

Implementing Evidence Based Community Rehabilitation Practices for Stroke Survivors in the MH and CW LHINs

1 INTRODUCTION

The West GTA Stroke Network's mandate is to ensure that stroke patients receive the 'right care, in the right place, at the right time'. In accordance with this mandate, a need was identified within the region to look at the current practices occurring in the outpatient and community rehabilitation settings. To do this a joint operational committee was created. This committee consisted of members from the West GTA Stroke Network's Rehabilitation Operational Committee and the West GTA Stroke Network's Community/ LTC Operational Committee. More specifically, the committee consisted of members from Halton Healthcare, William Osler, Trillium Health Partners (Mississauga Site and Credit Valley Site), the MH/CW Local Integrated Health Networks and the CW/MH CCAC's.

During committee meetings, several concerns surrounding current practices in community rehabilitation settings (both Out Patient or 'congregate' setting and in home) were raised such as prolonged wait times, poor communication between inpatient, outpatient and community teams and inequitable access to rehabilitation services across the region. Realizing that Stroke Best Practice Recommendations stress the importance of excellent team coordination, timely access to treatment and strong interprofessional communication, the committee decided to focus their attention on these issues. The group developed a Project Charter (see Appendix A) to help guide their work. The following document outlines the work done to examine the current state, develop standardized admission and triage criteria, compare and contrast services across the region and to identify possible tools that could be used to improve communication between OP and community rehab teams. Recommendations made by the committee are also embedded throughout this document and then summarized.

2 CURRENT STATE

A current state analysis of the Outpatient Programs located throughout the West GTA region confirmed that differences existed throughout the region with respect to admission criteria, services provided and wait times. See Table 1 below:

Table 1.

Item	Halton Health Care (HHS)- Step Up Program (and *Assess and Restore)	William Osler Health Systems (WOHS) Brampton Civic Site- Outpatient Rehab	Trillium Health Partners (THP)- Mississauga (M) Site Outpatient Rehab	THP- Credit Valley Hospital (CVH) Seniors and Rehabilitation Day Hospital Program
Admission Criteria ** see also Table 4 for more detailed intake considerations	18+ years, Resident of Oakville, Milton or Halton Hills discharged from HHS or family doc. from area. Requires at least 2 disciplines. Motivated to participate, transportation available, consented to treatment. Within 1 year post stroke. Physician referral required. * Also have Assess and Restore stream for frail elderly population (some different criteria). Majority of stroke patients attend the Step Up stream.	18+ years. Within one year post stroke; did not or is not receiving service elsewhere; has family physician; has transportation. Can obtain both single service and multiple services. Physician referral required.	18+ years, within 9 months post stroke; identified rehab goals; has transportation; medically stable; ability to tolerate up to three hours of treatment for multi service (complex) program; patient from THP or lives in THP catchment area; under the care of family physician (patient is given a list to help them find one if needed). Physician referral required.	18+ years, identified rehab goals, must require at least 2 services, patient must have been an in-patient at CVH hospital site with recent discharge, medically stable, has transportation, Physician referral required. Willing and able to participate in outpatient rehabilitation program.
Referral Sources	Any source, patients triaged for priority (acute first). Will take client from community up to one year post stroke.	Accept all referral's except those where patient has been through an OP program elsewhere (reviewed on a case by case basis with some exceptions made).	Sources include in-patient rehab therapists, family doctors and other hospitals (if patient lives in THP catchment area but received treatment at a different hospital). Community (i.e. CCAC or Family physicians).	Emergency, acute and rehab at CVH site (in hospital referral only). If the patient is on the MH CCAC Stroke Program they are only admitted post CCAC rehab.
Program Description	Am/pm day program.	Single service OT, PT and SLP with service bundles when possible.	Single service and multi service programs. Multi service or 'complex' program uses day hospital type model (patient's appointment booked back to back).	Program is open 3 days per week. Multi- service only. Patients are typically seen once per week with emphasis on home program.
Wait List Times (*varies over time)	1-5 Weeks depending on services needed.	PT waitlist approx. 8 weeks, OT 12-16 week, SLP 16 to 24 weeks.	PT 6-8 weeks, OT 8-12 weeks, SLP generally > 12 weeks.	2-4 weeks.

Item	HHS- Step Up Program (and *Assess and Restore)	WOHS- Outpatient Rehab	THP- M Site Outpatient Rehab	THP- CVH Site Seniors and Rehabilitation Day Hospital Program
Typical Clients	Step Up Program: Neurological conditions such as: Stroke, MS, Parkinson's *Assess and Restore: mixture of neurological and non- neurological conditions (seniors wellness/health).	Neurological conditions, primarily Stroke but also TBI, brain tumour resection, neck fusion, GBS, some MS/Parkinson's or other progressive disorder where patient is experiencing an acute exacerbation.	Stroke, ABI, new diagnosis of an acute nature or an acute exacerbation of a chronic neurological condition (i.e. MS).	Neurological conditions, stroke, mixed medical.
Services Provided	OT, PT, SLP	OT, PT, SLP	OT, PT, SLP, SW	OT, PT, SLP, RN, TR
LOS by Discipline	4-6 weeks, maximum target of 10 weeks. Will advocate for longer if required. Currently trialing a 'transition program' where patient's start with multiple sessions per week for the first 4-6 weeks and then decrease to once per week for the subsequent 4 weeks.	Depends on client's needs. Typically twice per week for 12 weeks, some attend once weekly for 24 weeks.	Up to 12 weeks for any service, generally patients attend 2 sessions per week with some flexibility to meet patient needs.	Approx. 6-8 weeks.
Outcome Measure Used (Program and/or Clinical)	No program measures used. Clinical outcome measures are discipline specific.	No program measures used. Clinical outcomes are discipline specific.	No program measures used. Previously used SAQUAL as a quality of life measure. Clinical outcomes measures are discipline and condition specific.	Clinical outcome measures are discipline specific.
Current Staffing (2015) (FTE's)	Step Up: PT=0.5 OT= 0.5 OTA/PTA= 0.5 SLP= 0.5 *Assess and Restore: 0.5 OT, 0.5 PT, 0.5 OTA/PTA, 0.5 SLP	PT= 1.0 OT= 1.3 SLP = 0.6	PT= 2.0 OT= 2.0 SLP= 1.1 OTA/PTA= 1.6 SW= 1.0	PT = 0.6 FTE OT = 0.6 FTE PTA/OTA= 0.2 FTE Nurse = 0.6 FTE SLP = 0.4 FTE TR= 0.4 FTE
Referral Volumes (2015/2016)	80 new stroke patients admitted to Step Up Program.	PT = 135 OT= 268 SLP= 107	PT= 219 OT= 288 SLP= 78 SW= 31	99 new patients admitted (day program model).

Graphs outlining staffing ratios and referral volumes are further outlined in section Graph 2, 3 and 4 on pages 7, 8 and 9.

A current state analysis of the two CCAC programs available to stroke patients living in the West GTA (Mississauga Halton and Central West CCAC's) also showed large variability. The difference are depicted in Table 2 below. Please note that the Mississauga Halton (MH) CCAC has a stroke specific program while the Central West (CW) CCAC does not have a community rehab program specific to stroke.

Table 2.

Item	MH CCAC Stroke Rehab Program	CW CCAC
Admission Criteria	<ul style="list-style-type: none"> Stroke diagnosis Recent discharge, diagnosis or referral from hospital/rehab/stroke prevention clinic Physician referral not required Identifiable goals for community reintegration 	<ul style="list-style-type: none"> Patient resides within the CW LHIN Eligible for CCAC Services
Referral Sources	Referred by hospital sites; may be direct from ED, acute, in-patient rehab	Hospital (in CW region) Community
Program Description	Timely intensive in home rehab	Servicing stroke patients under CCAC in-home services (including Wait At Home Rehab, Home Independence Program, In-Home Physiotherapy Service etc.) When appropriate system navigation and linkages to other community supports including stroke resources
Wait List Time	No wait list – service initiated within 10 days of referral	No wait list
Typical Patients	Patients requiring in home service either to complete their rehab or to move goals forward while awaiting OP rehab	Stroke Patients
Services Provided	OT, PT, SLP (RD and SW as needed)	PT,OT, SLP, RN, RD, SW and PSW as needed
LOS by Discipline	Up to 6 visits per service within first two weeks (depending on need); service may be extended another 4 weeks if active patient still has goals to achieve	LOS depends on patient's needs
Outcome Measures Used	FIM ASHA-NOMS RAI-CA to RAI-HC comparisons	Falls risk assessment tool (FRAT) Timed- Up and Go (TUG test) Tinetti Test & Falls Efficacy Scale Range of Motion Manual Muscle Testing SMART Goals

COMMONALITIES BETWEEN REGIONAL OUTPATIENT PROGRAMS

All programs accept patients who are at least 18 years of age and experiencing acute neurological conditions or acute exacerbations of chronic conditions (note for the CVH program this exacerbation would have had to require hospitalization for them to be accepted into the OP program).

Excluding Credit Valley, all programs accept patients living within their catchment area regardless of which hospital they were discharged from. All the OP programs require a physician's referral and all programs receive referrals from similar sources.

AREAS WHERE THEY DIFFER THE GREATEST

The models of care and staffing mixtures used by each outpatient program were noted to have the greatest variability throughout the region (day hospital style vs. single service vs. single service with multiservice programming). Although each program has OT, PT and SLP only the Mississauga site team has access to SW and only the Credit Valley Hospital team has access to nursing and TR (Therapeutic Recreation Therapist). Committee members noted that access to social work would benefit ALL programs as much of the therapist's time is currently being spent tending to the emotional, financial and employment needs of clients and their families (despite lack of expertise in these areas).

Differences were also noted in length of stay (LOS) and wait times. Reported length of stay (LOS) varied from a minimum of 4 weeks up to a maximum of 12 weeks (or longer depending on client goals). Reported waitlists varied from 1 to 24 weeks depending on the program and/or services required.

Change in staffing and referral volumes per site from 2008/2009 to 2015/2016 all showed a significant increase in volumes with either no staffing increase or a decrease in overall staffing. This will be further explored in section 5.4 Tracking.

After looking at this current state a number of problem issues were identified by the group. These issues are outlined below.

2.1 CURRENT STATE DATA SNAPSHOT – JAN TO JUNE 2016

Excel tables were set up for use by each organization in order to compare services across the region. These tables included:

- Date referral received
- Date patient discharged from referring source
- Date of uptake to each service (first appointment)
- Number of 30 minute units of time spent with each patient in direct and indirect service provision (items included in direct/indirect included below)
- Total number of visits
- LOS in days in the program (from first visit to last visit, this includes weekends where no therapy is actually provided)
- Comments section to capture no shows, cancellations and reasons or special circumstances
- Comment section to include note of patients kept on caseload for an extended period but who are only doing 'check in visits' at a particular frequency

This data was collected not only to compare services across the region but also to look at how well these services align with the best practice recommendations. Some organizations, for their own purposes, also tracked demographic data such as age, type of stroke and referring physician. In the future, continued tracking could be used to measure the outcomes of initiatives aimed at improving access to OP programming.

Data was collected from the following programs:

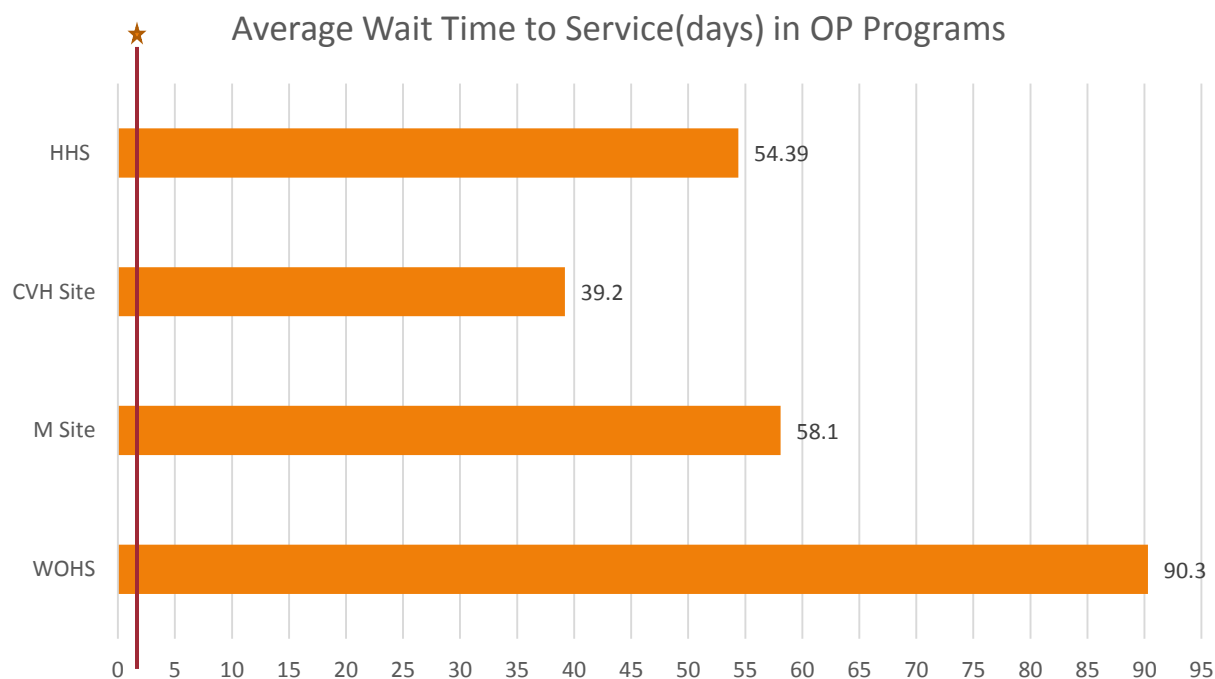
HHS: Halton Health Care Services Oakville Site, Combined Step UP & Assess and Restore Programs. While Step Up handles the majority of stroke patients there are several with stroke diagnosis in the Assess and Restore Stream as well. When the programs are separated this is indicated in the graphs as HHS Step Up and HHS A/R (for Assess and Restore).

