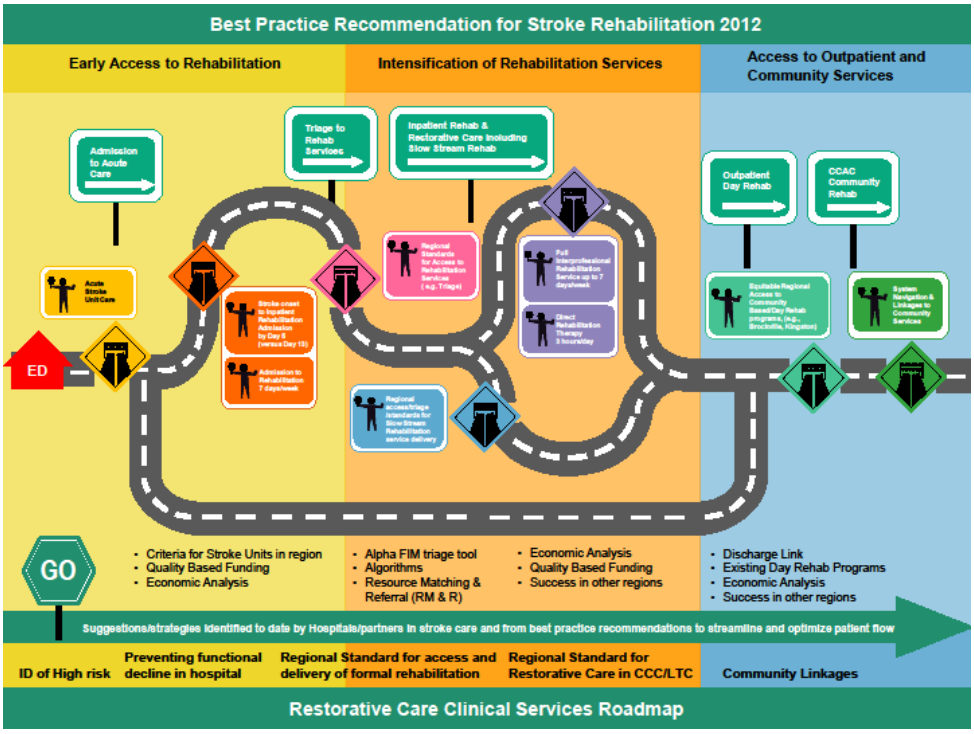
Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes in Southeastern Ontario

Using Stroke Care as a Model

January, 2013
SUMMARY REPORT



STROKE NETWORK *of* Southeastern Ontario

Acknowledgements

This initiative was a successful collaboration of the all of the Hospitals in Southeastern Ontario (SEO), the Southeast Community Care Access Centre (CCAC), their contracted service providers, the Stroke Network of Southeastern Ontario, and the Southeast Local Health Integrated Network (SELHIN). Hospitals involved included Quinte Health Care, Lennox and Addington County General Hospital, Providence Continuing Care, St. Mary's of the Lake Hospital, Kingston General Hospital, Brockville General Hospital and Perth Smiths Falls District Hospital. In addition to the Southeast Community Care Access Centre, the community provider agencies of Southeastern Ontario, including Quinte & District Rehabilitation Services, Kaymar Rehabilitation Services, and CommuniCare Inc., all collaborated on this initiative. Queen's University, School of Rehabilitation was also involved in the Forum planning. The ongoing participation and cooperation of the numerous health care agencies throughout Southeastern Ontario in the planning and development of the Rehab Forum Day warrants acknowledgement.

Special thanks to the Planning Committee Members for their dedication and commitment to this very important initiative:

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Executive Summary

On November 28, 2012, "Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes in Southeastern Ontario Using Stroke Care as a Model" took place as part of a first step in identifying potential solutions to improving patient flow and outcomes in Southeastern Ontario (SEO). This report will be used to guide the next steps of local and regional planning and implementation.

In 2011, advice of the Stroke Reference Panel was sought by the ER/ALC Expert Panel for delivery to MOHLTC around reduction of Alternate Level of Care length of stay (ALC-LOS). The Report of the Rehab/CCC Expert Panel was delivered to the Ministry of Health and Long Term Care and Health Quality Ontario, providing the following Rehabilitation Best Practice Priority Recommendations deemed to have the greatest impact on the ED/ALC crisis:

1. Earlier access to rehabilitation;
2. Intensification of rehabilitation services; and
3. Access to ambulatory and community rehabilitation.

The release of these priority recommendations reinforced the ongoing need for regional planning and implementation of rehabilitation system change across Southeastern Ontario (SEO). The need for focused attention in this area was further supported by the release of the Stroke Report Card to the South East Local Health Integrated Network (SE LHIN) in 2012, indicating low SE LHIN performance in rehabilitation indicators. The development of a regional plan to implement rehabilitation best practices became the top priority of the Regional Stroke Steering Committee.

The Stroke Report Card data indicated the following areas of concern:

- Limited access to Acute Stroke Units;
- Long wait times for inpatient rehabilitation;
- Lower numbers accessing inpatient rehab;
- Limited and inequitable access to outpatient rehabilitation;
- High number of acute patients discharged directly to LTC (limited access to rehab for severe strokes);
- The absence of a consistent standard for provision of intensive inpatient and “slow stream” rehabilitation; and
- High ALC rates.

Based on the needs evidenced by this data, the Regional Stroke Steering Committee committed to adopting and leading the development of a regional plan to implement provincial rehabilitation expert panel best practice recommendations for stroke care. The Regional Rehabilitation Forum was held on November 28, 2012, as a first step in this planning process.

The overarching objective of the Forum was *to identify opportunities to leverage rehabilitation across the continuum of care in order to improve patient flow and quality outcomes in Southeastern Ontario.* The participants were supported in achieving the following objectives to:

- Develop an increased awareness of the provincial Rehabilitation Expert Panel priority best practice recommendations using the stroke model as an exemplar;
- Contribute to the development a regional plan to support the implementation of the provincial rehabilitation recommendations for stroke as a demonstration for broader system change in alignment with the SE LHIN Restorative Care Roadmap;
- Understand the economic impact on the health system in SEO;
- Bring to life the potential impact of these recommendations through the patient experience;
- Understand the current status (i.e. strengths and gaps) of stroke rehabilitation across the continuum of care in SEO in relation to the Rehabilitation Expert Panel priority recommendations and
- Identify the current strengths, resources and barriers that need to be considered to implement the recommendations.

From the Forum, key themes emerged:

- The need for consistent **regional processes** and associated tools for **clustered care and access** to rehabilitation;
- Effective **planning and communication** for a cross-regional approach to support service consistency;
- Effective **health system navigation**;
- **Interprofessional training/education to build expertise and capacity** and to further prepare for best practice implementation;
- Requirement for an openness to delivery of best practice in new and innovative ways (e.g., **new models of care delivery**);
- The need to work regionally, across the continuum, and **out of silos**, managing **transitions**;
- The importance of **engagement** of all including our LHIN and executive **leadership** in support of these proposed broader system changes;
- Patient/Client and Family Engagement (**Patient/Client-Centred Care**).

It was also identified that some of the challenges that may arise from this work include:

- The issue of the critical mass needed for effective acute stroke unit implementation and how to organize acute stroke care across the region (i.e., evaluation by the Ontario Stroke Network indicates that a minimum of 130 ischemic stroke patients admitted annually is associated with improved outcomes);
- The issues around transitioning patients from acute to rehabilitation care given medical acuity of patients. There was discussion around the need for staff training and expertise in rehabilitation to accept more acute patients;

- Areas of significant inequity with respect to rehabilitation ambulatory day service in the region (e.g. Brockville and Kingston);
- The need to define standards for access, triage and service in relation to both rehabilitation and slow stream rehabilitation;
- Advocacy and awareness of the need for and benefits of rehabilitation.

Recommendations and Next Steps

The Regional Stroke Steering Committee members have endorsed this report and have made the following recommendations:

1. **Align work with Quality Based Funding recommendations** for stroke care being released in 2013-14.

2. **Engagement of all including leadership.** It is critical to engage senior leaders in the next steps around local planning. This report will be disseminated to all participants and to all members of the SE CCAC and Hospital Executive Forum (SECHEF). An invitation from the RSSC Chair will accompany the report inviting SECHEF members to participate in local leadership meetings to discuss the information shared, highlighting the identified local roadblock solutions and asking for advice with respect to local follow up, planning and implementation. Quality Based Funding will be highlighted in the invitation letter.

3. **Local level follow-up.** Best Practice Forums will be held in local areas validating and prioritizing the emerging themes for action. These Forums, funded as part of the 2013-14 Regional Stroke Education Plan, will establish improvement priorities for each area in the Region. Quality Based Funding and acute, rehabilitation and community best practices will be integrated into identified actions. This reflects the Phase II of the planning and implementation of rehabilitation system change. The Stroke Network will be working with stakeholders at their respective organizations and jurisdictions to facilitate implementation.

4. **Share Report and align work with the Restorative Care Clinical Services Roadmap Group.** Ongoing communication will be maintained with the SE LHIN and the Co-Chairs of the South East Restorative Care Clinical Services Roadmap in order to maintain alignment on planning related to mutual goals.

5. **Align work with the SE LHIN Integrated Health Service Plan** and other LHIN initiatives, including **Resource Matching & Referral (RM&R).**

6. **Learn from other Regions.** The Stroke Network will continue to update stakeholders on the learning occurring in other regions through contact with other Regional Stroke Networks, the Ontario Stroke Network and the Ontario Association of CCACs. The development of the LHIN Provincial Rehabilitation Alliance will be closely monitored in order to learn of other rehabilitation system initiatives across the province.

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INTRODUCTION

On November 28, 2012, the Regional Stroke Network held a Forum *"Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes in Southeastern Ontario Using Stroke Care as a Model"* as a first step to identify, plan and implement potential solutions for improving patient flow and outcomes in Southeastern Ontario (SEO). This report will be used to guide the next steps of local and regional planning and implementation.

PROVINCIAL BACKGROUND

The Rehabilitation (Rehab) and Complex Continuing Care (CCC) Expert Panel

The Rehab and CCC Expert Panel was formed in December, 2010 as a Subcommittee of the ER/ALC Expert Panel with the objective of re-thinking delivery of rehabilitation and complex care across the care continuum with a view to establishing a single, province-wide vision and conceptual framework for new rehab service delivery models. This work was conducted in two phases, with the initial phase providing guidance and advice to the ER/ALC Expert Panel for delivery to Ministry of Health and Long Term Care (MOHLTC) around reduction of Alternate Level of Care length of stay (ALC-LOS). The Phase I Report of the Rehab/CCC Expert Panel was completed in June 2011, and was delivered to the MOHLTC and Health Quality Ontario (HQO), providing the following priority recommendations:

1. Earlier access to rehabilitation;
2. Intensification of rehabilitation services; and
3. Access to ambulatory and community rehabilitation.

Phase II involved planning for capacity, accountability and sustainability of policies and frameworks relative to implementation of Phase I recommendations. The Rehab/CCC Expert Panel identified two working groups to provide recommendations in their identified areas: (i) Definitions Group: This group was appointed to identify a common set of definitions to adequately describe the processes to improve patient function, the categories of care provided, and locations of care. Initial draft definitions work was completed in October, 2011; and (ii) Data Use Group: This group was appointed to build on the work of the Definitions Group in order to establish an evidenced-based set of measurable patient outcomes for reporting, monitoring and embedding into quality patient care plans.

Ontario Stroke Network Stroke Reference Group

The OSN Stroke Reference Group has been supporting of the implementation of the Rehab/CCC Expert Panel Recommendations. The Ontario Stroke Network (OSN), in collaboration with the Stroke Reference Group and its stakeholders, completed the following:

- A Provincial Economic Analysis around rehab best practice priority recommendations;
- A Provincial Gap Analysis relating to earlier access, intensification and ambulatory/community rehab;
- A Provincial Best Practice Inventory, containing current initiatives in stroke rehabilitation relevant to the Recommendations;
- An Implementation Toolkit associated with this inventory, focused at an operational level for best practice implementation for use by various stakeholders, including LHINs, health care facilities and stroke regions.

Provincial Economic Analysis

As part of the quest of the MOHLTC to actively identify strategies to reduce the burden of ER/ALC on Ontario's healthcare system, the Rehabilitation and Complex Continuing Care Expert Panel examined the economic impact of rehabilitation on system efficiency and reducing hospitalization. While four rehabilitation sub-groups were identified as key contributors to the ED/ALC crisis (stroke, hip fracture, hip and knee replacement and acquired brain injury), the fiscal impact of applying rehabilitation best practices was specifically examined relative to stroke. Stroke is a main contributor to ALC days provincially and consumes the largest number of rehabilitation resources annually.

The Provincial Economic Analysis examined the potential economic impact of adopting the following stroke rehabilitation best-practice recommendations across Ontario:

- Timely transfer of appropriate patients from acute facilities to rehabilitation
    - Ischemic strokes to rehabilitation by day 5 on average
    - Hemorrhagic strokes to rehabilitation by day 7 on average;
- Provision of greater intensity therapy in inpatient rehabilitation
    - 3 hours of therapy per day
    - 7-day a week therapy ;
- Timely access to outpatient/community-based rehabilitation for appropriate patients
    - Early Supported Discharge with engagement of CCAC allied health professionals
    - Mechanisms to support and sustain funding for outpatient and/or community-based rehabilitation
    - 2-3 outpatient or Community-based allied health professional visits/ week (per required discipline) for 8-12 weeks
    - In-home rehabilitation provided as necessary;
- Ensuring that all rehabilitation candidates have equitable access to the rehabilitation they need.

It was determined that full attainment of the rehabilitation best practice priority recommendations provincially would not only result in improved patient outcomes, but would also result in **~$20M** made available annually for reallocation of resources to assist stroke patients in recovery and community reintegration.

Quality Based Funding

Under the *Excellent Care for All* Act, Health Quality Ontario (HQO) established a mandate to provide evidence-based guidance on health system funding policy. The work of HQO included establishing Quality Based Funding (QBF) to provide objective, evidence-informed advice around health care funding mechanisms, incentives, and opportunities to improve value in the Ontario health system. Development of 'episode bundles' for selected clinical areas occurred in 2011/12, and stroke care has been included in one of the four new clinical areas developed in 2012/13. The definition of episodes of care and recommendations on a care pathway and effective practices to be performed within the episode have been established based on best practice evidence, which will then inform costing of 'best practice' episodes to hospitals. The Ministry funding reform strategy involves a shift of hospital funding to a greater share of 'patient-based' funding, using a combination of aggregate Health-Based Allocation Model (HBAM) allocation funding and 'Quality Based Procedure' reimbursement for targeted clinical areas.

In 2013-14, the Ministry of Health and Long Term Care will be introducing QBF for stroke care that will incent hospital best practices. Funding will be incented in both inpatient acute care as well as inpatient stroke rehabilitation practices. The best practice evidence that informed QBF, including the rehabilitation priority recommendations, was the focus at the November 28, 2012 SEO Rehab Forum.

LHIN Rehabilitation Initiatives

In addition, the formation of the Rehabilitative Care LHIN Alliance is underway to improve rehabilitation knowledge across Ontario's LHINs. This Alliance will support province-wide standardization of rehabilitation initiatives to improve fiscal efficiencies, support greater access to service, standardize service delivery and support knowledge translation.

REGIONAL BACKGROUND

Following release of the Rehabilitation Best Practice Priority Recommendations, regional planning for the implementation of rehabilitation best practices was identified as a top priority by the Regional Stroke Steering Committee (RSSC) of SEO.

SEO Stroke Report Card Data

The need for focused attention in this area was further supported by the release of the Stroke Report Card to the South East Local Health Integrated Network (SE LHIN) in 2012 (Appendix "A") indicating low (red) SE LHIN performance in several best practice areas:

- Limited access to Acute Stroke Units (HSAA indicator): Acute stroke unit utilization rate was unchanged at 47% while the provincial mean was also low at 38% compared to a provincial benchmark of 88%. Improvement in this indicator was highlighted as essential to impact stroke mortality, recovery and health care utilization.

- Long wait times for inpatient rehabilitation: The median length of time from stroke onset to rehab admission remains unchanged and high at 13 days compared to a provincial mean of 10 days and almost twice the benchmark of 7 days. Best practice recommends a 5 to 7 day wait.
- High ALC rates (see below).
- Lower numbers accessing inpatient rehabilitation (HSAA indicator): The percent discharged from acute care to inpatient rehabilitation remained low at 29% compared to a provincial rate of 31% and benchmark of 42%, indicating an ongoing need for rehab system change in SE.
- Limited access to outpatient stroke rehabilitation: inequitable access to Day Rehab Programs in SEO, with only Belleville and Perth providing outpatient rehabilitation. Access to outpatient rehabilitation worsened from 10 %to 5% from 08/09 to 10/11. Sub-LHIN data continued to indicate high variance across the region with a rate of 0% in Brockville, again pointing to the need for system change to improve access.
- High number of acute patients discharged directly to LTC and limited access to rehabilitation for those with severe strokes: Although the proportion of those receiving inpatient rehabilitation with severe stroke had improved from 30 to 37% there remained a 10% rate of admission directly to LTC indicating an ongoing need to provide rehabilitation access to both moderate and severe stroke survivors, as the evidence indicates that all stand to benefit from rehabilitation.
- The absence of a consistent standard for provision of intensive inpatient and "slow stream" rehabilitation programs and the absence of outpatient day rehab programs in several parts of the region were highlighted as barriers to access and patient flow.

