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Stroke

Post-Acute Care Stroke

Program Standards Manual 1.0

Table of Contents

Program Standards

Program Standards

The standards for the program are listed below. Click the standard number to view the detailed information for each description.

Standard	Description
1.0	Program Management
2.0	Personnel Education
3.0	Patient/Caregiver Education & Support
4.0	Care Coordination
5.0	Medical Management
6.0	Quality Improvement

Definitions

Standard: Element or process determined to be necessary to meet the criteria for program.

Definitions: Evidence or information provided by the American Heart Association to assist the applicant in defining the standard.

Required Documentation: Evidence the applicant submits demonstrating adherence to or progress toward the program standards.

Standard 1.0: Program Management

The Post-Acute Care Stroke program defines its mission, goals, scope, and organizational structure. It identifies a stroke program champion(s) and organizes an interprofessional committee which oversees the Post-Acute Care Stroke program.

Definitions	Program Management: The systematic and operational oversight of the stroke rehabilitation program Interprofessional Committee (IPC): The committee that oversees and manages the facility's stroke rehabilitation program including the development of the program's mission, goals, scope, organizational structure, and implementation of these Standards. This committee is made up of one representative from each discipline that cares for the patient receiving stroke rehabilitation as well as representation from facility administration. The IPC is a programmatic committee not the clinical rounding team involved with direct patient care. The IPC may be a stand-alone committee specific to the stroke rehabilitation program or can be incorporated into an already existing overarching committee such as the facility's QAPI committee or general rehabilitation program committee. Stroke Rehabilitation Program Champion: Professional whose discipline is part of stroke rehabilitation services at the facility. This individual will have strong interest in upholding standards of care and improving quality of services for the stroke rehabilitation program. This role may be a dedicated, full-time position or an expansion of a current position such as a clinician, rehabilitation program manager or quality coordinator.
Standards	PM 1.0 The facility has a designated "stroke rehabilitation program champion" who oversees program coordination, patient advocacy, and quality management for the stroke rehabilitation program. PM 1.1 The Interprofessional Committee (IPC) meets at least quarterly and is composed of a representative from each discipline that provides care to the patient. Representatives must include: • Stroke Rehabilitation program champion • Member of facility administration • Quality Improvement Coordinator • Physician or Advanced Practice Provider (e.g., Family Medicine or Internal Medicine, Physical Medicine and Rehabilitation, Neurology) • Registered Nurse or Nursing Supervisor • Therapy Provider (at least one member of the therapy team is represented, e.g., physical therapist/occupational therapist/ speech language pathologist) • Case manager/Social Worker • Dietitian *Note: In some cases, an IPC member may fill more than one role* Consider the following as IPC members on an ad hoc basis • Psychologist • Pharmacist • Representative from referring acute-care facility (e.g., social worker, case manager)

	• Recreational Therapist • Stroke survivor and/or caregiver *Note*: Any of the IPC representatives may participate in-person or virtually by teleconference or video PM 1.2 The IPC has a program charter which includes the following: • IPC members and roles in the facility • IPC meet frequency and attendance • IPC meeting minutes/agendas • Stroke rehabilitation program goals/expectations • Facility demographics • Quality improvement process PM 1.3 The IPC will oversee Quality Improvement (QI) initiatives for stroke rehabilitation care (see QI category)
Required Documentation	☐ Interprofessional Team Roster (reference PM 1.1) ☐ The Post-Acute Care Stroke Program charter (reference PM 1.2) ☐ Meeting Minutes for all meetings ☐ If unable to meet this standard, please submit documentation of barriers to implementation

Standard 2.0: Personnel Education

Staff have the education, experience and training for the monitoring and management of stroke patients. The education program should be provided regularly and tailored to all levels of healthcare providers.

