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Knowledge and Inspiration 2010

Les connaissances et l'inspiration

Enhancing Community and LTC Rehabilitation Services for Stroke Survivors: Improving the System of Care

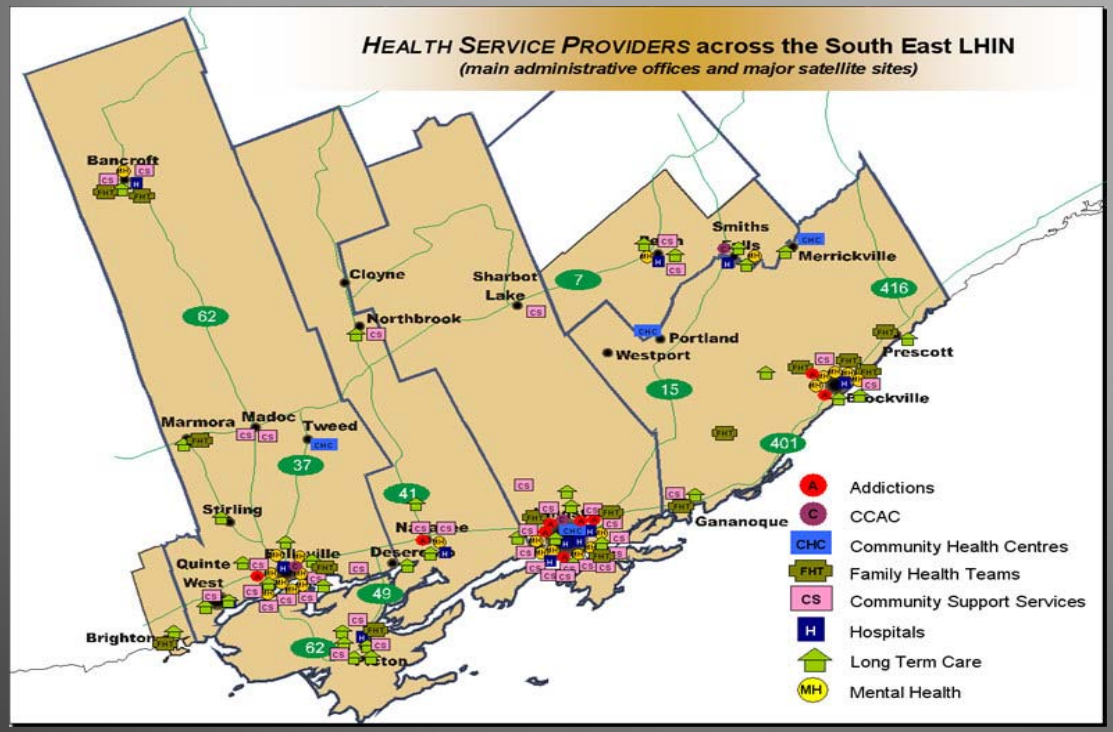
Objectives

- To demonstrate how this initiative supported clients in receiving the right level and intensity of rehabilitation services in the most appropriate care setting
- To identify key strategies utilized to assist service providers, case managers, Long Term Care Home staff and Hospital partners in the implementation of a new model of service delivery
- To review quality practices that enabled a positive care experience for the clients

Outline

- Identifying the Need
- The Proposal: Funding Linkages
- Nuts and Bolts of the Initiative
- Partnerships
- Successful Implementation
- Key elements, overcoming challenges
- Where are we now…
- Questions

Southeastern Ontario



Identifying the Need

- Regional Data
- Regional Rehabilitation Needs Assessment 2001
- Rehabilitation Pilot Project 2002-4
- Community Reintegration Needs Assessment 2007
- Research Evidence
- Best Practice Recommendations

⇨ **Current Access to Services Inadequate**

- New MOH directions- opportunity to re-visit pilot

⇨ **LHIN proposal for community stroke rehabilitation**

Use of the Evidence

Benchmark to Best Practice

- Canadian Best Practice Recommendations for Stroke Care (2008)
  - Access to outpatient and community rehabilitation is one of top ten priorities
- Rehabilitation Consensus Panel Report (HSFO 2007)
- Community Stroke Best Practice Guidelines (West GTA Stroke Network 2005)

The Proposal: Funding Linkages

Linking the evidence and local stroke rehabilitation needs to the **priorities** of MoHLTC and our LHIN

