Practice Innovation Institute
Engage. Transform. Reward.

Mini Pii Session
Workflow and Documentation Innovation
March 6, 2019

Lori Pearlmutter, PT, MPH, CPQH from North Country HealthCare presented and lead a conversation around workflow and documentation innovation.

Key points:

- Focus first on what measure you can pull good data on
- Identify population
- Engage the right people in goal setting
- Staff training, documentation and follow-ups are key – charting what was done is essential in measuring the outcomes (prove by documenting)
- Manage complex conditions following PCMH care management model

Challenges:

- Data overload – too much information from too many resources – must be able to understand what is valuable and useful for what you are targeting
- Not an easy process – make sure all voices are heard

Key things to remember:

- Use tools available to you already through your EHR – for example, Pre-visit prep form through Azara
- Developed a standing order for testing
- Update or create workflows for the process – continuously review and improve
- Meeting regularly with key players
- Open communication with key players
- Keep things moving in the process
- Reporting is essential

Feedback from attendees:

- All of this leads to reduction in administrative burden
- Request for more details specific to primary care – processes and workflows are relevant to all provider types

NORTH COUNTRY
HealthCare

Workflow and Documentation Innovation
North Country HealthCare

Lori Pearlmutter, PT, MPH, CPHQ and the wonderful team at NCHC

Initiation

- Goal- practice transformation
  - Began working with Practice Innovation Institute in 2016
  - Aligned with our Strategic Initiatives
    - Practice Transformation
    - High level Strategic Initiatives-5 total

  - #3 Create Integrated Care Teams
    - » Define Elements and implement use of integrated care plan

Integrated Care Team

- Clinical
  - Dental
  - CMO
  - Behavioral Health
- Community Health
- Informatics
- Finance
- Marketing
- Operations
- Pharmacy
- Quality

Identify population

High Risk Population Name	Definition	Registry Origination	Notes
High Risk Prediabetic & Diabetic	Pre – Denominator - patients seen at least once in last 12 months with A1C between 5.7 and 6.4 or 9+ as their first observation within a 24 month period Numerator – the subset of patients that have any increase in BMI or A1C observation in last visit that is greater than values in first visit or last visit A1C 9 or greater	PBI	Started as a prediabetic and got worse If we need to limit we should consider a % increase in BMI or A1C
High Acuity	Disclosed 1 or more: IPV Suicide ideation	PBI	
Hospital High Utilizers	Patient has Centricity documented 4 or more hospitalizations and/or ED visits in a 12 month period	PBI	
Lacking Preventive Screening	Any patient with one or more missing preventive screens (Colorectal, breast or cervical)	PBI	Implementing Mammogram Standing Order workflow
Controlled Substance Users	Z79.891 + 50 MEDs or greater for at least 90 Days	PBI	

Baseline Information

	July	August	Sept	Oct
Pre-Diabetic	243	255	251	276
Diabetic	943	899	906	891
Cervical Cancer Screening	44%	50%	44%	44%
Colorectal Cancer Screening	29%	29%	29%	29%
Breast Cancer Screening	40%	40%	40%	40%
Comprehensive Diabetes Care				
Blood Pressure	69%	68%	68%	38%
Eye Exam	23%	20%	20%	20%
HbA1c <7	32%	35%	34%	35%
HbA1c >9	37%	40%	39%	38%
Medical Attention for Nephropathy	80%	76%	76%	75%
SDOH – IPV				
SDOH – Suicide Ideation				
Opioid	1034	1069	1088	1114
High Utilizers	556	532	515	494

PCMH Care Management goals

- High Risk patients as defined by the Patient Centered Medical Home
  - Poorly controlled or complex conditions
  - Behavioral health conditions
  - Social determinants of health
  - High Utilizers of the ED/Hospitals
  - Lacking preventative screening
  -