SEO ALC Data

A summary of the ALC data in SEO was shared with both the Regional Stroke Steering Committee and the Rehab Forum Planning Committee, highlighting our urgent platform in SEO. A number of key points reflect our ED/ALC crisis in SEO, including:

- There is a 33% acute stroke ALC rate across SEO: 1 in every 3 acute bed days is designated ALC;
- Stroke is the second highest health condition associated with ALC days;
- 79% of the stroke ALC days in the Region's acute tertiary centre are designated ALC awaiting LTC;
- Stroke is a large consumer of health system resources and
- There is an ongoing opportunity for improvement in patient flow.

Regional Stroke Steering Committee Priorities

Based on the needs evidenced by this data, the Regional Stroke Steering Committee committed to addressing the following as its top priorities:

1. To adopt and lead the development of a regional plan to implement provincial rehabilitation expert panel best practice recommendations for stroke care (early

access from acute care, intensification of rehabilitation services, outpatient and community services);
2. As part of the regional plan, to make regional recommendations for funding reallocations needed to support rehab best practice recommendations based on an economic analysis.
3. As part of the regional plan, to make regional recommendations for addressing rehabilitation human resource shortages to support rehabilitation best practice recommendations.

Southeast Ontario Restorative Care Clinical Services Roadmap

Over the past three years, the SE LHIN had been involved in the development of Clinical Service Roadmaps (CSRs) designed to deliver more seamless patient care across the continuum, region-wide. The Restorative Care CSR was one of seven distinct roadmaps developed in our Region, with its priority foci as follows:

- Populations at risk of adverse outcomes
- Integration of care
- Patient flow
- ED/ALC crisis

The priorities of the Restorative Care CSR are in direct alignment with the best practice rehabilitation priority recommendations. The major themes established within the Restorative Care Clinical Services Roadmap would also clearly be supported through implementation of rehabilitation best practices. Those themes include:

1. Identification of High Risk Profile Elderly Group
2. Preventing Functional Decline in Hospital using senior friendly principles
3. Development of:
    a. Regional Standard for Access and Delivery of Formal Restorative Care
    b. Regional Standard for Other Restorative Care (LTC, CCC, Community)
4. Communication and Community Linkages

Recommended actions under the Restorative Care CSR included the development of standards for access to rehabilitation and restorative care; implementation of regional processes and tools for referrals and transition; resource adjustment to improve efficiencies and capacity; professional education; establishment of required linkages between acute care, formal restorative, community and long term care; and establishment of clear definitions for admission criteria and service delivery.

Planning Committee Actions

The Committee was comprised of 21 health care professionals across SEO from the Stroke Network, hospitals, CCAC, Queen's University and community rehabilitation therapy provider agencies, and was involved in numerous planning meetings from April to November, 2012. Information on the full membership of the Forum Planning Committee is available on the Acknowledgement page of this Report.

Forum Planning Committee members participated in a comprehensive background and rationale review and set priorities in designing the Forum day. Members were asked to think about system change and what was needed as a region in relation to the three priority rehabilitation recommendations. To facilitate the decision making process, a regional Rehabilitation Gap Analysis was completed (see Appendix "B") from which the planning committee identified the following regional priorities, by SEO organization:

I. Earlier access to rehabilitation
   - Day 5 onset to rehab

II. Intensification of rehabilitation services
   - Admission to rehab 7 days/week
   - Full interprofessional team service 7 days per week

III. Access to ambulatory and community rehabilitation
   - Access to ambulatory rehab (e.g., particularly, Brockville and Kingston)

Over the course of planning, it was acknowledged that Senior Leadership and LHIN engagement were both critical to the process. SE LHIN Committee membership acknowledged the fit of this work with the SEO ED/ALC crisis and the importance of aligning rehabilitation system change with that of the organizations' Strategic Plans. Upon review of Strategic Plans, general consensus was that rehab system change did, in fact, align with identified ED/ALC and patient flow priorities for most organizations; however, this needed to be clearly delineated in the engagement process. It was recommended that the Forum and subsequent regional rehabilitation planning highlight the impact of rehabilitation on ED/ALC, using stroke as an exemplar. Learning relevant to the rehab model for other diagnoses would also be considered.

For successful engagement it was also recognized that, in addition to alignment with the respective Organizations' Strategic Plans and Quality Improvement Plans (QIPs), a fit would also need to be demonstrated with the SE LHIN Integrated Health Service Plan (IHSP); and the SE LHIN Restorative Care CSR. Attached here as Appendix "C" is a Summary Chart highlighting the alignment of identified rehabilitation priorities with respective organizations' Strategic Plans, with consistent alignment noted relative to patient flow and the ED/ALC crisis. The summary document also notes alignment of rehab system change with the LHIN IHSP and Restorative Care CSR.

It was recognized that messaging for engagement of the LHIN, SE CCAC and Hospital executive leaders was critical. In addition to demonstrating the importance of the work relative to the ED/ALC crisis, it was critical to demonstrate how this work could inform "Wave 2" implementation of the Restorative Care Clinical Services Roadmap. RSSC

membership recommended that an executive invitation to the Forum from the RSSC Chair be sent to CEOs, CNEs, and Chiefs of Staff, noting LHIN participation (see Appendix "D").

A second invitation was developed for organization representation at the Forum directed to physicians, managers, practice leaders, clinical leaders, and academics. There was discussion regarding the mix of Forum invitees, and it was noted that both clinical and administrative expertise was needed at the Forum. It was agreed that this participant invitation would come from the Forum Planning Committee members directly to their staff (see Appendix "E").

Regional Economic Analysis

The Ontario Stroke Network was successful in a funding proposal to retain Matthew Meyers, health economist in the development of regionally focused business cases including economic impact analyses modelled on the provincial business case. This regional economic analysis was initiated to inform rehabilitation planning in SEO.

All this Provincial and Regional background work provided an ideal framework for evaluating rehabilitation as a solution to the ED/ALC crisis in Southeastern Ontario, using stroke as a model. It was felt that the greatest impact could be achieved by using this information to help to inform the Integrated Health Service Plan III (IHSP3) and the Restorative Care Clinical Services Roadmap.

THE FORUM - November 28, 2012

The target audience of the Forum day included administration, physicians, practice leaders, clinical leaders, nursing and allied health from across the continuum of care (i.e. acute, rehabilitation, complex continuing care, outpatient care, Community Care Assess Centre, community providers and long term care). The SE LHIN and academics were also targeted invitees.

The Forum itself was recognized as Phase I in the planning towards the development of a Regional Rehabilitation Plan. It was recognized that Phase II would follow with support for local level planning and implementation. The program goal was *to identify opportunities to leverage rehabilitation across the continuum of care in order to improve patient flow and quality outcomes in Southeastern Ontario.* In the Phase I planning, the participants were supported to achieve the following objectives:

- Develop an increased awareness of the provincial Rehabilitation Expert Panel priority best practice recommendations using the stroke model as an exemplar;

- Contribute to the development a regional plan to support the implementation of the provincial rehabilitation recommendations for stroke as a demonstration for broader system change in alignment with the SE LHIN Restorative Care Roadmap;
- Understand the economic impact on the health system in Southeastern Ontario;
- Bring to life the potential impact of these recommendations through the patient experience;
- Understand the current status (i.e. strengths and gaps) of stroke rehabilitation across the continuum of care in Southeastern Ontario in relation to the Rehabilitation Expert Panel priority recommendations and
- Identify the current strengths, resources and barriers that need to be considered to implement the recommendations.

Phase II, to be initiated within twelve months of the November 28, 2012 Forum, will focus on local-level follow-up. It is recognized that ongoing regional collaboration will provide the opportunity to support the planning and implementation of the formal restorative care/rehabilitation components of the Restorative Care Roadmap. In alignment with local strategic directions the Phase II process will plan and implement the recommendations within local settings.

The Regional Rehabilitation Forum entitled "*Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes in SEO Using Stroke Care as a Model*" was held on Wednesday, November 28, 2012. Ninety-six health care providers participated in the day, with excellent representation from hospital and CCAC Executive leadership across the Region, (CEO/COOs, CNEs, VPs and Board of Governors membership), hospital and CCAC Directors, Managers and Team Leaders, physicians, interprofessional clinical leaders, professional practice leads, patient flow and project leaders, including Queen's University and the SE LHIN. The Forum Agenda is attached as Appendix "F".

The agenda was structured to demonstrate the rationale for looking at rehabilitation as a potential solution to the ED/ALC crisis. Provincial and Regional context was provided and the following speakers shared their knowledge and expertise in demonstrating this urgent platform.

Dr. Mark Bayley, Chair of both the Provincial Rehabilitation Stroke Reference Panel and the Provincial Stroke Evaluation Advisory Committee, provided background on why rehabilitation matters, with an overview of the three priority rehabilitation best practice recommendations. Dr. Bayley reflected on the successes of other regions, including initiatives such as implementation of AlphaFIM in many regions; consolidation of stroke care into hospitals with stroke units and reallocation from CCC beds to intensive outpatient services.

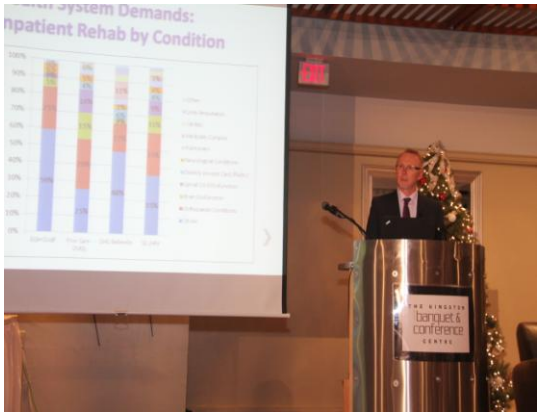
Dr. Bayley highlighted that the stroke best practices discussed at the Forum had been embedded in the principles of the upcoming Quality Based Funding. He reflected on

the system being broken: that change is necessary. Key indicators include that Ontarians still take an inordinately long time to get into stroke rehabilitation and do not get admitted as early as suggested by evidence; when admission does occur, rehabilitation service intensity continues to be insufficient. He also indicated that severe stroke patients are still not getting access to inpatient rehabilitation and that mild stroke patients are being admitted to inpatient rehab, as there is a lack of outpatient and community-based services. Dr. Bayley reflected that implementation of the priority recommendations and Quality Based Procedures could improve patient outcomes and health care efficiencies.

Dr. John Puxty, Co-Chair of the Restorative Care Clinical Services Roadmap, demonstrated the alignment of the rehabilitation best practice priorities with the work of the SE LHIN Restorative Care Clinical Services Roadmap. A Summary Chart reflecting this alignment is noted in Figure "1" below:

Figure "1": Priority Alignment

Best Practice Rehabilitation Priority Recommendations	Key Elements of Restorative Care Clinical Services Roadmap
Acute Stroke Unit Care	ID of High Risk Preventing Functional Decline
5-Day onset to Rehab	
7-Day a week Admission	
Regional Standards for Access	Regional Standard for Access and Delivery of Formal Rehab and Regional Standard for Restorative Care
Full Interprofessional Team 7 Days	
3 Hours Direct Therapy	
Regional Access/Triage for Slow Stream Rehabilitation/Restorative	
Equitable Access to Community Day Rehab	Communication and Community Linkages
System Navigation and Linkages	

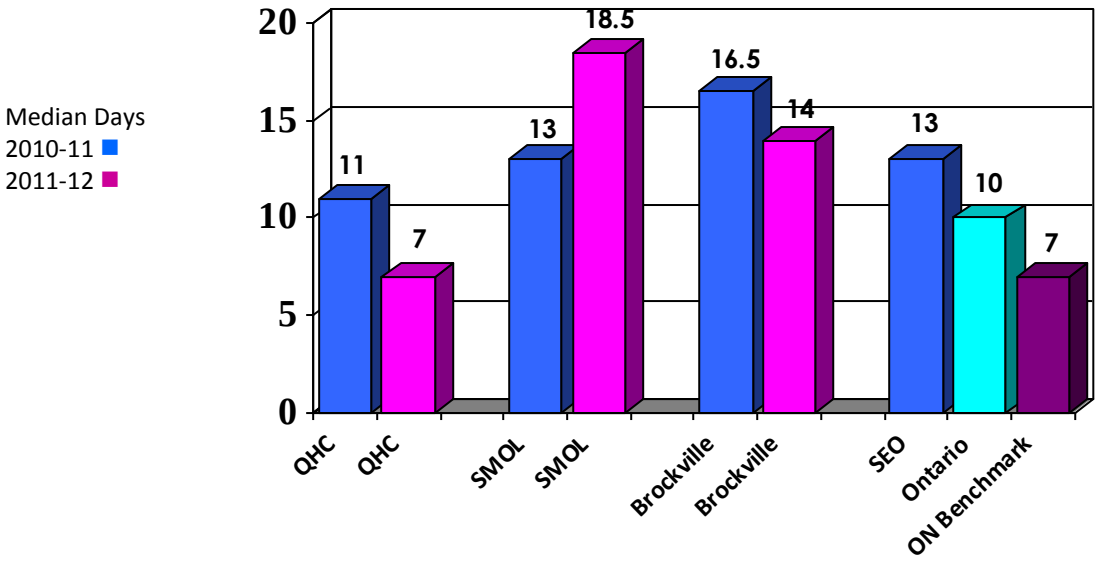


Dr. Stephen Bagg, Head of the Department of Physical Medicine and Rehabilitation, Queen's University and St. Mary's of the Lake Hospital, reviewed our current stroke data and ALC data in SEO reflecting on how SEO is measuring up relative to the best practices. Highlights of the ED/ALC crisis and the rehabilitation crisis evidenced by SEO ALC data and SE LHIN Stroke Report Card respectively are outlined above in the Regional Background section. See Figures "2", "3" and "4" below relative to some of the key information shared.

Figure "2": ALC by Condition in SEO (FY 10-11)

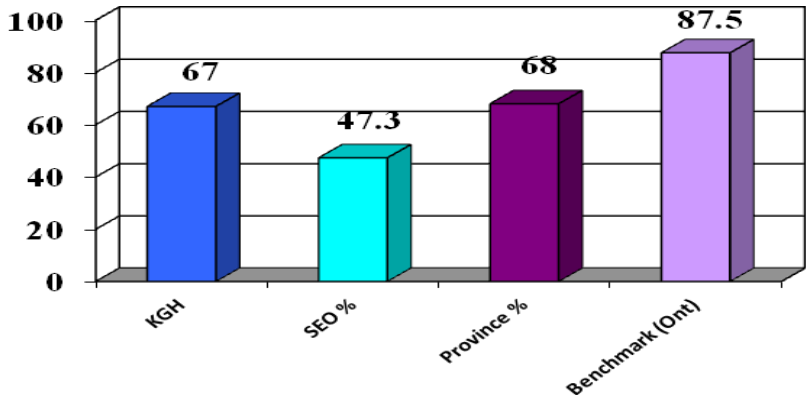
Rank	Health Condition (ISHMT)	% ALC
1	Other Factors influencing health status	11.9
2	Cerebrovascular Disease	9.2
3	Fracture of femur	6.7
4	Dementia	6.6
5	Other medical care (radiotherapy/chemo)	5.3
6	Other symptoms/signs/abnormal clinical/lab	4.9
7	Other diseases of the nervous system	4.6
8	COPD, bronchiectasis	4.1
9	Heart Failure	3.5
10	Other malignant neoplasms	2.6

Figure "3": Median Days from Stroke Onset to Rehabilitation Admission



In SEO, in 2010/11 patients waited longer for inpatient rehab (median wait time of 13 days versus a provincial median of 10 days, and a provincial "achievable benchmark" of 7 days). These rates showed variable improvements in 2011/12. The best practice target is onset to admission within five days. Dr. Bagg also noted the median wait time for freestanding rehabilitation organizations is 14 days.

Figure "4": Acute Stroke Unit Utilization Rates in 2010/11 (Percent)



It was noted that Kingston General Hospital is currently the only SEO hospital site with an Acute Stroke Unit. Quinte Health Care Belleville site currently clusters stroke patients, and a consolidated corporate Acute Stroke Unit is a current workplan priority. It should be noted that KGH stroke unit utilization rates improved to 80% in 2011/12 with an observed positive impact on reduced length of stay, reduced mortality rates, increased admission rates to inpatient rehabilitation services and decreased readmission rates.

Dr. Bagg reflected on the limited number of stroke patients accessing inpatient rehabilitation in SEO relative to the Provincial benchmark. SEO data reflect a high number of acute stroke patients being discharged directly to LTC, indicative of limited access to rehabilitation for more severe stroke patients. See Figures 5 and 6 respectively.

