A Scalability Assessment of the **Transitional Care** Stroke Intervention in Community Stroke Rehabilitation

Provincial Stroke Rounds

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Land Acknowledgement

McMaster University recognizes and acknowledges that it is located on the traditional territories of the Mississauga and Haudenosaunee nations, and within the lands protected by the Dish With One Spoon wampum agreement.

Objectives of Today's Rounds

1. Learn about the Transitional Care Stroke Intervention (TCSI) in community stroke rehabilitation.

2. Understand factors that influence the scalability of the TSCI across three diverse community stroke rehabilitation programs in Ontario.

Study Background

Study Purpose

Scalability Assessment

To assess the scalability and determine the readiness for scale-up of the Transitional Care Stroke Intervention with three CSR programs in Ontario selected to reflect diversity in:

- geography (urban/rural locations, northern locations)
- hospital-based outpatient clinics/in-home settings
- presence/absence of system navigator role

Transitional Care Stroke Intervention (TCSI)

- Co-designed with a variety of stroke experts, including patient research partners, healthcare providers, and policy makers
- Evaluated to date:
  - pragmatic feasibility study (2014-2017)[3]
  - multi-site pragmatic randomized controlled trial (2020-2022)[4]
  - scalability assessment (2023-2024)

- Six-month, virtual, evidence-based, patient-oriented intervention designed to complement standard outpatient stroke rehabilitation services:
  - to improve the quality and experience of transitions
  - to address gaps in post-acute care for older adults with multimorbidity receiving community stroke rehabilitation services
  - core components of intervention were based on literature and were designed to support self-management.

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Transitional Care Stroke Intervention
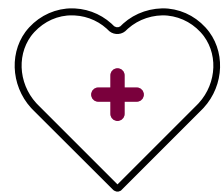
Care coordination by dedicated Care Coordinator/System Navigator & development of patient-centred care plan

Early **post-discharge** phone call

Up to 6 virtual **home visits**

Monthly virtual i**nterprofessional team conferences**

Secondary stroke prevention & health promotion education

Self-management & **community re-integration** support

System navigation support aided by "My Stroke Recovery Journey" Website

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Transitional Care Stroke Intervention

Activities During Virtual Home Visits

- Screening & assessment with standardized tools
- Use of evidence-based guidelines to prevent and manage stroke, other comorbidities
- Medication review & reconciliation
- Self-management support (problem-solving, decision-making, and goal-setting)
- Stroke management and prevention education
- System-navigation support
- Use of My Stroke Recovery Journey website
- Caregiver assessment and support
- Alerts (depressive symptoms, medication, dementia)

Transitional Care Stroke Intervention

System Navigation Support

- Identify & address risk factors for adverse events, e.g., avoidable hospital readmissions, safety issues
- Arrange community services & follow-up health-care appointments

- Facilitate communication between the patient, care partner, and health care team
- Support linkages & referrals to relevant health and social service providers
- Develop & evaluate an individualized patient-centred plan of care

Transitional Care Stroke Intervention
Results from Multi-site Pragmatic Randomized Controlled Trial

Primary Outcome

- No significant differences in baseline to 6-month risk of hospital re-admission

Secondary Outcomes

- Significant differences in physical functioning, stroke self-management, and patient experience

Cost Analysis

- No significant differences in total costs from baseline to 6-month

Implementation Facilitators

- Dedicated care coordinator/system navigator

- Use of standardized clinical assessment tools and alerts

- Shared electronic communication

Scalability Assessment
Intervention Scalability Assessment Tool

- Scalability is the ability of a health program demonstrated to be effective on a small scale and/or under controlled conditions to be expanded into routine practice to reach a greater proportion of the eligible population while still retaining effectiveness

- Scalability assessment is a systematic process to assess the suitability of a health program for population scale-up[5]

RESEARCH   Open Access

Intervention Scalability Assessment Tool: A decision support tool for health policy makers and implementers

Andrew Milat[1,2,3*†] iD, Karen Lee[2,3†], Kathleen Conte[2], Anne Grunseit[2,3], Luke Wolfenden[2,4], Femke van Nassau[5], Neil Orr[6], Padmaja Sreeram[7] and Adrian Bauman[2,3]

Check for updates

Scalability Assessment
Intervention Scalability Assessment Tool

Asks participants to consider:

Part A

- Problem

- Intervention

- Political context

- Evidence of effectiveness

- Intervention costs and benefits

- transitions in stroke care

- proposed program to address the problem (i.e., TCSI)

- current strategic/political/environmental context

- level of evidence available to support scale up of program

- known costs and quantifiable benefits

Scalability Assessment

Intervention Scalability Assessment Tool

Asks participants to consider:

Part B

- Fidelity & adaptation

- Reach & acceptability

- Delivery setting & workforce

- Implementation infrastructure

- Sustainability

- proposed changes to program required

- reach and acceptability to the target population

- the delivery setting and current workforce

- potential requirements for scale up

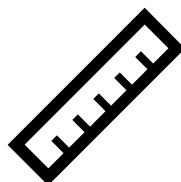- how could the program be sustained over time

Scalability Assessment

Data Collection and Analysis [6]
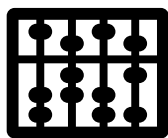
Working Group meetings

Working Group rating exercise

Document review and analysis

Key informant interviews

Quantitative analysis of ratings

Qualitative analysis of meeting minutes and interviews

Results

- Benefits to implementing the TCSI
- Implementation facilitators
- Implementation challenges

Benefits to Implementing the TCSI

- Evidence-based model

- Improved system navigation

- Enhanced post-stroke self-management skills

- Successful community re-integration

Support the person with stroke at critical transitions

- Support with system navigation

- Continuity of care during transitions

- Reduce the risk of "*things falling through the cracks*"

Implementation Facilitators

System-Level

- TCSI aligns well with Ontario Health initiatives such as the provincial model of care for CSR; core functions of navigation
- Could leverage other initiatives
  - CSR indicators and minimum data set for provincial approach to CSR data collection & reporting;
  - Ontario Health Teams' work on integrated care pathways for chronic conditions;
  - reorganization of home care
- Ontario Regional Stroke Networks

CSR Program-Level

- TCSI is consistent with local priorities and existing practice
- Some core components already part of usual care
- Adaptations to the local context and population
- Access to Regional Stroke Navigator or Acute Care Stroke Navigator roles
- Existing relationships with community supports and service providers
- Electronic health care records

Implementation Challenges

System-Level

- System integration, i.e., poor communication and coordination due to siloed services and health care sectors
- Lack of access to standard CSR in parts of the province; waitlists
- Lack of health human resources; shortage of primary care providers

CSR Program-Level

- Additional and ongoing funding
- Education, training and support
- Common digital platform
- Program quality monitoring

"What we've been learning from some of the different sites is that any kind of outcome evaluations that they're doing, it's an extra manual step for them to collect any kind of metrics to monitor the program and most folks have been saying they'd love to have some sort of infrastructure that automated that and made it easier to see."
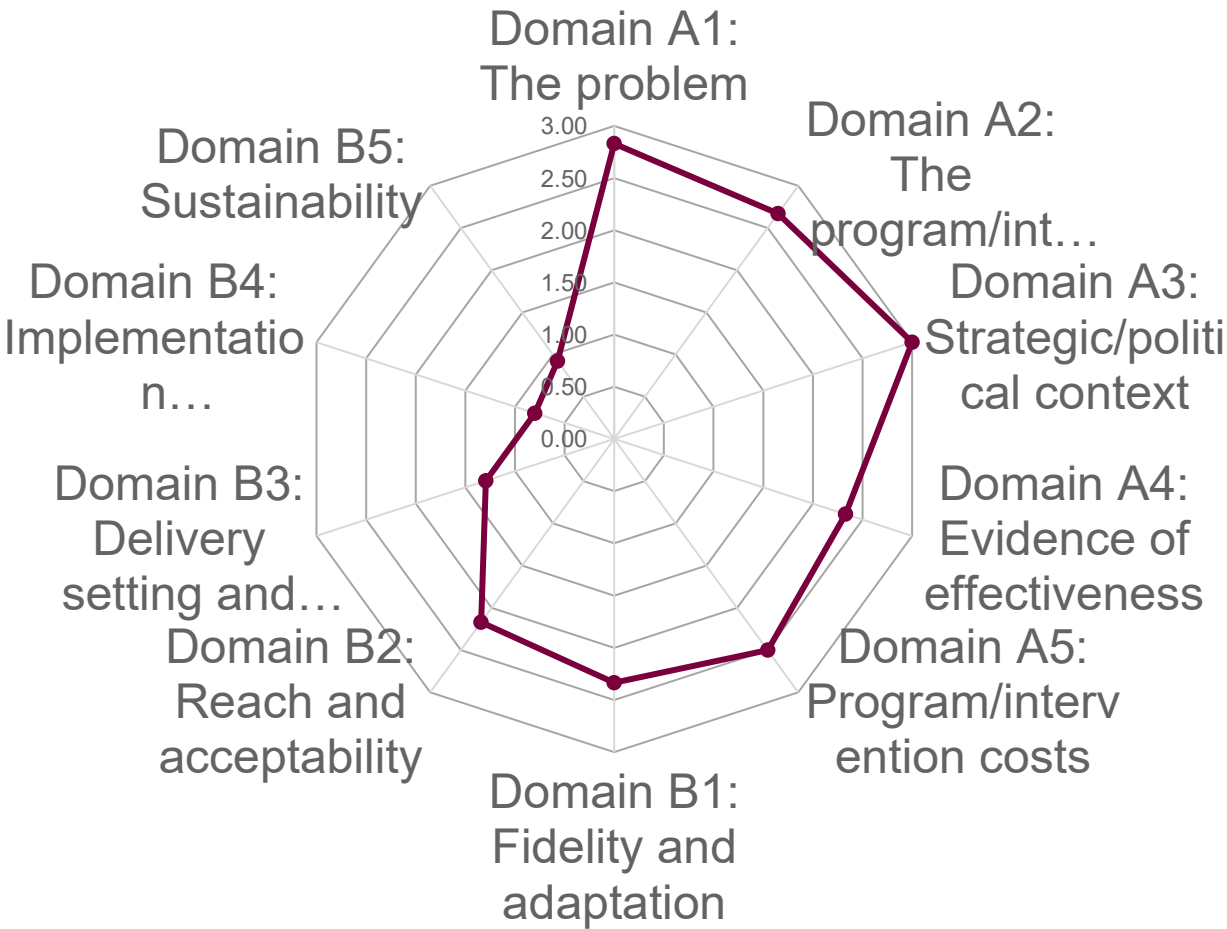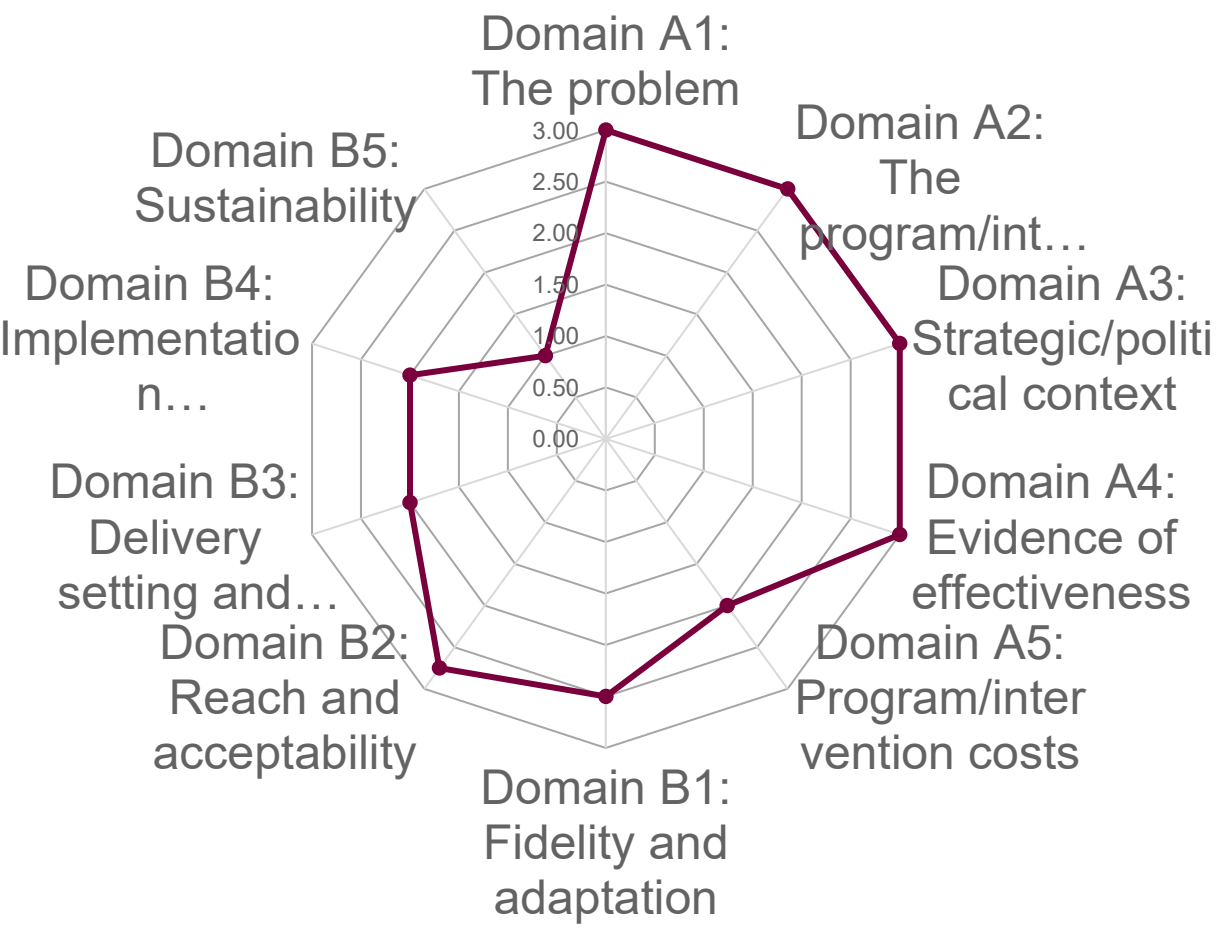
Site-Specific Scalability Assessments
Readiness Ratings
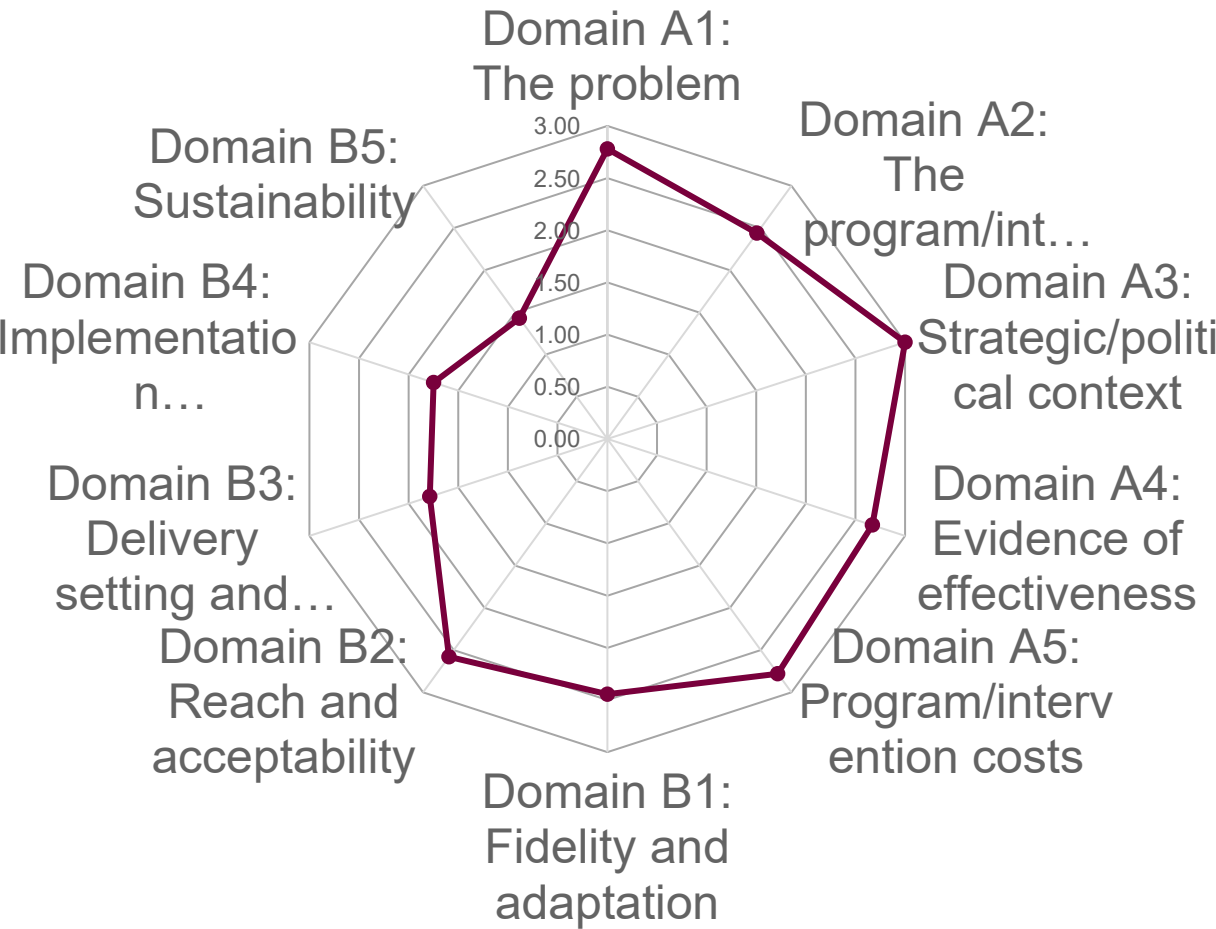
Site 1: Home-based

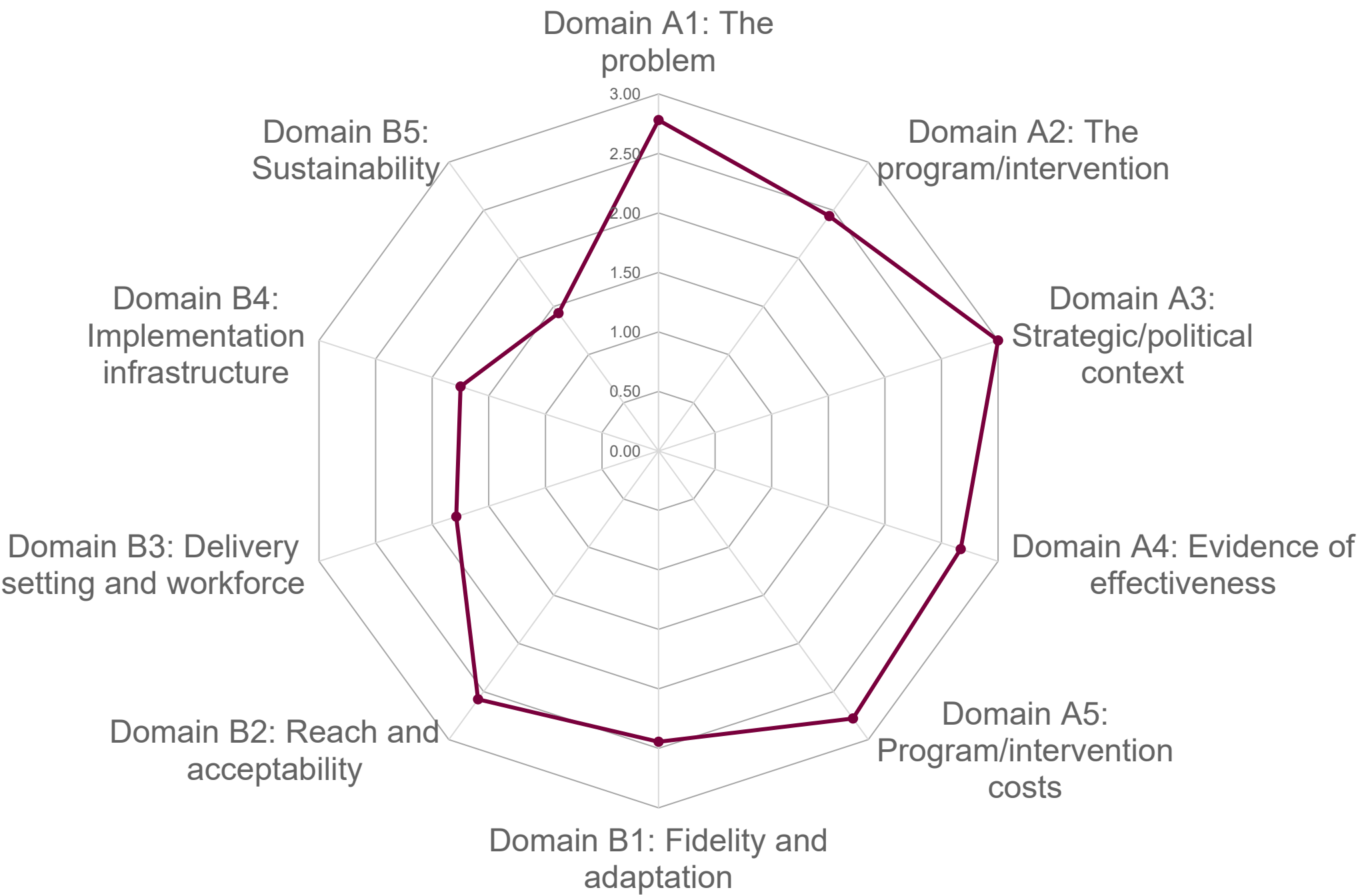**Site 2: Rural/remote hospital outpatient**

