Community Consultation Findings

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Objectives

- **Review** the current status of the community consultation
- Discuss the **results** of the community consultation and validate findings
- Review and prioritize identified **themes**
- Collect feedback on **recommendations for action**





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Community Consultation

STROKE STRATEGY *of* Southeastern Ontario

Building Capacity to Enhance Community Reintegration of People with Stroke

Final Report

December 14, 2007

Submitted to the Regional Stroke Steering Committee of Southeastern Ontario

STROKE NETWORK *of* Southeastern Ontario

WHAT WE HEARD:

CHARTING A COURSE FOR SUCCESSFUL COMMUNITY REINTEGRATION AFTER STROKE

2015 CONSULTATION REPORT

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Goals of Consultation

- Build on work completed in previous consultations (2007 and 2015)
- Identify **priority areas of change** to improve community reintegration following stroke
- Continued **collaboration** with stroke survivors and their caregivers (Community Reintegration Leadership Team)

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Steps for Consultation

1. Stroke Support Groups
2. Survey/1:1 Interviews
3. Fill the Gaps
4. Webinar for Healthcare Providers

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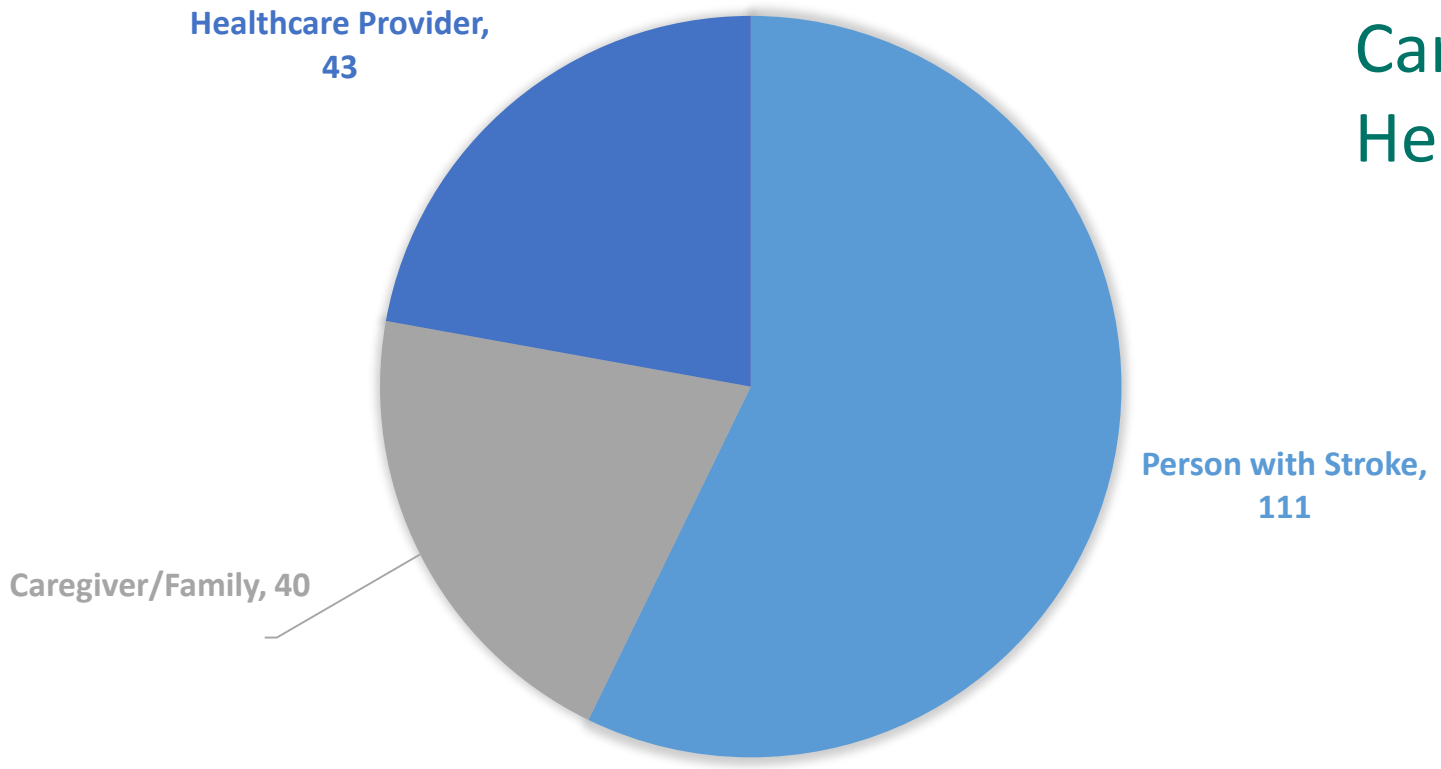
Demographics – Who Responded?



