



*Lead the Way with  
Advanced Care Management*

# Workbook

# Section 1: Using i2iTracks for Chronic Disease Management

## Chronic Disease Tracking in 2018

**Disease Management Definition**  
A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

### Why is it so important?

Today it is more important than ever to manage your patients with chronic diseases, conditions, or other problems. But why? Why is it so important to provide preventive care maintenance?

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**Take Inventory!**

What chronic diseases and conditions are you currently tracking?

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- Now ask yourself a few questions:
1. Do you still need to track this disease?
  2. Why are you tracking this disease?
  3. What other diseases and conditions should you be tracking?
  4. Do you receive any incentive payments for managing conditions?

### Disease Management Basics

#### Identifying Populations

The first step in disease management is to define the population who needs to be managed.

Start with:

- High Risk Patients
- High Utilizers of care
- Quality initiative requirements
- Recent trends

There are two i2iTracks tools that can help you identify these populations of patients easily:

- External Data Diagnostics Tool
- Patient Search

#### External Data Diagnostics Tool

The External Data Diagnostics tool is a window into the EHR/PM data that i2iTracks is interfacing with. This data is presented in a way that makes it easy for users to explore their EHR/PM data.

- Locate the most common DX/ICD codes used
- Locate the most common problem
- Locate frequently prescribed medications
- Locate frequently used CPT codes for preventive exams, behavioral health exams, family planning, etc.
- Locate unusually abnormal lab results, or frequently used lab tests
- Identify possible data entry errors

#### Exploring Populations with External Data Diagnostics

Log in to the External Data Diagnostics tool.  
File > Tools > External Data Diagnostics

1. What is the most common ICD code?  
\_\_\_\_\_
- How many occurrences?  
\_\_\_\_\_
- How many patients?  
\_\_\_\_\_
2. What is the most common CPT Code? \_\_\_\_\_
- How many occurrences?  
\_\_\_\_\_
- How many patients?  
\_\_\_\_\_
3. Is the Quest Lab Triglycerides mapped? \_\_\_\_\_
4. How many patients are on Coumadin/warfarin therapy? \_\_\_\_\_
5. When was the last occurrence date for ICD code E11.9?

What other uses do you see for the External Data Diagnostics tool?

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## Where does the Data Come From?

Data comes into i2iTracks several ways:

- Standard Interfaces
- Custom Data Integrator

### Standard Interfaces

Data for your Tracking Types can be updated through your EHR Interface:

- Allergies
- Medications
- Problems
- Vitals
- Labs
- Immunizations

Billing data – CPT and ICD codes from your Practice Management System.

### Custom Data Integrator (CDI)

Data for our Tracking Types that is not considered ‘standard’ can be updated from your EHR interface through the Custom Data Integrator. The Depression Screening and Smoking Query are examples of data brought into the CDI and mapped to a Tracks Profile Item.

### Building a Tracking Type Exercise:

*Northwest Clinic has decided they want to start tracking High Risk Patients: patients with at least 5 problems and 5 or more medications.*

*Your job is to build the Tracking Type in i2iTracks, as well as supporting reports, searches and proactive tools to help their care teams.*

#### STEP 1: Building a Tracking Type:

Complete Your Profile Item Worksheet – Determine all of the care indicators/data elements you will want to follow for the population in the following areas.

- Education
- Immunizations
- Procedures/Referral
- Problems
- Medications
- Other Profile Items
- Allergies
- Self-Management Goals
- Labs

## Tracking Types

In i2iTracks, Disease/Condition Management is done through Tracking Types. Tracking Types are used to group 'like' patients together. i2iTracks allows you to create an unlimited number of Tracking Types and customize them to your own care models.

Tracking types can be created to follow any population. For example, care coordination panels, Medication Assisted Therapy patients, Chronic Pain patients.

i2iTracks comes with some Tracking Types 'pre-configured' and ready for you to use immediately:

- Pap Tracking
- Mammogram Tracking
- Perinatal Tracking
- Childhood Immunizations

## What's in a Tracking Type?

A Tracking Type includes a 'profile' (or group) of health indicators, which include services, treatment, tests, referrals, etc. relevant to managing the specific condition or disease.

