What is a Care Alert?

A Care Alert is a brief, free-text electronic note written and modified by healthcare providers, preferably within the electronic medical record (EMR). The note should contain essential information about the patient to be used by the rest of the patient’s care team.

The goal of a Care Alert is to help all clinicians, who encounter a vulnerable/complex patient, avoid clinical misadventures, including unnecessary and potentially harmful hospitalizations, testing, and treatment. Care Alerts are used to standardize the process of communicating actionable information about the patient at the point-of-care. Care Alerts facilitate care coordination between healthcare settings in order to support effective and efficient follow up that preserves patient safety and well-being.

What are the General Principles of Care Alerts?

**Brief:** Convey information in a concise manner for easy reading.

**Durable:** Include information that will remain relevant to the patient for several months.

**Safe:** Avoid using absolutes (always, never) in consideration of provider clinical judgment.

**Respectful:** Use respectful language avoiding subjective or pejorative description of the patient.

**Compliant:** Provide information that conforms to regulations regarding restricted disclosures (ex. 42 CFR part 2).
How do I send Care Alerts to CRISP?

Care Alerts can be submitted to CRISP in a number of ways:

1. Patient Panel:
   - You may add a column entitled Care Alerts to your existing ENS patient panel (recommended)
   - You may wish to create a separate panel just for Care Alerts

2. Data Feed:
   - If you have or wish to implement a clinical data feed (usually CCD) with CRISP, you have the ability to include care alerts in that data feed.

Care Alerts View:

**Please contact a CRISP representative prior to submitting Care Alerts, regardless of how you plan to send them. Whether alerts are sent via panels or data feeds, CRISP will need to configure our system to accept your Care Alerts, and may need to work with a technical contact at your organization and/or EMR.**
How do I maintain Care Alerts in CRISP?

Care Alert hygiene is very important. When an organization edits/updates Care Alerts, CRISP will overwrite the previous alert with the most recent one. Please consider how you will notify CRISP of Care Alerts that need to be deleted/removed. You can notify us in the following preferred methods:

1. Inserting an additional column on the patient panel, indicating an alert that needs to be Deleted

2. Sending a blank alert for any that need to be removed. The blank alert will overwrite any existing Care Alert, effectively removing it from our database because CRISP can only have one Care Alert per patient from a single provider source (patients may have multiple Care Alerts from multiple providers).

3. Sending a Delete indicator in a specific segment of a data feed

4. Setting an expiration date for all Care Alerts – this applies to all alerts coming from a specific source.

For additional questions, contact your CRISP outreach representative or Sheena Patel, MD at sheena.patel@crisphealth.org
Example Care Alert Template

Demographics
- Name, DOB, Gender
- Date Care Alert Established
- Frequency of Care Alert review/renewal

Key Health Concerns: Include information such as:
- The patient’s typical presentation
- Frequent chief complaint/s, suggested interventions
- Diagnostic workups that have been recently completed (with results)
- Medication list as of a specific date. The medication list “as of” date is important to assist the provider to make a decision about medication treatment if necessary

Care Management Resources: Helpful information includes:
- Names, contact information, and availability of the primary care physician and/or care manager
- Names, contact information of key family members/next of kin
- Community programs available to, or that the patient may already be enrolled in
- If available, include insurance information as it often drives programs the patient may be eligible for
- Include any other relevant care team members, including specialists

Barriers to Care: Identify factors which affect the patient’s ability to follow up on recommended treatment, which may include:
- Transportation
- Financial instability
- Patient behavior such as non-compliance
- Lack of support or emotional resources
- Lack of housing
- Nutritional needs

Other: Please add information such as:
- Advance Directives
- Participation or referral to hospice or palliative care programs
- Presence of executed MOLST form
- Any additional, relevant comments