Planned Care, Population Management, & Data Management

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Informatics Philosophy & Core Functions

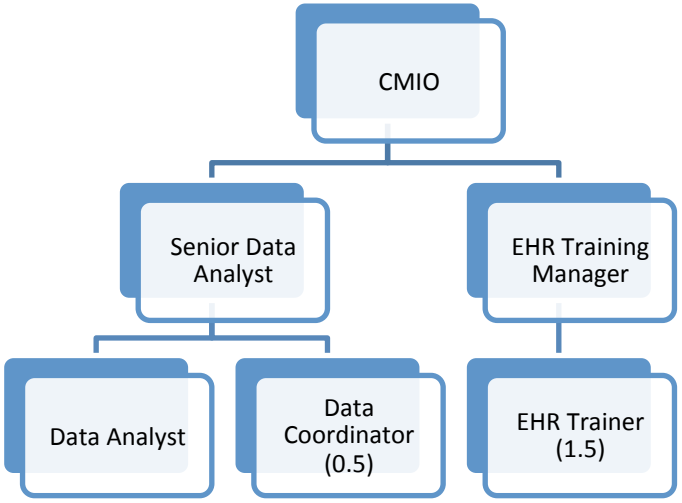
Petaluma Health Center

Core functions:

- EHR optimization
  - training
  - customization
- Data Analysis for Clinical and Operational data
- Other duties as assigned:
  - telemedicine
  - innovative tech
  - Equipment

Philosophy:

- Maximize the use of our technology
- Make sure that people are doing the work that requires human interaction



Population Health Structural Cornerstones

Petaluma Health Center

1. Huddle
2. Recall
3. Time dedicated to management of chronic illness
4. Identifying populations for services to improve health
   - Hepatitis C treatment
   - Behavioral Health and Addiction
   - Nutrition
   - Health education
   - Case Management & Navigation
   - Shared medical visits, wellness services

Huddle

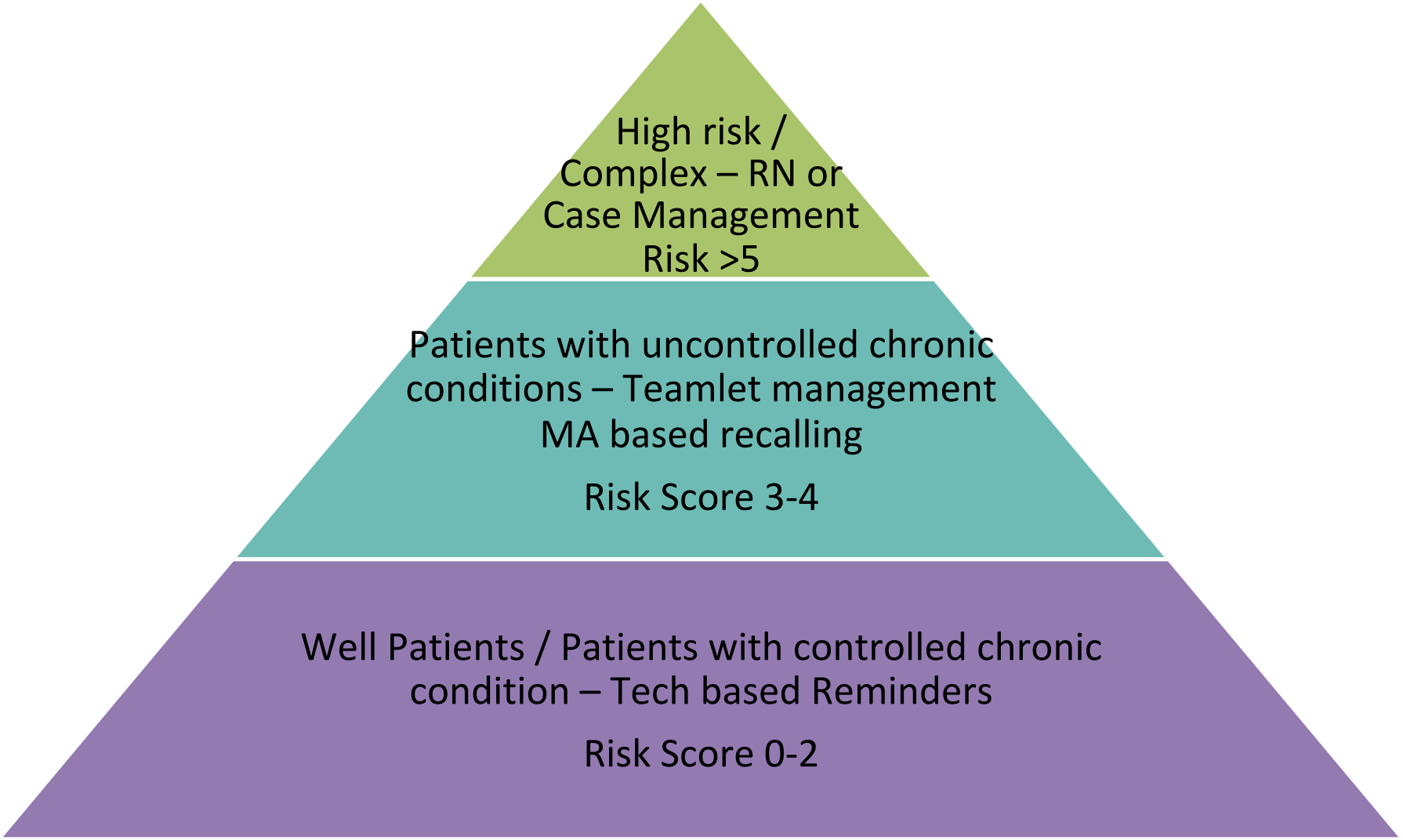
The purpose of the huddle is to systematically review patients' charts in order to prepare for patient visits.

