Objectives

- Recognize how failure in tracking processes may result in a potential bad outcome for a patient
- Review strategies for tracking:
  - Diagnostic tests
  - Hospital admissions and ED visits
  - Referrals
- Identify ways to use the EHR for tracking and reporting
- Review scenarios that can cause breakdowns in tracking and communication
Tracking is like a relay race…

- Decide upon the order of the handoffs
- Make sure that everyone knows what to do
- Make sure you constantly look to check to see when the handoff is coming
- Make sure the handoff is effective
- Know what to do if something unfortunate happens to quickly get back on track

Using your EHR as a tool for tracking

- Understand reporting
- Understand EHR terms to avoid confusion
- Know where the data on the report is coming from
- Validate the data
- Do NOT underestimate the impact of an upgrade
Why should you continue to focus on tracking?

- Deliver high quality patient care
- Improve patient communication
- Use EHR technology to monitor and report
- Attain external recognition (patient centered medical home [PCMH], meaningful use [MU])
- Avoid malpractice claims

Two of the most important reasons to keep on tracking....

- Weak spots in tracking systems can lead to tragic yet often avoidable patient outcomes
- Lost, missing, or erroneous diagnostic test results can alter both diagnosis and treatment
EHR technology is here to stay....

- In 2012, **72%** of office-based physicians used electronic medical record or electronic health record (EMR/EHR) systems, up from 48% in 2009.
- About 40% of office-based physicians reported having a system that met the criteria for a basic system, up from 22% in 2009.

EHRs and Health Centers

- About 90% of federally qualified health centers have implemented EHRs in at least one of their sites.

Source: HRSA

http://www.cdc.gov/nchs/data/databriefs/db111.pdf
NCQA Patient Centered Medical Home (PCMH) Standard 5: Track Care

Three key areas to track

- Hospital Admissions and ED Visits
- Diagnostic Studies
- Outside Referrals and Specialty Consults

PCMH 2011 Content and Scoring
Tracking: Hospital Admissions and Emergency Room Visits

Strategies to track and follow up with ED visits and hospital discharges

- Communicate key contact information
- Share after-hours notification plan
- Monitor incoming faxes and emails
- Build follow up slots into your appointment templates for post-ED or post-discharge visits
- Engage the patient
Additional tracking strategies if you are using an EHR

► Does the hospital have a provider portal to be able to log in to view or download test results?
► Is it possible to interface between the hospital and your EHR?
  ► Lab tests
  ► Radiology reports
  ► Newborn records
  ► ED records
  ► Consults
► Develop a test result review and scan policy.

Lessons learned: ED follow up

Concussion

12 year old d/c from ED. Asked to f/u with PCP the following day. Called and did not get an appt for three days. Mom did not sound like it was urgent. Pt had a slow bleed and ended up back in ED.
Lessons learned: weekend discharges

Newborn weekend discharge
Newborn with high bilirubin d/c on a Friday night. Mom was told to call the office to have baby seen on Saturday in PCP office. Pt not given an appt until Monday at 10 AM- Bilirubin was 21 resulting in an admission.

Lessons learned: diagnostic study results reported after patient discharge

Test results to PCP office AFTER patient d/c
Results of an x-ray faxed over to the PCP office after patient had been discharged from the ED. PCP thought hospital was going to call patient; PCP thought ED doc was going to call patient. Neither called the patient.
Lessons learned

- Figure out the best way to obtain records and documentation
- Do not rely on the patient’s word for testing that was done
- Have a system in place to communicate back and forth during off hours and weekends
- Have direct numbers to the newborn nursery and the emergency department
- Two sides to every story….patient is often not always as forthcoming or communicative as you might like

Start a new log each week
- Use this log to enter into the EHR if it can’t be done real time.
- Assign a person to follow up on this list and document the results of the follow up
Start a new log every month

Use this log to track receipt of the baby's records from the hospital [lab work, newborn hearing screening, Hep B]

### Tracking: Diagnostic Studies
### Tracking: diagnostic studies

- Track all ordered diagnostic studies
- Assign specific staff members to monitor the test tracking logs
- Periodically audit results to be sure that the providers have reviewed and initialed them
- Inform patients of all test results (including normal results)
- Document patient notification in the chart
- Document patient decisions not to undergo recommended tests and that patients have been informed of the risks

### Elements to include in a diagnostic test tracking policy

- Every test (including normal results) must be communicated to patients
- Specify time frame targets for communicating each type of result [critical, abnormal and normal]
- Need fail-safe contingency plans included [what if’s]
- The need for follow up is stressed and who is accountable
- Non-compliance is addressed
- Everything is documented
Lessons learned

► Document that patient was called with the result
  ■ “Mom called and notified” or “left vm” – not good enough. Need a bit more detail– which result was called?

