**TRANSITION MANAGEMENT THROUGH THE CONTINUUM OF CARE**

**STROKE RECOGNITION/ PREVENTION**
- Suspected TIA or non-disabling ischemic stroke
  - Immediate clinical evaluation and management
  - Further medical investigations; establish Dx, including use of risk stratification tool
  - Consult to stroke specialists
  - Stroke prevention education, risk factor management
  - OT: functional/cognitive/safety assessment if required
  - PT, SLP, SW referral as required
  - Home Care if required

**PREHOSPITAL PHASE/ EMS**
- EMS management of suspected stroke
  - Transport without delay using acute stroke algorithm
- Emergency department stroke care
  - Immediate clinical evaluation & investigations
  - Initiate treatment/management
  - Consult neurology and other specialist(s)

**ACUTE STROKE CARE**
- Specialized geographically defined stroke care; interprofessional team; initiate consults; initial rehab and other provider assessments; acute care management
- Prevention and /management of complications
- Advanced care planning, end of life care

**STROKE REHABILITATION**
- Primary care follow up
- Refer to rehab (Outpatient, Home-based, Day Hospital) if indicated
- Stroke prevention education
- Home Care, Dietitian, other
- Community resources
- Client and caregiver education
- Stroke recovery groups

**COMMUNITY MANAGEMENT / REINTEGRATION**
- Primary care follow-up
- Client-centered rehab; outpatient, home-based, day hospital, other
- Community reintegration
- Client and caregiver education
- Home Care, Dietitian, other
- Community resources
- Stroke recovery groups

**Important Elements and Goals for Transition Management:**
- Appropriate, safe and timely access to required services
- Efficient, seamless, flexible, fluid, transparent, easy to navigate
- Ongoing medical management
- Client-centered practice
- Inter-professional team approach and communication
- Effective transfer of information between referring & receiving clinicians
- High quality referral and transition
- Ongoing client, family & caregiver education; involve in care planning
- Opportunities / processes to re-access rehab & community services
- Equitable access

**Common Transition Points for Persons with Stroke**
- Primary care / Physicians Office
- Emergency Department
- Acute Care/Acute Stroke Unit
- Rehabilitation (inpatient, outpatient, day hospital, home-based /community)
- Home Care Program
- Interim and Long Term Care
- Palliative Care
- Home
- Community Services/Resources
- Peer Support /Stroke Recovery Support Groups

Stroke severity and other factors determine pathway followed along the continuum of care. Although this diagram depicts a linear path from left to right, not all persons with stroke move through the entire continuum, or in a left right direction. Regardless, elements below each phase should be considered in the care and transition of all persons with stroke.