NCACH Hospital Application Extension for Transitional Care Management and Emergency Department Diversion:

APPLICATION EXTENSION SUMMARY

Introduction:

The North Central Accountable Community of Health (NCACH) has been working with hospital partners to assist in Transitional Care Management and Emergency Department (ED) Diversion in 2019 based on models identified by the Transitional Care and Diversion Intervention (TCDI) Workgroup. Funding for 2020 is associated with a continuation of the work completed in 2019. Partners will be expected to provide additional updates on how they plan to build upon the current work and improve connections with other partners within the region.

Eligible Entities:

The 8 Hospital organizations within North Central Region are eligible to participate:

1. Columbia Basin Hospital
2. Confluence Health
3. Coulee Medical Center
4. Lake Chelan Community Hospital
5. Mid-Valley Hospital
6. North Valley Hospital
7. Samaritan Healthcare
8. Three Rivers Hospital

Reporting Requirements:

1. NCACH will require periodic written and verbal reports from implementation partners. Those reports will include:
   a. A detailed, updated implementation plan for Transitional Care Management and Emergency Department Diversion tactics in the organization
   b. An outline of how partners are currently working with organizations outside of their agencies to build partnerships
   c. Measures for program evaluation across the region.
2. Reports are due in the following Intervals
   a. December 2019 report that outlines key focus areas in 2020
   b. April Report – data metrics only
   c. July – Full report that includes narrative updates and data metrics
   d. October – data metrics only
   e. January (2021) – Full report that includes narrative updates and data metrics
3. Reporting requirements will be detailed in Memorandums of Understanding (MOUs) between the NCACH and each partner.

Length of Project Period:

The project period will start upon signing the MOU through **December 31, 2020**.

DRAFT

Payment of Awards:

Total award amount is up to $65,000 per organization. Awards will be paid to partners in the following cycles:

- Approval of extension: 40% of award amount
- Submission of report by July 15th: 30% of award amount
- Submission of report by January 2021: 30% of award amount

Application Submission Information:

Completed application extensions should be emailed to John Schapman (john.schapman@cdhd.wa.gov) by **5:00 on Friday December 20th, 2019.** For technical assistance, email John Schapman, or call 509-886-6435.

Application Funding Amounts:

Organizations are able to earn the up to amounts outlined for each section below:

Section	Up to Amounts
Section II: Transitional Care	$25,000
Section III: ED Diversion	$25,000
Section IV: Community Based Integration	$15,000
Total (Each)	**$65,000**

SECTION I: ORGANIZATION INFORMATION

Organization Information
Organization Name:
Funding Requested (TCM): $
Funding Requested (ED Diversion): $
Funding Requested (Community Based Integration): $
Total Funding Requested: $
Contact Name:
Contact Title:
Email:
Physical Mailing Address:
Phone:

SECTION II: TRANSITIONAL CARE MANAGMENT

Project Description (suggested word count – 1000 words)

Project descriptions includes an update to the current Transitional Care Management Work in 2019

Project Description: *Provide a description of how your organization will expand upon the work that your organization implemented as part of the Transitional care work in your original application (attached). Include details describing your organization's current status with TCDI work and how you plan to improve/expand upon this work in 2020.*
Timeline: *Describe the timeline and major milestones in 2020. How will you monitor project implementation progress and address delays?*
Sustainability: *What have you done during/throughout 2019 to ensure the sustainability of this project and/or sustainable change beyond the project period? If funding ends after 2020 will your organization continue to maintain this program?*

Social Determinants of Health: *How has this project focused on the social determinants of health in 2019? What specific components of social determinants of health do you plan to focus on in 2020?*
Connecting with Regional Partners: *Chronic Disease (including Mental Health) plays a large role in high inpatient utilization. How will the work you complete help to ensure that patients who are discharged from inpatient care are getting linked up with a Primary Care and/or Behavioral Healthcare Provider?*

Project Budget

Provide an estimated project budget to demonstrate how you will use the funds allocated to your organization. Provide a budget narrative (maximum word count is 500 words). Do you plan to leverage other funds? If so, please describe.

