

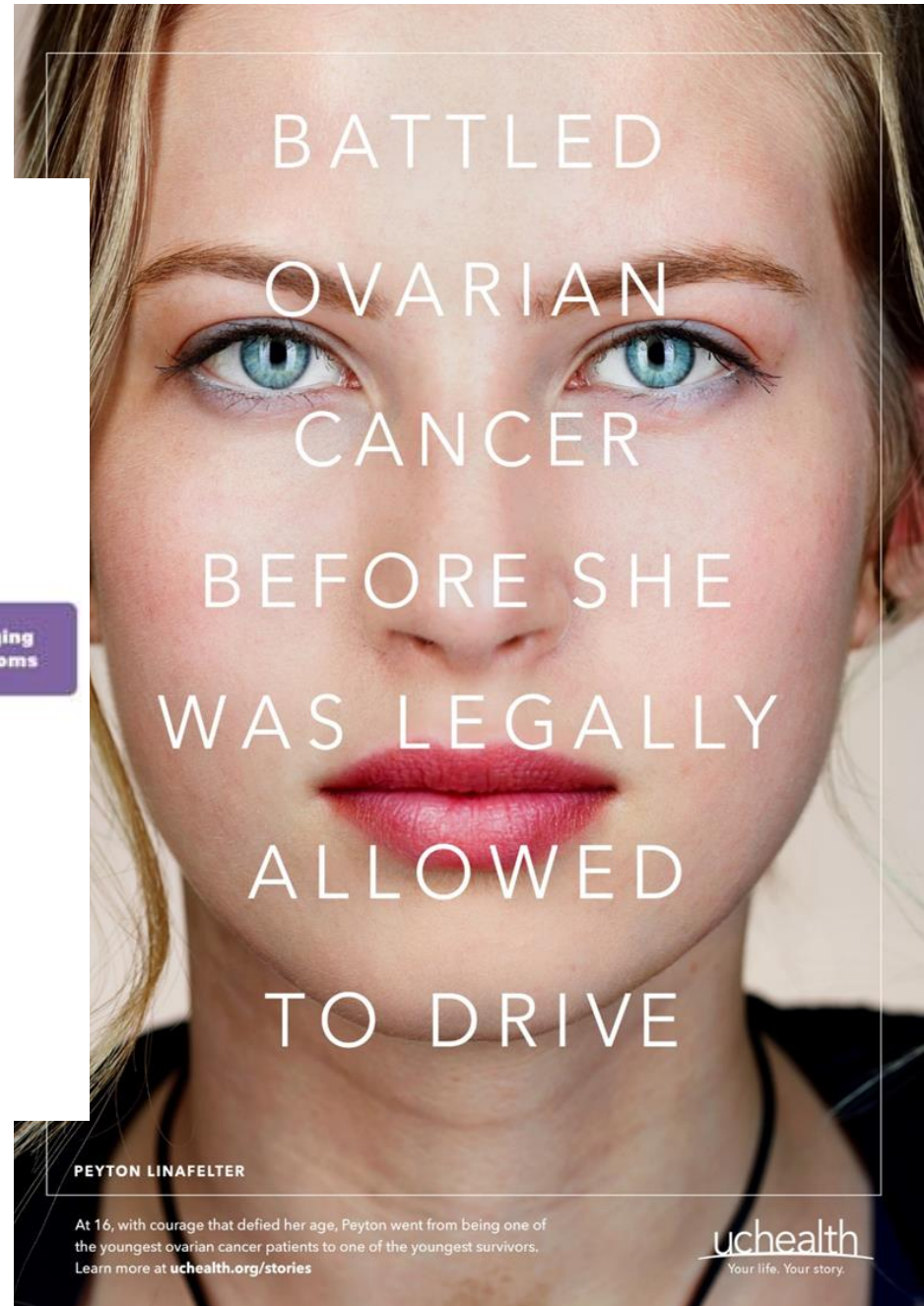
Care Management: Ambulatory, Acute and Post-Acute

Tami Snowden, MSN,RN,CMAC
VP, Ambulatory Population Health Management

Amanda Nenaber DNP, ACNS-BC
Interim Director, Collaborative Care Management

Melody Wright RN,CCM,CGMC
Director Regional Strategic Partnerships/PAC

What is Care Management?



PEYTON LINAFFELTER

At 16, with courage that defied her age, Peyton went from being one of the youngest ovarian cancer patients to one of the youngest survivors. Learn more at [uhealth.org/stories](https://www.uhealth.org/stories)



Definitions:

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Care management is a set of activities intended to improve patient care and engage patients and caregivers in a collaborative process to effectively manage their health conditions.

Continuity of care is concerned with quality of care over time. It is the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care.

