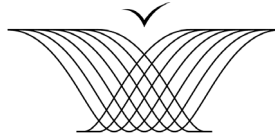


GTA REHAB
NETWORK

Low Tolerance Long Duration
Stroke Rehabilitation
Initiative Report

June 2004



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*Low Tolerance Long Duration
Stroke Rehabilitation Initiative
Report*

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1.0 INTRODUCTION & OBJECTIVES

In 2000, the Consensus Panel on Stroke Rehabilitation found that “specialized stroke rehabilitation units provide better functional outcomes for the same resources as general rehabilitation units.”¹ Yet, Low Tolerance Long Duration (LTLD) stroke rehabilitation (also known as slow stream) is currently not formally recognized as a discrete rehabilitation program. At present, only a few rehab and complex continuing care programs offer LTLD rehab services and of those that do, it is provided within various programs and at different resource levels. Findings from preliminary survey data and reports from providers also suggest that there is an inadequate amount of this type of rehabilitation service to meet the needs of this population of stroke survivors. As a result, LTLD stroke rehabilitation services are not readily available or accessible to stroke survivors.

The lack of adequate LTLD stroke rehab services notwithstanding, research findings have shown that patients who do receive LTLD stroke rehab can make significant gains.² Some patients improve to a level where they can be discharged home. Others continue to require residential care but at a reduced level of personal care support. There are also other patients who make sufficient functional gains to allow for a possible discharge home, but are unable to do so because of a lack of social support within the home environment. Nevertheless, whether patients are discharged home or require ongoing residential care following rehab, a reduction in the burden of care and improvement in quality of life are worthwhile rehab outcomes.

Difficulties in accessing LTLD stroke rehab have also been identified in two reports of the Greater Toronto Area (GTA) Rehab Network: *Needs Assessment and Plan for Integrated Stroke Rehabilitation in the GTA (2002)*, and *Analysis of Alternate Level of Care (ALC) Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity (2004)*. These reports, together with information found in current literature and the experience of stroke providers, all point to the need for program differentiation for LTLD stroke rehabilitation to provide a more effective and efficient delivery of care.

In light of these issues, the Stroke Rehab Task Group of the GTA Rehab Network convened a meeting of various stakeholders from across Ontario on February 16, 2004 to develop a consensus-based triage framework for Low Tolerance Long Duration stroke rehabilitation. The intense four-hour session included presentations from a panel of key experts on the literature, current LTLD stroke rehabilitation services, and potential measurement tools for determining severity and anticipated length of recovery. The presentations were followed by breakout sessions to discuss and reach consensus on a triage framework^a to assist in determining when patients are appropriate for LTLD stroke rehabilitation and to gain clarity and consistency on program components necessary to meet the needs of this population.

The following report summarizes the work of the GTA Rehab Network’s Stroke Rehab Task Group and the initial phase of the LTLD stroke rehab initiative. It includes background work of the Task Group, an account of the February 16, 2004 Consensus Session, the resulting consensus triage framework to determine when patients are appropriate for LTLD stroke rehab and program components that characterize LTLD stroke rehab. The Stroke Rehab Task Group recognizes that this report represents the first phase in the development of a common triage tool and that further consultation and collaboration with stakeholders is needed to ensure that the triage framework accurately describes stroke survivors who are appropriate for LTLD stroke rehab. As such, this report also outlines the next steps of the LTLD stroke rehab initiative.

^a This guideline/framework is based on a review of the literature, feedback from service providers and referrers, and stakeholder discussion. The guideline/framework has been developed with a focus on hospital-based rehabilitation.

2.0 BACKGROUND

2.1 Greater Toronto Area Rehabilitation Network

The GTA Rehab Network is a collaboration of organizations in the Greater Toronto Area that are involved in the planning and provision of rehabilitation services. It was established in 1999, on the recommendation of the Health Services Restructuring Commission (HSRC).

Vision

The vision of the GTA Rehab Network is to create an integrated rehabilitation system that is responsive to clients and their families and achieves equitable and timely access to quality services at the right time and in the right place.

Mission

The mission of the GTA Rehab Network is to provide a forum for collaboration, communication and consensus-building that enables its members, the providers of rehabilitation services, to work toward the vision of an integrated rehabilitation system and coordinate service, promote equitable access, address gaps, reduce duplication, increase research and education, and measure overall performance.

2.2 Low Tolerance Long Duration Stroke Rehabilitation Initiative

Needs Assessment and Plan for Integrated Stroke Rehabilitation

In 2001, the Ontario Ministry of Health and Long-Term Care (MOHLTC), together with the Heart and Stroke Foundation of Ontario (HSFO), provided funding for the GTA Rehab Network to conduct a needs assessment and develop a plan for a system of coordinated stroke rehabilitation services in the GTA. The resultant report, “*Needs Assessment and Plan for Integrated Stroke Rehabilitation in the GTA*”(2002), found that the rehabilitation needs of stroke survivors are not homogeneous.³ Differences in rehabilitation needs are reflected in such factors as stroke severity, age, and tolerance.⁴ However, current rehabilitation programming for stroke is not able to accommodate this diversity in rehabilitation needs. Stroke rehabilitation requires greater program differentiation as well as increased specialization to systematically meet patient needs in the most appropriate and efficient manner.⁵

These findings, in conjunction with the recommendations from the “*Needs Assessment and Plan for Integrated Stroke Rehabilitation in the GTA*” (2002) report, informed the direction taken by the GTA Rehab Network’s Stroke Rehab Task Group to launch an initiative that addresses the needs of stroke survivors requiring LTLTD stroke rehab. Specifically, the following recommendations guided the work of the Task Group:

Recommendation (8):

A common Triage Tool be developed/refined for consistent use, across the continuum of stroke care, in the GTA.

Recommendation (12):

The MOHLTC formally integrate the following programs of stroke rehabilitation into its planning triage framework:

- 1. Programs for high intensity-short duration rehabilitation;*
- 2. Programs for highly specialized and complex rehabilitation; and*
- 3. Programs for lower tolerance, longer duration (LTLTD) rehabilitation.*

Recommendation (14):

The GTA Rehabilitation Network in collaboration with the Regional Stroke Centres, take the leadership to work with providers of complex continuing care to initiate planning activity for a program of lower tolerance, longer duration stroke rehabilitation. This includes target populations, service components and resource requirements.

Evidence Supporting the Need for Low Tolerance Long Duration Stroke Rehabilitation

A series of snapshots over a five-month period conducted by the GTA Rehab Network on patients awaiting rehabilitation in alternate level of care (ALC) beds in the GTA revealed that 22% of patients awaiting rehab in ALC were in need of LTLTD rehabilitation.^b Of those, 31% were waiting specifically for stroke rehabilitation, comprising the largest population sub-group awaiting LTLTD rehabilitation.⁶ These patients often exhibit higher acuities, more complex care needs, higher resource needs, longer lengths of stay, and demonstrate slower gains in recovery.^{7,8} As a result, many patients in need of LTLTD stroke rehabilitation are often not accommodated by regular stream stroke rehabilitation programs. Instead, these patients are frequently discharged to long-term care facilities without a trial of rehabilitation.⁹ It is estimated that 11%-15% of stroke survivors are discharged directly to long-term care facilities.^{10 11} At other times, patients with more complex medical needs who are in need of LTLTD stroke rehab are admitted to complex continuing care (CCC). Although *some* rehab services may be available in *some* CCC facilities, adequate funding may not be available to provide the needed level of rehabilitation. Since patients who require LTLTD stroke rehabilitation are typically older, the size of this group will continue to increase as the population ages.¹² Concern exists that funding constraints for these alternative programs in CCC may cause organizations to divest from “slow stream” rehabilitation services as patient needs exceed funding levels, further rendering this population under-served.¹³

Garraway was the first to propose a triage concept of stroke patients based on severity.¹⁴ According to this triage model, stroke survivors are triaged into three bands – ‘upper’, ‘middle’, and ‘lower’. His triage model is used to classify patients with mild strokes who are likely to recover spontaneously into the ‘upper band’. Those with moderate deficits are placed in the ‘middle band’, and those with severe deficits (early FIM™ score^c < 40) are generally classified within the ‘lower band’. Traditionally, stroke rehab units have offered programming to the ‘middle band’ of stroke survivors¹⁵; however, patients with severe strokes have also been shown to make gains, particularly when they have access to the appropriate level of stroke rehabilitation.¹⁶ Evidence also exists to show that patients benefit more from care provided in a specialized program and clustered model of service delivery.¹⁷ Specialized and clustered programs enhance the effectiveness of care and service delivery by building on economies of scale, preventing provider fatigue, and maximizing efficient use of resources. Despite these findings, programs for LTLTD stroke rehabilitation, often referred to as “slow stream rehabilitation,” are not formally recognized as a discrete rehabilitation program for service delivery and funding purposes.¹⁸

^b This percentage is based on the number of patients whose referrals specified the type of rehab requested. As not all patient data included this information, it is likely that this figure is an underestimation of the number of patients in need of LTLTD rehab.

