Developing a 7-Day Therapy Model: Considerations for Success
Central South Regional Rehabilitation Intensity Forum
April 2016
Hamilton, Ontario

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Background on HHS

Our Sites

McMaster University Medical Centre
West Lincoln Memorial Hospital
Chedoke Hospital
St. Peter’s Hospital
McMaster Children’s Hospital
Hamilton General Hospital
Regional Rehabilitation Centre
Juravinski Hospital & Cancer Centre
Main St. West Urgent Care Centre
Patient presents to HGH ED with stroke requiring admission

**Band 1 - 7 South Acute Stroke Unit Care**
Assessment and Triage
LOS 2 - 5 Days

1. Confirm Diagnosis of Stroke, Stroke Etiology, start Secondary Stroke Prevention
2. Stabilize medical condition
3. Assessment of stroke rehabilitation needs by 7 South Interdisciplinary Team using Stroke Assessment Tools:
   - Stroke Severity (NIHSS)
   - Alpha FIM® Instrument (Functional Status)
   - MoCA (Cognitive Status)
   - Communication Screen
   - Family Support
   - Previous Living Environment

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<tr>
<th>Patient Groups (Impairment)</th>
<th>Patient Functional Level (Disability)</th>
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<tr>
<td>Band 2: (Mild Stroke)</td>
<td>Location: B2N</td>
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| Requires short duration of High Intensity Rehabilitation in order to be safely discharged home | • Alpha FIM score over 80
• Patient may have mild cognitive and communication deficits |

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<th>Band 3: (Moderate Stroke)</th>
<th>Location: B2N</th>
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| Requires short to moderate duration and Moderate Intensity Rehabilitation in order to be discharged | • Alpha FIM score between 40 - 80
• Patients demonstrate marked improvement but may be dependent in some areas at discharge from rehabilitation |

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<th>Band 4: (Severe Stroke)</th>
<th>Location: B2N/St. Peters – 2 West</th>
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| Requires a longer duration of Lower Intensity Rehabilitation | • Alpha FIM score less than 40 or
• Elderly patients with an Alpha FIM 40 – 60 |

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<th>Band 5: (Very Severe Stroke)</th>
<th>Location: 7 South</th>
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| Palliative patients         | • Alpha FIM score typically between 20 – 30
• Palliative stroke patients
• Decreased level of consciousness
• Not consistently participating or following commands |
| Patients who due to the severity of the stroke or other medical conditions are unable to participate in rehabilitation |

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<th>Band 6: (TIA/Mild Stroke)</th>
<th>Location: Home</th>
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| Do not require inpatient rehabilitation and is able to be safely discharged home with community services as needed based on needs | • Alpha FIM score over 80
• May require CCAC services, outpatient rehabilitation, YMCA Fit for Function Program, Stroke Prevention Clinic follow-up, Thrombosis Clinic follow-up, follow-up with Neurologist and with family physician|

**Community Services**
- HGH Stroke Prevention Clinic
- Regional Rehabilitation Centre - Outpatient Rehabilitation Services
- CCAC Community Supports Services
- Les Chater YMCA Fit for Function Program
- Hamilton Wentworth Stroke Recovery Association
- Hamilton Young Stroke Survivor Group
- Adult Day Services Programs
- SAM Community Based Aphasia Programs
- Convalescent Care Programs
- Retirement Home
- Long Term Care
Background:

**Rationale for the development of the 7-Day Model:**
- Disbanding of HGH ‘coverage pool’ for Physiotherapy
- Patient-care streams for week-end coverage at HGH site
- Stroke Best Practice Guidelines and Performance Measures: QBP for ischemic stroke, RPG LOS, Rehab Intensity, FIM® Efficiency, Onset to Rehabilitation, early mobilization, assessment and triage
- Overwhelming number of new assessments on Mondays
- Feedback from patients/families regarding lack of week-end therapy in Rehabilitation, particularly on long week-ends
Rehabilitation Intensity

Rehabilitation Intensity is:

• The amount of time the patient spends in individual, goal-directed rehabilitation therapy, focused on physical, functional, cognitive, perceptual and social goals to maximize the patient’s recovery, over a seven day/week period. It is time that a patient is engaged in active face-to-face treatment, which is monitored or guided by a therapist.

