STROKE NETWORK *of* Southeastern Ontario

Acute - Rehab - Community (ARC)

Stroke Services and Transitions Pathway

Regional Report

December 2019

Prepared by:

Stroke Network of Southeastern Ontario

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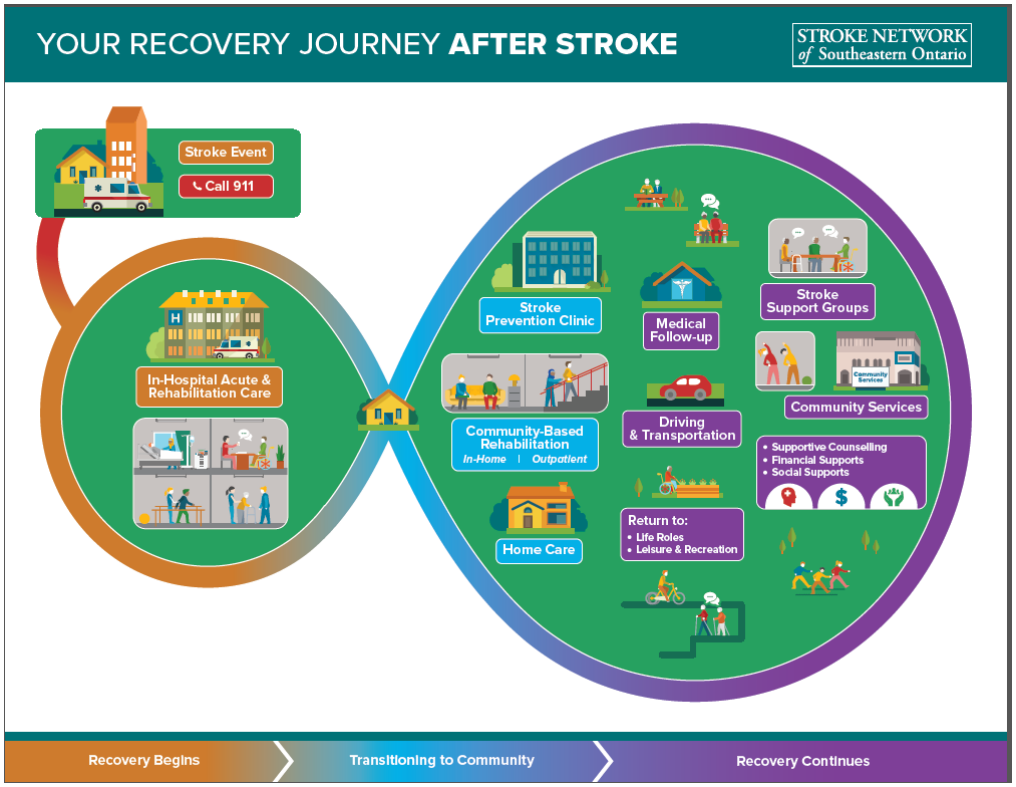

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1.0 Executive Summary

In 2019 the Regional Stroke Network established a regional priority to "*Support providers in the clinical implementation of a patient and family-centred approach to bundled care in acute/inpatient rehab/community stroke care*". This report on Acute Rehab and Community (ARC) Stroke Services and Transitions summarizes work to date to support this priority.

The key activities included:

A. Development of a one-page pathway of core elements across acute, rehab and community (ARC) stroke services highlighting transitions. This tool served as a basis to develop self-assessment tools for each acute, rehab and community stroke service across the region.
B. Completion of self-assessments for a total of 16 separate services across 12 organizations representing all the southeast stroke service provider groups. The breakdown of these by services was: Acute (3 teams), Inpatient Rehab (4 teams), Outpatient Rehab (2 teams), Home and Community Care (SE LHIN), Community Rehab Providers (3 teams), Community Support Services (3 teams). Overall, the self- assessments revealed the following:
    - Significant commitment and experience to provide stroke services and supports across the continuum;
    - Variation in teams' access to data for input into self-assessments;
    - Challenges in allied health resources across the region and across the continuum;
    - Impacts on response times between transitions (after hyper-acute) due to 5 day/week services;
    - Existence of gaps in creating warm hand-offs and closing the feedback loop between services and
    - Evident passion for stroke care across the region with a keen interest in learning from others.
C. Delivery of a collaborative networking event with 65 participants to share learning both within and external to the southeast and to begin initial identification of priorities for action. The design for this half-day event included the sharing of the ARC pathway and self-assessment results, providing a provincial and regional context, sharing regional and local updates on integrated stroke services and transitions, learning from outside our region (Waterloo Wellington), sharing the stroke survivor and family experience, and facilitating a discussion around key elements for hospital to community transfers to generate ideas for addressing the challenges identified in self-assessments.
D. Planning and support for ongoing local and regional follow-up activities to include: a) delivery of a Navigation workshop in 2020; b) compilation of a Transition Toolkit to support teams and c) support to local teams in developing and implementing action plans associated with their self-assessment and learning.

The overarching key message is that working as "one team" better supports the patient and family and prepares our region for future funding models based on integrative care approaches.

2.0 Introduction

An identified priority of the 2019/20 – 2020/21 Stroke Network of Southeastern Ontario (SNSEO) plan was to "*Support providers in the clinical implementation of a patient and family-centred approach to bundled care in acute/inpatient rehab/community stroke care*". In order to address this priority the following objectives were developed.

1. Develop a Southeast (SE) Stroke Pathway with common components and parameters in alignment with bundled funding/QBP standards.
2. Deliver a Regional Forum to:
   a) Support information on current state, expectations and gaps and to identify priorities for change/action;
   b) Support knowledge translation in bundled care through local action plans.

In order to select quality improvement activities or changes within or between teams that would best align with creating a unified experience for the patient and family, it was important to collectively identify common goals and current status. Therefore, over the past several months health care providers within the southeast collaboratively described core elements of the stroke recovery journey from the time of admission to acute care through to the community setting. At the same time, a group of patient and family advisors assisted in the development of a Patient Journey Map to depict the "ideal journey" from their perspective.

The key activities included:

1. Developing a one-page summary of core elements across acute, rehab and community (ARC). This became the Stroke Services and Transitions "ARC" pathway;
2. Facilitating the development by stroke survivors and families of a Patient Journey Map to depict the "ideal journey" from the patient and family perspective;
3. Facilitating self-assessments across the care continuum using the identified team and transition core elements;
4. Hosting a collaborative networking event to share learning both within and external to the southeast and to begin initial identification of priorities;
5. Identifying and supporting regional activities to enable progress particularly around transition activities; this included developing and promoting a toolkit of resources for use by teams to support transitions;
6. Conducting follow-up meetings with individual teams to respond to gaps and opportunities identified in the self-assessments, the focus for 2020/21.

3.0 Acute Rehab Community (ARC) Stroke Services and Transitions Pathway

Patients and families have consistently stressed the importance of a seamless journey where all teams and organizations are working within a common pathway to support stroke recovery. The creation of a pathway identifying common core elements of stroke services and transitions for acute, rehabilitation and community responded to this expectation. Note that a regional algorithm and detailed local

pathways and protocols already existed for hyperacute stroke and TIA management. Bundled care begins at the point of admission. Therefore, this pathway begins at the point of admission. It was recognized that our southeast stroke system has built expertise within teams and it was now imperative that the focus shift to how our teams might effectively act as "one team" for the patient and family. The development of the ARC pathway focused on high level clinical best practice elements that prepared for and supported patient transitions between teams. This also aligned with the goal of bundled care; integrating services that focus on quality to enable improved care and support.

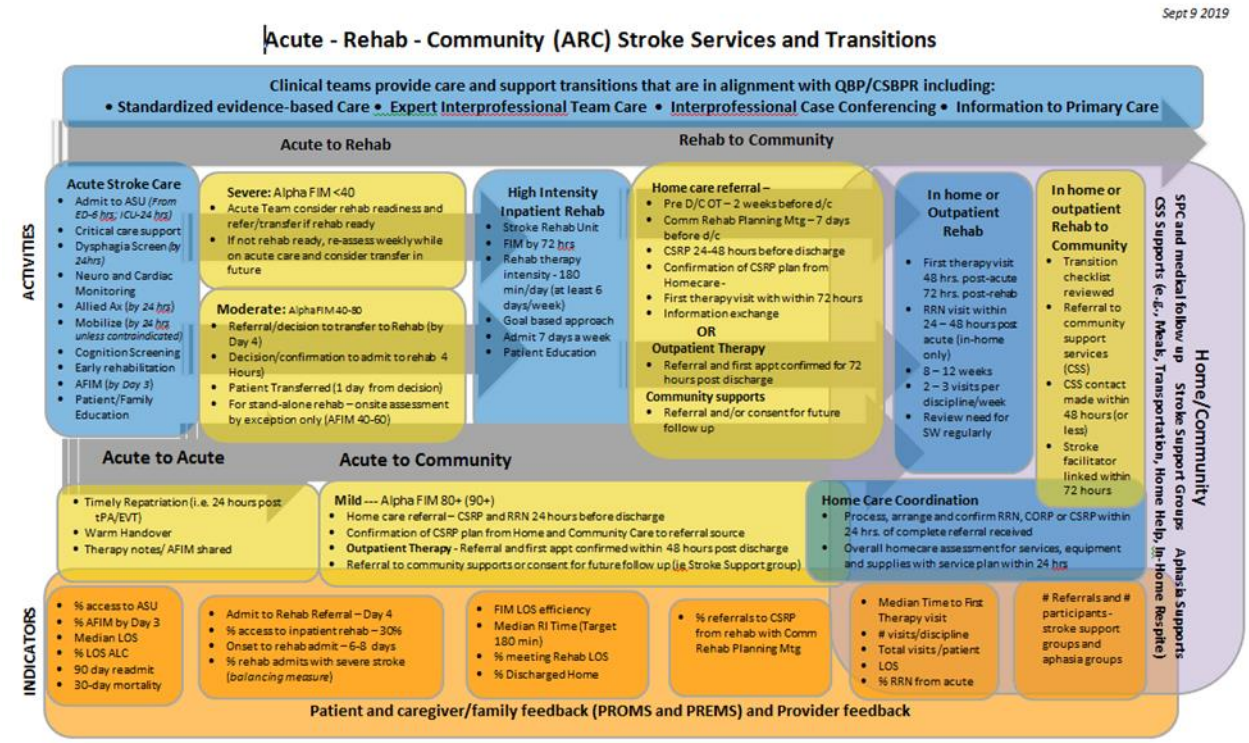


Figure 1: ARC Stroke Services and Transitions Pathway

In April 2019, work began to identify the key elements of stroke care and transition activities from the point of admission to acute care through transition to the community (ARC Pathway – see Figure 1 and Appendix A). Recognizing that the journey of each patient is different, the pathway is not intended to be linear, but rather, is intended to identify key components within each setting. For example, the pathway also illustrates that connections directly from acute care are needed for many patients while others may have a second hospital journey within inpatient rehabilitation. This tool complements the Patient Journey Map that was developed by patient and family advisors in 2019 (see Appendix B). The design of the Stroke Services and Transitions pathway allows for the delineation of elements that were "within a team" which are represented by blue boxes. The yellow boxes contain key elements occurring between or across teams during transitions. This work very quickly expanded to include community services that, while not currently identified as a funded part of bundled care, are critical to the support of patients and their families following transition to the community. Highlighting this inclusive approach, the pathway includes a violet box for home and community-based supports and services. Although Secondary Stroke Prevention Services are also understood to be critical to community

transitions and positive patient outcomes, these services were out of scope for bundled care and associated funding. This essential service was left off the transition pathway at this time.

The orange boxes at the bottom have high level key indicators that align with the various parts of the continuum. These indicators are either in current use in the region or are expected to be implemented as a part of bundled care. These indicators will continue to be updated as more information becomes available.

The entire pathway will be an iterative document as new key best practices emerge and/or evidence changes. The pathway is intended to provide a regional perspective and to reflect the services and flow of patients within the southeast. It formed the basis for developing team self-assessment tools which was the next phase in the project.

4.0 Self- Assessments

Throughout July to September 2019, teams across the continuum participated in short education sessions about the pathway and completed the self-assessment tool. The self-assessment tool included 2 components for each part of the continuum: a) core elements for activities within their team services and b) transition elements. Each team received the self-assessment relevant to their setting and service. For each element, teams were asked to consider their usual practice and assign a ranking of Complete, Partially Complete or Incomplete based on definitions described in Figure 2 below. This resulted in local conversations and self-assessments that reflected those conversations and individual team practices. This local exercise was intended to support quality improvement and, as such, it was the conversations which were of most benefit and produced some key areas to improve within all teams.

