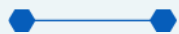


Transitions of Care for the Stroke Patient: *Going Home*

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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

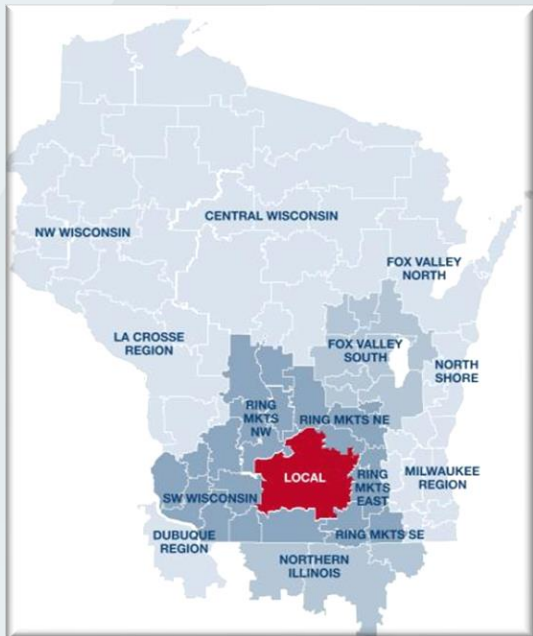
Joint Ventures and Affiliations

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



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



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.

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

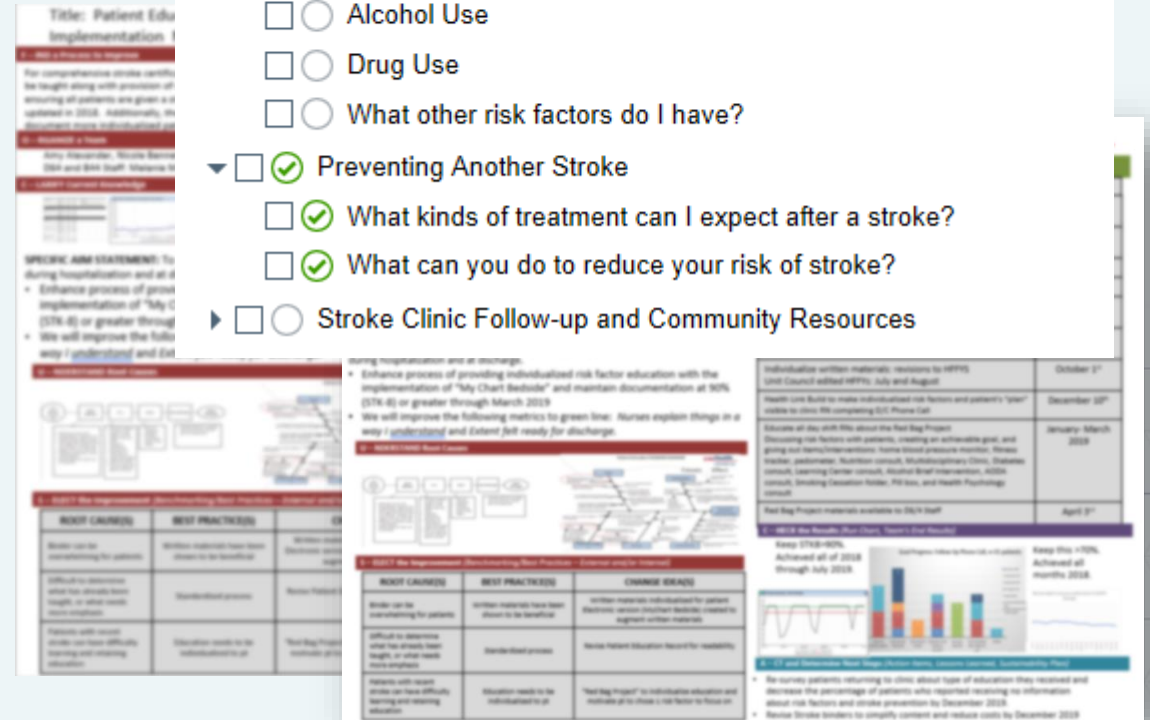
▼  Your Personal Risk Factors for Stroke

- High Blood Pressure
- Smoking and Tobacco Use
- High Blood Sugar
- Atherosclerosis and High Cholesterol
- Atrial Fibrillation ("A-Fib")
- Eating Habits
- Physical Activity
- Healthy Weight
- Sleep Apnea
- Alcohol Use
- Drug Use
- What other risk factors do I have?