► Beware of PENDING or PARTIAL lab results
  ■ Duplication of effort by providers
  ■ When seeing the same result over and over, providers can become insensitive to abnormal findings
  ■ Assumptions made as to who is to call and notify the patient or family

Lessons learned

► Watch for system failures
  ■ No labs coming over for x period of time means that there is a problem
  ■ Have a back up plan if your labs are not ‘coming over’ into the EHR properly

► Learn the reporting features of your EHR
  ■ Take a look at the tracking features in the EHR
  ■ Run reports and double-check them against manual logs to ensure their accuracy
  ■ Use reports and patient recaller systems from the EHR to make tracking more efficient
Lessons learned

- Watch the back log of scanning. Scanning backlogs can cause items to be missing from the record at the time of the patient visit.
- Sort lab results and scan the FINAL only—prevents several versions of the same information being scanned in multiple times.
- Track down missing or incomplete information!

- Ask for weekly scanning status reports
- Set up a ‘priority’ basket for items to be scanned first
- Monitor report to see if additional resources need to be given to scanning to get caught up
Tracking: Outside Referrals and Specialist Consults

Tracking systems: referral tracking

- Educate providers about the need to track referrals
- Set up a centralized communication system (or use the EHR) to input referrals, but if you input them, track them!
- Follow up with patients after 30-60 days from the date the referral was made if results or consult letter have not been received. Use the EHR or a manual log to track this data
- Notify the provider who made the referral if the patient has chosen NOT to follow through with the referral
Tracking Systems: Referral Tracking

► Ask specialists to contact the health center if a patient misses a referral appointment
► Ask the patients when they come in for a visit if they have ‘self-referred’ to any outside specialists
► Call the specialist office to obtain reports if the patient reports having gone for the visit but there is no available documentation
► DOCUMENT all follow up on referral activity including a patient or parent refusing to go to the appointment

Elements for a referral tracking policy

► Every referral is input into the tracking log (paper or electronic)
► Specify time frame targets for each type of referral (urgent, routine, and patient requested)
► Need fail-safe contingency plans included (what if’s)
► Parameters for referral follow up are specifically outlined as well as who is accountable.
► Patient non-compliance in following through with the referral is addressed
► Everything is documented
Lessons learned

- **Monitor availability and access to specialist appointments**
  - Tell patient to let you know if he or she can’t get an appointment within 30 days
  - Make sure you know which specialists take Medicaid

- **Educate the providers on how to manage (and document) non-compliant patients**
  - Patient refuses to go to the appointment or family member refuses to take them
  - Essential vs. Non-Essential Referrals

Lessons learned

- **Use those referral providers who respond to your patients’ needs** and communicate back to you in a timely manner

- **Communicate your standards to the referring providers:** We need to have this patient seen and information back to us within 30 days
Tracking: High-Risk or Chronic Patients

In addition to tracking individual diagnostic tests and referrals, sometimes you may need to set up a tracking system for identified high risk patients.

Who qualifies?
- Patients with a lot of medical issues or chronic disease
- Patients who are typical but have an event (car accident or trauma) that requires intensive follow up for a period of time
- Patients who have many different problems (including behavioral health issues) that require monitoring
- Set up guidelines for reviewing chronic patients monthly or quarterly
- Use a standard form to review services, medications and therapies
- Set up separate care plans for different types of clinical issues: diabetes, asthma, premature infant
How to Use the EHR for Tracking: Lessons Learned

### Summary

- In today’s environment tracking diagnostic studies is not optional
- Look at systems to avoid redundancies and rework
- Clearly outline who is supposed to do what (by job title not specific person)
- Have back up systems if staff or equipment is not functioning properly
- Do not be overwhelmed—break the process up into small components to foster the success experience

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**PCMH 3B: Identify High-Risk Patients**

The practice does the following to identify high-risk patients:

1. Establishes criteria and a process to identify high-risk or complex patients
2. Determines the percentage of high-risk patients in the population

Note: A sample of high risk patients will be used in the medical record reviews for 3C, 3D, and 4A.

