Memorandum

SUBJECT: CorHealth COVID-19 Stroke Memo #4 - **RECOMMENDATIONS FOR AN APPROACH TO RESUMING OUTPATIENT STROKE REHABILITATION SERVICES IN ONTARIO**

TO: Outpatient Stroke Rehabilitation Stakeholders

FROM: Office of the CEO, CorHealth Ontario

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DISCLAIMER: The information in this document represents general guidance based on current practice and available evidence. The document was developed by provincial clinical experts, reflecting best knowledge at the time of writing, and is subject to revision based on changing conditions and new evidence. This information is *intended to* be "guidance rather than directive," and is *not meant to replace clinical judgment, regulatory body requirements, organizational, or hospital policies*. Reference to Infection Prevention and Control (IPAC) or Personal Protective Equipment (PPE) in this document should not replace or supersede the IPAC and PPE protocols or directives in place at your organization.

Recommendations for an Approach to Resuming Outpatient Stroke Rehabilitation Services in Ontario

PREAMBLE

It is well documented that stroke rehabilitation services play a critical role in offering people with stroke and their families the best opportunity for optimal recovery. Strong evidence indicates that any form of continuing rehabilitation therapy is superior to no additional therapy and is associated with significantly reduced odds of a poor outcome, as well as greater improvements in function and mood[1]. Stroke rehabilitation has also been associated with a reduction in the severity and number of falls, as well as a reduced potential for hospital readmission. As such, stroke rehabilitation plays a critical role in the management of patient flow through the healthcare system and in the prevention of recurrent hospitalization.[2]

During the initial stages of the COVID-19 pandemic there were significant decreases in access to in-person ambulatory stroke rehabilitation (outpatient clinics). While some programs successfully transitioned to providing some outpatient stroke rehabilitation using virtual platforms and/or maintained essential visits with new restrictions, many programs temporarily closed completely for a variety of reasons. While virtual stroke rehabilitation continues to be an important aspect of the provision of rehabilitative care

[1] Outpatient Service Trialists. Therapy-based rehabilitation services for stroke patients at home. Cochrane Database of Systematic Reviews 2003, Issue 1. Art. No.: CD002925. DOI: 10.1002/14651858.CD002925.

[2] Robert Teasell (First Author), Nancy M Salbach (Co-First Author)., et al., on behalf of the Canadian Stroke Best Practices Advisory Committee. Canadian Stroke Best Practice Recommendations, 2019; Ottawa, Ontario Canada: Heart and Stroke Foundation

there is recognition that in-person stroke rehabilitation is required for certain interventions and persons with stroke.

On June 8, 2020, Ontario Health (OH) released the document Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care which provides high-level recommendations to support key planning criteria for increasing care delivery during the pandemic. As Ontario begins the gradual resumption of in-person ambulatory care services, CorHealth Ontario has worked in collaboration with stroke rehabilitation experts and other stakeholders across the province to discuss the gradual return to their full scope of services during the COVID-19 pandemic, including planning for the resumption of in-person outpatient stroke rehabilitation. This document reflects advice from this engagement and aims to provide specific guidance and considerations for the stroke sector.

GUIDING PRINCIPLES

1. Keeping front line health care providers healthy and clients protected is vital.
2. Minimizing the impact of COVID-19 on the mortality and morbidity of patients with stroke is a priority.
3. Aligning with province- and organization-specific infection prevention and control policies and protocols is important.
4. Promoting clinical activities while still preserving health service resources is important.
5. Ensuring patients continue to have access to urgent and/or essential care across the continuum.
6. Ensuring the best outcomes for patients and preserving best practice stroke care as much as possible.

ASSUMPTIONS

The guidance memo was developed with the following assumptions in mind:

- The key planning criteria and associated recommendations for implementation outlined in the Ontario Health document released on June 8, 2020 are satisfied before any increase in care activities.
- Despite the critical need to provide virtual stroke rehabilitation options, there are many situations where in-person services are necessary. The delivery of outpatient stroke rehabilitation will need to include both virtual and in-person care options.
- Some regions/programs will be better positioned to resume virtual or in-person stroke rehabilitation activity than others due to differences in capacity and/or rates of COVID-19 cases.
- Local programs and providers are in the best position to determine which clinical services are best delivered virtually or in-person, assuming the necessary provincial, regional, local and applicable health regulatory college requirements are met.

