The Center for Primary Care Informatics: CPCI for the C-Suite

Warria Esmond, Settlement Health
Barbara Hood, William F. Ryan CHC

Lisa Perry, CHCANYS
LuAnn Kimker, Azara Healthcare

CHCANYS Annual Conference
October 25, 2017

azara healthcare

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

Agenda

- Introductions
- Defining the Need
- Creating a Data Culture & Promoting Adoption
- Tools to Support Success
- Case Studies
  - Settlement Health
  - William F. Ryan Community Health Center
- Questions

Introductions

- Warria Esmond, MD, Chief Medical Officer, Settlement Health
- Barbara Hood, MBA, Chief Information Officer, William F. Ryan Community Health Center
- LuAnn K. Kimker, RN, MSN, Director of Clinical Innovation, Azara Healthcare
- Lisa Perry, MBA, MPP, Sr. Vice President, Quality and Technology Initiatives, CHCANYS

Do We Agree About What Work Is Useful?

All you've done is chisel all day! Do something useful, like helping your brother drag those rocks up the hill.

Population Health Management

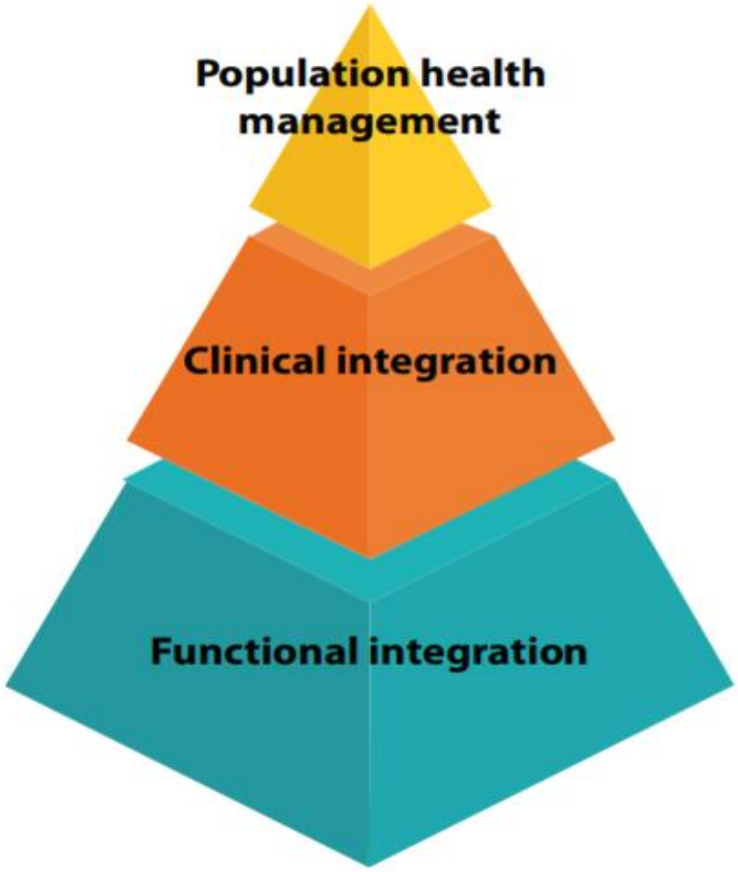
What it is….

"…a data driven healthcare delivery model that provides individualized care plans to populations based on health risks and conditions."

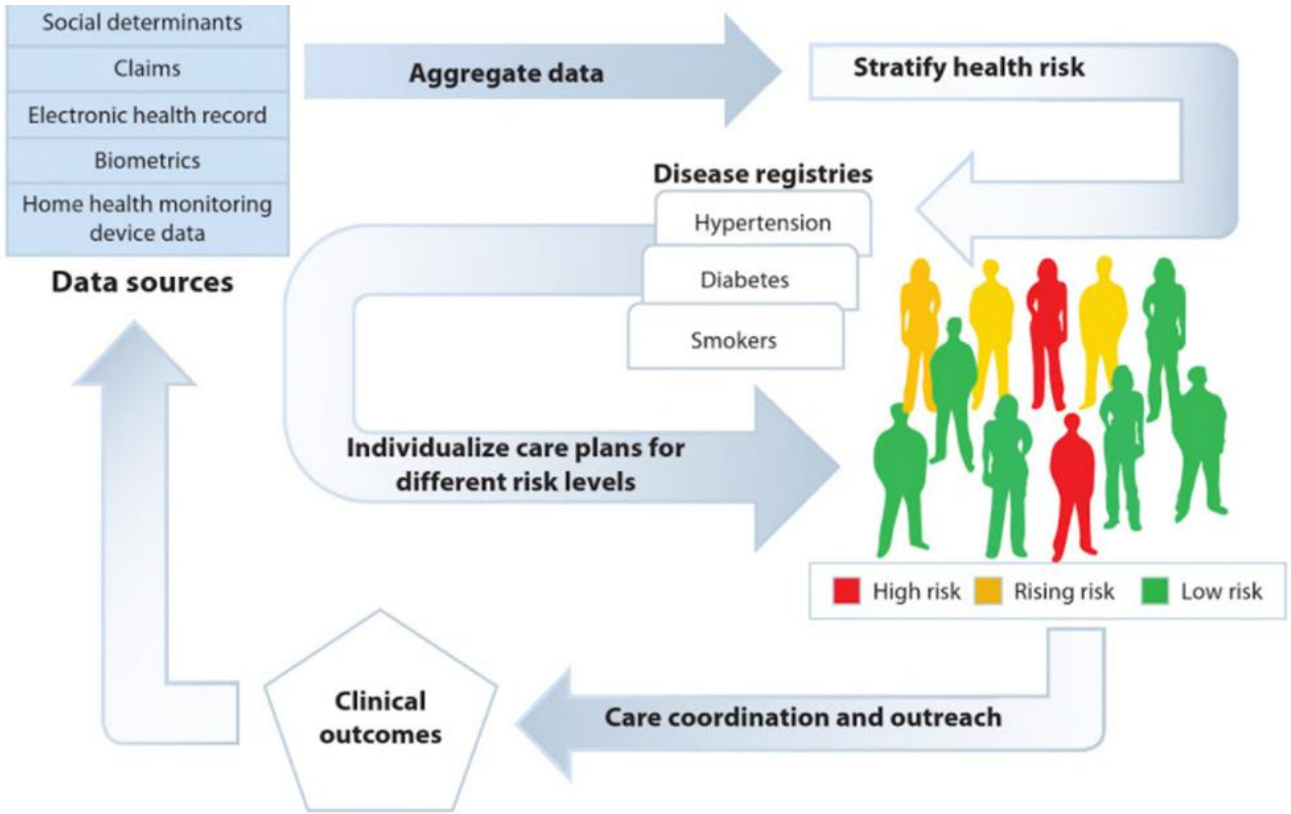
PHM uses

- data aggregation
- risk stratification and
- analytics

to design and monitor the effectiveness of treatments and interventions tailored to individual health profiles.



