Stroke Partners Day Event: A Focus on Community Rehabilitation

West GTA Stroke Network
November 4, 2021
12-2

WEST GTA Stroke Network

Welcome to our Community Stroke Partners Day Event!

- Please turn off your camera and put yourself on mute unless presenting
- If calling in and want to mute/unmute please press *6. Please do not place the call on hold while in the teleconference. Hang up and call back
- If you have any questions for the presenters please type them into the chat box throughout the event
- The event materials will be posted at the following link
- https://westgtastroke.ca/community-and-ltc-care/

WEST GTA Stroke Network

The Purpose of This Event:

- To provide updates on community stroke rehabilitation programs (outpatient and in home) in the West GTA Stroke Network region

WEST GTA Stroke Network

Post Event Survey

Survey Monkey link:
https://www.surveymonkey.com/r/YR9Y9VT

WEST GTA Stroke Network

Agenda:

- Trillium Health Partners Outpatient Neuro Rehab Services
- Trillium Health Partners Seniors and Rehabilitation Day Hospital (SRDH) Program
- Home and Community Care Support Services Mississauga Halton Stroke Program
- Central West Community Outreach Stroke Rehabilitation Program
- Lifemark's Community Step Up Program
- What's New in the West GTA Stroke Network

WEST GTA Stroke Network

Outpatient Neuro Rehab Services

Trillium Health Partners

Mississauga Hospital

Trillium Health Partners
Better Together

What we offer

Our neuro team of coordinated interdisciplinary rehab services:

- Occupational Therapy
- Physiotherapy
- Speech-Language Pathology
- Social Work

Any combination of services including single service

OHIP-funded services only (i.e., not WSIB or motor vehicle insurance)

Trillium Health Partners Better Together

What we offer

Occupational Therapy

- Arm and hand therapy
- Cognitive and visuoperceptual assessment and re-training
- Retraining of daily living skills
- Equipment recommendations
- Address community reintegration issues

Trillium Health Partners Better Together

What we offer

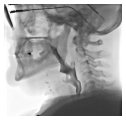
Physiotherapy

- Leg and ankle therapy
- Walking and balance re-training
- Re-training of facial muscles following Bell's Palsy and acoustic neuroma
- ADP assessment for walkers/canes
- Physical conditioning and endurance building

Trillium Health Partners Better Together

What we offer

Speech-language pathology



Assessment and treatment for:

- Speech difficulties (dysarthria)
- Aphasia (comprehension, retrieving words, expressing an idea; reading or writing)
- Cognitive communication (memory, reasoning, problem solving, organizing)
- Swallowing difficulties (including videofluoroscopic evaluation and rehabilitation of swallow e.g. expiratory muscle strength training)

Trillium Health Partners Better Together

What we offer

Social work

- Individual, family, marital counseling
- Assistance with financial needs
- Linkage to needed community resources
- Stress reduction

Trillium Health Partners Better Together

What we offer

Virtual services:

- OT, PT, SLP use OTN video call
- Social work offers phone appointments
- Can use laptop, tablet, or computer with webcam and microphone. Smart phone not recommended.
- If goals cannot be met on virtual therapy, we are able to move client to in person stream (may need to wait)

In person services:

- Offered at THP Mississauga Hospital, Monday to Friday (no evenings or weekends)
- Client must arrange own transportation
- Needs to bring a support person if they require assistance to use bathroom. Support person must be fully vaccinated.
- Wait is currently longer than virtual

Trillium Health Partners Better Together

What we offer

- Able to link to other services in the area:
  - **Stroke Navigators**
  - **Outpatient videofluoroscopic swallow study**
  - **Stroke Prevention Clinic**

13

Trillium Health Partners Better Together

Who to refer

Eligibility criteria:

- A recent stroke within the past 9 months

OR

- An acquired brain injury (e.g. TBI) within the past 12 months

OR

- A neurological condition (i.e. multiple sclerosis, degenerative conditions) with recent diagnosis or exacerbation

14

Trillium Health Partners Better Together

Who to refer

Eligibility criteria:

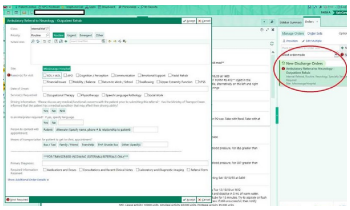
- Over 18 years old
- Medically stable
- Have shown recent progress in your recovery and have clear rehab goals
- Able to tolerate at least a 2-3 hour program plus transportation time
- Live within Trillium's service area (Mississauga and South West Etobicoke)
- Commit to attend regular sessions and complete recommended home activities and/or exercises
- Be under the care of a family physician
- Not be under the influence of drugs/alcohol

15

Trillium Health Partners Better Together

How to refer

- From within THP:
- Please use Epic orders, found under After Visit Procedures



16

Trillium Health Partners Better Together

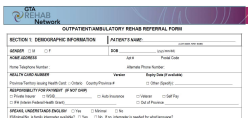
How to refer

- From community or other organization:
- Use GTA Rehab Network ambulatory rehab referral form
www.gtarehabnetwork.ca

Physician signature required

Fax to **905 848 7537**

Phone: **905 848 7280**



GTA REHAB Network

OUTPATIENT/AMBULATORY REHAB REFERRAL FORM

17

Trillium Health Partners Better Together

How to refer

- For all referrals:
  - Please include your own contact information
  - Please specify if patient would prefer virtual or in person therapy
  - Make sure diagnosis, date of onset, and therapies requested are filled out

18

Trillium Health Partners Better Together

Wait times

- **In Person**
  - OT – 4 months
  - PT – 2-3 months
  - SLP – 2-3 months

- **Virtual**
  - OT – 4-6 weeks
  - PT – 1-2 weeks
  - SLP – 0-1 week

*These are rough estimates of wait times. They fluctuate.

Trillium Health Partners Better Together

Contact Us

Trillium Health Partners – Mississauga Hospital
Outpatient Neuro Rehab Services
(905) 848 7280

Julia Harvey, PTA Julia.Harvey@thp.ca

Pamela Rahn, SLP Pamela.Rahn@thp.ca

Trillium Health Partners Better Together

Seniors and Rehabilitation Day Hospital (SRDH) Program

November 4th, 2021

Presented by:
Abigail James, RecT
Katie Pasquini, SLP

Trillium Health Partners Better Together

Agenda

- The SRDH Team
- Program Overview
- Referral Process
- Criteria
- Who We See
- Current Program Status
- Virtual Care Challenges
- Program Initiatives
- Post-Pandemic Plan
- Program Contact Information

Trillium Health Partners Better Together

The SRDH Team:

Trillium Health Partners Better Together

Program Overview

- The goal of the program is to prevent hospital admission, help facilitate earlier discharge home, and decrease patient length of stay.
- The program assists patients with transitioning from acute care and inpatient rehabilitation settings to the community.
- Patient length of stay and frequency of visits is determined by assessment and treatment goals.
- When applicable, patients are referred to appropriate community programs and/or resources upon discharge from the SRDH Program.

Trillium Health Partners Better Together

Program Overview
(continued)

- WHODAS 2.0 (WHO Disability Assessment Schedule), an interdisciplinary outcome tool, is completed on admission and at discharge.
- Discipline specific outcome measures.
- Caregiver Preparedness Scale is completed on admission and at discharge, when indicated.

Trillium Health Partners Better Together

Program Overview
(continued)

- Wait times to begin the program vary depending on referrals received.
- Priority is given to recent Trillium Health Partners (THP) discharges.
- All referrals are triaged by the RN, and they are prioritized based on referral source and information collected during triage.

Trillium Health Partners Better Together

Program Overview
(continued)

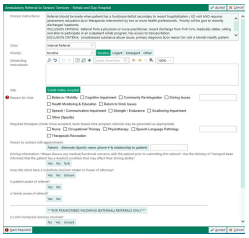
RN Triage Role

- Direct access to the patient's hospital chart:
  - allows for monitoring of test results, follow up appointments with specialists, and/or changes in medical status post discharge.
  - facilitates a seamless discharge, as the RN is able to closely liaise with the medical team.
- The program can accept more medically acute patients with close monitoring post discharge.
- EPIC system (internal THP electronic charting system) has improved communication and access to patient information.

Trillium Health Partners Better Together

Referral Process

- Internal referrals are completed in Epic.
- External referrals may be accepted based on triage. A paper referral form is available upon request.
- The referral requires a signature by a physician or nurse practitioner.