- Resumption of in-person outpatient stroke rehabilitation services will be a gradual process.
- The virtual care landscape will continue to evolve (e.g. patient and provider experience, organizational models/ workflow processes, health care provider responsibilities, organizational leadership/champions, compensation models, digital health, etc.).
- The delivery of outpatient stroke rehabilitation will need to accommodate to the potential ebb and flow of care delivery restrictions along the COVID-19 pandemic trajectory.
- The increase of outpatient in-person visits will be coordinated with other related services, recognizing the interdependent nature of the stroke system (e.g. community programs, Home and Community Care).

DETERMINING CLIENT PRIORITIZATION FOR WAIT LIST MANAGEMENT

When resuming services, programs may initially be faced with challenging decisions regarding which clients should be prioritized for service. In addition to the ethical framework outlined in the OH document released on June 8, 2020, a priority decision making process should be used in conjunction with clinical judgement to ensure equitable access and standardized prioritization. Where appropriate, the process should be developed collaboratively across the region. A process for prioritization is outlined below.

Consider first priority clients based on:

- New acute care referrals
- New inpatient rehabilitation referrals (supporting discharge from inpatient)
- Acute/inpatient rehabilitation/community referrals with no follow-up rehabilitation pre COVID-19
- High risk referrals from any source or previous level of therapy e.g. functional deterioration, safety concerns, risk of readmission, etc.

Second priority client level based on:

- Clients put on hold from in-person rehabilitation as a result of COVID-19 and who did not receive virtual therapy
- Clients who received only a minimal amount of virtual therapy services during COVID-19 restrictions

Third priority client level based on:

- Clients who received moderate amount of virtual therapy services during COVID-19 restrictions
- Return to work or return to driving needs

TIPS AND CONSIDERATIONS

- Clinical judgement and additional processes should be used to support the approach for prioritization especially when considering backlog versus current referrals (e.g. phone calls, triage tool, use of therapist or assistant).
- Ensure that existing clients who are receiving virtual rehabilitation are included in the prioritization process for in-person therapy.
- Consider previously used local program priority criteria and adjust to align with priority levels stated above.
- Maintain regular contact for those on the waitlist to identify risk or change in priority level.
- Consider diverting to other services that could meet client's needs (e.g. in home in-person rehabilitation, private pay).
- All priority levels should receive adequate staffing to support flow and movement in all parts of the waitlist.
- Consider opportunity to schedule single service sooner (e.g. physiotherapy only) versus waiting to address multi-disciplinary needs simultaneously to begin some therapy.

CONSIDERATIONS TO DETERMINE STROKE REHABILITATION SERVICES (IN-PERSON, VIRTUALLY OR HYBRID MODELS)

All outpatient stroke rehabilitation programs are encouraged to provide virtual services for all eligible clients when and where possible. A hybrid model of virtual care and in-person services should be considered as we prepare to increase the number of in-person visits.

For all clients referred to outpatient stroke rehabilitation, an initial discussion should be completed to identify client need, ability, client characteristics (e.g. immunocompromised), social supports, and interest for virtual, in-person or a combination (hybrid) model of stroke rehabilitation services (see Appendix 1).

Fluid communication between inpatient and outpatient teams should occur to ensure collaborative decision making and preparation between teams as to which clients will or will not do well in a virtual session (e.g. the client has the technology and if they need to be set up, will support the planning process for the client/family, etc.). Where possible, these discussions should occur prior to discharge from the inpatient setting to ensure appropriate services are available to meet the client's needs.

CONSIDER THE FOLLOWING CRITERIA FOR IN-PERSON VISITS

- A client requires an in-person clinical and/or functional assessment by a health care provider to gather critical information for informing care decisions that is not possible to gather accurately and confidently in a virtual platform (See table 1 for list).

- A client's rehabilitation needs require in-person support in order to be delivered safely and effectively (See table 1 for list).
- A client does not have access to or is unable to use virtual technology for the purposes of participating safely and effectively in stroke rehabilitation and cannot be supported to do so by a caregiver or family member (e.g. privacy, language barriers, financial barriers, internet access).
- Client consent/preference needs to be considered when recommending in-person or virtual care.

