Ontario Health atHome

South East Community Stroke Rehabilitation Program

About the Program

Returning home from hospital following a stroke can be a welcomed but difficult time and may leave you, your family and/or caregiver(s) feeling overwhelmed. The Community Stroke Rehabilitation Program in the South East is designed to help you through recovery, ensure your home environment is adapted to meet your new needs and connect you to other services you may require.

Stroke research has found that receiving intense, specialized rehabilitation for up to 12 weeks following discharge from hospital results in the best recovery. Your individual needs and goals will determine how much therapy you receive. These services are provided in your home by therapists that are contracted by Ontario Health atHome.

The Community Stroke Rehabilitation Program aims to:

- Support recovery
- Provide compassionate support
- Enable an earlier return home from hospital
- Assist with a smooth transition to home and to any ongoing community programs
- Improve information sharing between you, your family, caregiver(s) and health care provider(s)
- Prevent emergency room visits and readmissions to hospital

Planning Your Transition Home from Hospital

When preparing for hospital discharge, a community rehabilitation planning meeting may occur, which provides an opportunity for you, your family and/or caregiver(s) to meet with your hospital therapist(s) and one of your new community therapists, to discuss your goals and develop a plan for ongoing recovery.

Rehabilitation services provided may include:

- Occupational therapy (OT)
- Speech language therapy (SLP)
- Social work (SW)
- Physiotherapy* (PT)
  **In long-term care, PT will be provided by your long-term care home*

Your Rehabilitation Goals

Your rehabilitation goals provide the focus for your therapy plan. A team approach is the best way to make the most of your recovery, and you, your family and/or

caregiver(s) are at the centre of this care team. This approach also helps you return home from hospital sooner, improves your ability to participate in your community, return to work, school or volunteering, and overall to stay well living at home.

Once home, your community therapist(s) will arrange in-home therapy appointments, discuss and help you reach goals for recovery. Your plan is your own and may change throughout rehabilitation, and we encourage you, your family and/or caregiver(s) to be involved in all aspects of your therapy plan(s) and care.

Your goals may include, but are not limited to, improving mobility, hand dexterity, thinking and/or communication skills. A social worker can help with your emotional adjustment, provide work or school supports and assistance with applications for financial support, where applicable.

Ongoing Supports

Depending on your individual recovery, you may be eligible to continue receiving therapy services following the 12-week period. Throughout your time as an Ontario Health atHome patient, your team including your care coordinator will work with you to identify ongoing needs such as nursing, personal support, medical equipment and supplies or assistance connecting to community resources and/or programs. Please contact us if you feel your abilities or needs have changed.

Contact Information

You can contact us at any time by calling **310-2222** and ask to speak with your care coordinator.

Notes: