



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 Pearlmuter, 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 Centrality 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



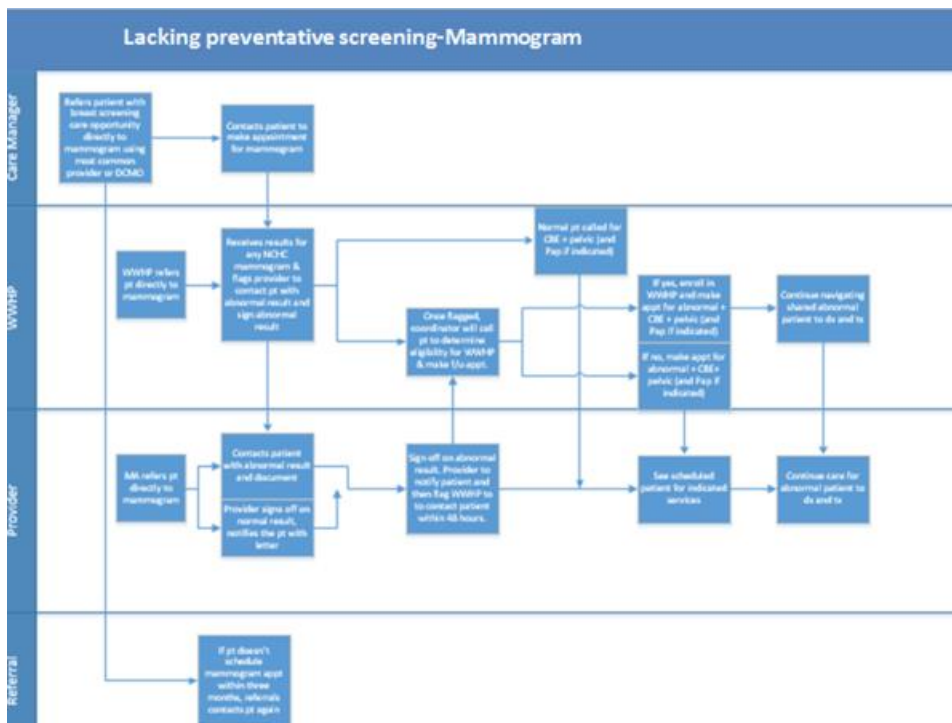
- Lacking preventative screening
- SDOH
 - Controlled Substances
- Poorly controlled or complex conditions
 - Diabetes

Strategic Initiatives

Team- Mammograms

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





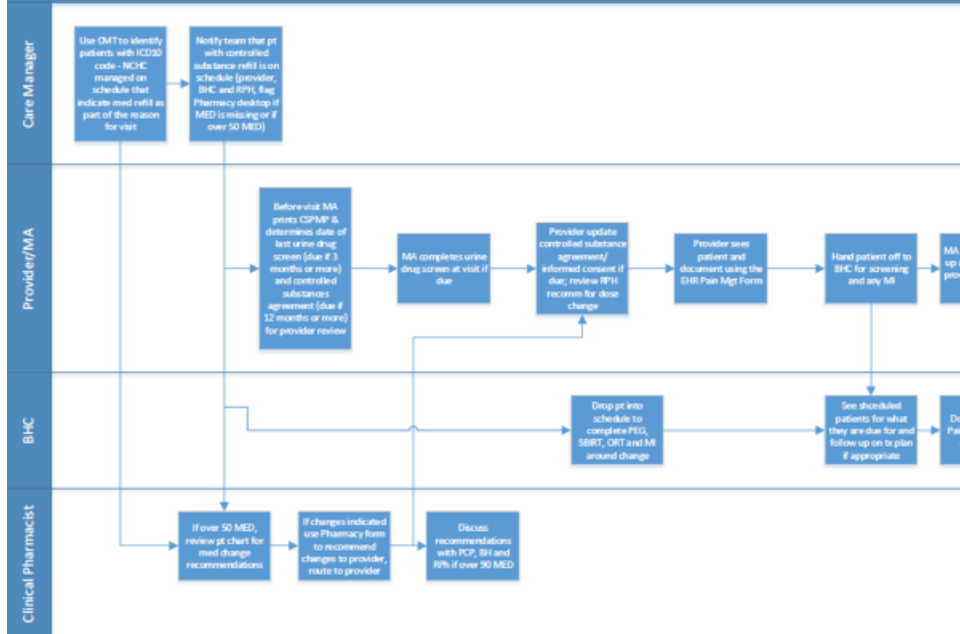
Team- SDOH Controlled Substances

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



Controlled Substances Workflow

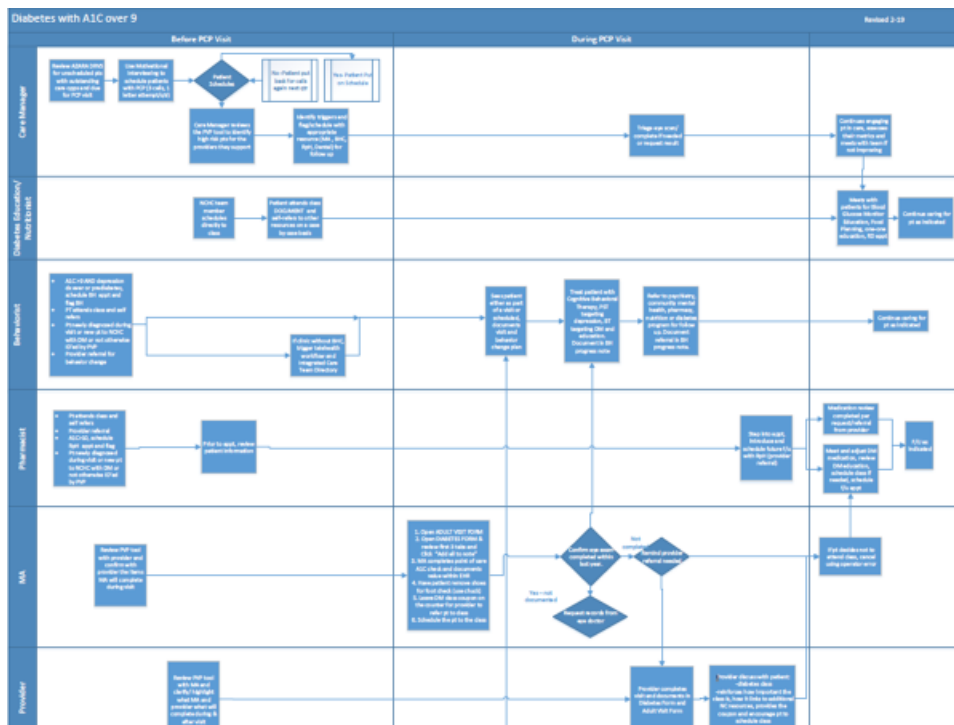
PRRs/HHAs will notify new pts that NC policy is to not fill prescriptions for controlled substances on 1st visit and ask established pts if they also need med refills at appt & doc



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

The screenshot shows a clinical decision support system interface. At the top, it displays patient information: "Update - Skin Test -- OR: Visit at FLAG-4RD on 1/23/2019 9:46:00 AM by Brandon Abbott DO [Doc ID: 1346]". The main area is titled "Disease Management" and "ANAIACC ASCVD Risk Estimator". A "Disease Management Advisor" section is active, showing a "Chronic Condition Alert" for "Diabetes, Hypertension, Depression". Below this, there are tabs for "Diabetes", "HIV", "Hepatitis C", "Cardiovascular", "Asthma", "Adult Obesity", and "Cancer Screening". The "Diabetes" tab is selected. A red box highlights the "Diabetes" tab, and another red box highlights the "Diabetes" form selection in the "Forms" list on the left. A red arrow points to the "Diabetes" form with the text "2.) Choose Diabetes". The "Forms" list on the left includes: Vital Signs, Initial Intake, SBIRT Intake, Adult CC HPI, Adult ROS, Patient History, Adult Preventive Care, Adult HM & Ed, Physical Exam, Disease Management Advisor, Accounts & Plan, Process Ltr. Orders, EBM Advisor, and Immunization Management. A red box highlights the "Disease Management Advisor" form with the text "1.) Click on Disease Management form".

- 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.

Diabetes Management - Exam DOB: 01/27/1979 Patient Age: 40 Years Old **add all to note**

Type of Screening	Last Screening	Protocol	Recommendation	Today	add
Blood Pressure	120 / 80 (12/17/2018)	Every Visit	Due		<input checked="" type="checkbox"/>
Left Foot Check	normal exam (12/17/2018)	Yearly	Protocol Satisfied	Visual: <input type="text"/>	<input checked="" type="checkbox"/>
		Yearly	Protocol Satisfied		<input checked="" type="checkbox"/>
		Yearly	Protocol Satisfied		<input checked="" type="checkbox"/>
Right Foot Check	normal exam (12/17/2018)	Yearly	Protocol Satisfied	Visual: <input type="text"/>	<input checked="" type="checkbox"/>
Right Pedal Pulse	2+ (12/17/2018)	Yearly	Protocol Satisfied	Pulse Rating: <input type="text"/>	<input checked="" type="checkbox"/>
Right Monofilament	sensory intact (12/17/2018)	Yearly	Protocol Satisfied	Monofilament: <input type="text"/>	<input checked="" type="checkbox"/>
Eye Exam	Excl: lack of insurance (01/11/2017)	Yearly after Age 12	Due	Date: <input type="text"/> Exclusion: <input type="text"/>	<input checked="" type="checkbox"/>
Dental Exam	Date: 08/01/2018 (08/25/2018)	Yearly	Protocol Satisfied	Date: <input type="text"/> Exclusion: <input type="text"/>	<input checked="" type="checkbox"/>
Depression Screening	PHQ-9 Score: 24 (07/10/2017) PHQ-2 Score: 0 (12/17/2018)	Yearly	Protocol Satisfied	PHQ-9	<input checked="" type="checkbox"/>

References: **ADA Standards of Care 2017** **AMA-Preventing Diabetes 2017** **Orders**

- 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

Diabetes Management - Labs DOB: 01/27/1979 Patient Age: 40 Years Old **add all to note**

Lab	Last Screening	Protocol	Recommendation	add
Hemoglobin A1c	12.6 (08/25/2018)	Every 3 Months	Due	<input checked="" type="checkbox"/>
Microalbumin/Creatinine Ratio		Yearly		<input checked="" type="checkbox"/>
OR Urine Protein	4+ (08/25/2018)	Yearly	Protocol Satisfied	<input checked="" type="checkbox"/>
OR Microalbumin		Yearly if Urine Protein Negative		<input checked="" type="checkbox"/>
Total Cholesterol		Yearly	Due	<input checked="" type="checkbox"/>
LDL	100 (07/12/2017)	Yearly	Due	<input checked="" type="checkbox"/>
HDL	75 (07/12/2017)	Yearly	Due	<input checked="" type="checkbox"/>
Triglycerides	440 (10/15/2013)	Yearly	Due	<input checked="" type="checkbox"/>

Flowsheet **Orders** **Problems**

