Partnerships for Care

HIV TAC TEAM

Electronic Health Records, Session #2

Community of Practice

Presenter: Heather Budd, The Massachusetts League of Community Health Centers

26 April 2016

Disclaimer

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HRSA
Health Center Program

Community of Practice Webinars for Partnership for Care (P4C) Projects

Webinar 2:

Identifying Data and Reports Needed for Quality Improvement

In Care Systems and Accountability for Performance Outcomes Supporting P4C Goals

Massachusetts League of Community Health Centers

Background

Partnerships for Care (P4C)

- Expand the provision of HIV prevention and care services within communities most impacted by HIV and better serve people living with HIV (PLWH), especially racial/ethnic minorities.
- Improve collaboration and leverage expertise among HRSA-funded health centers and CDC-funded state health departments.
- Support health center workforce development, infrastructure development, HIV service delivery across the HIV care continuum, and the development of sustainable partnerships with state health departments.

This funding is supported by the Affordable Care Act and the Secretary's Minority AIDS Initiative Fund.

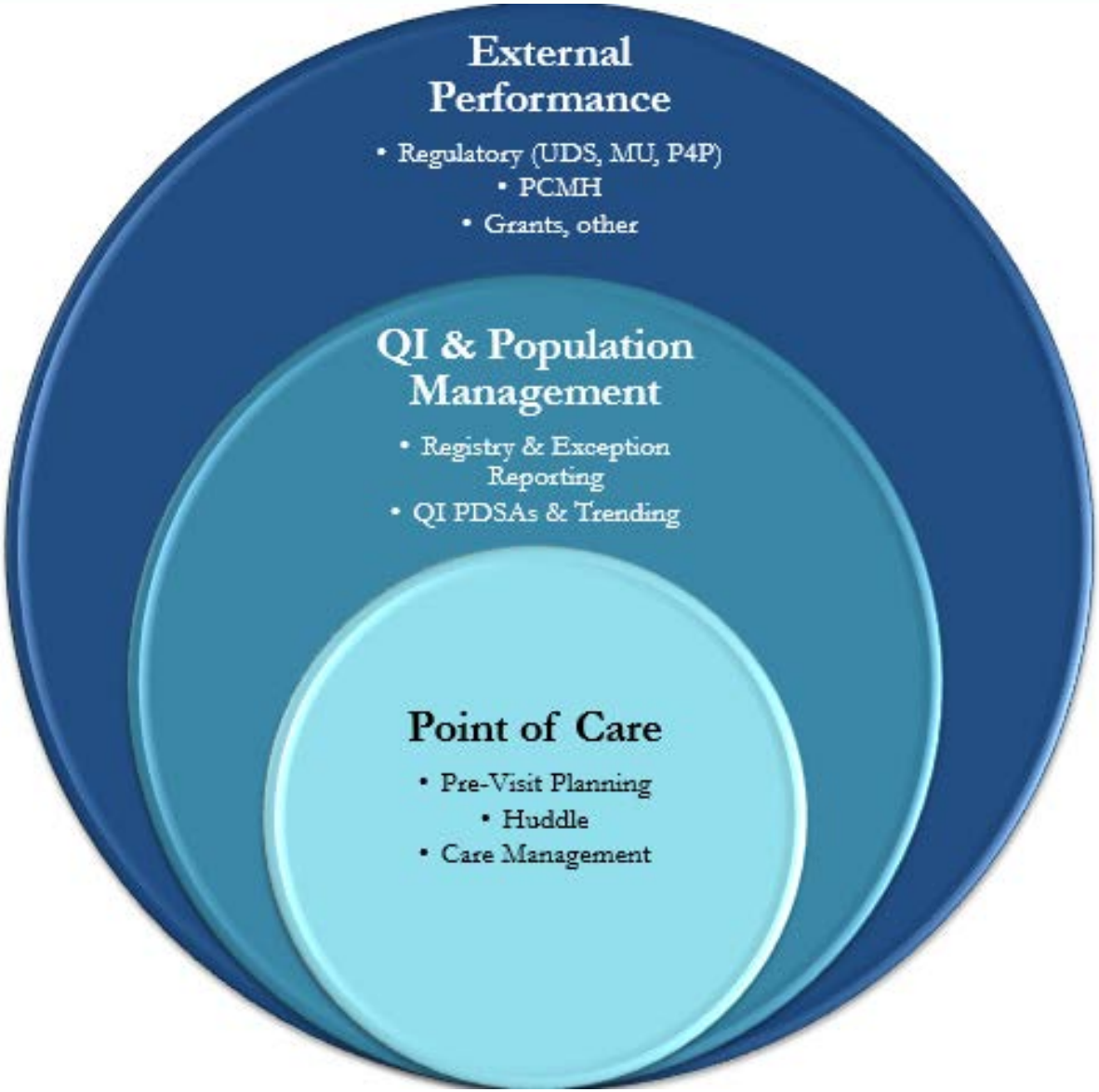
MEASURE AND REPORTING TOOLS

Assembling the Team: Roles & Responsibilities

A cross-functional team is critical to the success of the project to ensure quality of data capture, accuracy, extraction and measure results. ***Data is not just an IT project.***

