Introduction:
CommonSpirit Health Ambulatory COVID+
Care Coordination and Home Health Suggested Guidelines
2/8/21

The Care Coordination and Home Health workflows provide a bird’s-eye example of the expected activities that should occur once care coordination or home health is requested. A particular focus on communication and feedback loops back to primary care is included. These are not meant to be prescriptive, but rather offer an example of the workflow processes.
Care Coordination COVID Response Patient with No or Mild Dyspnea (May have SDOH Need)

2/8/21

CC receives Ambulatory Referral

RN

Patient contact confirm clinical status (No/Mild Dyspnea)

1. Review COVID Care Guidelines with patient
2. Schedule follow up video or telephone visit in 5 days and then 10 days with RN
3. Upload Care Guideline Tracking into Athena or other system (Tickler to LVN/navigator)

Assess Social Needs and refer as necessary (see below)

Initial, 1, 5, 10 Day RN visit change/worsening symptoms escalate to PCP

Communication Loop PCP

LVN/LPN/Navigator

Target within 72 hours from discharge

Done via telephone call & established process

May be assigned differently based on market

Verifies patient in Care Guideline tracking system

Calls patients 2 days after RN intake and every 2 days after to review tracking sheet

Change in care tracking/symptoms escalate per protocol

After 10 days tracking patient stable no change or deterioration. Complete care tracker form

Abbreviations
APP – Advanced Practice Provider
CC – Care Coordination
HH – Home Health
F2F – Face to Face
PCP – Primary Care Provider
PUI – Person Under Investigation
RPM – Remote Patient Monitoring
SBAR – Situation/Background/Assessment/Recommendation
SDOH – Social Determinants of Health
SOC – Start of Care

* Check with state licensing guidelines
Care Coordination COVID Response Patient with Moderate Dyspnea

RN
- CC receives Ambulatory Referral
  - Patient contact confirm clinical status (No Change in Dyspnea), Confirm if HH if ordered
  - 1. Review COVID Care Guidelines with patients
  - 2. Call patient every 2 days for next 2 weeks
  - 3. Value Based patient – Use tool A
  - 4. If not Value Based or declines CC continue to follow until breathing status returns to mild, then transition to LPN/LVN/Navigator
  - 5. Social Determinants of Health Assessment
- Remote Patient Monitoring or HH involvement?
  - Coordinate patient contacts and interventions
  - RN Encounters (Initial and every 2 days). If symptoms worsen, escalate to PCP
  - Communication Loop PCP

LVN/LPN/Navigator
- Verifies patient in Care Guideline tracking system
- Calls patients 2 days after RN intake and every 2 days after to review tracking sheet
- Change in care tracking/symptoms escalate per protocol
- Dyspnea Assessment
  - Wait 10 Days
  - Mild or Worse
  - Escalate to PCP & ask if HH needed
  - Not Needed
  - Continue following and reassess in a week.
- May be assigned differently based on market

Home Health
- HH process, refer to HH Workflows

Social Services
- Follow up based on RN Social Determinants of Health assessment

Target within 24-48 hours from discharge

Done via telephone call & established process

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1. Confirm breathing status as per Dyspnea evaluation.
2. Confirm if oxygen ordered and received
3. Confirm if Pulse Ox received at discharge
4. Identify and address SDOH
5. Confirm HH in place *IF* ordered

Follow up based on
RN SDOH assessment

Target within 24-48 hours

1. Review COVID Care Guidelines with patients.
2. Call pt every 2 days for next 2 weeks
3. Value Based patient – Use tool A
4. If not Value Based or declines CC continue to follow until breathing status returns to mild, then transition to LPN/LVN/Navigator
5. Social Determinants of Health Assessment

Done via telephone call & established process

Positive response to any urgent medical question?