Transitional Care refers to the coordination and continuity of health care during a movement from one healthcare setting to either another or to home, called care transition, between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.



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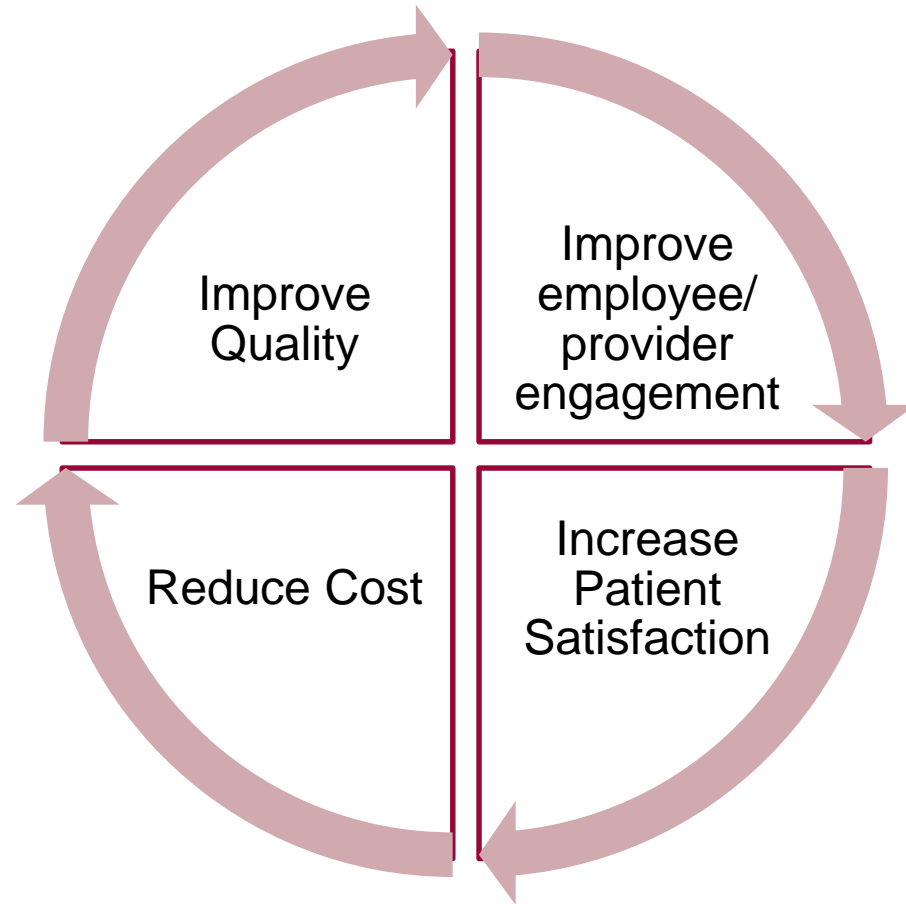
Care Management Vision

- Support physicians, clinicians, and staff in assuring right care, efficient care and respectful care for all our patients
- Support innovation and excellence in practice by providing ample education, training, experience and mentoring opportunities to our staff
- Engage our patients and families in directing their care and taking ownership of their health
- Become a valued and necessary internal consultant to the hospital and health system in forwarding its mission and achieving its stated goals



Care Coordination Model:

- Quadruple Aim:
 - Better patient outcomes
 - Improved efficiency = lower costs of care
 - Improved patient satisfaction
 - Improved employee satisfaction
- Continuity of Care
- Decrease Length of Stay (LOS)
- Achieve smoother throughput
- Specializing practice



School of Medicine

UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

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Ambulatory Care

Care Management, Disease Management & Transitions of Care

- Care managers, social workers and patient navigators partner with providers to support patient wellness and engagement
- Provides the coordination of care delivery across a population to improve clinical and financial outcomes through wellness promotion and maintenance, disease management and preventive care management
- Emphasis is placed on matching the level and type of care management services based on the individual needs of the patient
 - Complex Care Management
 - Disease Management
 - Transitions of Care
- Social workers address challenges in social determinants of health
- Ambulatory care management staff are either integrated into individual practices or provide support remotely for smaller sites or specific patient populations

Ambulatory Care Complex Care Management

- Highest level of primary care team engagement, as well as appropriate access to the patient's treatment neighborhood of specialists and care management team services, such as pharmacy, nutrition and behavioral health
- Patients entered into this level of management have been identified through data analytics as the highest risk patients, those with catastrophic illness or injury and those with the highest degree of medical complexity
- Provides individualized and intensive care management by implementing the primary physician's ambulatory treatment plan
- Nurse care managers focus on medical management of patients with one or more chronic conditions.
- Social workers address challenges in social determinants of health
- Ambulatory care management staff are either integrated into individual practices or provide support remotely for smaller sites or specific patient populations