▼ Preventing Another Stroke

- What kinds of treatment can I expect after a stroke?
- What can you do to reduce your risk of stroke?

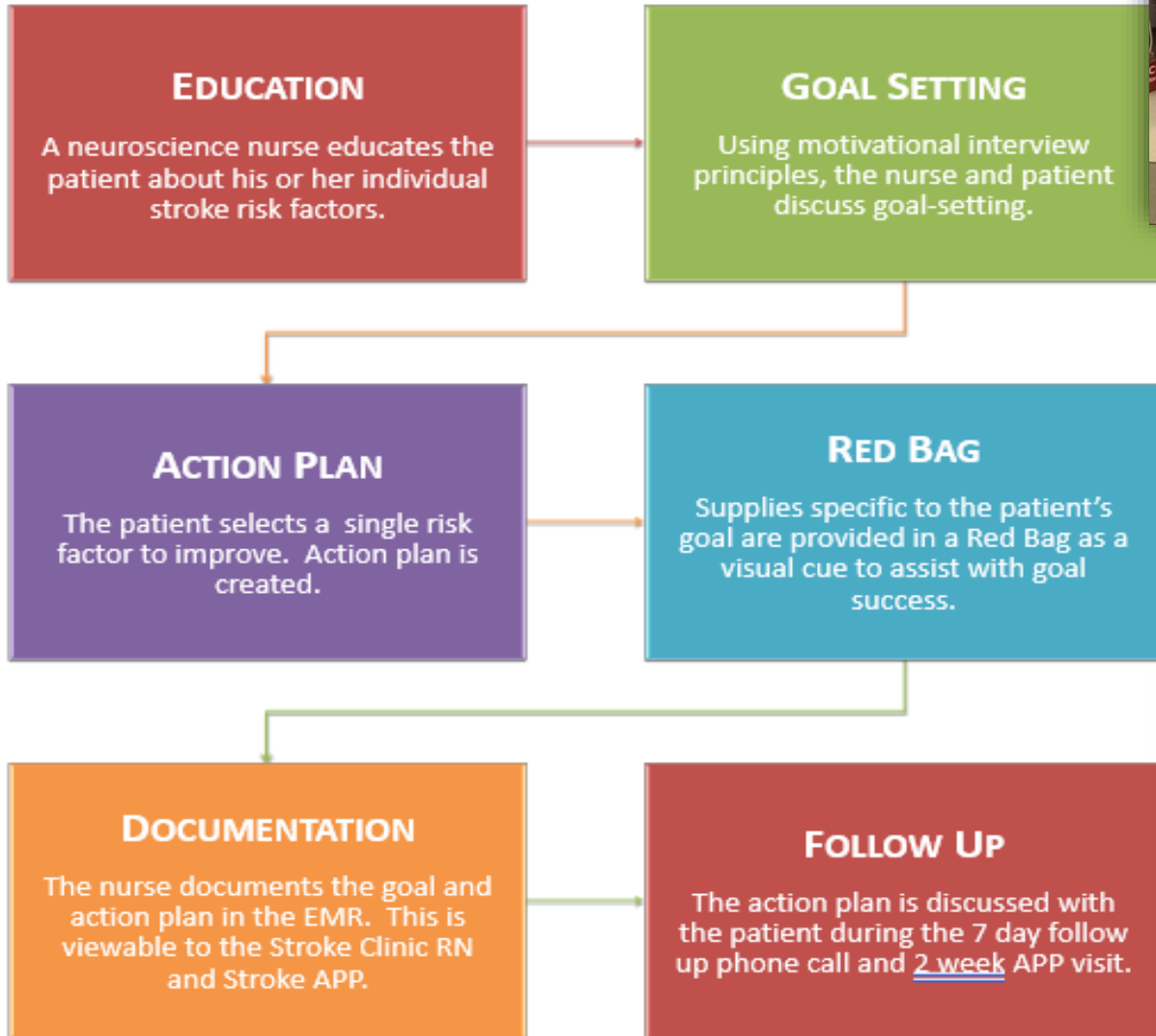
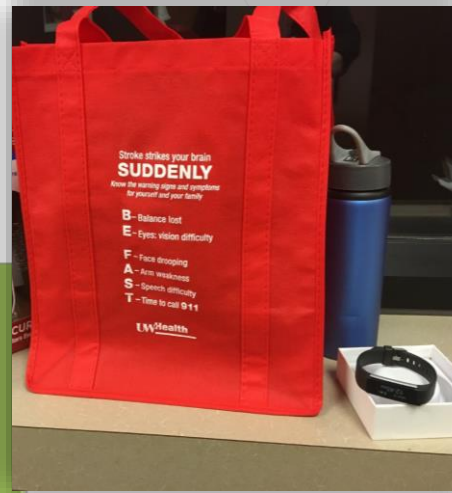
▶ Stroke Clinic Follow-up and Community Resources



