1

Jason Gleason
DNP, NP-C, FAANP, USAF Lieutenant Colonel (RET)

- Board Certified Nurse Practitioner Veterans Health Administration
- Senior Faculty Fitzgerald Health Education Associates
- Veterans Administration and Department of Defense Clinical Practice Guidelines for Stroke Rehabilitation Workgroup
- Montana State Stroke Workgroup
- Board member American Association of Nurse Practitioners
- National VA APRN Council
- Advisory board for Carelinx by Sharecare
- Advisory board for Purdue University Global
- Recognized for work in stroke from the floor of the U.S. Senate

2

2

Objectives

At the end of this presentation, the participant will be able to:

1. Synthesize stroke care and aftercare challenges facing patients, families, healthcare providers and communities.
2. Identify key enabling factors and barriers to successful stroke rehabilitation and recovery.
3. Conceptualize key community resources and different levels of stroke rehabilitation and aftercare.

3

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- Stroke Care Challenges
- Enabling Recovery
- Barriers to Recovery
- Care Expectations
- Implications on Practice
- Types of Rehab Facilities
- Tools
- Stroke Showdown

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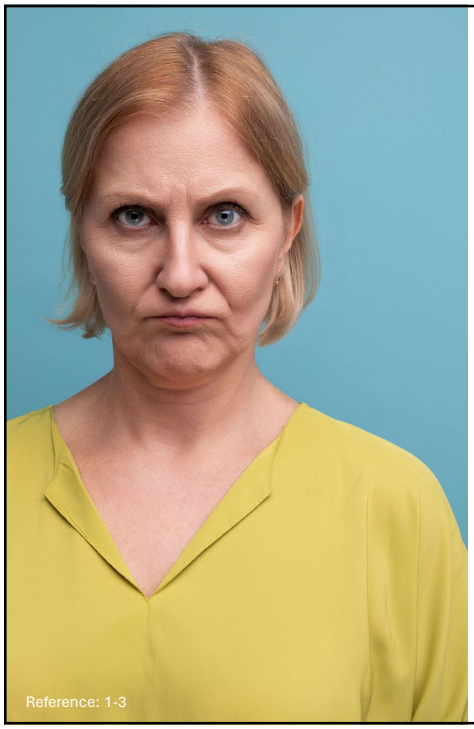

Stroke care challenges

763 stroke patients
28 acute care hospitals across the U.S.

35%
NO PHYSICAL THERAPY

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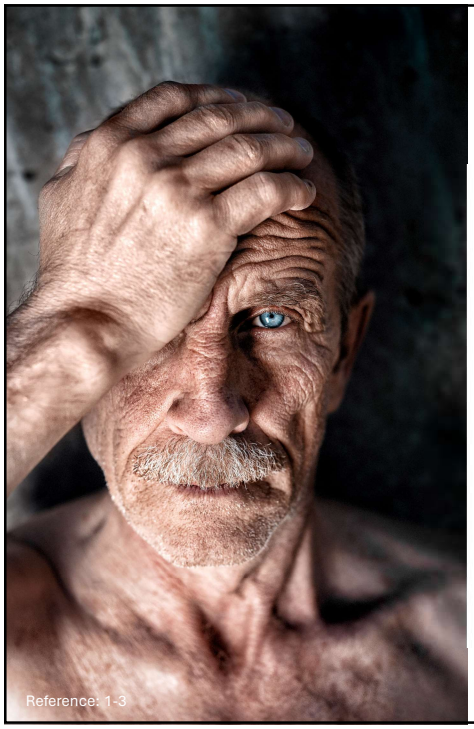

Stroke care challenges

763 stroke patients
28 acute care hospitals across the U.S.

48%
NO OCCUPATIONAL THERAPY

6

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Stroke care challenges

763 stroke patients
28 acute care hospitals across the U.S.

61%
NO SPEECH THERAPY

7

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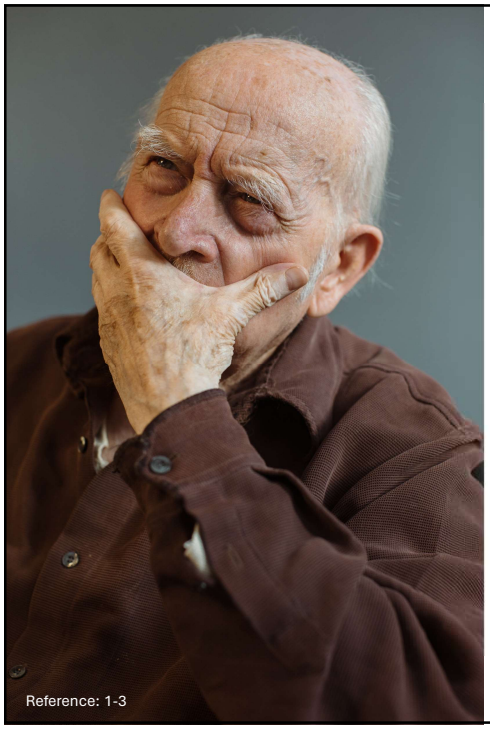

Stroke care challenges

13,550 Medicare patient records

>30%
NO POST-ACUTE REHABILITATION IN FIRST 30 DAYS

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Stroke care challenges

24,413 Medicare patient records:

59%

DID NOT SEE PT OR OT IN FIRST 30 DAYS AFTER DISCHARGE

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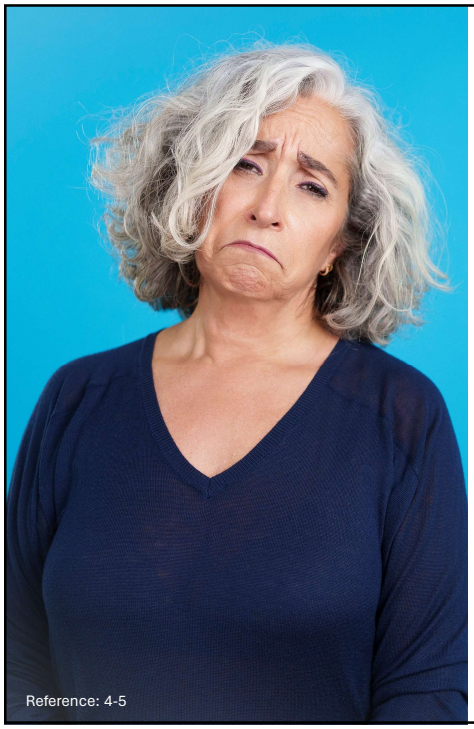

Stroke care challenges

2/3

of stroke patients do not recover the necessary upper extremity function for usual activities by 6 months when motor function plateaus

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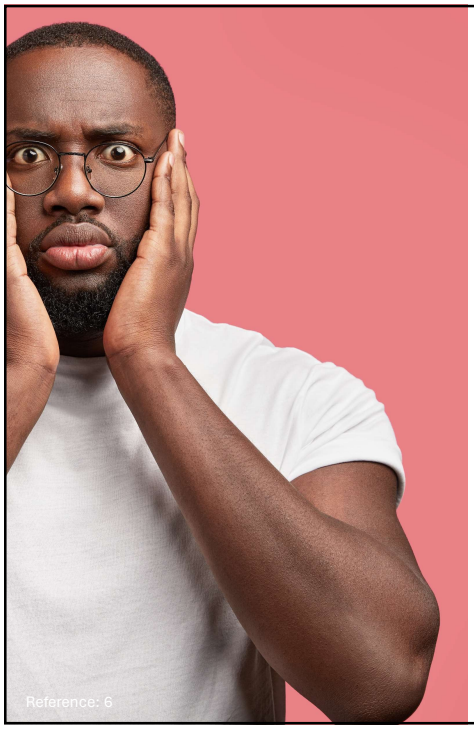

Stroke care challenges

55%

of stroke patients need additional inpatient care after acute hospital stay to maximize recovery and return home

11

11

Stroke care challenges

Health disparities among stroke patients

- Increased morbidity and mortality
- Increased risk of long-term institutionalization

Top reasons for readmission

- Recurrent stroke (65% within 12 months)
- Falls
- Aspiration and Pneumonia
- Urinary Tract Infections

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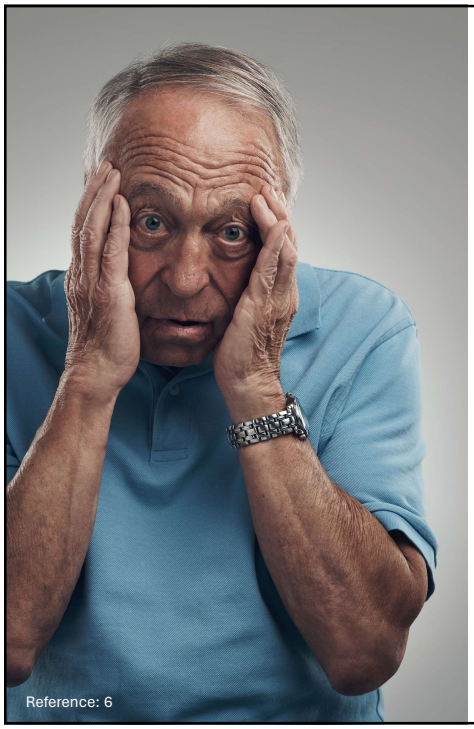

Stroke care challenges

Declined function among stroke patients

- Poor balance
- Visual deficits and disturbances
- Swallowing difficulties
- Incontinence
- Mobility issues
- Cognitive impairment (40%)
- Psychological/behavioral disorders

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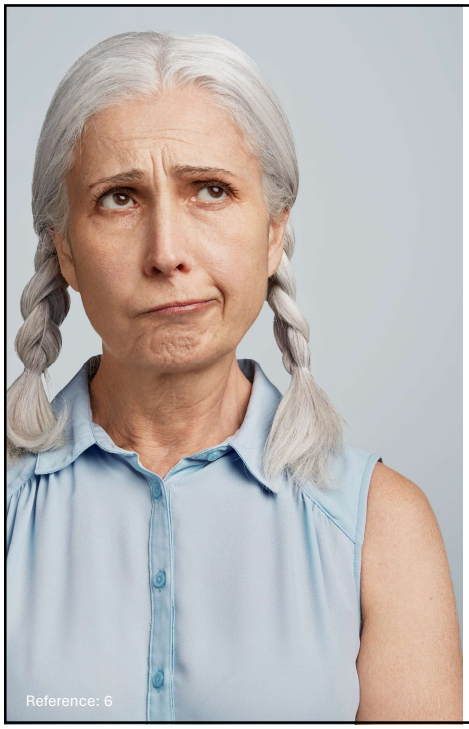

Stroke care challenges

Factors related to poor discharge planning

- Lack of collaboration among team
- Time constraints
- Lack of beds and resources
- Lack of readiness of patients and family to actively participate in recovery

Average length of stay for ischemic stroke **5.22 DAYS**

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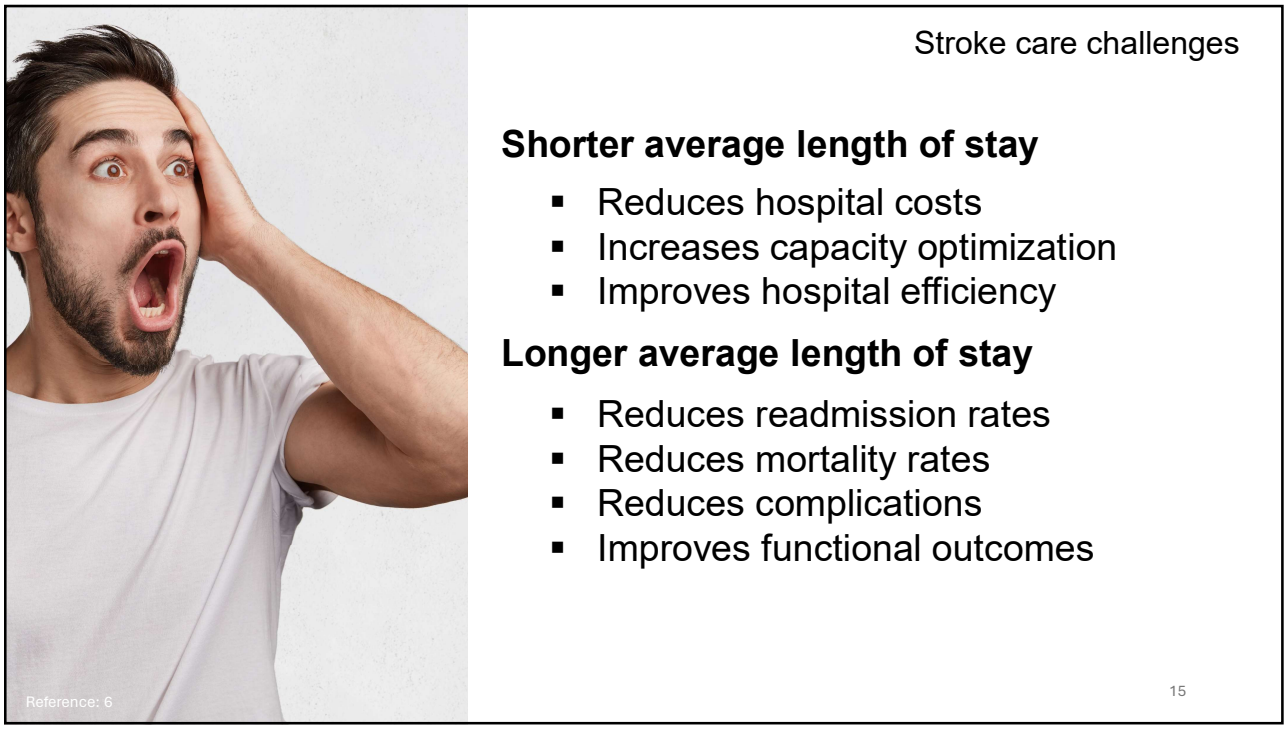
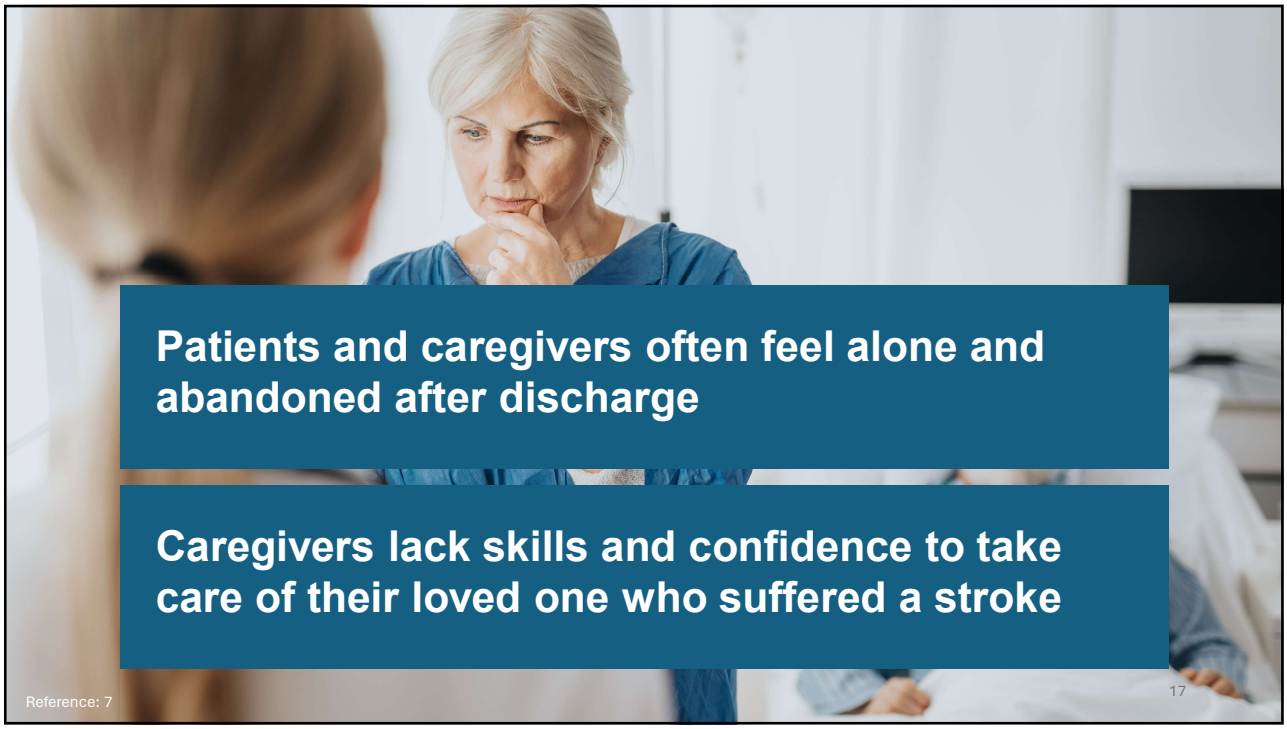

