Key Principles – Access to Stroke Rehabilitation
March 2019

Preamble:
Patients should be able to receive rehabilitative care in a facility close to home as quickly as possible, without being penalized for first receiving acute or rehabilitative care elsewhere due to the nature of their stroke[a] onset (e.g. while on vacation out of town) or established regional referral partnerships. Flexibility is needed when addressing the flow of patients across regions so that patient centered care is provided. This document presents "key principles" that capture the general essence of the issues generated when a patient requires a geographical transition for post-acute care or when rehabilitation referrals come from atypical referral sources. These "key principles" must be considered in addition to standardized eligibility criteria[1] and facility processes. While difficult to quantify, these atypical cases are small in number but have the potential to significantly impact upon seamless patient/family centered care, and may influence clinical efficiencies and program metrics.

Why This Matters:
In Ontario, health care transformation is occurring to ensure patients have better access to health services when and where they need it. Access to rehabilitation is an important part of building a connected health care system that centres on the needs of the patient and their families. It is expected that "Health care providers will be accountable for the patients they serve and will partner to effectively coordinate their care."[2]

Early rehabilitation results in improved outcomes and can allow individuals to continue to live, work and engage in their community. Canadian Stroke Best Practice recommendations state that rehabilitation plans should be patient-centered, based on shared decision-making, culturally appropriate, and incorporate the agreed-upon goals and preferences of the patient, family, caregivers and the healthcare team[3].

Key Principles: To be applied to decision making processes for access to bedded or community-based levels of rehabilitative care:

Key Principle	Rationale/Supporting References
1. Patient meets rehabilitation eligibility criteria.	Provincial standards for rehabilitative levels of care across the continuum of care, including eligibility criteria, have been established to provide clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care: 1. Definitions Framework for Bedded Levels of Rehabilitative Care 2. Definitions Framework for Community Based Levels of Rehabilitative Care Additionally, criteria have been developed as part of the Canadian Stroke Best Practice Recommendations[3] to provide guidance and increase consistency on key elements that should be considered in decision-making regarding stroke rehabilitation for individual patients. • BOX ONE: Eligibility and Admission Criteria for Stroke Rehabilitation: http://www.strokebestpractices.ca/stroke-rehabilitation/

[a] or other applicable condition requiring time sensitive rehabilitative care, i.e. trauma, fracture, acquired brain injury

2. A direct transfer to inpatient rehabilitation is in the best interest of the patient.	Direct transfers to inpatient rehabilitation should be possible from any setting if eligibility criteria are met, and all required referral information is complete. Transferring from an acute to acute site, when patient care needs do not require a subsequent acute admission to complete required rehab referral information is inefficient, costly and not patient centered. Facilities should determine if the patient may be more appropriate for a direct rehabilitation/inter-facility transfer. Canadian Stroke Best Practice Recommendations[4] state that strong relationships and formal agreements among healthcare providers within regions are recommended to increase the efficient and timely transition of patients. It is suggested that this concept would also extend to providers across regions.
3. Stroke rehabilitation should be delivered by a full complement of health professionals, experienced in providing post-stroke care, regardless of where services are provided.[3]	Canadian Stroke Best Practice Recommendations[3] speak to the value of receiving specialized stroke care across settings (acute care hospital, inpatient rehabilitation, ambulatory clinic, community-based services and programs). Similar to acute care, where guidelines[5] support patients being transferred to the most appropriate setting to meet their care needs, patients requiring stroke rehabilitation should have access to a full interprofessional stroke rehabilitation team as close to home as possible.
4. Patient's intended discharge address will align with catchment area of receiving program/facility.	Stroke is a life-altering event which may result in a prolonged hospitalization and a decreased level of independence compared to pre-stroke function. During hospitalization (acute or inpatient rehab) it may be determined that a patient may need to relocate upon discharge in order to support their ongoing care needs. This planned relocation upon discharge is often undertaken when it is determined that patients will need more care than they currently have in their home/home community. If a patient intends to relocate in order to receive best-practice care and/or to receive support from family/caregivers, it is recommended that they be deemed eligible for admission to the facility in the area of their *intended* new address. Delays in officially processing a change of address request can unduly impede timely access to rehabilitation care.

5. Discharge planning supports, in the final discharge destination, are required prior to transition to community.	The Canadian Stroke Best Practice Recommendations[4] outline numerous recommendations with respect to the complexity of discharge planning:
	• Effective discharge planning is essential for smooth transitions through the continuum of stroke care. Delayed or incomplete planning leads to prolonged hospital stays and an increased risk of adverse events following discharge. The use of discharge plans was associated with a significantly reduced LOS and a significant reduction in readmissions at 3 months.
	  ○ Processes, protocols, and resources for conducting home assessments by interprofessional team members prior to discharge should be available.
	  ○ Patients, family members and healthcare providers involved in each phase of care should all be involved in discharge planning to ensure effective and safe transitions.
	
	Transitions between and within health care settings pose a safety and quality of care concern for patients recovering from stroke. A consensus policy statement by the American College of Physicians in 2009 highlighted concerns of patient safety at transition points, particularly between inpatient and outpatient care[6].
	
	Effective communication and collaboration between the referring and the receiving program/facility in these cases is of utmost importance.

ACTION REQUIRED/RECOMMENDATIONS:

It is requested that the Regional Stroke Networks, Rehabilitative Care Alliance and CorHealth Ontario:

1. Adopt these key principles as part of rehabilitation system planning, policy change and bundled care planning for stroke.
2. Ensure that future rehabilitation funding models and evaluation metrics take into account patients entering rehabilitation outside of typical referral partnerships so as not to disincentivize patient-centered care.
3. Endorse and share the "key principles" with appropriate health care provider organizations to inform local implementation.

This document has been prepared by the Ontario Regional Stroke Networks through the Rehabilitation Transfer Working Group.

REFERENCES

1. Rehabilitative Care Alliance:
   Definitions Framework for Bedded Levels of Rehabilitative Care
   Definitions Framework for Community Based Levels of Rehabilitative Care
2. Ontario Ministry of Health and Long-Term Care. Building a Connected Public Health Care System for the Patient (February 26, 2019):
   https://news.ontario.ca/mohltc/en/2019/02/building-a-connected-public-health-care-system-for-the-patient.html
3. Canadian Stroke Best Practice Recommendations: Stroke rehabilitation practice guidelines, update 2015:
   http://www.strokebestpractices.ca/stroke-rehabilitation/
4. Canadian Stroke Best Practice Recommendations: Managing transitions of care following Stroke, Guidelines Update 2016:
   https://www.strokebestpractices.ca/recommendations/managing-stroke-transitions-of-care
5. Repatriation Guide Critical Care Services Ontario (2014):
   https://www.criticalcareontario.ca/EN/Toolbox/Repatriation/CCSO%20Repatriation%20Guide%20(2014).pdf
6. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. Snow V et al. J Gen Intern Med. 2009 Aug;24(8):971.