WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Electronic Health Records (EHR) Session #1
Community of Practice

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MODERATOR: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the electronic health records session number one, community of practice webinar. This webinar is brought to you by the Partnerships for Care, HIV Training Technical Assistance and Collaboration Center, or HIV TAC. The Partnerships for Care project is a three year multi agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project are to, one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training Technical Assistance and Collaboration Center. or HIV TAC. Our presenters today come from the Massachusetts League of Community Health Centers and our speaker today is Heather Budd. Miss Budd is passionate about clinical delivery transformation using data as a foundation for trust and measuring driving improvement.

Heather works at Azara Health Care which offers the business intelligence software DRVS, a scalable web-based data warehouse, reporting, and analytics solution for community health centers. Prior to that, she was the chief operating officer and director of quality at a community health center in Rhode Island. She led a care team transformation project which achieved NCQA PCMH level 3 and partnered with a Medicaid payer to blend claims and clinical data. Miss Budd was a health IT consultant and also started her career at Dana Farber Cancer Institute, where she developed her love for quality improvement and learned firsthand about care delivery and patient satisfaction. Please join me in welcoming Miss Budd.

HEATHER BUDD: Thank you so much, Steven, for that very nice introduction. And hello, everybody. We are really excited to be here today to speak with you about this very interesting topic that I think is still, there's a lot to learn. So as Steven said, we're very interested in hearing from you as the health centers that went through this. And I know there are other participants on the line, as well as health departments, et cetera. So any perspective is welcome.

And I'm going to skip over this as well, because Steven already reviewed the background for Partnerships for Care. And we're going to start talking about general data quality principles. And I just want to initiate by saying, listen I'm sure there are many of you who really understand this already. I'm going to go through this particular section relatively quickly, but it's really an intention to get everybody on the same page so that we can speak about the HIV specific material all from the same perspective.

This slide is really about bringing the quality chasm that can be present when there are gaps between these three different areas of care. The systems is the first thing that I'll talk about. And that's really your IT team, and sometimes your HR specialists who set up and maintain systems, and try to standardize key workflows, and are engaged in continue with quality improvements of staff. They're trying to make sure that the data is getting collected in a specific way, and that's because they have specific goals of trying to make sure that data is being collected in a uniform manner so that it's useful for both care delivery, but also outcomes and results for reporting.

Then there's the care delivery team that you see in a center who are the people actually documenting care. And the idea here is for them to be documenting in such a way that actually reflects the quality of care that's been delivered. Hopefully they're following those standards as well as offering feedback to the systems team so that there's a continuous conversation that's happening between the two so that data collection systems are always improving. And then hopefully they're using data at the point of care for actual care coordination and quality improvement as well.

And then finally, moving toward the more leadership aspect of things, thinking about results. And this is where we're looking for improved patient outcomes. So the triple aim, better quality, experience, and of course lowering costs. But also the importance of getting accurate data, and ideally the most credit for the patient care that's being delivered by an organization.

So one of the big points that I always like to make-- and any of you who happen to have been through an implementation with the Azara drive team will recognize this slide-- I like to emphasize the fact that none of this work is really just an IT project. IT, of course, is absolutely critical to the success. They help us set up EHRs and continue to make them work for us. But in order for there to really be good success in terms of collecting good data and then reporting good results, you really have to have all these different team members being involved.

So I'm not going to read through all this right now-- I think you guys can probably get this yourselves-- but the importance of quality, provider representation, clinical support as much as possible. Front line staff participation as well. All those things are ideal so that we can make sure we're getting a full perspective on what's happening.

So I'm going to walk you through the idea that the data elements that we collect are essentially the building blocks of measure. So all measures are broken down into a denominator and a numerator. And if we think of the denominator, often for measures we think about some of the

demographics associated with the patients, a name, medical record number, gender, date of birth. And then thinking about some of the diagnoses or assessments that are part of their record. So Perhaps they have a diagnosis of HIV, if we think about this particular area.

And then finally, qualifying encounters. So having had a visit or an encounter within the reporting time period then makes them part of the group of patients that we would be considering for the measure. And then when we think about the numerator component of the equation, it's usually some sort of screening, some sort of care or process that we want to make sure we're delivering for the patient, counseling, or a procedure.

So this is just kind of a funny slide, but the idea here is that your data elements that you're collecting over time serve you for many, many measures. So it's not that you just collect something and it only works for one measure. And so my metaphor for this is that it's very similar to social media.

So if you happen to post a silly picture on social media somewhere, these days the way that everything is so connected it can show up in many different places. And so it could be on Instagram, and then it goes to Facebook, and shows up in your Google account, and maybe it shows up in your WhatsApp picture, anything on Snapchat. So it's the idea that one data element can work for you in any ways.

So going back to this concept of data elements being the building blocks of measures. So the idea is that missing data elements are like holes in the foundation, right? So in this case, if we were using pretext or comments that the patient is HIV positive, as opposed to entering it into their problem list, it's not something that's going to be easily reportable.