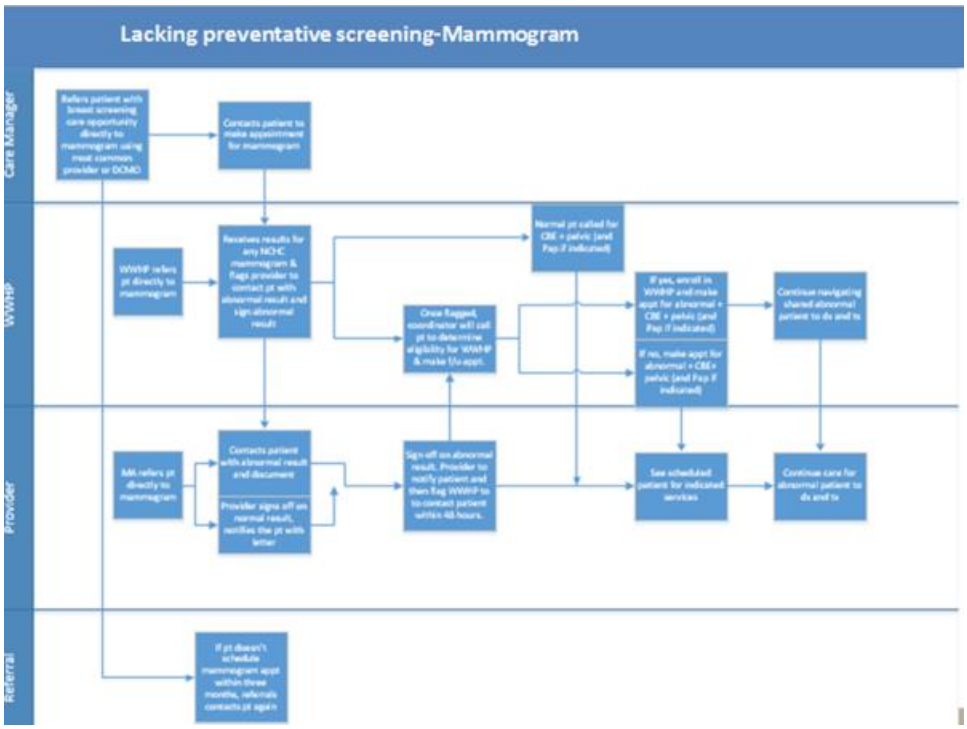
Care Management

- Lacking preventative screening
- SDOH
  - Controlled Substances
- Poorly controlled or complex conditions
  - Diabetes

