The South West Stroke Project is developing and implementing initiatives to improve outcomes for people with stroke and transient ischemic attack (TIA). The project has two phases. Phase I is implementing recommendations to realign inpatient acute and rehabilitative stroke care from 28 hospitals sites to 7 Designated Stroke Centres. Phase II is creating recommendations to enhance secondary stroke prevention, outpatient and community rehabilitation and stroke support services.

Phase I update
Implementing and evaluating the recommendations for the future of in-hospital stroke care

Local Stroke Working Group (LSWG) Updates

Grey Bruce LSWG
Grey Bruce Health Services – Owen Sound Hospital (GBHS – OSH) began to care for patients with stroke from Hanover & District Hospital and South Bruce Grey Health Centre on January 16. This will result in approximately 300 more people coming to GBHS – OSH’s emergency department each year, and approximately 100 additional admissions to acute care. This realignment news was covered by local media (for more info see “In the News” on pg. 10 of this newsletter).

What they’re saying in Grey Bruce about stroke realignment

“Patients who come in with stroke symptoms receive a CT scan for accurate diagnosis and, if appropriate, they are treated with tPA—a clot busting medication that can potentially reduce or eliminate the damaging effects of stroke—all within 60 minutes.”
- Joan Ruston-Berge, Manager, Rehabilitation and Stroke, Grey Bruce Health Services,

“Stroke affects not only the survivor, but the entire family. The move toward concentrating expertise at Designated Stroke Centres, like Grey Bruce Health Services – Owen Sound Hospital, is an important part of providing a safer system of practice for stroke care that will improve clinical outcomes for the patient receiving the recommended best practice treatment in the critical early hours following symptom onset.”
- Katrina Wilson, President and CEO, Hanover & District Hospital

“South Bruce Grey Health Centre wants our local patients to have the best health outcomes after a serious incident like a stroke. Changes to stroke care for the residents of Grey and Bruce Counties will ensure that expert, comprehensive care is provided in a centre of excellence within our region.”
- Paul Rosebush, President and CEO, South Bruce Grey Health Centre

“Grey County Paramedic Services is pleased to partner with the South West Stroke Project and local health care facilities to ensure patients having a stroke receive the highest possible level of care.”
- Mike Muir, Director, Grey County Paramedic Services

“Recognizing the signs and symptoms of stroke and calling 911 immediately ensures paramedics can begin stroke care quickly and get the patient to the appropriate hospital for prompt treatment.”
- Raymond Lux, Acting Chief of Bruce County Paramedic Services
Elgin Oxford Norfolk (EON) LSWG
On Jan. 11 the Secondary Stroke Prevention Clinic (SSPC) at St. Thomas Elgin General Hospital (STEGH) moved to the ambulatory care area. Beginning in February, the SSPC will be accepting patients with a suspected Transient Ischemic Attack (TIA) referred from the emergency departments at STEGH and Tillsonburg District Memorial Hospital (TDMH).

The Southwestern Ontario Stroke Network’s Stroke Rehabilitation Unit orientation modules were sent out to the Integrated Stroke Unit staff for completion by the end of March. Sandi Pincombe, Elgin Oxford Norfolk Stroke Coordinator, is organizing STEGH’s facility-wide learning event for May which will focus on in-house code stroke. An education session was held Feb. 9 for TDMH emergency department staff on the walk-in protocol to transfer patients with suspected stroke to STEGH.

Meetings are being arranged with EMS stakeholders regarding destination policies to support the transfer of individuals with suspected stroke to UH (if within the tPA/EVT time window) or to STEGH (when outside the time window).

Huron Perth LSWG
Now that the Huron Perth hospitals have realigned stroke care to Huron Perth Healthcare Alliance – Stratford General Hospital, work is underway to collect data to create a picture of patient flow to date, and to evaluate processes. The Huron Perth hospitals are working together to address any concerns that may arise in the moment, and to make any needed changes to ensure a good patient experience.

Discussions are continuing with EMS partners on the destination policies for Huron and Perth. Names have been submitted for the patient focus groups in February to garner feedback on realignment to date.

London Middlesex Oxford (LMO) LSWG
Alexandra Hospital in Ingersoll (AHI) went live with realignment of stroke care on Nov. 21, 2016. “Alexandra Hospital is pleased to work with the London Middlesex Oxford Local Stroke Working Group to ensure patients who present to our emergency department with stroke symptoms are able to be transferred to University Hospital (UH) to be seen by the stroke team quickly and efficiently,” says Lori Smith, Director of Clinical Services at AHI. “The teams at AHI and UH have worked closely to establish protocols and guidelines and work through details as needed to improve this process. The working group helps us to follow up on concerns and provides us with ongoing information and education.”