Now if you were doing just a chart audit, of course you would find it that way. But I think one of the biggest lessons learned that so many of the practices that I've worked with through the P for C project is the value of getting data into structured fields and having a home for all those important elements of data for the reporting needs for P for C so that you can use electronic reporting to do the reporting. So then the final thing might be, in terms of the numerator, if you simply free texted that the patient is being prescribed any of these antiretrovirals to help lower their viral load and control their symptoms, rather than again putting it into the med module, it's going to be much harder to find in terms of electronic reporting.

So the best case scenario, of course, is to put it right into the med module. We'll talk a little bit more about medications specific to HIV later and some of the challenges associated. So I just wanted to take another example of cervical cancer screening data elements, because of course paps are a big part of caring for our HIV population as well. The idea here is the name, MRN, gender, DOB, who is the patient and do they meet the AIDS criteria.

And then if we go over to the next bubble for qualifying encounters, does the patient qualify for the measure? Did they have an encounter during this time period? And then finally, does the

patient need a Pap based on not having had one of the past three years, or five years according to UDS measures if they had [AUDIO DISTORTED].

And then so if we look at the cervical cancer screening measures logic at work, you can see that all of those things that we just talked about and focused on collecting serve you for different measure sets. So meaningful UCQMs and cervical cancer screening every three years. The [INAUDIBLE] cancer screenings are also looking for a cancer screening to be done every three years. Although, I think they're actually changing to be more aligned with the way UDS has been collecting it, looking for every three years for women up to age 29 and then every five years for women who are 30 and older, as long as the test is accompanied by an HPV test.

Now those of you who of course are paying attention and realize that the PAL has come out recently for UDS and they're actually switching back to a little bit more conservative measure for this, just because they want to be aligned with meaningful use. And then finally, if you are chose to follow cervical cancer screening for PCMH, you'd be looking for that every three years as well. So the idea again is that the work that you're doing is going to feed multiple different sets of measures.

So then when we think about data quality and how things can fall apart, I have six kind of key areas that I like to focus on. And we'll just walk through each of them. So you've already heard me talk about structured vs unstructured data, and I think most of you are aware of this. But in particular, because this has been such an important lesson learned for the HIV data, I wanted to emphasize this.

Unstructured data examples might be anything that's been dictated into a record, so it's really only stored as voice, or even if it's been transcribed into essentially text or memo fields. Voice recognition typing, free text memo fields, all of those are things that represent unstructured data and are very hard to use later for actual electronic reporting. Structured data are things like radio buttons, lockdown pick-lists where you choose something from the pick-list so that the options are the same every single time. Check boxes, IDs for medications. So it's using a specific code that's been assigned by the federal government for different medications.

And then of course, everybody's very familiar with ICD9s and 10s from this year for diagnosis coding. And then also SNOMED codes fall into that same category. LOINCs are specific identifiers for labs, and then CPT codes for procedures. And the idea is to use a much codified data as possible, so that we can easily capture what's going on for a patient.

So connectivity. Now, this is really only relevant if you happen to be working with a data and reporting warehouse. and data is being sent to this reporting warehouse on some sort of a common basis, whether it be nightly, or monthly, or something like that. Sometimes things will change and connectivity gets cut off.

And so of course, if connectivity is cut off, the vendor that's pulling your data from your system and using it to calculate your performance isn't going to be consistent. And it will therefore not

represent your actual performance. So this is just a reminder to be aware of server migrations, firewall changes, expiring credentials, et cetera, that can sometimes cause these data gaps that you need to be aware of.

Workflow changes. So this is a big one. You know, I always like to say that we have a lot of very smart people, providers and stuff, at health centers and elsewhere who are using EHRs, and so they often think of new ways to record something.

And sometimes those ways are great and they will generate structured data. And other times they aren't really generating structured data and therefore would not be usable for reporting purposes. So it's really important to be out there in the field and aware of what's happening on the ground with your staff and how they're actually reporting and recording data, so that you can continue to get the information that you need. And so this is why it's so helpful to have a culture of communication around this, so that providers and staff feel like it's part of their role to let you know when they've discovered something new so that you can consider it and determine if it does meet your standards.

So this is a complicated looking slide, but what it really represents is that oftentimes when you are working with a lab company, they can unfortunately change results names. At their whim, I'm sure they're not doing it intentionally to hurt our reporting purposes, but they have very good reasons for doing it. They don't always communicate that they've decided to rename an A1c , for example.

They used to call it a glycosylated hemoglobin A1c, and now they've decided to call it a glucose HB A1c. That's something that you need to be aware of, because when you're using the results name to get credit for doing certain tests and getting those results back, you need to actually have the specific test results name. And so that can happen from external labs with an interface. It can happen where the results are coming back on paper and then they get scanned into the system and need to be entered in a particular spot in your records.

