From Wait to Care: Strategies to Improve Waiting Lists and the Waiting Experience in Community Stroke Rehabilitation

Guidance Document

2026

Ontario Health

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Introduction

Waiting lists remain a persistent challenge in health care and continue to hinder timely access to services. The increasing demand for community stroke rehabilitation (CSR) coupled with workforce shortages, funding constraints, and broader system pressures continue to contribute to delays in care.[1] For persons with stroke, prolonged waits can create frustration and anxiety, missed opportunities for optimal recovery, reduced quality of life, and financial strain. Delayed rehabilitation also places significant burdens on family members/informal caregivers, leading to increased responsibilities and fatigue.

The impact of waiting is not experienced equally.[2] Socioeconomic factors strongly influence access to care, with Canadians of lower income facing longer waits despite universal health insurance.[1] Many individuals lack extended health benefits or the means to access private services to offset delays, making equity a central concern in waiting list management.

Timely stroke rehabilitation is critical. Evidence shows there is a time-limited period of heightened neuroplasticity following stroke during which rehabilitation is most effective.[3] The Canadian Stroke Best Practice Recommendations (CSBPRs)[4] advise that in-home or outpatient rehabilitation ideally begin within 48 hours of discharge from an acute care hospital and within 72 hours of discharge from inpatient rehabilitation. CSR programs therefore face pressures to provide timely access while balancing the needs of those waiting with those already receiving care.[5] This has created a dilemma for staff and led CSR programs to identify waiting list management as a priority requiring provincial guidance.

Although the delivery of best-practice stroke rehabilitation exceeds current resourcing, recent provincial investments and the implementation of the Community Stroke Rehabilitation Model of Care[6] indicate important progress. In addition, CSR data collection and reporting creates opportunities to better understand access and service utilization, support quality improvement, and strengthen advocacy for additional resources. Building on these initiatives, further opportunities remain to improve timely, equitable access to CSR.

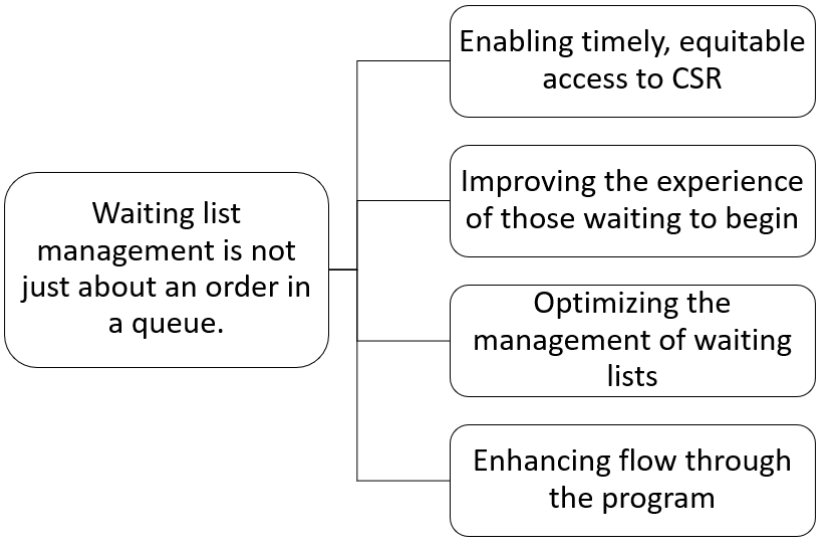

Figure 1. A broader view of waiting list management

Input from persons with stroke and their family members/informal caregivers shaped this work, highlighting that waiting is not simply about a position in a queue but about the experience (Figure 1). Their lived perspectives, several of which are shared in *italicized* quotes, directly informed the strategies outlined in this guidance document to ensure they are person-centred, compassionate, and equity-focused.

A positive waiting experience also requires strong collaboration between acute/inpatient stroke rehabilitation teams and CSR programs. Referral partners share responsibility for preparing persons with stroke for CSR by providing information, resources, and supports that promote continued recovery.

