



# Stroke Patient Transitions of Care Toolkit

MINNESOTA STROKE PROGRAM

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# Chapter 1: Introduction

*Transitions of Care* is the movement of patients among providers, different goals of care, and across the various locations where health care services are received. The goal of transition management is to facilitate and support seamless transitions across the continuum of care. It is also to achieve and maintain optimal adaptation, outcomes, and quality of life for patients, families, and caregivers following a medical event – such as a stroke.

In the past decade, Minnesota has made significant progress improving emergency treatment and inpatient care for acute stroke patients. However, the transition back home for these patients remains difficult. After a stroke, patients may experience physical, emotional, cognitive, and social complications. Poorly executed health care transitions increase the risk of medical complications, poor patient outcomes, and caregiver stress. Going home with a new disability raises concerns for health challenges and ultimately readmission to the hospital. Studies show that interventions like close coordination of care, along with early follow-up care after hospital discharge, reduce the rate of complications leading to readmission.

Transitioning patients between care settings starts in the hospital and requires coordination between health professionals. This coordination ensures that the patient’s health and personal needs are met. Creating a smooth transition for stroke patients from hospital to their homes and communities is vital. It requires building internal connections that branch out between hospitals, rehab facilities, home care agencies, clinics, and community-based organizations. Hospitals play a pivotal role in ensuring the transition for patients to home is smooth.

## **Purpose of Toolkit**

The purpose of this toolkit is to provide resources for staff at hospitals and other health facilities to help implement strategies to improve the transition for stroke patients from hospital to home. This toolkit provides tips, tools and resources for implementing these strategies.

The toolkit is organized into the following sections:

1. Project planning steps (Chapter 2)
2. Quality improvement project ideas (Chapter 3)
3. Post-discharge follow-up and data collection (Chapter 4)
4. Resources and References
5. Appendix (Templates and Tools)

Throughout this toolkit you'll see tips, examples, and references to tools that are ready-to-use.

**Tips and Ideas are in Yellow boxes**

**Examples are in Blue boxes**

**Templates are at the end – find links to them in Green (Blank Template: PDSA Worksheet)**

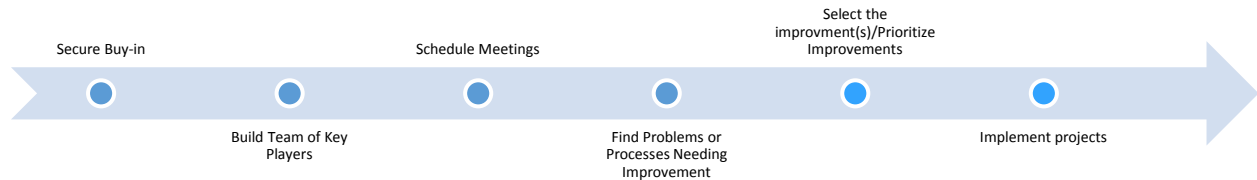
On the Minnesota Department of Health Stroke Program Resources web site, you can find:

- This toolkit
- Downloadable (ready-to-use) tools (Microsoft Word documents)
- Examples (completed samples) of various tools found in this toolkit.

To find these resources, go to: Minnesota Department of Health Stroke Program ([www.health.state.mn.us/stroke](http://www.health.state.mn.us/stroke))

## Chapter 2: Project Planning Steps

The following are steps that a hospital would likely follow to plan and implement a care improvement project for stroke patients transitioning from hospital to home. These can be adapted to meet the needs of your organization.



These steps are:

1. Secure Buy-in, Engagement and Ownership
2. Build a Team of Key Players
3. Schedule Meetings
4. Identify Areas for Improvement
5. Prioritize Areas for Improvement
6. Action Plan Development and Implementation

### Step 1: Secure Buy-in, Engagement and Ownership

When starting a transitions of care project for stroke patients, it is important to secure “buy-in” on an organizational level and from the individuals that you would like to participate in the project. Once individuals have bought into the project, then they can take ownership in it!



Securing buy-in may be challenging. A project usually starts with a person being really excited about A GREAT IDEA that will lead to change.

#### Getting Started

In order to secure buy in it is important to clarify your ideas about the change you want to see in your organization’s practice before talking to others.

1. **Identify rationale/need for change.** Put into writing how you came up with your idea and the reason you want to do it.

*Example: You notice that not all TIA patients receive follow-up calls from the hospital and you would like to start a quality improvement project to improve this. You think it will improve patient satisfaction and reduce future emergency department visits.*

**2. Investigate current practices.** As you think about a project, you need to understand current practices in order to identify areas that require improvement.

Example: *You have noticed that patients are not aware of their personal risk factors when they come back to the clinic for follow-up care and you wonder why this is.*

- *Individualization of stroke risk factors supports secondary prevention of stroke. Current practice provides a generic list of risk factors that are not specific to the patient. How can this be improved?*

## Organizational and Individual Buy-in

As you implement your quality improvement projects, barriers you encounter will require patience and individual buy-in while others may require the influence of executive leadership. Beyond simply removing barriers, having support and engagement from your senior leaders can help facilitate change.

### ORGANIZATIONAL/INDIVIDUAL BUY-IN

Organizational buy-in is needed for most projects to be successful. This means securing leadership support from your hospital, health system or clinic.

- ✓ Identify which member of leadership would be most appropriate to partner with. Who is familiar with the processes and policies related to stroke transitions of care.(e.g., CNO, CFO, or Director)?
- ✓ Discuss allocation of resources and time needed to drive plan forward. (e.g., resources, time, and moral support)
- ✓ Determine potential benefits to the organization. (e.g., improved patient satisfaction, improved care, and lower readmission rates)

Additional information can be found in the [“Build a team of key players”](#) section.

### Tips to engage stakeholders and secure buy-in:

- 1. Communicate your idea for change as a conversation.**
  - *“I went to the Minnesota Department of Health Stroke Conference last week and heard a speaker from Blue Ox Hospital talk about changes they made to improve transitions of care for stroke patients discharged from hospital to home.”*
- 2. Define the purpose for change**
  - *We want to do things differently to produce better outcomes for the patient, organization and community.*
- 3. Anticipate barriers.** *Barriers could include things like staffing, finances, or physical space.*
- 4. Develop a summary**
  - *Here’s what our change initiative is about.*
  - *We’d like to update our patient education materials so that they are more patient centered and are consistent between the hospital, clinic and rehabilitation.*

- **It's important to do because...(what's the benefit?)** *Updating the patient education materials and standardizing them across facilities where patients receive care will help the patient understand what a stroke is and ways to take care of themselves.*
- **Here's what success will look like, especially for you...***Patients will know their personal risk factors and what behavior changes need to be made. There will be less ED visits and readmissions.*
- **Here's what we need from you...***I would like your commitment to support the use of my time to bring a team together to work on this project, for the communication department to review and format the materials and then to roll it out the facilities.*

### **IDEAS FOR IMPLEMENTATION**

#### **Be Innovative:**

- This is your team's opportunity to design a system to improve patient transitions of care that will work in your hospital, health system and community
- This is the time to focus on teamwork and cooperation, and to share successes
- Use a "How can we do this better" approach rather than focusing on the negative

#### **Be Creative:**

- View this as a great opportunity to develop a better system to care for stroke patients
- Work together and share ideas for improvement to enhance the care of every patient
- It's a chance to implement new ideas and processes
- Be proactive
- Test changes in process on a few patients to see if your "hunch" works

Adapted from Get With the Guidelines™ Implementation Tips

[https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm\\_303754.pdf](https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm_303754.pdf)



## Step 2: Build Team of Key Players

Multi-disciplinary and cross-continuum team collaboration is essential for implementing a transitions of care project. The team should meet regularly to facilitate communication and collaboration, assess progress, and support improvement efforts in all clinical settings in which the stroke patient comes in contact.

**Include a Patient Perspective.** It is recommended to find a way to obtain input from patients on changes that will impact their care. This may be identified through chart review and tracking trends or through direct patient contact/experience. If possible, include a “customer” on your project team to share their journey from the patient perspective.

**Form the Team.** The initial core team should be recruited from each relevant area of care and administration. It should include those who are familiar with policies and processes as well as patient flow as they move from the hospital setting (ED or in-patient) to post-discharge follow-up with primary care, neurology and others. Additional members can be identified at the first meeting through a work flow analysis and at subsequent meetings as identified challenges and needs emerge and a work plan is developed as described in [Step 4](#).

Consider individuals who represent the following capacities and add others not on the list.

Hospital	Clinic and Community
Patient, Family and/or Caregivers	Patient, Family and/or Caregivers
Stroke Coordinator	Director of Primary Care
Neurology Providers	Primary Care Providers
ED Nurse/Manager	Clinic Manager
Stroke Navigator	Health Care Home Coordinators
Hospitalist	Neurology Clinic Providers
Home Health Care staff	Home Health Care staff
Case Management/Social Worker	Home Care staff
Chief Nursing Officer (CNO)	Nurse Line Coordinator
Rehab Director and/or Therapists (OT, PT, SLP)	Rehab Director and/or Therapists (OT, PT, SLP)
Nurse Manager - Neuro	Community Clinics
Director of Med-Surg/ICU and House Supervisors	Public Health
Health Plans	Health Plans
In-patient Pharmacists, Director of Pharmacy Services	Out-patient or Community Pharmacist
EHR Analyst	EHR Analyst
Quality Improvement Staff	Quality Improvement Staff
Community Initiatives Coordinator	Community Paramedics
Nutrition Services	Community Health Workers

Hospital	Clinic and Community
Abstractor	Community Agencies
Marketing Department	Marketing Department

**Create a Stakeholder Matrix.** After you have identified possible key participants, a stakeholder analysis matrix can be used to help identify and assess the importance of participation of key people, groups of people or institutions that might influence the success of the project.

1. Start with the list above. Identify all the capacities that will affect or be affected by the quality improvement project and list them and the individuals that represent them in the "Stakeholder Name and Role in Facility" column.
2. Review the stakeholder list and identify each person's specific interest in the project. Consider the project's benefit to the stakeholder; changes from the project that will affect the stakeholder; and activities that might cause conflict for the stakeholder. Document these interests in "Stakeholder Interest(s) in Project" column.
3. For each stakeholder, identify the importance of the stakeholder's role to the success of the project. Assign A for extremely important, B for important, and C for not important in the "Assessment of Stakeholder Importance to the Project" column. Consider the following:
  - a. The role the stakeholder must play for the project to be successful, and the likelihood that the stakeholder will play this role.
  - b. The likelihood of a stakeholder's negative response to the project
4. Contact individuals who are believed to be "extremely important" and "important" to the success of the project.

Example: Stakeholder Analysis Matrix		
Stakeholder Name and Role in Facility	Stakeholder Interest(s) in Project	Assessment of Stakeholder Importance to the Project (A = extremely important, B = important, C = not important)
Nancy Johnson, Stroke Coordinator		
Dennis Larson, Neurologist		
Laura Olson, HUC		
Morris Nelson, ER Nurse Manager		
Emily Erickson, Director of Nursing		
Peter Donaldson, Medical Director		
Wanda Tollefson, Quality Director		

**Blank Template: Stakeholder Analysis Matrix**

**Select the champion for the project and core members.** At the first meeting, complete a “Members Roles and Responsibilities” worksheet as a group to assist with team member buy-in and transparency. Update the worksheet throughout the project as new individuals become involved and or others change roles. See example below:

**ENGAGING PRIMARY CARE.** Essentia St. Mary’s Hospital engaged primary care from the start of their transitions of care project. The Systems Director for Primary Care and the Administrator of Primary Care were invited to every meeting. When input was needed from primary care physicians, they were invaluable at facilitating the process and later supporting training of primary care clinic staff in the needs of stroke survivors post-discharge.