Table 1: List of clinical needs or interventions requiring in-person assessment and/ or stroke rehabilitation

New onset of stroke with a recent discharge from an acute care or inpatient rehabilitation facility who present with or need any of the following:
• **Assessments, treatments and/or recommendations** pertaining to their ability to perform essential functional movements (e.g. gait aid prescription, practice with transfers, activities of daily living equipment set up) to prevent falls, hospital readmissions and to ensure basic home safety/accessibility. • **Hemiparesis requiring therapy**, including prescription of key functional activities and specific exercises to facilitate recovery, maintain and improve movement, prevent learned non-use in their affected limb(s)/trunk. • **Limb paresis/dysfunction requiring therapy**, including prescription of specific exercises prevent muscle contractures and pain due to increased tone. • **Language or swallowing difficulties** that impact safety require a Speech-Language Pathology assessment, treatment and recommendations regarding essential communication strategies, prevention of aspiration and subsequent complications such as pneumonia. • **Cognitive and/or perceptual difficulties** that require treatments to progress independence and safe living in the home. • **Emotional distress** (e.g. anxiety/depression) require counseling if provision via virtual care is not possible and supports to prevent further decline that may be caused by isolation or new medical/functional status post-stroke. • **Education on the use of new equipment** (e.g. transfer bath bench, wheelchairs), particularly when cognitive and perceptual difficulties limit independence and/or there is no caregiver/family available to assist. • Unable to perform **instrumental activities of daily living (IADLS),** or require further assessment to determine their ability • **Caregiver or family teaching** is required to support rehabilitation goals. • **Change in status** may require in-person visits to assess and treat as indicated (i.e. skin integrity issues, change in seating/positioning, lack of progression in rehabilitation goals, move to a new home environment or change in status of caregiver support). *Adapted from CorHealth COVID-19 Stroke Memo #2: Recommendations for an Ontario Approach to the Provision of Stroke Rehabilitation during COVID-19.*

OPPORTUNITIES FOR VIRTUAL CARE

When considering care plans, consider these interventions and clinical activities that can be supported in a virtual capacity. (Table 2)

Table 2: List of interventions and clinical activities to consider delivering in a virtual capacity.

Interventions and Clinical Activities
• Intake/history assessment where the information collected guides which disciplines will support the client and the level/intensity of support required • Social Work visits • Visits that include education/linking with community services, counseling, assistance with completion of forms/applications • Appropriate group interventions e.g. aphasia and memory group • Teaching or re-enforcing stroke education (may include use of different modalities such as videos, group education, print materials previously shared or 1:1 teaching) • Outpatient Case Conferences (between clinicians and/or with client/family) • Involvement of outpatient staff in family meetings during inpatient rehabilitation • Virtual meeting with outpatient team while client is still in acute care or in-patient rehab setting • Staff observation of home setting for a more customized treatment plan. • Visual equipment and safety check (e.g. bathroom set up) • Pre-driving training skills such as visualization and high level perceptual, visual, sensory and physical skills (e.g. Parkwood's Return to driving electronic toolkit). • Guided mental imagery • Paper pencil tasks augmented with use of document viewer camera to allow client to work on tasks without having to move camera simultaneously. • Use of annotation and white boards through technology platform (if available) for supported communication, error recognition, visual search exercises etc. • Treatment in-home with therapy partner present (e.g. caregiver, family/friends), or pre-determined safe location for therapy session within the home (e.g. use of corner of room for safety from falls). • Observation and provision of feedback for variety of functional tasks or exercises (e.g. gait, kitchen tasks, transfers, upper extremity/fine motor (once safety established). • Speech and language pathology therapy sessions where observation of therapists' face, mouth movement is important and not impeded by staff wearing a face mask and face shield (that would be needed in a face to face setting**)** • Regulated staff supervising assistants during treatment (across departments/sites/in-home) • Administering outcome measures (verbal survey type, functional scales such as the FIM) • Some assessment/screening tools may be appropriate to administer remotely (e.g. MOCA, Berg Balance Scale)

TIPS AND CONSIDERATIONS

- Continually re-evaluate virtual care clients in case of change in delivery mode is required.
- Virtual care if appropriate, may be facilitated by providing clients with required technology (e.g. tablet, webcam etc.).
- Conduct virtual visit test run with client and family while in the inpatient setting.
- Consider hybrid models (e.g. client coming in once/twice a week for in-person and then virtual care for remaining session(s) or client alternates weekly between in-person session and virtual care sessions).
- Ensure plan for staff training and support on integrating virtual care in practice. Education should be aligned with best practice and college standards.
- May need to consider treatment methods based on client's consent or lack thereof to participate in virtual or in-person therapy.
- Risks and benefits of rehabilitation and updated safety practices should be clearly and consistently explained to clients and families to promote the importance of participating in rehabilitation that best meets their needs.
- For evaluation and future planning purposes, programs should strongly consider the collection of client/process outcomes and tracking method of virtual care versus in-person rehabilitation, including clinician and end-user feedback.

