

COVID-19 UPDATE



Care Coordination and Right Level of Care

Situation

- The Care Coordination and Right Level of Care initiative was developed to:
 - ✓ Standardize and safely transition patients to the next level of care
 - ✓ Increase hospital capacity during COVID-19
- This will reduce the use of emergency department and inpatient/observation beds, keeping them for the sickest patients, while helping to reduce hospital length of stay, readmissions and total cost of care. It will also increase patient satisfaction and care coordination between acute and post acute.

Background

- An integrated team consisting of inpatient care management, ambulatory care management, emergency room, home health, hospice, skilled nursing facility program, respiratory therapy and DME developed a risk profile stratifying patients into appropriate discharge disposition level.
- All *current programs* were used to full potential without duplicating services.
- **New** programs include: expanded Post Acute Virtual Health (Home Health, Outpatient Rehab, Hospice, DME, IV, PAN SNF, Physicians at Home and Home-Based Palliative Care), Recovery at Home and Home Hospital.
- In addition, vulnerable patients from the Emergency Room, Observation or Inpatient settings may be discharged home, decreasing their exposure to unnecessary hospital pathogens while safely providing them hospital-level care.

Assessment and Recommendation

- In collaboration, Care Management, Post Acute Liaison and Physician will determine discharge disposition level.
- All COVID-19 positive patients discharging from AAH hospitals (all payers) will be enrolled in the Ambulatory Care Transition program which provides 30/90 day post hospital follow-up.

Continued on next page

Care Coordination and Right Level of Care

Level	Patient Level of Care	Advocate Aurora Health Program/Service
1	Discharged home with self care, can be followed by PCP in the community	Ambulatory Care Transition program, PCP
2	Co-morbidities, change in medical treatment, patient stable able to be discharged and managed in the home with home health	Home Health nursing, PT, and OT; Post Acute Virtual Health services; and Ambulatory Care Transition Program
3	Co-morbidities, acuity requires changing medical treatment and medical management in the home – adding APC to support home health	NEW! Recovery at Home: patients are provided services from APCs, home health nursing, PT, and OT ranging from in-person visits to video visits. Patients are also provided a pulse oximeter for home use to report their oxygen levels to the care team during their visits.
4	Requiring skilled level of care at facility setting, complex Social Determinants of Health (SDOH) affecting ability to go home	Skilled nursing facility placement
5	Discharge to Home Hospital Program	NEW! Home Hospital: patients are provided services from APCs, home health nursing, PT and OT ranging from daily in-person visits to virtual visits. Patients also receive oxygen services and a tablet that allows for real-time monitoring and video visits by the clinical team.
6	Discharge to Hospice, end of life care	Hospice
ALL	Symptom management, ACP conversations	Palliative Care

For more information visit our Webinar at:
[Care Coordination and Right Level of Care Webinar](#)

Or Contact:
Dawn Doe, Vice President Post Acute Value Based Programs
Dawn.doe@advocatehealth.com
630-935-5174

Kris Kelm, Vice President Integrated Care Management
kristine.kelm@aurora.org
262-787-2747

Created by: Dawn Doe and Kris Kelm
Created: April 22, 2020
Approved by: Denise Keefe