From Wait to Care: Strategies to Improve Waiting Lists and the Waiting Experience in Community Stroke Rehabilitation Guidance Document (guidance document) aligns with the CSBPRs and the provincial CSR Model of Care. Developed by Ontario Health in collaboration with CSR champions across the province, this guidance document is grounded in both clinical expertise and lived experience. (Figure 2).

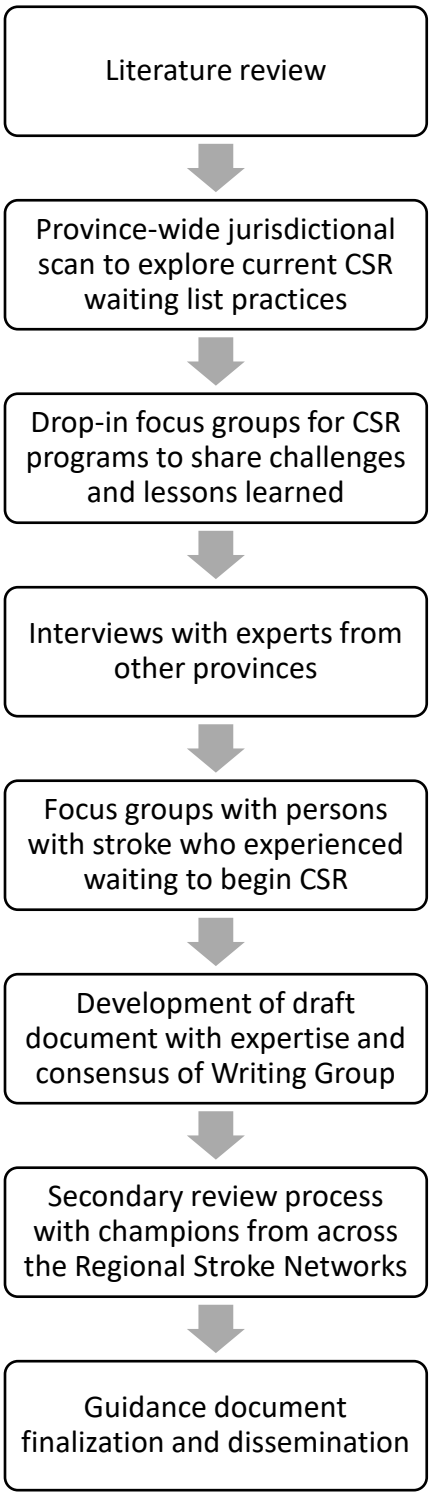

Figure 2. Guidance document development process

Purpose

The purpose of this guidance document is to provide in-clinic, in-home, and in-community CSR programs with strategies to:

- Enable timely, equitable access to CSR,
- Improve the experience of persons with stroke and their family members/informal caregivers while waiting to begin,
- Optimize waiting list management, and
- Enhance flow through the program.

While evidence on effective waiting list management in rehabilitation settings is limited[7,8], these strategies are guided by the core principle that **every eligible person with stroke should receive timely, equitable access to best-practice CSR**.

Outline

The strategies are organized into four sections:

1.0 Enabling timely, equitable access
2.0 Improving the experience while waiting to begin
3.0 Optimizing the management of waiting lists
4.0 Enhancing flow through the program

Strategies within each section are categorized as either:

Provincial recommendations for adoption by CSR programs

Supplementary ideas for CSR programs, in collaboration with Regional Stroke Networks, to consider

The document concludes with guidance on collecting access-related data and using dashboards to support continuous quality improvement around waiting list management and the waiting experience.

CSR programs are encouraged, within available resources, to work towards adoption of the provincially recommended strategies, where not already in place. CSR programs are also encouraged, based on interest and capacity, to consider supplementary ideas for adoption, with many benefiting from collaboration with the Regional Stroke Networks.

While providing leading practice examples is beyond the scope of this guidance document, CSR programs are encouraged to actively engage in the Ontario Health CSR Community of Practice (CoP) on Quorum (by clicking on the JOIN GROUP button if not already a member) to share waiting list management successes, tools and resources that have enabled timely, equitable access, dashboards that have guided access-related quality improvements, and solutions that have enhanced the experience for those waiting to begin CSR.

