Frequently asked questions – Stroke Community Indicator Collection

From 1 July 2018 the Ministry of Health in agreement with the National Stroke Network is planning on introducing a new indicator for community rehabilitation in stroke. During 2017-18 DHB stroke teams have been asked to start collecting information for this indicator or identify what is still needed in order to streamline internal reporting processes and to achieve national consistency when actual reporting begins.

This document is to help answer questions, clarify intent and guide processes.

Indicator 4: Community rehabilitation: (New)

60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehab team i.e. RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.

Numerator – number of patients referred for community rehabilitation that are seen face to face by the community rehabilitation team i.e. RN/PT/OT/SLT/Dr/Psychologist within 7 calendar days of hospital discharge. Target 60%

Denominator - number of patients discharged from hospital with a primary stroke diagnosis (i.e. ICD10 codes I61, I63 and I64) **and** referred for community rehabilitation (as defined by MOH Minimum Expectations (see attached) for guidance).

Note: When reporting the indicator we request you include the 'actual' raw numbers rather than just a 'percentage' figure.

Frequently asked questions:

Why do we need a community stroke rehab indicator?

The indicator is being implemented based on a similar successful strategy applied in the acute setting that has resulted in improved rates of patients being cared for in 'organised stroke services' and increased rates of thrombolysis. In the community there is evidence that smooth and timely transitions back into community results in better outcomes for patients. From the patient's perspective, a smooth and timely transition of their rehabilitation programme from inpatient to the community setting can result in less anxiety, sense of isolation and feelings of abandonment. This early face to face contact is just one measurable marker of service provision and responsiveness of community stroke. Other patient outcomes are not captured by this indicator but are still important.

Who should be considered for community rehabilitation?

The Australian Clinical Guidelines for Stroke Management 2017 include two fundamental principles that:

- Every stroke patient should have their rehabilitation needs assessed within 24-48 hours of admission to the stroke unit/service by members of the interdisciplinary team.
- Any stroke patient with identified rehabilitation needs should be referred to a rehabilitation service.

This includes patients discharging to the community from an acute stroke or in-patient stroke rehabilitation setting.

What patients are counted as referrals to the community stroke team?

Anyone with a discharge for an acute stroke event (ICD-10-AM codes 161, 163 and 164) from either an acute ward or rehabilitation ward who is referred to the community rehabilitation team within 7 days of hospital discharge.

Note: Patients discharged from rehabilitation are not coded using the stroke ICD-10-AM codes but rather denoted by a generic rehabilitation code (ICD-AM-Z50.9). To capture the final date of discharge of patients who spend some time in a rehabilitation unit your Business Intelligence Unit (analyst) needs to identify patients discharged from their 'acute' hospital event with one of the above ICD 10-AM codes, followed immediately (same day) by a rehabilitation inpatient stay.

What patients are not included in this community stroke indicator?

Some stroke teams admit patients with previous strokes or may take referrals directly from the community. This clinical practice is fine, but is intentionally not captured in this indicator.
Thus this indicator excludes:

- Patients admitted with a previous stroke who may have been re-referred for further therapy sessions.
- Patients with acute stroke who were not admitted to hospital.
- Patients referred from a GP.

What does 'face – to – face' mean?

This refers to the first actual meeting or intervention between staff and patient (i.e. physically in the same room) within 7 calendar days of discharge from hospital.
If your service has a telehealth component used for rehabilitation, it can include a tele-rehab consultation / contact using videoconferencing equipment.
It does not include a phone conversation or an email contact or pre-discharge meet/greet in the ward.

Who are included as eligible members of the team in the context of a first face – to – face visit?

Physiotherapist, Occupational Therapist, Speech Language Therapist, Registered Nurse, Social Worker, Doctor, Clinical Psychologist.
A therapy assistant contact alone is not eligible to be counted as a first face-to face contact for the purposes of this indicator.

Where can a community rehabilitation contact occur?

Sessions can be held in individuals' own home, outpatient setting or other community setting (e.g. workplace) depending on the individual's needs.

How early may a referral to the community rehab team be made?

This depends a little on your service but for this indicator it includes referrals made during their acute or rehab inpatient hospital stay (i.e. anytime from day 1 of admission).

How late can a referral to the community rehab team be made?

From a patients perspective the referral should be made at or prior to discharge, or as close to discharge as possible and no later than 7 days following discharge. A referral sent on Day 7 post discharge may not enable the service to meet the indicator of a face-to-face contact within 7 days. Referrals made after 7 days are being excluded to ensure that they are not being referred for new pathology, unrelated issues, or concerns that have come to light only once resettled into the community.

Does tele rehab count as a face – to – face contact?
Yes, but it must be an active therapeutic contact / intervention and involve videoconferencing – i.e. visual contact. A phone call does not count.

How is 'time to first face to face contact' calculated?
The timing refers to 7 calendar days and includes weekends and public holidays.
Timing begins from the date of discharge from hospital (either acute or inpatient rehab service).
It is not calculated from the date the referral is received or accepted by the community team.

Why is the target not 100%?
This is to allow for reasonable clinical variation e.g. the patient declines to be seen or is unwell, unavailable or the family are too busy.

Will the target change?
Yes, it is likely to be adjusted over time. While the ideal target is 80%, the target selected for the 2018/19 reporting period is 60% as a first step but may increase over time to 80%.

What does a community rehabilitation team constitute?
Please refer to the 'minimum' Community Rehabilitation Services Specifications.
https://strokenetwork.org.nz/resources/guidelines+%26+recommendations?src=nav.

If the Community Stroke Team does not meet the 'Minimum Community Rehab Services Specifications' does this mean the DHB will not meet the indicator and will need to report '0'?
Correct – these are minimum elements considered for provision of a community rehabilitation service. A narrative describing where the service is at and what is being done to ensure service provision should always be included.

