Partnering for Quality

Working together to improve health outcomes

Beyond an Electronic Paper File – Optimizing Your EMR

AFHTO Conference
October 28, 2015

Connecting you with care
Votre lien aux soins
South West CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Ouest

Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

A Healthier Tomorrow

Disclosures

Presenters:

Rachel LaBonté – Program Lead, Partnering for Quality Program

Gina Palmese – eHealth Coach, Partnering for Quality Program

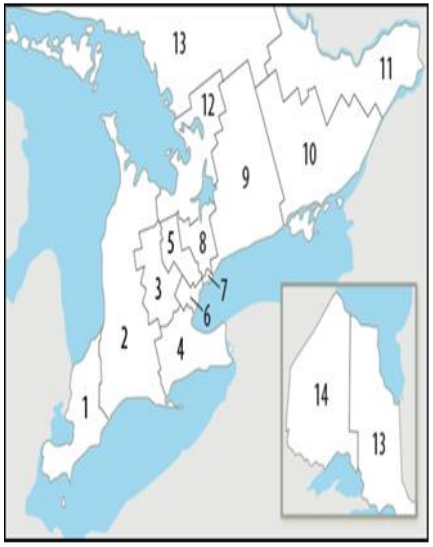
No Relationships with commercial interests or support to declare

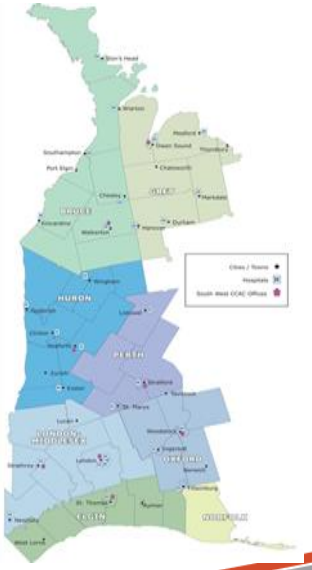
No conflict of interest to declare

Partnering for Quality - Who are we?

- Our mandate is to support primary care in optimizing their EMR in order to implement practice changes in chronic disease management.

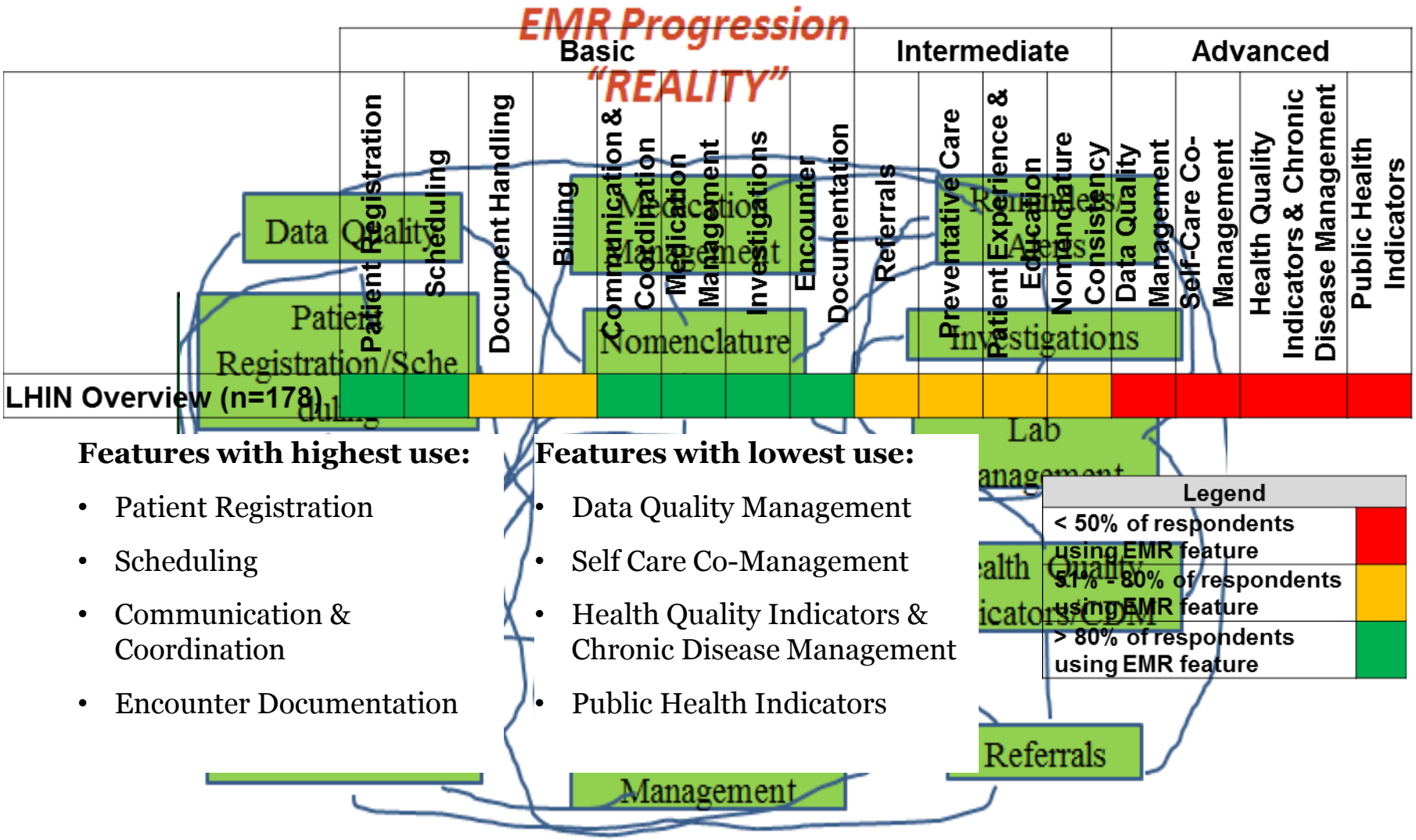
- Working with over 700 Stakeholders and 335 physicians (in all makes/models of primary care CHC, NPLC, FHT, FHO, Solo Practices)





