



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

NYS-HCCN

Analytic Tools for Team Based Care

April 28th, 2017 9:00 AM



Improving Patient Outcomes Through Data

CHCANYS NYS-HCCN Training

April 28, 2017



CONFIDENTIAL

This file contains information that is confidential to Azara Healthcare, LLC
Do not view, copy, distribute, or disclose without prior consent.

Agenda

- Introductions
- CPCI Overview
- Using Your Data to Tell a Story
- Registries
- CPCI Demo
- Dental and Behavioral Health Measures and Alerts
- What else can CPCI do for me ?

Greg Augustine



Chief Operation
Officer

LuAnn Kimker RN MSN

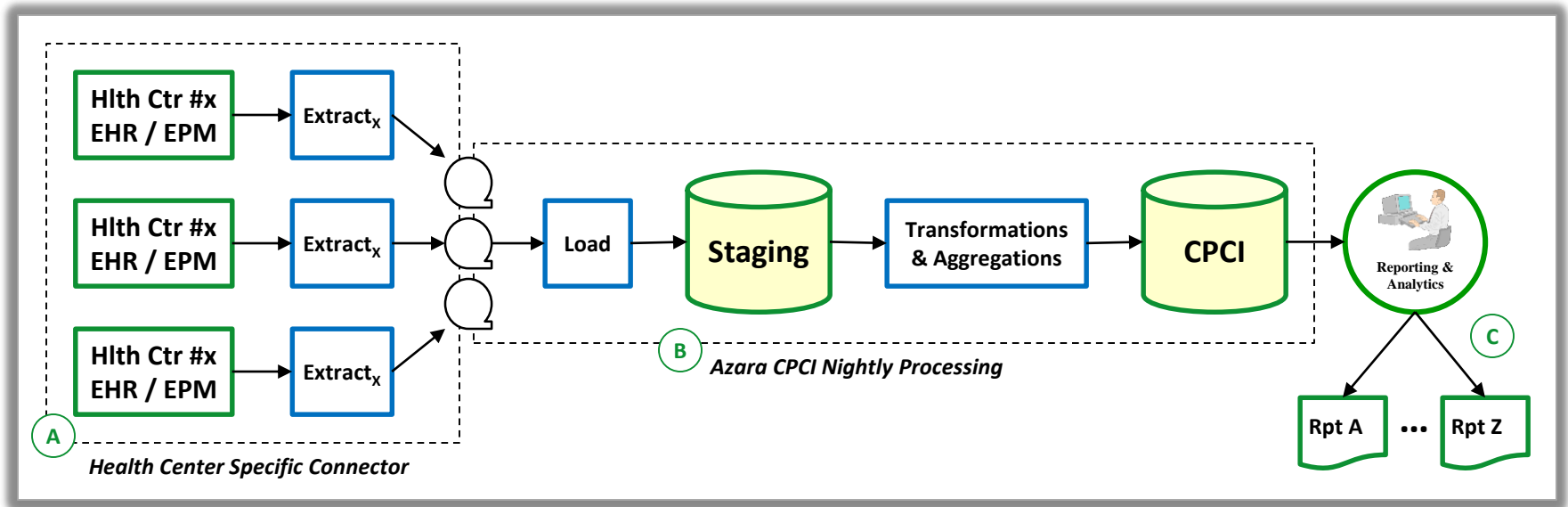


Director of Clinical
Innovation

CPCI – Connecting You to Success

- CPCI is a **reporting and analytics tool** that houses data from multiple CHCANYS site's
- Captures **structured EHR data** and can integrate with other data sources
- Provides **drill-down** capability
 - Network → CHC → Site → Provider → Patient*
- Provides multiple **levels of reporting** - Aggregate, Population and Point of Care - to be used by **various users** that provide and support the provision of quality, evidence based care

Technology – Application Architecture



How is CPCI Being Used in New York?

- CPCI is used to support many CHCANYS and Network-wide Initiatives
 - CDC Cancer Grant (Breast, Cervical, Colorectal Cancer)
 - NYS HCCN Grant
 - NYS AIDS Institute HIVQual
 - AHRQ Healthy Hearts
 - 1422 Grant (Diabetes, Hypertension)
 - DSRIP
 - Action Health NYC
 - TCPI Grant (Transforming Clinical Practice Initiative)
 - Payer Data Integration

- CPCI is used to support individual centers with...
 - Daily Visit Planning
 - UDS Reporting
 - PCMH accreditation
 - Meaningful Use
 - Center-specific responsibilities in support of Network Initiatives/other grants

CPCI Tools and Functionality

USING YOUR DATA TO TELL A STORY

Dashboards, Reports and Measures

Data is presented in CPCI in either a *Dashboard*, a *Report* or the *Measure Analyzer*

- ***Dashboards*** present data as a series of widgets in a graphical format.
- 3 Basic types of ***Reports*** group measures or key patient data.
 - Patient Visit Planning - ***PVP***
 - ***Scorecard*** Reports
 - Aggregated Data for Meaningful Use, UDS, PCMH
 - Clinical ***Registry*** Reports
 - Patient Level Detail for specific Chronic Conditions (e.g., Diabetes, Hypertension) or Preventive Care Segments (e.g., Adult Female, Adult Male)
- ***Measure Analyzer*** allows users to complete ad-hoc analysis for specific measures (e.g., A1c > 9)
 - Review trends
 - Benchmark providers
 - Identify outliers and disparities in care



Scorecard Report

Provides a quick snapshot of a group of measures, which may or may not be related.

