

Study	Model: Hospital Based Team or Community	Critical mass of ESD/ sample size	What are the underlying components of ESD?					System outcomes	Patient outcomes and assessments used	Cost savings
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AUSTRALIA/NEW ZEALAND										
Anderson, Rubenach, Mhurchu, Clark, Spencer, & Winsor, 2000	A community rehab team with in-reach coordinator. Acute patients to ESD vs. acute patients to inpatient rehab	86 / 398 patients 21.6%	Inclusion: Medically stable, able to participate in rehab, home environment suitable for modifications	Therapy sessions were conducted in the patient's home and individually tailored through mutually agreed upon goals over several weeks	Median duration of 5 weeks.	Coordinator, consultant in rehab, occupational therapist (OT), physio-therapist (PT), social worker (SW), speech-language pathologist (S-LP), nurses – all contracted to provide care based on need	Role of the coordinator involved: develop new team communication system, liaison with acute and rehab to identify patients, confirm eligibility, collect consent and data, setting goals, organize home modifications	Total duration of hospital stay in the experimental group was significantly reduced. Caregivers among the home based rehabilitation group had significantly lower mental health scores.	Outcomes: Nottingham Health Profile, Modified Barthel, MMSE, General Health Questionnaire Results: Patients did not differ significantly between the groups at 6 months after randomization	Average reduction in cost was 1/5 of conventional rehab – this difference was not statistically significant.
Hillier et al., 2010 (11 RCTs were reviewed)					3 weeks to 6 months			The primary author has no current or past involvement in providing ESD services.	Results favour functional improvement with home based rehab. Some RCT state lower direct costs, some state higher patient satisfaction	Some RCTs state lower direct costs
Lord et al., 2008		N = 30 over 2 years, 14 in community and 16 in PT group	Inclusion: First or recurrent stroke. Goal independent ambulation in community/ walk to their	Assistant led community-based gait training activities in the community or hospital-	An average of 13 treatments over 7 weeks in both groups.	Assistant in community with PT supervisor		Targeted intervention for gait independence – practical with assistants in the community but led to a limited number who were independent. Limited	Outcomes: Gait speed, six minute walk, confidence balance scale and subjective index of physical and social outcomes Results: No substantial	Lower costs for an assistant in the community but higher transportation costs.

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			letterbox, MMSE >24 no contraindica- tions to intense exercise.	based PT – motor relearning approach used.				application as this was not a goal of all stroke patients. Feasible to do but study volumes low	differences between groups after treatment or at 6 months. Gains in gait speed in both groups.	
CANADA										
Mayo et al., 2000 Although discussions are underway in Quebec regarding ESD, since the time of her study, Quebec currently does not have an ESD program	To introduce ESD concepts as an attempt to bridge the gap between those not able to go to inpatient or outpatient rehab or who do not need to go to inpatient rehab but still needed rehab services.	58/114 stroke patients within the ESD program Authors suggest that future studies include patients with no caregivers.	Inclusion: Stroke patients with motor deficits; had caregiver able to provide live- in care over a 4-week period; Exclusion: Post-stroke patients, still required the assistance > 1 to walk; cognitive impairment; significant co- conditions, no caregivers.	Therapy was provided as needed.	4-week program No more than 1 hour of active treatment session per day (a nursing visit could be scheduled on the same day as the therapy session). All participants received at least 1 home visit from nursing.	ESD team: nursing, OT, PT, S-LP, and dietary consultation. Case manager was usually the nurse.	Team member that had the most contact with the patient took on this role, this was usually the nurse or the PT	LOS was shorter with ESD vs. usual care (6 days) – total LOS for ESD on average was 10 days in acute care vs. 16 days with usual care. Total number of services received by the ESD group was lower than that received by the usual care group. ESD did not replace outpatient services; there were no outpatient services that specialized in stroke care. ESD did not replace home care services; home care services do not provide active rehab and therapists are not specialized in stroke care.	Outcomes: SF-36 physical health component; Timed Up and Go (TUG); Barthel Index, Older Americans Resource Scale for IADLs, Reintegration to Normal Living and the SF-36 Mental Health component. Results: No statistically significant difference between groups re: Barthel Index or TUG post 1 or 3 months. Significant impact on IADL and reintegration By 3 months, the ESD group showed a significantly higher score on the SF-36 physical health component ESD group, patients and families reported a sense of empowerment.	Potential cost savings due to decreased LOS in ESD group.

