White Board Presentation

http://ontariostrokenetwork.ca/blog/rehab-intensity-whiteboard-video-released

https://www.youtube.com/watch?v=5wF3KlYdttI

Towards 180 Minutes a Day: One Step at a Time

Facilitated by: Janine Theben, on behalf of the
Provincial Rehabilitation Intensity Working Group
January 13, 2016
1200-1330

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Objectives

At the end of this education session, you will be able to:

1. Share key messages from a stroke survivor's perspective on rehabilitation intensity
2. Share ideas and strategies used by organizations across Ontario to support stroke Rehabilitation Intensity and implementation.
3. Identify where to access current rehabilitation intensity resources.

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Definition of Rehabilitation Intensity

Rehabilitation Intensity is defined as:

The amount of time that a **patient** is engaged in active, goal-directed, face-to-face rehabilitation therapy, monitored or guided by a therapist, over a seven day/week period.

- *Physical, functional, cognitive, perceptual and social goals to maximize the patient's recovery*

Measuring Rehabilitation Time in the NRS:
 # minutes of Rehabilitation Intensity (defined above) for OT, PT, S-LP, OTA, PTA, CDA

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Sharing Successes

Agenda:

* Mike Gardner - Stroke Survivor, Kingston.
* Andrea Guth - Grand River Hospital, Kitchener.
* Joan Ruston Berge - Grey Bruce Health Services, Owen Sound.
* Jennifer Shaffer - St. John's Rehab - Sunnybrook, Toronto.
* Question & Answer Period.

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This is Mike's Story

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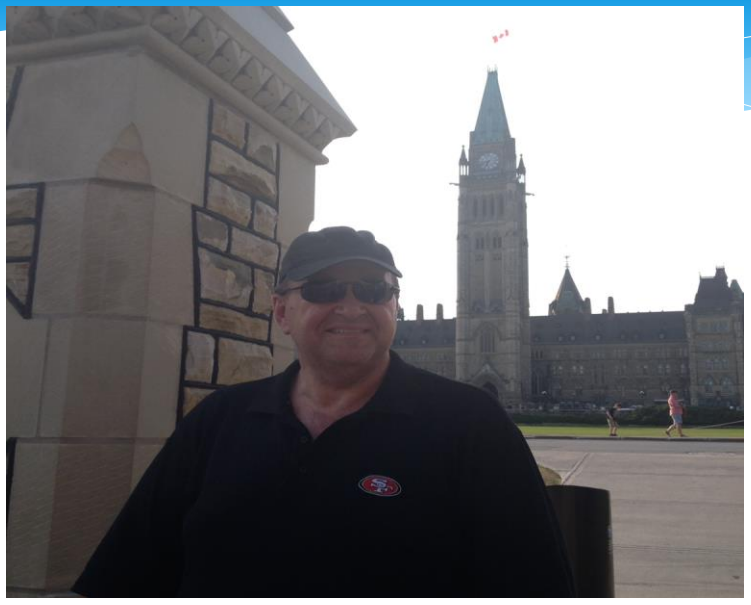
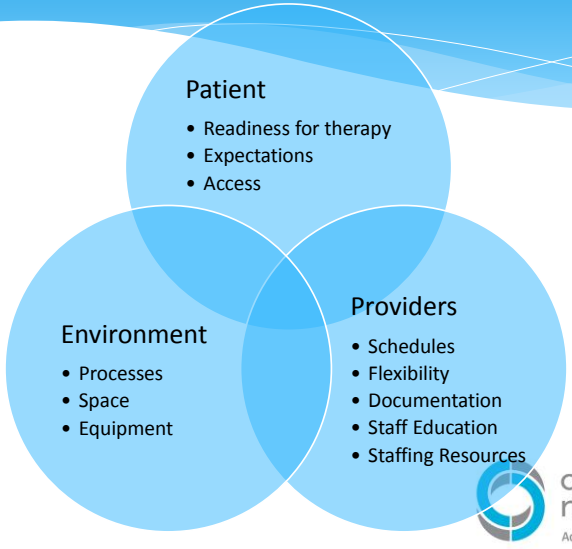