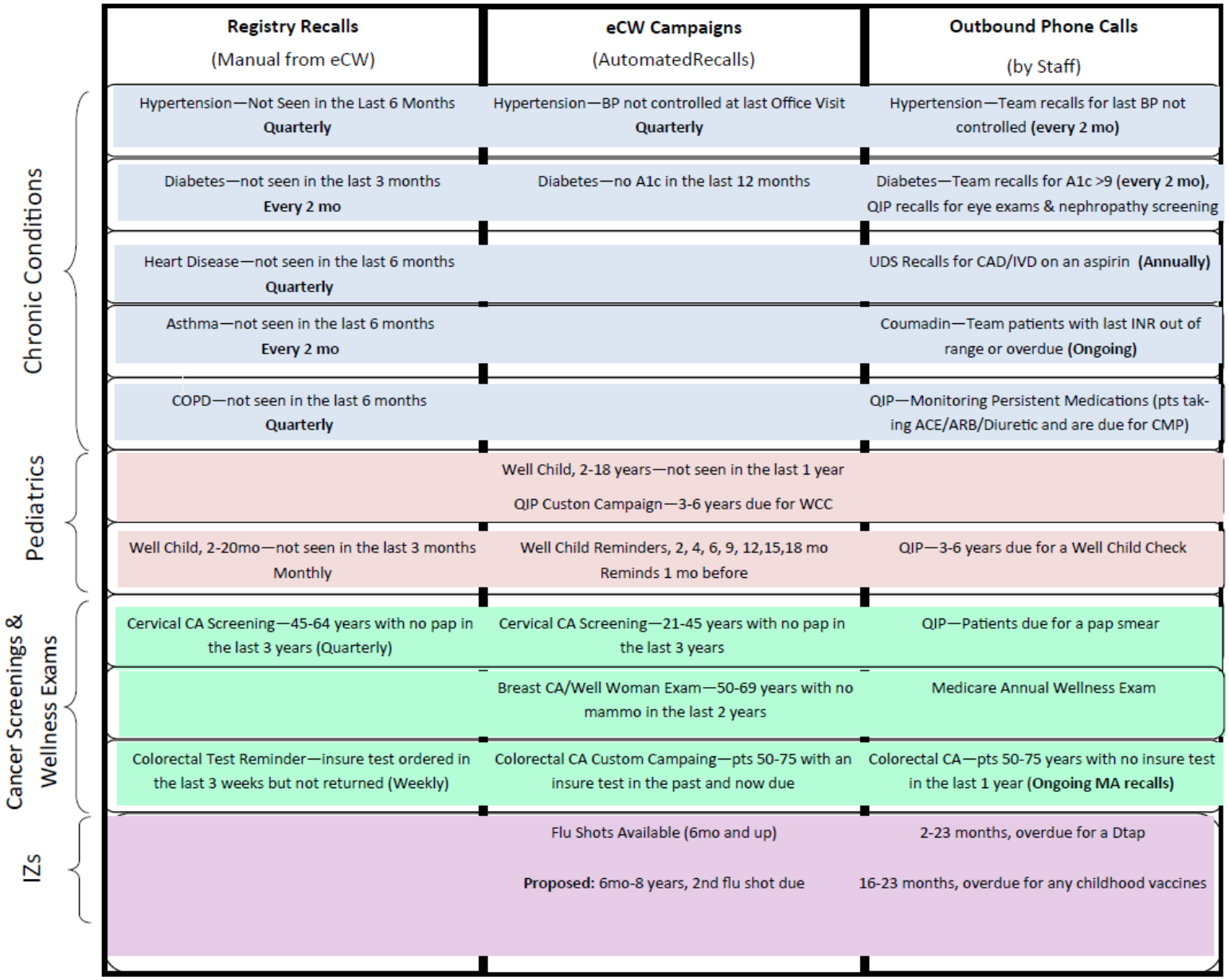
(How to huddle wiki)

Components of a hearty huddle:

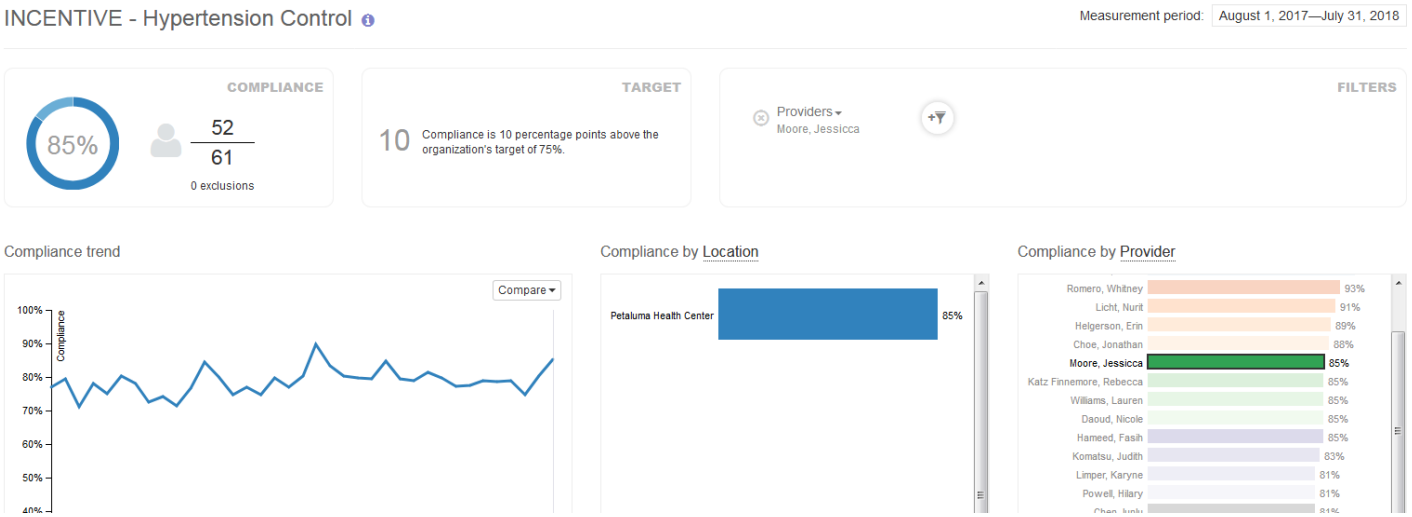
	Provider	MA
1. Clinical review	Talks through the clinical review	Types notes in chief complaints field
1. Visit Planning – Relevant (alerts in eCW for same day appts only)	Makes decision on what will be done today. Types notes in chief complaints field	Reads (Talks) complete lists of alerts to provider.
1. Merge Templates	Recommends templates to be merged	Merges templates as instructed or by protocol.
1. Anticipate needs from other team members	Discuss and anticipated patient needs with MA, Flow-coordinator and RN	Discuss and anticipated patient needs with MA, Flow-coordinator and RN, NOTES any anticipated needs in chief complaints field

