MINNESOTA STROKE PROGRAM

Transitions of Care for Stroke Patients

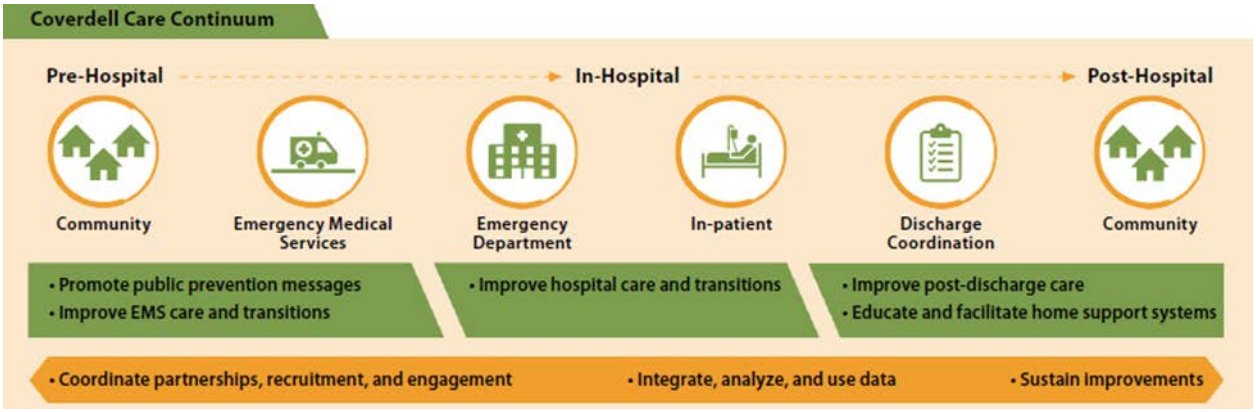
At the Minnesota Department of Health, we are putting strategies in place to improve care to stroke patients who are going home from the hospital. We work with health systems, hospitals, clinics and other partners to support the smooth transition of a patient's care between providers to:

- Improve patient and caregiver education
- Help stroke survivors and their families navigate the health system
- Find resources to meet their needs

Transitions of care

Transitioning patients between care settings requires coordination between health professionals. This coordination makes sure that a patient's health and personal needs are met, and that the right person is delivering the right care and services at the right time.

Creating a smooth transition for stroke patients from hospital discharge to their homes and communities requires building connections between hospitals, post-acute facilities, home care agencies, clinics, and community-based organizations.



Source: CDC Paul Coverdell National Acute Stroke Program

Reducing readmissions through improved transitions of care

In the past 10 years, Minnesota has made significant progress improving emergency treatment and inpatient care for acute stroke patients. However, the transition back home for these patients after hospital discharge remains difficult.

Many stroke patients experience health complications, are readmitted within 30 days, and often have a difficult time transitioning back to their lives. Studies show that interventions like close coordination of care, along with early follow-up care after hospital discharge, have lowered readmission rates.

Minnesota transitions of care strategies

The Minnesota Department of Health Stroke Program provides support for improving transitions of care. Our strategies include:

TRANSITIONS OF CARE FOR STROKE PATIENTS

Working with hospitals to put in place emerging practices that support the smooth transition of a patient's care between providers.

Example: Two hospitals conducted a pilot project to work with their affiliated primary care clinics to provide care coordination and follow-up for stroke patients discharged from the hospital to home. One hospital is working with their affiliated community paramedic program to offer home visits for stroke patients after they leave the hospital.

> "EVERYONE INVOLVED WAS EXCITED KNOWING THAT WE WERE HAVING AN IMPACT ON THE TRANSITIONS OF CARE FOR OUR STROKE PATIENT."
>
> Pilot hospital transitions of care champion

Facilitating learning projects that address the challenges of following up with patients from rural Minnesota who receive tertiary care in a large hospital and then return home to their community. We convene stakeholders to work on these issues and develop best practice models with hospitals and clinics across Minnesota.

Providing support for hospitals and clinics to collect quality of care data after discharge. These data support hospitals or clinics in identifying areas for improvement.

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> "IN THE HOSPITAL, I DIDN'T ALWAYS UNDERSTAND EVERYTHING THAT WAS BEING TAUGHT TO ME, AS I DIDN'T ALWAYS UNDERSTAND THE LANGUAGE USED – BUT WOULD NOD MY HEAD LIKE I DID UNDERSTAND. WHEN I WENT HOME, I FOUND THE STROKE EDUCATION BOOK SO HELPFUL, AS IT WAS WRITTEN IN A WAY THAT I COULD UNDERSTAND.
>
> - STROKE PATIENT