The Coalition of Orange County Community Clinics
Information Technology Activities

A case study on the pursuit of HIT in Community Clinic Healthcare.

Mike Matull
Director of Information Technology, COCCC
Session 2.07 HIT Case Studies: Community Clinic HealthCare
Who is COCCC?

- A non-profit membership organization
  - made up of 17 non-profit community clinic organizations (39 clinic sites) in Orange County California.
  - These clinics provide primary and specialty health care to the *poor and underserved* community members of Orange County.
  - In 2003, our clinic members saw 138,000 patients in 509,000 visits, a remarkable task considering the resource constraints that face our members.
Types of IT services

- Collaborative IT service contract
  - Provides basic IT infrastructure support
  - 12 of our members participate
- CCPro Practice Management System
  - Coalition owned PMS system (15 clinics)
  - Ongoing development and support
  - User group
CCPro Practice Management System

- CCPro has 5 modules
  - Patient registration
  - Patient scheduling
  - Accounts receivable
  - Billing (both EDI and hardcopy)
  - and Reporting
CCPro Patient Registration
CCPro Patient Scheduling
CCPro Accounts Receivable
CCPro Billing
CCPro Reporting
HIT Projects that are underway

- CCPro.net (complete re-write)
  - HL7 interfaces to clinical systems
  - “Lite” Clinical Module
  - Unique Patient Identifier
  - Data Warehouse support

- Data Warehouse
  - Master Patient Index (biometrics)
  - Encounters, and Clinical Information
UPI can offer several methods to capture patient identification.
If the biometric input was successful, then the patient record is displayed
If the patient was located on the UPI server, but not on the local server, the new patient ID field will be highlighted, and the patient can be added locally.
The biometric input was not successful, so back to the traditional methods of trying to find the patient. Key in the fields and click on Perform Search.
The search process will list all those entries matching the primary search criteria.
Advanced searching is allowed for the more daring persons.
Once we have the patient, a list of those visits by date and clinic are listed. Select the one you want.
The visit detail is displayed. Additional medications and treatment information can be obtained.
Detailed reports can be obtained.
Referrals
Recent HIT Initiative in Orange County

- (ABCD) Accessing Better Care for Diabetics

- A Chronic Disease Management Project in Orange County, CA.
Objectives

- Expand access to Preventative Specialty Care Services.
- Implement a Diabetes Patient Tracking and Management System.
- Creation/Enhancement of the Network of Providers by developing and adopting a new set of treatment guidelines – specific to patients served by community clinics.
Patient Tracking and Management System

● Requirements:
  – Easy to use
  – Case management
  – Integrate with existing PMS
  – Collect clinical measures
  – Expandable for other chronic disease measurements
  – Standard reporting
  – Provide input to data warehouse
Camit Pro

- Designed by Roche Diagnostics
- Can be installed on workstations and servers
- Paradox data base
- Allow BG meters to feed measurements directly into system
- Continued support and Development
- EMR? Not really, at least in the classical sense
Patient: 08 Patient_008
Date of Birth: 08/14/1953

Diabetes
Type of Diabetes: Type 1 since -
Target ranges: From 79 To 160 mg/dL Hypo below: 50 mg/dL

Measurements

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<th>Parameter</th>
<th>Previous Value</th>
<th>Last Value</th>
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<td>12/17/1997: 68.50 inches</td>
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<tr>
<td>BMI</td>
<td>09/23/1997: 29.07 kg/m2</td>
<td>12/17/1997: 30.55 kg/m2</td>
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<tr>
<td>Blood pressure</td>
<td>04/21/1997: 130/90 mmHg</td>
<td>12/17/1997: 126/76 mmHg</td>
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<tr>
<td>HbA1c</td>
<td>07/17/1997: 6.6 %</td>
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<td>Ketones</td>
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<tr>
<td>Cholesterol</td>
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<td>Triglycerides</td>
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<td>Proteinuria</td>
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<tr>
<td>BG</td>
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<tr>
<td>HbA1c</td>
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<td>%</td>
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<td>Albumin excretion</td>
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<tr>
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Clinical Measures Collected

- Blood Pressure
- Weight
- BMI
- Temperature
- Pulse
- Foot Exams
- Eye exams
- Exercise
- Diet
- Blood Glucose
- HbA1c
- Microalbumin
- Blood lipid profile
- Meds
- CoMorbidities
- Many others………. 
Challenges of Project

● Getting people to agree on standards:
  - What to measure
  - How to measure
  - Procedures

● Time and Money

● Integration with diversion technical platforms:
  - Different PMS/EMR
  - Hospital systems
  - System upgrades
Accomplishments of Project

- Adoption of standard health care protocols.
- Selection of a standard system for tracking chronic disease measurements.
- Establishment of electronic interface from CCPro to Camit Pro.
- Establishment of electronic HL7 interface to Unilab (and others).
- Set the stage for collective reporting (county wide).
Future of the project

- Expanding it to include other community clinics members.
- Expanding it to include other chronic diseases like Asthma and Hypertension.
- Creating a data warehouse that can be used by epidemiologist to assess the impact of changes to treatments and other outcome reporting.
Information Management Program Accessing Clinical Treatments (IMPACT)

IMPACT

- CCPro/Camit Pro
  - up to 14 clinics

- EMR/Camit Pro
  - up to 2 clinic

- Hospital Systems/Camit Pro
  - up to 3 clinics

Collective Outcome Reporting

Diabetes and other Chronic Disease info.
Conclusion

- HIT projects like this take time, money, and careful planning to implement.
- This type of project has the potential to have a positive impact on the state of disease management at a local level.
- IT is a tool, and is an integral part of the success of projects like this, but…….