STROKE ACTION PLAN (SAP) – APRIL 2013

STATEMENT OF WORK – SUEC & ESD SITES

Cardiovascular Health & Stroke SCN Project Overview

Background

The Alberta Provincial Stroke Strategy (APSS) has been successful in enhancing rural and urban stroke care across the province with improved outcomes and a 26% reduction in overall provincial mortality for ischemic and hemorrhagic stroke over 5 years. Some of these gains are from increasing access to stroke unit care across the province from 29% of all stroke patients in 2005 to 52% in 2011. Some clear discrepancies in care between rural and large urban centres remain. However, it has become evident from the experience of APSS that the global definition of a stroke unit is not relevant to smaller centres. This is due to low annual volumes of fewer than 20 stroke patients per year and a low number of hospital beds in general making it impractical to cluster or dedicate beds to stroke patients. The APSS created 'primary stroke centres' in select small urban and rural communities within Alberta which have attempted to give patients exposure to components of stroke unit care. This includes stroke-specific rehabilitation and specialized stroke nursing but this kind of 'stroke unit care' is not well defined nor are there clear standards established.

Most stroke patients require rehabilitation to return to their maximum potential functional level. For the best possible outcome, research has shown that stroke rehabilitation must be delivered early in the course of recovery, in a setting that provides the greatest amount of challenge and by an interdisciplinary team with expertise in stroke rehabilitation. Expert stroke rehabilitation services are usually available in inpatient settings. Unfortunately, only approximately 13-20% of stroke patients in Alberta are able to be admitted to dedicated rehabilitation hospitals on discharge from acute care.

Individuals who have experienced a mild to moderate stroke can benefit most from home/community-based rehabilitation. Stroke rehabilitation provided in the client's home not only frees up an inpatient bed, it achieves similar outcomes to inpatient rehab. It also promotes the adjustments in lifestyle required for stroke survivors to stay healthy right in their own home, and together with their family. Furthermore, the implementation of Early Supported Discharge (ESD) programs in Edmonton and Calgary has produced a 50% increase in the number of stroke patients who have access to intensive rehabilitation.

The combined approach of including Community Rehabilitation (CR) with ESD programs can target chronic stroke clients already in their homes who are at risk of hospitalization or admission to a LTC facility due to decreasing function. Timely and expert rehabilitation intervention may also decrease homecare services required. There is evidence from the literature that some stroke patients continue to have unmet rehabilitation needs long after the first several months post stroke and that this need can increase periodically.

Objectives

The purpose of this project is to improve the quality of, and access to stroke care in Alberta by:

1. Developing and implementing provincial guidelines for Stroke Unit Equivalent Care (SUEC) for all stroke patients accessing 15 rural and small urban primary stroke centres by March 31st 2015.
2. Implementing a community-based stroke rehabilitation service that includes ESD and CR for mild to moderate stroke patients at 5 of the 15 identified primary stroke centres by March 31st, 2014

Note: These two elements will be described separately below for clarity however the project intent is to have these two elements function as an integrated service.

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Project Scope

Deliverables:

Deliverable 1: Acute Inpatient care service using developed Best Practices in Rural (Stroke Unit Equivalent Care –SUEC)

Description:
The Stroke Action Plan Project will provide sites with the necessary additional staffing to carry out Best Practices on acute inpatient care services. SUEC focuses on identifying the minimum standards that are feasible for small urban and rural Primary Stroke Centres and that follow Canadian Stroke Best Practice Guidelines (CSBPG). Current practices in existing stroke programs shall be assessed and an individualized plan for enhancing care shall be implemented by working with the existing Stroke team. For sites that have implemented elements from the CSBPG, a large part of the project will focus on minimum requirements for the delivery of multidisciplinary rehabilitation services and implementing critical activities to support rehabilitation and adoption of CSBPGs. This service is also intended to integrate with any existing inpatient stroke services so that patients receive an integrated and seamless service.

Specifications:
At each site, the ESD/CR team will augment the acute inpatient stroke rehabilitation services. The role of the existing stroke team in ensuring CSBPG are met will continue but shall be enhanced with integration of the ESD/CR team. The stroke team will remain critical in the triaging of patients to the appropriate post-acute stroke rehabilitation service that will now include ESD/CR.

Participation in SUEC Improvement Collaborative Training sessions is required and encourages attendance by as many stroke team members along the entire continuum of care from the stroke team, acute care staff & rehab team, as possible. The first SUEC Collaborative is occurring December 3, 2013 in Edmonton. In addition, collection of specific inpatient care data (as described in deliverable 3) by team members is expected. This data will help support the continuation of the implementation beyond the length of the project.

Acceptance Criteria:
For this deliverable to be acceptable, all specifications above must be met.

