

# EMBED POINT-OF-CARE TOOLS



Clinical decision support tools are embedded in workflow to ensure that all members of the care team are aware of the patient's status on diabetes management and preventive measures, even if the current visit is for an unrelated problem. Protocols assist the care team in addressing patient needs.

The main purpose of clinical decision support (CDS) is to provide clinicians and patients timely health information to best inform clinical decisions at the point of care.

Most clinicians aim to practice evidence-based medicine, yet many are challenged in remembering the specific care recommendations that might apply to an individual patient. For this reason, CDS tools can alert clinicians to patient-specific care needs, providing customizable order sets, easy access to disease guidelines, reminders for chronic or preventive care, safety alerts, patient-specific treatment recommendations, or even advanced predictive analytics that assess a patient's risk of high-cost complications.

The best point-of-care tools provide valuable information beyond rules and alerts. First-generation diabetes point-of-care tools in outpatient settings, for instance, focused on prompts and reminders which improved test ordering but did not track intermediate outcomes of care such as glucose, blood pressure, or lipid levels. More sophisticated diabetes point-of-care tools use EMR data to provide patient-specific advice on medication use based on previous treatment, distance from goal, and evidence-based algorithms. These tools also organize clinical data in a thoughtful manner that facilitates decision-making.

## TIPS TO IMPROVE THE VALUE AND USE OF POINT-OF-CARE TOOLS

- Convene a core group dedicated to point-of-care tools. This team will review the content of the tools up front, review the guidelines as a group, and then decide together how to implement them.
- Focus practice resources and tools on care processes that will have the greatest population impact to avoid risk of alert fatigue.
- Ensure point-of-care tools align with organizational practice guidelines to avoid confusion.
- Create workflows that allow team members to manage certain alerts by practicing to the “top of their license.” (Caution: States have different guidelines on what registered nurses, licensed practical nurses, or medical assistants can do with standing orders versus direct physician orders.)
- Aim to reduce “clicks” by consolidating all information into a single-screen display.
- Consider incorporating these tools in patient-provider communications, such as patient portals, shared decision-making aids, or after-visit summaries.
- Remember that tools must save time for providers and be perceived as valuable in increasing the quality of care.
- Make certain that data is timely and accurate and creates a feedback process to improve data quality. False positives and negatives will undermine provider confidence and therefore reduce the effectiveness of these tools.
- Create a process to assess the usage and effectiveness of the tools.

# TOOL: DIABETES REVIEW LIST PROTOCOL

PREMIER MEDICAL ASSOCIATES, P.C.

## DIABETES REVIEW LIST

1. **Verify if patient has an active problem of diabetes.**
2. **Verify if patient has co-morbid conditions and transition the diabetes if needed.**
  - a. **Renal disease**-add or transition to **E11.29** (diabetes mellitus with chronic kidney disease)
  - b. **Retinal disease**-add or transition to **E11.39** (diabetes mellitus with ophthalmic manifestations)
  - c. **Neuropathy**- add or transition to **E11.40** (diabetes mellitus with neurologic manifestations)
  - d. **PVD**-add or transition to **E11.59** (diabetes mellitus with peripheral circulatory disorder)
  - e. **HTN**-add or transition to **E11.69** (diabetes mellitus associated with complication)
  - f. **Is patient on insulin?**- add **Z79.4** (current use of insulin)
3. **Verify when patient was last seen and if future appointment is scheduled.**
  - a. If overdue for appt (DM appt every 3 months), call patient to schedule.
4. **Verify if retinal eye exam done in past year.**
  - a. If done, verify result was data pointed. (attach eye report if the results needs data pointed)
  - b. If positive for retinopathy, add E11.39 to problem list if not already done.
  - c. Order retinal eye exam if not already done
  - d. Add eye doctor/facility to the patient care team
  - e. If retinal eye exam not done, call patient to set up
5. **Verify HgbA1c done within past 3 months.**
  - a. If not done, verify if order placed. Place order if not already done.
  - b. Call patient to set up
6. **Verify micro albumin done within past 12 months.**
  - a. If not done, verify order placed. Place order if not already done.
  - b. Call patient to set up
7. **Any patient refusals send a task to the site's nurse navigator.**

# TOOL: DIABETES MEDICATION REFILL AND VISIT FREQUENCY GUIDELINES

MERITER-UNITYPOINT HEALTH



## Diabetes Update – 2015

### MMG Diabetes Medication Refill and Visit Frequency Guidelines

Care Team actions: During most patient contacts and for chart prep, review the following

