Petaluma Health Center

Petaluma Health Center

HIMSS Davies Case Presentation
July 20, 2017

Petaluma Health Center works to ensure access to high quality, prevention-focused health care for residents of Southern Sonoma County

Welcome & Agenda

Time	Topic	Presenter
8:00am – 8:20am	Welcome & Introductions	Danielle Oryn DO MPH *Chief Medical Informatics Officer* Kathie Powell *Chief Executive Officer* Erick Ratliff *Director of IT*
8:20am – 9:20am	Case Study # 1 – Hypertension	Nurit Licht MD *Chief Medical Officer* Danielle Oryn DO MPH *Chief Medical Informatics Officer* Shaun Nelson MPH *Senior Data Analyst* Brian Burns *Chief Financial Officer*
9:20am – 10:20am	Case Study # 2 – Hepatitis C	Nurit Licht MD *Chief Medical Officer* Claire Feldman MPH *Director of Wellness* Danielle Oryn DO MPH *Chief Medical Informatics Officer* Shaun Nelson MPH *Senior Data Analyst* Brian Burns *Chief Financial Officer*
10:20am – 11:00am	Davies Committee Debrief	

About Petaluma Health Center

Founded in 1996
Became a Federally Qualified Health Center in 2000

Currently caring for 29,000 patients via 150,000 annual visits

<u>Sites:</u>
Petaluma Health Center
Rohnert Park Health Center
Mary Isaak Center – *Homeless Shelter*
San Antonio High School – *School Based Health Center*
Casa Grande High School - *School Based Health Center*
Santa Rosa Junior College Petaluma - *School Based Health Center*

Petaluma HealthCenter

Petaluma Health Center Services

Full spectrum family centered primary medical care for children and adults
Adult and pediatric dental care
Women's health including pregnancy care and gynecology consultation
Integrated behavioral health and psychiatry consultation
Wellness services:

- Acupuncture
- Chiropractic care
- Integrative Medicine consultation
- Nutrition
- Shared medical visits
- Community exercise programs

Specialty Care:

- Ophthalmology and Optometry
- Podiatry
- Endocrinology
- Rheumatology (telehealth)

Petaluma HealthCenter

About Petaluma Health Center

Recognition

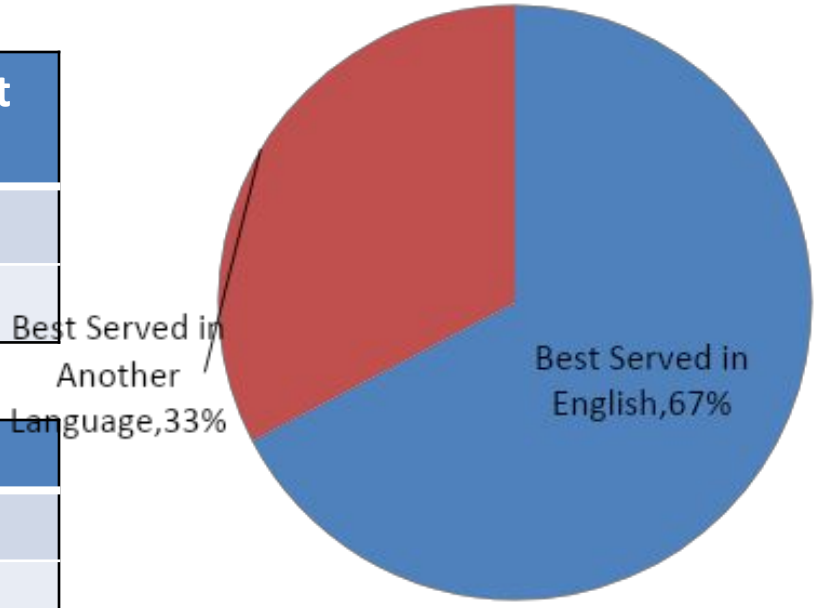
- NCQA Patient Centered Medical Home recognition, 2013 – present
- Joint Commission accreditation for Ambulatory Care with Primary Care Medical Home, 2015 - present
- HRSA Health Center Quality Leaders – 2016
- HRSA National Quality Leaders - 2016
- CDC Million Hearts Champion - 2015

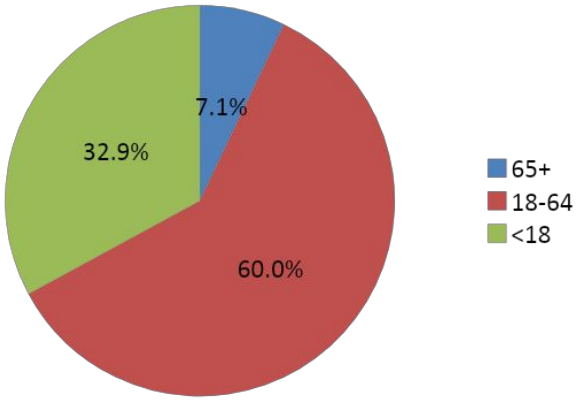
HIT Values

- Culture of innovation
- Tech-equity
- Maximize the value of the technology tools we have

	% of Patient Population
At or below 200% of poverty	75.2%
At or below 100% of poverty	27.6%

Patients by Race and Ethnicity	
Non-Hispanic White	45.6%
Racial and/or Ethnic Minority	50.6%
Hispanic/Latino Ethnicity	44.7%
Black/African American	1.8%
Asian	2.5%
American Indian/Alaska Native	0.3%
More than one race	0.4%

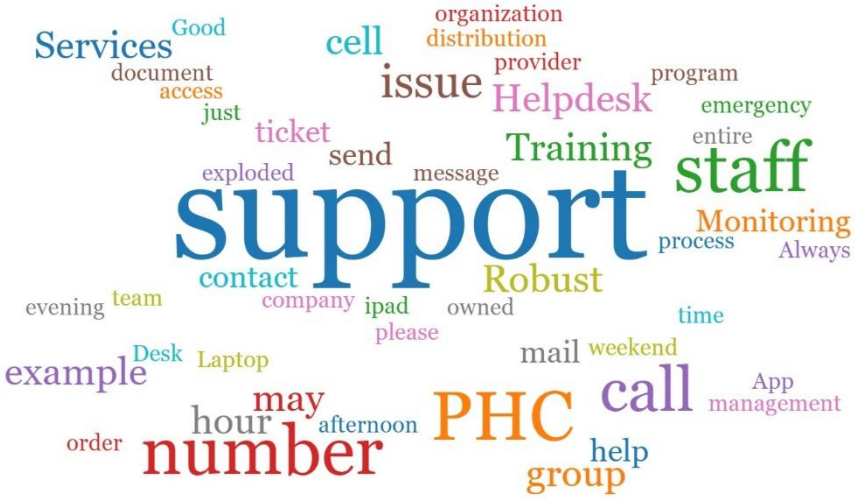


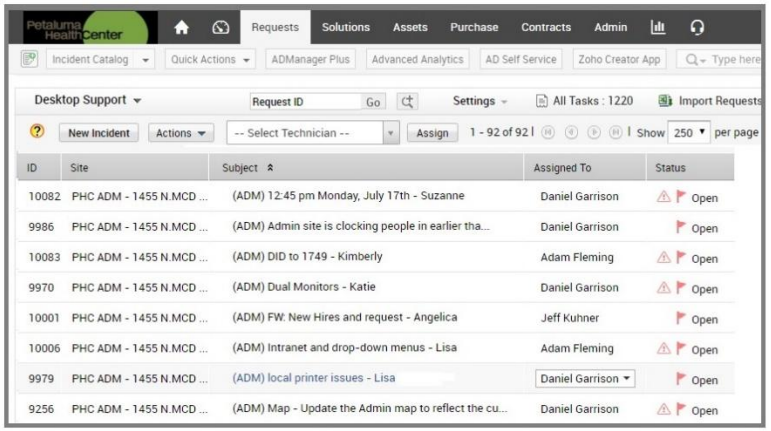


Petaluma Health Center

IT Support Services

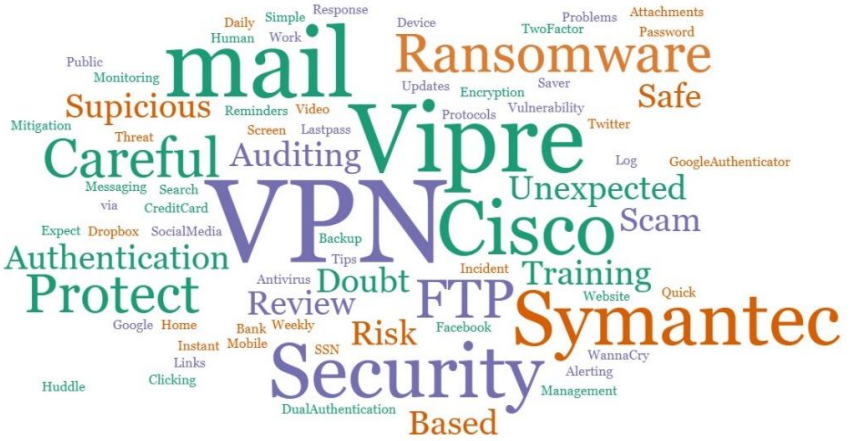
- Helpdesk Support
- Issue Notification
- Ticket Reporting
- Employee IT Training
- Uptime Monitoring
- Risk Mitigation
- Backup Review
- After Hours Call Support
- IT Project Management

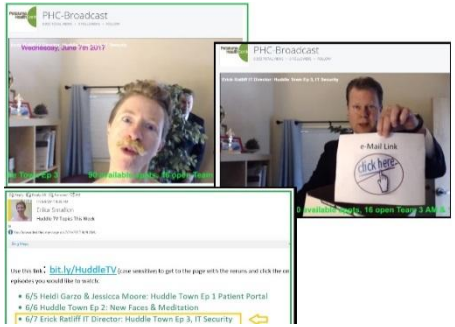


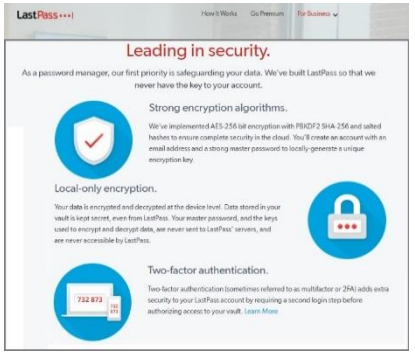


Security and Risk Management

- Human Based Monitoring
- Incident Response
- Antivirus Scanning
- Quick Tips and IT Help
- E-mail and Wiki Training
- Video Based Training
- Network Access Logging
- Yearly Risk Assessment
- Compliance Logging

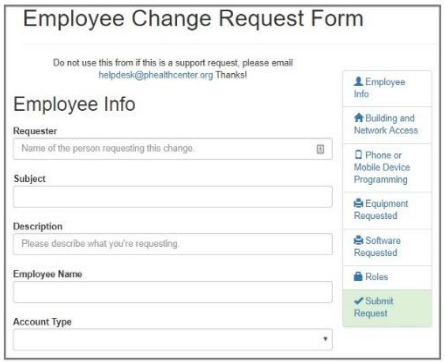


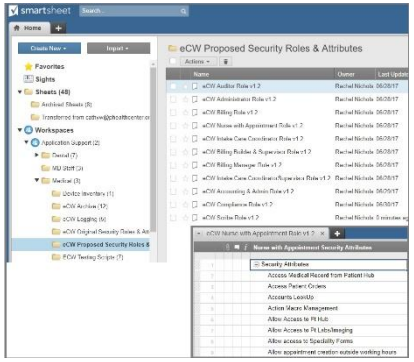




Change Request Management

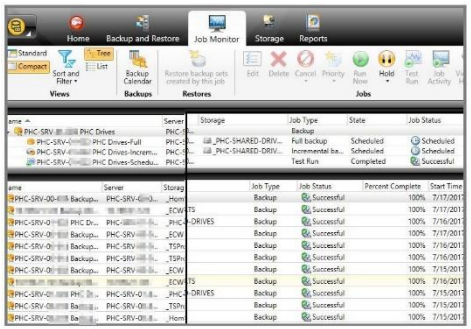
- Access Control
- Change Management
- Software Access Protocols
- Role Based Access
- eHR Access Logging
- Robust eHR Security
- File Share Monitoring

