Mayo Clinic Care Management: Collaboration Across the Continuum of Care

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Purpose: Describe Mayo Clinic's Care Management model including how collaboration and communication across the continuum of care are necessary to provide whole-person care to patients before, during, and after their hospital stay.

The Mayo Clinic Care Management model ensures patients are assessed for health, psychosocial, and discharge needs; and are provided the right care, in the right setting, in a timely manner. This model utilizes a multidisciplinary approach to assess patients and ensure all needs are met, and supports strategies to prevent unnecessary hospital days, readmission, and insurance denials.

Discharge planning starts at admission. Initial assessments are made to determine care, treatment and services that will meet the patient's initial and ongoing needs. Collaboration with the patient and family is crucial to develop a plan of care. Ongoing needs are reassessed throughout the episode of care and continual education for the patient and patient's family is conducted. Referrals for follow up care are made as needed to ensure the patient is successful upon discharge.

Some patients have complex medical, psychosocial and discharge needs. Having a multidisciplinary team to coordinate care to meet the needs of the patient is critical.

Conclusion

- The Mayo Clinic Care Management team consists of master level prepared social workers and case manager registered nurses
- Through collaboration and teamwork, the Care Management team supports patients throughout their hospitalization and ensures the patient's needs for continuing care, treatment, or services post-discharge are addressed.