Definitions	Personnel Education: Stroke education requirements for staff providing care or services to the individual receiving stroke rehabilitation

Standards	PE 1.0 The facility has an education policy, developed by the interprofessional committee, outlining the following:
	• Identified staff (regular & contract) requiring stroke education
	• The annual education requirement for identified staff
	• The education plan for new-hire staff
	• How education will be delivered
	• How educational outcomes are measured/assessed
	
	PE 1.1 The facility will maintain documentation that identified staff have met educational requirements
	
	PE 1.2 Annual educational content provided to all direct and indirect care staff who encounter stroke patients must include
	• Warning signs/symptoms of stroke
	• Demographic, medical, and behavioral risk factors for stroke occurrence and recurrence
	• Facility alert/escalation policy when stroke warning signs/symptoms have been identified
	
	PE1.3 All staff providing direct patient care (e.g., physicians, advanced practice providers, SLT, PT, OT, nursing personnel (all levels of licensure), CNAs, social workers, dietitians, etc.) will receive additional annual education specific to stroke which may include the following (consistent with the level of care they provide):
	• Common physical, cognitive, and emotional signs and symptoms relevant to post-stroke care and safety such as:
	  ○ Common physical issues (e.g., challenge with daily self-care activities (ADLs), falls, skin breakdown, mobility, swallowing, vision loss, pain, bowel/bladder)
	  ○ Common cognitive issues (e.g., disorientation, memory loss, lack of insight)
	  ○ Common emotional issues (e.g., post-stroke depression, anxiety, impulsivity, pseudobulbar affect)
	  ○ Common communication issues (e.g., aphasia, dysarthria, apraxia)
	• Evidence-based rehabilitation practices
	• Medical management of the patient with stroke
	• Stroke team roles and responsibilities, interdisciplinary team process & practices

Required Documentation	☐ Post-Acute Care Stroke education including: • New hire orientation/onboarding stroke specific education plan • Ongoing stroke specific education/training for staff and clinicians • Reference PE1.2- PE1.3 *Note: Learning objectives or table of contents are sufficient evidence for each educational event* ☐ Rosters attesting compliance for new employee stroke specific orientation ☐ Rosters attesting compliance for annual stroke specific training ☐ Post-Acute Stroke education policy or protocol outlining the staff and providers identified to complete annual stroke education ☐ If unable to meet this standard, please submit documentation of barriers to implementation

Standard 3.0: Patient/Caregiver Education & Support

The Post-Acute Care Stroke program provides the patient and caregiver individualized stroke education and support.

Guidance & Definitions	Patient/Caregiver Education: The education provided to the stroke rehabilitation patient and their caregiver(s).
Standards	PC1.0 An assessment is completed and documented prior to providing education to the patient/caregiver for the following: • Educational learning gaps, baseline knowledge, health literacy, and barriers to learning (e.g., aphasia) • Preferred method of receiving education (e.g., written, verbal, online, demonstration) • Preferred language of the patient/caregiver(s) • Caregivers' ability and willingness to provide care PC1.1: Patient and caregiver receive the following information and education throughout the course of admission and prior to discharge. These items should be documented in the patient record: • Individualized risk factors and stroke prevention (e.g., hypertension, smoking, sedentary lifestyle, medication management) • Stroke warning signs and symptoms and plan of action if signs and symptoms occur • Common subacute and chronic physical, emotional, cognitive, and sexual consequences of stroke • Individualized lifestyle coaching (e.g., diet, increased physical activity, stress reduction, smoking cessation, etc.) • Medication management including purpose, timing, dosage, potential side effects • Recognition of changes to emotional state for stroke survivors and caregivers (e.g., depression, anxiety, pseudobulbar affect) • Importance of keeping follow-up appointments after discharge (e.g., primary care physician, specialist physicians, outpatient therapy, referrals, laboratory studies etc.). PC1.2: The teach-back method should be used to assess the patient and/or caregiver's ability to safely perform and/or assist with tasks of necessity such as self-care, medication management, communication, and mobility PC1.3: Education frequency: • Upon admission • Upon change in status/care plan • Upon patient/caregiver request • Prior to discharge PC1.4: Education should be available in a variety of formats and at a level consistent with health literacy standards. Formats may include: • Online • Handouts/written materials • Individual in-person sessions/caregiver demonstrations *Note: While individual sessions are preferred, if a facility utilizes a group format, education and training should still be individualized and tailored to the patient and their home environment*