Person with Stroke = 111
Caregiver/Family = 40
Healthcare Provider = 43

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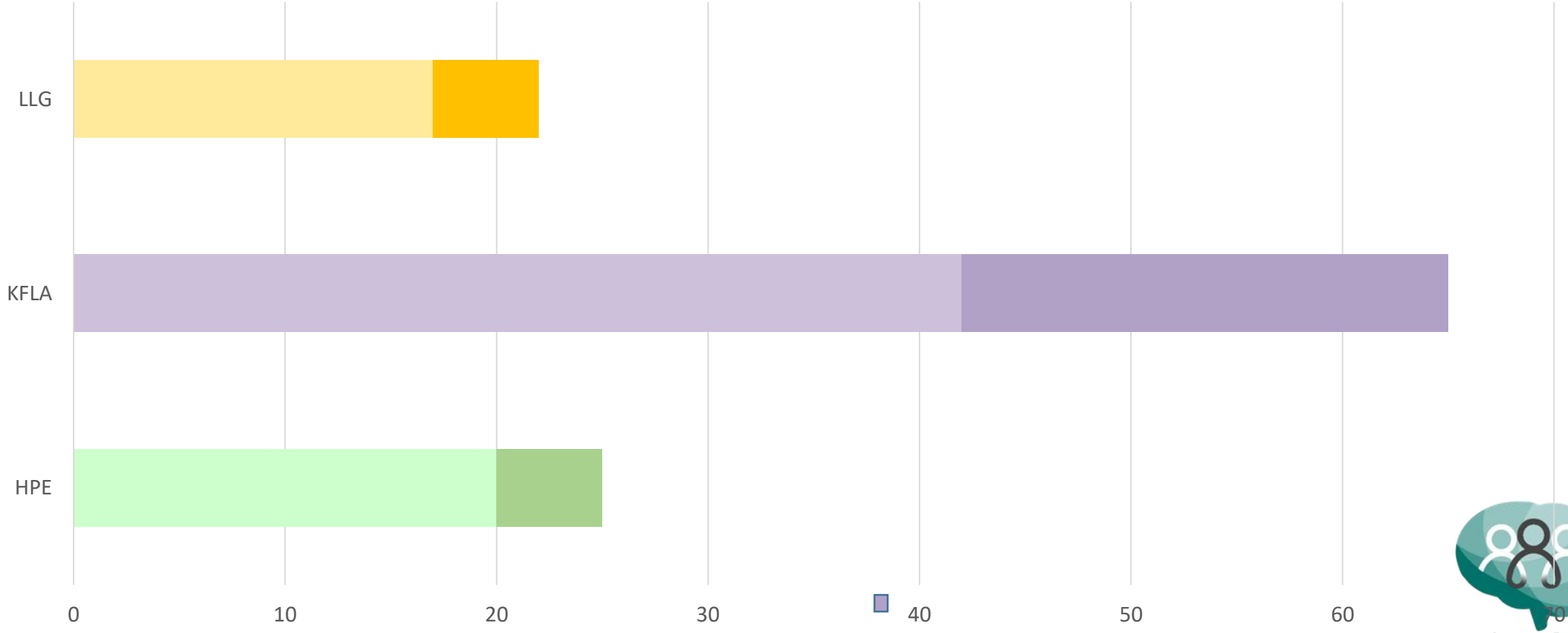
Demographics – Regional Data