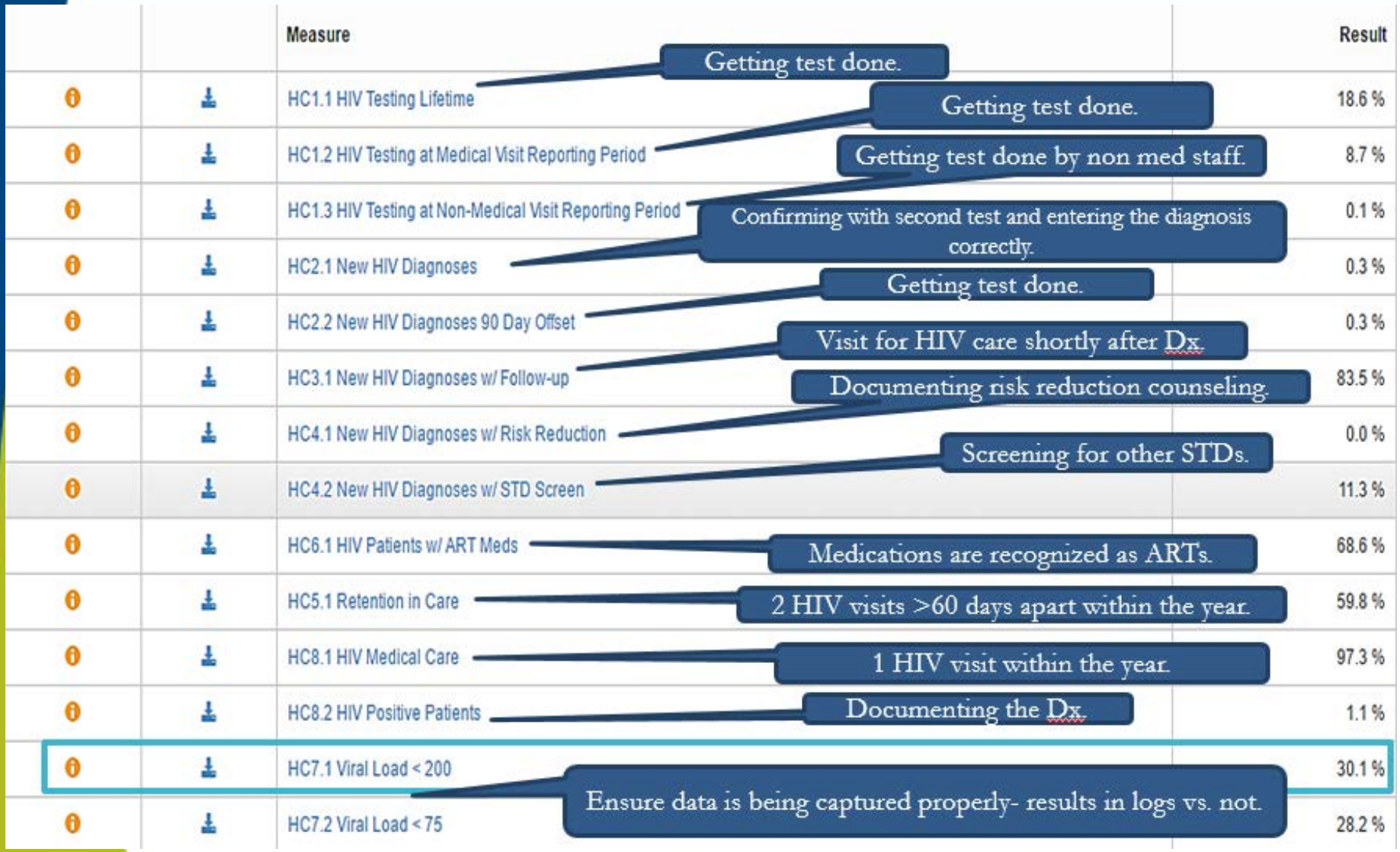
Team Roles	Team Member Responsibilities
Executive Sponsor	Leadership level sponsor for project Helps to acquire appropriate resources for program as needed
Population Management Lead	Responsible for population management at macro level Review of health home data
Network Admin/DBA	Provide access to Health Center network & EHR systems Population health management Connectivity & Performance support
EHR/HIT Expert	Identify EHR templates for data element capture Identify EHR tables for Orders, Labs, etc. Review patient population along with QI/Clinical team members
QI Specialist	Identify all data capture workflows Complete Lookup/mapping categorization Execute Data Validation Chart Audits where needed Review values for accuracies and investigates discrepancies
Provider Representative	Identify all data capture workflows Identify PHI data capture location & criteria Support QI Specialist in Data Validation Audits where needed Provide feedback on accuracy of data
Clinical Support	Identify all data capture workflows Identify PHI data capture location & criteria Support QI Specialist in Data Validation Audits Provide feedback on accuracy of data

Three Layers of Data Quality



EXTERNAL REPORTING

P4C Measure Scorecards

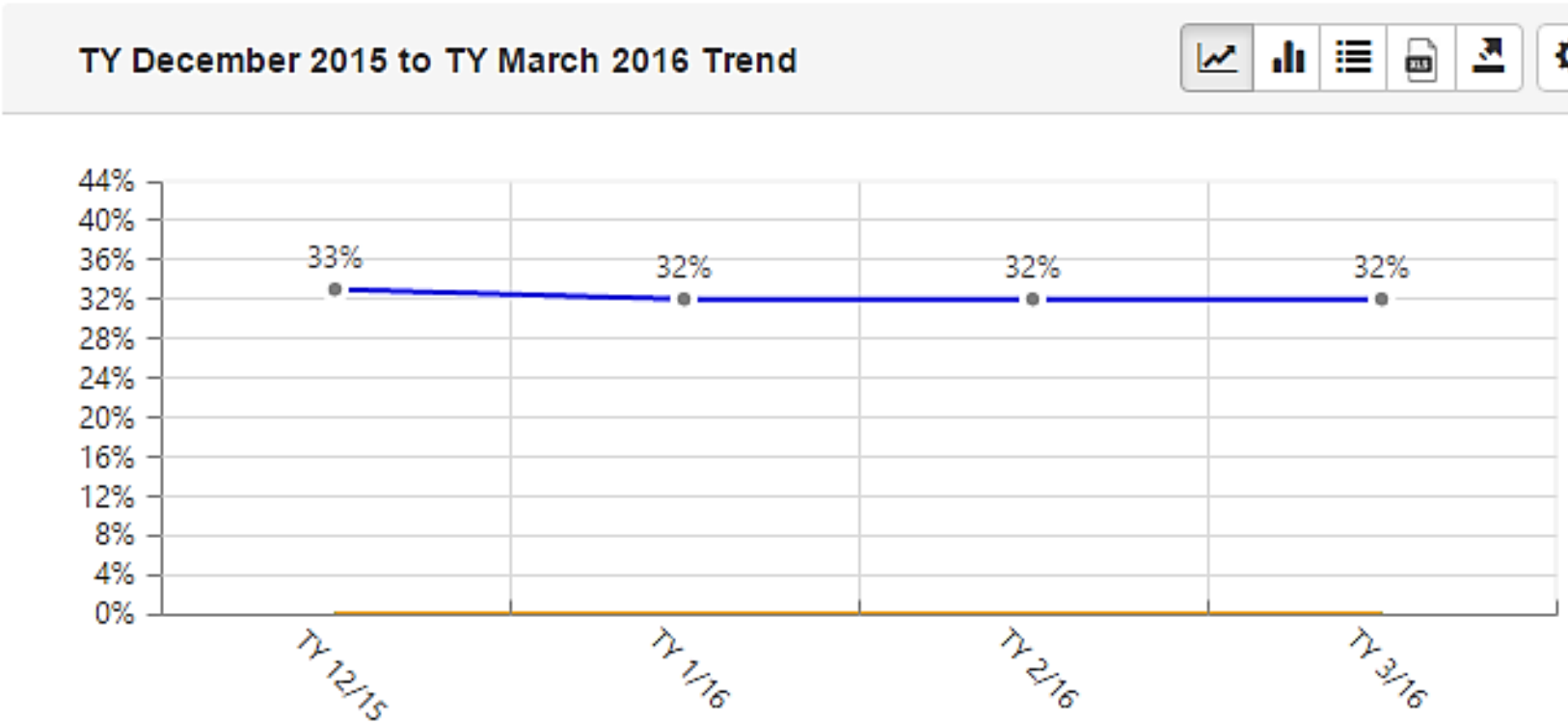


MEASURE ANALYSIS REPORTS AND DATA VALIDATION

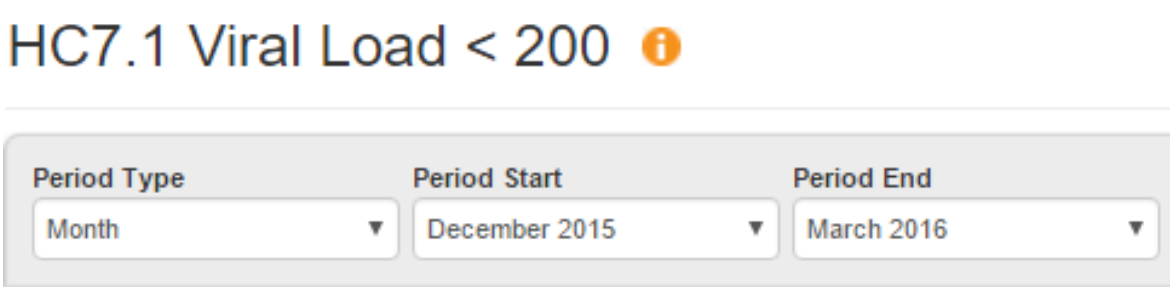
Analyze Your Performance Like a Sleuth

Viral Load <200 Measure: Trailing Year Health Center Performance Trend Line

View: Measure Analyzer Detail List



Consider Time Increments' Impact on Data



- View data monthly rather than by year or trailing year to give the data more life- less smoother to see:
  - Is there seasonality to the challenge?
  - Has there been a steady decline or sudden?
  - When did the decline begin?

