This year’s Annual Achievement Report provides a high level overview of the many successes in Toronto’s stroke system.

Through strategic leadership, the North & East GTA and the Toronto West Stroke Networks continue to advance the work relative to their strategic directions:

- Sustainable System Improvements
- Seamless Stroke Systems and
- Patient Experience

This Year in Review highlights some of the many initiatives undertaken within each strategic direction.

2017/18 has seen broader inclusion of persons with stroke and caregivers as partners within the structures and activities of the Networks. This has resulted in system improvement work that is relevant and meaningful to all stakeholders.

This report reflects the performance and collaborations of organizations within the North & East GTA and Toronto West Stroke Networks.

**Steering Committee Members**

Beth Linkewich
Deborah Goldberg
Dr. Frank Silver
Gayle Seddon
Ilsa Blidner
Kim Partridge
Maggie Bruneau

Malcolm Moffat (retired) /Dr. Dan Cass
Nicola Tahair
Dr. Rick Swartz
Ron Lacombe
Susan Woollard
Tina Smith

[www.tostroke.com](http://www.tostroke.com)
The North & East GTA and Toronto West Stroke Networks strive to continuously monitor and evaluate their performance through a comprehensive and sustainable cross-continuum dataset. This provides the opportunity to plan quality improvement initiatives aimed at supporting better access to stroke care.

### HYPERACUTE

**Number of rehab admissions FY 17/18**

- Fewer patients (5%) accessed high intensity rehab from acute care in FY 2017-18 compared to FY 2016-17 while there was an 8% increase in the number who accessed outpatient rehab.

### ACUTE

**Proportion of TIA or non-disabling stroke clients discharged directly from the ED with a referral to secondary prevention services**

- Target: 180 min

### REHABILITATION & COMMUNITY

**Note: median minutes are adjusted for assistant time**

- Median range of minutes per day of direct therapy in inpatient rehab hospitals FY 2016-17. Striving towards a target of 180 min/day.

- 79.6 to 145.3

**10 patients enrolled in the in-home early supported discharge pilot as part of the Stroke Integrated Funding Model**

- Patients seen 48 hours after discharge from acute care

**Demonstrated improvements include:**

- Timely access, positive patient and provider experience, achievement of patient goals and reintegration within the home setting
2017-18 brought with it a number of initiatives that sought to advance system planning and best practice implementation through stakeholder engagement, partnerships and implementation.

### E-Stroke Automatic Bed Offer
Starting November 2017, **ALL** patients with AlphaFIM® 60-80 (referred ≤ 7 days post stroke) received an automatic bed offer for high intensity rehab. Most patients transitioned home post rehab.

### Cognitive Orientation to daily Occupational Performance (CO-OP)

"CO-OP is a client-centred, performance based, problem solving approach that enables skill acquisition through a process of strategy use and guided discovery"  

- **65** clinicians trained in the CO-OP approach during a 2 day workshop.  
- Training of additional staff supported through online modules  
- **5** rehab hospitals have implemented CO-OP  
- **7%** in acceptance to high intensity rehab for patients with moderate cognitive impairment post CO-OP KT  
- **15%** in evidence of client-centered goal setting across all sites

### Improving the capacity of stroke teams to provide communicative access for persons with aphasia project
Trained staff reported a **28%↑** in level of confidence and **41%↑** in effectiveness in communicating with patients with aphasia following a knowledge translation intervention in supported conversation techniques.

### One Client, One Team: Toronto Central & Central LHIN Stroke Integrated Funding Model Project
The Ministry of Health and Long Term Care (MOHLTC) launched a pilot for bundled care.  
Integrated care pathways were implemented and tested using Plan-Do-Study-Act cycles and small tests of change. Results suggest that a bundled care approach can **break down silos**, **enhance cross sector coordination and integration**, **improve the patient experience** and **create shared accountability for cost and quality across the continuum of stroke care**. Planning for broader spread is underway.

### Virtual Community of Practice
- **Usage by device type**
  - **420** registered users
  - **>90%** in mobile usage
  - **<10%** on desktop  
- **2017 9,000+/month** in page views  
- **<2017 ~ 500/month**  
  - **21** new discussion forums  
  - **35** replies  
  - **40+** organizations represented within & outside the GTA
**PATIENT EXPERIENCE**

Patient and Family Advisors have been integral to advancing our work. They have been engaged in multiple initiatives to help inform system planning and an approach to evaluate the patient experience.

