Cross System Stroke Care Contingency Plan for Toronto

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Hyperacute System Level Contingency Plan

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	Conventional	Level One	Level Two	Level Three Crisis
Care Overview	All Regional Stroke Centres available for transfer – Walk-in and In-hospital Code Stroke and CritiCall can be activated.	One Regional Stroke Centre unable to maintain specialized hyperacute stroke services or significant risks identified	Two Regional Stroke Centres unable to maintain hyperacute stroke services or significant risks identified	If decision to cease inter-hospital transfers by Ministry, Paramedic Services and/or Toronto hospitals' decision
Actions		Regional Stroke Centres will develop internal strategies to support continued access to hyperacute stroke services (e.g. post tPA resource). Redirect to alternate RSC as required.	Walk-in and In-hospital Code Stroke Protocols in Toronto require STAT CT/CTA and simultaneously call RSC Stroke Neurologist to initiate consult and Redirect to alternate RSCs as required.	Supported remote delivery of thrombolysis for Walk-in Code Stroke Protocol only. No transfers would be made to RSCs

Triggers: Decisions for contingency care
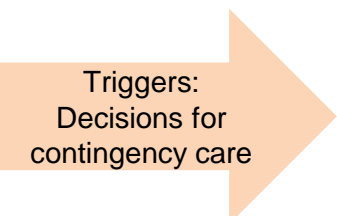
Significant risks identified at one RSC (e.g. ED, neuro-intervention, stroke team, medical imaging, critical care)

Significant risks identified at multiple RSCs (e.g. ED, neuro-intervention, stroke team, medical imaging).

3 or more RSCs are unable to maintain hyperacute stroke services

Adapted from Contingency Plan for Hyperacute Care in Toronto Jun 2020

Acute System Level Contingency Plan

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Care setting	Conventional (going forward)	Contingency Local	Contingency System	Crisis
Care Overview	• Repatriation from RSC to acute readmission within 24 hours • Capacity with critical care beds • All organizations to provide stroke best practice acute unit care	Impact on local provision of stroke best practices including: • access to stroke unit care • timely repatriation from RSC	Impact at a systems level, multiple stroke programs where a degree of the delivery of stroke specialized services are affected	Multiple stroke programs unable to provide specialized acute stroke services

Actions		Implement local contingency plan to sustain provision of specialized stroke unit care.
		
		The following resources may be applicable:
		
		COVID-19 Quick Reference Guides
		
		Post-thrombolysis monitoring in a ward bed (RSCs)
			TSNs will coordinate huddles* with acute care organizations
			
			Huddle considerations:
			• Organizational capacity to provide care to stroke patients
			• Transfer and/or repatriation of stroke patients between Regional Stroke Centres and acute care hospitals
			• Bypassing of acute care hospitals
			• Potential implications and timelines
			• Frequency of updates/monitoring
			  o Organization capacity to reopen
			  o Strategy for system wide re-opening of services for in-person visits	

Triggers: Decisions for contingency care →

Limited ability to provide stroke unit care internally and/or timely repatriation from RSC

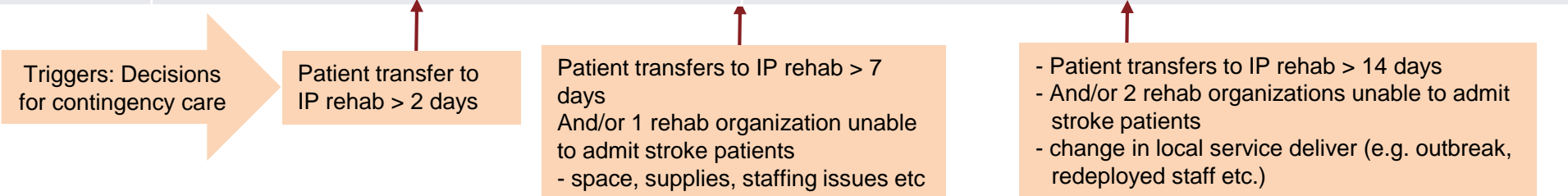Limited ability to provide stroke unit care at > 2 acute care site

- space, supplies, staffing issues etc

Limited ability to provide stroke unit care at > 3 acute care sites

- change in service deliver (e.g. outbreak, redeployed staff etc.)