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Teng et al., 2003	To estimate the costs associated with the ESD program compared to usual care. Secondary purpose: to estimate the impact of ESD on caregiver burden	58/114 stroke patients within the ESD program	See study above (Mayo et al., 2000)		Home group received a 4- week tailor- made home program of rehab and nursing services.	See study above (Mayo et al., 2000)	Team member that had the most contact with the patient took on this role, this was usually the nurse or the PT	See study above (Mayo et al., 2000) Results: Although not statistically significant, caregivers in the ESD group scored consistently lower on the Burden Index than caregivers with usual care (this includes those who care for persons with major functional limitations)	3 month follow-up. Primary outcomes: SF- 36 physical health component. Secondary outcomes: Burden Index	Costs for acute care stay were \$1383 for the home group vs. \$2220 for the usual care group.***
IRELAND										
Brewer & Williams, 2010 (Review of multiple studies)	Can be hospital or community based but should be linked with stroke unit		Inclusion: Stroke, consent, medically fit for D/C, can be supported at home, lives in designated area. Exclusion: cognitive issues affecting safety.	Goal driven. Focused on communicati on, ambulation and function. Gradual and planned discharge.		PT, OT, S-LP and SW. Links made with primary care and other disciplines like psychiatry.	Designated case manager oversees the D/C (including a home visit). Case manager ensures team meets on a regular basis	Shorter hospital stay with greatest reduction in hospital bed days with the severe stroke group. The analysis did not conclude that patients with severe stroke should be excluded from ESD.	More likely to be independent and living at home at 6 months after stroke when compared to the conventional services group. Greatest benefit in clinical outcomes with mild and moderate impairment (Barthel >9/20)	Estimated overall costs for ESD service were 9-20% less with ESD.
Donnelly et al., 2004	Community- based stroke team service.	59/113 patients Only 13% of all stroke admissions during the	Inclusion criteria: Stroke symptoms, 4 weeks; potential to benefit from		45 min sessions 3 months 2.5 visits/week on average.	Coordinator: 0.33 FTE; OT: 1.0 FTE; PT: 1.5 FTE; S-LP: 1.0 FTE; Rehab Assistant: 2.0		Re-admission rates were similar between the community-based and hospital-based groups. Community-based group spent fewer	Outcomes: Barthel Index, Nottingham ADL measure, Short-Form 36, Quality of Life assessment, Patient and Carer Satisfaction, and Carer	Community- based stroke team(CST) costs less than the hospital group *