Recalls


High risk / Complex – RN or Case Management
Risk >5
Patients with uncontrolled chronic conditions – Teamlet management
MA based recalling
Risk Score 3-4
Well Patients / Patients with controlled chronic condition – Tech based Reminders
Risk Score 0-2


Registry Recalls
(Manual from eCW)
eCW Campaigns
(AutomatedRecalls)
Outbound Phone Calls
(by Staff)
Chronic Conditions
Hypertension—Not Seen in the Last 6 Months Quarterly
Hypertension—BP not controlled at last Office Visit Quarterly
Hypertension—Team recalls for last BP not controlled (every 2 mo)
Diabetes—not seen in the last 3 months Every 2 mo
Diabetes—no A1c in the last 12 months
Diabetes—Team recalls for A1c >9 (every 2 mo), QIP recalls for eye exams & nephropathy screening
Heart Disease—not seen in the last 6 months Quarterly
UDS Recalls for CAD/IVD on an aspirin (Annually)
Asthma—not seen in the last 6 months Every 2 mo
Coumadin—Team patients with last INR out of range or overdue (Ongoing)
COPD—not seen in the last 6 months Quarterly
QIP—Monitoring Persistent Medications (pts taking ACE/ARB/Diuretic and are due for CMP)
Pediatrics
Well Child, 2-18 years—not seen in the last 1 year
QIP Custon Campaign—3-6 years due for WCC
Well Child, 2-20mo—not seen in the last 3 months Monthly
Well Child Reminders, 2, 4, 6, 9, 12,15,18 mo Reminds 1 mo before
QIP—3-6 years due for a Well Child Check
Cancer Screenings & Wellness Exams
Cervical CA Screening—45-64 years with no pap in the last 3 years (Quarterly)
Cervical CA Screening—21-45 years with no pap in the last 3 years
QIP—Patients due for a pap smear
Breast CA/Well Woman Exam—50-69 years with no mammo in the last 2 years
Medicare Annual Wellness Exam
Colorectal Test Reminder—insure test ordered in the last 3 weeks but not returned (Weekly)
Colorectal CA Custom Campaing—pts 50-75 with an insure test in the past and now due
Colorectal CA—pts 50-75 years with no insure test in the last 1 year (Ongoing MA recalls)
IZs
Flu Shots Available (6mo and up)
Proposed: 6mo-8 years, 2nd flu shot due
2-23 months, overdue for a Dtap
16-23 months, overdue for any childhood vaccines

Team Time – 45 min/month



Measure Results

All Patients | Compliant Patients | Non-Compliant Patients | Excluded Patients

Displaying 9 of 9 results Export

Search

Measure ↓	Start Date	End Date	Patient Name	MRN	Risk Score	DOB	Provider Name	Location	Msrmt Value	Numerator
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	3.0	[redacted]	Moore, Jessicca	Petaluma Health Center	144/80	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	4.0	[redacted]	Moore, Jessicca	Petaluma Health Center	145/72	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	3.0	[redacted]	Moore, Jessicca	Petaluma Health Center	140/81	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	5.0	[redacted]	Moore, Jessicca	Petaluma Health Center	140/72	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	1.0	[redacted]	Moore, Jessicca	Petaluma Health Center	152/93	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	4.5	[redacted]	Moore, Jessicca	Petaluma Health Center	160/87	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	5.0	[redacted]	Moore, Jessicca	Petaluma Health Center	153/96	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	2.5	[redacted]	Moore, Jessicca	Petaluma Health Center	132/90	N
INCENTIVE - Hypertension Control	08/01/2017	07/31/2018	[redacted]	[redacted]	2.0	[redacted]	Moore, Jessicca	Petaluma Health Center	141/83	N

Risk Stratification & Risk Scores

Petaluma Health Center

Running lists of patients for interventions

- Behavioral health
- Care Management
- Team nurse visits
- Shared / Group visits

Care teams – see the number at huddle

Use alerts/visit planning to drive services for particular risk groups

Panel adjustment or staffing adjustment for high risk panels

Risk Model

- Influenced by AAFP and other risk models (like HCC conditions)
- Incorporates risks, chronic conditions, SDOH, medications, ED utilization, and admissions

Point Values:

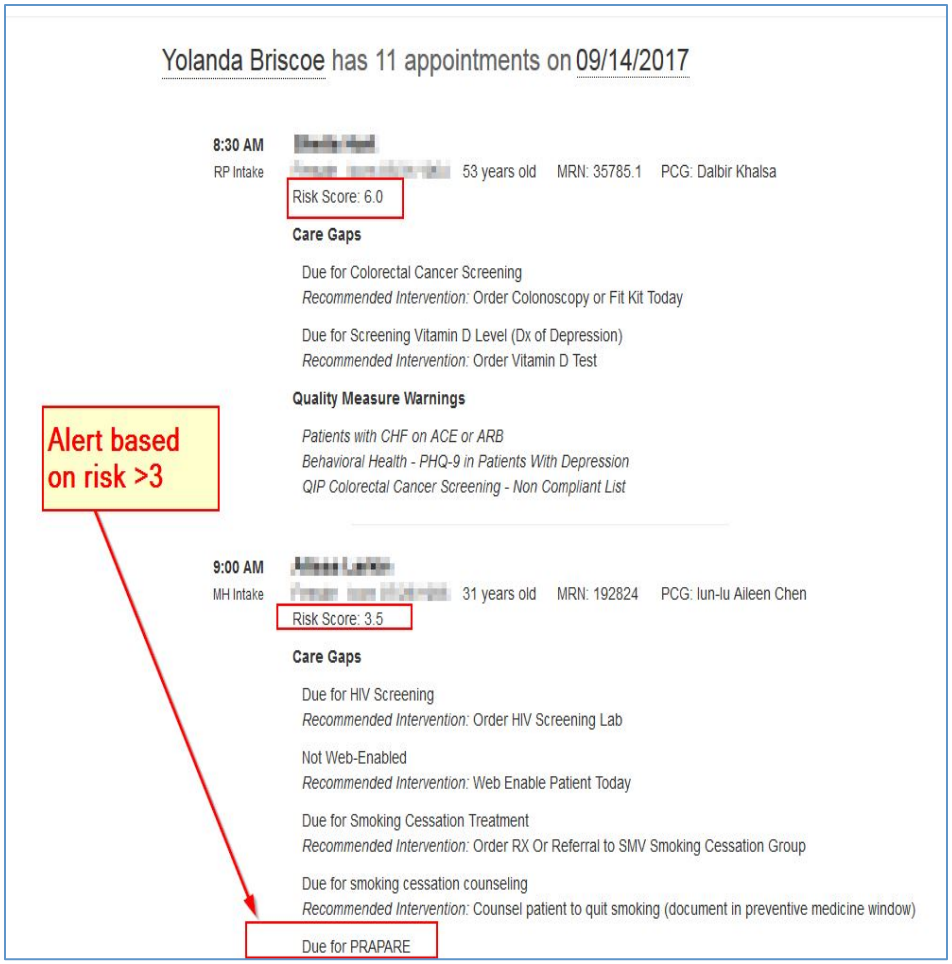
- Risks = ½pt
- Chronic conditions = 1pt
- SDOH and utilization mixed

