



STROKE RECOVERY ASSOCIATION
OF BRITISH COLUMBIA

Bridging the Gap: Helping Stroke Survivors and Family Caregivers from Hospital to Long Term Recovery

Community Stroke Navigator Program: Phase 2 - Final Report –
February 2017

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Executive Summary

Stroke survivors and family caregivers still consistently lack a supportive and informative connection to the healthcare system upon being discharged from hospital. This report's major finding is that use of a Community Navigator service shows great promise for assisting stroke survivors and caregivers with community reintegration after discharge from hospital following stroke. It helps in the understanding of their symptoms, assists them in finding the help and resources they need and has enormous potential for saving the health care system large sums of money because it can reduce the length of hospitalisation and help prevent future re-admissions.

The Community Stroke Navigator Program bridges the gap in transitions by providing a hospital peer visitation program and community navigation services and by strengthening partnerships with health and community organizations to improve support to stroke survivors and family caregivers once back in the community. It isn't uncommon for people affected by stroke to share common physical, emotional, social and financial needs. But every stroke is different and so a one-size fits all approach doesn't work. The Community Stroke Navigator helps stroke survivors and caregivers develop a personalized recovery plan with strategies to set goals, access community resources, fill information gaps and help build community and social networks.

The Community Navigator Program Phase 2 aimed to meet the needs of people affected by stroke post-hospital from Ladysmith and Campbell River through navigation services, peer visitation in hospital and education. Collaborative partnerships with Nanaimo Brain Injury Society (NBIS), March of Dimes Canada (MODC) and Nanaimo Regional District Hospital (NRGH) were developed to provide a stronger service in bridging the gap from hospital to home

The program served:

- 35 stroke survivors in hospital
- 83 stroke survivors and their caregivers from Ladysmith to Campbell River post-hospital discharge
- 60 participants in monthly stroke recovery/community integration education sessions

Key Findings

- **REFERRALS:** There were 95 referrals into the program. 77% of referrals came from NRGH and 23% were from the community. Of those referrals from the hospital, 42% were from the Intensive Outpatient Rehabilitation Program (IORP), 30% from Inpatient Rehabilitation and 5% were from Acute/Rapid Stroke Clinic. Of the 122 discharges from rehab, 57.3% were referred into the program.
- **ENROLLMENT:** There was a 95% enrollment rate and a 92% completion rate. In other words, of the 95 referrals received, 86 participants enrolled in Phase 2. Of those 86 assessments, 83 were completed.
- **RESPONSE TIME:** The average initial contact response time was 15 days.

- **REQUESTS FOR INFORMATION:** Finding resources (76.9%), goal setting (64.1%), caregiver support and decision making (51.3%) and stroke peer support (44.9%) were among the most frequently recurring requests for information. Just over half of participants are satisfied with their current level of assistance, suggesting a large gap in appropriate community-based services and resources to support ongoing long term recovery.
- **CAREGIVING:** Caregivers seem to have lower sense of self-worth or value attributed to their role in caring for the person affected by stroke. Family support and schedule interruptions seem to be most negative aspects of caregiving for those participants completing the assessment.
- **EDUCATION:** Education sessions for stroke survivors and family caregiver are an important element to provide timely education and ongoing support.

Recommendations

- **CORE FUNDING IS ESSENTIAL:** Core funding is required for continuity and quality programming. This core funding needs to find a home within the health authorities, the Ministry of Health or needs a dedicated fundraising activity attached to the program. However, the kind of community development skills this program requires are more likely to be found in community based organisations that operate at a grassroots level.
- **REVIEW BRAIN INJURY FUNDING MODELS:** Health authorities provide core funding to Brain Injury societies to deliver community program for ongoing support and management of brain injuries. We need to explore this model to see if a similar approach can be taken to support Navigator services. We need to determine what Health Authorities or the Ministry of Health require in terms of evidence that Navigation is a core and essential program in transitional management from hospital to home. We need to point to reductions in health costs this approach can achieve associated with readmission rates to hospital and unnecessary medical appointments
- **RESOURCE VOLUNTEER DEVELOPMENT COMPONENT:** There is growing and continued support that skilled volunteers are underutilized in service and program delivery. Developing a well-resourced and well utilized volunteer management program could help offset costs associated in program delivery of the Navigator program.
- **EXPAND HOSPITAL PEER VISITATION:** Expanding the Peer Visitation model to the community is another method to improve transitional management. Many of the stroke survivors requested a visit from a peer once they were back home. Well trained peer volunteers could assist with goal setting and community reintegration. This would dovetail with lay navigation.
- **TEST LAY NAVIGATION MODEL:** Possible areas to assist with transitions include:
 - Follow up in-home visit or telephone call within 60 days post discharge
 - Completion of Brief Action Plan (see Appendix J)
 - Provision of community resources and link to stroke recovery support programs
 - Identification of additional support required and flagging for professional care coordination if needed
 - Caregiver support kit and information on Family Caregiver series workshops/education sessions

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Introduction

Stroke survivors and family caregivers continue to lack a consistent supportive and informative connection to the healthcare system once being discharged from hospital. Community and health authorities are looking to better support individuals affected by stroke and their family caregivers through transitional and system navigation programs.

A Community Stroke Navigator works with stroke survivors and their caregivers to help them adjust to life back in their home and community. It isn't uncommon for people affected by stroke to share common physical, emotional, social and financial needs - but every stroke is different and so a one-size fits all approach doesn't work. The Community Stroke Navigator helps stroke survivors and caregivers develop a personalized recovery plan with strategies to set goals, access community resources, fill information gaps and help build community and social networks.

A recent evaluation of the 2013-4 Community Stroke Navigator Pilot Program (referred to as Phase 1) by Stroke Recovery Association of BC (SRABC) and a review of the Canadian Best Practice Recommendations for Stroke Care (Managing Transitions – updated in Fall 2013) identified the following areas as the highest priority of need for stroke survivors and caregivers:

1. Peer support while in hospital
2. The transition from hospital to their home community
3. Long term community stroke recovery support
4. Patient and family education, along the continuum of stroke care and transitions

Building on the success and recommendations from Phase 1, the Community Stroke Navigator Program - Bridging the Gap: Helping Stroke Survivors and Family Caregivers from Hospital to Long Term Recovery (referred to as Phase 2) continued to expand the scope of services of Phase 1 by introducing a Peer Visitation program in hospital, strengthening partnerships and laying the groundwork for a Lay Navigator framework.

Phase 2 key program deliverables included:

1. Continued implementation of the Community Stroke Navigator Program from Ladysmith to Comox Valley
2. Development and implementation of a Peer Visitation Hospital Program
3. Family caregiver education
4. Exploration of collaborative partnerships with Nanaimo Brain Injury Society (NBIS), March of Dimes Canada (MODC) and Nanaimo Regional District Hospital (NRGH) to bridge the gap from hospital to home
5. Planning and conducting a formative and process evaluation of the program
6. Preparing a final report outlining the evaluation findings

This report describes the outcome and process evaluation of Phase 2. The purpose of the evaluation was to determine whether the program's objectives were met, as well as what took place during the actual program and its process with respect to the exploration of collaborative partnerships with NBIS, MODC and NRGH and the development of a peer visitation hospital and family caregiver education program. Using a triangulation method, both qualitative and quantitative data provides comprehensive documentation of the project successes and challenges and its effect on the clients utilizing the program and community partners involved in development and delivery.



Program Funding

The core funder for Phase 1 and Phase 2 was Stroke Services BC. Boehringer-Ingelheim Canada also contributed to core funds for Phase 1. SRABC, NBIS and MODC supplemented core funding with in-kind support and additional funds for program development and volunteer development.

Program Development & Implementation

Phase 2 was delivered from October 2015 through September 2016. There were two stages in Phase 2: (1) program development and (2) program implementation

Program Development

Based on recommendations from Phase 1, development of the program occurred from April 2015 to September 2015. Information on program deliverables from key activities are found under Program Development Deliverables in the Findings section of the report on page 26. Similarities and differences between Phase 1 and Phase 2 are found in Appendix A.

Literature Review – Peer Support & Lay Navigation

Defining Peer Support and Lay Navigation

Peer Support

Peer support is defined as a system of giving and receiving help based on the principles of respect, shared responsibility, and mutual agreement of what is helpful (Miller & Stiver, 1997). In the context of stroke recovery, peer support isn't based on a medical model and doesn't involve diagnostic criteria. Peer support for stroke is firmly rooted in understanding someone else's situation empathically through the shared experience of having survived a stroke or caring for a stroke survivor.

Lay Navigation

There isn't a clear definition of navigation or lay navigation. This is changing as navigation services are becoming more mainstream with concurrent research being done on its effectiveness as a complimentary service to health and medical services.

Patient navigation in cancer care is defined as giving assistance to patients, survivors, families, and caregivers to help them access and navigate through the healthcare system and overcome barriers often found healthcare (Lorhan et al, 2014). Lay navigators are defined as someone who carries out functions related to navigation with no pay. The experience, skills, and background required of lay navigators varies depending on the gap that is being filled; volunteer navigators may act as a peer to the patient, speaking the same language (Kazanjian et al., 2009), sharing the same culture, or sharing the same experience with a disease, or they may be simply trying to help people access the support and services they need.

Peer Support

Peer support is often linked with positive long-term health and wellness. Findings from a 2009 Peer Mentoring Pilot Project Evaluation (SRABC, 2009) supports that participation in peer support is correlated with improved overall health, decreased depression, decreased sense of isolation and overall quality of life. Additionally, peer support programs provide evidence of stroke survivors being able to better accept their situation as well as achieving higher ratings for empowerment, self-management and decision-making (Hancock, 2009).

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McCabe suggests a positive effect of community-based rehabilitation programs using interventions with a peer support or supported relationship model component (McCabe et al., Feb 2007). Some key points from the literature relevant to this report are:

- Peer support can create a culture of health and ability as opposed to a culture of “illness” and disability. (Curtis, 1999).
- An Australian Mental Health Peer Supported Hospital-to-Home Service showed re-admission rates were reduced for the patients who received peer support compared to their earlier experiences of hospital admission (Lawn et al, 2006).
- The Longitudinal Study of Consumer/Survivor Initiatives in Community Mental Health in Ontario (2004) showed significant reductions among those with access to navigator services in their use of hospital services and discharge from hospital sooner.

Research also indicates that recovery from an illness can require frequent attention and one-to-one support. It is often costly and not feasible for professionals such as medical doctors to provide the support needed to facilitate a strong recovery. It has been suggested that a ‘win-win’ approach is utilizing volunteer peer support, whereby people can find support in their recovery as well as the added value of speaking with others who can empathize with their situation (Kessler et al, 2014, Hancock, 2009, Glanz et al, 1986).

Lay Navigation

Lay or volunteer navigation is non-medical support that fills a gap with patients and families as they go through a medical treatment or a portion of the health care system. Some key points from the literature:

- The experience, skills, and background required of these navigators varies depending on the gap that is being filled.
- The push to use volunteers stems from a sustainability model. Volunteers are cost-efficient, despite the need for supervision and a comprehensive training process (Center for the Advancement of Health, 2007).
- It appears volunteers tend to be more trusted by patients and clients than health professionals (National Stroke Foundation, 2009). With proper training, support and British Columbia Cancer Agency in Victoria found that accepting volunteers, not only peer navigators, avoids restricting the eligibility of potential, competent, navigators, since they don’t need to have personal experience with the condition, or disease. (Lorhan, Wright, Hodgson, & Westhuizen, 2014).

Currently, a research study entitled “VEER: Volunteers Engaged to Enhance Reintegration. Exploring the efficacy of volunteer supported patient care transition programs” is being conducted by researchers at Bridgepoint Collaboratory for Research and Innovation in Toronto, Ontario. The purpose of this study is to understand how volunteer supported patient care transition programs can help patients during the hospital to home transition.

This piece of research will be valuable in our future development work. This Community Navigator program is a case study in the Bridgepoint study. Results from that study are expected by early 2017.

Family Caregiving and Stroke

An identified area of need from Phase 1 findings was increased family caregiver support. Phase 2 included the addition of monthly family caregiver education sessions and during an assessment, an offer to have a one to one with the caregiver caring for the stroke survivor.

An informal or family caregiver is “a member of the immediate or extended family, a friend or a neighbour who provides support, care and assistance, without pay, to an adult or child who needs support due to a disability,

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mental or chronic illness, life-threatening illness or temporary difficulty” (Keefe, 2011, p. 4). Literature on caregiving burden and stroke includes the following key points of relevance to this report:

- Approximately 80% of people who survive a stroke return home to their community, and at least 50% require help from other people at home (Opara and Jaracz, 2010).
- When looking at interventions to ensure a successful return to home and community, a stroke survivor’s family support and support for the family must also be considered.
- One in eight caregivers assist loved ones recovering from stroke with case management functions such as health care system navigation (Opara and Jaracz, 2010).
- Many caregivers find the co-ordination role (similar to that of a case manager) the most stressful part of caregiving despite the fact it requires less time when compared to providing personal care or helping with other household management tasks (Duxbury, Higgins and Schroeder, 2009).
- Other caregivers expressed difficulty finding and accessing affordable home or community care services. In a study conducted by Hare et al, (2005) using focus groups with caregivers of stroke survivors, “participants felt that more information was needed about stroke, living with stroke and access to services in addition to a broader range of issues including networking opportunities, environmental adaptations and benefits advice” (in Salter, Teasell, Bhogal & Foley, 2008, p. 57).
- The more severe a stroke survivor’s level of physical and cognitive impairment, the more likely the caregiver will experience “an overwhelming sense of burden and depression, a decline in physical and mental health, reduced quality of life and isolation” (Lutz and Young, 2010, p. 153).
- Deeken et al, (2003) show that “caregivers who have unmet needs or a high burden level may be impeded in their ability to function effectively, including in their role as an ongoing support system for the patients (p. 17)”. The consequences of increased caregiver burden are greater use of the formal health care services and earlier institutionalization of loved ones in a residential care facility.