Self-Assessment Scoring:
C – Completed: indicates requirement has been achieved
P - Partially/In-progress: indicates requirement is partially in place, but ongoing work required for full implementation
I – Incomplete - indicate requirement not yet implemented; opportunity for improvement identified

Figure 2: Self Assessment Scoring Definitions

Self-assessments were completed with a total of 16 separate services across 12 organizations representing all the southeast stroke service provider groups. The breakdown of these by services was: Acute (3 teams), Inpatient Rehab (4 teams), Outpatient Rehab (2 teams), Home and Community Care (LHIN), Community Rehab Providers (3 teams), Community Support Services (3 teams).

A detailed summary of the self- assessment rankings for each part of the continuum can be found in Appendix C. Key observations for each part of the continuum are described below:

Acute Stroke Care: Partial gaps were identified related to the availability of the full interprofessional team 7 days a week and/or the capacity to meet timelines for several key elements (such as Alpha FIM scoring on Day 3). One team does not have access to social work as part of their team (QHC). Sustaining activities were noted to be a challenge and included, for example, sustaining stroke unit utilization rates (KHSC), dysphagia screening for nursing (Brockville) and use of stroke information packages (Brockville and KHSC). Other notable comments raised included delays or disconnects between medical team members and other team members that impacted discharge planning or communication with patient/family. Strengths were identified in awareness and delivery of stroke best practices and clinical protocols. Sites have varying degrees of access to outpatient therapy and information post-discharge.

Rehabilitation (Inpatient): Partial gaps were noted across all sites related to the availability of a full complement of the interprofessional team (PSFDH and QHC do not have access to social work) and to the capacity to deliver best practice rehabilitation intensity. Limitations were reported at all sites except QHC for admissions on weekends. Some challenges were reported across all sites in relation to consistent and standard linkages to community supports and services. Strengths were identified in knowledge of stroke best practices within the teams.

Rehabilitation (Community): Outpatient hospital based therapy and in-home teams reported limited resources to provide timely first appointments and limited capacity to sustain best practice therapy service levels. Use of assistants is not maximized in outpatient services and not used at all in the in-home setting. Outpatient and most community teams reported strength in community linkages. Community teams identified gaps with respect to sharing information with primary care and their ability to share stroke patient information packages. Community teams identified strengths in contacting clients within 2 day to arrange first visit.

Community Coordination and Supports: The support of Rapid Response Nurse (RRN) home care services were identified as a key component of this service area showing strength in timely visits and contact with patients. Gaps were identified by home and community care in the consistent sharing of information/status updates with primary care and in having consistent ways to follow up and offer social work services later in the process. Strengths were identified in timely communication and linkage with clients. Community Support Service agencies reported consistent processes to contact clients with strong internal processes available to link to supports or sister agencies offering a wide range of relatively consistent services across the region.

Overall, the self- assessments revealed the following:

- Significant commitment and experience to provide stroke services and supports across the continuum;
- Variation in teams' access to data for input into self-assessments;
- Challenges in allied health resources across the region and across the continuum;
- Impacts on response times between transitions (after hyper-acute) due to 5 day/week services;
- Existence of gaps in creating warm hand-offs and closing the feedback loop between services;
- Evident passion for stroke care across the region with a keen interest in learning from others.

These findings were used to help plan the Regional Stroke Services and Transition event in September 2019 to promote regional learning, sharing and development of action plans.

5.0 Regional Stroke Services and Transitions Symposium - Summary

5.1 Program Overview

The half-day event titled "*Facilitating Transitions Across the Stroke Care Pathway*" was held on September 18, 2019 in Kingston with 65 participants from across the continuum. Participants included managers, coordinators and front line providers.

The goals of the event were:
1) To share the southeast status related to integrated stroke services and transitions and;

2) To identify regional and local opportunities to support clinical implementation of a seamless, high quality patient experience in preparation for bundled funding.

The design for this half-day event included the sharing of the ARC pathway and self-assessment results, providing a provincial and regional context, sharing regional and local updates on integrated stroke services and transitions, learning from outside our region (Waterloo Wellington), sharing the stroke survivor and family experience, and facilitating discussion around key elements for hospital to community transfers. All presentations were posted on the SNSEO website for participants to access. The following outlines key messages from the event. These added to the pathway and self assessment materials which are addressed in the previous sections.

5.2 Learning from within our region

An overview of our regional and provincial context was shared highlighting the linkages between regional work to date and upcoming potential bundled care core elements and expectations. Key areas of focus to continue preparing for integrative care models include: a) Streamlined patient flow, b) access to stroke unit care and c) access to timely and expert rehabilitation (see Appendix D). Local sites shared current practices that support patient transitions with a common theme of enhancing communication between teams. For acute to acute repatriation, it was noted that frequent touch points across and within an organization are important. For acute to rehab transitions streamlined and enhanced communication was being piloted to enable faster transfers without onsite assessment. From acute to community, the key message was to use visual cues to help engage team members in important processes related to sharing key information in a timely manner. From inpatient rehab to day rehab, the focus was on easing patient stress by supporting them with information about the next phase of recovery and by providing appointment times and team introductions before hospital discharge.

5.3 Learning from other regions

The District Stroke Coordinator for Grand River Hospital and the Waterloo Wellington (WW) area shared the WW experience on integrated stroke planning and services. The Community Rehab Manager with the Waterloo Wellington LHIN connected remotely to share details on the WW coordinated bed access

and community stroke rehabilitation program. The following key lessons were learned from their presentations.

- Planning for acute, inpatient rehabilitation and community rehabilitation stroke care is integrated across partner sites with some shared roles.
- Implementation of automatic acceptance pathways to rehab supports best practice access to inpatient rehabilitation. This, in conjunction with a centralized coordinated bed access process streamlines admission to rehabilitation across rehab sites.
- Implementation of a stroke navigator role that has accountability across the continuum and a shared role between acute and rehabilitation supports patient flow.
- Development of a common tool supports navigation using "bands" of stroke severity to guide pathway and referrals.
- Provision of a Community Stroke Rehabilitation Program in-home through Home and Community Care is offered as a program of care or pathway model. This includes access to first therapy visits on the weekend and an expectation that the first therapist to visit the patient in the community would have already met the patient prior to hospital discharge.

The presentations created much discussion and resulted in follow up meetings to:
1) further discuss the acute to rehabilitation flow through a teleconference with the WW stroke navigator, WW rehab leads and the KHSC Clinical Stroke Bundled Care Working Group and 2) explore in more detail the WW community stroke rehabilitation program and its unique features. Our regions will continue to link to share learning.

5.4 Stroke Survivor and Caregiver Voice

Throughout the Stroke Services and Transitions project there has been a component of lived experience to help guide the plan, tools and conversations. Our Regional Stroke Steering Committee includes stroke survivor representation and identified this work as a priority, providing early input on the pathway. In addition, the pathway was shared at the Community Reintegration Leadership Team for their insights and key messages for clinicians. This group has a significant survivor and caregiver membership and provides a very credible and passionate check-in to focus on patient-centred quality improvement that aligns with lived experience. Linkages through this group led to further work with the local Kingston support group facilitator and support groups to develop two key forum presentations.

Key messages from stroke survivor and caregivers were shared through their stories about their recovery journeys. Within the Kingston groups, this experience was visually expressed in the creation of 3 stroke journey trees (key emotions at the time of the stroke, early post-hospital and later in the recovery process) (see Appendix E). Two key messages were shared at the forum from this journey tree work of the support groups. These were:

- *"A stroke journey doesn't finish when you walk out of the door of the acute unit, rehabilitation hospital, or even at the end of community rehabilitation. It is only beginning and continues on throughout the lives of those impacted by the stroke. It impacts everyday life."*

- *"The stroke recovery journey changes and moves in different directions, just as a tree grows and changes. No stroke is the same, but there are often similarities in the thoughts and feelings of all those who are affected by the stroke event. Health care professionals need to recognize this as they help those affected by stroke to navigate the very complex system of supports and services. And, it is critical to remember that this is an ongoing journey and support may be required at any point, along that journey, however far from the stroke event it may be."*

Following the presentation on journey trees – two stroke survivors shared some key messages about transitions and their journeys. The following key points are specific to supporting patients along their journey:

- *"Each survivor is different; treat each survivor as an individual and not just another stroke survivor and/or caregiver. Treat the survivor as a whole person, not as an illness/disability. Each situation will be different and some of survivors may be alone."*
- *"Though it is not the health care provider's first experience working with a stroke survivor/caregiver, it is their first and everything is new; they are anxious and scared. If they are having difficulty communicating, this adds to the stress. The health care provider many need to repeat information several times as the survivor and family may not always retain what has been said. "*
- *"The survivor's situation and support requirements may change over time; they need to be advised on what to do or how to access additional service at a later date."*

5.5 Making Quality Improvements between Hospital and Home

The final part of the workshop was focused on joint brainstorming to improve key components of the transition from hospital to home. A few examples were selected related to common challenges identified in the self-assessments. Groups were comprised of hospital and community providers and all participants had an opportunity to discuss two topics. All results/ideas were shared back with the entire group and are recorded in Appendix F. The following table summarizes the highest ranked "ideas" from a group voting process for each topic area (Table 1)

Improvement Area	Ideas "voted" to have most impact
Consistency in provision of the Stroke Information Package (SIP)	Reviewed with a person – not just provided with the "paper"
	Use of a transition checklist to ensure it happens
Booking appointments in the next part of the continuum – e.g. Stroke Prevention Clinic, Outpatient Therapy	Record all appointments in one spot Consider one contact point to share all information
Ensuring appropriate referrals/linkages are made	Use a checklist for referrals that have been completed and make it available to all team members
Ensuring next care provider has needed information	Implement an Integrated report for all team members
	Implement an integrated health record

Table 1: Highest Ranked Ideas for Identified Improvement Areas

Teams were then tasked to consider the self-assessment results and what ideas and learnings resonated with their team to help inform their local next steps. Follow-up check-ins will occur with each team that completed self-assessments to document their progress to date and identify action plans as they continue to move forward.

5.6 Feedback from the participants.

Overall feedback and evaluation of the regional event was positive. The following are a few comments that were shared by participants.

- *"Stroke survivors reminded me that this is their first stroke and so I need to address them, educate them, support them as such. Slow down [my communication]!"*
- *"More of these (sessions) please - where people come from across the numerous phases of the patient journey. The more we share and know each other - the better the system becomes."*
- *"Better communication is required at points of transition; ensuring our patients have the appropriate information at discharge".*

6. Regional Next Steps

The following regional activities have been identified to support further implementation of the ARC Stroke Services and transitions pathway:

- Disseminate summary of the work to date by posting on the Stroke Network of SEO website and by sharing directly with steering committee and stroke teams/participants.
- Continue supporting teams to work towards a "**one team**" integrative approach to stroke care.
- Develop and disseminate a transition tool kit/navigation supports. Include a communication guide for providers to more effectively explain system elements to patients. See Appendix G for tools shared at regional events to date).
- Support the spread of the Stroke Information Package and including the Patient Journey Map as a key resource.
- Plan a navigation workshop in 2020 to continue the focus on transition work.
- Continue to create linkages to share learnings across teams in the southeast and with other stroke regions in the province.
- Check-in and support local action plans for improvement ideas/shared learning.

7. Local Activities - Follow up action plans (2020/21)

The following activities have occurred from September to December 2019 linked to self assessment work, transitions and ARC pathway elements:

- Ensuring use of Stroke Information Package prior to hospital discharge at several sites
- Spreading of in-hospital consent process to enable stroke support group facilitators to contact patients following transition to the community

- Dissemination of the Patient Journey Map and support for its use in patient and family education
- Launch of the “Fast Track” project to improve access to rehabilitation in Kingston
- Improving communication strategies between teams including but not limited to:
    - New neurology form at KHSC
    - Improved communication of medical plans/status between acute, inpatient rehab and stroke clinic providers;
    - Warm hand-offs for acute repatriation across stroke resource nurses,
    - Rehab and In Home Therapy strategies to share key information and create linkage opportunities.

8. Project Summary to Date

In summary, the regional stroke services and transition pathway has been articulated with core elements in a one-page format to support learning within and across teams. The pathway and self-assessment process combined with a regional forum have stimulated local and regional action plans. Next steps will focus on developing regional resources, continuing dialogue about navigation and transitions and identifying concrete local action plans for the 2020/21 cycle of the current SNSEO work plan. The local plans will complement the regional work plan components. The key message to carry us forward is that working as “one team” better supports the patient and family on their journey.

