STROKE RECOVERY ASSOCIATION
OF BRITISH COLUMBIA

SRABC

COMMUNITY STROKE RECOVERY NAVIGATOR PROGRAM PHASE 2 :

Helping Stroke Survivors and Family Caregivers from Hospital to Long Term Recovery

Developed by:

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ABOUT SRABC

It is inevitable that the majority of British Columbians will have a personal connection to stroke recovery due to the 'two degrees of separation' - if you don't know a stroke survivor yourself, you do know someone who loves one.

SRABC's Vision

- Every stroke survivor in BC has respect, inclusion, and support in their home community.

SRABC's Mission Statement

- SRABC is committed to assisting stroke survivors and their caregivers throughout the province to improve their overall quality of life.

SRABC's Purposes

The purposes of the Association are:

a) To assist stroke survivors and their caregivers throughout the province to improve their overall quality of life and remain living independently;

b) To increase awareness within the community of the impact of stroke;

c) To raise awareness in the community of the services offered throughout the Province to stroke survivors and their caregivers.

d) To act as a resource for hospitals and for people concerned with the effect of cerebro-vascular accidents on individuals and their families;

e) To plan and promote programs of education and of assistance to stroke survivors in British Columbia;

f) To disseminate information on stroke prevention

STATEMENT OF NEED

- Recent project evaluations support a greater need for the right type of support at the right time for stroke survivors and family caregivers as they transition from hospital to home and in their ongoing long term recovery.
- Each Health Authority and the communities it serves have a variety of programs and services along the continuum of care in stroke treatment and recovery.
- Communities have different contexts, needs and history and therefore require different resources.
- Stroke survivors and family caregivers need coordinated support through interdisciplinary team through the continuum of stroke care and recovery.
- Stroke survivors and family caregivers are unique with varying challenges and therefore a wide variety of supports, services, information and resources are required for successful community integration.

Following the recommendations made by the Professional Advisory Committee (PAC), SRABC drafted a Sustainability Planning Framework (see Figure 1). The purpose is to provide a structure for creating a model of service delivery in order to reach a wider range of stroke survivors and caregivers.

SRABC Professional Advisory Committee Members

- Dr. John Millar - specialist in population and public health (community medicine). Clinical Professor Emeritus at the School for Population and Public Health at UBC and Vice President of the Public Health Association of BC.
- Deborah Rusch – Manager, Patient Programs, Research & Health Promotion - BC & Yukon, Heart and Stroke Foundation of Canada
- Dr. Jennifer Yao – Medical Manager, Acquired Brain Injury Program and the Adolescent Young Adult Program at GF Strong Rehab Centre / Clinical Assistant Professor Division of Physical Medicine & Rehabilitation, Residency Program Director

- Sacha Arsenault – Sacha Arsenault, Regional Lead, Health Services Integration & Stroke Strategy VCH/PHC
- Dina Collins – Speech-Language Pathologist, Acquired Brain Injury Program, GF Strong Rehabilitation Centre / Clinical Associate Professor, University of British Columbia
- Heather Branscombe - Physiotherapist and Clinic Director/Owner at Abilities Neurological Rehabilitation
- Wendy Johnstone - Project Manager, Community Stroke Recovery Navigator Program Project / SRABC Program Development Consultant
- Amit Kumar, Director, Consultant Occupational Therapist, Life Skills Therapy
- Tim Readman – Executive Director, Stroke Recovery Association of BC/ Clinical Associate Professor, University of British Columbia