Ambulatory Care Disease Management

- Provide support for patients in a largely centralized model with appropriate inclusion of specialized clinics and services
 - Heart failure
 - Chronic obstructive pulmonary disease (COPD)
 - Asthma
 - Depression
- Patients that can benefit from disease management programs are identified through our data analytics process and include those with chronic medical conditions, those with worsening risk scores and those with multiple chronic conditions
- Disease registries in Epic Healthy Planet are foundational to the clinical decision support and disease management programs
 - These registries are developed and maintained by the Epic Healthy Planet Steering Committee with the support of CU Medicine Office of Value Based Purchasing

Ambulatory Care Transitions of Care

- Careful management of transitions between episodes of care can reduce readmissions and recurring ED visits by using evidence-based models for all high-risk discharges from the hospital
- An assessment of risk of readmission (LACE+) prompts a review of the discharge plan, scripted communication with downstream providers and care management staff
 - Care managers and social workers respond to established triggers for doing more direct handovers between levels of care
 - Can direct a clinical pharmacist review of discharge medication reconciliation and in some instances suggest arrangement of physician to physician handover of patient care.
- Hospital Supported Transitions of Care and Readmissions Steering Committee

Ambulatory Care Roles and Responsibilities

➤ Care Manager RN

- A registered nurse who works collaboratively with physicians, staff and other health care professionals within his/her assigned clinical area to provide patient support services for *high-risk patients with complex conditions* to help coordinate clinical care delivery and ensure appropriate services are utilized at the right time and at the right place for inpatient and outpatient admits.
 - *Identification and stratification* of high-risk/complex patients through data analytics, including predictive modeling
 - *Assess and Coordinate care* delivered to a group of patients
 - *Facilitate communication* between care providers
 - *Oversees the follow-up* of consultations and that they are linked to other services
 - *Discusses care gaps* by phone or in person
 - *Eliminates task and intervention duplication* to plan of care delivery
 - *Develop care plans* to include goals and interventions

Ambulatory Care

➤ Social Worker CM/Clinical Social Worker CM (LCSW)

- A social worker who works collaboratively with physicians, staff and other health care professionals within his/her clinically integrated network (CIN) to provide support services that help patients navigate and address logistical complexities across the health care continuum to enable efficient care at the right place, cost and time.
 - *Identification and stratification* of patients through referrals from PCPs and Care Managers (outpatient and inpatient)
 - *Assessment of patient priorities, strengths and challenges barriers* to coordinated care on phone or in person.
 - *Facilitate communication* between care providers, member/family until barriers to coordinated care have been addressed
 - *Plan, implement, monitor, and amend* individualized services that promote clients' strengths, advance clients' well-being, and help clients achieve their goals.
 - *Provide and facilitate access* to culturally and linguistically appropriate community resources, systems and agencies based on psychosocial needs
 - **Clinical Social Worker CM (LCSW) only:** *May perform the duties of a counselor as needed to support staffing levels*

Acute Care

General Approach:

- Alignment between Ambulatory, Inpatient, ED, Post-Acute Care
- Service Based Care Management Model

Training, Onboarding and Workflows

- Standardized care-management training
 - Annual Training, Onboarding and Workflows renewal of Compass training tool for all
- Standardized Epic builds based on care-management business requirements

Care Management – IT developments

- Standardized Epic training on new builds and tools
 - Workflows to capture appropriate data elements
 - Care Progression Report
- Care Delivery Reports to stratify patient risk and direct care management focus

Summary ? Resize

← ↻ 🏠 📄 Index 📄 SBAR Handoff 📄 Active Orders 📄 ED 📄 Meds 📄 Ticket to Ride More ▾ Report: Care Progression 🔍 🛠️ 📄

Patient Class: Inpatient **Hospital Day:** 3

Expected Discharge Date [click to update](#) [Comment](#)

Expected Discharge Date:

Avoidable Days [Comment](#)

Responsible Party

-- at 07/02 1500

Other Delays

Other (comment) at 07/02 1500

Comment: PT POT EVALS ORDERED 6/30 STILL NOT DONE

Care Coordination

Most Recent Value

Patient currently lives **W/ children** yes 07/01/2017 1725

Nursing Shift Note

07/03/17

Xray L knee completed. Pain managed w/PO oxy. BP elevated overnight, improved w/PO hydralazine. Other vital signs stable. Still awaiting PT/OT eval. Patient needs lots of encouragement and assistance to move legs when trying to ambulate.

