Presentation at Community Stroke Rehab Alliance Meeting – SW LHIN

General	
Catchment area	South West LHIN – 22,000 sq km
Population served	~900,000
Referral Volume	2013 – 544 2014 – 600
Average LOS	53 days
Make up of Team	3 teams of 1RN, 1PT, 1OT, 1SLP, 1SW, 1TRS, 3RT (some variation due to population)
Support Staff	1 team assistant in London for all three teams, mostly for managing referrals and data. Partial admin support at HP and GB sites
Referral Process	2 page referral form, faxed, or phone call. No physician signature. Online referral soon.
Key aspects of the model	Joint venture involving 3 separate hospital systems, Specialized team, Self-Management focus, Treatment setting home & community, Service delivered to remote communities, Transition from long term care to community living, Community reintegration/linking with community services, Outcome measures on intake, discharge and 6 month follow-up (FIM, PHQ2/9, Bakas, RNLI)
Communication Strategies employed	Weekly rounds, email, cell phones
Types of services do the patients receive	Vision, driving screen, cognition, acupuncture, secondary stroke prevention, diet upgrades, communication, education, strengthening, balance, community reintegration, system navigation, connection to other resources (Social work counselling services)
Average number of visits per health professional each patient receives	2 – 8 per discipline, and up to 15 for the Rehabilitation Therapists Average total visits: 41
Partnerships	VON day program, Betty Cardno Day Program, Boys and Girls Club, Hutton House
Ongoing Projects/Studies	STRIVE home -telerehab project using OTN/ iPads for SLP treatment sessions 2014/15
Patient Satisfaction	
Patient and caregiver satisfaction survey results	2013 Results Very Satisfied and Satisfied (combined) – 91-96% range for the three teams 2013 Would Recommend CSRT – 94-96%
Clinical Outcomes	
Functional improvement results	Increase in FIM from intake to discharge, maintained at 6 months
Are treatment plans completed? Are treatment goals achieved?	Clients show fewer signs of anxiety (Allen et al.) Caregivers experience improvements in well-being (Allen et al.) Clients make gains on the FIM and domains of Stroke Impact Scale (Allen et al.)
Access and Transition	
Number of days from referral to the first treatment appointment	Average 8 – 10 days, though can range depending on caseload pressures, referral volumes
Types of organizations that refer patients to the program	Acute, rehab, CCAC, family physicians, self
Of the patients requesting treatment, how many actually received treatment?	93%.
Reasons why those patients did not receive treatment	No dx of stroke, significant dementia, declined services, deceased, moved out of the SW LHIN, better served by another program (e.g., outpatient, geriatrics)