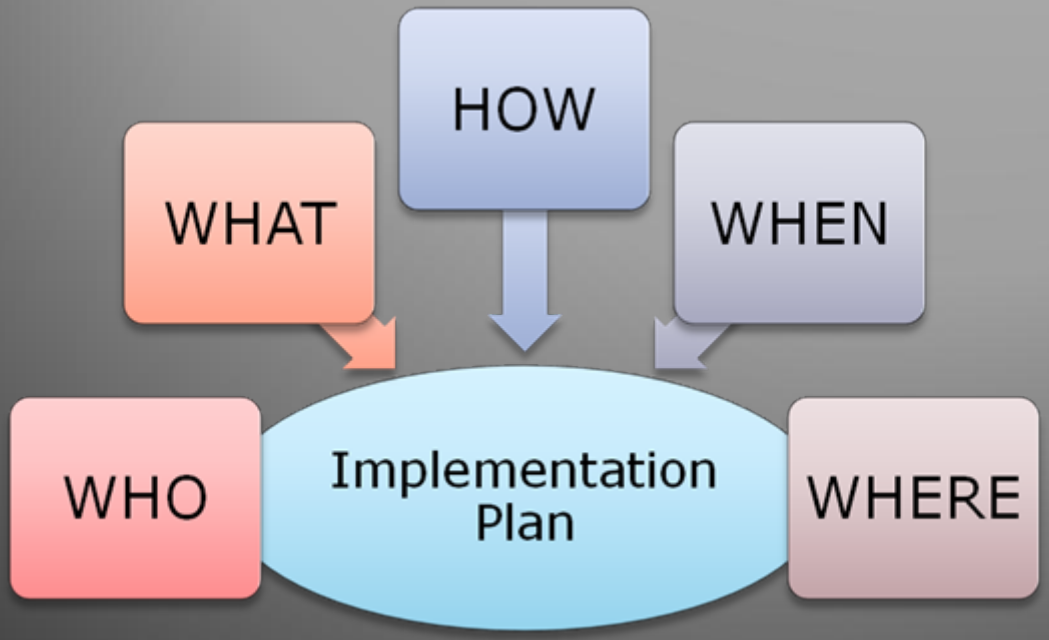
- Aligned with Integrated Health Services Plan (IHSP)
- Aligned with MOHLTC Provincial Priorities

Project Implementation: Nuts and Bolts

ENHANCING COMMUNITY & LONG TERM CARE STROKE REHABILITATION IN SOUTHEASTERN ONTARIO:
IMPROVING THE SYSTEM OF STROKE CARE

Process

Spend **significant** time on process at the start



Who and Where

*Identified in the hospital setting –

- NEW strokes being discharged to the Community or LTC setting
- From any hospital bed in the SE region
- Must meet CCAC eligibility criteria
- Have identified rehab therapy needs

What...Enhanced Levels of Service- Baseline

Normal	PT	OT	SLP	SW
Community	Weekly x 8	Weekly x 8	Weekly for the first 4 weeks and bi-weekly for the next 4 weeks	Not normally Provided
LTC	Not provided	Weekly x 3	Weekly x 3	Not normally provided

What…Enhanced Levels of Service-Enhanced

Enhanced Service	PT	OT	SLP	SW	Total Extra Therapy Services
1st 4 wks	Up 2/wk X 4 wks	Up 2 /wk X 4 wks	Up 1 /wk X 4 wks	Up 1 /wk X 4 wks	
2nd 4 wks	Up 1/wk	Up 1 /wk	Up 1 /wk biweekly	Up 1 /wk biweekly	
Total extra visits	12	12	6	6	Total = 36