Risk Level"

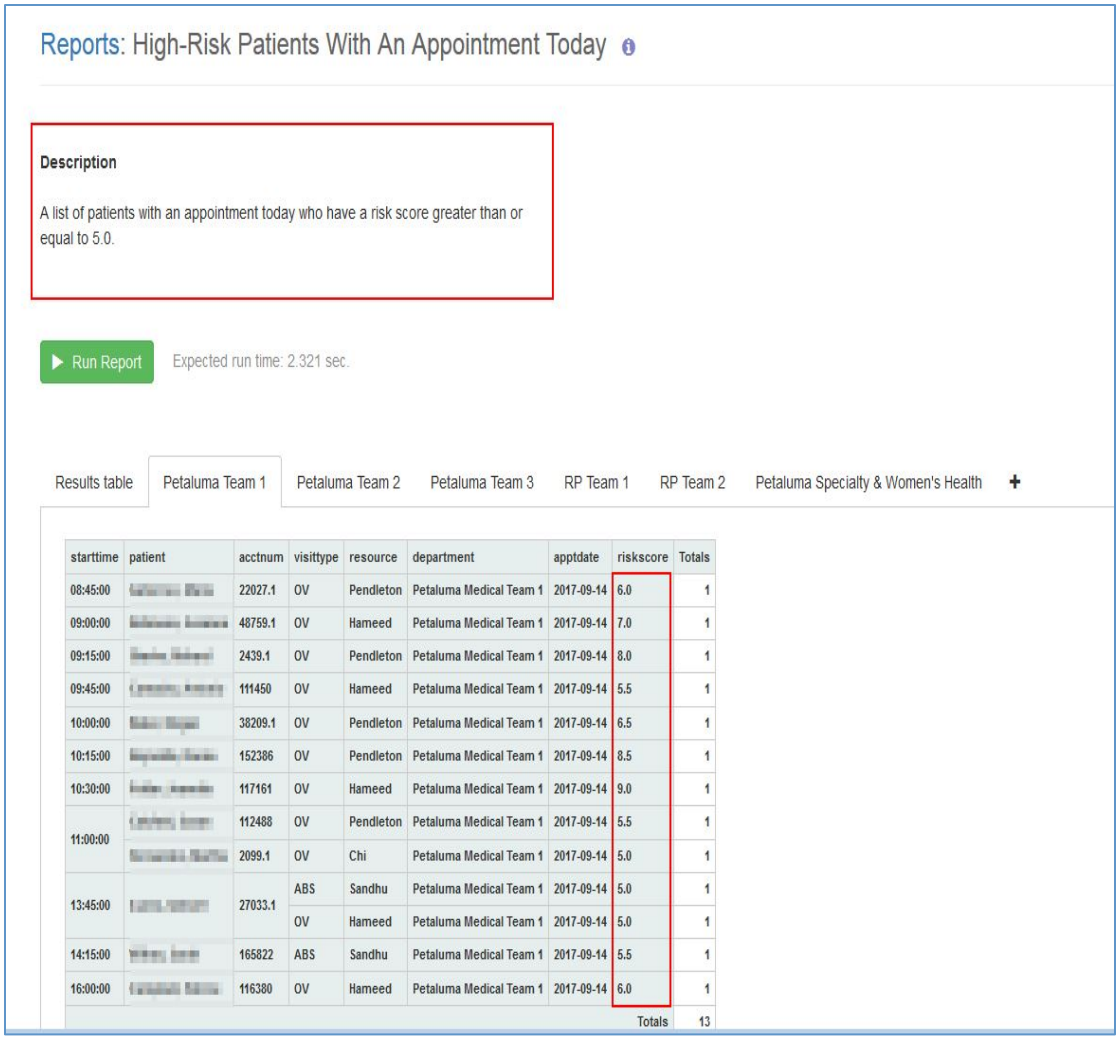
- 0-2 points = Low Risk
- 3-4 points = Medium Risk
- >5 points = High Risk

Risks	Point Value	Fields	Fields
BMI >29	0.5	Vitals	BMI field
smoking	0.5	Struc Data	Social history
prediabetes	0.5	Dx	Group - prediabetes
high triglycerides	0.5	Dx	E78.1
arthritis	0.5	Dx	Group - Arthritis
chronic pain (no opiates)	0.5	Dx	G89.4
Hypertension	0.5	Dx	I10
Conditions	Point Value	Fields	Fields
CHF	1	Dx	Group - CHF
COPD	1	Dx	Group - COPD
DM	1	Dx	Group - DM
CAD	1	Dx	Group - CAD
PVD/PAD	1	Dx	Group - vascular disease
MH	1	Dx	Group - 2703 MH diagnosis
Addiction	1	Dx	Group - sub use dx
Chronic Pain	1	Dx	G89.29
Stroke	1	Dx	Group - stroke
Cognitive decline	1	Dx	group - cog decline
Chronic Stress/Trauma	1	Dx	group - trauma
ESLD/Cirrhosis	1	Dx	Group - Cirrhosis
Add on	Point Value	Fields	Fields
Homeless	1	demogr	Info scrn
no insurance	0.5	demogr	Info scrn
Disabled? Or Dual	1	demogr	Info scrn
on anticoagulation	1	med	group - anticoagulation and other anticoag
on benzos	0.5	med	group - benzodiazapines
ED use >2	1	st Joes	
Hospital admit >0	1	st Joes	
>9 meds	1	Med list	
>9 conditions	1	Prob list	
uncontrolled illness add on	0.5	Dx	group - uncontrolled
FLAG - NEEDED	Point Value	Fields	Fields
ESRD	flag	Dx	Group - ESRD
HIV	flag	Dx	Group - HIV
Cancer	flag	Dx	Group - Cancer
0 - 2 points	Green		
3-4 points	Yellow		
>5	Red		
unpointed	Grey		