Inpatient Rehabilitation – Woodstock Hospital
On Jan. 18, 2017, the Steering Committee approved the operational request from Woodstock Hospital to continue to provide stroke in-patient rehabilitation services for all severity levels of stroke as follows:

Patients who have a stroke and reside in Oxford County and receive acute care at LHSC-UH, will receive inpatient rehabilitation at Woodstock Hospital if that is their preference (with exceptions for some patients such as those with neurologically complex conditions*).

This operational request, which will impact approximately 8 to 15 patients annually, was vetted by a sub-committee that looked at a range of factors including patient care and experience, clinical expertise/best practices, and system process. It will be evaluated in one year by the Sustainability Governance Committee.

*If patients are assessed at LHSC-UH as requiring neurologically complex stroke inpatient rehabilitation care they will be referred to St. Joseph’s Health Care London’s Parkwood Institute.
**Paramedic Transportation Agreements**

In response to feedback received from the Paramedic Services and the Regional Base Hospital, a new approach is being initiated for patient transportation agreements that will see the existing Memorandums of Understanding between paramedics and hospitals replaced with two agreements: Destination Policies for each paramedic service and Repatriation Agreements between impacted hospitals.

The changes to Destination Policies will be led through each district’s Local Stroke Working Group (LSWG). For example, for the Elgin, Oxford and Norfolk LSWG, Elgin, Oxford and Norfolk counties will each have their own Destination Policy created by the EON LSWG and paramedic partners.

**Supporting Regional Access and Flow for Stroke Survivors**

A LHIN wide review of Repatriation Agreements is underway to create capacity and flow in the system as a whole. To complement the completion date for the realignment of services on March 31, 2017, the stroke program will be the first to draft and trial a Non-Refusal Repatriation/ Transfer Agreement to support the right care in the right place.

**Evaluation**

Work is proceeding on finalizing the indicators on the Regional Stroke Dashboard. To gather patient and family feedback on realigned stroke services, focus groups are planned for early this year starting with Huron Perth.

A feasibility study is underway with patient follow-up phone calls at St. Jospeh’s Health Care London’s Parkwood Institute and Grey Bruce Health Services’ Owen Sound Hospital, at discharge and 90 days post-discharge, with the goal of having outcome measurements in place by March 31, 2017. Woodstock Hospital will also adopt the stroke process for conducting discharge phone calls and Stratford’s process will start April 1.

Some of the questions being asked in the follow-up phone calls are from the PROMIS 10 (a set of person-centred questions). The recommendation is that this tool be used throughout the stroke region to enable analysis of patient outcomes.

**Phase I Next Steps**

- finalizing Destination Policies with each paramedic service and respective hospitals in each district, including obtaining signatures from paramedic chiefs and hospital CEOs
- developing new Stroke Survivor Repatriation Agreements for hospitals and obtaining signatures from CEOs
- completing the realignment of stroke services in all districts for patients outside of the 3.5 hour window for tPA/EVT treatment through a bypass of local hospitals regardless of patient symptom onset time
- confirming adequate bed capacity in future state hospitals to support the full realignment of stroke services to designated stroke centres
- finalizing Regional Stroke Dashboard indicators
- continuing to develop sustainability and evaluation frameworks to monitor performance and quickly respond to system changes at a regional and district level.
The first session of the Case-Based Stroke Education Series was hosted by Huron Perth Healthcare Alliance - Stratford General Hospital on Jan. 26. Five Designated Stroke Centres in the South West and Erie St. Clair LHINs participated in this event, with 32 physicians and nurses attending. The event was well received with suggested future topics including stroke mimic differentiation, hypertensive stroke management, hemorrhagic stroke management, and stroke rehab management. The archived recording of this session can be viewed here: http://webcast.otn.ca/mywebcast?id=63278055

To support education for Emergency Department staff from non-designated hospitals on the recognition of stroke and TIA and the updated Walk-In Stroke Protocols, a one-pager of key messages is available for each stroke district. Click below to see your district-specific one-pager:

- Grey Bruce
- Huron Perth
- Elgin Oxford Norfolk
- London Middlesex Oxford

To support the ongoing accurate collection of rehabilitation outcome measures (i.e. Functional Independence Measure), a 30 minute education session is being offered to front-line nursing and allied health providing rehabilitation at Designated Stroke Centres. To maximize attendance, this session will be offered twice: once on Feb. 10 and once on Feb. 24 from 14:00 - 14:30, and archived for later viewing.