Description of Program Implementation

Referrals and client intake began October 15, 2015 and continued until September 30, 2016. Phase 2 was adopted as “the Navigator program” rather than Community Stroke Navigator program. The Navigator program was easier to remember and simpler for hospital and community organizations to refer to. The program’s catchment area included the main north to south corridor on Vancouver Island from Ladysmith to Comox Valley (excluding the Gulf Islands and Port Alberni). The Program Coordinator had office space at NBIS and worked remotely from home in Comox.

Approach

Community-based navigator programs are typically located outside of formal healthcare institutions; their role is to link people affected stroke (the survivors and caregivers) to both formal and informal resources (Freeman et al., 1995; Seek & Hogle, 2007. Like Phase 1, Phase 2 utilized



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the system navigation approach, which focuses on identifying and serving the needs of the client as a unique individual. It includes a holistic focus of addressing the social, psychosocial, emotional, and spiritual needs of a client and the design of a plan that best fits his or her goals, values and resources (Blackadar & Houle, 2009; Egan, Anderson, & McTaggart, 2010). The role and scope of activities of the Community Navigator Coordinator were like Phase 1 (see Appendix B).

Components of service

- Empowering the stroke survivor and caregiver to self-manage their post-hospital stroke recovery through education, supported decision-making and goal-setting
- Providing clients with resources that they can consult in the future
- Answering questions about post-stroke challenges – for the stroke survivor and the family caregiver
- Helping navigate the health care system, for the stroke survivor and the caregiver
- Linking to educational resources and programs to assist with recovery
- Connecting with local support, community and education programs

Referral Criteria

The referral criteria included:

- A confirmed diagnosis of ischemic or hemorrhagic stroke
- Living in the community prior to having a stroke
- Having a caregiver available and interested in participating

The referral form developed in Phase 1 was adapted and continued to make the referral process quick and easy (Appendix C). Stroke survivor consent was required on the form. Referrals were faxed, emailed or telephoned in directly to the Program Coordinator and clients were contacted within 2 weeks of referral into the program.

Description of Community Navigator Components

Peer Hospital Visitation Program

The Peer Hospital Visitation Program was developed as a direct result of feedback from Phase 1 – from both clients and health professionals including:

- Clients expressed a desire to be able to connect with someone with comparable experience of stroke as early as possible. They stated that this gave them hope and provided emotional support.
- Family caregivers expressed similar thoughts on having someone to talk to you about the future.
- The staff in the Intensive Outpatient Rehabilitation Program (IORP) and Inpatient Rehabilitation were very approachable and willing to partner to implement a peer visitation program.
- We modified existing referral form to include a box to tick for Hospital Peer Visitation.
- This program was only made available to patients receiving services in inpatient rehabilitation and in IORP. A partnership was created with NRGH Volunteer Services, NRGH Inpatient and IORP and the Navigator Program to orient and train peer volunteers.
- Volunteers were recruited and screened by the Navigator Program Coordinator. Volunteers were oriented with NHRG Volunteer services to receive hospital clearance. Volunteers were simultaneous trained by the Navigator Program Coordinator in peer support. We modeled the training program using NBIS's existing Peer Mentoring Program and MODC's Peers Fostering Hope program.
- The Peer Hospital Visitation program implementation is due to start in January 2017.



Community Stroke Navigation

Phase 2 continued with Community Navigation services, which is described broadly as “a strategy to ensure that patients or clients can access the “right person, right time in the right setting” (Cameron and Gignac, 2007). Interventions to increase stroke survivors and caregivers’ knowledge about community services and how to access them can increase their sense of competence and reduce depression (Reinhard, Given, Nirvana and Bemis, 2008).

Referral sources often described the service to referrals as “a community expert in stroke recovery to provide counselling and support once you and your family are back home”.

Like Phase 1, the scope of navigation services in Phase 2 was based on a brokerage case management model and included the following components:

- Client assessment and joint identified actions
- Follow up phone support/availability (at 3 months)
- Liaison with and referral community services
- Stroke survivor and caregiver education on self-management
- Access to monthly education sessions

Staffing

Phase 2 was delivered through a Program Coordinator, who was contracted to the equivalent of a 0.5 FTE for the duration of the program. Additionally, the Hospital Peer Visitation program was implemented by a staff member at NBIS (contracted for 6 hours a week) beginning in January 2016. The Lay Navigator Volunteer Package was completed by a volunteer resource contractor over a 60-hour period.

Program Flowcharts

Figure 1 describes the flow of a client using the Navigator Program from referral to follow up. Figure 2 shows the flow of the Hospital Peer Visitation Program.



Figure 1: Flowchart Phase 2 Navigator Program

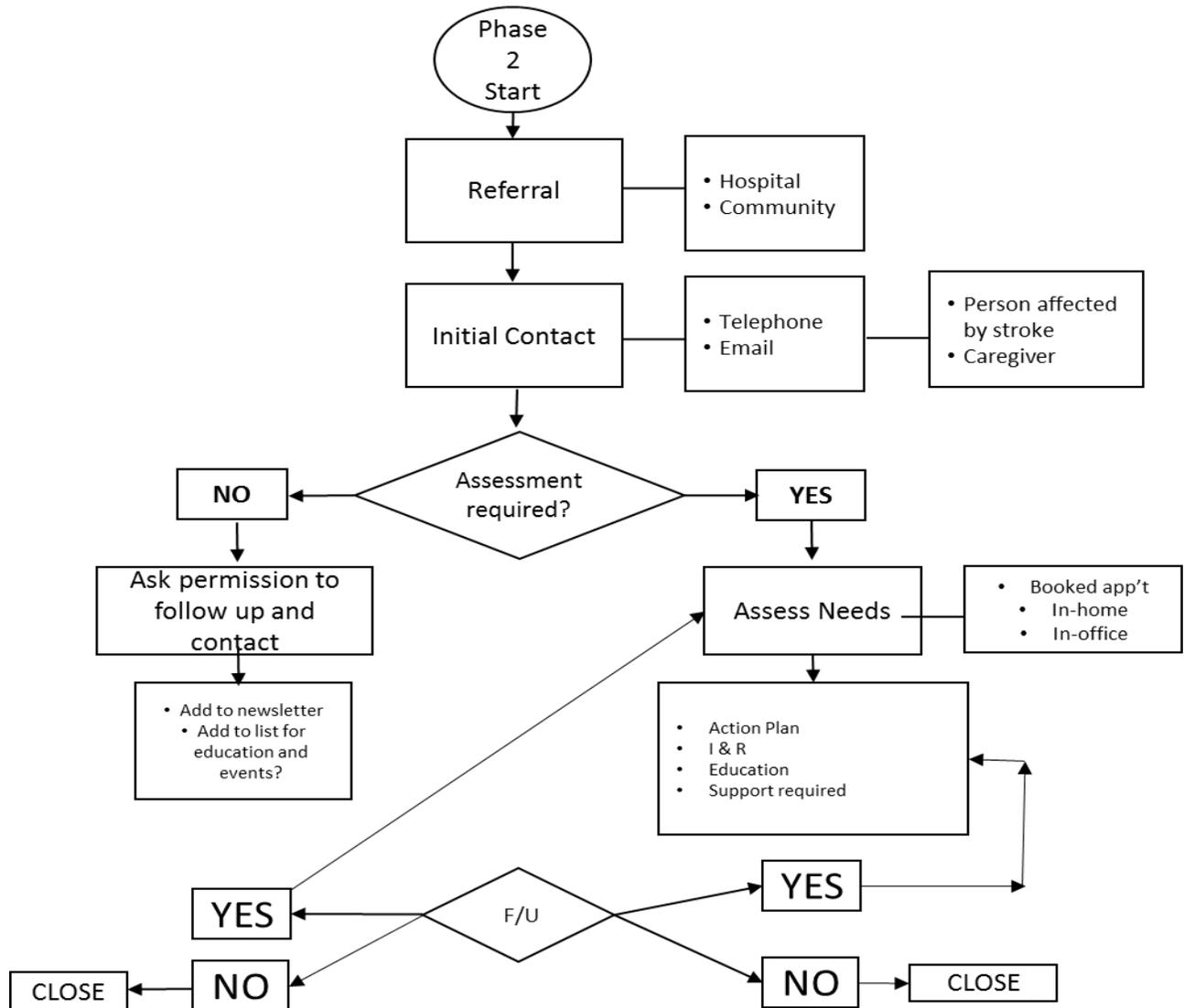
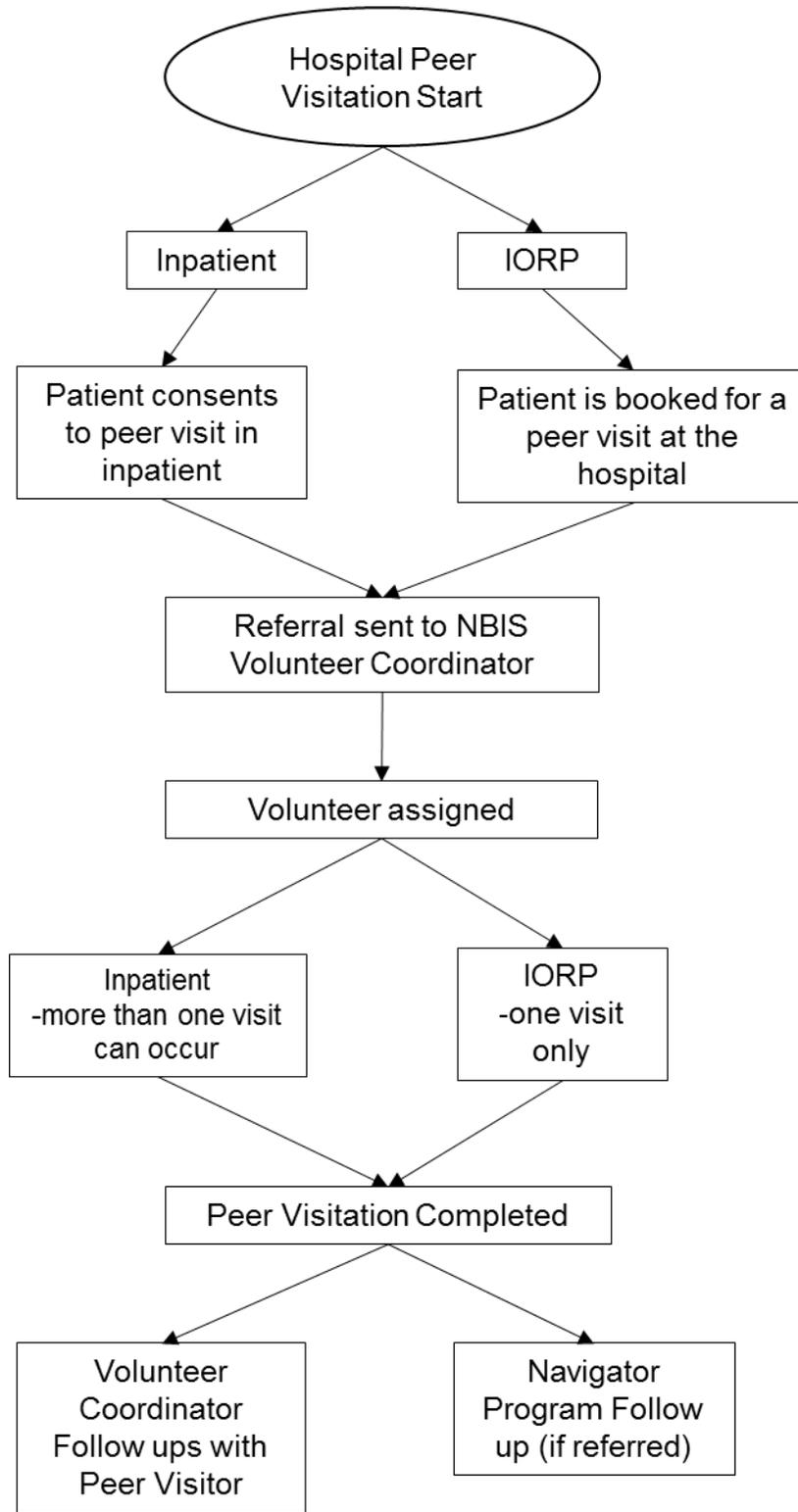




Figure 2: Flowchart Hospital Peer Visitation





Project Goal and Objectives

Goal

Phase 2 sought to operationalize and further develop the pilot program (Phase 1) based on Vancouver Island, targeting key communities within Island Health (VIHA), specifically NRGH.

