
CentraCare®

Care Coordination Model

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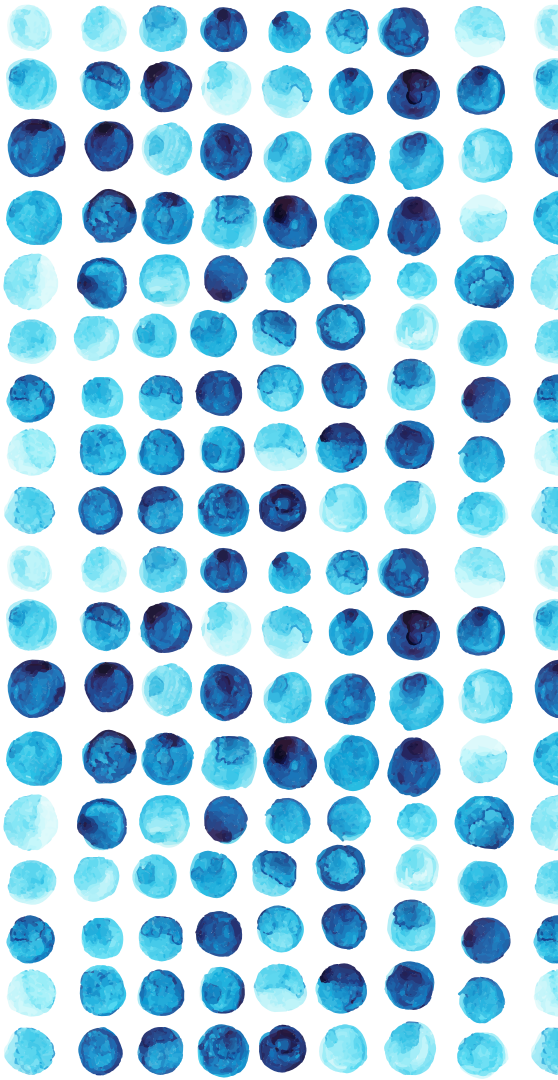

Purpose

- Care Coordination is a team of nurses working toward proactively engaging patients to achieve optimal health through a preventative health coaching model.
  - Improve Patient Health Outcomes and Reduce Cost of Care
  - Empower Patients
  - Develop Health Literacy
  - Increase Self-Management Skills
  - Enhance Independence to Achieve Graduation

Team Organization

- Intake and Referral Care Coordinators
- TCM Care Coordinators
- Social Workers
- Enrolled Care Coordinators

Intake & Referral Team | Overview

- Who
  - Registered Nurses
- Our Why
  - Patients
- How

Intake & Referral Team | Identification

- Referrals – Epic
  - Provider
  - Inpatient
  - Post-discharge
- Pediatric hospital follow-ups
  - Proactive screen through outreach
- Population Health
  - Lightbeam reporting

Intake & Referral Team | Process

- Comprehensive Assessment & Analysis
  - All identified patients
  - Motivational Interviewing to ascertain stage of change
- Challenges
  - What if patient …
    - Does not meet criteria?
    - Does not consent to enrollment?
- Next Steps & Ongoing
  - Communication
  - Learning as a team

Transitions of Care Management (TCM) Team | Overview

- Who
  - Registered Nurses and Licensed Practical Nurses
- Our Why
  - Patients
- How

Transitions of Care Management (TCM) Team | Process

- Hospital discharge reports
  - Run daily
- Outreach
  - Adult patients following up with Primary Care Provider
- Purpose
  - Prevent readmission
  - Enhance success with transition to home
  - Capture and mitigate concerns surrounding discharge
  - Identify patients who may benefit from ongoing care coordination

Social Work Team | Overview

- Who
  - Licensed Social Workers
- Our Why
  - Patients
- How

Social Work Team | Process

- Identification of patients
  - Referrals – Epic
    - Provider
    - Inpatient
    - Nurse Care Coordinator
- Assessment
  - Initial
  - Follow-up
- Next Steps & Ongoing
  - Navigating through limited resources

Enrolled Care Coordination

- Chart Review
  - Review Intake & Referral Teams assessment and make note of things we want to dig deeper on
  - Optional consultation with Intake and Referral team for clarification before reaching out to patient