Project Budget: through December of 2020	
EXPENSES	***NCACH funded***
Salaries, wages, and benefits:	
Supplies/Equipment:	
Other Expenses (itemize):	
Total	

Budget Narrative:

Section III: Emergency Department Diversion

Project Description (suggested word count – 1000 words)

Project descriptions includes an update to the current Emergency Department Diversion Work in 2019

Project Description: *Provide a description of how your organization will expand upon the work that was implemented as part of the Emergency Department Diversion work in your original application (attached). Include details describing your organization's current status with TCDI work and how you plan to improve/expand upon this work in 2020.*
Timeline: *Describe the timeline and major milestones in 2020. How will you monitor project implementation progress and address delays?*
Sustainability: *What have you done during/throughout r 2019 to ensure the sustainability of this project and/or sustainable change beyond the project period? If funding ends after 2020 will your organization continue to maintain this program?*

Social Determinants of Health: *How has this project focused on the social determinants of health in 2019? What specific components of social determinants of health do you plan to focus on in 2020?*
Connecting with Regional Partners: *Chronic Disease (including Mental Health) plays a large role in high Emergency Department utilization. How will the work you complete help to ensure that patients who are discharged from the Emergency Department are getting linked up with a Primary Care and/or Behavioral Healthcare Provider?*

Project Budget

Provide an estimated project budget to demonstrate how you will use the funds allocated to your organization. Provide a budget narrative (maximum word count is 500 words). Do you plan to leverage other funds? If so, please describe.

Project Budget: through December of 2019	
EXPENSES	***NCACH funded***
Salaries, wages, and benefits:	
Supplies/Equipment:	
Other Expenses (itemize):	
Total	

Budget Narrative:

SECTION IV: COMMUNITY BASED INTEGRATION

(suggested word count – 1000 words)

Acute care providers who are able to demonstrate how they will collaborate with other community-based providers in the region will receive additional funding. Responses will be evaluated based on how well you demonstrate you are creating new collaboration or expanding on current collaborative efforts.

Project Description: *Provide a description of how your organization will expand upon the work that was implemented as part of Community Based Integration in your original application (attached). Include details describing your organization's current status with the TCDI work and how you plan to improve/expand upon this work in 2020. If this is new work, please include why you have chosen not to expand on the work your organization focused on in 2019.*
Timeline: *Describe the timeline and major milestones in 2020. How will you monitor project implementation progress and address delays?*
Sustainability: *What have you done during/throughout 2019 to ensure the sustainability of this project and/or sustainable change beyond the project period? If funding ends after 2020 will your organization continue to maintain this program?*

Social Determinants of Health:

What specific social determinants of health has your organization focused on in 2019? What accomplishments has your organization demonstrated in addressing these Social determinants of health? How has your work in the social determinants of also impacted your organization's metrics associated with Transitional Care and/or Diversion Work (If organization selected focus areas)?

List community-based partners you will collaborate with:

Patients who are able to connect with local community-based organizations that provide care coordination to address the social determinants of health will likely receive the services they need to prevent them from coming back to acute care. How will you partner with community-based agencies in your area to ensure patients discharged from your organization connect with the services they need?

Budget:

Organizations that demonstrate collaboration with community-based partners are eligible to receive additional funding. How will the additional funding be used to ensure collaboration occurs? How will this collaboration benefit the non-hospital partners? What is the history of existing collaborations? What plans, if any, exist for extending collaborations? How are funds received going to be distributed among your organization and partners?

SECTION V: MEASUREMENT AND EVALUATION

Measurement and Evaluation:

In order to measure progress, it is important to track process and outcome metrics. Please describe any changes to how your organization is going to collect and report the following outcome metrics in 2020 (if applicable):

- Is there a measure closely linked to Social Determinants of Health that your organization can track in 2020?

SECTION VI: APPENDICES

A. Transitional Care Management Reference Guide
B. ER is for Emergencies Seven Best Practice Fact Sheet
C. Original TCDI Hospital Application

TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

NORTH CENTRAL ACCOUNTABLE COMMUNITY OF HEALTH

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

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NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

Introduction:

The North Central Accountable Community of Health Transitional Care and Diversion Intervention Workgroup has identified the regional Transitional Care Management Model (adopted by Confluence Health) as the approach we will implement across the region specific to Transitional Care. The attached document provides details on the model and outlines how organizations can engage in developing a regional Transitional Care Management process as part of the Medicaid Transformation Project.

