

**Communiqué – November, 2011**  
**Enhancing Community and LTC Based Rehabilitation**  
**Therapy Services for Stroke Survivors: Discharge Link**  
**A Joint Initiative of SE-CCAC, SEO Stroke Network and the SE-LHIN**

Timely, enhanced community and LTC rehabilitation services have been provided to stroke survivors in Southeastern Ontario since February 2009 with the launch of an innovative LHIN-funded project. Eligible stroke survivors receive **enhanced** Physiotherapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP) and Social Work (SW) services for two months following discharge home or to Long Term Care Home. These services are provided through the SE-CCAC (except in the case of PT in the LTC Home setting where LTC Home physiotherapy providers are utilized). Service plans focusing on goals identified by the patient and family are initially developed by the hospital interprofessional stroke team with the CCAC Case Manager. Collaborative care planning occurs across the hospital-community sectors through critical discharge link meetings for those returning home. For the LTC Home setting, an interprofessional care planning conference is scheduled following the patient's admission to the LTC Home. As part of its base budget, the CCAC will now receive ongoing targeted funds from the SE LHIN to support this new standard of care.

**Recent Presentations**

- The Enhanced Rehabilitation Stroke Services: Discharge Link was presented at the Ontario Stroke Network and Heart and Stroke Foundation Provincial Stroke Collaborative in Toronto, October 17, 2011. The Collaborative is an interprofessional educational event that brings together health care leaders and providers from across the continuum to meet and learn about what is new in stroke research and care.
- A digital poster on the Enhanced Rehabilitation Stroke Services: Discharge Link was presented and very well received at the annual Canadian Stroke Congress on October 4, 2011.

**Status Update**

FISCAL	N - Participants	n - Community	n - LTC
Feb. 2009 – March 2010	173	145	28
April 2010 – March 2011	182	153	29
April 2011 – August, 2011 (Partial)	95	91	4
<b>TOTALS TO DATE</b>	<b>450</b>	<b>389</b>	<b>61</b>

- Referral rates continue to be steady from both acute and rehab inpatient beds and across the facilities within the SE Region.
- Referrals by subregion remain consistent: KFLA 44%, HPE 35%; LLG 16%; Other/Unknown 5%
- An upward trend continues to be observed with therapy visit rates across the region.
- LTC Home Referrals are limited, however, communication and linkages with LTC Homes and contracted therapy providers continue to support referral process and standard of service delivery.

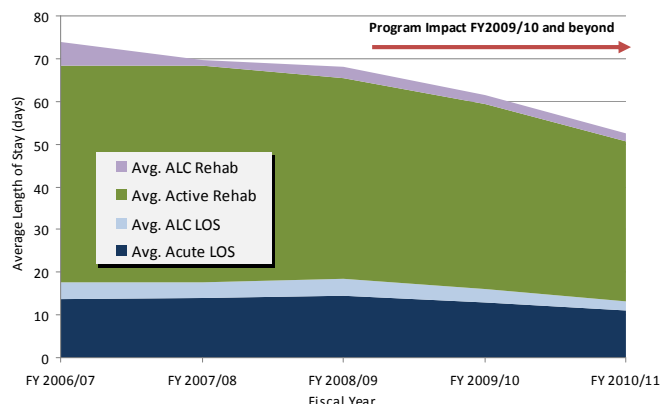
**Interim Outcome Evaluation**

**Wait Times**

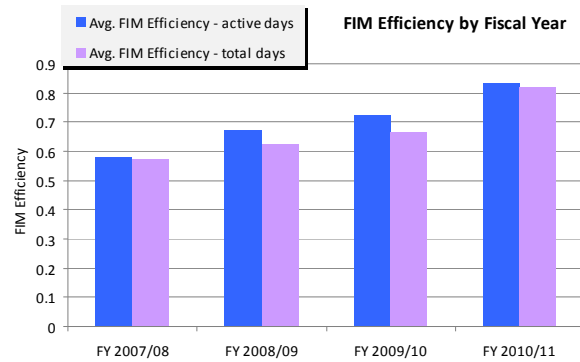
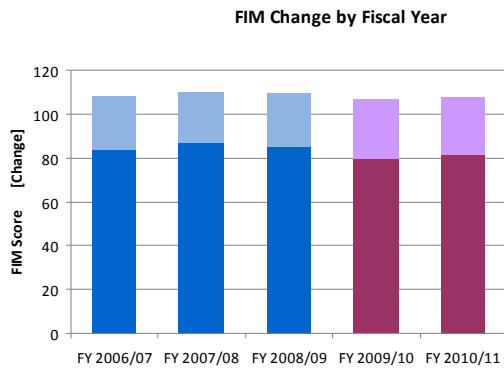
- Pre-implementation – average wait time to community rehab service **44 days**. Since implementation of enhanced rehab therapy initiative, the average wait time is now **4.9 days**

