

## Stroke Outpatients Embrace MyST's Team Approach and In-Home Visits

If Candace Coe was a quarterback for stroke patients she'd be coordinating a touchdown for stroke recovery with a new offensive team for outpatients.

As a clinical coordinator on the McMaster University, Aging Community and Health Research Unit (ACHRU) My Stroke Team (MyST) study, she is hearing how reassured and empowered stroke patients and their caregivers are to have help navigating outpatient rehabilitation services.

"The biggest thing I've learned is how invaluable it is to have a clinical coordinator for stroke patients," says Coe, who is an occupational therapist in the neurological outpatient department at Hamilton Health Sciences (HHS) "The stroke system needs to look towards that."



The ACHRU's [Strengthening Community-Based Stroke Care: A Feasibility Study of a Community Navigation and Rehabilitation Intervention that Includes a Mobile Health Solution. My Stroke Team \(MyST\)](#), is taking a step in that direction.

HHS has partnered with the ACHRU on the six-month intervention with staggered enrolment. This study involves 30 stroke survivors ( $\geq 55$  years) who are recovering from a stroke and have two more chronic conditions.

This is a new way of providing outpatient stroke rehabilitation services for older adults with multiple chronic conditions (MCC) and stroke living in the community, because it involves a stroke team (occupational therapy, physiotherapy, speech language pathology, social work, and registered nurse) who provide regular in-home visits and monthly case conferences, supported by the MyST web-based application (app).

Coe says being able to coordinate appointments for patients with other members of the stroke team, like a registered nurse (RN) or a social worker, is a huge improvement.

The opportunity to visit patients and their families in their home environment, or in the community, gives the team insight into how patients and their families are managing at home, that they normally would not have just seeing them in the outpatient department.

It's helped both patients and the healthcare providers. "They (patients) felt less anxiety about the future, and as we went along we could see their scores for reintegrating into the community were getting higher and higher. They were feeling better about their recovery and they had less anxiety about having another stroke and their health in general." She says patients also feel empowered by making some decisions for their recovery because they are involved in making decisions about their own care, and learned about home and community services that they didn't know existed.

As clinical coordinator, Coe recruited the patients into the study, conducted the initial interviews, and coordinated the development of a plan of care for each of the study participants. This involved determining which members of the team visit the patient, and working collaboratively with other home and community service providers involved in each patient's care, e.g., the Local Health Integration Network (LHIN), primary care, neurologist and physiatrist visits.

The stroke team has also been using the web-based MyST app to do all of their charting patient plans of care. While the app is still being tweaked, Coe says it is helpful with setting functional goals for a patient particularly when more than one member of the team is involved. "We can set timelines to that goal or make note of why that goal wasn't reached. Or why we need to push it back."

She says the app also allows the team to add in any information at any time and everyone on the team can see it. She likes to access a patient's visits and information so when she sees a patient she can easily access the information and she doesn't have to ask the same questions over and over and start from scratch.

She says it's an extremely complicated system for these stroke patients and their families to steer through because the health and social care services are set-up in silos and a lot of the care providers don't talk or discuss or share information. "My role has been to look at the whole picture and get all the information to try to link all the services together to meet the patients' needs. But it requires a lot of coordination timing and knowledge and background on what stroke recovery really should be and what is needed."

There are gaps in the current system and sometimes patients fall through the cracks, she says. For some patients, referrals haven't been made or they didn't go through and the patient ends up sitting at home waiting for the phone to ring while on the outpatient waiting list. So patients can have a lot of anxiety about what's happening to them, what's going to be happening and when their rehabilitation is going to start.

She says the study has the team thinking of a plan for the patient that is sustainable and they are trying to figure out how to cope and manage while they are in the community

and not regress. 'It makes us think beyond our silo and makes us think of the community and how we are function together. We are thinking about long-term sustainability, keeping that patient out of the hospital, keeping them healthy and happy longer term not just beyond our doors.'