THE MANAGEMENT OF COMPLEX PATIENTS ACROSS THE CARE CONTINUUM

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THANK YOU CMSNE FOR HAVING US TODAY TO SHARE OUR EXPERIENCES

We have no real or perceived conflicts of interest related to this presentation.

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AGENDA:

Provide overview of MGB strategy

Review of inpatient hospital teams

Description of Transitional Case Management team

Discuss Ambulatory CARE compass team

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OBJECTIVES:

1) Outline 2 essential responsibilities of the inpatient case manager that encourage collaboration across the care continuum.

2) Describe 2 important outcomes of the post acute transition care manager's collaboration with the SNFs

3) Name 2 outcome goals for the CARE Compass model

HOSPITAL CLINICAL SOCIAL WORK AND NURSE CASE MANAGEMENT AT MGB

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MASS GENERAL BRIGHAM STRATEGY

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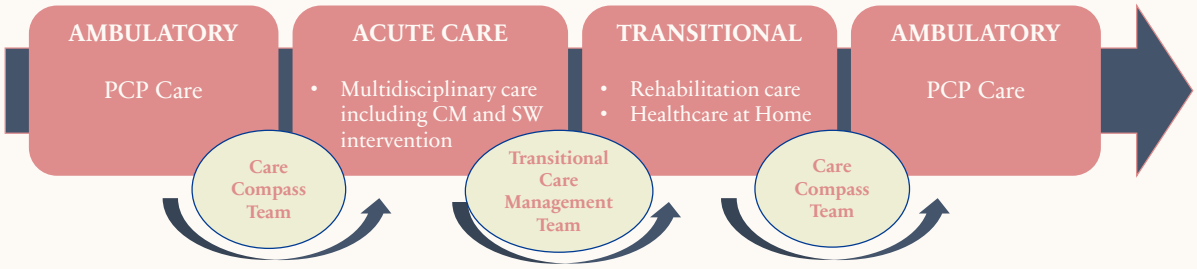
Care Continuum Management is an integrated approach that aims to provide seamless and coordinated healthcare services across various settings and stages of a patient's life.

- The integrated approach includes population health principles and is guided by best practice research and professional association's standards of practice
- Emphasis on collaboration among multidisciplinary team members, the patients, and caregivers to ensure high-quality, patient-centered care that meets individuals' unique needs.
- The goal is to achieve superb health outcomes, reduce healthcare costs, optimize reimbursement, ensure timeliness to patient progression across care transitions, and enhance patient experience by minimizing gaps and redundancies in care delivery.

CARE CONTINUUM

BUILDING BRIDGES TO CONNECT THE HIGH-RISK, TRANSITIONAL POINTS TO MAXIMIZE QUALITY AND MAKE FISCALLY-RESPONSIBLE DECISIONS



HOSPITAL CASE MANAGEMENT AND SOCIAL WORK DEPARTMENTS

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- Social workers and Nurse CM Locations: Emergency department, observation units, inpatient units, PACU, cover procedural areas if needed

- SW roles unique to clinical SW, RN case management roles unique to RNs, both separate assignments based on location in the hospital (unit-based):
  - Active participation and/or leading multidisciplinary rounds
  - Unit/service line focus on unit, regionalization of patients upon admit
  - Team approach to quality improvement, efficiencies, and patient satisfaction
  - SW consult-only structure, RN CMs cover all patients on unit
  - MGH and BWH have small group of SW & CMs for specialty, complex long stay patients (referral-based)

HOSPITAL CASE MANAGEMENT AND SOCIAL WORK DEPARTMENTS

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- Unique support roles including (depending on size and location) : case management assistants, social work assistants, community health workers, educators, data analysts, administrative assistants, and project management support
- Utilization Management is centralized at the MGB system level within the Care Continuum scope, works closely with Revenue Cycle
- All departments reporting through individual hospital, local leaders. Close relationships with operations, nursing, quality, financial services, digital, patient access, legal, risk, spiritual care, patient flow leaders, therapy, physician groups, and other multidisciplinary teams

SW AND CM TEAM MEMBERS FOCUS ON ADVOCACY (CMSA STANDARD E) :

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Getting to know the patient through thorough conversation, reviewing their history, visual observation, discussion with multidisciplinary team

Discover what is important TO THE PATIENT to design a unique care plan, including social drivers of health.

