BEACON’s Pursuit of Excellence
With MU of EHR
For Safety-Based Quality Improvement
through
Assessment and Enhancement
of the Workflow
in Primary Care settings

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Content of these Sessions

- MU: Background and Context
- Burden of Health Care Quality Gap
- Costs and their relationship with Quality
- Primary Care with MU of EHR: Attention to Workflow (WF) and Transitions

We will have a Break

- Systems Approach to How of WF Assessment and Redesign:
  * Traditional Approach
  * Singh's Approach

We will have a Break again!!

- Aids for WF assessment and improvement
- Systemic Factors and Culture that Impact WF Related Quality

- Trainers’ Pack
Background

Context
Meaningful Use

- Quality reporting
- Clinical Decision Support
- Improving care coordination
  - Engaging patients
  - Managing Population Health
- ...
The mission of the Western New York Beacon Community is to improve clinical outcomes and patient safety through the use of health information technology and health information exchange, focusing on improving overall Diabetes care management across all levels of care.

OUTCOME Measures: Quality  Cost  Public Health
Safe
Timely
Effective
Efficient
Equitable
Patient centred.
Safety is a fundamental system property.

Without safety there can be no quality of care. IOM
Unite Nations’ WHO is working towards declaring Patient Safety a Basic HUMAN RIGHT and has setup a World Alliance For Patient Safety
Formidable and Compelling Pressures:

Federal Government
Institute of Medicine (IOM)
Professional Bodies
Accreditation Authorities

If we do not heed they will make errors "expensive for us" "NEVER EVENTS"
In year 2000 Inst. Of Medicine was seeking 50% reduction in errors by 2005 !!!!!!!

Progress so far has been only modest and highly variable!
Morbidity and mortality as a result of drug-related problems in the ambulatory settings may cost more than $200 Billion/yr.

Up to 200,000 avoidable Deaths per year in outpatient Settings.

Srasfield in JAMA 2000.
The National Burden of Systemic Errors in the Health Care

Morbidity and mortality as a result of drug-related problems in ambulatory settings may cost more than $200 Billion/yr.

And then there are other adverse Events!!

Up to 200,000 avoidable Deaths per year in outpatient Settings. Srasfield in JAMA 2000.
Hazard Comparisons (rough) (AHRQ)

Lives Lost per year

Encounters (opportunities) for Each Fatality

Dangerous: More than 1 in a thousand (At the battle front)

Very Safe: Less than 1 in 10,000 thousand

Health Care

Bungee Jumping

Chartered Flights

Driving

Nuclear Power

After AHRQ
# International Rankings and National Health Expenditure (Through Patient’s Lens)

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Jan. 2008
Commonwealth Fund Report
Raises a question: are we that effective?
“Amenable mortality - deaths from certain causes before age 75 that are potentially preventable with timely and effective health care”
Money vs. Health.

Better health

Less state spending

Worse health

More state spending

Individual U.S. states

88

83

82

81

80

79

78

77

76

75

74

73

$4,000

$6,000

$8,000

Congressional Budget Office Head, Peter Orszag: Times Nov 08

Our Goal
Let us look at Cost Picture
Payers of $2.6 trillion US HC Costs

- Public Funds:
  - Medicare
  - Medicaid
  - Other (45%)
- Consumer:
  - Out of pocket
  - Private (19%)
- Employer-Provided Insurance (36%)

©G.Singh 2009/10/11
The chasm between what is done and what can be done is about 50%.

30 - 40% of the huge Health Budget is wasted.

35% of $2.6 trillion Health Budget >> $800 Billion/yr!
Take Home:

We must create and ride a health machine that will “change the world”

We want a “Toyota of Health Care”

We can all play a role in making this a reality
Why the ‘Machine’ of Primary Care First?
Importance of PC in the Ecology of Medical Care

1000 people

800 have symptoms

327 consider seeking medical care

217 visit a physician's office (113 visit primary care physician's office)

65 visit Cent. Alt. Med. provider

21 visit a hospital OPD

14 receive home health care

13 visit an emergency department

8 in a hospital

<1 in an academic health center

NEJM 2000, Green et al

G.Singh 2009/10/11
Our Mission is to Help Practices Shed Old Habits and Acquire Smarter ones that Add Value through MU
Meaningful Use

- Quality reporting
- Clinical Decision Support
- Improving care coordination
  - Engaging patients
  - Managing Population Health

