Community Stroke Rehabilitation Team

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Coordinator

Development of the model

In response to the request for proposal issued by the Ministry of Health and Long-Term Care in September 2001, the Southwestern Ontario Region submitted a pilot project titled:

"A Regional Stroke Rehabilitation System:
From Vision to Reality"

Development of the model

- This **Outreach Service** was effective in meeting the needs of service providers in the region and the clients/families they serve.
  - This is demonstrated by the demand for the service, high levels of satisfaction by the requesters and the improvement in knowledge self-rating by the participants.

- Pilot report submitted to the MOH December 2004

- Permanent funding received for 2009 launch

Development of the model

Designed to offer rehabilitation in the community for stroke survivors with on-going rehabilitation needs

Mandate

1. Provide rehabilitation in the most appropriate setting (home and community)
2. Offer secondary prevention, system navigation and community re-integration
3. Provide caregiver support

Community Stroke Rehabilitation Teams

Stakeholders

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

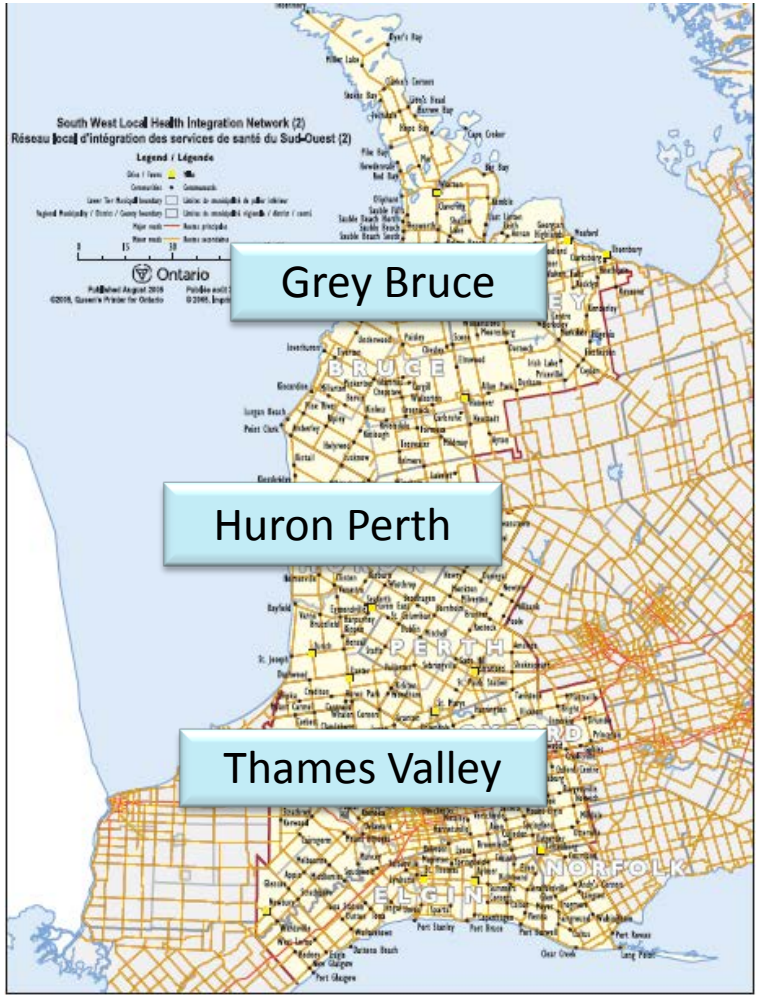
Ontario
South West Local Health Integration Network

HPHA
HURON PERTH HEALTHCARE ALLIANCE

St JOSEPH's HEALTH CARE LONDON

GREY BRUCE Health SERVICES

Key elements of the model – Access



Southwest Local Health Integration Network

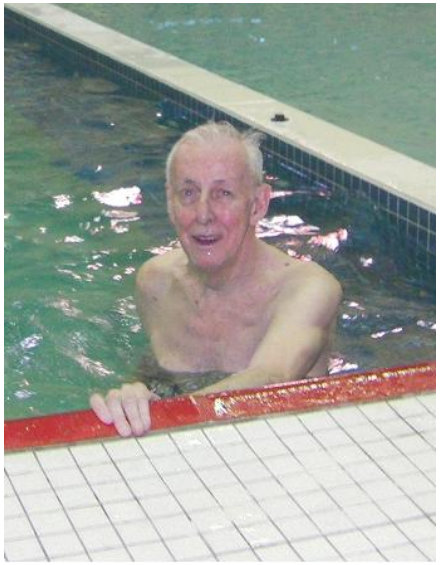
Community Stroke Rehabilitation Team

Key elements of the model – Multidisciplinary Teams

- Nurse
- Physiotherapist
- Occupational Therapist
- Speech Language Pathologist
- Social Worker
- Therapeutic Recreation Specialist
- Rehabilitation Therapist