"Creative problem solving, persistence, and a willingness to challenge existing policies are often necessary to ensure the patient's needs are met holistically" (Brusio, 2025, p 27)

SW AND CM TEAM MEMBERS FOCUS ON FACILITATION, COORDINATION AND COLLABORATION (CMSA STANDARD M) :

- The key link to those three actions is effective communication, especially with a large group of multidisciplinary team members in a fast-paced, intense environment (Bruner, 2025).
- Requires continuous learning to understand what is available for each individual patient to facilitate options. "Facilitate: make something possible (Bruner, 2025,p 25)."
- Demands complicated care coordination, and extensive collaboration with hospital team, external teams, patient, and family/caregiver.

POST-ACUTE CARE MANAGEMENT INPATIENT TCM AND SNF TCM ROLES

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MGB CCM EXECUTIVE DIRECTOR, COMPLEX CARE AND CARE CONTINUUM

CARE CONTINUUM

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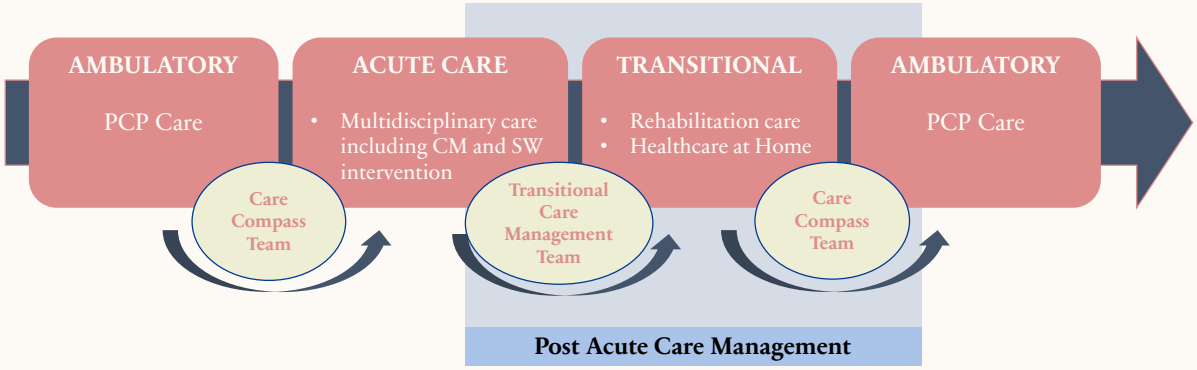

POST ACUTE CARE MANAGEMENT (PACM)

Purpose

- Ensure safe, timely, and coordinated transitions for Medicare ACO and TEAM patients moving from hospital to post-acute settings, promoting optimal recovery and reducing avoidable utilization.

PACM Program Overview

- The PACM program includes Transitional Care Managers (TCMs) supporting both inpatient and skilled nursing facility (SNF) settings.
- Currently, SNF TCMs provide oversight and coordination across SNFs in MA & NH.

PACM PROGRAM

Enhancing Quality of Care & Optimizing SNF Utilization

- Ensure the *right care* is delivered at the *right time* at the *right place*
- Promote safe discharge home
- Leverage the Collaborative Networks
- Reduce SNF length of stay
- Lower hospital readmissions

Role of the Transitional Care Manger

- Ensure continuity across the care continuum
- Serve as patient & family advocates
- Apply LOS decision support tools
- Facilitate smooth transitions of care
- Foster SNF partnerships

INPATIENT TCM ROLE

Hospital Admission

An inpatient TCM role to strengthen transitions and care coordination by:

- Enhancing interdisciplinary collaboration with hospital teams for safe discharge home
- Facilitate post-acute care planning via the SNF Collaborative Network
- Identify high-risk patients early to proactively address complex care needs leveraging the AM-PAC score.
- Ensuring warm handoffs to SNF TCMs
- Connecting patients to ACO resources (e.g., Care Compass referrals, frontloaded VNA, and community supports)

AM-PAC – Activity Measure for Post-Acute Care
6 Question assessment of the patient's current mobility status at the time of assessment is performed (i.e. not their pre-hospital baseline).