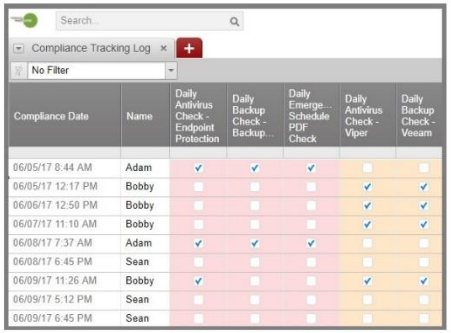




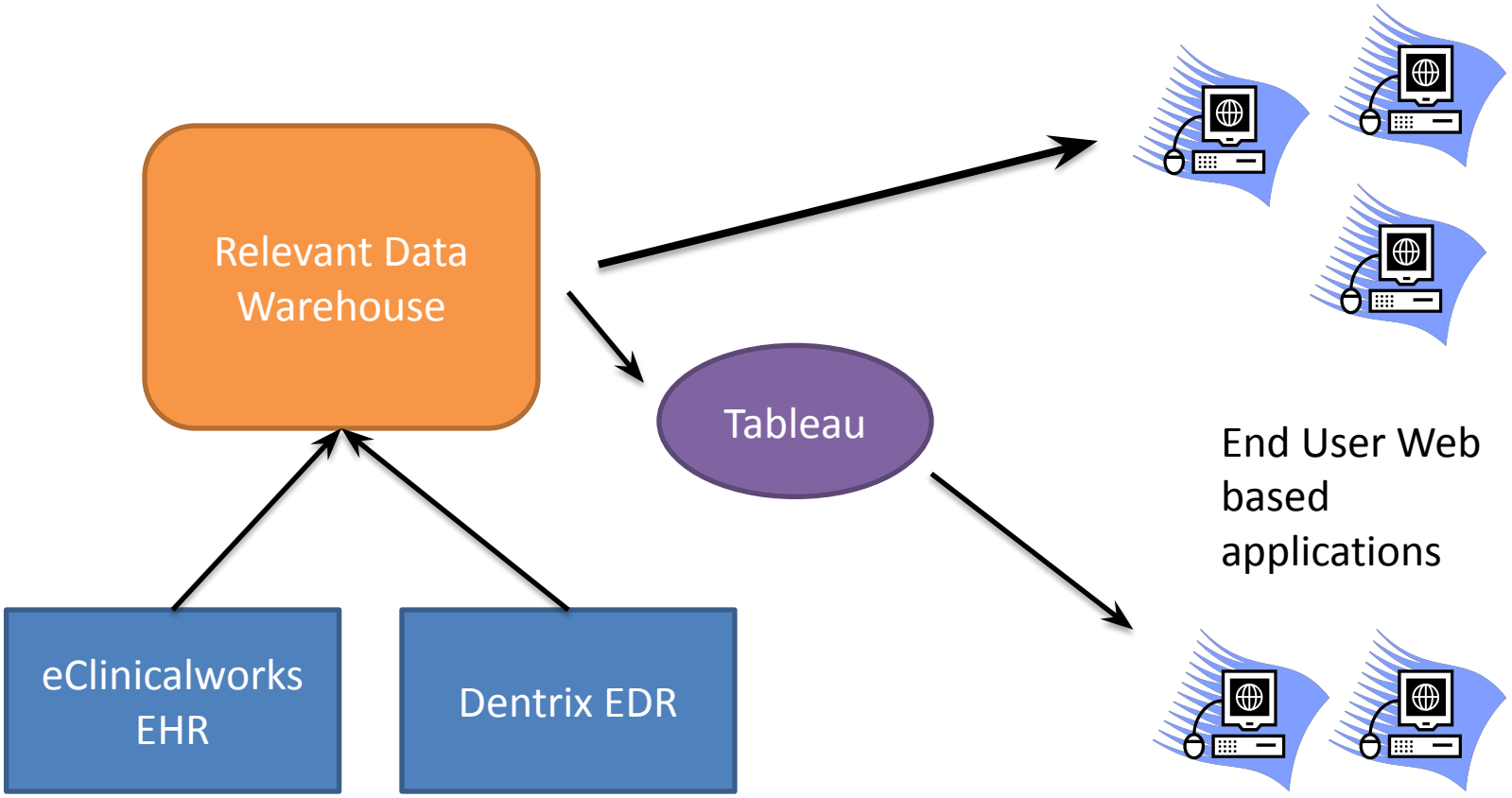
Backups and Archive

- On-Site and Cloud Backups
- SQL Backup
- File System Backup
- Backup Restore
- Validation Testing
- Monthly Archive
- IT Systems Review
- Disaster Recovery
- Business Continuity





IT Analytics Infrastructure



CASE 1: HYPERTENSION CONTROL

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Case 1: Hypertension Control

- Heart disease and stroke account for 25% of deaths in Sonoma County (2013)
- 7% of adults in Sonoma County have heart disease – compared with a state average of 5.9% (Sonoma Health Action)
- The percentage of patients with heart disease has increased from 2011 to 2014 (Sonoma Health Action)
- The prevalence of high blood pressure in Sonoma County is higher than both state and national prevalence levels

Better control of blood pressure reduces heart attacks and strokes.

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Case 1: Hypertension Control

Name	Benchmark	Source	Detail
CA FQHC	64.6%	UDS (2015)	
USA FQHC	63.8%	UDS (2015)	
National Private Ins	72%	HEDIS	90th percentile
National Medicaid	69%	HEDIS	90th percentile

Goal: Decrease heart attacks and strokes in our patient population by improving hypertension control.

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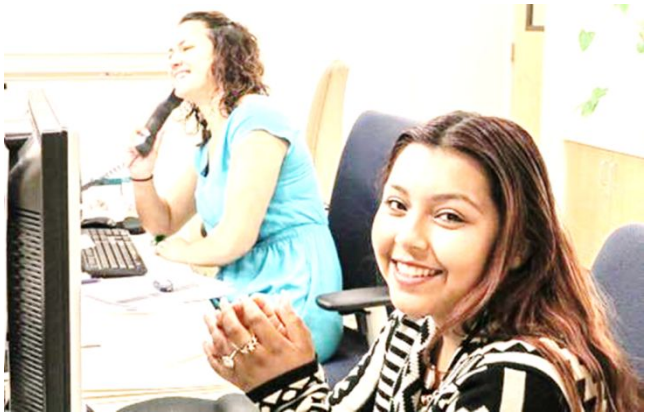
Case 1: Hypertension Control

- Many successive initiatives have improved hypertension control
- No new technology was implemented
- eClinicalworks EHR was customized for each initiative



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Case 1: Hypertension Control

1. PHC's internal quality improvement committee made a decision that hypertension was a priority
2. A work plan was formed based on the perceived needs from the quality improvement committee
3. Care teams chose a priority area to focus that team's improvement efforts on
   - Petaluma Team 2 chose to focus on hypertension
4. That team completed a number of rapid improvement cycles using the Plan-Do-Study-Act methodology
   - The informatics team was engaged in these cycles to customize the EHR and analytics software to support that work
5. Successes were brought back to the QI committee and operations group to be spread throughout the organization
   - The informatics team was engaged to train users on any EHR changes made
   - Feedback on EHR and analytics customization is accepted via email from all users and at in-person meetings

Case 1: Hypertension Control

Pre-visit

Standard care team huddle identifies patients with uncontrolled hypertension

Team Based Population Health

1. Care teams monitor performance using Relevant (Included in QI plan and provider incentive program)
2. Care teams make individual treatment plans for patients with uncontrolled hypertension during "team time"

Office Visit

Standard BP measurement and data collection process used by Medical Assistant

PCP or RN co-visit uses:

*Standard guideline for treatment

*Standard template

*Standard Order Set

Outside of Visit

Standard Patient Recall Protocols:

1. Patients who have a last BP reading over 140/90
2. Patients with hypertension diagnosis who have not had a visit in 6 months.

Case 1: Hypertension Control

Pre-visit

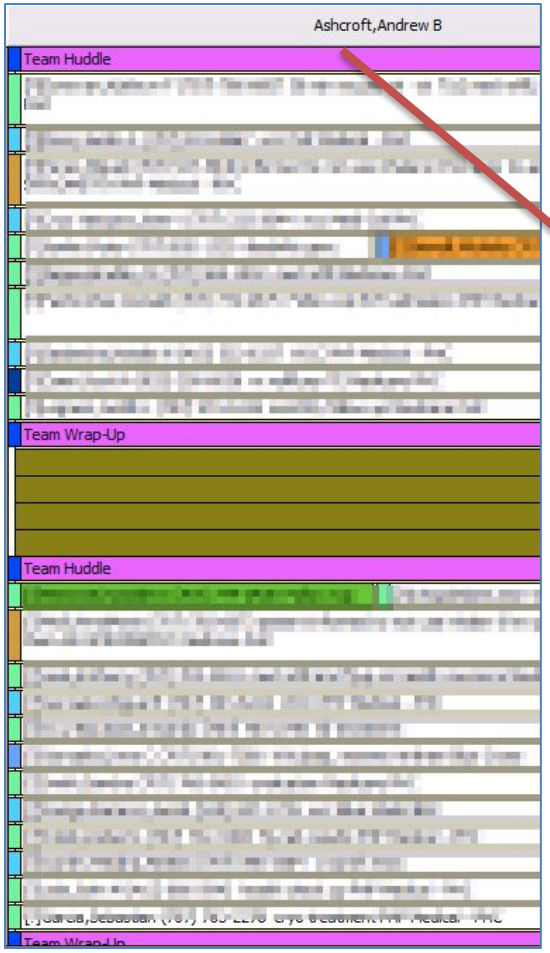
Standard care team huddle identifies patients with uncontrolled hypertension

Early changes to our process included using the hypertension alert during care team huddle.