- **Peers Fostering Hope community pilot program development, implementation and evaluation**
- **Community Expo for Healthcare Providers Working in Stroke Care**

---

**Patient & Family Experience Questionnaire (PFEQ)**

- **88 PFEQs completed**

The PFEQ is currently being used in outpatient rehab, secondary prevention clinics, and March of Dimes Canada support groups in Toronto.

---

**Recovery-oriented approach to support psychosocial, hopeful care**

To support patient experience across the care continuum, the TW and NEGTA Stroke Networks are develop a longitudinal, learning and knowledge translation program to enhance psychosocial care and the use of hopeful language. This program supports other stroke network initiatives such as Peers Fostering Hope, CO-OP and the use of the Canadian Occupational Performance Measure.

---

**Stroke Recovery Guide Website**

- **Global reach in 2017**
  - 2173 unique visitors reached the site in 2017 from 53 countries across 7 continents

- **Usage – Device Type**
  - Desktop: 70%
  - Tablet: 13%
  - Mobile: 16%

- **8665 page views in 2017**

[www.strokerecovery.guide](http://www.strokerecovery.guide)
Glossary


**MGSR = My Guide for Stroke Recovery.** A patient education resource to promote understanding of common challenges after stroke and support self management of ongoing needs and recovery.

**IFM = Integrated Funding Model.** A project funded by the Ministry of Health to promote development of ‘bundled’ (seamless) stroke care services across acute, rehabilitation community based organizations.

**Peers Fostering Hope.** A peer support program for individuals with stroke in hospital that provides emotional support and connection to another individual who has also experienced a stroke.

**Early Supported Discharge.** An approach where intensive rehabilitation services are provided in an outpatient setting to support an earlier discharge from an inpatient hospital bed.

**Virtual Community of Practice.** The Toronto Stroke Networks Virtual Community of Practice (VCoP) is an interactive platform for all stakeholders working, researching, and learning in the area of stroke care.

**Patient and Family Experience Questionnaire.** Novel stroke specific cross-continuum questionnaire which captures the experiences of persons with stroke and their family members across their care journey.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY</td>
<td>Fiscal Year</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischemic Attack</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>tPA</td>
<td>Tissue Plasminogen Activator</td>
</tr>
<tr>
<td>EVT</td>
<td>Endovascular Treatment</td>
</tr>
<tr>
<td>HIR</td>
<td>High Intensity Rehab</td>
</tr>
<tr>
<td>LTLD</td>
<td>Low Tolerance Long Duration</td>
</tr>
<tr>
<td>OPR</td>
<td>Outpatient Rehabilitation</td>
</tr>
</tbody>
</table>
## Data Sources*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of TIA/Stroke ED admissions for TSNs acute care hospitals</td>
<td>Ontario Stroke Evaluation Program, CIHI NACRS</td>
</tr>
<tr>
<td>Number of eligible ischemic stroke patients (funded, unfunded and non-OHIP) who received tPA and/or EVT</td>
<td>Toronto Western Hospital (TWH) and Sunnybrook Health Sciences Centre (SHSC) Regional Stroke Centres</td>
</tr>
<tr>
<td>Proportion of TIA or non-disabling stroke clients discharged directly from the ED with a referral to secondary prevention services</td>
<td>Ontario Stroke Evaluation Program, CIHI NACRS</td>
</tr>
<tr>
<td>Proportion of patients treated on a dedicated stroke unit</td>
<td>Ontario Stroke Evaluation Program, CIHI DAD</td>
</tr>
<tr>
<td>Access to high intensity rehab from acute care</td>
<td>TSNs E-Stroke, CIHI NRS</td>
</tr>
<tr>
<td>Median number of minutes per day of direct therapy received by inpatient stroke rehabilitation patients</td>
<td>Facility based analysis, CIHI NRS</td>
</tr>
<tr>
<td>Number of patients referred &amp; accepted to outpatient rehab from acute care</td>
<td>TSNs E-Stroke</td>
</tr>
</tbody>
</table>

* CIHI = Canadian Institute for Health Information  
  NACRS = National Ambulatory Care Reporting System  
  DAD = Discharge Abstract Database  
  NRS = National Rehabilitation Reporting System  

Performance reflects data from the N&E GTA and Toronto West Stroke Networks organizations unless otherwise stated.

For more information about the Toronto Stroke Networks, please visit [www.tostroke.com](http://www.tostroke.com)