8. COMPASS INTERVENTION PROCESS: POST-DISCHARGE

A. Overview
This section will describe activities related to the clinical process and generation of the patient care plan. These activities include:

- Step 5: Completion of a Follow-Up Call two days after hospital discharge
- Step 6: Completion of a clinic visit within 7-14 days after hospital discharge
- Step 6a: Completion of Post-Stroke Functional Assessment
- Step 6b: Completion of Post-Stroke Caregiver Assessment
- Step 6c: Completion of Post-Stroke Advanced Practice Provider Assessment
- Step 7: Completion of 30-day and 60-day follow-up calls

B. Completion of Follow-up call two days after hospital discharge

Description: The COMPASS Two-Day Call Procedure is performed by the PAC within two business days post-discharge. This instrument is designed to address any concerns post-discharge, reconcile medications, and schedule the 7-14-day clinic visit, if not already scheduled. The assessment can be conducted using the paper copy of the Two-Day Post-Discharge Follow up Call Assessment.

Note for High-Risk Patients and Emergencies:
If the stroke survivor (and/or caregiver) states that he or she is having worsening stroke symptoms or new stroke symptoms, this should prompt the PAC to recommend calling 911 and notifying the APP and PCP. Other non-emergent concerns should be triaged to the APP.

For effective delivery of the Two-Day Follow-up Assessment:
- The PAC will need to review the patient’s medical record before the follow-up call.
- The PAC will need to have readily available the patient’s medication list post-discharge and appointment date of the 7-14 clinical appointment (if available) for use during the follow-up call. If an appointment was not created, it will be established during this call.
- The PAC will need to have available the patient’s transportation services within his/her community using the COMPASS directory and patient’s county of residence.

Equipment: Two-Day Post-Discharge Follow up Call Assessment, paper copy (Appendix VII). If you are utilizing COMPASS-CP, you will utilize the electronic version of this assessment. For further instructions on how to use COMPASS-CP, please refer to the COMPASS-CP manual.

Administration - PAC:
1. The PAC will call the patient using the patient contact information from the EMR (home, mobile, work, or other). If the person cannot be reached, leave a general message stating your name, organization, who you are trying to reach and a call back number. Only leave a message at numbers for which the patient provided permission. Call the patient 2 times (up to 1 time per day for 2 days) within 2 business days of discharge and document the attempts in the electronic
medical record (this is required for TCM billing purposes). If able to reach the patient after two
days and the 7-14 day visit has not yet occurred, the Two-Day Assessment can still be
completed.

2. Once the patient or caregiver has answered the phone, use the paper copy or COMPASS-CP to
complete the Two-Day Post-Discharge Follow-Up Questionnaire.

3. When prompted to complete medication reconciliation, complete the medication reconciliation
using the discharged medication list in the patient’s medical record. Document any
discrepancies by comparing the discharged medication list and the medication list the patient
reports to the PAC. Ensure that the patient is taking the correct medications with the correct
dosages from the medication list in the patient’s chart.

4. If the patient has not established an appointment with his/her Primary Care Physician,
encourage the patient to establish one and relay the importance of a follow-up appointment.
Confirm with the patient if s/he needs assistance with setting an appointment. If so, assist the
patient with creating one for him/her.

5. If the prescribed therapies for the patient have not been scheduled, assist the patient with
scheduling these appointments.

6. Determine whether the patient has transportation issues with attending the 7-14 day
appointment. If so, inform the patient of the transportation resources using his/her county of
residence and the COMPASS community resource directory. Inform the patient/caregiver of
the importance of attending the appointment and encourage the patient/caregiver to reach out
to these community resources.

7. Triage any emergent issues immediately to the Advanced Practice Provider. These issues
include, but are not limited to, new symptoms since discharge, discrepancies in medications
during the medication reconciliation process, and any injurious falls since discharge.

B.1 Medication Reconciliation Procedure

Equipment: Medication Reconciliation Forms (see below for options).

