Waterloo Wellington CCAC Community Stroke Program

Stroke Collaborative 2014

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Map of Waterloo Wellington LHIN

Waterloo Wellington
Local Health Integration Network (3)
Réseau local d'intégration des services de santé de
Waterloo Wellington (3)

Legend / Légende

Ontario

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Background

Integration of Stroke Services Across the Continuum (April 1, 2014)

Waterloo Wellington Stroke Steering Committee

Stroke Implementation Task Force

LHIN Integration Order (August, 2013)

Hospital re-organization

CCAC to deliver best-practice stroke care

Reports

"Improving Access to Quality Stroke Care in Waterloo-Wellington" (2011);

"Transitioning to a System of Rehabilitative Care in Waterloo-Wellington" (2012)

Access

Outcomes

System efficiencies

Waterloo Wellington Stroke Steering Committee & Implementation Task Force

CCAC Community Stroke Program is One Component of the Waterloo Wellington Integrated Stroke Care System

TRANSITIONS OF CARE

Public Awareness

Prevention of Stroke

Hyper Acute Stroke Management

Acute Stroke Management

Rehabilitation

Community Reintegration

CROSS-CONTINUUM OF STROKE MANAGEMENT

Program Components & Timelines

Phase 1: November 2013

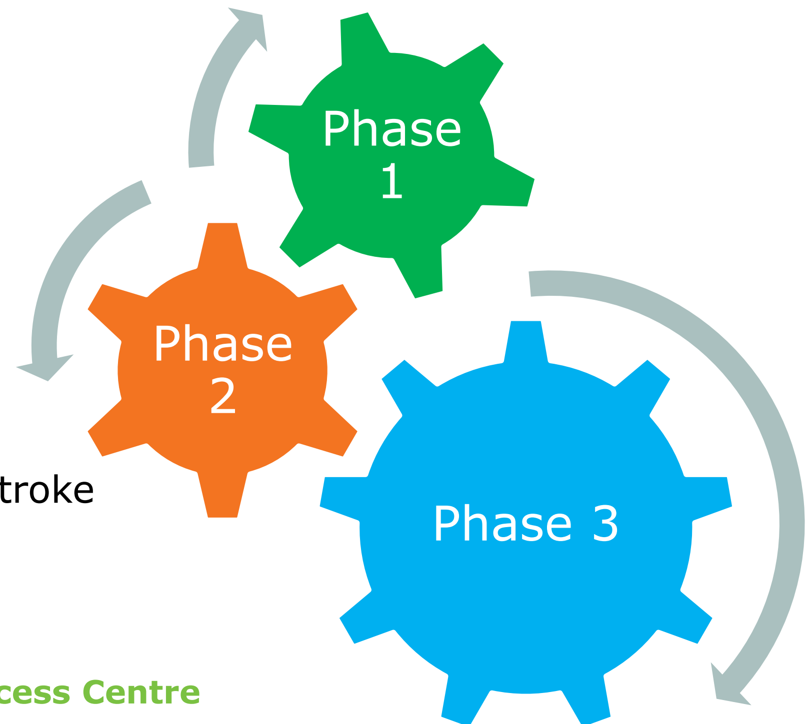
- Designated Stroke Care Coordinators: Hospital & Community
- First home visit by therapist within 48 hours of hospital discharge
- Link to Primary Care
- Clinical Rehab Pathway as per best practice guidelines; including rehab assistants

Phase 2: April 1, 2014

- Discharge Link Meeting (Rehabilitation & Acute Sites)
- Consolidated Service Provider – "Stroke Team"
- Use of Rehabilitation Assistants
- 24 hour on-call access
- Transition to Next Phase of Rehabilitation
- Evaluation