Model Selected:

Transitional Care Management (As adapted by Confluence Health)

Summary of Model:

Prior to discharge, hospital staff organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed. The bedside RN and inpatient case manager discuss instructions with the patient. The patient is sent home with written material that has all of this included on it in addition to a patient-specific summary of the visit. That document is called an AVS (After Visit Summary). The AVS summary is also used by the transitional care management RN's (TCM-RN) who make the post discharge hospital follow up phone call.

The TCM-RN makes a 24-48 hour (2 business days) post hospital discharge phone call that affirms that the patient has a follow up appointment with their PCP, medication review, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, and or caregiver help. Any problems are evaluated and directed to the appropriate resource. Patients are instructed to call their provider for certain symptoms or seek immediate medical attention based on severity of symptoms.

The TCM-RN identifies patients from a daily discharge report excluding discharged to hospice, assisted/skilled nursing facility, patients who left AMA, discharged to another facility, patients receiving hemodialysis, or those that are in another case-managed program. Patients who have a follow-up appointment the day after discharge are not called.

A prompt follow-up visit with their outpatient provider provides follow-up care, ongoing symptom and medication management and continuous access for the 30 day post-discharge period.

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

Target Population:

Patients discharged from impatient hospital care to home or supportive housing.

Target Measures For Transitional Care Models:

- Increase in follow-up post hospitalization physician/mid-level visits all patient's
- Decrease in unnecessary Inpatient Hospital Utilization
- Decrease in unnecessary Outpatient Emergency Department Visits
- Decrease in All-Cause Hospital Readmission Rate (30 Days)

Implementation partners may develop additional measures specific to their region.

Transitional Care Models Reporting Requirements:

1. NCACH will require periodic written and verbal reports from implementation partners. Those reports will include:
    a. Business plan outlining implementation plans for TCM in their organization
    b. Target Measures the organization will track and provide to NCACH to help in program evaluation across the region.
    c. Partners will be required to submit written reports electronically through an online portal.
2. Reporting requirements will be detailed in Memorandums of Understanding between the NCACH and each partner.
3. TCM partners will be expected to share with other hospital partners every other month on progress of implementation, best practices, and other potential issues.

Eligibility:

- Initial Pilot Partners in 2018: Hospitals with an annual Medicaid Discharge of >200 beneficiaries a year or have a current TCM program in place
- Partners who could join in 2019: All other hospital organizations with a Medicaid discharge of <200 beneficiaries a year

Funding Identifications:

Approximate funding to implement the transitional care model for organizations will be $35,000 over the course of implementation. This funding will cover the cost of staff time to implement the work and the cost to ensure the system is integrated into your organizations.

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

What is Transitional Care Management?

- Transitional Care Management (TCM) provides telephone discharge follow-up calls to patients discharged from the hospital setting. A brief review of symptoms, medication changes and follow-up care is discussed during this telephone call. The RN making TCM call then enters telephone note into the electronic medical record and forwards the note to the PCP.

- If a patient meets criteria for TCM, the provider who provides the hospital follow-up appointment with the patient may bill a TCM code which includes reimbursement for non-face-to-face services provided by staff. See criteria below for more information on who qualifies for TCM (Note: Medicaid does not accept billing codes at this time).

Criteria for TCM

- It is recommended that only Primary Care bill for TCM services, as whoever bills this code has to be willing to be responsible for all of the patient's medical conditions as well as psychosocial needs for 30 days post discharge

- No call is needed to be placed by TCM staff if the patient is seen by their provider for a hospital follow up office visit within 2 business days of discharge. The provider may bill for TCM without a call being made in this circumstance. TCM monitors the patient via the EMR to confirm they attend the appt. If they do not attend, the TCM call is made to the patient.

- Moderate risk patients must be seen by provider within 14 days (high risk patients should be seen within 7 days) of discharge for a **hospital f/u visit** (day of discharge is day #1 and this includes weekends.)

