

Navigating the Integrated Stroke Care Journey: Facilitator Guide

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About: This document is a **facilitator guide** related to the ***Navigating the Integrated Stroke Care Journey: Patient and Caregiver Perspectives*** interactive learning activity (or “journey map”). The journey map can be accessed through the following link: [Navigating The Integrated Stroke Care Journey: Patient and Caregiver Perspectives – Open Textbook](#)

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Facilitator's "Start Here" Guide

Excerpted from the **full Sample Learning Plan** in [Appendix A below](#): please adapt or adopt this quick start short lesson for your own purposes. Timing for activities and learner audience may be modified as needed.

Topic	Purpose and Details	Estimated Timing
Opening	Purpose: Grab learner's attention, build motivation, communicate why the lesson is important Options • Invite learners to connect personally to stroke care and rehabilitation • Draw on students' lived experience (e.g., practitioners supporting stroke patients) • Offer a compelling statistic Resources for Faculty Preparation Student Pre-Class Readings Sample opening material	5–10 mins.
Learning Outcomes	Purpose: present the learning objectives of the lesson.	3–5 mins.
Assess Student Understanding	Purpose: To assess what learners already know about Integrated Stroke Care.	5–10 mins.
Stroke Journey Activity	Purpose: To facilitate a walk through of the Journey Map tool in a synchronous format for students. Scripts Phase 1. Inpatient Hospital Care Phase 2. Community Rehabilitation Phase 3. Transition and Community Reintegration	45–50 mins.
Consolidate Learning	Purpose: Facilitate discussion with students about how topics of note are relevant to their future career development (pre-service) or current professional practice (post-diploma).	5–10 mins.
Summary	Purpose: to understand students' learning and experience using and/or observing the Journey Map Please ensure students complete the standard version of the feedback survey form.	10–15 mins.

Introduction to the Facilitator Guide

This learning activity, *Navigating the Integrated Stroke Care Journey: Patient and Caregiver Perspectives*, was adapted from the Stroke Journey Map created by the Central South Regional Stroke Network CSRSN in 2021, which illustrates the different phases a stroke patient may experience while recovering from stroke and navigating the healthcare system.

The activity is centered around an interactive journey map that depicts the experiences of patients, caregivers and staff through three phases of the stroke journey. The information is enriched by and made experiential through video narratives provided by a stroke survivor and two caregivers, key insights from a focus group of staff experts in interprofessional integrated stroke care and two supporting case studies.

The interactive experiential activity is intended to be facilitator-led. In this document, you will find:

- Theoretical underpinnings and competency frameworks influencing the project;
- Student learning outcomes;
- Required and recommended readings for instructors and students;
- Step-by-step instructions on how to lead learners through the interactive stroke journey map in a synchronous class format;
- Key takeaways and questions/prompts for discussion;
- A sample lesson plan that can be adapted for the format of each class (see [Appendix A](#));
- A sample feedback form which can also be adapted as needed (See [Appendix B](#)).
- An overview of the Ontario Stroke System for supplemental information (See [Appendix E](#)).

To prepare students for active participation in this activity, pre-class readings are provided for completion prior to class. The case studies that students will refer to are provided in the appendix (See [Appendix C](#)) for facilitator reference. The sample lesson plan includes suggestions on how the lesson can be introduced, learning objectives, and suggested pre-assessment, post-assessment and summary points. The lesson plan can be adapted according to the format and allotted time of your class.

Background

Stroke can be a life-changing event for individuals and their families. In a 2025 news release by the Heart and Stroke Foundation of Canada (HSFC), it was noted that in Canada, someone has a stroke about every five minutes. More recently, there has been an increase in the number of young people having strokes, and about 1 in 20 strokes occur in people under 45 years of age (Heart and Stroke Foundation of Canada (HSFC), 2025). Further, the number of people surviving stroke has increased over the last 10 years, and almost one million people are now living with the effects of stroke in Canada (HSFC, 2025).

Stroke is one of the leading causes of adult disability in Canada (HSFC, 2022). Its sequelae can include changes in physical abilities, such as communication, mobility, bowel and bladder control, and swallowing (HSFC, n.d.-b). There can also be changes to an individual's emotional well-being, energy levels, and thinking, such as cognitive changes, emotional changes, depression, fatigue and changes in perception (HSFC, n.d.-a). According to a 2022 report by the Heart and Stroke Foundation of Canada, half of all stroke survivors in Canada need help with daily activities like eating, bathing, dressing, or moving.

Each individual's stroke recovery journey is different, complex, and requires the involvement of many different healthcare professionals to assist them through their recovery. In reference to the stroke journey map developed by the Central South Regional Stroke Network in 2021, this journey can be divided into [3 phases](#):

1. Inpatient Hospital Care Phase
2. Community Rehabilitation Phase
3. Transition and Community Reintegration Phase

The **transition of care** between each of these phases is a critical point in the stroke journey, where a person's information and care needs are transferred between care providers, interprofessional teams, and settings (Registered Nurses Association of Ontario (RNAO), 2023). Communication and care process breakdowns can occur during these transitions, resulting in safety risks or adverse events for individuals (RNAO, 2023). A systematic meta-analysis of 32 studies reported that stroke survivors living in the community from various countries reported unmet care needs (Lin et al., 2021). In this review, the prevalence of unmet needs was 62.14%, indicating that at least one unmet need occurred within 6 months after stroke (Lin et al., 2021). The prevalence decreased to 22.43% after 6 months but then continued to increase to 81.37% at 2 years after stroke (Lin et al., 2021). The most commonly reported unmet needs of stroke survivors in the community include information needs, mobility needs, cognitive needs, secondary prevention, rehabilitation and social and communication needs (Lin et al., 2021).

Integration of Care

To ensure a more seamless transition between each phase, there is a need for integration of care. Integration of care means that services, providers, and organizations from across various care settings and sectors work in coordination with each other, complementing one another to ensure a seamless, unified system with continuity (Markle-Reid et al., 2020). A

2023 randomized controlled trial conducted by Markle-Reid et al. in Canada found that patients who received integrated interprofessional care in the community setting for 6 months had significantly greater gains in self-reported physical functioning, stroke self-management, and patient experience.

Additionally, a systematic review and meta-analysis of thirty-one randomized controlled trials by Tan et al. (2025) evaluated the effectiveness of multidisciplinary transitional care interventions and found improvements in patient outcomes, including functional status and quality of life. The review reported that patients' functional status improved when the multidisciplinary team included more than two professionals, allied health, and especially physicians and care coordinators, underscoring the importance of a coordinated and comprehensive team structure (Tan et al., 2025). Providing integrated care requires competence in person-centered care, interprofessional teamwork and collaboration, care coordination, digital skills, health promotion/disease prevention, a population health approach, leadership, and professional and ethical attributes (Barraclough et al., 2024).

Introduction to the Learning Activity

This learning activity aims to educate students/learners about **integrated interprofessional stroke care** in the community, enabling them to apply these principles in their professional practice. To support this aim, an experiential learning activity has been co-developed with input from stroke survivors, caregivers of stroke survivors, and experts in stroke care to increase students' knowledge, skills, and competency in providing equitable, integrated, interprofessional stroke care to vulnerable populations, with a specific focus on the community setting. This activity is also intended to increase student understanding of the impact of social justice, and diversity, equity and inclusivity (DEI) on individuals through the exploration of patients' experience of health inequities due to the Social Determinants of Health (SDOH), race, language, or cultural barriers, as these can pose as barriers during care transitions (RNAO, 2023). Furthermore, it supports the students' preferences for interprofessional authentic learning experiences (Price et al., 2025).

Student Learning Outcomes

Table 1

Student learning outcomes

By the end of the learning session, students/learners will be able to:	
1.	Define and apply the concepts and models of interprofessional integrated stroke care in Ontario.
2.	Critically analyze the facilitators and challenges in accessing equitable, diverse and inclusive stroke care related to several vulnerable populations.
3.	Describe the impact of social determinants of health on individuals living with stroke and access to care.
4.	Identify how this experiential learning opportunity impacts students' perspectives and understanding of patient and family experiences of stroke and how it will influence their future practice.

Suggested Material for Faculty Preparation

Table 2

Required and recommended readings for facilitators

Required
Barraclough, F., Smith-Merry, J., Stein, V., & Pit, S. (2024). An International Competency Framework for High-Quality Workforce Development in Integrated Care (IC): A Modified Delphi Study Among Global Participants. <i>International Journal of Integrated Care</i> , 24(2), 1-12. https://doi.org/10.5334/ijic.8258
Camicia, M., Lutz, B., Summers, D., Klassman, L. & Vaughan, S. (2021). Nursing's Role in Successful Stroke Care Transitions Across the Continuum: From Acute Care into the Community. <i>Stroke</i> , 52(12), e794-e805. https://doi.org/10.1161/STROKEAHA.121.033938
Liu, B., Cai, J., & Zhou, L. (2024). Effectiveness of Integrated Care Models for Stroke Patients: A Systematic Review and Meta-Analysis. <i>Journal of Nursing Scholarship</i> . https://doi.org/10.1111/jnu.13027
RNAO Best Practice Guidelines: Transitions in Care and Services (2023) https://rnao.ca/bpg/guidelines/transitions-in-care
University of Central Lancashire. (2022, February 22). <i>Stroke Specific Education Framework: 16 Elements of Care</i> . National Health Services in England. https://stroke-education.org.uk/framework/
Recommended
Barraclough, F., Smith-Merry, J., Stein, V., & Pit, S. (2021). Workforce Development in Integrated Care: A Scoping Review. <i>International Journal of Integrated Care</i> , 21(4), 1-14. https://doi.org/10.5334/ijic.6004
Goodwin, N. (2016). Understanding Integrated Care. <i>International Journal of Integrated Care</i> , 16(4), 1–4. https://doi.org/10.5334/ijic.2530
Heart and Stroke Foundation of Canada. (2026). <i>Stroke Systems of Care</i> . Canadian Stroke Best Practice Recommendations. https://www.strokebestpractices.ca/recommendations/new-stroke-systems-of-care
Kreber, C. (2001). Learning Experientially through Case Studies? A Conceptual Analysis. <i>Teaching in Higher Education</i> , 6(2), 217–228. https://doi.org/10.1080/13562510120045203
Markle-Reid, M., Valaitis, R., Bartholomew, A., Fisher, K., Fleck, R., Ploeg, J. & Salerna, J. (2020). An Integrated Hospital-to-Home Transitional Care Intervention for Older Adults with Stroke and Multimorbidity: A Feasibility Study. <i>Journal of Comorbidity</i> , 10, 1-21. https://doi.org/https://doi.org/10.1177%2F2235042X19900451

Toronto Stroke Networks. (2023). Stroke Services.

<https://www.tostroke.com/for-professionals/stroke-services/#:~:text=Integrated%20stroke%20care%20requires%20a.system-wide%20protocols>

World Health Organization. (2021, January 22). Rehabilitation Competency Framework.

<https://www.who.int/publications/i/item/9789240008281>

Student Pre-Class Readings

Table 3

Pre-class required and recommended readings

Required
Camicia, M., Lutz, B., Summers, D., Klassman, L. & Vaughan, S. (2021). Nursing's Role in Successful Stroke Care Transitions Across the Continuum: From Acute Care into the Community. <i>Stroke</i> , 52(12), e794-e805. https://doi.org/10.1161/STROKEAHA.121.033938
Goodwin, N. (2016). Understanding Integrated Care. <i>International Journal of Integrated Care</i> , 16(4), 1–4. https://doi.org/10.5334/ijic.2530
Liu, B., Cai, J., & Zhou, L. (2024). Effectiveness of Integrated Care Models for Stroke Patients: A Systematic Review and Meta-Analysis. <i>Journal of Nursing Scholarship</i> . https://doi.org/10.1111/jnu.13027
Markle-Reid, M., Fisher, K., Walker, K. M., Beauchamp, M., Cameron, J. I., Dayler, D., Fleck, R., Gafni, A., Ganann, R., Hajas, K., Koetsier, B., Mahony, R., Pollard, C., Prescott, J., Rooke, T., & Whitmore, C. (2023). The Stroke Transitional Care Intervention for Older Adults with Stroke and Multimorbidity: A Multisite Pragmatic Randomized Controlled Trial. <i>BMC Geriatrics</i> , 23(1), 687–22. https://doi.org/10.1186/s12877-023-04403-1
RNAO Best Practice Guidelines: Transitions in Care and Services (2023) https://rnao.ca/bpg/guidelines/transitions-in-care
University of Central Lancashire. (2022, February 22). <i>Stroke Specific Education Framework: 16 Elements of Care</i> . National Health Services in England. https://stroke-education.org.uk/framework/
Recommended
Heart and Stroke Foundation of Canada. (2026). <i>Stroke Systems of Care</i> . Canadian Stroke Best Practice Recommendations. https://www.strokebestpractices.ca/recommendations/new-stroke-systems-of-care
Markle-Reid, M., Valaitis, R., Bartholomew, A., Fisher, K., Fleck, R., Ploeg, J. & Salerna, J. (2020). An Integrated Hospital-to-Home Transitional Care Intervention for Older Adults with Stroke and Multimorbidity: A Feasibility Study. <i>Journal of Comorbidity</i> , 10, 1-21. https://doi.org/https://doi.org/10.1177%2F2235042X19900451
Toronto Stroke Networks. (2023). Stroke Services. https://www.tostroke.com/for-professionals/stroke-services/#:~:text=Integrated%20stroke%20care%20requires%20a,system-wide%20protocols

Theoretical Frameworks

Several competency and theoretical frameworks informed the development of this learning activity, including:

- The Competencies for High-Quality Workforce Development in Integrated Care by Barraclough et al. (2024);
- Rehabilitation Competency Framework as outlined by the World Health Organization (WHO, 2021);
- The Stroke Specific Education Framework by the University of Central Lancashire and National Health services England (2022);
- The Canadian Interprofessional Health Collaborative (CIHC) Competency Framework for Advancing Collaboration (2024);
- Kolb's Theory of Experiential Learning.

Please refer to [Appendix D](#) for detailed descriptions of each framework, or the “[Theoretical Perspectives and Competencies](#)” page in the pressbook for a short description of each framework.

