The AMEDD AHLTA Guide to Improved Healthcare Outcomes (Build 838.18)

Version 3.0

Prepared for the:

AMEDD AHLTA Implementation and Clinical Integration Office, Washington, D.C.

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Version	Section	Content of Change/Addition	Page Number
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Preface

The fielding of AHLTA, the switch to the Next Generation of TRICARE Contracts, and the continued move to performance-based budgeting have resulted in transformational changes in the clinical, business, and administrative processes within the AMEDD. Multiple often seemingly competing metrics and goals are presently in place. The apparent conflicts among requirements, metrics and goals often stems from each being treated as an end to itself. With completion of AMEDD AHLTA Block 1 Deployment (August 2006) and the fielding of AHLTA Build 838.18, the AMEDD will have the tools and experience with EMR use to bring these multiple metrics into a single process. Moreover, there will be the ability to centrally monitor, trend and report performance on core metrics. This ability will enhance MTF efforts to deliver optimal healthcare and target process improvement where needed.

This document has evolved through an understanding of how AHLTA is being used and how it may be better employed. Close coordination has occurred with OTSG Health Policy and Services (HP&S) to determine the metrics that should be initially targeted. Since it would be overwhelming to try to correct hundreds of issues at once, items were selected that are felt to be of the greatest clinical value, that are current readiness or accreditation issues, or that are linked to current performance-based budgeting. The long-term goal is to establish and transform our culture to collaboratively meet local, regional, and Service level needs in the most efficient manner possible. The use of integrated and automated processes will help facilitate the review and improvement of those processes using “Lean Six Sigma.” This will permit continued harvesting and sharing of best practices to benefit all MTFs, and most importantly, the care of the patient.

The implementation of the process outlined in this document, like much of the AHLTA implementation, will not be easy. MTFs will experience varying degrees of difficulty depending upon current efficiencies and staffing of clinics. The AMEDD has undergone considerable transition in clinical practices to decrease variation, increase efficiency, and improve outcomes. Tracking the outcome changes (from the implementation of process changes) and the cost of delivering care (down to the clinic level) will help in making subsequent decisions on personnel and system transformation.

It is the hope of the AMEDD AHLTA Project Office that this paper and its attachments will provide assistance at all levels within an MTF with successful transformation and outcome improvement in the areas of clinical care, readiness, and business processes. From continued field experience and command guidance, the Program Office will regularly update these documents.

Striving always to “Enhance the Excellence of Military Healthcare—AMEDD AHLTA.”

Very Respectfully,

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Program Manager, AMEDD AHLTA

Implementation and Clinical Integration

Section I—Overview

Background

AHLTA is the enterprise-wide electronic health records system for the Department of Defense (DoD) Military Health System (MHS). The AMEDD has now deployed the outpatient component (Block 1) to all MTFs. Since full rate deployment started in January 2004, fielding and use of AHLTA has experienced many challenges. Various issues delayed the fielding of the local cache (failover mode) Build 838, but it is now being deployed. Besides its ability to allow AHLTA use when the connectivity to the central Clinical Data Repository (CDR) is unavailable or the CDR is down, it comes with the first point-of-care decision-support tools, called wellness reminders.

The wellness reminders are patient-centric reminders that focus on elements of the United States Preventive Health Services Task Force (USPSTF) guidelines along with military readiness issues. A full list of the available reminders is located at the end of this section. The reminders can be coupled to an action that resets the timer on when the action is complete and next due. Depending on the type of reminder and action, the reminder can be set to either enterprise or MTF level. This is required because reminders that require ancillary test ordering must be set to order from the local legacy CHCS system. A recent meta-analysis of decision support tools found that there are four critical features of these tools, and if all four are present, 94% of studies showed a significant improvement in clinical practice (BMJ 14 Mar 05). The critical features are:

1. Automated provision of decision support as part of clinical workflow
2. Guidance provided as recommendations (actionable items), not assessments
3. Guidance provided at time and location of decision-making
4. Computer-based

AHLTA now provides these features. Additionally, the Automated Clinical Practice Guidelines (aCPG) outcomes tool that is being built will expand this capability further with the addition of registries and disease-specific information recall and reminders. In the expanded tool, the reminders will be patient-, condition-, and clinic-specific. Fielding of the aCPG tool is projected to begin with AHLTA build 843, likely in 2007.

Successful utilization of these tools will require both strategic and tactical implementation. The healthcare process could easily be overwhelmed with a mass of reminders to address. The strategic prioritization for fielding the reminders is critical. Additionally, each of these should be considered an extension of a single process aligned with organizational goals and policies. Tactically the implementation must be performed so that efficient use can occur and time and effort are not lost as patients and healthcare team members move.

This document outlines a process of care and recommends performance metrics to be evaluated for continued improvement.

