

Innovative Ways to Provide Stroke Rehabilitation Intensity (RI)

REAL TIME TRACKING LEADS TO DAILY RI HUDDLES AT GLENGARRY MEMORIAL HOSPITAL (GMH)

"At the end of the day, the tracking sheet is a great communication tool that really makes the difference in reaching our RI targets"
- Rehabilitation Manager & Physiotherapist

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GMH's Inpatient Stroke Rehabilitation Program identified an opportunity to increase RI time through real-time tracking of data. Last year, the team revamped their RI statistics sheet so that they could track each patient's RI by day and discipline. The revised statistics sheet started a conversation amongst the team, that led to a decision to start daily morning huddles to make sure RI targets were met. Huddles are attended by OT, PT, S-LP and rehabilitation assistants, and last 5 minutes or less.

As an interim goal, the team

identified 90 min/day as an incremental step towards achieving the provincial target of 180 min/day. When a patient's RI is not meeting this incremental goal, the team identifies ways to increase intensity.



GMH team during their RI Huddle
Examples of these strategies include:

- increasing time with a therapist or assistant;
- identifying that new goals need to be set; and
- identifying that the patient can be discharged early.

These huddles allow the team to make quick adjustments to their schedule so they can maximize RI time with their patients. Since implementation, median RI time has increased by 15 minutes to 89.3 minutes/day in Q3 18/19.

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'SUPPLY VS. DEMAND' MODEL FOR RI IN PETERBOROUGH

Peterborough Regional Health Centre Integrated Stroke Unit collaborated with their Quality Department to examine RI using a "Supply vs. Demand" model. For a three-week period OT, PT, S-LP and assistants recorded:

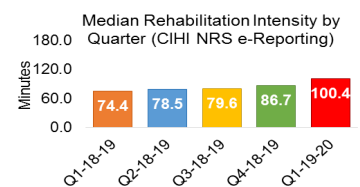
- "supply" by tracking the hours they were available to provide therapy on the unit;
- "demand" by looking at their daily caseload (including acute stroke and other non-stroke rehabilitation patients);
- barriers to achieving 180 minutes of RI.

Tracking led to heightened awareness of RI, more efficient

practices, and improved capturing of eligible RI time. More specifically, this initiative led to:

- validation of subjective barriers to meeting 180 minutes of RI (e.g. caseload, patient unwell/fatigued/declines to participate);
- support for the importance of weekend therapy provided by therapists;
- identification of the amount of time spent doing essential, non-direct patient care (e.g. rounds, charting, administrative tasks, conferences); and
- steadily improved RI time with

an increase of 26 minutes between Q1 2018/19 and Q1 2019/20.



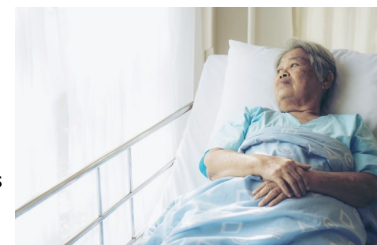
Next steps are to further evaluate essential non-direct patient care, and identify further ways to increase RI time.

For more information contact: Erin McHattie, HKPR District Stroke Coordinator emchatti@prhc.on.ca

Did You Know that Service Interruptions can Influence your RI metric?

According to the National Rehabilitation Reporting System (NRS):

- “Service Interruptions (30 calendar days or less in duration) occur when the service is temporarily suspended by the facility due to a change in the client’s health status. In a service interruption (SI), the client is expected to return to continue with the rehab goals that are being addressed in therapy. Service goals are still active and not yet met. If the service interruption is 30 days or less and the client returns for rehabilitation services for the same Rehabilitation Client Group ..., it is considered part of the original rehabilitation admission.”
- “Where the client is unable to participate in his or her rehab program but does not leave the bed, it is up to the team to decide if the health condition and/or the length of the SI are substantial enough that they affect the client’s progress in rehab. All service interruptions that result in the client being admitted to another unit ... must be captured. The SI start date ... in the NRS will be the same as the admission date to the other unit if the client leaves the rehabilitation unit. If the client does not leave the unit, the start date would be the date, determined by the clinical team, on which the interruption in service due to a change in medical status commenced. For SI of more than 1 day, the SI return date will be the same as the discharge date from the other unit, if a change in bed occurred. If there was not a change in bed, the return date would be the date, determined by the clinical team, on which the client was able to begin participating in rehabilitation again.”