And then also in-house. There are times when your in-house IT team may change the way that that's being represented, and it's important to make those changes in your reporting tools, whether they be your in-house reporting tools, or again if you're working with a data reporting warehouse vendor that you let them know that that change has occurred. So EHR and practice management system upgrades are also potential sources for changes in the way that data shows up. And that's again for your own reports or for data reporting warehouse reports.

So it's really important to make sure that if you go through an upgrade, that you're aware of any newly created tables or fields for newly created data elements, thinking about anything custom you might have created. For example, for HIV data reporting or recording so that you can make a great and informed decision about, OK here's some new things that our EHR or practice management vendor has made available to us. And we may have made some customizations in the past in order to accommodate our HIV data recording needs, but now the vendor has actually provided some fields that are part of the standard EHR. So you make a

decision about whether you want to incorporate those into your practice and do you retire some of the custom configurations that you made?

Or do you want to continue the custom content that you created? And so all those things, of course, have an impact on the reporting, whether it be our own reports or your vendor's reports. So there also is this challenge of measure definition changes. And I'm sure all of you are aware of this.

Generally, annual changes to data reporting programs are the norm. And sometimes they can occur more frequently, especially if it's in the early stages of a new area of inquiry. So I think probably many of you are aware that HIV reporting is kind of still growing. And so there may be some small changes to the P4C program as we go along, as we learn more about some of the idiosyncrasies of recording and reporting this data.

So things that I'm always interested in and checking in around is when a new definition comes in, do you have a place in your EHR to document all of the data elements that are required? Do you or your reporting vendor need to update the measure logic to reflect the changes? And then depending on the timing of the change, is a chart audit the only or the best method? So you really want to figure out the cost benefit analysis of those considerations.

So I'm a big fan of basically baking structured data into your EHR's DNA. So it sounds kind of complicated, but essentially the idea is to really make structured data the standard, to avoid this idea of backfilling data later or relying on chart audits. Now, we know for sure that in the P for C program we absolutely had practices who did chart audits, and for very good reason, because many of these data elements that are a part of the P4C measures were not things that you were typically used to recording in the record.

You may have been recording them on spreadsheets. Or they man been recorded in the record, but not in a structured way. The idea is to build the structured data fields for all reported data elements and other common data for care coordination so that you're prepared for the future reporting requirements. And of course, training clinicians and staff to create that structured data early, so that there's a culture of proper use of the EHR so that you have them when you get to the point where you're doing that reporting.

So now we're getting a little bit more into the specifics of structured data for HIV care. So again thinking about the quality programs and how as they expand, particularly around HIV care, the value of structured data has been improving greatly. So whereas in the past it was absolutely possible to kind of capture everything on a spreadsheet and do what you needed to, as the populations are getting greater and the demands for reporting are increasing, the avoidance of these time intensive manual chart reviews, structured data is going to be your best friend.

For me, having a clear home for that patient's specific information really reduces the time that clinicians spend searching for information. So whether it's being very clear about where you want them to record the particular data element that you're talking about, that helps to be

much more likely that they'll do so. And then on the flip side, anyone else who goes over the chart of that patient, whether it be your HIV care coordination staff, et cetera, will be much more likely to be able to find it because there is a specific home for it.

So I like to consider when to have structured data fields. And things that I think about are, do you ask the same question to most patients with the same condition? If that's the case, you probably want a space to keep it. Do the responses to the question follow a set of rules? Numbers you're looking for, dates, positive, negative, et cetera.

So of the results that you'd be looking for, a big one is the kind of patient education that you're giving. And then, do the answers meet clinical standards for the source and the detail. So again, are there units that are involved for particular results and things like that? And so if the answer to these questions is yes, your EHR really should have a place to ask and document the answers to the questions as structured data.

So here we're really going to go through a little exercise where we think about some HIV specific components and whether or not it makes sense to structure the data within the EHR. So the first question is, when did you get diagnosed with HIV? And I really feel like, yes, this is one that does need to be structured. And the reason is the data diagnosis is critical.

So it's important to document a onset date earlier than your intake, for example, if your center did not actually diagnose the patient. So many of you are aware that there's a measure out there that's looking for which patients actually initiated care within your organization. And the best way that we came up with to figure out whether or not you actually diagnosed them was to take the date that the person was entered into the problem list. So their HIV diagnosis was put on the problem list. That sometimes is referred to as the "create date" in data terms.

And if the onset date is actually earlier than that create date, then we assume that perhaps they were screened and their HIV diagnosis was confirmed at a different organization. So that's why it's so important to be very specific about what you're entering when you enter problem list information. There there's this question about what activities increased your risk. So this is another one that makes a lot of sense to have structured.

Exposure risk in the population is very important. We've worked a lot with the AIDS Institute in New York City and on some other reporting programs as well. And the value of having a standardized pick-list here has made all of the difference with many of the practices we've worked with.