A Competency Framework for High-Quality Workforce Development in Integrated Care by Barraclough et al. (2024)

This framework presents competencies to guide education facilities, workplaces, and accreditation in creating a trained workforce in integrated care. The framework includes eight key overarching domains and their related competencies. The domains include:

- Person-centred care,
- Interprofessional teamwork and collaborative practice,
- Care coordination,
- Digital skills and technology,
- Health promotion and disease prevention,
- Population health approach to care,
- Leadership,
- Professional and Ethical attributes.

Please refer to [Table 11](#) in Appendix D for more details.

The World Health Organization Rehabilitation Competency Framework (2021)

The World Health Organization (WHO) created a competency framework for rehabilitation in 2021 for all rehabilitation workers in five domains. These domains include:

- Practice,
- Professionalism,

- Learning and development,
- Management and leadership,
- Research.

The framework also includes activities associated with each competency. Please refer to the competency framework document for the different levels of mastery of each competency or activity, and the core knowledge related to each competency. Also, please see [Table 12](#) in Appendix D for further details.

The Stroke Specific Education Framework by the University of Central Lancashire and the National Health Service in England (2022)

The framework for stroke-specific education created by the University of Central Lancashire and the National Health Service of England (2022) outlines the knowledge and skills required by those caring for people with stroke, or who are affected by stroke. This framework comprises 16 elements of care and 4 elements of professional practice.

For the purposes of this learning experience, please refer to “Element 10: Specialist rehabilitation”, “Element 12: Seamless transfer of care”, “Element 13: Long term care”, “Element 14: Review”, “Element 15: Participation in community”, “Element 16: Return to work”, “Element 17: Professional behaviour and values”, “Element 18: Leadership, management, and governance”, and “Element 19: Education, training, and personal development”. Please visit the website for the framework for more in-depth information under each element. In addition, please refer to [Table 13](#) in Appendix D for more information.

The Canadian Interprofessional Health Collaborative Competency Framework for Advancing Collaboration (2024)

The Canadian Interprofessional Health Collaborative (CIHC) Framework (2024) guides educators, researchers, health administrators, service providers, and persons receiving care in fostering effective collaborative practice by focusing on supporting the application of knowledge, skills, attitudes, and values in real-world environments to guide behaviours that enhance collaboration. The framework has six interdependent competency domains including:

- Relationship-Focused Care/Services,
- Team Communication,
- Role Clarification and Negotiation,
- Team Functioning,
- Team Differences/Disagreements Processing,
- Collaborative Leadership.

The overarching goal of this framework is to improve healthcare and human services by promoting collaborative, relationship-focused partnerships for shared decision-making. Please refer to [Table 14](#) in Appendix D for more information.

Kolb's Theory of Experiential Learning (1984)

Kolb's theory of Experiential Learning influenced the experiential learning activity designed for students. Kolb's (1984) theory of Experiential Learning builds on the ideas of John Dewey (1938), who argues that education is grounded in experience and learning occurs through the reconstruction of and critical reflection on those experiences (Kreber, 2001). Kolb's (1984) theory asserts that knowledge is created through the transformation of an experience and that learning is only experiential when an experience is transformed into knowledge (Kreber, 2001). Please see [Appendix D](#) for further information about Kolb's theory of Experiential Learning.

About the Journey Map

The “Navigating the Integrated Stroke Care Journey” interactive journey map (as shown in **Figure 1**) is an experiential learning activity, divided into three phases: Inpatient Hospital Care, Community Rehabilitation, and Transition and Reintegration. This journey map can be located in the pressbook *Navigating The Integrated Stroke Care Journey: Patient and Caregiver Perspectives* through the following link:

[Navigating The Integrated Stroke Care Journey: Patient and Caregiver Perspectives – Open Textbook](#)

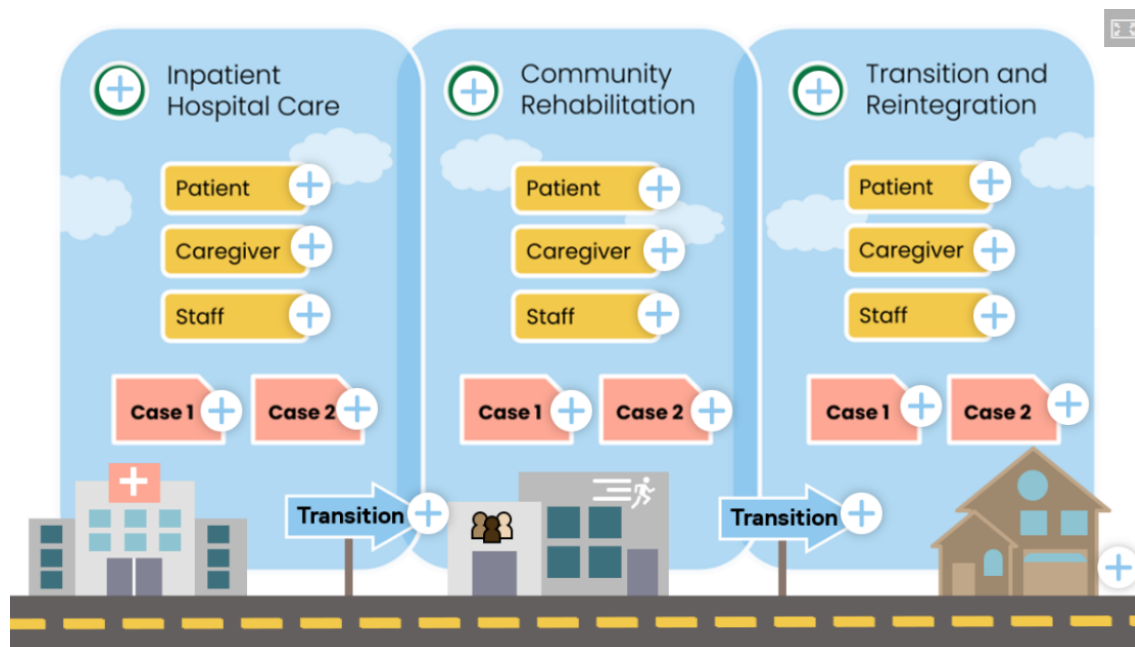


Figure 1: Screenshot of the interactive journey map learning activity.

About the Facilitator Guide

The activity is intended to be facilitated in a synchronous format, either in-person or online. The facilitator and students will go through the activity together, and the text portions of the activity will be read aloud in class. This guide provides key concepts to highlight to students and suggestions for how to facilitate the activity. Also, reflective questions and short activities are provided throughout this document to assist in the facilitation of the activity and maximize student learning through experience, as guided by Kolb’s experiential learning theory.

The information provided in the following sections is organized in accordance with the **planned progression of the activity**:

1. Click on the hotspots in the sequence outlined in **Table 4** for each phase.
2. After each hotspot, allocate time for the sample discussion prompts. These prompts help students critically reflect on the information being presented to them.
3. After each phase, pause and debrief to help students connect what they just learned to their prior experiences and imagine how this information will help change their practice in the future. Use the key concepts and the sample discussion questions provided in the debrief section to generate conversation.

Please refer to the interactive journey map as you read through this guide.

Table 4

Hotspots in each phase.

All three phases include the following clickable “hotspots” that open a pop-up with content.

#	Name of hotspot	Type of content	Description of content
1	<i>“Inpatient Hospital Care”</i> (phase 1) or <i>“Community Rehabilitation”</i> (phase 2) or <i>“Transition and Reintegration”</i> (phase 3)	Text	Introductory information about each phase in the stroke journey.
2	<i>“Patient”</i>	Video and text	Narrative vignette from an interview conducted with a patient.
3	<i>“Caregiver”</i>	Videos and text	Narrative vignettes from the perspective of two caregivers. Note: There is no relationship between the caregiver and patient narratives, as each narrative details separate experiences with stroke.
4	<i>“Staff”</i>	Text	Information gathered through two focus groups conducted with experts.
5	<i>“Case 1”</i>	Text	Details from the case study of “Mrs. Johnson”, a 60-year-old Black Canadian woman.
6	<i>“Case 2”</i>	Text	Details from the case study of “Mr. George Big Canoe”, a 68-year-old Anishinaabe man.
7	<i>“Transition”</i> (Phases 1 and 2 only)	Text	Information about the transition from one phase to the next, addressing important details about safety and Equity, Diversity and Inclusion (EDI) concepts.

Phase 1: Inpatient Hospital Care

Estimated time 45 mins

In this section, a description of each Phase 1 hotspot is provided, along with key concepts to highlight and sample discussion questions.

About Phase 1: Inpatient Hospital Care

The first phase of the stroke journey is the inpatient acute care (IAC) phase. Please refer to the hotspot to familiarize yourself with the content.

Recommended: For background information and overarching concepts related to Phase 1, review [Appendix E](#).

Hotspot 1: Inpatient Hospital Care

About this hotspot

Estimated time: 1 min 15 sec (+ 1 min for explanation)

This hotspot introduces to students the acute care phase of the stroke journey, which spans from the initial call to emergency services and emergent treatment to the inpatient acute and rehab care received by patients. It also introduces students to the various interprofessional team members who work with the patient during this phase.

Key concepts to highlight

- The types of stroke,
- The sequelae of the stroke,
- The settings where acute care is provided (i.e. regional stroke centers versus inpatient rehabilitation facilities),
- The various interprofessional experts involved,
- The required considerations in preparing patients for the transition out of the hospital.

Sample questions for discussion

None.

Hotspot 2: Patient

About this hotspot

Estimated time: 3 mins + 2 mins for discussion (+1 min for explanations)

This hotspot includes a short video vignette (1 min 50 sec) and text from an interview conducted with a patient about the acute care phase of his stroke journey. This patient had an ischemic stroke, leaving him with changes in speech and paralysis of his leg, for which he received acute care in the intensive care unit and inpatient stroke unit.

Key concepts to highlight

- Duration and setting of acute care,
- The initial rehabilitation that took place,
- The various professionals involved in his care,
- The impact of the stroke on his life.

Sample questions for discussion

1. What are some of the services he received from the interprofessional stroke team during this phase? (Occupational Therapist [OT], Physiotherapist [PT], Speech Language Pathologist [SLP], nurses, doctors, and pharmacists).
2. Reflect on the impact that the stroke event may have had on this patient's life. What are some impacts to consider? (mobility changes, impacts on employment, and impact on finances)
3. As a member of the interprofessional healthcare team, how can you help prepare this patient for discharge into the community? What are some considerations required in planning for the patient's discharge to home?

Hotspot 3: Caregiver

About this hotspot

Estimated time: 7 min 40 sec + 4 mins for discussion (+2 min for facilitator explanation)

This hotspot includes video (5 min 40 sec) and text vignettes from two caregivers:

1. Caregiver 1's father suffered an ischemic stroke that left him with paralysis in his left arm and mobility difficulties due to weakness in his left leg.
2. Caregiver 2's father, who was initially admitted for a mental health crisis, suffered an ischemic stroke with hemorrhagic transformation for which he was rushed to a regional stroke center as a "life or limb" call for emergent treatment.

Both caregivers explained that their fathers required care in a regional stroke center initially, then care in an acute stroke unit before being prepared for different discharge destinations.

Key concepts to highlight

- Important similarities and distinctions in each patient's trajectory, including the types of rehabilitation services they received, and how the patients were prepared for discharge to their respective destinations;
- Emotional, physical, and financial impact of the stroke on the patient and their caregivers;
- The level of advocacy required on the part of the caregivers;
- The impact of Social Determinants of Health (SDOH) – culture, language, socioeconomic status, etc. – on the patient and caregiver's ability to advocate for themselves.

Sample questions for discussion

Facilitators can ask students to answer some of these questions **in pairs or small groups** and then report back to the larger class.

1. Compare the experiences of the caregivers. What were some similarities and differences in their experiences with the health care team during this phase?
2. Reflect on the changes that occurred in the lives of patients due to the stroke. How did the stroke impact their ability to communicate and, therefore, advocate for themselves?
3. What are some of the ways in which the healthcare team effectively supported the patients and the caregivers? What are some ways that the team could have better supported them?
4. How do the different SDOH and EDI concepts impact the care that patients and their families receive during the acute care phase? How can you help the patients receive equitable care?
5. How can you, as a nurse, prepare these patients for transition to their respective discharge destinations? What services might these patients and their families require? Which interprofessional team experts do you anticipate needing to collaborate with, and what do you require of the other members to maximize the impact of your efforts?

Hotspot 4: Staff

About this hotspot

Estimated time: 1 min 30 sec + 2 mins for discussion (+1 min for facilitator explanation)

This hotspot includes knowledge gained from 2 focus group discussions with experts in interprofessional stroke care: one with acute care clinicians and the other with community-based stroke team members. This hotspot aims to highlight the differences in stroke patient care trajectories and needs based on various factors, particularly the SDOH.

Key concepts to highlight

- It can be difficult, but it is essential to help patients and families come to terms with the reality of their situations and guide patients and families through a sense of grief that many often face due to the changes in their lives caused by the stroke.
- The hospital setting does its best to rehabilitate the patient and provide the necessary referrals to prepare for discharge, but it is difficult for hospital staff to know whether the appropriate services are being provided, as these services can be difficult to coordinate.

Sample questions for discussion

These can be adapted for different learner groups.

1. As a nurse planning for discharge, what are some considerations you might take into account when planning for patient transition out of the hospital? Please refer to the RNAO and Heart and Stroke guidelines to assist in the planning. Which services might you consider? How will the SDOH impact the options you provide to patients?
2. What are some of the emotional impacts of the stroke on the patients and their families?
3. Reflecting on your readings and guidelines, in which ways can nurses facilitate a safe and seamless transition? Apply the principles of integrated care to your answer as well.
4. What are some considerations when communicating information to the patient and their families? (Aphasia, changes to vision, memory changes, cognitive changes, emotional state, language barriers, and cultural understandings)

Hotspot 5: Case 1

About this hotspot

Estimated time: 2 mins + 2 mins for discussion (+1 min for facilitator explanation)

This hotspot explores the parts of the first case study that align with how acute care may be experienced from the perspective of a Black Canadian Woman, in this case, 60-year-old Mrs. Sarah Johnson. Mrs. Johnson comes to the emergency with an ischemic stroke, and the case study describes the care she receives in detail.

