Transition of Care Outreach Process for Ambulatory Case Management

Admit/Discharge/ED visit and 3-day clinic MiPCT patient lists sent to Ambulatory CMs Mon-Fri to select patients for outreach

PCP or other referral source to Ambulatory CM must meet the following criteria:
1) recent hospitalization or ED visit
2) 1 or more chronic disease
(DM, COPD, CHF, CAD, Depression, HTN, Asthma, CKD-(Stage 3-4)
3) in MiPCT patient list (BCBSM, BCN, Medicare, Medicaid)

PCTC CM completes review of EMR- verifies CDs, reasons for PC sensitive ED Visits or Hospitalizations and verifies appointment scheduled

Using standing orders,
CM makes Initial outreach &
Patient enrolled into PCTC CM

Discharge with HHC? — YES

1. Contact Homecare Nurse *via Branch or 874-6500* and send PCTC referral form to intake team that PCTC is outreaching the patient.

2. Verify Med reconciliation- develop process- goal to have *med rec list prior to PCP appointment*

3. Discuss barriers to staying home/readmit risk

4. Determine anticipated duration of HHC

5. Develop plan for frequency of outreach R/T progress

eHomeCare Candidate? — YES

Follow eHomeCare Collaborative Process

Discharge to Home? — YES

1. Determine need for HHC; Did patient refuse? *(Complete referral form prn)*

2. Assess acuity and determine outreach frequency

3. Engage caregiver/key contact

- Ensures follow-up with HFMG PCP within 7 days of hospital discharge
- Educates patient on access and after hours follow-up

- Completes medication reconciliation

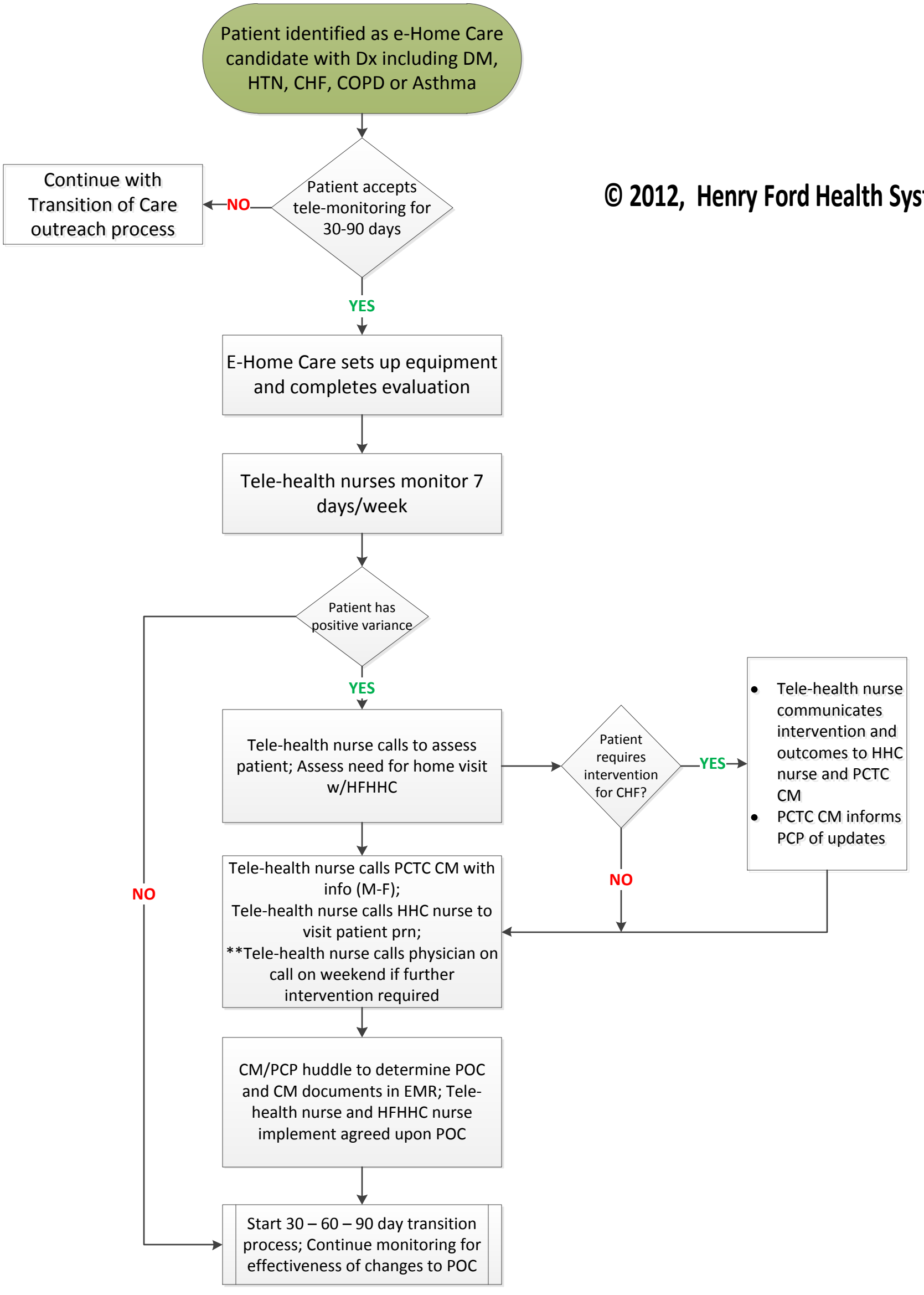
Follow Polypharmacy Collaborative Process ***in Development***