CVH-Site: Credit Valley Seniors and Rehabilitation Day Hospital Program

M-Site: THP Mississauga Hospital Outpatient Rehab Program

WOHS: William Osler Health Service Outpatient Rehabilitation Program at Brampton Civic Hospital Site

Graph 1: Wait time to service in days

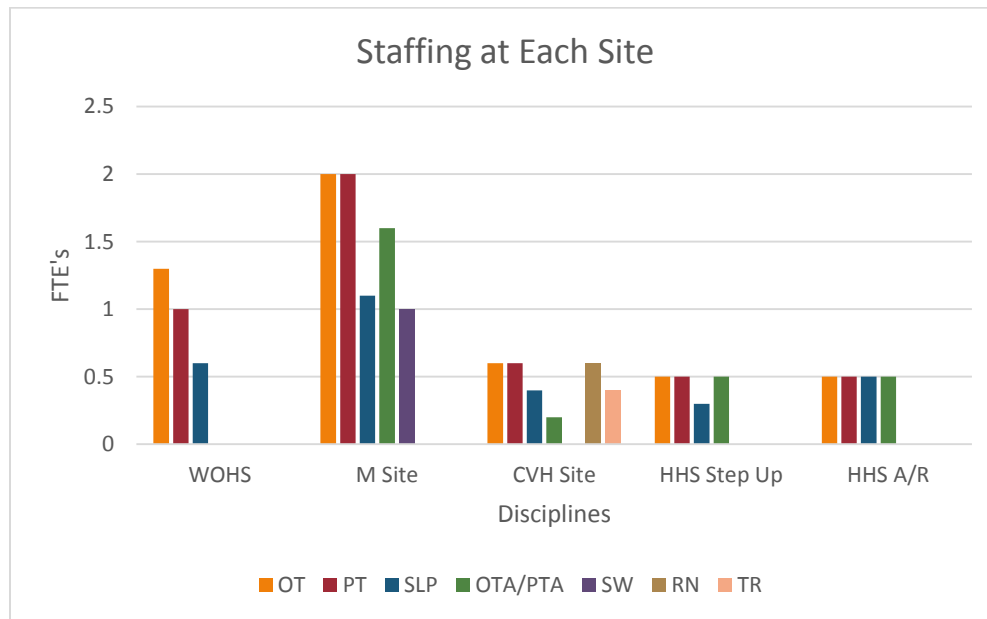


* in this graph HHS refers to combined average wait for stroke patients to Step Up &/or Assess and Restore Programming at HHS Oakville Site

(Best practice target★)

The **CBPR stroke rehab practice guidelines update (2015)** recommends “**outpatient or community based rehabilitation services should be available and provided by a specialized interprofessional team when needed by patients within 48 hrs of discharge from an acute hospital or within 72 hours of discharge from inpatient rehabilitation**” p 10 , as indicated by the red line on the graph. OP centres in the West GTA region do not meet this recommendation. This prolonged wait time is especially concerning in the Central West (CW) where there is limited access to community stroke rehabilitation post hospital discharge. The MH CCAC reports that the average wait time for patients to be picked up by their Community Stroke Rehab Program is approx. 2- 4 days. This wait time is much closer to the best practice benchmark.

Graph 2: Staffing at Each Site

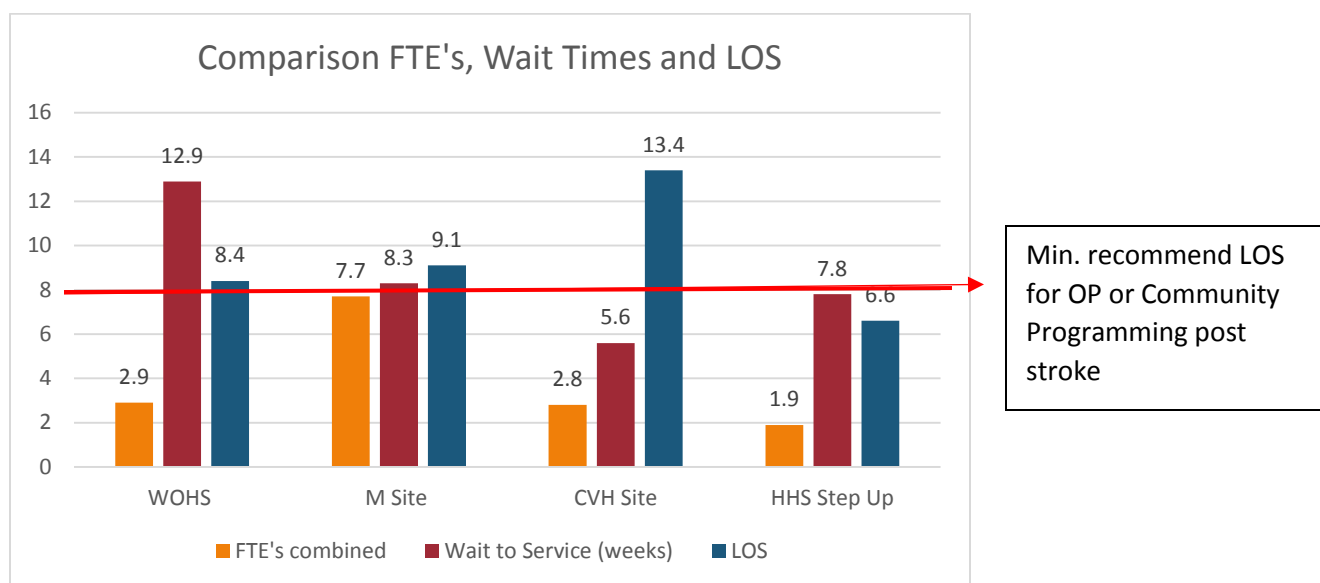


The CBPR (2015) indicates that outpatient or community based rehabilitation services should be available and provided by a specialized interprofessional team with stroke expertise. The types of therapies provided should be based on assessment of deficits (OT, PT, SLP and other as required). Furthermore, “Stroke rehabilitation should be delivered by a full complement of health professionals, experienced in providing post stroke care, regardless of where services are provided to ensure consistency and reduce the risk of complications” (p. 9). The graph above shows that all sites provide OT, PT and SLP. However, not all sites have access to additional team members such as Occupational Therapy and Physiotherapy Assistant (OTA/PTA), Social Work (SW), Nursing (RN), Therapeutic Recreation (TR) and/or a Dietician.

As seen in the graph below, staffing FTE's seems to have an effect on wait times and to some extent length of stay. Those sites with lower FTE complements and with high referral volumes also have longer wait times to service (or have implemented stricter triage criteria to handle caseloads as is the case with Credit Valley Hospital OP program).

Please note that the Credit Valley Hospital program may have a longer length of stay due to of the type of service delivery model used (they are only operating 3 days per week instead of 5 days per week). See Graph 3 below:

Graph 3: Comparison of total FTE's, Wait Times (in weeks) and LOS

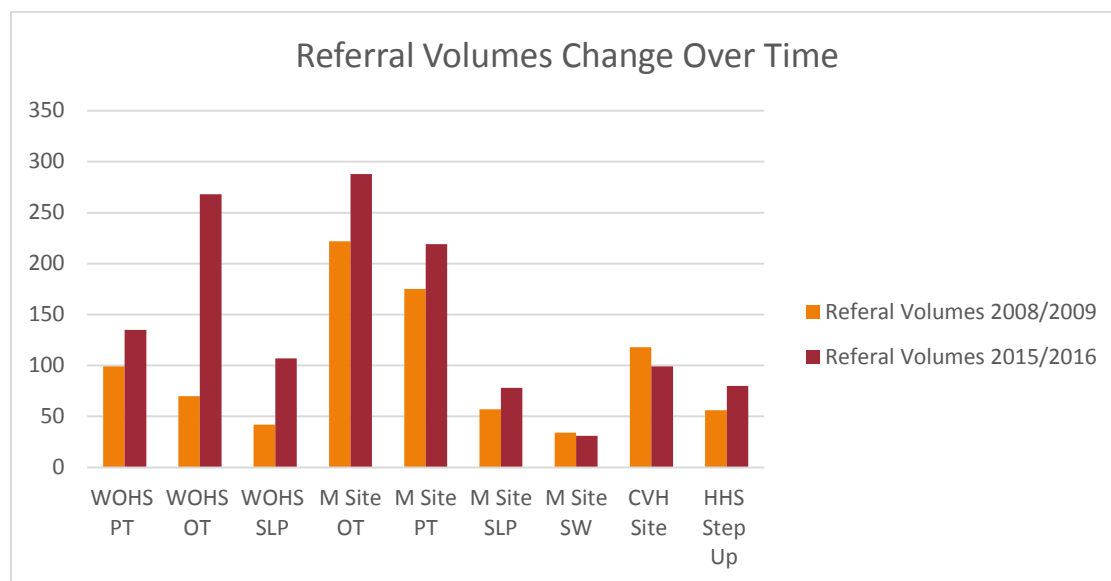


The recommended length of time for service provision is at least 8 weeks. The CBPR states “therapy should be provided for a minimum of 45 minutes per day per discipline, 2 to 5 days per week based on individual patient needs and goals for at least 8 weeks” (p 11). This would provide a total range of 2,160 minutes up to 5,400 minutes of therapy provision per patient assuming at least 3 disciplines (i.e OT, PT and SLP) were required. In our data set the total average minutes of combined OT, PT and SLP therapy time spent per patient throughout the region varied from 784 to 1,702 minutes. This practice is well below the best practice mark. .

The graphs below (graph 4) show the increases in referral volumes. In most cases sites have experienced decreases in staffing since 2008/2009, while referral volumes have increased drastically. Examples are:

- HHS Step Up Program had a 0.2 increase in OT and 0.1 increase in SLP but lost a 0.2 SW from 2008/9 to 2015/2016.
- At Mississauga Site OP Program, a 3.0 FTE for administrative assistants 8 years ago has been reduced to 1.0 FTE now. This admin. assistant reports having very limited time to service the OP program as she is also responsible for serving the Stroke Prevention Clinic, Neurology Clinic, VFSS bookings, and Pre-OP patient registrations.
- Up until 2007 the Mississauga Site OP Program ran as both single service and “Day Hospital” with greater staffing and ability to provide grouped programming. Since then 1.0 therapeutic recreation was cut from the program as well as 1.2 OTA being cut in total and a 1.0 RN. The program runs two waitlists, one for ‘single service’ and one for ‘complex patients’ who need more than one service. While the therapists makes every attempt to see complex patients at the same time whenever possible, our data snapshot showed an average a span of 28 days between when the patient attended their first visit with their first service provider (typically PT) and when they received the first visit with the last service provider to become involved in the patients care (typically OT or SLP).
- At WOHS there has been no change in staffing (no increase) since 2008.

Graph 4: Change or referral volumes 2008/2009 to 2015/2016



*Note for Step Up these only reflects referrals where the patient was also actually picked up onto service, it does not include referrals for patients which were explored but then denied access to the program for various reason.

Despite an increase in referral volumes to the regional outpatient programs, there has been no change in the staffing or resources (i.e. administrative assistance or technology) for all programs except CVH. Naturally this discrepancy has resulted in an increase in wait lists.

