Brant Haldimand Norfolk Community Stroke Rehabilitation Pilot Model Metrics Update

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ccac casc
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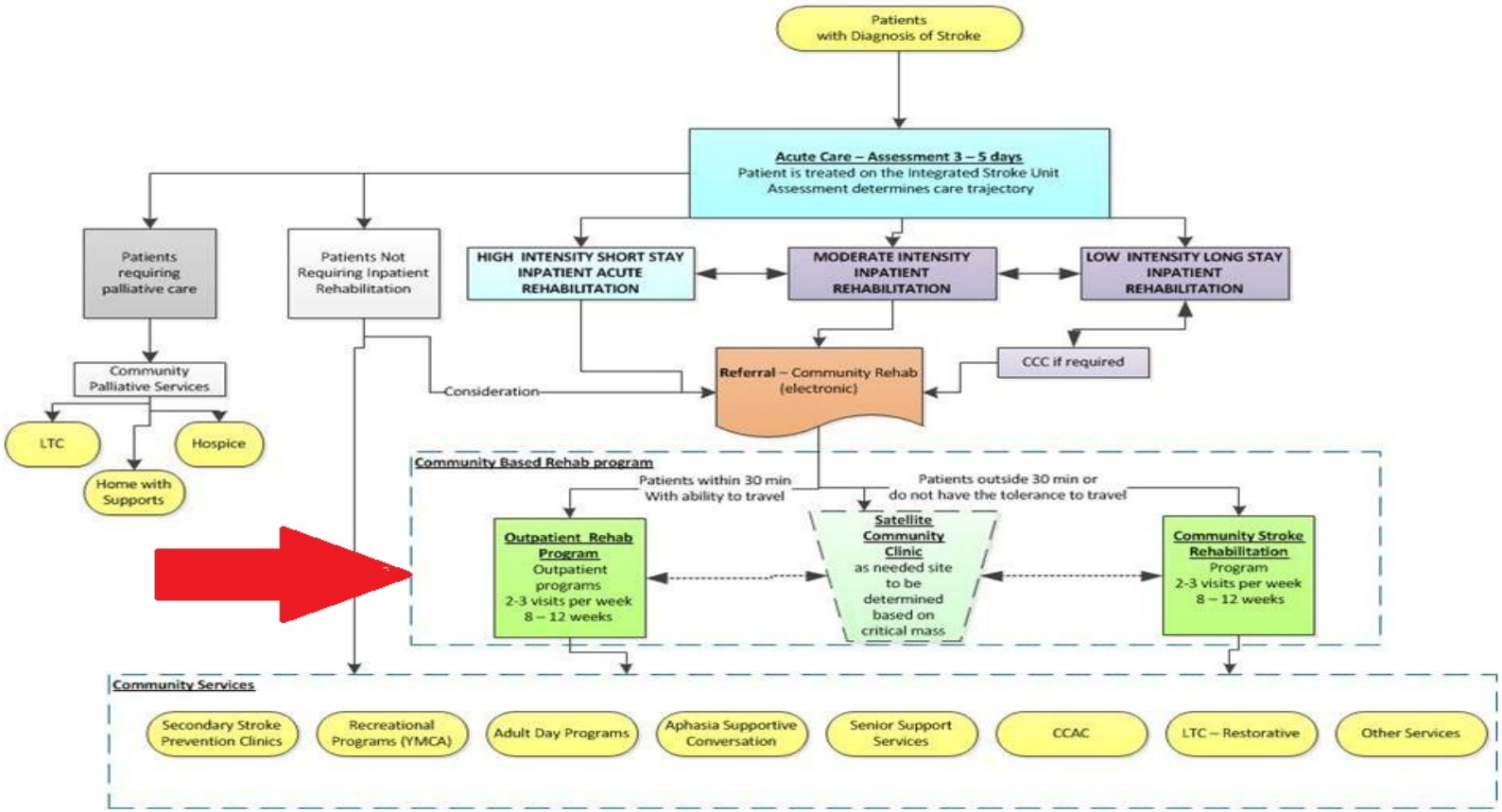
COMMUNITY STROKE REHABILITATION MODEL



CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires

Brant Community Healthcare System
The Willett, Paris
The Brantford General

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

Partners

Norfolk General Hospital

Central South Regional Stroke Network
Fewer strokes. Better outcomes.

