

# **HRSA Health Information Technology and Quality Webinar**

**“Using Health IT for Care Coordination Across  
Inpatient and Outpatient Settings”**

**Date: 5/18/2012**

**US Department of Health and Human Services  
Health Resources and Services Administration**

# Upcoming HRSA Health IT and Quality Announcements

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- **HIMSS Jobmine for Safety Net Providers** (Free Job Postings for HRSA Grantees and Safety Net Providers). Email [hfigge@himss.org](mailto:hfigge@himss.org) for more information.
- **Competency Exam for Health IT Professionals** , vouchers available for free exams, email [healthit@hrsa.gov](mailto:healthit@hrsa.gov)
- **Next HRSA Health IT and Quality Webinar "Health IT Project Management 101: How to Avoid Failure"** June 22, 2PM (ET). Registration Now Open.
- **New HRSA Health IT and Webinar Website.** Webinars Now Organized by 6 User Friendly Categories. Please visit <http://www.hrsa.gov/healthit/toolbox/webinars/> to see all of HRSA past webinars.
- HRSA's "**April/May Health IT and Quality Newsletter**" Available Online.
- New HRSA "**Network Guide**" is now available on the HRSA Health IT website.
- New HHS Briefing Paper "**Understanding the Impact of Health IT in Underserved Communities and those with Health Disparities**" Available online.
- **ONC's Releases New Guide on "Health Information, Privacy and Security and Meaningful Use"**

# Introduction

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## Presenters:

- Dr. Martin Serota - AltaMed Health Services
- Mr. Wil Franklin - St. Louis Integrated Health Network
- Ms. Bethany Johnson - St. Louis Integrated Health Network
- Ms. Susan Wilson - Missouri Primary Care Association
- Dr. William Reiter- HealthShare Montana

# AltaMed

QUALITY CARE WITHOUT EXCEPTION™

## Using IT for Health Care Coordination at AltaMed May 18, 2012

**Martin Serota, MD; Vice President & Chief Medical Officer**



## OVERVIEW

- AltaMed Background
- AltaMed IT Platform
  - Current
  - Future
- Data Governance

## WHO IS ALTAMED (FQHC)?

AltaMed is one of the largest independent Federally Qualified Community Health Center in the U.S.

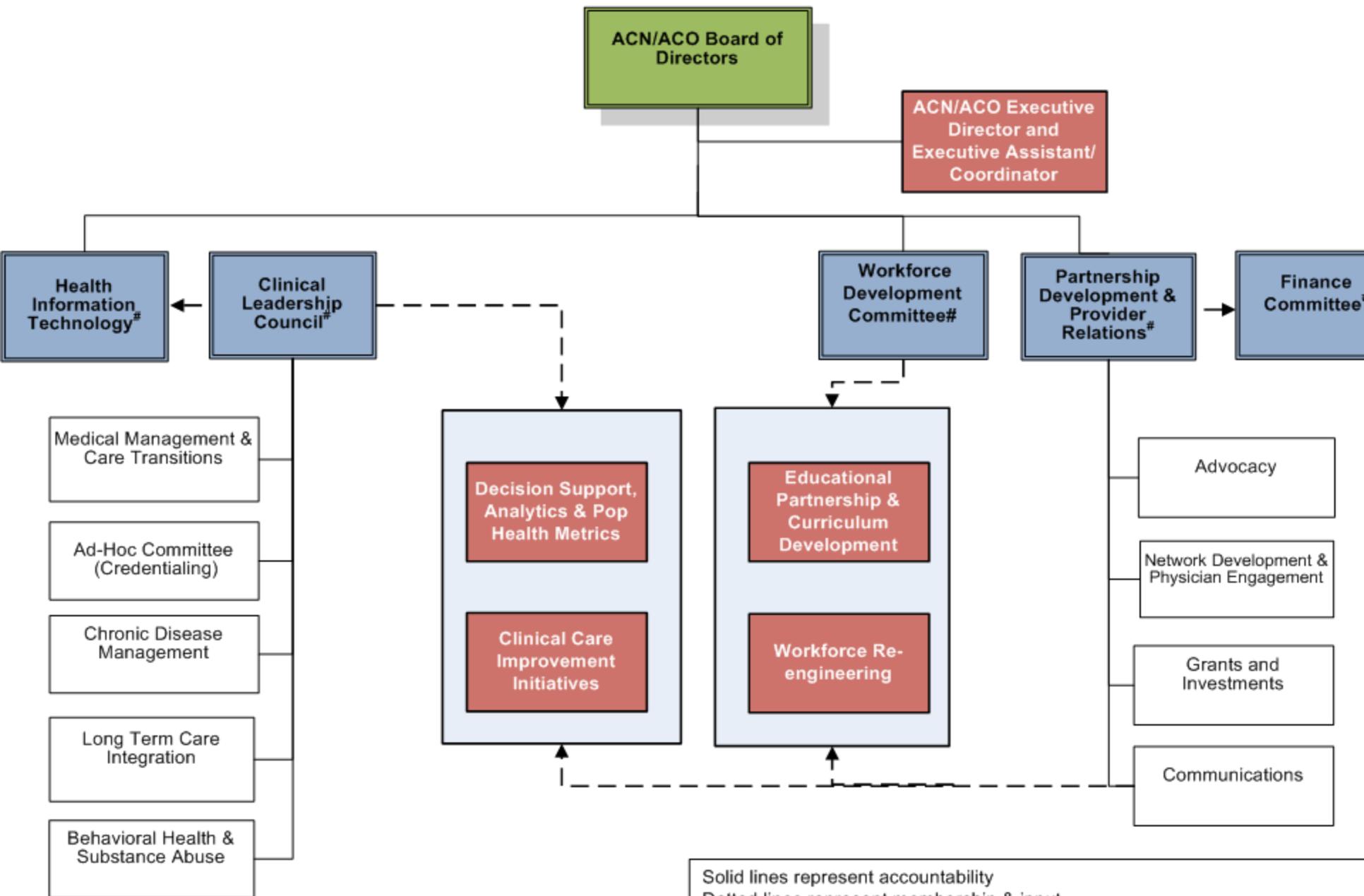
- Operating revenues of more than \$220 million.
- 1,900 employees across 43 sites
- 125,000 patients served; 855,000 annual visits
- 195 providers, mid-level practitioners, and nurses

AltaMed is the first health care organization in the nation to be accredited by the Joint Commission as a Primary Care Medical Home

- Medical Services include:
  - Primary Care
  - Patient Center Medical Home (PCMH)
  - “Wraparound” IPA
  - Youth Services
  - PACE
  - HIV Services



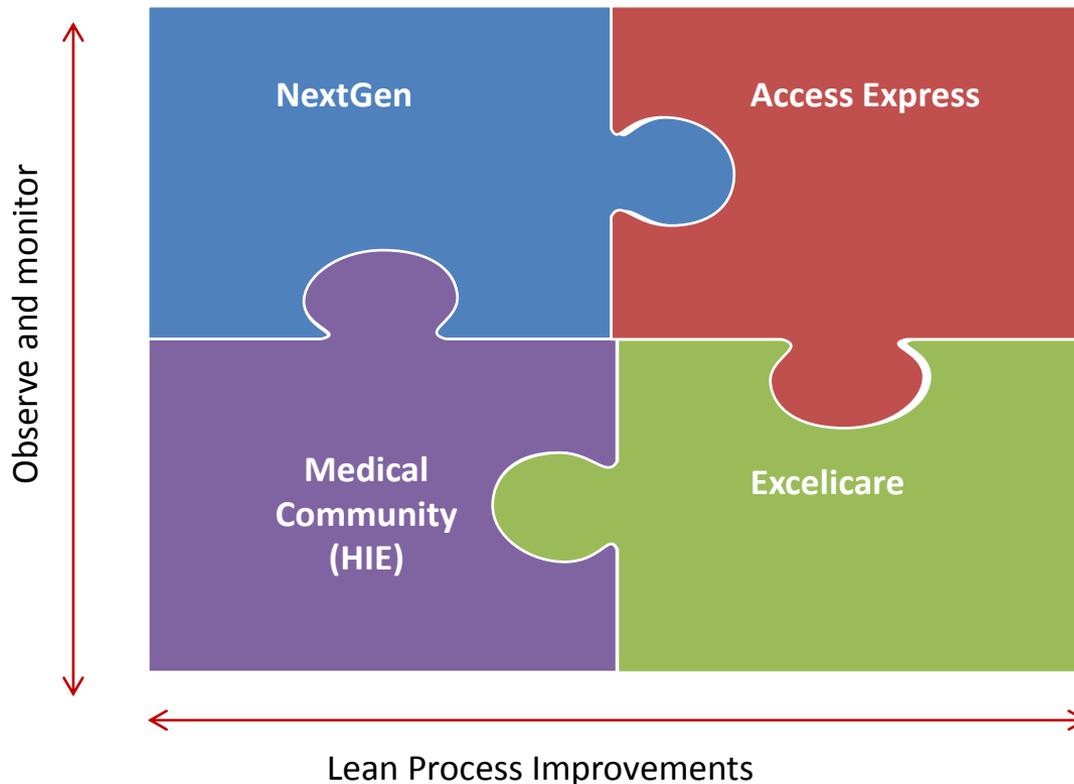
# Los Angeles Regional Accountable Care Organization



Solid lines represent accountability  
 Dotted lines represent membership & input  
 \*Populated by members of the ACN committees and experts in respective fields  
 #Chair of each committee reports to Steering committee

## Engaging People , Process and Technology for better coordination of care

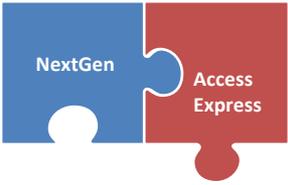
AltaMed will focus on 3 integrated IT platforms to engage with the community physicians, our ACN partners and to implement constant process improvements to improve quality, enhance patient experience and provide value



## NextGen

AltaMed is currently using NextGen EHR software in the clinics.  
Also, AltaMed is using NextGen to transition care between inpatient and outpatient in selected hospital settings

- AltaMed case manager (CM) is stationed at partner hospital
- Throughout stay and upon discharge CM consults with patient
- Inpatient physician uses NextGen for discharge summary
- CM enters transition of care information data into NextGen
  - ✓ RX reconciliation, outpatient appointment, etc.
- Data in NextGen is exposed to AltaMed primary care physicians for transition of care coordination



# Access Express

Access Express provides a bidirectional provider portal providing connectivity with the delivery system in our communities, extending the reach of our PCMH.

