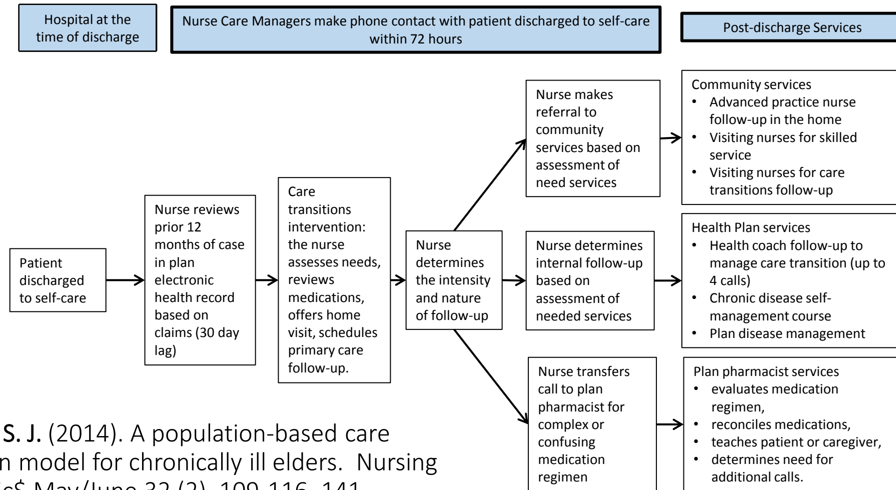
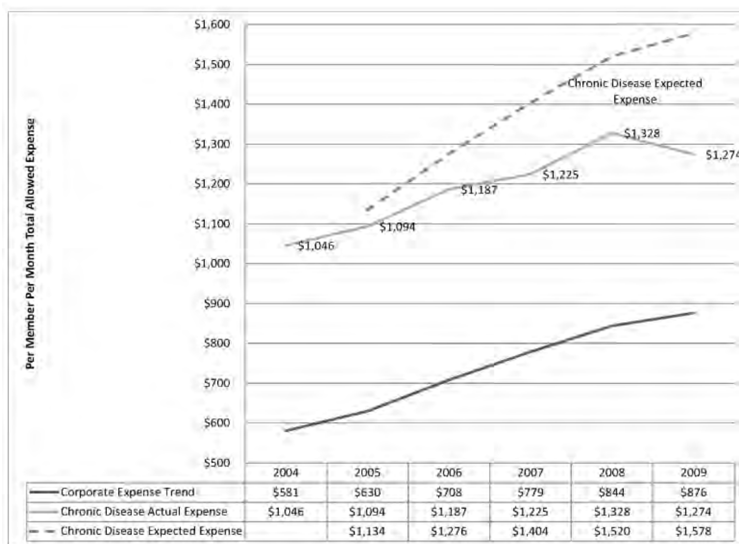
Workflow of Population-Based Care Transitions Management



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

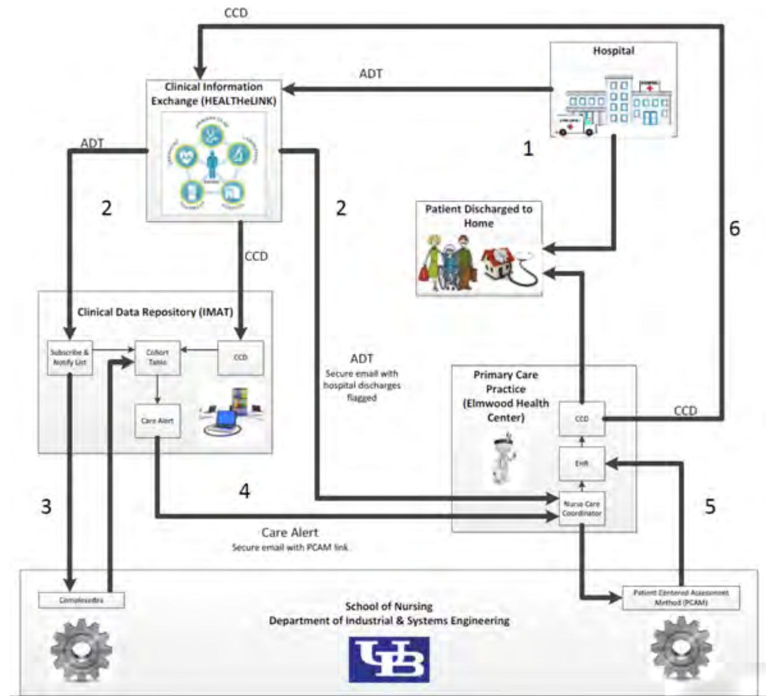
Medical Expense Trends Comparing all Medicare with Medicare Chronic Cohort Actual and Expected, 2004-2009



