Stroke Care Plans and Personalized Education
Stroke Coordinators' Meeting
September 25, 2024

I. Perception of Risk Factors

A. How do you identify risk factors?
B. What questions do you ask to help identify risk factors?
C. What are your sources?

Sources to help identify risk factors	
Internal	**External**
• EMR- Home medications, medical history • Patient • Family	• Care Everywhere • EMS Records • Community Needs Assessment • GWTG Data • CDC Risk Factor Maps
Questions to ask to identify risk factors	
• What are your risk factors? • Do you know what a risk factor is? • Do you know what a stroke is? • Do you have a PCP? • Do you see your PCP for regular visits? • Why do you go see your PCP? • What medications do you take? • What are those medications for? • Has anyone ever told you, that you snore at night or stop breathing for short periods? • Do you know what your goals are (BP, BS, LDL)? Has anyone ever told you that you have "high blood pressure, high cholesterol, or high blood sugar?"	
Strategies to help identify risk factors	
• Use layman's terms (high blood pressure vs. hypertension) • Elicit their understanding of stroke and how risk factors are associated with stroke. • Know your community health status to clue you in to what is more prevalent in your area. • Ask about the symptoms rather than the risk factor (for sleep apnea ask about snoring or if anyone has told them they have irregular breathing while sleeping). • Find out if they know their blood pressure, blood sugar, and cholesterol goals. • Ask the same question in different ways (do you have high blood pressure? What is your blood pressure usually? Is that good or bad? Why do you take amlodipine?)	

A. How do you identify risk factors?

i. As a Quality Coordinator
    1. Health history on admission
    2. Documentation by providers in the notes

ii. Other comments

1. Look at HNP and Neurology note.
2. Talk to patient's family.
    a. Keep in mind that some people may not understand their diagnosis e.g., hypertension. These are teaching moment opportunities as some may not know their risk factors and may not realize they are directly related to their diagnosis of stroke.
3. Assure information in the EHR is accurate.
4. Case management and provider notes.
5. Education via conversations with patients and family members
    a. Huge educational gaps with many patients that need to be addressed
    b. Need to involve the whole care team, including provider/s. Some patients do not understand they had a stroke even after being in the hospital.

II. **Teaching Methods: Patient Education**

Effective:

Teach back *with demonstration/verbal understanding

Specific, concise handouts

Stroke Booklets, but only if you are able to personalize them

Volunteers, mainly for pt experience. Pt's more willing to open up

PT/OT/SLP assisting with continuing educational thread

Ineffective:

QR Codes

Large stroke booklets or handouts with too much information that has not been personalized (overwhelms patient)

Staff Education

Effective:

Teaching during rounds

Daily updates at huddle board

Symposia and conferences with engaging speakers

"Hot Topics" (like a 4P)

Required hours

Staff survey

Out of the box ideas (Escape Room)

Ineffective:

Emails

Large chunks of information

Online CBLs that are easy to click through

A. What methods and media do you use?

i. Ischemic Stroke Booklet
ii. AHA/ASA "Let's Talk about Stroke"
    1. Risk factors page – leave on units. (Atrium Health Neurosciences developed a page)
        a. Interactive to allow patients to write in the book. They can check their risk factors.
            i. What to expect during the hospital stay: who will see them, tests they will receive, etc.
        b. Life after stroke
        c. B/P Log
        d. BE FAST
        e. The booklet is a soft-sided workbook. Julia R. has an electronic version that she can share.
        f. iPad that patients can log into to watch stroke-assigned videos
        g. TVs that patients can log into. For patients and families.
    2. Atrium Health - Stanly, Albemarle also use the handbook.
    3. Atrium Health University (Ronda Vani):
        a. Packet with magnet, pen, Ronda's card, information on stroke support groups.
        b. Also uses the booklet described above.
    4. Cone Health
        a. Uses teach back.
        b. Documents to meet Joint Commission requirements.
        c. Videos and tracks which ones patient watches.
    5. UNC Health – Nash has a similar booklet they use with their patients.

III. Innovation and Design for improved risk factor education in the Electronic Health Record

EHR Functionality	Education Materials
• Partnership with EHR company to build Stroke Friendly Foundation/Default	• "One-Pager" document that is customizable to patient (can AI help?)