EHR Technology

H Info. Exchange

Quality Improvement

Diabetes

Practice Redesign-WF
Our Main Challenges

1. About 30% of all EHR implementations fail.

2. There appears to be no evidence that EHRs alone improve quality or cost.

3. Regional Extension Centers are MU clearinghouse and assistance hub for Elig.Pys. and Hosp.
Introduction of an EHR in a Primary Care can have expected and unexpected / unintended patient safety/quality consequences
Caution Unintended Consequences

e.g. :
• “alert fatigue” due to numerous flags
• overestimation of EHR functionality
• lower productivity
• computer intrudes as a “third person”
• decreased practitioner performance
• clinician dissatisfaction
A Real Setting Example: Influence of EMR - Before & After

Average of TOP FIVE Hazards

Vulnerabilities

12 Domains of Practice

© SAR Singh
In Light of the Foregoing:
BEACON Synergy Model
has identified TWO critical gaps that need to be bridged with

1. Support for workflow/ work process re-design with EHR implementation because:
   • workflow is often cited as the No. 1 “pain point” by providers.
   • EHR is 1 part technical and 2 parts culture and work process changes.

2. Improve transitions/continuity of care- to come later!
Likely Benefits WF Design to Primary Care Practices include

- A more systematic approach to diagnosis and treatment in general.
- Increased effectiveness of teamwork and communication.
- Adapting and extending the structured tools used in the Diabetes study to the care of other patients with this chronic disease.
- Greater feelings of professional self-worth, combined with increased community recognition of the practice.
- Added opportunity and support for practice staff to move into new roles or learn new skills.
- Increased understanding of research and its benefits.
- Increased Reliability/Quality through Consistency
What is Workflow or Work process?

It certainly must be PATIENT centered and is 4-Dimensional
• Advance towards MU
• EHR implementation presents opportunity to design new and better workflows
• Opportunity to review patterns of work that may never have been examined before!!!
Why / Objectives: SPECIFIC

• **Comfort** - Assuring that work stations are adjustable and suited to the task, whether sitting, standing, spending hours at the computer or on the phone

• **Efficiency** - Locating work teams in convenient proximity, placing equipment near workers who use it most

• **Communication** - Organizing each department for the most effective means of communicating internally and externally with co-workers and customers

• **Productivity** - Maintaining a logical flow throughout the office ( = $$$$!!!)

• **Effectiveness** - Establishing clear goals and objectives for the work environment

• **Safety of Patients and Staff**

• **Patient and Staff Satisfaction**

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Who that makes the Change worthwhile and satisfying

TEAMWORK with Accountable Champion/Leader
Diagnose the main barriers to fulfilling the chosen MU

“Requirements”
What is TEAM Work in Our Context?:

General

• It is Not about the Top Management Making Decisions
• It is Not Debating
• It is Not about Negotiating or Bargaining

• It is about Discussing
What is TEAM Work in Our context? : Discussing

Doing “DODAR”

Diagnose

Review

Consider Options

Assign tasks

Decide

Take advantage of your gap analysis

Do not forget to appoint a ‘steward’ and set a time table
What is TEAM / Group Decision Making in Our Context?

3 Ingredients are Essential:

Open mind  receive ideas from everywhere
Common sense
Courage
TEAM Empowered Discussion
That Leads to ‘Ownership’
Here are some tips:

• Furnish preparation material/aids in advance of meeting
• Appoint “Task Master”/ Steward / accountable leader
• Orient and inspire/motivate the team
• Clarify the purpose of the meeting
  a. Assess current WF?
  or b. Redesign Better WF?

• Use Flip chart / Board
• Restrain the verbose and encourage the shy
• Distinguish facts from opinions
• Distinguish creative thinking and criticism
• Make decisions – not too soon and not too ‘late’
• Record decisions and get commitment
• Thank every one
• ACT
Where

Transitions
When

As and When
Remember Synergy!
The Quality-Conscious Worker: Understands the **system** in which s/he works:

* Entities in the system
* Interactions between entities
* Her/ his role in the system
* Threats of & Opportunities for errors
Example of a Machine/System
Purpose: to get water out of the well
Within the overall system, there are Micro-Systems:
- Battery, Motor, etc.
Two Key Steps in Systems Approach Involve:

**ANALYSIS:** Clear Identification of all the Processes and entities involved, and the domains in which they exist.

**SYNTHESIS:** Clear Identification/establishment, for each domain, of the all the interactions or desired interactions between the processes and entities, and expression of these in a systems model.
ANALYSIS: Clear Identification of all the Processes and entities involved, and the domains in which they exist.

