Care Alert Sprint
In-Person Working Meeting

April 26, 2017

COLLABORATIVE HEALTHCARE STRATEGIES

Maryland Hospital Association

Agenda

- Welcome, Objectives
- Session 1: Care Alerts
- Session 2: Workflow
- Lunch
- Session 3: Value, Expected Benefit
- Next Steps, Adjourn

Welcome

Objectives

Connecting to Purpose

Session 1: Key Elements of Care Alerts

Purpose of Care Alerts

- Instantly accessible, succinct, need-to- know-NOW info on vulnerable patients, at the point of care
- Valuable advice/guidance/help, clinician- to-clinician, regarding complex patients we share across care settings and even different hospitals
- Care Alerts are a tool to:
  - Improve quality (better information)
  - Improve safety (reduce duplication, avoid harm)
  - Facilitate coordination (reduce fragmentation)
  - Save clinicians time
  - Reduce potentially avoidable utilization (unnecessary admissions)

Compendium of Care Alert Examples

Type 1: Notification of Care Management

- “This patient receives community-based care management to assist with housing, transportation and mental heath coordination. Her care manager is (name) RN who may be reached at (#).”
- “Client is participating in Transitions of Care Community Care Management. Her Care Coordination team is (name), RN and (name), HC. They can be reached at (#) Monday - Friday 9:00am- 4:30pm.”
- “Client is currently connected to My Sister's Place for long term case management. Case manager assigned is (name) at (#).”
- “Care Alert Created by (name & title), Care Team Member Email: (email) Care Team Member Phone #: (#) Date & Time: (date, time) Care Alert Additional Info: Patient is care coordinated by (name), RN at (org). Can be reached at (#). Pt followed by multiple specialist throughout the State of Maryland.”

Type 1: Notification of Care Management

Bravo/Cigna Healthspring Care Management Plan (template)

- This patient has BRAVO/Cigna-Healthspring Insurance. BRAVO/Cigna-Healthspring has a large collection of resources and a walk-in clinic for all of their patients. This patient has been designated a High-Utilizer by BRAVO and has access to their “Complex Care” services which include case management, social work, pharmacy assistance, transportation, and food during their visits. They would like to pick up this patients after each discharge in order to help them secure services.
- If patient presents during WALK IN CENTER BUSINESS HOURS (M-F 8a-6p, Sat 9a-4p) please do the following:
  - Clear the patient of any emergent medical condition
  - Call walk-in clinic charge nurse @443-257-2540 (cell) – CALL EVEN IF YOU HAVE “SOLVED” THE PATIENT PROBLEM
    - They will arrange for transportation (a van) to the walk-in center and then transport the patient home as well
    - Given them the security desk phone number to call when transport arrives – xxx-xxx-xxxx
  - Discharge the patient to waiting room to wait for transport
- If patient presents after WALK IN CENTER BUSINESS HOURS
  - Check for accuracy of patient’s address and telephone number
  - Have operator page the BRAVO hospitalist on call
    - Notify the of any barriers the patient is facing to getting care so that they can set up resources; they will arrange to have patient contacted and seen ASAPR. Transportation is provided.
  - Refer patient to the BRAVO walk-in center for future visits that are not life threatening (transport provided):
    - 312 N Martin Luther King Jr Blvd 2nd Floor Baltimore MD 21201 (Located behind Rite Aid on MLK Blvd and W Saratoga St xxx-xxx-xxxx

Type 2: Patient Care Resources

- “Patient lives alone, however family is very supportive. May benefit from home care. Plan is to consider JHHC. Son Kevin (#)”
- ”Client transitioned to new hospice facility, Gilchrist Hospice, on (date).”
- “Patient has been set up with Encompass HH. Becoming increasingly wheelchair bound- with MS. They have a home Hoyer lift.”
- “Patient 's home care Nurse is from Comprehensive Nursing services (#) (Nurse xx) (#) Weekly: CBC W/DIFF, BMP, ESR, CRP”
- Care Alert Created by (name & title, email) Date & Time: (date) Family/Social Dynamics: Patient / family do not agree on care plan - patient is competent to make own decisions. Critical Tasks (resources): patient is presently under Care Coordination within Patient Centered Medical Home at (org) by (name) RN; may contact (#).”

Type 3: Convey Chronic Baseline/Pattern

- “Mr. F is a gentleman who commonly dials 911 on weekends and holidays, noting shortness of breath. He does have COPD and his baseline, everyday physical exam is notable for wheezes and rhonchi. His CXR will show a LLL ‘infiltrate’ that has been stable for 15 years. Please call his PCP, Dr. C, on her cell phone (#) if you are contemplating invasive testing or admission. Please note patient can be (and often is) seen daily in her office, which is located in his apartment building. Please note he has low literacy skills and will not be able to comprehend written discharge or medication instructions.”

- “Mr. P is a diabetic who has frequent exacerbations of CHF, usually due to missed doses of medication or dietary indiscretion. He usually does well with 40 mg IV furosemide and close follow up the next day. Securely text Dr. Y to arrange follow up or discuss his case if you feel admission or further evaluation may be necessary.”