- NextGen Data is imported into Access Express to enhance medical management capabilities for all AltaMed Patients and Providers
- Access Express will support the coordination of care by providing real time access to medical management data
- Expanded communication capabilities with secure messaging and same day receipt of approved authorizations
- Enhanced tracking of authorization compliance for improved analysis
- Preferred provider selection capability (narrower networks)



## Excelicare

AltaMed is currently in the process of deploying a patient portal, clinical data repository and clinical integration engine that will allow patients and providers outside of AltaMed to view specific, discrete clinical data which is gathered and organized from multiple sources into a comprehensive patient record.

- Uses portals to communicate with providers and patients
- Allows HIE capture and exchange of data supporting coordination of care
- Allows patients to view and update their CCD (Enhanced CCD)
- Allows patient to email their providers
- Utilities allow real-time application of clinical rules and protocols
- Supports tracking outcomes across the delivery system
- Supports predictive modeling

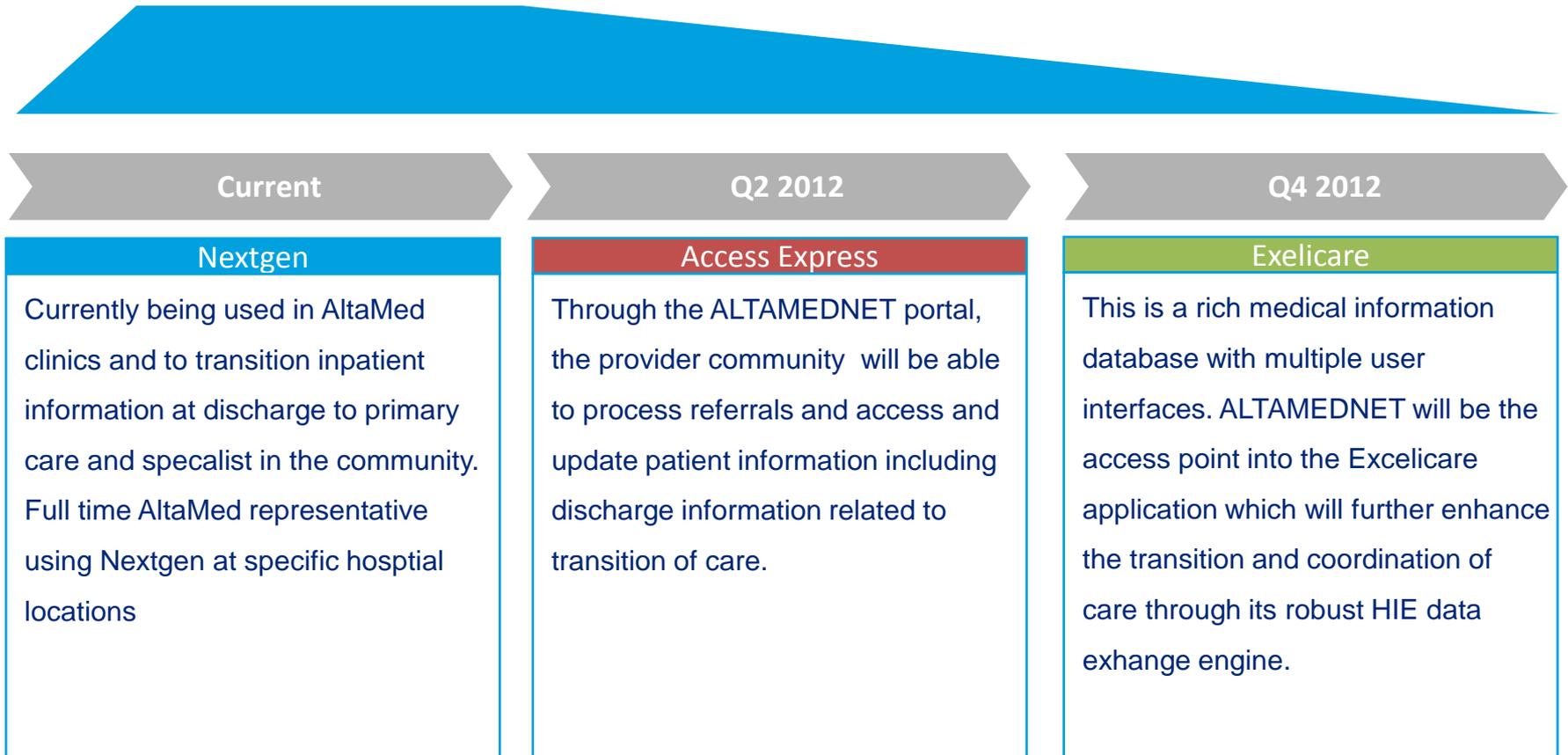


## Medical Community (HIE)

AltaMed's goal is to deliver meaningful patient information across a substantial population of providers and promote greater patient and provider interaction

- Continue to access and organize patient information across a multitude of delivery systems
  - ✓ IE. Pharmacy, Radiology, Providers, Hospital, Lab, Health Insurer
- Disseminating healthcare information across a multi-disciplinary continuum of care and presenting the information in a standard-compliant Continuity of Care Document (CCD)
- More robust exchange of data supporting coordination of care among ACO/ACN partners

# AltaMedNet Timeline



Source: insert source information here

# Process

Continuous Process Improvement to support optimal workflows and performance

## Nextgen

- Solicit provider and clinical staff input
- Analysis of current processes
- Offload data entry duties from provider where applicable
- Design more efficient Nextgen intake templates (less entry time)

## Access Express

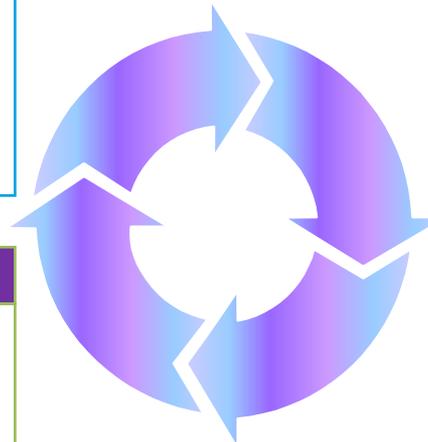
- Continually define and refine authorization adjudication rules to meet changing patient needs
- Provide perpetual training to users of AE to utilize its full functionality
- Outreach and education based on authorization compliance

## Medical Community

- Promote Utilization
- Publish best practices with regard to information and utilization
- Solicit feedback to improve patient and provider experience
- Add users and contributors

## Excelicare

- Continue to expand data inputs
- Constantly monitor data integrity
- Promote paperless lean processes
- Apply strategies to promote utilization of technology
- Education on the ever expanding power of the application

