NEXTGEN USERS:
Chronic Care Tab/PCMH Processes

SEPTEMBER 4, 2012
1:00–2:00PM

the Health Collaborative
where collaboration creates transformation

PLEASE REMEMBER TO PUT YOUR PHONE ON MUTE

NOT HOLD

WE WILL HEAR YOUR BACKGROUND MUSIC!

THANK YOU IN ADVANCE!

the Health Collaborative

Chronic Care Management Template

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September 4, 2012

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Chronic Care Management Template

- **The Initial Problems**
  - **No existing, one-stop spot in EHR for efficiently and effectively documenting Chronic Care Management.**
  - **The need to document Chronic Care Management in order to attain PCMH status.**

Chronic Care Management Template

- **The Initial Goal**
  - **One location to quickly and concisely document Chronic Care Management**
  - **A one-page document that could be used by Medical Assistants, Nurses, and Providers alike.**
  - **A generic document that could cover all chronic problems (CHF, Diabetes, Obesity, etc.)**

Chronic Care Management Template

- **The Initial Efforts**
  - **We listed the PCMH standards that we were not able to effectively document.**
    - **Criteria in which we must show examples that we meet the criteria:**
      - 3C2 - Individual treatment goals set and plan of care together (Examples)
      - 3C4 - Assess and address barriers when patient has not met treatment goal (Examples)
      - 3C6 - Refer for additional care management (Examples)
      - 5B5 - Ask patients/families about self-referrals and requesting reports from clinicians (Ex.)
    - **Criteria in which we must meet a specific goal in order to meet the criteria:**
      - 3D4 - Assess patient/family understanding of medications (Goal: 50%)
      - 3D5 - Assess pt response to meds/barriers to adherence with dates of updates (Goal: 50%)
      - 4A1 - Provide educational resources or refer for self-management (Goal: 50%)
      - 4A3 - Develop and document self-management goals in collaboration (Goal: 50%)
      - 4A4 - Document self-management abilities (Goal: 50%)
      - 4A5 - Provide self-management tools to record self-care results for pts/families (Goal: 50%)
      - 4A6 - Counsels patients/families to adopt health behaviors (50%)

    * Must-Pass

Chronic Care Management Template

- **The Initial Efforts**
  - **Solicited feedback from front-line staff.**
  - **Mocked-up potential templates.**
  - **Collaborated with programmers.**
  - **Programmers created initial template and we began testing.**
  - **Continued testing and enhancements.**

Chronic Care Management

Chronic Conditions:

Last Addressed	Chronic Problem	Code
05/01/2012	Hypertension	401.9
05/08/2012	Asthma	493.90
04/26/2012	Headache	784.0
05/01/2012	Yellow eyes	782.4
06/05/2012	Hyperglycemia	275.42
06/01/2012	Elevated liver function tests	790.6

Self-Management Abilities:

1 = least confident in abilities, 5 = Very confident in abilities.

	1	2	3	4	5	
Follow your meal plan?	○	○	○	◉	○	
Follow your exercise plan?	○	○	○	○	○	
Judge when you should go to the doctor?	○	○	◉	○	○	Prior
Understand and take medication(s) properly?	○	○	◉	○	○	Reading
Readiness for change?	◉	○	○	○	○	4

(1 = not interested in change, 5 = Actively interested)

Patient / Provider Relationships: (highlight a row to display details)

Last Name	First Name	Phone #	Specialty	Provider Role	Provider Id
Rahrer	David	5213012247	Family Pract	attending physician	5A6CC85B-B3A5-47CC-8CE8-DCCF...
Gibson	Smith	4582612325	Cardiology	consulting provider	9C9C2456-3CC3-4B89-A2C2-4F95...
Woods	Kathleen		Diabetes	Diabetic Educator	
Dashoff	Thomas			specialist	