At the CVH site, the program staffing and operation times decreased in 2010 from a fully staffed program that ran 5 days/week, to a 3 day/week program (RN/PT/OT 3 days per week and TR/SLP 2 days per week). To manage the continued demand, the program changed their specific triage criteria to only accept patients who were in-patients at their own hospital. The data reflects that there was only as small decrease in referrals, despite the change in staffing and referral criteria.

Other factors that could be influencing wait lists were noted in the comment sections of the data sets:

- Unable to contact patient to book appointment (multiple calls being made or trying to track down correct phone numbers)
- Cancellations (often without enough notice to allow team members to book another patient in)
- In-appropriate referrals (which still take time to be reviewed and triaged)

A key finding was that none of the OP programs within the region have access to administrative support for scheduling, phone calls or other administrative tasks. In the CVH program the nurse is responsible for screening patients, triaging referrals, organizing referrals for team assessment and scheduling. These tasks take up approx. 0.2 of the 0.6 nursing FTE. Mississauga Site is currently trialing a process in which their OTA/PTA perform triaging and patient phone calls each week for approx. 3 hours. HHS reports they will soon be having administrative staff take on these tasks.

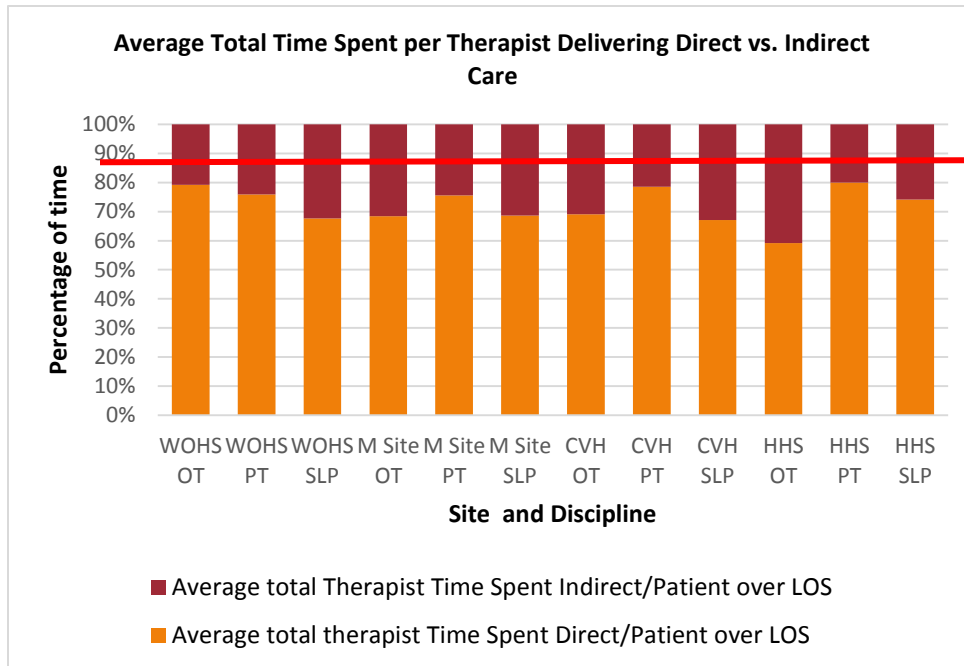
The committee also examined how much time therapists were spending on delivering direct and indirect patient care. In order to ensure that all sites were using the same classification system for direct and indirect care a FAQ sheet was sent out to the clinical teams (See Appendix D). Direct care was defined as: time spent in assessment or treatment or co

treatment of patients, joint or group therapy (time split amongst the patients in the group), phone calls related directly to patients goals.

Indirect care included: any phone calls or administrative tasks related to scheduling or other administrative issues (not specific to patient functional goals), phone calls or interaction with family members where patient was NOT present,

The following graph compares direct and indirect minutes per discipline at each site:

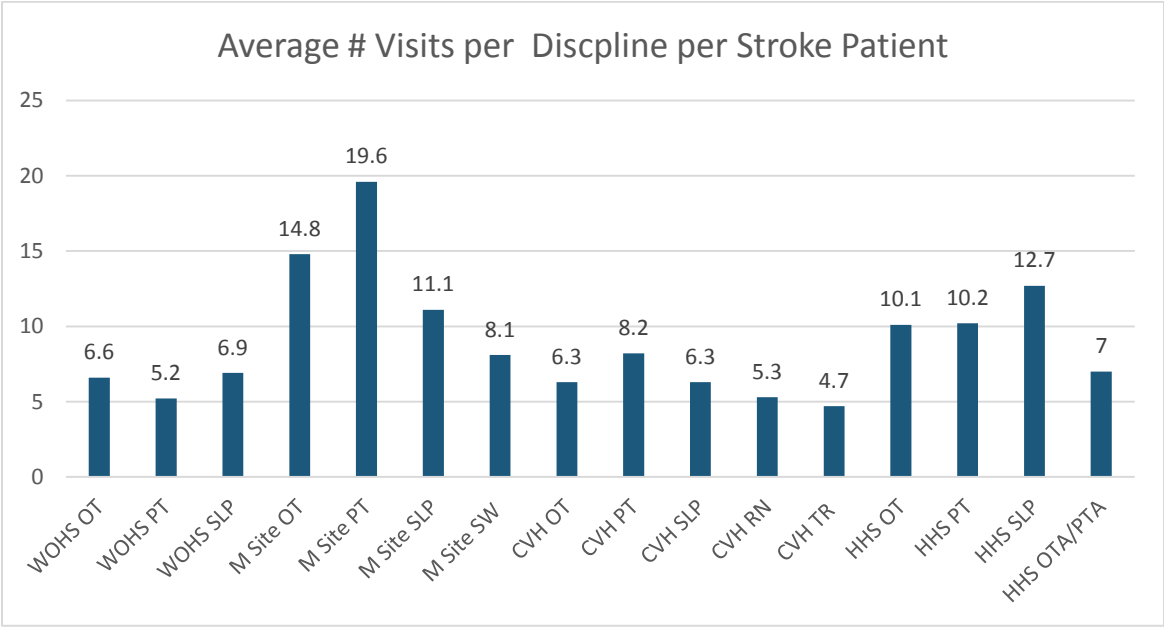
Graph 5: Time spent in direct and indirect care per discipline (OT, PT, SLP)



A general rule of thumb is the 80/20 rule. This rule means that a therapist will devote 80% of their time for direct treatment and 20% of their time for indirect care needs. Lack of administrative support could be a reason for more time being spent by the therapist on the indirect care with their patients.

We then looked at the average number of visits provided per discipline per stroke patient at each site over the average LOS. See below:

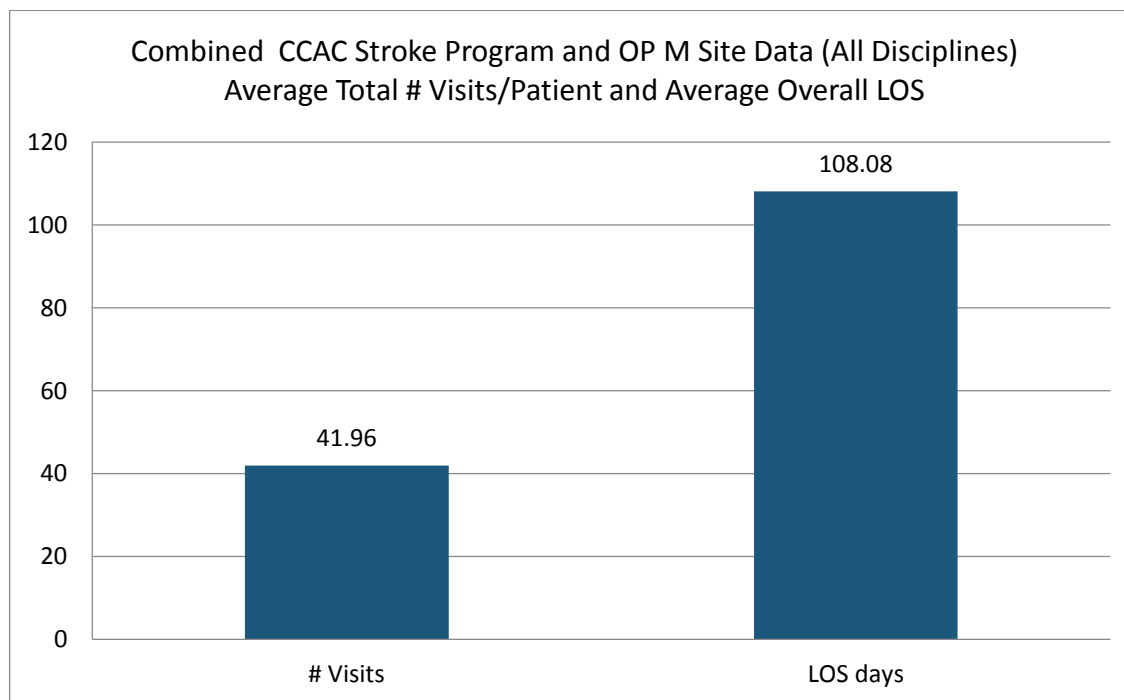
Graph 6: Average Number of visits per stroke patient for each discipline at each site



Average number of minutes of therapy provided per discipline was found to all be at or above the best practice minimum of 45 minutes per session except for at Credit Valley , where there programming is set up to treat in 30 minute blocks. The stroke best practice recommends that ‘therapy should be provided for a minimum of 45 minutes per day per discipline, 2-5 days per week, based on individual patient needs and goals for at least 8 weeks” (p 11). That would mean providing a minimum of 16 visits (2 visits per week, 1 provider, 8 weeks) up to a maximum of 120 visits (5 visits per week, 3 providers, 8 weeks). As you can see from the graph above only the PT from the Mississauga Site is able to meet the minimum therapy frequency recommendation (if OP programming only is taken into consideration). In order to determine the overall frequency of visits and LOS for patient who attended both in home community rehab provided by the MH CCAC Stroke Program and the OP programming data from these two programs was pulled and matched. HHS was not able to provide us with a data set which included patient’s names or identifiers and so we were unable to match data for this site.

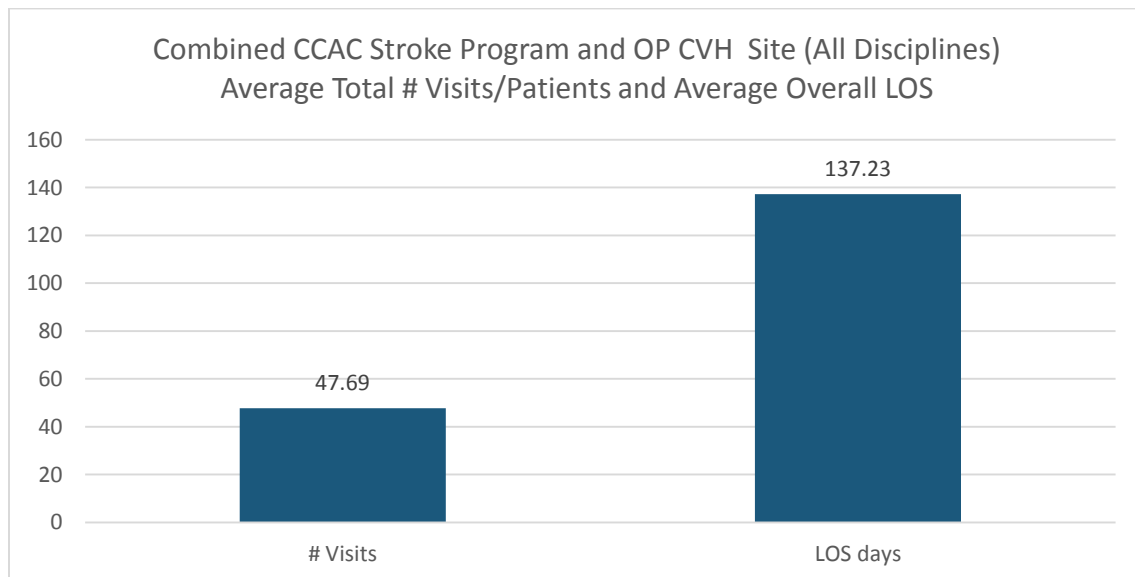
We were thus able to identify patients who received rehabilitation from both the Mississauga Site Outpatient Rehabilitation Program and the MH CCAC Stroke Rehab Program (graph 7) and those that attended CVH Site Seniors Day Hospital and Rehabilitation Program and also participated in the MH CCAC Stroke Rehab Program (graph 8).

Graph 7: Combined # Visits and LOS for patient who attended both MH CCAC Stroke Rehab Program and Mississauga Site OP Programming



When looking at the “whole picture” (CCAC + Outpatient visits) the total number of visits on average was 41.96. This is within the best practice range of 16 up to 120 visits (with room for improved frequency of visits). If we combine the LOS of these two programs patients are staying a total of 15 weeks on service. Improved frequency of visits could lead to shorter overall LOS. If this would be in the patient’s best interest has yet to be explored by this group. Sixty seven percent (67%) of patients in this data set attended both in home community rehab and OP programming.