Figure 5: Population-Based Proportion of Acute Stroke Patients Accessing Designated Inpatient Rehabilitation Beds (2010-11)

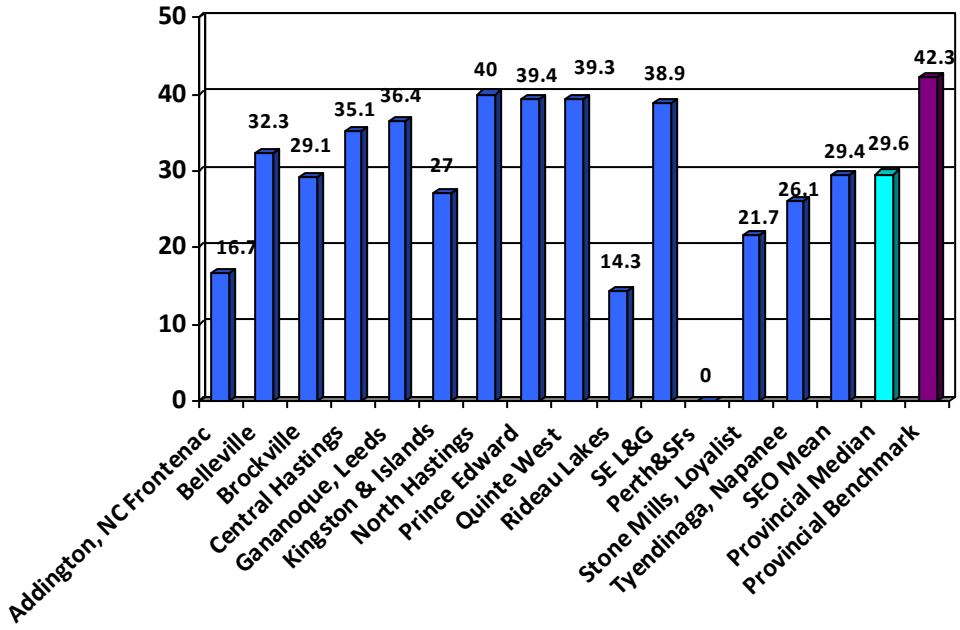
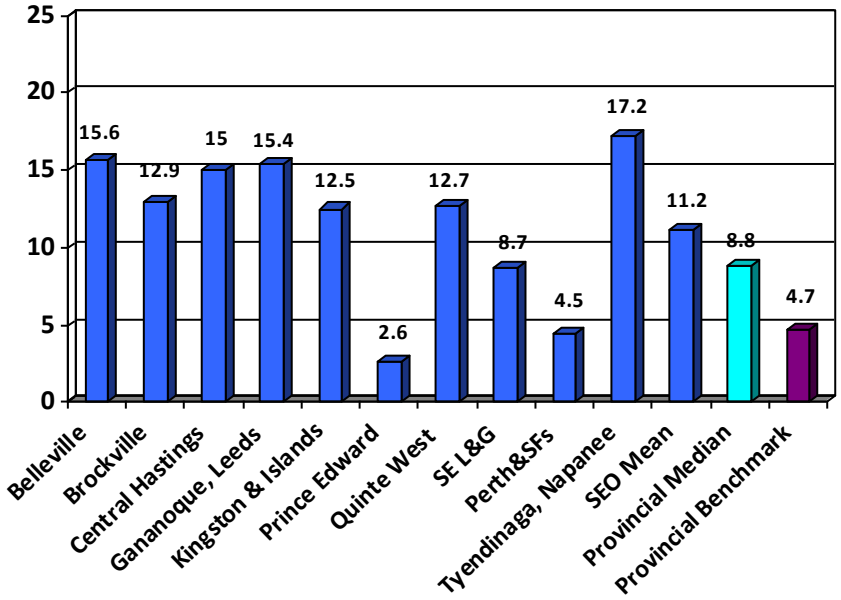


Figure 6: Proportion of Stroke Patients Discharged Directly from Acute to LTC



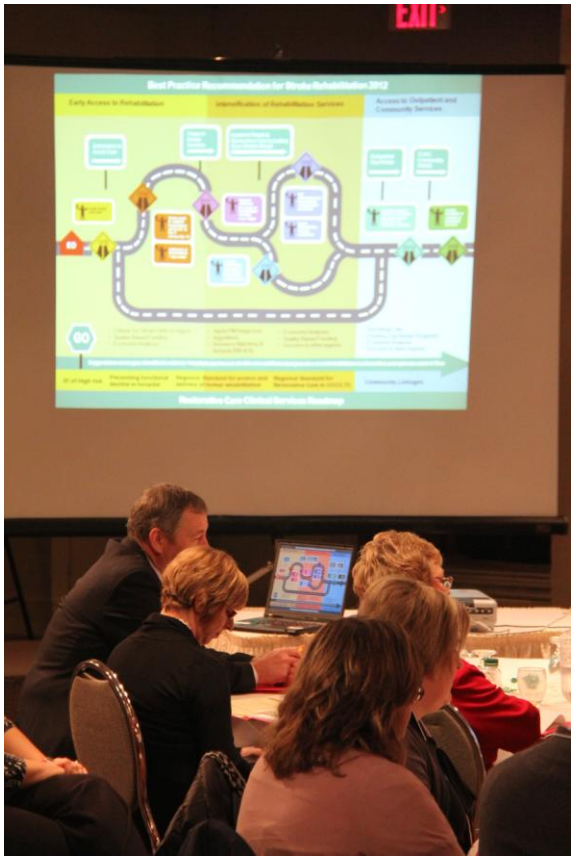
Some Regional success stories were also highlighted, including sharing of data relative to the Discharge Link Enhanced Community-Based Stroke Rehabilitation Services and the St. Mary's of the Lake Pilot for their Day Rehab Services.

Two stroke survivors, Dr. Dan Brouillard and Mr. Steve Peirson, shared their personal experiences, reflecting on the importance of rehabilitation to their ongoing recovery. Some of their challenges were shared relative to their significant life changes and experiences navigating the rehabilitation system following discharge from hospital. Their respective stories humanized the experience for stroke survivors and stressed the ongoing positive impact rehabilitation has had on their lives and on those of their families.

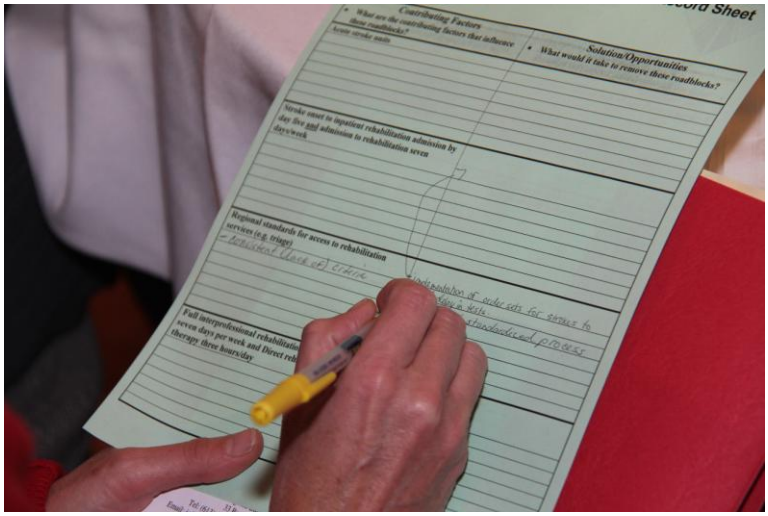
Matthew Meyers, Project Coordinator for the provincial and regional economic analyses of stroke best practices for the Ontario Stroke Network, shared the results of Provincial and Regional Economic Analyses, reflecting on fiscal efficiencies associated with implementation of best practices. Matthew advised that based on 100% attainment of the best-practice model for stroke rehabilitation in SE Ontario, the potential to free up resources annually in SEO is $2.7 M. The reallocation of resources to achieve best practice implementation would require $1.6 M to support human resources for both inpatient acute and inpatient rehabilitation services and another $1.2 M to achieve full enhancement of community-based rehabilitation. While this reflects a cost-negative impact of $100,000, this model also assumed no services currently in place. Given that SEO has already implemented enhanced community-based rehabilitation services, where other areas of the province have not, it is expected that practice implementation could be achieved in a cost-neutral manner. Matthew reiterated the impact that Quality Based Funding will have on best practice implementation. He stressed that efficiencies can be achieved through a better system of patient care, and that both patients and providers stand to benefit.

Appendix "G" reflects the roadmap graphic which was referenced throughout the Forum day, framing the patient's journey and existing barriers to receiving best practice care. This graphic provided a framework for the afternoon, interactive session. A

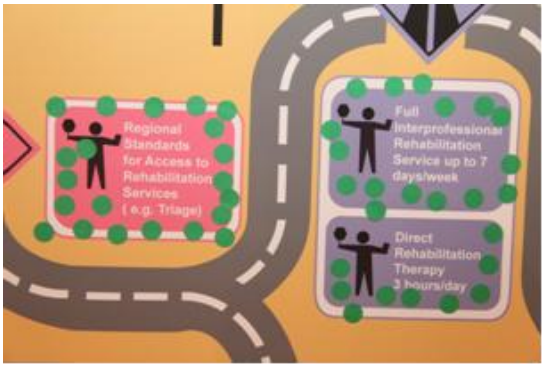
corresponding geographic map depicting the dispersion of rehabilitation roadblocks across the Southeast also formed part of the Forum resource package (see Appendix "H").



The morning information and expertise provided background for the interactive afternoon session. A summary sheet for participants to note ideas throughout the day relative to roadblocks, contributing factors and potential solutions, supported information sharing in the Global Café (see Appendix "I").



A Global Café is an approach to sharing perspectives and learning from each other, and is designed to allow a large group of people to quickly share their ideas in a way that facilitates the generation of deeper and broader understanding, ideas and actions. Groups of people rotate through discussion groups in a very limited amount of time. The group members change each time. Each table discusses and develops ideas and actions around one idea or problem. The groups then switch tables and the next group uses the previous group's or groups' ideas to build on and develop plans which are built from a deeper understanding of the original topic or problem.



A full copy of the Forum materials can be obtained from our website via the following link: http://strokenetworkseo.ca/profedpresents. In addition, Appendix "K" provides a web-based resource listing relative to rehabilitation best practices, which was shared on the Forum Day.

A video of the Forum Day was produced and will be available on the SEO Stroke Network website at: www.seostrokenetwork.ca

STAKEHOLDER INPUT - SOLUTIONS/OPPORTUNITIES

A. Solutions Identified at Forum

The Global Café focused on confirming the identified roadblocks to implementation of rehabilitation best practices, identifying the contributing factors to those roadblocks and examining solutions to remove the roadblocks. Figure 7 below outlines some of the potential solutions discussed during the Global Café relative to the respective roadblocks:

Figure 7: Solutions Identified at Forum in Overcoming Roadblocks

Acute Stroke Unit Care (ASU)
• Identify specific ASU access points, with fewer sites receiving stroke patients • Requires cross-Regional engagement (broad buy-in) • Identify champions/leaders • Regionalization of standards and processes to support standardization and consistency; use of clinical care pathways and order sets • Educate and build awareness of the importance of ASU care - health care professionals and public
Stroke Onset to Inpatient Rehabilitation Admission by Day Five; Admission to Rehabilitation Seven days/week
• Acute physician support following transfer to rehab to address medical acuity • Medical acuity – care pathways with transitions and benchmarks and staff education • Standards of acuity on rehab unit – communication (to rehab) • Full IPC team 7 days/week • Discharges over weekend • Rehab specific transfer note – functional admission/discharge • AlphaFIM and tools for assessing readiness • "Step down" unit that can handle acuity and rehab together • Mild strokes to community
Regional Standards for Access to Rehabilitation Services (e.g. Triage)
• Bed designation may need to change • Quality Based Funding – prepare; awareness • Transition protocols for physicians – consults; repatriation • For stroke use standardized process for triage using an objective tool (AlphaFIM) • Training and expertise for all staff to deal with increase acuity, job shadowing • More specific criteria for medical stability for rehab (look at Physical Medicine & Rehabilitation) • Education for physicians' understanding of rehabilitation • Standardized process for non-stroke patients (e.g., other)
Regional Access/Triage to Slow Stream Rehabilitation
• Define rehabilitation service standards within Complex Continuing Care (CCC) • Regional standardization of referral systems, including processes, definitions, triage • Equity of funding across region for CCC

Full Interprofessional Rehabilitation Service up to Seven Days per week and Direct Rehabilitation Therapy Three Hours/Day
• Educate senior leadership and physicians about change • Inpatient and Day Rehab 7 days/week • 7 day interprofessional treatment plan • Aligning funding with best practices (Quality Based procedures) • Consider innovative service delivery models, incorporating rehab assistants • More groups on weekend, innovative weekend schedules • Creative collaboration amongst therapies, rehabilitation assistants and nursing • Family participation and education to build confidence and readiness for discharge
Equitable Regional Access to Community Based/Day Rehabilitation Programs
• Equitable access to Day Rehab Community Services • Describe/define rehabilitation; achieve consistency in admission criteria; service delivery; common service delivery models; improve communication between facilities and teams • Need for regional rehabilitation advisory with LHIN and Senior Executive engagement • Build expertise of community providers, best practice education opportunities • Systems/policy change for base / consistent, evidence-based funding models • Building community capacity and primary care capacity • Early information to patient about community services • Direct referral to Day Rehab, improve efficiencies/assessment • Facilitate access/transportation to rehab centres
System Navigation and Linkage to Community Service
• System navigation and linkages to community throughout the patient journey (i.e., appropriately linked in community, they do not return to hospital) • Earlier, dedicated, continuous system navigation for community services, e.g. navigation pathway • Introduction of community services into the hospital setting to support early discharge • Need for a single point of contact for community services/resources • Community needs assessment gap identification • Recommend a LHIN supported strategy to overcome transportation barrier • Need for enhancement and sustainment of peer support groups

Appendix "J" is a Summary Chart reflecting the comprehensive key points raised by all groups relative to contributing factors to rehabilitation roadblocks and potential solutions. This information will inform the development of a Regional Rehabilitation Plan and subsequent local level implementation planning.

B. Solutions Identified Through Forum Participant Survey

Preliminary feedback was extremely positive throughout the day, with many indicating the content was timely relative to the patient flow crisis and to the anticipated changes in quality based funding. The format was well-suited for all those in attendance. Formal evaluation was conducted via Survey Monkey.

As noted earlier, ninety-six health care providers participated in the Forum, with excellent regional representation from the continuum of care and from a variety of perspectives. Of those participants, 40 completed the post-Forum evaluation survey.

Representation for evaluation encompassed administration, Executive Leadership, Registered Nurses, Allied Health Professionals, Physicians and Quality Improvement representatives. Sectoral representation for the Forum participant survey was also balanced across Acute Care settings, Inpatient Rehab, Outpatient Rehab, Outpatient Clinics, Community, and others (including 'cross continuum' and educational institutions). Feedback from the group reflected that the objectives of the day were clearly defined and met. Overall, 92.3% of participants indicated that the Forum met or exceeded expectations.

Survey questions were posed to participants around potential changes in practice as a result of the Forum and how those changes could be supported for implementation. These responses have been included in the tables on pages 20 and in Appendix "L".

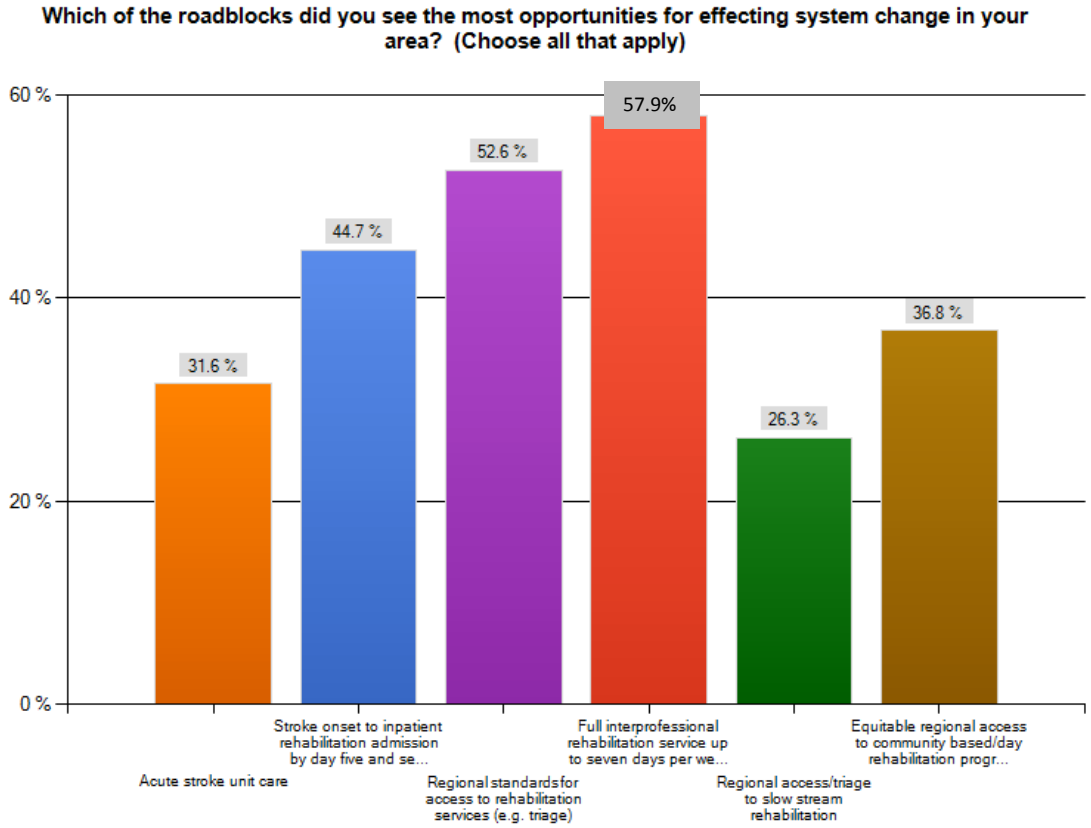
The participant evaluation also afforded the opportunity to consolidate qualitative information about the Forum. Overall, feedback from the day was very positive. Some of the things people valued most included:

- *A coming together of the spectrum of health care providers and decision makers to focus on possible solutions with a framework of relevant, thought-provoking data.*
- *Valuable to tie into Quality Based Funding. It was forward thinking. The reality that the resources are in the system -- it's just how the resources are being used that is needed to make the improvements to achieve best practices.*
- *Seeing the larger regional picture of stroke rehab and the important use of restorative care with patients who are not able to start the more intensive rehab.*
- *Great opportunity to network and to learn more about the wealth of resources that are available for stroke patients across the continuum. I was able to identify some new tools that I will now use in my daily practice.*
- *The feedback and stories of the stroke survivors. They presented some key points in that progress and [recovery] potential to go well beyond three months. Clients need to feel secure and confident in the services available and provided once they leave the hospital.*
- *The Regional economic analysis provided the data that supports the need to make changes to our current system, and how this can be achieved.*
- *I found that how [the economic analyst] showed the importance of rehab from a financial perspective to be really interesting. It has never been put that way before.*
- *The Global Café session was very interesting. I was able to meet our partners in health care.*
- *The Forum gave me hope that the systems will improve. I believe there was commitment in the room to really make the changes happen.*

- *I found the data supporting intensive rehab for the severe stroke survivors interesting and affirming in the fact that these patients can improve and need the expert care given within a rehabilitation setting.*
- *I am keen to support seven day per week and three hour per day of rehabilitation, however I do not think system change can be done in isolation. There needs to be a plan to ensure change can be rolled out across the continuum of care.*

Participant Survey findings included priorities for action planning at the local level. Figure 8 below reflects the group's perspective for the greatest opportunity for change by best practice / roadblock.