J. Andrieni, Chapter 9: Population Health Management, the Lynchpin of Emerging Healthcare Delivery Models. From "America's Healthcare Transformation: Strategies and Innovations," edited by R. Phillips. Http://tinyurl.com/h8we2th



Aggregate Normalize Data
- Claims
- EHR
- Other

Segment Population
- Condition
- Risk Scores
- Screenings
- Other

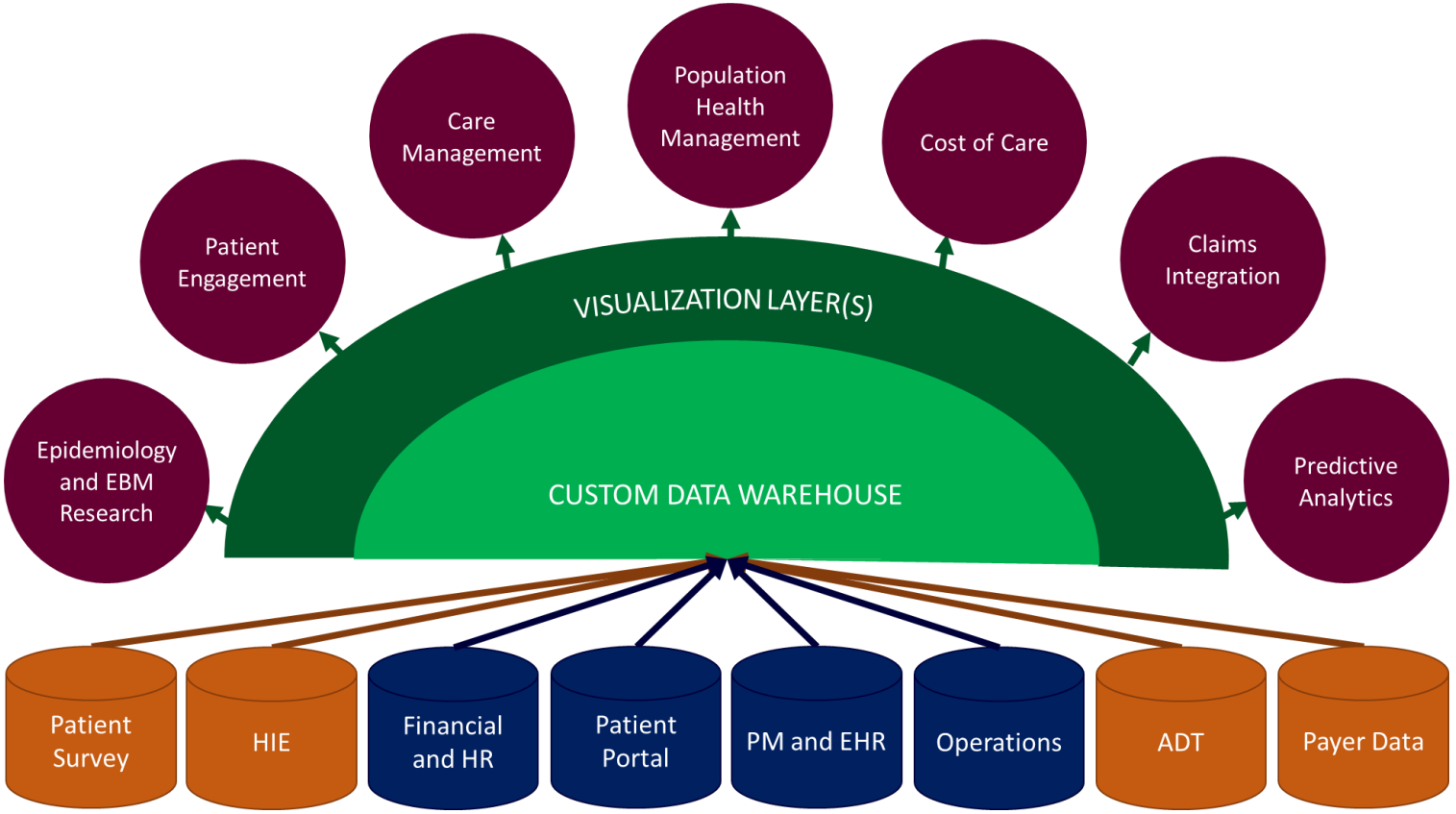
Reporting
- Quality and Care Gaps
- Cost and Utilization

Care Management
- Provider based
- Provider defined

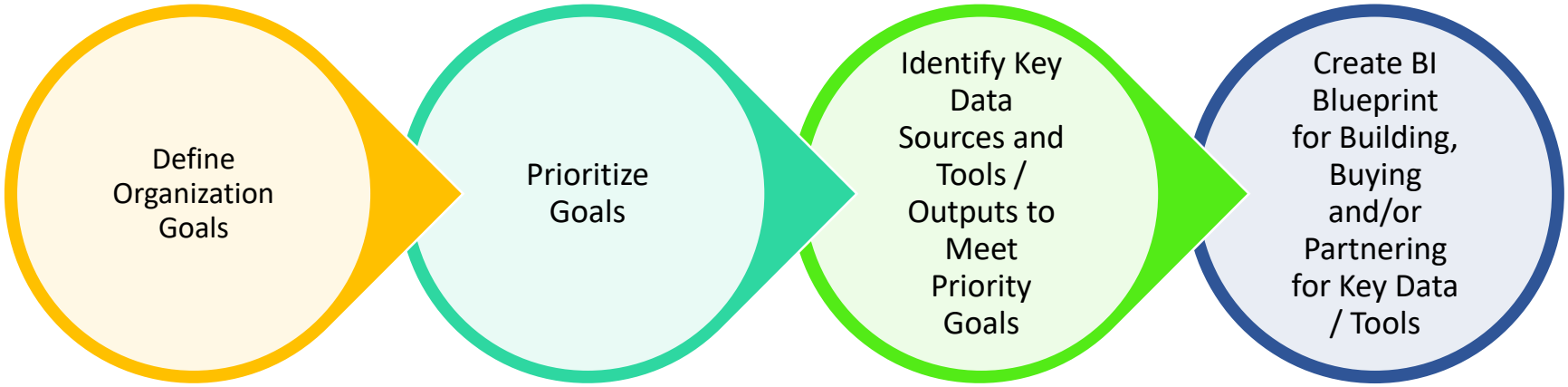
Chilmark: 2017 Healthcare Analytics Market Trends Report