Systematic review of charts to anticipate needs of patients including:

1. Clinical review
2. Alert review
3. Merge templates
4. Anticipate needs from ancillary team members or services

Huddle Alert



CDSS Alerts

Classic alerts | Patient Test | PCG | Ignore Office Visits | Show: All Alerts

Measure Name	Last Done	Fq	Due Date	Status	Orders
Alcohol use screening		12 M	07/17/2017		Audit-C
Asthma symptom assessment		12 M	07/17/2017		Asthma
Body Mass Index		24 M	07/17/2017		
BP control in HTN (140/90)		12 M	07/17/2017		
Cervical cancer screening		36 M	07/17/2017		SUREPATH PAP SMEA W/ASCUS HPV FP *PHC
Depression followup		12 M	07/17/2017		PHQ9
HIV screening		6 M	07/17/2017		HIV 1/HIV 2 - SCREEI WITH REFLEX CONFIRM *PHC
Patients see assigned PCG	07/17/2017	12 M	07/17/2018		
Smoking status	05/23/2010	12 M	05/23/2011		Tobacco Control

Generic Practice Alerts

Case 1: Hypertension Control

Office Visit

Standard BP measurement and data collection process used by Medical Assistant

PCP or RN co-visit uses:

*Standard guideline for treatment

*Standard template

*Standard Order Set

Started work on hypertension control on one care team:

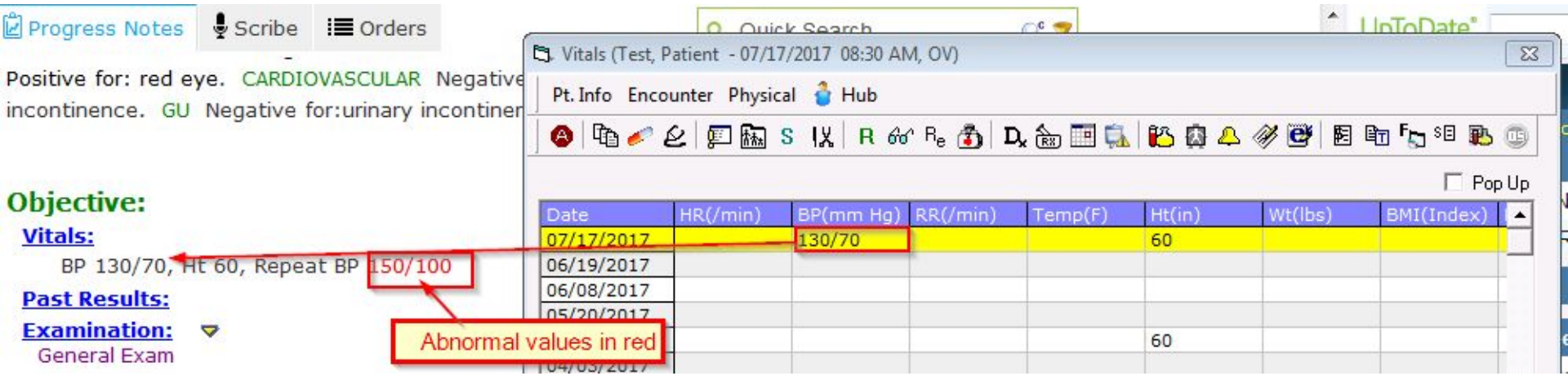
- Standard BP measurement and repeat measurement
- Standardized data collection process in the EHR

PHC adopted a hypertension control guideline with our health center coalition

- Meetings and trainings held for providers and nurses that improved buy-in from both groups

Standard documentation templates and order sets were implemented to be used in provider and nurse-provider co-visits.

Standard BP Data Collection



Management of

ADULT HYPERTENSION

BLOOD PRESSURE (BP) GOALS

<140/90 mm Hg – for age 18-59 & age 60 and over with Chronic Kidney Disease (CKD)[3] or Diabetes
Optional for other patients at high risk of cardiovascular events[2]
<150/90 mm Hg – for age 60 and over in the absence of Chronic Kidney Disease (CKD)[3] or Diabetes

ACE-Inhibitor[2] / Thiazide Diuretic

Lisinopril / HCTZ
(Advance as needed)
20 / 25 mg x ½ daily
20 / 25 mg x 1 daily
20 / 25 mg x 2 daily
Pregnancy Potential: Avoid ACE-Inhibitors[1]

If ACEI intolerant or pregnancy potential →

Thiazide Diuretic
HCTZ 25 mg→ 50mg
OR
Chlorthalidone 12.5 mg→25 mg

If not in control →

For ACEI intolerance due to cough, use ARB

Add Losartan 25 mg daily →50 mg daily → 100 mg daily
Pregnancy Potential: Avoid ARBs[1]

If not in control →

Calcium Channel Blocker[1]

Add amlodipine 5 mg x ½ daily → 5 mg x 1 daily → 10 mg daily

If not in control →

Spironolactone or Beta-Blocker[1]

IF on thiazide AND eGFR ≥ 60 mL/min/1.73m^2 AND K < 4.5
Add spironolactone 12.5 mg daily → 25 mg daily
OR
Add Metoprolol ER 25 mg daily → 50 mg daily → 100 mg daily → 200 mg daily
OR
Atenolol 25 mg daily → 50 mg daily (Keep heart rate > 55)

If not in control →

- Consider medication non-adherence

Hypertension Documentation Template

Subjective:

Chief Complaint(s):

HPI:

Cardiac Risk Assessment

EXERCISE _____.

DIET: _____.

Cardiovascular

HYPERTENSION _____, .

HOME BP MONITORING _____.

MEDICATION ADHERANCE _____.

ASSOCIATED SYMPTOMS _____.

DENIES _____.

Self-Management

LAST SELF MANAGEMENT GOAL: see last note for details.

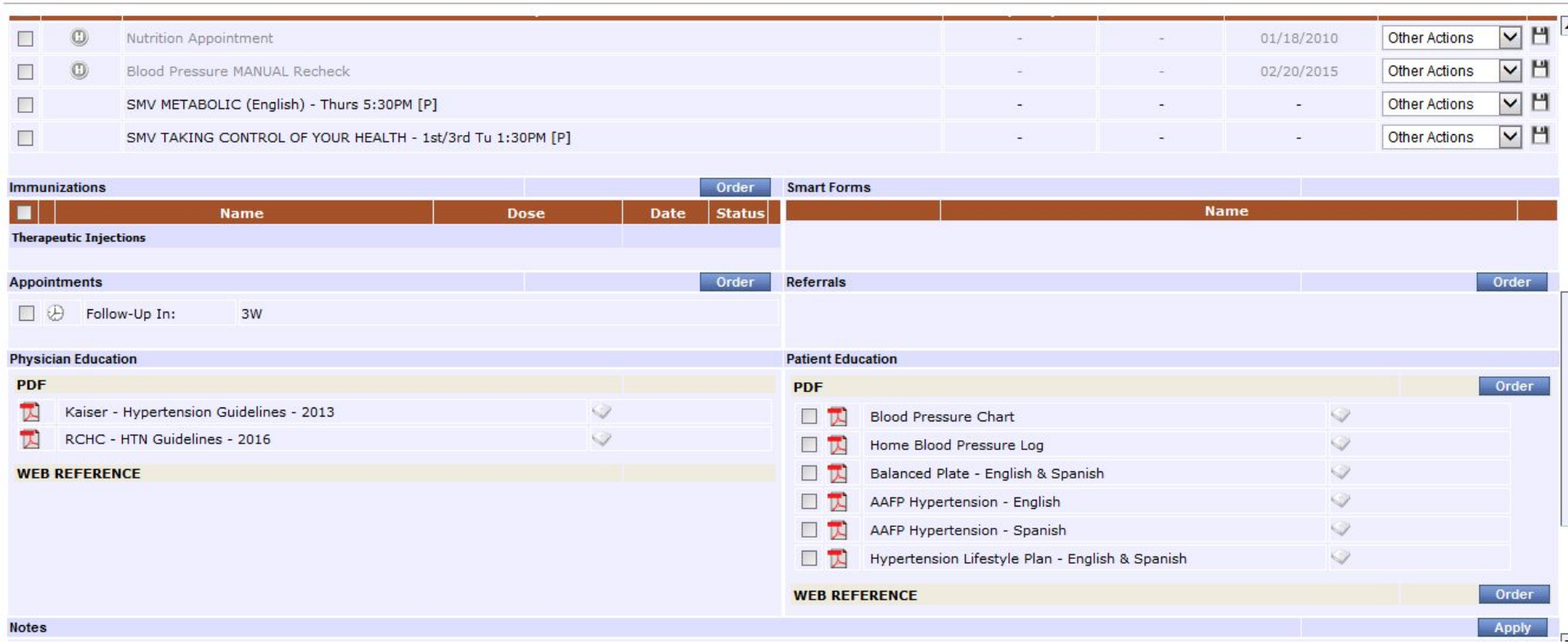
SELF MANAGEMENT GOAL: Documented in Preventive Medicine.

Hypertension Goal for 18 - 59 and / or CKD or DM: <140/90

Hypertension Goal > 60 without CKD or DM: <150/90.

Hypertension Order Set – Part 1

Hypertension Order Set – Part 2



Case 1: Hypertension Control

Outside of Visit

Standard Patient Recall Protocols:

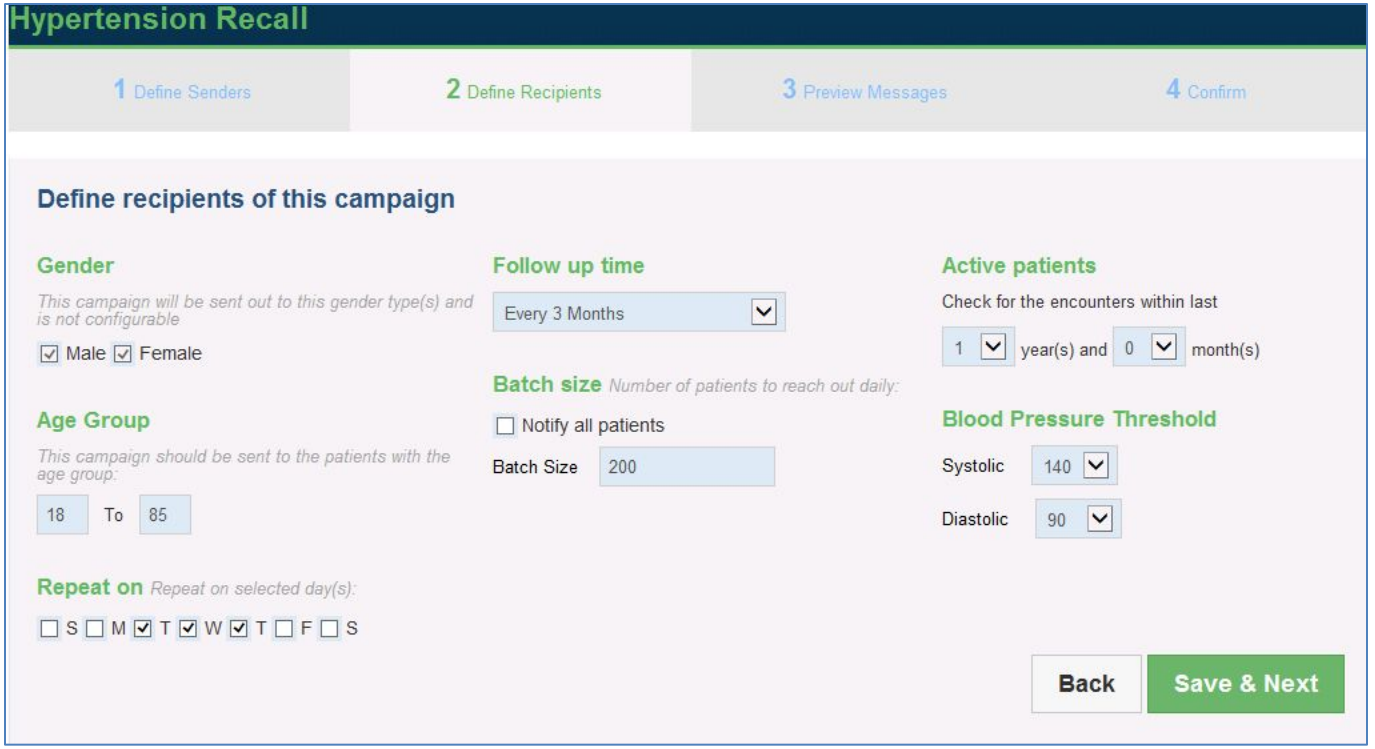
1. Patients who have a last BP reading over 140/90
2. Patients with hypertension diagnosis who have not had a visit in 6 months.