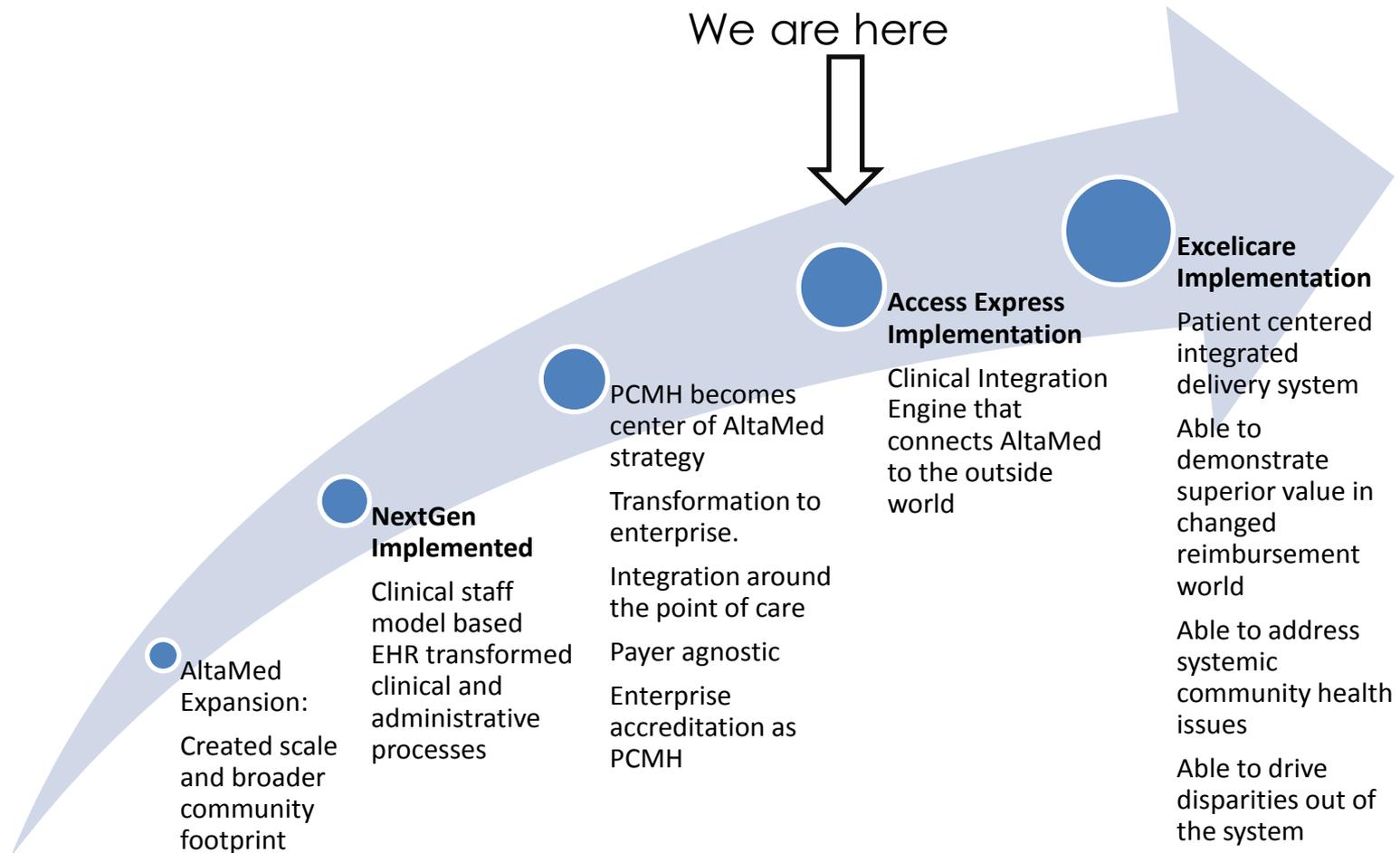


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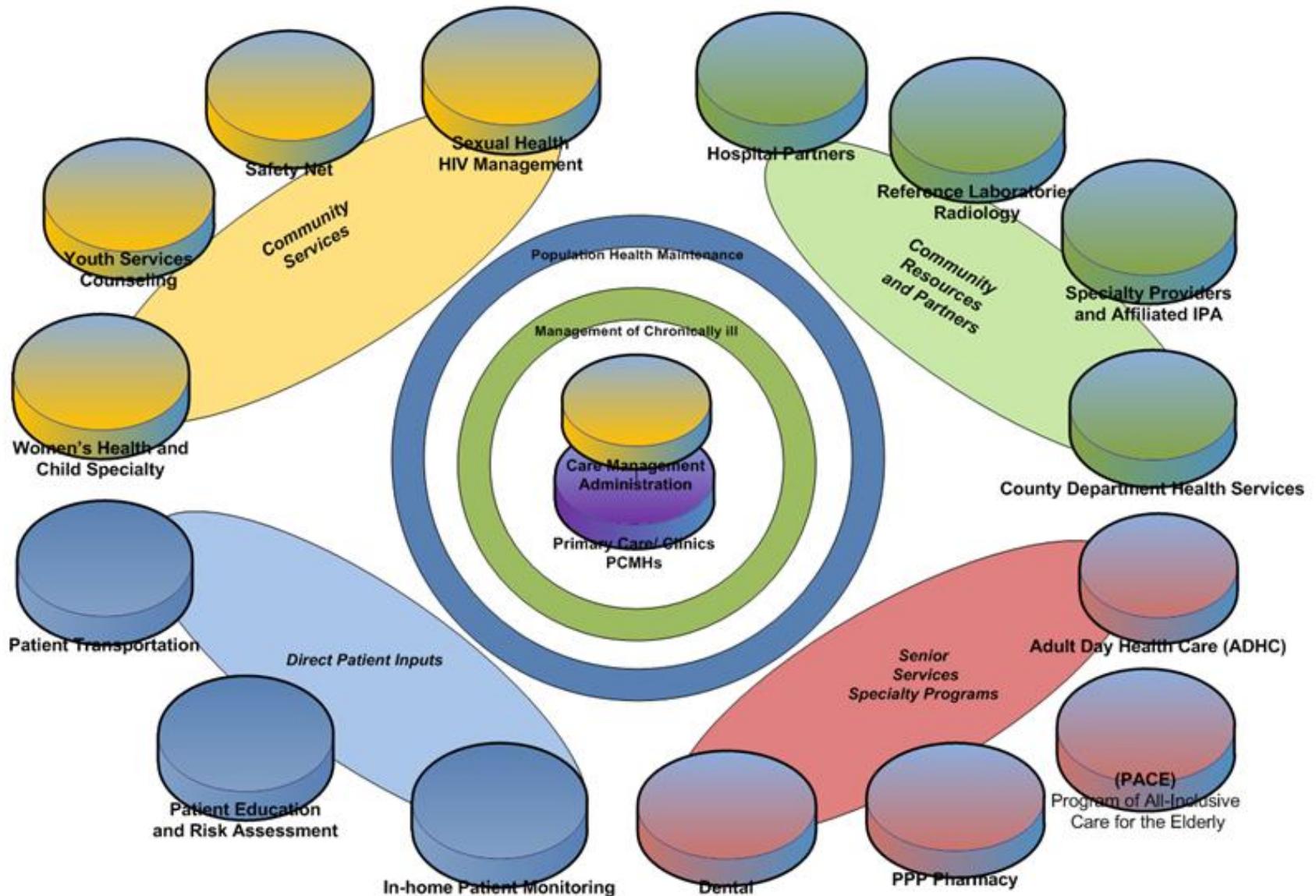
# Data Governance

- “Opt out” - exceptions for psych and HIV (HIPAA Rules)
- AltaMed data governance resides at Medical Informatics, reporting to “Enterprise”
- ACO/ACN data governance resides at HIT Committee which reports to the Board
- Lots of opportunity for “going rogue”

AltaMed’s Current Maturity Level along the Transformation Arc



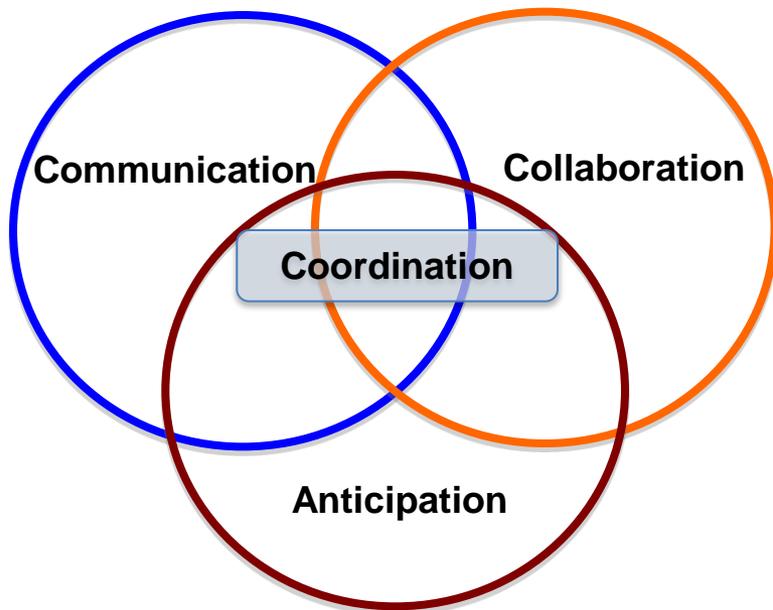
# Vision Realized



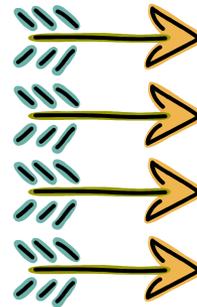
# Vision Realized

*“Transform into a clinically integrated healthcare delivery system prepared for reimbursement based upon value and quality, not volume”*

## “Quadruple Quiver”



- Martin Serota



## “Triple Aim”

*Improving the experience of care*

*Improving the health of populations*

*Reducing per capita cost of healthcare*

-Donald Berwick

# St. Louis Integrated Health Network: Relentless Pursuit of a Care Coordination Solution

# Overview

- Background And Context: Healthcare Disparities
- The Response: Primary Care Home Initiative
- Theory Vs. Practicality: What Actually Happened
- Relentless Pursuit Of A Solution: Results Despite The Odds
- How We Did It, Lessons Learned
- Q/A

# Background

- World-class center for medical research, training, and delivery of health care services.
- Controversy and Crisis exist for low-income St. Louisans
  - 1979 closure of Homer G. Phillips teaching hospital
  - 1985 closure of City's remaining public hospital
  - Formation of a regional hospital for City and County and ceased operation in 1997
  - St. Louis ConnectCare formed and faced financial crisis
  - St. Louis Civic Progress recommended the development of a "Regional Health Commission"

# The Reality of Healthcare Disparities

- Healthcare disparities reflect that vulnerable patients still lack adequate medical and behavioral care.
- Many uninsured and underinsured patients lack a primary care home.
- Patients experience difficulty navigating the healthcare system.
- Many patients resort to episodic care at EDs as their primary source of medical services.