Business Intelligence

A set of data analysis and visualization tools that collect data from a variety of sources, and arrange and display the information optimally for analytics.

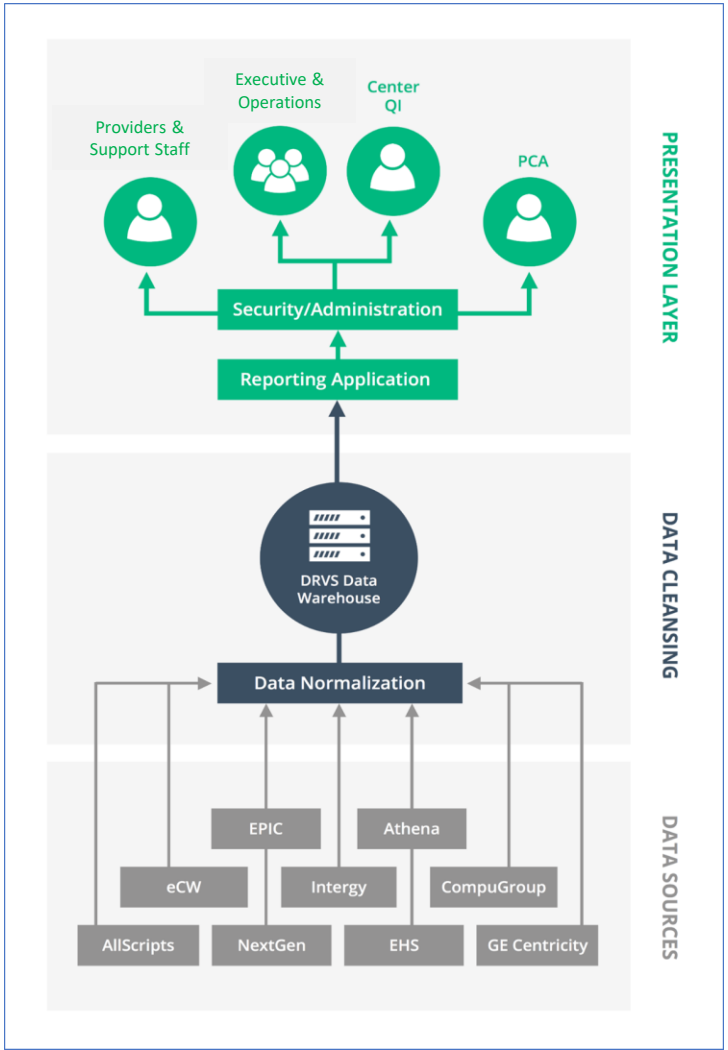


Building Your Strategy



- List out your goals for the next 1-5 years
- Rank each goal to identify the top priorities
- For each goal map out the needed data sources, tools & outputs
- Evaluate and select BI models
- Put the four decisions together in your blueprint

CHCANYS' Center for Primary Care Informatics (CPCI)



The CPCI:

- Extracts data from EHRs
- Integrates data from external sources e.g., RHIOs, payers
- Calculates performance metrics
- Provides dashboards and reports for performance monitoring
- Provides clinical and operations workflow tools

INTEGRATION & ADOPTION OF CPCI

CREATE THE CULTURE, REALIZE THE ROI

Rationale for CHCANYS Centralized Data Warehouse

- Benchmark & Collaborate
- Improve care delivery (at POC)
- Support care management and population health
- Measure performance - tell your story
- Implement & enhance cost-effective IT capacity
- Integrate with State & local Systems (e.g. HIE)
- Respond to external data requests
  - Payers (Affinity, United Healthcare, Healthfirst, HealthPlus)
  - Government (DSRIP, PPS)
  - Academic institutions/researchers
  - Patients
  - Funders

This doesn't have to be you.

Take Care of Your Data – It's A Valuable Commodity

Requires

Time

Talent

Treasure

Essentials of an Effective Data Program

- Leadership and Vision
  - Embedding data in the culture of the organization
- Frequent presentation of data throughout the organization
  - Leadership (all levels), Performance/Quality Improvement, Operations, Clinical Care Teams, Providers, Nursing, Finance, IT
- Commitment to validate the data & keep it clean
  - Data Governance – standard workflows; change control
  - Data Hygiene
- Resources to maximize adoption of data tools by clinical, operations and administrative staff
- Training and Education
  - Must be a learning organization

Return on Investment

3 – 22%
Relative Change

	Measure	Average Baseline	Average at End of Intervention	Relative Percent Change	% of Sites with Improvement > 5%
CDC Project	Breast Cancer Screening	34.2%	41.8%	22.2%	41.7%
	Colorectal Cancer Screening	36.7%	44.8%	22.1%	50.0%
	Cervical Cancer Screening	41.7%	45.0%	7.9%	41.7%
Healthy Hearts	Aspirin Use	78.0%	85.3%	8.8%	63.2%
	ASCVD Statin Therapy	71.0%	77.1%	8.4%	52.6%
	LDL Statin Therapy	67.0%	72.9%	8.2%	36.8%
	Tobacco Screening	78.0%	84.8%	7.9%	36.8%
	Hypertension Control	63.0%	65.7%	3.0%	36.8%