Care Team Alerts



Identifying Patients for Intervention



Reports: High-Risk Patients With An Appointment Today

Description

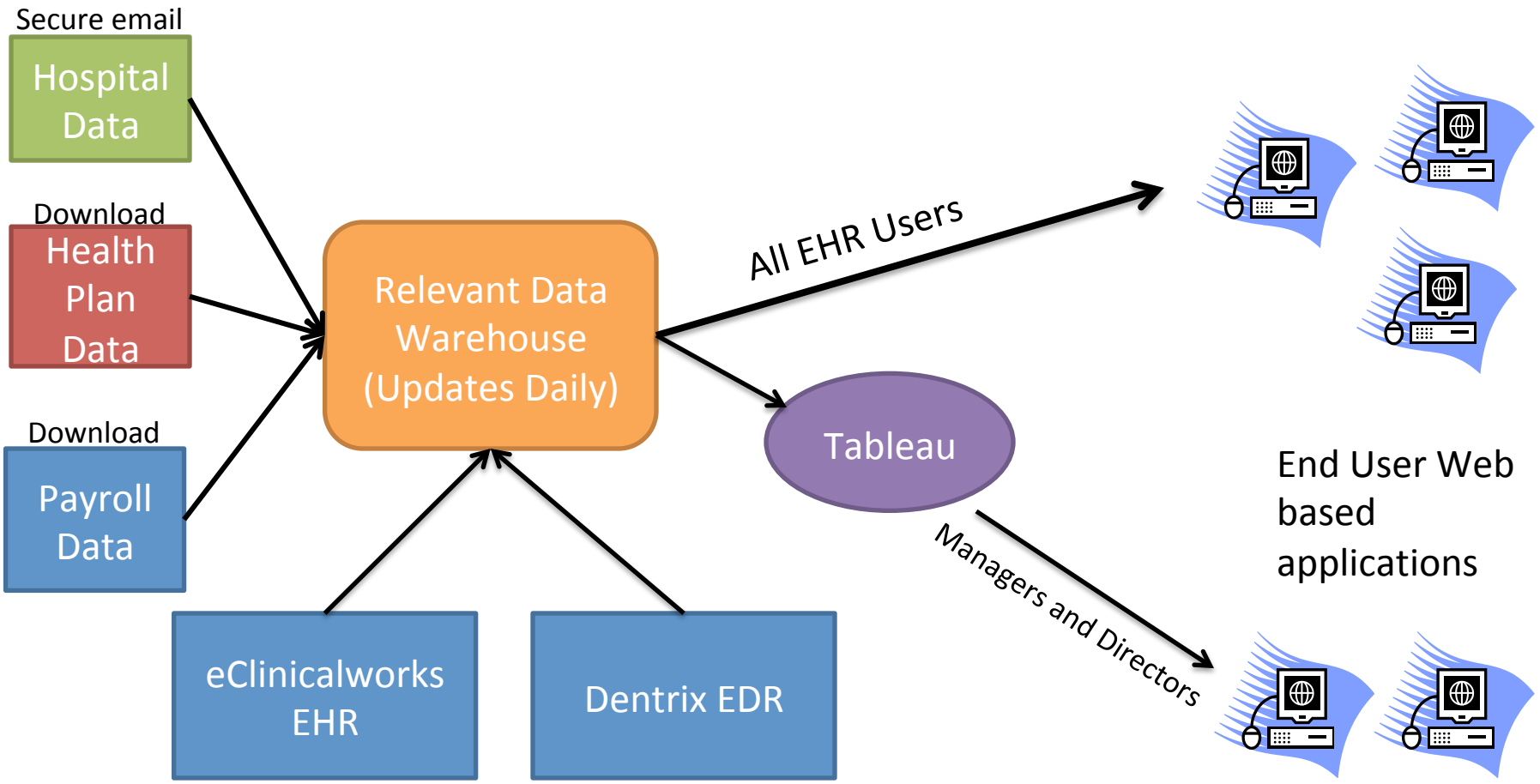
A list of patients with an appointment today who have a risk score greater than or equal to 5.0.

▶ Run Report Expected run time: 2.321 sec.

Results table | Petaluma Team 1 | Petaluma Team 2 | Petaluma Team 3 | RP Team 1 | RP Team 2 | Petaluma Specialty & Women's Health | +

starttime	patient	acctnum	visittype	resource	department	apptdate	riskscore	Totals
08:45:00	[redacted]	22027.1	OV	Pendleton	Petaluma Medical Team 1	2017-09-14	6.0	1
09:00:00	[redacted]	48759.1	OV	Hameed	Petaluma Medical Team 1	2017-09-14	7.0	1
09:15:00	[redacted]	2439.1	OV	Pendleton	Petaluma Medical Team 1	2017-09-14	8.0	1
09:45:00	[redacted]	111450	OV	Hameed	Petaluma Medical Team 1	2017-09-14	5.5	1
10:00:00	[redacted]	38209.1	OV	Pendleton	Petaluma Medical Team 1	2017-09-14	6.5	1
10:15:00	[redacted]	152386	OV	Pendleton	Petaluma Medical Team 1	2017-09-14	8.5	1
10:30:00	[redacted]	117161	OV	Hameed	Petaluma Medical Team 1	2017-09-14	9.0	1
11:00:00	[redacted]	112488	OV	Pendleton	Petaluma Medical Team 1	2017-09-14	5.5	1
	[redacted]	2099.1	OV	Chi	Petaluma Medical Team 1	2017-09-14	5.0	1
13:45:00	[redacted]	27033.1	ABS	Sandhu	Petaluma Medical Team 1	2017-09-14	5.0	1
			OV	Hameed	Petaluma Medical Team 1	2017-09-14	5.0	1
14:15:00	[redacted]	165822	ABS	Sandhu	Petaluma Medical Team 1	2017-09-14	5.5	1
16:00:00	[redacted]	116380	OV	Hameed	Petaluma Medical Team 1	2017-09-14	6.0	1
							Totals	13

Data Mining


Secure email
Hospital Data
Download
Health Plan Data
Download
Payroll Data
Relevant Data Warehouse (Updates Daily)
eClinicalworks EHR
Dentrix EDR
All EHR Users
Tableau
Managers and Directors
End User Web based applications

