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An Introduction to Post-Acute Stroke QBP Recommendations on Outpatient and Community Rehabilitation

June 5 2015

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Pre-presentation Instructions

- Please keep microphone on mute unless you are asking a question
- The presentation and Executive Summary is available at www.ontariostrokenetwork.ca
- There will be a question and answer period at the end of the presentation
- Please email info@ontariostrokenetwork.ca

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Speaker:

- Dr. Mark Bayley, OSN Evaluation Champion and Chair of Stroke Evaluation and Quality Committee, Co-Chair HQO Phase Two Expert Panel

Objectives:

1. To provide a brief overview of Quality Based Procedures
2. To provide an overview of the recommended practices for stroke QBP's for community and outpatients.
3. To provide an opportunity for discussion & questions

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Acknowledgement

- Health Quality Ontario's Clinical Handbook for Stroke: Acute and Post-Acute was developed by Health Quality Ontario on behalf of the Ministry of Health and Long Term Care with the Stroke Episode of Care Provincial Phase 2 Expert Advisory Panel
- The content of this presentation follows content of the Quality Based Procedures for Stroke: Acute and Post Acute Clinical Handbook
- South West Ontario Stroke Network for their contribution to this presentation

Phase 2 Expert Panel for Health Quality Ontario: Episode of Care for Stroke

Name	Role	Organization
Dr Mark Bayley	Physiatrist	University Health Network
Christina O'Callaghan	ED	Ontario Stroke Network
Dr Leanne Casaubon	Stroke Neurologist	University Health Network-Toronto Western
Dr Adam Steacie	Family Physician	Ontario Medical Association
Dr Robert Teasell	Physiatrist	St Joseph's Health Care
Connie McCallum	Nurse Practitioner	Stroke Prevention Clinic, Niagara Health System
Trixie Williams	Lead, Vascular Health	Central East LHIN
Armi Armesto	Clinical Nurse Specialist	Stroke Prevention Clinic, Sunnybrook Health Sciences
Dr Dan Brouillard	Stroke Survivor	Kingston
Nadia Hladin	Manager Professional Practice Rehabilitation	VHA Home Healthcare
Karen Sutherland	Service Lead	Specialized Community Stroke Rehab Team, St Joseph's Health Care, Parkwood
David Ure	Coordinator	Community Stroke Rehab Team
Sarah McEwen	Research Scientist	St John's Rehab
Stefan Pagliuso	Regional Stroke Rehabilitation, Community & LTC Coordinator	Central South Stroke Network
Jim Lumsden	Regional Program Director	Champlain Regional Stroke Program
Paula Gilmore	Regional Program Director	South West Ontario Stroke Network
Joan Southam	Home Health Senior Manager/Project Specialist	CBI-LHIN
Matthew Meyer	Project Coordinator	Ontario Stroke Network
Nicole Martyn-Cobianco	Program Head Human Services	University of Guelph-Humber
Holly Sloan	Speech Language Pathologist	Trillium Health Partners
Rebecca Fleck	Regional Education Coordinator	Central South Stroke Network

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About the OSN

- The OSN provides provincial leadership and planning for the Ontario's 11 Regional Stroke Networks (Ontario Stroke System) by:
  - *establishing province-wide goals, strategies & programs to implement BP's across the care continuum;*
  - *leading or facilitating provincial initiatives & aligning regional/LHIN plans*
  - *evaluating performance, benchmarking & reporting on provincial, LHIN & Regional Stroke Network progress; &,*
  - *Managing the KT program.*

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Regional Stroke Networks

- Ontario's 11 RSN's support the 14 LHINs
- Each stroke network is a collaborative partnership of health care organizations and providers that:
  - *span the care continuum from prevention to community re-engagement.*
  - *develop and implement strategies to achieve equitable access and improved outcomes for stroke survivors and their families through the integration of stroke best practices across the care continuum*
  - *Will support the LHIN implementation of QBP's*

