

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

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INTRODUCTION

In the fall of 2016, stroke rehabilitation in the community and outpatient setting was identified as a provincial priority by the eleven regional stroke networks. To address this priority a working group, consisting of clinical experts from across the province, was formed. One of the initiatives identified by this group was to collect, create and share 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 ([retrievable HERE](#)). This report is one of the resources developed through this process.

The purpose of this report is to identify common challenges to the implementation of best practices in the post-acute episode of care (i.e. outpatient rehabilitation) and to identify various strategies that are being used throughout the province to address these challenges. This report highlights innovative thinking being used by outpatient programs throughout Ontario and is meant to prompt further discussions, networking, sharing and collaboration. Some examples make reference to specific programs whereas others are more general. It is suggested that stakeholders reach out to their Regional Stroke Contacts if they are interested in being directed to programs that are implementing these strategies. Although this report focuses on outpatient rehabilitation programs, it may be possible to apply these strategies to other settings along the continuum of care.

METHODS

Interviews were conducted with ten outpatient rehabilitation programs from across Ontario. Programs were eligible for selection if they reported having comprehensive stroke rehabilitation services in the [Ontario Stroke Evaluation](#)



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[Report: A Focus on Stroke Rehabilitation](#)¹. The working group selected a convenience sample of programs throughout Ontario located in small and large urban areas. See Appendix A for details of participating programs.

Interview questions were developed by working group members to capture the program structure and functioning and their implementation of stroke best practices². Semi-structured, informal interviews with each of the ten selected programs were conducted by Regional Stroke Rehabilitation and/or Community and Long-Term Care Coordinators.

Interview responses were reviewed by working group members to identify common emerging themes relating to the implementation of stroke best practices.

KEY FINDINGS

Note: Not all questions were answered by every respondent, and answers varied in terms of depth and breadth provided. As such, the information summarized below should be seen to provide a snapshot of what respondents deemed to be important in terms of their challenges and facilitators to the implementation of best practice recommendations.

¹ Derived from facilities that responded “yes” on the Ontario Stroke Rehabilitation Survey to having hospital funded/governed rehabilitation services delivered in a hospital setting that are provided by an interprofessional team (at a minimum, OT, PT and SLP) specifically assigned to the service, using a case-coordination approach with regular team meetings and the capacity to provide 2–3 visits a week for 8–12 weeks. Does not include programs or services funded or governed by CCACs or community-based physiotherapy clinics, and aligns with the Rehabilitative Care Alliance definition of outpatient/ambulatory rehabilitation used in their validation study, with the exception of the number of visits and team composition (see <http://www.rehabcarealliance.ca/outpatient/-/ambulatory>)

² Interviews were conducted in reference to stroke best practices as described in the Quality Based Procedures: Clinical Handbook for Stroke (Acute and Postacute), Dec. 2016 (QBP)



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Program Description

Structure

All programs interviewed have been providing services for at least five years, with the newest program launching in 2012. The structure of these programs varied, with:

- 3/10 providing stroke specific rehabilitation services,
- 5/10 providing stroke rehabilitation under the umbrella of neuro-rehabilitation, and
- 2/10 providing stroke rehabilitation under the umbrella of general rehabilitation.

Location

Three of the ten programs interviewed were located within freestanding rehabilitation facilities (rehabilitation site is geographically separate from acute care) and seven were located within facilities that provide both acute care and rehabilitative care.

Commonalities and Variations

Commonalities noted between the programs interviewed were

- Referral sources
 - Acute care and inpatient (IP) rehabilitation were noted to be the main referral sources for these programs.
 - Occasional referrals are received from the community.
 - All programs indicated acute and inpatient referrals receive the highest priority.



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- Eligibility criteria
 - 8 of the 10 programs interviewed stated that they accept patients requiring both single-service and multi-service programming.
- Length of stay/frequency of therapy
 - The average length of stay and frequency of visits for each program was dependent on patient goals as well as individual patient factors (range 4-12 weeks)
- Majority of programs were not using an outcome measure to evaluate the overall effectiveness of programming, although Bridgepoint Active Healthcare – Sinai Health System and Providence Healthcare did indicate they are part of a pilot project currently testing program outcome measures. i.e. Community Rehab Assessment Tool pilot through the Rehab Care Alliance (*more information available on this at:*
<http://www.rehabcarealliance.ca/outpatient/-ambulatory-1>)