With direction from our internal quality improvement committee, informatics team implemented technology-based recall systems (improved from letters)

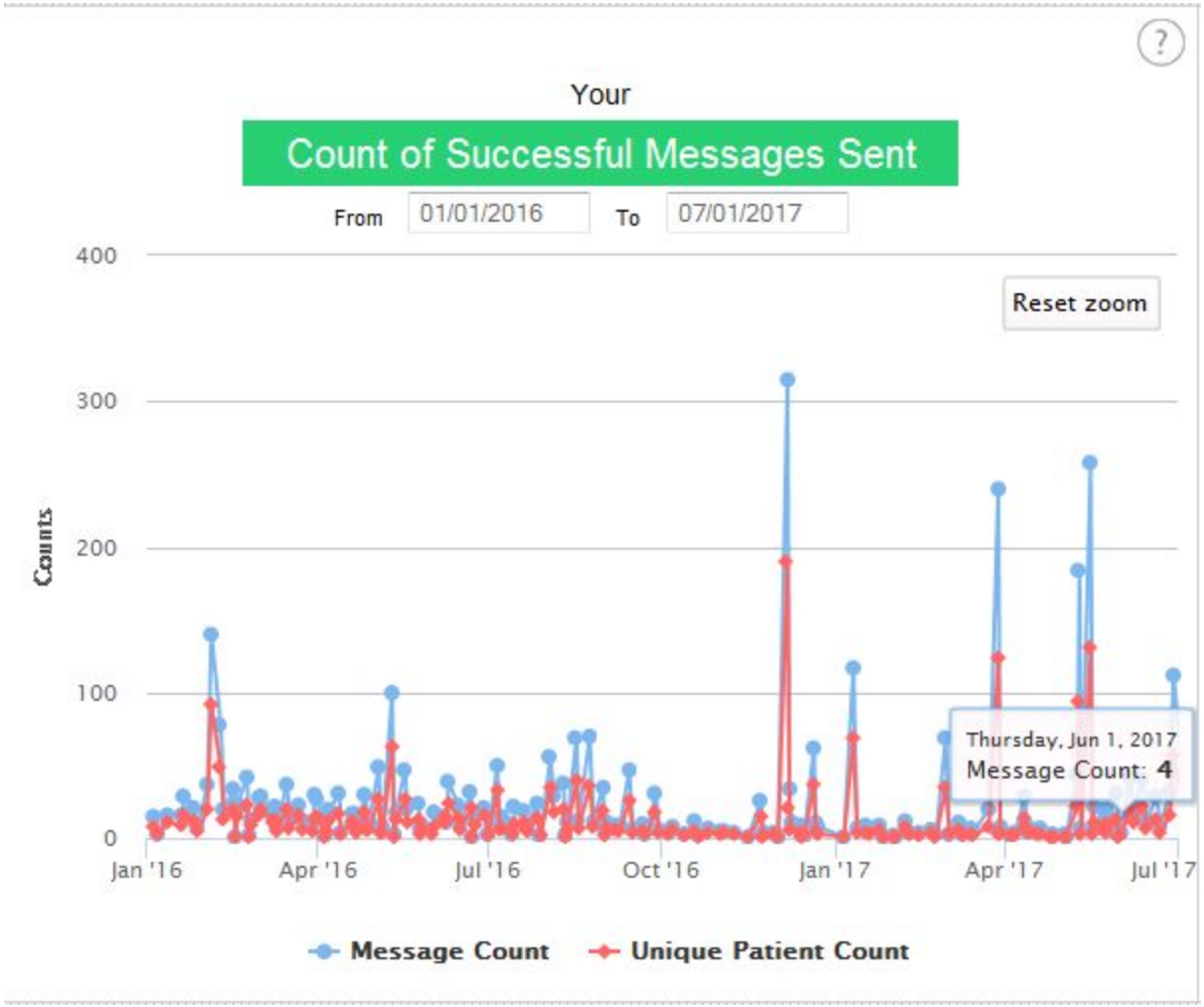
- Automated voice messages
- Text messages
- E-mail
- Patient portal app notification

Recall Protocols – email, portal, text, phone message

1. Patients with last BP uncontrolled
2. Patients with controlled BP but no visit in 6 months



Uncontrolled BP Recall Messages Sent



Case 1: Hypertension Control

Team Based Population Health

1. Care teams monitor performance using Relevant (Included in QI plan and provider incentive program)
2. Care teams make individual treatment plans for patients with uncontrolled hypertension during “team time”

Care teams began using one team meeting a month to review uncontrolled hypertension cases and make individual plans for patients.

Relevant – our web-based analytics platform was implemented Spring 2016

The new web-based system became available for teams to track progress and identify patients for intervention.

INCENTIVE - Hypertension Control

Measurement period: July 1, 2016—June 30, 2017

COMPLIANCE

2167 / 2867

0 exclusions

TARGET

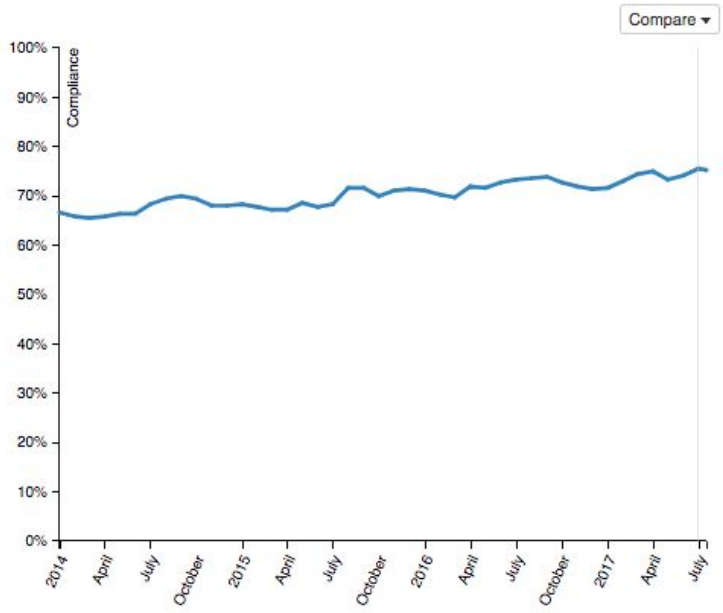
1

Compliance is 1 percentage points above the organization's target of 75%.

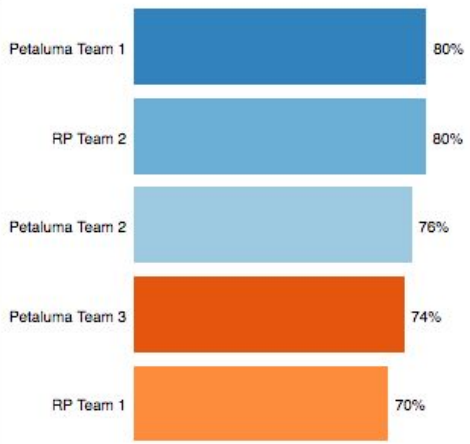
FILTERS

Locations ▾ All	Providers ▾ All	Provider Teams ▾ All	Payers ▾ All
Payer Groups ▾ All	Genders ▾ All	Races ▾ All	Ethnicities ▾ All

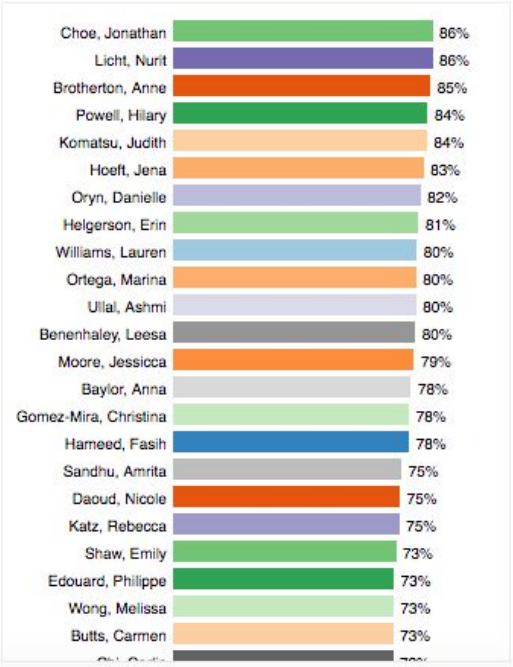
Compliance trend



Compliance by Provider Team



Compliance by Provider



INCENTIVE - Hypertension Control

Measurement period: July 1, 2016—June 30, 2017

COMPLIANCE

85%

56
66

0 exclusions

TARGET

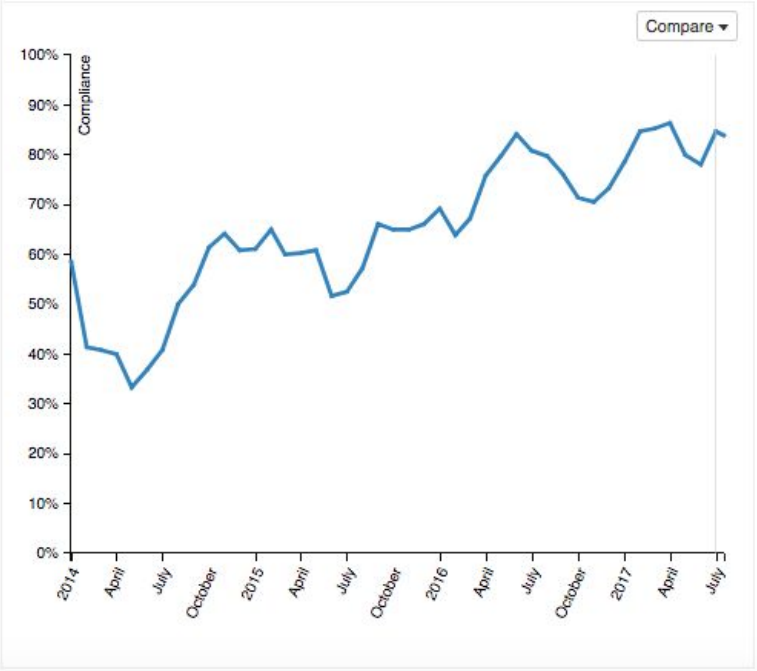
10

Compliance is 10 percentage points above the organization's target of 75%.

FILTERS

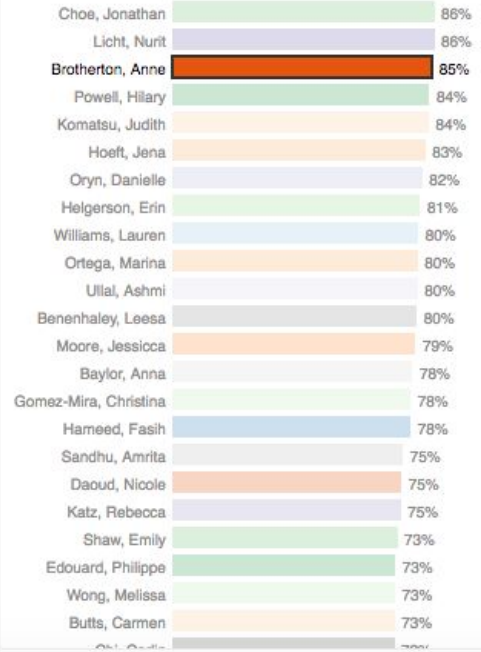
Locations ▾ All	Providers ▾ Brotherton, Anne	Provider Teams ▾ All	Payers ▾ All
Payer Groups ▾ All	Genders ▾ All	Races ▾ All	Ethnicities ▾ All