Administration - PAC:
1. In the Two-Day Post Discharge Assessment, the PAC will be prompted to complete medication
reconciliation.
2. Complete medication reconciliation by using the Medication List from the Discharge Summary.
The PAC may use the Medication Reconciliation Form in the Medication Adherence Toolkit
or a locally-available resource. Clarify any discrepancies between the two lists.
3. The PAC will verify over the phone the following for each stroke prevention medication (anti-
hypertensive, cardiovascular, lipid-lowering, anti-platelet, anti-coagulant) in the medication list
in the EMR or in the discharge summary:
a. Patient has had a prescription filled or has a supply of that medication from prior to the stroke. Verify a Yes or No for each medication.
b. If no, verify that the patient or caregiver has a prescription for the needed medication and identify/agree on a plan for getting the needed prescription(s) filled promptly, that day if possible.
c. If no, also consider referral to a community pharmacy with Advanced Practice Capabilities. (See CCNC or NCMD lists of participating pharmacies with wrap-around services listed in the Community Resources Directory). Note that many pharmacies on this list provide home delivery and can review medications with the patient/caregiver. Recommend that the patient fill ALL medications at a single pharmacy to facilitate tracking/monitoring.

4. For each listed stroke-relevant medication in the discharge summary, the PAC will verify over the phone that:
   a. Patient is taking each stroke-relevant medication according to prescription instructions. Verify a Yes or No for each medication.
   b. If no, identify source of non-adherence using the Medication Adherence Work-up/Intervention Tool and consider referral to a community pharmacy with Advanced Practice Capabilities.

5. Ask the patient who is responsible for managing your medications? (Patient vs. Caregiver).
6. Ask the patient, “Do you have any concerns about your medications?” Yes or No. Any voiced concerns that may require input/prompt action by a provider is referred to the APP.
7. If this patient is high risk as identified by being prescribed 10 or more medications and/or is prescribed warfarin or other high-risk medications, consider referral to a community pharmacy with Advanced Practice Capabilities (see COMPASS website for list of pharmacies in the CCNC Pharmacy Network).
8. Once the medication reconciliation has been completed, mark “Yes” on the Two-Day Post Discharge Assessment Form.
C. Completion of a clinic visit within 7-14 days after hospital discharge

**Description:** The 7-14 Day Post-Acute Stroke Care Clinic visit includes both the PAC and the APP to complete three standardized clinical assessments directly with the patient and/or caregiver within 7 to 14 days of discharge (not business days so this includes weekend days).

The assessments conducted in the 7-14 day appointment in their specific order are the following:

1. Post-Stroke Functional Assessment conducted by the PAC
2. Stroke Caregiver Assessment (if needed) conducted by the PAC
3. Advanced Practice Provider Assessment conducted by the APP

These assessments are described in detail below and paper copies of the assessments can be found in the appendix. These assessments are not required but are recommended to optimize patient outcomes. The total duration of this visit may take approximately 60 minutes.

If you are utilizing COMPASS-CP, these assessments are done electronically. They provide the patient with an individualized care plan, recommend referrals and connections to community resources, and create a summative report for other providers involved in the patient’s follow-up care (i.e., Primary Care Physician and outpatient and home health rehabilitation providers).

At the beginning of the 7-14 Day Stroke Care Clinic Visit:

1. The PAC will need to open the patient’s chart and assess the following:
   - Was the patient transferred to a nursing home?
   - Did the patient die following the Two-Day Follow-up Call?
   - Is the patient currently hospitalized?

2. If any of the above three items occurred, the PAC is to document this in the EMR. This will conclude the 7-14 Day Clinic Visit – the Post-Stroke Functional Assessment, Stroke Caregiver Assessment, and the Advanced Practice Provider will not be completed, and an Care Plan will not be created.

3. If the above three items are not applicable to the patient, and the patient did not show up to the appointment visit, the PAC is to document “No-Show for an unknown reason” in the EMR.

D. Completion of Post-Stroke Functional Assessment

**Equipment:** Post-Stroke Functional Assessment, paper copy (Appendix VIII). If you are utilizing COMPASS-CP, you will utilize the electronic version of this assessment. For further instructions on how to use COMPASS-CP, please refer to the COMPASS-CP manual.
For effective delivery of the Post-Stroke Functional Assessment:
- The assessment is to be completed on average in 10-20 minutes.
- Only questions on the assessment are to be asked. It is important for the PAC to refrain from probing further questions.

