Community Stroke Rehab Model of Care

June 14, 2023

Travis Wing

Presentation Outline

- Community Stroke Rehab Model of Care
- CSR in the Southeast
- CSR Access Pathways
- Gap Analysis Results
- Future opportunities and next steps

strokenetwork
SOUTHEASTERN ONTARIO

Community Stroke Rehab Model of Care

Released September 2022

MOH Plan to Support Community Stroke Rehab

- Purpose: multi-year project to enable an equitable, integrated and patient-centered system of care that supports recovery of people after experiencing stroke.

- Scope: planning, development and implementation of a comprehensive post-stroke publicly funded community rehabilitation programs across Ontario to provide post-stroke community-based care in a consistent and equitable way.

- Initial funding investment for 2022-23 for necessary planning and information gathering to inform Community Stroke Rehabilitation (CSR) program development.

Community Stroke Rehab: Key Challenges

Access	• Provincial gap in access to community stroke rehabilitation • Rehabilitation services not optimized as a system to support patient flow and best practice
Best Practices	• No standard of care for Community Stroke Rehabilitation, hence variable regional implementation of services (i.e., no standard of care) • No consistent approach / tools to measure patient outcomes in community rehab to measure Functional status, Re-integration, Patient/Caregiver experience, etc.
Data	• Lack of outpatient rehabilitation data • Inconsistent reporting of metrics and lack of standard definitions • Virtual care measurement and evaluation not in place across settings • Lack of detailed data makes it hard to accurately quantify the access gap across regions

CorHealth CSR Project

Year 1 Milestones

- **Assess Gap**
  - Understand the gap between the
  - Current state and best practice of CSR in Ontario
- **Inform Decisions**
  - Understand and evaluate access, timeliness and utilization/volumes of CSR using data collected at community-based rehabilitation service providers
- **Implement Recommendations** Implementation of local, regional and provincial recommendations to improve the CSR system

strokenetwork
SOUTHEASTERN ONTARIO

CSR Model of Care

Population

Team Members

Referral Process

Care Settings

Duration of Care

Clinical Delivery

strokenetwork
SOUTHEASTERN ONTARIO

Who should be receiving the care/services?

Stroke Survivors

- Meaningful goals
- Medically manageable and safe in-home setting
- Willing to participate

Includes:

- Persons with stroke who have goals related to transferring skills learned in the hospital setting to the home
- Persons with stroke who require varying intensity and frequency of rehabilitation
- Persons with stroke who only require one rehabilitation discipline and/or case management or care coordination

CSR Model of Care

Population

Team Members

Referral Process

Care Settings

Duration of Care

Clinical Delivery

strokenetwork
SOUTHEASTERN ONTARIO

Who should be delivering the care?

- Teams should include at a minimum OT, PT, SLP, Therapy Assistants, and SW, administrative assistant and stroke care coordinator/navigator
- Nurse or access to a nurse with stroke expertise
- Pathways for accessing additional team members and specialists for consultation, assessment or treatment

What are the areas for provider training and development?

- Process in place to keep team members up to date on available community resources appropriate for persons with stroke, their families and caregivers
- Process for continuing education on stroke best practices to CSR Team members
- Training in supportive conversation for adults with Aphasia for all team members

CSR Model of Care

Population

Team Members

Referral Process

Care Settings

Duration of Care

Clinical Delivery

strokenetwork
SOUTHEASTERN ONTARIO

How is care accessed?

- Clear referral pathways with acceptance criteria available and communicated to all referral sources
- Multiple referral sources should be accepted including from acute care, IP rehab, primary care, stroke prevention clinics and clinicians working in home care and person with stroke
- Person with knowledge about stroke reviews referrals- meet Best Practice standard for processing referrals (within 24-48 hrs.)
- Linking inappropriate referral to other services where appropriate
- **Transition planning**

CSR Model of Care

Population

Team Members

Referral Process

Care Settings

Duration of Care

Clinical Delivery

strokenetwork
SOUTHEASTERN ONTARIO

Where should care be delivered?

- Mix of both outpatient clinic setting and the home setting according to the person with stroke's needs and goals
  - In person
  - Virtual
  - Groups
- Movement between settings can be non-linear

CSR Model of Care

Population

Team Members

Referral Process

Care Settings

Duration of Care

Clinical Delivery

strokenetwork
SOUTHEASTERN ONTARIO

How long are services provided and how are person with stroke transitioned?

