Canadian Stroke Best Practices

CANADIAN STROKE BEST PRACTICE RECOMMENDATIONS

Rehabilitation, Recovery and Community Participation Following Stroke

Part One: Stroke Rehabilitation Planning for Optimal Care Delivery

Evidence Tables

Outpatient, Community-Based Stroke Rehabilitation & Early Supported Discharge

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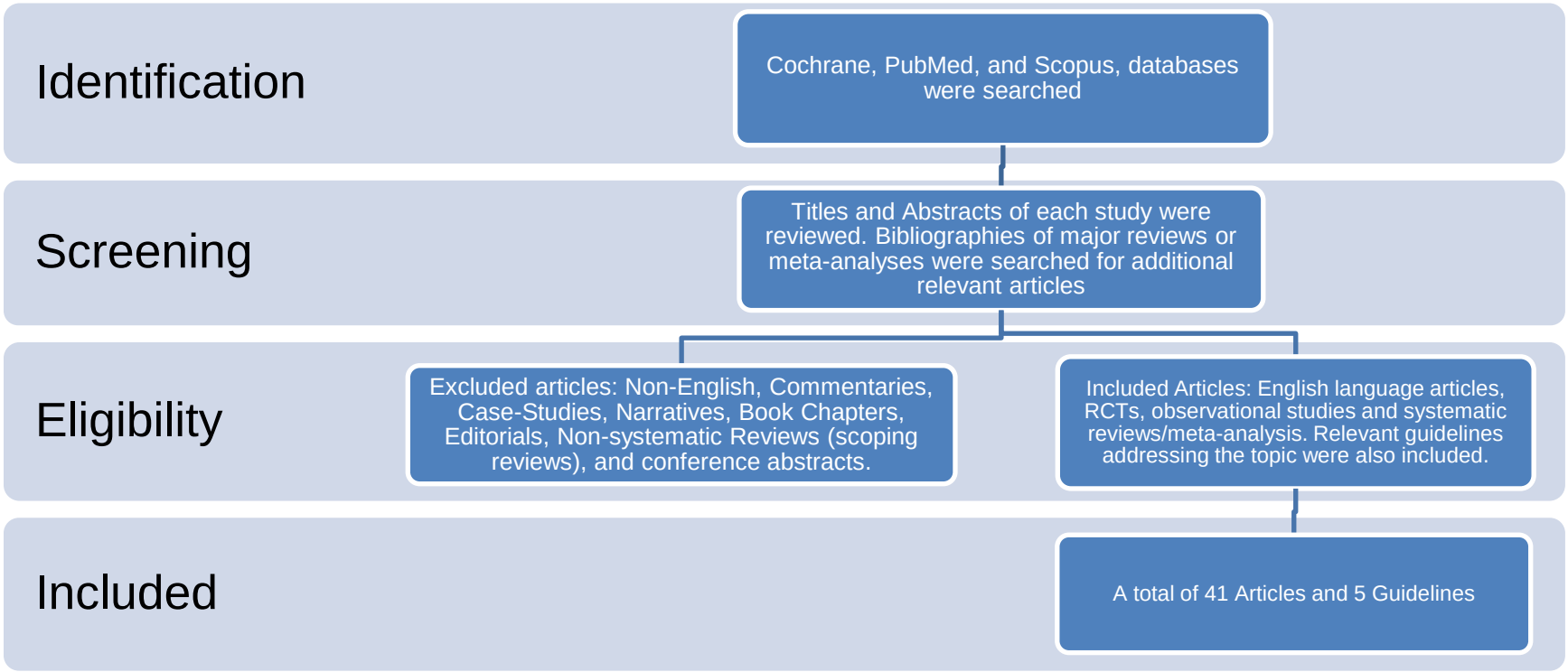
Table of Contents

Search Strategy



Cochrane, PubMed, and Scopus databases were searched using terms such as Stroke AND (“early supported discharge” OR outpatient OR community OR home) AND (rehabilitation OR therapy OR intervention). Titles and abstract of each article were reviewed for relevance. Bibliographies were reviewed to find additional relevant articles. Articles were excluded if they were: non-English, commentaries, case-studies, narrative, book chapters, editorials, non-systematic review, or conference abstracts. Additional searches for relevant best practice guidelines were completed and included in a separate section of the review. A total of 41 articles and 6 guidelines were included and were separated into categories designed to answer specific questions.

Published Guidelines

Guideline	Recommendations
Management of Stroke Rehabilitation Working Group. VA/DoD clinical practice guideline for the management of stroke rehabilitation. Washington (DC): Veterans Health Administration, Department of Defense; Version 5.0 – 2024. **Available at: https://www.healthquality.va.gov/guidelines/Rehab/stroke/**	There is insufficient evidence to recommend for or against implementing transitional care rehabilitation interventions (e.g., home-based services after hospital discharge) or early supported discharge to improve activities of daily living or functional disability following stroke. Neither for nor against
Mead GE, Sposato LA, Silva GS, Yperzeele L, Wu S, Kutlubaev MA et al. **Systematic review and synthesis of global stroke guidelines for the World Stroke Organization.** ***Int J Stroke*. 2023 Jun;18(5):499-531.**	Offer early supported discharge services for those with mild to moderate disability (Strong recommendation)
National Clinical Guideline for Stroke for the UK and Ireland. London: Intercollegiate Stroke Working Party; 2023 May 4. **Available at: www.strokeguideline.org.** **(selected)**	Early supported discharge and community stroke rehabilitation should be provided by a service predominantly treating people with stroke. [2023] Patients undergoing rehabilitation after stroke who are not eligible for early supported discharge should be referred to community stroke rehabilitation if they have ongoing rehabilitation needs when transferred from hospital. [2023] Therapy provided as part of early supported discharge should be at the same intensity as would be provided if the person were to remain on a stroke unit. [2023] The intensity and duration of intervention provided by the community stroke rehabilitation team should be established between the stroke specialist, the person with stroke and their family/carers, and be based on clinical need tailored to goals and outcomes. [2023]
Hornby TG, Reisman DS, Ward IG, Scheets PL, Miller A; and the Locomotor CPG Appraisal Team. **Clinical Practice Guideline to Improve**	… clinicians should use moderate- to high-intensity walking training interventions to improve walking speed and distance in individuals greater than 6 months following acute-onset CNS injury as compared with alternative interventions (evidence quality: I-II; recommendation strength: strong for individuals with stroke). … clinicians may consider providing strength training to improve walking speed and distance in individuals greater than 6

Guideline	Recommendations
Locomotor Function Following Chronic Stroke, Incomplete Spinal Cord Injury, and Brain Injury. ***J Neurol Phys Ther*. 2020 Jan;44(1):49-100. (selected)**	months following acute-onset CNS injury as compared with alternative interventions (evidence quality: I-II; recommendation strength: weak for individuals with stroke and iSCI).
Clinical Guidelines for Stroke Management 2017. Melbourne (Australia): National Stroke Foundation. Section 4. Rehabilitation	Where appropriate stroke services are available (see Practical information section), early supported discharge services should be offered to stroke patients with mild to moderate disability. Strong recommendation. Home-based rehabilitation may be considered as a preferred model for delivering rehabilitation in the community. Where home rehabilitation is unavailable, stroke patients requiring rehabilitation should receive centre-based care. Weak recommendation.
Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC et al; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. **Guidelines for adult stroke rehabilitation and recovery: a guideline for healthcare professionals from the American Heart Association/American Stroke Association.** ***Stroke* 2016;47:e98–e169**	ESD services may be reasonable for people with mild to moderate disability. Class IIb; LOE B. Organized community-based and coordinated interprofessional rehabilitation care is recommended in the outpatient or home-based settings. Class 1; LOE C After completion of formal stroke rehabilitation, participation in a program of exercise or physical activity at home or in the community is recommended. Class 1; LOE A

Evidence Tables

Early Supported Discharge (ESD)