What…Enhanced Levels of Service- Potential

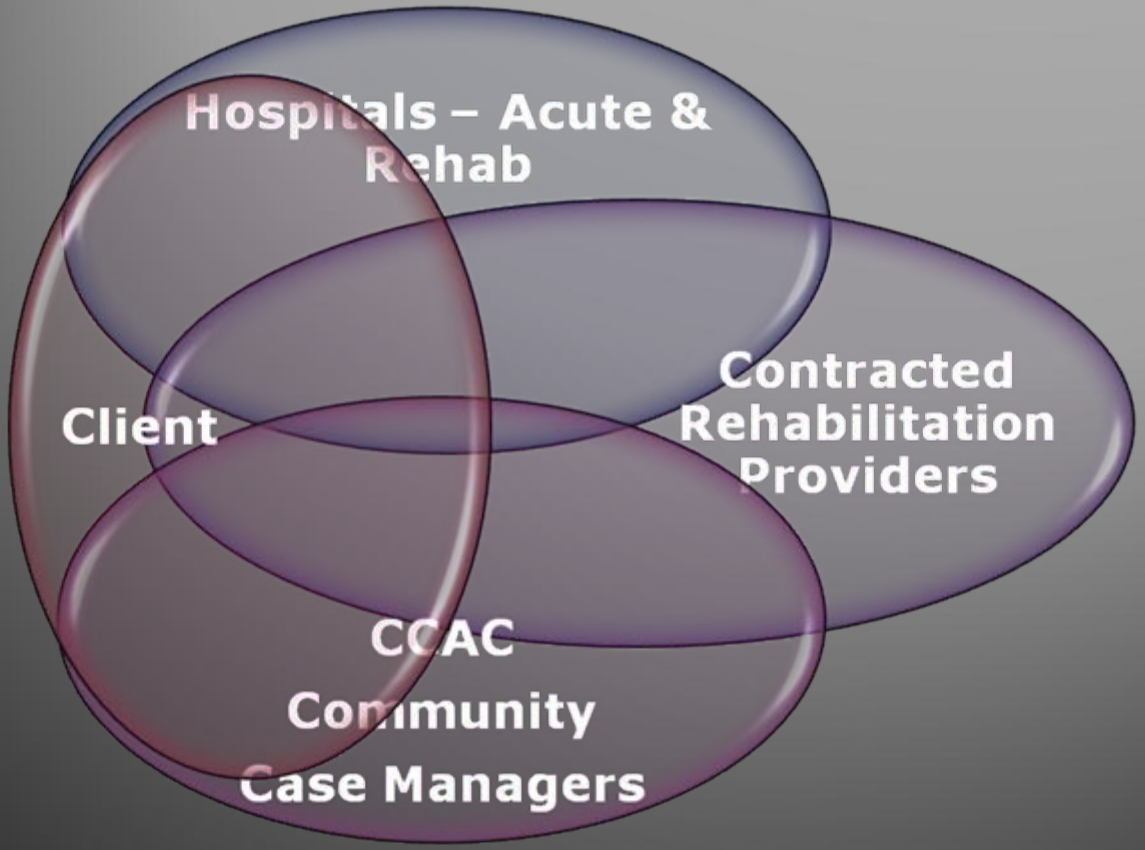
Enhanced Service	PT	OT	SLP	SW
1st 4 wks	3/wk X 4 wks	3 /wk X 4 wks	2 /wk X 4 wks	1 /wk X 4 wks
2nd 4 wks	2/wk X 4 wks	2 /wk X 4 wks	1 /wk x 4 wks	1 /q 2 wks/ x 4 wks

How…Creating Partnerships

Collaborative partnership is KEY to success!

Phase One

Three groups of providers….. one vision for the client

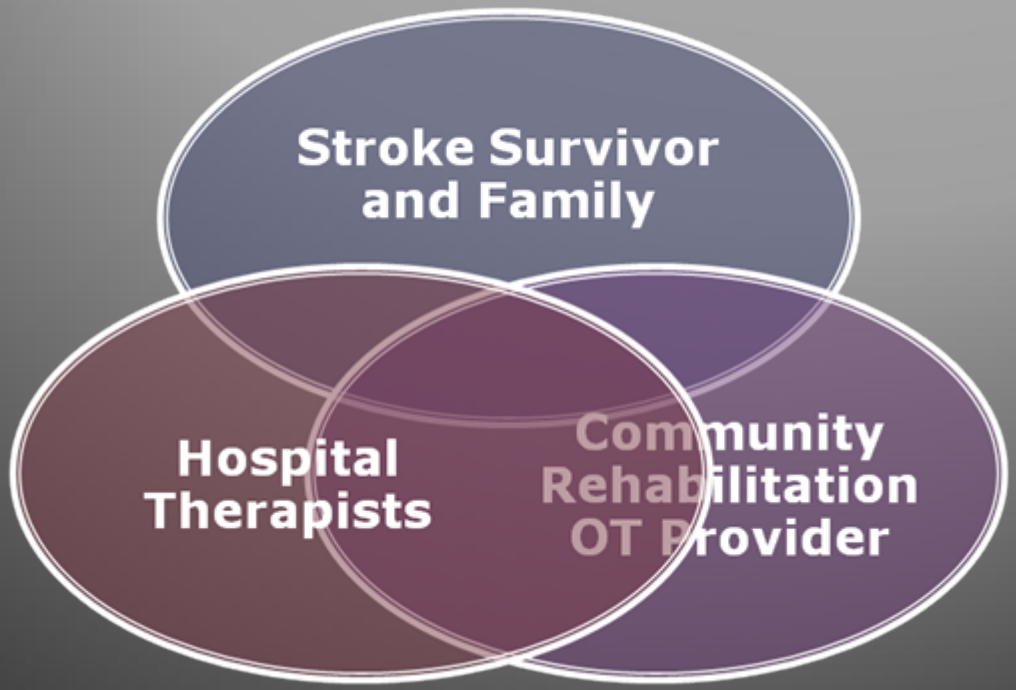


Program Model

- Services – PT, OT, SLP, SW
- Time frame – 8 weeks
- Front end loaded – ↑↑ services in 1st 4wks
- Timely first visit
- Individual Service Plan – first 4 weeks by Hospital Team; second 4 weeks by Community Therapy team
- Discharge link meeting

