7. COMPASS INTERVENTION PROCESS: PRE-DISCHARGE

This section will describe activities related to capturing COMPASS eligible patients and the initial patient encounter. These activities include:

- Step 1: Identification of Stroke and TIA Patients
- Step 2: Initiation of Patient Contact during Enrollment Process
- Step 2a: Notify patient of COMPASS standard of care

A. Identification of Stroke and TIA Patients

A.1 Summary
The COMPASS Model case identification and screening procedure uses daily review of stroke admissions and screening of electronic medical records to identify participants for eligibility prior to hospital discharge. While patient identification depends on your site, current COMPASS hospitals have noted using stroke rounds, patient lists by ICD-10 codes, and other methods to identify all COMPASS-eligible patients.

COMPASS-CP (optional): If your hospital has COMPASS-CP integrated with your Electronic Medical Record (EMR), the case identification process is automated. COMPASS-CP pulls patients in by admitting ICD-10 codes and discharge dates automatically. To learn more about COMPASS-CP identification process, refer to the COMPASS-CP manual.

A.2 Administration (by PAC):
Identification of Stroke and TIA Patients:
- Conduct prospective case identification by reviewing admissions on a daily basis. When possible, review admissions on weekends; otherwise, screen weekend admissions on the following Monday.
- Query the electronic medical records (EMR) from different lists in the hospital such as the stroke service, ED, observation logs, and neurology consults. This query will generate a daily consensus or ‘report’ of stroke patients. Refer to Appendix II for list of key words, codes, and chief complaints.
- In the event, a patient is discharged with a questionable TIA, please refer to Appendix IV and Section A.1 for further inclusion and exclusion criteria.

A.3 Inclusion and Exclusion criteria for TIA in COMPASS
Definition of TIA:

Helpful Hint
Communicate across the hospital!
Get to know different department heads so you are notified any time there may be a stroke patient in the hospital. The ER staff can be especially useful in capturing TIA patients who often go home within hours of presentation.
Transient episode of neurological dysfunction caused by focal brain, spinal cord, or retinal ischemia, without acute infarction [Easton, et al Stroke 2009; 40:2276-2293.]

Inclusion criteria:
- Final discharge diagnosis of TIA
- MRI negative for ischemic stroke or infarct
- Symptoms lasting greater than 5 minutes (the majority of TIAs last between 5 and 60 minutes, but symptoms could be longer, so there is no upper limit for symptom duration)

Exclusion criteria for TIA:
- Final discharge diagnosis is TIA vs. another diagnosis, which could include the following:
  - Complicated migraine (i.e., headache is a prominent symptom along with focal neurologic symptoms)
  - Infection
  - Syncope
  - Reactivation of old stroke symptoms
  - Delirium
  - Medication reaction, side effect, or intoxication
  - Angina
  - Seizure

A.4 Equipment

‘Participant Eligibility Screening Form’ (Appendix V), is available on paper in the COMPASS website as an option for abstracting data if desired. If you are utilizing COMPASS-CP, patient information will be automatically pulled from the patients EMR.

‘Participant Enrollment Form’ (Appendix VI), is available on paper in the COMPASS website as an option for abstracting data if desired. If you are utilizing COMPASS-CP, patient information will be automatically pulled from the patients EMR.

Administration (by PAC):
The COMPASS Study included the following criteria of patients and the results of the study can be generalized to this group. This criteria is the recommended patient population for administering the COMPASS model:
- 18 years of age or older
- English or Spanish speaker
- Admitted as an inpatient or kept as an observation/ED patient without admission (excludes admissions for elective carotid endarterectomy only)
- Diagnosed with ischemic stroke, hemorrhagic stroke (excluding subdural or aneurysmal hemorrhage), or TIA
A.5 Note regarding Spanish speakers

In the case where the patient is a non-English speaker whose primary language is Spanish, an interpreter who can communicate with the participant should be available during the Initial Patient Contact and subsequent clinic visit and telephone surveys. The patient and caregiver should receive the COMPASS materials in Spanish, which are all available on the COMPASS website.

1. Obtain the patient’s contact information and an alternate contact number. Enter this into the patient’s EMR or, if desired, the Enrollment Form. Paper versions of the form can be used to complete sections of the form during the patient visit.