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
Jee et al. 2022 **South Korea** **Systematic review & meta-analysis**	Using the RoB tool, the majority of trials were at low risk of selection bias and reporting bias.>50% of trials were at high risk of performance bias.	20 RCTs, published after 1997 that recruited patients with stroke or TIA.	Patients were randomized to receive either conventional care or any care service intervention that included rehabilitation or support provided by professional medical personnel with the aim of accelerating and supporting home discharge.	**Primary outcomes:** LOS, disability, mortality, Caregiver Strain Index (CSI)	ESD programs were not associated with a significant reduction in hospital LOS (SMD=-0.13, 95% CI −0.31 to 0.04 days). Results from 6 trials included. ESD programs were not associated with a significant improvement in ADLs (SMD=0.79, 95% CI -0.04-1.18). Results from 10 trials included. ESD programs were not associated with a significant improvement in mRS scores (SMD=-0.11, 95% CI -0.38-0.17). Results from 4 trials included. The odds of death were not reduced significantly with ESD programs (OR=0.80, 95% CI 0.56-1.17). Results from 5 trials included. ESD programs were not associated with a significantly better CSI scores (SMD = −0.66, 95% CI −1.93 - 0.61). Results from 5 trials included.
Rafsten et al. 2019 **Sweden** **RCT *Gothenburg Very Early Supported Discharge study (GOTVED*)**	CA: ☑ Blinding: Patient☒ Assessor ☑ ITT: ☑	140 patients admitted to an acute stroke unit with mild to moderate stroke and a BI score of > 50 points on day two of stroke. Mean age was 74.1 years, 61% were men.	Patients were randomized 1:1 to receive continued rehabilitation in their homes with a multidisciplinary team from the stroke care unit for a maximum of 1 month (VESD group) or to a control group that received support as usual after discharge including home care service and outpatient rehabilitation.	**Primary outcome:** Hospital Anxiety and Depression Scale-Anxiety subscale (HADS-A) at 3 months and 1 year **Secondary outcome:** mRS score at 3 months and 1 year	The patients in the VESD group received a median of 11 visits from the team over 4 weeks, with each visit lasting an average of one hour. After discharge from the VESD team, 58% of patients received continued rehabilitation during the first year. 76% of patients in the control group were referred to some sort of continued rehabilitation after discharge from the stroke unit, while 6 patients received inpatient rehabilitation. At 3 months the median HADS-A score was significantly lower in the VESD group (2 vs. 4, p=0.05), but there was no significant difference at 12 months (median of 3 vs. 4, p=0.48). The

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					percentage of persons with a HADS-A score ≥8 did not differ between groups at 3 months (21% vs. 21%) of 12 months (22% vs. 20%). The median mRS score was significantly lower in the VESD group at 3 months (2 vs. 2, p<0.001) but not at 12 months (2 vs. 2, p=0.08).
Tam et al. 2019 **Canada** **Cost-effectiveness analysis**	N/A	100 patients enrolled in a fast-track stroke rehabilitation program at two facilities. Mean age was 59 years, 25% were women.	Patients who were 'fast-tracked' (FT) to receive high-intensity outpatient rehabilitation within a week of discharge after stroke were compared to a simulated cohort of patients who were not 'fast-tracked' (remaining in acute or receiving inpatient rehabilitation). Patient costs and outcomes over a 12-week time horizon were included.	**Primary outcome:** Number of inpatient rehabilitation bed days saved with FT program and cost savings.	The projected inpatient bed days for non FT patients (i.e., those who stayed in inpatient rehabilitation) was 27.38 days vs. 22.34 bed days for FT patients (net inpatient bed days saved by FT was 5.04). The projected inpatient bed days for non FT patients who were transferred directly from acute care was 14.0 days vs. 0 bed days for actual FT patients (net inpatient bed days saved by FT was 14.0). Per additional inpatient day saved, the FT program cost an additional CAN$37 for patients who were discharged from acute care and an additional CAN$404 for those discharged from inpatient rehabilitation. These costs were both cheaper than the cost of an additional inpatient bed day in acute care ALC (CAN$698).
Langhorne et al. 2017 Early Supported Discharge Trialists **UK** **Cochrane Review**	N/A	17 RCTs (n=2,422) patients who had been admitted to hospital with clinical diagnosis of a stroke. Mean age of patients in all studies ranged from 60-80 years. 13% to 70% (median 33%) of patients were eligible for ESD services within each trial. The typical patient had an initial Barthel Index (BI) score of 14/20.	Patients were randomized to receive usual care or an alternative service that aimed to decrease LOS. 3 treatment contrasts were identified. The control condition in all trials was inpatient stroke rehabilitation: 1) ESD using a multidisciplinary team which coordinated discharge from hospital, post-discharge care, and provided rehabilitation and patient care at home. Team on a regular basis to	**Primary Outcomes:** Composite of death or dependency at end of scheduled follow-up **Secondary Outcomes:** Death, death or need for institution care, extended ADL scores, satisfaction with services, LOS, readmission to hospital.	The odds of the primary outcome at end of scheduled follow-up (median duration of follow-up was 6 months) were significantly lower for patients receiving ESD services (OR=0.80, 95% CI 0.67 to 0.95). Results from 16 trials included. The associated number needed to treat (NNT) per 100 patients was 5. The benefits were greatest among patients with mild-moderate disability (initial Barthel Index score 10-20 vs. BI<9) There was no reduction in the odds of death associated with ESD (OR=1.04, 95% CI 0.77- 1.40) at the end of scheduled follow-up. Results from 16 trials included. There was a significant reduction in the odds of

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			plan patient care (n=9). 2) ESD team coordination in which discharge home and the immediate post-discharge care was planned and supervised by a coordinated multidisciplinary team, but care was then handed over to existing community-based agencies who provided continuing rehabilitation and support at home, typically using a non-multidisciplinary team approach (n=4). 3) No ESD team coordination-therapies were provided by uncoordinated community services or by healthcare volunteers (n=4).		death or the need for institutional care associated with ESD (OR=0.75, 95% CI 0.59-0.96) at the end of scheduled follow-up. Results from 12 trials included. The associated NNT per 100 patients was 5. ESD was associated with slightly greater improvement in extended ADL performance (SMD= 0.17, 95% CI 0.04-0.30). Results from 11 trials included. Patients who received ESD services were more likely to report being satisfied with services (OR= 1.60, 95% CI 1.08-2.38). Results from 5 trials included. ESD was associated with a significantly shorter LOS (MD=-5.5, 95% CI -2.9 to -8.2 days). Results from 16 trials included. ESD was not associated with a significantly greater likelihood of readmission to hospital (OR= 1.09, 95% CI 0.79-1.51). Results from 6 trials included.
Santana et al. 2016 **Portugal** **RCT**	CA: ☑ Blinding: Patient☒ Assessor ☑ ITT: ☒	190 patients aged, 25-85 years admitted to the stroke unit (SU) of a single facility, who had some residual disability (max FIM score of 100 permitted). Patients with major speech and language problems, major psychological illness or dementia or severe comorbidity, were excluded. Mean age was 67 years, 53% were men. 33% of screened patients were eligible to participate.	Patients were randomized 1:1 to an ESD group or usual care. Patients in both groups received early rehabilitation. Patients in the ESD group had a case manager who co-ordinated the ESD team members (OT, PT and a psychologist). Patients were treated by ESD therapists during their hospital SU stay, and following discharge home. Patient received approximately 8 home visits over a one-month (maximum) period. Patients and carers also received information on	**Primary outcome:** FIM **Secondary outcomes:** Frenchay Activity Index (FAI), the World Health Organization WHOQOLBREF quality of life assessment (WHOQOLBREF), Short Form-5D, BI and Mini Mental State Examination	There was no significant difference between groups in mean FIM scores at baseline (69.0 vs. 70.5, p=0.59), 2 months (104.6 vs. 105.6, p=0.80) or 6 months (107.4 vs. 106.6, p=0.82). There was no significant difference between groups in mean LOS on the SU (9.8 vs. 10.0 days, p=0.80). There were no significant differences between groups in mean FAI scores between groups at baseline or 6 months. The results for the remaining secondary outcomes are not reported. 34 patients were lost to follow-up.

