

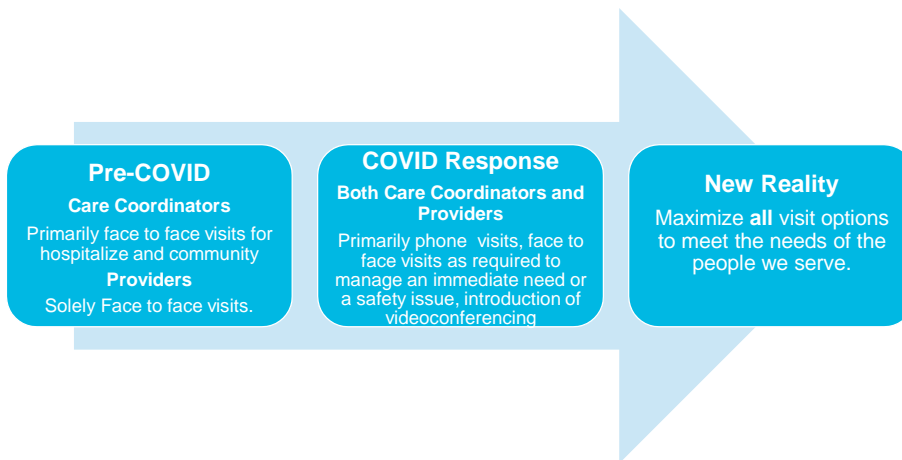
North Simcoe Muskoka LHIN | RLISS de Simcoe Nord Muskoka

Virtual Home Care for Stroke and Acquired Brain Injured People in NSM LHIN

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Virtual Care in Home and Community Care



Virtual Care in Home and Community Care

Immediate COVID challenges and barriers

- Cancellation of in-home visits and care by patients who and asked that their services be temporarily put on hold
- Facility visitor restrictions
- Facility COVID outbreaks
- Health Human resources limitations – available staff, work from home.
- Availability/conservation of Personal Protective Equipment (PPE)

Virtual Care in Home and Community Care

Implementation Virtual Care

Care Coordinators

- Informed consent and security for videoconferencing
- Videoconferencing technology availability
- Developed processes, documentation standards
- Educate staff

Providers

- Guidelines; Face-to-face, videoconferencing and telephone visits.
- Virtual care visit billing rates

Supporting Stroke Care

- Continued to receive referrals from the hospitals to the community for patients who recovering from a stroke.
- Significant decrease in the # of Stroke Pathway referrals from all but one LHIN Hospital.
- Continue to provide services using the method that best met the person's needs and the situation.

NSM LHIN Home and Community Care

Stroke and Acquired Brain Injury (ABI) Pathways

- Package of rehabilitative services provided to adult patients who have experienced a stroke or ABI.
- May be provided along with nursing and personal support.
- Focus on improving functional abilities and reintegration into the community.

Stroke and ABI Pathways

Eligibility

- Valid Ontario Health Card.
- Services must be required to enable the person to remain in their home.
- Unable to access community services.
- Must have long-term rehabilitation goals related to maximizing independence and community integration.
- Reasonable expectation that the person will benefit and improve.

Stroke and ABI Pathways

Referral: generated from hospital rehabilitation units

Services:

- NSM Home and Community Care Coordinator
- Any combination of 2 Therapy Services: Occupational Therapy – 8 visits, Physiotherapy – 16 visits, Speech Language Pathology – 6-14 visits, Social Work – 8 visits
- Nursing, Personal Support, Dietician authorized as required and following HCC Guidelines.
- Short Term (30 days) equipment rental may also be provided to support hospital discharge.

It is recognized that the anticipated pathway of recovery for a stroke survivor is variable and services will be adjusted as required. Therapist requests therapy service discharge when patient achieves their goals.

Expansion of Virtual Care in Home and Community Care

- Evaluate lessons learned from immediate need to deliver care virtually: How many services were provided virtually? What worked, what didn't, what do we keep doing, improve, stop doing?
- Development of Guiding Principles and Central Region work plan to improve access to care using virtual care.
- For stroke care take into consideration CorHealth COVID-19 Memo #4 Recommendations as they relate to Home and Community Care.
- Look for opportunities to expand virtual care, hybrid model (ex. Virtual OT Hospital Pre-Discharge Assessments).

Resources

Core Health, Memorandum #4. Recommendations for an approach to resuming outpatient stroke rehabilitation services in Ontario. July 7, 2020. [https://www.corhealthontario.ca/CorHealth-COVID-19-Stroke-Memo4-\(July-7-2020\).pdf](https://www.corhealthontario.ca/CorHealth-COVID-19-Stroke-Memo4-(July-7-2020).pdf)

NSMLHIN Home and Community Care Stroke and Acquired Brain Injury Pathways – A resource for Health Care Professionals. March 10, 2020.

Pan-LHIN Guidelines for Virtual Home Care, Central LHIN, April 20, 2020.

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11