This is referred to as a care model, your standards or protocols that your organization will follow.

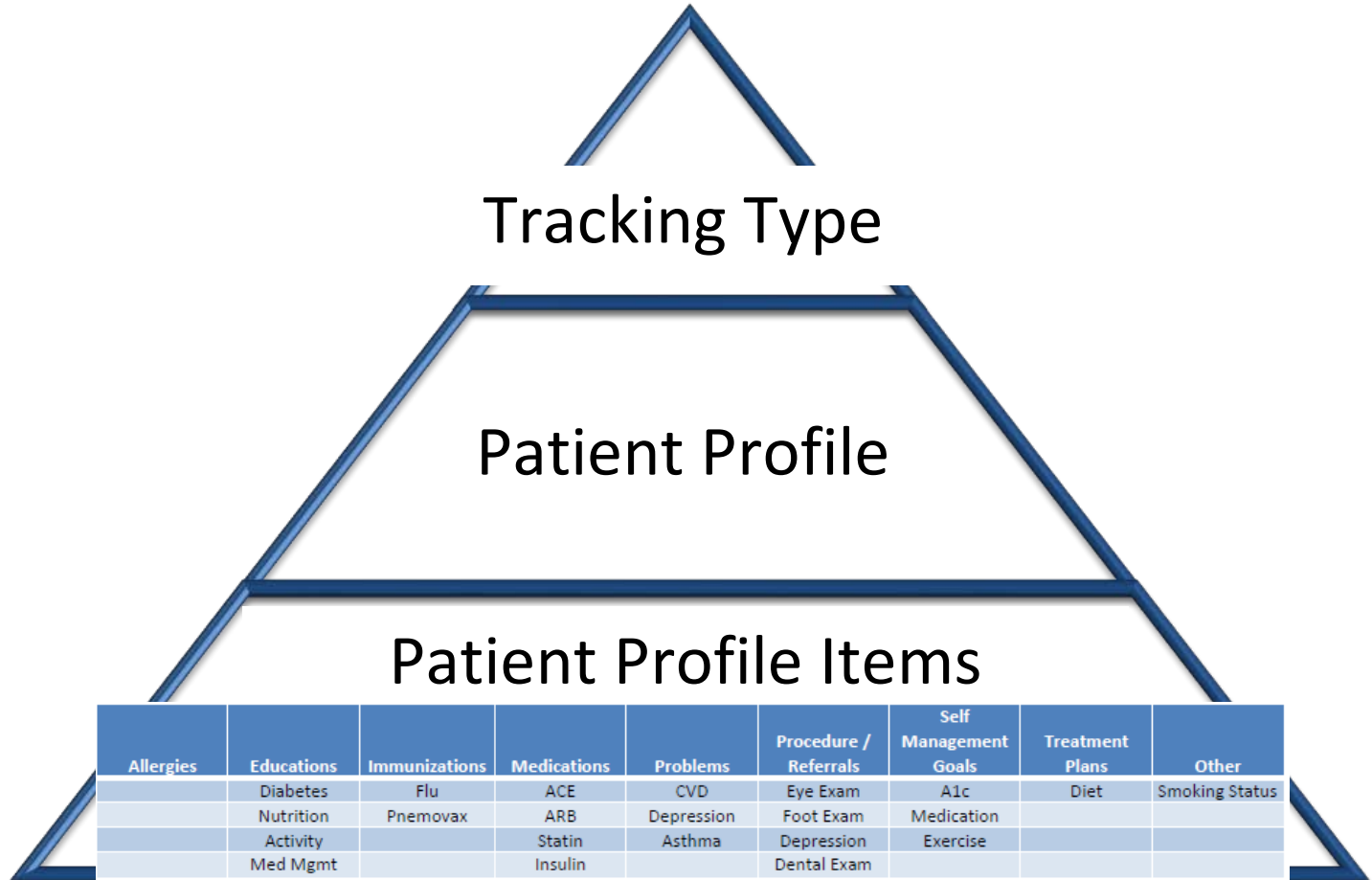
## Building a Tracking Type

Easy Steps!

