Supplementary Table 1

Intervention Scalability Assessment Tool

Part A: Setting the Scene	
Domain	Brief Description
A1. The problem	Considers the problem that is being addressed in terms of who it affects, what it affects, and how it is currently being addressed.
A2. The intervention	Describes the intervention to address the problem.
A3. Strategic/political context	Considers the current contextual factors (e.g., strategic, political, environmental) that are potentially important influences on the intervention to be scaled up.
A4. Evidence of effectiveness	Considers the state of evidence available to support the scale-up of the proposed service, such as research literature and/or other evaluations of the intervention.
A5. Intervention costs and benefits	Considers the costs of the intervention delivery as well as any benefits.
Part B: Intervention Implementation Planning	
B1. Fidelity and adaptation	Considers whether proposed changes to the intervention would be required for scale-up.
B2. Reach and acceptability	Considers the reach and acceptability of the intervention for the target population.
B3. Delivery setting and workforce	Considers the setting of intervention delivery and the delivery workforce.
B4. Implementation Infrastructure	Considers the potential implementation infrastructure required for scale-up.
B5. Sustainability	Considers the potential longer-term outcomes of the scale-up and how, once scaled up, the intervention could become sustainable.

Note. Adapted from "Intervention Scalability Assessment Tool" by A. Milat et al. [11]

Supplementary Table 2

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No.	Item	Location in Text/Comment
1	Interviewer/facilitator	Methods (Data Collection and Analysis). Three different authors conducted the key informant interviews and the first author facilitated the work group meetings.
2	Credentials	Methods (Research Team Reflexivity). Authors' experience with qualitative and mixed methods design documented.
3	Occupation	Methods (Research Team Reflexivity). Three authors are PhD prepared nursing faculty, one author is Masters' prepared research coordinator, and two student research assistants supported the study (undergraduate and graduate students).
4	Gender	Gender of research team is not reported in manuscript.
5	Experience and training	Methods (Research Team Reflexivity)
6	Relationship established	Methods (Recruitment). Participants were not known to the first author prior to study commencement.
7	Participant knowledge of the interviewer	Not stated in text: participants were aware through the informed consent document and process the purpose of the research and the research team's goals of informing stroke care delivery improvements in the province.
8	Interviewer characteristics	Methods (Research Team Reflexivity)
9	Methodological orientation and theory	Methods (Study Design and Framework: The Intervention Scalability Assessment Tool)
10	Sampling	Methods (Recruitment)
11	Method of approach	Methods (Recruitment)
12	Sample size	Results (Participants)
13	Non-participation	Not stated in text: After providing informed consent, none of the participants refused to participate. Participants did not drop out during course of study.
14	Setting of data collection	Methods (Data Collection and Analysis)
15	Presence of non-participants	N/A
16	Description of sample	Results (Participants) and Table 1
17	Interview guide	Supplementary Table 2
18	Repeat interviews	N/A

19	Audio/visual recording	Data Collection and Analysis (Community Stroke Rehabilitation Working Group Meetings and Key Informant Interviews)
20	Field notes	N/A
21	Duration	Data Collection and Analysis (Community Stroke Rehabilitation Working Group Meetings and Key Informant Interviews)
22	Data saturation	Data saturation was not congruent with the methodology but rather a credible representation of scalability readiness. Data Collection and Analysis (Mixed Methods Analysis)
23	Transcripts returned	Key informant interview transcripts were not returned but working group meeting minutes were shared with the working group members, along with the radar plots of the quantitative readiness assessment.
24	Number of data coders	Data Collection and Analysis: for each data source, research team members involved in analysis were noted.
25	Description of the coding tree	Data Collection and Analysis: for each data source, process for coding (directed content analysis and rapid qualitative analysis) were described.
26	Derivation of themes	Data Collection and Analysis (Mixed Methods Analysis)
27	Software	N/A
28	Participant checking	N/A
29	Quotations presented	Direct quotations were not provided but rather key informant interviews, working group meeting minutes, document analysis, and quantitative survey data were integrated.
30	Data and findings consistent	Results (Scalability Readiness of the Transitional Care Stroke Intervention)
31	Clarity of major themes	Results (Scalability Readiness of the Transitional Care Stroke Intervention). Main themes summarized at start of this section.
32	Clarity of minor themes	Results (Implementation Benefits and Implementation Considerations for Scale Up)

Note. Criteria taken from Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007;19(6):349-357. DOI: https://doi.org/10.1093/intqhc/mzm042 N/A = not applicable in this study.

