Stroke Transitions of Care
Hospital Environment to Home
Disclosures

NONE
Objectives

- Understand the importance of effective transitional care from the acute hospital to home in the stroke population
- Discuss strategies for a successful transition and identify innovative solutions
Importance of Transitions Of Care

- Avoid re-admissions
- Improve quality of life
- Financial well being of the healthcare system
- 2012: CMS imposed a 1% Penalty for excess readmissions on MI, CHF and Pneumonia with a projected increase of 3% in 2015.

What percentage of Stroke patients are discharged to home directly from the hospital?

1. 10%
2. 35%
3. 49%
4. 65%
Which are contributing factors to a hospital re-admission?

1. Inadequate Medication Reconciliation
2. Lack of knowledge regarding risk modification
3. Poor Communication among care providers
4. Failure to follow up with healthcare provider
5. All of the above
Definition of Transitions of Care

- A passage from one life phase, or condition, to another, - one healthcare environment to another.

- New ways of looking at the world and developing new ways of living it.
Why Do We Care?

- Patient Protection and Affordable Care Act
- SAVE $17 billion dollars by preventing hospital re-admissions
- CMS will be basing their reimbursements on re-admissions; and considering patient satisfaction scores as well.

Stroke Readmissions

Stroke is a major global health problem

- 14% of stroke survivors will have a recurrent stroke within one year of primary event. (Summers et al., 2009)
- 13-20% of stroke victims will be re-admitted to the hospital within 30 days (Nahab et al., 2012)
- 30% of stroke patients will be re-admitted within 90 days. (Fonarow et al., 2011)
49% of stroke patients are discharged home;
53% of these admission are avoidable
29% because of inadequate output coordination
16% for incomplete evaluations
9% Delay in palliative care
ONLY 5% had follow up appointment within the 1st week of discharge.

Wisel, Iver, Sunnrhagen (2012). Navigating the Poststroke Continuum of Care, Journal of Stroke and Cerebrovascular Disease, Vol 22, No 1
Nahab, Takesaka, et al., (2012) Avoidable 30-day re-admissions among patients with stroke, the Neurohospitalist 2(1) 7-11
CASE STUDY

- On 9/17/2013; 28 yo female admitted through the ED for right sided numbness; headache, double vision and mild expressive aphasia. Symptoms had started 16 hours ago while partying in NYC. No past medical history; no past medications.

- **Hospital course:** Admitted to stroke unit; consult with Neurology; NIHSS upon admission was 2; CTH was negative for acute process, MRI of brain showed acute left pontine infarct. MRA was negative with patent carotid and vertebral arteries. Hypercoagulable workup was negative. 2D echo was negative and TEE completed.

- **Disposition:** Patient discharge home on day 5, ambulating with a mild gait disturbance; and mild dysarthria. Acute rehabilitation was recommended but patient refused. Stroke instructions were provided. Follow up appointment was made with primary care physician; TEE results were pending. Medications: Aspirin,. Discharge summary suggested follow up with Cardiology for loop recorder.
Factors Contributing to Readmission

- Poor health literacy
- Meager understanding of diagnosis
- Inability to identify signs of stroke
- Non-compliance or poor management of personal risk factors
- Non-compliance with Medication regime
- No Follow up care
- Confusion: due to TOO MANY TRANSITIONS with multiple health care providers
Transition of Care Models

S.M.A.R.T

Coleman Care
Transition

Nayor’s Transitional Care Model
Common Elements of Care Models

- Engagement
- Needs based assessment
- Collaboration
- Coordination of care
THE FOUR TIERS of Successful Transition

Self Care Management

Medication Adherence

Early Follow Up and Support

Communication and Transfer of Information
Ineffective planning and coordination of care undermines patient satisfaction, facilitates adverse events and contributes to re-admissions.
Key Players for Successful Transitions

- Transition Coach/Discharge Coordinator (Nurse or Nurse Practitioner)
- Case Manager
- Social Worker
- Rehabilitation Professionals
- Hospitalists
- Pharmacist
- Primary Care Physicians
- Community Neurologist
#1. Self Care Management

requires collaborative care.

- Set the Stage/ Discharge planning
  - Begin with mutual goal setting: what is patient’s goal for discharge
  - Assess readiness to learn and motivation develop a shared agenda
What do I need to do?
What is my main problem?
Why is it important for me to do this?
Self Care Management/ Empowerment

Take Action

- Teach back method
- Find daily teachable moments; provide written, verbal and audio education
- Close the Loop with a structured discharge plan - easy to read; explicit
- “Red flags” provide prompts for when and who to call before returning to ED
#2. Medication Adherence

- Reconciliation to reduce medication discrepancies.
- Teach when, why and how to take prescribed medications.
- Engage a Pharmacist to educate and reconcile to avoid potential adverse events.
RN Follow Up Calls

Follow up phones calls bridge the Gap
Communication: Physician Handoff

- 12-34% of the time Patient arrives to PCP office before Discharge summary.
- Does Your Discharge Summary Arrive within 48 hours?
- Is the Primary Care Physician familiar with Stroke protocols?
- What is your method of communication?
- Electronic Health Record

#3 Early Outpatient Follow up

- Ensures a coordinated care plan
- Supports the patient for self care management
- Manages adjustments to medications; incomplete evaluations; education.
- Facilitates Outpatient referrals: NeuroPsych; rehabilitation; cardiology; sleep centers
- Home Care Visit
- Telephone Support
Challenges of Stroke Discharge

Period of Heightened Vulnerability !!

Shortened Length of Stay

- Impaired short term memory
- Impaired capacity for learning
- Difficulty with language comprehension
- Cognitive Impairment; Neglect
- Depression
- Denial/ Stigma
Challenges of Stroke Discharge

- "Two-thirds of nurses are 'too busy to talk to patients' and 80% admit to rationing care"

Steps We Have Taken

- Multidisciplinary Team Rounds
- Discharge contract written in “First” person
- Stroke APN Nurses do majority of education with Staff Nursing back-up
- Dedicated Nurse makes phone calls
- Engaged Concierge service to make appointments prior to d/c
- Engage Pharmacist to fill prescriptions and educate patient
Discharge Checklist

✓ Legible discharge medication list
✓ Medication information print outs
✓ Fill prescriptions before discharge
✓ Appointments
✓ Does Patient Know FAST acronym
✓ Understand when to call 911
✓ Encourage patient to keep journal
✓ Permission to Call
✓ Know when to call Primary Physician
✓ Know when to call Neurologist
Take Home Message

- Multidisciplinary *Anticipation and Preparation*
- Follow up appointments for strategic planning
- Telephone Follow up - bridging the inpatient-outpatient transition
- Communicate the Information with Community Physician (faxes, patient as courier)
- Comprehensive Education:
  - Written instructions and verbal instructions
- Community Referrals / Home Care / Population Health
Case Study

- Patient was readmitted on 10/31/2013 for new left sided numbness, and a chronic headache x 1 month. She had stopped taking her ASA - she states ran out. CM showed one episode of atrial fibrillation. MRI this admission now shows tiny multiple right subacute infarcts in the left and right internal capsule.

- POOR TRANSITIONAL CARE: Her failed follow up; No support at home; poor understanding of condition and social situation.

- TEE results had no follow up; Discharge recommendations for Loop recorder were not completed. Follow up with Cardiology was not completed.
Patient Survival Guide

- Armed with Information to take Personal Health Record to all appointments
- Carry a List of medications
- Access to Own Electronic Health Record
- IT - Continuum of Care Documents
- Access Stroke Resources on the Web.

Coming soon
THANK YOU