• Create automations within the EHR linking patient risk factors to education
  ○ Link Risk Factor Education Plans to the Problem List/H&P
  ○ Automate Education template through use of order sets
  ○ SDOH connected to Risk Factors
  ○ Auto print on AVS
  ○ Lab results to trigger in risk factors and other consults needed (LDL – dietician consult)
• Utilize a co-morbidity care plan
• AVS Template with hard stops for completion by RN
	• Utilizing QR codes/My Chart

Communication of Education Completed/Ongoing/Needed
 	
• RN and Interdisciplinary Handoff SBAR of Education progress
• Interdisciplinary documentation and accountability of risk factor identification, education, and documentation on care plan/education plan.
• Manual/visible checklist for education for patients – visible to patient, family, care team
	Terminology/Verbiage
	
	• Select language that resonates with patients
	  ○ Brain attack vs. Stroke
	  ○ Rephrase risk factors – life and health factors that place you at a higher risk of having a stroke

Processes • Utilize Discharge Unit to finalize education prior to patient leaving hospital	

A. If you had all of the money in the world to address stroke, how would you use it?
    i. More user-friendly EHRs
        1. Documentation of risk factors
            a. Be able to give patients the information they need.
            b. My Chart would be "smarter:"
                i. Automatic assignments into patient portals.
    ii. AI use:
        1. For stroke patients, they would receive prompts.
        2. Patient would be able to open up their own My Chart to see their risk factors, how to address them, etc.
        3. Education planning for and at discharge:
            a. With stroke diagnosis, videos automatically ordered:
                i. When stroke education care plan is added, via order set, generate list of recommended videos.

b. Automatically pull and print information:
    i. Message at discharge in My Chart with a PDF of stroke booklet that stays in My Chart for future reference/use.
4. Computer system would be more aware of needed tasks and help with documentation of them. Send reminders to nurses and others on the care team.

iii. Having a Navigator
1. Not wearing as many "hats," including that of Navigator, along with other duties and responsibilities including Stroke Coordinator, etc.

IV. Continuity Post Discharge

1. How would you provide on-going education post-discharge?
2. How do we help patients with multiple risk factors, chronic disease, etc.?
3. How do we coordinate with primary care?

Programs for Risk Factor Modification after Discharge

1. Perform SDOH assessment prior to discharge to determine how they impact risk factor modification. Target education/interventions on barriers impacting management strategies.
2. Smoking cessation programs.
3. Coordinated weekly face-to-face classes for risk factors and disease management.
4. Target families and caregivers with risk factor modification education/strategies.
5. Phone call follow-ups to provide additional education and assistance with risk factor modification/strategies.
6. Have community resource guides with lists of services related to risk factors: DM, dietary, food, medication, exercise, transportation (AHA App for locating available community resources).
7. Offer EMS and Community paramedic programs – enroll while in hospital and designed to provide ongoing education, home safety assessment, medication reconciliation, obtain resources (equipment/ramps/transportation).
8. Offer Stroke Support Groups – meetings that target risk factor management (address food/cooking, medication reconciliation, access to care and resources).
9. Ensure administrative support to decrease barriers for the creation and implementation of strategies.
10. Partner with companies that have knowledge and capabilities on methods to reach and engage community members. They do not have to be the clinical expert.

Venues for general education:

1. Annual stroke luncheons
2. Stroke survivor and caregiver conferences
3. Farmer's market
4. Health fairs – community events, industry, targeted populations
5. Traveling Healthcare vans
6. Parish nurses

Helping patients with multiple risk factors, chronic disease management

1. Electronic record notifications/education – i.e. My Chart
2. Silver Sneakers (Medicare population) – free meals, activities, education
3. Mobile Health Clinics – targeting geographic or specific populations
4. Social media – daily posts to engage population
5. Apps for monitoring blood glucose levels, blood pressure – feedback loop
6. Virtual rehabilitation – risk factor education?

Coordination of Care with Primary Care Provider (PCP)

1. Engaging PCP office to offer additional information to reinforce risk factor modification provided in acute care (posters, materials, disease management).
2. Coordinate transitions from Stroke Clinic, Bridge Clinic to PCP office. Timing: 1 visit, 6 months, 12 months?

Continuity Post Discharge

a. Stroke Follow-up Clinic
    i. Include case management
        1. Assure medications are filled.
        2. Schedule follow-up appointments.
    ii. Close loops-include community paramedics and community health workers (CHWs) in team-based care and engage them for post-acute ongoing education and care.