- 8-12 weeks on average
- Frequency guided by best practice (45 min per day per required discipline, 2-5 days per week)
- Flexibility in use of visits over time and delivering care at times most optimal for persons with stroke's success
- Time to first visit
  - 48hrs from Acute
  - 72hrs from Rehab

Ontario Health

Transition out of the program

- Ensure persons with stroke have a good understanding of how and when this will occur
- Community re-integration planning
- Communication is key
- Contact information for continued advice and support from required persons and services
- Peer supports
- Person initiated follow up pathways /planned follow ups

CSR Model of Care

Population

Team Members

Referral Process

Care Settings

Duration of Care

Clinical Delivery

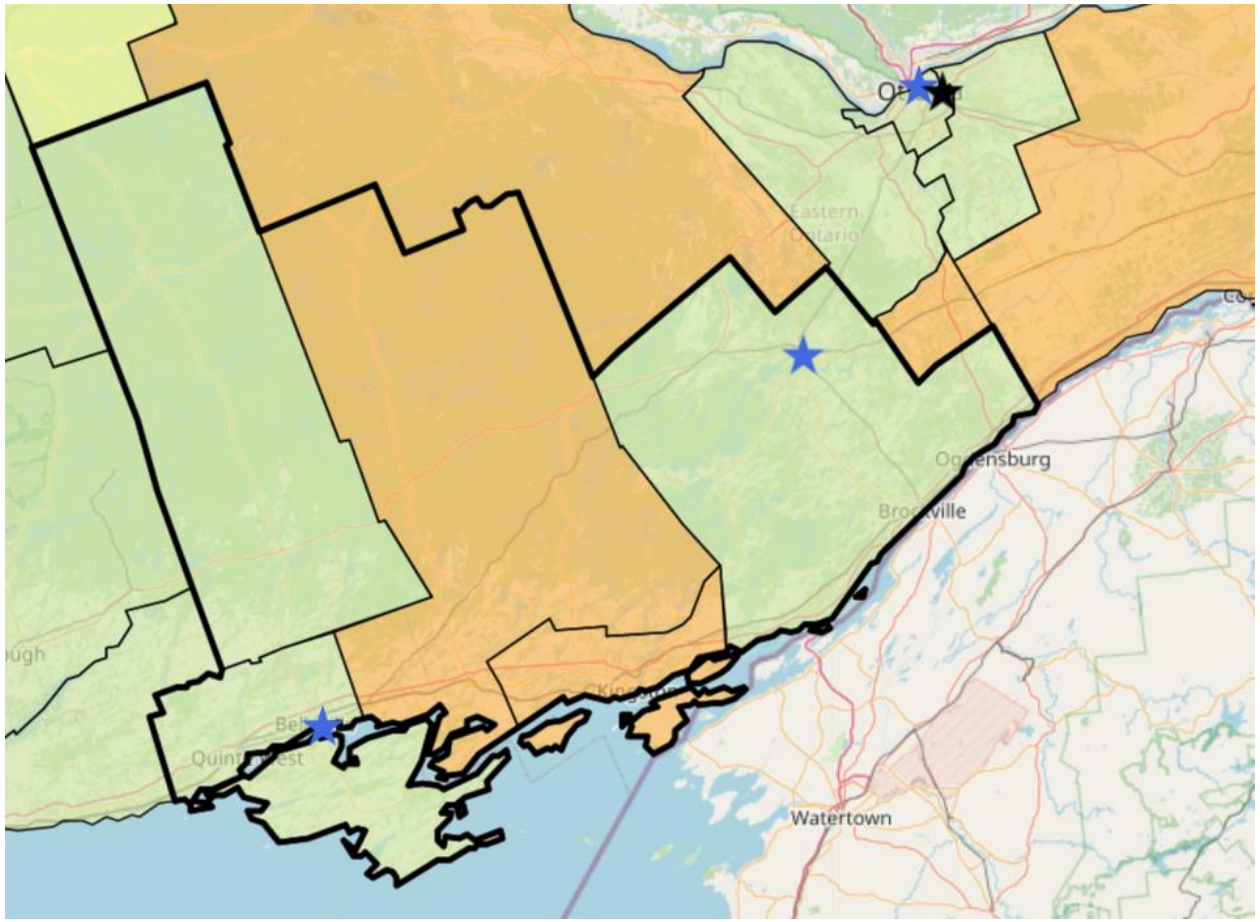
strokenetwork
SOUTHEASTERN ONTARIO

What care should be delivered?

