

Mission	To facilitate, coordinate, implement and sustain development of an integrated delivery system for best practice stroke care in Grey and Bruce		
	Roles and Responsibilities		
Components	Community Capacity and Integration	Individual and Family Capacity	Health Care Organizations
<p>Health Promotion</p> <p>All individuals</p> <p>And</p> <p>Primary Prevention</p> <p>All individuals at risk for Stroke</p>	<p>Promote and organize community activities for the reduction of stroke e.g. Active 2010; Good Food Box; Pedometer Program; FOCUS Low Drinking Guidelines</p> <p>Identify and work with non-traditional community partners to establish the community stewardship of health e.g. churches</p> <p>Present healthy lifestyle information sessions.</p> <p>Participate in policy development on healthy lifestyles.</p> <p>Identify and participate in local and regional awareness campaigns</p> <p>Promote and support the use of libraries for health information and motivational tools for active, healthy living.</p> <p>Promote community fitness project for individuals with a disability.</p> <p>Participate in awareness events such as the Big Bike.</p> <p>Support media presentations on stroke and living with stroke.</p> <p>Promote and advertise community resources to assist in maintaining a healthy lifestyle.</p> <p>Assist in adapting lifestyle information and resources to the community e.g. First Nations</p>	<ul style="list-style-type: none"> • Participate in risk reduction and self-management initiatives • Use the libraries for guided health information on stroke through Health Information Prescription Project • Know the warning signs of stroke • Participate in educational opportunities on risk factor reduction and healthy living. • Be familiar with resources available locally to assist in establishing a healthy lifestyle. • Seek help when risk factors are not controlled. • Participate in research 	<p>Education</p> <ul style="list-style-type: none"> • Identify and support the provision of education to health care professionals to enhance best practice stroke care in the community and LTC. <p>Evidence-based Practice</p> <ul style="list-style-type: none"> • Identify best informed practice in healthy lifestyle promotion • Participate in the Towards Evidence Informed Practice Project • Act as knowledge broker for stroke prevention information e.g. creation or use of tools to assist in community development, individual lifestyle change or health provider knowledge and intervention <p>Delivery System Design</p> <ul style="list-style-type: none"> • Participate on the Network Chronic Disease Management Framework • Participate on the Southwestern Stroke Strategy Prevention Committee • Input to the LHIN CDM team <p>Information System/Communication</p> <ul style="list-style-type: none"> • Identify opportunities to use individuals stories to increase stroke awareness • Participate in media campaigns and opportunities e.g. FOCUS • Participate in evaluation projects • Keep current on data concerning lifestyle promotion, risk reduction e.g. Heart and Stroke Blood Pressure Campaign • Keep current on local stats on chronic disease • Audit practices and implement improvements <p>Partnerships</p> <ul style="list-style-type: none"> • Identify potential partners especially in primary health care, community • Develop and support partnerships with other healthcare organizations and coalitions (Healthy Living Partnership, Partners in Health, Regional Stroke Prevention Committee) • Partner with provincial agencies for health promotion (Heart Health Coalition, Ontario Prevention Clearinghouse)

Secondary Prevention

Promote the use of the secondary prevention clinic.
Promote appropriate referrals to stroke prevention clinic.

Promote the use of community resources to initiate or maintain healthy living.

Assist community agencies in engaging their residents in healthy living – evidence-based practices; inclusion of those with impairments

Engage communities in planning for prevention activities and strategies

Know where to seek help and resources.

Participate in lifestyle modification and risk reduction programs.

Be knowledgeable and compliant with medication and lifestyle changes.

Engage in self management.

Attend the stroke prevention clinic.

.As appropriate trial BP monitors at home.

Give feedback on services and resources.

Know the warning signs of stroke and seek help.

Participate in research.

Education:

- Identify and support the provision of education to health care professionals including physicians to enhance best practice stroke care in the community and LTC.
- Develop tool kit for health professionals on the main messages for lifestyle change for use on acute care, rehab and community
- Develop a PSW tool which would trigger specific actions to help PSWs support their clients in stroke prevention
- Standardize patient education and approaches including Understanding of TIA book.

Evidence-based

- Identify and implement best informed practices e.g Behaviour Modification Framework
- Act as a knowledge broker for EBP
- Develop tools to assist in knowledge transfer e.g. TIA Algorithm; use of the ABCD score
- Participate in the regional pilot for the standardized questionnaire for stroke prevention clinic

Delivery System Design

- Establish a behaviour modification framework
- Implement and support a TIA ER protocol
- Develop a case management system to improve navigation of the system for individuals with TIA.
- Identify and pursue opportunities for integrated disease management.

Information System:

- Use ALERTS to communicate best evidence to stakeholders
- Participate in Stroke Performance Indicators for Reporting, Improvement and Translation (SPIRIT) database
- Use other available data bases
- Patient feedback process to be developed.

