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
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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.
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.
What is the right mix of visits and Care STEPs?
Care STEP$s 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

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<th>Care STEP</th>
<th>Location</th>
<th>Who</th>
<th>When</th>
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<td><strong>Manual Entry under Touches Tab</strong></td>
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| 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!

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<th>Touch Category</th>
<th>Examples</th>
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<tr>
<td>Transportation Assistance</td>
<td>Transportation to medical appointment, social services appointment, assistance navigating public transportation</td>
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<tr>
<td>Social Determinants of Health Screening</td>
<td>Completing PRAPARE tool</td>
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<tr>
<td>Case Management</td>
<td>Case Manager for: Complex Care, Diabetes, Transitional Care Management</td>
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<tr>
<td>Accessing Community Resource/Service</td>
<td>Finding resources: Food, Housing, Legal Services, Immigration paperwork.</td>
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<tr>
<td>Gaps in Care Outreach</td>
<td>Speak to patient/family about gaps in care and support patient in closing the gaps.</td>
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<td>Education Provided in Group Setting</td>
<td>Living Well Class/Tomando Control</td>
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<td>Support Group Participant</td>
<td>Group Participants: Chronic Pain, Diabetes Support, Centering Pregnancy, Centering Parenting</td>
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<td>Exercise Class Participant</td>
<td>Yoga, Zumba, etc.</td>
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<tr>
<td>Health Education Supportive Counseling</td>
<td>Teach patient how decreasing BMI can decrease risk for chronic diseases like hypertension or diabetes.</td>
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<td>Coordinating Care Clinical F/U &amp; Transitions in Care Setting</td>
<td>ED outreach calls, referral to Hospice, notification that patient was transitioning to or from a care facility, emergency room or hospital admissions follow-up.</td>
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<td>Coordinating Care Dental</td>
<td>Scheduling a well child visit for dental sealant. Schedule a Diabetic with dental appointment.</td>
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<tr>
<td>Warm Hand-Off, Non-Billable</td>
<td>Asking a Clinical Pharmacist, BHP, and Dietitian to come into appointment with provider.</td>
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<tr>
<td>Behavioral or Mental Health Screening</td>
<td>Doing PHQ 9, GAD 7, SBIRT/CRAFFT and speak to patient about result.</td>
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<td>Online Portal Engagement</td>
<td>Talk to patient about MyChart and help patient to sign up. MyChart encounters.</td>
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<tr>
<td>Health and Wellness Call</td>
<td>Speak to patient about lab result, i.e. cholesterol result, reason for statin, Med S/E, Recheck and prevention of CAD</td>
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<td>Home Visits, Non-Billable</td>
<td>CHW doing home visit to assess patient SDH</td>
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<td>Home Visits, Billable</td>
<td>Provider doing home visit on a home bound patient.</td>
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<td>Advanced Technology Interactions</td>
<td>Telemetry visits.</td>
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Care STEPs Data Analytics
Visits and Care STEPs – per 100 patients
Engagement Profiles Breakdown

- Visit, Care STEP: 61%
- Visit, No Care STEP: 22%
- No Visit, Care STEP: 12%
- No Visit, No Care STEP: 5%

Legend:
- Visit, Care STEP
- Visit, No Care STEP
- No Visit, Care STEP
- No Visit, No Care STEP
Care STEPs per 100 patients – by Site

CareSteps per 100 patient - by Site

- Health_and_Wellness_Call
- Behavioral_or_Mental_Health_Screening
- Education provided, group setting
- Coordinating Care: Clinical Follow-up and Transitions
- Accessing community resource/service
- Online_Portal_Engagement
- Health Education Supportive Counseling

VG BEAVERTON | VG CORNELIUS | VG HILLSBORO | VG NEWBERG | VG YAMHILL COUNTY | VGYC EVANS STREET
Top 5 Visit Utilizers - Care STEPs Breakdown

- UDS_VISIT
- TELEPHONE_ENC
- MYCHART_ENC
- HOME_CARE_VISIT_ENC
- TELEMEDICINE_ENC

- Accessing community resource/service
- Coordinating care information management
- Health Education Supportive Counseling
- Support group participant

- Education provided: group setting
- Exercise class participant
- Home visits, non-billable
- Transportation assistance
- Flowsheet
- Panel management outreach
- Warm hand-off, non-billable

- Case Management
- Coordinating Care: Clinical Follow-up and Transitions
- Coordinating care dental
- Dental
- Dental
- Dental

Statistics:
- 19 visits
- 16 visits
- 16 visits
- 15 visits
- 15 visits
No Visits - Highest Care STEPs

- MTGroup
- Case_Management
- Education provided: group setting
- HOME_CARE_VISIT_ENC
- TELEMEDICINE_ENC
- TELEPHONE_ENC
- Coordinating Care: Clinical Follow-up and Transitions
- Coordinating care dental
- Exercise class participant
- Flowsheet
- Home visits, non-billable
- Panel management outreach
- Transportation assistance
- Warm hand-off, non-billable
- Accessing community resource/service
- Coordinating care information management
- Health Education Supportive Counseling
- Support group participant
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

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<td><strong>Access Goals:</strong> Use the Care STEPs categories to develop one new mode of access/service delivery.</td>
<td>Evaluate patient engagement or satisfaction with new modes of access/service delivery.</td>
<td>Use Care STEPs categories to create one new patient-driven mode of access/service delivery for target populations identified through the PHE quadrant.</td>
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Care STEPs Design Canvas Activity

**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
Set up 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 ongoing use