

Project Work Plan Stroke Transitions of Care Project - EXAMPLE

PROJECT OVERVIEW

Name of Agency:

Blue Ox Medical Center

Dates of Project:

August 1, 2017 – July 31, 2018

Goal:

To improve the stroke and TIA patient's quality of care and quality of life, health outcomes, and to reduce avoidable complications, adverse events and readmissions.

Audience:

- Stroke patients discharged from Blue Ox Medical Center to home,
- Stroke patients transferred from Blue Ox Medical Center to another hospital and then return to home to be cared for by their local physician, and
- TIA patients discharged from the emergency department to home.

Purpose:

- Improve hospital discharge planning, including communication to the primary care provider for stroke and TIA patients being discharged home.
- Improve coordination of follow-up phone calls for stroke and TIA patients
- Demonstrate the impact of this model using identified metrics and evaluation methods.

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.

Project 1 Title:	Patient Engagement and Follow-up
Strategy 1:	Determine the hospital to home need and gap and implement activities to address the gap
Objectives:	Between 8/1/17 – 7/31/18, 100% of stroke and TIA patients discharged to home will have received identified patient education and follow-up plan Between 8/1/17 – 12/30/17, 95% of patients and/or family members will be able to identify their personal risk factors for stroke

Activities	Lead staff	Who else will be involved?	Timeline Start and Finish Dates	Progress achieved and outcomes (completed on a regularly scheduled basis)
<p>1. Patient Education</p> <ul style="list-style-type: none"> Review existing materials used in ED, in-patient, rehab, and affiliated primary care clinics. Update materials so they contain the same information and are consistent in all settings Train key staff in all settings 	(Name) Stroke Coordinator	(Name) Director of Med-Surg Key staff responsible for patient education in rehab and primary care	4/1/17 - 6/30/17	
<p>2. Incorporate referral to MN Stroke Association – Resource Facilitation Program into discharge workflow in EHR and patient education materials</p> <p>Educate nursing staff, case managers and social workers on the Resource Facilitation Program including how to discuss with patients what it has to offer and how to enroll them</p>	(Name) Stroke Coordinator	(Name) Director of Med-Surg Med-Surg nurses, case managers, social workers	6/1/17 – 6/30/17	
<p>3. Use “teach-back” method to assure patients are aware of their individual risk factors for stroke</p>	(Name) Director of Med-Surg	(Name) Stroke Coordinator Med-Surg nurses	8/1/17 – 12/30/17	