- Clinical Assessments as per best practice guidelines
- Readiness and education needs of person with stroke, their families and informal caregivers
- Evidence based treatment as well as:
  - General emotional and psychosocial supports
  - Vocational Rehabilitation
  - Community reintegration planning
  - Return to driving
  - Education and counselling on impact of stroke on relationships

Community Stroke Rehab in Southeastern Ontario

CSR in the Southeast



CSR Services Available

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

- Sites with OP CSR Only
- Sites with OP & In-home CSR
- Low volumes (<25)/ Developing CSR Sites

strokenetwork
SOUTHEASTERN ONTARIO

CSR in the Southeast

In Home Programs

- HCCSS-SE
- Kaymar Rehabilitation
- Quinte District Rehab
- CommuniCare Therapy

Outpatient Programs

- Quinte Health
- Perth Smiths Falls District Hospital

CSR in the Southeast

- Community Stroke Rehab Program provided by HCCSS-SE was established in 2009
- Program provides intensive, specialized In-Home therapy for stroke survivors for up to 12 weeks.
- Therapy teams include:
    - Physiotherapy
    - Occupational Therapy
    - Speech Language Pathology
    - Social Work
    - Rehab Assistants

strokenetwork
SOUTHEASTERN ONTARIO

Home and Community Care Support Services South East
Community Stroke Rehab Program 2021/2022

549 admissions to the Community Stroke Rehab Program, a decrease of 4% from the previous fiscal year.

81% of patients received visits from at least two disciplines. 7% of patients received visits from all four disciplines.

Median time to first therapy visit increased from 4 to 5 days.

Individuals in rural settings had lower average of PT & OT visits.

158 Community Rehab Planning Meetings. 29% of CSRP Patients received a CoRP Meeting.

78% of patients received at least one virtual visit from their therapist:
PT 58% | OT 70% | SLP 41% | SW 42%

HOME AND COMMUNITY CARE SUPPORT SERVICES
South East

strokenetwork SOUTHEASTERN ONTARIO

Program Summary and Resources

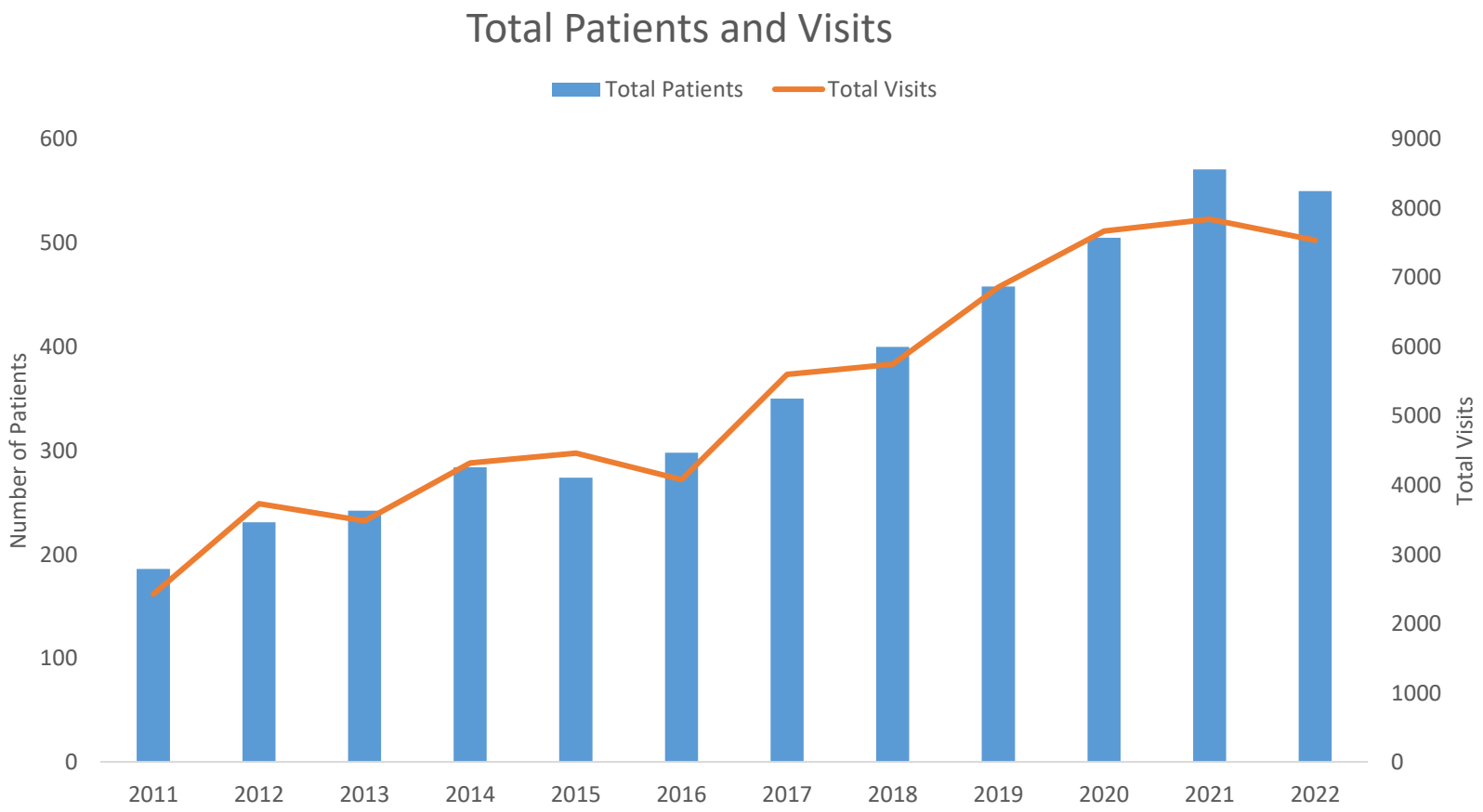
Community Stroke Rehab Program Description

