Person Centred Navigation

Provincial and Regional Context

April 8 2021

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Outline

- Quick Recap of Regional Transition Work
  - One- Team
  - South East Acute – Rehab – Community Pathway
  - Patient Journey Map
  - Stroke Information Package
  - Team level initiatives – improving linkages - RRN, CSS Referrals, Community Rehab Checklist
- What is Navigation?
- Guiding Principles
- Everyone's Roll – Characteristics of Navigation
- New Work – Navigation Tool Kit

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“One Team”

The system needs to function as “ONE team” from the patient’s perspective……

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Acute - Rehab - Community (ARC) Stroke Services and Transitions

Clinical teams provide care and support transitions that are in alignment with QBP/CSBPR including:
• Standardized evidence-based Care • Expert Interprofessional Team Care • Interprofessional Case Conferencing • Information to Primary Care

ACTIVITIES

Acute to Rehab

Acute Stroke Care
- Admit to ASU *(From ED-6 hrs; ICU-24 hrs)*
- Critical care support
- Dysphagia Screen *(by 24hrs)*
- Neuro and Cardiac Monitoring
- Allied Ax *(by 24 hrs)*
- Mobilize *(by 24 hrs unless contraindicated)*
- Cognition Screening
- Early rehabilitation
- AFIM *(by Day 3)*
- Patient/Family Education

Severe: Alpha FIM <40
- Acute Team consider rehab readiness and refer/transfer if rehab ready
- If not rehab ready, re-assess weekly while on acute care and consider transfer in future

Moderate: Alpha FIM 40-80
- Referral/decision to transfer to Rehab (by Day 4)
- Decision/confirmation to admit to rehab 4 Hours)
- Patient Transferred (1 day from decision)
- For stand-alone rehab – onsite assessment by exception only (AFIM 40-60)

High Intensity Inpatient Rehab
- Stroke Rehab Unit
- FIM by 72 hrs
- Rehab therapy intensity - 180 min/day (at least 6 days/week)
- Goal based approach
- Admit 7 days a week
- Patient Education

Rehab to Community

Home care referral –
- Pre D/C OT – 2 weeks before d/c
- Comm Rehab Planning Mtg – 7 days before d/c
- CSRP 24-48 hours before discharge
- Confirmation of CSRP plan from Homecare -
- First therapy visit with within 72 hours
- Information exchange

OR

Outpatient Therapy
- Referral and first appt confirmed for 72 hours post discharge

Community supports
- Referral and/or consent for future follow up

In home or Outpatient Rehab
- First therapy visit 48 hrs. post-acute 72 hrs. post-rehab
- RRN visit within 24 – 48 hours post acute (in-home only)
- 8 – 12 weeks
- 2 – 3 visits per discipline/week
- Review need for SW regularly

In home or outpatient Rehab to Community
- Transition checklist reviewed
- Referral to community support services (CSS)
- CSS contact made within 48 hours (or less)
- Stroke facilitator linked within 72 hours

Acute to Acute

- Timely Repatriation (i.e. 24 hours post tPA/EVT)
- Warm Handover
- Therapy notes/ AFIM shared

Acute to Community

Mild --- Alpha FIM 80+ (90+)
- Home care referral – CSRP and RRN 24 hours before discharge
- Confirmation of CSRP plan from Home and Community Care to referral source
- **Outpatient Therapy** - Referral and first appt confirmed within 48 hours post discharge
- Referral to community supports or consent for future follow up (ie Stroke Support group)

Home Care Coordination
- Process, arrange and confirm RRN, CORP or CSRP within 24 hrs. of complete referral received
- Overall homecare assessment for services, equipment and supplies with service plan within 24 hrs

Home/Community

SPC and medical follow up Stroke Support Groups Aphasia Supports
CSS Supports (e.g., Meals, Transportation, Home Help, In-Home Respite)

INDICATORS

- % access to ASU
- % AFIM by Day 3
- Median LOS
- % LOS ALC
- 90 day readmit
- 30-day mortality

- Admit to Rehab Referral – Day 4
- % access to inpatient rehab – 30%
- Onset to rehab admit – 6-8 days
- % rehab admits with severe stroke (*balancing measure*)