- ✓ Review most recent A1c
- ✓ Verify that meds are filled and check medication response/tolerance
- ✓ Check standing/future lab orders and create standing orders as needed (A1c, LDL, serum creatinine, urine micro-albumin) if needed
- ✓ Reinforce home glucose monitoring if patient is monitoring
- ✓ Assure next visit is scheduled

Last A1c	Refills	Visit frequency	Additional Care Team Actions
1. New medication regardless of A1c	60 days max	Office visit within 30 days	<ul style="list-style-type: none"> <li>• Contact every 2 weeks via phone or MyChart</li> </ul>
2. Last A1c >6 months ago	30 day refill	Office visit within 30 days	
3. A1c typically less than 7	6 month refill	Every 6 months	<ul style="list-style-type: none"> <li>• Screen for hypoglycemia</li> </ul>
4. A1c 7.0 to 7.9	3 month refill	Every 3 months	
5. A1c 8 - 9	3 month refill	Every 3 months	<ul style="list-style-type: none"> <li>• If A1c <math>\geq</math> 8 for 6 months pend order to DCT and/or pharmacists</li> </ul>
6. A1c >9	1-3 month refill based on compliance, comorbidities, home blood glucose monitoring	Visits every 6 weeks	<ul style="list-style-type: none"> <li>• Contact every 2 weeks via phone or MyChart</li> <li>• Monitor blood glucose checks via MyChart or phone outreach</li> <li>• Pend order to DCT</li> </ul>

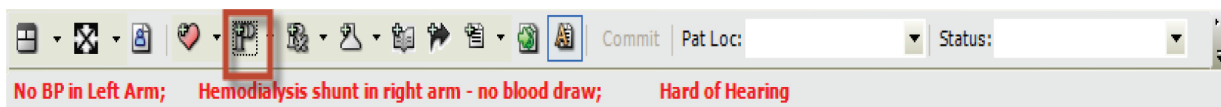
A1c Control Goal

#### List of useful DM related smart phrases (type "Diabetes" to view full list)

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• <i>Lastdiabetes3ref</i> (last 3 diabetes lab results)</li> <li>• <i>Medrfdm</i> (last office visit DM labs/refill info)</li> </ul> | <ul style="list-style-type: none"> <li>• <i>Diabeticteach</i> (review DM teaching book/ glucometer)</li> <li>• <i>DM foot exam</i></li> </ul> |
|---|---|

## Accessing Diabetes CareGuides

- Within your note, click the “Problem” icon on the “Clinical Toolbar”



- Highlight any “Diabetes” diagnoses (if you click the icon that looks like a note, you are “assessing” it, if you just want to access the CareGuide, highlight the words) on the left in the “Active Problems” list, then click the “CareGuide: CHC Diabetes....” button on the menu bar at the bottom.

# Accessing Diabetes CareGuides

The screenshot displays a medical software interface with a tabbed menu at the top: Problems, Meds, Allergies, Orders, Results. The 'Problems' tab is active, showing a list of 'Active Problems' under the 'My Priority' filter. The list includes:

Name	ICD-9	ICD-10	Managed By
<b>Health Maintenance/Risks</b>			
Health Maintenance	V70.0	Z00.00	
<b>Other Problems</b>			
Diabetes mellitus	250.00	E11.9	
Urinary tract infection	599.0	N39.0	
Vitamin d deficiency	268.9	E55.9	

At the bottom of the interface, there is a navigation bar with buttons: New, My Priority, Refine, Convert, and CareGuide: CHC Diabetes Mellitus, Type 2, Adult. A red arrow points to the 'CareGuide' button.