Eligible stroke survivors following their hospital discharge to either community or long-term care (LTC) receive the appropriate level of therapy to support their ongoing rehabilitation through the provision of: PT, OT, SLP, and SW.

Community Stroke Rehab Program		
	Weeks 1-4	Weeks 5-12
OT	Up to 12 visits over 4 weeks	Up to 16 visits over 8 weeks
PT	Up to 12 visits over 4 weeks	Up to 16 visits over 8 weeks
SLP	Up to 8 visits over 4 weeks	Up to 8 visits over 8 weeks
SW	Up to 4 visits over 4 weeks	Up to 4 visits over 8 weeks

strokenetwork SOUTHEASTERN ONTARIO

CSR in the Southeast



strokenetwork
SOUTHEASTERN ONTARIO

Community Stroke Rehab Access Pathway

Denotes select patients only

Pathways to Community Stroke Rehab (CSR)

***CSR Team:**
Person with stroke, OT, PT, SLP, SW, Stroke Navigator/Care Coordinator, Administrative Support, Rehabilitation Assistants

CSR Team collaborates with:
- Nursing with expertise in stroke
- Dietician, recreation therapy, other
- Medical support (general to specialist)
- Mental health supports
- Specialty clinics (spasticity, seating, pain, other)

⁺Community Supports:
- Return-to-work/vocation supports
- Return to driving supports
- Exercise groups
- Communication groups
- Family and caregiver supports
- Peer support groups
- General health and wellness programming
- Chronic Disease Self-Management Programming
- Other supports specific to your community and person with strokes goals around community re-integration
- Adult Day Programs

Persons with stroke living in the community who need CSR assessment for entry or re-entry *(referrals from primary care, community clinicians, stroke prevention clinic, ED, self-referral and/or patient-initiated follow-up post initial CSR stay)*

Persons with stroke discharged from hospital *(transitioning from acute care, high-intensity, or low intensity rehab)*

Pathway 1: **Consultation and Advice by CSR team**

Does the person require Pathway 2 services?

Yes

No

***Pathway 2**: **Community Stroke Rehabilitation Team/Program** (*Patient-centred care provided by interprofessional team with stroke specific expertise; provided in-home and/or clinic setting)*

Pathway 3: **Transitioned to Community Re-Integration Directly by In-Hospital Team**

^Pathway 4:
Transitioned to Long Term Care:
- After in-hospital stay
- After CSR services
- Already in Long Term Care with need for CSR

^Currently out of scope; potential future pathway

⁺Community Supports:
Explore readiness for involvement in community re-integration early and enable connection to supports

Transition from the CSR program
- When initial goals are met and when transition to community supports is appropriate
- Ensure person with stroke has contact information and has received education around reasons for follow up with CSR team or other community supports

Patient/provider-initiated follow-up pathway

Estimate of CSR demand based on volume of Acute stroke patients admitted in a selected geography (e.g subregion)