Opportunities



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Local successes and quality improvement strategies that have enhanced stroke rehabilitation intensity

OBJECTIVES

- Understand the Grand River Hospital Inpatient Rehabilitation Unit
- Review the catalyst for change, including Waterloo Wellington stroke system changes
- Outline quality initiatives implemented at Grand River Hospital – Inpatient Rehabilitation
- Discuss strategies to increase rehabilitation intensity
- Review data demonstrating outcomes of change
- Discuss challenges encountered

INPATIENT REHABILITATION UNIT

- 33 beds
- 18 stroke beds, 15 mixed rehab beds
- Geographically separated on two courts
- Medical coverage with 2 family physicians
  2 days per week, 3 days per week
- 4 OT's, 4 PT's, 3 TA's*, 1 SLP, 0.6 CDA, 0.6 SW, 0.4 REC, RD

*Rehab Assistant

BEFORE AND AFTER

Prior to 2013

- 3 OT's, 3 PT's, 2 TA's
- No OT/PT teams
- Ratio 1:11 for all patients
- All staff attend rounds
- Discharge dates established based on team discussion
- Communication with family as needed

After 2013

- 4 OT's, 4 PT's, 3 TA's
- OT/PT therapy teams
- Stroke 1:6, Mixed 1:15
- One team member attends rounds for group
- Discharge dates established using RPG and QBP targets
- Discharge letters/family meeting within 7 days

QUALITY INITIATIVES

- Quality Council
- **Model of Care**
- **Group Programming**
- **Discharge Planning**

MODEL OF CARE

- Implemented in 2013
- Integration of therapy staff into morning care routine
- Nursing and therapy communication
- OT's and TA's working 0700 – 1530
- PT's working 0800 – 1600 OR 0830 – 1630
- ADL assessment/practice
- Transfers/ambulation
- Assistance in dining room with containers and U/E tasks

GROUP PROGRAMMING

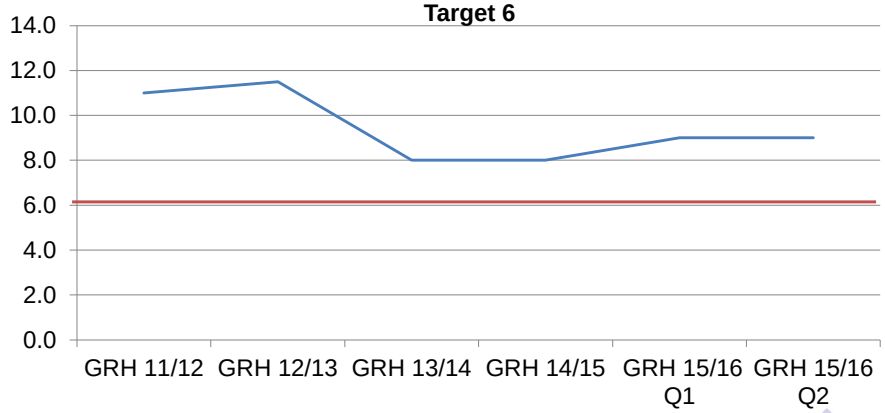
- Sit < - > Stand group
- GRASP group (functional upper extremity training)
- L/E group (seated and standing)
- U/E group
- Aerobic training group
- Meeting needs of all patient groups
- Goal: increased goal directed therapy, increased patient activity throughout the day

DISCHARGE PLANNING

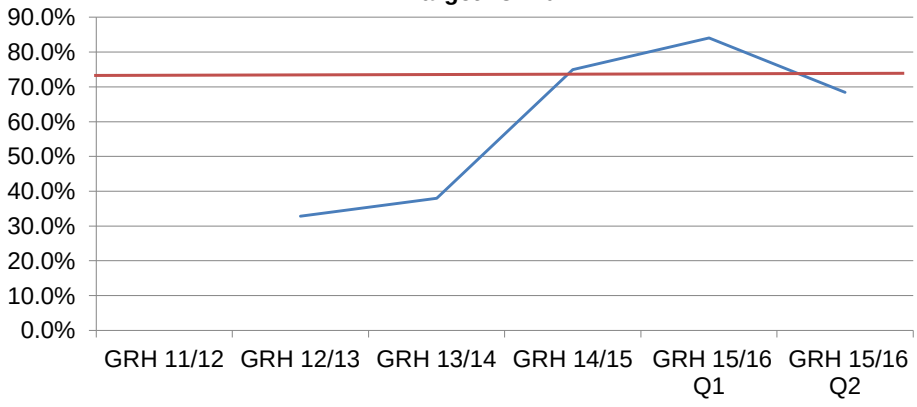
- Bullet Rounds
- Multidisciplinary Team Rounds
- Primary Contact
- Family meetings
- Discharge letters
- Community Stroke Program