Stroke care challenges
Shorter average length of stay
Reduces hospital costs
Increases capacity optimization
Improves hospital efficiency
Longer average length of stay
Reduces readmission rates
Reduces mortality rates
Reduces complications
Improves functional outcomes
Reference: 6
15

15


Enablers and Barriers in Hospital to Home Transitional Care for Stroke Survivors and Caregivers
2021 Systematic Review
29 Large Studies
Reference: 7
16

16


Patients and caregivers often feel alone and abandoned after discharge
Caregivers lack skills and confidence to take care of their loved one who suffered a stroke
Reference: 7
17

17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Factors enabling recovery

Three key enabling factors

- Partnership approach
- Being prepared to navigate health and social care services
- Developing self-management skills and capabilities

19

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Factors enabling recovery

Partnership approach to care

- Engaging patient and family in goal setting and decision-making
- Family centered approach
- Skills practice before discharge
  - Build confidence
  - Confirm skill attainment
  - Identify questions, concerns and issues before going home

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Factors enabling recovery

Partnership approach to care

- Individualized information
  - Verbal explanation
  - Written material
- Promote dignity and respect
- Compassion and Sensitivity
- The three A's to care
  - Approachable
  - Accessible
  - Available

21

21

Factors enabling recovery

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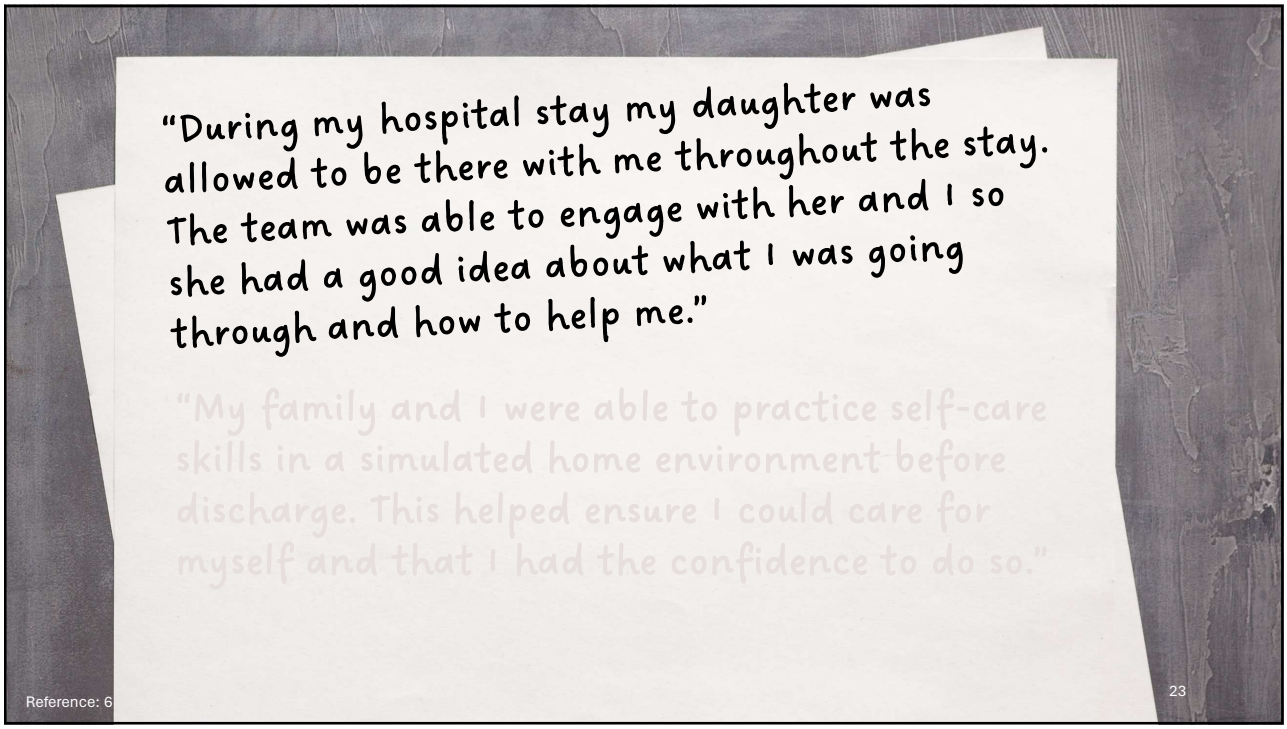
"During my hospital stay my daughter was allowed to be there with me throughout the stay. The team was able to engage with her and I so she had a good idea about what I was going through and how to help me."
"My family and I were able to practice self-care skills in a simulated home environment before discharge. This helped ensure I could care for myself and that I had the confidence to do so."
Reference: 6
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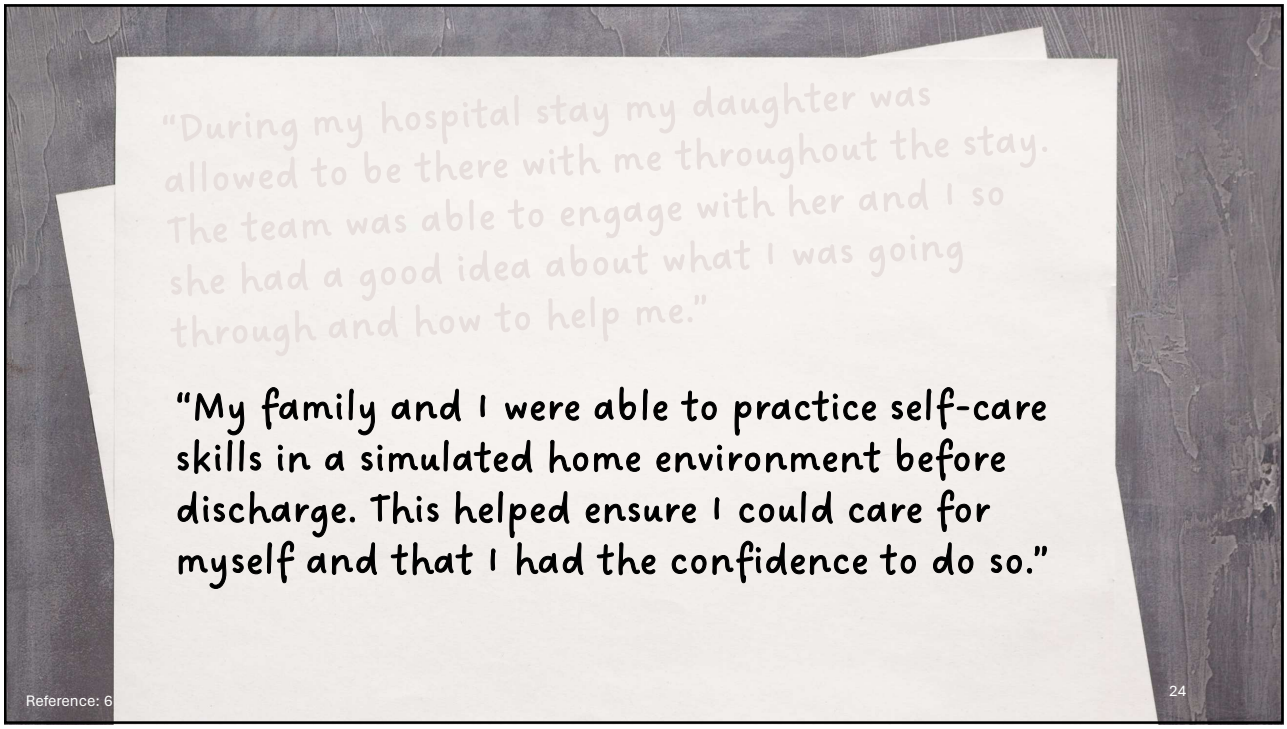
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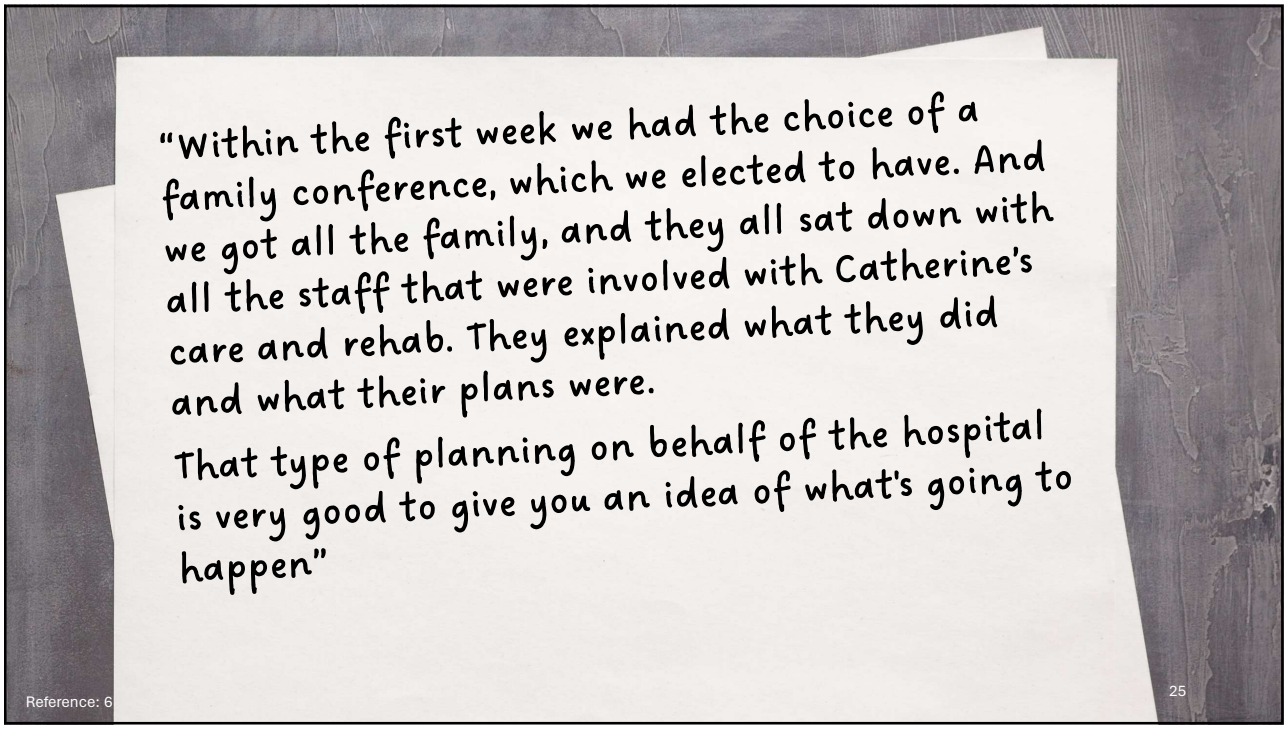
"Within the first week we had the choice of a family conference, which we elected to have. And we got all the family, and they all sat down with all the staff that were involved with Catherine's care and rehab. They explained what they did and what their plans were.
That type of planning on behalf of the hospital is very good to give you an idea of what's going to happen"
Reference: 6
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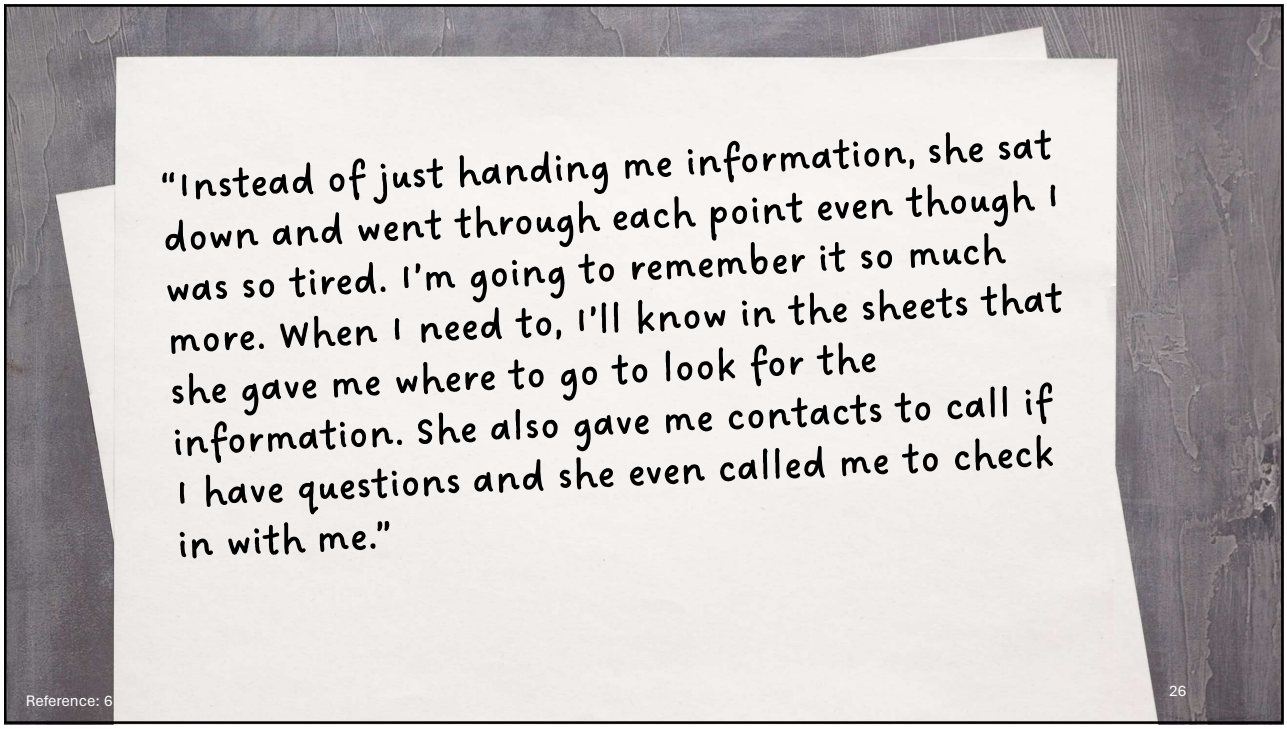
"Instead of just handing me information, she sat down and went through each point even though I was so tired. I'm going to remember it so much more. When I need to, I'll know in the sheets that she gave me where to go to look for the information. She also gave me contacts to call if I have questions and she even called me to check in with me."
Reference: 6
26

26

Factors enabling recovery

Being prepared to navigate health and social care services

- Competency and confidence built by the healthcare team
- Sense of safety reinforced with continuity of post-discharge follow-up services
- Maintain recovery momentum
  - Discharge services
  - Community rehabilitation
  - Social care services

