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Stroke Education Program to Reduce Readmission: A Benchmark Study

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A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

December 5, 2021

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Acknowledgments

First and foremost, I would like to thank God for giving me the strength and courage to pursue another degree. Because of His grace, I was able to balance life while pursuing this degree. Secondly, I would like to thank my daughter, Karis, for being my inspiration and motivation. Thank you for being so patient while sacrifices were made. Those sacrifices were not in vain. I would like to thank my family for their support and encouragement. To the University of Texas at Tyler instructors, thank you for your support and guidance. Thank you to all of those that have poured into me and helped me during my academic journey.

Executive Summary

Stroke is a major cause of long-term disability and mortality in the United States, exemplifying a complex chronic disease with high co-morbidity, associated healthcare costs, and readmission rates. Unfortunately, patients diagnosed with strokes often present to acute care settings with stroke events after they have had been previously diagnosed. Readmission rates among stroke patients are as high as 13% with most readmissions being unplanned and many avoidable (Brom et al., 2021). An estimated 6.6 million Americans aged 20 years and older have had a stroke, and each year approximately 795,000 people experience a new or recurrent stroke (Duncan et al., 2017).

Readmissions in the immediate post-discharge phase of care may reflect unresolved problems in the hospital and poor discharge planning (Brom et al., 2021). The purpose of this benchmark project is to demonstrate the need for a new and improved discharge education process. I propose establishing a program that will emphasize providing adequate education prior to discharge, tailoring to the patient's health literacy. This program entails providing education verbally, physically, and visually. The teach-back method will also be utilized as well as the implementation of follow-up phone calls post-discharge. Providing education in different ways will assist patients in not only retaining the information provided but applying it as well.

1. Rationale for the Project

The transition between hospital and home is often fragmented, leading to adverse health outcomes, hospital readmissions, and increased healthcare costs (Markle-Reid et al., 2020). Globally, stroke is the second highest cause of death and the third-highest reason for disability. Despite acute stroke management being highly protocolized, variation still exists

regarding patient outcomes. One-year post-stroke, 40.4% of patients had been readmitted in a US Medicare study and only 15% of patients survived admission-free for 5 years (Rohweder et al., 2017). Reducing hospital readmission is a focus of national quality initiatives designed to minimize costs of care and the burden of disease. The annual cost of unplanned rehospitalizations has been estimated at >\$17 billion for Medicare alone; thus, this focus is likely to sharpen as public reporting of readmission data becomes more common and as financial incentives for reducing readmissions increase.

Stroke readmissions are a priority because they are common and associated with high mortality, morbidity, and cost. Reducing hospital readmission is an important goal to optimize post-stroke care and reduce costs (Terman et al., 2018). The characteristics of patients at highest risk for readmission parallel those of the population with low health literacy (Cloonan et al., 2013). Providing educational materials in several ways will increase health literacy and contribute to the reduction of hospital readmission. Cloonan et al. (2013) define health literacy as the ability to obtain, communicate, process, and understand the basic health information and services needed to make appropriate health decisions. It is an essential skill for self-management after discharge.

2. Literature Synthesis

Several articles were collected that demonstrated interventions such as providing education, making phone calls post-discharge, and using the teach-back method were sufficient in reducing readmissions. Multiple studies emphasized the importance of discharge planning and having a transitional care program after hospitalization for acute stroke. The interventions incorporated into the transitional care program consisted of coaching, providing education, and

initiating follow-up phone calls post-discharge. Lin, et al. (2020) and Janet Prvu Bettger, et al. (2012) established the effect of health coaching strategies on health outcomes and hospital readmissions. The authors stressed the importance of initiating interventions before discharge. The focused interventions were providing education and health coaching to patients and family members. It was determined that health coaching and education equated to better health outcomes regarding quality of life and depression than readmissions.

Gonçalves-Bradley, et al. (2016) completed a randomized control trial (RCT) to assess the effectiveness of planning the discharge of individual patients discharged. The authors concluded that a discharge plan can be a stand-alone intervention or may be embedded within another intervention. They also concluded that a discharge plan tailored to the individual patient brings a small reduction in hospital length of stay and reduces the risk of readmission to hospitals. Mabire, et al. (2017) highlighted that nursing discharge planning interventions such as education/teaching, medication self-management, post-discharge follow-up phone calls were necessary interventions to be considered when implementing a transitional care program.