Strategies

Effective strategies balance timely access to care within the limitations of time and resources.[9,10,11,12,13,14] Ideally, CSR is delivered within a coordinated, integrated regional stroke care pathway. Through this approach, CSR programs can improve operational efficiency, manage waiting lists more effectively, shorten waiting times, and enhance the experience of persons with stroke and their family members/informal caregivers while they wait to begin CSR.

1.0 Enabling timely, equitable access

"*It is frightening and frustrating as you wonder if you will ever be normal again. I was concerned that valuable recovery time was slipping away.*"

1.1 Develop clear referral pathways and processes

Clear referral pathways and processes support efficient referral management, timely access to CSR, and reduced waiting lists. Those involved in referral coordination play a key operational role, and referral management systems can streamline workflows, reduce administrative burden, and improve efficiency – particularly when integrated with electronic medical records (EMRs).

"I had an in-home assessment and rehab while I waited for outpatients. The services helped to support my transition home and provide initial routine."

The aim is to minimize the administrative burden for referral partners and referral coordinators, supporting efficient referral management and timely access to CSR.

Provincial Recommendations

- Develop and educate referral partners on referral pathways and processes.
- Build trusting relationships with referral partners to enable automatic acceptance of referrals without an intake assessment, where appropriate.
- Conduct regular team rounds or huddles to review access-related dashboards, referrals, and waiting lists to balance demand and capacity.
- Audit waiting lists after a defined extended waiting period to confirm ongoing need for CSR or identify changes in status.

Supplementary Ideas

- Explore referral management systems that integrate with EMRs.
- Apply lean-inspired approaches (e.g., value stream mapping) to reduce non-value-added steps in referral processes.[15,16]

1.2 Facilitate referral quality and completeness

High-quality, complete referrals reduce the need for intake assessment visits or phone calls and minimize required follow-up with referral partners. Complete referrals also support timely prioritization and reduce unnecessary delays in scheduling and re-scheduling. The Canadian Stroke Best Practice Recommendations Checklist of Core Transition Summary Information[17] can be considered a best-practice minimum for a quality referral.

Additional information that may support timely admission includes:

- Primary contact person and phone number
- Availability for CSR appointments
- Confirmation that transportation arrangements have been initiated
- Supportive conversation/interpreter requirements

The aim is to enable timely acceptance, prioritization, and scheduling without an intake assessment, supporting a smooth transition into CSR.

Provincial Recommendations

- Develop a standardized referral form that meets the best-practice minimum and facilitates efficient intake and scheduling.
- Ensure referral forms are accessible to referral partners and provide education on the information required to support high-quality referrals.
- Ensure referral review is completed by rehabilitation professionals with stroke expertise.

Supplementary Ideas

- Establish standards for time from referral receipt to intake decision (ideally within 24 to 48 hours).
- Adopt a consistent referral form across neighbouring CSR programs.
- Create feedback loops for incomplete referrals to improve future referral quality.

1.3 Adopt clear acceptance criteria

Clear and transparent CSR acceptance criteria support care delivery, reduce unnecessary referrals, and maximize limited resources. The CSBPRs outline general eligibility criteria for stroke rehabilitation.[18]

Aligned with the CSR Model of Care, CSR programs should also consider accepting persons with stroke who:

- Experienced a stroke **up to one year** prior to referral
- Require **only one** rehabilitation discipline

The aim is to reduce referrals that do not meet acceptance criteria and improve referral prioritization, enabling faster access for those waiting to begin CSR.

Provincial Recommendations

- Adopt CSBPR eligibility criteria and additional criteria aligned with the CSR Model of Care.
- Educate referral partners on acceptance criteria.
- Identify referral partners from whom referrals may be accepted without an intake assessment.
- Proactively connect individuals who are not eligible for CSR with local/regional community supports.

Supplementary Ideas

- Provide feedback to referral partners when referrals do not meet acceptance criteria, including suggested alternatives.

Manage Re-Entry into the CSR Program

The CSR Model of Care supports re-entry to CSR up to one-year post-discharge for persons with stroke with clear, achievable goals. Re-entry requires balancing patient need with program capacity. For programs able to offer re-entry, it can provide follow-up care and linkages to additional community supports.