**Length of Stay (LOS):**

Mean active LOS for acute-plus-rehab group has decreased from just under 70 days in fiscal 2008/09 (pre implementation) to 53 days in fiscal 2010/11

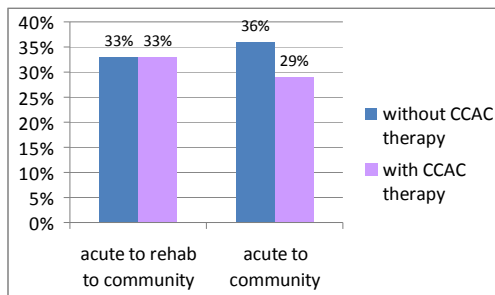


- Mean active LOS for acute-plus-rehab group has decreased by 15.7 days
- Significant LOS reduction has not negatively impacted patient functional outcomes (see graph re consistency in FIM change scores)
- Resulting in a positive impact on FIM LOS Efficiency



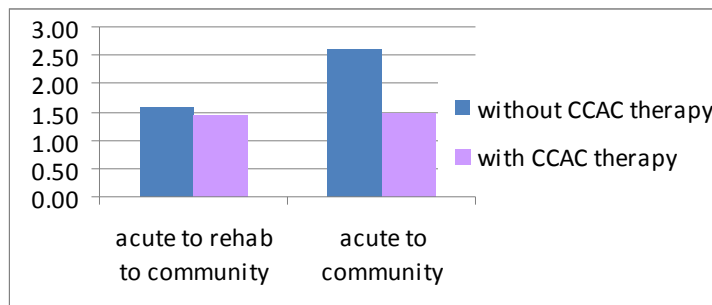
### Readmission Rates

Readmission rates (9/10 to 10/11) - % with at least one readmission within 1 yr of index stroke event



- Lower readmission rates observed for clients receiving CCAC enhanced community rehab services, who were discharged directly from inpatient acute setting
- Highest readmission rates seen for those who received no inpatient or CCAC rehab follow-up

Readmission visits – avg. visits per follow up client within 1 year after index stroke event



- Average number of readmission visits per client lower for those clients receiving CCAC enhanced community rehab services
- For patients discharged directly from acute - 1.5 readmission visits within one year with enhanced therapy versus 2.6 visits for those without

*The provision of timely intensive stroke rehabilitation services upon transition to the community has a positive impact on health system utilization and stroke survivor outcomes.*

### Reminders

1. Consider recommending **Social Work** for both Community and LTC Home discharges.
2. Share discharge planning information as early as possible, and arrange critical **Discharge Link** meetings.
3. Continue to support the **Care Planning meeting** in LTC Homes.
4. Refer **patients** being **discharged to LTC Home** and **advise Gwen Brown** (information below) when a referral is made.
5. Consider the SEO Stroke Network funding available for education in the form of **Shared Work Days** to link with stroke experts. For shared work day applications visit [www.strokenetworkseo.ca/profedatlas](http://www.strokenetworkseo.ca/profedatlas)
6. If you have any interesting **stroke survivor success stories** please contact one of the project leads below.

### To Contact Us

**Caryn Langstaff**  
Regional Stroke Rehabilitation  
Coordinator for SEO  
613-549-6666 x 6841  
[langstac@kgh.kari.net](mailto:langstac@kgh.kari.net)

**Jo Mather**  
Manager, Client Services  
SE CCAC  
613-544-8200 x 4112  
[jo.mather@se.ccac-ont.ca](mailto:jo.mather@se.ccac-ont.ca)

**Gwen Brown**  
Regional Stroke Community & LTC  
Coordinator for SEO  
613-549-6666 x 6867  
[browng2@kgh.kari.net](mailto:browng2@kgh.kari.net)