Acute - Rehab - Community (ARC) Stroke Services and Transitions

Clinical teams provide care and support transitions that are in alignment with QBP/CSBPR including:
• Standardized evidence-based Care • Expert Interprofessional Team Care • Interprofessional Case Conferencing • Information to Primary Care

Acute to Rehab

Acute Stroke Care
- Admit to ASU *(From ED-6 hrs; ICU-24 hrs)*
- Critical care support
- Dysphagia Screen *(by 24hrs)*
- Neuro and Cardiac Monitoring
- Allied Ax (*by 24 hrs*)
- Mobilize (*by 24 hrs unless contraindicated)*
- Cognition Screening
- Early rehabilitation
- AFIM (*by Day 3*)
- Patient/Family Education

Severe: Alpha FIM <40
- Acute Team consider rehab readiness and refer/transfer if rehab ready
- If not rehab ready, re-assess weekly while on acute care and consider transfer in future

Moderate: AlphaFIM 40-80
- Referral/decision to transfer to Rehab (by Day 4)
- Decision/confirmation to admit to rehab 4 Hours)
- Patient Transferred (1 day from decision)
- For stand-alone rehab – onsite assessment by exception only (AFIM 40-60)

High Intensity Inpatient Rehab
- Stroke Rehab Unit
- FIM by 72 hrs
- Rehab therapy intensity - 180 min/day (at least 6 days/week)
- Goal based approach
- Admit 7 days a week
- Patient Education

Rehab to Community

Home care referral –
- Pre D/C OT – 2 weeks before d/c
- Comm Rehab Planning Mtg – 7 days before d/c
- CSRP 24-48 hours before discharge
- Confirmation of CSRP plan from Homecare -
- First therapy visit with within 72 hours
- Information exchange

OR

Outpatient Therapy
- Referral and first appt confirmed for 72 hours post discharge

Community supports
- Referral and/or consent for future follow up

In home or Outpatient Rehab
- First therapy visit 48 hrs. post-acute 72 hrs. post-rehab
- RRN visit within 24 – 48 hours post acute (in-home only)
- 8 – 12 weeks
- 2 – 3 visits per discipline/week
- Review need for SW regularly

In home or outpatient Rehab to Community
- Transition checklist reviewed
- Referral to community support services (CSS)
- CSS contact made within 48 hours (or less)
- Stroke facilitator linked within 72 hours

Home/Community
SPC and medical follow up Stroke Support Groups Aphasia Supports
CSS Supports (e.g., Meals, Transportation, Home Help, In-Home Respite)

Acute to Acute

- Timely Repatriation (i.e. 24 hours post tPA/EVT)
- Warm Handover
- Therapy notes/ AFIM shared

Acute to Community

Mild --- Alpha FIM 80+ (90+)
- Home care referral – CSRP and RRN 24 hours before discharge
- Confirmation of CSRP plan from Home and Community Care to referral source
- **Outpatient Therapy** - Referral and first appt confirmed within 48 hours post discharge
- Referral to community supports or consent for future follow up (ie Stroke Support group)

Home Care Coordination
- Process, arrange and confirm RRN, CORP or CSRP within 24 hrs. of complete referral received
- Overall homecare assessment for services, equipment and supplies with service plan within 24 hrs

ACTIVITIES

INDICATORS

- % access to ASU
- % AFIM by Day 3
- Median LOS
- % LOS ALC
- 90 day readmit
- 30-day mortality

- Admit to Rehab Referral – Day 4
- % access to inpatient rehab – 30%
- Onset to rehab admit – 6-8 days
- % rehab admits with severe stroke (*balancing measure*)

- FIM LOS efficiency
- Median RI Time (Target 180 min)
- % meeting Rehab LOS
- % Discharged Home

- % referrals to CSRP from rehab with Comm Rehab Planning Mtg

- Median Time to First Therapy visit
- # visits/discipline
- Total visits /patient
- LOS
- % RRN from acute

Referrals and # participants - stroke support groups and aphasia groups

Patient and caregiver/family feedback (PROMS and PREMS) and Provider feedback

YOUR RECOVERY JOURNEY **AFTER STROKE**

STROKE NETWORK *of* Southeastern Ontario

Appendix B - Patient Journey Map

Stroke Event

Call 911

In-Hospital Acute & Rehabilitation Care

Stroke Prevention Clinic

Community-Based Rehabilitation

In-Home | *Outpatient*

Home Care

Medical Follow-up

Driving & Transportation

Return to:

- Life Roles
- Leisure & Recreation

Stroke Support Groups

Community Services

- Supportive Counselling
- Financial Supports
- Social Supports

Recovery Begins | **Transitioning to Community** | **Recovery Continues**

YOUR RECOVERY JOURNEY **AFTER STROKE**

As you recover, you may require support from some of the healthcare and community services listed below. These may change over time. Speak to any member of your healthcare team if you have questions or call 310-2222. It is important to remember that everyone's recovery will be different.

Recovery Begins

In-Hospital Acute & Rehabilitation Care

- ☐ Emergency care
- ☐ Acute Stroke Unit care
- ☐ Inpatient rehabilitation
- ☐ Integrated Stroke Unit
- ☐ Complex Continuing Care

☐ Other _____

Your Healthcare Team may include:

- ☐ Communicative Disorders Assistant
- ☐ Dietitian
- ☐ Doctor
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Occupational Therapy Assistant
- ☐ Patient Care Assistant
- ☐ Peer Visitor
- ☐ Personal Support Worker (PSW)
- ☐ Physiotherapist
- ☐ Physiotherapy Assistant
- ☐ Recreation Therapist
- ☐ Social Worker
- ☐ Speech-Language Pathologist

☐ Other _____

Notes _____

_____

_____

_____

_____

_____

Transitioning to Community

Stroke Prevention Clinic

- ☐ Stroke specialist doctor
- ☐ Stroke specialist nurse
- ☐ Dietitian

☐ Other _____

Community-Based Rehabilitation

- ☐ Outpatient Rehabilitation
  - ☐ Physiotherapist
  - ☐ Occupational Therapist
  - ☐ Speech-Language Pathologist
  - ☐ Other _____
- ☐ In-Home Rehabilitation
  - ☐ Rapid Response Nurse
  - ☐ Occupational Therapist
  - ☐ Physiotherapist
  - ☐ Speech-Language Pathologist
  - ☐ Social Work
  - ☐ Other _____

Home Care

- ☐ Care Coordinator
- ☐ Nurse
- ☐ Personal Support Worker (PSW)
- ☐ Dietitian
- ☐ Meal Delivery
- ☐ Equipment
- ☐ Respite
- ☐ Caregiver Support

☐ Other _____

Recovery Continues

Stroke Support Groups

- ☐ Stroke Survivor & Caregiver Groups
- ☐ Aphasia Programs
- ☐ Living with Stroke Programs

Community Services

- ☐ Supportive Counselling
- ☐ Financial Supports
- ☐ Social Supports
  - ☐ Adult Day Programs
  - ☐ Spiritual Supports
  - ☐ Cultural Centres & Supports

☐ Other _____

Medical Follow-Up

- ☐ Family doctor
- ☐ Nurse Practitioner
- ☐ Specialist doctor
- ☐ Nurse
- ☐ Physician Assistant
- ☐ Smoking cessation
- ☐ Diabetes Education

☐ Other _____

Transportation

- ☐ Return to Driving Programs
- ☐ Accessible Transportation Supports

Return to:

- ☐ Life Roles
- ☐ Work/School Services
- ☐ Volunteering

☐ Other _____

- ☐ Leisure & Recreation
  - ☐ Stroke Specific Exercise Programs
  - ☐ Community Exercise Programs
  - ☐ Recreation Programs
  - ☐ Hobbies

STROKE NETWORK *of* Southeastern Ontario

Acute - Rehab - Community (ARC)

Stroke Services and Transitions Pathway

Self-Assessment – Regional Summary

September 2019

Self-Assessment Scoring:

C – Completed: indicates requirement has been achieved

P - Partially/In-progress indicates requirement is partially in place, but ongoing work required for full implementation

I – Incomplete - indicate requirement not yet implemented; opportunity for improvement identified

Acronyms:

ASU=Acute Stroke Unit

ICU = Intensive Care Unit

FIM=Functional Independence Measure (used in inpatient rehab)

CSRP = Community Stroke Rehab Program

RRN = Rapid Response Nurse

SW = Social Work

ISU = Integrated Stroke Unit

AFIM=Alpha FIM (used in acute care)

LOS = Length of Stay

CORP – Community Rehab Planning Meeting

ESD = Early Supported Discharge (community rehab 5x/week)

HV = Home Visit

Acute Stroke Care – Self-Assessment

ASU	Requirement	Site 1	Site 2	Site 3
1	Stroke Patients are admitted to Acute Stroke Unit (ASU) (Target 80%)	P	C	C
2	Clinical team practices in alignment with CSBPR/QBP recommended treatments/evidence-based care and follow collaborative care plan in place	P	C	C
3	ASU has interprofessional team (MD, RN, PT, OT, SLP, RD, SW)	C	I	C
4	Team available 7 days a week (PT, OT, SLP specifically)	I	P	I
5	Critical Care Support available	C	C	C
6	Cardiac Monitoring available (atrial fibrillation, other arrhythmias, and cardiac issues)	C	C	C
7	Diagnostics completed in timely manner (i.e. CTA, Follow up CT, Labs, Echo, ECG, Holter ...)	P	C	C
8	Dysphagia Screening protocol in place including process for nursing education	C	C	P
9	Neuro Monitoring in place including process for nursing education	C	C	C
10	Allied Ax within 24 - 48 hours of admit (PT, OT)	P	C	C
11	Protocols in place for mobilization within 24 hours (unless contraindicated)	C	C	C
12	Cognition Screening	C	C	C
13	AFIM by Day 3	P	P	C
14	Early rehabilitation initiated post-assessments	P	C	C
15	Patient/Family Education and Support provided including Stroke Information Package	C/P	C	P
16	Patient and Family Discharge Communication Process	C	C	C

Acute Stroke Unit - Transitions – Self Assessment

	Requirement	Site 1	Site 2	Site 3
ATC	**Acute to Community (ATC)**			
1	Alpha FIM 80+ - discharge home with CSRP or outpatient is considered as first option	C	C	C
2	Process in place to refer to Community Stroke Rehabilitation Program (CSRP) including RRN a minimum of 24 hours before discharge	P	C	C
3	Process in place to link patients to community supports (stroke support groups, transportation, meals, etc) – ie consent for stroke support group facilitator to follow up	I	C	C
4	Written discharge instructions provided to patient and family with opportunity to review and confirm information (ie Patient Oriented Discharge (POD) format)	C	C	C
5	Information is transferred to Primary Care provider to facilitate primary care follow up post hospital	C	P	C
6	Follow up check in 24-48 hours post discharge (i.e. follow up phone call)	I	C	I
7	Outpatient therapy appointment booked and communicated prior to discharge (where available)	I/NA	P	I/NA
8	Referral made to the Stroke Prevention Clinic on Discharge	C	C	C
9	Diagnostics not completed as an inpatient are arranged for outpatient follow up	C	P	C
ATR	**Acute to Rehab (ATR)**			
1	Alpha FIM 40 – 80 – Referral/Decision to transfer to rehab by Day 4 (unless medically not ready)	C	P	C
2	Alpha FIM 0-39 – Assess for rehab readiness, rehab referral/transfer to rehab, re-assess weekly	C	P	C
3	Education with patient and family on rehabilitation	C	C	C
4	Advise patient/family on decision from rehab site	C	C	C
5	Prepare patient for safe transfer (meds list updated, acute discharge complete by rehab transfer, information shared with rehab team and family notified of transfer as appropriate)	C	C	C
ATA	**Acute to Acute (ATA)**			
1	Repatriate within 24 - 48 hours to local stroke unit (Regional Centre only)	C	P	C
2	Share Alpha FIM if transfer after Day 3	C	C	C
3	Share Allied Health Assessments	P	C	C
4	Warm Hand Over between sites	C	C	C
ALTC	**Acute to LTC (ALTC)**			
1	Refer to CSRP for transition to LTC (refer to at minimum OT)	C	C	C

