

EFFECTIVENESS OF AN OCCUPATIONAL THERAPY-FOCUSED STROKE
TRANSITIONAL CARE PROGRAM IN AN INPATIENT
REHABILITATION FACILITY

By

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Abstract

Introduction: As a global health issue, stroke is one of the most common causes of disability for individuals around the world. The American Heart Association (2024) mentions that stroke is the fifth-highest cause of mortality and the top cause of disability in the United States. Objective: This project aimed to assess the change in the perceived readiness of individuals after implementing an occupational therapy (OT)-focused transitional care program for patients with stroke and their caregivers before returning home. Methods: The recruitment process for participants involved purposive sampling methods. The study utilized both the Readiness for Hospital Discharge Scale-Short Form (RHDS-SF) or Preparedness Assessment for the Transition Home After Stroke Instrument^{®s2018} (PATH-s) to assess the perceived readiness of individuals with stroke and their caregivers at an inpatient rehabilitation facility (IRF) before and after completing the Stroke Transitional Care Program (STCP). Results: An OT-focused STCP increased perceived readiness to return home before hospital discharge for patients with stroke; contrary, it did not significantly affect caregivers. Conclusion: The stroke population and the OT profession will benefit from further research to contribute to the limited body of knowledge and the continual application of STCP in practice.

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Dedication

This doctoral capstone project is dedicated to my late grandmother, Marcelina Ujano Tapat. In addition to my parents and loved ones who have continuously supported me through my graduate journey.

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Introduction

According to The American Heart Association (2024), strokes are the fifth highest cause of mortality and the top cause of disability in the United States. A stroke is the result of an interruption of blood supply to the brain. There are three classifications of stroke: transient ischemic attacks, ischemic, and hemorrhagic strokes. A transient ischemic attack is a mini-stroke or a warning sign that a major stroke may occur, and symptoms last for less than an hour. Approximately 87% of all occurrences are ischemic strokes, which happen when there is a blockage in the blood vessels that deliver oxygen to the brain. Hemorrhagic strokes make up roughly 13% of stroke cases; this happens when a weak blood vessel bursts and blood leaks into the subdural areas of the brain (The American Heart Association, 2024). A stroke can significantly impact an individual's physical, cognitive, communication, and psychological abilities. One of the most common physical limitations that may happen is hemiparesis or hemiplegia, characterized by a partial or complete loss of motor function on one side of the body. Aphasia is one of the many possible cognitive communication consequences associated with a stroke, presenting with deficits in one or more areas of expressive communication, receptive language, and a decreased ability to perform bilateral tasks. Furthermore, individuals may experience psychological effects such as emotional instability, anxiety, and depression.

Although stroke is one of the leading causes of disability in the world that comes with many challenges, there is limited evidence supporting the use of transitional care programs within IRFs for this population. Nevertheless, developing and implementing a STCP at an IRF before discharge will increase the perceived readiness to return home for those who have experienced a stroke and their caregivers. The literature indicates that after this life-changing

experience, many people report decreased independence, increased caregiver burden, and hospital readmission, not to mention limited resources to assist in these areas.

Significance of Study and Relevance to Occupational Therapy

OT practitioners develop interventions to promote health, well-being, and participation (“OT practice framework”, 2020). The American Occupational Therapy Association [AOTA] (n.d.) seeks to enhance OT practice, education, and research by establishing standards and advocating for its members, the OT community, and the public. OT, being an inclusive profession, aims to provide practical solutions that make it easier for people to engage in activities of daily living (ADLs). There is no gold standard or care and a recognizable gap in the literature regarding STCP in combination with OT. Concerning the principles of justice, beneficence, advocacy, and access, an OT practitioner must provide information and resources to those needing OT services to decrease obstacles to accessibility (“AOTA 2020 occupational therapy code of ethics”, 2020). Furthermore, adding to existing literature may bridge the gap of greater possibilities while expanding the knowledge and involvement of the OT profession.

The American Occupational Therapy Foundation [AOTF] (n.d.) envisions a dynamic science that advances understanding to facilitate efficient, evidence-based OT. Their mission is to further OT science so that it can assist individuals in fully engaging in meaningful occupations. AOTF’s goal is to increase the capacity for OT research, initiate partnerships between researchers and practitioners, broaden the organization’s leadership role in the OT industry, and develop a structure to support the dissemination of research. Integrating evidence-based OT interventions such as a STCP enhances patient recovery. Overall contribution in different areas may benefit individuals who experience stroke and their caregivers in need. STCP

may enable them to participate in ADLs, offer better awareness of the risks associated with various treatments, and allow patients a more active role in planning their care.

Statement of Problem

Perceived Problem

Every 40 seconds, a stroke occurs in the United States, affecting approximately 795,000 individuals annually, and ranks among the world's major causes of adult disability and mortality (Camicia et al., 2022; Centers for Disease Control and Prevention, 2023; Chen et al., 2021).

Although stroke-related mortality rates have decreased due to medical advancements in stroke rehabilitation, Camicia et al. (2022) explain that disability is still a significant concern and that post-discharge care for those who have experienced strokes along with their caregivers is frequently insufficient and disorganized, leaving their needs unmet. Although IRFs offer interprofessional programs to educate family members about stroke treatment, family caregivers typically lack the essential training and support to provide sufficient care at home (Camicia et al., 2022). This insufficient transitional care gap leads to higher rates of avoidable preventable readmissions, increased safety risks, and higher healthcare expenses. During the time in an IRF, caregivers frequently lack the necessary expertise in this novel role to assess if they are ready to deliver care at home.

Significance for Occupational Therapy

This project aims to evaluate Southern Nevada adults and their caregivers' perceived readiness to transition from hospital to home following a stroke. An individual's perceived readiness to return home is a notable problem for the OT profession as this is recognized as one of the most challenging aspects of the rehabilitation process by individuals who have experienced a stroke and their caregivers (Pascual et al., 2018). Chen et al. (2015) mention that stroke-related adverse events, high caregiver burden, social isolation, and low quality of life were all linked to unmet needs in rehabilitation. The study identified the necessity of diverse learning

styles and formats, including didactic in-person sessions, hands-on skill-building, and positive interactions. OT practitioners view individuals through a holistic approach that adapts the environment, occupation, or both to the person who is a vital component of the therapy team. When a person goes through a life-changing event, like a stroke, an OT practitioner can assist them with reaching their goals. Lin et al. (2022) implemented transitional care to improve the independence, emotional and physical functioning of individuals who have experienced a stroke while supporting their caregivers. STCPs can incorporate function, adaptation, and occupational participation through the quality and quantity of education, including the need for reliable resources. It is within the ethical duty of an OT practitioner to provide quality resources to patients. If research has identified this area as a problem, the OT profession must take action.

García-Pérez et al. (2021) emphasize that OT practitioners focus on creating, maintaining, enhancing, and recovering everyday tasks and ADLs connected to meaningful occupations and performance skills based on the practice framework; OT addresses dysfunctions and improves one's health. Thus, the primary objective of an OT intervention plan is to improve the individual's quality of life and general well-being by helping reduce activity limitation and promote functional independence by providing support in becoming independent to perform ADLs by minimizing challenges and educating them on achieving the highest level of autonomy. Through the use of assistive devices, maintaining consistency in rehabilitation therapy, and connecting them with personal support, OT practitioners can help reduce activity limitations and promote functional independence. Additionally, stroke care includes preventative, rehabilitation, and participation constraints, especially before discharge from the hospital. OT plays a role in stroke rehabilitation at every stage, from providing family or social support to working directly with the patient through counseling. Initially focused on re-education and training in

fundamental and instrumental ADLs, occupational intervention focuses on sensory-motor and perceptual-cognitive performance skills. Later, the experts suggested that OT practitioners focus on individuals, social aspects, and integration interventions.

Anticipated Outcomes for the Project

The project's anticipated outcome is to develop and implement a STCP at Encompass Rehabilitation Hospital at Desert Canyon (EHDC), in addition to increasing perceived readiness for patients who experienced a stroke and caregiver to return home. The community site would receive a PowerPoint presentation about general stroke information, home modifications, adaptive techniques and equipment, medication management, nutritional education, and community resources through the STCP. At the end of each STCP, participants would receive a pocket-size quick reference stroke guide that includes all material discussed. EHDC staff would have access to the materials created to continue the STCP with their patients.

Need for Project

A needs assessment was completed through a literature review and informally through EHDC's staff and patients. Chen et al. (2021) reported that most individuals with stroke are released from the hospital and go home, but managing care at home while undergoing rehabilitation and recovery can be difficult for them and their family caregivers during this time. These circumstances make it more difficult for individuals to meet their recovery and rehabilitation objectives during this transition. To enable a triumphant return to the community, the impact that a stroke may have on the physical, psychological, and spiritual well-being of patients and their caregivers must be considered. The lack of preparedness of those who have suffered a stroke and their caregivers before discharge might exacerbate the absence of professional assistance for self-management of rehabilitation and recovery following a stroke.

The healthcare team assesses a patient's readiness for discharge based on a variety of clinical factors; however, patient's assessment of their preparedness may differ from those of their healthcare professionals, including a patient's safety, satisfaction, and achievement of medical, emotional, and social goals (Kaya et al., 2017).

Problem/Population Intervention Outcome Question

The problem/population intervention outcome question was, for families and individuals with stroke, will implementing a STCP at an IRF enhance perceived readiness to return home upon discharge? The literature review section will examine the question at hand more thoroughly.

Operational Definitions

- Stroke: Individuals admitted to EHDC with a stroke and caregivers preparing for discharge. The patient's medical condition and type of stroke were determining factors in measurement.
- OT- Focused Transitional Care Program: An OT-focused STCP developed to offer primary education and resources to individuals who have experienced a stroke and their caregivers. The RHDS-SF and the PATH-s measure it.

Literature Review

The following literature review explores numerous studies covering the effectiveness of transitional care programs for individuals who have experienced a stroke and their caregivers. The Person Environment Occupation (PEO) Model and the Transformative Learning Theory guided this review. It investigates the OT practitioner's role in stroke rehabilitation, existing transitional care programs, the challenges of individuals who have had a stroke, and their caregiver's struggles. Individuals might experience an abrupt shift in their lives, becoming dependent on family members and feeling unprepared to deal with their novel conditions or disabilities. Family members may be unfamiliar with their new caregiver duties and may suffer caregiver burden. Both the individual with stroke and their caregivers must prepare for the transition from the hospital to home.

Occupational Therapy and Stroke Rehabilitation

To examine implementation techniques and outcomes in OT and stroke rehabilitation, Murell et al. (2021) conducted a coping analysis. The authors found a benefit in using theories, models, and frameworks to guide implementing strategies and assessing outcomes. One of the most popular implementation strategies was the distribution of instructional materials. Previously established research has shown that influencing clinical practice patterns requires more than educational resources. OT practitioners frequently assess preparedness and identify barriers and facilitators while encouraging evidence-based practice. When implementation strategies ignore these facilitators and barriers, they fail to produce significant, long-lasting, practical improvements. Distribution of educational materials, readiness evaluations, educational outreach, and identifying facilitators and barriers were the most frequently utilized. The weakness of this study is that scoping reviews tend to have a bias in the topic of interest, and there needs to be

mention of the utilization of transitional care when it comes to OT. However, the advantage is that it supports the need for and importance of OT's role in stroke rehabilitation, whether it be a caregiver or an individual who recently experienced a stroke.

It is essential to assess the effects of these interventions as OT's unique approach and collaboration with individuals involved in the rehabilitation process are noteworthy. García-Pérez et al. (2021) executed a prospective randomized controlled clinical trial to assess if functional independence is enhanced when combining OT with standard care during hospital discharge following a stroke, as opposed to a control group that received only standard care. After thoroughly analyzing the scientific literature, the authors revealed that OT intervention may benefit patients with stroke before hospital discharge regarding caregiver burden and patient functional improvement. While some countries incorporate OT activities into the discharge process, with beneficial outcomes such as functional independence, existing models do not incorporate such therapies. Caregivers collaborated to develop an OT intervention program that would improve functional outcomes and facilitate an easier transition for individuals with stroke to return home by teaching them specific care and neurorehabilitation techniques. The weakness of this study is the possibility of biases that may have derived from the participant's adherence to treatment, which may have skewed the results. However, the study provides insight into the relationship between OT's role in transitional care in an IRF regarding the stroke population.

OT plays a crucial role in stroke rehabilitation, and it is essential to understand how to implement effective interventions. Puhr and Thomas (2015) discussed the different interventions administered by OT practitioners regarding transitional care for individuals with stroke in an IRF or hospital rehabilitation to home. Interventions included medication management, early discharge, and emotional support for patients and caregivers. In addition to continuing

rehabilitation, they exchanged information with the primary care physician, educated about stroke, secondary prevention, and provided the patient with community-based resources. Transitional care may influence post-stroke challenges, and it is possible that this care is being planned with certain aspects already in place before release. Preplanning is appropriate since transferring from one environment to the next entails planning for discharge. Evidence supporting the use of transitional care models in the stroke population is limited and often needs to be revised. Thus, there is a need for studies to be completed in the United States healthcare so that therapies can remain relevant, and the population highlights how critical it is to increase the body of knowledge about successful stroke rehabilitation. The weakness of this study includes difficulties identifying the causes and effects of any one activity due to the variety of treatments available and the need for more guidelines for implementing them. Therefore, there needs to be a specific method to incorporate the findings into practice to improve patient transitional care. However, there is evidence of the need to use STCPs and that multiple interventions may aid in the successful preparation before discharge.

