FOR DISCUSSION PURPOSES ONLY

DISCUSSION DOCUMENT: In Patient Rehab admissions directly from ED for stable mild and moderate strokes facilitated by Stroke Navigator

This discussion document is intended to support organizational planning during the unprecedented reality of COVID19. In order to increase capacity within acute care beds, it may be possible to admit some medically stable mild and moderate stroke survivors directly from EDs to Rehabilitation (IP Rehab or Community Rehab). While this proposed pathway is not aligned to Stroke Best Practices, given the expected COVID demands on organizations, this care pathway will support stroke survivors to access appropriate medical care while freeing resources for the COVID response.

This pathway supports COVID admissions by increasing capacity within in-patient acute beds, and ensures stroke survivors access appropriate care in a safe environment. It also reduces patient risk of exposure to COVID.

Implementation Considerations: each organization will need to determine how, when and if this pathway supports their capacity requirements. Organizations may choose to implement this pathway immediately to support staff training and process development or implement at a future date as required.

Possible admission pathways for ED Stroke Patients to Rehabilitation:

1. ED to an inpatient rehab bed
2. ED to Community rehab (virtually or combination of virtual and in-person for at risk patients)

Implementation Considerations

1. Identifying potential rehab candidates that are mild and moderate.
   - Should the AlphaFIM be used as a triage tool in the ED? As per QBP, The AlphaFIM® should be completed as close as possible on Day 3 after the physician orders admission to the acute care hospital setting, regardless of where the patient is physically located (e.g. ED, ICU etc.).
   - This process would need to be modified i.e Day 1 could start from the time of stroke or symptom onset are first documented or observed (this is the process for in-house strokes).
   - Appropriate candidates could be those with an AlphaFIM score between **60-110**.

2. Workup would need to be completed while the patient is in the ED. This would include the following:
   - CT, MRI/MRA, Carotid US,
   - Holter (24h), ECG, Echo/TEE/Bubble Study
   - Lipid Profile, BG (fasting), Hb A1C
   - Swallowing assessment/diet recommendations

3. A confirmed diagnosis of stroke

4. Etiology and management plan (antiplatelet, anticoagulant, other). These may not be initially clear and should not delay access to rehabilitation.

5. Medically stable – HR, BP under control, no active infection, all other medical issues stable

6. Patient should demonstrate rehab readiness with goals (see Appendix A)

It is strongly recommended to create a Stroke Navigator role within ED to support this pathway. This position could be created from an existing allied health or nursing role.

Other Considerations

- Timing of when stroke navigator should respond to new strokes in the ED? E.g Responding to code stroke in the ED? Receiving a page?
- How are identified rehab candidate referrals communicated to rehab sites ? E.g.Stroke Navigator completes "Pre-Admission Form" and emails or faxes to rehab site along with supplementary information (OT, PT, SLP, SW, Consultation notes etc.), telephone communication? How is bed assignment communicated?
- Awareness of nearby rehab sites' capacity to admit new patients in the event own site has no rehab beds available.
- Process during weekends (when there is no coverage)
- What would occur, if there is no capacity to administer the AlphaFIM? Would staff rely on stroke symptoms, type of stroke, workup, comorbidities, age etc..
- How will staff be informed of new processes/pathway

Training

- AlphaFIM training if planning to be used and if staff is not credentialed.
- Supported Conversations for Persons with Aphasia (online) link

Challenges

- Completion of workup while patient is in the ED
- Availability/capacity for home and community care to provide services required by patient.
- With increasing demand for OTN across disciplines and programs, delays/challenges may occur. Alternate technology platforms (e.g. Webex, Zoom, Skype etc.) may need to be considered to allow community rehabilitation services to be maintained.

Appendix A: INCLUSION CRITERIA FOR REHABILITATION (aligned with CSBP):

Readiness for Inpt. rehab:

- The patient demonstrates the ability to participate, which includes:
  -Stamina to participate in the program demands/schedule (1-2 hours of therapy);
  - Ability to follow at minimum one-step commands, with communication support if required;
  -Sufficient attention, and short-term memory to progress through rehabilitation process.

- Consents to participate in stroke rehabilitation and demonstrates a willingness and motivation to participate in the rehabilitation program

Readiness for Community rehab:

- Goals can be met in the community via virtual care (patient must have wifi and device)
- The patient can attend therapy alone or if assistance is required a caregiver is available to attend therapy sessions.
- Demonstrates an ability to learn and carryover
- The patient's current medical, personal care, or rehabilitation needs can be met in the community *** there is variability in the level of service HCC is able to provide across the region.*
- Consents to participate in stroke rehabilitation and demonstrates a willingness and motivation to participate in the rehabilitation program.
- Plan for secondary stroke prevention determined