Disease Management Program

Reducing Avoidable Re-hospitalizations and Promoting Self-Management

- Multidisciplinary Team: RN, PT, OT, ST, MSW, Home Health Aide
- Transitional Care:
    - Hospital to Home Care
        - Admitted to our services within 24 hours of hospital discharge
        - Front-loading Skilled Nursing visits
    - Home to Primary Care Physician (PCP)
        - Early follow-up appointment with PCP following hospital discharge
        - SBAR Communication
- Patient Education
    - Standardized Disease Specific Teaching Guides
    - Emergency Plan “Red Flags”
        - RN On-call 24 hours/day
        - “Call the Nurse First” Campaign
    - Disease Specific Zone Tools and Symptom Management
- Medication Management
    - Reconciliation and Review, Teaching, Adherence
- Self-Management Support
    - Motivational Teaching/Coaching
    - Telemonitors
        - Daily Vital Signs, Oxygen sats, Weights, and Trending
        - Telephonic visits and outcome trending by RN