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Authors: *David J. Gladstone (Chair, First Author), M. Patrice Lindsay (Corresponding Author), James Douketis, Eric E Smith, Dar Dowlathshahi, Theodore Wein, Aline Bourgoin, Jafna Cox, John B. Falconer, Brett R. Graham, Marilyn Labrie, Lena McDonald, Jennifer Mandzia, Daniel Ngui, Paul Pageau, Amanda Rodgerson, William Semchuk, Tammy Tebbut⁸, Carmen Tuchak, Stephen van Gaal, Karina Villaluna, Norine Foley, Shelagh Coutts, Anita Mountain, Gord Gubitz, Jacob A Udell, Rebecca McGuff, Manraj K.S. Heran, Pascale Lavoie and Alexandre Y. Poppe (Co-Chair, Senior Author); on Behalf of the Canadian Stroke Best Practice Recommendations Advisory Committee, in collaboration with the Canadian Stroke Consortium.*

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Corresponding Author:

Dr. M. Patrice Lindsay, RN, PhD, FWSO
Senior Editor, Canadian Stroke Best Practice Recommendations
Director, Health Systems Change,
Heart and Stroke Foundation, Canada
PH: +1-647-528-4361 Email: patrice.lindsay@heartandstroke.ca

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Appendix One

Descriptions and Definitions

Scope of the Secondary Prevention of Stroke Module:

This Secondary Prevention of Stroke module focuses on management of recurrent stroke risk reduction in patients who have experienced an initial stroke or transient ischemic attack. In some cases, this module will also guide healthcare providers with guidance for individuals at high risk of a stroke or transient ischemic attack based on current health status and the significant presence of one or more vascular risk factors.

Primary prevention and the reduction of risk factor prevalence in the general population are not the main focus of the *Canadian Stroke Best Practice Recommendations*; therefore, only selected recommendations related to primary prevention are included. A comprehensive set of recommendations for primary prevention are available in existing high quality guidelines developed by other organizations (such as Canadian Cardiovascular Society, Hypertension Canada Blood Pressure guidelines, Canadian Task Force on Preventative Health Care, and the Canadian Physical Activity Guidelines).

Primary prevention

Primary prevention can be a population-based approach to prevent disease among communities or an individually based clinical approach to disease prevention, directed toward preventing the initial occurrence of a disorder in otherwise healthy individuals. Primary prevention can be implemented in the primary care setting, and the physician, nurse practitioner, team nurses, physician assistant, pharmacist or patient may initiate a discussion of heart conditions, stroke, and vascular cognitive impairment risk reduction. It can also be implemented at a population level using legislative, regulatory, and public awareness interventions.

Primary prevention and health promotion recommendations related to heart conditions, stroke, transient ischemic attack, vascular cognitive impairment, and peripheral vascular disease emphasize the importance of screening and monitoring and treating those patients at high risk of a first clinical event. Primary prevention areas of focus include lifestyle (healthy diet, physical activity, being tobacco-free, stress reduction and limiting alcohol, recreational drugs), and screening and management of medical risk factors such as hypertension, dyslipidemia, diabetes, and atrial fibrillation.

Implementation of primary prevention strategies ideally would involve a Shared Decision-Making conversation between the patient and the provider to ensure the patient's goals are incorporated into therapy decisions.

Primary prevention also includes the development of strategies to improve population health such as policies that create environments that facilitate making healthy choices the easier choices (examples include smoke-free legislation, revised Canada's Food Guide as well as policies that support active and public transportation). These strategies are often led by health-oriented organizations and agencies such as Heart & Stroke, Canadian Cardiovascular Society, Canadian Lung Association, Canadian Cancer Society, Thrombosis

Canada, Hypertension Canada, Diabetes Canada, Alzheimer Society of Canada, Health Canada, and national and provincial public health agencies and services.

Secondary prevention:

Secondary prevention is an individually based clinical approach aimed at reducing the risk of a recurrent vascular event in individuals who have already experienced a stroke, angina, transient ischemic attack, myocardial infarction, heart failure, heart rhythm abnormalities, structural heart disease, vascular cognitive impairment or peripheral vascular disease.