# Diabetes CareGuide

		Name
		<input type="checkbox"/> Quality Metric Orderables (corresponding metric is not satisfied until order is...)
		HGB A1C
		LC001453 Hemoglobin A1c
		LC221010 Lipid Panel w/ Total Chol 221010
		LC303756 Lipid Panel
		Microalbumin (Lab)
		<input type="checkbox"/> Quality Metric Screens, Follow-Up Plans and Counseling
		*QM - Depression Screen, Result and Follow-Up Plan
		*QM - BMI Follow-Up Plan
		*QM - BP Screen and Follow-Up Plan
		*QM - Depression Result and Follow-Up Plan (for Patient Point Screens)
		*QM - Fall Risk Screen
		*QM - Tobacco Cessation Counseling
		<input type="checkbox"/> Quality Metric Resultables (Please obtain hard copy for outside results)
		*QM - A1C Last Done
		*QM - Diabetic Eye Exam Last Done
		*QM - Diabetic Foot Exam Last Done
		*QM - LDL Last Done
		*QM - Microalbumin Last Done
		<input type="checkbox"/> Quality Metric Deferrals
		*QM - Deferrals / Exclusions (for vaccine deferrals, also defer in QBM window)
		<input type="checkbox"/> Immunizations
		Hepatitis B
		Influenza
		Pneumo (Pneumovax)
		<input type="checkbox"/> Follow-ups and Referrals
		<input type="checkbox"/> Referrals
		Ophthalmology Consult
		Podiatry (Foot/Ankle) Consult

# TOOL: CLINICAL QUALITY SOLUTION

PREMIER MEDICAL ASSOCIATES, P.C.

**Patient Dashboard**

View:

- > Care Actions
- > Health Goals
- > Appointments
- > Populations

▼ Care Actions
Sort by: Importance ▲ ▼

⚠ DM	Eye exam near due	03/30/2015	🔍
⚠ DM	Urine albumin screening near due	04/08/2015	🔍
⚠ DM	Lipid panel near due	04/08/2015	🔍
✅ DM	Foot exam up-to-date	10/14/2015	🔍
✅ DM	HbA1c up-to-date	6%, 10/14/2015	🔍
✅ Prev	Flu immunization given within current flu season	10/14/2015	🔍
✅ Prev	Pneumonia vaccination given after age 50	10/17/2015	🔍
✅ Prev	Pneumonia vaccination given after age 65	10/17/2015	🔍
✅ Prev	Tdap/Td vaccination up-to-date	04/24/2015	🔍
✅ Prev	Zoster vaccination administered after age 50	10/27/2015	🔍

▼ Health Goals
Sort by: Importance ▲ ▼

⚠ Prev	BP: S≥ 120 and < 140 and/or D ≥ 80 and < 90	129 / 68 mmHg, 10/14/2015	🔍
⚠ Risk	Some chronic conditions	Disease RAF: 0.368	🔍
✅ DM	HbA1c < 7	6%, 10/14/2015	🔍

▼ Appointments
▲ ▼

Next appointment of type PE 20

▼ Populations
▲ ▼

- ⊕ "Chronic Kidney Disease"
- ⊕ "Hypertension"
- ⊕ "Diabetes"
- ⊕ "Nephropathy"

- ✅ Good
- ⚠ Warning
- 🔴 Attention Needed
- 🔍 Missing Data
- 🚫 Exclusion
- 🔄 In Progress

# TOOL: HEALTH MAINTENANCE

THEDACARE PHYSICIANS



## Best Practice Alerts/Health Maintenance

Best Practice is an alert that gives information on what a patient needs due to:

- A diagnosis (e.g. diabetes)
- Age related immunization or procedure (e.g. mammogram at intervals)

Health Maintenance (HM) is a preventative health tracking system and means of tracking the status of the best practice alerts. Health maintenance items may be satisfied at a ThedaCare site or at external clinics which is "abstracted" into the patient's chart.

### View Patient's Health Maintenance (HM)

- 1 Go To patient's **Snapshot** activity

Health Maintenance	Late	Due	Soon	Hold
DIABETES-ANNUAL EYE EXAM		3/19/1936		
DIABETES-6 MONTH HGBA1 C		3/19/1936		
DIABETES-ANNUAL CREATININE		3/19/1936		
DIABETES-ANNUAL NEPHROPATHY CHECK		3/19/1936		
ADULT TETANUS		3/19/1951		

Or

Patient Header

Ambulatory, Pri\* E # Pref name (None) DOE: Sex Allergies(03/23/10) PCF **FM DUE** INS FISERV CCHC\* MyChart Inactive Acv Dr No Scan

