August 15, 2023

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Community Stroke Rehabilitation Model of Care

Southeast Region: Current State and Gap Analysis Results

Session Outline

- CSR Model of Care
- Project milestones
- Gap analysis results
- Next steps

Community Stroke Rehab: Model of Care

CSR Definition from Model of Care

- Community stroke rehabilitation is defined as care provided by an interprofessional team with stroke specific expertise, who are guided by best practice recommendations.
- Care is provided in a person centered and coordinated manner, on average over 8-12 weeks, and is delivered in the settings that best meet the needs of person with stroke's goals (home and/or clinic setting and/or both).
- CSR allows the opportunity for access from the community, from hospital and for re-entry to services, with follow up as required and linkages to community supports to ensure successful maintenance of functional recovery and community re-integration.
- See the full Model of Care for Community Stroke Rehabilitation for more information.

CorHealth CSR Project Milestones

Community Stroke Rehabilitation

3-5 Year Framework towards developing a Standardized and Equitable CSR Program

Assess	Inform	Measure	Implement
Assess Gap • Goal 1: Understand the gap between the current state and best practice of community stroke rehabilitation (CSR) in Ontario.	Inform Decisions • Goal 2: Understand and evaluate access, timeliness and utilization/volumes of CSR using data collected at community-based rehabilitation service providers.	Measure Outcomes • Goal 3: Recommend a functional patient outcome measure(s) that can be feasibly and practically administered in CSR.	Implement Recommendations • Goal 4: Implementation of local, regional and provincial recommendations to improve the stroke system of care.

Community Stroke Rehabilitation

Year 1 Milestones

- Developed and launched a provincial Model of Care for CSR
- Conducted a current state assessment of CSR services and Gap Analysis
- Developed Local, Regional and Provincial Recommendations
- Created an ideal state of community stroke rehabilitation access (patient pathways to CSR services)

Assess Gap

- Defined performance indicators
- Standardized and defined CSR minimum data set
- Conducted detailed investigation for data platform
- Developed an implementation plan

Developed a CSR data strategy, including

- Developed an equitable distribution of early investments with OH Regions and Stroke System leaders

Implement recommendations

Gap Analysis Results

Current State Assessment & Gap Analysis Methodology

- In partnership with Heart & Stroke and Regional Stroke Directors; Rehabilitation Coordinators were also instrumental collaborators
- Two (2) surveys were administered: CSR program and “No Program”
- 18 stakeholder engagement sessions:
  - 11 Stroke Networks
  - 3 Focused Sessions covering North*, Home Care, “No Programs”
  - 4 persons with lived experience (PWLE) including one focused on younger stroke and one for persons with aphasia
- Summary of attendance:
  - Stroke Network sessions: 260 participants
  - Focused sessions: 74 participants
  - PWLE sessions: 50 participants

*Additional FNI HCC engagement was conducted by North West Stroke Network.