^c FIM™ is a trademark of the Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. The Functional Independence Measure (FIM) assesses physical and cognitive disability in terms of burden of care. It includes an 18-item ordinal scale that measures independence in self-care, sphincter control, mobility, locomotion, communication, and social cognition. The optimal timing for stroke rehab assessment is 5-7 days post-stroke onset.

3.0 APPROACH

3.1 Low Tolerance Long Duration Stroke Rehab Survey

The GTA Rehab Network's Stroke Rehab Task Group conducted a survey on LTLD stroke rehabilitation across the GTA in September/October 2003. The data that was collected captured the perspectives of providers and referrers on the definition of LTLD stroke rehabilitation as well as the supply and demand for LTLD stroke rehabilitation services.

The wide range and variant nature of the survey responses highlighted the complexity and ambiguity surrounding LTLD stroke rehabilitation. The Task Group concluded that to obtain more clear and concise information, a consensus definition of LTLD stroke rehab was required. An LTLD stroke rehab consensus session was proposed to bring together stakeholders from across the province to develop a definition that would be used consistently by service providers in the Ontario region.

3.2 Draft Definition for LTLD Stroke Rehabilitation

In preparation for the consensus session, a subgroup of Stroke Rehab Task Group members, stroke rehab providers and referrers prepared a draft definition of LTLD stroke rehabilitation that incorporated information from the LTLD stroke survey, a review of the literature, and consultations with representatives from various disciplines and organizations. As a result, a number of factors that affected the triage of patients to LTLD stroke rehabilitation were identified (i.e. severity, age, expected length of stay (LOS), rate of recovery, frequency/duration of rehab, the presence of comorbidities, and the presence of family/social supports). Details on each component are included in Appendix C.

Based on the discussions, it became apparent that one definition alone could not represent all patients in need of LTLD stroke rehabilitation. Assessment of the factors involved in the triage of these patients cannot be done in isolation of each other owing to individual differences among stroke survivors and the potential interactive effect among these factors. The definition would need to be broad enough and flexible enough to allow for the consideration of these factors in various combinations in order to allow for individual differences among this population of stroke survivors.

3.3 Triage Framework for LTLD Stroke Rehabilitation

This realization led to a shift in the approach from establishing one definition to developing a *triage framework* to be used as a general *guideline* to assist in determining when patients are appropriate for LTLD stroke rehabilitation. The triage framework would include general profiles to illustrate the characteristics of these patients and to distinguish them from patients who are more appropriate for a regular stream stroke rehab program. Once developed, the triage framework could then be used to describe the program requirements to meet the needs of this population.

3.4 Key Components of the Draft Triage Framework Determined Prior to Consensus Session

Drawing on the information that was gathered for the initial draft definition, a draft triage framework was prepared for the Consensus Session to assist in determining the *level* of rehab most appropriate for stroke rehab candidates. The draft triage framework included three key assumptions regarding the status of the stroke rehab candidate. It assumed that the patient is:

- Medically stable for stroke rehabilitation
- Able and willing to participate in stroke rehabilitation
- Likely to improve from stroke rehabilitation

To further delineate the profiles of patients in need of LTLD stroke rehab, the question was posed, “what factors play the greatest, overriding role in generally determining if a patient is appropriate for LTLD stroke rehabilitation?” Based on the discussions and research findings, several factors were identified. Ultimately, three factors were identified as the primary characteristics deemed to be most important in deciding what stream of stroke rehab is most appropriate: initial stroke severity, age¹⁹, and tolerance.^{20 21}

Severity

Initial stroke severity for the purpose of stroke rehabilitation triage can be measured using a functional outcome measure such as the Functional Independence Measure (FIM). As an example, the literature suggests that patients with an early FIM score of less than 40 are likely to benefit more from and should be admitted to a slower-paced, less intensive rehabilitation program.^{22 23} Please note that the FIM assessment measure was selected arbitrarily as one tool to assess stroke severity. Organizations may use other tools to determine level of severity.

Age

The literature suggests that stroke patients **less than 55 years of age** often do well regardless of initial stroke severity. Thus younger stroke patients, less than 55 years of age, should almost always be admitted to an inpatient intensive rehabilitation program.^{24 25 26}

The literature also suggests that if a patient suffers from a severe stroke (FIM < 40) and the **patient is greater than 55 years of age**, then he or she is more likely to need LTLD stroke rehab.²⁷

However, the age criterion differs when patients have suffered a stroke of less severity (i.e. FIM > 40). Patients who have suffered a stroke of moderate severity and who are **greater than 75 years of age**, should be admitted to an LTLD stroke program. Those who are less than 75 years of age can generally be admitted to a regular stream program.²⁸

Tolerance

Tolerance, with respect to stroke rehabilitation, is related to both the frequency and duration of rehabilitation intervention.²⁹ In general, patients who can only tolerate rehabilitation sessions that are of shorter duration are more appropriate for an LTLD stroke rehab program. Frequently, these patients may not be able to tolerate a set number or duration of sessions each day as is expected in regular stream rehab. Specific benchmarks for tolerance to distinguish between regular stream and LTLD rehab have not been clearly established.

Utilizing each of these key components, an initial draft of the triage framework was developed for distribution and further discussion at the consensus session. (See Appendix D)

4.0 LOW TOLERANCE LONG DURATION STROKE REHAB CONSENSUS SESSION

On February 16, 2004, stakeholders from across Ontario convened in Toronto to come to consensus on a triage framework for LTLD stroke rehabilitation. To ensure that the triage framework could have broad applicability for stroke survivors throughout the province, stakeholders from all major regional stroke centers across Ontario were invited to attend. Invitations were extended via the stroke coordinator in each region.

Participants included:

- Administrators
- Discharge planners/case managers
- Nurses
- Occupational therapists
- Psychiatrists
- Physiotherapists
- Researchers
- Social workers
- Speech and language pathologists
- Students

Organization types included:

- Acute Teaching Hospitals
- Community Care Access Centres
- Ministry of Health and Long-Term Care (MOHLTC)
- Regional Stroke Networks
- Rehabilitation Hospitals
- University of Toronto

The regions represented at the session included:

- Barrie
- Brant
- Brantford
- Burlington
- Hamilton
- Kingston
- Toronto
- London
- Stratford
- Mississauga
- Newmarket
- Orangeville
- Orangeville
- Owen Sound
- Thunder Bay
- Whitby

A list of attendees is included in Appendix B.

The morning of the consensus session opened with a panel of experts in the field of rehabilitation who presented on the literature, current provider experiences and assessment tools. Details of the presentations included factors used to define LTLD stroke rehab in the literature, descriptions of typical patients appropriate for LTLD stroke rehab, reviews of current programs offering LTLD stroke rehab, and an overview of a typical tool used to assess LTLD stroke rehab.

The information provided in the presentations laid a foundation for discussion in the breakout group sessions. These sessions included participants from a variety of disciplines and regions across Ontario.

