ST PETER'S HEALTH PARTNERS
Capital Region Health Connections

Health Home
2212 Burdett Avenue
Troy NY 12180
ph (518) 271-3301
fx (518) 271-5009
sphp.com

Care Transition Case Vignettes

CASE VIGNETTE: Greg

Greg enrolled with the Health Home program in October 2020. According to the Problems Tab, Greg is diagnosed with PTSD, Tourette's syndrome, Anxiety, Asthma, and Mononeuropathy of his limbs. The DOH 5055 lists the MCO-MVP, Samaritan Hospital, St. Peter's Health Partners, and PCP-Whitney Young. The Comprehensive Assessment identifies Greg is at risk of falls due to his diagnosis of neuropathy and does not take his medications as prescribed. The Assessment further indicates Greg would like to secure a Home Health Aide and find a job. Like the Assessment, the Plan of Care indicates Greg's goal is to connect with a Home Health Aide and explore career options in order to become more independent. Over the past year, Greg has visited the emergency department five times, with the two most recent hospital visits occurring in October 2021 and December 2021.

On October 18, 2021, according to Hixny documentation, Greg was brought to Albany Medical Center via ambulance after experiencing chest pain for about one week. Greg identified he believed the pain was due to gas and sought out urgent care services earlier that week for the same reason. The hospitalist advised Greg to take over-the-counter pain relievers as well as follow up with his primary care provider and gastroenterologist. Hospital records also indicate Greg is diagnosed with GERD and is prescribed Omeprazole to manage this condition.

The Care Coordinator responded to the Hixny alert as follows:

- The Care Coordinator responded on 10/20/2021 after receiving a Hixny alert indicating Greg was seen at Albany Medical Center.
- Note documentation indicates the Care Coordinator checked Hixny for documentation and uploaded to CareManager, however this was not evidenced in the chart. The Care Coordinator attempted to reach Greg and left a voicemail.
- On 10/28/2021, contact was made with Greg and note documentation identified "During the call the Member stated that the Member was doing well and that there was no concern to report." It appears the Care Coordinator took this information at face value and did not inquire about Greg's recent emergency room visit.

On December 17, 2021, according to Hixny documentation, Greg was brought to Albany Medical Center via ambulance with a complaint of chest pain. The hospitalist recommended Greg should follow up with cardiology within a week for further evaluation.

The Care Coordinator responded to the Hixny alert as follows:

- The Care Coordinator responded to the alert the same day Hixny records indicated Greg was seen at Albany Medical Center.

- The Care Coordinator tried to find documentation in Hixny regarding this event, however no documentation was available. The Care Coordinator attempted to contact Greg and left a voicemail.
- The next attempt to reach Greg was 1/26/2022, and during this call Greg identified he "has been sick lately and has just started to recover." The Care Coordinator encouraged Greg to "get well soon." There was no mention of the previous hospital visits.

Questions:

1.) Is there an opportunity to update the Problems Tab?

2.) Are there opportunities to update the DOH 5055?

3.) What are some Objectives that should be captured on the Plan of Care based on the information described above?

4.) What are some next steps the Care Coordinator could have taken in order to better assist Greg following his hospital visits?

CASE VIGNETTE: Tina

Tina enrolled with the Health Home program in December 2018. According to the Problems Tab, Tina is diagnosed with anemia, bipolar disorder, chronic kidney disease, hypertension, GERD, and asthma. The DOH 5055 lists the MCO-CDPHP, Samaritan Hospital, Albany Medical Center, St. Mary's Hospital, PCP-Troy Family Health Center, and HCBS-Kee to Independent Growth. The Comprehensive Assessment identifies Tina uses a walker, needs to follow up with an eye doctor, has interest in advance directives, and is linked with outpatient mental health treatment. The Plan of Care indicates Tina's goal as preparing to graduate from the Health Home program and her barriers as her anxiety and other various illnesses.

