FOR DISCUSSION PURPOSES ONLY

DISCUSSION DOCUMENT: Recommendations for Essential Community Based Stroke Rehabilitation

This discussion document is intended to support organizational planning during the unprecedented reality of COVID-19. In order to support access/flow, reduced hospital LOS and safety for Stroke Survivors, organizations should maintain essential post-hospital rehabilitation services.

While partners plan for COVID 19, the Southwestern Ontario Stroke Network is reminding everyone that post hospital community-based stroke rehab services (outpatient or in-home) are considered essential services. The information below provides some suggestions for discussion and to help support COVID planning.

Maintaining essential services in community-based stroke rehab support:

- In-patient Access/Flow
- Reduced hospital LOS
- Reduce Readmissions / ED revisits
- Safety for patients in their home environment
- Access to care in their home environment
- Reduce COVID exposure risk for healthcare providers and patients

As a result, the Southwestern Stroke Network has made recommendations to address resources and delivery models that will optimize flow to the community. The expectation is that teams work together with partners at their local and regional levels to implement the recommendations.

<u>Opportunities</u>

- **Mixed Methods Rehabilitation models:** by supporting a community-based model that provides in-home support for those patients most as risk, and virtual rehabilitation for most others, this will free up resources (ie reduced travel) to support stroke survivors who are being discharged earlier (ie by providing visits daily)
    - Where possible (especially if using telerehab), staff should meet referred patients on the unit prior to their d/c to do a warm hand-off.
- **Reducing community length of stay:** by shortening community LOS to 4 weeks, this will free up resources to support stroke survivors who are being discharged earlier
    - Where possible, online resources/apps and virtual community groups (e.g. MOD support groups, Life After Stroke etc.), should be used to supplement rehabilitation programs and assist with end of service transitions.
- **Adjusting Discharge Goals:** given the unprecedented demands that COVID may require of the system, it would be prudent to alter the discharge goals for in-patient therapy such that patients are discharged when they are safe and able to continue their care in a virtual rehab model.

By implementing the suggestions above, in-patient units will be able to safely reduce the LOS by:

- Within in-patient rehabilitation units, teams should be functioning within an Early Supported Discharge paradigm; patients who meet the following characteristics should be discharged to receive care in the community
    - Medically stable, and can manage safely in their home environment

    - Has family supports
    - Primary rehabilitative needs and goals can mostly be met within a virtual care model of care with or without the assistance of a caregiver. Services can be provided up to five times a week as determined by the patient and therapist.
- Within in-patient acute units, teams should be considering discharge direct to home-based programs for patients who meet the following criteria:
    - Medically stable, and can manage safely in their home environment with or without HCC
    - Has family supports
    - Primary rehabilitative needs and goals can mostly be met within a virtual care model of care with or without assistance of a caregiver. Services can be provided up to five times a week as determined by the patient and therapist.
    - Plan for secondary stroke prevention determined.
- Within the ED, teams should be considering discharge direct to home-based programs for patients who meet the following criteria:
    - Workup (CT, Echo, Holter, Carotid US, etc.) completed and confirmed stroke diagnosis including determination of etiology and management plan (although etiology may not be initially clear, it should not delay access to rehabilitation).
    - Medically stable, and can manage safely in their home environment with or without HCC
    - Has family supports
    - Primary rehabilitative needs and goals can mostly be met within a virtual care model of care with or without assistance of a caregiver. Services can be provided up to five times a week as determined by the patient and therapist.
    - Plan for secondary stroke prevention determined

Challenges

- **Virtual Care:** there will be some patients who cannot be discharged early due to the limitations in virtual care (ie teaching transfers via virtual care)
    - During the in-patient LOS, rehabilitation should focus on those elements which do not lend themselves to virtual therapy
- 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. This includes phone visits when video is not possible.

The resources freed from the above recommendations, will allow a dedicated number of staff to provide community based stroke rehabilitation services for stroke patients discharged from the ED, acute care and inpatient rehabilitation and will also allow the opportunity for new rehabilitation delivery models to be implemented such as a modified Early Supported Discharge.