Trillium Health Partners Better Together

Criteria

Admission Criteria	Who We Do Not Accept
• 18 years or older and recently discharged from any THP site (from ED, acute care and inpatient rehabilitation) • Patients must have a functional deficit secondary to a recent hospitalization or ED visit at THP • All patients are assessed by the RN • Patients must require at least two of the provided therapies (PT, OT, SLP, RecT) • Patients must have rehabilitation goals and be able to participate in therapy	• Patients living in Long Term Care • Patients with unaddressed substance abuse issues • Patients whose primary diagnosis and/or reason for referral is related to a Mental Health Disorder

Trillium Health Partners Better Together

Who We See

- Neurological conditions
- Orthopedic conditions
- Rheumatology conditions
- COVID-19
- Failure to Thrive
- Functional decline and deconditioned due to a complex hospital stay
- Complex medical conditions, and/or multiple co-morbidities
- Falls
- Dementia and delirium

Trillium Health Partners Better Together

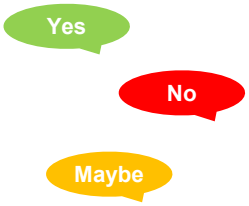
Current Program Status

- Virtual sessions through OTN (Ontario Telemedicine Network).
- Program staffing, structure and program admission criteria are the same as pre-pandemic status.

Trillium Health Partners Better Together

Virtual Care Challenges

- Patient safety concerns.
- Technology and access barriers.
- Not all referrals received are appropriate for virtual therapy.
- Some patients are on a waitlist for in-person care due to challenges.



Trillium Health Partners Better Together

Program Initiatives

COVID-19 Patients

- Our experience with more complex medical conditions put us in an ideal position to support COVID-19 patients.
- RN was in a position to quickly and efficiently triage COVID-19 patients.

Trillium Health Partners Better Together

Program Initiatives (continued)

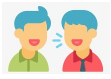
The Recreation Therapy Role

- PreCOVID-19, Recreation Therapy followed the Leisure Ability Model.
- Currently, the treatment shifted to the Leisure and Wellbeing Model, with a focus on promoting strengths and wellness.

Trillium Health Partners Better Together

Post – Pandemic Plan

Proposed Hybrid Model



- A combination of in-person and virtual care to decrease "patient footprints" in the hospital.
- Allows the opportunity to complete in-person assessment/ treatment, as needed.
- Provide an alternative to in-person care, for individuals that may experience barriers getting to the hospital.

Trillium Health Partners Better Together

Program Contact Information

Laura Hargreaves, Registered Nurse

Seniors and Rehabilitation
Day Hospital Program
Trillium Health Partners - Credit Valley Hospital

laura.hargreaves@thp.ca

Mobile: 647-241-1557
Office: 905-813-1100 x 6528

Trillium Health Partners Better Together

Questions

Trillium Health Partners
Better Together

HOME AND COMMUNITY CARE SUPPORT SERVICES
Mississauga Halton

STROKE PROGRAM

Annual Stroke Meeting
Astra Bukola Ohioma, Manager, HCC - Clinical and Specialty Programs
November 4, 2021

Ontario

Abbreviations

- MH – Mississauga Halton
- HCCSS – Home and Community Care support Services
- THP – Trillium Health Partners
- HHS – Halton Healthcare Services
- NUT – Nutrition
- OT – Occupational Therapist
- PT – Physiotherapist
- SW – Social Works
- SLP – Speech Language Pathology
- RT – Respiratory Therapist

STROKE PROGRAM

MH-HCCSS Rehab Programs

- MH HCCSS has several rehabilitation programs/pathways:

1. Total Hip
2. Total Knee
3. PT Streams/PT Models of care 1-3
4. OT Pre-Discharge Assessment
5. Allied Health Visits
6. Rapid Recovery
7. Lymphedema
8. Stroke Program
9. My Way Home
10. Covid Reconditioning (HHS)

MH HCCSS Stroke Program

- The Stroke Program at the Mississauga Halton HCCSS has been designed to enable timely, intensive, specialized community-based rehabilitation for mild to moderate stroke patients transitioning from hospital to home.
- The purpose of the program is to help patients return home sooner, by providing effective rehabilitation for patients in the comfort of their own home
- The Stroke Program is a team based rehabilitative support program that includes core disciplines of PT/OT/SLP and NS/HOM/NUT/SW as needed.

