BJC Accountable Care Organization

Better health. Better health care. Better value.

Inpatient/ED Care Coordination Guidelines for BJC ACO 3 Day SNF Waiver Patients

a. ACO team/inpatient care coordination team communicate when potential SNF waiver patient is identified from the daily ACO Admission report
b. **ACO CM/SW confirms eligibility (Patient, Provider, SNF) and determines appropriateness**
c. Inpatient care coordinator will provide SNF waiver education material and affiliate SNF list to patient/family after patient approved for SNF waiver
d. Referrals will be sent to 3 SNF waiver affiliates via Allscripts
e. Inpatient attending physician to communicate with ACO Physician to discuss and confirm appropriate assessment/diagnosis/treatment plan
f. Inpatient Care Coordination team will fax Individualized Care Management Plan to ACO Physician to be completed and signed
g. Once Individualized Care Management Plan has been returned to inpatient care coordinator, discharge plan can be finalized with patient, family and SNF
h. Inpatient care coordinator will fax the completed Individualized Care Management Plan to the ACO team and SNF prior to transfer
i. Transfer patient when stable

Please ensure that the BJC ACO team has been contacted prior to transferring the BJC ACO patient

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