Transitions of Care for the Stroke Patient: *Going Home*

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March 2021

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At a glance...

UW Health is the integrated health system of the University of Wisconsin-Madison caring for more than 650,000 patients each year, comprised of seven hospitals, 1,785 employed physicians, 77 clinic locations and a partnership in a 350,000-member health plan.

UW Health is governed by the UW Hospitals and Clinics Authority and partners with the UW School of Medicine and Public Health to fulfill its patient care, research, education and community service missions.

Madison Hospitals
- University Hospital
- American Family Children's Hospital
- UnityPoint Health-Meriter*
- UW Health at The American Center
- UW Health Rehabilitation Hospital

Regional Hospitals
- Swedish American Hospital, Rockford, IL
- Belvidere Medical Center, Belvidere, IL

UW Health Clinics
UnityPoint Health-Meriter Clinics*
Throughout Wisconsin and Northern Illinois

UW Medical Foundation
UW faculty physician practice

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

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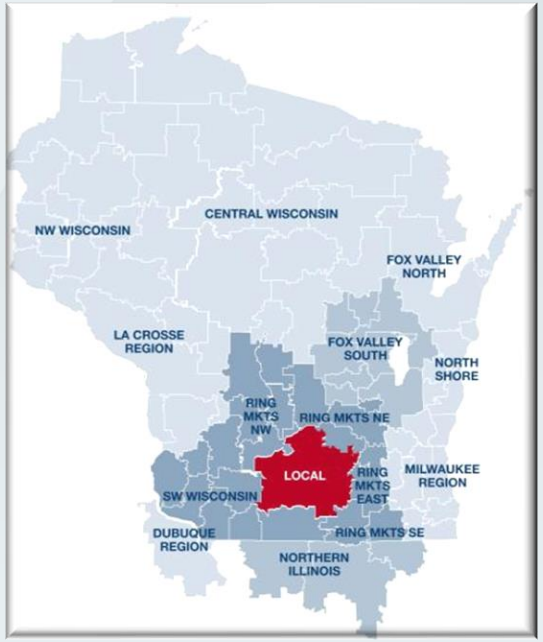
Joint Ventures and Affiliations
Cancer centers, surgery centers, dialysis programs, home health, infusion and many other programs and services including a *Joint Operating Agreement with UnityPoint Health-Meriter

UW Comprehensive Stroke Program

Mission Statement

To promote high quality stroke care in the Wisconsin region through clinical service, public and professional education and academic research



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Background

- Advanced treatment has driven morbidity and mortality rates down
- This had led to an increase in stroke patients discharged home
- Hospital-initiated interventions to support transitions of care (TOC) must begin before discharge and nurses are key to success
  - Communication between providers at d/c
  - Patient and family education
  - Follow up phone calls

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The nurse's role within the transition of care… is extremely important to lessening the patient, family, and clinician strain… (Stutzman, 2019)

Hospital-initiated Support

- Therapy consult for disposition recs
- Early rehabilitation/physiatry consult
- Handoff and provider to provider communication
  - Discharge Order Set
  - After hospital care plan
  - Discharge Summary templated and faxed to PCP

Discharge Recommendations

	Most Recent Value
Physical Therapy Clearance For Discharge Status	NOT Cleared For Discharge Home
Occupational Therapy Clearance For Discharge Status	NOT Cleared For Discharge Home
Speech Therapy Clearance For Discharge Status	Cleared For Discharge Home
Discharge Disposition Recommendation (PT)	Home (But not today. Patient requires more acute care therapy.)
Discharge Disposition Recommendation (OT)	Home (But not today. Patient requires more acute care therapy.)
Discharge Disposition Recommendation (SLP)	Home
Recommended vehicle for transportation upon discharge	Personal vehicle
Physical Therapy Services Recommended After Hospital Discharge	Home Health Physical Therapy
Occupational Therapy Services Recommended After Hospital Discharge	Home Health Occupational Therapy
Speech Therapy Services Recommended After Hospital Discharge	Home Health Speech Therapy

Why Were You Hospitalized?

You were hospitalized for a Stroke

Your stroke was caused by lack of blood flow to an area of your brain due to damage to small vessels deep in your brain (small vessel disease).

Your modifiable risk factors for stroke include High blood pressure, High cholesterol , Smoking, and Diabetes (high blood sugars)

Things you can do to reduce your risk of stroke in the future include:
- Take your medications as ordered by your provider. Your medications include Aspirin, Blood pressure lowering medications, Cholesterol lowering medication (statin) and Medications to control your blood sugar
- Eat a healthy diet
- Be active
- Alcohol use in moderation
- Don't smoke or be around second-hand smoke

It is important for you to follow up with your primary care provider for ongoing stroke risk factor reduction.