Supplementary Ideas

- Offer scheduled post-discharge follow-ups (e.g., at six months and one year) to support recovery and reduce unplanned re-entry.
- Provide single-discipline therapy, where appropriate, for re-entry.
- Offer time-limited re-entry trials with defined goals and expectations.

1.4 Apply equitable prioritization criteria

"I was experiencing swallowing issues and choking, but I still had to wait six weeks."

Prioritization supports timely and equitable access by ensuring those with urgent needs are seen first while minimizing bias. While approaches such as specific timely appointments to triage (STAT) appointments immediately on referral can reduce waiting times[19], the recommended approach is a small set of clearly defined **Priority 1** criteria. All other referrals should be scheduled on a first come, first served basis, based on the "date ready for rehab/referral date", consistent with the CSR Data Reporting Initiative (DRI).*

Priority 1 criteria typically focus on safety and include:

- ✓ Home safety risks (e.g., falls, swallowing)
- ✓ Imminent social support risks (e.g., housing, medication access, caregiver support)
- ✓ High risk of re-hospitalization or rapid decline

The aim is to ensure those with the highest need begin CSR as quickly as possible, while others access care in the most equitable manner.

Provincial Recommendations

- Implement Priority 1 criteria and schedule all other referrals on a first come, first served basis.
- Conduct an intake assessment only when required to confirm Priority 1 status.
- Educate referral partners on prioritization criteria to improve transparency and manage expectations.
- Ensure prioritization is completed by rehabilitation professionals with stroke expertise.

1.5 Enhance access through virtual stroke rehabilitation

Studies show that virtual stroke rehabilitation (telerehabilitation) is both feasible and effective for persons with stroke, including those with motor, cognitive, and communication challenges.[20,21,22,23] Its benefits extend beyond direct therapy to include education, skills training, transitional planning, and peer support. A key advantage is improved access, enabling individuals in rural, remote, or underserved communities to receive timely, equitable CSR

* The NACRS Clinic Lite Data Requirements Document for Ontario Community Stroke Rehabilitation Data Reporting Initiative outlines data elements to support consistent, high-quality CSR data reporting.

across geographic boundaries. Lived experience also highlights reduced travel fatigue, greater confidence in self-management, decreased reliance on others, and lower out-of-pocket costs.[4,24] Virtual care can also improve scheduling (e.g., an individual may start virtual therapy with one discipline) and reduce waiting times for rehabilitation[25], though successful implementation depends on adequate digital literacy and access to appropriate technology. Shared decision-making between the individual and the health care team is essential to determine the most appropriate approach – in-person, virtual, or hybrid stroke rehabilitation.

The aim is to enhance access to CSR through flexible, technology-enabled care.

Provincial Recommendations

- Use the Canadian Stroke Best Practices Virtual Stroke Care Implementation Toolkit[26] to guide the implementation of virtual stroke rehabilitation.
- Establish clear processes to support decision-making for virtual stroke rehabilitation considering therapy type, patient comfort, provider familiarity with virtual modalities, and safety.
- Offer a virtual visit when in-person rehabilitation is not available or feasible.

2.0 Improving the experience of waiting to begin

"Waiting lists can't be avoided, so set me up for success with education, home exercises, and information about what to expect."

2.1 Coordinate the transition from hospital to CSR

"I wish someone sat with me and my family and explained what has happened to me and discussed what comes next."

A positive waiting experience begins with effective transition planning and strong collaboration between referral partners and CSR programs. Referral partners share responsibility for preparing persons with stroke for CSR by providing local/regional information, resources, and supports that promote continued recovery. Warm clinical handovers between at least one member of the acute/inpatient stroke rehabilitation team and CSR

Lived Experience Insight: Clear guidance on discharge from hospital

"I really appreciated that the hospital provided me with physical and speech exercises prior to discharge."

