



## Facilitating Transitions in Stroke Rehabilitation clients. The SCRIPT Project

Toronto West Stroke Network

- Dr. Mark Bayley, Chair, SCRIPT Advisory Committee
- Jacqueline Willems, Regional Coordinator, Toronto West Stroke Network
- Mary Ann Neary, Manager, Allied Health, University Health Network
- Laurie Hurley, Project Coordinator, SCRIPT Project
- Nicola Tahair, Research Associate, SCRIPT Project

## OUTLINE



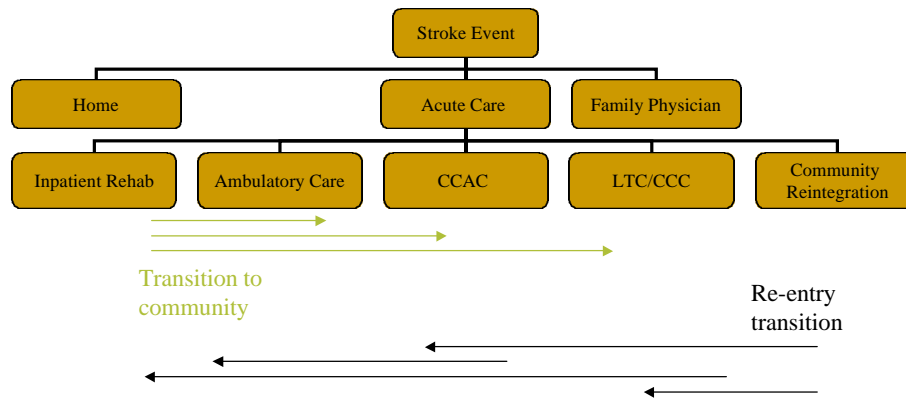
- Background
- Objectives
- Methods
- Results and Challenges
- The Vision/Benefits

## Background



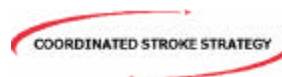
- 1/6 Rehabilitation Pilots for the Ontario Stroke Strategy
- Urban environment with large number of organizations with multiple rehab providers
- Goal: improve access, coordination, outcomes
- SCRIPT= Stroke Coordinated Referral Initiative Pilot Toronto

## Rehabilitation Setting Options for clients with Stroke



Host site	Acute	Inpatient Rehab	Ambulatory Care/Day Hospital	CCAC	LTC/CCC
UHN	X				
Mt Sinai Hospital	X				
SWCHSC	X				
St Michael's Hospital	X				
St Joseph's Health Centre	X				X
North York General Hospital	X	X			X
St John's Rehabilitation Hospital		X	X		
Providence Centre		X			X
Bridgepoint Health		X	X		X
Toronto Rehab Institute		X	X		X
West Park Healthcare Centre		X	x		
Toronto CCAC				X	
Leisureworld					X

## Objectives Phase 1



- Exploration of strengths and weaknesses of current referral processes
- Design of new centralized referral system
  - Standardized forms
  - Aligned admission criteria
  - Defined wait criteria
  - Creation of Triage Tool
  - Creation of Brochures to educate clients
  - Staff training
  - Database setup

## Objectives Phase 2



### Collect baseline measures

- ❑ Activity and participation status (FIM) of discharged clients
- ❑ Cognitive status
- ❑ Severity tracking: CT scan results, CNS scale
- ❑ Client preference for placement
- ❑ Actual referral destinations
- ❑ Length of stay at each destination
- ❑ Wait time
- ❑ Response time to referral requests
- ❑ # of services accessed at next destination
- ❑ Client satisfaction with service at departing agency

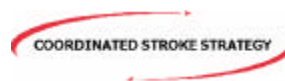
## Objectives Phase 3



### Implementation of centralized referral process

- ❑ Monitor process for compliance
- ❑ Evaluate change from baseline measures

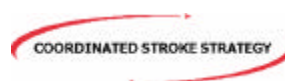
## Methods



### Champions Tasks

- Recruit clients; ensure client consent is received
- Manage information on clients in project who are at their facility,
- Ensures data collected appropriately, on time
- Advocate for use of referral system
- Identify most timely route to obtain permission to collect data on site.
- Provide feedback on feasibility of collecting data in an ongoing fashion
- Forward communications strategies
- Assist to identify key personnel on site required to participate (chiefs of staff, health care teams)
- Be listed in consent form to call if problems