• Organizations should strive for 7 days per week of intensive rehabilitation therapy to maximize patient recovery and reduce risk of deterioration in function due to lack of therapy on weekends.
Guiding Principles

• Maintain staffing levels during the week
• Ensure Therapeutic Week-End Passes continued
• Incorporate Therapists and Assistants
• ‘Smoothing’ of assessment workload in Acute
• Opportunities for Rehabilitation beyond 5-days/week
• Incorporate Stroke Best Practice Guidelines (early assessment, mobilization and triage, AFIM® by day 3 and FIM® within 72 hours)
Considerations

• Backfill dollars for week-day coverage and vacation
• Maintain stroke ‘expertise’ across 7 Days
• Communication with other team members
• Expanding therapy team to include new members (Change Management, Hand-over Processes)
• Role of therapists and assistants on week-ends
• Messaging to patients and families
Development Process

- Leadership introduced concept to frontline staff, including rationale, guiding principles and considerations
- Support from Interprofessional Affairs, Organizational Development, Health Safety and Wellness, Regional Stroke Team
- Collaborative decision on which model to pursue (leadership/staff)
- Development of new schedule/rotation for staff
- Hiring and orientation of part-time staff
- Working Group to develop Prioritization Matrix and Hand-Over Tools/Processes
- Timelines for starting and evaluation
- Messaging to the larger team, and HHS stakeholders (e.g., SAM)
- Messaging to patients and families
- Ongoing evaluation and improvements
Model

• 1 OT, PT and OTA/PTA work Saturdays and Sundays and some stats

• OT & PT complete collaborative assessments on 7S in the a.m. (Prioritization Matrix)

• OT & PT compete collaborative assessments and treatment on B2N in the p.m. (Prioritization Matrix)

• OTA/PTA – work on Rehabilitation only, on the week-end (focus on ADLs, Hand Therapy and Physical Therapy programming)
Prioritization Models for Weekend Therapy

7 South (Acute)

As per the primary therapist:

- **Priority 1**
  - New Stroke Admissions/Day 3 AlphaFIM(R)
  - Chest Physiotherapy

- **Priority 2**
  - Stroke Discharges
  - Cognitive Assessment/Functional Tasks for Stroke

- **Priority 3**
  - Therapeutic interventions for Band 2s and 3s awaiting transfer to B2N

- **Priority 4**
  - Other
    - Band 4s
    - Band 5s
    - Off Service Discharges
Prioritization Models for Weekend Therapy

B2N (Rehabilitation)

As per the primary therapist:

Priority 1
- New rehabilitation admissions assessed and initiated on rehab goals/72-hour FIM(R) completion

Priority 2
- Therapeutic intervention for stroke patients at risk of deterioration without weekend treatment

Priority 3
- Provision of goal-directed therapy for those Band 2 and 3 patients with discharge goals that require increased 1-1 guided intervention

Priority 4
- Other
  - Band 4s
  - Band 5s/ALC
MEMO:

To Patients and Families in the Integrated Stroke Program:

The Integrated Stroke Program (including 7 South Acute and B2 North Rehabilitation) is pleased to be introducing week-end coverage by our Occupational and Physiotherapy team. The objective of weekend coverage is to facilitate earlier assessments for stroke patients, according to the best practice guidelines for stroke recovery. The priority for weekend coverage will be patients who are newly admitted and/or who are at risk of decline.

The Integrated Stroke Program is committed to ongoing quality improvement in order to provide excellent patient care and achieve positive patient outcomes. We will continue to evaluate our new weekend coverage model and look for opportunities for improvement.

If you have questions or concerns regarding our weekend coverage in the Integrated Stroke Program, please do not hesitate to contact me.

Sincerely,

Krista Trow, BA, MSc,
Clinical Manager,
Integrated Stroke Program,
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Evaluation

- 3-month evaluation meeting in February, with OT, PT, Assistants and stake-holders
- Check-in, group evaluation of what was working well and what needed to be improved
- Working well: communication between therapists/assistants, refined hand-over processes, ease of assessments on Monday mornings, therapist schedules, earlier patient mobilization, lack of interruptions on the week-end
- Needs improvement: need more part-time staff; gym safety, need for continuing communication to families and team education regarding week-end Prioritization Matrix, reinforce Therapeutic Passes on week-ends, team-building/trust; no admit to Rehab on week-ends
Evaluation

- 6-month evaluation scheduled for end-May
- *Outcome measures to review:*
  - Onset Days to Rehabilitation
  - Timeliness of AFIM® and FIM® completion
  - FIM® Efficiency
  - Rehabilitation Intensity
  - RPG length of stay
  - Patient/Family Evaluation
  - Therapist Satisfaction
Next Steps

• Evaluation of data
• Is RI being impacted by expanding to 7 days?
• Do we have the right model design?
• Opportunities to add other disciplines to the week-ends (e.g., SLP, CDA, SW)
• Week-end patient flow (admit to Rehab)
Acknowledgements

7-Day Model Development Team:

Anthony Ciavarra
Cathy Cuneo
Darlene Venditti
Elizabeth McKay
Jennifer Kodis
Jennifer Robinson
Jenny Deaves
Julie D’Entremont
Kathryn LeBlanc
Krista Trow

Louise MacRae
Marcela Bandi
Michaela Ferguson
Natalie Singh
Season Kam
Sandy Veit
Sheila Boatman
Stef Pagliuso
Vicky Good-Dubecki
Questions?