Figure 8 – Participant Survey Chart: Opportunities by Roadblocks



The post Forum participant survey provided some additional information in consideration of specific applications relative to system change opportunities.

Potential Specific Applications Identified in Participant Survey
• inpatient pathways that include automatic rehabilitation therapy involvement; • clustering of stroke patients in both acute and rehab settings; • consistent, objective access to rehabilitation; • establishment of more acute stroke units; • moving resources to allow for earlier access to rehabilitation; • increased access to pharmacy, lab and physician coverage for earlier rehab admission; outpatient services in all parts of the Region and/or development of a mobile unit; • stronger communication linkages amongst service providers; • increase in available rehab beds; and increasing clinical expertise

The participant survey asked how the Stroke Network can support local follow-up and action planning workshops for local implementation. A number of opportunities were identified and are summarized in the table below. Opportunities identified by each local area are outlined In Appendix "L".

Identified Strategies for Support for Local Follow-Up
• dissemination of best practice guidelines with implementation of best practices at all levels; • information regarding allocation of funding for therapists on weekends; • additional training for registered nurses to assist with therapy goals; • physician education on the benefits of rehabilitation in order to influence physician practice; • development of clear criteria for inpatient and 'slow stream' rehab; development of a consistent triage process for these patients; • focus on service delivery models and education programs; • support understanding the patient journey and self-navigation vs system navigation support; • advocacy for increasing human resources; • support the development of a general activity program for the weekends for stroke patients; • support acute and rehab stakeholders in working together to remove roadblocks.

SOLUTIONS - EMERGING THEMES FOR ACTION

Following comprehensive review of all stakeholder input, clear key themes became evident. Although the themes have been categorized for clarity, it is recognized that they are all interrelated. The key themes for action generated through stakeholder engagement include:

Regional Processes

- clustered care
- standards centred around patient vs resources
- associated standardized tools and processes
- bed designation and reallocation
- established slow paced rehabilitation programs for those with severe stroke
- equality of service provision across the Region
    - Day Rehab services
    - Slow Paced Rehab
    - Outpatient services
- alignment of funding with best practice through Quality Based Funding

Communication

- flow of patient information across sectors; electronic medical record
- communication of expectations
- e-referral and resource matching

Health System Navigation

- early and dedicated navigation support
- community and primary care linkages

Interprofessional Education / Building Expertise and Capacity

- understanding and awareness of rehab benefits (physicians, administration and all staff)
- skills and abilities to meet the needs of complex, severe, more acute patients
- expertise in community
- building capacity and trust

Models of Care Delivery

- recruitment strategies
- new and innovative models of care
- family engagement in patient care
- weekend coverage, staggered hours
- working to full scope
- utilizing rehabilitation assistants

Cross Continuum / Working out of Silos / Managing Transitions

- effective hand offs and transition processes
- "preparing the way" (e.g., preparing for medical acuity, readiness of community resources)
- repatriation and transfers

Engagement of Staff, Physicians, Leaders and LHIN

- senior leaders
- LHIN
- Staff and physician champions

Patient/Client and Family Engagement (Patient/Client-Centred Care)

- peer support groups
- weekend passes
- early information and education to patient

It was noted that some of the challenges that may arise from this work include:

- The issue of the critical mass needed for effective acute stroke unit implementation and how to organize acute stroke care across the region (i.e., evaluation by the Ontario Stroke Network indicates that a minimum of 130 ischemic stroke patients admitted annually is associated with improved outcomes);
- The issues around transitioning patients from acute to rehabilitation care given medical acuity of patients. There was discussion around the need for staff training and expertise in rehabilitation to accept more acute patients;
- Areas of significant inequity with respect to rehabilitation ambulatory day service in the region (e.g. Brockville and Kingston);
- The need to define standards for access, triage and service in relation to both rehabilitation and slow stream rehabilitation;
- Advocacy and awareness of the need for and benefits of rehabilitation.

RECOMMENDATIONS AND NEXT STEPS

The Regional Stroke Steering Committee members have endorsed this report and have made the following recommendations:

1. **Align work with Quality Based Funding recommendations** for stroke care being released in 2013-14.

2. **Engagement of all including leadership.** It is critical to engage senior leaders in the next steps around local planning. This report will be disseminated to all participants and to all members of the SE CCAC and Hospital Executive Forum (SECHEF). An invitation from the RSSC Chair will accompany the report inviting SECHEF members to

participate in local leadership meetings to discuss the information shared, highlighting the identified local roadblock solutions and asking for advice with respect to local follow up, planning and implementation. Quality Based Funding will be highlighted in the invitation letter.

3. **Local level follow-up.** Best Practice Forums will be held in local areas validating and prioritizing the emerging themes for action. These Forums, funded as part of the 2013-14 Regional Stroke Education Plan, will establish improvement priorities for each area in the Region. Quality Based Funding and acute, rehabilitation and community best practices will be integrated into identified actions. This reflects the Phase II of the planning and implementation of rehabilitation system change. The Stroke Network will be working with stakeholders at their respective organizations and jurisdictions to facilitate implementation.

4. **Share Report and align work with the Restorative Care Clinical Services Roadmap Group.** Ongoing communication will be maintained with the SE LHIN and the Co-Chairs of the South East Restorative Care Clinical Services Roadmap in order to maintain alignment on planning related to mutual goals.

5. **Align work with the SE LHIN Integrated Health Service Plan** and other LHIN initiatives, including **Resource Matching & Referral (RM&R).**

6. **Learn from other Regions.** The Stroke Network will continue to update stakeholders on the learning occurring in other regions through contact with other Regional Stroke Networks, the Ontario Stroke Network and the Ontario Association of CCACs. The development of the LHIN Provincial Rehabilitation Alliance will be closely monitored in order to learn of other rehabilitation system initiatives across the province.

Moving On

Already, informal action planning is underway in SEO. For example, following the Forum, physician leads across acute and rehab settings discussed a plan for acute specialist participation in rehabilitation interprofessional rounds to facilitate patient transitions, education and sharing of knowledge between the Rehab and Acute teams around issues of acuity. This type of transition activity could have a beneficial impact on stroke onset to rehabilitation admission times.

Appendix "A"
SE LHIN Stroke Report Card 2010-11

Poor performance[1]
Acceptable performance[2]
Exemplary performance[3]
Benchmark not available[4]

Indicator No.	Care Continuum Category	Indicator [5]	LHIN FY 10-11 (FY 09-10)	Variance within LHIN (min - max)	Provincial Benchmark[6]	High Performer	
						Facility/SubLHIN	LHIN
1	Public Awareness and Patient Education	Proportion of patients who arrived at ED less than 3.5 hours from stroke symptom onset.	37.0% (39.9%	23.0 - 49.4%	52.0%	Eligin	2, 11
2	Prevention of Stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000	1.5 (1.4)	1.0 - 2.1	1.1	Northwest Mississauga	0
3	Prevention of Stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	17.8 (13.5)	0.0 - 23.3	14.3	Lakeridge Health -	7
4	Prevention of Stroke	Proportion of ischemic stroke/TIA patients with atrial fibrillation prescribed or recommended anticoagulant therapy on discharge from acute care.	71.5% (74.9%)	50.0 - 100.0%	86.0%	Queensway-Carleton Hospital	0
5	Prevention of Stroke	Proportion of ischemic stroke patients without atrial fibrillation who received carotid imaging prior to hospital discharge.	78.7% (90.5%)	33.3 - 100.0%	92.8%	Markham Stouffville Hospital	5
6	Acute Stroke Management	Proportion of suspected stroke/TIA patients who received a brain CT/MRI within 24 hours of arrival at ED.	81.9% (72.8%)	0.0 - 96.4%	97.7%	Cambridge Memorial Hospital	5, 7
7	Acute Stroke Management	Proportion of ischemic stroke patients who arrived at ED less than 3.5 hours from symptom onset and received acute thrombolytic therapy (tPA) (excluding those	43.9% (29.9%)	0.0 - 60.7%	61.2%	Trillium Health Centre	0
***8**	***ACUTE STROKE MANAGEMENT***	***PROPORTION OF STROKE/TIA PATIENTS TREATED ON A STROKE UNIT AT ANY TIME DURING THEIR INPATIENT STAY.***	***47.3% (46.1%)***	***0.0 - 76.1%***	***87.5%***	***North Bay General Hospital***	***0***
9	Acute Stroke Management	Proportion of stroke (excluding TIA) patients with a documented initial dysphagia screening performed during admission to acute care.	57.6% (62.6%)	0.0 - 71.4%	83.7%	Thunder Bay Regional Hlth Sciences Centre	14
10	Acute Stroke Management	Proportion of ALC days to total length of stay in acute care.	34.1% (n/a)	0.0 - 40.6%	14.0%	Halton Healthcare Services -Oakville	2
***11**	***ACUTE STROKE MANAGEMENT***	***PROPORTION OF ACUTE STROKE (excluding TIA) PATIENTS DISCHARGED FROM ACUTE CARE AND ADMITTED TO INPATIENT REHABILITATION.***	***29.4% (28.4%)***	***0.0 - 60.0%***	***42.3%***	***Chatham-Kent***	***1***
12	Stroke Rehabilitation	Proportion of stroke (excluding TIA) patients discharged from acute care who received a referral for outpatient rehabilitation.	4.6% (9.7%)	0.0 - 27.3%	12.1%	Burlington	14, 13
13	Stroke Rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation (RCG-1 and RCG-2).	13.0 (13.0)	11.0 - 16.5	7.0	Grey Bruce HS-Owen Sound	9
14	Stroke Rehabilitation	Rehabilitation therapy staff/bed ratio for inpatient stroke rehabilitation.	--	--	--	--	--
15	Stroke Rehabilitation	Proportion of ALC days to total length of stay in inpatient rehabilitation (Active+ALC) (RCG-1).	6.9% (n/a)	2.1 - 12.1%	6.3%	Trillium Health Centre	6
16	Stroke Rehabilitation	Median FIM Efficiency for moderate stroke in inpatient rehabilitation (RCG-1).	0.7 (0.6)	0.5 - 0.9	1.1	Royal Victoria Hospital	9
17	Stroke Rehabilitation	Mean number of CCAC visits provided to stroke/TIA patients in 2008/09 and	6.7 (6.2)	n/a	6.8	n/a	5, 3
18	Stroke Rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe strokes (RPG= 1100 or 1110) (RCG-1).	36.7% (30.2%)	33.3 - 50.0%	46.9%	Royal Victoria Hospital	0
19	Re-integration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	11.2% (10.2%)	0.0 - 54.5%	4.7%	Manitoulin-Sudbury	13
***20**	***RE-INTEGRATION***	***AGE- AND SEX-ADJUSTED READMISSION RATE AT 30 DAYS FOR PATIENTS WITH STROKE/TIA FOR ALL DIAGNOSES (per 100 patients).***	***5.6 (7.9)***	***3.2 - 12.1***	***8.0***	***Kingston General Hospital***	***10***

[1] *Poor Performance* = Below 50th percentile
[2] *Acceptable Performance* = At or above 50th percentile and > 5% absolute/relative difference from benchmark
[3] *Exemplary Performance* = Benchmark achieved or within 5% absolute/relative difference from benchmark
[4] *Data not available or benchmark under development*

[5] Facility based analysis (excluding indicators 1, 2,11, 12 and 19) for patients aged 18 to 108. Indicators 1, 4 - 9, 12 are based on FY1011 (FY0809 displayed in brackets) OSA data otherwise CIHI databases. (Low rates are desired for indicators # 2, 3, 10, 13, 15, 19 and 20.)

[6] Provincial benchmarks were calculated using the ABC methodology, except for indicators 3, 15 and 20 where the provincial rate was used. For benchmarking methodology, see Weissman et al. J Eval Clin Pract. 1999; 5(3):269-81.

[7] High performing acute sites include high volume institutes (those that treat more than 100 strokes per year) and high performing rehab sites include sites with moderate volumes (those that admit more than

* Hospital Service Accountability Agreement indicators, 2010/11

-- data not available

Appendix "B"
SEO Rehab Gap Analysis

Best Practice Recommendations for Stroke Rehabilitation
SEO Gap Analysis – Updated May, 2012

Priority: Earlier Access from Acute Care				
Best Practice Recommendation	**Current State (Regional/Provincial)**	**SEO Current Resources and Processes**	**Implementation System Issues**	**Performance Indicators**
All stroke/TIA patients requiring inpatient care **Admission to Acute Stroke Unit**	**Provincial** • 26 stroke units (OSA 08/09) • 29% (5104 pts) admitted to stroke unit (OSA 08/09) Location of Stroke Units: 52% pts@ RSC 37% pts @ DSC 4% pts at Non designated **Regional** • **(69% SEO – FY10/11 0SA)** • Sites KGH and QHC Belleville • 69% of patients to unit at KGH • 78% of patients to Q5 at QHC	• Acute Stroke Unit at RSC; planning commenced towards ASC at DSC • BGH has critical mass to support Acute Stroke Unit	• Rural and remote areas do not have the capacity and/or critical mass to form stroke units • Resources from rural remote areas may need to be reallocated to identified stroke unit sites/organizations • Lack of an integrated system of care for stroke in most regions	• % stroke pts admitted to stroke unit • % pts who had an acute therapy assessment within 48hrs of admission • % of mild, moderate and severe strokes d/c to inpatient rehab • % d/c from acute directly to LTC/CCC • Mortality rates • Readmission rates • Complication rates • LOS • ALC
Interprofessional Team Care on acute stroke unit	**Provincial** • Variations in levels of rehab service provision on holidays and weekends • Variations in rehab service provision in acute	• Not all acute teams caring for stroke include core members • KGH has acute stroke unit PT, OT, SLP, RD (no Rec)	• Variation in recommendations to ensure best practice core team composition for acute stroke pts • Human resource	• % pts who had an acute therapy assessment within 48hrs of admission • Acute LOS • Readmission rate

	care • Designated stroke centres have enhanced staffing (best practice teams)	• QHC Belleville site working towards 4-6 bed unit on Q4 Acute Medicine – current acute services available at **QHC Belleville :** PT (including limited weekend/holiday), OT, RD, SLP • **QHC Trenton:** PT, OT, SLP – for swallowing only, RD, Rec • **QHC Picton:** PT, OT rarely for ADL environmental Ax, SLP – for swallowing only, RD • QHC North Hastings – PT only • L&ACGH – no acute stroke unit, therapy available in acute: PT, OT, RD, .2 SLP • PSFDH – Smiths Falls - No acute stroke unit, but therapy available in acute - PT, OT, SLP, RD • Brockville GH – no acute stroke unit – Acute site Charles St site - **Therapy available in acute: PT, OT, RD;** SLP three days/wk	capacity to ensure core team composition • Access to therapy generally limited to 5 days/week	

