SUPPLEMENTAL MATERIAL

SUPPLEMENT 1A

Two-Day Post-Discharge Follow-Up

ID Number: | | | | | | Form Code: | 2 | D | A | Y | | Date: 7JUN2016 Version 1.0

ADMINISTRATIVE INFORMATION (0a-0b are auto-populated)

0a. Completion Date: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐☐☐

A. Hi. My name is ______________________, and I am calling on behalf of the stroke team of (name of hospital from which patient was discharged). May I speak to (patient name)?

☐ Yes, patient is available → **Go to Question 1**
☐ No, patient is not currently available → **Go to Section B**
☐ No, patient is deceased → **End Two-Day Post-Discharge Follow-Up**
☐ No, patient is hospitalized → **End Two-Day Post-Discharge Follow-Up**
☐ No, patient is in a skilled nursing facility → **End Two-Day Post-Discharge Follow-Up**

B. May I please speak to (patient name)'s primary caregiver?

☐ Yes → **Go to Section D** ☐ No → **Go to Section C**

C. May I please get the primary caregiver's name and number?

Name of the primary caregiver: ____________________________
☐ I don't know the primary caregiver's name or number
☐ No, I refuse to provide caregiver's number

Number of primary caregiver: (__ __ __) __ __ __ - __ __ __ __
☐ I don't know the primary caregiver's name or number
☐ No, I refuse to provide caregiver's number

→ **End Two-Day Post-Discharge Follow-Up**

D. (Patient name) was discharged from the hospital approximately two days ago, and I would like to follow up with you to see how he/she has been doing.

To whom am I speaking with?
Name: _________________________

D (a). What is your relationship with (patient name)?
☐ Spouse
☐ Sibling
☐ Son/Daughter
☐ Neighbor/Friend
☐ Parent/Legal Guardian
☐ Other → **Go to Question E (c)**

D (b). Specify for "other" _____________

D (c). Does the (patient name) have communication challenges that prevent him/her from answering questions?

- ☐ No
- ☐ Yes, significant aphasia
- ☐ Yes, cognitive deficits
- ☐ Both, significant aphasia & cognitive deficits
- ☐ No response

→ **Go to Question 1**

The Post – Acute Care Coordinator will now ask the following open-ended questions of the patient:

You were discharged from the hospital approximately two days ago, and I would like to follow up with you to see how you have been doing

1. I would like to discuss your medications and any changes that have been made. (Obtain medication list. Complete medication reconciliation, and list any discrepancies). Was medication reconciliation completed?

   ☐ Yes → **Go to Question 1a**

   ☐ No → **Go to Question 1c**

   1a. Were there any discrepancies during medication reconciliation?

   ☐ Yes ☐ No → **Go to Question 2**

   1b. ________________________________

   1c. Why was medication reconciliation not completed?

   ____

2. Do you have any concerns about your medications?

   ☐ Yes
   ☐ No → **Go to Question 3**

   2a. What are these concerns?

   ☐ ________________________________

   ☐ No Response

3. Are you on Coumadin (Warfarin)?

   ☐ Yes ☐ No → **Go to Question 4**

   3a. Have you had a test to see how long it takes for your blood to clot? This is known as an INR test.

   ☐ Yes ☐ No → **Go to Question 4**

   3b. What is your INR (Typical normal range 2-3)?

   ☐ __________
   ☐ I don't know
   ☐ No response

   3c. When did you have your INR test?

		/			/				

Month Day Year

☐ I don't know
☐ No response

4. Have you had any **new** stroke symptoms since being discharged from the hospital?
☐ Yes ☐ No → **Go to Question 5**

4a. What are these new symptoms?

	Yes	No	No Response
Numbness or weakness of the face, arm, or leg, especially on one side of the body	☐	☐	☐
Confusion / trouble understanding	☐	☐	☐
Difficulty speaking	☐	☐	☐
Trouble seeing in one or both eyes	☐	☐	☐
Trouble walking	☐	☐	☐
Dizziness, loss of balance or coordination	☐	☐	☐
Severe headache	☐	☐	☐
No response	☐		

5. After being discharged from the hospital, some stroke survivors may need a primary caregiver to provide assistance with activities such as taking your medicines, bathing, dressing, performing housework, and/or going places around town. Is there a primary caregiver who is currently assisting you with these tasks?
☐ Yes ☐ No → **Go to Question 6**

5a. What activities is your primary caregiver assisting with?

	Yes	No	No Response
Medication management	☐	☐	☐
Assisting with ADLs (bathing, dressing, feeding, etc.)	☐	☐	☐
Assisting with IADLs (cooking, housework, shopping, etc.)	☐	☐	☐
Transportation	☐	☐	☐
None	☐		
No response	☐		

5b. What is the name of the primary caregiver? ____
☐ No response

5c. What is the primary caregiver's relationship to you?
☐ Spouse
☐ Sibling
☐ Son/Daughter
☐ Neighbor/Friend
☐ Parent/Legal Guardian
☐ Other → **Go to Question 7d**
☐ No response

5d. Specify "other": _________________________

6. Do you have a follow-up appointment scheduled with your primary care provider?
☐ Yes
☐ No → **Go to Question 7**
☐ I don't know → **Go to Question 7**

6a. What is the date and time of your follow-up visit at your primary care provider?

		/			/				

Month Day Year

- ☐ I don't know
- ☐ No response

6b. What is the first and last name of your primary care provider?

- ☐ ____________________
- ☐ I don't know
- ☐ No response

7. Do you have a follow-up appointment scheduled with our comprehensive stroke clinic? (Post-Acute Care Coordinator will need to have appointment date readily available).
   - ☐ Yes, I do have an appointment → **Go to Question 8**
   - ☐ No, I don't have an appointment (Post-Acute Care Coordinator will confirm an appointment was not established) → **Go to Question 9**
   - ☐ I don't know if I have an appointment (Post-Acute Care Coordinator will confirm appointment or establish an appointment) → **Go to Question 11**

8. What is the date and time of your follow-up visit at our Comprehensive Stroke Clinic?
   - ☐ Patient confirmed date and time correctly → **Go to Question 11**
   - ☐ Patient didn't confirm date/time correctly or patient didn't know date/time → **Go to Q 10**

9. I will now establish an appointment for you to our Comprehensive Stroke Clinic. Your appointment is on (XX/XX/XXXX) at (XX:XX AM/PM). Did appointment get established?
   - ☐ Yes → **Go to Question 11** ☐ No

   9a. Why did appointment not get established?
   - ☐ Patient prefers to follow-up with his/her own PCP or another doctor
   - ☐ Patient reported that he/she is too sick or disabled to attend
   - ☐ Patient cannot afford to attend the 7-14 day visit
   - ☐ Patient does not have transportation
   - ☐ Patient reported that he/she lives out of the area & doesn't want to travel
   - ☐ No available appointment within 14 days
   - ☐ Other: __________________

10. Your appointment at our Comprehensive Stroke Clinic is on (XX/XX/XXXX) at (XX:XX AM/PM) Did confirmation take place?
    - ☐ Yes ☐ No

11. Have you had any falls since your discharge?
    - ☐ Yes ☐ No → **Go to Question 11a**

    11a. Did you sustain any injuries and have to go to the emergency room or see a doctor?
    - ☐ Yes ☐ No ☐ No response

12. Were you prescribed home health services after hospital discharge?
    - ☐ Yes ☐ No → **Go to Question 13** ☐ I don't know → **Go to Question 13**

12a. What home health agency will provide you with home health care?
- ☐ ______________________
- ☐ I don't know
- ☐ No response

12b. What service(s) has been scheduled?

	Yes	No	N/A
Home health PT	☐	☐	☐
Home Health OT	☐	☐	☐
Home Health SLP	☐	☐	☐
Home Health Nursing	☐	☐	☐
No response	☐		

12c. Do you plan to receive and continue the home health service(s) that have been scheduled?
☐ Yes ☐ No ☐ No response

12d. [If a service(s) has not been scheduled], why hasn't the service(s) been scheduled?
- ☐ I chose not to participate in home health services
- ☐ The home health agency has not contacted me to schedule appointments
- ☐ Other

→ **Go to Question 14**

13. Were you prescribed any outpatient therapy after hospital discharge?
☐ Yes ☐ No → **Go to Question 14**

13a. What service(s) has been scheduled?

	Yes	No	N/A
Outpatient OT	☐	☐	☐
Outpatient PT	☐	☐	☐
Outpatient SLP	☐	☐	☐
No response	☐		

13b. Do you plan to attend and continue the therapy service(s) or appointment(s) that have been scheduled?
☐ Yes ☐ No ☐ No response

13c. [If a service(s) has not been scheduled], why hasn't the service(s) been scheduled?
- ☐ I chose not to participate in outpatient services
- ☐ There were not any available appointments in the outpatient rehabilitation center
- ☐ Other

You had a stroke, and it's important to remember the signs and symptoms of a stroke and when to go to the emergency department. An easy way to remember this is think of the word, FAST.
Face. Look for an uneven smile.
Arm. Check if one arm is weak or numb.
Speech. Listen for slurred speech.
Time. Call 911 immediately.

14. As a reminder, attending your appointment at the Comprehensive Stroke Clinic is important for your recovery, health, and independence. Do you have any issues with transportation that may prevent you from attending your appointment?
☐ Yes → **Go to Section F** ☐ No → **Go to Section G**

(F) There are resources within your area that can assist you with transportation to our comprehensive stroke clinic if you need assistance getting to your appointment. (Post-Acute Care Coordinator will relay resources to patient or caregiver) Thank you for taking the time to answer these follow-up questions. We have scheduled you to come to our Comprehensive Stroke Clinic on (XX/XX/XXX) at (XX:XX AM/PM).