- Completes initial assessment;
- Develops plan for coordination of care in collaboration with PCP;
- Completes depression screen by 3rd contact

- Engages patient in self management with goal setting;
- Utilizes PST/MI skills to educate patient on disease management;
- Provides care coordination and follow-up referrals to identified areas of need.

Continue above plan of action until patient reaches goals and/or is disengaged from PCTC

E-Home Care Collaborative Process with Ambulatory Case Management for Tele-health Patients



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Start of 30-60-90 day e-Home Care process following hospital transition for patients with Chronic Diseases: COPD, Asthma, CHF, DM, HTN

- PCTC CM sends a PCTC referral form to the HHC intake team by fax 313-874-6501
- Tele-health (TH) nurse notifies Patient Centered Team Care (PCTC) CM of enrollment start date

First 30 days- Tele-health monitoring of BP, HR, SP02, weight, survey prn

Tele-health nurse sends weekly reports to PCTC CM through email; if no PCTC CM reports go directly to PCP

PCTC CM reviews Philips TH website for 30 day trends and prn

PCTC CM schedules appointment (office appt whenever possible) to review trends with patient

Patient assessment to include:
- Re-evaluate condition;
- Assess for readmission potential;
- Variances requiring intervention;
- Active changes in plan or meds;
- Ability to self-manage

Patient has + variances & requires continued monitoring

NO

Transition patient off TH over the next month if:
- No readmission in 30 days;
- No change in treatment plan,
- No active med titration,
- Patient is progressing to SM
- PCP in agreement after consultation

Tele-health is discontinued and PCTC CM continues self management for 30 days and re-evaluates

Patient meets criteria for disengagement from CM

NO

Continue with PCTC CM

YES

Patient disengaged from CM

Yes

- Keep patient on TH for 30 more days – up to 90 days and huddle update with PCP;
- PCTC CM schedules next 30 day office appointment and assesses need for PCP visit as needed

- PCTC CM calls Tele-health nurse office with plan;
- PCTC CM submits Tele-health note to Provider for review and signature;

Repeat process up to 90 days

PCTC CM:
- Collaborates with PCP regarding plan of care and follow-up
- Reassesses for palliative care potential
- Revise plan of care as needed

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