Partnerships:

- Participate on the regional stroke prevention nurse network
- Identify and work with CDM partners
- Establish linkages with appropriate pharmaceutical companies for prevention initiatives
- Participate in the provincial stroke prevention roundtables.

Stroke Management – Acute and Rehabilitation

- Support the provision of evidence-based stroke care
- Support family and friend of the stroke survivor e.g. library information prescription project; spiritual support through churches; social support

- Participate in assessment, treatment and discharge planning including goal setting.
- Be part of the recovery and rehabilitation team.
- Be knowledgeable about your condition. Ask questions. Use the patient pathway.
- Seek information. Give feedback.
- Become a self-manager.
- Participate in educational opportunities.
- Awareness of caregiver burden and the need for training as a caregiver.

- **Education**
 - Develop and implement strategies for healthcare providers to develop stroke expertise.
 - Assist with clinical pathway training .e.g. stroke scale training
 - Support dysphagia screening training
 - Support patient and caregiver education and training
- **Evidence-based**
 - Use the Heart and Stroke Foundation Best Practice Guidelines for Stroke in development of program, treatment and education
 - Develop and disseminate the Evidence-Informed Practice Workbook for OT and PT
 - Alerts issued on EB practice e.g. Older Client
 - Clinical Nutrition Resource
 - Knowledge broker for evidence based stroke information
 - Implement Evidence to Practice Research Project
 - Participate on Ontario Consensus Panel on Stroke Rehabilitation
 - Implement Caregiver Burden Research Project
- **Delivery System Design**
 - Support of re-direct protocols and transportation/ EMS prompt card
 - Development and implementation of clinical pathways
 - Participation on the LHIN Rehabilitation Priority Action Team
 - Participation on the Regional Stroke Rehabilitation Committee
 - Participation on the GBHS Clinical Service Team Rehab.
 - Develop and implement a caregiver strategy
 - Develop an effective model of triage and transition from each section of the continuum e.g. TIP tool, Alpha FIM
- **Information/Communication**
 - SEAC data base for District Stroke Centre
 - HAPS readmission and LOS indicators
 - Ontario Stroke Audit
 - Audit best practice and disseminate findings
- **Partnerships**
 - GBHS, SBGHC, Hanover, Evidence-based Care Prog.
 - CCAC
 - Regional Centre/Ontario Stroke System

Community Re-engagement

Participate, support and promote re-engagement activities e.g. stroke or CDM support groups, exercise programs, supported conversation groups

Facilitate inclusion and accessibility.

Environmental support for activities for individuals with stroke e.g. community space

Encourage stroke survivors to be community volunteers.

Participate in forums or information gathering on issues related to stroke care in the community.

Ensure recreational and leisure opportunities for stroke survivors.

Discuss and resolve transportation issues in the community.

Encourage social support for individuals living in LTC.

Support vocational opportunities for individuals with stroke.

Participate in the Living with Stroke Program.

Participate in appropriate fitness and exercise programs.

Participate in language, perception and cognitive programs and activities.

Seek out participation opportunities in the community.

Participate if appropriate in vocational or volunteer programs/education.

Attend driver retraining if appropriate.

Be aware of the signs of depression and seek help.

Be aware of community resources.

Be aware of how to re-enter the system if needed.

Thrive.

Participate in research

Education

- Develop and implement strategies for healthcare providers to develop stroke expertise e.g. Tips and Tools
- Develop and implement strategies for communities and community workers to increase knowledge and skills for stroke management in community
- Use Living with Stroke Program
- Standardizes education package for individual with stroke returning to community
- Participate on the Geriatric Education Cooperative

Evidence-based

- Implement the use of the Best Practice Guidelines for community
- Develop and Implement a community pathway/guidelines – outpatients, day away programs, community recreation, LTC
- Issue ALERTS
- Assist in forming a LTC physiotherapy network
- Act as a knowledge broker – Make It So group
- Participate in the Telephone follow-up Project
- Pilot the fitness centre for individuals with disabilities.

Delivery System Design

- Develop and implement community pathway/guidelines/ navigation system
- Map out community journey. Identify gaps and solutions.
- Participate in community planning. And development of services e.g. driving school; recreation opportunities
- Implement Community Engagement Framework

Information/Communication

- Access data on community re-engagement e.g. CCAC, LTC, community program
- Develop methods for feedback on the re-engagement experience and relate status to acute and rehab statistics
- Audit best practices and share

Partnerships

- CCAC, LTC, Home and Community Support Services, VON, Care Partners, Paramed, Red Cross, Recreation, Closing the Gap
- Active Living Alliance for Canadians with a Disability
Active Living Ontario