Light = Support Group **Dark = Survey**

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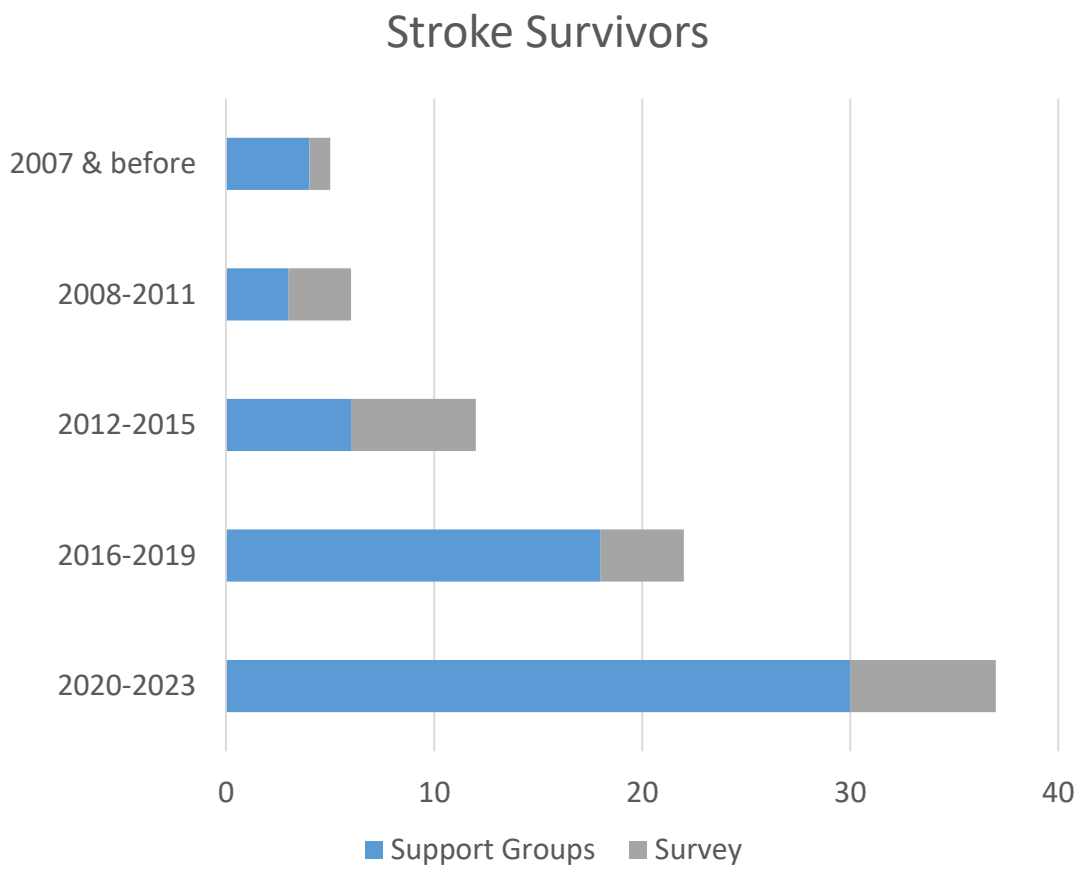
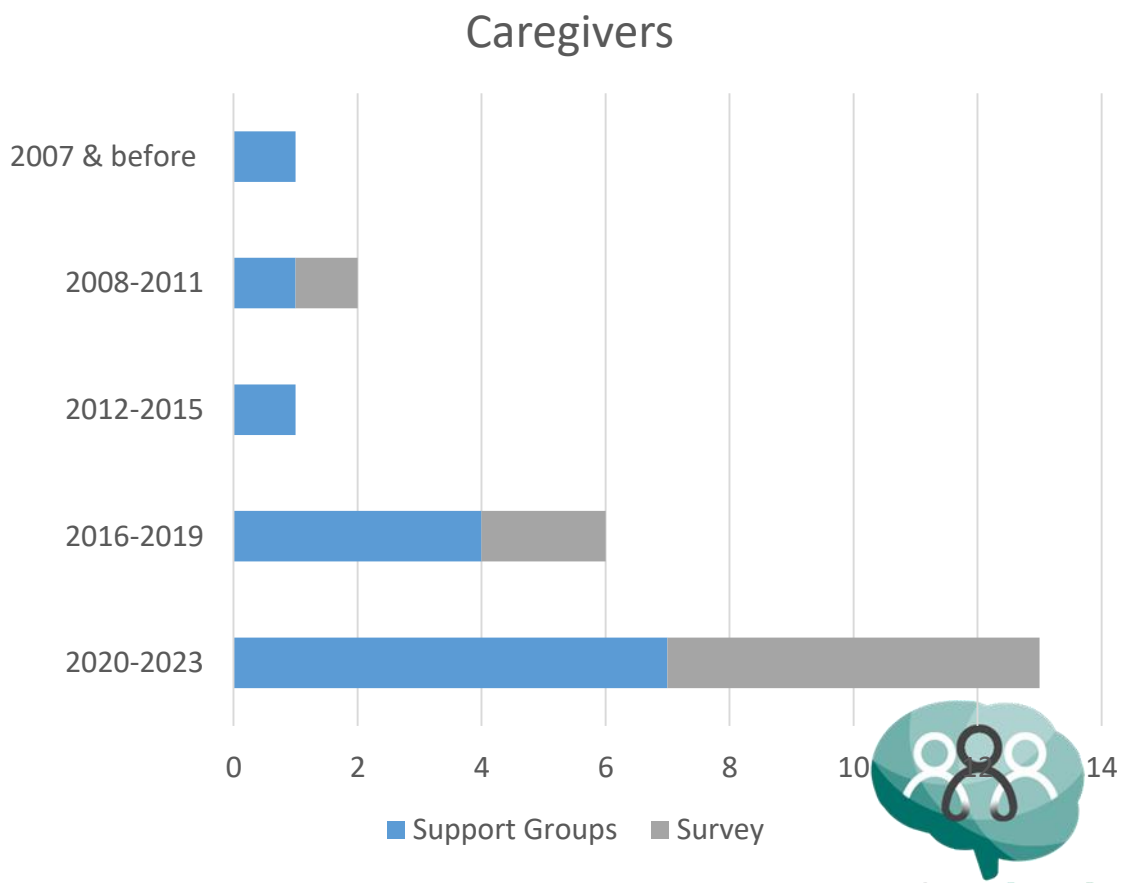
Demographics – Time Since Stroke