Transitions
Hospital to Community

Discharge Link Meeting



How

Stroke Survivor Identified in Hospital

Eligible for CCAC Services – Hospital CCAC Case Manager	**Hospital Team recommends service plan x 4 weeks – Discharge Link**

Services are instigated in the Community per Service Plan

CCAC Community Case Manager	**OT, PT, SLP, SW – eval at 4 weeks and recommend next 4 weeks**

Enhanced Services Delivered up to 8 Weeks

Stroke survivors has rehab needs and eligible for CCAC services – continues under normal process	**Stroke survivor has rehab needs and are not eligible for CCAC services – ambulatory setting**

Phase Two

Bringing the vision to the LTC Home Sector

Program Model

- Services – OT, SLP, SW
- Time frame – 8 weeks
- Front end loaded – ↑↑ services in 1st 4wks
- Timely first visit
- Individual Service Plan – Initial OT to establish first 4 weeks, second 4 weeks by Community Therapy team
- Therapists to connect with staff i.e. PT in LTC

How

Stroke Survivor Identified in Hospital

Eligible for CCAC Services – Hospital CCAC/PCS Case Manager

Initial OT visit arranged to establish plan for OT, potentially SW, SLP

Services are instigated in the Community per Service Plan

CCAC Community Case Manager

OT, SLP, SW – eval at 4 weeks and recommend next 4 weeks

Enhanced Services Delivered up to 8 Weeks

Stroke survivors ongoing rehab needs would be managed by the LTC homes

Communication and Support

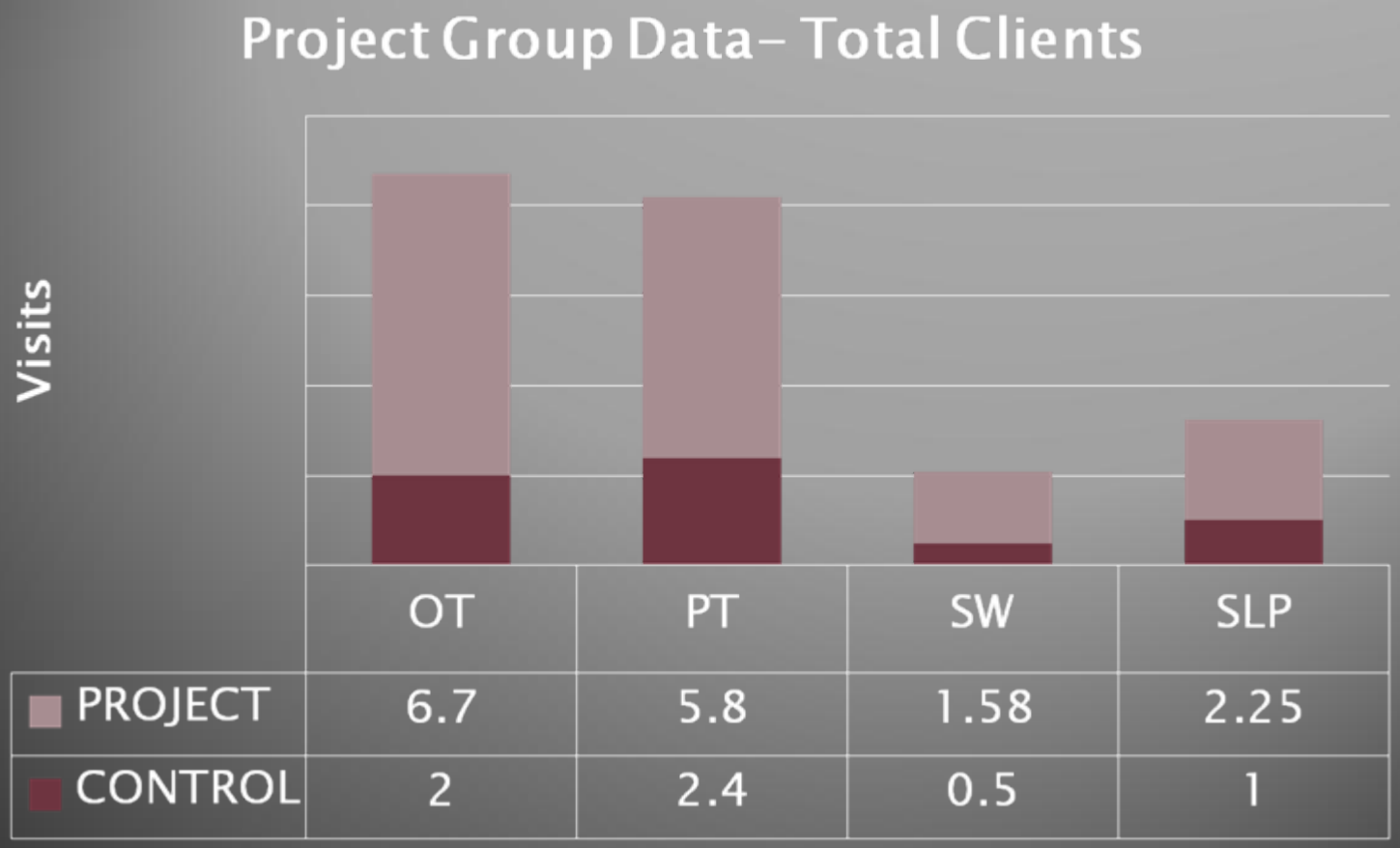
- Visibility
- Communication
- Follow up
- Updates
- Support the champions