Secondary prevention recommendations are directed to those risk factors shown to reduce recurrent and prolong survival after vascular conditions, including attention to lifestyle (prudent diet, reduced sodium intake, increased level of activity, maintaining ideal body weight, smoking cessation, and controlling alcohol intake), and management of medical conditions such as hypertension, dyslipidemia, and heart rhythm management (e.g., atrial fibrillation). Secondary prevention recommendations can be addressed in a variety of settings—acute care, vascular prevention clinics (generalized or specific to conditions such as stroke, heart failure, post myocardial infarction), and community-based care settings. They pertain to patients initially seen in primary care, those who are treated in an emergency department and then released and those who are hospitalized and receive treatment in hospital because of angina, myocardial infarction, heart failure, heart rhythm abnormalities, structural heart disease, stroke, transient ischemic attack, vascular cognitive impairment or peripheral vascular disease.

Recommendations for secondary prevention of vascular conditions should be implemented throughout the recovery phase, including during inpatient and outpatient rehabilitation, reintegration into the community and ongoing follow-up by primary care practitioners. Secondary prevention should be addressed at all appropriate healthcare encounters on an ongoing basis following angina, myocardial infarction, heart failure, heart rhythm abnormalities, structural heart disease, stroke, transient ischemic attack, vascular cognitive impairment, or peripheral vascular disease.

Transient ischemic attack (transient ischemic attack):

Transient ischemic attack (often called a ‘mini-stroke’) is a clinical diagnosis that refers to a brief episode of neurological dysfunction caused by focal brain, spinal cord, or retinal ischemia, with clinical symptoms, and without imaging evidence of infarction (Easton, 2009; Sacco et al, 2013). Transient ischemic attack and minor acute ischemic stroke fall along a continuum. Transient ischemic attack symptoms fully resolve within 24 hours (usually within one hour). If any symptoms persist beyond 24 hours, then this would be considered a stroke, not a transient ischemic attack. A transient ischemic attack event is significant as it can be a warning of a future stroke event. Patients and healthcare professionals should respond to an acute transient ischemic attack as a potential emergency.

Transient ischemic attack and minor acute ischemic stroke follow along a continuum that cannot be differentiated by symptom duration alone.

Minor Stroke:

A minor ischemic stroke (also sometimes referred to as mild, or non-disabling stroke) refers to a brain infarct that is typically small and associated with a mild severity of clinical deficits or disability and may not require hospitalization.

Note: For practical purposes, individuals presenting with symptoms of transient ischemic attack or minor stroke should all follow similar assessment, diagnosis and management processes as described throughout this module. Differentiation between transient ischemic attack and minor stroke is less relevant, and all management should be informed by clinical history, presentation, and diagnostic imaging. Current evidence has shown that at least 20% of individuals presenting with transient ischemic attack will experience a subsequent more involved stroke, emphasizing the need for aggressive secondary prevention for this group (NEJM 2016).

Ischemic Stroke

An ischemic stroke is an episode of neurological dysfunction caused by focal cerebral, spinal, or retinal cell death attributable to ischemia (blockage of an artery or vein), based on pathological, imaging, or other objective (clinical) evidence of cerebral, spinal cord, or retinal focal ischemic injury based on symptoms persisting ≥ 24 hours or until death, or until other etiologies have been excluded (Sacco et al 2013).

Cerebral Venous Sinus Thrombosis Stroke (CVST)

A cerebral venous sinus thrombosis stroke is an infarction or hemorrhage in the brain, spinal cord, or retina because of thrombosis of a cerebral venous structure. Symptoms or signs caused by reversible edema without infarction or hemorrhage do not qualify as stroke (Sacco et al 2013).

Cryptogenic Stroke:

Cryptogenic stroke is defined as a brain infarction not clearly attributable to a definite cardioembolism, large artery atherosclerosis, small artery disease or other identifiable cause despite extensive investigation (Saver et al 2017). This group accounts for 25 to 40% of all stroke (Saver, 2016; Yaghi et al, 2017).