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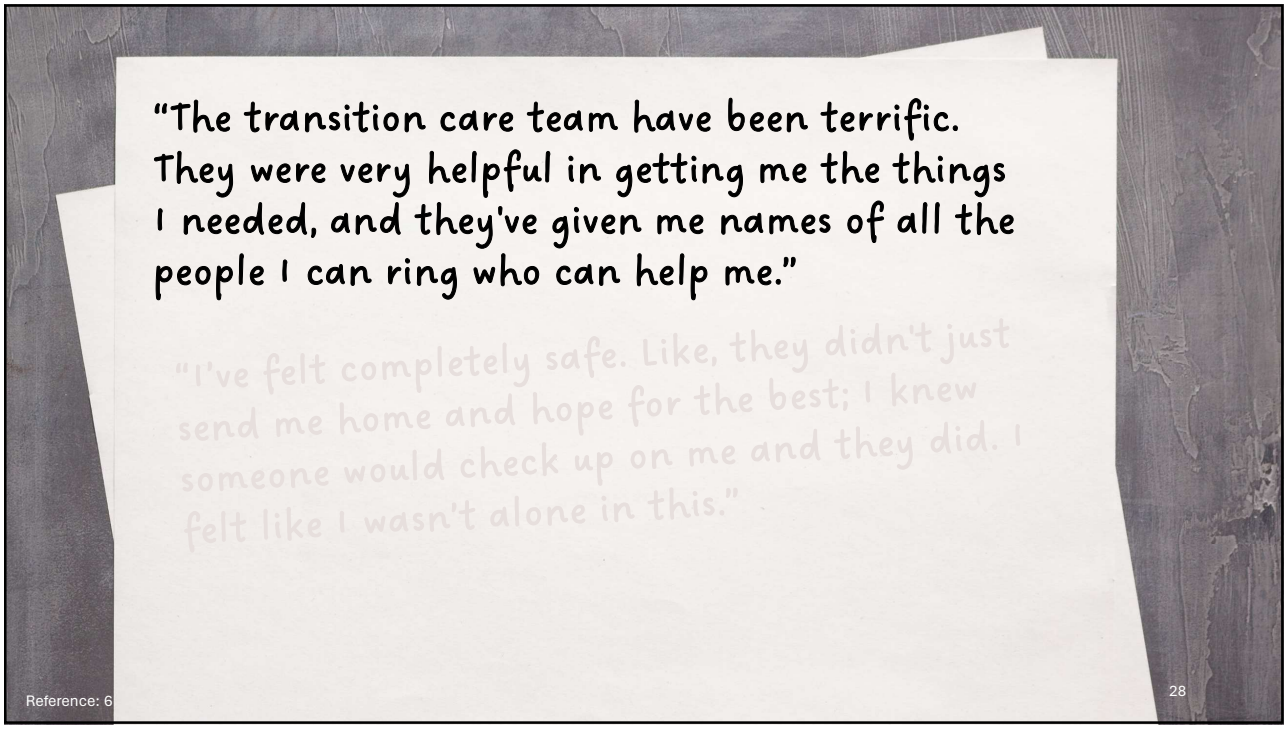

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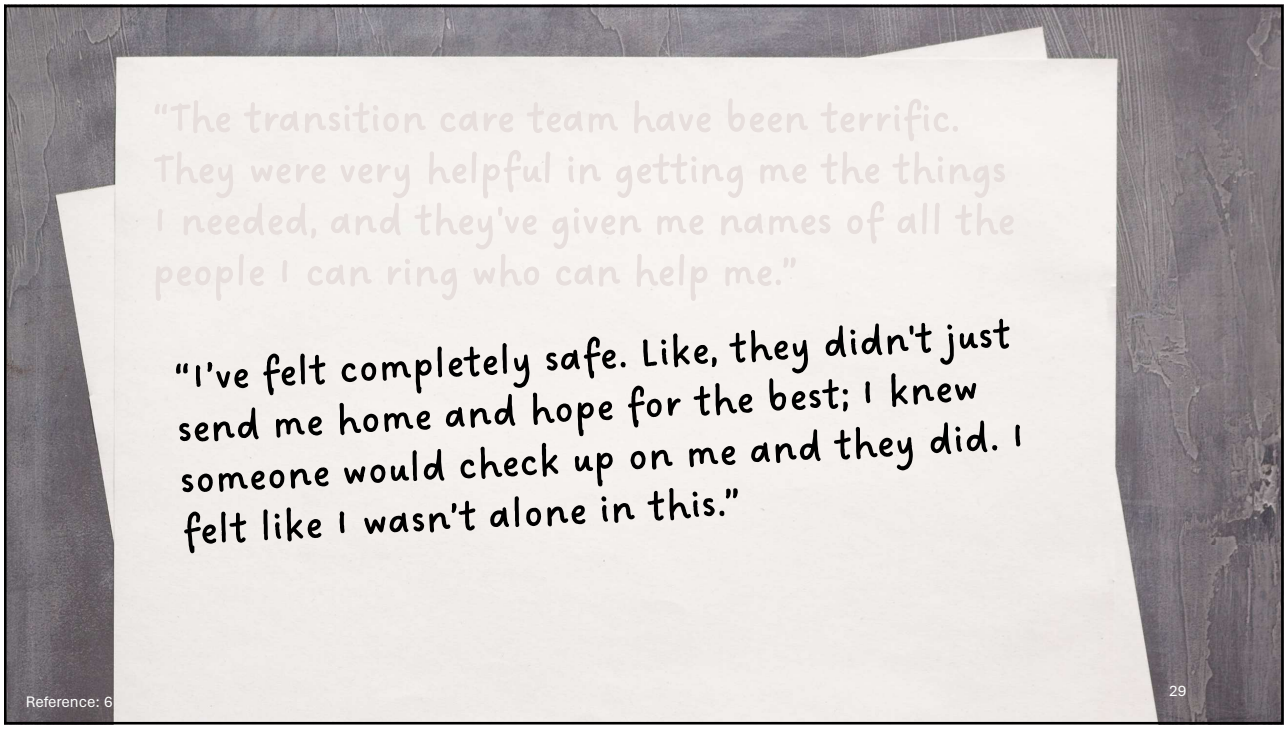

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Factors enabling recovery

Developing self-management skills

- Positive thoughts
  - Realize condition was more manageable than thought
- Positive self-appraisal of functional improvement
  - Develop confidence
  - Realistic goals and expectations
  - Recovery takes time
  - Accepting reality of stroke
- Self-efficacy
  - Built on mastery over caregiving and self-management activities

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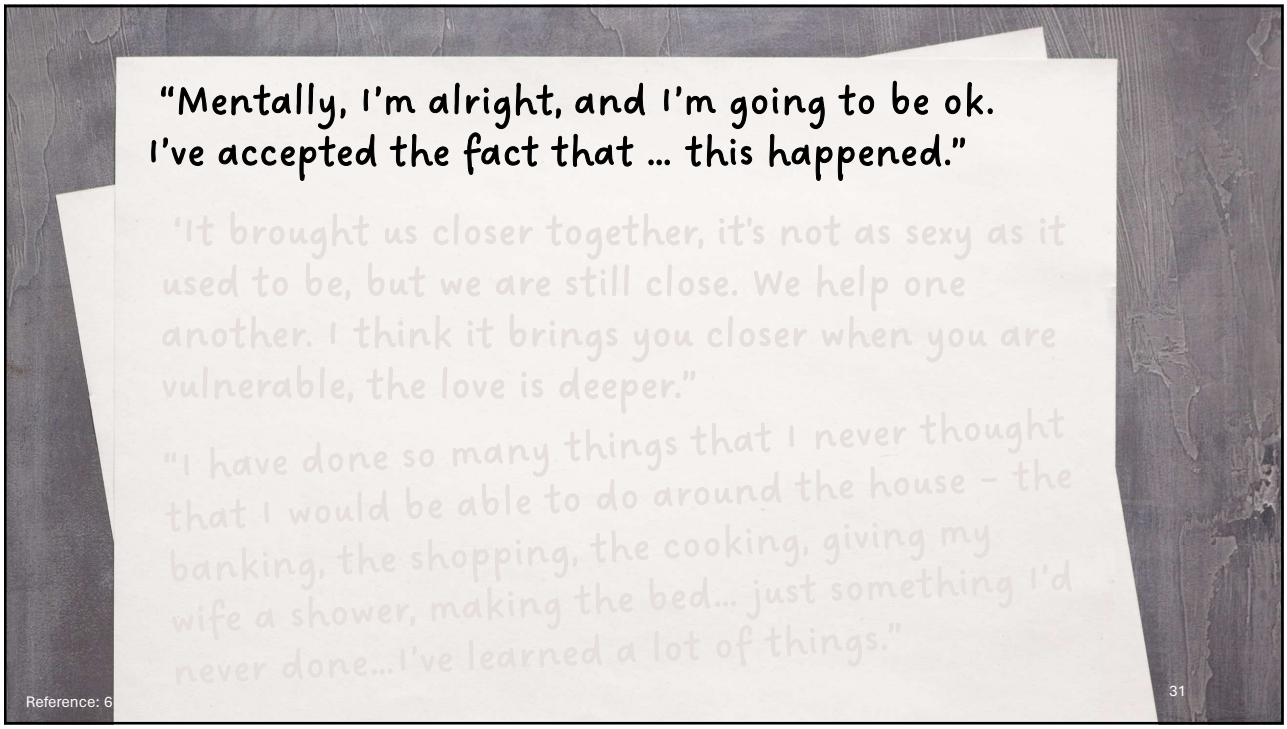
"Mentally, I'm alright, and I'm going to be ok. I've accepted the fact that ... this happened."
"It brought us closer together, it's not as sexy as it used to be, but we are still close. We help one another. I think it brings you closer when you are vulnerable, the love is deeper."
"I have done so many things that I never thought that I would be able to do around the house - the banking, the shopping, the cooking, giving my wife a shower, making the bed... just something I'd never done...I've learned a lot of things."
Reference: 6
31

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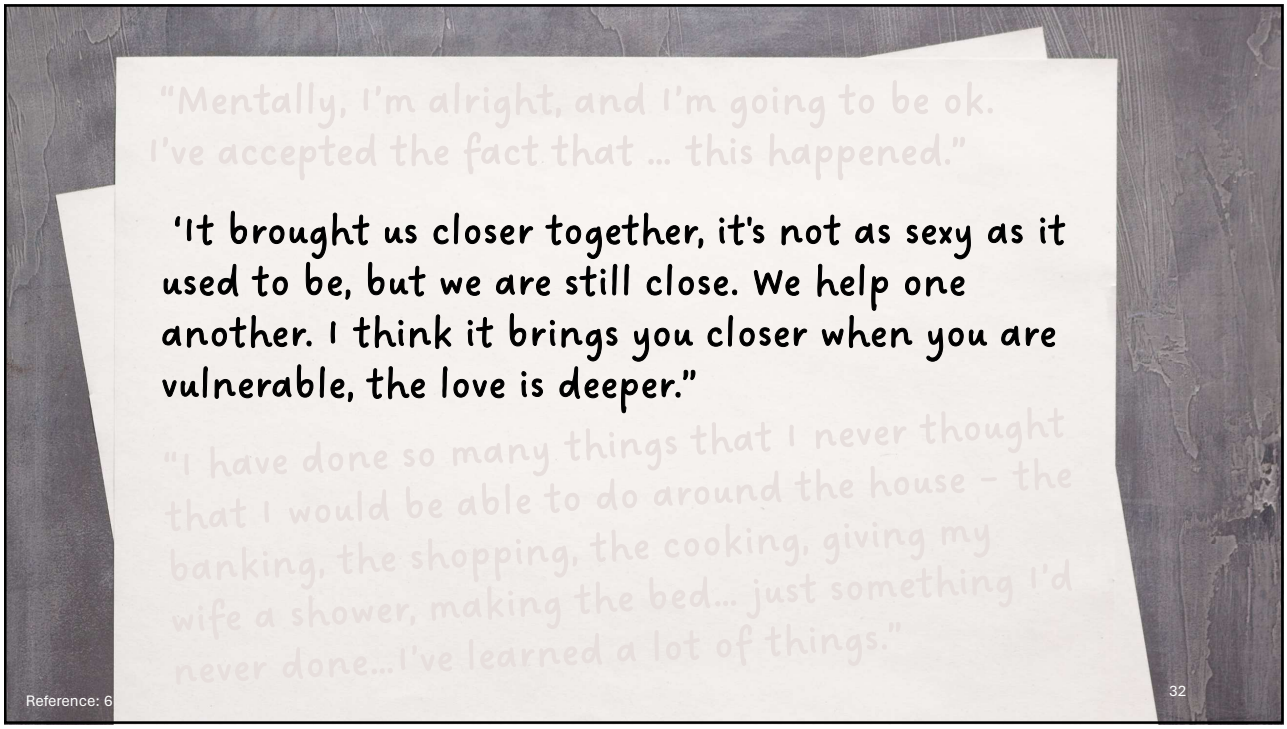
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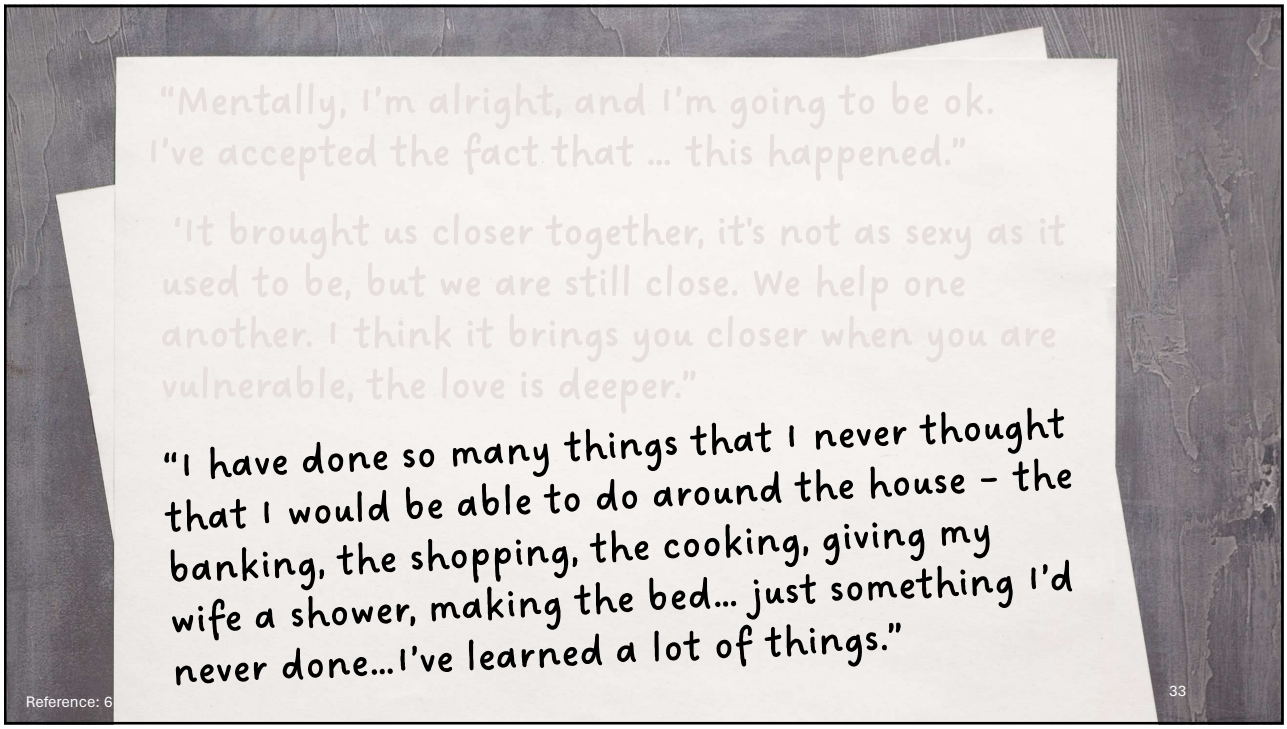

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Barriers to recovery

Three barriers

- Gaps in discharge planning
- Factors affecting self-care
- Inability to cope with challenges

34

34

Reference: 9, 10, 12

Barriers to recovery

Gaps in discharge planning

- Discrepancies in discharge priorities between patients, families and health professionals
- Lack of compassion from clinicians
- Care more about physical needs than emotional needs
- Discharged home with unanswered questions and concerns
- Lack of hands-on training in daily personal care activities

35

35

"They took special care with regard to my diet and giving me my medication on time. However, they were rarely concerned with my feelings. Actually, the most important thing for a patient is to feel like they are cared about"

"When you ask a question, they do not answer. There are so many things and tips a nurse knows, which would take months for us to learn, but they did not tell us if we asked them."