Have there been any recent illnesses? If so, what and when? So this one is a maybe, in my opinion. And the reason is that it kind depends on the severity and the relevance of the illness to the patient's HIV care if that illness was really not diagnosed by the organization.

So if an HIV patient had pneumonia recently, then that seems like something that we would absolutely want to know about. But if they just have step throat or-- I'm not clinician, so you'll

have to take my comments a little bit with a grain of salt. But if there's something that's really less severe and less relevant to their care, then it may not make as much sense to make the effort to put it on the problem list.

And then what medications are you currently on? So this one is really essential. And I think everybody's familiar with this. Just the meaningful use medication reconciliation measure that we've all been working on for years at this point, it's so important to understand the full breadth of the medications a patient is on, even if some of those things are over-the-counter medications. So most reporting requires an NDC code, that's the federal designation. And there's also something called RX Norm, which is really drug class categories. So all of your antiretrovirals would fall into specific categories, for example. Or some other method or type of code to identify medications.

Using an EHR's medication module is really the only way to produce these. So you've got to make sure they get into the med module. And then what HIV care have you received outside the facility? So this is trickier to structure. If there are ways to do so, then I think it's a great idea, but it can be very challenging to capture it.

These days, I think there's an emphasis on transmitting care summaries, but most EHRs cannot metabolize or bring in a care summary directly into the record if it's been electronically transmitted from a different care provider. So until we get more to that point, I think we're going to still have to rely on some other methods, or perhaps scanning some of this information into patient documents and looking there.

So we did some thinking about this. And P4C reporting covers a lot of different areas of HIV testing and treatment. And as we broke down the P4C program into three different phases, in order to tackle the challenges that are associated with each of them So we're going to look at screening and diagnosis, the intake itself, and then the ongoing management of the patient.

So we'll start with that screening and diagnosis phase here. So this is the easiest of the three phases to track, because it typically comes down to lab data, meaning HIV test results which is typically structured. And then of course, if you didn't actually diagnose the patient with HIV, you would enter it into the problem list with that earlier onset date, as I mentioned earlier. Whether the center is doing a point of care rapid test or sending out sample structured data really should exist for the lab type, meaning the order, the collection date, and the result date as well as the result itself, positive, negative, unknown. And we are going to spend a little bit more time going into detail about the results themselves, because they have been an area of a lot of complexity, particularly for electronic reporting.

So just speaking about patient intake, there's a lot of opportunity for structured data that is missed here. And there is a screen shot that's here, and it may be a little bit small for you guys, but it will be part of your slides and you can peruse this later. But inadequate structure in data fields result in often important information being stored in spreadsheets, as I've mentioned, that sort of thing. So as much of the critical things that you ask patients at intake really should

be stored in structured data as much as possible. We've already talked about the onset date and the diagnosis date, and really those should live in the problem list.

HIV treatment start date. Now, that can be different if you did not initiate the treatment yourself, right? And I think a lot of practices have different opinions as well on what initiate treatment actually is. So many of you will initiate a phase of doing some baseline resistant testing, figure out which medication a patient should go on, an arguably that's part of the initiation of treatment. Generally speaking, we tend to look at from the date a medication was prescribed, but I'm interested to hear how other people feel about that as well.

About the exposure risk factors, as we mentioned before, how HIV was likely transmitted to the patient. Sexual preference, and then also the importance of sexual orientation and gender identity. So this has been an area of focus for health centers across the nation, because it's very clear that it's going to be required for UDS in calendar year 2016, and it's already part of meaningful use as well. So there's going to be a need to capture this information.

And we recognize that that's not such an easy thing. Who should be doing this at the organization? It's very sensitive information, and we want to make sure we treat the patient's privacy very carefully. And then also how to get the right information. So the difference between a person who was born as a man and now identifies as a woman because she has actually had the surgery to change her gender. But thinking about what scanning still needs to occur for a patient, and so all of those different factors are important.

Sexual preference, of course, may mean that a patient needs some additional testing as well to follow up on the rest of their HIV care. Management of the patient. So managing HIV care in the long term, of course, relies on cross-team coordination. And we've seen that with many of the practices that we've worked with.

So many of you are starting to invest in HIV care managers or coordinators to sort of be the ones that hold a lot of the keys to what's going on with the patients. Having data stored, for example, of labs in the best kind of form that exists. Logical object identifiers, names, and codes, that's what LOINCs stand for. And then medications, again NDC and RX Norm really improved the long term reporting accuracy, but also the ability to manage the patient because now we actually know what they're on in terms of medication. And we know what labs have been done for the patient.

So P4C, the key areas in managing are the labs, for example, CD4, a viral load, baseline resistance, and I'm sure there are more than these. And then medications, whether they be the ARVs or other STD treatment if that's needed. And then of course, care coordination. And this really is more focused on care that may be received elsewhere. For example, it could be thinking about behavioral health, particularly if it's not offered at your health center, as an example.