Sub-sets of Community Stroke Rehabilitation Pathways	Estimated Percentage of Acute Stroke Volumes	Translation of Volume Demand based on Sample of Acute Stroke Volumes = 1000 pts (for a geographic region)
Acute to CSR	**20%**	200
Acute to High-Intensity Rehab to CSR (with or without stay in Low-Intensity Rehab in-between) . High-intensity rehab refers to rehab occurring in NRS beds	90% of the 30% of patients who proceed to high intensity IP rehab will required CSR = **27%**	270
Acute to Low-Intensity Rehab to CSR (with or without stay in high-intensity rehab in-between). Low-intensity rehab refers to rehab occurring in CCC beds.	Approx. 50% of the 4% of persons with stroke who proceed to low-intensity rehab will require CSR = **2%**	20
Stroke Prevention Clinic to CSR	**3%**	30
Primary Care, Community Care, Out of Province/Other Referral Sources to CSR	**3%**	30
Patient or Provider Initiated Follow-Up Post CSR Stay to re-entry in CSR	**5-8%**	80
Long-Term Care to CSR (currently out of scope)	**0.3%**	
Total demand for Community stroke rehabilitation in this scenario (60-63% of total acute stroke volumes)		**630 patients/year**

Gap Analysis Results

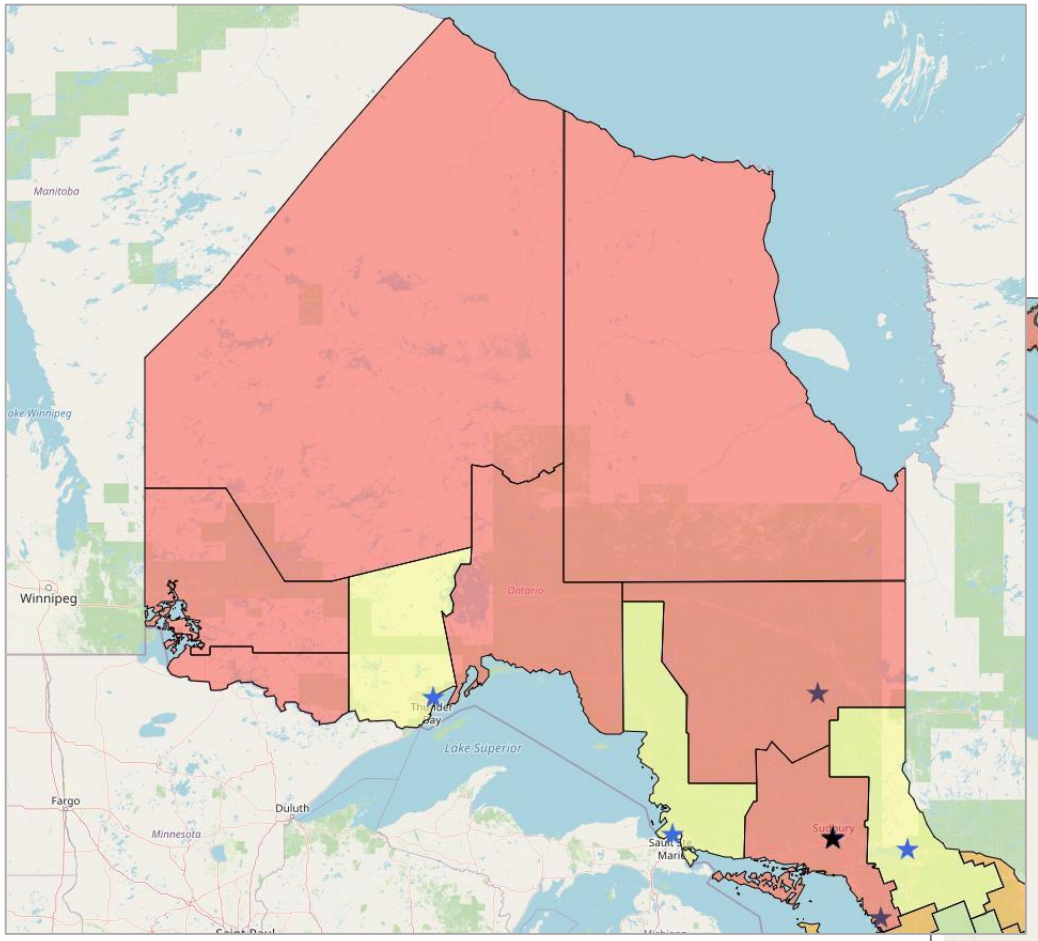
Current State Assessment & Gap Analysis Methodology