New Section for Avoidable Days - Link takes you to the Avoidable Delays Navigator

If there is a comment, hover to see it

New Section for MSSP - Only displays for Medicare patients

Medicare Shared Savings Program (MSSP) Patient:

If the patient is being discharged to a Skilled Nursing Facility (SNF) they **MUST** stay three midnights before being transferred.

10 Day MAR

10 Day MAR

New Section for Therapy Consults

Medications

Scheduled

Medication

allopurinol (ZYLOPRIM) tablet 100 mg
100 mg, PO, Daily

enoxaparin (LOVENOX) 80 mg/0.8 mL injection 70 mg
70 mg, SC, Q12H

MD **PCP - General, Family Medicine**
720-848-9000

100 Denver CO 80238

MD **Consulting Physician, Family Medicine**
720-848-9000

rb
AF Williams Clinic 3055 Roslyn Street Suite 100 Denver CO 80238

Provider: (Not yet assigned)

PT/OT/SLP Consult Orders Expand | Hide

(168h ago through future)

Start	Ordered
06/30/17 2002 > PT eval and treat ONCE	06/30/17 2003
06/30/17 2002 > OT eval and treat ONCE	06/30/17 2003
06/30/17 1837 OT eval and treat ONCE	06/30/17 1836
06/30/17 1837 PT eval and treat ONCE	06/30/17 1836

New Section for Care Plan

- Link takes you to the Care Plan activity
- The Report shows a "read only" view of the Care Plan

Respiratory Therapy D/C Recommendations 5/5/2016

Resolved	Last Documented In
✔ Pharmacy Medication Counseling 9 resolved	Oncology Medicine Gyn Onc Unit (3/29/2016 - 3/31/2016)

[Care Plan](#) [Report](#)

Post-Acute Care (PAC)

Building narrowed networks of PAC providers : In partnering with the highest quality post-acute care providers in the geographic regions that UCHealth serves, our patients benefit from a true care continuum that reaches beyond the walls of the hospital and supports better communication, better transitions between settings, better quality of care, and higher patient satisfaction.

Referral Volumes, patterns and relationships identified, request for Information (RFI) distributed to 3 ,4, 5 star facilities and agencies, RFI's thoroughly reviewed with individual site visits and leadership interviews conducted . Preferred Provider Network chosen with Regional Provider Network available.

- **Skilled Nursing Facilities: completed**
- **Home Health Care Agencies: completed**
- **Long Term Acute Care Hospitals: RFI's sent**
- **Inpatient Rehabilitation Facilities: RFI's sent**
- **Extended- Stay beds for Homeless patients: Coming soon**
- **Hospice) home and facility-based):**
- **DME and Oxygen providers:**
- **Infusion Therapy companies:**



Post-Acute Care (PAC)

PAC education, training and program development:

- **Tools developed to better understand the different eligibility benefits** and admission criteria for successful placements into PAC settings
- Multiple training presentations provided for UCHealth care managers in all regions for increased understanding of Population Health initiatives and role of PAC in successfully achieving the Quadruple Aim.
- **Scripting developed on how to provide informed choice** to patients in support of the Preferred Provider networks
- **Performance and communication metrics** developed to align PAC providers with UCHealth care continuum and population health initiatives
- **Formal and contractual alignment with SNF PPN** to accommodate MSSP SNF 3 Day Rule Waiver, coming 1/2018
- **RepTrax vendor policy and process** for registration of PAC Provider Representatives was developed for compliance, quality and safety.

Post-Acute Care (PAC)

Cross-continuum communications:

- **DOC-Line templates for ED transfers** from any PAC setting
- Improved After Visit Summaries transferring accurate discharge and transfer information relative to PAC setting
- **EPIC read-only access given** for all Preferred Provider agencies and facilities for easy retrieval of the most accurate and concurrent information
- **Quarterly meetings with Preferred Providers** for communication, education, process improvement opportunities
- **Deployment of clinical practice standards** and expectations across the PAC settings
- **Sharing concurrent EPIC and claims-based outcomes** with the PPN providers for ongoing engagement and improvement
- **A SharePoint site on The Source** was developed for Post-Acute Care is the repository of all Preferred Provider Networks, and all education and training materials for PAC

What is the “Ask”? What is the “Challenge”?

The Ask:

Ambulatory Care: Help to identify high risk / high need patients that would benefit from Care Management services.

Acute Care: Partner with disciplines across all care settings to coordinate care and communicate the transition plan.

Post Acute Care (PAC): Always utilize the UCHHealth Preferred Provider PAC Networks that have been thoroughly vetted for quality and system alignment when discharging or transferring a patient into a PAC setting.

The Challenge:

To foster a culture of ownership of our patients and responsibility to our colleagues as we transition patients across and among care settings.



