# Community Stroke Rehabilitation Program

Presentation to SFH & RNOC Symposium

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# Creating the Community Stroke Rehab Program

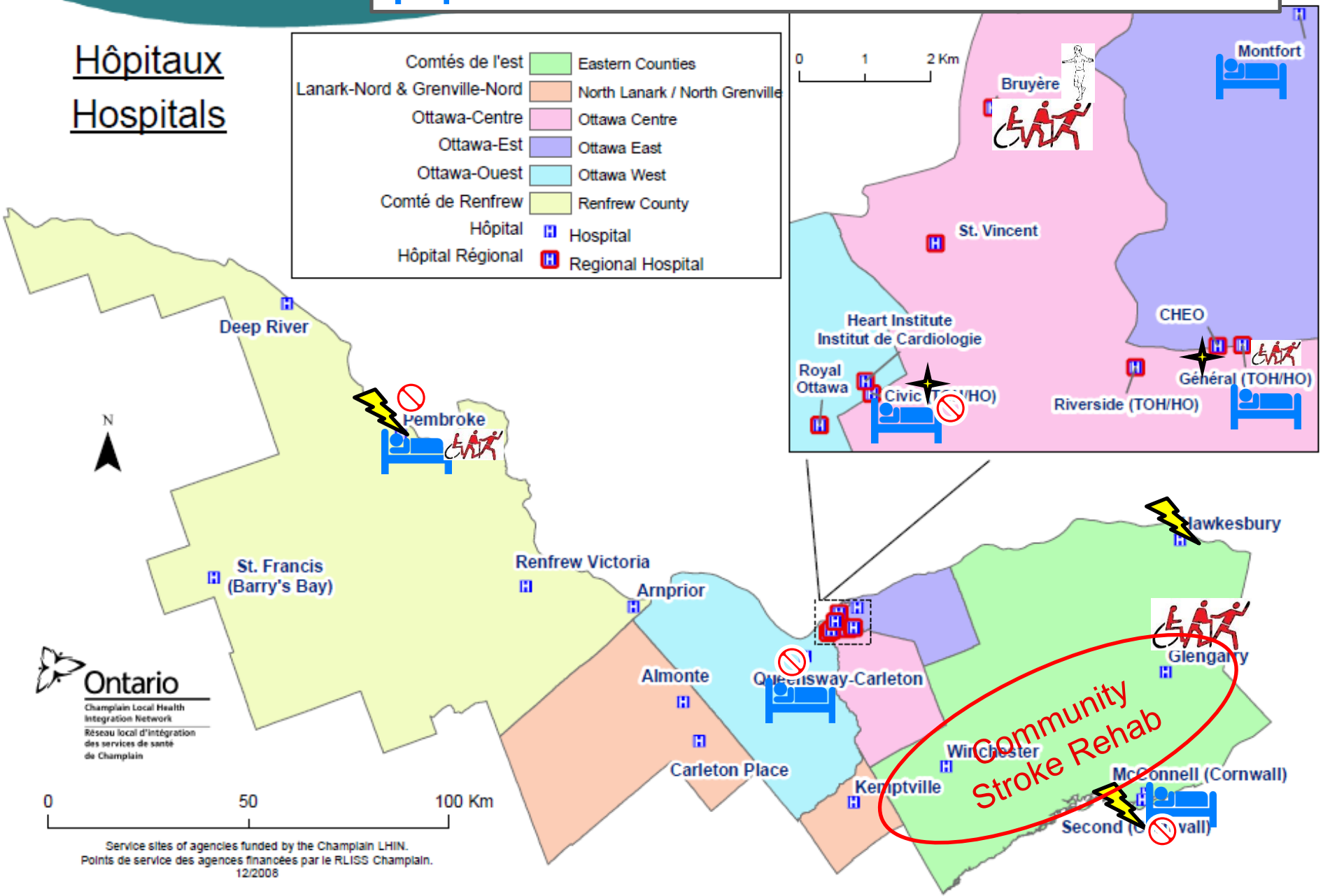
- Lack of outpatient services in Champlain
- Strategic and Operational goal of Champlain Regional Stroke Network
- Collaborative effort over ~12 months
  - Reviewed: the literature; similar programs in other LHINs, provinces, countries; QBP recommendations
  - Working Group, Patient Focus Groups informed 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

Champlain **LHIN**
**RLISS** de Champlain

Telestroke site
Stroke Prevention Clinic
Designated stroke unit
Inpatient Stroke Rehab
Outpatient Stroke Rehab

# Hôpitaux
# Hospitals

| | |
|---|---|
| Comtés de l'est | Eastern Counties |
| Lanark-Nord & Grenville-Nord | North Lanark / North Grenville |
| Ottawa-Centre | Ottawa Centre |
| Ottawa-Est | Ottawa East |
| Ottawa-Ouest | Ottawa West |
| Comté de Renfrew | Renfrew County |
| Hôpital | Hospital |
| Hôpital Régional | Regional Hospital |




Ontario
Champlain Local Health Integration Network
Réseau local d'intégration des services de santé de Champlain

Service sites of agencies funded by the Champlain LHIN.
Points de service des agences financées par le RLISS Champlain.
12/2008

# 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 | Intervention | Discharge |
|---|---|---|---|
| Outputs | # of referrals<br>Average # of days to first visit<br>Median # of days to first visit<br>Average # of days to first therapy visit<br>Median # of days to first therapy visit | Average # therapy visits per patient who completed program<br>Median # therapy visits per patient who completed program<br>Proportion of patients who received each type of therapy<br>Average # discipline specific visits (of those who received each discipline)<br>Average # discipline specific visits (of those who completed the program) | # who complete program<br>Average LOS<br>Median LOS |
| Short-term Outcomes: | Average RNLI pre, post and change<br>YTD # patients with pre and post RNLI scores<br>Average COPM pre, post and change for performance/ satisfaction<br>YTD # patients with pre and post COPM scores<br>PHQ-9 or SADQ: % with depression pre and post;<br>YTD # patients with pre and post depression scores<br>% referred to community programs<br>Client/carer satisfaction | | |
| Long-term Outcomes: | # of ALC day at primary referring acute care hospitals: CCH and WDMH (Pre/post implementation)<br># of patients discharged direct to LTC/CCC (Pre/post implementation)<br>LOS in acute care and inpatient rehab (Pre/post implementation)<br>% severe strokes in inpatient rehab (Pre/post implementation)<br>Adherence to RPG group LOS targets in inpatient rehab (Pre/post implementation)30 day readmission to hospitals: CCH. HGMH, WDMH (Pre/post implementation)<br>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?