Aging, Community and Health RESEARCH UNIT

McMaster University

Transitional Care Stroke Intervention (TCSI) Study

Implementation of a virtual transitional care intervention to optimize hospital to home transitions for older adults with stroke and multimorbidity

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Background:

Older adults with stroke and multi-morbidity experience frequent and fragmented care transitions which are often poorly supported and coordinated after leaving the hospital. The Transitional Care Stroke Intervention (TCSI) was designed to improve the quality and experience of transitions from hospital to home for older adults (> 55 years) with stroke and multi-morbidity and their family caregivers.

The TCSI is a complex 6-month intervention provided by an interprofessional (IP) team of health care providers (comprised of Occupational Therapist, Physiotherapist, Registered Nurse, Social Worker, Speech Language Pathologist) that includes:

- early post-discharge follow-up,
- system navigation support and care coordination,
- up to 6 virtual home visits by the IP team
- IP team conferences,
- self-management and community re-integration support,
- secondary stroke prevention and health promotion education,
- linkages to local health (primary care, outpatient rehabilitation, community services) and social services.

Aim:

To describe the facilitators and barriers to implementing the TCSI from the perspective of healthcare providers and managers.

Design and Methods:

- A qualitative descriptive study design was used.
- Healthcare providers involved in delivering the TCSI from two study sites in Ontario, Canada were included.

Data collection consisted of…

6 surveys with a total of **4** managers

4 focus groups with a total of **12** providers

24 monthly outreach meetings with the (IP) care team

10 meetings with the Care Coordinators, and study-related documentation.

- The Consolidated Framework for Implementation Research informed a directed content analysis approach.

Key Findings:

Facilitators:

- Including a Registered Nurse in the stroke rehabilitation interprofessional (IP) team was seen as essential for medication management and preventing and managing chronic conditions in this complex population
- The screening tools and Alerts facilitated the connection between the IP team and the patient's primary care physician.
- Standardized assessments facilitated the identification and management of issues proactively
- Self-management tools assisted providers and participants in creating and meeting patient care goals
- SharePoint, a team collaboration electronic platform, securely shared patient information among the IP team members.

Barriers:

- Providers found it challenging to conduct the visit and complete the usual and study-related documentation in one hour.
- Some patients found virtual visits challenging
- Providers found it challenging to deliver care virtually, including the inability to conduct a hands-on assessment. Demonstrating exercises and conducting a medication review and a home safety assessment was particularly problematic when completed virtually.

This project was part of a study funded by the Canadian Institutes of Health Research (CIHR, ref no: PJT 166026). This project was also undertaken, in part, thanks to funding from Dr. Markle-Reid's Canada Research Chairs program.

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