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			secondary prevention and resources available in the community.		
Gjelsvik et al. 2014 **Norway** **RCT**	CA: ☑ Blinding: Patient☒ Assessor ☑ ITT: ☑	167 patients admitted to a stroke unit within 7days of stroke, and 5 days of admission to the stroke unit, who lived at home prior to stroke, had a NIHSS score of 2–26, and had no serious comorbidities. Mean age was 72 years, 55% were men. Mean baseline BI was 95. 18.2% of screened patients participated.	Patients were randomized to one of three groups: 1) ESD and day unit rehabilitation (n=52); 2) ESD and home rehabilitation (n=60); and 3) control group (n=55). Day unit and home rehabilitation services were primarily facilitated by PT and OT for body functioning and task-oriented training. The treatment lasted up to 5 weeks post discharge from the stroke unit. The control group was discharged as normal and provided with outpatient therapy on an as-needed basis.	**Primary Outcome**: Postural Assessment Scale for Stroke (PASS). **Secondary Outcomes:** Trunk Impairment Scale-modified Norwegian version (TIS-modNV), functional ambulation categories (walking ability), Timed Up-and-Go (TUG) test, 5m Timed Walk (5mTW), and self-report of activity and body related functioning (NRS 0–10; 0=best, 10=worst). Outcomes were assessed at baseline and 3 months post discharge.	There were no significant differences in median PASS scores between groups: Group 1 (0, IQR 4, 95% CI -0.25–1.51) vs. Group 2 (1, IQR 2, 95% CI 0.29–2.13) vs. Group 3 (1, IQR 3, 95% CI 0.24–2.10); p=0.832. There were no significant differences in TIS-modNV scores in pair-wise comparisons between groups. There were no significant differences between groups in mean TUG test or 5mTW. Self-report activity and body-related functioning: Patients in Group 1 reported significantly greater improvement in walking compared to the control group (p=0.004). Group 2 reported significantly greater improvement in ADLs compared to the control group (p=0.006). There were no significant differences in self-report balance, physical activity, pain or tiredness scores between groups.
Askim et al. 2004, 2006 **Norway** **RCT**	CA: ☑ Blinding: Assessor ☑ ITT: ☑	62 patients with stroke, admitted to an acute stroke unit within 7 days hours of symptom onset, with a Scandinavian Stroke Scale (SSS) score >2 and <58; and living at home before the stroke. Mean age was 76 years, 52% were men.	Participants were randomized to either an extended stroke unit service (ESUS; n=31) or an ordinary stroke unit service (OSUS; n=31) following baseline evaluations. The ESUS consisted of stroke unit treatment combined with a home-based programme of follow-up care coordinated by a mobile stroke team that offers ESD. Services were rendered during the first 4wk post	**Primary Outcome:** Independence (mRS 0-2) at 52 weeks post stroke **Secondary outcomes:** LOS, mRS scores at 6 and 26 weeks, Barthel Index (BI), Nottingham Health Profile (NHP) and Caregiver Strain Index (CSI) at 6, 26 and 52 weeks **Additional outcomes (2006):** Berg Balance Scale (BBS), walking speed,	There was no significant difference between groups in the percentage of patients who had achieved the primary outcome (ESUS 38.7% vs. OSUS 51.6%, p=0.44). There were no significant differences between groups on many of the secondary outcomes except for NHP Social subscore at 26 weeks, favouring the ESUS group (median score of 0 vs. 11, p=0.046). Initially at 1wk follow-up, patients in the OSUS group showed significantly faster walking speed (1.03±0.43m/s vs. 0.78±0.36m/s; p=0.043) and a trend toward better BBS score (35.4±21.4 vs. 28.6±21.4; p=0.0144) compared to those in the ESUS group. However no subsequent differences

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			discharge.	and motor subscores of SSS at 6, 26 and 52 weeks.	were seen in later follow-ups. Changes within the ESUS group showed a significant increase in the BBS score from 1 to 6wk (p=0.013) and a trend toward improvement from 1 to 26wk (p=0.051). In addition, there was a significant increase in walking speed from 1 to 6wk (p=0.022), from 1 to 26wk (p=0.044), and from 1 to 52wk (p=0.028). Such changes were not seen within the OSUS group.
Langhorne et al. 2005 **UK** **Patient-level meta-analysis**	NA	Data from 11 trials (n=1,597) including patients recruited from hospital with a clinical diagnosis of stroke. Selection of patients in the included trials were based on residual disability, medical stability and practicality (i.e living locally). Mean/median ages ranged from 68-78 years.	RCTs compared conventional care vs. an ESD intervention. ESD services were initiated with the first 2 days of discharge and continued for up to 6 months. When team composition was described, all trials included OT/PT, and SLP. The control condition in all trials was multidisciplinary inpatient rehabilitation. Prespecified subgroup analyses included patients' age, sex, presence of a carer, and initial stroke severity	**Primary outcome:** Death or dependency (BI score of 19/20 or a Rankin score of <2) at the end of follow-up. **Secondary outcomes:** Death, place of residence, ADL score, extended ADL score, subjective health status, mood or depression score, outcomes for carers (mood and subjective health), and satisfaction of patients and carers.	Median duration of follow-up was 6 months. The risk of the primary outcome was reduced significantly for patients in the ESD group (OR=0.79, 95% CI 0.64-0.97, p=0.02). There was a significant subgroup interaction by team ESD coordination (p=0.04). Services with coordinated multidisciplinary ESD team showed significantly reduced odds of the primary outcome compared with ESD without team coordination. There was no significant reduction in the risk of death associated with ESD (OR=0.90, 95% CI 0.64-1.27, p=0.56). The odds of death or institutionalization were significantly lower for patients in the ESD group (OR=0.74, 95% CI 0.56-0.96, p=0.02) There were no significant differences between groups in ADL scores, patients' subjective health status or mood scores. There were no significant differences between groups in carers' subjective health status or mood scores. ESD group LOS was significantly shorter (weighted mean difference= –7.7, 95% CI –10.7 to –4.2, p<

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
					0.0001)
Indredavik et al. 2000 **Fjaertoft et al. 2011 (5-year outcome)** **Norway** **RCT**	CA: ☑ Blinding: Patient☒ Assessor ☑ ITT: ☑	320 patients admitted to an inpatient stroke unit within 7 days of symptom onset, with Scandinavian Stroke Scale (SSS) scores of 3-56, and who were living at home prior to stroke. Mean age was 74 years, 53% were men.	Participants were randomized 1:1 to receive care on an enhanced stroke unit service (ESUS) that consisted of acute and rehabilitation services with an ESD component provided by a mobile team, or an ordinary stroke service (OSUS).	**Primary Outcome:** Independence (BI ≥95 and mRS ≤2) at 26 weeks post discharge **Secondary Outcomes:** BI and mRS scores at 6 weeks post discharge, the proportion of patients who were at home, institutions of deceased at 6 and 26wk, and LOS.	The odds of independence at 26 weeks (defined by mRS criteria) were significantly higher for ESUS patients (65% vs. 51.9%, OR=1.72, 95% CI 1.10–2.70; p=0.017, but not when BI criteria were applied (60.0% vs. 49.4%, OR=1.54, 95% CI 0.99 to 2.39). There were no significant differences between groups in the number of patients who were independent at 6 weeks using either the mRS or BI criteria (54.4% vs. 45.6%, p=0.118, and 56.3% vs. 48.8%, p=0.179, respectively). At 6 weeks, a significantly higher number of patients in the ESUS group were living at home (74.4% vs. 55.6%; p=0.00010), while significantly fewer were institutionalized (23.1% vs. 40.0%; p<0.001). By 26 weeks, there were no significant differences between groups in place of residence or mortality (home: 78.8% vs. 73.1%; p=0.239; Institution: 13.1% vs. 17.5%; p=0.277; dead: 8.1% vs. 9.4%; p=0.692). The mean LOS was significantly shorter in the ESUS group (18.6 vs. 31.1 days; p=0.0324). **5-year outcomes** There was no significant difference between groups in the proportion of patients who were independent using mRS criteria (35% vs. 29%, p=0.213). A significantly larger proportion of patients in ESUS group showed improvement in mRS scores from 1 year to 5 years (16% vs. 9%; p=0.048). A significantly higher proportion of ESUS patients were living at home (46.5% vs. 34.4%; p=0.022) At one year there were 5 dropouts (all (OSUS). At 5

