Stroke Community and Outpatient Rehabilitation Provincial Integrated Work Plan (PIWP)
FINAL REPORT – June 2018

Executive Summary

The main purpose of this provincial group was to create a repository of tools and resources to support the implementation of stroke best practices in the community and outpatient setting as outlined by the Canadian Stroke Best Practice Recommendations and the Quality-Based Procedures: Clinical Handbook for Stroke (Acute and Post - acute) December 2016

Key components of this PIWP work include:

1. A resource tool outlining methodology to do an estimate demands analysis for stroke outpatient/community rehabilitative services based on a region's own geography.
2. Summary of common emerging facilitators and change ideas that outpatient (OP) programs have implemented to meet stroke best practices.
3. A decision making algorithm to assist clinical teams to determine what factors to consider when referring patients to existing programs.

Background

Community stroke rehabilitation is an essential part of the stroke system as identified in the Quality-Based Procedure Clinical Handbook (QBP). Based on the November 2016 Ontario Stroke Evaluation report, "A Focus on Rehabilitation" it was demonstrated that access to comprehensive outpatient or community-based stroke rehabilitation services is not equitable across the province. It was also important to further advance the work of the Community Stroke Rehabilitation Models in Ontario (2016) report that gave insights into 4 four well established outpatient programs and information on emerging models. At a provincial meeting of the 11 regional stroke networks, community and outpatient rehabilitation was identified as a priority area of focus to support common model development and implementation of stroke best practice elements.

Purpose

The overarching purpose of this work is to support regions and individual organizations in conducting a needs analysis for their outpatient and community rehabilitation programming. This work was also designed to support the collection, creation and sharing of resources to assist existing programs in implementing and delivering stroke care as aligned with the QBP Phase II: Community/OP Rehabilitation Handbook.

Work Plan Description

Two priority areas were defined:

1. Support regions/organizations to conduct an initial needs analysis for outpatient and/or community based stroke rehabilitation services.
2. Collect, create and share resources to assist in implementing and delivering QBP Phase II: Community /OP Rehabilitation recommendations.

Deliverables

1) For the estimated demands analysis:

a) **Community and Outpatient Stroke Rehabilitation Services: A Framework for Estimating Volumes, Planning and Referral Considerations** – a document outlining planning principles with sample assumptions and program delivery assumptions.

i) Community Stroke Rehab Volumes Predictor - an excel template where calculations can be made to determine expected annual volumes of patients requiring community stroke rehabilitation (outpatient and/or home based), based on assumptions described by regions or organizations.
ii) Program team composition estimator – an excel template where calculations can be made to estimate the staffing FTEs/complement for outpatient model, in home or hybrid/mixed model, based on assumptions described by regions or organizations.

2) For resources to support QBP implementation:

a) **Exploring Implementation of Stroke Best Practices in a Sample of Community and Out-Patient Rehabilitation Settings in Ontario**

– A sample of outpatient programs across Ontario were interviewed to understand the facilitators and change ideas or strategies that enabled implementation of stroke best practices (Note: Individual transcribed interviews/interview notes available to

Stroke Network Rehab Coordinators should more detail be required). The themes generated can be useful to other programs that are planning community stroke rehabilitation services. Programs will need to consider their own resources, regional and stroke population needs when utilizing this resource.

b) **Community Stroke Rehabilitation Pathways** - A flow diagram to assist clinical decision making regarding how to referral to services when home and/or outpatient setting are available in the same area.

Summary of Accomplishments

Limitations

The estimated demands analysis work is based on estimates and assumptions from best practice treatment guidelines, existing regional work and modelling. This has been simplified to support high level planning. Regional context and resources are important considerations. While the model does not reflect planning for an additional early supported discharge component at this time, it can easily be adapted by increasing the intensity of the services in the visits and staffing predictors.

Exploring Regional Implementation of Stroke Best Practices in Outpatient Rehabilitation Setting in Ontario. Only rehabilitation programs self-identified as providing comprehensive services were selected for the interview process. Rural sites, single service design models and in- home models were not represented. It is noted that there is constant change and innovation occurring and future ways to capture and share these innovations should be considered.

Community Stroke Rehabilitation Pathways decision making algorithm generated discussion about how this tool was only representative of the 'current state' where in-home and OP rehab models are offered to stroke patients, or where care is delivered in "solos" , and where some regions deter transfer of clients fluidly from one setting to another. Thus an infographic was developed to demonstrate that a hybrid model, as defined above, has the possibility to become the ideal future state as an example of patient-centred and innovative care delivery.

Future Considerations

Future consideration for estimated demands analysis: As sites/regions use the tools for planning considerations, more data can become available to add to the limited data that exists in the outpatient and community rehabilitation sectors. These tools have the potential to be further developed and refined. Currently, these tools are meant to help

with initial planning and should be used in conjunction with regional stroke network teams and other stakeholders as described. While these predictors provide broad estimates, locally planning areas may need to and are encouraged to adapt tools to meet their needs or to scope a current state project that may support work towards robust implementation in the future.

Future considerations for facilitators in meeting QBP's in Community/OP Rehabilitation: Building on the success/experiences of the programs who were interviewed and learning from their challenges are important. There were key areas for future consideration identified including: data/outcome measures to provide better understanding of patient outcomes, the need for flexibility in programming, fewer barriers in admittance criteria (especially with respect to timing of entry to programs), flexibility in service intensity and location of service provision in order to provide services that meet patient's individualized goals. Ongoing community models should be developed to ensure service equity across the province and meet patient's needs within the context of the region's geography, volumes and populations served. Examples include but are not limited to: Early supported discharge programs, community hubs, hybrid models of care.

Sustainability Plan

The documents produced are intended to be a point-in-time assessment and resource to support planning and implementation related to the community treatment section of the QBP Clinical Handbook (2016). Currently, there is not a formal plan in place to update this work regularly but this could be considered if this is identified as a future priority. It is anticipated that regions will take the work or its components and adapt them to the local context for use. This work may also be a precursor to future work within the context of rehabilitation provincially and could be updated or expanded in collaboration with CorHealth Ontario and/or the Rehabilitative Care Alliance as priorities continue to emerge and be established.

Knowledge Translation Strategies

Materials will be distributed electronically to Regional Directors, District Stroke Coordinators, Rehabilitation Coordinators, Community and Long Term Care Coordinator and Education Coordinators within each stroke network for use regionally as appropriate. Each network will be encouraged to house the documents on their website and use them to support local conversations/planning with their partners. Final documents will be provided to CorHealth to add to the Provincial Integrated Work Plan (PIWP) Inventory on the CorHealth website. Materials will be housed in shared folders

accessible by all PIWP workgroup members and final documents will be available to stroke network rehabilitation coordinators in their shared folders for ongoing access.

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