<b>Example: Members Roles and Responsibilities Worksheet</b>		
<b>Date</b>	<b>Hospital</b>	<b>Primary Care Clinic (or other agencies)</b>
<b>Member/Role</b>	Who should be involved? Name and position	Who should be involved? Name and position
Champions	<i>(NAME) - Stroke Coordinator</i>	<i>(NAME) -- Dir of Primary Care Services</i>
Core team members	<i>(NAME) - Director of Med-Surg/ICU and House Supervisors (NAME) - CNO (NAME) - Community Health Initiatives Coordinator (NAME) - Advanced Practice Nurse- Neurology</i>	<i>(NAME) - Health Care Home Coordinator (NAME) Clinic Manager (NAME) Staff Nurse</i>
Other team members	<i>(NAME) - Case Manager (NAME) - Director of Acute Rehab (NAME) – Medication Therapy Management Pharmacist (NAME) – Abstractor (NAME) – Social Worker</i>	<i>(NAME) – EHR Analyst (NAME) – Nurse Line Coordinator (NAME) Front Desk Staff</i>
Meetings – Who should attend?	Champions and Core team members	Champions and Core team members
Setting up meetings		
Work plan development		
Data analysis and reporting		

- Champion – responsible for representing project, **primary decision-maker**, monitoring process, primary documenter, scheduling meetings
- Core Team Members - key contributor, content expert or responsible implementing specific activities
- Other Members – contribute information, knowledge and skills to a specific project component. Provide periodic input.

Template Source: Stroke Program, Minnesota Department of Health 2018

**Blank Template: Members Roles and Responsibilities Worksheet**

## Step 3: Schedule Meetings

### Meeting tips!

The information below assumes the “champion” will be the meeting facilitator. If not, the champion should work with the meeting facilitator in planning each meeting.

- Set the tone of collaboration by making the time convenient for the members. Arrange for members to join by web or telephone conferencing.
- As a group establish a purpose for meetings.
- Think about how to facilitate meetings, draw people out, communicate effectively, etc.
- Come prepared with an agenda. The agenda should be action oriented with specific activities to act upon. It should track assigned responsibilities for members. Keep track of all items on the agenda and ensure each one gets accomplished, even if deferral is a necessary action.
- Find a note taker – either the facilitator or ask for a volunteer.
- Assign sub-groups specific tasks and the authority to accomplish those tasks potentially without formal meetings. These groups can decide how decisions will be made.
- FLEXIBLE STRUCTURE. In rural hospitals, the lead for a stroke transitions of care project often balances quality improvement work with other administrative duties and patient care assignments. Have open discussions at each meeting to discuss meeting frequency and length to determine what works for all team members.

## Step 4: Identify Areas for Improvement

This important step is about identifying processes to improve through process improvement projects related to transitions of care. Identifying these gaps will take time and require team collaboration. Below are four methods to assist you in this work.

1. Analyze existing data
2. Conduct literature reviews, patient interviews, and multidisciplinary meetings
3. Conduct a work flow analysis to identify what is working well and what could be changed
4. Identify gaps, challenges and areas for improvement

**Tip:** As you work on this project, you may learn that there are other individuals at your hospital working on similar issues surrounding transitions of care. Seize the opportunity to collaborate and avoid duplicate work.

### 1. Analyze existing data

**Review clinical data.** Review your institution-level performance on clinical measures. Data might come from: American Heart Association’s Get With The Guidelines-Stroke™ Patient Management Tool, Minnesota Stroke Portal, and hospital electronic health records.

**Example****Measures with the Lowest Performance Rates**

% of stroke patients who were seen in the ED within 30 days of hospital discharge

% of stroke patients who stopped taking medications within 30 days of discharge without being told to do so by their medical provider

**Review non-clinical data.** These data might come from surveys, recommendations from meeting minutes, reports, or employee suggestions. Examples:

- a. Percent of patients for whom personal stroke risk factors were discussed with patient and/or family caregiver prior to discharge
- b. Percent of patients discharged to home that had a follow-up appointment made prior to discharge with primary care provider
- c. Percent of patients for whom staff reviewed the stroke education binder prior to discharge
- d. Percent of TIA patients seen in the ED and not admitted that had a follow-up appointment made with primary care and/or neurology prior to leaving hospital

## 2. Conduct literature reviews, patient interviews, and multidisciplinary meetings

1. Conduct a literature review specific to stroke transitions of care and also transitions of care in general. Include a review of national guidelines. Identify best or promising strategies. This can help you identify mistakes or successes of others. In the [Resources and References section of this toolkit](#) you will find references to literature for practice and topic areas.
2. Conduct patient interviews in order to gain insight into the firsthand experience with the transition of care process.
3. Meet with the staff from other departments (e.g., quality department, rehab, discharge planning, case management ) to identify existing or planned efforts related to:
  - a. Transitions of care
  - b. Data flow metrics (e.g., readmission rates)
  - c. Discharge process
  - d. Reducing readmissions
  - e. Care coordination
  - f. Medication reconciliation and management

## 3. Conduct a Process or Work Flow Analysis

This step may be referred to as **work flow analysis, process mapping, developing a flow chart, or developing a work flow.**

Completing a map of the work flow is a method used to show the individual steps of a process in sequential order. In quality improvement, flow-charting is used to graphically show the actual steps of a process – in comparison to the *ideal* steps. The map should reflect how the current transitions

of care process *actually* works, not how it is supposed to work.

## Process Mapping is about DISCOVERY, as a team

### Benefits of Process Mapping

- Visibly displays the reality of the current process
- Includes steps of the process and roles of the participants
- Identifies how many people/areas are part of a single process
- Prompts thinking about how to better prepare patients for transitions of care
- Can be a team-building activity, as members will become aware of the role each one plays in transitions of care for stroke patients

**TIP:** Have two flipcharts in the room – one for a *Parking Lot* and another for *Opportunities*

**Parking Lot:** Keep track of ideas that come up

**Opportunities:** Note ideas and solutions that are generated yet don't fit on the process map

### Steps to Successful Process Mapping

1. **Schedule a team meeting to define the process to be diagrammed.** It is important to have representation from areas that have an impact on transitions of care and touch the patient as they proceed on their path from hospital arrival to post-discharge follow-up. As you map out a patient's path, participants will identify new information about who the patient interacts with, when and for what, related to patient care.
2. **Pick a method for organizing the information for the work flow.**  
The following are options to organize all the information. Some methods described allow for more flexibility to adjust your work flow during the meeting while for others this would be completed post-meeting.
  - a. MDH Stroke Program **Stroke Patient Process Flow Map.** This can be completed in real-time using a computer projected onto a screen or it can be verbally discussed and the facilitator/team leader can complete the template post meeting. The sample categories on the form can be used if needed to facilitate discussion.

**Blank Template: Process Flow Map**

- b. A **white board**. This would probably involve one person drawing out the steps as team members say them. A white board allows for changes during the brainstorming. Take a picture of the white board at the end of the meeting so that the information can be easily transferred to a document.
- c. **Flipcharts and post-it notes**. Individuals record each step individually and then puts them in order on the flip chart.
- d. **Swim Lane Mapping**. This is similar to a flow chart in that it maps out a process and decisions. However, a swim lane places events and actions in “lanes” to delineate a person/groups responsible or a specific sub process. A swim lane map includes time, people (or job functions) and task process.

**Blank Template: Swim Lane Process Map**

**3. Map out the transitions of care process.** Include all details related to **patient flow and transitions of care** starting when the patient arrives at your facility to discharge, and all follow up care. (rehab, medication management, follow up appointments, follow up calls etc)

**4. Gather the information and organize on the work flow.**

**Brainstorm** all the steps in the process as it currently exists and add to the work flow. Ask several times during the meeting if any steps or points of contact are missing. Start the meeting with a probing question. Examples:

- a. What are all the steps in the process for a stroke patient discharged from the hospital directly to home?
- b. How do you engage patients, caregivers and/or families?
- c. How is patient education incorporated into your work?
- d. How are you supporting inter-professional communication during the transition period (between nurses, physicians, case management, OT, PT, etc.)?
- e. During hospitalization when is the patient assessed for the impact of social determinants of health (e.g., housing instability, food insecurity, transportation problems, utility help needs, and safety concerns)?

**Tips for Process Mapping**

- Encourage participants to gather co-worker input frequently throughout the project so that potential challenges can be detected early.
- Ensure that you do not improve one part of the process at the expense of another.
- Consider developing an “actual” and an “ideal” flowchart for each process to easily identify the potential problem areas in the “actual” process.

**4. Arrange the steps into a sequence and ask the following questions:**

- a. What do we need to know more about?
- b. What steps are missing that would improve transitions of care?
- c. Are activities happening at the best time for the patient? (i.e., patient education)
- d. Where are the gaps and challenges in care?
- e. What processes do not work?
- f. Are there any steps that might benefit or negatively impact one population over another?

## 5. Identify gaps, challenges and areas for improvement

1. Discuss the workflow of a stroke patients transitions of care by utilizing the process map developed
2. As a group, highlight on the work flow map potential gaps and areas for improvement that might develop into quality improvement projects.

### **Touch Points after Stroke**

Once a patient leaves the hospital, they may get several calls from different people (e.g., primary care transitions care management nurse, hospital stroke navigator or primary care health care home coordinator) representing different organizations (e.g., hospital, clinic or health plan). They may also have many medical appointments scheduled with different providers. Coordinating these calls and appointments is important for improving care and avoiding duplication. The chart in [Appendix 5: Touchpoint after Stroke – Sample](#), is a real-world sample of the care coordination and follow-up process that might occur after a patient leaves the hospital to go home. In this example, the team completing the chart found that the patient receives five phone calls from five different people within the 24-48 hour post-discharge time period. This new information can be used to change processes so that the patient does not receive so many calls.

**Blank Template: [Touchpoints after Stroke](#)**



## Step 5: Prioritize areas for improvement

You now have a list of potential projects – in fact, the opportunities may seem endless. Now it's time to prioritize them and select the one(s) to address. The following tools can be used to select a improvement areas.

- **Criteria for Selecting Process Improvement Opportunities – Transitions of Care for Stroke Patients.** First, each team member individually completes this tool for each proposed project by assigning a score based on defined metrics in four areas: need, ability, impact and alignment. Then, each person fills in their total score for each project evaluated on one form. The total scores for each proposed project are then averaged and compared by the whole team.

**Tools and Templates: [Criteria for Selecting Process Improvement Opportunities](#)**

- **Multi-Voting Technique:** Multi-Voting is typically used when a long list of potential quality improvement projects must be narrowed down to a top few. It works best when participants are in the same room. Outcomes of multi-voting are appealing as this process allows a project that may not be a top priority of any individual but is favored by all, to rise to the top. In contrast, a straight voting technique would mask the popularity of this type of project making it more difficult to reach a consensus. This technique can be used after a list of projects has been generated through another quality improvement process. Once you have completed this step, you are ready to develop a work plan.

**Tools and Templates: [Multi-Voting Technique](#)**

## Step 6: Action plan development and implementation

### Developing an action plan or work plan

- ✓ Develop an action plan that can be used to coordinate and guide the quality improvement project(s) the team plans to work on (Plan-Do-Study-Act (PDSA) worksheets may be a helpful format to use.
- ✓ Start implementing your action plan and track your outcomes

The templates described below will assist you in developing a plan to answer the following questions:

#### 1. MDH Project Work Plan

This work plan template is used to organize your project and also can be used to monitor the status of your work. It allows for organizing your work by outcomes and strategies.