Required Documentation	☐ Copy of the documentation or charting system template that reflects all components of the identified education in PC1.1 ☐ The table of contents from any education material provided to the stroke patient/caregiver ☐ Policy or protocol detailing frequency of education for patient/caregivers ☐ Copy of patient/caregiver education resources or handouts ☐ If unable to meet this standard, please submit documentation of barriers to implementation

Standard 4.0: Care Coordination

The program demonstrates care coordination across the system of care for the stroke patient in three domains: pre-admission, throughout the patient's admission to the Post-Acute Care facility, and at discharge.

Definitions	Care Coordination: The ability of the stroke rehabilitation program to coordinate and deliver treatment across the continuum of care. Organized Clinical Care Team: A group of physicians/advanced practice providers, nurses, therapists, dietitians, social workers, and other health professionals that have an established line of collaboration, communication, and cooperation to provide patient and family caregiver centered care.
Standards	CC1.0 The stroke rehabilitation program has a documented process to facilitate transitions to and from any level of care. A written handoff report (can be supplemented verbally) should be received prior to the patient's arrival to and at discharge from any level of care (e.g., acute care, IRF, SNF, PCP, LTACH, home health). The report should include the following: • Medical Diagnoses • Medical and therapy treatments received and ongoing • Current Medications • Required follow-up (further diagnostic work/medical follow-up) • Current mobility and treatment recommendations • Current ADL status and treatment recommendations • Current communication issues and treatment recommendations • Current cognitive issues and treatment recommendations • Current behavioral issues and treatment recommendations • Current emotional issues and treatment recommendations • Bowel/bladder management status • Wound management status • Lines/drains in place • Fall prevention plan/history of falls • Swallowing evaluation studies including modified barium swallow/FEES study results (if performed) • Diet recommendations or NPO/alternative nutrition support plan • Other precautions as appropriate • Family and or support system details • Contact person and phone number at the referring/receiving facility for the post -acute facility or discharge facility to call with questions *Note: For patients being transferred back to acute care urgently, an abbreviated summary of the recent treatment history may be provided* CC1.1: There is an organized clinical care team that has weekly team conferences to review: • Progress towards goals • Individualized plan of care • Discharge plan for each patient • Appropriateness of current level of rehab care CC1.2: The clinical team performs, incorporates, and documents findings from a social determinants of health evaluation into the individualized plan of care.

	CC1.3 The clinical care team provides ongoing communication regarding the patient's plan of care and discharge plans to both the patient and family members and/or caregiver(s). This should be documented in the patient care record. CC1.4: The stroke rehabilitation program has a referral protocol in place which includes: • A process for providers to place referrals to address individual patient needs (e.g., medical specialist, behavioral health, etc.) • A process for referrals to be performed in a timely manner based on the patient's condition • Recommendations from the referral are available and accessible to all care providers within 1 business day of completion. CC1.5: The facility has a documentation system/consolidated medical record in place that allows for information to be accessible 24/7 by all team members CC1.6: For patients who will be discharged home an assessment of gaps in family caregiver readiness to provide care at home occurs at least 3 days prior to discharge CC1.7: Individualized discharge planning is an ongoing process that begins at admission, includes the patient, family members and/or caregiver(s), and addresses and documents the following: • Discharge location (e.g., home, nursing home, long-term care facility, acute care, etc.) The type of medical care that will be needed (e.g., wound care, etc.) • Anticipated recovery • Anticipated areas of assistance by family members and/or caregiver(s) • Medications • Diet • Durable medical equipment will be in place prior to discharge • Contact information of an identified staff member whom the patient/caregiver may call with any questions after discharge *Note: The facility should return these calls within 24 hours* CC1.8: In addition to the items listed in CC1.7, for individuals who are returning home, discharge planning with family members and/or caregiver(s) includes and documents the following: • Community resources specific to the medical and psychosocial needs of the patient and family members and/or caregiver(s) • Referrals to outpatient or home health therapies made and communicated to the patient/caregiver prior to discharge (if applicable) • Appointments with the patient's primary care provider and any relevant medical specialists (e.g., neurologist, PM&R physician) made and communicated to the patient/caregiver prior to discharge • Home health agency referrals are made prior to discharge (if applicable) • Counseling on driving safety and information on driving evaluation programs (if applicable) • Counseling regarding return to work and information on return-to-work programs (if applicable) • Available stroke survivor and caregiver support groups (in-person or online) CC1.9: A designated staff member(s) maintains an updated list of available community resources for the patient and family/caregivers. CC1.10: The stroke rehabilitation program has telephone contact with the patient and family members and/or caregiver(s) within 2 business days of being discharged home to assess post-discharge status including:

	• Confirmation of referrals and community-based resources (e.g., home health services, Meals on Wheels) • Confirmation of scheduled appointment with a primary care provider (e.g., advance practice provider or physician) within 14 days • Medication compliance • Management of caregiving issues or concerns *Note: The post-acute facility may use an external company to meet this requirement* *Note: The facility will make a second attempt to contact the patient/caregiver if unable to reach on the first attempt*
Required Documentation	Policy, procedure, or protocol documentation used for the following documentation (do not send PHI): ☐ Stroke admission intake/screen following as described in CC1.0 ☐ Handoff report for incoming admissions from the referring facility ☐ Interprofessional management of stroke patient ☐ Communication of plan of care to patient/caregiver ☐ Stroke Care Plan ☐ Admission and required medical and functional assessments (MD/NP/PA, Nurse, rehab therapists) ☐ Medication reconciliation ☐ Assessment of deterioration in stroke patient ☐ Documentation or template used for weekly care conferences as outlined in CC1.1 of the manual ☐ Social determinants of health evaluation template ☐ Referral process or protocol for consultative services as outlined in CC1.4 of the manual ☐ Discharge summary template as outlined in CC1.7-CC1.8 of the manual ☐ Transitions of care processes ☐ Strategies employed to reduce readmissions such as follow up appoint scheduled prior to d/c, palliative care, transportation barriers, medication adherence, post discharge follow up phone calls ☐ Copy of community resources for patients and caregivers ☐ Copy of template or documentation for post-discharge phone call as outlined in CC1.10 of the manual ☐ If unable to meet this standard, please submit documentation of barriers to implementation

Standard 5.0: Medical Management

The Post-Acute Care Stroke program's ability to provide post-acute care to persons with a stroke diagnosis.

Definitions	Medical Management: The stroke rehabilitation program's ability to provide medical care and rehabilitation to post-stroke patients
Standards	MM1.0: The stroke rehabilitation program has the following practitioners available to provide care 5 or more days a week. This may be in-person or via telehealth: • Speech language pathologist • Physical therapist • Occupational therapist MM1.1: The stroke rehabilitation program has the following practitioners available for assessment and consultative services. This may be in-person or via telehealth: • Social Work • Dietitian • Behavioral and Mental Health Professionals (may include psychologists, LCSW, psychiatrists, etc.) MM1.2: The stroke rehabilitation program has medical staff (e.g., physician, advanced practice provider) available 24/7 to assess and manage medical complications. This service may be provided via telehealth. MM1.3: The stroke rehabilitation program has a physician or advanced practice provider available on-site at least 3 days per week MM1.4: It is recommended but not required that a PM&R physician and/or neurologist be available to consult regarding the rehabilitation program as well as to see individual patients on a consulting basis. MM1.5: The facility has at least one registered nurse on-site 24/7 *Note: It is recommended that the facility has one Certified Rehabilitation Registered Nurse (CRRN) on staff* MM1.6: The stroke rehabilitation program has a documented protocol in place to escalate management of recognized medical complications. This protocol should include a plan to expedite transfers to acute care as needed. *Note: The stroke rehabilitation program returns patients back to the same referring facility when feasible and medically appropriate* MM1.7: The stroke rehabilitation program incorporates current evidence-based guidelines relevant to medical management of post-acute stroke, as advised and updated by the IPC. MM1.8: The stroke rehabilitation program has implemented a method to ensure that current evidence-based guidelines are followed *Note: This could be through this use of order sets/pathways/protocols that are built and reflective of the identified evidence-based guidelines* MM1.9: The stroke rehabilitation program has current evidence-based standardized protocols for the following: • Skin breakdown/contractures prevention

