Details	
Catchment area	• Waterloo Wellington
Population served	• New diagnosis of stroke – being discharged from a local hospital. • Band 2, 3, or 4 according to WW Stroke Banding Model • Need for multi-disciplinary stroke rehabilitation • Willing to participate • Rehabilitation needs are best met in the home • Patient lives greater than 30 minutes from an outpatient program
Referral Volume (anticipated/actual)	• 156 clients anticipated for year • Currently 74 clients between 1st April 2014 & 30th September, 2014
Average LOS	• Pathway length: 12 weeks. • Current average LOS: 10 weeks.
Make up of Team	• Stroke Care Coordinator • Occupational Therapist (Lead Therapist) • Physiotherapist • Speech Language Pathologist • Social Worker • Dietician • Rehab Assistants (OTA, PTA, CDA) 2 community stroke teams for Waterloo Wellington boundaries.
Support Staff	• Rehab Assistants (OTA, PTA, CDA)
Referral Process	• Admitted to Waterloo Wellington region hospital for new stroke • Assessed, triaged, & assigned band 2, 3, or 4 by hospital Care Coordinator • Discharge Link Meeting (Rehabilitation & Acute Sites) • Discharged to home, linked with consolidated Service Provider – "Stroke Team"
Key aspects of the model	• Discharge Link Meeting (Rehabilitation & Acute Sites) • Designated Stroke Care Coordinators (hospital and community) • Consolidated Service Provider – "Stroke Team" • First visit by community therapist within 48 hours of hospital discharge • 12 week care pathway • Use of Rehabilitation Assistants • 24 hour on-call access to community stroke team • Transition to next phase of rehabilitation
Communication Strategies employed	A Stroke Passport is under development by the Waterloo Wellington Integrated Stroke Program. CCAC is contributing to the development of the passport, and planning around distribution to patients.
Types of services the patients receive	• Occupational Therapy • Physiotherapy • Speech Language Pathology • Social work • Nutrition • Future phase of the model is to add nursing and PSW into the stroke team.
Average number of visits per health professional	• Available visits to provide an intensity of therapy (OT, PT, SLP, SW, Nut, Rehab

each patient receives	Assistants) that is in keeping with best practice (45 min-3hour visits; 3-5x/week)
Partnerships	• WWLHIN • Waterloo Wellington Integrated Stroke Program • Hospital Partners: Grand River Hospital, Guelph General Hospital, Cambridge Memorial Hospital, St. Joseph's Health Centre Guelph • Saint Elizabeth Health Care • Care Partners
Ongoing Projects/Studies	Partnering with the School of Public Health and Health Systems at the University of Waterloo for evaluation. The program evaluation will look at patient functional change, patient experience, and system impact.
Patient Satisfaction	
Patient and caregiver satisfaction survey results	Evaluation pending
Clinical Outcomes	
Functional improvement results	Evaluation pending
Are treatment plans completed? Are treatment goals achieved?	Evaluation pending
Access and Transition	
Number of days from referral to the first treatment appointment	Discharge Link Meeting: meeting with hospital stroke team, community stroke team, hospital stroke Care Coordinator, patient and family prior to discharge from hospital. Initial visit by community therapist, within 48 hours of hospital discharge.
Types of organizations that refer patients to the program	• Waterloo Wellington acute or rehab stroke hospital site.
Of the patients requesting treatment, how many actually received treatment?	
Reasons why those patients did not receive treatment	