



**Acute - Rehab - Community (ARC)**  
**Stroke Services and Transitions**  
**Moving Towards One Team**

***Presented by: Shelley Huffman***

***November 27, 2019***

# “One Team”

***The system needs to function as “ONE team” from the patient’s perspective.....***



## Activities

- ✓ SE Stroke Pathway with common components and parameters
- ✓ Self-assessment of team core elements within and between teams
- ✓ Regional Forum September 2019 – learn and be inspired



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

Clinical teams provide care and support transitions that are in alignment with QBP/CSBPR including:

- Standardized evidence-based Care
- Expert Interprofessional Team Care
- Interprofessional Case Conferencing
- Information to Primary Care

## Acute to Rehab

## Rehab to Community

### Acute Stroke Care

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

### Severe: Alpha FIM <40

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

### Moderate: Alpha FIM 40-80

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

### High Intensity Inpatient Rehab

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

### Home care referral –

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

OR

### Outpatient Therapy

- Referral and first appt confirmed for 72 hours post discharge

### Community supports

- Referral and/or consent for future follow up

### In home or Outpatient Rehab

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

### In home or outpatient Rehab to Community

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

## Acute to Acute

## Acute to Community

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

### Mild --- Alpha FIM 80+ (90+)

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

### Home Care Coordination

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

ACTIVITIES

INDICATORS

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

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

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

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

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

- # Referrals and # participants - stroke support groups and aphasia groups

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

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

# Self Assessments

Included 2 components - core elements within team activities and transition elements

Self-assessments completed with:

- Acute (3 teams), Inpatient Rehab (4 teams), Outpatient Rehab (2 teams), Home and Community Care (LHIN), Community Rehab Providers (3 teams), Community Support Services (3 teams)

Rankings: Complete, Partial or Incomplete on each elements

# Examples - within team

## Acute Stroke Care – Self-Assessment

ASU	Requirement	Site 1	Site 2	Site 3
1	Acute Stroke Unit (ASU) (Target 80%)	P	C	C
2	CSBPR/QBP recommended treatments/evidence based care	P	C	C
3	Interprofessional team (MD, RN, PT, OT, SLP, RD, SW)	C	I	C
4	Team available 7 days a week ( PT, OT, SLP specifically)	I	P	I
5	Critical Care Support available	C	C	C
6	Cardiac Monitoring	C	C	C
7	Diagnostics completed in timely manner	P	C	C
8	Dysphagia Screening	C	C	P
9	Neuro Monitoring	C	C	C
10	Allied Ax - within 24 - 48 hours	P	C	C
11	Mobilization within 24 hours (unless contraindicated)	C	C	C
12	Cognition Screening	C	C	C
13	AFIM by Day 3	P	P	C
14	Early rehabilitation initiated post-assessments	P	C	C
15	Patient/Family Education and Support/Stroke Information Package	C/P	C	P
16	Patient and Family Discharge Communication Process	C	C	C

# Examples - Transition

## Community Stroke Rehab - Transition to Community Supports - Assessment

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

# Self – Assessment Summary

- Significant **commitment and experience** to provide stroke service and supports across the continuum
- Teams **vary in their access to data** for input into their self-assessments
- **Allied health resources** a challenge across the region
- System (after hyper-acute) functions **5 days/week** impacting response times between transitions
- **Gaps in creating warm hand-offs** and closing the feedback loop between services
- Passion for stroke care across the region – interest in **learning from others**



# Regional Event

## Goals:

- To share current state of stroke services and transitions
- To identify regional and local opportunities to support clinical implementation of a seamless, high quality patient experience in preparation for bundled funding



# Voice of the Stroke Survivor

*“Though it is not your first experience working with a stroke survivor/caregiver, it is our first and everything is new, we are anxious and scared. You may need to repeat information several times as we do not always retain what you have said.”*

*“Our situation and support requirements may change over time, we need to be advised on what to do or how to access additional services at a later date.”*

*“Be patient, do not rush...”*



# Learning about Integrated Stroke Care from Waterloo Wellington

- Integrated planning and system integration across partner sites
- Automatic acceptance pathways to rehab
- Coordinated bed access for rehab beds
- Stroke Navigator role
- Use “bands” of stroke severity to guide pathway
- Community Stroke Rehab – offered as a program of care/pathway model, includes weekend first visit, use of assistants



# Improving Home to Community Transitions... Suggestions

- **Consistent use Stroke Information Package**
  - *Reviewed with a person – not just the “paper”*
  - *Use of transition checklist to ensure it happens*
- **Booking Appointment in next part of the continuum – e.g. SPC, OP therapy**
  - *Record all appointment in one spot*
- **Ensuring appropriate referrals/linkages**
  - *Checklist for referrals made/available to all team*
- **Ensuring next care provider has needed information**
  - *Integrated report for all team members*



# What Participants Had to Say....

“Stroke survivor’s reminded me that this is their first stroke and so I need to address them, educate them, support them as such. SLOW DOWN!”

Better communication is required at points of transition; ensuring our patients have the appropriate information at discharge

More of these (sessions) please - where people come from across the numerous phases patient journey. The more we share and know each other - the better the system becomes.”