To register or for more information, please contact your local District Stroke Coordinator or Lyndsey Butler, Regional Education Coordinator, at 519-685-8500 x34899 or Lyndsey.butler@lhsc.on.ca

Visit the South West Stroke Project Phase I education web page for more information on upcoming education and available resources at http://swostroke.ca/swsp-phase1-education/

Dr. Shanil Narayan, third from left, speaking at the first Case-Based Stroke Education session.
Phase II update

Creating recommendations for the future of post-hospital stroke care

Here’s an update on the initiatives underway for the two project teams: the Community Rehabilitation and Recovery for Stroke Survivors (Community Rehabilitation & Recovery) Project Team and the Secondary Stroke Prevention Project Team.

In January, the Phase II Steering Committee Co-Chairs Roy Butler and Anne Campbell presented the draft recommendations to the CNE Leadership Forum, and Deb Willems, Co-Chair of the Stroke Rehabilitation & Recovery Project Team, presented to the Southwest Ontario Aboriginal Health Access Centre.

Gwenyth Stevenson, Regional Prevention and Thames Valley Coordinator, is working with the LHIN Primary Care physician leads to validate the recommendations related to primary care. She is continuing to vet the draft recommendations with physician specialists, and is connecting with nurse practitioners to discuss their role with patients who do not have a primary care provider. The draft recommendations will continue to be updated based on feedback from these presentations.

Work is continuing on refining these recommendations, with the Community Rehabilitation & Recovery and Secondary Stroke Prevention recommendations now woven together under four themes:

- Community Hubs
- Specialized Intensive Rehabilitation Teams
- Ongoing Support & Recovery
- Rapid Specialized Medical Services

Stroke System Planning Model

Based on the work performed to date by the Project Team, combined with evidence from the Quality-Based Procedures: Clinical Handbook for Stroke (Acute and Postacute), a stroke system planning model has been developed. This model estimates the number of patients who would access each post-hospital rehabilitation and recovery service, and secondary stroke prevention service in the proposed future state system; for example, how many would access each Community Hub.

In the coming months this model will continue to be refined and elements shared with regional stakeholders. This work will help to inform future Stroke Project work by further defining possible implementation strategies.

Next Steps

- continuing with presentations of draft directional recommendations from February through to March to stakeholders in the South West LHIN including Community Support Services Council, CEO/CCAC Leadership Forum, and the South West LHIN Board of Directors
- finalizing Phase II draft directional recommendations report
- high level planning for implementation, which includes gathering data and resources to inform the implementation phase
- working with a graphic designer to develop diagrams to depict the directional recommendations and the patient journey for the final report.
Following people with stroke and TIA through the continuum of care

The brain’s ability to recover from a stroke is greatest in the first three to six months following a stroke. In some cases, recovery may even continue for years. With stroke survivors spending about a week in acute care and, if required, about four weeks in inpatient rehabilitation, there is still the potential for significant recovery when they leave the hospital. That’s why it is so important to continue specialized intensive rehabilitation for those who require it after they are discharged from hospital into the community.

After discharge from hospital, stroke survivors in the South West LHIN can access specialized intensive therapy in two ways:

- Community Stroke Rehabilitation Teams
- Outpatient Rehabilitation.

The interdisciplinary teams from these services meet regularly and set coordinated care plan for clients, and strive to meet the best practice which indicates the intensity of treatment is two to three visits per week for 8 to 12 weeks for each of the core disciplines (Occupational Therapy, Physiotherapy, and Speech Language Pathology).

Community Stroke Rehabilitation Teams

The Community Stroke Rehabilitation Teams (CSRTs) provide intensive therapy right in the home. Partnering closely with the Community Care Access Centre and primary care providers, the CSRTs provide the therapy, education and support to help stroke survivors reach their potential. This includes support for families and caregivers.

There are three CSRTs in the South West LHIN located in:

- Grey Bruce, based at Grey Bruce Health Services – Owen Sound Hospital
- Huron Perth, based at Seaforth General Hospital
- Thames Valley, based at St. Joseph’s Health Care London - Parkwood Institute, and serving Oxford, Elgin, Middlesex and Norfolk (west) Counties

Referrals to the CSRTs come from many sources including patients, physicians, and inpatient acute or rehabilitation units. Referrals are managed centrally at Parkwood Institute by Karen Heys, CSRT Team Assistant. Susan Davis Bailey, CSRT Coordinator, is also based at Parkwood Institute and coordinates the three teams and manages the Thames Valley team. The Grey Bruce and Huron Perth CSRT teams are managed by Joan Ruston Berge and Bonnie Thompson respectively.