Forms the basis for incentives from MCOs, NYS VBP, and HRSA

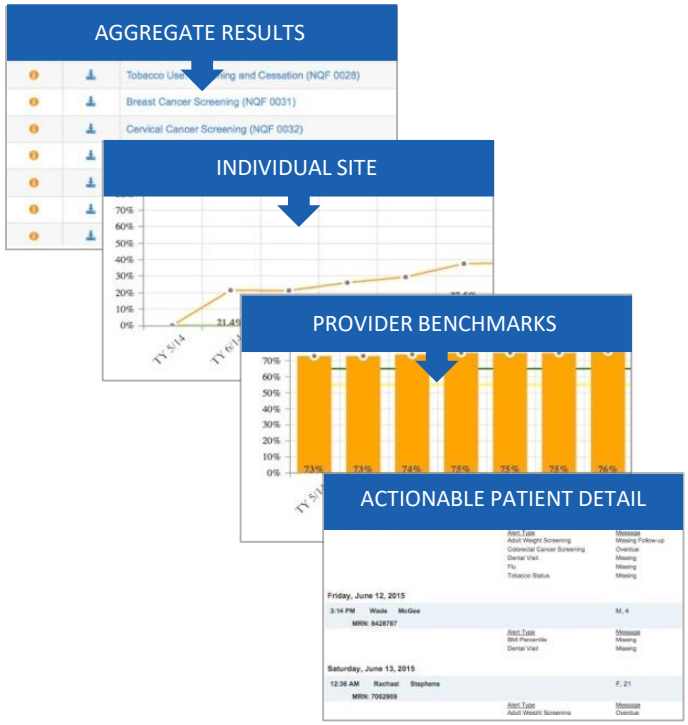
33-66% of the sites
5%+ Improvement

CPCI TOOLS FOR SUCCESS

CPCI Capacity

CPCI Supports Clinical Quality and Cost Management by Integrating Data Tools into Everyday Practice:

- Dashboards
- Clinical Quality Measures – graphs, tables, scorecards, dashboards
- Patient Visit Planning
- Referral Management
- Registries
- Panel Management
- Payer Integration
- Enrollment data
- Claims/total medical expense
- Utilization
- RHIO data
- Risk-scoring
- Operations & Finance measures
- Substance use/pain management



Panel Management

Active Pts, Past 3 Yrs

TY September 2017

12,574

Pts w/ Qualifying Encounter in past 3 years

Active Pts, Past Yr

TY September 2017

8,869

Gap

Inactive Pts (No visit in past year)

TY September 2017

3,705

Pts without Qualifying Encounter in past 12 months

Average Panel Size

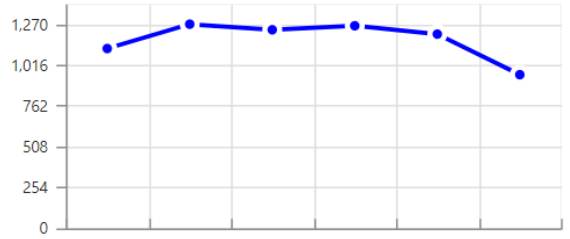
September 2017

11,813

Pts w/ Qualifying Encounter

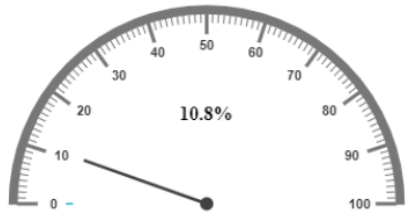
Pts with F2F Encounters

September 2017



Provider Continuity, Past Yr

September 2017



Panel Age Stratification

September 2017

Age	Numerator	% Total
18-25	1,593	13
26-45	3,825	32
3-6	747	6
46-64	2,706	23
65 +	606	5
7-17	2,119	18
<= 2	217	2

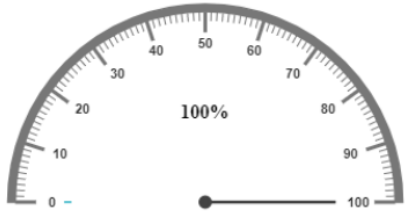
Pts with F2F by Risk

September 2017

Patient Risk	Denominator	% Total
High	871	90.8%
Low	13	1.4%
Moderate	75	7.8%

Usual Provider Assigned

TY September 2017



Attribution and TME

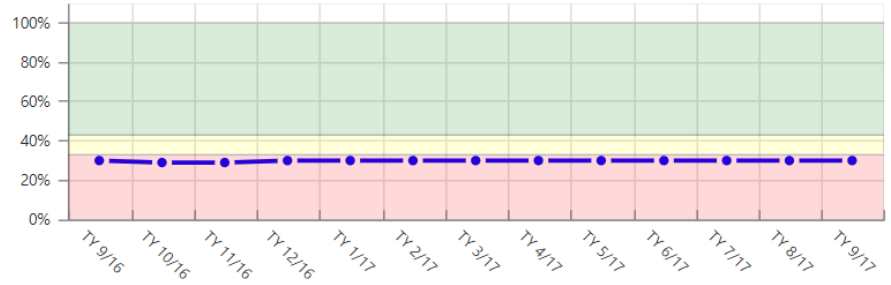
Attributed Members

13,470
Members Eligible During the Period

Unmatched Members

9,454
Unmatched Members

Timeline Trend



Matched Members Group By Age

Age	Match Rate	Matched Members	Members
<= 2	30%	72	241
3-6	30%	258	867
7-17	31%	753	2,430
18-25	30%	550	1,844
26-45	30%	1,284	4,321
46-64	29%	877	3,072
65 +	32%	222	695

Matched Members Group By Cost

Cost Group	Match Rate	Matched Members	Members
No Cost Data	29%	10	35
$0-5k	30%	3,821	12,837
$5k-10k	20%	8	40
$10k-25k	36%	50	138
$25k-50k	30%	127	420

Matched Members Group By Last Encounter

Last Encounter	Matched Members	% Total
No Encounter	691	17%
0-180	1,460	36%
181-365	889	22%
366-720	800	20%
>720	176	4%
Totals	4,016	