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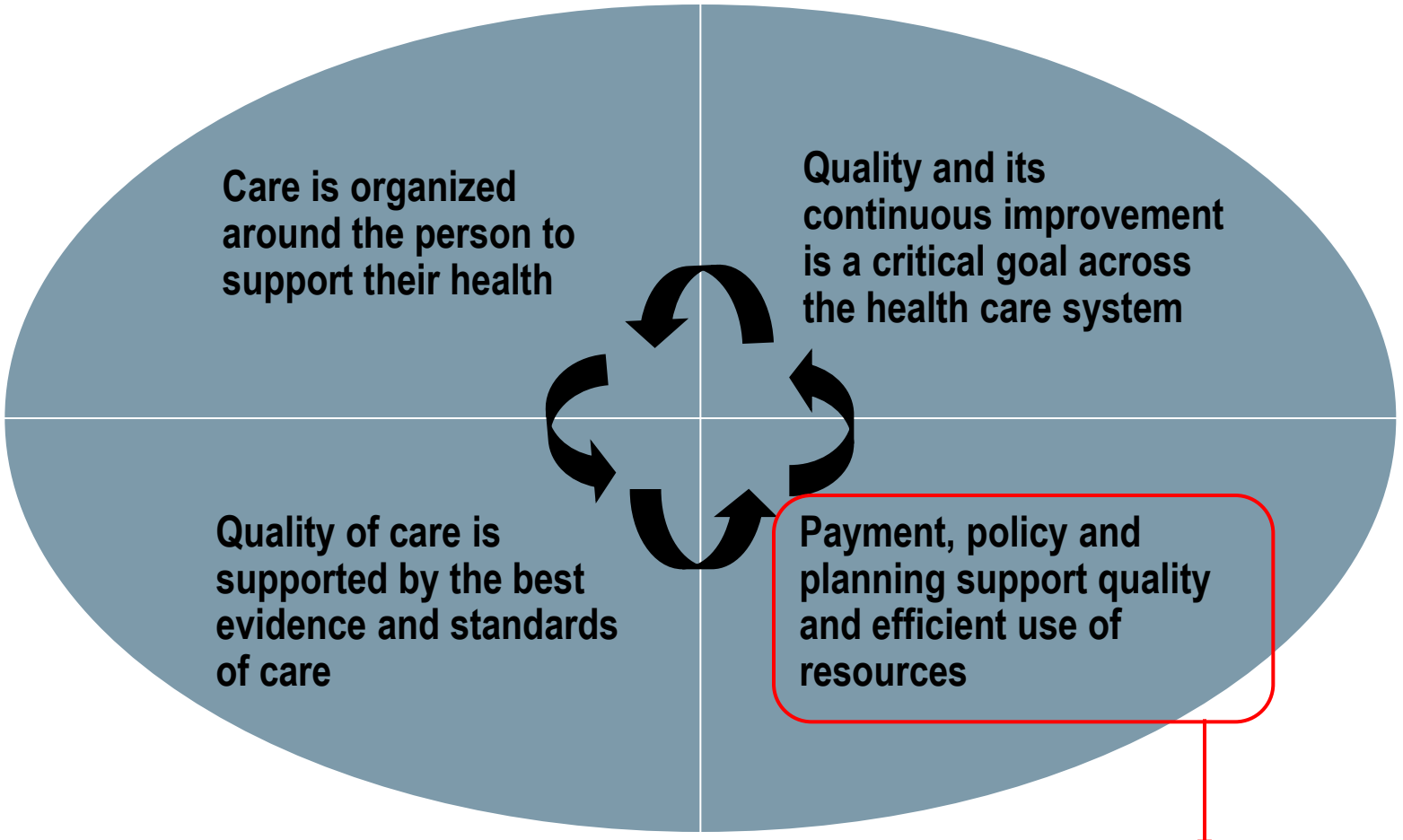
Quality Based Procedures