# The Response to Healthcare Disparities

- Regional Health Commission formed (RHC)
- St. Louis Integrated Health Network formed as a priority recommendation from the RHC
- Seed funding from HRSA assisted the formation of the IHN as a Health Center Controlled Network (HCCN)

# IHN Scope and Mission

- IHN is a partnership of providers that serve over 200,000 uninsured and underinsured residents in St. Louis City and County
- IHN Mission—To improve ***quality***, ***accessibility***, and ***affordability*** of health care in St. Louis City, County and St. Charles areas through increased coordination and integration of health care services

# IHN Provider Membership

## **Federally Qualified Health Centers:**

- Betty Jean Kerr's Peoples' Health Centers
- Crider Health Center
- Family Care Health Centers
- Grace Hill Neighborhood Health Centers
- Myrtle Hilliard Davis Comprehensive Health Centers

## **St. Louis County Department of Health**

## **St. Louis City Health Department**

## **St. Louis ConnectCare (Specialty Care/Urgent Care for the Safety Net)**

## **Medical Schools:**

- St. Louis University School of Medicine
- Washington University School of Medicine

## **Technical Advisors:**

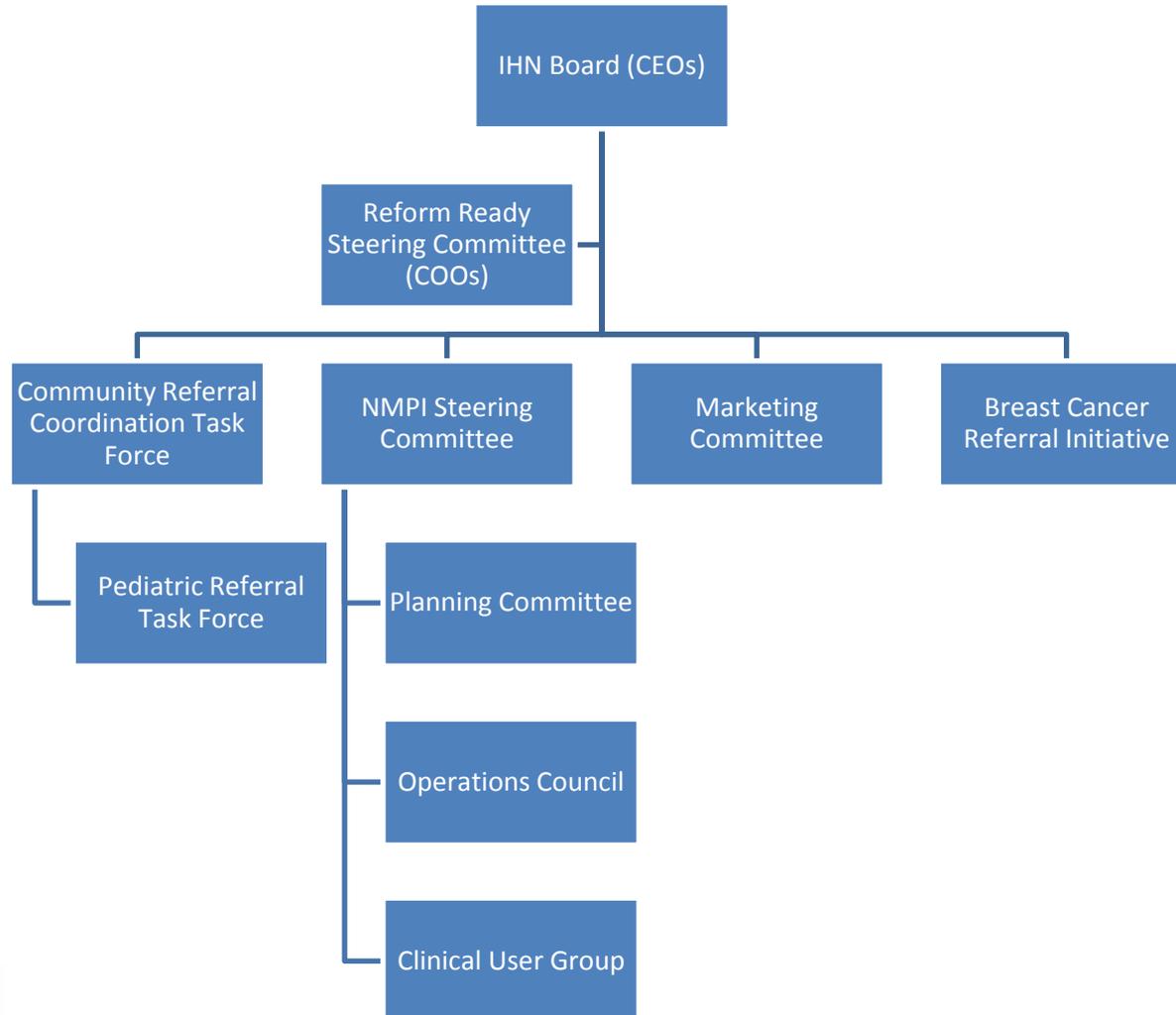
- Missouri Primary Care Association (MPCA)
- Regional Health Commission (RHC)

**7 Hospital Emergency Departments work in partnership with the IHN Providers**

# IHN: What We Do

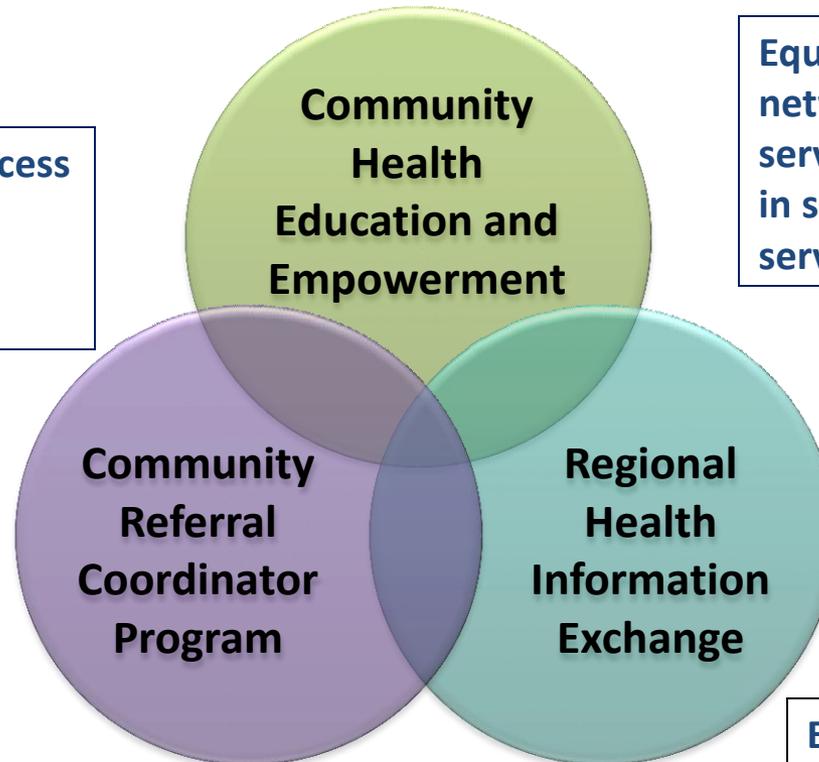
- IHN is a partnership of providers that serve over 200,000 uninsured and underinsured residents in St. Louis City and County
- What we do
  - Facilitate collaborative efforts
  - Implement regional recommendations
  - Create opportunities for system improvements

# IHN Governance and Structure



# IHN's Response to Disparity

Provide a coordinated process for referring emergency department patients to a primary care home



Equip patients to navigate the network of health care services and assist providers in sustaining high quality services

Enable exchange of essential patient information across providers

# Primary Care Home Initiative

Patient care is improved by focusing on:

- Connecting Medicaid and uninsured patients with a primary care home
- Reducing non-emergent use of ER
- Enhancing coordination, quality, and efficiency of care through secure electronic exchange of patient health information

# NMPI and CRC Programs

Community  
Referral  
Coordinators

Provide a coordinated  
process for referring  
Emergency Department  
patients to a primary care  
home



Regional  
Health  
Information  
Exchange  
(NMPI)

Enables the exchange  
of essential patient  
information across  
providers

## Improved patient care:

- Connecting underserved patients with a primary care home
- Reduce non-emergent use of ED's
- Enhance coordination, quality & efficiency of care through the exchange of data
- Use local resources cost effectively

# CRC Program

- Community Referral Coordinator program focuses on connecting patients to a medical home
- Currently in seven hospitals
- CRC is located within the hospital Emergency Department

# Theory Vs. Practicality



- Hi-Tech introduced
- State given planning grant for Statewide HIE development
- Rules changed, stricter policies for data sharing
- Created partnership with Missouri Primary Care Association which increased the amount of clinical data to position health centers to better prepare for statewide exchange

# Relentless Pursuit of a Solution

- Focused effort on CRC program, care coordination efforts across the region, and community empowerment and marketing
- Convened region around multiple CMS initiatives surrounding:
  - Care Coordination
  - Readmissions
  - Medical Home Initiatives
- Became the regional solution