Viral Load Data Challenges

Labs

- LOINC vs. order name
- Standardizing lab results to calculate result based measures

Results

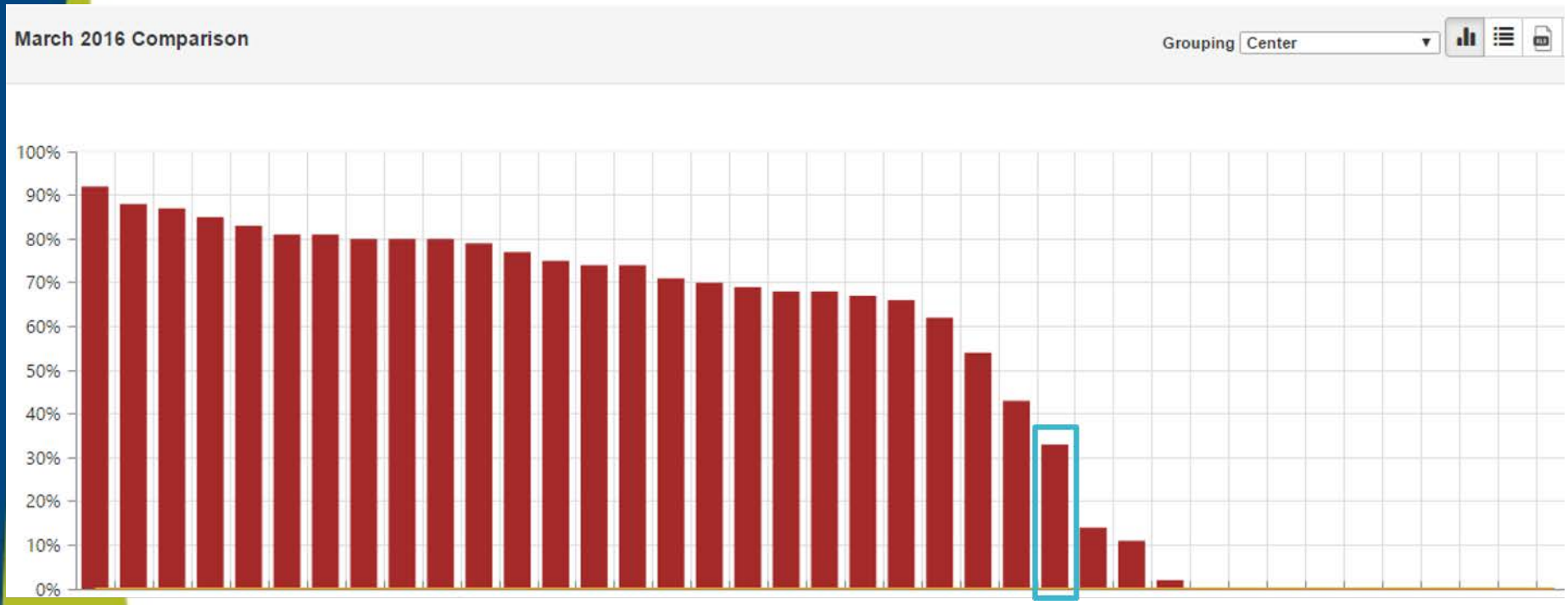
- Log Copies vs. Standard Numeric results
- Ensuring a reporting system can differentiate which results are logs compared to standard will enable the system to make consistent meaning of the results, and calculate measures correctly.

$$\log 5623 = 3.74997$$

This means $10^{3.74997} = 5623$

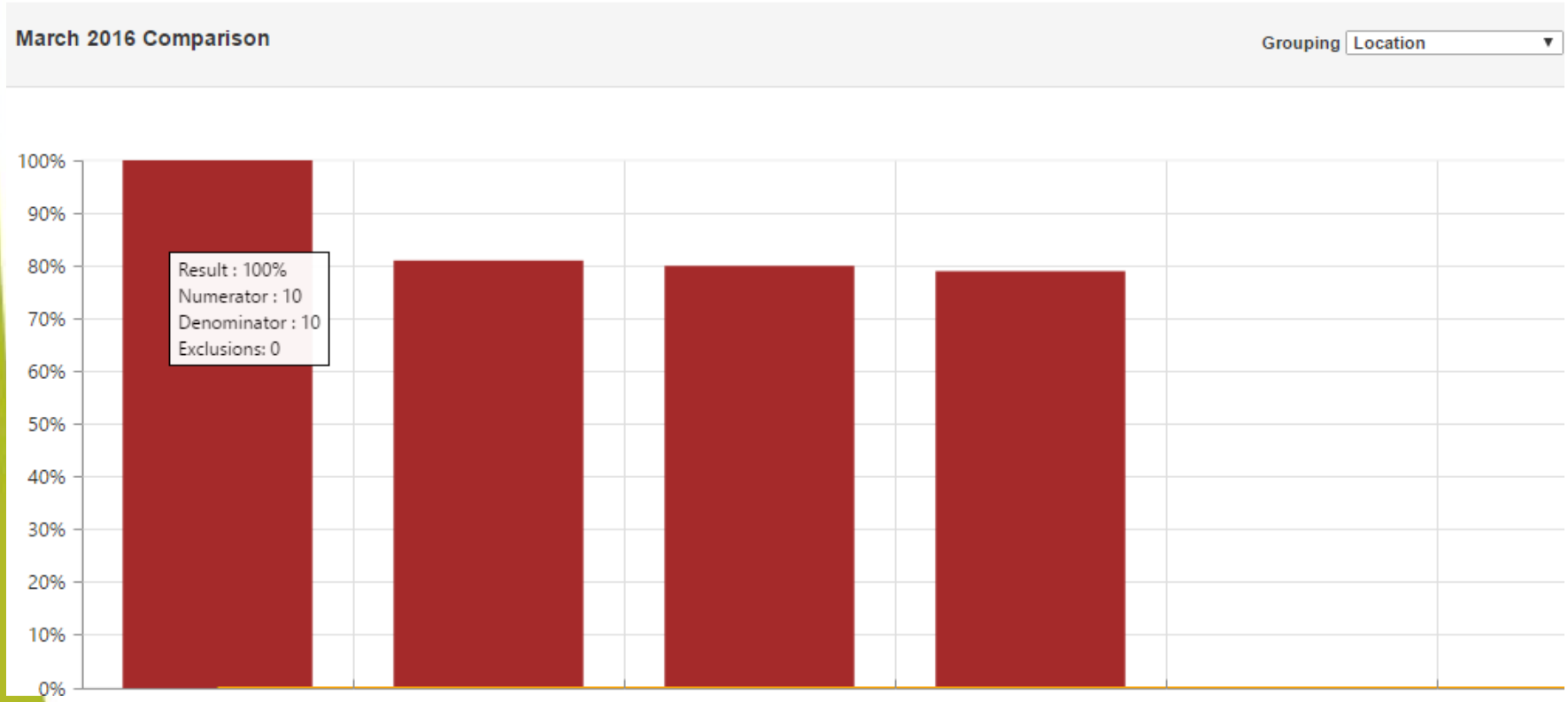
Mental check: $10^3 = 1,000$ and $10^4 = 10,000$.

