STROKE NETWORK *of* Southeastern Ontario

Operationalizing Interprofessional Outcome and Assessment Measures for Stroke Care in Hastings & Prince Edward Counties

Summary Report
January 27 2015 - Interprofessional Workshop

The following is a summary of the workshop that was guided by the planning committee with representation from acute, rehab and community. The committee used a pre-survey of teams regarding current use of outcome measures and assessment tools in HPE, previous workshop experience across the South East, follow up recommendations from a previous workshop held in HPE in 2009 and the Canadian Best Practice Recommendation's "Stroke Rehabilitation Screening and Assessment Tools". The focus of this summary is to provide post-workshop reflection, and most importantly action plans that came from the workshop.

Participants

Fifty health care professionals from interprofessional care teams in Hastings & Prince Edward Counties (HPE) working with stroke patients in acute, rehabilitation and community participated in the one day workshop. This included physiotherapists, occupational therapists, speech language pathologists, dietitians, nurses, social workers, pastoral care, recreation therapists, administration and CCAC care coordinators.

Program Objective

Identify how to improve use of the standardized outcome and assessment measurement tools recommended for use across the continuum of care in HPE. By the end of this workshop participants will have had the opportunity to:

- Review outcome and assessment measures currently in use and those previously recommended for use across the continuum of care in HPE and how they align with the Canadian Stroke Best Practice Recommendations
- Better understand the use and interpretation of the recommended outcome and assessment measurement tools
- Better understand the implications for use of the outcome and assessment measurement tools in the patient's plan of care within and across patient care teams
- Validate the recommended set of standardized outcome and assessment measurement tools
- Identify next steps to ensure the use of the recommended outcome and assessment measurement tools for optimal patient care across the care continuum
- Enhance interprofessional collaboration through understanding of the outcome and assessment measures used, understanding the roles and scope of practice of the interprofessional team members and by creating a common language
- Network and share stroke expertise across the continuum of care

Action Planning and Next Steps

The workshop focused on outcome measures and assessment tools selected by the planning committee. The agenda included presentations about the current use of outcome measures and assessment tools in HPE, brief presentations on the selected tools and a case study demonstrating use across the continuum (see Agenda in Appendix A). After the presentations, attendees participated in carousel table discussions to develop actions related to: 1) How should these tools be incorporated into care across the continuum in HPE? and 2) What next steps should take place to support use of these tools at the personal level, team level and between teams?

The following is a summary of that discussion and action plans by domain of outcome measure and suggestions generated from the groups. This summary will be sent to all the participants. The planning committee members will be asked to follow up on action planning with their teams. (Full transcription of the flip charts are attached in Appendix B)

Functional Independence – Canadian Occupational Performance Measure (COPM)

In general, the group seemed quite interested in this tool – particularly in the community. It was identified that there would need to be some education/in-service about the tool and the specific instructions to use. There also is a need to access the actual tool and supporting documents. The tool itself may be more appropriate at certain stages of rehabilitation but seemed interest and benefit across the continuum but less so in acute.

> Next steps: Beth Steinmiller will work to organize an inservice within QDR and explore further adoption opportunities in the community. Hospital and staff from other organizations could be invited to participate.

Functional Independence – Re-integration to Normal Living Index (RNLI)

This tool seemed to develop smaller level of interest in general however for those who did discuss it felt that it may have some further application for community clients. Use of the tool may help some system navigation in later stages of recovery when client can accurately reflect how they are managing in the community. For those who are completing it such as the Rehab Day Program, it was thought it would be good to share with others such as CCAC at discharge.

> Next steps: Karen Voth has offered to be a resource if others try the tool and wanted to discuss experience. At a regional level – the outcome measures lists will be updated to include this tool. Short term was for rehab day to share the tool as part of discharge summary to CCAC.

