



# Patient-Centered Primary Care Home Program Update

September 2019

## Tips for Patient-Centered EHR Use

A key component of several PCPCH Standards, Electronic Health Records (EHRs) are a valuable tool for achieving many advanced primary care home functions such as improved population tracking, care coordination, improved communication, and patient safety. Despite these benefits, EHR implementation can sometimes accompany concerns over its effect on the provider-patient relationship and physician burnout.

The following are a list of tips from various sources including the *American Medical Association*, *Becker's Health IT & CIO Report*, *EHR Intelligence*, *Medical Economics*, *Patient Engagement HIT*, and *Paediatrics Child Health* to help clinic staff balance effective EHR use with positive patient and provider experiences.



## Tips for Improving Patient Experience with EHRs

- 1. Review the patient's chart beforehand:** Acquaint yourself with visit concerns, problems and previous notes before entering the examination room to improve efficiency and optimize patient satisfaction. Separation of routine data entry will increase the time available for interacting with your patient and their family.
- 2. Ensure some amount of face-to-face contact, especially during initial encounter and sensitive topics:** For the first minute or so of the patient encounter (known as the "Golden Minute") talk to the patient without using EHRs or any other form of technology. Maintain it as much eye contact as possible throughout the visit and allow time by encouraging the patient to ask questions if they don't understand something. When a patient starts discussing a sensitive or emotional topic, turn away from the EHR screen and look only at the patient.
- 3. Establish visibility of EHR ("Triangle of Trust"):** Create a triangle configuration in the room that allows the physician and patient to both view the EHR and the physician to address the patient. Let the patient look on while entering information into the EHR; doing so not only helps build trust with the patient but ensures the accuracy of the information because the patient is there to confirm it.
- 4. Familiarize patient with role of EHR:** Be open about everything you're doing with the EHR in the patient's presence; this demonstrates that you are not ignoring them while typing. Don't hesitate to talk about the benefits of the EHR and make it a tool for engaging patients by jointly reviewing data such as lab results and specialists' reports. Displaying negative emotion towards EHR may leave a lasting impression on the patient.
- 5. Continue interacting with and engaging patient:** Continue communicating with your patient while you enter data into their record. When discussing data, point to the screen and show the patient the results such as specific laboratory values and where they fall within their normal range.
- 6. Log-off in full view:** Signing off of the patient's chart while the patient is present helps reassure them that their information remains private and won't be viewed by anyone else.

## Tips for Improving Staff Experience with EHRs

- 1. Ask vendor for detailed EHR training:** Work with your vendor to provide role-based training that addresses the unique needs of your practice and patient population.
- 2. Delegate initial lab reviews:** Ask medical assistants to perform first-level reviews of electronic lab results and highlight important information that requires a physician's attention. This information can then be flagged.
- 3. Use patient portals:** Engage patients with portal technology to reduce the volume of phone traffic. Educate patients about portal etiquette so they understand what questions are and aren't appropriate for the portal. Set the expectation that messages will be returned within 24-48 hours.
- 4. Take advantage of templates and shortcuts:** Many EHR systems include documentation templates or allow users to create their own. These can significantly reduce the time required to chart for patient visits, findings, referrals, and more. Shortcuts allow physicians to use standard language for certain repetitive types of advice (e.g., elevate and ice the injury).
- 5. Use copy-and-paste functionality:** When used appropriately (i.e., with validation of data), practices save a considerable amount of time using this functionality. Keep in mind though that copy-and-pasting patient information from chart to chart can create patient safety and data integrity issues if used incorrectly.
- 6. Automate preventive maintenance reminders:** Send automated messages directly to patients prompting them to set up appointments online. This process helps address care gaps for mammograms, annual visits/check-ups,

and other preventive services. It also removes any related tasks (e.g., patient reminders) from staffs' work queue.

7. **Go mobile at the point of care:** If available, try using your EHR on a tablet or other mobile device that provides the ability to perform data entry anywhere at any time while facing the patient. Mobile EHRs offer increased flexibility while maximizing time both with patients and between patient visits.
8. **Leverage live or virtual medical scribes:** Medical scribes, also called documentation assistants, can lower physician documentation burden and improve efficiency, workflow and patient-physician interaction.

#### Sources:

- [American Medical Association: The overlooked benefits of medical scribes](#)
- [Becker's Health IT & CIO Report: 6 stats on EHR-related physician burnout and 7 tips to combat it](#)
- [EHR Intelligence: 7 Time-Saving EHR Use Tips to Boost Physician Productivity](#)
- [Medical Economics: Use EHRs as tool to improve communication, build trust with patients](#)
- [Patient Engagement HIT: 3 Best Practices for Balancing EHR Use and Patient Engagement](#)
- [Paediatrics Child Health: Top 10 tips for effective use of electronic health records](#)

## Become Involved: Upcoming Needs Assessments

### Well-Child Visits:

The Transformation Center will be hosting needs assessment calls focused on the 2020 CCO incentive metric for well-child visits (ages 3-6). Two calls will be with CCO staff, and one call will be with clinic staff and referring organizations. These calls will give participants an opportunity to share successes, barriers, and requests for support with OHA and each other. Participants will also learn what others have done or are planning to do for this metric. The calls will inform future technical assistance.

