Taking Plans of Care from Clinician to Patient-Centric

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Session 119 Palazzo G 10:00AM

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DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Conflict of Interest

Judi Binderman, MD MBA MHSA
Lauren Garrick, RN

Our employer, Community Medical Centers, participates in the ZynxHealth Client Reference program.
Agenda

- Organizational transition to patient centered / problem based care
- Leveraging technology & investing in clinical decision support tools
- Interdisciplinary care plans & communication
- Patient focused needs / goals
- Patient/family education tools coordination
Learning Objectives

Outline the significance of the medical condition and problem-based patient care with clinical decision support

Explain the selection process for a clinical decision support tool and the foundational work to maintain an ongoing enterprise-wide user adoption commitment

Describe the journey to interdisciplinary care planning and desire to focus on the patient’s clinical and personal goals

Identify the goal to remove duplication and clutter from EHR and care plan documentation

Discuss outlying questions we are working towards and enlist feedback from our healthcare colleagues
Community Medical Centers

- Community Regional Medical Center
- Clovis Community Medical Center
- Fresno Heart & Surgical Hospital
- Community Behavioral Health Center
Satisfaction

- Improving quality of care
- Easy transitions in care
- Accessible evidence
- Reducing documentation burden
Are you currently using a clinical decision support solution?

1. Not currently
2. Currently Implementing
3. Recently went live
4. Long term user
Universal Need for Change...

**Figure 1. Survey Item:** How Often Do You Need Information to Support Your Nursing Role? (749 Respondents)

- 26.7% (n=200) frequently (several times per week)
- 32.8% (n=246) regularly (weekly)
- 28.3% (n=212) occasionally (1-2 times per month)
- 12.1% (n=91) rarely (less than once per month)

Source: *Readiness of U.S. Nurses for Evidence-Based Practice*
Culture of Clinical Evidence

EBP Organizational Culture

Context of Caring

Research Evidence and Evidence-Based Theories

Clinical Expertise (e.g., evidence from patient assessment, internal evidence, and the use of healthcare resources)

Patient Preferences and Values

Clinical Decision Making

Quality Patient Outcomes

Culture of Clinical Evidence
What does NNT stand for?

1. Not Necessarily Treatable
2. Number Needed to Treat
3. Neonatal Tetanus
4. Neat Net Tricks
Goals in Clinical Decision Support Implementation

- Enhance quality of care
- Decrease unnecessary variation in care
- Improve resource efficiency
Growth Opportunity: Tools at the Point of Care

Incorporating Clinical Evidence:

- Homegrown research & materials
- Third-party vendor software as a service (SAAS)
- Third-party vendor purchased locally installed solution

Evidence based practice tools: Build vs. Buy

- Order sets
- Interdisciplinary plans of care
- Algorithms
- Targeted education & discharge plans

- Go-live tools mostly ‘home grown’ or eminence-based
- Limited time / teams to review/validate evidence & update tools
## The Process – Quality Initiative

<table>
<thead>
<tr>
<th>Lead Selection Team</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Chief Medical/Quality Officers</td>
<td>✓ Narrowed Selection by Quality Director</td>
</tr>
<tr>
<td>✓ Chief Nursing Officers</td>
<td>✓ Vendor Presentations</td>
</tr>
<tr>
<td>✓ Chief Nursing Informatics Officer</td>
<td>✓ Calls with product clients</td>
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<tr>
<td></td>
<td>✓ Attending Vendor User Group</td>
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Selection Process

Goal: Eliminated Homegrown Research & Materials

– Limited resources for build & maintenance
– No school of nursing affiliation / focused evidence research
– Limited ability to join care plans / order set content
– Need to incorporate nationally accepted best practices
Vendor Selection Criteria

- Workflow / usability of evidence
- Frequent update of clinical evidence
- Invested partnership with E.H.R.
- True Integration into E.H.R.
- Product updates easily accessible

- Quality Tools for Stakeholder Review
- User friendly build – GUI interface
- Project Guidance & Support Services
- Continued product development
- Documented client results
Getting Evidence-Based CDS to the Point of Care

Select/create evidence-based CDS
- Order sets, plans of care, rules, practice guidelines and other supporting evidence

Establish/maintain appropriate governance
- Evidence continuously changing
- Requires process to keep current

Use evidence-based CDS at point of care
- Requires inclusion within EHR appropriate to workflow
Which of these is NOT one of the 5 rights of clinical decision support?

1. Right information
2. Right person
3. Right venue
4. Right time in the workflow
Rapid Build Design & Implementation Process

<table>
<thead>
<tr>
<th>✔ Content coordinator hired</th>
<th>✔ 2-Day Interdisciplinary Design Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Vendor training &amp; partnership</td>
<td>✔ Clinical leads “deputized” decision makers</td>
</tr>
<tr>
<td>✔ Project plan w/ executive summaries</td>
<td>✔ Follow up sessions to complete build</td>
</tr>
<tr>
<td>✔ Utilization report / top diagnoses</td>
<td>✔ One facility pilot</td>
</tr>
<tr>
<td>✔ Style / build principle development</td>
<td>✔ Education developed &amp; distributed</td>
</tr>
<tr>
<td>✔ Recruited clinical leads from each facility</td>
<td>✔ User Validation / Test Sessions</td>
</tr>
</tbody>
</table>
Finding a clinical intervention solution?

