Touchpoints after Stroke – EXAMPLE

Winterland Hospital - Completed November 1, 2018

Touch Points after Stroke for Patients Discharged from Hospital to Home

Care Coordination and Follow-up

Font colors correspond to facility conducting follow-up: Health Plan; Neurology Clinic; Primary Care Clinic; Hospital; Rehab

Time-frame contact is made with patient or family after discharge (e.g. 12-24 hours, 14 days)	Method of follow-up (e.g. phone call, in-person visit)	Who follows up? (e.g. hospital ED nurse, primary care clinic transitions care management nurse)	Patient eligibility for receiving call or needing visit	What is provided?
12 – 24 hours	Phone Call	Health Plan Care Coordinator or Case Manager	Depends on: Payer of insurance Health plan Patient's complexity or functionality	Coordinates patient's health services Supports patient in obtaining necessary and preferred resources, services, and informal supports Completes comprehensive assessment and helps meet needs, as indicated (e.g. making appointments, arranging transportation, etc.)
12-24 hours	Phone Call	Hospital Nurse Line	Patients that meet criteria for high risk of readmission	Survey questions to assess how patient is doing, answer questions, affirm they know who to call if questions, and make referrals if needed
24 – 48 hours	Phone call	Hospital ED Nurse Hospital Medical-Surgical Nurse	All stroke patients discharged home	Seven question survey to assess how patient is doing, answer questions, and make referrals if needed
24 – 48 hours	Phone call	Hospital In-patient or outpatient Rehab	Patients with orders for in-patient or out-patient rehabilitation	Confirmation of appointments and answering any questions

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24 – 48 hours	Phone call	Outpatient Neurology Clinic Stroke Navigator	Patients at higher risk of readmission	Questions to assess how patient is doing, answer questions, and make referrals if needed
24 – 48 hours	Phone call	Primary Care Health Care Home Coordinator	Patient eligible for health care home care coordination	Questions to assess how patient is doing, answer questions, make referrals if needed and remind of follow-up appointments
24 – 48 hours	Phone call	Primary Care Transitions Care Management Nurse	Patients that are receiving or eligible for Transitions Care Management or Chronic Care Management but not enrolled in a health care home	Questions to assess how patient is doing, answer questions, make referrals if needed, remind of follow-up appointments and ask if they would like to participated in Chronic Disease Self- Management Program
10 - 14 days	Visit	Primary care provider	All stroke patients discharged home	Questions to assess how patient is doing, answer questions, make referrals if needed and remind of other follow-up appointments. Physical assessment, review of discharge and transitions of care plans including medication and review of "post-stroke checklist."
21 days				
30 days data collection and intervention	Hospital	Stroke Coordinator	Every patient discharged from hospital directly to home	Minnesota Stroke Registry or Get with the Guidelines®
90 days				

Adapted from Allina Health/Courage Kenny Rehabilitation Institute 3/2017

**NOTE: this is ONLY a SAMPLE. Content will be determined based on facility policies and protocols*