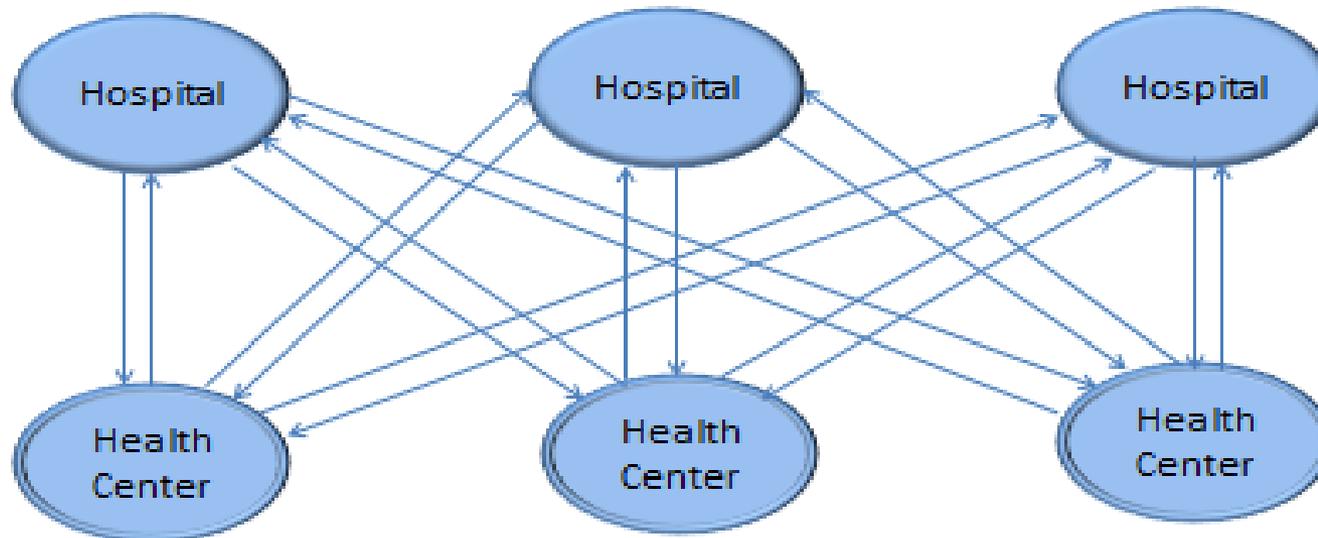
# CRC Program Outcomes



- 50% increase in encounters per quarter from 2008 to 2011
- Quadrupled referrals per quarter from Hospitals to CHCs from 2008 to 2011 (300 to 1500)
- Show rates are now double the national average for referrals from hospitals to CHCs (20% vs 40%)
- Inpatient expansion is on course at 5 hospitals and showing promising results
  - 50% of inpatient referrals attend follow-up appt.

# CRC Program Outcomes

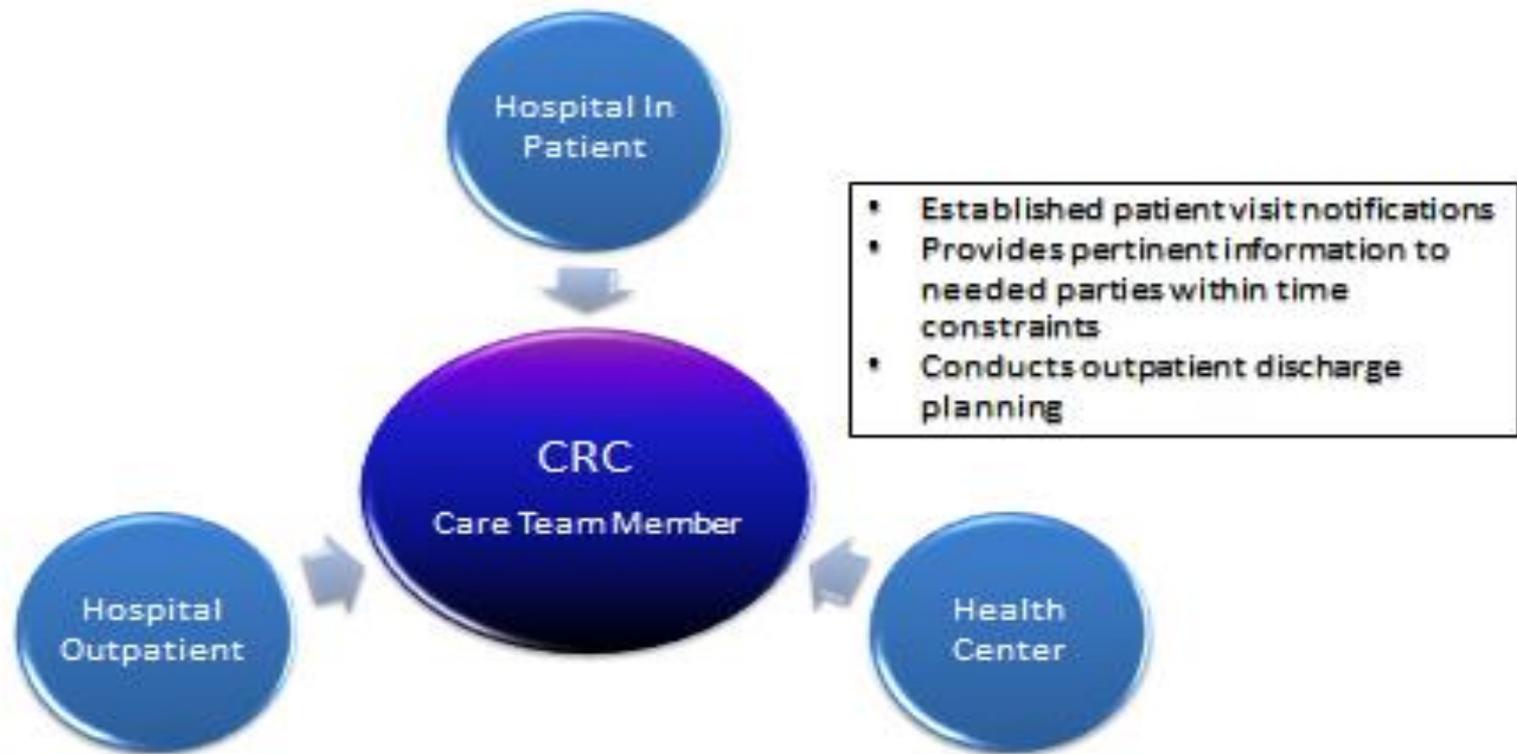
Current State – No CRC Coordination



Confusion, lacking in consistency, needs not met, adds work for all

# CRC Program Outcomes

## Future State – CRC Coordination



**Coordinated, Consistent, and Streamlined**

# P.U.L.S.E.

## Primary Care

Choose your own doctor to treat disease and keep you healthy

## Urgent Care

If you want help now, but your life is not in danger

## Lifestyle Services

Take care of yourself with a healthy lifestyle

## Specialty Care

Get extra treatment and/or tests. It is by appointment only

## Emergent Care

If you need help now and your life may be in danger go to a hospital emergency department for life-threatening problems



## Our Locations

### BETTY JEAN KERR PEOPLE'S HEALTH CENTERS

- A** Central Health Center  
5701 Delmar Boulevard  
St. Louis, MO 63112      314.367.7888
- B** North Health Center  
11642 West Florissant Avenue  
Florissant, MO 63032      314.838.8220
- C** West Health Center  
7200 Manchester Road  
Maplewood, MO 63143      314.781.9162

### CRIDER HEALTH CENTER

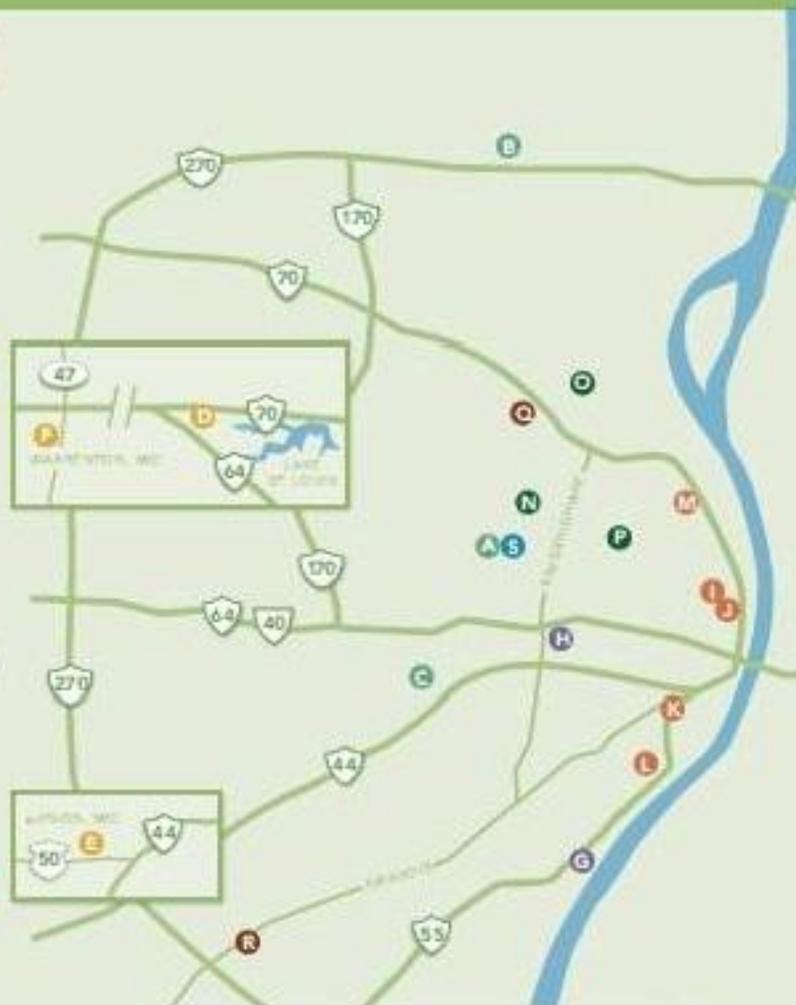
- D** Crider Health Center  
1082 Crosswinds Court  
Wentzville, MO 63385      636.332.6000
- E** Urges Clinic  
1780 Old Highway 50 East  
Union, MO 63084      636.583.2251
- F** Warrinton Clinic  
1428 North Highway 27, suite B  
Warrinton, MO 63383      636.456.1500

