Definitions

Transition refers to the movement of patients among healthcare locations, providers, different goals of care, and across the various settings where healthcare services are received. *Refer to Figure 2 The Canadian Best Practices Model for Transitions of Care Following a Stroke.*

Transition management includes working with patients, families, and caregivers to establish and implement a transition plan that includes goal setting and that has the flexibility to respond to evolving needs. Successful transition management requires interprofessional collaboration between healthcare providers, patients, families, and caregivers. It encompasses the organization, coordination, education, and communication required as patients, families and caregivers move through the stages and settings for stroke treatment, recovery, reintegration, adaptation, and end-of-life care.

The goal of transition management is to facilitate and support seamless patient, family, and caregiver transitions across the continuum of care, and to achieve and maintain optimal adaptation, outcomes, and quality of life for patients, families and caregivers following a stroke. This incorporates physical, emotional, environmental, financial and social influences.

Caregiver, within this module, refers to a more informal network of care that supports a person who has had a stroke, such as family, friends, and neighbours.

Community, within the context of the Canadian Stroke Best Practice Recommendations, is defined from a multi-dimensional perspective: as the physical, social, and care environment where individuals reside after experiencing a stroke. Community as an environment would include any setting that is outside the hospital settings, where one would reside and resume life roles and activities following a stroke. Therefore, community as an environment would include family home, assisted living, long-term care, and other residential settings.

Community Reintegration involves return to participation in desired and meaningful activities of daily living, community interests and life roles following a stroke event. The term encompasses the return to active community living and contributing to one's social groups and family life. Community reintegration is a component in the continuum of stroke care; rehabilitation includes identifying meaningful goals for community reintegration and through structured interventions facilitates resumption of these activities to the best of patient abilities. The stroke survivor, family, friends, stroke recovery associations, rehabilitation programs and the community at large are all integral to successful community reintegration.

Home Health Care, also referred to as 'home care', is defined as providing medical, nursing, rehabilitation and personal care services to patients in a home setting rather than in a medical facility. Home care services enable patients to remain safely in their home by increasing their independence to tend to their everyday needs at home, continuing their rehabilitation therapy, promoting ongoing recovery, identifying risks, facilitating home-modifications, and providing assistance for personal care and mobility.

Home health care may include skilled nursing services and social workers, in addition to speech-language pathologists, occupational and physical therapists, and personal care workers. In many cases, it includes assistance with cooking and other household chores, and assistance with financial management. Home health care professionals monitor ongoing medical and rehabilitation needs, medication compliance and management, access to disability services, vocational assistance, and caregiver support and burden. Home-based care may be provided exclusively in the home or combined with care in the community (such as in day centres or under arrangements made for respite care). In parts of Canada, some home care services, such as rehabilitation services, are also available for residents in assisted living and long-term care settings.

Long-term care is the provision of formal organized institutional care for three or more unrelated people in the same place. Long term care is provided for people of all ages who have long-term health problems and need assistance with the activities of daily living (ADL) in order to enjoy a reasonable quality of life (World Health Organization [WHO], 2000). The goal of long-term care is to ensure that an individual who is not fully capable of long-term self-care can maintain the best possible quality of life, with the greatest possible degree of independence, autonomy, participation, personal fulfilment, and human dignity.

The need for long-term care following a stroke is influenced by changing physical, mental, and/or cognitive functional capacities, their abilities and levels of independence prior to the stroke, and the availability of family and caregivers. Many people may regain lost functional capacities over a shorter or longer period of time following stroke, while others decline. The type of care needed and the duration of such care are thus often difficult to predict (WHO).

Each long term care home provides an organized 24 hour program of nursing, personal support, medical, pharmacy and interdisciplinary care services based on the assessed needs of residents and guided by an individual written plan of care. Appropriate long-term care includes respect for each individual's values, preferences, and needs. In many provinces in Canada, each long term care home is considered to be primarily the home of its residents. It is to be operated to promote and maximize independence of each resident as well as to provide dignity and security, safety and comfort and to meet the physical, psychological, social, spiritual and cultural needs of its resident population. Admission to a long term care home is based on provincial health insurance eligibility and an independent assessment by a case manager or community-care service provider (Ontario Long Term Care Association).

Self-management, in this document, refers to the ability of individuals to manage all aspects of their health following a stroke. It includes knowledge, skills, attitudes and behaviours for managing physical, cognitive and lifestyle changes, in addition to managing symptoms, treatment (rehabilitation), and secondary prevention strategies. It involves active participation of the individual in a plan developed collaboratively with healthcare professionals. The goal of self-management is to empower the individual to have a better quality of life by developing self-efficacy, which is the level of confidence than an individual has in their ability to succeed in coping with their condition.

Stroke Navigator/Case Manager is a specific health care professional role which provides patient and family-centred support to stroke survivors and their families needed to successfully transition across the continuum of stroke care (including stages and settings of care. The stroke navigator/case manager is often a social worker or similarly trained professional, and is often engaged in the acute care phase, and in many regions, continues on for the first six months following stroke, depending on patient and family needs.

The stroke navigator/case manager works closely with other health, social care, voluntary and community providers to ensure a seamless delivery of care and service. This is accomplished by providing information on available services, processing referrals, linking with primary care providers and other medical specialists required by the patient, and assisting patients and families to address and access financial, transportation, and other concerns that may negatively impact recovery and successful transitions. Additional roles should also include facilitating contact with stroke support organizations and local peer support groups for patients and families following stroke. The stroke navigator/case manager also provides emotional support to stroke patients, families and caregivers, and assists with the practical aspects of adaptation following stroke (Stroke Foundation, United Kingdom).

Support for patients, families and caregivers following stroke refers to providing direct care, access to required services, and facilitating linkages to resources to ensure that patient, family and caregiver needs are met throughout the continuum of stroke care. The goal of patient, family and caregiver support is to equip each individual with the tools and information required to manage their recovery or

the recovery of a family member after stroke and optimize participation and fulfillment of life roles; tailored to unique needs, coping mechanisms, strengths, challenges and living situation.

Supported Living Environments refers to residential living locations where individuals may transition following acute and sub-acute care for a stroke, and where they continue to receive healthcare services within a coordinated and organized system. The levels of support and service received are dependent on the individual's physical, functional and cognitive abilities and ongoing health care needs, as well as available social support from family members and caregivers. Supported living environments are settings where individuals can maintain as much control over their lives as possible, while receiving the supports they need to maintain their health and safety.

Supportive living environments may include a range of settings and support service levels, such as: private home or residence where health care services are brought to the stroke survivor; group settings such as lodges, transitional care or respite centres where the stroke survivor resides with others with similar care and support needs; assisted living settings where the individual has their own private room(s) within a residential setting and access to personal care support, group meals, organized social activities, and transportation; advanced assisted living and full care environments such as nursing home settings.

Training, within the context of this module, training refers to activities aimed at acquiring knowledge and skills necessary for the person with stroke, families and caregivers. Training activities are bidirectional and collaborative between the healthcare providers, patients, family and caregivers.