Improving stroke care through better integration of nursing and personal support

Paul Holyoke, PhD
Director, Saint Elizabeth Research Centre
PaulHolyoke@SaintElizabeth.com
www.saintelizabeth.com/research
Outline

1. Phases 1&2 - WW Community Stroke Program
2. Phase 3 Planning
   – How we did it
   – What we considered
   – The result
3. Next steps
Phase 1&2 – WW Community Stroke Program

- Instituted in 2012
- Part of LHIN-wide stroke strategy
- Goal: community reintegration using best practices
Stroke best practices

• Well developed for hospital-based care
• Community reintegration best practices extrapolated from hospital best practices
  – Sustained over +/- 60 days
  – Multiple disciplines
  – Rehabilitation intensity
Care pathway

Hospital  Home  Community

Care Pathway
12 weeks, 76 visits
Care Coordinator, PT, OT, SLP, RD, SW & rehab assistant

Discharge Link
<table>
<thead>
<tr>
<th>Interventions</th>
<th>CCAC Designated Stroke Hospital CC</th>
<th>CCAC Designated Stroke Community CC</th>
<th>Initial</th>
<th>Interim</th>
<th>Transition / Pre-Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Discharge</td>
<td>RAI-CA completed.</td>
<td>Contact client within 72 hours of return home</td>
<td></td>
<td></td>
<td>Liaise with service providers and community supports for updates on service specific goal attainment and outcome evaluation.</td>
</tr>
<tr>
<td>1-2 weeks</td>
<td>Confirm AlphaFIM® (if acute) FIM® (if rehab) completion (FIM to be completed by hospital team)</td>
<td>Complete RAI-HC.</td>
<td>Continue to facilitate referrals to community supports/resources &amp; address any access to services/care barriers</td>
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<tr>
<td>3-4 weeks</td>
<td>Investigate need for inpatient rehab care</td>
<td>Assess and identify client specific stroke risk factors (e.g. medication compliance/home safety), assess readiness for client change &amp; engage in self-management techniques</td>
<td>Ensure information sharing of client’s overall status and care needs with circle of care</td>
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<td>5-8 weeks</td>
<td>Assess client/caregiver concerns about returning home and provide support in transitioning to home</td>
<td>Provide client/caregiver with education to support planning to minimize risk and manage crises</td>
<td>Investigate client progress, goal attainment and evaluate outcomes expected to be achieved within first month of returning home;</td>
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<td>9-12 weeks</td>
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<td></td>
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<td>Establish discharge/transition plan in coordination with client, family and team</td>
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**Designated Stroke Care Coordinator (CC)**

**Care Pathway sample**
## Care Pathway - providers

### Designated Stroke Care Coordinator (CC)

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Initial</th>
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<th>Transition / Pre-Discharge</th>
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<tr>
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<td>• Follow CCM client services standards of care by population • Coordinate and chair care teleconference with “Lead therapist” (week 10-12) • Investigate client progress, goal attainment and outcome evaluation • Update client overall care plan in accordance with outcomes and goal attainment (i.e. service plan) • Establish discharge/transition plan in coordination with client, family and team • Follow up on any outstanding referral(s), as necessary</td>
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<tr>
<td>5-8 weeks</td>
<td>• Complete RAI-HC. • Assess and identify progress, goal attainment and evaluate outcomes expected to be achieved within first month of returning home; • Coordinate and chair inter-professional care conference at 3 weeks post-discharge • Re-assessment and evaluation of attainment (i.e. service plan) • Consider transition to community independence • Re-assess at regular intervals to assess for readiness for rehab in alternate care setting (e.g. outpatient services, congregate care) • Follow up on referral(s), as necessary</td>
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- client/caregiver concerns about returning home and provide support in transitioning to home
- Set date for CCAC/ hospital Discharge Link meeting to discuss rehab goals and plan for transition to the community – ensure invitation to service provider
- provide support planning to minimize risk and manage crises
- Liaise with primary care provider (e.g. physician, NP), or FHT/community pharmacy as necessary
- change & engage in self-management techniques

- Provide client/caregiver with education to facilitate discharge process
- Support staff in identifying and developing home care goals and care plan
- Coordinate and chair inter-professional care conference at 3 weeks post-discharge
- Re-assessment and evaluation of attainment (i.e. service plan)
- Consider transition to community independence
- Re-assess at regular intervals to assess for readiness for rehab in alternate care setting (e.g. outpatient services, congregate care)
- Follow up on referral(s), as necessary
- Investigate client progress, goal attainment and outcome evaluation
- Update client overall care plan in accordance with outcomes and goal attainment (i.e. service plan)
Care Pathway – interventions and outcomes

