Provincial Integrated Work Plan

A Navigation Model to Support Persons with Stroke Transitioning to the Community

Final Report

Background

In 2011/12 the Ontario Stroke Network established a Provincial Integrated Work Plan (PIWP) Committee. The intention of this committee was to optimize the integration of provincial work and coordinate activities that could benefit the 11 stroke regions and advance the OSN strategic priorities and work plan. Two priority areas for action were identified in the first annual cycle - *Early Supported Discharge* and *A Navigation Model to Support Persons with Stroke Transitioning to the Community*.

The work of the *Navigation Model to Support Persons with Stroke Transitioning to the Community* group was informed by the Canadian Best Practice Guidelines for Stroke Care, Section 6.0 Taking Action in Stroke Transitions of Care, which states that patients and families should be provided with information, support and access to services throughout transitions to the community following a stroke to optimize the return to life roles and activities[1]. The committee scoped the work plan to consist of 5 deliverables. These were approved by the working committees of the Ontario Stroke Network, each comprised of the regional stroke Network staff to ensure outputs would be aligned to regional needs. As the project evolved, a 6th deliverable was added by the working group. Each deliverable is defined below along with the rationale for inclusion, a brief summary of associated actions, and outcomes.

Overall Goal:

The intention of this committee was to create resources for health service provider organizations and/or teams to support improved processes for the transition of persons with stroke from inpatient care to the community. Each project deliverable may be used as a stand alone resource or in conjunction with the other deliverables to support the development of a transition model. It should also be noted that persons with stroke and their families may also find some resources compiled for this project very useful e.g., Discharge Linkage Checklist. The unique needs of each person with stroke and their caregivers should be taken into consideration in the application of this model.

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[1] *Lindsay MP and Gilmore P, on behalf of the Stroke Transitions of Care Writing Group. Chapter 6: Managing Stroke Transitions of Care.* Lindsay MP, Gubitz G, Smith E, Bayley M, and Phillips S (Editors) on behalf of the Canadian Stroke Best Practices and Standards Advisory Committee. Canadian Best Practice Recommendations for Stroke Care: 2013; Ottawa, Ontario Canada: Heart and Stroke Foundation of Canada and the Canadian Stroke Network

Deliverable #1: Defining current navigator roles in Ontario

A small working group was established to review current roles in the province related to navigation. The roles that were reviewed included Stroke Navigators working in inpatient and community settings. Results from a provincial questionnaire completed by stroke navigators informed the development of a roles and responsibilities chart for the different types of navigators identified. Definitions were generated for each role to establish a common understanding of titles and aid in the development of a navigation model. The chart provides a quick reference to the commonalities and differences across the navigator roles in Ontario.

Deliverable #2: To identify guiding principles to support development of a navigation model

An informal literature search was completed and following review and discussion, a need was identified for a common definition of community and community service providers which is included in the guiding principles document. The working group agreed to common themes from the literature resulting in eight core principles. These were reviewed by experts in the field of transitions and statements for each guiding principle were generated to provide detail and insight into the scope of the guiding principle. The guiding principles were subsequently used to shape the remaining deliverables created by the committee.

Feedback garnered from experts in the field of transitions was used to inform the development of the Guiding Principles. Each guiding principle is accompanied by a statement which provides detail and insight into the principle. The Guiding Principles were used to shape the foundation of the work of this initiative.

Deliverable #3: To review the Canadian Stroke Best Practice Recommendations to ensure alignment between this project and best practices.

A thorough review of the Canadian Best Practice Recommendations for Stroke: Section 5.0: Rehabilitation and Section 6.0: Transitions resulted in a summary document which highlights the alignment between the best practices and the project. Supporting documents created for deliverables one (current provincial navigator roles) and two (guiding principles) were updated to reflect alignment with best practices.

Deliverable #4: To complete and summarize a formal literature review of navigation models supporting patient transitions to the community.

A review of documents suggested by the working group members and articles identified through a literature search of related to navigation models was conducted. The literature search supported the integration of evidence-based best practice into the final navigation elements and supporting resources. Results of the literature search were used to inform the work required to fulfill Deliverables 5 and 6.