PREPARING CLIENTS TO TRANSITION FROM AN INPATIENT TO OUTPATIENT REHABILITATION SETTING

- Essential professional conversations between inpatient and outpatient teams to collaboratively determine virtual versus face-to-face care in outpatient setting (or if inpatient rehabilitation is required from acute setting).
- Patients learning and trialing technology is an important activity of daily living and should be part of therapy starting in the inpatient setting.
- Outpatient staff should meet (virtually, by phone or in-person) with clients (and inpatient team members) while clients are still in inpatient setting to assess needs, appropriateness for virtual care and to prepare them for their outpatient rehab experience (e.g. review home exercises, clarify follow up instructions).
- Upon transition, conduct warm clinical handovers between inpatient and outpatient teams.
- Virtual technology could be used for outpatient and acute/inpatient teams to meet with client to go through home exercise program, discuss appropriateness for virtual care, set up technology, and discuss next steps.
- Leverage online education resources (e.g. Guide for Stroke Recovery).
- Consider booking first outpatient appointment before the client is discharged from acute care or inpatient rehabilitation.

- Consider outpatient follow-up phone call with client/family in the community to ensure that client/family are prepared for initial in-person or virtual outpatient visit.
- Consider a designated point of contact to assist with transitions (e.g. stroke navigator).

ADDITIONAL CONSIDERATIONS FOR RESUMING SERVICES

While recognizing that requirements and planning criteria outlined in the COVID-19 Operational Requirements: Health Sector Restart guidelines on May 26, 2020 (Version 1.0) as well as the OH document released on June 8, 2020 must be met, the following list provides additional considerations for resuming in-person stroke rehabilitation services.

HUMAN RESOURCE CAPACITY

- For organizations/regions with multiple specialized rehabilitation services, prioritize resumption of services not offered elsewhere (e.g. specialized neuro clinic versus general rehabilitation where client needs can be met in the community).
- Stagger start times amongst health professional teams, to help flag priorities for other team members.
- Consider new roles for therapy assistants or support staff for completing virtual care "tests calls" and/or education with clients regarding virtual connection prior to therapy appointment.
- Consider implementation of virtual groups (Graded Repetitive Arm Supplementary Program, memory, aphasia, education).
- "Partner" with other rehabilitation partners with stroke expertise including acute and community care (consider private sector referrals or partnerships when appropriate).

ENVIRONMENTAL MEASURES/ PHYSICAL DISTANCING

Treatment space:

- Staff can be physically spaced away from client during portions of the in-person visits if client is independent/safe, e.g. verbal component of an initial assessment.
- Spread out equipment and tables in treatment area.
- Suspend group programming and consider virtual groups.
- Establish a maximum number of people allowed in the gym at all times.
- Remove unnecessary items from the environment (e.g. equipment/decorative accents, newspaper/magazines).
- Establish flow control (tape on floor that promotes physical distancing and guides clients on where to go etc.).
- Use of plexiglass partition for table-top treatment activities (speech therapy, occupational therapy).
- Do a walk-through of treatment area to help with planning optimal physical distancing.

Waiting areas/Hallways:

- Move bifold to create sections for different areas of clinic environment stroke clinic; label equipment, set out a few chairs for caregivers).
- Installation of plexiglass barriers if possible.
- Directional traffic in hallway/exits and/or staff meet clients in waiting room to escort client to the treatment area.
- Advising clients/caregivers to arrive no earlier than 5 minutes prior to treatment and not to be late, as this can impact physical distancing plan.
- If travelling in their own vehicle, advising client to wait in their vehicles until the clinic is ready to see them. The clinicians can call/text client/caregiver on their cell phone when the space is open.