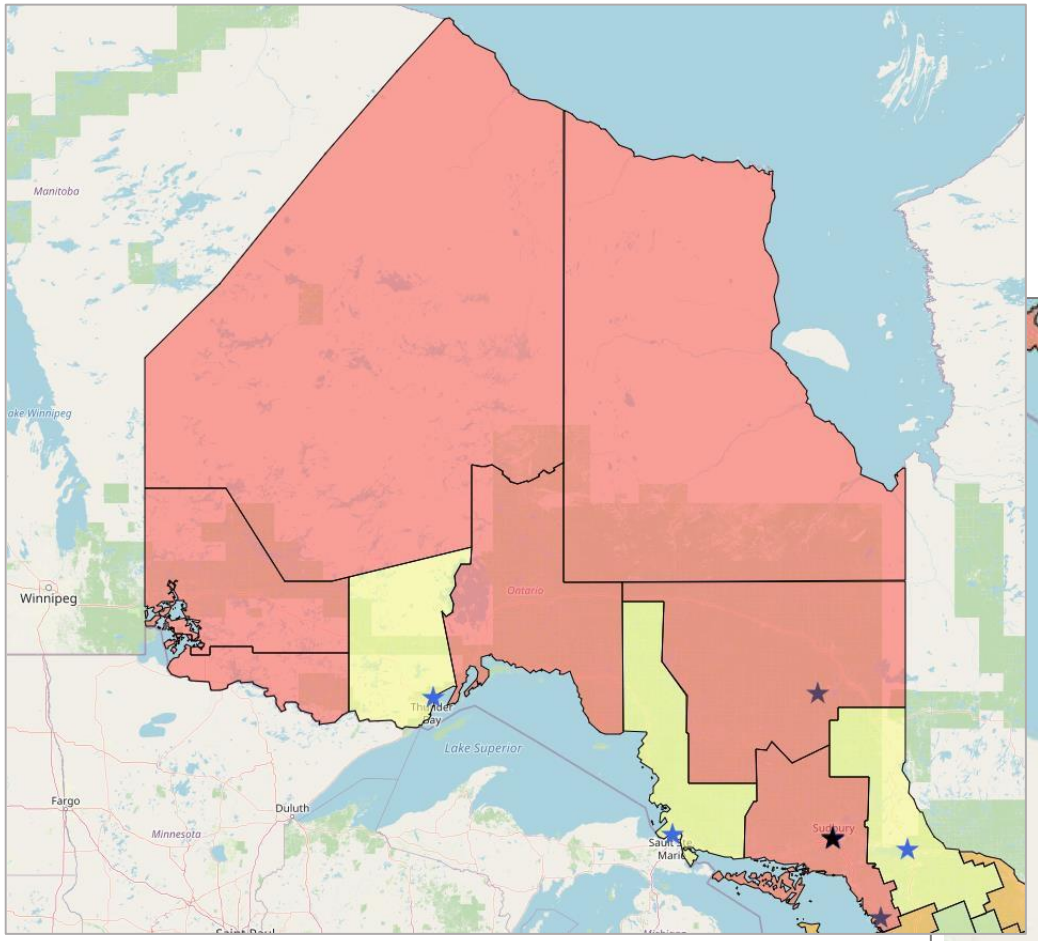
Current State: Introduction

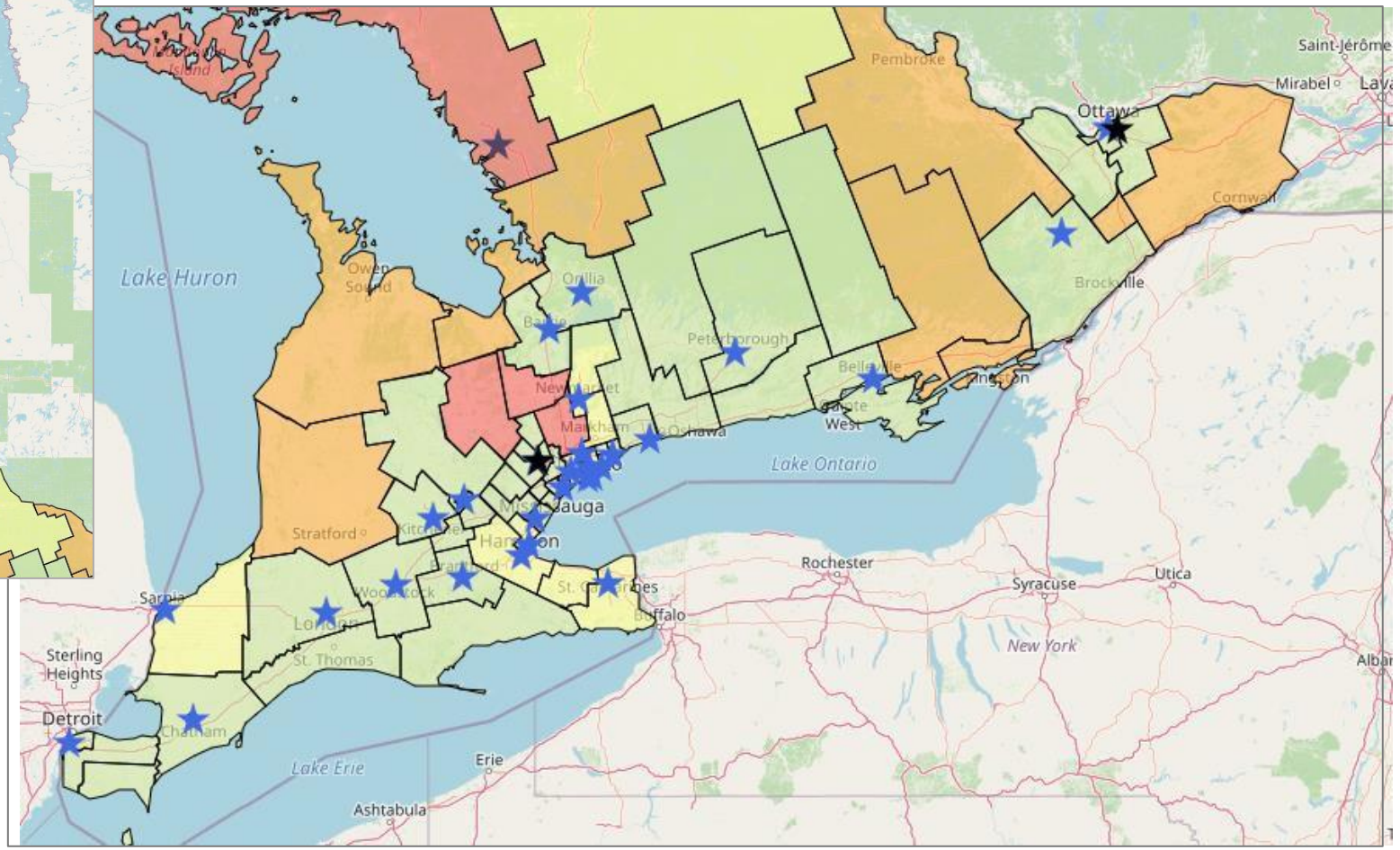
For the purposes of assessing current state, a CSR Program was defined as having at minimum some capacity to provide physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) stroke services as a team.

