Pre-launch Checklist

COMPASS Staff

✓ Establish a “back-up” APP and PAC in the event the current APP / PAC are not at work due to a sickness, vacation, etc.
✓ Get the “back-up” staff trained on the COMPASS Model.

Assessments/Care Plan

✓ Have hard copies of your Two-Day Follow-Up Call Assessment in the station you will be making these calls.
✓ Have hard copies of the Post-Stroke Functional Assessment, Stroke Caregiver Assessment & Advanced Practice Assessment in the clinic, if utilizing these assessments.
✓ Have your Care Plan template ready for appointments.

Additional Resources

✓ If able, ensure the PAC gets access to a pager to aid in patient identification. It may help the PAC to know when an eligible COMPASS patient has been discharged, the emergency department receives a CODE STROKE, etc.
✓ Find out if the hospital conducts any morning discharge meetings. It may help the PAC to attend these to see what stroke patients may get discharged from the hospital.

Scheduling Appointments

✓ Get the appropriate training to schedule or request appointments.
✓ If needed, establish communication and partnerships with front desk, access center, medical residents, etc. to ensure the appointments do get scheduled or requested.
✓ Ensure communication has been established to notify the PAC when a patient has canceled or rescheduled the appointment.

Printing

✓ Ensure all printers being used to print the Care Plan are programmed into the same computers being used in clinic.
✓ Ensure that there is enough printer paper and ink cartridges.
✓ Practice printing and creating the Care Plans in all printers so the PAC can see which one prints the fastest.

Referral and Community Resources

✓ To assist the APP, become familiar with the referral process of therapy, higher level of care, community resources, etc. Reviewing this referral process will enable the PAC to assist the APP with care coordination during the Two-Day Post Discharge Follow-up Call and during the clinic visit.
✓ Ensure that the PAC and APP have reviewed the cover letter template and the process for accessing or retrieving the Care Plan. This process will be used to provide the patient’s PCP, Home Health Agency, or Outpatient Rehabilitation Agency the Care Plan.
Home Health and Outpatient Rehabilitation Team

✓ PACs and APPs should work collaboratively with their COMPASS-trained home health agencies and outpatient rehabilitation agencies to identify a team lead nurse and a team lead therapist from each of them. These team leads, also known as the organization’s champion team, will serve as the liaison between the PACs and APPs and will ensure that the Home Health/Outpatient Rehab Checklist is being followed as well as ensure that their front line staff are properly trained by using the ‘train-the-trainer’ model. As a reminder, the team leads will be identified using the home health and outpatient rehab organizations listed on the site’s Community Resource Network Grid.

✓ The PACs and APPs should implement an ‘operations’ meeting with the champion teams of each agency to identify the following:

  o Referral process for each agency. Who does the PAC and APP need to send the cover letter and referral to after the clinic visit? A central intake person, the champion lead, etc.?
  o Identification of a COMPASS patient. Most patients get referred to therapy before discharge so that services can be implemented after discharge. The cover letter with the patient’s Care Plan is only given to the agencies after the clinic visit which is 7-14 days after hospital discharge. What steps should the PAC and APP take to ensure that each stroke patient referred during discharge is easily recognized as a ‘COMPASS patient’ to the agency?