Embolic Stroke of Undetermined Source (ESUS) *Embolic stroke of undetermined source* describes a subset of cryptogenic strokes that represent approximately 9 – 25% of ischemic strokes, that meet the following criteria (Tsivgoulis et al, 2017; Ntaios, JACC 2020 [17%]):

- Acute brain infarct visualized on neuroimaging; not a subcortical lacune < 1.5 cm.
- Absence of proximal atherosclerotic vessel stenosis $> 50\%$
- No atrial fibrillation or other major-risk cardioembolic source
- No other likely cause of stroke (e.g., dissection, arteritis, cancer)

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Appendix Two

Recommended Laboratory Investigations for Patients with Acute Stroke or Transient Ischemic Attack*

Note: This list presents the recommended initial laboratory tests for patients with stroke and transient ischemic attack. Patient presentation, clinical judgment, and local stroke protocols should be considered in selecting appropriate laboratory investigations and the timing of completion.

Recommended Laboratory Investigations for Patients with Stroke and Transient Ischemic Attack		
Complete Blood Count (CBC)	International Normalized Ratio (INR)	Partial Thromboplastin Time (PTT)
Electrolytes	Creatinine and glomerular filtration rate (eGFR)	Liver enzymes (e.g., AST, ALT)
Random Glucose or Hemoglobin A1C	Either a fasting plasma glucose, or 2-hour plasma glucose, or glycated hemoglobin (A1C), or 75 g oral glucose tolerance test	Lipid profile (Fasting optional and decision should be based on individual patient factors)

Additional Laboratory Investigations for Consideration in Specific Circumstances

Note: All patients are individuals, and some may require additional investigations to fully understand their clinical situation. The investigations noted below may not be indicated in many stroke patients and should be considered in selected stroke patients based on clinical presentation and medical history

Optional Laboratory Investigations			
Calcium, Magnesium, Phosphate	If female less than 50 years of age, consider pregnancy test		Blood cultures if infection suspected (per individual institutional protocol)
ESR	CRP		Troponin, where indicated
Blood and/or urine drug screen		HIV, syphilis serology, where indicated	
Thrombophilia Screen – For consideration in selected patients <i>only if clinically indicated</i>.			
<i>Recommend consultation with a specialist in thrombosis to evaluate for hypercoagulable state</i>			
Anticardiolipin antibodies, Beta-2-glycoprotein	Lupus anticoagulant	Sickle cell screen	Serum homocysteine and vitamin B12
Venous Thrombosis Testing - For consideration in selected patients <i>only if clinically indicated</i>.			
<i>Recommend consultation with a specialist in thrombosis to evaluate for hypercoagulable state</i>			

Protein S	Protein C	Factor V Leiden
Prothrombin gene mutation	Antithrombin III	
Special considerations especially in young adults and children with stroke in absence of identified etiology <i>(Note there is not a strong evidence base for these investigations, and they should be considered only in selected stroke patients based on clinical presentation and medical history.) Consultation with a hematologist or neurologist is recommended.</i>		
Consider LP for CSF analysis (cell count and differential, protein, glucose, bacterial and viral studies; possibly cytology/flow cytometry if CNS lymphoma is a consideration)	Brain biopsy (if vasculitis of the central nervous system or angiocentric lymphoma is a consideration)	
Catheter cerebral angiography	Further genetic tests – CADASIL, Fabry's, MELAS	

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Appendix Three

Suggested Management of Antiplatelet Therapy for Elective Surgery

Legend: ASA, acetylsalicylic acid; CABG, coronary artery bypass graft.