Where are we now…

Clients Referred	**145**
Services	
PT	**109**
OT	**130**
SLP	**40**
SW	**45**
Discharge Link Meetings	**61**

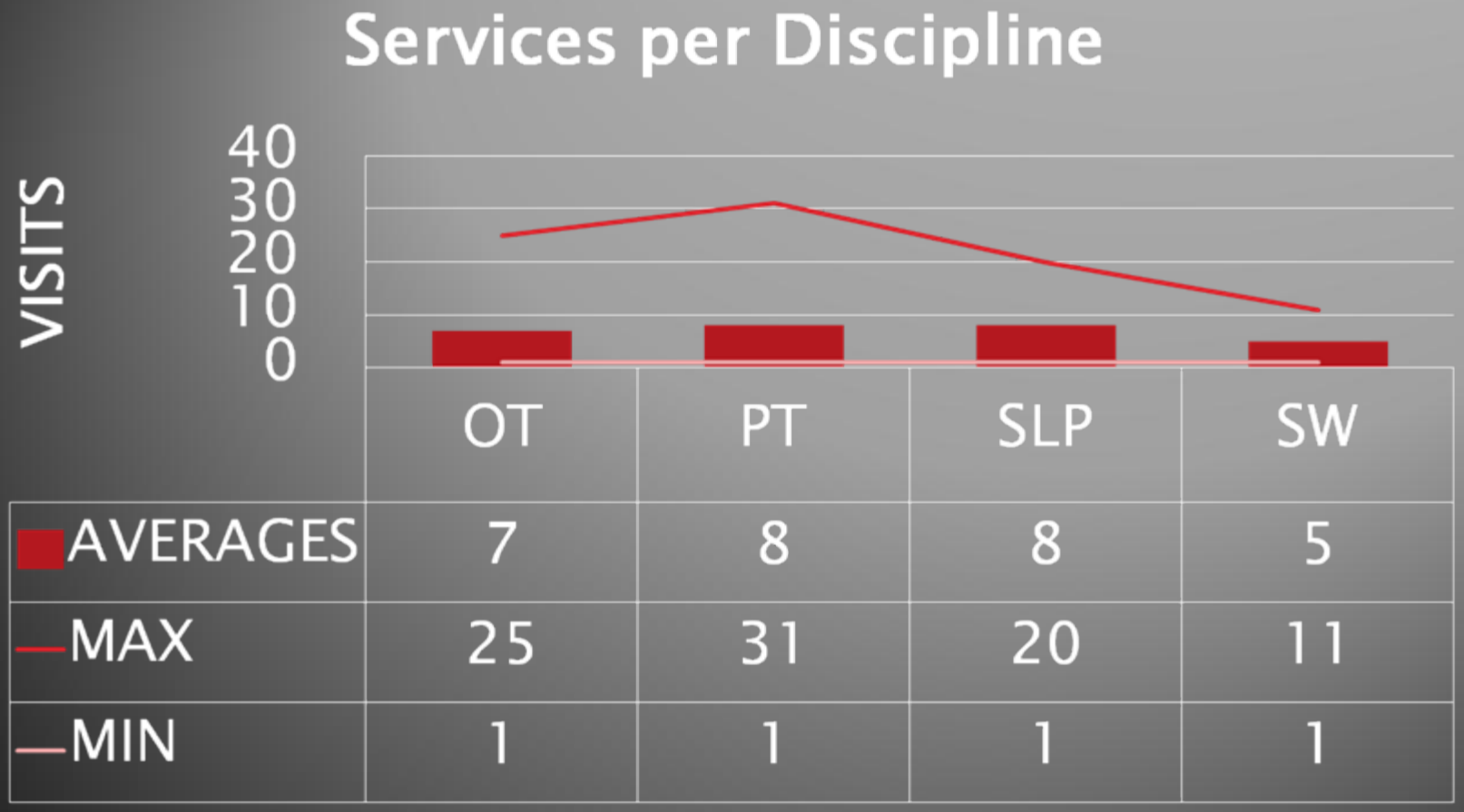
- Total of 145 clients have accessed enhanced therapy services
- Successfully arranged 61 discharge link meetings
- 70% of the referrals have come from the Rehab unit beds
- 24% of the referrals from acute beds