### FAMILY CARE HEALTH CENTERS

- G** Carondelet  
401 Holly Hills Avenue  
St. Louis, MO 63111      314.353.5190
- H** Forest Park Southeast  
4352 Manchester Avenue  
St. Louis, MO 63110      314.531.5444

### GRACE HILL NEIGHBORHOOD HEALTH CENTERS

- I** Murphy O'Fallon Health Center  
1717 Biddle Street  
St. Louis, MO 63106      314.814.8700
- J** St. Patrick Center  
800 North Tucker Boulevard  
St. Louis, MO 63101      314.814.8700
- K** Souldard-Benton Health Center  
2220 Lamp Avenue  
St. Louis, MO 63104      314.814.8700



### GRACE HILL NEIGHBORHOOD HEALTH CENTERS (continued)

- L** South Health Center  
3930 South Braclawey  
St. Louis, MO 63118      314.814.8700
- M** Water Tower Health Center  
4114 North Florissant Avenue  
St. Louis, MO 63107      314.814.8700

### MYRTLE HILLIARD DAVIS COMPREHENSIVE HEALTH CENTERS

- N** Comprehensive Health Center  
5471 E. Martin Luther King Drive  
St. Louis, MO 63112      314.367.5820
- O** Florence Hill Health Center  
5541 Riverview Boulevard  
St. Louis, MO 63120      314.389.4566
- P** Homer G. Phillips Health Center  
2425 North Winster Street  
St. Louis, MO 63113      314.371.3100

### SAINT LOUIS COUNTY DEPARTMENT OF HEALTH

- Q** North Central Community Health Center  
4000 Jennings Station Road  
Pine Lawn, MO 63121      314.679.7800
- R** South County Health Center  
4580 South Lindbergh Boulevard  
Sumner Hills, MO 63127      314.615.0400

### SPECIALTY SERVICES

- S** St. Louis ConnectCare  
Smiley Urgent Care Center  
5335 Delmar Boulevard  
St. Louis, MO 63112      314.879.6300  
(No appointment necessary)

### URGENT CARE SERVICES

- S** St. Louis ConnectCare  
Specialty Services  
5335 Delmar Boulevard  
St. Louis, MO 63112  
(Contact your doctor for a referral)

For more information, please  
call your center or visit  
[www.stlouisIHN.org](http://www.stlouisIHN.org).

# How we did it, Lessons Learned



- Provided neutral convening table and left blame at the door—focused on collaboration
- Transparency of data management/reporting and program performance—outputs to outcomes transition
- Provided human connection—CRCs have access to hospital EMR and will soon have access to CHC EMRs
- Built on established and agreed upon resources and goals
- Built TRUSTING relationships through honest dialogue, CHC/Hospital collaborative efforts, and consensus building

# Q/A



- Contact Information:
  - Bethany Johnson-Javois, MSW—CEO
    - [bjohnson@stlouisihn.org](mailto:bjohnson@stlouisihn.org)
  - Wil Franklin, M.S., LPC—Chief Program Officer
    - [wfranklin@stlouisihn.org](mailto:wfranklin@stlouisihn.org)



# **Using IT to Coordinate Care Transitions in Missouri**

**Missouri Primary Care  
Association Center for Quality**

**May 18, 2012**



# Section 2703 of the Affordable Care Act

- Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide **Health Home Services** for enrollees with qualifying chronic conditions.
- Missouri received approval from the Centers for Medicare & Medicaid Services (CMS) for two State Plan Amendments to be able to provide Health Home Services to Missourians who are Medicaid eligible participants with chronic illnesses.



# Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion
- **Comprehensive transitional care including follow-up from inpatient and other settings**
- Patient and family support
- Referral to community and support services



# Goals of the Primary Care Health Home Initiative

- **Reduce inpatient hospitalization, readmissions and inappropriate Emergency Room visits**
- **Improve coordination and transitions of care**
- Implement and evaluate the Health Home model as a way to achieve accessible, high quality primary health care and behavioral health care;
- Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model; and
- Support primary care and behavioral care practice sites by increasing available resources and improving care coordination to result in improved quality of clinician work life and patient outcomes.



# Data Management and Analytics

- Hospital and ER utilization from claims
- **Notification of Hospital Admit from MO HealthNet Division (Missouri Medicaid) concurrent authorization system**
- **Care Coordination via CyberAccess**
- Medication Adherence reports
- Clinical Information via MPCA data warehouse



# Contact Information

- Susan Wilson- [swilson@mo-pca.org](mailto:swilson@mo-pca.org)
- Angela Herman- [aherman@mo-pca.org](mailto:aherman@mo-pca.org)

Missouri Primary Care Association

3325 Emerald Lane

Jefferson City, MO 65109-6879

(573) 636-4222

[www.mo-pca.org](http://www.mo-pca.org)

# HealthShare Montana

Montana's State-Designated Entity  
for Health Information Exchange (HIE)

Supporting Care Transition & Quality Improvement

William M. Reiter, MD, FACP

Chief Medical Information Officer

[wmreiter@healthsharemontana.org](mailto:wmreiter@healthsharemontana.org)

Cleary N. Waldren, BS, Senior Project Manager

[cwaldren@healthsharemontana.org](mailto:cwaldren@healthsharemontana.org)

May 18, 2012

# HealthShare Montana (HSM) Architecture



HSM is implementing statewide HIE using aggregated CCR/CCD-standard data under a collaborative agreement with the Office of the National Coordinator for HIT (ONC). The design and use cases were inspired by two HRSA grant awards to Community Hospital of Anaconda, a rural Critical Access Hospital:

Small Health Care Provider Quality Improvement Program Grant

2006 – 2008

Rural Health Network Development Grant

2008 –2011

# The Continuity of Care Record/Document (CCR/CCD):

- The CCR or CCD contains an extract of a person's medical information and can include the core data required in the CMS Final Rule for electronic health record programs
- It has been standardized in terms of content and technical specifications
- It can be populated as a stand-alone document or extracted from an EHR
- It can be exchanged electronically, viewed using any web browser, copied to electronic media or printed on paper
- It can be used in a clinical data repository for information analysis that can provide key performance measure reports to providers and other users