Objectives

Post development phase, the collaborative team of MODC, NBIS and SRABC finalized the program objectives:

1. Conduct 100 Community Stroke Recovery Navigator assessments
2. Develop 3 new guides for stroke survivors and family caregivers specific to transitioning back into the community post-stroke
3. Develop and implement Peer Hospital Visitation Program
4. Develop and implement 6 Family Caregiver Education sessions
5. Develop a framework for a Lay Volunteer Navigator Program
6. Development of package of information and tools for stroke survivors and family caregivers transitioning from hospital to home
7. Enhance and accelerate the inclusion of transitional management and community reintegration from hospital to the community
8. Make recommendations on a sustainable service delivery model
9. Make recommendations on volunteer management needs to support the service delivery model
10. Share findings on community reintegration and transitional management to add to the body of knowledge on stroke care in BC
11. Make key recommendations on how to establish contact with primary care, increasing awareness within hospital management systems of community based stroke recovery and identify possible avenues to include service delivery models in transitional management

Evaluation Methodology

Both formative and process evaluations were conducted to assess the effectiveness and efficiency of Phase 2.

Formative and process evaluation objectives include:

1. Measure the impact of Phase 2 specifically:
 - a. Did the program reach its intended population?
 - b. How did the program serve the intended population? (Service Utilization)
2. Assess Family Caregiver Burden & Education
3. Hospital Peer Visitation review
4. Demonstrate project objectives met (program deliverables met in Phase 2)
5. Measure client satisfaction
6. Determine staff, volunteer and collaborative team member satisfaction with Phase 2 including perceived impact of Phase 2, increased coordination of care and improved communication between health authority rehabilitation services and community.
7. Identify issues related to project management and implementation that can be used both immediately and in the future to improve project quality.

Phase 2 Program Evaluation Plan can be found in Appendix D and details evaluation questions and measured outcomes.



Findings

Findings of Phase 2 are broken into sections per evaluation questions.

Reach to Intended Population

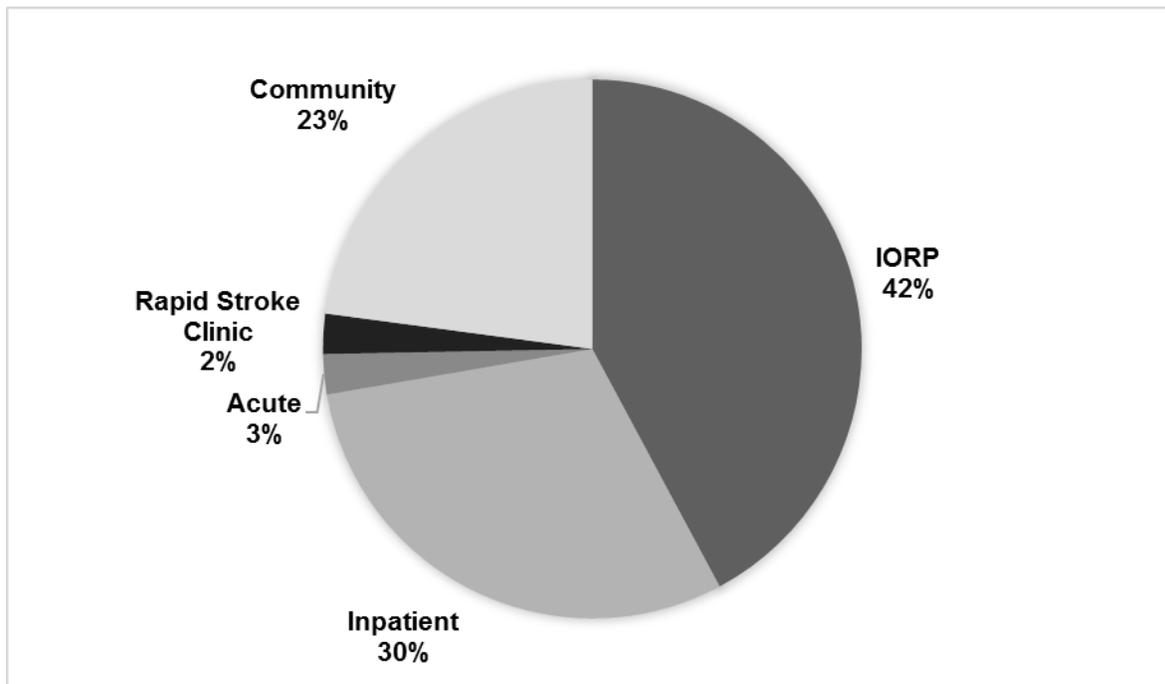
To answer the first evaluation question, “Did Phase 2 reach its intended population?” a review of number of referrals, source of referrals and enrollment rate helped to show how participants were referred into the program, how long it took for initial contact and who enrolled and completed an assessment. Phase 2 focused primarily on building the referral system with NRGH and the results reflect this intent. We did collect basic demographic information on participants however, not on family caregivers. We used the Community Navigator Intake form (see Appendix E) to collect demographic information.

Referrals and their sources

There were 95 referrals into Phase 2 between October 15, 2015 and September 30, 2016. Phase 2 invested time in developing strong linkages with NRGH and this is reflected in referral sources.

Figure 3 shows the source of referrals; 77% of referrals came from NRGH and 23% were from the community. Of those referrals from the hospital, 42% were from the Intensive Outpatient Rehabilitation Program (IORP), 30% from Inpatient Rehabilitation and 5% were from Acute/Rapid Stroke Clinic.

Figure 3: Source of Referrals



One of statistics identified in the 2013 Canadian Best Practice Recommendations for Stroke Care we wanted to capture was patient referrals into community programs. While we could not access full data, we could access some specific data from hospital rehab.

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Table 1 shows the number of stroke admissions into rehab from Nov 1, 2015 to Sept 30, 2016.

Table 1: NRGH Rehab Stroke Discharges between Nov. 1, 2015 to Sept. 30, 2016

Gender	Number of Discharges	% of Discharges	Average Age
F	46	38%	73
M	76	62%	73
Total	122	100%	73

Of the 122 discharges from rehab, 70 (or 57.3%) were referred into the program.

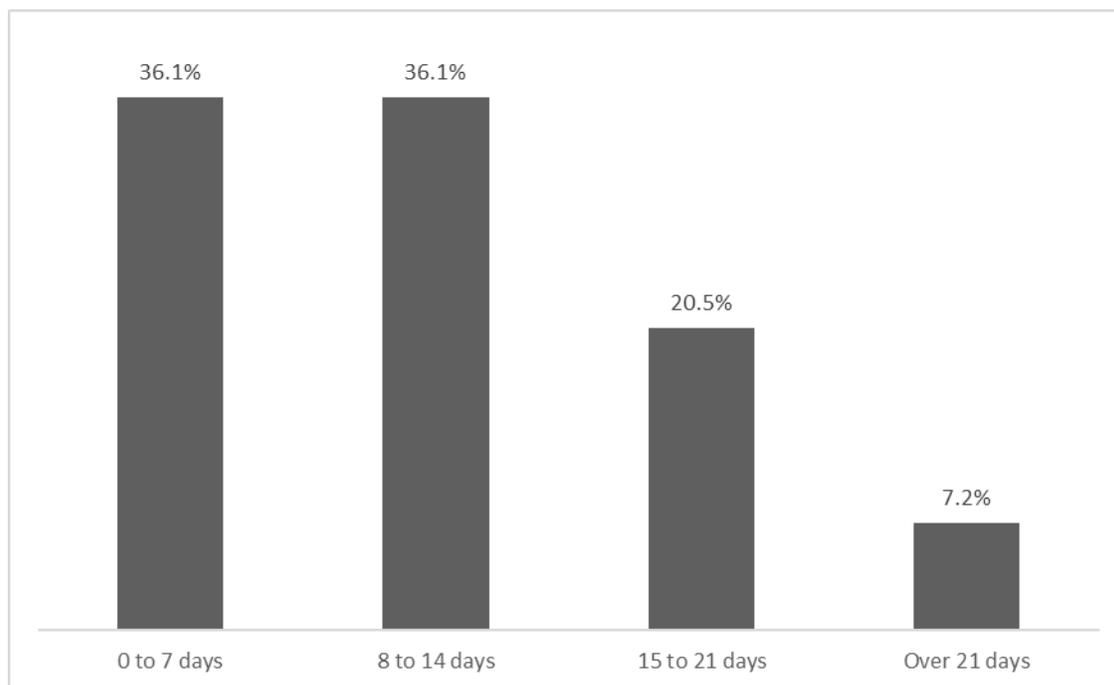
Enrollment and Completion

There was a 95% enrollment rate and a 92% completion rate. In other words, of the 95 referrals received, 86 participants enrolled in Phase 2. Of those 86 assessments, 83 were completed. The criterion for completion rate was based on one assessment completed with the participant. The remaining 3 assessments took place outside the project’s timeframe.

Initial Contact Response Time

Participants from Phase 1 expressed contact time could be shortened, between two and four weeks post-hospital discharge. In Phase 2, we made this one of our goals – to make initial contact with referrals and set an appointment date within 2 weeks. The average initial contact response time was 13 days. Almost 75% of all participants were initially contacted within 2 weeks. Figure 4 shows initial contact response time by number of days. Typical reasons for a delay included inaccurate contact information, no voice mail and Program Coordinator vacation.

Figure 4: Initial Contact Time



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Participant Demographics

Table 2a summarises participant demographics. Some key points:

- The average age of participants was 66.4 years old
- The highest proportion of participants were between 70 to 79 years (almost 24%); however, the second highest were between the ages of 50-59 years (23.2%). Of note is the 12% of participants were 80 years and over, likely compounding the complexity of their recovery.
- Most participants were male (56.1%)
- All participants had their strokes within the previous 2 years. The majority of participants had their stroke less than year ago (56.7%)
- Almost 83% of participants were admitted to hospital
- 22% of participants were unsure what type of stroke they had; 41.5% had an ischemic stroke while 36.6% had a hemorrhagic stroke
- Over 73% of participants were living with a spouse or partner and 18% were living alone.

Table 2a: Participant Demographics

Age	n=82	%
< 50	5	6.1%
50-59	19	23.2%
60-69	13	15.9%
70-79	22	26.8%
> 80	10	12.2%
Gender	n=82	%
Male	46	56.1%
Female	36	43.9%
Date of Stroke	n=82	%
< 1 year	69	84.1%
1-2 years	13	15.9%
Admitted to hospital	n=82	%
Yes	68	82.9%
No	14	17.1%
Type of Stroke	n=82	%
Ischemic	34	41.5%
Hemmoraghic	30	36.6%
Not known	18	22.0%
Living Arrangements	n=82	%
Spouse	60	73.2%
Children	5	6.1%
Other family	2	2.4%
Alone	15	18.3%



Geographic Location

NRGH services patients from all over Vancouver Island. Table 2b shows the city where participants resided. The majority of patients in inpatient rehabilitation are not local to Nanaimo, which could explain the high percentage of referrals from Parksville/Qualicum (39%) as well as from communities in the more northern part of Vancouver Island (14.6%). There is no hospital in Parksville/Qualicum so the majority of stroke patients are seen at NRGH.

Table 2b: Geographic Location

City	n=82	%
Nanaimo	34	41.5%
Parksville/Qualicum	32	39.0%
Comox Valley	6	7.3%
Campbell River	6	7.3%
Ladysmith	4	4.9%

Key Points: Did Services Reach Intended Audience?

- Based on the consistent number of referrals, the demographics and the increase in referrals from inpatient and outpatient services, Phase 2 reached its intended target population. However, it is only reaching a portion of that population. Clients not captured by Phase 2 include:
 - Stroke survivors presenting at ER but not admitted to hospital
 - Stroke survivors admitted to acute and discharged without rehabilitation
 - Stroke survivors who are transferred to other hospitals
 - Stroke survivors who didn't live in the catchment communities
- While there was a 10% decrease in referrals from Phase 1, it can likely be attributed to two factors: (1) the relationship building activities with NRGH and staff and (2) the gap between Phase 1 and Phase 2. Firstly, our goal was to bridge the gap between hospital discharge and home for stroke survivors and their family caregivers. We invested all our community linkage activities into improving our referral process and relationships with staff at NRGH. We spent very little time engaging with community referrals. Compared to Phase 1, Phase 2 showed an increase in referrals from NRGH. The increase in referrals from these sources shows success in our investment.
- Secondly, there was almost a year between Phase 1 and Phase 2. We felt a loss in momentum in collaboration with NRGH. It initially took time to reintroduce the concept of the Navigator Program and to educate and increase awareness among staff.
- There was a change in social workers in Inpatient services approximately halfway through the program. This made a huge difference in referrals. There were challenges in getting referrals from the social worker in the first half the program. However, the social worker for the second half had returned to the hospital after several years working in the community. She experienced firsthand the gap in support from hospital to home. When she returned to the hospital, because of this awareness and her understanding of the value in referrals prior to discharge, we experienced a positive impact on our referrals.
- We wanted to capture statistics referred to in the Canadian Best Practice Recommendations (2013):
 - The proportion of stroke survivors discharged from hospital who received a referral into the Community Navigator Program
 - The proportion of stroke survivors who return to hospital for non-stroke issues within 3 months.
- It was initially very difficult to obtain statistics from the hospital in this area, not for lack of want on the staffing end. It requires a great deal of time for the statistician to gain permission, to filter and sort data

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who to ask (for permission). As result we were only able to access data for the proportion of stroke discharges from rehab.

