uds ACMS

Advanced Care Management Solutions

Referral Made to UDS ACMS

Web: www.udservices.org/ACMS
Email: advancedcaremanagement@udservices.org
Phone: 717-286-0258

Intake Department
Response Within 1 Business Day

ACMS Care Management Team* meets with referring partner

Follow up visit by care manager scheduled in hospital setting

- SDoH assessment completed
- Individualized plan of care based on SDoH needs identified
- Internal UDS referrals as needed – wound care, home modifications, home care, etc.
- Goals identified
- Discharge plan of care identified

Discharge planning meetings scheduled to review patient(s) as deemed necessary by referring partner

Patient Discharged

Short Term SNF

- Supported by ACMS
- Collaborate with staff at SNF plan of care and behavioral plan
- Continue to follow in community setting after discharge

Long Term SNF

- Supported by ACMS for 3 months
- Collaborate with staff at SNF plan of care and behavioral plan
- Monthly site visits

Community Setting

- Supported by ACMS for 6 months
- Collaborate with patients support system to continue plan of care to meet long term goals
- Community Referrals
- Provide necessary education – medication management, fall prevention, etc.
- Wound Care program follow up (if applicable)

ACMS team includes: CRNP, Wound Care RN, Care Managers, Intake Coordinator