South West LHIN funded – hosted at the South West CCAC

What problem does this solution address?



Features with highest use:

- Patient Registration
- Scheduling
- Communication & Coordination
- Encounter Documentation

Features with lowest use:

- Data Quality Management
- Self Care Co-Management
- Health Quality Indicators & Chronic Disease Management
- Public Health Indicators

The Solution

DATA STANDARDIZATION

Why bother?

Critical to ensure the right decisions are being made with the right data located in the right place at the right time

=

DATA INTEGRITY

- Accessing point of care patient information
- Reducing clinical workflow duplication
- Optimized use of the right forms, templates or stamps
- Patient recalls at the right time
- Population Health
- Engagement in Health Links
- Etc.

Data Standardization Tools…

ICD codes: Problem List	
70	Viral Hepatitis (Acute)
249	Pre-Diabetes (HbA1C between 6-7)
250	Diabetes Mellitus
272	Hypercholesterolism
290	Dementia
296	Bipolar Depression
300	Anxiety
303	Alcoholism
304	Drug Dependence
305	Smoking
309	Acute Situational Crisis
311	Depression
314	ADHD
401	Hypertension
428	CHF
436	Stroke (CVA)
491	COPD
493	Asthma
571	Cirrhosis of the Liver
573	Other Liver Disease
585	Chronic Renal Failure
733	Osteoporosis
896	Immunization
897	Economic Problems
898	Marital Difficulties
901	Family Disruption/Divorce
902	Educational Problems
905	Occupational Problems
906	Legal Problems

Social History
ACP/ACD
Alcohol
non-drinker (tick box)
Contraception
Disability: WSIB/ODSP/CPP (dropdowns)
DNR
Driving Status
Drugs
EDITH
Employment
Family: list members
Hobby
Marital Status
Narcotic Agreement
Tobacco (current/ex-smokers: dropdowns)
non-smoker (tick box)

Family Hx	
429	CVD

Infectious Alerts (Alerts Captured in Demographics)
HIV
Hepatitis B or C
MRSA
TB, VRE positive patients

Influenza Tracking Codes (Billing)	
G590	Active Immunization with a Visit
Q590	Active Immunization without a Visit (sole reason for visit)

Immunization Tracking Codes (Billing)	
G840	Quadracel: Quadrivalent vaccine (DTaP-IPV)
G841	Pedicel: Pentavalent vaccine (DTaTIPV-Hib)
G842	Hepatitis B vaccine
G843	HPV vaccine
G844	Menjugate (Conjugate meningococcal C vaccine)
G845	MMR vaccine
G846	Prevnar / Pneumovax (Conjugate pneumococcal vaccine)
G847	Adacel (TdaP vaccine)
G848	Chicken Pox (Varicella vaccine)