Other HIV reporting grants are interested in self-management goals, patient education, dental visits, again that behavioral health that I was just talking about, nutrition, and really there's some greater specificity for the population in terms of looking at these pieces. And we'll talk about that in a later slide. So some of the data challenges that we encountered, and we heard from you that you encountered. So I wanted to go into some detail around this, particularly around the labs.

So we've already talked about LOINCs versus names and standardizing lab results to calculate the measures electronically, wherever possible. In working with many of you trying to do this reporting electronically, we realized that there was a need to do some results overriding. And this is a concept that basically means we have to map a lot of different possible results for a test to determine that it is in fact positive, because those positive test results come back in so many different forms. So basically, we have to think about what are all the different tests that can be performed to check for-- we're giving the example here of genital chlamydia.

So some of that is results with LOINC if any of that testing is being done point of care, which pretty infrequently is done. We take care of it with the logical object identifier naming component. But then the main thing is this idea of what is considered to be positive for chlamydia. And many of you are probably used to seeing this. It's something I've been familiar with in the past with Pap results, because commonly it will say in the result field, see comment or see Pap. And you really have to go to the actual comments to understand whether the patient result is positive, or negative, or abnormal, or normal.

So just as an example with the chlamydia screening, you can see listed here all of the different things that we've seen that actually indicate a positive chlamydia test. And so what that means is that we have to go through and make sure that we're mapping all of these possible result names as positive. And that's in order to be fully comprehensive in understanding whether patients have a positive chlamydia test.

And so this, of course, translates to other things as well. The baseline resistance testing, typically with the viral load, that's a little bit more straightforward because it does show up in logs and also in just regular numbers. But it's really understanding the difference between those two things and what's considered to be normal. So generally speaking, the specificity of the test, for example, looking at-- generally speaking, it can't get lower than 20, for example, because the test is not sensitive enough to count viruses less than 20. So we would consider a less than 20 essentially is zero.

So there's just a lot of components to this. And I'm curious to hear from you guys about this as well, as we start our discussion later. So again, we've talked a lot about medications already, making sure that we have all the different medications that a patient is on. And I just want to point out to you, there are some EHR system differences in how medications are handled, particularly those that are prescribed elsewhere.

So I know, for example, that GE, it just stores those medications that are prescribed elsewhere in a completely different table. So knowing that you need to make sure you're accessing information from that table, as well as the current medications that were prescribed by the organization in a different table, pulling those together to get that complete list is really important.

Self-management goals, patient education, specific education about topics. So for example, when you're talking about nutrition education for a patient, there is an interest in understanding their appetite as well as their diet. So it's not just your typical UDS nutrition education talking about healthy eating. It's really trying to understand how the patient is actually hungering for food and also what sort of choices they're making in terms of food.

And then care coordination. Again, these are your dental visits, behavioral health, as well as the mental health checks. So again, additional specificity for the HIV population looking at PTSD, for example. And then there are things beyond that as well.

So then this is really just about alignment with other HIV initiatives that are out there. So I just wanted to mention that for some of the services that are required, there's alignment with the United States Preventive Task Force on some of the guidelines and the intent with lifetime testing, focuses on ages. And then there's of course alignment with UDS. As we've already mentioned, the newly diagnosed HIV patients and the linkage to care.

And to date, there's been no focus on reviewing P4C relative to the HIVQual project, but there are overlaps. And it's possible that there will be extensions or expansions of either of these programs where there's going to be even additional overlap. So this is why we're excited about having worked with many of you on these projects, and learning and sharing some of the best practices as we are today.

So we're going to spend just a little bit of time on measure and reporting tools here, but the next webinar that we're going to be doing is actually going to be much more focused on this. How do we actually leverage the data that we're collecting? So one of the things I like to focus on in terms of understanding data quality and reporting is that there really are three different layers, and the results that you get can be very different on each of these layers. And the expectation that they should be the same is not accurate.

So the biggest one that people often focus on is the external report performance. So this would be your regulatory reporting. P4C would fall under this, anything that you create for an external entity in terms of reporting.

The next layer is really where you actually manage the population and manage your quality performance. So QI and population management. Using registries, exception reporting, helping to use data to drive your planned use study [INAUDIBLE] cycles, then looking at trends. And then finally the layer of point of care.

So this is where you're actually using the data at the point of care, whether it be for pre-visit planning, huddling, care management, et cetera. And I've definitely worked with practices who have a pretty significant HIV population. And they've invited their HIV care coordination managers to huddles and to be part of their pre-visit planning, so that they're really addressing the HIV needs of the patient and also the ongoing preventative care needs for the patient as well. So they're not focusing on one thing, but they're making sure they take care of the whole patient.

