Community Stroke Rehab
A Pilot Project in SD&G

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Canadian Best Practice Stroke Recommendations state that stroke survivors with continuing rehabilitation goals should have access to specialized community rehabilitation after leaving the hospital or inpatient rehabilitation.
The Ontario Quality-Based Procedures: Clinical Handbook for Stroke states individuals with residual impairment after stroke should receive therapy services to set goals and improve task—oriented activity.
In Champlain, less than 1/3 of stroke survivors receive a referral to outpatient rehabilitation compared to the provincial benchmark.
Patient Flow Algorithm

(Champlain Regional Stroke Network Presentation November 12, 2015. Presented by Beth Nugent, Interim Director CRSN)
Community Stroke Rehabilitation for Stormont, Dundas, Glengarry & Akwesasne

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Introduction

- Canadian Best Practice Stroke Recommendations state that stroke survivors with continuing rehabilitation goals should have access to specialized community rehabilitation after leaving the hospital or inpatient rehabilitation.
- The Ontario Quality-Based Procedures: Clinical Handbook for Stroke states individuals with residual impairment after stroke should receive therapy services to set goals and improve task-oriented activity.
- Community stroke rehabilitation, including therapy in the home, is currently provided across Ontario in the South East, Waterloo Wellington, South West and Hamilton Niagara Haldimand Brant LHIN.
- In Champlain, less than 10 of stroke survivors receive a referral to outpatient rehabilitation compared to the provincial benchmark.

Objectives

- Short term: plot community stroke rehabilitation in the SDG-A area to optimize a Champlain service delivery model, optimize outcomes for stroke survivors and optimize use of acute and inpatient resources.
- Long term: continue to expand access to outpatient and community stroke rehabilitation services across the Champlain region.

Methodology

- The authors of this poster were members of a working group to prepare an HSP funding proposal to the Champlain LHIN, submitted July 2015.
- The proposal reflected program design that incorporated GBP clinical guidance, the Champlain Regional Stroke Rehabilitation System, appropriate budget suggestions from the LHIN and input from stroke survivors and care partners.

Table 1: Clients Recommended to Receive Outpatient Rehab?

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Characteristics</th>
<th>Care Pathway</th>
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<tbody>
<tr>
<td>Mild Stroke</td>
<td>AlphaFIM score 81-116, without other major complications</td>
<td>Acute care, then outpatient or community rehabilitation</td>
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<tr>
<td>Moderate Stroke</td>
<td>AlphaFIM score 41-80 or higher with complications (age, cognitive issues, severe apraxia, others)</td>
<td>Acute care, inpatient rehabilitation, then outpatient rehabilitation</td>
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<tr>
<td>Severe Stroke</td>
<td>AlphaFIM &lt;41</td>
<td>Acute care then possibly inpatient rehabilitation or COC followed by inpatient rehabilitation then outpatient rehabilitation in community or LTC</td>
</tr>
</tbody>
</table>

According to GBP, almost all stroke patients discharged to community should receive rehabilitation subject to criteria. Examples: criteria for admission for inpatient rehabilitation: medically stable, potential to progress, ability to learn and retain information, endurance/ambulation of 30-60 min therapy plus travel time 3-4 times per week.

Lower endure could be treated in the home.

References


INTEGRITY • COMPASSION • ACCOUNTABILITY • RESPECT • ENGAGEMENT
Community Stroke Rehabilitation Program

Jeanne Bonnell, Program Manager
Dorothy Kessler, Project Manager
Program Overview

* Specialized outpatient stroke rehabilitation service
* Provides intensive, time-limited rehabilitation
* Focus on individual client goals and integration into community programs and services.

* Professional services:
  - Care coordination
  - Nursing
  - Occupational therapy
  - Physiotherapy
  - Communication therapy
  - Social Work

* Clients receive therapy 1-2 times/week for up to 8 weeks in a clinic setting Cornwall (Centre de Santé Communautaire de l’Estrie) or in their homes
Admission Criteria

- Diagnosis of recent stroke
- Discharged from hospital and residing within the Stormont, Dundas, Glengarry region and Akwesasne (Ontario) area
- Discharge to home or a Retirement Home
- Medically stable
- As a guideline, clients admitted directly from acute care should have a discharge AlphaFIM® > 80.
- Ability to learn and retain information
Admission Criteria

* Potential to progress
* Endurance/tolerance of 30 – 60 min of therapy
* Able to identify goals related to functioning at home or in the community, willingness to participate
* Able to attend therapy alone or a caregiver is available to attend therapy sessions if assistance is required
* Potential to travel to clinic for some therapy
Referral Process

* Ensure the patient meets all of the above admission criteria
* Complete a CCAC referral form
  a. Under “Relevant Diagnosis/Information for referral”, indicate Community Stroke Rehabilitation Program and specify therapy discipline(s) required
  b. Include relevant discipline reports and contact information.
* Fax referral to Hospital Portal (regular hospital CCAC fax number) between 8 am - 3 pm Monday to Friday
Next Steps

- Go live – January 18-25
- Communication
  - CCAC Information sheets (English/French)
  - Presentation to stakeholders
- Evaluation
  - Short term – monthly
  - Long term – every 6 months/yearly