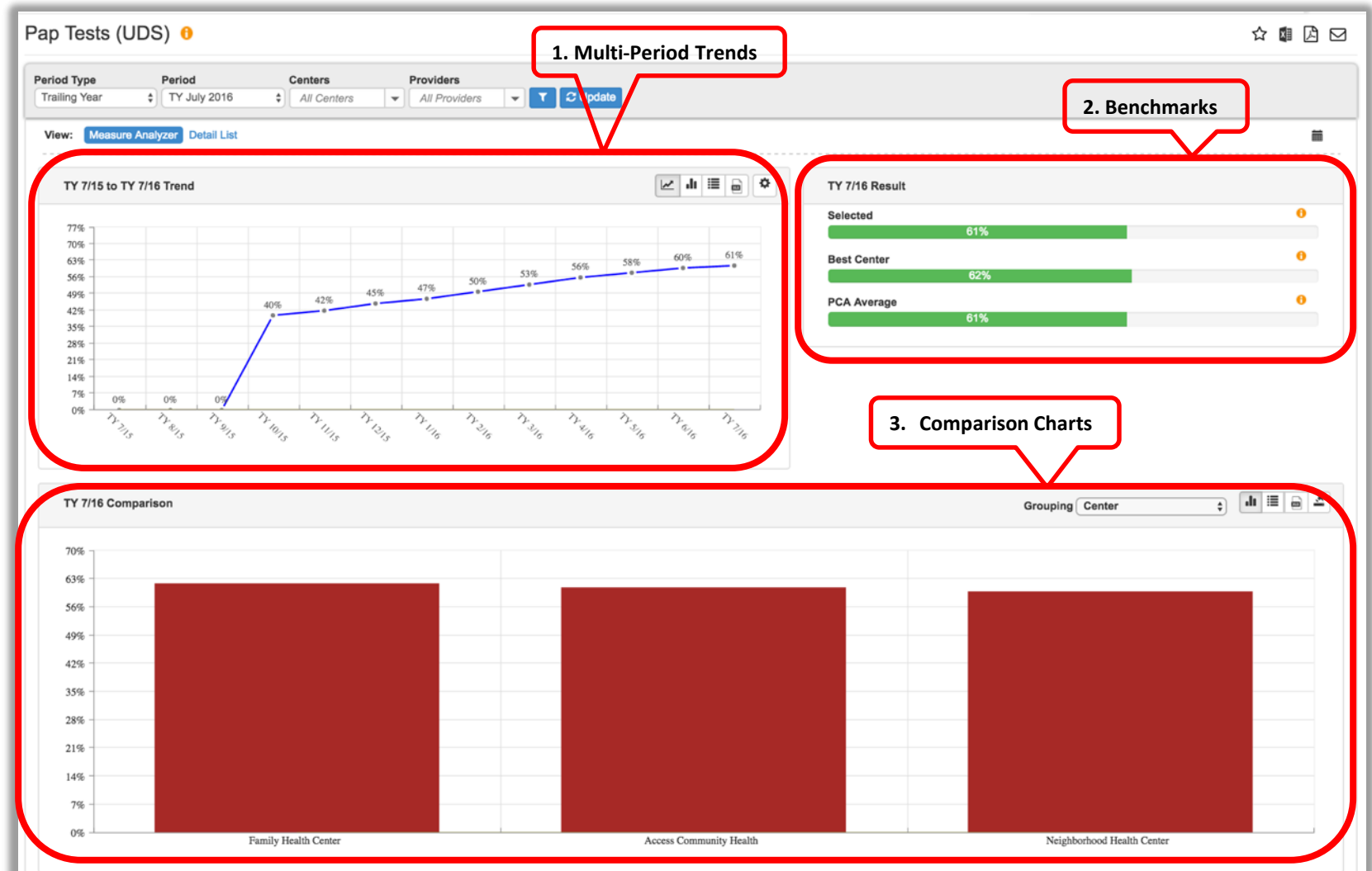
- Measure
- Result (%)
- Target (%)
- Performance Indicator
- Numerator
- Exclusions
- Denominator