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		evaluation period were considered suitable	rehab; not in a LTC; no pre- existing disability. Study group likely less severe stroke patients.			FTE		days in hospital (median difference was 0.5 days).	Strain Index. Results: No significant differences in outcome measures at baseline and 12 months except higher satisfaction reported by the community- based stroke group.	
NORWAY										
Askim et al., 2004		62 stroke patients	Inclusion: Patients living in 3 rural communities, live 30 to 90 minutes driving distance from the hospital, admitted to the stroke unit within 72 hours - 7 days after stroke onset.	Extended service consists of stroke unit treatment combined with a home-based program of follow-up care coordinated by a mobile stroke team that offers.	During the first four weeks after discharge.	Nurse, OT, PT, and consulting service of a physician. Mobile team from the acute stroke unit.	ESD works in close cooperation with the primary health care system during the first four weeks after discharge	No significant difference in LOS. Note: ESD program in Trondheim is still ongoing. Results: No positive effect on functional outcomes but a trend towards better quality of life (e.g., less social isolation at 26 weeks).	Primary outcomes: Modified Rankin Scale (mRS) 52 weeks post stroke onset. Secondary Outcomes: mRS at 6 and 26 weeks; Barthel Index, Nottingham Health Profile and Caregiver Strain Index at 6, 26, and 52 weeks post stroke onset; mortality during the 52 weeks post stroke onset.	
Bautz- Holter et al., 2002 (Compared ESD with convention al rehab) Study had limited statistical		88/ 436 (20%); patients from June 1997 to January 1999.	Inclusion: Medically stable, home dwelling, not severely disabled before stroke Barthel Index 5–19. 72 hours after stroke onset.		4 weeks after d/c ESD patients were seen in outpatient clinic	Assessed by hospital based Nurse, OT, and PT – served as primary contact. ESD services provided by 11 different local areas		Median length of stay in hospital was 22 days for the ESD group and 31 days for the control group.	Primary outcomes: Nottingham Extended ADL Secondary outcomes: General Health Questionnaire, Montgomery Depression, mortality, patient and carer satisfaction	

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power									Results: ESD reported better subjective well being	
Fjaertoft et al., 2003	Hospital based team	160/320 received stroke unit care and ESD	Defined boundary, stroke, inclusion 72 hours of admission, and <7 days after onset of symptoms, Scandinavian Stroke Scale 2-57, ability to live indep. Prior to stroke.	Extended stroke unit service (ESUS) 1) assessment 2) home visit and D/C 3) D/C meeting 4) Rehab arranged at home or outpatient 5) visit 3-5 weeks post D/C 6) Meeting 3 months post D/C	First four weeks after discharge then passed on to primary care team.	PT, OT, nurse, and consulting stroke physician.	Team coordinates D/C & rehab.	56.3% in ESD versus 45% in the conventional group were independent. No significant differences in BI score and final residence. LOS in the ESD was 18.6 vs. 31.1. Clients with moderate to severe stroke benefit most from ESD.	Primary outcome: independence as assessed by modified Rankin Scale at 52 weeks. Secondary Outcomes include Barthel Index, final residence, LOS and analyses to identify patients who benefited most from ESD	
Fjaertoft et al., 2011	Hospital based team	160/320 received stroke unit and ESD	Please see Fjaertoft et al., 2003	Please see Fjaertoft et al., 2003	Follow-up for 1 month post D/C	PT, OT, nurse, and part time physician.	One therapist acted as a case manager.	No difference with modified Rankin scale but trend toward greater improvement in ESD group. More patients were dead or institutionalized in ordinary stroke unit group. A greater proportion of clients in ESD lived at home.	Mortality, residence and functional outcomes including modified Rankin scale at 5 years.	
Indredavik, Fjaertoft, Ekberg, Loge, & Mørch, 2000	Enhanced Stroke Unit services that included acute and ESD by a	320 / 468 over a 24 month period	Inclusion: Scandinavian Stroke Scale between 2-57, living at home pre			Nurse, PT, OT, and part-time MD	One of the therapists acted as a case manager Team based in	Decrease inpatient stay 19 days vs. 31 days Discharge home 64 % vs. 46%	Primary outcomes: Barthel Index (BI) and Rankin Scale (RS) 26 weeks post stroke	