Deliverable #5: To identify and recommend essential elements of a navigation model to support transitions to the community for persons with stroke and their families in Ontario

To support persons with stroke transitioning to the community, a list of essential elements for a navigation model was developed. The elements are listed according to what should be considered from a system, clinical and individual (navigation) perspective. An infographic was developed to illustrate the components of each level and how each component informs the concept and role of Navigation. In addition a "Discharge Linkage Checklist" was developed for clinicians to facilitate planning for persons with stroke leaving their organization, and includes key linkages that should be considered prior to the transition to the community.

Deliverable #6: To identify resources available to implement a navigation model to support persons with stroke transitioning to the community and make recommendations based on identified gaps

Information related to resources or limitations associated with navigation and transitions to the community was synthesized from the work of the previous deliverables. The listing of organizational resources created is intended to assist regions developing navigation models while the clinical resource listing is directed at teams who are providing support to patients and families transitioning to the community.

Recommendations for Future work

As noted above, the six deliverables comprising the PIWP *A Navigation Model to Support Persons with Stroke Transitioning to the Community* may be used as stand alone resources or in conjunction with other deliverables to support the development of an effective transition model. Organizations should give consideration to the significant benefits that might be realized by incorporating a navigator role into the implementation of a navigation model.

Further research focused on development and implementation of navigation models supporting persons with stroke transitioning to the community is required. This could include:

- Development of a business case that would provide a foundational template for regions/organizations wishing to apply for funding in support of a navigation model, including an evaluation of system efficiencies (e.g., cost savings)
- Investigating the capacity to translate a stroke-specific navigation model to other populations or to implement a collaborative model inclusive of several client groups
- Determine feasibility of implementing a navigation model and a Stroke Navigator position including a definition of the scope of the role of a Stroke Navigator and what would be of most benefit to persons with stroke and their family through a pilot study
- Evaluation of how such a model might support an Early Supported Discharge program
- Further review of the terms 'care partners' and 'transitions' is required to determine a common definition and scope of their meaning

Conclusions

The deliverables completed over the course of this project have resulted in a number of resources that can be used to facilitate the establishment of a navigation model to support persons with stroke transitioning to the community. The project has also developed numerous stand-alone deliverables that can be used as quick reference documents to support specific aspects of transition planning for persons with stroke which include:

1. Current Navigation Roles and Responsibilities Chart
2. Guiding Principles Chart
3. Literature Review
4. Model Elements
5. Developmental Infographic
6. Discharge Linkage Checklist
7. Resource Repository (Resources and Gaps; Resources for Organizations; Clinical Resources Listing)

The committee's suggestion, as a result of completing this work, is that a formalized process that considers system, clinical and individual (navigation) level factors to support transitions to the community for persons with stroke would be beneficial. Considerable opportunity exists for interested researchers or program evaluators to strengthen the literature about community transition and navigation for persons with stroke. In the interim, the resources compiled and the essential elements defined by the committee may serve as a good starting point from which to inform health service providers wishing to do more in this area of care.

References

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In Lindsay MP, Gubitz G, Bayley M, and Phillips S (Editors) on behalf of the Canadian Stroke Best Practices and Standards Advisory Committee. Canadian Best Practice Recommendations for Stroke Care: 2013; Ottawa, Ontario Canada: Heart and Stroke Foundation and the Canadian Stroke Network.

Lindsay MP and Gilmore P, on behalf of the Stroke Transitions of Care Writing Group. Chapter 6: Managing Stroke Transitions of Care.
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Acknowledgements

On behalf of the Provincial Integrated Work Plan working group '*A Navigation Model to Support Persons with Stroke Transitioning to the Community',* we would like to acknowledge the phenomenal work of the organizations, committees, key stakeholders and experts involved in this project.

We would first like to acknowledge the leadership of both the Ontario Stroke Network and the Provincial Integrated Work Plan Committee. The determination of streamlined provincial priorities, shaping of work plans and guidance throughout the course of the year was greatly appreciated and played a large part in the successful completion of this provincial integrated work plan.

The work group would also like to acknowledge the Canadian Stroke Best Practice Recommendations. The Best Practices formed the foundation for the work plan and was a key resource used by the working group in the completion of the deliverables and achieving the overall goal of the work plan.

Next, the work group would like to acknowledge the hard work and dedication of the external reviewers for this project. The team of external reviewers who were called upon multiple times throughout the course of this work plan dedicated time and effort into providing constructive feedback that led to the development of a comprehensive and more transferable product upon completion.

Finally, we would like to thank the working group members for their time, dedication and commitment to this project. It was through their efforts that that this high-quality, user-friendly model was created. It was a pleasure working with each and every one of them.

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