Post-discharge follow-up phone calls were revealed to be an effective intervention in each article. Condon, et al. (2016) determined that follow-up phone calls made within seven days to discuss stroke education, secondary prevention, medication adherence, and evaluation for post-stroke complications were effective in reducing 30-day readmissions. Jayakody, et al. (2016) found five out of ten studies that were effective in reducing readmissions within 30 days. However, they concluded that TFU alone is not effective in reducing readmissions when implemented alone. TFU combined with other intervention components, such as education, discharge planning, and medication assessment were effective in reducing readmissions.

Randomized controlled trials (RCTs) by Deng, Yang, and Xiong (2020) and Wong and Yeung (2014) explored the effect of an integrated transitional care program on health outcomes, quality of life, and hospital visits. Both studies combined the interventions of home visits with telephone calls. Wong and Yeung (2014) concluded that mere telephone calls are not enough to bring about significant patient outcomes in readmissions. Combining the two Interventions was proven to improve health-related outcomes, increased quality of life, and reduce hospital visits.

Although home visits were recommended as a possible intervention, it is not considered to be feasible. The interventions that displayed promise in reducing readmissions and were considered feasible were having a discharge plan in place, education, and telephone follow-up calls (TFU). Another intervention that had a positive effect on the reduction of readmission rates was the utilization of the teach-back method. Oh, et al. (2019) focus on the teach-back method (TBM) when delivering education. Teach-back methods are reported to improve patient outcomes by encouraging patient understanding and participation. "Ineffective and inadequate discharge education can lead to failure of self-care after discharge, which increases the likelihood of readmission and secondary health problems." (Oh, et al., 2019, p. 306). Similarly, Dinh et al. (2016) also discussed the utilization of the TBM. Generally, fewer readmissions and hospitalization were seen in the intervention groups, although they were not always statistically significant. It was reported that there was a 39% reduction in all-cause hospital readmission rates in the intervention group compared with that of the control group. These studies indicate that a reduction in readmission rates or hospitalizations might be a promising outcome for studies with the teach-back method, although further explorations are required to provide stronger evidence.

Of the 12 articles collected, two articles discoursed the effectiveness of video-based education. Appalasaamy, et al. (2020) provided a single-blind, randomized controlled trial with 216 post-stroke patients who were randomly assigned to receive either a combination of video narratives or standard care alone. The intervention included a video narrative that showed improvement in health literacy and self-management. Denny et al. (2017) concluded that an educational video was associated with improved stroke knowledge, self-efficiency, in reorganizing stroke symptoms, and satisfaction with education in hospitalized stroke patients.

3. Project Stakeholders

According to Knickman and Elbel (2019), a stakeholder group is a set of people who have a strong interest in how something in our society is done. In addition, Stakeholders generally have some power in shape and what happens. Therefore, it is imperative to select a team to implement this project. For this benchmark project, stakeholders will include the Chief Nursing Officer (CNO), the director and managers of the medical-surgical unit, registered nurses on the medical-surgical unit, nursing supervisors, case managers, and stroke patients and their families/caregivers. To determine if this project will be successful, the patient preferences and values must be considered. A committee that will consist of nurse leaders and a few selected nurses will meet weekly to discuss the progress of the project.

4. Implementation Plan

For this benchmark project, the proposed implementation is to establish a program that will emphasize providing adequate education verbally, physically, and visually. Phase one will consist of tracking readmissions for stroke patients using the quality database, the Nationwide Readmissions Database (NRD) assessed by the quality department. Another source of data

collection is via the electronic medical record (EMR), Cerna. The primary source of data will come from Cerna.

Phase two will consist of educating the nurses on the new process that is to be implemented because they are the ones that perform discharges. The nurses are to be educated on all the education that will be given to the patient, how to perform the teach-back method, how to initiate the educational videos, and how to conduct follow-up phone calls. According to The Joint Commission website, appropriate education for stroke patients must include activation of the emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke (2020). All of this material is already instilled in the patient's electric health record (EHR). The nurse will simply have to print the material, staple it together and provide it to the patient/caregiver. This material should be given and reviewed utilizing the teach-back method with the patient/caregiver the moment a confirmed stroke diagnosis has been made.