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
					years, there were 14 (n=5, ESUS; n=9, OSUS).
Bautz-Holter et al. 2002 **Norway** **RCT**	CA: ☑ Blinding: Patient:☒ Assessor: ☑ ITT: ☑	82 patients admitted to an acute stroke unit within 6 days of symptoms onset. Patients were eligible for inclusion if they were medically stable, home-dwelling prior to stroke, and not severely disabled (BI 5–19, 72 hours post stroke). Median age was 78 years, 45% were men. 20.2% (n=88) of patients screened were eligible for inclusion, and 82 agreed to participate.	Participants were randomized to receive either ESD (n=42) or usual care (n=40). Both groups received acute care for 3–12 days on the stroke unit and were then transferred to the stroke rehabilitation unit. In the ESD group, immediate preparation for discharge and co-ordination of community-based rehabilitation was made.	**Primary Outcome:** Nottingham Extended ADL (NEADL) at 3- and 6-months post stroke **Secondary Outcomes:** General Health Questionnaire (GHQ), Montgomery Asberg Depression Rating Scale, mortality, patient and career satisfaction, and place of residence.	The median LOS was non-significantly shorter for patients in the ESD group (22 vs. 31 days, p=0.09). There were no significant differences between groups in median scores of individual items or total scores of the NEADL, at either 3- or 6-months post stroke. At 3 months, the median GHQ scores were significantly lower for the ESD patients 19.5 vs. 26, p=0.02), but not at 6 months (24 vs. 22, p=0.74). There were no significant differences between groups in the proportions of patients alive/dead or home/institutionalized at either 3 or 6 months. There were 5 losses to follow-up in the control group and 6 in the ESD group.
Mayo et al. 2000 **Canada** **RCT**	CA: ☑ Blinding: Patient☒ Assessor: ☑ ITT: ☒	114 patients with stroke onset within the previous 28 days, with moderate disability, living with a caregiver and who were medically stable. Patients with cognitive impairment, disabling coexisting conditions, and those who required the assistance of >1 person to walk at 28 days post stroke, were excluded. Mean age was 70 years, 38% were men. 12.6% (n=194) of patients with stroke admitted to acute care were eligible for inclusion. 114 agreed to participate.	Participants were randomized to receive either a home intervention (n=58) or usual care (n=56). Patients in the intervention group received an intensive, individualized home rehabilitation program, provided by a multidisciplinary team for 4 weeks, following accelerated discharge from hospital. Patients in the control group were to receive inpatient rehabilitation services (but only 27% of patients received home care or inpatient rehabilitation)	**Primary Outcome**: Physical component of the Short Form-36 (SF-36), assessed at one- and 3-months post stroke. **Secondary Outcomes**: Canadian Neurological Scale, Stroke Rehabilitation Assessment of Movement, SF-36 Mental Health component, Barthel Index, Reintegration to Normal Living, Timed Up and Go, Older Americans Resource Scale for IADLs.	Duration of acute hospital stay was significantly shorter for patients in the intervention group p (9.8 vs. 12.4 days, p<0.05). The mean SF-36 physical component scores were significantly higher in the intervention group at 3 months (42.9 vs. 37.9, p=0.018). There was no significant difference between groups at one month (i.e immediately following the intervention). Patients in the intervention group achieved significantly greater gains on IADL and RNL sores from months one to 3. There were no other significant differences between groups for any of the other secondary outcomes. There were 7 dropouts in the home intervention group and 11 in the usual care group.
Anderson et al.	CA: ☑	86 admitted to hospital	Participants were	**Primary Outcome:**	Mean time from stroke onset to randomization was

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2000 **Australia** **RCT**	Patient: Blinding ☒ Assessor ☑ ITT: ☑	and requiring rehabilitation following an acute stroke. Patients were eligible for inclusion if they were medically stable, capable of participating in a community-based rehabilitation program, their home environment was suitable for simple modifications, and the community rehabilitation team and a general practitioner were available to provide care. Mean age was 72 years, 56% were men. Median BI score at baseline was 85. 21.6% (n=86) of patients with stoke admitted to hospital were eligible for inclusion.	randomized to receive either ESD with home-based rehabilitation (n=42) or conventional care (n=44). Participants in the intervention group were discharged from hospital within 48 hours of randomization and received individually tailored treatment from a community rehabilitation team within the participants' home. Maximum and minimum durations of treatment were not specified. Participants in the control group received inpatient rehabilitation.	Short Form-36 (SF-36) at 6 months. **Secondary Outcomes:** Nottingham Health Profile, Modified Barthel Index, Mini-Mental State Examination, General Health Questionnaire-28 (GHQ-28), Adelaide Activities Profile, McMaster Family Assessment Devise (General Functioning Subscale).	14 days. Participants in the intervention group received home rehabilitation for a median duration of 5wk (range: 1–19wk). Mean length of stay was significantly shorter for patients in the ESD group (15 vs. 30 days, p<0.001, 95% CI for difference: -22.0 to -6.0). At the 6 months follow-up, there were no differences between groups in any mean components scores of SF-36 items. There were no significant differences between groups for any of the secondary outcomes at 6 months. Caregivers of patients in the home group had significantly lower mean SF-36 mental health sub scores at 6 months (69.6 vs. 82.0, p=0.01).

Outpatient & Community-Based Rehabilitation

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
Systematic reviews & meta-analyses					
Chi et al. 2020 **Taiwan** **Systematic review & meta-**	Using the Cochrane risk of bias tool, none of the trials achieved the	49 RCTs including 4,597 persons living at home recovering from a stroke. Mean age was 66.2 years, 42.1% were women. 11 trials	Trials compared home-based rehabilitation therapies (OT, PT) provided with the aim of improving physical function vs. usual care, no care or active control. The focus in	**Primary outcome:** Standardized measures of physical function	Home-based rehabilitation was associated with a moderate improvement in function (Hedges' *g*=0.58; 95% CI 0.45-0.70). Younger age, male sex, first-ever, acute stroke episode, and receiving rehabilitation training from a

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
analysis	criteria of low risk of bias according to the 6 domains	recruited patients in the acute stage (<6 months) and 6 trials included patients with stroke in the chronic stage. In 20 trials the chronicity of stroke was unclear.	most trials was ADL training. The average length of interventions was 18.9 weeks (range 3-144 weeks).		caregiver were moderator variables associated with greater improvements.
Fens et al. 2013 **Netherlands** **Systematic Review**	N/A	14 trials (n=2,389) including participants ≥18 years, residing in the community after hospitalization or inpatient rehabilitation patients following stroke. In 11 trials the mean age of patients was >70 years. In 13 studies, patients were recruited immediately following discharge from hospital (acute n=12, rehabilitation, n=1), while in one trial, patients were included ≥ 18 months post stroke.	Trials examining multidisciplinary outpatient programs were included. Four types of interventions were identified: assessment performed (n=2), assessment combined with follow-up care (n=8), rehabilitation (n=3), and education (n=1). Therapy duration ranged from 3 weeks to 12 months. Control conditions were usual care (n=13) and less-intensive therapy (n=1)	**Primary Outcomes:** Measures of ADL and social participation	Duration of follow-up ranged from 3 and 12 months. Outpatient therapy was not associated with significantly greater improvements in measures of ADLs in any of the included trials. The most commonly-used measures included BI (n=9), Frenchay Activities Index (n=4), and extended ADL (n=3). No trials assessed measures of social participation. Outpatient therapy was associated with significantly greater improvement in measures of Quality of Life in 2/8 trials (one trial of assessment combined with follow-up care' studies, reported significantly better mean SASIP-30 scores, and one study of rehabilitation interventions reported significantly higher mean EQ-5D score).
Hillier & Inglis-Jassiem 2010 **Australia** **Systematic Review & Meta-Analysis**	N/A	11 RCTs (n=1,711) including patients ≥18 years who were discharged from inpatient rehabilitation or hospital to home. Mean/median ages ranged from 53 to 78.3 years.	Trials compared home-based rehabilitation with hospital-based services (day hospital or outpatient), usually composed of a multidisciplinary team. Duration and intensity of treatment: treatment lasted for 3 weeks to 6 months, or as long as required. Treatment intensity was not stated in 4 of the included	**Primary Outcome:** Functional independence **Secondary Outcomes:** Carer satisfaction/stress. Duration of follow-up ranged from 3 to 12 months.	Overall, no significant differences in outcomes were reported in 4 trials, with the reporting of some benefits in favour of home-based group in 7 trials (lower cost, less carer strain, lower readmission). No trials reported any benefits in favour of centre-based rehabilitation. Pooling of data were possible for BI scores only. At 6-8 weeks and 3-6 months post intervention, home-based rehabilitation was associated with significant mean difference in BI scores (MD=1.00, 95% CI 0.12–1.88; p=0.03; and MD=4.07, 95% CI 0.81-7.93, p=0.01, respectively). Results from 2