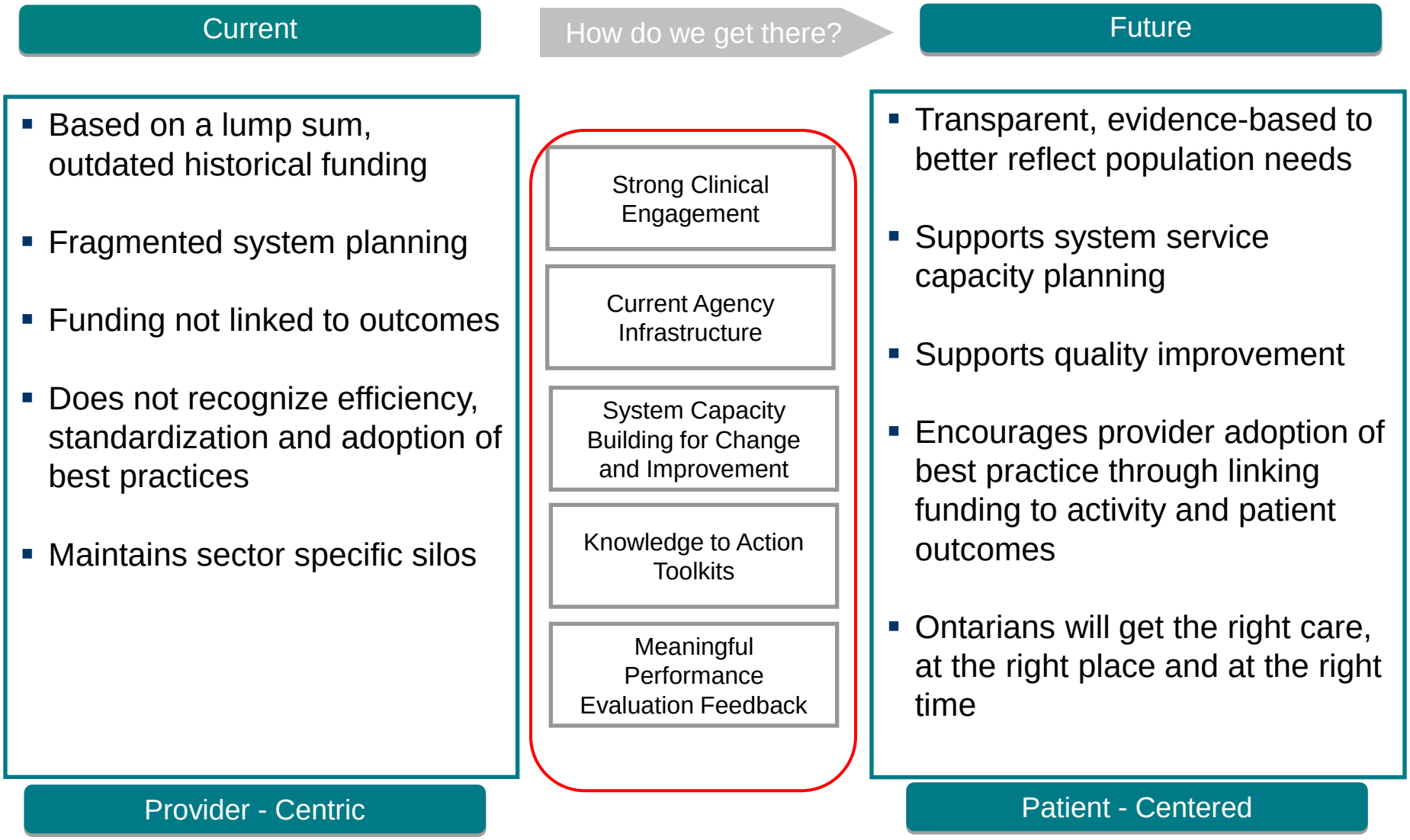
The path forward: The Excellent Care for All Strategy is anchored by principles reflecting *high quality as the primary driver to system solutions…*