- CSR is currently provided by 50 programs in Ontario's hospitals and Home Care and Community Support Services (HCCSS) sector with most programs in the hospital sector
    - In the hospital sector, CSR is delivered by a multi-disciplinary dedicated CSR team. Hospital based Care is primarily provided in the outpatient clinic setting, and some programs provide care in-home.
    - Some hospital-based CSR programs provide a hybrid model of outpatient and in-home CSR delivered by the same team.
    - In the HCCSS sector, CSR is delivered primarily in the patient home, with some care occurring in an outpatient clinic setting.
- While persons with stroke ideally require access to both clinic-based and home-based rehabilitation to meet their goals, the mix of outpatient vs in-home CSR care **provision varies significantly across regions**

Snapshot of Ontario CSR Service Access by Sub-Region

December 2022





★ Sites with OP CSR Only

★ Sites with OP & In-home CSR

★ Low volumes (<25)/ Developing CSR Sites

CSR Services Available

- No CSR Services
- OP CSR Only
- In-home CSR Only
- OP & In-home CSR

Note: Presence of a CSR Program within/adjacent to a sub-region does not guarantee access for the full subregion

Highlights of Current State and Gaps of CSR in Ontario

Highlights of Current State and Gaps of CSR in Ontario

Access

- 26% of stroke patients that should receive CSR services do not
- Wait time to access CSR can range from less than 2 weeks to 7 weeks or more
- 10/76 sub-regions have no access to in-home or outpatient CSR care
- 7/76 sub-regions have In-Home only access to CSR care
- 44% gap in the intensity (duration and frequency) of care
- CSR programs define the maximum intensity/duration of services irrespective of patients' needs/goals;
- 47% of programs do not allow re-entry for new rehabilitation goals.

Highlights of Current State and Gaps of CSR in Ontario

Capacity

- Some CSR programs offer 8-12 weeks of service; however, intensity of service varies significantly
- ~50% of CSR programs report using virtual care
- 57% of CSR programs do not have PT/OT/SLP/SW as part of their core team
- 80% of programs do not have access to psychologists, psychiatrists, or neuropsychologists for consultation
- Limited specialized health human resources issues exist

Highlights of Current State and Gaps of CSR in Ontario

Rurality

- 13% of Ontarians who have a stroke reside in rural areas
- Significant challenges to access CSR in rural areas: weather, long travel distances, transportation infrastructure, technology/connectivity issues, limited availability of health human resources (HHR), and diseconomies of scale
- Significant number of limited or no CSR programs in subregions primarily in the North Region

Highlights of Current State and Gaps of CSR in Ontario

Patient Centered

- Navigating the current fragmented system is a prominent challenge for persons with stroke
- CSR providers lack time to coordinate care; 30% of programs do not have EMR that all team members can access
- Stroke survivors often struggle with anxiety, depression, and social isolation, making mental health and emotional health support an integral part of their recovery
- CSR programs don’t have the capacity to provide ongoing counselling and support related to the impact of stroke on mental health nor do they provide linkages to publicly funded mental health services
- CSR providers identified the following populations as having less access than others: Indigenous peoples, people experiencing homelessness, Mennonites, and non-English speaking people.

