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Care STEPs: From Documentation to Care Redesign

Charles Ashou, Oregon Primary Care Association

Framework for Transformation

New Visit Types

- Online Portal Engagement
- Health and Wellness Call
- Home Visit (Billable Encounter)
- Home Visit (Non-Billable Encounter)
- Advanced Technology Interactions

Education, Wellness and Health Promotion

- Care Gap Outreach
- Education Provided in Group Setting
- Exercise Class Participant
- Support Group Participant
- Health Education Supportive Counseling

Coordination and Integration

- Coordinating Care: Clinical Follow Up and Transitions in Care Settings
- Coordinating Care: Dental
- Behavioral Health and Functional Ability Screenings
- Warm Hand-Off

Reducing Barriers to Health

- Social Determinants of Health Screening
- Case Management
- Accessing Community Resource/Service
- Transportation Assistance

The Reality…


THAT TIME YOU HEARD
THERE'S A NEW DOCUMENTATION REQUIREMENT
memegenerator.net

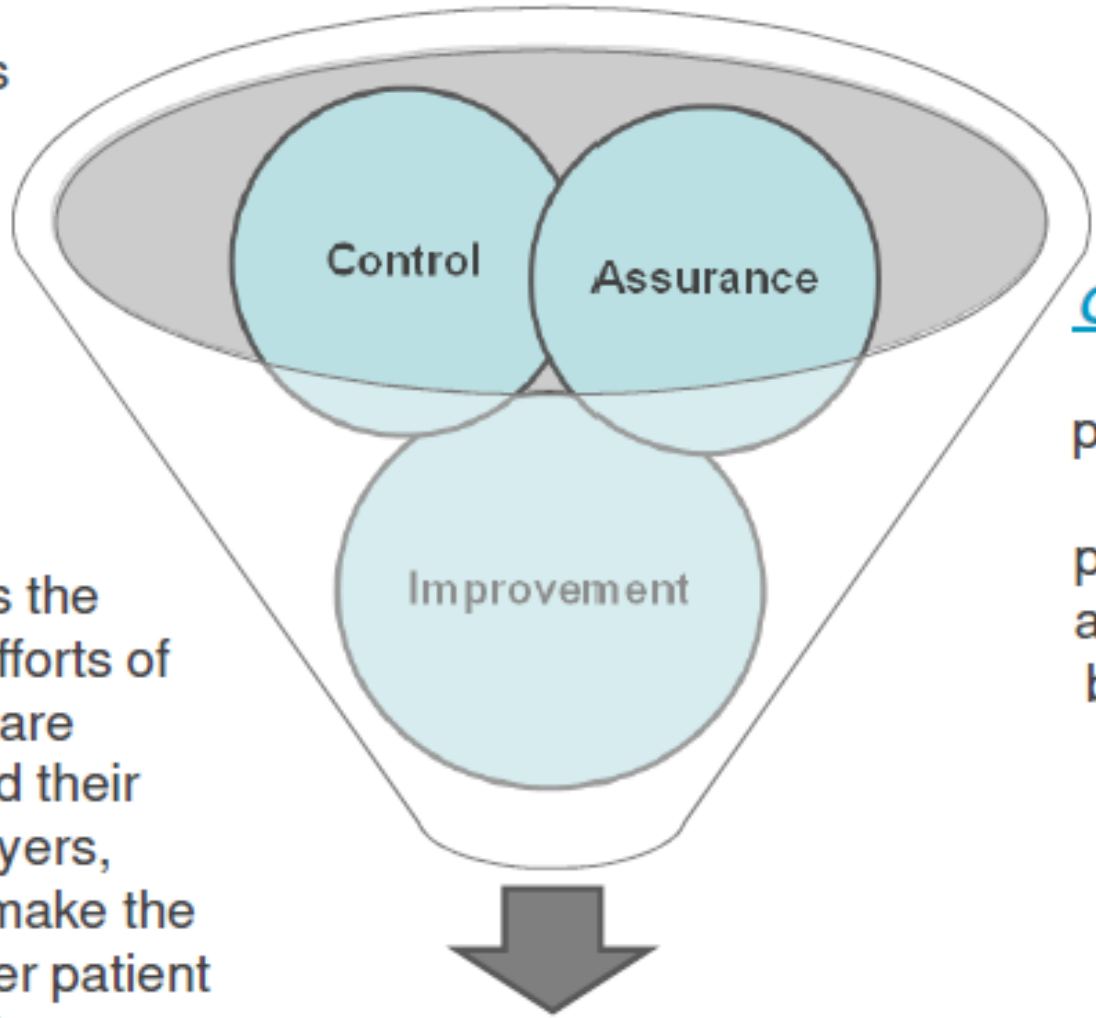
	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
	Mem_Touch_StartDate	Mem_Touch_EndDate	Refusal_Reason	Closure	ACA	Cur_PCP	MRN	Last_Office_Visit	Cur_Primary_Location	Report_Period_Begin	Report_Period_End	MTGroup	OtherGroup	TotalTouches	UDS_VISIT
2	2013-03-01			N		PAISLEY, KIRA		03/19/2015		03/01/2013	02/28/2015	8	24	32	13
3	2013-03-01			N		CECIL, VALERIE		03/23/2015	OHSU RICHMOND	03/01/2013	02/28/2015	10	8	18	4
4	2013-03-01			N		JACOBSEN, EMILY		02/23/2015	OHSU RICHMOND	03/01/2013	02/28/2015	9	3	12	6
5	2013-03-01			N		RISSER, AMANDA		07/30/2014	OHSU RICHMOND	03/01/2013	02/28/2015	2	0	2	3
6	2014-03-21			N		FOX, ALLISON L		04/01/2015	OHSU RICHMOND	03/01/2013	02/28/2015	1	3	4	1
7	2013-05-17			N		CECIL, VALERIE		03/17/2015	OHSU RICHMOND	03/01/2013	02/28/2015	19	17	36	10
8	2013-03-01			N		JACOBSEN, EMILY		02/23/2015	OHSU RICHMOND	03/01/2013	02/28/2015	6	5	11	6
9	2013-03-01			N		CECIL, VALERIE		10/14/2014	OHSU RICHMOND	03/01/2013	02/28/2015	4	1	5	7
10	2013-03-01			N		GIDEONSE, NICHOLAS		10/28/2014	OHSU RICHMOND	03/01/2013	02/28/2015	0	2	2	2
11	2013-03-01			N		CECIL, VALERIE		03/11/2015	OHSU RICHMOND	03/01/2013	02/28/2015	6	8	14	12
12	2013-11-07			N		RISSER, AMANDA		03/16/2015	OHSU RICHMOND	03/01/2013	02/28/2015	4	3	7	8
13	2013-03-01	2013-08-13	Moved out of area	Y				09/04/2012		03/01/2013	02/28/2015				
14	2013-03-29	2013-10-15	Transitioned primary care	Y				05/16/2013	OHSU RICHMOND	03/01/2013	02/28/2015	3	9	12	5
15	2013-03-01			N		COLEMAN, CLIFF		01/28/2015	OHSU RICHMOND	03/01/2013	02/28/2015	62	73	135	65
16	2013-03-01			N		DAKE, SABRINA		02/27/2015	OHSU RICHMOND	03/01/2013	02/28/2015	3	20	23	5
17	2013-03-01			N		POSTMAN, RACHAEL O		03/18/2015	OHSU RICHMOND	03/01/2013	02/28/2015	2	6	8	4
18	2013-03-01			N		DEGAN, MONIQUEA		11/27/2012	OHSU RICHMOND	03/01/2013	02/28/2015				
19	2013-03-01			N		DEGAN, MONIQUEA		01/14/2015	OHSU RICHMOND	03/01/2013	02/28/2015	9	24	33	11
20	2013-03-01			N		DAKE, SABRINA		12/19/2014	OHSU RICHMOND	03/01/2013	02/28/2015	8	15	23	3
21	2013-03-01			N		MILANO, CHRISTINA E		02/04/2015		03/01/2013	02/28/2015	0	1	1	1
22															
23															
24															
25															
26															