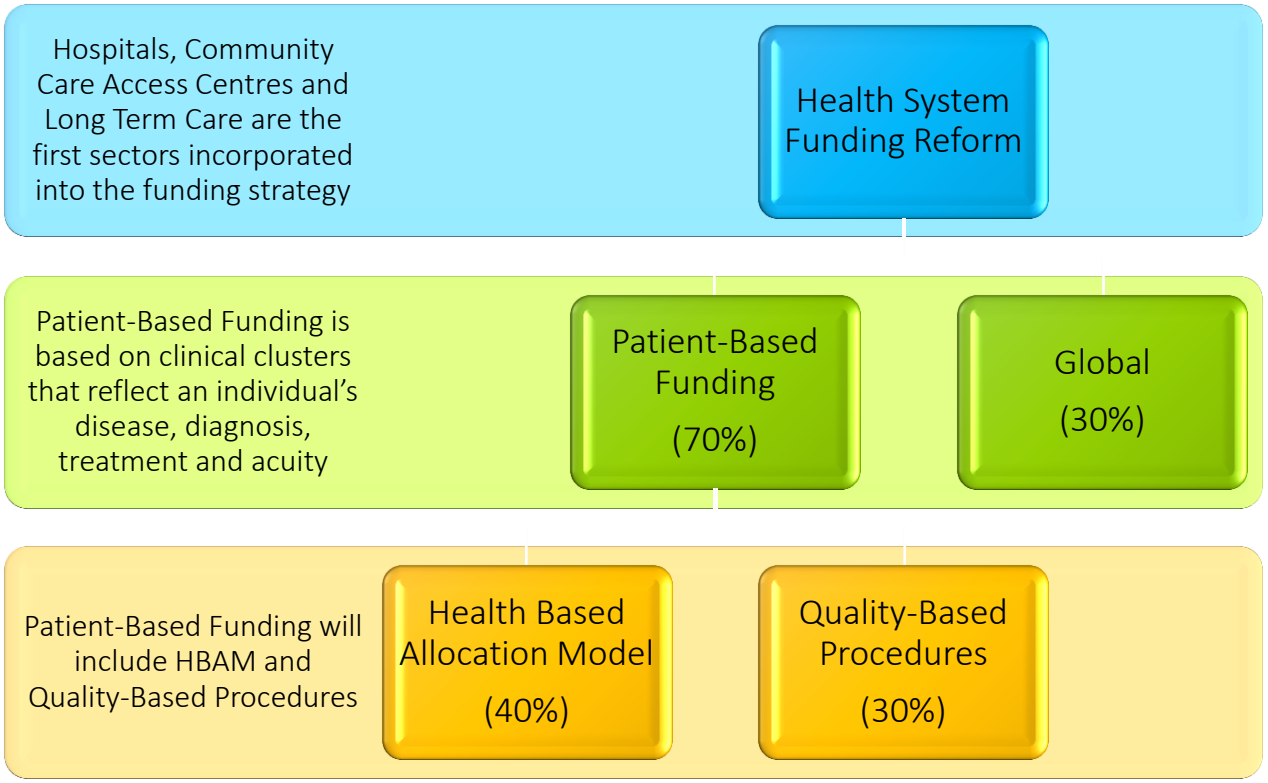
Value = Quality/Cost

Health System Funding Reform

The successful transition from the current, 'provider-centered' funding model towards a 'patient-centered model' will be catalyzed by a number of key enablers and field supports



The variations in patient care perpetuated by the historical funding approach, warrant the move towards a system where 'money follows the patient'



(N.B. 40% and 30% noted is hospital specific; will be different for other sectors)

HBAM is a 'made in Ontario' funding model that distributes allocations to organizations in accordance with population needs and their ability to provide cost-effective care.

Quality Based Procedures (QBPs) are clusters of patients with clinically related diagnoses or treatments that have been identified by an evidence-based framework as providing opportunity for process improvements, clinical re-design, improved patient outcomes, enhanced patient experience and potential cost savings

Key Steps of the Process

1. Define patient cohorts and grouping approach

- Disaggregate broad patient population (e.g. stroke) into hospital-based patient groupings with similar clinical and utilization characteristics
- Recommend factors to consider for acuity / severity adjustment (e.g. age, comorbidities, social factors)

2. Develop a pathway model for the episode of care

- What is the index event commencing the episode?
- What are the key phases, branches and decision points within the patient episode of care?
- What proportion of patients proceed down each branch of the pathway?

3. Recommend evidence-based practice throughout the episode

- What are the effective practices that should take place within each component of the episode?
- What is the strength of the evidence supporting each of these practices?
- How often should these practices should be delivered?