1. Review DEM for data elements identified in Patient Profile Worksheet
2. Create a Patient Profile
3. Set up the Tracking Type
  - a. Attach the Patient Profile
  - b. Determine how Tracking type will populate
    - i. Auto-Assign
    - ii. Search
    - iii. Manually Add Patients
4. Go back to the Patient Profile Items to add the Schedules/Protocols for all data elements that you want to alert on the Morning Huddle.

## Building your Tracking Type

The structure of your Tracking Type resembles a pyramid. The bottom of the pyramid contains all of the many health indicators (profile items) that are combined into the middle layer (patient profile), which is attached to the top (Tracking Type).



## Patient Profile Items

Patient Profile Items are the health indicators.

1. Allergies
2. Educations
3. Immunizations
4. Medications
5. Problems
6. Procedure/Referrals
7. Self-Management Goals
8. Treatment Plans
9. Other Profile Items
10. Events

As data comes into i2iTracks from your EHR Interface, these profile items can be automatically updated if they are mapped or linked.

## Mapping Items with a Standard Interface

Mapping is all about defining equivalents. For Profile Items, mapping is defining what data elements in your EHR are equivalent to the i2iTracks data element. For example, I have an i2iTracks medication of ACE Inhibitor – so, what medications in my EHR are an ACE Inhibitors?

In i2iTracks, you can map Profile Items that are Allergies, Medications, or Problems to data from your EHR.

An example is:

1. ACE Inhibitor: Include all medications that end in “PRIL” except Prilosec.
2. Problem of Hypertension: ICD9 401.xx; ICD10 I10

### STEP 2: Building a Tracking Type Exercise: Patient Profile Items

Setup > Data Element Manager

Build your Patient Profile Items. If the item is already in your library, you do not need to add it.

- **Patient Profile Items**
  - Education
    - Exercise/Physical Activity Counseling
    - Diet/Nutrition Counseling
  - Immunizations
    - Influenza
  - Medications
    - ACE Inhibitor, Unspecified (i2i)
    - ARB, Unspecified (i2i)
    - Aspirin (i2i)
    - DM Medication
    - Lipid Lowering Medications
    - **Opioids - Review mapping - add Vicodin**
  - Problems
    - Asthma, Any
    - Bipolar Disorder
    - Coronary Artery Disease
    - Congestive Heart Failure
    - **COPD – Map J44.x Codes**
    - Depression
    - Diabetes Type I or Type II
    - ESRD
    - Hyperlipidemia
    - Hypertension, Essential
    - Obesity
  - Procedures/Referrals
    - Depression Screening
    - ER Visit
    - **Hospitalization – Map 99221 - 99234**
  - Other
    - NACHC Risk Score
    - Tobacco Status
      - Current, Past, Never

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**Patient Profile Item Schedules**

Patient Profile Items can be customized to follow your care model’s schedule and protocol. For example, let’s say that our diabetic patients should have a flu shot each year. If a patient has not had a flu shot in the appropriate time frame, an alert will show on the patient account, the morning huddle report, visit summary, etc. This reminds the care team of services that are due.

There are three categories of profile items that allow schedules:

- Procedure/Referrals
- Immunizations
- Educations

You can create multiple schedules for the same item. For example, a male patient may have a different schedule than a female patient, or patients with diabetes may have a different schedule than a patient with another condition.

In addition, you can also add schedule to lab tests.

Protocols can be created to alert for any data element available in Tracks as a Search filter. Protocols allow an organization a lot of flexibility in what types of activities can alert on the Morning Huddle.

**Patient Profiles**

The Patient Profile combines all the associated Patient Profile Items into one group.

Patient Profiles are used so that i2iTracks knows what Profile Items need to be displayed or reviewed for each Tracking

Types or Visit Summary and when you view profile data about on a patient.

**STEP 3: Building a Tracking Type: Patient Profile**

[Setup > Patient Profiles](#)

Build a Patient Profile using the list of profile items shown on the previous page.