Member Matching / Enrollment Dashboard

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

COMMUNITY HEALTH CENTER FQHC QUALITY

Dashboards - Health Plan Enrollment Matching

Period Type
Trailing Year

Members

Mbr Visit St

Last Encounte

No Encounter
0-180
181-365
366-720
>720

Selected Patients for Matched Members

Filtered by : InverseNumerator

Plan	Name	Member Number	Matched	Eligbility Start	Eligbility End	EHR MRN	Age	DOB	Age Group	Sex
Group Health	BOCZAR, BRENDAN	4080A	N	1/4/2017	5/30/2017		30	5/4/1987	20-34	M
Group Health	AMRINE, KIMBER	4084A	N	4/29/2017	8/24/2017		25	9/21/1991	20-34	F
Community Health Plan	HILLSETH, CONNIE	4089A	N	5/27/2015	5/30/2017		10	12/27/200	5-12	M
Group Health	GOLD, KIMIKO	4095A	N	2/23/2017	8/4/2017		8	7/17/2008	5-12	F
United Health Plan	KARABIN, ARNULFO	4098A	N	7/25/2016	8/27/2017		46	12/28/197	45-64	M
Group Health	ALGEE, JESSIKA	4118A	N	7/18/2015	6/23/2017		15	5/30/2002	15-19	F
United Health Plan	LEBSOCK, GLINDA	4109A	N	2/25/2017	5/27/2017		29	10/15/198	20-34	F
Group Health	DERUITER, LEANA	4159A	N	5/28/2015	7/28/2017		43	1/5/1974	35-44	F
Group Health	HEININGER, GERARD	4160A	N	4/12/2017	7/4/2017		38	8/21/1978	35-44	M
United Health Plan	KAYS, FRED	4163A	N	3/7/2017	6/1/2017		52	5/28/1965	45-64	F
United Health Plan	BELUE, HYMAN	4206A	N	8/1/2015	6/5/2017		51	3/17/1966	45-64	M
Community Health Plan	KUZMINSKI, WM	4222A	N	7/29/2015	7/18/2017		23	4/27/1994	20-34	M
Group Health	BECKLEY, RUFUS	4242A	N	5/22/2015	8/30/2017		6	4/27/2011	5-12	M
Community Health Plan	KARCZ, CARISA	4254A	N	9/11/2016	7/28/2017		57	3/3/1960	45-64	F

1 of 28 pages (460 items)

atched
mbers
8,106
6,893
16,962
22,206
51,553
26,721

Members
8,881
11,354
104,603
28,600
141,748

United

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

COMMUNITY HEALTH CENTER FQHC QUALITY

Clinical Quality – HEDIS Member vs Patient Measures

Dashboards - Cervical CA - Member vs Pt Results

Period: September 2017 | Providers: Providers | Plans: HealthFirst | Update

of Members Assigned
TY September 2017

10,663
Members Eligible During the Period

Eligible Members
TY September 2017

4,107
Members w/ Qualifying Visit

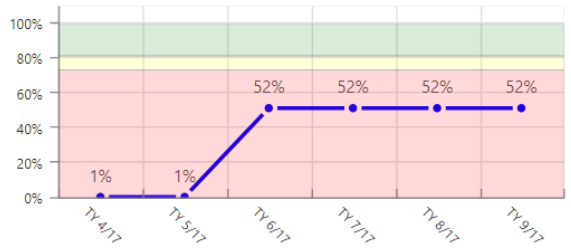
Eligible Patients
TY September 2017

2,092
Pts w/ Qualifying Visit

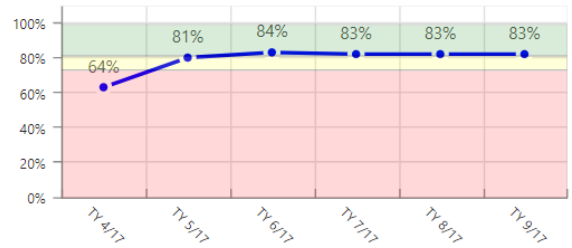
Unmatched Members
TY September 2017

3,603
Unmatched Members

Cervical CA Screen (CCS) Mbr Based
TY September 2017



Cervical CA Screen (CCS) Pt Based
TY September 2017



CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

COMMUNITY HEALTH CENTER FQHC QUALITY

Hypertension

Patients with Hypertension

1,804

Pts w/ HTN

Undiagnosed Hypertension

37

Pts w/ 2 readings of BP >= 140/90 on separate visits

Risk Level of HTN Pts

Patient Risk	Denominator	% Total
High	1,687	94%
Low	7	0%
Moderate	110	6%
Totals	**1,804**	

HTN Provider vs Ctr

Selected

85%

Center Average

85%

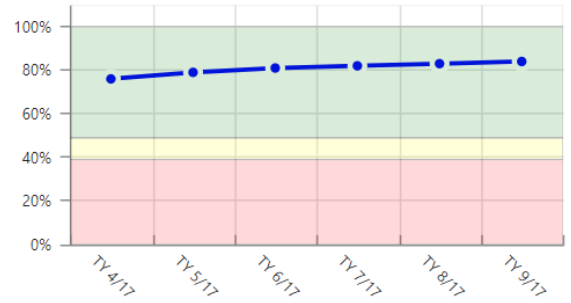
HTN BP Control by Age

Age	Result	Numerator	Denominator
15-19	73%	38	52
20-34	84%	509	606
35-44	86%	351	410
45-64	84%	522	618
65 +	86%	102	118