Data Quality

Petaluma Health Center

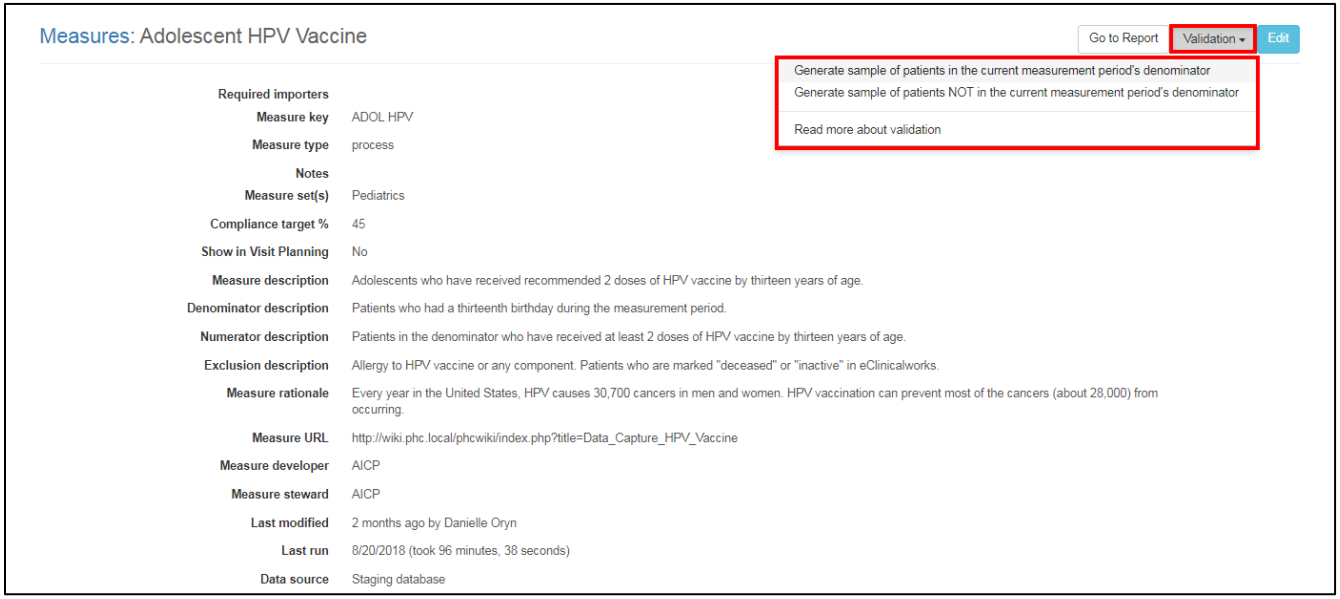
Training and Instruction

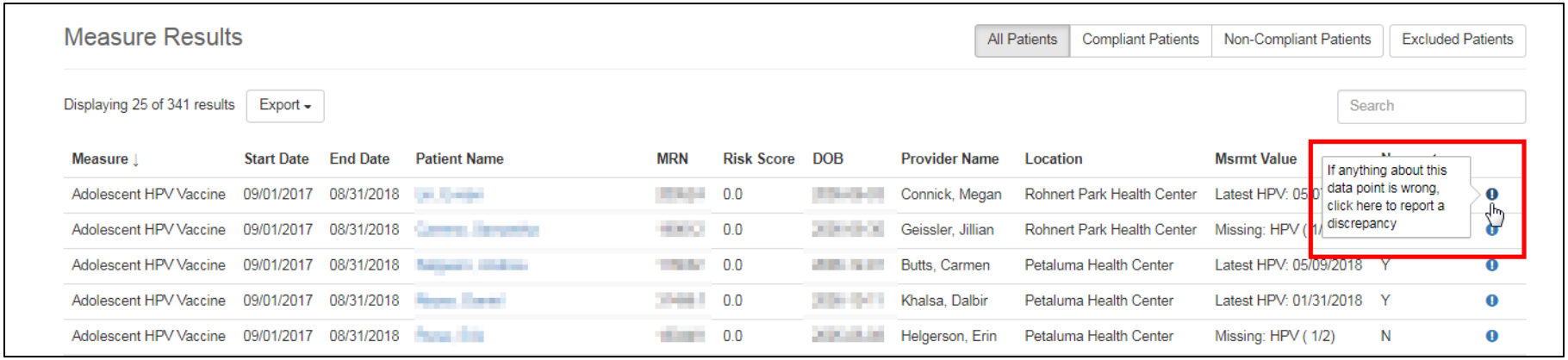
- Onboarding
- Connected to relevant
- 1:1 re-training