Although the literature has shown success with transitional care, evaluating the outcomes of these interventions on an individual is essential. Sit et al. (2016) conducted a single-blinded, randomized controlled trial with 210 individuals who experienced a stroke. The researchers assigned participants to either the control group, which received usual care from physical and OT, or the patient empowerment intervention, a transitional care program in addition to usual care, to investigate the program's effects. They used self-reported instruments to see self-efficacy, self-management behavior, and functional recovery outcomes. The program consisted of two parts: small groups and a phone intervention. The groups went through several weekly topics, beginning with sharing their stroke journey and identifying personal strengths,

limitations, and support. Following a discussion on becoming stroke-safe for life, which included making lifestyle changes, managing vitals to prevent recurring strokes, and recognizing signs and symptoms. Other topics include developing or maintaining an active lifestyle, addressing precautions in the home environment, coping with chronic symptoms that could be physical or psychological, and ways to monitor or manage them. The healthcare professionals provided a personalized plan for managing their stroke and a workbook to the participants, who expressed similar barriers. Before discharging the patients, the medical staff provided them with a comprehensive review of all the topics covered. Finally, telephone follow-up to address help with perceived barriers they may have encountered while at home, along with encouraging and commending participants on adjustments made. Results show that the program improved self-efficacy, illness management, self-management behaviors, and functional recovery compared to the control. The weaknesses of the study were that it took a multi-face approach, making it difficult to determine which component of the program was practical, and this being a nurse-led study with OT as usual care. However, the study relied on self-report assessments for participants, as they are easy to administer and require minimal expertise or training. Moreover, the aim was to provide education, including several of the components mentioned in the program, which may be advantageous for developing a novel STCP.

The aforementioned articles focused on OT's role and relationship to stroke rehabilitation. With the constant increase in individuals who experience a stroke, it is imperative to understand implementation strategies and outcome measures that support OT's medical necessity in stroke rehabilitation (Murrel et al., 2021). It is noteworthy that OT takes a specialized cooperative approach with all parties involved in the recovery stage, and it is crucial to evaluate the impact of these interventions (García-Pérez et al., 2021). Given the discussion of

OT's role in stroke rehabilitation, OT practitioners must be well-versed in beneficial and practical interventions (Puhr & Thomas, 2015). Despite studies supporting the effectiveness of transitional care, it is essential to assess each person, as everyone is unique and requires different assistance (Sit et al., 2016). OT professionals often perform readiness assessments, successfully promote the application of evidence-based strategies, and identify obstacles. So, there is a high possibility that an individual will encounter an OT practitioner at one point in their recovery.

Existing Transitional Care Programs

Limited studies exist that discuss the use of transitional care programs with OT and the stroke population. Avci and Gozum (2021) performed a descriptive qualitative study to investigate the perspectives and experiences of caregivers of individuals with stroke involved in the Transitional Care Model Stroke Turkey discharge planning program. The researchers selected 23 caregivers using a purposive sampling method and conducted interviews to gather their experience with the program. The program included hospital and home visits, phone calls, and web-based training. The hospital staff provided education on all stages of stroke prevention; the website provided risk factors and how to manage medication during hospital visits. During home visits, staff evaluated the individual's environment and identified the barriers that needed addressing. Results showed satisfaction with interventions such as telephone calls and website access available around the clock, providing continuous resources. However, caregivers mentioned that other therapy options were more successful, such as home visits being the most beneficial of the interventions, and participants were pleased with the transitional care program. The weakness of this study was the methodology, as the focus was on the participant's success when they were in a home setting and did not focus on interventions before hospital discharge. However, the strength is that it provides insight to identify areas for development by observing

the effectiveness of a transitional care model personalized for those who experienced a stroke and their caregivers, which may guide the creation of a successful STCP.

Transitional care models can help recognize potential adverse outcomes and highlight the positive components that a STCP should include. Deng et al. (2020) conducted a pilot randomized controlled study with a blinded assessment to investigate the efficacy of an integrated transitional care program on health outcomes in individuals who experienced a stroke. The hospital stroke unit in China recruited 98 individuals between October 2018 and March 2019. Each participant underwent stroke unit-based care, consisting of acute medical care, early rehabilitation, and health education. Individuals in the intervention group received ongoing therapy at home from a multidisciplinary team, whereas patients in the control group received secondary stroke prevention. During home visits, rehabilitation therapists provided continuing stroke treatment and coordination of medication by general practitioners and nurses, in addition to self-management education concerning risk factors and warning signs of a stroke. Following discharge, all patients underwent follow-up interviews at four and eight weeks. Findings revealed that transitional care has a positive impact compared to secondary stroke prevention. The study only implemented the program in one country, which limits its generalizability to other settings. Moreover, the program needed to be longer to evaluate its long-term effects. However, the primary strength is that information about transitional care programs is viable and beneficial to health outcomes such as quality of life, ADLs, and caregiver burden, which all play a role in a person's perceived readiness to return home.

To develop a program plan for a theory- and evidence-based intervention in hopes of reducing caregiver burden among individuals with stroke, Hall et al. (2019) gathered data from qualitative interviews and two systematic reviews. Participants comprised six female caregivers

who provided care for 10 years or less. The first four steps of intervention mapping guided the development process, including needs assessment, identification of results and priorities, theoretical techniques and implementation choice, and program development. The suggested intervention 'Preparing is Caring' addressed this need by connecting caregivers to essential information, in addition to emotional and practical assistance. A single point of contact provided intervention before, during, and shortly following the patient's transition from hospital to home. It included theory-based components such as training packages with information and support for providers and staff, along with elements to help caregivers feel prepared. Results show that caregivers must feel prepared before and throughout the transitional period to reduce the burden. Some areas for improvement of the study were the nature of the procedure and the unexpected changes that require additional preparation, making it time-consuming, and their sample did not include individuals who experienced a stroke. However, the study may serve as a roadmap for structuring and including specific components of a novel STCP for caregivers.

While understanding how current programs are structured is crucial, examining how well these programs work on patient outcomes is vital. Wong and Yeung (2014) conducted a randomized control trial to test the effectiveness of a four-week transitional care program for patient-related outcomes, including quality of life and patient satisfaction, in addition to clinical outcomes such as functional performance, depressive symptoms, and healthcare utilization. Both intervention and control groups received routine hospital-based physical training programs within the first three weeks after discharge. The intervention group received the transitional care program before discharge, which lasted four weeks after discharge. The program had three components: holistic care, transitional care track, and holistic care managers. Specific needs of the participants were addressed during the holistic care treatments, including managing their

symptoms, preventing a stroke from reoccurring, improving physical function, encouraging healthy behavior, developing resilience, and managing their emotions. Researchers collected the baseline scores eight weeks following hospital release and four weeks following the conclusion of the transitional care program. The results demonstrated that a four-week transitional care program is sufficient for stroke patient's clinical outcomes after discharge. The program's length was one of the study's weaknesses, as the average stay at an IRF is two weeks or less, so the methodology may not be transferable. The use of data to enhance the approaches needed to satisfy the needs of the stroke population, such as the capacity for self-care, continued exercise, adherence to medication, and upholding a healthy diet, is one of the program's strengths.

Another study by Lin et al. (2022) conducted a two-arm parallel randomized controlled experiment to evaluate the effectiveness of a nurse-led health coaching program for stroke survivors and their caregivers in hospital-to-home transitional care in China. Characteristics of the 140 participants included those 18 years or older who experienced their first stroke, had intact cognition, were able to speak without aphasia, and were going to be discharged home in a week. Additionally, caregivers had to meet the minimum age requirement of 18. The hospital's baseline data collection randomly allocated each participant to the intervention or usual care group during the 12- and 24-week follow-ups. Data was placed into sequentially numbered and sealed envelopes to inform each dyad of their group assignment. The intervention included health coaching before discharge, establishing transitional care goals, improving self-care skills, modifying the home environment, improving physical function, and managing medication, in addition to managing and preventing stroke adverse events. The outpatient clinic completed weekly phone assistance and bi-weekly in-person coaching sessions as part of the follow-up intervention at week 12. Results showed that compared to the usual care group, there were

significant improvements in participants' quality of life, self-efficacy, stroke-related knowledge, decrease in hospital readmissions, and caregiver burden. The study's weaknesses stem from conducting it outside the United States and the choice of methodology. Nevertheless, the strengths include evidence that transitional programs positively affect outcomes related to stroke rehabilitation, specifically minimizing caregiver burden, and reducing the risk of unexpected hospital readmissions during the hospital-to-home transition.

Examining previously utilized models is essential for understanding how to develop an efficient STCP. Laws et al. (2021) conducted a qualitative descriptive study to collect caregiver and stroke survivor narratives about their experiences receiving transitional care to improve Naylor's Transitional Care Model. The authors recruited participants based on their literacy and cognition, in addition to whether they planned to go home after discharge from the IRF. The five focus groups the participants could choose from were caregivers-only, stroke survivors-only, or a combination group. Interviews focused on dyad involvement, complexity management, education, well-being, care continuity, and accountability. Instead of using real names, the researchers transcribed the interviews from audio recordings using participant codes. The findings demonstrated that stroke survivors' and caregivers' demands are not entirely satisfied by post-acute stroke care. They discovered that psychological and transportation difficulties were also highlighted, in addition to the topics described. Patient's and caregivers' engagement revealed a need for information, communication, and a single point of contact to facilitate interactions with professionals. Unmet self-care needs, financial stress related to unemployment or healthcare costs, and the need for caregiver assessments for readiness were some of the barriers to participation. Furthermore, participants mentioned needing assistance in physical health, addressing environmental factors, receiving services, resources, transportation, personal

care, ADLs, and engagement. The study's weaknesses include the volume of new information that participants were required to learn quickly and the lack of supplementary resources for post-discharge reference. The results support the idea that stroke is a chronic condition; in addition, individuals with stroke and caregivers should be supported by developing new transitional care models.

The articles of this section discussed some existing transitional care programs available for individuals who experienced a stroke and caregivers. A program aimed at reducing the burden for caregivers can adopt various methods such as in-person visits, hospital check-ups, phone calls, and web-based training to provide transitional care (Avci & Gozum, 2021). Client-centered transitional care programs may yield better results than conventional treatments (Deng et al., 2020). Resources and tools, like training manuals and ongoing educational programs, may benefit individuals with strokes and caregivers in the hospital and after returning home (Hall et al., 2019). A holistic approach to treatment may help manage and treat symptoms, control and prevent stroke recurrence, enhance physical function, promote healthy behavior, build resilience, and manage emotions (Wong & Yeung, 2014; Laws et al., 2021). There were significant improvements in participant quality of life, self-efficacy, knowledge of stroke, reduction in hospital readmissions, and caregiver burden compared to the standard treatment (Lin et al., 2022). Future program development can benefit from an understanding of the many advantages and disadvantages of the transitional care programs that are currently in place.

Barriers for Individuals Who Experienced a Stroke and Caregivers

To establish a theoretical framework for enhancing stroke caregiver preparation based on the experiences of stroke family caregivers, Lutz et al. (2016) conducted a grounded theory study. The authors recruited English-speaking caregivers of patients diagnosed with first

ischemic or hemorrhagic stroke to discharge home as participants from two IRFs in the southeast of the United States. The authors conducted open-ended interviews to collect data during their stay at the IRF and six months after discharge. The findings revealed critical areas where families felt unprepared to take on the caregiver role following discharge from IRF. A plan for enhancing caregiver readiness was developed with a risk assessment of the patient and caregiver to identify along with prioritize gaps in the patient's demands and the caregiver's commitment and capacity. The methodology of this study is one of the weaknesses given that it imposes time constraints for future research and increases attrition by following up with individuals six months after discharge. Fortunately, this study's strength lies in its innovative approach to improving outcomes for those who have had a stroke and family caregivers, especially considering the current focus on enhancing care coordination, patient-centered care, and care transitions to help increase patient safety and lower readmission rates.

Experiencing a new disease, such as suffering from a stroke, can cause a significant amount of harm not only to the affected person but also to their loved ones. Chen et al. (2015) implemented an interpretative design to investigate the perspectives of community-dwelling first-time stroke survivors and their caregivers on their involvement in stroke rehabilitation. This study occurred in South Australian public hospitals from March to May 2013. It involved 22 English-speaking, first-time stroke survivors who had received at least four weeks of post-discharge therapy together with their caregivers. Data collection through in-person audiotaped semi-structured interviews covering topics such as experiences transitioning from the hospital to participant's homes and problems encountered in community care and rehabilitation. Results demonstrated a need for more communication and continuity of treatment in different settings after discharge. In addition, participants had inadequate health literacy and required basic

knowledge regarding strokes. Further, responses conveyed a belief that rehabilitation goals were constantly shifting during recovery and overlooked in busy clinical environments before hospital discharge. One of the study's weaknesses concerning the finding's generalizability may be the setting, and omitting non-English speakers narrows the understanding of what this population needs for individuals of different ethnic and culturally rich groups. The study provided insight into the support that individuals with stroke and caregivers require throughout the recovery process despite only discovering issues after patients left the hospital.

An additional study by Chen et al. (2021) synthesized qualitative results from research on stroke survivors' and informal caregivers' experiences in hospital-to-home transitional care using a systematic review and meta-synthesis. The results showed that because of the shorter hospital stay, participants and their caregivers had to take on more challenging care once they were discharged and returned home. Inadequate post-discharge assistance and gaps in discharge planning result in insufficient care for participants and caregivers, limiting their capacity to adjust to post-stroke changes. Individuals who have had a stroke and their caregivers require integrated transitional care that encourages shared decision-making and allows them to maintain their autonomy at home. Collaborations with those who have had strokes and caregivers improve discharge plans, boost expertise in navigating health and social care systems, and improve self-management skills. Weaknesses include a wide range of data utilized through this review, which may need the most current information. The study's strength lies in its ability to make people aware of the gaps in transitional care and the importance of learning about clinical guidelines and protocols for discharge planning and transitional care. Transitional care will enable a collaborative approach with patients and caregivers to develop and provide tailored interventions.