Meaningful Use - 2014 General Practice CQMs

		Measure	Target	Result	Numerator	Denominator	Exclusions
		Breast Cancer Screening (NQF 0031)	0 %	65 %	535	822	0
		Cervical Cancer Screening (NQF 0032)	0 %	65 %	787	1,218	0
		Colorectal Cancer Screening (NQF 0034)	0 %	35 %	513	1,479	0
		Falls Screening for Future Fall Risk (NQF 0101)	0 %	34 %	426	1,238	0
		Screening for Clinical Depression and Follow-Up Plan (NQF 0418)	0 %	75 %	3,329	4,440	0
		Screening for Clinical Depression and Follow-Up Plan 12-17 yrs (NQF 0418)	0 %	76 %	295	387	0
		Screening for Clinical Depression and Follow-Up Plan 18+ yrs (NQF 0418)	0 %	75 %	3,034	4,053	0
		Screening for Clinical Depression (NQF 0418 Modified)	0 %	80 %	3,559	4,440	0
		Screening for Patients With Depression (NQF 0418 Modified)	0 %	0 %	0	0	0
		Hypertension: Improvement in Blood Pressure	0 %	0 %	0	98	15

1 of 1 pages (10 items)

Detailed information about one specific measure with trends and comparisons.



Patient Visit Planning Report

- Clinical information organized by patient – conditions, risks, care gaps
- The Patient Visit Planning report can be run:
 - Prospectively to prepare and plan for patients’ upcoming appointments
 - Retrospectively (based on patients’ most recent encounter) to review the success of care teams planning, preparation and execution

Clinical Operations - Visit Planning ☆ 📄 📧

Start Date End Date Period Tense Centers Providers 🔼 Update

Providers categorized by last name Total Providers:18

A
B
C
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S
T
U
V
W
X
Y
Z

– Augustine, Greg 5 Scheduled Appointment(s)

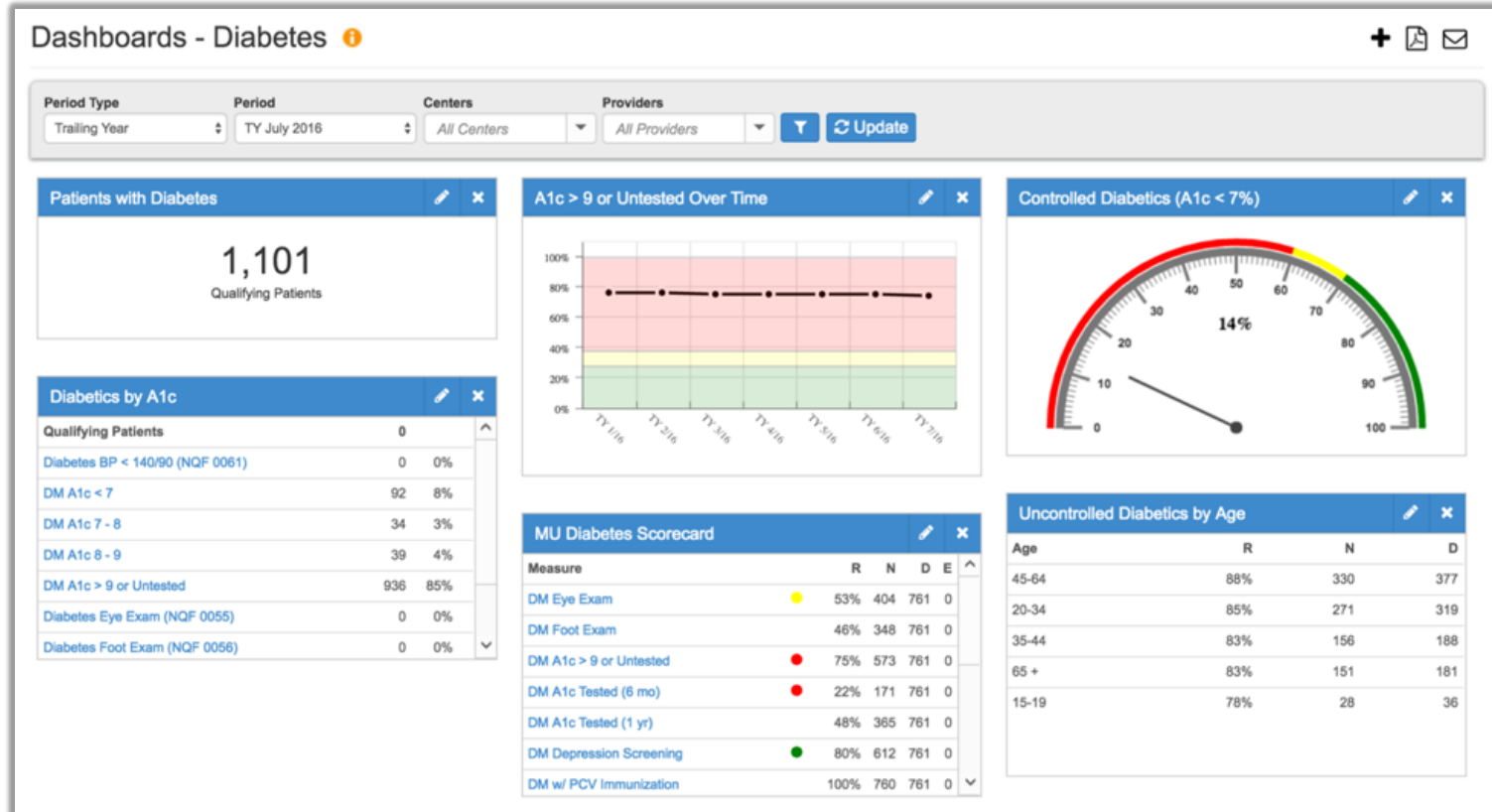
[Export this Provider to PDF](#)