Send to Emergency Room

CC receives system generated outreach list

Is HH ordered? NO

Use relevant swim lane based on license of team member

CC receives system generated outreach list

Is HH ordered? NO

YES

HH process, refer to HH workflows

Follow up based on RN SDOH assessment

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Initiating Home Health from Ambulatory Care COVID+ Patient with Mild/Moderate Dyspnea

**Ambulatory Clinic**
- Provider determines pt may benefit HH by ID of COVID+ or PUI
- Order workflow initiated provider orders/referral. If care coordination also involved indicate this on order set

**Home Health (HH) Agency**
- Order received
- Contact w/ in 1 day
- Admin intake complete
- Care Type designation COVID+/PUI
- Verify F2F or plan to obtain
- RN/Therapy visit within 24 hours for initial assessment
- Notify CC that HH has admitted and will be primary during episode
- Enroll patient in RPM either Mobile or Tablet based
- Ensure remote visits if patient declines RPM

**Remote Patient Monitoring (RPM)**
- Issue peripherals if not provided by PCP/CC
- Enrollment on RPM
- Parameters set for individual norms to monitor
- Daily RPM Monitoring
- Patient Monitoring Daily 8am – 5pm
- Video Visits as needed

**Continuing Care Decisions**
- Telehealth Nurse communicates with Case Manager as escalation process indicates
- Long Term Sequelae needs for continued care
- At discharge, HH will fax discharge summary to PCP

**Criteria for COVID Escalation**
- Green: no action needed
- Yellow: Contact patient & Case Mgr, triage/educate/determine needs
- Red: contact Patient & Case Mgr, initiate visit
- PCP and/or APP contacted for escalation decision, further orders.

**Target within 24-48 hours from discharge**
- 1. Confirm orders include RPM and that HH has RPM available
- 2. Verify parameters set which triggers escalation process via SBAR with change in condition
- 3. Indicate patients Care Type COVID+/PUI
- 4. Per Federal Regulations patient needs “face-to-face” within 90 days before SOC or within 30 days of SOC

**Communication Loop PCP**
- Issue peripherals for RPM
- No further skilled need
- Results of evaluation

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Initiating Home Health from Ambulatory Care non-COVID Patient w/ Chronic Disease Potential for Exacerbation

**Ambulatory Clinic**
- Prov. determines patient may benefit HH for Chronic Disease Management or COVID Risk Factors
- Order workflow initiated Provider orders/Referral. If care coordination also involved indicate this on order set

**Home Health (HH) Agency**
- Order received
- Contact w/in 1 day
- Admin intake complete
- Care Type designation COVID+/PUI.
- Verify F2F or plan to obtain
- RN/Therapy visit within 24 hours for initial assessment
- Notify CC that HH has admitted and will be primary during episode
- Enroll patient in RPM either Mobile or Tablet based
- Ensure remote visits if patient declines RPM

**Remote Patient Monitoring (RPM)**
- Issue of peripherals (if not provided by PCP/CC)
- Enrollment on RPM
- Parameters set for individual norms to monitor
- Daily RPM Monitoring
- Patient Monitoring Daily 8am – 5pm
- Video visits as needed

**Continuing Care Decisions**
- Telehealth Nurse communicates with Case Manager as escalation process indicates
- Long Term Sequelae needs for continued care
- At discharge, HH will fax discharge summary to PCP

**Target within 24-48 hours from discharge**
1. Confirm orders include RPM and that HH has RPM available
2. Verify parameters set which triggers escalation process via SBAR with change in condition.
3. Indicate patients is a risk for COVID from CDC list
4. Per Federal Regulations patient needs “face-to-face” within 90 days before SOC or within 30 days of SOC

**Criteria for COVID and/or Chronic Disease Mgt. Escalation**
- Green: no action needed
- Yellow: Contact patient & Case Mgr, triage/educate/determine needs
- Red: contact Patient & Case Mgr, initiate visit

- PCP and/or APP contacted for escalation decision, further orders.

**Communication Loop PCP**
- No further skilled need

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