SNF TCM ROLE

SNF Admission

TCM role at collaborative SNFs:

- Partner with SNF teams to ensure delivery timely, high-quality care including weekly rounds
- Utilize length of stay prediction tools to monitor SNF progress, address discharge barriers, and guide appropriate care transitions
- Conduct weekly onsite SNF visits to meet patients and interdisciplinary teams
- Advocate for patient needs across care settings
- Strengthen collaboration between SNFs and providers for seamless transitions
- Connecting patients to ACO resources (e.g., Care Compass referrals, frontloaded VNA, community supports)
- Conduct post-discharge follow-up calls after discharge home from SNF

BENEFITS OF COLLABORATIVE SNF NETWORK MEDICARE ACO PATIENTS

Post-Acute Care Management Program

- Coordinated Care
- On-site patient visits at SNF
- Weekly rounds with SNF Teams
- Enhanced communication with PCP
- Access to ACO Resources

Shorter SNF Length of Stay

- **Support shared goals and drive timely discharges**

Higher Quality and Safety

- **Collaboration with SNF with ongoing performance monitoring**

Supports Value Based Care

- **Support shared goals and drive timely discharges**

SNF CASE STUDY

History:
68-year-old female with metastatic breast cancer and brain metastases, admitted to Inpatient Hospital for failure to thrive, weight loss, weakness, and poor oral intake. Discharged to a skilled nursing facility (SNF) for diet optimization and rehabilitation.

Barriers:
- Cognitive impairment due to brain metastases and anxiety.
- Limited social supports; lives alone with intermittent help from nephew and resistant to adding additional home support.

TCM Interventions:
- Met with patient at SNF, attended care plan meeting and ensured 24/7 private pay support was arranged before discharge.
- Post-discharge identified that patient had cancelled 24/7 support and was in an unsafe environment. Leveraged established trust to engage family and arrange interim support.
- Coordinated care with Primary Care, Oncology team, and home care to address safety concerns, ensure medication management and to bridge gaps in care.
- Provided ongoing guidance to nephew, connected him with assisted living options, and expedited paperwork with Primary Care for next day admission.
- Facilitated conversation with Oncology team and patient to align with patient's goals and cancer progression, leading to a hospice referral.

Patient Outcome:
- Established trust enabled early identification of unmet needs post-discharge, allowing for rapid coordination of support, transition to a safer environment, and hospice care.

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CARE COMPASS

Maryann Vienneau, Director Clinical Operations,
Population Health Services Organization

CARE COMPASS

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We are transforming into a new redesigned program for complex care management

CARE Compass:

Guiding complex care toward better outcomes — and more days at home

CARE Compass will embody the following principles:

- Coordinating wraparound care
- Anticipating and acting on risk
- Reducing readmission and admission risk
- Enabling stability at home

WHAT CARE COMPASS WILL DO

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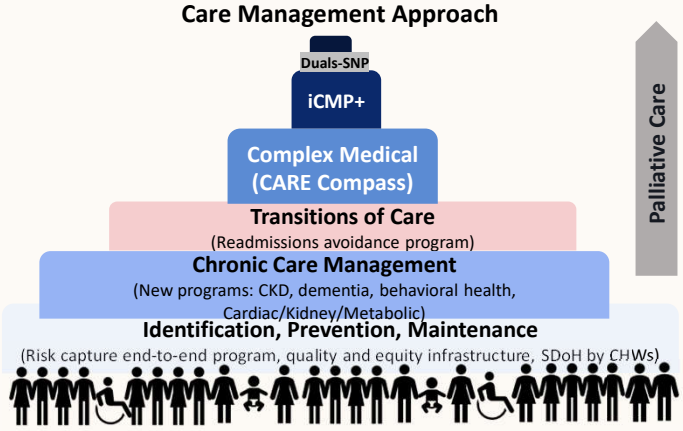
CARE Compass uses an ambulatory, team-based , regional model for coordinating complex care management delivering a more agile, responsive and scalable approach that will:

- **Improve patient outcome**s by proactively managing chronic and complex conditions across ALL care settings. "CARE Compass teams will "**Meet** patients where they are" both figuratively and literally, including primary or speciality care, ED, inpatient and at home
- **Expand patient access** by increasing our team's capacity to serve a broader pool of high-risk patients over a larger geographic area
- **Enhance quality and reporting** with standardized workflows, shared goals and stronger performance tracking.
- **Ease the burden of our entire system** by better supporting our primary care clinicians, reducing inpatient admissions, and alleviating capacity challenges.

MGB PHSO NEW VISION FOR CARE MANAGEMENT

Intervene earlier to **slow our patients' progression to the complex medical stage**

A More Comprehensive and Scalable Care Management Approach



650,000+ Patients in Risk-Based Contracts

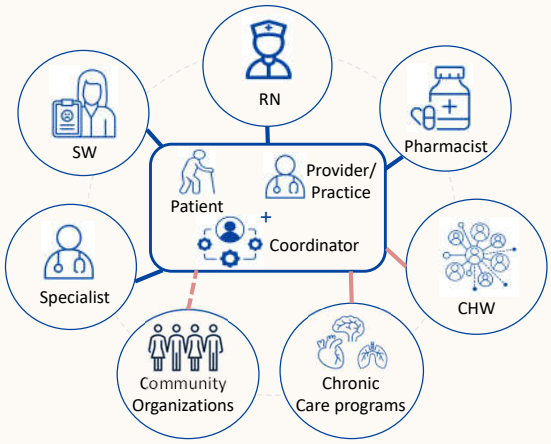
How we will achieve our vision:

Transform our programming to support chronic care interventions

- **Better identify patient needs** via risk documentation
- **Engage in health maintenance** via our quality strategy
- Follow/**stabilize patients during transitions of care**
- **Preserve iCMP for the medically complex** and take a tailored approach for dual eligibles
- **Better integrate goals of care**

TEAM-BASED CARE MODEL

CARE Compass



Coordinator: patient quarterback; admin tasks, regular patient outreach and follow up

RN: Clinical assessments, PDAs, care plan creation, ED diversion , medication management, education, symptom management, quality gaps

SW: Behavioral Health assessments, ED diversion, symptom management, SICs

Pharmacist: med review, medication titration (CMTM), medication reconciliation, education

CHW: SDoH gap closures, address social barriers

Daily Team Based Collaboration

Patient list review
- Chase list/referrals
- Clinical Team: clinical chart review

Care Plan Management
- Update provider on patients' status (critical milestones or regular updates)
- Review and update progress to roles

Post-Discharge Workflow:
- Initial Call
- Weekly follow-Up calls

Patient activity/outreaches
- New patient outreach
- Real-time ED/Inpatient collaboration
- Clinical team outreach, e.g. home, telephone , office
- Follow-up reminders and appointment confirmations
- SDoH follow up

Huddles
- Pre-Daily Huddle: perform clinical prep
- Daily Huddle: address urgent issues
- Share updates, barriers, and successes
- Weekly Huddle: new patients and reassessments
- Monthly Huddle: In-depth patient review

Documentation and task review
- Update care plans, PCC notes
- Flag patients for reassessments and additional support
- Review task list to prep for next day
- Prepare for next daily huddle