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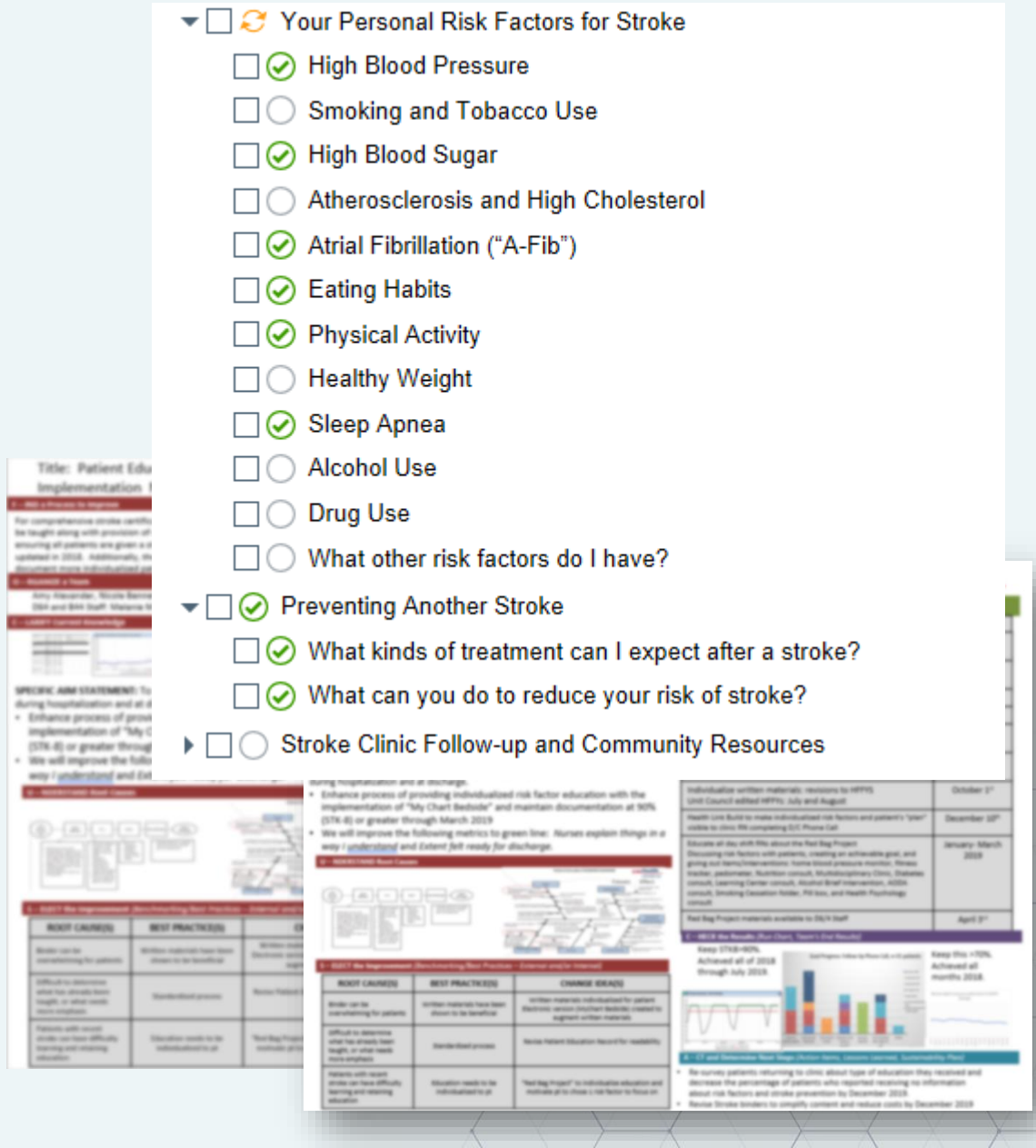
Patient & Family Education

- Engage the patient and care partner in discharge planning
- Evidence-based educational strategies:
  - Written materials, online programs
  - Education tailored to patient's health, medical and cultural needs
  - Individualize risk factors
- MyChart- online platform for patient education



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Red Bag Project: Patient Goal Setting

Education

A neuroscience nurse educates the patient about his or her individual stroke risk factors.

Goal Setting

Using motivational interview principles, the nurse and patient discuss goal-setting.

Action Plan

The patient selects a single risk factor to improve. Action plan is created.