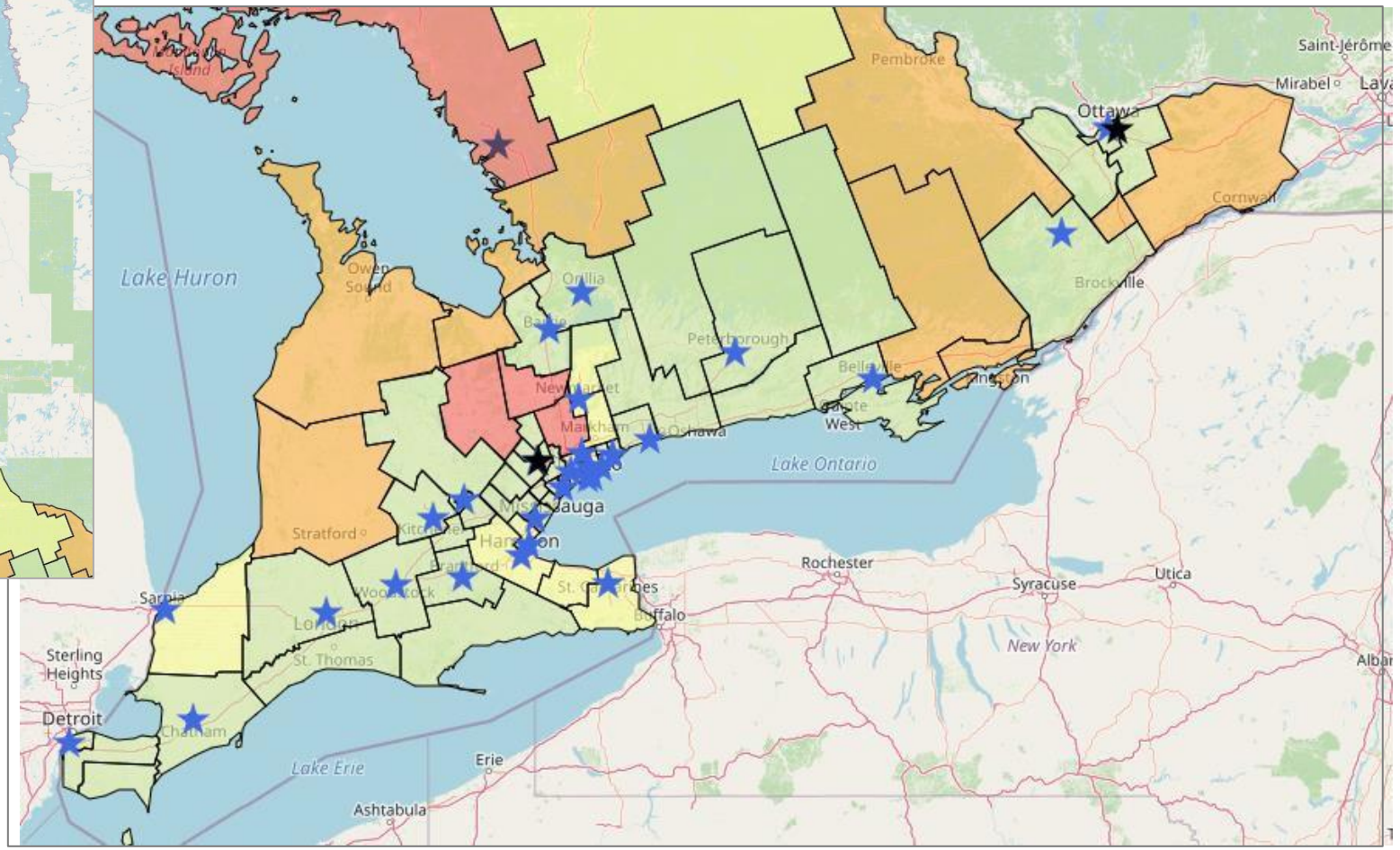
- In partnership with Heart & Stroke and Regional Stroke Directors; Rehabilitation Coordinators were also instrumental collaborators
- Two (2) surveys were administered: CSR program and “No Program”
- 18 stakeholder engagement sessions:
  - 11 Stroke Networks
  - 3 Focused Sessions covering North*, Home 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.

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

Gap Analysis Results

Provincial Themes	Access, service intensity and duration
	Patient centred care
	Patient/family centred care to adjust to impact of stroke
	System Integration
	Specialized stroke services
	Funding and Health Human Resources

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis Results

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

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis Results

Local Themes	Extended wait times
	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

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis Results

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

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis Results

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

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis

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

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis – 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

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis – 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

strokenetwork
SOUTHEASTERN ONTARIO

Gap Analysis – 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

strokenetwork
SOUTHEASTERN ONTARIO

Opportunities to align to Model of Care

What components of the Model of Care are already in place in the southeast?

What components of the Model of Care would have the most impact if implemented?