## Project Team Tasks



- Maintain strict privacy and confidentiality of all client records
- Acquire needed licenses
- Administer development, collation and reports generated from database
- Train champions and rehab professionals to complete referral process tools
- Track incomplete records, clean and monitor data

## Timelines



- Start dates for each phase:
  - Phase One: project design: begun November 1-2002, completed August 31, 2003.
  - Phase Two: Baseline: Begun June 4, 2003- completed mid October 2003.
  - Phase Three: implementation: Began mid-October 2003- completed September 2004

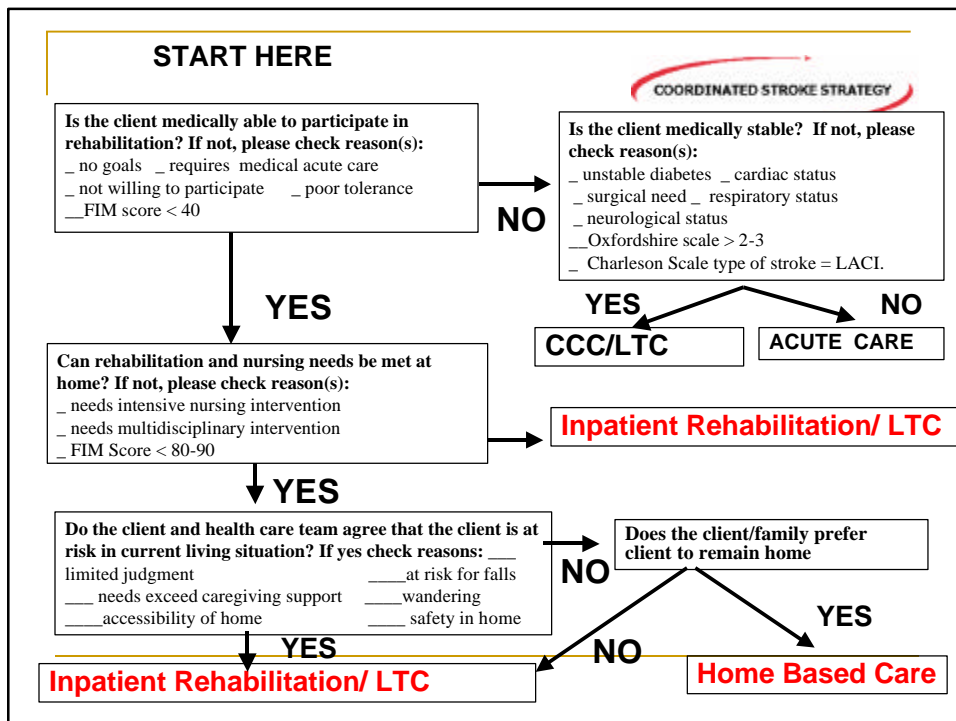
## Milestones

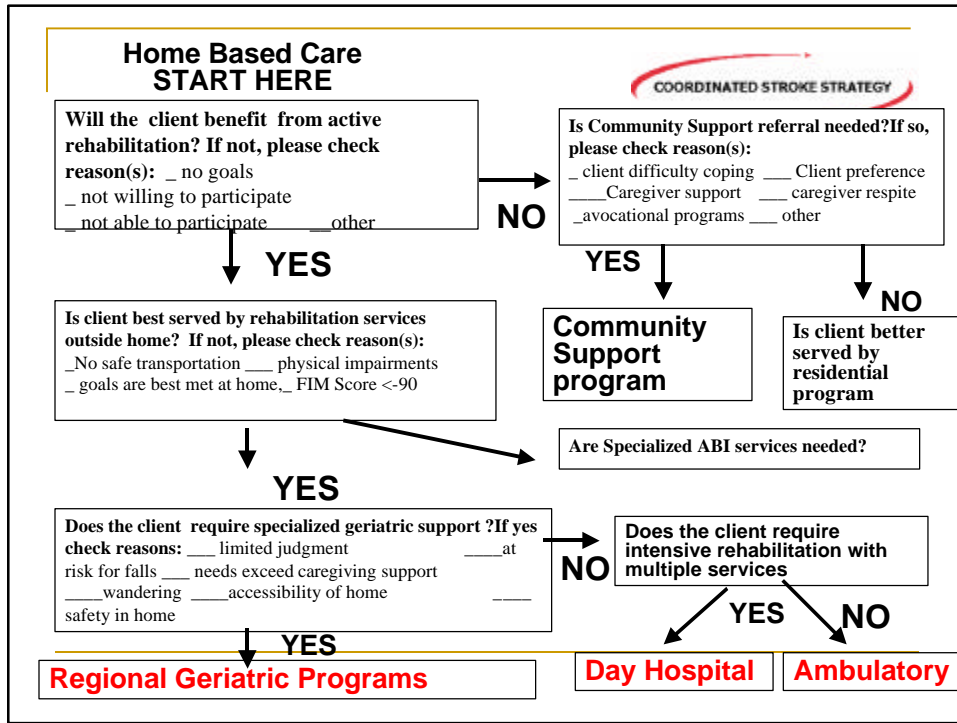


- Ethics approval for implementation at 13 sites
- Database and website operational
  - Transition Information Guide Completed, available on SCRIPT website <https://www.onstrokenetworkto.com>
  - Standardized assessment and referral form completed, on SCRIPT website
  - Admission Criteria templates finalized September and on GTA Rehab Network website; [www.gtarehabnetwork.com/main.asp](http://www.gtarehabnetwork.com/main.asp)
  - Triage Tool completed, on line at [http://www.gtarehabnetwork.ca/s\\_main.asp](http://www.gtarehabnetwork.ca/s_main.asp)
  - Contract finalized with NRC Picker to share data from CPRS (Client Perceptions of Rehabilitation Services) Questionnaire