Red Bag

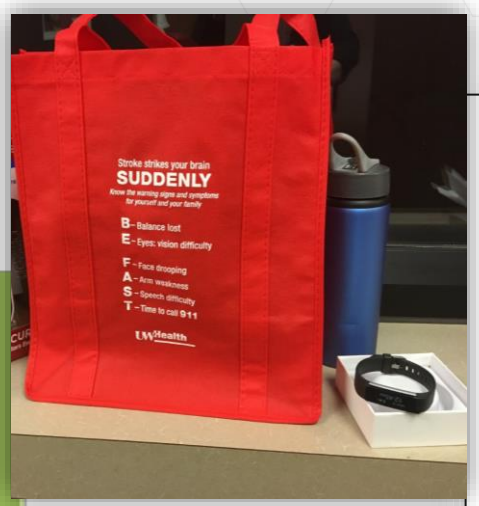
Supplies specific to the patient's goal are provided in a Red Bag as a visual cue to assist with goal success.

Documentation

The nurse documents the goal and action plan in the EMR. This is viewable to the Stroke Clinic RN and Stroke APP.

Follow Up

The action plan is discussed with the patient during the 7 day follow up phone call and 2 week APP visit.



My Action Plan to Prevent Stroke

The change I want to make is: _____

Please circle the number below that shows how important it is to you to make this change:

Not important									Very important
1	2	3	4	5	6	7	8	9	10

My Goal and Plan for a Healthy Change

It is easier to make a change when you set a goal and make a plan to reach it. Please fill in the blanks below and share your answers with your health care team who can support you.

My goal for next week or month is:

I will _____

This is my plan to reach my goal:

How much: _____

When: _____

How often: _____

Resources and support I will need to reach my goal: _____

Things that could make it hard to reach my goal: _____

This is how I will deal with these things: _____

Please circle the number below that shows how sure you are (confident) that you can reach your goal:

Not sure ... Very sure

9 10

...nore.

...so you feel more sure

Did the patient select a goal for secondary stroke prevention?

Yes taken yesterday

Yes | No

Blood Pressure Monitoring

Diet Change

cut down on sugary drinks taken yesterday

Exercise Goal

Blood Sugar Monitoring

monitor blood sugars prior to meals taken yesterday

Smoking Cessation

Other

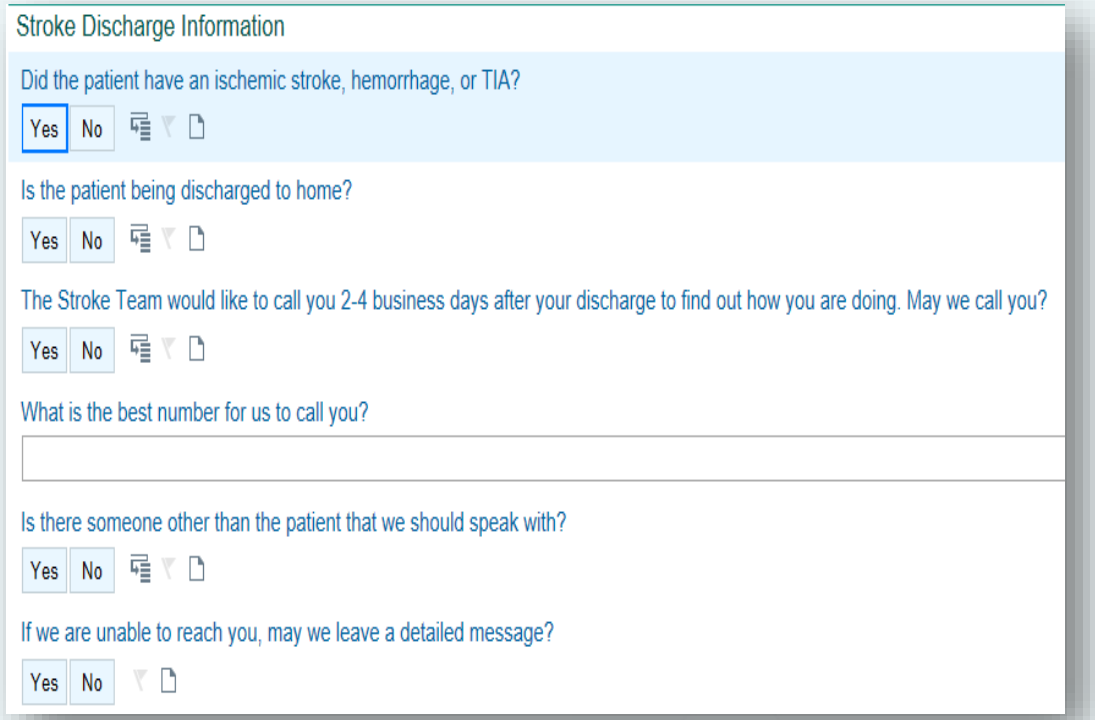
Follow Up Phone Calls

Phone calls can identify key issues at discharge including:

- Problems understanding discharge instructions
- Obtaining outpatient appointments
- Problems filling prescriptions
- Other issues with medication management
- New or worsening symptoms

Strategies for successful follow up call:

- Identify appropriate provider to make the calls
- Ensure provider making calls has access to electronic medical record and discharge summary
- Develop standard script and formatted questions
- Track call outcomes to help provide feedback to inpatient and outpatient providers
- Create resource network for person making calls to facilitate care



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Follow Up Phone Calls Triage Algorithm: Coverdell Resources

WISCONSIN COVERDELL STROKE PROGRAM

Stroke Follow-Up Call Triage Algorithm

This tool provides triage guidance to staff who perform follow-up phone calls with stroke survivors and their caregivers. It assists them in locating relevant information within the medical record, and provides next steps to ensure stroke survivors and their caregivers receive the answers they need.

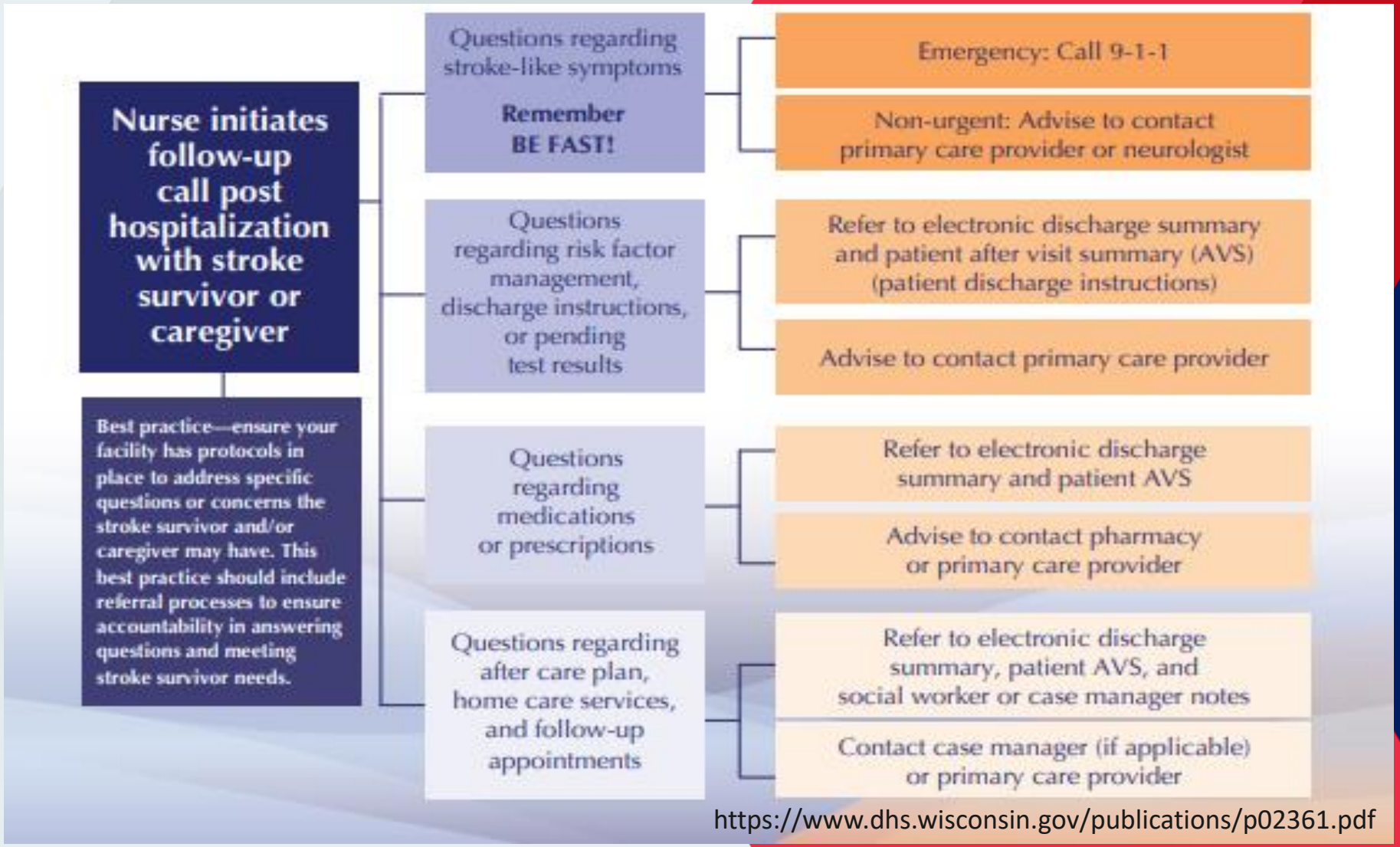
Nurse initiates follow-up call post hospitalization with stroke survivor or caregiver