Section II—The Outcomes-Based Clinical Care Process

Introduction

Historically, each new initiative to improve outcome has been treated as a separate event. Each implementation came with a clinical or functional champion, process, metrics and often an entire Process Action Team. This method is costly to implement, track and sustain. The efforts at one MTF often did not translate to improved outcomes at other facilities, as either different outcomes were emphasized or the process was different, thereby failing to reduce the work burden or cost. This implementation cycle was typical of the process used to field clinical practice guidelines. Clinical outcomes are not the only outcomes of concern. Others include readiness, business (financial) and regulatory (JCAHO, DoD, Army, etc). These outcomes were often tasked to a section of the facility for accountability, yet one who did not have control over the actions necessary to achieve the outcome. Achieving (or attempting to achieve) any outcome carries a cost to the MTF in personnel, equipment, and other direct costs. The performance of many interventions simultaneously does not make them more effective, but it can make them more efficient. With common overarching processes at each MTF, global efficiency is improved as the total burden of work is diminished. Finally, the cost to the patient in time and illness cannot be a secondary event. Efficient delivery of care and improved outcomes have direct benefit. The move to Relative Value Unit (RVU) monitoring of workload has provided the business model to allow focus on better care while maintaining productivity. The additional metric of Cost (salary)/ RVU can further measure the efficiency at the clinic. MTF (speed), and RMC (distance). The Per Member Per Month (PMPM) cost at the AMEDD level provides a measure of global effectiveness.

For each of the steps in the clinical process that follow, a recommended series of actions is listed. These actions emphasize the team approach and target specific metrics. The actions are locally actionable and can be monitored centrally. It is the hoped that all future regulations will include sections specifying recommended ways to accomplish the tasks with the available tools, associated metrics, and methodology. This will allow continued organizational synergy and ensure that effective IM/IT tools.

Check-In—Clerks

The clerk will check the patient in to his/her appointment. The following actions may be accomplished:

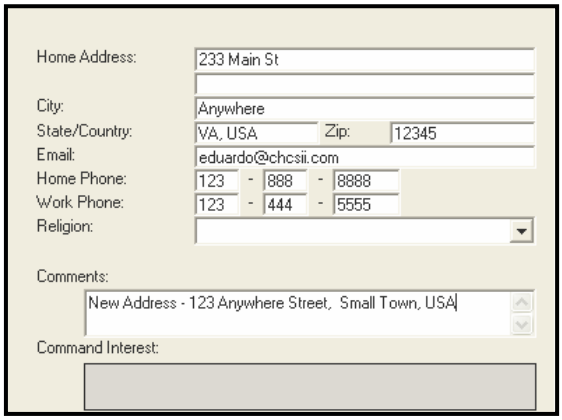
1. The clerk will open patient demographics folder

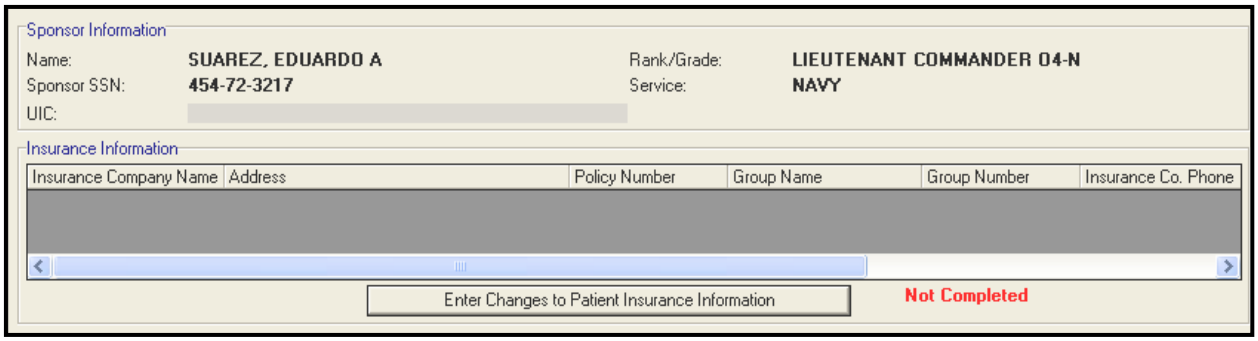
   a. Local telephone contact information will be placed in the local information free text area. This area is NOT overwritten by DEERS. *(Note: this assumes that the information in CHCS is updated as part of the normal process when a patient calls for an appointment booked in CHCS.)*

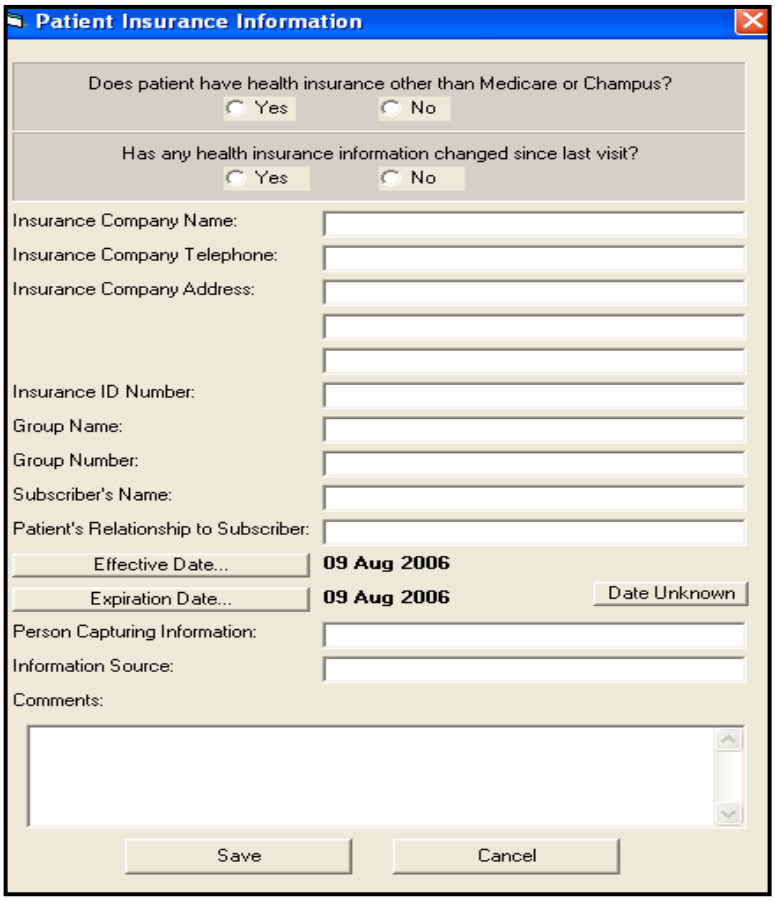
   b. Insurance status is reviewed and a date is entered in the "expiration date" field to indicate the next date to check status (annually).

