Secondary Stroke Prevention through Patient Engagement in Health Promotion
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Background
• More than half of all Americans with stroke are noncompliant with their healthcare provider’s medication and lifestyle recommendations
• Successful management of stroke risk factors has the potential to reduce stroke recurrence by 70-80%
• A review of the literature indicates that the risk of a secondary stroke following a primary event is particularly significant in the first 30 days with a 5-year risk of 25 to 30%
• Strategies for monitoring, supporting, and educating stroke patients should be implemented early in their care and maintained to reduce the potential for a recurrent stroke

Purpose
• To develop a comprehensive health care plan for all patients who are discharged with a diagnosis of an Ischemic Stroke or Transient Ischemic Attack (TIA) in order to minimize the risk of a secondary stroke
• To facilitate patient engagement in comprehensive care that addresses compliance challenges
• To enhance a patient’s motivation with careful assessment of their readiness to make and maintain lifestyle changes along with the necessary tools, caregiver support, and education

Key Components
• Patient contact occurs at 30-days, 90-days, and one year after hospital discharge
• Electronic tool incorporates best practice strategies from national stroke/TIA guidelines and standardizes physician and nurse management of patients through their first year of recovery
• Uniform electronic documentation eliminates the need for cumbersome chart reviews
• Data reports are compiled directly from the patient’s Electronic Medical Record (EMR)
• Monthly staff meetings improve communication and coordination of process
• Quarterly educational sessions increase staff knowledge and improve job satisfaction
• Follow-up phone calls for patients who cannot come into clinic
• Anticipated outcomes are a decrease in the occurrence of future strokes, complications, and improvement in quality of life

Patient Engagement
• Program enables patient self-management between visits and optimizes utilization of trained nurses to educate, coach, assess progress, and answer questions
• Self-management includes knowledge of signs and symptoms of stroke, when to call 911, and understanding risk factors
• Self-monitoring of clinical parameters completed by patients at home
• Assessment of patient compliance and address non-compliance issues is the nurse’s responsibility

Lessons Learned
• Staff education and user friendly electronic tool essential for success
• Nursing leadership for process imperative for coordination and communication with discharge planners, schedulers, providers, clinic staff, and information technologists (IT)
• IT support crucial to integrate the technical infrastructure with quality improvement efforts
• Administrative support key to facilitate clinic pattern flow and to accommodate change

Conclusions
• Optimal stroke care cannot stop at discharge from the hospital
• Nurse-driven follow-up program not only provides continued education and support for stroke patients but also gathers quality outcomes data
• Evidence suggests that optimal stroke recovery and prevention of recurrence is dependent upon patient engagement in their plan of care
• The benefits of prevention and treatment for patients with stroke, cardiovascular disease, and/or associated risk factors are improvement in quality of life, prevention of secondary events, and a decrease in disease related complications
• Program is a model for achieving better outcomes at lower costs for patients who are at risk for serious illness or who are managing a chronic condition

References

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