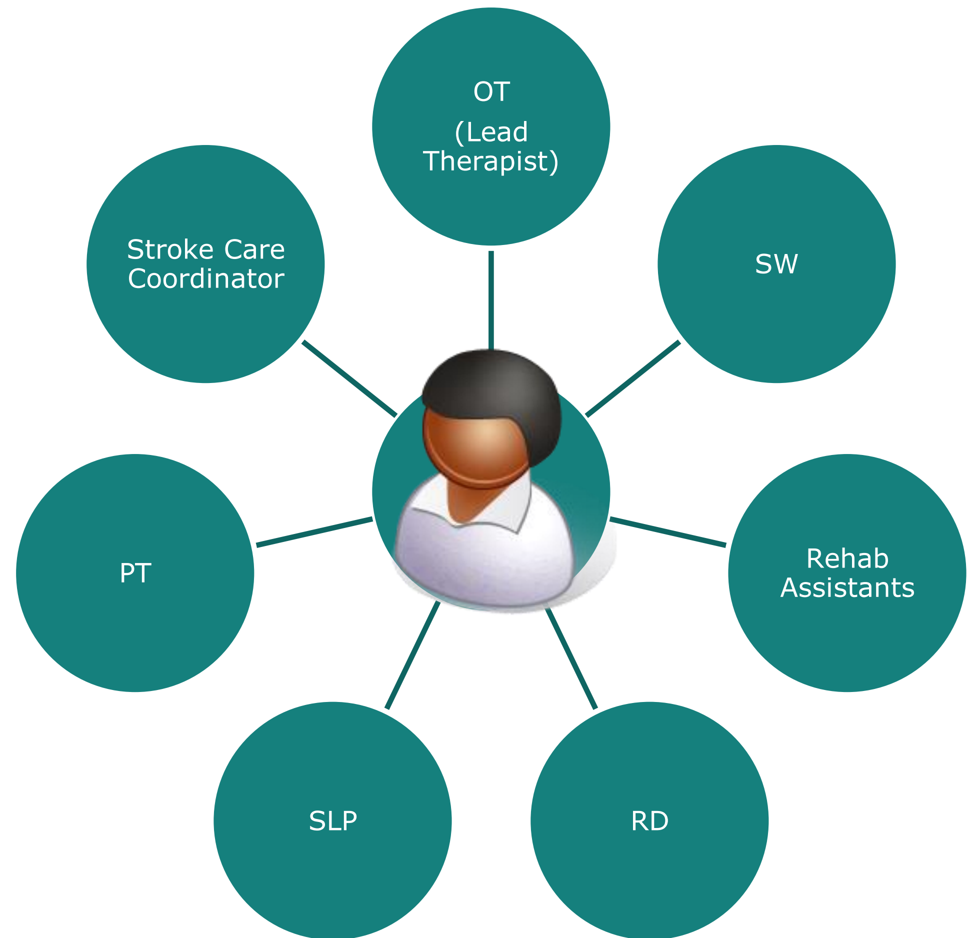
Phase 3: Fall 2015

- Incorporate Nursing & PSW into Stroke Team

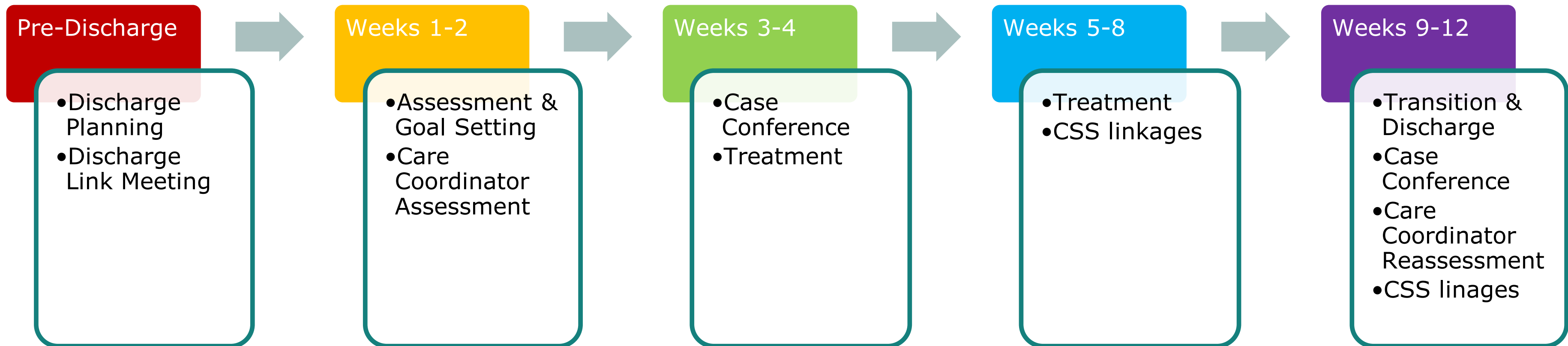


Consolidated Service Provider - "Community Stroke Team"

- Care Coordinators
  - Dedicated
  - Additional training and knowledge of stroke system and resources
- Stroke Team
  - Dedicated
  - Education and skill requirements:
    - Neuro/stroke rehabilitation
    - Knowledge of stroke best practices
    - SCA™
    - Best practice assessment tools



WWCCAC Stroke Pathway



- Based on the clinical stroke pathway developed by NSM CCAC and adopted by the OACCAC. Based on Canadian Stroke Best Practice Guidelines, and validated by the OSN.
- Defines expected outcomes and interventions of the Care Coordinator and Therapists; OT typically the lead therapist and attends Discharge Link.
- Available visits to provide an intensity of therapy (OT, PT, SLP, SW, Nut, Rehab Assistants) that is in keeping with best practice (45 min-3hour visits; 3-5x/week)
- Patient's progress determines how he/she move through the pathway.
- Patient transitioned to the next phase of rehabilitation upon completion of the pathway.

Waterloo-Wellington Banding Model:
- Used to Guide Patient Flow & Eligibility

Band 1
Assessment and Triage; TIA

Band 2
Short Stay Rehab
High Intensity and Short Duration

Band 3
Moderate Intensity/Duration

Band 4
Low Intensity/Long Duration

Band 5
Severe Strokes
Palliative
Little or No Improvement

Outpatient or Community Program

No