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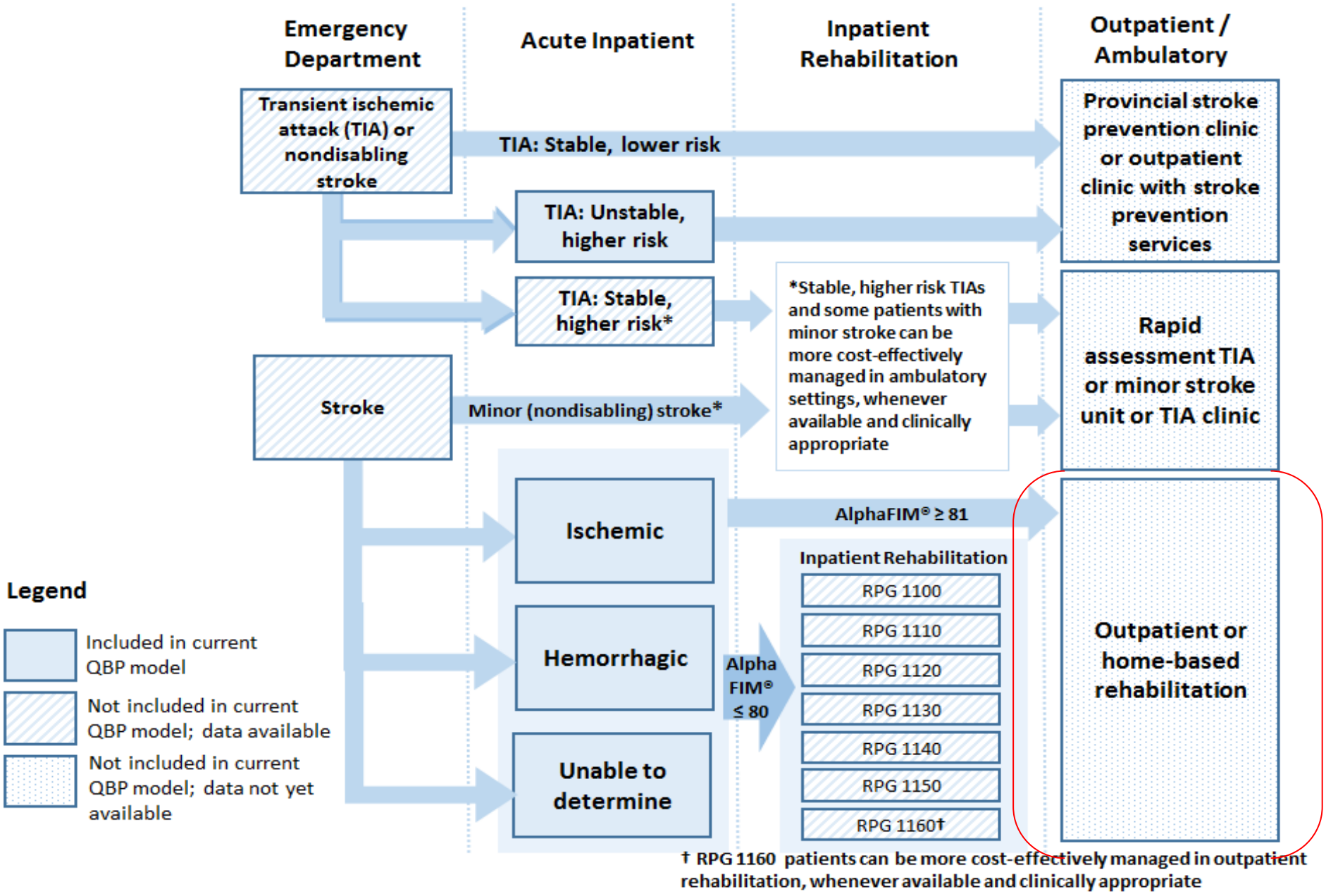
Key Principles for Handbook

- The scope of the handbook includes both hospital care and post-acute, community care
- Recommended practices reflect best patient care possible, regardless of cost or barriers to access
- Recommended practices, supporting evidence, and policy applications will be reviewed and updated at regular intervals
- The integrated handbook does not involve detailed unit costing or pricing

Organization of Handbook

TIA or Minor (Nondisabling) Stroke	Stroke
ACUTE EPISODE OF CARE (p.41-52)	**ACUTE EPISODE OF CARE (p.86-99)**
Module 1: Early Assessment Module 2: Early Treatment Module 3: Admission to Acute Care Module 4: Admission to Inpatient Rehabilitation N/A Module 5: Secondary Prevention	Module 1: Early Assessment Module 2: Early Treatment of AIS & ICH Module 3: Admission to Acute Care 3a: Acute IP Treatment 3b: Prevention of secondary complications Module 4: Admission to IP Rehab Module 5: Secondary Prevention
POST ACUTE EPISODE OF CARE (p.54-82)	**POST ACUTE EPISODE OF CARE (p.101-131)**
Module 5: Secondary Prevention Module 6: Predischarge/DC Planning Module 7: Early Supported Discharge N/A Module 8: Community Assessment Module 9: Community Treatment Module 10: Cross-Continuum Processes	Module 5: Secondary Prevention Module 6: Predischarge/Discharge Planning Module 7: Early Supported Discharge Module 8: Community Assessment Module 9: Community Treatment Module 10: Cross-Continuum Processes

Flow Chart for the Stroke Patient Cohort Across Care Settings



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QBP & the Stroke Clinical Handbook- ED, Acute Key Messages

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Key Messages ED and Acute

- Early assessment and treatment
- Imaging including vascular
- Referral to Secondary Prevention
- Access to thrombolysis
- Telestroke
- Admission to stroke unit:
  - *Specialized, geographically defined*
  - *Interprofessional stroke team*
- Completion of AlphaFIM® Day 3
- LOS 5 days

