SUPPLEMENTAL DIGITAL CONTENT. RECOMMENDATIONS & EXEMPLARS FOR STROKE SPECIFIC COMPREHENSIVE TRANSITIONAL CARE DELIVERY

Operational Definition of Transitional Care Component[17]	**Stroke-specific Operational Definition for Transitional Care Components that Emerged are Underlined.**
Patient engagement:	Optimizing the central role of engaging individuals through deliberate and consistent efforts of patients, caregivers, healthcare professionals and systems to identify what outcomes of their care is most important and provide patient with a tailored care plan; assess their perspectives, needs, and capabilities (e.g. provide support and encouragement); foster shared decision making regarding plans of care; promote shared accountability for actions related to these care plans (e.g. provide a list of community-based stroke healthcare professionals, stroke resources, support groups, and stroke camps); and ensure trusting, reciprocal, and respectful relationships
Caregiver engagement	Optimizing the central role of engaging caregivers by performing a caregiver assessment and providing caregiver preparedness resources through deliberate and consistent efforts of healthcare professionals and systems to identify what outcomes of care are most important to caregivers related to their role in caring for patients (e.g. establishing a support system, emotional support resources, patience and communication skill building , respite care resources); assess their perspectives, needs, and capabilities beyond the caregiver assessment (e.g. employment and financial challenges, work-life imbalances, time management skills, capacity to perform physical tasks, support in role shifts, and caregiver health support); foster shared decision-making related to patients' plans of care; promote shared accountability for actions related to these care plans; and ensure reciprocal and respectful relationships.
Complexity management:	Within the context of a tailored, comprehensive care plan, patients will receive care that is holistic, consistent with patient goals and characterized by anticipation, prevention, or early identification of problems (including health problems that develop during the acute hospitalization) that represent the most common clinical reasons for poor outcomes among the target population (e.g. patient and caregiver comorbidity). This high-risk, chronically ill population presents clinicians and caregivers with challenging care issues associated with managing complex physical needs (e.g. support with gait, coordination, balance, ADLs, and fatigue), emotional, psychological challenges (e.g. support with depression, impulsivity, altered personality, anxiety, and anger) and social needs (e.g. social isolation secondary to stroke consequences, lacking family or social support, and financial insecurity). One critical dimension of complexity management is medications. Medication management is person-centered care characterized by an organized effort to ensure optimum therapeutic outcomes through greater accuracy in medication use and reduction of adverse events (e.g. medication management strategies, reducing out-of-pocket medication costs, drug compatibility and dose and unit conversion training). Efforts to promote adherence are integrated within a comprehensive care plan.
Patient Education:	Continuous interactive teaching and learning processes (e.g. continual access to web-based multi-modal and aphasia-targeted content) involving the healthcare team and patient. Participation should be based upon an assessment of patient goals and designed to enable patients to assume increased responsibility for their own health (e.g. use of scaffolding techniques, visual images, games, integrating patient goals with benchmarking progress reports); use strategies that encourage patients to make healthier lifestyle decisions; avoid or reduce adverse events related to condition or treatments (e.g. periodic case review); ensure continuity of care; and promote independence in activities of daily living (e.g. skills training in grooming, dressing, household tasks, and vocational rehabilitation).
Caregiver Education	Conduct a caregiver assessment, identify caregiver needs and goals, and provide a tailored patient care plan. Deliberate and consistent efforts to involve caregivers with decision-making regarding patient care. Prepare caregiver (by using incremental, iterative education strategies, including an identified feedback loop and contact person) with the skills needed to care for patient when transitioning to home, including skills in differentiating between normal consequences

	of stroke and early identification and management of worsening symptoms. Caregivers are provided with a local, web-based repository for access to community resources and supports (e.g. ADL training, respite care, support groups, stroke counselors and public health nurses, a hotline, grieving and loss services, and resources to support social determinants of health) to develop competencies and confidence that can help provide for patients' needs and address their own needs.
Patient and Caregiver Well-being	Recognition of patients' and caregivers' emotional reactions to stressful experiences and deliberate efforts of healthcare team members to acknowledge such reactions (e.g. denial of emotional reactions, communication, honesty, trust, financial security concerns), foster coping skills (e.g. support groups, counseling, strategies to optimize survivor independence and caregiver overall life balance), enable care recipients to be respected and treated as whole human beings, and support decisions that contribute to patients' and caregivers' quality of life (e.g. healthy diet, exercise, time for self, spiritual or religious practices, leisure activities, and financial stability) and transportation and driving challenges (e.g. assess for suitability to drive, support for driving instruction, use of public transportation, and ride sharing applications) .
Care Continuity	Provide patient and caregiver with a tailored, individualized care plan. Comprehensive implementation of individualized care plans, including ensuring timely access to appropriate, high-value health and community-based services (including an access point with a case manager, community or public health nurse, or patient advocate, in-home follow-up, and periodic case review) (management continuity), timely exchange of information between and among all team members (e.g. immediate provision of stroke support group information (informational continuity), and access to continuous sources of care via one access point, case manager, or patient advocate to foster trust with patients and caregivers (relational continuity).
Accountability	Assuming responsibility for ensuring high-quality implementation of TC services customized to meet individualized needs of patients and caregivers. Clinician accountability refers to defining the roles and responsibilities of identified healthcare team members, partnerships between healthcare professionals and patients and caregivers in designing tailored plans of care commensurate to health literacy attainment and ensuring effective delivery and implementation of these plans. Team accountability refers to the responsibility of each healthcare professional to contribute expertise and actively collaborate with all team members, including patient and caregiver, to ensure that patients and caregivers achieve their health and care plan goals. Organizational accountability refers to the system's responsibility to ensure an environment and services for a minimum of six months after returning home (e.g. on-going in-home assessments, psychological services, a patient or insurance advocate) conducive to optimizing the TC experiences of patients and caregivers.