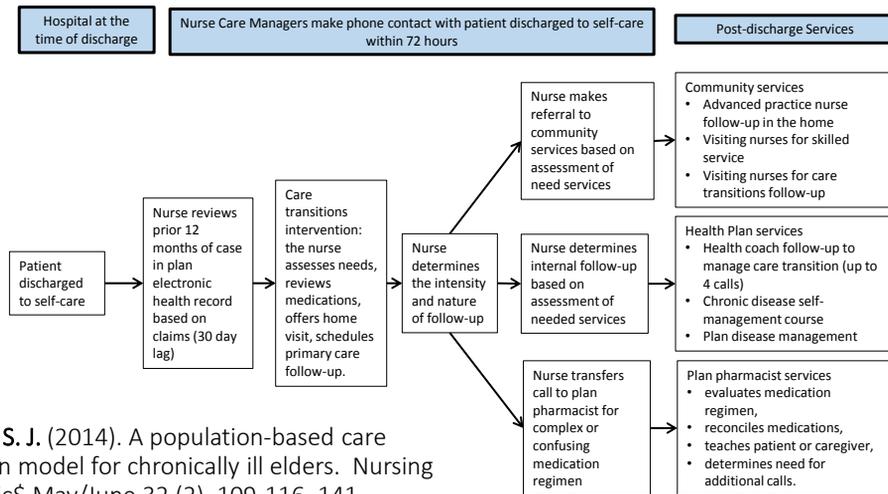
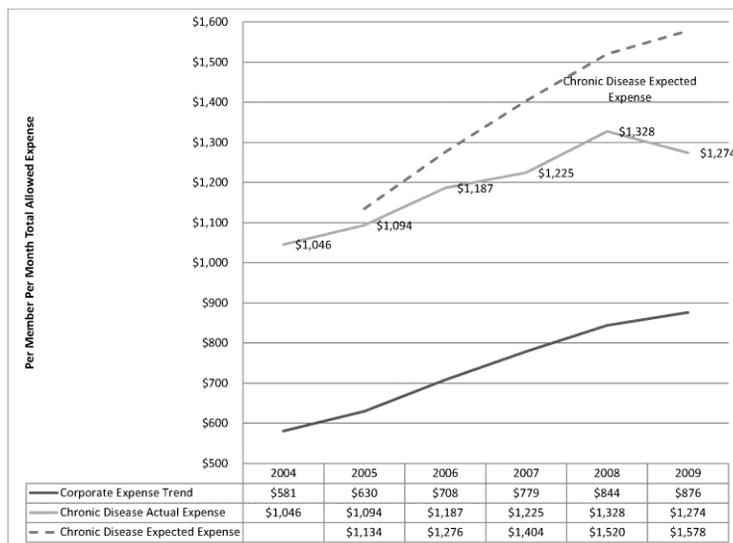


## Workflow of Population-Based Care Transitions Management



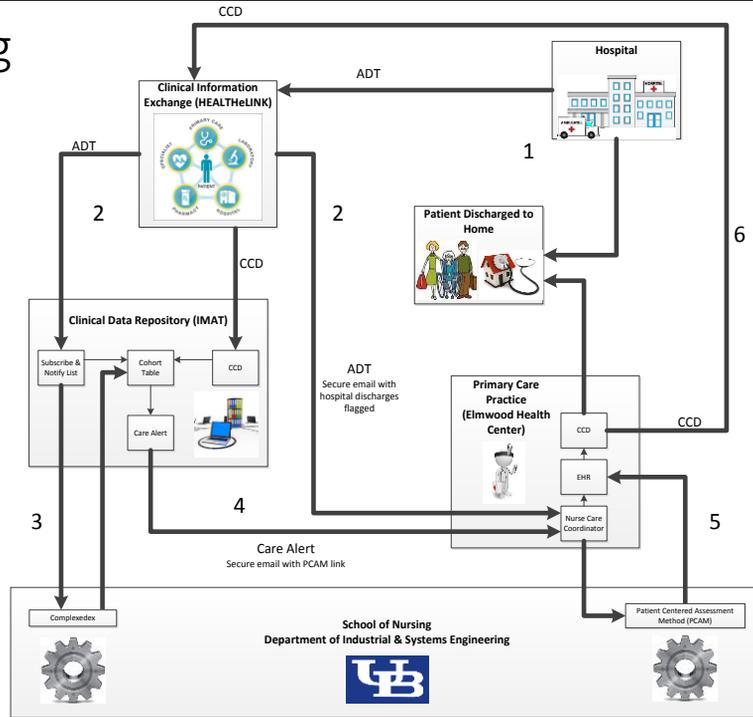
Hewner, S. J. (2014). A population-based care transition model for chronically ill elders. *Nursing Economic\$* May/June 32 (2), 109-116, 141.