Key elements of the model

- Specialized team
- Treatment setting home & community
- Service delivered to remote communities
- Transition from long term care to community living
- Community reintegration/linking with community services
- 6 month follow-ups after discharge



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Development and implementation

Key Success Factors:

- Ease of referral
- Comprehensive data base
- Outcome measures on intake, discharge and 6 month follow-up (FIM, PHQ2/9, Bakas, RNLI)
- Self-Management focus
- Communication:
  - Weekly Rounds, cell phones, Wi-Fi

Metrics

- Referrals per month: 50
- Days – referral to first contact (2014 ave.): 6.8 (goal: 7 days)
- Days – contact to first visit (2014 ave.): 7.4
- Days –length of service (2014 ave.): 53 (2011: 125 days)
- Days – Max Ave. Length of service: 84
- Average visits per client: 41
- Average intake FIM - 2013: 100
- Minimum intake FIM - 2013: 26

Client Experience

GB	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
The Team members and I decided together what would help me	17	9	2	3	1	32
	53%	28%	6%	9%	3%	
	81%					
My Therapy Program was explained to me in a way that I could understand	19	11	0	1	1	32
	59%	34%	0%	3%	3%	
	94%					
The team helped me adjust to my life after stroke	19	11	1	1	1	33
	58%	33%	3%	3%	3%	
	91%					

HP	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
The Team members and I decided together what would help me	20	12	2	1	0	35
	57%	34%	6%	3%	0%	
	91%					
My Therapy Program was explained to me in a way that I could understand	26	8	0	2	0	36
	72%	22%	0%	6%	0%	
	94%					
The team helped me adjust to my life after stroke	24	6	3	1	0	34
	71%	18%	9%	3%	0%	
	88%					

TV	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
The Team members and I decided together what would help me	29	16	2	0	1	48
	60%	33%	4%	0%	2%	
	94%					
My Therapy Program was explained to me in a way that I could understand	33	13	1	0	1	48
	69%	27%	2%	0%	2%	
	96%					
The team helped me adjust to my life after stroke	31	12	2	1	1	47
	66%	26%	4%	2%	2%	
	91%					

Evaluation and Outcomes – System Impact

Parkwood Hospital - Inpatient Rehabilitation Program

Year of implementation:

- 32% decrease in alternate level of care days
- 18% decrease in average length of stay
- 44.9% decrease in days waiting for admission to inpatient rehabilitation

Evaluation and Outcomes

Evaluating the Effectiveness of Southwestern Ontario's Community Stroke Rehabilitation Teams

- Gains on the FIM and the physical, communication and social participation domains of Stroke Impact Scale
- Fewer signs of anxiety and depression
- Required less caregiver assistance
- Caregivers (informal, unpaid) experienced improvements in well-being over the course of the program
- Patient and caregiver gains were maintained at 6 month follow-up

Allen et al. Evaluating the effectiveness of Southwestern Ontario's Community Stroke Rehabilitation teams. *Stroke* 2013; 44:e213 and *Canadian Journal of Neurological Sciences* (in press)

Evaluation and Outcomes

Projecting the Impact of Southwestern Ontario's Community Stroke Rehabilitation Teams: An Economic Analysis

Based on the analysis, **it is suggested that the community stroke rehabilitation team model is a cost-effective way to provide community rehabilitation services**.

Allen et al. Assessing the impact of Southwestern Ontario's Community Stroke Rehabilitation Teams: An economic analysis. *World Congress of Neuro-Rehabilitation*, Istanbul Turkey, April 2014.

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Evaluation and Outcomes

A Comparison of Rural versus Urban Stroke Survivors Treated with a Home-based, Specialized Stroke Rehabilitation Program

When provided with access to a home-based, specialized stroke rehabilitation program, **rural dwelling stroke survivors make and maintain functional gains comparable to their urban-living counterparts.**

Allen et al. A comparison of rural versus urban stroke survivors treated with a home-based specialized stroke rehabilitation program. *Stroke* 2013; 44:e192.