5.0 OUTCOMES

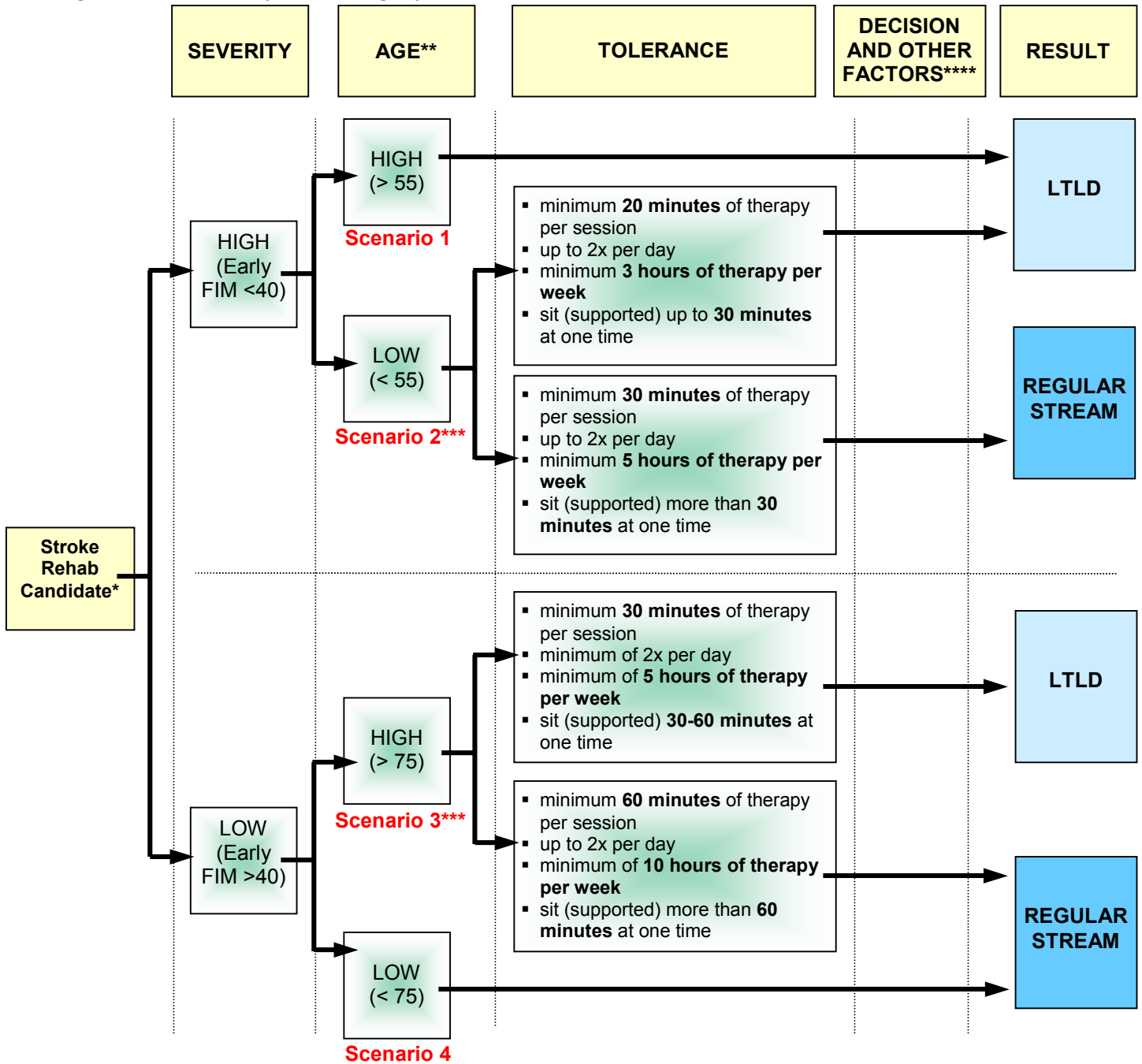
5.1 Consensus on the Triage Framework for LTLD Stroke Rehab

The initial draft of the triage framework was distributed to participants in advance of the consensus session. The factors of severity and age were agreed to be primary factors for consideration in the triage process of patients to either regular or LTLD stroke rehab. The benchmarks for each of these two factors, which were proposed based on findings from the literature, were also approved. The primary task of participants was to add to these components by determining benchmarks for the third factor, tolerance, and to identify any additional factors that may need to be considered in the triage of LTLD stroke rehab patients. By doing so, the expanded triage framework would allow for a more client-centred model of care in which individual characteristics of stroke rehab candidates can be taken into consideration during the triage decision-making process. The tasks of determining these additional factors thus became the focus of the discussion for the smaller breakout groups.

A worksheet that described four possible patient scenarios was provided to participants to guide the discussion during the breakout sessions. An example of the worksheet is in Appendix E. The triage decision is relatively clear in the event that both age and severity are either low or high. When both age and severity are low, patients are generally appropriate for regular stream rehab. Conversely, when both age and severity are high, patients are generally appropriate for LTLD stroke rehab. However, the triage decision becomes more challenging when age and severity are on opposite continuums. In these cases, the third factor of tolerance is considered to further assist with the triage decision. Participants in each breakout group reviewed the patient scenarios and identified benchmarks for tolerance.

Following the breakout sessions, feedback from each group was reported and compiled to determine an overall consensus on a triage framework for LTLD stroke rehab (see Appendix F). The decision tree (see Figure 1) is the final triage framework resulting from the Consensus Session. This triage framework is not intended to be used as a prescriptive tool but more as an adjunct to clinical judgment and general guideline in the triaging of stroke rehab candidates.

Figure 1: Framework for the Triage of Stroke Rehab Patients



* This triage framework is to assist in determining **the level** of stroke rehab that is appropriate. This framework assumes that the patient is a candidate for stroke rehab, i.e. is medically stable, able and willing to participate in stroke rehabilitation, and likely to improve from stroke rehabilitation.

** These benchmarks for age (i.e. 55 and 75 years of age) are based on literature findings regarding the use of age as a prognostic factor in determining rehab outcomes.

*** Because younger stroke survivors generally have good recovery regardless of stroke severity, the tolerance threshold is lower for younger stroke rehab candidates with severe strokes who are to be routed to regular stream rehab than the threshold set for older stroke rehab candidates.

**** Other factors that may be considered once stroke severity, age, and tolerance for rehab have been taken into account include: cognitive status, presence and complexity of comorbidities, family/social support, and incontinence.

Describing the Triage Framework:

Note: To be used as a GENERAL GUIDELINE to assist with the triaging decision of stroke rehab patients.

Scenario 1: Patients with more severe strokes (i.e. early FIM <40) and whose age is > 55 are *generally* appropriate for LTLD stroke rehab. Tolerance is not a primary consideration for decision-making.

Scenario 2: Patients with more severe strokes (i.e. early FIM <40), but whose age is <55: tolerance is also considered:

- If the patient can tolerate **20 minutes** of therapy per session, up to two times a day, for a minimum of **3 hours of therapy per week**, and can sit supported up to **30 minutes** at one time, then this patient is *generally* appropriate for LTLD stroke rehab.
- If the patient can tolerate more, then this patient is *generally* appropriate for regular stream rehab.

Scenario 3: Patients with moderate strokes (i.e. early FIM >40), but whose age is >75: tolerance is also considered:

- If the patient can tolerate at least **30 minutes** of therapy per session, two times a day, for a minimum of **5 hours of therapy per week**, and can sit supported up to **60 minutes** at one time, then this patient is *generally* appropriate for LTLD stroke rehab.
- If the patient can tolerate more, then this patient is *generally* appropriate for regular stream rehab.

Scenario 4: Patients with moderate strokes (i.e. early FIM >40) and whose age is <75 are *generally* appropriate for regular stream rehab. Tolerance is not a primary consideration for decision-making.

Additional notes on the triage framework:

When to Consider Other Factors

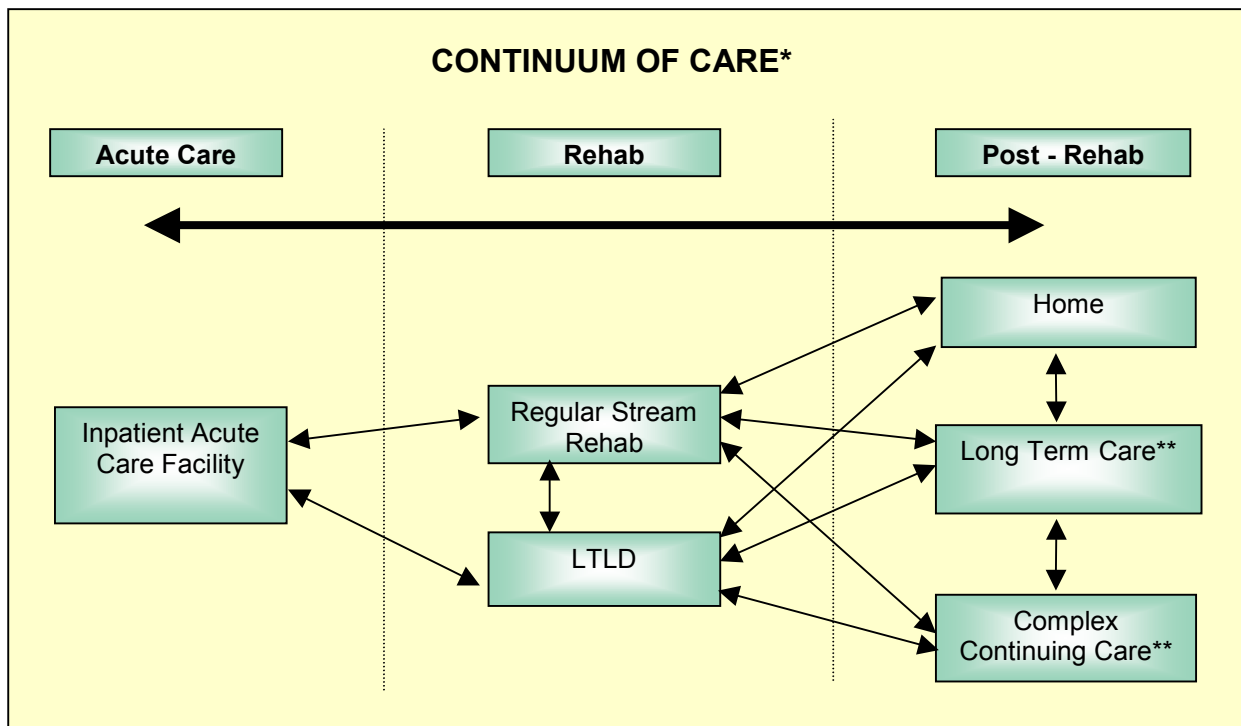
In cases where the tolerance is unclear, the following additional factors were identified as the most significant to consider in the triaging decision: *cognitive status, comorbidities, family/social support, and incontinence.*

Triage framework is to be used as a Guideline

This triage framework is designed for use as a **general guideline** to assist in the triaging of patients to the appropriate level of stroke rehab. It is acknowledged that there will be exceptions, and clinical judgment will always prevail.