- Questions regarding stroke-like symptoms (Remember BE FAST!)
  - Emergency: Call 9-1-1
  - Non-urgent: Advise to contact primary care provider or neurologist
- Questions regarding risk factor management, discharge instructions, or pending test results
  - Refer to electronic discharge summary and patient after visit summary (AVS) (patient discharge instructions)
  - Advise to contact primary care provider
- Questions regarding medications or prescriptions
  - Refer to electronic discharge summary and patient AVS
  - Advise to contact pharmacy or primary care provider
- Questions regarding after care plan, home care services, and follow-up appointments
  - Refer to electronic discharge summary, patient AVS, and social worker or case manager notes
  - Contact case manager (if applicable) or primary care provider

Best practice—ensure your facility has protocols in place to address specific questions or concerns the stroke survivor and/or caregiver may have. This best practice should include referral processes to ensure accountability in answering questions and meeting stroke survivor needs.

The Wisconsin Department of Health Services collaborates with MetaStar Inc. to provide the Wisconsin Coverdell Stroke Program. The program is supported by the Grant or Cooperative Agreement Number, DP006674, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

WISCONSIN DEPARTMENT OF HEALTH SERVICES P-02361 (02/2019)



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https://www.dhs.wisconsin.gov/publications/p02361.pdf

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Follow Up Phone Call Script

Stroke Transitions of Care Follow Up Phone Call

- How does the patient think they are doing since discharge?
- Is the patient experiencing any new or worsening problems or troubling symptoms following discharge?

Medications

- Was new stroke medication reconciliation done with the patient?
- Did the patient get their prescriptions filled?
- Is patient compliant?
- Were any medication discrepancies noted?

Falls

- Have you had a fall at home?

Risk Reduction

- Are you checking your blood pressure at home or in the community?
- Are you using tobacco currently?

UW Risk Reduction

- Did the patient select a goal for secondary stroke prevention? (Diet Change, Blood Sugar, Blood Pressure, Smoking Cessation, Exercise)
- How is the patient doing with their goal?
- What barriers are making it hard for them to reach their goal?
- What success are they having with their goal?

Appts and Driving/Work Restrictions

- Does the patient have a PCP?
- Patient appointments already made:
- Appointments patient needs to make:
- Consult to Social Work made?
- Reviewed driving restrictions with patient?
- Reviewed work restrictions with patient?

BE FAST and Calling 911

- Does the patient know the s/s of stroke (BEFAST)?
- Does the patient know who to contact for stroke symptoms?
- Does the patient know where/who to call if they have any questions/concerns?
- Total time (minutes) spent on phone call:

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Coverdell Post Discharge Data Collection

- Reviewed at Discharge Transitions of Care Committee
- 2021 QI work:
  - Meet with Clinic RNs monthly
  - Appts scheduled prior to discharge
  - Blood pressure monitoring

WI Coverdell Hospitals Report Card: Post-Hospital Discharge					
		Goal	Your Hospital	WI Coverdell Hospitals	All Hospitals
Higher is Better	Blood pressure monitoring by patient	≥50%	5%	14%	12%
	Stroke patients reporting blood pressure	≥85%	N/A	100%	N/A
	Appointment scheduled prior to discharge	≥70%	0%	66%	19%
ower Is Better	ED visits	≤10%	12%	15%	4%
	Falls reported by patient	≤10%	0%	2%	0%
	Medication stoppage	≤10%	2%	1%	0%
	Tobacco use	≤10%	0%	26%	13%
	First contact re-hospitalization	≤10%	5%	9%	N/A

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A call for future research

Outcome constructs to be measured:

- Interventions to improve physical functioning at 12 months
- Interventions targeting 3- and 12-month medication adherence
- Sustainable chronic disease management
- Strategies to reduce stroke risk factors at 12 months

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Thank you!

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