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QBP & the Stroke Clinical Handbook – Inpatient Rehabilitation Key Messages

"Time is Function"

- Brain is "primed" to "recover" early post-stroke
- Delays in starting rehab are detrimental to recovery (Biernaskie et al., 2004)
  - *Day 5 admission = marked improvement*
  - *Day 14 admission = moderate improvement*
  - *Day 30 admission = no improvement vs. controls*
- A single day delay in starting neuro-rehabilitation affects the functional prognosis of patients at discharge. This delay is also associated with increased rates of institutionalization at discharge.(Neurología. 2012;27:197—201)

Key Messages IP Rehab

- Admission to a stroke rehabilitation unit specialist rehab team
- Procedures should enable **admission 7 days/week**
- Recommended staffing:
  - *PT/OT: 1/6pts /6 inpatient beds*
  - *SLP: 1:12*
- Pts with AlphaFIM® score >80 should be discharged to outpatient rehab

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Key Messages

- Stroke pts should receive at least **3 hours of direct** task-specific therapy per day (Level A) at **least 6 days a week** (OSN)

- The FIM tool should be used as the standard assessment tool (OSN)

- Pts with **moderate or severe stroke** who are rehab ready and have rehab goals should be given the opportunity (Level A)

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Acute/IP Rehab Patient Groups

Changes from previous edition

What's New: Modules 1-3: Acute

- Brain Imaging interpreted immediately **by a health care professional with expertise** in reading CT and /or MRI.

- Patients should have access to a specialized interprofessional team **7 days a week**.

Other: A few minor clinical changes.

What's New: Module 4: IP Rehab

- IP rehabilitation team should consist of:
  - *Physiatrists, other physicians with expertise/core training in stroke rehabilitation, occupational therapists, physical therapists, speech-language pathologists, nurses, social workers and dietitians*
  - *Additional members could include recreation therapists, psychologists, vocational therapists, educational therapists and rehabilitation therapy assistants*
- Stroke patients should receive, via an individualized treatment plan, at least 3 hours of direct task-specific therapy per day by the IP stroke team for **at least 6 days per week**
- All discharged patients should be given **secondary prevention**

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Post-acute Care Patient Groups

Community/OP Rehab

Patient Group	Patient Characteristics/ Triage Criteria	Recommended Care Pathway
1. Stroke: mild (AlphaFIM® 81–125)	Patients presenting to hospital with acute stroke, with an early AlphaFIM® score of 81–125 recorded within 72 hours of presentation to hospital, or without other considerations (e.g., advanced age, caregiver availability, severe cognitive/perceptual needs, severe aphasia/dysphagia, profound inattention/neglect)	Admit to acute inpatient care if discharge home is unsafe or otherwise contraindicated FOLLOWED BY Discharge to the first of the following settings that is clinically appropriate and available: • Home/community, and referral to outpatient clinic with stroke-prevention services • OP/home-based rehab • IP rehab, followed by OP/home-based rehab

Patient Group	Patient Characteristics/ Triage Criteria	Recommended Care Pathway
2. Stroke: moderate (AlphaFIM® 41– 80)	Patients presenting to hospital with acute stroke, with an early AlphaFIM® score of 41–80 recorded within 72 hours of presentation to hospital, or with significant considerations (e.g., advanced age, caregiver availability, severe cognitive/perceptual needs, severe aphasia/dysphagia, profound inattention/neglect)	Admit to acute inpatient care FOLLOWED BY Admit to inpatient rehabilitation FOLLOWED BY Discharge home with outpatient/home-based rehabilitation and/or community-based supports, where required

Patient Group	Patient Characteristics/ Triage Criteria	Recommended Care Pathway
3. Stroke: severe (AlphaFIM® 40 or less)	Patients presenting to hospital with acute stroke, with early AlphaFIM® score of 40 or less recorded within 72 hours of presentation to hospital	Admit to acute inpatient care FOLLOWED BY: Admit to IP rehab, if able to tolerate, OR (if not able to tolerate) consider as candidate for discharge to CCC or slow-stream rehabilitation program, followed by admission to IP rehab where possible FOLLOWED BY: D/C home with OP/home-based rehabilitation and/or community-based supports, where required

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Overview of Modules 6-9

Module 6: Community

Discharge Planning Recommendations:

- **Standardized processes in place** to ensure before transition, a **follow-up appointment(s) scheduled with primary care provider** for after transition.
- Patients receive **follow-up phone call** from designated health care professional **within 48 hours of discharge from hospital to home** to monitor progress, enhance pt education, and ensure Home care services in place
- All necessary equipment and training occurs **prior to discharge**

Key Messages

- Well-resourced, coordinated, specialized IP team (affiliated with discharging hospital)
- Available **within 48 hrs** from acute and **72 hrs** of discharge from inpt rehab
- Provided **5 days per week at same level of intensity** as IP setting

Implementation Considerations

- Does not currently exist in Ontario, LHINs need to find capacity to ensure access
- Hospitals should manage waiting list for patients waiting in the community for hospital-based rehabilitation

Module 7 :ESD

Good to be home

Module 8 Community Assessment

Key Messages

- Driving -**Should not resume driving** until assessed
- Swallowing- Pts with new or worsening dysphagia be **referred** to SLP/RD
- Communication-Pts with known/suspected communication difficulties be referred to SLP
- Nutrition-**Screen** for malnutrition & dehydration
- Visual Perception-**Screen** for visual perceptual deficits
- Depression-**Screen for depression/risk**
- Cognition-Pts with vascular risk factors should be **screened** for vascular cognitive impairment
- Falls-**Screen** at admission for **risk of falls**

Key Messages

- Timing -
  - *Rehab should begin as early as possible once medical stability established*
  - *Should be available within 48 hours of discharge from an acute care hospital or 72 hours of discharge from inpatient rehabilitation*
- Interprofessional, specialized team
- OT, PT & SLP **2-3 visits per week, for 8-12 weeks**
- Structured to provide **as much therapy as possible** within first 6 months after stroke

Module 9 : Community Rx: General Rehab & Core IP Team

Module 9 : Community Rx: General Rehab & Core IP Team

Key Messages

- Coordinated care plan
- Pts previously employed should be assessed for/provided vocational counselling
- Self management/educational plan
- Family counselling

Module 9b-g: Recommended Practices

- Mood & cognition
- Swallowing, nutrition/hydration, & communication
- Physical activity, fitness & ADLs
- UE management
- Shoulder & central pain management
- LE mobility

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Implementation Considerations

- Resources available to encourage timely access and required intensity of service
- PT,OT &SLP should be provided 3 times/week =9 visits over 7 days /week
- Progress should be reviewed at 8 weeks post hospital discharge
- Community based exercise programs should be available
- The pathways to the evidence based recommendations should be adopted by all providers
- Post acute medical discharge should consider patients home environment

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Evaluation of Outcomes of QBP Implementation

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Strategy for Patient Oriented Research (SPOR) Project

- Overarching goal is to **translate research results** into **improved health outcomes** for Canadians
- Excellent **alignment** between **SPOR goal** and Ontario's focus on **evidence-based person-centred health care** as per ECFAA and Ontario's Action Plan for Health Care
- **OSN SPOR Project Objectives:**
  - *Ensure patient/family perspective incorporated into QBP implementation and the iterative evaluation*
  - *Inform development and implementation of QBPs for stroke in Ontario*
  - *Perform an iterative evaluation of stroke and where feasible other QBP implementation strategies*
  - *Develop a framework for ongoing evaluation of QBPs*

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QBP Resources

- Six rapid reviews from the community home care handbook for short stay populations were included as part of the evidence for the post-acute episode of care

- Two rapid reviews as part of the evidence in the acute episode of care

- Go to http://www.hqontario.ca/evidence/publications-and-ohtac-recommendations/rapid-reviews

Welcome to the Ontario Stroke Network - Windows Internet Explorer

http://www.ontariostrokenetwork.ca/rehab.php

time is brain acute stroke management

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::: WELCOME

::: SELECT A RESOURCE TOPIC :::

Stroke Rehabilitation Standards of Care | Health System Level Tools and Guidelines | Clinical Tools and Resources for Implementation | Educational Resources | Success Stories Inventory | Performance Indicators