Key concepts to highlight

- The stroke features: type of stroke, stroke symptoms, and stroke sequelae;
- Emergent assessments and treatments received;
- Settings in which the patient was cared for;
- Types of rehabilitation services provided in the hospital;
- Common experiences patients and their caregivers might have while receiving care.

Sample questions for discussion

1. Reflect on the care that Mrs. Johnson received. What would you take into consideration when planning her transition out of the hospital?
2. Consider the intersection of being a Black Canadian woman and her experience during the acute care phase. How might this impact the care that was provided to her, her needs during the acute care phase and her needs to transition out of the hospital?
3. How can you ensure that Mrs. Johnson receives equitable care?

Hotspot 6: Case 2

About this hotspot

Estimated time: 1 min + 2 mins for discussion (+1 min for facilitator explanation)

This hotspot includes the information from the second case study that aligns with the acute care phase. Mr. Big Canoe belongs to the Indigenous community and lives in a remote reserve outside the catchment area of many services.

Key concepts to highlight

- Role of EDI and SDOH in the experiences and care of this patient.
- The remoteness of his residence, the amount of time and coordination emergency response takes in his area, and how this may limit a person's eligibility for time-sensitive treatment options.

Sample questions for discussion

1. What does it mean to provide culturally sensitive and patient-centered care, and how would you apply this when caring for Mr. Big Canoe in the hospital?
2. What are some considerations when planning for the discharge of Mr. Big Canoe?
3. Keeping the guidelines for safe transitions and integrated care in mind, identify which other health care professionals should be involved in the interprofessional team. How can you ensure smooth transitions through the use of integrated care principles?
4. Identify the impact of the SDOH on your plan for the rehabilitation of this patient.

Hotspot 7: Transition

About this hotspot

Estimated time: 1 min 30 sec + 2 mins for discussion (+1 min for facilitator explanation)

This is the last hotspot to click for the acute care phase. This hotspot provides the opportunity to learn how to help patients and their caregivers with the transition of care from within the hospital to the community setting.

Key concepts to highlight

- Various settings that patients can transition to,
- How to ensure safe transitions in care,
- Impact of the SDOH and DEI on transitions in care,
- Importance of integration of care.

Sample questions for discussion

Tie back to the [Learning Outcomes](#).

1. Describe one major issue you perceive as likely to surface for stroke patients as they experience this transition point.
2. Identify one action you feel an acute care nurse is professionally obligated to take to help minimize the harms transitioning stroke patients may experience following their transition from acute or community care.
3. What is a personal action you could take that would help? Describe, in professional terms, one benefit and one risk (to yourself, to the patient, to their family) that might result from taking such an initiative.

Debrief Activity

Estimated time: 5-15 mins (instructors can choose items)

Please pause after going through all the hotspots under the acute inpatient phase to give students an opportunity to reflect and engage in interactive discussion about what they just learned.

Some questions you may use (not all need to be discussed, you may choose) to engage students in critical discussion include:

1. What are some commonalities in the experiences of the patients, caregivers, experts and the patients in the case studies? What are some key differences?
2. What is the impact of the various SDOH on the experience of each patient, caregiver and the case studies patients?
3. Consider what the team could have done to better support the patients and their caregivers and promote patient- and family-centered care.
4. What are some key considerations when planning for patient discharge and rehabilitation for patients transferring out of the hospital to various settings, such as supported living or home?
5. How can the RNAO's best practice guidelines be used to promote a safe transition?
6. How might the backgrounds of each patient impact their experiences with the healthcare system so far?

Phase 2: Community Rehabilitation

Estimated time: 47 mins and 15 sec

About this phase:

In this section, a description of each Phase 2 hotspot is provided, along with key concepts to highlight and sample discussion questions. The second phase of the stroke journey revolves around rehabilitation in the community setting. Some key overarching concepts include:

- The involvement of an interprofessional team in the care of a patient in the community is based on patients' varying levels of care needs;
- The impact and importance of integrated stroke care;
- The effects of the SDOH on equitable access to care in the community and how best to support them. For example, consider:
 - Coverage of services through the government;
 - Persons whose employment status has changed or whose socioeconomic status impacts their ability to afford medications, equipment (such as walkers, back chairs, wheelchairs), or rehabilitation services and how this impacts recovery;
 - The impact of education, age, or language on communication, accessibility to education materials or the ability to use virtual services;
 - The physical and cognitive changes that result from the stroke and how they can impact a range of accessibility factors, including, but not limited to, transportation, communication or use of a computer/phone;
 - Accessibility services for those in supportive housing.
- The roles and responsibilities of caregivers and their impact on their lives;
- The right timing for peer support and patient or caregiver readiness for such conversations.

Hotspot 8: Community Rehabilitation

About this hotspot

Estimated time: 1 min 15 sec (+ 30sec for facilitator explanation)

This hotspot introduces students to the second phase of the stroke journey: patient rehabilitation in the community setting.

Key concepts to highlight

- The types of community settings (e.g., outpatient rehabilitation, in-home community care);
- The various interprofessional team members working with patients in the community;
- The follow-ups that are needed;
- The cost associated with services.

Sample questions for discussion

None.

Hotspot 9: Patient perspective

About this hotspot

Estimated time: 3 mins 30 sec + 2 mins for discussion (+1 min for facilitator explanation)

This hotspot contains a video (2 min) and a text description of the patient's perspective of his transition from the hospital to home with community rehabilitation support.

Key concepts to highlight

- Services received by the patient,
- Having to learn to navigate and coordinate some services on his own,
- Government coverage of services,
- Costs associated with required services,
- Follow-ups that he received,
- The need to better support care coordination and navigation in the community,
- The impact of the SDOH on service accessibility.

Sample questions for discussion

- 1) In which ways did the team prepare the patient well for transfer to the community?
- 2) Based on your knowledge of integrated care, how might the patient have been better supported in the community?
- 3) What are some of the barriers to accessibility of services that you noticed? Which SDOH can you identify?

Hotspot 10: Caregiver perspective

About this hotspot

Estimated time: 10 mins + 4 mins for discussion (+2 min for facilitator explanation)

This hotspot contains two videos (6 mins and 20 sec) and text about experiences during the community rehabilitation phase from the two caregivers' points of view.

1. Caregiver 1's narrative talks about her father's having to first go to an assisted living facility and then home to live with her brother. She mentions that the definition of home changed for her father. There was also a significant amount of advocacy required on the caregiver's part to get the patient approved for the services that were needed for the patient. She talks about the high level of support her father received in the assisted living facility, but how he became depressed. He was then shifted to Caregiver 1's brother's home, where significant costly adjustments had to be made to make the home accessible, and extensive advocacy was once again required to gain access to the necessary services for her father. When services were arranged, they were limited, or there was a cost associated with them.
2. Caregiver 2 also talks about her father's need for physiotherapy, occupational therapy and nursing visits in the community, but that the services were limited and there was much advocacy required on the part of the caregiver to obtain access to those services. Her father's case worker prepared her mother well by informing her of the follow-ups that they would receive and helping them with the appropriate referrals. The patient's mental health condition significantly impacted his motivation to continue doing his exercises.

Key concepts to highlight

- The different kinds of settings in which community care takes place;
- The level of advocacy required to gain access to the necessary services for the care of the patient in the community;
- The limitations on the services;
- The physical/emotional/mental barriers posed by the sequelae of the stroke;
- The impact of this event on the caregiver's life.

Sample questions for discussion

- 1) Compare the experiences of the patients and their caregivers. What are some of the challenges they both encountered during this phase?
- 2) What are some of the gaps in and barriers to services described by these caregivers?
- 3) What are ways in which you can better support these caregivers and patients?
- 4) Consider the impact of the SDOH and EDI on the experiences of the caregivers and patients. What were some facilitators versus barriers to a smooth recovery journey? How might the journey look different for a patient who comes from a low-income immigrant family?

Hotspot 11: Staff perspective

About this hotspot

Estimated time: 1 min 30 sec + 2 mins for discussion (+1 min for facilitator explanation)

Informed by inpatient and outpatient stroke clinicians, this hotspot outlines key topics for discussion with learners.

Key concepts to highlight

- Initial assessments and referrals for outpatient services, e.g., OT, PT, Social Worker (SW), and SLP;
- Long wait times for outpatient rehabilitation;
- Unpredictability of the stroke recovery journey with fluctuations in progress and changing patient needs over time;
- The varying accessibility to services based on geographical areas;
- Lack of standardized services and the need to pay for some services;
- Lack of mental health resources for stroke patients;
- Barriers to service access, such as transportation challenges, limitations from the stroke, fatigue post stroke, and socioeconomic status;
- Post-stroke depression screening for patients and caregiver fatigue;
- Role of peer support in providing social connection, hope, and reducing isolation for both patients and caregivers and how it fosters a sense of community that can contribute to more attainable recovery goals;
- The importance of stroke-specific therapy;
- Feelings of confusion and overwhelm due to the complexity of outpatient services;
- The need for navigation and coordination support for services, therefore, solidifying the need for integrated care.

Sample questions for discussion

- 1) What is the role of the initial assessment? How might the delay in referrals impact patient outcomes? How can we improve access to timely care?
- 2) How can you help caregivers and patients manage their expectations and fluctuations of the stroke journey?
- 3) What might be some barriers to access of healthcare services for patients in remote areas? What are some ways to improve access?
- 4) How can standardization and integration of care improve access for patients?
- 5) How can we better support the caregiver's need for respite?
- 6) What are some important follow-ups for the patient in the community?

Hotspot 12: Case Study 1

About this hotspot

Estimated time: 1 min 30 sec + 2 mins for discussion (+1 min for facilitator explanation)

This hotspot explores the parts of the first case study (Mrs. Sarah Johnson's case) that align with the community rehabilitation phase.

Key concepts to highlight

- The types of rehabilitation services Mrs. Johnson receives in the community;
- Whether she was prepared adequately in the hospital for discharge and use of services;
- How her normal has changed in terms of mobility, driving, and work;
- The emotional impact of being dependent on others;
- The importance of social support and peer support;
- The need for caregiver respite;
- Mrs. Johnson's need for virtual meetings;
- The importance of education on how to prevent a second stroke and how the recovery journey is non-linear;
- The intersection of how being a woman, being Black, being Black-Canadian, and being a Black-Canadian woman may impact her risk of having another stroke and how it may impact her access to services.

Sample questions for discussion

- 1) Was Mrs. Johnson adequately prepared for discharge? What are some considerations for her discharge?
- 2) As a Black-Canadian woman with strained finances, what are some ways to improve her ability to access services?
- 3) What are some emotional and mental impacts of the stroke sequelae on the patient?

Hotspot 13: Case Study 2

About this hotspot

Estimated time: 1 min + 2 mins for discussion (+1 min for facilitator explanation)

This hotspot explores the parts of the second case study (Mr. Big Canoe's case) that align with the community rehabilitation phase.

Key concepts to highlight

- Mr. Big Canoe's cultural needs and the remoteness of his discharge location, as he is returning to a reserve that sits beyond the catchment area of services;
- The limitations on accessibility to services due to the need to travel and the lack of services offered in his area;
- The funding for his community rehabilitation;

- The limited follow-up Mr. Big Canoe had with a physician, which can impact how his risk for a second stroke or other conditions is managed;
- His need for virtual support and the need to consider whether or not he has the necessary equipment, the skill to use it and how the sequelae of the stroke might impact his ability to use these services;
- The need to integrate his cultural practices into his rehabilitation activities;
- The need to prepare him and his family well for discharge and ensure a comprehensive handover of care;

Sample questions for discussion

- 1) Identify what the team did well to prepare this patient for discharge. What might be done differently?
- 2) Identify how the team supported this patient well while he was continuing with rehabilitation in the community.
- 3) Consider how the SDOH and EDI concepts may pose as barriers or facilitators for the care of this patient.

Hotspot 14: Transition

About this hotspot

Estimated time: 1 min + 2 mins for discussion (+1 min for facilitator explanation)

This hotspot represents the transition of the stroke journey from participating in community rehabilitation to the next phase, community reintegration, where stroke survivors resume their life roles.

Key concepts to highlight

- Transitions are not linear, as survivors may require acute care at any time;
- The impact of stroke on each patient or caregiver differs, so it is essential to be aware of the potential range of impacts and the resources or services that different patients may require to enable them to live a full life in the community;
- The risk of another stroke event and the importance of prevention;
- The importance of safe transitions.

Sample questions for discussion

- 1) Consider the assessments healthcare workers must complete to help transition the patient to a more integrated role in society.
- 2) What impacts might the SDOH and EDI concepts have on your planning to provide further resources to the patient?

- 3) Consider the impact on caregivers and family members. How might you provide respite for them?

Debrief Activity

Estimated time: 5 mins

After going through all the hotspots in the community rehabilitation phase, please pause to allow students to reflect on and discuss what they learned.

Sample questions for discussion

1. From the perspective of a stroke patient, what is one way that this transition point may resemble the previous transition? What is one key difference?
 2. Did you notice any experiences that were common amongst the patients, caregivers, staff and case study patients? Did you notice any significant differences?
 3. Consider how the SDOH impacted each person's (patient, caregivers and case study patients) experience with health care. How might the SDOH have posed as barriers or enablers for smooth access to health care in this phase?
 4. What is one thing you would do differently as a nurse caring for the patient, caregivers or case study patients in the community?
 5. Describe one major issue you perceive as likely to surface for stroke patients as they experience this transition point.
 6. Identify one action you feel an acute care nurse is professionally obligated to take to help minimize the harms transitioning stroke patients may experience following their transition from acute or community care.
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Phase 3: Transition and Community Reintegration

Estimated time: 35 mins and 30 seconds

About this Phase:

In this section, a description of each Phase 3 hotspot is provided, along with key concepts to highlight and sample discussion questions.