- A personalized information package with instructions to continue recovery at home
- A realistic understanding of my recovery, how to stay safe, and what to expect
- Contact information for the CSR program
- A CSR appointment before going home

program team - conducted face-to-face or virtually with persons with stroke and family members/informal caregivers - are widely recognized as best practice and help reinforce continuity and trust.[27,28,29] Whenever possible, individuals eligible for CSR should be identified early during their hospital stay and supported through a coordinated handover. Where resources are limited, CSR programs are encouraged to prioritize handovers for those who may benefit most such as individuals with complex clinical needs, challenging social circumstances, or safety concerns.

"While my father waited for rehabilitation, I did home exercises with him on my own. I was not provided any information."

The aim is coordinated communication between teams so that persons with stroke feel informed and supported throughout the transition, particularly when waiting for CSR.

"My discharge was very well coordinated, the transitions were well planned, and my outpatient visits were already scheduled."

Provincial Recommendations

- Schedule an initial CSR visit prior to hospital discharge, whenever feasible.
- Facilitate warm clinical handovers, whenever feasible.
- Partner with acute/inpatient stroke rehabilitation teams to ensure persons with stroke receive:
  - ✓ A patient-oriented discharge summary (PODS) with a written recovery plan
  - ✓ Information on supports including transportation and equipment
  - ✓ CSR program contact information and location instructions

Supplementary Ideas

- Participate in acute/inpatient stroke rehabilitation rounds to build collaborative relationships and identify individuals eligible for CSR.
- Where this is not feasible, hold regular (e.g., quarterly) acute/inpatient stroke rehabilitation and CSR program team check-ins to discuss opportunities to collaborate and integrate processes.
- Implement a peer support role to support transition to CSR.

Lived Experience Insight: Communication from the CSR program while waiting to begin

"I was given the contact information for the program, knew what to expect, and knew who to call. I was told the wait would be a few weeks."

- One point of contact
- Transparency around timeline
- A call from the CSR program to connect and offer information, support, and encouragement

2.2 Communicate openly

"It was a scary six weeks not hearing from anyone."

Waiting can be one of the most challenging parts of the stroke journey. Clear, empathetic, and proactive communication helps to reduce anxiety and ensures persons with stroke understand what to expect. Communication should avoid impersonal language and support trust, understanding, and patient experience.

"I felt like I was nagging. They told me to wait my turn."

The aim is to maintain meaningful contact with those on the waiting list to provide reassurance, transparency, and confidence, and foster positive experiences.

Provincial Recommendations

- Provide honest and realistic estimates of waiting times.
- Identify a designated CSR program contact person for questions.

Supplementary Ideas

- Offer a telephone check-in after a defined waiting period (e.g., two weeks) to share updates, answer questions, and provide information.

2.3 Empower with support, education, and resources

"It is very easy to fall into a depression when you are waiting for services."

Recovery should not pause while persons with stroke wait for CSR. Providing education, resources, and navigation support helps to reduce anxiety and frustration, promotes self-management, and improves readiness for rehabilitation. Navigation support from both the acute/inpatient stroke rehabilitation team and CSR team plays a critical role in connecting individuals to local services, community-based supports, and recovery information during this transition.[30]

Lived Experience Insight: Peer and mental health supports

"I got involved in everything I could. I got involved with community programs, peer support, joined day programs."

- Connections to community peer stroke recovery groups and programs to share with others who have had similar experiences
- Counselling support

"I think a stroke navigator could have made a significant difference for my father."

The aim is to empower persons with stroke and family members/informal caregivers while waiting, supporting recovery and improving their experience.

"Peer support would have been beneficial while waiting."

Provincial Recommendations

- Connect persons with stroke and family members/informal caregivers to local peer support groups and community-based programs.
- Offer navigation support whenever possible.
- Collaborate with the Regional Stroke Network to maintain a current list of trusted educational resources and community-based services on the network website.
- Where local options are limited, connect persons with stroke and family members/informal caregivers with provincial and national programs and resources.

Lived Experience Insight: Stroke recovery information and resources

"I really valued the stroke passport resource provided by the hospital. It became my second bible."

- Written information that is local, easily accessible and considers the unique needs of those with communication challenges
- Include family members whenever possible any time information is shared
- Repeat the information as it is often difficult to fully absorb it the first time

Supplementary Ideas

- Offer virtual or in-person group education sessions aligned with the Canadian Stroke Best Practice Recommendations Education and Self-Management Checklist[31] to individuals on the waiting list.