Graph 8: Combined # Visits and LOS for patient who attended both MH CCAC Stroke Rehab Program and Credit Valley Seniors Day Hospital and Rehabilitation Program

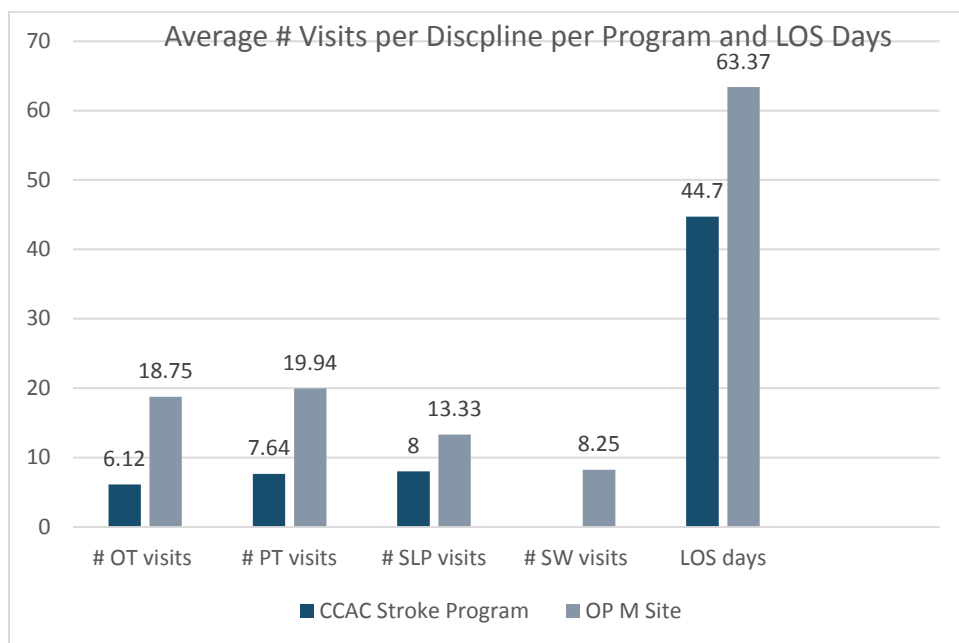


Above we see an average of 47.69 visits in total and a total LOS average of 137.23 days of 19 weeks. Thirty eight percent (38%) of patients attended both in home community rehab and OP programming in this data set.

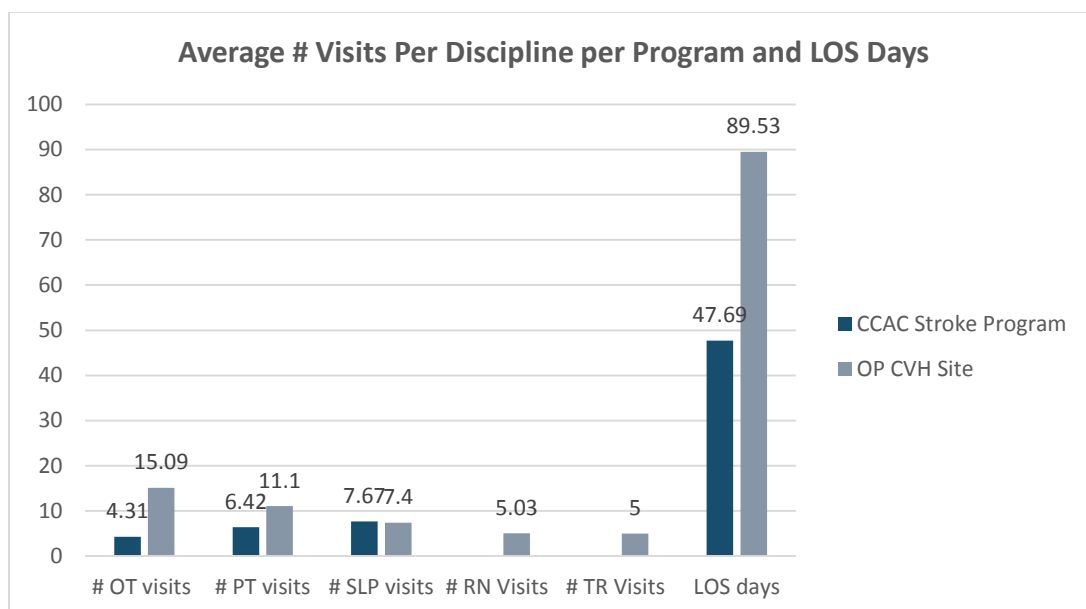
If we combine both programs (CVH and M site with CCAC Stroke Program) the average number of visits is 44 visits over 17 weeks, this is approx. 2.5 visits per week (for all disciplines required). If a patient required all three disciplines (OT,PT, SLP) that means an average visits frequency of 0.83 visits per discipline per week for stroke patients.

The CCAC Stroke Rehab Program was not designed to replace a stroke patient's need for outpatient programming, rather to provide goal directed therapy to those patients who could benefit from in home therapy, those who had goals amendable to in home therapy and/or to help bridge the gap between discharge from hospital and uptake into OP programming. As we can see below, the frequency of visits and LOS between the OP and CCAC Stroke Programming varies (see graph 9 and 10 below).

Graph 9



Graph 10



It was also noted that the overall number of visits provided by the in-home team varied greatly from the OP team. In the CCAC Stroke Program/M-Site OP data set patients received on average 15.41 visits from CCAC therapists and then received 60.28 therapy visits or sessions on average in OP programming. In the CCAC Stroke Program/CVH OP data set patients received on average 12 visits in total from CCAC therapists and then 39.76 visits or sessions with CVH program team members.

3 PROBLEM

Issues identified by the joint Rehab and Community/LTC Operational Committee with the current processes:

- Differences in admission and triage criteria used by outpatient programs throughout the region.
- A lack of consistency in services offered throughout the region in both OP and CCAC models and professionals available in each program (single vs. multiple service model, some outpatient departments have access to TR, SW and Nursing others do not, frequency and intensity of each program and service varies).
- Different wait times depending on program referred to and/or services required.
- Lack of communication strategies/tools for use between outpatient and CCAC service providers (especially problematic in the MH LHIN where stroke clients often transfer from in-home community rehab to outpatient rehab).

These issues are important because:

- Treatment can vary depending on where the client resides - this does not represent equitable access to care nor does it align with stroke best practices.
- Long wait lists for OP rehab can have a negative impact on client's recovery. Current wait lists to OP programming do not align with stroke best practices.
- CCAC Stroke Program is not always able to 'bridge the gap' between hospital exit and uptake into OP programming.
- The intake and triage processes currently being used do not align with stroke best practices.
- The gap in communication between outpatient and community staff may negatively impact how patients transition from one service to another (i.e. missing information, duplication of assessments, patient receiving multiple phone calls from different providers wanting to book appointments).
- Lack of communication creates increased administrative time for both the OP program and SPO (Service Provider Organization) staff .

4 TASKS UNDERTAKEN BY THE JOINT REHAB AND COMMUNITY OPERATIONAL COMMITTEE

- Capture the current state of admission processes, referral sources, program models (including services provided) wait times, length of stay and outcome measures used
- Compare current triage practices used with the Canadian Best Practice Recommendations and other provincial models
- Develop a standardized triage process to be used for stroke patients being referred to outpatient departments in the West GTA.
- Trial use of standardized triage criteria in the West GTA
- Present recommendations to West GTA Stroke Network Steering Committee to facilitate implementation
- Promote the use of goal focused communication when discussing timing and plans across the stroke care continuum
- Create resource documents to assist with future initiatives to improve community and or outpatient programs within the West GTA Region
- *Develop a communication strategy between outpatient and community based therapists to improve communication, trust and transition of the stroke client, starting with a contact sheet for the region.

*Task is ongoing

5 DELIVERABLES

5.1 TRIAGE GUIDELINES

A gap analysis was performed indicating wide variability in the current triage practices used by outpatient programs within the region (see Table 1 above)

Utilizing the Canadian Best Practice recommendations and the work of the Toronto Stroke Networks, the Rehab and Community/LTC Committee *initially* created the following triage criteria:

Criteria	Priority	Notes/Comments
Pt. coming from Acute/ER/SPC	1	ER, SPC, Acute, SLP assessment for swallowing (triage based on urgency); community referrals where patient was 'missed' but originated from one of the above settings.
Pt. coming from Inpatient Rehab	2	Accept by date of discharge from facility/setting NOT by date of referral if referral done while patient still on in-pt. rehab; community referrals if patient was 'missed' but originated from in-pt. rehab setting.
Pt. coming from SSR/Restore/Convalescent Care	3	Accept by date of discharge from facility/setting NOT by date of referral received
Pt. coming from Community	4	Consider reason for referral and patient situation. Secondary triage by date of referral.
* Pt. coming from different hospital	N/A	Prioritize as per above if patient lives in geographical area of OP site
Pt. coming from MH LHIN CCAC Community Stroke Rehab Program	1 or 2	Dual referral will continue to go to Community Rehab and OP programs. Triage based on date of discharge from referring source.

Please note that each organization may also have discipline specific 'sub-criteria' that clinicians use to further triage clients (See Appendix B). For example an occupational therapist with two referrals identified as priority 2 may use their clinical judgment to decide which patient will be picked up first. This clinical judgment would involve taking into consideration demographics, caregiver availability, safety concerns and urgency of goals (return to work, driving etc.)

Note that WOHS chose to use a colour coding system (Red, Yellow and Green) rather than a numbering system for their triage process. Their system still follows the guidelines listed above.

The CCAC Community Stroke Program was originally set up in order to ‘bridge the gap’ of time between discharge from the in-patient setting and uptake into OP programming. Research shows that front loading therapy is important for stroke patients as interruptions in rehabilitation can be associated with poor long term outcomes (Jorgensen et al. 1995). Although the CCAC Community Stroke Program was initially designed for ‘milder’ stroke patients the program eventually expanded. Now any patient returning to the home post-stroke is eligible for service as long as they have goals amenable to community rehab. Currently stroke patients can be referred to both community rehab and OP programming at the time of discharge (dual referral) (either from acute, in-patient rehab or Assess and Restore/SSR program). In our data snapshot our analysis showed that 67% referred from Trillium Health Partners Mississauga Site received both MH CCAC Stroke Program and M Site OP Programming and 38% referred from Credit Valley received both CCAC Stroke Program and CVH Seniors and Rehabilitation Day Hospital Program.

Some of the OP programs within the West GTA will contact the client upon receipt of the referral (to tell them they are on the waitlist), other programs will contact the patient when a spot becomes available (these practices vary from one site to another). At the same time the therapists working within the CCAC Community Rehab Program from the contracted Service Provider Organizations (SPO’s) (there are 5 in total) call the patient to book in their appointments. Capable clients are asked to notify the OP program when their community rehab is complete. If the patient is unable to call-in, the OP program will contact them periodically to determine the status of their community rehab.

Committee members felt that the referral process could be more discriminating. Discussion occurred around the concept of sending only a single referral at the point of hospital discharge to *either* the CCAC Stroke Program *or* the OP program. To determine which service to initially refer to (community vs. outpatient) the clinician would need to consider any special circumstances that the client may have. This decision process could be supported by a decision making algorithm or decision support tool. This tool would take into consideration factors such as: distance from OP program/transport issues, if supervision is required to travel, age of client, pre-morbid functional status, caregiver availability, type of patient goals and where these goals might best be met initially. Once the patient had then been picked up and assessed by one service, cross- referrals between Community Rehab and OP setting could then be possible based on client need. The CBPR 2015 states “Outpatient and/or community-based services should be delivered in the most suitable setting based on patient functional rehabilitation needs, participation-related goals, availability of family/social support, patient and family preferences which may include in the home or other community setting” (p 11).

The group felt that eliminating dual referrals could possibly make transitions more seamless and provide more goal directed, transparent and equitable access to community rehab and/or OP programming for stroke patients. When a dual referral is made from the in-patient setting it is difficult to predict functional status or continued patient rehabilitation goals 4-8 weeks down the line once community rehab programming is complete. Referring so far in advance may be creating inappropriate referrals to the outpatient setting. Furthermore our data snapshot showed that after receiving CCAC in home rehab services the stroke patients are still waiting an average of 44 days to enter OP programming for those who attended at THP M site OP Program (to update by first available provider – typically PT) and 9 days wait between end of CCAC Stroke Program visits and uptake into CVH Seniors and Rehabilitation Day Hospital Program (uptake into grouped programming). In terms of communication the group agreed that regardless of the patient’s starting point, messaging around LOS in program should be related to patient’s goals (reasonable and achievable) and NOT number of visits or time ‘allowed’. The group felt it is important to emphasize that rehab is a process, not a place.