This section explored the barriers faced by those who have had strokes and caregivers after being discharged to their homes. Upon release, caregivers assume increasingly demanding responsibilities due to shorter hospital stays (Chen et al., 2021). Family members stated they felt unprepared to assume the role of a caregiver, and their needs were not met by post-acute stroke care (Lutz et al., 2016). Individuals lacked sufficient health literacy and required education on strokes, communication, and treatment continuity across several settings (Chen et al., 2015). To fully develop a successful STCP, it is critical to understand an individual's obstacles, address areas of concern, and find solutions.

Synthesis

The frequency and occurrence of strokes are increasing, and for many individuals, this results in disabilities. Several post-stroke impairments have a detrimental effect on a person's physical, mental, and emotional health. All individuals involved often encounter OT practitioners during every stage of the rehabilitation process and require assistance in support and guidance through a novel condition (García-Pérez et al., 2021; Murrel et al., 2021). OT's unique treatment approach has positive outcomes when paired with usual care (García-Pérez et al., 2021; Puhr & Thompson, 2015). Based on the literature, the transition from hospital to home is recognized as the most challenging aspect of the rehabilitation process by individuals with stroke and caregivers (Avci & Gozum, 2021; Camicia et al., 2022; Chen et al., 2021; Lutz et al., 2016; Pascual et al., 2018). There is no efficient standard care or transitional care program for stroke survivors and caregivers (Avci & Gozum, 2021; Camicia et al., 2022; Chen et al., 2015). There is a lack of education and information given to patients and caregivers before discharge (Chen et al., 2021; Chen et al., 2015; Lutz et al., 2016). Transitional programs can minimize caregiver burden and reduce the risk of unexpected hospital readmissions during the hospital-to-home

transition (Deng et al., 2020; Lin et al., 2022; Lutz et al., 2016; Wong & Yeung, 2014). Thus, to support stroke survivors and their caregivers, it is imperative to identify, develop, and implement efficient treatment strategies such as STCP within the OT profession.

Statement of Purpose

This project assessed the perceived readiness of individuals before and after implementing a STCP for people who experienced a stroke and their caregivers before being discharged home from an IRF. The STCP's primary objective was to better prepare individuals for their return home by offering education and resources. The program includes general information regarding stroke, home modifications, medication management techniques, adaptive techniques, and equipment. In addition, resources available for individuals recovering from a stroke and their caregivers or families are provided locally, online, and through the phone. Learning all of this will hopefully decrease caregiver burden, minimize hospital readmissions, and assist in dealing with the negative repercussions of a stroke. This STCP intends to provide reliable resources and incorporate evidence-based research. The outcomes were to increase preparedness, knowledge, and resources for managing post-stroke challenges and introduce an evidence-based protocol to utilize in practice.

Hypotheses

It was hypothesized that implementing a STCP at an IRF would enhance the perceived readiness of individuals who have experienced a stroke and caregivers before discharging home.

Problem/Population Intervention Outcome Question

This project aimed to address the following question: For families and individuals with stroke, will implanting a STCP at an IRF enhance perceived readiness to return home upon discharge?

Theoretical Framework

The frameworks used to develop this capstone project were the PEO model and the Transformative Learning Theory. Law et al. (1996) highlight the PEO model as the transactional relationship between person, environment, and occupation. According to the (*Occupational therapy practice framework*, 2020) a person's domain comprises roles, self-concept, cultural background, personality, health, cognitive, physical performance, and sensory capacities. In addition, environmental factors encompass the physical, cultural, institutional, social, and socioeconomic environment. The term "occupation" refers to the several types of occupations that a person engages in to maintain, express, and fulfill oneself.

Utilizing the PEO model is beneficial when creating an occupation-centered program because it helps an individual see a person as a whole and how their environment and the occupation that they are doing affect their performance. Understanding that everyone deals with and reacts to certain situations differently is essential. Therefore, experiencing a stroke has life-changing effects on individuals, whether they are patients or even caregivers. When looking at the person, there are many different things to consider, such as client factors. These are things such as one's values, beliefs, spirituality, body functions, and body structures. In addition to performance patterns, a person's habits, routines, roles, and rituals. Then, performance skills like motor, processing, and social interaction skills. The environment includes physical, such as being in an IRF and social environment, as well as the communication between the medical staff, patient, other patients, or caregivers. The last element is occupation, an activity meaningful to the individual, such as participating in a STCP.

When considering this project, the Transformative Learning Theory was chosen to pair with the PEO model. Created by Mezirow (1997), this theory helps educators understand that

individuals learn through their experiences, and those experiences reshape the way they think, feel, and perceive information. This learning theory looks at an individual experiencing a disorienting dilemma, such as a stroke. Then, the introduction of STCP marks a recognition of discontent and a need for transformation, prompting them to take necessary action. Finally, they take an approach to integrate new perspective into their lives, utilizing education and resources given.

When combined, these theoretical frameworks can effectively assist with a person's perceived preparedness level for returning home before being discharged from the hospital. The PEO model considers the individual, their surroundings, and their occupations. The parties involved in this scenario include the patient or their caregiver, the hospital, and the STCP. The transformative learning theory can assist OT practitioners in tailoring the STCP to better meet the needs of individuals who have recently received a stroke diagnosis. The program enables the OT practitioner to concentrate on each patient or caregiver's unique requirements, allowing optimal use of time during the course.

Methodology

Agency Description

EHDC, an IRF located in Las Vegas, Nevada, was the location for conducting this capstone project. During their stay at EHDC, the patients had to complete three hours of therapy daily, which may involve speech, physical, and OT. This agency supports the proposed capstone project because EHDC is the leading provider for stroke, orthopedics, and other complex neurological conditions. Additionally, EHDC has earned the Joint Commission's Gold Seal of Approval® for Disease Specific Care Certification in stroke rehabilitation.

Target Population, Sampling Design, and Recruitment Procedures

EHDC admitted individuals who suffered from a stroke, along with their caregivers, were the target population for this project. The target population for which generalizations were developed were individuals who had experienced a stroke along with caregivers. The best approach to match the study's objectives was employing a purposive sample design, improving the study's rigor, data quality, and results (Campbell et al., 2020). Considering that EHDC patients' average length of stay may last two weeks, purposive sampling is especially effective when looking at information-rich cases or using limited resources. Recruitment was accomplished by visiting individual rooms, offering a brief overview of the program, and having the patient sign an informed consent form if they expressed an interest.

Participants

Inclusion criteria were as follows: Patients with stroke and their caregivers, age ≥ 18 years, proficient in English, agreeable to the program. Exclusion criteria were as follows: Have stroke as their post-secondary diagnosis, ≤ 18 years, non-English Speaking, and cognitive disorder. The disadvantage of omitting individuals with strokes as their post-secondary diagnosis

may reduce the number of participants. However, individuals who are admitted to EHDC are focused on primary referral. At the time of implementation, the number of participants in this project depended on the available patients and caregivers who met the inclusion criteria.

Approach and Study Design

This project utilized a pre-and post-test mixed methods design to determine whether a STCP may enhance an individual's perceived readiness to return home. Mixed methods design incorporating both quantitative and qualitative data (Wasti et al., 2022) and pre-and post-test designs allow comparison of participant responses from before and after intervention (Stratton, 2019). While there is a risk of response shift bias with a pre-and post-test design, using a mixed methods approach has the disadvantages of being time-consuming and requiring comprehensive data collecting and processing. However, mixed methods design has the advantage of providing triangulation, which may minimize research bias caused by a single method, improve validity by approaching the same topic with different instruments, and establish credibility by offering an overarching view of the problem (Wasti et al., 2022). Additionally, evaluating the effect of a program on change in reported attitudes, knowledge, and behaviors is another benefit of using a pre-and post-test design (Stratton, 2019).

This study's design was most appropriate since the purpose of the pre- and post-test was to determine if an intervention influences an individual. Instrumentation may provide a risk to pre- and post-intervention assessment scoring; nevertheless, instruments were administered and scored by a single person throughout to guarantee consistency. Furthermore, the Hawthorne effect may be evident as individuals know they are participating in a study; however, every participant was visited three times weekly to establish rapport.

Methods and Procedures

EHDC was contacted regarding introducing and implementing a STCP within their facility. Clearance was received and granted an exemption by The University of Nevada, Las Vegas Institutional Review Board. Self-report questionnaires and semi-structured interviews were implemented as data collection methods. Before beginning the program, participants completed a demographics form and either the RHDS-SF (Appendix A) or PATH-s (Appendix B). A semi-structured interview was conducted following the program. The confidentiality of participants was maintained by assigning pseudonyms and storing findings in a secure location within EHDC.

Developmental Phase

Program preparation included competence in all areas: the purpose, methodology, procedures, and administration of instruments. Moreover, a PowerPoint presentation (Appendix C), including general information concerning stroke and community resources, and a pocket-size quick reference guide (Appendix D) were developed based on literature and feedback from therapy staff and patients. A trial program was completed on two individuals recruited through EHDC's stroke support group. The trial was completed in a single session, lasting for 30 minutes. The purpose of trialing the program was to execute all study design procedures, verify the program's feasibility by examining participant inclusion and exclusion criteria, program setup, gather data, and test the use of instruments. After obtaining consent, individuals underwent screening to ensure they were appropriate for the program. The administrator must thoroughly understand the purpose, methodology, and procedure for successfully implementing the program.

Implementation Phase: Data Collection

Data collection occurred at EHDC in participants' private rooms from February 2024 to March 2024 with a new set of patients. Chart reviews were completed through EHDC's database daily to recruit newly admitted individuals who experienced a stroke. Confidentiality was maintained by keeping rooms closed to the public during the designated data-gathering dates and times. Once consent forms (Appendix E) were distributed and signed by each participant, the assessments and pseudonyms were also given at admission to maintain the participant's confidentiality. Depending on their needs, the program was implemented towards each participant's targeted discharge date, lasting about one hour or less. The program consisted of a PowerPoint presentation and a pocket-size reference guide given to participants at the end. After the program, patients participated in an open-ended interview to get additional information on perceived readiness. The data was evaluated, and the relationships uncovered were reported to EHDC along with a manual and resources that can be used for the program's continuation.

Outcome Phase: Data Management and Analysis

Initial data management began after the successful completion of participant consent forms. Paper forms were stored securely at EHDC, and all data collected was stored in Google Drive, a password-protected system, and exported to Version 29 of IBM Statistical Package for the Social Sciences software (SPSS). To ensure data was accurately transferred, the data was cross-checked with paper documents and online systems to establish consistency between Google Docs, paper documents, and SPSS. Descriptive statistics were analyzed for perceived readiness for discharge for participants with stroke and caregivers utilizing SPSS. The pre-and post-RHD-SF or PATH-s were analyzed and compared using the Wilcoxon Signed Rank Test. Each assessment and the subscale's personal status, knowledge, perceived coping, and expected

support were run separately. A content analysis was completed for interview questions to find the themes amongst participant responses.

Instrumentation

The RHDS-SF forms are available as a self-report tool completed by the patient. The short forms contain eight items and measure four domains of discharge readiness: Personal status, knowledge, perceived coping ability, and the expected support the patient will have. Total scores are calculated by obtaining the mean of item scores, and the potential range is 0 (not ready) to 10 (completely ready). The RHDS-SF has high validity and reliability ($p < .05$) (Kaya et al., 2017). The disadvantage of this instrument is that it was intended for post-surgical patients. Nonetheless, investigations have revealed that it is appropriate for the needs of individuals with stroke to assess their readiness to discharge from the hospital to home (Chen et al., 2022).

The PATH-s instrument is a 25-item self-administered assessment developed to assess the caregiver's commitment and capacity before discharge and assume a novel role. This instrument evaluates readiness in preexisting caregiver factors, financial resources, home accessibility, plans for self-care, and relationships with the individual who experienced a stroke. The PATH-s has good concurrent and predictive validity ($p < .05$) (Camicia et al., 2021; Camicia et al., 2022). Calculating the sum (1-100) or average score (1-4) of the items can determine the score. Thus, caregivers may need to intervene if any given item scores two or below. Only a few studies have utilized this tool, which is a disadvantage. However, the studies that have used it found good reliability and validity. Moreover, it can assess caregiver's readiness, pinpoint areas where targeted interventions can be applied to improve the transition back home, and minimize the negative impact of caregiving (Camicia, et al. 2022).

The Patient Demographics sheet included gender, age, ethnicity, level of education, living situation, prior and current level of function, and type of stroke. Three questions were asked during a semi-structured interview: Participant's feelings post-program, additional information required, and whether they feel prepared to go home. One disadvantage is that the investigator created the demographics form and semi-structured interview. Peer reviewed studies have yet to utilize them. The lack of use in a peer-reviewed study reduced the reliability and validity of the results. However, both were intended to enhance the understanding of the purpose of the study.

Ethical and Legal Considerations

When reviewing ethical and legal considerations for this project, the AOTA Code of Ethics, EHDC policies and regulations, and the Institutional Review Board - UNLV, IRB #: UNLV-2023-560 were referenced. The AOTA code of ethics was developed to guarantee that OT practitioners are committed to promoting inclusion, participation, safety, and well-being for individuals utilizing services at any stage of life, health, or illness, as well as enabling all service recipients to meet their occupational demands (AOTA 2020 OT code of ethics, 2020). The program adhered to all UNLV and Institutional Review Board regulations, which include protecting participant privacy, safety, and ethical treatment.

Results

Participants

A total of 24 participants underwent screening and were recruited, with 12 people meeting the inclusion criteria and expressing interest in the STCP from February 2024 to March 2024. The sample consisted of 2 caregivers along with 10 individuals who experienced a stroke admitted and receiving care at EHDC.

