BRIDGING GIPS IN THE CONTINUUM OF CARE THROUGH LOCAL PARTNERSHIPS

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THE STORY BEGINS WITH A CHRONICALLY-ILL PATIENT BEING DISCHARGED AFTER MULTIPLE HOSPITALIZATIONS

PCP SAYS: "WHAT WE NEED IS A CARE DELIVERY TEAM THAT CAN HELP MANAGE SYMPTOMS OF CHRONICALLY-ILL PATIENTS ACROSS THE CONTINUUM OF CARE. I AM REFERRING YOU TO NTSP'S PALLIATIVE CARE PROGRAM." THE PATIENT DIAGNOSED WITH CHF ENTERS THE CLINIC - BASED PALLIATIVE CARE PROGRAM AND IS MET BY A PHARMACIST WHO COMPLETES MEDICATION RECONCILIATION . . .

... SOCIAL WORKER DISCUSSES GOALS OF CARE, COMPLETES ADVANCE CARE PLANNING, HELPS COORDINATE CARE AND PROVIDES DISEASE EDUCATION.

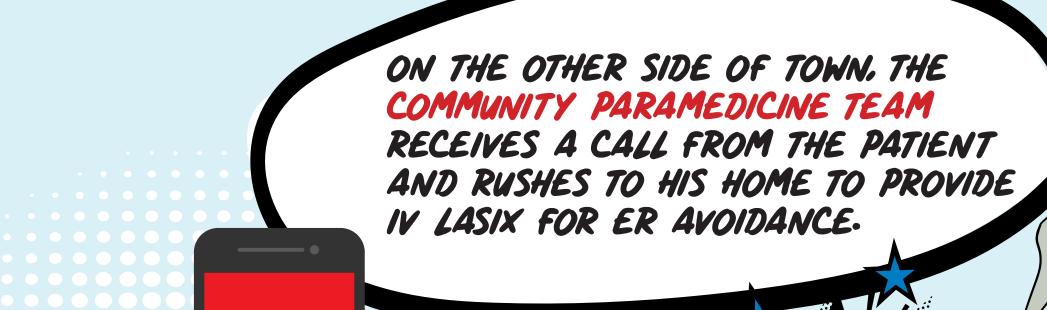
MEANWHILE, THE PATIENT'S SYMPTOMS ARE WORSENING AND REQUIRE FREQUENT MEDICATION ADJUSTMENTS; NEW DIAGNOSES OF COPD AND CKD ARE MADE. THE PATIENT IS SEEING THE PCP FREQUENTLY AND IT'S BECOMING MORE DIFFICULT FOR THE PATIENT TO COME TO THE CLINIC TO SEE THE PHYSICIAN.



SOCIAL WORKER SAYS: 'I KNOW
YOU WANT TO FEEL BETTER. AND I
KNOW YOUR WIFE NEEDS HELP. SHE
THINKS YOU WOULD BENEFIT FROM A
WALKER. I THINK THE HOME-BASED
PROGRAM IS WHAT YOU NEED.''

BACK AT THE HOME-BASED PROGRAM, THE NURSE PROVIDES PRIMARY SYMPTOM MANAGEMENT, VISITS ARE MADE BY A CHAPLAIN, SOCIAL WORKER, NURSE PRACTITIONER AND PHYSICIAN. THE 24/7 URGENT ISSUES HOTLINE IS ACTIVATED.

...THE CARE DELIVERY TEAM CONTINUES TO VISIT THE PATIENT AND AFTER 1 MONTH OF STEADY DECLINE IT IS DETERMINED THAT AN INCREASE IN PAIN CONTROL MEDICATION IS NEEDED. THE TEAM ALSO EVALUATES THE PATIENT'S GOALS OF CARE, AND POSSIBLE NEED FOR HOSPICE, AND AGREE TO DISCUSS THIS REGULARLY.



TO THE RESCLE

FOR THE FORESEEABLE FUTURE, THE PATIENT CONTINUES TO RECEIVE VISITS FROM THE CARE DELIVERY TEAM AND THE PHARMACY IS CONTACTED TO PROVIDE IM LASIX AND STEROIDS TO HELP PREVENT HOSPITALIZATIONS.

AFTER IMPLEMENTATION,
63% OF PATIENTS ENROLLED IN
THE PROGRAM FOR MORE THAN
ONE MONTH RESULTED IN A 27%
PMPM DECREASE IN PART A AND
B MEDICAL EXPENSES.

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THE STORY CONTINUES ...