

ABSTRACT

Title: The AHLTA Co-Sign: Consult Tracking and Care Coordination in the Medical Home Port Environment

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Introduction

As the Military Health System has embraced the Patient Centered Medical Home (PCMH) concept for primary care delivery, coordination of care between caregivers has taken on greater importance. While the closed electronic medical record of the MHS (AHLTA), allows for full visibility of most direct care performed at the MTF, it also introduces vulnerabilities. Written documentation of a patient's network care (including all referrals as well as care delivered in network Urgent Care Centers or Emergency Departments) is not accessible within AHLTA. Naval Hospital Oak Harbor (NHOH) recognized that when providers lack timely information regarding either network care or acute care, patient care suffers.

The first goal of this initiative was to develop a consistent process whereby the primary care manager (PCM) would automatically be notified of any care received within the civilian network. A process was developed whereby all written documentation from external referrals is faxed to dedicated lines, and converted to PDF files automatically. The referral management office would then create a Telephone Consult (TELCON) within the AHLTA system and append the written referral documentation to the TELCON utilizing the AddNote function. Upon signing the note, the referral management office would identify the PCM as a required co-signer of the note. AHLTA would automatically alert the responsible PCM that new information about the referral was now available. After review, the PCM would co-sign the note to close the encounter. The information is thereafter easily retrievable to the PCM or any other provider under the "Previous Encounters" section on AHLTA.

Naval Hospital Oak Harbor also recognized that when a PCM is informed of all the acute care delivered to their empanelled patients, they can better manage any follow on care needs. For this reason, we wanted a process that included automatic notification of the PCM for any direct care obtained within the MTF Emergency Department or Urgent Care Center. A process was instituted whereby the Urgent Care Center staff identified the PCM for all patients presenting for care. The UCC Clerk created a Tasking within AHLTA with the PCM as the Assignee. Similar to the process described for referrals, AHLTA would automatically notify the responsible PCM that there were Urgent Care Center notes to review through the Tasking function. After review, the PCM would change the status of the Tasking to "completed" to close the encounter.

After instituting both measures, the Primary Care Managers now have near-100% documentation of all care obtained by their beneficiaries, both direct care and network care. This information is timely, accurate, and consistent. Having access to these records allows for a greater quality of care coordination by the PCMH team, and allows for a superior experience of care for the patient.

Methods

The goal of this initiative was to develop a consistent process whereby the primary care manager (PCM) would be automatically notified of any care received within the civilian network. A process was developed as follows:

1. A referral location of "OH Referral Center" was created within CHCS/AHLTA.
2. ALL consults generated within the MTF are selected by the referring provider to go to "OH Referral Center". The specific requirement of the referral is specified in the text block.
3. Referral Management Staff directs all "OH Referral Center" consults to the appropriate direct care or network provider/clinic. They therefore maintain 100% visibility of all generated consults.
4. Generated referral letters to network providers specify requirement to fax all referral documentation to a dedicated NHOH or TriWest line within 10 days.
5. Incoming faxes of referral documentation are automatically converted to PDF files utilizing the Zimbra program.
6. Referral Management staff access incoming PDF files and link with a previously generated consult request.
7. Utilizing AHLTA, Referral Management staff generate a TelCon (utilizing the 99499 E&M code and v68.9 ICD9 code).
8. The PDF referral note is cut and pasted into the AddNote section of AHLTA.
9. The AHLTA encounter is signed by the Referral Management staff, who then specifies that a cosigner (the PCM) is required.
10. PCMs receive the "Co-sign" alert in AHLTA when a note becomes available. They review and sign the note, thus closing the encounter.
11. The referral documentation is now permanently available under the "Previous Encounters" menu of AHLTA.
12. MOUs are developed with local civilian Emergency Departments to fax any UCC/Emergency Department encounter documentation as soon as available. This information is added into the medical record using the above described process.

Recognizing that PCMs' need to be aware of all acute care obtained within the MTF as well, a process was instituted whereby the Urgent Care Center encounters were automatically forwarded to the PCM.

1. Urgent Care Center (or Emergency Department, as applicable) staff identify the PCM (utilizing CHCS) for all patients presenting for care.

2. A Tasking is created within the Tasking module specifying the PCM as the assignee.
3. PCMs receive the “Tasking” alert in AHLTA when a note becomes available. They review the encounter in the Previous Encounters section.
4. The PCM may add internal notes in the “Note History” or append the note using the “New Note” section.
5. The Tasking may be forwarded to other members of the care team for awareness or to coordinate follow-on care.
6. The PCM changes the status of the tasking to “completed”, thus ending the tasking.

There was a requirement for additional Referral Management staff to initiate this project—essentially 1 FTE worth. No additional staffing resources were required for the UCC note co-signing. The consult tracking requires the electronic 278 program, as well as an electronic fax to PDF converter (i.e. Zimbra).

Various aspects of this project were put into place between 2009 and 2011. Performance measures were subjective staff satisfaction with the process, as well as percentage of referrals with visit documentation in AHLTA.

Results

After the process was instituted, referral management was able to track the return of referral information from the consultant utilizing the electronic 278 program. This electronic system allowed for 100% accountability of all referrals, ensuring that documentation was received for all kept appointments. Network providers were contractually obligated to provide written documentation of their notes to TriWest within 10 days. This process was primarily put in place in 2009, and is now operating smoothly. The direct care UCC co-sign process was instituted in June 2011, and has also been working well. Primary Care Managers are now able to receive timely feedback about all care delivered to their beneficiaries, both direct care and network care. If the patient was seen the MTF Urgent Care Center, or civilian Emergency Department, the PCM is notified the next day automatically. After reviewing the encounter, the PCM can arrange follow-up care, as needed. In addition, when patients are seen by the PCM for routine care, referral documentation from network providers can be easily accessed under the “Previous Encounter” menu, and allows for better care coordination.

The primary obstacles which we have encountered are:

- 1) The process of copying information from the PDF file of the referral documentation to a TelCon within AHLTA is slightly labor intensive. Dedicated staff are required to accomplish this. At Naval Hospital Oak Harbor, this process occurs within the Referral Management Office. During times of lean staffing, as occurred at NHOH following a recent staffing gap, the time from retrieval of the referral documentation to incorporation into AHLTA may be delayed.
- 2) For near-100% accountability, MOUs must be developed with local network facilities to ensure acute care (UCC or Emergency Department) encounter documentation is rapidly forwarded to the Referral Management Office. At Naval Hospital Oak Harbor, which is geographically isolated, there are a limited

number of network hospitals. This makes this target more easily achievable than at other locations centered in large metropolitan areas.

Conclusion

The response to this initiative at Naval Hospital Oak Harbor has been overwhelmingly positive. Newly arriving providers are often amazed how easily acute care and referral care is tracked, and feel this makes their patient encounters much more productive. By ensuring that the information on all acute care and referral care is automatically “pushed” to the provider, and requires a co-sign to close-out, we believe the process minimizes the potential for lost information. The PCM remains fully aware of all care that their beneficiary obtains, promoting the concept of the PCMH Medical Neighborhood. Although the full process has been implemented in stages, we have been operating with complete implementation for over six months, and believe this is sustainable indefinitely with our current staffing. Since all MTFs are utilizing AHLTA, the possibility exists to implement a similar process throughout the MHS. Giving the PCM complete awareness and record information of their empanelled patients is the fulfillment of the continuity premise which is central to the Patient Centered Medical Home.