On May 27, 2022, Tina was admitted to Samaritan Hospital after complaining of chest pain, nausea, and vomiting. Tina was hospitalized for five days and discharged home. The uploaded discharge paperwork indicates Tina will need to follow up with Capital Cardiology within 1 to 2 weeks to further evaluate her chest pain. Tina was seen in consultation with Upstate Gastroenterology for her abdominal pain, nausea, and vomiting. She underwent an endoscopy while hospitalized that showed a small hiatal hernia and erosive duodenopathy without bleeding. She will need to follow-up with gastroenterology for biopsy results and ongoing care. Tina's diagnosis of chronic kidney disease stage IV has progressed to end-stage renal disease. Tina did opt for home dialysis and will need to follow-up with Dr. Arora for nephrology care and initiation of home dialysis. Lastly, it was recommended Tina should follow up with her primary care provider within one month for this hospitalization. Changes were made to Tina's medications while hospitalized and all scripts were sent to her outpatient pharmacy. Tina was discharged with the diagnoses of hypertensive disorder, gastric ulcer, percutaneous coronary angioplasty, acidosis, hyperglycemia, hyperchloremia, leukocytosis, anemia, asthma, and renal failure.

The Care Coordinator responded to the Hixny alert as follows:

- The Care Coordinator contacted Tina on 5/31/2022 and was transferred to her hospital room phone. Tina did not answer so the Care Coordinator arrived at the hospital to visit with Tina in-person. While there, the Care Coordinator spoke with a nurse and Tina voiced concern regarding her health and stress levels since she continues to have custody of her grandson. The nurse indicated a social worker would be involved regarding this portion of her care. The Care Coordinator reached out to Kee to Independent Growth (Heather) regarding Tina's concern about her health and custody of her grandson. Heather identified she would be able to write a letter to attach with discharge paperwork and submit to the court in hopes this will help to support signing over her rights.
- On 6/1/2022, the Care Coordinator spoke with the hospital discharge coordinator to go over recommendations prior to Tina's discharge that day.
- On 6/3/2022, the Care Coordinator called Tina to go over her discharge summary and support her with scheduling recommended appointments.

Questions:

1.) Is there an opportunity to update the Problems Tab?

2.) Are there opportunities to update the DOH 5055?

3.) What are some Objectives that should be captured on the Plan of Care based on the information described above?

4.) What were some best practices evidenced in this case?

5.) What are some next steps you would take now that follow up appointments have been scheduled?

CASE VIGNETTE: Nicole

Nicole enrolled with the Health Home program in May 2019. According to the Problems Tab, Nicole is diagnosed with substance abuse, high blood pressure, congestive heart failure, and AIDS. The DOH 5055 lists the MCO-CDPHP, St. Peter's Hospital, Samaritan Hospital, Albany Medical Center, PCP-AMC HIV medical group, as well as several other specialists (cardiology included). The Comprehensive Assessment identifies Nicole visited the emergency department twice within the past year for COPD related concerns, is not linked with outpatient mental health treatment, and has a history of substance use. The Assessment further identifies staying engaged with medical treatment and keeping viral loads undetected as most important to her. The Plan of Care indicates Nicole's goal as connecting with a substance abuse peer support specialist and barriers as becoming easily overwhelmed.

On February 21, 2022, Nicole was admitted to Samaritan Hospital for two days after complaining of chest pain. The Care Coordinator promptly visited Nicole in the hospital the same day, however, note documentation was vague regarding details of the visit so it was unclear if collaboration occurred with inpatient providers. Nicole was discharged a couple of days later and the Care Coordinator spoke with Nicole to review her hospital discharge paperwork. According to the uploaded discharge paperwork, Nicole began to experience chest pain after she used crack-cocaine. While Nicole was inpatient, she tested positive for cocaine and opiates. Discharge paperwork recommended Nicole should continue on antibiotics for five days post-discharge, follow up with her PCP in one week, follow up with cardiology within two weeks, refrain from drug use, quit smoking, and repeat a chest x-ray within six weeks.

Nicole expressed interest in finding substance abuse peer supports which was added to the Plan of Care as an Objective. The Care Coordinator spoke with Nicole about following up with her PCP and cardiologist, including the need for a repeat chest x-ray, however the Plan was not updated to reflect cardiology related needs. That said, the Care Coordinator supported Nicole in scheduling follow up appointments with her PCP and cardiologist. Nicole's discharge diagnoses are as follows, chronic systolic CHF, nonischemic cardiomyopathy, COPD without exacerbation, obstructive sleep apnea, essential hypertension, hyperlipidemia, tobacco dependence, vitamin D deficiency, depression, bipolar disorder, polysubstance abuse (positive for cocaine and opiates), HIV positive, and morbid obesity.

Questions:

1.) Is there an opportunity to update the Problems Tab and DOH 5055?

2.) What are some Objectives that should be captured on the Plan of Care based on the information described above?

3.) What were some best practices evidenced in this case? Opportunities for improvement?

4.) What are some next steps you would take now that follow up appointments have been scheduled?