Processes:
1. Assessment of the patient
2. Formulation of plan of management
3. Implementation of the plan
4. Feedback regarding the patient’s progress, results of investigations and interventions, etc
5. Review and learn (adaptive evolution of the complex system)
ANALYSIS: Clear Identification of all the Processes and entities involved, and the domains in which they exist.

Entities:

1. Patents, Families, Friends and Communities
2. Health System Workers
3. Leadership and Teams
4. Non-human entities such as equipment, supplies, charts, electronic medical records, etc
ANALYSIS: Clear Identification of all the Processes and entities involved, and the domains in which they exist.

Domains:
1. Home/Community
2. Office/Clinic
3. Emergency Room
4. In-patient
5. Regulatory Authorities
SYNTHESIS: Clear Identification/establishment, for each domain, of all the interactions or desired interactions between the processes and entities, and expression of these in a systems model.

The resulting model is better and greater than the sum of the individual parts.

In this example there are two levels of modeling:

1. Overall level = ‘Macro-model’
2. Detail level = ‘Micro-model’ (various)
   a. Influence Diagram
   b. Precedence Diagram
Micro-System of Primary Care
Functions of Modeling:

**Accelerate progress to MU**
Furnish a common and shared vision for formation of leaders and teams - including patients
Enhance learning and memory, identify problems, their understanding and solutions
Education of patients, e.g. every patient has the whole history of interventions/encounters recorded on her/his war and battle plans. Will help reduce patient-attributable errors
Interdisciplinary education
Provide a platform for simulation-based training
Creation of visual data base - enhancing EMR - EHR
Powerful means of dissemination of tailored information
Let us look at Some examples
Coffee Making Workflow Example
!!Location is Fictitious!!
Living Life

Life is not a race, but indeed a journey.
Be genuine, work hard, be choosy.
Say “thank you,” “I love you,” and “great job” each day.
Go to church, take care of your faith.
The Lord gives and the Lord takes.
Let your hands give more than you take.
Love your life and what you do.
Do it with passion, with purpose, and do it as best you can.
Lack of planning does not make plans a matter.
It allows you to drop the things which you aspire to be.
Laugh at the little things in life and
love the small things in life.
Almost all of the best things really are small.

From the soul. Take that.
Plan for tomorrow. Remember
you’ve been blessed.
A Simple Example of Patient Flow
Coming to Work
In the Morning
example
Steps

- List all the activities (A) you can think of (say total of x activities)
- Let us pick one of them, say activity $A_n$ (out of 1 to x)
- **We must ask three questions about this activity**
  1. Which activity/ies must precede $A_n$? Immediately
  2. Which activity/ies must follow $A_n$? Immediately
  3. Which activity/ies can take place simultaneously with $A_n$?
Let us Do it!!
As a learning Exercise
Now let us look at Testing Process examples

Testing Plays Very Important Role in Diabetes Management

(15-50% of all PC errors can be associated with testing mismanagement)
System for ordering labs and obtaining results

Does anyone have any experience with this kind of system?

R and G Singh
REDESIGNED System for ordering labs and obtaining results

Note: Fewer steps – less opportunity for error
- more efficient

Redundancy – backup in place for critical components
Here are Aids to Workflow Assessment and Redesign
Examples of widely used Esoteric Icons

There are a number commercial software packages!!
Let us have another 15 min. a break!

Next Session Will be Hands-on: Literally!

with 3+2 aids
First Step when you arrive in an office is to assess current Workflow practices
MOTIVE behind design of aids in team members’ hand

With Awareness of
Aid to Workflow Assessment and Redesign

Open Office
- Unlock Doors
- Turn on Lights, TV (in waiting room)
- Set up Computers
- ………

Information Input
- Appointment Schedule
  - (a) Existing Patient
  - (b) New Patient
- Patient Demographics
  - Insurance
  - Address
- ………

Patient History
- Prepare New Patient Info.
  - Paper
  - Electronic
- Scan Paper Charts
  - New – especially Old
- ………

Check-in
- Record Patient Arrival
- Verify Personal Information
- Escort Patient to Exam Room/Area
- Prepare Patient
  - a. Weigh and record
  - b. Measure BP and record
  - c. Expose relevant area of Patient
- ………