Site 3: Hospital outpatient with navigator role

Site-Specific Results
## Site 1: Home-based CSR program

- Agreement that a dedicated care coordinator/system navigator would enhance care delivery
- Adaptations would be required for local context:
  - Use of stroke care binder instead of website to support care planning and system navigation
  - Leverage other programs to conduct early post-discharge call (i.e., acute care unit); and provide community support post-discharge from CSR (i.e., community peer education and support group)

Site-Specific Results

Site 2: Rural/remote hospital-based outpatient CSR program

- Recommended regional care coordinator role outside of CSR team could provide navigation support
- Adaptations would be required for local context:
  - Computer-facilitated virtual care would not be ideal for all persons with stroke and care partners
  - Group-based education and goal-setting
  - Leverage other programs to provide support post-discharge from CSR (i.e., community self-management program)
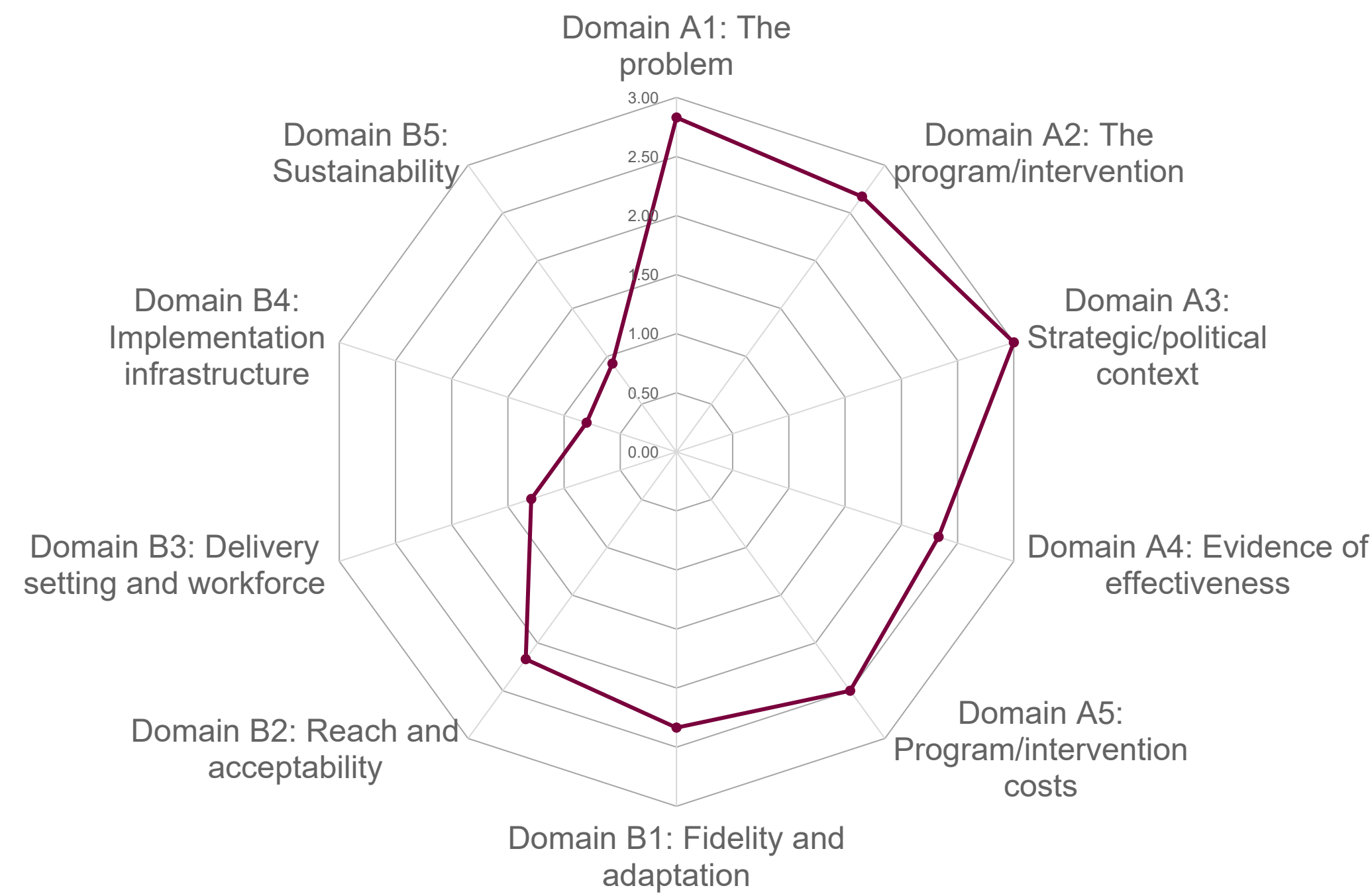
Site-Specific Results