FAT FACTS
Monounsaturated Fat
good
Polyunsaturated Fat
not-so-bad
Saturated Fat
not-so-good
Trans Fat
bad
Controle su diabetes.
Más que comida, es vida.
Oatmeal
QUICK-1 MINUTE
Veg
CHo

Source: Lloyd, R. *Quality Health Care: A Guide to the Development and Use of Indicators, 2nd edition,* Jones and Bartlett Publishing, 2017.

Quality Control is a process by which procedures and methods are established to review and standardize the reliability and quality of all factors involved in the production of products or services.

Quality Improvement is the combined and unceasing efforts of everyone (e.g., healthcare professionals, patients and their families, researchers, payers, planners and educators) to make the changes that will lead to better patient outcomes (e.g., health), better system performance (e.g., care) and better professional development.



Quality Assurance is any systematic process of checking or auditing periodically to see if a product or service being developed is meeting specified requirements, targets or goals.

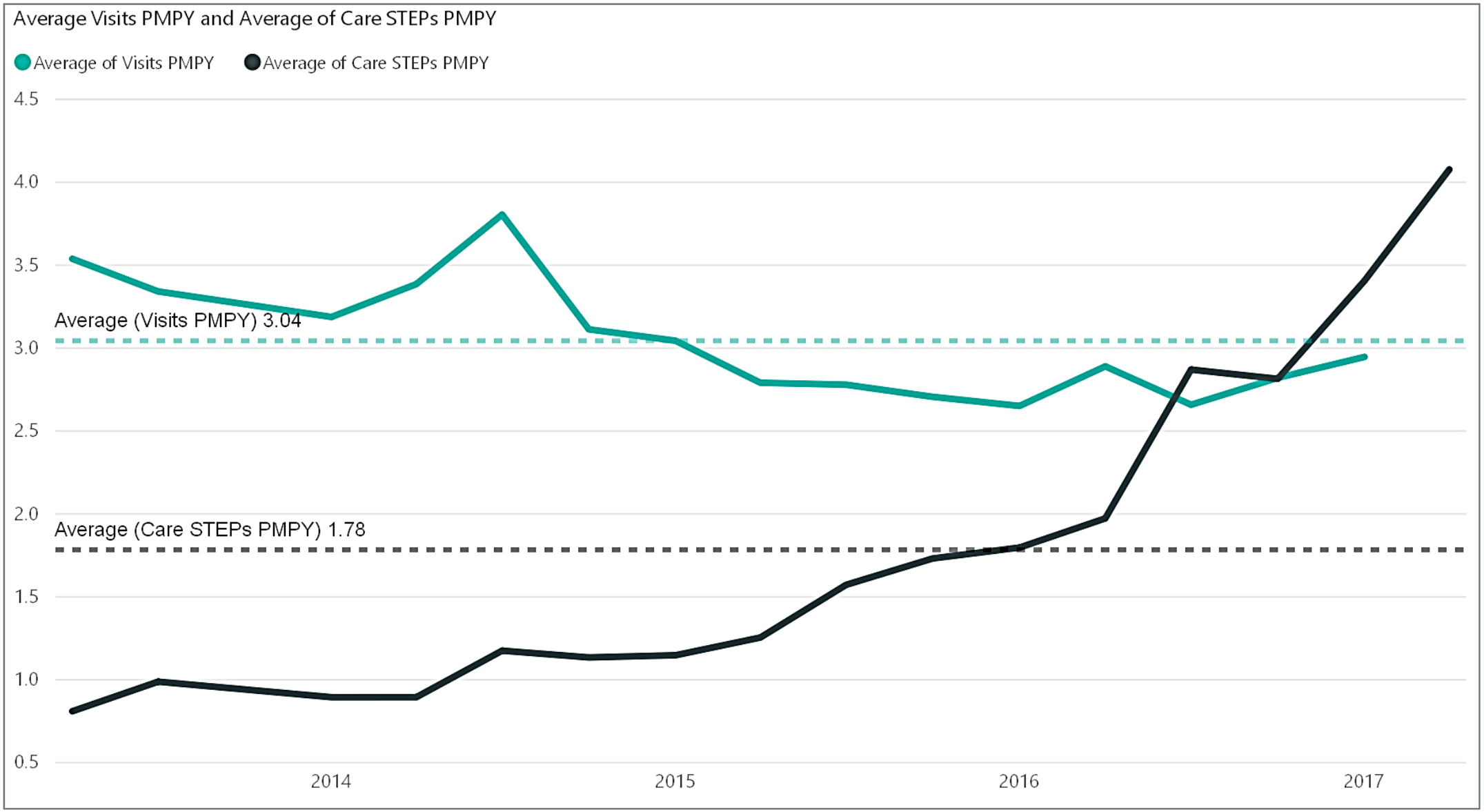
7

Agenda

- How do we make Care STEPs more than an exercise in documentation and reporting?
  - Care STEPs program data
  - Utility of Care STEPs report
- How do we incorporate QA and QI in our Care STEPs work?
  - Ensuring accurate documentation for future benchmarking and impact analytics?
  - Explore new Care STEPs to implement based on target population needs

Why document Care STEPs?

- Continue to get paid by the state for patients without the need of an office visit.
- Have data that demonstrates the value produced by care teams in and outside of visits.
- Track non-visit based services and new visit types so that we can correlate services with changes to outcomes, utilization and cost.
- Through focusing on target populations with medical and non-medical conditions, figure out which preferred care/services improve outcomes.


Average Visits PMPY and Average of Care STEPs PMPY
Average of Visits PMPY
Average of Care STEPs PMPY
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
Average (Visits PMPY) 3.04
Average (Care STEPs PMPY) 1.78
2014
2015
2016
2017