OUTCOMES

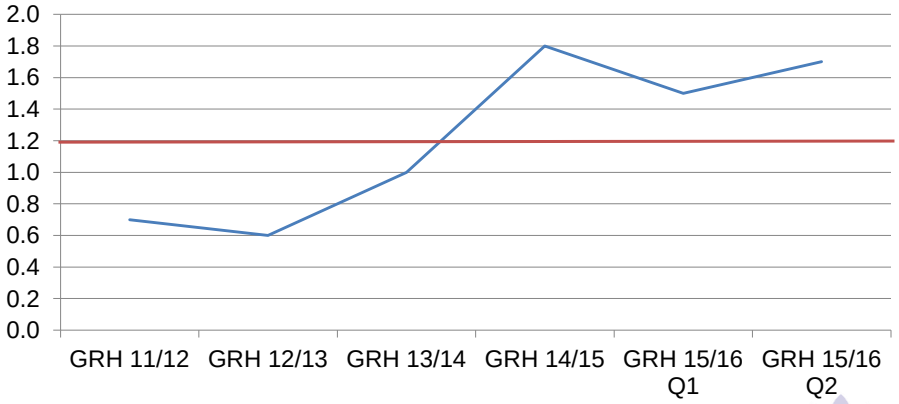
Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation (RCG-1 and RCG-2).
Target 6



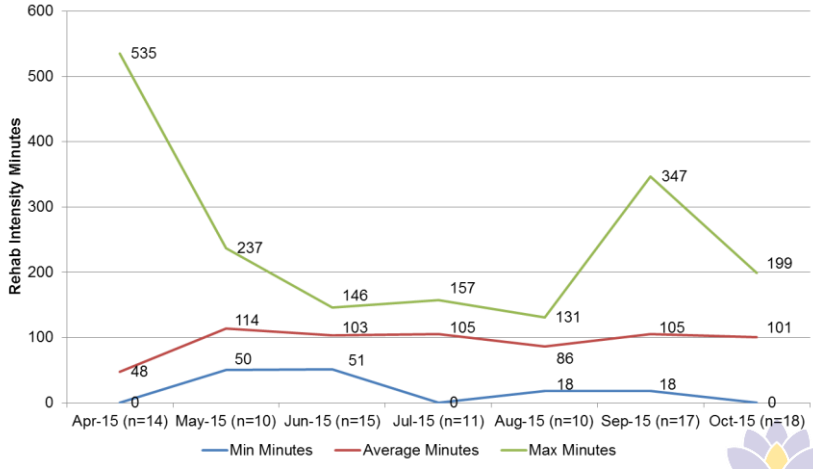
Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay
Target 73.1%



Median FIM Efficiency for moderate stroke in inpatient rehabilitation (RCG-1).
WWLHIN 12/13 - 0.8
Target 1.2



REHABILITATION INTENSITY MINUTES PER ACTIVE TREATMENT DAY
APRIL 1 – OCTOBER 31, 2015*



*Preliminary Raw Data

CHALLENGES

- Roles and responsibilities in morning care (for therapy staff and nursing)
- FIM documentation
- Staffing (part time availability)
- Staff from other areas not comfortable providing care on unit

QUESTIONS

Andrea Guth
Program Director, Waterloo Wellington Integrated Stroke Unit
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GRAND RIVER HOSPITAL
Advancing Exceptional Care

