Collaborative Navigation:

Sharing from the Field

Natalie Aitken MSW/RSW
Brockville General Hospital

COLLABORATIVE NAVIGATION

Role: Social Worker Medical Floors

Location: Brockville General Hospital

Timing of Interventions: Acute Stroke Unit & Rehab Stroke Unit, Begins upon admission and stay involve until discharge from hospital.

KEY NAVIGATION NEEDS

Navigation Need:

- Patients and families are often interacting with the hospital services for the first time and do not know who does what.

Intervention:

- SW acts as the primary contact for questions/concerns *outside of medical updates
- BGH with the help of Patient Advisors developed a patient guide to help patients and their support person have a greater understanding of what happens in the acute and rehab phase follow a stroke

Welcome to the Integrated

STROKE UNIT

This package includes both
acute and rehab care information to
help you recover following a stroke.

If you or your family/caregiver have any questions please go to your nursing station and don't be afraid to ask your question.

Endorsed by Patient & Family Advisory Council

Brockville General Hospital

KEY NAVIGATION NEEDS

Navigation Need:

- Stroke patients and their primary support person (often spouse) have concerns regarding finances
  - ***sometimes it is unknown if/when a patient will be able to return to work*

Intervention:

SW activities as part of acute and rehab stay regarding this navigation need

- Explore the worry regarding finances, ensure letter for employer, help with paper work
- If returning to work does not appear likely helping explore disability, unemployment, ODSP/OW, CPP-D
- Ensuring that the primary support person is referred to financial counselling *remove stigma*
- Helping fill out forms if primary support person is overwhelmed and is open to this level of support

KEY NAVIGATION NEEDS

Navigation Need:

- Stroke Survivors and their primary support persons want to talk early and often about discharge

Intervention:

- SW facilitates a family meeting early on in the stroke rehab stay. Sometimes these meetings are small (including only pt. and spouse) and other times the entire inpatient rehab team comes to review function and home care rep is present.
- Having the conversation and speaking realistically about the anticipated level of support required and the level of support/services offered in the community allows pt.'s and support persons to make informed decisions about their discharged plan.
- Continue to take time to check in as one question can bring about additional questions – explain who the care team is and individuals roles this helps to equip the pt. and support persons with the information they need to make them feel prepared for discharge. Use a discharge check list to guide conversations.

ADDITIONAL PATIENT INFORMATION continued

PATIENT SAFETY CHECK LIST

Ensure you and your caregiver(s) have reviewed all necessary information during your stay.

Things I need to know or do to ensure a safe transition home	✓	✓
I have reviewed the following information:	Patient	Healthcare Provider
I know when I am going home (or to by discharge location)		
I or my family have made arrangements for transportation.		
I know how to make my home ready for my return home.		
I have a list of my medications, with dosages.		
I know when and how to take my medication.		
I know what type of help I need to take my medications correctly.		
I know what to eat and what not to eat.		
I know how to make the food consistencies that have been recommended (ex. Thickened liquids, minced, etc.)		
I know what activity level is right for me.		
I know what type of help I need with walking around the house, on stairs and outside.		
I have the right aid for mobility (ex. Walker, cane, etc.)		
I know what type of help I need in the kitchen to make meals safely.		
I know what type of help I need with bathing and going to the toilet, and who can help me.		
I have the right equipment for bathing and toileting.		
I know what care services I will get, when they will start, and their contact numbers.		
I know what appointments with specialists have been booked for me and I have their contact numbers.		
I know what outpatient services I need to attend.		
I know when to follow-up with my family doctor.		
I know symptoms I should watch for and when I should dial 911 vs calling a physician right away.		
I know what my driving restrictions are and how I am going to manage getting to where I need to go.		

KEY LEARNINGS/NAVIGATION TIPS

1. When there is a high level of post stroke cognitive impairment the support person is often overwhelmed during interactions with the team. Offer to take notes for them if you suspect this.
2. Ensure you set the stage for questions to be asked – “Is there anything I didn’t ask that you think is important for us to explore?”

Collaborative Navigation:
Sharing from the Field

Megan Maziarski, RN, BScN

COLLABORATIVE NAVIGATION

Role: Rapid Response Nurse

Location: Home & Community Care Support Services- South East

Timing of Interventions: within 48 hours of referral, 1-2 visits as needed.

KEY NAVIGATION NEEDS

Navigation Need:

- Review the discharge plan and Patient's ability to complete the plan, including resources (health teaching) required.

Intervention:

- Collaborating with the Family and Patient, ensure that all appointments are secured and that communication is completed to PCP, pharmacist, Care Coordinator as needed (i.e. clinical status update and medication reconciliation/recommendations reported)

KEY NAVIGATION NEEDS

Navigation Need:

- Support the Patient/Family with new diagnosis or change in health status (i.e. s/s stroke, weakness, changes in vision, importance of heart/stroke med compliance, attending f/u)

Intervention:

- Assess understanding of the health condition, supporting with health teaching, including disease management, life-style changes, medications, and/or additional community supports that are available to them (i.e. complex strokes may need transportation support/virtual follow up appointments, medication swallowing concerns, additional home care/respite for family etc)

KEY NAVIGATION NEEDS

Navigation Need:

- Safe medication management at home.