Treatment Progress: ◉ Tx Goals ○ Protocols — Refresh

RED ZONE - Maximum support needed
Overall Stratification Score = 6

Risk Assessment

Encounter Date/Time	04/25/2012 09:04 AM	04/21/2012 02:17 PM	04/05/2012 01:04 AM	05/21/2012 09:54 AM	05/16/2012 08:05 AM
BP- Systolic		129	142	129	
BP - Diastolic		88	92	76	
BMI		23.08	38.88	.88	
HgbA1C	6.8 on 04/05/2012	6.8 on 04/05/2012	6.8 on 04/05/2012	12.8 on 05/11/2012	12.8 on 05/11/2012
Smoking	current	current	current	current	current
Peak Flow		0.0	240.0	0.0	

Barriers:

☑ Cost / Side effects of tx ☑ Difficulty learning ☑ Financial ☑ Lack of understanding of tx ☑ Unable to read
☑ Depression PHQ9 ☑ Emotional issues ☑ Lack of trust in staff ☑ Medication / Tx side effects Other:

Treatment Goals:

Date Goal Set: / / Goal: My Phrases Target Date: / / Status:

Date Goal Set	Goals - MOST RECENT	Target Date	Status	Last Updated
04/05/2012	Patient will reach an LDL level of 100 or less	04/15/2012	new	04/05/2012
05/21/2012	BP less than 120/80.	06/21/2012	partially met	04/05/2012
05/21/2012	Patient will reach/maintain BP less than 140/90	07/21/2012	partially met	04/05/2012
05/21/2012	Patient will reach/maintain A1C of 8% or less	07/21/2012	not met	05/21/2012
05/21/2012	Patient will reach an LDL level of 100 or less	07/21/2012	new	05/21/2012

Self Management Goals:

Date Goal Set: / / Goal: My Phrases Confidence Level: Target Date: / / Status:

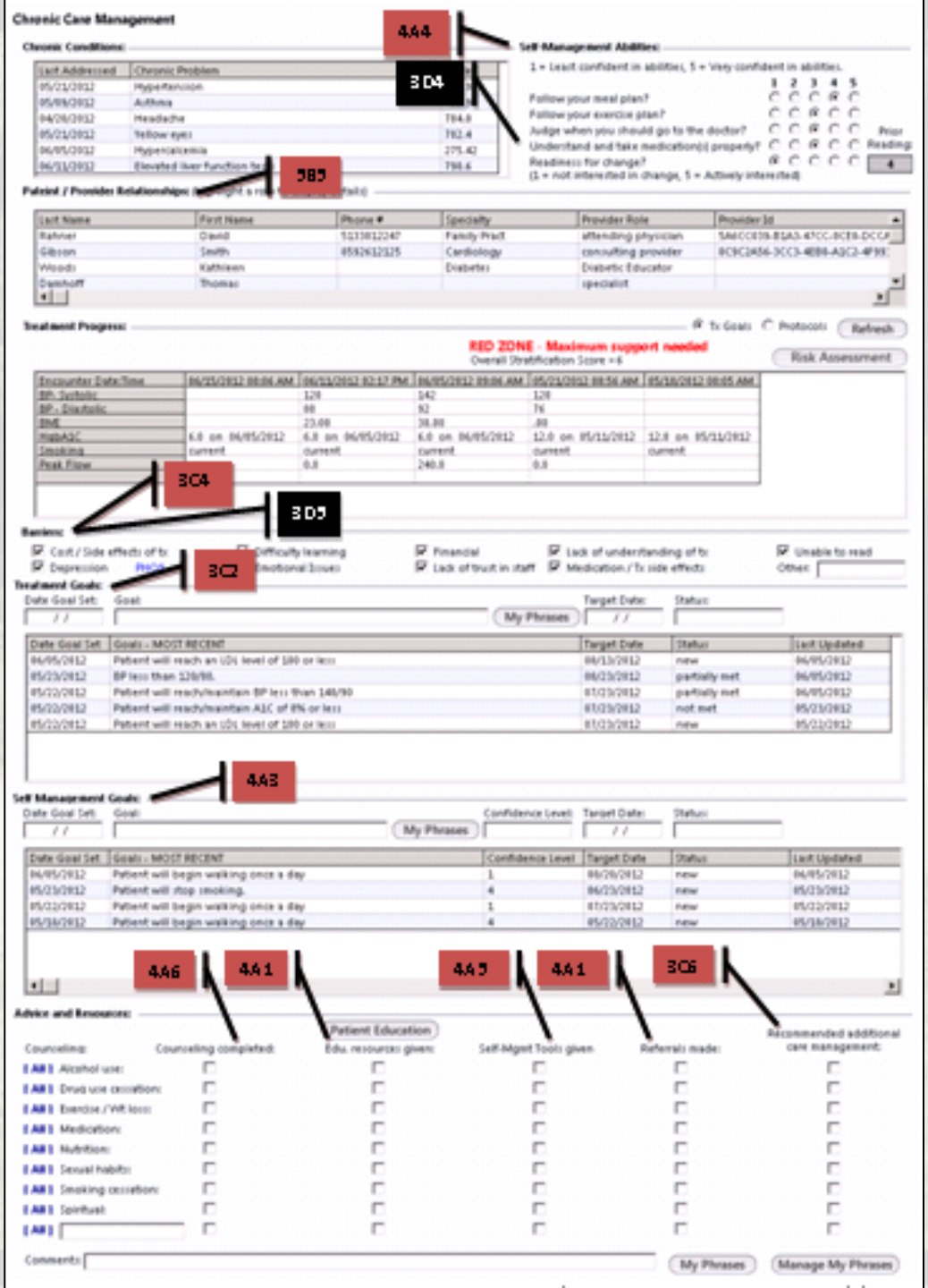
Date Goal Set	Goals - MOST RECENT	Confidence Level	Target Date	Status	Last Updated
04/05/2012	Patient will begin walking once a day	1	06/26/2012	new	04/05/2012
05/21/2012	Patient will stop smoking.	4	06/25/2012	new	05/21/2012
05/21/2012	Patient will begin walking once a day	1	07/25/2012	new	05/21/2012
05/16/2012	Patient will begin walking once a day	4	05/22/2012	new	05/16/2012