Monitoring

- Validation at build
- Continuous validation tool/discrepancy reporting tool

Validation and Discrepancy Tools



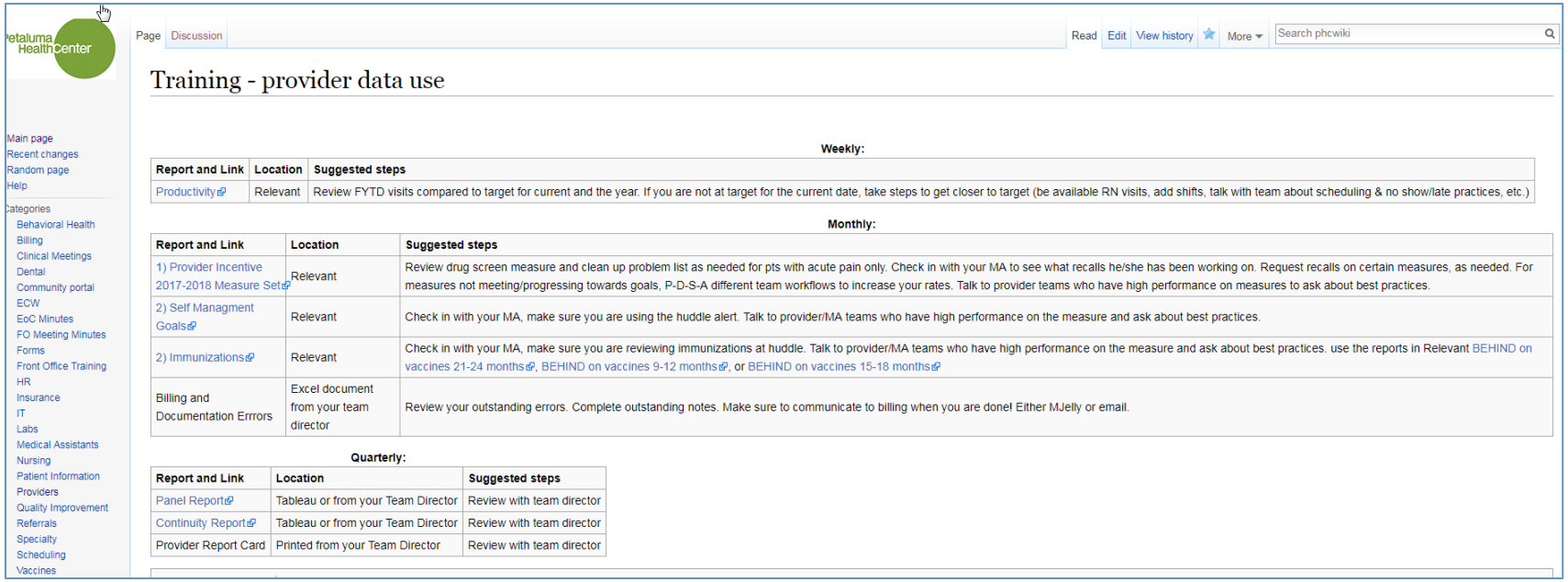


Data Use Training

Onboarding

Regular team meetings

How-to guides on PHC wiki



Page Discussion

Read Edit View history More Search phcwiki

Training - provider data use

Main page
Recent changes
Random page
Help

Categories
Behavioral Health
Billing
Clinical Meetings
Dental
Community portal
ECW
EoC Minutes
FO Meeting Minutes
Forms
Front Office Training
HR
Insurance
IT
Labs
Medical Assistants
Nursing
Patient Information
Providers
Quality Improvement
Referrals
Specialty
Scheduling
Vaccines

Weekly:

Report and Link	Location	Suggested steps
Productivity	Relevant	Review FYTD visits compared to target for current and the year. If you are not at target for the current date, take steps to get closer to target (be available RN visits, add shifts, talk with team about scheduling & no show/late practices, etc.)

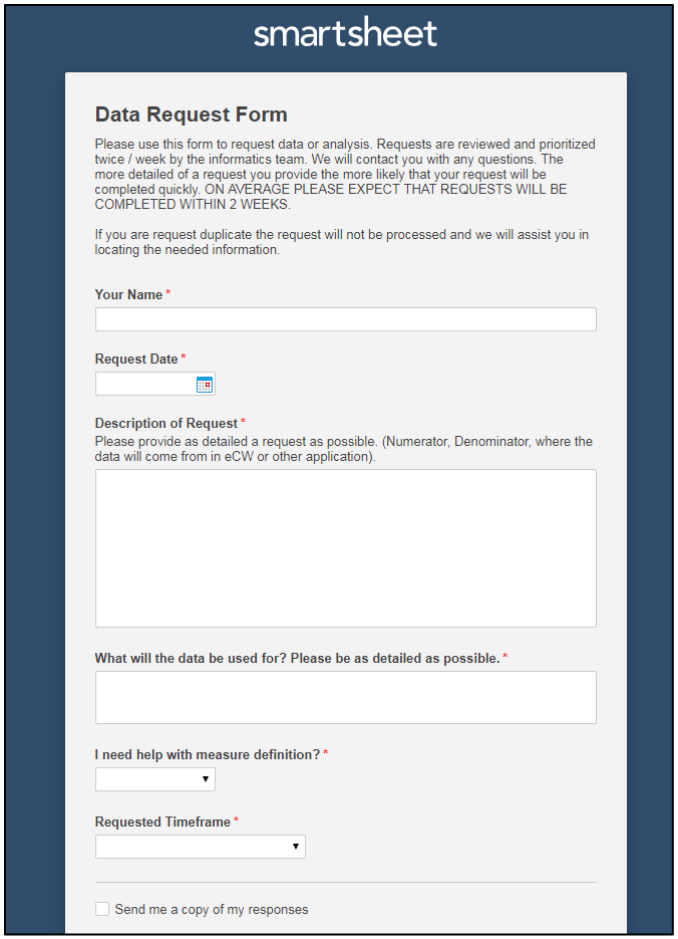
Monthly:

Report and Link	Location	Suggested steps
1) Provider Incentive 2017-2018 Measure Set	Relevant	Review drug screen measure and clean up problem list as needed for pts with acute pain only. Check in with your MA to see what recalls he/she has been working on. Request recalls on certain measures, as needed. For measures not meeting/progressing towards goals, P-D-S-A different team workflows to increase your rates. Talk to provider teams who have high performance on measures to ask about best practices.
2) Self Managment Goals	Relevant	Check in with your MA, make sure you are using the huddle alert. Talk to provider/MA teams who have high performance on the measure and ask about best practices.
2) Immunizations	Relevant	Check in with your MA, make sure you are reviewing immunizations at huddle. Talk to provider/MA teams who have high performance on the measure and ask about best practices. use the reports in Relevant BEHIND on vaccines 21-24 months, BEHIND on vaccines 9-12 months, or BEHIND on vaccines 15-18 months
Billing and Documentation Errrors	Excel document from your team director	Review your outstanding errors. Complete outstanding notes. Make sure to communicate to billing when you are done! Either MJelly or email.

Quarterly:

Report and Link	Location	Suggested steps
Panel Report	Tableau or from your Team Director	Review with team director
Continuity Report	Tableau or from your Team Director	Review with team director
Provider Report Card	Printed from your Team Director	Review with team director