Habit / Comfort

- Bank on personal experiences
- Ask a colleague / peer
- Check resources on unit
- Tech savvy – web search

Best Practice

- Assess / define problem
- Research / Evaluate evidence
- Plan / Implement into practice
- Evaluate results
Treatment / Clinical

- Increasing Patient Problem Specific Interventions & Education
- Increasing Patient Problem Specific Care Communication
- Evidence & Education at the fingertips
Problem-Oriented Medical Record (POMR)

...an approach to patient care record keeping that focuses on the patient’s specific health problems requiring immediate attention, and the structuring of a cooperative health care plan designed to cope with the identified problems...

The electronic medical record allows us to leverage these and other patient care advances.
- Administer medications as ordered
- Manage patient’s environment
- Implement and maintain appropriate pain scale and pain management for patient
Interdisciplinary Communication

Improving the ability to offer highly integrated personalized care

• Team collaboration
• Shared Goals / Achievements
• Discharge / Transition planning
• Patient/family satisfaction
Communication
Condition / Patient Problem Care Plans

Respiratory Care → Gas Exchange-Impaired

Follow Prescribed Diet → Nutrition Altered

Physical Therapy Plan → Growth & Development – Impaired Mobility Impaired
Individualized care

Screening tools / patient assessment helping determine care plan

<table>
<thead>
<tr>
<th>Suicide Risk</th>
<th>6 months prior to screening trigger</th>
<th>6 months with SAD persons score triggering care plan</th>
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<tbody>
<tr>
<td></td>
<td>171 Instances of care plan use</td>
<td>721 instances of use</td>
</tr>
<tr>
<td></td>
<td>Mainly in Behavioral Health Facility</td>
<td>Multiple Departments / Diagnoses</td>
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Problem list / physician guidance to care plan & education interventions

CMC STK 8 Core Measure Compliance 2015

- Community Medical Center-Clovis: 100% (Jan-Jun) 99% (Jul-Dec)
- Fresno Community Medical Centers: 100% (Jan-Jun) 99% (Jul-Dec)
- Fresno Heart Hospital: 99% (Jan-Jun) 100% (Jul-Dec)
- Aggregate: 100% (Jan-Jun) 100% (Jul-Dec)
Clinical references embedded in care plan and education screens
Prevention and patient education

Physician Initiated Clinical Decision Support & Patient Education Automation

- Problem List Update
- CHF ICD-9 / 10 Grouper

Trigger of Quality Measure Content

- Non-Interruptive Alert Posted

Education Launched

- HF Care Plan w/ Education Interventions
- CHF Video Bundle

Pathway video titles appear next to interrelated education interventions from care plan and under the same patient problem heading to facilitate documentation.

Education, heart failure self-management

Video: Managing HF: At Hospital Discharge (CHF Pathway)

Video: Managing HF: Handling Flare-ups (CHF Pathway)
Problem List

Hospital (Problems being addressed during this admission)

Heart failure

Title/Topic/Teaching Point:

- Heart failure self-management - Quality Measure
- Home exercise program
- Medication management - anticoagulants
- Physical activity cessation - Cardiac
- Post-discharge follow-up - Quality Measure
- Prescribed medication - Quality Measure
- Sexual activity
- When to call provider - Quality Measure

Prevention and patient education

- Patient prompted with four questions about the videos watched. Responses help validate understanding.
- Education materials chunked in manageable increments. Patient congratulated on education completion and provided with review.
- Intermission provided between phases of learning. Patient prompted for length of intermission:
  - Ø No intermission
  - 4 hours
  - 8 hours
  - 12 hours

Let's review what you have learned. If the patient does not click “Continue,” the prompt remains on the screen until the patient clicks it and if the TV is turned off, when it comes back on, the "Continue" is still there.

EHR captures the questions and answers in Patient Education Record.

Interactive Video System
Video titles integrated into education intervention topics generated from patient condition based care plan
Prevention and patient education

- **Problem Oriented**: Make Patient Relevant education easily used / accessible in the EHR
- **Evidence-Based**: Comfortably Incorporate evidence based practice, staff & patient education into workflow
- **Standardized Excellence**: Connect and provide standardization with available tools to best meet patient learning needs.
Prevention and patient education – Patient information and education is easily included within the plans of care to encourage engagement and reduce preventable readmissions.
PATIENT GOALS & BELIEFS
Patient Engagement
Stroke

Stroke Geometric Length of Stay

- CCMC: 2.95, 2.63
- CRMC: 5.70, 5.11
- FHSH: 1.19, 1.18

Stroke 30 Day Readmission Rates

- CCMC: 12.50%, 6.45%
- CRMC: 10.71%, 7.20%
- FHSH: 1.33%, 0.96%
Summary

Potential impact of evidence based / patient centered care

Value in finding appropriate tools / workflows

Cultural changes for successful adoption

Patient & staff satisfaction opportunities

Continued system optimization
Questions/Comments

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