Compare Your Performance with Peers



Compare Your Locations

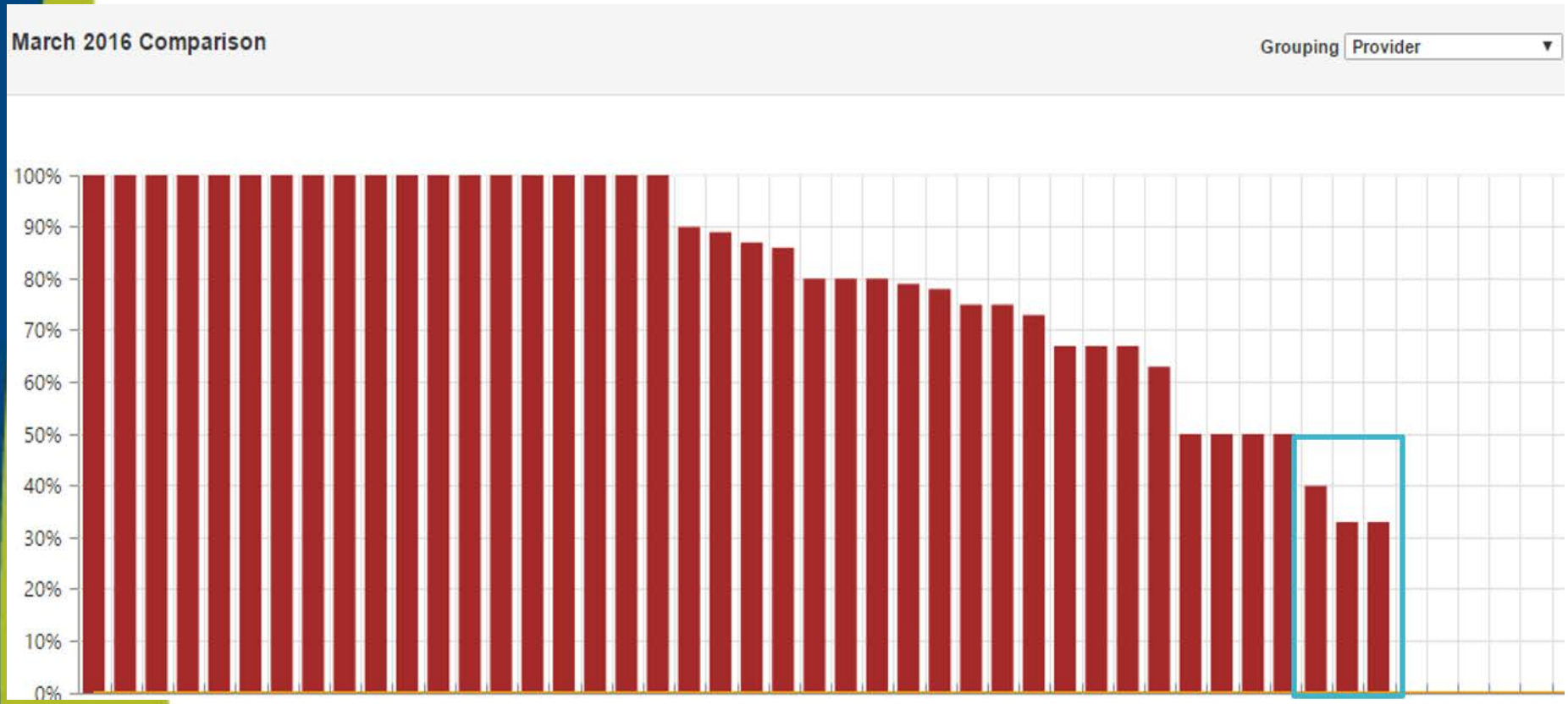
Consider the services offered, staffing model, layout, resources and patient population in case it may impact the results.



Compare Your Providers

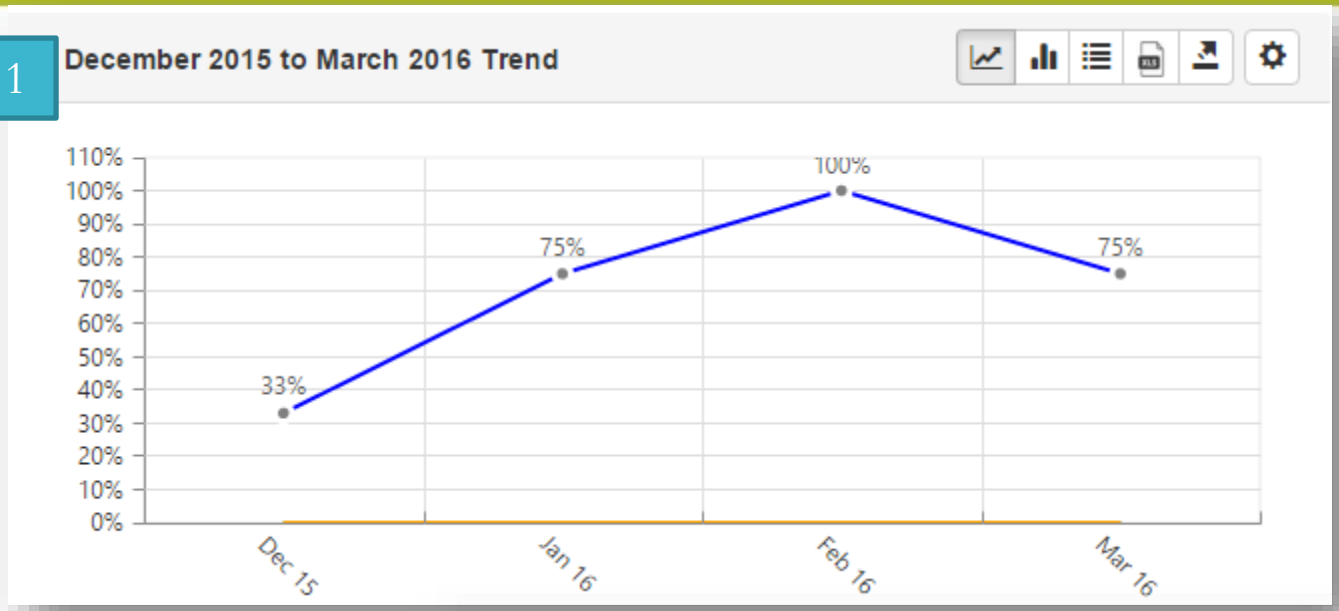
Data management: Are there a few providers ordering a Viral Load test that is not coming back with a result that's captured by a reporting tool? If so, fix the reports.