Compliance trend

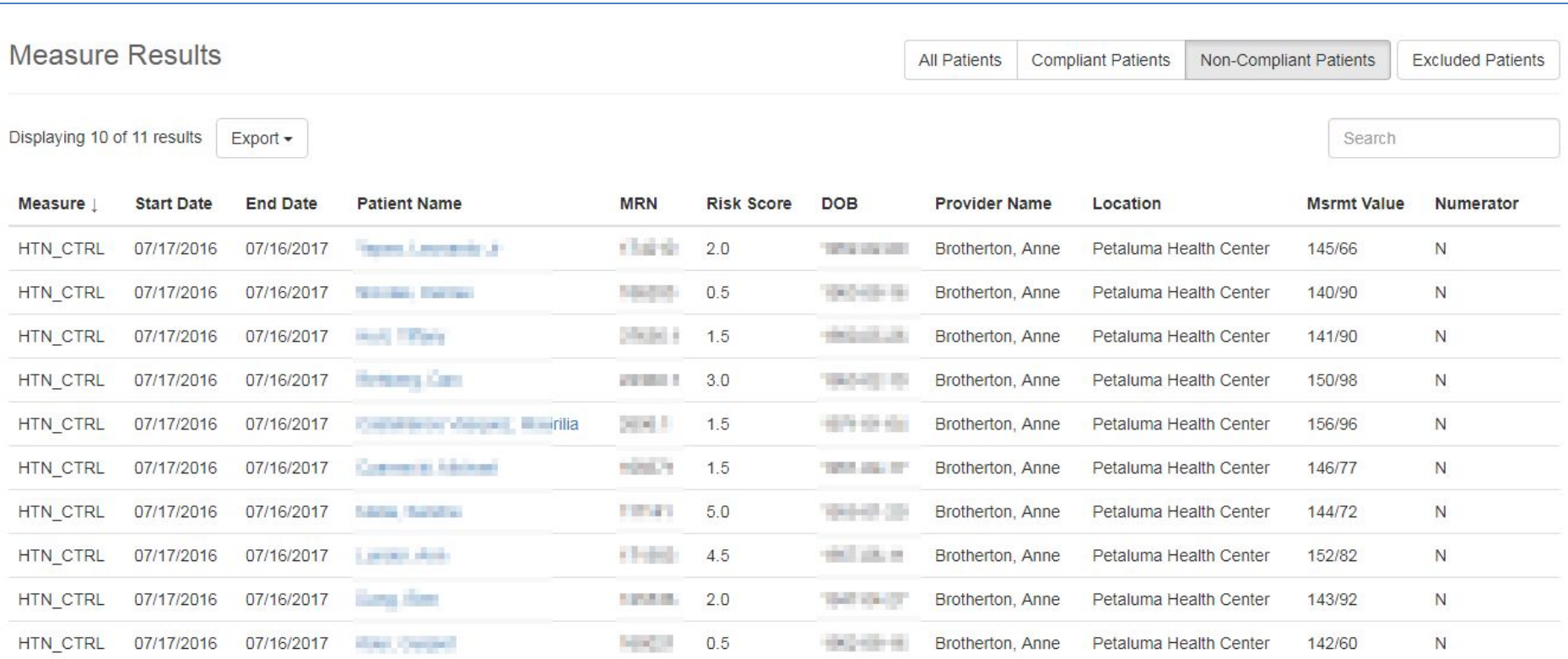


Compliance by Provider Team

Compliance by Provider



Uncontrolled BP List by Provider/Team



Measure Results

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

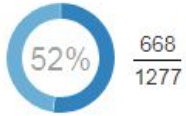
Displaying 10 of 11 results Export

Search

Measure ↓	Start Date	End Date	Patient Name	MRN	Risk Score	DOB	Provider Name	Location	Msrmt Value	Numerator
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	2.0	[redacted]	Brotherton, Anne	Petaluma Health Center	145/66	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	0.5	[redacted]	Brotherton, Anne	Petaluma Health Center	140/90	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	1.5	[redacted]	Brotherton, Anne	Petaluma Health Center	141/90	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	3.0	[redacted]	Brotherton, Anne	Petaluma Health Center	150/98	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	1.5	[redacted]	Brotherton, Anne	Petaluma Health Center	156/96	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	1.5	[redacted]	Brotherton, Anne	Petaluma Health Center	146/77	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	5.0	[redacted]	Brotherton, Anne	Petaluma Health Center	144/72	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	4.5	[redacted]	Brotherton, Anne	Petaluma Health Center	152/82	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	2.0	[redacted]	Brotherton, Anne	Petaluma Health Center	143/92	N
HTN_CTRL	07/17/2016	07/16/2017	[redacted]	[redacted]	0.5	[redacted]	Brotherton, Anne	Petaluma Health Center	142/60	N

NURSING - PHASE Patients on Appropriate Medications

Percentage of PHASE-Eligible Patients on an Aspirin Med, an ACE/ARB AND a Statin



Measure Results

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

Displaying 10 of 609 results

Export

Search

Measure ↓	Start Date	End Date	Patient Name	MRN	Risk Score	DOB	Provider Name	Location	Msrmt Value	Numerator
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	3.5	[redacted]	Gomez-Mira, Christina	Petaluma Health Center	Aspirin: Aspirin, ACE_ARB: Lisinopril, Statins: None	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	4.0	[redacted]	Pendleton, John	Rohnert Park Health Center	Aspirin: Eliquis, ACE_ARB: None, Statins: Simvastatin	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	2.0	[redacted]	Sandhu, Amrita	Petaluma Health Center	Aspirin: Aspirin, ACE_ARB: None, Statins: None	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	1.0	[redacted]	Ortega, Marina	Petaluma Health Center	Aspirin: None, ACE_ARB: None, Statins: None	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	8.5	[redacted]	Nicol, Annie	Petaluma Health Center	Aspirin: None, ACE_ARB: Lisinopril, Statins: None	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	7.5	[redacted]	Upton, Sean	Petaluma Health Center	Aspirin: None, ACE_ARB: None, Statins: None	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	1.5	[redacted]	Romero, Whitney	Petaluma Health Center	Aspirin: Aspir-81, ACE_ARB: None, Statins: Atorvastatin Calcium	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	1.5	[redacted]	Khalsa, Dalbir	Petaluma Health Center	Aspirin: Aspirin Low Dose, ACE_ARB: Lisinopril, Statins: None	N
msr_61	07/17/2016	07/16/2017	[redacted]	[redacted]	1.5	[redacted]	Ullal, Ashmi	Rohnert Park Health Center	Aspirin: Aspirin, ACE_ARB: None, Statins: Simvastatin	N

INCENTIVE - Hypertension Control

COMPLIANCE

76%

2167
2867

0 exclusions

TARGET

1 Compliance is 1 percentage points above the organization's target of 75%.

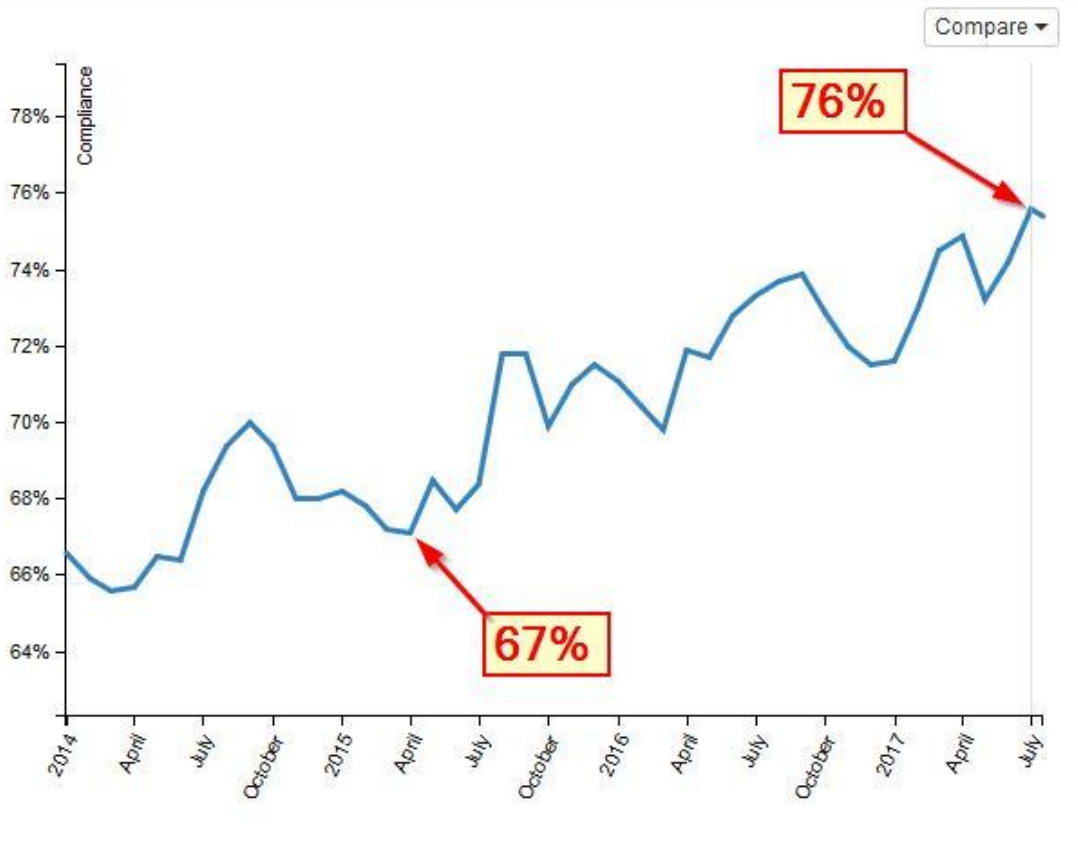
Locations
All

Provider
All

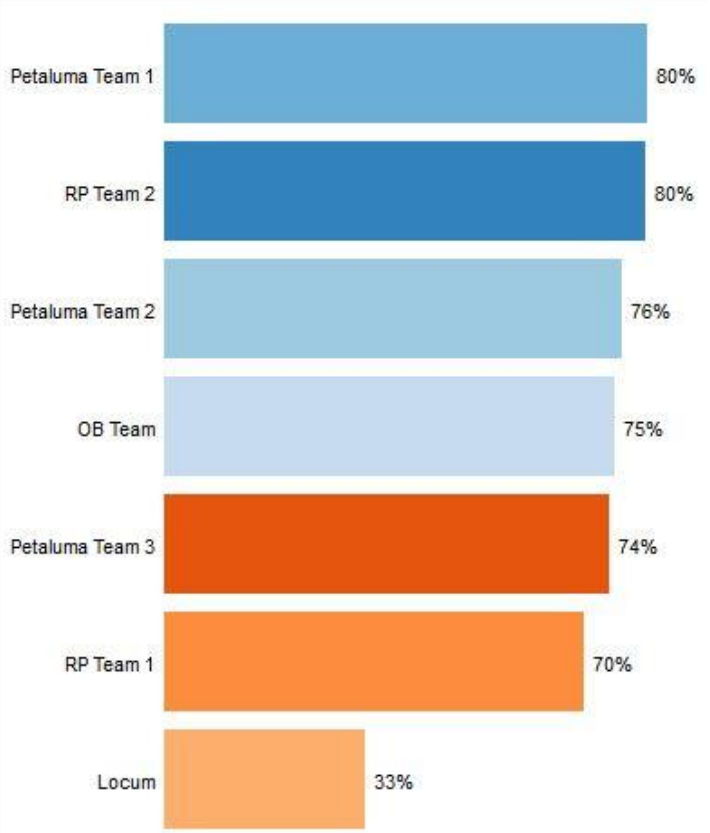
Payer Groups
All

Genders
All

Compliance trend



Compliance by Provider Team



Case 1: Hypertension Control

Financial Benefit	April 2015 – March 2017
Partnership Health Plan's Quality Improvement Plan (QIP) funds related to accomplishing our goal for control of hypertension	$60,000
HRSA Quality Improvement awards related to performance on hypertension control	$20,000
Funding for Preventing Heart Attacks and Strokes Everyday (PHASE) program.	$33,000
Total Financial Benefit	$113,000

Petaluma HealthCenter

Case 1: Hypertension Control

Other Outcomes and Lessons Learned

Improved satisfaction of providers and nurses with co-management of patients

Patients have given positive feedback:

- Improved ability to get an appointment by having follow up appointments with nurses
- Reminders to come in for follow up

Medical assistants are more engaged in working with patients:

- Talking to patients about blood pressure
- Educating people on control ranges
- Setting self-management goals with patients

We have learned the importance and benefit of clinical standardization

Spreading initiatives that work on one care team to others was a challenge

Providing real-time, usable data and time to use that data to manage the population resulted in the largest improvement!