Strategic Initiatives

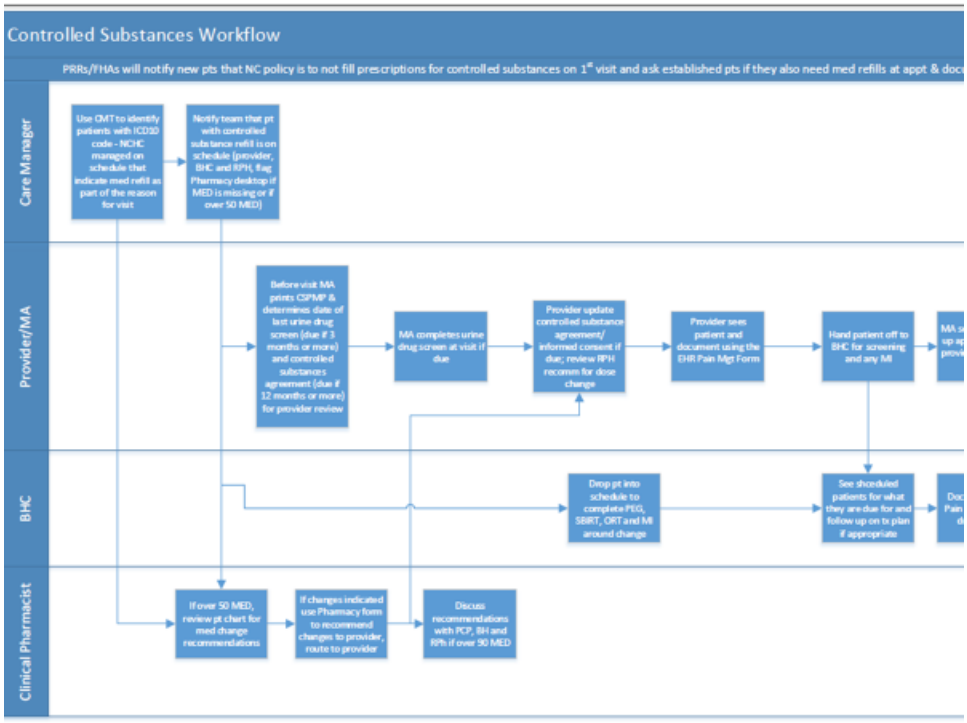
Team- Mammograms

- Care management
- Population Health Coordinator
- Referral coordinators
- WWHP



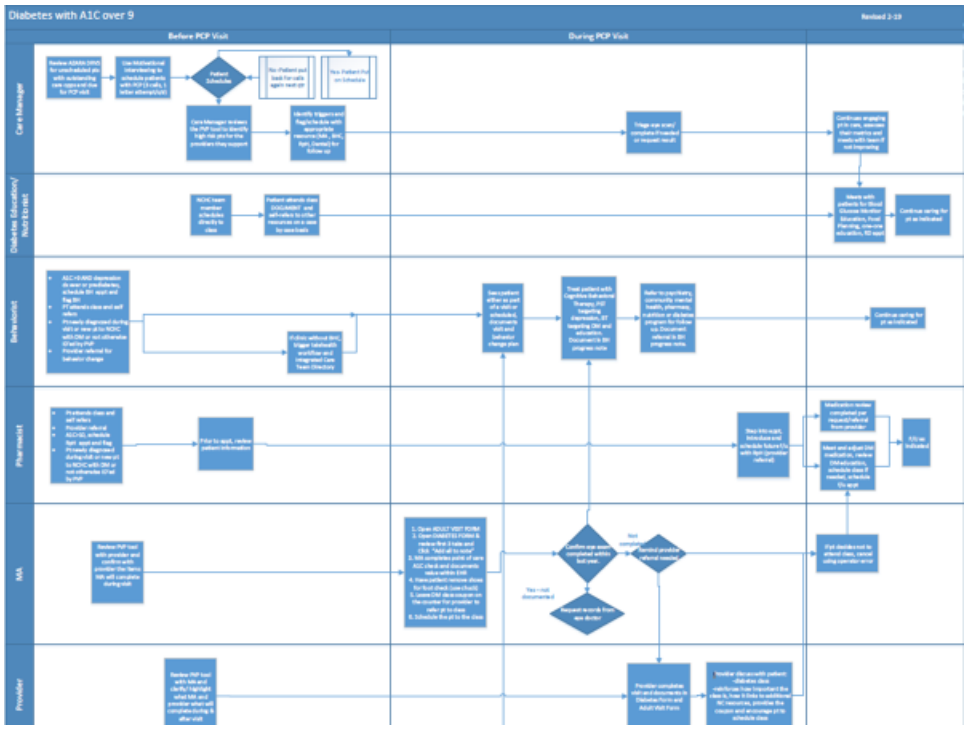
Team- SDOH Controlled Substances

- Behavioral Health
- Care management
- Clinical
  - CMO, DCMO
- HIV – Ryan White
- Community Health
- Informatics
- EHR- Training team
- Operations
- Pharmacy
- Quality

