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

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

Acute to Rehab

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

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

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

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

Rehab to Community

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

OR

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

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

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

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

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

Acute to Acute

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

Acute to Community

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

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

ACTIVITIES

INDICATORS

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

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

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

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

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

Referrals and # participants - stroke support groups and aphasia groups

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