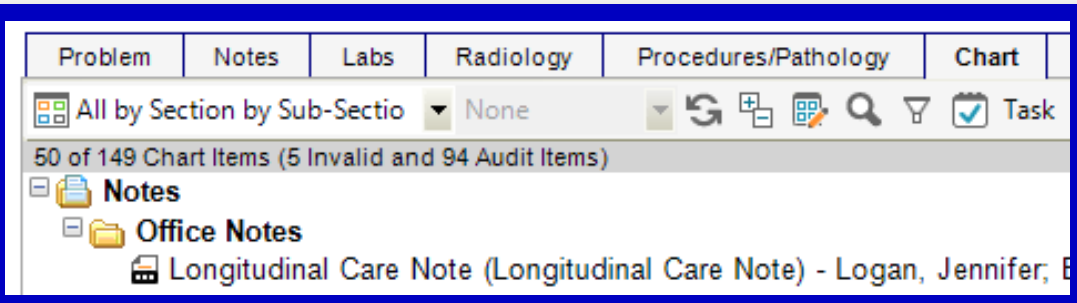
QI Weekly

30-Day Post-Acute Follow-Up

As part of the new ACO, we are now receiving information on patients who have been discharged home from a SNF or rehab facility. We are working with AnewCare on a pilot project where we follow these patients for 30 days, in an attempt to prevent hospital readmissions whenever possible.

Longitudinal Care

One of our centralized case managers, Betty Dellinger, RN, will be following this patient population, using the Longitudinal Care Note, which you will begin seeing in the chart. Approximately a week after discharge, Betty will contact the patient and set up a time to call weekly. The plan will be to check in once or twice during the week, to ensure that they have the services they need, and are feeling well. The note will remain open for 30-days, and will be available under the Office Notes section on the Chart tab. The goal is to keep patients out of the hospital whenever possible, and if they need additional long-term care, to get them readmitted directly back to the SNF or rehab facility.



The note will outline the time spent, as well as any issues the patient has during the 30-day post acute period. The case manager will remain in close communication with the provider during this time period with any issues that arise. At the end of the 30-day period, the note will be sent to the provider for review and signature. We will not be billing these initially, but hope to be able to use the new Principle Care Management code once we have the workflow down.

Date: 2/24/2020