Site 3: Hospital-based outpatient CSR program with navigator role

- Recommended dedicated care coordinator outside of the CSR team in addition to the navigator role on the team to facilitate connections to the community and improve community re-integration
- Adaptations would be required for local context:
  - Group-based education and peer support
  - Leverage existing databases of community programs for stroke instead of adapting the My Stroke Recovery Journey website
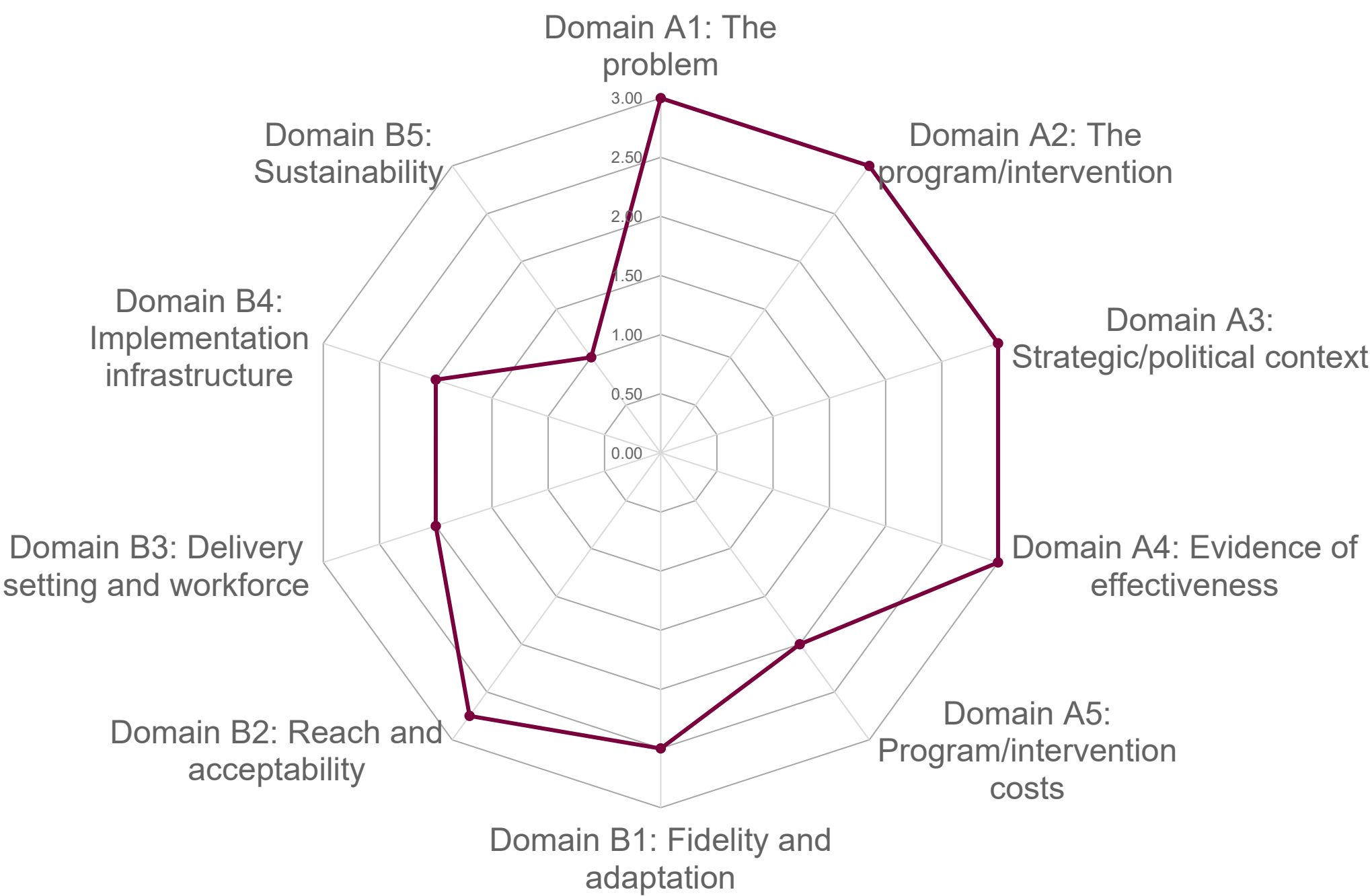
Conclusions

- Participants shared benefits to implementing the TCSI
- The scalability assessment identified facilitators and barriers to the scalability of the TCSI
- Scalability assessment can be a useful tool to assess readiness for implementation

Conclusions

- Evidence-based programs require adaptations to the local context and population
- Co-design of program adaptations should be done locally with patient partners, health and community care providers and leaders, and decision-makers
- CSR Community has a wealth of knowledge and innovations to achieve integrated care

Next Steps

Future Partnerships

- Conducting scalability assessments with other programs
- Developing virtual care as a facilitator of transitional care
- Understanding the effectiveness of different models of navigation in CSR
- Developing and evaluating a data collection and reporting strategy for CSR
- Collating and evaluating an implementation toolkit for the TCSI

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