Individuals who Experienced a Stroke

Of the ten individuals with stroke, 80% were female, making up a majority of the sample; the remaining two patients (20%) were male. Participant's ages ranged from fifty to ninety-three. In terms of ethnicity, most individuals were of Caucasian (60%), Asian (20%), Ethiopian (10%), and mixed ancestry (10%) backgrounds. A large portion of the population was retired (60%), with the remaining individuals either working full-time (30%) or being unemployed (10%). Many participants had completed high school (60%) or college (40%). Many of the participants reported living with relatives (60%), while others reported living by themselves (20%), with their spouse (10%), or in an assisted living facility (10%). One hundred percent reported that their prior level of function was independent. The current level of function ranged from majority minimal assistance (50%) to moderate assistance (50%). Finally, most participants were unsure of what type of stroke they experienced (70%), with two reporting ischemic stroke (20%) and one transient ischemic attack (10%). Table 1 presents the characteristics of participants who experienced a stroke.

Table 1: Characteristics of the Sample of Individuals with Stroke

Patients	Gender	Age	Ethnicity	Education	Employment	Residence	PLOF	CLOF	Type
A	M	82	Caucasian	College	Retired	Wife	IND	Mod	TIA
B	F	76	Multiracial	College	Retired	Family	IND	Min	IS
C	F	58	Ethiopian	HS	Fulltime	Friend	IND	Min	Unk
D	F	63	Caucasian	HS	Unemployed	Homeless	IND	Min	Unk
E	F	86	Caucasian	HS	Retired	Family	IND	Mod	IS
F	F	57	Asian	HS	Fulltime	Self	IND	Min	Unk
G	F	79	Caucasian	HS	Retired	AL	IND	Min	Unk
H	M	57	Caucasian	HS	Fulltime	Self	IND	Mod	Unk
I	F	74	Caucasian	HS	Retired	Family	IND	Mod	Unk
J	F	92	Asian	College	Retired	Family	IND	Mod	Unk

Notes. Demographics of participants with stroke. PLOF=Prior level of function, CLOF=Current level of function, Type=Type of stroke, M=Male, F=Female, HS=Highschool, AL=Assisted living, IND =Independent, Mod A=Moderate assistance Min A= Minimal assistance, TIA=Transient ischemic attack, IS=Ischemic stroke, and Unk=Participant could not identify what type of stroke they had.

Caregiver

Two female caregivers served as the total representative sample for this project. The two participants, Asian and multiracial, were 58 and 73. The highest level of education attained by both participants was a college degree (100%). While one of the caretakers worked full-time, the other was retired. Every participant stated that they lived with an individual who experienced a stroke (100%) and that their family members had previously been entirely independent (100%) in all ADLs. While one caregiver reported partial assistance, the other stated that the person they planned to care for currently functioned at a maximal level. Ultimately, one caregiver reported an ischemic stroke, while the other was unsure of the kind of stroke that the individual they were planning on caring for experienced. Table 2 presents the characteristics of participants who experienced a stroke.

Table 2: Characteristics of the Sample of Caregivers

Ps	Gender	Age	Ethnicity	Ed	Employment	Reside	PLOF	CLOF	Type
A	F	73	Multiracial	HS	Retired	Yes	IND	Mod	IS
B	F	58	Asian	College	Fulltime	Yes	IND	Min	Unk

Notes. Demographics of caregivers. Ps=Participants, Ed=Education, PLOF=Prior level of function, CLOF=Current level of function, Type=Type of stroke, HS=Highschool, IND =Independent, Mod=Moderate assistance, Min=Minimal assistance, IS=Ischemic stroke, and Unk=Participant could not identify what type of stroke they had.

Perceived Readiness to Discharge

Quantitative Data for Individuals who Experienced a Stroke

To determine the overall readiness for hospital discharge, a 10-point Likert scale was utilized to answer eight questions. Individuals' pre-and post-results for overall readiness for hospital discharge showed low scores (3.50) upon admission; however, scores increased (7.00)

following participation in the STCP. There are four subscales: Personal status, Knowledge, Perceived coping ability, and Expected support. During admissions, scores were on the lower end of the scale (personal status (3.40), knowledge (2.30), perceived coping abilities (3.40), and expected support (5.30)); nevertheless, all subscales (personal status (7.00), knowledge (7.20), perceived coping skills (7.10), and expected assistance (M=7.30)) showed increases in scores after individuals participated in the STCP. Table 3 illustrates a comparison of the 10 participants' pre-and post-STCP assessments based on the Wilcoxon Signed Rank test results on perceived readiness for discharge.

Table 3: Comparison of Pre- and Posttest RHDS-SF Items

	Pretest		Posttest		Wilcoxon	
	M (SD)	Mdn (Q ₁ - Q ₃)	M (SD)	Mdn (Q ₁ - Q ₃)	t-score	p-value
Readiness for Hospital Discharge	3.50 (1.18)	3.00 (2.75-5.00)	7.00 (1.41)	7.00 (5.75-8.25)	2.82	< 0.05
Personal status	3.40 (1.71)	3.00 (2.00-5.00)	7.00 (2.11)	7.00 (5.75-9.00)	2.40	< 0.05
Knowledge	2.30 (2.16)	2.00 (0.00-3.25)	7.20 (2.39)	7.50 (6.00-9.25)	2.71	< 0.05
Perceived coping ability	3.40 (2.32)	3.51 (1.50-5.25)	7.10 (1.85)	7.50 (5.75-8.25)	2.82	< 0.05
Expected support	5.30 (2.91)	5.00 (2.75-8.25)	7.30 (3.20)	8.00 (4.00-10.00)	1.76	> 0.05

Note. The pre- and posttest N=10. The overall readiness for hospital discharge and four subscales: personal status, knowledge, perceived coping ability, and expected support. The M=Mean, SD=Standard Deviation, Mdn=Median, Q₁=25th percentile, & Q₃=75th percentile is based on the Likert scale of 0-10 (0 =not ready, low energy, know nothing at all, not at all, or none to 10=totally ready, high energy, know all, extremely well, or a great deal). t-score=Standardized test statistics, p-value = Probability was calculated using the Wilcoxon Signed Rank Test.

Table 4: Comparison of Pre- and Posttest Personal Status Questions from RHDS-SF

Participant	How physically ready are you to go home?		How would you describe your energy today?	
	Pretest	Posttest	Pretest	Posttest
A	3	10	7	8
B	2	10	2	8
C	6	5	6	1
D	0	9	5	10
E	0	7	4	7
F	0	7	3	8
G	1	10	1	4
H	0	5	5	5
I	0	4	10	7
J	5	4	5	6

Note. N=10. Comparison of participant's personal status responses from before and after the STCP.

Table 5: Comparison of Pre- and Posttest Knowledge Questions from RHDS-SF

Participant	How much do you know about problems to watch for after you go home?		How much do you know about restrictions (what you are allowed and not allowed to do) after you go home?	
	Pretest	Posttest	Pretest	Posttest
A	4	9	0	10
B	2	8	2	9
C	0	6	0	7
D	0	10	0	10
E	2	6	3	6
F	3	8	3	8
G	4	8	4	8
H	0	4	0	0
I	1	7	2	5
J	7	7	6	4

Note. N=10. Comparison of participant's knowledge responses from before and after the STCP.

Table 6: Comparison of Pre- and Posttest Perceived Coping Ability Questions RHDS-SF

Participant	How well will you be able to handle the demands of life at home?		How well will you be able to perform your personal care (for example, hygiene, bathing, toileting, eating) at home?	
	Pretest	Posttest	Pretest	Posttest
A	5	7	9	10
B	2	10	7	10
C	0	6	5	6
D	0	9	0	6
E	4	7	4	7
F	0	8	0	7
G	5	8	7	8
H	5	5	0	3
I	2	3	6	9
J	4	5	0	4

Note. N=10. Comparison of participant's perceived coping ability responses from before and after the STCP.

Table 7: Comparison of Pre- and Posttest Expected Support Questions RHDS-SF

Participant	How much help will you have if needed with your personal care after you go home?		How much help will you have if needed with your medical care needs (treatments, medications) after you go home?	
	Pretest	Posttest	Pretest	Posttest
A	1	1	10	0
B	10	10	10	10
C	0	3	4	5
D	9	10	9	10
E	8	8	8	7
F	0	8	3	7
G	1	5	4	3
H	9	10	0	10
I	1	10	5	10
J	6	8	4	8

Note. N=10. Comparison of participant's expected support responses from before and after the STCP.

Qualitative Data for Individuals who Experienced a Stroke

During the post-interview, responses about feelings reported after participating in the program were: Feeling good, informed, quick reference guide, visuals, and resources. One participant said, “I appreciate everything that I learned because I feel more informed.” While another one expressed, “I feel good. I rate it a 10. I love the quick reference guide, and I enjoyed the videos because it provided visuals. The presentation was very down-to-earth.” One participant reported, “I’m going to continue everything when I leave; this was a good refresher.” Finally, another participant expressed feeling, “Good, I really liked the information towards the end (resources).”

Responses regarding additional information that would be helpful or make them feel more comfortable going home were continuation of treatment after discharge, family support, and equipment. One participant reported, “I want to find a place where I am able to get the same treatment because I made so much progress.” Another participant reported, “When this first happened to me, my family didn’t believe me, and they still don’t understand how I feel or what to do; I want them to get support so they can understand what I’m going through.” One of the participants also reported, “It’s so hard for me to get around. It would be so much better for me and my husband if I had an electric wheelchair so that I can move around the house on my own while he is at work and he won’t have to worry about me.” When asked about their readiness to return home, all the participants responded yes.

Quantitative Data for Caregivers

Table 4 illustrates a comparison of the two participants’ pre-and post-STCP assessments based on the results of the Wilcoxon Signed Rank test on preparedness to transition home after stroke. Utilizing a 4-point Likert scale, 25 questions assessed the preparedness of caregivers to

take on a novel role before hospital discharge. The overall score for the preparedness assessment for the transition home scores increased when comparing scores before (78.00) and after (80.50) participating in the STCP. Four subscales emerged from the assessment: long-term implications, commitment, capacity, and social context. Scores for long-term implications: prognosis and insight, increased when comparing scores before (2.50) and after (3.00) participating in the STCP. Conversely, scores for commitment: willingness increased when comparing scores before (2.50) and after (3.00). Additionally, capacity was broken down into five items: (1) Formal and informal resources, (2) Pre-stroke caregiver experience, (3) Financial resources, (4) Pre-existing health problems, and (5) Home and transportation accessibility. Three (formal and informal resources (2.00), pre-stroke caregiver experience (4.00), and preexisting health problems (4.00)) of the five capacity item scores increased after individuals participated in the STCP with financial resources (3.50), home and transportation accessibility (3.50) remaining the same. Moreover, social context: commitment and capacity (3.00) remained the same.

Table 8: Comparison of Pre- and Posttest PATH-s Items

Construct/Items	Pretest		Post test		Wilcoxon	
	M (SD)	Mdn (Q ₁ - Q ₃)	M (SD)	Mdn (Q ₁ - Q ₃)	t-score	p-value
Preparedness for transition home	78.00 (0.00)	78.00 (58.50-58.50)	80.50 (0.71)	80.50 (60.00-60.00)	1.34	p > 0.05
Long-term implications: prognosis and insight	2.50 (0.71)	2.50 (1.50-2.25)	3.00 (0.00)	3.00 (2.25-2.25)	1.00	p > 0.05
Commitment: willingness	4.00 (0.00)	4.00 (3.00-3.00)	3.50 (0.71)	3.50 (2.25-3.00)	-1.00	p > 0.05
Capacity: formal and informal resources	1.50 (0.71)	1.50 (0.75-1.50)	2.00 (1.41)	2.00 (0.75-2.25)	1.00	p > 0.05
Capacity: pre-stroke caregiver experience	3.50 (0.71)	3.50 (2.25-3.00)	4.00 (0.00)	4.00 (3.00-3.00)	1.00	p > 0.05
Capacity: financial resources	3.50 (0.71)	3.50 (2.25-3.00)	3.50 (0.71)	3.50 (2.25-3.00)	0.00	p > 0.05
Capacity: preexisting health problems	3.50 (0.71)	3.50 (2.25-3.00)	4.00 (0.00)	4.00 (3.00-3.00)	1.00	p > 0.05
Capacity: home and transportation accessibility	3.50 (0.71)	3.50 (2.25-3.00)	3.50 (0.71)	3.50 (2.25-3.00)	0.00	p > 0.05
Social context: commitment and capacity	3.00 (0.00)	3.00 (2.25-2.25)	3.00 (0.00)	3.00 (2.25-2.25)	0.00	p > 0.05

Note. The pre- and posttest N=2. Overall preparedness to transition home and subscales: long-term implications, commitment, capacity, and social context. The M=Mean, SD=Standard Deviation, Mdn=Median, Q₁=25th percentile, & Q₃=75th percentile is based on the Likert scale of 1-4(1-2=Requires assistance and 3-4=Ready for transition home). t-score=Standardized test statistics, p-value = Probability was calculated using the Wilcoxon Signed Rank Test.