Clinical Situation	Suggested Pre- and Post-operative Management
Patient receiving ASA alone having non-cardiac surgery	<ul style="list-style-type: none"> interrupt ASA 7-10 days before surgery in most patients; resume 5-7 days after surgery consider continuing ASA, without interruption, in patients with a prior stroke or a coronary stent continue ASA, without interruption, in patients having carotid endarterectomy
Patient receiving ASA alone and having CABG surgery	<ul style="list-style-type: none"> continue ASA around the time of CABG, without interruption*
Patient receiving ASA + clopidogrel and having non-cardiac surgery**	<ul style="list-style-type: none"> continue ASA around the time of surgery, without interruption* hold clopidogrel 5-7 days pre-operatively and resume 1-2 days after surgery
Patient receiving ASA + clopidogrel and having CABG surgery	<ul style="list-style-type: none"> continue ASA around the time of surgery, without interruption* hold clopidogrel at least 5 days before surgery resume clopidogrel 1-2 days after surgery
Patient receiving ASA + ticagrelor and having non-cardiac or CABG surgery	<ul style="list-style-type: none"> continue ASA around the time of surgery, without interruption* hold ticagrelor at least 2 days before surgery resume ticagrelor 1-2 days after surgery
Patient receiving ASA + prasugrel and having non-cardiac or CABG surgery	<ul style="list-style-type: none"> continue ASA around the time of surgery, without interruption* hold prasugrel 7-10 days before surgery resume prasugrel 1-2 days after surgery

** Continue ASA, without interruption* - This implies that ASA is taken on the day of surgery and the first postoperative day, acknowledging that there may be circumstances when this is not feasible (e.g., patient cannot take medications by mouth); in such cases, management is left to the treating clinician with the option to administer ASA per rectum.*

*** Patient receiving ASA + clopidogrel and having non-cardiac surgery** - Management should be individualized depending on the clinical indication for dual antiplatelet therapy and, typically,*

would require consultation with other specialists, for example, a cardiologist in patients with a coronary stent.

In patients who are taking Aggrenox (ASA + dipyridamole) for a prior stroke and are having carotid endarterectomy, Aggrenox can be continued without interruption; alternatively, Aggrenox can be withheld on the day of surgery to eliminate the added antiplatelet effect of dipyridamole while retaining the antiplatelet effect of ASA."

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Appendix Four

Core Elements of Delivery of Secondary Stroke Prevention Services

A critical component of secondary stroke prevention is access to specialized stroke prevention services (SPS), ideally provided by dedicated stroke prevention clinics. Stroke prevention clinics (or similar vascular prevention clinics, services or models of care) provide a comprehensive interdisciplinary approach to prevention of first or recurrent stroke, conduct detailed assessments by a range of healthcare disciplines, facilitate timely access to appropriate diagnostic testing and interventions, and provide education to patients and families. They also promote continuity of care between acute care facilities, rehabilitation services, the patient, their family and caregivers, primary care providers, and other community care service providers.

In 2016, the Heart and Stroke Foundation conducted a Stroke Prevention Services Resource Inventory (SPSRI) through which 123 stroke prevention services were identified across Canada. Services were available in every province; however, there were considerable differences between prevention services with respect to structural elements such as models of care, hours of operation, SPS team members, and availability of diagnostic services; process elements such as wait times for appointments and wait times to access services such as imaging and Holter monitoring; and outcome elements such as monitoring quality of care and stroke recurrence rates.

The SPSRI inventory was created using a modified Delphi methodology. The foundation of the SPSRI is the Canadian Stroke Best Practice Recommendations, and in particular this module on the Secondary Prevention of Stroke. A review of the literature was performed to identify different models of prevention services, and core elements of such services. Consultations were then held with stroke prevention service providers, funders, and policy makers. An extensive list of elements of prevention services was then developed that aligned with the evidence-based best practice recommendations. The draft SPSRI underwent three rounds of voting by a wide range of stroke care clinicians, managers, patients, and funders to identify the final set of elements for the inventory. SPSRI was sent to a specific contact person at each of the 123 identified SPS. A total of 119 services completed the inventory (97% response rate). Analysis of the responses informed further refinement of the inventory and final inclusion list of core elements of stroke prevention services.