The patient would NOT qualify for TCM billing reimbursement if any one of the following is present:

- Patients receiving hemodialysis

- OB Patients

- Patients discharged to skilled nursing (Assisted living and AFH **DO** qualify for TCM)

- Patients discharged on hospice

- Pediatric patients

- Patients within a post-operative global period, if not medically necessary

NOTE: If a patient is re-admitted to the hospital before follow up appointment, no call will be made. A TCM attempt will be made at subsequent discharge from the hospital. TCM staff will attempt to call patients who don't qualify for TCM call, such as surgical bundle patients or patients with a f/u within 2 days of discharge, if time permits.

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

Hospital Discharge Follow Up: (TCM WORKFLOW)

1. A daily report of hospital discharges will be sent to the TCM staff. All patients will receive a TCM call within 2 business days of discharge with the exception of patients listed in number 4 below.
2. After review of available hospital & EMR documentation, the Hospital Discharge Follow Up call will be made using the TCM template and entered into the EMR using the category of TCM (code 402) in the **Telephone Call** note.
    a. The note will be routed to the Provider that will be seeing the patient for the hospital follow up visit along with the following message: The TCM call has been completed, the hospital follow up visit may qualify for a "moderate complexity visit code of 99495" or a "high complexity visit code of 99496".
3. The TCM tool will prompt the reviewer to confirm or coordinate a follow up visit with the PCP. A patient with moderate medical decision complexity needs a follow up appointment with the PCP within 14 days of discharge, and a patient with high medical decision complexity needs an appointment with the PCP within 7 days of discharge. A follow up visit can be made with an MD, Physician Assistant or a Nurse Practitioner.
4. TCM will not call patients who are:
    a. Discharged to a SNF, Assisted Living, Acute Inpatient Rehab, or another transfer to an Acute Inpatient Facility
    b. Home with Hospice
    c. Jail
    d. If the patient leaves AMA
    e. Observation status patients
    f. Patients who have expired
    g. Mother/baby
    h. Patient who are seen by the provider's office within two business days of discharge and a note reflecting this will be made in the EPIC record.
    i. If the discharge documentation is unavailable. This will be documented in the medical record.

RISK LEVEL	Presenting Problems	Diagnostic Procedures	Management Options Selected
High Risk Requires any ONE of these elements in ANY of the three categories listed	• One or more chronic illness, with severe exacerbation or progression • Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARF • An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular imaging, with contrast, with identified risk factors • Cardiac EP studies • Diagnostic endoscopies, with identified risk factors • Discography	• Elective major surgery (open, percutaneous, endoscopic), with identified risk factors • Emergency major surgery (open, percutaneous, endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate, or to deescalate care because of poor prognosis

5. Every attempt will be made to initiate the initial follow up call with patient contact within two (2) business days of patient's discharge date.
6. Any problems or concerns that arise during the TCM initial follow up call will be directed to the discharging provider or PCP for follow up via EMR for internal PCP and for external PCP print your note and fax it to the appropriate office.

TRANSITIONAL CARE MANAGEMENT DISCHARGE FOLLOW-UP

Discharge Unit/Location: ***

Discharge Date: ***

Discharging Provider: ***

Primary Discharge Diagnosis/Diagnoses: ***

Does the patient have help at home?: ***

Patient status post discharge: ***

Medication Questions or Concerns: ***

Follow-up appointments: ***

Services arranged at discharge (DME, O2, HH/Hospice):

