

ALBERTA PROVINCIAL STROKE STRATEGY PILLAR COMPONENTS

APSS PILLARS KEY COMPONENTS OF OPTIMAL STROKE CARE			
Health Promotion and Disease Prevention	Emergency Services and Acute Care	Rehabilitation and Reintegration	Provincial Evaluation and Quality Improvement
<p>Primary Prevention</p> <ul style="list-style-type: none"> ▪ Population health programs to decrease the development of risk factors ▪ Primary prevention programs focused on established disease risk factors for stroke (hypertension, cholesterol, diabetes, AF) ▪ Management of risk factors (leverage existing initiatives Chronic Disease Management, Primary Care Networks, Health Link etc.) <p>Awareness</p> <ul style="list-style-type: none"> ▪ Organized public awareness programs on signs of stroke and emergency response <p>Secondary Prevention</p> <ul style="list-style-type: none"> ▪ Secondary stroke prevention for high risk individuals (TIA, previous strokes, other high risk populations) including a plan for lifestyle modification, pharmacotherapy, access to education resources and communication with family physician ▪ Early carotid revascularization 	<p>Acute Episode</p> <p>Notification and Response of EMS</p> <ul style="list-style-type: none"> ▪ EMS awareness, rapid assessment and transport protocols to nearest primary or comprehensive stroke centre <p>Acute Treatment of Stroke in ED</p> <ul style="list-style-type: none"> ▪ Non-primary stroke hospitals have written protocols to transfer patients in timely way to the appropriate destination ▪ Protocols and stroke team for acute stroke in ED ▪ Timely neuroimaging ▪ Early and appropriate acute stroke care +tPA within 3 hours/or -tPA <p>Inpatient Care for Stroke Admissions</p> <ul style="list-style-type: none"> ▪ Stroke unit or geographically designated beds ▪ Evidence-based pathways/protocols to ensure organized interventions, targeting prevention of complications and ensuring early mobilization and rehabilitation ▪ Multidisciplinary stroke team with enhanced knowledge of stroke care and mandate to coordinate care ▪ Notification of family physician during all phases of care ▪ Early discharge planning and smooth transitions to ensure appropriate and timely access to service (education, support, follow-up instructions, primary care arrangements) ▪ Standardized information and processes transferred to ensure continuity of care and case management 	<p>Inpatient Rehabilitation</p> <ul style="list-style-type: none"> ▪ Standardized (system) screening evaluation to determine impairments and most appropriate level of rehabilitation ▪ Comprehensive rehab plan to initiate early, intensive, coordinated multidisciplinary stroke rehab. Recovering movement, daily activities, communication ▪ Rehab plan reflects severity of stroke ▪ Early discharge planning and smooth transitions (education, support, follow-up instructions, primary care arrangements, secondary prevention services) ▪ Standardized information and processes transferred to ensure continuity of care and case management <p>Going Home - Post-Discharge Rehabilitation and Care</p> <ul style="list-style-type: none"> ▪ Ensure appropriate level of rehabilitation in various settings ▪ Follow-up at regular intervals ▪ OPT/Community Rehab ▪ Home Care ▪ Care Centres and Assisted Living <p>Stroke ‘Thrivers’/Community Reintegration</p> <ul style="list-style-type: none"> ▪ Becoming social, dealing with emotions, returning to work, getting around ▪ Support from families and friends ▪ Caregiver support and education 	<p>Monitoring and Evaluation</p> <ul style="list-style-type: none"> ▪ Strategy Evaluation Framework (Performance measures for stroke components (Outcomes and Implementation) ▪ Provincial Approach <p>Specific Activities</p> <ul style="list-style-type: none"> ▪ Quality of Data - Validation of Stroke Diagnostic Codes ▪ Stroke Audit Tools ▪ Registry/Chart Review audit for baseline and outcomes ▪ Stroke Surveillance Systems