**For clinics and referring organizations (Head Start, WIC, etc.):** October 10, noon-1 p.m.

- Register here: <https://attendeegotowebinar.com/register/7182001557583856141>.
- Phone number: 888-808-6929; Participant code: 7307397
- Contact: Adrienne Mullock, [adrienne.p.mullock@dhsoha.state.or.us](mailto:adrienne.p.mullock@dhsoha.state.or.us)

### Oral Health Metrics:

The Transformation Center will be hosting needs assessment calls focused on the CCO incentive metrics for oral health: evaluation for adults with diabetes, and members receiving preventive dental services, ages 1-5 (kindergarten readiness) and 6-14. Two calls are with CCO and DCO staff; the last call is with clinical staff and others referring for these services. All three calls will inquire about both metrics. These calls will give participants an opportunity to share successes, barriers, and requests for support with OHA and each other. Participants will also learn what others have done or are planning to do for these metrics. The calls will inform future technical assistance.

**Dental clinics, clinics with integrated oral health care, and community groups that refer for dental services: October 31, noon to 1 p.m.**

- Register here: <https://attendeegotowebinar.com/register/2421842986771431437>
- Phone number: 877-336-1829; Participant code: 3100151

## Assessing & Addressing Patients' Social Needs

Increasing attention to the impact of the social determinants of health and health equity has been met with increasing focus on strategies to address patient's unmet social needs. A [Center for Health Care Strategies brief](#) on this subject examines how some organizations have gone about assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying community resources and tracking referrals.

This resource includes links to several assessment tools that have been created or adapted by [Transforming Complex Care](#) sites in order to better capture patients' social needs and barriers to care. Examples of these screening tools are available to download below:

- [Social Determinants Screening Tool \(AccessHealth Spartanburg\)](#)
- [Self-Sufficiency Outcomes Matrix \(OneCare Vermont\)](#)
- [PRAPARE Tool \(Redwood Community Health Coalition\)](#)
- [Community Paramedicine Pilot Health Assessment \(ThedaCare\)](#)
- [Social Needs Assessment \(Virginia Commonwealth University Health System\)](#)



## Coming Up: Events and Trainings

### Webinar: Clinic Strategies for Diabetes Management

The Transformation Center invites clinical staff to a **webinar focused on the Diabetes: HbA1c poor control incentive metric**. The webinar features representatives from Winding Waters Clinic and Old Town Clinic, who will share how they create workflows, address social determinants of health, offer team-based care and involve pharmacists, among other best practices for diabetes care.

**When:** October 30, 2019, noon to 1 p.m.

**Webinar registration:** <https://attendee.gotowebinar.com/register/4881099753763970829>

### Free Behavioral Health Integration Event

#### Innovative Care for Behavioral Health and Substance Use Disorders: Payment, Data and System Strategies

This one-day event will offer peer-to-peer learning on how CCOs, primary care practices and specialty behavioral health organizations are integrating behavioral health. Topics will include the benefit of integration in reducing emergency department use amongst those with mental illness, effective use of data, and substance use disorder strategies.

**When:** October 30, 2019, 8 a.m.–4 p.m.

**Where:** Salem Convention Center (tentative)

**Audience:** CCO behavioral health directors, CCO medical directors, primary care practices, CMHPs, behavioral health providers

**Registration:** <https://www.eventbrite.com/e/innovative-care-for-behavioral-health-and-substance-use-disorders-payment-data-and-system-strategies-tickets-66411513625>

**Contact:** Summer Boslaugh (summer.h.boslaugh@dhsoha.state.or.us, 503-753-9688), Transformation Analyst, OHA Transformation Center.

## Questions?

We are here to help! Contact us at [PCPCH@dhsoha.state.or.us](mailto:PCPCH@dhsoha.state.or.us).

## About the Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Homes (PCPCH) are health care clinics that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered care. The PCPCH Program administers the application, recognition, and verification process for practices applying to become Patient-Centered Primary Care Homes. The program is also working with stakeholders across Oregon to support adoption of the primary care home model. For more information visit [www.PrimaryCareHome.oregon.gov](http://www.PrimaryCareHome.oregon.gov).

*The mission of the PCPCH Program is to be a trusted partner in primary care, collaborating with stakeholders to set the standard for transformative, whole-person, and evidence-based care.*