(G) Thank you for taking the time to answer these follow-up questions. We have scheduled you to come to our Comprehensive Stroke Clinic on (XX/XX/XXX) at (XX:XX AM/PM).

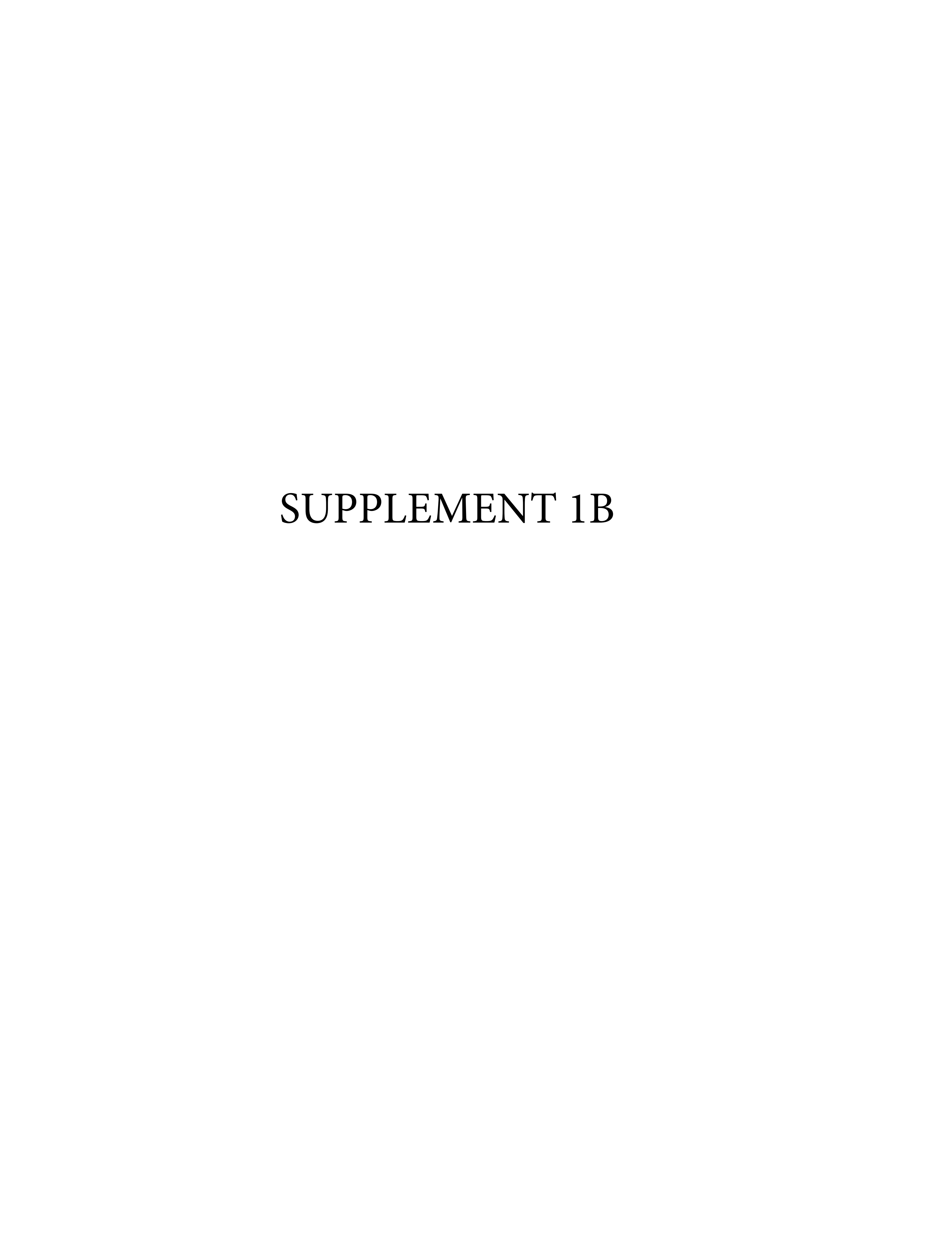
15. Are there any challenges or discrepancies to medication reconciliation, or any concerns (new or worsening symptoms, patient sustaining an injurious fall, etc) that need to be immediately triaged to the Advanced Practice Provider?

    ☐ Yes ☐ No

    15a. What are these challenges or concerns?

    ____

END OF 2-DAY POST-DISCHARGE FOLLOW-UP



SUPPLEMENT 1B

SUPPLEMENT 1b

Post-Stroke Functional Assessment for Personalized Care©

For Each Patient, the *"Right Care, Right Place, Right Time"*

ID Number: ☐☐☐☐☐ Form Code: P S F A ☐ Date: 10FEB2017 Version 2.0

ADMINISTRATIVE INFORMATION (0a-0b are auto-populated)

0a. Completion Date: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐☐☐

We are going to ask you a series of questions about your health and well-being, and your ability to take care of yourself and move around since your stroke. Some questions will also ask you about your preferences for care. The goal is to share this information with your doctors, nurses, and therapists so that they can develop a care plan made especially for you. Please answer the following questions on the state of your health or function and the activities you would prefer to do to help you recover and stay healthy.

1. Since you were hospitalized for your stroke, have you had enough to buy your medicines and take them as your doctor prescribed?
   ☐ Yes ☐ No ☐ No response

2. Do you know any of the risk factors that may lead to a stroke? ☐ Yes ☐ No → **Go to Question 3**

   2a. What are these risk factors? (check all that apply)
   - ☐ High Blood Pressure
   - ☐ Smoking
   - ☐ Diabetes or High Blood Sugar
   - ☐ Irregular Heart Beat (Atrial Fibrillation)
   - ☐ Heart Disease
   - ☐ High Cholesterol
   - ☐ Physical Inactivity
   - ☐ Sickle Cell Anemia
   - ☐ Family History of Stroke
   - ☐ Prior Stroke
   - ☐ Response not on this list

   2b. Did the patient know <u>any</u> of the risk factors for stroke? ☐ Yes ☐ No

3. Compared to others your age, how would you rate your health since your stroke using a scale of 1 to 5, with 1 being “poor” and 5 being “excellent?”

   (1) Poor (2) Fair (3) Good (4) Very Good (5) Excellent ☐ No response

4. Can you go up and down 10 stair steps without help? ☐ Yes ☐ No ☐ No response

5. How difficult is it to use your hand most affected by your stroke?

   (1) Cannot use at all (2) Very difficult (3) Somewhat difficult (4) A little difficult (5) Not difficult at all
   ☐ No response

6. Have you fallen in the last 3 months? ☐ Yes ☐ No → **Go to Question 8**

   6a. In the last 3 months, did you get injured and need to go to the doctor or emergency room due to a fall?
   ☐ Yes ☐ No ☐ No response

   6b. Have you fallen more than once in the last 3 months? ☐ Yes ☐ No ☐ No response

7. Have you fallen since your stroke? ☐ Yes ☐ No → **Go to Question 8**

   7a. How many times have you fallen since your stroke?__________ ☐ don’t know ☐ No response

8. Please continue this sequence: 1, A, 2, B, 3, C, _, _, _, _, _, _.

   Choose “yes” if the patient completed the entire sequence correctly.
   ☐ Yes ☐ No ☐ No response

9. How many different medications do you take per day?______________ ☐ don’t know ☐ No response

10. Is there someone to help you move about, bathe, dress, etc. for 30 days if you ever need assistance?
    ☐ Yes ☐ No → **Go to Question 11**

    10a. What relationship is he/she to you?
    ☐ Spouse
    ☐ Sibling
    ☐ Son/Daughter
    ☐ Neighbor/Friend
    ☐ Parent/Legal Guardian
    ☐ Other (Specify) → **Specify other in 10b**
    ☐ No response

    10b. Specify other: ___________

11. Since your stroke, have you often been bothered by feeling down, depressed, or hopeless?
☐ Yes ☐ No ☐ No response

12. Since your stroke, have you often been bothered by little interest or pleasure in doing things?
☐ Yes ☐ No ☐ No response

***Note: There are 5 pathways to complete the Post-Stroke Functional Assessment. If the first 12 questions are answered a certain way, only specific questions will need to be asked for the remainder of this assessment. See pages 9-10 for criteria of the 5 pathways.**

13. Over the next 3 months, do you think your health is going to:
☐ Improve
☐ Stay the same
☐ Get worse
☐ No response

14. What are your primary reasons for staying as healthy as you can?
(Open-ended question)

For example,

	Yes	**No**	**No Response**
Work – return to work	☐	☐	☐
Social – visit with friends, go out, and/or travel	☐	☐	☐
Family – visit with family, play with my grandchildren	☐	☐	☐
Independence – be independent, take care of myself	☐	☐	☐
Better quality of life	☐	☐	☐
Other → **Specify other in 14b**	☐	☐	☐
No response	☐		

14b. Specify other_____________

These next few questions ask about your ability to take care of yourself and move around.

