Enhancing Community–Based Therapy for Stroke Survivors

Protocols for Stakeholders
Case Managers (or designate)

Clients Discharged to the Community Setting

The case managers make the decision regarding client eligibility for CCAC service upon the client's discharge from the inpatient setting to the community.

Hospital Case Manager Role (these may vary to meet the administrative procedures of different settings).

1. Potential clients - identified in the usual CCAC case management assessment to determine if the client is eligible for CCAC services.
2. Once determined eligible the case manager will arrange the discharge link if possible. The discharge link visit **must be** face to face. The case manager will contact the community therapy provider to arrange the discharge link visit. The case manager will provide the name of the client's **inpatient OT/ contact number** to the **service provider (for the CCAC OT)** who will be providing the client's therapy in the community. The case manager will inform the client's **inpatient OT** that the client will be receiving the enhanced therapy and that the **CCAC OT** will be in touch to coordinate a time for the **Discharge Link Meeting.**
3. Planning/ organizing for this meeting could start as early as two weeks prior to discharge with the DL meeting ideally occurring within 72 hrs of discharge (see Guidelines for the DLM – separate document). The case manager will complete the referral and forward to the service provider. The therapy service provider will need to confirm the date of the discharge link meeting with the hospital case manager.
4. The hospital case manager in consultation with the hospital therapy team will also establish the initial plan of care. The hospital case manager will be responsible to authorize the first 4 weeks of the service plan and the plan could include all recommended therapy services – refer to the Enhanced Therapy Services Guidelines below. The service plan will also include that the community therapy providers provide a **verbal update** to the community case manager at the two week point in the service plan. The case manager will complete the appropriate documentation and follow the CHRIS BP. When sending the service offer the case manager will ensure it is noted in the provider notification that the referral is for "enhanced therapy for stroke".
5. The hospital case manager will communicate with the community case manager in the usual manner.
6. Case managers are to refer to the CHRIS BP to support them in the correct CHRIS documentation for this referral.

Eligibility Criteria for Enhanced Services

Clients will:

- Be 16 years of age or older and live in Southeastern Ontario
- Have had a recent stroke or a diagnosis of stroke
- Will be eligible for CCAC follow up therapy at home or in a residential care facility (not a LTC facility or nursing home)

Guidelines for the Enhanced Therapy

- The Project supplies funding for increased therapy **above and beyond** the level of therapy that the CCAC would normally provide.

- The amount of increased therapy will be determined by the client's therapy goals within a maximum funding envelope.

This funding covers the following activities:

a) The Discharge Link meeting
b) Provider visits (per the guidelines below)

Pre-Discharge: The CCAC OT attends the **Discharge Link Meeting** with the inpatient OT, the client, and/or caregiver(s).

First 4 weeks: Up to: 2 extra visits/wk of OT and PT
1 extra visit/wk of SLP and SW *****

4-8 weeks: Up to: 1 extra visit/wk of OT and PT
1 extra visit/2wks of SLP and SW *

CCAC Baseline Guidelines for Therapy Services/ Application of Enhanced Services

For this initiative we have provided standard baselines for therapy services and the enhanced services will be above these baselines. The Pre-discharge link will be considered enhanced services if able to be arranged.

- **OT is normally weekly for 8 weeks; Enhanced services could be increased up to 3 visits per week for the first 4 weeks and up to 2 visits per week for the next 4 weeks**
- **PT is normally weekly for 8 weeks; Enhanced services could be increased up to 3 visits per week for the first 4 weeks and up to 2 visits per week for the next 4 weeks**
- **Social Work is normally as required; Enhanced services could be increased up to weekly for the first 4 weeks and up to bi-weekly for the next 4 weeks – See SW Note * below**
- **Speech is normally weekly for the first 4 weeks and bi-weekly for the next 4 weeks; Enhanced services could be increased up to 2 visits per week for the first 4 weeks and up to weekly for the next 4 weeks**

	CCAC Baseline Services	Enhanced Services Initial 4 Weeks	Enhanced Services Second 4 Weeks
OT	**Weekly for 8 weeks**	**Up to: 2 extra visits/wk of OT** CM could therefore authorize in the service plan up to 3 visits per week for the first 4 weeks	**Up to: 1 extra visit/wk of OT** CM could therefore authorize in the service plan up to 2 visits per week for the next 4 weeks
PT	**Weekly for 8 weeks**	**Up to: 2 extra visits/wk of PT** CM could therefore authorize in the service plan up to 3 visits per week for the first 4 weeks	**Up to: 1 extra visit/wk of PT** CM could therefore authorize in the service plan up to 2 visits per week for the next 4 weeks
SW	**Social Work is normally as required**	**Up to: 1 extra visit/wk of SW** CM could therefore authorize in the service plan up to weekly visits for the first 4 weeks	**Up to: 1 extra visit/2wks of SW** CM could therefore authorize in the service plan up to bi-weekly for the next 4 weeks
		SW NOTE: * On a case-by-case basis if deemed appropriate, the service plan can be extended over 12 weeks (rather than 8) for **Social Work** services.	
SLP	**Weekly for the first 4 weeks and bi-weekly for the next 4 weeks**	**Up to: 1 extra visit/wk of SLP** CM could therefore authorize in the service plan up to 2 visits per week for the first 4 weeks	**Up to: Up to: 1 extra visit/2wks of SLP** CM could therefore authorize in the service plan up to weekly for the next 4 weeks

Community Case Manager Role

Community case manager will be responsible for the ongoing service plan.

1. The therapy service providers will be updating the case manager at the two week point in the service plan.
2. The community case manager will be responsible for establishing the second 4 week block in collaboration with the therapist. They will look to the baseline/ enhanced services when establishing the plan and will authorize the second 4 weeks based on the guidelines.

Community case managers may receive clients from CAT that have been discharged from SE hospitals and have been missed by the hospital CM for this initiative (i.e. WE discharges). The community case managers will also receive referrals from hospitals outside the SE for clients who could be eligible for the enhanced services. CAT when they receive referrals for this client population will process as per the normal process and the responsibility of establishing the enhanced service plan will become the community case managers in collaboration with the therapy providers in the community. The client must meet the criteria for the eligibility criteria for this initiative (noted previously).The case manager will work with the therapy providers who are doing the initial visit in the home to establish the service plan and will use the baseline/enhanced guidelines. The case manager when follow the CHRIS BP for the stroke strategy initiative.

For Further Information Contact:

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