In phase three, the nurse will obtain the iPad stored on their unit and bring it into the patient's room along with printed material. The nurse will turn on the iPad, locate the YouTube app, and proceed to type in stroke education for patients and families. An animated video that is less than 6 minutes will be displayed that discusses stroke in detail using verbal explanations and illustrations. This will be the preferred video for English-speaking patients. If the patient is a non-English speaking patient, the nurse will then type "stroke education" and the preferred language of the patient. The nurse will first review the packet with the patient and caregivers by sitting down explained the material. Afterward, the nurse will choose the appropriate video and allow the video to be watched. Once this is completed, the nurse will reenter the room and

access for comprehension of the educational material by asking questions. Printed templates will be provided for nurses to use for the assessment (see Appendix A). At the point of discharge, the nurse will again review the stroke packet and have the patient/caregiver watch video once again.

A follow-up phone call will be conducted by a nurse 48-hours post-discharge to answer any questions, remind the patient of follow-up visits, and reiterate education. The nurse will obtain contact information before discharge (see Appendix B). The nurse will use script and documents on the sheets provided (see Appendix C). The nurse will obtain contact information along with preferred language, and the ideal time to call from the patient before discharge. The discharge summary will be available for the nurse to review before calling. The call will focus on the assessment of health status, medications, and appointments. The documents will be kept in folders located at the nursing station. There must be a 30-day waiting period to allow data to be developed. Therefore, there will be a 30-day time frame after implementation to collect this data. Phase 4 will consist of gathering readmission data to compare pre-and post-intervention. After the implementation phase has concluded, data will be collected, compared, and documented using the form (see Appendix D). The data obtained will be presented to stakeholders to display if the proposed intervention decreased readmission rates for stroke patients.

5. Timetable/Flowchart

The development of a PICOT question was initiated through previous coursework. Evidence was gathered and presented to management. However, due to the recent healthcare crisis, the ability to implement the proposed intervention was not permitted. Therefore, the

following action plan was created for this benchmark study. The projected timeline and flowchart for the completion of this project are in Table 1 and Figure 1. This project is expected to take 15 weeks to complete.

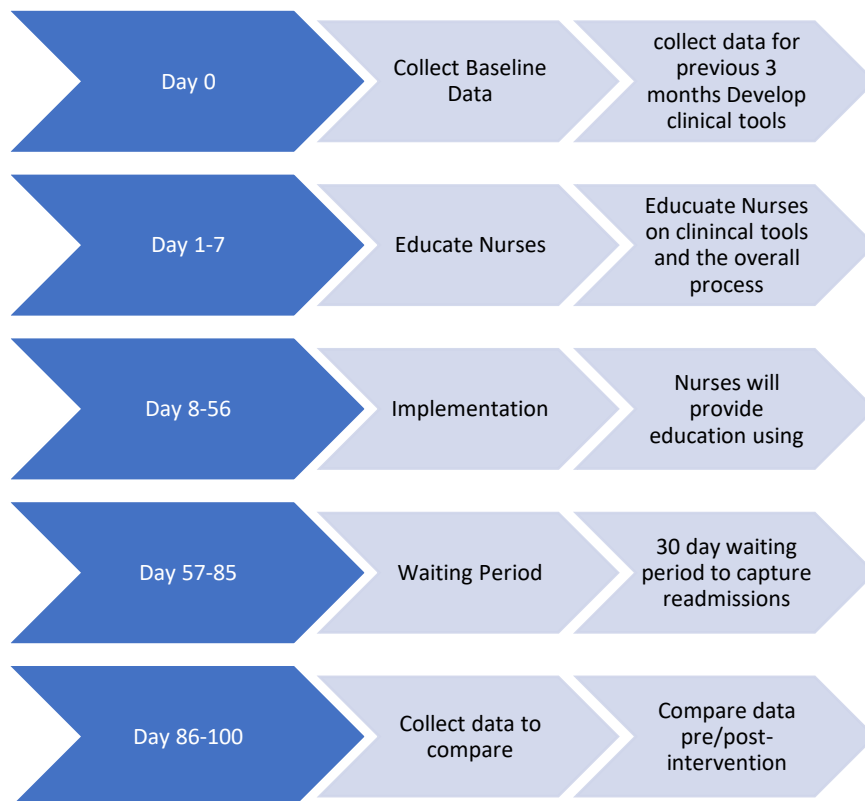
Table 1

Stroke Education Timeline

Week	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Data collection. Develop clinical tools	█															
Educate nurses		█														
Implementation			█	█	█	█	█	█	█	█						
Waiting period											█	█	█	█		
Data collection. Analyze															█	
Disseminate Evidence																█