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
			trials, and was based on individual need in one trial. In the remaining trials, therapists visited patients an average of 1–3×/wk.		studies included. At 6 months, there was no significant difference in BI scores (MD= 0.65,95% CI -0.50 to -1.81; p=0.27. Results from 6 trials included).
Outpatient Service Trialists 2003 **UK** **Cochrane Review**	N/A	14 trials (n=1,617) including patients who were living at home prior to stroke and within 1 year of stroke onset. Mean ages ranged from 55 to 75 years, percentages of men ranged from 37% to 67%. The mean/median LOS in hospital was reported in 6 trials and varied from 7–85 days.	Service interventions included those that were home-based (n=2), or day hospital or outpatient clinic based (n=12), were provided by OT/PT or multidisciplinary staff, whose aim was to improve task-oriented behavior. In most of the trials the comparison was usual or routine care. The focus of treatment was ADL performance, leisure (OT) n=8; mobility (PT) n=2 and was provided by a multidisciplinary team in 4 trials. Therapy duration ranged from 5 weeks to 6 months. In 12 trials, patients were recruited following discharge from hospital. In 4 of these trials, patients had received a course of rehabilitation. In 2 studies, patients were recruited from home.	**Primary Outcome:** Death or poor outcome (deterioration, dependency, need for institutionalization), and performance of ADL. **Secondary Outcomes:** Death at end of scheduled follow-up, death or need for institutional care, death or physical dependence, EADL, and mood. .	Mean duration of follow-up ranged from 3 to 12 months. Outpatient services were associated with a significant reduction in the risk of death or poor outcome (OR=0.72, 95% CI 0.57–0.92; p=0.009). Results from 12 trials included. Outpatient services were not associated with a significant reduction in the risk of death at end of follow-up (OR=1.10, 95% CI 0.76–1.59; p=0.60. Results from 14 trials included) or a significant reduction in the risk of death or institutionalization at end of scheduled follow-up (OR=0.81, 95% CI 0.54–1.21; p=0.30. Results from 6 trials included). Outpatient services were not associated with a significant reduction in the risk of death or dependency at end of scheduled follow-up (OR=0.93, 95% CI 0.70–1.22; p=0.60). Results from 7 trials included. Outpatient services were associated with significantly greater improvements in ADL, EADL and mood scores (SMD=0.14, 95% CI 0.02–0.025; p=0.02, SMD=0.17, 95% CI 0.04–0.30; p=0.01 and SMD=0.11, 95% CI -0.04–0.26; p=0.02, respectively.)
Clinical Trials					
Managing Aftercare for Stroke (MAS): MAS-II - A		100 patients ≥18 years, recovering from an ischemic stroke which had occurred within the	Single group intervention study of comprehensive multidisciplinary stroke care, provided in both an	**Primary outcome:** EuroQoL-5D, assessed at 12 months	The trial was completed in March 2021. Awaiting results.

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
Longitudinal Complex-interventional Study in Post-rehabilitation Stroke Patients **(NCT03097146)**		previous 6 months. Patients to be recruited from a single centre.	outpatient setting (e.g., secondary prevention) or in the community, close to the patients' home, based on a case management system ("Ambulanzpartner").	**Secondary outcomes:** Post Stroke Checklist (PSC), mRS, BI, modified Ashworth Scale (MAS), Pain Detect, Freiburg questionnaire for coping (FKV), Montreal Cognitive Assessment (MoCA), Token Test, Hamilton Rating Test for Depression, all assessed at 12 months	
Han et al. 2020 **Taiwan** **RCT**	CA: ☑ Patient: Blinding ☒ Assessor ☑ ITT: ☑	26 persons recovering from stroke, recruited from a single hospital with an mRS score of 2-4. Mean age was 67 years, 65% were men. Mean time form stroke onset to randomization was 53 months in the control group and 23 months in the intervention group (p=n/s)	Participants were randomized to receive a 6-week home-based rehabilitation program, aimed at improving ADLs provided for 50 minutes weekly or conventional rehabilitation (30 minutes each of OT/PT 2x/week) in the hospital.	**Primary outcomes:** Canadian Occupational Performance Measure (COPM) and the Barthel Index-based Supplementary Scales (BI-SS), which assesses actual performance, ability, and self-perceived difficulty	2 patients in the control group dropped out. Mean baseline COPM performance scores for the intervention and control groups were 4.4 and 4.2, respectively. At the end of 6 weeks, the mean change in score was 1.3 for the intervention group and 0.2 for the control group (p=n/s). Mean baseline COPM satisfaction scores for the intervention and control groups were 4.2 and 4.0, respectively. At the end of 6 weeks, the mean change in score was 1.3 for the intervention group and 0.0 for the control group (p=n/s). Mean baseline total BI scores for the intervention and control groups were 36.3 and 40.4, respectively. At the end of 6 weeks, the mean change in score was 6.6 for the intervention group and 0.2 for the control group (p=0.004). There was significantly greater improvement in the intervention group for the BI ability score, with no significant differences between groups in the actual performance or self-perceived difficulty scores.
Rasmussen et al. 2016 **Denmark**	CA: ☑ Blinding: Patient☒	71 adult patients recovering from acute stroke who had been receiving care on an	Patients were randomized to to receive multidisciplinary home-based rehabilitation for 5 days/week up to 4 weeks	**Primary outcomes:** mRS score at 90 days **Secondary outcomes:**	Median 90-day mRS scores were significantly lower in the intervention group (2 vs. 3, p=0.04). There was significant improvement favouring the

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
RCT	Assessor ☒ ITT: ☒	acute stroke unit for ≥3 days, with a premorbid mRS of 0-3 who had been able to live on their own prior to stroke. Median age was 78 years, 58% were women. Baseline mRS score was 4.	after discharge to replace part of usual rehabilitation services (n=38) or to receive continued guideline-based rehabilitation (n=31). Prior to home discharge, as soon as patients in the home-based therapy group were able to train at home, representatives of the team drove the inpatient home 1-3 times per week, where physical exercises and activities of daily living were performed before the inpatient was returned to the hospital.	modified Barthel-100 Index (mBI), Motor Assessment Scale (MAS), CT-50 Cognitive Test, and EuroQol-5D	intervention group in median MAS scores at 90 days (intervention group final score 38, improvement from baseline 14 vs. control group final score 29, improvement from baseline 5). There was no significant improvement between groups in median mBI scores at 90 days (intervention group final score 93, improvement from baseline 29 vs. control group final score 90, improvement from baseline 20). There was no significant improvement between groups in median CT-50 scores at 90 days (intervention group final score 45, improvement from baseline 5 vs. control group final score 46, improvement from baseline 4). There was significant improvement favouring the intervention group in median EuroQol-5D scores at 90 days (intervention group final score 0.77, improvement from baseline 0.19 vs. control group final score 0.66, improvement from baseline 0.27). Total treatment costs were $US 54,118 in the intervention group vs. $US 54,242.
Olaleye et al. 2014 **Africa** **RCT**	CA: ☑ Blinding: Patient☒ Assessor ☑ ITT: ☒	52 patients with stroke levity scale (SLS) score ≥6, who had been discharged from inpatient care within the previous 2 weeks. Mean age was 61 years. There were significantly more males in the home group (63 vs. 28%, p=0.01)	Patients were randomized to one of two groups: 1) primary health centre group (n=25), or 2) home group (n=27). Patients in both groups underwent task-specific rehabilitation consisting of strength (free weights), balance, and gait exercises. Number of sets and repetitions were tailored based on patient tolerance and performance. Treatment duration and intensity for	**Primary Outcomes:** Modified Motor Assessment Scale (MMAS), Short Form-Postural Assessment Scale (SF-PASS), Reintegration of Normal Living Index (RNLI), and 10-metre walkway. Outcomes were assessed every 2weeks	There were no statistically significant differences between the primary health centre group or the home-based group in motor function (p=0.94), balance (p=0.65), level of handicap (p=0.90) or walking speed (p=0.69 at baseline; p=0.73 at week 10). Both groups experienced statistically significant improvements in within group scores for motor function, balance, level of handicap and walking speed (p=0.01).

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
			both groups was 2×/week (45–60min/session) for 10 weeks.		
Markle-Reid et al. 2011 **Canada** **RCT**	CA: ☑ Blinding: Patient☒ Assessor ☑ ITT: ☒	101 persons with stroke or TIA, sustained within the previous 18 months, who were eligible to receive home care services, living in the community. Mean age was ~73 years, 55% were men. Stroke chronicity was <6 months among 70% of participants.	Participants were randomized to receive home visits by a dedicated interprofessional team of healthcare providers, as required for a maximum of 12 months or usual care (home care). The intervention was individually tailored to the participant's rehabilitation needs/goals and was developed through a collaborative process with decision makers and front-line providers. The foci of the intervention were health management, life roles, social network, environment, communication, mobility, caregiver support, and financial management.	**Primary outcome:** Change in SF-36 scores **Secondary outcomes:** Change in Stroke Impact Scale (SIS) scores, Personal Resource Questionnaire (PRQ-85-Part 2), Epidemiological Studies in Depression Scale (CES-D), depression & anxiety (Kessler-10), The Short Portable Mental Status Questionnaire (SPMSQ) and Reintegration to Normal Living Index (RNLI)	19 participants were lost to follow-up, distributed equally between groups. Persons in the intervention group received 4.3 Community Care Access Centre visits, 29.1 nursing visits, 5.2 OT visits, 7.8 PT visits, 2.4 RD visits, 1 SW visits, 1.5 SLP visits, and 242 hours of care by a personal Support Worker. Persons in the usual care group received 1.1 Community Care Access Centre visits, 20.4 nursing visits, 5.3 OT visits, 4.3 PT visits, 0.4 RD visits, 0.4 SW visits, and 1 SLP visits, and 169 hours of care by a personal Support Worker. There was no significant difference between groups in mean change in SIS summary score from baseline. There were no significant differences between groups in mean change in any of the 8 SIS subscale scores, although there was a difference of >5 points (i.e. clinically significant), favouring the intervention group for the SIS subscale score of physical function. There were no significant differences in mean change scores for any of the secondary outcomes. Sex was not examined as a potential effect size modifier in subgroup analysis. The mean cost of the intervention was $2,750 greater compared with usual care over the 12-month period.
Bjorkdahl et al. 2006 **Sweden**	CA: ☑ Blinding: Patient☒	58 patients admitted consecutively to an inpatient rehabilitation unit following first-ever	Patients were randomized to participate in a 3-week program of continued rehabilitation (9hr/wk) either	**Primary Outcome:** The Assessment of Motor and Process Skills (AMPS)	There were no significant differences between groups on any of the outcomes assessed. Both groups achieved modest gains in most of the outcome measure assessed.