High Intensity Inpatient Rehabilitation – Self Assessment

Inpt Rehab	Requirement	Site 1	Site 2	Site 3	Site 4
1	Patients admitted to a stroke rehab unit	C	C	C	C
2	Clinical team practices in alignment with CSBPR/QBP recommended treatments/evidence-based care	C	C	C	C
3	Access to interprofessional team (Minimum of MD, RN, PT, OT, SLP, SW, RD)	C	I	C	P
4	Therapy staff: PT/OT staffed 1:6 beds, SLP 1:12 beds	P	I	P	I
5	Therapy staff – PT/OT/SLP - available at least 6 days a week	I	C	I	I
6	Team members have support and access to best practice updates/education	C	C	C	C
7	FIM completed by 72 hours	C	C	P	C
8	All allied assessments started in 48 hours of admission	C	C	C	P
9	Rehab therapy intensity – 180 min/day (at least 6 days a week)	P	P	P	I
10	Patient education including use of stroke information package	P	C	C	C
11	Goal based rehabilitation with regular interprofessional team conferences	C	P	C	C
12	Patient and Family Discharge Planning Conference or communication process	C	C	C	C
13	Admit 7 days a week	I	C	P	I

Inpatient Rehab – Transitions – Self Assessment

	Requirement	Site 1	Site 2	Site 3	Site 4
ATR	**Acute to Rehab**				
1	Alpha FIM 60+ referred from acute are automatically accepted and transitioned to high intensity rehab	P	C	C	P
2	Referral reviewed and decision to admit to rehab made within 2 – 4 hours - Rehab team	I	C	P	P
3	Patient transfer arranged within 1 day of decision (pending bed availability)	C	C	C	C
4	Alpha FIM <60 – review referral for high intensity rehabilitation (consider low intensity if not eligible)	C	C	C	I
RTC	**Rehab to Community**				
1	Home Care: If required – complete referral for pre-d/c OT 2 weeks prior to predicted discharge date	P	P	C	C
2	Home Care -Complete referral for Community Rehab Planning Meeting 7 days before discharge	C	P	P	C
3	Home Care - Complete referral for CSRP 48 hours before discharge	C	C	C	C
4	Home Care -Request face to face assessment from home and community care where appropriate	C	C	C	C
5	Outpatient – refer and confirm outpatient appt (72 hrs post discharge) prior to patient leaving	P	C	NA/I	P
6	Process in place to link patients to community supports (stroke support groups, transportation, meals, etc) – ie consent received on all stroke patients for stroke support group facilitator to follow up	I	P	C	P
7	Written discharge instructions provided to patient and family with opportunity to review and confirm information (ie Patient Oriented Discharge (POD) format, Therapy instructions,)	P	C	C	C
8	Information is transferred to Primary Care provider to facilitate primary care follow up post hospital	C	P	C	P
9	Follow up check in 24-48 hours post discharge (ie follow up phone call)	I	C	I	C
RLTC	**Rehab to LTC**				
1	Refer to CSRP for transition to LTC (refer to at minimum OT)	NA/I	C	C	C

Community Stroke Rehabilitation (Outpatient) - Self - Assessment

	Requirement	Site 1	Site 2
HOutpt	**For referrals from Acute and Rehab:**		
1	Availability of PT, OT, SLP, SW with stroke expertise	**I**	**P**
2	Capacity to deliver stroke rehabilitation for 12 weeks	**C**	**C**
3	Capacity to deliver 2 – 3 visits per discipline/week	**P**	**P**
4	Process in place to ensure Social Work is offered initially and again prior to discharge	**I**	**I**
5	Ability for team to case conference (ideally with patient/family)	**P**	**C**
6	Assistants deliver up to 30% of therapy visits (where assistants are available)	**P**	**I**
7	Transition includes referrals to stroke specific and other community services (process in place to ensure occurs)	**C**	**P**
RTOutpt	**For Rehab Referrals:**		
1	Capacity to provide first therapy visit within 72 hours	**P**	**I**
ATOutpt	**For Acute Referrals:**		
1	Capacity to provide first therapy visit within 48 hours	**P**	**I**
ESD	**For Early Supported Discharge/High Intensity Community Rehab:**		
1	Capacity to delivery OT,PT, SLP 5 days a week for at least 2 weeks	**I**	**I**
2	Other requirements as above	**I**	**I**

Community Stroke Rehabilitation – (Outpatient)
Transition to Community Supports – Self - Assessment

Outpt to Comm	Requirement	Site 1	Site 2
1	Referral to community supports – stroke specific (support groups/exercise groups) and generic (meals, transportation, respite, home help etc.)	C	C
2	Referral to SW has been discussed and referral considered if not yet linked	P	I (?)
3	Provides written instructions for ongoing maintenance activities to continue recovery	C	C
4	Confirms patients has Stroke Information Package and able to provide if needed	C	C
5	Return to life roles and recreation is discussed and linkages made as required.	C	C
6	Consider patient goals and determine if referral to home care rehab or other services as required.	C	C
7	Discharge information and recommendations are shared with primary care	C	C

HCC – Care Coordination - Self - Assessment

	Requirement	
	In-Home Services – after patient has been discharged from hospital (file stays with Access Team until services secured and pt discharge (day of discharge)	
RRN	**RRN Program**	
1	• RRN contacts patient within 24 hours to arrange a HV (including weekends)	**C**
2	• RRN visit occurs within 24-48 hours post discharge	**P**
3	• RRN report sent to Community Care Coordinator and primary care	**C**
4	• RRN will do a follow-up HV if warranted (such as if pt. confused, if pt. has++ meds and requires additional health teaching)	**C**
CC	**Transition Home – In Home Care Coordination (Community Team)**	
1	• Completes home visit and interRAI-HC – within 2 weeks (or earlier based on caseload alignment)	**C**
2	• Adjusts services and equipment/supplies based on assessment	**C**
3	• Reviews service provider reports and respond to change in pt. needs for services, equipment or supplies; monitor progress towards pt goals	**C**
4	• Service Plan Summary updates shared with Primary Care	**P**

HCC Care Coordination - Transitions – Self Assessment

	Requirement	
	Transition after Community Rehab Complete (final service provider report received).	
CCC	**Community Care Coordinator:**	
1	• Calls patient/family to confirm discharge of therapy plan	C
2	• Reviews other services and need to stay on home care program	C
3	• Offers SW again prior to discharge if not yet received	P
4	• Reviews need for and links patients to relevant community supports as able/available (e.g., stroke support groups, transportation, meals, etc.)	C
5	• Communicates summary of home care services provided and therapy discharge notification to primary care	P

Community Stroke Rehabilitation (In-Home) - Self - Assessment

	Requirement	Org 1	Org 2	Org 3
H to CSRP	**For referrals from Acute and Rehab:**			
1	Availability of PT, OT, SLP, SW with stroke expertise	**P**	**C**	**P**
2	Capacity to deliver stroke rehabilitation for 12 weeks	**C**	**C**	**P**
3	Capacity to deliver 2 – 3 visits per discipline/week	**C**	**C**	**P**
4	Process in place to ensure Social Work is offered throughout patient's stay on the program (initially, during and at discharge)		**C**	**P**
5	Ability for team to case conference (ideally with patient/family)	**I**	**P**	**C**
6	Assistants available to deliver up to 30% of therapy visits (where assistants are available)	**I**	**I**	**I**
R to CSRP	**For Referrals from Rehab:**			
1	Ability to participate in CoRP meeting with hospital team with 5 days' notice	**C**	**C**	**C**
2	Capacity to provide first therapy visit within 72 hours	**P**	**P**	**P**
A to CSRP	**For Referrals from Acute:**			
1	Capacity to provide first therapy visit within 48 hours	**I**	**P**	**P**
ESD	**For Early Supported Discharge/High Intensity Community Rehab:**			
1	Capacity to delivery OT, PT, SLP 5 days a week for at least 2 weeks	**I**	**I**	**I**
2	Other requirements as above			

Community Stroke Rehab - Transition to Community Supports - Assessment

	Requirement			
H to CSRP	**Transition from Hospital**	**Org 1**	**Org 2**	**Org 3**
	Accept referrals within 1 hour through Health Partner Gateway with LHIN	C	C	C
	Contact client to arrange visit (within 2 days)	C	C	C
CSRP to Comm	**Transition after Comm Rehab Complete**			
	Referral to community supports – stroke specific (support groups/exercise groups) and generic (meals, transportation, respite, home help etc.)	C	C	P
	Referral to SW has been discussed and referral considered if not yet linked	C	C	P
	Provides written instructions for ongoing maintenance activities to continue recovery	C	C	C
	Confirms patient has Stroke Information Package and able to provide if needed	I	**P**	I
	Return to life roles and recreation is discussed and linkages made as required.	C	C	P
	Consider patient goals and determine if referral to home care rehab or other services as required.'	C	P	C
	Discharge information and recommendations are shared with primary care	I	I	I
	Transition checklist completed	I	**P**	I

Community Support Services - Transitions – Self Assessment

CSS	Requirement	Org 1	Org 2	Org 3
1	Upon receiving referral – time to first client contact is 48 hours or less	C	C	C
2	Time to in-home assessment (inter RAI CHA) for services is 7 days or less	C	C	C
3	Upon stroke referral a linkage is made with stroke facilitator within 72 hours	C	C	C
4	Process in place to connect/refer to other “sister agencies” or supports as needed	C	C	C
5	Internal process in place to link between stroke specific services and “regular” services	C	C	C
6	Clients can receive some services (meals, transportation, home help) prior to in home assessment	C	C	C

CSS Services offered	Org 1		Org 2		Org 3	
	Y/N	Fee	Y/N	Fee	Y/N	Fee
Stroke Specific Services						
Stroke Support Groups for clients	Y	N	Y	N	Y	N
Stroke Support Groups for caregivers	Y	N	Y	N	Y	N
Stroke Support groups for “younger” stroke	Y	N	Y	N	Y	N
Stroke Social/Recreation or Peer led group	Y	N	Y	N	N	n/a
Support stroke Peer visiting in local hospital	Y	N	N	n/a	Y	N
Support stroke peer visiting in home	Y	N	Y	N	N	n/a
Stroke education – Living with Stroke Program	Y	N	Y	N	Y	N
Aphasia Conversation Groups	Y	N	Y	N	Y	N
Stroke Exercise Groups (indicate cities/town or locations in comments)	Y	N	N	N	Y	N
Other Stroke Specific Supports (please name)	Y	N	Y	N	Y	N
General Community Supports						
Meals on wheels	Y	Y	Y	Y	Y	Y
Frozen Meals	Y	Y	Y	Y	Y	Y
Home Help	Y	Y	Y	Y	Y	Y
Transportation	Y	Y	Y	Y	Y	Y
Caregiver Support and Education	Y	N	N		Y	N
Foot care (clinic)	Y	Y	Y	Y	Y	Y
Foot care (in-home)	Y	Y	Y	Y	N	n/a
In-Home Respite	Y	Y	Y	Y	Y	Y
Overnight respite	Y	Y	N		Y	Y
Adult Day Programs	Y	Y	N		Y	Y
SMART Program (Seniors Maintaining Active Roles Together)	Y	N	N		N	n/a
Friendly Visiting	N	N	Y	N	N	n/a
Telephone Reassurance and safety checks	N	N	Y	N	N	n/a
Client Intervention and Assessment	Y	N	Y	N	Y	N
Therapeutic Recreation Programming	N	N	Y	Y	Y	N
Driver Refresher	N	N	Y	Y	N	n/a
Social or Congregate Dining/Diner’s Club	Y	Y	Y	Y	Y	Y
Senior Exercise and Fall Prevention	Y	N	N	n/a	Y	N
Lifeline	Y	N	N	n/a	Y	Y