Variations noted between the programs interviewed included:

- Assessment/screening tools used

Note: Tools reported were based on verbal reports, this is not necessarily an exhaustive or discipline specific list

- Over 20 different tools were identified, however the most commonly reported assessment/screening tools were:
 - Berg Balance Scale,
 - Montreal Cognitive Assessment
 - Chedoke McMaster Stroke Assessment
 - 9 Hole Peg Test and
 - Motor Free Visual Perception Test.
- Processes for community reintegration:
 - Most programs indicated that they referred patients onto community based programs. The most common programs reported were :
 - Community based exercise (e.g. TIME Together in Movement and Exercise), Fit for Function, VON Exercise Programs)



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- Peer support groups (e.g. March of Dimes Recovery Chapters)
- Aphasia programs
- Home Based Programs (e.g. LHIN Homecare)
- Self-Management Programs (e.g. Living with Stroke, Moving on After Stroke)

Challenges

During the interview process, respondents were asked to identify what they considered to be challenges to the implementation of best practice in the community and outpatient rehab setting³. The main challenges identified were: A) lack of communication/coordination B) lack of resources, and C) Individual patient factors/patient complexity.

A) Lack of Communication/Coordination

Lack of coordination/communication along the continuum of care was identified as a major challenge for smooth transitions. Lack of effective communication processes was described as contributing to ‘non clinical’ use of therapist time to re-screen referrals, clarify information, as well as time spent scheduling or booking appointments. Sites reported poorly defined communication pathways between outpatient programs, homecare and community care and no clear regional or Local Health Integration Network (LHIN) level pathways to help with flow to or between outpatient and home care which impacts discharge planning.

B) Lack of Resources

Lack of resources was identified as a major challenge to delivering comprehensive, interprofessional and timely rehabilitation. Many programs described staffing “cut-backs” in which key members of the interprofessional team were either eliminated or reduced. In particular, programs mentioned limited access to team members who play a critical role in transition and discharge planning (i.e. stroke navigator, social work, and dedicated care

³ Interviews were conducted in reference to stroke best practices as described in the Quality Based Procedures: Clinical Handbook for Stroke (Acute and Postacute), Dec. 2016 (QBP)

coordinator). Furthermore, staffing cut backs coupled with high referral volumes was described as a main contributor to long waitlists and difficulty meeting best practice recommendations for timely access to care.

Programs also indicated a lack of community services for the stroke survivor post rehabilitation. For some programs, it was an actual absence of these services and for others it was a lack of knowledge regarding the services available. The absence of services was described as a major challenge to discharge planning, community reintegration and ongoing support for the stroke survivor and family.

C) Individual Patient Factors/Patient Complexity

Individual patient factors were commonly identified as challenges to implementing stroke best practices. In particular, patient factors were described as barriers to meeting time-based recommendations such as starting outpatient rehabilitation 48-72 hours post discharge (recommendation (r) 4.1.21). These patient factors included: dealing with severe and complex stroke patients whom do not always fit into a pre-defined stroke pathway; difficulty accommodating patients with transportation issues, and patients feeling unready or overwhelmed to start the outpatient program soon after discharge from the hospital.

Addressing Challenges

It became apparent through the interview process that many programs have implemented various processes to address these challenges. These processes will be referred to as facilitators to the implementation of stroke best practices and will be discussed in the following section.

Facilitators

Note: Programs that were interviewed are highlighted below, that being said these innovations/strategies may not be unique to these programs.



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Respondents were asked to identify the various aspects of their program which have enabled them to implement stroke best practices. As responses were reviewed, five overarching themes were identified: team set up, communication, partnerships, creative use of resources, and patient centeredness. It is noted that facilitators described may support sites in addressing more than one of the above mentioned challenges.

However, during site interviews, challenges and facilitators were not directly correlated and are therefore presented independently.

1.0 Team Setup, Functioning and Composition

Team setup (i.e. location or proximity to referring sources), functioning (i.e. single service, multi service, day program, grouped, or individual programming) and composition (i.e. team makeup) were noted to have an impact on timely access to services (r 4.1.2¹), smooth transitions (r 1.0²), team communication (r 4.1.4b¹) and the ability to build and maintain stroke expertise amongst team members (r 1.0a¹).

