Community Stroke Rehabilitation Program

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Creating the Community Stroke Rehab Program

- Lack of outpatient services in Champlain
- Strategic and Operational goal of Champlain Regional Stroke Network
- Collaborative effort over ~12 months
  - Reviewed: the literature; similar programs in other LHINs, provinces, countries; QBP recommendations
  - Working Group, Patient Focus Groups informed service delivery model
  - HSIP to LHIN with CCAC as lead service provider and numerous partners (e.g. CCH, HGMH, CRSN, CSCE)
- Champlain LHIN funded for 1+ year pilot
Program Overview

• Specialized outpatient stroke rehabilitation service
• Provides intensive, time-limited rehabilitation
• Focus on individual client goals, promoting self-management and integration into community programs and services.
• Professional services:
  - Care coordination
  - Nursing
  - Occupational therapy
  - Physiotherapy
  - Communication therapy
  - Social work
• Clients receive therapy in a clinic setting (Cornwall Centre de Santé Communautaire de l’Estrie) or in their homes
Admission Criteria

- Resident of Stormont, Dundas, Glengarry region and Akwesasne (Ontario) area
- Diagnosis of recent stroke
- Discharge to home or a Retirement Home
- As a guideline, clients admitted directly from acute care should have a discharge AlphaFIM® > 80

- Referrals must come through CCAC Hospital Care Coordinator
- Fax referral to Hospital Portal (regular hospital CCAC fax number) between 8 am - 3 pm Monday to Friday
Service Delivery

- At enrollment, patients are:
  - Visited by the Rapid Response Nurse visit (72h)
  - Evaluated by the Therapist Team Lead (1wk)
  - Assessed by Interdisciplinary Stroke Rehab Team

- Therapy is provided over 8 weeks
  - Setting therapy goals (individualized treatment plan)
  - 2 visits per week

- At discharge, patients:
  - Are linked with community support services
# Draft Evaluation Framework

**Components**

**Intake/Assessment**
- # of referrals
- Average # of days to first visit
- Median # of days to first visit
- Average # of days to first therapy visit
- Median # of days to first therapy visit

**Intervention**
- Average # therapy visits per patient who completed program
- Median # therapy visits per patient who completed program
- Proportion of patients who received each type of therapy
- Average # discipline specific visits (of those who received each discipline)
- Average # discipline specific visits (of those who completed the program)

**Discharge**
- # who complete program
- Average LOS
- Median LOS

## Short-term Outcomes:
- Average RNLI pre, post and change
- YTD # patients with pre and post RNLI scores
- Average COPM pre, post and change for performance/satisfaction
- YTD # patients with pre and post COPM scores
- PHQ-9 or SADQ: % with depression pre and post;
- YTD # patients with pre and post depression scores
- % referred to community programs
- Client/carer satisfaction

## Long-term Outcomes:
- # of ALC day at primary referring acute care hospitals: CCH and WDMH (Pre/post implementation)
- # of patients discharged direct to LTC/CCC (Pre/post implementation)
- LOS in acute care and inpatient rehab (Pre/post implementation)
- % severe strokes in inpatient rehab (Pre/post implementation)
- Adherence to RPG group LOS targets in inpatient rehab (Pre/post implementation)
- 30 day readmission to hospitals: CCH, HGMH, WDMH (Pre/post implementation)
- Exploring options to re-administer RNLI, COPM and Depression tool at 6 months
System Outcomes

*Right Care in the Right Place at the Right Time…*

- Appropriate LOS meeting QBP targets
  - In acute care at CCH, others (5, 7 day LOS)
  - In stroke rehab at HGMH (RPG LOS)
  - Reduction in ALC days at CCH, others
- Appropriate sub-acute setting
  - Reduced discharges to LTC, CCC
  - Increase in number of patients to outpatient stroke rehab
  - Increase of severe stroke survivors in inpatient stroke rehab
Contributors

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Questions?