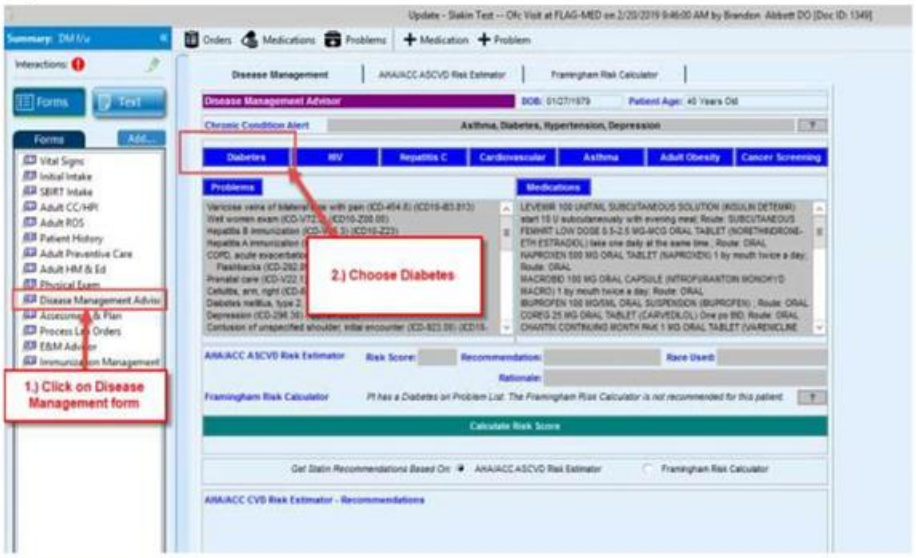


Team- Diabetes

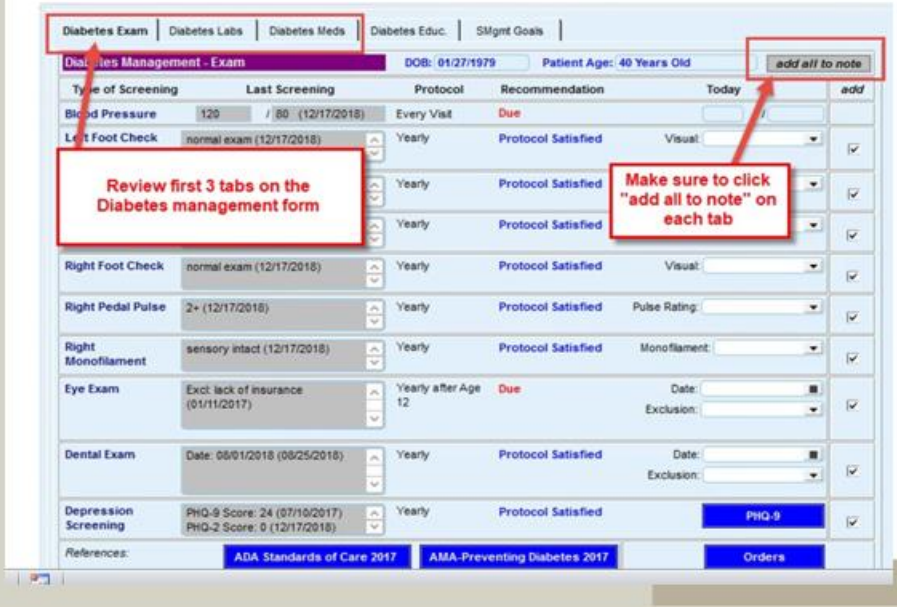
- Behavioral Health
- Care management
- Clinical
  - CMO, DCMO
- Community Health
  - Diabetes programs
- Dental
- Operations – clinic managers
- Pharmacy
- Population Health
- Quality



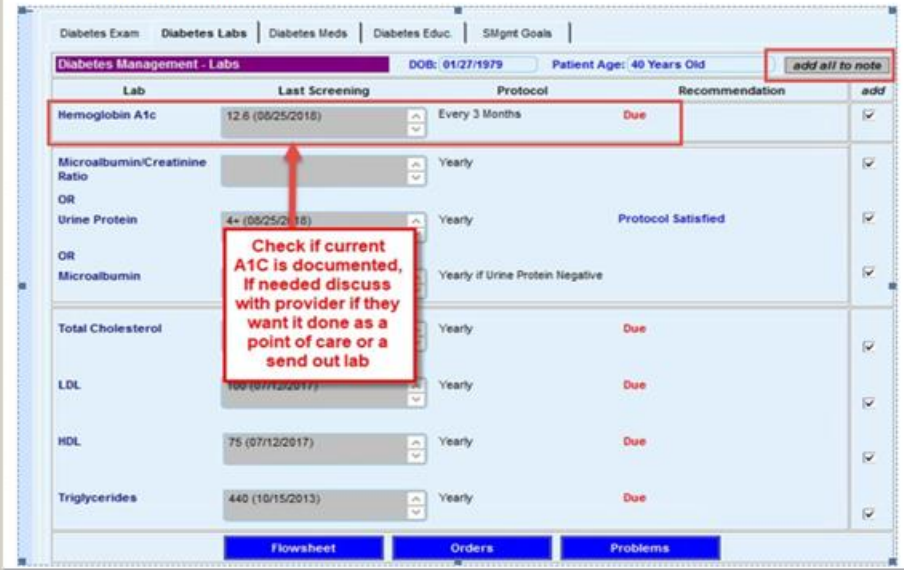
1. Patient here for Diabetes visit. Click on the Disease management advisor form, then click on the Diabetes form