HTN BP Control

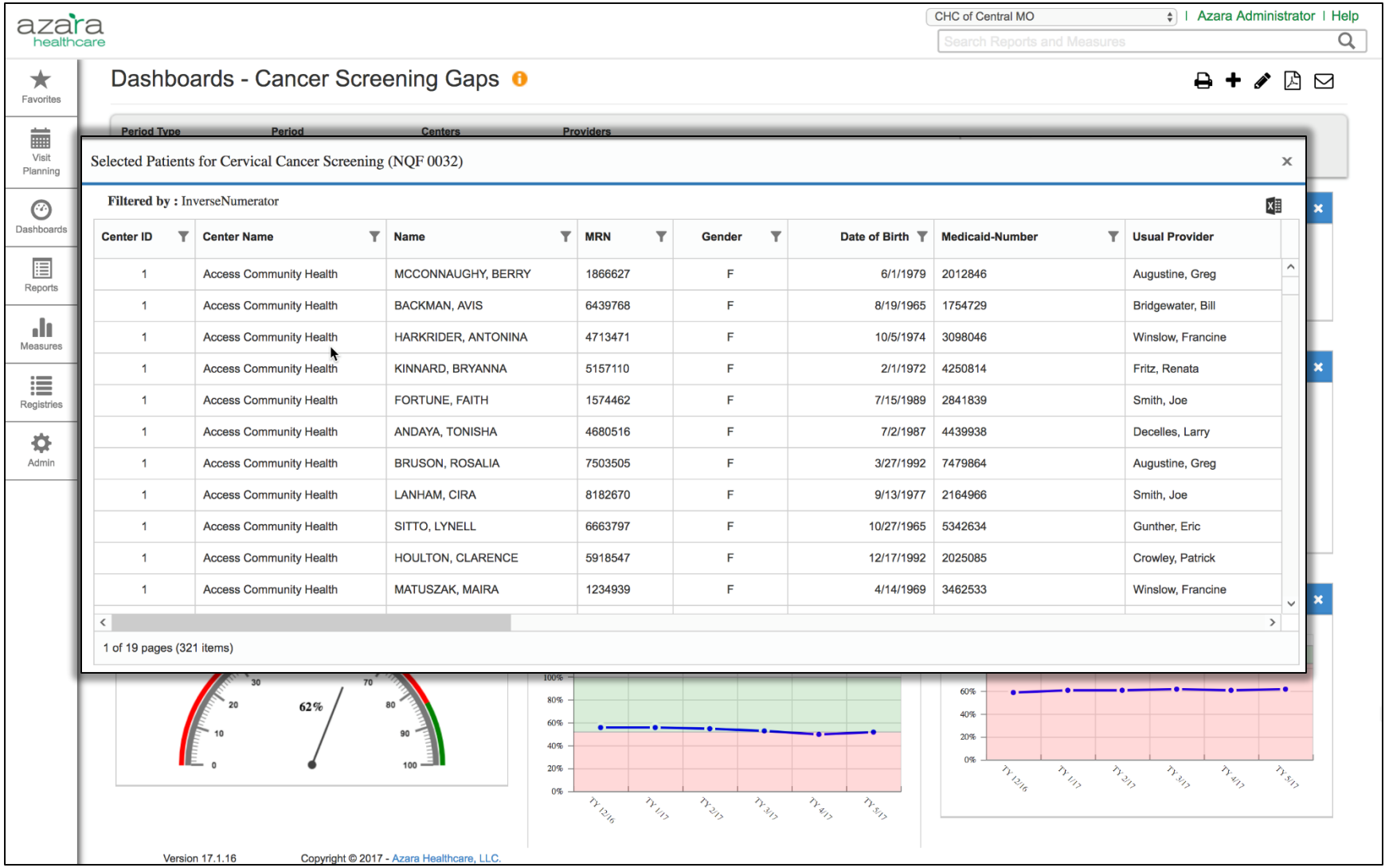
Pts w/ HTN	1,804	
Pts w/ BP >= 140/90	269	15%

HTN BP < 140/90



HTN Comorbidities

Cerebral Palsy	513
Chronic Non-malignant Pain	1,505
COPD	866
Coronary Artery Disease	1,464
Coronary Artery Disease No MI	1,382
Depression/Bipolar	1,320
Diabetes	1,136


azara healthcare
CHC of Central MO | Azara Administrator | Help
Search Reports and Measures
Favorites
Visit Planning
Dashboards
Reports
Measures
Registries
Admin
Dashboards - Cancer Screening Gaps
Period Type
Period
Centers
Providers
Selected Patients for Cervical Cancer Screening (NQF 0032)
Filtered by : InverseNumerator
Center ID | Center Name | Name | MRN | Gender | Date of Birth | Medicaid-Number | Usual Provider
1 | Access Community Health | MCCONNAUGHY, BERRY | 1866627 | F | 6/1/1979 | 2012846 | Augustine, Greg
1 | Access Community Health | BACKMAN, AVIS | 6439768 | F | 8/19/1965 | 1754729 | Bridgewater, Bill
1 | Access Community Health | HARKRIDER, ANTONINA | 4713471 | F | 10/5/1974 | 3098046 | Winslow, Francine
1 | Access Community Health | KINNARD, BRYANNA | 5157110 | F | 2/1/1972 | 4250814 | Fritz, Renata
1 | Access Community Health | FORTUNE, FAITH | 1574462 | F | 7/15/1989 | 2841839 | Smith, Joe
1 | Access Community Health | ANDAYA, TONISHA | 4680516 | F | 7/2/1987 | 4439938 | Decelles, Larry
1 | Access Community Health | BRUSON, ROSALIA | 7503505 | F | 3/27/1992 | 7479864 | Augustine, Greg
1 | Access Community Health | LANHAM, CIRA | 8182670 | F | 9/13/1977 | 2164966 | Smith, Joe
1 | Access Community Health | SITTO, LYNELL | 6663797 | F | 10/27/1965 | 5342634 | Gunther, Eric
1 | Access Community Health | HOULTON, CLARENCE | 5918547 | F | 12/17/1992 | 2025085 | Crowley, Patrick
1 | Access Community Health | MATUSZAK, MAIRA | 1234939 | F | 4/14/1969 | 3462533 | Winslow, Francine
1 of 19 pages (321 items)
62%
Version 17.1.16
Copyright © 2017 - Azara Healthcare, LLC.