Mobility – Stroke Rehabilitation Assessment of Movement (STREAM)

Validated interest of the group to continue to use in the rehab setting and expand its use in the community. Discussion around processes to have STREAM information (more information on the score components vs just the percent) shared with community so information is available prior to first visit. Pam Bell identified as potential trainer.

> Next Steps: QHC team discussion on trial of process to share information with the community (no lead identified yet).

Mobility – Chedoke Arm & Hand Activity Inventory (CAHAI)

This was a new tool introduced to the participants so much of the discussion was around questions and a need to better understand when to use the tool and a need for education for all. Potential to use this in follow up to the STREAM when upper extremity has been identified as a key area of focus.

> Next Steps: Arrange further education on the tool, select the best version and arrange for "kits" to be available for use. (no lead identified yet)

Cognition – Motor-Free Visual Perception Test 3rd edition (MVPT-3)

Conversation around version of tool and ensuring recommended version is available for use in all areas. Opportunity for education to other team members who do not administer the tool to better understand the scores and what it may mean functionally to the stroke patients or caregivers supporting them.

> Next Steps: Jennifer Levy, QHC to follow up on versions of tools and review key opportunities to communicate results with team members.

Cognition – Montreal Cognitive Assessment (MoCA)

Group interested in better educating team and each other around best use of the tool (who is appropriate, alternate for aphasic clients, as well as when re-testing is appropriate). Key theme is around education that it is a screener and not a capacity assessment and there may be some opportunity here as well to educate on what the scores mean.

> Next Steps: Jennifer Levy, QHC to follow up on specific questions and share back with QHC team. Consider approach to stroke team education about the MoCA and support for those asked to administer it.

Communication – Frenchay Aphasia Screening Test (FAST) and Language Screening Test (LAST)

Overall, there seemed to be more interest in the LAST. Both tools were new to the group. As it is a new tool first step was to become more familiar and do a little more research about the LAST and find out if anyone is using it and have any further information or recommendations from practice. Opportunity to pilot it within QHC at sites where SLP coverage is more sparse to help screen prior to consult.

> Next Steps: Shawn Allen and Natasha Uens were interested in learning more and exploring the opportunity for a pilot on a unit (? Picton)

Emotion – Brief Assessment Schedule Depression Cards (BASDEC) and Patient Health Questionnaire (PHQ-9)

Conversation largely focused on BASDEC. Interest in each QDR Social Worker having access to a set of cards. Could be used broader than for stroke which would enable increased use and practice. May be some training needed. QHC would like to see more discussion on the BASDEC assessment at rounds and support for processes when the screening is complete. May need to work on a standardized approach to regularly complete the screen. Opportunity for QDR social work to consider the PHQ-9 as standard screening tool.

> Next Steps: Regional Team to investigate how to purchase the BASDEC tool and share with participants. Melissa Roblin to follow up on consideration of enhancing use of the BASDEC at QHC and incorporate into rounds discussion for education of other team members. Lead not identified for QDR – but interest in purchase and training (? Beth Steinmiller to follow up)

Participant Feedback Next Steps/Action Plans

Through the post-workshop survey participants were asked to reflect and share what they could do at the personal, team and between team level to support the use of outcome measures and assessments across the continuum in HPE. The responses for each question are below.

Participants were asked to share what they would do **personally** after attending the workshop. In general – the responses were largely around 1) starting to use a new tool 2) share more information at rounds 3) making it a more standard part of the their practice.

Comments received:

- Use 1-2 new outcome measures in stroke assessment -Able to interpret scores from hospital d/c notes to gear
  towards treatment
- Check InterRai regarding other service providers and obtain reports. Use STREAM as tool in the community and
  forward to other service providers.