Continuum of Care

The triage framework is designed to assist with the triaging decision of a stroke rehab candidate to either LTLD or regular stream stroke rehab. Please note that this is one triaging point within an overall continuum of care for a patient and does not limit a patient’s movement to different levels of care within the continuum as needed.



* This diagram illustrates the different levels of care across the continuum. Ideally, the system should be flexible in its capacity to provide access to the various levels of care as patients’ needs change. However, it is generally more difficult for patients to re-enter rehab from the post-rehab phase of the continuum. This could be owing to a lack of resources and/or expertise in some settings to assess a patient’s changing needs and/or potential for rehabilitation.

** Rehabilitation is provided in some LTC and CCC settings; therefore, there is some overlap between rehab and post rehab.

5.2 Using the Triage Framework to Define an LTLD Stroke Rehabilitation Program

The consensus session not only served to distinguish between patients who are appropriate for LTLD stroke rehab and those who are appropriate for regular stream, but it also led to a common understanding of the program components of LTLD stroke rehab. The following descriptions of regular and LTLD stroke rehabilitation were drawn from the triage framework discussed and agreed upon at the Consensus Session.

Rehabilitation

Rehabilitation is a progressive, dynamic, goal-oriented process aimed at enabling a person with impairments to reach his or her optimal mental, physical, cognitive, communicative and/or social functional level. It is multidimensional, consisting of prevention and treatment of medical complications, restoration of maximal independence of psychosocial coping and adaptive functioning, promotion of community reintegration and enhancing quality of life for stroke survivors.³⁰

Regular Stream Stroke Rehab

Regular stream stroke rehabilitation is geared towards patients with moderate strokes. If using an early FIM score³¹, these patients score between 40 and 80 and are generally 19-75 years in age. Typically, they are able to tolerate a minimum of 60 minutes of therapy per session and their overall expected length of stay averages approximately 30 to 60 days. However, stroke rehab candidates who are older than 75 years of age may also be suitable for regular stream stroke rehab if they are able to meet these tolerance benchmarks. Regular stream stroke rehab is also able to accommodate stroke rehab candidates with severe strokes (i.e. FIM < 40) if they are younger than 55 years of age, able to sit supported for more than 30 minutes at one time and can tolerate a minimum of 30 minutes of therapy per session, up to twice per day, for a minimum of 5 hours of therapy per week. A lower tolerance threshold is set for these younger stroke rehab candidates because they generally have good outcomes regardless of stroke severity.

Regular stream stroke rehab can accommodate patients with comorbidities; but only to the extent that the comorbidities do not affect a patient's ability to participate in rehabilitation intervention with respect to the tolerance levels outlined above.

Low Tolerance Long Duration (LTLD) Stroke Rehab

LTLD stroke rehab is generally geared towards patients with severe strokes (i.e. an early FIM score of less than 40 as one example of a severity measure). This program is also appropriate for patients who may have an early FIM score of greater than 40 but who are much older (i.e. greater than 75 years of age). Depending on the age of the patient and severity of the stroke, patients are able to tolerate between 20-30 minutes of therapy per session, for a maximum total of 5 hours per week. The average length of stay in LTLD stroke rehab generally ranges between 60 to 180 days. Further, these patients generally have cognitive impairments and comorbidities that affect their ability to tolerate the intensity of a regular stream stroke rehab program. Additional functional characteristics of patients appropriate for this program may include: previous strokes; transfer dependence; difficulty in following two to three step commands; presence of hemi-neglect; incontinence, and limited family/social supports.

General Characteristics of Patients Not Appropriate for LTLD Stroke Rehab

The participants were also asked to come to consensus on characteristics of those patients who are not only inappropriate for regular stream rehab, but also LTLD stroke rehab. Common characteristics identified include patients who have no rehab goals or have no capacity for functional improvement; lack motivation to participate in a rehabilitation program, or have severe cognitive, learning and behavioral impairments.

6.0 ADDITIONAL FEEDBACK ON THE CONSENSUS SESSION

6.1 Name for LTLD Stroke Rehab

Feedback from Participants

Initially, the Stroke Rehab Task Group used the term “Lower Intensity, Longer Duration” (LILD) to describe the level of stroke rehabilitation discussed at the Consensus Session. Participants at the Consensus Session were asked to include feedback on the appropriateness of LILD as a designation to describe this type of stroke rehab. Of those who responded, the majority believed that LILD stroke rehab was most appropriate, followed by “slow stream rehab.” Other names that were suggested were (in order of popularity): resource intensive rehab; long duration rehab; specialized, complex rehab; sub acute rehab; slow to recover rehab; reactivation or restoration; or moderate intensity rehab.

However, there was significant concern expressed about the need to minimize possible confusion between the terms “lower intensity” rehab as it applies to rehab intervention and “higher intensity” as it relates to a greater need for resources. Many respondents believed that the use of “lower intensity” as part of the designation for this type of rehab undermines the significance of the higher need for resources and could adversely influence policy and funding considerations. As such, using the term, “low tolerance, long duration,” stroke rehabilitation was also proposed for additional feedback.

Upon discussion, the Stroke Rehab Task Group decided that for the purposes of policy and planning, the term “**low tolerance long duration**” (**LTLD**) will be used to describe the *generic* program or service. Organizations are free to use whatever term they wish for their own programs, with consideration that consensus was achieved on the overall concept of the program as described by the triage framework and definition.

6.2 Evaluation

The Consensus Session achieved its overall objective to advance the understanding of LTLD stroke rehab among rehab providers and to develop a common triage tool for use across the continuum. Noteworthy secondary benefits of the Consensus Session were derived from the opportunity for over 70 representatives from a wide range of disciplines and sites across the province to meet and share their knowledge, expertise, and perspectives on the needs of this population of stroke survivors. Through this sharing, service providers gained an increased awareness of the challenges and complexities involved in defining and enhancing access to LTLD stroke rehab. A more detailed summary of participants’ evaluation responses is included in Appendix F.

7.0 NEXT STEPS

7.1 Validating the Triage Framework

Members of the Stroke Rehab Task Group agreed that the triage framework should be “tested” using existing programs to validate that it accurately describes and identifies patients who would benefit from LTLD stroke rehabilitation. The SCRIPT (Stroke Referral Initiative Pilot Toronto) Pilot Project of the Toronto West Stroke Network has developed a standardized rehab assessment and referral process for stroke patients in the GTA. Task Group members are consulting with members of the SCRIPT project to compare the triage framework with existing rehab referral information from the SCRIPT database to demonstrate the efficacy of the triage framework. The SCRIPT Project has also agreed to validate the triage framework using statistical analysis. Once validated, the triage framework can be used in the process of tracking volumes and determining the level of services and resources required to meet the needs of this population.

7.2 Revisiting the LTLD Stroke Initiative Objectives

The ultimate intent of this stroke rehab initiative is to improve access to inpatient LTLD rehabilitation and enhance consistency in LTLD programming across Ontario. The newly developed triage framework and consensus-based definition of LTLD stroke rehab represent the first steps towards this end.

As stated earlier in this report, LTLD stroke rehab is not recognized as a discrete rehabilitation program. The availability of LTLD stroke rehab is therefore largely dependent on the programming decisions of individual organizations to provide this service; however, the lack of designated funding for LTLD stroke rehab poses a significant barrier for most organizations to do so. As a result, many stroke survivors who could benefit from LTLD stroke rehabilitation are discharged from acute care directly to long-term care without the benefit of a trial of rehabilitation.³²

The next challenge for the Stroke Rehab Task Group is to address this issue to ensure that LTLD stroke rehab is available, accessible and able to adequately meet the needs of stroke survivors. To this end, the Stroke Rehab Task Group will work to obtain recognition of and appropriate funding for LTLD stroke rehabilitation programs. It will conduct a study to describe the characteristics of LTLD stroke rehab candidates and determine the resources, outcomes and costs associated with an LTLD stroke rehab program. The results of the study will be used to develop a business case for submission to the MOHLTC that demonstrates LTLD stroke rehab as a client-centred model of care that optimizes client functioning, reduces burden of care and is cost-effective in its use of resources and rehab beds.