2. After the initial visit with the patient, if desired, complete the remainder of the Enrollment Form.

3. Document your visit as in a progress note.

4. Schedule the patient’s follow-up clinic visit within a week or two of their discharge date.

Helpful Hint

Patient Contact Information

Patients with cognitive or communication deficits may have difficulty relaying or recalling their address, phone number, etc. Having this information on hard copies will allow the patient to see this information on paper and can easily give a “nod” for a “yes” for a correct address, phone number, etc. Additionally, asking the patient about this information first, and then realizing this data does not match the information on the medical record after the patient has been discharged, may slow the process. It is vital to obtain an accurate phone number to complete the 2-day call aspect of the model.

Helpful Hint

Who is a ‘caregiver’? The COMPASS model also has a component of identifying caregiver needs and stress and strain. People may have differing definitions of a caregiver. We define a caregiver as the person who will be helping the patient when they get home with everyday activities such as bathing, purchasing, taking medications, transportation, shopping, etc.

B. Initiation of Patient Contact in-hospital, pre-discharge

B.1 Summary

The PAC will visit eligible patients in the hospital, notify the patients that the hospital’s standard of care for patients in their situation is the COMPASS model, notify the patient that they will be contacted within a day or two via telephone, and schedule their follow-up clinic appointment. If you identify the
patient has immediate needs, such as transportation to their clinic visit or financial assistance for their medications, begin connecting that patient to community resources that can help.

B.2 Introducing the Model and Providing Materials at Discharge
The PAC will visit eligible patients in the hospital prior to discharge to explain the COMPASS model intervention as their hospital’s standard of care recommended for all stroke and TIA patients being discharged directly home. The PAC can provide COMPASS materials to the patient prior to discharge including:

- Blood Pressure (BP) Log
- Blood Pressure Educational Handout
- Relevant COMPASS Matters documents

During the patient’s initial encounter, the PAC should explain the basic tenets of the model and be prepared to answer general questions or to direct the patient to the website.

Helpful Hint

Why do I need to visit the patient prior to discharge?

From the 42 hospitals we studied during the COMPASS Study, we learned from our PAC’s that visiting a patient prior to their discharge was a strong factor in the patient flowing through the entire COMPASS model. Patients that were able to put a face to the nurse calling them in a day or two, were more likely to pick up and more likely to return for their clinic visits. Many PAC’s found this to be one of the most important components of the model. If you have the available time resources, sit with the patient and explain their transitional care plan. If you cannot see the patient prior to discharge, have another health professional stop by and let the patient know you’ll be giving them a call!

B.3 Administration (by PAC):

1. Meet eligible patients and their caregivers before discharge to introduce the COMPASS Model and to answer any questions. Offer the patient relevant COMPASS documents.
2. Explain to the patient the overall goals of COMPASS saying:

“The goal of the COMPASS Model is to define the best way to care for stroke survivors after they go home from the hospital. Our team wants to help you find your way forward after a stroke to recovery. I will be calling you two days after your discharge to follow-up on how you are doing and to see if you need anything before you come in for your 7-14 day visit. You will be scheduled for a visit at our Post-Acute Stroke Care Clinic. We would like you to come back within 7 to 14 days after your discharge. During this visit, you will see me and our Advanced Practice Practitioner. We will do a comprehensive assessment to identify any roadblocks that could affect your recovery and provide you with resources that can help you with your recovery. After this visit, I will call you 30 days and 60 days after your
“discharge to follow-up with you.”

3. Give the participant a card with your name and contact information, so they have one person they can contact for all their questions.
4. Provide the patient with the BP log and BP Education Handout and recommend the use of a home BP cuff or alternative strategy if necessary. For patients who do not have a home BP cuff, but are receiving home health or outpatient PT, OT, or speech therapy, encourage the patient to request that their BP be taken at each visit by these providers and to record this information in their BP log. On the BP log, an individualized target BP is listed as well as an acceptable range and alert values for calling the primary care physician or going to the Emergency Department.
5. Schedule a follow-up visit between 7 and 14 days after discharge.
6. Explain that the PAC will be calling to follow-up with them at 2, 30 and 60 days after discharge.
7. Complete the Enrollment Form by asking questions from the form that could not be obtained from the patient’s medical record.
8. Answer any outstanding questions.