And then this is just an example from our system, but I'm sure many of your reports look similarly, of the P4C measures scorecard. So this is all the P4C measures and then the results. This is kind of made up results, but results that you might show in terms of your performance. And the nice thing about the way our system works is you can actually drill into the information below on each of these measures to understand the performance better. But I think, many of you also use other reporting systems locally, et cetera, so all of those methods are absolutely valid.

So we're really going to get into some of the challenges and opportunities now. And this is really where I'm hoping that you guys are going to have some things to add to our discussion. So I just want to start out, because this is a slide that I'm really wanting to invite you guys to jump in and talk to me, and talk to the rest of us about actually what your experience was with P4C reporting.

And I just want to start out by saying, feel free again to raise your hand if you do have something to say, and Steven will unmute you so that you can add your voice to this discussion. I just want to say that many of the P4C practices that we worked with did do both a combination of chart audits and then some electronic reporting. Or perhaps even entirely chart audits.

And the reason for that is that there's this kind of catch up period where some of these data elements that were acquired for P4C weren't necessarily things that you were recording in structured ways in the past. And so I'm really interested to hear what some of your experience was in that. So feel free to raise your hands and let us know what you've experienced. And you can see, there's also a second question here as well asking what resources were needed to actually make this possible?

So did you have to throw a lot of bodies at this project? Did you have what you needed? Was this something QI could do for you? Did you need to involve your HIV care coordinators, that kind of thing. So anything that you want to add to this is definitely welcome.

MODERATOR: OK, if you'd like to chime in on this, please use the Raise your Hand feature and I will unmute you. We did get one question that came in that reads, "one of the reporting requirements requests the number of routine HIV tests performed during non-medical visits. The EHR only captures medical visits. Is there a way to capture this electronically?"

HEATHER BUDD: Yes. So we actually-- this is a great question. There's a slide that address this a little bit later, but I'm happy to talk about it for a minute here. We spend a lot of time talking to HERSA, the program leaders, about this and trying to understand what was meant by a non-medical visit. And I think the idea that they're trying to get to here is, how many HIV tests are really being done in the course of non-medical visits?

So if you, for example, went to a behavioral-- if a patient went to a behavioral health person in your organization, that behavioral health person decided to order an HIV test, they found perhaps something that the patient shared with them, who knows. And they got screened for HIV as a result of that, they want to try to understand what effort is being made there. And so you're right, it's not something that's easily defined within the EHR, but there is a way to tell if you connect the encounter during which the HIV screen was ordered with the resource who actually ordered it to determine whether it was a non-medical provider or medical provider. So that's how we got around it in terms of the electronic version of the reporting.

If you were just looking through the records, it might be harder to do that if you were trying to report it from the chart audit perspective. I can see the challenge there. Anybody else have anything to add to that? Because I know there are people who are more experts than me on this.

MODERATOR: We have Andrea Brooks. Unmuting you now. Go ahead and ask you question.

UNIDENTIFIED PARTICIPANT: It's actually not a question, but more so of a comment around how we interpreted the non-medical visits. So for us, one of the things that we found was that as we were ordering-- the test may have been ordered during the medical visit but actually performed during a lab only visit. Let's say because we built it in-- we're doing blood-based testing so it's not really a point of care test. So with the blood-based test, as we're doing the test, a provider may order it, they're seeing a patient in the afternoon, ordering an HIV test amongst their other labs, but some of their labs have to be fasting.

So instead of them sort of doing one blood draw there and then having to come back to do another one, we just have them come back for a lab only visit where we're doing the blood collection. And so the way that our system has it, that wouldn't show up as being part of a regular medical visit, but the order of it happened during a particular medical visit. The performance of the test happened on a different day.

HEATHER BUDD: Right. So you would count that as being part of medical, even though it doesn't necessarily easily show up that way. Is that what you're saying?

UNIDENTIFIED PARTICIPANT: No. We count that as a non-medical visit, because it didn't happen during the actual visit itself, where some of them happen same day as the visit as other stuff id going on. And that was the only way that we could find it in our system. The other part of it is, most of the patients who come into our center are being seen for medical services, not anything outside of that.

UNIDENTIFIED PARTICIPANT: OK

UNIDENTIFIED PARTICIPANT: We just expanded behavioral health around the same time that we expanded our HIV services.

UNIDENTIFIED PARTICIPANT: OK, great. Thank you for sharing that. Anything else?

MODERATOR: We do have a question that came in. Lab-only visits are initiated by the provider. Wouldn't that be a medical visit?

HEATHER BUDD: Yeah, yeah. I mean, I definitely agree that that is actually probably a medical visit. I think what, I think her name was Andrea, was sort of talking about is just the difficulty of differentiating the two, especially if you're doing electronic reporting-- or doing, sorry, chart audit reporting. But I agree, I think that what I understood-- and again, there's a slide on this in the future, and we'll talk about it a little bit more-- but what my understanding from HERSA is, they're really trying to understand where the testing is being initiated. So they can understand which resources that the health center are responsible for getting the HIV screening completed.