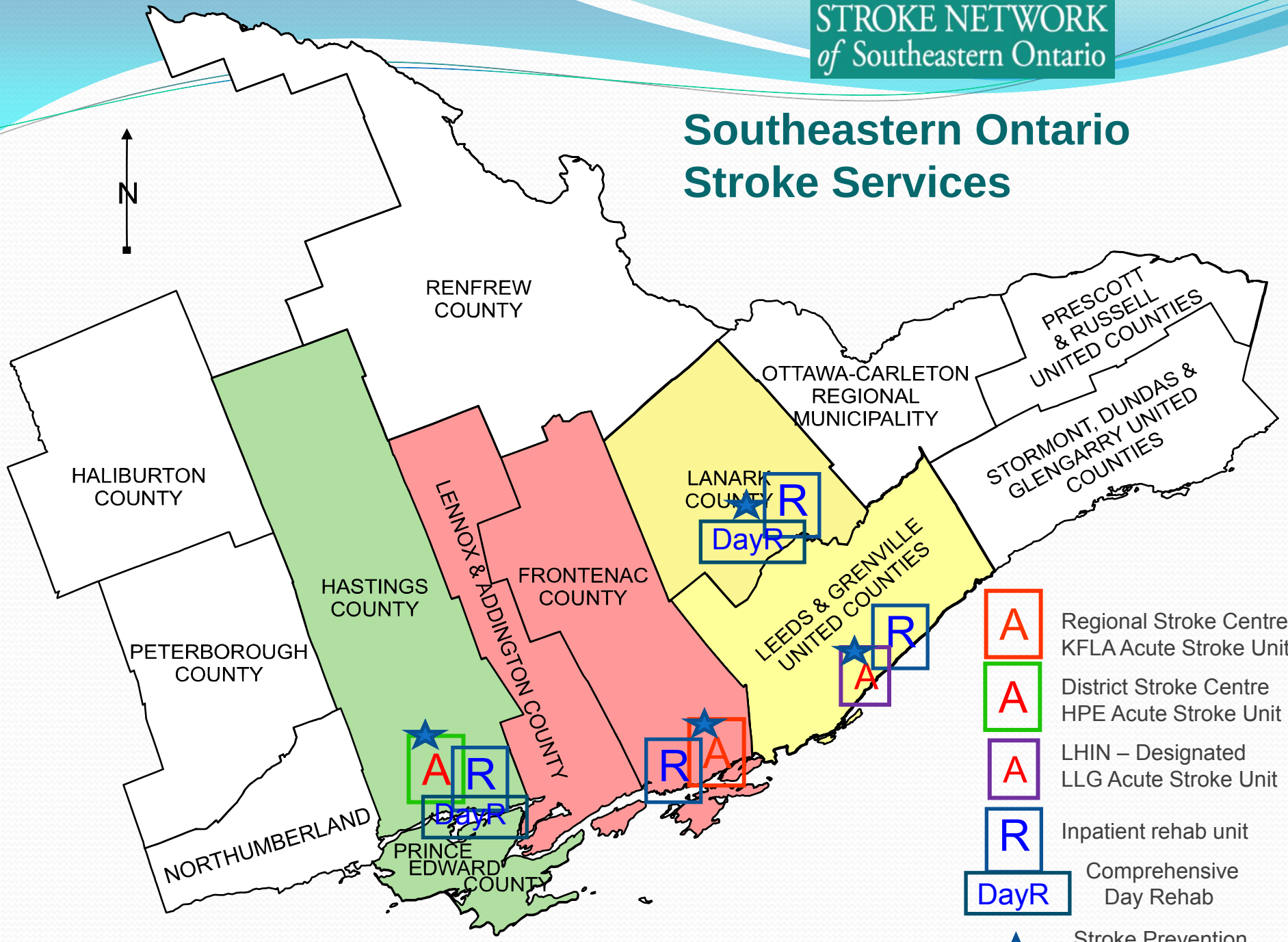
STROKE NETWORK *of* Southeastern Ontario

Regional & Provincial Context: (R)Evolutions in Stroke Care Improvements; How Does "Bundled Care" Fit?

Cally Martin
Regional Director, Stroke Network of SEO
Sept 2019

STROKE NETWORK of Southeastern Ontario

Southeastern Ontario Stroke Services



STROKE NETWORK of Southeastern Ontario

Equal Access to Quality Stroke Care in Stroke Survivor Dan's Words:

"This means care is ALL ONE COLOUR to me"

Dr. Dan Brouillard

South East Stroke Report Card

Growing Volumes

Acute ALC

Onset to Rehab

Flow thru Rehab

Ontario Stroke Report Card, 2017/18:
South East Local Health Integration Network

CorHealthOntario.ca

● Exemplary performance[1] ■ Acceptable performance[2] ▲ Poor performance[3] ☐ Data not available or benchmark not available

Indicator No.	Care Continuum Category	Indicator[4]	LHIN FY 2017/18 (2016/17)	Variance Within LHIN[5] (Min–Max)	Provincial Benchmark[6]	High Performers[7]	
						Sub-region/Facility	LHIN
1 ▲	Public awareness and patient education	Proportion of stroke/TIA patients who arrived at the ED by ambulance.	58.7% (62.0%)	57.8 - 59.3%	65.9%	Western Champlain sub-region	1, 11
2 ▲	Prevention of stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000 population).	1.6 (1.5)	1.4 - 1.8	1.1	Oakville sub-region	7, 8, 6
3§ ☐	Prevention of stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	12.2 (11.1)	9.5 - 28.1	-	-	11
4 ▲	Prevention of stroke	Proportion of ischemic stroke/TIA inpatients aged 65 and older with atrial fibrillation who filled a prescription for anticoagulant therapy within 90 days of discharge from acute care.	71.0% (67.8%)	62.5 - 86.7%	85.6%	East Mississauga sub-region	5, 12
5 ■	Prevention of stroke	Proportion of ischemic stroke inpatients who received carotid imaging.	83.3% (85.3%)	33.3 - 92.6%	93.0%	Thunder Bay Regional Health Sciences Centre	14, 3
6 ●	Acute stroke management	Median door-to-needle time among patients who received acute thrombolytic therapy (tPA) (minutes). Target*: 30 minutes	31.5 (42.0)	24.0 - 65.0	33.0	Kingston Health Sciences Centre – Kingston General Site	10
7§ ●	Acute stroke management	Proportion of ischemic stroke patients who received acute thrombolytic therapy (tPA). Target*: >12%	14.4% (15.1%)	9.8 - 21.8%	17.7%	London Middlesex sub-region	11, 4
8§ ●	Acute stroke management	Proportion of stroke/TIA patients treated on a stroke unit[9] at any time during their inpatient stay. Target*: >75%	80.5% (76.7%)	74.8 - 88.8%	81.8%	Quinte sub-region	3, 10
9 ■	Prevention of stroke	Proportion of ischemic stroke/TIA patients discharged from the ED and referred to secondary prevention services.	79.1% (74.7%)	0.0 - 100.0%	95.1%	Hamilton Health Sciences Corp - Juravinski	None
10§ ▲	Acute stroke management	Proportion of ALC days to total length of stay in acute care.	33.0 (32.1)	0.0 - 72.8%	8.2%	Bluewater Health, Sarnia	3
11§ ▲	Acute stroke management	Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation. Target*: >30%	30.2% (27.9%)	14.5 - 36.0%	47.8%	Lambton sub-region	1
12§ ☐	Stroke rehabilitation	Proportion of acute stroke (excluding TIA) patients with mild disability (AlphaFIM > 80) discharged home.	75.9% (80.0%)	73.9 - 84.1%	*	*	14, 3
13§ ▲	Stroke rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation.	11.0 (11.0)	4.0 - 15.0	5.0	Quinte Health Care – Belleville General Site	None
14§ ■	Stroke rehabilitation	Median number of minutes per day of direct therapy received by inpatient stroke rehabilitation patients. Target*: 180 minutes/day	74.9 (71.5)	72.4 - 80.0	107.6	West Park Healthcare Centre	None
15§ ▲	Stroke rehabilitation	Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay target.	50.7% (51.3%)	40.0 - 62.4%	86.6%	Providence Healthcare	12
16 ▲	Stroke rehabilitation	Median FIM efficiency for moderate stroke in inpatient rehabilitation.	1.0 (0.9)	0.8 - 1.6	1.6	Providence Healthcare	3, 12
17 ●	Stroke rehabilitation	Mean number of home and community care rehab visits provided to stroke patients on discharge from inpatient acute care or inpatient rehabilitation in 2016/17–2017/18.	15.3 (12.9)	-	13.1	South East Home and Community Care	10, 3
18§ ▲	Stroke rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe stroke (RPG 1100 or 1110).	35.7% (45.7%)	20.0 - 40.9%	56.2%	Grand River Hospital Corp-Freeport Site	None
19§ ■	Reintegration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	3.9% (6.4%)	1.0 - 6.5%	1.9%	Guelph-Puslinch sub-region	None
20§ ☐	Reintegration	Age- and sex-adjusted readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients). Target*: 10.0	6.6 (5.1)	5.2 - 11.0	-	-	10

*Benchmark has not been specified for this indicator.

Hospital Service Accountability Agreement indicator, 2015/16

- Data not available

§ Contributes to QBP performance

[1] Benchmark achieved or performance within 5% absolute/relative difference from the benchmark.
[2] Performance at or above the 50th percentile and greater than 5% absolute/relative difference from the benchmark.
[3] Performance below the 50th percentile.
[4] Facility-based analysis (excluding indicators 1, 2, 4, 7, 8, 11 and 19) for patients aged 18–108. Indicators are based on CIHI data. Low rates are desired for indicators 2, 3, 6, 10, 13, 19 and 20.
[5] Excludes sub-regions or facilities with fewer than six patients.
[6] Top benchmark achieved between 2015/16 and 2017/18. Benchmarks were calculated using the ABC methodology (Weissman et al. J Eval Clin Pract 1999; 5(3):269–81) on sub-region or facility data.
[7] Sub-region/Facility: Highest performer among acute care institutions treating more than 100 stroke patients per year, rehabilitation facilities admitting more than 62 stroke patients per year, or sub-regions with at least 30 stroke patients per year. LHIN: Top two with exemplary performance.
[8] Targets based on international, national and provincial targets, please refer to full report for details.
[9] The revised definition was developed with the consensus of Ontario Stroke Network regional directors (February 2014). There were 16 stroke units in 2013/14, 21 in 2014/15, 28 in 2015/16, 35 in 2016/17, and 39 in 2017/18

CorHealth Ontario

STROKE NETWORK of Southeastern Ontario

SE Stroke Report & Progress Cards

Strong hyperacute and acute performance

Strong Community Stroke Rehab Program

Low % discharged to LTC

Low readmission rates

High and growing stroke volumes – need prevention

Challenges in flow to rehab & through rehab

Persisting ALC rates

Best Practice Stroke Care along the Patient Journey

Prevention | **Emergency Care** | **Acute Care** | **Rehabilitation** | **Community Services**








GO

GO

Capacity !!!

GO

GO

Growing Volumes!!!

GO

Equal Access to Quality Stroke Care

Fewer strokes. Better outcomes.

STROKE NETWORK of Southeastern Ontario

Regional Stroke Workplan Priorities 2019-2021

1. Primary and Secondary prevention- links
2. Hyperacute care: EVT and Thrombolysis
3. **Support Bundled Funding: Acute to Rehab to Community Transitions**
4. Sustain gains; continue to build expertise and capacity (e.g. Prevention, Acute Stroke Units, Rehab, Community Supports)

CorHealth Ontario

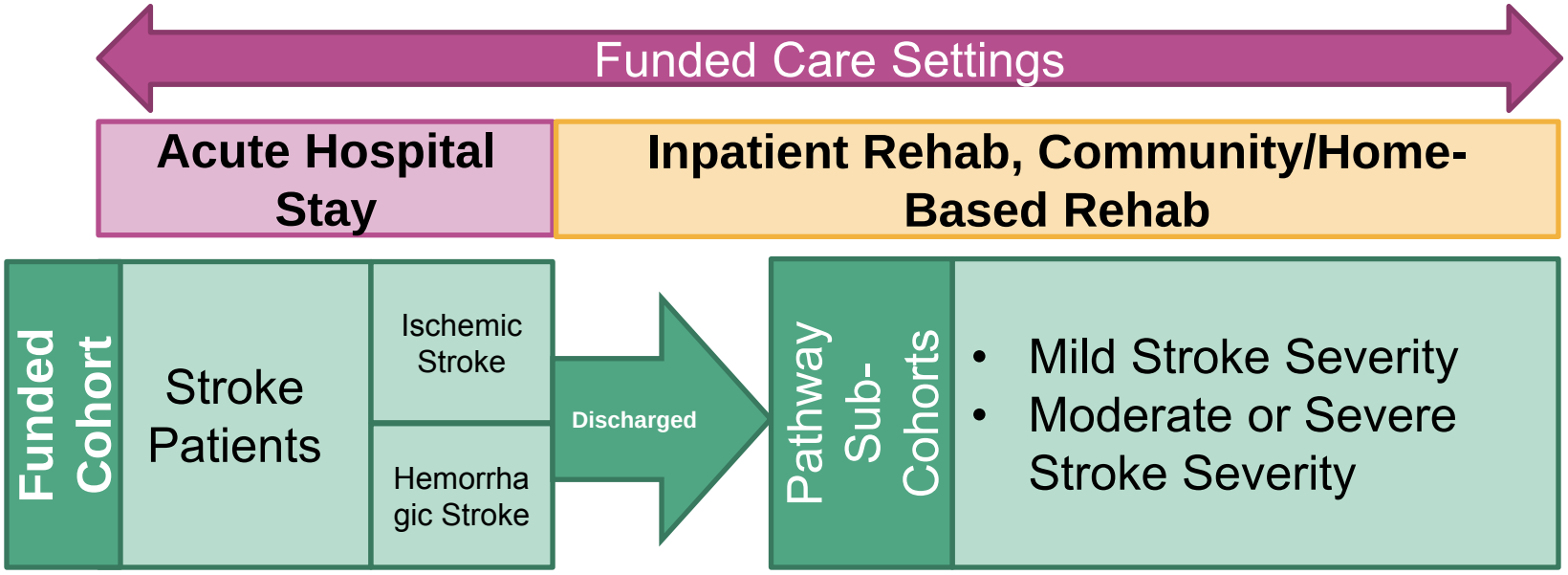
Advancing cardiac, stroke and vascular care

Stroke Bundled Funding
Resource Deck

June 20th, 2019

Proposed Stroke Bundle
Scope of Bundled Care Pathway

- Proposed funded cohort, sub-cohorts, and the care settings included in the bundle



- Proposed bundle duration: **up to 6 months**
  - ~8-10 days acute LOS + 48.9 days IP rehab[1] + 12 weeks (84 days) community rehab[2]

[1]QBP Handbook (4.4.1) [2]QBP Handbook (9.5-9.7).