2.4 Have a digital presence

A clear and accessible digital presence can be a key touchpoint for persons with stroke and family members/informal caregivers. Easily available program information and links to local resources promote transparency, sustain communication, and improve the waiting experience.

The aim is to provide accessible information to support individuals while they wait to begin CSR.

Supplementary Ideas

- Develop a CSR webpage in collaboration with the communication team or Regional Stroke Network.
- Utilize voice mail and email (with consent) to share updates and direct individuals to community-based and online resources.

2.5 Gather waiting list experiences

"The waiting period intensified the emotional adjustment after my stroke."

Input from persons with stroke and family members/informal caregivers who have waited – or are waiting – for CSR provides valuable insight into gaps and opportunities for improvement.

Lived Experience Insight: Support navigating next steps

"The navigator was great. He did a lot for us, explained timelines, offered to help with employment insurance."

- A list of community-based services and practical guidance, encouragement, and support to navigate next steps including connecting with local programs, arranging transportation, obtaining equipment, and securing financial aid

The aim is to embed lived experience into program planning and improvement.

Supplementary Ideas

- Gather feedback on waiting experiences to inform quality improvement efforts.
- Share how feedback influenced changes, reinforcing the value of lived experience.

3.0 Optimizing the management of waiting lists

3.1 Explore a centralized intake model

Centralized (single-entry) intake models improve efficiency by standardizing referral processes, reducing duplication, and decreasing administrative burden.[32] They provide real-time visibility of referrals and waiting lists, allowing referrals to be directed to the most appropriate setting and supporting more equitable access. Evidence from the Auditor General of Ontario highlights the limitations of fragmented, provider-specific waiting lists and supports system-wide, coordinated intake approaches for community-based services, including rehabilitation.[33]

The aim is to improve referral management through a centralized approach that reduces duplication, administrative effort, and waiting times, ultimately improving access to CSR.

Supplementary Ideas

- In collaboration with the Regional Stroke Network:
  - ✓ Explore centralized intake across neighbouring CSR programs
  - ✓ Consider a local/regional approach to access-related dashboards and multidisciplinary rounds or huddles
  - ✓ Explore local/regional collaboration to create consistent communication and standardized referral management practices

3.2 Adopt effective scheduling practices

"I was put in back-to-back therapy sessions, but it was too much and I needed breaks."

Efficient scheduling benefits persons with stroke, their family members/informal caregivers, the CSR program, and the health care system by reducing waiting times, improving coordination, minimizing cancellations, and optimizing use of clinical capacity. There are several different approaches to scheduling that CSR programs can consider for implementation, each with trade-offs (Table 1). This is not a complete list, and CSR programs are encouraged to consider combining elements from these approaches to improve access.

Table 1. Scheduling approaches, their advantages and disadvantages, and key considerations

Approach	Description	Advantages	Disadvantages	Key Considerations
Intensity-based scheduling	• Visit frequency/ duration driven by clinical goals and recovery	• Most closely aligned with best practice (dose-response relationship) • Outcome-focused • Links resources with clinical rationale	• Hard to sustain with limited resources • Complex to manage • May not reduce waiting lists	• Use assistants and group programming • Monitor outcomes to ensure equity

Approach	Description	Advantages	Disadvantages	Key Considerations
Fixed/block scheduling	• Recurring, set appointment times for the duration of care • Caseloads organized in predictable blocks	• Predictable for individuals/ caregivers (e.g., transportation planning) • Easy caseload management • Predictable timelines for scheduling new referrals • Supports routine	• Limited flexibility for missed visits • Hard to fill cancellations • Waiting times increase when blocks are full • Inefficient if attendance is inconsistent • Prioritizes administrative ease over individual need	• Clear attendance/ cancellation policies required • Consider overbooking for no-shows • Schedule back-to-back visits where appropriate
Group-based scheduling	• Group therapy alongside planned one-on-one sessions	• Increases capacity without added staff • Supports peer interaction	• Less individualized care • Less flexible scheduling • Perception of lower effectiveness • Not suitable for all • Requires adequate space/ equipment	• Group by functional level • Combine with one-on-one sessions to meet goals
Hybrid flexible scheduling	• Mix of recurring with reserved, flexible appointments (e.g., urgent, new, rescheduled)	• Balances predictability and flexibility • Adapts to changing needs • Supports responsiveness	• Operationally complex to manage • Requires strong scheduling infrastructure • Flex spots can erode if not used properly	• Clear definition of how flex spots are to be utilized • Regularly review flex spot utilization