Goals

- Support stroke patients and their families in the community.
- Improve and facilitate transitions in care to the community.
- Facilitate community reintegration.
- Build trust and inter-professional communication between team members.
- Build stroke expertise and team-based care in the community.
- Achieve secondary prevention through integration with primary and other care providers.
- Provide navigation to stroke resources along the continuum.

43

MH HCCSS Stroke Program….cont'd

- The expected LOS is 6 weeks with 6 visits per needed rehab discipline over the first 3 weeks.
- Target Population:
  - ❑ Rehab – independence
  - ❑ Rehab – optimal
  - ❑ Maintenance and prevention of decline

44

MH HCCSS Stroke Program Eligibility Criteria

- 18+ years old, resides in the MH HCCSS area
- Eligible for HCCSS services
- Stroke diagnosis
- Recent discharge, diagnosis or referral from hospital/rehab/stroke prevention clinic
- A physician referral is not required
- Identifiable goals for community reintegration
- Exclusion: Greater than one year post stoke (consider alternate program), assessed for Rapid Recovery or Home First program.

45

MH HCCSS Stroke Program Status

- The program is currently active.
- Recent change in its Manager at MH-HCCSS.
- Visits are made both virtually and in person (Report from our database shows NUT, OT, PT, SLP and SW). No virtual for RT.
- Note: There is an SLP shortage in Halton Community

46

Program Highlights

- Monthly Rehab Best Practice Monthly meetings
- Referrals for all services
  - Q1=35: April(0), May (19), June (16).
  - Q2=68: July (26), August (23), September (19)
  - Q3=20: October (20), still in progress

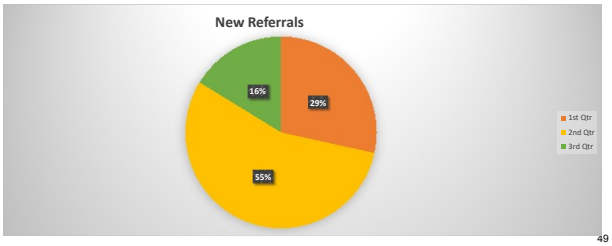
47

New Referrals to Stroke Program 2021

New Referrals

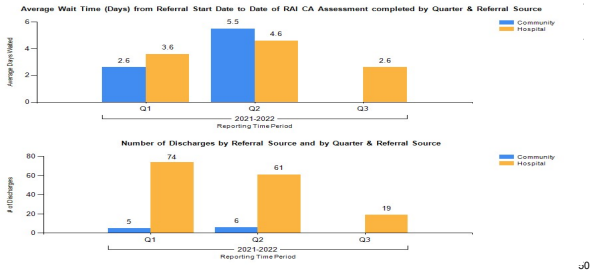
48

New Referrals for all Services



49

Wait Times



50

Discharge from the Stroke Program

- Discharge Disposition: Patients are discharged to
- - Outpatient rehab at THP or HHS,
- - Community support sector (Adult day programs, Exercise or Falls prevention classes),
- - Self-management.

51

Contact

Astra Bukola Ohioma. RN, BN, NSWOC, MTM, MN(c)

Manager, HCC - Clinical and Specialty Programs

Home and Community Care Support Services

astra.ohioma@lhins.on.ca

Tel: 905-855-9090 x 5354 | Cell: 905-601-4818

Richelle Doak

Clinical Practice Lead – Rehabilitation (currently on maternity leave)

52

The End!!!

Questions?

53

Central West **LHIN**

Healthy Change

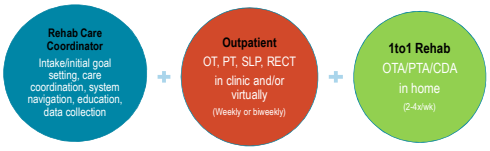
Community Outreach Stroke Rehab Program

A Partnership Between
William Osler Health System +
Home & Community Care Support Services

November 2021

William Osler Health System · 1to1 Rehab · WEST GTA Stroke Network · Ontario Local Health Integration Network