1.1 Impact of co-location of referring sources and the OP Program:

Shared examples include:

- Promotion of smooth patient transitions and communication with flexible teams/ disciplines that work in both the inpatient and outpatient settings.
- Co-locating inpatient and outpatient programs (programs are located in the same building) to promote smooth transitions between programs.

Specific examples include:

- Quinte Health Care Day Rehab Program:
 - Rotates team members through acute care, inpatient rehabilitation and day hospital rehabilitation to promote expertise and flow as well as enhance trust for making referrals.
 - Co-locates the Stroke Resource Nurse, Stroke Prevention Clinic and Rehab Day Hospital to improve access to expertise and best practice support.

1.2 Importance of a Dedicated Care Coordinator/Stroke Navigator

NOTE: The terms 'care coordinator' and 'stroke navigator' are used differently by the various programs and the roles of these team members varies across programs. The



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reader is advised to follow up with the individual facilities for more information related to specific examples listed below.

A variety of care coordination models were described by the OP programs interviewed. Some of these models involve the use of stroke navigators or dedicated care coordinators with stroke knowledge, and/or patient flow coordinators. All of these positions were described by respondents as being beneficial to the program as they promoted smooth transitions (r1.0²), timely access (r 4.1.2¹), intensity/frequency of treatment (recommendation 4.1.4¹) and team communication (r4.1.4b¹).

Shared examples include:

- Utilizing a Stroke Navigator to ensure access to appropriate programming, linking between inpatient, outpatient and community programs and/or linking the patient to community services
- By incorporating a dedicated stroke care coordinator or stroke navigator into the team, therapists were able to dedicate more time to assessment and treatment of patients thereby improving access and intensity.

Specific examples include:

- Freeport Outpatient Clinic has a CCAC/LHIN care coordinators on site to foster relationships/linkages between OP and community partners.

In 2014/2015, several resources ([Navigation Model to Support Persons with Stroke Transition to the Community](#)) were developed for health service organizations and/or teams to support stroke survivors' transitions from inpatient care to the community.

1.3 Service Delivery Model

Various service delivery models were noted to facilitate timely access to services (r4.1.2¹), intensive rehab therapy (r 4.1.4c¹) and interprofessional collaboration (r 4.1.4b¹).

Shared examples include:

- Offering both single service and multi service streams allows faster access to OP services when needed.



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- Prioritizing those who have had a recent stroke, those coming from acute care and/or those coming from in-patient active rehab allows timely access for those who are deemed in most need of services.
- Having access to additional disciplines on their team (dietitians, social workers, neuropsychologists, physiatrists, therapeutic recreation, administrative assistant and/or clerk) allowed patients to receive the support needed to meet their goals.

1.4 Professional Development

Investing in professional development was noted to have a positive impact on developing and maintaining stroke expertise (r1.0a¹). The stroke networks were described as an essential resource, supporting the funding and provision of stroke specific continuing education (e.g. education on best practice updates) as well as providing leadership for best practice implementation. Some programs noted that having access to these continuing education activities allowed for the development of clinical champions, facilitating ongoing expertise within their teams. These champions also assisted OP programs to build, maintain and develop awareness of other parts of the care continuum to enable smooth transitions.

Specific examples include:

- Providence Healthcare utilizes Neurology Practice Consultants to provide ongoing mentorship to the outpatient team
- Woodstock Hospital has partnered with the Southwest Stroke Network to improve their stroke rehab orientation process by using an online learning management system within their website. (www.swostroke.ca/stroke-rehab-unit-orientation/).
- Quinte Health Care Day Rehab Program promotes stroke expertise by appointing Neuro ‘champions’ in PT and OT. These champions rotate through the Acute Stroke Unit, Inpatient Rehab Unit and the Rehab Day Hospital to provide mentorship.
- Bridgepoint Active Healthcare – Sinai Health System utilizes Allied Health Education Specialist and Clinical Practice Leaders to support new members of



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the team. They have also incorporated the Core Competencies for Stroke into their staff professional development to encourage stroke expertise.

Note: The [Core Competencies for Stroke](#) are a framework consisting of stroke competencies for six disciplines – Nursing, Occupational Therapy, Physical Therapy, Speech-Language Pathology, Social Work, and Recreation Therapy. They were created to support health care professionals who may be working in stroke care to build stroke expertise. Each competency contains a number of learning objectives, recommended learning resources/knowledge translation tools and suggested evaluation methods.