## **Blank Template: Project Work Plan Stroke Transitions of Care Project**

### **2. Stroke Quality Improvement Transitions of Care Initiative Project Plan**

This project plan is used to plan and coordinate the work of a specific quality improvement project. It defines the scope, resources, objectives and execution of a project. You may choose to take a key activity from your work plan/quality improvement plan and develop it further by putting more detail into the form.

## **Blank Template: Stroke QI Transitions of Care Project Plan**

### **3. Plan – Do – Study – Act (PDSA) worksheet**

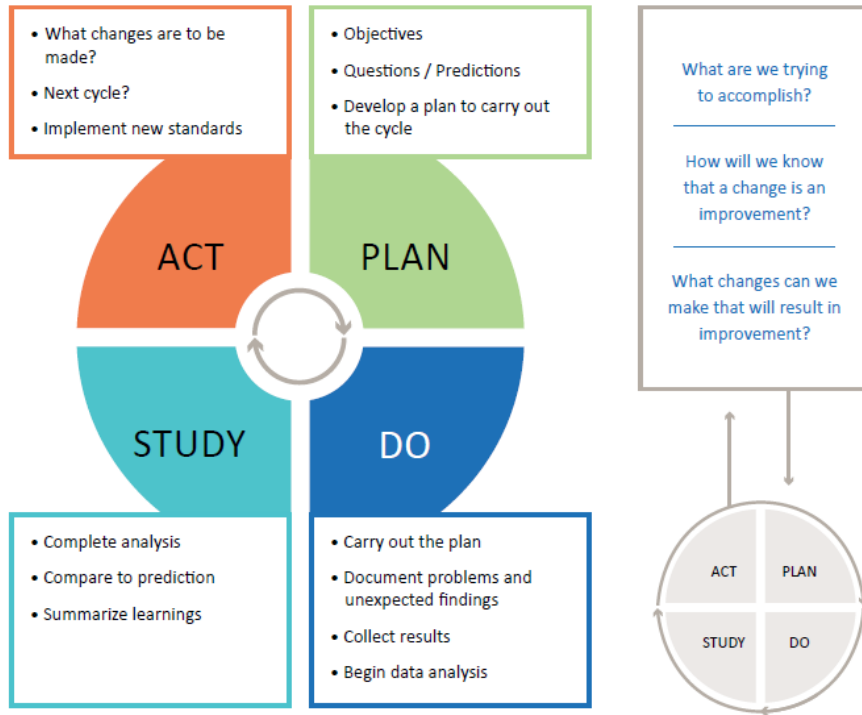
The PDSA cycle is an interactive, four-stage problem solving model used for improving a process or carrying out a change. The PDSA process can be used to test a change in the in the real work setting. The four stages are:

- **Plan:** Recruit a team, draft an aim statement, describe current context and process, describe the problem, and identify causes and alternatives
- **Do:** Implement action plan
- **Study:** Determine if the plan resulted in an improvement
- **Act:** Standardize a positive change, or do another PDSA cycle if negative change

#### **EXAMPLE**

- **Plan:** Develop new patient education binder and provide it and a bag to carry it in to five stroke patients being discharged from hospital to home
- **Do:** Education binder and bag given to five patients and asked to read it and bring to follow-up appointments
- **Study:** Patients were asked at follow-up appointments if they read and used binder and four out of five said yes. Three out of four brought it to the appointment
- **Act:** Continue to provide patient education binder and bag to patient and discuss with family members to see if this increases use and bringing it to appointments.

The PDSA cycle is the scientific method, used for action-oriented learning.



**Blank Template: PDSA Worksheet**

Source: <http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

**Action Plan Implementation:**

- Now the plan of action is complete and your team can begin their work!
- Use the plans to keep track of your projects and make adjustments as needed!

## Chapter 3: Transitions of Care QI Project Ideas

To assist you in generating ideas for transitions of care quality improvement projects, examples from the literature and from projects implemented by Minnesota hospitals described below. They are organized by the following practice areas:

1. Transition from Hospital to Home and Outpatient Clinics: Focus on use of quality metrics, inter-professional/multidisciplinary team, communication, coordination, discharge planning, transition of care plan, health equity, leverage technology
2. Transition to Community and Post-Discharge Follow-up: Focus on follow-up appointments, post-discharge follow-up, transition of care plan, leverage technology
3. Provider Education: Focus on education of primary care providers that includes nuances of stroke care and the provision of culturally and linguistically appropriate care
4. Patient and Caregiver Education and Engagement: Focus on ensuring processes are in place to engage patients, family, and other caregivers, elevate their status as essential members of the team and prepare them for managing care at home
5. Medication Reconciliation and Management: Focus on medication reconciliation and medication therapy management

Within each practice area you will find:

- Examples of Gaps and Challenges
- Guiding Statements for Successful Transitions
- Examples of Quality Improvement Projects

### 1. Transition from Hospital to Home

#### Gaps and Challenges

- Patients return to emergency department or are readmitted too frequently.
- Team-based care does not exist.
- Identifying and tracking all stroke and TIA patients is difficult.
- Poor communication between patient's providers, especially those using different electronic health record systems.
- Transitions plans do not consider issues around health equity or take social determinants of health into consideration.
- Patients do not have a blood pressure cuffs at home and/or do not know how to use one.
- Patients do not have a primary care physician or the name of their physician.

- Patient has multiple care providers and is unsure who is in charge.
- Primary care providers do not receive hospital medical records before the follow-up appointment.

## Guiding Statements for Successful Transitions

- An **inter-professional team** will provide care both within the hospital and after discharge.
- Efficient **Communication** occurs across the care continuum engaging clinical, non-clinical and community services.
- A focus on **patient-centered care** makes it easier for patients to continue to improve after they return home.
- A **comprehensive discharge** plan considers patients and family needs.
- **Transition plans** are in place and followed so that the patient's care is **coordinated**.
- The **geographic location** of where the patient lives and was treated for their stroke must be taken into consideration when making decisions about transitional care.
- The care model supports seamless care that includes access to **appropriate and timely services**.
- **Health equity** in care means that there is equity in health outcomes for all people regardless of their race, age, mental health, sexual orientation, economic status, geographic location, disability or gender identity, etc. A focus on health equity means that as we develop policies and procedures to improve transitions of care we consider if they might differentially impact (positively and negatively) certain population groups. This examination can be used to make changes that intentionally benefit all populations and especially those that experience health inequities.
- **Leverage technology** to improve patient care and outcomes, e.g., optimize EHR utilization and use of telehealth.

## Sample Quality Improvement Projects

### Use of Quality Metrics

1. Conduct root cause analysis of problems.
2. Implement blood pressure cuff distribution and education project to hospital patients to foster self-monitoring in their home.

### Inter-professional/Multidisciplinary team

3. Map team members' roles and responsibilities to identify gaps and solutions related to transitions of care.
4. Implement a unit-based, multi-disciplinary rounding process for care providers to review patients' care needs and transition plans at their bedsides. Patients, families and other caregivers should be included.

### Communication

5. Improve communication between hospital and primary care providers. Interventions may include processes for transferring information, providing discharge summaries in a timely manner, defining accountability for care, and methods for direct provider communication.

6. Develop work flows and order sets for the transition of care for patients whose primary provider is within or outside discharging health system.

#### Coordination

7. Coordinate patient care plans between hospital and clinic care coordinators.
8. Implement feedback loop from hospital to the patient's post-discharge providers so they have access the patient's medical records prior to the follow-up appointment.
9. Add Stroke Navigator position to conduct post-discharge follow-up phone calls within 72 hours, 14 days and at 30-days post discharge or at other times as needed.

#### Discharge Planning

10. Develop a work flow for discharge planning that begins soon after stroke admission and continues to post-discharge follow-up.
11. Create a comprehensive discharge plan that can be in a written, visual or recorded format. It should include but not be limited to final clinical diagnosis, follow-up appointments, medications, nutritional needs, family support, transportation concerns, health literacy status, personal risk factors, and knowing whom to call if they have questions or concerns.
12. Develop a system to risk screen patients and tailor post-discharge follow-up to patient risk. Implement a process to schedule a follow-up appointment for TIA patients prior to leaving the emergency department (patients not admitted or held for observation).

#### Transitions of Care Plan

13. Develop a specific stroke transitions of care plan in the EHR that is electronically sent from the hospital to the patient's primary care clinic upon discharge.
14. Measure the percent of stroke and TIA patients discharged from the hospital whose transitions of care summary plan was sent to primary care clinic "opened" at the clinic prior to the patient's first follow-up appointment.
15. Standardize transition plans, procedures, and forms for stroke and TIA patients.

#### Health Equity

16. Include in workflow a process to review policies through a health equity lens.
17. Include patient screening for impact of social determinants of health.

#### Leverage technology

18. Use EHR (in-basket if using Epic) to notify primary care provider that a patient has had a stroke and is being discharged.
19. Develop system for stroke coordinator to be able to identify confirmed stroke and TIA patients needing follow-up.

### **Resources and References**

General Resources, Collaboration and Communication; Team-based Care, Discharge Planning, Follow-up Post Discharge, Health Equity, Leverage Technology

## 2. Transition to Community and Post-discharge follow-up

### Gaps and Challenges

- Patients face challenges with transportation, food insecurity, poor housing, or lack of social supports.
- Patients have multiple follow-up appointments and they do not know they need to attend all of them.
- Access to specialists like a physical and rehabilitation physician or neurologist may be limited due to geographic distance from providers or lack of available appointment openings, leading long delays in post-discharge appointments.
- Primary and Comprehensive Stroke Centers do not know what services are available for patients in rural communities or at Acute Stroke Ready Hospitals.
- No system to track if patients attended their follow-up appointments.
- Insufficient coordination and information sharing between the hospital and community care providers.
- Patients referred to home health services, but do not actually receive services.
- No communication to transferring hospital about when patient was discharged or whether a follow-up appointment has been scheduled.
- Primary care providers are unaware that their patient had a stroke or that their patient has been discharged and needs follow-up.

### Guiding Statements for Successful Transitions

#### Transition to outpatient clinics

- Systems are in place to assist in the transfer of patient records and patient care from hospital to clinics and community.
- For stroke patients going home after discharge, processes and mechanisms are in place in the emergency department, acute care, primary care, rehabilitation settings, and community settings to address efficient communication between settings and healthcare providers.
- Transition of care programs implemented should be evidence or practice based (e.g., Project Red, RARE, Care Transitions Program®).

#### Post-discharge follow-up

- Ensure that transition plans are in place and followed so that the patient's care is coordinated between one caregiver and another. Interventions may include use of care coach, transition coordinator or stroke navigator.
- The geographic locations of where the patient lives and where the patient was treated for their stroke must be taken into considerations when making decisions about transitional care and services.

- The care model will support seamless care by ensuring access to appropriate and timely services.
- Patients should receive follow-up calls at several touch points post discharge, i.e., within 72 hours, at two weeks, at 30-days.
- At the post-discharge follow-up appointment, the primary care provider will discuss warning signs, patient’s personal risk factors for stroke, when to call, diet, daily activities, a list of things to follow and things to avoid. It is also an opportunity to discuss end of life planning, assess social barriers, reinforce and adjust the plan of care as necessary and also to perform medication reconciliation and medication management.