The Community Outreach Stroke Rehab Model



55

Staff and Clinicians

Home and Community Care Support Services, Central West

- Kevin Cheng (Rehab Care Coordinator)
  905-796-0040 x.7121

Brampton Civic Hospital

- Nancy Pearsoll (0.6 FTE Occupational Therapist)
- Lisa Brake (0.6 FTE Occupational Therapist)
- Deborah Ensing (0.8 FTE Physiotherapist)
- Violetta Krichevski (1.0 FTE Speech-Language Pathologist)
- Deanna Riddle (0.4 FTE Recreation Therapist)

1to1 Rehab

- Mona Tang (Rehab Assistant Coordinator)

56

Eligibility Criteria

- **Adult** 18 years of age or older
- **Reside within CW LHIN**
- **Acute or recent stroke**
- **Medically stable**
- **Demonstrated post stroke progress**
- **Motivated**, with **clear goals** and able to tolerate the intensity of an outpatient rehab program (2-3 hours of therapy per visit) plus commute time (if required)
- **AlphaFIM >80** for patients being discharged from acute care
- **Rehab Patient Group (RPG) of 1150 or 1160** (mild stroke) if being discharged from inpatient rehab
- **Transportation** for patients who wish to participate in-person at the Brampton Civic Hospital
- **Virtual Access (Zoom)** for patients who wish to participate virtually.

57

Mandatory Referral Documents

- **Physician Orders**: The "Neurological Rehabilitation Services" referral form signed by a physician.
- **AlphaFIM**: Attach a printout of the alphaFIM for patients from acute care.
- **RPG**: Attach a printout of the RPG score for patients from inpatient rehab.
- **Rehab Multidisciplinary Notes:** Attach the rehabilitation notes from OT, PT, SLP as appropriate.
- **Consult Notes:** Attach physician consult notes documenting the diagnosis of the stroke along with medical diagnostic summaries (ie. CT/MRI scans).

58

Treatment Expectations

- Client-driven goals (COPM)
- Estimated 1-2 visits per week with PT, OT, SLP, and RECT, as required
- Estimated 2-3 visits per week with PTA, OTA, CDA's providing ongoing interventions in the home, as necessary
- Approximately 8-12 week program duration
- Since April 2020, interventions provided in-clinic and/or virtually through ZOOM platform.
- Wait times can vary throughout the year. Current wait time is approximately 2-3 weeks for initial appointment with therapists.

59

Innovations/Changes Since COVID19

<u>As of March 2020:</u>

- COSR program closed from March 2020 - April 2020
- COSR program relaunched/reopened in April 2020 offering key services virtually as the clinic remained closed to in person until August 2020
- Intake assessments are now completed over the phone by care co-ordinator
- Since August hybrid model of care offered – in person in clinic and/or virtually
- Clinicians continue to deliver care both remotely and in-clinic

60

Advantages of Offering Virtual/Hybrid Model of Care

- Increased flexibility in program delivery
- Increased access for those who lack transportation
- Increased opportunity for participation from family/support persons
- Providing person-centred treatment in the right setting
- Providing support for community integration and introduction to device use/video conferencing platform
- Possibility for expanding the program to group sessions

61

Evaluation of the Program

Patients describe their journey with COSR to be collaborative, educational, individualized, and helped them to adapt to life after a stroke.

"I love the program and from the start it's been rough and tough but I've come a long way. Doing the program over Zoom is good - it's helped me a lot. When I'm face-to-face I get nervous and shy, but with Zoom I can be open and comfortable to express myself. I like that it's always on time and they let me know if there is a problem [with connecting online]. The therapists always send a lot of homework [via email] and make sure you are caught up."

62

Questions?

63

Lifemark's Community Step Up Program

Barbara Kawczak
Manager, Community Programs

Ontario

lifemark Seniors Wellness

Main Contact for Program

For Referrals:

Megan Whalen
Community Programs Coordinator
Toll Free: **1.800.315.4417**
Local: **416.399.7351**
Megan.Whalen@lifemark.ca

Online Referral:

https://www.lifemarkseniorswellness.ca/stepupprogramform

or

Fax: 1.855.412.6627

Program Operations

Kristy Musialik
Director, Community Partnerships
Cell: **289-237-8677**
kristy.musialik@lifemark.ca

lifemark Seniors Wellness

65

Program Details

Since 2016 we have serviced over 1000 frail seniors

- 6 week outpatient program
- Therapies include PT, OT & SLP
- Clients attend 2 days / week for 1.5 hours
- Clients are treated on a 1-1 basis
- Currently all treatments are provided virtually
- Discussions with Host Sites are in progress to restart in person care – no timelines yet

