Care Management Tools

- What are Care Management Tools?
  - Alerts
  - Dashboard
- Sample workflows for organizations using Care Management Tools
Care Management Tools: Why?

Are you looking for reliable notifications when all your patients are in the hospital, ED or SNFs?

With Care Management tools, you get:

• near real time updates
• from all RI acute care hospitals
• from Genesis skilled nursing facilities
• for your whole panel of patients
• all the time
How it works…

1. RIQI signs Business Agreements with organizations & with acute-care hospitals and SNFs

Hospitals & SNFs

RIQI

Care Management Services

Practices, ACOs

2. Subscribe to a Full Panel or a Selected Panel of Members

3. Receive Real-time Alerts and/or Dashboards for your panel
## Participating Facilities

### Acute Care Hospitals
- Hasbro Children’s Hospital
- The Miriam Hospital
- Newport Hospital
- Rhode Island Hospital
- Kent Hospital
- Women & Infants Hospital
- Memorial Hospital of RI
- Landmark Hospital
- Rehabilitation Hospital of RI
- Lawrence + Memorial
- Lawrence + Memorial Westerly
- Our Lady of Fatima Hospital
- Roger Williams Medical Center
- South County Hospital

### Skilled Nursing Facilities
- Coventry Skilled Nursing & Rehab
- Grand Islander Center
- Grandview Center
- Greenville Center Skilled Nursing & Rehab
- Greenwood Center
- Kent Regency
- Pawtucket Center Skilled Nursing & Rehab
- South County Nursing & Rehab Center
- Warren Center Skilled Nursing & Rehab

**NOTE:** This does not currently include Butler, Bradley, VA or DoD.
When your patients go to ED/Inpatient/SNF

RIQI Care Management Services

Patient visits ED, Hospital, SNF

ADT

Alerts

Real-time CM Alerts Received by Care Team

Practices, ACOs

Real-time CM Dashboards Available to Care Team

Dashboards
Near real time updates from RI acute care hospitals

NEW! The Lifespan CoC document is included as an attachment to Alerts

Screenshots contained in this document and on any training files do not contain Protected Health Information (PHI).
All data presented for training purposes has been randomly generated from databases of fictitious data.
Care Management Dashboards

Members Currently Inpatient or in the ER

Members Discharged in the Past 72 Hours

Inpatient and Emergency Admissions by Month

...... Data is updated every 45 minutes
## Unique CurrentCare ID #:

If the patient is enrolled, enter into CurrentCare Viewer for more info

<table>
<thead>
<tr>
<th>#</th>
<th>MPIID</th>
<th>Enrollment Status</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>DOB</th>
<th>Age</th>
<th>Gender</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>111000</td>
<td>Enrolled</td>
<td>Masako</td>
<td></td>
<td>Hillyer</td>
<td>1988-02-09</td>
<td>28</td>
<td>F</td>
<td>7626 Rock Creek St.</td>
</tr>
<tr>
<td>3</td>
<td>333000</td>
<td>Enrolled</td>
<td>Tabatha</td>
<td></td>
<td>Baeza</td>
<td>1944-02-12</td>
<td>72</td>
<td>F</td>
<td>840 SE. Oakwood Ave.</td>
</tr>
<tr>
<td>4</td>
<td>444000</td>
<td>Not Enrolled</td>
<td>Ettie</td>
<td>M</td>
<td>Maslowski</td>
<td>1964-02-11</td>
<td>52</td>
<td>F</td>
<td>8942 Cherry Drive</td>
</tr>
<tr>
<td>5</td>
<td>555000</td>
<td>Enrolled</td>
<td>Lavona</td>
<td></td>
<td>Fabela</td>
<td>1923-01-08</td>
<td>93</td>
<td>F</td>
<td>8348 Hillcrest Dr.</td>
</tr>
<tr>
<td>6</td>
<td>666000</td>
<td>Enrolled</td>
<td>Antione</td>
<td></td>
<td>Routt</td>
<td>1935-04-04</td>
<td>81</td>
<td>M</td>
<td>9552 South Bradford Avenue</td>
</tr>
<tr>
<td>7</td>
<td>777000</td>
<td>Not Enrolled</td>
<td>Moises</td>
<td></td>
<td>Eichler</td>
<td>1951-08-21</td>
<td>65</td>
<td>M</td>
<td>553 Riverview St.</td>
</tr>
<tr>
<td>8</td>
<td>888000</td>
<td>Enrolled</td>
<td>Paris</td>
<td>A</td>
<td>Eliason</td>
<td>1957-11-12</td>
<td>58</td>
<td>M</td>
<td>340 Redwood Street</td>
</tr>
<tr>
<td>9</td>
<td>999000</td>
<td>Not Enrolled</td>
<td>Mckinley</td>
<td></td>
<td>Stumpff</td>
<td>1939-11-03</td>
<td>76</td>
<td>M</td>
<td>8737 Shady St.</td>
</tr>
</tbody>
</table>
Assigned Room: If the hospital provides this, we can save time locating our patients.