Early mobilization (within 24 hours of admission)	**Provincial** • Data unavailable to assess compliance with recommendation • Note: Australia AVERT trial	• RSC and DSC acute order sets incorporate early mobilization best practices • QHC 100% compliance with tPA order set. Non-tPA Acute stroke order set currently being revised. TIA order set currently under review as well.	• Process to assess compliance is not available • Access to therapy generally limited to 5 days/week	• Complication rates • % of pts who had an acute therapy assessment within 48 hrs • Acute LOS
Day 3 **AlphaFIM** completion	**Provincial** • Provincial variation • 78 facilities using Alpha FIM; 87% of participating organizations completed AlphaFIM prior to Day 5 • Minimal use of Alpha FIM for d/c decision making for access to rehab • Current mandate to complete Alpha FIM within 3 days (72 hours) from acute admission • Breakdown in completion of AlphaFIM due to illness / vacation	• AlphaFIM in use in SEO at Quinte Health Care, Belleville, Lennox and Addington Counties General Hospital; Kingston General Hospital • Standardized process for data collection and use required • Plans for implementation at Brockville General Hospital and re-launch at QHC Belleville • Completion target is Day 3 in SEO currently - KGH average 4.6 days for AlphaFIM completion • Further work for all sites in use as part of triage for rehab	• Lack of provincial mandate to utilize AlphaFIM for rehab triage • Provincial infrastructure required to licence, train and support data collection for Alpha FIM; opportunity to include within CIHI DAD • Staff availability to meet training and recertification requirements • Potential for improved integration of Alpha FIM into care within an interprofessional stroke unit. • Each region required to purchase license (limitation of license to incorporate data into EMR) and cost of training and credentialing / recertification	• Number of AlphaFIMs completed on target day (SPIRIT Acute) • % of pts within AlphaFIM categories who were d/c to planned rehab destination • Onset days to admission to rehab; all and by stroke type

Day 5 – Onset to Rehab	**Provincial** • Days from stroke onset to inpt rehab pt admission: 11 days (SEQC 10/11) **Regiona**l • **SEO 13 days (F10-11 Report Card)** **Provincial** • Acute stroke LOS Mean 12.6; Median 6 • ALC Days Mean 17.2, Median 7 • 40% of acute stroke pts admitted to rehab were designated as ALC waiting for Rehab	• SEO admissions 5 day per week • Issues of acuity KGH to SMOL without repatriation agreement	• Rehab admissions generally limited to 5 days a week to freestanding rehab facilities • Rehab programs lack capacity to admit higher level acuity pts • Potential increase in acute readmission due to higher acuity level	• Onset days to admission to rehab; all and by stroke type • ALC waiting for Rehab • Acute LOS by Alpha FIM category/ RPG • Acute D/C destination by Alpha FIM category/ RPG • All cause readmission rate
Triage - All stroke patients who require inpatient should be admitted to Inpatient Rehabilitation	**Provincial** • 30.7% of pts admitted to rehab (SEQC 2011) • Proportion of acute stroke (excluding TIA) patients discharged to inpatient rehabilitation is an HSAA indicator (**SEO 29.4% - F10-11 Report Card)** • 20.3% of rehab admissions are mild patients (RPG 1150,1160) going to inpatient rehab because of lack of rehab in community • Severe stroke pts limited and variable access to IP rehab ; 31.9% all rehab admissions are severe	• QHC Belleville uses standardized triage form and admission criteria (process under review) • SMOL standardized referral process with physiatrist consult • BGH has standardized triage form • No repatriation agreement in place to support SMOL acceptance of severe patients	• Lack of standardized admission criteria/ candidacy for admission to rehab • Limited use of AlphaFIM data in supporting triage process • Inadequate access to community rehab for mild stroke patients causing admission to inpatient rehabilitation; • Lack of community programs that deliver appropriate therapy intensity • Inadequate access to inpatient rehabilitation for severe stroke patients	• % of mild, moderate, severe pts d/c to inpt rehab • % DC from acute directly to LTC/CCC • Proportion d/c from acute who received referral for outpatient rehabilitation (Rehab Day Hospital vs Enhanced Therapy CCAC vs CCAC)

	(RPG 1100 & 1110) - (**SEO 36.7% severe admits to rehab - F10-11 Report Card)** • D/C destination after acute hosp: 7% admitted to LTC (**SEO 11.2% - F10-11 Report Card)** Windsor Rehab admitting 50% of all stroke; 50% of severe go to IP rehab		whose only other option is LTC <u>NOTE:</u> At QHC, there is a Slow Stream Rehab Program that is part of the CCC unit where severe strokes are often admitted to which can also serve as a transition to inpatient rehab once tolerance for therapy increases • Nurse staffing model in inpatient rehabilitation not sufficient to support higher volume of severe stroke patients • Therapy intensity in CCC and LTC (restorative) not as effective in achieving independence and discharge to the community for severe stroke patients as compared to high intensity rehabilitation; these clients will need to access high intensity programs. • Reassessment of benchmarks for LOS in inpatient rehabilitation needed due to admission of fewer mild strokes pts and increase admission of severe stroke patients to inpatient rehab.	

All stroke patients who require inpatient rehabilitation should be admitted to a **Stroke Rehabilitation Unit**	**Provincial** • 8 stroke rehab units in Ontario in 2007/08 • 24.3% pts admitted to stroke rehab units 07/08= 731; 731/3010 =24.30% (from NRS data of above 8 stroke rehab units; SEQC Tech report 2010)	• SMOL only 'stroke rehab unit' in SEO	• General rehab programs may not have the critical mass and resources to create a stroke unit • Resource allocation opportunities to identified stroke unit sites/organizations	• % stroke pts admitted to stroke unit • Mortality rates • FIM efficiency by RPG • Post rehab Discharge destination • % DC home who came from home
Priority: Rehabilitation Intensification				
Best Practice Recommendation	**Current State (Regional/Provincial)**	**SEO Current Resources and Processes**	**Implementation System Issues**	**Performance Indicators**
Full Interprofessional Team on inpatient rehabilitation **BP Staff to Bed Ratios:** PT 1:6 OT 1:6 SLP 1:12 SW 1:12	**Provincial** • Incomplete teams • Lack of standards for team composition for inpatient rehabilitation service resulting in high variation across province • Rehabilitation beds / therapist in 2009/10 PT- median (IQR) = 10 (8-11.7) OT- median (IQR) = 11.1 (9.1-12.9) SLP- median (IQR) =28.8 (19.3 – 50) • Limited allied health coverage for vacation/illness • Adoption of IPC model variable	**QHC - Belleville site** 18 designated rehab beds -occupancy 93% -daily therapy - PT 2.5, PTA 1.0, OT 2.0, OTA .5 SLP .3, RD - no psychology, SW or physiatry 38 CCC beds used for SSR, Complex Care or palliative With lower intensity therapies based on patient's need/tolerance, PT 1.5, PTA 1.5 OT 1.0, OTA 0.5, SLP .3, RD, Rec 1.0 **PC SMOL** 46 designated rehab beds -occupancy 82% -daily therapy	• Lack of standards and fiscal resource to ensure team composition includes core team members • Lack of stroke champions (physician/nurse practitioner) to lead the program and implement best practice • Human resource capacity to establish core team (varies by region) • Lack of organizational support to implement IPC model	• Inventory of IP Rehab staffing and/or compliance with new standards • Rehabilitation Beds / therapist • Rehab LOS by RPG FIM Efficiency

		PT 1.4, OT 1.8, SLP 1, RD, SW .6, Rec. .6; psychology, physiatry; 1 CDA, 1 OTA L&ACGH ____ CCC beds, providing PT, OT, SLP, RD, SW, Rec (hiring) **PSFDH – Perth** 6 ***un****designated* rehab beds -occupancy 92% -daily therapy 1 PT, .5 OT, .2 SLP, RD, physiatry No SW or psychology; .3 Rehab Asst 8 SSR beds - .5 PT; .1 OT; .1 SLP; .3 Rehab Asst. **Brockville GH** **Garden St site** ***5 designated rehab beds, 1 undesignated rehab bed*** -occupancy 94% -daily PT/OT therapy: 1 ***PT; 1 OT; .6 SLP; 1 Rec; 1 PTA; RD*** Physiatry – weekly consult with SMOL No SW or Psychology **BGH Restorative Care Program** 15 CCC beds designated as		

		restorative at Garden St site PT/OT/Rec up to 3x/wk as indicated		
Admission 7 days per week	**Provincial** • Days from stroke onset to admission to inpt rehabilitation: 11 days; (**SEO 13 - F10-11 Report Card)** • Days from ready for admission to admission: 2.7 (Mean) 1 (Median) • FIM efficiency is lower than targeted due to delays in getting to rehab • 7 day/wk admission in some facilities (St Johns Rehab, St Joseph's, Thunder Bay)	Limited 7-day/wk admission in SEO (QHC Belleville occasionally does weekend admissions)	• Freestanding rehabilitation facilities lack access to physician/NP, pharmacy, and support services • Stroke expertise to manage increased acuity patients will require resource to build capacity Union negotiations may be required to accommodate expansion of service	• Days from stroke onset to admission to rehab • Acute LOS and ALC • All cause readmission rates Total LOS (acute & rehab)
Full IPC service 7 days per week	**Provincial** • 5 day week service in most facilities, with some agencies with less than 5 day a week service/therapy • Some examples of 7 day a week service (St Johns Rehab) • Variations across province for use of weekend pass as part of rehabilitation • LOS and FIM Efficiency variable; ALOS range 24.8-44.5; FIM Efficiency	• No full IPC service 7 days/wk in SEO • Weekend/day pass process and pass to discharge process in place at QHC Belleville	• Mechanisms to identify and support funding reallocations • Lack of staffing models for 7day/week service for allied health • Union negotiations may be required to accommodate expansion of service • Support to facilitate culture shift will be required • Need for clinical lead with data interpretation skills and access to decision support to provide timely	• Rehab LOS by RPG • FIM efficiency by RPG • Number of admissions/yr • Post rehab Discharge destination • % DC home of those who came from home Readmissions to acute

	range 0.6-1.1 • (**SEO FIM efficiency (moderate) .7, provincial benchmark 1.1 - F10-11 Report Card)** • Some facilities achieving improved FIM Efficiencies with targeted benchmarks for LOS by RPG (Parkwood, SJHC London; Bluewater, Sarnia)		information from NRS data by RPG that can be shared with frontline staff • Administration support to incorporate into early discharge planning and implement during weekly rounds	
Direct Therapy 3 hours per day	**Provincial** • Provincial variation in amount of direct therapy time • Examples of 3 hrs direct therapy/day o Windsor Regional Hospital • Lack of documentation of amount of therapy provided from patient perspective • Some facilities achieve therapy intensity targets with group work	• Inconsistency in SEO regarding workload measurement by patient and/or diagnosis. • Variability within SEO - staffing models/compliment insufficient and/or incomplete	• Lack of provincial standards for rehab designation - Team members; IPC; Expertise • Lack of innovative interprofessional approaches to model of care delivery • Human health capacity concerns to deliver intensity therapy recommendation • Lack of standard process to monitor amount of therapy received/day from patient perspective • Lack of critical mass impacts staffing models and ability to achieve best practice and system efficiencies particularly regarding direct therapy delivery	• Frequency, intensity and duration of therapies received during inpt rehab • FIM Change by RPG • FIM efficiency by RPG • Rehab LOS • % DC home who came from home Post rehab Discharge destination
Rehab ALC priority access to LTC	**Provincial** • Variation in access to LTC Mean # of days ALC in	• Priority access to LTC limited to acute care in	• Priority access to LTC limited to acute care	• Median # of days ALC • Number of

	Rehab 6.5 (**SEO 11.2 - F10-11 Report Card)**	SEO	• CIHI NRS does not have a field for ALC days in rehab	admissions/yr • Rehab LOS • Acute LOS
Priority: Access to Ambulatory / Community Rehabilitation				
Best Practice Recommendation	**Current State (Regional/Provincial)**	**SEO Current Resources and Processes**	**Implementation System Issues**	**Performance Indicators**
Early Supported Discharge (ESD) from Acute and Rehab	**Provincial** • Acute LOS: Mean 12.6, Median 6 days • ALC Days Mean 17.2, Median 7 • Readmission rates 8.3 per 100 • Current CCAC service levels consultative not treatment: mean visits 4.1, median visits 3 • 20.3% of rehab admissions are mild patients (RPG 1150,1160) going to inpatient rehab because of lack of rehab in community • LOS for Mild in Rehab is mean 20.6; median 17 days • CCAC service wait times (mean 33.3; median 27 days) • **SEO CCAC wait times average 4.9 dayS** **Provincial** • Lack of access to outpatient programs; Proportion of stroke	**QHC Belleville site** - Rehab Day Hospital – PT, OT, SLP, RD, Rec, SW; (Outpatient physio available at TMH/NH/PEC, but stroke patients encouraged to attend day hospital due to interprofessional approach and neuro expertise) • Use of estimated discharge date set on admission to inpatient rehab based on Avg LOS for like RPG at benchmark facilities • Bullet Rounds **SMOL** – Pilot trial for rehab day program **L&ACGH** – No rehab day hospital; PT only for outpatient services **BGH** – no outpatient services; no rehab day hospital	• Need for provincial model, including standards and criteria for ESD (AlphaFIM of 90+) • Need for interprofessional specialized team care for stroke in the community (CCAC is single service model; outpatient services are primarily single service; Day Hospitals have largely been closed or cut back • Human resource capacity required to maintain timely service: eliminate wait listing • Reduced number of outpatient rehab programs to access • Stability and sustainability of service • Need to incorporate criteria for ESD into assessments developed	• LOS Acute & Rehab • ALC Acute & Rehab • Time to first visit (CCAC, outpt, mobile team) • # of visits by each discipline within first 60 days post d/c • Readmission rates • Functional status change (RAI or FIM) • Caregiver burden/assistance • Community integration/ participation

	patients discharged from acute care who receive a referral for outpatient rehabilitation is 4.6% (Report Card) • Current CCAC eligibility criteria may not be applicable to those referred to ESD • Fragmented communication across transitions • Lack of access to enhanced attendant care/ supports in early d/c phase for ALC pts • Lack of system to track data for outpatient service provision • Lack of standardized outcome measures across the continuum.	**Perth** – rehab day hospital; PT, OT, SLP, RD, RN, groups offered, 10 spaces - outpatient services available, primarily PT – OT and SLP outpatient services limited Enhanced Community Based Rehabilitation services now standard of care in SEO	by single point of access to post-acute care • Fragmented communication links across transitions • Lack of access to enhanced attendant care/ supports in early d/c phase for ALC pts • Lack of system to track data for outpatient service provision and outcomes • Lack of existence of provincial ambulatory database • Need for identification, training and implementation of standardized outcome measures	
Access to Ambulatory Rehab – Timely; appropriate intensity; interprofessional	**Provincial** • Waiting lists for existing outpt programs • Erosion of ambulatory care services; since 2009/10, 8 outpatient programs have closed compared to only 2 that have been newly opened • Lack of access to outpatient programs; Proportion of stroke patients discharged from acute care who receive a referral for outpatient	• See RDH and outpatient resources in SEO above	• Need for provincial model, including standards and criteria for ambulatory rehab • Mechanisms in place to support and sustain funding • Establishment of provincial ambulatory care database • Need for community based programs with supporting mechanisms and process to access (eg. Stroke Recovery,	• LOS Acute & Rehab • ALC Acute & Rehab • Wait time to first visit • FIM efficiency by RPG • Functional status change • Number of visits by each discipline within first 60 days of d/c • Post stroke Depression screening/assessment • Caregiver burden • Community integration • Linkages with community services for ongoing support

	rehabilitation is 4.6% ON Report Card • Variation in service provision- many are single service and not interprofessional, often pulled to inpatients • In 2009/10, total staff for outpatient rehabilitation in Ontario were: PT- 112 FTEs; OT- 51.8 FTEs; SLP- 31.1 FTEs • Variation in intensity of rehab • No data collection system in CIHI • Limited Transportation services to outpt rehab often limits access		safe and effective community based exercise programs) • Identify strategy to address transportation/distance issues for stroke survivors to be able to attend ambulatory rehab programs • Identification, training and implementation of standardized outcome measures	
Enhanced Community (CCAC) **Rehab Services** – Timely; appropriate intensity (2-3 visits per required therapy per week X 12 weeks; interprofessional	**Provincial** • CCAC service wait times (mean 33.3; median 27 days) • **(CCAC wait time in SEO 4.9 day average)** **Provincial** • 9 of 13 responding CCACs noted CCAC rehab services were wait listed; all CCACs with wait lists reported a system of prioritization; wait times for less urgent patients ranged from 1 month to nearly 1 year • Current CCAC service levels low, primarily consultative: mean visits	• Enhanced Community Based Rehabilitation services now standard of care in SEO, improving intensity, timeliness, prioritization and fluid transition • Continually reviewing appropriate service intensity related to clients' ability to tolerate multi services in the home setting and client's health status. • In the home setting – client/family involved in the treatment goals and	• Development of local service provision model (System navigation roles) • Mechanisms in place to support and sustain funding • CCAC human health rehab services resource plan required • Training and implementation of standardized outcome measures required • Development of interprofessional model of care with appropriate service intensity and	• LOS Acute & Rehab • ALC Acute & Rehab • CCAC time to first visit • Number of visits by each discipline within first 12 weeks of d/c • Change in functional status (Admission RAI, D/C RAI) • Readmission rates • Post stroke Depression screening/assessment • Caregiver burden/assistance • Community integration/participation • Linkages with community services for ongoing support

	4.1, median visits 3 • **(SEO – mean visit rate 12.2 (SECCAC CHRIS 10-11)** • Mean # of CCAC rehab services offered has not changed since 07/08, little variation in service intensity across LHINS • CCAC prioritization of clients may delay time to first visit Some current initiatives: • Providence Healthcare Project: Sector linkage Model for Improved pt Flow: shifted hospital resources to CCAC aggressive needs-based rehab with focus on sustained independence at home • **SEO CCAC enhanced community based support stroke rehab** • SW LHIN Specialized Community Stroke Rehabilitation Teams	service delivery as client adjusts to home/social life as well as an intensive rehab program.	team/family meetings • Utilization of telehealth to support assessment and delivery of rehab • Use of standardized communication and transition tools • Community based programs in place with supporting mechanisms and process to access (eg. Stroke Recovery, safe and effective community based exercise programs	

Appendix "C"

Strategic Plan Alignment Chart

[Update to include CCAC Sept Strat Plan info]

SE LHIN Alignment with Integrated Health Services Plan 2 (IHSP2) (2010-13)
SE LHIN Vision promotes integrated or seamless care within the continuum of care, in partnership with internal and external stakeholders. Five aligning **IHSP2 priorities**:
• Enhancing a Culture of Patient-Centred Care
• To improve the patient experience
• To improve the efficiency and effectiveness with which individuals move within and between health-care services
• Reducing the Incidence and Prevalence of Alternate Level of Care
• To reduce the number of people who wait in hospital for an alternate level of care
• For those who do wait in an alternate level of care, to shorten the time they spend waiting as ALC
• To change 'culture of placement' to a 'culture of going home'
• Improving Access in Emergency Room Care
• To meet provincial standards for waiting times in emergency rooms
• To increase home support within the community to reduce the need of going to Emergency Rooms (ER)
• For those who access the ER, to reduce waiting time by improving ER capacity and performance
• To ensure clients who can be cared for at home are supported to remain in their homes
• Developing Regional Program Management
• To regionally standardize access to and use of selected specialized medical care
• To consider the establishment of centres of excellence for specialized medical/surgical procedures
To maximize capacity across the South East health-care system by managing selected services at multiple sites through one coordinated management structure

SE LHIN Alignment with Clinical Services Roadmap

Restorative Care is considered to be a 'crucial part of the ER/ALC strategy that has not yet been addressed in a strategic manner in the South East LHIN'. The intended outcomes of RCSR include:

- Reduction in avoidable decline in function within hospital and ER stays by target populations
- Improved access to appropriate level and range of therapeutic, environment and socio-economic services which are supportive of improved functional outcomes
- Improved functional outcomes and increased capacity for independent living within the community associated with sustainable reductions in ER/ALC pressures and the need for LTC

Priority 1 – High Risk Screening Process

Objectives:

- Develop a screening tool to help the health care system to flag individuals that are at risk of functional decline and/or adverse outcomes and for whom additional assessments/treatments/supports are desirable.
- Implement this tool consistently throughout the system of care.