Advice and Resources:

Patient Education

Counseling:	Counseling completed:	Edu. resources given:	Self-Mgmt Tools given:	Referrals made:	Recommended additional care management:
[Alt] Alcohol use:	☐	☐	☐	☐	☐
[Alt] Drug use cessation:	☐	☐	☐	☐	☐
[Alt] Exercise / Wt loss:	☐	☐	☐	☐	☐
[Alt] Medication:	☐	☐	☐	☐	☐
[Alt] Nutrition:	☐	☐	☐	☐	☐
[Alt] Sexual habits:	☐	☐	☐	☐	☐
[Alt] Smoking cessation:	☐	☐	☐	☐	☐
[Alt] Spiritual:	☐	☐	☐	☐	☐
[Alt]	☐	☐	☐	☐	☐

Comments: My Phrases Manage My Phrases


Chronic Care Management
444
Chronic Conditions:
3D4
Self Management Abilities:
1 = Least confident in abilities, 5 = Very confident in abilities.
Follow your meal plan?
Follow your exercise plan?
Judge when you should go to the doctor?
Understand and take medication(s) properly?
Readiness for change?
(1 = not interested in change, 5 = Actively interested)
Prior Reading
4
Patient / Provider Relationships:
3B5
Last Name
First Name
Phone #
Specialty
Provider Role
Provider Id
Rahrer
David
5133812247
Family Pract
attending physician
Gibson
Smith
8582612325
Cardiology
consulting provider
Woods
Kathleen
Diabetes
Diabetic Educator
Dashoff
Thomas
specialist
Treatment Progress:
Tx Goals
Protocols
Refresh
RED ZONE - Maximum support needed
Overall Stratification Score = 6
Risk Assessment
Encounter Date/Time
06/05/2012 08:06 AM
06/11/2012 02:17 PM
06/05/2012 09:06 AM
05/21/2012 08:56 AM
05/16/2012 08:05 AM
BP: Systolic
120
142
128
BP: Diastolic
88
92
76
BMI
23.08
38.88
.88
HgbA1C
6.0 on 06/05/2012
6.0 on 06/05/2012
6.0 on 06/05/2012
12.0 on 05/11/2012
12.0 on 05/11/2012
Smoking