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
RCT	Assessor ☑ ITT: ☑	stroke, who were discharge home. Median age was 53 years, 75% were men. Mean LOS in acute care was 28 days and 65 days on rehabilitation unit.	at home (n=30), or in a hospital-based day clinic (n=29). Patients in the home group were offered training based on their own needs (i.e. personal care, shopping) while those in the day clinic group received care that that was more impairment oriented. Patients in the home group received the services of an OT/PT while patients in the day clinic were treated by a multidisciplinary team.	**Secondary Outcomes:** FIM, Instrumental Activity Measure (IAM), 30-metre walk test, NIHSS, Barrow Neurological Institutes Screening (BNIS), costs. Assessments were conducted at baseline (discharge), 3 weeks, 3 months and 1 year following discharge.	The costs associated with home group rehabilitation were lower (€1,830 vs. €4,410). There was a single loss to follow-up.
Lincoln et al. 2004 **UK** **RCT**	CA: ☑ Blinding: Patient ☒ Assessor ☑ ITT: ☒	421 patients r≥16 years, requiring the intervention from more than one rehabilitation discipline, following a stroke, sustained within the previous 2 years. Mean age was 72 years, 52% were men.	Patients were randomized to receive routine care (n=232; day hospital, outpatient services) or care from the community stroke team (n=189). Care was provided for as long as was required by a multidisciplinary team. Patients in the community stroke team (CST) groups received a median of 18 sessions, including an average of 4.8 hours of PT, 3.8 hours of OT, 2.0 hours SLP therapy, 1.9 hours with a mental health nurse and 0.5 hours with a rehabilitation support worker	**Primary Outcome:** Barthel Index score at 6 months after referral **Secondary Outcomes:** Extended ADL (EADL), General Health Questionnaire (GHQ-12) by patient and carer, Carer Strain Index (CSI), and EuroQoL	There was no significant difference between groups in median (IQR) BI scores. BI (mobility): 16 (12–18) vs. 16 (12–19); p=0.83. BI (domestic): 3 (0–9) vs. 2.5 (0–8); p=0.70. BI (leisure): 6 (3–9) vs. 7 (3–9); p=0.34. There were no significant differences between groups in median (IQR) EADL scores: 24 (13–38) vs. 25.5 (11–39); p=0.94. There were no significant differences between groups in median (IQR) GHQ-12: 13 (10–21) vs. 15 (11–230); p=0.79. There were no significant differences between groups in median (IQR) Euro-QoL scores except emotional support (favouring the community stroke team group) Knowledge: 8 (2–3) vs. 2 (1–3); p=0.24. Practical help: 3 (2–3) vs. 3 (2–3); p=0.39. **Emotional support: 3 (2–3) vs. 2 (2–3); p=0.02.** Overall satisfaction: 3 (2–3) vs. 2 (2–3); p=0.08. Median Carer Strain Index scores were significantly

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
					lower in the CST group 8 (5-10) vs. 10 (6-12), p=0.03 Overall carer satisfaction was significantly better in the CST group. Losses to follow-up and dropouts: n=101 (community stroke team), n=132 (routine care).
Gilbertson et al. 2000 **Gilbertson & Langhorne 2000** **UK** **RCT**	CA: ☑ Blinding: Patient☒ Assessor ☑ ITT: ☑	138 patients who planned to return home following discharge from hospital with a diagnosis of stroke, who required additional OT services. Median age was 71 years, 44% were male. Mean time from stroke onset to randomization was 26 days.	Patients were randomized to receive either 6 weeks of domiciliary occupational therapy (n=67) comprising 10 visits lasting 30–45min each, tailored to recovery goals identified by patient or to receive routine post-stroke follow-up care. Routine care (n=71) included inpatient rehabilitation, a home visit prior to discharge, support services and equipment, regular review at a stroke clinic, and referral to day hospital for selected patients.	**Primary Outcomes:** Nottingham EADL, deterioration in function, and death. **Secondary Outcomes:** Barthel Index, Canadian Occupational Performance Measure (COPM) London Handicap Scale (LHS), and Dartmouth COOP Charts. Assessments were conducted at baseline, 8 weeks and 6 months	At 6 months, there were no significant differences between groups in median (IQR) scores in EADL: 28 (15–38) vs. 21 (14–38), p=0.48; BI: 17 (15–19) vs. 17 (13–18), p=0.25, or LHS: 0.41 (0.38–0.53) vs. 0.45 (0.29–0.64); p=0.57. Change in BI: 0 (-2–2) vs. -1 (-3–0); p=0.04. Deaths: 2 (OT group) vs. 1 (control group). Change in COPM (satisfactions cores) from baseline to 7weeks: 1.63 (0–3) vs. -0.4 (-2–1); p=0.0001. Change in COPM from baseline to 7 weeks (performance scores): 1 (0–2.8) vs. 0 (-2.5–1); p=0.0006. Dartmouth COOP charts (scores at 7weeks): Physical condition: 5 (4–5) vs. 5 (5–5); p=0.19. Emotional condition: 2 (2–4) vs. 3 (2–4); p=0.02. Social activities; 4 (2–4) vs. 3 (2–40); p=0.93. Quality of Life: 3 (2–3) vs. 3 (2–3); p=0.35. Losses to follow-up: n=7 (OT group), n=5 (control group).
Walker et al. 1999 **2001 (1-year follow-up)** **UK**	CA: ☑ Blinding: Patient ☒ Assessor ☑ ITT: ☒	185 patients who sustained a stroke within the previous month and who had not been admitted to hospital. Mean age was 74 years, 55% were men. Median BI score at baseline was	Patients were randomized to receive up to 5 months of OT (n=94) at home at a frequency of service that was agreed upon by patient and therapist, or to a no intervention control group (n=91), although patients	**Primary Outcome:** Nottingham EADL score **Secondary Outcomes:** Barthel Index, Carer Strain Index, and General Health Questionnaire (0–84)	**6-month outcomes** Patients in the OT group had significant higher median (IQR) EADL and BI scores (16 [11–18.75] vs. 12 (6–17), p=0.009; and 20 [18–20] vs. 18 [16–20], p=0.002, respectively. Median Carer Strain Index (IQR) scores were significantly lower in the OT group 1 (0–4) vs. 3 (1–

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
RCT		18. 29% of patients had sustained a previous stroke.	could access existing services in the community. On average, patients in the OT group received 5.8 visits (range 1–15), lasting an average of 52 minutes.	(GHQ).	6), p=0.02. There was no significant difference between groups in median GHQ-28 (patient): 20 (14–30) vs. 23 (15–35), p=0.29. **One-year outcomes:** Patients in the OT group had significantly higher median EADL scores 13 (13–18) vs. 11 (4–17), p=0.04. There were no significant differences between groups in median BI scores (19 [16–20] vs. 18 [15–20], p=0.16) or GHQ 28 (patient): 20 (15–30) vs. 18 (13–31), p=0.62. There were 22 losses to follow-up: n=10 (OT group), n=12 (control group).
Gladman et al. 1993 (3 and 6-month outcomes) **Gladman et al. 1994 (one-year outcomes)** **UK** **RCT (DOMINO study)**	CA: ☑ Blinding: Patient ☒ Assessor ☑ ITT: ☒	327 patients with acute stroke discharged from 2 acute and 3 rehabilitation units. All patients were to discharged home. Patients spent a median of 20 days in hospital prior to randomization. Mean age was 70 years, 52% were men. Median admission BI score was 16.5.	Patients were randomized by strata (discharge from the Health Care of the Elderly wards, General Medical wards or the Stroke Unit) to receive domiciliary care (n=162), provided by occupational and physical therapists for up to 6 months, or to routine care (hospital-based geriatric day hospital; n=165). The number of treatment sessions received between groups were similar.	**Primary Outcome (at 6mo):** Extended ADL. **Primary Outcomes (at 1yr):** Mortality, requirement for institutional care, NHP score ≥30, Barthel Index, and Extended ADL. **Secondary Outcomes**: Barthel Index and Nottingham Health Profile (NHP).	**3 and 6-month outcomes** There were no significant differences between groups in median total extended ADL scores (overall or grouped by strata) at either 3 or 6 months. Within the stroke unit stratum, patients in the home-based therapy group had significantly higher median extended ADL sub scores at 6 months (household: 5 vs. 3, p<0.05, leisure 2.5 vs. 2, p<0.05). There were no significant differences between groups at 3 or 6 months in median BI scores of NHP scores at 6 months (overall or grouped by strata) There were trends towards increased risks of death and poor outcome (death/institutionalization) in the home-based therapy group at 6 months (RR=2.3, 95% CI 1.0–5.05; p=0.05, and RR=1.7, 95% CI 1.0–5.05; p=0.05). **One-year outcomes:**