Table 9: Comparison of Pre- and Posttest PATH-s Questionnaire

Readiness items	Participants			
	A		B	
	Pre	Post	Pre	Post
How much do you understand about the stroke survivor's expected recovery over the next 6 months?	2	0	2	3
How much do you understand about how the stroke will affect you lives over the next 6 months?	3	4	2	3
How much do you understand about what you need to do to get things ready before the stroke survivor goes home?	3	4	3	4
How much do you understand about what assistance the stroke survivor will need with personal care (such as bathing, using the toilet, dressing, and moving around) when he/she goes home?	4	4	3	4
How much experience have you had providing physical help with personal care (such as bathing, using the toilet, dressing and moving around) for someone who has a stroke or other disability?	2	4	4	4
How prepared are you to provide the stroke survivor assistance with personal care (such as bathing, using the toilet, dressing and moving around) when he/she goes home?	4	3	3	3
How willing are you to provide personal care (such as bathing, using the toilet, dressing, and moving around) for the stroke survivor when he/she goes home?	4	4	4	4
How much time will you have to provide personal care for the stroke survivor when he/she goes home?	4	4	3	3
Do you have any health problems (for example difficulty bending or stooping, back or joint problems, heart issues, memory, depression, anxiety or other health challenges)?	2	3	4	3
Do you think your health problems will affect your ability to provide care for the stroke survivor?	4	4	4	4

Do you have family and/or friends who are capable of providing help with the stroke survivor's personal care (such as bathing, using the toilet, dressing, and getting in and out of bed)?	1	1	3	2
Do you think these family and/or friends will be available to help with the stroke survivor's personal care when needed?	1	1	3	3
Do you have other roles and responsibilities other than providing care for the stroke survivor (for example: work, volunteer work, childcare, pet care, meal preparation, laundry, home maintenance and yard work)?	1	1	2	2
How will your other roles and responsibilities impact your availability to provide care for the stroke survivor?	3	4	3	1
Do you have other people (for example co-workers, your church, a club or social group) who will be able to help you with your other responsibilities (for example: work, volunteer work, childcare, pet care, meal preparation, laundry, home maintenance and yard work)?	1	1	1	4
How much experience do you have helping someone else with daily activities like shopping, errands, taking to appointments, medications, banking, etc.?	4	3	4	4
How willing are you to help the stroke survivor with daily activities such as shopping, errands, taking to appointments, medications, banking, etc.?	4	4	4	3
How concerned are you about your ability to continue providing care for the stroke survivor for the next year?	4	4	4	3
Is there enough money available to pay for things not paid for by insurance, Social Security income, Workers' compensation, In Home Support Services, or other benefits (for example medications, someone to help with personal care, medical equipment, shower chair, co-pays)?	4	4	3	3
Will there be any accessibility problems for the stroke survivor getting around in the house or using the toilet or shower (for example, the width of doorways, stairs, ramp access) in the home where he/she will be living?	3	4	2	3

Will you need to make any changes to the home (e.g. ramp, widen doors) to make it accessible?	4	4	3	3
Is there enough money available to pay for the necessary changes to the home to make it accessible?	4	4	3	3
Will the stroke survivor have accessible transportation (e.g. car that he/she can get in and out of, someone to drive, Paratransit, etc.) that he/she can use to go places (e.g. the doctor, grocery store)?	4	4	4	4
Thinking over the past year, how much conflict have you had in your relationship with the stroke survivor?	4	4	3	4
How mentally prepared are you to be a caregiver?	4	4	4	3

Note. (N=2). Mean scores are based on 25 questions that were scored using a four-point Likert scale (1-4, scores with “not applicable” are scored either 1.1 or 4.1. For research purposes, this allows the “not applicable ratings” to be distinguished from a 1 or a 4 rating for data analyses. For clinical purposes, a score of 1.1 = 1; a score of 4.1 = 4)

Qualitative Data for Caregivers

During the post-interview, Participant A reported that the program offered excellent information and valuable resources. The caregiver expressed that the individual whom they are going to be taking care of was very athletic and independent before having a stroke. They were aware of the significant impact a stroke had on the life of their loved one and were doing their best to support them by accepting them at the stage they were in and simply being there for them. Participant A said they were eager for their loved one to return home. However, they were concerned about assisting them when leaving the hospital because being there meant the patient had access to therapy and round-the-clock care. The caregiver added that they are overjoyed to witness their loved one's progress and that all they can do is remain optimistic that someone would be able to connect them to resources or assistance so that their loved one can continue getting better.

Moreover, participant B expressed how impressed they were with the program and how it gave them much valuable information they had never considered. The caregiver reported that they were grateful to have the quick reference guide on hand for easy access or to pass it along to the caregiver who is frequently with their loved one. The caregiver said that their loved one was completely independent in all aspects before having a stroke. The caregiver indicated that they are prepared to bring their loved one home. Since a personal care assistant will always be present to help with meal preparation and grooming needs, the caregiver is not worried about their loved one returning home.

Discussion

After experiencing a stroke, an increasing number of individuals are discharged home with functional limitations and require assistance participating in meaningful occupation. Family members who often do not feel prepared or ready to take on the new caregiver role offer this assistance. The literature suggests that healthcare professionals should pay attention to the specific needs of individuals who experienced a stroke and their caregivers before transitioning them from the hospital to their home.

Application to Occupational Therapy

As an integral part of many healthcare teams, OT practitioners are well-versed in addressing this gap. To improve OT practice, education, and research, The AOTA (n.d.) sets standards and takes a holistic approach to advocate for individuals including, members, the OT community, and the public. Comparably, The AOTF (n.d.) views a dynamic science that advances knowledge to enable effective, evidence-based OT to develop a framework to support the dissemination of research, expand the organization's leadership role in the OT industry, and boost the capacity for OT research. Moreover, there needs to be a gold standard and a discernible gap in the literature concerning the conjunction of STCPs and OT.

Program Overview

Providing education and evidence-based interventions through a STCP may increase understanding of the OT profession's medical necessity in this area. A STCP was developed and implemented at EHDC to address an individual's perceived readiness to return before hospital discharge. The program offered fundamental knowledge on stroke types, warning signs and symptoms, and strategies for preventing recurrent strokes. In addition to common limitations regarding physical, communication, and cognition, as well as emotional and personality changes,

adjustments and adaptations could be made to help address these challenges that people may encounter at home. Occupations such as mobility, showering, dressing, eating, communicating, medication/vital management, physical activity, and nutrition were also addressed. In this process, 10 patients and two caregivers completed a demographic sheet at admissions, the appropriate assessment to evaluate their readiness to discharge from hospital to home given before and after, and an open-ended interview question after the STCP.

Readiness for Hospital Discharge for Individuals with Stroke

After completing the STCP, there was a statistically significant ($p > 0.05$) increase in the overall perceived readiness for hospital discharge for individuals who experienced a stroke, thus rejecting the null hypothesis. The STCP developed and implemented at EHDC demonstrated a positive difference in perceived readiness to return home when comparing scores before and after program completion. The literature supports this study's findings, indicating that utilizing transitional care programs and interventions can improve an individual's perceived readiness to return home before hospital discharge (Avci & Gozum, 2021; Deng et al., 2020; Hall et al., 2019).

When further examining a person's overall perceived readiness, it is essential to consider subscales such as personal status, knowledge, perceived coping abilities, and expected support. When comparing assessments completed before and after participating in the STCP, there was a statistically significant increase in personal status ($p < 0.05$), knowledge ($p < 0.05$), and perceived coping skills ($p < 0.05$), rejecting the null hypothesis. However, the relationship between a person's reported preparedness to return home and expected support ($p > 0.05$) did not exhibit a statistically significant difference.

Additionally, questions for expected assistance consisted of asking the individual how much help they will have with personal and medical care when returning home. Responses in this area showed no significant changes in assistance with medical care needs when returning home; however, there was a significant difference in assistance with personal care. Scores preset this way could be because many participants indicated at the beginning of the program that they had either insufficient or sufficient support systems; hence, responses to these questions stayed consistent upon program completion. Notably, the scores of one participant exhibited an abrupt change in expectations. Before the STCP, their score for expected assistance was high; conversely, by the end, they had reported low scores. Scores were due to their satisfaction with their progress while in the hospital and their concern that, once returning home, they would not be able to get assistance to continue their therapy.

A semi-structured interview was completed following the program's conclusion to gain additional insight into the perspectives of the individuals who had experienced a stroke. Regarding the program, every participant expressed nothing but positive feedback, including feeling good. Their answers could be influenced by various things, such as having a good experience because they finished the STCP, getting regular care, or even just being near to leaving the hospital. Various factors could depend on their responses, such as having a positive experience due to completing the STCP, receiving usual care, or even being close to hospital discharge. Most participants appreciated the quick reference guide they received at the end of the STCP.

Participating in the program may have contributed to this, as it is standard procedure to provide individuals who have experienced a stroke with a booklet that has an overwhelming amount of information. Staff members are rarely able to sit down with patients to go through the

material in detail. Additionally, the pocket-sized quick reference guide allows them to carry it with them perpetually, emphasizing crucial facts that individuals should be aware of and offering community resources. Furthermore, most participants reported feeling more informed and thought the pocket-size quick reference guide they received at the end of the program would be beneficial when they went home. As a result of receiving in-depth instruction in all aspects of managing post-stroke challenges, each participant may have felt more prepared to return home. Sufficient attention was also given to the areas that each participant was most concerned about, and they were all allowed to ask questions throughout the whole program.

The participants also shared their perspectives concerning what may help them feel better prepared to return home. The primary concern highlighted by participants was the need for continuation of therapy after discharge. Many of them felt unprepared to discharge without access to outpatient clinics or any establishment where they could receive care and continue excelling in their recovery. Moreover, another participant mentioned the value of family support and wished their family could understand matters from their perspective. Acquiring the appropriate adaptive equipment was the final discussion area to enhance perceived readiness for returning home.

The need for transitional care has been shown in the literature to improve both clinical results and the perception of readiness to return home. The implementation of transitional programs can cater to the specific needs of individuals with stroke, enhancing their independence and offering comprehensive care treatments that encompass symptom management, stroke prevention, enhancement of physical function, promotion of healthy behavior, emotional regulation, and resilience building (Lin et al., 2022; Wong & Yeung, 2014). The literature lacks

documentation on how to provide support to individuals who have experienced a stroke and need to determine their perceived readiness to return home.

Preparedness for the Transition Home After Stroke for Caregivers

Conversely, when comparing scores from before and after the STCP, data for caregiver responses appeared to have no statistically significant difference in their level of preparedness for transitioning home. Scores may be the result of an insufficient number of participants, which made it difficult to assess the program's effect. Caregivers displayed high preparedness, as indicated by a score higher than two before they completed the STCP. Furthermore, they scored exceptionally well in categories including social context and commitment. Any item with a score of two or less may necessitate caregiver intervention from OT in that area. The responses indicated that long-term implications, such as stroke prognosis and insight, must be addressed. Supplementary to capacity, it considers pre-stroke caregiving experience, formal and informal resources, preexisting health issues, and home accessibility.

The caregivers answered the same questions, and they provided similar responses. They found the program helpful in providing resources and information that would benefit them at home. Caregivers expressed concern about being prepared and confident of their ability to assume this novel role to support their loved ones successfully. Since the pocket-size quick reference guide will be easily accessible, both caregivers expressed how excited they were to have it at home or in the community. Furthermore, several characteristics, such as the patient's age, ethnicity, education, and employment, as well as the patient's present functional level and the type of stroke their family member suffered, may influence the caregiver's responses.

A plethora of literature has supported the need for a program that may enhance caregiver preparedness to return home with an individual who experiences a stroke. Caregivers have

acknowledged that many therapeutic methods, including home visits and transitional care programs, are beneficial interventions (Avci & Gozum, 2021). To reduce caregiver burden and improve their readiness to take on a novel role, it is imperative that caregivers feel prepared before, during, and after the transitional phase (Hall et al., 2019). Additionally, when researchers compared transitional care to standard care, they found notable improvements in caregiver burden, self-efficacy, knowledge about stroke, and quality of life (Lin et al., 2022).

Stroke Transitional Care Program Related to Theoretical Models

Moreover, the OT profession takes pride in implementing a client-centered, holistic approach that considers the person, environment, and occupation, similar to the PEO model. The PEO model plays a significant role for individuals who are involved in the recovery process, whether it is an individual who experienced a stroke or their caregiver. During the recruitment process and the education of patients about the STCP, it was evident that all participants were different. Each participant may have similar ethnicities, genders, and other characteristics. However, everyone was unique because they had different personal domains, including client factors, occupations, contexts, performance patterns, and skills. The environment in this case was the IRF, where the individual has access to around-the-clock care from medical staff.

Although the same IRF admitted the participants, it might have positively or negatively impacted their experiences. The actual STCP was considered the occupation. Participants received a briefing on the program before they participated, and they expressed interest in the program being meaningful and beneficial for them. Incorporating a learning theory with the PEO model was essential because the program mainly focused on education. The transformative learning theory helps educators understand that individuals learn through their experiences, and those experiences reshape the way a person thinks, feels, and perceives information (Mezirow,

1997). While participating in the program, many people had the opportunity to discuss their personal experiences and how their current status affected them, and they were able to vent to someone about anything and everything. In conjunction with the transformative learning theory, the PEO model embodied the necessary tools to help individuals enhance their perceived readiness to return home before discharge from the hospital.

Limitations

While this study makes innovative contributions to implementation science, stroke rehabilitation, and OT, it has several limitations. The limitations of this project are as follows: Insufficient time as the data collection process lasted only two months. Selection error as individuals were required to sign informed consent, showing interest in participating. Limited amount of patients due to purposive sample design and the number of individuals admitted with a stroke at the time of data collection. Random errors, participant's experience with the staff and the hospital environment, and comprehension of assessments. Data may not be generalizable due to lack of randomization. Biases resulting from the conduct and involvement of family members in the procedure and the dedication of users and caregivers to therapy may cause variations in the results. Assumptions are as follows: Participants will be able to understand the instrument's questions. Participants will be honest with their responses. Participants find stroke information and resources meaningful for a safe transition from hospital to home. Levels of perceived readiness to return home will increase post-program. Stroke negatively impacts an individual physically, psychologically, and their ability to communicate.