- ***

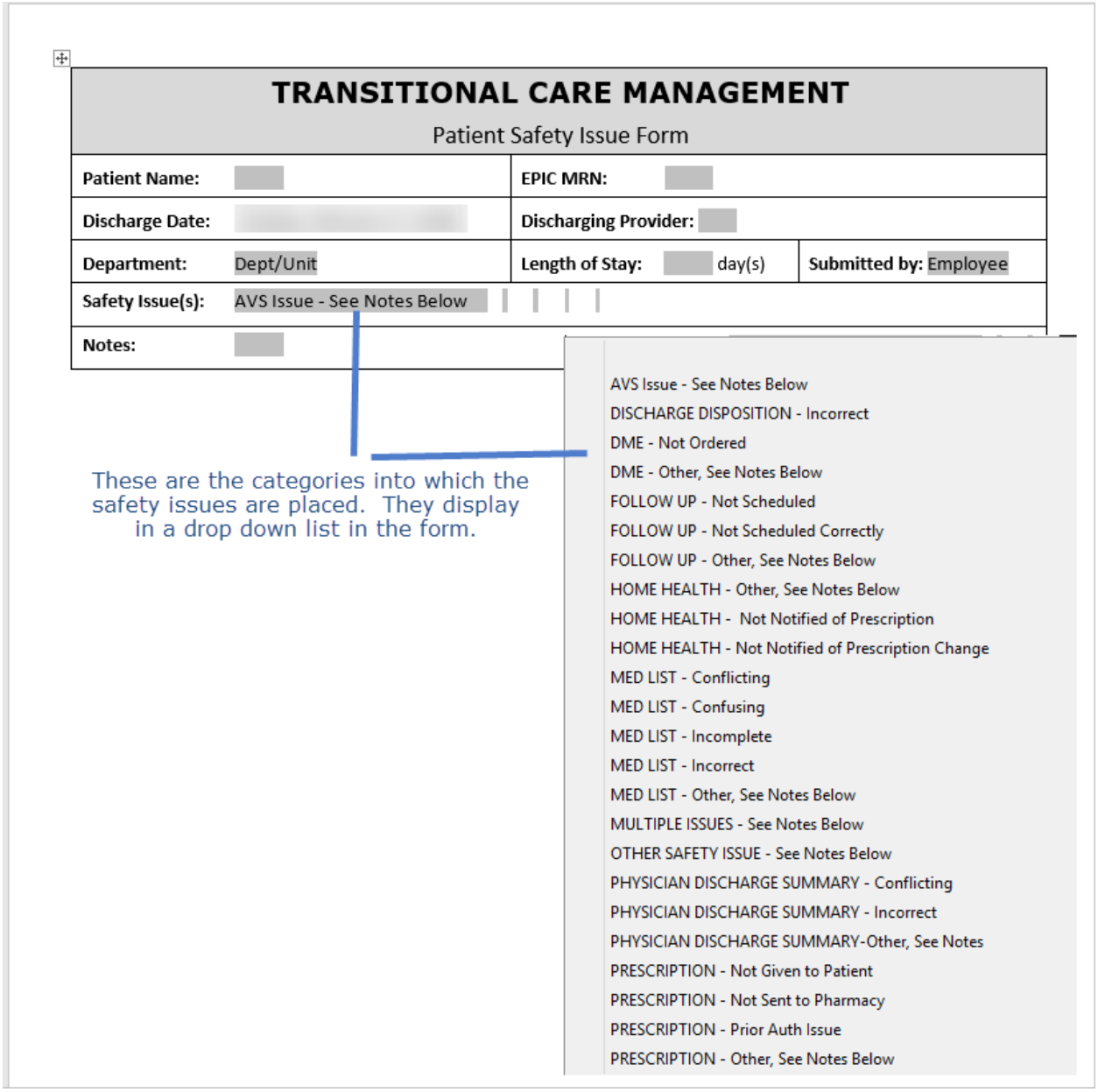
Patient has been instructed to call their provider if:

- ***

Patient has been instructed to seek immediate medical attention for the following symptoms:

- **SEVERE CHEST PAIN**
- **SEVERE SHORTNESS OF BREATH**
- **FEVER > 101.5 THAT IS NOT RELIEVED BY MEDICATION**
- **RAPIDLY WORSENING SYMPTOMS**

Transitional Care interactive contact is complete.



TRANSITIONAL CARE MANAGEMENT

Patient Safety Issue Form

Patient Name:		**EPIC MRN:**		
Discharge Date:		**Discharging Provider:**		
Department:	Dept/Unit	**Length of Stay:**	day(s)	**Submitted by:** Employee
Safety Issue(s):	AVS Issue - See Notes Below			
Notes:				

These are the categories into which the safety issues are placed. They display in a drop down list in the form.