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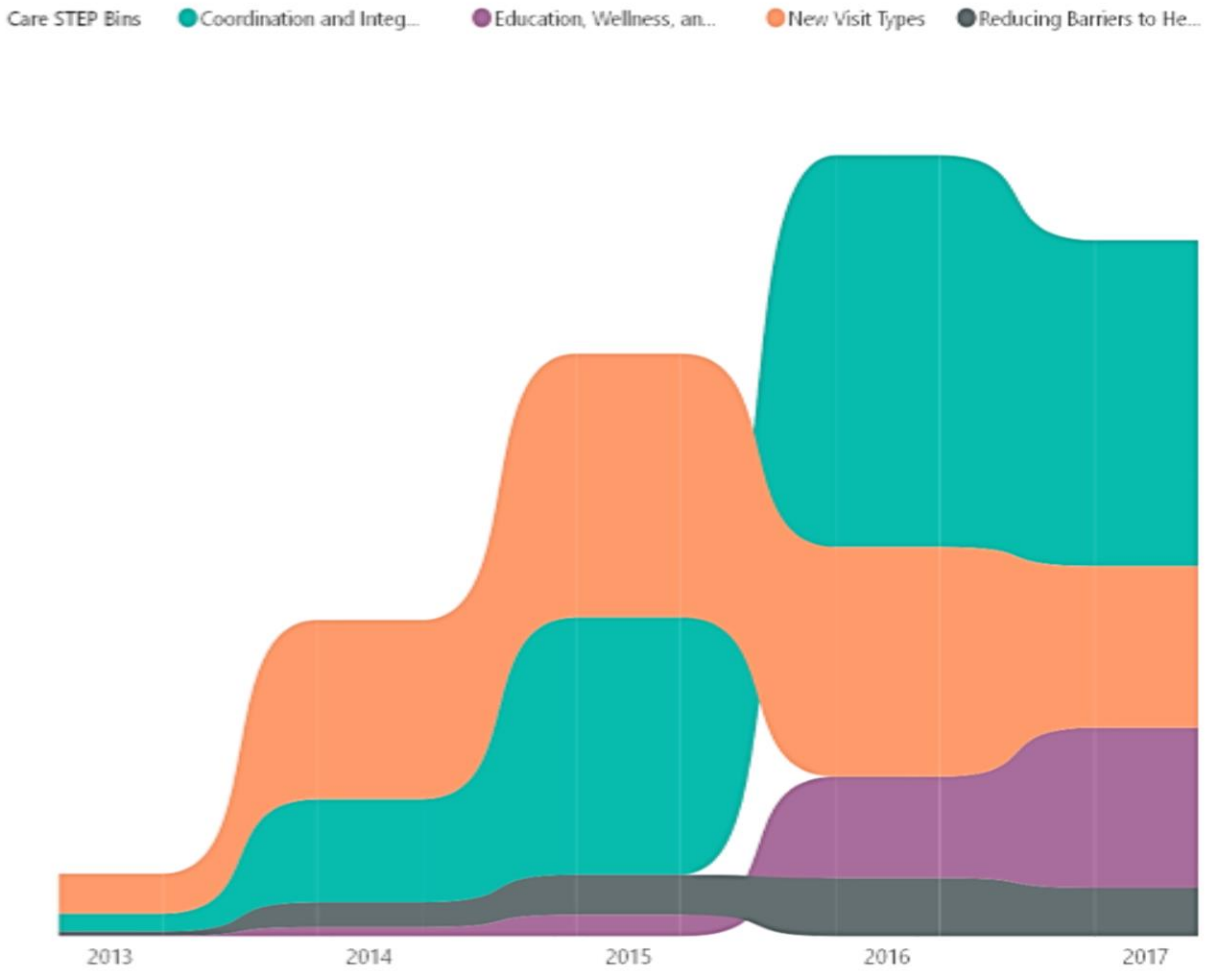
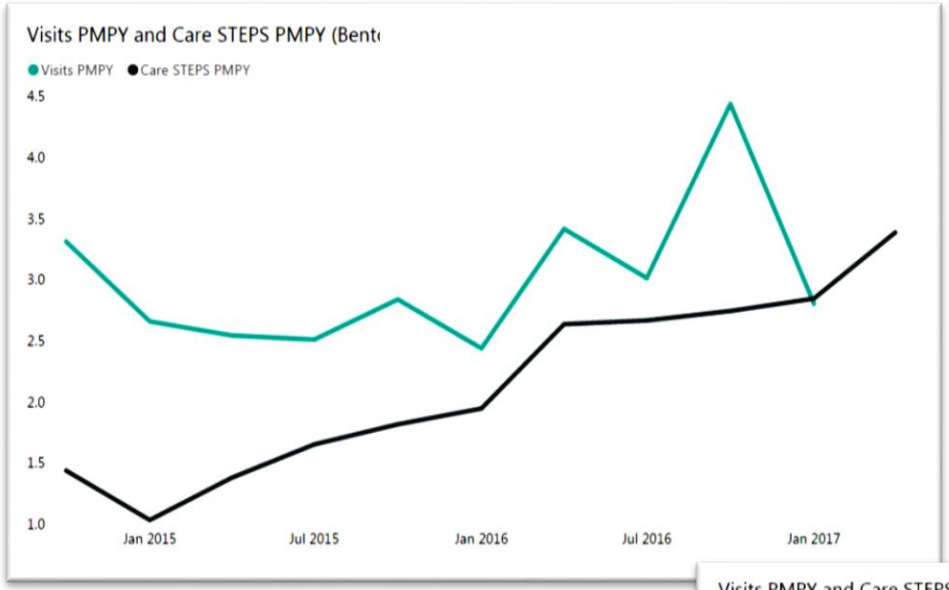
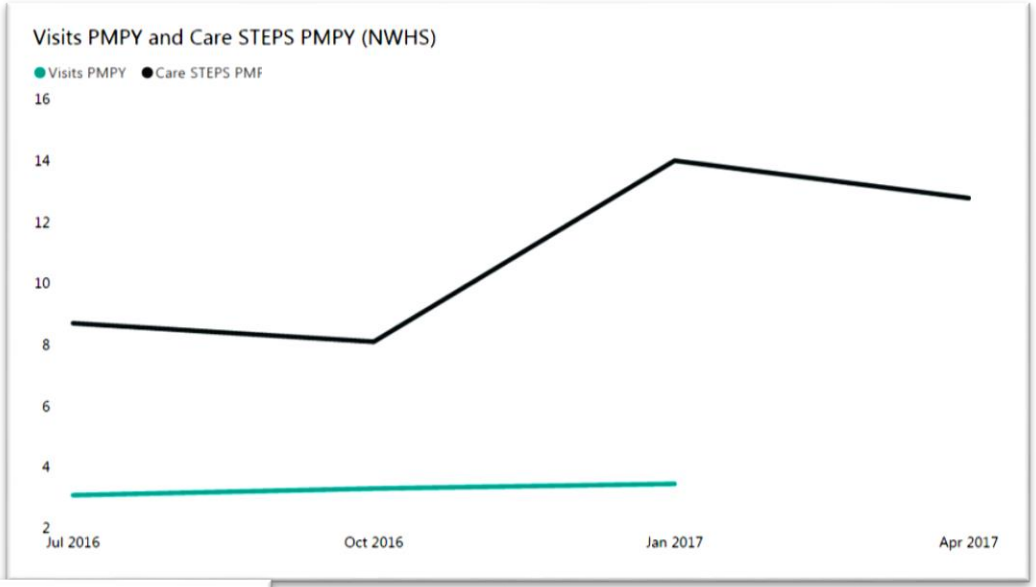
Care STEPs Breakdown