West Haldimand General Hospital

Development of HNHB- CSR Brant Haldimand Norfolk Pilot Model

- Integration of the Community Stroke Rehab Model into the care path of the Integrated Stroke Unit (ISU)
- Identification of patient's rehabilitation needs in the hospital stay, within 24-72 hours
- Strong link with District and/or Regional Stroke Centre's ISU

Development of HNHB- CSR Brant Haldimand Norfolk Pilot Model

- Strong link with primary care physician
- Post discharge interdisciplinary meetings monthly
- Transferability of model (is the model able to be spread across the HNHB based on the pilot results)
- Standardized reporting requirements

Development of HNHB- CSR Brant Haldimand Norfolk Pilot Model

- Consistency of Service Provider Stroke Team (80% of care is to be provided by a consistent OT/PT/SLP in the community)
- Stroke Team Members Expertise (e.g. FIM, MoCA (OT), Neuro Motor Rehab, Supportive conversation for Adults with Aphasia)
- Dedicated Care Coordination

Development of HNHB- CSR Brant Haldimand Norfolk Pilot Model

- Time to first visit within 72 hours following hospital discharge for provider and the Care Coordinator

- Care pathway into streams (mild, moderate, severe) based on best practice standards: 2-3 outpatient or community based allied health professional visits/week (per required discipline) for 8-12 weeks and incorporates milestones and opportunities for reassessment

Eligibility

- Persons post stroke will be triaged into two CSR programs
    - Outpatient clinic based therapy
    - Outreach home based therapy (CCAC)
- Eligibility for in home therapy will be based on the following criteria:
    - Live beyond a 30 minute drive of a specialized clinic based OP stroke rehab program (BCHS)
    - Do not have the tolerance to travel 30 minutes to an OP program and participate in therapy

Care Coordination -Value for the Patient

- Dedicated Community Care Coordination
- Assessment in patients home within 72 hours of CCAC admission
- Additional training for Care Coordinator (Hemispheres training, Aphasia)
- Standardized assessment tool (interRAI-CA, RAI-HC)
- Link patients to community programs (Health Care Connect to find a physician)
- Referral to other agencies (Adult Day Program, supportive groups in community, other rehab in the community)
- Connection with service providers (post discharge meeting monthly, updates)
- Care Coordinator housed in office to address urgent patient calls
- Assistance with transitioning to alternate levels of care (RHs, LTCHs)
- Coordinates post discharge stroke team meetings monthly

Community Stroke Rehabilitation Pilot Model

Metric Results from December 2013-June 2014
(Data Source: HNHB CCAC CHRIS)

Community Stroke Rehabilitation Pilot Model

Stream & Services	# Patients	Visits	Avg. Visits per Person
PT Visits			
Mild	2	7	3.5
Moderate	2	19	9.5
Severe	6	103	17.2
OT Visits			
Mild	3	18	6.0
Moderate	2	20	10.0
Severe	6	113	18.8
SLP Visits			
Mild	3	51	17.0
Moderate	1	43	43.0
Severe	5	66	13.2

Average visits per person were highest in the Severe stream for PT and OT. Average visits per person for SLP were higher in the Mild stream and highest in the Moderate stream

Community Stroke Rehabilitation Pilot Model

Services	# Patients
# Patients Received PT Services	10
Total PT Visits	129
Average PT Visits per Person	12.90
# Patients Received OT Services	11
Total OT Visits	151
Average OT Visits per Person	13.73
# Patients Received SLP Services	9
Total SLP Visits	160
Average SLP Visits per Person	17.77