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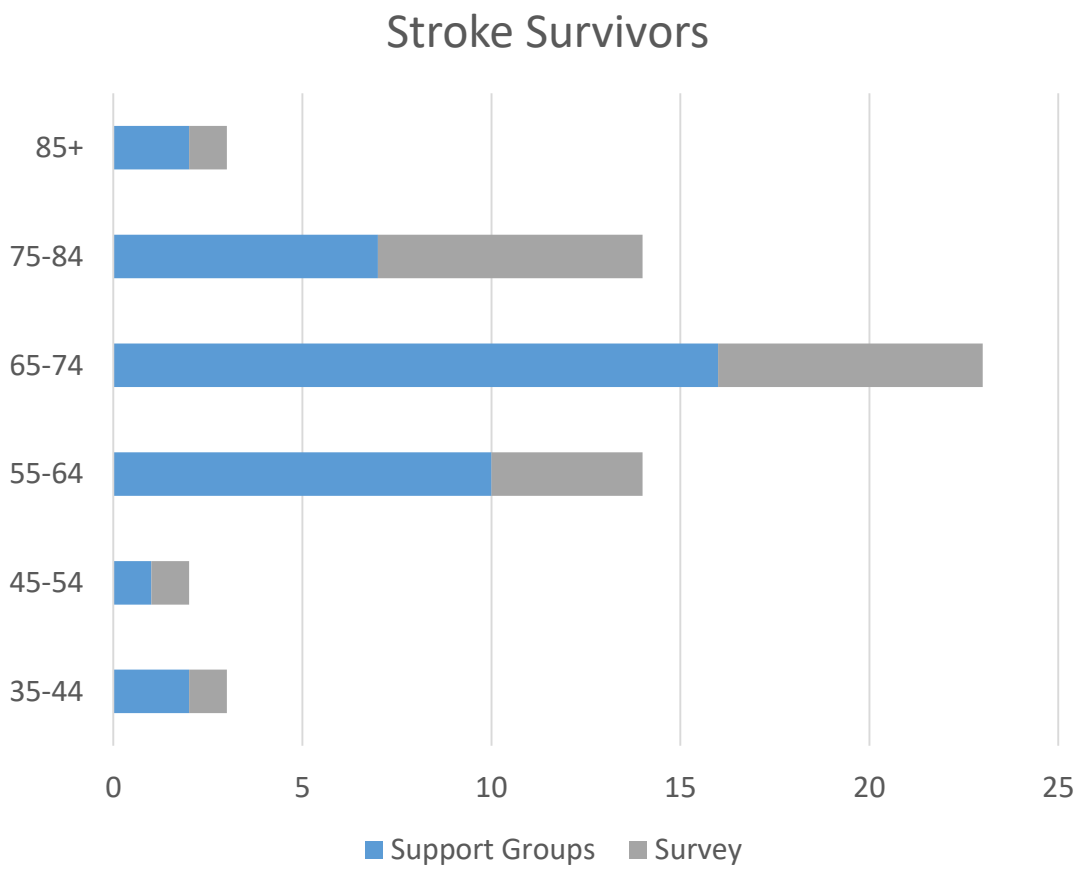
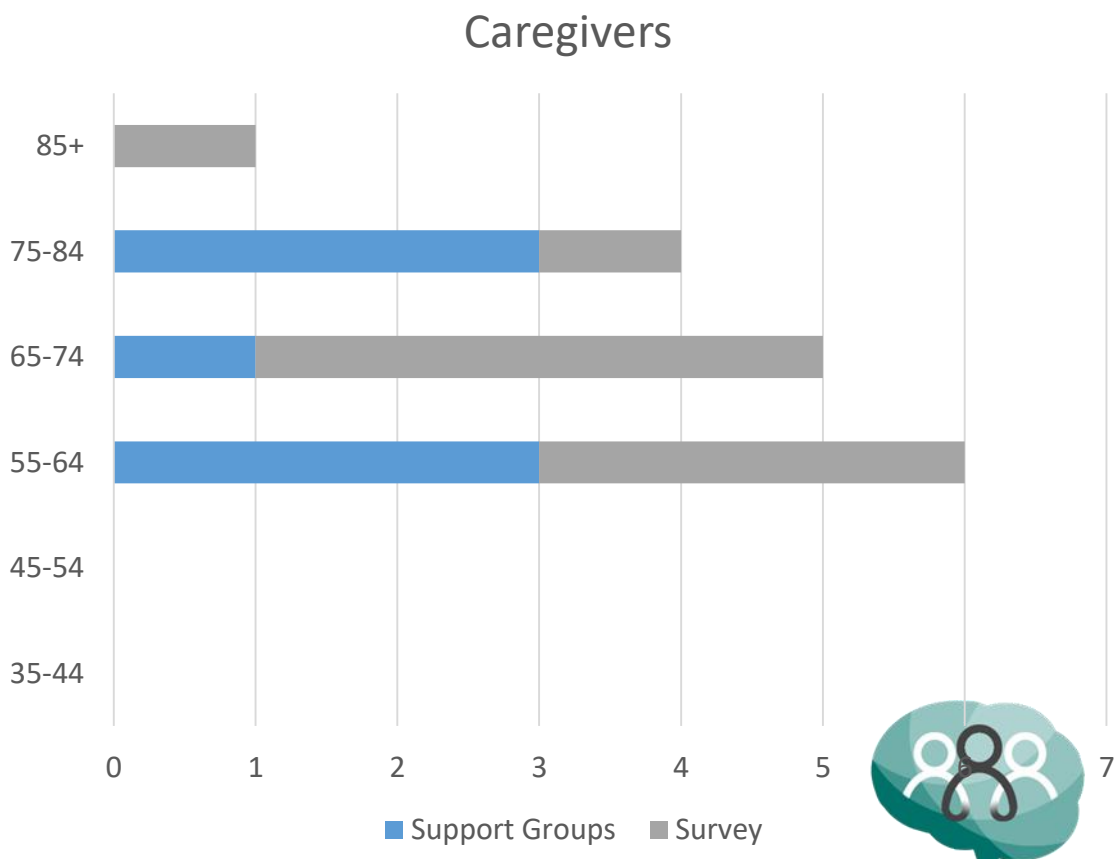
Demographics – Age