Approach	Description	Advantages	Disadvantages	Key Considerations
Open access/next appointment scheduling	• Appointments booked one to five days in advance • Capacity reserved for new referrals	• Reduces waiting times • Lowers no-show rates • Responsive to individual availability and needs	• Difficult with high referral volumes or staffing shortages • Resource-intensive • Potential inequities in access • Transportation planning challenges	• Harder to implement with existing waiting list • Requires clear understanding of demand and capacity • Hybrid models are often more feasible
Tiered access	• Individuals triaged by acuity/ complexity • High-need receive intensive one-on-one therapy; lower-need receive less frequent or group care	• Prioritizes highest-need individuals • Clinically driven scheduling • Supports higher volumes	• Risk of underserving lower tiers • Triage may be difficult to standardize fairly • Individuals may feel deprioritized • Requires reassessment for tier changes	• Use validated tools for triage • Define step-up/down criteria • Monitor equity across tiers

Regardless of the model used, electronic scheduling systems can improve efficiency, automate reminders, and manage complex multidisciplinary schedules. Integration with EMRs further reduces administrative burden.

The aim is to schedule CSR appointments efficiently, supporting effective waiting list management and flow into the program.

"I could have started my physio first instead of waiting for all the therapists to be ready."

Provincial Recommendations

- Implement an **initial contact policy** for new referrals:
  - ✓ At least two phone contact attempts over approximately one week
  - ✓ Close referral one week after last contact attempt if no reply
  - ✓ Inform the person with stroke and primary care provider (PCP)/referrer in writing regarding referral closure
- Implement a **planned delayed start policy**:
  - ✓ Acceptable reasons for delay (e.g., illness, transportation)
  - ✓ A maximum delay of approximately one month, depending on the nature of the delay, after which the referral is closed
  - ✓ Inform the person with stroke and PCP/referrer in writing regarding referral closure
- Offer staggered starts if one of the required disciplines is available before others.
- Maximize use of rehabilitation assistants.
- Hold regular team rounds or huddles to review schedules, caseloads, and anticipated discharges.

Supplementary Ideas

- Work with the information technology team to further explore smart scheduling functions within existing EMR platforms.
- Establish program-level expectations for caseloads and appointment benchmarks to support consistency and capacity optimization.
- Investigate group-based rehabilitation models such as circuit class therapy.[34,35]

4.0 Enhancing flow through the program

4.1 Adopt clear cancellation, attendance, and hold policies

Missed CSR appointments disrupt recovery and reduce access for others waiting to begin. Clear, consistently applied cancellation, attendance, and hold policies protect therapy time, support predictable scheduling, and improve operational efficiency and flow. They must be applied, however, with care and empathy in a manner that considers social determinants of health and family member/informal caregiver responsibilities and minimizes barriers to participation.

The aim is to reduce unused appointments, enhance flow through the CSR program, and optimize capacity while maintaining a compassionate, person-centred approach.