And so if it was ordered by the provider, it really is kind of coming from the medical realm. And if it's coming from a behavioral health provider or specialist, then that's really an example of one that they want to understand as being done by someone who is non-medical. Now if you had an example where you were at a lab visit, and for whatever reason the lab tech suggested that you got an HIV screen in addition to whatever other labs were being drawn, then that one could potentially be seen as initiated by non-medical, from what I understand HERSA is hoping for. Now again, this is the first year that we're doing a lot of this reporting, so it makes sense to me that there's confusion in some of these areas.

MODERATOR: OK, it looks like Cindy has audio enabled now. Go ahead and ask your question.

UNIDENTIFIED PARTICIPANT: Hi. Can you hear me now.

MODERATOR: Yes, we can.

UNIDENTIFIED PARTICIPANT: OK, awesome. Great. So I had a response to the question about how can you differentiate between non-medical versus medical testing from our experience. And then I had a couple questions just overall based on our experience here.

One of the things that we differentiate here is we had to create an obs term. We're using Centricity, so we created an obs term for rapid test kits. The way funding is structured in our area is that there is a separate fund. We actually have a non-clinical tester who does rapid testing. And frequently, what happens is if we have a patient or a client come to the clinic for a substance abuse visit, or a mental health visit, or a housing support visit, those three types of visits are considered non-medical. And any of those providers may refer the client, or the client may request an HIV test.

They can either go to the medical clinic through triage or walk through. Or they can request to be referred to the tester. And we've coded the obs term so that we can link rapid testing done by the non-clinical tester as a non-medical test. And that way we can tell if housing support, or addictions, or behavioral health, not medical, referred to or engaged that patient in for testing. So that's one way we've done it here.

Now, one thing that's tricky that we discovered though-- and again, there was a really great slide in your presentation really thinking about how one piece of data could be co-opted or used by more than one user for more than one purpose-- we did discover that. You have to be very careful when you set up your EHR to do that, because in creating an obs term for a rapid test by our counseling testing resource, the non-medical tester, we identified then that unfortunately the addictions team created a field for HIV testing, yes/no. And somehow the field for yes ended up being linked to that particular term for the non-medical testing. So we ended up double counting.

So I think there's a real need that when you look at your EHR, to also have an understanding of when you think about implementing a new field who else might use, or inadvertently or accidentally misuse that field. So you make sure you're not counting inappropriately.

HEATHER BUDD: Great point, Cindy.

UNIDENTIFIED PARTICIPANT: And then one thing I wanted to ask about is I noticed that on one of your slides you mentioned that there are HIV data collection phase. I was curious about, had there been any thought to aligning the data collection phases to the five phases or focus areas with the P4C project? Because the focus areas are screening, I think, then looking at risk reductions-- I'm sorry. We have screening, we have linkage to care, and we have our retention and engagement, adherence, and then PI. So I'm just curious if there's any thought to maybe aligning the collection phases to the P4C project itself?

HEATHER BUDD: Well I think we certainly can. And again, I think there's much more emphasis on some of those areas in the coming webinars, where we really kind of delve into how do we actually do some of the things that you've just talked about. So yes, I think there's going to be more focus on that for sure.

UNIDENTIFIED PARTICIPANT: OK. And then just a general comment. One of the things that I didn't see covered-- and I don't know if this is going to covered in the future-- but I think in terms of our data challenges, our data challenges had to do with GIGO, garbage in, garbage out.

And we really learned a lot about our own documentation practices and a lot of things we didn't know about how people duplicated where to enter things. So for example, we discovered we have more than five ways somebody can document an HIV test. And we also discovered there are more than 10 ways IV drug use can be documented. And they don't always mean the same thing.

So just for organizations that are trying to go down this path, you have to really think outside the project to see who is measuring or counting points of care that overlap with HIV care. And the other thing too that I don't know was addressed was, we ended up having to do some data validation on our end. And through that data-- if you decide to use a third party vendor, you need to make sure that your third party vendor will support you in doing data validation. Data validation means that you assume a data warehouse or an external party is going to have aligned all of your data to a specific measure definition. But what isn't always known is if you're really talking about apples to apples.

So for example, we discovered that one field that was built into the third party vendor's data warehouse was not being used the way we used it. And so we ended up, in the end out of the 14 measures, we had to do our own reporting for three of the measures. And then we found out that for eight of the remaining measures we had to use a combination of a third party data and also custom reviews, including some chart reviews.

So I think it just needs to be understood that it's really good to understand the data. But also, if you decide to get a third party vendor, you can't necessarily assume it's going to be perfect out of the box. There still is some work involved with it.