2.0 Communication

Programs described various ways they were able to effectively meet stroke best practices by improving communication within the interprofessional team, and/or across the care continuum (e.g. between teams or with stakeholders). Several programs also commented on the ways they used technology to support this communication.

2.1 Within Teams

Meetings, huddles or informal discussions act as facilitators to care coordination (r 4.1.4 b¹), timely access to care (r 4.1.2¹) and interprofessional collaboration (r 4.1.2¹).

Shared examples include:

- Co-locating therapists offices in a single common area thereby encouraging team discussions and group huddles.
- Having a single manager, (i.e. outpatient and inpatient programs are managed under the same portfolio) allowing consistent communication and effective use of resources
- Developing a process to ensure that patients receive an OP appointment prior to leaving the inpatient setting allows for timely access and smoother transitions ([retrievable HERE](#)) (link to Inpatient and Out Patient Rehab Referral Transition Standards 2018, Toronto Stroke Networks)

Specific examples include:



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- Bridgepoint Active Healthcare – Sinai Health System’s inpatient team uses a flagging system for high risk patients (e.g. patients with suspected depression or patients at risk of deterioration) so that the outpatient program can prioritize them appropriately or ‘fast track’ for improved access ([e stroke screen retrievable HERE](#))
- Hotel Dieu Shaver Health and Rehabilitation Centre improves communication between team members by holding weekly case conferences and quick team meetings every morning just prior to patient arrival time. While patients arrive they are greeted by volunteers who lead them into the facility and orient them to their schedule for the day.

2.2 Cross Continuum

Communication with external partners was described by programs as a key facilitator to implementing smooth transitions from both the inpatient setting to the outpatient setting and from the outpatient setting to the community (r 1.0²).

General example:

- Fostering linkages through working groups, committee work and initiatives led by Regional Stroke Network

Specific examples include:

- St Joseph’s Care Group supports communication with external partners by participating in a bi-annual Stroke Transition meeting, a meeting which brings together acute, inpatient rehabilitation and outpatient/community rehabilitation providers.
- Grand River Hospital - Freeport Campus Outpatient Neuro Rehabilitation Clinic has established communication pathways between the in-home and outpatient programs to allow patients to flow seamlessly to and from the programs. If it is determined that patient requires movement from one program to the other, a teleconference is arranged involving the clinical managers and a team member from each program to discuss the reason for the transfer, goals for the transition and how the transition will be made. A



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status update form is used to help support the transfer of written information. This communication not only supports smooth transitions but also helps to ensure that patients are receiving their rehabilitation in the most appropriate setting. They also perform a Discharge Link Meeting between the IP rehab team and the LHIN Home Healthcare Stroke Pathway Team when required. The Discharge Link meeting is an in-hospital meeting held prior to the in-patient discharge which brings together the patient, family, one or more members of the inpatient team, LHIN HCC coordinator and a member of the in-home stroke team. The meeting's focus is a discussion of what the care plan will look like on discharge, the goals for in-home rehabilitation and discussion of whether additional in-home services will be needed (for example, personal support services).

2.3 Technology

Several programs described the use of technology to support care coordination (r 4.1.4 b¹), timely access to care (r 4.1.2¹), and the provision of stroke survivor education (r 2.0- 2.4²). More specifically, shared electronic charting between inpatient and outpatient teams; electronic scheduling and telemedicine technologies were used to support these processes.

General examples include:

- Use of centralized electronic scheduling systems or software to coordinate patient therapy schedules.

Specific examples include:

- Bridgepoint Active Healthcare – Sinai Health System utilizes a shared electronic repository of resources to facilitate awareness of and referral to community services. This database is kept up to date by case managers and team members.
- St. Joseph's Hospital Neurology Outpatient Services leverages telemedicine technology to support peer to peer communication, patient education, client/family support, SLP services, specialist consultation and transition planning for patients being discharged home to another community.



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- St. Joseph's Hospital Neurology Outpatient Services have shared access to electronic charting/medical records (i.e. Meditech) to facilitate improved communication between acute, inpatient and outpatient rehabilitation settings.
- Grand River Hospital- Freeport Campus Neuro Rehab Clinic has a fast track scheduling system (i.e. Care Dove) for stroke entry to their clinic. This allows clinicians from acute and rehab facilities to set up patients with their initial assessment prior to discharge
- Programs in Toronto utilize an electronic referral system (E-Stroke) from acute to OP services that promotes standardized referral processes and automatic acceptance of acute care referrals. Processes also include meeting target start dates and standard communication to patients and families. The system allows for collection of data Toronto wide (wait times, referral volumes).