<table>
<thead>
<tr>
<th>Designated Stroke Care Coordinator (CC)</th>
<th>Pre-Discharge</th>
<th>1-2 weeks</th>
<th>3-4 weeks</th>
<th>5-8 weeks</th>
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</thead>
<tbody>
<tr>
<td>Initial</td>
<td>Interim</td>
<td>Transition / Pre-Discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventions</td>
<td>CCAC Designated Stroke Hospital CC</td>
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<tr>
<td></td>
<td>• RAI-CA completed.</td>
<td>• Confirm AlphaFIM® (if acute) FIM® (if rehab) completion (FIM to be completed by hospital team)</td>
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<tr>
<td></td>
<td>• Confirm</td>
<td></td>
<td></td>
<td></td>
<td>• Update client overall care plan in accordance with outcomes and goal attainment (i.e. service plan)</td>
</tr>
<tr>
<td>Expected Outcomes</td>
<td>1) Prior to discharge, if applicable, home safety assessment findings will be shared with CCAC/hospital to support safe transition.</td>
<td>1) Consider client goals and plan for transition to the community – ensure invitation to service provider</td>
<td>2) Re-assess at regular intervals to assess for readiness for rehab in alternate care setting (e.g. outpatient services, congregate care)</td>
<td>2) Follow up on referral(s), as appropriate:</td>
<td>2) Follow up on any outstanding referral(s), as appropriate:</td>
</tr>
<tr>
<td></td>
<td>2) Necessary</td>
<td>2)</td>
<td>2)</td>
<td>2)</td>
<td>2)</td>
</tr>
<tr>
<td></td>
<td>• Discuss rehab goals and plan for transition to the community – ensure invitation to service provider</td>
<td>• Liaise with primary care provider (e.g. physician, NP), or FHT/community pharmacy as needed</td>
<td>• Re-assessment and evaluation of professional care plan at 3 weeks post-discharge</td>
<td>• Follow up on referral(s), as appropriate:</td>
<td>• Establish discharge/transition plan in coordination with client, family and team</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Follow CCM client services standards of care by population</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Coordinate and chair care teleconference with “Lead therapist” (week 10-12)</td>
</tr>
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<td></td>
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<td>• Investigate client progress, goal attainment and outcome evaluation</td>
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<td>• Establish discharge/transition plan in coordination with client, family and team</td>
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</tbody>
</table>
| | | | | | • Follow up on any outstanding referral(s), as appropriate:
# Care Pathway - phases

## Designated Stroke Care Coordinator (CC)

<table>
<thead>
<tr>
<th>Care Coordinator (CC)</th>
<th>1-2 weeks</th>
<th>3-4 weeks</th>
<th>5-8 weeks</th>
<th>9-12 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Discharge</strong></td>
<td><strong>Initial</strong></td>
<td><strong>Interim</strong></td>
<td><strong>Transition/Pre-Discharge</strong></td>
<td></td>
</tr>
<tr>
<td>CCAC Designated</td>
<td>CCAC Designated</td>
<td>CCAC Designated</td>
<td>CCAC Designated</td>
<td></td>
</tr>
<tr>
<td>- Return to (acute) FIM® (if rehab) completion (FIM to be completed by hospital team)</td>
<td>- Complete RAI-HC.</td>
<td>- Support resources &amp; address any access to services/care barriers</td>
<td>- Coordinate and chair care teleconference with “Lead therapist” (week 10-12)</td>
<td></td>
</tr>
<tr>
<td>- Investigate need for inpatient rehab care</td>
<td>- Assess and identify client specific stroke risk factors (e.g. medication compliance/home safety), assess readiness for client change &amp; engage in self-management techniques</td>
<td>- Ensure information sharing of client’s overall status and care needs with circle of care</td>
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<td>- Assess client/caregiver concerns about returning home and provide support in transitioning to home</td>
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</tr>
<tr>
<td>- Set date for CCAC/hospital Discharge Link meeting to discuss rehab goals and plan for transition to the community – ensure invitation to service provider</td>
<td>- Liaise with primary care provider (e.g. physician, NP), or FHT/community pharmacy as necessary</td>
<td>- Re-assessment and evaluation of</td>
<td>- Establish discharge/transition plan in coordination with client, family and team</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Follow up on any outstanding referral(s), as necessary</td>
</tr>
</tbody>
</table>