Hotspot 15: Transition and Community Reintegration

About this hotspot

Estimated time: 1 min (+1 min for facilitator explanation)

This hotspot describes the transition and community reintegration (TCR) phase of the stroke recovery journey, where individuals aim to return to meaningful activities, community involvement, and life. The degree to which reintegration to formal roles occurs depends on the individual patient's recovery status. During this phase, individuals may require assistance in resuming employment, educational roles, and leisure and recreation activities, while continuing to access community services and maintain medical follow-up.

Key concepts to highlight

- The need for longer-term in-home community support (e.g. in-home assistance at night);
- The limited or lack of government assistance;
- The financial burden on families to afford services and the cost of private care which can be frustrating for clinicians too;
- Students should recognize this as a gap in care.

Sample questions for discussion

none

Hotspot 16: Patient Perspective

About this hotspot

Estimated time: 3 mins 30 sec + 2 mins for discussion (+1 min for facilitator explanation)

In the video vignette (2 mins and 24 sec) and text, the patient describes relying on peer support groups to gain a sense of social support and belonging with other stroke survivors. He described that having other peers to talk with provided a sense of social connection and helped alleviate his depression and anxiety. Peer support fostered the patient's confidence and motivation to reintegrate into the community. He was also motivated to prevent further complications, and so he made lifestyle changes.

Key concepts to highlight

- The presence of anxiety and depression in stroke survivors, worsened by stroke sequelae;

- Peer support as a way to find social support, connection and relatability with others who have aphasia and functional changes;
- The ability of the patient to focus on the positives and find a positive meaning in his experience;
- The need to relearn some basic skills, like socializing in a new way;
- Having to find new kinds of employment (due to changes in speech, the ability to drive to work or paralysis);
- The need to balance treatment costs while seeking employment.

Sample questions for discussion

1. How has this patient's life role changed after his stroke?
2. How can the SDOH act as both barriers and facilitators to the successful reintegration of the patient into the community?
3. In what ways can the healthcare team support the patient's successful reintegration into the community and workforce?

Hotspot 17: Caregiver Perspectives

About this hotspot

Estimated time: 3 min + 2 mins for discussion (+1 min for facilitator explanation)

1. **Caregiver 1** (17 sec video) describes that her father was not able to work as he previously did and lost his business. His eating, recreation and social habits had to change. There was a lack of help with transportation, cooking and socializing. Although the caregiver finds a silver lining in becoming closer to her father after the stroke, she reflects on the strain on herself and her siblings of becoming caregivers, especially with regard to the aspect of sharing the load within each sibling's means.
2. **Caregiver 2** (1 min and 2 sec video) describes that following the stroke, her father had to go into early retirement. She also describes the communication challenges that come with aphasia and having to find a new identity, having to cope, and having to advocate for themselves. She also emphasizes the need for integrated and patient-centered care when supporting the individual.

Key concepts to highlight

- The mental and emotional toll of going from being in an independent and leadership position at work to now losing a sense of independence, and having to rely on others for basic life needs;

- The role reversal of going from being a caregiver for their family to being cared for by their family;
- The impact of losing a source of income and a business that required years of work to build;
- The impact of the pandemic's isolation period on patients who were already isolated;
- The importance of depression screening after stroke;
- The impact of taking on the role of caregiver for children in families and the changes in family dynamics that occur;
- The changes that occur in employment and finances;
- The role of communication in the lives of individuals and what it means to not be able to communicate when it comes to advocating for oneself, accessibility to services, and everyday activities;
- Identity renegotiation, as the changes resulting from a stroke may lead to changes in one's sense of self and identity.

Sample questions for discussion

1. Reflect on the ways in which loss of normal life roles or activities impacts the patient. How can the team support the patients in finding their new normal?
2. How might your understanding of these impacts influence your care of the stroke patient in the future?

Hotspot 18: Staff Perspective

About this hotspot

Estimated time: 1 min + 2 mins for discussion (+1 min for facilitator explanation)

Within this hotspot, first, the focus is on the process of accessing and receiving services in the community and the evolving needs of patients. Patients may require help with simple everyday tasks, such as a companion on public transport, for group activities, shopping and navigating their environment safely.

Key concepts to highlight

- The gaps in these services and the limitations to access them;
- Help students explore the various barriers to accessing these services, such as cost, a lack of culturally sensitive care, geographical barriers, and limitations on the services offered by the government;
- Barriers also exist for virtual services, such as the availability of equipment, network connection or the ability of patients to type/click/see;
- The mental and emotional consequences of the stroke and how that complicates the recovery journey;

- The changing needs of patients and their trajectories.

Sample questions for discussion

- 1) Reflect on what you have learned. What key concepts might you consider when conducting discharge planning or planning for services in the community in the future?
- 2) What are some considerations based on the impacts of the stroke, the SDOH, and EDI when planning care during this phase

Hotspot 19: Case study 1

About this hotspot

Estimated time: 30 sec + 1 min for discussion (+1 min for facilitator explanation)

Mrs. Johnson was previously earning a living as a grocery clerk and was also a caregiver for one of her parents. She was already experiencing financial constraints as a result.

Key concepts to highlight

- Reflect on Mrs. Johnson's ability to go back to work and the government support that is available to her.

Sample questions for discussion

- 1) Reflect on Mrs. Johnson's changing roles and her risk of depression. Consider the mental and emotional consequences of not being able to perform her usual roles in life.
- 2) How might the sequelae of the stroke limit Mrs. Johnson's ability to reintegrate into the community?

Hotspot 20: Case study 2

About this hotspot

Estimated time: 30 sec + 1 min for discussion (+1 min for facilitator explanation)

Mr. Big Canoe participates in cultural ceremonies and gatherings and is well supported by his family. He has a gradual improvement in his physical abilities and communication skills.

Key concepts to highlight

- Reflect on the importance of culture in the reintegration of Mr. Big Canoe.

Sample questions for discussion

- 1) What is the importance of culture when helping this patient reintegrate into the community?
- 2) How might the health care team support the process of his reintegration?

Concluding Debrief Activity

Estimated time: 10 mins (+2 min for facilitator explanations)

After having gone through all the hotspots in the transition and community rehabilitation phase, please pause to allow students to reflect on their learning and engage in a discussion. This is the final debrief point, so it is suggested to reflect on the entire activity. Depending on the students' experience level, different questions can be used or questions can be adapted.

Sample questions for discussion:

New Students

- 1. What do you notice as key similarities and differences between the communities you have been learning about and those represented in these examples?

Current Practitioners

- 2. Consider the communities within which you currently work. What do you notice as key similarities and differences from the examples and cases represented here?
 - Within the three phases represented here?
 - During transitions?

For All Learners

- 3. The categories of "patient," "caregiver," and "staff" clearly represent a wide variety of community members and professionals and a range of lived experiences.
 - Identify one experience or moment from each of their stories that, if you were to encounter it, you feel well-equipped, personally and professionally, to address, and briefly describe how you would do so.
 - Consider one experience from each that you currently feel poorly-equipped to address, and identify services or supports (either from within the community, across the region, or that are available elsewhere) that you feel would be most helpful.

Conclusion

Estimated time: 17-20 mins

The interactive learning activity is complete. To conclude the learning experience, the sample learning plan recommends a short, informal post-assessment to determine whether students achieved the intended learning outcomes. Have a short class discussion and ask the students about:

- Interesting concepts and key takeaways they learned during the activity.
- Comments.
- How learners will apply what they have learned to their practice in the future. Perhaps use prompts such as, “How might this new knowledge change the way you engage with patients?”

Please explain to the students the format through which the learning will be assessed through a formal assessment.

Finally summarize and reiterate key points, and situate learning in the broader context of the course. Tie the information back to learning outcomes.

Please dedicate time (5-8 mins) at the end of class to have students complete the feedback form provided.

Thank you for your immense time and effort in preparing for and facilitating this learning activity for the students.

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Appendix A

Sample Learning Plan

This learning plan follows the BOPPPS model for structuring class time that is outcome-focused and offers opportunities for student engagement and assessment (Wilfrid Laurier University Teaching Excellence & Innovation (WLUTEI), n.d.). The BOPPPS structure for class time stands for the following (WLUTEI, n.d.):

- B - Bridge in
- O - Learning Outcomes
- P - Pre-Assessment
- P - Participation
- P - Post - Assessment
- S - Summary

Below, readers will find recommendations on how facilitators can structure class time. This plan can be adapted as needed for the context of each class.

Table 5

Suggested Session Agenda

The following recommendations are based on a class time of 100 minutes.

Section	Details and Materials, Resources	Time
Bridge In	Purpose: Grab learner's attention, build motivation, communicate why the lesson is important To hook the learners, choose <i>one or two</i> from the following suggested ways to begin discussion: 1) To help learners connect personally to the lesson and empathize with the frustrations of a fragmented system, begin by asking whether they have experienced making a phone call to a company and having long wait times, being juggled between departments, needing multiple phone calls, being placed on long holds and then receiving conflicting information. ○ Use the experiences shared and have students imagine a health care system that is fragmented. For example: "Imagine having to navigate rehabilitation, living with a	5-10 mins

	new normal and coordinating home care services, but these services do not communicate with one another.” 2) To draw on the varying experiences of students and create student investment in the topic, you can ask about: ○ Students’ experiences with working in a community setting to provide care for chronic conditions ○ Experience with a family member or self needing community care for chronic conditions 3) The following compelling statistics can emphasize the scale of stroke and need for home care in Canada: ○ Between 2022 and 2032, the population of 65+ seniors is expected to grow by 34% (Health Canada, 2024) ○ Approximately 700,000 families in Ontario rely on home care annually (Health Canada, 2024) ○ Stroke ranked fourth on the list of leading causes of death in Canada in 2023 (Statistics Canada, 2025) ○ About every five minutes, someone in Canada has a stroke (Heart & Stroke Foundation of Canada (HSFC), 2025). ○ There is an increasing number of young people having strokes (HSFC, 2025). About one in 20 strokes occurs in people under 45 years of age (HSFC, 2025). ○ According to the Heart and Stroke Foundation of Canada, in 2025, almost one million people are living with stroke. ○ Stroke is one of the leading causes of adult disability in Canada (Heart and Stroke Foundation of Canada, 2022). According to a 2022 report by the Heart and Stroke Foundation of Canada, half of all stroke survivors in Canada need help with daily activities like eating, bathing, dressing, or moving. ○ A systematic meta-analysis of 32 studies regarding unmet needs of community-dwelling stroke survivors from various countries reported the following (Lin et al., 2021): ■ The most reported unmet needs of stroke survivors in the community include information needs, mobility needs, cognitive needs, secondary prevention, rehabilitation and social and communication needs (Lin et al., 2021).	
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	■ The prevalence of unmet needs was 62.14% with at least one unmet need within 6 months after stroke (Lin et al., 2021). The prevalence decreased to 22.43% after 6 months but then continually increased to 81.37% at 2 years after stroke (Lin et al., 2021). Somewhere along the way, needs are being missed for our patients once they are in the community. ○ A 2023 randomized controlled trial conducted by Markle-Reid et al. in Canada found that patients who received integrated interprofessional care in the community setting for 6 months had significantly greater gains in self-reported physical functioning, stroke self-management, and patient experience. Connect these statistics to the learning activity. Consider what they imply, i.e. the interprofessional integrated approach. For example: ● The statistics demonstrate that the <i>occurrence of stroke is high</i> in the community and has a great impact on the lives of individuals. Many survive but are <i>left with disabilities</i> as a result. Effects of stroke may include communication difficulties, swallowing issues, mobility problems, bowel and bladder issues, paralysis, fatigue, depression, vision problems, cognitive issues, and loss of sensation (Public Health Agency of Canada, 2017). ● Persons experiencing stroke usually have other <i>comorbidities</i> that also require care. The complexity of each person's needs can differ based on these factors, and they may need the help of several health care professionals. However, research has shown that once stroke survivors are transitioned into the community, some of their <i>care needs are missed</i>. ● <i>Integrated interprofessional stroke care</i> is an approach to care that can help coordinate and integrate the services provided by various health care professionals into a seamless system. Integrated interprofessional care models have shown positive patient outcomes. This is a good opportunity to engage students. Ask them what this means for their practice? How might this information change the way they practice in the future?	
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Learning Outcomes	Purpose: present the learning objectives of the lesson. By the end of the session, students will be able: 1. To define and apply the concept and models of interprofessional integrated stroke care in Ontario; 2. To critically analyze the facilitators and challenges in accessing equitable, diverse and inclusive stroke care related to several vulnerable populations; 3. To describe the impact of social determinants of health on individuals living with stroke and access to care; 4. To identify how this experiential learning opportunity impacts students' perspectives and understanding of patient and family experiences of stroke, and how it will influence their future practice. Link to course outcomes: Connect these outcomes to the larger outcomes of the course or to other relevant content in the course (e.g. competencies). You can also now explain how assessment will take place and evaluation of the learning module. Introduce the activity format: • This learning session will be facilitated using an experiential learning activity about integrated interprofessional stroke care. • The facilitator will lead the activity and walk the learners through a journey map exploring different stages in a person's stroke journey from the hospital to the community. • During this activity, students will be shown <i>vignettes</i> of patient and caregiver experiences in each phase. The <i>perspectives of expert</i> stroke clinicians will also be shared, and the students will be able to reflect on <i>case studies</i> and how they align with each phase of the stroke journey. • There will be <i>reflective questions</i> and other <i>activities</i> throughout the larger activity to aid student application of important concepts.	3-5 mins
Pre-Assessment	Purpose: To assess what learners already know about the subject.	5-10 mins

	Pre-Assessment: The students were provided with pre-readings and case studies to help familiarize them with key concepts that will be explored and applied during this activity. To establish a baseline of what is already known, a preassessment can be completed through a poll or Kahoot, Mentimeter, Slido, I-Clicker. Suggested poll topics based on pre-readings: 1. What is your understanding of integrated care? – word cloud 2. Recommendations for safe transitions as described by the RNAO – Multiple choice, e.g. which of the following is not a recommendation for safe care transitions? 3. Recommendations for transitions and community participation after stroke as per the Heart and Stroke Foundation guidelines – application type questions to select the correct response. You can quickly provide feedback or supplement any gaps in knowledge if students did not have the chance to prepare for class.	
Participation	Purpose: To deliver the activity and engage the students in active learning. Activity: Interactive Stroke journey map • Please refer to the facilitator guide on how to walk students through the stroke journey map. The guide includes suggestions on follow-up reflective questions that can be asked or small activities to guide the discussion and reinforce key points, such as: ○ The role of the social determinants of health in the way the stroke journey is experienced by patients ○ How might the experiences of the patients, as shared through the vignettes, be enhanced using the recommendations provided for integration of care and safe transitions ○ Apply key concepts to case studies.	45-50 mins
Post-assessment	Purpose: To assess if the students achieved the learning outcomes. Have a short class discussion and ask the students about:	5-10 mins

	• Interesting concepts and key takeaways they learned during the activity. • Comments. • How learners will apply what they learned to practice in the future. Perhaps use prompts such as, “How might this new knowledge change the way you engage with patients?” Please explain to the students the format through which the learning will be assessed through a formal assessment.	
Summary	Purpose: reflect and integrate the learning. • To summarize, reiterate key points and situate learning in the broader context of the course. Tie the information back to learning outcomes. • Please dedicate time at the end to have students complete the feedback form provided by the team to elicit student feedback.	10-15 mins

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Appendix B

Student Feedback Survey

This form is intended to be used as an evaluation tool to gather feedback on user experience, and in what ways and to what extent the experiential learning activity helped the students to achieve the intended learning outcomes. These questions are formulated for upper-level and/or graduate-level students to complete at the end of the activity. There are three optional questions included at the end of this sheet that instructors can include as appropriate. The questions can be adapted as needed for the context of each class.