Petaluma HealthCenter

CASE 2: HEPATITIS C TREATMENT

Case 2: Hepatitis C Treatment

- Hepatitis C causes significant health problems for those infected with the virus
- Patients with chronic hepatitis C are at risk for liver failure and liver cancer
- Sonoma County's HCV rate among females is 16% higher than the state average*
- Sonoma County HCV rate among adults 20-30 has nearly tripled from 2011 to 2015*
- From 2011 - 2015 HCV rates for both women and men in Sonoma County have risen over 175% and 220%, respectively*
  - Improved screening and/or increased HCV transmission?

*. https://archive.cdph.ca.gov/programs/Documents/Sonoma_HCV.pdf

Case 2: Hepatitis C Treatment

- HCV treatment has become more tolerable for patients
  - able to treat more types of Hepatitis C and treatment is more available
  - The CDC estimates that 1% of the population has chronic HCV
    - 50% of those with the virus are not diagnosed
  - FQHC patients may be at higher risk than other populations in the community
  - PHC decided to begin to offer treatment for Hepatitis C in primary care.

Case 2: Hepatitis C Treatment

1. Providers at PHC with expertise in providing Hepatitis C treatment in primary care proposed to our internal quality improvement committee a new program to begin treatment groups at PHC
2. The Wellness team began work on creating workflows for the treatment groups using their existing shared medical visit model
3. Providers were recruited based on interest and expertise to facilitate the shared visits
4. A staff member of the wellness team was trained to be the case manager for the program
5. Guidelines for treatment were adopted from Partnership Health Plan
6. Informatics team was engaged to provide EHR customization, clinical decision support and analytics customization for the new program

Workflows – Treatment in Shared Medical Visit Model

Pre- treatment

- Up to 8 pts per session
- 1-2x/month
- RN education
- GI-FNP reviews cases with MA prior to visit
- Provider meets 1:1 with patient & MA
- Orders labs, imaging, screening if eligible/ ready for treatment

Initiating Treatment

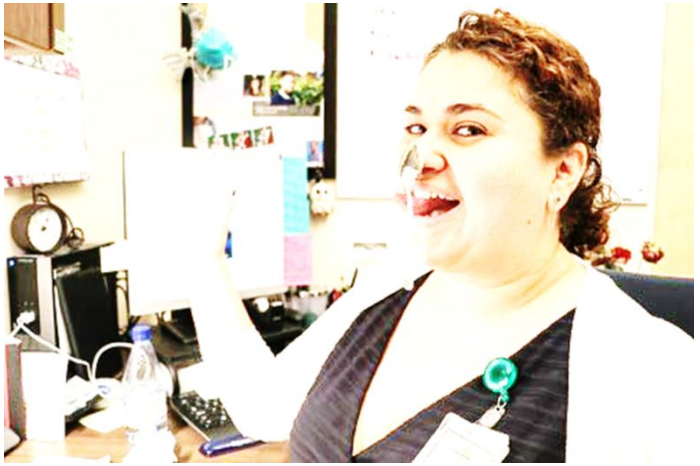
- 1-2x/month
- provider chart prep/review w/ HCV coordinator
- Education & RX in group setting
- Face to face time is conducted in front of entire group, unless 1:1 time needed
- Vaccines administered
- Lifestyle & global liver health reviewed
- Referred to CERES PROJECT for nutrition/ cooking

Treatment Maintenance

- Up to 10 per group
- 1-2 x/month
- Each cohort starts together regardless of stage of treatment
- Check in, group sharing, discussion of side effects
- Nutritionist, Cooking Demos, Ongoing holistic lifestyle education
- 1:1 if necessary
- Labs ordered & reviewed
- Support, engagement, education

Case 2: Hepatitis C Treatment

- No new technology was implemented
- eClinicalworks EHR was customized for each initiative
- Implemented new workflows to support pathway to treatment via shared medical visits.



Case 2: Hepatitis C Treatment

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- Nutritionist, Cooking Demos, Ongoing holistic lifestyle education

Pre- treatment

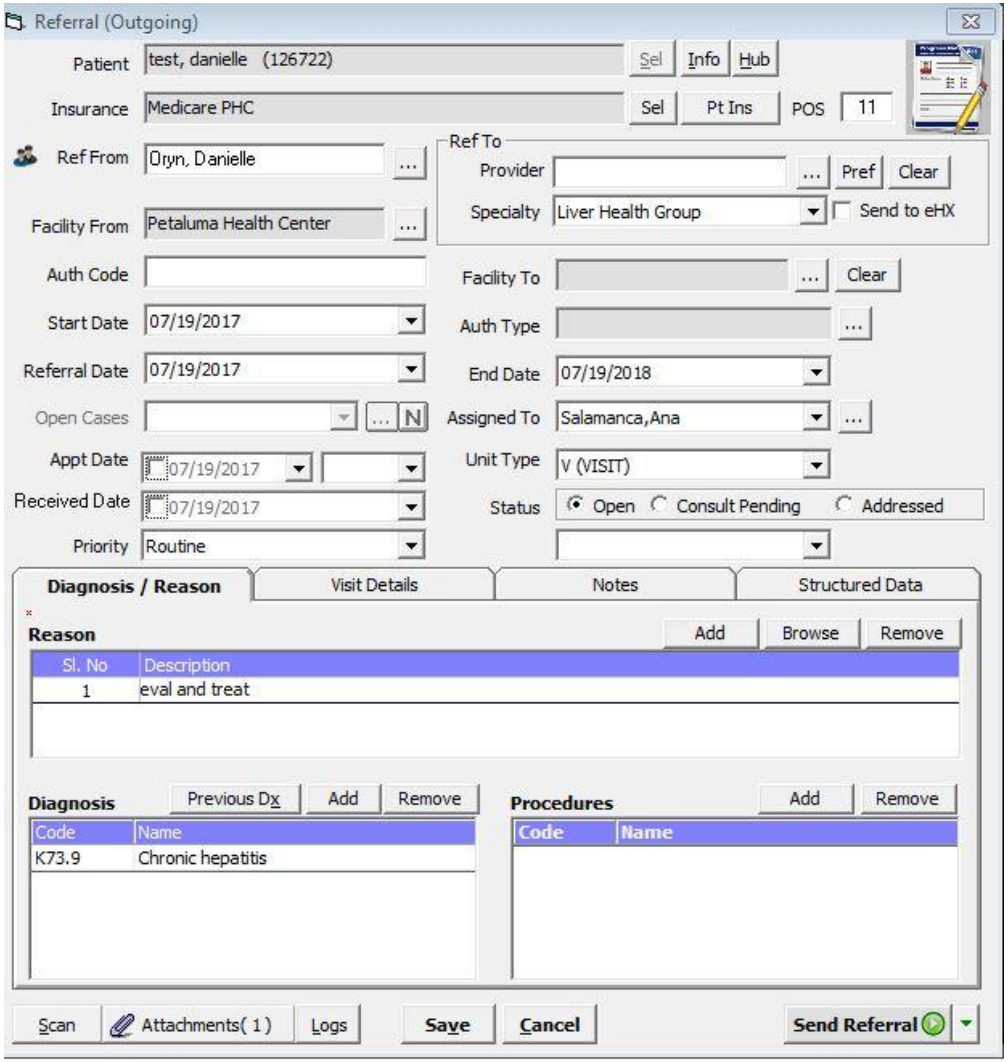
<u>Health IT Support for Pre-Treatment</u> <u>Process:</u>

- Created reports using our analytics systems to generate lists of patients who could be invited to treatment
- Customized the EHR to create a pathway for referral to the groups
- Created an order set to provide decision support for workup of Hepatitis C
- Created a huddle alert to improve the rate of population-based screening for Hepatitis C
- Created a documentation template to make the group visit documentation more efficient

APRI/FIB4 Report

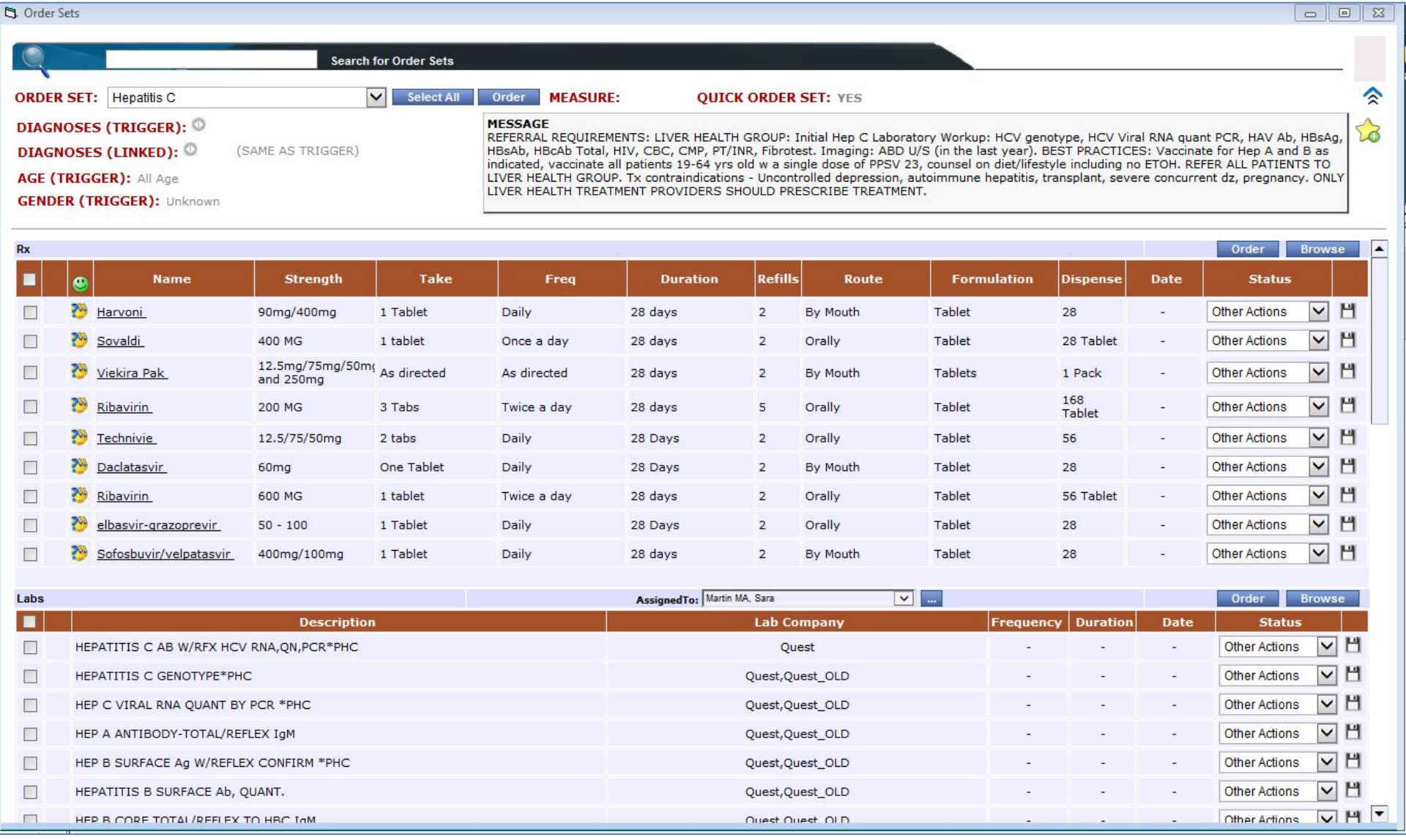
Acct #	DOB	Age	PCP	AST Value	ALT Value	Plt Count	FIB-4	APRI	Primary Insurance
116376		42	Butts	127	104	35	14.94	9.07	PHP Medical
40380.1		62	Nicol	175	139	103	8.93	4.25	Medicare NGS
45968.1		58	Brotherton	111	162	67	7.55	4.14	
164612		63	Sandhu	85	66	60	10.99	3.54	PHP Medical
50512.1		52	Powell	188	178	139	5.27	3.38	PHP Medical
4450.1		59	Ashcroft	106	78	81	8.74	3.27	Meritage Medical Network
117074		59	Butts	90	35	72	12.47	3.13	PHP Medical
162687		62	Nicol	153	97	123	7.83	3.11	PHP Medical
35822.1		63	Choe	126	161	122	5.13	2.58	PHP Medical
157721		49	Upton	67	30	68	8.81	2.46	PHP Medical
175846		56	Sandhu	131	242	133	3.55	2.46	PHP Medical
19957.1		62	Upton	126	137	129	5.17	2.44	PHP Medical