3.0 Creative Use of Resources

There were a host of creative ways OP programs were dealing with their high referral volumes or long wait times. This creative use of resources helps to facilitate timely access to services (r 4.1.2¹). Some hospitals reported reviewing their funding allocations and stroke flow processes and re-distributed resources along the stroke care continuum.

Shared examples include:

- Having one person coordinate scheduling (e.g. Program assistant) frees up time for the therapists to work directly with patients.
- Use of a case management model or care coordinator model allows the team to appoint a team member to act as the 'team lead' for each patient. Activities may include goal setting, completing team outcome measures, orienting the patient or completing team discharge documents.
- Using group education classes and/or group programming to fill the gap while patients are 'waiting' to start individualized therapy

Specific examples include:



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- Grand River Hospital –Freeport Campus Neuro Rehab Clinic has group classes for cognition, upper extremity/fine motor, and endurance/exercise classes as an adjunct to their individual therapies
- Providence Healthcare creatively uses flexible staffing assignments to enable patients to continue receiving therapy from their former inpatient therapists while awaiting their first outpatient visit.
- Providence Healthcare meets high volume demands by utilizing casual therapists on an as needed basis.
- Bridgepoint Active Healthcare – Sinai Health System patients continue to attend the same speech group from their IP active rehab as they wait for individualized therapy.

4.0 Patient Centeredness

One of the four core principles of the *Excellent Care for All Act* is that “*care is organized around the person to support their health*” (MOHLTC, 2016)³. Many survey respondents spoke to a variety of ways in which their programs demonstrated patient centeredness. More specifically, they spoke to how the location of their services, scheduling of appointments, communication methods, educational tools, and selection of outcome measures supported patient centered care.

It was identified that at times taking into account patient needs and preferences conflicted with stroke best practices, in particular the targets for time to first visit for outpatient and/or community-based rehabilitation (r4.1.2¹). As noted previously, some patients expressed feeling overwhelmed when they first returned home and preferring a period of time to get settled before starting outpatient programming. As such, identifying patients who are not ready to access the service early may help to alleviate no-shows/cancellations, allowing others on program wait lists to access treatment earlier. However, it remains important that therapists stress the importance of timely intervention in terms of



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overall recovery. Innovative models have been developed throughout the province to accommodate both the patients' needs and timely access.

Shared examples include:

- Scheduling appointments back to back (e.g. one hour OT, then one hour PT, then one hour SLP) making the patient's visit to OP therapy more efficient.
- Promoting patient centred care by developing care plans with the patient, providing the care plan in writing to the patient and discussing the care plan with the patient and family at team/family conferences. Patients and family members are also invited to attend weekly team meetings.
- Team members performing initial consultations together (e.g. OT/PT combined), minimizing duplication of assessment tasks for the patient.

Specific examples include:

- Within Waterloo Wellington LHIN, patients being discharged from Grand River Hospital Freeport Campus Outpatient Neuro Rehabilitation Clinic have access to a community stroke rehabilitation team in addition to outpatient services. This allows for flexibility in treatment setting depending on the model which patients are discharged to, e.g. patients at a lower functional level can be seen in the community and patients who are at a moderate or higher level of functioning can be referred to the outpatient clinic. Patients are seen in the setting that is most appropriate to their functional goals
- Hotel Dieu Shaver Health and Rehabilitation Centre promotes patient centered care by using an adapted version of the Patient-Specific Functional Scale (PSFS) a patient-focused outcome measure that evaluates performance on individually identified goals.
- Bridgepoint Active Healthcare - Sinai Health Systems created a Priority Setting Guide for patient to assist them in focusing on their top priorities allowing patient to optimize their therapy time ([retrievable HERE](#)). This site also uses a follow-up visit post discharge (4 weeks post discharge) to support the patient with community re-integration.



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- Bridgepoint Active Healthcare – Sinai Health System has the benefit of having specialty clinics already established within their site allowing patients to better meet their goals (includes seating clinic, vocational rehab, assistive augmentative communication clinics and pool program)

5.0 Partnerships

Several programs stressed the importance of partnerships when implementing stroke best practices. These partnerships were described by programs as being formal and/or informal linkages between outpatient programs and other partners along the continuum of care (e.g. inpatient programs, community programs).