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

COMMUNITY HEALTH CENTER FQHC QUALITY

Dashboards - Cancer Screening Gaps

Dashboards - UDS 2016 vs Current

Period	Centers	Providers	Service Lines
September 2017	Centers	Providers	Primary Care

Update

UDS Performance - 2016

2016

Measure	Result	Numerator	Denominator	Exclusions
Appropriate Rx for Asthma	87%	3,780	4,333	465
BMI Screening & Follow-Up 18+	63%	167,704	266,524	12,946
CAD Lipid Therapy	63%	3,431	5,419	0
Cervical Cancer Screening	51%	58,356	114,667	16,726
Child Wt Screening /BMI/Nutritional/Physical	49%	36,972	75,282	329
Childhood Immunization Status	21%	1,436	6,742	0
Colorectal Cancer Screening	31%	30,972	100,259	767
Depression Screening & Follow-Up	62%	154,208	250,405	58,613
DM A1c > 9 or Untested	32%	12,634	39,291	0
DM A1c < 8	57%	22,227	39,317	0
HIV and Pregnant	0%	16	14,544	0
HIV Linkage to Care	63%	22	35	0
HTN Controlling High BP	59%	50,135	85,421	916
IVD Aspirin Use	65%	8,676	13,337	1,571
Tobacco Use: Screening & Cessation	87%	162,216	187,172	0

UDS Performance - Current TY

TY September 2017

Measure	Result	Numerator	Denominator	Exclusions
Appropriate Rx for Asthma	85%	3,909	4,581	550
BMI Screening & Follow-Up 18+	61%	170,173	276,811	12,093
CAD Lipid Therapy	66%	3,581	5,456	0
Cervical Cancer Screening	49%	57,711	117,032	19,111
Child Wt Screening /BMI/Nutritional/Physical	50%	37,182	74,729	300
Childhood Immunization Status	23%	1,607	6,883	0
Colorectal Cancer Screening	33%	35,409	105,860	719
Depression Screening & Follow-Up	66%	170,034	257,649	60,607
DM A1c > 9 or Untested	33%	13,662	41,456	0
DM A1c < 8	56%	23,090	41,456	0
HIV and Pregnant	0%	19	13,142	0
HIV Linkage to Care	100%	40	40	0
HTN Controlling High BP	60%	52,672	87,170	797
IVD Aspirin Use	65%	8,027	12,314	1,457
Tobacco Use: Screening & Cessation	87%	164,076	188,582	0

CPCI: Continuing Enhancement

- CPCI was founded to support long term goal of ensuring CHCANYS members are successful in a value-based payment model
- CPCI has evolved as member needs evolved, and has provided significant benefits both at the individual member level and overall network level
- CPCI is a nationally recognized model for FQHC data integration
- National and regional trends indicate the need for sophisticated data analytics capacity will continue to grow
- Regional trends indicate CPCI must continue to evolve to meet additional member needs

Recommended CPCI Enhancements to Support:

1. Contract Negotiation
2. Performance Improvement
3. Care Management
4. Delegated Credentialing

Azara's Roadmap for Product Development

- Includes most of the recommended enhancements
  - Development Timeline runs from now through Q3 2018
  - Includes:
    - Risk Scoring - Now to Q4 2017
    - Care management passport – Q4 2017 to Q1 2018
    - Tools for match rate & outreach improvement – Q4 2017 to Q2 2018
    - Proactive Gap Reporting – Q1 2018
    - Contract Dashboards – Q1 to Q2 2018
    - Drilldown into Total Medical Expense and Claim Line Detail – Q1 to Q3 2018
    - Transactional care plans – Q2 2018 to Q3 2018

A TALE OF TWO CITIES

CASE STUDIES

RYAN NETWORK
William F. Ryan Community Health Network

C-Suite-PCI

Tools for Success

Presented by: Barbara Hood
Chief Information Officer

The William F. Ryan Community Health Network

"where healthcare is a right, not a privilege"

- Founded 50 years ago in 1967
- One of the first 6 pilot FQHCs
- 18 locations throughout Manhattan
- Serving over 47,000 patient annually
- NCQA Level 3 PCMH
- Joint Commission accredited

- 90% live at or below 200% FPL
- 57% receive Medicaid
- 12% receive Medicare
- 11% privately insured
- 19% uninsured

CPCI Journey

- Implemented in 2013, by the Informatics team over 8 weeks
- QI department was non-existent; IT-Informatics took leadership
- A comprehensive data management platform that meets reporting needs and is in-line with local, state and federal quality guidelines
- A proactive user-friendly tool for disease management & closing care gaps
- Thorough data validation process to ensure data integrity prior to deployment
- Project management approach to implementation & end-user adoption
- Scalability: New tools/features would be added, i.e., PVP, HIV Registries, etc.

Executive Buy-In

- Leadership must understand the value of data
- Foster a network-wide data culture

I ❤ Data

- Adopt a project management approach
- Encourage shift to being a more data-driven organization by leveraging the tool
- Resource the project appropriately:
  - Staff
  - Time
  - Funding
  - Build Technical Capacity

Staff Composition

Informatics Team:
- Configurations
- Data Validations
- New Enhancement Designs
- New Alert Requests
- Workflow designs

Health IT Training Coordinator:
- Configurations
- Feature enhancements
- Staff training and provisioning

IT Help Desk:
- Create and terminate accounts
- Ensure data feed is current from EMR

End User:
- Utilization of registries
- Utilization of PVP (daily)
- Population Health Management

Value of CPCI

- Shifts healthcare delivery from a reactive to proactive approach
- Improves quality incentive reimbursement and quality care compliance
- Leveraged PVP tool for daily operations and point of care screenings
- Leveraged CPCI reporting for DSRIP reporting & program monitoring
- Continued to add value to the PVP for initiatives like:
  - RHIO consent taking
  - Patient Portal connections
  - Geriatric Functioning Assessment
  - Learning Assessment
- HIVQual data reporting time and effort significantly reduced
- Generates scorecards for provider performance
- Dependable and stable platform with minimal additional burden to IT staff

Settlement Health's Journey with CPCI

Warria Esmond MD
Chief Medical Officer
Settlement Health and Medical Services
CHCANYS Conference
October 25th , 2017

Settlement Health

FQHC in East Harlem, New York since 1977

2 clinical sites
- 14,000+ unduplicated patients
- 70% Hispanic, 23% African American
- 50% primary language Spanish

12 FTE Providers – including CNMs/NPs
- Women's Health
- Pediatrics
- Internal Medicine
- Family Medicine
- Podiatry
- Nutrition

Settlement Health

Involved in multiple transformation projects

- Transforming Clinical Practice Initiative (TCPI)
- Dramatic Performance Improvement (DPI)
- Delivery System Reform Incentive Payment (DSRIP)
- Patient Centered Medical Home (PCMH)
- CHIPA

The Beginning

What were our goals for an electronic health record?

Participation in PCHIC helped define the true goals of EMR implementation for 26 safety net providers in New York City

Data, Data, Data

Thoughts Along the Way

What does it take to leverage the power of the Electronic Health Record?