Provincial Recommendations

- Offer a virtual or phone visit to accommodate individuals who cannot be available for an in-person visit, where appropriate.
- Communicate all policies verbally and in writing at program entry and document understanding and commitment.
- Consistently apply the policies with empathy.
- Implement a clear **cancellation policy**:
  - ✓ Requesting 24 hours' notice when unavailable
  - ✓ Rescheduling when more than 24 hours' notice is provided for an acceptable reason
  - ✓ Considering appointments cancelled with less than 24 hours' notice as missed
- Define **acceptable reasons for cancellation**:
  - ✓ Illness
  - ✓ Conflicting medical appointment
  - ✓ Caregiver unavailability
  - ✓ Severe weather
  - ✓ Transportation issue
- Implement a clear **attendance policy**:
  - ✓ Discussion of attendance concerns after two missed appointments
  - ✓ Discharge after three missed appointments, depending on the reasons
- Implement a **medical hold policy**:
  - ✓ Acceptable reasons (e.g., medical instability, active investigations, hospital readmission, changes in mental health status)
  - ✓ Medical clearance to restart the program, depending on the nature, severity, and duration of the medical change
  - ✓ A maximum hold of approximately two weeks (in alignment with the CSR DRI) after which discharge occurs
- Implement a clear **patient readiness hold policy**:
  - ✓ Acceptable reasons (e.g., limited activity tolerance, caregiver unavailability, transportation issues, financial challenges)
  - ✓ Responsibility for follow-up rests with the person with stroke and their family member/informal caregiver
  - ✓ Consideration of a planned restart date (i.e., a pre-determined hold length)
  - ✓ A maximum hold of approximately one month, depending on the nature of the hold, after which discharge occurs

4.2 Prioritize self-management

Building self-management skills enables persons with stroke to take an active role in their recovery and community re-integration. Higher self-efficacy supports smoother transitions into and out of CSR, reduces reliance on formal services, and improves program flow by creating capacity for others to begin rehabilitation.

The aim is to empower persons with stroke, with support from family members/informal caregivers, to self-manage their ongoing recovery and long-term health, thereby improving flow through the program.

Provincial Recommendations

- Link persons with stroke with existing self-management programs.
- Provide individual and/or group self-management education aligned with the Canadian Stroke Best Practice Recommendations Education and Self-Management Checklist.[31]
- Share self-management resources:
  - ✓ Canadian Stroke Best Practices - Enabling self-management following stroke: A checklist for patients, families, and caregivers[36]

CSR Data to Improve Timely Access

Systematic CSR data collection and monitoring enable a clearer understanding of access, service utilization, and care gaps, and support continuous quality improvement. CSR dashboards provide real-time visibility into performance, support data-driven decision-making, and have been shown to improve timely access to rehabilitation for persons with stroke. CSR programs are encouraged to develop dashboards, establish performance targets or benchmarks, and review data regularly through team rounds or huddles.

CSR programs that consistently have a waiting list may wish to consider the following access and flow metrics to display in a dashboard and guide improvement efforts. A few examples shared by CSR programs include:

- Number of new referrals
- Number of new persons beginning rehabilitation
- Number of persons actively receiving rehabilitation (i.e., current caseload by discipline)
- Number of persons waiting to receive rehabilitation (priority 1 and others by discipline)
- Median number of days on the waiting list (i.e., median number of days between date ready for rehab/referral date and date of first rehab attendance/visit by discipline)
- Number of cancellations
- Number of no shows
- Number of persons discharged from the program
- Average length of stay (days or weeks) in the program

These metrics can then be used to calculate additional operational indicators such as expected weekly discharges or the rate of waiting list clearance.

Consistent use of data and dashboards supports targeted actions to strengthen program and system performance and improve timely, equitable access to CSR for persons with stroke.

Acknowledgements

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Persons with Lived Experience

Input from persons with stroke and family members/informal caregivers with experience waiting to begin CSR was gathered by Regional Stroke Rehabilitation Coordinators who spoke individually to persons with stroke, attended stroke-specific Patient and Family Advisory Councils, and facilitated focus groups in partnership with the March of Dimes After Stroke Program. There were over 65 participants in total.

Secondary Review Process

Members of the Ontario Health (CorHealth) Stroke Rehabilitation Advisory Committee (SRAC) participated in a secondary review process to provide feedback on the draft guidance document. The SRAC is co-chaired by Dr. Benjamin Ritsma (Physiatrist, Providence Care, Queen's University, Kingston) and Shelley Huffman (Regional Director, Southeastern Ontario Stroke Network), and includes clinical stroke experts, stroke rehabilitation clinicians and administrators, Regional Stroke Network Rehabilitation Coordinators and Regional Directors, and patient advisors.

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