A framework of key components of delivering prevention services (Figure Two), and a comprehensive list of the core elements of stroke prevention services (Table Two). The purpose of this framework and list of elements is multifaceted, and are to:

- enable stroke prevention service providers, regardless of size or location, to assess the types and level of services provided.
- identify gaps in the core elements of prevention services to inform planning, development, and quality improvement initiatives.
- identify issues of access to stroke prevention services, based on location of services as well as hours of operation (e.g., once a week versus daily), and availability of healthcare professionals and diagnostic services (e.g., CAT scanner) onsite.

- to identify the list of elements present and not yet available that serve as enablers to implementation of the stroke best practice recommendations included in this update of the Secondary Prevention of Stroke Best Practices update 2020.
- to strengthen service provision and increase accountability.

FIGURE TWO:

CSBPR CORE ELEMENTS OF STROKE PREVENTION SERVICES UNDERLYING FRAMEWORK

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TABLE TWO: H&S CSBPR Core Elements of Stroke Prevention Services (Update 2020)

Secondary Prevention Services (SPS) Core Element	Alignment with CSPBR* Sections	Description ^
Organizational Elements of Stroke Prevention Services		
Designated Prevention Services	CSBPR-SPOS Section 1, 3	<input type="checkbox"/> The SPS is identified and acknowledged within the local/regional health system as providing stroke prevention services. <input type="checkbox"/> The SPS is conducted in a specific space within a hospital or the community, such as within the ambulatory/outpatient clinics or a physician's office, or through virtual modalities.

		<ul style="list-style-type: none"> <input type="checkbox"/> The SPS follows protocols and pathways for an individualized evidence-based prevention strategy for patients. <input type="checkbox"/> Emergency departments have responsibility to provide SPS to patients or ensure referrals are made to an appropriate SPS prior to patient discharge from the ED. <input type="checkbox"/> The timing of initial assessment in the SPS is based on current recommended time frames based on time from symptom onset and presentation. Access to the SPS will be expedited based on risk stratification. <input type="checkbox"/> The SPS are accessible to stroke and transient ischemic attack patients with disabilities (e.g., physical, cognitive, and perceptual). <input type="checkbox"/> The SPS make provisions to provide care to and support patients with aphasia and other communication challenges.
Operation Times		<ul style="list-style-type: none"> <input type="checkbox"/> The SPS has set hours of operation that are communicated to all referral sources.
Stroke Team Staffing	SPOS Section 1	<ul style="list-style-type: none"> <input type="checkbox"/> The SPS has access to an interprofessional group of stroke experts, including neurology, internal medicine, vascular surgery, neurosurgery, rehabilitation medicine, neuropsychiatry, nursing, pharmacy, psychology, neuropsychology, rehabilitation therapy (such as physiotherapy, occupational therapy, speech-language pathology), social work, dietetics, community liaisons/navigator, research, and administration. <input type="checkbox"/> Additional Experts are accessed directly within the SPS or through timely pre-arranged referral patterns outside the SPS. <input type="checkbox"/> Staff have appropriate training and education to remain current with updates to the CSBPR. <input type="checkbox"/> Staff are able to provide care to persons with aphasia and other communication challenges (such as having skills in supportive conversation).
Service Scope	SPOS Section 1	<ul style="list-style-type: none"> <input type="checkbox"/> The SPS has a clearly defined scope of practice that is communicated to referring sources – states the range and types of services offered, such as same day urgent referrals, or less urgent services only. <input type="checkbox"/> The SPS defines its role as providing at minimum a one-time assessment; or additionally assessment and short-term follow-up, long-term follow-up, and/or collaborative care with primary care practitioner.
Referral Mechanisms	SPOS Section 1 Acute Stroke Management,	<ul style="list-style-type: none"> <input type="checkbox"/> The SPS has a standardized referral process and documentation (e.g., referral form) to access services. <input type="checkbox"/> The SPS has a designated person coordinating referrals and scheduling appointments appropriate to degree of