15. Can you walk for at least 15 minutes without getting short of breath or needing to stop and rest?
☐ Yes ☐ No ☐ No response

16. Can you walk without feeling unsteady?
☐ Yes ☐ No ☐ No response

17. Can you get up out of a chair **without** using your hands?
☐ Yes ☐ No ☐ No response

18. Can you use the phone to call your family or doctor if needed?
☐ Yes ☐ No ☐ No response

19. Can you prepare your own meals or do your own housework without any assistance?
☐ Yes ☐ No ☐ No response

20. Can you bathe/take a shower and dress yourself without any assistance?
☐ Yes ☐ No ☐ No response

21. Are you having trouble controlling your bladder or bowels?
☐ Yes ☐ No ☐ No response

Because ability to remember is so important for managing your health, I am going to ask a few questions about this area of your life. There really is no right or wrong answer. These are helpful questions to assist your doctors and nurses to help you have the assistance you need to manage your health.

22. Can you tell me the day of the week, month, and year? (Choose "Yes" if the patient was able to correctly identify day of the week, month, and year.)
☐ Yes ☐ No ☐ No response

I am going to read a list of words to you that you will have to remember. Please listen carefully. When I am through, repeat as many words as you can remember. It doesn't matter in what order you say them.

Trial 1: School, blue, apple.

I am going to read the list for a second time. Repeat as many words as you can.

Trial 2: School, blue, apple.

I will ask you to recall these words again later on in this assessment.

23. Tell me why you are taking two of your medicines. (Choose "Yes" if patient was able to recall two medicines and reasons for taking them).
☐ Yes ☐ No ☐ No response

24. Does anyone help you manage your medications? (Puts your medicine in a pill box, hands your medicines to you, etc).
☐ Yes ☐ No ☐ No response

25. In the last month, **were you unable** to buy your medicines because of not having enough money?
☐ Yes ☐ No ☐ No response

26. Do you stop taking your medicine if you feel better or worse?
☐ Yes ☐ No ☐ No response

27. Do you ever forget to take your medicine?
☐ Often
☐ Sometimes
☐ Rarely
☐ Never
☐ No response

28. Please recall the three words I asked you to remember. It doesn't matter in what order you list them. (Choose "Yes" if patient was able to recall all 3 words : school, blue, apple).
☐ Yes ☐ No ☐ No response

29. Since your stroke, do you eat at least two meals a day?
☐ Yes ☐ No ☐ No response

30. Since your stroke, have you had new problems swallowing or chewing your food?

☐ Yes ☐ No ☐ No response

31. Since your stroke, have you had increased stiffness in your hand, arm, or leg that interferes with your activities of daily living?

☐ Yes ☐ No ☐ No response

32. Since your stroke, have you been able to drive yourself to and from places?

☐ Yes ☐ No ☐ No response

33. If unable to drive, is there someone who can take you to the doctor or pharmacy?

☐ Yes ☐ No ☐ No response

34. Do you have one doctor that knows you and all of your medical conditions?

☐ Yes ☐ No → **Go to Question 39**

35. What is the doctor's first and last Name?_________________ ☐ don't know ☐ No response

36. Have you seen him/her in the past 3 months?

☐ Yes ☐ No → **Go to Question 38**

37. Have you seen him/her since your stroke?

☐ Yes ☐ No ☐ No response

38. In the past 3 months, did you miss any scheduled appointments with this doctor?

☐ Yes ☐ No ☐ No response

39. Do you have a network of family and friends who visit you as often as you like?

☐ No, I am often lonely
☐ Yes, I can count on my family and friends to lean on when I feel down
☐ No response

40. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?

☐ Yes ☐ No ☐ No response

41. Since your stroke has your relationship with your family become more difficult or stressed?

☐ Yes ☐ No ☐ No response

42. In the last 3 months, with the exception of your stroke, how many times were you seen in the emergency department?

_________________ ☐ don't know ☐ No response

43. How many times in the last 3 months have you been hospitalized overnight, with the exception of your hospitalization due to your stroke?

_________________ ☐ don't know ☐ No response

44. What home health services are you currently receiving?
(Open-ended question)

	Yes	No	No Response
None → **Go to Question 45**	☐		
Nursing	☐	☐	☐
Physical Therapy	☐	☐	☐
Occupational Therapy	☐	☐	☐
Speech & Language Therapy	☐	☐	☐
Personal Care Assistant	☐	☐	☐
No response → **Go to Question 45**	☐		

45. What type of outpatient therapy are you currently receiving?
(Open-ended question)

	Yes	No	No Response
None	☐		
Outpatient Physical Therapy	☐	☐	☐
Outpatient Occupational Therapy	☐	☐	☐
Speech & Language Therapy	☐	☐	☐
No response	☐		

46. What Durable Medical Equipment (DME) are you currently using?
(Open-ended question)

	Yes	No	No Response
None	☐		
Walker	☐	☐	☐
Cane	☐	☐	☐
Wheelchair	☐	☐	☐
Bath Safety Equipment (Toilet rails/frames, shower bench/seat)	☐	☐	☐
Bedside Commode	☐	☐	☐
No response	☐		

47. What is the best way to reach you to discuss your health and how you are doing?

☐ Telephone call → **If checked, answer 47a**
☐ Text message → **If checked, answer 47a**
☐ Email → **If checked, answer 47b**
☐ I will visit My Health portal on the internet
☐ No response

a. What is the best number to reach you?______________________ ☐ don't know ☐ No response

b. What is your email address?______________________ ☐ don't know ☐ No response

Your doctor and nurses want to take good care of you and respect your values and views. Your doctor wants to make sure he/she understands your views on treatment so they can take good care of you. Because unexpected things can happen, you have the right to make decisions about your healthcare. This includes the right to accept or refuse medical or surgical treatment when you are seriously ill or lose the ability to participate in decision-making about your own treatment. Fortunately, you have the right to plan and direct the types of healthcare and life sustaining treatments you wish to receive in the future. You can do this by making an advance directive (living will). An advance directive gives you a voice in decisions about your medical care.

48. Do you have a living will? ☐ Yes → **Go to Question 49** ☐ No

48a. Would you be interested in information to assist you in creating a living will?
☐ Yes ☐ No ☐ No response

49. Did someone other than the patient answer the majority of these questions?
☐ Yes ☐ No

49a. What was their relationship to the patient?
- ☐ Spouse
- ☐ Sibling
- ☐ Son/Daughter
- ☐ Neighbor/Friend
- ☐ Parent/Legal Guardian
- ☐ Other (Specify) → **Specify other in 49b**
- ☐ No response

49b. Specify other: ____________

Based on your answers, we have found the following [Summarize to patient results from the questionnaire].

What support/services do you have to help you? And what resources would you like to receive in order to help you?

Thank you for responding to our questions. I am going to discuss your questionnaire with the provider (nurse practitioner/physician assistant/physician) and use your responses to arrange any services that will be useful to ensure the best possible stroke recovery. Do you have any questions for me?

[The question and checklist below will only be completed at Wake Forest Baptist Medical Center – Vanguard Site]

To be completed by the interviewer. Which of the following factors do you think this patient will need help or assistance with to speed their stroke recovery?

- ☐ Activities of Daily Living (Bathing, dressing, walking)
- ☐ Exercise to improve strength, balance, and endurance
- ☐ Falls prevention
- ☐ Durable medical equipment or home modifications
- ☐ Transportation to follow-up appointments
- ☐ Manage medications (pill box, etc)
- ☐ Monitor/control of stroke risk factors (blood pressure, hypertension)
- ☐ Pharmacy referral
- ☐ Financial assistance to purchase medications
- ☐ Depression services, treatment, and support
- ☐ Patient doesn't have a primary care physician & needs help getting one
- ☐ Identify caregiver to assist & be available during instructions
- ☐ Refer to Outpatient Therapy (PT/OT)
- ☐ Refer to Speech and Language
- ☐ Refer to Home Health Services
- ☐ Refer to Skilled Nursing Home
- ☐ Refer to Community Services
- ☐ Assistance with Advance Directive
- ☐ Nutritional support
- ☐ None

