MICHIGAN.GOV/STROKE

MI STROKE ALERT

MICHIGAN'S ONGOING STROKE REGISTRY TO ACCELERATE THE IMPROVEMENT OF CARE

A PAUL COVERDELL NATIONAL ACUTE STROKE REGISTRY

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Michigan's Ongoing Stroke Registry to Accelerate the Improvement of Care (MOSAIC) works to implement an integrated stroke system of care focused on quality improvement (QI) across the stroke care continuum. To achieve this, MOSAIC efforts focus on linkage of EMS, hospital, and discharge data and provider feedback. The system integrates pre-hospital care through promotion of hospital-EMS data sharing and communication, and program evaluation. MOSAIC currently has seven centers participating in reporting of post-discharge data. The long-term objectives for post-discharge data collection and analysis are to increase control of hypertension and cholesterol among stroke patients, improve coordination of care after hospital discharge, and reduce 30-day readmission rate and Emergency Department visits for complications post-stroke event.

[COMMUNITY PARA] MEDIC MINUTE

Kristine Kuhl, Community Integrated Paramedicine Coordinator, MDHHS

Helping you to help others

Community Integrated Paramedicine (CIP) is an innovative solution designed to bridge gaps in local healthcare by providing the right care to the right people at the right time in the right setting without competition or duplication of services. Experienced paramedics receive additional training that broadens their capacity to conduct home safety assessments and fall prevention; patient education; medication reconciliation; social determinant assessment and resource connection; utilization of telemedicine; and point of care testing. CIP programs utilize licensed EMS providers working within the construct of a licensed EMS agency than can produce significant financial and resource savings by capitalizing on the underutilized problem-solving skills of experienced paramedics.

Services offered by CIP programs vary greatly ranging from post discharge follow-ups to help curb readmission rates, to in-home evaluation of care plan compliance for newly diagnosed chronic disease patients. Some services have partnered with hospitals and providers to decrease unnecessary Emergency Department visits and increase access to care utilizing telemedicine. CIPs can connect with physicians, conduct point of care testing, initiate treatment, and arrange primary care physician follow-ups. Some even have the capacity to transport to alternate destinations such as urgent cares or physician's offices.

For more information, contact Kristine Kuhl, CIP Coordinator, at kuhlk2@Michigan.gov.

DATA DASHBOARD

More than 110,000 stroke event records in the MOSAIC database

There were **6,026 EMS runs** with a primary or secondary impression of stroke in Michigan in 2018

Average **on-scene time** for **suspected stroke** for MI in 2018 was **15 minutes**

MOSAIC participating MCAs and EMS agencies accounted for **36% of 2018 MI stroke runs**

RESEARCH ROUND-UP

Mathew Reeves, PhD, Department of Epidemiology, MSU
Anne Hughes, PhD, School of Social Work, MSU

MARK YOUR CALENDAR:

ANNUAL MOSAIC CONFERENCE:

June 7, 2019
Location: Livingston County EMS

Heart and Stroke Walk/Run (Detroit): May 18, 2019

National EMS Week: May 19-23

Transitioning home after an acute stroke can be overwhelming for patients and their families. Physical, emotional and social challenges that are a direct consequence of the stroke and are further exacerbated by the limitations of the health care system that has evolved to care for these patients. Challenges to post-stroke care include short in-patient stays (mere days), rotating health care staff and changing care settings, poor communication between providers, and lack of knowledge and limited health literacy of patients and caregivers.

Unfortunately, there are few transition-related services in the community that are designed to help newly discharged stroke patients navigate the transition period back to home. In 2017 the Michigan Stroke Transitions Trial (MISTT) study completed an analysis that helps us better understand the specific challenges associated with stroke transitions. The study identified patient and caregiver needs after being discharged home. About half the patients were discharged home following a stay in a rehabilitation unit; the average time from hospital admission to return home was 14 days. Patients were enrolled from three hospitals in Ann Arbor and Lansing. Average age was 66 years, 49% were female, 21% were non-White, 86% had ischemic stroke, 72% had mild stroke at admission (defined as an NIHSS of 1-5), and 67% had mild disability at the time of discharge (defined as a modified Rankin score of <=2).

Within a week of transitioning home, a social worker completed an in-home biopsychosocial assessment with the patient and caregiver to identify unmet needs and goals. Stroke knowledge and education was the most frequently indicated need (74%) with 69% of patients having moderate or high level of need for stroke information. Over half (53%) of patients assessed did not know how to prevent stroke, and 29% did not know the cause of stroke.

Financial needs and concerns were also common and are an immediate stressor that can have a negative impact on recovery. Roughly a third of patients reported difficulty in meeting monthly expenses, needing assistance getting connected to entitlements, and/or not being linked to eligible income sources. Pre-existing comorbid medical problems also present a challenge for patients. Other medical conditions, such as cancer or diabetes, accounted for approximately 15% of medically-related needs. Patients also reported medical difficulties with taking medications and keeping appointments.

While challenges and struggles were common, patients also reported many strengths when it came to management of their transition; family support, relationship stability, and social (community) support were common sources of strengths. The combination of a stable social support system with access to community-based resources and support services can be leveraged by an informed health care team to improve a patient's recovery after a stroke event.

Fact sheets from the MISTT study can be found on the MOSAIC website: www.Michigan.gov/stroke.

More information on the MISTT study can be found at www.mist.msu.edu or by contacting Michele Fritz, Project Manager, at mfritz@epi.msu.edu.