Beyond the Report

MANAGING PRODUCTIVITY THROUGH TARGETED DATA COLLECTION IN AN ELECTRONIC MEDICAL RECORD

Laura Bazhdari, LMSW
Katie Bierlein, LMSW, MPH

The Institute for Family Health

- Federally Qualified Health Center
- New York: NYC & Upstate
- Our Mission: To improve access to high quality, patient-centered care targeted to the needs of medically underserved communities.
- Our Patient Population

Care Management

- Health System Engagement
  - Care Coordination
  - Primary Care/Behavioral Health Integration
  - Avoidable ED Utilization
- Health Homes
  - Patient-Centered Goal-Setting
  - Addressing Social Determinants of Health
- Supervisory Structure
  - LMSW Coordinators
  - RN Coordinators
  - Care Navigators

Developing the Report

- How did we develop it?
  - Data collection; EMR
- Why do we use it?
  - Meeting Outcomes
  - Continuous Quality Improvement
  - Increasing Patient Contact
  - Improving Service Quality

Prioritizing High Risk Populations

- Suicide Risk
- Emergency Department Use
- Children
- HIV
- Elderly
- Complex Mental Health Conditions
- Complex Medical Conditions

Tracking Patient Contact

- Patients in ‘Outreach’
- Enrolled Patients
- Past clinical encounters
- Future clinical encounters
- Telephonic
- Face to Face

Billing Support

- Episode
  - HH
  - General
  - At Risk
  - Children's
  - CCM
- Insurance Type

Task Completion

- Risk Categorization
  - HML
    - Housing
    - Incarceration
    - Mental Health Inpatient
  - Assessment Completion
    - Past Due/Coming Due
  - Care Plan Review
    - Past Due/Coming Due