Quality Improvement: Look to harvest best practices from the providers at 100% or other high score.



Investigate Individual Providers' Trends

1



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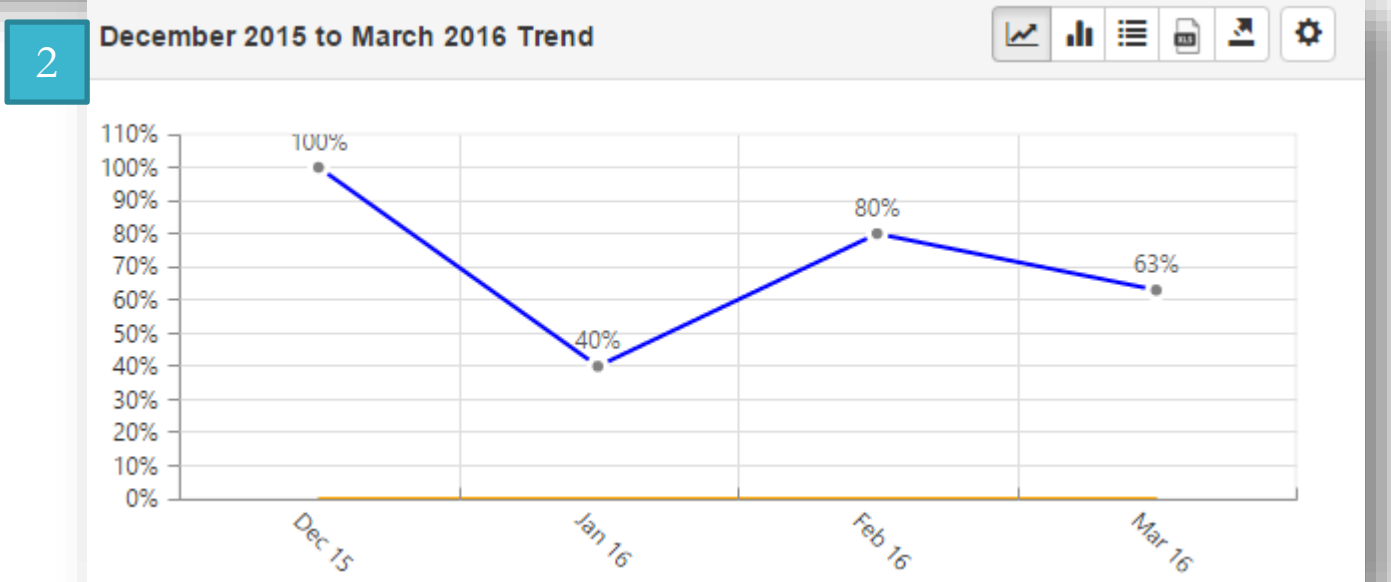
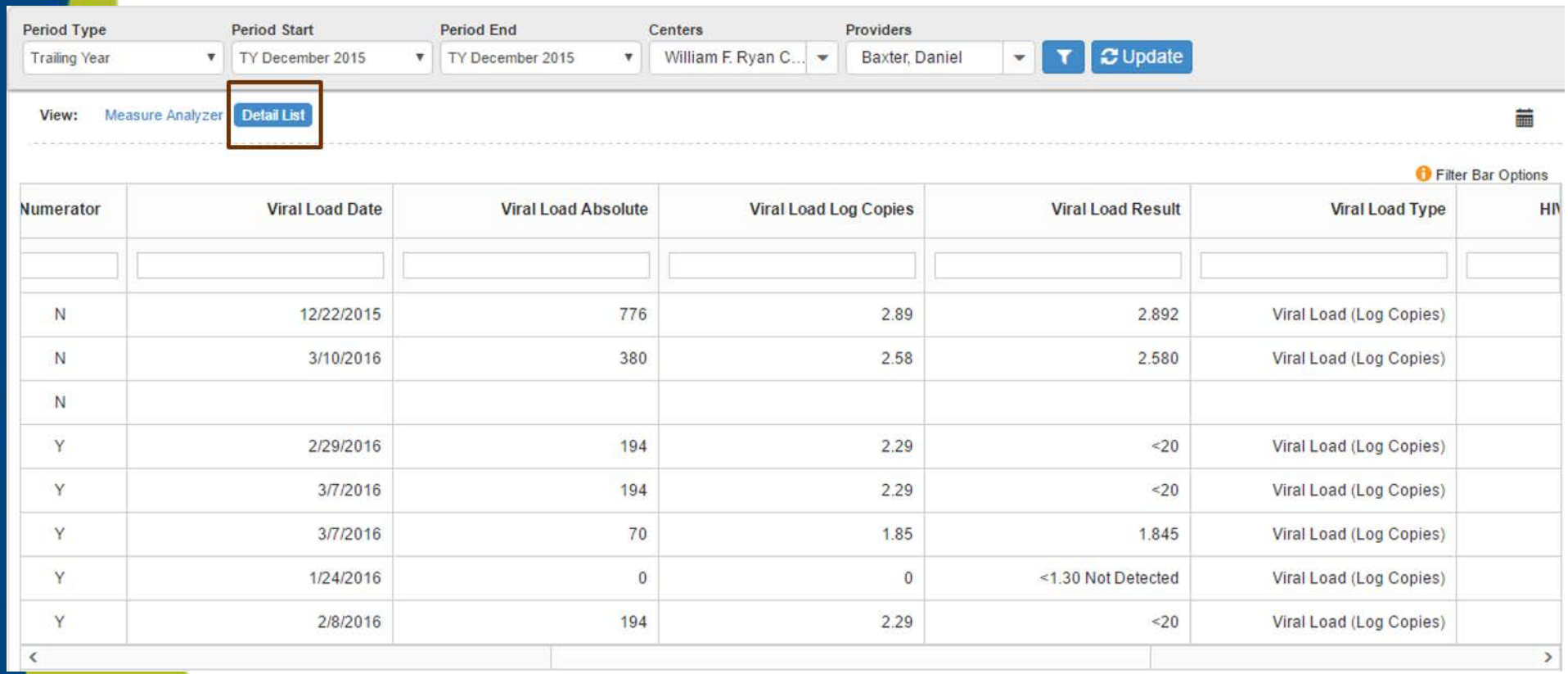


Hypothesize Interventions for Improvement

- Plan a PDSA Cycle based on the findings of your analysis.
- Do the intervention, possibly with a small set of provider teams.
- Study your results via data and collect feedback.
- Act: Determine if intervention should stay in place, be altered, or test a new intervention if you encountered failure.

Generate Detail List

1. Click on the Detail List hyperlink to see patients associated with the measure in the period selected.
2. Compare data in the EHR on a select group of patients. Look closely at the Viral load result format.



