Annual Achievement Report







This Annual Achievement Report profiles system performance and accomplishments of activities in hyperacute, acute, rehabilitation and community sectors. It highlights our collaborative planning efforts and commitment to improving stroke care service delivery in Toronto.

The North & East GTA and Toronto West Stroke Networks continue to focus efforts on 4 key priority areas:

- Leadership: Highly visible and responsive Networks within regional and provincial domains
- Sustainable System Improvements: A comprehensive and sustainable data set used to drive system improvement
- Seamless Stroke Systems: Equitable access to best practice stroke care across the continuum; shared ownership for patient and stroke system outcomes
- Patient Experience: Engaged and responsive Networks who partners with persons with stroke and family/caregivers in designing the system

2019 brought about multiple staffing changes to the regional teams. We welcomed Michelle Mohan, Regional Education Coordinator, Donna Cheung, E-Stroke Coordinator, and Tina Sahota, Regional Stroke Coordinator.

Through our collaborative efforts and work with our stakeholders, we have been paving the way for change!

Steering Committee Members

Ilsa Blidner
Dr. Leanne Casaubon
Dr. Dan Cass
Kim Partridge
Tina Smith
Kim Cook
Dr. Rick Swartz
Deborah Goldberg
Beth Linkewich
Susan Woollard

REGIONAL STROKE CENTRES (RSCs)

Toronto Western Hospital (TWH) Sunnybrook Health Sciences Centre (SHSC)



ischemic stroke patients received tPA at TWH and SHSC (FY 19-20)

246

282

ischemic stroke patients received EVT at TWH and SHSC (FY 19-20)



code stroke patients arrived at RSCs via ambulance for hyperacute assessment (FY 19-20)



patients arrived at community hospitals and were transferred to RSCs (FY 19-20)

SECONDARY PREVENTION

of TIA or non-disabling 82.4% stroke patients were discharged directly from the ED with a referral to secondary stroke prevention services (FY 18-19)



3,174

TIA/ Stroke ED admissions to acute care hospitals (FY 18-19)



of patients were treated on a 60.2% of patients were treated a designated acute stroke unit (FY 18-19)

REHABILITATION



patients accessed high intensity rehab in Toronto from acute care (FY 18-19)

OUTPATIENT REHAB

of admissions were patients 47.5% with severe stroke (FY 19-20)





patients were referred and accepted to outpatient rehab from acute care (FY 19-20)

Standards of Care (SOC)

Is comprised of a self-assessment of performance on expected standards for each part of the continuum. The self-assessments assist organizations in developing quality improvement plans and inform system level planning.

14 organizations completed the SOC self-assessment in 2019.

Themes from self-assessment results:

- Variations in the degree of best practice implementation exists across the continuum.
- Access to specialized teams, stroke experts, resources, equipment, and timely evidencebased treatment options was the most commonly identified theme with opportunities for improvement.

Click <u>here</u> to see examples of quality improvement plans developed from the Standards of Care process.

Access to Hyperacute Care

Regional protocols have been updated to improve access to hyperacute treatment for appropriate patients in Toronto.

New screening measures were introduced in emergency departments to support the identification of patients most likely to benefit from endovascular therapy (EVT).

All community hospitals in Toronto are **now** using an updated walk-in code stroke protocol that provides access to EVT at Regional Stroke Centres for patients up to 24 hours post stroke (select cases).

3 community hospitals have implemented a new in-hospital code stroke protocol for access to hyperacute care for admitted patients experiencing stroke.



Stroke Bundled Care

Enhances the coordination and integration of care across care sectors including:

- Inpatient rehabilitation
- Outpatient rehabilitation including early supported discharge
- Home-based rehabilitation including early supported discharge

GOAL: Provide sustainable and equitable access to best practice stroke services through designated geographical hubs closest to home.

These hubs will be achieved through the collaboration of 6 bundle holder hospitals in Toronto.

In each hub, all bundled care services will be provided by **dedicated interprofessional teams with expertise in stroke** working together across the continuum of care in each.

Strategic Direction: Patient Experience

Patient and Family Advisors (PFAs)

20 Active PFAs

members of the PFA Advisory Committee



Additional PFAs' contributions to:

- Education materials;
- Annual Collaborative and stroke month events;
- 8 teaching videos for the Psychosocial and Hopeful Care initiative;
- Bundled Care planning.

Building Capacity in Psychosocial and Hopeful Care Initiative

- 6 stroke teams engaged as 'early adopters'
 - 3 acute care
 - 3 rehabilitation
- Pre-implementation self-efficacy survey completed by 198 staff across the 6 teams



- 26 facilitators completed the train the trainer program
- Stroke teams are now completing the 8 e-learning modules
- Practice-based small group learning sessions started in January

Patient and Family Experience Questionnaire (PFEQ)

The PFEQ is being administered in:

4 Stroke Prevention Clinics and

3 outpatient rehab facilities.

300+

Surveys completed since Nov 2017



Peers Fostering Hope Program

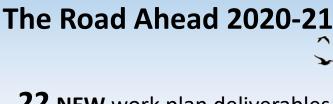


Provided total of **950** hours









22 NEW work plan deliverables Sustaining **30** initiatives

The Toronto West and North & East GTA Stroke Networks will be updating their strategic priorities for 2021-2026 with input from stakeholders.

Response to COVID-19

- Quick Reference Guides and Checklists developed
- Patient and family stroke virtual care resources made available on

www.tostroke.com

 System-level planning for restoration of outpatient stroke rehab services across Toronto (hybrid – in-person and virtual) **Focus** of the next phase of stroke bundled care implementation:

- 1. Community re-integration
- 2. Centralized referral process and automatic bed offers for inpatient stroke rehab
- 3. Data reporting and monitoring
- 4. Collaborative procurement
- 5. Community-based stroke rehab competencies



Network

Initiatives

Strategic

Planning

Bundled Care



Performance reflects data from organizations within the North & East GTA and Toronto West Stroke Networks unless otherwise stated.

Indicator	Data Source
Number of code stroke patients arrived at RSCs via ambula assessment	nce for hyperacute Toronto Paramedic Services
Number of ischemic stroke patients who received tPA at TV number of ischemic stroke patients who received EVT at TV	
Number of patients who arrived at community hospitals are and SHSC	nd transferred to TWH Toronto Paramedic Services
Number of TIA/ Stroke ED admissions for acute care hospit Excludes Unity Health – St. Michael's Hospital and Michael	
Proportion of patients were treated on a designated acute Excludes Unity Health	stroke unit Ontario Stroke Evaluation Program, CIHI DAD
Proportion of TIA or non-disabling stroke clients discharged with a referral to secondary stroke prevention services Excludes Unity Health and Michael Garron Hospital	d directly from the ED Ontario Stroke Evaluation Program, CIHI NACRS
Number of acute stroke patients who accessed high intens	ity rehab in Toronto CIHI NRS
Proportion of patients admitted to high intensity rehab wit Toronto	th severe stroke in CIHI NRS
Number of patients referred and accepted to outpatient re in Toronto	hab from acute care TSNs' E-Stroke Rehab Referral System
CIHI Canadian Institute for	Health Information DAD Discharge Abstract Database
NACRS National Ambulatory	Care Reporting System NRS National Rehabilitation
ut the Toronto Stroke Networks, please visit <u>www.tostroke.com</u> .	Reporting System