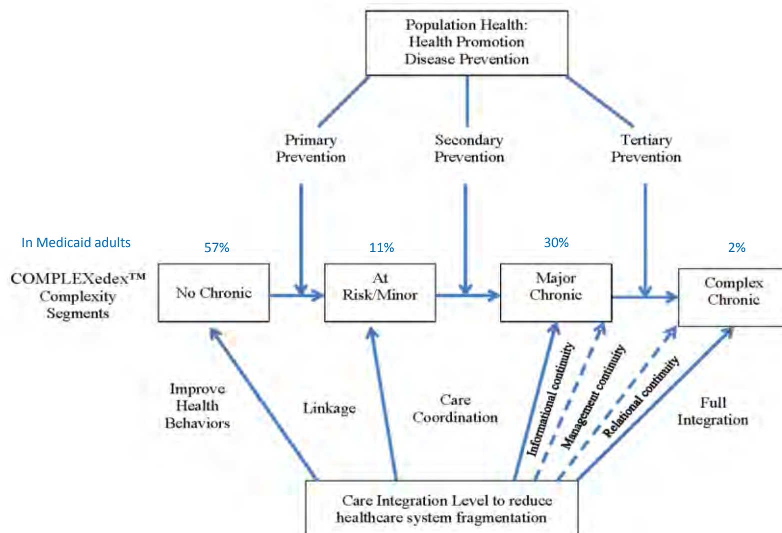
	2004	2005	2006	2007	2008	2009
Corporate Expense Trend	$581	$630	$708	$779	$844	$876
Chronic Disease Actual Expense	$1,046	$1,094	$1,187	$1,225	$1,328	$1,274
Chronic Disease Expected Expense		$1,134	$1,276	$1,404	$1,520	$1,578

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



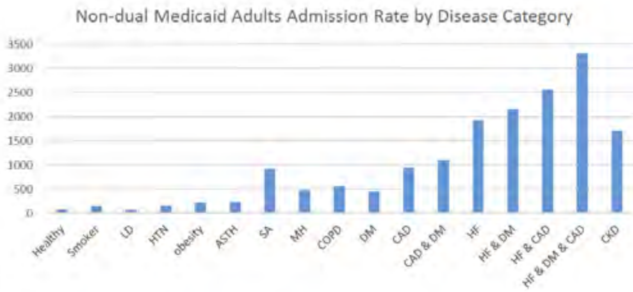
Risk Stratified Care Management Model

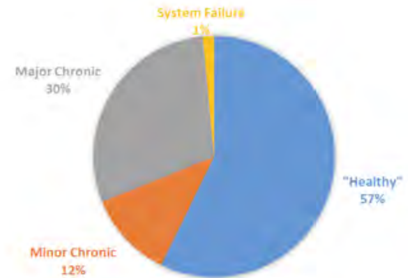


Hewner, S. J., & Seo, J. Y. (2014). Informatics role in integrating population and patient centered knowledge to improve care transitions in complex chronic disease. *Online Journal of Nursing Informatics (OJNI), 18 (2)*.

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





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

To

Cc

Date 04/24/2015 10:07

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

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
        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.

's contact information:
```

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

Health Literacy and Communication			
1. How well does the client **now understand** 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 but 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 **engage** 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
Routine Care	**Active monitoring**	**Plan Action**	**Act Now**

tool available freely at www.pcamonline.org

Research Collaborators and Community Partners

UB Family Medicine

Family Medicine and Community Health

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!"