Aging, Community and Health RESEARCH UNIT

McMaster University

Transitional Care Stroke Intervention (TCSI) Study
A pragmatic randomized controlled trial of an outpatient-based virtual transitional care stroke care intervention

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Impact Statement:

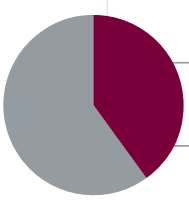
Effective, scalable and adaptable models of integrated care are needed to improve the experience and quality of transitions from hospital to home for older adults with stroke and multiple chronic conditions.

WHY?

Stroke is the leading cause of death and adult disability in Canada.

Every year in Canada, there are over **50,000 new strokes–one stroke every 10 minutes**. About **426,000** Canadians are living with the effects of stroke.

Up to 80% of older adult stroke survivors are discharged home following hospitalization and will require ongoing rehabilitation and support;



The risk of recurring stroke is high within the first year **(nearly 40%)**

Approximately 92% of older adults with stroke have at least two additional chronic conditions

Stroke costs the Canadian economy more than **$3.6 billion yearly** in physician services, hospital costs, lost wages, and decreased productivity.

WHAT?

The purpose of this study is to evaluate the implementation and effectiveness of a new Transitional Care Stroke Intervention compared to usual stroke care on hospital readmission, mental and physical functioning, self-management, patient experience, and health service use and costs in older adults with stroke and two or more chronic conditions.

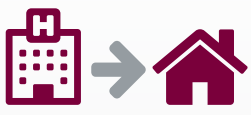
The Transitional Care Stroke Intervention is a virtual six-month program delivered by an Interprofessional care team of outpatient healthcare providers. The team includes a Care Coordinator, Occupational Therapist, Physical Therapist, Registered Nurse, Speech Language Pathologist and Social Worker.

HOW?

The overall goal of the Transitional Care Stroke Intervention is to improve the quality and experience of transitions from hospital to home for older adults with stroke and multimorbidity.

Transitional Care Stroke Intervention components include:

1) Development of a comprehensive discharge plan using the Patient Oriented Discharge Summary (PODS)



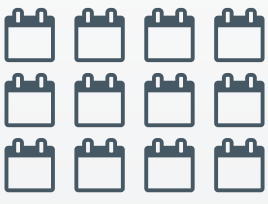
2) A post-discharge telephone call by the Care Coordinator

3) Up to six virtual visits by an interprofessional team

4) Care coordination and the development of a patient-centred care plan

5) System navigation support providing linkages to primary care providers and other health and community services supported by an online tool, "My Stroke Recovery Journey" website

6) Monthly interprofessional team case conferences



What do the researchers expect to find?

Researchers expect that the Transitional Care Stroke Intervention will result in a decrease in (all cause) hospital readmissions, and improvements in mental and physical health, self-management, and patient experience at no additional cost, from a societal perspective.

Key Messages:

- Older adults with stroke have high health and social complexity and multimorbidity, requiring ongoing care from multiple health and community service providers
- Post-acute stroke care is complex and fragmented with poor quality transitions from hospital to home resulting in increased risk of recurrent stroke, readmission to hospital, and poor health outcomes.
- Poor quality transitions from hospital to home have been linked to readmission, increased healthcare costs, lower quality of life and reduced patient and caregiver satisfaction.

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CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

McMaster University
Institute for Research on Aging