



ICare Use Cases

A continuously updated summary document
describing ICare use cases completed to date

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Seton High Alert Program

Type of Setting

Multiple Emergency Departments (EDs) within a single organization

Implementation Date: ??

Summary:

The purpose of using ICARE in this case is to better coordinate the treatment of patients who present at Seton EDs throughout Austin on a regular basis. ICARE is used to research the clinical background and health system usage patterns of the patients.

Postconditions/Value:

The “frequent flyer” patient’s care is managed more effectively in the ED setting. Those who are drug seekers are handled appropriately, and those who have chronic or recurring conditions receive better coordinated care, and are referred back to their primary care clinic. In both cases, ED utilization is reduced. The ICare data is important to the success of the program because it helps with research, keeps narcotic prescriptions in reason, and confirms patient’s information.

Case Study: *Drug Seeker*

- Opiate abuse – A patient with a history IV drug abuse who left hospital site against medical advice with IV in place
- Issued a narcotic termination letter to the patient, contact with PCP, made a plan that no narcotics would be given without the approval of PCP
- No other system visits noted, increased visits to other hospital system noted
- ICARE used to monitor city wide visits. Visits noted to non-hospital system sites.

Seton Asthma Program/ICC Asthma Network

Type of Setting: Asthma management program

Implementation Date:

Summary:

The Seton Asthma program uses ICare data to identify potential patients to participate in the case management/education program. A weekly report from ICare shows those Asthma patients who have presented for care at an ICC member hospital. The demographic data from this report is then used for patient outreach activities.

Postconditions/Value:

Patients with Asthma are identified and targeted for case management and education. The result of these efforts, which are facilitated by the ICare system, is that the patient’s Asthma is better managed, thereby improving quality of life and reducing the number of future visits to the hospital.

Case Study:

- Family with four children with Asthma identified by ICare report
 - Global reduction in symptoms for all children
 - Reduction in prescribed medications
 - Reduction in missed school days
 - Reduction in ED visits

ATCMHMR - Psychiatric & Counseling Services

Type of Setting: MHMR local authority, psychiatric services department

Implementation Date: 5/5/08

Summary:

Providing access to data from ICare informs the psychiatrist and case worker of recent medical events, and gives the psychiatrist valuable clinical information which will help in deciding on the best medication to prescribe. Also, ICare data indicates to ATCMHMR which patients are stable and established with City of Austin clinics, and thus could be referred back to their PCP for ongoing care in the EMERGE program.

Postconditions/Value:

The ATCMHMR ICare Use Case establishes a business process flow for the Center's use of ICare data to improve care, leverage services, and address costs. Previous encounter data increases accuracy of diagnosis and treatment, in addition to opening paths of referrals, which in turn open slots for other patients to get into services with ATCMHMR.

Case Study:

Joe is an ATCMHMR client who has been stabilized and referred back to his PCP at the CHC for ongoing treatment of his psychiatric condition within the EMERGE program. ATCMHMR staff was able to see in ICare that Joe had previous encounters at the CHC, and would be a candidate for EMERGE. The resulting benefits were:

- Better integration of physical & psychiatric treatment.
- More convenient for Joe, thus promoting better compliance with treatment.
- More normalized setting.
- Opens up a slot at ATCMHMR for more intense clients in need of services.

St. David's MATCH Program

Type of Setting: Inpatient to primary care transitional clinic

Implementation Date: 8/31/08

Summary:

The St. David's MATCH program provides follow-up and transitional services after a patient is discharged from an Inpatient stay. For a period of up to 6 weeks, the patient is seen at the MATCH clinic, and is then transitioned to an appropriate clinic, taking into consideration past history found in ICare, and on current benefits and medical condition.

ICare is also used to follow up on patients to make sure they made their appointment with the PCP. Finally, ICare is used in program evaluation of the MATCH program, to determine the effectiveness of the program in impacting the healthcare utilization patterns of patients.

Postconditions/Value:

ICare provides the MATCH program with a tool that helps transition patients to the most appropriate setting for primary care, thus supporting the core mission of the MATCH program. ICare's ability to monitor utilization patterns subsequent to participation in the MATCH program is the key to determining the effectiveness of the program.

Case Study:

Not yet available

People's Community Clinic

Type of Setting: Non-profit clinic

Implementation Date: 8/31/08

Summary:

The main purpose of using ICARE in this case is to better coordinate the treatment of patients who present for care at a clinic after having been hospitalized, those who are presenting at several different clinics; and additionally to coordinate the care of patients with chronic diseases.

Postconditions/Value:

ICare provides a tool to better manage patients healthcare utilization. Encouraging patients (and especially those with chronic conditions) to seek care from a single PCP in a clinic environment will promote better health outcomes and reduce costs for the clinics. Following up on hospital visits will have a similar effect of improving health and reducing hospital costs.

Case Study:

Not yet available

Front Steps Recuperative Care Program

Type of Setting: Post-hospitalization respite care for homeless patients

Implementation Date: 7/31/08

Summary:

The purpose of using ICARE in this case is to better coordinate the treatment of homeless patients who are discharged from an inpatient hospital stay, but at risk for recitivism.

Postconditions/Value:

Using ICare data, Front Steps program staff is able to better determine the needs of the patients in their care. Identifying patterns of hospitalizations helps staff to understand

what issues are leading to the patient's recidivism, and viewing prior clinic relationships aids in re-establishing primary care. Reports generated from ICare help in determining whether or not the Front Steps program has been successful in preventing future hospitalizations.

Use Cases In Development...

The following use cases are in the process of being developed:

- WCCHD
- Front Steps recuperative care program
- UT Family Wellness Center
- Seton Shoal Creek Hospital / C.I.C
- Dell Children's Medical Center
- Volunteer Healthcare Clinic
- St. David's Healthcare (not location-specific)

Use Cases "On Deck"...

The following use cases have been prioritized to be developed next:

- St. David's South Austin Hospital ED
- AISD
- Seton Community Clinics
- City of Austin CHCs
- Seton Medical Center
- Lone Star Circle of Care