<table>
<thead>
<tr>
<th>Provider First Name</th>
<th>Provider Last Name</th>
<th>StartTime</th>
<th>EndTime</th>
<th>Facility</th>
<th>Site</th>
<th>Assigned Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Salguero</td>
<td>2016-05-02 05:07:26</td>
<td>2016-05-03 07:31:26</td>
<td>LMK</td>
<td>Landmark Medical Center</td>
<td>LMC A11</td>
</tr>
<tr>
<td>Temple</td>
<td>Nowell</td>
<td>2016-05-03 22:15:10</td>
<td>2016-05-05 00:39:10</td>
<td>LMK</td>
<td>Landmark Medical Center</td>
<td>LMC A17</td>
</tr>
<tr>
<td>Ward</td>
<td>Salguero</td>
<td>2016-05-01 14:56:33</td>
<td>2016-05-02 17:20:33</td>
<td>SC HOSPITAL</td>
<td>South County Hospital</td>
<td>316</td>
</tr>
<tr>
<td>Marie</td>
<td>Fay</td>
<td>2016-05-03 23:56:33</td>
<td>2016-05-05 02:20:33</td>
<td>GENESIS</td>
<td>Grandview Center</td>
<td>N05</td>
</tr>
</tbody>
</table>
# ER/Inpatient Visits in 6 mo: did we know about these? Should this patient be high risk?

<table>
<thead>
<tr>
<th>Admit Reason</th>
<th>Admit Description</th>
<th>Referring Clinician</th>
<th>Discharge Location</th>
<th>Discharge Disposition</th>
<th>ER Visits 8 mo Total</th>
<th>Inpatient Visits 8 mo Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>painful urination</td>
<td>E</td>
<td>GOOD</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>alcohol withdrawal uncomplicated</td>
<td>I</td>
<td>SMITH</td>
<td>CNE Home Care VNA</td>
<td>6</td>
<td>90</td>
<td>2</td>
</tr>
<tr>
<td>LOW BACK PAIN, FEVER</td>
<td></td>
<td></td>
<td>HOME</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>ABD PAIN, BACK PAIN</td>
<td>ER</td>
<td>EDDY</td>
<td>HOME-HEALTH</td>
<td>26</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>RASH</td>
<td>ER</td>
<td>DOE</td>
<td>REHAB</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Sprain</td>
<td>I</td>
<td></td>
<td>HOSPICE</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>STOMACH LOWER BACK PAIN</td>
<td>DIS IN</td>
<td>SAD</td>
<td>HOME</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Vertigo</td>
<td>I</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>3 - Elective</td>
<td></td>
<td>VNA OF CARE NEW ENGLAND</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Drilldowns Include

- **Patient Demographics**
  - MPI ID (CurrentCare ID)
  - CurrentCare Enrollment Status
  - Patient/Client Name
  - Date of Birth
  - Age
  - Gender
  - Address
  - Phone Number
  - Provider Name

- **Encounter Information**
  - Health Care Facility
  - Site
  - Assigned Room
  - Encounter Start and End Time
  - Encounter Type (ER or Inpatient)
  - Admission Reason
  - Admission Description
  - Referring Clinician
  - Discharge Location
  - Discharge Disposition
  - Referring Clinician Name

- **Calculated Fields**
  - Number of ER visits within the past six months
  - Number of Inpatient visits within the past six months
Care Management Workflows

• Care Management Tools are *flexible*:
  • It is easy to modify a selected workflow

• **Common workflows**
  • Individual Alerts (Dashboard access for additional data)
  • Team/Centralized Alerts (Dashboard access for additional data)
  • Export from Dashboard
Craft Management Services Workflow: Dashboard Only

**Nurse (assigned to retrieve data)**

- **Daily:** Log in to the Care Management Dashboard
  - In the ‘Patients Discharged in the Past 72 Hours’ section, select any bar in the graph
  - Click the ‘Listing ALL’ button
  - Export to Excel using the Export button
  - Configure data for distribution to Team*

**Team (NOMs/Social Workers)**

- **Daily:** receive and review Care Management data via Excel spreadsheet
  - Is the patient currently in the hospital (ED/Impatient)?
    - Yes → Triage: Does Reason for Visit/Diagnosis warrant immediate intervention?
      - Yes → Provide immediate intervention/outreach to patient and hospital
      - No → Document in EHR as appropriate
    - No → Outreach, as appropriate, to patient for education and follow-up care
  - Document completed intervention/follow-up in EHR

*Excel configurations may include:
- Merging list with the previous list and removing duplicates
- Adding columns for entering additional data regarding assigned team member and/or documentation of completion of follow-up
- Hiding columns, as preferred, to condense document view
End Users are reporting that data from Care Management Tools is helping *improve care*:

“Having the Care Management Alerts increases the timeliness with which we can provide therapies to our patients. If we don’t know they have a problem, then there is nothing we can do. If we have *knowledge*, we can provide treatment.”

“The Care Management Dashboard creates a “just in time” opportunity for us. By having information about our patients’ admissions and discharges, we can connect with them *when they need us the most*. With the information we have from the Dashboard, we build *trust* and *engagement*.”