Stroke QI Transitions of Care Initiative Project Plan (EXAMPLE)

Note: this is an example of a quality improvement project. If you choose to conduct a similar project, the content should be adapted based on your specific agency and its policies and protocols.

1. Hospital Name: Blue Ox Medical Center **Project Lead: Mary Smith (Stroke Coordinator)** Project Title: Increasing the number of post-discharge follow-up appointments with primary care provider (PCP) scheduled prior to hospital discharge for stroke patients and TIA patients discharged to home.	**2. Champion and Core Team Member/Roles:** • Champion – Mary Smith (Stroke Coordinator) • Core Member – Joan Hicks (Stroke Navigator) • Core Member – Emily Greenbaum (Neurology APN) • Core Member – Latisha Brown (Health Care Home Coordinator) • Core Member – Maria Garcia (Quality Improvement Coordinator)
3. Opportunity Statement: Describe why you are initiating this effort: The goal is to schedule stroke patient appointments with their primary care provider, before the patient is discharged from the hospital. Currently the rate is only 50%.	4. **Objectives: Describe what the project aims to accomplish. SMART objectives (Simple, Measurable, Attainable, Results-oriented and Time-Bound).** Between April 1 and June 30, 2017 increase the number of post-discharge PCP visits scheduled for stroke patients from 50% to 70%.
5. Metrics: What information/data will you collect to measure the success of the project? At the end of one month, we will run a report to see if patients with a final clinical diagnosis of stroke or TIA patients had a follow-up appointment scheduled with a PCP prior to leaving the hospital. Also, the ED log will be compared with the report to see if it is capturing all TIA patients.	**6. Key Stakeholders:** • Stroke patients and their families • Blue Ox Medical Center (Hospital) • Blue Ox Medical Clinic (Clinic)
7. Communication Plan: Staff education training will be provided by Mary Smith on the procedures for tracking stroke patients and also scheduling the appointments. On the first Monday of the month, Mary will review the statistics with staff on the percentage of follow-up appointments made prior to discharge.	**8. Considerations: List any assumptions, constraints, obstacles and risk associated with the project.** • It is not clear who will be responsible for scheduling patients who are discharged on the weekend. We are not sure if TIA patients are currently receiving post-discharge follow-up. • Joan Hicks is going on parental leave in a month.