- “Patient is prone to sepsis related to his feet (diabetic ulcers) and has had septic arthritis in the past. This often presents as confusion and stroke like symptoms.”

Type 3: Convey Chronic Baseline/Pattern

- “Patient often gets septic with no clear source and then shows signs of cellulitis 24-48 hours later. He responds well to Vancomycin. If he comes in with sepsis, please cover for skin and soft tissue infection in addition to other potential sources.”

- “ESRD on hemodialysis. Noncompliance with dialysis at times, has open chair at XXXX. Usual days are Tu-Thr-Sa. CHF baseline: BNP >500. COPD: on home O2 at 3L. Chronic Pain: please verify reports of pain medication with patient’s pharmacy, none reported on CRISP.”

Type 4: Advisement for Management

- “Mr. Q is followed by Dr. D for pain management. Should his treatment plan involve the use of controlled substances, kindly text Dr. D at (#) to discuss the best course of action.”

- “This patient has been provided a management plan for chronic pain and medical needs. Patient with frequent visits for minor complaints. During business hours, please contact PCP, Dr D. who can see the patient in clinic. No prescriptions of any kind, including narcotics, non-narcotic pain meds, and medication refills, should be written for the patient from the ER unless these are for an EMERGENT condition. For anything else, she will need to see Dr. D. This should be explained to the patient at every visit. During business hours, please contact the CHW at (#) or at Care Transitions Liaison at (#) to see the patient in the ED to secure follow up care. After hours, please leave a message on the Care Transitions phone line at (#) so that a member of the team can follow up with the patient.”

- “Dr. (name) - pain management, (location).”

Type 4: Advisement for Management

COPD/Asthma Management (template)

- @name@ has been identified as a patient who appears to have difficulty managing their COPD/asthma in the community. It is recommended that:
  - If there is no specific objective criteria to admit or place in an observation status (such as low O2 sat or failure to space nebs), please try to discharge the patient if it is safe to do so
  - Please write orders for pre and post nebulation peak flows
  - Administer a long acting INTRAMUSCULAR steroid (such as Decadron) prior to discharge.
  - Give the patient an albuterol MDI for home; write for “2 puffs” of an MDI, the patient can take the inhaler home afterwards.
  - During business hours, please contact the Community Health Worker at 443-683-0565 or a Care Transition Liaison at xxx-xxx-xxxx to see the patient in the ED to secure follow up care. After business hours, please leave a message on the care transitions after hour phone line a xxx so that a member of the team can follow up with the patient.

This plan approved for this patient by the Care Coordination Committee, a multidisciplinary team of physicians, social workers, case managers, nurses, outcomes managers, health advocates, and other members of the patient care team, on (date)

Type 5: Chronic/Complex Care Update

- "Continuity of Care/Program Note Entered On: 04/11/2017 by (name) Continuity of Care/Program Program Notes : (patient name) PCP: (name) Insurance: Self-pay Care Coordinator: (name, #) Medical: 1. Confirmed sickle beta thalassemia by Hb electrophoresis on (date) at GW and right eye blindness. 2. No narcotics to go. No narcotics in ED unless clinically indicated. 3. Patient need psych eval for possible mental illness (not for SI/HI) and medication management after. Please hold patient until Psychiatrist can see patient. Please call Dr (name) or on-call Psych to come eval patient. 4. Avoid Benadryl and IV pain meds in ED unless otherwise indicated. 5 . Have Transitional Care follow patient upon discharge from ED to eval home situation and social situation. 6. Get patient cab from ED at discharge to location to identify location for follow up and document. 7. Have (name) come to eval patient. Please call (name) to work through insurance issues when holding for psych."