8.0 APPENDICES

8.1 Appendix A

GTA Rehab Network Stroke Rehab Task Group Members

Malcolm Moffat	President and CEO, St. John's Rehabilitation Hospital (<i>chair</i>)
Jatinder Bains	Health Planner, Simcoe-York Region District Health Council
Mark Bayley	Medical Director, Neurorehab Program, Toronto Rehabilitation Institute
Shann Beck	Director, Program Development/Regional Stroke Strategy Coordinator, North and East GTA-Ontario Stroke Region
Monica Codjoe	Manager, Neuro-Rehabilitation Services, West Park Healthcare Centre
Arleen Corey	Program Leader, Rehabilitation and Related Services, Lakeridge Health Corporation
Janet Harris	Executive Director, Durham Access To Care
Sonia Jacobs	Senior Health Planner, Toronto District Health Council
Carole Leacock	Hospital Consultant, Ministry of Health and Long-Term Care
Kathryn LeBlanc	Regional Coordinator, West GTA Stroke Network
Mary Lewis	Manager, Government Relations, Heart and Stroke Foundation of Ontario
Kim Martin	Manager, Strategic Initiatives and Psychology, Baycrest Centre for Geriatric Care
Scott McLeod	Senior Health Planner, Halton-Peel District Health Council
Dr. John Patcai	Physiatrist, St. John's Rehabilitation Hospital
Krystyna Skrabka	Regional Coordinator, Central East Stroke Network
Josie Walsh	Vice-President, Programs and Chief Nursing Executive, Providence Healthcare
Gaye Walsh	Vice-President, Programs and Allied Health Services, Bridgepoint Health
Jacqueline Willems	Regional Stroke Coordinator, Toronto West Regional Stroke Network
Elizabeth Woodbury	Program Manager, Hospital Programs, Ontario Ministry of Health and Long-Term Care
Charissa Levy	Executive Director, GTA Rehab Network
Sue Balogh	Project Coordinator/Planner, GTA Rehab Network
Ruquaiyeh Siddiqi	Project Coordinator/Planner, GTA Rehab Network

GTA Rehab Network Stroke Consensus Day Planning Subgroup

Malcolm Moffat	President and CEO, St. John's Rehabilitation Hospital (<i>chair</i>)
Dr. Mark Bayley	Medical Director, Neurorehab Program, Toronto Rehabilitation Institute
Kathryn LeBlanc	Regional Coordinator, West GTA Stroke Network
Mary Lewis	Manager, Government Relations, Heart and Stroke Foundation of Ontario
Gaye Walsh	Vice-President, Programs and Allied Health Services, Bridgepoint Health
Charissa Levy	Executive Director, GTA Rehab Network
Ruquaiyeh Siddiqi	Project Coordinator/Planner, GTA Rehab Network

8.2 Appendix B

GTA Rehab Network Stroke Rehab Task Group Consensus Session Attendees – February 16, 2004

Nicole Allard	Bridgepoint Health, Toronto
Jamie Arthur	SMART/Toronto Community Care Access Centre, Toronto
Paul Asselin	Toronto Rehabilitation Institute, Toronto
Dr. Stephen Bagg	Providence Continuing Care Centre, Kingston
Jatinder Bains	Simcoe-York Region District Health Council, Newmarket
Susan Barreca	Hamilton Health Sciences (for Barb Ansley), Hamilton
Dr. Mark Bayley	Toronto Rehabilitation Institute, Toronto
Anna Bluvol	St. Joseph's Health Care, London
Heather Bruce	Brant Community Healthcare System, Brantford
Dr. Vincent Chien	Bridgepoint Health, Toronto
Monica Codjoe	West Park Healthcare Centre, Toronto
Kathi Colwell	Bridgepoint Health, Toronto
Arleen Corey	Lakeridge Health Corporation, Whitby
Mary Helen Dale	Stratford General Hospital, Stratford
Pat D'Ambrosio	Royal Victoria Hospital, Barrie
Amy DeHueck	Joseph Brant Memorial Hospital, Burlington
Carolyn Descotes	West Park Healthcare Centre, Toronto
Alexis Dishaw	Ontario Ministry of Health and Long-Term Care, Toronto
Robbyn Draimin	Providence Healthcare, Toronto
Dr. James Edney	Toronto Rehabilitation Institute, Toronto
Jackie Eli	Bridgepoint Health, Toronto
Stephen Hall	Bridgepoint Health, Toronto
Janet Harris	Durham Access to Care, Whitby
Suzanne Horn	Providence Healthcare, Toronto
Brandon Howell	University of Toronto, Toronto
Laurie Hurley	Toronto West Stroke Rehab Pilot Project, Toronto
Sharon Jankowski	St. Joseph's Health Care, London
Sandy Jenkins	Brant Community Healthcare System, Brantford
Marta Krywonis	Etobicoke Community Care Access Centre, Etobicoke
Shahida Kurji	University Health Network, Toronto
Mark Landy	Grey Bruce District Stroke Centre, Owen Sound
Leslie Larkin	Brant Community Healthcare System, Brantford
Kathryn Leach	West Park Healthcare Centre, Toronto
Carole Leacock	Ontario Ministry of Health and Long-Term Care, Toronto
Charissa Levy	GTA Rehab Network, Toronto
Mary Lewis	Heart and Stroke Foundation of Ontario, Toronto
Karyn Lumsden	Credit Valley, Mississauga
Cally Martin	Kingston General Hospital, Kingston (<i>via teleconference</i>)
Malcolm Moffat	St. John's Rehabilitation Hospital, Toronto
Judy Moir	GTA Rehab Network, Toronto
Cheryl Moher	Royal Victoria Hospital, Barrie
Mary Ann Neary	University Health Network, Toronto
Jennifer Nairn	Brant Community Healthcare System, Brantford
Doris Noble	Huron Perth District Stroke Centre, Stratford
Michelle Perrella	Brant Community Healthcare System, Brantford

Dr. John Patcai	St. John's Rehabilitation Hospital, Toronto
Ashnoor Rahim	North York Community Care Access Centre, North York
Jennifer Scott	North York Community Care Access Centre, North York
Ruquaiyeh Siddiqi	GTA Rehab Network, Toronto
Krystyna Skrabka	Central East Stroke Network, Toronto
Mary Solomon	Grey Bruce District Stroke Centre, Owen Sound
Colleen Stroud	University Health Network, Toronto
Dara Taylor	Ontario Region Stroke Network, Toronto
Debbie Taylor	Toronto Community Care Access Centre, Toronto
Denise Taylor	St. Joseph's Care Group, Thunder Bay
Dr. Gary Teare	University of Toronto/Toronto Rehabilitation Institute, Toronto
Dr. Robert Teasell	Parkwood Hospital, London
Nathalie Topdjian	University Health Network, Toronto
Dianne Walkom	Huron Perth District Stroke Centre, Stratford
Gaye Walsh	Bridgepoint Health, Toronto
Josie Walsh	Providence Healthcare, Toronto
Mary Wheelwright	Headwaters Health Care Centre, Orangeville
Jacqueline Willems	Toronto West Regional Stroke Strategy Network, Toronto

8.3 Appendix C

Factors Influencing the Triage to LTLD Stroke Rehab

(as determined in preparation for the discussion at the Consensus Session on February 16, 2004)

The following list includes components that were identified as factors considered in determining a patient’s appropriateness for LTLD stroke rehab. The components were identified based on the survey results, review of the literature, and discussion from various stakeholders.

<i>Defining Criteria</i>	<i>Definition</i>					
Measurement tools	<p>1. FIM Scores³³ Teasell noted that stroke patients whose early FIM scores* are lower than 40 are characteristic of more severe strokes and may also have serious medical co-morbidities that add to the stroke disability. Thus, patients with an early FIM of <40 were more likely in need of LTLD stroke rehab**.</p>					
	<table border="1"> <thead> <tr> <th>Mild Strokes</th> <th>Moderate Strokes</th> <th>Severe Strokes</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> • Referred to as “upper band” • Early FIM score > 80 • Early Motor FIM score > 62 </td> <td> <ul style="list-style-type: none"> • Referred to as “middle band” • Early FIM 40 – 80. • Early Motor FIM 38-62 </td> <td> <ul style="list-style-type: none"> • Referred to as the “lower band” • Early FIM < 40 • Early Motor FIM < 38 </td> </tr> </tbody> </table>	Mild Strokes	Moderate Strokes	Severe Strokes	<ul style="list-style-type: none"> • Referred to as “upper band” • Early FIM score > 80 • Early Motor FIM score > 62 	<ul style="list-style-type: none"> • Referred to as “middle band” • Early FIM 40 – 80. • Early Motor FIM 38-62
Mild Strokes	Moderate Strokes	Severe Strokes				
<ul style="list-style-type: none"> • Referred to as “upper band” • Early FIM score > 80 • Early Motor FIM score > 62 	<ul style="list-style-type: none"> • Referred to as “middle band” • Early FIM 40 – 80. • Early Motor FIM 38-62 	<ul style="list-style-type: none"> • Referred to as the “lower band” • Early FIM < 40 • Early Motor FIM < 38 				
Severity **	As determined by functional status; may be assessed with tools such as the FIM. Stroke severity has a direct correlation with tolerance and length of stay as it affects the intensity and duration of rehab intervention.					
Age**	Generally, stroke survivors >55 years of age can be better managed in a less intensive rehabilitation environment. Elderly stroke rehab patients (greater than 75 years of age) are more likely to benefit from a lower tolerance, longer duration program.					
Length of Stay***	An <i>expected</i> LOS range of approximately 60 to 180 days.					
Rate of Recovery***	Rate of Recovery = (Functional Gains)/(Specified Time Period)					
Tolerance, Frequency & Duration of Rehab***	Patients can tolerate rehabilitation 2-3 times/week. However, the duration of therapy is shorter due to patients’ lower tolerance to rehabilitation . (10-30 minutes per session as opposed to 60 minutes in a regular rehab program.)					
Comorbidities***	<p>Comorbidities are considered with respect to:</p> <ul style="list-style-type: none"> ▪ Their impact on the patient’s <i>cognition</i> and <i>tolerance</i> to respond to rehab intervention. ▪ A patient’s “fragility” and tolerance. ▪ LOS needed <p>Common comorbidities affecting a patient’s tolerance include:</p> <ul style="list-style-type: none"> ▪ Previous CVA ▪ Respiratory Illness ▪ Cardiovascular Disease ▪ Parkinson’s Disease ▪ Need for Dialysis <p>Based on discussion of survey results and sub group meetings.</p>					