Intervention:

- Completion of Best Possible Medication History and Medication Reconciliation.

KEY LEARNINGS/NAVIGATION TIPS

1. **Tip 1**: Understanding and compliance of heart/stroke medication regime post RRN interventions.
2. **Tip 2**: Reduced re-bound admission success d/t support from RRN with system navigation, home and community care stroke needs, completing follow up appointments with their PCP and out-patient stroke prevention clinic.

Collaborative Navigation:
Sharing from the Field

Crystal Newman, BScN, RN. MN
Vascular Protection Clinic

Perth and Smiths Falls District Hospital

Patients and Families THE Heart OF Care

COLLABORATIVE NAVIGATION

Role:

- Vascular Protection Clinic Nurse: Registered clinic

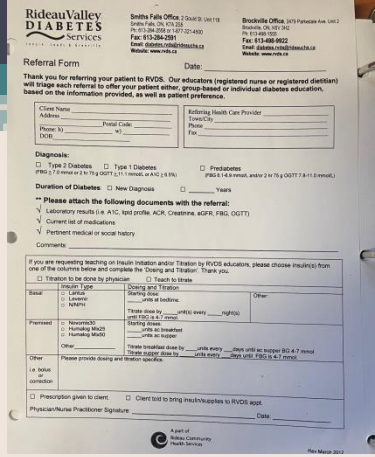
- **Location:** Perth & Smiths Falls District Memorial Hospital – Perth Site

- **Timing of Interventions:** VPC Clinic is held weekly on Wednesday afternoons

Perth and Smiths Falls District Hospital

Patients and Families THE Heart OF Care

KEY NAVIGATION NEEDS Examples


Rideau Valley DIABETES Services

Referral Form

Date:

Thank you for referring your patient to RVDS. Our educators (registered nurse or registered dietitian) will triage each referral to offer your patient either, group-based or individual diabetes education, based on the information provided, as well as patient preference.

Client Name
Address
Postal Code
Phone: h)
w)
DOB:

Referring Health Care Provider
Town/City
Phone
Fax

Diagnosis:
☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Prediabetes

Duration of Diabetes: ☐ New Diagnosis ☐ _____ Years

** Please attach the following documents with the referral:
√ Laboratory results (i.e. A1C, lipid profile, ACR, Creatinine, eGFR, FBG, OGTT)
√ Current list of medications
√ Pertinent medical or social history

Comments:

If you are requesting teaching on Insulin Initiation and/or Titration by RVDS educators, please choose insulin(s) from one of the columns below and complete the 'Dosing and Titration'. Thank you.

☐ Titration to be done by physician ☐ Teach to titrate

	Insulin Type	Dosing and Titration
Basal	☐ Lantus ☐ Levemir ☐ NPH	Starting dose: _____units at bedtime. Titrate dose by _____ unit(s) every _____ night(s) until FBG is 4-7 mmol.
Premixed	☐ Novomix30 ☐ Humalog Mix25 ☐ Humalog Mix50 Other _____	Starting dose: _____units at breakfast _____units at supper Titrate breakfast dose by _____units every _____days until at supper BG 4-7 mmol Titrate supper dose by _____units every _____days until FBG is 4-7 mmol
Other i.e. bolus or correction	Please provide dosing and titration specifics:	

☐ Prescription given to client. ☐ Client told to bring insulin/supplies to RVDS appt.

Physician/Nurse Practitioner Signature: _____ Date: _____

A part of Rideau Community Health Services

Rev March 2013

Navigation Need:

Vascular Protection Clinic patients who are interested in or in need of further diabetic education or guidance to help manage their diabetes.

- Patients coming to the Vascular Protection can have a previous diabetes diagnosis, borderline or a new diagnosis.

Intervention:

Referral to a community service – Rideau Valley Diabetes Services

- Consultation and individual approach to managing diabetes.
- Rideau Valley Diabetes Services provide detailed information about managing DM and help the patient with their specific needs.

Perth and Smiths Falls District Hospital

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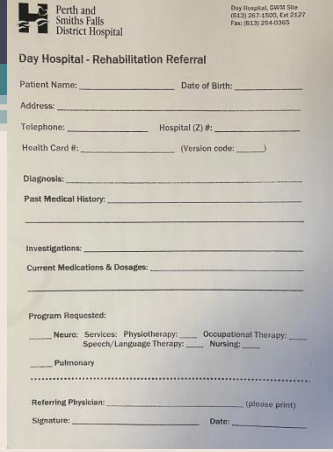
KEY NAVIGATION NEEDS Examples


Perth and Smiths Falls District Hospital

Day Hospital - Rehabilitation Referral

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Hospital (Z) #: _____

Health Card #: _____ (Version code: _____)

Diagnosis: _____

Past Medical History: _____

Investigations: _____

Current Medications & Dosages: _____

Program Requested:

____ Neuro: Services: Physiotherapy: ____ Occupational Therapy: ____ Speech/Language Therapy: ____ Nursing: ____

____ Pulmonary

Referring Physician: _____ (please print)

Signature: _____ Date: _____

Navigation Need:

Vascular Protection Clinic patients sometimes require further rehabilitation, physiotherapy, occupational therapy, speech language pathology.