**Documentation:**

- Process to identify patients
- Report showing number and percentage of high-risk patients
Additional Questions?
clinical_RM_program@ecri.org
610-825-6000, ext. 5200
More info at:
www.ecri.org/clinical_RM_program
Thank You!
Referral Tracking Log

**Week Ending:**

Flag for ED, Rad and Dx Tests = 5 days
Flag for all other consults/referrals = 30 days

<table>
<thead>
<tr>
<th>#</th>
<th>Patient Last Name</th>
<th>Patient First Name</th>
<th>DOB</th>
<th>Date of Visit</th>
<th>Referring Provider or SELF referral [See Key Below]</th>
<th>Type of Referral [see Key Below]</th>
<th>Flag Date for F/U</th>
<th>F/U actions Taken</th>
<th>Report Rec'd and Scanned (Y/N)</th>
<th>Initials</th>
<th>Additional information (diagnosis, X-ray, dx test, or symptoms)</th>
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Referral Key:

- ENT
- Ortho
- Derm
- Ophthal
- Allergy
- Pulm
- Beh Health
- X-Ray (remember what type)

Provider Key:

- JS = John Smith
- SJ = Susie Jones
- AM = Al Most
<table>
<thead>
<tr>
<th>Med Rec ID(s)</th>
<th>Last Name</th>
<th>First Name(s)</th>
<th>DOB</th>
<th>PLEASE USE THE KEY BELOW</th>
<th>Did our doctors round on the patient? (Y/N)</th>
<th>Hospital Records Scanned into EHR? (Y/N)</th>
<th>Attending OB</th>
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<td>Newborn Delivery: MC = Medical Center</td>
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Revision: 10/2012
SCANNING STATUS REPORT

Week of ______________________________________

Scanning Guidelines:
- All items received in the practice should be scanned into the correct patient record within two working days of receipt in the office.
- All medication/prescriptions need to be scanned into the patient record immediately.
- All piles should be worked from the ‘bottom up’ so the oldest ones are completed first.

<table>
<thead>
<tr>
<th>Item</th>
<th>Oldest Date of Item waiting to be scanned</th>
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<tbody>
<tr>
<td>Priority Basket</td>
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<tr>
<td>What is the date of the oldest item in the priority basket?</td>
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<td>Oldest Date of Patient Registration forms</td>
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<td>Approx how many Vaccine (Shot) records are there to scan?</td>
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<td>Oldest date of outside letters from other physicians</td>
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<td>Oldest date of Lab Results (non Quest)</td>
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<td>Other:</td>
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Are there any other issues that administration should be made aware of related to scanning?

Signature of Person Completing Scanning Status Report: ______________________________

Date:________________
# Care Plan Oversight Review

**Name:** ________________________  **Date Completed:** __/__/__

DOB __/__/__  **Chart #** ____________

**Ins:** _______  **ID#** ______________

2nd **Ins** _______  **ID#** ______________

Requires Pre-cert/auth  □ Yes  □ No

**Medicaid #** __________________

**Patient Address/Phone**

______________________________

______________________________

**Emergency Contact/Telephone:**

______________________________

**Medical Home Address/Phone**

**PCP** _________________________

**Care Coordinator**

**Fax#**

**Contact** _____________________  **Phone** ___________

**ICD-9**  **Diagnosis**

______________________________  

______________________________

______________________________

**Allergies:** ______________________

______________________________

**Pharmacy:** ______________________

**Tel No:** ______________________

**DME Supplier:** ______________________

**Tel No:** ______________________  **Fax #:** ______________________

**I use:** ______________________  ______________________  ______________________  ______________________

**Medication/Special Formula**  **Dose**  **Time**  **Route**  **Ordered by/date**  **D/C’d**

<table>
<thead>
<tr>
<th>Medication/Special Formula</th>
<th>Dose</th>
<th>Time</th>
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<th>Ordered by/date</th>
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**Lead Service Coordinator** ________________________  **Agency** ______________________

**Name:** ________________________  **DOB:** ______________________

**Provider MD’s/Therapists**  **Service**  **Freq**  **Address**  **Telephone**  **Fax**

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<th>Provider MD’s/Therapists</th>
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Current Needs and Plan of Care:

| Staff Signature/Title: ______________________________ | Date:__/__/__ |
| PCP Signature: ____________________________________ | Date:__/__/__ |

I give my permission to share the information on the care plan with all of my child’s provider’s except: _____________________________________________________

| Parent/Caregiver Signature: ______________________ | Date:__/__/__ |

Date sent to providers: ______________________________ by ______________

**Medical Necessity Letter Requested?**  Yes  No  
**Date:**

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