<i>Defining Criteria</i>	<i>Definition</i>
Family/Social Support***	The availability of family/social supports is considered as it may affect the LOS in rehab required for a patient; however, this indicator is not used as a primary deciding factor.
General Functional Characteristics of Patients in need of LTLD stroke rehab***	Patients in need of LTLD stroke rehab may: <ul style="list-style-type: none"> ▪ Often have suffered from previous strokes ▪ Have multiple co-morbidities ▪ Lack relatively sufficient family support ▪ Need the use of a hooyer lift ▪ Have a sitting tolerance of not more than 5-10 minutes ▪ Present with aphasia ▪ Have difficulty following three step commands ▪ Be disoriented x3 with reduced judgment and insight ▪ Have hemi-neglect ▪ Be incontinent

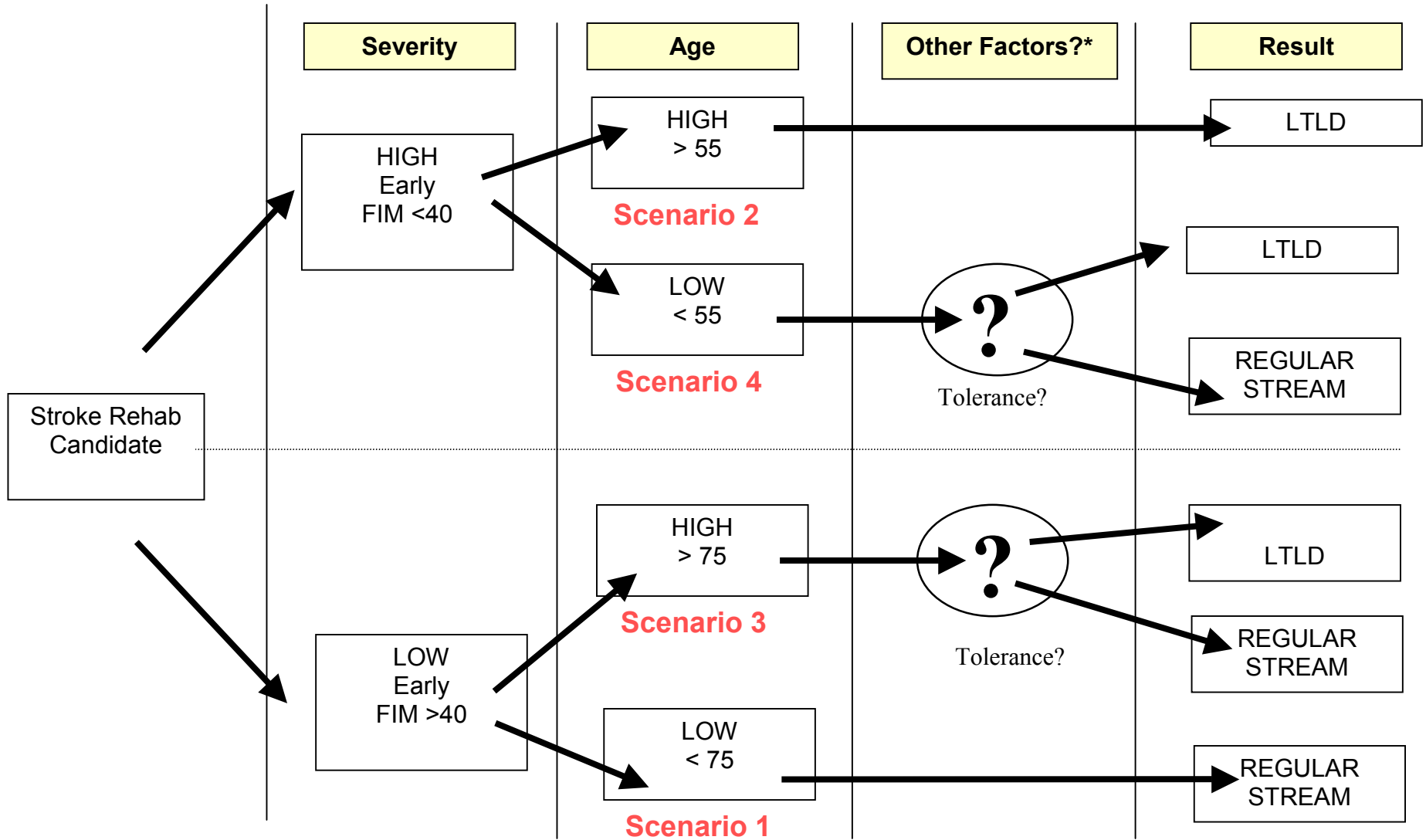
* *Note: Early FIM scores are assessed 5 to 7 days post onset*

** *Teasell 2003; Heart & Stroke Foundation, Best Practice Guidelines for Stroke Care.*

*** *GTA Rehab Network Stroke Subgroup Meeting Minutes. November 12, 2003; December 16, 2003; January 22 & 26, 2004.*

8.4 Appendix D

Initial Draft Triage Framework: (Pre-Consensus Session)



*What other factors need to be considered when the triage decision remains unclear after considering the factors of 'severity' and 'age'? Is **tolerance** the third key factor that comes into play? If so, how is tolerance defined with respect to LTLD stroke rehab?

8.5 Appendix E

Breakout Session Questionnaire



GTA REHAB NETWORK STROKE REHAB TASK GROUP LOWER TOLERANCE LONGER DURATION STROKE REHABILITATION INITIATIVE

Consensus Session: February 16, 2004
BREAKOUT GROUP SESSION

WORKSHEET – SCENARIO 3

1. PROPOSED DRAFT DEFINITIONS

Note: The following proposed draft definitions are to be used as preliminary guidelines to assist with the breakout group discussions and questionnaire. These definitions will be revisited for discussion AFTER completion of the questionnaire.

Rehabilitation

Rehabilitation: A progressive, dynamic, goal-oriented process aimed at enabling a person with impairments to reach his or her optimal mental, physical, cognitive, communicative and/or social functional level. It is multidimensional, consisting of prevention and treatment of medical complications, restoration of maximal independence of psychosocial coping and adaptive functioning, promotion of community reintegration and enhancing quality of life for stroke survivors.³⁴

Regular Stream Stroke Rehab

Regular stream rehabilitation is geared towards patients with moderate strokes, as measured by an early FIM score between 40 and 80 (as one example) and who are generally 19-75 years in age. This program offers rehabilitation to patients who can tolerate at least 60 minutes of therapy per session and their overall expected length of stay averages approximately 4 to 6 weeks.^{35 36} This program can accommodate patients with comorbidities; but only to the extent that the comorbidities do not affect a patient's ability to participate in rehabilitation intervention with respect to the tolerance levels outlined above.

Lower Tolerance Longer Duration (LTL) Stroke Rehab

LTL stroke rehab is generally geared toward patients with moderate to severe strokes, as measured by an early FIM score of less than 40 (as one example).³⁷ These patients are generally over 55 years of age. This program is also appropriate for patients who may have an early FIM score of greater than 40 but who are much older, i.e. greater than 75 years of age.³⁸ Patients in this program can tolerate therapy for a maximum of 20-30 minutes per session for a total of no more than 2-3 hours per week.^{39 40} The average length of stay in LTL stroke rehab can range between 60 to 180 days.^{41 42} Further, these patients generally have comorbidities that affect their ability to tolerate the intensity of a regular stream stroke rehab program.^{43 44} Additional functional characteristics of patients appropriate for this program may include: previous strokes; multiple co-morbidities; need for a hooyer lift; sitting tolerance of not more than 5-10 minutes; presence of aphasia; difficulty in following two to three step commands; presence of hemi-neglect; and incontinence.