Supplementary Table 3

Key Informant Semi-Structured Interview Guide

1. What do you feel would be the benefits of implementing the TCSI?
2. To what extent could the TCSI be integrated in your program?
3. What infrastructure will be required to implement the program?
4. What other aspects, if any, of the program would need to be changed before scale-up?
5. Looking ahead, are you aware of any changes to organizational policies that might affect the implementation of the TCSI?
6. How do you think program fidelity could be monitored if scaled up? (fidelity is the extent to which parts of the program are delivered as originally planned)
7. What measures are currently in place that could be used to monitor the program over time (e.g., ongoing quality assurance)?
8. What relevant policy and research evidence are you aware of that could inform our scalability assessment of this program?
9. If you have experience with scaling-up another intervention or program, what were the lessons learned that are relevant to scaling up the TCSI?
10. Do you have any additional comments or feedback on the scalability or scale-up of the TCSI that you would like to share?

Supplementary Table 4

Intervention Scalability Assessment Tool Mean Ratings by Site

Domain and Readiness Assessment Question(s)	Site 1	Site 2	Site 3
Domain A1: The Problem	2.78	2.83	3.00
Q1. Is supporting transitions for stroke survivors (especially older adults aged 55+ with stroke and other chronic conditions) and their care partners/families, of sufficient concern/priority to warrant scale up of the TCSI?	2.78	2.83	3.00
Domain A2: The Program/intervention	2.44	2.67	3.00
Q2. Will the outcomes intended by the TCSI address the needs of patients in your program and the problem of supporting transitions in stroke care?	2.44	2.67	3.00
Domain A3: Strategic/political context	3.00	3.00	3.00
Q3. To what extent is supporting transitions in stroke care consistent with policy/strategic directions or priorities of your program, your organization and the larger stroke community?	3.00	3.00	3.00
Domain A4: Evidence of effectiveness	2.67	2.33	3.00
Q4. Based on the evidence available, do you think the TCSI will be effective in supporting transitions in care for stroke survivors who require community-based stroke rehabilitation?	2.67	2.33	3.00
Domain A5: Intervention costs	2.78	2.50	2.00
Q5. Based on the evidence available, do you think the benefits of the TCSI could outweigh the costs?	2.78	2.50	2.00
Domain B1: Fidelity and adaptation	2.45	2.34	2.50
Q6. What changes or adaptations to the core components of the TCSI, if any, would you recommend to maximize its scalability? *[free text question]*	NR	NR	NR
Q7. If the core components of the TCSI are changed or adapted as you recommended, are the impacts likely to be favourable?	2.89	2.67	2.50
Q8. To what extent can the fidelity of the TCSI be monitored or maintained if it is implemented at scale within your program?	2.00	2.00	2.50

Domain and Readiness Assessment Question(s)	Site 1	Site 2	Site 3
Domain B2: Reach and acceptability	2.58	2.17	2.75
Q9. Do you think the TCSI has potential to reach stroke survivors who require community-based stroke rehabilitation at scale?	2.38	2.17	3.00
Q10. Do you think the TCSI is likely to be acceptable to stroke survivors who require community-based stroke rehabilitation?	2.78	2.17	2.50
Domain B3: Delivery setting and workforce	1.79	1.29	2.00
Q11. Is your program consistent with those used in previous studies of the TCSI?	1.43	1.40	2.00
Q12. Is your program's workforce consistent with the workforce in previous studies of the TCSI?	1.71	1.20	2.00
Q13. Is the TCSI likely to be acceptable to your team?	2.38	1.40	2.00
Q14. The TCSI requires integration into existing organizational structures. Do you think this is likely to be feasible?	1.63	1.17	2.00
Domain B4: Implementation infrastructure	1.75	0.80	2.00
Q15. Do you think that the implementation infrastructure required to scale-up the TCSI will be feasible to acquire?	1.75	0.80	2.00
Domain B5: Sustainability	1.43	0.92	1.00
Q16. Is the level of integration of the TCSI into your program that is required for implementation at scale sustainable?	1.57	1.17	2.00
Q17. Is the level of resourcing required to implement the TCSI at scale within your program sustainable?	1.43	0.80	0.50
Q18. Is the delivery workforce required to implement the TCSI in your program sustainable?	1.29	0.80	0.50

Note. Adapted from “Intervention Scalability Assessment Tool” by A. Milat et al.[11] Each domain/question was rated from 0 to 3 using the following scale: 0 (not at all), 1 (to a small extent), 2 (somewhat), 3 (to a large extent). NR = this question was not rated. TCSI = Transitional Care Stroke Intervention.