Review Encounter
- Prepare Follow-up Plan and Order
  - e.g. make appointment for patient
- ………

Provider
- Review Patient Data:
  - a. Vital Signs
  - b. Allergies
  - c. Medications
  - d. Immunization/s
  - e. Personal Habits Including: Smoking, Alcohol, Drugs
- Diagnose:
  - (a) Acute
  - (b) Chronic
- Documentation 'Encounter':
  - 1. Patient Complaint/Problem
  - 2. Examination Finding/s
  - 3. Medication
  - 4. Allergies
  - 5. Vital Signs
- Create Order and Plan;
  - Including Referrals and Testing
- ………

In-bound Telephones and E-mails
- Review Encounter
- Prepare Follow-up Plan and Order
  - e.g. make appointment for patient
- ………

Input
- ………

Follow-up and Check out by Staff
- Check Order
- Collect Specimen/s if Required
- Give paper Order to Patient
- Check Status/Track Test and Results
- Receive Results:
  - (a) In House Resource
  - (b) External Resource
- ………

Receive Documents IN from Other Settings
- Seek Clarification When Required
- Edit Information Received
- Record Information Received
- ………

Transition of Patient OUT
- Manage Data Transfer:
  - Paper to Electronic or E to E or E to P
- Document Reconciliation:
  - (a) Incorrect Patient
  - (b) Incorrect Doctor
  - (c) Incorrect Encounter
- ………

Administration and Billing
- Payroll
- Scheduling of Staff Duties
- Assignment
- Procuring Office Supplies
- Procuring Educational Materials
- Organize Regular Meeting
- Maintenance
- Liaison/PR
- Manage Receivable and Payables
- Send Bills: Paper and Electronic
- ………

Designed to Reduce Cognitive Biases

TRIAGE Calls (when)
- Appointment Request
- Refill Request
- Appointment Request
- Request for Test Res.
- Billing Questions
- ………

IDEN
- Log A
- Info
- Make
- ………

Internal/External
- Transcriptions
- Scanning Correspondence
- Credentialing of Staff
- Furnishing and Maintaining Patient Kiosk in Waiting Room
- Conduct Patient Satisfaction Survey, Analyze, and Disseminate
- ………

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Likely Process-Candidates for Workflow Assessment and Redesign for VALUE ENHANCEMENT

1. Scheduling Appointments
3. Patient Check-in
4. Insurance Eligibility Check
5. Patient Flow through the Office
6. Chart Structure and Flow through the Office
7. Provider Report Dictation and Transcription
8. Patient Check-out
9. Pharmacy Prescriptions and Refills
10. Test Ordering and Tracking
11. Referrals to Specialists and Appointments
12. Patient Telephone Access
13. Patient Telephone Message/s
14. Office Layout
15. Staffing
16. Patient Billing Structure and Process
Why / Objectives: GENERAL

• Advance towards MU

• EHR implementation presents opportunity to design new and better workflows

• Opportunity to review patterns of work that may never have been examined before!!!
Why / Objectives: SPECIFIC

• Comfort - Assuring that work stations are adjustable and suited to the task, whether sitting, standing, spending hours at the computer or on the phone

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• Communication - Organizing each department for the most effective means of communicating internally and externally with co-workers and customers

• Productivity - Maintaining a logical flow throughout the office ( = $$$$!!!)

• Effectiveness - Establishing clear goals and objectives for the work environment

• Safety of Patients and Staff

• Patient and Staff Satisfaction
Second Step when you arrive in an office is to enhance Workflow practices To help STEEEP climb!
You Must be Aware of Systemic Factors that can Impact WF Related Quality of Care
Systemic Factors that can Impact Quality of Care

1. Complexity of the process of care
2. Variability from patient to patient
3. Inconsistency in the standards of care
4. Poor interfacing (e.g. transition between settings)
5. Lack of error-preventing barriers
6. Lack of initiative to handle the unforeseen
7. Use of inappropriate time constraints
8. Use of hierarchical culture in the system
9. Human fallibility – *to Err is Human*
1. Complexity of the process of care:

- Many systems in healthcare are highly complex.
- They evolved over time in a fragmented way.
- They are typically not designed with safety in mind.
- The systems in general consist of serial and parallel sub-systems.
1. Complexity of the process of care:

**Serial Sub-system:**

The longer the chain the lower is the likelihood of success.
1. Complexity of the process of care

Parallel Sub-system:

With single process link: success rate of 95% (Assumed)

With 2 parallel processes: Success rate = 99.75%
With 3 parallel processes: Success rate = 99.99%
1. Complexity of the process of care: What can we do to overcome this problem?

a) Simplify:
   Every effort should be made to simplify the system by decreasing the number of links.

b) Introduce Redundancy:
   At the most critical points, parallel sub-systems should be introduced to provide redundancy.
2. Variability from patient to patient: Patients are highly variable individuals and need treatment that accommodates this individuality.

Examples are co-morbidity, preferences and family circumstances.
3. Inconsistency in the standards of care:
The success of a process improves when it is carried out frequently, consistently and is standardized.

Protocols, clinical pathways, etc. can help.

In achieving standardization, the patient’s individual needs should not be sacrificed.
4. Poor interfacing (coupling) in the process:

‘Coupling’ between the health care processes can be ‘tight or ‘loose’. In a tight process the steps follow one another so closely that a variation (e.g. error) in the output of one step cannot be recognized and responded to before the next step is underway. This next step may not have been designed to handle this error and therefore may itself fail, causing a cascading effect leading to an adverse event.
5. Lack of error-preventing barriers:

It is virtually impossible to design and operate a 100% safe system. The challenge is to prevent errors from propagating and leading to adverse events.

Checks and redundancies should be designed and coupled into the processes of the system to provide barriers to protect patients and health care workers.
6. Lack of initiative to handle the unforeseen:

Unforeseen circumstances will arise even in a smoothly operating system. In such circumstances, rigid rules may fail to achieve satisfactory outcomes. Individual judgment and initiative are superior. Individuals should therefore be granted autonomy and the ability to use their own initiative and be inventive when necessary in these unusual situations.
Systemic Factors that can Impact Quality of Care

7. Use of inappropriate time constraints:

Poor staffing and the tendency to prioritize productivity over safety are serious causes of quality problems.
8. Inappropriate use of Hierarchy:
Use of Hierarchical structure in a team/group creates a less reliable system in any industry. “Captain is always right; don’t question the captain’ attitude is a recipe for failure.

Effective multidisciplinary teamwork based on communication, mutual respect, collaboration and trust can make large improvements in safety and quality.
Recognizing the Relative Importance of Five Strategies for Improvement in Patient Safety
Recognizing the Relative Importance of Five Strategies for Improvement in Patient Safety

Punitive action directed against individuals
Counseling and retraining Staff and Pt.
Process Redesign
Technical and Technological System Enhancement
Cultural Changes
1. Punitive action directed against individuals: Not only least likely to succeed but is most likely to be counter productive. It demoralizes work environment and thus undermining quality. **Culture of blame has to be replaced with culture of safety.**

Lack of awareness of the extent of error frequency is the main obstacle to improvements.

This lack persists because the vast majority of errors are not reported. To err is human but failure to create a culture of acknowledging errors and learning from and correcting them is folly.

Typically only 5% of known errors are reported and many are unknown.

Non-punitive environment encourages reporting and learning to improve
2. Counseling and retraining Staff and Pt.:

Most workers are adequately trained to perform their job tasks – retraining is not generally the solution.

However, there is scope to train people to be more safety conscious and work better in teams.

Licensing and accreditation bodies and professional societies are making efforts to enhance safety through training.

Training has to encourage non-hierarchical team working, reporting and learning from errors, and safety problem solving.

Training through team simulation is very effective and gaining popularity.
3. Process Redesign:
The primary care process has to be seen as a sub-system composed of all the entities (animate and inanimate) and all the interactions/links in space and time, for achieving a common objective.

Human errors are generally caused by system failures.

A poorly designed process has latent errors that are difficult for humans working in the system to see since they may be hidden, e.g. computers, layers of management, poor space layout and hand-offs.

They are poorly interfaced/coupled with lack of checks, redundancies and barriers to errors. These present opportunities for improvements in safety.
4. Technical and Technological:

This includes, apart from information technology, drugs, equipment and procedures.

Judicious use of technology compliments and supplements human abilities, enhancing performance and reducing errors.

Use of IT from the point of care to medication administration; providing prompt and reliable diagnostics, helping identify appropriate treatment, monitoring, drug design, etc.