At the time of this work, our MH CCAC partners did not feel that the above proposed model (removal of dual referral) would work with their current model or service provision. They noted the following barriers:

- It could take time away from the community therapist's direct therapy time as the therapists would now have to spend time filling out referral forms.
- Community therapists often do not know if and where a referral to outpatient rehabilitation has already been made. This could result in referral duplication.
- This could lead to poor flow between community and OP rehab as stroke patients would have to wait to get into OP programming after finishing their community rehab.
- Patient referred to OP *only* would then receive no community rehab and be losing valuable time (from a neurological and functional recovery perspective) with NO rehab provision while waiting to access that program due to long wait times.

According to the Copenhagen Stroke Study (Jorgenson et al., 1995) there is a 9-10.5 week window in which the best functional and neurological recovery for moderate stroke patients will occur. For mild stroke patients this window is shortened to 5 to 6.5 weeks. It is therefore, essential that patients receive timely goal oriented rehab.

Based on the above discussions and barriers identified the triage guidelines were designed to continue with dual referrals. The dual referral means that patients on the MH CCAC Stroke Community Rehab Program are moving up the waitlist as they are receiving in home therapy (bridging the gap). Please note that the issue of dual referrals does not exist in the Central West as there are no stroke specific community rehab programs in this region.

Please note that Credit Valley OP program accepts patients from referral sources 1, 2 and 3 as long as the patient originated from CVH (as an in-patient). They will accept from 4 (community) under special circumstances.

5.2 BARRIERS TO IMPLEMENTATION OF TRIAGE GUIDELINES BY ORGANIZATION

Once the triage guidelines were completed, representatives from each of the outpatient departments reflected on the possible barriers to their implementation. Table 3 outlines the identified barriers and possible solutions.

Table 3

Site	Barrier/Concern	Solution
William Osler (Brampton Civic OP Program)	1) Priority 4 patients may be missed in acute care/ER and go to family physician to obtain referral. 2) The current wait lists are long (2-3 months) and although this initiative may help, the real issue is lack of human resources. 3) Since WOHS program allows for single service models of therapy patients are triaged separately by each service based on both the patient's needs and the discipline specific triage guidelines (i.e. what constitutes need for earlier uptake for PT may not be the same for OT and/or SLP). 4) From an administrative perspective it is difficult to manage 3 different wait lists and apply these triage guidelines.	Problem solving is ongoing.
Trillium Health Partners - Credit Valley Site (Seniors and Rehabilitation Day Hospital Program)	1) The dual referral to both CCAC and Outpatient Rehab programs results in duplication of work (i.e. client is assessed by both programs). 2) Communication with CCAC is a big barrier.	1) Clear referral guidelines to help referring clinicians determine which setting is the most appropriate to refer patient to. (CCAC, outpatient rehab or both).

	<p>Numerous phone calls are made to find out the discharge date from CCAC Community Rehab services.</p> <p>3) Limited staffing. Under current staffing levels OT and PT and nursing treat patients on Tuesday, Wednesday and Thursday and speech and TR treat patients on Tuesday and Thursday.</p> <p>4) Delayed sending of referrals and the various avenues in which referrals are sent (i.e. fax, drop off); referrals being misplaced before getting to our triage nurse.</p> <p>5) Patient transportation is an issue (i.e. waiting for TransHelp to be set up can cause delays).</p> <p>6) Currently patients are not being seen within the recommended 48-72 hour time frame.</p>	<p>2) Patients having the name and number of their CCAC therapist or case manager written out for them. Triage nurse is now communicating directly with patient and asking patient to find out discharge date.</p> <p>3) Adequate staffing would allow the Day Hospital staff to visit the patient prior to discharge and ensure that client was referred to the appropriate service. Increase staffing of SLP and TR to Wednesdays would allow more dates available to book multidiscipline treatment times.</p> <p>4) Educating hospital staff as to when, how and where to send referrals.</p> <p>5) Collaborate with the CCAC to ensure that the TransHelp application is complete.</p> <p>6) Screening Appointment could be scheduled within 48-72 hours to meet the triage nurse before starting treatment with the rest of the team.</p>
Trillium Health Partners – Mississauga Site OP Neuro Program	<p>1) Lack of resource/time to do the triaging.</p> <p>2) Lack of time to educate referral sources (Restore, McCall, Inpatient, Runnymede, and CCAC and outpatient department).</p> <p>3) Lack of consistency with messaging related to the wait times for staff to share (actual wait time to service uptake is unknown).</p> <p>4) Patient often ready to come to therapy but no transportation has been arranged.</p>	<p>1) Administrative assistant to assist with triaging (PTA)-all of the referrals. Setting one day aside for this.</p> <p>2) Provide referring sources with short in-service education sessions. These sessions could be supported by the West GTA Stroke Network.</p> <p>3) Better education – tracking and reporting of wait lists on regular basis?</p> <p>4) Setting up of transportation by referral source.</p>
Halton Health Care – Step Up Program	<p>1) New Triage guidelines must be cleared and approved by upper management.</p> <p>2) Lack of resources/ time needed to educate referral sources, especially community referrals.</p> <p>3) Client transportation (set up) can delay services.</p> <p>4) Long wait lists for priority 1-3 patients, significantly delays treatment for priority 4 patients.</p>	<p>1) Streamlined process.</p> <p>2) Adequate staffing and consistent allotment of time. Set up meetings with referral sources with assistance of West GTA Stroke Network.</p> <p>3) Facilitating set up of transportation by referral source.</p> <p>4) Could the concept of client pull be used for non-urgent referrals?)</p>
Community Care Access Centre	<p>1) If MH CCAC community rehab therapists have to make referrals to outpatients therapy time will be lost to administrative duties (approximately one visit)</p> <p>2) GTA OP Rehab Referral Forms require a Doctor's signature when issued from the community.</p> <p>3) Concern that stroke patients in the community will wait longer or too long to get into OP if they are referred AFTER community rehab is done and this will adversely impede their progress.</p> <p>4) Community therapist are often unaware a referral to OP setting has been made or they may not know which program the patient has been referred to,</p>	<p>1 & 2) Change proposed triage guidelines so that dual referral will continue to both Community Rehab Program and OP programming.</p> <p>3) Continue using the Community Rehab program as a 'stop gap' or 'bridge' between hospital discharge and uptake into OP program so as to limit wait times or time spent without rehab for patients.</p> <p>4) Send OP brochure or d/c info sheet home with patient indicating that they have been referred to OP's and to which program they have been referred (contact information) -</p>

	<p>hence they don't know who to call when they are finishing up with community therapy to alert them patient is ready for the next setting.</p> <p>*Note For CW CCAC there is no community rehab program for stroke patients currently</p>	<p>could make this part of the patients discharge package?</p> <p>Discuss with SPO's the potential for community rehab therapists to give the OP team a 'heads up' when they know the patient is coming to the end of their community rehab visits.</p> <p>During the order entry in the hospital setting (I.e. in Meditech) note the fact that OP referral has been made and to which setting (I.e. CCCAC Stroke Program (pt. also referred to OP M site) so this info can go to the SPO and hopefully get to the clinicians.</p>
Site	Barrier/Concern	Solution
Service Provider Organizations Clinical Staff	<p>1)Therapists commented they often feel unaware of the process for getting the patient from the community setting into the OP setting and that because of this they would not feel confident doing this referral without some education.</p> <p>2)Lack of connection or ability to communicate with referring team and the team referred to (in-patient hospital team and OP team).</p> <p>3) Difficulty getting information from the in-hospital partners in a timely manner (often they do not have the discharge summary, assessment results and goals until after the first visit (therapists must go into first visit "blind").</p> <p>4) Decreased knowledge of community resources for stroke patients (for some therapists, not all). Some patients may be more appropriate for community re-integration programming rather than OP after their in-home rehab.</p>	<p>1) Education being provided by Stroke Navigators to community therapists on this process for those stroke patients that qualify for their service. Further education could be provided via a joint education session with OP teams and CCAC therapy providers set up with assistance from West GTA.</p> <p>2) Continue to work on communication strategies such as one page 'contact list' which provides contact information for main SPO and OP contacts.</p> <p>3)?</p> <p>4) Encourage community rehab therapists and/or their practice leaders/supervisors/managers servicing stroke patients to attend our Community Stroke Partners Day in Sept which provide information on all our community partners.</p>

Above we can see that the overall LOS of 108.8 days or 15 weeks surpasses best practice recommendations but that the intensity of service provision could be improved.

5.3 ADMISSION CRITERIA FOR OP AND COMMUNITY PROGRAMMING

A current state was conducted to determine the admission criteria currently be used by each program. In addition to Table 1, the table below (Table 4) indicates whether or not certain information was considered when determining if a patient would be admitted or not admitted into a program.

Table 4

Item considered in	HHS	WOHS	THP M Site	THP- CVH	MH CCAC
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regards to admission related to Best Practice Recommendations					
Initial Stroke Severity	No- but present level of function is considered (i.e. must be able to transfer with the assistance of 1-2 persons as there is no mechanical lift available	No – but present level of function is considered (i.e. must be able to transfer with the assistance of 1 person as there is no or OTA/PTA to assist with transfer.	No but we should developed a rehab readiness tool to determine things like potential or carry over at home. Present level of function is important as well as how much therapy they have had so far (should be considered but this is not current practice)	No: the initial severity does not always dictate outcome. Does not provide picture of person's rehab potential. Each person may have varying degrees of physical, cognitive, language and social impairment that can be targeted separately by each member of our IP team	No- patients admitted when referred by hospital if they meet CCAC eligibility requirements
Functional Deficits/Burden of Care as per AFIM or FIM	We are not provided with this information at present	No – we do not receive this info	No –	No- this information is not the primary consideration when deciding on admission as we consider other factors (acuity of stroke, achievable goals, inter-disciplinary need)	No – however patient must be a candidate to be safely cared for in the home with the resources available
Location and Type of Stroke.	No	No	No	No	No
Types of Therapy Required	Yes – because we have less staffing for SLP service. Also patient must require at least 2 service to be admitted into program	No	No	Yes – patient must require a minimum of 2 disciplines to be admitted into program	No

Cognitive Status	Yes – lack of ability to demonstrate carry over of treatment goals to home setting would be reason to deny access	Yes – must be able to follow instructions and participate in therapy or have a significant other willing to assist with home programming when there are memory issues	Yes – patient needs to be able to learn, follow directions, follow strategies at home and transfer skills learned into the home setting. Cannot be agitated, uncooperative, not under influence of drug/alcohol, no wandering behaviors or inappropriate behaviors	Yes- patient needs to be able to actively participate in program. Severe cognitive impairments where the patient is best served learning to function in the home environment may not be accepted	No- although care plan goals will reflect patient's ability to participate in rehab (i.e. may focus more on home safety/community reintegration as well as Care Coordination role in connection resources)
Time Since Stroke	Yes – we accept stroke patients within 12 months post stroke	Yes – within 12 months post stroke	Yes – within 9 months post stroke.	Yes – priority given to referral from CVH emergency and acute care floors. Accept patients who were in-patient in our OWN hospital only- in order to facilitate hospital discharge and transition of care.	Yes – for those greater than one year post stroke, an alternate CCAC program should be considered
Caregiver Availability	Not required unless needed for transport	Not required unless patient needs for transport or for carry over of home program	Only required if accessibility is an issue (for transport or mobility) or if patient requires assistance for toileting	Caregiver is needed if patient requires assistance to get to the OP program	No – not with respect to admission to stroke program
Transportation Availability	Requires transport to and from setting	Requires transport to and from setting	Requires transport to and from setting	Requires transport to and from setting	No

CCAC CW program was not included in this table as they do not specifically provide post stroke community rehab.

After reviewing the current admission criteria currently being used within the region the committee developed a list of “Recommended General Admission Criteria for OP Programs and Community Rehab Programs”. These recommendations were also based on information obtained from The Canadian Best Practice Recommendations (2015).

Recommended General Admission Criteria for OP and Community Rehab Programs in West GTA Region (for Stroke patients)

1. Acute or recent stroke (less than one year) OR for those more than one year post stroke the requirement of an interprofessional team is needed.
2. Medically stable, co-morbidities addressed (able to participate, vitals stable, follow up medical investigations complete or have been arranged)
3. Min. level of patient function is present. (Patient has the stamina to participate in the program; able to follow one-step command with communication support if required; patient has sufficient attention, short term memory and insight to progress through rehabilitation)
4. Demonstrated post stroke progress including potential to return to baseline function or increased post stroke functional level with rehabilitation
5. SMART goals established
6. Consent obtained (through patient or substitute)
7. No behavioral issues limiting ability to participate at a minimum level
8. Patient does not have severe cognitive impairment
9. Patient is not already receiving treatment elsewhere and needs being met
10. Patient does not have a terminal illness with short survival expected
11. Patient is willing to participate
12. Stroke etiology is clear and prevention intervention has started (* would be ideal, OP teams do not currently receive this information).