Scheduling:

- Stagger client appointments.
- Stagger staff breaks and staggered start times (e.g. schedule into early evening to allow for more overall volumes in light of physical distancing and enhances safety measures).
- Schedule vulnerable clients as first appointment of the day.
- A portion of staff working virtually at specific time/days while the other portion is working with clients in-person.
- Having same staff for common shifts e.g. always the same OT and PT working in the clinic on Mondays, Tuesdays and Wednesdays, and working virtually on Thursdays and Fridays.
- Increased time slot per client to allow extra time for cleaning/infection control i.e. 45 min time slots, where 30 min is used for treatment and last 15 min is used to wipe down surfaces and time for clients to go to next session or to leave the treatment area.
- Consultation with Hospitality services/ Organizational cleaning services to increase and plan for scheduled cleaning in highly frequented areas such as treatment area, hallways and washroom facilities (e.g. cleaning between morning and afternoon treatment sessions).

Visitors/Caregivers:

- Approved visitors/caregivers should only attend therapy sessions if needed.

SCREENING, INFECTION CONTROL AND USE OF PPE

- Designated person doing all screenings prior to client appointments.
  - Use consistent method of communicating client expectations regarding masks, hand hygiene etc.
- Staff screening includes temperature taken daily on entry.
- Passive screening (sign on door, wall) ONLY in conjunction with active screening.
- Process in place to communicate screening outcome of client (+/-) from hospital door to outpatient clinic entry (e.g. checkered arm band if positive screen).

- Point of care risk assessment i.e. actions and follow up (switch to future virtual care, don PPE etc., ensure access to PPE).
- Handout for clients explaining why the therapist is wearing (or not wearing) PPE or why they need a mask; use of aphasia-friendly handouts where appropriate.
- Observation of PPE donning and doffing by colleague to ensure proper procedure (especially when not regular use).

ACKNOWLEGEMENTS

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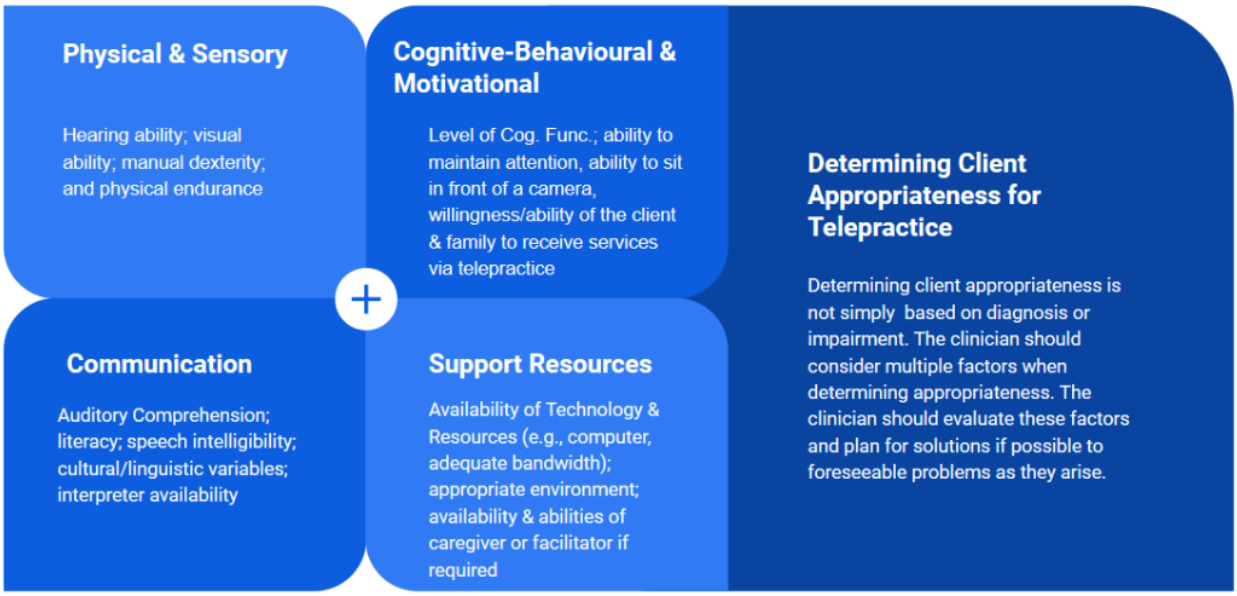
APPENDIX 1: APPROPRIATE CLIENT SELECTION AND SAFETY



Source:
https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934956&section=Key_Issues#Client_Selection
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