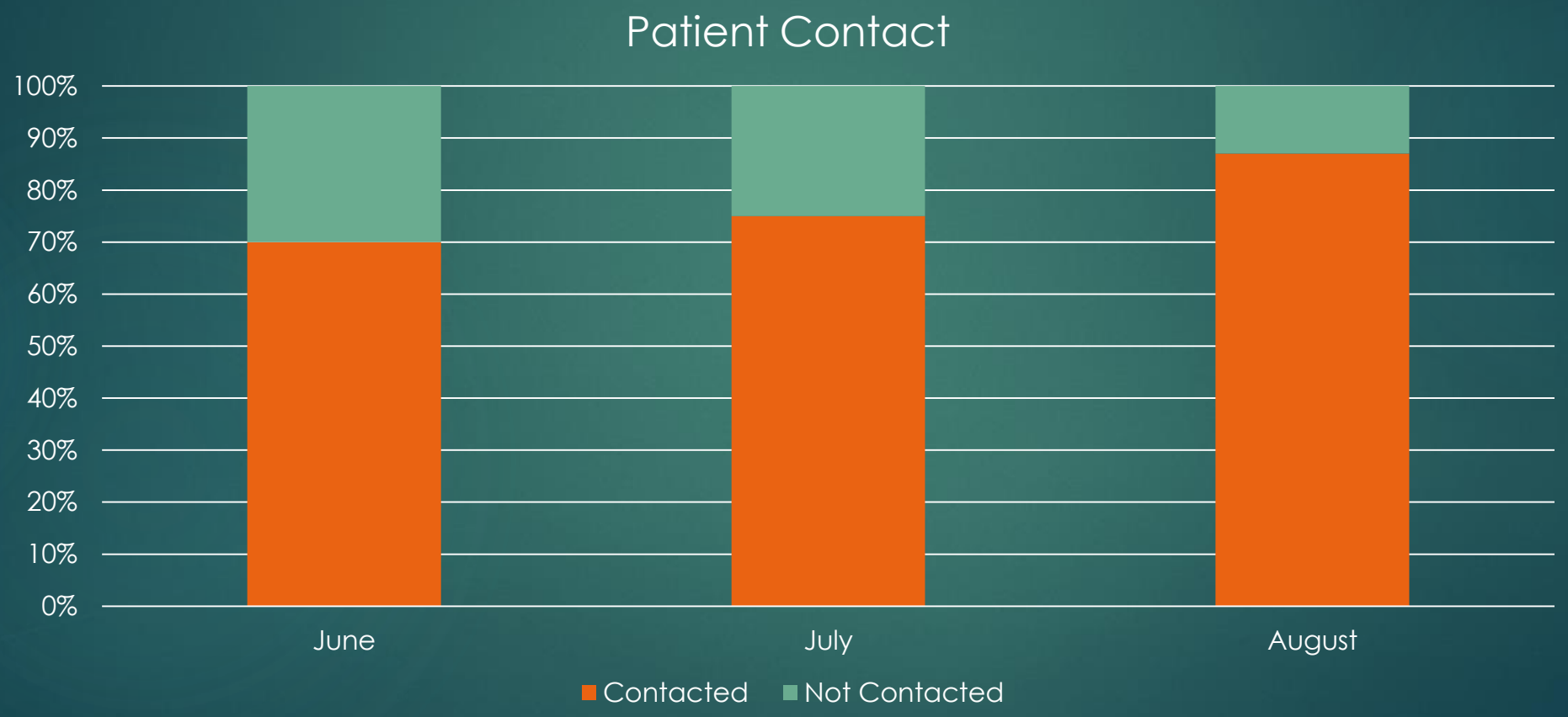
Tracking Follow-up

- Next Scheduled Appointment/Department
- Status of patient communication (MyChart)
- Chart ‘sticky notes’

Staff-driven

- Ability to individualize Report
  - HIV Navigator
    - Last Viral Load
  - Children's Health Home
    - Childhood Immunization due date
  - Mental Health Focus
    - Last PHQ-9 Score
  - Patient Location
    - Zip code

Results: Increased Patient Contact



What's Next?

- Integrate Population Health Metrics
  - Quality Metrics/Preventive Care
- Identify trends over time
  - Individually compare monthly contact w/in Report
- High Risk Committee
  - ICD-10 Codes
- Evolving Report
  - Flexibility

Public Health Significance

- Improving Interdisciplinary Communication & Collaboration
- Organizing service provision to high risk population
- Macro/Micro Utilization
  - Care Navigators, Managers
- Improving Health System Engagement
- Identifying/Providing appropriate interventions

Questions?

Thank You!

Laura Bazhdari, LMSW
lbazhdari@institute.org

Katie Bierlein, LMSW, MPH
kbierlein@institute.org

Active Care Team Report Sample

Suicidality	ED User	MRN	Patient Name	Primary Insurance	Medicaid ID	Active Care Mgt. Episode	Care Mgt. Type	Name of Health Home	Adult/Children's HH	HH Status	HH Enrollment Date
!		xxxx	Doe, John	Healthfirst Medicaid Managed Care	AxxxxZ		Health Home	CCMP	Adult	Enrolled	1/1/2017
		xxxx	Miller, Sarah	Medicare Part B	AxxxxZ		General		Adult	Outreach	
		xxxx	Douglas, Tim	Metroplus Medicaid Managed Care	AxxxxZ		Health Home	CCMP	Children's	Enrolled	2/5/2017

IFH CM Non Face-to-Face Contact	IFH CM Face-to-face Contact	Last HML Date	Com Assessment	Care Plan Date	Next Dept.	Next Appt.	PCP	Care Navigator	Pt. Portal Status	My Sticky Note Text
●	○	10/5/2017	2/1/2017	2/1/2017	FPCH Family Med	11/10/2017	Joe Anderson, MD	Anna Jones	Active	Pt requires appt reminders
○	●				Harlem Center for Counseling	10/25/2017	Amy Hill, MD	Diana Lee	Declined	Consult with Nurse on med list
○	○	11/1/2017	3/5/2017	4/5/2017	Care Management	11/15/2017	Deena Velasquez, MD	Anna Jones	Pending	Discuss ACS case with Dr. Jones