- 1)Educate fellow staff members on what we learned at conference and begin to implement outcome measures
  that are relevant to our profession 2) Document better and more specify on Physio outcome measures especially
  in discharge summaries.
- Try to use STREAM and other tools as part of my report when requesting client go to Day Hospital
- Using different tools such as LAST and FAST to assess patients prior to SLP seeing pt. Share the resources that are available from stroke network and aphasia institute
- Educate my peers in school on the importance of ensuring the continuum of care is as seamless as possible, and how outcome measures can play a role in that. 2) include some of the information that I learned at the workshop on my placement project
- I plan on accessing/ interpreting these assessment tools more often in my own practice to review and to assist
  with my own specialized assessment and care planning for the community.
- Implement use of tools that can be used by any discipline (specifically FAST and LAST) help to inform other coworkers
  about the tools used.
- I'm going to use the pqh9 with my clients as indicated and will look at purchasing the Basdec assessment as well.
  Also, for those persons I see who have had a stroke, I will be more mindful of where I sit in the continuum of care
  and what role I play in supporting recovery and quality of life.
- Standardized depression screening for stroke patients Work at increasing communication of OM to our community partners
- Utilization of BASDEC in CCAC (i.e. follow up post In patient) Red Flags in patients file for all to see.
- Incorporate new assessment tools as appropriate -learn more about assessment tools
- Develop an algorithm for QHC related to Alpha FIM – work with staff to ensure adequate training on outcome measures

Through the post-workshop survey, participants were also asked to share what **their team** could do to improve use of the outcome measures after attending the workshop. In general – the responses were largely around 1) education 2) communication of scores and 3) increasing standardization of use of tools to ensure completed regularly

Comments received:

- Host in-service on STREAM and CAHAI outcome measures -Ensure team has appropriate tools necessary to carry out outcome measures
- With team members being of the same profession, all team members: 1) be well educated regarding AlphaFIM and STREAM. 2) be consistent in using these tools.
- 1) Use the recommended outcome measures consistently 2) Divide up outcome measures by profession for those measures that are not neccesarily discipline specific (i.e. The BASDEC) so they actually get done and not missed.
- We will have an in service for the whole team to review tools and encourage their use especially when referring clients on
- Designation staff to work specifically in stroke unit, to help with continuity of care and better outcomes for patients
- 1) educate ourselves on some of the outcome measures that we have never completed before 2)
  better share information about the scores of tools and what that means for us and the patients make sure we are using appropriate tools at appropriate times
- Each have our own tool set and make this screening standardized in our team.
- Increase consistency of assessments and talk a standard language
- Communication, Awareness, education to all Teams
- Revise process related to completing MOCAs -Develop better guidelines re: when/where to complete different outcome measures

Through the post-workshop survey, participants were also asked to share what could be done **between teams** to improve use of the outcome measures after attending the workshop. In general – the responses were largely around 1) education 2) communication of scores – consider electronic documentation of tools/scores when completed and 3) sharing results with next team (such as community providers)

Comments received**:**

- Report outcome measure scores on discharge report -Use same outcome measures when applicable
- Invite other professionals to provide education/interpretation regarding the ass't/outcome tool which they are using. Provide other professionals education regarding our ass't/outcome tools.
- 1) having consistent outcome measures that are used amongst each profession 2) Having the outcome measures on Meditech (at the hospital) so that it is easy to look up results and not have to refer to the chart.
- Communicate at discharge the scores and then again when transferring to Day Hospital from Home Care
- Better communication tools between designations
- Communicate about what works and what doesn't and who should be doing what
- Make sure we are all using the same tool/version of the tool communicating that/when tools have been used and the scores
- Providing outcome information across the continuum of care. Perhaps we can adopt an approach re: regular intervals of assessment that can be shared across the span of intervention from stroke onset through to end of treatment in the community.
- Communication between acute inpatient and community, PCPs, etc
- Use the same measures so can share scores and see change -Communicate better results of therapy

Lastly participants were asked what would **help them implement** changes?
The common theme seemed to be around support for education and team planning around better awareness of roles for completing the measures and some accountability in this regard.