Type 5: Chronic/Complex Care Update

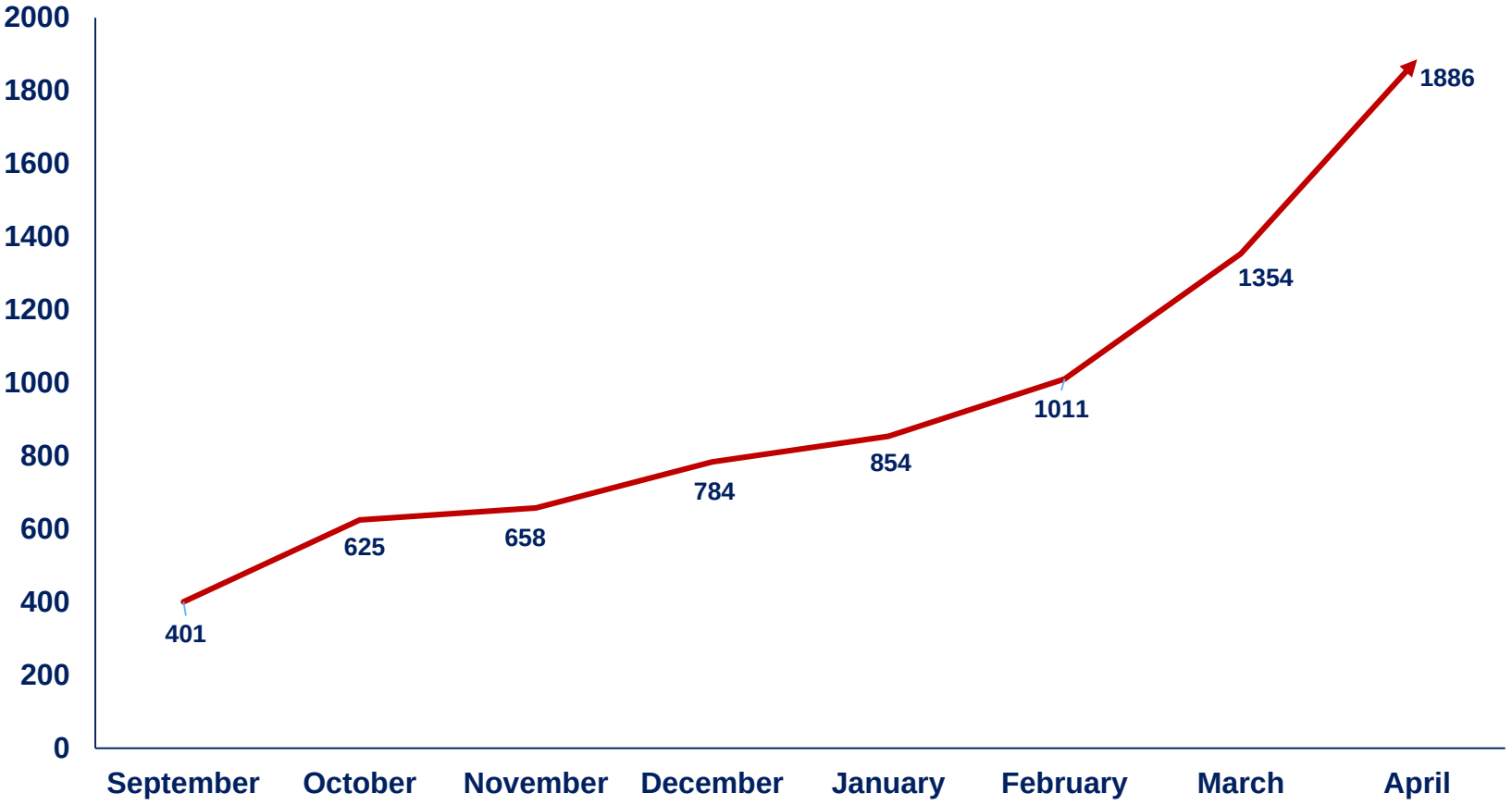
- “Patient is undergoing work up for suspected Stage 3 lung cancer. Please contact Dr. B on his cell (#) to discuss plan of care. Dr. B's office can administer patient IV hydration, usually same day appointments. You can reach patient's Care Manager, (name, #) to assist with any follow up care needs. Potomac Case Management is also following patient. Please try to coordinate prescription delivery with (name) Pharmacy on any new medications as pt will often not fill because he doesn't feel well enough to leave his home. CM dept. can assist with any co pay costs due to limited finances. Advanced Directives/MOLST on record.”

Key Elements Emerging in Examples

- ✓ Purpose of care alert
- ✓ Patient is high risk and/or part of an enhanced program
- ✓ Chronic / recurrent care seeking pattern
- ✓ Chronic clinical/behavioral baseline / complaint
- ✓ Recommended actions
- ✓ Key contact information

Session 2: Creating Care Alerts

Care Plans and/or Care Alerts in CRISP*



*Medicare FFS High Needs Patients

Models of Producing Care Alerts

- The Care Transitions / Population Health Team
  - Care Transitions/Pop Health teams develop care alerts for the patients (who need them) in their programs
  - **Benefit:** Component of care transitions/care management work
  - **Benefit:** Can measure what % of patients in CT/CM program have a care alert, using that to inform your process/progress
  - **Limitation:** Patients not known to or served by the program would not have a mechanism for having a care alert drafted

Models of Producing Care Alerts

- ”Clinical indication” approach
  - Any care provider can author (MD, care transitions, SW, etc)
  - **Benefit:** same concept as any note, “natural workflow”
  - **Benefit:** don’t artificially limit which patients get care alerts
  - **Limitation:** not as defined a workflow process; less able to define a “denominator” and measure % penetration, progress

Models of Producing Care Alerts

- "Worklist approach"
  - Generate a list of high utilizers, review chart, create care alert
  - **Benefit:** focus on HU, regardless of whether they are "engaged" or "enrolled" in care management program
  - **Benefit:** readily identifiable, quantifiable, can measure progress
  - **Limitation:** chart review approach, if not connected to real-time patient care may not be as efficient/effective as other models

Models of Producing Care Alerts

- "Committee approach"
  - Multidisciplinary committee manages process
  - **Benefit:** clear designation of authority
  - **Benefit:** high visibility in the organization, credibility
  - **Limitation:** production of high volume of care alerts may be limited if constrained by meeting schedule, time lag

Discussion: Producing Care Alerts

Thank you for your commitment to improving care for high needs patients & reducing PAU

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