# Example of Tool to better coordinate referral

## Triage tool for Stroke Patients





**COORDINATED STROKE STRATEGY**

- Example of SCRIPT Web based referral form

File Edit View Favorites Tools Help

COORDINATED STROKE STRATEGY **Toronto West Stroke Network**

The SCRIPT (Stroke Coordinated Referral Initiative Pilot, Toronto) Project

HOME | ABOUT US | FACILITIES | REFERENCES

**Demographics: Max Factor**

Added by Laurie Hurley on 07/24/2003; Last updated by Laurie Hurley on 08/18/2003;

**Identifier**

Fields marked with an asterisk (\*) are required.

\* First Name: Max  
 \* Last Name: Factor  
 \* Gender: Male  
 \* Birth Date: (yyyy/mm/dd) 1985 / 2 / 10  
 Health Card Number: 12345678  
 Province/Territory Issuing Health Card: Ontario  
 MRN Number: 32345  
 \* Service Provider: Tahar, Nicole

**Demographics**

Marital Status: Married  
 Primary Language Spoken: Greek  
 Home Address: 37 Moberly Ave Toronto ON  
 Mailing Address: (if different from home address)

File Edit View Favorites Tools Help

COORDINATED STROKE STRATEGY **Toronto West Stroke Network**

The SCRIPT (Stroke Coordinated Referral Initiative Pilot, Toronto) Project

HOME | ABOUT US | FACILITIES | REFERENCES

**Medical Assessment: Max Factor**

Added by Laurie Hurley on 07/24/2003; Last updated by Laurie Hurley on 08/11/2003;

Fields marked with an asterisk (\*) are required.