Reference: 6

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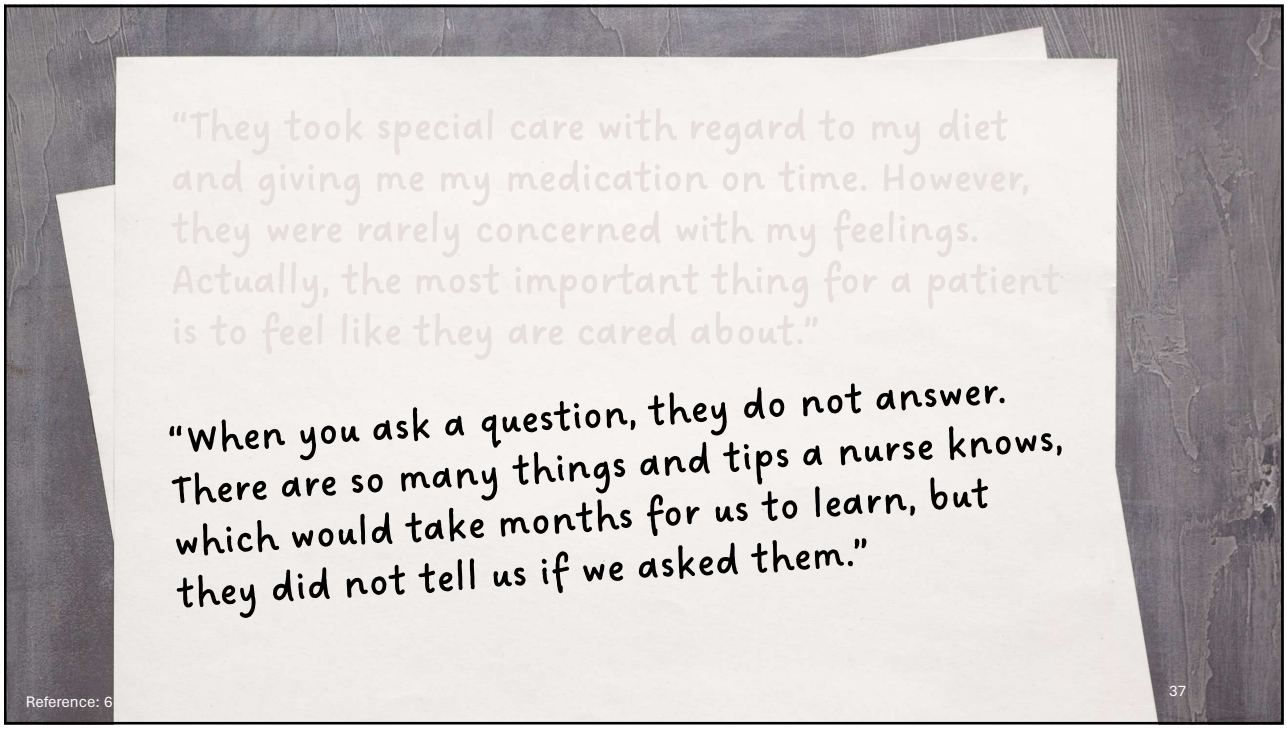

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Barriers to recovery

Factors affecting self-care

- Home is not the hospital
- Rely on caregivers to maintain activities of daily living
- Lack of caregiver training
- Inadequate community support
- Lack of follow-up jeopardized continued rehabilitation
- Long wait times for outpatient care
- Caregivers being taken for granted
- Financial constraints

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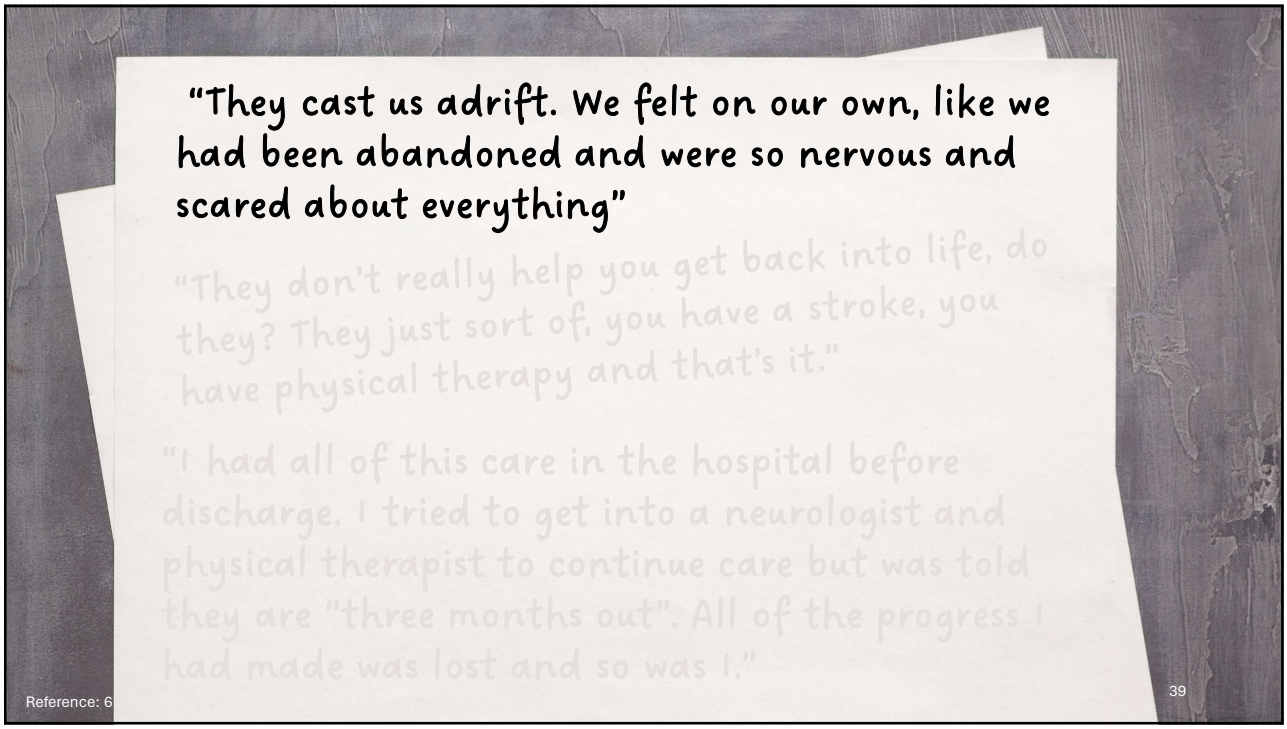
"They cast us adrift. We felt on our own, like we had been abandoned and were so nervous and scared about everything"
"They don't really help you get back into life, do they? They just sort of, you have a stroke, you have physical therapy and that's it."
"I had all of this care in the hospital before discharge. I tried to get into a neurologist and physical therapist to continue care but was told they are "three months out". All of the progress I had made was lost and so was I."
Reference: 6
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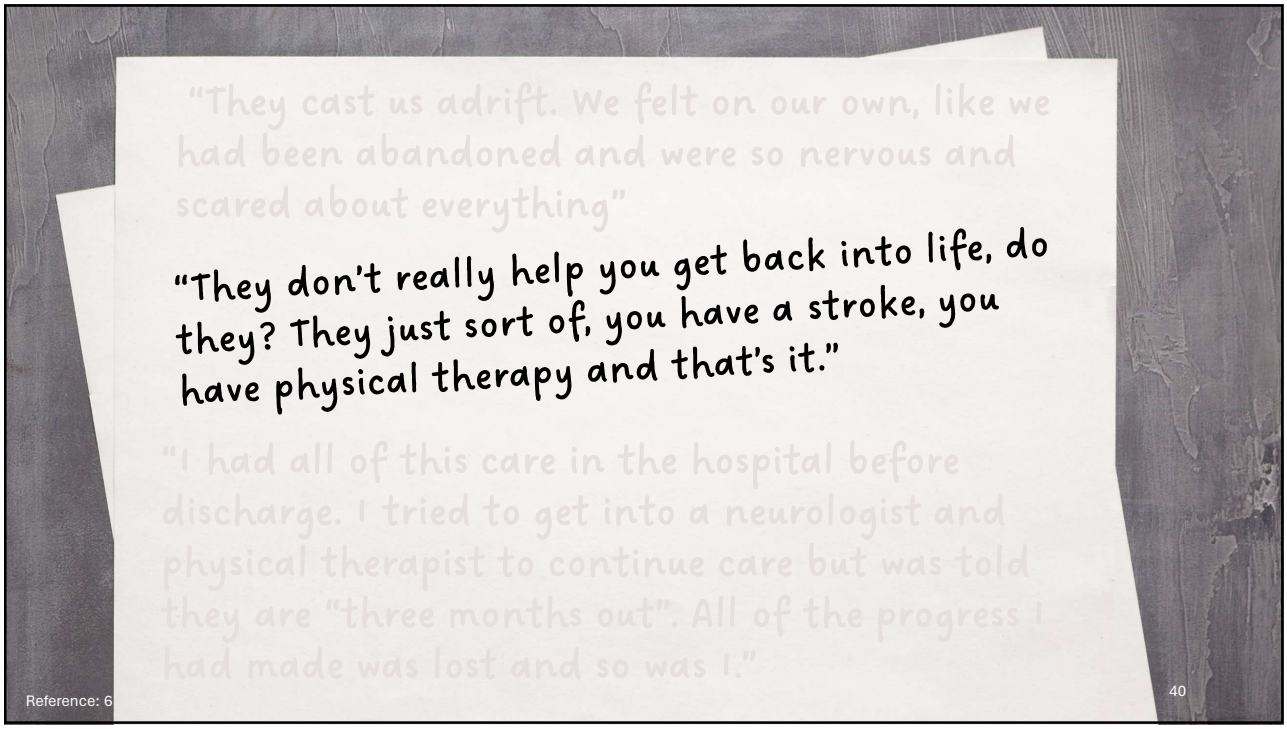
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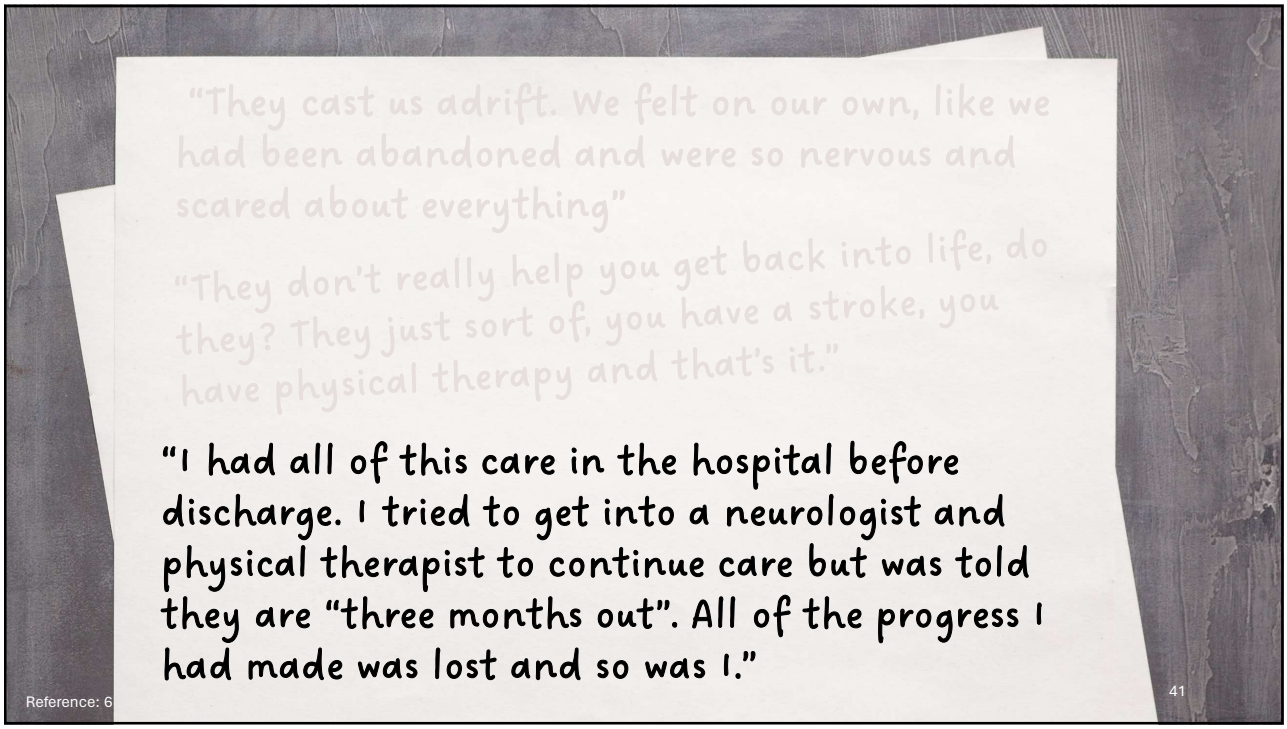
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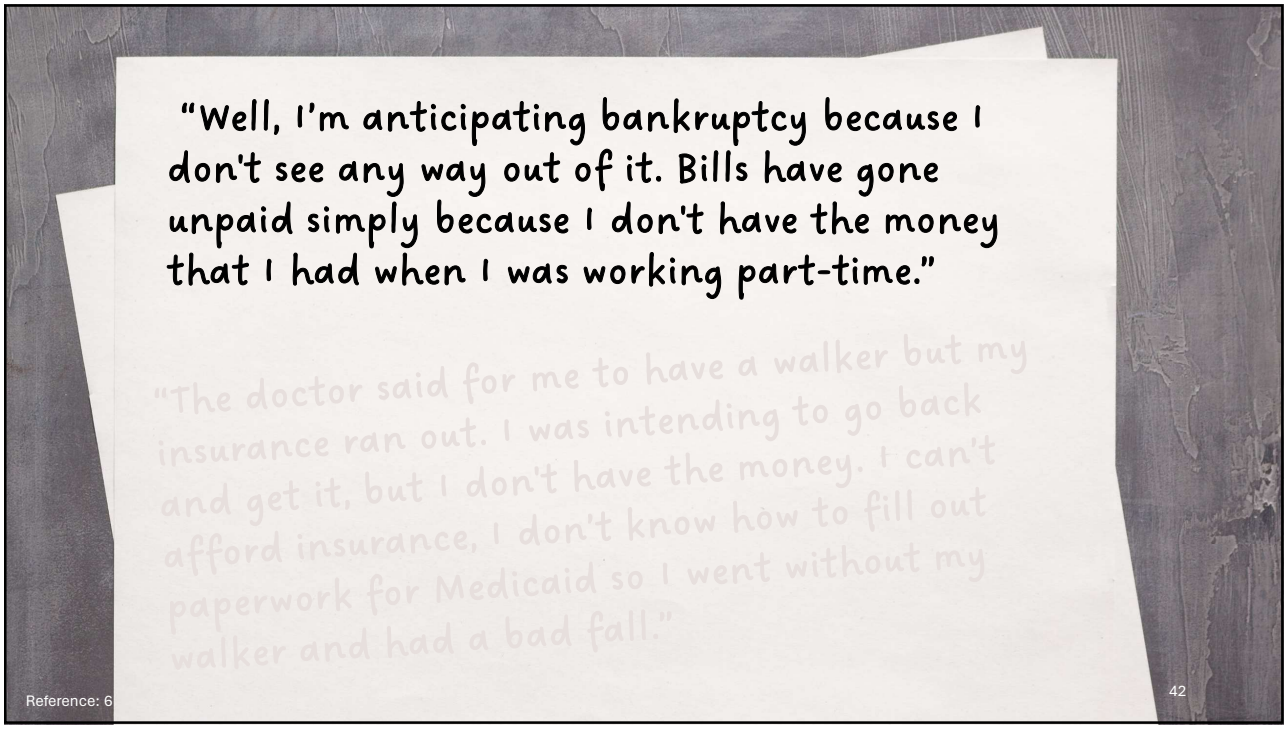
"Well, I'm anticipating bankruptcy because I don't see any way out of it. Bills have gone unpaid simply because I don't have the money that I had when I was working part-time."
"The doctor said for me to have a walker but my insurance ran out. I was intending to go back and get it, but I don't have the money. I can't afford insurance, I don't know how to fill out paperwork for Medicaid so I went without my walker and had a bad fall."
Reference: 6
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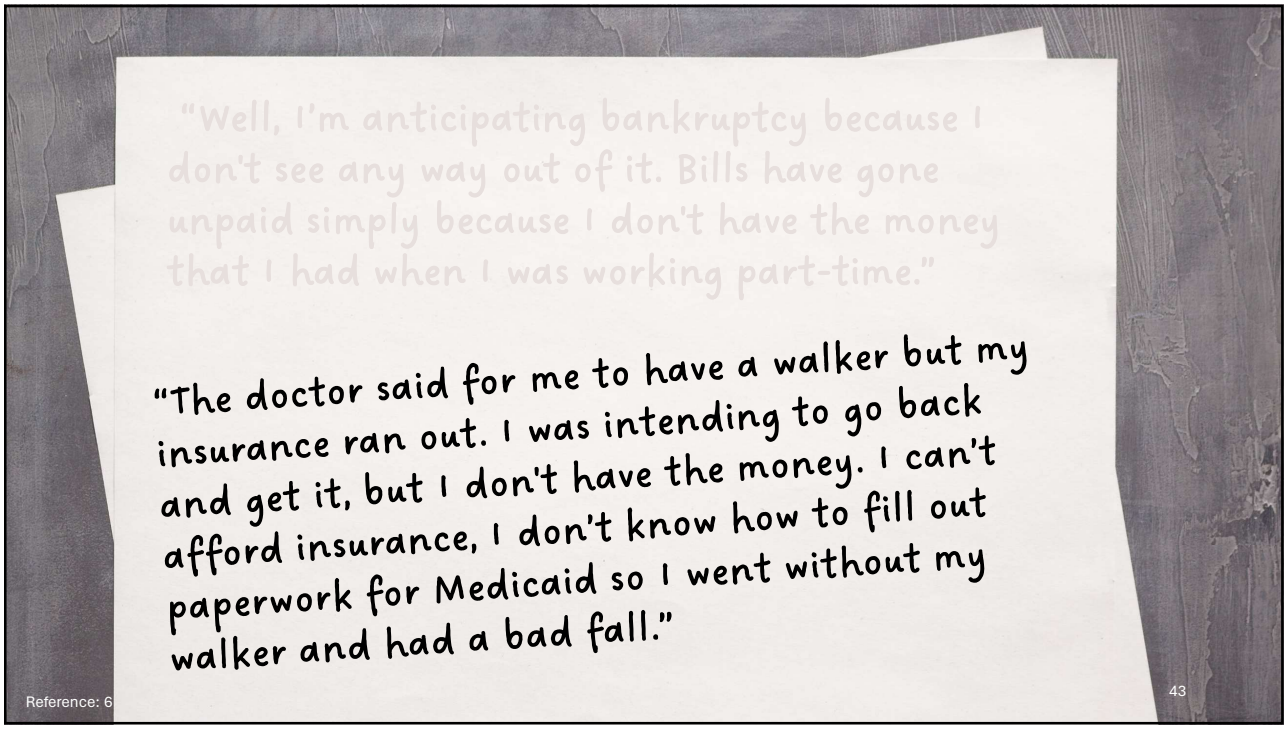
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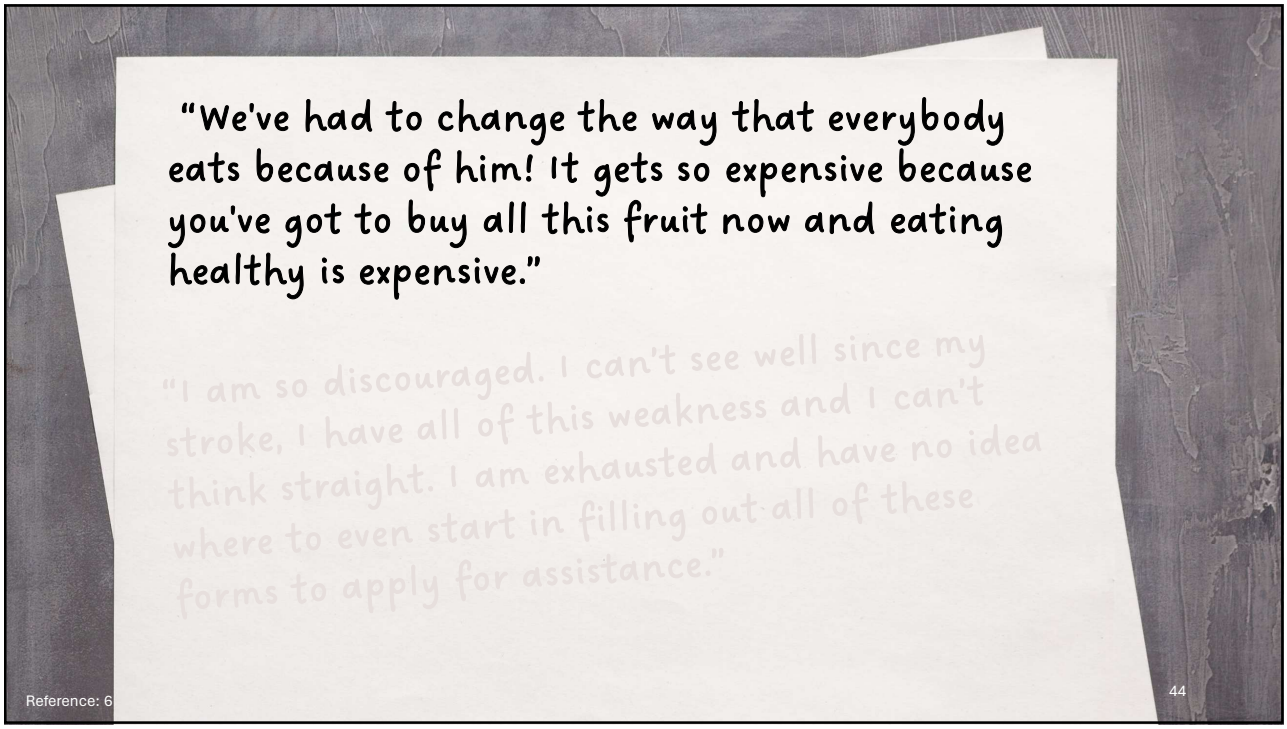
"We've had to change the way that everybody eats because of him! It gets so expensive because you've got to buy all this fruit now and eating healthy is expensive."
"I am so discouraged. I can't see well since my stroke, I have all of this weakness and I can't think straight. I am exhausted and have no idea where to even start in filling out all of these forms to apply for assistance."
Reference: 6
44