- AVS Issue - See Notes Below
- DISCHARGE DISPOSITION - Incorrect
- DME - Not Ordered
- DME - Other, See Notes Below
- FOLLOW UP - Not Scheduled
- FOLLOW UP - Not Scheduled Correctly
- FOLLOW UP - Other, See Notes Below
- HOME HEALTH - Other, See Notes Below
- HOME HEALTH - Not Notified of Prescription
- HOME HEALTH - Not Notified of Prescription Change
- MED LIST - Conflicting
- MED LIST - Confusing
- MED LIST - Incomplete
- MED LIST - Incorrect
- MED LIST - Other, See Notes Below
- MULTIPLE ISSUES - See Notes Below
- OTHER SAFETY ISSUE - See Notes Below
- PHYSICIAN DISCHARGE SUMMARY - Conflicting
- PHYSICIAN DISCHARGE SUMMARY - Incorrect
- PHYSICIAN DISCHARGE SUMMARY-Other, See Notes
- PRESCRIPTION - Not Given to Patient
- PRESCRIPTION - Not Sent to Pharmacy
- PRESCRIPTION - Prior Auth Issue
- PRESCRIPTION - Other, See Notes Below

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

Case Management Initial Assessment

Patient main health concern is: ***

How do symptoms interfere with your life? ***

What has helped in the past? ***

Are you able to manage finances, shop, prepare meals, household chores, grooming, and hygiene? Who helps you with any of this? Do you use adaptive equipment? (Walker, reacher, shower bench, oxygen) ***

Do you have any vison, hearing, learning or communicating problems? ***

Can you identify strengths and supports in your life? (Such as education, employment, family, friends, children, or spirituality) ***

Who is part of your health care team? (Such as social worker, neurology, behavioral health, support people, cardiology, etc.) ***

Can you tell me about your healthy habits? (Exercise, alcohol, drugs, tobacco) How did you establish this habit? What motivates you to continue to do this? ***

What habits do you need to improve and are you interested on working on them now? If not, why not? What is interfering with making these changes? On a scale of 1 – 10 how motivated are you in making a lifestyle change? ***

What can you tell me about your medications? Do you know what you take, including time, dose, and purpose of medications? Do you have trouble affording your medications? How do you take your medications? (Pharmacy filled medication box, bubble pack, medication box) ***

Do you have any other issues we have not discussed such as advanced care planning, legal issues, trauma/abuse, financial, preventative screenings, vaccinations, falls, ? * Goal: *****

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

CH Tiering Tool for Case Management Services Eligibility

Chronic condition is defined as a condition that lasts longer than six months or may recur.

Severe condition is defined as a major, potentially unstable condition that, without optimal care, is likely to worsen or lead to more serious problems resulting in severe illness and/or impairment.

Referral from: ***
Referral regarding: ***

1. List patient's severe or chronic conditions: ***

2. Has patient been admitted to the hospital 2 or more times in the past year? *** A) If yes, how many and length of stay:***

3. Has patient been seen in the ER 2 or more times in the past 6 months? ***
   A) If yes, how many visits and was patient admitted to the hospital: ***

4. Has patient been seen in the WIC 3 or more times in the past 6 months? *** A) If yes, how many? ***

5. Does the patient take more than 6 prescriptions? *** A) If yes, how many? ***

6. Is the patient advanced in age (over 75 years) and frail? ***

7. Does the patient have cognitive impairment or a mental health diagnosis? ***

8. Are there concerns with the patient/ caregiver's ability to meet patient needs? ***

9. Is the patient using a high level of resources, medications, visits, treatments, phone calls or community resources? ***

10. Is the patient's social support inadequate? ***

Scoring: Each yes is worth one point. Each chronic condition is worth one point up to total of 4.

