STROKE NETWORK of Southeastern Ontario

Successful Community Reintegration – Community Reintegration Leadership Team Stroke Network of SEO Workplan – Community Reintegration Priorities

RESOURCES

- Persons with stroke & caregivers
- Stroke Network Community Reintegration Leadership Team (CRLT)
- Local Stroke Support Groups
- Heart & Stroke Foundation
- Canadian Best Practice Recommendations; RNAO Transitions Best Practice Guideline; Community Stroke Quality Based Procedures (QBP)
- Health Partners: acute/rehab hospitals and Stroke Prevention Clinics, SECCAC & provider agencies, Community Support Services (CSS), Long Term Care Homes (LTC), primary health care, retirement homes, ABI Network, Pathways to Independence
- Regional Stroke Steering Committee & Subcommittees
- Regional Stroke Team
- Ontario Stroke Network (OSN)
- Ontario Telemedicine Network (OTN)
- LHIN & MOHLTC
- Post-secondary institutions
- Funding – Regional Stroke Team (education, KT tools)
- Funding – within partner budgets
- Space and equipment – partner facilities
- Transportation
- Media
- Municipal, county & local resources
- Adaptive exercise programs (e.g., Revved Up, YMCA)

ACTIVITIES

Support for Recovery & Active Engagement
- Promote Linkages to CSS & local recreation facility programs
- Sustain Living with Stroke programs & pilot OTN outreach
- Link stroke survivors and families to volunteer opportunities
- Promote healthy living through facilitated self-management
- Promote use of Guidelines for Community Based Exercise

System Navigation
- Sustain system navigation role of Support Group Facilitators
- Co-design navigation model with stroke survivors/caregivers
- Promote access to local resource guides, programs & services
- Expand Peer Visiting to all hospitals across SEO

Support to Work Through the Emotions
- Sustain and build reach of Community Support Groups
- Promote depression screening in community settings
- Promote ABI Psychiatry Link
- Discharge Link/Enhanced CCAC Rehab – promote SW
- Expand Peer Visiting across SEO - build a mentorship model
- Assess capacity to develop LTC support group programs

Support at Home
- Promote SMILE and Respite Programs, CCAC services
- Promote CSS and other services for non-medical supports
- Develop stroke-specific skills in the provision of stroke care

Mobility in the Community
- Advocate for equitable transportation access
- Support stroke survivor/caregiver input into accessibility policy
- Build health service provider awareness re: accessibility

Access to Rehabilitation
- Sustain Discharge Link/ CCAC Community Rehab
- Promote uptake of LTC Stroke Care Plans
- Establish or sustain Day Rehab Programs
- Pilot a Communication Group (with OTN outreach)
- Promote equity of access across region

OUTCOMES

Equitable access to the appropriate community programs and services at the right time for persons with stroke and caregivers.

Persons with stroke and caregivers are informed re available supports and services through discharge planning and ongoing system navigation.

Persons with stroke and caregivers are engaged in co-designing system changes required to deliver stroke best practices in community

Equitable access to sustained, facilitated support groups across SEO that effectively meet the needs of persons with stroke and

Community and in-home services encompass the holistic needs of persons with stroke and caregivers including psychosocial needs

GOAL

Living in the community supported by programs and services that optimize quality of life

OUTCOME MEASURES

% with Stroke discharged to
- outpatient rehab
- CCAC Discharge Link/Rehab
- CSS services
- Stroke and Caregiver Support Group Services
- Peer support services
- Directly from acute to LTC

Satisfaction of persons with stroke and caregivers with information and system navigation

Stroke Survivor Support group evaluation:
- Source of referrals
- Quality of Life – Stroke Impact Scale perceived recovery
- Caregiver Burden
- Stroke Services Questionnaire
- # of LWS programs offered/yr
- Documented gaps in access to stroke support groups

RAI assessment to be used to investigate Quality of Life measures such as:
- Stress reduction
- Psychosocial support
- Depression

CCAC Enhanced Rehab
- Referrals by discipline
- Visits by discipline
- Wait to 1st CCAC rehab visit
- Hospital Readmission rates
- 30 day mortality rates

ENABLERS: Communication/Information Management, Knowledge Translation, Collaboration, Evaluation, Advocacy