Each CSRT team has a registered nurse, physiotherapist, occupational therapist, and speech language pathologist, social worker, and recreation therapist and rehabilitation therapist/facilitators. While the duration of therapy received depends on personal needs and rehabilitation goals, currently the average length of CSRT service is approximately two months.

For more information on the CSRTs: https://www.sjhc.london.on.ca/stroke-rehabilitation-programs/community-stroke-rehabilitation-team
Huron Perth CSRT

Back row: Holly Graham, TRS; Megan Querin, SLP; Chelsea Coghlin-Fewster, RT; Halee McCann, RT.

Front row: Grace Benedict, RN; Sarah McIntosh, OT; Erin Bickell, SW; Crystal Stewart, RT; Bela Makwana, PT.

Grey Bruce CSRT Team

From left, Stephanie Hughes, OT; Alison Farrar, PT; Kelly Miller, Rehab Facilitator (RF); Kim Dutfield, RN; Jennifer Beaney, RF; Stephanie Barker, OT; Sharon Gray, SW; Tammy Robinson, admin support; Caris Hamilton; SLP; Natasha Buchanan, RF.

Absent from photo: Jenna Underwood, Recreation Therapist; and Joan Ruston Berge, Manager.

Thames Valley CSRT Team

Back row: Crystal Branco, SLP; Karen Heys, Team Assistant; Sarah McSheffrey, SLP; Susan Davis-Bailey, Coordinator; Erin Estabrooks, RN; Christine Naraine, RT; Heather Beecroft-Rock, SW; Cathy Smiley, OT; Eric Keep, SW; Rob Ziegler, RT.

Front row: Sara Pollock, RT; Martha Scott, OT; Paula Wilcox, PT; Janice Wilson, PT; Meaghan Macpherson, RT; Laura Veenstra, TRS; Fabian Krupski, PT. Absent from photo: Karen Sutherland, RN; Larissa McBean, Unit Secretary; Janna Elder, RT; Desiree Hayes, RT; Mireille Testa, OT; Ellyn Suski, SLP.
Specialized stroke outpatient programs

Specialized outpatient rehabilitation is for stroke survivors who have the physical ability and the means of transportation to leave the home and attend an outpatient program. These programs offer stroke survivors a chance to connect with peers, and to use rehabilitation equipment that would not be available through home based teams.

In the South West LHIN there are two intensive outpatient programs serving stroke survivors: St. Joseph’s Health Care London’s Comprehensive Outpatient Rehabilitation Program (CORP) at Parkwood Institute and Woodstock Hospital’s Intensive Rehabilitation Outpatient Program (IROP).

St. Joseph’s Health Care London’s Parkwood Institute – CORP

Parkwood Institute offers a specialized neurological outpatient program called CORP (Comprehensive Outpatient Rehabilitation Program). Therapists here primarily treat stroke, as well as some other neurological conditions. Therapy includes physiotherapy, occupational therapy, speech-language pathology and social work. Both single-service and multi-service referrals are accepted. On average, the length of stay with the CORP program is 10 weeks with two visits per week.

At Parkwood Institute physiatrists Drs. Doherty, Macaluso, Teasell and Viana, who specialize in physical medicine and rehabilitation, follow stroke survivors in outpatient clinics.

Parkwood Institute also offers stroke survivors specialty clinics that include seating assessments and botox treatments for spasticity.

“Providing a direct conduit from inpatient to outpatient care helps with system flow efficiencies, enabling our inpatient rehab beds to be available for acute patients while maximizing the recovery window for the rehab patient in a timely manner,” says Eileen Britt, Neuro/Stroke Rehabilitation Coordinator at Parkwood Institute.

Patients referred to CORP directly from acute care at London Health Sciences Centre – University Hospital, or from inpatient rehabilitation at Parkwood Institute, are given priority, as well as referrals that highlight safety concerns such as patients from the community who are falling or demonstrating swallowing challenges.

Eileen adds that the value of CORP is its location at Parkwood Institute with easy access to physiatry outpatient clinics and specialty consultations, there is continuity of care from the inpatient unit, and there

The CORP Team at Parkwood Institute
Back row: Heather Cassidy, OT and Tricia Shoniker, OT. Front row: Darlene Vandesompele, PT; Danya Walker, SLP; Shannon Honsberger, OT; Krisztina Huszar, PT; Maria Fraumeni, Office Assistant; and Eileen Britt, Coordinator.
are linkages with Community Stroke Rehabilitation Teams on site. It is a one stop stroke service. CORP supports patients with their reintegration to their community and previous life role. Opportunities to support return to work, return to school, and return to life’s most meaningful activities are encompassed in the stroke patient’s individualized care and treatment plans. The interdisciplinary team is very experienced and experts in the care, treatment and recommendations they provide so patients have complete confidence and can maximize their potential.