Did the gap analysis capture all of the gaps you have experienced?

strokenetwork
SOUTHEASTERN ONTARIO

Next Steps

Share Gap Analysis results

- Southeast webinar – Summer 2023
- Sub-region workshop – Fall 2023

Review and align with CSR Data Strategy

- Outcome Measure pilot in KFLA

Readiness for CSR funding opportunities

strokenetwork
SOUTHEASTERN ONTARIO

Welcome to Quorum

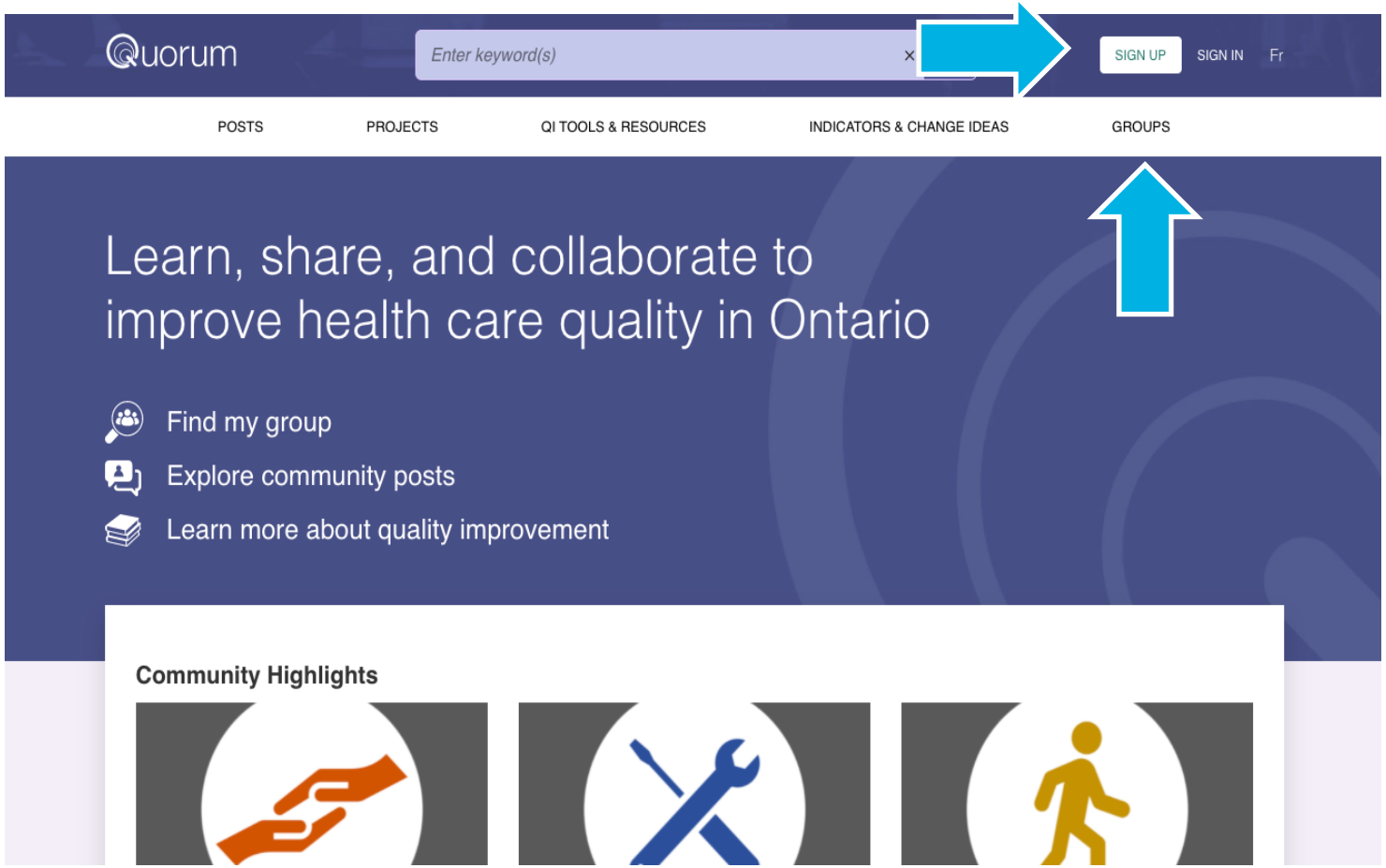
- Quorum is Ontario Health's online health care quality improvement community.
- We will be using Quorum as part of our **Community Stroke Rehabilitation Community of Practice**.

