



RESEARCH ON THE RUN

Integrated care and transitions

Integrated stroke care in home care

This is a plan to modify a therapy-based best-practice stroke program to one that brings all providers – including rehabilitation professionals, rehabilitation assistants, nurses and personal support workers – together to provide person-centred integrated care to people in their homes.

Key learnings

Engaging frontline providers work to figure out how to integrate 8 different healthcare disciplines into best-practice stroke care in the community.

Focusing on a client's goals for stroke recovery, rather solely on the providers' goals, is a good way to bring the provider team together to collaborate.

Flexibility in care pathways should be exercised to meet different clients' goals and stages of recovery and reintegration into the community

Project overview

In 2013, the Waterloo Wellington Community Care Access Centre (WW CCAC) launched its Community Stroke Program, consolidating care coordination and up to 76 home visits over 12 weeks by occupational therapy (OT), physiotherapy, speech language, social work and registered dietitian services into a best-practice, OT-led pathway for community reintegration.

The next phase was to integrate nursing and personal support services, to promote continuity of care, effective communication and role clarity and optimal scope of practice to achieve optimal outcomes for clients.

What did we do?

The Saint Elizabeth Research Centre facilitated planning for Phase 3. The Health Service Provider delivering the Community Stroke Program, Care Partners and Saint Elizabeth Health Care, agreed to participate.

A Steering Committee was formed, composed of representatives of the WW CCAC, Care Partners, the Saint Elizabeth Service Delivery Centre in WW, and the Saint Elizabeth Research Centre. The Steering Committee met regularly throughout the planning to discuss experiences and preliminary outcome data collected from Phase 1 and 2 deliberate on ideas, opportunities and next steps for Phase 3.

The two-day workshop with frontline healthcare providers from acute care, inpatient rehabilitation, outpatient rehabilitation and home care who would be involved in the program in Phase 3. A modified ADAPTE process¹ guided the workshop and 8 recommendations for Program changes

¹ The ADAPTE Collaboration: **The ADAPTE process: resource toolkit for guideline implementation. Version 2.0.** In. Available from <http://www.g-i-n.net>; 2009.

emerged.

The Steering Committee supported all the recommendations, but had a number of suggestions about timing and implementation.

What did we find?

The recommendations for changing the Pathway were as follows:

- Ensure continuity in care delivery
- Train all disciplines on stroke and roles
- Focus on the client's goals
- Add more flexibility to the care pathway
- Add nursing visits
- Implement a common communication platform
- Improve transitions in and out of the pathway
- Blend outpatient and in-home rehabilitation

While dedicated teams might be ideal, the practicality of designating the same therapists, nurses and personal support workers for the program was seen as difficult to achieve. For that reason, common training about stroke and the roles of all potential team members is recommended.

For a common approach of care, an OT Lead will work with the client to identify his or her goals, and provider team members will align their therapeutic goals to the client's goals. With increased flexibility the OT Lead will personalize the Pathway to meet the client's goals.

The plan also calls for increased communication capacity across the team, so that the members can share progress, assist each other to reach the client's goals, and ensure client concerns are known to all so that they can be addressed consistently.

Nursing visits should be added to the pathway to start stroke education and identify issues such as medication management.

It is recommended to rename the Discharge Link meeting at the Pathway start as a “Transition Meeting,” and to begin the transition to community supports earlier, with another “Transition Meeting” at the end to engage community providers.

While merit was seen in being able to substitute outpatient hospital-based therapy for some elements of in-home therapy for some clients, it was agreed that more work is needed to identify when this would be appropriate and how it would work

Innovative approach:

Practicing PFCC is challenging because it requires PFCC principles to be embedded throughout the organization and health care system, not just at the point of care, to ensure staff are supported to take this approach. This requires a significant culture shift.

IMPACT: How are we moving Knowledge to Action?

- The implementation of this plan is subject to the many activities in the home care sector in WW
- The method of establishing the plan, and some of the elements of the plan are being refined, adapted and used in other areas, e.g. planning integrated care in palliative care and wound care

Who are our collaborators?

- Waterloo-Wellington Community Care Access Centre
- Care Partners
- Saint Elizabeth

How was this research funded?

Saint Elizabeth funds the Research Centre as an element of its social innovation mission. The contributions of the WW CCAC, Care Partners and Saint Elizabeth Service Delivery Centre were provided in-kind.

For more information about this project, please see our PFCC webpage:

www.saintelizabeth.com/research

Or contact:

research@saintelizabeth.com

About the Saint Elizabeth Research Centre

Saint Elizabeth Health Care has made a strategic commitment to research — \$10 million over 10 years.

At the Saint Elizabeth Research Centre, we study the needs of people, their caregivers, and health care providers to develop innovative solutions to improve health and care experiences across the continuum/ more effective approaches to care. The Research Centre has four areas of focus: integrated care and transitions, end of life care, caregivers and person and family centred care.

Our goal is to improve people’s health and care.

We work on innovative solutions for tough problems.

We see possibilities everywhere.