      i. If the Other Health Care (OHI) insurance check is current (within the last year), no action

      ii. If over one year, the clerk will update the information and, if the patient has a third party insurance or a change in third party insurance, a paper form will be obtained and signed before leaving the check-in desk.







By clicking "Enter Changes to Patient Insurance Information" a new area will open allowing modifications and changes to insurance information.

The patient's encounter must be opened for this function to be available. (Example to the left.)

Hard copies of this information should also be maintained and sent to appropriate MTF areas to ensure data is accurately captured.

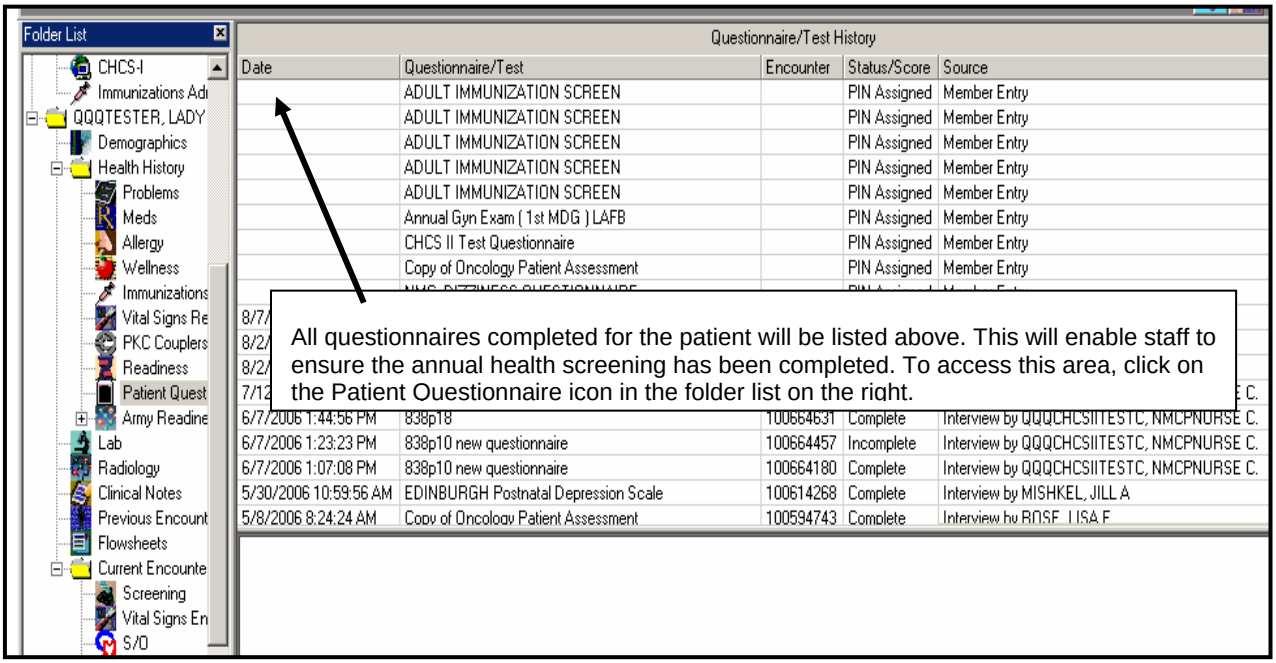
2. AMEDD Annual Screening Questionnaire

   Clerk checks to see if annual questionnaire is current, and if not, assigns PIN (for AHLTA kiosk) or indicates to screeners (for paper or other method) that the questionnaire is due.

   Note: The clerk will need to be assigned one of the following roles depending on the workflow used:

   i. Ward clerk—This role permits the user to assign and view questionnaires.

   ii. Ward clerk with limited orders—as above and allows the clerk to address reminders.



3. Questionnaires--Future State:

   a. The Questionnaire tool will include drop down selections for patients and include questions that patient MUST answer (Build 844).

   b. The Questionnaire tool will include items that flag alerts to the medical staff depending upon the answer given. This will be useful in numerous areas, including prescreening, such as ADTMC (Build 844).

   c. Clerks will complete third-party insurance on a form in AHLTA that can be e-mailed in a secure fashion to the TPOC office.

   d. Patients will be able to sign themselves in using their ID card. Upon checking in, the computer will present “forms” that the patient needs to complete or are due, such as HIPAA privacy statement, TPOCs, etc. The clerk will verify and assist patients with form completion and computer use issues.