current
current
current
current
current
Peak Flow
0.0
240.0
0.0
3C4
3D5
Barriers:
Cost / Side effects of tx
Depression
PHQ9
Difficulty learning
Emotional Issues
Financial
Lack of trust in staff
Lack of understanding of tx
Medication / Tx side effects
Unable to read
Other:
3C2
Treatment Goals:
Date Goal Set:
Goal:
My Phrases
Target Date:
Status:
Date Goal Set
Goals - MOST RECENT
Target Date
Status
Last Updated
06/05/2012
Patient will reach an LDL level of 100 or less
06/13/2012
new
06/05/2012
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BP less than 120/80.
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Self Management Goals:
Date Goal Set:
Goal:
My Phrases
Confidence Level:
Target Date:
Status:
Date Goal Set
Goals - MOST RECENT
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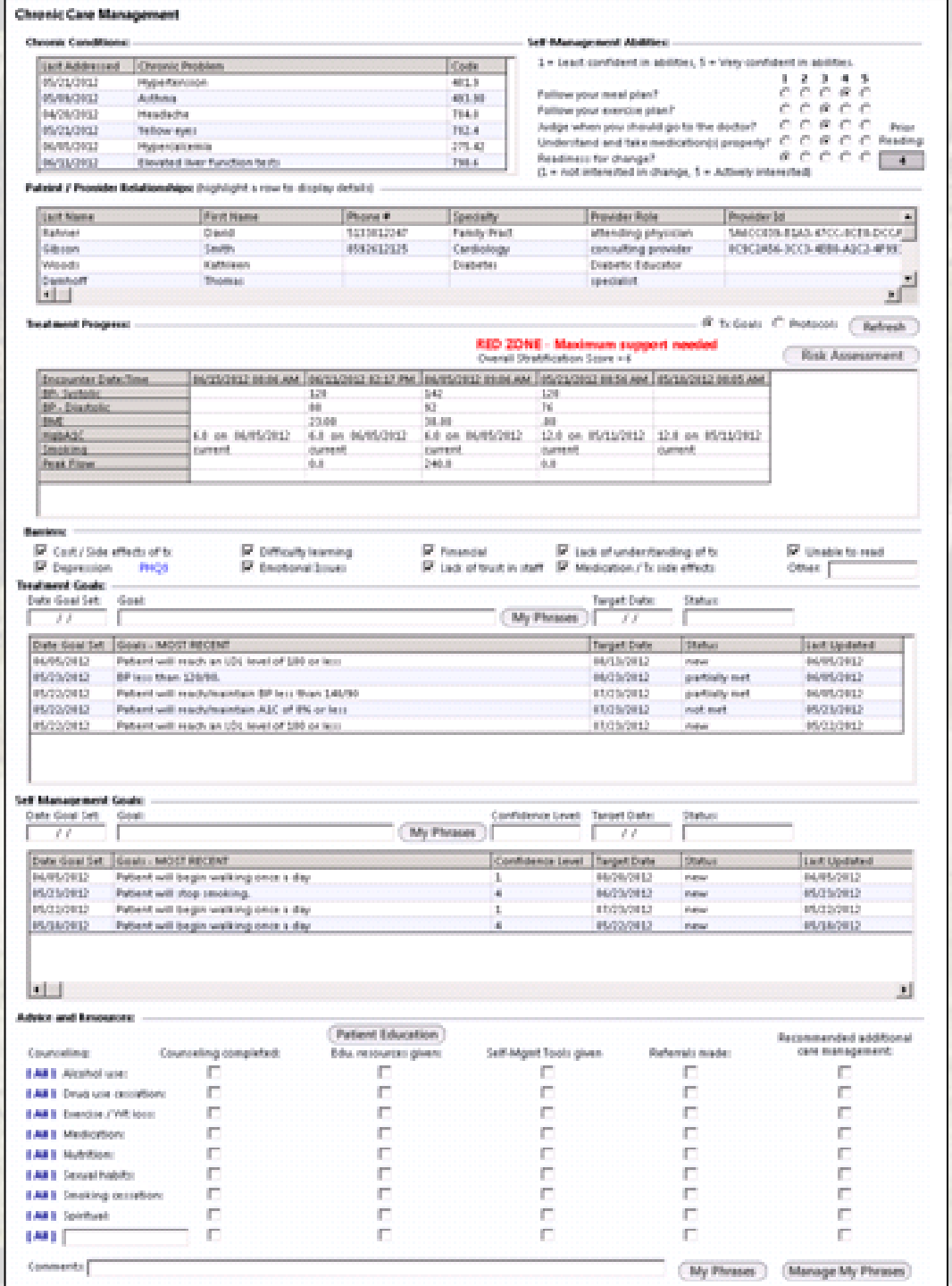
Last Updated
06/05/2012
Patient will begin walking once a day
1
06/26/2012
new
06/05/2012
05/21/2012
Patient will stop smoking.
4
06/21/2012
new
05/21/2012
05/12/2012
Patient will begin walking once a day
1
07/21/2012
new
05/12/2012
05/16/2012
Patient will begin walking once a day
4
05/22/2012
new
05/16/2012
446
441
445
441
3C6
Advice and Resources:
Patient Education
Counseling:
Counseling completed:
Edu. resources given:
Self-Mgmt Tools given
Referrals made:
Recommended additional care management:
[All] Alcohol use:
[All] Drug use cessation:
[All] Exercise / Wt loss:
[All] Medication:
[All] Nutrition:
[All] Sexual habits:
[All] Smoking cessation:
[All] Spiritual:
[All]
Comments:
My Phrases
Manage My Phrases