Figure 1

Stroke Education Flowchart



6. Data Collection Methods

First, data will be collected using the NRD database and Cerna to get a baseline of the patients previously admitted and discharge with a stroke diagnosis. The NRD is part of a family of databases and software tools developed for the Healthcare Cost and Utilization Project (HCUP). The NRD is a unique and powerful database designed to support various types of analyses of national readmission rates for all patients, regardless of the expected payer for the hospital stay (NRD Overview. Healthcare Cost and Utilization Project, 2021). Cerna reports can be obtained that include the patient's MRN admission dates and diagnosis and discharges dates, and readmissions. The outcome measure for this project is the 30-Day readmission rate. This data can be tracked and compared against previous data to determine whether the interventions have been effective in reducing readmission rates.

Data will be collected up to 3 months before the purposed interventions. Two months after the implementation, readmission rates will be evaluated to determine if a reduction in readmission rates has occurred. Then, the nurses will keep track of all participants by retaining their MRN, admit date, and discharge date (see Appendix D). Finally, the team leader will collect this data and use it to begin post-intervention readmission data.

The main objective is to evaluate the effectiveness of interventions on readmission rates however, surveys will be collected to evaluate patient's and nurse's feedback. Utilizing the pre and post-intervention comparison design, The one-sample t-test can be used to analyze results. The t-test developed by William S. Gosset (also known as Student's t-test and the two-sample t-test) is commonly used to compare one sample mean on a measure with another sample mean on the same measure. The outcome of the t-test is used to draw inferences about how different

the samples are from each other. It is probably one of the most frequently relied upon statistics in inferential research (Jankowski et al., 2017). It is typically implemented on small samples (One-Sample T-test, 2021). The difference in readmission percentage will show the efficiency of the change project.

7. Cost and Benefit Discussion

Anticipated costs for this project include paper to print educational materials. Fortunately, each unit houses an iPad which can be used to show Stroke videos. There is no additional cost for materials. Nurses are encouraged to present educational materials at the patient's bedside and make follow-up phone calls during their free time. However, there may not be time to make follow-up phone calls during a nurse's shift. Therefore, there may be a small cost for nurse's time as they may pick up shifts to make phone calls. These interventions are feasible and can easily be incorporated. There are no other additional costs foreseen at this time.

8. Discussion/Results

The expectation of this benchmark project will not only be to reduce readmission rates by to increase patients' health literacy as well. In preparation for this project several studies were found and reviewed that discussed interventions to decrease readmission rates within 30 days. However, there was no specific intervention indicated that could reduce readmissions alone. Most of the evidence collected suggested incorporating two or more interventions together would have a better outcome. After collecting evidence and presenting it to a manager, It was recommended for me to do a benchmarks project due to staffing shortages and increased census from COVID-19. Although the implementation of the presented

interventions is very feasible, the organization was not structured to incorporate new interventions at this time. When the hospital has returned to pre-pandemic status, it is anticipated that this project will be implemented in the months to come.

9. Conclusion/Recommendations

Readmissions are costly to hospitals and displeasing for patients and their families. Enhancing the standard education program to include multiple ways information is retained can increase patients' health literacy and decrease readmission rates. Studies have shown that education is vital for a patient's self-management. Therefore, it is recommended that all learning styles be explored to ensure patients retain the education provided. Several studies, such as systemic reviews and RCTs, have provided evidence that suggests customized education tailoring to patients' learning abilities can reduce readmission. The next step for this project would be to continue to eliminate barriers and implement this into practice.

References:

- Appalasamy, J. R., Quek, K. F., Md Zain, A. Z., Joseph, J. P., Seeta Ramaiah, S., & Tha, K. K. (2020). An evaluation of the video narrative technique on the self-efficacy of medication understanding and use among post-stroke patients: A randomized-controlled trial. *Patient Preference and Adherence, Volume 14*, 1979–1990. <https://doi.org/10.2147/ppa.s253918>
- Brom, H., Brooks Carthon, J. M., Sloane, D., McHugh, M., & Aiken, L. (2021). Better nurse work environments associated with fewer readmissions and shorter length of stay among adults with ischemic stroke: A cross-sectional analysis of United States hospitals. *Research in Nursing & Health, 44*(3), 525–533. <https://doi.org/10.1002/nur.22121>
- Cloonan, P., Wood, J., & Riley, J. B. (2013). Reducing 30-day readmissions health literacy strategies. *The Journal of Nursing Administration, 43*(7/8), 382–387. <https://doi.org/10.1097/nna.0b013e31829d6082>
- Condon, C., Lycan, S., Duncan, P., & Bushnell, C. (2016). Reducing readmissions after stroke with a structured nurse practitioner/registered nurse transitional stroke program. *Stroke, 47*(6), 1599–1604. <https://doi.org/10.1161/strokeaha.115.012524>
- Deng, A., Yang, S., & Xiong, R. (2020). Effects of an integrated transitional care program for stroke survivors living in a rural community: A randomized controlled trial. *Clinical Rehabilitation, 34*(4), 524–532. <https://doi.org/10.1177/0269215520905041>
- Denny, M. C., Vahidy, F., Vu, K. Y., Sharrief, A. Z., & Savitz, S. I. (2017). Video-based educational intervention associated with improved stroke literacy, self-efficacy, and patient satisfaction. *PLOS ONE, 12*(3). <https://doi.org/10.1371/journal.pone.0171952>

- Dinh, T. T., Bonner, A., Clark, R., Ramsbotham, J., & Hines, S. (2016). The effectiveness of the teach-back method on adherence and self-management in health education for people with chronic disease: A systematic review. *JBI Database of Systematic Reviews and Implementation Reports*, *14*(1), 210–247. <https://doi.org/10.11124/jbisrir-2016-2296>
- Duncan, P. W., Bushnell, C. D., Rosamond, W. D., Jones Berkeley, S. B., Gesell, S. B., D'Agostino, R. B., Ambrosius, W. T., Barton-Percival, B., Bettger, J. P., Coleman, S. W., Cummings, D. M., Freburger, J. K., Halladay, J., Johnson, A. M., Kucharska-Newton, A. M., Lundy-Lamm, G., Lutz, B. J., Mettam, L. H., Pastva, A. M., ... Vetter, B. (2017). The Comprehensive Post-Acute Stroke Services (COMPASS) study: design and methods for a cluster-randomized pragmatic trial. *BMC Neurology*, *17*(1). <https://doi.org/10.1186/s12883-017-0907-1>
- Elbel, B., & Knickman, J. R. (Eds.). (2019). Keeping Americans Healthy. In *Jonas and Kovner's Health Care Delivery in the United States*, 12th Edition (12th ed., pp. 103–128). Springer Publishing.
- Gonçalves-Bradley, D. C., Lannin, N. A., Clemson, L. M., Cameron, I. D., & Shepperd, S. (2016). Discharge planning from hospital. *Cochrane Database of Systematic Reviews*. <https://doi.org/10.1002/14651858.cd000313.pub5>
- Jankowski, K. R., Flannelly, K. J., & Flannelly, L. T. (2017). The t-test: An influential inferential tool in chaplaincy and other healthcare research. *Journal of Health Care Chaplaincy*, *24*(1), 30–39. <https://doi.org/10.1080/08854726.2017.1335050>.
- Jayakody, A., Bryant, J., Carey, M., Hobden, B., Dodd, N., & Sanson-Fisher, R. (2016). Effectiveness of interventions utilising telephone follow up in reducing hospital readmission within 30 days for individuals with chronic disease: A systematic review. *BMC Health Services Research*, *16*(1). <https://doi.org/10.1186/s12913-016-1650-9>

- Lin, S., Xiao, L. D., Chamberlain, D., Newman, P., Xie, S., & Tan, J.-Y. (2020). The effect of transition care interventions incorporating health coaching strategies for stroke survivors: A systematic review and meta-analysis. *Patient Education and Counseling, 103*(10), 2039–2060.
<https://doi.org/10.1016/j.pec.2020.05.006>
- Mabire, C., Dwyer, A., Garnier, A., & Pellet, J. (2017). Meta-analysis of the effectiveness of nursing discharge planning interventions for older inpatients discharged home. *Journal of Advanced Nursing, 74*(4), 788–799. <https://doi.org/10.1111/jan.13475>
- Markle-Reid, M., Valaitis, R., Bartholomew, A., Fisher, K., Fleck, R., Ploeg, J., & Salerno, J. (2020). An integrated hospital-to-home transitional care intervention for older adults with stroke and multimorbidity: A feasibility study. *Journal of Comorbidity, 10*.
<https://doi.org/10.1177/2235042x19900451>
- Miller, K. K., Lin, S. H., & Neville, M. (2019). From hospital to home to participation: A position paper on transition planning poststroke. *Archives of Physical Medicine and Rehabilitation, 100*(6), 1162–1175. <https://doi.org/10.1016/j.apmr.2018.10.017>
- NRD Overview. Healthcare Cost and Utilization Project.* Agency for Healthcare Research and Quality. (2021, October). Retrieved from www.hcup-us.ahrq.gov/nrdoverview.jsp.
- Oh, E. G., Lee, H. J., Yang, Y. L., & Kim, Y. M. (2019). Effectiveness of discharge education with the teach-back method on 30-Day readmission: A systematic review. *Journal of Patient Safety, 17*(4), 305–310. <https://doi.org/10.1097/pts.0000000000000596>
- One sample t test.* GraphPad. (2021). Retrieved October 22, 2021, from <https://www.graphpad.com/quickcalcs/oneSampleT1>.