Numerator	Viral Load Date	Viral Load Absolute	Viral Load Log Copies	Viral Load Result	Viral Load Type	HI
N	12/22/2015	776	2.89	2.892	Viral Load (Log Copies)	
N	3/10/2016	380	2.58	2.580	Viral Load (Log Copies)	
N						
Y	2/29/2016	194	2.29	<20	Viral Load (Log Copies)	
Y	3/7/2016	194	2.29	<20	Viral Load (Log Copies)	
Y	3/7/2016	70	1.85	1.845	Viral Load (Log Copies)	
Y	1/24/2016	0	0	<1.30 Not Detected	Viral Load (Log Copies)	
Y	2/8/2016	194	2.29	<20	Viral Load (Log Copies)	

Make A Validation Spreadsheet to Chart Findings

Name	MRN	Denominator	Numerator	Viral Load Date	Viral Load Absolute	Viral Load Log Copies	Viral Load Result	Viral Load Type	HIV Diagnosis	Diagnosis Code	Pass/Fail	Comments

Name	MRN	Denominator	Numerator	Viral Load Date	Viral Load Absolute	Viral Load Log Copies	Viral Load Result	Viral Load Type	HIV Diagnosis	Diagnosis Code	Pass/Fail	Comments
Mouse, M	234212	Y	N								F	EHR shows viral load done on 2/12/16.

Communicate findings to your vendor or internal report writing team.

REGISTRIES FOR POPULATION MANAGEMENT

HIV Behavioral Health Registry Needs

HIV Diagnosis	Diagnosis Code	Depression Screen	Depression Screen Result	Depression Screen Type	Violence Screening	Tobacco Status Date
1/9/2011	042	1/10/2016	0	PHQ-2 Depression Screen		5/19/2015

Tobacco Status Result	Tobacco Cessation	Anxiety Screen	PTSD Screen	Cognitive Function Assessment	Sleeping Habits Assessment	Appetite Assessment	Psychosocial Assessment
R			5/19/2015	5/19/2015	5/19/2015	9/15/2015	

HIV General Data Registry Needs

HIV Diagnosis	Diagnosis Code	BP Date	BP Systolic	BP Diastolic	Ophthalmology Referral	Med Reconciliation	Last Physical	Rectal Exam

Rectal Exam	Colonoscopy	Mammogram	HTN	Last Flu	FLU Ct	Last PCV	PCV Ct	PCP Prophylaxis Meds

HIV Lab Registry Needs

Most Recent CD4 Dt	Most Recent Cd4	Min Cd4	Min CD4 Dt	Tuberculosi Date	Tuberculosi Result	PAP Date	PAP	Viral Load Date	Viral Load Absolute	Viral Load Log Copies	Viral Load Result	Viral Load Type	Anogenit HPV	Baseline Resistance Test
1/7/2016	650	281	7/25/2014	10/2/2015	Negative			1/7/2016	0	0	<20	Viral Load		

1. Population Management: Use registries for outreach to patients who need to come back in for visits, screenings, tests, medications etc.

2. Care Management: Sort Ascending or Descending on results like labs to assess the patient's health and need for intervention.

HIV DATA AT THE POINT OF CARE

Looking Out for Patient Care

Facilitates more efficient pre-visit planning for *preventative and chronic care, all in one report.*

- Displays ***only*** relevant and actionable items to help teams prepare for visits.
- Displays active diagnoses and relevant risk factors.
- Alerts indicate whether particular clinical parameters, labs or screenings are (a) missing, (b) overdue or (C) out of range.
- Alerts are configurable for the center, not user.

Use as an efficient clinical management tool, where success on measures is a by-product of use.

- Visit planning alerts based on national standards (UDS, MU, HEDIS) and *set to the strictest standard* where conflicts exist among them.
- Focus on a single goal.

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Visit Planning Report

Combines Registry & Preventative Care Alerts, by Provider, ordered by appointment, in one report.

— Cranston, Bill — 2 Scheduled Appointment(s)

Export this Provider to PDF

1:25 PM | Friday, September 11, 2015 — **Visit Reason: Well Child Visit**

Gomez, Jose	DOB: 11/23/2006	Gender: M	Phone: 522-113-5837	PCP: Cranston, Bill
MRN: 780239	Age: 9	Risk Level: Moderate	Language: Spanish	

Diagnoses	Alert	Message	Most Recent Date	Most Recent Result
Asthma	Nutritional Counseling	Missing		
	Physical Activity Counseling	Missing		
Risk Factors	BMI Percentile	Overdue	8/15/2014	90
OBS	Asthma Severity	Overdue	8/15/2014	

3:45 PM | Friday, September 11, 2015 — **Visit Reason: Headaches**

Perkins, Sonja	DOB: 3/18/1962	Gender: F	Phone: 522-788-5001	PCP: Gunther, Eric
MRN: 5112866	Age: 53	Risk Level: High	Language: English	

Diagnoses	Alert	Message	Most Recent Date	Most Recent Result
DM, HTN, DEP, COPD	Mammogram	Missing		
	Pap Smear	Missing		
Risk Factors	A1c	Overdue	8/15/2014	10.2
SAD, SMIP	BP	Result out of Range	8/15/2014	150/95
	Eye Exam	Missing		
	Flu	Missing		
	Tobacco Status	Missing		
	LDL	Overdue	5/15/2013	90.1

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https://drvs.azarahealthcare.com/documentation/help/Release8PVP.swf

Sample Patient Alerts

Name	Description
Adult Weight Screening	Alert will trigger if patient has not had a BMI in the past year, or if most recent BMI was < 18 or >= 25 for patients < 65 yrs old, or if most recent BMI was < 22 or >= 30 for patients >= 65 yrs old. This alert is not editable.
Asthma Severity	Alert will trigger if Asthma Severity has not occurred in the last {configurable- stock is 36500} days. Alert only applies to patients >= 0 yrs old and <= 85 yrs old. Patient must have NQF 0047 Asthma Diagnosis. Ages and gender are configurable.
Asthma Control	Alert will trigger if a patient with an active diagnosis of Asthma, with Persistent severity, does not have an active Asthma Control Drug listed in the medication list. Alert only applies to patient >= 0 years old and <= 85 years old. Ages and gender are configurable.
BMI	Alert will trigger if BMI has not occurred in the last 365 days. Alert only applies to patients >= 18 yrs old and <= 150 yrs old. Ages and gender are configurable.
BMI Percentile	Alert will trigger if BMI Percentile has not occurred in the last {configurable- stock is 365} days. Alert only applies to patients >= 2 yrs old and <= 17 yrs old. Ages and gender are configurable.
BP	Alert will trigger if Blood Pressure has not occurred in the last 365 days, or if numeric_1 value is >= {configurable stock is 140} and numeric_2 value is >= {configurable - stock is 90}. Alert only applies to patients and <= 85 yrs old. Patient must have Diabetes or Hypertension or IVD or AMI or CABG or PCI. Ages and gender are configurable.
Chlamydia Screening	Alert will trigger if Chlamydia Screen has not occurred in the last Alert will trigger if Chlamydia Screen has not occurred in the last {configurable- stock is 365} days. Alert only applies to Female patient >= 16 years old. Ages and gender are configurable.
Colorectal Cancer Screening	Alert will trigger if patient has not had a colonoscopy in past 10 years, flexible sigmoidoscopy in past 5 years, or FOBT/FIT in past year, for patients >= 50 yrs old and <= 75 years old. This alert is not editable.
Dental Visit	Alert will trigger if Dental Access has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 0 yrs old and <= 150 yrs old. Ages and gender are configurable.
Depression Screening	Alert will trigger if Standardized Depression Screen has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 18 yrs old and <= 150 yrs old. Patient must not have EP 0418 Exclusion. Ages and gender are configurable.
Diabetes A1c	Alert will trigger if A1c has not occurred in the last {configurable - stock is 180} days, or if numeric_1 value is >= {configurable - stock is 7}. Alert only applies to patients >= 0 yrs old and <= 85 yrs old. Patient must have Diabetes. Ages and gender are configurable.
Diabetes Eye Exam	Alert will trigger if Eye Exam has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 0 yrs old and <= 85 yrs old. Patient must have Diabetes. Ages and gender also configurable.
Diabetes Foot Exam	Alert will trigger if Foot Exam has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 0 yrs old and <= 85 yrs old. Patient must have Diabetes. Ages and gender also configurable.
Diabetes Nephropathy Screening	Alert will trigger if Nephropathy Screening has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 0 yrs old and <= 85 yrs old. Patient must have Diabetes. Ages and gender also configurable.
Flu	Alert will trigger if Flu has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 1 yrs old and <= 85 yrs old. Ages and gender also configurable.