Data Request System



Assigned to	Flag	Completed Date	Requester Name	Request Date	Description of Request	Requested Timeframe
	☆		Lauren Williams	08/31/18	Number of patients with diabetes per provider Number of patients with pre-diabetes per provider	1 Month
	☆		Alaina Cantor	08/16/18	Bright Heart Health monthly report. Please see email forwarded by Danielle and/or I can forward again email with two data requests (word and excel). We will need to generate data back to the beginning of the year and then moving forward on a monthly basis.	2 Weeks
	☆		Tiffany Jimenez	08/14/18	Please change Relevant Care Gap alert for Depression Screening to start at age 16 years. Ok'd by DO. Please let us know when it's completed so we can notify staff.	2 Weeks
	☆		Tiffany Jimenez	08/14/18	Fix Behind on Vaccines relevant reports: 9-12 months, 12-17 months, 18-24 months.	1 Week
	☆		Tiffany Jimenez / Kir	08/13/18	Dental recall list: Kids 9 months-35 months with no appt in dental. Add column for Outside dental home (MA template in WCC, i'll send a screenshot).	1 Week
Shaun	☆	08/20/18	Jessicca Moore	08/10/18	I want to know how many patients who said they were unemployed looking for work (PRAPARE) had an appointment or a warm hand off with a navigator in the past 9 months. I don't know if you're able to look back to Sept-Oct 2017 to compare, but I realize we didn't get a baseline. I'm not sure how navigators document warm handoffs or if it is the same. Might try running it with the number of those patients who had a procedure referral to a navigator as well. I'll be out the 13th-19th, but would love to have this by the 20th when my call with Jim will take place :).	1 Week
	☆		Rachel Nichols	08/06/18	Request eBO report listing item keys from the following tables, with any associated description fields, flag fields, etc. asyncitemkeys dentalitemkeys	2 Weeks

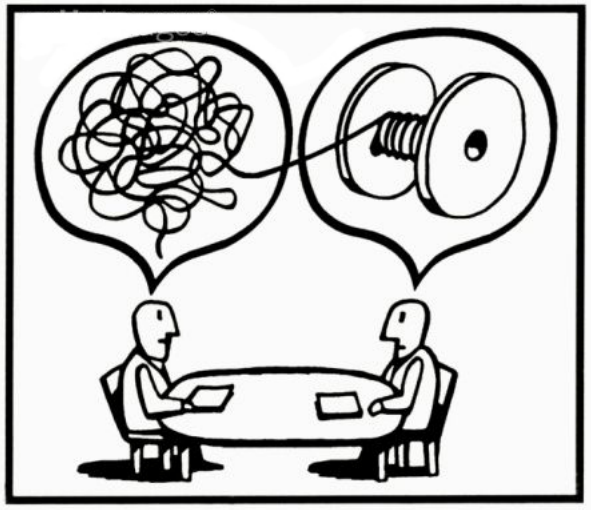
Management of Measures

Petaluma Health Center

Measures

Care Gaps

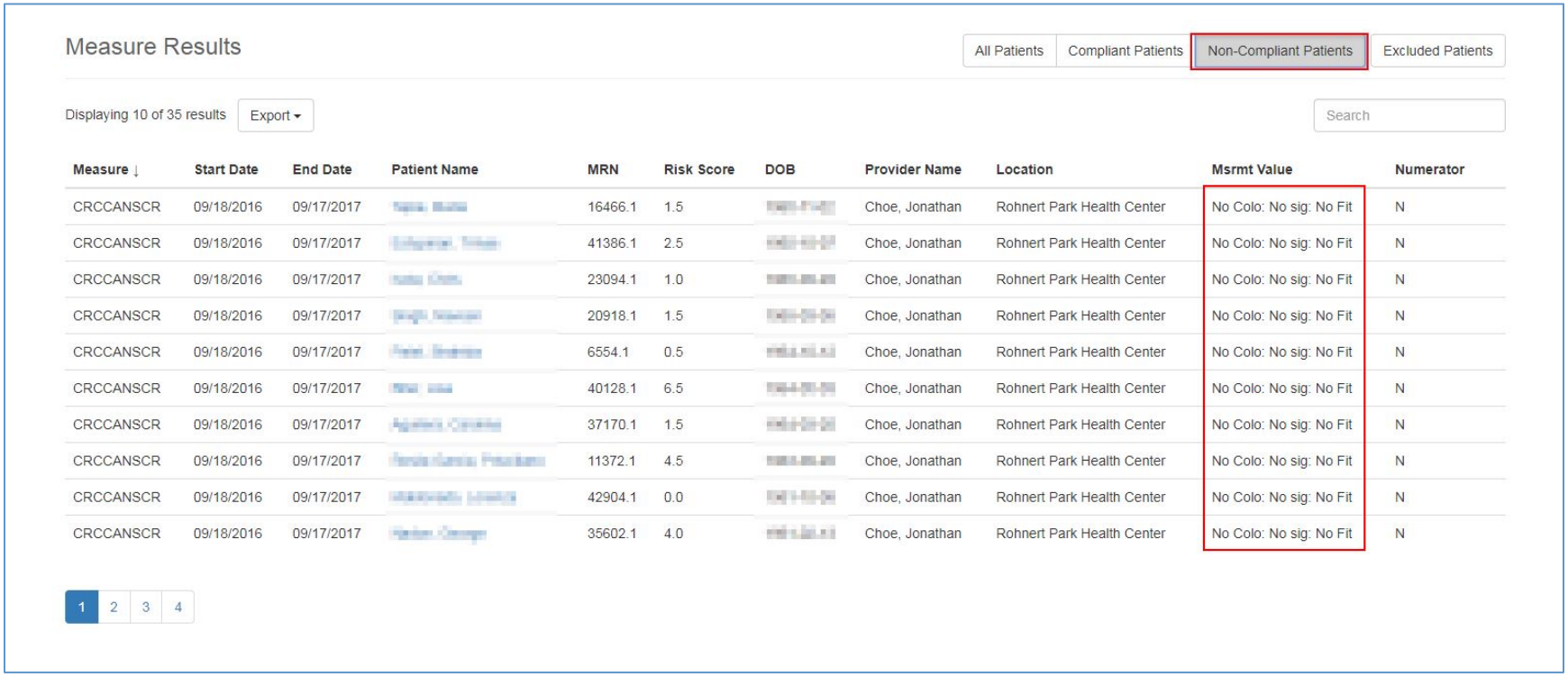
Reports



Relevant Data

Participants saw the back-end of Petaluma's Relevant system.

Drill Down View



Measure Results

All Patients | Compliant Patients | Non-Compliant Patients | Excluded Patients

Displaying 10 of 35 results Export

Search

Measure ↓	Start Date	End Date	Patient Name	MRN	Risk Score	DOB	Provider Name	Location	Msrmt Value	Numerator
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	16466.1	1.5	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	41386.1	2.5	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	23094.1	1.0	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	20918.1	1.5	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	6554.1	0.5	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	40128.1	6.5	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	37170.1	1.5	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	11372.1	4.5	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	42904.1	0.0	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N
CRCCANSCR	09/18/2016	09/17/2017	[redacted]	35602.1	4.0	[redacted]	Choe, Jonathan	Rohnert Park Health Center	No Colo: No sig: No Fit	N

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