Administration - PAC:
1. Complete the assessment as directed by the survey form. During the administration of the assessment, face the patient and also allow the patient to see the questions and responses, if need be. If the patient is not able to answer the questions on the assessment because the patient is aphasic and/or has communication or cognitive deficits, the PAC may use a caregiver (or proxy) to complete the assessment, if one is present. If not, remind the proxy/caregiver that it is important to gather the patient’s responses. The patient’s perspective will allow you to generate an individualized care plan for the patient and recommend referrals based on the patient’s input.
2. If the patient is not able to answer the questions on the assessment, the PAC will be prompted to use a caregiver (or proxy) to complete the assessment.
3. If neither the patient nor the caregiver (or proxy) is available to complete the assessment form, prepare the patient for the APP visit.

As background, the Post-Stroke Functional Assessment is a patient-reported outcome measure. Meaningful, clinical, decision-making is based on the patient’s input and response alone, rather than judgments or views made by a clinician. Therefore, it is important that the PAC complete the assessment using only the questions on the assessment.

Additionally, it is important that the PAC gather responses made by the patient, instead of a proxy/caregiver, so the Care Plan can be generated and referrals made from the patient’s perspective. However, if the patient is aphasic and/or has communication or cognitive deficits, the PAC will need to direct the proxy/caregiver to assist with answering the questions.

FAQ

What happens when the patient has a decline in health during the 7-14 day visit?

There may be situations where a patient attends the 7-14 day visit but has a decline in health that leads to an immediate admission to the hospital. Therefore, the visit does not occur in its entirety, and a Care Plan could not be generated. If possible, the PAC is encouraged to visit the patient in the hospital and provide the Care Plan to the patient. The circumstances may require modification of the Care Plan depending on the reason for re-hospitalization.
E. Completion of Post-Stroke Caregiver Assessment

Certain questions from the Post-Stroke Functional Assessment will trigger the need for the PAC to complete the Post-Stoke Caregiver Assessment. The caregiver assessment should be completed if the patient needs assistance with making meals, managing their medication, and transportation.

If the caregiver assessment is needed and, for some reason, the caregiver is not attending the follow-up appointment with the patient, the PAC is encouraged to contact the caregiver by phone to complete the assessment, if time permits.

For more information about the caregiver assessment, its importance, and introducing the assessment to the caregiver, please refer to the webinar, “Caregiver Assessment and Engagement”, on the COMPASS website in the Webinar and Training Videos section.

Equipment: Stroke Caregiver Assessment Form, paper copy (Appendix IX). If you are utilizing COMPASS-CP, you will utilize the electronic version of this assessment. For further instructions on how to use COMPASS-CP, please refer to the COMPASS-CP manual.

Administration - PAC:

1. If the Post-Stroke Functional Assessment has identified the need for a caregiver, the PAC should complete the Stroke Caregiver Assessment. Complete the assessment form as directed. If no need has been identified, the PAC does not need to complete this assessment.
2. If the need for a caregiver has been identified, but the caregiver is not present, plan to contact the caregiver listed in the EMR.
3. After the PAC administers the required assessments, the PAC will report out to the APP prior to the APP seeing the patient and provide them with identified resources needed.

F. Completion of Post-Stroke Advanced Practice Provider Assessment

Equipment: Post-Stroke APP Assessment Form, paper copy (Appendix X). If you are utilizing COMPASS-CP, you will utilize the electronic version of this assessment. For further instructions on how to use COMPASS-CP, please refer to the COMPASS-CP manual.

FAQ

What is the importance of the Post-Stroke Caregiver Assessment? Some patients only need help with transportation. Why do I need to complete the caregiver assessment for that reason alone?

An aspect of the COMPASS model is to reduce caregiver stress and strain. COMPASS has identified a caregiver as someone who assists with activities of daily living, transportation, and medication management. Although a patient may be functional and independent with only needing assistance with transportation by family members, this assessment is needed to analyze whether caregivers have any other competing demands, health problems, and stress that interferes with their ability to assist their loved ones with even the most minute tasks.
Administration - APP:
1. After the patient has seen the PAC, the APP will review the Post-Stroke Functional Assessment and Caregiver Assessment responses and recommended referrals.
2. The APP will then complete the Post-Acute APP Assessment during the visit, which is the guide to the neurological, medical, and prevention strategies for the patient.

G. Generation of the Care Plan
The generation of the Care Plan depends on the hospital’s process for creating Care Plans. We recommend you utilize the Matters Documents and your Community Resource Network to individualize this care plan.