Comments received:

- As the AlphaFIM is mandated, it would help if the use of other ass't/outcome tools were standardized. The two round table discussions, Communication and COPM, I attended did not indicate that the LAST or FAST or COPM were being used consistently among SLPs and OTs respectively.
- I think it needs to be mandated that strokes have the following outcome measures done and that specific professions are responsible for carrying out specific ones. Otherwise there is no accountability.
- Once we have had an in-service of use of 1 or 2 tools, updates at team meeting to see if therapists are using them. Also seeing the scores come from the hospital will remind us to use them
- Work with other disciplines to implement the changes
- I plan to further my interprofessional education at school.
- Some sort of form/checklist to show when/that tools have been used and scores.
- Discussion with my team and then having a representative provide info about our approach to other service providers.

Regional Stroke Network Actions and Follow up:

Based on discussions during the workshop and post-workshop feedback there are some elements that the Regional Stroke Network will contribute. These are listed below.

- Conduct a 6 month follow up – check in with the original planning committee members or other designates in the above next steps for update on progress and review of potential further regional support required.

- Review and update as needed SNSEO outcome measures resources with input from key stakeholders. The tools originally developed for use by CCAC Care Coordinators can be updated and reviewed for use by a larger audience.
    - SEO Outcome Measure Summary Sheet
    - Outcome Measures Interpretation Resource-Stroke Network of Southeastern Ontario
    - Red Flags for Care Planning - Outcome Measure Reference Guide - For Use with Acute Stroke Discharges

- The SNSEO had ordered a few copies that can be provided to teams who are ready to implement for regular use.

- Offer adhoc support to smaller workgroups as needed (ie can support some information gathering beyond HPE).

- Explore and consider other follow up educational opportunities as needed.

Appendix A

Operationalizing Interprofessional Outcome and Assessment Measures for Stroke Care in Hastings & Prince Edward Counties

Tuesday, January 27, 2015
Maranatha Church, Belleville

Time	Topic	Presenters
1130 -1215	**Lunch & Registration** o Network with your colleagues	
1215 -1225	**Introduction**	
1225 -1250	**Outcome and Assessment Measures used in Hastings & Prince Edwards Counties** o National Best Practice Outcome Measures o HPE Recommended Outcome Measures o Current use of Outcome Measures in HPE	N. Uens
1250-1410	**Tools to Focus On** **Functional Independence:** o Reintegration to Normal Living Index (5 min) o InterRAI & Contact Assessment (5 min) o Canadian Occupational Performance Measure (COPM) (5 min) **Motor/Mobility:** o STREAM (5 min) o Chedoke Arm & Hand Activity Inventory (CAHAI) (5min) **Cognition/Perception:** o Motor-Free Visual Perception Test 3rd edition(MVPT-3) (5min) o Montreal Cognitive Assessment (MoCA) (5min) **Communication**: o Language Screening Test (LAST) (5 min) o Frenchay Aphasia Screening Test (FAST) (5 min) **Emotion:** o Brief Assessment Schedule Depression Cards (BASDEC) (5 min) o Patient Health Questionnaire (PHQ-9) (5min) **Dysphagia & Nutrition**: o Screening Tool for Acute Neurological Dysphagia (STAND) (5 min)	K. Voth D. Michel A. Quilty & B. Steinmiller A. Irsag P. Bell J. Levy J. Levy S. Allen S. Allen M. Roblin M. Slapkauskas M. Roblin
1410-1440	**Outcome Measures Used Across the Continuum of Care in Hastings & Prince Edward Counties – Case Study**	