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	trained mobile team vs. ordinary stroke services Close cooperation with primary healthcare system and rehab at home.		stroke onset, patients who experience a stroke 72 hours after admission and 7 days after stroke symptoms).				the stroke unit D/c meeting on day of discharge re: plans and f/u Post 3 months, offer of rehab at home vs. outpatient	Early supported discharge seems to improve functional outcome and reduce the length of stay in institutions compared with traditional stroke unit care.	Secondary outcomes: BI, RS 6 weeks post, proportion patients home/ deceased, LOS Results: BI and RS had better outcomes with ESD; patients were more independent. After 6 weeks, a higher proportion was independent.	
SPAIN										
Mas & Inzitari, 2012 (Review of multiple studies)	Most were community teams.		Acute stroke, defined area, medical stability, moderate stroke. Exclusion: cognitive impairment, severe stroke, previous LTC. Clarification on "sufficient cognitive function and ability to consent".	Need to tailor ESD services to different types of stroke patients, specifically complex patients and not only mild strokes	Need to define adequate duration and intensity of ESD	Physician (*consultant), nurses, PT, OT, S-LP, rehab assistants, SW, and admin support.	Discharge was planned by a case manager from ESD team after discussion with patient and a pre-discharge assessment.	Provides a summary table of main significant positive outcomes of ESD trials vs. conventional care p. 3	Death or dependency, death or institution, extended ADL score, length of hospital stay, patient satisfaction with services. May be beneficial to test ESD using functional outcomes such as walking speed, motor recovery and balance.	Beneficial to take into consideration the full costs, including the indirect costs (formal and informal care giving) in cost evaluation.
SWEDEN										
Bjorkdahl, Nilsson, Grimby, & Stunnerhagen 2006	Community based rehab in the home setting vs. day rehab	90 patients from Jan 1998 to Dec 2001 who were going		Home program was task oriented support,	9 hours/week x 3 weeks – followed with outpatient therapy	OT and PT			Primary outcomes: Assessment of motor and process skills Secondary outcomes:	Total costs: 1830 euros (home group) vs. 4410 euros (Day Clinic)

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	clinic.	home; 30 / 59 patients randomize to the home group.		information and training by both OT and PT, in natural context	FIM® Score was 101 at 3 weeks on average.				FIM®, 30 m walk test, NIHSS etc. Results: Earlier functional improvements in home group, not significantly different between groups. Seemed to be an earlier improvement on some measures for the home group.	The cost of the home group was less than half of the cost of the day clinic group.
von Koch et al., 2001		42/83 patients who were moderately impaired 5- 7 days after acute stroke.	Eligible patients had: first stroke, impaired motor capacity and/or dysphasia, continent, independent with feeding on Katz ADL Index, MMSE score >23	Tailor made programs by outreach team.	Up to 4 months post hospital discharge, average 14 weeks, mean number of home visits 12, mean total time consumption 23 hours and 20 minutes, face to face = 54%	OT, PT, and S- LP.	One therapist was assigned as a case to coordinate the early d/c and home rehab for which she was the main provider of rehab services. Weekly meetings	Conceivable negative consequences due to decreased LOS (e.g., increased number of deaths, falls, outpatient visits, or in use of home-help service or informal care were not found)	1-year follow-up Outcomes: motor capacity, time to walk 10 m, manual dexterity, Barthel ADL Index, Katz ADL Index, Katz Extended ADL Index, Frenchay Activities Index, Sickness Impact Profile (SIP), Sense of Coherence, SIP. Barthel ADL Index. Results: No significant differences in most measures of patient outcomes that leaned in favour of rehab at home.	Lower use of inpatient hospital resources for patients receiving ESD.**
Thorsen, Holmqvist, & Koch, 2006	Study looked at resource use in ESD for a period	30/54 patients	Inclusion: Mildly or moderately impaired 5-7		Average duration was 14 weeks Average	OTs, PTs, and S-LPs	One therapist was assigned as a case to coordinate	Difference in the mean total length of hospitalization observed with a	5 year follow up. Outcomes: Survival, motor capacity,	

