Project 4: Dashboard Prototyping Logic

Preventing Missed First Follow-Up After Discharge — IMH

Stage 1: Metrics

Metric	What It Measures	Why It Matters	Concerning Threshold
Time from discharge to TCU scheduling	Whether the TCU follow-up was scheduled/confirmed before the patient physically left the unit	This is the earliest prevention point — an unscheduled TCU at discharge is the seed of every downstream failure	No TCU scheduled at discharge → auto-flag if not resolved within 24 hours
Time from ES escalation to first CM contact attempt	Whether the CM has made a first contact attempt after triage/right-siting	Delay here compresses the window for the 3-call best-effort protocol and NOK outreach	No documented contact attempt within 2 working days of assignment
TCU attendance detection lag	Time between the TCU appointment date and when attendance status is confirmed across EPIC/NEHR/private clinics	This is the core breakdown point — nothing today proactively surfaces a missed appointment	Appointment date passed with no attendance check logged within 24–48 hours
Days since default with no re-contact attempt	For a first default, whether the 3 best-effort re-contact attempts (4-calendar-day window) are underway	IMH's 4-day standard is looser than best practice for high-risk cases; delay compounds risk during an unmonitored window	No documented attempt by day 3 of the 4-day window
Physician response lag after subsequent default	Time elapsed since a subsequent default was escalated to the treating physician, against the 48-hour response standard	This is where the workflow has no specified backup — if the physician doesn't respond, nothing currently catches it	No physician response logged within 48 hours (should auto-trigger Consultant/Team Lead escalation)
Risk reassessment status post-default	Whether risk has been reassessed since a default occurred, and by whom	Ownership is unassigned in the current workflow — this metric exposes the authority-accountability gap directly	Default occurred >48 hours ago with no risk reassessment logged, or logged with no assigned owner
Proportion of caseload disengaged after single contact	Share of patients disengaged to Case Tracker after just one successful contact, without prior CM relationship history	Early disengagement risks silently dropping a patient who hasn't met a real stability bar	Disengagement logged without a documented stability-bar check
Documentation completeness rate (.cmutel + case notes)	Whether all four required log elements (time of occurrence, time of recognition, action taken, people notified) are present	Undocumented coordination is functionally the same as coordination that didn't happen — this is the audit-trail integrity metric	Any logged event missing one or more of the four required fields

Stage 2: Inputs & Outputs

Inputs

- CM ID / caseload filter (or Team Lead view)
- Auto-populated patient list, pulled from EPIC/NEHR/.cmutel
- "As of today" date anchor for thresholds
- Filters: risk level, escalation stage, days-in-state

Outputs (ranked by urgency)

- Red Flag Queue — patients past threshold with no action logged; patient, days overdue, owner, required action
- Scheduling Gate Status — TCU unconfirmed at discharge, 24-hr flag status
- Contact Attempt Tracker — call count/dates vs. 2-day and 4-day windows
- Escalation & Physician Response Panel — live 48-hr countdown, auto-escalates to Consultant/Team Lead

- Risk Reassessment Flags — defaults >48 hrs with no reassessment; owner left blank by design
- Documentation Completeness Indicator — per-patient/CM score against 4 required fields
- Documentation Prompt — one-click log action, embedded in every alert

Stage 3: Simulation

Scenario: Discharged 4 days ago, no contact logged, TCU appointment yesterday with no attendance record, CM caseload = 34.

Surfaced: Red Flag Queue (contact lag + attendance lag); Contact Tracker shows 0/3 calls, window closed day 2; Scheduling Gate clear.

Alerts: Contact-window breach (day 2); attendance-check overdue (day 4); escalation-to-Team-Lead (inferred from zero attempts).

Recommended actions: Check EPIC/NEHR/private clinics for attendance; if missed, start 4-day re-contact protocol; review why contact window was breached; flag pending risk reassessment.

Weaknesses & Responses

- Can't tell "no attempt" from "unlogged attempt" → acknowledged as v2 limitation
- Escalation trigger relies on inference, not a logged event → fixed: alert on deadline passed, not just on failure logged
- No caseload-weighting in urgency ranking → out of scope for v1, documented as known gap
- "Scheduled" treated as "confirmed" at the gate → fixed: track patient confirmation separately

Stage 4 : Role-specific Alignment

Dashboard Actions	Intended roles	Right roles	What changed
Red Flag Queue	Case Manager	yes	Filter by the owner field so CM sees only CM-actionable flags (contact, attendance, scheduling); route risk-reassessment and physician-response flags to the Consultant's queue instead.
Scheduling Gate Status	Case Manager	yes	No change to the CM view. Aggregate rate (% unconfirmed TCU) can roll into Admin's capacity/trend view, without patient-level detail.
Contact Attempt Tracker	Case Manager	Yes	No change needed.
Escalation & Physician Response Panel	Consultant	Yes	Confirm the panel shows only the escalated case and countdown, not the CM's underlying contact-attempt detail.
Risk Reassessment Flags	Consultant	partially	Default-route to Consultant/Team Lead once the 48-hr threshold passes, while still logging that ownership was originally unassigned that keeps the authority-accountability gap visible instead of letting it disappear.

Dashboard Actions	Intended roles	Right roles	What changed
Documentation Completeness Indicator + Prompt	Case Manager/Admin	NO	Split into two views: CM sees a real-time per-case score plus the log Prompt; Admin sees only an aggregated, de-identified team-level completion rate and trend — no prompts, no per-case detail.

Synthesis

What it measures: Absence and delay at each handoff (RCA-identified gaps), not raw activity.

What the CM sees: Urgency-ranked red flags, each tagged with an owner and a one-click log prompt.

Strongest / weakest: Strongest at closing the TCU-detection gap (Section 3); weakest on caseload strain and documentation-vs-action conflation like both trace back to the authority-accountability root cause.