Enrolled Care Coordination

- Rapport Building
- No Formal Assessments on First Call
- Discuss doing a “Longer Call” or our Assessment & Care Plan
  - Completed When the Patient is Ready
- Voluntary Program
- Customized to Each Patient

Enrolled Care Coordination | Assessment and Care Plan

- Whole Person Health
  - SDOH
  - Living Arrangement
  - Family Dynamics
  - Diet
  - Exercise
  - Sleep Habits
  - Water Consumption
  - Support System
  - Advance Care Directives
  - Assistive Devices
  - ADLs
  - Recent Appointments
  - Recent Hospitalizations/ED Visits
  - Recent Falls or Injuries
  - Mobility
  - Chronic Pain
  - Communication Needs
  - Preferred Learning Methods
  - Learning Barriers
  - Preventative Health

Enrolled Care Coordination | Assessment and Care Plan

- Chronic Conditions Discussions
  - Assess Knowledge Levels on disease management
  - Ask Me Three:
    - What is your main health concern?
    - What do you need to do about this?
    - Why is this important?
- Care Gaps
  - Assessing Barriers to Optimal Health
  - Needs for Education

Enrolled Care Coordination | Assessment and Care Plan

- Provide Education using Health Coaching Model
  - Disease Management – how to take care of yourself from day to day
  - Signs and Symptoms of a chronic condition exacerbation
    - Teaching patients to catch things early to prevent ED visit or Hosp Admission and have a provider appointment instead
  - Long Term Effects – what happens if your condition is left untreated?
  - What do your labs or other diagnostic testing mean? Why are we checking it?
  - Create Ongoing Teaching Plan using EMR based Nursing Care Plans
    - Problem
    - Goal
    - Checklist Tasks Set to Reach Goal
  - Encourage Independence and Self-Management
  - Critical Thinking to Prioritize Nursing Interventions and Education

Enrolled Care Coordination | Assessment and Care Plan

- Goal Setting
  - Creating Achievable Patient Centered Goals Around Chronic Conditions
  - Action Steps made by the patient

Enrolled Care Coordination | Assessment and Care Plan

- Ongoing Plan
  - What will we focus on in the future?
  - Prioritize Important Problems
  - Make a list of future plans, not always patient-facing to avoid patient overwhelm
    - One thing at a time unless the patient prefers and can handle more

Enrolled Care Coordination | Follow Up Plan

- Monthly Phone Calls
- Follow Up on Goals
  - Praise for success
  - Look at Barriers
  - Check Progress
  - Keep encouraging and motivating
  - Follow up on Education and understanding – is there a need for more education?
- What has changed since we talked to our patient last?
  - New Dx?
  - New Medication or changes made by providers?
  - New Symptoms r/t chronic disease?
  - Upcoming appointment/procedure they are anxious about?
  - Recent injuries or change in status to chronic illnesses?

Enrolled Care Coordination | Post ED and Hospital Stay Calls

- Mission of these calls is to prevent future admissions or ED visits
  - Discuss Reason for Visit
  - Was this preventable?
    - Right Time, Right Place
  - Discuss Methods to prevent future Re-occurrence
    - Go back to Education on chronic conditions
    - Do they understand changes or updates made?
  - Is this related to the patients' chronic condition and the goals you are working on?
    - Does the care plan need to be changed? Was this a major event that goals need to be re-evaluated?

Enrolled Care Coordination | Case Study

- Pediatric Asthma Example

KPI's

- Reduce cost of care by reducing utilization and improving patient health.
  - Reduce Hospital admissions and ED visits
  - Increase Provider and Specialty visits
  - Decrease the cost of care

Count of Pre/Post Intervention Visits by Patients with Care Coordination Episode					
Percent Change	*-48.5%*	*-24.3%*	*53.2%*	*NA*	*-17.0%*
Non-PCP visits changed by -36.3%					
Pre/Post Visits by	**Visit Type**				
Care Coord Pts	**Emergency**	**Hospitalization**	**PCP**	**Urgency**	**Total**
Pre-Intervention	97	74	47		**218**
Post-Intervention	50	56	72	3	**181**
Total	**147**	**130**	**119**	**3**	**399**