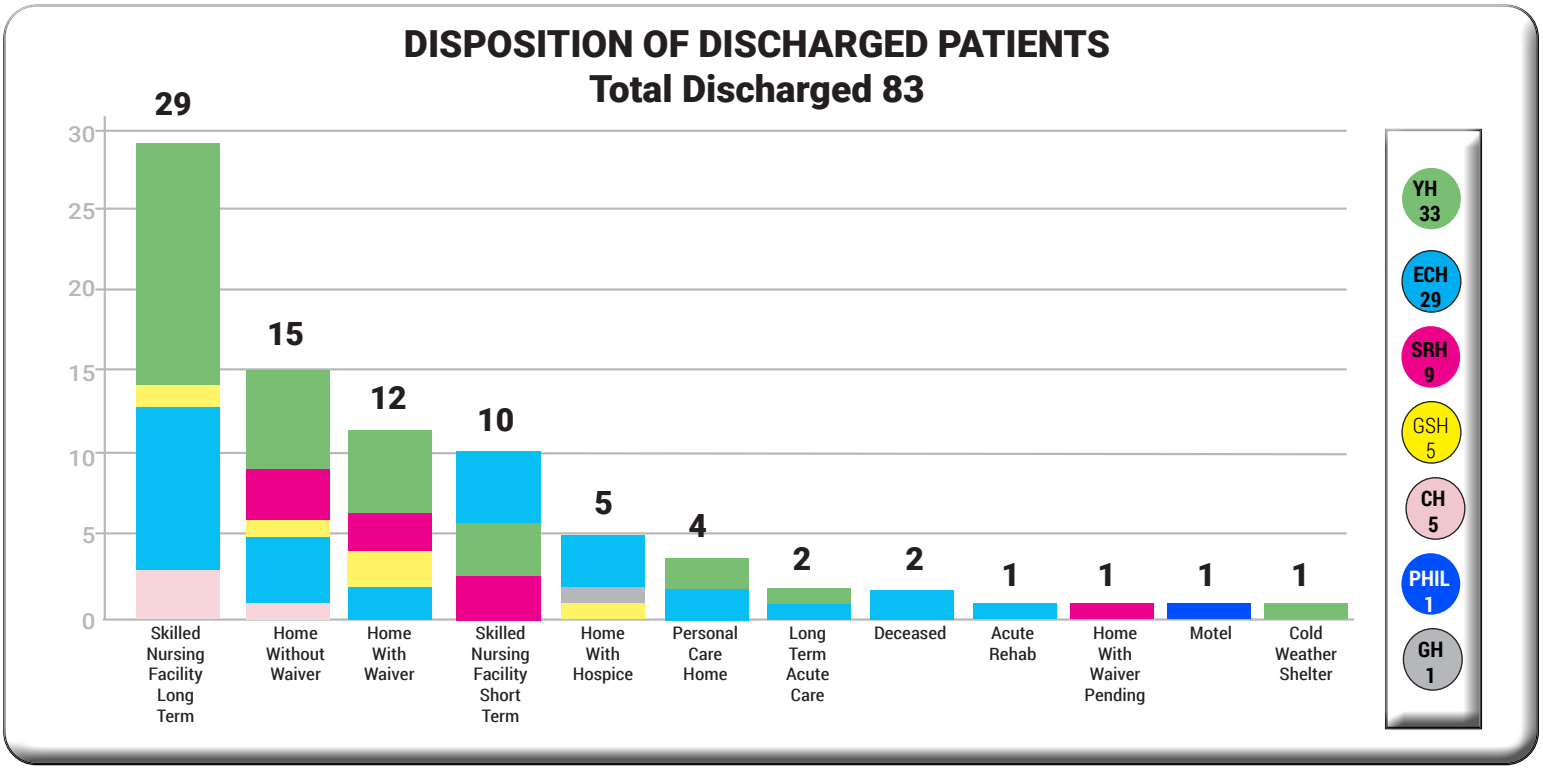
uds ACMS
Advanced Care Management Solutions

