Stroke Transitions of Care
Transitions of Care Toolkit

Q & A

What is transitions of care?

- The movement of a patient from one setting of care to another or home (Transitions of Care, 2018).

Why is transitions of care processes important?

- With every transition, there is potential for miscommunication and an increased risk for adverse outcomes. A systemic process that involves patient/caregiver and multidisciplinary team, reduces this risk.
- A lot of information is provided during the hospitalization and discharge process. A patient is not always ready to engage during those times and often returns home without adequate knowledge of diagnosis, medical treatment provided during stay, what to do once home, etc.

Who needs a Stroke Transitions of Care process?

- Any facility that admits and discharges stroke patients.
- What is involved in a transitions of care process?
- Multi-disciplinary team, patient/ caregiver begins discharge coordination at the time of admission.
- Education throughout the entire hospital stay.
- Follow up with appropriate physician.
- Follow-up telephone call or visit consisting of patient status, addressing patient's needs, and data collection.

Link to TOC Toolkit:
https://www.healthy.arkansas.gov/programs-services/topics/stroke-resources

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Facts

- 3.8 million 30-day readmissions with a 14 percent readmissions rate at an average cost of $15,200 each was reported in 2018 (Weiss & Jiang, 2021).
- An early, discharge preparation process has shown significant decrease in hospital stays, readmission risks, and mortality risks (Bajorek & McElroy, 2020).
- With a routine transitions of care process, patient compilations are discovered earlier and provide multiple opportunities to address needs.

Stroke Transitions of Care Toolkit

- Provides hospitals with the ADH post-discharge recommendations for transitions of care.
- Provides an organized process for data collection pertaining to stroke patients by providing tool, tips, and resources for organizing the process.