Chronic Care Management

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Follow your exercise plan?	○	○	○	○	○	
Judge when you should go to the doctor?	○	○	◉	○	○	Prior Reading:
Understand and take medication(s) properly?	○	○	◉	○	○	
Readiness for change?	◉	○	○	○	○	4

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Dashoff	Thomas			specialist	

Treatment Progress: ◉ Tx Goals ○ Protocols — Refresh

RED ZONE - Maximum support needed

Overall Stratification Score = 6 — Risk Assessment

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Understand and take medication(s) properly?	○	○	◉	○	○
Readiness for change? (1 = not interested in change, 5 = Actively interested)	◉	○	○	○	○

Prior Reading: 4

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Woods	Kathleen		Diabetes	Diabetic Educator	
Damhoff	Thomas			specialist	

Treatment Progress: ◉ Tx Goals ○ Protocols [Refresh]

RED ZONE - Maximum support needed
Overall Stratification Score > 6

[Risk Assessment]

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- ☑ Difficulty learning
- ☑ Emotional Issues
- ☑ Financial
- ☑ Lack of trust in staff
- ☑ Lack of understanding of tx
- ☑ Medication / Tx side effects
- ☑ Unable to read
- Other:

Treatment Goals:

Date Goal Set: / / | Goal: | My Phrases | Target Date: / / | Status:

Date Goal Set	Goals - MOST RECENT	Target Date	Status	Last Updated
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Advice and Resources:

Patient Education

Counseling:	Counseling completed:	Edu. resources given:	Self-Mgmt Tools given	Referrals made:	Recommended additional care management:
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[All] Drug use cessation:	☐	☐	☐	☐	☐
[All] Exercise / Wt loss:	☐	☐	☐	☐	☐
[All] Medication:	☐	☐	☐	☐	☐
[All] Nutrition:	☐	☐	☐	☐	☐
[All] Sexual habits:	☐	☐	☐	☐	☐
[All] Smoking cessation:	☐	☐	☐	☐	☐
[All] Spiritual:	☐	☐	☐	☐	☐
[All]	☐	☐	☐	☐	☐

Comments:

My Phrases Manage My Phrases

Chronic Care Management Template

- **The Continued Efforts**
  - **Resisting tendency to over-crowd and over-complicate.**
  - **Intentionally working to keep generic.**
  - **Training of staff.**
  - **Working to expedite process (added 10 minutes initially, 5 minutes for update to rooming process).**
  - **Adding features with future collaboration in mind.**

Thank you!

Questions?

Making Modifications and Enhancements

Shannon Nielson
HealthSource of Ohio

the Health Collaborative