CCAC Stroke Program

Eligibility for WW CCAC Stroke Program:

- Band 2, 3, or 4
- Need for multi-disciplinary stroke rehabilitation
- Willing to participate
- Rehabilitation needs are best met in the home
- Patient lives greater than 30 minutes from an outpatient program

Acute & Rehab vs CCAC Stroke Volumes

Number of Patients

60
50
40
30
20
10
0

47 45 44 42 49

20 15 10 11 15

April May June July August

Month

Total Acute+Rehab
WWCCAC

Average: 45.4

Average: 14.2

Approximately 31% of total Stroke Volume

Waterloo Wellington Community Care Access Centre

Number of Stroke Pathways Started & Completed 1 Apr - 17 Aug 2014

	Value
Total # of Pathways	63
Pathway Completed: goal met	28
Client Still Active on Pathway	27

Waterloo Wellington Community Care Access Centre

Therapy Utilization as a Percentage of Patient Pathways
1 Apr - 17 Aug 2014

120%
100%
80%
60%
40%
20%
0%

97% **86%** **44%** **59%** **16%**

Visit OT Visit PT Visit SW Visit SLP Visit RD

Time per Visit by Therapy Discipline
1 Apr - 17 Aug 2014

Average Length of Stay approximately 10 weeks

	Visit OT	Visit PT	Visit SW	Visit SLP	Visit RD
Average time per visit (mins)	58	58	63	57	61
Min. time per visit (mins)	15	30	50	30	60
Max time per visit (mins)	95	90	90	75	75

Patient & Caregiver perspective on impact of program:

- Patient Experience Survey

Magnitude of Functional Change:

- RAI-HC
- Barthel Index
- RNLI

System Impact:

- Hospital re-admission rates
- In-patient rehabilitation length of stay

Program Evaluation