10:24 AM Monday, February 01, 2016				Visit Reason:
Parker, Jodi MRN: 1006220	DOB: 8/6/2003 Age: 12	Gender: F Risk: Moderate	Phone: 831-170-6269 Language: Arabic	PCP: Fay, Tom
Diagnoses	Alert	Message	Most Recent Date	Most Recent Result
HTN IVD	Dental Visit LDL	Overdue Out of Range	4/1/2015	113
Risk Factors	Nutritional Counseling Physical Activity Counseling	Overdue Overdue		

12:04 PM | Monday, February 01, 2016 Visit Reason:

Dashboards

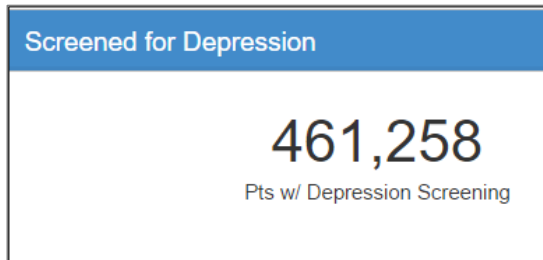
- Select measure information organized to understand and drive the management of a population of patients or understand program performance.
- A stock set of dashboards are now available that include



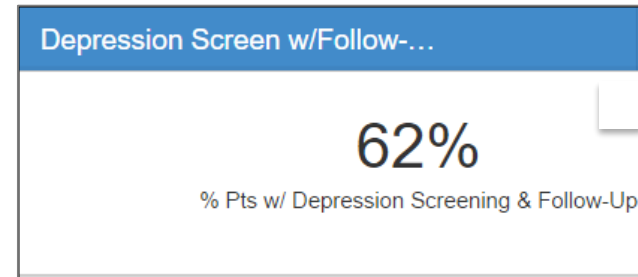
Creating an Effective Dashboard

Behavioral Health

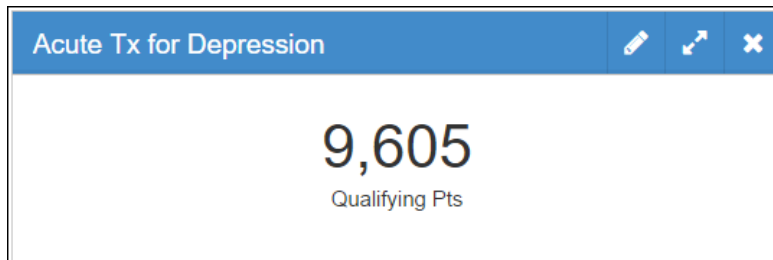
How many patients are you screening for DEPRESSION?



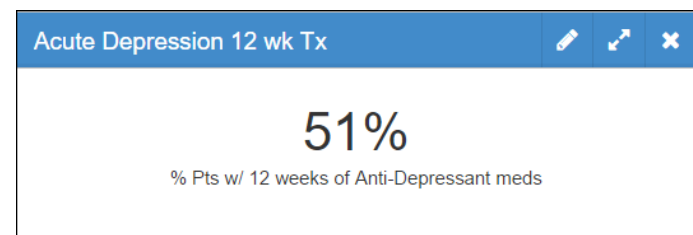
What % are screened or have follow up?



How many patients are you treating for acute depression?



How many of those treated are on medication for 12 wks?



Dig Deeper

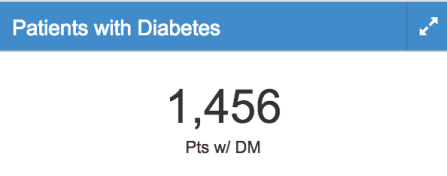
- Identify what are the important aspects of the program or population that you want to understand at a quick glance...
 - What other measures are related?
 - Do you want to see a group of measures?
 - Do you want to see the breakdown by age?