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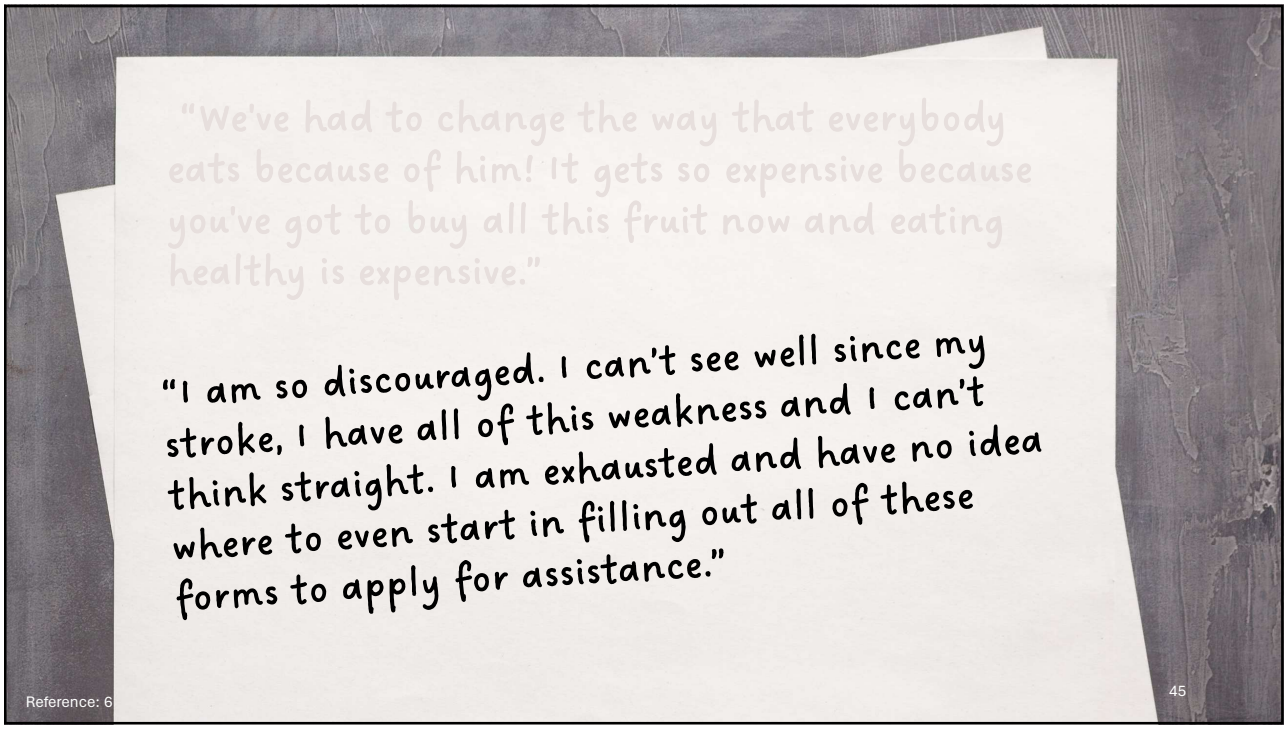

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Barriers to recovery

Inability to cope with challenges

- Acceptance of poststroke physical, cognitive and emotional impairments impacts recovery
- Perceive themselves as a stranger
- Difficulties adjusting to disability
- See themselves as a "burden"
- Social disengagement and isolation
- Caregivers struggle to adapt to role
- Caregivers increased responsibilities
- Caregiver isolation and burn-out

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46

Barriers to recovery

Factors affecting self-care

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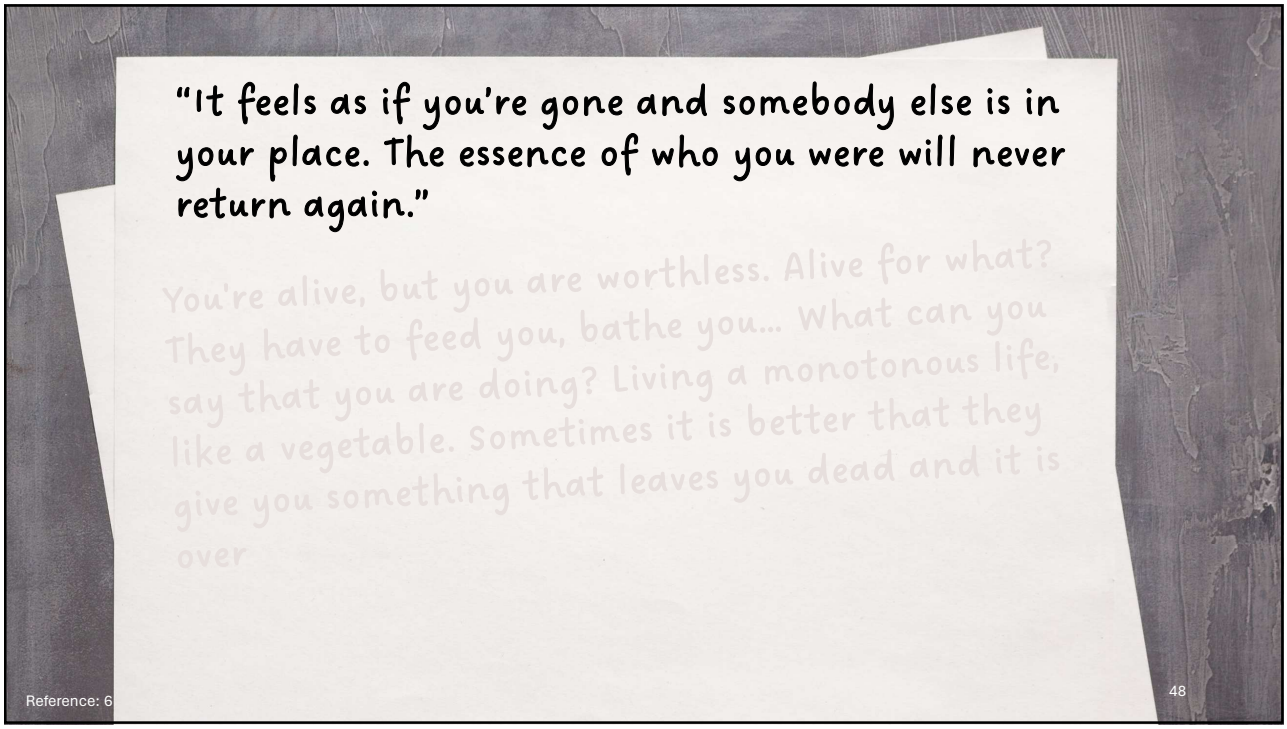