	• VTE Prophylaxis • Bowel/bladder management • Pain management • Management of dysphagia including means for alternative feeding MM1.10: The stroke rehabilitation program implements a current evidence-based comprehensive fall safety/mobility management program for the patient which includes all the following: • Medication assessment for agents that contribute to falls • Strength/balance training • Appropriate mobility device aids • Timely access to voiding/bathroom • Appropriate footwear MM1.11: The following assessments and screenings are completed, and evidence-based treatment is initiated if needed: • An assessment of the patient should be performed by a physician or advanced practice provider within 24 hours of admission to the facility • Swallow screen within 24 hours of admission to the facility • A fall risk assessment within 24 hours of admission to the facility • Mobility assessment within 24 hours of admission to the facility • Activities of daily living assessment within 24 hours of admission to the facility • A skin integrity screening should occur within 24 hours of admission to the facility • A cognitive screening should be done within 72 hours of admission to the facility • A speech-language pathologist formally assesses communication impairment in all patients who have communication/aphasia deficits within 72 hours after admission to the facility • Depression screening within 72 hours of admission to the facility
Required Documentation	☐ Copies of order sets, protocols, and processes related to frequency and availability of rehab and consultative services as outlined in MM1.0 – MM1.5 ☐ Admission assessment template(s) ☐ Rehabilitation assessment template ☐ Daily nursing assessment template ☐ Copies of order sets, protocols, pathways specific to facility (please do not send PHI), including areas outline in MM1.7- MM1.11 ☐ Protocol for escalation of care when patient medical complications arise ☐ If unable to meet this standard, please submit documentation of barriers to implementation

Standard 6.0: Quality Improvement	
Ongoing quality improvement measuring adherence to evidence-based guidelines aimed at improving care and outcomes for stroke patients in the post-acute care setting.	
Definitions	Quality Improvement: A continuous process the stroke rehabilitation program uses to evaluate current performance and areas where enhanced practices are needed to improve quality of care.
Standards	QI1.0: The stroke rehabilitation program collects and tracks regular compliance data on standardized stroke rehabilitation measures and stroke rehabilitation outcome metrics (See Appendix 1). This data is routinely shared with the IPC, at least on a quarterly basis. QI1.1: The interprofessional committee identifies opportunities for performance improvement and implements performance improvement plans. QI1.2: The interprofessional committee monitors performance improvement plans as demonstrated by the following: • Interprofessional committee meeting minutes to reflect discussions/action items for each performance improvement plan • Communication of performance improvement plan to front-line and administrative staff at least quarterly. • Development of an educational plan as deemed necessary for any performance improvement plan o Documentation to reflect education plan • Follow-up assessments completed to ensure the education is effective QI1.3: The stroke rehabilitation program develops and utilizes standardized tools to ensure quality improvement initiatives are followed (e.g., post-discharge telephone script, receiving checklists, handoff reports, EMR templates)
Required Documentation	☐ QCT data collection for the required stroke measures and outcome metrics. (See Appendix 1). ☐ Performance improvement and educational plans for the identified stroke measures ☐ IPC meeting minutes to reflect compliance tracking/data sharing ☐ Copies or examples of standardized tools used to ensure QI initiatives are followed (e.g., post-discharge telephone script, receiving checklists, handoff reports, EMR templates) ☐ If unable to meet this standard, please submit documentation of barriers to implementation