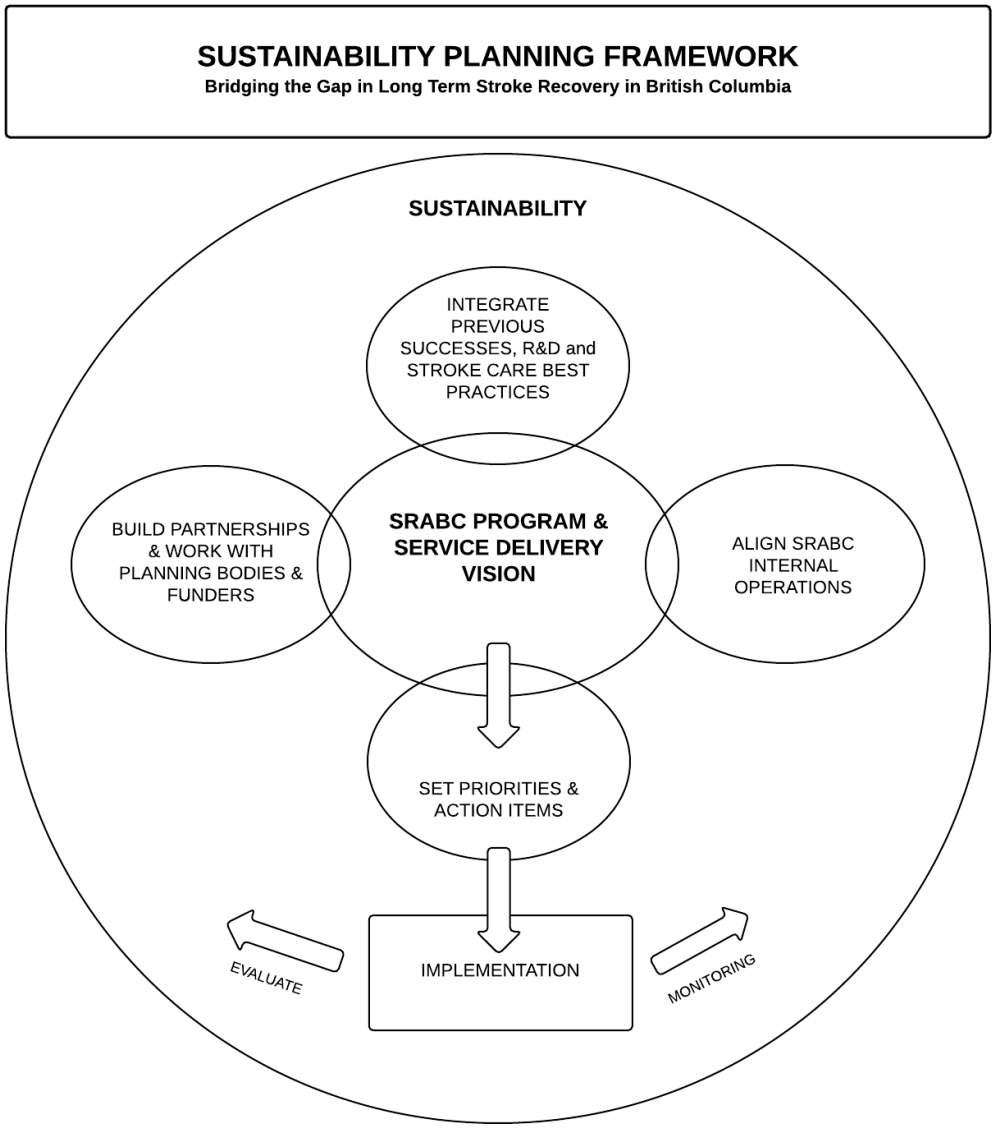
DESCRIPTION OF PROJECT

When reviewing the Planning Framework, SRABC clearly isn't able to implement the overall model of program and service delivery. However, to start meeting a wider range of stroke survivors and caregivers in BC, there is an urgent need to begin the process.

Recent research and program evaluation by SRABC and review of the Canadian Best Practices (Managing Transitions – updated in Fall 2013) identifies the following areas as the highest priority of need for stroke survivors and caregivers:

1. Support while in hospital
2. The transition from hospital to their home community, referred to as Transition Management
3. Long term community stroke recovery support referred to as Community Reintegration
4. Patient and Family Education, along the continuum of stroke care and transitions

FIGURE 1: PLANNING FRAMEWORK



Our proposed prototype project, **"Helping Stroke Survivors and Family Caregivers from Hospital to Long Term Recovery"**, seeks to operationalize a program based on Vancouver Island, targeting the Greater Nanaimo area within Island Health.

The prototype program would include the following five components:

1. Hospital Support Program including: peer visitation and support and information sessions in hospital
2. Follow up in the community within 60 days of post-hospital discharge through a Lay Navigator Program
3. Development of specific information and education modules for people affected by stroke as soon as they get home

4. Family caregiving education modules based on Stroke Recovery Canada's evidence-based programming- Family Informal Caregiver Stroke Education and Support (FICSS) Program
5. Referral into specific programs and resources including Heart and Stroke Foundation's Living with Stroke, SRABC Stroke Recovery Branches, programs and resources and other community based programs, such as those offered by community recreation centres.

TIMEFRAME

The program development piece of this prototype is being completed from February 2015 to April 2015.

The prototype will begin May 1, 2015.

STRATEGIC PARTNERSHIPS

SRABC's strategic partners with inpatient rehabilitation and the Intensive Outreach Rehabilitation Program at NGRH, the Nanaimo Brain Injury Society (NBIS), March of Dimes and the Family Division of Family Practice in Nanaimo will help champion the "Bridging the Gap" prototype project. Vancouver Island University is interested in providing support with the evaluation framework.