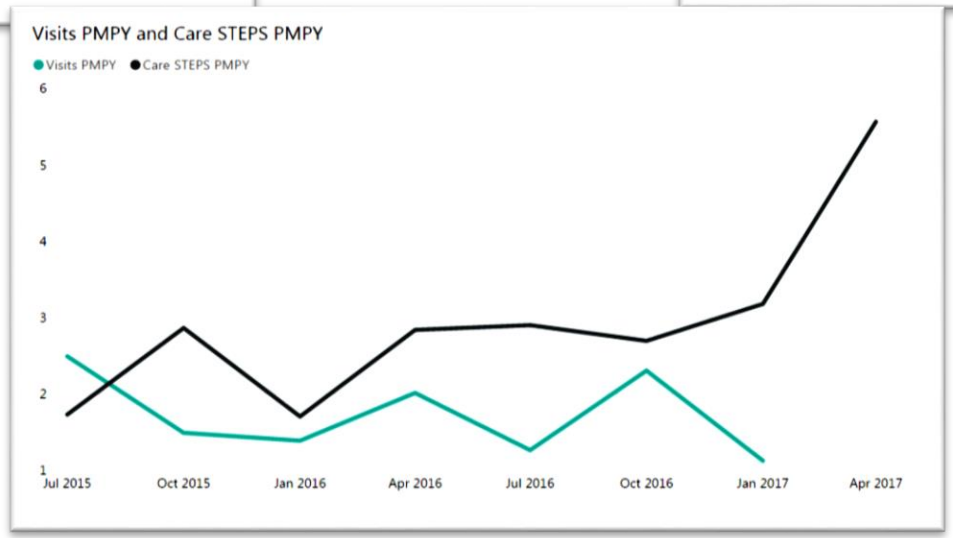


Care STEP Bins	2013	2014	2015	2016	2017	Total
Coordination and Integration	**3583**	**21348**	**52864**	**80294**	**66827**	**2249**
Behavioral Health and Functional Ability Screening	3518	20280	39863	58602	50296	**1725**
Coordinating Care - Dental	35	241	248	325	165	**10**
Coordinating Care: Clinical Follow-up and Transitions	24	679	11858	19477	15178	**472**
Warm Hand-Off, Non-Billable	6	148	895	1890	1188	**41**
Education, Wellness, and Health Promotion	**147**	**1896**	**4518**	**20925**	**33040**	**605**
Care gaps outreach	62	1126	1420	3169	3886	**96**
Education Provided: Group Setting	35	247	833	852	1151	**31**
Exercise Class Participant	1	275	2002	2064	780	**51**
Health Education Supportive Counseling				14429	26975	**414**
Support Group Participant	49	248	263	411	248	**12**
New Visit Types	**2754**	**36756**	**54090**	**47119**	**33126**	**1738**
Advanced Technology Interactions	92	1189	1723	1354	2559	**69**
Health and Wellness Call	2227	20219	27998	25389	14726	**905**
Home Visits, Non-Billable	47	353	346	976	633	**23**
Online Portal Engagement	388	14995	24023	19400	15208	**740**
Reducing Barriers to Health	**748**	**5223**	**8382**	**12162**	**10099**	**366**
Accessing community resource/service	675	4628	8055	10023	8803	**321**
Case Management				518	325	**8**
Transportation Assistance	73	595	327	1621	971	**35**
Total	**7232**	**65223**	**119854**	**160500**	**143092**	**4959**

What is the right mix of visits and Care STEPs?







Care STEPs Documentation

Implementation Checklist

Measuring progress

1. Create Care STEPs documentation process improvement plan
2. Establish a QA and auditing process to ensure that documentation accurately reflects clinic services
3. Create an implementation plan with workflows in place for all positions that are qualified to conduct Care STEPs
4. Set targets for each staff role and Care STEP category in year 2.
5. Systematize training efforts (i.e. include Care STEPs training in New Employee On-boarding, designate CS leads per care team, etc.)

Trainings

- Imbed Care STEPs in new employee on-boarding and staff trainings
- Create a documentation culture across care teams

Care Team Workflow Map

Care STEP	Location	Who	When
Manual Entry under Touches Tab			
Coordinating Transitions in Care Setting	Touch List	1. Transitions/Pod RN 2. Clinical Pharmacy	Pod RN – dc f/u calls
Coordinating Information Management	Touch List	1. Transitions RN	
Coordinating Care: Clinical f/u	Touch List	1. Transitions/Pod RN 2. BHC 3. Clinical Pharmacy	Coor with specialists, care homes, SNF.
Care Plan Setting Activities	Touch List	1. Transitions/Pod RN 2. BHC	Care Management
Accessing Community Resource/Service	Touch List	1. Transitions RN	
Panel Management Outreach	Touch List	1. Pod RN	f/u calls
Home Visit: Non-Billable	Touch List	1. Transitions/Pod RN 2. Clinical Pharmacy	
Education Provided: Written Material	Touch List	1. Pod RN/Maternity	
Education Provided: Group Setting	Touch List	1. BHC 2. Maternity Care RN	
Warm Hand-Off	Touch List	1. BHC 2. Clinical Pharmacy 3. Pod RN	Brought into provider visit