<table>
<tr><td>1440 -1500</td><td>Break (20 min)</td></tr>
<tr><td>1500 – 1600</td><td>Focus Groups – Carousel Table Discussions
Cross-sectoral, interprofessional groups
Rotation through 2 out of 5 tables listed below
Action Questions:
➢ How should these tools be incorporated into care across the continuum in HPE?
➢ What next steps should take place to support use of these tools at the personal level, team level and between teams?
TABLES
Functional Independence
➢ Reintegration to Normal Living Index
➢ InterRAI & Contact Assessment
Functional Independence
➢ Canadian Occupational Performance Measure (COPM)
Motor / Mobility
➢ STREAM
➢ Chedoke Arm & Hand Activity Inventory (CAHAI)
Cognition / Perception
➢ Motor-Free Visual Perception Test (MVPT-3) (5min)
➢ Montreal Cognitive Assessment (MoCA)
Communication
➢ Language Screening Test (LAST)
➢ Frenchay Aphasia Screening Test (FAST)
Emotion
➢ Brief Assessment Schedule Depression Cards (BASDEC)
➢ Patient Health Questionnaire-9 (PHQ-9)</td></tr>
<tr><td>1600 -1630</td><td>Action Planning

Report back and clarification
➢ How should these tools be incorporated into care across the continuum in HPE?
➢ What next steps should take place to support use of these tools at the personal level, team level and between teams?</td></tr>
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Appendix B – Summary Notes from Flipcharts

Domain	*Reflections*	*Actions*

Functional Independence	**COPM:**
	• Incorporating in care across the continuum
	  o A tool everyone uses
	  o Meaning making – whole person, what is important
	  o All disciplines trained to use
	  o Broader assess/observation by all team members – in all settings
	  o Change philosophy of service delivery
	  o COPM applied to all patients – follow patient
	  ▪ Need to increase collaboration, share info – '10 min chat' to share participation to set goal accompli'n
	• Patients struggle to make goals, COPM - ++ great assistance with goal setting
	• Comprehensive whole person
	• Commitment to education
	• Helps therapist engage client – reframing the client
	• Works well in rehab day hosp
	  o More challenging at the acute stage
	  o Help client move on – 'putting scope into client's hand'
	• COPM may be more appropriate at specific stages of rehab
	• Place to help clients reframe – move towards goals, move towards new goals
	• Acknowledging values/expectations
	• Universal – by discipline
	• Not so much across continuum
	
	• Is it effective across the continuum?
	• Is it appropriate for all leves of cognitive ability?
	• Understand the full assess. Tool
	• Want to use it!
	  o Whole person
	  o Client centred
	  o Comprehensive
	  o Engages all disciplines moving in the same direction
	
	RNLI:
	• System navigation – referrals, links
	• Useful in community
	  o Therapy
	  o Support groups
	  o ?Care Coordinator
	• Communication
	• Communication of scores/?tool in action, recommendation
	• Admin – CCAC Therapy
	• Support groups
		• Communication
		• Explore new users – try it!
		• Regional – add to outcome measure list
		• Call Karen if you try it and have questions
		
		• RDH – forward info with CCAC
		• Regional level – red flag actions

Mobility	**STREAM:** • Can the score be used for utilization of resources in the community – appropriate for enhanced or not? • Does it have to be same person doing the same test? –	• To use rehab/RDH/community on most strokes (as appropriate) • Education – community • Pam Bell as "trainer"

	eg, OT/PT tag team and complete certain items fo the measure
	• ?time consuming in the community – but – could be used with the initial Ax as carers U/E, L/E and mobility – not for acute
	  o Improve communication between teams and within teams
	
	CAHAI:
	• What can we do?
	• Which version?
	• Who would (overlap) do the tool, OT?, PT?
	• When?
	• Functional base – may pick up some cognitive issues
	
	• Like the tool
	• Overlap with OT/PT in the community who completes this
	• Communication
	• Strokes with U/E deficits
	• Not necessarily right away
		• Support to ensure community therapists - "GAP" - have the OM info prior to seeing the pt's for first time, ?can pt go home with info to give to therapist?
		• Support in the community to use this tool
		• Have necessary forms available
		• Understanding the scores
		• To have more info on the scores than just final %
		• ?use of D/C link meeting to share the info
		
		• All have a kit – equipment readily available
		• Education for all
		• Who
		  o Communication – personal/team/inter-team
		• When
		  o ?look at STREAM
		  o U/E score – CAHAI
		  o So – if ?Cognition
		  o Need kits (equipment)
		  o ?which version – more standard t/o continuum – use same version
		
