# *Deliverable #5: Essential Elements of A Navigation Model to Support Persons with Stroke Transitioning to the Community*

**Systems Level**

**At a systems planning level the following elements have been identified as important to aid navigation of persons with stroke through the transition to the community:**

| |
|---|
| 1. Strong relationships/communication mechanisms between HSP across the continuum of stroke care |
| 2. Service gaps and strategies to address gaps are identified |
| 3. A model of community based care is created that is informed by patient experience to ensure the needs of persons with stroke can be appropriately met. |
| 4. Mechanisms are in place to ensure timely access to services post-discharge from hospital |
| 5. Patient education materials |
| 6. Indicators/outcomes of success are identified |

**Clinical Level**

**At the clinical or program level the following elements have been identified as important to aid navigation of persons with stroke through the transition to the community:**

| |
|---|
| 1. A stroke navigation process is integrated as part of the transition preparation for all persons with stroke and begins as early as possible after admission |
| 2. Patient and care partner empowerment is supported through engagement, self-management and education |
| 3. Partnerships with community based organizations are established including communication processes to facilitate continuity of care |
| 4. Transition planning is patient/care partner-centered incorporating cultural preferences and beliefs. |
| 5. Personal and environmental barriers to the transition are minimized. |

**Navigator Role/Process**

**The following are core elements to the navigation process that should be considered for successful transition to the community and could be fulfilled by the role of a Stroke Navigator in acute or inpatient rehabilitation. In both acute care and inpatient rehabilitation it is essential that there is facilitation of discharge/transition planning as well as patient, family and caregiver education regarding discharge/transition planning.**

| **Discharge/Transition Planning** |
|---|
| 1. Facilitate team assessment and documentation of patient, family and caregiver learning needs and goals. This should include inquiry about previous information received, information retention, and new and ongoing learning needs, and ensure patient and family are active participants |
| 2. Provide information and resources to enable self-management to help patients and families navigate the healthcare system |
| 3. Facilitate transfer of pertinent information from inpatient setting to community providers in a timely manner |
| 4. Facilitate the development of a discharge plan in collaboration with the interprofessional team, patient and family<br>a. Identify any potential discharge barriers and/or concerns<br>i. When necessary, facilitate suitable accompaniment in order to access appropriate services<br>b. Develop a post-discharge follow-up plan<br>c. Education focusing on discharge planning options and access to community resources<br>d. Provide education and support for caregivers |
| 5. Ensure that a key contact person is in place for patients and their families through transition planning and community reintegration |
| 6. Ongoing education should be individualized and coordinated across transition points, and across the continuum, and include reinforcement of information previously taught and not retained<br>a. Facilitate the use of telemedicine technology to increase access to ongoing support services |
| **Early Supported Discharge (ESD)** |
| 1. ESD programs where available, should be strongly considered in discharge/transition planning for persons with stroke transitioning to the community |
| **Long Term Recovery** |
| 1. Facilitate re-access to rehabilitation for those patients who experience a change in their functional status |
| **Long Term Care** |
| 1. Facilitate appropriate discharge planning and clear communication between facilities for those |

| patients transitioning to LTC |
|---|
| 2. Establish relationship with long-term care facilities to re-access rehabilitation when appropriate |