Guidelines for Presentation at Community Stroke Rehab Alliance Meeting

Details	
Catchment area	Area of SE LHIN
Population served	Any person over 16 who has suffered a recent stroke and is eligible for CCAC therapy services in the community or in LTC
Referral Volume (anticipated/actual)	~270 per year
Average LOS	LOS on Enhanced Therapy Program is up to 8 weeks (SW may be up to 12 weeks)
Make up of Team	CCAC Care Coordinators, contracted therapy staff (PT, OT, SLP, SW – for LTC Homes, PT is provided by the Home)
Support Staff	CCAC team assistants
Referral Process	Regular CCAC referral
Key aspects of the model	Additional therapy - OT, PT, SLP - visits available for first 8 weeks post discharge from hospital (up the 12 weeks for SW). Discharge link meeting between hospital OT and community OT prior to patient discharge from hospital.
Communication Strategies employed	Regular CCAC to SP communication including annual Communiqué, regular CCAC-Rehab Provider meetings. Also, CCAC Client Services meetings.
Types of services do the patients receive	Additional therapy – see Key Aspects above
Average number of visits per health professional each patient receives	For fiscal 13/14 Acute Referrals – OT 5.4, PT 6.7, SLP 4.3, SW 5.6 Rehab Referrals – OT 6.3, PT 7.6, SLP 5, SW 3.6
Partnerships	Stroke Network + SE CCAC
Ongoing Projects/Studies	Semi-annual data evaluation and annual Communiqué trending results since program inception in 2009 (see current Communiqué attached). Also, will have findings published in *Topics in Rehab* (date of publication Nov/Dec 2014). Report from pilot and Communiqués to date can be found on Stroke Network of Southeastern Ontario website – for pilot project http://www.strokenetworkseo.ca/projects/news/regional-projects/completed-projects and for Communiqués http://www.strokenetworkseo.ca/projnewprojects
Patient Satisfaction	
Patient and caregiver satisfaction survey results	Individual interviews were conducted with a number of program participants in fiscal 2010/11.
Clinical Outcomes	
Functional improvement results	Change in functional recovery was measured in pilot project using the Functional Independence Measure (FIM®) at three, six and twelve months post discharge for the usual care control group and the enhanced therapy group. At three months post discharge, the usual care group dropped -2.08 FIM® units while the enhanced group improved +7.32 FIM® units. This disparity in functional change increased by 12 months with the enhanced group attaining a change of +11 units while the usual care group did not sustain the functional level measured at hospital discharge.
Are treatment plans	Yes there are treatment plans and goals are identified

Program Summary

completed? Are treatment goals achieved?	
Access and Transition	
Number of days from referral to the first treatment appointment	< 5days (from hospital d/c to first therapy visit (average for fiscal 13/14 was 4.3 days (median 4 days)
Types of organizations that refer patients to the program	Hospitals – acute and rehab. Infrequent referrals from other CCACs and LTC Homes.
Of the patients requesting treatment, how many actually received treatment?	All
Reasons why those patients did not receive treatment	