Student Feedback Survey

Thank you for participating actively in this learning experience. Your feedback is important to us and will help us improve this learning experience for future learners. Please take a few minutes (approximately 5-8 minutes) to complete this short feedback form.

1. Did today's session meet or exceed your expectations? [Select one]
 - ☐ Yes
 - ☐ No
 - ☐ Unsure
2. What, if anything, do you now feel you know more about, understand better, or can do differently after today's session? [Open]
3. What is the most urgent thing you still need to know? [Open]
4. What could have been done better to make for a more effective learning experience? [open]
5. Was the content relevant, easy to understand, or did it have a good flow? Is there anything that could improve the delivery of the content? [Open]
6. Please rate the following statements in relation to your level of knowledge or skill now, compared with how you felt before starting the activity.
 - ☐ Now I have a better understanding of the concept and models of interprofessional integrated stroke care in Ontario [rating]

Strongly disagree | Disagree | Neither disagree nor agree | Agree | Strongly agree

- Now I feel equipped to critically analyze the facilitators and challenges in accessing equitable, diverse and inclusive stroke care related to several vulnerable populations [rating]

Strongly disagree | Disagree | Neither disagree nor agree | Agree | Strongly agree

- Now I am able to describe the impact of social determinants of health on individuals living with stroke and access to care [rating]

Strongly disagree | Disagree | Neither disagree nor agree | Agree | Strongly agree

- Now I am able to identify how this experiential learning opportunity impacts my perspectives and understanding of patient and family experiences of stroke and how it will influence my future practice [rating]

Strongly disagree | Disagree | Neither disagree nor agree | Agree | Strongly agree

7. Identify one action you will take as a result of this learning experience in relation to your current or future practice.
8. Please identify one example of how this activity has helped you to develop and apply critical thinking and reasoning skills in planning collaborative person-centred care for vulnerable individuals living with stroke and other chronic conditions [open]
9. Please share any final comments reflecting on your experience during the activity. [open]

Optional Questions for Consideration Depending on Learner Group

10. Please describe one example of an ethical problem you feel better able to identify, analyze and solve within complex patient situations. [open]
11. Please indicate one action you will take that will demonstrate your respect for diversity and the plurality of ideas related to persons living with stroke and their unique situations. [open]
12. Please describe one dimension of a patient's social and cultural context that seems most important to acknowledge across all different stroke models. [open]

Appendix C

Case Studies

The following case studies can be provided to students to guide discussion and reflection about the varying care needs of patients transitioning to the community after having a stroke. Some important points for reflection include the services patients require, impact on patients and caregivers, barriers or facilitators to service access and integration, impact of the determinants of health on patient experiences and how culture shapes the experiences of individuals.

Table 9

Case study 1: Mrs. Sarah Johnson

Case Study 1: Women and Stroke

Key concepts

- Risk factors;
- Different presentation/symptoms;
- Common symptoms: Numbness or weakness in the face, arm or leg; Trouble speaking or understanding speech; Vision problems; Trouble walking or a lack of coordination or balance; Severe headache without a known cause;
- Symptoms in women: Disorientation and confusion or memory problems; Fatigue; Nausea or vomiting;
- Black women have the highest prevalence of stroke - triple the risk of white women of the same age.

Patient Information:

- **Name:** Mrs. Sarah Johnson
- **Age:** 60 years old
- **Ethnicity:** Black Canadian
- **Medical History:** Hypertension (high blood pressure), Type 2 diabetes and occasional migraines.
- **Employment:** Works full-time as a grocery clerk

Presenting Complaint: Mrs. Johnson arrives at the emergency department via ambulance, accompanied by her daughter, complaining of a sudden onset of weakness on the left side of her body and difficulty speaking. Her daughter reports that Mrs. Johnson seemed confused and was unable to speak clearly.

Initial Assessment: EMS called the Emergency Department at the District Stroke Centre in Vaughan to notify the neurologist of an incoming stroke, and an Acute Code Stroke Protocol is activated.

- **Vital Signs:** Blood pressure is elevated at 180/100 mmHg, heart rate 90 bpm, respiratory rate 18 breaths/min, oxygen saturation 97% on room air, temperature 37°C (98.6°F), and capillary blood glucose measures 7 mmol/L.
- **Neurological Examination:** Mrs. Johnson presents with left-sided hemiparesis (weakness) affecting both her arm and leg, with a noticeable facial droop on the left side. She is also exhibiting dysarthria and mild aphasia

History from Daughter:

- Mrs. Johnson's daughter reports that her mother has been managing her hypertension with medication but has had intermittent difficulties with compliance due to side effects. She also mentions that her mother has been under stress lately due to financial concerns and caring for an ailing parent.

Timeline of Events:

- **Onset:** Symptoms began approximately 45 minutes prior to hospital arrival.
- **Progression:** Mrs. Johnson's symptoms have been worsening since onset, initially starting with mild weakness and progressing to the current level of severity, which is significant movement loss on her left side.

Inpatient Hospital Care Interventions:

- **Immediate Management:** The staff are waiting for Mrs. Johnson to arrive. When she arrives, she is immediately weighed in the ambulance bay on the stretcher. She is then moved into an assessment area where blood work is drawn, and an IV is inserted. The stroke neurologist completes an NIHSS (National Institute of Health Stroke Scale) assessment to measure the severity of the stroke and accompanies Mrs Johnson to the CT scanner to have an immediate non-contrast CT of the head to look for evidence of stroke and, importantly, to rule out a hemorrhage in the brain.
- **Medications:** Once a CT is completed and a hemorrhagic stroke is ruled out, the stroke neurologist tells Mrs Johnson and her daughter that she is having a stroke caused by a blood clot in her Right Middle Cerebral Artery (RMCA). The stroke neurologist explains that Mrs Johnson is a good candidate to receive a thrombolytic to break up the clot and will be assessed for Endovascular Thrombectomy (EVT), a procedure to mechanically remove the blood clot, and may need to go to Sunnybrook Hospital. The neurologist discussed the risks and the benefits of the treatment with Mrs Johnson and her daughter and obtained her consent to receive Tenecteplase (TNK). Mrs Johnson is given a bolus dose of TNK. The stroke neurologist calls Critical and asks to speak with the "stroke endovascular team". Her brain imaging is sent

through an electronic system called Emergency Neuro Imaging Transfer System (ENITS). Mrs. Johnson is assessed as per the 4/24 EVT stroke protocol and is sent to Sunnybrook Hospital for EVT treatment. She is admitted to critical care for 24 hours post-procedure prior to being repatriated to the Integrated Stroke Unit at the Cortellucci Vaughan Hospital.

- **Diagnostic Tests:** A CT scan of the head is performed to rule out hemorrhage initially and prior to discharge from the ICU to look for evidence of hemorrhagic transformation and assess the extent of ischemic changes in the brain. Further diagnostic testing will include an MRI, Cardiac Holter Monitor, possible carotid Doppler blood work, and possible videofluoroscopy (VFF) and Electroencephalogram (EEG). The main objective for the testing is to try to determine the underlying cause of stroke so as to prevent further strokes from occurring.
- **Monitoring:** Continuous monitoring of neurological status using the Glasgow Coma Scale, Canadian Neurological Scale, blood pressure, vital signs, PHQ-9 (Patient Health Questionnaire -9), and ASDS (Acute Stroke Dysphagia Screening) is initiated.
- **SLP assessment:** SLP was consulted for a swallowing/communication assessment to determine, as per stroke protocol. SLP reported that mild dysphagia is indicated and recommended mildly thickened liquids, bite-sized regular solids, with meds crushed in puree. SLP also completed a communication assessment indicating mild expressive aphasia, moderate dysarthria and mild cognitive communication disorder.
- **Cognitive Assessment:** OT completed cognitive screening using the Montreal Cognitive Assessment (MoCA). Mrs. Johnson scored 18/30, indicating a mild cognitive impairment.
- **OT/PT Assessment:** An Alpha-FIM and FIM score, which are functional outcome measures, are obtained by the OT and PT within the first 48 hours of admission. These are functional outcome measures, and the Alpha-FIM is used as a care triaging tool to assist the team in anticipating what level of care Mrs. Johnson will require. Mrs. Johnson scored a 60 on the Alpha-FIM, indicating a moderate stroke that will likely require inpatient rehabilitation prior to discharge.

Family Support: Mrs. Johnson's daughter is updated regularly on her mother's condition and is counselled about the potential outcomes and next steps in her care.

Family Experience: Mrs. Johnson's daughter reports feeling frustrated with the frequent change in doctors and never knowing when the doctor will be in to talk with her. She is grateful for the care her mother receives but sometimes feels dismissed/ignored by staff members, who seem overwhelmed by the number of patients they are taking care of (some take the time to speak with her, others don't make eye contact and come and go quickly). As a result, she feels she cannot leave her mother's side, and the stress in her own family and work life is building.

Hospital Course: Acute care and rehabilitation

- Mrs. Johnson responds well to the TNK and EVT treatments, with gradual improvement in her left-sided weakness and aphasia over the next 24 hours. She stays in an acute stroke bed for 5 days and then begins inpatient rehabilitation for a total of 21 days. Fortunately, she is admitted to an Integrated Stroke Unit. This is where a patient can get both acute and rehabilitation care from the same bed. An estimated date of discharge has been set for July 31. Mrs Johnson is currently walking with a two-wheeled walker and needs assistance for her ADLs (activities of daily living) and her IADLs (independent activities of daily living). Swallowing ability and speech have improved but she has difficulty with speech fluency and pronunciation. Family reports she occasionally exhibits unusual behaviours, such as forgetting recent conversations or calling them in the night, confused about what time of day it is. They find this behaviour very unsettling since Mrs. Johnson was always a very organized and sharp individual.
- She receives secondary prevention measures for stroke, including an adjustment of her antihypertensive medications, statins, and diabetes management.

Discharge Planning:

- Mrs. Johnson is being discharged after completing a long acute and inpatient rehabilitation stay. A referral is sent to the York Community Stroke Rehab Program for PT and SLP so that she can continue improving her mobility, improving her speech and cognitive communication disorder, and to monitor swallowing safety. While at the clinic, she will also benefit from the stroke and social worker education and navigation services.
- Mrs Johnson has been working with the unit social worker who helped her to complete the Mobility on Request Paratransit Service application in the York Region. The social worker also shared with Mrs Johnson and her daughter the “*Returning to Work*” resources from the Heart and Stroke Foundation and gave her information on short-term and long-term disability. The social worker also shared a copy of the “*Guide to Stroke Recovery*” produced by the Toronto Stroke Network. To help support Mrs Johnson’s daughter the social worker shared information about CHATS (Community and Home Assistance to Seniors) and supports available for caregivers. She highlighted for her a link to a document entitled “*Caregiver 101 Handbook*”. The social worker has suggested that the outpatient rehabilitation referral should include seeing an occupational therapist to assist with a driving readiness assessment.
- Mrs Johnson has expressed feeling down about not being able to work and needing to rely on her daughter to take care of both her and her mother. She feels the pressure to get better quickly. Mrs Johnson consistently scores a 9 on the PHQ-9 assessment (Patient Health Questionnaire) while in hospital, which is classified as mild on the depression assessment tool (PHQ-9). The **primary care nurse** gives Mrs. Johnson a brochure with information about the York Stroke Survivor Support Group and offers to contact the organizer on her behalf. The nurse also completes a referral for Mrs Johnson to attend the Aphasia, Communication and Disability Program in Vaughan organized by the March of Dimes organization. The group offers an adult day program

geared to assist members with improving their communication while providing respite care for caregivers. The nurse also explains the virtual meeting options.

- Mrs. Johnson's physician has referred her to the Stroke Prevention Clinic for ongoing secondary prevention support.
- Her daughter receives education on stroke risk factors, signs of recurrence, and the importance of medication compliance. The family is also told that if they see any signs or symptoms, they should **call 911**. Calling 911 is important because the paramedics work from a prompt card that guides them as to which hospital in the region is most appropriate for their care.

Table 10

Case Study 2: Mr. George Big Canoe

Case Study 2: Stroke with Indigenous Populations

<https://www.heartandstroke.ca/what-we-do/indigenous-health>

Patient Information:

- **Name:** Mr. George Big Canoe
- **Age:** 68 years old
- **Ethnicity:** Canadian Indigenous (Anishinaabe First Nations)
- **Community:** From a remote reserve far north of Toronto called "Chippewas of the Georgina Island First Nation"
- **Medical History:** Hypertension, Type 2 diabetes, and chronic back pain.