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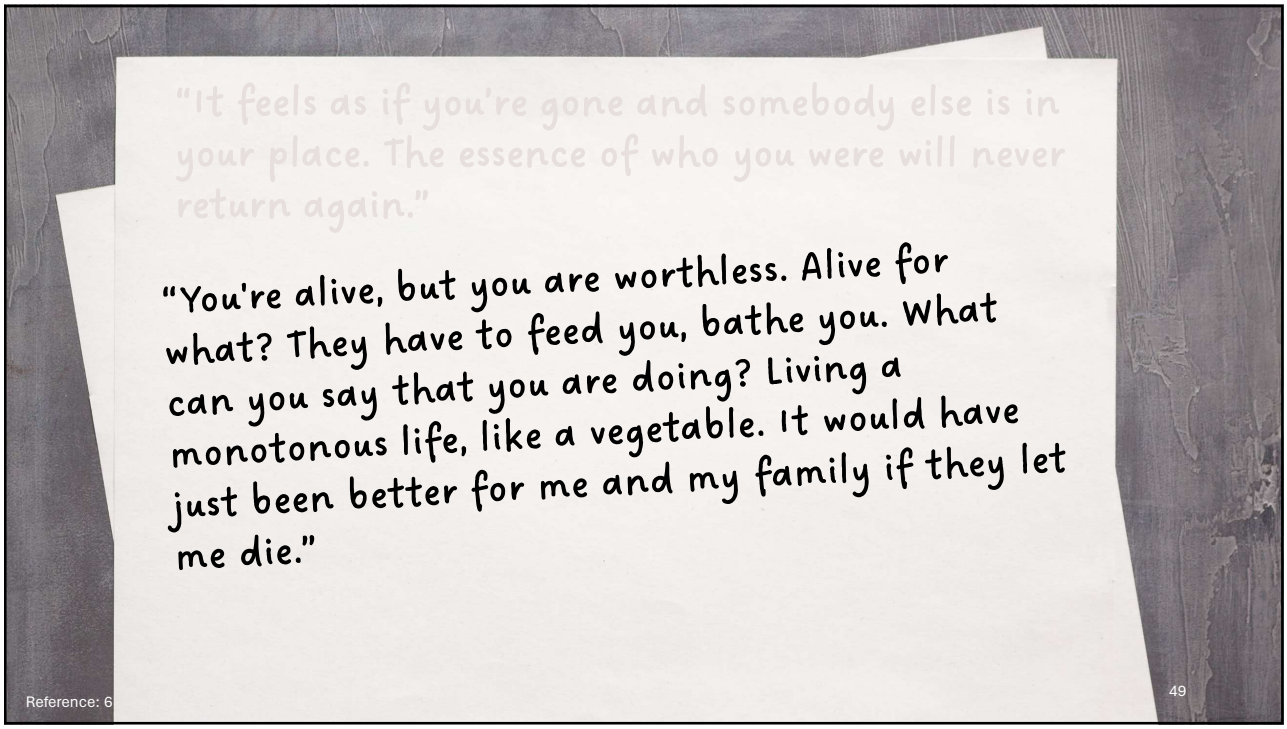
"It feels as if you're gone and somebody else is in your place. The essence of who you were will never return again."
"You're alive, but you are worthless. Alive for what? They have to feed you, bathe you. What can you say that you are doing? Living a monotonous life, like a vegetable. It would have just been better for me and my family if they let me die."
Reference: 6
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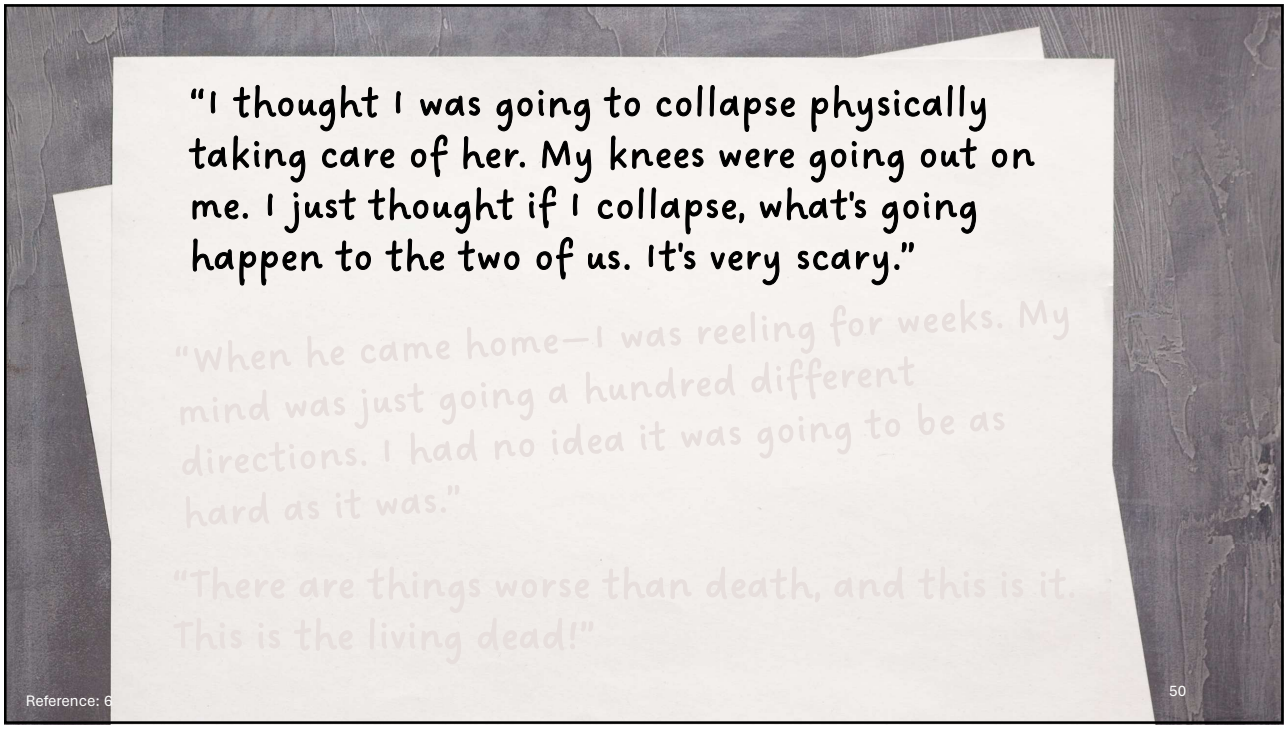
"I thought I was going to collapse physically taking care of her. My knees were going out on me. I just thought if I collapse, what's going happen to the two of us. It's very scary."
"When he came home—I was reeling for weeks. My mind was just going a hundred different directions. I had no idea it was going to be as hard as it was."
"There are things worse than death, and this is it. This is the living dead!"
Reference: 6
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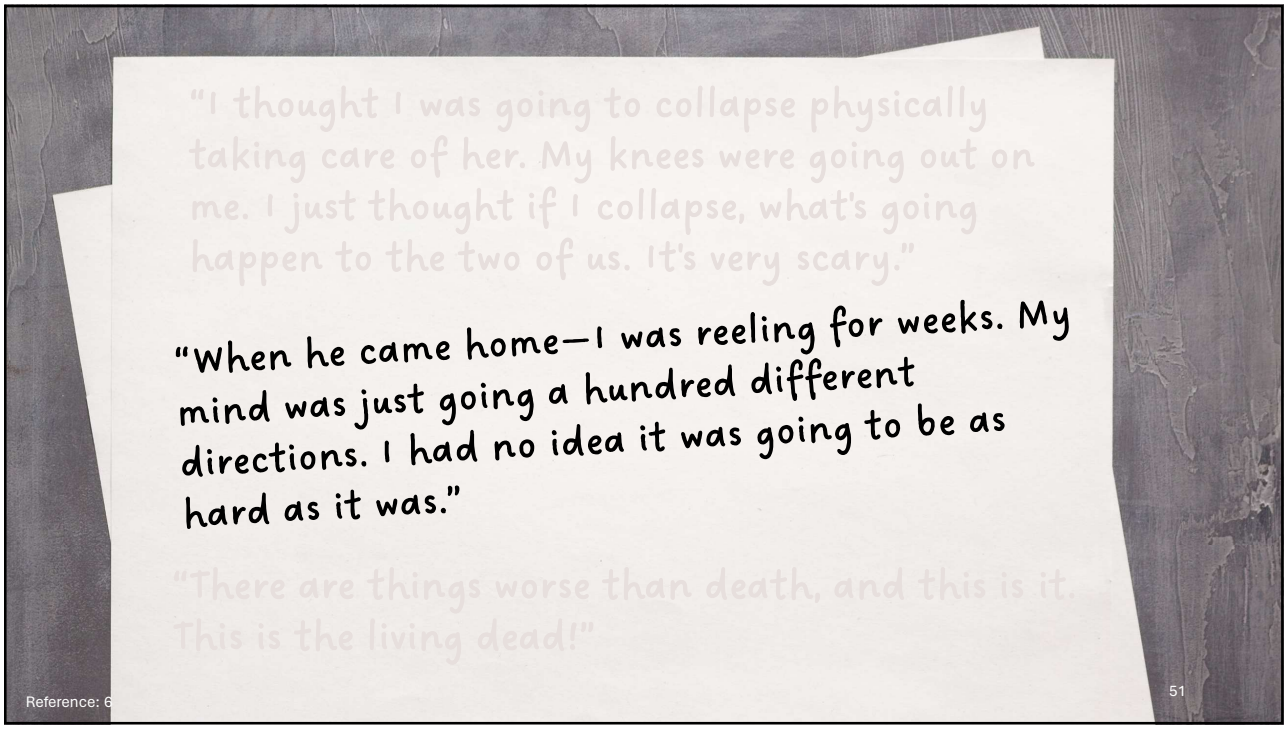
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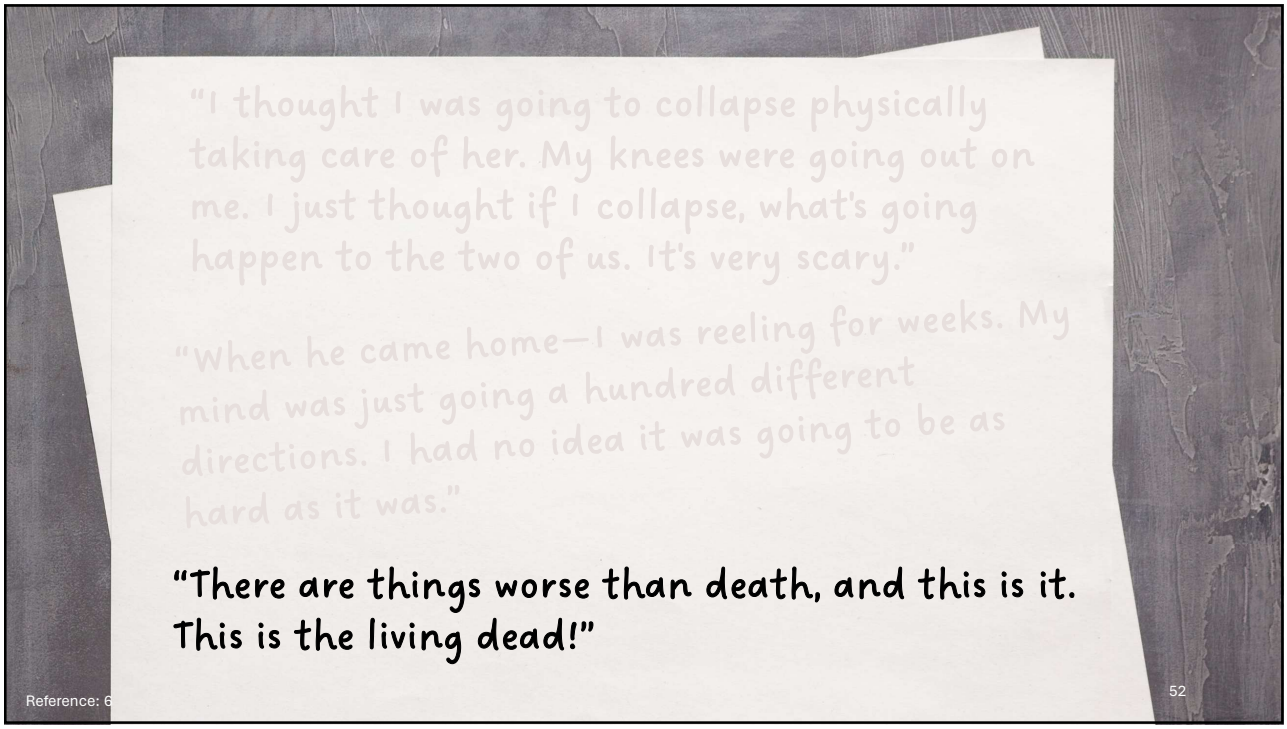
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52

Barriers to recovery

Impact on family members of loved ones who die from stroke

- Severe anguish and grief
- At risk for prolonged grief disorder
- Social disengagement and isolation
- Reset of social norms
- Financial insecurity
- Limited support and resources
- Risk for suicidal ideology
  - Older adult males have highest rate of completed suicide

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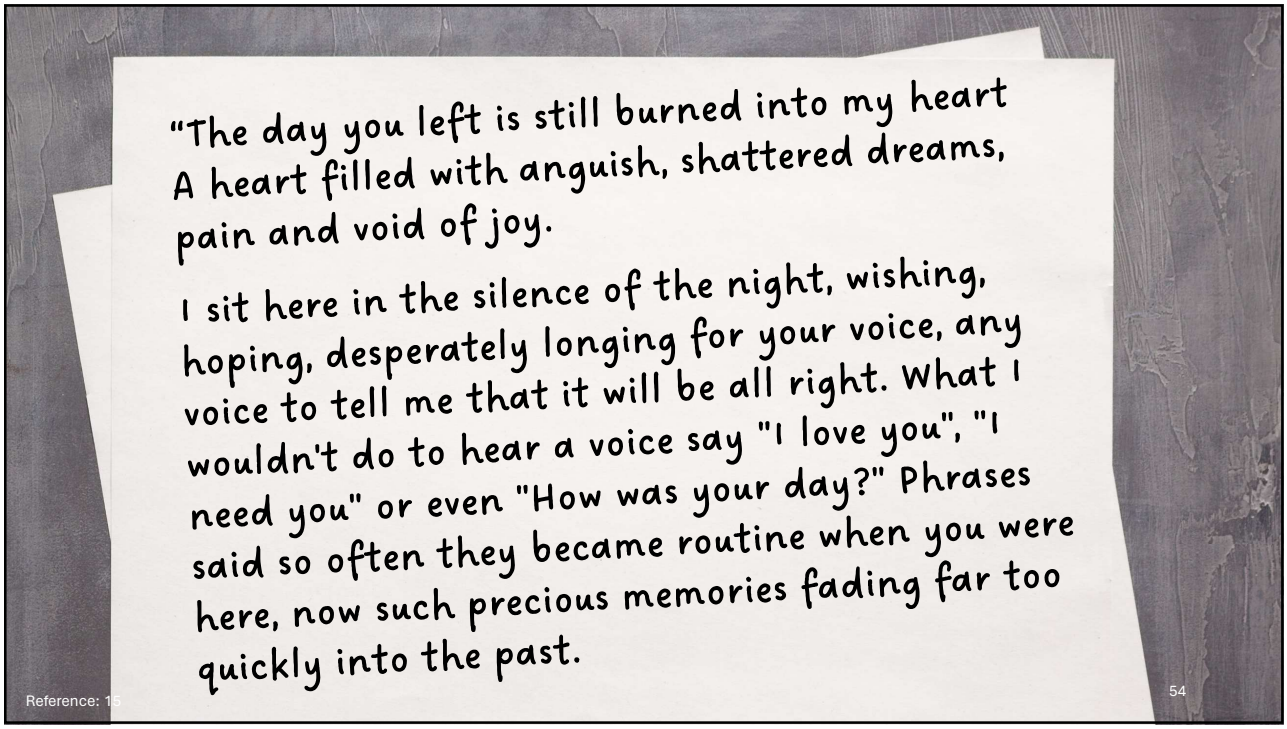