How to get reproducible, reliable data?

How to develop good data for provider feedback?

How to meet future reporting expectations?

How to develop a “dashboard” for the organization?

Why Implement a Data Warehouse Solution?

Partnership/Shared Resources/Economy of Scale seemed to be a wise and cost effective strategy to realize the goals of data and reporting

Difficult to justify the expense necessary to accomplish a "robust" data strategy

Worked closely with other GE Users in NYC – Charles B. Wang

~ 2010 HRSA Funded HCCN for GE Users – first data warehouse developed

2013 Implemented Azara data warehouse

Where Are We today?

CPCI used across organization

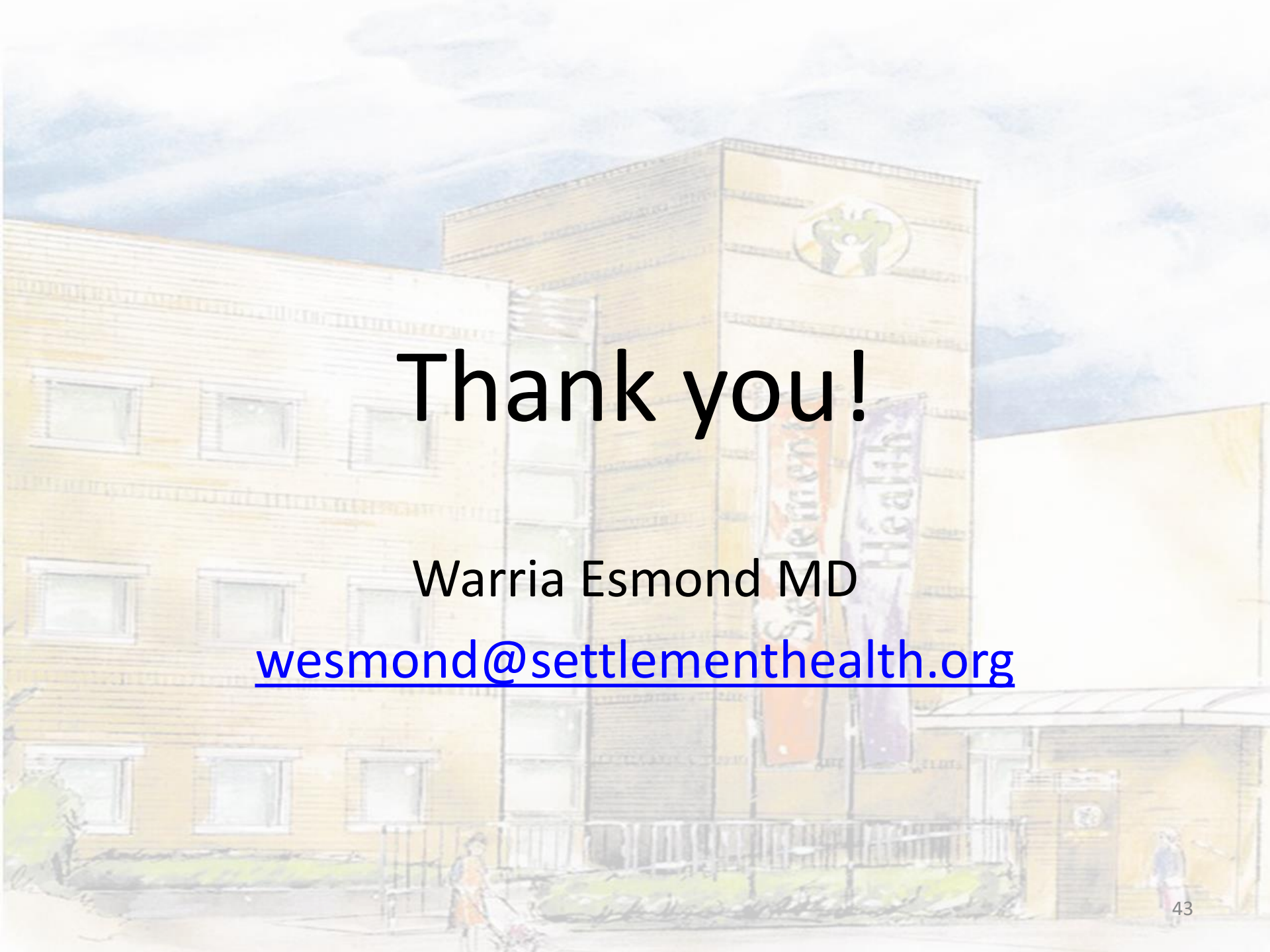
BPHC reporting
Quality Improvement
Pre Visit Planning
Care Management Team
DSRIP
Referral reconciliation
Satisfying curiosity/Answering questions that arise
And more….

Drivers of Successful Data Use

Leadership
- What is important to the success of the organization?
- How do we develop a culture of data driven care?
- Organization wide QI activities

HRSA Expectations
- Population Based Reporting
- Focus on Quality and Performance

Environment
- Value Based Payment
- Population Health
- Practice Transformation



Thank you!

Warria Esmond MD

wesmond@settlementhealth.org

Highlights of Peer Experience: Ingredients for Success in Your Analytics Program

- Leadership Support & Champions
- Staff dedicated to Adoption and Data Quality
- Widespread sharing of the data in your FQHC
- A strong Change Control Process
- A structured Data Hygiene Program – start small!
- A plan for managing & maximizing your data systems


obrigado
Dank U
Merci
mahalo
Köszi
спасибо
Grazie
Thank you
mauruuru
Takk
Gracias
Dziękuję
Děkuju
danke
Kiitos

For more information, please contact CHCANYS' Quality & Technology Senior Team or Azara Healthcare

Lisa Perry
Sr. Vice President, Quality & Technology Initiatives
lperry@chcanys.org
212-710-3815

Amy Grandov
Sr. Director, Health IT & Analytics
agrandov@chcanys.org
212-710-4185

Diane Ferran
Vice President, Clinical Affairs & Performance Improvement
dferran@chcanys.org
212-710-3814

LuAnn Kimker
Director Clinical Innovation, Azara Healthcare
Luann.kimker@azarahealthcare.com
781-258-2260