- Use the best graphic or widget to meaningfully display that information
 - Trendline
 - Scorecard

BH Scorecard				
Measure	R	N	D	E
Adolescent Well-Care Visits	52%	92,893	179,745	0
Substance Abuse Screening	16%	417	2,575	0
Tobacco Use Assessment and Cessation	0%	0	0	0
Depression Screening & Follow-Up	0%	0	0	0
Anti-Depressant Continuation Treatment For 6 month	49%	3,140	9,605	0
HC1.1 HIV Testing Lifetime	44%	177,468	406,270	0

Meaningfully Display of the Information

Counter



Measure Family

Diabetics by A1c			
Pts w/ Diabetes	1,456		
Pts w/ A1c < 7	373	26%	●
Pts w/ A1c >= 7 and A1c <= 8	82	6%	●
Pts w/ A1c > 8 and A1c <= 9	83	6%	●
Pts w/ A1c > 9	286	20%	●
Pts w/ no A1c	632	43%	●

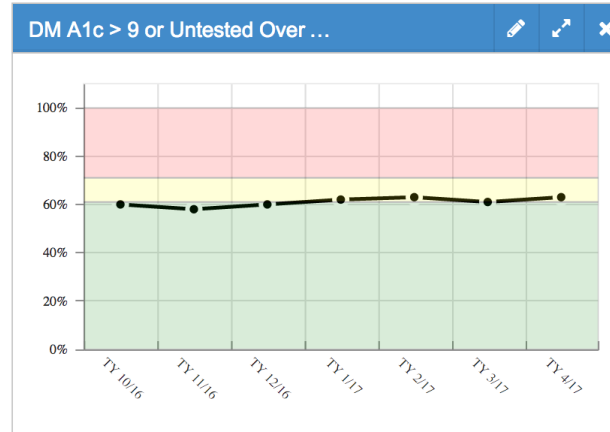
Mini Scorecard

MU Diabetes Scorecard					
Measure	R	N	D	E	
DM Eye Exam	49%	707	1,456	0	●
DM Foot Exam	37%	533	1,456	0	●
DM A1c < 7	26%	373	1,456	0	●
DM A1c Tested (6 mo)	32%	468	1,456	0	●
DM A1c Tested (1 yr)	63%	920	1,456	0	●
DM BP < 130/80	50%	735	1,456	0	●
DM BP < 140/90	85%	1,244	1,456	0	●

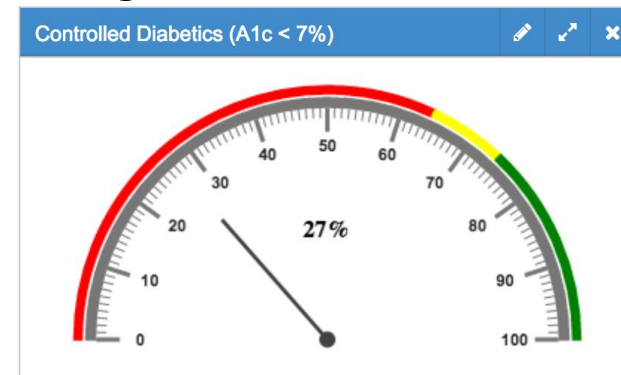
Comparison Chart

Uncontrolled Diabetes by Age			
Age	R	N	D
15-19	100%	1	1
65 +	100%	2	2
20-34	67%	24	36
45-64	64%	25	39
35-44	52%	12	23

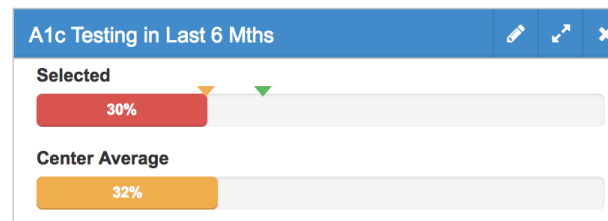
Trendline



Gauge



Benchmark



How many patients have an annual dental visit?

How many children have dental decay or cavities?

What is the age range needs the most focus for dental exams?

What percent of children had fluoride treatment?

Can I see this for just my dental patients?

Managing the Population

REGISTRIES REDEFINED

Clinical Registry Reports

- Population management tool for chronic conditions and preventive care, as well as data quality
- Create reports with patient level detail that can be used to
 - Retrospectively analyze data based on their most recent encounter
 - Prospectively analyze data based on their next appointment
- Common set of data elements in each report (e.g., Patient Name, MRN) and a set of data element specific to the Chronic Disease or Preventive Care category

Clinical Registries - Diabetes ⓘ

Start Date: 1/25/2016 | End Date: 2/1/2016 | Period Tense: Most Recent Enco... | Centers: All Centers | Providers: All Providers | Update

Filter Bar Options ⓘ

Name	Age	MRN	Primary Payer	Most Recent Qualifying Enc	Provider	Location
Jackson, Teri	19	6752990	Aetna	1/15/2016	Fay, Tom	70 Blanchard Rd.
Nelson, Drew	26	4266098	Medicaid	12/4/2015	Lowry, Zach	70 Blanchard Rd.
Gross, Juanita	59	3860284	Medicare	1/25/2016	Gunther, Eric	1400 Cambridge St.

