

Ohio Coverdell Stroke Program
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Title of Presentation: Transitions of Care – Implementing Processes for Obtaining Follow-up after Hospital Discharge

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Background: Follow-up post hospital discharge is an important component of the TOC process. Scheduling follow-up appointments prior to discharge streamlines processes and improves the probability that stroke patients will successfully complete their follow-up. Five follow-up questions were developed and added to the Ohio Stroke Patient Management Tool in 2009. Three questions relate to primary care and two relate to neurology/neurosurgery follow-up.

Objective: The primary goal of this quality initiative was to improve the percent of admitted stroke patients with a neurological follow-up appointment scheduled and documented before discharge. The primary outcome measured was the percentage of stroke admissions that had documented follow-up appointment with a neurology specialist prior to hospital discharge. The secondary outcome was the percentage of successfully completed follow-up appointments.

Population: Patients with ischemic or hemorrhagic stroke who were discharged home were included. In order for the appointment to be entered as successful there needed to be documentation of a date, time and provider. Eligible providers were either physician, physician assistant or advanced practice nurse in the specialty of neurology, neurosurgery or vascular surgery.

Design: Each hospital collected three months of baseline data. An intervention specific to the needs of each institution was developed, implemented and tracked for at least three months. All data were collected internally and de-identified prior to sending for analysis

Conclusion: The interventions led to an increase in the rate of appointments documented prior to discharge from 27.1% pre-intervention to 50.8% post-intervention. More work is needed to reach 100% adherence. Those with a documented appointment prior to discharge were more likely to be seen in follow-up. Despite the increase in appointments documented prior to discharge, there was no improvement in the overall rate of completed follow-up appointments. Reasons for this requires more exploration, but may be due to patient factors not yet identified.

Lessons Learned: The buy-in of hospital administration, physicians and staff making the appointments was critical to the success of the intervention. Tracking whether appointments were completed was more challenging when the physician office was not connected to the hospital electronic medical record.

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