Tester: Laurie Hurley

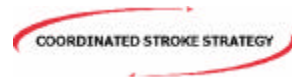
\* Assessment Date: 2003 / 7 / 24 (yyyy/mm/dd)  
 \* For which episode: St Michael's Hospital - 07/23/2003

**Charlerson Comorbidities Scale**

**Weighting impact of Comorbidities on rehab potential**

Instructions: For each pre existing co morbid condition, assign a weighted score using the chart below. Total all scores for the final impact score. Example: chronic pulmonary (1) + lymphoma (2)= total score (3). Scores > 2-3 may significantly impact abilities to participate/benefit from rehab.

Condition	Weight
<input type="checkbox"/> Myocardial Infarct	1
<input checked="" type="checkbox"/> Congenital Heart failure	1
<input type="checkbox"/> Peripheral vascular disease	1
<input type="checkbox"/> Cerebrovascular disease	1
<input type="checkbox"/> Dementia	1
<input type="checkbox"/> Chronic pulmonary disease	1
<input type="checkbox"/> Connective tissue disease	1
<input type="checkbox"/> Ulcer disease	1



## How did the current system perform?

- Baseline Results

## Baseline completed



- 75 clients enrolled
- 3/6 acute care sites participated
- All rehab sites participated
- CCAC and Day Hospitals participated

### Implementation Phase begun

- Training in forms (November)
- Recruiting and faxing in recruited clients (November)
- Implementing electronic referral (February)



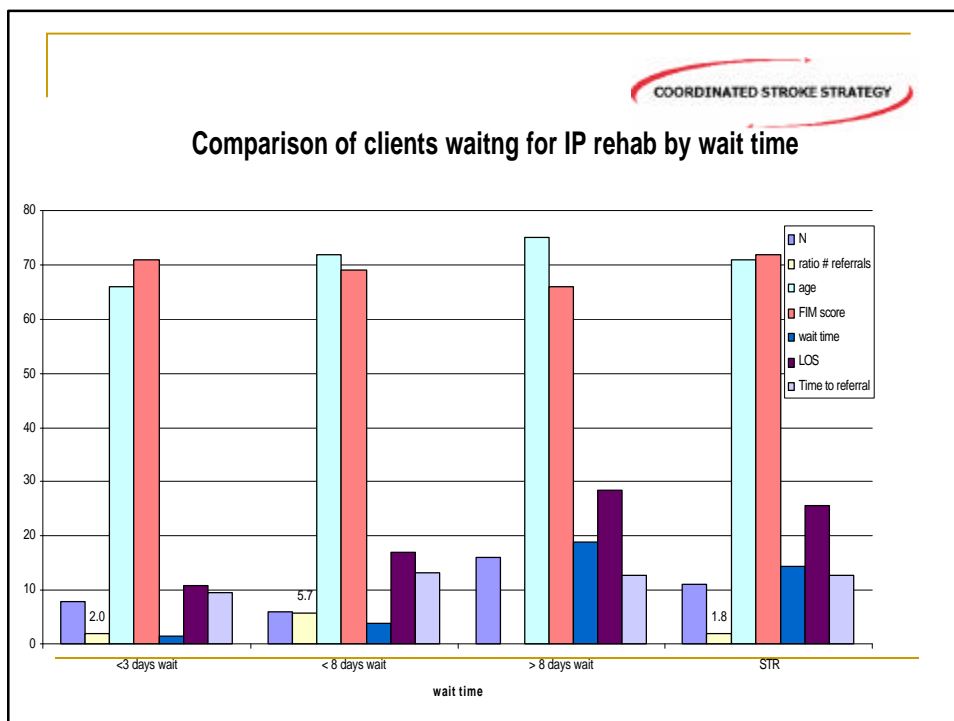
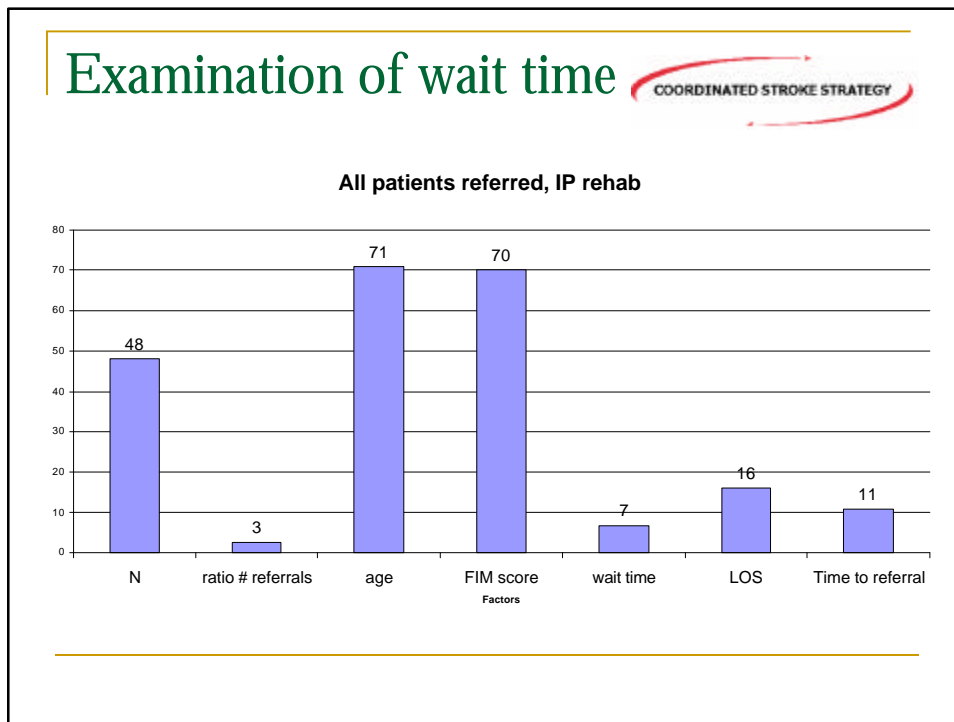
## Outcomes