Presenting Complaint: Mr. Big Canoe was identified as having signs of Stroke including slurred speech and right arm weakness by his family members. They called emergency services. Emergency responders arranged for transportation by boat to the mainland, from where he was transported to a District Stroke Center. He was found to have had an ischemic stroke and was given a thrombolytic. He was then admitted to a stroke unit where rehabilitation was started. Due to the stroke, he was left with right-sided weakness and difficulty with fine-motor movements of his right hand. He developed mild expressive aphasia as a result of the stroke, and he occasionally struggles to find the right words. This has posed a challenge in how he communicates his needs.

Mr. Big Canoe is **preparing for discharge** from the hospital. He will return to his community where he will need to continue to receive stroke rehabilitation care. Mr Big Canoe is a York Region resident, and his community is very north of the service area boundaries. His closest hospital is Southlake Regional Health Centre. His community has a health centre with a community health nurse who will help to navigate his care needs. The centre has many

services but does not offer outpatient rehabilitation. It can take around 1 hour and 20 minutes to travel between the community and the nearest outpatient rehabilitation centre. There is a boat that runs daily from May to Thanksgiving weekend in October, a ferry boat that runs from April to December that can carry up to 18 cars and 50 walking passengers, a water taxi and in the winter months an airboat or ice road. Mobility and travelling on and off the island can become especially difficult due to weather conditions. Weather conditions can cause delays in travelling and changes to ferry operations. Depending on the season and the type of transportation chosen, travel to and from appointments will need to be coordinated with the schedules of the ferries or taxis and require prior approval for funding under the Non-Insured Health Benefits Program (NIHB) processed by the Community Health Nurse. Coordination for follow-up appointments will need to be made with the Community Health Centre, much of the responsibility of which falls on Mr. Big Canoe's family.

Assessment: A successful transition to home will include follow-up with a doctor who visits the community the second Tuesday of every month. The physician will need to provide necessary secondary stroke prevention care, including medication management, monitoring, care and education. The clinic will monitor his height and weight, and he will be added to the list of clients seeing the diabetes educator for support with lifestyle changes to reduce his risk of a second stroke. His blood pressure will need to be monitored, and he will learn to monitor his own blood pressure between physician visits. Due to the remoteness of his community, it will be key to assess Mr. Big Canoe and his family's ability to access and use virtual means for care and resources. clinic. The reliability of technology and Mr. Big Canoe's or his caregiver's ability to access and navigate virtual services will be a key consideration when including these services in the discharge plan. In addition, Chippewas of the Georgina Island does not have medical stores or pharmacies on the island. The required medications and supplies will be arranged, coordinated, and brought in from the mainland prior to Mr. Big Canoe's discharge to prevent any gaps in care.

Neurological Examination: Mr. Big Canoe presents with residual right-sided weakness and difficulty with fine motor movements of his right hand. He also has mild expressive aphasia, occasionally struggling to find the right words. In response to the distance from his place of residence to the outpatient stroke clinic, the inpatient rehabilitation team referred him to the many virtual resources available, such as the Graded Repetitive Arm Supplementary Program (GRASP) offered online through the March of Dimes Canada. In addition to the support he will receive from the Community Health Nurse it was determined that he would also benefit from the FollowMD.ca virtual clinic where patients are seen virtually by specialist physicians and followed frequently to ensure progress through their goals.

Cultural Considerations: (Note - not all community members practice traditions and each tribe practices differently)

- **Traditional Healing Practices:** Mr. Big Canoe's family and community elders are actively involved in his recovery process. Traditional healers and the patient himself, if he follows tradition, may want to perform smudging ceremonies for cleansing and blessing both in acute care and upon returning home. It is important to note that most hospitals in Canada now have Indigenous liaisons that can help the team to understand his cultural practices (Southlake Hospital has a Liaison), using sweetgrass, sage and cedar to promote spiritual healing and well-being. It may also involve tobacco offerings, having spiritual objects (pipe, rocks, eagle feathers, medicine bundles) and people nearby.
- **Cultural Safety:** Healthcare providers in the community are trained in cultural safety and humility, ensuring that Mr. Big Canoe feels respected and understood in his cultural context. They incorporate traditional beliefs and practices into his care plan with his consent. The team should be aware of and discuss the importance of cultural safety, such as: not touching or moving cultural objects without asking for permission (The objects go through special ceremony and someone touching them will change the energy of the object); not cutting or touching a person's braid; awareness of designated smudging areas; flexibility with family presence and visitation as the visitors bring energy to help their loved one's heal; and accommodating requests such as to drum and chant at the bedside, especially when loved ones are gravely ill.

Rehabilitation Plan:

- **Physical Therapy:** This will not happen at the community centre. The team will need to build a home exercise program that will enable his family to support his ongoing recovery at home. The exercises will need to focus on improving his strength, balance, and mobility, with meaningful and relatable activities such as hunting and fishing.
- **Occupational Therapy:** It will be especially important to try and link him to many virtual programs, if this is an option for him. To ensure discharge readiness, resources and handouts will be shared by the team with the Community Health Nurse in a telephone conversation as a warm handover, and his family will receive training prior to discharge on how to help with his exercises. The team will meet with Mr. Big Canoe and his caregiver to help prepare them for discharge home by reviewing the plan they co-developed with them for rehabilitation after discharge. Any concerns or questions will be explored and more information provided during this meeting. A copy of the resources available to them and information discussed during the meeting will be provided to support them during Mr. Big Canoe's return home. Mr. Big Canoe will need to take part in activities to help regain function in his right hand. The hospital staff will need to share this information with the Community Health Nurse. Many communities offer residents drum, belt and moccasin-making activities where he can practice using

his hand. It will also be important to have assigned exercises and instructions so that he works on his hand rehab daily.

- **Speech Therapy:** Mr. Big Canoe can be referred to the March of Dimes Aphasia and disability communication group offered virtually, as no in-person programs currently exist on the island. He may also be a member of an elder committee in his community.

Family and Community Support:

- Mr. Big Canoe's family plays a crucial role in his rehabilitation journey, providing emotional support and actively participating in his care. Community members should be encouraged to visit him regularly.

Nutritional and Lifestyle Support:

- A dietitian works with Mr. Big Canoe to ensure his diet supports his recovery and manages his diabetes. Traditional foods such as wild game, blueberries, tea berry, cranberry, wild onions, fiddleheads, bannock, moose meat, deer meat, rabbit meat, partridge, trout, salmon, smelts, mackerel, sea bass, lobster, and shellfish are emphasized, reflecting his cultural dietary preferences and nutritional needs.

Follow-Up Care:

- Regular follow-up appointments are scheduled with the community healthcare team to monitor Mr. Big Canoe's progress and adjust his rehabilitation plan as needed.
- Health education sessions are conducted to empower him and his family with knowledge about stroke prevention, medication adherence, and recognizing warning signs.

Community Integration and Long-Term Care:

- As Mr. Big Canoe progresses in his recovery, efforts are made to integrate him back into community life. He participates in cultural ceremonies and gatherings, contributing his wisdom and experience to younger generations.

Outcome:

- Over time, with the support of his family, community, and healthcare providers, Mr. Big Canoe shows gradual improvement in his physical abilities and communication skills. He becomes a source of inspiration within his community, demonstrating resilience and the importance of cultural healing in stroke rehabilitation.

Appendix D

Theoretical frameworks

A Competency Framework for High-Quality Workforce Development in Integrated Care by Barraclough et al. (2024)

This framework presents competencies to guide education facilities, workplaces, and accreditation in creating a trained workforce in integrated care.

Table 11.
Competency Framework for High-Quality Workforce Development in Integrated Care (2024)

Competencies	Team members should be able to...
Person-centred care: teams place individuals and their support networks at the center of care planning and delivery.	● Promote shared identification of strengths and have a comprehensive understanding of the individuals' needs. ● Increase individuals' and caregivers' knowledge, skills and confidence in navigating the health and social care system. ● Empower individuals to participate in their own care. ● Actively involve and support caregivers and respond to signs of caregiver distress.
Interprofessional teamwork and collaborative practice: team members work effectively across multiple disciplines, care settings, and services to provide high-quality, coordinated care.	● Work effectively in teams across disciplines and settings. ● Collaborate with service providers within the acute, primary, and informal care sectors. ● Share information and data across teams, service providers, and individuals and their families. ● Demonstrate well-developed negotiation skills.
Care coordination: team members organize and integrate care across multiple services.	● Adopt a care coordinator role and emphasize effective communication. ● Demonstrate the ability to effectively coordinate care within a complex system. ● Demonstrate knowledge of local and national policies and programs, and communicate them to others. ● Identify and collaborate with a range of professionals.
Digital skills and technology: team members should have digital literacy	● Engage patients and families through technology-based communication tools. ● Use a range of technology to coordinate care.

and technological proficiency.	● Utilize linked datasets and population health management tools to analyze data and identify trends to inform and evaluate integrated care. ● Use shared electronic patient records for communication and collaboration.
Health promotion and disease prevention: team members empower individuals, families and communities to make informed decisions that support overall wellbeing.	● Facilitate behaviour change among individuals, families, and communities to promote health, resilience, wellbeing, and disease prevention. ● Obtain an integrative and comprehensive history. ● Have knowledge of community resources and preventative programs. ● Provide education on self-care strategies and resources, and incorporate them into all care plans.
Population health approach to care: team members use a population health approach to improve community health.	● Identify and address community needs by understanding available resources, population data, and gaps in healthcare delivery. ● Demonstrate knowledge of population health strategies and programs. ● Understand how to navigate the system. ● Identify and refer vulnerable populations and those experiencing health inequalities to appropriate support programs. ● Understand the social determinants of health and their impact on population health.
Leadership: team members guide change, promote collaboration, and create environments that support person-centered, system-wide improvements.	● Develop as leaders and role models to advocate for and support the implementation of integrated care. ● Demonstrate leadership in person-centred and collaborative practice. ● Implement shared governance across multiple stakeholders and sectors. ● Work with service providers and people with lived experience and use research methods to drive change and improve services.
Professional and ethical attributes: team members model integrity and ethical behaviour with a commitment to self-awareness, continuous	● Demonstrate the following professional and ethical practitioner attributes: ○ Practicing and integrating self-care strategies ○ Engaging in continuous learning, supervision and maintaining evidence-informed practice ○ Becoming mentors, teachers and peer learners ○ Showing empathy and emotional intelligence

growth, and inclusive, compassionate practice.	○ Practicing reflective thinking and learning ○ Demonstrating competencies in working with differences (cultural, social and neurodiversity).
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The World Health Organization Rehabilitation Competency Framework (2021)

The World Health Organization (WHO) created a competency framework for rehabilitation in 2021 for all rehabilitation workers, comprising five overarching domains. These domains include practice, professionalism, learning and development, management and leadership, and research. The framework also contains the associated activities for each competency. Please refer to the competency framework document for the different levels of mastery of each competency or activity, along with the core knowledge for each competency.

Table 12.

Key takeaways from the WHO Rehabilitation Competency Framework (2021)

Domain	Competencies - the worker:	Activities - activities include:
<i>Practice</i>	● Places the person and their family at the center of practice. ● Establishes a collaborative relationship with the person and their family. ● Communicates effectively with the person, their family, and their health-care team. ● Adopts a rigorous approach to problem-solving and decision-making. ● Works within their scope of practice and competence.	● Obtaining informed consent for rehabilitation ● Documenting information ● Conducting rehabilitation assessments ● Developing and adapting rehabilitation plans ● Referring to other providers ● Implementing rehabilitation interventions ● Evaluating progress towards desired outcomes ● Discharging and ensuring appropriate continuity of care
<i>Professionalism</i>	● Demonstrates ethical conduct ● Maintains professionalism ● Works collaboratively ● Manages professional responsibilities	● Managing risks and hazards ● Undertaking quality improvement initiatives ● Participating in team forums ● Advising on rehabilitation
<i>Learning and Development</i>	● Continues to learn and develop ● Supports the learning and development of others	● Managing own professional development ● Supervising and teaching others

	• Works to strengthen rehabilitation education and training	
Management and Leadership	• Works to enhance the performance of the rehabilitation team • Works to enhance the performance of rehabilitation service delivery • Acts as a rehabilitation advocate	• Managing a rehabilitation team • Managing rehabilitation service delivery • Monitoring and evaluating rehabilitation service delivery
Research	• Integrates evidence in practice • Works to strengthen evidence for rehabilitation	• Designing and implementing research • Disseminating evidence • Strengthening rehabilitation research capacity

The Stroke Specific Education Framework by the University of Central Lancashire and the National Health Service in England (2022).

The framework for stroke-specific education, created by the University of Central Lancashire and the National Health Service of England (2022), outlines the knowledge and skills required by those caring for people with stroke or affected by stroke. This framework comprises 16 elements of care and 4 elements of professional practice.

For the purposes of this learning experience, please refer to “Element 10: Specialist rehabilitation”, “Element 12: Seamless transfer of care”, “Element 13: Long term care”, “Element 14: Review”, “Element 15: Participation in community”, “Element 16: Return to work”, “Element 17: Professional behaviour and values”, “Element 18: Leadership, management, and governance”, and “Element 19: Education, training, and personal development”. Please visit the website for the framework for more in-depth information under each element.

Table 13.