Provincial Work in Progress: Stroke care recommendations on key decision points and minimum requirements

- **Implementation date? – Key message: GET READY**
- **Criteria & Guidelines to Align with QBP Handbook and Canadian Stroke Best Practice Recommendations**
- **Transfers of Stroke Patients between Acute Hospitals**
- **Acute Stroke Care: Minimum Requirements/Core Elements**
- **Stroke Rehabilitation: Minimum Requirements/Core Elements**
- **Complex Continuing Care versus Rehabilitation??**
- **NACRS lite to monitor outpatient rehabilitation**

DRAFT Recommended Criteria & Guidelines For Stroke Bundle Holders & Participants - ACUTE

Recommended Key Elements & Requirements for *Acute Inpatient Stroke Care* for Successful Implementation of the Bundle:

Acute Care:

- **Stroke Unit**
  - All confirmed stroke patients should be **admitted to a designated stroke unit**[1] as soon as possible (ideally within 24 hours of hospital arrival).
  - The stroke team should consist of a **dedicated**[2] **interprofessional stroke team with expertise** in stroke care inclusive of MD, nursing, OT, PT, SLP, SW, RD.
  - Complete **initial assessment within 24-48 hours** of admission using appropriate validated tools.
  - To optimize outcomes & efficiencies, admitted stroke volumes should be *at least* **125 stroke patients/year/institution** for acute stroke units and *at least* 100 stroke patients/year/institution for integrated stroke units (a specialized IP stroke unit providing both acute and rehabilitation services).
    - Stroke Unit volume requirements include all stroke patients, including ischemic and hemorrhagic stroke, EVT and TIA (i.e., Special Project 340 in the DAD)
- **Stroke Team Availability**
  - The core Interprofessional Stroke Team with expertise in stroke care available **7 days/week** (at minimum MD, nursing, OT, PT, SLP); This is recommended best practice, and recognized while not currently consistently available across the province, it is important for timely care and achieving efficiencies.
- **Assessment**
  - **AlphaFIM®** should be completed on or **by day 3 after admission** (target day 3, admission day is day 1) and **referral to rehabilitation** should occur as soon as appropriate, **targeting day 4** or earlier (inpatient, or community-based [outpatient, in-home, or ESD])
- **Education, cross continuum prevention assessment and care coordination**
  - Ongoing interprofessional patient/family education to support transitions and risk factor management
  - Arrange appointments (information shared verbally and in writing prior to discharge) as appropriate for diagnostics, outpatient care, Stroke Prevention Clinic, Primary Care Provider (PCP), other follow up required

[1]A geographical unit with identifiable co-located beds (eg 5A -7, 5A-8, 5A-9, 5A-10, 5A-11) that are occupied by stroke patients 75% of the time and has a dedicated inter-professional team with expertise in stroke care with the following professionals at a minimum nursing, physiotherapy, occupational therapy, speech language pathologist"
[2]Individuals who spend the vast majority of their time treating stroke patients and regularly complete education about stroke care

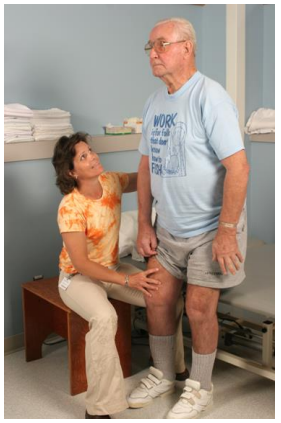
DRAFT Recommended Criteria & Guidelines For Stroke Bundle Holders & Participants- REHAB

Recommended Key Elements & Requirements for *Rehabilitation (Post-Acute Care)* for Successful Implementation of the Bundle:

Rehabilitation (Post-Acute Care):

Timely Access

- In collaboration with the acute provider, rehabilitation should begin **as early as possible** after medical stability is reached



Inpatient Rehab

- Acute ischemic stroke: **6 days** from acute admission
- Hemorrhagic stroke: **8 days** from acute admission

Outpatient Rehab

- Within **48 hours** of discharge from acute hospital
- Within **72 hours** of discharge from inpatient rehabilitation

Specialized Rehabilitation Services/Facilities

- During inpatient rehabilitation, care should be formally coordinated and organized on a geographically defined, **specialized stroke rehabilitation unit**. Where not available, a mixed unit would be accepted.
- A **dedicated interprofessional rehabilitation team** with stroke expertise should be available to support inpatient and community (home based and outpatient) rehabilitation services (minimum MD, RN, OT, PT, SLP, SW, RD).

DRAFT Recommended Criteria & Guidelines For Stroke Bundle Holders & Participants- REHAB

Recommended Key Elements & Requirements for *Rehabilitation (Post-Acute Care)* for Successful Implementation of the Bundle:

Rehabilitation (Post-Acute Care):

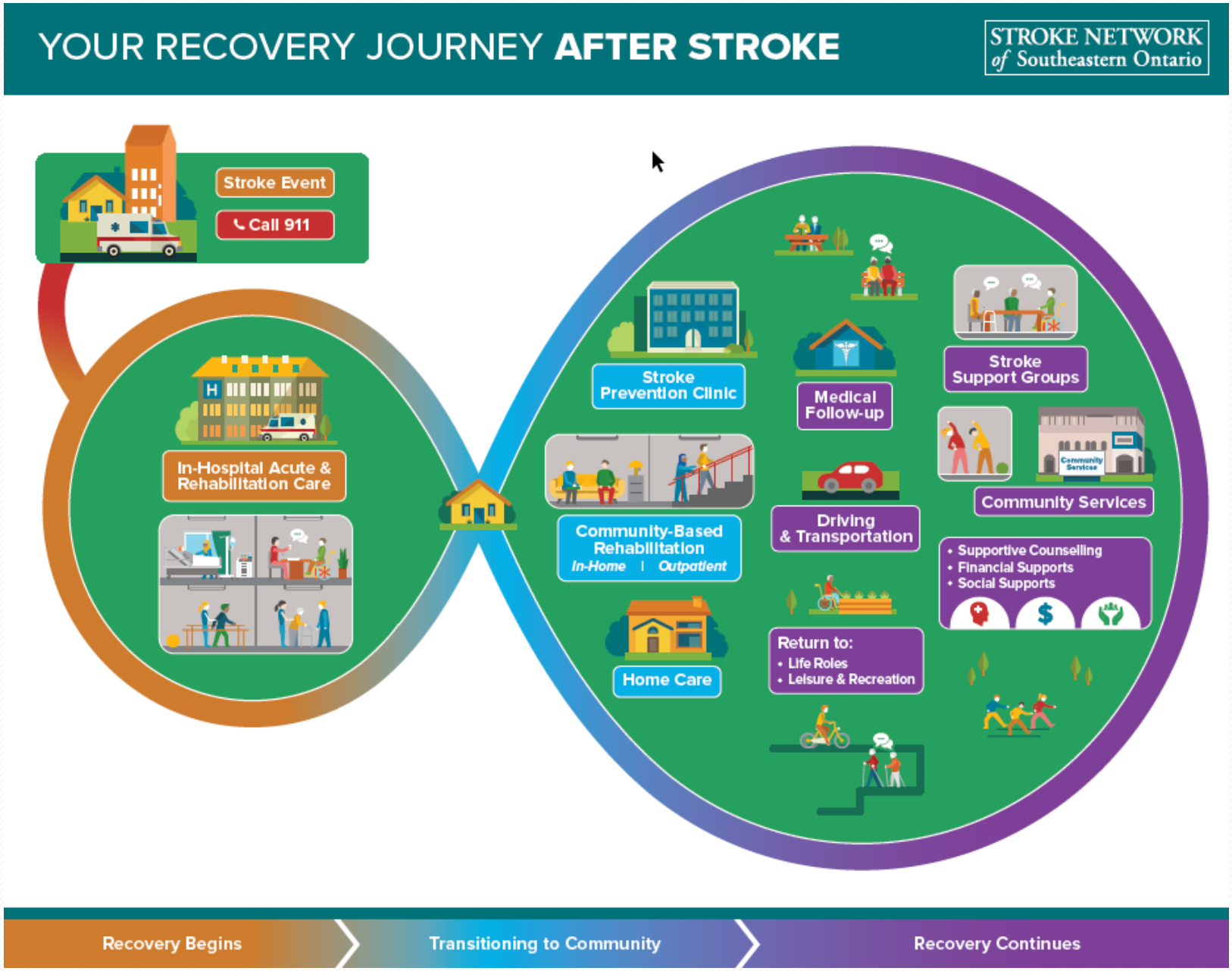
Rehabilitation Therapy

- Patients post-stroke should have access to participate in intensive, goal-directed one-on-one therapy to meet functional needs
- **Appropriate Intensity** should be provided to patients:
- **Inpatient Rehab**
  - 3 hours/day, ≥6 days/week
- **Community Based Rehab (Outpatient or Home-Based Rehab)**
  - 2-3 visits (per required discipline)/week, 8-12 weeks; 45 minutes/day/discipline
- **Early Supported Discharge**
  - 5 days/week at the same level of intensity as they would have received in the inpatient setting (i.e. 3 hours/day shared between disciplines). The duration of intervention offered as ESD should be based on patient needs and the existence and type of other community-based stroke services operating in the area (approximately 2-4 weeks)

Cross-continuum prevention assessment and care coordination

- Ongoing interprofessional patient/family education to support transitions and risk factor management
- Arrange appointments (information shared verbally and in writing prior to discharge) as appropriate for further diagnostics, outpatient care, Stroke Prevention Clinic, Primary Care Provider (PCP), other follow up required

The Future: Navigation through Less Roadblocks?



Appendix E - Patient Journey Trees

Creating stroke journey trees provided an opportunity to visually capture the ongoing emotional changes experienced by those impacted by stroke. Stroke survivors and caregivers were asked to think of words that represented the feelings and thoughts they had at three points in their recovery journey; immediately following the stroke event, transitioning home and present day.

*The emotions highlighted in the first tree in the **first few days after stroke** (left) included uncertainty, fear, exhaustion, confusion, sadness and feeling alone. Key interventions at this time revolved around patience, the need for effective, responsive education and linking to emotional supports such as social workers and, for the caregivers, linking to peers.*

*The journey tree representing the emotions experienced when **transitioning home** (right) included feelings of joy, hope, apprehension and feeling overwhelmed. Important interventions in response to this transition focused on supports and resources; sharing linkages to and clear, concise explanations of available supports and services, sharing of information as it is needed, recognition for and response to role changes, financial concerns and emotional wellbeing.*

*The final tree which represented **present day** (left) feelings saw a repetition of many of the feelings (stroke recovery can be a lifelong journey). One notable change was that the feelings of loneliness expressed in the initial trees did not occur in the final tree. Stroke survivors and caregivers attributed this to participation in the stroke support groups that provided an opportunity to share challenges, successes, experiences and stories. This linking can be an important component of community interaction.*

Appendix F – Quality Improvements between Hospital and Home - Idea Generation (Full notes)

Facilitated Brain Storming – September 18th, 2019
Facilitating Transitions Across the Stroke Care Pathway

There were 4 potential areas for improvement described for the participants and through a facilitated exercise of idea generation followed by nominal group voting on clustered ideas, "most impactful" ideas as voted by the group were identified. These are identified in the list with **** and **bold** font. All teams may find varying ideas useful to them in making improvements in hospital to home transitions.