		• Communication between disciplines in the area of care
		• Education for all
		• Need kits/equipment – QDR, QHC
		• Communication – of the version used

Cognition	• How should tools be incorporated?
	• **MVPT-3**
	  o Standardized version use – use MVPT-3 not MVPT-R
	• **MoCA**
	  o Clear guidelines on when/who to use with
	  o Info on what scores mean
	• Communication about when/what has been done across continuum
	• Standardized version use of MVPT
	• Clear guidelines on what MoCA is for, when to use and how often
	• Better communication across continuum re: scores
		• Tool needs to be available
		• Find out how often test should be done (from creators)
		• Education/info available for team on what scores mean and impact on function
		• Education on who tests are appropriate for – ie, aphasia
		• Find alternate test to use for pt's with aphasia
		• Educate on functional implications of scores
		• Communication method for staff to share results for test
		• Check College guidelines re: version use of tests
		• Ensure access to MVPT-3 in all appropriate areas to use
		• Find out from MoCA creator clear guideline on appropriate amount of time between tests
		• Education to team on what results mean, impact on function and who not to use with (ie, aphasia)
		• Look into alternate cognitive tool for client's with aphasia
		• Communication method to share results with team

Communication	• Benefit of tools for non-SLP members of team (LAST – informs need for SLP referral) • ICU and ER appropriate as brief and trans-professional – identifies need for more 'fine-tuning' • ?usefulness as retest (LAST does have 2 versions)	• Learn more about tools (FAST and LAST) (who has used?, how?, other screening tools to support) • How to capture other communicational challenges that may be missed with LAST (eg

	• TIA - ?absence of 'full workup' – brief tool to ID aphasia (LAST) and make referral
	• FAST – increase detail/domains
	  ○ ER/ICU – LAST (cross continuum)
	  ○ Non-SLP – esp when SLP not available
	  ○ CCAC CC – LAST (cross continuum)
		dysarthria)
		• Pilot in conducive environment – establish best area to pilot and who?
		• Why LAST not in CBR
		• Champions (knowledge)
		• Communication – how to easily share what has been done – results – checklist/tool
		• Prioritization tool for SLP
		• LAST – short and more mobile so great for acute – wider variety of pts appropriate for
		• FAST – increase time and complicated picture and other barriers (vision, mobility) so not great for acute – better for post-acute
		  ○ Pictures – alligator/crocodile, TV/monitor
		• Resources (SLP focus on swallowing)
		• Objective measure to ID change
		• Education
		• Logistics (where kept, how accessible)
		• Learn more about tools
		  ○ Where being used
		  ○ Who using/why/how
		  ○ Other supporting tools
		  ○ CBR inclusion
		• Pilot (Shawn & Natasha)
		  ○ Where (stroke unit?)
		  ○ Who
		  ○ Champions
		  ○ Communication (sharing score)
		  ○ Logistics (where housed, accessed…filed)
		  ○ Education strategy (?prioritization tool for SLP), (?objective tool to measure change)
		• Evaluate pilot (eg SLP prioritization, trans-discipline, results sharing)
		• Disseminate further

Emotion	• Each SW has a set of cards • Regional program can possibly facilitate purchase of cards • Communication to community - ?passport/ red flags for CCAC • Need a more standardize approach • Increase BASDEC usage in hospital • Onion-head cards: potential for aphasic patients • Screening standardized – who?, when? • Helpful for more than stroke patients	• BASDEC purchase • Increase awareness of BASDEC in hospital • QDR SW implement PHQ-9 as standard screening • Increase communication to community • Outcome measure (BASDEC) discussion at rounds • Increase screening in hospital by using team approach • DQR SW each have BASDEC cards • BASDEC on Kardex/?CCAC message • Not just screening for stroke patient • BASDEC training