Conclusion

After experiencing a stroke, an increasing number of individuals are discharged home with functional limitations and require assistance with ADLs. Family members who do not feel prepared or ready to take on the new caregiver role commonly offer this assistance. The literature suggests that healthcare providers should focus on addressing the specific needs of individuals who have had a stroke and their caregivers before transitioning them from the hospital to the home.

Recommendations

Individuals who had a stroke reported a significant increase in their readiness to return home before discharge after completing the STCP. Based on the findings, the recommendation is to continue optimizing the STCP for patients and caregivers at EHDC. In contrast, there was no statistically significant difference in caregiver's preparedness to transition from hospital to home. During data collection, the small number of caregivers available made it difficult to accurately evaluate the STCP's effectiveness. This project's contribution to the OT profession involves the potential application of STCP in future OT interventions to improve the standard of patient care.

Implications for Research

Subsequent research may examine the utilization of STCP as a supplement to standard care. It would be beneficial to conduct a follow-up study at EHDC and implement the same program to see if there is consistency in outcomes. Furthermore, to gain a better understanding of the demands and barriers faced by individuals with stroke as well as those who will be providing care for them at home. Future studies should investigate if the STCP alone enhances a patient's perceptions of their readiness to transition from hospital to their homes. Understanding perceived readiness for patients who have experienced a stroke and caregivers may be accomplished by

comparing participant outcomes by including a control group of individuals who only receive standard care at EHDC and a STCP receiving standard care. Further research may pursue an intervention to address expected support, which did not show any statistically significant difference among patients, to increase an individual's perceived readiness to return home.

Implications for Practice

This STCP may be the foundation of a robust program that EHDC can offer to future patients and caregivers. At the moment, patients who are admitted to the EHDC for a stroke are enrolled in a developing stroke care program. While speaking with patients, most of them report that medical staff must provide them with adequate resources or education. There is potential that the OT practitioners who are already involved in the current stroke programs offered at EHDC will continue to use or implement the STCP. It may be possible to modify the STCP to better meet the needs of OT practitioners, patients, and caregivers with whom they collaborate. For OT practitioners, a quick workshop with all the materials and presentations could be highly advantageous in understanding the STCP better.

Future Implications for OT

When it comes to serving the occupational demands of society, OT aspires to be a strong, well-known, science-driven, and evidence-based profession (AOTA's Centennial Vision and Executive Summary, 2007). OT practitioners are well-versed in addressing this gap. Results demonstrated that an abundance of individuals with strokes at EHDC exhibited low self-reports concerning their knowledge, coping skills, personal status, and expected support in terms of being prepared to go home upon being admitted to the IRF. The literature corroborates these results, as many authors have noted that the most challenging aspect of the process is often the transition from the hospital to home. Those who were completely independent before their stroke

and now required maximum assistance or were entirely dependent when completing all ADLs may find themselves in an entirely new predicament where they are unable to comprehend what happened to them. A stroke can negatively impact all aspects of the OT domain, such as engagement support, general health, and overall well-being. All these elements encompass the person, client factors, performance patterns, and skills. Apart from their context, these could be the environmental or personal factors in which they were placed or will need to stay after being discharged from the hospital. Finally, meaningful occupations are those that individuals have a desire to do or must do to survive and live meaningful lives. Further research on stroke, transitional care, and OT is necessary.

Appendix A

READINESS FOR HOSPITAL DISCHARGE SCALE -- ADULT FORM ©

Please fill in the circle next to your answer. The answers are on a 10-point scale from 0 to 10. The words below the number indicate what the 0 or the 10 means. Pick the number between 0 and 10 that best describes how you feel. For example, circling number 7 means you feel more like the description of number 10 than number 0 but not completely.

1. How physically ready are you to go home?	0 1 2 3 4 5 6 7 8 9 10 Not ready Totally ready
2. How would you describe your energy today?	0 1 2 3 4 5 6 7 8 9 10 Low energy High energy
3. How much do you know about problems to watch for after you go home?	0 1 2 3 4 5 6 7 8 9 10 Know nothing at all Know all
4. How much do you know about restrictions (what you are allowed and not allowed to do) after you go home?	0 1 2 3 4 5 6 7 8 9 10 Know nothing at all Know all
5. How well will you be able to handle the demands of life at home?	0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely well
6. How well will you be able to perform your personal care (for example, hygiene, bathing, toileting, eating) at home?	0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely well
7. How much help will you have if needed with your personal care after you go home?	0 1 2 3 4 5 6 7 8 9 10 None A great deal
8. How much help will you have if needed with your medical care needs (treatments, medications) after you go home?	0 1 2 3 4 5 6 7 8 9 10 None A great deal

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Appendix B



Preparedness Assessment for the Transition Home after Stroke (PATH-s) Instrument^{©2018}

Michelle Camicia & Barbara J. Lutz, 2018

About the PATH-s Instrument

The Preparedness Assessment for the Transition Home after Stroke (PATH-s^{©2018}) Instrument was developed by Michelle Camicia, PhD RN CRRN CCM NEA-BC FARN FAHA FAAN and Barbara Lutz, PhD RN CRRN PHNA-BC FAHA FAAN through research funded by the Rehabilitation Nurses Foundation (RNF). RNF is the charitable arm of the Association of Rehabilitation Nurses (ARN).

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Instructions for Use/Scoring

The PATH-s^{©2018} was designed to be a self-administered instrument to assess caregiver preparation/readiness prior to a stroke survivor's discharge from an inpatient rehabilitation facility. The sum score (1-100) or average score (1-4) of the items can be used to identify level of caregiver preparedness.

For clinical use

After the caregiver completes the PATH-s^{©2018}, the nurse, therapist, social worker, or other clinician should review each item. A score of 2 or lower on any item may indicate a need for caregiver intervention in that area.

Interventions should be tailored to address those items where the caregiver scores 2 or lower.

1. How much do you understand about the stroke survivor's expected recovery over the next 6 months?
 - I have no understanding about the stroke survivor's expected recovery over the next 6 months. (1)
 - I have little understanding about the stroke survivor's expected recovery over the next 6 months. (2)
 - I have some understanding about the stroke survivor's expected recovery over the next 6 months. (3)
 - I have a lot of understanding about the stroke survivor's expected recovery over the next 6 months. (4)

2. How much do you understand about how the stroke will affect your lives over the next 6 months?
 - I do not understand how the stroke will affect our lives over the next 6 months. (1)
 - I understand a little about how the stroke will affect our lives over the next 6 months. (2)
 - I understand some about how the stroke will affect our lives over the next 6 months. (3)
 - I understand a lot about how the stroke will affect our lives over the next 6 months. (4)

3. How much do you understand about what you need to do to get things ready before the stroke survivor goes home?
 - I do not understand what I need to do to get ready before the stroke survivor goes home. (1)
 - I understand a little about what I need to do to get ready before the stroke survivor goes home. (2)
 - I understand some about what I need to do to get ready before the stroke survivor goes home. (3)
 - I understand a lot about what I need to do to get ready before the stroke survivor goes home. (4)

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4. How much do you understand about what assistance the stroke survivor will need with personal care (such as bathing, using the toilet, dressing, and moving around) when he/she goes home?
- I do not understand what assistance the stroke survivor will need with personal care when he/she goes home. (1)
 - I understand a little about what assistance the stroke survivor will need with personal care when he/she goes home. (2)
 - I understand some about what assistance the stroke survivor will need with personal care when he/she goes home. (3)
 - I understand a lot about what assistance the stroke survivor will need with personal care when he/she goes home. (4)
5. How much experience have you had providing physical help with personal care (such as bathing, using the toilet, dressing and moving around) for someone who has a stroke or other disability?
- I do not have any experience providing physical help with personal care for someone who has a stroke or other disability. (1)
 - I have less than one-month experience providing physical help with personal care for someone who has a stroke or other disability. (2)
 - I have at least one month but less than a year experience providing physical help with personal care for someone who has a stroke or other disability. (3)
 - I have a year or more of experience providing physical help with personal care for someone who has a stroke or other disability. (4)
6. How prepared are you to provide the stroke survivor assistance with personal care (such as bathing, using the toilet, dressing and moving around) when he/she goes home?
- I am not prepared to provide the stroke survivor assistance with personal care when he/she goes home. (1)
 - I am a little prepared to provide the stroke survivor assistance with personal care when he/she goes home. (2)
 - I am somewhat prepared to provide the stroke survivor assistance with personal care when he/she goes home. (3)
 - I am very prepared to provide the stroke survivor assistance with personal care when he/she goes home. (4)

7. How willing are you to provide personal care (such as bathing, using the toilet, dressing, and moving around) for the stroke survivor when he/she goes home?
- I am not willing to provide any personal care for the stroke survivor. (1)
 - I am willing to provide a little personal care for the stroke survivor. (2)
 - I am willing to provide some personal care for the stroke survivor. (3)
 - I am willing to provide a lot of personal care for the stroke survivor. (4)
8. How much time will you have to provide personal care for the stroke survivor when he/she goes home?
- I will not have any time to provide personal care for the stroke survivor. (1)
 - I will have a little time to provide personal care for the stroke survivor. (2)
 - I will have some time to provide personal care for the stroke survivor. (3)
 - I will have a lot of time to provide personal care for the stroke survivor. (4)
9. Do you have any health problems (for example difficulty bending or stooping, back or joint problems, heart issues, memory, depression, anxiety or other health challenges)?
- I have many health problems. (1)
 - I have some health problems. (2)
 - I have a few health problems. (3)
 - I do not have any health problems. (4)

10. Do you think your health problems will affect your ability to provide care for the stroke survivor?

- Not applicable: I do not have any health problems. (4.1)*
- I think my health problems will greatly affect my ability to provide care. (1)
- I think my health problems will somewhat affect my ability to provide care. (2)
- I think my health problems will slightly affect my ability to provide care. (3)
- I do not think my health problems will affect my ability to provide care. (4)

11. Do you have family and/or friends who are capable of providing help with the stroke survivor's personal care (such as bathing, using the toilet, dressing, and getting in and out of bed)?

- I do not have any family and/or friends who are capable of providing help with the stroke survivor's personal care. (1)
- I have a few family and/or friends who are capable of providing help with the stroke survivor's personal care. (2)
- I have some family and/or friends who are capable of providing help with the stroke survivor's personal care. (3)
- I have many friends and/or family who are capable of providing help with the stroke survivor's personal care. (4)

12. Do you think these family and/or friends will be available to help with the stroke survivor's personal care when needed?

- Not applicable-I do not have any family and/or friends who will be available to help with the stroke survivor's personal care. (1.1)*
- I do not think these family and/or friends will be available to help when needed. (1)
- I think these family and/or friends will seldom be available to help when needed. (2)
- I think these family and/or friends will sometimes be available to help when needed. (3)
- I think these family and/or friends will be available to help when needed. (4)

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13. Do you have other roles and responsibilities other than providing care for the stroke survivor (for example: work, volunteer work, childcare, pet care, meal preparation, laundry, home maintenance and yard work)?
- I have many other roles and responsibilities other than providing care for the stroke survivor. (1)
 - I have some other roles and responsibilities other than providing care for the stroke survivor. (2)
 - I have few other roles and responsibilities other than providing care for the stroke survivor. (3)
 - I do not have any other roles and responsibilities other than providing care for the stroke survivor. (4)
14. How will your other roles and responsibilities impact your availability to provide care for the stroke survivor?
- Not applicable-I do not have any other roles and responsibilities other than providing care for the stroke survivor. (4.1)*
 - My other roles and responsibilities will greatly impact my availability to provide care for the stroke survivor. (1)
 - My other roles and responsibilities will have some impact on my availability to provide care for the stroke survivor. (2)
 - My other roles and responsibilities will have little impact on my availability to provide care for the stroke survivor. (3)
 - My other roles and responsibilities will not impact my availability to provide care for the stroke survivor. (4)
15. Do you have other people (for example co-workers, your church, a club or social group) who will be able to help you with your other responsibilities (for example: work, volunteer work, childcare, pet care, meal preparation, laundry, home maintenance and yard work)?
- I do not have any other people who will be able to help with my other responsibilities. (1)
 - I have a few other people who will be able to help with my other responsibilities. (2)
 - I have some other people who will be able to help with my other responsibilities. (3)
 - I have a lot of other people who will be able to help with my other responsibilities. (4)

16. How much experience do you have helping someone else with daily activities like shopping, errands, taking to appointments, medications, banking, etc.?

- I do not have any experience helping someone else with daily activities. (1)
- I have less than one month experience helping someone else with daily activities. (2)
- I have at least one month but less than a year experience helping someone else with daily activities. (3)
- I have a year or more experience helping someone else with daily activities. (4)

17. How willing are you to help the stroke survivor with daily activities such as shopping, errands, taking to appointments, medications, banking, etc.?