Specifically, these partnerships were described to facilitate:

- discharge planning (r 3.2²),
- community reintegration (r 4.0²),
- ongoing support of the stroke survivor and family (r 1.0²), and
- referral to community-based services (r 4.0²).

General examples include:

- Partnering with Cardiac Rehabilitation programs to leverage resources and improve access to secondary prevention as well as aerobic exercise
- Partnerships with the regional stroke networks which support ongoing education and stroke expertise.

Specific examples include:

- Providence Healthcare initiated a partnership with Variety Village to create the *Rehab to Community Transition Program* to support patients as they transition from formal rehabilitation to ongoing self-management and community-based exercises.
- St Joseph's Care Group created a partnership with a community fitness centre by developing a physiotherapy role which is dedicated to assisting patients as they transition to community exercise programs. This physiotherapist screens



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patients for participation as well as assisting in the organization of the classes and training of community exercise provider partners.

- St. Joseph's Hospital Neurology Outpatient Services rehabilitation programs have improved access to outpatient services by partnering with a supportive housing facility to allow for temporary lodging for out of town patients during outpatient rehabilitation. This lodging enables them to access services that they otherwise would be unable to attend due to geography and/or transportation issues.
- Grand River Hospital- Freeport Campus Neuro Rehab Clinic has a partnership with the YMCA and their Neurofit program, as well as Aphasia Group and the March of Dimes: Survivors Supporting Survivors and Stroke Survivor Group.

ADDITIONAL INNOVATIONS

Below are some innovative strategies and examples from other programs that were not interviewed that were used to support implementation of stroke best practices in the community/OP rehab settings.

- The Toronto Rehab Fast Track OP Program. This program provides intensive short-term therapy for individuals with a mild-moderate stroke using an innovative, flexible, and interdisciplinary approach, with the aim of reducing demand on inpatient resources.
- The Community Outreach and Stroke Rehab Team in the Central West CCAC/LHIN is a collaborative effort between hospital (William Osler Health Systems) and Community Care (CW CCAC). This team serves milder stroke patients coming from acute care or rehab and is made up of clinicians from both the hospital and a Service Provider Organization under contract with the CW LHIN Home and Community Care. These clinicians work together as one team in either the hospital outpatient setting and/or a community location to help patients meet their goals.
- Visual road maps illustrating the stroke journey from the patient perspective have been developed in some regions (e.g. Health Sciences North Sudbury Visual Road Map) and are being used in the acute care setting to support



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patient transitions to the next stage of recovery. Resources such as this may also be helpful to use in the OP setting to support transitions to the community.

Conclusions

Similar to many areas of healthcare, outpatient stroke rehabilitation programs across the province demonstrate creativity with existing resources in order to implement stroke best practices. Delivering services to a patient population with a wide variety of needs is challenging, particularly when the outcomes may not be as tangible to measure and demonstrate as other programs. A clear focus for all the programs is the importance of team set up, communication, creative use of resources, patient centeredness and partnerships. Transitioning stroke patients into OP programs and then on to other community programs was critical to patient flow and meeting best practices. In many case examples, it is the processes in place to support these linkages that speak to their success. The other main focus seemed to be meeting patient goals and developing unique ways to ensure stroke expertise, timely access, and program models to meet stroke best practices. Technology was often used to support these processes

Limitations

Only rehabilitation programs self-identified as providing comprehensive services were selected for the interview process. Due to this selection process the following programs were not represented in this initiative: rural sites, single service design models and in-home models. The scope of this report does not include home-based stroke rehabilitation programs, as a comprehensive report, [Community Stroke Rehabilitation Models in Ontario](#), is available for reference. Despite the limitations, the examples provided will be useful to programs as they plan community stroke rehabilitation services, either in hospital or other settings. As with any planning or adoption of new ideas, sites will want to consider their own context and stroke population needs, but would be encouraged to review the facilitators described here to apply to some of their local challenges.



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Future Considerations/Opportunities

Supporting stroke survivors to have timely access to OP/community rehabilitation programs, building on the success of these examples and learning from their challenges is important. Key areas for future consideration to enhance delivery of stroke best practices and build on the experiences of the programs surveyed are:

- Provincial processes and support for data/outcomes measures to provide more comprehensive evaluation in the future
- Enhancing services to offer broader availability including extended hours, 5-7 day a week programming, (many programs have limited offerings currently)
- Flexible program entry points and intensity to meet patient goals/readiness
- Continue patient education and support to understand risks and benefits of attending outpatient programs with consideration of follow up or other supports for patients who choose or are unable to attend the outpatient service
- Ability to follow or re-connect stroke survivors at later points in their recovery
- Community programs need to be a comprehensive network of coordinated services that stroke survivors can access at various points in recovery.
- Additional community models should be developed which have the flexibility to meet patient needs, i.e. Early Supported Discharge, Community Hubs or hybrid models of care.