- Our recommendation from Phase 1 to collect additional statistics would still bring immense value and insight into how to improve transitional services and follow up with stroke survivors and families:
 - Overall # of strokes in the catchment area each month
 - # of stroke patients presenting to emergency but not admitted to hospital in the catchment area each month
 - # of stroke patients admitted to acute in the catchment area each month
 - # of stroke patients transferred to a different hospital then where they presented?
 - Proportion of stroke admissions who return to hospital within 3 months

Community Navigator Service Utilization

How participants use a service is important to understand in program delivery and ongoing development. Data collected on the Contact/Activity Log (Appendix F) were summarized to present the following information:

- Service Utilization
- Areas Participants Expressed Needs for Support & Information
- Time spent by Program Coordinator

Service Utilization

Figure 5 shows the types of services offered and utilized by Phase 2 participants. On average clients used 3.12 services.

Figure 5: Types of services offered and utilized

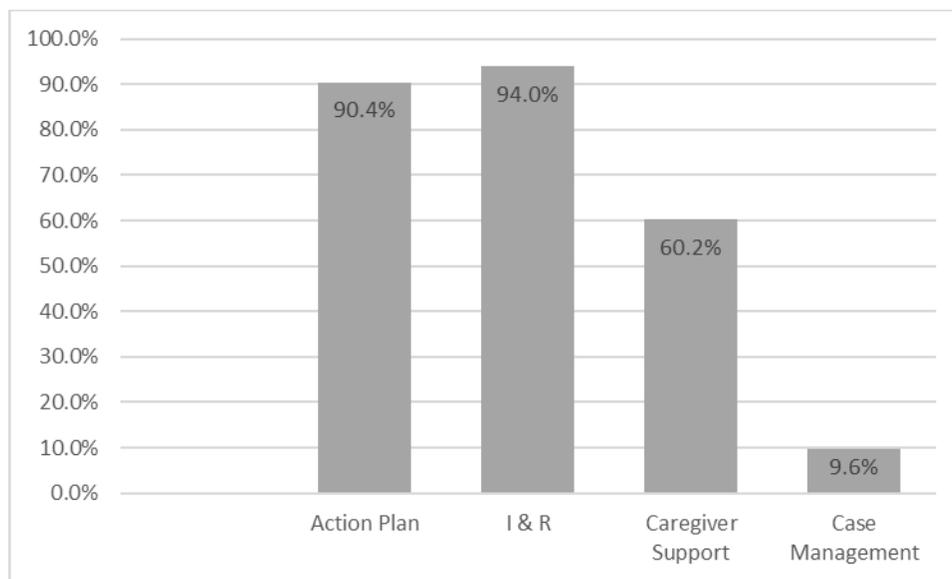


Table 3 shows that of the 95 referrals, 92.2% received an assessment (n=83). Of the 83 assessed, 90.4% receiving an action plan, 94% received information and referrals and 60% received caregiver support. Just under 10% needed case management activities which included hands-on support in coordinating services and making sure referrals were going through and additional coaching.

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Table 3: Service Utilization of Participants

Action Plan	90.4%
I & R	94.0%
Caregiver Support	60.2%
Case Management	9.6%

Just over 92% received an assessment. Of those receiving an assessment, 94% received information and referral services and 90.4% received a written up follow up action plan. Caregiver support was provided with 60.2% of participants and just under 10% of participants required case management services.

Table 4 shows a breakdown of areas in which participants expressed a need for further support and information and referral.

Table 4: Most Frequently Expressed Needs

Area of Requested Information & Referral	N	% based on overall # of I&R requests
Housing	6	7.7%
System Navigation	9	11.5%
Vocational Support	12	15.4%
Emotional Challenges post stroke	14	17.9%
Transportation	15	19.2%
Counselling	16	20.5%
Financial matters	19	24.4%
Legal Issues	20	25.6%
Fatigue	20	25.6%
Disability Information	20	25.6%
Finding a doctor	20	25.6%
Ongoing speech therapy	25	32.1%
Ongoing physiotherapy	30	38.5%
Self-Advocacy	30	38.5%
Future care planning	32	41.0%
Stroke Peer support	35	44.9%
Decision making	40	51.3%
Caregiver Support	40	51.3%
Goal setting	50	64.1%
Finding community resources	60	76.9%

Highlights and additional details from Table 4 include:

- Like Phase 1, the range and diversity of expressed needs supports previous findings that stroke survivors and caregivers are heterogeneous.
- Finding resources (76.9%), goal setting (64.1%), caregiver support and decision making (51.3%) and stroke peer support (44.9%) were among the most frequently recurring requests for information. The Navigator Coordinator used several tools including Brief Action Planning, Goal Attainment Scale, and Ottawa Personal Decision Making Tool to support participants.

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- Those participants receiving information and referral requested an average of 6.84 sources to assist in their on-going recovery or caregiver role.
- Caregiver support was delivered in a one to one telephone call or in person visit (depending on the family situation) to provided education and emotional support. Referrals were made to a provincial organization dedicated to family caregivers (Family Caregivers of BC) as well as local caregiver support groups.

3 Month Follow Up Telephone Call

An area identified in the 2013 Canadian Best Practice Recommendations for Stroke Care, is consistent follow up and support once back in the community. Phase 2 followed up with participants approximately 3 months post initial assessment. The purpose of the follow up was a general check in to see how they were doing (to close the loop), to provide additional support if required, to ask if they were readmitted to hospital in the last 3 months and to measure satisfaction levels with the Phase 2.

Follow up Requested

Of the 71 follow up calls made, 26 (36.6%) were completed (defined as making contact with the person assessed and/or the family caregiver). In the other 45 cases, up to 3 attempts were made to establish a follow up. Of those 26 completed, 14 (53.8%) participants wanted additional telephone support. In those 14 cases, the Phase 2 Program Coordinator reviewed the action plan with the participant and provided information and referral and/or emotional support. Table 5 summarizes the findings of follow up.

Table 5: Follow Up Requested

Number of Follow up Calls Made	71
Completed Follow ups	26 (36.6%)
Additional support requested	14 (53.8%)

Hospital Re-admission

Participants were asked if they were re-admitted to hospital for non-stroke reasons in the last three months. Of the 26 completed calls, only 1 (3.8%) participant was re-admitted to hospital for a complication unrelated to stroke. While this indicator can't directly link readmission rates to having contact with the Navigator Program, it does support the notion that community supports and follow up could contribute to lowering medical visits and hospital readmissions. It also possibly reflects that participants who go through rehabilitation programs tend to be more prepared functionally for living back at home than stroke survivors who are discharge from ER or acute settings.

Key Points: Community Navigator Service Utilization

- Like Phase 1, the range of services provided to participants by Phase 2 reflects the importance of having a follow up conducted once stroke survivors and families are transitioning back home.
- Like Phase 1, the amount of case management activities performed on behalf of clients was limited due to the time intensity involved in coordination, advocacy and counseling involved. The focus of the program is to support clients in self-advocacy, self-management and their own long term stroke recovery.
- Table 6 shows there is a great deal of variance in what type of information, referrals and support stroke survivors and caregivers need. This reflects the well-established fact that every stroke is different and supports the notion that participants should “receive the right type of service, information and support at the right time”.
- Because of Phase 1, we knew that nurturing and expanding partnerships in the hospital was critical to the program's success. This is very evident with increases in referrals to the program (which is ongoing but under other funding through NBIS) and with the implementation of a collaborative hospital peer visitation program.

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- A gap from Phase 1 was filled by offering monthly family caregiver education series with a formal structure and varied topics and professionals. Although there appeared to be an increase in perceived knowledge post education sessions, rigorous methods weren't applied to how data was gathered and what was measured.
- Based on the low uptake of the 3 month follow up telephone call, it appears that providing follow up post-hospital discharge within 2-3 weeks is the more beneficial of the two contact points.

Assessment of Family Caregiver Burden & Effectiveness of Education

Three specific areas we hoped to capture information on were:

- Use of caregiver one to one support
- Change in knowledge pre and post education programming for stroke survivors and family caregivers
- Measure of burden of care for family and informal caregivers of stroke survivors living in the community

One to one Caregiver Support

As shown in Table 5, 60% of caregivers wanted one to one caregiver support. The one to one support would vary in length depending on the caregiver's needs, however, the average length of the one-to-one was 20 minutes. All sessions were done over the phone or in-office at NBIS.

Caregiver Burden

We measured caregiver burden using the Caregiver Reaction Assessment Tool (CRAI). The scale measures 5 different domains, using a 5 point Likert scale:

- Caregiver's esteem assesses the value or worth attributed to caregiving as a result of the experience being rewarding or causing resentment (7 items);
- Lack of family support assesses the caregiver's perception of being left with most of the caregiving responsibility or of family members working together (5 items);
- Impact on finances assesses the adequacy, difficulty, and strain of finances on the caregiver and family (3 items);
- Impact on schedule assesses the extent to which caregiving interrupts or interferes with the caregiver's regular activities (5 items);
- Impact on health assesses the caregiver's capability to provide care and health in relation to caregiving (4 items).

The self-esteem domain aims to measure positive experiences of caregiving. A higher score reflects a higher sense of how caregiving conveys personal self-esteem. The other domains, lack of family support, impact on finances, schedule interference and impact on health assess the negative experiences of caregiving. Higher scores reflect a more negative impact on the caregiver.

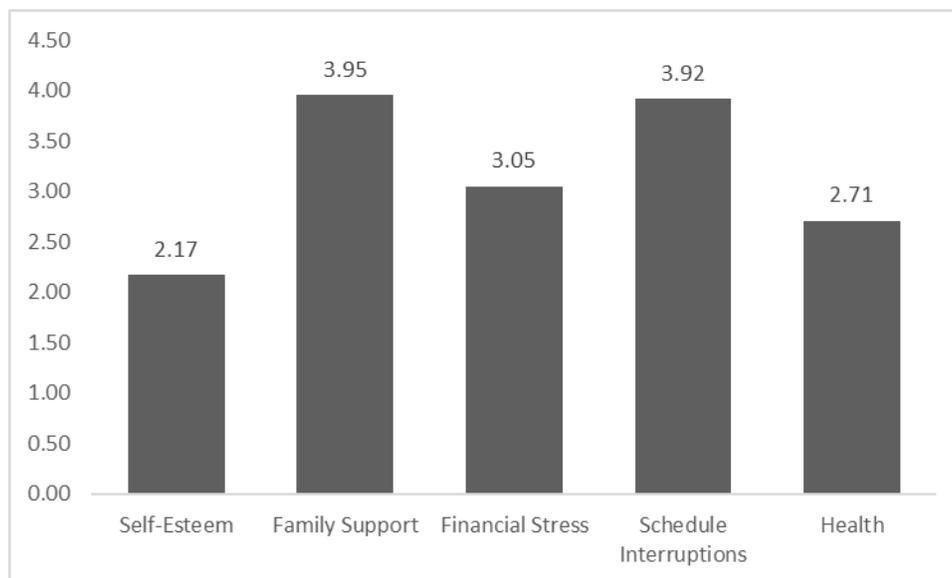
We hoped more caregivers would complete the tool; however, only 17.9% (14 of 78 caregivers) of participants completed the CRAI.

Overall average burden (average of the 4 domains measuring negative aspects of caregiving) was 3.41. Figure 6 shows the average of perceived caregiver burden broken down by domain. The average score for self-esteem was 2.17 suggesting a lower sense of self-worth or value attributed to caring for the person affected by stroke. Family support and schedule interruptions seem to be most negative aspects of caregiving for those participants completing the assessment.

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Figure 6: Caregiver Burden, Average scores



During one-to-one support, many caregivers discussed challenges in being able to manage as caregivers – emotionally, physically, and finding time to keep themselves healthy. Caregivers’ ability to cope with their role varied based on the complexity of the stroke, the care required from them and other life aspects impacting their role. Caregivers in the workforce and/or with children at home expressed challenges in finding time however, seemed to have more social supports in place. Older spousal caregivers appeared to seek out support groups to help cope with the emotional challenges of caregiving.

Six family caregiver education sessions were developed and held. 60 participants attended and 23 participants completed a very short 3 question pre/post questionnaire. Some family caregivers were accompanied by the person affected by stroke and the pre/post questions were adjusted to reflect this. Table 6 shows the results from the pre/post questionnaire. Generally, participants felt an increase in their knowledge post education sessions, which is beneficial overall to their role in caregiving or in their long-term recovery.

Table 6: Pre & Post Perceived Knowledge Levels

	Pre (N=23)			Post (N=23)		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
I feel knowledge increased about living with stroke OR caring for someone with stroke	43.5%	30.4%	26.1%	78.3%	13.0%	8.7%
I feel confident in my abilities to manage my recovery OR as a caregiver	52.2%	34.8%	13.0%	73.9%	21.7%	4.3%
I am familiar with programs and resources that are available to me	52.2%	26.1%	21.7%	73.9%	17.4%	8.7%

Key Points: Family Caregiver Burden & Education

- Acknowledging and supporting family caregivers is a very important component in bridging the gap from hospital to home.