## Sample Quality Improvement Projects

### Follow-up Appointments

1. Create and implement a system for scheduling follow-up appointment prior to discharge from acute care during regular hours and when patient is discharged during off-hours. System might include referral to clinic scheduling using the EHR followed by a call to the patient to schedule the appointment.
2. Include in patient discharge summary the date and time of post-discharge follow-up appointment and the name of the provider.
3. Review data to assess if patients are receiving the follow-up services included in their discharge plan such as home care.
4. Create and implement a system to provide timely feedback after discharge from the hospital that received a patient for specialist care to the hospital that transported the patient and include the name of primary care provider and if a follow-up appointment was scheduled the time and data of appointment.

### Post-discharge follow-up

5. Implement Transitions Care Management (TCM) for Medicare patients.
6. Hospitals should develop a process for contacting patients and/or their caregivers post-discharge. Needs that may be addressed include assistance with medication reconciliation, scheduling primary care visits, and addressing non-medical issues.
7. Complete the "Touchpoints after Stroke" chart to determine who is calling patients when and then adjust call timing to avoid duplication.
8. Add “Quality of Life” screening tool to post-discharge follow-up at two points such as 7 days post discharge and 30 days post-discharge.
9. Adapt the patient “Post-Stroke Checklist” and use at clinic follow-up appointments.
10. Implement process to improve warm-handoffs between social services and stroke clinic staff.
11. Conduct post-discharge follow-up with stroke patients at 72 hours, 14 days or 30 days post-discharge. Follow-up can be conducted in a variety of locations (e.g., hospital, primary care clinic, specialty clinic, community paramedicine agency) and by a variety of staff (e.g., nurses, advanced practice nurses, stroke navigators, quality staff, community health workers, community paramedics or physician assistants, care coach, stroke navigator).
12. Use a standardize script during post-discharge follow-up calls.



13. Develop work flow to document post-discharge follow-up.
14. Include community health workers as part of team-based care to improve attendance at follow-up appointments, navigating and accessing community services, and providing patient education.
15. Add screening for falls to hospital, clinic and follow-up assessments.
16. Home visits can be provided post-discharge by home health, public health, community paramedics, community health workers, or community pharmacists. They can assess for risk factors that lead to unnecessary emergency department visits or readmissions such as fall assessment, medication reconciliation and management, and screening on social determinants of health.

#### Transitions of Care Plan

17. Develop a specific stroke transitions of care plan in the EHR that is electronically sent from the hospital to the patient's primary care clinic upon discharge; plan should include information about patient's stroke and plan for follow-up care – including reasons for any medication changes.
18. Measure the percent of stroke and TIA patients discharged from the hospital whose transitions of care summary plan was sent to primary care clinic "opened" at the clinic prior to the patient's first follow-up appointment.
19. Standardize transition plans, procedures, and forms for stroke and TIA patients.

#### Leverage Technology

20. Optimize use of telehealth for providing post-discharge patient follow-up appointments with neurologists, primary care providers and other providers as appropriate.
21. Use technology for patient education such as tablets/iPads and apps
22. Include a social determinants of health screening tool in the EHR and tracking of appropriate referrals.
23. Use e-health (patient portal) to stay in contact with patient and manage their care.
24. Build the transitions of care summary into the hospital EHR and set up a system so that it is sent to the patient's primary care provider electronically.
25. Incorporate patient referrals to Minnesota Stroke Association/Minnesota Brain Injury Alliance Resource Facilitation Program into discharge work flows.

### Resources

[Collaboration and Communication; Team-based Care, Discharge Planning, Follow-up Post Discharge, Leverage Technology, Patient and Family Engagement](#)

## 3. Provider Education

### Gaps and Challenges

- Primary care providers lack knowledge in nuances of stroke care and secondary prevention.
- Providers need training in the provision of culturally and linguistically appropriate care.

## Guiding Statements for Successful Transitions

- Implement culturally and linguistically appropriate care i.e., Culturally and Linguistically Appropriate Services (CLAS) standards: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and communication needs.
- A focus on health equity means that as we develop policies and procedures to improve transitions of care we consider if they might differentially impact (positively and negatively) certain population groups such as populations of color or American Indians. This examination can be used to make changes that intentionally benefit all populations and especially those that experience health inequities.

## Sample Quality Improvement Projects

1. Increase the number of stroke and TIA patients discharged from the hospital to home that have had a teach-back session with the nurse prior to discharge.
2. Increase collaboration between stroke neurologists, hospitalists, and primary care teams.
3. CLAS standards are implemented and followed.
4. Neurologists and primary care providers collaborate to develop training for primary care providers within their health system on stroke and stroke follow-up care.
5. Trainings on shared decision-making and team-based care are offered.
6. Train staff in motivational interviewing techniques.

## Resources

[Collaboration and Commination; Team-based Care, Health Equity, Provider Education](#)

# 4. Patient and Caregiver Education and Engagement

## Gaps and Challenges

- Patients feel bombarded with information, and find it difficult to sort out what is important.
- Patients don't always understand the discharge instructions.
- Family members are not provided education about stroke or their family member's needs.
- Discharge summary is not easy for patients to understand.
- Not all patients are able to adhere to follow-up recommendations.

## Guiding Statement for Successful Transitions

- Support a holistic approach to care and education that considers the patient's and caregiver's physical, emotional, psychological, linguistic and cultural needs, and their environment.
- Patient experience should be taken into consideration so that their needs can be appropriately addressed.
- It is important to assess each patient's activation level and tailor teaching approaches to the patient's level.

- Provide “right- time” education that reflects individualized topics of interest, considers health literacy levels and supports a person's ability to identify and address barriers, enabling self-management and patient’s readiness to hear the information.
- Providers need to support patients and families in making informed decisions about care and treatments using a shared-decision making process.
- Promote stroke patient and caregiver autonomy and empowerment by engaging them in all aspects of goal setting and care planning.

## Sample Quality Improvement Projects

1. Focus on patient engagement through counseling on medication management, individual risk factors, disease-specific management strategies, and resources for addressing post discharge concerns.
2. Utilize teach-back method. It is important for staff to ensure that patients understand the information they have been given. The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understands.
3. Review patient education materials to see if they meet health literacy and plain language standards. Plain language is a strategy for making written and oral information easier to understand and an important tool for improving health literacy.
4. Staff can be trained to use “Ask Me 3” framework to increase patient engagement and assist with improving health literacy.
5. Incorporate patient input into your change process.
6. Coordinate and standardize patient education across the health care settings and at all “touchpoints.”
7. Implement best practice tobacco cessation initiative based on the United States Public Health Service Guideline, Treating Tobacco Use and Dependence – 2008 Update, otherwise known as the “5 A’s” model. <http://clearwaymn.org/wp-content/uploads/2013/02/FINAL-Essentia.pdf>
8. Increase the number of patients that understand their individual risk factors for stroke prior to discharge.
9. Use e-health to manage patient information and stay in contact with patients.
10. Use technology for patient education such as tablets/iPads and apps.
11. Develop programs to help assure health equity in care.

## Resources

[Advance Care Planning](#), [Health Equity](#), [Leverage Technology](#), [Patient and Family Engagement](#)

# 5. Medication Reconciliation and Management

## Gaps and Challenges

- Keeping medication lists up-to-date in the medical record as patients transition between care settings.
- Lack of communication between providers regarding reasons for a medication change.
- Patients do not understand what medications they should be taking or how to take them.

- Patients do not refill medications.
- Families are not prepared or able to assist patient with the medications.

### **Guiding Statement for Successful Transitions**

- Medication Reconciliation and Management should be implemented in all stages of transitions of care from initial hospital contact through when the patient is home. The focus should be on improving the use of medications' for the patient's condition, that the patient understands the purpose of the medication and is taking them as prescribed.

### **Sample Quality Improvement Projects**

1. Implementing medication reconciliation and management program in-person or by phone within 30 days post-discharge.
2. On first follow-up appointment, patient is asked to bring all medication (prescription and non-prescription) to the clinic in a "brown paper bag" for review prior to seeing provider.
3. A pill box is provided to each stroke patient upon discharge from the hospital.
4. Medication list is reconciled on each transfer and at each follow-up appointment.
5. All patients with complex medications are referred for Medication Therapy Management in the in-patient and outpatient setting.
6. Include medication reconciliation and adherence questions as part of the 30-day follow-up phone call.

### **Resources**

Health Equity, Medication Reconciliation and Management, Patient and Family Engagement

## Chapter 4: Post-discharge Follow-up and Data Collection

Many hospitals and their health care partners follow up with patients within 30 days post-discharge. As a participant in the Minnesota Stroke Program, hospitals (or affiliated clinics) are asked to voluntarily collect case-level data at approximately 30 days post-discharge on stroke patients discharged from hospital to home. For most facilities, the follow-up contact at that time will be by telephone. However, it could also be during a home visit by a community paramedic or the patient could complete part of the survey in their patient health portal. Structured post-discharge survey tools have been developed with consideration to guidelines and evidence-based strategies for transitions of care practices for acute stroke patients from hospital to home.

The 30-day post-discharge follow-up has two purposes:

- **To assess patient health status and follow up care coordination between all service lines.**
- **To collect data on key indicators related to patient's health status, post-discharge care and outcomes.** MDH will work with the hospital to find a method for submitting their case-level data. Options include but are not limited to: entering data into a survey instrument unique to the hospital and exporting data to MDH; building the survey into your EHR and exporting data to MDH; entering the data into the Minnesota Stroke Registry or using American Heart Association's Get With The Guidelines-Stroke™ Patient Management Tool operated by IQVIA. For these methods, patient-level data are abstracted (collected) in the same way and entered into the appropriate tool.

Once the data is collected, the aggregated patient-level data from the follow-up helps facilities ensure continuous improvement of stroke care by aligning clinical care and processes with the guidelines. It can be used to find opportunities for improvement and to implement QI activities. Patient data should be reviewed regularly by the stroke coordinator and others as appropriate.

Below are examples of quality improvement projects that might improve the status on quality metrics developed by the Centers for Disease Control and Prevention. Your hospital can also develop their own quality metrics to track for successes and the need for improvement.