<u>Program Development</u>

The prototype builds on the recently completed Community Stroke Recovery Navigator Program (completed date August 2014). In partnership with NBIS, NGRH and March of Dimes, the program development piece of this prototype is being completed from February 2015 to April 2015.

PERFORMANCE MEASURES

Using the Performance Measure outlined in the 2013 Canadian Best Practice Recommendations for Stroke Care, Managing Stroke Care Transitions, section 6.5 the Prototype program will seek to identify:

- Proportion of stroke survivors who are discharged from hospital who receive a referral into the 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).
- Number of stroke survivors and/or family caregivers who are given information on formal and informal educational programs, care after stroke, available services, process to access available services, and services covered by health insurance
- Number of stroke survivors and family caregivers attending hospital information sessions
- Number of stroke survivors participating in peer support visits and lay navigator program
- 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

We anticipate the prototype program will have additional outcomes including:

- Increased coordination of care and services between the acute/rehab and community sectors.
- Clarity of roles and expectations in the provision of long term stroke recovery.
- Improved liaison and communication among all key stakeholders from planning bodies, funders, hospitals and other community-based organizations across the full continuum of stroke care.
- Enhanced positive relationships and collaboration among all key stakeholders.
- Improved patient satisfaction.
- Activities, projects and protocols that are sustainable and can be standardized in the long term.
- Better understanding of the epidemiology of stroke and the potential costs savings of health care.

DELIVERABLES

Key deliverables for the "Bridging the Gap" program include:

- 4 new education modules for stroke survivors and family caregivers specific to transitioning back into the community post-stroke:
    - Focus of modules are addressing the long term needs to stroke survivors and family caregivers
    - Topics include:
        - Play Your Way to Recovery: Getting back to living life the way you want
        - I Think I Can: Building confidence in everyday activities post-stroke
        - A Marathon of Recovery: Managing fatigue post-stroke
        - My Brain Doesn't Work That Way Anymore: Re-thinking and re-wiring your brain post-stroke
    - Facilitator notes, Powerpoint presentation and accompanying participant workbooks
    - Implementation of 5 training sessions for each education module to train existing Stroke Recovery Branch Coordinators and volunteers to deliver in their community
- 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
- Development of a Lay Volunteer Navigator Program
    - 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)
    - Train 3-4 lay navigators in peer coaching and in existing community navigator intake/assessment and BAP model (Brief Action Planning) model
    - Development of a Lay Navigator volunteer training manual
    - Identify 3 Stroke Recovery Branches to partner and collaborate with to offer lay navigation within the community
- Development of a Peer Volunteer Hospital Support Program

    - Development and implementation of a peer volunteer hospital support program to provide 1:1 peer volunteer support for stroke survivors in hospital
    - Train 5-6 peer volunteers to provide support and hope to stroke survivors in hospital
    - Development of a volunteer training handbook for the Peer Volunteer Hospital Support Program
    - Identify 3 Stroke Recovery Branches to partner and collaborate with to offer hospital support program
- Community Stroke Recovery Packages
    - Development of package of information and tools for stroke survivors and family caregivers transitioning from hospital to home
    - Information and tools including:
        - Guides to Recovering from a Stroke
        - List of regional and local helpful community resources and how to access them
        - Referral form to “Bridging the Gap” program
        - DVD – 7 Steps to Stroke Recovery
        - Development and inclusion of 3 new Guides to Stroke Recovery specific to transitional management and family caregiving for stroke
- Community Engagement and Health Sector Collaboration
    - Enhance and accelerate the inclusion of transitional management and community reintegration from hospital to the community
    - Participate in quality improvement efforts
    - Enhance/build relationships in existing initiatives such as
        - Stroke Collaborative
        - Chronic Disease Self-Management
        - Patients as Partners and Patient Centered Care committees
        - Community resources to support Home and Community Care (e.g. Better at Home, Home is Best)
        - Champions in Stroke Care within health authority
        - Divisions of Family Practice
    - Increase pool of stroke survivors and family caregivers to participate in committees, forums, presentations and consultations
- Make recommendations on a sustainabie service delivery model
- Make recommendations on volunteer management needs to support the service delivery model
- Knowledge transfer: Share our findings on community reintegration ad transitional management to add to the body of knowledge. Make key recommendations on how to penetrate primary care, increasing awareness within hospital management systems of community based stroke recovery and identify possible avenues to include service