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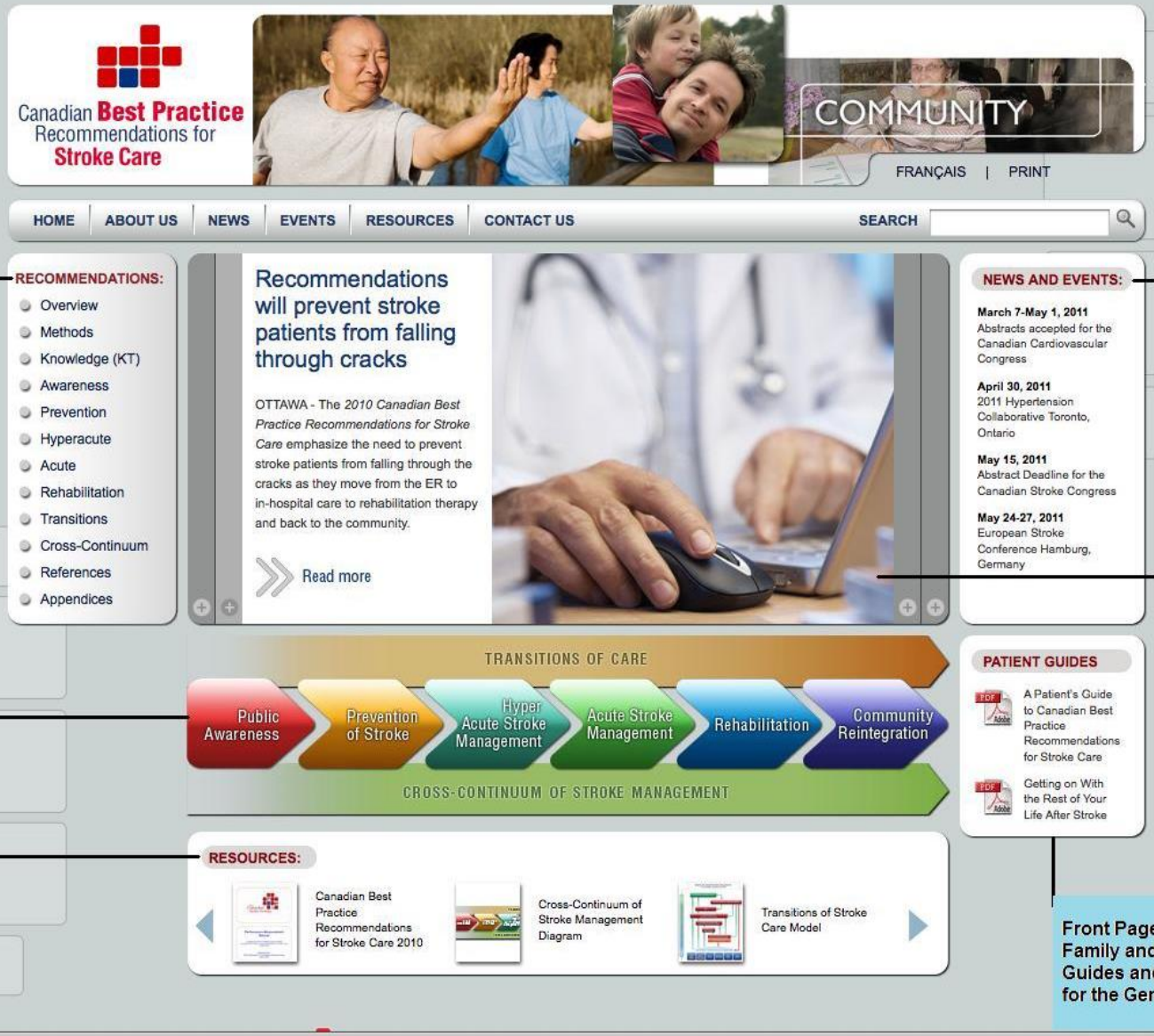

Direct Access to Specific Best Practice Recommendations

Up-to-date Conference and Research Events for Health Professionals in Stroke Care

Real-Time Updates on Key Stroke Topics and Best Practice Updates

Quick Access to Knowledge Translation Tools and Resources

Front Page Access to Family and Patient Guides and Resources for the General Public

Next steps

- OSN has created an Executive Summary of the Handbook available on the OSN website
- Corrections/formatting changes being compiled by OSN to provide to HQO for consideration
- Support dissemination and KT; OSN providing educational webinar/videoconference (archived):

  June 5 (OP & Community Rehab) and June 24 (TIA)
- Collaborate with MoH, HQO, CIHI and others to improve data quality and availability
- Advance stroke QBP implementation through OSN Strategy for Patient-Oriented Research (SPOR) project

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Q&A/Discussion

- What approach would you recommend for further communication and engagement?

- Any success stories you would like to share?

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