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- Caregivers who completed the CRAI reported a lower sense of self-worth or value attributed to caring for the person affected by stroke.
- Family support and schedule interruptions seem to be most negative aspects of caregiving for those participants completing the assessment.
- Timely education for family caregivers is vital to increasing knowledge and skills and providing on-going support.

Program Satisfaction

Like Phase 1, we implemented a “reactive satisfaction”, which measured the participant’s immediate positive or negative response to the services provided. Based on previous satisfaction surveys, responses tend to be very positive. We wanted to keep the evaluation short and easy to complete and focus on content of the assessment, timely service and providing adequate assistance. We therefore opted to ask the questions outlined in Table 7 at the end of the assessment.

Of the 83 assessments, 63 participants chose to answer the satisfaction survey. The feedback is summarized in Table 9. We opted to combine the ‘strongly agree’ and ‘agree’ categories. There were no responses in the ‘unsure’ category or in the ‘strongly agree’ category so results were simplified into ‘agree/disagree’.

Table 7: Participant Satisfaction, Navigator Program

Question	Agree	Disagree
My referral and assessment were responded to promptly	100%	0%
The Navigator Coordinator was knowledgeable and helpful	100%	0%
The Navigator Program increased my awareness of resources available for stroke survivors and	92%	8%
The program answered my questions about post-stroke challenges	85%	15%
The program answered my questions about caregiving for someone with a stroke	67%	33%
I felt included in setting goals for a long-term recovery	96%	4%
The program increased my understanding about long term recovery stroke recovery	92%	8%
The program increased my understanding of what I can do to continue recovering from my stroke.	77%	23%
The program provided me with education materials on ways to manage my recovery.	77%	23%
I would recommend the Navigator Program to other people affected by stroke, brain injury and their caregivers.	100%	0%

Like Phase 1, Phase 2 was very well received by participants. Providing information and education at different times in recovery is an important part of self-management, providing knowledge of self-advocacy and support people affected by stroke based on their own personal needs. Having a knowledgeable, resourceful and empathetic Navigator is critical to the success of the program. I think this last point is very important and perhaps needs to be highlighted in the exec summary

As with most satisfaction surveys, responses are typically positive. We did, however, identify some areas for improvement:

- Providing additional caregiver education and strategies. It’s unclear if caregivers wanted more information on general caregiving strategies or those specific to stroke.



- There isn't a specific formula or established evidenced-based practices for long term stroke recovery in the community. Additionally, the understanding of the term long-term recovery may differ from participant to participant. At the time of Phase 2, SRABC was continuing the process of developing education and video materials for the 7 Steps to Stroke Recovery, which focuses on long term recovery and caregiver support.
- Phase 2 didn't include a group education series for stroke survivors in its implementation owing to restricted time and resources. Phase 1 group education sessions were very successful and popular with participants.

Hospital Peer Visitation Review

Originally our peer visitation review was going to be based on the evaluation conducted of March of Dimes Canada's (MODC) Peers Fostering Hope Program. However, it was difficult for our MODC collaborative lead to obtain the evaluation questions in time for our timeframe. We used an informal process evaluation and held a group evaluation with the volunteers and staff. Findings are limited to number of peer visits and an informal evaluation from peer volunteers to capture emerging themes.

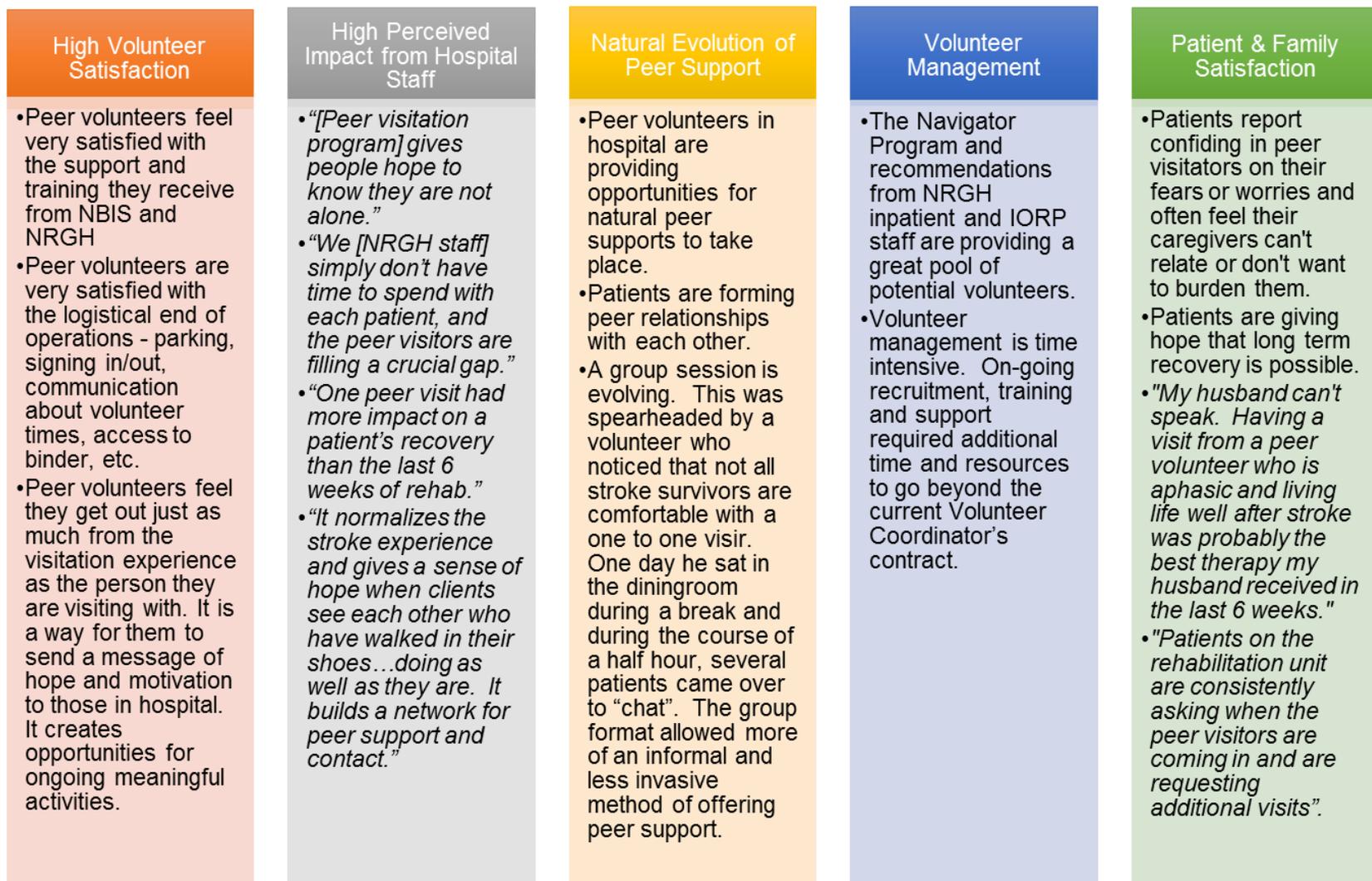
From March 2016 to September 2016, 3 trained peer volunteers visited with 35 stroke survivors from the inpatient and outpatient rehabilitation program. Of those 35 visits, 19 were completed inpatient and 15 were done as part of the outpatient rehabilitation program. Five themes emerged from the Group Peer Hospital Visitation Evaluation, as shown in Figure 7.

Figure 7: Themes from Group Peer Hospital Visitation Evaluation





Figure 8: Group Evaluation Feedback and Themes (expanded)t





Program Deliverables Performance

The goal of this section of the report is to determine if the Phase 2 met the deliverables outlined in the initial proposal. In Table 8, we review program deliverables performance. Appendix G provides a detailed explanation of how the deliverable was met.

Table 8: Program Deliverables

Deliverable	Outcomes
DEVELOPMENT PHASE – APRIL 2015 TO OCTOBER 2015	
Hold a Community Forum for stroke survivors, ABI clients and family caregivers	<ul style="list-style-type: none"> • Held April 2015 at Beban Community Centre, Nanaimo • 8 community members attended
Create a list of identified key stakeholders within community organizations, Island Health & NRGH	<ul style="list-style-type: none"> • 20 one-to-one and/or team meetings conducted with key stakeholders including • Through engagement, we developed and delivered the Peer Visitation Hospital program. This program is a partnership between Volunteer services at NRGH, IORP, Acute & Inpatient Rehabilitation and the Community Navigator Program. • Purpose of meetings were to: <ul style="list-style-type: none"> ○ Determine ability and willingness to collaborate ○ Develop program partner expectations ○ Engage key stakeholders and increase knowledge of community linkage gaps ○ Recommendations to fill identified gaps in services and programs
A multi-disciplinary Advisory Committee	<ul style="list-style-type: none"> • We identified potential Advisory Committee members, local to Nanaimo, and held an initial meeting in June 2015. • The Committee felt their expertise and community connections would be best suited to one-to-one requests. • Monthly reports were presented to SRABC’s Professional Advisory Committee (PAC). The PAC provided feedback and suggestions as needed.
A review and outline of current Best Practices in Navigator programs in BC	<ul style="list-style-type: none"> • Initial review showed few Navigator Programs in BC. Expanded reach to Canadian and International. • System Navigation Literature Review completed August 2015.

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Deliverable	Outcomes
A list of potential funders for on-going sustainability for Community Navigator beyond year one	<ul style="list-style-type: none"> • Potential philanthropists and community grants to support the Navigator Program were identified. The partners in the project (SRABC, MODC and NBIS) further explored leads to best determine where to invest time to write proposals. • United Way approved \$6000 funding to NBIS. • NBIS wrote a successful proposal to BCBA in June 2016 to secure one year funding for the Community Navigator Program to continue from October 2016 to July 2017.
An established protocol plan and process to implement Hospital visitation program	<ul style="list-style-type: none"> • Hospital Visitation program development finalized in October 2015. • There was a delay in obtaining the Hospital Visitation forms and processes from MODC resulting in a delay in the Hospital Visitation volunteer program. • The implementation and management of a Peer Visitation Hospital program required approximately 8 hours per week. The collaboration decided to fund a volunteer resource and management position for 6 months to implement the Peer Visitation program starting in December 2015.
IMPLEMENTATION PHASE – OCTOBER 2015 TO SEPTEMBER 2016	
Deliverable	Outcomes
Community Navigator Assessments	<p>Number of referrals: 95 Number of assessments completed: 83</p>
Development of a Peer Visitation Program	<ul style="list-style-type: none"> • Development and implementation of a peer volunteer hospital support program to provide 1:1 peer volunteer support for stroke survivors in hospital completed. • Trained 3 volunteers to date. • Three new volunteers recruited to complete orientation and training by November 2016 We began visitation in Outpatient in March 2016 and visitation in Inpatient in June 2016. • Visits to date: <ul style="list-style-type: none"> ○ Inpatient: 19 ○ Outpatient: 15
Evaluation of Peer Visitation	<ul style="list-style-type: none"> • Conducted a group volunteer evaluation of their experiences with the visitation to date. • Held Group evaluation held with peer hospital volunteers in September 2016 • Informal review conducted with NRGH staff
Deliverable	Outcomes

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<p>Explore partnership and collaborative opportunities</p>	<ul style="list-style-type: none"> • Our strongest collaborations continue with NRGH and key stakeholders at community level. We felt the program would succeed if we invested energy on partnerships on a local level including with Home and Community Care, Division of Family Practice and local service and health providers.
<p>Development and implementation of a volunteer lay navigator training program to provide 1:1 peer coaching to stroke survivors and family caregivers</p>	<ul style="list-style-type: none"> • A lay navigator volunteer package was developed
<p>Development of package of information and tools for stroke survivors and family caregivers transitioning from hospital to home</p>	<ul style="list-style-type: none"> • Completed and distributed to various units and waiting areas at NRGH
<p>Development and inclusion of 3 new Guides to Stroke Recovery specific to transitional management and family caregiving for stroke</p>	<ul style="list-style-type: none"> • The following 3 new guides to stroke recovery were developed: • Understanding Aphasia • Exercise and Mobility • 7 Steps to Stroke Recovery • Guides can be downloaded at: http://strokerecoverybc.ca/recovering-from-a-stroke/guides-to-recovering-from-a-stroke/ • Videos can be accessed at: 7 Steps to Stroke Recovery https://www.youtube.com/watch?v=GHJL42xFuz8 Exercise and Mobility: https://www.youtube.com/watch?v=BHfqFGj_tTw Communication and Language: https://www.youtube.com/watch?v=ZIFUhuOrhWw
<p>Awareness materials and educate referrals</p>	<ul style="list-style-type: none"> • Developed a variety of e-blasts, email templates, weekly reminders and a “What You Need to Know” sheet for staff and health professionals. • Regularly attend staff meetings at various units (IORP, Rapid Stroke Assessment Unit, Inpatient, Social Worker meetings) to education staff on the Navigator and Peer Visitation program. • Attended 35 staff and/or partner organization meetings during the implementation phase.
<p>Provide family caregivers with education sessions on a variety of topics related to caregiving for someone affected by brain injury and stroke.</p>	<ul style="list-style-type: none"> • In collaboration with NBIS, we facilitated 6 family caregivers education sessions serving 60 participants:



Collaboration and Strengthening Partnerships

Current limitations in funding for non-profit organizations in BC creates serious challenges to secure funding for long-term program sustainability. Phase 2 brought opportunities to strengthen partnerships and collaboration to better serve stroke survivors and family caregivers. The benefit of partnerships and collaborations are known to include:

- Knowledge transfer and exchange between organizations
- Institutional strengthening (policy; governance etc.)
- Decentralized approach to service delivery
- Meets a requirement of funders who are increasingly expecting collaborative approaches and provides credibility to funding agencies
- Permits a prudent, cost-efficient and strategic use of each organization's available resources (people/dollars/time)

Two distinct partnerships were further explored and developed in Phase 2:

- Strengthening partnership with NRGH
- Collaboration between SRABC, NBIS and MODC

NRGH Partnership

Phase 2 relied heavily on continuing to expand and strengthen partnerships within the hospital in Nanaimo (NRGH). In Phase 1, we established contact and credibility. Phase 2 aimed to broaden the partnerships to increase referrals from NRGH, to establish a peer hospital visitation program and to include other staff members in processes.