Inpatient Rehab System Level Contingency Plan

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Care setting	Conventional (going forward)	Contingency Local	Contingency System	Crisis
Care Overview	On receipt of referrals for IP rehab: Patient transfers to IP rehab within 2 days	On receipt of referrals for IP rehab: Patient transfers to IP rehab within 7 days	On receipt of referrals for IP rehab: Patient transfers to IP rehab within 14 days	Patient transfers to alternate IP rehab sites or units, using quick reference guides, consults with stroke teams with expertise, etc 3 IP rehab organizations unable to admit rehab patients Trained staff unavailable, no critical supplies, facility unsafe

Actions		Implement local contingency plan to sustain provision of specialized stroke unit care.
		
		TSNs initiate bi-weekly status monitoring
		
		Organizations contact TSNs if delay in patient transfers due to above issues
			TSNs will:
			• Coordinate huddles*
			• E-Stroke users notified (E-Bulletin)
			• Closing specified IP program(s) in E-Stroke, as appropriate
			Organizations to participate in huddles*
			
			Huddle considerations:
			• Organizational capacity to provide care to stroke patients
			• Organizational capacity to see additional patients
			• Additional communication required
			• Potential implications and timelines
			• Frequency of updates/monitoring
			  o Organization capacity to reopen
			  o Strategy for system wide re-opening of services for in-person visits	

Triggers: Decisions for contingency care

Patient transfer to IP rehab > 2 days

Patient transfers to IP rehab > 7 days
And/or 1 rehab organization unable to admit stroke patients
- space, supplies, staffing issues etc

- Patient transfers to IP rehab > 14 days
- And/or 2 rehab organizations unable to admit stroke patients
- change in local service deliver (e.g. outbreak, redeployed staff etc.)

Outpatient System Level Contingency Plan

Toronto Stroke Networks

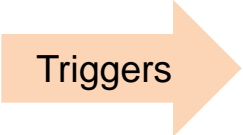| Status of Care	Conventional (going forward)	Contingency Local	Contingency System	Crisis
In-person	Patient with new onset of stroke with a recent discharge from acute or inpatient rehab: First therapy visit within 7 days^ (usual patient care)	Patient with new onset of stroke with a recent discharge from acute or inpatient rehab: First therapy visit within 14 days^	Patient with new onset of stroke with a recent discharge from acute or inpatient rehab: First therapy visit within 1 month	No in-person visits All organizations unable to provide in-person care e.g. trained staff unavailable, no critical supplies, facility unsafe
		See next slide for system level actions		
Virtual	Exclusive virtual visits are not considered best practice care	Patients requiring interventions and clinical activities that can be supported by virtual care*: First therapy visit within 14 days^	Patients requiring interventions and clinical activities that can be supported by virtual care*: First therapy visit < 14 days^	All patients to receive virtual care
Hybrid	For a subset of patients: First therapy visit within 7 days^	For a subset of patients: First therapy visit within 14 days^	For a subset of patients: First therapy visit < 14 days^	No hybrid model of care provided

^ indicates business days

Triggers: Decisions for contingency care →

Organization experiencing space, supplies, staffing issues etc

And/or

First in-person therapy visit is > 7 days

1 to 2 organizations unable to provide in-person care due to change in local service deliver (e.g. outbreak, redeployed staff etc.)

And/or

First in-person therapy visit is > 14 days

≥ 3 organizations unable to provide in-person care

And/or

First in-person therapy visit is > 1 month

*CorHealth COVID-19 Stroke Memo #4 - RECOMMENDATIONS FOR AN APPROACH TO RESUMING OUTPATIENT STROKE REHABILITATION SERVICES IN ONTARIO

Outpatient System Level Contingency Plan: Triggers and Actions

Toronto Stroke Networks

Status of Care	Conventional (going forward)	Contingency Local	Contingency System	Crisis
Triggers	Organization experiencing space, supplies, staffing issues etc And/or First in-person therapy visit is > 7 days	1 to 2 organizations unable to provide in-person care due to change in local service deliver (e.g. outbreak, redeployed staff etc.) And/or First in-person therapy visit is > 14 days	≥ 3 organizations unable to provide in-person care And/or First in-person therapy visit is > 1 month	
Actions		Implement local contingency plan to sustain provision of specialized stroke care. TSNs initiate bi-weekly OP waitlist monitoring Organizations contact TSNs if unable to provide in-person care	TSNs will: • Coordinate huddles* • E-Stroke users notified (E-Bulletin) • Closing specified OP program(s) in E-Stroke, as appropriate Organizations to participate in huddles*	TSNs will: • Coordinate huddles* • E-Stroke users notified (E-Bulletin - Virtual Care only) • Closing specified OP programs in E-Stroke, as appropriate Organizations to participate in huddles*

