**Poster #11**

# Community Transitions in Outpatient Stroke Rehab: Co-designed with Persons with Stroke, Caregiver, & Community Partners

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Canadian Foundation for Healthcare Improvement
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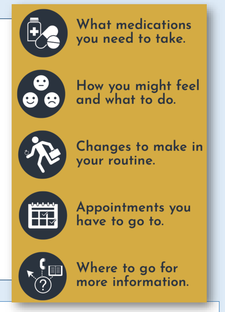
PODS Patient Oriented Discharge Summary | OPENLAB a proud member of UHN

## Background

- Each year, more than 62,000 strokes occur in Canada[1]. Readmission rate for persons with stroke is about 14%; estimating 13% of readmissions are preventable[2].
- Patient-Oriented-Discharge-Summary (PODS) has shown to reduce readmission rates[3].
- In 2017, PODS was implemented in the Inpatient Stroke Services.
- In 2018, Outpatient Stroke Services began to examine and refine how community and discharge transitions of patients and caregivers are supported, including the implementation of PODS.
- As part of transition preparation, it is important to emphasize the engagement of caregivers[4] and to collaboratively address transitions across the continuum: from hospital to community[5].

### What is PODS?

- Co-developed by patients and health care providers[6].
- Specifies 5 key areas to include during discharge teaching.
- Provides easy-to-understand instructions to guide discharge.
- Supports use of teach-back.




## Objectives

This quality improvement initiative aims to:

1. Improve patient and caregiver preparedness for discharge transitions from Stroke Outpatient Services.
2. Enhance linkages between hospital-based and community-based services to support patient and caregiver transitions.
3. Improve patients' and caregivers' awareness and access to community resources to support transitions.

## The Partnerships


## Addressing Transitions as a Continuum

## Understanding Current State

### About Toronto Rehab Stroke Services

- Stroke Outpatient Rehab consists of 3 teams of services located in 2 sites:

| FAST TRACK University Centre | DAY HOSPITAL University Centre | OUTPATIENT Rumsey Centre |
|---|---|---|

- ***Referral sources:*** Acute Care, Inpatient Rehab, & Community.
- Patients from Fast Track may or may not transition to Day Hospital / Outpatient Stroke Service.
- The Outpatient Transitions / PODS initiative includes all 3 service areas.

### Current State Learnings

- Patients and caregivers regularly report they are well supported for their transitions.
- Current state mapping and analysis primarily revealed 3 opportunities:

(1) Priority/Goal setting form was not used consistently to guide patients and caregivers to set goals.

(2) Some patients and caregivers (a) do not know which resources to connect with, and/or (b) have difficulty connecting with services after discharge.

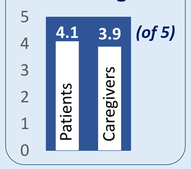
(3) Written discharge recommendations are not always available for patients and caregivers.

I'm still in university. They helped me get accommodations and set me up with (programs). **It helped me have a smooth transition** (to school) and I did well because **I had all these supports in place.**

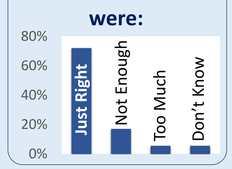
### Base-Evaluation

- Completed:
  - ✓8 Patient Interviews & 10 Patient Surveys
  - ✓3 Caregiver Interviews & 7 Caregiver Surveys
  - ✓24 Staff on-line and paper Surveys

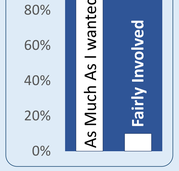
**Average rating of preparedness at discharge:**



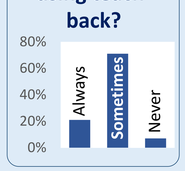

**Patients reported the amount of information received were:**




**Caregivers were involved:**




**Clinicians' confidence in using teach-back?**



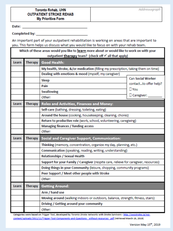

**Finding resources for myself was hard. If I did not see the Social Worker, I would not have known.**

**Lots of information too early on.**

Good idea to have **joint meeting between husband and wife** but having **separate meeting with the caregiver alone** just to discuss where we are at and what we need would be helpful.

## Quality Improvement Implemented & In Progress …

### Goal or Priority Setting



- Patient, Caregiver, and Community Partners, as well as the clinical teams all emphasized the need to address transitions as a continuum, starting at Goal Setting. This prompted the question: ***"Are we asking the right questions to help patients and caregivers identity their needs?"***
- The **Priority / Goal Setting** Form was revised based on the Trigger Tool[7] from *Toronto Stroke Networks*. The form provides prompts to guide patients to self-reflect and to help identify their needs and goals.
- Prompts are also included to **invite caregivers** to be involved and to **consider caregivers' needs**.
- Standardized processes are now in place to guide teams to use the revised form.

### Connecting *Inpatient & Outpatient* Stroke Services to the Community

- Patients & caregivers met & connected with representatives from *Central Neighbourhood House* (CNH) in-person regularly. This is on hold during pandemic.
- *Peer Fostering Hope (PFH) Hospital Visitation Program* gives patients and caregivers opportunities to liaise with Stroke Survivors. A 2nd PFH Volunteer has joined us! Virtual meetings are now in place during pandemic.
- A collaboration with *March of Dimes Canada* to provide telephone follow-up post-discharge is offered to all patients. This continues during pandemic.

### Support Access to Resources and Self-Management

- Piloting a Stroke-related **community resource tool** to foster patients' and caregivers' awareness of common resources that they can access after discharge.
- This aims to minimize gaps especially when Social Workers are not involved.
- **Teach-back training** was provided to Inpatient and Outpatient teams to foster use in daily practice and when preparing for transitions.

### Teach-Back Meeting

- The teams are currently developing the process and tools to support the addition of a **1:1 Teach-Back (PODS) meeting** to occur about 1 week prior to discharge.
- This meeting aims to use a teach-back format to guide patients/caregivers to reflect on and to consolidate their learnings and plans that are pertinent in supporting community transitions, such as ongoing goals and resources that they may access.

## Conclusion

- All Stroke Outpatient Services are now using the revised Priority / Goal Setting form in practice.
- The ability to meet the CNH's representatives in-person has helped improve patients' comfort to try CNH after discharge. This "warm-handover model" may also foster participation with other services.
- Collaborating with Patient, Caregiver, and Community Partners have created opportunities to build stronger linkages for patients and caregivers to connect with and to receive ongoing support in the community after discharge.
- The next steps involve the development of Teach-Back meetings, and to refine the processes and tools used to support community transitions and self-management of patients and caregivers.

**References**

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