Stroke Rehabilitation Intensity

District Stroke Centre, Owen Sound
January 13, 2016
Joan Ruston Berge

Stroke Network
Southwestern Ontario
Serving Erie St. Clair and South West LHINs

Objectives

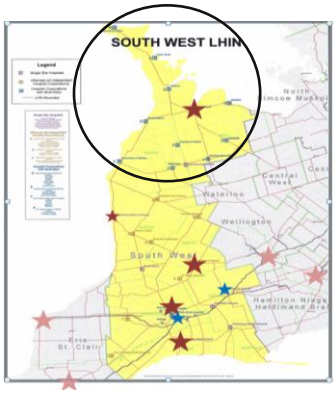
Describe one initiative implemented by our Rehabilitation team to increase Rehab Intensity

Electronic Scheduling Board

Grey Bruce Health Services Rehabilitation Unit

- 16 bed General Rehab plus 4 Restorative Care
- ~ 200 admissions/yr
- ~50% population strokes
- Therapy 5 days/week currently
- Acute stroke Unit to Rehab 4.2 days (Q1 2015/16)
- Allied Health no replacement for vacation, sick etc

Therapists	FTE
PT	2
OT	1.4
PTA	1
OTA	1
SLP	.6
SW	1
Rec Therapist	.6



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Electronic Scheduling Board

- Replaced large magnetic therapy whiteboard with electronic version that is internet based (Cerner)

Rationale

- Create efficiencies and maximize resource intensity
- Planning focused on the patients day versus therapists day
- Enable ease of access for therapists and nursing
- Maintain a colour coded visual representation for patients, families, staff, volunteers

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Regional Rehab Site Visit
Team Priorities

Priorities for Improvement Related to Increasing Rehabilitation Intensity

Staffing Resources	**All**
Patient Access • patient readiness for therapy times • competition for limited treatment times	**Bluewater, Owen Sound, St Thomas** Woodstock, Parkwood (portering)
Scheduling • improve coordination, maximize efficiency and communication • provide options to rapidly build tolerance	**Windsor** Chatham, Owen Sound, St Thomas, Bluewater
Team Coordination/Processes • efficiency of time spent in rounds, meetings • appropriate personnel for each task	Bluewater, Windsor, Stratford
Space & Equipment • availability of necessary equipment • access to sufficient space	**Parkwood** Chatham
Patient Expectations • provide culture/expectation of active participation • seek patient experience to inform change	**Woodstock** Windsor
Documentation • builds on work already completed in acute care • charting by exception	**Stratford**
Staff education • build on stroke expertise • availability of education in accessible formats	

Technology Designed To Meet Clinical Need

Electronic Board Must Haves…

- Automatic population of admissions and discharges from Cerner
- Large, colourful and highly visible display for patients, staff and families
- Provide patient safety info (icons, colour coding - ie isolation, falls risk)
- Fluid – refreshes and updates continually
- Access from therapist offices (view and schedule)
- User friendly

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Features

- Visual view of the patient day
- Can schedule when patient is not available Therefore saves time looking for patients
- Colour blending = 2 therapists are working together
- One time or reoccurring appointments

Features

- Good visual of # hours of therapy patient is scheduled for over the day – allows therapists to add 'extra' session
- Source of truth (quick glance)
- Printable for volunteers
- Increase collaboration between entire team

GBHS Lion's Head | GBHS Markdale | GBHS Meaford | GBHS Owen Sound | GBHS Southampton | GBHS Wiarton

Electronic Scheduling Board

Challenges

- Training time (4 hours) and associated costs
- Scheduling requires upfront time
- Schedule/Board must be updated whenever a change is made to remain accurate
- Not all Rehab therapy staff work on Rehab exclusively (some in other sites) so must log in for visual – also a positive as it is now accessible remotely
- Initial costs – 52" monitor, thin client ~$1000-&1200

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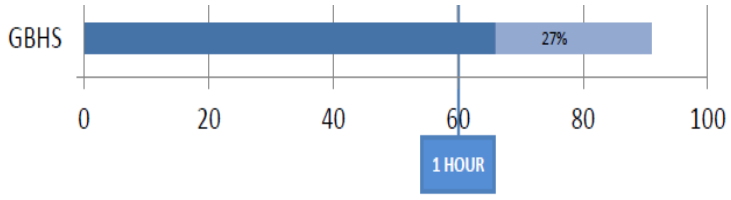
Rehab Intensity Q1 2015 2016