Screening/Vital signs

The screener will review with the patient his/her current medications, to include prescription compliance and over-the-counter (OTC) meds. They will also update on the problem list any change to the patient’s family history, surgical history, allergies, and problems.

The screener will check the patient questionnaire history (if not already performed by the clerical staff) to see if the AMEDD Annual Screening Questionnaire has been completed in the last 12 months. This questionnaire is used to meet both annual JCAHO screening questions requirements and the Army's Periodic Health Assessment Requirement. The same form is used for all patients 17 years of age or older. If the questionnaire has not been completed by the patient in the last 12 months, the screeners ensure that a current questionnaire is completed. Only the AMEDD Annual Screening Questionnaire in the Enterprise Questionnaire folder will be used for this purpose as its use can be viewed and monitored by all MTFs.

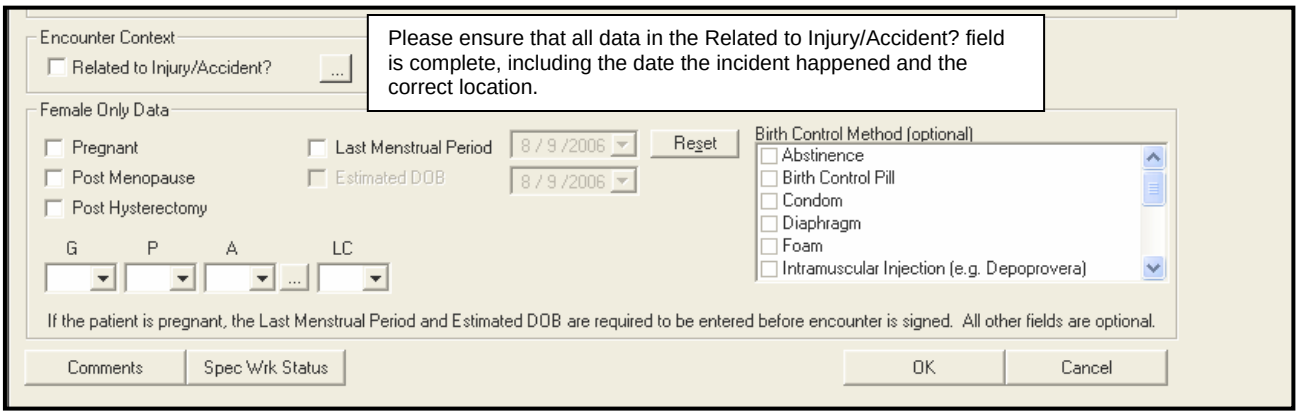
After completing the above, the screener will complete at least the minimal items listed below in the screening and vital signs modules. The AMEDD Screening AIM form will be used to capture the items listed below after they are reviewed with the patient. The screener should not waste time documenting items in the screening and vital sign module that will be captured on the AMEDD Screening AIM form. The items completed will allow central monitoring and reporting on MPL maintenance and medication reconciliation actions.

1. Items to document

    a. Screening

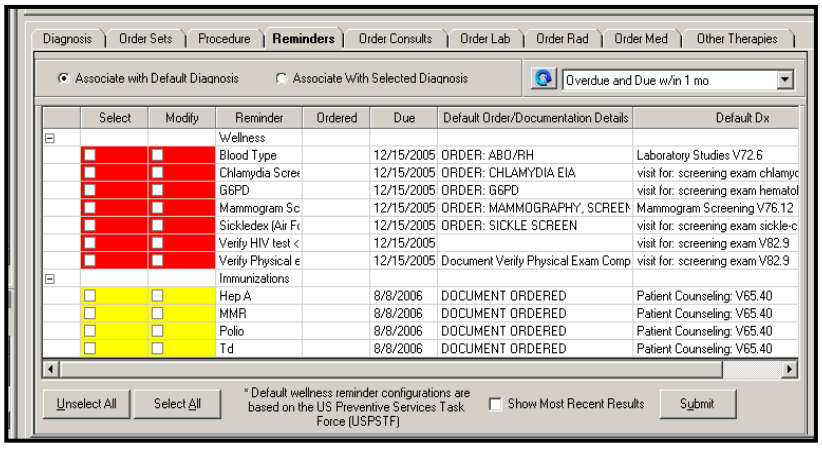
        i. Encounter Context (Related to injury?). This box will be checked "yes" if this visit is for a condition related to an injury.

        ii. Female data as appropriate.



        iii. Wellness reminders will be addressed as follows:

            1) Active duty. For some clinics and reminders, "appropriately addressed" may simply mean reminding the service member this is due and providing appropriate directions. Others require orders or other action. The reminders are found in the A/P module under the Reminders tab.