*Note: The table continues with more detailed activities for each phase.*
Occupational Therapy Overall Outcome: Client will live safely at home and will achieve maximum independence in ADL/IADL with or without supports (8/16 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week)

<table>
<thead>
<tr>
<th>Pre-Discharge</th>
<th>1-2 weeks</th>
<th>3-4 weeks</th>
<th>5-8 weeks</th>
<th>9-12 weeks</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions</strong></td>
<td><strong>Initial</strong></td>
<td><strong>Interim</strong></td>
<td><strong>Initial</strong></td>
<td><strong>Interim</strong></td>
<td><strong>Initial</strong></td>
</tr>
<tr>
<td><strong>Hospital Therapist:</strong></td>
<td>• Review findings from hospital assessments and determine need for further testing/evaluation (e.g., FIM, Barthel, RNLI)</td>
<td>• Attend inter-professional case conference at 3 weeks</td>
<td>• Evaluate goal attainment and re-adjust plan as required.</td>
<td>• Repeat stroke assessment tools (e.g., FIM, Barthel, RNLI)</td>
<td>• Desired outcomes achieved</td>
</tr>
<tr>
<td>• Complete Hospital Rehabilitation Report</td>
<td>• Evaluate recommended equipment and home/vehicle modifications</td>
<td>• Continue to teach and modify adapted methods for task specific activity completion (applying *motor learning principles).</td>
<td>• Initiate discussion regarding discharge.</td>
<td>• Liaise with Community CC, regarding discharge plan.</td>
<td>• Discharge</td>
</tr>
<tr>
<td>• Hospital CC in conjunction with hospital therapists recommend whether a pre-discharge home safety assessment is necessary or whether a high priority OT visit is necessary upon client’s discharge from hospital.</td>
<td>• Further assessment of ADL/mobility/arm function needs, as required (OT/PT role)</td>
<td>• Continue with home assessment and modification recommendations, as applicable</td>
<td>• Finalize funding for equipment and home modification</td>
<td>• Liaise with other disciplines</td>
<td></td>
</tr>
<tr>
<td><strong>Community OT:</strong></td>
<td>• Provide education regarding the safe use of equipment and adaptive techniques</td>
<td>• Liaise with inter-professional team on clinical plans relevant to mutual client goals</td>
<td>• Link with community resources.</td>
<td>• Liaise with Community OT:</td>
<td>• Continued follow up on funding applications</td>
</tr>
<tr>
<td>• Participate in discharge linking meeting</td>
<td>• Follow through with repetitive and novel tasks to challenge the client to acquire necessary motor skills to use the involved limbs during functional activities*</td>
<td>• Continued follow up on funding applications</td>
<td></td>
<td></td>
<td>• Completion of ADP application, as applicable</td>
</tr>
<tr>
<td>• Complete if applicable a pre-discharge, home safety assessment &amp; make recommendations to decrease risks and ensure safe transition home</td>
<td>• Follow up regarding funding applications-ADP, insurance</td>
<td>• Facilitate access to the community for integration and re-engagement</td>
<td></td>
<td></td>
<td>• Link with community resources.</td>
</tr>
<tr>
<td>*motor learning principles.</td>
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</table>

## Care Pathway – providers

### Occupational Therapy

**Overall Outcome:** Client will live safely at home and will achieve maximum independence in ADL/IADL with or without help. (Assessment of 45 min-3 hrs, 3-5 days per week)

<table>
<thead>
<tr>
<th>3-4 weeks</th>
<th>5-8 weeks</th>
<th>Transition / Pre-DischARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions</strong></td>
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<td>Continue to teach and modify adapted methods for task specific activity completion (applying <em>motor learning principles</em>).</td>
<td>Liaise with Community CC.</td>
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<td>- Hospital CC in conjunction with hospital therapists</td>
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<td>Regarding discharge plan.</td>
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<td><strong>Community OT:</strong></td>
<td></td>
<td>Discharge</td>
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<td>- Participate in discharge linking meeting</td>
<td>Evaluate goal attainment and re-adjust plan as required</td>
<td></td>
</tr>
<tr>
<td>- Complete if applicable a pre-discharge home safety assessment &amp; recommendations to decrease risks and ensure safe transition home</td>
<td>Initiate discussion regarding discharge</td>
<td></td>
</tr>
<tr>
<td>- Follow up regarding funding applications: ADP, insurance</td>
<td>Finalize funding for equipment and home modification</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Link with community resources.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liaise with other disciplines</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Interventions specific to the care pathway.*
Care Pathway – outcomes defined