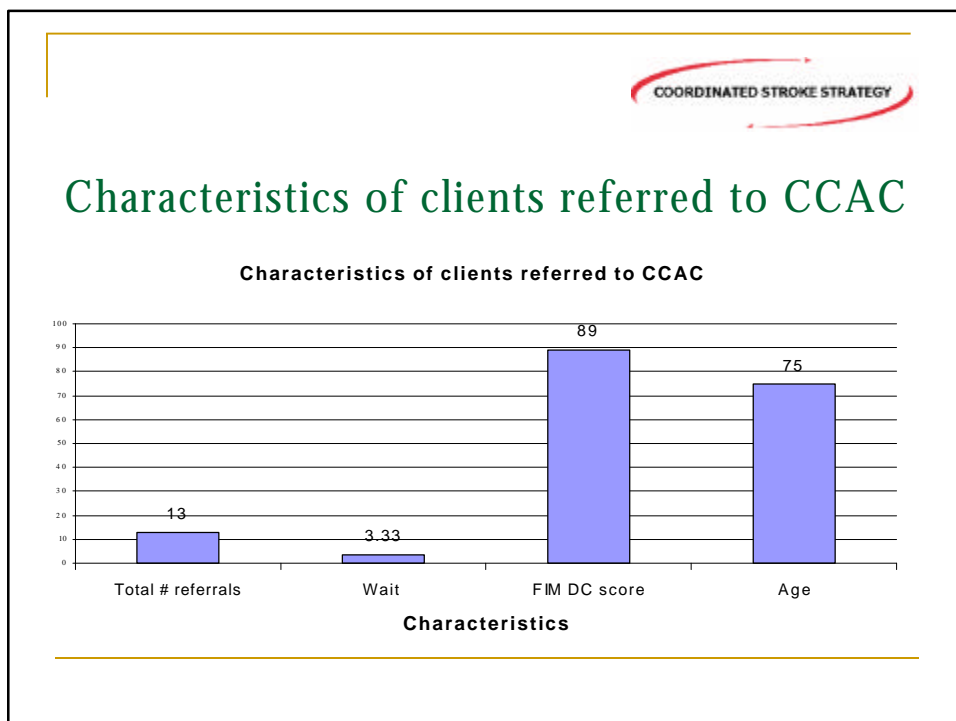
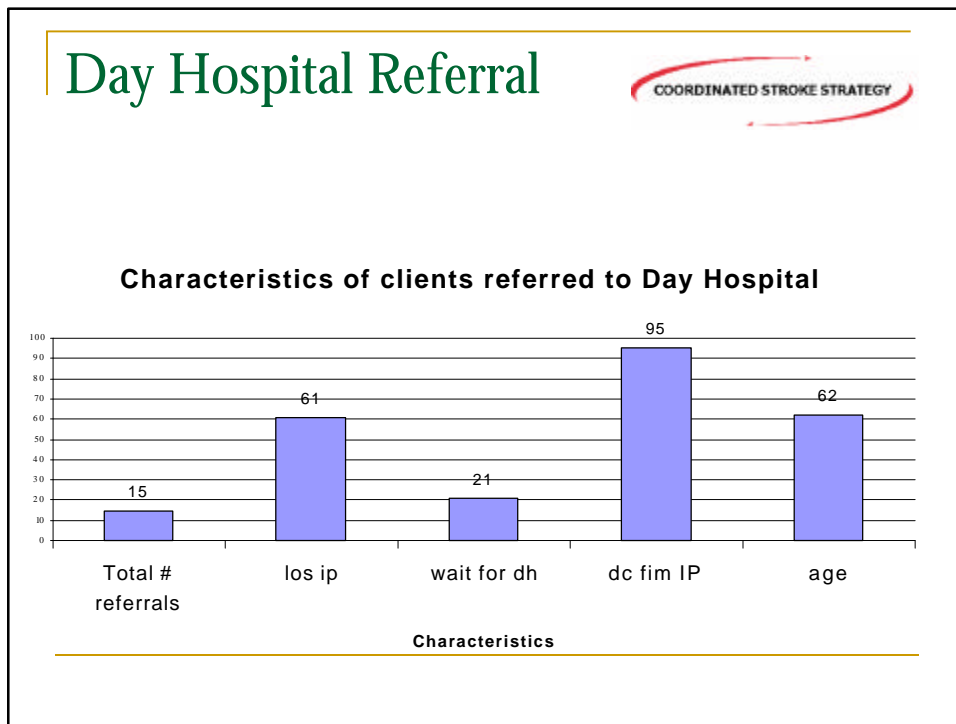
- Describe the current referral system for stroke patients
- Types of referrals made
- Wait times
- Ratio of referrals to transitions
- Patient profiles
- Administration
- What clients think about the referral process
- Where efficiencies can be achieved through a centralized process