Benefits:

- Enhanced identification and surveillance of at-risk individuals
- Improved Functional Outcome
- Reduction of avoidable ED visits
- Reduction of avoidable acute / rehab admissions and LOS
- Reduced ALC designations

Priority 2 – Reducing Avoidable Loss of Function

Objectives:

- Assess individuals at risk for functional decline or ALC in hospital
- Implement best practice programs and support for individuals
- Support creation of senior-friendly environments in hospital

Benefits:

- Avoidable loss of function is minimized for individuals, which leads to reduced length of stay within hospital and decreased need of further health care use
- Fewer individuals will have their discharge trajectory altered to Long Term Care, resulting in efficient use of Long Term Care resources
- Maintaining function within individuals will contribute to a more sustainable health system
- Reduced length of stay within formal restorative programs such as rehabilitation and geriatrics

Priority # 3a – Formal Restorative Programs

Development of a regional standard for "formal" restorative care services including geriatrics and rehabilitation.

Objectives include:

- Develop and implement standards for access / admission criteria and referral processes for those requiring rehabilitation and specialized geriatrics
- Develop and implement formal relationships / linkages between informal and formal restorative care programs to promote access and facilitate transitioning.
- Develop and implement evidence-based norms for delivery of the formal restorative care services noted in 1 and 2 above.
- Develop innovative and flexible models of coordinated interprofessional rehabilitation in the community to improve equity of access, to respond to gaps/local need and to build rehabilitation capacity

Priority #3B – Other Restorative Programs

Development of a regional standardized program (admission criteria and referral processes) for access to restorative care in CCC, LTC and community. Objectives include:

- Develop recommendations for access to restorative care (slow stream rehabilitation) in Complex Continuing Care Hospitals in the SE
- Implement streams of care within CCC, which will entail clear pathways and focus of care
- Develop recommendations for access to convalescent care beds in LTC in the SE
- Identify, and implement where lacking, the necessary linkages across the continuum e.g., slow stream rehab with formal rehab and other services in LTC and community
- Reinforce and enhance the provision of restorative care within Long Term Care and community

Priority #4 – Community Linkages and Integration

To improve community linkages, increase awareness of specialized areas in community or non-acute care facilities. Ensure awareness and utilization of community supports to enable high risk individuals to remain in and/or return to the community. Objectives include:

- Providing a system navigation mechanism for HSPs to assist with sustaining people in the community
- Improve awareness of and access to an appropriate range of community supports
- Enhancing timely and effective communication during transition points
- Establish and streamline processes for referrals between providers

Alignment with Strategic Plans - QIPs

QHC / HPE	SMOL / KFLA	KGH / KFLA	LA / L&A	BGH / LG	PSF / Lanark	CCAC / Providers
Create an exceptional patient experience. • Reduce wait times in Emergency Rooms (ER). - Use of Value Stream Analysis of the patient's journey from triage in ER to inpatient admission to identify system issues and wasted time. Provide effective care transitions. • Reduce the number of "alternative level of care" (ALC) patients in hospital through: - incorporate the use of daily bullet rounds to consistently review all inpatients and ensure appropriate care setting, and to proactively identify the necessary steps to move patients through the healthcare system. - Collaborate wtih CCAC through daily review of ALC patients to assess discharge status and proactively identify actions to move patients to most appropriate care setting.	[Note: QIP Agreement - heavily focused on safety, falls, infection control, and budget - reviewed HSAA and MSSAAs] Performance indicators, individuals served, face-to-face visits, hours of care. Community Engagement and Integration: • The HSP will engage the community when setting priorities for the deliverty of health services and in developing plans; and • In conjunction with the LHIN, identify opportunties to integrate services available to the local health system to provide appropriate, coordinated, effective and efficient services.	Transform the patient experience through a relentless focus on quality, safety and service. • 2015 Outcome: All preventable delays in the patient journey to, within and from KGH are eliminated 2012-13 Milestones: • KGH overall average length of stay (LOS) is better than expected length of stay; • The Emergency Department wait time for admitted patients is improved by 20%. Increase our focus on complex-acute and speciality care. 2015 Outcomes: • KGH services are well aligned and integrated with the broader health-care system. • Best evidence use to guide practice.Quality Improvement Plan target 2012-13 Milestones: • Clinical Services Roadmap initiatives launched. €Evidence-based guidelines are adopted in 12 clinical areas.	QIP 2011-12 - Reduce our ER length of stay for admitted patients Strategic Plan 2010-2013 Strategic Imperative 2 – Quality Culture - Quality is a systematic approach in search for excellence. Objectives for sustaining a Quality Culture involves us in: • Pursuit of solving identified problems. • Achieving changes with stability and control Strategic Imperative 4 - Stable Workforce • Ensuring adequate human resources to meet the strategic goals and operational plans of our organization. This means the right people with the right skills at the right time. Strategic Imperative 8 – Alliance Building • LACGH will seek out opportunities in collaboration leading to partnerships and building alliances • On a Regional basis, LACGH will fully	[Strategic Plan not online yet] - from QIP Expand Enhanced Activation and Restorative Care Initiative: • To implement enhanced activation on 2 East to reduce loss of functional ability in the elderly, thereby reducing the acute care LOS and reduction of the number of clients from 2 East who are transferred to Restorative Care. • Reducing unplanned readmission rate through improved collaboration with community partners (i.e. ensuring supports are in place in the home prior to discharge; teaching completed prior to discharge). Collaborating with CCAC and LTC homes to reduce ALC numbers and wait time.	Quality Improvement Plan is in alignment with the Strategic and Operational Plans [not online as yet]: Two top priorities: • Improved Patient Satisfaction in the Emergency Department; and • Reduced ALC days. Focused on closer working relationships and partnerships with community partners (e.g., BGH, SECCAC, Carleton Place). Context: The challenges and risks include uncertainty of operational base funding from LHIN, availability of CCAC to work hand in hand, increasing pressure to address the needs of an aging population, ongoing challenge of high percentage of ALC patients (primarily waiting nursing home beds).	**CCAC** Two Priority Strategic Themes: (i) Sustaining Value and (ii) Client Outcome, Quality and Safety. Priority Strategic Goals include: Coordinate the appropriate care services and safety protocols for all client populations to meet their assessed needs and deliver the best possible client health outcomes; Deliver a positive care experience by facilitating optimal fl ow through the continuum of care to deliver the right care at the right place and time; Continue to engage with our partners, stakeholders and community to ensure their needs are refl ected in our plans;. Establish the quality and continuous improvement infrastructure, processes and culture to support the delivery of high quality care; CCAC Mission: To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care. Expansion of the CCAC System Navigation Role, providing consistent access points for all as they enter and move through programs, including physical rehabilitation. **Context:** The Ontario government remains committed to reducing Alternative Level of Care (ALC) pressures by building on previous investments through its Wait Time Strategy and Aging at Home Strategy by increasing funding to the community services sector by approximately three percent per year over the next three years. These investments will strengthen access to care in the home and the community and help manage acute care costs by freeing up hospital beds and unclogging emergency rooms. **Kaymar** Work within an integrated community care system wherein **collaboration** and communication with the South East Community Care Access Centre (CCAC) and its Case Managers results in **maximal resource utilization** and **enhanced client outcomes**. As a contracted service provider with the South East CCAC, Kaymar participates in and complies with a stringent system of provincially mandated **accountability** measures and reporting. **Communicare** **Client-centered** - our main goal in addressing our clients' needs is to effect **measurable, functional changes** in client status to participate in life as fully as possible. We emphasize open **communication, respect and collaboration**. We are committed to **innovation** and **excellence in service delivery**. We are committed to building and enhancing **community partnership**. We are community rehabilitation professionals **continuously improving our quality of care.**

CCAC / Providers	CCAC and Provider Priority Recommendations
	Earlier Access from Acute Care
✓	**Day 5 Onset to Rehab** admission
	Rehabilitation Intensification
✓	**Full Interprofessional Team** on inpatient **rehabilitation ***
✓	**Admission** to Rehab **seven days** per week
✓	Full Interprofessional Team service **seven days** per week *
✓	Direct **therapy three hours** per day
✓	All stroke patients requiring inpatient rehab should be admitted to a **Stroke Rehabilitation Unit**
	Access to Community / Ambulatory Rehabilitation
✓	**Early Supported Discharge** (ESD)** from Acute and Rehab
✓	Access to **Ambulatory Rehab** - timely; appropriate intensity; full interprofessional team
✓	**Enhanced Community** (CCAC) **Rehab** services

Alignment with Strategic Plan / QIP

CCAC Two Priority Strategic Themes: (i) Sustaining Value and (ii) Client Outcome, Quality and Safety. Priority Strategic Goals include: Coordinate the appropriate care services and safety protocols for all client populations to meet their assessed needs and deliver the best possible client health outcomes; Deliver a positive care experience by facilitating optimal fl ow through the continuum of care to deliver the right care at the right place and time; Continue to engage with our partners, stakeholders and community to ensuretheir needs are refl ected in our plans;. Establish the quality and continuous improvement infrastructure, processes and culture to support the delivery of high quality care; CCAC Mission: To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access,

Expansion of the CCAC System Navigation Role, providing consistent access points for all as they enter and move through programs, including physical rehabilitation.

Context: The Ontario government remains committed to reducing Alternative Level of Care (ALC) pressures by building on previous investments through its Wait Time Strategy and Aging at Home Strategy by increasing funding to the community services sector by approximately three percent per year over the next three years. These investments will strengthen access to care in the home and the community and help manage acute care costs by freeing up hospital beds and unclogging emergency rooms.

Kaymar

Work within an integrated community care system wherein **collaboration** and communication with the South East Community Care Access Centre (CCAC) and its Case Managers results in **maximal resource utilization** and **enhanced client outcomes**. As a contracted service provider with the South East CCAC, Kaymar participates in and complies with a stringent system of provincially mandated **accountability** measures and reporting.

Communicare

Client-centered - our main goal in addressing our clients' needs is to effect **measurable, functional changes** in client status to participate in life as fully as possible. We emphasize open **communication, respect and collaboration**. We are committed to **innovation** and **excellence in service delivery**. We are committed to building and enhancing **community partnership**. We are community rehabilitation professionals **continuously improving our quality of care.**

Quinte & District Rehabilitation

Client-centred service, committed to **quality and safety**; **multidisciplinary team,** managed by therapists; Caring, professional, **leading practices**; Committed to **community partnerships**; Promoting a **healthy and safe work environment**

QHC / HPE	SMOL / KFLA	KGH / KFLA	LA / L&A	BGH / LG	PSF / Lanark	CCAC / Providers	Priorities and Best Practice Recommendations Summary
Earlier Access from Acute Care							
✓	✓	✓ Kidd 7		✓		n/a	All stroke pts requiring inpatient care will be admitted to **Acute Stroke Unit**
✓	n/a					n/a	**Interprofessional Acute Care Team** on Acute Stroke Unit *
✓	n/a	✓				n/a	**Early mobilization** (within 24 hours of admission)
✓	n/a			✓		n/a	Day 3 AlphaFIM completion
✓	n/a	✓		✓	✓	✓	**Day 5 Onset to Rehab** admission
✓	n/a				unknown	n/a	**Triage** - all stroke patients requiring inpatient rehab should be admitted to Inpatient Rehabilitation
Rehabilitation Intensification							
		n/a		✓	✓	✓	**Full Interprofessional Team** on inpatient **rehabilitation ***
✓		✓				✓	**Admission** to Rehab **seven days** per week
✓			n/a		✓ 5-day	✓	Full Interprofessional Team service **seven days** per week *
	✓	n/a				✓	Direct **therapy three hours** per day
		n/a	n/a	n/a - 6 beds	n/a - 6 beds	✓	All stroke patients requiring inpatient rehab should be admitted to a **Stroke Rehabilitation Unit**
Access to Ambulatory / Community Rehabilitation							
	✓					✓	**Early Supported Discharge** (ESD)** from Acute and Rehab
	✓	n/a		✓		✓	Access to **Ambulatory Rehab** - timely; appropriate intensity; full interprofessional team
						✓	**Enhanced Community** (CCAC) **Rehab** services

Legend

- Minimal engagement. Work may be initiated, however less than 40% of the recommendation is being met
- Moderate engagement with 40% to 90% of the recommendation being met
- The majority of the parties are engaged and at least 90% of the recommendation is being met
- Not applicable

* IPC - Note concerns in Region re lack of SW, SLP, Psychology and Physiatry

** ESD as defined in stroke literature (Cochrane Review), intensive, interprofessional intervention with specific specialist training of rehabilitation, community care and stroke.

✓ Identified as priority

Appendix "D"
Executive Invitation

STROKE NETWORK *of* Southeastern Ontario

Ontario Stroke System
Fewer strokes. Better outcomes.

'Date"

"Address'

Dear: *(respective CEO's, CNE's, COS's, Board Chairs)*

ED/ALC and Patient Flow: Consider this Solution!

Invitation to Participate: *Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes in Southeastern Ontario using Stroke Care as a Model*, Wednesday, November 28, 2012

Strategies to improve patient flow and quality outcomes are of critical importance to our health care system. **Health system change requires proactive regional planning for rehabilitation access**. The Stroke Network of SEO is working with the region in alignment with the SE LHIN Restorative Care Clinical Services Roadmap to address rehabilitation access and system change that will **improve patient flow, maximize quality outcomes and reduce healthcare spending.**

You are invited to participate in a regional forum to lead the development of the rehabilitation plan that we **all** need to improve our health system. This forum, ***Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes in Southeastern Ontario*** will be held Wednesday, November 28, 2012, from 0900 to 1600 at the Days Inn, 33 Benson Street Kingston. The program objectives and forum agenda are attached.

The SE LHIN is supportive of using the stroke model as an exemplar for potential economic efficiencies that also will improve quality of care. SEO ALC data in relation to stroke care and rehabilitation access in our region will assist in providing some context:

- Stroke is the condition with the second greatest ALC rate across SEO
- One in three days of a stroke patient's acute care LOS is an ALC day (34% ALC days as a proportion of total acute LOS)
- Our SE Stroke Report Card indicates that access to rehabilitation is limited in our region. A smaller percentage of our stroke patients receive inpatient rehabilitation than across the province. Our patients endure longer rehab waits and a greater percentage go straight from acute care to LTC receiving no rehabilitation, despite evidence that even the more severe stroke patients stand to benefit from these services.

In 2013-14, the MOHLTC will introduce **Quality Based Funding** for stroke care that will incent best practices.

The absence of a consistent standard for provision of intensive inpatient and "slow stream" rehabilitation programs and the absence of outpatient day rehab programs in several parts of the region are contributing to these access and patient flow issues.

The Ministry of Health and Long Term Care established an Expert Panel on the Impact of Rehabilitation on ED/ALC rates and recently recommended the following best practices:

- Early access to rehabilitation
- Intensification of rehabilitation services
- Provision of intensive outpatient and community rehabilitation services

A provincial economic analysis of the provision of these best practices has indicated potential for significant cost savings. A related regional analysis is being applied to Southeastern Ontario.