	Sections 1, 3	<p>urgency.</p> <ul style="list-style-type: none"> <input type="checkbox"/> The SPS is aware of, and in communication with all potential referral sources regarding referral process and target response times. <input type="checkbox"/> All referring sources are aware of the referral process and required documentation for access to the SPS. <input type="checkbox"/> The SPS has processes to regularly review and prioritize referrals and respond appropriately based on degree of urgency. <input type="checkbox"/> The SPS monitors wait times from referral to first assessment appointment. <input type="checkbox"/> The SPS provides access to patients living outside the immediate catchment for the service, to support patients living in rural and remote settings.
Use of Technology – Virtual Care	Virtual Care Section 1	<ul style="list-style-type: none"> <input type="checkbox"/> The prevention service considers virtual care technology to increase access to services for all patients, especially those living in rural and remote settings without local access to stroke specialists and those who do not require in-person visits. <input type="checkbox"/> The SPS established/validated criteria to determine the best modality for each patient and each encounter based on the purpose and goals for each visit, and taking into account patient values, preferences, and health needs. <input type="checkbox"/> A contingency plan should be established to have patients seen in person in a timely way should the need arise following a virtual care encounter.
Access to Diagnostic Services	SPOS Section 1, 7, 8, 10, 11, 12 ASM Sections 1, 3	<ul style="list-style-type: none"> <input type="checkbox"/> The SPS has timely access to relevant diagnostic services onsite (brain and vascular imaging with CT scan/MRI, CTA, carotid ultrasound, ECG, Holter monitoring, prolonged cardiac monitoring, echocardiogram, laboratory services). <input type="checkbox"/> Agreements are in place with diagnostic departments to access services on a more urgent basis when required (e.g., same day, 24-hour, one week). <input type="checkbox"/> If services are not available on site, agreements are in place for timely access to diagnostic services within the region, or next closest facility providing such services without undue wait times.
Care Delivery Elements of Stroke Prevention Services		
Screening and Assessment	SPoS; ASM; MCF	<ul style="list-style-type: none"> <input type="checkbox"/> SPS routinely screens patient for vascular risk factors in accordance with current evidence-based stroke guidelines. <input type="checkbox"/> The SPS has a defined set of validated screening practices that includes timing of such screens in accordance with best available evidence. <input type="checkbox"/> Lifestyle risk factors to be assessed include smoking,

		<p>lifestyle behaviours, diet, weight, exercise, sodium, alcohol consumption, birth control and hormone replacement therapy, recreational drug use, and medication adherence.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Screening for medical risk factors include blood pressure, depression, cognition, atrial fibrillation, bleeding risk, lipids, diabetes, and other underlying cardiac issues. <input type="checkbox"/> Assessment for sequelae of stroke, including stroke severity, physical functioning, swallowing, fatigue, depression, cognition, and post-stroke neuropathic pain as appropriate. <u>H&S Post-Stroke Checklist</u> available to support screening of patients. <input type="checkbox"/> Protocols in place for use of validated tools to support assessment and diagnosis. <input type="checkbox"/> Process in place to refer patients to other specialists as required to determine or confirm presence of risk factors (such as cardiology for atrial fibrillation determination).
Diagnosis and Etiology	SPoS; ASM; MCF	<ul style="list-style-type: none"> <input type="checkbox"/> Diagnosis should specify the type of stroke or transient ischemic attack the patient has experienced (i.e., ischemic, or hemorrhagic, and if latter whether subarachnoid or intracranial hemorrhage). <input type="checkbox"/> Underlying etiology should be determined with appropriate investigations when possible and communicated to care providers and patient.
Treatment	SPoS sections 3-12	<ul style="list-style-type: none"> <input type="checkbox"/> Develop individualized stroke prevention plan for each patient, including defining agreed upon goals of care. <input type="checkbox"/> Initiate treatment strategies for identified risk factors and clinical conditions as specified in the CSBPR. <input type="checkbox"/> Process in place for timely access to carotid revascularization services onsite or through referral to closest centre providing services, within CSBPR target treatment times (as soon as possible, within 2 weeks of index stroke or transient ischemic attack event). <input type="checkbox"/> SPS has processes in place to access rehabilitation (inpatient or community) to meet needs of patients.
Follow-up Practices	SPoS all sections ToCFS Rehab	<ul style="list-style-type: none"> <input type="checkbox"/> On follow-up, SPS routinely monitors patients for achievement of therapeutic targets and stability within targets. <input type="checkbox"/> On follow-up, SPS routinely monitors patients for adherence to prescribed risk factor management strategies and therapies. <input type="checkbox"/> SPS re-assesses patients for ongoing physical, functional, psychological, and social changes. <input type="checkbox"/> SPS has process in place for patients and primary care providers to re-access SPS services for a patient if changes in health status, or additional consultation on