HEATHER BUDD: Absolutely. And I think particularly, Cindy, in the initial year of reporting, where everybody's kind of learning what the intention is. I always like to talk about measures being-- measure interpretation is absolutely an art and not a science. We wish it was more of a science, but it's just not. So thank you for all those comments, and you got a lot in there. And I do know we need to move on, because we're sort of running short on time. But we so appreciate you jumping in.

You know, I am curious to hear from you guys about the challenges of some of the sexual orientation and gender identity issues. Obviously for P4C there's been a little bit more focus on sexual preference because of some of the risk exposure components to that. But this whole thing is not simple. And as I mentioned before, the workflows ideally need more standardized, et cetera.

So the next slide I have is actually again a little bit more of a discussion about how your practice was actually starting to capture some of these things, if you're capturing them at all. Who does it? How is this impacting? So I just want to know, what's been your experience if any of you have anything to add to this area.

I think this is something that's going to continue to crown again as it's being more and more incorporated into UDS, we'll all have to do this. But I think many of you have had to do some of this earlier because of P4C. So I'm curious to hear if anybody has anything to add.

MODERATOR: OK. If anyone has any comments on this, please raise your hand and we will So you. I think Cindy would like to chime in again on this.

HEATHER BUDD: Great.

UNIDENTIFIED PARTICIPANT: We are actually-- I'm really interested to hear how anybody particularly using Centricity is handling this, because we are not able to modify our fields. All we have is basically gender at birth, male, female, or unknown. And we're really struggling with this one. And we've talked to GE about this, and we've been told that because adaptation for MU3 won't happen until 2017, 2018, they're not planning on making any changes until that point.

So we're kind of struggling with where to put this, because in our patient flow the first person who could ask this question would be registration. But the practice management screens don't allow any modification. And then if we put it anywhere else in the chart, then there's the risk of not everybody using the fields consistently.

HEATHER BUDD: Sure, absolutely. Yup, that's consistent with what I've kind of been concerned about too. And I've been working closely with the Fenway Institute in some of the other projects I've been involved with, and it seems that they feel pretty strongly that having registration actually be the area where this is collected is the best practice. So that you're more likely to get that consistency that you were just talking about, Cindy.

So I think it's tricky. And it's tricky to get to the degree of granularity that's needed here too. If you ask someone what their gender is, the gender they identify with may be very different from the gender that they were born as.

And so how the question itself is asked is really essential and really important, particularly making patients feel safe in giving an honest answer as well. So yeah, I think there's going to be more to come about this. Is there anybody else that's raising their hand, Steven?

MODERATOR: We have a couple comments that came in. One person said, we utilize Centricity and the only option would be to have a change in the practice management system.

HEATHER BUDD: Yup, OK.

MODERATOR: And another person said, we are struggling too. Haven't been able to properly address this using Intergy.

HEATHER BUDD: OK. So it sounds like it's a couple different EHRs that have this issue.

MODERATOR: Community Health Center module can be used to capture gender information as an alternative to practice management system.

HEATHER BUDD: OK, interesting. All right, well let's keep going, because I am very aware of the time. We're already at 2 o'clock. And I think maybe we can talk about this next time as well. What are the other resources that practices are using for care coordination, other than some of the things we've already talked about?

So this is really just the last slide. And we can certainly take maybe one or two questions, if there are any, that are out there. This is a little brief commercial for the next time that we're all going to meet together, Tuesday, April 26 from 1:00 to 2:00, Eastern.

And so we look forward to seeing you then. And I'll just let Steven take it from here. Are there any questions?

MODERATOR: OK. If there are any questions that are still out there, please feel free to raise your hand. And we can also take typed questions, if you'd like to type them. OK, I'm not seeing any. Victor, would you like to jump in here?

VICTOR RAMIREZ: Thank you, Steve. And thank you for everybody taking time out of your day and joining us today. I do want to make one correction to this slide. The session is scheduled for Tuesday, April 26. To registration for the second session is open, it's Tuesday, April the 26.

So we hope that-- we went over a little bit of time. I mean, there's a lot of material that needs to be covered.

VICTOR RAMIREZ: Just to add, please, we do want health centers to participate in not only the COPs, but also our regular webinars at co-presenters. Some of you might have gotten messages from me previously. But going forward, again both for this series on electronic health records, we might go and ask for health centers to participate. And also for the other COPs and the other webinars that we have planned, please we hope that everybody is open to participating as a co-presenter.

If you wish, please just email me. My information is right here on the slide. And I will provide you with more details on what we would be looking for. Steve?

MODERATOR: OK, thanks. Heather, did you have any closing thoughts before I wrap it up here?

HEATHER BUDD: No. Just it was a pleasure to work with you guys today. And look forward to the subsequent webinars from here.

MODERATOR: Thank you again for participating in today's webinar. And thank you, Miss Budd, for that excellent presentation. If you have any additional questions for the P4C project or for Miss Buss, please email us at p4chivtac@mayatech.com. Take care everybody, and we'll see you next time.