American Stroke Association.
A division of the American Heart Association.

TRANSITIONS IN CARE AND COMMUNITY REHABILITATION

Adult Stroke Rehabilitation & Recovery Guideline

Effective transition of care after stroke is essential to ensure continuity of treatment, support recovery and promote successful community reintegration.

The period following hospital discharge is particularly critical, as stroke survivors may face new physical, cognitive, emotional and safety challenges while adapting to life at home. Successful transitions require accurate communication of clinical information across care settings, timely follow-up and coordination of rehabilitation and support services. Equally important is addressing the needs of family caregivers, who often provide practical, emotional and daily living support but may themselves experience significant stress and unmet needs.

Community-based interventions can help address barriers to recovery. Individualized referral to appropriate community resources strengthens support systems, enhances participation in meaningful life roles and improves long-term outcomes for stroke survivors and their caregivers.

Here are key recommendations from the American Heart Association and American Stroke Association's 2026 Guideline for Adult Stroke Rehabilitation and Recovery. The comprehensive guideline details the best clinical practices in providing care for adults recovering from stroke. For more information about these recommendations, please refer to the full guideline at Heart.org/StrokeRehabGuideline.

The recommendations highlighted here address one of six major topics covered within the guideline:

- ☐ **The Rehabilitation Program**
- ☐ **Prevention and Medical Management of Comorbidities**
- ☐ **Assessment**
- ☐ **Sensorimotor Impairments and Activities**
- ☐ **Cognition and Communication**
- ☑ **Transitions in Care and Community Rehabilitation**

ENSURING MEDICAL AND REHABILITATION CONTINUITY THROUGH THE REHABILITATION PROCESS AND INTO THE COMMUNITY

- Discharge planning specific to the transition from hospital to community should begin in the hospital and be individualized to address health literacy, sociodemographic vulnerabilities and stroke-specific needs.
- Alternative methods of continuity of care using telehealth might be considered to deliver transition care services from hospital to home.

CAREGIVER ENGAGEMENT AND SUPPORT

- Active and intentional engagement of caregivers as early as possible and throughout rehabilitation can be beneficial to improve knowledge about stroke, mental health and caregiver burden.
- Involving caregivers in education and training using teach-back about care and rehabilitation activities can be beneficial to improve patient and caregiver outcomes such as experience of care, activities of daily living and mobility.
- Participation in a tailored caregiver-focused, multicomponent psychosocial or psychoeducational intervention can be beneficial to improve caregiver mental health, burden and/or family functioning.

REFERRAL TO COMMUNITY RESOURCES

- Individually tailored information about and referrals to up-to-date community resources should be provided throughout the continuum of care to facilitate access to such services.
- Interactive education (such as teach-back or two-way communication) with follow-up can be beneficial to improve stroke survivor knowledge and reduce anxiety and depression.
- Administration of the Post-Stroke Checklist can be useful to identify stroke-related health problems and inform individualized referrals.
- Referral to self-management or lifestyle intervention programs can be useful to improve stroke outcomes.

COMMUNITY REHABILITATION AND TELEREHABILITATION

- Upon hospital discharge, ongoing community- or home-based rehabilitation is recommended, when feasible, to achieve functional goals.
- For stroke survivors discharged home, home-based multidisciplinary rehabilitation is a reasonable alternative to clinic-based rehabilitation to achieve functional goals in mobility, self-care and cognitive/communicative function.
- For survivors discharged home after mild to moderate stroke, telerehabilitation therapies are reasonable alternatives to in-person therapies when access to these in-person therapies is limited or absent.

SEXUAL FUNCTION

- It may be reasonable for healthcare professionals to discuss issues of sexual function. (Sexual dysfunction is reported in more than 50% of stroke survivors and is unrecognized and under-addressed for various reasons.)

RECREATIONAL, LEISURE AND SOCIAL ACTIVITY PARTICIPATION

- An individualized assessment and treatment plan is recommended to address changes in leisure and social participation patterns.
- It is recommended to screen and discuss social health — including social isolation, feelings of loneliness, and limited social support and networks — to decrease stroke mortality and secondary stroke risk and improve quality of life.
- To address reduction in post-stroke leisure activity, individually tailored education, counseling, caregiver-mediated support and structured programming can help promote holistic health, enhance community participation and reduce mortality risk.

RETURN TO WORK

- Tailored vocational rehabilitation programs for stroke survivors can increase the success of return to work following a stroke.
- An assessment of vision, perception, manual dexterity, motor abilities, cognitive ability and job-specific demands can be beneficial to tailor services and promote return to work.
- Modified job duties and work adaptations are reasonable to support return to work.
- Fatigue management, cognitive and psychosocial support, and early employer engagement in vocational rehabilitation are reasonable for promoting return to work.

DRIVING

- For stroke survivors with impairments that could impact safe driving (such as cognitive, perceptual or physical impairments), referral for an on-road test administered by an authorized person is recommended to determine fitness to drive.

Stroke rehabilitation requires a sustained and coordinated effort from a large team, with the patient and the patient's goals at the center. In addition to the patient, the team includes family and friends, other caregivers (e.g., personal care attendants), physicians, nurses, physical and occupational therapists, speech-language pathologists, recreation therapists, psychologists, nutritionists, social workers and others.

Among these team members, communication and coordination are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie the entire stroke rehabilitation and recovery guideline.