**STEP 4: Building a Tracking Type: Tracking Type**

[Setup > Tracking > Custom Tracking](#)

Create a new Tracking Type for High Risk Patients

- Attach the new Patient Profile

**STEP 5: Building a Tracking Type: Profile Item Schedules**

[Step 1: Data Element Manager > Select Data Type > Education > Diet/Nutrition Counseling > Schedule](#)

[Step 2: Setup > Tracking > Lab Tracking > Labs](#)

Create the following Profile Item Schedules/Protocol that apply to patients with the High Risk Tracking Type:

Education:

- Exercise: 1 / year
- Nutrition: 1 /year

Immunizations:

- Flu: 1 / year

Procedures:

- Depression Screening: During 1.1.18 – 12.31.18

Other Profile:

Smoking Status: 1/year

Labs:

- HbA1c: 1/year
- LDL: 1 / year
- CMP (Comp Metabolic Panel) – Add Schedule for a BUN 1/year



## Viewing the High Risk Patients Profile

View your list of patients that are assigned to the new Tracking Type in the Tracked Patient List.

### **STEP 6: Building a Tracking Type: Updating the High Risk Patients Tracking Type to Patients**

Adding Patients to Tracking Type through a Patient Search:

Tracks Today > Run Patient Search: Add to Tracking Type: High Risk Patients > Select All Patients > Actions > Attach to High Risk Patients Tracking Type

Any time new patients populate on this list, they need to be added to the Tracking Type.

### **STEP 7: Building a Tracking Type: Viewing the High Risk Patients Tracking Type for Patients**

Patients > Tracked Patient List

How many patients are assigned? \_\_\_\_\_

## Section 2: Preparing Searches and Reports to Analyze Data for Better Care Delivery

### *i2iTracks Analytics Tools*

i2iTracks has several different Analytics tools that you can use to help you in your efforts to deliver better and more efficient care to your patients.

- Easy/Customizable Reports
- Patient Search
- Population Health Analytics Reports
- Population Health Analytics Dashboards
- Standard / Canned Reports

### Health Registry Reports

Health Registry Reports are easy and customizable disease management reports. These reports can be quickly created and provide a wealth of knowledge about a population of patients.

Health Registry reports starts with some standard data.

Total Patient and Visit Counts  
Demographic Information: Age, Gender, Race, Language, Insurance  
Vitals Information: BMI, Blood Pressure

The remaining part of the report is customizable. You can include any profile item, women's health item, or even labs.

### **STEP 8: Building a Tracking Type: Create a Health Registry Report**

Create a Health Registry Report for High Risk Patients.

*Population:* Active patients assigned to the High Risk Patients Tracking Type who had at least one visit (of any type) in the reporting period. Include all the Profile Items from your Tracking Type.

Add the following Labs:

- HbA1c
- LDL

Customize date ranges as follows:

- Flu: 1 / year
- Exercise Education: 1 / year
- Nutrition Education: 1 / year
- LDL: 1 / year

Customize lab value range:

- LDL: < 100, >=100
- HbA1c: <7, between 7-8.9, >=9

Run your report for the period 7/1/17 to 6/30/18.

Record:

- Total Patient Included: \_\_\_\_\_
- Female Patients: \_\_\_\_\_
- BMI >29: \_\_\_\_\_
- Average BP: \_\_\_\_\_
- Flu Vaccine Recvd: \_\_\_\_\_
- Exercise Education Recvd: \_\_\_\_\_
- LDL Average: \_\_\_\_\_
- LDL < 100: \_\_\_\_\_
- HbA1c Average: \_\_\_\_\_
- HbA1c >= 9: \_\_\_\_\_

### Advanced Patient Searches

Patient Search can be used to assist in the care management of many diseases many ways.

- Identify patients who need follow-up
- Create patient lists by provider or facility
- Find out who has had an abnormal lab/test
- Discover who is overdue for a visit

**What is the difference between a 'Patient Search' and a 'Report'?**

- A Patient Search returns a list of patients that match your criteria.
- A Report returns statistics (numbers) about the population.

**Describe when you would choose to print a report instead of a search:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**STEP 9: Building a Tracking Type: Create Advanced Patient Searches**

Before you create new searches for High Risk Patients Tracking, set up a new Search Group called High Risk Patients Searches.

