Dashboard logic for urgent crisis referrals

At shift change, a referral can show “sent” while the team still needs to establish who will call the patient. This design follows each case from missed outreach through clinician acceptance, patient contact and transfer to the next shift.

1 What the dashboard measures

Metric	What it measures	Why it matters	When to flag
M1 Discharge outreach	Working days from acute discharge to the first documented call attempt.	A patient may leave hospital without a check-in.	IMH standard route: two working days pass with no attempt. Exclude weekends and public holidays.
M2 Attendance unknown	Past first appointments without a verified attendance outcome.	A blank record can hide either attendance or a missed visit.	Proposed: appointment has ended and attendance is blank. Send for verification.
M3 Missed visit unmanaged	Calendar days from a confirmed missed visit to the first documented management action.	An absence can be logged without anyone acting.	IMH indicated route: flag when four calendar days expire without action. Assign an owner on detection.
M4 Urgent referral unaccepted	Open urgent referrals without acceptance by a named clinician; show elapsed time since sending.	A shared inbox can receive a request that nobody owns.	Proposed: show pending immediately. Escalate if direct handoff ends unanswered or acceptance is still missing at handover.
M5 Patient contact unresolved	Accepted referrals with no recorded outcome by the agreed time, or an unsuccessful call with no retry plan.	Acceptance alone cannot show whether the patient received help.	Proposed: flag a missing contact deadline, a missed deadline, or a failed call without a retry owner and time.
M6 Shift coverage unconfirmed	Open actions without incoming staff acceptance of the owner, action and due time.	Tasks can disappear between shifts even when everyone worked their own list.	Proposed: any unaccepted open action at outgoing sign-off requires live transfer to a covering person.

Timing boundary. The IMH charts give routine follow-up windows. The reviewed material leaves the urgent acknowledgement interval open. The proposed urgent flags use workflow events; local leads would need to confirm the escalation route and timing before use.

What the case manager enters and sees

2 Inputs and outputs

Start of shift. Select the team, shift and assigned cases. An integrated version would prefill the case identifier, discharge date, appointment and attendance status, current CM and source update time. In the prototype, enter these as sample data. Show active caseload as context.

Record an event. Select the case and event: attendance verified, call attempted, urgent referral sent, clinician accepted, patient reached, or shift cover accepted. Capture the event time separately from entry time. Keep “unknown,” “unanswered” and “reached” distinct.

Fields that depend on the event. For outreach, enter the outcome, any documented clinician direction, next owner and review time. For an urgent referral, enter the recipient, handoff outcome, named accepting clinician and agreed contact deadline. For shift transfer, record the covering person and read-back time.

Display order	What the case manager sees and does	Metric and failure caught
1 Urgent actions	Unanswered urgent handoffs appear first, with time sent and current owner. The sending CM calls the duty crisis lead and informs the CM lead. Use the approved on-call route if the duty lead is unreachable.	M4 · A sent referral is mistaken for accepted care.
2 Patient contact due	Show accepting clinician, agreed callback time, last outcome and retry plan. At the deadline, the CM checks directly with the responder and records what happened.	M5 · Referral accepted but patient contact or the retry is unresolved.
3 Shift handover	List every open action with owner and due time. Incoming staff read it back. The duty lead arranges interim coverage for anything unclaimed.	M6 · A shift ends while outstanding work has no confirmed cover.
4 Follow-up and verification	Show overdue discharge outreach, blank attendance and confirmed missed visits separately. The CM checks outreach, the scheduler verifies attendance, and the CM lead assigns unclaimed work.	M1–M3 · Silence in a record hides a missing call, visit or follow-up.
5 Documentation history	One timeline per referral shows who did what, when it happened and when it was entered. Prompt for missing owner, outcome or next review. Only resolve the relevant flag.	M1–M6 · A voicemail, forwarded message or late entry makes work look complete.

Testing the logic on a Friday handover

3 Simulation report

Scenario used. On Friday, the CM has 34 active patients. One patient was discharged Monday, four days earlier. No holiday intervened. The first visit was scheduled Thursday; attendance is blank. No follow-up contact or attempt appears in the record.

What surfaced. One patient card shows two open questions: did anyone attempt the discharge call, and did the patient attend Thursday's visit? The 34-case workload is visible to the lead; it has no validated alert threshold in this design.

Alerts triggered. M1 is overdue because the two-working-day call was due Wednesday. M2 requests attendance verification. M3 requires a confirmed missed visit; even if Thursday's absence is verified, its four-calendar-day window runs to Monday. The available facts do not establish an urgent referral.

Recommended actions. The CM checks for a late or off-system call record and makes outreach if still outstanding. The scheduler verifies the visit. If attendance is confirmed, close M2 only. If missed, log Thursday as the event date and assign the CM to begin missed-visit management. Relay new safety concerns promptly under the existing pathway.

Urgent branch test. Suppose the treating clinician directs an urgent response at 15:50. The CM's direct handoff goes unanswered. M4 flags the call to the duty crisis lead immediately. At 16:00 sign-off, M6 also flags any open task without accepted cover. A named clinician then accepts and agrees to call at 16:15. Acceptance resolves M4; if no outcome is recorded by 16:15, M5 flags the follow-up. These are fictional event times.

Weaknesses identified and how I responded

Late phone notes can look like silence. I added separate event and entry times plus a check with the clinician before classifying a delay. Work done outside every available record still needs human verification.

Missing data can hide the patient entirely. I added a shift reconciliation between the discharge or appointment roster and the open list. If the source roster is itself stale, the display should show its update time and the lead should verify coverage manually.

Several warnings can duplicate work. I grouped flags under one case and assigned a primary action. Clearing attendance cannot clear an urgent referral. The tool can flag missing evidence; assessing the patient remains the clinician's responsibility.

What I would carry into the prototype

What will the dashboard measure and why?

I would measure the time a patient spends waiting between identifiable steps. The most important distinction is between a referral being sent, a named clinician accepting it, and someone reaching the patient. Each event answers a different question about who still needs to act.

What does the case manager see first?

I would open with a worklist of unresolved urgent handoffs. Each entry should tell me who owns the next action, when it is due and whom to call if the first person is unavailable. Routine outreach and attendance checks belong below those cases so I can find them without losing sight of an urgent referral.

Where is the logic strongest and where could it fail?

It is strongest at shift change because the outgoing and incoming teams can check every open action against a named owner. It is weakest when someone accepts a referral or reaches the patient by phone before recording it. I would use that flag to verify what happened and distinguish a delayed response from a delayed note.

Basis for the design

IMH ES Process V250801, steps 9–14, 17, 19a and 23; Post Discharge Process V250801, steps 3a, 6a, 8, 10–11 and 14b. Both were supplied as course materials.

Project 1 CM Stakeholder Map; Project 3 IMH Guidelines and Workflow Summary and Decision Tree for Urgent Referrals at Shift Change. These documents distinguish accepted handoffs from patient contact and identify where local backup rules need confirmation.

External benchmarks reviewed in Project 3: Australian NSQHS Communicating for Safety Standard, actions 6.08–6.09 (structured handover and timely risk communication); AHRQ TeamSTEPPS Check-Back (receiver confirms understanding and sender verifies).