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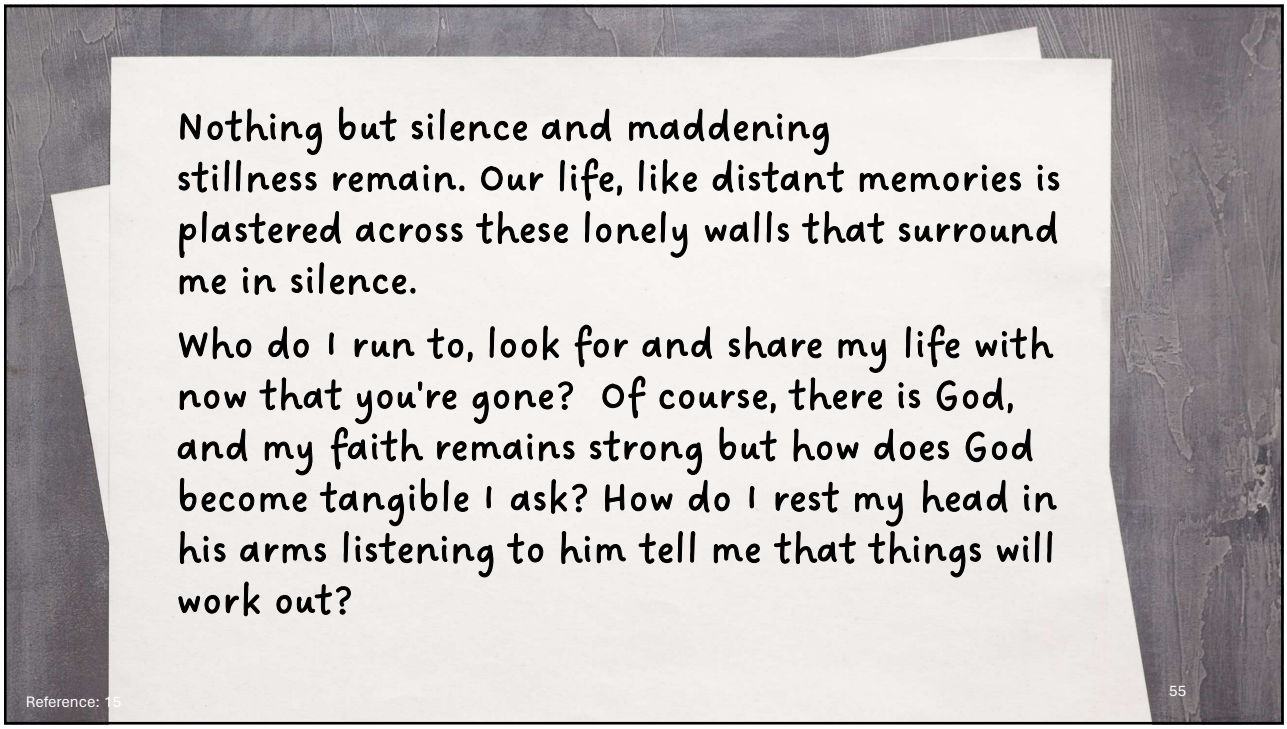
Nothing but silence and maddening stillness remain. Our life, like distant memories is plastered across these lonely walls that surround me in silence.
Who do I run to, look for and share my life with now that you're gone? Of course, there is God, and my faith remains strong but how does God become tangible I ask? How do I rest my head in his arms listening to him tell me that things will work out?
Reference: 15
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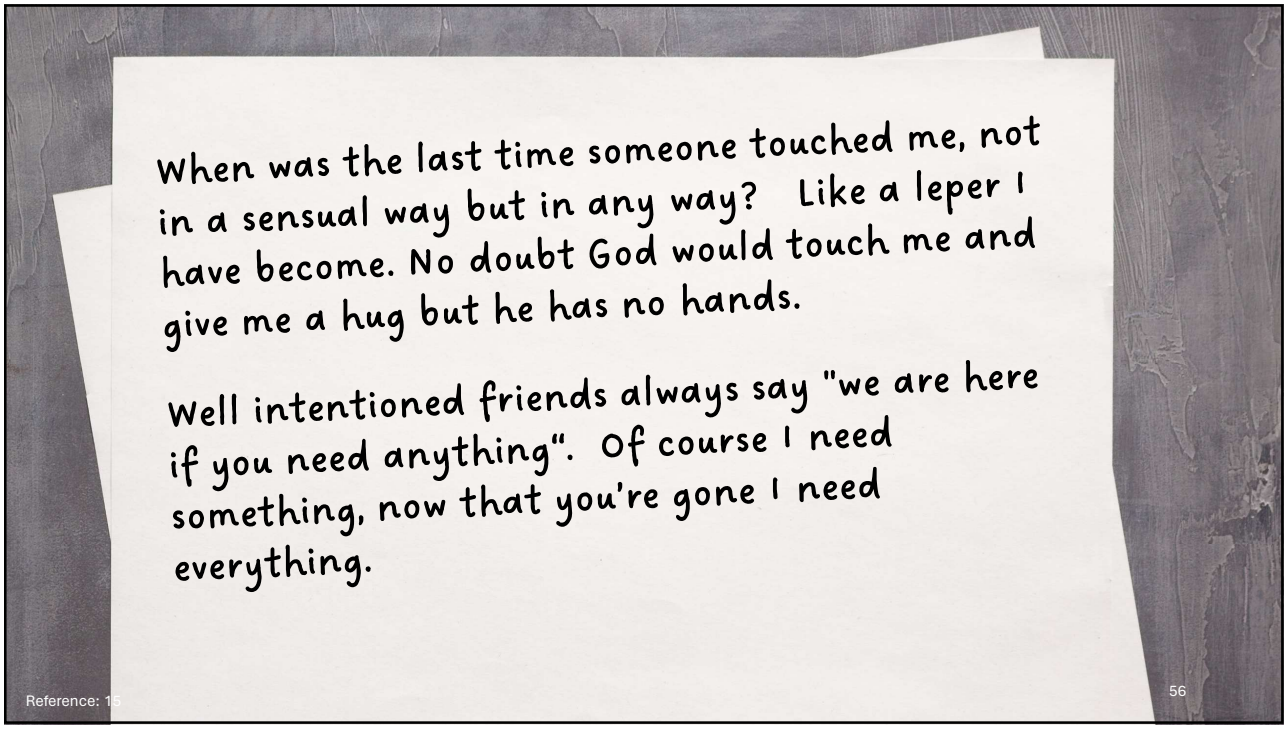
When was the last time someone touched me, not in a sensual way but in any way? Like a leper I have become. No doubt God would touch me and give me a hug but he has no hands.
Well intentioned friends always say "we are here if you need anything". Of course I need something, now that you're gone I need everything.
Reference: 15
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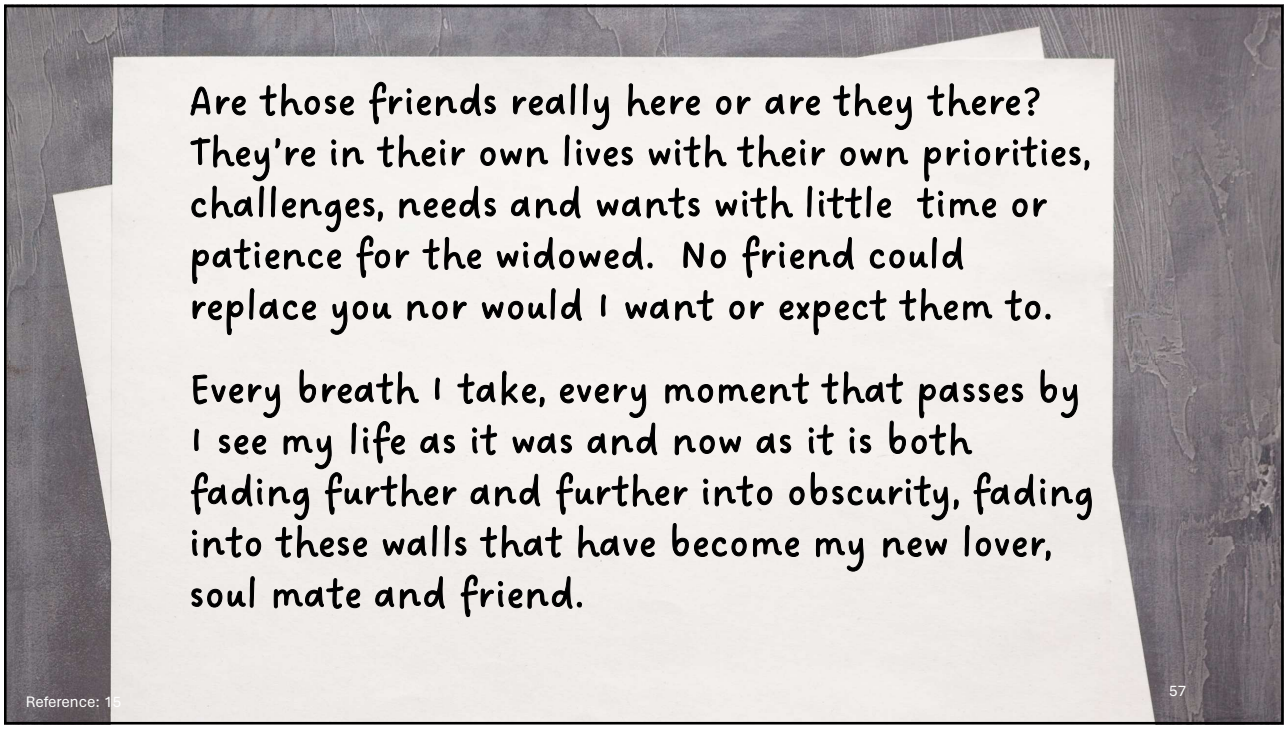
Are those friends really here or are they there? They're in their own lives with their own priorities, challenges, needs and wants with little time or patience for the widowed. No friend could replace you nor would I want or expect them to.
Every breath I take, every moment that passes by I see my life as it was and now as it is both fading further and further into obscurity, fading into these walls that have become my new lover, soul mate and friend.
Reference: 1
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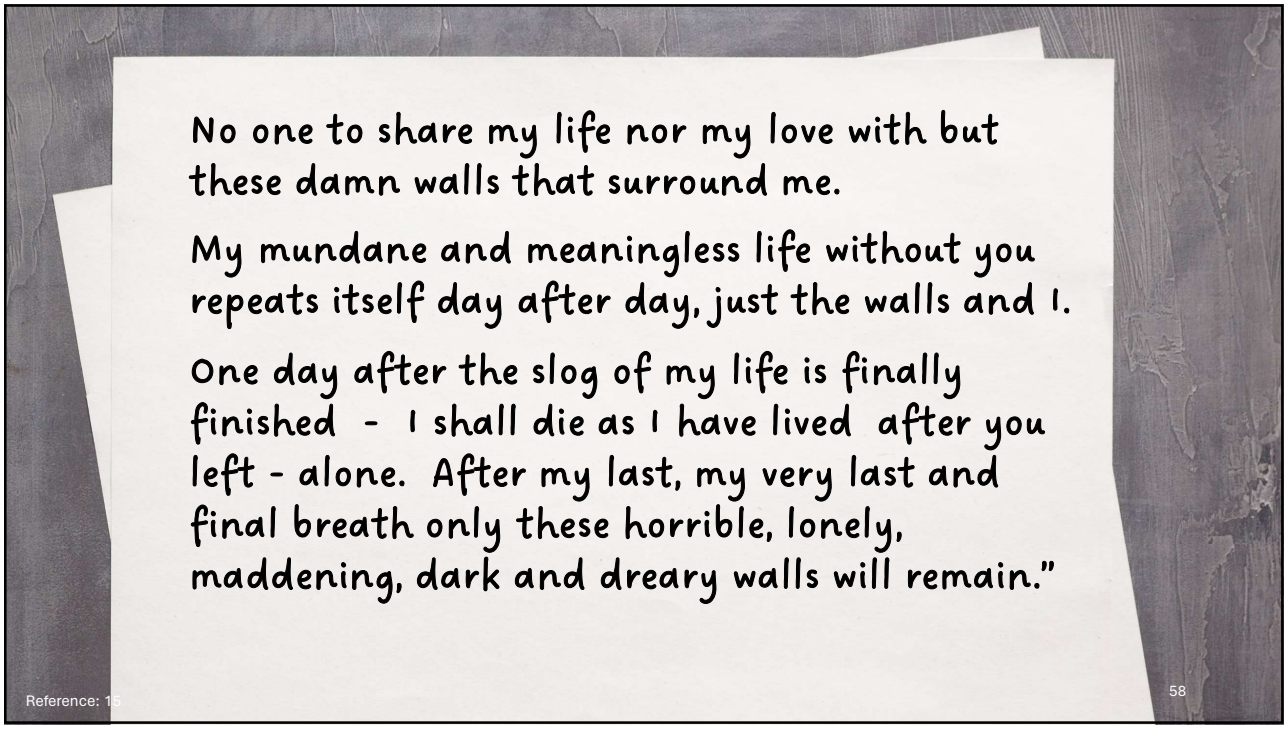
No one to share my life nor my love with but these damn walls that surround me.
My mundane and meaningless life without you repeats itself day after day, just the walls and I.
One day after the slog of my life is finally finished - I shall die as I have lived after you left - alone. After my last, my very last and final breath only these horrible, lonely, maddening, dark and dreary walls will remain."
Reference: 1
58

58

Expectations of care

- Ensure skills are set before home
- Education starts when stroke strikes
- Compassionate and holistic care
- Central point of contact is vital
- Regular “Check-ins”
- Home safety evaluation before D/C
- Services and benefits assistance
- Timely following with therapy, neurology and primary care services
- Community support groups
- Mental health and social services

59

59

Impact on clinical practice

- Protocols and clinical guidelines need to be generated and utilized
- Nurses, therapists and stroke coordinators ideal to lead programs
- Stroke coordinators are more than number crunchers to maintain certification
- Hospitals and health systems need to invest financial and tangible resources into transition programs
- Utilize telehealth for equitable care in rural and remote areas

60

60

Types of stroke aftercare facilities

Element	Inpatient Rehab Facility	Long-term Acute Care Hospital	Skilled Nursing Facility	Home Care
Description	Gold Standard of Care Most intensive rehab 25% of Stroke Patients	Focus on Medical and Nursing Care and Rehab	Skilled Nursing services Stay longer than 32 days	Rehab and Nursing services at home MD, DO, NP orders
Ideal patients	Significant neurological deficits Moderate medical management needs Medically stable Strong enough to participate in 3 hours or more of therapy 5 days/wk Average LOS: 2 weeks 70% of patients are well enough to go home	Complex health needs Ventilators, wounds, dialysis, IV therapy, tracheostomy care Rehab based on patient tolerance	Need rehab but are not able to complete 3 hours/day 5 days per week Medical and nursing needs can be met with medical/nursing resources	Cannot leave home readily due to physical or mental incapacity **or** lack of transportation

Reference: 6

61

61

Types of stroke aftercare facilities

Element	Inpatient Rehab Facility	Long-term Acute Care Hospital	Skilled Nursing Facility	Home Care
Team	Physiatrist (Team lead) Rehabilitation Nurse Social Worker Physical Therapist Occupational Therapist Speech Therapist Mental Health Provider	Internist (Team lead) Physiatrist (Consult) Registered Nurses Social Worker Physical Therapist Occupation Therapist Speech Therapist	Physician or Nurse Practitioner as Medical Director Registered Nurses Licensed Practical Nurses Certified Nursing Assistants PT, OT, ST	MD, DO. NP refers and writes ongoing orders Registered Nurse Licensed Practical Nurse Certified Nursing Assistant PT, OT, ST
Focus	Medical management, Bowel/bladder function, Skin integrity, Nutrition, Mobility and self care, Cognition, Pain and spasticity, Adjustment, Orthotics, Discharge, Family Support/Education	Medical management, Cognition and communication, Skin integrity, Nutrition, Wound care, Pain and Spasticity, DME Orthotics, Funding for care needs, Family Support/Education	Skin integrity, Nutrition, Medication administration, Pain and Spasticity, Bowel and Bladder, Mental health, Discharge planning, DME Orthotics, Family Support/Education	Skin Integrity, Bowel and Bladder, Medication administration, Mobility and self-care, Pain and Spasticity, Nutrition, DME orthotics, Family Support/Education

Reference: 6

62

62

Types of stroke aftercare facilities

Element	Inpatient Rehab Facility	Long-term Acute Care Hospital	Skilled Nursing Facility	Home Care
Regulatory requirements	Medicare required physiatrist approve each patient for IRF admission Patient complete at least 3 hours per day, 5 days per week of PT, OT, Speech therapy, Orthotic and prosthetic services Physiatrist must visit patient 3 times per week to provider treatment and ensure progression	Medicare LOS must be greater than 25 days on average 3-day intensive care unit LOS or 96 hours of mechanical ventilation on a respirator No requirement for rehab hours at this level	MD, DO or NP can be medical director RN required to be onsite 8 hours a day, 7 days per week Medical director visit every 30 days for 1st 3 months then every 60 days 3-day qualifying hospital stay within 30 preceding days Daily skilled services	Certified as homebound PT, OT, ST 1-3 times per week RN visits 1-7 times per week for woun care, medication management, bowel and bladder function Medicare: Maximum 60 days for homecare Usually few weeks after hospitalization

Reference: 6

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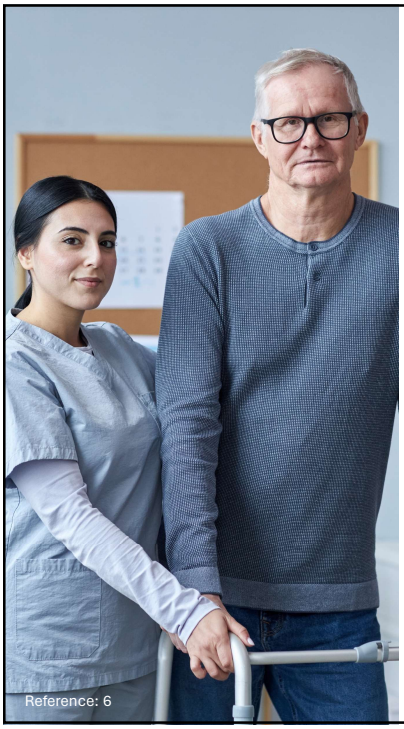

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Skilled nursing facility: Outpatient Rehabilitation

- Services provided in outpatient facility
- Wide variety of rehab services
- Physical, Occupation and Speech Therapy
- Driving evaluation
- Orthotic and adaptive technology
- Wheelchair clinic
- Vocational rehab
- Electrical stimulation
- Robotic and virtual reality therapy
- Therapy frequency 1-3 times per week

64

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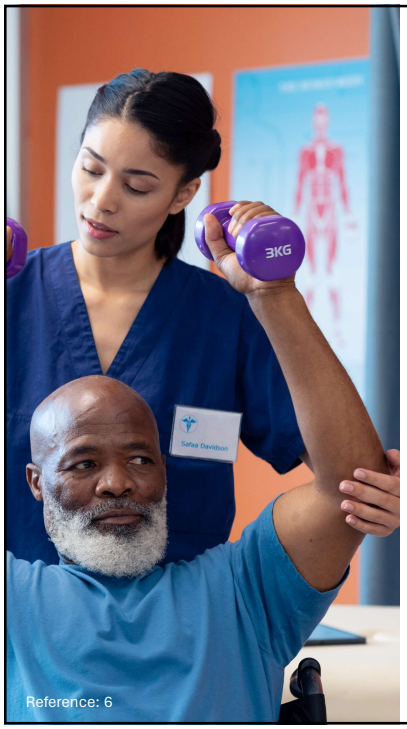

Skilled nursing facility: Outpatient Rehabilitation

- Ideal patients
  - Able to be transported to clinic 1-3 times per week
  - Benefit from focus on higher level of mobility and instrumental ADL skills such as driving not addressed in home therapy
- Regulatory requirements
  - Cap on Medicare expenditures for PT, OT, ST each year
  - Medicare pays 80% of the cost of therapies up to $2,330 year