Prvu Bettger, J., Alexander, K. P., Dolor, R. J., Olson, D. W. M., Kendrick, A. S., Wing, L., Coeytaux, R.

R., Graffagnino, C., & Duncan, P. W. (2012). Transitional care after hospitalization for acute stroke or myocardial infarction. *Annals of Internal Medicine*, *157*(6), 407.

<https://doi.org/10.7326/0003-4819-157-6-201209180-00004>

Rohweder, G., Salvesen, Ø., Ellekjær, H., & Indredavik, B. (2017). Hospital readmission within 10 years post stroke: frequency, type and timing. *BMC Neurology*, *17*(1).

<https://doi.org/10.1186/s12883-017-0897-z>

Specifications manual for joint commission national quality measures. The Joint Commission. (2020).

Retrieved October 10, 2021, from

<https://manual.jointcommission.org/releases/TJC2021A/DataElem0209.html>.

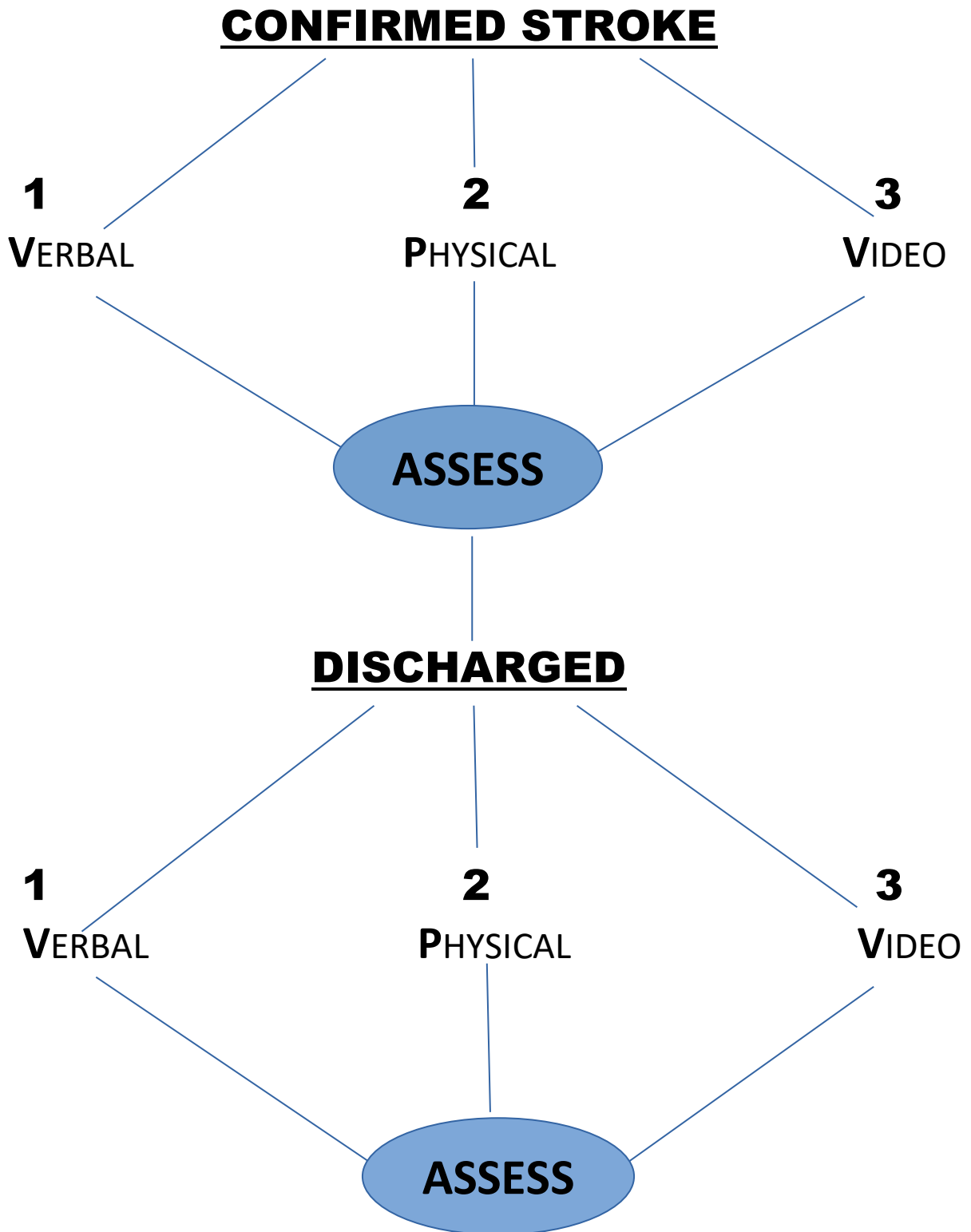
Terman, S. W., Reeves, M. J., Skolarus, L. E., & Burke, J. F. (2018). Association between early

