Presentation at Community Stroke Rehab Alliance Meeting – HNHB LHIN

General	
Catchment area	HNHB LHIN – 7,000 square km
Population served	1.4 Million in HNHB catchment area and 81,543 CCAC served, Brant and HN catchment area
Referral Volume (anticipated/actual)	December 1, 2013 to October 31, 2014 -33 patients on the pilot and will increase a pilot continues. Anticipated volume was between 54-58.
Average LOS	101 days /approx. 8-12 weeks (from admit to 3 months or the referral code has ended)
Make up of Team	2 Care Coordinators, Stroke Navigator, OT/PT/SLP
Support Staff	Client Services Assistant, Decision Support, Administrative Assistant support
Referral Process	Electronic referral from Meditech to CCAC
Key aspects of the model	The pilot model includes several opportunities to improve both the outcomes and experience of stroke patients in the region, based on best practice standards in stroke care. Key features of the model include: - Specialized CCAC staff, to meet the unique needs of stroke patients - Access to home and community care for stroke patients in Brant and Haldimand-Norfolk - More integrated care from hospital to home, to ensure comprehensive acute and rehabilitation stroke care that includes hospital, primary care and home care.
Communication Strategies employed	Weekly rounds, team meetings, monthly discharge link meeting (interdisciplinary), monthly implementation team working group, quarterly executive committee
Types of services do the patients receive	PT, OT, SLP, system navigation, Information and referral
Average number of visits per health professional each patient receives	12 – 18 visits per discipline: 15 for PT, 12 for OT and 18 for SLP Average total visits: 38
Partnerships	LHIN, Brant Community Healthcare System, Norfolk General Hospital, West Haldimand General Hospital, Central South Regional Stroke Network, HNHB CCAC
Ongoing Projects/Studies	Project has been extended for 2 months with ongoing metrics collection. Review and analysis at one year mark
Patient Satisfaction	
Patient and caregiver satisfaction survey results	Patients were called at the 3 month mark to determine their level of satisfaction with how the team has been supporting them post hospitalization. 6 of the 12 patients (March- June) agreed to provide feedback. (Non- participants included, language barrier, unavailable, did not want to participate). • Overall, how satisfied were you with the help you or your loved one received from the team? – 100% of respondents indicated they were Satisfied or Very Satisfied. • The team members and I decided together what would help me. – 33% strongly agreed they felt included in deciding together what would help them – 50% neither agreed or disagreed: Comments: -"The plan was outlined for us". – 17% strongly disagreed -- Comments: "The amount of service in the beginning was overwhelming" • My therapy program was explained to me in a way that I could understand. – 83% either strongly agreed or agreed

Program Summary

	– 17% strongly disagreed • The team helped me adjust to my life after stroke. – 83% either strongly agreed or agreed – 17% disagreed Comment "I am not sure we will ever adjust" • Would you recommend this team to another family member of friend needing this type or assistance? – 83% Yes – 17% Maybe
Clinical Outcomes	
Functional improvement results	Increase in FIM from intake to discharge, average of 89 to 102 Increase in RNLI from initial to discharge, average of 64 to 83
Are treatment plans completed? Are treatment goals achieved?	Goals achieved for 85% of patients
Access and Transition	
Number of days from referral to the first treatment appointment	Average 5 days for Care Coordinator Average 4 days for Service Provider
Types of organizations that refer patients to the program	Brant Community Health Care System
Of the patients requesting treatment, how many actually received treatment?	100%
Reasons why those patients did not receive treatment	N/A