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
					The percentage of patients experiencing a poor outcome did not differ significantly between groups (27 vs. 19%, p>0.05). There were no significant differences in median BI or EADL scores between groups (BI: 17 vs. 18; p>0.05, and EADL: 8 vs. 10; p>0.05). There was no significant difference between groups in the proportion of patients with NHP scores >30 (39 vs. 29%, p>0.05). Losses to follow-up: None.
Young & Forester 1992 **UK** **RCT** **Bradford Community Stroke Trial**	CA: ☒ Blinding: Patient ☒ Assessor ☑ ITT: ☒	124 patients >60yr who were about to be discharged from hospital following a recent stroke with persistent disability.	Patients were stratified by time interval between stroke onset and discharge and by disability at discharge, and randomized to attend a geriatric day hospital (n=61) 2×/wk for post-stroke care or to be treated at home (n=63) by one of five experienced community physiotherapists.	**Primary Outcome:** Barthel Index (BI) at 6 months following discharge home **Secondary Outcomes:** Motor Club Assessment (MCA), Frenchay Activities Index (FAI), Nottingham Health Profile (NHP), and General Health Questionnaire (GHQ).	At 6 months, 52% of the day hospital patients were still receiving treatment compared with only 21% of the patients in the home physiotherapy group (p=0002). Patients in the day hospital group attended a median of 31 times compared with a median of 15 visits received by patients in the home physiotherapy group (p<0.0001). The median (IQR) BI and MCA scores at 6 months were significantly higher in the home physiotherapy group (15 (12–18) vs. 17 (15–19); p<0.01, and 39 (32–43) vs. 41 (37–44); p=0.01, respectively). There were no significant differences between groups in the median scores of other secondary outcomes (FAI: 5 (3–11) vs. 9 (3–16); p=0.07; NHP: 21 (9–38) vs. 15 (5–40); p=0.32 and GHQ (carers): 3 (0–7) vs. 1 (0–5); p=0.22). 16 patients were lost to follow-up: n=9 (hospital group), n=7 (home physiotherapy group).
Qualitative studies					
Fisher et al. 2023	NA	20 National Health Service clinical staff participants, from 3	A single virtual focus group interview was completed with each community stroke	**Primary outcome:** Identification of barriers & facilitators	High levels of need were reported across multiple domains for survivors including continence, communication and physical function.

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
UK **Qualitative study**		multidisciplinary teams providing home-based stroke rehabilitation	rehabilitation team (maximum of 7 members) in providing home-based rehabilitation for patients with severe disability (mRS 4-5). Interviews lasted between 75 and 92 minutes. Team members included positions such as occupational and physical therapists, nurses and Speech-Language Pathologists		Interventions often required multi-agency collaboration in order to optimize the available resources and specialist skills. There was lack of clarity regarding who was ultimately responsible for providing components of rehabilitation for stroke survivors with severe disability. Teams provide rehabilitation for this population but are insufficiently commissioned or resourced to fully meet their needs. Incomplete and disjointed pathways with resultant healthcare inequalities were commonly reported. Teams used a variety of strategies to overcome these barriers including upskilling a diverse range of partners to capitalize on the skills and resources across health, social care and voluntary sector boundaries employing multiagency collaboration. Teams established and engaged networks of stakeholders in order to advocate on behalf of stroke survivors.

Home-based Exercise Programs

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
Upper-Extremity Focused					
Wong et al. 2020 **Norway**	PEDro scores ranged from 4-8.	15 RCTs or quasi RCTs that included persons with upper limb activity limitation following stroke. In 80% of the trials, the	Trials compared self-administered home-based, structured upper limb practice to improve upper limb activity vs. nonstructured	**Primary outcome:** Measures of upper limb activity	*Home-based practice vs no intervention* Home-based practice did not significantly improve activity (SMD= 0.00, 95% CI –0.47 to 0.48; 275 participants)

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
Systematic review & meta-analysis		chronicity of stroke was >6months. Most participants were moderate-to-severely disabled at baseline.	home-based practice (n=10) or no intervention (n=5). Session length ranged from 20 to120 min, frequency ranged from 3 to 7 times a week, and duration from 2 to 8 weeks.		*Structured home-based practice vs nonstructured home-based practice* Structured home-based practice was not significantly better than non-structured home-based practice (SMD= –0.05, 95% CI –0.22 to 0.13; 513 participants).
Barzel et al. 2015 **Germany** **Cluster RCT *HOMECIMT***	CA: ☑ Blinding: Patient ☒ Assessor ☑ ITT: ☑	156 patients ≥18 years, cognitively intact with mild to moderate impairment of arm function, associated with a stroke sustained at least 6 months earlier, who had a caregiver prepared to be a non-professional coach. Mean age was 63 years, 40% were women.	71 practices were stratified by region, and randomized 1:1 to either home constraint-induced movement therapy (CMIT, n=85 patients) or standard therapy (n=71 patients) for 4 weeks. In the home CIMT group, therapists conducted 5 home visits to instruct the patient and the coach in the principles of home CIMT, set goals and work through exercises, focusing on everyday practice. Patients were instructed to train in their home environment for 2 h each day, accompanied by a coach and to wear a mitten to immobilize their non-affected hand during the exercises. Patients in the standard therapy groups received 5 hours of routine therapy provided by a therapist.	**Primary outcomes:** Motor Activity Log (MAL), Wolf Motor Function Test (WMFT), assessed after the intervention **Secondary outcomes:** Motor Activity Log (MAL), Wolf Motor Function Test (WMFT), assessed at 6 months, 9-Hole Peg Test, ADL, IADL	At the end of treatment, patients in both groups had significantly improved MAL (QOM) scores, but the change in scores from baseline was significantly greater for patients in the CIMT group (adjusted mean change from baseline (0.56 vs. 0.31, MD= 0.26, 95% CI 0·05–0·46, p=0·0156). Both groups improved on the WMFT (performance time) from baseline to 4 weeks, although the difference between groups was not significant (-25.6% vs. -27.5%, MD=2·65% (–17·94 to –28·40, p=0·815). At 6 months follow-up, the mean difference from baseline in MAL (QOM and AOU sub scores) was significantly greater for CIMT patients. At 6 months follow-up there were no significant differences between groups in mean change from baseline for WMFT (performance time) or WMFT (functional ability). At 6 months follow-up there were no significant differences between groups in mean change from baseline for any of the other secondary outcomes. 9 patients were lost to follow-up (5 CIMT, 4 standard therapy)
Coupar et al. 2012 **UK**	N/A	4 RCTs (n=166) that recruited patients living in their homes following a stroke. Mean age ranged	Trials comparing a home-based exercise program which targeted the upper extremity under the	**Primary outcomes:** Measures of ADL and functional movement	The Barthel Index was used as an ADL measure in 2 trials. At neither the end of the treatment period, nor at the end of follow-up, were home-based exercise programs associated with a significant