Create the following Patient Searches:

1. All patients in High Risk Patients Tracking who have had any type of visit in the last 1 year. Total: \_\_\_\_\_
  - a. How many belong to Dr. Green? \_\_\_\_\_
2. All patients in High Risk Patients Tracking who have had any type of visit in the last 1 year who have not had a Flu Vaccine in the past 1 year. Total: \_\_\_\_\_
3. All patients in High Risk Patients Tracking who have had any type of visit in the last 1 year who have had an LDL in the last 1 year where the most recent result is >100. Total: \_\_\_\_\_
  - a. Who has the highest LDL? \_\_\_\_\_
4. All patients in High Risk Patients Tracking who have had any type of visit in the last 1 year who have the problem of Depression. Total: \_\_\_\_\_
  - How many are age 50+ \_\_\_\_\_

**(For more practice, additional search scenarios are on page 13)**

Let's take a deeper look at Advanced Patient Search. Some searches require more 'logic' to filter down to the population that you need. Below is the list of logic operators available in the Patient Search:

## AND

### '*this*' AND '*that*'

Example: Diabetes AND most recent HbA1c >9

Patients on this list would be all patients with diabetes who had an HbA1c >9 on their most recent test.

## OR

### '*this*' OR '*that*'

Example: Diabetes OR most recent HbA1c >9

Patients on this list would be all patients with diabetes (no matter their HbA1c result), and patient who had an HbA1c >9 on their most recent test (no matter if they were diagnosed with Diabetes).

## NOT

### '*this*' but NOT '*that*'

Example: Diabetes NOT most recent HbA1c >7

Patients on this list would be all patients with diabetes but will **exclude** patients who had an HbA1c >7 on their most recent test.

## ( ) Parentheses

### '*this*' and (either '*that*' or '*a different that*')

Example: Diabetes AND (most recent HbA1c >9 or most recent LDL >100)

Patients on this list would be all patients with Diabetes who had either an HbA1c most recent test >9 or had an LDL most recent test >100.

### Patient Searches (Continued)

5. Dr. Maxwell's patients in High Risk Patients Tracking not on a lipid lowering medication. Total: \_\_\_\_\_
6. Dr. Maxwell's patients in High Risk Patients Tracking not on a lipid lowering medication whose last LDL > 100. Total: \_\_\_\_\_
7. All patients in High Risk Patients Tracking with any of the following: no Flu in the last year, no Exercise Education in the last year, no LDL test in the last year. Total: \_\_\_\_\_
8. All patients age 40-69 in High Risk Patients Tracking who also have any type of Asthma or all patients age 18-75 in High Risk Patients Tracking that also have Depression. Total: \_\_\_\_\_
9. All patients that have had 1 visit in the last 2 years with 3 BP > 140/90 in the last year and do not have a problem of Hypertension. Total: \_\_\_\_\_

Record your totals for each of the above items.

## Section 4: Advanced Techniques to Provide Proactive Care in the Clinic

i2iTracks is set apart from every other Population Health Management system because of its in-depth proactive care features, providing many tools to help you deliver care in a timely and efficient manner.

### *The Planned Visit*

Utilize the following tools to help you get prepared for your daily appointment in a proactive manner.

### Morning Huddle Report

### iTi – Care Team Huddle

### Visit Summary Form

The Visit Summary Form is a tool that can be used by the care team before, during, and after a patient's visit.

**BEFORE:** Pre-Visit Planning: Identify what needs the patient has at today's visit. What is the focus and how do you need to prepare? Does the patient need a lab test, a referral, an immunization? Review the patient's problem list or med list. Evaluate trends in BMI, BP, or A1c, etc.

**DURING:** Use the visit summary as a learning tool with the patient. Show them their graphs of performance for lab results or vital. Discuss prior goals and treatment plans. Remind them of outstanding referrals, etc. Use it like a report card for self-care.

**AFTER:** Give the form to the patient to take home with them. Explain how it can serve as reminders for goals.

## Building a Visit Summary for your new Tracking Type

Create a new Visit Summary Form for your new High Risk Tracking Type.

Include:

- A box that shows medication, problems, allergies, alerts and upcoming items
- 3 columns showing all of the High Risk Patient Profile Items: Problems, Procedures, Immunizations, etc (See page 7).
- Include Labs in one of the columns:
  - HbA1c
  - LDL
- Include the following histories:
  - BP
  - LDL
- Include the following graphs:
  - BMI
  - LDL
  - HbA1c
- Create a nice footer with your Health Center name, address, and phone numbers