0 - 3 = Case Management not indicated
4 - 6 = Chart review only
7+ = Active Case Management

Score: ***

Plan/ Case Management Indicated? ***

Type (Active/Chart Review/None)? ***

Additional Review:

Recent Skilled Nursing Facility admission? ***
2 or more missed/canceled appointments in last 3 mos? ***
Preventative/Health Maintenance up to date? ***
Last PCP visit? ***
Scheduled appointments? ***
Caregiver Authorization on file? ***

Additional Information: ***
Conclusion/Plan of Care: ***

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

Pediatric Case Management Initial Assessment

Childs Name: ***

Legal Guardians: ***

Guardian's phone numbers: ***

Primary language of guardian: ***

School child attends: ***

IEP or 504 Plan: ***

Where does child live? ***

Who does child live with? ***

Stable housing? ***

PCP: ***

Main health concerns: ***

Specialists: ***

Dentist name and last visit: ***

OT/PT/ST: ***

DME provider: ***

Vision loss: ***

Hearing Loss: ***

Behavioral Health: past or present ***

Suicide attempts: ***

Medical Equipment: ***

Alcohol, tobacco, substance abuse: ***

Adequate financial sources ***

Guardian disabled? ***

Reliable transportation? ***

ACES:

Emotional abuse: *** **Emotional neglect:** *** **Physical neglect:** ***

Physical abuse: *** **Sexual abuse:** *** **Household substance abuse:** ***

Mother treated violently: *** **Household mental illness:** *** **Divorce:** ***

Incarceration: ***

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

Pediatric Tiering Tool for Case Management Services

Referral from: * Reason for referral:**
***

1) Does the patient have a severe or chronic condition? ***
   - If yes, please list: ***

2) Has the patient ever been diagnosed with breathing problems? ***

3) Two or more inappropriate ER visits in the last 12 months: ***

4) Number of WIC visits in last 12 months: ***

5) Number of hospitalizations in the last 12 months: ***

6) Number of provider visits in the last 12 months: ***

7) Does the child take medication regularly? ***
   - If yes, number and names: ***

8) Does the child have any cognitive impairment or a mental health diagnosis? ***

9) Are there any concerns with the parent/caregiver ability to meet the child's needs? ***

10) Is the child/parent/caregiver unable to comply with the treatment plan, including medications? ***

11) Is the patient using a high level of resources, medications, visits, treatments, phone calls or community resources? ***

Scoring: Each question is worth one point and each chronic condition is worth one point, up to a total of 4 points.

0-3= Case Management not indicated
4-6= Chart review only
7+= Active Case Management

Score: ***

Plan/ Case Management Indicated? ***

Type: ***

Additional Review:
Missed appointments in the last 12 months? ***
Preventative/ Health Maintenance up-to-date? ***

Specialty clinic visits up-to-date? ***
Last PCP visit? ***
Scheduled appointments? ***

Additional Information:

Conclusion/ Plan of Care:
If contacted, Case Management services explained to patient/parent? Patient/Parent accepted or declined?

NCACH TRANSITIONAL CARE MANAGEMENT RESOURCE GUIDE

Comparison of Transitional Care Management and Case Management Services

Activity	TCM	CM	Frequency
Preparation for transition within a multidisciplinary team	Prior to discharge, hospital staff organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed.	The Inpatient RN-CM (IPCM) actively participates in discharge rounds and reports necessary findings to the Outpatient RN-CM (OPCM).	Daily
Identifying patients to participate	Identifies Non-Managed Care Discharged Patients from a daily discharge report excluding discharged to hospice, assisted/skilled nursing facility or patients receiving hemodialysis. Patients who have a follow-up appointment the day after discharge are not called.	Case Managed patient care panels RNCM's manage patients who have one or more of 12 identified chronic conditions, as well as social determinants of health that negatively impact their wellness.	Daily
Individual meeting with patient prior to discharge	Prior to discharge the IPCM and the bedside RN discusses instructions with the patient. The patient is also send home with written material that has all of this included on it. That document is called an AVS (After Visit Summary). The AVS summary is also used by the TCM RN's who make the post discharge hospital follow up phone call.	Prior to discharge the IPCM and the bedside RN discusses instructions with the patient. The patient is also send home with written material that has all of this included on it. That document is called an AVS (After Visit Summary). The AVS summary is also used by the OPCM who makes the post discharge hospital follow up phone call.	One time, prior to discharge
Post discharge phone call	**Transitional Care Nurse** post discharge phone call affirms that the patient has a follow up appointment with their PCP, medication review, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, AFH/ALF, and or caregiver help. Any problems identified will be worked on and then directed to the PCP's office.	**OPCM** post discharge phone call affirms that the patient has a follow up appointment with their PCP, medication review, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, AFH/ALF, and or caregiver help. Any problems identified will be worked on and then directed to the PCP's office.	**CH-TCM**: One time, 24-48 hours post-discharge **C-TRAC:** One time, 48-72 hours postdischarge
Weekly follow-up	N/A	**OPCM** calls each participant weekly for four weeks	Weekly
Transition to active case management or discharge status	N/A	At the completion of these phone calls the **OPCM** will assess using the tiering tool to transition the patient to either active case management or discharge status.	At completion of four Weekly follow-up calls

