Helpful Hints & Frequently Asked Questions

It’s important that the PAC uses every resource possible to ensure efficiency when implementing COMPASS within the hospital. We have provided resources, helpful hints, and frequently asked questions to make this implementation a smooth process.

1. Case Ascertainment

I. Attending Morning Meetings

Some hospitals may have morning discharge planning meetings where physicians, pharmacists, therapists, social workers, and case managers come together to discuss possible discharges for the day and provide an update on the status of each patient on stroke services. Attending these meetings will provide the PAC with information of patients’ disposition upon discharge and will reduce spending extra time searching through the hospital’s EMR system to identify patients being discharged home.

II. Paging System

Some hospitals have a paging system where all members of the stroke team have a pager. The pages may include stroke admissions, CODE STROKES, stroke discharges, etc. If this is the case, it may help for the PAC to have a pager as well. This will assist the PAC with enrolling all stroke patients into COMPASS.

III. Collaborating with the Stroke Team

If attending morning discharge planning meetings is not possible, it may also help for the PAC to reach out to other members of the stroke team to ensure that all stroke/TIA patients receive the COMPASS model. Other team members may include social workers, case managers, physical therapists, neurologists, medical residents, etc.

2. Should PACs use the contact information in the EMR or collect new information during the initial encounter?

Patients with cognitive or communication deficits may have difficulty relaying or recalling their address, phone number, etc. Having the address, phone number, and email address printed on hard copies will allow the patient to see this information on paper and can easily give a nod for a “yes” or “no” for a correct address, phone number, etc. Additionally, asking the patient about this information without having it written down first, and realizing the information is wrong after the patient has been discharged, may slow the model.
3. Who is a ‘caregiver’?

People may have differing definitions of a caregiver. We are simply asking for the person who will be helping the patient when they get home with everyday activities such as bathing, purchasing, taking medications, transportation, shopping, etc.

4. 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?

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

5. 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 okay. Encourage the patient to still attend the 7-14 day visit, as you will be discussing different needs than the Primary Care Provider.

6. What if the patient was discharged on a weekend or holiday?

Patients discharged on weekends, holidays, or on a PAC 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 follow-up clinic visit.

7. 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 rehospitalization.

8. 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.

Other Frequently Asked Questions

9. What is the time frame to complete the 30-/60-day follow-up calls? Is there flexibility in conducting these calls?

   Most certainly! We understand that it is difficult to conduct a follow-up call exactly at the 30/60 day mark. You may call the patient 10 days before or up to 10 days after the due date of the 30/60 day call.

10. What patients are appropriate for a 30-/60- day call?

   During the follow-up calls, the PAC will ask the patient if he/she is participating in any of the resources recommended on the care plan. Therefore, 30-/60- days calls are only to be completed if the patient attended the clinic visit AND received an care plan.

11. What happens if the patient is readmitted with another stroke/TIA after recently just being discharged from a previous admission for a stroke/TIA?

   When this happens, you will restart the patient’s COMPASS Model of care. For example, if the patient has already been to the clinic for their follow-up visit, and immediately after was readmitted, you will take the patient through the full model of care again, if the patient is discharged home.

12. If the patient wants to be followed-up in the clinic before the 7th day post-discharge, will this still count as the 7-14 day clinic visit?

   Most certainly! The clinic visit may be completed within 7 days of discharge, or within 14 days of discharge. If a patient wants to have his/her follow-up visit two, three, or four days, etc. after discharge, this is acceptable and can be counted as the 7-14 day visit.

13. I am scheduling the patient for his/her 7-14 day follow-up visit, but the clinic is busy, and the only available appointment is past the 14 day window. What do I do?

   This is acceptable. We understand that some clinics may be booked, and the only available appointment is 15, 16, 17, etc. days after hospital discharge. Please continue to set the appointment at the earliest available time slot so that the patient can still continue the standard
model of care and receive an individualized Care Plan. However, if you are using the billing TCM codes 99495 (14 day) and 99496 (7 day), you cannot bill for a visit past 14 days. You will need to use one of the extended visit codes, 99215 and 99214, based on medical decision-making complexity. Occasionally, it may be necessary to use the prolonged service code, 99354, in addition to the return patient codes listed above.