The number of visits and average visits per person were highest for SLP, followed by OT and lastly PT

Community Stroke Rehabilitation Pilot Model

Stream	# Patients	Goal Met		80% Consistency in Service Delivery		Patient Discharged to a Community Program	
		Yes	No	Yes	No	Yes	No
Mild	3	3	0	3	0	3	0
Moderate	2	2	0	1	1	2	0
Severe	6	3	3	6	0	6	0
Total	**11**						

72% (8 out of 11) patients met their program goals; 3 patients went to hospital

10 out of 11 of patients had 80% consistency in service delivery

All patients were discharged to a community program

Community Stroke Rehabilitation Pilot Model

DRS (Depression Rating Scale)	# At Admission	# At 3 Months
DRS 0	7	8
DRS 1	1	3
DRS 2	1	0
DRS 3	1	0
DRS 4	1	0

From admission to 3 months – DRS Score remained the same for 6 patients; improved for 4 patients; worsened for 1 patient

Community Stroke Rehabilitation Pilot Model

RNLI (Reintegration to Normal Living Index) Score	# Patients	Avg. RNL1 Initial	# Patients	Avg. RNL1 Discharge
Mild	3	79	3	98
Moderate	2	55	1	72
Severe	4	52	2	68

Used to evaluate degree to which a patient is able to return to normal life. Higher scores represent better perceived integration (up to a max of 100)

Scores From Initial to Discharge
Mild – Increased by 24%
Moderate – Increased by 31%
Severe – Increased by 31%

Community Stroke Rehabilitation Pilot Model

FIM (Functional Independence measure) Scores	Number of Patients	Avg. FIM at Admit	Number of Patients	Avg. FIM at Discharge
Mild	3	114	3	124
Moderate	2	80	2	104
Severe	6	70	6	83

Measures level of disability and indicates how much assistance is required to carry out activities of daily living. Higher scores represent increased independence (up to a max of 126)

Scores From Admit to Discharge
Mild - Increased by 9%
Moderate – Increased by 30%
Severe – Increased by 19%

Community Stroke Rehabilitation Pilot Model

All 11 of the patients received a

Inter-RAI CA on admission, a RAI-HC within 72 hours and at 3 months, from a CCAC Care Coordinator

100% of patients had a RAI-HC completed at admission and at 3 months

Community Stroke Rehabilitation Pilot Model

Background

- Patients were called at the 3 month mark to determine their level of satisfaction with how the team has been supporting them post hospitalization.
- 6 of the 12 patients (March- June) agreed to provide feedback. (Non- participants included, language barrier, unavailable, did not want to participate)
- Patients or Caregivers were approached (4 caregivers, 2 patients)

Preliminary Results

- Overall, how satisfied were you with the help you or your loved one received from the team?
  - 100% of respondents indicated they were Satisfied or Very Satisfied.
- The team members and I decided together what would help me.
  - 33% strongly agreed they felt included in deciding together what would help them
  - 50% neither agreed or disagreed: Comments: “The plan was outlined for us”.
  - 17% strongly disagreed Comments: “The amount of service in the beginning was overwhelming”
- My therapy program was explained to me in a way that I could understand.
  - 83% either strongly agreed or agreed
  - 17% strongly disagreed
- The team helped me adjust to my life after stroke.
  - 83% either strongly agreed or agreed
  - 17% disagreed Comment “I am not sure we will ever adjust”
- Would you recommend this team to another family member of friend needing this type or assistance?
  - 83% Yes
  - 17% Maybe

Community Stroke Rehabilitation Pilot Model

Survey Comment

"We were not expecting all of the care that we received from the CCAC. Myself and my sister are very busy and appreciative of all the support for my mom"

Community Stroke Rehabilitation Pilot Model

In summary this CSR model provides seamless transition through a standardized care path that details the patient's journey from ER to community. The model facilitates collaboration between Hospital and community supporting patients to work on their Rehab goals in a home setting.

Thank you!