outpatient visits and readmissions after ischemic stroke. *Circulation: Cardiovascular Quality and Outcomes*, *11*(4). <https://doi.org/10.1161/circoutcomes.117.004024>

Wong, F. K., & Yeung, S. M. (2014). Effects of a 4-week Transitional Care Programme for discharged

stroke survivors in Hong Kong: A randomised controlled trial. *Health & Social Care in the Community*, *23*(6), 619–631. <https://doi.org/10.1111/hsc.12177>

Appendix A



Initial Assessment

Questions	1	2	3
What is a Stroke? What happens? Symptoms?	No answer Wrong answer _____	Mentions blood clots or blocked artery FAST _____	Verbalize process in detail FAST _____
What are the Risk Factors?	No answer Wrong answer _____	List 1 or 2 _____	List 2+ and states how to decrease RF _____
What are the medications prescribed after a stroke?	Able to name medication _____	Able to name medication and state indication _____	Able to state medication, indication, and side effect _____

Discharge Assessment

Questions	1	2	3
What is a Stroke? What happens? Symptoms?	No answer Wrong answer _____	Mentions blood clots or blocked artery FAST _____	Verbalize process in detail FAST _____
What are the Risk Factors?	No answer Wrong answer _____	List 1 or 2 _____	List 2+ and states how to decrease RF _____
What are the medications prescribed after a stroke?	Able to name medication _____	Able to name medication and state indication _____	Able state medication, indication, and side effect _____

Appendix B

Follow Up Phone Call Pre-Discharge Information

Patient Name _____

Discharge Date _____

Preferred Language _____

Preferred Phone Number: Home ____ **Cell** ____ **Work** ____

Number _____

Best Time to Call _____

Contact Person _____

Relationship to Patient _____

Appendix C

Follow up Script

Hello Mr./Ms. _____. This is _____ Nurse for _____ at MHHS. I just wanted to call and check on you. How are you doing? Do you have a few minutes to answer a couple of questions that will help us improve how we teach patients and their families to better care for themselves after leaving the hospital?

Has your **follow up appointment** been made? Will you be able to keep this appointment? It's VERY important that you attend all your follow up appointments.

Let's talk about your **medicines**. Were you able to get ALL of your medications filled? _____ If not, why? _____ Is the list of medicines we gave you helpful? I just want to remind you that it is VERY important that you take your medications as directed by your doctor. Do you have any questions about your medications? Do you understand why you are taking these medications?

Have you looked at your **discharge plan** since you left the hospital? Has it been helpful?

Did you find the **stroke education package** helpful? On a scale 0-10 how would you rate the education reading material? Circle one.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

And the video? On a scaled 0-10 how would you rate the **educational video**? Circle one.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

I appreciate you taking the time to speak with me about your care. I hope you have a great day!

Appendix D

Data Collection Form for Evaluation

Patient MRN	Date of Admission	Date of Discharge	Readmitted in 30 days		Readmit Diagnosis	Date Data obtained
			Y	N		