ontario stroke network
Advancing the Ontario Stroke System

Ontario Stroke Network
Stroke Rehabilitation Best Practice Initiatives

Organization	Contact Person	Name of Initiative	Program Offering	Date Implemented	Outcomes to Date	Success Factors	Lessons Learned	Resources	Future Plans
Parkwood Hospital, St Joseph's Health Care London(SJHC)	David Ure CSRT Coordinator David.Ure@sjhc.london.on.ca 519-685-4292 ext 42615 Deb Willems SWOSN Deb.willems@lhsc.on.ca 519-685-4292 ext 42681	Community Stroke Rehabilitation Teams (CSRT) Admission criteria: • Adult stroke survivors with rehabilitation needs • Client's needs are best met by specialized stroke rehabilitation services in the community • Client consents, is motivated and able to participate • Client has specific and achievable rehabilitation goals Service Priorities: • Onset to 3 months • LTC residents with identified	3 teams, funded by the South West LHIN through the Aging at Home Initiative; one team in each of the three LHIN planning areas: North (GreyBruce), Central (HuronPerth) and South (Thames Valley: Oxford, Elgin and Middlesex Counties). Interprofessional teams consist of 1.0 FTE RN, OT, PT, SW; 0.5 FTE SLP and Recreation Therapist; and 2.0 FTE Rehabilitation Therapists (support personnel). New Model of Care includes: • Specialized interprofessional team service delivered to remote communities • Home and community treatment settings • Flexibility in customizing treatment plans • Primary caregiver focus • New roles (TRS,RT) • Transition from LTC to community living • Community reintegration/linking with community programs/services and capacity building • Hubs of activities • Educating community support staff • 3, 6 month follow-ups • Consultations available post discharge	Jan 2009	**Overall:** ·~300 clients served per year ·wait list: 1-4 weeks ·ALOS 20 weeks ·Mean 17 visits/client (range 1-83) ·enabled 5 clients to return home from LTC **Clinical Outcomes:** CSRT clients made statistically significant gains on the FIM™ ($p<0.001$), and the physical ($p=0.01$), psychosocial ($p<0.001$) and recovery ($p<0.001$) domains of the SIS between admission and discharge, that were maintained at follow-up. Clients admitted to the program also displayed fewer symptoms of depression ($p<0.001$) and required less caregiver assistance ($p=0.01$) at discharge compared to when they were first admitted to CSRT care. **System impacts:** Inpatient	**For receiving funding:** - Aging at Home Initiative - Rehab within LHIN IHSP - Evidence Based Review of Stroke Rehabilitation identified evidence for specialized interprofessional teams - Gap analysis and consensus on rehab priorities in SWO region had been completed; access to rehab for stroke in community a top priority for stakeholders. **Implementation:** - Project Advisory Group included hospitals, CCAC, SWOSN, DSCs - Affiliation with DSC: full continuum of stroke care and access to inpatient health record. - Stroke Network infrastructure to support education, implementation of best practices, innovation. - Full orientation to new model of care and vision; IPC training within orientation. - Evaluation framework included in initial planning	·Partner with CCAC for safe transition from hospital to home, then transition to CSRT care. ·Communication and marketing requires concerted, ongoing effort; experienced a drop off in referrals. ·Despite full orientation and vision process for IPC model, over time tendency for staff to revert to previous practice models; requires ongoing support/ reminders/processes to sustain. Challenges: Introducing new program Inappropriate referrals Resources Travel Weather Geographic limit to services Tips: • Link your project to LHIN/MOH priorities • Reference evidence & best practices • Target specific regional needs • Partner, collaborate,	**Funding proposal** D:\HSIP Aging at Home SW LHIN Stroke **Video** http://www.youtube.com/watch?v=ZL9UUEB5C70 **Referral Form** Referral Form.pdf **Brochure** CSRT Brochr.pdf **Info Sheets** CSRT InfoSht Doctor.pdf CSRT InfoSht Family.pdf **Rounds** Rounds Revised.doc **Initial Assessment** Initial Interview Form 2010.doc **Learning Objectives** Shared_LO_Self-Eval uation_Tool_April_20 RevisedLearning_Pla InTemplateforJan200	Ongoing program evaluation. Research proposal for economic evaluation of the CSRTs submitted for funding.

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		potential to go home • People living alone			Rehabilitation Program SJHC: 32% ↓ in ALC days 18% ↓ in ALOS 44.9% ↓ in days waiting for admission to rehab. **Survey Results:** Clients reported team services: - met their needs (97%) - enabled them to stay at home (93%) - ↑ QOL (96%) - ↑ independence (88%) - Helped return to family roles (69%) and social activities (59%). 100% Caregivers reported that the team helped reduce the stress of caregiving. Stakeholders reported team impacts included: - shorter hospital LOS - ↓ER visits - ↓ hospital re-admissions - stroke risk factors better managed		integrate • Identify leadership/champions • Consider process • Include communication strategy • Learn as you go	 Moving Forward With Stroke.PDF **Team Orientation**  Threadsdocument.doc  Copy of 2ndGreyBruceOrienta	