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(Follow-up study to von Koch et al study - see above)	longer than 12 months		days post acute stroke.		number of visits was 12		the early d/c and home rehab for which she was the main provider of rehab services.	<p>significant difference in mean total length of hospitalization still at 5 year.</p> <p>No difference in groups related to subsequent hospital admissions.</p> <p>No difference between groups in total outpt rehab, but ESD group had more rehab at home and the control group had more outpt rehab.</p> <p>ESD meta- analysis the reduction in bed days was more striking for hospital outreach services than for community in-reach services</p>	dysphasia, ADL, social activities, subjective dysfunction, and self-reported falls. Results: For the ESD group, more patients were independent in extended ADL and active in household activities.	
UNITED KINGDOM										
Chouliara et al., 2013	<p>Study involved 2 ESD services in Nottinghamshire (termed Site A and Site B).</p> <p>Site A: urban setting; Site B: urban/semi-rural setting.</p>		Both ESD services had the following inclusion criteria: -Barthel Index \geq 14/20; ability to transfer independently or with assistance of one (\pm		<p>7 days per week</p> <p>1-2 intervention episodes per day up to 6 weeks</p> <p>If there was a lack of stroke community rehab services, length of</p>	Both services have multi-disciplinary teams and specialists. Both sites had a 16-patient caseload. Site A: Stroke MD, PT, OT, S-LP, Stroke Nurse, Mental Health Nurse, SW, Assistant	Site A reported a flexible approach that permitted staff to inform decisions regarding who could benefit from ESD. Site B reported close working	Without compromising the intensity of rehab input, sites mentioned that their services have been successful in reducing the length of hospital stay		

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			equipment); medically stable; rehab goals		intervention could be extended further than 6 weeks for Site B.	Practitioner, Rehab Support Worker, and Admin. Support. Site B: Stroke MD, PT, OT, S-LP, Stroke Nurse, Clinical Psychologist, Rehab Support Worker, and admin. support.	relationships with the acute service, which facilitated the identification of appropriate patients.			
Fearon et al., 2012 (Cochrane Review; 14 RCTs were reviewed)						3.0 FTE (MD, Nursing, OT, PT, SW, and S-LP)		ESD group showed significant reduction in hospital stay to 7 days. Greatest benefit in trials with coordinated ESD teams for mild to mod disability. Improvements in ADL, satisfaction in services. No significant difference for carers health status, mood	Primary outcomes: Death, dependency, place of residence Secondary outcomes: ADL scores, health status, mood, carer outcomes Results: Average Barthel Index score was 14/ 20	
Fisher, Gaynor, Kerr, Langhorne, Anderson, Holter-Bautz, Indredavik, Mayo,	ESD trialist agreed that an ESD team should be based in the hospital and disagreed that an ESD team should	Eligibility criteria should be flexible allowing expert decision making and judgment	Refer to Table 1 Consensus Document on Implementation of Early Supported Discharge Services	And Table 3 Consensus Document on Implementation of Early Supported Discharge Services		Staff must have specialized stroke care knowledge. Refer to Table 1 of article Note: team composition	Refer to Table 2 Consensus Document on Implementation of Early Supported Discharge Services	Success of the program should be indicated by measurable outcomes including patient functionality and resource use measures such as length of stay on		

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Power, Rodgers, Ronning, Holmqvist, Wolfe, & Walker, 2011 (Panel to assess effectiveness of ESD)	be based in the community. ESD service relies on cooperative and collaborative decision making between ESD and acute care service.	rather than being tied rigidly to scores.	Regarding Team Composition (Fisher et al., 2011).	Regarding Intervention (Fisher et al., 2011).		was based on a 100-patient-per-year caseload. Members include PT, OT, nurse, S-LP, physician, SW, secretary and rehabilitation assistant. Stroke physician must be available but not necessarily within the team	Regarding Model of Team Work Each patient should be assigned a key worker. Early supported discharge team should be organised by a team coordinator.	ward and readmission rates. Success could also be measured by subjective reports.		
Gladman & Lincoln, 1994	DOMINO study compared domiciliary to hospital based rehab in 2003; a 1-year follow-up was also conducted.	327 patients who were discharged home 18-21 days after acute admission.			Up to 6 months; if patient required more therapy, they went to outpatient services.			At 1 year follow-up, domiciliary rehab benefits were lost while patients with outpatient services continued to improve. Day hospital may be better at preventing death or institutionalization	Outcomes: Extended ADL, Barthel Index, Nottingham Health Profile. Results: At 6 months follow-up, domiciliary services were better for improving household ability and leisure.	
Kalra et al., 2000 (Comparison between stroke unit care, stroke team care,		152/457 patients assigned to stroke unit care group, 152 patients assigned to	Inclusion: Patients within 72 hours of stroke onset; moderate severe strokes, could be at home	Domiciliary care: Managed in their own home by a specialist team.	Maximum provision: 3 months.			No significant differences in institutionalization between the 3 groups.	Primary outcomes: death and institutionalisation at 1 year. Dependence measured by modified Rankin scale and	