If you are utilizing COMPASS-CP, an automatic individualized eCare Plan will be created based on the patient’s responses and identified needs. This eCare Plan can be printed and given to the patient as well as be placed in their EMR. For further instructions on how to use COMPASS-CP, please refer to the COMPASS-CP manual.

Administration - PAC:
1. The PAC will use methods of motivational interviewing, if needed, to review the patient’s goals for care and preferences for care. The PAC will let the patient and caregiver know what to expect after the 7-14 day visit, such as an appointment with their PCP, and that the PCP should be shown the Care Plan and given access to it. **It is vital that the patient/caregiver bring the Care Plan to other upcoming physician/provider appointments.** The Care Plan should also be the focal point of discussion with home health providers and outpatient therapists, as appropriate.
2. Make collaborative recommendations for management and referrals.

H. Completion of 30-day and 60-day Follow-Up Calls
The 30-day and 60-day follow-up calls are performed by the PAC using the paper assessments within 30 and 60 days after the patient has been discharged from the hospital. This process is designed to ensure the patient is routinely checking his/her blood pressure and following the other recommendations on their Care Plan including participation in the community resources recommended.

There is a range of time within which the 30- and 60-day follow-up calls can be completed with a window of up to 10 days before or 10 days after the scheduled dates of the call. For example, 30-day calls can be completed from 20 days to 40 days after the patient is discharged from the hospital, and 60-day calls can be completed from 50 days to 70 days after discharge.

The 30- and 60-day follow-up calls are only to be completed if: 1) the patient attended the clinic visit; and 2) a Care Plan was created. If the conditions are not met, the 30- and 60-day calls are not recommended.

If you are utilizing COMPASS-CP, 30- and 60-day calls are not a part of the process, but the PAC can still make these calls using the paper assessments, if desired.
I. Referral and Connections to Community Resources

**Equipment:** Electronic Medical Record, Community Resource Directory.

**Administration – APP and PAC:**
1. The APP will make referrals to home health, outpatient therapy, order durable medical equipment, etc. as needed.
2. The APP will order appropriate prescriptions for medications as needed based on the medical and neurological assessments.
3. The PAC will utilize the Community Resource Directory and make recommendations for referrals based on the Care Plan.

J. Patient Receipt of Care Plan and Resources

**Equipment:** Care Plan, Community Resource Directory, and patient educational resources.

**Administration - PAC:**
1. Once the clinic visit assessments have been completed, the PAC will be able to create an individualized care plan depending on hospital procedures.
2. The patient will also receive a list of their medications (if not in the standard after visit summary from the clinic EMR), and additional services/resources that may be related but are not on the Care Plan.
3. The PAC provides patient with BP log and BP Education Handout and recommends 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, the patient will be encouraged to request that their BP is taken at each visit by these providers and will record this information in their BP log.
4. 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. The PAC will provide information on non-pharmacologic strategies to reduce BP: salt restriction, physical activity, and diet high in fruits and vegetables, such as the Dietary Approaches to Stop Hypertension or DASH Diet and/or the Mediterranean type diets that include whole grains, low-fat dairy products, poultry, fish, legumes, olive oil, and nuts and limitations on sweets and red meats.
6. Patients with atrial fibrillation will be given the Atrial Fibrillation Handout.
7. Patients on warfarin for atrial fibrillation or other reason: INR goals will be discussed (the INR therapeutic range should be listed in the hospital progress notes).
8. Patients with diabetes will be given the Diabetes Handout. Target blood sugars and monitoring will be discussed as well as help with acquiring a glucometer, if needed.
9. All patients receive a Cholesterol Handout and, for those discharged on a statin, emphasize the importance of medications on reducing LDL and decreasing the risk of recurrent stroke or heart attack. The LDL target is generally less than 100, but patients with atherosclerotic stroke (carotid stenosis, intracranial stenosis, small vessel disease), coronary artery disease, peripheral artery disease) will all be recommended to take statins for secondary prevention, regardless of LDL.
10. Remind the patient the PAC will call him/her at 30 and 60 days.
K. Sharing the Care Plan with PCPs and Home Health Agencies

The Care Plan can and should be shared with a patient’s PCP and home health agency to standardize messaging and a patient’s recovery. The APP or PAC can make copies of the Care Plan and attached it to the cover letter to be sent to the PCP and/or home health agency via fax or encrypted e-mail. The cover letter template can be found on the COMPASS website. This Care Plan should also be given to the patient and caregiver.