Rehabilitation Time in Minutes

Therapist Time
Assistant Time

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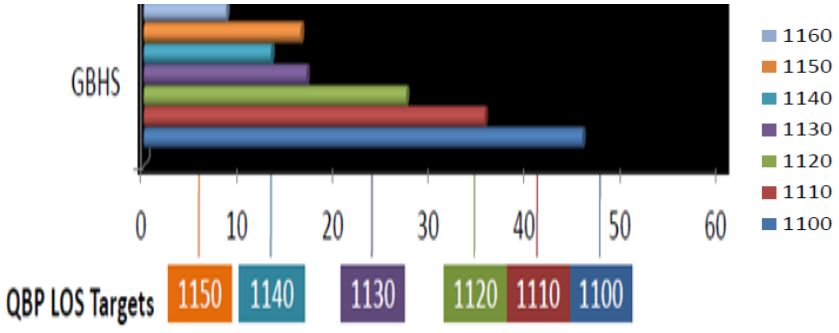
LOS by RPG for 2014/15



Rehabilitation Length of Stay in Days

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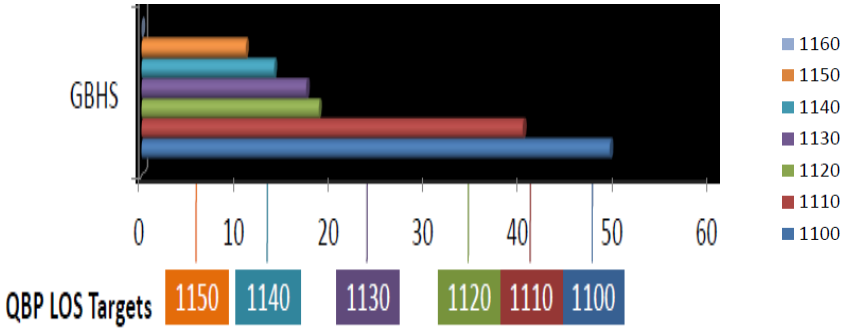
LOS by RPG Q1&2, 2015/16



Rehabilitation Length of Stay in Days

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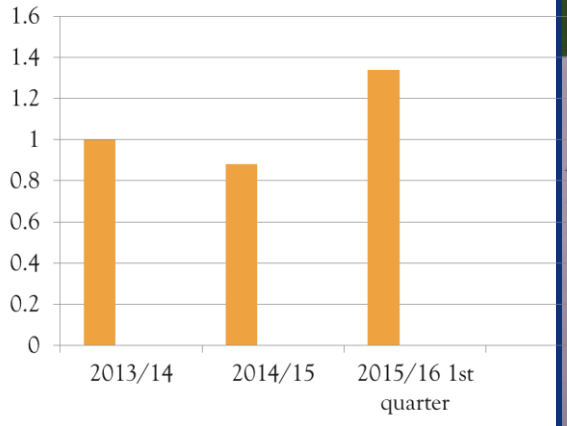
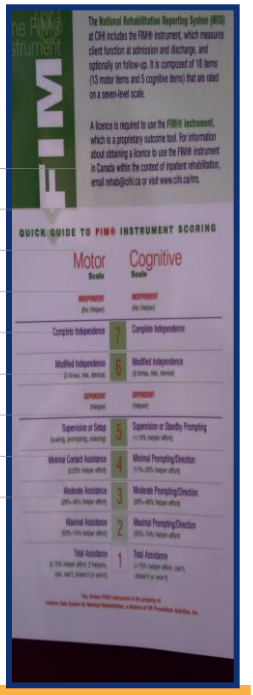
FIM Efficiency





GBHS Rehab Team

Thank You

Questions?

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Implementing Rehabilitation Intensity: Ensuring a Seamless Integration of Clinical and Support Processes

Jennifer Shaffer
Professional Practice Leader, Physiotherapy
January 13, 2016

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ST. JOHN'S REHAB

Rehab Intensity

"The patient time spent in **individual** rehabilitation therapy that is aimed at achieving therapy goals based on physical, functional, cognitive, perceptual and social means in order to maximize the patients recovery"

QBP Clinical Handbook for Stroke

Rehab Intensity:

- key indicator for evaluating efficiency and effectiveness of stroke care
- benchmark is 180 minutes of direct task-specific therapy per day by the interprofessional stroke team (OT, PT, and SLP)

Our task:

- Applying these requirements in a rehab setting
- Providing and recording sufficient rehab intensity

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Collaborative Process

Who?