(Rehabilitation Minimum Data Set Manual, Feb. 2018 Module 2: Clinical Coding and NRS Training)

In determining the RI metric, the reporting of data is over the ‘active’ rehab length of stay. The calculations for RI reporting should not include any RI minutes during SI days that are between the start and end dates of the SI. Therefore, it is important for you and your teams to accurately record SI days, which will alter your RI metric and improve your data quality. It is also important that all team members are aware of these key processes.

Consider the following to enhance your RI processes and data quality:

- How does your team capture and report Service Interruptions? Do you have confidence in your processes?
- How does your team communicate and discuss potential Service Interruptions and who ultimately decides this?
- How does your team determine when a Service Interruption is over and when the patient can return to active rehab?
- Who is responsible for recording the Service Interruption within the NRS report?

Knowledge Check

If a patient cannot achieve 3 hours of intensive therapy per day should this provide an indication that they are not ready for inpatient stroke rehabilitation?

NO. This should not be considered an indication that the patient is not suitable for inpatient stroke rehabilitation, nor should it be considered a criterion for inpatient stroke rehabilitation candidacy or admission.

As all stroke patients should receive rehabilitation therapy in an active and stimulating environment (Canadian Stroke Best Practice Recommendations for Stroke Care, 2015), therapists will need to structure the therapy time to suit their patients’ endurance, needs and goals. Ideas for accommodating patients with lower tolerance could include:

- shorter therapy sessions provided at higher frequency (e.g. 15 to 20 minute increments throughout the day);
- therapy provided at the bedside as opposed to the gym area; or
- therapy coupled with their ADL treatments.

As such, one of the goals of therapy would be to improve activity tolerance in a gradual manner. Developing strategies to achieve this goal would require collaboration and problem solving with the patient, family member(s), and the interprofessional team.

<p style="text-align: center;">STROKE REHAB INTENSITY</p> <p>Definition: “The amount of time the patient spends in individual, goal-directed therapy, focused on physical, functional, cognitive, perceptual, communicative and social goals to maximize the patient’s recovery, over a seven day/week period. It is time that a patient is engaged in active face-to-face treatment, which is monitored or guided by a therapist.”</p> <p><small>*The rehabilitation intensity definition was developed and approved by the Ontario Stroke Network Stroke Reference Group in 2012. This definition was later revised by the Ontario Regional Stroke Networks’ Rehabilitation Coordinator Group in 2018.</small></p>	<p style="text-align: center;">STROKE REHAB INTENSITY</p> <p>Guiding questions to determine if your activity is included in Rehabilitation Intensity (RI) measurement:</p> <ol style="list-style-type: none"> 1. Was I assessing, monitoring, guiding or treating the patient face-to-face? 2. Was my activity with the patient one-on-one*? 3. Was the patient actively engaged in the activity throughout the session? 4. Were the therapy activities helping the patient achieve his/her goal(s) and maximize his/her recovery? <p>If the answer to all questions is YES, include the activity in RI measurement.</p> <p>If the answer to any question is NO, do not include the activity in RI measurement.</p> <p><small>*with the exception of co-treatment/collaborative treatment</small></p>
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RI Resources

Stroke Rehabilitation Intensity supporting resources, such as a Stroke Rehabilitation Intensity Pocket Card (illustrated above), FAQs, and more, are available by clicking [HERE](#).

Would you like more information about Rehabilitation Intensity?

Within the West GTA Stroke Network your Regional Rehabilitation Coordinator is: Stacey Williams, Stacey.Williams@thp.ca