Ontario

lifemark Seniors Wellness

66

Wait Times

Virtual Wait Times

- PT/OT – 1 week from time of referral
- SLP – End of December – Recruitment in process

In Person Wait Times

- Host Sites provide Lifemark with in-kind space
- Partners are in RH and LTC
- Pandemic hit their residents the hardest and taking a conservative approach to re-opening
- Discussions are occurring about re-opening – no timelines to share at this time

Ontario

lifemark Seniors Wellness

67

Inclusion Criteria

- Frail Senior or older adult with comorbidities
- Client has experienced a recent functional decline and has **restorative potential**
- Require a coordinated approach to rehab - must require a minimum of **2** out of the 3 disciplines
- Must be **medically stable** to participate in the 6 week program
- Must be able to ambulate with assistance
- Must be able to tolerate **1.5 hour visit**
- Client is motivated to participate in program
- Must be able to perform own peri-care or have caregiver assistance

Note: Physician Referral is NOT Required

Ontario

lifemark Seniors Wellness

68

Suitability for Virtual Care

Clients Should Have the Following:

- Have a smart device – laptop, computer, tablet with webcam
- Have strong internet access
- Have an email address
- Be comfortable with navigating an online platform or caregiver support to assist with each session
- Have an attention span of 1.5 hours or a caregiver that will attend each session to redirect
- Not require hands on manual therapy

Ontario

lifemark Seniors Wellness

69

lifemark Seniors Wellness

70

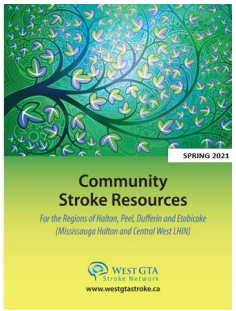
What's New in the West GTA Stroke Network

West GTA Stroke Network

Community Resource Booklet

Download for free or e-mail us westgtalinks@hc.on.ca

https://westgtastroke.ca/community-resource-book/

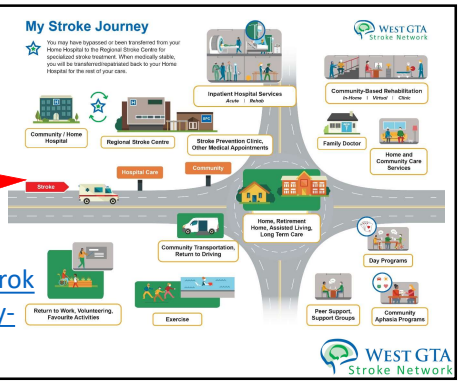


West GTA Stroke Network

Patient Journey Map

Download for free at:

https://westgtastroke.ca/community-and-ltc-care/



Virtual Classroom

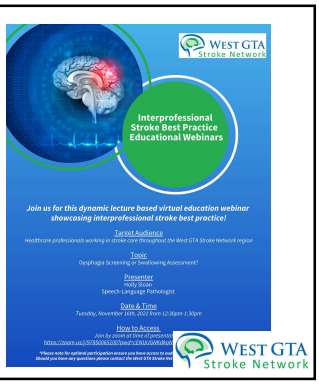
Create an account and learn for free:

https://westgtastroke.ca/classroom/

WEST GTA Stroke Network

Upcoming Events

Target Audience
Healthcare professionals working in stroke care throughout the West GTA Stroke Network region
Topic
Dysphagia Screening or Swallowing Assessment?
Presenter
Holly Sloan
Date & Time
Tuesday, November 16th, 2021 from 12:30pm-1:30pm
How to Access
Join by zoom at time of presentation:
https://zoom.us/j/97850065100?pwd=cENUUGNKdkpNME9HcGVrZU13VFQvQT09



Return to Vocations Toolkit

- The Central East and West GTA Stroke Network have collaborated on creating a return to vocations toolkit for persons with stroke and clinicians
- Return to vocations refers to return to school, return to volunteering and return to work
- Resource will be completed before March 2022

RETURN TO VOCATIONS POST STROKE TOOLKIT

STROKE NETWORK

WEST GTA Stroke Network

Join Our Mailing List

Join our mailing list at:

https://westgtastroke.ca/sign-up/

Thank you for joining us today!