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Bridging the Gap: Developing a Hospital and Community Care Pathway for Stroke Survivors

Stroke Recovery Association of BC / Fraser Health Integrated Health Network - Community Wellness Initiative

The transition from specialized medically-based stroke services to the community where the survivor lives, works, and socializes marks the true beginning of life after stroke. Community re-integration represents the longest period of stroke survivorship when viewed from the perspective of the whole continuum of stroke. The transition process for stroke survivors and caregivers back into BC's communities is informal with no established and proven pathways.

Fraser Health Authority's Integrated Health Network Community Wellness Initiative provided the Stroke Recovery Association of BC (SRABC) with a grant to establish a system for connecting with stroke survivors within Fraser Health Authority while in hospital, in order to help link them to stroke recovery resources in their community post-discharge.

Findings from the project support that a care pathway for stroke survivors and their families from hospital to home is very complex and highly individualized. Although many respondents felt the current care pathway was working well, several barriers were highlighted including:

- Challenges in completing assessments in a timely manner.
- Limited Human Resources.
- Information through transfers can get lost.
- Disconnect between hospital discharge and community-based services.
- Difficulty in accessing the right type of help at the right time.
- Need for formalized patient and family stroke education.
- An expressed desire from health providers to connect stroke survivors to the community while still in hospital.

Health and service providers need to recognize that there is no "discharge" from stroke recovery. A proposed Community Reintegration Care Pathway is provided as a very tentative approach to define the process from hospital to home (see Appendix B. Community Reintegration Pathway Model). Key aspects to a successful transition include a community-based approach to hospital discharge involving follow up with stroke survivors once back home, on-going support to assist with system navigation and access to support and services in the community.

Future recommendations include:

- Increasing the capacity and resources of SRABC's Stroke Recovery Branches.
- Improving liaison between community organizations serving stroke survivors.
- Creating a focus on the Community Integration aspect of the BC Stroke Action Plan.
- Closing the gap between discharging patients and ensuring that their needs are met in the community.
- Adequate provision of translation and interpretation services and cultural sensitivity resources.
- Implementing the second phase of this study - a Community Stroke Linkage Program, using the Care Pathway.

The proposed community reintegration care pathway is based on both findings from the in-depth interviews and the literature review. The overall principle of the pathway is based on the view a stroke survivor's journey is directly related to an ongoing need to communicate with

various services and resources during recovery - and to meet the needs of the survivor and their family at the right time.

The objectives of the proposed community reintegration pathway are:

1) Stroke survivor and caregivers receive information about stroke, long-term recovery and resources and services in the community.
2) Provide a “safety net” for stroke survivors discharged from hospital and also follow up once settled into home environment.
3) Changing needs are identified and responded to in a timely manner.
4) Improve the current stroke care pathway and programs for stroke survivors.

1.1 THE COMMUNITY REINTEGRATION PATHWAY

1. Stroke Survivor/Caregiver Registration Process: two critical components in the pathway are continuity of support once discharged from hospital and ensuring equity of access to services for all stroke survivors and caregivers.

A registration process would allow existing survivors/caregivers in the community to self-refer or be referred by family, family physician, Home Health Care and other programs within FHA or other service providers.

Newer stroke survivors and caregivers would be directly referred through hospital or rehabilitation discharge.

The process would facilitate multi-level entry points for stroke survivors to access stroke specific and community-based services.

2. Entry in Database: stroke survivors and caregivers would be given a status depending on their current needs such as 'active', 'inactive' or 'opted out'.

3. Standardized Intake: a standardized intake process provides initial contact with registered stroke survivors and caregivers. The intake process identifies current needs and assessment for appropriate community programs and services.

4. Follow Up & Action Plan: development of a plan of action through an in-home visit or telephone consultation, for addressing identified needs. The standardized plan of action addresses the what, where, when and how of providing information about appropriate services.