



## ☰ CASE STUDY

# Gilchrist Improves Care Management for Geriatric Patients with Real-Time Encounter Alerts

Gilchrist's elder medical care practice helps individuals manage their health in the late stages of life and leverages real-time alerts delivered via the Encounter Notification Service® (ENS®), powered by Audacious Inquiry, to provide timely outreach to support care transitions and communicate treatment goals in the event of a hospitalization.

## Gilchrist Supports Elder Patients with Serious Illness and End-of-Life Care

Gilchrist is a nationally recognized, nonprofit leader in serious illness and end-of-life care located in central Maryland. Offering elder medical care, counseling, and hospice, Gilchrist helps people at every stage of serious illness live life to the fullest and make informed choices about their care. One of the key challenges when it comes to care management for complex patients is communicating across care settings and teams to ensure the patient's care plan follows them through the health system. Gilchrist needed a way to ensure that each patient's care plans could be communicated in real-time during a health event, especially any time a patient was admitted to the emergency department (ED).

## The Challenge: Ensuring Patient Care Plans Are Available at Point of Care

For older individuals suffering from multiple, complex, and/or chronic health conditions, coordinating treatment across the healthcare system can be challenging. Geriatric medical care programs assist patients with many aspects of this care management process, including coordination between treating providers. An important component of geriatric care is advanced care planning, helping patients document their preferences for end-of-life care.

Advanced care planning is crucial to ensure that, in the event of a decline in health status, the patient's wishes are honored when it comes to their desired setting and mode of treatment. Communication with the ED clinicians is particularly important, as many geriatric patients are brought to the ED to assess the severity and implications of a change in health status. At this time, it is important to know the patient's wishes for their care going forward and communicate clearly with the treating physician to ensure the patient's plan is followed.

**Real-time coordination of patient ED admission allows geriatric nurses to reach out at the point of care to discuss the patient's prognosis, care plan and treatment options.**



However, a survey of patients over age 65 admitted to the ED found that half of the patients interviewed had done advance care planning, but just 4% of those actually had their advance directive recorded in their electronic health record (EHR). Another study published in the Journal of Palliative Medicine found that only 13% of patients had their advance care planning details recorded in their electronic health record (EHR), and even among those whose primary care provider and ED provider used the same EHR, just 19% had an advance directive code recorded in the EHR. Ensuring that patients' end-of-life directives are respected is



**Real-time alerts ensure Gilchrist's managers are equipped to provide timely outreach and communicate treatment goals.**



**24/7 nurse helpline allows geriatric nurses to reach out to the treating physician at the point of care.**

critical to providing quality care and reducing unnecessary procedures for patients who have indicated preferences for do not resuscitate (DNR) orders and more.

Advance directives, like other EHR data, should travel with patients throughout their journey in the healthcare system. One way to address this issue is by ensuring that a patient's care team is alerted when the patient is admitted to the emergency room or hospital. The patient's care team or primary care provider may be able to fill gaps in patient needs and treatment plans during a health event in which an ED provider is treating them. This is only possible if the patient's care team is aware of the health event in real time.

## ENS Alerts: Real-time Care Coordination

Gilchrist's elder medical care practice helps individuals with complex chronic illness coordinate and manage their health in the late stages of life. When patients are hospitalized, real-time alerts ensure that Gilchrist's case managers are equipped to provide timely outreach to support care transitions and communicate treatment goals.

These alerts are delivered via the Encounter Notification Service® (ENS®) powered by Audacious Inquiry. When patients in Gilchrist's geriatric medical care program are taken to the ED, an ENS alert is sent to Gilchrist's 24/7 nurse helpline. Timely knowledge of patient ED admission allows geriatric nurses to reach out at the point of care to discuss the patient's prognosis, care plan, and treatment options with the treating physician. By providing this real-time care coordination, Gilchrist's geriatric care managers help ensure patients receive care according to their expressed care plan.

## Outcomes: Providing Timely Outreach to Respect Patient Care Plans

Care management is especially important for geriatric patients who often have complex medical needs. When patients' care plans follow them through the healthcare system, unwanted hospitalization and treatment are reduced. Encounter alerts help case managers stay up-to-date on patients' status to better coordinate care. Rapid outreach shortens length of hospital stay for patients who specify a preference for inpatient or in-home hospice care following a change in condition.

Timely notification of patient hospitalization allows geriatric nurses to provide the outreach necessary to ensure that the patient's wishes, as expressed through their advanced care plan, follow them through the healthcare system. The ENS alerts facilitate real-time response, enabling Gilchrist's nurses to communicate care plans at the point of care.

**Rapid outreach shortens length of hospital stay for patients who specify a preference for inpatient or in-home hospice care following a change in condition.**