Key takeaways from the Stroke Specific Education Framework (2022)

Element	Required knowledge	Required skills
Element 10: Specialist Rehabilitation	• The range of potential impacts of stroke on individuals and their families, including psychological, social, physiological, sensory,	• Collect and interpret a thorough medical history • Recognize the signs and symptoms related to the impacts of stroke

Stroke survivors access rehabilitation services, and survivors and their caregivers require high-quality, stroke-skilled services as soon as possible in all 3 phases, including within the hospital, immediately following transfer, and for as long as required thereafter.	neurological and neuropsychological effects • The cause of, interactions between, assessment of, management of, and treatment of the above impacts. • Principles and techniques of multidisciplinary stroke assessment and rehabilitation • Screening measures • Safe moving, handling and positioning • Ways to facilitate communication • Health promotion approaches • Ways to enable those affected by stroke to take an active role in recovery • Pharmacological and non-pharmacological interventions and secondary prevention • Full range of resources • Equipment and technology • Implications of stroke on lifestyle • Transfer/discharge process, long-term management and rehabilitation	• Determine, plan and initiate the appropriate assessments, investigations, interventions and treatments • Use a range of communication methods, resources and approaches • Provide a psychologically-informed, patient-centred assessment, formulation and intervention • Use safe moving, handling and positioning methods • Provide a range of stroke-specialist rehabilitation techniques and the clinical rationale for the chosen technique • Assist in the management and development of a behaviour change plan that is patient-centered. • Assist, encourage, and facilitate post-stroke physical, social, and cultural reintegration • Identify and refer to appropriate resources • Identify the need and when to refer individuals to specialist treatments
Element 12: Seamless transfer of care A workable, clear, and patient and caregiver-centered discharge plan is developed by the multidisciplinary team with other services such as transport and housing.	• Assessment and management of the effects of stroke to identify care and ongoing rehabilitation needs • Implications of stroke for lifestyle, driving, occupation, including voluntary work or education, and social participation • The range of local and national resources and services for stroke survivors, especially for: ○ Transfer ○ Short and long-term needs assessment ○ Packages of care ○ Continued rehabilitation and psychological care ○ Finance and personal budgets	• Determine, plan, and initiate appropriate assessments, including risk assessments, to determine care and support needs on discharge, and minimize risk • Assess, discuss, and review goals, outcomes, and a discharge plan • Identify the need for and when to refer for specialist or differing treatment • Identify resources and services to overcome barriers and facilitate effective and efficient discharge for those affected by stroke

	○ Respite care ● Principles of good discharge planning for transition between services, cessation of services, and for transfer of care to the community, including education for those impacted by stroke ● Principles of multi-agency working	
Element 13: Long term care A range of services are in place and accessible to support the individual long-term needs of those affected by stroke	● The assessment and management of the effects of stroke to inform long-term care ● The impacts of stroke on survivors and their caregivers, and assessment methods ● Implications of stroke on lifestyle, driving, occupation, and social participation ● Risk factors for further vascular events ● Pharmacological and non-pharmacological interventions for secondary stroke prevention and to promote recovery after stroke, and their potential adverse effects ● Resources and services relating to long-term care, housing, transport, adjustments, and supporting independent living when possible ● Communication methods ● Assessments of medication adherence, factors that impact it and how to motivate and facilitate engagement	● Recognize stroke-related communication difficulties and adapt communication methods. ● Discuss current events, risk of future events, need for and timeframe of assessments, rationale for interventions and treatments, timeframes, and possible side effects ● provide timely information, advice and support ● Monitor progress and modify plan on an ongoing basis ● Assess, discuss and review goal-setting and outcomes with those impacted by stroke ● Identify resources and services to support long-term care needs; liaise with services; work across agencies; share information; and communicate referral arrangements. ● Assess post-stroke apathy and readiness for behaviour modification and support change ● Deliver and evaluate self-management programs.
Element 14: Review The primary care service offers those affected by stroke a review of their health and social care status, as well as their secondary prevention needs.	● The assessment and management of the effects of stroke ● Ways to assess and meet the needs of those affected by stroke ● Available resources and services ● Implications of stroke on lifestyle ● Risk of further vascular events ● Pharmacological and non-pharmacological	● Take and interpret a thorough medical history from all stakeholders and carry out decision-specific mental capacity assessments ● Recognize stroke-related communication difficulties and adapt communication methods. ● Discuss the current event, risk of future events, rationale for interventions and treatments, timeframes, and possible side effects ● provide timely information,

	interventions for secondary prevention and to promote recovery, and their potential adverse effects • The methods, resources, and approaches available to facilitate communication • Medication adherence, factors that impact it and how to motivate and facilitate engagement	advice and support • Monitor progress and modify plan on an ongoing basis • Assess, discuss and review goal-setting and outcomes with those impacted by stroke • Assess medication adherence and facilitate improved engagement • Plan appropriate assessments and treatments • Identify the need for additional/specialty/differing interventions/referrals • Evaluate the review process and act on results
Element 15: Participation in community Those affected by stroke are enabled to live a full life in the community	• The assessment and management of the effects of stroke and their impact on community participation • Local and national resources/services for those with stroke, especially those relating to community participation • The need for and method of assessment of those impacted by stroke • Implication of stroke for lifestyle • The methods, resources and approaches available to facilitate communication with those affected by stroke	• Assess, discuss and review goal-setting and outcomes • Monitor progress on and modify the plan with those affected by stroke • Plan appropriate assessments and treatments for community participation • Identify the need for and when to refer for more specialist or differing treatments • Identify the full range of local and national resources to facilitate participation and inclusion
Element 16: Return to work Those affected by stroke are enabled to participate in paid, supported, and voluntary employment.	• The effects of stroke and how they may affect return to work or education • How to assess and manage the impact of stroke • Legislation on employment, discrimination and health and safety at work • The role of healthcare professionals in vocational rehabilitation • The resources and services available to those affected by stroke • The meaning of “reasonable adjustment” in the workplace, how to adapt to the work	• Refer to a vocational rehabilitation service • Identify resources and services available to support return to work or education for those affected by stroke, liaise, and communicate with all involved parties • Assess for, advise on, and review the need for workplace adaptation, assistive technology and environmental adaptations to overcome work-related activity limitations. • Create a personalized plan for return to occupation • Advise employers, colleagues

	environment, and the employer's responsibility • Available technology to assist with functional and activity limitations • Ergonomic principles • Accessibility issues and solutions • The relationship between meaningful engagement in occupation and health and well-being • Benefits in relation to occupation, including voluntary work and education • Workplace assessment, including risk, job analysis, return to work planning and job retention • Models of vocational rehabilitation and vocational case management • Vocational rehabilitation guidelines and standards	and educators about the effects of stroke and negotiate a plan of return to work/education • Recognize the need for benefits, advise and refer • Conduct or refer for a workplace assessment and risk assessment • Set goals for return to or retention of work • Case manage or refer for case management • Implement vocational rehabilitation guidelines
Element 17: Professional Behavior and Values Staff understand how to conduct themselves professionally at all times, in accordance with working guidelines, communicate effectively, and work collaboratively.	• Abilities and developmental needs to deliver evidence-based care • Barriers to effective professional communication and different communication strategies and tools to improve communication. • The code of professional conduct • Policies that guide professional practice, service improvement and research • Person-centered and values-based care • Methods of implementing behaviour change interventions • Evidence-based practice and the roles of applied health and social care • The roles of and interplay between multi-disciplinary team members and the wider team • working in partnership with individuals, families, caregivers, and stakeholders • factors contributing to workplace stress and ways to	• Demonstrate self-reflection and identify developmental needs • Articulate opinions in a clear, evidence-based manner, and communicate complex information effectively • Practice according to the code of conduct • Practice person-centered and values-based care to support decision-making and care planning. • Exercise professional expertise and judgement for ethical decision making and complexity management within the scope of practice, ensuring the safety of all. • Use evidence in practice. • Act as a role model • Demonstrate understanding of responsibility and autonomy, and acknowledge limitations of own competence and professional scope of practice • Build professional working relationships with colleagues to work effectively in the

	promote mental health and wellbeing, emotional intelligence, and improved resilience the principles of time management and workload planning	multi-disciplinary team. - Identify when there is a requirement to breach confidentiality, when legal advice is required, and when to escalate to a senior clinician - Demonstrate digital literacy
Element 19: Education, training, and personal development Staff understand the importance of lifelong learning for the individual, team, and their patients, and continually take opportunities to engage in, and encourage education.	- Importance of continued development - The role of critical self-reflection in personal development and regular assessments of learning needs - How to create an effective learning environment - Theories underpinning clinical education and mentorship - The theory of evidence-based practice and the role of research-informed teaching - Assessment and evaluation methods - Knowledge mobilization and capacity building	- Show a positive attitude to practice, learn and self-develop - Undertake a personal learning needs assessment, demonstrate critical self-reflection, set goals and develop a learning plan - Contribute to and promote the professional development of others - Teach others - Devise and deliver research-informed learning - Promote learning and create a supportive and engaging learning environment - Provide constructive, informative, and factual feedback

Kolb's Theory of Experiential Learning

Kolb's (1984) theory of experiential learning builds on the ideas of John Dewey (1938), who posits that education is grounded in experience and that learning occurs through the reconstruction of and critical reflection on those experiences (Kreber, 2001). Kolb's (1984) theory argues that knowledge is created through the transformation of experience and that learning is experiential only when an experience is transformed into knowledge (Kreber, 2001). For experiential learning to occur, students must be directly involved in it (Kolb, 1984; Kreber, 2001). This engagement can occur through action or reflection, which allows the transformation of knowledge to occur (Kreber, 2001). Figure 1 shows Kolb's 1984 (as represented in Kreber, 2001) model of experiential learning, which contains two dimensions:

- Prehension* of experience - this dimension explains how students grasp experiences through either apprehension (felt qualities; includes intuitive, creative and tacit knowledge) or comprehension (conceptual interpretation and symbolic representation).

- *Concrete experience* - this is a direct, sensory and intuitive engagement with the learning experience and is related to apprehension.
- *Abstract conceptualization* - this is the analytical or symbolic understanding of material related to comprehension.
- *Transformation of experience* - this dimension explains how experiences are processed and how learning occurs. Learning occurs when an experience is transformed through internal reflection on the learning event or actively manipulating the outside world.
 - *Reflective observation* - related to internal reflection and is achieved through thoughtful review.
 - *Active experimentation* - related to active manipulation of the outside world or practical application.

These dimensions combine into the four-stages of the learning cycle

- Concrete experience - an encounter with the new experience or situation
- Reflective observation - thoughtful observation and reflection on the experience
- Abstract conceptualization - formation of theories or models based on reflection
- Active experimentation - testing of new theories through actions

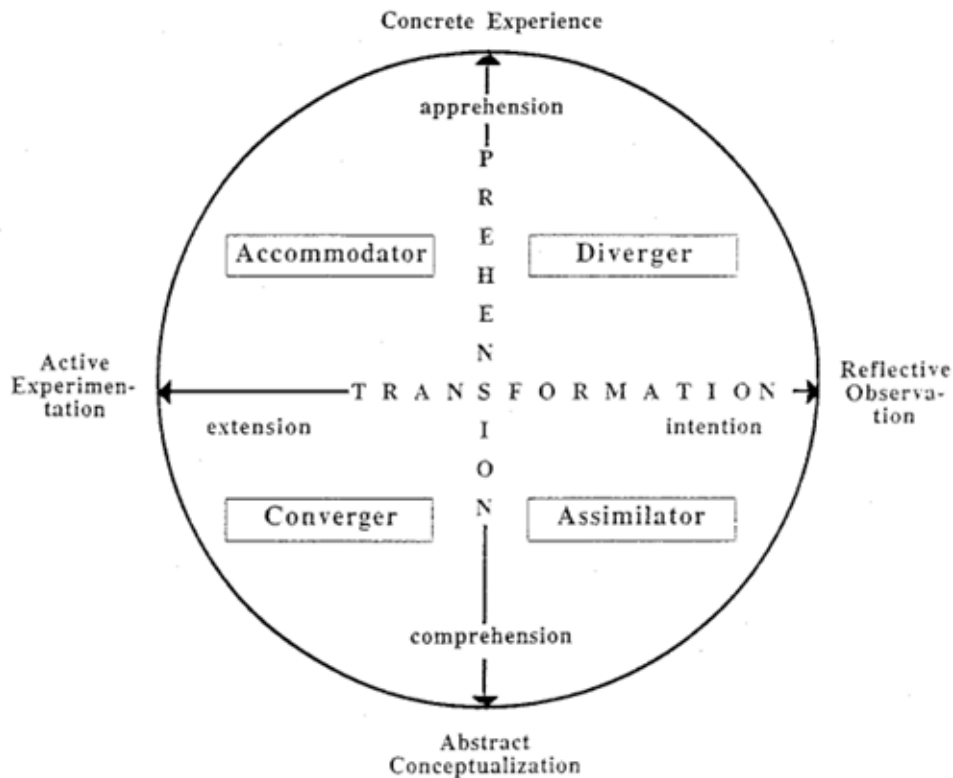
Types of knowledge resulting from the intersection of the two dimensions:

- Divergent knowledge: a result of apprehension and reflective observation.
- Assimilative knowledge: a result of comprehension and reflective observation.
- Accommodative knowledge: a result of apprehension and active experimentation.
- Convergent knowledge: a result of comprehension and active experimentation.

Meaningful learning occurs when learners work through all four phases of the learning cycle.

Figure 2.

Kolb's (1984) Model of Experiential Learning



Note. From “Experiential Learning: Experience as the Source of Learning and Development,” by D. A. Kolb, 1984, Prentice-Hall. © 1984 by Prentice-Hall. Used under fair dealing for the purpose of education.

In this activity, the journey map represents the abstract conceptualization and is meant to help contextualize the concrete experience students may not have had yet, as well as support reflective observation on experiences of patient and caregiver journeys they might have gained in other contexts of their studies or even lived experiences beyond school (Kreber, 2001). One important consideration the developers want to point out is that the linear abstraction of phases of care could be seen as both a valuable way of approaching design and delivery of services and supports, but also as potentially harmful in the ways they might permit lapses in service and support between transition points, that is, without intentional and supportive service integration considered from the outset. During this activity, students will be provided with information through narrative vignettes, written information from focus groups with experts, and case studies, which help provide context for the experiences that students will engage with in the future (Kreber, 2001). Students will process information on an emotional and intuitive level, and information will take hold based on how it feels to them (Kreber, 2001).

These narratives are organized into a journey map comprising three commonly experienced phases of the stroke journey, and include points of transition between phases (Kreber, 2001). The instructors will facilitate the progression through this journey map. They will ask questions to help students distinguish key concepts within and between the narratives and

phases. This enables symbolic and analytical comprehension of concepts, thereby facilitating abstract conceptualization (Kreber, 2001).

To help students transform knowledge and for learning to occur, facilitators will pose critical reflective questions throughout the different stages of the activity to promote reflective observation, internal reflection and thoughtful review (Kreber, 2001). These questions will ask students to think creatively about how to solve the problems posed. Students will then be asked to relate the knowledge they have gained to previous experiences and to hypothetical situations through the debriefing activities and the final evaluation activity. This will facilitate active experimentation with newly acquired knowledge (Kreber, 2001).