## Post-Hospital Quality Data Measures (CDC)

Post-hospital quality performance measures		Examples of QI Projects
1	% of patients identified as tobacco users on hospital admission for acute stroke who are still using tobacco at 30-days post hospital discharge	<ol style="list-style-type: none"> <li>1. Develop process for referring patients who smoke to statewide QUITPLAN Helpline or hospital/health plan based programs</li> <li>2. Offer smoking cessation medication to smokers who want to stop smoking</li> <li>3. Integrate best practice tobacco dependence treatment into work flows: standardized tobacco user identification, documentation, brief intervention, and referral practices based on best practices in tobacco cessation. (Known as 5's)</li> </ol> <p><b>Resources:</b></p> <ol style="list-style-type: none"> <li>1. Example from Essentia Health Care: <a href="https://www.essentiahealth.org/services/tobacco-cessation/">https://www.essentiahealth.org/services/tobacco-cessation/</a> and Clearway MN™ <a href="http://clearwaymn.org/wp-content/uploads/2013/02/FINAL-Essentia.pdf">http://clearwaymn.org/wp-content/uploads/2013/02/FINAL-Essentia.pdf</a></li> <li>2. United States Public Health Service Guideline, Treating Tobacco Use and Dependence – 2008 Update, otherwise known as the “5 A’s” model. Example from Essentia Health <a href="http://clearwaymn.org/wp-content/uploads/2013/02/FINAL-Essentia.pdf">http://clearwaymn.org/wp-content/uploads/2013/02/FINAL-Essentia.pdf</a></li> </ol>
2	% of stroke patients who were seen in the ED within 30 days of hospital discharge	<ol style="list-style-type: none"> <li>1. Incorporate discharge planning into work flow and start immediately upon admission</li> <li>2. Implement post-discharge follow-up phone call within 72 hours of discharge</li> <li>3. Add Stroke Navigator position at the hospital to conduct post-discharge follow-up phone calls within 72 hours and at 30-days post discharge. Helps assure post-discharge appointments are made and kept</li> <li>4. Use telehealth at the clinic for patient care follow-up with neurology, primary care providers and others as appropriate</li> </ol> <p><b>Resources:</b> CentraCare Health Telestroke/Vascular Neurology Clinic <a href="https://www.centracare.com/about-us/news-publications/news/2018/centracare-health-to-expand-telestrokevascular-neurology-clinic/">https://www.centracare.com/about-us/news-publications/news/2018/centracare-health-to-expand-telestrokevascular-neurology-clinic/</a></p>
3	% of stroke patients checking BP outside of their healthcare provider office visits (at home or in the community)	<ol style="list-style-type: none"> <li>1. Blood pressure cuff distribution and education project to hospital patients prior to discharge</li> <li>2. Utilize Community Health Workers to conduct post-discharge follow-up with patients in the clinic and/or their homes</li> <li>3. Utilize Community Paramedics to conduct post-discharge follow-up with patients in the home and/or by phone</li> </ol> <p><b>Resources:</b></p> <ol style="list-style-type: none"> <li>1. Million Hearts <a href="https://millionhearts.hhs.gov/">https://millionhearts.hhs.gov/</a></li> <li>2. Resources and References Section: <a href="#">Home Blood Pressure Monitoring</a></li> </ol>
4	% of stroke patients reporting 2 or more falls within 30 days of discharge	<ol style="list-style-type: none"> <li>1. Include fall assessment as part of home visit.</li> <li>2. Screen patients for falls within the hospital and clinic and on follow-up calls</li> </ol> <p><b>Resources:</b></p> <ol style="list-style-type: none"> <li>1. Minnesota Department of Health. <a href="http://www.health.state.mn.us/injury/links.cfm?GcLink=Fall">http://www.health.state.mn.us/injury/links.cfm?GcLink=Fall</a></li> <li>2. Centers for Disease Control and Prevention. <i>A Home Fall Prevention Checklist for Older Adults</i>. <a href="https://www.cdc.gov/HomeandRecreationalSafety/pubs/English/booklet_Eng_desktop-a.pdf">https://www.cdc.gov/HomeandRecreationalSafety/pubs/English/booklet_Eng_desktop-a.pdf</a> STEADI – Stopping Elderly Accidents, Deaths and Injuries <a href="https://www.cdc.gov/steady/materials.html">https://www.cdc.gov/steady/materials.html</a></li> </ol>

Post-hospital quality performance measures		Examples of QI Projects
		3. Minnesota Hospital Association. <i>Quality and Patient Safety; Preventing Patient Falls</i> . <a href="https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-initiatives/falls#/videos/list">https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-initiatives/falls#/videos/list</a>
5	% of stroke patients who stopped taking medications within 30 days of discharge without being told to do so by their medical provider	<ol style="list-style-type: none"> <li>1. Train staff in motivational interviewing techniques</li> <li>2. Improve patient education materials and make consistent across settings</li> <li>3. Include in 30-day post-discharge follow-up phone calls questions to address medication adherence</li> <li>4. Implement team-based care. Pharmacists can be integrated into the care team</li> </ol> <p><b>Resources:</b></p> <ol style="list-style-type: none"> <li>1. Care Transitions Program. <i>Medication Discrepancy Tool (MDT®)</i> <a href="http://caretransitions.org/wp-content/uploads/2015/08/MDT.pdf">http://caretransitions.org/wp-content/uploads/2015/08/MDT.pdf</a></li> <li>2. Minnesota Department of Health. <i>Team-based Care</i>. <a href="http://www.health.state.mn.us/divs/healthimprovement/programs-initiatives/in-healthcare/pharmacist.html">http://www.health.state.mn.us/divs/healthimprovement/programs-initiatives/in-healthcare/pharmacist.html</a></li> <li>3. Resources and References Section: <u>Medication Reconciliation and Management</u></li> </ol>
6	% of stroke patients that had a follow-up appointment scheduled prior to discharge	<ol style="list-style-type: none"> <li>1. Establish system for making follow-up appointment prior to discharge and system to remind patient to attend appointment</li> <li>2. Create and implement a system for scheduling patient follow-up appointments when patient is discharged during off-hours.</li> <li>3. Include follow-up appointment information on patient discharge summary</li> <li>4. Receiving hospital Includes follow-up appointment information on feedback sent to transporting hospital</li> </ol> <p>Resources:</p> <ol style="list-style-type: none"> <li>1. Reducing Avoidable Readmissions Effectively (RARE) Campaign; Summary Report: <a href="http://www.rarereadmissions.org/areas/transcare.html">http://www.rarereadmissions.org/areas/transcare.html</a></li> <li>2. Resource and References Section: <u>General Resources and Follow-up Post-Discharge</u></li> </ol>
7	% of stroke patients who were readmitted to a hospital within 30 days of discharge	<ol style="list-style-type: none"> <li>1. Obtain data on 30-day readmission rates and identify the root cause of patient readmissions within that time period</li> <li>2. Develop a stroke specific transitions of care summary in the electronic health record that is shared between providers</li> </ol> <p>Resources:</p> <ol style="list-style-type: none"> <li>1. Agency for Healthcare Research and Quality. <i>Hospital Guide to Reducing Medicaid Readmissions</i>. <a href="https://www.ahrq.gov/sites/default/files/publications/files/medread-tools.pdf">https://www.ahrq.gov/sites/default/files/publications/files/medread-tools.pdf</a></li> <li>2. <i>Reducing Readmissions After Stroke With a Structured Nurse Practitioner/Registered Nurse Transitional Stroke Program</i> (Stroke. 2016;47:1599-1604. <a href="https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.115.012524">https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.115.012524</a></li> </ol>
8	% of stroke patients discharged to home who have died by 30 days	<ol style="list-style-type: none"> <li>1. Obtain data on 30-day mortality rates and identify the root cause of patient deaths within that time period</li> </ol> <p>Reference</p> <ol style="list-style-type: none"> <li>1. Langhorne, P., Taylor, G., Murray, G., Dennis, M., Anderson, C., Bautz-Holter, et al. (2005). Early supported discharge services for stroke patients: A meta-analysis of individual patients data. <i>The Lancet</i>,365(9458), 501-506. <a href="https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)17868-4/fulltext">https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)17868-4/fulltext</a></li> </ol>

# Resources and References

## General Resources

1. Better Outcomes for Older Adults through Safe Transitions (BOOST) <https://www.hospitalmedicine.org/clinical-topics/care-transitions/>
2. *Health Care Home Care Coordination: Toolkit for Working with Persons with Complex Needs and Older Adults*; August 2013, updated January 2015. [http://mn4a.org/wp-content/uploads/HCH-Clinic-Coordinator-Toolkit\\_3-19-15\\_ADA-FINAL.pdf](http://mn4a.org/wp-content/uploads/HCH-Clinic-Coordinator-Toolkit_3-19-15_ADA-FINAL.pdf)
3. National Transitions of Care Coalition. Healthcare Professionals, Available Tools and Resources. <http://www.ntocc.org/WhoWeServe/HealthCareProfessionals.aspx>
4. Project RED (Re- engineered Discharge) <https://www.bu.edu/fammed/projectred/>
5. Reducing Avoidable Readmissions Effectively (RARE) Campaign; Summary Report [http://www.rarereadmissions.org/documents/RARE\\_Recommended\\_Actions\\_Care\\_Transitions.pdf](http://www.rarereadmissions.org/documents/RARE_Recommended_Actions_Care_Transitions.pdf) ; Best Practices/Strategies for Transitions of Care <http://www.rarereadmissions.org/areas/transcare.html>
6. The Care Transitions Program© <https://caretransitions.org/>

## References:

1. Camicia, M., & Lutz, B. J. (2016). Nursing's Role in Successful Transitions Across Settings. *Stroke*,47(11). <https://www.ahajournals.org/doi/abs/10.1161/strokeaha.116.012095>
2. Kernan, W. N., Ovbiagele, B., Black, H. R., Bravata, D. M., Chimowitz, M. I., Ezekowitz, M. D., et al. (2014). Guidelines for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack. *Stroke*,45(7), 2160-2236.
  - a. Executive Summary accessed at: [https://stroke.ahajournals.org/content/suppl/2014/05/01/STR.0000000000000024.DC1/Executive\\_Summary.pdf](https://stroke.ahajournals.org/content/suppl/2014/05/01/STR.0000000000000024.DC1/Executive_Summary.pdf)
  - b. [https://professional.heart.org/professional/ScienceNews/UCM\\_423868\\_Update-to-the-AHAASA-Recommendations-for-Secondary-Stroke-Prevention.jsp](https://professional.heart.org/professional/ScienceNews/UCM_423868_Update-to-the-AHAASA-Recommendations-for-Secondary-Stroke-Prevention.jsp)
3. Prvu-Bettger J, McCoy L, Smith EE, Fonarow GC, Schwamm LH, Peterson ED. Contemporary Trends and Predictors of Post-acute Service Use and Routine Discharge Home After Stroke. *Journal of the American Heart Association: Cardiovascular and Cerebrovascular Disease*. 2015;4(2):e001038. doi:10.1161/JAHA.114.001038.
4. The Joint Commission. Hot Topics in Health Care - Transitions of Care: The need for a more effective approach to continuing patient care. June 2012 [http://www.jointcommission.org/assets/1/18/Hot\\_Topics\\_Transitions\\_of\\_Care.pdf](http://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf)

## Project Planning Steps

1. Gap analysis tools from RARE (Reducing Avoidable Readmissions Effectively): Care Transitions Support – Gap analysis form [http://www.rarereadmissions.org/documents/Gap\\_analysis\\_care\\_transitions.doc](http://www.rarereadmissions.org/documents/Gap_analysis_care_transitions.doc)
2. Minnesota Department of Health. Quality Improvement Toolbox <http://www.health.state.mn.us/divs/opi/qi/toolbox/>



## References

1. CFMC the Medicare Quality Improvement Organization for Colorado. Engaging Physicians in Improving Care and Transitions and Reducing Readmissions: A Practical Guide for QIO's. Retrieved 9/4/18  
<https://caretransitions.org/wp-content/uploads/2015/07/Engaging-Physicians.pdf>
2. The Commonwealth Fund: In Focus: Improving Patient Flow—In and Out of Hospitals and Beyond <https://www.commonwealthfund.org/publications/newsletter/focus-improving-patient-flow-and-out-hospitals-and-beyond>

## Advance Care Planning

1. Honoring Choices Minnesota. <https://www.honoringchoices.org/>
2. Minnesota Board on Aging. Advanced Care Planning. <http://www.mnaging.net/Advisor/HealthCareDirective.aspx>
3. Minnesota Department of Health. Questions and Answers about Health Care Directives. <http://www.health.state.mn.us/divs/fpc/profinfo/advdir.htm>

## Collaboration and Communication; Team-based Care

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## Discharge Planning

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2. Canadian Stroke Best Practice Recommendations. (April 2016) Checklist of Core Discharge Summary Information  
<http://www.strokebestpractices.ca/transitions/interprofessional-communication/> or  
<http://www.strokebestpractices.ca/wp-content/uploads/2013/10/box3.pdf>
3. IDEAL Discharge Planning Overview, Process, and Checklist  
[https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4\\_Tool\\_1\\_IDEAL\\_chklist\\_508.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklist_508.pdf)
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- Minnesota Health Literacy Partnership. Site offers a variety of trainings and presentations to help educate individuals and health professionals about the importance of health literacy. <http://healthliteracymn.org/resources/presentations-and-training>
- The *National Culturally and Linguistically Appropriate Services (CLAS) Standards* from the Office of Minority Health at the U.S. Dept. of Health and Human Services. Standards are a set of 15 action steps and provide a blueprint for individuals, health, health care organizations to implement culturally, and linguistically appropriate services. CLAS is about respecting the whole individual and responding to the individual's health needs and preferences. <https://www.thinkculturalhealth.hhs.gov/clas>
- The Joint Commission
- This document compares the CLAS standards to The Joint Commission's 2015 Standards for the *Hospital Accreditation Program* <https://www.jointcommission.org/assets/1/6/Crosswalk-CLAS-20140718.pdf>
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## Leverage Technology