Case 2: Hepatitis C Treatment

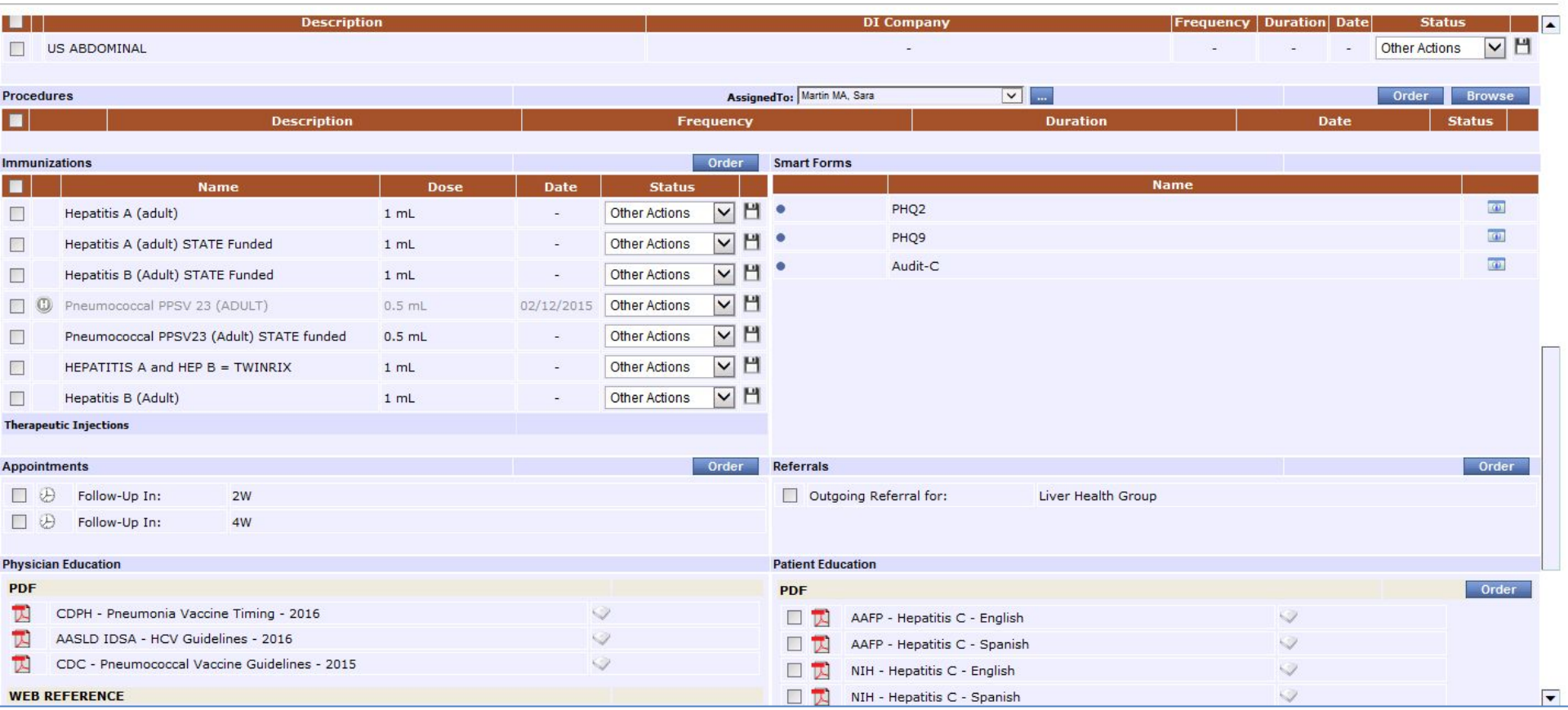


- The way that providers can refer patients for treatment
- Creates a group or list of patients to be treated

Hepatitis C Order Set – Part 1



Hepatitis C Order Set – Part 2



Description	DI Company	Frequency	Duration	Date	Status
US ABDOMINAL	-	-	-	-	Other Actions

Procedures — AssignedTo: Martin MA, Sara — Order | Browse

Description	Frequency	Duration	Date	Status

Immunizations — Order

Name	Dose	Date	Status
Hepatitis A (adult)	1 mL	-	Other Actions
Hepatitis A (adult) STATE Funded	1 mL	-	Other Actions
Hepatitis B (Adult) STATE Funded	1 mL	-	Other Actions
Pneumococcal PPSV 23 (ADULT)	0.5 mL	02/12/2015	Other Actions
Pneumococcal PPSV23 (Adult) STATE funded	0.5 mL	-	Other Actions
HEPATITIS A and HEP B = TWINRIX	1 mL	-	Other Actions
Hepatitis B (Adult)	1 mL	-	Other Actions

Therapeutic Injections

Smart Forms

Name
PHQ2
PHQ9
Audit-C

Appointments — Order

Follow-Up In:	2W
Follow-Up In:	4W

Referrals — Order

Outgoing Referral for:	Liver Health Group

Physician Education

PDF

- CDPH - Pneumonia Vaccine Timing - 2016
- AASLD IDSA - HCV Guidelines - 2016
- CDC - Pneumococcal Vaccine Guidelines - 2015

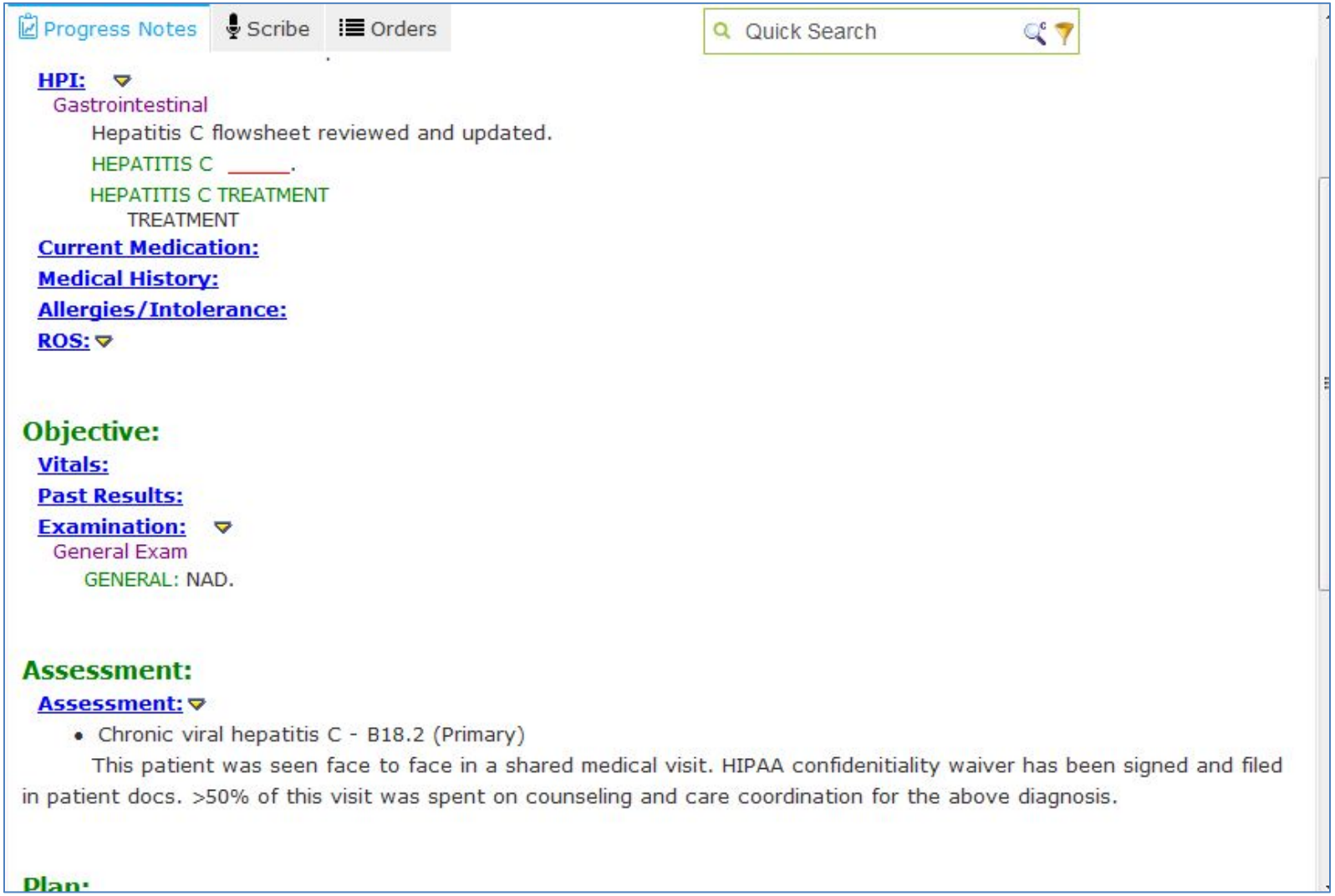
WEB REFERENCE

Patient Education

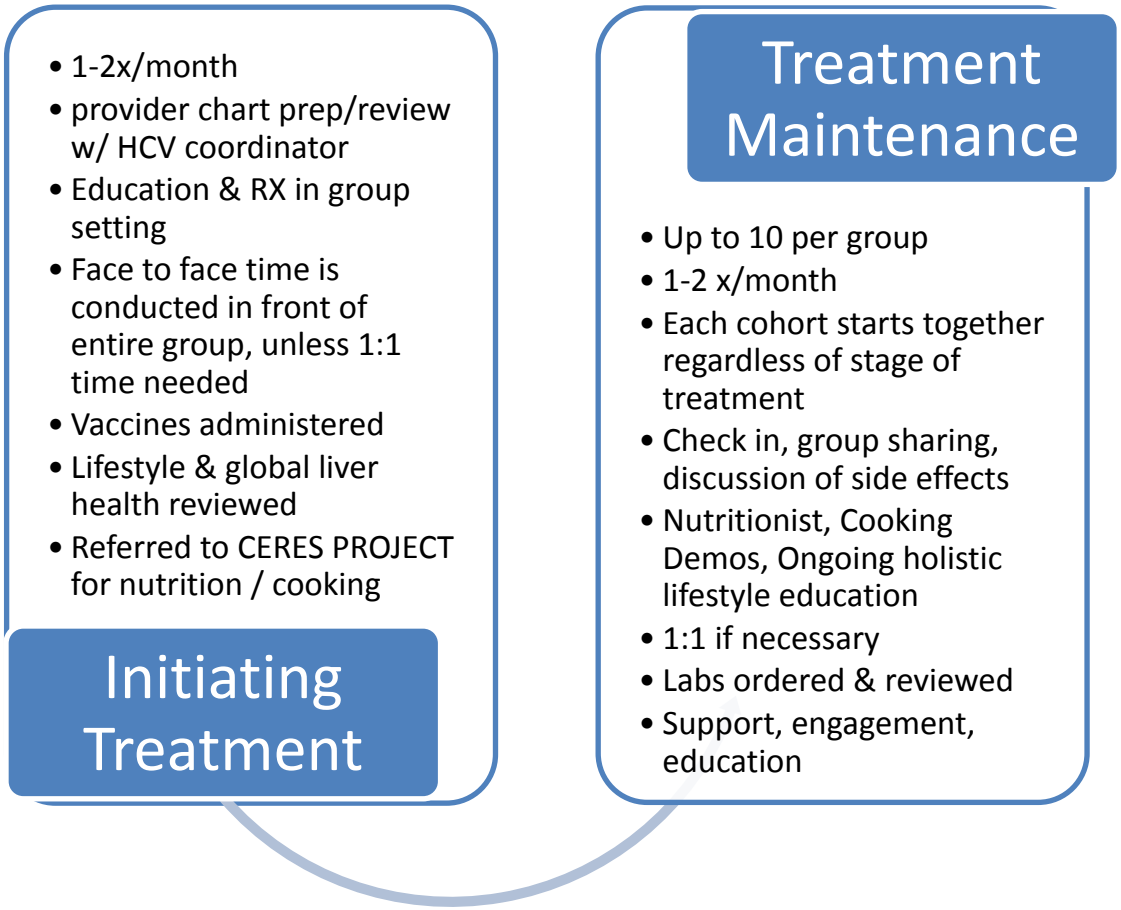
PDF — Order

- AAFP - Hepatitis C - English
- AAFP - Hepatitis C - Spanish
- NIH - Hepatitis C - English
- NIH - Hepatitis C - Spanish

Hepatitis C Documentation Template



Case 2: Hepatitis C Treatment



<u>Health IT Support for Pre-Treatment Process:</u>

- Created and implemented a documentation template to improve efficiency of documentation of the shared medical visits
- Launched new reports on analytics platform to track progress on screening and treatment

Hepatitis C Documentation Template

Progress Notes | Scribe | Orders | Quick Search

HPI:

Gastrointestinal

Hepatitis C flowsheet reviewed and updated.