Clinical Registry Reports

- Result set can be sorted on any column by clicking on the column heading
- Reports may be exported as either an Excel spreadsheet or PDF tearsheet
- Results can be searched / filtered using the filter box at the top of each column

Clinical Registries - Diabetes ⓘ

Start Date: 1/25/2016 | End Date: 2/1/2016 | Period Tense: Most Recent Enco... | Centers: All Centers | Providers: All Providers | Update

Name	Age	MRN	Primary Payer	Most Recent Qualifying Enc	Provider	Location
Jackson, Teri				1/15/2016	Fay, Tom	70 Blanchard Rd.
Nelson, Drew				12/4/2015	Lowry, Zach	70 Blanchard Rd.
Gross, Juanita				1/25/2016	Gunther, Eric	1400 Cambridge St.
Barker, Blanche				11/19/2015	Decelles, Larry	Main St. Office
Francis, Kelvin				9/10/2015	Rabbit, Jessica	Main St. Office
Leon, Milton				12/18/2015	House, Gregory	70 Blanchard Rd.

Patient Information

Usual Provider: Plant, Robert

Date_of_Birth: 02/05/1974

Race: Unreported/Refused to Report Race

Ethnicity: Hispanic/Latino

Language: English

Address: 389 Cambridge St

Zip: 05867

State: MA

Phone: 800-963-4624

1 of 10 pages (59 items) | Page Size: 6

Clinical Registry Reports - Custom

In addition to the 'stock' registries that are part of CPCI ... *custom registries* can now be created

Registry Administration [Edit](#)

[Registry Administration](#) / [Depression Screening - Lowell](#)

— Data Elements

Please specify the columns you would like to be available for patients in the registry. Most demographic columns will only show up in the hover text box that happens when the user hovers over the patient name column in the registry, so if you would like those included please be sure to include the patient name item as well.

Categories

Categories	Name
Demographics	First Name
Encounter	Middle Name
Immunization	Last Name
Lab	Address 1
MPCA CMT Medication Data	Address 2
Medication	City
Other	State
Screening	Zip Code
Vitals	Date of Birth
All	Date of Death
	Email Address
	Family Size

[Add >](#)

[< Remove](#)

Name
Language
Patient Expired
Patient Inactive
Primary Payer
Qualifying Encounter
Next Appointment
Depression/Bipolar
Pregnancy
PHQ-2 Depression Screen
PHQ-9 Depression Screen
Depression Screening
Depression Follow-Up

Custom Registry Reports

In addition to the 'stock' registries that are part of CPCI ... *custom registries* can now be created

Registries - Depression (Custom) ⓘ

Start Date: 04/20/2017 | End Date: 04/27/2017 | Period Tense: Most Recent Encou... | Centers: Centers | Providers: Providers | Update

Filter Bar Options ⓘ

Name	MRN	Age	Primary Payer	Most Recent Enc	Most Recent Provider	Most Recent Location	Next Appointment	Next Appointment Provider	Depression Bipolar Diagnosis Date	Depression Bipolar Diagnosis	Pregnancy	Pregnancy Code	PHQ-2	Phq-2 Result
HAUSLER, MILAN	9962797	20	Medicare	7/4/2016	Green, Leslie	Main Office	4/26/2017	Cranston, Bill	4/29/2015	296.24				
SUMERA, ABDUL	9172026	41	Coventry	12/17/2015	Bar, Samuel	Neighborhood Medical Center	4/26/2017	Bar, Samuel						
RANTANEN, EDUARDO	6287191	5	Medicaid	2/17/2017	Pane, Janet	Main Office	4/25/2017	Fay, Tom	2/17/2017	296.24			2/17/2017	0.0
FONTENELLE, FREEDA	3283021	30	BCBS	4/23/2017	Reddington, Robert	Adult Health	4/23/2017	Bar, Samuel	9/18/2015	296.24			3/14/2017	3.0
SUVADA, ELINOR	1214446	20	BCBS	12/16/2016	Lynes, Lori	Adult Health	4/26/2017	Paul, Jessica	12/3/2016	296.24			12/16/2016	4.0
PRESSWOOD, MIKE	7123687	36	Coventry	2/14/2017	Reddington, Robert	Neighborhood Medical Center	4/24/2017	Paul, Jessica					2/14/2017	4.0

How to Create a Custom Registry Report

So **how** do can you get a custom registry ...

1. Create a support ticket and an Azara resource will reach back to understand your requirements and configure an appropriate registry
2. Reach out to a CHCANYS team member with whom you are working

And if you find that you have frequent custom registry needs

3. Create a support ticket with Azara inquiring about getting the access and training to create your own registries

What else can CPCI do for me??

MORE CPCI FUNCTIONALITY

Payer Integration- Cost per Member Report

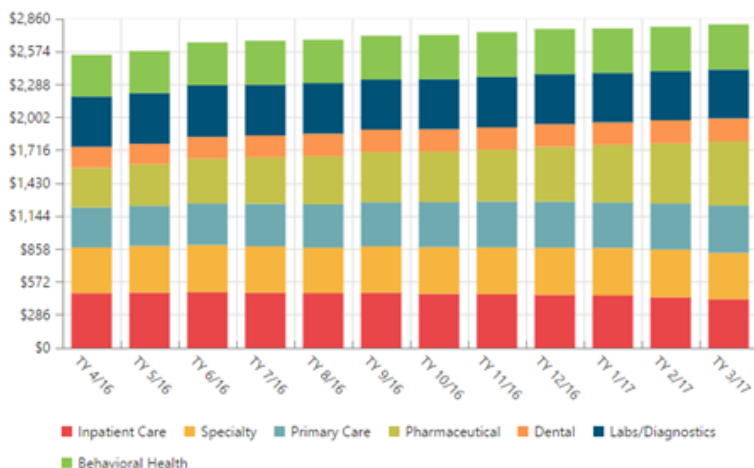
Cost per Member



Period Type: Trailing Year | Period: TY March 2017 | Centers: Centers | Update

View: Measure Analyzer | Detail List | Target: Demo | Primary Target : 1 | Secondary Target : 1