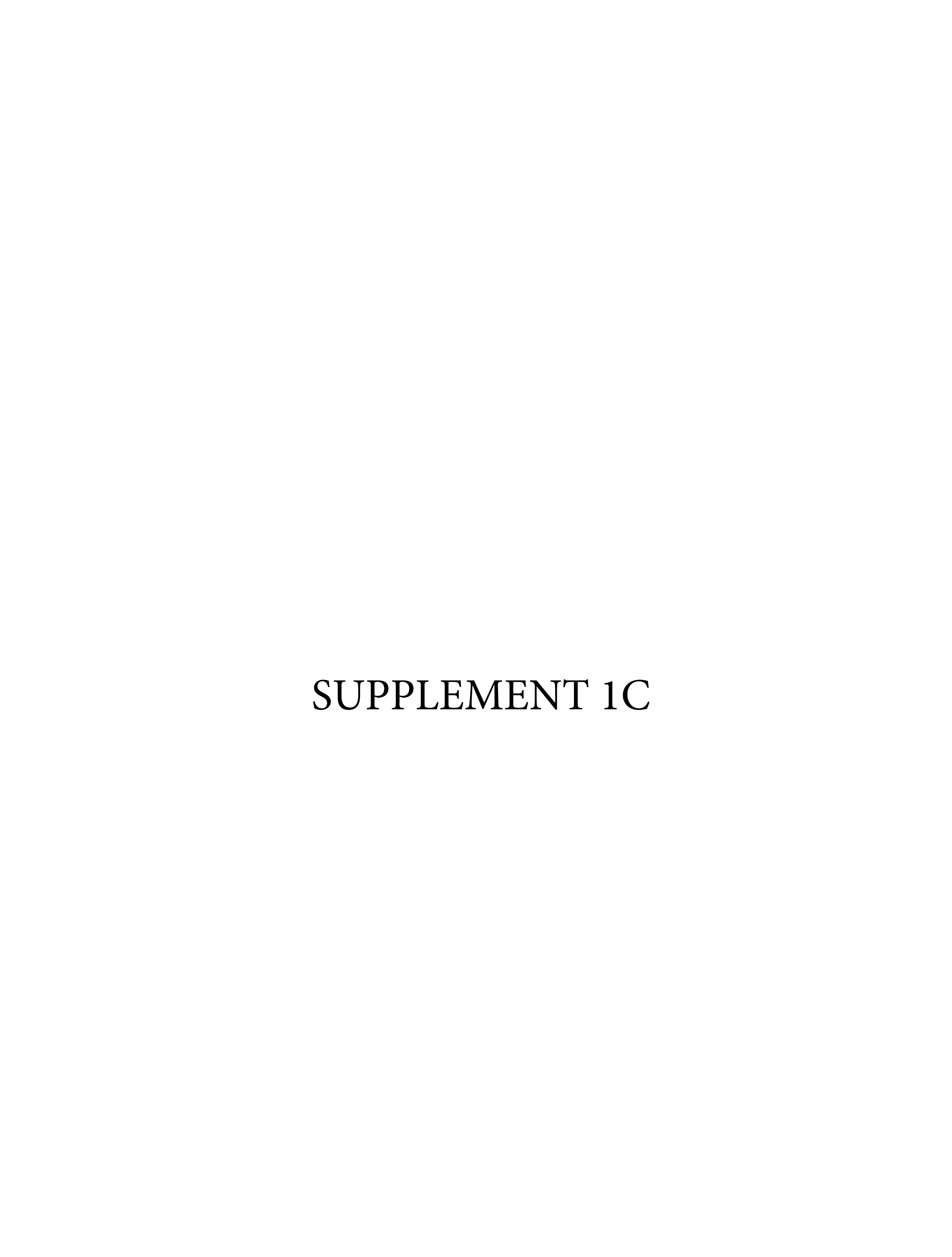
Thank you!

Thanks for completing this questionnaire!
Go out and live the best day possible.
You deserve it.

END OF POST STROKE FUNCTIONAL ASSESSMENT

Pathway #1: Patient answers first 12 questions positively or 'risk factor' questions (2, 2b) are the only questions answered negatively. **<u>If the following criteria are met:</u>** **Question 1: Yes** **Question 2: Yes or No** **Question 2b: Yes or No** **Question 3: (3) Good or (4) Very Good or (5) Excellent** **Question 4: Yes** **Question 5: (4) A little difficult or (5) Not difficult at all** **Question 6: No** **Question 8: Yes** **Question 9: 4 or less** **Question 10: Yes** **Question 11: No** **Question 12: No**	**<u>Only the following questions will be asked:</u>** **Question 14** **Question 26-27** **Question 34-38** **Question 42-43** **Question 47**
Pathway #2: 'Depression' questions (11, 12) are the only question answered negatively and everything else positive. OR 'depression' (11, 12) and 'risk factor' questions (2, 2b) are only answered negatively, everything else positive. **<u>If the following criteria are met:</u>** **Question 1: Yes** **Question 2: Yes or No** **Question 2b: Yes or No** **Question 3: (3) Good or (4) Very Good or (5) Excellent** **Question 4: Yes** **Question 5: (4) A little difficult or (5) Not difficult at all** **Question 6: No** **Question 8: Yes** **Question 9: 4 or less** **Question 10: Yes** **Question 11: Yes OR No response** **Question 12: Yes OR No response**	**<u>Only the following questions will be asked:</u>** **Question 14** **Question 26-27** **Question 34-38** **Question 40-41** **Question 42-43** **Question 47**

Pathway #3: 'Polypharmacy' question (9) is the only question answered negatively and everything else positive. OR 'polypharmacy' (9) and 'risk factor' questions (2, 2b) are only answered negatively, everything else positive. **If the following criteria are met:** **Question 1: Yes** **Question 2: Yes or No** **Question 2b: Yes or No** **Question 3: (3) Good or (4) Very Good or (5) Excellent** **Question 4: Yes** **Question 5: (4) A little difficult or (5) Not difficult at all** **Question 6: No** **Question 8: Yes** **Question 9: (5 or more) OR (I don't know) OR (No response)** **Question 10: Yes** **Question 11: No** **Question 12: No**	**Only the following questions will be asked:** **Question 14** **Question 22** **Question 26-28** **Question 34-38** **Question 42-43** **Question 47**
Pathway #4: 'Polypharmacy' question (9) and 'depression' questions (11, 12) are the only questions answered negatively and everything else positive. OR 'polypharmacy' (9) and 'depression' (11, 12), and 'risk factor' questions (2, 2b) are only answered negatively, everything else positive. **If the following criteria are met:** **Question 1: Yes** **Question 2: Yes or No** **Question 2b: Yes or No** **Question 3: (3) Good or (4) Very Good or (5) Excellent** **Question 4: Yes** **Question 5: (4) A little difficult or (5) Not difficult at all** **Question 6: No** **Question 8: Yes** **Question 9: (5 or more) OR (I don't know) OR (No response)** **Question 10: Yes** **Question 11: No** **Question 12: No**	**Only the following questions will be asked:** **Question 14** **Question 22** **Question 26-28** **Question 34-38** **Question 40-43** **Question 47**
Pathway #5: If none of the above pathways are met, then the whole stroke functional assessment will need to be completed.	


SUPPLEMENT 1C

Stroke Caregiver Assessment©

For Each Caregiver the *"Right Care at the Right Time"*

ID Number: ☐☐☐☐☐ Form Code: S C A ☐☐ Date: 27MAR2016 Version 1.0

ADMINISTRATIVE INFORMATION (0a-0c are auto-populated)

0a. Completion Date: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐☐☐

0c. Caregiver ID: ☐☐☐☐☐☐☐

A. *[Patient name] has indicated that he/she has assistance with some, or all, routine activities of daily living and that he/she depend on the help of a caregiver. Are you [patient name]'s primary caregiver?*

☐ Yes → **Go to Section C** ☐ No → **Go to Section B**

B. Who is the patient's primary caregiver, and what is the best number I can reach him/her? (Obtain name and number so that Post-Acute Care Coordinator can call primary caregiver).

Name of the primary caregiver: ________________________-______

Number of primary caregiver: (__ __ __) __ __ __ - __ __ __ __

C. *Since you are the primary caregiver, I would like to discuss the services and tasks that [patient name] needs assistance with during his/her stroke recovery. Do you have time to answer a few questions? This will take about 5 minutes to complete.*

1. What is your name? ____________ ☐ No response

2. What is your relationship?
   - ☐ Spouse
   - ☐ Sibling
   - ☐ Son/Daughter
   - ☐ Neighbor/Friend
   - ☐ Parent/Legal Guardian
   - ☐ Other
     - a. Specify for "other" _____________
   - ☐ No Response

3. What is your age? ___________ ☐ No response

4. What is your gender? ☐ Male ☐ Female ☐ No response

5. Do you provide assistance for **[patient name]** with any of the following activities?

6. Which of those activities do you need additional assistance with?

	5. Provide assistance? If Yes, go to Q6 →			**6. Caregiver needs help with task?**		
	Yes	**No**		**Yes**	**No**	**No response**
a. Bathing / showering	☐	☐		☐	☐	☐
b. Dressing	☐	☐		☐	☐	☐
c. Getting out of bed / chair	☐	☐		☐	☐	☐
d. Helping to / from bathroom	☐	☐		☐	☐	☐
e. Feeding	☐	☐		☐	☐	☐
f. Preparing Meals	☐	☐		☐	☐	☐
g. Shopping	☐	☐		☐	☐	☐
h. Laundry	☐	☐		☐	☐	☐
i. Handling finances	☐	☐		☐	☐	☐
j. Assistance with housework	☐	☐		☐	☐	☐
k. Transportation to medical appointments	☐	☐		☐	☐	☐
l. Transportation to grocery store, places around town, etc.	☐	☐		☐	☐	☐
None → **Go to Section B**	☐					
No Response → **Go to Section B**	☐					

7. Do you assist **[patient name]** with medications?

☐ Yes → **Go to Question 7a and b (skip 7c)** ☐ No → **Go to Question 7c**

7a. Can you name at least two medicines that **[patient name]** is taking and why he/she is taking these medications?

☐ Yes
☐ No
☐ No Response

7b. Do you need assistance with managing the patient's medications?

☐ Yes ☐ No ☐ No response

7c. Does someone else assist with managing the patient's medications?

☐ Yes ☐ No ☐ No Response

8. Compared to others your age, how would you rate your health using a scale of 1 to 5, with 1 being “poor” and 5 being “excellent?”

   ☐ Poor (1)
   ☐ Fair (2)
   ☐ Good (3)
   ☐ Very Good (4)
   ☐ Excellent (5)
   ☐ No response

9. Do you have any health problems or other responsibilities that affect your ability to assist **[patient name]** with his/her care and recovery?

   ☐ Yes ☐ No ☐ No Response

10. Are you feeling stressed since **[patient name]** had his/her stroke?

    [Define stress as needed: Stress means a situation in which a person feels tense, restless, nervous, and/or anxious, or is unable to sleep at night because his or her mind is troubled all the time].

    ☐ Yes ☐ No → **Go to question 11**

    10a. Would you like to talk with someone about coping with your stress?