HEPATITIS C _____.

MEDICATION SIDE EFFECTS None.

MEDICATION ADHERANCE Taking medications as directed with no missed doses.

Current Medication:

Medical History:

Allergies/Intolerance:

ROS:

Objective:

Vitals:

Past Results:

Examination:

General Exam

GENERAL: NAD.

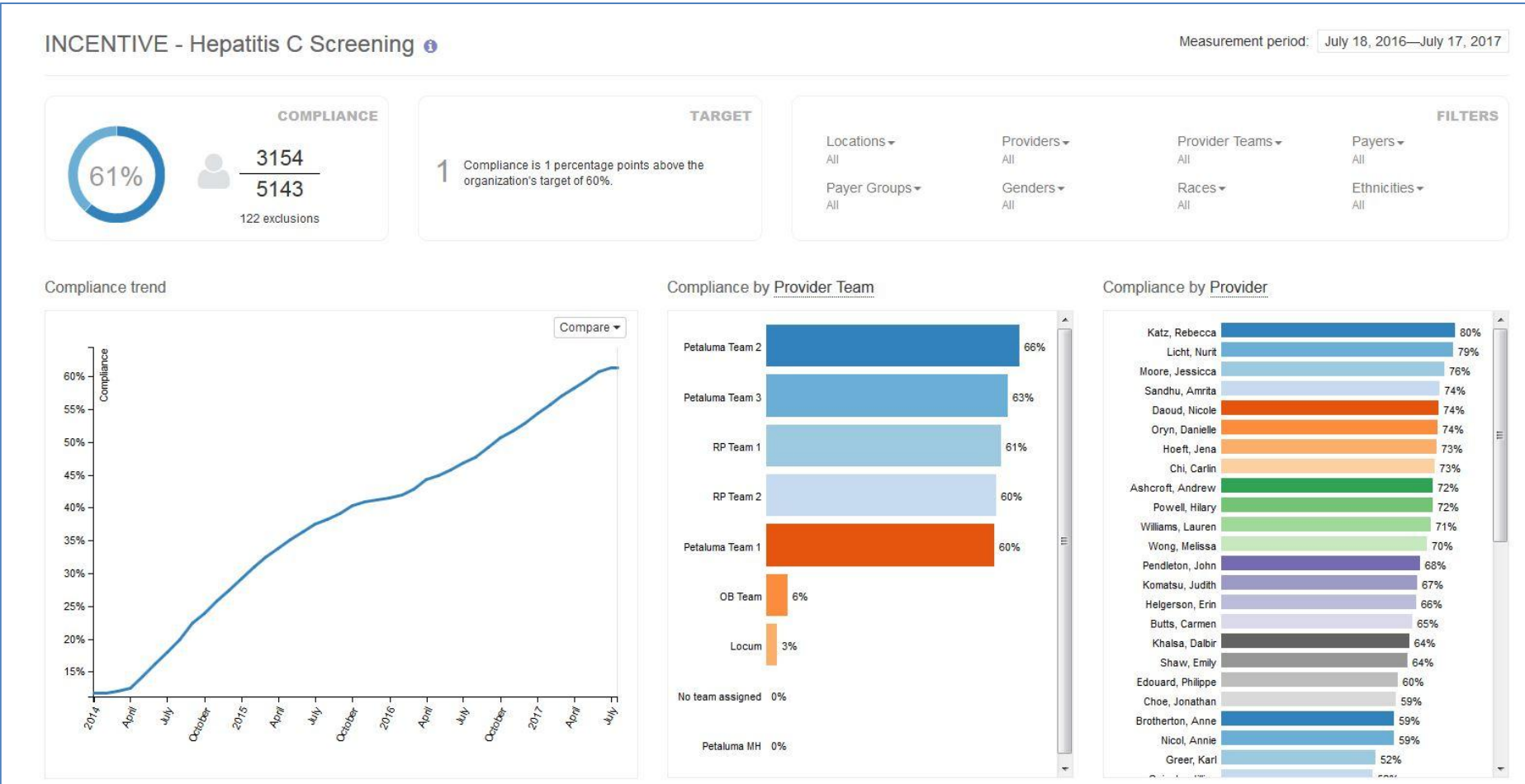
Assessment:

Assessment:

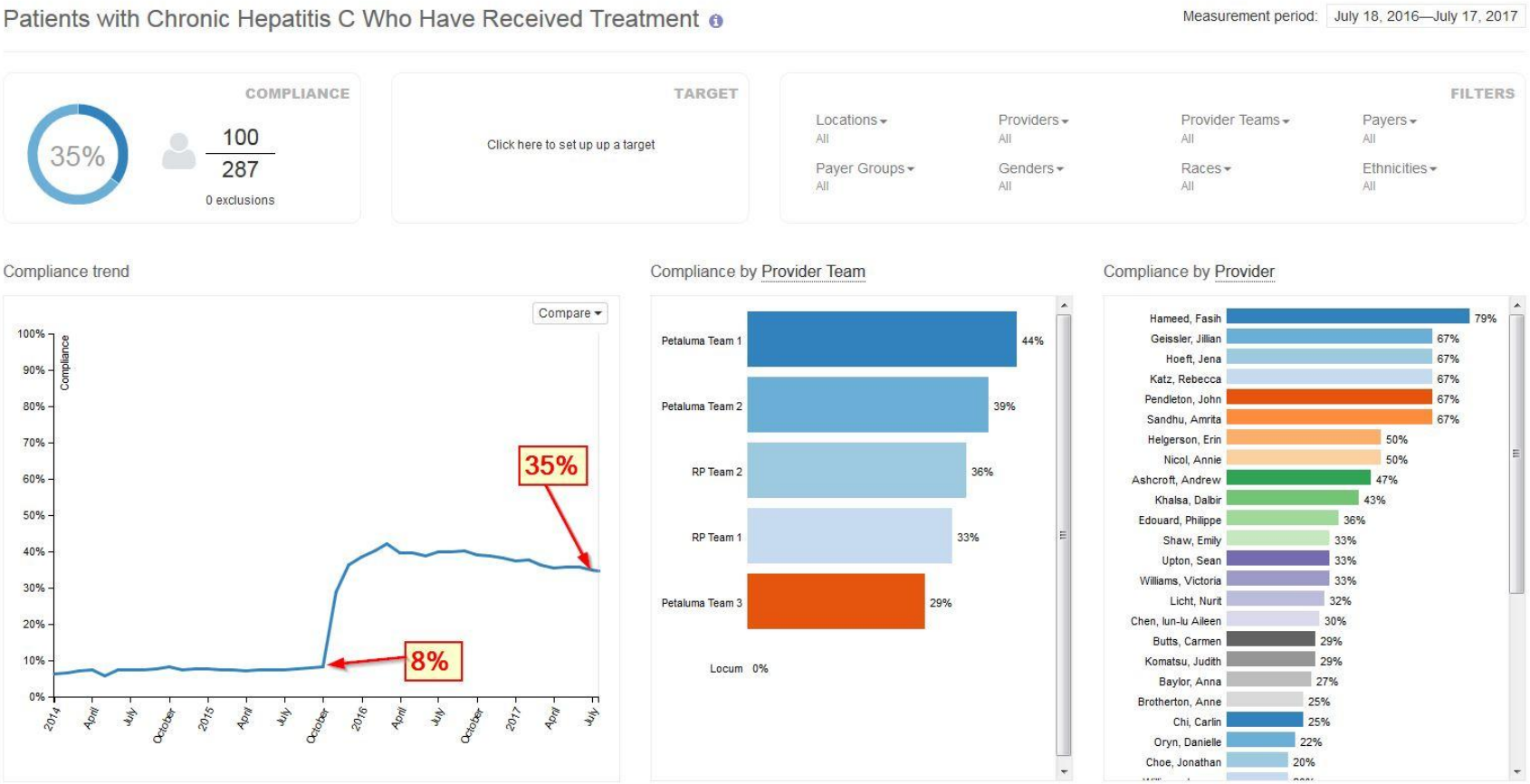
- Chronic hepatitis C without hepatic coma - B18.2 (Primary)

This patient was seen face to face in a shared medical visit. HIPAA confidenitiality waiver has been signed and filed in patient docs. >50% of this visit was spent on counseling and care coordination for the above diagnosis.

Hepatitis C Population Screening



Quantitative data and sustained improvement



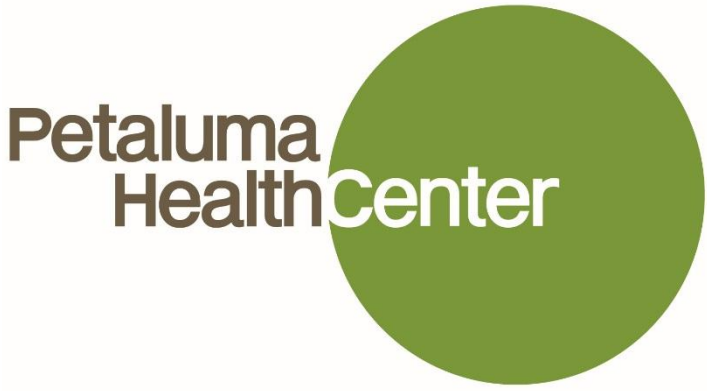
Case 2: Hepatitis C Treatment

Financial Benefit	September 2015 – March 2017
530 additional office visits	$111,000
340B pharmacy program income related to medications for hepatitis C	$86,000
Total	$197,000

Case 2: Hepatitis C Treatment

Other Outcomes and Lessons Learned

- Improved access to treatment for our patients and we even began accepting outside referrals from other health centers and PCPs in the area
- Patients reported that they preferred the group based treatment model to traditional treatment
- Providers and care-teams were happy that patients would be invited to treatment without needing PCP referrals.
- We found that using analytics to identify patients who qualify for treatment was more effective than previous efforts to have providers select patients for referral
- Group documentation templates helped the staff conducting the shared medical visits be more effective
- With this program's success and growth we are now planning to cross train staff in other departments in some of the case management work.



Danielle Oryn, DO MPH
Chief Medical Informatics Officer
Petaluma Health Center
danielleo@phealthcenter.org
707-559-7500