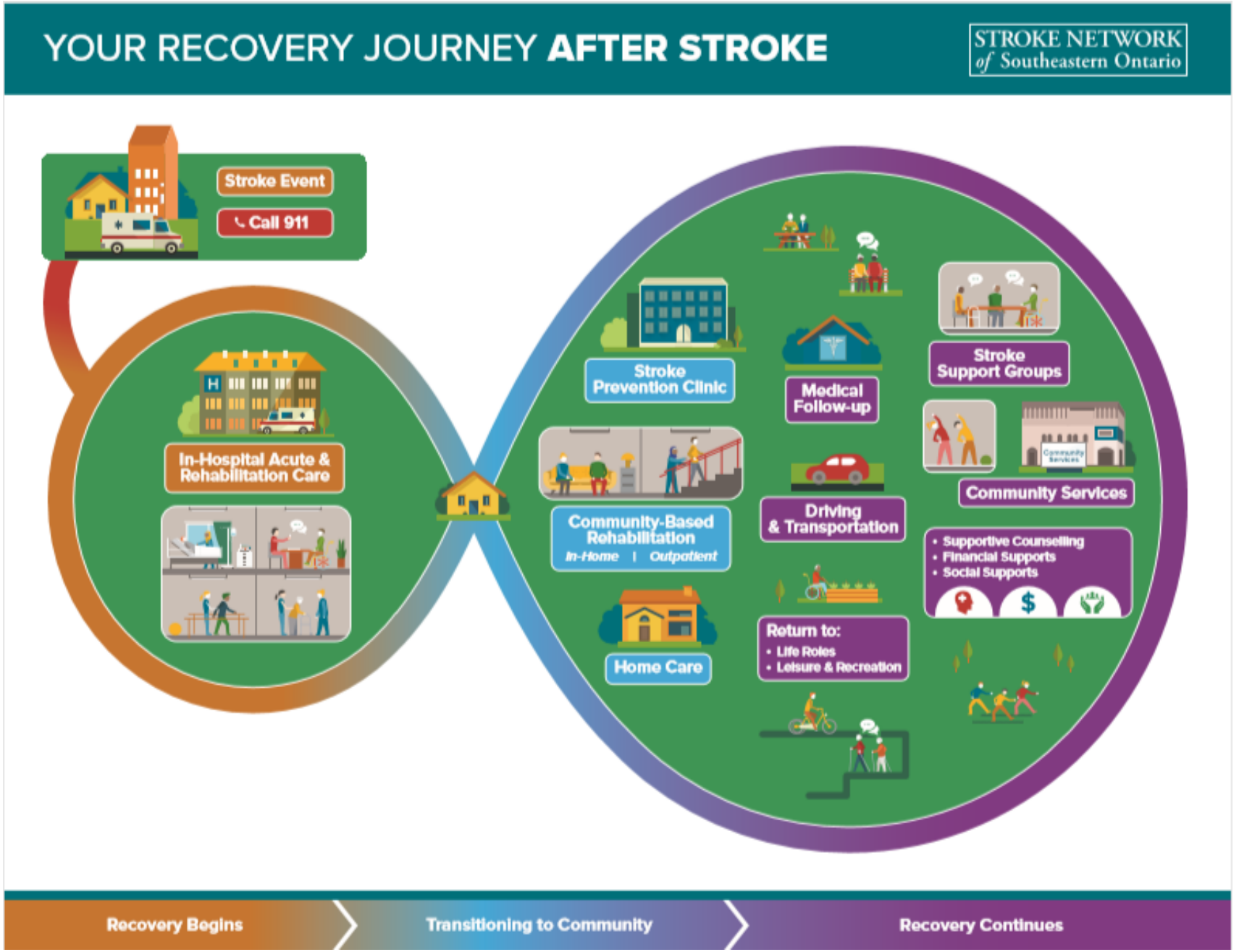
- FIM LOS efficiency
- Median RI Time (Target 180 min)
- % meeting Rehab LOS
- % Discharged Home

- % referrals to CSRP from rehab with Comm Rehab Planning Mtg

- Median Time to First Therapy visit
- # visits/discipline
- Total visits /patient
- LOS
- % RRN from acute

Referrals and # participants - stroke support groups and aphasia groups

Patient and caregiver/family feedback (PROMS and PREMS) and Provider feedback



Patient Journey Map

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Stroke Information Packages

- Spread use of Stroke Information Packages; include patient journey map
- Use of same resources across the continuum

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Team level initiatives - Improving Transitions

- **Consistent use Stroke Information Package**
  - *Reviewed with a person – not just the "paper"*
  - *Use of transition checklist to ensure it happens*
- **Booking Appointment in next part of the continuum**
  - *e.g. SPC, OP therapy before leaving hospital*
- **Ensuring appropriate referrals/linkages**
  - *Hand off /linkage to community rehab provider and/or support groups while in hospital*
  - *Use of community rehab transition checklist at completion of therapy*

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What is Navigation?