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Sample Patient Alerts (cont)

Name	Description
Infant Well-Child Check (HEDIS W15)	Alert will trigger if patient has not had 6+ well child visits by 15 months. This alert is not editable.
Annual Well-Child Check (HEDIS W34)	Alert will trigger if a Well-Child Visit has not been coded with a CPT code within the last {configurable - stock is 365} days . Alert only applies to patients >= 3 yrs old and <= 6 yrs old. Ages are configurable so practices can use this to remind them about well-child checks needed for adolescents and young adults.
Hep C	Alert will trigger if a Hep C screen has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 18 yrs old. Ages and gender are configurable.
HIV Screening	Alert will trigger if HIV Screen has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 18 yrs old. Ages and gender also configurable.
LDL	Alert will trigger if LDL has not occurred in the last {configurable - stock is 365} days, or if numeric_1 value is >= {configurable - stock is 100}. Alert only applies to patients and <= 85 yrs old. Patient must have Diabetes or Hypertension. Ages, diagnoses, and gender are configurable.
Lipid Lowering Therapy	Alert will trigger for patients with an active diagnosis of CAD (including acute MI), and patient does not have an active prescription for a Statin drug on the medication list. Alert only applies to patients >=18 yrs old and <= 85 yrs old. Age, gender, and diagnoses are configurable.
Mammogram	Alert will trigger if Mammogram has not occurred in the last {configurable - stock is 365} days. Alert only applies to female patients >= 40 yrs old and <= 70 yrs old. Patient must not have a mastectomy or history of breast cancer. Ages and gender are configurable.
Most Recent BP Elevated *(by request)*	Alert will trigger if most recent BP result was 140/90 or greater. Alert only applies to patients >17 and <=100 yrs old. Patient must not already have Diabetes; Essential Hypertension; Hypertension; IVD, AMI, CABG, or PCI. Ages, gender, and diagnoses are configurable.
Nutritional Counseling	Alert will trigger if Nutritional Counseling has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 2 yrs old and <= 17 yrs old. Ages and gender are configurable.
Pap	Alert will trigger if Pap has not occurred in the last {configurable - stock is 1095} days. Alert only applies to female patients >= 24 yrs old and <= 65 yrs old. Patient must not have Hysterectomy. Ages and gender are configurable.
PCV	Alert will trigger if Pneumococcal immunization has not occurred in the last {configurable - stock is 36500} days. Alert only applies to patients >= 65 yrs old and <= 85 yrs old. Ages and gender are configurable.
Physical Activity Counseling	Alert will trigger if Physical Activity Counseling has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 2 yrs old and <= 17 yrs old. Ages and gender are configurable.
Prenatal Care	Alert will trigger if patient has been identified as pregnant but does not have trimester of entry to prenatal care and location (at health center or elsewhere) documented. This alert is not editable.
Tobacco Cessation	Alert will trigger if patient's most recent tobacco status in the past year was 'Y' and patient has not had tobacco cessation in the past year. This alert is not editable.
Tobacco Status	Alert will trigger if Most Recent Tobacco Status has not occurred in the last {configurable - stock is 365} days. Alert only applies to patients >= 18 yrs old and <= 150 yrs old. Ages and gender are configurable.

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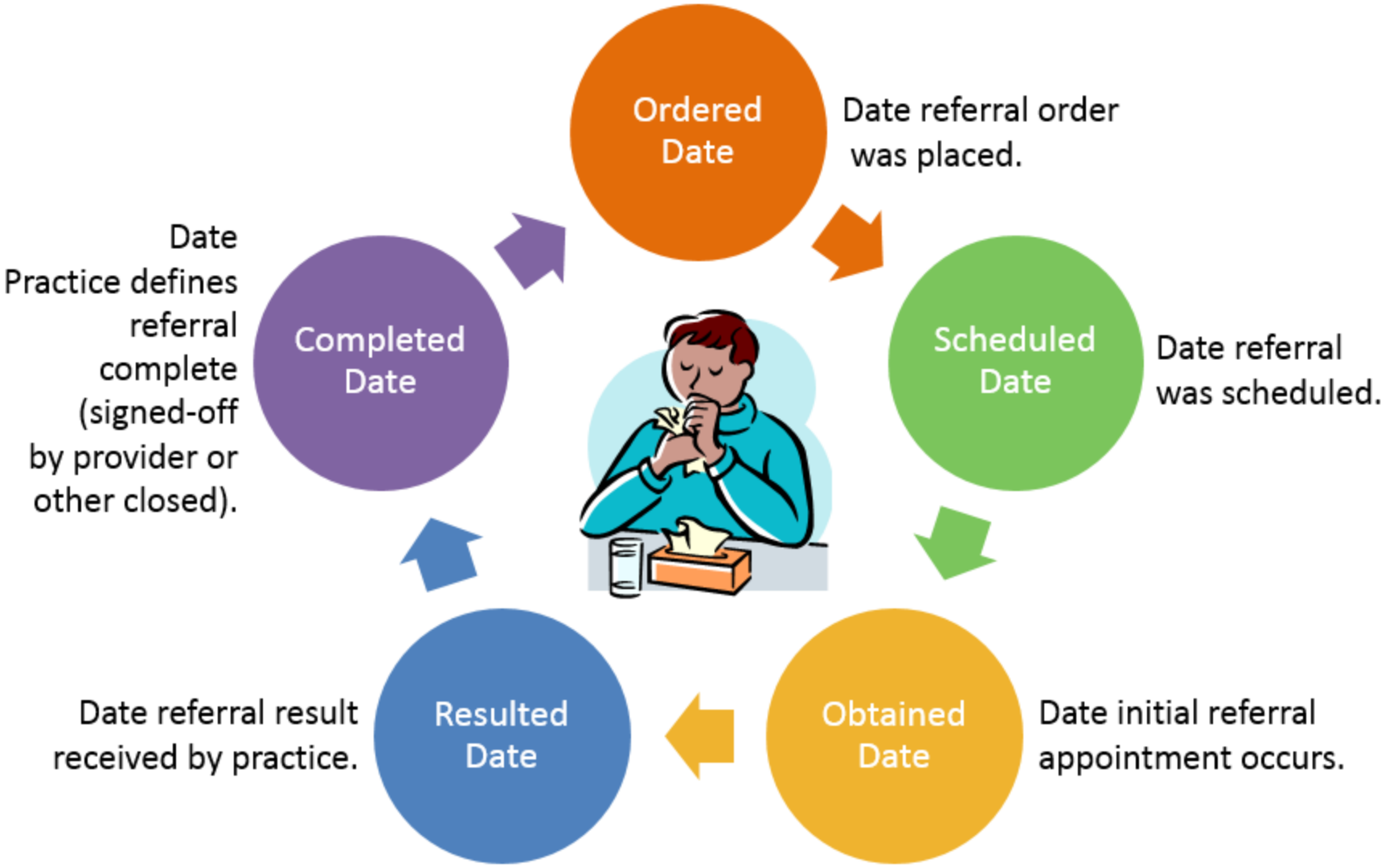
REFERRAL MANAGEMENT AND CARE COORDINATION

