Evaluation

For the **Provincial Stroke Rounds Planning Committee**:

- To plan future programs
- For quality assurance and improvement

- For **You**: Reflecting on what you've learned and how you plan to apply it can help you enact change as you return to your professional duties

- For **Speakers**: The responses help understand participant learning needs, teaching outcomes and opportunities for improvement.

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Please take 2 minutes to fill the evaluation form out. Thank you!

Mitigating Potential Bias

The Provincial Stroke Rounds Committee mitigated bias by ensuring there was no industry involvement in planning or in the education content.

The Ontario Regional Education Group (OREG) host member, on behalf of the Provincial Stroke Rounds Committee, reviewed the initial presentation supplied by the speaker to ensure no evidence of bias.

Areas of Reflection

How does your organization, network and/or role within the stroke system support patients and caregivers throughout **multiple transition points?**

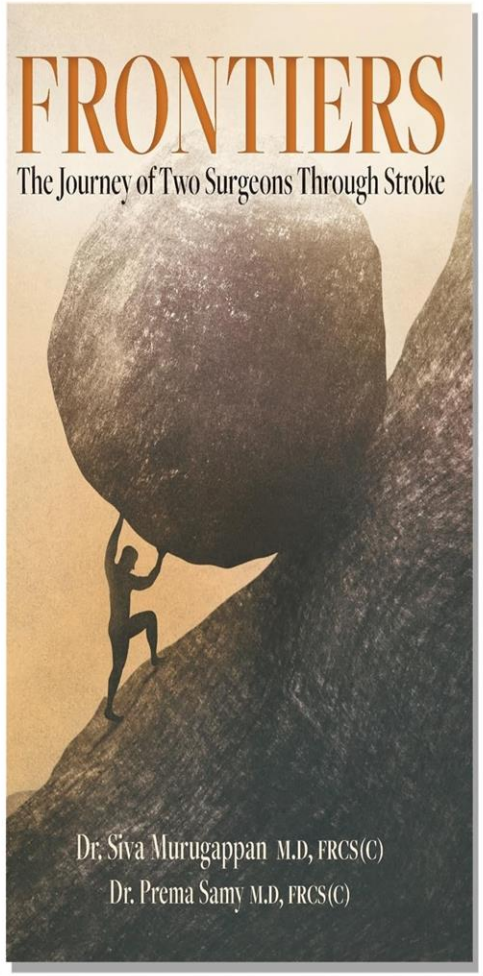
Considerations:

- Does education address various aspects of recovery?
- Is individual readiness and goal setting considered?
- Are caregivers involved in discharge teaching?
- Do teaching strategies involve self-management?
- Do conversations support vocational needs? Are referral systems in place?

Amplifying the Patient Journey to Support Transitions in Stroke Care

Provincial Stroke Rounds: April 3rd, 2024

Presented By: Dr. Siva Murugappan and Dr. Prema Samy



Disclosure of Affiliations, Financial Support, & Mitigating Bias

Speakers: Dr. Murugappan and Dr. Samy

Affiliations : *We have no relationships with for-profit or not-for-profit organizations*

Financial Support: *This session/program has not received financial or in-kind support*