Topic #1: Consistent delivery of Stroke Information Package

- **Focus on the people – not just the package, review package together with patient ****
- **Use a transition checklist and document package is given ****
- Keep on wall/door in room or another visual placement package
- Give at admission
- Make part of patient discharge criteria in acute care, SIP delivery to patient and signed off by RN or MD or Case Manager
- Laminate teaching cards for teaching points in acute care
- HCP to reference or use at all appointments (continue its use thru continuum)
- Designated volunteer to deliver the package
- Keep in room wit gowns/gloves etc.
- Have GPs reference/use it
- Have stroke survivor groups make more packages so they are ready to use
- Give on specific Day - i.e. Day3
- Make it part of the MAR (med book…)
- Common name of folder – "red folder"
- Integrate into frontline standards
- Communication of changes
- Ensure all team members know about SIP and all the contents
- Document other items within the package to encourage use
- Next transition – confirm it was received or give again
- Use a visual tool at rounds/huddles to cue/confirm given
- Customize for specific deficits – i.e. aphasia
- Put the contents on 211 –loaded, healthline
- Email info/contents to family
- Folder to use on nights/weekends
- Stroke support groups make packages so ready
- Have Drs aware of package and reference it
- Designate a volunteer to give it to patients
- Choose a specific day – like day 3, make it part of MAR
- Use along continuum
- Have in doctor's offices and clinics
- Designate sign off to confirm delivered before discharge
- Part of D/C plan or My Discharge Plan
- Available at walk-in clinics in community
- Include/education for medical students
- Review with family and patient prior to discharge
- Two copies – one for patient and one for family if needed

Appendix F – Quality Improvements between Hospital and Home - Idea Generation (Full notes)

Facilitated Brain Storming – September 18th, 2019

Facilitating Transitions Across the Stroke Care Pathway

- Review at 30-day SPC follow up and at 6 months post stroke
- Agree when to give it out as a team/region
- Review with professional practice and other hospital committees/education groups
- Have session with patients – pts together during rehab with team to share; answer questions and review information, rotate role
- Provide to med students during their training
- Review as part of professional development sessions – including contents

Topic #2: Making sure the patient has appropriate appointments booked before they go to the next part of the continuum – e.g. SPC, OP therapy

- **Include all follow up appointments in 1 spot with phone number and a contact person (ie my discharge plan) and link with primary care ****
- One-point person to book
- Arrange/confirm before leave hospital
- Referral provides call back
- Early identification of need for referral
- Equip patient/family to book
- Integrated health record that includes home care
- Automatic consent
- Improved predictive discharge planning/date
- Stroke Care Coordinator
- Provide phone #
- Build trust in system
- Standardized discharge checklist
- At CORP meeting make initial visit appointment then
- Book 1st home visit during CORP mtg
- Book Stroke Prevention clinic appt before discharge
- Confirm at family conference the appts that are set up
- Follow up with patient to ensure that appts have been made
- Document the appointments/referrals made/fax/scanned etc. – in kardex, chart etc.
- Just do it – have doctor follow up booked/give pt. card with appt/provide SPC appt and determine any other needed (i.e. follow up vision etc.)
- Help to book appts before they go up – put everything in writing
- Stroke case manager
- Use technology – smart phone appt, email appointments to patients -- i.e. – Spas can do it, why not health care?
- Expand CORP mtg to include other services not just OT
- Make it part of d/c package – list referrals/appointments, clinic #s, primary contact, if they follow up or if someone will call them

Topics #3: Making sure the patient has appropriate referrals made – e.g. Social Work, Community Support Services

- **Checklist if referral to service made from - hospital, LHIN, community therapist and communicate this so it is known by all ****

Appendix F – Quality Improvements between Hospital and Home - Idea Generation (Full notes)

Facilitated Brain Storming – September 18th, 2019

Facilitating Transitions Across the Stroke Care Pathway

- **Consider ways for automatic referral to SW ****
- Increasing awareness of options available in the client's community specifically
- Friendly "face off"
- Warm handover opportunities
- Educate client about ongoing referral options
- Service delivery summary completed and checked before discharge
- Loop document "road map" (patient journey map)
- Who is responsible to make sure this happens?
- Who is checking in @ 1 point of time – i.e. 90-day mark?
- Having a discharge planner (H+CC) or otherwise to create comprehensive plan
- Use of transition checklist to guide referrals
- Repeated offerings of services if decline is stated the first time
- Timeline to follow up
- Encourage referral to be delayed if its too much at initial time of discharge
- Checklist for discharge/allied
- Stagger start time for service providers
- Discuss goals to help determine referrals needed
- Timing appropriate for social work – may be throughout service plan, should be client centred vs time limited
- Automatic referrals and opt out if service not needed – CSS services?
- To ensure referrals – education to care providers/to public – radio adds, TV, social

Topic #4: Ensure there is a process for the care provider at next part of continuum to get needed information

- **One health record that crosses the sector ****
- **Integrated report for all team members ****
- Method of determining who (with contact info) will provide care at next level and include EPC (essential professional conversation)/warm handover
- Mini discharge summary to send between care providers (checklist consultation between providers to determine important/essential info). A full detailed discharge summary can follow.
- Teleconference between health care providers all together
- Permission for home care coordinator to access the e-record when doing assessment
- Determine ownership of printing/identifying allied health reports
- Communication at each transition point – acute – community, acute to rehab, rehab to community
- Provider to follow up with next provider to ensure reports received
- Provide CC with d/c plan
- Hospital e-record permissions for sharing within circle of care
- Inconsistent permissions at different hospitals with the LHIN – (i.e. not Brockville)
- More concise discharge reports in formatted template
- Central location (physical) for all reports to be sent to LHIN
- Mandated documents to be sent – medication list, discharge summary, outcome measures
- Regional health information database
- Electronic receipt of d/c summary

Appendix F – Quality Improvements between Hospital and Home - Idea Generation (Full notes)

Facilitated Brain Storming – September 18th, 2019

Facilitating Transitions Across the Stroke Care Pathway

- CORP meeting for all therapists not just one – (Hosp OT to Comm OT, Hosp PT to Comm PT, Hosp SLP to Comm SLP, Hosp SW to Comm SW)
- CORP meeting (OT, PT, SLP)
- Allied health discharge summaries provided to case managers to send with patient consent to community therapists
- Provide patient with patient discharge plan
- Funded face to face or telephone meetings to review plan of care (beyond the CORP)
- Team case conferences as an expectation to share goal with team and providers
- Standardized form/checklist
- Key person designated at each part of continuum
- Across team communication
- Same documentation system
- Feedback loop - formalize this process
- Consent for info sharing
- Include/empower client during process

STROKE NETWORK *of* Southeastern Ontario

Acute - Rehab - Community (ARC)

Stroke Services and Transitions Pathway

Transition Tools

September 2019

Standard Clinical Tools - Acute

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

PATIENT INFORMATION

Patient Care Order Set

Review Due Date: 2021 October

Acute Stroke and Transient Ischemic Attack (TIA) Discharge and Follow-up QBP Order Set	TRANSCRIPTION

Discharge Date and Disposition

☒ Discharge date: _____(yyyy-mm-

***Consider Inpatient Rehabilitation or Complex Continuing Care for patients with a
less than 40, Inpatient Rehabilitation for patients with early Alpha FIM® score betw
stroke rehabilitation (in-home/outpatient) for patients with early Alpha FIM® scor

☐ Discharge/transfer stable patient to:

☐ Home / Previous place of residence ☐ Long Term Care
☐ Providence Care Hospital ☐ Other _____

Discharge Patient Care

☒ Discontinue IV fluids
☒ Remove IV lines including saline locks unless being transferred to acute
☒ Discontinue telemetry

Diagnostic Investigations Pending/Planned at the time of d

Prescriber to provide new requisitions
Do not need to be transcribed
***Forward the requisitions by Fax/Tube system to the intende

☐ CT Head Non-Contrast at ☐ KHSC (via tube system-15) or ☐ _____
☐ CT Angiography at ☐ KHSC (via tube system-15) or ☐ _____
☐ MRI Head at ☐ KHSC (via tube system-15) or ☐ _____
☐ Carotid Doppler at ☐ KHSC (Fax:613-548-1321) or ☐ _____

Cardiac Testing

***For patients with TIA or embolic stroke without identified etiology where s

My Discharge Plan

1

_____'s Discharge Plan Date of Birth_____

I came to hospital on _____ and lef

I came to hospital because I had a stroke or a transient i

Before I leave the hospital

After talking with my healthcare team, I'll tell them in my own words w
we talked about. This helps to make sure they've covered everything cl
It also helps to explain things that may have been a bit confusing.

Before I go home, I'll make sure I can to do these things:

- I can tell you why I was in the hospital
- I can tell you what I'll do if my symptoms don't get better or co
  back

Medications I need to take

	Yes	N
Did someone go over my medications with me?	☐	☐
Do I understand my medications?	☐	☐

If I said "No" to one of these questions I should talk to a Nurse or Pharmacist before I leave

How I might feel and what to do

How I might feel	What to do
I have new stroke or TIA symptoms: • My face is	**Call 911 right away** **Don't drive to the hospital!**

ACUTE STROKE BEST PRACTICES REMINDER CHECKLIST

Stroke Unit Care Saves Lives

- ☐ **Neuro Assessment: Canadian Neurological Scale (CNS)** is used to compare baseline stroke severity, quantify neurological recovery and identify early deterioration.
- ☐ Administer Tylenol for **temperature** >37.5.
- ☐ Monitor **heart rate and rhythm** - arrhythmia is common.
- ☐ Treat **blood pressure** if above 220/120 for patients NOT receiving tPA, not having hemorrhagic stroke and not accompanied by MI, acute renal failure or aortic dissection.
- ☐ Glucometer checks q4h for 48h if admission **glucose** abnormal, then reassess. Results > 10 or < 4 reported and treated.
- ☐ **Swallowing Function**: Keep patients NPO until STAND or SLP consult is done. **Oral Care** at least twice a day & increase frequency for patients who are NPO.
- ☐ **Assess for Pain**. Shoulder pain is common.
- ☐ **Mobilize** unless contraindicated.
- ☐ **VTE prophylaxis** administered for patients with limited mobility (e.g., SCD or LMWH, fluids, mobilization).
- ☐ **Hydrate**- ensure IV in place if patient is NPO.
- ☐ **Bowel management**. Assess for constipation. Provide laxatives prn.
- ☐ **Avoid indwelling urinary foley catheter**. If clinically needed, reassess within 24h for removal.
- ☐ **Contact Your Acute Interprofessional Stroke Team.**
- ☐ **Provide patient & family education and support** including discharge planning (e.g., patients prescribed an oral anticoagulant should be educated regarding importance of daily adherence & dangers of missed doses).

- ✓ Stroke Survivor & Caregiver Support Groups have expanded across region (including Aphasia Conversation Groups)
- ✓ Community Stroke Rehabilitation Program Updated
- ✓ Hospitals following health literacy principles & providing Patient Oriented Discharge Plans
- ✓ Discharge order set developed
- ✓ Standard Stroke Information Package compiled. Packages located in the Stroke Unit. When the time is right, patients and families are provided with the Stroke Information Package. Packages contain these core materials:
  - Your Stroke Journey
  - Bookmark directing patients to SouthEasthealthline.ca Website containing many community stroke resources and services
  - Stroke Survivor Group brochure
  - Community Stroke Exercise Program flyer (if available)
  - Caregiver resource

Information can always be added to the package depending on patient and family needs.