Gap Analysis Results - Southeast

Process Gaps

CSR team coordination and communication

Minimal integration between CSR services and other providers along the care continuum

Highly variable or no access to CSR

Lack of transition support after CSR

Resource Gaps

Lack of sufficient health human resources

Virtual care delivery challenges

Lack of transition support after CSR

Lack of transportation strategy

No education strategy for patients/families/caregivers

Highly variable or no access to CSR

Outcome Gaps

Extended wait times

Highly variable or no access to CSR

Gap Analysis Results - Southeast

Local Themes

- Poor CSR team coordination and communication
- Lack of sufficient health human resources
- Minimal integration between CSR services and other providers along the care continuum
- Lack of a transportation strategy

Gap Analysis Results - Southeast

Local Themes

- Virtual care delivery challenges
- Lack of transition support and available community support programming after CSR
- No education strategy for patients/families/caregivers
- Highly variable or no access to CSR
- Extended wait times

Gap Analysis Results - Southeast

Process Gaps

- CSR team coordination and communication
- Minimal integration between CSR services and other providers along the care continuum
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- Lack of transition support after CSR

Gap Analysis Results - Southeast

Resource Gaps

- Lack of sufficient health human resources
- Virtual care delivery challenges
- Lack of transition support after CSR
- Lack of transportation strategy
- No education strategy for patients/families/caregivers
- Highly variable or no access to CSR

Gap Analysis Results - Southeast

Outcome Gaps

- Extended wait times
- Highly variable or no access to CSR

Gap Analysis - Persons with Lived Experience (PWLE) Themes

Lack of patient navigation and care coordination

- Patients are required to advocate for themselves and self-navigate or have their family/caregivers take on this role; this leads to additional burden, stress, and anxiety
- Support is found in very random places and seems dependent on someone "kind" to help them
- Patients feel lack of navigation delays access and impacts their outcomes; drive some patients to the private sector at personal cost

Gap Analysis - Persons with Lived Experience (PWLE) Themes

Limited duration and frequency

- Long wait lists to access CSR services limit flexibility in duration and frequency of care
- Staffing availability (e.g. vacation coverage, vacancies) impacts duration and frequency
- Limitations may be set on the number of home care visits a patient receives
- Programs often end abruptly rather than winding down slowly over a longer period

Gap Analysis - Persons with Lived Experience (PWLE) Themes

No education strategy for patients/families/caregivers

- Patients were not given educational materials, those who did receive materials did not have a CSR team member review information with them
- Insufficient education is provided on stroke prevention, fatigue, cognitive impacts or stroke and accessing supports
- Impact of stroke on relationships is often missed or inadequately addressed
- Education is not coordinated

Gap Analysis - Persons with Lived Experience (PWLE) Themes

Lack of a transportation strategy

- If lose their driver's license and now rely on transportation services or family/caregivers for transportation
- If there are no programs to provide transportation; persons with stroke may be unable to access outpatient care.
- Eligibility criteria for transportation services prevents some patients from accessing the service
- Accessible transportation is not always available depending on where the person lives

Discussion

Are there any surprises in the results?

What is the most important gap in our region?

What investments are needed?

Gap Analysis Results - Southeast

Process Gaps

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Lack of sufficient health human resources

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Outcome Gaps

Extended wait times

Highly variable or no access to CSR

Priority Gaps: Potential Opportunities

- Travel Strategy
- Therapy schedules and intensity
- Enabling staff to provide care in more than one setting
- Virtual Care
- Access to stroke experts for support/resource
- Transition support and care coordination
- Other?

Next Steps

Next Steps

Local collaboration

Funding opportunities

Provincial CSR dataset