The collage displays various educational materials:

- Flowcharts:** Diagrams showing patient pathways and decision points for stroke prevention and management.
- Tables:**
 - Table 1:** A table with columns for 'BEST PRACTICES' and 'CHANGE GRADE'. It lists educational goals and corresponding best practices.
 - Table 2:** A table with columns for 'BEST PRACTICES' and 'CHANGE GRADE'. It lists educational goals and corresponding best practices.
- Charts:** A bar chart showing data for 'Keep this 100% Achieved all months 2024' and another chart showing 'Keep this 100% Achieved all months 2024'.
- Text Documents:** Various informational sheets and brochures, including one titled 'Patient Education Implementation'.

Red Bag Project: Patient Goal Setting



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				
1	2	3	4	5	6	7	8	9	10

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

Stroke Discharge Information




Did the patient have an ischemic stroke, hemorrhage, or TIA?

Yes No   

Is the patient being discharged to home?




Yes No   

The Stroke Team would like to call you 2-4 business days after your discharge to find out how you are doing. May we call you?



Yes No   

What is the best number for us to call you?

Is there someone other than the patient that we should speak with?

Yes No   

If we are unable to reach you, may we leave a detailed message?

Yes No  



Follow Up Phone Calls Triage Algorithm: Coverdell Resources

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.

Remember BE FAST!

- B**ALANCE
- E**YES
- F**ACE
- A**RMS
- S**PEECH
- T**IME TO CALL 9-1-1

TIME TO CALL 9-1-1 Every second counts!