Human judgement is still superior to electronic, electrical and mechanical machines when dealing with unexpected contingencies but the latter improve process consistency and enhance compilation and processing of information.

A technologically based system is free from the vagaries of human emotion and fallibility of human memory.
We must Understand the Value of Climate-based Quality
Adopt Systems (Holistic) Approach: Address fragmentation and decentralization to capture and understand *complexity* of the system, to create a shared Common vision
Example of a Machine/System

Purpose: to get water out of the well

Within the overall system, there are Micro-Systems:
- Battery, Motor, etc.
Manifestation of Safety Climate: Expressing itself in *Measurable* Attitudes and Perceptions

Framework of Interactive Contributors to the Construct of Culture of Patient Safety: Manifesting as Safety Climate, which Expresses itself (partly) in *Measurable* Attitudes and Perceptions with Numerous Cybernetic loops with the Culture.
5. Cultural Changes:
The core objective is to shift from a culture of blaming individuals to the creation of safe Systems. Involves creating, sustaining and continually enhancing a harmonious conglomeration of attitudes in the whole system of care that establish safety as the overriding priority in health care. In this culture, safety is the overtly expressed personal concern of every individual and group, starting from the patient to the leadership of the health care organization. Collaboration, trust, respect, tolerance of human limitations and empathy are key components of the attributes called for.
Meaningful Use

• Quality reporting
• Clinical Decision Support
  • Improving care coordination
    • Engaging patients
    • Managing Population Health

EHR Technology

H Info. Exchange

Quality Improvement

Practice Redesign-WF
Definition of MU

1. Electronic Health Record [Certified] use
2. Exchange of health information electronically
3. Quality reporting

Must meet 15 core requirements + 5 from menu of 10
Core Set of Requirements

1. Use computerized order entry for medication orders.
2. Implement drug-drug, drug-allergy checks.
3. Generate and transmit permissible prescriptions electronically.
4. Record demographics.
5. Maintain an up-to-date problem list of current and active diagnoses.
6. Maintain active medication list.
7. Maintain active medication allergy list.
8. Record and chart changes in vital signs.
9. Record smoking status for patients 13 years old or older.
10. Implement one clinical decision support rule.
11. Report ambulatory quality measures to CMS or the States.
12. Provide patients with an electronic copy of their health information upon request.
13. Provide clinical summaries to patients for each office visit.
14. Capability to exchange key clinical information electronically among providers and patient authorized entities.
15. Protect electronic health information (privacy & security)
5 Additional Requirements from ‘menu’

1. Implement drug-formulary checks.
2. Incorporate clinical lab-test results into certified EHR as structured data.
3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.
4. Send reminders to patients per patient preference for preventive/follow-up care
5. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)
6. Use certified EHR to identify patient-specific education resources and provide to patient if appropriate.
7. Perform medication reconciliation as relevant
8. Provide summary care record for transitions in care or referrals.
9. Capability to submit electronic data to immunization registries and actual submission.
10. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission.
Trainers will be equipped with:

1. Orientation Power Point Presentation

2. 220 magnetic icons of 40 diff. designs

3. Dry erase magnetic board (3’x2’)

4. 6 sheets of aid to perception and WF assessment and improvement

* Awareness of categories of usually missing info.
* Aid to reducing cognitive and emotive biases
* Likely candidates for WF assessment and Improv.

* Consider including last three slides

Additional set of equipment to be presented to the Office
Categories of missing clinical information during primary care visits

- Lab results: 45%
- Letters/dictation: 39.5%
- Radiology results: 28.2%
- History and physical exam: 26.8%
- Current and prior medications: 23.3%
- Pathology results: 15%
- Immunization records: 12.3%
- Procedures: 7.3%
Likely Process-Candidates for Workflow Assessment and Redesign for VALUE ENHANCEMENT

1. Scheduling Appointments
2. Scheduling of Patients for Physicians
3. Patient Check-in
4. Insurance Eligibility Check
5. Patient Flow through the Office
6. Chart Structure and Flow through the Office
7. Provider Report Dictation and Transcription
8. Patient Check-out
9. Pharmacy Prescriptions and Refills
10. Exam Results and Tracking of Testing
11. Referrals to Specialists and Appointments
12. Patient Telephone Access
13. Patient Telephone Message/s
14. Office Layout
15. Staffing
16. Patient Billing Structure and Process