

3-DAY SNF WAIVER INDIVIDUALIZED CARE MANAGEMENT PLAN

Patient Name:		Patient Address:											
Responsible Party/Relationship:													
Date of Birth:		Sex: M <input type="checkbox"/> F Code Status:											
Principle Diagnosis: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> ALTERED FLUID AND ELECTROLYTE BALANCE</td> <td><input type="checkbox"/> ORTHO/FRACTURE</td> </tr> <tr> <td><input type="checkbox"/> CELLULITIS</td> <td><input type="checkbox"/> PNEUMONIA</td> </tr> <tr> <td><input type="checkbox"/> CHF</td> <td><input type="checkbox"/> UTI</td> </tr> <tr> <td><input type="checkbox"/> COPD/ASTHMA</td> <td><input type="checkbox"/> ACUTE FUNCTIONAL DECLINE WITH ANTICIPATED RESPONSE TO THERAPY</td> </tr> <tr> <td><input type="checkbox"/> OTHER _____</td> <td></td> </tr> </table>				<input type="checkbox"/> ALTERED FLUID AND ELECTROLYTE BALANCE	<input type="checkbox"/> ORTHO/FRACTURE	<input type="checkbox"/> CELLULITIS	<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> CHF	<input type="checkbox"/> UTI	<input type="checkbox"/> COPD/ASTHMA	<input type="checkbox"/> ACUTE FUNCTIONAL DECLINE WITH ANTICIPATED RESPONSE TO THERAPY	<input type="checkbox"/> OTHER _____	
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<input type="checkbox"/> OTHER _____													
Surgical Procedure:													
ACO Provider/PCP Responsible for initiating the admission and Care Management Plan:													
Name:		Telephone Number:											
		After Hours Number:											
SNF affiliate designee responsible for accepting patient and implementing Care Management Plan:													
Name:		Telephone Number:											
		After Hours Number:											

Proposed Problems:

- Alteration in Activity Tolerance
- Alteration in ADL's
- Alteration in Ambulation/Balance/Mobility
- Alteration in Bowel Function
- Alteration in Cardiac Status and/or vital signs
- Alteration in Fluid and Electrolyte balance
- Alteration in Nutritional Status
- Alteration in Pain
- Alteration in Respiratory Status
- Alteration in Skin/Tissue Integrity
- Other (Specify) _____

BJC Accountable Care Organization

Order: Patient Name/DOB _____

- Assess and treat according to documented disease protocol
- Establish Bowel Routine
- Notify physician of abnormal labs and associated symptomology
- Pain Management Protocol
- PT/OT/ST Evaluation and Treat
- Social Services to evaluate and coordinate needed services for discharge planning
- Establish functional home insulin regiment
- Other (Specify) _____

Goal:

- Absence of infection
- Maintain fluid and electrolyte balance within patient's defined range of _____
- Maintain functional bowel pattern
- Maintain/regain desired body weight of _____
- Maintain stable blood glucose levels
- Maintain stable cardiac status and/or vital signs within patient's defined range of _____
- Maintain stable respiratory (ventilation, oxygenation, airway clearance) status within patient's defined range of _____
- Maintain stable vital signs
- Manage pain control
- Improve ability to perform ADL's to allow a safe transition to their home/next site of service
- Improve ability to perform ambulation with/without assistive device safely to allow transition to their home/next site of service
- Improve tolerances to activity to allow a safe transition to their home/next site of service
- Patient does not experience burning, hesitancy, hematuria or frequency
- Prevent and or minimize complications related to _____
- Other (Specify) _____

Interventions:

- Administer supplemental O2 as ordered
- Assess and monitor respiratory status including post activity pulse ox
- Assess for and report signs and symptoms of fluid and electrolyte imbalance
- Assess for and report changes in mental status
- Assess for patient understanding of home glucose regiment
- Assess, monitor, and document ability to perform ADL's safely
- Assess, monitor, and document adequate hydration
- Assess, monitor, and document bowel routine including frequency and consistency of stool
- Assess, monitor, and document deterioration in condition
- Assess, monitor, and document for hematuria, hesitancy, frequency, and burning
- Assess, monitor, and document need for assistive device(s)
- Assess, monitor, and document pain level as indicated to minimize pain level
- Assess, monitor, and document safe utilization of assistive device(s)

Accountable Care Organization

Interventions (continued): Patient Name/DOB _____

- Assess, monitor, and document weight and fluid retention
- Assist patient with proper breathing exercises
- Complete dressing and or treatment as directed
- Determine response to increased activity and modify routine to increase tolerance
- Evaluate general nutritional state, obtain baseline weight
- Identify safety hazards that may occur in the home and demonstrate response to avoid injury
- Monitor and document voiding pattern
- Monitor intake and output
- Pt has developed emergency plan if fall /injury occurs
- Reinforce airway clearance activities suction when indicated
- Review ordered labs and check for abnormal values
- Training for straight cath as needed
- Other (Specify) _____

I certify that this beneficiary meets requirements to receive confirmed SNF services under the waiver as described in 425.612(a) (1) (ii).