TY 4/16 to TY 3/17 Trend



Comparison

Grouping: Cost Type

DRVS Cost Type	Average Cost per Assigned Member	Total Cost Incurred by Active Assigned Members in Period	Members with active assignments in period
Pharmaceutical	\$557	\$2,490,239	4,473
Labs/Diagnostics	\$424	\$1,895,586	4,473
Inpatient Care	\$423	\$1,890,860	4,473
Primary Care	\$411	\$1,836,693	4,473
Specialty	\$403	\$1,803,640	4,473
Behavioral Health	\$393	\$1,758,570	4,473
Dental	\$201	\$897,775	4,473

This is an example of one of the payer integration reports that can be made available with this functionality.

If you are interested in accessing this report, reach out to CHCANYS at HCCN@chcanys.org or Azara support at support@azarahealthcare.com

Additional CPCI Functionality

- PRAPARE – *coming soon...*
 - Available in next release due by Memorial Day
 - Expanded database will store the Social Determinants associated with PRAPARE
 - Centers can then engage with Azara to map this data from their systems for use in filters, registries, etc. with CPCI

- Payer Integration
 - Health Centers need to know what happens outside their walls
 - Payers/Health Plans are assigning their “members” to centers and engaging in risk and shared savings type of arrangements
 - Azara has a module dedicated to integrating (a) enrollment / roster data and (b) claims / total medical expense data

CPCI DEMO

Measures & Alerts

DENTAL AND BEHAVIORAL HEALTH

Measure/Alert	Definition
Child Dental Sealant UDS	Percentage of children, age 6-9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period.
Children Who Have Dental Decay or Cavities CMS eCQM 75v5.1	Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.
Primary Care Prevention Intervention CMS eCQM 74v6.1	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.
Dental Visit Alert	Alert will trigger if Dental Visit has not occurred in the last 1 years.

Vital Measure Information:

Measure Name	UDS Table, Section, Line #	NQF Number	Key Differences from Prior Year UDS	Measure Description
Dental Sealants for Children between 6-9 Years (Oral health sealant for children between 6–9 years)	Table 6b, Section N, Line 22	NA	Although measure title is age 6 through 9 years, draft eCQM reflects age 5 through 9 years; Health centers should continue to use age 6 through 9 years, as measure steward intended	Percentage of children, age 6 – 9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period.



Dental Sealants for Children 6-9 Years*,**

DENTAL SEALANT

NUMERATOR

Number of patients in the denominator who have had a dental sealant applied.

CDT: D1351
SNOMED: 234713009

Custom mapped
Dental Sealant on
First Molar



Legend

Default

Customer
Request

Not Used

DENTAL ENCOUNTER

DENOMINATOR

Number of patients aged 6-9, with at least one dental encounter during the current measurement year, and documented moderate/high risk ever.

Oral assessment or comprehensive or periodic oral evaluation during the past year.

CDT: D0191, D0120, D0145,
D0150, D0180

AND

MODERATE /HIGH CARIES RISK EVER

Pre-existing treatment of or diagnosis of caries , or caries risk, ever documented.

CDT: D0602, D0603
SNOMED: 609399004, 609401005, 609402003,
609403008, 109568006, 109569003, 109571003,
109574006, 109575007, 109577004, 163152009,
25840002, 442231009, 442551007, 65413006,
80753001, 95249000, 95252008, 95253003, 95254009
ICD: 521.x, 525.13, K02.x, K08.13x, K08.43x

Custom mapped risk such as dummy CPT, checkbox, radio button or pick list.

EXCLUSIONS

Un-erupted teeth, restoration of permanent molar, sealant placement, tooth not sealable.

Dummy Code or other custom mapped exclusion indicating "All first molars are un-sealable."

This could be because of tooth malformations, pulpitis , abscess, or lack/ loss of all four molars.

NOTE WELL: DRVS is not using the exclusion codes provided in the AHRQ/CMS draft measure value set for this measure because we do not get enough detail (tooth numbers, etc.) to be able to appropriately determine if exclusion is appropriate from dental charge codes

*For practices who offer dental services

**For Azara customers who send dental codes to their PM system for billing

Measure/Alert	Definition
Screening for Clinical Depression and Follow-Up Plan NQF 0418 / CMS eCQM 2v6.3	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Screening for Clinical Depression NQF 0418 Modified/ CMS eCQM 2v6.3	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter.
Diabetes Depression Screening NQF 0059 Modified / CMS eCQM 122v5	Percentage of patients 18-75 years of age with diabetes who had a depression screen during the last 12 months.