# HIE & Care Transition

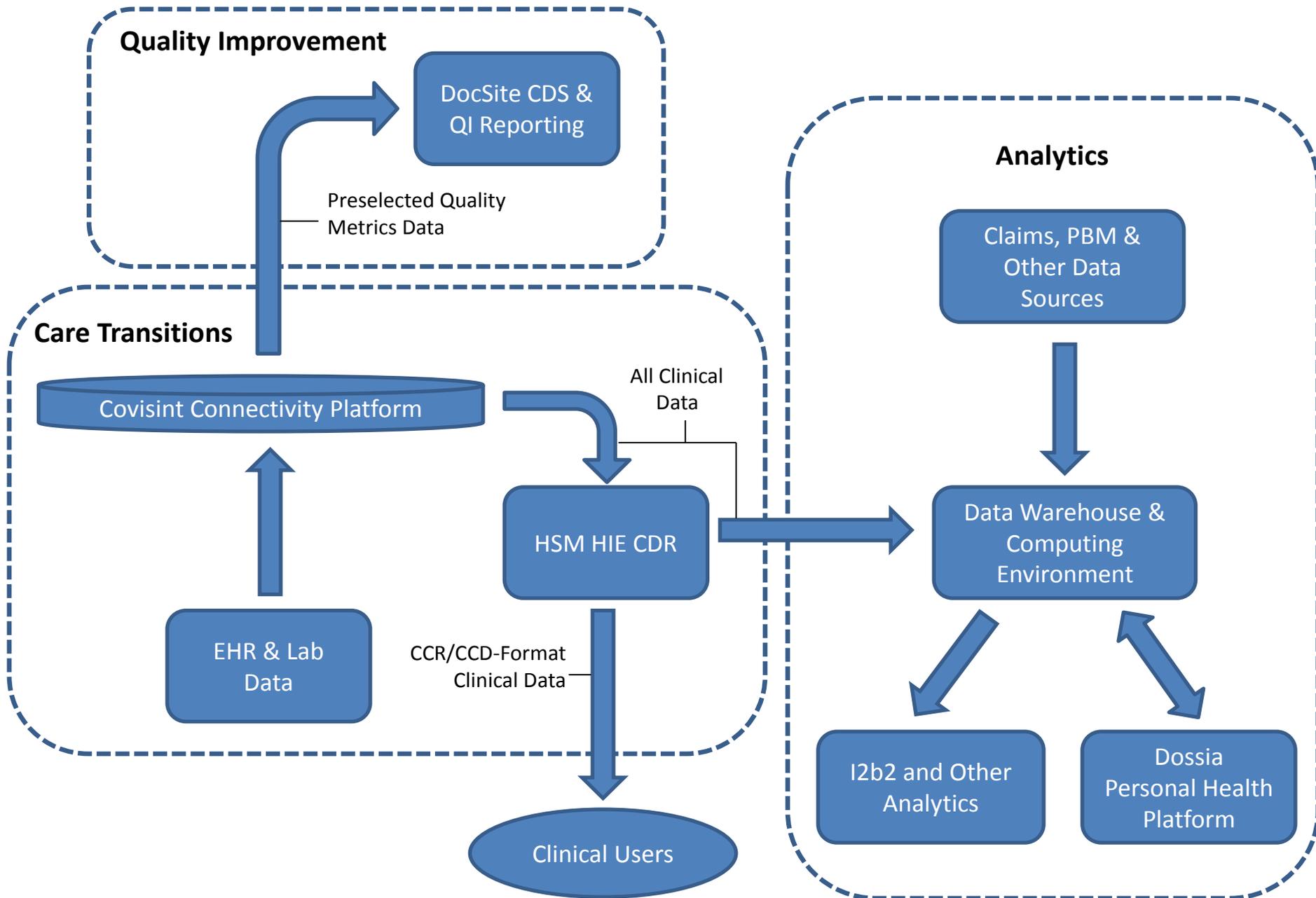
Factors Associated with Hospital Readmission:

“an inadequate relay of medical- and care-related information by hospital discharge planners to patients, caregivers and/or post-acute care providers”\*

HSM will improve care transitions and reduce hospital readmissions in its statewide population by allowing collaborating organizations throughout a large frontier state to effectively integrate disparate HIT systems

\*Congressional Research Service. *Medicare Hospital Readmissions* – September 2010

# HSM Infrastructure & Data Use: Care Transition, Quality Improvement & Analytics



# On-Demand HIE Patient Search Screen

Welcome cwaldren! | User's Guide | Change Password | My Account | Quit | Support

**docsite**  
CARE. ELEVATED.

Home Reports Administration News Editor Applications

HIPAA privacy timeout in: 60:00

**Patient Search**

Last Name: Reiter

First Name:

Middle Name:

DOB:

Gender: Unspecified

Zip:

Search Clear Add New

Search All Sites

**Sites**

Reiter Foundation

**Patients**

In Practice	Opt-out	Patient Name	Gender	DOB	Address	Status
	••	<a href="#">Reiter, William</a>	Male	9/9/1955	,, 59711	Active

Page size: 20

1 items in 1 pages

# Access to CCR/CCD Information for Care Transition

**docsite**  
CARE. ELEVATED.

Welcome cwaldren! | User's Guide | Change Password | My Account | Quit | Support

HIPAA privacy timeout in: 53:30

Home Patient Data Reports Administration News Editor Applications

**Patient:** William Reiter    **Date of Birth:** 09/09/1955    **Gender:** Male    **Phone:** Not available    **Address:** , 59711    **Actions..** ▾

**Patient Data**

- Refer Patient
- Patient Information
- Quick Entry
- Lab Entry
- Allergies
- Single Entry
- Survey Entry
- History Entry
- Patient Alerts
- Measure Review
- Medications Review
- Visit Comment Review
- Survey Review
- History Review
- Online VP Review
- Growth Chart
- Lab Viewer
- Visits
- Demographics

**Managed Conditions**

Managed Condition	ICD-9	Date Diagnosed
HTN		unspecified
Prevention		

**Allergies** [Add New](#)

View: Active Allergies ▾

Allergy	Note	Severity	Date Diagnosed	Status	Last Updated	Source
No Known Drug Allergy - Class		NotSpecified	05/08/2012	Active	5/8/2012 11:21:00 PM	Reiter Foundation

**Current Medications** [Add New](#)

Medication Name	Directions	Status	#/Days/Refs	Date of Rx	Source
Olmesartan medoxomil 20 MG Oral Tablet [Benicar]		Continue	//	05/08/2012	Reiter Foundation

**Community CCD**

- View Practice CCR
- Save CCR to XML
- Save CCR to PDF
- Send CCR
- Community CCD
- Practice CCD

# Example of a CCR Summary Display

## Continuity of Care Record

**Date Created:** Wed May 09, 2012 at 02:49 PM UTC-05:00  
 William Reiter MD (System User)  
**From:** Edward Amberg PA (Principal Provider)  
 Reiter Foundation (Care Facility)  
 DocSite Patient Planner V3 (Healthcare Information System)  
**To:**  
**Purpose:**

### Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address / Phone
William Reiter	Sep 09, 1955	Male	DocSiteID 1011442	Home: 59711

### Alerts

Type	Date	Code	Description	Reaction	Source
Allergy	May 08, 2012		No Known Drug Allergy - Class	-NotSpecified	<a href="#">William Reiter</a>
Alert	Sep 01, 2011	Today's Visit Type (DocSite Codes)	Today's Visit Type: Planned visit [ Ref - NA ]		<a href="#">William Reiter</a>
Alert	Sep 01, 2011	BP SBP (DocSite Codes)	BP SBP: 120 mmHg [ Ref - < 130 ]		<a href="#">William Reiter</a>
Alert	Sep 01, 2011	BP DBP (DocSite Codes)	BP DBP: 80 mmHg [ Ref - < 80 ]		<a href="#">William Reiter</a>

### Problems

Type	Date	Code	Description	Status	Source
Condition			HTN	Active	<a href="#">DocSite Patient Planner V3</a>
Condition	May 08, 2012		Prevention	Active	<a href="#">DocSite Patient Planner V3</a>

### Medications

Medication	Date	Status	Form	Strength
Olmesartan medoxomil 20 MG Oral Tablet [Benicar] (Olmesartan medoxomil 20 MG Oral Tablet)	May 08, 2012	Active	Oral Tablet	20 MG

### Immunizations

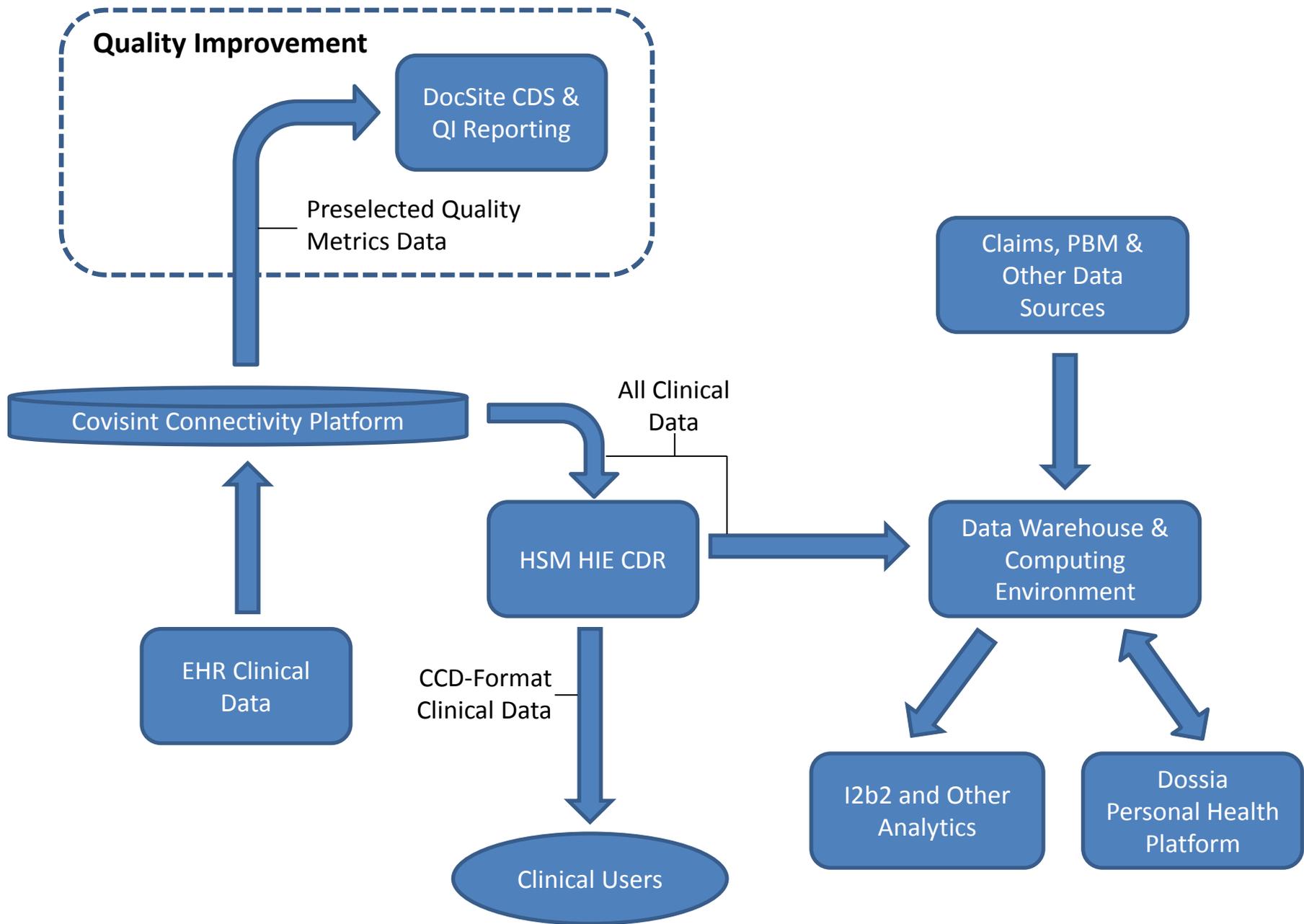
Code	Vaccine	Date	Route	Site	Source
88	influenza, NOS (IM)	Sep 01, 2011			<a href="#">DocSite Patient Planner V3</a>