CentraCare Health – Telestroke/Vascular Neurology Grant -

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2. RARE Campaign: Patient and Family Engagement; <http://www.rarereadmissions.org/areas/dischargeprep.html>
3. RARE Campaign: *Gap Analysis: Patient and Family Engagement Gap Analysis* [http://www.rarereadmissions.org/documents/Gap\\_analysis\\_patient\\_family\\_engagement.doc](http://www.rarereadmissions.org/documents/Gap_analysis_patient_family_engagement.doc)
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5. Section 4, Tool 14, Supportive Communication <https://www.stratishealth.org/documents/HITToolkitcoordination/4-Supportive-Communications.pdf>

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## Patient Resources

1. AHA on-line support network [heart.org/supportnetwork](http://heart.org/supportnetwork);
2. Disability HUB Minnesota. <https://disabilityhubmn.org/>
3. Mayo Clinic website: Diagnosis and Treatment, Stroke Recovery and Rehabilitation. <https://www.mayoclinic.org/diseases-conditions/stroke/diagnosis-treatment/drc-20350119>
4. Minnesota Board on Aging and Area Agencies on Aging. Senior Linkage Line. <http://www.seniorlinkageline.com/>
5. Minnesota Stroke Association/Brain Injury Alliance Resource Facilitators provide free, two-year telephone support assisting people in navigating life after stroke as they transition back to family life, work, school and community. Individuals can be referred by a professional or self-refer at any time. Provides access to bilingual staff and access to interpreters. <https://www.braininjurymn.org/support/resourceFac.php>

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## Home Blood Pressure Monitoring

National Association of Community Health Centers (NACHC). Patient- friendly video demonstrates proper use of home blood pressure monitors. [View NACHC Video](https://www.youtube.com/watch?v=BAAdYc-5uc0)  
<https://www.youtube.com/watch?v=BAAdYc-5uc0>

## Provider follow-up resources

1. Post-Stroke Checklists
  - a. Post-Stroke Checklist for Patients. This checklist was mentioned during the meeting. It was developed by the Global Stroke Community Advisory Panel (GSCAP) and endorsed by the World Stroke Organization.
  - b. National Stroke Association <http://www.stroke.org/stroke-resources/library/post-stroke-checklist-survivors-and-caregivers>
  - c. Article describing tool development FYI: Development of a Post stroke Checklist to Standardize Follow-up Care for Stroke Survivors; Philp, Ian et al. *Journal of*

Stroke and Cerebrovascular Diseases, Volume 22, Issue 7, e173 - e180. Accessed 3/7/17 at [http://www.strokejournal.org/article/S1052-3057\(12\)00360-6/fulltext](http://www.strokejournal.org/article/S1052-3057(12)00360-6/fulltext)

2. Stroke Specific Quality of Life Scale (SS-QOL): [https://www.strokengine.ca/en/family/ssqol\\_family/](https://www.strokengine.ca/en/family/ssqol_family/)
3. Fall prevention
  - a. Centers for Disease Control and Prevention. A Home Fall Prevention Checklist for Older Adults. [https://www.cdc.gov/HomeandRecreationalSafety/pubs/English/booklet\\_Eng\\_desktop-a.pdf](https://www.cdc.gov/HomeandRecreationalSafety/pubs/English/booklet_Eng_desktop-a.pdf)  
STEADI – Stopping Elderly Accidents, Deaths and Injuries  
<https://www.cdc.gov/steady/materials.html>
  - b. Minnesota Department of Health  
<http://www.health.state.mn.us/injury/links.cfm?GcLink=Fall>
  - c. Minnesota Hospital Association. Quality and Patient Safety; Preventing Patient Falls. <https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-initiatives/falls#/videos/list>

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#### Provider Education

1. Motivational Interviewing: Building a Foundation for Effective Patient Engagement: [Video](#) and [Handout](#): [Lake Superior Quality Innovation Network](#). Mia Croyle Presenter, July 2017
2. Shared Decision Making – Training Learners will explore shared decision making, a model of patient-centered care. Topics include defining and describing the shared decision making approach, when and how to make use of shared decision making, and what steps should be taken when implementing this model in your organizational setting. This online course was developed in partnership with Stratis Health. Register on the [MDH Learning Management System](#).

#### References:

1. Darves, B. 2009. Collaboration key to post-stroke follow-up. ACP Internist. <https://acpinternist.org/archives/2009/10/stroke.htm>
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## Appendix 1: MDH Learning Project: Transitions of Care for Stroke Patients

In 2017, the Minnesota Department of Health Stroke Program convened a Learning Project to create shared learnings on transitions of care for stroke patients. It focused on patients from urban areas and the special needs of patients from rural communities who began treatment in a community hospital and were transferred to a larger hospital with specialists, and then came back home to be cared for by their local doctors. Incorporated into the Learning Project were lessons learned from the transitions of care pilot projects implemented in several areas of Minnesota. The information gleaned from the Learning Project are woven throughout this toolkit.

The Learning Project began by reviewing evidence-based and promising transitions of care models found in the literature. Many of these evidence-based models focus on reducing readmissions or improving transitions for multiple diseases and conditions. These models form the foundation for stroke specific transitions of care programs.

The following are commonly referenced models that have been supported by research and evaluation:

1. **Project RED (Re- engineered Discharge)** <https://www.bu.edu/fammed/projectred/>
2. **Reducing Avoidable Readmissions Effectively (RARE) Campaign; Summary Report** [http://www.rarereadmissions.org/documents/RARE\\_Recommended\\_Actions\\_Care\\_Transitions.pdf](http://www.rarereadmissions.org/documents/RARE_Recommended_Actions_Care_Transitions.pdf) ; Best Practices/Strategies for Transitions of Care <http://www.rarereadmissions.org/areas/transcare.html>
3. **The Care Transitions Program©** <https://caretransitions.org/>
4. **Better Outcomes for Older Adults through Safe Transitions (BOOST)** <https://www.hospitalmedicine.org/clinical-topics/care-transitions/>

The Joint Commission's June 2012 Report, "*Hot Topics in Health Care - Transitions of Care: The need for a more effective approach to continuing patient care*" summarizes the care transition models and offers elements that improve patient outcomes ([The Joint Commission, 2012](#)).

A promising stroke specific model is described in the 2016 article *Reducing Readmissions after Stroke with a Structured Nurse Practitioner/Registered Nurse Transitional Stroke Program* and shows how a nurse practitioner structured clinic is a model that may reduce readmission at 30 – days post discharge ([Condon et al. 2016](#)).

Learning Project participants also explored challenges and gaps for a smooth transition of care for patients from rural areas following a stroke. Some of these can be addressed through quality improvement (QI) projects by a hospital alone but others require coordination within and across health systems. From this start, suggested themes and statements underlying a practice model for the transitions of care for stroke patients from hospital to home were developed. These complement and support the elements found in the literature. They are:

7. **Evidence-based and practice informed care.** Elements of a care model for stroke survivors will be identified based on best available evidence and informed by current



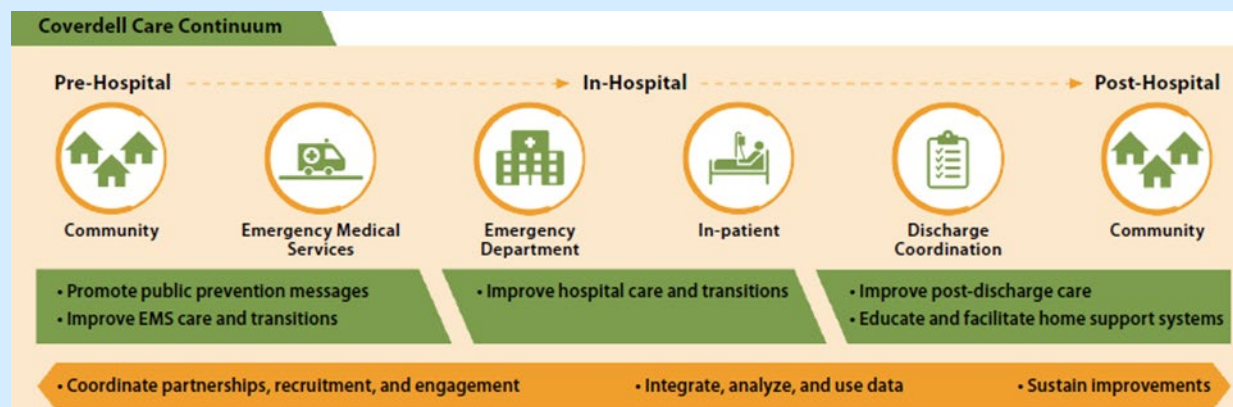
stroke specific best practices. Evidence-based processes and tools for transitions of care in general will inform the base of knowledge.

8. **Accessible and timely follow-up care.** Care model will support seamless care by ensuring access to appropriate and timely services. This will include clinic visits and post-discharge follow-up telephone calls.
9. **Multidisciplinary Teams.** Health services, including specialized stroke care, will be provided to the stroke survivor and their caregiver(s) by a multidisciplinary and inter-professional teams both within the hospital and after discharge to ensure quality outcomes.
10. **Care coordination and inter-professional communication.** Communication and coordination occurs across the care continuum. Clinical, non-clinical and community providers engage together to support client/patient-centered care. Care coordination can be provided by hospital based stroke navigators, primary care health care home coordinators with stroke education, local public health or others. Care coordination facilitates warm handoffs, increased communication between the patient's care providers and better patient understanding of whom to contact with questions or concerns.
11. **Use of technology including electronic health records (EHR).** Technology will be leveraged to improve patient care and outcomes. This includes optimizing EHR utilization (e.g., for decision support, improving patient centered care), optimizing use of telehealth for post-discharge follow-up appointments, and use of technology for patient education (i.e., tablets/iPads and apps).
12. **Patient and Caregiver Education.** Provide "right- time" education that reflects individualized topics of interest, considers health literacy levels and supports a person's ability to identify and address barriers. It enables self-management and patient's readiness to hear the information. Staff can be trained in the teach-back method to help ensure patients understand the information they are given.
13. **Patient and caregiver(s) engagement.** A holistic approach to care considers the patient/caregivers physical, emotional, psychological, linguistic and cultural needs, and environmental factors. It engages the patient and caregivers in shared health care decision-making and care planning including all aspects of goal setting. Teaching staff to use "Ask Me 3" framework increases patient engagement and assists with improving health literacy.
14. **Geographically defined services.** The geographic locations of where the patient lives and where the patient was treated for their stroke must be taken into considerations when making decisions about transitional care.
15. **Advancing Healthy Equity.** Health equity in care means that there is equity in health outcomes for all people regardless of their race, age, mental health, sexual orientation, economic status, geographic location, disability or gender identity, etc. A focus on health equity means that as we develop policies and procedures to improve transitions of care we consider if they might differentially impact (positively and negatively) certain population groups. This examination can be used to make changes that intentionally

benefit all populations and especially those that experience health inequities. The Culturally and Linguistically Appropriate Services (CLAS) standards can be used to assess and improve stroke services so they support effective, equitable, understandable and respectful care. Care and services must be responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

With knowledge about themes and statements underlying the practice model, gaps and challenges to a smooth transition of care for their patients, and suggestions from practice and literature, quality improvement activities were identified for the following practice areas: transitions from hospital to home and outpatient clinics; transition to community and post-discharge follow-up; provider education; patient and family engagement; and medication reconciliation and management. Further information can be found in the Quality Improvement Projects section.