2. SCENARIO: 3 - LOW SEVERITY, HIGH AGE

Please refer to Appendix B: Triage Framework for the Triage of Stroke Rehab Patients

An 80-year-old patient experiences a moderate stroke (early FIM 55). Above and beyond severity and age, it is proposed that a patient’s tolerance for therapy be the third key factor in determining when a patient is appropriate for LTLTD stroke rehab.

3. QUESTIONNAIRE

<p>1) Tolerance With scenario #3 in mind as described above, please review the following components of <u>tolerance</u> and discuss how they should be used to determine when a patient is appropriate for LTLTD stroke rehab.</p>		
<p>a) Duration Suggested tolerance level for LTLTD stroke rehab: 20-30 minute per sessions (up to a max of 2 – 3 hours per week.)</p>	<p><input type="checkbox"/> Agree <input type="checkbox"/> Disagree with the following modifications: _____</p>	
<p>b) Frequency Suggested tolerance level is a maximum of 2 sessions per day up to 5 days a week</p>	<p><input type="checkbox"/> Agree <input type="checkbox"/> Disagree with the following modifications: _____</p>	
<p>c) Activity Related to Tolerance* Assuming a patient receives assistance/supervision to engage in an activity, <i>how long can a patient who is appropriate for LTLTD stroke rehab tolerate</i> each of these activities <i>as specified in minutes?</i></p> <p>*Note: Please consider a patient’s tolerance to engage in these activities for a specific period of time; not whether the patient can perform them (as measured by the FIM)</p>	i. Sitting Supported	_____ Minutes
	ii. Sitting Unsupported	_____ Minutes
	iii. Standing	_____ Minutes
	iv. Propelling in a wheelchair/walking	_____ Minutes
	v. Eating	_____ Minutes
	vi. Dressing	_____ Minutes
	vii. Grooming	_____ Minutes
	viii. Bathing	_____ Minutes
	ix. Toileting	_____ Minutes
	Other (please specify):	_____ Minutes

2) What other factors would need to be considered above and beyond age, severity and tolerance to make a decision as to whether a patient is appropriate for LTLD stroke rehab?

(Please rank the following in order of importance using "1" as most important and "NC" for factors not considered.)

Need for Assistance With Transfers

Perception

Communication

Cognitive Status

Depression

Neglect

Aphasia

Dysphagia/G-tube feeding

Cardiac Condition e.g. Congestive Heart Failure

Sensory Status

Presence of Comorbidities

Incontinence

Presence of Social/Family Support

Socio-economic Status

Other (Please specify _____)

Other (Please specify _____)

3) In light of what patients look like (based on your responses above), what changes need to be made to the draft proposed definitions of regular stream and LTLD stroke rehab outlined on Page 2?

4) What type of patient is not appropriate for LTLD stroke rehab?

8.6 Appendix F

LTLD Stroke Rehabilitation - Summary of Consensus Session Feedback

ISSUES FOR DISCUSSION	SCENARIO 3: LOW SEVERITY, HIGH AGE				SCENARIO 4: HIGH SEVERITY, LOW AGE			
	Group 1	Group 2	Group 3	Summary	Group 4	Group 5	Group 6	Summary
1. Tolerance								
a) Duration	<ul style="list-style-type: none"> Min 30 min/session Max 5 h/wk 	<ul style="list-style-type: none"> 2 – 7 h/wk 	<ul style="list-style-type: none"> 30-60 min/session 	Can tolerate a maximum of 30-60 minutes of therapy per session up to twice/day, 5 days/week.	<ul style="list-style-type: none"> 15-30 min/session 	<ul style="list-style-type: none"> 3-5 h/week 	<ul style="list-style-type: none"> 20-30 min 3-6 hours 	Can tolerate a maximum of 15-30 minutes of therapy per session up to twice/day, 5 days/week.
b) Frequency	<ul style="list-style-type: none"> 2 /day Max 5 days/wk 	<ul style="list-style-type: none"> 2 /day Max 5 days/wk As per tolerance 	<ul style="list-style-type: none"> 2 /day Max 5 days/wk As per tolerance 		<ul style="list-style-type: none"> 2 /day Max 5 days/wk 	<ul style="list-style-type: none"> 2 /day Max 5 days/wk 	<ul style="list-style-type: none"> Max 3/day 	
c) Activity				Generally, can sit (supported) no longer than 60 minutes at a time. If the patient can generally tolerate more than 10 minutes of these other activities, then they would be more appropriate for regular stream rehab				Generally, can sit (supported) no longer than 30 minutes at a time. If the patient can generally tolerate more than 10 minutes of these other activities, then they would be more appropriate for regular stream rehab.
<i>Sit Sptd*</i>	60-90	30	60		30	30	30	
<i>Sit Unsptd*</i>	Max 2 min	0	0-1			0-5		
<i>Standing</i>	0	0				0-5		
<i>Wheelchair/Walking</i>	0	0				0-5		
<i>Eating</i>	0	15-30				5-10		
<i>Dressing</i>	0	15-30				1-10		
<i>Grooming</i>	0	15-30	Not time but ability to participate			5-10		
<i>Bathing</i>	0	15-30				5		
<i>Toileting</i>	0	15-30				5-10		
<i>Other</i>								

* Sitting supported and unsupported tend to be seen as the most important tolerance activity indicators.

ISSUES FOR DISCUSSION	SCENARIO 3: LOW SEVERITY, HIGH AGE				SCENARIO 4: HIGH SEVERITY, LOW AGE			
	Group 1	Group 2	Group 3	Summary	Group 4	Group 5	Group 6	Summary
2. Other Factors above and beyond severity, age, and tolerance? (Top five)	1. Cardiac 2. Family/ Social Support 3. Co - morbidities 4. Gross Obesity 5. Rehab Goals	1. Cognitive Status 2. Perception/ Neglect 3. Communication /Aphasia 4. Incontinence 5. Depression	1. Premorbid Activity level 2. Awareness of incontinence 3. Cognitive Status	Most prominent considerations: 1. Cognitive status/Perception 2. Co-morbidities 3. Family/social Support	1. Motivation 2. Co-morbidities 3. Family / Social Support 4. Communication 5. Cognitive status	1. Perception/ neglect/sensory status 2. Cognitive status 3. Co-morbidities 4. Incontinence 5. Family/ Social Support	1. Perception 2. Cognitive status 3. Co-morbidities 4. Cardiac	Most prominent considerations: 1. Cognitive status 2. Perception 3. Co-morbidities 4. Family/social Support
3. Changes to LTLD Definition	<ul style="list-style-type: none"> ▪ Max duration of 5 hours / week 	---	<ul style="list-style-type: none"> ▪ Add sitting supported longer ▪ Consider premorbid activity 	<ul style="list-style-type: none"> ▪ See revised definition 	<ul style="list-style-type: none"> ▪ Consider adding measure of motivation ▪ Perceptual status ▪ Communication and difficulty with one step commands 	<ul style="list-style-type: none"> ▪ Add qualifier that level of activity be done within 7 days post stroke 	<ul style="list-style-type: none"> ▪ An integrated therapy environment ▪ Designed with targeted goals ▪ Frequent shorter formal therapy sessions 	<ul style="list-style-type: none"> ▪ See revised definition
4. Types of Patients Not Appropriate for LTLD Stroke Rehab	<ul style="list-style-type: none"> ▪ No rehab goals ▪ Inability to learn ▪ Mild and can go home 	---	<ul style="list-style-type: none"> ▪ See assumptions ▪ Severe dementia / cognitive deficits ▪ Poorly managed mental illness 	<ul style="list-style-type: none"> ▪ Severe Cognitive Impairments ▪ No capacity for functional improvement ▪ Lack of motivation ▪ Inability to learn ▪ Severe behavioral issues 	<ul style="list-style-type: none"> ▪ Lack of motivation ▪ Not able to tolerate rehab ▪ Severe behavioral issues ▪ Cognitive status ▪ Life expectancy < 6 months 		<ul style="list-style-type: none"> ▪ Severe cognitive impairment ▪ No capacity for functional improvement 	<ul style="list-style-type: none"> ▪ Severe Cognitive Impairments ▪ No capacity for functional improvement ▪ Lack of motivation ▪ Inability to learn ▪ Severe behavioral issues

8.7 Appendix G

Summary of Evaluation Responses from Consensus Session of February 16, 2004

Of the 75 total attendees, 55% (41) of the evaluation forms were returned. Of those who responded, 27% (11) worked in acute care, 53% (22) worked in an inpatient rehab/day hospital setting, and 15% (6) worked in a community facility. Further, of those who responded, 51% (21) worked within the GTA while 27% (11) worked outside the GTA.

What was liked most?