a) DNA

b) HIV

c) Sickle Screen

d) G6PD

e) Immunizations

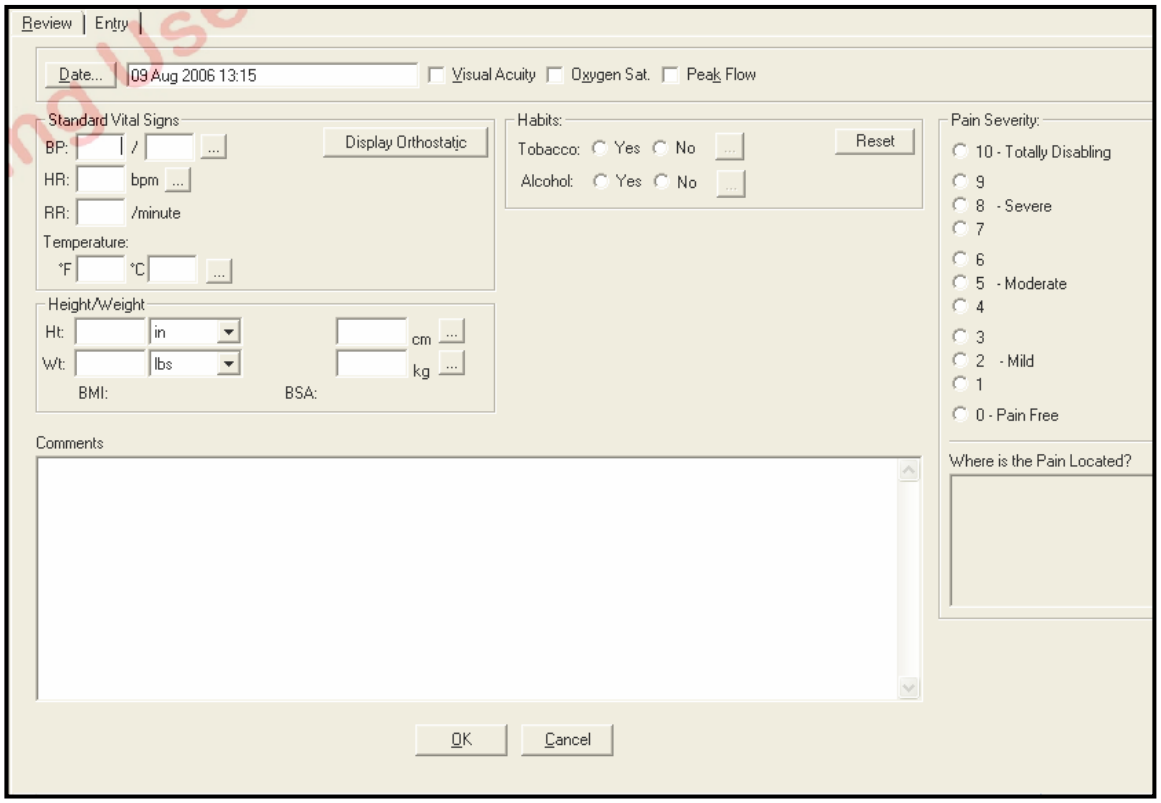
2) Others — Per clinic SOP

b. Vitals

i. Standard Vital Signs

ii. Height/Weight

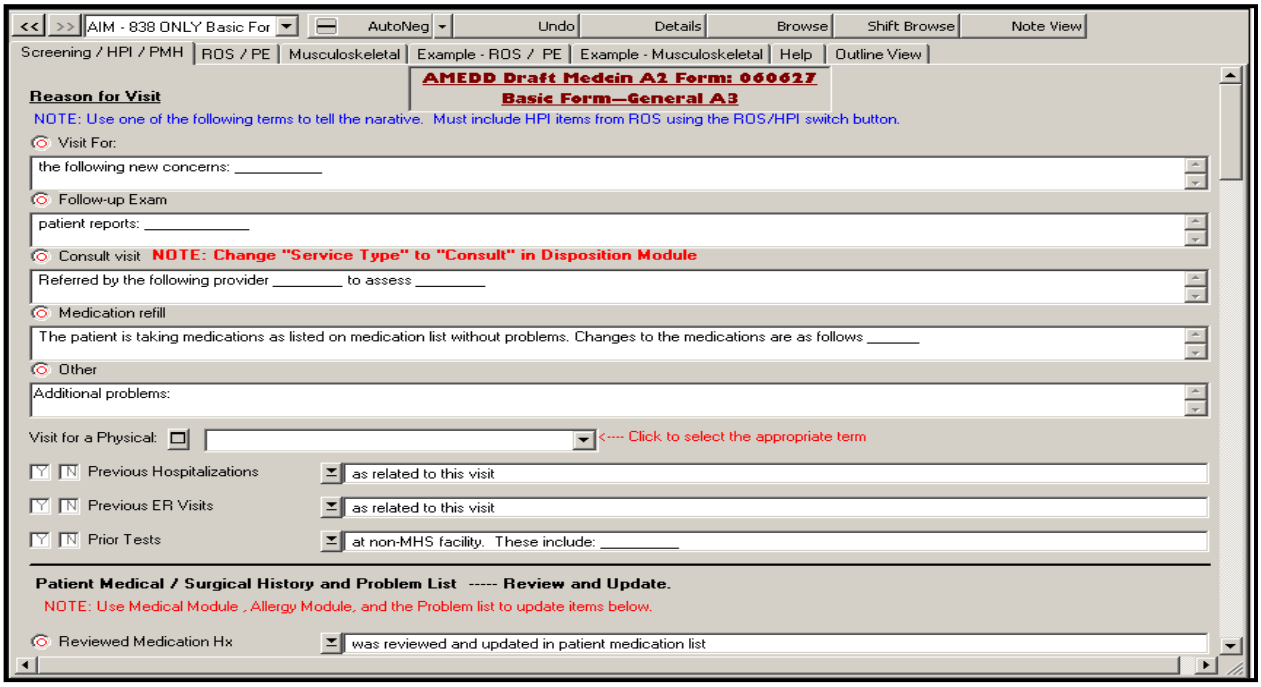
iii. Pain Scale and comments (if a value of “1” or greater is recorded). Comments should address location, duration, and current treatment.