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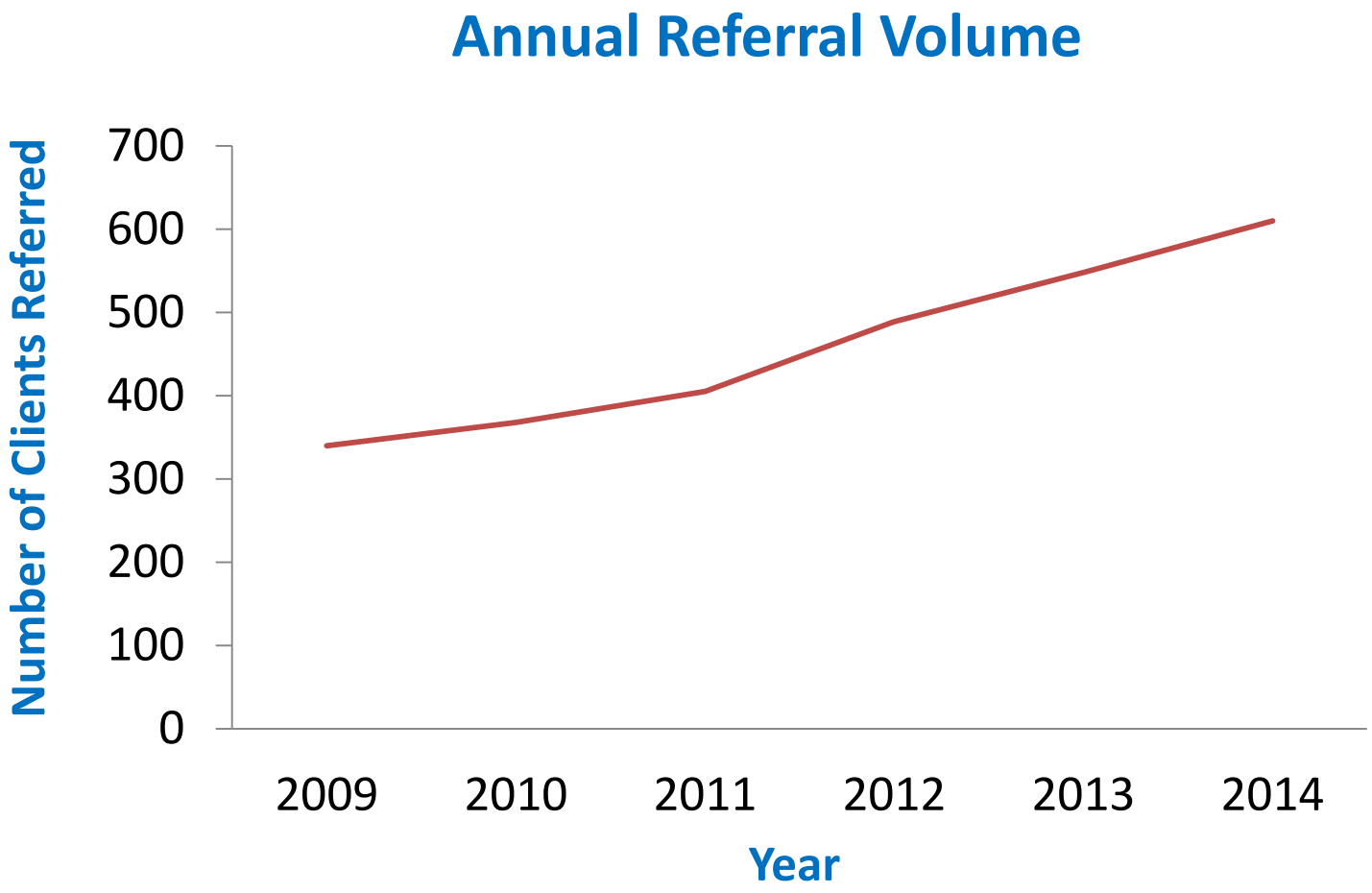
Community Stroke Rehabilitation Teams

Challenges

- Originally, awareness of the program
- Then, consistent referral patterns
- Now, increasing referral volumes

Development and implementation



COMMUNITY Stroke Rehabilitation TEAM

Community Stroke Rehabilitation Teams

Finances

- Challenge
  - Matching resources to continually growing referral volume

Creative Collaborations

In order to work within our resources, the CSRT is:

- **Sharing** geographically appropriate referrals with the Huron Perth team which currently has less volume pressure
- Engaging in the **STRIVE Home** project, using tele-rehabilitation to improve time and cost efficiency
- Engaging in opportunities to create appropriate **discharge locations**
  - Oxford Adult Day Program
  - Elgin Adult Day Program
  - Transitional, Adaptive, Aquatic Program for Seniors
  - Hutton House Community Stroke Exercise Program

Factors to Consider for the Future

Quality Based Procedures (QBP)

- Reducing inpatient length of stay will lead to more clients in the community requiring active rehabilitation, and at a higher acuity level
- Higher functioning stroke clients will no longer be admitted in inpatient settings, requiring services in the community