5.4 MANAGING THE TRIAGE OF STROKE PATIENT INTO OUTPATIENT SERVICES

A concern identified by all the OP partners was the possibility of lower priority patients getting “missed”. To address this concern the group brainstormed possible guidelines that could be used to ensure that those who were triaged as lower priority do eventually get picked up into service. These ideas included:

- Use of the concept of client pull into service: For example, lower priority patient receives a letter they have been referred to OP and it is their responsibility to call and book their appointment. They are provided with a telephone number they can call and a time frame for booking appointments. During this time frame, available appointments or openings within the next two weeks can be filled with those that call the ‘hotline’.
- Use of a max. time limit – i.e. Once a patient has reached a maximum wait time of, for example, 12 weeks, they would then be re- assigned a Triage level of 1 to be picked up into the OP programming quicker

Currently all sites are using a maximum time limit for triage of lower priority clients onto service.

All sites agreed that having a designated person (preferably of administrative background) to assist with scheduling, receiving phone calls, making phone calls and triaging. Having a designated person perform these tasks would allow therapist to devote more of their time to treating clients. Two of the four sites have an OP team member (the OTA/PTA at M site and the RN at CVH site) who sets aside a small portion of time each week for screening of referrals, triaging and

booking. One site (HHS Step Up) is planning on having administrative staff take on this role (previously handled by the OTA/PTA). WOHS does not currently have access to admin for these tasks and each therapist is responsible for handling their own admin whenever they have an extra few minutes (between patient booking or if a patient cancels last minute and spot cannot be filled). Furthermore, electronic scheduling was discussed as something to be further explored by sites currently scheduling on paper.

5.5 IMPROVING COMMUNICATION BETWEEN COMMUNITY REHAB AND OP SETTINGS

In the Central West there is limited community rehab provided, thus little need for communication between the community and OP rehab teams. The CW is only able to provide care within funding. Currently this funding allows for a limited number of PSW and rehab visits for stroke patients. When a client does receive in home PT or OT there is little to no communication between those providers and the OP team. OP clinicians report that occasionally a community therapist will call the OP centre to advocate for their client to be picked up into OP programming as quickly as possible.

For the MH area several ideas were brainstormed to improve the lines of communication between hospital, community rehab and OP teams including:

- A short sheet – communication sheet that outlines briefly what was done in the community, goals that were met and goals that are still ongoing. This could be sent with the patient when they attend subsequent OP programming.
- A patient binder with their goals (met to date, still requiring attention). This binder would go with the patient from IP to community home rehab to OP programming
- A therapist contact information sheet with both SPO organization and OP contact information (*created and currently in draft form see Appendix E).
- Use of Connect One portal for accessing information
- Community therapists could call into OP's when the patient is ready to attend (*when they are aware a referral to the OP setting has been made and to where)
- Ensuring the appropriate OP brochure for each site is given to patients pre-discharge and they are aware they have been referred to this service and where to contact this service if needed. Include in the patient discharge package.
- Process mapping – pursue a joint process mapping exercise with in-hospital and community partners to see where the barriers are in getting the stroke patient's information from one setting to another
- Expand the stroke navigator role so that they can assist with transfer of information and the patient from one setting to another and expand their role so this service is available at sites other than THP-M site only

To date at THP M-site efforts have started to educate in-patient team members to hand out the OP brochure to patients when a referral has been made to that program. This is to be accompanied with education for the patient and family/caregivers regarding the difference between community rehab and OP programming, and the numbers where they can call to get in contact with either team. An OP team member has been invited to attend the THP Stroke Quality Council's "Patient Education" meetings in order to incorporate needed viewpoints into the development of this package or binder to be used on the stroke unit that could go with the patient along their trajectory. The OP clinicians would like to ensure the patient discharge checklist indicates a referral was made to the OP team and for what reasons/goals.

To date at THP CVH-site efforts are underway to educate in-patient team members about the Seniors and Rehabilitation Day Hospital Program to help facilitate appropriate referrals to the program. To assist with this a new referral form has

been made with a clear outline of admission criteria. As well, an information sheet of the program is being printed which will be distributed to hospital staff (including doctors, nurses, discharge planners etc.) to further educate staff about the program and to help generate appropriate referrals to the program. In addition, a patient brochure is currently being made which will be handed out to patients referred to the program to further clarify and help ease transition of care.

Overall all agreed a more fluid transfer between sites (OP and Community) with improved lines of communication would improve the continuity of care for stroke patients and has the potential to improve patient outcomes, especially if patients could move between the home and OP setting based in response to their needs and goals. The CBPR (2015) notes that new findings have strengthened the evidence for continued care through outpatient services. MH CCAC is open to the idea of a referral going from the OP setting back to the community setting if the OP team felt there were continued goals related to community reintegration.

Ultimately all these ideas to improve the communication between settings is a Band-Aid to a larger system problem which sees the stroke patient moving from 'silo' to 'silo'. Verbal reports from stroke survivors to the Stroke Navigators and to therapists working in the MH CCAC Community Stroke Rehab Program indicate they are often confused and overwhelmed once they get home. They receive multiple phone calls from different service providers post discharge in order to set up their community rehab and OP rehab appointments and they often do not understand why 'these people don't talk to each other'. Patients prefer to complete their community visits before attending outpatient programming, which indicates a level of satisfaction with their in home rehab programming. When they reach OP programming patients report they are often repeating information that they already provided to the community therapists because their health information is not travelling along with them. As a future state the West GTA Stroke Network envisions one team providing community rehabilitation to stroke patients - whether this is provided in the home setting or in a congregate (i.e. outpatient) setting (which could be located within the hospital or in the community). (See Appendix F for Recommended Elements of a Community Stroke Rehab Team).

5.6 CREATION OF RESOURCE DOCUMENTS FOR FUTURE PLANNING

Below is a table which outlines the preferred or required elements of a community rehab and/or OP model that would meet the stroke best practice guidelines and better serve the stroke populations in the West GTA area. This table is based on work done by Laura Allen for the Ontario Stroke Network (OSN) as part of her best practice review of current Community Rehab Models serving stroke patients in Ontario. This report provides organizations throughout the province with a guide which can be used if they are looking to improve their current program or establish new program. This report can be used to ensure that programs are aligning with best practice. This report can be found on the OSN website at: <http://ontariostrokenetwork.ca/stroke-qbp-resource-centre/wp-content/uploads/sites/2/2014/01/Community-Stroke-Rehabilitation-Models-in-Ontario-Final-June-2016.pdf?7ce83e>.

Table 5

Best Practice Recommendation	Details on this Recommendation	Number	Proposed model? (Y?N)
Integration of any community stroke rehab model into the stroke care pathway	Standardized process and follow up with community designate within 48-72 hours of discharge home. Goal oriented discharge plan.	6.4	

Dedicated care coordinator	Coordinated care plan ensures continuum between community providers, primary care providers, and where applicable hospital providers; care coordinator to determine eligibility for services; responsible for ongoing assessment and reassessment of needs, promotes ongoing communication between team members. Utilize a “case management” approach where the most responsible clinician is the care coordinator.	9.4.4, 9.4.5, 9.4.7	
Time to first visit 48-72 hours following hospital discharge	Provide within 48 hours of acute discharge or 72 hours of in patient rehab discharge	9.2.2	
Therapy intensity based on best practice standards	2-5 OP or Community Rehab allied health professional visits/week (per required discipline) for min. 45 minutes each for <i>at least</i> 8 weeks (or more based on patient need and goals -may include use of rehab assistants). (Note this intensity is for Community Rehab or OP only, not applicable to ESD- Early Supportive Discharge).	9.5.1,9.6.2,9.7.2	
Dedicated care team with core disciplines	Available based on needs of client, OT, PT, SLP as well as nurse, psychologist, primary care provider, social worker, registered dietitian, pharmacist, therapeutic recreation, therapy assistants and family/caregivers , 80% consistency of stroke team members	9.4.1	
Regular interdisciplinary team meetings	Planned, regular therapy team meetings; discussion and updating of client goals, progress and discharge planning	9.4.2	
Qualifications of Stroke Team Members – stroke expertise	As a program there are procedures and supports in place to develop stroke expertise, 80% of clients seen by consistent clinician are receiving rehabilitation for stroke. OSN Provincial Core Competency Framework group is currently looking at the minimum standards that are required to work in stroke.	9.4.3,10.4.1	
Standardized Reporting	Consistent with program specific outcomes measure collected; physical activities, ADL or mobility limitations should be assessed for targeted rehabilitation; standardized clinical outcomes measure should be used;	10.1.4	
Availability of Early Supportive Discharge (ESD) . **NOTE: ESD is not the same or synonymous with community rehab.	Interprofessional team (PT, SLP, OT, Nurse, physician, SW and admin assistant); continuity of team members from in-patient, provided within 48 hours of acute discharge and 72 hours of rehab discharge, intensity=5 days per week at inpatient rehab intensity	7.2,7.3,7.3.1,7.3.2	

Recommended elements for a future stroke community rehab program based on research:

- Hospital or congregate setting based team that has the flexibility to see patient in their homes as well. (Hybrid model) (Herbert et al. 2016).
- Patient goal oriented therapy with flexibility (in location and intensity) to meet patient goals in appropriate environment (home or congregate setting) (Fisher et al., 2013, Geddes & Chamberlain, 2001, Greene, 2002, Von Koch et al., 2015).
- Appropriate Intensity of Services (Best Practice indicates min. 45 minutes per day per discipline, 2-5 days per week for at least 8 weeks) (CBPR, 2015))
- Time to first visit (home or congregate setting) = 48-72 hours (CBPR, 2015))
- Reduced transition points for patients

- Ensure flow of communication between in-patient and community settings, open communication with referral sources (Geddes & Chamberlain, 2001, Fisher et al., 2014, Taule et al., 2015).
- Excellent links between hospital, community teams and community re-integration resources
- Stroke expertise of team members required. Rehab services provided as a minimum PT, OT, SLP with OTA/PTA/CDA provision. Access to other IP team members recommended as needed (i.e. SW, RN, Pharmacy, Dietician) (Berger et al., 2014; Fisher et al., 2013, Geddes et al. 2001,, Webster, 2001, CBPR, 2015)).
- Embedded health promotion, secondary prevention (i.e links to Stroke Prevention clinic) and self-management principles and education (Fisher et al., 2013, Taule et al., 2011, CBPR, 2015)
- Weekly rounding/team meetings (Allen et al., 2014, Anderson et al., 2000, Berger et al, 2000, Geddes et al., 2001a, Greene et al., 2002, Langhorne et al., 2014, Lincoln et al., 2004, Markle-Reid et al., 2011, CBPR, 2015))
- Team members take turns being the 'care coordinator' (case management model) (*Coordinator must be someone involved in patients actual care/rehab provision) (Greene, 2002, CBPR, 2015))
- Team gets to know patients and is also involved in advocating for or developing needed community resources in their region

The Community Stroke Rehabilitation Models in Ontario report (2016) also identified these important lessons learned after reviewing current community rehab models serving stroke patients across Ontario:

- Importance of patient centered focus
- Importance of stroke expertise and consistency in care providers
- Importance of timely and consistent communication
- Importance of access to documentation from the hospital (i.e. shared record)
- Tailoring the model to meet regional need
- Community partnerships are essential
- Importance of ongoing program monitoring and evaluation

The following system level considerations or questions can be used to guide those looking at creating or adapting current community rehab or out-patient program models:

- What are the referral volumes (enough for a dedicated team?) and admin. support?
- Where are the patients? Location of patients (rural vs. urban, hot spots?)
- How easy is the communication and transitions between settings?
- Is there potential to pool resources?
- What is the cost vs. gain? (ensure model aligns with best practice which is backed by research meaning optimal gains expected for patients). Will more be gains be made over time? (i.e. will efficiencies be found by having a higher functioning team over time)
- Does this system or program fit the patient, or are we trying to make the patient fit the system?