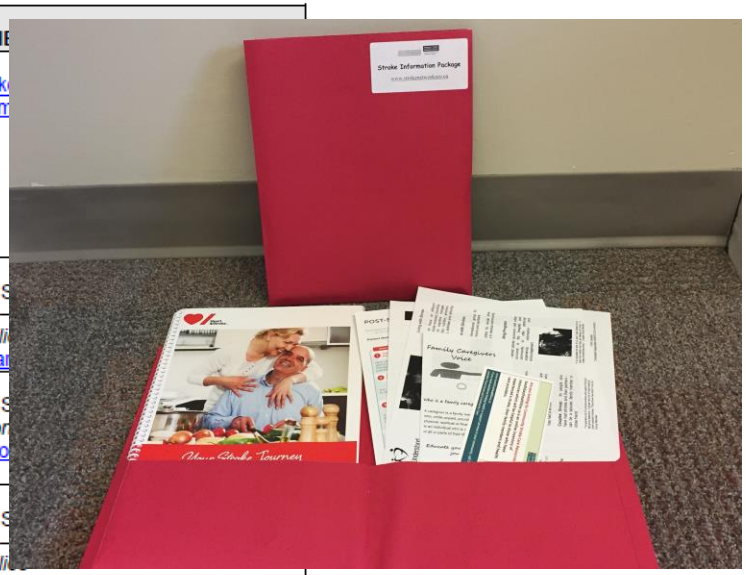
Stroke Information Package

STROKE NETWORK *of* Southeastern Ontario

INFORMATION ON STROKE FOR PATIENTS & FAMILIES

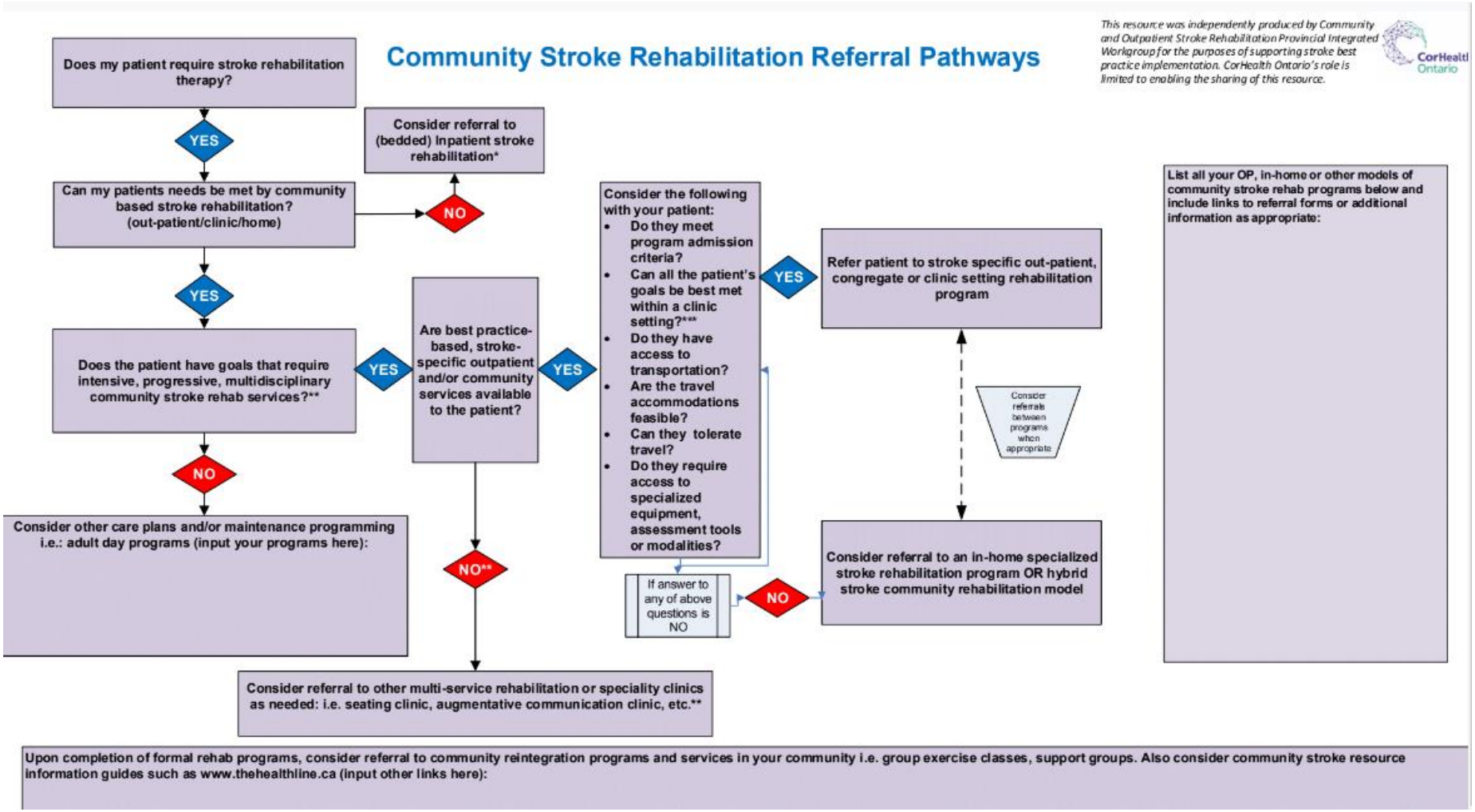
RESOURCE	DESCRIPTION	WHE
Heart & Stroke Publications	Books designed to help stroke survivors and caregivers understand stroke and recovery. • *Your Stroke Journey* • *Taking Charge of Your Stroke Recovery* or the *Post Stroke Checklist* For some clients. It may be appropriate to also provide them with *Stroke in Young Adults.*	www.heartandstrok under Health Inform
Healthline – Stroke Resources	Bookmark that provides link to this web-based resource. The **Stroke Resources** tab on the Healthline provides information for individuals with stroke and families/caregivers in ten different domains.	Stroke Network of S *Patient Education –* *Patients and Famili* Healthline Bookmar
Stroke Support Groups - Regional	Brochure for support groups for individuals with stroke and family/informal caregivers offered in Belleville, Kingston, Brockville and Perth. All groups are free, facilitated by a professional and meet monthly.	Stroke Network of S *Community Suppor* Stroke Support Gro
Community-Based Exercise Programs for People with Stroke	Brochure designed for persons with stroke and families to assist them in determining if a community-based exercise program will meet their needs.	Stroke Network of S *Patient Education –* *Patients and Famili* Exercise Brochure
Stroke Specific Exercise Programs	Brochures for community-based exercise programs adapted to the needs of stroke survivors. All programs are free.	Stroke Network of Southea *Community Supports* Stroke Specific Exercise P
Caregiver Support	Family Caregivers Voice is a caregiver-led group that is committed to educating family caregivers on their journey using the invaluable experience of other family caregivers as mentors.	www.familycaregiversvoice Stages of Caregiving Brochure

For stroke survivors with aphasia, please consider including additional resources. Two sites providing free downloadable resources are:
The Aphasia Institute https://www.aphasia.ca/shop/. Navigate to box *If you work or live in Ontario you may be eligible for free downloads of our products*. Complete the form and instructions will be emailed.
Amy's Speech & Language Therapy Inc. http://www.amyspeechlanguagetherapy.com/communication-boards.html
As well, both The Aphasia Institute (Toronto) and The Aphasia Centre (Ottawa) are excellent on-line resources.



Stroke Information for Patients and Families

Algorithms for Referrals



Early access to community programs

SOUTH EAST LHIN HOME & COMMUNITY CARE

COMMUNITY STROKE REHAB PROGRAM 2018/19

447 referrals to the Community Stroke Rehab Program. An increase of 19% from previous fiscal.

53% were referred from an **acute** care setting, **40%** were referred from a **rehab** setting and 7% were referred from other settings.

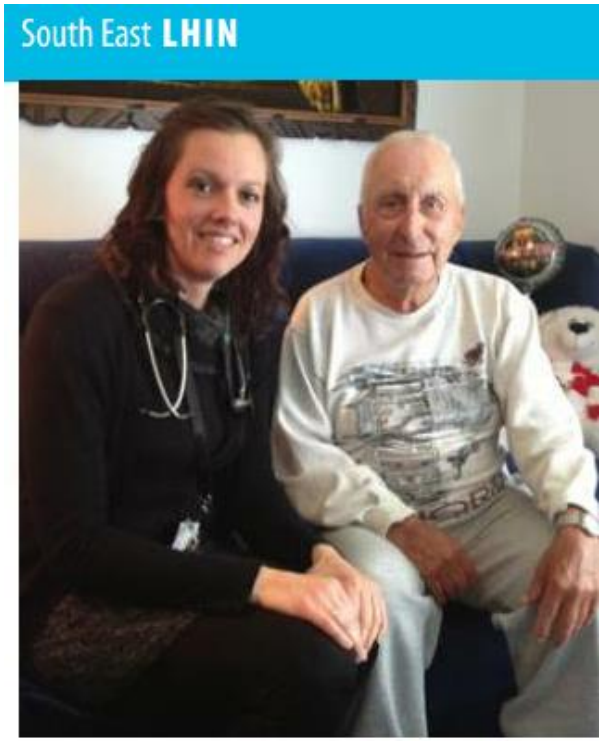
Median time to first therapy visit stable at 4 days

+1

Patients in rural and small population centres averaged one additional wait day for services.

Median age for male patients was 71 and for females was 77.

Average number of therapy visits received by patients was **15**



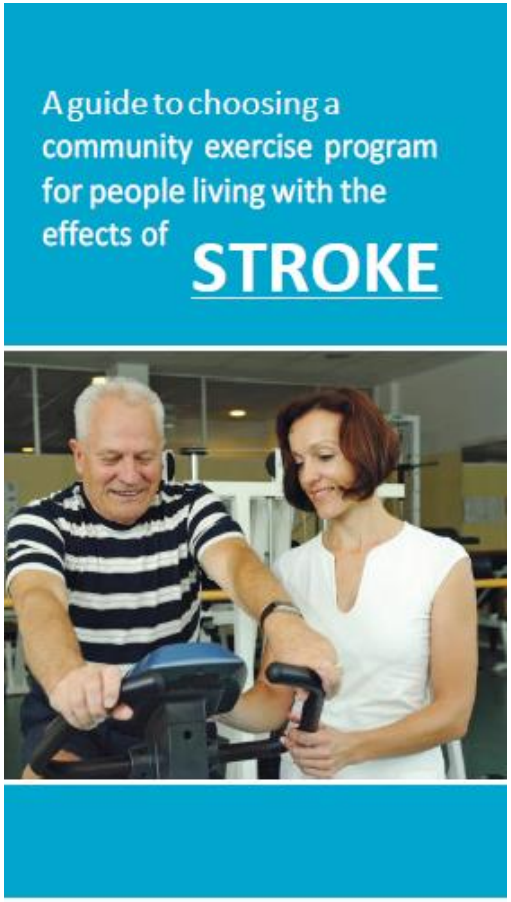
Rapid
Response
Nurses (RRN)

Checklist support community linkages

COMMUNITY STROKE REHAB PROGRAM
TRANSITION CHECKLIST –

This checklist will support the identification of and linking to community supports and services following discharge from the Community Stroke Rehab Program. As a global resource, it is recommended that the Stroke Resources microsite on the front page of South East Healthline be shared with the client/family. (www.southeasthealthline.ca)

	Organization	Link
Rehabilitation • Does the client need ongoing rehab services? • Are they eligible for ongoing Home & Community Care services? • Is outpatient rehab an option to meet ongoing needs (are they eligible, is there OP therapy available in the client's area, do they have transportation)?	• Home and Community Care Toll free at 310-2222 • Multidisciplinary Outpatient Rehab Perth 613-267-1500 X 2127 Belleville 613-969-7400 X 2633 • Outpatient Physiotherapy Kingston – Providence Care Hospital 613-544-4900 ext. 53231	Home and Community Care Perth Outpatient Rehab Belleville Outpatient Rehab Kingston Outpatient Physio
Community Exercise Groups • Could they safely participate in a community program (is there a program available in their area & do they have transportation)? • Is there an opportunity to connect with the exercise provider prior to the client's discharge? • Is there an opportunity for the therapist to attend an exercise class with the client prior to discharge?	• Stroke Specific Exercise Groups (Perth, Belleville, Trenton, Kingston, pending in Brockville) Perth & Brockville 1-800-465-7646 X 2301 Kingston 1-613-634-0130 X 3414 Belleville & Trenton 1-800-301-0076 X 3414 • Revved Up (Kingston) 1-613-533-6000 X 79283	Stroke Exercise Groups Revved Up
Returning to Life Roles/Vocations • Is the client considering a return to work or school?	• Stroke Network of Southeastern Ontario 613-549-6666 X 3853 • Community Brain Injury Services 613-547-6969 • Pathways 613-962-2541 • March of Dimes 613-549-4141	www.strokenetworkseo.ca Community Brain Injury Services Pathways March of Dimes



STROKE NETWORK *of* Southeastern Ontario

www.strokenetworkseo.ca

Patient Journey Map