B.4 Assessing Patient Complexity and Scheduling the 7-14 Day Clinic Appointment

Equipment: Electronic Medical Record

Administration (by PAC):
- Assess whether the patient meets criteria for **high complexity** (seen within 7 days) or **moderate complexity** (seen within 14 days). High complexity patients are identified as high risk for readmission if they have any of the following: 2 or more hospitalizations in the year prior to stroke, started on warfarin in the hospital (especially when prescribed with bridging therapy), had an initial NIHSS of > 10, dysphagia and recommended thickened liquids at discharge (high risk for dehydration), history of congestive heart failure, cryptogenic stroke with need for prolonged cardiac monitoring to assess for atrial fibrillation, high fall risk, labile blood pressures at discharge, or a challenging social situation that requires additional support.

FAQ

**What happens if the patient does not live close to the hospital to attend the 7-14 day visit or lives in a different state?**

Encourage the patient to attend the 7-14 visit; however, if the patient lives far away, emphasize the importance of close follow-up with the PCP. The PAC is to still conduct the post-discharge follow-up call.

**What happens if the patient refuses to schedule a 7-14 day visit because the patient prefers to follow-up with his/her own PCP?**

This is OK. Encourage the patient to still attend the 7-14 day visit, as you will be discussing different needs than the Primary Care Provider.
coordination soon after discharge. All other stroke patients would be considered moderate complexity. The PAC may recommend the APP review the chart and/or visit the patient in the hospital prior to discharge to determine the level of complexity, if not clear.

- The PAC will work with the patient to schedule the **7-14 day Post-Acute stroke care** clinic visit and record the date and time of the patient visit in the electronic medical record.

- Whenever possible, try to schedule the 7-14 day visit no later than 14 days after the discharge date. If the patient is at high-risk of complications before a 7-14 day visit based on the 2-Day Post-Discharge Follow-up Assessment and medication reconciliation, schedule a visit as soon as possible.

- Advise the patient to be prepared that the 7-14 day visit may take 60 to 90 minutes, recommend that the patient’s caregiver come to the visit and bring bottles of medications the patient is taking, and inquire and support patient to get transportation to the visit if needed.

### B.5 Incorporating Motivational and Behavioral Messaging

The initial patient encounter is the most important component of the enrollment process. When incorporated correctly with positivity and encouragement, the patient will attend the 7-14 day follow-up with progression and better health outcomes. To ensure effective and positive health outcomes for the patient, the PAC is encouraged to not only relay the script mentioned above during the encounter but also to incorporate the following messages:

- The importance of attending the 7-14 day appointment and scheduling a follow-up appointment with the primary care provider. If transportation is a challenge, encourage transportation services. Encourage the primary caregiver to attend the appointments as well.

- The importance of checking and keeping a log of the patient’s blood pressure. Encourage the patient to bring the blood pressure log to the 7-14 day appointment.

- The importance of physical activity during stroke recovery. Encourage the patient that physical activity is an important piece in reducing his/her risk of another stroke. If the patient is not able to incorporate exercise for a given length of time due to functional limitations, encourage the patient to do small tasks around the house to keep his/her body moving. These tasks may include gardening, doing laundry, dancing, cleaning, etc.

- The importance of continuing home health or outpatient services if they were prescribed. Some patients may refuse home health or outpatient services after hospital discharge. Explain to the patient the benefits of continuing and engaging in nursing and therapy services.

- The importance of using durable medical equipment (DME). Some fall-risk patients may have
a walker, cane, etc. but may not currently use them. Encourage the patient to use DME especially if they have physical mobility limitations or they are at risk of falls.

**Helpful Hint**

**What if the patient was discharged on a weekend or holiday and I wasn’t able to conduct the initial encounter?**

Patients discharged on weekends, holidays, or on a sick day should still receive the COMPASS model. Call the patient as you would for their two-day call to establish a personal connection and explain the standard of care you would in person. The Blood Pressure handouts and Matters documents can be handed to the patient at their clinic visit.