5.7 THE SKY'S THE LIMIT BRAINSTORMING EXERCISE

The committee participated in a 'blue sky' brainstorming exercise. In this exercise committee members were asked to describe what the ideal outpatient or community rehab program (for stroke patients) would look like if there were no limits/barriers. Below are the ideas they came up with:

- Faster access to service
- Both single and multi-service provision with a good scheduling system, possibly electronic
- Transportation would be provided to patients to and from the setting
- No 'time limit' to LOS – i.e. LOS in the program would be entirely based on patient's needs and goals
- Ability to accept referrals from both public and private pay patients

- Keeping the same therapy team from inpatient rehab to OP rehab setting
- More staffing resources to meet volume demands
- Weekend and evening programming would be provided (including recreation therapy programming)
- Access to psychology and neuropsychology support
- Health education component would be built into programming
- Better access to “back to work” and “back to driving” resources
- Rehab intensity could be flexible to meet patient’s needs (flexible length of time for appointments)
- Interdisciplinary care plan that follows the patient across transitions (in-patient to out-patient and/or community rehabilitation)
- Additional funds for purchasing materials such as treatment tools, equipment, assessments and memory books
- Better medical support (for example a doctor associate with the OP clinic or program)
- Better connections with support groups and community re-integration programming

5.8 RECOMMENDATIONS

Many of the group’s recommendations are embedded throughout the document. Below is a synopsis of these recommendations:

1. Adoption of agreed upon triage criteria and admission criteria. Further education to be provided to referring sources regarding admission criteria and purpose of the programming to ensure appropriate referrals.
2. Implementation of the one page contact sheet by OP and community rehab partners. This sheet has been created and is going through final review
3. Transportation to OP settings to be arranged in advance by the referring source whenever possible to avoid delays in patients being able to access OP programming. Further education on this to be provided to referring partners.
4. Continuation of the groups work to examine the following:
 - a. Changing current system of dual referral to CCAC Stroke Rehab and OP programing in the MH LHIN by examining how other programs throughout Ontario are handling flow to and between their OP centres and in home community rehab programming. This research may benefit the CW LHIN as well should they move forward at some point with Community Stroke Rehab programming. Application to the Ideas Advanced Learning Program has been done to move this work forward. Care will need to be taken in developing appropriate decision tools as we can see from the data and graphs above these two programs provide very different frequency and intensity of service.
 - b. Examine opportunities for improve scheduling in OP centres by exploring other scheduling systems (electronic or other) being used in Ontario. Collecting information on what other OP centres throughout the province are using.
5. Each organization should closely examine the model of care they are using in their outpatient settings. There do seem to be some gains in terms of ease of scheduling, holding regular interproffesional team meetings and family care conferences in a multi service or ‘day hospital’ like model. As well, it may be much more convenient for patients to receive all their services on certain days and over a shorter time frame, as opposed to having services stretched out over time as they move from one service provider to the other (i.e. first PT, then OT, then SLP). That being said, programs offering ‘grouped’ programming only should also have the flexibility to accept patients requiring only a single service when needed, as these teams have the stroke expertise required to work with the clientele which other services may not be able to provide (i.e. PT OHIP clinics). It would be pertinent to gain a patients perspective on the most patient centered way to deliver these services while maintaining fiscal responsibility.

5.9 APPENDICES

Appendix A – Project Charter

Appendix B - Discipline specific triage criteria if available/used

Appendix C- Roles of Clinician's in OP Therapy Programs across the West GTA Region

Appendix D – FAQ sheet for data collection (need to insert!)

Appendix E – Recommended elements of a Community Stroke Rehab Team based On Research Draft

Appendix F – One page contact sheet with referral criteria

<p>Title:</p> <p>Improve and standardize access of appropriate stroke patients to outpatient rehabilitation programming.</p>	<p>Scope/Boundaries:</p> <p>Acute, rehab and community referrals to outpatient department.</p>
<p>Team:</p> <p>-Executive Sponsor (someone on senior management who will be accountable at a senior level, will remove barriers, ensure adequate resources are provided, etc.) This will likely be each manager's director.</p> <p>-Team Lead : Janine Theben and Maggie Traetto</p> <p>-Process Owners: Martha Budgell, Jo-Anne Chen, Cathy Renoud, Nadia Wolyshyn</p> <p>-Improvement Advisor: Nicole Pageau</p> <p>Team Members: West GTA Rehab & C&LTC Operational Committee Members which include both management and front line staff from outpatient departments, CCAC and the LHINs.</p>	<p>Problem Statement:</p> <p>WHAT is the issue?</p> <ul style="list-style-type: none"> • Differences in intake criteria to outpatient departments throughout the region and a lack of consistent triage criteria throughout the region • Lack of communication strategies between outpatient and CCAC staff • A lack of consistency in services offered in each region (single vs. multiple service model, some outpatient departments have access to TR, SW and nursing) • Different wait lists for outpatient services depending on area. <p>WHY this is important: Depending on where the client resides impacts the treatment that the client received. Long wait lists for OP rehab can have a negative impact on client's recovery. The currently utilized intake and triage process may not be in line with best practices. The silos that exist between outpatient and community staff may negatively impact how a client transitions through services (i.e. missing information, duplication of assessment...).</p>
<p>Aim Statement:</p> <p>By July, 2016 organizations with the West GTA region will:</p> <ul style="list-style-type: none"> • Standardize intake criteria and triage process for stroke clients accessing outpatient departments throughout the region and align them with best practices • Compile a communication strategy to improve the relationship and communication between outpatient and community staff working with stroke survivors. 	<p>Measures:</p> <p>-Outcome Measures: Wait time for outpatient department</p> <p>-Process Measures: Number of OP sites adopting new triage criteria,</p> <p>-Balancing Measures: CCAC referral volumes</p>
<p>Root Causes of the Problem:</p> <ul style="list-style-type: none"> • Lack of consistency between outpatient departments in intake and triage guidelines • Inconsistency in service levels between outpatient departments • CCAC and outpatient therapists work in two different departments/locations with different managers with a lack of communication strategy resulting in a siloes. • <p>References:</p> <p>Toronto Stroke Networks Outpatient Process. Canadian Best Practice Guidelines and EBRSR.</p>	<p>Change Ideas:</p> <ul style="list-style-type: none"> • Comparing the current triage of stroke clients in the outpatient department with best practices and other models utilized in the province • Develop standardized intake criteria to outpatient departments in West GTASN. • Use standardized triage criteria and utilize case management approach (designated health care professional will). • Present recommendations to West GTASN steering committee to facilitate implementation • Develop a communication strategy between outpatient and CCAC staff to improve communication, trust and transition of the stroke client. •

	<p>References:</p> <p>OSN, Impact of Moving to Stroke Rehabilitation Best Practice in Ontario Final Report, 2012)</p> <p>Canadian Best Practice Recommendations for Stroke Care http://www.strokebestpractices.ca/index.php/overview/> Overview and Methods</p>
<p>Anticipated Barriers and mitigation Strategies:</p> <p>BARRIERS</p> <ul style="list-style-type: none"> • Resource barriers to hire additional staff • Staff resistance to change • System design impeding communication between outpatient and CCAC staff <p>MITIGATION</p> <p>Ask managers for dedicated time for outpatient and CCAC staff for education and their involvement in process</p>	<p>Anticipated Timeline</p> <p>Start: Current state and ideal state research/discussion and information gathering June to Sept 2015 Development of new triage guidelines and other documents to assist in standardizing and streamlining process to be built into report: October to Dec 2015 Report with recommendations for changes for Steering Committee: March 2016 Adoption of report recommendations? End: Dec 2016</p> <p>Key Milestones</p> <p>Report to steering committee presented by March 31, 16. Implementation of recommendations by September 2016</p>
<p>Resources Required:</p> <p>Budget: Managers of each organization may need to backfill staff occasionally for project work Dedicated Staff Time : Committee members, one to two hours meeting time bi-monthly</p>	<p>Signatures:</p> <p>Signals that these individuals have read the Charter and are aware of the project focus, and at minimum, commit to and agree with the design, set up, and resource requirements at the early stages.</p> <p>Executive Sponsor: _____</p> <p>Process Owner: _____</p>

Appendix B: Discipline Specific Triage Criteria

BRAMPTON CIVIC HOSPITAL

Outpatient Occupational Therapy

Triage of Neurology Clients (Trial)

The following are considered when delegating a client into a triage colour.

RED: High urgency

Little or no contact with OT after neurological diagnosis

- seen in ER or stroke prevention clinic and sent home
- seen in acute care, assessment by OT may have been initiated
- have NOT had inpatient rehab

Functional status

- previously working, driving, supervising/providing care for others
- lives alone and/or minimal supports in place

Premorbid status, including age, indicates increased potential for recovery

Referral is indicative of single assessment required and/or minimal treatment (example driving assessment)

YELLOW: Moderate urgency

Have had OT assessment and recommendations made

Short inpatient rehab stay

Specific achievable functional goals; good prognosis (recognizable gains made in rehab)

Premorbid status, including age, indicates increased potential for recovery

GREEN: Lower urgency

Have had comprehensive inpatient rehab stay, usually on slow stream, may have transferred to active rehab during their stay or longer active rehab stay due to complex recovery

Functional status significantly compromised

Must have specific achievable functional goals however these may need to be accomplished with compensatory strategies

Generally have CCAC involved on discharge

HOMEWORK: FUNCTIONS OF TEAM MEMBERS (SLP, OT, PT, Social Work, Therapeutic Recreation) IN THE OUTPATIENT DEPARTMENT

SLP

Assessment and treatment for:

- ☑Speech difficulties, i.e. dysarthria and apraxia of speech
- ☑Language difficulties, i.e. aphasia (comprehension, recalling words, expressing an idea; reading or writing)
- ☑Cognitive communication (memory, verbal reasoning, problem solving, pragmatics (i.e., being socially appropriate in interactions), verbal organization)
- ☑Swallowing difficulties

Additional tasks:

- ☑Patient and family education, counselling, and support
- ☑Partner training in supported conversation
- ☑Preparing pt for return to work/return to school
- ☑Preparing simple AAC aids (communication book, customize iPad AAC software, life history book)
- ☑Initiating referrals for other SLP services (AAC clinic, videofluoroscopic swallow study)
- ☑Link to community resources/services (e.g., PHDABIS, community aphasia group, Seniors Life Enhancement Centre, and many others)

OT

Services provided:

- ☑Cognitive/Perceptual assessment and remediation
- ☑Assessment and retraining of ADLs (i.e. dressing, grooming, feeding, transfers etc)
- ☑Assessment and retraining of IADLs (i.e. housekeeping, driving, meal preparation, employment).
- ☑Physical remediation (upper extremity remediation, sensory re-education, fine motor, Modified constraint induced movement therapy, Mirror therapy etc).
- ☑Link to community resources (i.e. PHABIS, Outreach programs, Prevocational programs, driver rehabilitation programs, Next Step program, Mississauga stroke breakers, seniors life enhancement etc.)
- ☑Explore assistive devices and funding resources (if required. Most often, client's already have their wheelchair etc. which allows us to focus on other goals).
- ☑Family education and support reports for LTD , CPP disability (for clients on caseload only).

PLEASE NOTE: we are not a certified driver rehabilitation centre. We provide a cognitive/perceptual screen for skills required for driving. This screen is used to assess readiness for further assessment by a certified driver assessment centre. We also provide treatment for areas identified as impacting on returning to this goal.

Also, we are not a prevocational program. We assess readiness for further assessment from a vocational program, neuropsychologist. We also provide treatment for impairments noted to implicate return to this goal.

PT

- ☑Assessment and treatment for all neurological conditions
- ☑Assessment and treatment for all post op spinal conditions with neurological sequale
- ☑Assessment and remediation of functional impairments
- ☑Assessment and treatment for pain and joint restrictions.
- ☑Assessment and remediation for balance, gait, strength and deconditioning.
- ☑Assessment and remediation for community balance and gait impairments (including those due to cognitive, visual/spatial issues)
- ☑Assessment and recommendations for AFOs
- ☑Assessment, recommendation for mobility aids, including ADP application.
- ☑Assessment and treatment of facial weakness due to Bell's Palsy or resection of an Acoustic Neuroma.
- ☑Assessment and work hardening (may need a better word) for return to school or work.
- ☑Recommendations for return to school or work schedule. Liaise with school/employer.
- ☑Family education and support.
- ☑Link to community resources (supports or programs)

☑ Reports for LTD, CPP disability.

