FOR DISCUSSION PURPOSES ONLY

DISCUSSION DOCUMENT: Implementation of Urgent TIA/Minor Stroke Clinics

This discussion document is intended to support organizational planning during the unprecedented reality of COVID19. Urgent TIA/Minor Stroke Clinics can reduce ED workload, support reduced TIA/mild stroke in-patient admissions, and reduce exposure risk due to required followup ambulatory appointments.

This pathway supports COVID admissions by reducing in-patient acute admissions, reduces ED workload, and ensures TIA/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.

Can urgent TIA/mild stroke outpatient clinics be supported to see patients directly from the ED, and in the same day obtain all required tests, be consulted for stroke prevention, and then discharge home?

- Can this pathway also push the upper limit of stroke severity (i.e. all mild, some moderate) for discharge home?

PATHWAY CONSIDERATIONS:

Direct consult from emerg to urgent TIA/mild stroke outpatient clinics for TIA/ stroke patients at high risk for recurrent event.

(i) Physician to triage/assess in emerg to determine if patient can be discharged home with supports
(ii) Patient can be monitored remotely (e.g. virtual homecare)
(iii) Referral to Stroke Prevention Clinic for follow up care (e.g. evisit)

IMPLEMENTATION CONSIDERATIONS

1. Physician may consider decisions that push upper limits of admission criteria to avoid an admission and identify patients who are stable enough to be discharged home.
2. Consider having dedicated appointments on hold for diagnostic tests for incoming stroke patients.
3. All tests to be completed during the initial hospital visit where possible - timely access to brain and vascular imaging (CT/MRI, CTA, carotid U/S), cardiac diagnostics (ECG, Holter, prolonged cardiac monitoring, ECHO) and labs (refer to CSBPR for recommended timeframes). This optimizes the value of the initial hospital visit and ensures that the patient does not have to return for further tests.
4. Consider virtual remote monitoring options.
5. Referral to appropriate community support agencies that can continue to monitor risk and status upon discharge to home/community.

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REQUIREMENTS:

- On-call stroke specialist and stroke nurse
- OTN / home monitoring options

CONSIDERATIONS:

- Cardiac monitoring - MCards can be mailed to patient's home (https://m-healthsolutions.com/)
- Patient may need to be monitored and cannot go home alone

CHALLENGES/ BARRIERS:

- After hours coverage
- Patient may live alone
- Availability of community support services