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and domiciliary care)		stroke-team care, and 153 patients assigned to domiciliary care.	with supports Exclusion: Mild and severe strokes, were LTC or severed disability						Barthel Index. Results: Better outcomes with stroke unit care vs. stroke-team care or domiciliary care.	
Langhorne et al., 2007 (Review of 12 RCTs, including an illustrative example of an ESD service in Stockholm)	Most trials took place in urban centres.		ESD services appeared to be more effective in patients with moderately severe stroke (Baseline Barthel Index of > 45/100).	ESD service in Southwest Stockholm entailed a rehab program based on the patient's need	ESD service in Southwest Stockholm: duration varied from 4-29 weeks; content and frequency of home visits ranged from 3-31 visits.	ESD services were more likely to be effective when provided by a specialized multi-disciplinary team (PT, OT, S-LP, MD, nursing, and SW)	ESD service in Southwest Stockholm involved a case manager.	Outcomes: Primary outcome: length of index hospital admission. Other outcomes: the number of re-admissions and total cost of service interventions. Results: Length of hospital stay for those receiving ESD services was, on average, reduced by 8 days. Hospital re-admission rates during follow-up were similar between the 2 groups. Carer outcomes did not differ significantly between the 2 groups	Primary outcomes: death or dependency (defined as a Barthel Index of < 19/20 or a Rankin score of > 2) recorded at the end of scheduled follow-up. Secondary outcomes: death, place of residence, ADL score, subjective health status, mood or depression score, carer mood and subjective health, and patient and carer satisfaction. Results: Patients receiving ESD greater chance of being alive and independent at follow-up. No significant differences in outcomes for death, ADL score, subjective health status, or mood scores.	All studies concluded that the potential savings (from hospital bed days released) was greater than the cost of community components of the ESD service.

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									ESD patients likely to report satisfaction with outpatient services.	
Langhorne, Jepsen, & Larsen, 2014 (Review of multiple studies)	ESD teams have been distributed evenly between a community or hospital base.	14 eligible trials n=2139	Elderly, clinical diagnosis of stroke, medical stability, living in local area. Typical Barthel index is from 10-17/20	Functional, task activities. Team met regularly. Withdrawal of ESD by 1 month (57%), 3 months (3%) and not specified (7%). 1 st visit assesses the life situation. Consecutive sessions focus on ADL (30%), IADL (39%) and coordination (14%)	Treatment started on day of discharge (36%), within 2 days (14%) and within one week (50%). Ongoing rehabilitation was daily (36%), 3-5 days per week (50%) and <3 days per week (16%).	Specialized in stroke (n=10) or neurological rehab (n=3) with one mixed rehab team. Three full time positions per 100 patients as a typical case mix.	Contact with ESD team done through the case manager during the hospital admission. In 30% the contact was made within the first week, 54% "early" and 16% of the time after 1 week.	The length of hospital stay was reduced by 6 days. Hospital readmission rates were similar between ESD and conventional care groups.	ESD were less likely to result in death or dependence than those that received conventional care. Patients in ESD were more likely to report satisfaction.	"ESD represents a special win-win situation for both patients and health finance bodies"
Lincoln et al., 2004		421 recruited. 189 patients were assigned to the community team and 232 patients	Inclusion: Anyone with a stroke in the last 2 years, over 16 and needing more than one discipline. Exclusion:	Community multidisciplinary stroke team or routine care available in either outpatient, day hospital or community OT services.	Number of visits: Community team 0-115, median 18. Average duration of therapy (in hours): 4.8 PT, 3.8OT, 2 S-LP, 1.9	OT, PT, S-LP, and mental health nurse.	The patients received an initial assessment visit at home by two members of the team. Following this the team allocated	Study to determine if this type of care should be extended to other regions. Results: No difference in independence level or mood but greater caregiver satisfaction, emotional support and reduced caregiver strain in	Outcomes: Barthel Index, Extended ADL, general health questionnaire, EuroQol, Caregiver Strain Index, satisfaction with care, and knowledge of stroke.	