Where are we now…



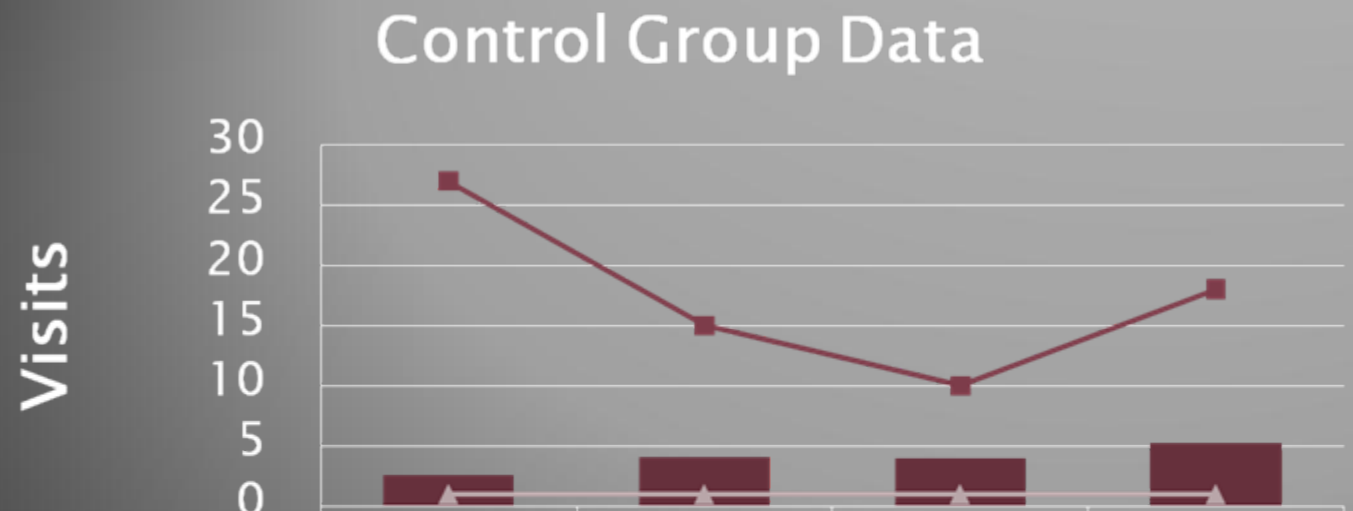
	OT	PT	SW	SLP
PROJECT	6.7	5.8	1.58	2.25
CONTROL	2	2.4	0.5	1