Creating Common Definitions

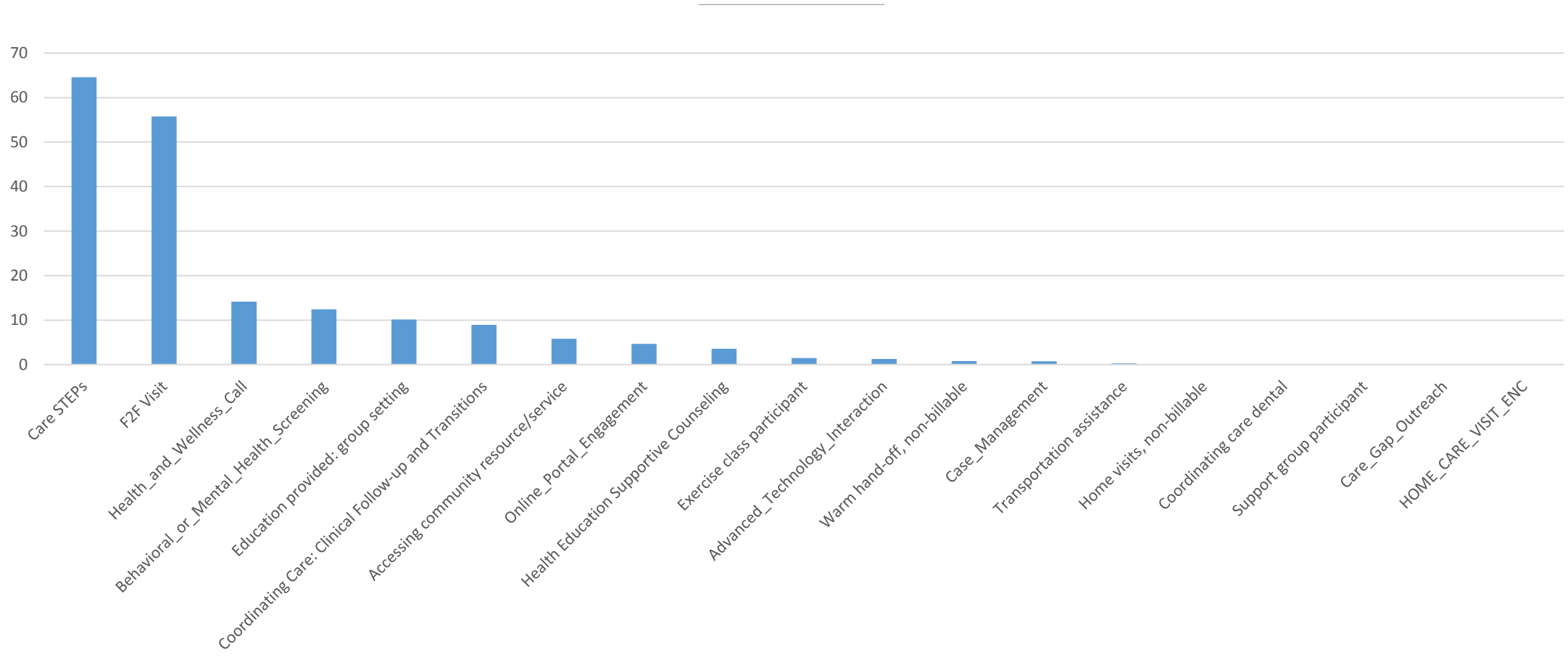
Make It Count!

What to Document in Epic

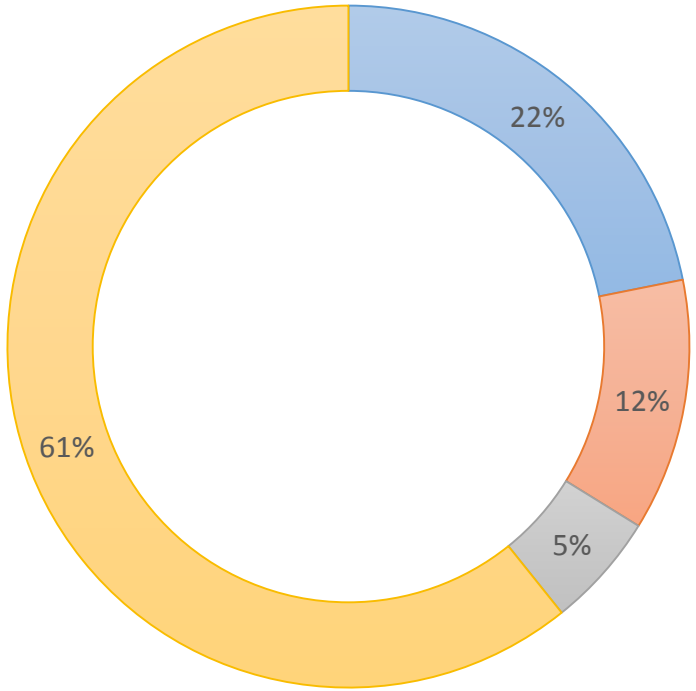
Touch Category	Examples
Transportation Assistance	Transportation to medical appointment, social services appointment, assistance navigating public transportation
Social Determinants of Health Screening	Completing PRAPARE tool
Case Management	Case Manager for: Complex Care, Diabetes, Transitional Care Management
Accessing Community Resource/Service	Finding resources: Food, Housing, Legal Services, Immigration paperwork.
Gaps in Care Outreach	Speak to patient/family about gaps in care and support patient in closing the gaps.
Education Provided in Group Setting	Living Well Class/Tomando Control
Support Group Participant	Group Participants: Chronic Pain, Diabetes Support, Centering Pregnancy, Centering Parenting
Exercise Class Participant	Yoga, Zumba, etc.
Health Education Supportive Counseling	Teach patient how decreasing BMI can decrease risk for chronic diseases like hypertension or diabetes.
Coordinating Care Clinical F/U & Transitions in Care Setting	ED outreach calls, referral to Hospice, notification that patient was transitioning to or from a care facility, emergency room or hospital admissions follow-up
Coordinating Care Dental	Scheduling a well child visit for dental sealant. Schedule a Diabetic with dental appointment.
Warm Hand-Off, Non-Billable	Asking a Clinical Pharmacist, BHP, and Dietitian to come into appointment with provider.
Behavioral or Mental Health Screening	Doing PHQ 9, GAD 7, SBIRT/CRAFFT and speak to patient about result.
Online Portal Engagement	Talk to patient about MyChart and help patient to sign up. MyChart encounters.
Health and Wellness Call	Speak to patient about lab result, i.e. cholesterol result, reason for statin, Med S/E, Recheck and prevention of CAD
Home Visits, Non-Billable	CHW doing home visit to asses patient SDH
Home Visits Billable	Provider doing home visit on a home bound patient.
Advanced Technology Interactions	Telemedicine visits.