- Limited availability of in-home services
- Patient requires assistance managing vertigo symptoms

Intervention:

Day Hospital – Rehabilitation referral – within the Perth Hospital

- Provide more OT/PT to help improve mobility
- Opportunity to access additional services

Perth and Smiths Falls District Hospital

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KEY LEARNINGS/NAVIGATION TIPS

- **Individual needs and goals**
  - Each patient have different and unique needs; assessments and referrals need to be tailored to each patient.

Perth and Smiths Falls District Hospital

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Thank you!

Crystal Newman, BScN, RN, MN
Vascular Protection Clinic
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Perth and Smiths Falls District Hospital

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Collaborative Navigation:
Sharing from the Field

Shannon Mulholland, PT
Kaymar Rehabilitation
(Service Provider for Home & Community Care Support Services South East)

COLLABORATIVE NAVIGATION

Role: Community Physiotherapist

Location: In Patient's Home or other community location

Timing of Interventions: Post-Hospital (5 days post stroke to 6 months or longer); Chronic stroke returning for updated programming

KEY NAVIGATION NEEDS

Navigation Need:

- Ensuring access to ongoing exercise programming

Intervention: Link with Appropriate Exercise Follow Up

- Refer to a stroke specific or other appropriate exercise program (virtual or in-person)
- Example: Refer to Revved Up (complete referral form with patient, fax medical clearance form to primary care to send to Revved up, confirm application)
- NEW with COVID:
  - indicate need to wait for in person or participate in “Revved Up at Home” (virtual exercise)
  - Revved up assessor complete virtual intake evaluation with PT in the home

KEY NAVIGATION NEEDS

Navigation Need:

- Ensuring access to ongoing exercise programming

Intervention: Co-ordinating in home exercise follow-up

- Facilitate training PSW to support in-home exercise program (as applicable – e.g. respite PSW)
- Attendant Care Outreach (for eligible clients)
- Family member to supervise/support

KEY LEARNINGS/NAVIGATION TIPS

Tip 1.
Help complete referral forms with patient

Tip 2.
Start before discharge so there is a visit or two to provide follow up and ensure success

Tip 3.
On Discharge Summary – suggest re-referral for upgrade/review of exercise plan 6-12 months later

Tip 4.
Unsure about Readiness to Transition to Exercise Programming (maximized functional mobility?, in home or outside programs? aerobic ability?, safety?) Consider Shared Work Day opportunity to review with an experienced colleague.

Collaborative Navigation:
Sharing from the Field

Emilia Leslie, MSW, RSW

VON
Live Every Day.

COLLABORATIVE NAVIGATION

Role:

- Stroke Support Services Coordinator: Facilitator and Co-Facilitator of various Stroke Support Groups (e.g. SS, AWA, CG, SLP)

- **Location:** Greater Kingston Victorian Order of Nurses (GK VON)

- **Timing of Interventions:** Community based – Short and Long Term

KEY NAVIGATION NEEDS Examples

Navigation Need:

Stroke Survivor (SS) who is interested in transportation to medical appointments.

- Transportation is a common and much needed support for SS's as various effects from stroke can impact a SS's ability to drive as well as prolong license reinstatement.
- Transportation is frequently supported by Caregivers, which can impact the schedules of both caregiver and survivor, and create different challenges.
- Transportation services can alleviate caregiving burden and improve SS independence.

Intervention:

Referral to community service - VON Transportation.

- Discuss the specifics of the need to find an individualized approach.
- Provided information and make suggestions based on specific needs.
- Facilitate referral to chosen service and follow up with SS.

KEY NAVIGATION NEEDS Examples

Navigation Need:

Stroke Survivor (SS) with Aphasia wanting to continue to improve speech

- Increased social interactions provide opportunities to practice speech and communication strategies.
- Impact of pandemic has decreased social opportunities.
- Limited availability of Aphasia services is a noted gap in required recovery supports.

Intervention:

Community Stroke Support Services supports individualized care

- Discuss individual's goals and objectives.
- Explore options and provide creative solutions, adapting when necessary.
- Offer of virtual Volunteer Peer Support Services and 1:1 meetings with Coordinator

KEY LEARNINGS/NAVIGATION TIPS

Tip 1.

- **Working from where they are at** (e.g. We may see needs, but they may not be the same as the client's needs/goals)

Tip 2.

- **Explore Together** (e.g. What has been used?, What hasn't worked?, What is in place?) & **Check-ins** with Client (e.g. How is it going?, Is this working?)

Thank you

GK VON Stroke Support Services Coordinator – Emilia Leslie

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