Immunizations (in Patient's CPP)
Tetanus

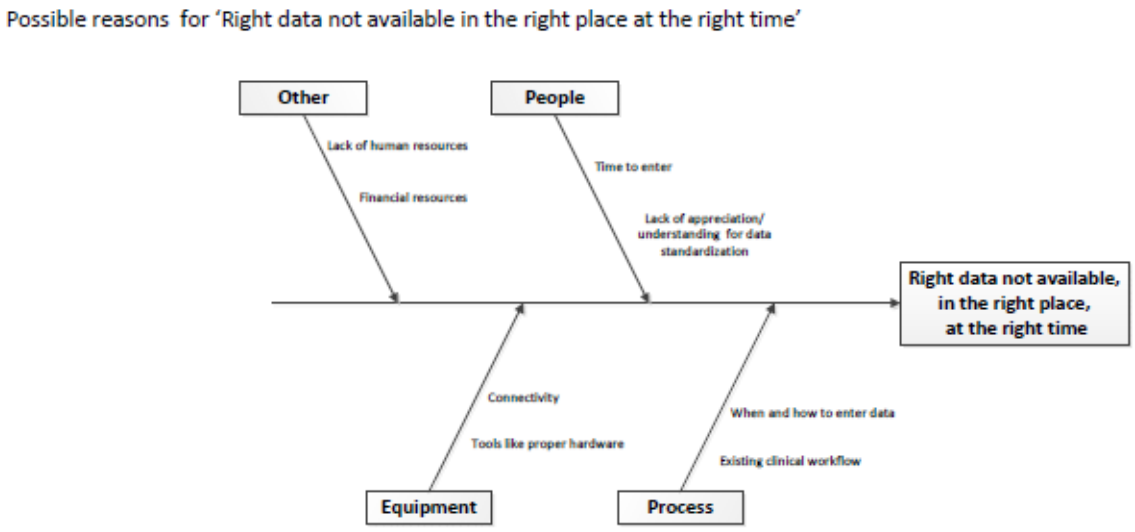
Preventative Care Tracking Codes (Billing)	
Q130	Influenza Vaccine TRACKING CODE for Patients Age 65 and Over - out of office
Q011	Pap Smear TRACKING CODE for Patients Between Age 35 and 70
Q140	Pap Smear EXCLUSION CODE for Patients Between Age 35 and 70
Q131	Mammogram TRACKING CODE for Patients Between Age 50 and 70
Q141	Mammogram EXCLUSION CODE for Patients Between Age 50 and 70
Q132	Immunizations TRACKING CODE for Patients Age 2 and Under
Q133	Colorectal Screening TRACKING CODE for Patients Between Age 50 and 74
Q142	Colorectal Screening EXCLUSION CODE for Patients Between age 50 and 74

Procedures & Preventative Care
Pap Smear. : System
Exclude Pap Smear : System
Mammogram : System
Exclude Mammogram : System
Colonoscopy : System
FOBT : System
Exclude FOBT : System
spirometry : Diagnostic Testing *
ECG : Diagnostic Testing *
Echocardiogram : Diagnostic Testing *
PHQ-9 : Screening
PPS : Screening
Cognitive Screen : Screening
Thoracic Screen : Screening
BMD : Screening

* variations in Diagnostic Testing (i.e. diagnostic test, diagnositic testing)

Implementing the Solution:

- It's not just about a tool – it's about empowering clinicians/teams
- It's using simple quality improvement methodology to get to the root cause (change management)
- Need to actualize the benefits to clinicians at every level ($$; patient care; quality focus, Professional College requirements)



Sustainability: Keeping things on track

- **Commitment** from leadership and of staff to keep the work going
- **Understanding** of tools that need to be in place for data integrity sustainability
- **Training**/learning to enhance skill level
- **Feedback mechanism** – how will you know if things stay on track if you don't monitor.

How does solution make a difference to patients?

- **Accurate and reliable** data in the right place at the right time (at point of care and to retrieve data)
- Clinicians understand how their **data entry impacts patient care** and entire team
- **Improved screening** due to real time data vs. retrospective data
- **Increased organized care** – information in the right spot minimizes searches

I have found the help I have received through the DSP project to be invaluable in optimizing my EMR use. I am now able to complete my documentation much more efficiently and effectively allowing for timely access to data.
- Physician