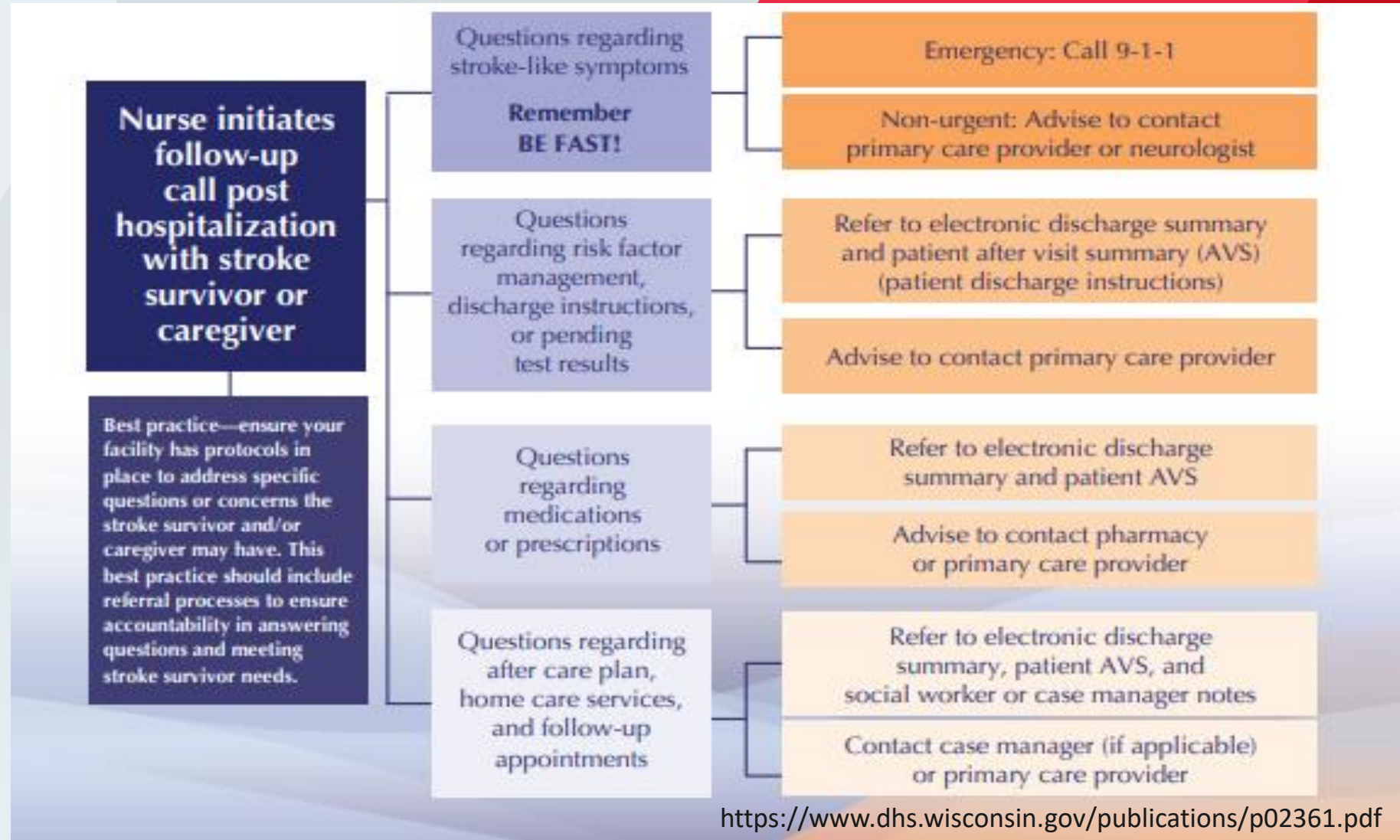
Nurse initiates follow-up call post hospitalization with stroke survivor or caregiver

- Questions regarding stroke-like symptoms
 - 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.

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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:

Coverdell Post Discharge Data Collection

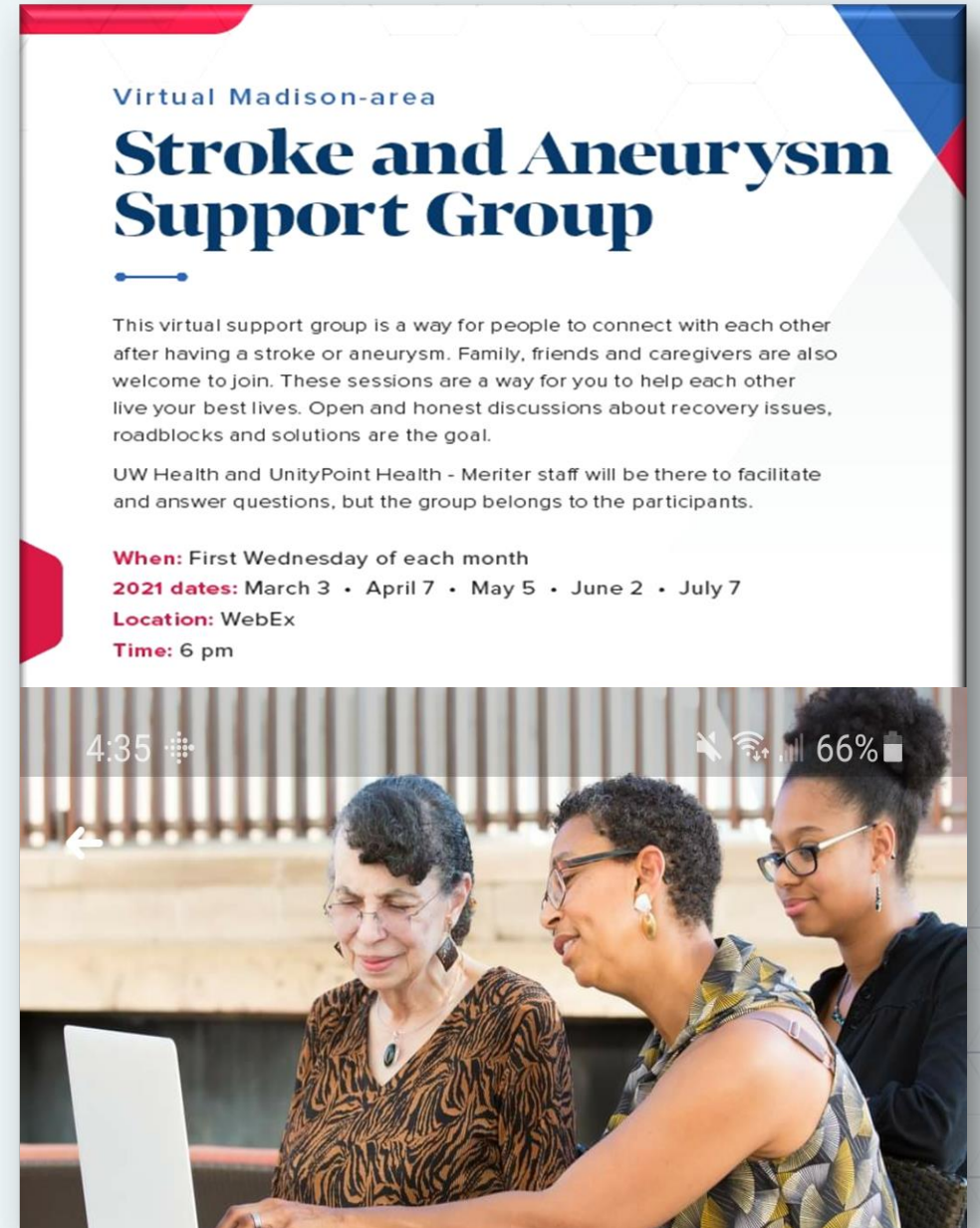
- Reviewed at Discharge Transitions of Care Committee
- 2021 QI work:
 - Meet with Clinic RNs monthly
 - Appts scheduled prior to discharge
 - Blood pressure monitoring

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%
Lower 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

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



Virtual Madison-area
Stroke and Aneurysm Support Group

This virtual support group is a way for people to connect with each other after having a stroke or aneurysm. Family, friends and caregivers are also welcome to join. These sessions are a way for you to help each other live your best lives. Open and honest discussions about recovery issues, roadblocks and solutions are the goal.

UW Health and UnityPoint Health - Meriter staff will be there to facilitate and answer questions, but the group belongs to the participants.

When: First Wednesday of each month
2021 dates: March 3 • April 7 • May 5 • June 2 • July 7
Location: WebEx
Time: 6 pm

4:35 66%

The screenshot shows a mobile device interface with a video player. The video shows three women of diverse backgrounds looking at a laptop screen together. The top status bar shows the time as 4:35 and battery level at 66%. The video player has a back arrow on the left and a mute icon on the right.

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Stroke Strikes Suddenly

RECOGNIZE THE SIGNS

Balance loss

Eyes and vision changes

Face drooping

Arm weakness or numbness

Speech slurred or trouble speaking

Terrible headache

DON'T STALL,
MAKE THE CALL
911

UWHealth

Thank you!

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