Wellspan Annual Metric Review
July 2022 through June 2023

	# Referrals	# Referrals w/ Serious Mental Illness/Dementia	Average Length of Stay Admit to Referral	# Hospital Discharges	Average Length of Stay Referral to Discharge	30 Day Re-Admit to Wellspan
Chambersburg Hospital (CH)	5	3	92	5	44	0
Ephrata Community Hospital (ECH)	25	19	15	29	28	1
Gettysburg Hospital (GH)	1	1	574	1	12	0
Good Samaritan Hospital (GSH)	6	3	19	5	42	0
Philhaven Mt. Gretna (PHIL)	1	1	302	1	51	0
Surgery Rehab Hospital (SRH)	11	7	58	9	24	1
Waynesboro Hospital (WH)	0	0	0	0	0	0
York Hospital (YH)	38	24	44	33	41	4 *
	87 **	**58**	**48**	**83**	**34**	**6**

* Number includes 2 patients with multiple readmissions

** Referrals 6/22/22 - 7/1/22 not included in this report



- There was a 28% improvement on length of stay after referral to ACMS.
- Independent waiver enrollment can take 3 - 6 months. With ACMS involvement, waiver enrollment typically takes 4 - 6 weeks (one patient took only 15 days to enroll into waiver). ACMS Care Managers continue their eligibility to act as Service Coordinators for select MCO's allowing for the period from waiver enrollment to services started to be greatly improved.
- MCO's require initial assessments to be done within 10 days; ACMS is able to do initial assessments next day with authorizations confirmed within the first 10 days.
- Admissions to SNF Long Term are after hundreds of referrals sent electronically by the hospital. The personal approach and connections from ACMS facilitate these transfers which were not possible when sent electronically.

UDS ACMS - CASE STUDY

Patient Profile

- 20 year old male involved in a motorcycle accident which left him paralyzed and in a wheelchair. Prior to the accident, he was living in a group home organized by Children and Youth of Lancaster County.

Hospital Treatment

- Patient was referred to UDS ACMS after being in the hospital for 142 days following of intensive rehabilitation in Philadelphia for a complete thoracic spinal cord injury.

Discharge & Placement

- Prior to the accident, the patient was living in a group home organized by Children and Youth of Lancaster County. He could not return due to his needs, and he was unable to live with his father, who was also disabled. Due to his age, his recent refusal of therapies and the amount of hardware in his back as a result of the accident and recovery, it was very hard to find accepting skilled nursing home placement.
- ACMS started the housing search by referring him to the 811 program. Upon meeting with the ACMS care manager, a rapport was established. The Care Manager explained to the patient the process of nursing home transition with the waiver program, and the focus switched from finding housing to, again, working to find short-term placement in a skilled facility with the goal of returning to the community.

- ACMS began the waiver enrollment process, social security disability application and updated his information with the 811 program.
- ACMS was able to find an accepting facility within 4 days and obtained a private room for the patient. They were also able to obtain the staff Wi-Fi password, Wi-Fi extender a SD card which allowed the patient to use his PS5, his favorite past time, effectively.
- The Care Manager acted as liaison with the patient and facility physical and occupational therapists to have the patient agree to the testing needed in order for him to leave the facility. Eventually, he progressed to where he was awarded the privilege of leaving the facility whenever he wanted. The Care Manager empowered the patient to engage in his own 'adulting' behavior and started to line up things for his discharge into the community.
- Patient regularly checked on his SSDI application, the status of his waiver enrollment, went through his mail, and with the help of his Care Manager, set up a PA ABLE account where he moved his SSDI money when it was awarded.

Community Integration

- Through updating his 811 application, it was learned he was at the top of the list for an apartment and chose an accessible apartment in Lancaster City.
- The Care Manager worked with the patient to assist with signing the lease, starting utilities for his apartment, making sure he had the medical equipment and supplies he needed, as well as assisting the assigned Service Coordinator in finding caregivers.

- The patient was discharged from the skilled nursing facility to his home in the community where he is living independently with waiver supports. He is looking forward to continuing his therapies through outpatient options.
- He wants to go back to school for automotive education and was introduced to OVR to assist in reaching this goal. He is looking forward to working and continuing to thrive in his community.