Evaluation of a post stroke follow up service

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StrokeConnect

Supporting stroke survivors, their family and carers from hospital to home

Stroke FOUNDATION

› **Online information**, fact sheets and videos for family and friends

› **My Stroke Journey kit** provided in hospital to guide recovery

Arriving at hospital ››

› **StrokeLine's** health professionals are there for you every step of your journey

› **Follow up call** when you arrive home (in participating states)

Behind the scenes

› **My Stroke Journey** helps you at rehabilitation or home

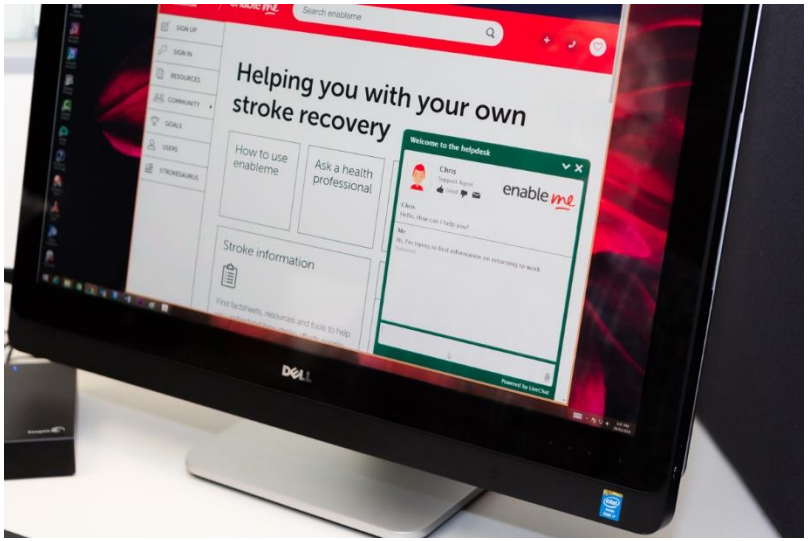
Discharge from hospital ››

To rehabilitation or home ››

› Join Australia's online stroke community **EnableMe.org.au**

Recovery ››

What is *Follow Up*

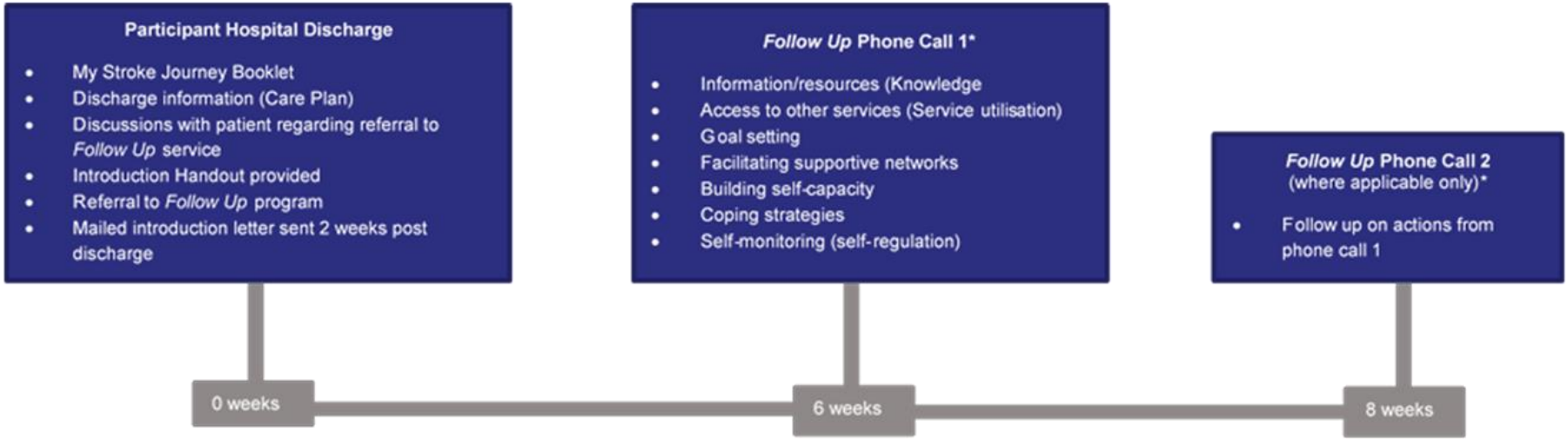


Aim:
To ensure stroke survivors, carers and families have what they need to achieve their best recovery and improve quality of life through:

- Provision of expert information, advice and support and ensure this is maintained throughout Stroke recovery
- Delivery accessible information and resources
- Enable connection and Community
- Partner with Health Professionals

What is *Follow Up*

- Outbound Telephone Service
- Referral into service by treating team
- Interdisciplinary team of allied health professionals with expertise in stroke
- Contact stroke survivors and carers ~6 weeks post-hospital discharge
- GP letter outlining service provided



Evaluation of the service

Aims:

To investigate clients, service officers, referring clinician and General Practitioners' perceptions of the *Follow Up* service strengths and weaknesses, assess changes in self-efficacy following the intervention, assess referral pathways, service delivery, communication and stakeholder engagement, and provide recommendations for ongoing evaluation.