The Canadian Interprofessional Health Collaborative Competency Framework for Advancing Collaboration (2024)

The Canadian Interprofessional Health Collaborative (CIHC) Framework (2024) guides educators, researchers, health administrators, service providers, and persons receiving care in fostering effective collaborative practice by focusing on supporting the application of knowledge, skills, attitudes, and values in real-world environments to guide behaviours that enhance collaboration. The framework has six competency domains, which are interdependent.

The overarching goal of this framework is to improve healthcare and human services by promoting collaborative, relationship-focused partnerships for shared decision-making.

Table 14.

The CIHC competency framework for advancing collaboration (2024)

Domain	Description
Relationship-Focused Care/Services	Team members collaborate and coordinate the building of purposeful, inclusive, culturally safe, respectful and trusting relationships in care and service delivery.
Team Communication	Team members promote clear, responsive, respectful, effective, and inclusive communication among team members through shared language, active listening, removing barriers to communication and documentation.
Role Clarification and Negotiation	Team members understand and negotiate roles to support collaborative, relationship-focused care using individual strengths and expertise and recognize the person receiving the care as the expert in their experiences.

Team Functioning	All team members work interdependently and collaboratively to coordinate efforts, make shared decisions, and achieve shared goals efficiently.
Team Differences/Disagreements Processing	Team members address disagreements constructively to maintain team cohesion and respectful relationships.
Collaborative Leadership	All team members share leadership and accountability, value each other's knowledge, skills, expertise, strengths, and perspectives, and support each other in achieving desirable shared goals.

Important considerations underpinning the Framework:

- Inclusion, Access, and Equity
 - Inclusion, Access, and Equity are essential considerations that guide the application of all competencies, ensuring effective collaborative practice within the team that is respectful of the diversity within the team members and the person receiving care. Considerations include the differences in culture, ethnicity, race, gender, sexual orientation, ability, socio-economic positions, barriers to accessing care, and accessibility of services.
- Complexity:
 - The complexity of each person's care needs can vary, requiring an individualized, person-centred approach that depends on multiple professions and sectors collaborating with each other.
- Care and Service settings:
 - The context in care and service settings is an important consideration when collaborating with team members. This includes the person's circumstances, for example, food insecurity, home environment, work conditions, or supports available. This can also include the circumstances of the team, for example, teams that communicate virtually or asynchronously. In these instances, it is important to consider all available tools, share information openly among all, make decisions collaboratively, and respect each professional's expertise.

Appendix E

About Phase 1: Inpatient Acute Care

The first phase of the stroke journey is the inpatient acute care (IAC) phase.

- This phase begins when the person experiencing stroke initiates contact with the health care system due to signs or symptoms of stroke. This phase includes the initial emergent care and treatment provided to the at a Regional Stroke Centre (RSC) immediately following a stroke, and the inpatient acute and rehabilitation care received in a District or Community hospital (Central South Regional Stroke Network (CSRSN), 2021).
- At the regional stroke centre, individuals receive emergent diagnostic care and treatment for patients who meet criteria (Toronto Stroke Networks [TSN], 2023). Once patients are either ruled out or no longer require services at the RSC, they may be transferred to a community hospital for ongoing acute medical care as inpatients (TSN, 2023).
- At the community hospital, a specialized interprofessional stroke team is involved in caring for patients and focuses on beginning stroke rehabilitation within 24-48 hours (TSN, 2023). The team typically includes medical specialists (neurology and general internal medicine), nursing, occupational therapy (OT), pharmacy, clinical nutrition, social work (SW), physiotherapy (PT), and speech-language pathology (TSN, 2023). Stroke rehabilitation helps persons with stroke relearn skills or learn new skills to complete daily tasks (TSN, 2023). In acute care, stroke rehabilitation usually begins within 24-48 hours of hospitalization (TSN, 2023).

Overarching Concepts for Phase 1

Some key overarching concepts to have students reflect on throughout the inpatient acute care phase of the activity include:

- The different trajectories of individuals with stroke based on the type of stroke they have had, the consequences of the stroke, comorbidities and the social determinants of health (SDOH)
- The different ways to best support patients through the uncertainty of recovery and the emotional consequences of the event.
- The several and varying services needed to help patients rehabilitate.
- Challenging assumptions, for example, the assumption that only older adults have strokes or cultural/racial assumptions.
- The impact of the SDOH, including but not limited to social status, access to health services, race, culture and social support, on the stroke journey. Consider the following:
 - Patients who have Ontario Health Insurance Plan (OHIP) coverage versus those who do not. These patients receive acute care in the hospital but may not have the means to afford care in the community without OHIP.

- Patients and caregivers who have a language barrier may have difficulty communicating their needs or understanding the information being imparted to them.
- The impact of aphasia and the untrue assumption that patients with aphasia have cognitive deficits.
- The ability of people to access services (ex., Access to technology or knowledge of computers when accessing online services).
- The complexity of navigating the healthcare system. Have students consider how best to support patients and families, how much information to give without overwhelming them, how to tailor the services that are offered according to the needs of the patient, and the need to keep up-to-date with the best practices.
- The interprofessional team that is involved in the care of the patient so they can help the patient better navigate the system.
- The challenges that a lack of or inconsistent communication between the hospital and community services can pose during transition and the need for warm handovers with good communication.
- The importance of safety culture and the need for staff to be able to speak up to support safe patient transfers.

Appendix F

Ontario's Stroke System

Acute Care

Within the stroke services framework of Ontario, hospitals are classified based on the type of specialized acute stroke services they provide and the role they play within the system in leading, developing, implementing, coordinating, and integrating of stroke care or administration (Ontario Health, 2025b).

The stroke care system in Ontario is organized into eleven regional networks that provide cross-continuum stroke care within the province (Ontario Health, 2025a). This continuum includes primary prevention, secondary stroke prevention, the pre-hospital phase, the hyperacute phase, the acute phase, rehabilitation, and community re-engagement (Ontario Health, 2025a). The regional stroke systems comprise a network of care providers that identify, prioritize and implement initiatives to promote timely access to specialized stroke care (Ontario Health, 2025a). These networks include:

- Regional Stroke Centres or Enhanced District Stroke Centres (Ontario Health, 2025a),
- District stroke centres, depending on geographical requirements (Ontario Health, 2025a),
- Community hospitals (Ontario Health, 2025a),
- Stroke Prevention Clinics (Ontario Health, 2025a),
- Rehabilitation providers (Ontario Health, 2025a),
- Community-based providers (Ontario Health, 2025a),
- A governance structure (Ontario Health, 2025a).

Regional Stroke Centres provide the largest range of specialized clinical services, including neurosurgery, endovascular thrombectomy, thrombolysis, a community stroke prevention clinic and a stroke unit (Ontario Health, 2025b). They also support a stroke network team and lead the development, implementation, coordination and integration of the stroke system within a defined region (Ontario Health, 2025b).

When a regional stroke system covers a large geographical area, it may be further divided into smaller stroke districts to support the collaborative identification, prioritization, and implementation of opportunities aimed at promoting timely access to specialized stroke care in support of the broader regional stroke system (Ontario Health, 2025a). The leadership for these districts is provided through *District Stroke Centres* (Ontario Health, 2025a). District Stroke Centres provide thrombolysis, and have a stroke unit and a community stroke prevention clinic (Ontario Health, 2025b). They also provide leadership, development, implementation and integration for the stroke care continuum within a defined district (Ontario Health, 2025b). There are *Enhanced District Stroke Centres* that also provide all the services that District centres provide but to a defined region rather than a district (Ontario Health, 2025b).

Non-Stroke Service Hospitals do not offer specialized clinical stroke services on-site but they have established protocols that help facilitate access to specialized stroke services for individuals identified as needing these services (Ontario Health, 2025b).

For a list of regional and district stroke centres in Ontario, please visit: [Cardiac, Stroke & Vascular Centres - CorHealth Ontario](#)

Community Stroke Rehabilitation

Community Stroke rehabilitation (CSR) is person-centered, coordinated care provided by an interprofessional team with stroke specific expertise, delivered in a setting and frequency that best meets the needs of the person with stroke (Ontario Health, 2022). It allows the opportunity for re-entry to services, follow-up care, and connecting to community supports to maintain functional recovery and community re-integration (Ontario Health, 2022). Ontario Health (2022) notes that variability exists in the CSR programming offered in the province.

The key components in this model are:

- Population (Ontario Health, 2022),
- Team members (Ontario Health, 2022),
- Referral Process (Ontario Health, 2022),
- Care settings (Ontario Health, 2022),
- Duration of care (Ontario Health, 2022),
- Clinical delivery (Ontario Health, 2022).

Key underpinnings include:

- The importance of stroke-specialized teams;
- The importance of a person-centred, individualized approach to care planning and implementation, including timing, duration and frequency of therapies provided;
- Designing care programs with the aim of helping individuals reach their goals of returning to meaningful life activities and roles;
- The importance of setting up programs within the integrated stroke pathway to ensure seamless transitions between care settings, which is supported by high levels of communication and coordination between team members working in different settings along the pathway.

Population

Persons with stroke with ongoing achievable and meaningful rehabilitation goals should have access to specialized stroke services after their hospital stay, and eligible persons should be identified early to facilitate improved transitions (Ontario Health, 2022). Persons may require varying intensity and frequency, and varying rehabilitation disciplines (Ontario Health, 2022).

Team members

The community stroke rehabilitation team is a specialized, interdisciplinary team of clinicians who are specialized in stroke and stroke rehabilitation (Ontario Health, 2022). Teams

include, at minimum, occupational therapy, physiotherapy, speech-language pathology, social work, and a dedicated stroke care coordinator/navigator (Ontario Health, 2022). The team may also include a nurse with stroke expertise, rehabilitation assistants, administrative supports, pathways for accessing additional team members or specialists, neurological rehabilitation program (in areas where dedicated stroke teams are not available), and a primary care physician (Ontario Health, 2022).

Referral Process

Referrals to community stroke rehabilitation can occur from inpatient settings, primary care, stroke prevention clinics, and home and community care teams (Ontario Health, 2022). Referrals and transition planning should be planned with the person's goal in mind and in partnership with persons with stroke, family members, informal caregivers, and both the referring and receiving teams before the transition (Ontario Health, 2022). Each region or sub-region is responsible for ensuring that community stroke rehabilitation services are provided as part of a coordinated and integrated stroke care pathway, for example, through centralized referral access (Ontario Health, 2022).

Care Settings

Settings for rehabilitation can be a mix of outpatient clinics, home and virtual (Ontario Health, 2022).

Duration of Care

Ontario Health (2022) notes that the CSR program is provided, on average, over eight to twelve weeks, at a frequency dictated by the needs and goals of the person with stroke, and guided by best practice, which is noted as 45 minutes per day per required discipline and two to five days per week. Visits should be flexible and occur at a time that works best for the person with stroke (Ontario Health, 2022). Re-entry to the program can occur for persons with stroke who meet eligibility criteria up to one year after discharge from the program (Ontario Health, 2022). If the person consents, follow-ups can be provided at regular intervals, usually 6 months and one year after discharge from the program, with clear objectives for follow-ups (Ontario Health, 2022). After one year, monitoring and support should occur with the person's primary care provider (Ontario Health, 2022).

Clinical Delivery

Clinical Assessment. Assessment of a person with stroke includes assessment of impairment, functional limitations, role participation restrictions, and environmental factors using validated tools (Ontario Health, 2022). Tools should be adapted to accommodate communication limitations of a person with stroke (Ontario Health, 2022). The person, their family, and informal caregivers should be assessed for readiness of education, ability to integrate knowledge, training, and psychosocial support (Ontario Health, 2022).

Treatment. Clinicians should use evidence-based treatments and involve persons with stroke, their families, and informal caregivers in planning care and transitions (Ontario Health,

2022). Persons with stroke and their caregivers should be provided with general emotional and psychosocial supports, links to community programs, agencies that provide these services, vocational rehabilitation, community re-integration planning, exploration of return to driving, an emphasis on self-learning and practice, education about the impact of stroke on relationships, and opportunities for check-ins (Ontario Health, 2022).

Education. The educational needs of people with stroke, and their families/informal caregivers should be reassessed and updated regularly, and education should be individualized and implemented based on their learning needs and goals (Ontario Health, 2022). The opportunity to interact with the team and review progress or adjust care plans should be provided (Ontario Health, 2022). Education should be provided on how to support and care for persons with stroke at home, risk factors and their management, and goals of care discussions (Ontario Health, 2022).

Care Delivery Formats. Formats can include one to one therapy, virtual consultations/care, telemedicine, and in-person or virtual group sessions (Ontario Health, 2022).

Transition Out of the Program. It should be clearly communicated when the transition from the formal CSR program to community rehabilitation will occur (Ontario Health, 2022). Contact information of persons or services for continued support, peer support groups, and information for person-initiated CSR follow-up pathways should be provided (Ontario Health, 2022).

Team Processes. Communication is key for high-functioning teams, including with the person with stroke and their family members/informal caregivers (Ontario Health, 2022). A case coordination approach is recommended (Ontario Health, 2022). Some important components outlined for the maintenance of high-functioning teams include:

- Team meetings held at regular intervals (one to two weeks) to review new referrals, plan care and scheduling therapy visits (Ontario Health, 2022);
- Continuous quality improvement (Ontario Health, 2022);
- Working closely with community agencies that provide social services, health promotion and wellness programming, and keeping up to date with available community resources (Ontario Health, 2022);
- Simple and secure tools for communication amongst team members (Ontario Health, 2022);
- Access to the right technology and equipment for care delivery based on best practice and care delivery setting (Ontario Health, 2022);
- Providing training in supportive conversation with adults with aphasia to all team members (Ontario Health, 2022);
- Continuing education on stroke best practices (Ontario Health, 2022).

Caregiver resources

The HSFC compiles a list of resources for caregiver support across the provinces and territories, which can be accessed through: [Caregiver support | Heart and Stroke Foundation](#)