Deliverable 2: Early Supported Discharge Service and Community Rehab for Stroke Care

Description:
Stroke ESD is a home/community-based service designed for mild to moderate stroke patients where stroke rehabilitation (rehab) is delivered in the patient's home instead of in the hospital. This service is designed to be intensive and patient goal driven. It provides the full spectrum of rehab where possible including speech language pathology, occupational therapy, physiotherapy and recreation therapy as well as nursing and social worker support. ESD significantly increases patient access to rehab and provides equivalent rehab services as inpatient rehab services for stroke patients with mild to moderate disability. This helps transition patients smoothly to continue their care in their own homes and communities and to provide rehab at the right time and place.

Specifications:

This service can potentially provide the full spectrum of rehab professionals if appropriate and available for the area and has allocated budget as follows. There is flexibility to adjust these FTE between disciplines within the allocated budget pending needs and available resources:

1. 0.5 Clinical Lead (OTII) – provide day to day management, provide evaluation feedback to unit manager, help with hiring staff, and ensure best practices are employed..
2. 0.5 Clerk III – administrative work as well as data entry from collected data. Coordination with SAP data collector.
3. 0.6 Occupational Therapist (OT I)
4. 0.5 Physiotherapist (PT I)
5. 0.4 Speech language pathologist II (SLP II)
6. 0.5 Social Worker II (SW II)
7. 0.5 Recreation Therapist I (RT I)
8. 0.4 Registered Nurse (RN)
9. 2.0 Therapy Assistants (TA)

Other than the Clerk, each of the team members delivering direct patient care will need a class 5 driver's license and access to an automobile. Therapy/service delivery times are expected to be tracked for all patients. Due to the community-based nature of the service delivery, the project will provide hired staff with cell phones and laptops on an as needed basis and all travel expenses incurred by staff while visiting patients in their homes is compensated. Sites will need to provide a dedicated space for the clerk and drop-in office space for a minimum of 5 ESD staff members at a time. The project provides a budget to modify current space if required. All staff member will participate in two start-up/Kaizen training sessions provided by the Stroke Action Plan's Practice Lead and Rehab Lead. In addition, some members will be asked to participate in an Improvement Collaborative Training sessions at participating AHS sites. The first ESD Collaborative session will be booked for a full day in March 2014, location TBA, and further collaboratives will occur quarterly until end of project, March 2015. The ESD portion will be amalgamated into the SUEC collaboratives thus may not duplicate staff involvement with SUEC collaboratives depending on individuals involved.
As the SUEC and ESD/CR are components of Stroke Care Delivery and the SAP's goal is to enhance current stroke services, the expectation is to intersect existing stroke initiatives at each site to help foster integration of care.

Acceptance Criteria:
For this deliverable to be acceptable, all the above specifications must be met. .

Deliverable 3: Stroke Patient Data

Description: Stroke patient data is the information gathered to monitor and evaluate the impact of the changes in acute inpatient stroke care over the duration of the project. This data will initially be collected manually through forms attached to the patient charts. Following discharge, the data collection forms will either be faxed to SAP's data collector or entered by local staff if feasible. During the course of the project, updates to the form may occur through addition or deletion of data elements. This will not be considered outside the scope of the project (unless the change has > 5% impact on overall schedule/timelines). In the specifications below is the list of elements that we will be collecting.

Specifications:

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Below are the proposed indicators that ESD/CR/SUEC staff is expected to collect:

Inpatient data elements (see appendix):

- SAP SUEC Staff Hour Tracking Sheet
- SAP SUEC Data Collection Form

Early Supported Discharge data elements:

Tool/Instrument	ESD Administration date	Scores/Info collected	Data Collector	HOW
AusTOMs OT	Intake date DC date	Admit scores DC scores	Intake therapist Last prof staff	F2F F2F
COPM	Intake date DC date	Admit scores DC scores	Intake therapist Last prof staff	F2F F2F
FIM™ Instrument	Intake date DC date	Admit scores DC scores	Intake therapist Last prof staff	F2F F2F
Client Experience Survey	2 weeks post service DC	Client experience	Admin Assistant	Phone
Participation	6 mos. from stroke date	RNLI	Admin Assistant	Phone
% returning to work	6 mos. from stroke date	question on 6 mo. ff-up	Admin Assistant	Phone

Process Indicators for ESD:

ESD Process Indicators	Data Elements
Inpt LOS	Inpatient admit date Inpatient DC date
Days to referral	Inpatient admit date Referral date
Referral to meet & greet	Referral date Meet & greet date
Referral to intake	Referral date Intake date
Intake to first therapy	Intake date First therapy date

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Intake to first TA contact	Intake date First TA appointment date
Days on service	ESD Intake date ESD DC Date
Weeks on service	ESD Intake date ESD DC date
Continuing care/rehab needs	Post DC referrals
Geographical distribution	Residence postal code
Service wait times	hospital discharge date ESD Intake date
Case cost	staff travel time Actual treatment times

Acceptance Criteria:

For this deliverable to be accepted, the above elements must be collected for all stroke patients and delivered to the SAP project team as feasible by the site. In addition, as the project progresses, additional elements may be amended.

