Title:

Improving Stroke Transitions of Care through APN-Led Shared Medical Appointments

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Session Title:
Rising Stars of Nursing Invited Posters - Group 1
Slot (superslotted):
RSG STR 1: Thursday, September 25, 2014: 9:45 AM-10:30 AM
Slot (superslotted):
RSG STR 1: Thursday, September 25, 2014: 2:30 PM-3:15 PM

Keywords:
Shared Medical Appointments, Stroke and Transitions of Care

References:

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Learning Activity:

	LEARNING OBJECTIVES	EXPANDED CONTENT	TIME ALLOTTED	FACULTY/SPEAKER	TEACHING/LEARNING METHOD	EVALUATION/FEEDBACK

		OUTLINE				
	Example Critique selected definition of the term, "curriculum"	**Example** Definitions of "curriculum" Course of study Arrangements of instructional materials The subject matter that is taught Cultural "training" Planned engagement of learners	**Example** 20 minutes	**Example** Name, Credentials	**Example** Lecture PowerPoint presentation Participant feedback	**Example** Group discussion: What does cultural training mean to you?
	Describe the difference between shared medical appointments and individual appointments	Compare and contrast the elements of shared medical appointments with individual appointments	3 minutes	Kathleen Burns, MSN, RN, ACNS-BC, ACCNS-A/G, CEN	Poster presentation Participant feedback	Discussion with individuals: In what settings and populations have shared medical appointments been effective and what other populations could shared medical appointments be used for
	List three transitional needs addressed	Describe topics included in shared	3 minutes	Kathleen Burns, MSN, RN, ACNS-BC,	Poster presentation Participant feedback	Discussion with individuals: What are population specific topics that could be

at a transitional shared medical appointment	medical appointments related to transitional needs of patients discharged to home.		ACCNS-A/G, CEN		included in shared medical appointments to improve patient transition to home

Abstract Text:

Great strides have been made in the treatment of acute stroke, with thrombolysis and interventional treatments decreasing stroke mortality and morbidity. In addition, evidence-based interventions aimed at secondary prevention are now initiated as standard treatment for stroke and TIA patients. Unfortunately, lack of patient understanding of personal risk factors and risk reduction strategies as well as poor perception of severity of risk have been identified as barriers to compliance with discharge treatment plans.

Patients with chronic illnesses are at high risk for readmissions when discharged to home, a risk that increases when patients do not fully understand their chronic illness, the severity of their illness, their medical plan of care, and risk reduction strategies. Stroke and TIA patients transitioning to home, many who are overwhelmed with complex health care needs and new disabilities, offer a unique challenge for care providers. With decreased length of stays and increased workloads, nurses struggle to meet the education and discharge needs of patients transitioning directly to home. Improving transitions from hospital to home presents an opportunity to develop programs that foster patient-centered holistic care resulting in reduced readmissions and improved patient outcomes.

Shared medical appointments (SMAs) may offer a solution for meeting the transitional needs of stroke and TIA patients. SMAs are group appointments designed to address issues encountered by patient diagnosed with similar chronic conditions. As with usual individual appointments, SMAs include checking vital signs, reconciling medications and an exam. The main difference between SMAs and usual appointments lies in time set aside for patient education delivered in a non-traditional format where patients learn from each other as well as from the provider. When held for primary care patients with chronic illnesses (i.e. diabetes, congestive heart failure), the literature reports outcomes that include: improved biophysical measures; lower healthcare utilization; increased disease-related knowledge; improved self-efficacy and self-management skills; and high patient satisfaction scores. Although there is limited evidence of SMA use in acute stroke or as a transitional model of care, the similarities in chronic disease management, including the need for education and risk factor modification, suggest that SMAs may be beneficial for the stroke/TIA population transitioning to home.

With their advanced education and training, APNs demonstrate many competencies relevant to SMAs, including the provision of direct clinical practice, expert coaching and advice, clinical and professional leadership, and collaboration. They are also skilled at facilitating patient-centered group dynamics and utilizing motivational interviewing techniques. This project incorporates the benefits of the SMA, the skills of the APN, and the transitional needs of newly discharged stroke and TIA patients to create a new model of care, an APN-led transitional SMA for stroke. Under this model, stroke and TIA patients discharged to home attend a transitional SMA 1-2 weeks following discharge. With an APN provider and RN facilitator, individual risk factors for stroke, medication management, risk prevention strategies and stroke recognition education is provided in a group setting.

This study will be a prospective intervention design. The purpose of the study will be to determine if transitional SMAs for stroke increase patient perception of understanding of individual stroke risk factors, secondary stroke prevention strategies, and stroke recognition in stroke/TIA patients discharged to home. The aims of the study are to identify if stroke/TIA patients perceive an increase in understanding of individual stroke risk factors, secondary prevention strategies, and stroke recognition following attendance at a transitional SMA for stroke and to describe patient satisfaction with the SMA process/format. The study will be conducted at a community hospital that is certified as primary stroke center. The sample will include patients diagnosed with an acute stroke or TIA who are transitioning from the inpatient hospital setting to home or assisted living. Data will be collected using two surveys administered immediately following the SMA. A five question survey will elicit a yes/no response to assess patient perception of increased understanding of preventative medication compliance, individual risk factors for stroke, risk reduction strategies, stroke recognition, and what to do for signs of stroke; and a SMA patient satisfaction survey will utilize a 5-point Likert scale, asking eight questions to determine patient level of satisfaction with the SMA process/format. Data collection will begin for this study once IRB approval has been achieved.