



Getting Started Guide

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Table of Contents

1	Getting Started.....	2
2	Patient Overview	2
2.1	Creating Patients.....	2
2.2	Patient Information.....	2
2.3	Visual Indicators	3
2.3.1	Advanced Directives.....	3
2.3.2	Blood Pressure Moderate.....	3
2.3.3	Blood Pressure Severe.....	3
2.3.4	High Appointment No-Show Rate	3
2.3.5	Low Income	3
2.3.6	No Education	3
2.3.7	Pulse Moderate	4
2.3.8	Pulse Severe	4
2.3.9	University Education	4
2.4	Medications.....	4
3	Care Coordination	4
3.1	Overview	4
3.2	Care Path Templates	4
3.3	Assigning Care Plans to Patients	5
3.4	Personalizing Care Plans.....	5
3.5	Monitoring Patient Progress	5
3.6	Adding Multiple Care Plans.....	6
3.7	Patient Vital Processes	6
3.7.1	Overview	6
3.7.2	Blood Pressure.....	6
3.7.3	Resting Heart Rate.....	7
4	Dashboards	7
4.1	Overview	7
4.2	Care Coordination – Alerts Dashboard	7
4.3	Care Coordination – All Dashboard.....	7
4.4	Care Coordination – My Dashboard.....	7
5	Configurations.....	8
5.1	Installing Managed Solution.....	8
5.2	Uninstalling Managed Solution	8
6	Contact Tribridge	8

1 Getting Started

The prerequisite for downloading Health360 Care Coordination in App Source, is to have an existing Dynamics 365 online trial environment. In order to download this trial, start by clicking the “Try It” button and then following the steps in the following link:

<https://www.microsoft.com/en-us/dynamics365/customer-service>

Once the Dynamics 365 online trial is installed, you are now ready to get started with Health360 Care Coordination. Start by clicking the “Try” button and then following the steps in the following link:

https://appsource.microsoft.com/en-us/product/dynamics-365/tribridge_health360.2ca8cb47-4e93-4e1c-af86-784041b4d8a9

2 Patient Overview

2.1 Creating Patients

The patient entity leverages the base Dynamics CRM Contact entity for demographic information, but has been specifically tailored to complement information from clinical systems with patient preferential, behavioral and social determinants of care. Patients can integrate from upstream systems or entered directly in CRM. Patients are identified within Dynamics CRM via their name, though healthcare identifiers have been added to allow for unique identification and integration with clinical systems.

2.2 Patient Information

The Patient record starts with General information. Name, phone, email, address, etc. The Details section contains additional descriptive information that can be used to identify the patient. This includes demographic characteristics and identification numbers. The MPI/Corporate ID is the single most important for the purposes of matching patients within Dynamics CRM to their related information in other systems.

All Patients have a Care Team which uses the out of the box Connections. The care team users are part of the clinical team (ie. Nutritionist, RN, etc.). Family consists of the patients’ relatives, primarily used to contact with information regarding the patient. Also on the patient form is the patient’s contact preferences along with the best time to be reached. The “About Me” section includes personal questions and the patient’s allergies, stressors, and transportation methods. Most of the personal fields are used to trigger the Visual Indicators (ie. Education, Transportation Issues, etc.). The patient has a section for activities and alerts. Activities are primarily used for proactive tasks like obtaining the patient’s medical history. Alerts are primarily used for reactive tasks like calling the patient about an abnormally high blood pressure. The user can always use the patient site map to navigate to any patient related entity, it is sectioned into four different areas of entities: Care Planning, Clinical, Preferential/Social, and Assessments.

2.3 Visual Indicators

Visual indicators are round icons located at the top of the patient form that allow the user to quickly get high level information about the patient. The list below includes the trial visual indicators and how they are displayed:

2.3.1 Advanced Directives

The Advance Directives icon is displayed if 1 or more Advance Directives records are created/exist for the Patient. If you delete all the existing Advance Directives records on a patient, this icon will not be displayed.

2.3.2 Blood Pressure Moderate

The Blood Pressure Moderate icon is displayed if the Patient has the following:

- Systolic Blood Pressure that is greater than 120
AND
- Diastolic Blood Pressure that is greater than 80.