- I am not willing to help the stroke survivor with daily activities such as shopping, errands, taking to appointments, medications, etc. (1)
- I am willing to help the stroke survivor with a few daily activities such as shopping, errands, taking to appointments, medications, etc. (2)
- I am willing to help the stroke survivor with some daily activities such as shopping, errands, taking to appointments, medications, etc. (3)
- I am willing to help the stroke survivor with a lot of daily activities such as shopping, errands, taking to appointments, medications, etc. (4)

18. How concerned are you about your ability to continue providing care for the stroke survivor for the next year?

- I am very concerned about my ability to continue providing care for the stroke survivor for the next year. (1)
- I am somewhat concerned about my ability to continue providing care for the stroke survivor for the next year. (2)
- I am a little concerned about my ability to continue providing care for the stroke survivor for the next year. (3)
- I am not concerned about my ability to continue providing care for the stroke survivor for the next year. (4)

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19. Is there enough money available to pay for things not paid for by insurance, Social Security income, Workers compensation, In Home Support Services, or other benefits (for example medications, someone to help with personal care, medical equipment, shower chair, co-pays)?
- We do not have money to pay for things not covered by insurance or other benefits. (1)
 - We have a little money to pay for things not covered by insurance or other benefits. (2)
 - We have some money to pay for things not covered by insurance or other benefits. (3)
 - We have enough money to pay for things not covered by insurance or other benefits. (4)
20. Will there be any accessibility problems for the stroke survivor getting around in the house or using the toilet or shower (for example, the width of doorways, stairs, ramp access) in the home where he/she will be living?
- There will be a lot of accessibility problems for the stroke survivor in the home. (1)
 - There will be some accessibility problems for the stroke survivor in the home. (2)
 - There will be a few accessibility problems for the stroke survivor in the home. (3)
 - There will not be any accessibility problems for the stroke survivor in the home. (4)
21. Will you need to make any changes to the home (e.g. ramp, widen doors) to make it accessible?
- A lot of changes need to be made to the home to make it accessible. (1)
 - Some changes need to be made to the home to make it accessible. (2)
 - A few changes need to be made to the home to make it accessible. (3)
 - No changes need to be made to make the home accessible. (4)

22. Is there enough money available to pay for the necessary changes to the home to make it accessible?

- Not applicable-There are no changes necessary to make the home accessible. (4.1)*
- We do not have money to pay for the necessary changes to the home to make it accessible. (1)
- We have a little money to pay for the necessary changes to the home to make it accessible. (2)
- We have some money to pay for the necessary changes to the home to make it accessible. (3)
- We have enough money to pay for the necessary changes to the home to make it accessible. (4)

23. Will the stroke survivor have accessible transportation (e.g. car that he/she can get in and out of, someone to drive, Paratransit, etc.) that he/she can use to go places (e.g. the doctor, grocery store)?

- I am not certain if the stroke survivor will have accessible transportation that he/she can use to go places. (1)
- I am a little certain that the stroke survivor will have accessible transportation that he/she can use to go places. (2)
- I am somewhat certain that the stroke survivor will have accessible transportation that he/she can use to go places. (3)
- I am very certain that the stroke survivor will have accessible transportation that he/she can use to go places. (4)

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This work was funded by an RNF grant and is distributed by ARN.
For more information: <https://rehabnurses.org/pathtool>.

Camicia & Lutz, 2018 – 9

24. Thinking over the past year, how much conflict have you had in your relationship with the stroke survivor?

- We have substantial conflict between us. (1)
- We have some conflict between us. (2)
- We have a little conflict between us. (3)
- We do not have conflict between us. (4)

25. How mentally prepared are you to be a caregiver?

- I am not mentally prepared to be a caregiver. (1)
- I am a little mentally prepared to be a caregiver. (2)
- I am somewhat mentally prepared to be a caregiver. (3)
- I am very mentally prepared to be a caregiver. (4)

* Scores with “not applicable” are scored either 1.1 or 4.1. For research purposes, this allows the “not applicable ratings” to be distinguished from a 1 or a 4 rating for data analyses. For clinical purposes, a score of 1.1 = 1; a score of 4.1 = 4

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Publications:

Camicia, M.E. Lutz, B.J., Joseph, J.G., Harvath, T.A., Drake, C.M., Theodore, B.R., & Kim, K.K. (2021) Psychometric properties of the preparedness assessment for the transition Home after stroke instrument. *Rehabilitation Nursing*.

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2020

ISC_Caregiving acro:

Camicia, M., Lutz, B.J., & Theodore, B. (2019). The Preparedness Assessment for the Transition Home After Stroke (PATH-s) Predicts Important Domains of Health and Well-being Associated with Caregivers of Stroke Survivors. Poster Presented at the International Stroke Conference, Honolulu, HI.



Camicia

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This work was funded by an RNF grant and is distributed by ARN.

For more information: <https://rehabnurses.org/pathtool>.

Camicia & Lutz, 2018 – 11

M.A.R.C.I.E.:

Stroke Transitional Care Program

Maximizing Autonomy - Raising Confidence - Increasing Engagement



Marcelina "MARCIE"



Stroke is a **Global health issue** and one of the most common causes of disability around the world

In the **United States** alone...

5th highest cause of mortality and top cause of disability

~795,000 people suffer from a stroke each year

Transition from hospital to home **most difficult** part

(Center for Disease Control and Prevention, 2023b)

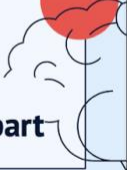

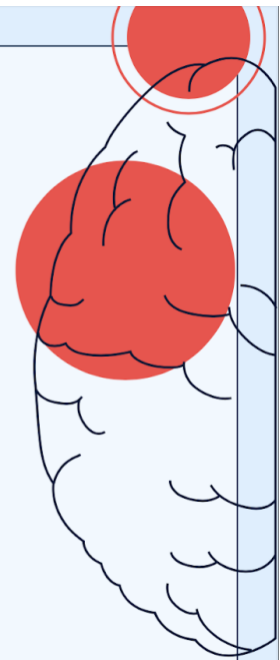


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01 General Information

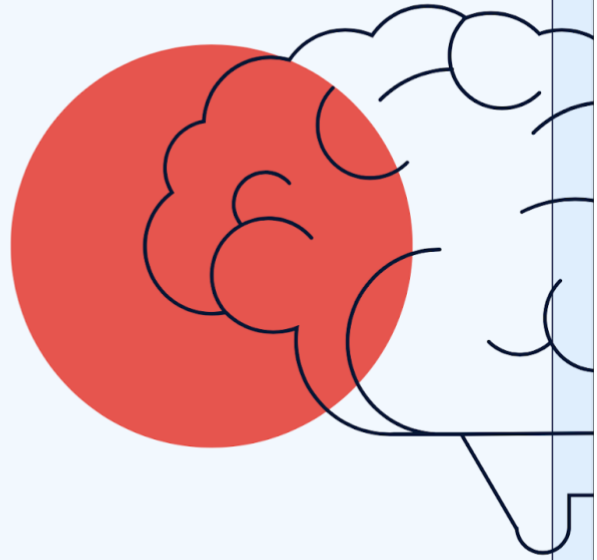
02 Life After Stroke

03 Resources



01

General Information



What is a
STROKE?

F

ace



A

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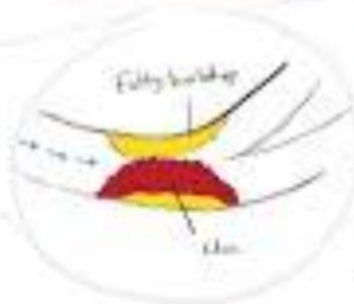
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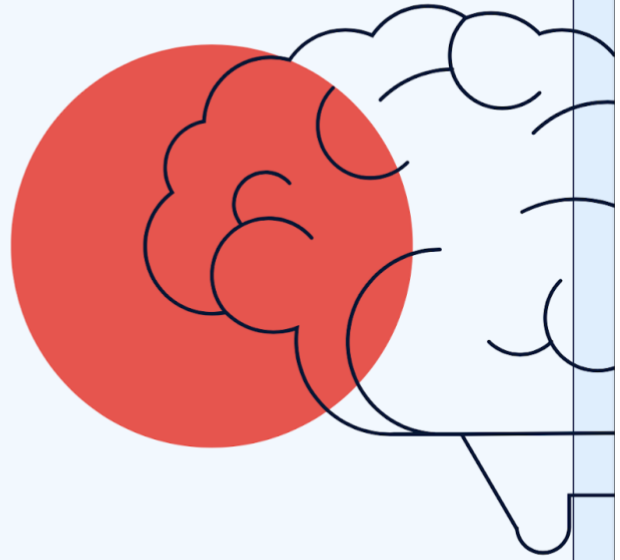
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(HealthSketch, 2015)

02

Life After a Stroke



Common Physical Limitations

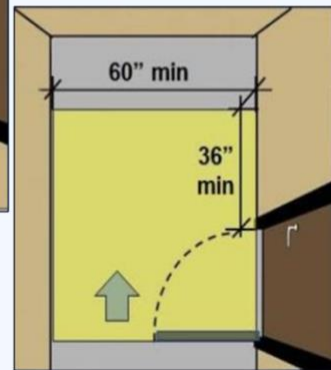
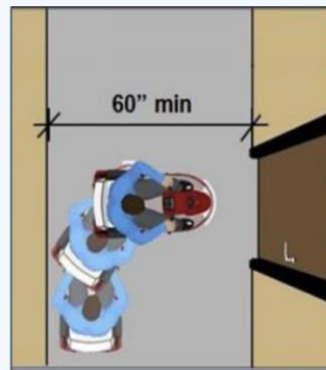
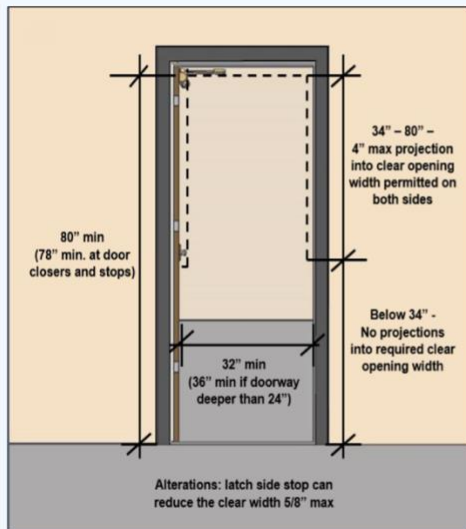
- Weakness/paralysis on one side of the body
- Fatigue
- Spasticity (stiff muscles)
- Seizures



(American Stroke Association, 2019)

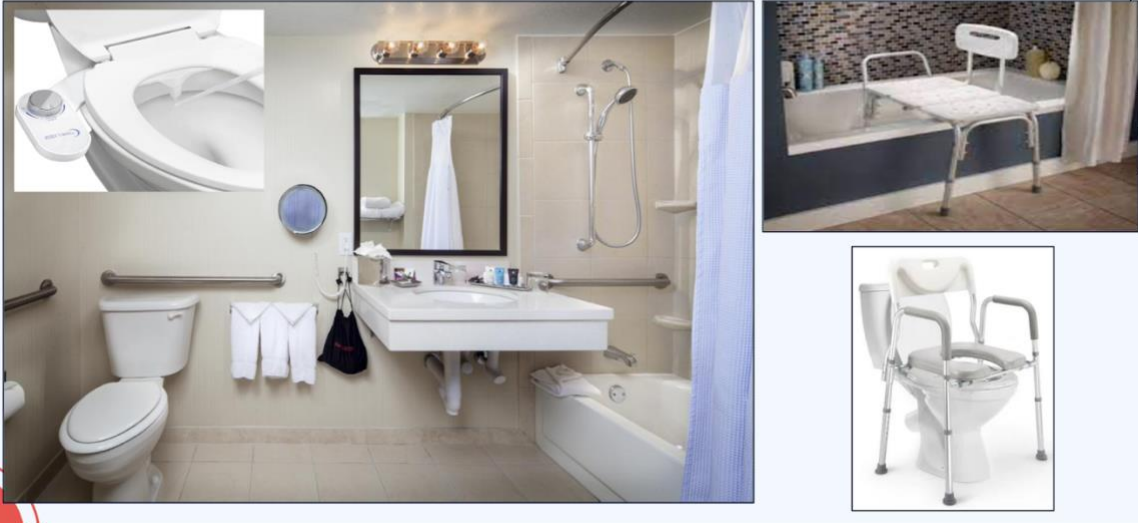


Home Modifications: Entryways



(United States Access Board, 2015)

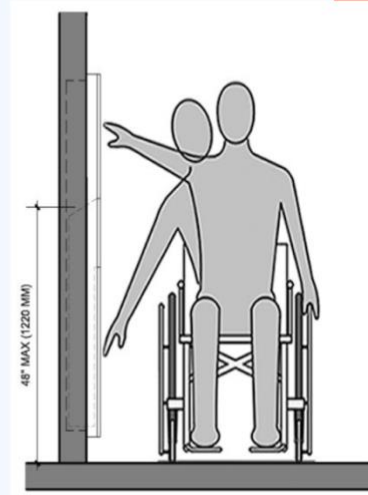
Home Modifications: Bathrooms



Home Modifications: Living Room



Home Modifications: Bedroom



(Johns Hopkins Medicine, 2022b)



Adaptive Equipment

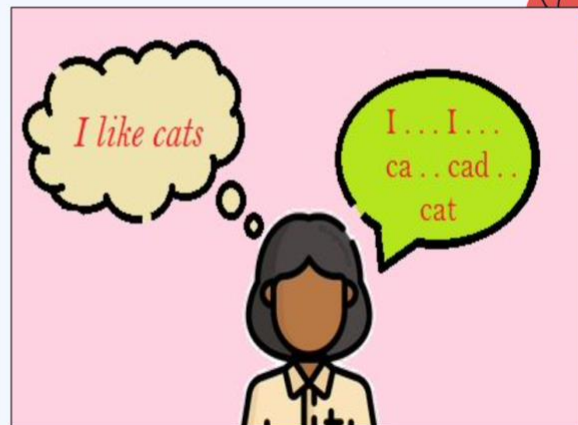


Home Modifications: Kitchen



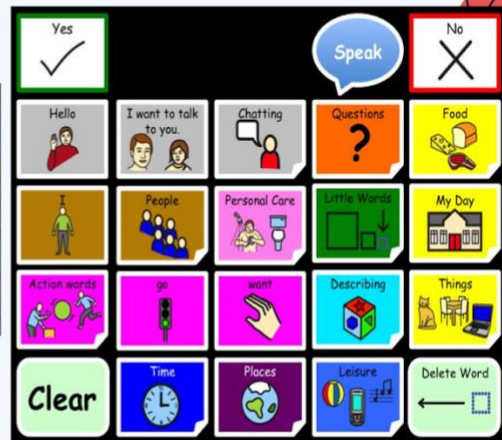
Common Communication and Cognitive Limitations

- Ability to speak
- Trouble understanding certain things



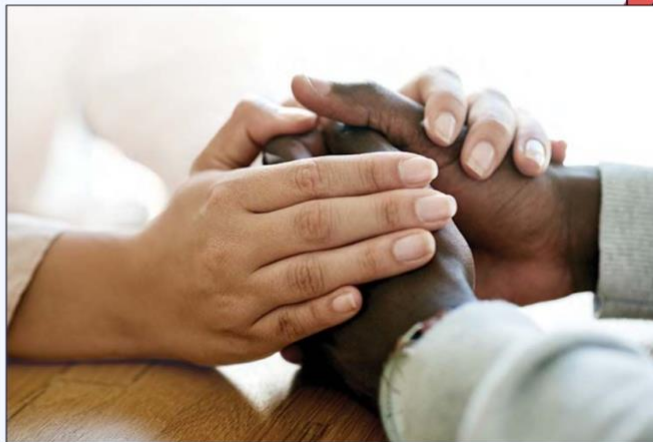
(American Stroke Association, 2019)

Adaptive Equipment/ Techniques for Communication



Common Emotional and Personality changes

- Depression
- Anxiety
- Uncontrolled crying or laughing



(American Stroke Association, 2019)

Cognitive Behavioral Therapy: Mindfulness Meditation

<https://mindfulnessinstituteforemergingadults.com/student-resources/free-guided-meditations/>



Physical activity



Medication Management



DID YOU TAKE YOUR MEDS TODAY?