Enhanced Services Provided…



- **Average wait for “first visit” 4.5 days**

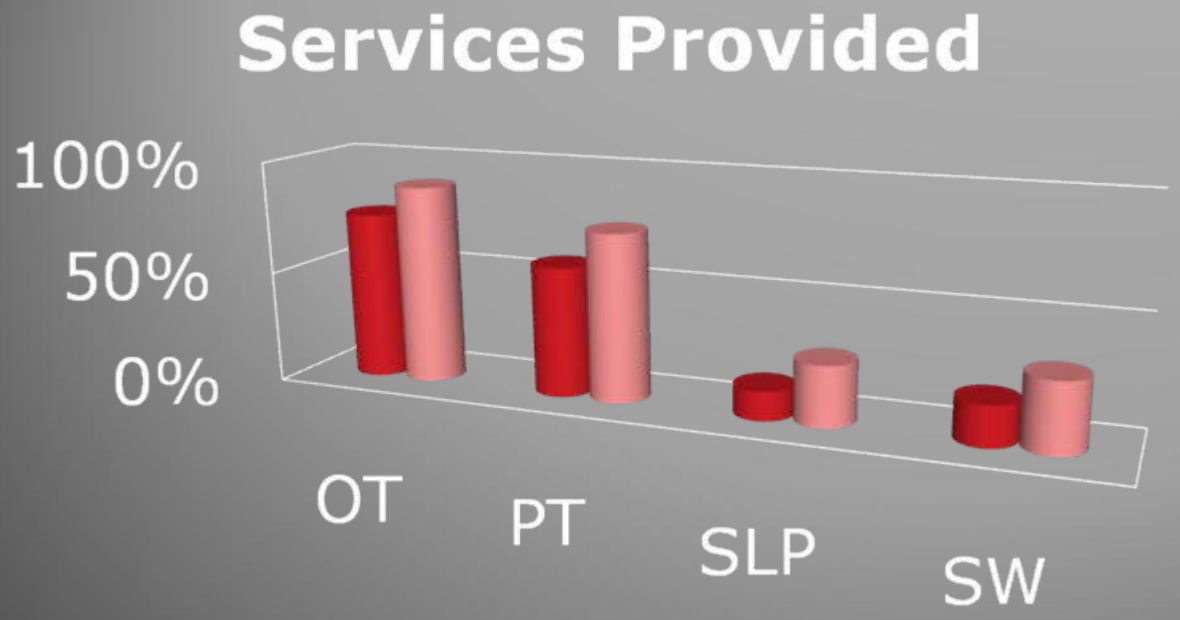
In Comparison…



	OT	PT	SLP	SW
AVERAGES	2.6	4.1	4	5.3
MAX	27	15	10	18
MIN	1	1	1	1

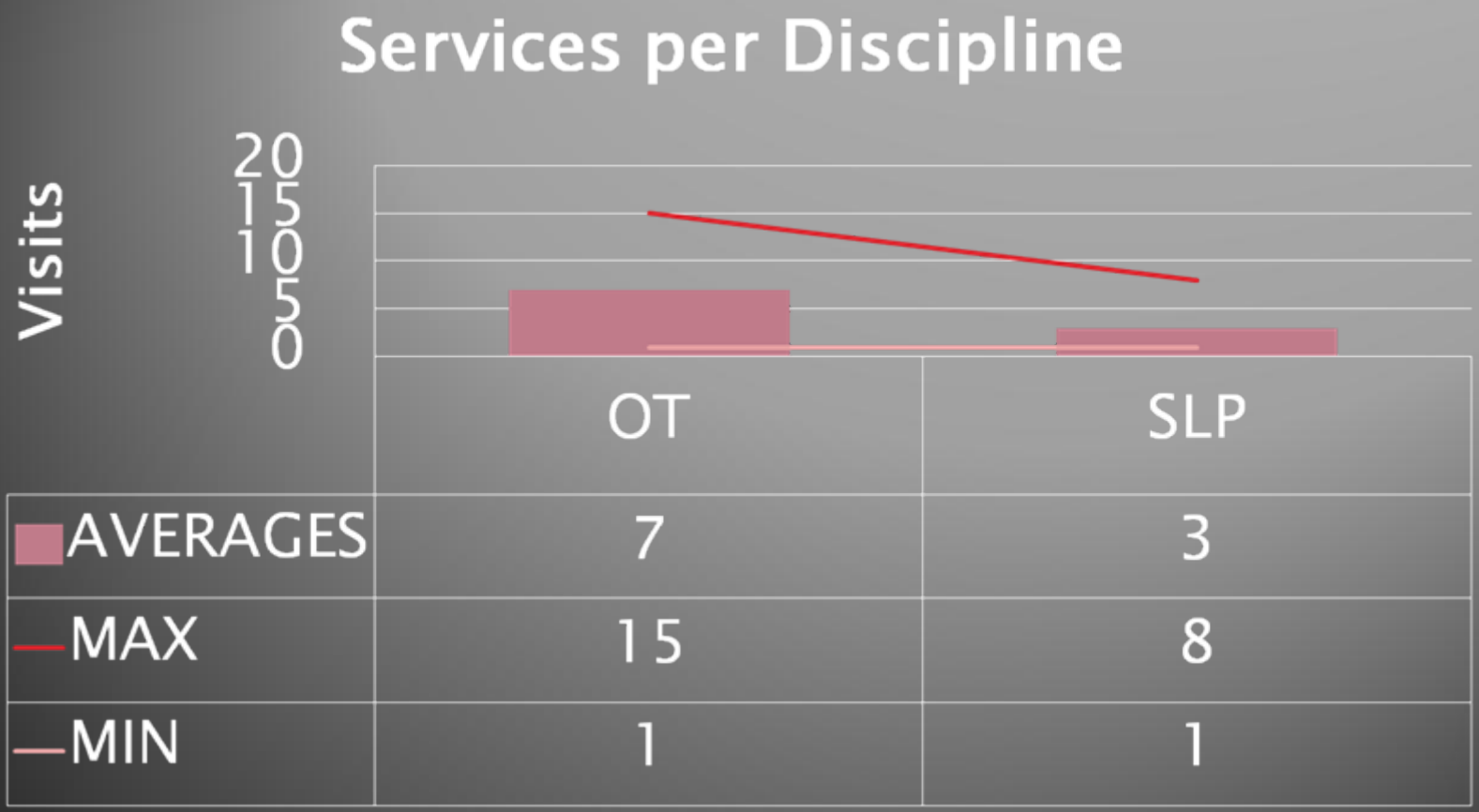
- **Average wait for “first visit” in the range of 10 days**