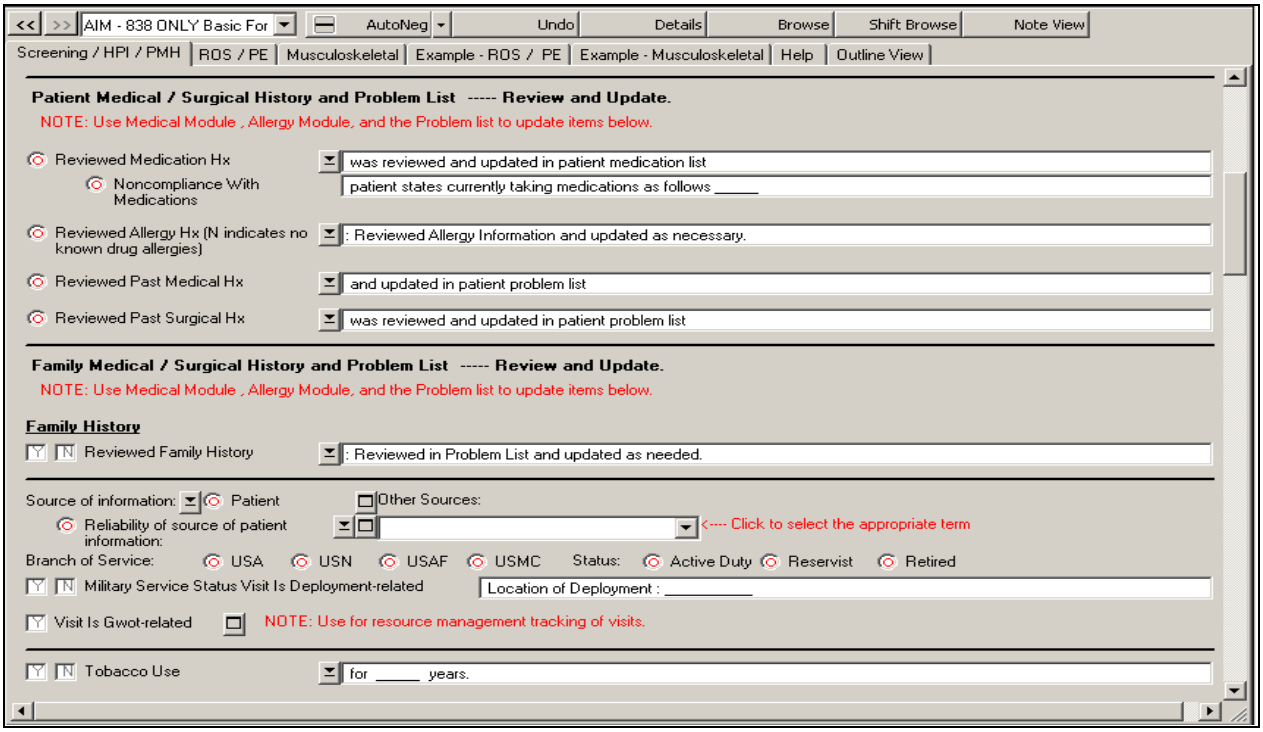


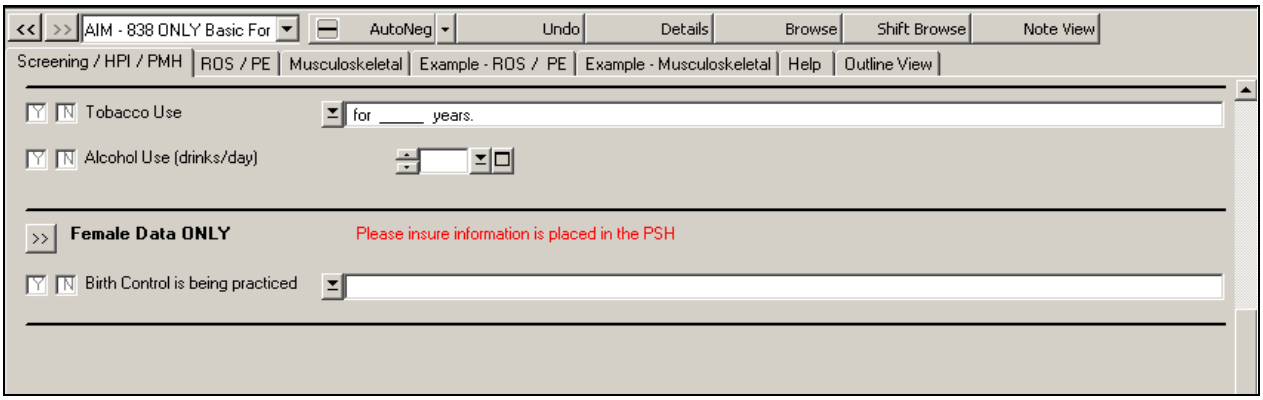
c. AMEDD Screening AIM Form

i. Reason for visit and narrative in patient's words entered in free text

ii. All other questions on the form that are addressed. (Note: This permits the compliance actions to be tracked, as these specific MEDCIN terms will be tracked)







2. Current Workflow Considerations

   a. Nursing station can print the AHLTA SF600 with Autocite included for the patient to review while getting vital signs taken or while waiting for screening. This will allow the screener to only open modules where changes need to occur. (NOTE: Family history should currently not be Autocited due to a programming error. The date for correcting this error has not yet been defined.)

   b. The nurse places this sheet and any necessary additional comments in the location that the provider will be able to see it. (e.g., Exam room door as a clinic tracking sheet.)