ACO Provider _____ Date/Time _____

SNF designee _____ Date/Time _____

Please fax completed form back to the ACO at 314-362-2289

General Guidelines:

- Above stated SNF affiliate will manage the beneficiary's care and will, in collaboration with the designated ACO Care Manager, work to facilitate a seamless transition from the SNF affiliate to the beneficiary's ACO primary care provider or other provider as determined by the care team and beneficiary at the time of discharge.
- Above stated SNF affiliate will provide high quality and efficient care and will deliver sufficient preparation and education to beneficiary's to ensure a safe and orderly transfer or discharge from the facility within an optimum length of stay.
- Information regarding the beneficiary's care, assessment and progress towards goals will be shared across care sites and made available to all members of the care team using secure email, fax or provider portal in the Care Management software.
- Once admitted, communication between the above stated SNF affiliate and the designated ACO Care Manager will occur weekly, after the SNF affiliate's discharge planning meeting. This ensures that all parties will have the most up to date information available when communicating and coordinating the beneficiary's plan of care. Upon discharge, the beneficiary's designated ACO Care Manager will contact beneficiary to ensure continuity of care and assess for ongoing care management needs.
- Questions, concerns or inquiries regarding the Care Management Plan should be directed to the ACO medical director and health care professional responsible for the ACO's quality assurance and improvement program, Dr. Douglas Pogue, by contacting 314-996-6199.

Accountable Care Organization

Provision of High Quality and Efficient Care Delivery:

- Once the patient has been accepted by a designated SNF affiliate, the assigned ACO Care Manager and the referring party (Inpatient, Outpatient) designee will review the patient's status, physician orders, and the proposed Individualized Plan of Care to help facilitate a seamless transition from the referring facility to the SNF affiliate. Any identified gaps in care will be addressed and plans made to transition the patient to the next level of care.
- An initial admission call between the ACO Care Manager and the designated SNF affiliate will occur on the day of admission and will include a review of the physician's ordered Plan of Care, including problem list, expected outcome and prognosis and measurable treatment goals.
- To help facilitate an optimal length of stay regarding this episode of care, the SNF affiliate designee and the ACO Care Manager will collaborate at a minimum weekly to discuss the patient's progress towards identified goals and any newly identified goals and/or barriers will be discussed along with symptom management and planned interventions, medication management, the individual responsible for each intervention and the anticipated discharge date.
- Following the update meeting, the SNF affiliate designee will review the Plan of Care with the patient/family to educate them regarding the upcoming transition from the SNF affiliate and their next level of care, the anticipated discharge date and the role of the ACO Care Manager. The ACO Care Manager will update the patient's ACO Primary Care Provider via EMR notes regarding the patient's progress and anticipated discharge date. Any urgent needs will be addressed via telephone.

Facilitating a Seamless Transition of Care:

- Upon identification of the patient's discharge date, the SNF affiliate designee will notify the ACO Care Manager and begin the SNF affiliate Transition Discharge Checklist.
- The checklist includes, but is not limited to, the SNF affiliate designee scheduling the patient's first ACO Primary Care Provider follow-up visit within 5 – 7 days post discharge, identification of any community/social resources to be accessed, orders for Home Health, a current medication list along with any newly identified medications, prescriptions, discharge instructions, a summary of the episode of care along with an updated Plan of Care.
- Upon transition to a long-term care facility, the ACO Care Manager will initiate an interaction with the accepting facility to introduce her/his self and explain their role. During this interaction, the ACO Care Manager will review and update the Plan of Care with the accepting facility to help facilitate a seamless transition to the next level of care and provide the designated ACO Care Manager's contact information.
- Upon transition to a home environment, the SNF affiliate designee and the ACO Care Manager will review the current Plan of Care and the patient's pending discharge status prior to the patient discharging from the facility. The patient/family will be educated by the SNF affiliate designee regarding the ACO Care Manager's continuing role and the schedule for their follow up call.
 - The ACO Care Manager will contact the patient within 24 hours of discharge to assess the patient, verify post-discharge follow-up appointment within 5-7 days with the patient's ACO Primary Care Provider, perform medication reconciliation, provide education and update the Plan of Care to reflect the patient's current needs and plan for care coordination with other providers. The ACO Care Manager will also assist with the coordination of Home Health or any community/social based resources.
 - Once immediate discharge needs are addressed, on-going patient management will occur through the ACO Transitions of Care Management Program.

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Revised: 6/26/2018, 10/24/2019, 1/4/2022 + 8/3/2022, 11/16/2022