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
Cochrane review		from 53 to 70.2 years.	supervision of healthcare professional, compared with usual care or placebo, were examined. Treatment contrasts included an exercise program that was designed to improve strength, balance and endurance, and to encourage more use of the affected extremity vs. usual care (n=2) and trials that compared virtual reality + telerehabilitation at home vs. either virtual reality training in hospital with a therapist present or conventional therapy (n=2). Duration of the programs ranged from 4 to 12 weeks.	**Secondary outcomes:** Extended ADL and motor impairment	difference in scores (MD=2.85; 95% CI -1.43 to 7.14, and MD=-1.70, 95% CI -5.51, to 2.11; results from 1 RCT). The Wolf Motor Function test was used to assess functional arm/hand movement. Results from 2 subgroups from the same trials, were pooled. Home-based exercise program was not associated with significantly higher scores (MD=2.24, 95% CI -0.24–4.73). The Lawton Instrumental ADL Scale points was used to assess Extended ADL performance in 2 trials. Home-based therapy was not associated with significantly higher scores (MD= 0.83 95% CI -0.51 to 2.17). The Fugl Meyer was used to assess motor impairment in 3 trials. At the end of the treatment period, home-based exercise programs were not associated with significantly higher scores (MD=1.46; 95% CI -0.58 to 3.51).
Lower extremity Focused					
Boyne et al. 2023 **USA** **RCT**	CA: ☑ Blinding: Patient ☒ Assessor ☑ ITT: ☑	55 persons aged 40-80 years, with chronic stroke living in the community with a walking speed of ≤1.0 m/s and who could walk on a treadmill for at least 3 minutes. Mean time since stroke was 2.5 years. Mean age was 63 years, 65.5% were men.	Participants were randomized 1:1 to a high-intensity interval training (HIIT) or moderate-intensity aerobic training (MAT). Target training volume for both groups was 45 minutes 3 times per week for 12 weeks. The sessions were completed in rehabilitation and exercise laboratories from recruiting centres. The HIIT protocol used repeated 30-second bursts of walking at maximum safe speed, alternated with 30- to 60-second rest periods,	**Primary outcome:** 6-Minute Walk Test (6MWT) **Secondary outcomes:** Self-selected and fastest speeds, (10-m walk test), PROMIS Fatigue Scale, and aerobic capacity, measured by oxygen consumption rate (VO_2) mL/kg/min	Mean distance walked on 6MWT at baseline was 196 metres in the HIIT group and 177 m in the MAT group. At 4 and 8 weeks, the mean changes in distance walked from baseline in the 6MWT in the HIIT group were 27 and 58 m, respectively vs. 12 and 29 m in the MAT group. At 12 weeks, the mean change was 71 m in the HIIT group vs. 27m in the MAT group. At 12 weeks, the mean difference in change between the groups was 44 m (p=0.005), favouring the HIIT group. At 12 weeks, the mean improvement in both self-selected and fastest walking speed favoured the HIIT group (+0.13 and 0.20 m/s, respectively).

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
			targeting a mean aerobic intensity above 60% of the heart rate reserve (HRR). The MAT protocol used continuous walking with speed adjusted to maintain an initial target of 40% of the HRR, progressing up to 60% of the HRR as tolerated.		At 12 weeks there were no significant differences in mean between group changes for the PROMIS Fatigue Scale or VO_2
Koc et al. 2015 **Turkey** **RCT**	CA: ☒ Blinding: Patient ☒ Assessor ☒ ITT: ☒	72 patients with subacute ischemic stroke, sustained within the previous 30 to 90 days, with baseline BI scores of scores of 60–80, who were ambulatory with supervision and/or an assistive device, and were living at home.	Patients were randomized to a home-based exercise (intervention) group or usual care (UC) group. The home-based exercises were designed to improve strength, balance, and endurance and to encourage use of the affected extremity. The program was delivered by a nurse researcher (one hour/visit, 2 visits/week for 12 weeks). Patients in the UC group received home visits by the research staff every 4 weeks for health education and to check their vital signs.	**Primary outcome:** BI score at end of treatment period	The mean baseline BI scores for patients in the intervention and control groups were 66.2 and 67.8, respectively (p=1.00). There was significant within-group improvement in mean BI scores over the treatment period, assessed at baseline, 4, 8 and 12 weeks, for patients in the intervention group, but not the UC group. At 12 weeks, the mean BI score was significantly higher for patients in the intervention group (82.0 vs. 69.5, p<0.0001). There were no dropouts.
Duncan et al. 2003 **United States** **RCT**	CA: ☑ Blinding: Patient ☒ Assessor ☑ ITT: ☑	92 patients > 50 years, with stroke onset of within 30 to 150 days, able to ambulate 25 feet independently with mild to moderate stroke deficits defined by a Fugl-Meyer score of 27-90 for upper and lower extremities, an Orpington Prognostic Scale score of 2.0-5.2, and palpable	Patients were randomized to the control group (n=48) or the intervention group (n=44). The experimental group received visits from an occupational or physical therapist in the home for 12–14 weeks (total of 36 sessions, each lasting 90 minutes). The intervention	**Primary Outcomes:** Fugl-Meyer Motor Score, Wolf Motor Function Test, 10-metre walk, Six-Minute Walk and Berg Balance Scale. Outcomes were assessed at baseline and 3 months (post intervention)	Patients in both groups improved over the treatment period. Patients in the intervention group experienced significantly greater gains in Berg Balance Scale scores, 6-minute walk distance, and gait velocity, after adjusting for baseline scores: Berg balance score: Mean difference in change between groups 2.72 (SE 0.79); p<0.001. 10-m gait velocity: Mean difference in change

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
		wrist extension on the involved side. Mean age was 69 years, 54% were men.	focused on range of motion, flexibility, strengthening, balance, upper extremity use, and endurance. Patients in the control group received routine care as specified by their family physician.		between groups 0.08m/s (SE 0.04); p<0.05. 6-min walk distance: Mean difference in change between groups 28.21m (SE 12.52); p<0.05.

Transition to Home

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
O'Callaghan et al. 2022 **Ireland** **Systematic review**	All trials were assessed as having a high risk of bias.	17 RCTs including persons returning home after admission to an acute or rehabilitation stroke service. Sample sizes ranged from 33 to 6, 024. participants. Mean age ranged from 60 to 76 years. The proportion of women ranged from 17% to 63%.	In all trials, patients were randomized to receive a transitional care program or usual care (control group). Most of the interventions were educational, and delivered in person and via telephone/letters/instant messaging platforms, and directed at the patient and to the caregiver (n=5). Interventions were delivered mainly by nurses or an interdisciplinary team. Interventions were provided up to 6 months post discharge.	**Primary outcome:** Functional status **Secondary outcomes:** Depression & anxiety (HADS-A), SF-36, hospital readmission	Data from 14 trials were available for pooled analyses. At 3 months, the mean Barthel Index scores were significantly higher in the intervention group (MD=7.87, 95% CI 3.93-11.81; 5 trials included). GRADE: very low At ≥6months, the mean Barthel Index scores were significantly higher in the intervention group (MD=2.91, 95% CI 0.003-5.8; 6 trials included). GRADE: very low At 6-12 months, symptoms of depression were significantly lower in the intervention group (SMD=-0.17, 95% CI -0.29 to -0.05; 4 trials). GRADE: low Within 6 months, symptoms of anxiety were significantly lower in the intervention group (MD=-1.7, 95% CI -1.84 to -0.52; 2 trials). GRADE: very low

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
					Within 6 months, SF-36 scores were significantly higher in the intervention group (MD=1.3, 95% CI 0.85-1.76; 3 trials). GRADE: very low The intervention did not increase the risk of hospital readmission (RR=1.04, 95% CI 0.77-1.41; 4 trials included). GRADE: ?

Person-Centred Care

Study/Type	Quality Rating	Sample Description	Method	Outcomes	Key Findings and Recommendations
Martín-Sanz et al. 2022 **Spain** **Qualitative study**	NA	31 persons with moderate or severe stroke in the subacute or chronic stage. Mean age was 64 years, 35.5% were women. Mean time since stroke was 38 months.	Three researchers conducted semi-structured interviews, which were analyzed using thematic analysis.	**Primary outcome:** Not applicable	Three main themes were identified: (a) The person behind the “patient” label, recognizing the person beyond their illness and valuing their identity and individual characteristics. Categories included: Recognizing identity, sharing your life story and holistic care (b) The person at the centre of care, considering themselves as an active agent in their own care and respecting their preferences and expectations for their care process. Categories included participation in decision making and building bonds (c) Training for person-centred care (PCC), providing health professionals with tools to achieve professional skills for the implementation and development of the PCC model. Categories included emotional and personal competencies, professional role and the healthcare organization as a barrier.

Abbreviations

ADL: Activity of Daily Living	BI: Barthel Index	CA: Concealed Allocation

CI: Confidence Interval	ESD: Early Supported Discharge	FIM: Functional Independence Measure
IADL: Instrumental Activities of Daily Living	IQR: Interquartile Range	ITT: Intention to treat
MD: mean difference	mRS: modified Rankin Scale	N/A: Not assessed
OR: Odds Ratio	OT: Occupational Therapist	PT: Physiotherapist
SLP: Speech & Language Pathologist	SMD: Standardized Mean Difference	

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