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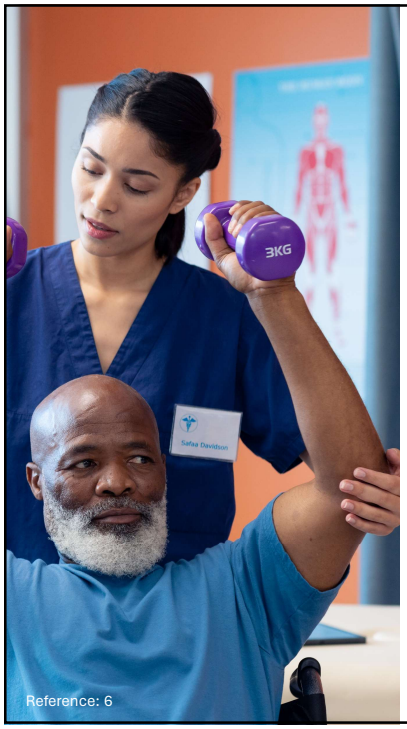

Skilled nursing facility: Outpatient Rehabilitation

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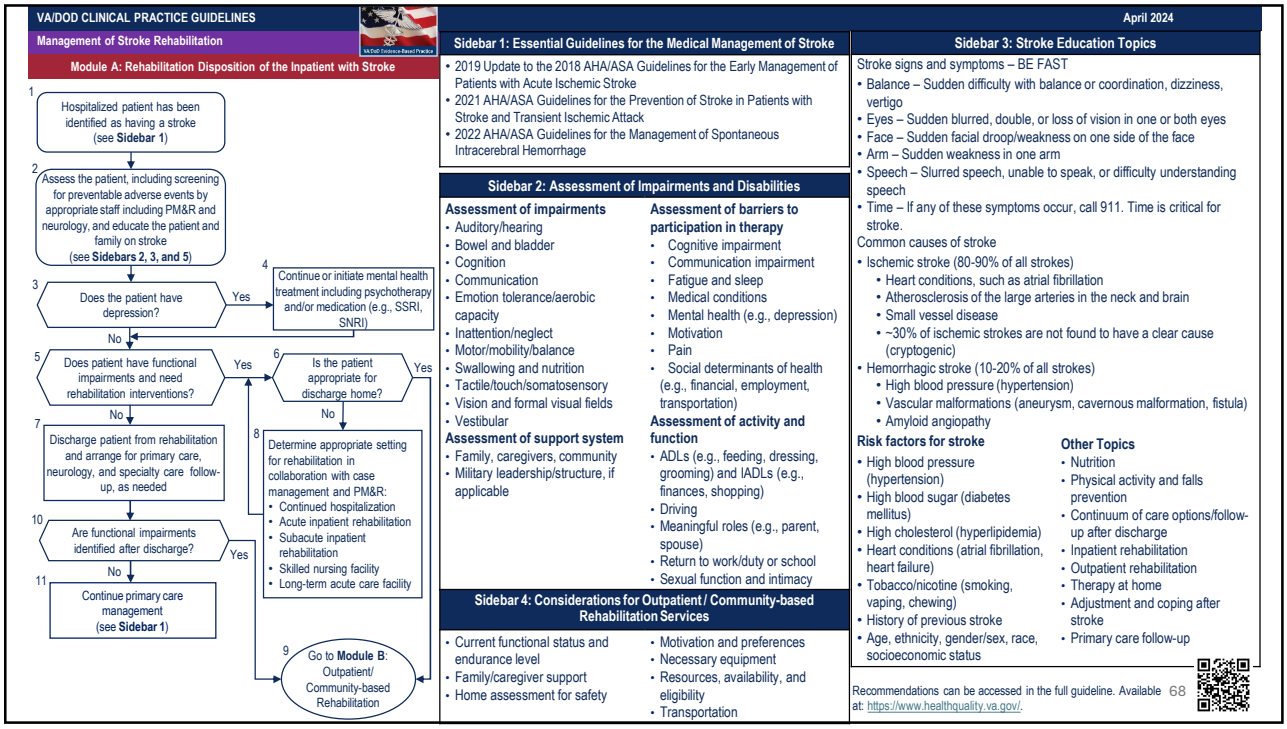
Tools
DRAFT
U.S. VETERANS ADMINISTRATION AND
U.S. DEPARTMENT OF DEFENSE
Management of Stroke Rehab Guidelines
Coming 2024
67

67


VA/DOD CLINICAL PRACTICE GUIDELINES
Management of Stroke Rehabilitation
Module A: Rehabilitation Disposition of the Inpatient with Stroke
1 Hospitalized patient has been identified as having a stroke (see Sidebar 1)
2 Assess the patient, including screening for preventable adverse events by appropriate staff including PM&R and neurology, and educate the patient and family on stroke (see Sidebars 2, 3, and 5)
3 Does the patient have depression?
Yes
4 Continue or initiate mental health treatment including psychotherapy and/or medication (e.g., SSRI, SNRI)
No
5 Does patient have functional impairments and need rehabilitation interventions?
Yes
6 Is the patient appropriate for discharge home?
Yes
No
7 Discharge patient from rehabilitation and arrange for primary care, neurology, and specialty care follow-up, as needed
8 Determine appropriate setting for rehabilitation in collaboration with case management and PM&R:
• Continued hospitalization
• Acute inpatient rehabilitation
• Subacute inpatient rehabilitation
• Skilled nursing facility
• Long-term acute care facility
10 Are functional impairments identified after discharge?
Yes
No
11 Continue primary care management (see Sidebar 1)
9 Go to Module B: Outpatient/ Community-based Rehabilitation
April 2024
Sidebar 1: Essential Guidelines for the Medical Management of Stroke
• 2019 Update to the 2018 AHA/ASA Guidelines for the Early Management of Patients with Acute Ischemic Stroke
• 2021 AHA/ASA Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack
• 2022 AHA/ASA Guidelines for the Management of Spontaneous Intracerebral Hemorrhage
Sidebar 2: Assessment of Impairments and Disabilities
Assessment of impairments
• Auditory/hearing
• Bowel and bladder
• Cognition
• Communication
• Emotion tolerance/aerobic capacity
• Inattention/neglect
• Motor/mobility/balance
• Swallowing and nutrition
• Tactile/touch/somatosensory
• Vision and formal visual fields
• Vestibular
Assessment of support system
• Family, caregivers, community
• Military leadership/structure, if applicable
Assessment of barriers to participation in therapy
• Cognitive impairment
• Communication impairment
• Fatigue and sleep
• Medical conditions
• Mental health (e.g., depression)
• Motivation
• Pain
• Social determinants of health (e.g., financial, employment, transportation)
Assessment of activity and function
• ADLs (e.g., feeding, dressing, grooming) and IADLs (e.g., finances, shopping)
• Driving
• Meaningful roles (e.g., parent, spouse)
• Return to work/duty or school
• Sexual function and intimacy
Sidebar 4: Considerations for Outpatient / Community-based Rehabilitation Services
• Current functional status and endurance level
• Family/caregiver support
• Home assessment for safety
• Motivation and preferences
• Necessary equipment
• Resources, availability, and eligibility
• Transportation
Sidebar 3: Stroke Education Topics
Stroke signs and symptoms – BE FAST
• Balance – Sudden difficulty with balance or coordination, dizziness, vertigo
• Eyes – Sudden blurred, double, or loss of vision in one or both eyes
• Face – Sudden facial droop/weakness on one side of the face
• Arm – Sudden weakness in one arm
• Speech – Slurred speech, unable to speak, or difficulty understanding speech
• Time – If any of these symptoms occur, call 911. Time is critical for stroke.
Common causes of stroke
• Ischemic stroke (80-90% of all strokes)
• Heart conditions, such as atrial fibrillation
• Atherosclerosis of the large arteries in the neck and brain
• Small vessel disease
• ~30% of ischemic strokes are not found to have a clear cause (cryptogenic)
• Hemorrhagic stroke (10-20% of all strokes)
• High blood pressure (hypertension)
• Vascular malformations (aneurysm, cavernous malformation, fistula)
• Amyloid angiopathy
Risk factors for stroke
• High blood pressure (hypertension)
• High blood sugar (diabetes mellitus)
• High cholesterol (hyperlipidemia)
• Heart conditions (atrial fibrillation, heart failure)
• Tobacco/nicotine (smoking, vaping, chewing)
• History of previous stroke
• Age, ethnicity, gender/sex, race, socioeconomic status
Other Topics
• Nutrition
• Physical activity and falls prevention
• Continuum of care options/follow-up after discharge
• Inpatient rehabilitation
• Outpatient rehabilitation
• Therapy at home
• Adjustment and coping after stroke
• Primary care follow-up
Recommendations can be accessed in the full guideline. Available at: https://www.healthquality.va.gov/.
68

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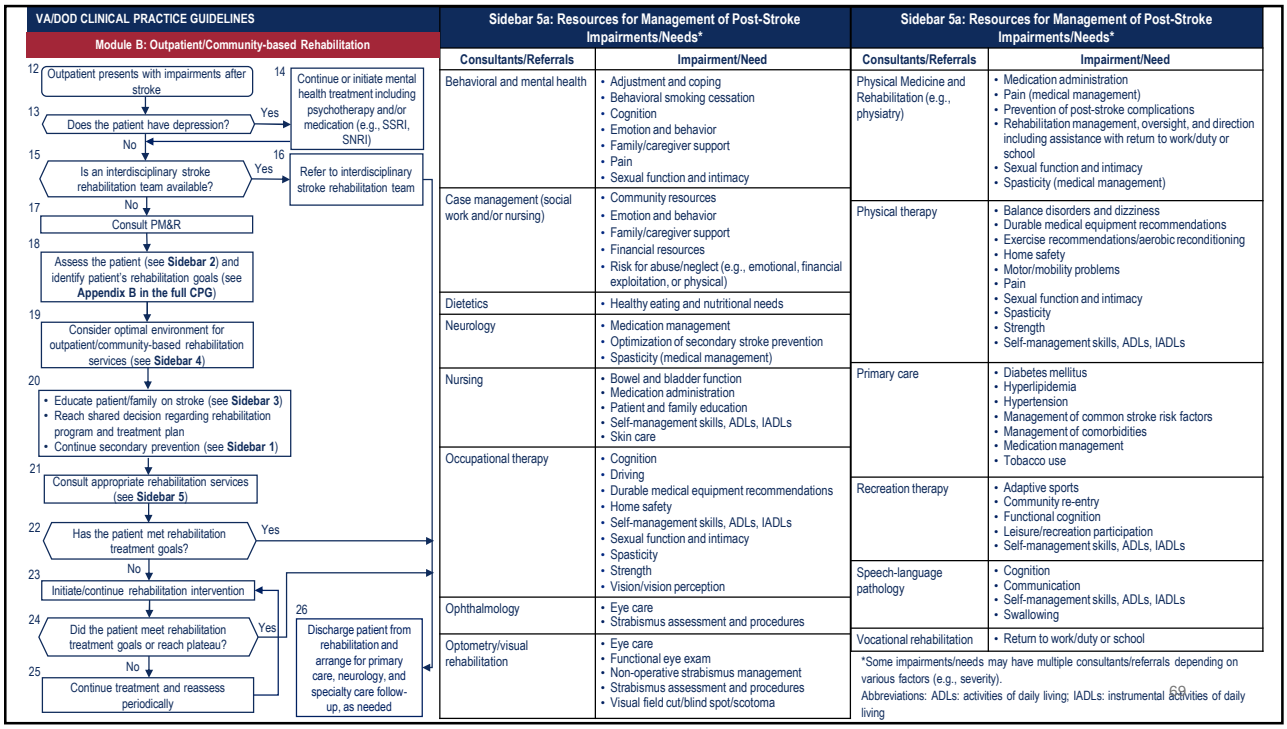

Sidebar 5a: Resources for Management of Post-Stroke Impairments/Needs*

Consultants/Referrals	Impairment/Need
Behavioral and mental health	• Adjustment and coping • Behavioral smoking cessation • Cognition • Emotion and behavior • Family/caregiver support • Pain • Sexual function and intimacy
Case management (social work and/or nursing)	• Community resources • Emotion and behavior • Family/caregiver support • Financial resources • Risk for abuse/neglect (e.g., emotional, financial exploitation, or physical)
Dietetics	• Healthy eating and nutritional needs
Neurology	• Medication management • Optimization of secondary stroke prevention • Spasticity (medical management)
Nursing	• Bowel and bladder function • Medication administration • Patient and family education • Self-management skills, ADLs, IADLs • Skin care
Occupational therapy	• Cognition • Driving • Durable medical equipment recommendations • Home safety • Self-management skills, ADLs, IADLs • Sexual function and intimacy • Spasticity • Strength • Vision/vision perception
Ophthalmology	• Eye care • Strabismus assessment and procedures
Optometry/visual rehabilitation	• Eye care • Functional eye exam • Non-operative strabismus management • Strabismus assessment and procedures • Visual field cut/blind spot/scotoma

Sidebar 5a: Resources for Management of Post-Stroke Impairments/Needs*

Consultants/Referrals	Impairment/Need
Physical Medicine and Rehabilitation (e.g., physiatry)	• Medication administration • Pain (medical management) • Prevention of post-stroke complications • Rehabilitation management, oversight, and direction including assistance with return to work/duty or school • Sexual function and intimacy • Spasticity (medical management)
Physical therapy	• Balance disorders and dizziness • Durable medical equipment recommendations • Exercise recommendations/aerobic reconditioning • Home safety • Motor/mobility problems • Pain • Sexual function and intimacy • Spasticity • Strength • Self-management skills, ADLs, IADLs
Primary care	• Diabetes mellitus • Hyperlipidemia • Hypertension • Management of common stroke risk factors • Management of comorbidities • Medication management • Tobacco use
Recreation therapy	• Adaptive sports • Community re-entry • Functional cognition • Leisure/recreation participation • Self-management skills, ADLs, IADLs
Speech-language pathology	• Cognition • Communication • Self-management skills, ADLs, IADLs • Swallowing
Vocational rehabilitation	• Return to work/duty or school

*Some impairments/needs may have multiple consultants/referrals depending on various factors (e.g., severity).
Abbreviations: ADLs: activities of daily living; IADLs: instrumental activities of daily living

69

70

Tools

Post-Acute Continuum for Stroke Care
American Academy of Physical Medicine and Rehabilitation

Medicare Healthcare Compare
Compare quality and outcomes for different healthcare facilities

Patient's Stroke Discharge Checklist
American Stroke Association

2021 Prevention of Stroke in Stroke Patients
American Stroke Association

70

Tools

Secondary Stroke Prevention Checklist
American Stroke Association

Secondary Stroke Patient Handout
American Stroke Association

Healthcare Provider Rehab Resources
American Stroke Association

Stroke Support Group Finder and Info
American Stroke Association

71

71

Tools

Hospice Finder and Support
National Hospice and Palliative Care Organization

Mental Health Therapist Finder
Psychology Today

Medicare Application Resources and Tools
U.S. Centers for Medicare and Medicaid Services

Montana Medicaid and Assistance Tools
Montana Department of Health and Human Services

72

72

Tools

Montana Stroke Workgroup
Montana Department of Health and Human Services

Montana Mission: Lifeline Stroke
American Stroke Association

Montana Brain Injury Resources
Brain Injury Alliance Montana

The Rehabilitation Hospital of Montana
The Rehabilitation Hospital of Montana

73

73

Tools

Montana Stroke Workgroup
Montana Department of Health and Human Services

Montana Mission: Lifeline Stroke
American Stroke Association

Montana Brain Injury Resources
Brain Injury Alliance Montana

The Rehabilitation Hospital of Montana
The Rehabilitation Hospital of Montana

74

74

"Beyond disease there is a human being, a family, a provider, heroes and team - find them."

"Encourage patients to not let their circumstances change them but empower them to use their circumstance to change the world".

"Patients cannot be what they cannot see…
…show them the way"

"Be the spark of hope that empowers patients to get past nope!"

"Strive to have patients leave appointments feeling like a million-bucks instead of a buck-fifty."

"Pull out all of the stops to empower our patients to turn their long shots into sure shots!"

"Make small achievements big and big challenges small, taking fear out of it all"

Jason Gleason, DNP, NP-C, FAANP
USAF/ANG LIEUTENTANT-COLONEL (RET)

75

75

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77

77

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80

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