Overall, NRGH staff felt the partnership had a very strong impact on bridging the gap from hospital to home for patients and families. It is best captured by the following quotes in Figure 9.

Other key elements to the success of the partnership with NRGH in Phase 2 were:

Buy-In from Staff

- Referrals are increasing into the program - this is also having a positive impact on the awareness within the hospital and providing the groundwork to expand the program into acute with direct referrals to the Navigator. This couldn't happen without champions at NRGH.

Formal Structure and Processes

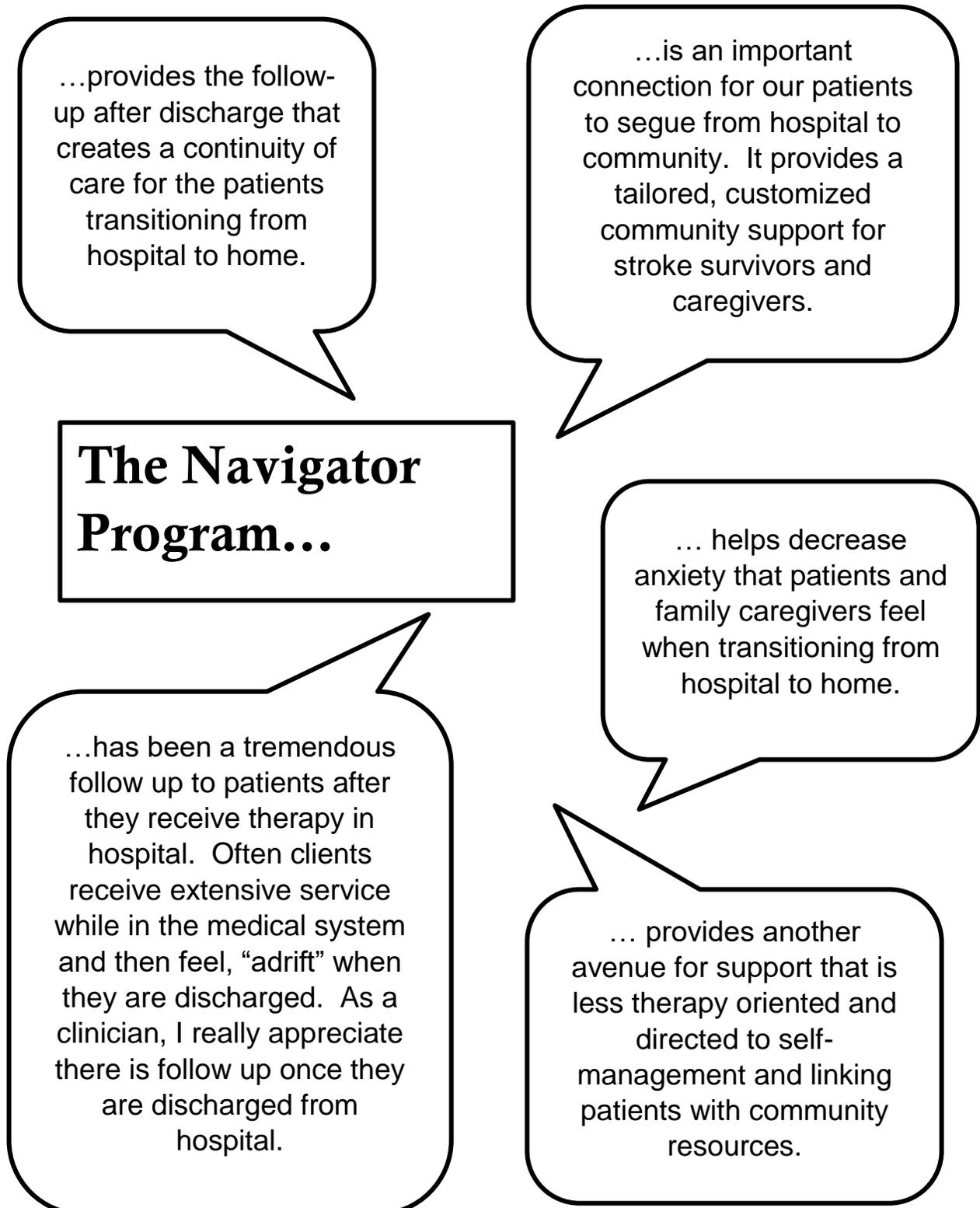
- Adopting an ongoing PDSA cycle requiring adaptations to changes and new information, provided a critical element in developing proper flow charts, processes and procedures. Having a formal structure and processes allows the program to be easily scalable to other hospitals and health care settings.

Communication

Communication across different organizations with different priorities and timelines can be a slow process. The Navigator Program and NRGH staff kept in regular contact regarding referrals, improving processes, staying connected and apprised on initiatives, new projects, change in staffing, etc.



Figure 9: Perceived Impact of the Navigator Program, NRGH staff



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SRABC, NBIS & MODC Collaborative

Team members from the collaborative were asked to highlight achievements, strengths and challenges in the collaborative and where applicable, contributions to the overall planning and delivery of Phase 2. Overall, all partners from the collaborative felt the collaborative was successful in advancing the Navigator Program by:

- Access to different funding streams
- Opportunity to provide a tested delivery model developed in Phase 1
- Expanding the target population to ABI and stroke
- Bringing together different health and service organizations for one common goal

The collaboration achieved a tested, proven service delivery model for navigation, hospital visitation and community education that improves the transition from hospital to home.

The collaboration took significant steps towards providing a continuum of care for people living with stroke and other forms of ABI on discharge from hospital.

Contributions from Partners

The contributions from each of the collaborative partners were diverse. The primary funder of the program was Stroke Services BC. Each of the collaborative partners felt their organizations contributed in different areas of the program including facility space, administration, program development, formal processes and funding.

Areas for Improvement

There was overwhelming agreement that the concept of collaborative work is positive and beneficial in moving forward program initiatives. It has the potential for sustainability through the combined resources of partners. Going forward, the following were identified as ways to improve the collaborative relationship:

- Establish clearer goals and direction for all partners and leaders
- Address challenge areas at outset within a broader MOU
- Establishing certainty around budget and financial sustainability of the collaboration is the highest priority

Appendix H highlights the successes and lessons learned in the collaborative relationships and Appendix I provides a SWOT analysis of Phase 2.



Recommendations

Sustainable service delivery model

Further investigation and research into how to design a sustainable service delivery model is needed

- Hiring staff with the skill set to provide Navigator services including intake, assessment and follow up are less costly than a paid contractor.
 - It is estimated that a half time FTE Navigator employed at \$18.00 to \$20.00 per hour could manage 25-30 incoming referrals per month.
- Providing Navigation services by phone, in-office and in-hospital (prior to discharge) will reduce the cost with travel time and mileage. It also affords the ability to expand the geographic catchment area of the program without increasing costs.
- Use findings from the research being done by Bridgepoint give full name and refer to relevant section of the report on lay navigation and the groundwork completed in this project, test a lay navigation program delivered by skilled volunteers. There are various aspects of navigation that can be done by volunteers who are empathetic and resource experts.
- Navigation services require a skilled staff person to provide oversight, supervision, training, support of staff and volunteers. This staff person is also key to developing partnerships with hospital, primary care and managing those partnerships.
- Core funding is required for the provision of continuity of and quality programming. This core funding needs to find a home within the health authorities, the Ministry of Health or needs a dedicated fundraising activity attached to the program. Having it rest on one local or provincial organization's shoulders creates risk in various areas including board buy-in and support, sustainable funding and being able to provide continuity in service delivery.
 - Explore how Brain Injury Programs and Societies evolved to receiving core funding. Health authorities provide core funding to Brain Injury societies to deliver community program for ongoing support and management of brain injuries. What do Health Authorities or the Ministry require in terms of evidence that Navigator is a core and essential program in:
 - transitional management from hospital to home
 - reductions in health costs associated with readmission rates to hospital and unnecessary medical appointments

Volunteer Management

Develop a volunteer management system to support the service delivery model

- There is growing and continued support that skilled volunteers are underutilized in service and program delivery. Developing a well-resourced and well utilized volunteer management program could help offset costs associated in program delivery of the Navigator program.
 - Expansion of the hospital peer visitation program in other parts of NRGH, additional financial and human resources are required. The current staff person is able to manage the current load of volunteers; however, expansion of the program isn't possible within the existing model.
 - Diversification of volunteers would meet a broader need of people affected by stroke. Younger stroke survivors and those with cultural diversity would enrichen the program.
 - Offering one to one peer services in the community would provide an additional level of support for individuals affected by stroke. Many participants in the Hospital Peer Visitation program expressed a need and desire for a peer visit in community.

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- The processes and information management systems are well established for the Hospital Peer Visitation program and easily scalable to other hospitals. Establishing key contacts and stroke champion in other hospitals is the very first step.
- Resourcing and testing a lay navigation model is a logical next step in reducing costs in delivering navigation services. Using Bridgepoint’s research to develop the program is a first step. NRGH is a logical first place to start as the buy-in from the hospital is high, partnerships exist and there is an existing funded Navigator Program.

Penetrating Primary Care

Identify strategies for making contact with key stakeholders in primary care and getting their buy-in and cooperation

- Every nonprofit organization providing support complimentary to primary care are asking themselves the same question, “How do we work in harmony with primary care?”
 - One place to start is to research if there are billing codes associated with referrals to community services. This could be investigated through Doctors of BC.
 - Living with illness and/or disability accounts for over 40% of the BC’s population and almost 50% of all health system expenditures. This population group requires a significant, sustained, and coordinated effort on the part of health service providers to achieve the best possible health outcomes. With the shift to Primary Care Homes in BC, identifying key contacts within the new model are critical to increasing awareness on linking primary care to community base organizations.
 - Developing and using simple referral forms and key messages are crucial.
 - Penetrating committees that address living with illness/disability are one avenue to increase awareness and build partnerships to penetrate primary care.

Increase Awareness within Hospital Systems of Community Based Stroke Recovery

- *Identify strategies for increasing awareness within hospital management systems of community based stroke recovery including:*
 - Lobbying to sit on stroke planning committees within Island Health
 - Identifying a champion (at NRGH we have a few)
 - Consistency and regularity in communication
 - Face to face time in various forms – education for staff to patient and family education
 - Including staff in development of delivery of programs
 - Increasing awareness and establishing partnerships takes time and consistency. There is no short cut in this area.



Transitional Management Improvement

Identify possible avenues to advocate for including service delivery models in hospital to home transitional management including:

- Expanding the Peer Visitation model to include other units will greatly contribute to improving transitional management from acute settings
- Having referral forms available in the ER is a small start.
- Expanding the Peer Visitation model to the community is another method to improve transitional management. Many of the stroke survivors requested a visit from a peer once back home in the community.
- Test the Lay Navigation Model. Well trained and supported peer volunteers could assist with goal setting and community reintegration. This would dovetail with professional and lay navigation. This would include:
 - Developing a volunteer management strategy
 - Securing core funding for staffing
 - Developing training for volunteers in areas including Motivational Interviewing and Brief Action Planning (see Appendix J)
 - Clear delineated roles for Lay Navigation
 - Possible areas to assist with transitions include:
 - Follow up in-home visit or telephone call within 60 days post discharge
 - Completion of Brief Action Plan
 - Provision of community resources and links to stroke recovery support programs
 - Identification of additional support required and flagged for professional care coordination if needed
 - Caregiver support kit and information on Family Caregiver series start dates
-

Appendices

Appendix A: Similarities and Differences Between Phase 1 & Phase 2

Appendix B: Community Stroke Recovery Navigator Program Coordinator Service Activities

Appendix C: Referral Form

Appendix D: Phase 2 Program Evaluation Plan

Appendix E: Client Intake Form

Appendix F: Client Activity Log – Sample

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Appendix A: Similarities and Differences Between Phase 1 & Phase 2

Similarities and Differences Phase 1 & Phase 2		
Client Activities	Phase 1	Phase 2
Hospital Peer Visitation Program	×	✓
Initial Contact Response Time	Approx. 6 weeks	Approx. 2 weeks
Stroke Group Education Sessions	✓	×
Family Caregiver Group Education Sessions	×	✓
In-home assessment	✓	✓
Telephone follow up	✓	✓
Case management activities	✓	×
Co-create action plan	✓	✓
Community referrals	✓	✓
Partnerships & Community Linkages	Phase 1	Phase 2
Partnership – NRGH IORP	✓	✓
Partnership – NRGH Inpatient	×	✓
Partnership – NRGH Volunteer Services	×	✓
Partnership – NRGH Social Work Department	×	✓
Collaboration – MODC & NBIS	×	✓
Development & Education Activities	Phase 1	Phase 2
Lay (Volunteer) Navigator Program Framework	×	✓
Hospital Peer Visitation Program	×	✓
Hospital Peer Visitation – Volunteer Training Program	×	✓
New Stroke Recovery Guides	✓	✓

Appendix B: Community Stroke Recovery Navigator Program Coordinator Service Activities

Client Assessment and Service-Care Plan

- Management of referrals for Phase 2 participants
- Completion of intake assessments using the intake questionnaire
- Writing and typing of a service-care plan

Information and Referral

- Research service and resource options for clients with other providers
- Referral to community resources, as required and with consent.
- Provision of written and verbal information related to stroke recovery and caregiving. Sources included books, social media, websites, videos, research and general articles, etc.
- Develop a directory of stroke recovery resources, programs and services

Community Linkage

- Outreach to and networking with community based partners

Case management

- Provided case management services when social resources were not available or limited non-existent or limited and the participant required assistance, support, information and/or advocacy to meet their needs.
- System navigation: including the identification of appropriate community resources, how to access their system, and initiating a referral.