Mitigating Potential Bias: *There are no conflicts of interest to disclose*

Objectives

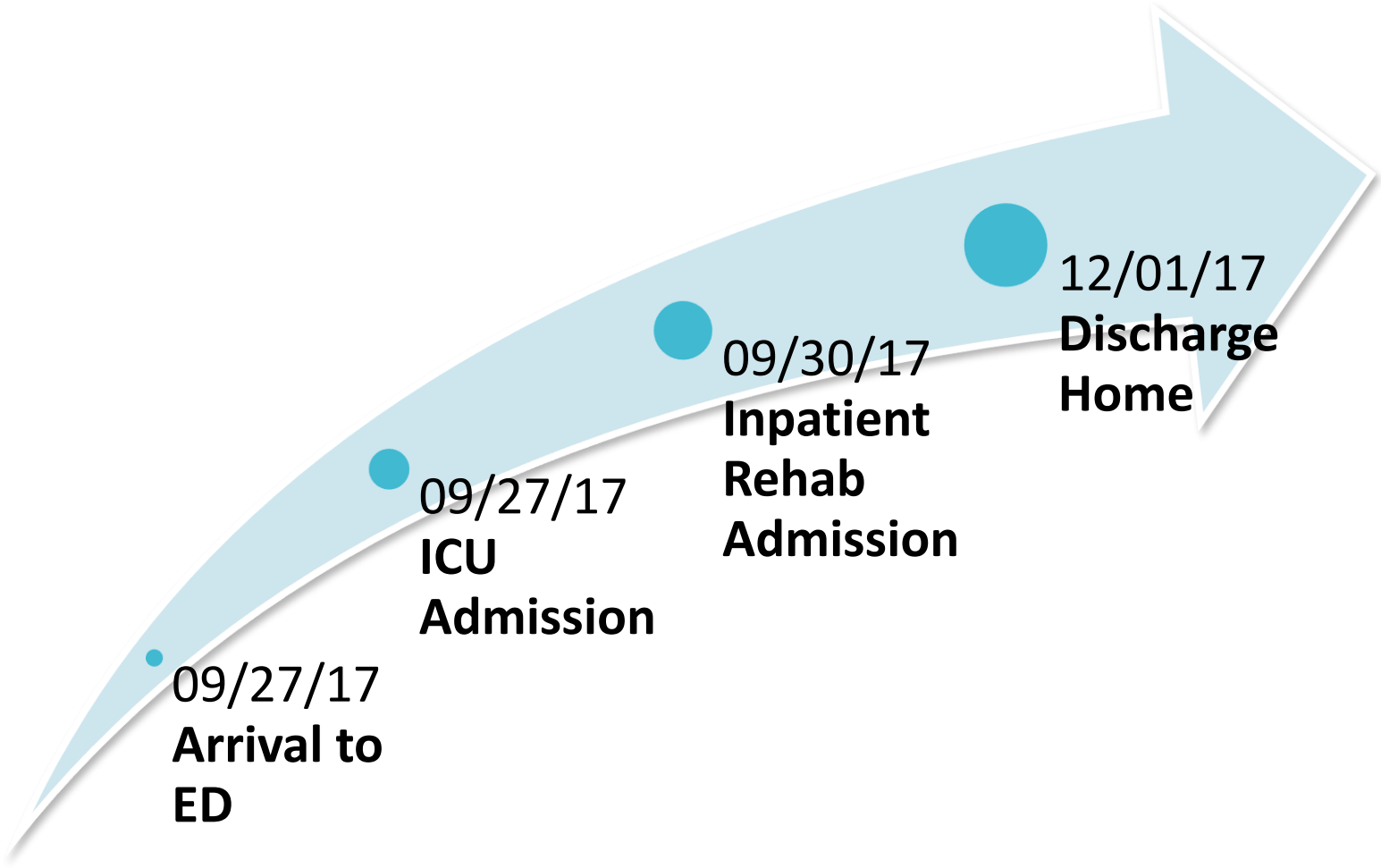
Upon completion of this session participants will be able to:

1. **Understand** the unique experiences of two physicians - a stroke survivor and caregiver - as they navigate the stroke system;

2. **Recognize** the complexities of life after stroke and identify holistic strategies to achieve optimal community reintegration;

3. **Identify** areas in care that can be improved upon to enhance transitions within the stroke system.

Care Transition Points



Stroke Recognition

Experience	Key Transitions & Relevant Education	Areas of Opportunity
• Stroke day • Quick action	• Witnessed stroke • Code stroke	• Public info on patient experiences

Transition #1: Hyperacute to Acute Inpatient

Experience	Key Transitions & Relevant Education	Areas of Opportunity
• Arrived at Emergency Department • TPA received within 20 minutes • ICU x 2 days	• Stroke recognition education • Witnessed stroke	• Code Stroke

Transition #2: Acute to Rehab

Experience	Key Transitions & Relevant Education	Areas of Opportunity
• Multiple visitors and therapy sessions • Emotional and "Foggy" • Exhaustion • Frustration • Resiliency, to never give up despite the unknown	• Transitioning work responsibilities • Bladder control	• SSRI's (depression screening) • Support through information and expectation of phases of recovery

Transition #3: Inpatient Rehab to Home

Experience	Key Transitions & Relevant Education	Areas for Improvement
• Sudden change in routine • The amount of therapy diminished • Mental recovery focused on finding purpose and managing stress • Musculoskeletal challenges, required chiropractor & acupuncture	• Rehab Library • Parkwood Resources • Provided cognitive exercises • Preparing the home environment • Personally had to top-up community services (i.e. personal care worker, training, physio)	• Caregiver Support (i.e resources, marital therapy) • Focus on self care advocacy • Holistic approach (i.e Ayurvedic treatments, chiropractor, acupuncture) • Patient resources to top up physical therapy and counselling