The Outcome

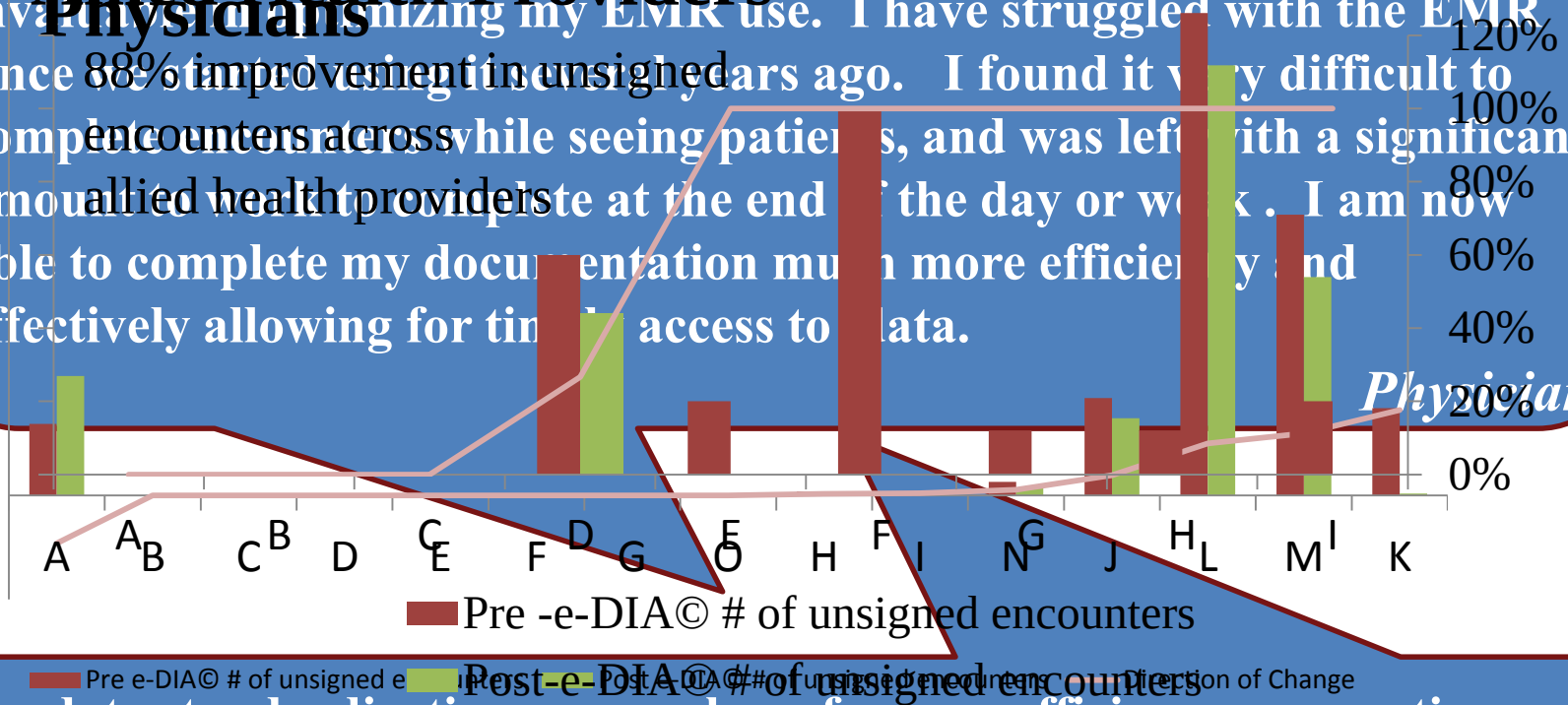
Allied Health Providers

88% improvement in unsigned encounters across allied health providers

Physicians

I have found the help I have received through this work to be invaluable in optimizing my EMR use. I have struggled with the EMR since we started using it several years ago. I found it very difficult to complete encounters while seeing patients, and was left with a significant amount of work to complete at the end of the day or week. I am now able to complete my documentation much more efficiently and effectively allowing for timely access to data.

Physician



Comparing volume of unsigned encounters pre e-DIA© and post e-DIA©. In Physicians 'B-I' maintained zero unsigned encounters during project while remaining physicians decreased or eliminated encounters entirely.

The data standardization process has , from an efficiency perspective, allowed us to identify specific patient populations by ICD coding. In Comparing volume of unsigned encounters pre e-DIA© and post e-DIA©. Allied health providers A-E maintained zero unsigned encounters during project while remaining AHP's decreased or eliminated encounters entirely.

allowed us to identify specific patient populations by ICD coding. In Physicians 'B-I' maintained zero unsigned encounters during project while remaining physicians decreased or eliminated encounters entirely. Allied health providers A-E maintained zero unsigned encounters during project while remaining AHP's decreased or eliminated encounters entirely. Both measures will contribute to better patient care and quality outcomes.

Physician