Provincial Summary of Implementation Strategies to Achieve the *"Recommendations for an Ontario Approach to the Provision of Stroke Rehabilitation during COVID-19"*

1. HUMAN RESOURCE CAPACITY

- Using out-patient (OP) staff in areas that are closed to support neuro OP services that remain open.
- Most sites have redeployed OP staff to in-patient (IP) units or other needed roles.
- Creation of education tools to support non-stroke specialist staff care for stroke patients (mostly targeted towards acute stroke care)

Note: Minimal evidence found of system-wide capacity planning to ensure allied health capacity for stroke rehabilitation across the continuum. Most human resource contingencies have been due to other strategies implemented to prepare for COVID-19 units or site reorganization.

2. IN-PATIENT (ACUTE/REHAB) PHASE

- Primary adjustment seems to be moving towards more therapy in patient rooms to: 1) adhere to isolation practices, 2) respect physical distancing for staff/patients in congested therapy areas or 3) respond to therapy areas being repurposed for other uses.
- Extension of LOS in both acute and rehab settings has occurred to support more complex discharge planning and ensure safe transitions to community where typical rehabilitation services may not be available.
- Teams have been linking virtually with family members to support patients and discharge planning (e.g. family conference, family visiting, viewing home for pre-discharge assessment).
- Adaptations made to physical environment to enable physical distancing (e.g. schedule changes to limit patients/therapists in a therapy gym; installation of Plexiglass for speech therapy area to maintain view of face for oral motor therapy).

3. SUPPORTING TRANSITIONS TO COMMUNITY

- Therapists who will be following patient in the community have opportunity to connect directly to patient and/or therapy team prior to discharge from IP rehabilitation either in-person (hospital-based teams) or virtually (home care based teams).
- Patients being provided additional rehabilitation activities/progressions from IP (acute/rehab) units to support recovery in the community.
- Hospital staff assigned to support virtual connections with family and to help teach technology for future tele-rehabilitation visits.
- Follow up phone calls implemented by hospital teams to ensure safe transitions upon discharge.

4. DELIVERY OF ESSENTIAL/URGENT STROKE REHABILITATION (OUTPATIENT/HOME/COMMUNITY)

- Hospital based teams, and community teams with established access, are using OTN platform for virtual follow-up
- Very few hospital sites providing in-person OP therapy, community teams making essential in-home visits only as necessary (i.e. virtual care not feasible/appropriate), filling gaps for some OP department closures.
- Sites are allowing flexibility to use patient preferred or readily available virtual technology options upon consent following appropriate discussions regarding risk and privacy (e.g. FaceTime, Skype).
- Many teams providing first visit in-person and then developing a virtual care plan if appropriate.
- Telephone calls are commonly used to provide virtual care, as not all therapists or patients have access/ability to use video-based platforms.
- Additional resources in place to review individual patient cases to support decision making regarding need for in-person versus virtual visits.

For more details on specific strategies please contact your local Regional Stroke Rehabilitation Coordinator (RSRC):

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