			*Huddle considerations:
			• Organizational capacity to see additional patients (in-person and virtual)
			• Re-distribution of patients to other sites for in-person care
			• Additional communication required
			• Frequency of updates/monitoring
			  ○ Organization capacity to reopen
				*Huddle considerations:
				• Potential implications and timelines
				• Additional communication required
				• Frequency of updates/monitoring
				  ○ Organization capacity to reopen
				  ○ Strategy for system wide re-opening of services for in-person visits

Appendix

Decision Making Process for Hybrid Model of Outpatient Rehabilitation During COVID-19

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Acute to Outpatient Rehab Referral:

1. Acute care referral made to outpatient (OP) rehab services
2. Essential Professional Conversation with OP program to determine/discuss:
   a. Virtual care or in-person* visits?
   b. Timeliness of access to OP rehab (capacity)?
   c. Based on #1 and #2, determine between inpatient or outpatient rehab (or alternative OP site)?
3. Ensure the contact information entered into the E-Stroke rehab referral (home phone number and alternate phone number) reflects the best numbers for OP rehab to contact the patient following discharge.

Inpatient Rehab to Outpatient Rehab Referral:

1. Inpatient rehab referral made to outpatient (OP) rehab services
2. Warm handovers between inpatient and outpatient while patient still in inpatient setting:
   a. OP conducts initial assessment
   b. Determine plan for first visit (virtual or in-person*)
   c. Discuss frequency and duration of visits
   d. Complete virtual visit test run, where appropriate
   e. Obtain consent for virtual care in place before discharge

OP referral response with appointment date/time:

- Within 1 business day for acute care referrals
- Prior to discharge for inpatient rehab referrals

- OP rehab (start of therapy) within 7 days of discharge from acute/IP rehab

Considerations for in-person care:
- *New onset of stroke with a recent discharge from acute care*
- *Inpatient rehabilitation who requires in-person OP rehab services (see list below),*
- *Does not have access to virtual care*

May also include clients with:
- Functional mobilization issues that require assessments/recommendations (e.g. gait aid prescription, transfer practice, ADL equipment set up etc.) to prevent falls, readmissions and enhance home safety/accessibility.
- Limb paresis requiring therapy to improve movement, prescription of exercises to prevent muscle contractures, pain and increased tone.
- Communication or swallowing difficulties
- Emotional distress (e.g. anxiety/depression)
- Cognitive and perceptual difficulties requiring treatments to progress independence and safe living in the home.
- New equipment requiring education
- Inability to or require further assessment to perform instrumental activities of daily living.
- Caregiver or family require teaching to support rehabilitation goals, or no caregiver/family available
- Change in status (function, environment, social situation)
- When patient safety would be compromised with virtual care

Adapted from CorHealth Recommendations for an Ontario Approach to the Provision of Stroke Rehabilitation during COVID-19

Contingency Planning: In-person vs hybrid vs virtual

Toronto Stroke Networks

Considerations for in-person care:
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- New equipment requiring education
- Inability to or require further assessment to perform instrumental activities of daily living.
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- Change in status (function, environment, social situation)
- When patient safety would be compromised with virtual care

Considerations of interventions and clinical activities that can be supported in a virtual capacity.

- Intake/history assessment where information guides which disciplines and the level/intensity of support required
- SW linking with community services, counseling, assistance with completion of forms/applications
- Appropriate group interventions e.g. aphasia and memory group
- Teaching or re-enforcing stroke education
- Case Conferences
- Staff observation of home setting
- Visualize equipment and safety check
- Pre-driving training skills such as high level perceptual, visual, sensory and physical skills
- Guided mental imagery
- Paper pencil tasks augmented with use of document viewer camera
- Use of annotation and white boards through technology platform (if available) for supported communication, error recognition, visual search etc
- Treatment in-home with therapy partner present, or pre-determined safe location within the home for therapy session
- Observation/feedback for functional tasks/exercises
- SLP sessions where observation of therapists' face/mouth movement is not impeded by face mask/shield (as it would be in in-person session)
- Regulated staff supervising assistants during treatment
- Administering outcome measures/assessment/screening tools that may be appropriate to administer remotely (e.g. MOCA, Berg Balance Scale)

Considerations for hybrid model of care

- Patients who require in-person care with a combination of other aspects of care that can be delivered virtually