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		were assigned to routine care over 2 years.	had community rehab in the last 2 years.		mental health worker, and 0.5 rehab support worker.		therapist according to the nature of the patient's problems.	community stroke group.		
Rudd et al., 1997	Community based	167/331 patients with stroke (mean age 71)	Inclusion: Patients who lived alone and, transfers independent or lived with a resident carer and were able to transfer with help.	Rehab in home: Individual care plans provided to patients.	Maximum duration is 3 months with a maximum visit of 1 visit per day from each therapist. Provision of therapy for patients with impairment was better in the patients treated in the community.	1.0 FTE PT, 1.0 FTE OT, 0.5 FTE S-LP, 1.0 FTE therapy aide, and physician consultant.	Weekly meetings Patients stayed in hospital until all social services were organized	No increased re-admission rates or stress to carers with the community therapy group. LOS was reduced (12 vs. 18 days) Results: After 1 year, no significant differences in clinical outcomes apart from increased satisfaction with hospital care in the community therapy group.	Primary outcomes: Barthel Index at 12 months Secondary outcomes: Motoricity Index, MMSE, and Frenchay Aphasia Screening Test, disability using the Rivermead ADL Scale, Hospital Anxiety and Depression Scale and 5 m walk, Nottingham Health Profile, Caregiver Strain Index and patient and carer satisfaction ratings.	
Young & Forster, 1992		N=124– 61 randomised to day hospital, 63 randomised to home therapy; 1 of 5 had community therapists. 6 month follow-up on n=108: 52 in day hospital	Inclusion: >60 years of age with a new stroke with persisting disability; and patients who are about to be discharged home from acute care.	Day hospital 2 days a week or home PT Small percentage also received S-LP in both groups	Median of 31 attendances in 6 months for day hospital group vs. median 15 visits for home therapy group. Both groups had nursing care at home and home care support.			Results: At 6 month follow-up, home therapy had slightly better outcomes with less intervention and more cost effectiveness. Less stress on carers in the home group.		

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		and 56 in home PT								

*For the 1st 6 months, mean cost of inpatient care for the CST was lower than hospital-based program (£7831 vs. £9864).

For the 1st 6 months, community services cost more for hospital-based program due to the relatively higher utilization level and the high cost of day hospitals (£2100 vs £1012) and district nursing (£323 vs £59). Costs of combined package of inpatient care and community rehab compared with package of hospital rehab and traditional after care was, on average, £1578 less per patient at the 6 month follow-up.

The cost of community services during the 2nd 6 month period was reduced from £3655 to £1350 (hospital based rehab group); and from £3468 to £869 (CST group).

Although not statistically significant, the CST group cost less at 12 months than the hospital-based group (£11,734 vs £9,680).

** Cost of health care and rehab for 5 patients over 1 year (with ESD) was similar to that for 4 patients (with usual care, no ESD).

Note: authors caution this comparison and suggest that an economic health care analysis be done that includes true total cost of home or routine rehab.

*** Average costs of providing the 4-wk home intervention service was \$943 per person.

Total cost generated by persons assigned to the home group averaged \$7784 per person, which was significantly lower than \$11,065 per person for those assigned to usual care.

A large proportion of the cost differential between the 2 groups arose from re-admissions, for which the usual care group generated costs more than quadruple than those of the home intervention group.

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