If you hover over this icon, the Systolic Blood Pressure figure over the Diastolic Blood Pressure figure will be displayed. Example: 125 over 85

2.3.3 Blood Pressure Severe

The Blood Pressure Severe icon is displayed if the Patient has the following:

- Systolic Blood Pressure that is greater than or equal to 140
OR/AND
- Diastolic Blood Pressure that is greater than or equal to 90.

Please note that if the Patient only matches with one of the blood pressure requirements, the other blood pressure must contain a number greater than 1 in order for the icon to be displayed. Example: If the Systolic Blood Pressure figure is 150, the Diastolic Blood Pressure must contain a figure greater than 0 for the icon to be displayed.

If you hover over this icon, the Systolic Blood Pressure figure over the Diastolic Blood Pressure will be displayed. Example: 140 over 90

2.3.4 High Appointment No-Show Rate

The High Appointment No-Show rate icon is displayed if the Appointment no-show rate field has 'High' selected. If you hover over this icon, "High Appointment No-Show rate" will be displayed.

2.3.5 Low Income

The Low Income Icon is displayed if the Household Income field has 'Less than \$24,999' selected. If you hover over this icon, "Less than \$24,999" will be displayed.

2.3.6 No Education

The No Education icon is displayed if the Education field has 'Some High School' selected. If you hover over this icon, "No Education" will be displayed.

2.3.7 Pulse Moderate

The Moderate Pulse is displayed if the Patient has a pulse of 75 or greater but less than 82. If you hover this icon, the exact Pulse Rate will be displayed.

2.3.8 Pulse Severe

The Severe Pulse icon is displayed if the Patient has a Pulse of 82 or more. If you hover over this icon, the exact Pulse Rate will be displayed.

2.3.9 University Education

The University Graduation icon is displayed if the Education field has any of the following selected: Bachelor's Degree, Master's Degree or Doctoral Degree. If you hover over this icon, "University Education" will be displayed.

NOTE: Visual indicators are part of a limited trial. A complete visual indicator library is available upon purchase.

2.4 Medications

Health360 integrates with FHIR (Fast Healthcare Interoperability Resources) to display the patient's current medications. The user will click on the "FHIR Medications" button on the Patient form, and a process will link the Patient's MRN with the associated FHIR medications, and the results display in an iframe in CRM. The data includes the following details: medication names, dosages, clinical notes, medication status, prescription date, and if the medication has been taken.

3 Care Coordination

3.1 Overview

The Care Coordination module in Health360 is used to monitor and care for patients on a perpetual basis in a personalized matter. Care Plans can include any combination of chronic diseases plans, care transition plans, behavioral health plans, ongoing community based supports and services, wellness programs, etc.

The Care Path entity structure serves as a template for a care management schedule. Once a Patient is ready to be monitored, a Care Plan or multiple Care Plans will be added to a patient. The Care Plan will have defaulted values from the Care Path entities. Those defaulted values can be personalized to better suit the patient's medical and personal needs. Clinicians will then use the custom user interface to carefully monitor and care the patient's diseases, as well as remain aware of when the next encounters should occur.

NOTE: Care Path templates are part of a limited trial data set. Care path content is also available for purchase. Health provider's own pathways/protocols can also be loaded and/or maintained in Health360.

3.2 Care Path Templates

Care Path Templates are chronic/transition plans with goals and associated target and action values for each. These values can later be personalized once the plan has been assigned to a patient, but when the plan is first added the template values are defaulted. Care Path Goals help to describe the Goals that can be used to address a particular issue within a care plan. The essential elements of a goal are the vital value type, patient modifier, target, action and frequency. Goals can be either quantitative or qualitative. The

vital value type indicates what goal is being measure (ie. Blood Pressure, Depression, Step Count, etc.). The patient modifier is related to the vital value type, this is used to create different goals for the same vital value type based on different groups of patients. Common patient modifiers include: All, Most Patients, Elderly/Frail/Comorbid. Target is the actual goal. If the goal is quantitative the fields allow for the separate storage of the metric values to allow CRM workflows to compare target metrics with actual metrics. If the goal is qualitative, the goal is stored in a text field. Actions are the criteria that needs to be met in order to prompt clinical attention. Quantitative goals use this field to automatically create alerts.