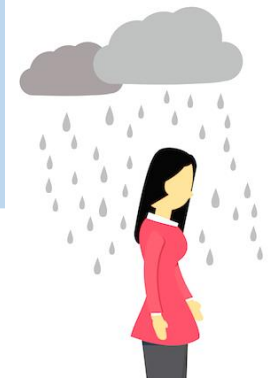
Behavioral Health Measures / Alerts (2)

Measure/Alert	Definition
<p>Antidepressant Medication Management – Effective Acute Phase Treatment</p> <p>NQF 0105 / CMS eCQM 128v5.0</p>	<p>Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).</p>
<p>Anti-Depressant Medication Management – Effective Continuation Phase Treatment</p> <p>NQF 0105 / CMS eCQM 128v5.0</p>	<p>Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months).</p>
<p>Depression Screen</p>	<p>Alert will trigger if Standardized Depression Screen has not occurred in the last 1 years. Alert only applies to patients >= 12 yrs old. Patient must not have Depression/Bipolar.</p>
<p>Depression Screening Follow-up</p>	<p>Alert will trigger if patient depression screen results are positive OR PHQ-2 >=3 OR PHQ-9 >= 10 but no depression follow-up on the same day or day after positive screening. This alert is not configurable.</p>

Screening for Depression and Follow-Up

Vital Measure Information:

Measure Name	UDS Table, Section, Line #	NQF Number	Key Differences from Prior Year UDS	Measure Description
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Table 6b, Section M, Line 21	0418	Follow up has to happen within one day rather than within the measurement year as it did in the past with UDS. e-CQM does not include patients who refuse to participate, urgent or emergent situations, if the patient's functional capacity or motivation to improve impacts the accuracy of results	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.



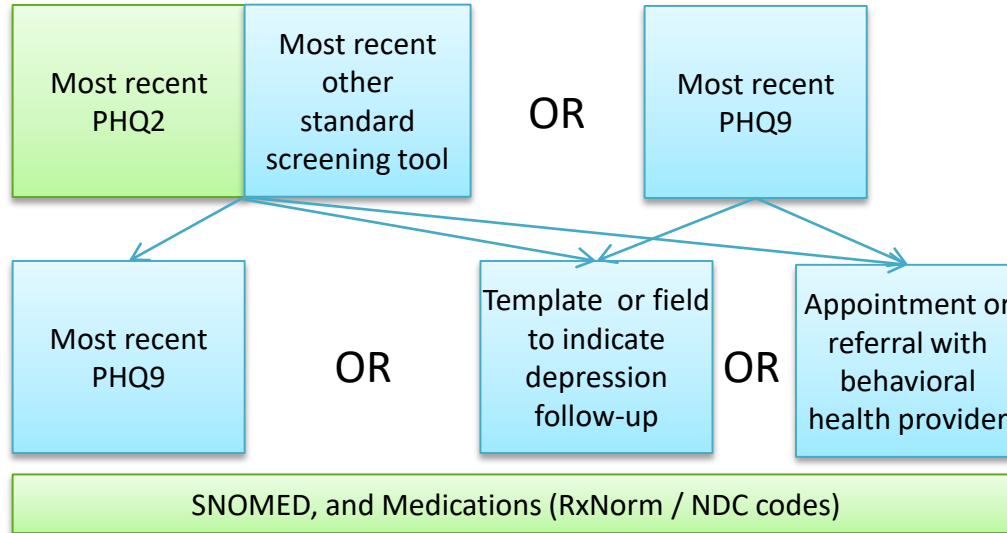
Depression Screening & Appropriate Follow-Up

NUMERATOR

Patients aged 12+ who were

- 1) screened for depression with a standardized tool and, **if positive**,
- 2) had a follow-up plan documented within one day.

INITIAL SCREEN



DENOMINATOR

Patients aged 12 + at some point during measurement year who had 1+ medical visit during reporting year.

QUALIFYING PATIENT

- Include patients who were born on or before December 31, 2004.
- CPT Codes which constitute a qualifying encounter according to the measure spec (see Technical Specifications in i Button).
- Include **patients screened before being diagnosed** with Depression or Bi-Polar, **during the measurement period** to credit practices for the depression screening work they are doing (per HRSA).

EXCLUSIONS

Patients with active Depression / Bi-Polar diagnoses.

DIAGNOSIS

- Exclude patients with active Depression or Bi-Polar diagnosis (see list of codes).

Legend

- Default
- Customer Request



GREG AUGUSTINE

Chief Operating Officer

Gregory.augustine@azarahealthcare.com

LUANN KIMKER RN, MSN

Director of Clinical Innovation

Luann.kimker@azarahealthcare.com



If you have additional questions based on today's presentation, please contact:
HCCN@chcanys.org