Transition #4: Community Reintegration

Experience	Key Transitions & Relevant Education	Areas for Improvement
• After working 80+ hours a week, I had a lot of extra time • Mental Load (i.e. stress, confusion, altered purpose) • Decision made to return to work (scrutiny, frustration, confidence)	• Participated in post-stroke rehab (i.e. driving rehab, golf rehab)	• Lack of collegial and professional support returning to work • Delays in returning to full duties • Access to services to support confidence, motivation, and depression

Caregiver Perspectives

Hyperacute-Acute	Acute- Rehab	Rehab- Home	Community Reintegration
• WE had a stroke	• This was an overwhelming time during the 9-week admission • Continued working full-time	• Focused on preparing the home environment • Primary focus is on the patient, self-care is important • Personal Coach	• Driving to appointments and rehab • Balancing day to day

Highlights: Areas of Opportunity

Processes

- Code Stroke
- SSRI
- Access to outpatient rehab

Education

- List of contacts and website
- YouTube Videos
- Podcasts
- Memoirs

Services

- Outpatient Supports
- Driving Rehab
- Mental Health Supports
- Caregiver Supports
- Vocational support

Future Considerations

Transition management often includes:

- Multidisciplinary team involvement
- Caregiver education
- Follow-up care

There remains a lack of comprehensive literature to further support a standardized approach to transition management.

Strengthening **resources**, integrating **individualized processes,** and **growing patient partnerships** can:

- Improve community re-integration
- Support quality of life
- Reduce the rate of hospital readmissions

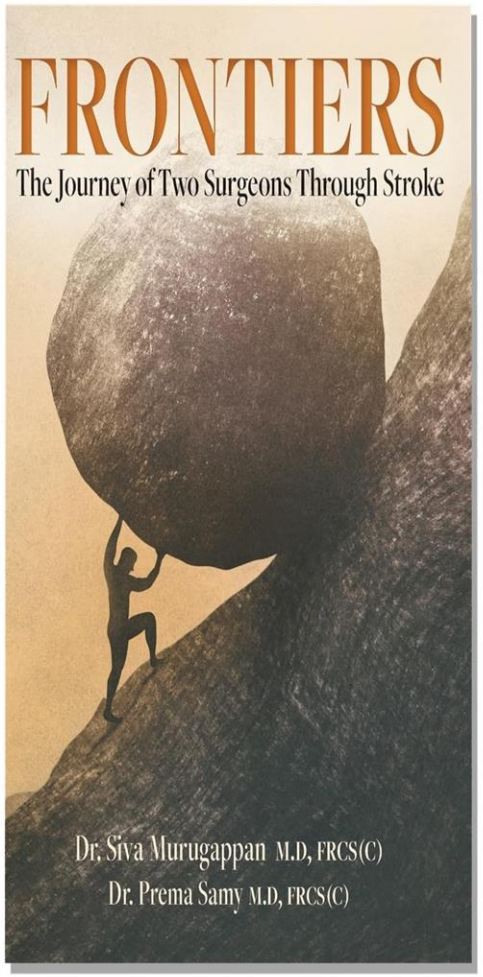
(Chen et al., 2021; Miller et al., 2019)

Closing Remarks

1. The medical complexity of individuals and the role of the informal caregiver **continues to rise**
2. It is important to maintain a stroke system of care that best **supports patients and families** throughout transitions
3. Highlighting the unique patient and caregiver perspective allows us to uncover areas of **systemic opportunity**

(Mountain et al., 2020)

Thank-You!



For additional information please visit:
www.frontierstroke.com and/or email premapriyax@yahoo.com

Questions

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References

Chen, L., Xiao, L. D., Chamberlain, D., & Newman, P. (2021). Enablers and barriers in hospital-to-home transitional care for stroke survivors and caregivers: A systematic review. *Journal of Clinical Nursing*, *30*(19–20), 2786–2807. https://doi.org/10.1111/jocn.15807

Miller, K. K., Lin, S. H., & Neville, M. (2019). From hospital to home to participation: A position paper on Transition Planning Poststroke. *Archives of Physical Medicine and Rehabilitation*, *100*(6), 1162–1175. https://doi.org/10.1016/j.apmr.2018.10.017

Mountain A, Patrice Lindsay M, Teasell R, et al. Canadian Stroke Best Practice Recommendations: Rehabilitation, Recovery, and Community Participation following Stroke. Part Two: Transitions and Community Participation Following Stroke. International Journal of Stroke. 2020;15(7):789-806. doi:10.1177/1747493019897847