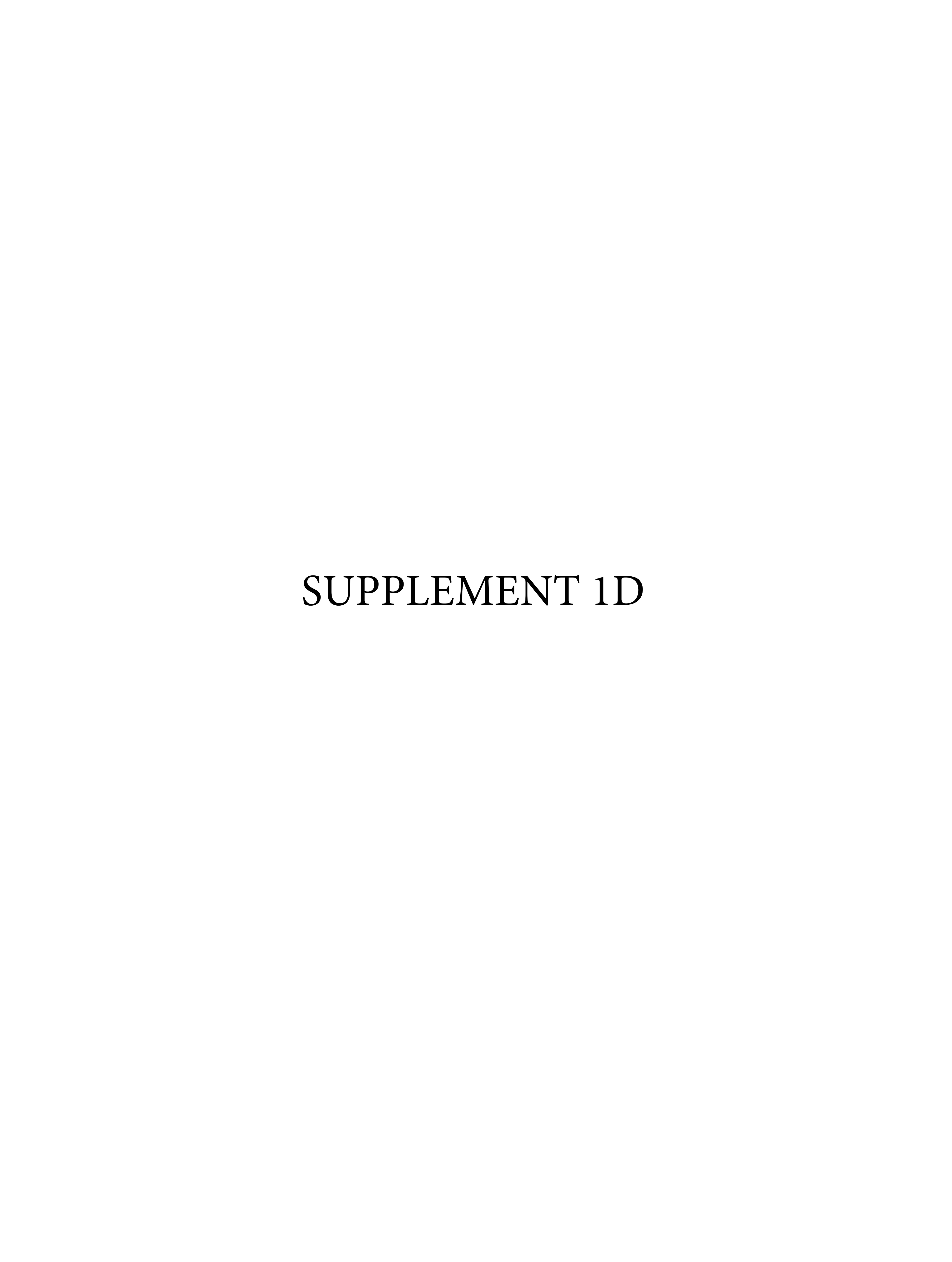
    ☐ Yes ☐ No ☐ No response

11. Has anyone discussed with you the signs and symptoms of a stroke, and when to call 911?

    ☐ Yes ☐ No → **Proceed to script below**

It’s important that you are aware of the signs and symptoms of a stroke and when to go to the emergency department. And easy way to remember this is to think of the word, FAST.
Face. Look for an uneven smile.
Arm. Check if one arm is weak or numb.
Speech. Listen for slurred speech.
Time. Call 911 immediately.

END OF STROKE CAREGIVER ASSESSMENT



SUPPLEMENT 1D

Post Stroke Advanced Practice Assessment

For Each Patient the *"Right Care, Right Place, Right Time"*

ID Number: | | | | | | Form Code: | P | S | A | P | A | Date: 31MAR2016   Version 1.0

ADMINISTRATIVE INFORMATION (0a-0b are auto-populated)

0a. Completion Date: |__|__| / |__|__| / |__|__|__|__| (Month / Day / Year)   0b. Staff ID: |__|__|__|__|__|

1. Since the stroke, on average, how many minutes/ per day has the patient engaged in continuous physical activity?
   - ☐ Walking/ moving about for <10 min/day
   - ☐ Walking/moving about for 10-20 minutes/day
   - ☐ Walking/moving about for > 20 minutes/day
   - ☐ No response

2. Did you educate patient on importance of physical activity?
   ☐ Yes ☐ No

3. How often does the patient smoke cigarettes?
   - ☐ Not at all → **Go to Question 4**
   - ☐ Some days
   - ☐ Every day
   - ☐ No response

   3a. Has the patient received counseling to end addiction to cigarettes?
   ☐ Yes ☐ No ☐ No Response

4. Does the patient exceed the recommended alcohol per day? (1-2 drinks/day for men, 1 drink for women) (Wine=5oz., beer=12 oz.)
   ☐ Yes ☐ No ☐ No Response

5. Does the patient engage in recreational drug use? (marijuana, cocaine, heroin, street drugs/ non-prescription opioids)
   ☐ Yes ☐ No ☐ No Response

6. Has patient received counseling to end addiction to recreational drug or alcohol?
   ☐ Yes ☐ No ☐ No Response

7. Blood Pressure

Systolic ____________ mm HG
Diastolic ____________ mm HG

8. HgbA1c ____________ ☐ Not Available

9. INR ____________ ☐ Not Available

10. LDL ____________ (mg/dL) ☐ Not Available

11. Are there any severe communication deficits such as severe dysarthria, expressive or receptive aphasia that require speech therapy?

☐ Yes ☐ No

12. If indicated, MOCA score ____________

☐ Not Indicated
☐ Patient refused

13. If indicated, PHQ-9 _________________

☐ Not Indicated
☐ Patient refused

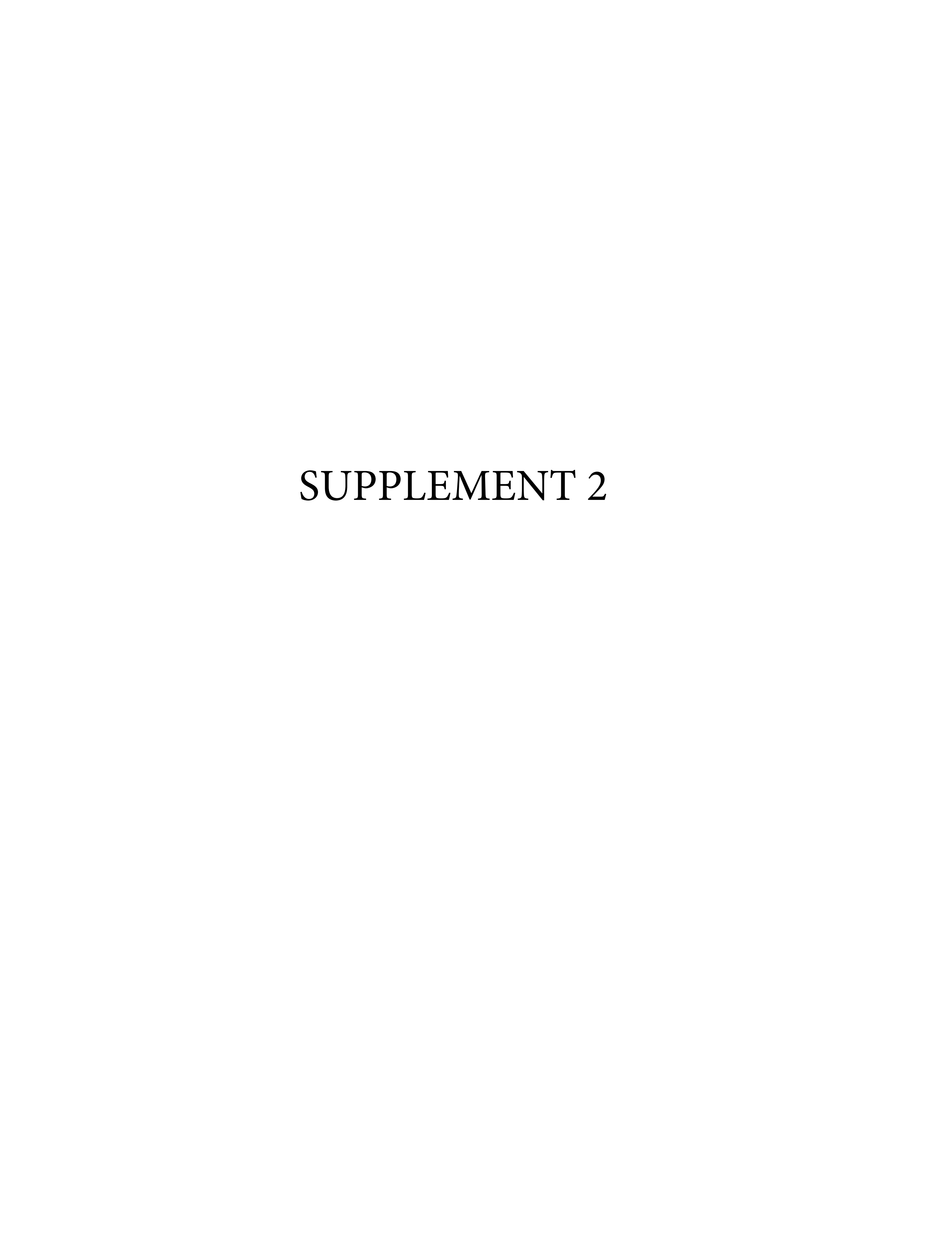
14. Modified Rankin score

☐ 0 No symptoms at all
☐ 1 No significant disability despite symptoms; able to carry out all usual duties and activities
☐ 2 Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
☐ 3 Moderate disability; requiring some help, but able to walk without assistance
☐ 4 Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
☐ 5 Severe disability; bedridden, incontinent and requiring constant nursing care and attention

15. If the patient needs a caregiver, does the patient have a willing and able caregiver? (provider opinion)

☐ Yes ☐ No ☐ Patient does not need a caregiver

END OF POST STROKE AP ASSESSMENT


SUPPLEMENT 2

Care Plan

After my stroke, I can GET BETTER! I can recover!