Care STEPs Data Analytics

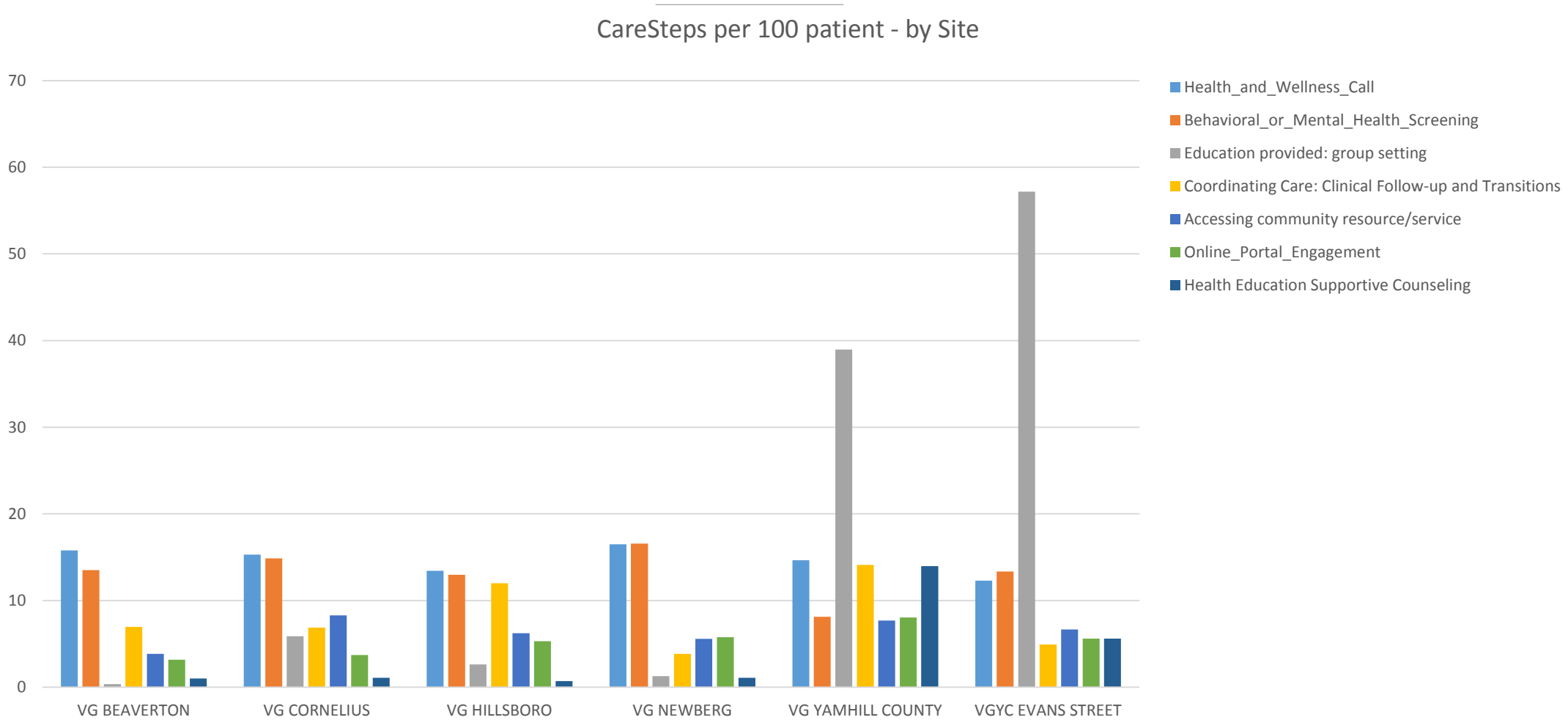
Visits and Care STEPs – per 100 patients

