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## CONFERENCE ABSTRACT

# **Integrated transmural care pathway for stroke patients after discharge from the hospital: the growth towards a total concept in cooperation with primary care partners in southwest-Flanders**

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Every year, nearly 27,000 Belgians suffer a stroke. After discharge from the hospital there is follow-up. In this best practice, we want to discuss the initiatives that AZ Groeninge has taken over the years to achieve an integrated transmural care pathway for stroke patients after discharge from the hospital in collaboration with primary care, regional GP-associations and home care organizations.

**Transmural care pathway for stroke care:** Prof. Dr. Peter Vanacker, neurologist AZ Groeninge, took the initiative in 2017 to roll out the transmural clinical care pathway for stroke in the south West-Flanders region together with GP -associations and neurologists from various hospitals. Other primary care partners were also involved such as the Pharmacists Association and home care organizations.

Through uniform cooperation of health care providers and coordinated follow-up to support stroke patients, they succeeded in offering better care to stroke patients after discharge.

Guidelines were developed for GP's, home care nurses and pharmacists. To ensure continuity of care and enhance patient empowerment, a diary was also given to the patient to record key parameters and issues.

In 2020, the care pathway was expanded with the Chronic Care Project "De Brug".

The following additional items were added:

- commitment to communication between the care providers of the stroke team
- commitment to the conversation ""good use of medicines"" after stroke
- focus on clarifying questions
- commitment to lifestyle through health vouchers that encouraged stroke patients to make lifestyle changes.

**Strokecoach:** In AZ Groeninge, the transmural care pathway was supplemented with a specific coaching program for stroke patients.

The strokecoach is responsible for a personal follow-up of stroke patients to promote therapy compliance, disease insight, reduction of their cardiovascular risk profile. The coaching process runs between 6 and 24 months depending on patient preference.

**Jobcontent of our strokecoach is to:**

- play an intermediary role between GP's, home care services and the hospital.
- be point of contact for stroke care in the region.
- do more intensive screening for early and late complications and compliance. Thus, complications are captured more quickly. Together with the primary care team, the strokecoach will motivate the patient to achieve health goals and prevent for stroke recurrence.

**Stroke2Gether:** Electronic stroke recovery pathway. AZ Groeninge is also participating in the EFRO project "Stroke2Gether". This is a digital recovery pathway for stroke patients after discharge by a smartphone app. Medical en therapy follow-up and health prevention are built in, through monitoring, education and coaching, live and remote. In addition, there is also a rights recognition module so that patients are also guided more proactively in the administrative and financial aspects and care support in collaboration with the social services of the insurance companies.

**Decision:** AZ Groeninge has already completed a long journey in cooperation with its primary care partners to arrive at an integrated care pathway for stroke patients.

In the following years, the main focus will be on the evaluation and adjustment of the developed instruments and the cooperation to further optimize the aftercare for this patient group.