3.3 Assigning Care Plans to Patients

A patient can have multiple care plans added. If they are added at different times, any goals that overlap will already be personalize. The clinician should verify that the patient still belongs to the modifier selected. Some goals have different modifiers based on the care plan.

3.4 Personalizing Care Plans

Personalize Mode is where the clinician would select all of the goals that the patient should be on, and personalize them to meet the patient's needs. The user interface classifies all of the goals by the following sections: Personal Goals, Tests/Vitals, Medications, Activity/Nutrition, Support Services, and Behavioral Health. As the clinician is going through and personalizing the goals, he/she would open one section at a time and select the appropriate modifier. Each goal can have several modifiers for a specific vital value type. In other words, this is a way to categorize the level of care that patient needs for a specific goal. For example, blood pressure goals use the modifiers "Most Patients" and "Elderly/Frail". Elderly/frail patients may never reach certain blood pressure ranges that most patients will maintain, the goal here is to make sure the patient's current blood pressure doesn't continue to get worse.

In Personalize Mode, the goal, frequency, and trigger values will be defaulted from the Care Path. At this time the clinician may update the numerical values for quantitative goals and text for qualitative goals, as well as the frequencies for in range and out of range if needed. This can also be done at a later time after the goal has already been added. For example, if a patient baseline for blood pressure is higher than the defaulted range, the clinician can personalize the individual goal that will better suit that patient.

3.5 Monitoring Patient Progress

Monitor Mode allows the clinician to see all the goals the patient is being monitored for. It also is an easy way to view what the patient's target for each goal, as well as the last result along with the last result date and the recommended next due date. If a patient has a last result, that goal will be considered as "Met" if the goal is in the range of the target value, or "Not Met" if the goal falls outside the target boundaries. All goals that are met will contain green text, and goals that are not met will be classified in red. Any goal that is under the orange tab are open goals that the patient still needs data for. The clinician is able to view any individual goal from Monitor Mode by clicking on the "..." button. The UI will navigate to Personalize Mode for that specific goal. On this screen the clinician can change the goal target and the frequencies. The last result information will be displayed on this screen as well as the prompt criteria. The patient modifier can also be changed on this screen if the clinician determines that the patient is better suited in a different modifier category.

All of the quantitative goals will be automatically determined as met or not met through the values that are on the Patient Vitals for each goal. When a patient vital is created, a background process is triggered

and will automatically set the goal attributes. At the moment, qualitative goals must be manually entered in Monitor Mode, and the clinician will be able to type what the last result and the goal state of the qualitative goal.

3.6 Adding Multiple Care Plans

A patient can be assigned multiple care plans, the list of care plans to be added gets filtered to only include care plans not associated to the patient. If the current care plan and the new one being added shares one or some of the same goals, those goals will not get added again and the goals will be monitored once for all related care plans. If a goal has the same vital type but different modifiers, the clinician will be able change the modifier if needed, and the goal will only appear once in Monitor Mode.

3.7 Patient Vital Processes

3.7.1 Overview

The workflows below all fire when a Patient Vital record is created. It first checks for the vital type to equal the one related to that workflow. Next, it waits for the Observation Date and Time UTC to be converted to local time, and for the related care plan goal to be mapped to vital record. Once completed, the process verifies that the patient's related goal is selected. The workflow will end if the patient does not have a selected goal, but if a goal is selected the process will continue to check whether or not the goal has been met. Following these steps, each of the workflows below have a different condition to be satisfied before considering the vital is in range of the related goal. Those individual conditions are outlines below. If the goal is in range a custom workflow will calculate the next due date using the in range frequency fields on the related care plan goal. The next due date is simply the next date the patient is recommended to retake the vital. The related goal record is also updated with the following attributes: goal state is set to "Met", last result date is the local observation date and time, the last result is the vital value, and the next due date is calculated date from the custom workflow. A very similar process is done for out of range vitals, only exception is the custom workflow uses the out of range frequency fields to calculate the next due date, and the goal state in this scenario will be set to "Not Met". All of the processes below also have prompt criteria that will trigger an alert. This criteria cannot be personalized and is hard coded into the workflows. The criteria for each process is detailed below.