My goal(s) for recovery:
~friends

This is my **Care Plan** that is specific to my needs. My COMPASS team will use this plan to help care for me. I can find my way to recovery, independence and health if:

- I Manage My Blood Pressure
- I Am Physically Active – Movement Matters
- I Ask for Help When I Need It
- I Am Willing to Manage My Medications and Lifestyle Choices

My COMPASS team will review this plan with me and will be available for any questions. Please SHARE this Care Plan with all members of your healthcare team which may include primary care provider, nurses, pharmacist, home health and outpatient therapists .

Name of Post-Acute Care Coordinator ____

Telephone Number ___________________________

Thank you,
The health care team at ____

Be hopeful and positive!

SUPPLEMENT 2

My goal(s):
~friends

Name: Mary Poppins April 6, 2018

COMPASS COMPREHENSIVE POST-ACUTE STROKE SERVICES	What are my concerns?	Why is this important to me?	How do I find my way forward?
Numbers: **Know My Numbers. Know My Risks.** NUMBERS N	My Blood Pressure is **160 / 90**	High blood pressure damages the arteries that bring blood to the brain. This can cause another stroke. A blood pressure less than 120/80 is considered normal.	Healthy numbers lead to a healthy life. Keeping track of my numbers will decrease my chances of having another stroke. I can take my blood pressure every morning and keep a log of my blood pressure numbers. I can also check my blood sugar levels daily and keep a log of these numbers as well.
	My hemoglobin A1c level is **8**	Diabetes is a risk factor for stroke. Keeping track of my blood sugar levels can reduce my risk of another stroke. My ideal A1c level is around 7.	
	My LDL (bad) cholesterol level is **100**	A high LDL (bad) cholesterol level puts me at risk for another stroke. My bad cholesterol level should be less than 70.	

COMPASS: Finding my Way to Recovery, Independence, and Health

My goal(s):
~friends

Name: Mary Poppins April 6, 2018 Page 3

COMPASS COMPREHENSIVE POST-ACUTE STROKE SERVICES	What are my concerns?	Why is this important to me?	How do I find my way forward?
Engage: **Be engaged to to promote physical activity & safe mobility** E ENGAGE	I have fallen or I am at risk for falling.	I am more likely to fall since I had a stroke. Improving my balance and strength will help decrease my chances of falling and improve my overall independence.	I can decrease my chances of falling by: • Working with a physical therapist in my home or an outpatient clinic. • Attending a falls prevention class • Using appropriate walking aids for support • Having a home safety assessment

COMPASS: Finding my Way to Recovery, Independence, and Health

My goal(s):
~friends

COMPASS COMPREHENSIVE POST-ACUTE STROKE SERVICES	What are my concerns?	Why is this important to me?	How do I find my way forward?
Engage: Be engaged to to promote physical activity & safe mobility E ENGAGE	I may only be physically active for less than 20 minutes per day	**Movement matters for my stroke recovery.** I can decrease my risk for another stroke, increase my endurance, and feel better if I am physically active.	I can be more active by: • Working with a physical and/or occupational therapist in my home or an outpatient clinic. • Exercising regularly on my own or in an exercise class. • Walking every day for at least 20 minutes a day. I can break this up into smaller chunks 10 minutes at a time. • Movement around the house can keep me physically active as well (e.g. doing laundry, gardening, putting up groceries).
Engage: Be engaged with my health care team E ENGAGE	I need a regular doctor (primary care provider) who knows my medical history and conditions.	A primary care provider will help me monitor my cholesterol, blood pressure, blood sugar and blood thinning.	I can find a primary care provider by: • Using the information given to me in the stroke clinic • Using the information on free clinics if I do not have insurance

My recovery and my health require that:

Numbers • **I manage my blood pressure**

Engage • **I am physically active - Movement Matters**

Support • **I ask for help when I need it**

Willingness • **I am willing to manage my medications and lifestyle choices**

For additional information, and to investigate local community resources, visit the COMPASS study website at:

https://www.nccompass-study.org/

You can also visit the American Stroke Association's Life after Stroke web page for more resources to help you move forward in your recovery:

http://www.strokeassociation.org/STROKEORG/LifeAfterStroke/Life-After-Stroke_UCM_308546_SubHomePage.jsp#

You can access this care plan online using the following details:

https://compass.phs.wakehealth.edu/GetMyEcarePlan.cfm

Access code: 23058AC3

Concerns from my CARE plan that could affect my recovery:

I have fallen or I am at risk of falling.

I do not have a primary care provider and I need to get one.

Am I getting the type of care I need? My Care Plan suggests I may benefit from:

Home Health Care

- Currently, I may need help with activities such as meal planning, taking my medicines, bathing, and/or dressing.
- Home health care uses a variety of health care services. To optimize stroke recovery and regain independence, we recommend: ~skilled nursing care ~physical or occupational therapy

Close monitoring of my medical problems is necessary to prevent readmission to the hospital.

Who should I call for questions or concerns?

Dial 911 if I experience changes in speech, vision, or walking; or any new sudden onset of one-sided weakness or numbness of the face, arm, or leg.

An easy way to remember the signs and symptoms of a stroke is to think of the word FAST.

Face. Look for an uneven smile.
Arm. Check if one arm is weak or numb.
Speech. Listen for slurred speech.
Time. Call 911 immediately.

Call my primary care provider for any medical questions that are not related to my stroke.

Call the COMPASS team for any questions about my stroke or TIA such as recently prescribed medications, recent hospitalization, home health or outpatient therapy, or community and pharmacy referrals.

Community Resources: Engage

Piedmont Area Falls Prevention Coalition **Falls Prevention**	
Organization and Program Information:	(336) 904-0300 1398 Carrollton Crossing Drive Kernersville, NC 27284

Wake Forest Baptist Health **WFBH Medical Fitness Program**	
Organization and Program Information:	(336) 716-8402 131 Miller Street Winston-Salem, NC 27103 http://www.wakehealth.edu/Inpatient-Rehabilitation/Resources-for-Living-with-Stroke.htm

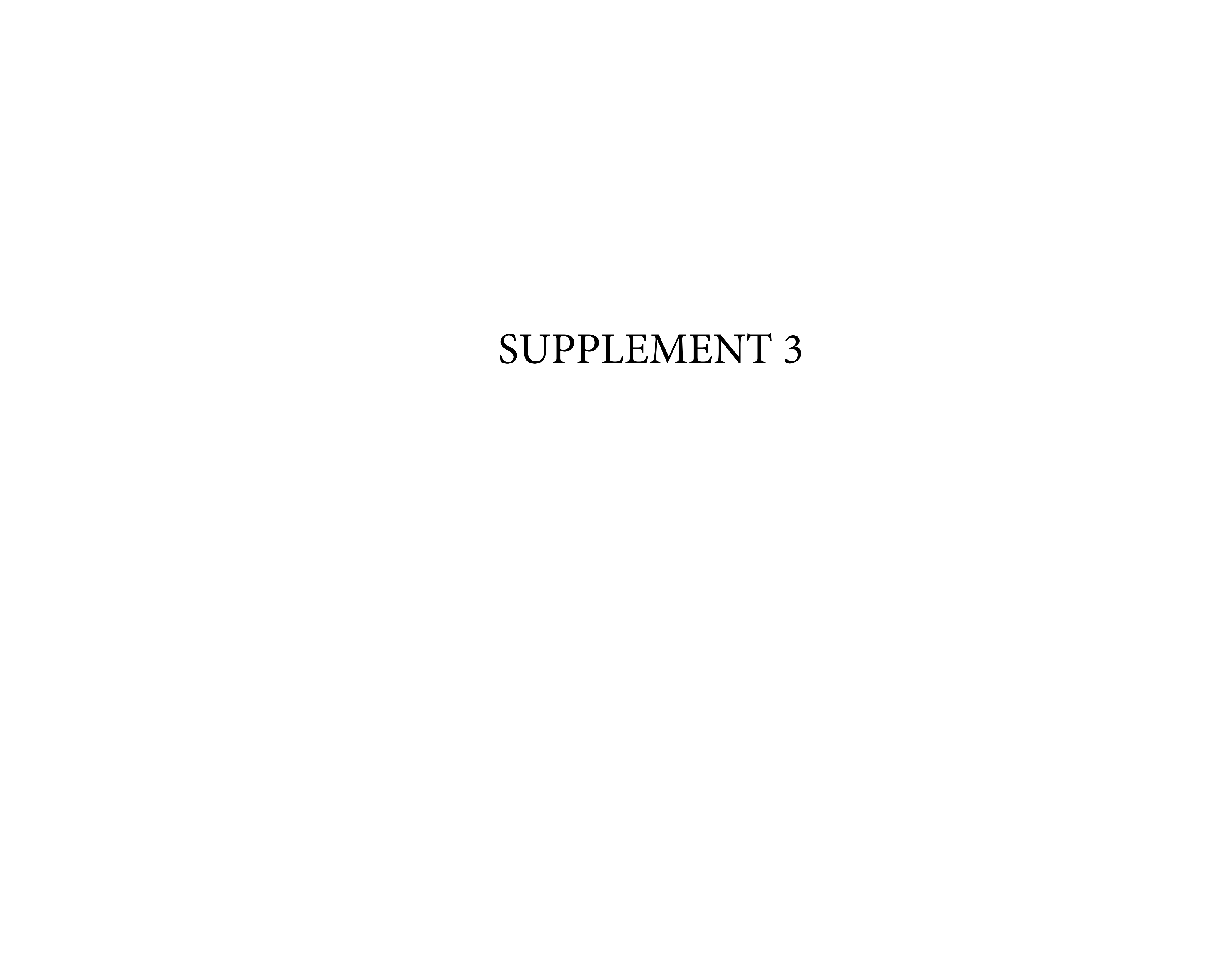
Wake Forest Baptist Health **Neurorehabilitation Community Exercise Program**	
Organization and Program Information:	(336) 716-8004 132 Miller Street Winston-Salem, NC 27103 http://www.wakehealth.edu/Outpatient-Rehabilitation/Neurorehabilitation-Therapy-Center/Community-Exercise-Program.htm
This program has special eligibility requirements, please see website.	

