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Care Transition Case Vignettes: Answer Guide

CASE VIGNETTE: Greg

1. Is there an opportunity to update the Problems Tab?
   Yes, Greg was diagnosed with GERD according to the 10/18/2021 hospital discharge paperwork.

2. Are there opportunities to update the DOH 5055?
   Yes. The only hospitals currently listed on the DOH 5055 are Samaritan Hospital and St. Peter's Health Partners. Since Greg typically visits Albany Medical Center, there is an opportunity to update the 5055 to include this hospital in order to better facilitate care.

3. What are some Objectives that should be captured on the Plan of Care based on the information described above?
   a. Medication adherence/management. The Comprehensive Assessment indicates Greg does not always take his medications as prescribed. According to the hospital discharge paperwork, he is prescribed Omeprazole to manage his diagnosis of GERD. It will be important to problem solve for any barriers related to taking his medications as prescribed.
   b. Follow up with gastroenterology and cardiology should be added to the Plan.
   c. Addressing hospital use should be added to the Plan. Greg seems to be aware of urgent care resources as he used an urgent care facility prior to going to the hospital in October. However, Greg used an ambulance to get to the hospital on both occasions. Due to the nature of Greg's complaints (chest pain), the emergency room may have been the appropriate option, but it may be worth continuing to educate Greg about his options prior to going to the hospital, including transportation options, in non-urgent situations.

4. What are some next steps the Care Coordinator could have taken in order to better assist Greg following his hospital visits?
   a. Obtain, upload, and utilize discharge paperwork. In this case, the Care Coordinator attempted to obtain discharge paperwork on both occasions but was not successful in locating the paperwork. In this situation since the Care Coordinator does not have consent to speak with Albany Medical Center, it would have been appropriate to reach out to MVP or Greg's primary care provider for additional information.
   b. Attempt to reach Greg more than once following a Hixny alert. There were gaps between the first unsuccessful attempt to reach Greg following a Hixny alert and the next successful contact. By that point, these hospitalizations seemed to fall off of the radar and were not mentioned thereafter.
   c. Increase collaboration with consented providers to ensure Greg is following hospital recommendations and problem solve for any potential barriers to avoid a re-hospitalization.
   d. Overall, Greg's long-term goal is to become more independent and obtain a job. If his health conditions are not successfully managed, it is unlikely he will successfully reach this goal.

CASE VIGNETTE: Tina

1. Is there an opportunity to update the Problems Tab?
   Yes, Tina was discharged with new diagnoses that are not listed under the Problems Tab. It will be important to include these diagnoses, so they are linked as Associated Problems on the Plan of Care.

2. Are there opportunities to update the DOH 5055?
   Yes, Tina is now linked with new specialists following this hospitalization. These providers should be added to the 5055 to ensure ongoing collaboration can occur.

3. What are some Objectives that should be captured on the Plan of Care based on the information described above?
   Tina was referred for dialysis treatment as well as follow up with nephrology, gastroenterology, and cardiology. It will be important to ensure the Plan is amended to include these changes. There is also an opportunity to ensure Tina's mental health is appropriately addressed on the Plan to include managing her stress levels regarding her custody concerns.

4. What were some best practices evidenced in this case?
   a. Timely response to Hixny alert.
   b. Meeting Tina in-person at the hospital.
   c. Coordinating care with inpatient nurses upon admission and discharge.
   d. Reaching out to HCBS provider to inform her about custody issues and the impact this has on Tina's health.
   e. Obtaining, uploading, and utilizing the discharge paperwork to guide next steps.
   f. Thoroughly reviewing discharge paperwork with Tina and assisting with scheduling follow up appointments.

5. What are some next steps you would take now that follow up appointments have been scheduled?
   Once proper consents are in place, ongoing collaboration with these new providers will be a key component to ensure any concerns or updates are shared with the care team. It will also be important to follow up with Tina's mental health providers regarding her stress levels and custody issues as this seems to impact Tina quite a bit. The Plan of Care indicates Tina's goal as preparing to graduate from the Health Home program and her barriers as anxiety and various illnesses. Problem solving for these barriers will help to ensure Tina is progressing towards her long-term goals.

CASE VIGNETTE: Nicole

1. Is there an opportunity to update the Problems Tab and DOH 5055?
   Yes, Nicole was discharged with new diagnoses that are not listed under the Problems Tab. It will be important to include these diagnoses, so they are linked as Associated Problems on the Plan of Care.

   Nicole's PCP and cardiologist are both listed on the 5055. There may be an opportunity in the near future to update the 5055 to reflect peer support providers, as needed.

2. What are some Objectives that should be captured on the Plan of Care based on the information described above?
   Cardiology related needs should be added to the Plan based on Nicole's diagnoses and needs post-hospitalization. It will be important to ensure other needs such as substance use and medical needs (such as HIV, COPD, and quitting nicotine use) are actively addressed on the Plan. Additionally, the Care Coordinator should inquire about Nicole's interest in addressing her mental health as the Comprehensive Assessment identifies she is not linked with mental health treatment and medical records from her recent hospitalization indicate she is diagnosed with bipolar and depression. There may be an opportunity to address this on the Plan if Nicole is interested.

3. What were some best practices evidenced in this case? Opportunities for improvement?
   Some best practices include:
   a. The Care Coordinator's prompt response to the Hixny alert.
   b. Visiting with Nicole while she was inpatient in the hospital.
   c. Obtaining, uploading, and utilizing discharge paperwork.
   d. Updating the Plan to include an Objective related to substance use.

   Some opportunities for improvement consist of updating the Plan to address other needs (as mentioned above, under question 2) and increase collaboration with inpatient and outpatient providers.

4. What are some next steps you would take now that follow up appointments have been scheduled?
   Some next steps consist of improving ongoing collaboration with providers in order to ensure any concerns or updates are shared with the care team, including appointment attendance. Nicole has many comorbidities and more recently relapsed on substances so it will be important to work together with providers to address this. According to the Plan of Care and Assessment, Nicole wants to remain engaged with medical treatment, keep viral loads undetected, and connect with a substance abuse peer support specialist. Updating the Plan and utilizing this as a 'road map' to guide care activities will help Nicole work towards these identified goals.