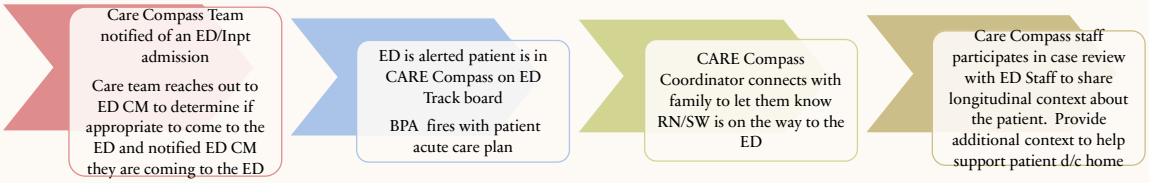
CORE CARE MANAGEMENT LEVERS (FRAMEWORK)

Each lever can operate **pre-event, at-event, or post-event**

FIVE CATEGORIES:

Clinical Optimization	Rapid Access and Care Substitution	Care Transitions & Post-Discharge Support	Real-Time ED Interventions	Behavioral, Social, and Activation Supports

HIGH LEVEL VISION FOR ED AND IP ENGAGEMENT WITH CARE COMPASS



When patient discharged home from the ED, Care Compass team takes point to follows up with patient to complete a post discharge assessment to ensure patient has a follow up appointment with provider, home supports as outlined in the post discharge plan developed by ED/Inpt CM.

Care Compass team outreaches to patients weekly via phone or home visit to ensure stability and reduce the risk of readmission.

ED/INPT COLLABORATION: A PATIENT STORY

- **Patient Snap Shot**
- Paranoid schizophrenia, HTN, obesity
- Newly diagnosed testicular cancer
- Unemployed, inconsistent psychiatric engagement
- Lives with uncle; aunt is activated HCP
- Enrolled in CARE Compass (iCMP) since 10/2024
- High risk for readmission
-
- **Acute Event 11/28–12/2/2025**
- Cancer Center referral → inpatient admission with ICU stay
- High risk for medical, psychiatric, and social destabilization post-discharge

CARE Compass in Action

- **Proactive, coordinated intervention across settings**
- **Inpatient ↔ CARE Compass SW**
  - Inpt CM and SW real-time connection at d/c
  - Activated HCP and engaged family
  - Coordinated Social Security and community supports
- **RN Follow-Up**
  - Addressed post-discharge medical concerns (e.g., rash)
  - Reinforced outpatient follow-up
- **CCC Administrative Support**
  - Ensured PCP and insurance alignment
  - Closed logistical gaps that often derail care
- **Cross-Team Collaboration**
  - Inpatient, Cancer Center, and CARE Compass SW aligned
  - Transportation arranged to oncology
  - Joint outpatient follow-ups secured
  - Family encouraged to attend visits

Outcome

- **1 inpatient admission** (11/28–12/2/2025)
- **1 brief ED visit** (Cancer Center–directed)
- **No readmissions**

Remarkable community stability given extreme medical and psychosocial risk

Without CARE Compass…
Likely trajectory without coordinated intervention:

- Fragmented discharge planning
- Missed oncology and primary care follow-ups
- Medication non-adherence and psychiatric destabilization
- Family unclear on decision-making role
- ED used as default access point
- **High likelihood of rapid readmission**

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FINAL TIPS & TAKEAWAYS

- Intervene early and often- before a clinical crisis, when possible, meet the patient where they are
- Cross team collaboration through verbal handoff, electronic exchange, and alignment is key
- Close the loop across transitions- be proactive and intentional with bi-directional communication between teams especially during discharge
- Identify and address social and behavioral drivers, consider them first order risks
- Clear documentation of the what and the why to enable shared understanding and continuity

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Bruner, E. (2025). Standard M: Facilitation, coordination, and collaboration. *CMSA Today, 8*. 24,25, & 29.

Brusio, M. (2025). CMSA Standard of professional case management practice- Standard E: Advocacy. *CMSA Today, 6*. 27-28.

Centers for Medicare and Medicaid Services (2025). *TEAM (Transforming Episode Accountability Model)*. https://www.cms.gov/priorities/innovation/innovation-models/team-model

Slide 29

VM1 [@Barry, Kimberly A., RN] and [@Escobar, Trancy B.] - started a few takeaways , assuming we will discuss this morning.
Vienneau, Maryann M., 2026-01-12T12:55:58.362

THANK YOU!