Social Work

- ☑ Assessment and treatment for all neurological conditions
- ☑ Individual; family and marital counselling
- ☑ Evaluation of financial needs
- ☑ Link to financial resources
- ☑ Assistance with completion of financial applications (i.e., LTD, Ontario Works, CPP Disability)
- ☑ Link to community resources (e.g., Family Service Association, Parks and Rec, Legal Aid)
- ☑ Educate on stress reduction (e.g., deep breathing)

Nursing:

- ☑ Screens and triages referrals and organizes referrals for team assessment and scheduling
 - ☑ Describes program, identifies goals, confirms transportation arrangements to and from appointments, and confirms agreement to attend.
 - ☑ Visits patients on the units prior to discharge when able.
- Responsible and accountable for decisions and actions in the provision and management of nursing care for patients
- ☑ Provides nursing assessment ensures follow up appointments/diagnostics testing from discharge summaries have been ordered/completed and are being followed up by appropriate discipline. . Contributes to care plan development, and provides goal oriented treatment interventions
 - ☑ Provides patient and family education and supports to address medical, cognitive, emotional and self-care needs
 - ☑ i.e., understanding diagnosis, prognosis and treatment/medication use and safety/coping strategies/Life style changes/safe daily routines, referrals)
 - ☑ Develops patient educational resources and assists team with the development and maintenance of resource centre
 - ☑ Liaises with external care providers to ensure health care needs are met and safety is maintained
 - ☑ Performs as a coach/mentor/consultant employing sound critical thinking skills which are key to achieving patient outcomes and facilitating team function
 - ☑ Participate in program planning, continuous quality improvement and evaluation
 - ☑ Measure and monitor vital signs, weight and blood sugars.

Outcome measures for Nursing:

- Pain
- Mood
- Respiratory, cardiac, GI, musculoskeletal, follow up appointments/diagnostics

Therapeutic Recreation Role/Responsibilities at THP-CVH Senior's and Rehab Day Hospital

Primary Function:

Therapeutic Recreationist provides coordinated interdisciplinary outpatient care within the health care continuum, assisting patients in the transitioning from the hospital to the community. The Therapeutic Recreationist will assess patients referred by their physician to the Seniors and Rehabilitation Day Hospital Program. Where appropriate, the Therapeutic Recreationist will set therapeutic goals with the patient and family, including discharge to a community program/service. The Therapeutic Recreationist provides assessment of physical, cognitive, social and emotional dysfunction, along with leisure interests, as well as treatment to promote better performance in functional activities, maximize potential and optimize function for maximal independence. Also included are the planning and implementation of treatment and/or education programs to improve function and independence, and transitioning patient safely from hospital to their home and/or with the connection to community programs and/or services.

List of Specific Duties and Responsibilities

Patient Care:

- ☑ Participate, as part of the interprofessional team, in goal setting, evaluation and discharge planning of the Seniors and Rehabilitation Day Hospital patients.
- ☑ Use appropriate assessment skills to help establish a plan of action by prioritizing and setting goals of treatment in conjunction with patient.
- ☑ Provide education, and make recommendations to appropriate community programs/services in conjunction with patient to set an effective discharge plan.
- ☑ Obtain and document informed consent for assessment and treatment by Therapeutic Recreationist.
- ☑ Communicate patient assessment findings, treatment program, and progress with other health care professionals involved in the patient's care and share responsibility for development and implementation of interprofessional care where indicated.
- ☑ Participate in weekly interprofessional progress rounds, and monthly professional practice meetings.
- ☑ Act as case manager for assigned patients; having responsibility for setting schedule, contacting and acting as contact for patient and patient's family. As case manager, also, making sure that appointments are booked in the computer.
- ☑ Participate in the co-ordination of patient treatment and communicate with other community health care professionals within the "circle of care".
- ☑ Attend relevant Seniors and Rehabilitation Day Hospital meetings/conferences.
- ☑ Assist and participate on an ongoing basis in the development and achievement of the Seniors and Rehabilitation Day Hospital goals and objectives.
- ☑ Assist and participate in developing, implementing and practicing quality improvement within the Seniors and Rehabilitation Day Hospital.
- ☑ Liaises with external care providers to ensure care needs are met and safety is maintained.
- ☑ Maintain and research community partnerships with community programs/services for effective discharge planning.

Non-Patient Care:

- ☑ Document relevant assessment data, keep current and timely progress and discharge notes for all referred patients while following the professional standards.
- ☑ Document required workload measurements data in a timely and accurate manner.
- ☑ Assist in the education, supervision and orientation of Therapeutic Recreation interns/students/volunteers in the hospital.
- ☑ Maintain a focus on continuing professional development by attending and presenting in-house sessions and attending continuing education courses out of hospital and taking part in ongoing reflective practice.

Outcome Measures for TR:

Activity scores i.e. the Wii fit scores. The idea is as a patient's functional skills improve their leisure participation skills will improve and therefore scores improve. This is a gross generalization but the organization does not use regulated tools. For regulated tools there is the leisure diagnostic battery and leisure competence measure that would be most appropriate but they take hours to administer.

How do we track patients requiring 2 person assist/two therapists co-treating: Each discipline should track their own time. So if OT and PT co treat for 30 minutes, the OT inputs 30 minutes direct time, the PT inputs 30 minutes direct time,

How do we track group treatment: The therapist providing the group treatment will input the total time spent delivering the group. I recommend the total group time is split amongst the group participants. For example: A 60 minute group with 6 patients – therapist will record 10 minutes of direct time per patient.

How do we track phone calls with patient and family? : Phone calls with patient related to treatment issues/goals would be direct time. Phone calls with patient related to appointment bookings, missed appts. scheduling etc. would be indirect time. Phone calls with family members or caregivers or any interaction with persons other than the patient regarding counselling, care, supports etc. where the patient is NOT present would be indirect. If the patient is present and the time would be counted as direct if it is related to patient treatment, assessment, patient goals. If the patient is present but the intention is administrative – like booking future appointments it would still be indirect. Time spent without the patient present filling in forms, talking to insurance, writing reports, reading the chart is indirect time.

Do we count indirect time that happens after a patient is discharged? No – I think you can use one of the comment boxes in the table to make note if you wish (i.e. post discharge follow up required with this pt. – approx. time = 60 minutes) and we will certainly highlight this seems to be an issue across the sites if we see this comment popping up frequently. The sites using workload measurement to extract data will not be able to track these because once the patient is discharged you cannot enter on them anymore.

- Hospital or congregate setting based team that has the flexibility to see patient in their homes as well. **(Hybrid model)** (Herbert et al. 2016).
- Patient goal oriented therapy with flexibility (in location and intensity) to meet patient goals in appropriate environment (home or congregate setting) (Fisher et al., 2013, Geddes & Chamberlain, 2001, Greene, 2002, Von Koch et al., 2015).
- Appropriate Intensity of Services (Best Practice indicates min. 45 minutes per day per discipline, 2-5 days per week for at least 8 weeks) (CBPR, 2015))
- Time to first visit (home or congregate setting) = 48-72 hours (CBPR, 2015))
- Reduced transition points for patients
- Ensure flow of communication between in-patient and community settings, open communication with referral sources (Geddes & Chamberlain, 2001, Fisher et al., 2014, Taule et al., 2015).
- Requires excellent links between hospital, community teams and community re-integration resources
- Stroke expertise of team members required. Rehab services provided as a minimum PT, OT, SLP with OTA/PTA/CDA provision. Access to other IP team members recommended as needed (i.e. SW, RN, Pharmacy, Dietician) (Berger et al., 2014; Fisher et al., 2013, Geddes et al. 2001,, Webster, 2001, CBPR, 2015)).
- Embedded health promotion, secondary prevention (i.e links to Stroke Prevention clinic) and self-management principles and education (Fisher et al., 2013, Taule et al., 2011, CBPR, 2015)
- Weekly rounding/team meetings (Allen et al., 2014, Anderson et al., 2000, Berger et al, 2000, Geddes et al., 2001a, Greene et al.,, 2002, Langhorne et al., 2014, Lincoln et al., 2004, Markle-Reid et al., 2011, CBPR, 2015))
- Team members take turns being the 'care coordinator' (case management model) (*Coordinator must be someone involved in patients actual care/rehab provision) (Greene, 2002, CBPR, 2015))
- Team gets to know patients and is also involved in advocating for or developing needed community resources in their region (Geddes & Chamberlain, 2001)

Appendix F: Once page contact sheet with referral criteria

Organization	Contact Person	Phone	Email
CBI Home Health (MH CCAC contracted provider)	Danielle St- Pierre Manager of Therapy Services	Office: 905-560-6326 Toll Free: 1-866-209-9979 ext. 12112 Fax: 905-560-3331	dstpierre@cbihomehealth.ca
Closing the Gap Healthcare (MH CCAC contracted provider)	Nadia Perruzza, OT. Reg. (Ont.) Client Service Manager	Office: 905-306-0202 ext. 3480 Mobile: 647-401-3295 Fax: 905.268.1067	nadia.perruzza@closingthegap.ca
Halton Healthcare Step Up Program	Brenda Chisholm, OTA Nela Wilson, SLP	Office: 905-338-4367 Fax: 905-815-5134	bchishol,@haltonhealthcare.com
Heaman Communication Services (MH CCAC contracted provider)	Ginette Lalonde Branch Manager and Speech-Language Pathologist	Office: 1-877-877-4757 ext. 332	g.lalonde@heamancommunication.ca
Mississauga Halton Community Care Access Centre	Chris Linton, B.A., B.Sc. (OT), OT. Reg. (Ont.) Manager, Patient Care-Rehab	Office: (905) 855-9090x5356 Toll free: 1-877-336-9090 x5356 Cell: (416) 997-5165	christine.linton@mh.ccac-ont.ca
St. Elizabeth Health Care (MH CCAC contracted provider)	Waleed Noor, MSc OT. Reg. (Ont.) Rehab Services Supervisor	Office: 905- 826-0854 ext. 149670 Cell: 647-464-9112	waleednoor@saintelizabeth.com
THP Credit Valley Hospital Seniors and Rehabilitation Day Hospital Program	Cheryl Montana RN CEN©	Office: 905-813-1100 ext. 6528	Cheryl.Montana@trilliumhealthpartners.ca
THP Mississauga Hospital Out Patient Rehab Program		Office: 905-848-7280	outpatientneuorehabservices@trilliumhealthpartners.ca
VHA Rehab Solutions (MH CCAC contracted provider)	Vicki MacCallum Supervisor, Rehab GTA West	Office: 416-489-2500 ext. 2651 Fax: 416-482-4627	vmacallum@vha.ca
WOHS Brampton Civic Hospital Out Patient Rehab Program		Tel: 905-494-2120 ext. 56540 <i>Note: Changes are being made to registration so this number may be updated</i>	

A General Overview of Outpatient Admission Criteria for West GTA Region

Criteria	Yes	No
Acute or recent stroke (less than one year) OR greater than one year post stroke but requires interprofessional team		
Medically stable, co-morbidities addressed (able to participate, vitals stable, follow up medical investigations complete)		
Minimum level of patient function is present (Patient has the stamina to participate in the program; able to follow one-step commands with communication support if required; sufficient attention, short term memory and insight into rehabilitation progress)		
Demonstrated post stroke progress including potential to return to baseline function or increased post stroke functional level with rehabilitation		
SMART goals established		
Consent obtained (through patient or substitute decision maker)		
No behavioural issues limiting ability to participate at a minimum level		
Client does not have severe cognitive impairment		
Client is not already receiving treatment elsewhere and needs being met		
Client does not have a terminal illness with short survival expected		
Client is willing to participate		
Stroke etiology is clear and prevention intervention has started		
Organization Specific Sub-Criteria		
Trillium Health Partners Mississauga Hospital Outpatient Program		
Able to transfer with one person assist, caregiver able to attend for those who require assistance with toileting		
Trillium Health Partners Credit Valley Hospital Seniors and Rehab Day Hospital Program*		
Signed referral from a physician or nurse practitioner		
Adults 18 years or older who have recently been discharged from the ED or any Inpatient Unit at CVH		
Patients must have a functional deficit secondary to a recent hospitalization or ED visit at CVH		
Patients must require at least two of the provided therapies (PT, OT, SLP, TR). All patients are seen by RN		
Patients must be medically stable and have rehab goals		
Patients must arrange their own transportation		
William Osler Health Systems Brampton Civic Site**		
One person transfer, independent in toileting or caregiver available		
Goals established on initiation of program		

* *Exclusion Criteria for Credit Valley:*

- Patients in Long-Term care
- Discharged from other hospital
- Unaddressed substance abuse/mental health issues
- Patient has access for rehabilitation benefits through Motor Vehicle Insurance or Workplace Safety and Insurance Board (WSIB)

** *Exclusion Criteria for Brampton Civic*

- Do not accept clients that are receiving or have completed outpatient rehab



6 REFERENCES

Herbert et al. (2015). Canadian Stroke Best Practice Recommendations: Stroke Rehabilitation practice guidelines, update 2015.

Jorgensen, HS., Nakayama, H., Raaschou, HO., Vive-Larsen, J., Stoier, M., Olsen, TS. (1995). Outcome and time course of recovery in stroke. Part II: Time course recovery. The Copenhagen Stroke Study. Archives of Physical Medicine and Rehabilitation, May 76(5), 401-12.