Workflow of Population-Based Care Transitions Management


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

Coordinating Transitions HIE

Risk Stratified Care Management Model

Creating Chronic Cohort and Disease Hierarchy

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Complexity Segment</th>
<th>Service Need</th>
<th>Disease Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic</td>
<td>System Failure</td>
<td>Full Integration</td>
<td>CKD &amp; HF with and without comorbidity</td>
</tr>
<tr>
<td>Chronic</td>
<td>Major Chronic</td>
<td>Care Coordination</td>
<td>DM, CAD, COPD, Asthma, mental health &amp; substance abuse</td>
</tr>
<tr>
<td>Non-chronic</td>
<td>Minor Chronic</td>
<td>Linkage</td>
<td>Obesity, hypertension, lipid disorder, smoking</td>
</tr>
<tr>
<td>Non-chronic</td>
<td>“Healthy”</td>
<td>Health Promotion</td>
<td>Healthy</td>
</tr>
</tbody>
</table>

![Bar chart and pie chart showing admission rates by disease category.]

![Webmail interface with a Care Transitions Alert message.]

Message 26 of 303

**Care Transitions Alert**

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
- Hypertension
- Obesity
- Asthma
- Behavioral Health
- COPD
- Diabetes
- Coronary Artery Disease
- Heart Failure
- 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.

[Contact information field]
University of Minnesota’s Patient Centered Assessment Methodology (PCAM) tool available freely at www.pcamonline.org

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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 |
“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!”