Services Overall…



	OT	PT	SLP	SW
Control Group	75%	58%	13%	18%
Project Group	89%	75%	27%	31%

LTC Homes


Services per Discipline
Visits
20
15
10
5
0
OT
SLP
AVERAGES
7
3
MAX
15
8
MIN
1
1

Evaluation and Health System

Data Collection – Linking of CCAC data with:

NACRS	CIHI DAD	NRS
• ER visits • Dx codes • Costs • Procedures/consults • D/C deposition	• Hospital Admission • Dx codes • LOS • ALC designation • ALC days • D/C disposition	• Adm and D/FIM • LOS • D/C disposition • RCG /RPG

Early Success Stories

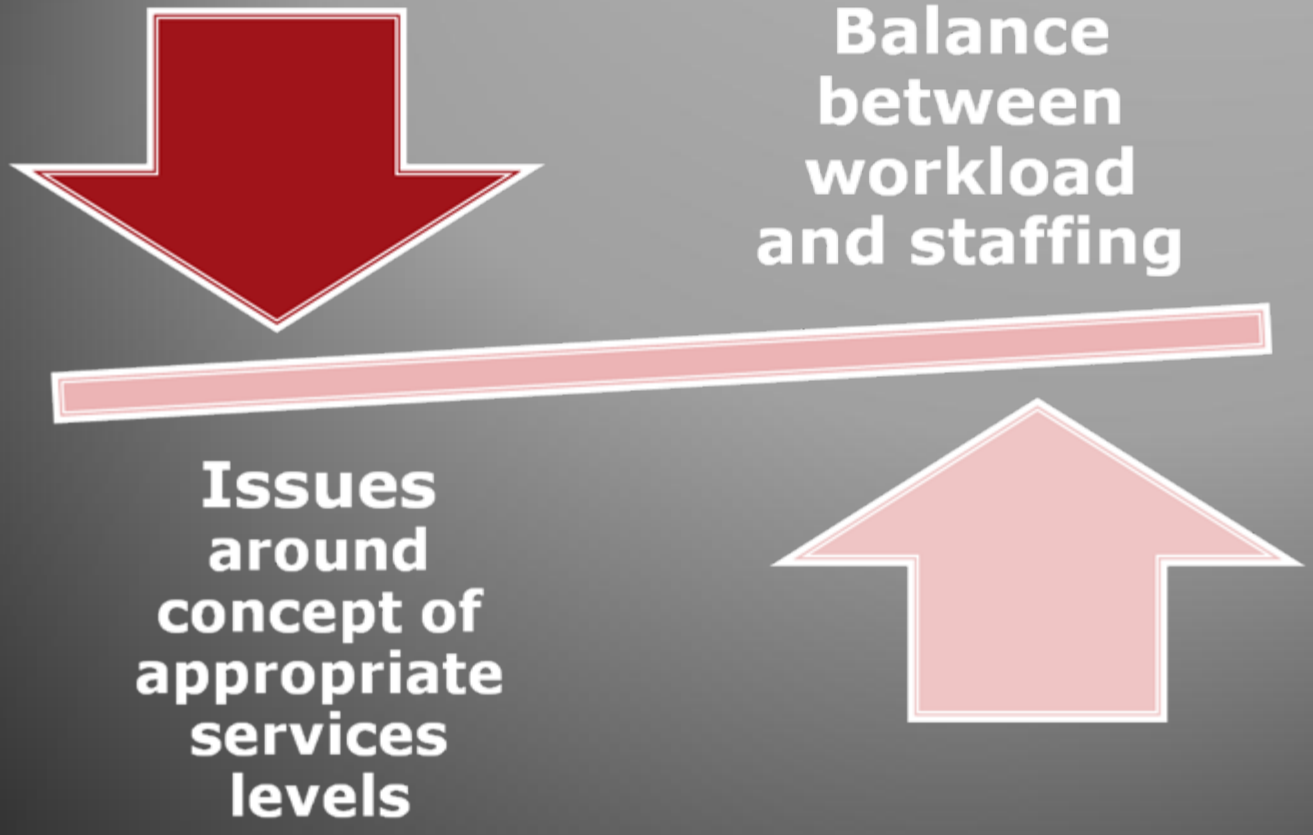
- ✓ QHC Rehab data
  - Decrease in rehab LOS from 54 to 41 days
  - Increase from 15% to 39% in those discharged home with service
  - Increase from 72 to 88% in those discharged back home
- ✓ Positive experience of Discharge link
- ✓ Increased understanding of needs related to social work
- ✓ Increasing dialogue and understanding between sectors
- ✓ Funding to continue to allow full evaluation

Overcoming Challenges

Geography

- **Very rural**
- **Divide between 2 community therapists**

Overcoming Challenges



Consultative versus Treatment Model

Overcoming Challenges

- Keeping everyone in the LOOP
- Communication and open dialogue

Overcoming Challenges

- DATA Collection

Questions

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