Evaluation of the Community Stroke Rehabilitation Teams

Executive Summary
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Executive Summary

In 2008, three Community Stroke Rehabilitation Teams were established, one in each of the three planning areas of the South West LHIN: Thames Valley, Huron Perth, and Grey Bruce. Each interprofessional team is managed by their respective health organizations; St Josephs Health Care London, Huron Perth Healthcare Alliance and Grey Bruce Health Services, and aligned with the local District Stroke Centre. The aim of these teams is to provide post-hospital rehabilitation services in order to maximize patient outcomes during a critical post-stroke time period. This report describes the methods and results of an evaluation of client, caregiver and key stakeholder perspectives of the Community Stroke Rehabilitation Teams.

Evaluation Objectives: The identified objectives of the evaluation were to:

i) Describe the perspectives of clients and caregivers on the impacts (benefits) associated with the Community Stroke Rehabilitation Teams
ii) Describe the perspectives of key stakeholders on the impacts (benefits) associated with the Community Stroke Rehabilitation Teams

Design and Sources of Information: A mixed methods (quantitative and qualitative methods) approach was employed to meet the objectives of this evaluation, using the following sources of information:

- **Client and Caregiver Satisfaction Survey:** A paper-based satisfaction survey was completed by 72 individuals: 43 clients and 28 caregivers.
- **Client and Caregiver Interviews:** In-depth interviews were conducted with 12 individuals: 8 clients and 4 caregivers.
- **Key Stakeholder Survey:** An on-line survey was completed by 20 key stakeholders representing community, acute care, and long-term care sectors.
- **Key Stakeholder Interviews:** In-depth interviews were conducted with 10 key stakeholders representing community, acute care, and long-term care sectors across the three teams in this region.
- **Review of existing documentation:** Information/documents (e.g., letters, e-mails, newspaper stories) reflecting the experiences of those involved with the team were reviewed.

RESULTS:

Overall

- 97% of clients/caregivers were satisfied with the help they received from the team
- 89% would recommend the team to another family member or friend needing this type of assistance
- the majority of key stakeholders (75%) were satisfied with the care provided by the team
- the majority of clients and caregivers interviewed (67%) reported that the service they received from the team was better than any other health care they received in the past.

Clients/caregivers reported that the help they received from the team:

- met their needs (97%)
- contributed to their quality of life (96%)
- contributed to their independence (88%)
**Self-Management and Community Reintegration**
Changes consistent with self-management principles experienced as a result of involvement with the team:

- improved health and functional ability (75%)
- improved ability to manage changes in life (71%)
- improved mood (60%),
- improved ability to manage stroke risk factors (56%)
- improved knowledge of where and how to get help in the community (61%)
- return to family roles (69%) and social activities (59%)

Some clients and caregivers began to attend community exercise programs (32%), support groups (25%), and day programs(19%) as a result of team involvement. Team member facilitation of reintegration by practicing skills needed to attend programs with clients was identified as **critical to client success.**

Mobility impairments and lack of transportation were noted as barriers to community reintegration.

**Caregiver Support**

All of the caregivers interviewed reported that the team helped to reduce the stress or burden of caregiving through the provision of emotional support and advice regarding how to manage and cope with stressful situations arising as a result of the stroke.

**Health System Impacts**

**Long-Term Care Avoidance:**

- 93% of clients surveyed reported that the help they received from the team contributed to their ability to stay at home.

- Clients interviewed reported that their involvement with the team **prevented nursing home or long-term care placement** because the care provided met their goals for independence, improved functional ability, and focused on activities of daily living.

- Clients discharged to independent living from LTC.

**Decreased Hospital Usage:**

- Shortened hospital lengths of stay for both acute care and the inpatient rehabilitation programs knowing that a specialized service was available in the community.
• A low percentage of stroke survivors (fewer than the provincial average\(^1\)) had a stroke related hospital readmission during or following their involvement with the team.

• Key stakeholders believed that the teams had a positive impact on reducing ER visits, hospital admissions and stroke risk factors. These impacts were felt to result from attention to functional recovery (e.g. reduced fall risk) and secondary stroke prevention.

