Care Continuum

Hospital

Ted has an asthma attack and goes to the ED.

This is Ted. Ted is an 8 year old with diabetes and asthma.

Community health worker visits Ted's home to assess for possible asthma triggers and refers patient to Care Management Program.

In the ED, the provider is aware that Ted has already been to the ED five times this year for his asthma. The provider decides to admit Ted. Once admitted the nurse case manager reviews Ted's chart and refers Ted to the Care Management Program.

Ted's family has several barriers to care. Ted's mom is a single parent, and has one younger child. She is underemployed and currently works two part-time jobs, requiring her to leave Ted and his sister with friends and relatives. They have a vehicle, but it breaks down frequently and gas money is always tight.

Home

Care manager assists Ted's mom in providing support for community resources such as obtaining medication. Since pharmacy is closed when mom is off, care manager arranges for delivery of medications. Care manager also calls LogistiCare and shows mom how to arrange for transportation. Care manager connects Ted's mom with other community support services that may be of benefit.

Pharmacy

Care coordinator identifies patient as eligible for Care Management Program and refers patient.

Care manager meets with Ted and his mother together to discuss the benefits of the Care Management Program. Ted's mother agrees to enroll Ted in the program.

Community Resources

Asthma specialist identifies patient as eligible for Care Management Program and refers patient.

Care manager develops a care plan with Ted and his mother and sets them up on Nemours app so they can view patient portal and do telehealth visits. Care plan is shared with patient, provider, specialist and school nurse.

School nurse meets with Ted and refers Ted to Care Management Program via NemoursLink.

Care manager has frequent communication with Ted's primary care provider and care coordinator in the practice to inform them of Ted's progress to goals and any barriers that may exist. Care manager will provide a smooth discharge back to care coordinator once Ted successfully completes Care Management Program.

Care manager calls Ted and his family on a weekly basis to provide any assistance with progress on Ted's goals working to achieve self-management of his condition.

Care manager communicates with school nurse on Ted's plan for care management to ensure Ted has the needed support in school. This will assist Ted in taking needed medication and avoiding triggers while at school.

Clinic/Primary Care Office

School