# Improved Care Transition & Reduction in Hospital Readmissions

- University of Pennsylvania Transitional Care Model, CHF Patients:\*
  - 36% reduction in readmissions (52 weeks)
  - 39% reduction in cost of care (52 weeks)
- Implications in Montana:
  - CHF Medicare discharges 2011, six largest facilities:
    - 662 people
  - Total In-Patient Hospital Cost:
    - \$4,407,450
  - Saving with 30% reduction in readmissions (in-patient costs only):
    - \$1,322,235

\*Mary Naylor, Ph.D., F.A.A.N, R.N., Dorothy Brooten, Ph.D., F.A.A.N, R.N., and Roberta Campbell, M.S.N., et al., "Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized Clinical Trial," Journal of the American Geriatrics Society, vol. 52, no. 5 (May 1, 2004), pp. 675-684.

# HSM Data Infrastructure: Care Transition, Quality Improvement & Analytics



# Clinical Decision Support (CDS) as Part of Care Transition for Identifying Unmet Needs & Improving Outcomes

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Home Patient Data Reports Administration News Editor Applications

**Patient:** William Reiter    **Date of Birth:** 09/09/1955    **Gender:** Male    **Phone:** Not available    **Address:** , , 59711    **Actions..** ▾

**Patient Data**

- Refer Patient
- Patient Information
- Quick Entry
- Lab Entry
- Allergies
- Single Entry
- Survey Entry
- History Entry
- Patient Alerts
- Measure Review
- Medications Review
- Visit Comment Review
- Survey Review
- History Review
- Online VP Review
- Growth Chart
- Lab Viewer
- Visits
- Demographics

**Sites**

Reiter Foundation ▾

**Patient Search**

Last Name: Reiter

First Name:

Middle Name:

**Patient Alerts**

Actionable Alerts only.

**Clinical**

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
BP SBP	120 mmHg	9/1/2011	< 130	< 130	3/1/2011
BP DBP	80 mmHg	9/1/2011	< 80	< 80	3/1/2011

**LAB/Testing**

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Lipids-fasting					
HDL	mg/dl				
LDL-C	mg/dl				
Triglycerides	mg/dl				
K+	meq/L				
Creatinine (Plasma)					

**Immunizations**

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Tetanus					

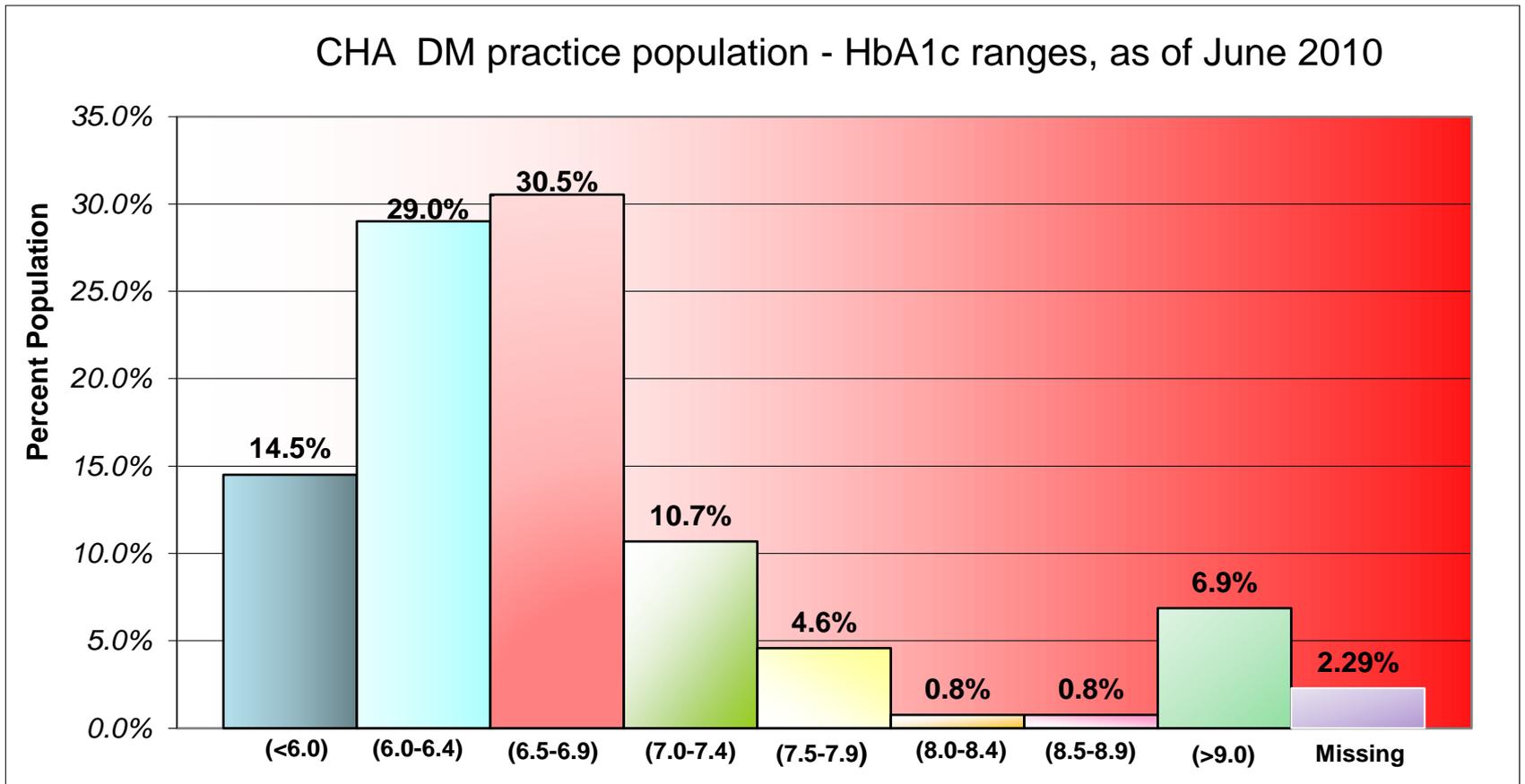
**Depression Screen PHQ-total score >3 consider add'l eval**

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Over Past 2 Wks how often bothered by little interest or pleasure in doing things					
Over Past 2 Wks how often bothered by feeling down, depressed, or hopeless					

**Screening**

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Glucose Screen for Metabolic Syndrome and Diabetes. NAcept has diabetes					
CV 10-Year Risk (Male)					
PSA	ng/mL				

# CDS Used During Care Transition to Improve Outcomes



MT HEDIS DM population, HbA1c < 7%: 50.3%

CHA DM population, HbA1c < 7%: 74.05%

# Summary:

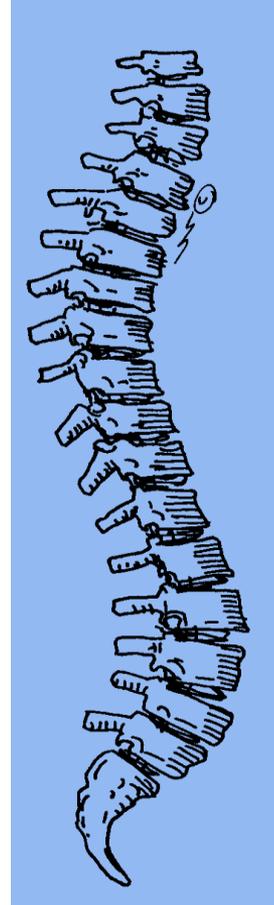
- HIE can be used to support care transition across all settings by providing access to care summary information
- Improved care transition can have a significant effect on reducing hospital readmission and cost
- CDS technology can be used at time of care transition to identify and address unmet goals and so improve outcomes

Thank You!

HealthShare Montana

Montana's HIT Backbone!

[www.healthsharemontana.org](http://www.healthsharemontana.org)



# *Office of Health Information Technology and Quality*

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Additional HRSA Health IT and Quality Toolboxes and Resources including past webinars can be found at:

<http://www.hrsa.gov/healthit>

<http://www.hrsa.gov/quality>

Additional questions can sent to the following e-mail address:

[HealthIT@hrsa.gov](mailto:HealthIT@hrsa.gov)

- US Department of Health and Human Services
- Health Resources and Services Administration