- Leadership team established to guide the process:
  - Operational
  - Professional Practice / Education
  - NRS Coordinator, Workload Coordinator and Decision Support
  - IT / Application Specialist

What?

- Identified gaps with meeting the QBP requirements
  - Staffing ratios
  - Treatment models
  - Space and equipment resources
  - Workload measurement and National Rehab Reporting System (NRS)

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Staffing Ratios

Revised staffing ratios: more clinicians see fewer patients for more time

	Previous	Revised
OT	1 : 10	1 : 6
PT	1 : 9	1 : 6
SLP	1 : 20	1 : 12

Therapist : Patient

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Treatment Models

Previous	Revised
Trending toward more group classes – to enable more patients to be seen in therapy	Therapy is primarily 1:1 Groups are viewed as supplementary

Group therapy:

- Seen as still being beneficial
- Yet does not specifically fall under the rehab intensity definition of **individualized**, direct, task-specific therapy

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Therapy Space

Previous	Revised
• One OT treatment room for the unit • One PT treatment room for the unit • 2 SLP treatment rooms	In addition to the standard treatment rooms: - Converted offices into additional treatment rooms for OT, PT (including isolation treatment) - Additional SLP treatment room

- New equipment purchased for these rooms
- Provides more options for individualized treatment

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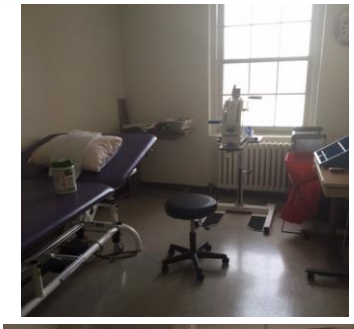

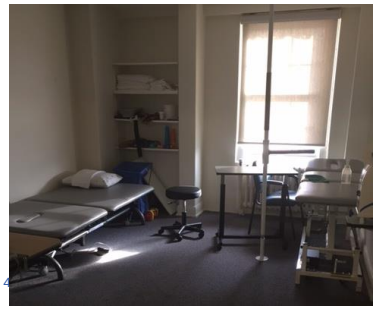

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Stroke Cohort

- As per the Best Practice guidelines, created a cohort of stroke beds on a mixed unit
- Patients co-located with a dedicated care team
  - Sub-teams of OT, PT, SLP
  - Starting to incorporate nurses into the sub-teams
  - Makes day to day communication more efficient
  - Stroke huddles take place on Day 2-3
  - Weekly rounds focusing on review of goals required for discharge

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Workload Measurement / NRS

- Modified workload measurement system to incorporate recording requirements for Rehab Intensity and for NRS.
  - Includes categories for co-assessment and co-treatment (face to face with patient)
    - Assessment or Therapeutic Intervention - Solo
    - Assessment or Therapeutic Intervention - With therapist
    - Assessment or Therapeutic Intervention - With assistant
  - No need to enter workload **AND** Rehab Intensity
  - Clinicians enter their workload using the extra categories for co-assessment and treatment where applicable
  - Calculations for rehab intensity are done in the background
  - Validation report run to ensure excellent data quality

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Workload Measurement / NRS

- NRS vendor solution to upload the RI data quarterly prior to submission
- Re-certified all of our clinicians in NRS to ensure accurate depiction of patient status and classification into RPGs.