If the DHB contracts a private provider to provide its community rehabilitation service, is the private provider expected to meet the Minimum Service Specifications?
Yes it is although it is the DHB that will be held accountable by the Ministry of Health if the target is not met.
While the Ministry has no specific jurisdiction over private providers in this instance, the DHBs do and so all service level requirements/expectations should be included in the contract between DHB and private contractor.

Minimum Ministry of Health Expectations to meet designation of 'Community Stroke Rehabilitation Service'

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- An interdisciplinary community rehabilitation team with stroke specific skills, who support people with stroke to transition seamlessly into the community.
- The team includes the following members:
    - Nurse Specialist or Speciality Nurse
    - Allied Health Professionals (including PT, OT, SLT and social work) with expertise in stroke
    - Medical practitioner with expertise in stroke medicine
    - Access to, dietetics, psychology and NASC as required
- Team members have access to stroke specific training (minimum 8 hrs/ year)
- A single point of entry for referrals for all adult stroke service users and health professionals
- Work in partnership with the patient and family/Whanau to enhance autonomy and self-management, with use of 'homework' to increase intensity of practice and activity levels
- Documented goal specific rehabilitation plans for each patient that are developed in conjunction with the patient and their family
- Ability to deliver up to three sessions per week of Physiotherapy, Occupational Therapy or Speech Language Therapy as needed in the first four weeks of the community rehabilitation* programme to work towards patient/family/whānau goals. Sessions may be delegated to trained therapy/rehabilitation assistants as appropriate.
- A weekly interdisciplinary team meeting
- Strong links between the in-patient rehabilitation team and the community team to assist with discharge planning and to discuss long term goals for the patient's rehabilitation once they are in a community setting
- Established processes for communicating effectively with GPs, other primary care providers and the Stroke Foundation and options for ongoing rehabilitation in the community.

**Sessions can be held in individuals own home, outpatient setting or other community setting depending on the individual's needs.*

NB: The above list was compiled by the National Clinical Leader, Stroke to support MoH DHB site visits and quarterly report evaluation. It is based on the "NZ Organised Stroke Rehabilitation Service Specifications (in-patient and community)" document prepared by the National Stroke Network in December 2014. For more detail please refer to this document.

NATIONAL STROKE NETWORK

*This diagram is a broad example of NZ models for community rehabilitation services. You will need to work with your analyst to select the model that best applies to your DHB and then define the "data rules" for collecting the indicator according to your circumstances.

Discharge following acute stroke

ICD 10 CODES – I61, I63, I64

DISCHARGE FROM EITHER AN ACUTE OR INPATIENT REHAB SETTING

Referral to the appropriate Community Stroke Rehabilitation Service for your DHB*

NB: some DHBs may have more than one service applicable – your business intelligence analyst will need to know which services to include

- Early Supported Discharge - all age service
- Early Supported Discharge - over 65
- Community Stroke Team –all age service
- Community Stroke Team – over 65 only
- Community Rehab Team (not stroke specific)
- Other configuration (e.g. Outpatient rehab)

Referral accepted by appropriate team

Seen by a member of the community team as a face to face appointment.

Time between discharge date and face to face appointment measured

Target 60% seen face to face within 7 calendar days of discharge.

Exemplars

Canterbury DHB

Number (and %) of acute stroke patients discharged from hospital (with diagnosis of acute stroke I61, I63, and I64,) (this includes patients with the acute admission in Christchurch Hospital and transferred to Burwood for rehab) **AND** who are referred for community rehabilitation (referred between admission date and 7 days past discharge date). (Number becomes denominator).

Number of referred patients receiving face-to-face input from CSRS within 7 days (becomes numerator).

Stroke discharge:

- Principle diagnosis with acute stroke codes: (I61, I63 and I64). [This includes patients with the acute admission in Christchurch Hospital and transferred to Burwood for rehab]

Referrals to:

- Community Stroke Rehabilitation Service
- Referral outcome as 'Accepted'
- Referral received date between admission date to 7 days post discharge date

Seen by Community Team (appointment)

- Appointment as face-to-face appointment and appointment seen

Seen within 7 days:

- Dates between discharge date and appointment date are within 7 days.

Taranaki

Number (and %) of acute stroke patients discharged from hospital(with diagnosis of acute stroke 161, 163 and 164,) (this includes patients with the acute admission and rehab in Taranaki Base Hospital and or those transferred to Hawera for rehab) AND who are referred for community rehabilitation (referred between admission date and 7 days past discharge date). (Number becomes denominator).

Number of referred patients receiving face-to-face input from community rehabilitation service (ICATT) within 7 days (becomes numerator).

Stroke discharge:

- Principle diagnosis with acute stroke codes: (I61, I63 and I64). [This includes patients with the acute admission in Taranaki Base Hospital and transferred to Hawera Hospital for rehabilitation, or remaining at Base for rehabilitation].

Referrals to:

- Intermediate Care (Clinic)
- Referral outcome as 'Accepted'

- Referral received date between admission date to 7 days post discharge date

Seen by Community Team (appointment):

- Appointment as face-to-face appointment and appointment seen (as per clinic attendance or encounters)

Seen within 7 days:

- Dates between discharge date and appointment date are within 7 days.

Counties Manukau

Percentage of Acute Stroke Patients transferred to Community Stroke Rehabilitation
Numerator – Number of Acute Stroke Patients referred to and seen face to face by community rehab team within 7 days. (Includes patients from both the acute and rehab stroke wards)
Denominator – Total Volumes of Stroke Events by Principal Diagnosis (ICD10 codes I61, I63 and I64) referred to Community Stroke Rehabilitation within 7 days post discharge.