The majority of respondents, 59% (24), indicated that the one aspect valued most was the mix of caregivers in attendance and the variety of perspectives presented from different disciplines across the province. The opportunity to meet and hear different perspectives enriched the consensus-building process. Attendees also generally found the presentations to be informative and helpful in providing the essential background and foundation for discussion. Others expressed appreciation in learning more about the literature and what other programs were experiencing with respect to LTLD stroke rehab. Participants also commented positively on the opportunity to participate in discussion and provide feedback in the breakout sessions. The composition of each breakout group was predetermined to ensure the best possible mix of representation from various disciplines, sites, and regions. Many participants indicated that the structure and organization of the Consensus Session, the provision of scenarios and the discussion using the worksheet helped to focus the group toward overall consensus.

Ways to improve?

The majority of respondents, 63% (26) also commented on the time available for discussion and the length of the overall session. According to the feedback, many attendees believed that although the tight schedule really helped focus the discussion, more discussion time during and after the breakout sessions could have been beneficial. The desire for more time may reflect the great interest and significance of LTLD stroke rehab to all those who attended. Additional advice included: requests for a summary/follow-up report; more discussion around the continuum of care (i.e. community position); assessing the current need for LTLD rehab services; more focus on the evidence; and more discussion around discharge criteria. Additional logistical feedback included: providing presentation handouts (now available at www.gtarehabnetwork.com); providing clearer guidelines for the breakout group discussion; and having separate rooms for the breakout groups.

How did the session affect your views?

The most frequent comment given was a greater appreciation for the complexity around defining LTLD stroke rehab needs and programs while hearing the different ways LTLD stroke rehab is viewed and served. Other comments included realizing the interdependence and shifting significance of factors affecting the triage of patients to LTLD stroke rehab. Concern was also expressed about the multiple programs and names under which this population is served; the understanding of the significance of lower intensity and higher resource needs; and the resulting implications for policy and funding directions.

ENDNOTES

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- ¹ Heart & Stroke Foundation of Ontario: *Stroke Rehabilitation Consensus Panel Report*, May 2003, p. 70.
 - ² Robert Teasell, Norine Foley, Sanjit K. Bhogal, Jeffrey Jutai, & Mark Speechley, *Evidence-Based Review of Stroke Rehabilitation: Module 4-Managing the Stroke Rehabilitation Triage Process*. Department of Physical Medicine and Rehabilitation, St. Joseph's Health Care London, Parkwood Hospital, London, Ontario and the University of Western Ontario and the Department of Epidemiology and Biostatistics, the University of Western Ontario, London, Ontario, 2003, pp. 4-20.
 - ³ GTA Rehab Network, *Needs Assessment and Plan for Integrated Stroke Rehabilitation in the GTA*, February 2002, p. 23.
 - ⁴ MP Alexander MP. Stroke Rehab Outcome. "A potential use of predictive variables to establish levels of care." *Stroke*, 1994; 25:128-134.
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 - ⁶ GTA Rehab Network, *Analysis of Alternative Level of Care (ALC) Snapshots: Patients Awaiting Rehabilitation in ALC and Inpatient Rehabilitation Capacity*, May 2004, p. 13.
 - ⁷ Teasell et al. *Evidenced-Based Review of Stroke Rehabilitation*, p. 16.
 - ⁸ GTA Rehab Network, *Needs Assessment*, p. 24.
 - ⁹ GTA Rehab Network, *Needs Assessment*, p. 24.
 - ¹⁰ NE Mayo, S. Wood-Dauphinee, S. Ahmed, C. Gordon, J. Higgins, S. McEwen & N. Salbach, "Disablement following stroke." *Disabil Rehabil* 1992; 21: 258-268. In Teasell, *Evidence-Based Review of Stroke Rehabilitation: Module 3: Background Concepts of Stroke Rehabilitation*, p. 3.
 - ¹¹ C. Tran, Z. Nadareishvili, L. Smurawska, PL Oh & JW Norris. "Decreasing costs of stroke hospitalisation in Toronto." *Stroke* 1999; 30 : 185-186. In Teasell et al, *Evidence-Based Review of Stroke Rehabilitation, Module 3*, p. 3.
 - ¹² Heart & Stroke Foundation of Ontario: Coordinated Stroke Strategy. *Heart and Stroke Best Practice Guidelines for Stroke Care: A resource for implementing optimal stroke care*. Ontario, 2003, p.37.
 - ¹³ GTA Rehab Network, *Needs Assessment*, p. 24.
 - ¹⁴ MS Garraway, AJ Akhtar, DL Smith & ME Smith . "The Triage of Stroke Rehabilitation." *J Epidemiol Community Health*. 1981;35:39-44
 - ¹⁵ Teasell, Robert. *Stroke Rehabilitation Data-Based Project: Rehab of the Severe Stroke Patients*. Presentation at the Stroke Rehabilitation Initiative Consensus Session, February 16, 2004.
 - ¹⁶ Teasell et al. *Evidence-Based Review of Stroke Rehabilitation: Module 4-Managing the Stroke Rehabilitation Triage Process*. p. 4.
 - ¹⁷ Heart & Stroke Foundation of Ontario. *Best Practice Guidelines for Stroke Care. A resource for implementing optimal stroke care*, Ontario, 2003, p. 47.
 - ¹⁸ GTA Rehab Network, *Needs Assessment*, p. 24.
 - ¹⁹ Teasell et al, *Evidence-Based Review of Stroke Rehabilitation Module 4*, pp 4-20.
 - ²⁰ GTA Rehab Network Stroke Sub Group Meeting Minutes. November 12, 2003; December 16, 2003; January 22 & 26, 2004.
 - ²¹ GTA Rehab Network Stroke Rehab Task Group. Low Intensity Long Duration Stroke Rehabilitation Survey – Greater Toronto Area, 2003. (Data from survey responses).
 - ²² Teasell et al., *Evidence-Based Review of Stroke Rehabilitation Module 4*, p. 19.
 - ²³ Heart & Stroke Foundation of Ontario. *Best Practice Guidelines for Stroke Care. A resource for implementing optimal stroke care*. Ontario, 2003, p. 63.
 - ²⁴ MP Alexander MP. Stroke Rehab Outcome. "A potential use of predictive variables to establish levels of care." *Stroke*, 1994; 25:128-134.
 - ²⁵ Teasell et al., *Evidence-Based Review of Stroke Rehabilitation Module 4*, p. 19.
 - ²⁶ Heart & Stroke Foundation of Ontario. *Best Practice Guidelines for Stroke Care*, p. 63.
 - ²⁷ Teasell et al., *Evidence-Based Review of Stroke Rehabilitation Module 4*, p. 19.
 - ²⁸ Teasell et al., *Evidence-Based Review of Stroke Rehabilitation Module 4*, p. 19.
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 - ³¹ Asberg, KH, Nydevik I. "Early prognosis of stroke outcome by means of Katz Index of activities of daily living." *Scand J Rehabil Med* 1991;23:187-191. In Teasell et al. *Evidence-Based Review of Stroke Rehabilitation: Module 4: Managing the Stroke Rehabilitation Triage Process*, p. 4

- ³² GTA Rehab Network, *Needs Assessment*, p. 24.
- ³³ *Guide for the Uniform Data Set for Medical Rehabilitation (including the FIM instrument), Version 5.1: Australia*. Buffalo, NY 14214: State University of New York at Buffalo; 1997.
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- ³⁵ GTA Rehab Network Stroke Sub Group Meeting Minutes. November 12, 2003; December 16, 2003; January 22 & 26, 2004.
- ³⁶ GTA Rehab Network Stroke Rehab Task Group. Low Intensity Long Duration Stroke Rehabilitation Survey – Greater Toronto Area, 2003. (Data from survey responses).
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- ³⁸ Heart & Stroke Foundation of Ontario. *Best Practice Guidelines for Stroke Care*, Ontario, 2003, p.63.
- ³⁹ GTA Rehab Network Stroke Sub Group Meeting Minutes. November 12, 2003; December 16, 2003; January 22 & 26, 2004.
- ⁴⁰ GTA Rehab Network Stroke Rehab Task Group. Low Intensity Long Duration Stroke Rehabilitation Survey – Greater Toronto Area, 2003. (Data from survey responses).
- ⁴¹ GTA Rehab Network Stroke Sub Group Meeting Minutes. November 12, 2003; December 16, 2003; January 22 & 26, 2004.
- ⁴² GTA Rehab Network Stroke Rehab Task Group. Low Intensity Long Duration Stroke Rehabilitation Survey – Greater Toronto Area, 2003. (Data from survey responses).
- ⁴³ GTA Rehab Network Stroke Sub Group Meeting Minutes. November 12, 2003; December 16, 2003; January 22 & 26, 2004.
- ⁴⁴ GTA Rehab Network Stroke Rehab Task Group. Low Intensity Long Duration Stroke Rehabilitation Survey – Greater Toronto Area, 2003. (Data from survey responses).