Woodstock Hospital - IROP

Woodstock Hospital offers the clinic-based Intensive Rehabilitation Outpatient Program (IROP) that provides interdisciplinary rehabilitation to clients with neurological, orthopaedic and cardiorespiratory conditions as they transition from acute care into the home. The program promotes function and independence and also strives to prevent hospitalization.

Each rehabilitation plan is individualized and developed in collaboration with the client to meet their goals. The length of stay in the program varies and is based on each individual’s rehabilitation plan, but averages six to eight weeks in duration. To be eligible for IROP, clients must require a minimum of two health disciplines and can receive physiotherapy, occupational therapy, speech language pathology, social work and recreation therapy.

Dr. Oleg Tugalev, a hospital-based physiatrist, provides physician support to clients and the team through clinic visits and regularly scheduled patient rounds.

“The program has been a tremendous asset to our community” says Sean Willis, Director of Therapy at Woodstock Hospital. “It not only offers support to our inpatient rehabilitation unit and provides continuity of care for our clients, but it is based in Oxford County and can facilitate personalized re-integration back into their community.”

Once stroke survivors are finished with the CSRT and/or specialized outpatient services, they can continue their recovery at community-based programs such as exercise classes and stroke specific Adult Day Programs.

The Phase II draft directional recommendations are geared toward ensuring stroke patients have adequate opportunities for continued recovery after discharge. These recommendations will be presented to the South West LHIN Board of Directors in March 2017.
In the news

Grey Bruce stroke realignment – media coverage

Owen Sound Sun Times
Blackburn News
Bayshore Broadcasting
The Kincardine Independent
Kincardine News
South Bruce Grey Health Centre website

Grey Bruce Health Services:
- posted to newsflash section of intranet
- posted on web
- Tweet sent via @GreyBruceHealth: All stroke pts in #GreyBruce to be treated @ Designated Stroke Centre at the Owen Sound Hospital: http://ow.ly/U3qF3089JhP @SouthWestLHIN

South West Stroke Project partners will work to improve stroke care across region

Grey-Bruce is playing an integral role in the South West Stroke Project.
The program is realigning stroke care in the South West Local Health Integration Network (LHIN) to ensure people who have a stroke or TIA (transient ischemic attack or mini-stroke) receive the best possible stroke care, and achieve the best possible outcomes. “South Bruce Grey Health Centre wants our local patients to have the best health outcomes after a serious incident like a stroke,” said Paul Rosselows, president and CEO at South Bruce Grey Health Centre.

“Changes to stroke care for the residents of Grey and Bruce Counties will ensure that expert, comprehensive care is provided in a centre of excellence within our region. The project will seestroke expertise concentrated at our two Designated Stroke Centres, including, within our region, Grey Bruce Health Services – Owen Sound Hospital and Alexandra Marine and General Hospital in Goderich. With stroke every minute counts, so it is vitally important for people who are having the signs of stroke to call 911 immediately so the paramedics can begin care as quickly as possible en route to the closest Designated Stroke Centre. Recognizing the signs and symptoms of stroke and calling 911 immediately ensures paramedics can begin stroke care quickly and get the patient to the appropriate hospital for prompt treatment,” said Raymond Lau, acting chief of Bruce County Paramedic Services.

View the Grey Bruce 911 stroke video about the importance of calling 911. Realignment of stroke care in Grey Bruce to the District Stroke Centres will be complete in March 2017. In realigning stroke services, we are helping to ensure people across our LHIN are getting equitable access to best practice stroke care,” said Michael Barrett, CEO of the South West LHIN. “Stroke survivors have the best outcomes when they are cared for as a unit that specializes in stroke services and provides best practice care. These changes to how we deliver stroke care are helping to reduce mortality and improve the outcomes of stroke survivors throughout our geography.” For more information on the South West Stroke Project at swstroke.ca/about-us.

From Kincardine News

F.A.S.T. video promotion
Please continue sharing the 30-second F.A.S.T. video specific to your stroke district to encourage people to call 911 if they experience the signs of stroke.

South West Stroke Project web pages
Click here to view the South West Stroke Project web pages—a central resource for upcoming education opportunities and tools to help you communicate about the South West Stroke Project work.