting occurs up to 72 hours prior to the client's discharge**.** However it may happen up to 2 weeks prior to the discharge.

How quickly can a DL meeting be set up?
The DL meeting can be arranged with 4-5 days' notice.

Who is involved in a DL meeting?
The DL meeting occurs between client, family (with client's consent), Inpatient OT and the OT who is scheduled to work with the client when he/she transitions to the community (Community OT). The inpatient team will need to ensure an appropriate meeting space and the availability of the client/family for the DL meeting. Other team members may attend as appropriate.

What happens if the client is transitioning to a LTCH?
Clients with a stroke who are transitioning to a LTC Home would not have a DL link meeting arranged in hospital. With a referral for Enhanced Community Stroke Rehab, the Community OT will arrange a care plan meeting with the DOC/Designate. The planning meeting will include the LTC home PT, DOC or designate, client and family when possible and other care providers as deemed appropriate.

April 2016