Scope Exclusions:

Emergency and hyper acute treatment for stroke patients is excluded in this project.

Detailed Assumptions

It is assumed that:

- Hiring and daily supervision will be conducted by an appropriate manager at each site. Assistance will be provided where needed by the Project Team. It is suggested that following the OT II (Clinical Lead's) hire, this person will provide assistance to the Manager assigned in hiring the rest of the team. Management time will be a contribution in kind for general team supervision and time-keeping by each site unless special arrangements are made and approved by the SCN Manager. However, assistance will be provided by the SCN Manager to site managers for all recruitment processes including providing job descriptions approved through Job Evaluation, posting approvals and e-People on-boarding of new staff. The SCN Manager will also provide financial oversight to the project.
- All required ESD/CR staff will be hired by end of February 2014 if possible in order to provide teams enough time to have a measurable impact on patient outcomes by the end of project evaluation in March 2015.
- As the SUEC and ESD/CR are components of Stroke Care Delivery and the SAP's goal is to enhance current stroke services, integration with the existing St. Mary's Hospital Stroke Team is assumed. This will be validated by the SAP Practice Lead and Rehab Lead.

Constraints

The following restrictions apply to the project:

- Training must be under way by February, 2014 due to time constraints of the project.
- Implementation must be under way by March, 2014 due to time constraints of the project.
- Funding for this project will discontinue by March, 2015 unless sites are able to demonstrate acceptable outcomes as determined by senior AHS executive. If sites are successful in achieving these outcome, a 'transition to operations' plan will be implemented at the appropriate time and the site-based positions will become operationally funded.

High Level Schedule/Timelines:

1. A one week start-up/Kaizen training session is planned during first month once project team has been hired.
2. As we only have one set of SAP trainers, implementation of ESD/CR/SUEC is planned in a phased approach with other 4 named sites in the province to occur from September, 2013 to March, 2014 as determined by site readiness and SCN staff availability to provide start-up and training.
3. Where appropriate, a second Kaizen training session is planned to commence 10 to 12 weeks after the first ESD/CR client intake session.
4. Improvement Collaborative sessions will occur quarterly until the end of the project in March 2015.
5. Development of a transition to operations plan is planned for February 2015.

Scope Management

The following will be used to manage scope and the scope revision requests:

- Project scope changes will be documented, created into amendments, and approved by the SCN sponsor.
- Scope Changes will be specified and detailed which will be an agreement among the Project Manager and the Sponsor.
- Changes in the scope will be managed by the project manager will take responsibility for the implementation of this change.

Appendix 1

Stroke Action Plan Data Sheet – SUEC Staff Hour Tracking Sheet

ULI: ____________ Page ____

Date (dd-mmm-yy)	OT Hours	PT Hours	RT Hours	LSP Hours	Assistant Hours

Appendix 2

Stroke Action Plan Data Collection Form – SUEC Data collection Sheet

Chart Number		Date/Time of Initial Rehab Assessment	(dd-mmm-yy:hh:mm)
Hospital Name:		Projected Admission Alpha FIM Score	
Was patient admitted to a unit that manages stroke patients?	1. YES 2. NO	Date/time Alpha FIMs Done post registration to Hospital :	(dd-mmm-yy:hh:mm)
ULI:			
PHN:			
SEX (circle one)	1. Female 2. Male 3. Other	Post-acute Rehab Referral Date/Time:	(dd-mmm-yy:hh:mm)
Year of Birth:	(yyyy)	Projected Discharge Alpha FIM Score:	
Month of Birth:	(mm)	Date/Time of Discharge:	(dd-mmm-yy:hh:mm)
Day of Birth:	(dd)		
Postal Code:			
Date/Time Registered to Hospital	(dd-mmm-yy:hh:mm)		
Date/Time Standardized Stroke Order Sets Initialized	(dd-mmm-yy:hh:mm)	Discharge To (circle one number):	1. Home with ESD support only 2. Home with HC support only 3. Home w/ HC &ESD support 4. Home without support 5. Acute Inpatient care 6. Inpatient Rehab Facility 7. Senior housing 8. DSL 3 9. DSL 4 10. DSL4 Dementia 11. Long term care
Date/Time of Swallowing Screening:	(dd-mmm-yy:hh:mm)		
Date/Time of	(dd-mmm-yy:hh:mm)		

First Oral Intake:		facilities 12. Deceased 13. Other