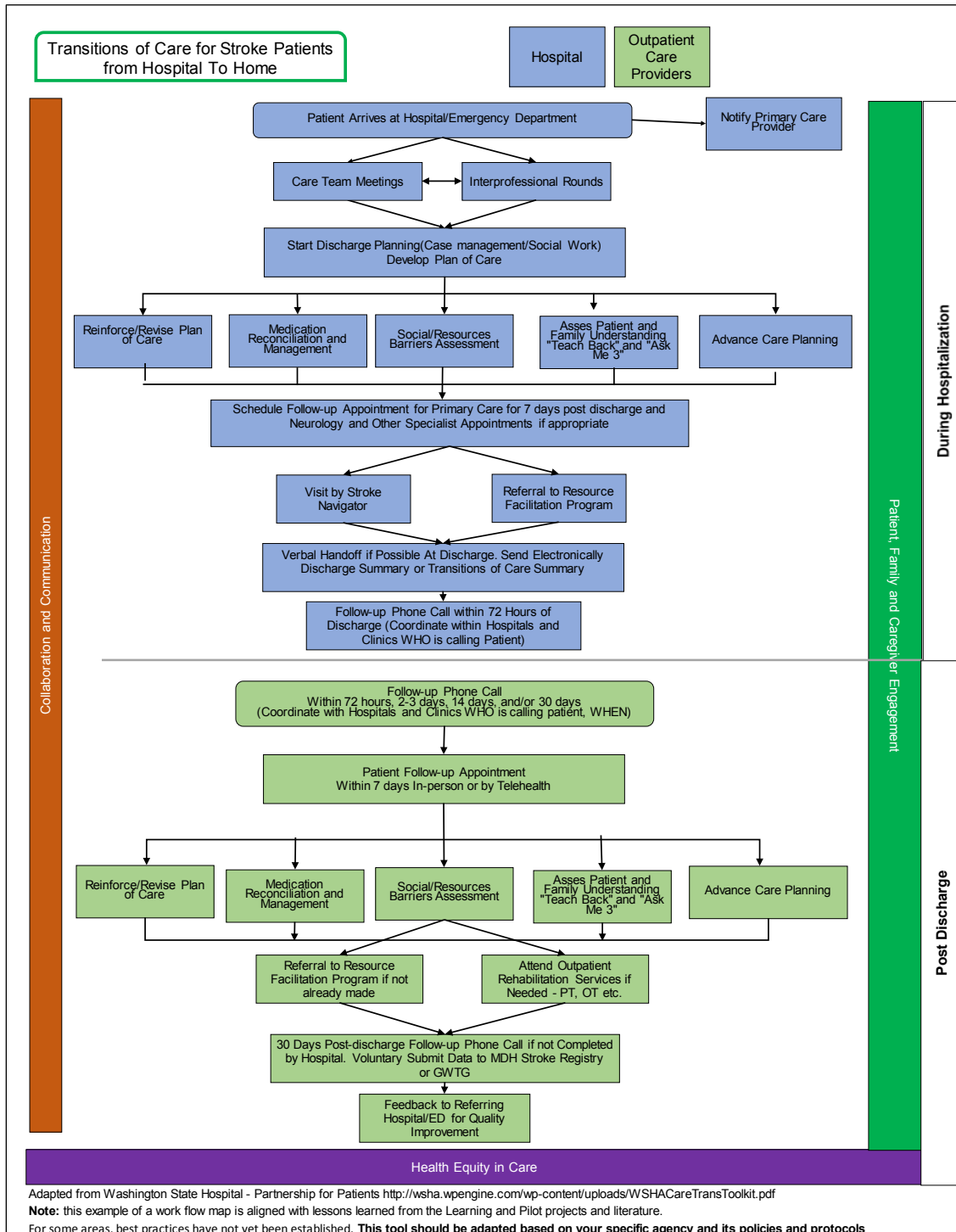
The following graphic represents the Centers for Disease Control and Prevention (CDC) Paul Coverdell National Acute Stroke Program’s vision of the stroke care continuum, starting with community prevention messages. It includes pre-hospital, in-hospital and post-hospital services. It continues to the community level with rehabilitation and home support if needed and the promotion of individual and public stroke prevention messages.



Source: Centers for Disease Control [https://www.cdc.gov/dhdsp/programs/about\\_pcnasp.htm](https://www.cdc.gov/dhdsp/programs/about_pcnasp.htm)

## Appendix 2. Flow Map

This flow map provides a framework for visualizing the transitions of care for stroke patients from hospital to home. It illustrates a stroke patient's transition across the care continuum from the hospital to outpatient clinics, rehabilitation services and home. The standard practice for your hospital may be different from this. This framework should be modified for the specific needs or requirements of your hospital or health system. For example, your hospital might recommend a physician visit within 14 days rather than a phone call or they might require a closer follow-up plan with patients at high risk of readmission.



# Tools and Templates

# Stakeholder Analysis Matrix Worksheet

Stakeholder Name and Role in Facility	Stakeholder Interest(s) in Project	Assessment of Stakeholder Importance to the Project (A = extremely important, B = important, C = not important)

Adapted from "Quality Improvement—an ACC Clinical Toolkit"  
[https://cvquality.acc.org/docs/default-source/qi-toolkit/14a\\_stakeholder-analysis\\_12-10-13new.pdf?sfvrsn=9478fbf\\_2](https://cvquality.acc.org/docs/default-source/qi-toolkit/14a_stakeholder-analysis_12-10-13new.pdf?sfvrsn=9478fbf_2)  
by Minnesota Department of Health Stroke Program 2019

## Members Roles and Responsibilities Worksheet

- Champion – responsible for representing project, the primary decision-maker, monitors process, primary documenter, schedules meetings
- Core Team Members – key contributors as process owners, content experts, or responsible for implementing specific activities
- Other Members – contribute information, knowledge, and skills to a specific project component and provide periodic input

<b>Date:</b>	<b>Hospital</b>	<b>Primary Care Clinic (or other Agencies)</b>
<b>Member/Role</b>	<b>Who should be involved? Name and position</b>	<b>Who should be involved? Name and position</b>
Champions		
Core team members		
Other team members to invite as needed		
Meetings – Who should attend?		
Setting up meetings (dates/times/venue – in person or conferencing)		
Work plan development		
Data analysis and reporting		
<i>(Add other roles)</i>		

*Stroke Program, Minnesota Department of Health 2019*

# Criteria for Selecting Process Improvement Opportunities

<b>Transitions of Care for Stroke Patients (Part 1)*</b>	
Individual Ranking of Each Proposed Project	
NAME OF HOSPITAL _____	DATE COMPLETED: _____

<b>Criteria are weighted equally</b>	Project 1	Project 2	Project 3	Project 4	Project 5
<p><b>Need</b></p> <p>How much of the current processes are working well?</p> <ul style="list-style-type: none"> <li>• Process is working well</li> <li>• Patients and staff satisfied with current processes</li> <li>• Data is available to understand the current state and track performance.</li> </ul> <p>Assign a score of 1, 5 or 9:            1 = Process working well and little need for project            5 = Process working okay and some need for project            9 = Process not working well and high need for project</p>					
<p><b>Ability</b></p> <p>Are there staff that have the time and resources (e.g., materials, equipment, training, funding, and leadership support) to participate in the project and implement changes?</p> <p>Assign a score of 1, 5 or 9:            1 = little time and resources available            5 = some time and resources available            9 = a lot of time and resources available</p>					
<p><b>Impact</b></p> <p>How much value will the outcome of this project bring to our hospital/ organization and stroke patients?</p> <ul style="list-style-type: none"> <li>• Project will benefit a large number of staff and/or patients and improve patient outcomes</li> <li>• Lessons learned from this project apply to other areas of hospital/organization care</li> </ul> <p>Assign a score of 1, 5 or 9:            1 = little value            5 = some value            9 = high value/essential to customer</p>					
<p><b>Alignment</b></p> <p>To what extent is the project aligned with the stroke program's goals for transitions of care</p> <p>Assign a score of 1, 5, or 9:            1 = does not align            5 = aligns with some strategies            9 = aligns with strategies</p>					
<b>Total Project Score:</b>					

<b>Transitions of Care for Stroke Patients (Part 2)*</b>					
<b>Overall Ranking of Each Proposed Project</b>					
	Total Score Project 1	Total Score project 2	Total Score Project 3	Total Score Project 4	Total Score Project 5
Person 1					
Person 2					
Person 3					
Person 4					
Average Score	=sum of above/4	=sum of above/4	=sum of above/4	=sum of above/4	=sum of above/4

*Source: Stroke Program, Minnesota Department of Health March 2017;  
Adapted from Minnesota Office of Continuous Improvement*



## Multi-voting Technique

**Multi-voting is typically used when a long list of potential quality improvement projects must be narrowed down to a top few.** It works best when participants are in the same room.

Outcomes of multi-voting are appealing as this process allows a project which may not be a top priority of any individual but is favored by all to rise to the top. In contrast, a straight-voting technique would mask the popularity of this type of project, making it more difficult to reach a consensus. This technique can be used after a list of projects has been generated through another quality improvement process.

Step-by-Step Instructions:

1. **Round 1 Vote** – The list of projects that were previously generated are posted for everyone to see, such as written on a white board, or a flip chart. Each participant votes for their highest priority items. In this round, participants can vote for as many projects as desired or, depending on the number of items on the list, a maximum number of votes per participant can be established. For example, if 10 items are on the list, the participants could be asked to choose their five highest priority items. Prior to the meeting, the facilitator should decide on the number of votes per participant.
2. **Update list** - Projects with a vote count equivalent to half the number of participants voting remain on the list and all other projects are eliminated. In the example below there are six participants so the projects receiving three or more votes were posted for the group to review.

Potential Projects EXAMPLE	Round 1 Vote	Round 2 Vote	Round 3 Vote
Medication reconciliation	XXXX		
Data collection–patient follow-up 30 days post discharge	XXXX		
<del>Stroke specific discharge summary</del>	XX		
Blood pressure cuff distribution project	XXXX		
<del>24–72 hour post discharge follow up</del>	XX		
<del>Addition of stroke navigator</del>	XX		
Stroke patient education materials	XXXXX		
<del>Feedback loop for patients transported from discharging hospital to receiving hospital and discharged home</del>	XX		
<del>Partner with primary care clinic</del>	XX		
<del>Standardized script for 24 hour follow up</del>	X		
Sign up of patients for Resource Facilitation program	XXXX		
Transitions of Care Specific Order Set	XXX		

3. **Round 2 Vote** – Each participant votes for their highest priority items from this condensed list. In this round, participants can vote the number of times equivalent to half the number

of projects on the list. In this example, six items remain on the list; each participant can cast three votes.