Community Stroke Rehab CoP

- The Community Stroke Rehabilitation Community of Practice (CoP) is for Regional Stroke Network staff, Ontario Health regional staff, and clinical and administrative staff involved in implementing the new Model of Care for Community Stroke Rehabilitation across Ontario.
- Through this CoP members will increase their awareness of leading practices and gain access to resources, tools and strategies that can be used to improve the quality of care provided within existing CSR programs and in standing up new programs.
- Members will work together to identify solutions to common challenges, share lessons learned, and collaborate towards future sustainability of programs.
- The CSR CoP includes a mix of synchronous and asynchronous communications channels to stayed connected, and support members of the CSR CoP:
  - Virtual CoP Meetings
  - Online Platform (Quorum)

How to Join

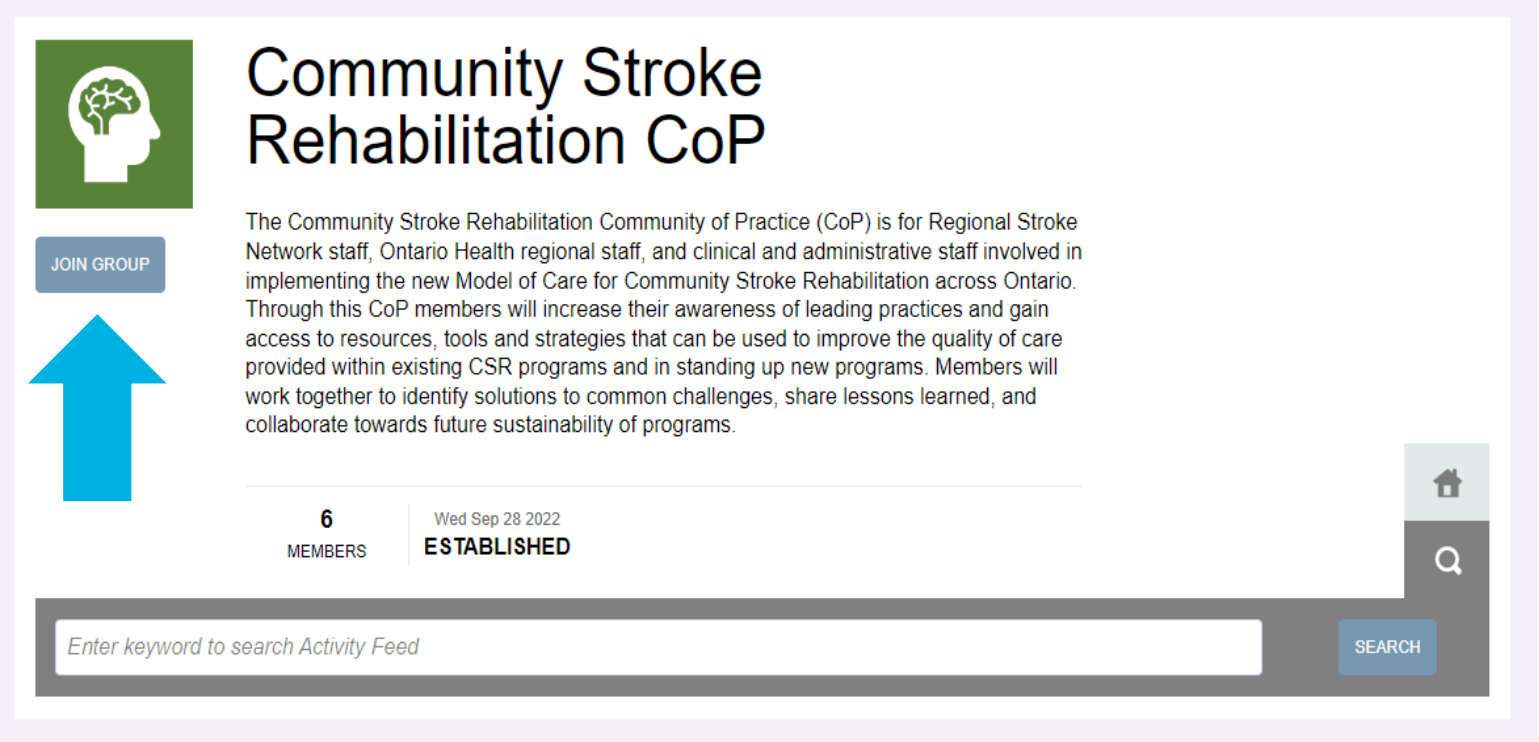
- Create an account on Quorum by clicking on the SIGN-UP button.
- Visit the GROUPS page



quorum.hqontario.ca

How to Join (continued)

- Visit the Community Stroke Rehabilitation Community of Practice and click the JOIN GROUP button.
- *You will be notified via email when access is granted.*



Subscribe to Updates

- Don’t forget to click on “**subscribe to updates**” once you’re in the group!
- Subscribing means you will be notified via email when there is new activity in the group.