Appendix 1

Data Collection and Reporting of Post-Acute Stroke Clinical Measures and Outcome Metrics

Post-Acute Stroke Clinical Measures

Instructions for Reporting Post-Acute Stroke Clinical Measures: Include all adult (age 18 and older) patients who have a principle diagnosis of stroke and discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility.

(CM1) Speech Language Therapy (SLT) for Aphasia
Measure Description: Percentage of stroke patients with aphasia who receive SLT during post-acute rehabilitation

(CM2) Education About Impact of Stroke
Measure Description: Percentage of stroke patients and/or caregivers who receive education about stroke, including the following: personal risk factors for stroke, common physical, emotional, cognitive, and sexual consequences of stroke, warning signs for stroke, activation of emergency medical system, the need for follow-up after discharge, and medications prescribed.

(CM3) Poststroke Depression Screening
Measure Description: Percentage of stroke patients who receive a structured depression assessment screen (e.g. the Patient Health Questionnaire-9)

(CM4) VTE Prophylaxis
Measure Description: Percentage of stroke patients with impaired mobility who receive some form of VTE prophylaxis during post-acute rehabilitation stay

(CM5) Discharge Follow-Up
Measure Description: Percentage of stroke patients and/or caregivers who receive a follow-up phone call within 2 business days after discharge home

(CM6) Admission Assessment
Measure Description: Percentage of stroke patients who have an assessment performed by a physician or advanced practitioner within 24 hours of admission to the facility

Instructions for Reporting:

Include all adult (age 18 and older) patients who have a principle diagnosis of stroke and discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility.

1. Speech Language Therapy (SLT) for Aphasia

   Measure Description: Percentage of stroke patients with aphasia who receive SLT during post-acute rehabilitation

   Denominator:
   A. *Initial Population: Identify all patients, 18 years of age and older, who have a principle diagnosis of stroke, discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility*
   B. *Inclusions: Stroke patients with aphasia*
   C. *Exclusions: Stroke patients with altered level of consciousness that prevent interaction with a speech-language pathologist, stroke patients who died during short-stay stroke rehabilitation stay, stroke patients who are unable to participate in therapy because of medical instability*

   Numerator: Stroke patients with aphasia who received SLT during post-acute rehabilitation stay

2. Education About Impact of Stroke

   Measure Description: Percentage of stroke patients and/or caregivers who receive education about stroke, including the following: personal risk factors for stroke, common physical, emotional, cognitive, and sexual consequences of stroke, warning signs for stroke, activation of emergency medical system, the need for follow-up after discharge, and medications prescribed.

   Denominator:
   A. *Initial Population: Identify all patients, 18 years of age and older, who have a principle diagnosis of stroke, discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility*
   B. *Inclusions: All patients with stroke. For individuals lacking communication or cognitive ability to participate, family or caregivers should be provided this education*
   C. *Exclusions: Stroke patients who are unable to communicate because of cognitive or communication limitations and who lack family or other caregivers, stroke patients receiving comfort/palliative/hospice care*

   Numerator:

Stroke patients and/or caregivers who received education about stroke, including the following: personal risk factors for stroke, Common physical, emotional, cognitive, and sexual consequences of stroke, warning signs for stroke, activation of emergency medical system, the need for follow-up after discharge, and medications prescribed.

3. Poststroke Depression Screening

Measure Description: Percentage of stroke patients who receive a structure depression assessment screen (e.g. the Patient Health Questionnaire-9).

