

Background

Timely Transfer of Appropriate Patients from Acute Facilities to Rehabilitation: Early Access to Stroke Rehabilitation across the Continuum

Current State:

Currently in Ontario, our system of care does not always provide stroke survivors with appropriate, timely and equitable access to stroke rehabilitation. Data collected through the Ontario Stroke Evaluation Program indicates:

*Access to timely, intensive stroke rehabilitation will result in **decreased mortality, less need for LTC, more people returning home, and more people having improved quality of life.***

- The median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation varied across the LHINs from 7.0 – 15.0 days¹.
- The proportion of stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation varied across the LHINs from 23.7 – 38.7% (provincial benchmark 42.3%)¹.
- The proportion of Stroke/TIA patients treated on a stroke unit at any time during their inpatient stay ranged across the LHINs from 0.0 – 70.1% in Ontario (provincial benchmark 87.5%)¹. Stroke unit care is associated with improved outcomes, early assessment of rehabilitation needs, accelerated mobilization, and provision of early rehabilitation therapy².

Evidence:

Stroke survivors benefit from timely intensive rehabilitation services delivered by a specialized interprofessional team². The Stroke Reference Group recommends transfer from acute care to rehabilitation by **day 5 for ischemic strokes and day 7 for hemorrhagic strokes**^{3,4}. Depending on stroke survivors' needs, this rehabilitation may be delivered on an inpatient stroke rehabilitation unit, as an outpatient, or in the community.

Impact:

The earlier the rehabilitation starts, the better the outcome. "In fact, people who start rehabilitation later may never recover as much as those who start early"² (Lindsay et al, 2010, p 106). Access to early, intensive, appropriate stroke rehabilitation improves functional status of stroke survivors. Evidence demonstrates improvement in arm and leg motor recovery, walking mobility, independence in self-care, participation in leisure activities, positive communication outcomes, increased well-being and social participation, and enhanced swallowing function².

When organized rehabilitation care is provided on a stroke unit it has been additionally shown to:

- reduce death and disability
- reduce the need for institutionalization
- reduce hospitalization length of stay
- increase walking mobility, functional status, and quality of life².

Access to Outpatient and Community-Based Stroke Rehabilitation:

- improves independence
- is associated with improved functional outcomes, and reduces the odds of poor outcomes
- enhances mobility and fitness
- reduces or prevents the number and severity of falls
- enables clients to access relevant information about community programs and resources
- increases participation in functional activities of daily living and extended activities of daily living
- reduces potential for hospital readmission and healthcare and caregiver burden².

The time is right to make rehabilitation system change:

Improved and timely access to best practice stroke rehabilitation will lead to improved health system flow and provide an opportunity to alleviate Emergency Department (ED) and ALC pressures⁴. Timely access to best practice stroke rehabilitation across the care continuum will also improve functional outcomes of stroke survivors.

For more information on timely access to stroke rehabilitation, please contact the:

Regional Director, Stroke Network of SEO at 613-549-6666 x3562 or martinc@kgh.kari.net

Or the Ontario Stroke Network at 416-489-7111, www.ontariostrokenetwork.ca or info@ontariostrokenetwork.ca

References:

- 1 Hall R., Khan F., O'Callaghan C., Kapral MK, Hodwitz K, Fang J., Bayley M. (2012) *Ontario Stroke Evaluation Report 2012: Prescribing System Solutions to Improve Stroke Outcomes: Ontario Stroke Report Card, 2010/11*, Toronto: Institute for Clinical Evaluative Sciences.
- 2 Lindsay M.P., Gubitz G., Bayley M., Hill M.D., Davies-Schinkel C., Singh S. and Phillips S. (Update 2010). *Canadian Best Practice Recommendations for Stroke Care. On behalf of the Canadian Stroke Strategy Best Practices and Standards Writing Group. 2010*; Ottawa, Ontario Canada: Canadian Stroke Network. Retrieved from: www.strokebestpractices.ca.
See: Best Practice Recommendations 5.3 – Delivery of Inpatient Stroke Rehabilitation; 5.2 Stroke Rehabilitation Unit Care; 5.6 Outpatient and Community-Based Stroke Rehabilitation.
- 3 Rehabilitation and Complex Continuing Care Expert Panel. (2011) *Rehabilitation and Complex Continuing Care Expert Panel: Phase I Report*. Toronto, Ontario. Retrieved from: <http://www.nelhin.on.ca/WorkArea/downloadasset.aspx?id=11680>
- 4 Meyer M., O'Callaghan C., Kelloway L., Hall R., Teasell R., Meyer S., Allen L., Leci E. (2012) In collaboration with Ontario's Stroke Reference Group. *The impact of moving to stroke rehabilitation best practices in Ontario. Final Report*. Retrieved from: http://ontariostrokenetwork.ca/pdf/The_impact_of_moving_to_stroke_rehabilitation_best_practices_in_Ontario_OSN_Final_Report_Sept_14_2012.pdf