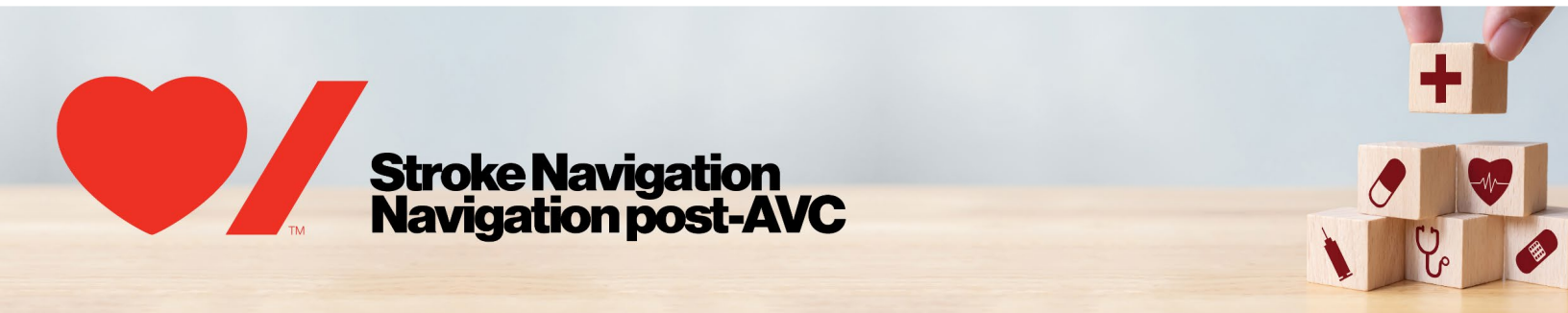
Stroke Navigation F21/22 Program Report

Total referrals F21/22: 170

Hospitals referring: 15

SN hours provided to date: 567 hours



Program Summary

Adjusting to life back in the community after experiencing a stroke can be difficult. In fact, the transition from the hospital to the community has been consistently mentioned as a challenge by both stroke patients and their care partners. Yet, up to 70% of people who have a stroke return home.

Stroke Navigation is an accessible, bilingual, and free community service, designed to help people with stroke to adjust to life back home. The Stroke Navigation program helps people who have had a stroke to make sense of their diagnosis but also supports recovery goals, stroke self-management, system navigation, and the prevention of secondary strokes

Stroke navigators offer stroke education, connect patients with available resources, and guide patients through and around barriers they may experience.

Throughout the process, the client will have the opportunity to action plan and work on goal setting in hopes of increasing their confidence level, ability to self-manage on their own and to reintegrate back into their community post-stroke.

Ultimately, Stroke Navigation aims to prevent avoidable re-hospitalization and early entry into long-term care while supporting quality of life.

Stroke Navigation – Client process through program

After receiving a referral, the client will get a call from Heart & Stroke's Stroke Navigator to talk to them about the program and invite them to book their first session. Clients can choose to see their stroke navigator by phone, video-conferencing, or in-person where applicable. Sessions are of a duration of 1 hour in length and the client can be followed for a duration of one year from intake.

Once a client accepts and books their first session they will have an initial Meet & Greet where the stroke navigator takes the time to listen to the client's stroke journey, current needs and obtain the client's consent to participate to the SN program. The following session gives the chance to the stroke navigator to complete the onboarding documents (Client Intake Form, Post-Stroke Checklist and Pre-Test if the client has consented to participate in the research component of the program).

In each of the follow-up sessions (weekly or bi-weekly) the client will determine priority areas, go through some education on stroke and stroke prevention (Your Stroke Journey guide). In addition, the client will have the chance to develop a goal-based plan by using the SMART goal system to help with confidence and self-management post-stroke.

At the beginning of each session, the stroke navigator will ask for an update of how the client has been doing in between sessions and if they have any priority areas they would like to work on for the session. When required, the stroke navigator is able to provide the client with the necessary resources, access to programs and services or help with navigation within the health and/or social system.

As the client continues along with their stroke recovery process, the Stroke Navigation sessions occur less often – once a month or once every 3 months. This allows for the client to continue to work on the goal they have set for themselves and to develop a level of confidence to be able to self-manage their condition.

When the client is ready for discharge, they will have a session with their stroke navigator and look at their progress so far, evaluate their SMART goal and to see if they require any more education, resources or tools. At this time, the stroke navigator will complete the Discharge form and post-test (when applicable). This will allow the client to be able to give their feedback on the Stroke Navigation program and collect data for program evaluation purposes. In some instance, when a client feels they require more support in behaviour change and goal setting, they will have the option to transition into the LWBV program.

SN Program data

Impacts of program to date – Clients are reporting improvement in the following areas - Stroke knowledge, secondary prevention, stroke self-management, quality of life, access to services and prescription knowledge.

Demographics	
Average age of clients	66 years old
Sex	48.89% - Female 51.11% - Male
Location	28.9 % - Rural 71.1% - Urban
First Language	22.2% - English 77.8% - French

Client data	
# of referrals for F21/22	170
# of client discharge to date	48
# of clients enrolled in SN program to date	90
Average # of sessions	6.5 sessions
Average hours in session with SN	6 hours
Total number of SN hours direct client care to date	567 hours
Preferred method of meeting	Phone

Client Discharge Survey Feedback	
% of clients who would recommend SN program	100%
% of clients who would felt supported	98%
% of clients who have met their goal	73%

Testimonials

I don't think I could have done it without your help. I think that anybody out there would be pleased to know that you are there for us! I didn't know you were there until you called - changed my outlook, confidence, ability to get to the next steps. Glad you were part of my journey!

I am thankful for your program. I started looking for help after my 1st stroke in 2014 (I called HSFNB) and I could not find anything, I felt alone. All I wanted to do was talk to someone who understood what happened to my body and brain. I needed that 1:1 to be able to communicate with someone about my thoughts and fears after leaving hospital, I am glad I was able to get referred to your program!

It gave me some direction and support. It made me feel good about myself and I can see where I was progressing, it made me focus on where I am (want to be) instead of where I was.

The helpfulness and support and knowing it was there and there was no judgement, no right or wrong. That made a big big difference!

It helped me to understand why I was responding to things the way I was, it helped me to understand why things were no longer the same as they used to be. When I was first contacted I didn't think this would be any help especially over the phone but it helped me to understand why things were different and how I can deal with things because they are different. It helped me to deal with the changes that I was working through that I did not have to work through before.

The encouragement from talking with you and how we were able to reason things out and get to the real heart of the matter. It is a very apt title, (Stroke Navigator) there are a lot of different things coming at you at once when you have a stroke. It's like you are the captain of the ship and are able to see what is coming, the challenges and work around them.

Strategic Vision for Stroke Navigation program F22/23

- Implement a Stroke Navigation program with a target of 100 clients/year.
- Establish a system for stroke support groups.
- Support Stroke best practice care in NB.