- Update list** – All votes were re-tallied and the three area receiving three or more votes were posted for the group to view

Potential Projects	Round 2 Vote	Round 3 Vote
<del>Medication reconciliation</del>	<del>XX</del>	
Data collection – patient follow-up 30 days post discharge	XXXX	
<del>Blood pressure cuff distribution project</del>	<del>XX</del>	
Stroke patient education materials	XXXX	
Sign up of patients for Resource Facilitation program	XXXX	
<del>Transitions of Care Specific Order Set</del>	<del>XX</del>	

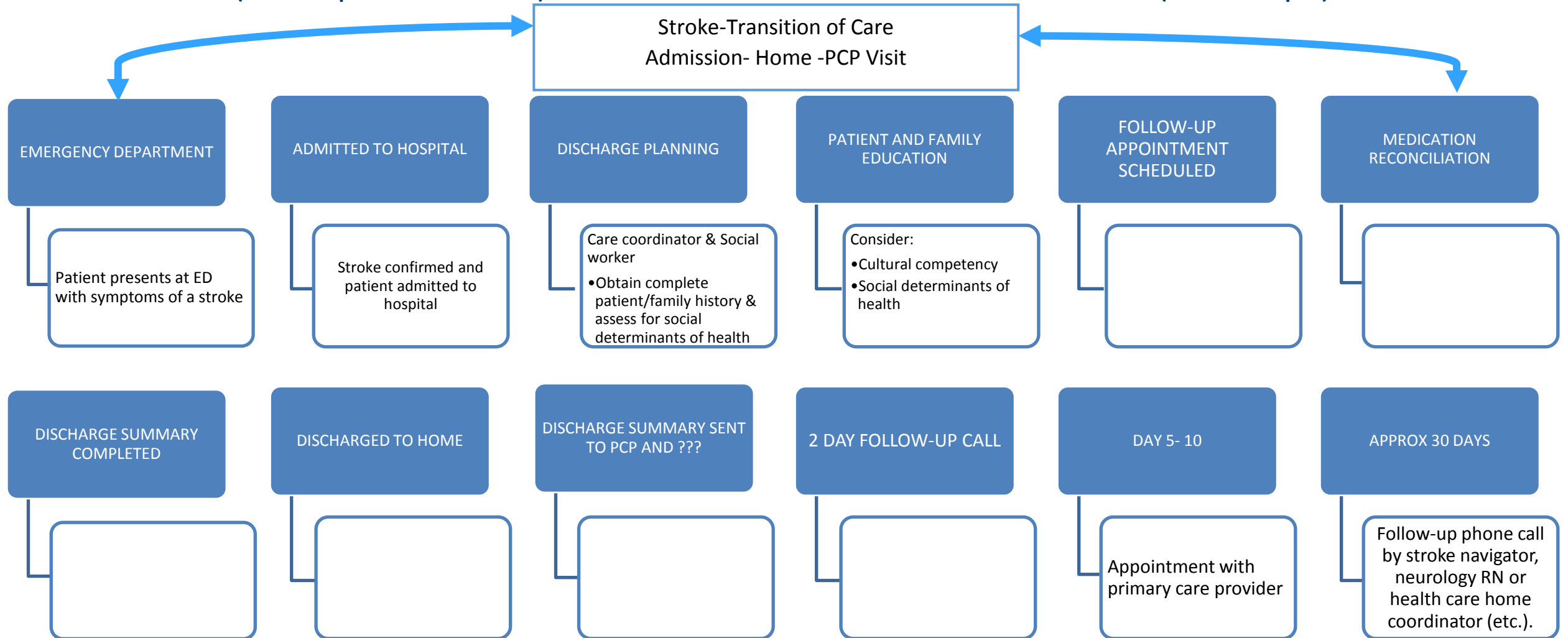
- Repeat** – Step 3 should be repeated until the list is narrowed down to the desired number of projects.
- Update list** – In this example, all participants voted up to two times and the only item with four or more votes, “**Data collection – patient follow-up 30 days post discharge,**” was the chosen focus area for a QI project.

Potential Projects	Round 3 Vote and winner!
Data collection – patient follow-up 30 days post discharge	XXXXXX
<del>Stroke patient education materials</del>	<del>XXX</del>
<del>Sign up of patients for Resource Facilitation program</del>	<del>XXX</del>

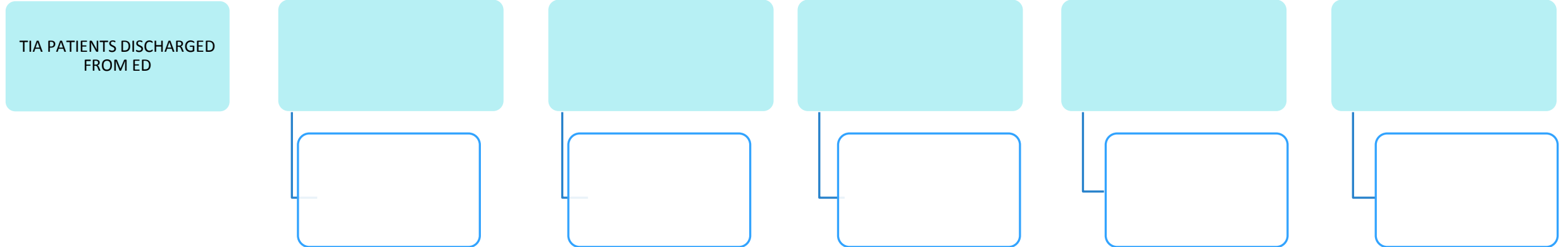
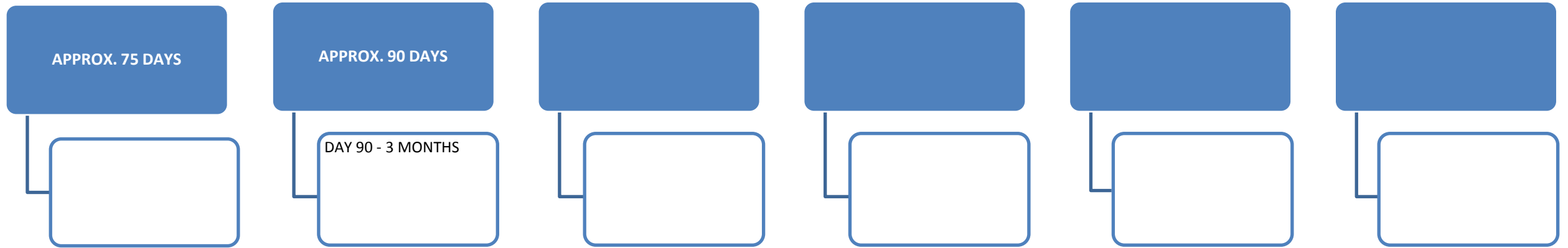
Excerpted from National Association of County and City Health Officials “Guide to Prioritization Techniques. <http://www.naccho.org/uploads/downloadable-resources/Guide-to-Prioritization-Techniques.pdf>, accessed on 3/28/17

# Process Flow Map

(Insert hospital and clinic name) **PROCESS FLOW FOR STROKE PATIENTS DISCHARGED TO HOME (Date Developed)**



*Model for illustrative purposes only – Process is different for every hospital.*



Timely Access to Care    Patient, Family and Caregiver Engagement and Activation    Collaboration and Communication    Health Equity in Care

*Model for illustrative purposes only – Process is different for every hospital. Develop by Minnesota Department of Health Stroke Program*

## Swim Lane Process Map

Timeline				
Social Worker or Case Manager				
Stroke Coordinator				
HUC				
Neurology RN				
Stroke Navigator				
Neurologist				
Hospitalist				
Family/Caregiver				

*Stroke Program, Minnesota Department of Health, 2018*

## Touch Points after Stroke

**(INSERT NAME) Hospital – Completed (INSERT DATE)**

**Touch Points after Stroke for Patients Discharged from Hospital To Home: Care Coordination and Follow-up**

Font colors correspond to facility conducting follow-up: Health Plan; Neurology Clinic; Primary Care Clinic; Hospital; Rehab

Time-frame contact is made with patient or family after discharge (e.g., 12-24 hrs, 14 days)	Method of follow-up (e.g., phone, in-person visit)	Who follows up? (e.g., ED nurse, primary care clinic transitions care management nurse)	Patient eligibility for receiving call or needing visit	What is provided?

Template used by permission from Allina Health/Courage Kenny Rehabilitation Institute (3/2017)

# Project Work Plan: <Transitions of Care Project Name>

## PROJECT OVERVIEW

**Name of Organization:**

**Dates of Project:** *Start and end date of project as mm/dd/yyyy*

**Goal:**

*The goal should be related to transitions of care for stroke patients that are discharged from hospital to home. A goal describes the purpose toward which your efforts are directed. Goals indicate the desired outcomes for the patient’s or community’s health status. Goals are long-range and broad in scope. A goal may or may not be measurable.*

**Audience:** *List your customers for this project.*

**Purpose:**

*This describes the outcomes you would like to improve or change, or what the projects aims to accomplish. The purpose does not need to be measurable.*

<b>Project 1 Title:</b>	<i>In a couple of words, describe the specific project you plan to work on. Use a new table for each project.</i>
<b>Strategy 1:</b>	<i>Describe the strategy you will use to address the project. There can be more than one strategy for a project</i>
<b>Objective:</b>	<i>Objectives are specific to what you are intending to accomplish. Objectives pertain to what will happen within the target population. They are written in a SMART format: Specific, Measurable, Achievable, Relevant and Time-bound. A common format: By (when, date), (percent or number of change from a stated base) of (what population) will (indicator – do what, change how).</i>

<b>Activities</b> <i>List what the hospital will do related to the strategy to meet the objectives. List activities in logical and chronological sequence.</i>	<b>Lead staff</b>	<b>Who else will be involved?</b>	<b>Timeline Start and Finish Dates</b>	<b>Progress achieved and outcomes (completed regularly)</b>
<b>1.</b>				
<b>2.</b>				

## Stroke QI Transitions of Care Initiative Project Plan

<p>1. <b>Hospital Name:</b>                  2. <b>Project Lead:</b>  <b>Project Title:</b></p>	<p>3. <b>Champion and Core Team Member/Roles:</b></p> <ul style="list-style-type: none"> <li>• <b>Champion:</b></li> <li>• <b>Core Member:</b></li> <li>• <b>Core Member:</b></li> <li>• <b>Core Member:</b></li> <li>• <b>Core Member:</b></li> </ul>
<p>4. <b>Opportunity Statement: Describe why you are initiating this effort:</b></p>	<p>5. <b>Objectives: Describe what the project aims to accomplish. SMART objectives (Simple, Measurable, Attainable, Results-oriented and Time-Bound).</b></p>
<p>5. <b>Metrics: What information/data will you collect to measure the success of the project?</b></p>	<p>6. <b>Key Stakeholders:</b></p> <ul style="list-style-type: none"> <li>•</li> </ul>
<p>7. <b>Communication Plan:</b></p>	<p>8. <b>Considerations: List any assumptions, constraints, obstacles and risk associated with the project.</b></p> <ul style="list-style-type: none"> <li>•</li> </ul>



# PDSA Worksheet for Testing Change

Hospital:

Prepared By:

Date:

## Aim

**Overall goal you wish to achieve; make sure it is time-specific, measurable, and defines the specific population of patients that will be affected**

*Every goal will require multiple smaller tests of change*

## Plan

### 1. Describe your test of change

Change	Person responsible	When to be done	Where to be done	Status (not started, in process, delayed, not on track or completed)

### 2. List tasks needed to set up this test of change

Tasks	Person responsible	When to be done	Where to be done	Status

### 3. Predict what will happen when the test is carried out

Predicted Outcome	Measures to determine if prediction succeeds

**Do:** Describe what actually happened when you ran the test

**Study:** Describe the measured results and how they compared to the predictions

**Act:** Describe what modifications to the plan will be made for the next cycle from what you learned

[This goes back to the "Plan" step again]