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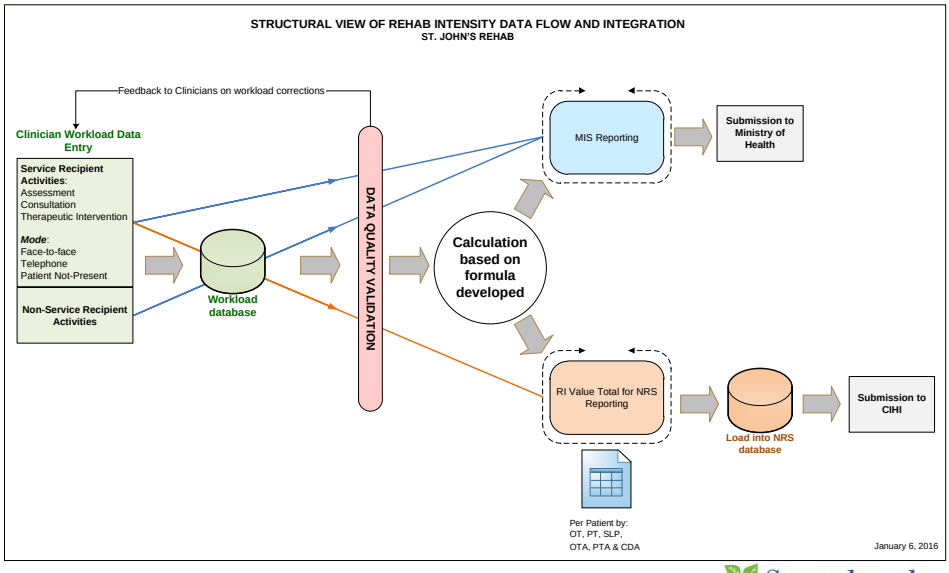

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Results

- Success with Rehab Intensity collection has been achieved by engaging in a collaborative process to ensure a seamless integration of clinical and support processes
- There is value in creating an integrated workload system that captures Rehab Intensity, with no additional time requirement for clinicians to calculate
- From April 2010 – March 2015, therapy time for stroke patients has increased by 54%

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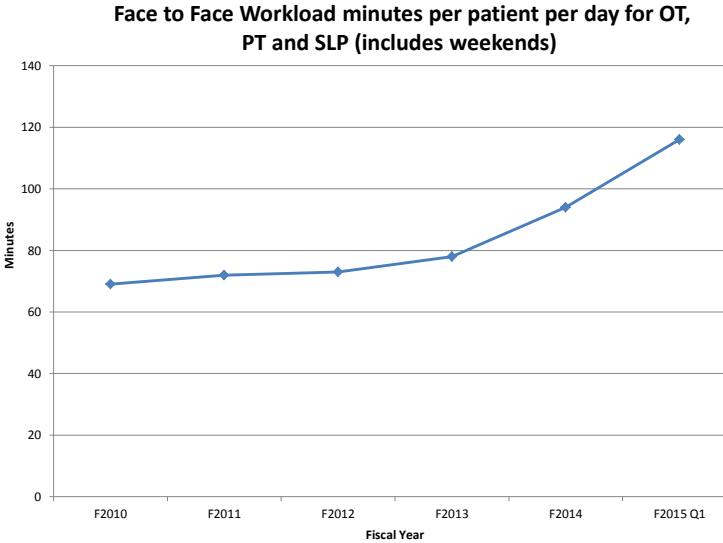

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Next Steps

- Evaluate this initiative from the perspectives of data quality as well as the patient experience and staff satisfaction
- Provide system leadership as we share experiences and successes with partner hospitals

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Contact Us

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Questions

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Resources Developed to Support Rehabilitation Intensity Data Collection and Implementation

Resources

- **Ontario Stroke Network – Stroke Quality Based Procedures Resource Centre**
  - www.ontariostrokenetwork.ca
  - Clinical Tools & Resources for Implementation In-Patient Rehabilitation
  - Rehabilitation Intensity
- **Virtual Community of Practice**
  - www.strokecommunity.ca
  - Discussion Forum: Rehabilitation Intensity

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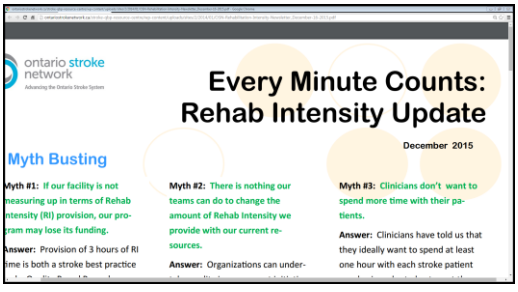
Rehabilitation Intensity Resources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Every Minute Counts: Rehab Intensity Update

December 2015

Myth Busting

Myth #1: If our facility is not measuring up in terms of Rehab Intensity (RI) provision, our program may lose its funding.