Denominator:

A. *Initial Population:* Identify all patients, 18 years of age and older, who have a principle diagnosis of stroke, discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility
B. *Inclusions: All patients with stroke*
A. *Exclusions: Stroke patients with severe cognitive or communication impairments in whom depression cannot be adequately screened for or diagnosed*

Numerator:
Stroke patients to whom a structured inventory for depression is administered (e.g. the Patient Health Questionnaire-9

4. VTE Prophylaxis

Measure Description: Percentage of stroke patients with impaired mobility who receive some form of VTE prophylaxis during post-acute rehabilitation stay.

Denominator:

A. *Initial Population: Percentage of stroke patients with impaired mobility who receive some form of VTE prophylaxis during post-acute rehabilitation stay*
B. *Inclusions: Stroke patients with impaired mobility*
C. *Exclusions: Individuals with documented contraindication to IPC, heparins, Factor Xa inhibitor, Warfarin and VFP*

Numerator:

Stroke patients with impaired mobility (unable to ambulate) who received VTE prophylaxis (Low dose unfractionated heparin (LDUH), Low molecular weight heparin (LMWH), Intermittent pneumatic compression devices (IPC), Factor Xa Inhibitor, Warfarin, or venous foot pumps (VFP)) throughout post-acute rehabilitation until ambulation is regained or discharged from post-acute care

5. Discharge Follow-Up

Measure Description: Percentage of stroke patients and/or caregivers who receive a follow-up phone call within 2 business days after discharge home

Denominator:

A. *Initial Population: Identify all patients, 18 years of age and older, who have a principle diagnosis of stroke, discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility*
B. *Inclusions: Stroke patients discharged home*
C. *Exclusions: Individuals discharged to a setting other than home*

Numerator:
Stroke patients and/or caregivers who received a follow-up phone call within 2 business days after discharge home to assess the following: initiation of referrals and community-based resources (e.g., home health services, Meals on Wheels), confirmation of scheduled appointment with a primary care provider within 7-14 days, medication compliance, assessment of caregiving issues and concerns

6. Admission Assessment

Measure Description: Percentage of stroke patients who have an assessment performed by a physician or advanced practitioner within 24 hours of admission to the facility

Denominator:

A. *Initial Population: Identify all patients, 18 years of age and older, who have a principle diagnosis of stroke, discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility*
B. *Inclusions: All stroke patients*
C. *Exclusions: Stroke patients who died or were transferred out within 24 hours of admission to the facility*

Numerator:
Stroke patients who had an assessment performed by a physician or advances practitioner within 24 hours of admission the facility

Appendix 1 (cont.)

Post-Acute Stroke Outcome Metrics

Instructions for Reporting Post-Acute Stroke Outcome Metrics: Include all adult (age 18 and older) patients who have a principle diagnosis of stroke and discharged during the current quarter after receiving short-stay stroke rehabilitation at your facility.

(OM1) Stroke Rehabilitation Discharges from the Program
Metric Description: Number of short-stay rehabilitation patients with a principle diagnosis of stroke who are discharged from your facility each quarter

Values Recorded:

A. Number of patients

(OM2) Stroke Rehabilitation Average Length of Stay
Metric Description: Average length of stay for short-stay rehabilitation patients with a principle diagnosis of stroke

Values Recorded:

A. Defined as Arrival Date minus Discharge Date (or Admission Date minus Discharge Date if Arrival Date is missing). Average length of stay for short-stay stroke rehabilitation population each quarter.

(OM3) Stroke Rehabilitation Discharge Disposition
Metric Description: The final place or setting to which the short-stay rehabilitation patient with a principle diagnosis of stroke is discharge on the day of discharge

Values Recorded:

A. Percentage of discharge dispositions by category for each quarter:
    a. Home
    b. Home with homecare
    c. Hospice or Palliative Care (Home or Inpatient)
    d. Long Term Care (either within the same facility or another facility)
    e. Hospital
    f. Assisted Living/Personal Home Care
    g. Died
    h. Other (Inpatient Rehab, Skilled Nursing Facility-short term, CAH with swing beds)

Resources

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