NOTE: The automated patient vital processes are part of a limited trial. Processes that create alerts for protocols can be purchased and customized for a health provider's own pathways/protocols.

3.7.2 Blood Pressure

The Blood Pressure goals are all quantitative and are classified as part of the Test/Vitals section. Both Systolic Blood Pressure and Diastolic Blood Pressure are part for the Blood Pressure workflow, and each of these vital values are reported as separate vitals. These goals are associated to the Diabetes, Elderly Care, Hypertension and Transitional Care care plans. For the vital to be in range, the blood pressure vital value needs to be less than or equal to the target value, and greater than or equal to the target value two field. Otherwise, if the Blood Pressure value is greater than the target value or less than the target value two field, the goal is considered out of range. Alert records will be created when the action criteria on the care plan goal has been reached.

3.7.3 Resting Heart Rate

The Resting Heart Rate goal is quantitative and are classified as part of the Test/Vitals section. This goal is associated to the Diabetes, Elderly Care, Hypertension and Transitional Care care plans. For the vital to be in range, the resting heart rate vital value needs to be less than or equal to the target value, and greater than or equal to the target value two field. Otherwise, if the Blood Pressure value is greater than the target value or less than the target value two field, the goal is considered out of range. Alert records will be created when the action criteria on the care plan goal has been reached.

4 Dashboards

4.1 Overview

Health360 dashboards are collections of charts and data lists showing various combinations of patients, care plan components and activities. The dashboards are fully configurable. For example, view selectors can be added to allow a dashboard chart to show all patients, only a user's patients, or another team user's patients. The number and size of charts or lists on a view can be easily modified.

Dashboards and corresponding components of charts and lists are fully interactive. Chart drilldowns can be performed to filter into desired data records. Data lists can be used to navigate to detailed data items. The list views within a dashboard are often reused from other locations within the system. Available columns, column widths and sorting are the same within both views, though the view can be copied if the dashboard view needs a summarized set of columns.

4.2 Care Coordination – Alerts Dashboard

The Alerts dashboard is a custom tile user interface that sorts tiles based on the most recent alert and severity. Tiles displayed on this dashboard are either level 3, 4 or 5. Alert level 5 being the most severe, these are the red alerts. The number on the colored tabs indicate the amount of alerts of that type that the patient has. For example, if the patient has a red, orange and yellow tab on his/her alert tile, and each of those tabs have the number one, that means that the patient has three total alerts, and one of each type. All of the alerts include a high level description of the issue. A clinician can click on "more" button and this will navigate to a view of all of the patients associated alerts. The alerts can be filtered on "All Patients" or just "My Patients". This dashboard also includes overdue goals, open activities, and active patients.

4.3 Care Coordination – All Dashboard

A system wide view with visibility for all Patient data and all Activity data. Notice the higher record counts for activities and patients. Icons in the upper right-hand corner of each chart allow the user to directly view the records used to generate the chart. Alternatively, the user can click on the portion of the chart for drill-down, and select any field on the entity.

4.4 Care Coordination – My Dashboard

A daily to-do list view with visibility for my Patient data and my Activity data. Notice the lower record counts for activities and patients. This is often the default view for an individual Care Manager or Care Coordinator allowing them to see patients and activities assigned to them.

5 Configurations

5.1 Installing Managed Solution

Once the managed solution has been installed, the administrative user will need to publish the Health360 Theme. In order to do so, the user will need to navigate to CRM Themes, by clicking on Settings > Customizations > Themes. Then click on the Health360 Theme and click on the Publish button.

5.2 Uninstalling Managed Solution

Before uninstalling the Health360 managed solution. The administrative user will need to delete the Health360 Theme record. In order to do so, the user will need to navigate to CRM Themes, by clicking on Settings > Customizations > Themes. Then select the Health360 Theme and click delete. After the theme has been deleted, select the CRM Default Theme and click on the Publish Theme button in the navigation ribbon. Once these steps have been completed, the managed solution can be uninstalled by navigating to Settings > Solutions selecting the solution to be deleted, and then clicking on the delete button.

6 Contact Tribridge

To contact our subject matter experts please provide the information below using the link provided. If you need immediate assistance feel free to contact us at 1 (888) 495-4749.

<http://www.tribridge.com/about/contact>