		<p>prevention management is required.</p> <ul style="list-style-type: none"> <input type="checkbox"/> SPS has process in place for patients who do not have a primary care provider, to assist with identification of a primary care provider, or continuing to follow patient as required within the SPS. <input type="checkbox"/> The SPS staff have processes in place to review each patient's driving status (e.g., driver/non-driver, holds drivers' license) and follow National guidelines and reporting requirements when indicated.
Communication and Continuity		<ul style="list-style-type: none"> <input type="checkbox"/> Must have timely method of communication of recommendations to the referring physicians, the patient's primary care provider, and other members of the patient's circle of care to ensure continuity of care. <input type="checkbox"/> Communications should address and include information on completed assessments and findings, diagnosis, etiology, treatment plan, prescribed/recommended therapies, additional referrals, and clarification on who is responsible for ongoing follow-up, prescription renewals, and long-term management as well as referral back to SPS if needed.
Patient and Family Elements of Stroke Prevention Services		
Education, Promotion of Self-Management	ToCFS Sections 1, 2 SPoS Section 7	<ul style="list-style-type: none"> <input type="checkbox"/> SPS routinely provides personalized verbal education to patients and families, and caregivers. <input type="checkbox"/> The SPS provides written and electronic educational resources (such as HSF Your Stroke Journey). <input type="checkbox"/> The SPS assesses patient, family and caregiver knowledge, self-management capability, and learning needs for skills and coping mechanisms (e.g., using HSF Post-Stroke Checklist). <input type="checkbox"/> Education materials are available in a range of formats, are culturally appropriate for the catchment population, aphasia friendly, and other languages as required. <input type="checkbox"/> Translation services available for patients during SPS visits if required.
Linkages	ToCFS Section 6	<ul style="list-style-type: none"> <input type="checkbox"/> Provide patients and families with links to community resources and programs to support stroke recovery and implementation of prevention strategies, such as smoking cessation programs, community dietitians, community-based exercise programs, diabetic education programs, stroke support groups. <input type="checkbox"/> The SPoS is able to initiate appropriate referrals for home care support services, specialized equipment, and process for driving assessment as required. <input type="checkbox"/> The SPoS is able to recommend and or refer patients to community resources and programs to support adherence to prescribed risk factor management strategies and

		therapies (including pharmacotherapies) thereby supporting stroke recovery.
Outcome and Quality Elements of Stroke Prevention Services		
Quality and Accountability	All modules	<ul style="list-style-type: none"> <input type="checkbox"/> The SPS has mechanisms in place to routinely collect data on patients, including time intervals from referral to follow-up, services provided, effectiveness/outcome of care, physical measurements (e.g., weight, blood pressure); and can capture changes over time. <input type="checkbox"/> The SPS has a process for reporting data to staff, funders, and patients. <input type="checkbox"/> The SPS compares performance to pre-set targets and benchmarks and engages in quality improvement initiatives to achieve targets and readjust as appropriate. <input type="checkbox"/> The SPS should engage in relevant clinical research in the area of stroke prevention when possible.

^ Based on literature review, Delphi-process feedback, Canadian Stroke Best Practice Recommendations, and Accreditation Canada Stroke Distinction Standards. * SPoS – Secondary Prevention of Stroke Best Practice module; ASM – Acute Stroke Management guidelines module; MCF – Mood, Cognition and Fatigue CSBPR module; ToCFS – Transitions of Care Following Stroke module; Rehab – Stroke Rehabilitation module