Service Theoretical framework

Models and Key Construct

Chronic Care Model (CCM)[1]

CONSTRUCT = SELF-MANAGEMENT SUPPORT[2,3,4]

Principles of Chronic Condition Self-Management Support

- Knowledge of condition (2)
- Negotiate a care plan (3)
- Engagement in activities that project/promote health (4)
- Monitor and management signs and symptoms of condition (2 & 3)
- Manage physical, emotional and interpersonal relationship impacts of condition (3, 5 & 6)
- Adopt lifestyles that promote health (7)

MEASUREMENT ITEMS (See Table 1)

1. Demographics
2. Health Knowledge & Awareness
3. Chronic Condition Management
4. Health Service Utilisation
5. Social Support
6. Coping Planning
7. Healthy Lifestyles
8. Stroke Self-Efficacy
9. Goals
10. Satisfaction
11. Quality of life
12. Process

DESIRED HEALTH OUTCOMES

Short Term Desired Behavioural Outcomes:

1. Improved access and knowledge of health services
2. Improved health literacy in healthy lifestyle and secondary stroke risk factors
3. Improved self-management behaviours (e.g. management of physical and mental disabilities or management of medication)

Long Term Health Outcome

1. Improved stroke self-management
2. Improved quality of life

Evaluation Project Method

- **Recruitment**
  - Stroke Survivors, families and carers referred into service
  - Queensland Health staff
  - GP's
- **Consent**
  - Obtained as part of the delivery of the Follow Up service
- **Eligibility**
  - Stroke Survivors aged 18 years and older who are referred to the follow up service
  - TIA patients at high risk of multiple TIAs
  - Initially entering into Residential Aged care
- **Data Collection**
- **Client Surveys**
  - Baseline Survey
  - Follow up Survey 6 weeks post service call

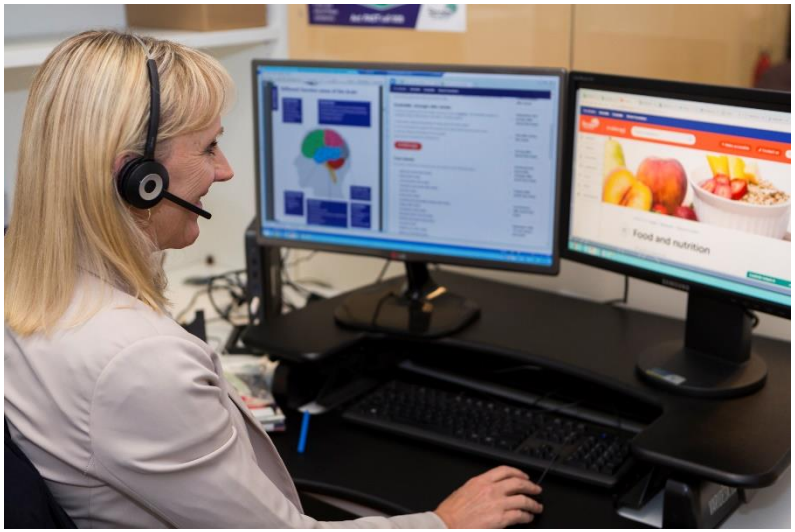
Key findings at a Glance

Tailoring services

Follow up team members provided tailored advice to suit their clients needs and health concerns.

- Clients presenting with risk factors discussed prevention with **98%** receiving information on high BP, high cholesterol and and overweight or obese; and
- **89.8%** of those who identified lifestyle risk factors.

- **100%** of clients reporting depression or anxiety received mental health resources
- **82%** reporting fatigue and **78%** reporting sensory impairments received appropriate resources.



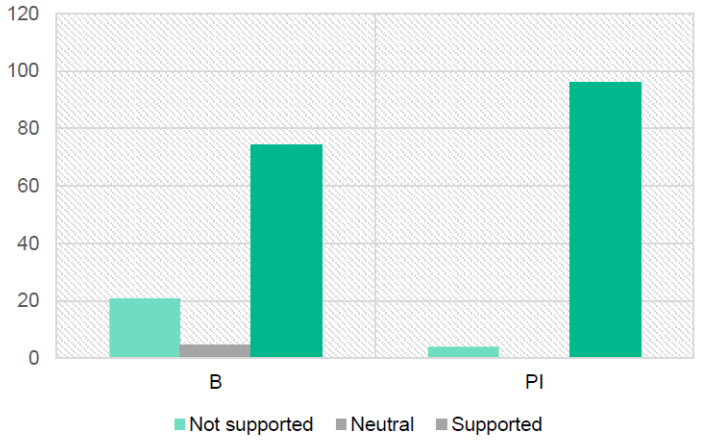
Key findings at a Glance

Impact Post Intervention

87% agreed that high cholesterol and poor diet and sedentary behaviour increases the risk of secondary stroke

74% adopted a healthier lifestyle including increased physical activity, maintaining a healthy weight and improving mental health

Utilisation of health services to a variety of specialties ***increased*** with the greatest utilisation to Psychologists



Perceptions of Support - GP

Key findings at a Glance

Satisfaction

85% were satisfied or very satisfied with the *Follow Up* service

92% were satisfied or very satisfied with the resources and materials

87% indicated that the service met almost or most of their needs

75% Hospital representatives; and

100% GPs agreed that the service improves knowledge of secondary risk factors of stroke and assist clients with self-managing and improving confidence post stroke.

'Very grateful for all the assistance given to me. Thank you'

Recommendations

- ***Quality of Delivery****:* Consider informing all clients about the availability of Chronic Disease Management plans;
- ***Client Outcomes:*** Implementation of a short screening tool at the beginning and end of each service call
- ***Client Outcomes:*** Consideration of a short distress screening tool at the beginning and the end of each call

Limitations

- Evaluation only conducted in a 6 month timeframe
- Limited number of client data collected
- Sample size too small to detect statistical difference for QoL and Self efficacy

Questions

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References

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“I never knew a simple health check could have prevented my stroke”
- **Stephen** stroke survivor