- Assumes that health care services to the person with stroke and their care partners will be provided by **an interprofessional team** using a client centred philosophy of care
- Navigation serves to **enable seamless care** by ensuring access to appropriate and timely services and to support successful return to the community.
- Navigation is the process by which **patients are guided** through the health care system and around barriers encountered

Adapted from work by the Ontario Stroke Network Provincial Integrated Work Group Patient Navigation July 2014

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Navigation Principles
For Persons with Stroke and Care Partners

1. Informed by best practice
2. Empowerment through support for autonomous decision making
3. Timely and Individualized Education
4. Timely connections to appropriate resources and supports to optimize community reintegration.
5. Integration and communication across the care continuum
6. Holistic and Culturally Sensitive Approach
7. Address transition barriers through intervention and advocacy across health and social services
8. Leverage technology and/or other existing regional resources

Adapted from work by the Ontario Stroke Network Provincial Integrated Work Group Patient Navigation July 2014

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Navigation Characteristics

- Occurs within inpatient system or community setting, at any point along the stroke recovery experience by team members with stroke system knowledge
- Provides support and guidance to patients, care partners and/or other interprofessional team members
- Improves quality of life by easing the adjustment to post-stroke life through education and improved access to community services and/or health care resources
- Ensures best practice care for persons with stroke including triage and/or supporting access to appropriate units/programs
- Relies on collaboration with system partners to optimize patient care

Adapted from work by the Ontario Stroke Network Provincial Integrated Work Group Patient Navigation July 2014

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SNSEO Navigation Toolkit

- Regional Project Underway
- Collects/Collates various resources
- Support stroke team members across the continuum
- Enhance navigation skills
- Enhance stroke system knowledge
- Provides access to information/contacts to support navigation

Opportunity for Input!

Discussion Today and Workshop Evaluation Survey

or please contact:

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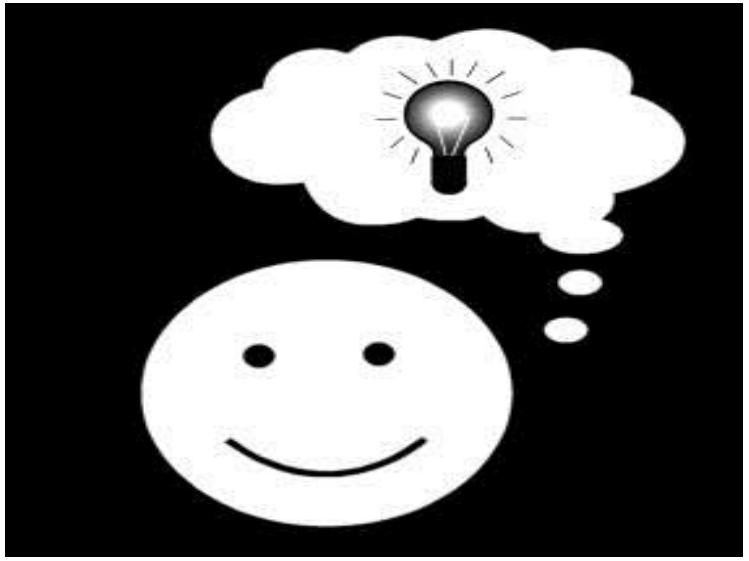

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Concluding thoughts…

- One in eight caregivers assist loved ones recovering from stroke with case management functions such as health care system navigation *(Opara and Jaracz, 2010)*
- Many caregivers find the co-ordination role the most stressful part of caregiving despite the fact it requires less time when compared to providing personal care or helping with other household management tasks *(Duxbury, Higgins and Schroeder, 2009).*
- Every stroke is different and so a one-size fits all approach doesn't work. Navigation along the journey helps stroke survivors and caregivers develop a personalized recovery plan with strategies to set goals, access community resources, and fill information gaps.

Adapted from BC report Bridging the Gap: Helping Stroke Survivors and Family Caregivers from Hospital to Long Term Recovery Community Stroke Navigator Program: Phase 2 - Final Report – February 2017

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Moving towards “One Team”

Building Stronger Links

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