Monitoring and Follow-Up

- Follow up by telephone with clients to determine client's satisfaction with service-care plan

Hospital Peer Visitation Program

- Work with volunteer coordinator to plan, implement the program and train and support volunteers

Family Caregiver Education

- Develop content, coordinate and delivery community-based stroke recovery education

Program Management

- Monthly reports
- Monthly meetings with Collaborative and staff at NBIS
- Regular meetings with staff and Executive Director
- Filing and database management
- General program planning activities

Community Navigator & Peer Visitation Program

For Stroke, Acquired Brain Injury & Family Caregivers

REFERRAL & CONSENT FORM

The Community Navigator & Peer Visitation Program will help persons affected by stroke and acquired brain injury and their caregivers by visiting in hospital and providing a follow-up once back in the community to help navigate them to the right services and resources in their community as well as answer questions about on-going recovery post-hospital discharge.

To refer a patient, please complete this form and return it by FAX at **1-866-737-0273** or by e-mail to navigator@nbis.ca.

Name: _____

Phone: _____ Email: _____

Next of Kin & relationship: _____

Phone (if different than above): _____

CLIENT CONSENT

Client consents for referral to the Community Navigator & Peer Visitation Program

Client Signature: _____ Date: _____

REFERRAL MADE BY:

Self

VIHA program: HCC → IP Rehab Acute care OP Rehab

Community Agency: (_____) →

Other: _____

OFFICE USE:

Date of Referral: _____

Description: _____

Appendix D: Phase 2 Program Evaluation Plan

Evaluation Questions	Measured Outcomes
Did Phase 2 reach its intended population?	<ul style="list-style-type: none"> • Referrals & sources • Enrollment and completion • Initial contact response time • Participant demographics
<p>What services were offered to clients? Did they require further assistance at 3 months?</p>	<ul style="list-style-type: none"> • Scope of Navigation services • Follows up completed • Additional support required • Proportion of stroke survivors discharged from hospital who receive a referral into the Bridging the Gap program. • Proportion of stroke survivors who return to the emergency department or hospital setting for non-physical issues following stroke (e.g., failure to cope).
How did we impact Family Caregiver Burden & Education?	<ul style="list-style-type: none"> • Change in knowledge pre and post education programming for stroke survivors and family caregivers • Measure of burden of care for family and informal caregivers of stroke survivors living in the community
Hospital Peer Visitation Review	<ul style="list-style-type: none"> • Number of stroke survivors participating in peer support visits • Volunteer satisfaction • NRGH staff satisfaction
Were the goals and objectives of Phase achieved?	<ul style="list-style-type: none"> • See objectives on page 8
What was the level of satisfaction of clients and partners?	<ul style="list-style-type: none"> • Client satisfaction survey • Volunteer, staff and collaborative team informal and group feedback
What did a process evaluation of program implementation and management reveal?	<ul style="list-style-type: none"> • SWOT analysis of the program • Was there a perceived increase in coordination of care and improved communication between rehab and community.

Appendix E: Client Intake Form

GENERAL INFORMATION

Name: _____ Today's Date: _____

Gender: Male Female Your Age: _____

What city do you live in? _____

Date of Stroke (MM/YY): _____

Were you admitted to hospital? Yes No

Did you go to inpatient rehabilitation Yes No

Type of stroke: Ischaemic (clot) Hemorrhagic (bleed) Not Known

Have you had a previous stroke? Yes No

If Yes, date of previous stroke (Year only): _____

MY LIVING ARRANGEMENTS

I live in a:

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> house | <input type="checkbox"/> retirement home |
| <input type="checkbox"/> apartment | <input type="checkbox"/> no fixed address |
| <input type="checkbox"/> mobile home | <input type="checkbox"/> other: _____ |

I live with:

- | | |
|---|--|
| <input type="checkbox"/> spouse/partner | <input type="checkbox"/> alone |
| <input type="checkbox"/> children | <input type="checkbox"/> private caregiver |
| <input type="checkbox"/> other family members | <input type="checkbox"/> Other: _____ |

Please check 'yes' or 'no' or N/A (not applicable) to each of the following questions:

What areas are you having difficulty with? Please check all that apply.):

- | | |
|--|--|
| <input type="checkbox"/> difficulty with arm and hand function | <input type="checkbox"/> boredom |
| <input type="checkbox"/> eating well and preparing meals | <input type="checkbox"/> taking care of myself |
| <input type="checkbox"/> impulsiveness | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> difficulty walking and getting around | |
| <input type="checkbox"/> household tasks | |
| <input type="checkbox"/> fatigue | |
| <input type="checkbox"/> difficulty with vision and perception | |
| <input type="checkbox"/> difficulty swallowing | |
| <input type="checkbox"/> difficulty with memory | |
| <input type="checkbox"/> talking and understanding | |
| <input type="checkbox"/> safety in the home | |

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MY COMMUNITY SERVICES

	YES	NO	N/A
I have been referred to Home and Community Care (VIHA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am receiving:			
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am attending outpatient rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	N/A
I am receiving the following community support services:			
Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with the amount of assistance that I receive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- I would like to learn more on:
- adjusting to life after stroke
 - ways to improve my quality of life
 - how to support and care for my loved one
 - managing emotional changes
 - managing my finances
 - learn about community resources
 - learn how to reduce risk of another stroke
 - other: _____

HEALTH MANAGEMENT

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I am taking all of the medicines that my doctor(s) has prescribed.	0	1	2	--
I understand <u>why</u> I am taking all my prescription medications	0	1	2	--
I understand <u>how</u> to take all my prescription medications.	0	1	2	--
All my questions about the medicines I am taking have been answered.	0	1	2	--
I have told my doctor about all the other drugs, vitamins, or supplements that I am taking.	0	1	2	--
I am sleeping well	0	1	2	--
I am eating well	0	1	2	--
My ability to chew and swallow is the same as before my stroke	0	1	2	--

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	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
My thinking is the same as before my stroke.	0	1	2	--
My emotions are similar to before my stroke.	0	1	2	--
I feel that I can deal with life events as they happen.	0	1	2	--

DAILY ROUTINES

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I am comfortable preparing my own meals.	0	1	2	--
I am able to look after my personal needs - dressing, bathing/showering, nail care (hands and feet).	0	1	2	--
I am able to toilet myself - getting to the bathroom on my own, using the toilet.	0	1	2	--
I know about continence products (e.g. Depends	0	1	2	--
I am comfortable caring for my children.	0	1	2	--
I am able to manage my daily tasks at home (e.g. washing dishes, doing laundry, vacuuming, dusting, yard work, snow removal).	0	1	2	--

WORK

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I have returned to my previous work.	0	1	2	--
I feel able to return to work.	0	1	2	--
I have a plan to return to work.	0	1	2	--
I feel able to participate in retraining for a new job or other education	0	1	2	--
I feel able to participate in volunteer activities.	0	1	2	--
I am able to concentrate well and participate in all activities at work.	0	1	2	--
I have enough energy for work.	0	1	2	--

MY SOCIAL NETWORK

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I am comfortable rejoining the groups and activities that I was involved in prior to my stroke.	0	1	2	--
I go out of the house about as often as I did before my stroke.	0	1	2	--
I have someone who give me emotional support.	0	1	2	--
I am able to do the things I want to do.	0	1	2	--

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MY HOME

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I am able to get around my home easily. .	0	1	2	--
I am using special equipment to move around our home (e.g. walker, raised toilet seat, grab bars).	0	1	2	--
My home has been adapted to help me with my mobility (e.g. wheelchair ramps, stair rails).	0	1	2	--
I am always steady on my feet.	0	1	2	--
I receive help in and around my home from people who do not get paid to help me - friends, relatives, volunteers, family.	0	1	2	--

MY COMMUNICATION

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I feel able to communicate my needs and desires.	0	1	2	--
I always understand what people are saying.	0	1	2	--
I am satisfied with the way I communicate.	0	1	2	--
I feel comfortable communicating in groups.	0	1	2	--
I have aids to help me communicate - pictures, communication board, etc	0	1	2	--

MY COMMUNITY MOBILITY

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I have returned to driving.	0	1	2	--
I am comfortable driving in my local area/short distances.	0	1	2	--
I am comfortable driving long distances.	0	1	2	--
I am comfortable driving at night.	0	1	2	--
I would like to start driving again, etc	0	1	2	--
I know where to go for a driving assessment so I can start to drive again.	0	1	2	--
I am comfortable using transportation services (e.g. public transit, accessible transit, volunteer drivers).	0	1	2	--
I am able to get to those places I need to - grocery shopping, rehabilitation, doctor's appointments, work	0	1	2	--

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MY FINANCES

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I am comfortable managing my finances - banking, paying bills.	0	1	2	--
I have enough money for my needs.	0	1	2	--
I am receiving disability insurance/pension).	0	1	2	--
I know how to get financial assistance - disability, pensions, disability tax credit, etc.	0	1	2	--

CAREGIVER SUPPORT (to be answered by primary caregiver)

	Does not describe my situation	Partially describes my situation	Fully describes my situation	N/A
I am comfortable caring for him/her and understand what his/her needs are.	0	1	2	--
I feel that I am coping well emotionally.	0	1	2	--
I am receiving enough respite.	0	1	2	--
I have someone who provides me with emotional support.	0	1	2	--

Is there anything else you would like to ask us? Is there anything else you would like us to know?(add a separate page if necessary)

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Appendix E: Client Activity Log – Sample

Client Name: Mrs. Robb

Date	Contact/Activity	Results of Contact/Activity
March 7/16	Mrs. Robb, coordination of assessment	Left message with possible date and time
March 10/16	Mrs. Robb, confirming assessment date	Confirmed assessment date
March 17/16	Home visit to Mrs. Robb	Complete in home visit
March 24/16	Mailed service action plan Mrs. Robb and her caregiver	
May 15/16	Called Mrs. Robb to follow up on service action plan	Mrs. Robb felt confident in implementing activities but would call if she needed more assistance.

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Appendix F: Program Deliverables

Deliverable	Outcomes
DEVELOPMENT PHASE – APRIL 2015 TO OCTOBER 2015	
Hold a Community Forum for stroke survivors, ABI clients and family caregivers	<ul style="list-style-type: none"> • Held April 2015 at Beban Community Centre, Nanaimo • 8 community members attended • Feedback from participants through a survey and focus group questions • Although we were disappointed by the numbers in attendance, the quality of information was very helpful in reaffirming the purpose of the Community Navigator Program and garnered a few new members as well as a potential individual for the Advisory Committee • Key themes: not enough support with hospital discharge, difficulty finding the right service, caregivers feel overwhelmed with care management, very little follow up provided through our health care system
<p>Create a list of identified key stakeholders within community organizations, Island Health & NRGH</p> <ul style="list-style-type: none"> • Purpose of meetings were to:word spacing is odd here <ul style="list-style-type: none"> ○ Determine ability and willingness to collaborate and in what areas regarding the Community Navigator program ○ Develop program partner expectations ○ Engage key stakeholders and increase knowledge of community linkage gaps ○ Recommendations to fill identified gaps in services and programs 	<ul style="list-style-type: none"> • 20 one-to-one and/or team meetings conducted with key stakeholders including <ul style="list-style-type: none"> ○ Intensive Outreach Rehabilitation Program (IORP) Team at Nanaimo General Regional Hospital ○ Stroke Nurse, North Island Stroke Clinic and at Nanaimo General Hospital, ○ Private practitioners, including neuro-physiotherapist, speech language therapist ○ Social Work Department at NRGH ○ Social worker at Home and Community Care Nanaimo ○ Rehabilitation manger St. Joseph's Hospital ○ Social Work Department at Campbell River Hospital ○ Stroke Recovery Branch Coordinators – Duncan, Nanaimo, Oceanside and Comox Valley • Reviewed and refined referral process from IORP, Inpatient and Acute for stroke • Increased knowledge of benefits of Community Navigator Program with key staff at NRGH. One staff quoted, “We are so glad that our patients and families can benefit from this valuable community link”. • Through engagement, we developed and delivered the Peer Visitation Hospital program. This program is a partnership between Volunteer services at NRGH, IORP, Acute & Inpatient Rehabilitation and the Community Navigator Program.
A multi-disciplinary Advisory Committee	<ul style="list-style-type: none"> • We identified potential Advisory Committee members, local to Nanaimo, and held an initial meeting in June 2015. Program development was almost complete. • The Committee felt their expertise and community connections would be best suited to one-to-one requests. • Monthly reports were presented to SRABC’s Professional Advisory Committee (PAC). The PAC provided feedback and suggestions as needed.