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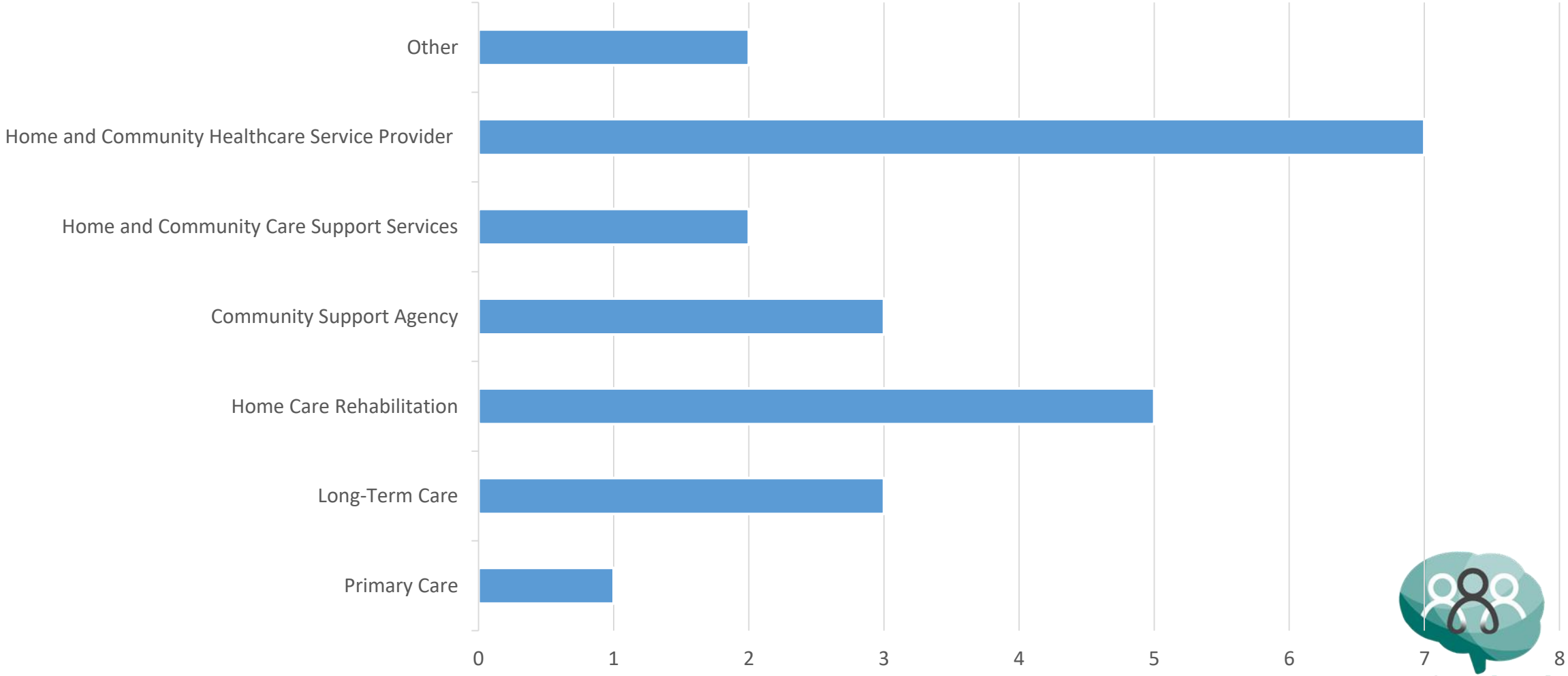
Healthcare Provider Data