Occupational Therapy Overall Outcome: Client will live safely at home and will achieve maximum independence in ADL/IADL with or without supports (8/16 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week)

- Client will live safely at home and will achieve maximum independence in ADL/IADL with or without supports (8/16 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week)

Community OT:
- Participate in discharge linking meeting
- Complete if applicable a pre-discharge, home safety assessment & make recommendations to decrease risks and ensure safe transition home

required (OT/PT role):
- Provide education regarding the safe use of equipment and adaptive techniques
- Follow through with repetitive and novel tasks to challenge the client to acquire necessary motor skills to use the involved limbs during functional activities*
- Follow up regarding funding applications- ADP, insurance

as applicable:
- Liaise with inter-professional team on clinical plans relevant to mutual client goals
- Continued follow up on funding applications
- Completion of ADP application, as applicable
- Facilitate access to the community for integration and re-engagement
Care Pathway – number of visits

**Occupational Therapy Overall Outcome:** Client will live safely at home and will achieve maximum independence in ADL/IADL with or without supports (8/16 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week)
Care pathway

• Community reintegration best practices extrapolated from hospital best practices
  – Sustained over +/- 60 days
  – Multiple disciplines
  – Rehabilitation intensity
• And... transition from hospital to home care is addressed
Delivery of Phases 1&2 care pathway

• Consolidation of care by provider organization
  – Care Partners, Saint Elizabeth
• Integration of therapy assigned to provider organizations to manage
• Care pathway and implementation iterated over time
Outcomes – preliminary data

Preliminary data

For some clients, improved:

– functional outcomes (e.g. ADLs, IADLs)
– community reintegration
– frailty scores in clients
– depression, cognitive performance
Phase 3

• Vision: incorporate nursing & PSW into the pathway

• Issues
  – Best practices don’t address PSW
  – Nursing role in community reintegration
  – Rehabilitation intensity
  – Consolidation of provider organizations
  – Resources to do the planning
Saint Elizabeth Research Centre

- Integrated Care and Transitions
- Person and Family Centred Care
- End-of-Life Care
- Caregivers

Projects in provinces & territories: 8
Partners & stakeholders: 31
Presented to: 4302 people
Offer to the WWCCAC and provider organizations

• Strategic focus on integrated care and transitions
• Research project funded by Ontario Stroke Network to look at PSW role in stroke rehabilitation
Integrated care concepts

- Informational Continuity
- Relational Continuity
- (Care) Management Continuity

(Haggerty et al., 2003)
Integrated care concepts

- Security and confidence rather than seamlessness
- Provider knows client’s life situation, for coherence
- Coordination and information transfer are assumed
- Care plans help clinician coordination
- Knowing what to expect and having contingency plans provides security

(Haggerty et al., 2014)
Steps in the planning process

- MOU
- ADAPTE workshop
- Analysis
- Steering Committee
- Report
ADAPTE workshop

• 2 days
• 23 frontline providers
  – CCAC
  – Hospital – inpatient and outpatient
  – Home care
• Comprehensive review of the Stroke Program and experience to date
  – 8 areas for moving the pathway to phase 2
Steering committee

- 6 meetings
- Organized ADAPTE workshop attendees
- Reviewed ADAPTE workshop considerations
  - Supported the substance of all the recommendations, and suggested an alternative approach for one recommendation
1. Designated or Integrated Team?

**Designated team**

- Ideal BUT
  - reality of volumes
  - reality of health human resources
  - reality of the structure of health care
- Make sure the care is integrated by knowledgeable health care workers working collaboratively
- Team work integrated and coordinated by OT Lead
2. Training

Training good but too targeted

1. Training on stroke – *same* for all providers
   - Interprofessional Learning Objectives for Stroke Care
   - Taking Action for Optimal Community and Long-Term Stroke Care: A resource for healthcare providers