## Medical Expense Trends Comparing all Medicare with Medicare Chronic Cohort Actual and Expected, 2004-2009

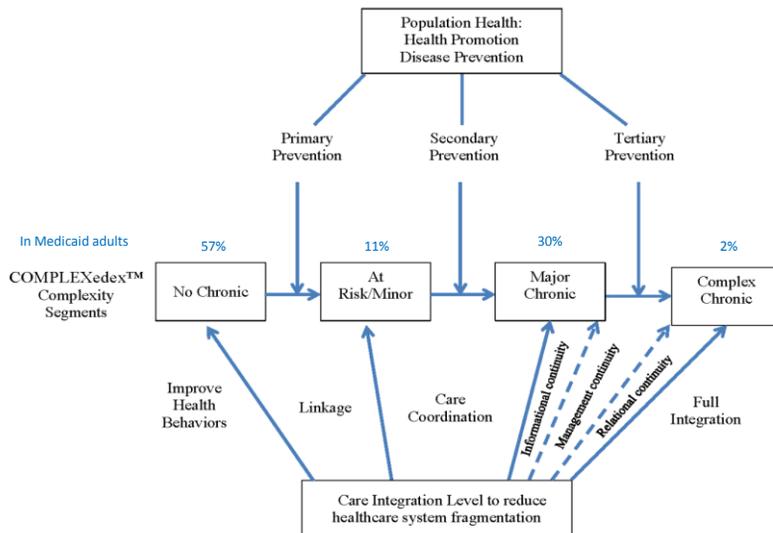


Hewner, S. J. (2014). A population-based care transition model for chronically ill elders. *Nursing Economic\$* May/June 32 (2), 109-116, 141.

# Coordinating Transitions HIE



# Risk Stratified Care Management Model

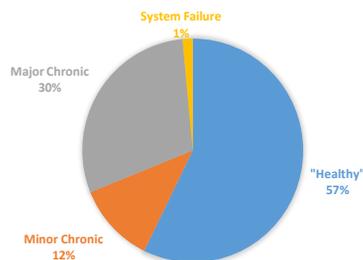
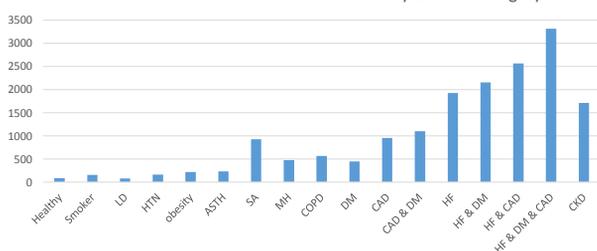


**Hewner, S. J., & Seo, J. Y.** (2014). Informatics role in integrating population and patient centered knowledge to improve care transitions in complex chronic disease. *Online Journal of Nursing Informatics (OJNI)*, 18 (2).

# Creating Chronic Cohort and Disease Hierarchy

Cohort	Complexity Segment	Service Need	Disease Category
Chronic	System Failure	Full Integration	CKD & HF with and without comorbidity
Chronic	Major Chronic	Care Coordination	DM, CAD, COPD, Asthma, mental health & substance abuse
Non-chronic	Minor Chronic	Linkage	Obesity, hypertension, lipid disorder, smoking
Non-chronic	"Healthy"	Health Promotion	Healthy

Non-dual Medicaid Adults Admission Rate by Disease Category



Webmail 24 Provider Directory Sign Out

Back Compose Reply Reply all Forward Delete Print Mark More Move to...

**Inbox** 24  
Drafts  
Sent  
Trash

**Care Transitions Alert** Message 26 of 303

From: [Redacted]  
To: [Redacted], [Redacted]  
Cc: [Redacted]  
Date: 04/24/2015 10:07

[Redacted] was discharged from Buffalo General Medical Center on 2015-05-10 with the primary diagnosis of SOB and was an inpatient.

[Redacted] is at greater risk of readmission related to a history of Chronic disease. Chronic conditions in the medical record include:

- Smoking
- Lipid Disorder
- x Hypertension
- Obesity
- x Asthma
- x Behavioral Health
- x COPD
- Diabetes
- Coronary Artery Disease
- Heart Failure
- x Chronic Kidney Disease

The relative risk of admission is 16.1 times greater than a person without chronic disease. Their highest disease category is CKD.

[Redacted]'s contact information:

[Redacted]

## University of Minnesota's Patient Centered Assessment Methodology (PCAM)

Health Literacy and Communication			
1. How well does the client <b>now understand</b> their health and well-being (symptoms, signs or risk factors) and what they need to do to manage their health?			
Reasonable to good understanding and already engages in managing health or is willing to undertake better management	Reasonable to good understanding <b>but</b> do not feel able to engage with advice at this time	Little understanding which impacts on their ability to undertake better management	Poor understanding with significant impact on ability to manage health
2. How well do you think your client can <b>engage</b> in healthcare discussions? (Barriers include language, deafness, aphasia, alcohol or drug problems, learning difficulties, concentration)			
Clear and open communication, no identified barriers	Adequate communication, with or without minor barriers	Some difficulties in communication with or without moderate barriers	Serious difficulties in communication, with severe barriers
<b>Routine Care</b>	<b>Active monitoring</b>	<b>Plan Action</b>	<b>Act Now</b>

tool available freely at [www.pcamonline.org](http://www.pcamonline.org)

## Research Collaborators and Community Partners



**UB** Family Medicine



COMPUTER SCIENCE AND ENGINEERING



## Practice Redesign and Care Transformation

*“In the morning I go through the list of ADTs and notify the doctors about admissions, I send ED discharges to the triage nurse, and then I’m waiting to get the Care Transitions Alert the next day – it’s changed our workflow. ...When we get a Care Transitions patient, I let everyone know – the MD, the nurses who check people in, and our billing department.”*

*“The PCAM helps with mental health patients who are a lot more complex. The PCAM has me ask questions I wouldn’t have asked before.”*

*“I love it – It’s been great just to know someone has been discharged because in the past we never knew. ...Some patients thank you for calling and for the follow-up ...there has been more communication for the entire practice!”*