In alignment with the Restorative Care Roadmap of the SE LHIN, **we are requesting executive leadership participation on November 28th to identify opportunities to leverage rehabilitation across the continuum of care in order to improve patient flow and quality outcomes in Southeastern Ontario.**

Please RSVP by fax to Charlette Eves at (613) 548-2454 using the attached **RSVP Confirmation Form by October 19th.** For further information please contact the Rehabilitation Forum Planning Committee leader(s) from your organization *"name"* and/or Caryn Langstaff, Regional Stroke Rehabilitation Coordinator by email at langstac@kgh.kari.net or by phone at 613-549-6666 ext 6841.

We look forward to seeing you on November 28, 2012.

Sincerely

_____

Karen Gill, Chair
Regional Stroke Steering Committee of SEO

cc RSSC members from respective organization
cc Planning Committee members from respective organization
cc Cally Martin, Caryn Langstaff
cc Dr. Puxty and Jo Billing, Co-Chairs, SE Restorative Care Clinical Services Roadmap
cc Sabrina Martin, ED/ALC Lead, SE LHIN

Appendix "E"
Participant Invitation

STROKE NETWORK *of* Southeastern Ontario

ED/ALC and Patient Flow: Consider this Solution!

Invitation to Participate

Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes in Southeastern Ontario using Stroke Care as a Model

Wednesday, November 28, 2012, Days Inn, Kingston Ontario

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In alignment with the Restorative Care Roadmap of the SE LHIN, the Stroke Network of Southeastern Ontario is requesting your participation on November 28th to identify opportunities to leverage rehabilitation across the continuum of care in order to improve patient flow and quality outcomes in Southeastern Ontario. Please let Sue Saulnier, Regional Stroke Education Coordinator, Stroke Network of Southeastern Ontario (saulnies@kgh.kari.net) know if you are able to attend. If you have any questions please contact Caryn Langstaff, Rehabilitation Coordinator, Stroke Network of Southeastern Ontario (lanstac@kgh.kari.net) or myself. We look forward to hearing from you. Please confirm your attendance as early as possible.

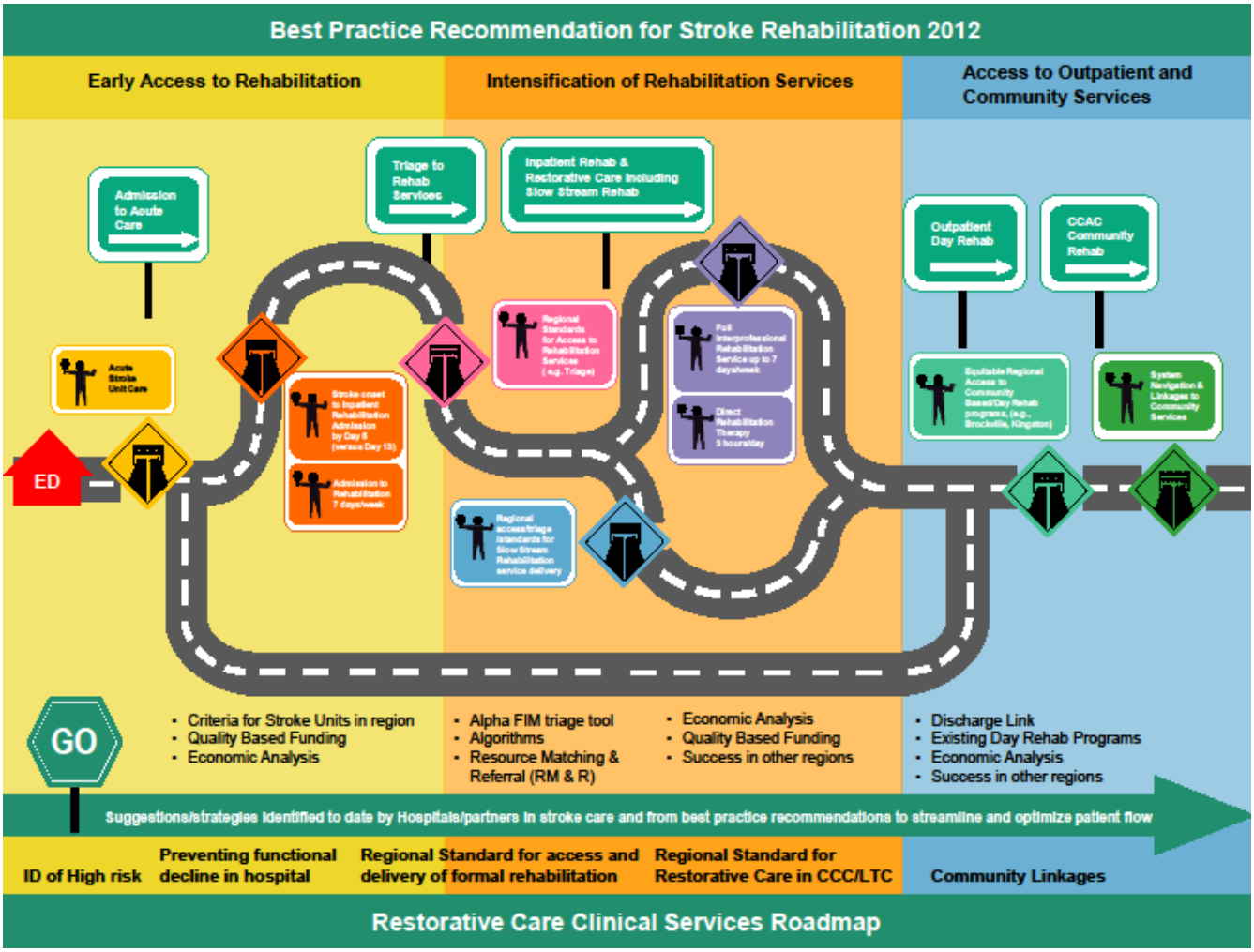
Appendix "F"
Agenda

STROKE NETWORK *of* Southeastern Ontario

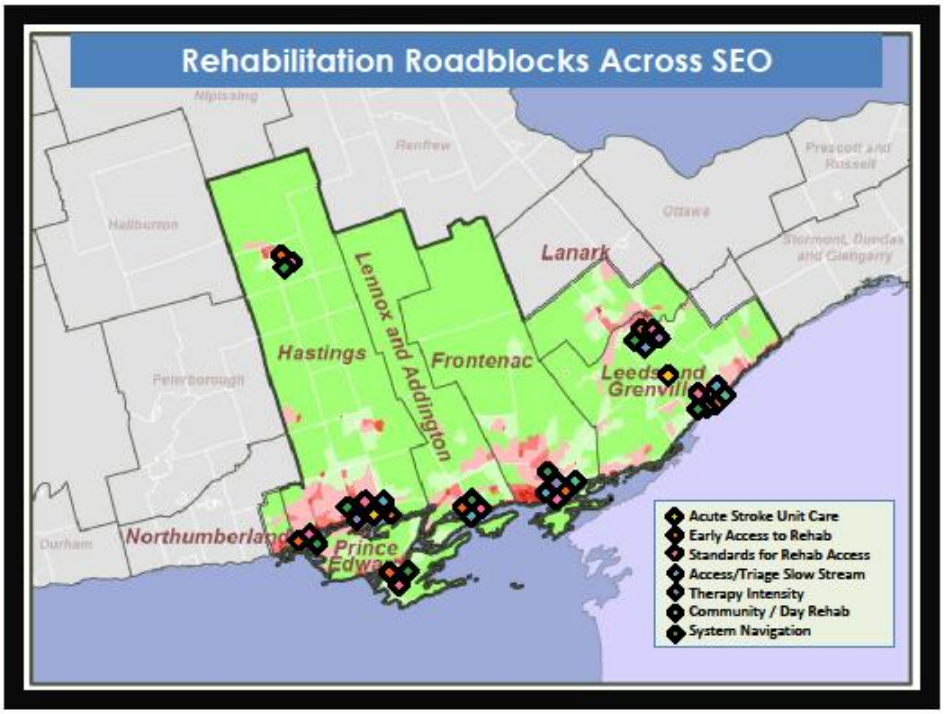
Leveraging Rehabilitation to Improve Patient Flow & Quality Outcomes
In Southeastern Ontario using Stroke Care as a Model
November 28, 2012,
Days Inn, Kingston Ontario
Agenda

Time	Agenda Topic	Presenters
0900-0910	**Welcome**	Caryn Langstaff, MSc, SLP(C) Regional Stroke Rehabilitation Coordinator,
0910-0920	**Connecting the Dots in Southeastern Ontario: Restorative Care Clinical Services Roadmap, Patient Flow and Rehabilitation System Change**	Dr. John Puxty, MB ChB FRCPC Co-Chair, Restorative Care Roadmap Geriatrician, Director, Centre for Studies in Aging & Health at Providence Care, Chair, Division of Geriatric Medicine, Queen's University, Director, Southeastern Ontario Regional Geriatric Program
0920-1005	**Provincial Context: Why Rehabilitation Matters; Repairing a Broken System**	Dr. Mark Bayley, MD, FRCPC Medical Director, Brain and Spinal Cord Rehabilitation Program Associate Professor, University of Toronto Chair, Stroke Evaluation Advisory Committee
1005-1025	**Break**	
1025-1110	**Patient Flow Roadblocks Across the Southeast: How Does Our Rehabilitation System Measure Up?**	Dr. Stephen D. Bagg MD, FRCPC Associate Professor and Head Dept. of Physical Medicine and Rehabilitation Queen's University & St. Mary's of the Lake Hospital
1110-1150	**Experiences of the Stroke Survivor: Humanizing the Patient Journey**	Steve Peirson Dan Brouillard
1150-1235	**Lunch**	
1235-1325	**Reducing Health Care Costs While Improving Patient Outcomes: A Regional Economic Analysis of the Impact of Rehabilitation Best Practice**	Matthew Meyer, BAH, Biology and Human Health, Project Coordinator, Ontario Stroke Network PhD Candidate, Epidemiology and Biostatistics, Schulich School of Medicine and Dentistry, Western Vanier Canada Graduate Scholar
1325-1335	**Reconnecting the Dots in Southeastern Ontario for Rehabilitation System Change**	Dr. John Puxty, MB ChB FRCPC
1335-1355	**Validating Rehabilitation System Roadblocks**	All
1355-1410	**Break**	
1410-1540	**Leveraging Rehabilitation to Improve Patient Flow and Quality Outcomes: System Opportunities** ➢ **What are the contributing factors that influence the roadblock?** ➢ **What would it take to remove the roadblock?**	All
1540-1600	**Reflecting on the Recommendations**	All

Appendix "G"
Rehab Roadblocks Graphic



Appendix "H"
Roadblocks – Geographic Map



Appendix "I"
Roadblocks Summary Worksheet

My Roadblock Contributing Factor and Solution/Opportunity Record Sheet

Contributing Factors • What are the contributing factors that influence these roadblocks?	Solution/Opportunities • What would it take to remove these roadblocks?
Acute stroke units	
Stroke onset to inpatient rehabilitation admission by day five and admission to rehabilitation seven days/week	
Regional standards for access to rehabilitation services (e.g. triage)	
Full interprofessional rehabilitation service up to seven days per week and Direct rehabilitation therapy three hours/day	

My Roadblock Contributing Factor and Solution/Opportunity Record Sheet

Continued (page 2 of 2)

Contributing Factors • What are the contributing factors that influence these roadblocks?	Solution/Opportunities • What would it take to remove these roadblocks?
Regional access/triage to slow stream rehabilitation	
Equitable regional access to community based/day rehabilitation programs (e.g. Brockville and Kingston)	
System navigation and linkage to community services	

Appendix "J"

Global Café - Rehabilitation Best Practices
Summary of Discussions

Acute Stroke Unit Care	
Contributing Factors to Roadblock	**Potential Solutions to Roadblock**
• Lack of dedicated/clustered resources/space • Lack of dedicated staff resources expertise • Inconsistency (MD/all staff) • Fluctuations in patient volumes • Patient flow/access competitions • No standard pathway/care pathway with challenges of access to documentation • PT/OT on weekends ($'s), general access issues • Multiple places where patients arrive (many hospitals accepting) • At point of admission identifying a patient with stroke (clinical and administrative) • Early involvement of the right people (PT, OT, etc.)	• Cluster access points (reduce # of receiving locations) • Champion/leaders → buy-in • Care plans with automatic consults (include team in care plan development) • Pre-printed order sets (NOT LONG!) • Regionalization of standards (share) • Broad group of people, bought-in • Education and awareness • Review process of assigning patient – increase consistency
Key Solutions	
• Cluster access points (less sites receiving) • Identify champions/leaders • Have a clinical pathway • Regionalization of standards (share and learn) • Educate and build awareness of the evidence • Develop processes that support consistency • Pre-printed order sets • You need a broad group of people to be bought-in	
Stroke Onset to Inpatient Rehabilitation Admission by Day Five; Admission to Rehabilitation Seven days/week	
Contributing Factors to Roadblock	**Potential Solutions to Roadblock**

• Lack of beds (rehab to ALC)
• Lack of bed (acute) – ED waiting for acute
• Separate locations
  ○ Diagnostics
  ○ Non-urgent transportation
  ○ Repatriation process absent (for medical decline)
  ○ Communication process
  ▪ ↑stability - ↓communication
• Lack of timely access – acute
  ○ Lack of referral to allied health
• Medical acuity
  ○ Issues not resolved in 5 days (e.g. tube feeds heparin drips)
  ○ Medical procedures/nursing (rehab unable to provide)
  ○ Staffing models – based on acuity, e.g. 1 RN for 24 beds in rehab/CCC
• Lack of full team over weekend – acute/rehab
	• Medical acuity – acute care pathways/transition pathway
	  ○ Formal repatriation process so patient can transfer back to acute
	• Acute physician support following transfer to rehab
	• Combined care model (physician) and IPC team
	  ○ ↑intensity with medically complex
	• Establish standards of acuity (receiving patients)
	  ○ Communication
	• Rehab specific transfer note – functional brief, efficient
	• Standard tools – functional access – AlphaFIM
	• Building capacity – staff education, RN for acuity issues
	• Mild strokes – rehab service in community – Day Hospital
	• Full IPC team – 7days
	• Discharges over weekend

• ICU stay - 24 hrs ICU – tPA; hemorrhagic may be 3 days ICU
• Lack of social work
• LOS – rehab – lack of community
• Awareness of LOS targets (best practice)
• 7 day admission
  ○ Physician coverage – Resident/Physician (not family doc)
  ○ Standardize criteria for docs
• Discharges difficult on weekends
  ○ Lack of confidence CCAC connection will be made
	• IPC – roles and responsibilities

Solutions

- Acute physician support following transfer to rehab
- Combined care model – all disciplines
- Building capacity – skills/education to handle early/severe strokes
- Full IPC team 7 days/week
- Discharges over weekend
- Rehab specific transfer note – function on admission and discharge
- Medical acuity – care pathways with transitions and benchmarks
- AlphaFIM and tools for assessing readiness
- Standards of acuity on rehab unit – communication (to rehab)
- "Step down" unit that can handle acuity and rehab together
- Interprofessional care roles/responsibilities
- Mild strokes to community

Regional Standards for Access to Rehabilitation Services (e.g. Triage)

Contributing Factors to Roadblock	Potential Solutions to Roadblock

• Lack of model to access – criteria lack consistency
• Even when processes exist there can be differences of opinion in how to interpret the process
• Issues of making a judgment call without a standard tool
• Not using AlphaFIM leaves lack of consistency
• Need flexibility to be patient-centred
• Lack of rehab beds – leads to movement to other beds even if rehab needed – CCC/ALC
• If don't end up in rehab then may end up in less intensive program while await rehab bed
• Limit to number of "slow stream" beds at SMOL rehab
• Unable to capture NRS rehab data on those receiving slow stream rehab or in undesignated beds (PSFDH)
• An incentive is that CCRS pays well for rehab
• Nursing model to support ↑activity in rehab
• Wait for diagnostics
• Patients being "medically stable" (If not stable, delays transfer and results in safety issues)
  ○ Unclear what "medically stable" means (means different things to different people/providers)
• Medical supervision needed for more acute patient (e.g., Intensivist vs family doctor)
• 80/20 paperwork! (need simpler) screen tools (outcome), inpatient assessment should be at 2 days
	• Physician understanding of impact of rehab
	• Roadmap – standardized process that all can use to understand (algorithm)
	  ○ Consistent referral process
	  ○ Patient flow coordinator
	  ○ Team leaders on Slow Stream Rehab and Rehab know process
	  ○ Definitions
	  ○ Standardized tool (e.g., AlphaFIM)
	  ○ Change to Quality Based Funding
	  ○ May require re-designation of beds to capture what is being provided (rehab vs acute or CCC)
	  ○ Training, expertise and nurse/patient ratio
	• Training of staff to handle ↑acuity:
	  ○ Lines/PICS
	  ○ Trachs
	  ○ IV antibiotics
	  ○ Total parenteral nutrition (e.g., PEG tube feeds)
	  ○ Anticoagulation / heparin drips
	• Pharmacy and staff available to handle issues like TPN 24/7
	• Staff mix
	• Transition "protocol" for physicians for transfer of care earlier in stay
	• Need for medical "safety net" built into the triage/standards
	  ○ Repatriation support and consult system
	• Better understanding of each other's constraints and how to

	help • Understanding change • Change management, especially with relation to transitioning • Job shadowing would help to build understanding across transitions (acute→rehab→CCC)