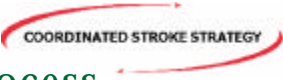
## Definitions



- Episode
- Referral
- Response
- Rehab ready
- Slow to recover
- Medically stable
- Admissions criteria



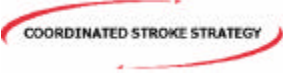




### Time to complete referral process

Teams' work	Minutes
*Time spent to make referral decision, IP	19*3= 57 minutes
AC Time by SW/DC to refer patient	62
AC Time by HCT to assess patient	73
AC Time by administrator to manage referral	22

**\* 1<sup>st</sup> bed policy: 3 referrals sent q each acute care patient needing IP rehab**

- 
- Challenges as we move to implementation...

## Transitioning to electronic referral



### Deliverables reached

- All champions and intake personnel trained in electronic referral system
- Moving to all electronic referrals in next 2 weeks

### Challenges

- Some champions can't download information
- Some champions don't have CD drives
- Some champions need to develop knowledge, skills to effectively navigate database

## Recruitment



### Deliverables reached

- 124 patients recruited as of January 28-04
- If recruitment plans met, we will recruit 650 clients in Project by September 30, 2004

### Challenges

- Difficulty identifying patients with rehab needs in LTC
- Need for shorter form for community referral

## Definitions



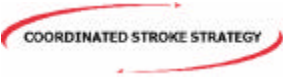
### Low Intensity Long Duration Rehab

- Better definitions needed to clarify clients who need LILD VS. active rehab VS. LTC.