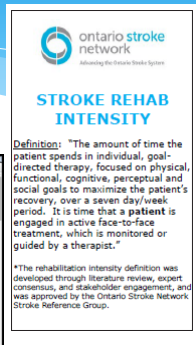
Answer: Provision of 3 hours of RI time is both a stroke best practice

Myth #2: There is nothing our teams can do to change the amount of Rehab Intensity we provide with our current resources.

Answer: Organizations can under-

Myth #3: Clinicians don't want to spend more time with their patients.

Answer: Clinicians have told us that they ideally want to spend at least one hour with each stroke patient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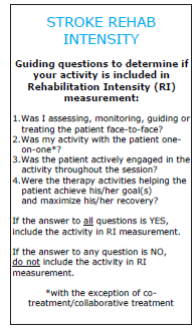
STROKE REHAB INTENSITY

Definition: "The amount of time the patient spends in individual, goal-directed therapy, focused on physical, functional, cognitive, perceptual and social goals to maximize the patient's recovery, over a seven day/week period. It is time that a patient is engaged in active face-to-face treatment, which is monitored or guided by a therapist."

*The rehabilitation intensity definition was developed through literature review, expert consensus, and stakeholder engagement, and was approved by the Ontario Stroke Network Stroke Reference Group.


STROKE REHAB INTENSITY

Guiding questions to determine if your activity is included in Rehabilitation Intensity (RI) measurement:

1. Was I assessing, monitoring, guiding or treating the patient face-to-face?
2. Was my activity with the patient one-on-one*?
3. Was the patient actively engaged in the activity throughout the session?
4. Were the therapy activities helping the patient achieve his/her goal(s) and maximize his/her recovery?

If the answer to all questions is YES, include the activity in RI measurement.

If the answer to any question is NO, do not include the activity in RI measurement.

*with the exception of co-treatment/collaborative treatment

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Listing of all Regional Rehabilitation Coordinators

NAME	EMAIL	PHONE	FACILITY/SITE/REGION
Beth Nugent	bnugent@toh.on.ca	613-798-5555 x14430	Champlain Regional Stroke Network
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Nicola Tahair	nicola.tahair@uhn.on.ca	416- 690-3660	Toronto Stroke Networks
Sylvia Quant	sylvia.quant@sunnybrook.ca	416-480-6100 x 7424	North & East GTA Stroke Network
Stefan Pagliuso	pagliuso@hhsc.ca	905-527-4322 x 44127	Central South Regional Stroke Network

What can you do as a clinician?

- Are there ways to maximize therapy time?
- How can you change the way you schedule patients to meet their endurance and participation needs?
- How can you coordinate with interprofessional team members to support therapy sessions with your patients?
- Can you advocate for changes to equipment, space, processes on your unit?
- How can you use volunteers, families, and caregivers to support the process?

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Thank You!

Questions?

Members of OSN Rehabilitation Intensity Working Group:

- Beth Linkewich (Co-Chair), Sylvia Quant (Co-Chair), Donelda Sooley, Janine Theben, Deb Willems, Shelley Huffman, Amy Maebrae-Waller, Judy Murray, Jennifer White, Jennifer Fearn, Jennifer Beal, Gwen Brown, Linda Kelloway, and Ruth Hall.

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OSN Website: How to access the Rehabilitation Intensity resources

Steps for accessing the stroke rehab intensity resources:

1) Go to http://ontariostrokenetwork.ca/
2) Click on the '**Healthcare Providers/Partners**' tab near the top and select '**Stroke Quality Based Procedures Resources Centre**' from the drop-down menu
3) Within the navigation section, click on '**Clinical Tools and Resources for Implementation**'
4) Click on the green link called '**Clinical Tools and Resources for Implementation: In-Patient Rehabilitation**'
5) Go to the '**OSN Rehabilitation Intensity Resources**' section and select the resource link(s) that you are interested in accessing/downloading.

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