"What I see with our clients, who I know have a relationship or are involved with the team...if there wasn't that connection some of these folks would probably go to the hospital much more often.”
(key stakeholder)

**Strengthened Partnerships in the Community:**
• improved care coordination and integration were significant themes arising in this evaluation
• the majority of stakeholders felt that the team services improved stroke survivor and caregiver’s awareness and use of available community resources and supports
• 60% of stakeholders indicated that the teams contributed to increasing other provider’s knowledge and skills in managing stroke care
• increased and strengthened partnerships among community services

"We have a true partnership with the team...our program has just been enhanced 100%.”
(key stakeholder)

**Improved Model of Care:**
• interprofessional, coordinated, specialized team services
• client-centred and practical care that is compassionate, encouraging and enabling
• access to recovery focused rehabilitation in the community (75% improved)
• inclusion of professional services focused on client/caregiver adjustment and support (social work), and community reintegration (recreation therapy)
• majority reported improved continuity of care following discharge from hospital

**Challenges** reported by clients, families and key stakeholders were related to:
• wait times for therapy
• a desire for more therapy
• demands greater than the team can meet
• communication/transition across services
• a desire for more follow-up post discharge
• restrictive eligibility criteria
• accessing help with specialized services (e.g. Assistive Devices Program)

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Suggestions for improvements provided by clients, families and key stakeholders:
- earlier referral to prevent delays in service
- more therapy (amount, length of time)
- increase resources to meet the increasing demands for service and to improve the timeliness of access to care
- improve communication among partners, particularly the CCAC
- better promote/ market the services of the team
- more regular follow-up post discharge from the team than is currently available

CONCLUSIONS
Based on the findings of this evaluation, the following conclusions can be made about the Community Stroke Rehabilitation Team as operated within the South West LHIN:

There is much support for the CSRT:
- It has been well received by clients and caregivers, health professionals and key stakeholders across sectors.
- The teams provide a vital service to stroke survivors and their caregivers in the community.
- The results of the evaluation suggest effectiveness is consistent across the three teams
- The teams have had significant impact on increasing access to expert rehabilitation and support and on reintegration into the community.

The team has achieved its client-related objectives:
- improved client care
- improved functional recovery
- reduced caregiver burden
- improved client health
- reintegration into the community
- increasing client capacity to remain in their homes, increasing their quality of life and satisfaction with care.

The team has achieved significant health system improvements:
- improved and equitable access to rehabilitation in the community
- reduced length of hospital stay
- LTC avoidance
- Reduced ER visits and hospital readmissions

There are some challenges to the team’s continued efficacy and sustainability:
- Increasing demand for service challenges the teams to provide service in a timely manner. Outcomes (and subsequent cost savings) associated with shortened length of hospital stay and long-term care avoidance may provide justification for additional resources.
- Communications with care partners are a focus of continuous improvement and would address several of the suggestions for improvements, such as those related to the need
to better promote and market the team across sectors, clarify eligibility criteria and to connect health sectors.

Evaluation Limitations: There are several limitations to this evaluation. The number of clients, caregivers, and key stakeholders that could be interviewed for this evaluation was limited by the resources that were available, however, despite this it was apparent that saturation was achieved (no or minimal new information was generated from the last interviews conducted) and consistent themes were identified across the stakeholder groups. Data related to impacts of the team on the health care system is by self report and anecdotal. Quantitative data to support or refute identified impacts and challenges is not available from this evaluation. There is potential for duplication of reports in situations where both a client and their caregiver completed a survey; as survey completion was anonymous, it was not possible to separate this out.

NEXT STEPS:

Further research:  
- An investigation utilizing costing information and hospital data (e.g., ED readmission rates, reduced hospital admissions, reduced length of hospital stay) to compare CSRT clients with a group of clients not seen by CSRT would provide further evidence of effectiveness and cost benefit. A proposal for this project, in partnership with Lawson’s Aging, Rehabilitation and Geriatric Care Research team, has been submitted to the Canadian Institute for Health Research.

Expansion to other regions and sharing of lessons learned:  
- The success of the community stroke rehabilitation teams in this region makes it a potential model for other regions of the province. Despite research evidence supporting the use of community based stroke rehabilitation teams as an opportunity to improve quality and coordination of stroke care and to reduce costs associated with acute care use\(^2\), very few exist in community settings across the province.

- Sharing lessons learned from the development and implementation of the teams could inform expansion to other areas of the province. Attendance and presentations at regional, provincial, and national conferences will allow team members to celebrate successes and also to network with other stroke care experts and learn about opportunities for on-going performance improvement.