Solutions

- For stroke: standardized process for triage using an objective tool (AlphaFIM)
- Job shadowing to increase awareness
- Physician understanding of rehab
- Standardized process for both stroke and non-stroke patients
- More specific criteria for medical stability for rehab (look at Physical Medicine and Rehab)
- Training and expertise for all staff to deal with increase acuity
- Bed designation may need to change
- Quality Based Funding – prepare; awareness
- Transition protocols for physicians – consults; repatriation

Regional Access/Triage to Slow Stream Rehabilitation

Contributing Factors to Roadblock	Potential Solutions to Roadblock

• Who owns (SPR), where is this service located, what are the structures?
• Lack of knowledge re: this "continuum"
• Inconsistent use of term SPR (vs convalescent care, true reactivation, LTC)
• Clear definition
  ○ Amount of time
  ○ Frequency
  ○ Limited interventions (per week)
• Should "slow" stoke rehab remain in rehab beds
• Discharge supports/community for these clients outside LTC
• Role of the cognitive deficit patient in SPR vs AE
• Rehab resources
• Clarity in D/C planning processing for community risk patients
• Acute care consistent use of standard tool, e.g. InterRAI/FIM
• No similarity/consistency of the sector
• Mind sets that this is not a "passive" model
• Inequity in CCC restorative
• "Unique" use of term restorative
• Hard to help patients understand where they are going or should go
	• Remove/reassign term of "SLOW" as per the pace for this rehab sector
	• Should CCAC remove discharge plans as per access to convalescent beds
	• Add 2 or 3 SPR beds at regional facilities for the 16 SPR strokes/year
	• Preadmission data set to assess patient as SPR candidates
	• Regional agreement on an outcome tool for admission (InterRAI, AlphaFIM) from acute to sub-acute
	• Same definition SPR for region
	• Clarify CCC first then allocate the other programs
	• Equity in funding from LHINs for SPC in CCC across region

Solutions

- Define rehab services within CCC (CM, SPR, PCU)
- Clarify care plan/pathway for "the reality" of services
- Equity of funding across region for SPR in CCC
- Standard referral systems
  - Processes
  - Definitions
  - Triage
  - All sites

Full Interprofessional Rehabilitation Service up to Seven Days per week and Direct Rehabilitation Therapy Three Hours/Day

Contributing Factors to Roadblock	Potential Solutions to Roadblock

• Always done this way, nurses hold fort on W/E, new "team" dynamics
• Weekend passes sooner
• Chronic fatigue, portering time, number of assessments, significant cognitive issues
• Transfer patient - therapist – therapist?
  ○ i.e. learn from job share
• *HARD DISCUSSIONS/hope/HOME
• Current caseload, double book: 8, 10 varies
• Some patients need 2 therapist at once (OTA and OT)
• Psychsocial need for Social Worker and Rec. Therapy
• Family status / coping
• Depression / deconditioning
• FUNDING – not aligned
  ○ Therapists seen as burden of costs
  ○ Not seen as saving money
• Critical mass/many other diagnoses
  ○ Certain number to make it worth doing/clustering
• Recruitment/retention/casual
  ○ Backfilling
• Lack of standardized care
• Culture for rehab professionals - not always organized; caseload transition and collaboration
• Staffing shifts
• Philosophy of care/staffing models
• Medicine – more nursing oriented
• Rehab – more therapy
• Too much time charting
• Repeated assessments
• "College says you have to do assessments"
• Measuring minutes of therapy, not visits/attendance
• Administrators don't consistently understand best practice
• Administrators have to make tough decisions
• Therapist expertise and comfort with stroke
• Flexible hours
• Support systems – hospital need to be present
• Physicians need to be aware
• How do patients get a chance at home if there are limited weekend passes?
	• What would it take to remove this roadblock?
	• Full Interprofessional rehab team 7 days/week x3 hrs/day
	• Redevelopment
	  ○ 80% therapy on unit
	  ○ 'bits' of therapy, real time, i.e. assess during meals (dietician/SLP)
	• ↓depression, deconditioning
	• New times of work? 0830-1630, 1000-1800
	  ○ +Achieve balance
	  ○ + weekend +GROUPS
	• Learn from job share expertise
	• Tight teams
	• ↑Student placement
	• 6 = doable caseload/scope
	  ○ ↑Safety net at home (patient, family) ↑Confidence and readiness for discharge
	• Educate senior leadership
	• More non-nursing leadership
	• Show economic analysis
	• Aligning funding with best practice
	• Coverage schedule for therapists
	• Interprofessional treatment plan electronic patient record
	• Education of all team as to treatment, e.g. sit – pivot – transfer
	• Educate patients/families
	• Working collaboratively with community, e.g. home assessment
	• Use assistants on weekend

Solutions

- Open mind to use resources better/different! i.e. ↑ education to OTA/PTA/CDA
- Inpatient and Day Rehab 7 days/week
- 7 day interprofessional treatment plan
- More groups on weekend – ↑ space; quiet
- Try to make weekends more comfortable – innovate schedules
- Stagger hours, i.e. 0830-1630; 1000-1800, choice, PFFC
- Rec Therapy non-traditional hours, i.e. community reintegration

- Creative collaboration, i.e. PT and Rec (TC); Rec and SLP (CG); OT and PT
- Use of rehabilitation assistants
- Full scope! – OTA, PTA, CDA – autonomy
- Nursing staffing on weekends – same as therapy
- ↑ nursing role in supporting rehab specialty/rehab
- Family participation on weekend:
  - ↑safety net
  - ↑confidence
  - ↑readiness
- Aligning funding with best practices (Quality Based procedures)
- Educate senior leadership
- Educate physicians about change
- Mechanisms for hand-off
- Educating patients
- Discuss transition with CCAC community therapy

Equitable Regional Access to Community Based/Day Rehabilitation Programs

Contributing Factors to Roadblock	Potential Solutions to Roadblock

• Lack of accountability/responsibility by hospital for community care – (not CCAC)
• Respond to immediate pressures for cost control without a long term system vision
• Silo for business approach (across province)
• Attention is on centre not on outreaching impact
• Need to recognize quick fixes aren't working
• Different community priorities
• Transportation
• Rurality of services
• Fear of of becoming territorial about jobs, programs if re-route dollars
  ○ Balancing community/hospital funding
• Lack of education services/resources – available or consistent
• Lack of understanding that what might work or be necessary in hospital, is not the same in home
• Many clients fall through cracks – criteria may be too narrow; as well inconsistency of admission criteria across programs
• COMMUNICATION – patient and provider lack of knowledge
• Variety of different service models, outpatient-day rehab
  ○ Makes communication and consistency challenging
• Remember community = CCAC DAY/OPT
• Confusion with what programs are and provide
• Long term availability services
• Geography
• Human resources – short term and long term
• TRUST that community can do the job – it may be done differently but can be equally effective
• Use of assistants
• Tradition ≠ innovation
	• Recognizing long term role of family health teams
	• New perspective of who provides outpatient care
	  ○ Shared CCAC/outpatient with remote areas to ↓client travel
	  ○ Mobile unit
	• More SE LHIN direction focus on system across hospitals; more dialogue between senior leaders and experts (therapy) – from those that do the work
	• $ for transportation assistance
	• Stroke survivors to help educate family/stroke clients (stroke survivor group)
	  ○ ↓stress, help transitions, tap into existing models/frameworks , e.g. MS Society
	• LHIN support, e.g. regional network
	• Rehab lead/champions (if not enough volume per site to get expertise) to help education; best practice; bring consistency across region – again aligns with system approach
	• Standard admission criteria and models of care across sites
	• ↑Networking – regularity between sites/professionals
	• How to support in community
	• Better use electronic/tech
	  ○ Blog
	  ○ E-Forum
	  ○ StrokEngine
	  ○ Teleconference/videoconference
	  ○ Taped webinars
	• Group email lists
	• Reallocation and reprioritization of current outpatient resources
	• Consistent and predictable – long term funding for community programs
	• Expertise and resources to evaluate programs = expertise

- **Lack of knowledge**
  - Educators
  - Clients
  - Providers
  - Policy makers
- Rehab systems – mod-severe stroke….not getting referred
- Stereotyping a "rehab patient"
- Wait lists – related to $
- Communication between team
- Electronic Medical Record within and between sites
- Lack of Day Rehab and Outpatient
- Current outpatient models – don't fit need
- Inconsistent funding – staffing issues
- Extensive assessment process
- No direct access from acute to Day rehab
- Staffing issues
- Communication structures between acute → rehab
- Physician understanding of services
- Space (place for lunch, rest….)
- Transportation
- Geography – rural
- Accessing stroke expertise
- Currently funding models
  - Access to rehab professionals at primary care
- Individual cost /$
- Self-management – facilitator of health
- Describe/define rehab
- Educate students
- Centralize and have transparency, re: resources
- Stroke network $ - ongoing to maintain expertise and gather evidence
- Triage at acute care to determine - *more systematic process
- Education – standardized and efficient tools to make early decisions
- Early patient information at acute care, i.e. visual map
- Electronic mapping of resources to patients
- Resource matching
- Establish team of community stroke experts
- Mobile stroke team
- Shared care – with primary care teams
- Build capacity at primary care
- Ramp up "shared work day/fielding training"
- Subsidizing other community programs

Solutions

- Opportunities/innovation:
  - Create an interactive series of case scenarios links to acute stroke to educate and correct stereotypes
  - Knowledge-based (evidence – tacit – 1 med experience) informal consistent funding models
- Early information to patient about community services
- Timely patient information to community provider services
- Build expertise of community providers
  - Shared care with primary care providers/team
  - Ramp up current initiatives "shared work day"
- Access to Day Rehab – community services
  - EMR – communication (between teams); transportation
  - Tension between expertise and dispersion of knowledge
  - Community stroke team
  - Primary care capacity
- Building community capacity
  - Patients; educators; policy makers; providers
  - Expertise
    - About stroke care
    - About rehab
    - About community resources
  - Funding
    - Predictable – 1 term funding
- Systems/policy change – "land of pilot projects"
- Direct referral to Day Rehab
  - Short/efficient
  - Assessment
- Facilitate access/transportation to rehab centres

- Need more community/day rehab/outpatient resources
- Describe/define rehab
- Standardized education
  - Efficient tools to measure/benchmark
- Remembering:
  - Community – Day Rehab, Outpatient, CCAC, private, peer supports, other community programs, FHT
  - ALL OF THIS
- Communication
  - Client and family via – stroke survivor; build on other frameworks
  - Professional – e-communication; network; shared care; rehab advisory
  - System senior leader dialogues
  - SE LHIN – directive; focus on system approach
- Consistency vs standardized of care
  - Common admission criteria
  - Common service delivery modes
  - Regional rehab lead
    - Support, education
    - Build experience
- Model of delivery
  - $ transportation
  - Use of mobile units
  - Potential FHT for long term care vision
  - Shared care opportunities, outpatient – community
  - Geography
  - Human resources
- Improve communication between teams and facilities who offer community rehab
- Make community resources transparent
- Stabilize funding for resources

System Navigation and Linkage to Community Service	
Contributing Factors to Roadblock	**Potential Solutions to Roadblock**

• Whether resources are available
• Knowledge of available resources
  ○ Need inventory
  ○ Community needs assessment
• Not a seamless process – blocks exist across system and not just when going home
• Need to enhance partnerships and bring community resources into hospital (info)
• Services not overt/known to patients/families/health service providers
• Lack of system/service navigation
  ○ *Lack of clear identification of those who need extra support
• Timeliness and continuation of the system navigation, "passing the baton" - *for caregiver
• Problems with referral process and transportation to get there
	• Care pathway – for system navigation
	• Focus on the caregivers
	• ↑peer support for like conditions
	• Complete community assessment of resources and gaps
	• Dedicated resources for system navigation
	• Earlier and continuous navigation throughout the system – throughout the journey
	• Streamlined referral process and supports to get to site for care/services
	• Strengthen team approach and integration of resources
	  ○ Bringing community resource rep into hospital
	• Single point of contact

Solutions

• System navigation and linkages to community
• System navigation - should be depicted in illustration to show its importance across, throughout the journey
• When people are linked appropriately in community, don't return to hospital
• Earlier, dedicated, continuous system navigation for community services, e.g. navigation pathway
  ○ Introduction to community services – bringing into hospital setting – discuss prior to discharge how they can assist a client
• Need for a single point of contact for community services/resources
  ○ Provision of info re: services for H.S providers
• Community needs assessment gap identification
  ○ Acknowledge transportation to be a huge barrier and recommending a focused LHIN supported strategy be developed
• Enhancing peer support groups

Appendix "K"
Stroke Rehabilitation
Resource List

The Canadian Best Practice Recommendations for Stroke Care are intended to provide up-to-date evidence-based guidelines for the prevention and management of stroke. The goal of disseminating and implementing these recommendations is to reduce practice variations in the care of stroke patients across Canada, and to reduce the gap between knowledge and practice. Recommendations are updated every two years to ensure they continue to reflect contemporary stroke research evidence and leading expert opinion. Visit their website at: **http://www.strokebestpractices.ca**

Through its membership in the Ministry of Health and Long Term Care ER/ALC Rehab/CCC Expert Panel, the Ontario Stroke Network established stroke rehabilitation standards of care. This resource centre provides health system planners and clinicians with descriptions of the stroke rehabilitation standards, tools to support implementation and success stories. Visit the OSN Rehab Portal at: **http://www.ontariostrokenetwork.ca/rehab.php**

Evidence-Based Review of Stroke Rehabilitation is the most comprehensive and up-to-date review available examining both therapy-based and pharmacological interventions associated with stroke rehab. Visit EBRSR at: **http://www.ebrsr.com**

StrokEngine has been developed with the support of the Canadian Stroke Network to support the use of evidence-based stroke rehabilitation in clinical practice. StrokEngine is recognized for its scientific rigor by the Canadian Cochrane Center. Visit Stroke Engine at: **http://strokengine.ca**

The Stroke Network of Southeastern Ontario is one of 11 regional systems established across the province to work with the Ontario Stroke System and our regional communities to achieve our Vision and Mission. The Vision of the OSS is "*Fewer strokes. Better outcomes*". The Mission is "*to continuously improve stroke prevention, care, recovery, and reintegration*". **http://strokenetworkseo.ca**

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Appendix "L"
Local Level Input from Participant Survey

Local Area	What opportunities for system change do you feel most compelled to support?	For these opportunities please provide suggestions for how this local level follow-up can be supported.
Hastings Prince Edward	• Use of Alpha FIM to support referral/triage processes. • Clustering of stroke in both acute and rehab settings. • Human resources • Education at the acute care stage to plan for best practice rehabilitation outcome • Acute stroke unit care • Regional standards for access to rehabilitation services	• Education on best practice at the acute care stage
KFL&A	• Moving resources to allow earlier access to rehab. • Education in rehab setting to handle medical acuity • More access to pharmacy, physician coverage, lab, etc. • Out-patient services being available in all parts of the region through infrastructure in one place or through a mobile unit. • Day hospital options being maximized in SMOL and the smaller acute care hospitals - Brockville, L&A (already in QHC and Perth/Smiths Falls) • Regional access/triage to slow stream rehabilitation -- having our clients/patients be admitted to rehab. earlier (when medically stable) • Increase in available rehab beds to accommodate patient when ready for transfer • Up to seven days per week of direct rehab therapy hours/day as tolerated • Increasing knowledge base/clinical expertise of the CCAC allied health. • 7 days and 3 hours per day of rehab • System change cannot be done in isolation. There needs to be a plan to ensure change can be rolled out across the continuum of care. • Better coordination between the acute providers and the specialized rehab provider or the community agency that will support the patient • Acute stroke unit care and timely admission to rehabilitation	• Clear criteria for slow stream vs regular stream rehab and consistent way of triaging these patients. • Until out-patient services can be enhanced, extra funding to CCAC for PT and OT in the community, similar to Enhanced therapy model. • Funding • Education in the community; shared work days. • Encouraging teams to host/preceptor students from diverse professions to see how collaboration works in practice. • At local level get the acute care and the rehab stakeholders together to enable inpatient rehab admission by day five and seven day admission to rehab.

Lanark	• Front loading of service as soon as possible after admission. • Consistent, objective access to rehab • equitable regional access and services as this is where i can contribute • Stronger/better communication linkages amongst the stroke service providers. • 7 day a week therapy, 3 hours per day	• Lobbying LHIN, MOHLTC to make sure bureaucrats understand the importance of rehab. • Allocating funding to having therapy on weekend; and/or additional training for nurses for therapy goals. • Physician education on the benefits to rehab. Nursing education also required to influence physician practice, especially in acute care • Standard criteria and service models; • Patient/client support and education programs • Bringing together all of the players who can truly effect change to the system. • Human resources • Develop a general activity program for the weekends where all stroke patients could be involved no matter what their deficits.
Leeds Grenville	• In-patient pathways that allow automatic referrals to allied health. • Establishing Acute Stroke Units. • Equitable regional access and services • Stronger/better communication linkages amongst the stroke service providers.	• Best practice guidelines being outlined, disseminated and implemented • Provide support with acute strokes • Establish guidelines to determine rehab readiness. • Standardization of criteria and service models; • Patient/client support and education programs • Bringing together all of the players who can truly effect change to the system.