Or

Health Maintenance activity

Health Maintenance

Topic	Date
DIABETES-ANNUAL EYE EXAM	
CREATININE YEARLY	
DIABETES-ANNUAL CREATININE	
HGBA1C EVERY 3MO	<a href="#">4/23/2004</a>
DIABETES-ANNUAL LIPID PANEL	<a href="#">4/23/2004</a>
DIABETES-ANNUAL NEPHROPATHY CHECK	<a href="#">4/23/2004</a>
MAMMOGRAM 50-75	1/6/2006 (Done)
PAP AGE 23 - 64	1/6/2006 (Done)
COLONOSCOPY 2 YR SCREENING	<a href="#">4/17/2007</a>
FLU SHOT	1/18/2007
ADULT TETANUS	7/20/2005

**Due Dates are in Date Order**

Click blue links to see results or scanned document that satisfied the modifier

**Legend**

- Overdue
- Due On
- Due Soon
- Postponed

**Override Type Abbreviations**

Done	Done
(N/S)	Reason not specified
Declined (inactive)	Declined
Postponed (inactive)	Postponed
Prv Comp (inactive)	Previously completed



Or

**Click Visit Navigator – Best Practice Alerts**

Chief Complaint ▾ ▶ **BestPractice Alerts**

Allergies ▾

Verify Rx Benefits ▾

Reconcile Dispens... ▾

Disclaimer ▾

Medications ▾

Vitals ▾

History ▾

**BestPractice ▾**

- ▼ DT immunization is due before 15 years of age.
- ▼ Diabetic annual eye exam is due. Use Hlth maintenance override to record if already done.
- ▼ A more specific code is needed for billing. Please enter a more specific diagnosis code.
- ▼ A 3 month ALT LEVEL is due  
Last GPT: Not on file
- ▼ Patients >70 years old should have an ABI (for Vascular Pilot doctors only).

**Health Maintenance** – Document that the alerts were satisfied. The patient had these done at either a Thedacare facility or an external clinic.



Health maintenance items will be marked "satisfied" automatically when done at a Thedacare site.

1 GoTo **Health Maintenance** activity (see step 1 above)

2 Click the appropriate procedure that was satisfied at an external clinic.

**Health Maintenance**

Override Remove Override Edit Modifiers Report Update HM

Due Date	Topic	Date
10/15/1977	ADULT TETANUS	
10/15/2002	MAMMOGRAM 40-49	
10/15/2011	PAP AGE 23 - 64	10/15/2009

3 Click **[Override]**

4 Fill in the Date completed, type **Done**, add Comment (e.g. Name of clinic, provider, and results). Click **[Accept]**.

**Override Topic - ADULT TETANUS**

Date: 9/7/2009 Type: Done

Comment: \_\_\_\_\_

**Accept** Cancel

5 The health maintenance plan is satisfied.

|09/07/2019 |ADULT TETANUS

|09/07/2009-Done

### Add Patient Modifiers

Some patient modifiers are automatically applied for a patient, for example, immunizations or PAP. You may add or remove a patient from the health maintenance plan. For example, a patient is diabetic and the diabetic modifier is added to the patient's chart.

1 GoTo **Health Maintenance** activity

2 Click **Edit Modifiers** button



3 The Health Maintenance Modifiers screen appears. Click the spyglass on a blank row to see available modifiers.



4 Double click the modifier. Click **[Accept]** to add it to the patient's health maintenance list.

### View/Print Patient's Health Maintenance Report

1 From the Health Maintenance activity, click **[Report]**



2 The Health Maintenance Report displays. Click **[Close]** to close the report.

Health Maintenance

← Back

**You can also print the report**

#### Health Maintenance Report

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#### Health Maintenance Summary

PNEUMOVAX IMM	Overdue	3/19/2001	
COLONOSCOPY( EVERY 10 YEARS) ONCE OVER 50	Overdue	3/19/1986	
ADULT TETANUS	Overdue	3/19/1951	
DIABETES-ANNUAL EYE EXAM	Overdue	3/19/1936	
DIABETES-6 MONTH HGBA1C	Overdue	3/19/1936	
DIABETES-ANNUAL CREATININE	Overdue	3/19/1936	
DIABETES-ANNUAL NEPHROPATHY CHECK	Overdue	3/19/1936	
FLU SHOT	Next Due	10/1/2010	
DIABETES-ANNUAL LIPID PANEL	Next Due	9/3/2010	
	Done	9/3/2009	<a href="#">LIPID PANEL</a>
	Done	1/6/2009	<a href="#">LIPID PANEL</a>

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#### Health Maintenance Modifiers

Diabetic

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#### Patient Information

##### Patient Demographics

Address  Phone

Close