Represents those that completed all survey responses

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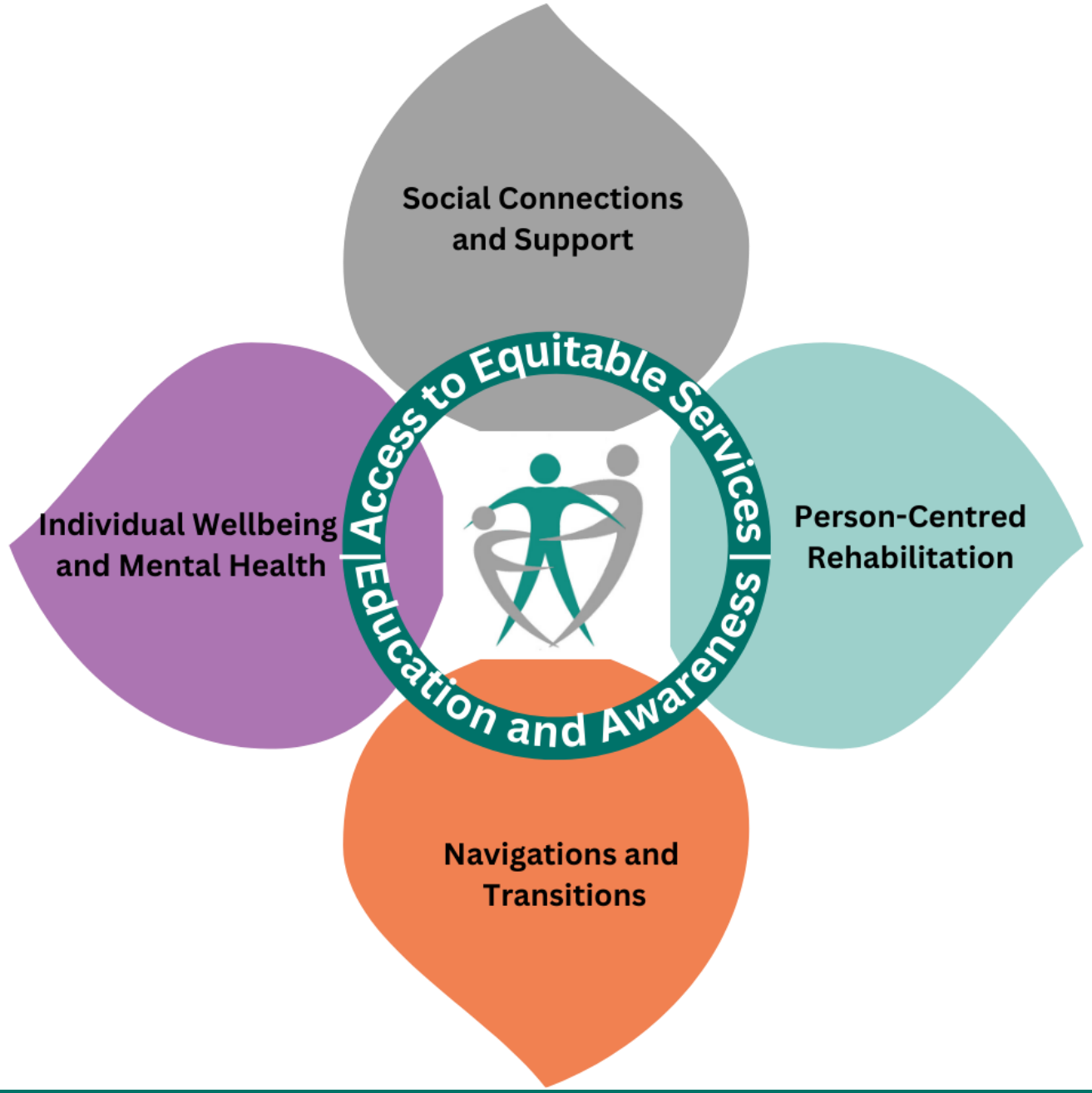