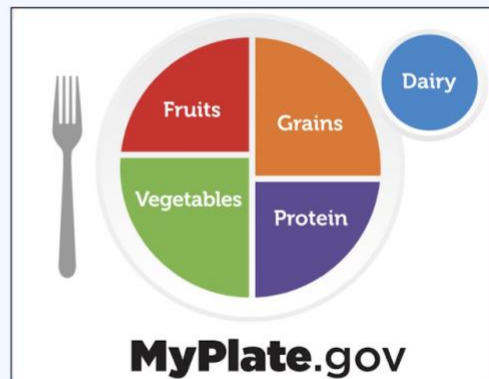
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
AM <input type="checkbox"/>	AM <input type="checkbox"/>	AM <input type="checkbox"/>	AM <input type="checkbox"/>	AM <input type="checkbox"/>	AM <input type="checkbox"/>	AM <input type="checkbox"/>
PM <input type="checkbox"/>	PM <input type="checkbox"/>	PM <input type="checkbox"/>	PM <input type="checkbox"/>	PM <input type="checkbox"/>	PM <input type="checkbox"/>	PM <input type="checkbox"/>
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Nutrition

Limit foods containing:

- **Saturated fat**
 - Processed meat
 - Pastries
 - Fried foods
- **Added salt**
 - Seasonings
 - Sauces/marinades
- **Added sugars**
 - Sugar sweetened soft drinks
 - Energy drinks and sports drinks



(Stroke Foundation, n.d.)

Nutrition

<https://www.myplate.gov/myplate-plan>

Food Group Amounts for 1,800 Calories a Day for Ages 14+ Years

Fruits	Vegetables	Grains	Protein	Dairy
1½ cups	2½ cups	6 ounces	5 ounces	3 cups
Focus on whole fruits Focus on whole fruits that are fresh, frozen, canned, or dried.	Vary your veggies Choose a variety of colorful fresh, frozen, and canned vegetables—make sure to include dark green, red, and orange choices.	Make half your grains whole grains Find whole-grain foods by reading the Nutrition Facts label and ingredients list.	Vary your protein routine Mix up your protein foods to include seafood; beans, peas, and lentils; unsalted nuts and seeds; soy products; eggs; and lean meats and poultry.	Move to low-fat or fat-free dairy milk or yogurt (or lactose-free dairy or fortified soy versions) Look for ways to include dairy or fortified soy alternatives at meals and snacks throughout the day.



Limit Choose foods and beverages with less added sugars, saturated fat, and sodium.

- Limit:**
- Added sugars to **less than 45 grams** a day.
 - Saturated fat to **less than 20 grams** a day.
 - Sodium to **less than 2,300 milligrams** a day.



Activity Be active your way:

Children 6 to 17 years old should move **60 minutes** every day. Adults should be physically active at least **2½ hours** per week.

U.S. Department of Agriculture. (n.d.)



VITALS

Heart Rate: 60-100 bpm

Blood Pressure:

120/80 mmHg

Oxygen: 95-100 O₂

Temperature: 98.6 F

VITALS



Heart Rate: ↓60 ↑100

Blood Pressure:

↑180/120

Oxygen: ↓90

Temperature: ↑101

03

Resources



Resources: Community

Name	Address	Contact
Nevada Community Enrichment Program	6375 W Charleston Blvd 1200, Las Vegas, NV 89146	(702) 259-1903
DRIVEN NeuroRecovery Center	701 E Bridger Ave Suite 150, Las Vegas, NV 89101	(702) 463-4874
SilverSneakers	https://tools.silversneakers.com/Eligibility/CheckEligibility	(866) 584-7389
RTC Paratransit & Accessibility	600 S. Grand Central Pkwy. Ste. 350 Las Vegas, NV 89106	(702) 228-4800

Resources: Home Support

Name	Address	Contact
Visiting Angels	81180 N. Town Center Dr. Ste 100 Las Vegas, NV 89144	(702) 407-1100
Assisting Hands Home Care	7469 W. Lake Mead Blvd. Ste 140 Las Vegas, NV 89128	(702) 919-0231
Home Modifications – RAMP Nevada Senior Services	901 North Jones Boulevard Las Vegas, NV 89108	(702) 538-8743

Resources: Local Stroke Support Groups

Name	Address	Contact
Encompass Health Desert Canyon Stroke Support Group	9175 W. Oquendo Rd. Las Vegas, NV 89148	Anthony Griffith (702) 252-7342 anthony.griffith@encompasshealth.com
Valley Health Speciality Hospital Stroke Support Group	8656 W. Patrick Ln. Las Vegas, NV 89148	Katherine Fischer, OT (702) 468-1720 katie.fischer@uhsinc.com
MountainView Stroke Support Group	3150 N. Tenaya Way Suite 114 Las Vegas, NV 89128	Tanya Oetjen, RN (702) 962-9468 Tanya.Oetjen@hcahealthcare.com
Henderson Stroke Support Group	10301 Jeffreys St. Henderson, NV 89052	Laura McGinnis, OT/L (702) 939-9448 Laura.McGinnis@encompasshealth.com

Resources: Mental Well-Being

Name	Address	Contact
Las Vegas Neurology Center	2020 Wellness Way. Se 300 Las Vegas, NV 89106	(702) 432-2233
Neurology Center of Las Vegas	2480 Professional Ct. Las Vegas, NV 89128	Appointments: (702) 936-3309 General Questions: (702) 405-7100
Dr. Marilyn Strada PhD	8565 S. Eastern Ave Se 106 Las Vegas, NV 89123	(702) 635-6555 DrStrada@gmail.com

Resources: Phone & Online Support

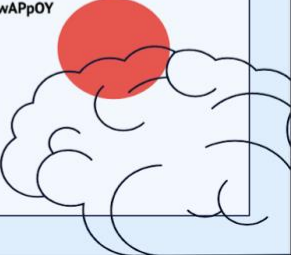
Name	Contact
American Heart Association Stroke Family Warmline	6:30 a.m.-3 p.m. Monday-Friday 1-888-4-STROKE (1-888-478-7653)
Nevada 211	2-1-1 or 1-866-535-5654
American Heart Association Support Network	https://supportnetwork.heart.org/s/



Thank you



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- U.S. Department of Agriculture. (n.d.) My plate plan. <https://www.myplate.gov/myplate-plan>
- 

Appendix D

STROKE
QUICK REFERENCE
POCKET GUIDE

M.A.R.C.I.E.

F.A.S.T.
A R P I
C M E M
E S E E
H CALL 9-1-1

M.A.R.C.I.E.

VITALS
Heart Rate: 60-100 bpm
Blood Pressure:
120/80 mmHg
Oxygen: 95-100 O2
Temperature: 98.6 F

M.A.R.C.I.E.

LOCAL STROKE SUPPORT GROUPS
Encompass Desert Canyon
(702) 252-7342
Henderson
(702) 939-9448
MountainView
(702) 962-9468
Valley Health Specialty Hospital
(702) 468-1720

M.A.R.C.I.E.

**THANK
YOU**

M.A.R.C.I.E.

**DID YOU
TAKE YOUR
MEDS
TODAY?**

M.A.R.C.I.E.

VITALS
Heart Rate: ↓ 60 ↑ 100
Blood Pressure:
↑ 180/120
Oxygen: ↓ 90
Temperature: ↑ 101

M.A.R.C.I.E.

**COMMUNITY
RESOURCES**

PRESENTATION

M.A.R.C.I.E.

MENTAL WELL-BEING
Las Vegas Neurology Center
(702) 432-2233

Neurology Center of Las Vegas
(702) 405-7100

M.A.R.C.I.E.

HOME SUPPORT
Visiting Angels
(702) 407-1100

Assisting Hands Home Care
(702) 919-0231

Home Modifications - RAMP
Nevada Senior Services
(702) 538-8743

M.A.R.C.I.E.

COMMUNITY RESOURCES
Nevada Community Enrichment Program
(702) 259-1903

DRIVEN NeuroRecovery Center
(702) 463-4874

SilverSneakers
(866) 584-7389

RTC Paratransit & Accessibility
(702) 228-4800

M.A.R.C.I.E.

PHONE & ONLINE SUPPORT
American Heart Association Stroke
Family Warmline
1-888-478-7653
Nevada 211
1-866-535-5654

American Heart Association Support
Network
<https://supportnetwork.heart.org/s/>

M.A.R.C.I.E.

**COMMUNITY
RESOURCES**

PRESENTATION

M.A.R.C.I.E.

**THANK
YOU**

M.A.R.C.I.E.

Appendix E



INFORMED CONSENT

Department of Brain Health

TITLE OF PROJECT: EFFECTIVENESS OF AN OCCUPATIONAL THERAPY-FOCUSED STROKE TRANSITIONAL CARE PROGRAM IN AN INPATIENT REHABILITATION FACILITY

INVESTIGATOR(S): DANNIEL TAPAT

For questions or concerns about the program, you may contact Danniell Tapat at tapatd1@unlv.nevada.edu.

For questions regarding the rights of individuals, any complaints or comments regarding the manner in which the program is being trialed, contact the **UNLV Office of Research Integrity – Human Subjects at 702-895-0020 or via email at IRB@unlv.edu**.

PURPOSE OF THE PROJECT

You are invited to participate in a stroke transitional care program. The purpose of this program is to assess the perceived readiness of individuals prior to implementing a transitional care program for stroke patients and their caregivers before returning home.

PARTICIPANTS

You are being asked to participate in the program because you fit this criterion:

- Admitted due to experiencing a stroke.
- 18 years or older
- Patient/caregiver at Encompass Health Rehabilitation Hospital of Desert Canyon
- Proficient in English (read, speak, and understand)

PROCEDURES

If you volunteer to participate in this program, you will be asked to do the following:

1. Attend a one-hour stroke transitional program.
2. Complete an evaluation method before and after the program.

BENEFITS OF PARTICIPATION

There may be direct benefits to you as a participant in this program. However, we hope to learn if a stroke transitional care program will increase perceived readiness to return home.

RISKS OF PARTICIPATION

There are risks involved in all programs. This program may include only minimal risks. You may become uncomfortable when answering some questions.

COST /COMPENSATION

There may not be financial cost to you to participate in this program. The program will take 60 minutes of your time. You will not be compensated for your time.

CONFIDENTIALITY

All information gathered in this program will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this project.

VOLUNTARY PARTICIPATION

Your participation in this program is voluntary. You may refuse to participate in this program or in any part of this project. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this program at the beginning or any time during the program.

PARTICIPANT CONSENT:

I have read the above information and agree to participate in this program. I have been able to ask questions about the project. I am at least 18 years of age. A copy of this form has been given to me.

Signature of Participant

Date

Participant Name (Please Print)

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Curriculum Vitae

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Education

University of Nevada, Las Vegas 2021-2024
Occupational Therapy Doctorate
Capstone Title: Effectiveness of a Stroke Transitional Care Program at an Inpatient Rehabilitation Facility

California State University, East Bay 2015
B.S. in Kinesiology with focus in Therapeutic studies
Minor in Biological Science

Related Work Experience

Fyzical Therapy and Balance Centers 2018 – 2021
D. Keith Kleven Institute of Physical Therapy Rehabilitation 2017 – 2018

Related Fieldwork Experience

Level IE – Sam Schmidt Foundation/ DRIVEN NeuroRecovery Center 2023
Level IIB – Piller Child Development 2023
Level ID – Cornerstone Christian Academy and Tykes Preschool 2023
Level ID – Speakeasy Therapy Services - North Las Vegas 2023
Level IC – Cornerstone Christian Academy and Tykes Preschool 2022
Level IIA – Encompass Health of Desert Canyon 2022
Level IB – Encompass Health of Las Vegas 2022
Level IA – The Garden Foundation 2021

Professional Affiliations

American Occupational Therapy Association 2021 – Present
Student Occupational Therapy Association 2021 – 2024
Coalition of Occupational Therapy Advocates for Diversity 2023 – Present
Alpha Phi Fraternity 2012 – Present

Scholarships

Occupational Therapy Doctorate General Program Scholarship 2023
Occupational Therapy Doctorate Out of Area Fieldwork Assistance Scholarship 2023
Occupational Therapy Doctorate Capstone Support Scholarship 2024