This resource was independently produced by Community and Outpatient Stroke Rehabilitation Provincial Integrated Workgroup for the purposes of supporting stroke best practice implementation. CorHealth Ontario's role is limited to enabling the sharing of this resource.

References

1. Hebert D, Teasell R, on behalf of the Stroke Rehabilitation Writing Group. Stroke Rehabilitation Module 2015. In Lindsay MP, Gubitz G, Bayley M, and Smith EE (Editors) on behalf of the Canadian Stroke Best Practices and Advisory Committee. Canadian Stroke Best Practice Recommendations, 2015; Ottawa, Ontario Canada: Heart and Stroke Foundation.
2. Cameron JI, O'Connell CM, on behalf of the Managing Stroke Transitions of Care Writing Group. Managing Stroke Transitions of Care Module 2015. In Lindsay MP, Gubitz G, Bayley M, and Smith EE (Editors) on behalf of the Canadian Stroke Best Practices and Advisory Committee. Canadian Stroke Best Practice Recommendations, 2015; Ottawa, Ontario Canada: Heart and Stroke Foundation.
3. Ministry of Health and Long-Term Care. (2016) Excellent Care for All, Legislation, Regulations and Policy. Retrieved from <http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/>



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Appendix A: Participating Programs

Organization	Location	Program Contact(s)	Regional Stroke Network Contact	Regional Stroke Network
1. Bridgepoint Active Healthcare – Sinai Health System	Toronto	Paula Shing, Clinical Manager Ambulatory Care Kimberley Meighan, Case Manager Ambulatory Care Paula.Shing@sinaihealthsystem.ca	cheungd@smh.ca	South East Toronto Stroke Network
2. Élisabeth Bruyère Hospital	Ottawa	Lila Zitouni, Clinical Manager lzitouni@bruyere.org	bedonnelly@toh.ca	Champlain Stroke Network
3. Grand River Hospital-Freepoint Campus Neuro Rehab Clinic	Kitchener	Ellen Richards, Clinical Manager, 519-749-4300 extension 7285	venditti@hpsc.ca	Central South Stroke Network
4. Health Sciences North Short Term Assessment and Treatment (STAT) Program	Sudbury	Melanie Paul, Clinical Coordinator, Seniors Care Transitions, mpaul@hscsudbury.ca	jfearn@hscsudbury.ca	Northeastern Ontario Stroke Network
5. Hotel Dieu Shaver Health and Rehabilitation Centre	St. Catharines	Jeane Davis-Fyfe, Manager Jeane.Davis-Fyfe@hoteldieushaver.org	venditti@hpsc.ca	Central South Stroke Network
6. North Bay Regional Health Centre	North Bay	Bill O'Donnell bill.odonnell@nbrhc.on.ca Shelly Hawton, District Stroke Coordinator shelley.hawton@nbrhc.on.ca	jfearn@hscsudbury.ca	Northeastern Ontario Stroke Network
7. Providence Healthcare	Toronto	Sharon Crossan, Manager, scrossan@providence.on.ca	cheungd@smh.ca	South East Toronto Stroke Network
8. Quinte Health Care Day Rehab Program	Belleville	Derk Damron, Manager, Rehabilitation Therapy and Stroke ddamron@ghc.on.ca	Shelley.huffman@kingstonhsc.ca	Southeastern Ontario Stroke Network
9. St. Joseph's Care Group: St. Joseph's Hospital Neurology Outpatient Services	Thunder Bay	Scott Munro, Clinical Managers munros@tbh.net 807-343-2441	frenche@tbh.net	Northwestern Ontario Stroke Network

10. Woodstock Hospital - Intensive Rehabilitation Outpatient Program	Woodstock	Sean Willis, Director of Therapy & Woodstock Rehab Clinic 519-421-4211 x2231, swillis@wgh.on.ca	Margo.Colliver@lhsc.on.ca	Southwestern Ontario Stroke Network
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