Descriptions of various Care Coordination Services

Transitions of Care Management:

A service provided to all patients who are discharged from the Hospital. This work can either be done with the inpatient or outpatient department. If done in the outpatient, PCP offices can receive discharge lists from local hospitals to notify them when their patients have left their facility.

Clinical Case Management:

Organizations may have two types of Case Management

- Inpatient Case Management evaluate patients while they are hospitalized. Patients are assessed for discharge needs Care plans are put in place to meet those needs. This is an episodic type of care with no ongoing contact with the patient.
- Outpatient Case Management patients are referred from a variety of sources, including ED, providers, inpatient case managers, office staff, etc. Case managers assess and develop an individualized care plan with the patient and their support person/family which will help to facilitate the health and wellbeing of the patient as they continue living in their home. Case Management may follow these patient's for a period of time or indefinitely.

Health Homes:

A program focused on Medicaid patients with a PRISM score of > 1.5. RNs act as care coordinators and the state has a very structured program with strict guidelines and documentation requirements which they follow. Patients have the right to decline to participate, but the goal is to keep the patients out of the ED. The program continues until the patient meets the goals they have set, they decide they no longer want to participate or their insurance changes. Patients typically have multiple co-morbidities and social determinates of care that prevent them from being successful in their healthcare.

Attachment B

Washington State Hospital Association | Washington State Medical Association | American College of Emergency Physicians Washington Chapter | Washington State Health Care Authority

Seven Best Practices:

1. **Electronic Health Information** – Adoption of an electronic emergency department information system on a statewide basis to create and act on a common, integrated plan of care related to patients with high needs (5 or more visits in a rolling calendar year) by all emergency rooms, payors, mental health clinics, and is sent to primary care providers.

2. **Patient Education** – Dissemination of patient education materials by hospitals and payors to help patients understand and utilize the appropriate resources for care. This would include plans sharing with patients and providers where they can get off hours coverage for primary or urgent care including through nurse call lines and having this information easily available on their web sites.

3. **Identify Frequent Users of the Emergency Department and EMS** – Frequent emergency department (ER) or EMS users are identified as those patients seen or transported to the ER five (5) times within the past 12 months. Hospitals should identify those frequent ER users upon arrival to the emergency department and develop and coordinate case management, including utilization of care plans. Plans, EMS, and mental health clinics will work with patients with five or more visits to identify and overcome core issue which is documented in statewide information system.

4. **Develop Patient Care Plans for Frequent ER Users** – A process to assist frequent ER users with their care plans, such as contacting the primary care provider within 72-96 hours and/or notifying the PCP of an ER visit if no follow-up is required. Payors will provide the information system with the names of the primary care or group for Medicaid patients and provider fax number.

5. **Narcotic Guidelines** – Reduce drug-seeking and drug-dispensing to frequent ER users through implementation of guidelines that incorporate the WA-ACEP guidelines.

6. **Prescription Monitoring** – ER Physician enrollment in the state's Prescription Monitoring Program (PMP). The PMP is an electronic online database used to collect data on patients who are prescribed controlled substances ensuring coordination of prescription drug prescribing practices.

7. **Use of Feedback Information** – Designation of a hospital emergency department physician and hospital staff responsible for reviewing the reports of frequent ER users to ensure interventions are working, including a process of reporting to executive leadership.

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