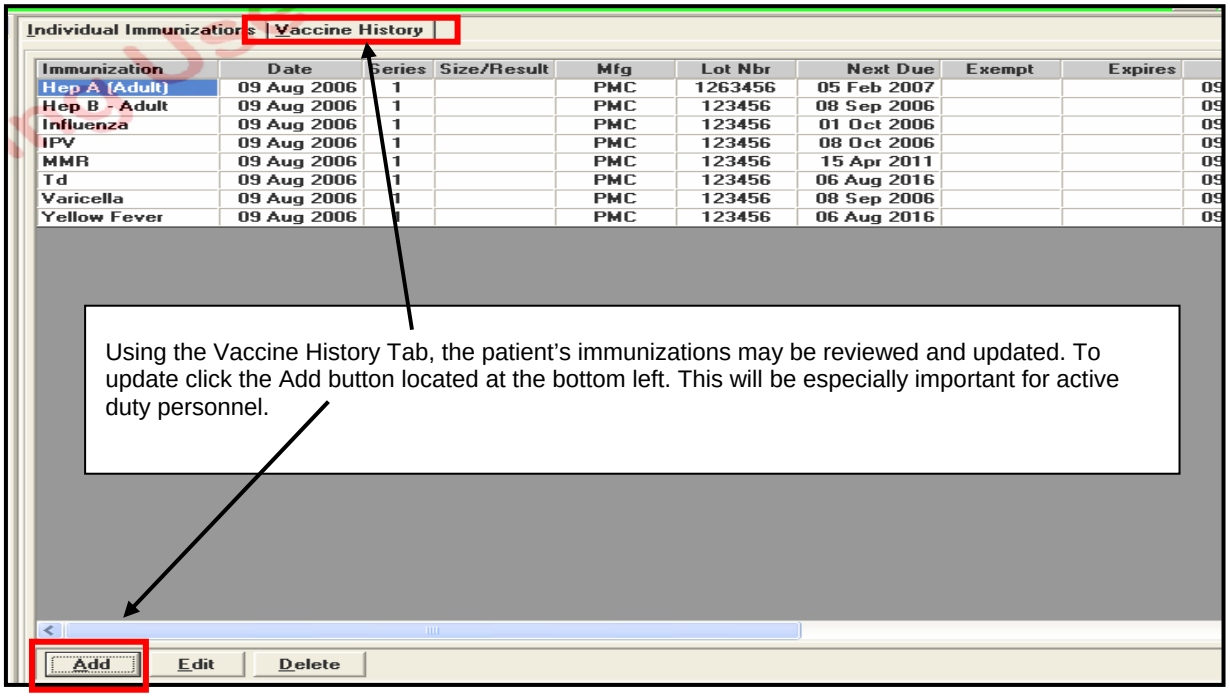
3. Actions

   a. Refresh Autocite

   b. Per clinic SOP and depending on available time, take action to update issues listed in the reminders.

   c. Autocite the Annual Questionnaire into current encounter.

   d. Document all immunizations in AHLTA, including those on active duty. Only document active duty immunizations in MEDPROS if the patient is at an SRP site. MEDPROS use for immunizations will be discontinued when the CDR/MEDPROS bidirectional interface is active.



4. Future State:

   a. Patients will update information in their AHLTA problem list using TRICARE Online (TOL). The staff will verify the information and it will be placed into AHLTA. (Part of HAMTD project – Funded)

   b. The aCPG tool will provide patient-, disease- and clinic-specific reminders. This will also include automatic retrieval and display of defined test data in the encounter note. (Scheduled for AHLTA Build 843)

   c. Vitals signs captured by screening staff will automatically feed the coding calculator so that the screener or providers does not have to click these buttons in the MEDCIN encounter. (Build 843)

   d. Screening and vital signs modules will be merged into a single module. (Build 843)

      i. Allows for all entry from one module

      ii. Includes use of the AIM Form as above

      iii. Permits clinic-specific templates or other AIM Forms to be surfaced for clinic-specific questions.

Provider

1. Reviews information entered by staff.

   a. Assumes control of the S/O note started by staff using the "EDIT—NO-YES" steps and edits initial information entered by staff if needed.