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Core Principles

1. **Stroke-Specific Education**
   - Stroke Survivors/Caregivers
   - Healthcare Providers
   - General Public
2. **Access to Equitable Care**
   - Equitable service based on need
   - Transportation/parking/return to driving
   - Follow-up
   - Affordability

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Recommendations for Action

1. **Education for healthcare providers** to improve stroke-specific knowledge.
2. Incorporate stroke education and awareness into the **school** curriculum.
3. Improve resources for returning to **driving**.

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Support Groups and Social Connections

GOING WELL	IMPROVEMENTS	HOW
• **Stroke support groups** • Mentoring educating others • **Family and friends**/social events • Community	• Lack of support • Lack of support for young caregivers and young stroke survivors	• More groups • Promote awareness • More caregiver groups • Group for young caregivers

"You find out who your friends are and who walks away"

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Recommendations for Action

1. Secure funding to maintain and develop **stroke support services.**
2. Promote **awareness** of stroke support groups.
3. Improve supports for those caring for persons with stroke (e.g. **young caregivers**).

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Person-Centred Rehabilitation

GOING WELL	IMPROVEMENTS	HOW

• Rehabilitation across the continuum of care
• **Aphasia Supportive Conversation Groups**/speech therapy
	• More rehabilitation
	• ***Individualized***
	  • Lack of therapists
	  • Not reaching intensity
	• Outpatient therapy
		• **Improve access**
		• Aphasia Support Conversation Groups
		• **Person-centred care**

"Your book is 2D and I'm 3D"

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Recommendations for Action

1. Initiate a method to provide **communication**/feedback to the client.
2. Increase the frequency of **Aphasia Supportive Conversation Groups.**
3. Improve **equitable access** to rehabilitation in the community setting.

Individual Wellbeing and Mental Health

GOING WELL	IMPROVEMENTS	HOW

• Routine/ meaningful activity
• Resiliency
• Volunteering
• Exercise/ nutrition
	• **Mental health supports**
	  ○ Stroke-specific knowledge
	  ○ Coping/grief/dealing with loss
	• **Invisible impacts** of stroke
	• Younger stroke survivors/caregivers
		• Improved support for **mental health**
		• More exercise
		• Interests
		• Younger stroke survivor/caregiver support

"Life is upside down right now"

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Recommendations for Action

1. Improved support for **mental health** in persons with stroke and their caregivers .
2. Increase the frequency of stroke-specific **exercise** classes.
3. Provide support for leisurely activities/**interests** in the community (e.g. music, camera club).

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Navigation and Transitions

GOING WELL	IMPROVEMENTS	HOW
• **Awareness** of community services • Team approach • Stroke Support Group Facilitator presence in hospital • **Communication/ referral** • Family conferences	• Hospital to community **transition** • Unaware of services • Reach individuals not accessing services (support groups) "The minute you walk out that door you fall off a cliff"	• **Communication,** information and linkages • Tool • Case Manager/ system navigator/ phone call

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Recommendations for Action

1. Improve the **communication and referral** process from hospital to community.
2. Provide a tool/support for persons with stroke to **navigate** the system once discharged from hospital.
3. Focus on stroke **prevention**, living well with stroke and adequate **follow-up.**

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THANK YOU!

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