2. Training on provider *roles*

3. Self-evaluation tool

4. Platform for sharing training
<table>
<thead>
<tr>
<th>Learning Area</th>
<th>Nurse</th>
<th>OT</th>
<th>Pharm</th>
<th>PT</th>
<th>RD</th>
<th>RT</th>
<th>SW</th>
<th>SLP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Principles of Stroke Care</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2. Anatomy and Physiology of Stroke</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Cardiovascular and Respiratory Effects</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>4. Psychosocial Effects</td>
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<td>5. Communication</td>
<td>Yes</td>
<td>Yes</td>
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<td>6. Mobility &amp; Complications of Immobility</td>
<td>Yes</td>
<td>Yes</td>
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<td>7. Routine Activities of Daily Living</td>
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<td>8. Instrumental Activities of Daily Living</td>
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<td>9. Cognitive, Perceptual, Behavioural Changes</td>
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<td>10. Sexuality</td>
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<td>11. Nutrition</td>
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<td>12. Dysphagia</td>
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<td>13. Skin Care</td>
<td>Yes</td>
<td>Yes</td>
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<td>14. Continence Management</td>
<td>Yes</td>
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<td>15. Primary &amp; Secondary Stroke Prevention</td>
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<td>16. Transition Management</td>
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TAKING ACTION FOR
OPTIMAL COMMUNITY AND
LONG-TERM STROKE CARE

A Resource for Healthcare Providers

Updated November 2015
3. Focus on the client’s goals

Currently the **goals for the client are recorded; no consistent way for the client’s goals to be recorded and acted upon**

- Recommend recording goals in two ways
3. Focus on the client’s goals

- Defining the **client’s goals**
  - Easier said than done
  - Each profession has its own approach
  - Adapt Goal Attainment Scaling

- OT Lead helps client set goal(s)
- OT Lead records goals
- Client records goals
- Goal(s) shared with other providers
- Other providers’ activities show alignment to the goal(s)
- Goals reviewed periodically and updated as necessary
4. Flexibility in the care pathway

*Pathway perceived to be inflexible*  
– provider combinations, timing

- Total max visits stays the same (but see 5. Nursing)
- Nurses can be included in the mix of rehabilitation-focused providers, where necessary
- OT Lead can change which combination of providers over time is appropriate, *including nurses and PSWs*, to achieve the client’s goals
The rehab intensity question

• “... Canadian Best Practice Recommendations for Stroke Care state that therapy provided in the outpatient and/or community based setting should involve “a minimum of 45 minutes per day (up to 3 hours per day), 3-5 days per week” (p.33), and be “based on individual patient needs and goals.”

• “The ideal intensity for community-based rehabilitation is unknown.”

• What is “rehab”?  
• Appears to be related to *actual activity* in the session  
  – not the length of the visit  
  – not necessarily the provider

4. Flexibility in the care pathway

- Given evidence on intensity, good reason to explicitly include nurses and PSWs as part of the team
  - Always incorporate them to help client achieve goal
  - Always incorporate in rehab plan to assist team
  - 4 explicit times for “OCAR” to align/re-align efforts
5. Nursing visit

Medication and education at the beginning
• Specifically add ~2-3 nursing visits at the beginning
  • Help prioritize and address non-rehab needs, sort out medications
    – Add another visit at 4-8 weeks in to ensure medication is appropriate; identify other issues
• Nurses can be part of the main pathway providers – to be decided by OT Lead
6. Communication platform across settings

*Communication by email ok, but not enough*

- Goal book for client
- E-platform for *communication* across settings
7. Transitions into and out of pathway

*Discharge Link meeting good, need more*

- Rename Discharge Link meeting as “Transition Meeting”
- Empower the team to start referrals to the community services throughout the pathway
- Establish a formal “Transition Meeting” at the end of the pathway to transfer accountability for continuity for community services
8. Outpatient and in-home rehab

*Sometimes outpatient rehab should be part of the pathway*

- Evidence says in general, neither has more advantages
- Cross-setting reimbursement difficult
- Work on guidelines for deciding which would be better
Evaluation

Outcomes
• Client experience – WatLX™
• Team collaboration – AITCS (Orchard, Western U)
• Clinical outcomes – same as phase 1

New processes
• Training, self-assessment tools, goal setting, client/provider
  goal alignment, nursing visits, flexibility

Incremental value?
Overall comments

• A high desire to focus on the client and “ignore” setting boundaries
  – easier said than done! **but** we have a strong expression of desire to move forward
  – and a strong platform to structure common work around client and client goals
Implementing the plan

• Still under consideration
• Financial impact analysis was planned but not enough data were available
Questions or comments?
Improving stroke care through better integration of nursing and personal support

Paul Holyoke, PhD
Director, Saint Elizabeth Research Centre
PaulHolyoke@SaintElizabeth.com
www.saintelizabeth.com/research