Community Resources: Engage

Wake Forest Baptist Health **StrokeFit Exercise Class**	
Organization and Program Information:	(336) 716-8007 131 Miller Street Winston Salem, NC 27104

First Choice Home Care **Falls Prevention Program**	
Organization and Program Information:	(336) 285-9107 1515 Cornwallis Dr. Greensboro, NC 27408 https://1stchoicehomecareinc.com/

Piedmont Triad Regional Council Area Agency on Aging **Extended Health Community Programs**	
Organization and Program Information:	(336) 904-0300 1398 Carrollton Crossing Drive, Kernersville, NC 27284 http://www.ptrc.org/index.aspx?page=204
This program has a special referral process, please see website.	

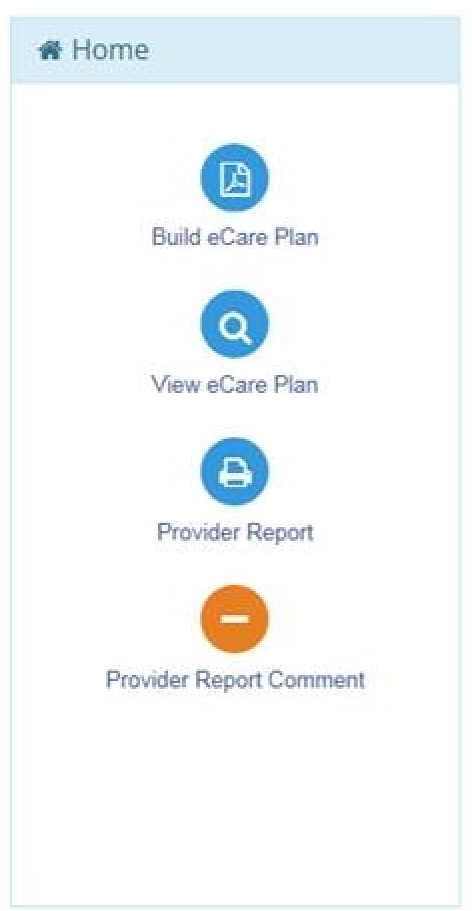


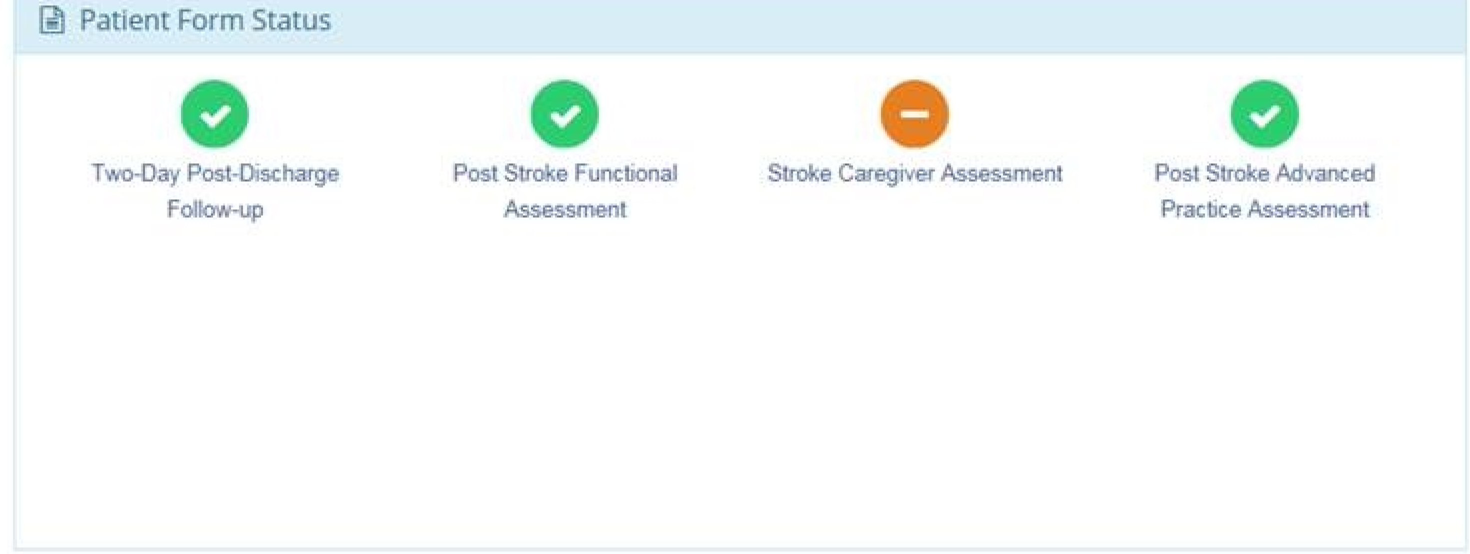
SUPPLEMENT 3

SUPPLEMENT 3

COMPASS
COMPREHENSIVE POST-ACUTE STROKE SERVICES

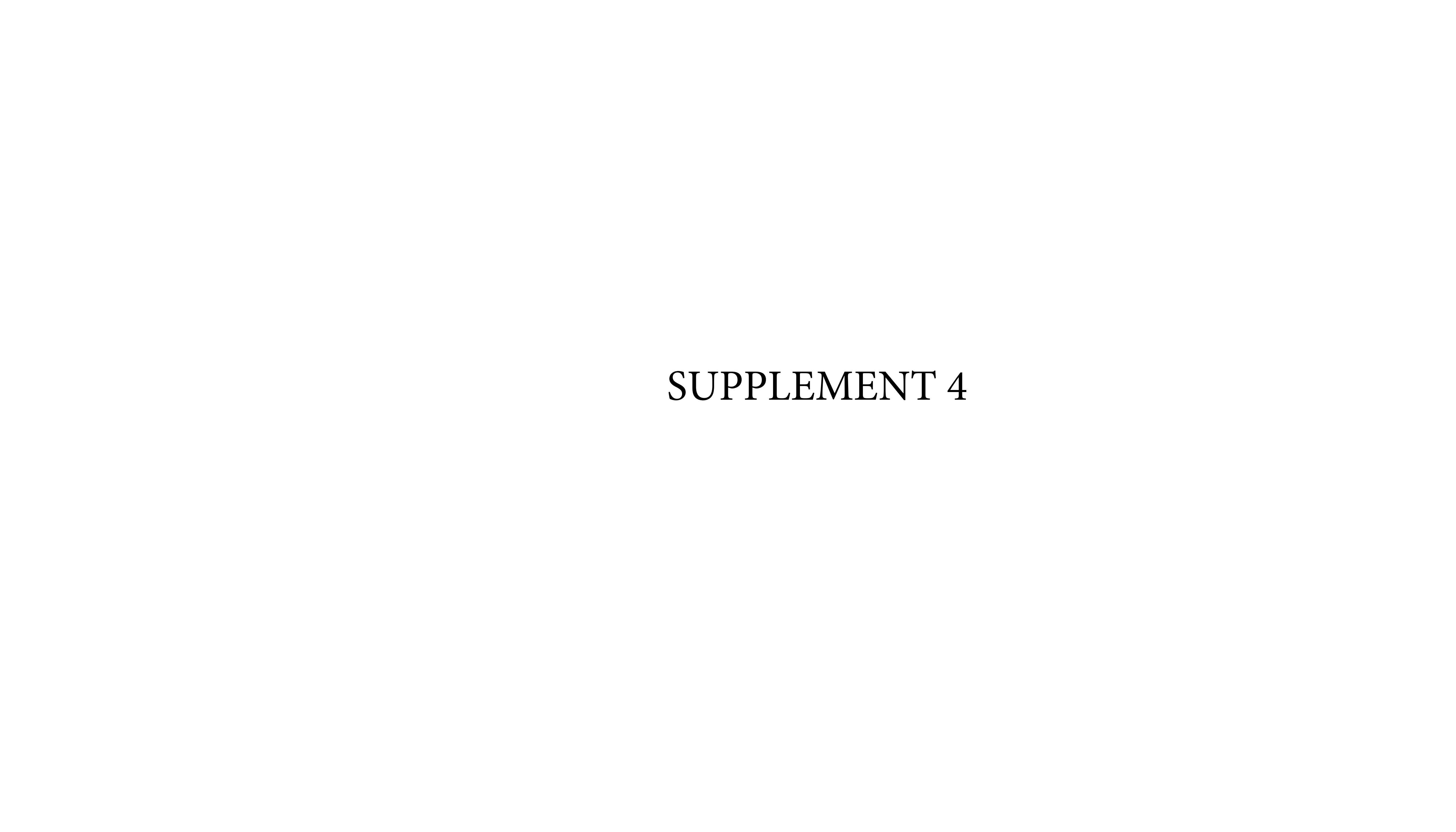
Date: 03/16/2018 09:30 AM / Patient: / Age: 79 / Compass ID:

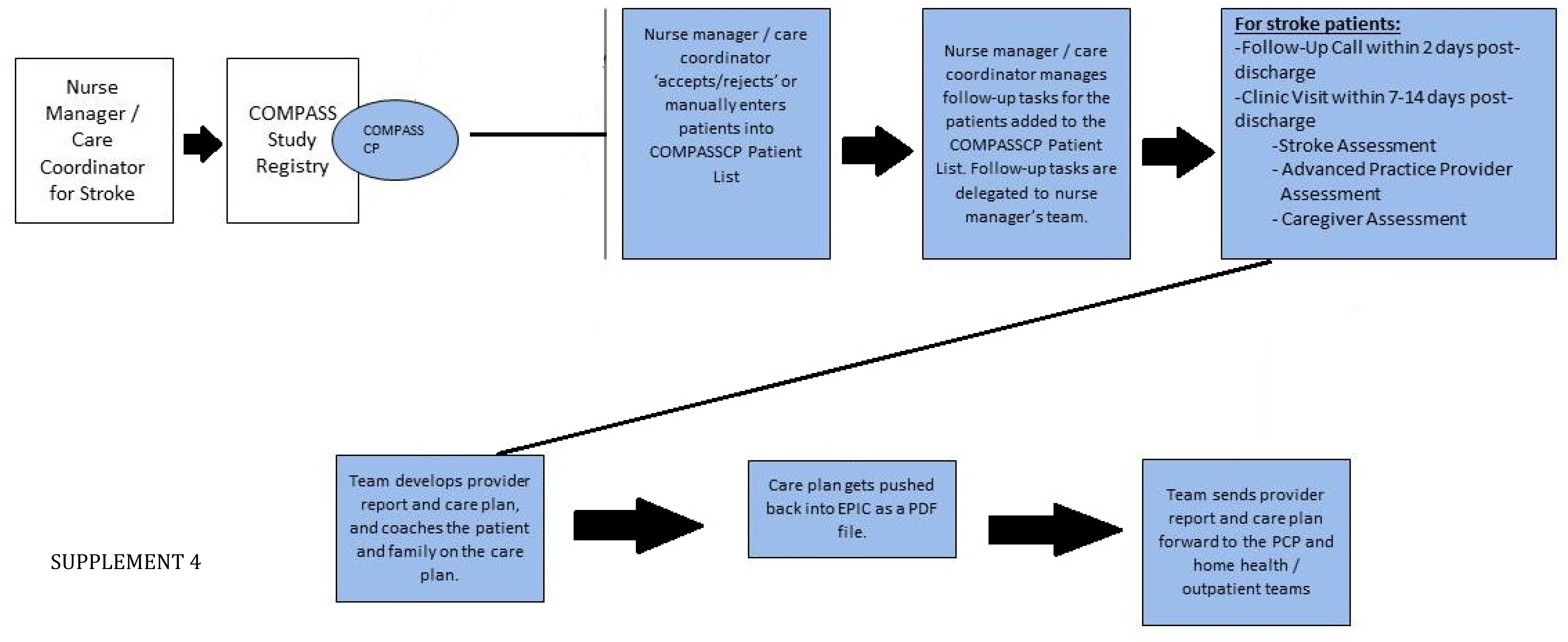




Patient Demographics

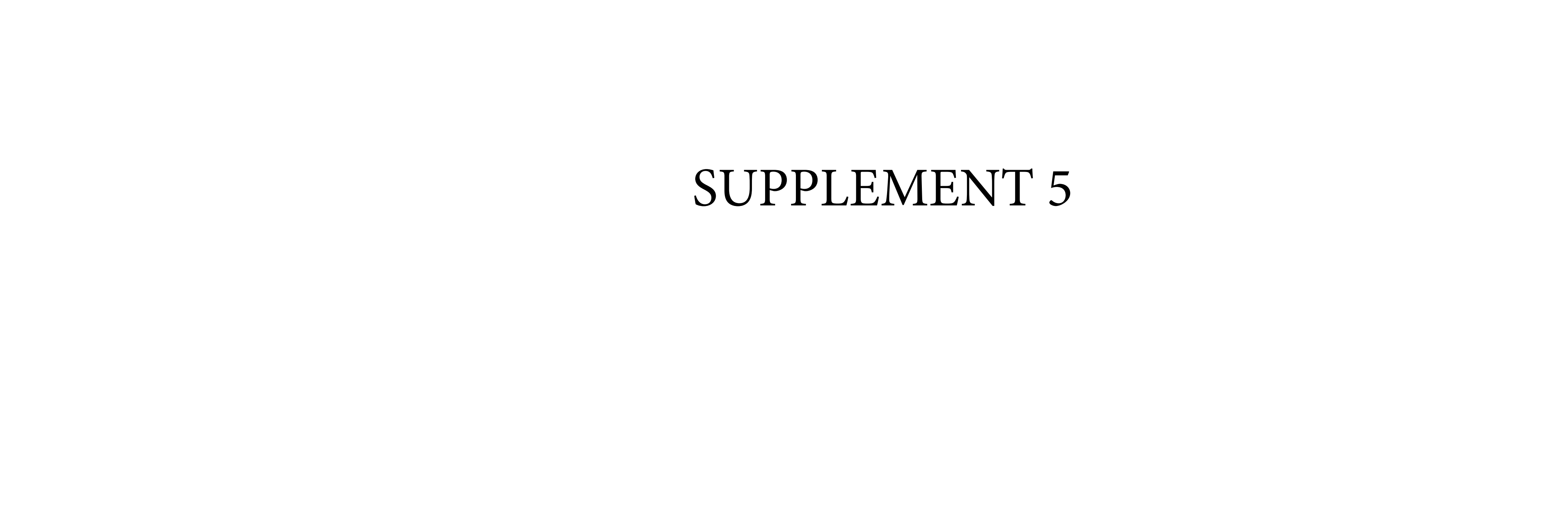
Compass ID:	(COMPASS)	**Patient Name:**	
Date of Birth:		**Age:**	79
Gender:	Male	**State / County of Residence:**	NC / Catawba


SUPPLEMENT 4

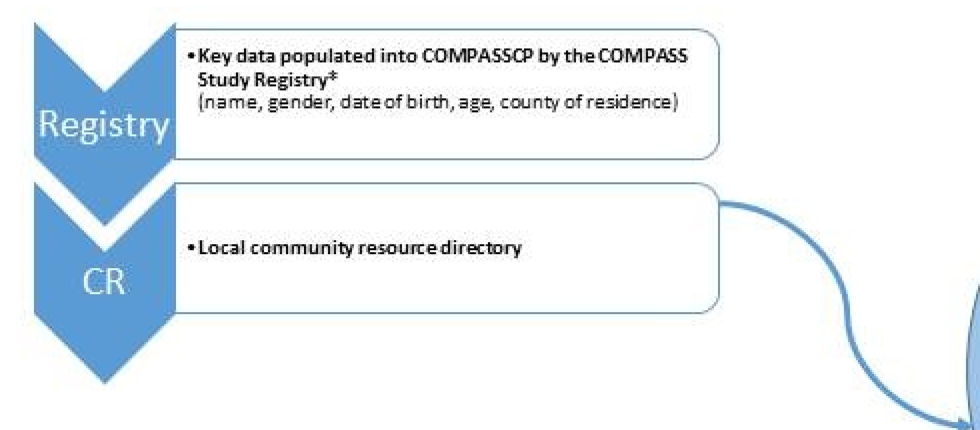


SUPPLEMENT 4

SUPPLEMENT 5



COMPASS-CP© Architecture for Stroke



COMPASS-CP© Algorithms

Mobile friendly COMPASS-CP© App
(to capture patient responses)

COMPASS-CP© Assessments

- Two Day Post-Discharge Follow-up (by phone, by nurse)
- Post Stroke Functional Assessment (in-person, by nurse)
- Stroke Caregiver Assessment (in-person, by nurse)
- Advanced Practice Provider Assessment (in-person, by APP)

COMPASS-CP© Downloadable Reports

- Patient Care Plan
- Provider report

Patient Care Plans and Provider Reports are sent back to EHR system with capability of being sent to the provider's in-basket and care management team. Care plans also available through patient portal.

Secure Cloud Storage for COMPASS-CP© data

* In the future, COMPASS Study Registry will be replaced by an EHR-integrated registry.