   b. Addresses pain and compliance issues, as appropriate, in encounter note

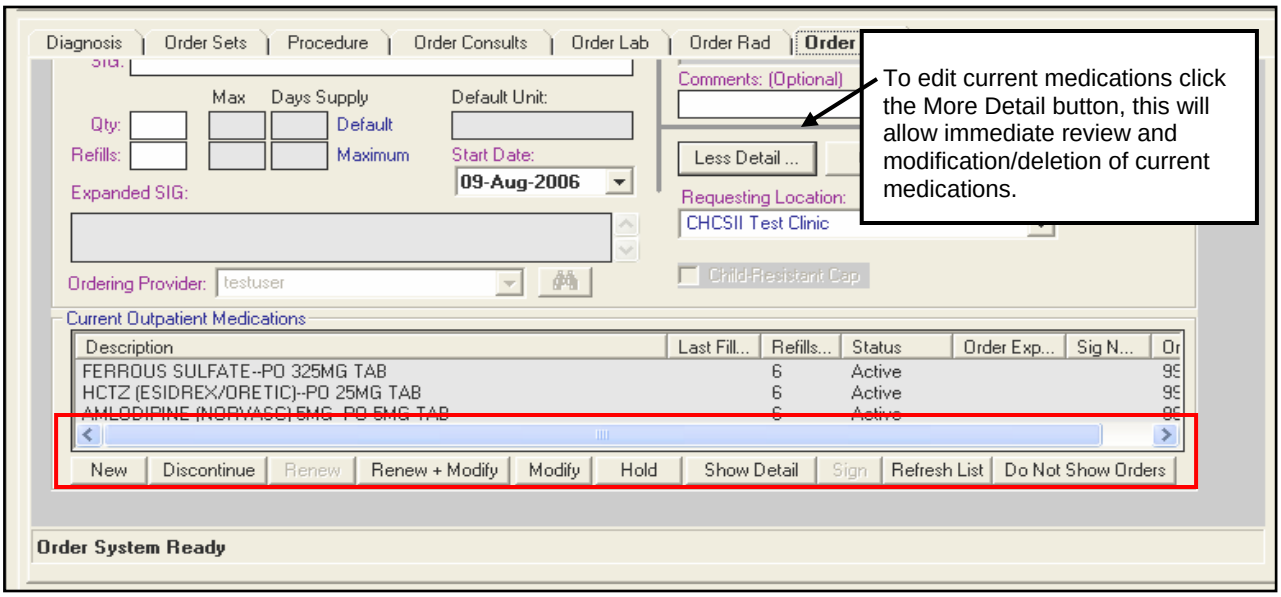
2. S/O—Completes S/O using personal preference for template or AIM form, etc

3. A/P Module

a. Diagnosis

i. Adds current diagnosis

ii. Makes inactive or deletes items on problem list as appropriate



b. Medications

i. Enters modifications to any medication that the person is currently taking, to include modifying current prescriptions and deleting/making inactive medications that are no longer needed or duplicates.

ii. Adds any additional OTC medications that are discovered or adjusts items entered by staff via the medication module.

iii. Wellness Reminders—Signs or addresses wellness reminders as appropriate.

iv. History—Updates/modifies as appropriate

4. Readiness Module (when mapped)

a. Review items

b. Documents

i. PHA Date completed (Date of that exam)

ii. Deployability status—on that date

c. Use AHLTA profile module as appropriate

5. Signing—Signing Notes indicates review and concurrence with team-entered documentation.

6. Future State:

iv. Vital signs will no longer have to be clicked in template or AIM form. The patient status as an established or new appointment will also be automatically determined. (Part of Coding automation enhancements — Build 844)

v. The provider will be automatically signed into CHCS and the CDR so that module changes will be faster at the point they open a patient's encounter. (Part of Performance Enhancement — Build 844).

Section III—Metrics and Monitoring

Although this process may seem daunting and time consuming, the time associated with its use will decrease for everyone as its use across the AMEDD increases and the baseline documentation level increases. The time needed to document will decrease when only changes to previous visit history are required to be documented and as the skills of those performing documentation improves. There will also be reduced work as all sites are supporting each other. The providers' documentation time should decrease as the supporting healthcare team completes more of the documentation. Central monitoring and reporting will remove the reporting and tracking workload burden from the MTFs, allowing personnel re-allocation to support direct patient care. Finally, additional metrics targeting additional outcomes for improvement will be added in stepwise fashion.

Metrics

1. Percent of patients with the following reviewed and updated at each visit (metric by MTF and clinic)
    a. Problem List
    b. Family History
    c. Surgical History
    d. Medication (medication reconciliation)
2. Percent of patient visits that had the annual questionnaires reviewed within the last twelve months.
3. Percent of patients that had Pain Scale documented at each visit.
4. Outcomes (My MTF)
    a. Mammogram compliance (HEDIS)
    b. Pap smear compliance (HEDIS)
    c. Diabetic Care — Hemoglobin AIC ordered appropriately
    d. Pneumococcal Vaccination Rate (over age 65 seen in primary care clinic)
    e. Readiness

Section IV—Policy Review

The AMEDD AHLTA Program Office will work to review and link related AHLTA policies to this guidance. This will aid in developing a systematic approach to improving outcomes, tools, and processes from enterprise feedback. This includes the ability to capture, and centrally monitor/report the data as appropriate.

Local policies should also be reviewed to determine if changes are warranted to improve efficiency and reduce unnecessary work. Duplicate information entry and tracking should be avoided.

Section V—Outcome Prioritization

To avoid overwhelming the healthcare system in “catching up” on outcomes as the new processes are put into place, activation of reminders and monitoring of outcomes will be prioritized. The initial outcomes have been prioritized based upon current regulations and documented evidence of health outcome improvements. Further prioritization will be defined by AMEDD leadership as part of upcoming Healthcare Outcome Improvement Summits.

Pleas refer to the following documents for additional information:

Attachment 1 — 838 User Manual

Attachment 2— Provider Manual

Attachment 3— Nursing Manual

Attachment 4— BPR Document

Attachment 5 — Best Practices/ FAQ

Attachment 6 — Immunizations

Attachment 7 — Wellness Reminders: Set-up and use recommendations