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Deliverable	Outcomes
A review and outline of current Best Practices in Navigator programs in BC	<ul style="list-style-type: none"> • Initial review showed few Navigator Programs in BC. Expanded reach to Canadian and International. • System Navigation Literature Review completed August 2015.
A list of potential funders for on-going sustainability for Community Navigator beyond year one	<ul style="list-style-type: none"> • Potential philanthropists and community grants to support the Navigator Program were identified. The partners in the project (SRABC, MODC and NBIS) further explored leads to best determine where to invest time to write proposals. • United Way approved \$6000 funding to NBIS. • NBIS wrote a successful proposal to BCBA in June 2016 to secure one year funding for the Community Navigator Program to continue from October 2016 to July 2017.
An established protocol plan and process to implement the following programs within NRGH <ul style="list-style-type: none"> • Hospital visitation program • Lay Navigator Program 	<ul style="list-style-type: none"> • Hospital Visitation program development finalized in October 2015 and included: <ul style="list-style-type: none"> ○ Posters for hospital ○ Referral form into the Navigator and Hospital Visitation program ○ Information package for hospital staff to hand out ○ Cheat sheet for hospital staff ○ Program delivery model and processes ○ MOU between NRGH and the Collaboration-what's that? ○ Final documentation to collect statistics ○ Final process for patient bookings • There was a delay in obtaining the Hospital Visitation forms and processes from MODC resulting in a delay in the Hospital Visitation volunteer program. • The implementation and management of a Peer Visitation Hospital program required approximately 8 hours per week. The collaboration decided to fund a volunteer resource and management position for 6 months to implement the Peer Visitation program starting in December 2015. • The Community Navigator averaged approximately 18 hours a week and was not able to complete the volunteer resource component within the above hours.
IMPLEMENTATION PHASE – OCTOBER 2015 TO SEPTEMBER 2016	
Deliverable	Outcomes
Community Navigator Assessments	Number of referrals: 95 Number of assessments completed: 83 Referral Sources: <ul style="list-style-type: none"> - IORP: 35 - Inpatient: 25 - Rapid Stroke Clinic: 4 - Community: 19

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	** Remaining assessments were completed when funding started from BC BIA and allowed for continuity and no disruption in service delivery.
Deliverable	Outcomes
Development of a Peer Visitation Program	<ul style="list-style-type: none"> • Development and implementation of a peer volunteer hospital support program to provide 1:1 peer volunteer support for stroke survivors in hospital. We developed and implemented the Peer Visitation volunteer program: <ul style="list-style-type: none"> ○ Application form ○ Interview form) ○ Reference form ○ Confidentiality form ○ Position Description ○ Volunteer Agreement Volunteer performance review form ○ Handbook ○ Orientation Powerpoint ○ Volunteer Management checklist to support staff through the volunteer management cycle • Trained 3 volunteers to date. • Three new volunteers recruited to complete orientation and training by November 2016 • We began visitation in Outpatient in March 2016 and visitation in Inpatient in June 2016. • Visits to date: <ul style="list-style-type: none"> ○ Inpatient: 19 ○ Outpatient: 15
Evaluation of Peer Visitation	<ul style="list-style-type: none"> • Conducted a group volunteer evaluation of their experiences with the visitation to date. • We attempted to collaborate with previous work and evaluation done by MODC in their Ontario hospitals, but had ongoing challenges in receiving the documentation in time for the October timeframe. • Held Group evaluation held with peer hospital volunteers in September 2016 • Informal review conducted with NRGH staff

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Deliverable	Outcomes
Explore partnership and collaborative opportunities to offer the education modules as a continuation of Heart & Stroke “Living with Stroke” and/or GF Strong’s Connecting The Dots...A Provincial Stroke Education Toolbox	<ul style="list-style-type: none"> • Our strongest collaborations continue with NRGH and key stakeholders at community level. We felt the program would succeed if we invested energy on partnerships on a local level including with Home and Community Care, Division of Family Practice and local service and health providers.
Development and implementation of a volunteer lay navigator training program to provide 1:1 peer coaching to stroke survivors and family caregivers (in person or over the telephone)	<ul style="list-style-type: none"> • A lay navigator volunteer package was developed including: <ul style="list-style-type: none"> ○ Application form ○ Interview form ○ Reference form ○ Confidentiality form ○ Position Description ○ Volunteer Agreement ○ Volunteer performance review form ○ Handbook & Orientation Powerpoint ○ Volunteer Management checklist to support staff through the volunteer management cycle <p>After development of the basic volunteer requirement for a Lay Navigation Volunteer framework, we decided to delay further development. The time commitment involved to develop a training program, recruit volunteers and manage the program was beyond the scope of the programs current funding model. We will explore further options as part of the final report and recommendations.</p>

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Deliverable	Outcomes
Development of package of information and tools for stroke survivors and family caregivers transitioning from hospital to home	<p>The brochure of Community Navigator Program is complete.</p> <ul style="list-style-type: none"> • Community Navigator Program brochure completed • Outline of package of information for NGRH staff completed • Distribution of materials to NGRH completed in August and ongoing as required • Ongoing discussion regarding on packaging and where best to distribute within hospital, i.e., ER & Acute. • Navigator rack card, Stroke Recovery Guides, NBIS tear off sheet and MODC Caregiver Guide are being inserted in to the Rehabilitation package at NRGH.
Development and inclusion of 3 new Guides to Stroke Recovery specific to transitional management and family caregiving for stroke	<ul style="list-style-type: none"> • The following 3 new guides to stroke recovery were developed: • Aphasia • Exercise • 7 Steps to Stroke Recovery • Content for the guide to Fatigue Post-Stroke completed. • Guides can be downloaded at: http://strokerecoverybc.ca/recovering-from-a-stroke/guides-to-recovering-from-a-stroke/ • Videos can be accessed at: 7 Steps to Stroke Recovery https://www.youtube.com/watch?v=GHJL42xFuz8 Exercise and Mobility: https://www.youtube.com/watch?v=BHfqFGj_tTw Communication: https://www.youtube.com/watch?v=ZIFUhuOrhWw
Awareness materials and educate referrals	<ul style="list-style-type: none"> • Developed a variety of e-blasts, email templates, weekly reminders and a “What You Need to Know” sheet for staff and health professionals. • Regularly attend staff meetings at various units (IORP, Rapid Stroke Assessment Unit, Inpatient, Social Worker meetings) to education staff on the Navigator and Peer Visitation program. • Attended 35 staff and/or partner organization meetings during the implementation phase. • Connected with each stroke group to educate Coordinator on referrals and distribute referral forms. • Landing page on MODC website completed. Referral form and brochure on the site. https://www.marchofdimes.ca/en/programs/abi/pages/cnp.aspx



Appendix H: Successes and Challenges of NBIS, SRABC & MODC Collaborative

Successes	Challenges
<p>Formalized Partnership: Achieved a formalized collaboration on paper in the way of a MOU was established.</p> <p>Community Development: increased awareness of a gap in service for people affected by stroke allowing for “buy-in” from NRGH and other health professionals. Collaboration with a local, provincial and national organization opens doors that might have otherwise been shut had a single organization tried knocking on a door</p> <p>Teamwork: strengthened the interpersonal and professional relationships connecting individuals on the team and respective organizations to enable a collaborative initiative in allied fields. Partners were all very qualified and experienced in respective fields. Partners enjoyed a very healthy set of relationships and communicated well across organizational borders.</p> <p>Communication: regular community and reports and “facetime” meetings.</p> <p>Global Approach: Combination of a national, provincial and local view provides a diversity of perspectives and uses collective strengths to create, customize and implement a solution to fill a service gap in the community</p> <p>Shared Vision: Partners in the collaborative shared a vision, goals and ownership of the program.</p>	<p>Systems interface: each organization's internal 'systems' are exceptionally varied and it is challenging to find an effective way for organization’s system to interface with one another.</p> <p>Time and priorities: collaboration takes more time, is more complex and requires organizations to prioritize the relationship to achieve the project’s vision</p> <p>Branding: We didn’t put in enough time at the start of the relationship into developing a “unique” brand for the collaboration.</p> <p>Miscommunication: communication is organic and organizations change constantly. Communicating shifts to the collaborative is key to avoid miscommunication.</p> <p>Differing governance systems: when decisions need to be made, there can be a bottleneck in action as a result of a governing system delaying what is required to move the activity forward</p> <p>Funding Uncertainties: it was difficult for the collaborative to find sustainable funding. The program was able to continue through NBIS’ successful application to the BCBIA.</p>

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Appendix I: SWOT Analysis

<p><u>STRENGTHS</u></p> <ul style="list-style-type: none"> • Ongoing financial and organisational support of SRABC and the CSRN project by Stroke Services BC • Central to this program was a single point of follow up that provides stroke survivors families with a more streamline process, and to know that someone has time to listen to their needs and work with them to find solutions. • Although access is multi-entry, the key component is follow up was being done by the established partnerships and the Community Navigator. • Education of Rehabilitation and Hospital Staff • Collaboration contributed to advancing Phase 2 • Hospital Peer Visitation allows for continuity of care and helping to bridge the gap from hospital to home • Follow up in the community has a huge impact on stroke survivors and families to feel supported in ongoing recovery • Another huge win for the program was a shift in health professional perspective on the criteria for referral. The social work departments were instrumental in conveying message of education patients and other staff at discharge to be open to a follow up once discharged back into the community. The philosophy of “you won’t know what you need until you get back home” was a key message. 	<p><u>WEAKNESSES</u></p> <ul style="list-style-type: none"> • The length of time for a program to take hold. It was unfortunate that after the project ended in 2014, there was almost a year gap before we could resume assessments. It took a better part of a year to regain the momentum in referrals in 2015-16. • The absence of ongoing funding. We were fortunate that BCBIA could provide funding to continue the program. We’ve expanded our reach to include all ABI – stroke and non-stroke related. • Limited Performance measures: challenging to show impact on the performance measures from the Canadian Stroke Strategy (2013) due to lack of access to statistics from hospital and health authorities. We also don’t have the capacity to conduct evidence-based studies due to limited resources. • Being a small community based organization outside of the health and medical mainstream made for a longer period to establish credibility. • Limited capacity: part time Coordinator made it challenging to sustain scope of project
<p><u>OPPORTUNITIES</u></p> <ul style="list-style-type: none"> • Use of findings and recommendations in the development of a framework for service delivery for long-term stroke recovery in the community • Development of a national business plan for funding of long-term stroke recovery in the community in partnership with MODC • Expansion to include ABI • Reach out to off-site locations – GF Strong, VGH (Victoria), VGH (Vancouver) • Expansion of Peer Hospital Visitation program into other Health Authorities and Regional Hospitals • Use Navigator research to delivery lay navigation • Ability to reduce cost by using Navigator staff to conduct assessment at a lower wage than a consultant. A program manager is still required to provide oversight and management of the program. • Utilization of skilled, trained and supervised volunteers 	<p><u>THREATS</u></p> <ul style="list-style-type: none"> • Absence of continued Funding • Capacity of organizations to scale and sustain programs, both financially and with human resources • Limited capacity of organisations to promote the importance and value of CSRN services in <u>long-term stroke recovery in the community</u>



Appendix J: Brief Action Planning

Taking Care of My Health or Well-Being

16 Mar 2015

Today's Date: _____

My health or well-being goal is: _____

1) Make an action plan:

Is there anything you'd like to do for your health or well-being in the next week or two? If there isn't anything you'd like to do for your health or well-being right now, you might want to consider this again in the future. If yes, fill in the following details. Some of these may not apply. Try to be as specific as possible.

My Action Plan	My Answers	Comments
What would you like to do?		
Where?		
When and how often? (What time of day will you do this? If it happens more than once—how often will it happen?):		
How long or how much? (minutes, servings, etc.)		
When will you start?		

2) Review your plan

2a) How sure or confident are you that you will be able to accomplish your plan?

Not sure at all 0 1 2 3 4 5 6 7 8 9 10 Very sure

***Note:** If you chose 6 or lower, go to question 2b. If you chose 7 or higher, go on to question 3.

2b) How might you change your plan to make it possible to raise your number to 7 or higher?

3) Check how you are doing

- I will do this myself
- I will check with someone else (a family member or a healthcare team member)
 Who is that person? _____

How and when would you like to check in (i.e. in a week or a day, by phone or in person)

Adjust your plan as needed. Remember to celebrate things that went well!



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