- Why we are collecting the data....  
Long Term Deliverables

## Assumptions

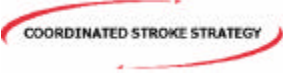


Need	Capacity
We need better definition for types of rehab need	There can be sufficient capacity for different levels of rehab needs
We need effective triage to appropriate programs	Access can be from community and institutions; re-entry with new needs
Decision makers need confidence in referral information to make intake decisions	Appropriate teams are available or can be developed to meet special and complex needs
Client preference is a primary consideration	Funding formulas can accommodate patients with more long term needs

## Long Term Deliverables; SCRIPT Project

*Premise: An effective and efficient referral process is ensured by*

- Improving quality of information sent for making referral decisions
- Appropriate triage
- Tracking patients across the continuum of rehabilitation care and using results for quality improvement
- Maintaining an up to date inventory of stroke programs
- Promoting transparent admissions criteria
- Reducing need for multiple referrals to IP rehab



## Long Term Deliverables; SCRIPT Project



### *Premise: Further....*

- Promoting client preference for rehab placement
- Identifying and addressing access issues for clients seeking rehab who are not in acute care or IP rehab.
- Promoting best practices/interdisciplinary team with expertise in stroke for recognized stroke programs
- Identifying gaps in referral services and closing gaps; inappropriate referral, capacity, equity, access, integration and coordination

## Visioning and Benefits



TANGIBLE BENEFITS EXPECTED	
<p><b>Referrers</b></p> <ul style="list-style-type: none"> <li>❑ Must save time</li> <li>❑ Referral Data must be complete</li> <li>❑ One form</li> <li>❑ All organizations available spots must be transparent</li> <li>❑ Resolution for difficult to place clients</li> <li>❑ Standards for admission, wait list management</li> <li>❑ Decreased wait time</li> </ul>	<p><b>Clients</b></p> <ul style="list-style-type: none"> <li>❑ Know referral date in advance</li> <li>❑ Choose preferred site</li> <li>❑ Decreased wait time</li> <li>❑ Better information on system</li> <li>❑ Information maintained for future reference</li> </ul>
<p><b>Organizations</b></p> <ul style="list-style-type: none"> <li>❑ Data must be complete to be useful for improvement</li> <li>❑ All organizations transparent about referral processes</li> <li>❑ Standards for admission, wait list management, resolution for difficult to place clients</li> </ul>	<p><b>Network</b></p> <ul style="list-style-type: none"> <li>❑ Process sustainable post Project</li> <li>❑ Organizations must share client information, cooperate</li> <li>❑ Data identifies gaps in access, integration, coordination of care</li> <li>❑ Use of best evidence improves effectiveness, efficiency</li> </ul>

BURDENS	
<p><b>Provider</b></p> <ul style="list-style-type: none"> <li>■ Must gather objective information for referral</li> <li>■ Must complete forms</li> <li>■ Must ensure all info on all forms is completed</li> </ul>	<p><b>Client</b></p> <p>Privacy and confidentiality concerns</p>
<p><b>Organizations</b></p> <ul style="list-style-type: none"> <li>❑ Data must be complete to be useful</li> <li>❑ Best outcome for the client may not be the best outcome for the organization</li> <li>❑ Organizations must be transparent about referral processes; eg. list wait times, available spots, train interdisciplinary teams, comply with best practice guidelines</li> </ul>	<p><b>Network</b></p> <ul style="list-style-type: none"> <li>❑ Must sustain database (\$\$\$\$)</li> <li>❑ Must provide administrative support for audit of referral, promote best practice, train in tool use</li> <li>❑ Must enforce standards</li> </ul>

## Thanks for Listening!



- Any Questions?
- For discussion:
  - When making intake/referral decision, What information do you rely on most?
  - What information do you not rely on significantly?