# Moving towards “One Team”

## Regional support:

- Develop navigation supports/skills
  - Workshop 2020
  - Toolkit
  - Communication guide for providers to explain system elements/transitions to patients
- Spread use of Stroke Information Packages; include patient journey map
- Linkages and learning from others
- Check in and support local action plans for improvement ideas/sharing



# Moving towards “One Team”

## Local changes:

- Ensuring use of stroke information package prior to hospital discharge
- Spread of consent process for stroke support contact in the community
- Make Use of Patient journey map
- “Fast Track” to improve access to rehabilitation in Kingston
- Improved communication strategies between teams



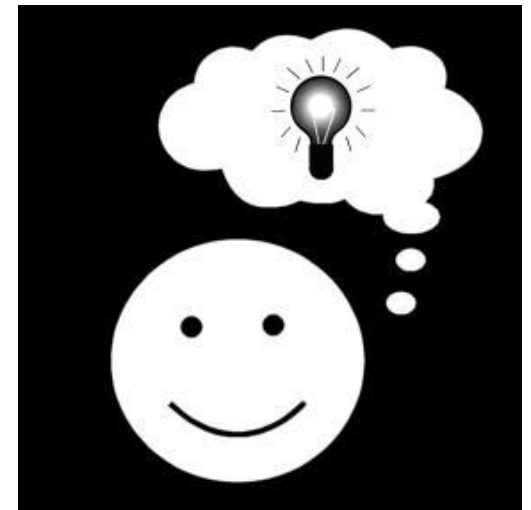
Building  
Stronger  
Links

Share what you or your team/partners are working on!

# Moving towards “One Team”

## What can I do today.....

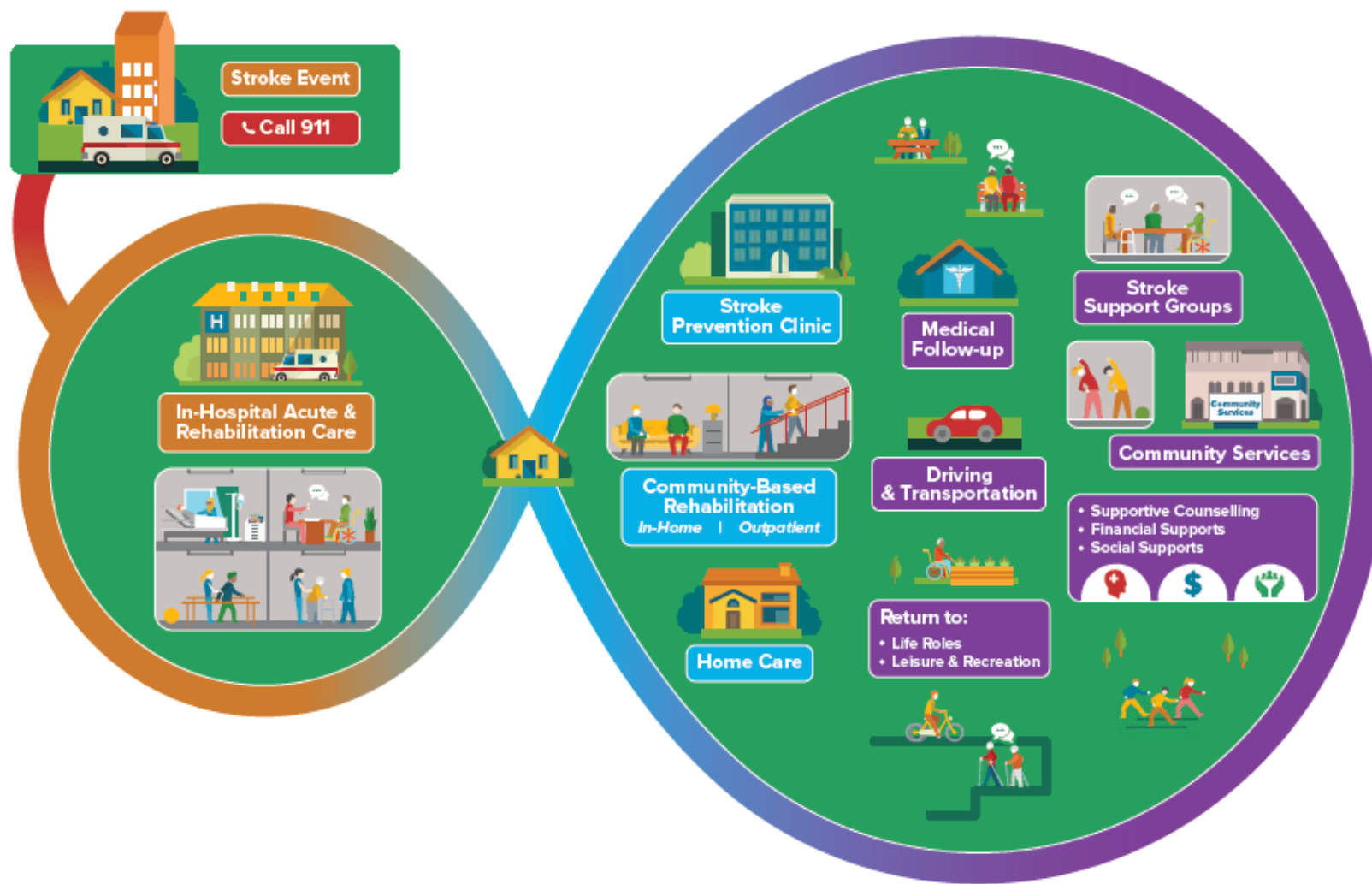
- Be patient/slow down when teaching patients about steps in their journey
- Practice “warm hand off” between teams whenever possible
- Set up the next phase of the journey for success by sharing information
- Learn about other parts of the journey to help with navigation





# YOUR RECOVERY JOURNEY AFTER STROKE

STROKE NETWORK  
of Southeastern Ontario



Recovery Begins

Transitioning to Community

Recovery Continues