Enhancing Community–Based Therapy for Stroke Survivors

Guidelines for the Discharge Link Meeting

I Background: Enhancing Community-based Rehabilitation for Stroke Survivors

The project goals include:

For Stroke Survivors: to improve access to timely enhanced community rehab services for improved function, emotional support and satisfaction with transition to home.
For Healthcare Providers: to improve information flow and stroke care expertise.
For the Health Care System: to decrease Emergency Room visits and hospital readmissions by supporting transition to home for those with new stroke and providing timely enhanced community rehabilitation support.

Therapy Interventions: Enhanced Therapy will consist of an increased amount of therapy, above what would normally be provided. Clients may also participate in a Discharge Link Meeting between the Hospital OT and the Community OT which takes place <u>before</u> the client is discharged from hospital.

The Discharge Link Meeting: Clients may participate in a Discharge Link meeting. This meeting occurs between the hospital inpatient occupational therapist (OT) and the CCAC OT prior to discharge. (Physiotherapists and Speech Language Pathologists will continue to exchange treatment information in the usual way). The purposes of the Discharge Link meeting are:

- To improve the communication of client goals, therapy plans and treatment techniques through a face-to-face meeting of the inpatient OT and the Community OT.
- To increase client involvement by allowing the client to be part of the process.

II Guidelines for Arranging the Discharge Link Meeting

1. The CCAC case manager (or designate) will inform both the inpatient and community OTs of the imminent discharge of a stroke client to the community. The Discharge Link meeting will only be considered for clients who are being discharged from hospitals to areas that are serviced by the same provider (i.e. Kingston hospitals to KFLA and QHC to HPE but not QHC to KFLA or Kingston hospitals to HPE or LLG).
2. The CCAC OT will contact the hospital OT and coordinate the DL meeting <u>(must be face to face)</u> to take place just prior to the client's discharge from the inpatient setting. 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.
3. The inpatient OT will arrange for the client and his/her caregivers to be present at the DL meeting if possible. The DL meeting takes place.
4. In the acute setting:
   if LOS > 7days, proceed with DL meeting;
   if LOS < 7 days, DL meeting is optional

III Topics for Discussion at the Discharge Link Meeting

The following are *suggested* topics to discuss at the DL meeting.

- Client's history
- Client's goals in inpatient setting (those attained, those still outstanding)
- Therapeutic treatment
- Client's response to treatment, suggested approaches.
- Client's progress (functional abilities, other assessments results)
- Client's goals for community and home
- Role of caregivers, family support
- Special needs in community
- Equipment and adaptations
- Where possible and feasible, written materials or instructions such as photos or sketches will be made available at this meeting.

Note:

Please note that the Discharge Link Meeting is not intended do replace any other normally scheduled meetings such as the home assessment. The CCAC home assessment and communications regarding home modifications (if required) will continue in the usual way. The DL meeting will focus on client goals and ongoing therapy to facilitate stroke recovery in the community and/or home environment.

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