Typical Referral Process Steps



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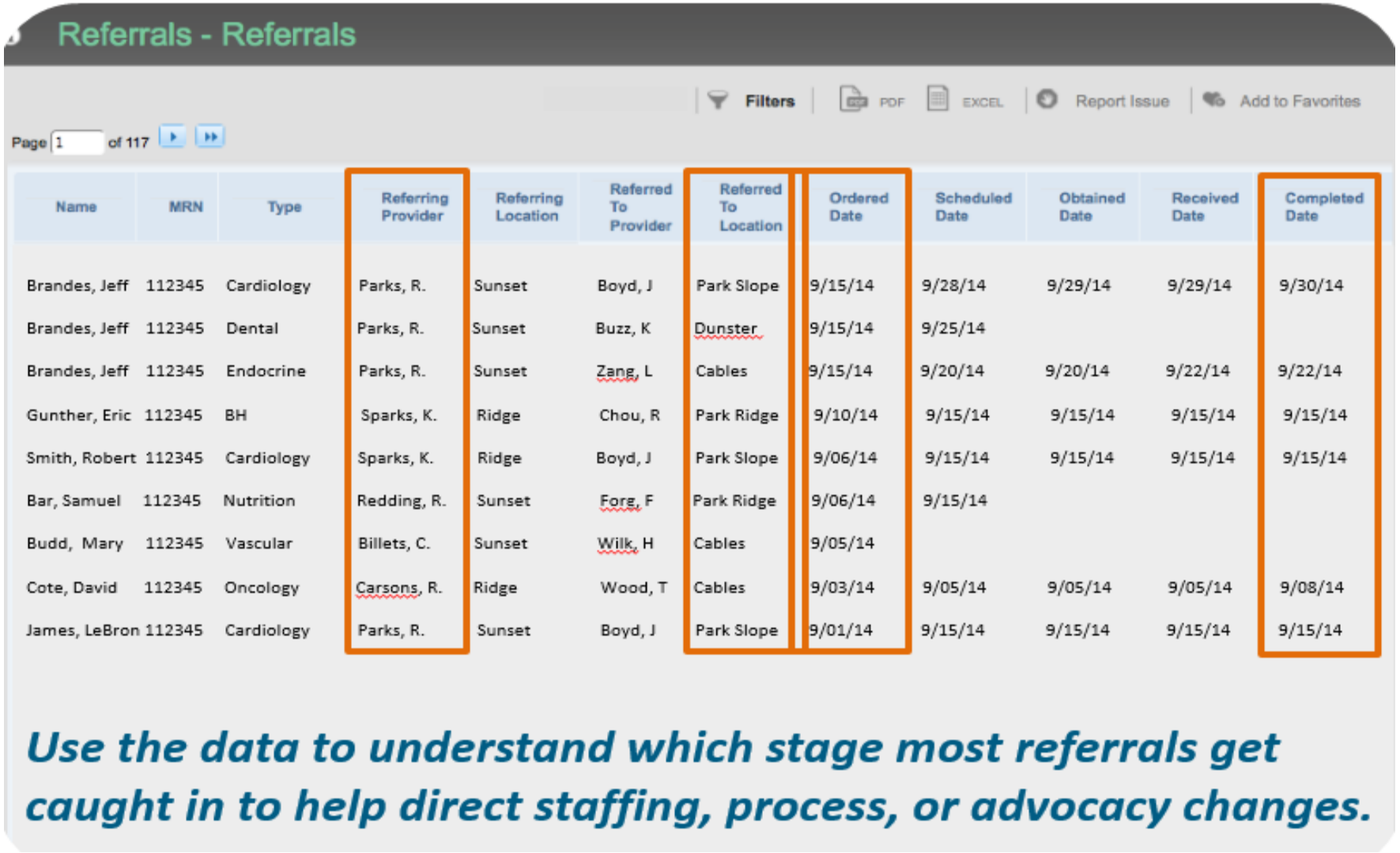
Referral Log / Registry



Referrals - Referrals

Filters | PDF | EXCEL | Report Issue | Add to Favorites

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Name	MRN	Type	Referring Provider	Referring Location	Referred To Provider	Referred To Location	Ordered Date	Scheduled Date	Obtained Date	Received Date	Completed Date
Brandes, Jeff	112345	Cardiology	Parks, R.	Sunset	Boyd, J	Park Slope	9/15/14	9/28/14	9/29/14	9/29/14	9/30/14
Brandes, Jeff	112345	Dental	Parks, R.	Sunset	Buzz, K	Dunster	9/15/14	9/25/14			
Brandes, Jeff	112345	Endocrine	Parks, R.	Sunset	Zang, L	Cables	9/15/14	9/20/14	9/20/14	9/22/14	9/22/14
Gunther, Eric	112345	BH	Sparks, K.	Ridge	Chou, R	Park Ridge	9/10/14	9/15/14	9/15/14	9/15/14	9/15/14
Smith, Robert	112345	Cardiology	Sparks, K.	Ridge	Boyd, J	Park Slope	9/06/14	9/15/14	9/15/14	9/15/14	9/15/14
Bar, Samuel	112345	Nutrition	Redding, R.	Sunset	Fore, F	Park Ridge	9/06/14	9/15/14			
Budd, Mary	112345	Vascular	Billets, C.	Sunset	Wilk, H	Cables	9/05/14				
Cote, David	112345	Oncology	Carsons, R.	Ridge	Wood, T	Cables	9/03/14	9/05/14	9/05/14	9/05/14	9/08/14
James, LeBron	112345	Cardiology	Parks, R.	Sunset	Boyd, J	Park Slope	9/01/14	9/15/14	9/15/14	9/15/14	9/15/14

Use the data to understand which stage most referrals get caught in to help direct staffing, process, or advocacy changes.

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Best Practices for Sharing Info with Other Agencies

- Dedicated HIV Care Coordinator staff members, if affordable, can be the best liaisons for care between the center medical and specialty teams, behavioral health, and other external agencies (like Health Departments) and medical facilities

- Any practices interested in sharing their approach?
  - Success or challenges

Contact

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