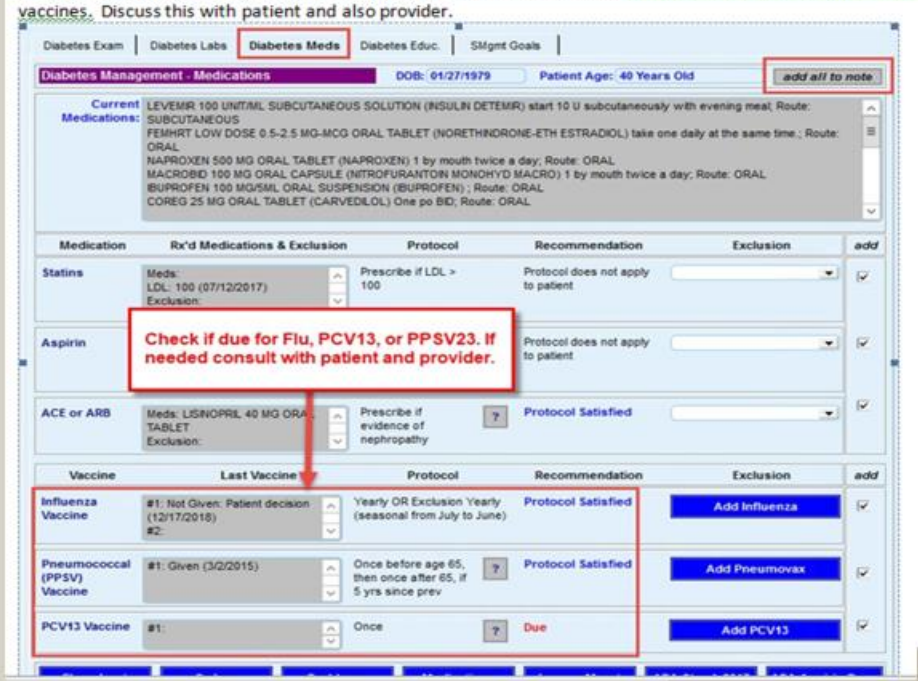
2. Once you have loaded the Diabetes form, you will then review the first 3 tabs. When reviewing the tabs please make sure you click the "add to note" button. This will display the information in the text view of the document.



3. Under the first tab Diabetes Exam - make sure the patient has had their Foot exam, Eye exam, Dental exam and, the Depression Screening done. If patient needs foot exam have them remove shoes and socks, also place chuck under feet. If patient needs eye exam arrange for retinopathy screening appointment (if available on Retinal screen schedule) or have provider refer for eye exam. If patient states they have had recent exam already done request records for chart sure the patient has had their A1C done in the last 3 months. If needed discuss with provider if they want an in-house A1C (point of care) or an outside lab order



5. Make sure the patient has had their Flu, PCV13 and, PPSV23 vaccines. If the patient is due for any of thes vaccines. Discuss this with patient and also provider.



Once all screenings have been checked ask patient if they have attended any of our DM education classes. If the patient has not been to a class you can leave a DM education coupon for patient. If patient would like to attend DM classes make sure to book the patient for next