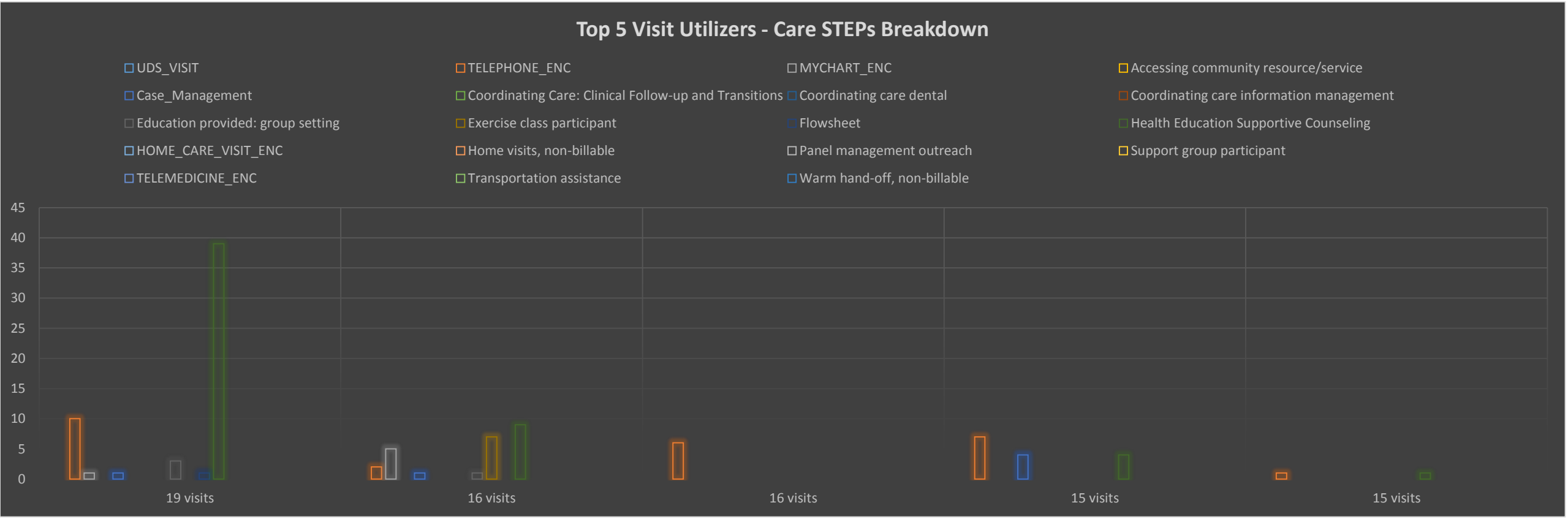


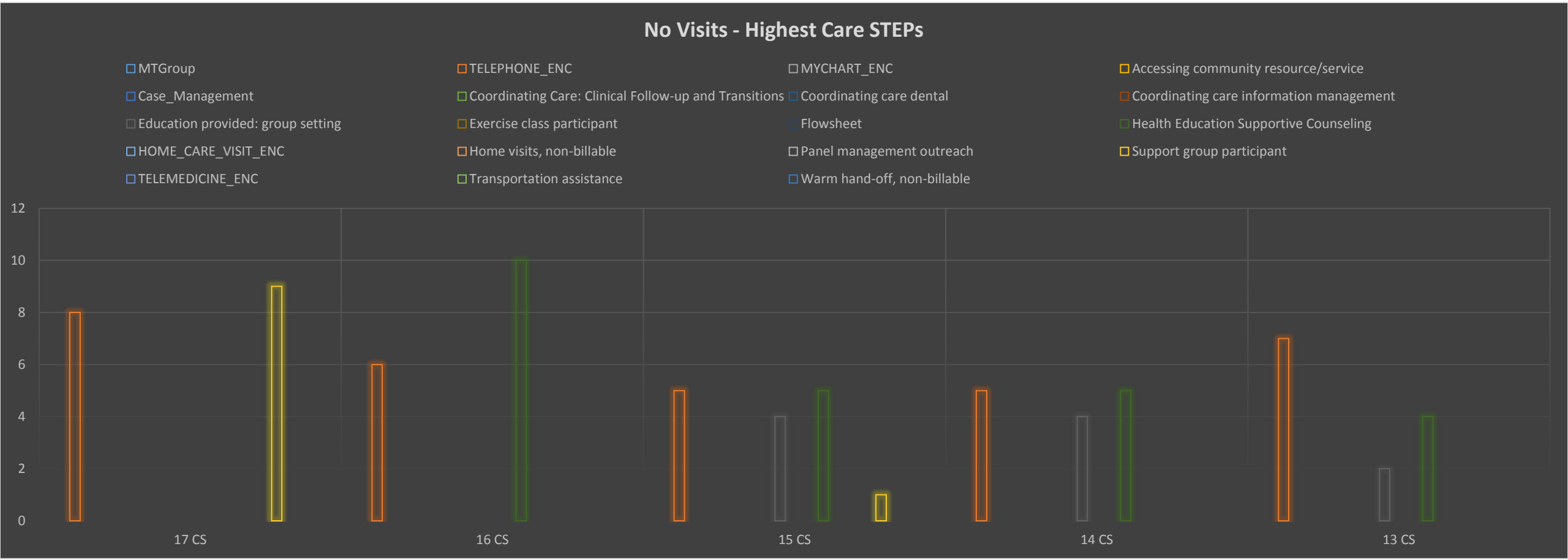
Engagement Profiles Breakdown



Care STEPs per 100 patients – by Site




Top 5 Visit Utilizers - Care STEPs Breakdown
UDS_VISIT
TELEPHONE_ENC
MYCHART_ENC
Accessing community resource/service
Case_Management
Coordinating Care: Clinical Follow-up and Transitions
Coordinating care dental
Coordinating care information management
Education provided: group setting
Exercise class participant
Flowsheet
Health Education Supportive Counseling
HOME_CARE_VISIT_ENC
Home visits, non-billable
Panel management outreach
Support group participant
TELEMEDICINE_ENC
Transportation assistance
Warm hand-off, non-billable
45
40
35
30
25
20
15
10
5
0
19 visits
16 visits
16 visits
15 visits
15 visits


No Visits - Highest Care STEPs
MTGroup
TELEPHONE_ENC
MYCHART_ENC
Accessing community resource/service
Case_Management
Coordinating Care: Clinical Follow-up and Transitions
Coordinating care dental
Coordinating care information management
Education provided: group setting
Exercise class participant
Flowsheet
Health Education Supportive Counseling
HOME_CARE_VISIT_ENC
Home visits, non-billable
Panel management outreach
Support group participant
TELEMEDICINE_ENC
Transportation assistance
Warm hand-off, non-billable
12
10
8
6
4
2
0
17 CS
16 CS
15 CS
14 CS
13 CS

Now, your turn!

1. Break into groups of 2-3
2. Grab a mock data file
3. Brainstorm ways to turn the Care STEPs report into an actionable, meaningful tool at your health center
4. Prepare to report out your top 2 ideas to the group
5. Reconvene in 15 minutes!

From Data to Care

	Foundational	Intermediate	Advanced
Access Goals:	Use the Care STEPs categories to develop one new mode of access/service delivery.	Evaluate patient engagement or satisfaction with new modes of access/service delivery.	Use Care STEPs categories to create one new patient-driven mode of access/service delivery for target populations identified through the PHE quadrant.

Care STEPs Design Canvas Activity

New Visit Types

- Online Portal Engagement
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- Home Visit (Non-Billable Encounter)
- Advanced Technology Interactions

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- Coordinating Care: Dental
- Behavioral Health and Functional Ability Screenings
- Warm Hand-Off

Reducing Barriers to Health

- Social Determinants of Health Screening
- Case Management
- Accessing Community Resource/Service
- Transportation Assistance

Setup a Care STEPs Site Visit!

Contact Charles or Ariel at OPCA if interested!

- Provide instructions for Care STEPs documentation workflows
- Explore opportunities for care team optimization, service delivery design using the Care STEP framework
- Discuss uses of data among QI staff and care teams
- Provide laminated resources for on-going use