CHCANYS

Community Health Care Association of New York State

Enhancing PCMH Sustainability

with

CHCANYS' Data Warehouse:

The Center for Primary Care Informatics

CHCANYS CPCI CENTER FOR PRIMARY CARE INFORMATICS

Defining New Directions

The New York State Center for Primary Care Informatics

- CHCANYS is developing the New York State Center for Primary Care Informatics (CPCI) to support improvements in quality of care, patient and population health outcomes, and containment of health care costs.

- This initiative is a priority goal in the CHCANYS Strategic Plan.

The New York State Center for Primary Care Informatics

- As a central CPCI strategy, CHCANYS is developing and implementing a statewide data warehouse
  - Collects data from multiple sources, including EHRs, to create an integrated database for enhanced analysis & reporting
  - Provides actionable data & valuable reporting at individual health centers
- CPCI will support Health centers with technical assistance from CHCANYS' Clinical Quality Improvement and Health IT Programs.

Our Partners

- Azara Healthcare
  - Exclusive licensee of the DRVS, Data Analytics and Reporting Visualization Software (software behind the CPCI)
  - Set up specifically to deliver DRVS to the Community Health marketplace using a Software as a Service (SaaS) model
  - Formal relationships with four major Primary Care Associations: MA, MO, NY & CA
  - Deployed and live with 50 Community Health Centers across those states, NM & WA

- Arcadia Solutions
  - 200 + person Health Care Consultancy assisting providers and health insurers to deliver on the shared goal of effective, safe, and low-cost healthcare
  - Specialize in large scale data reporting and analytics
  - Extensive experience with Primary Care Associations and Community Health Centers
  - Long history with Mass League & California PCA
  - Part of the Pohlad Family of Companies, a multi-billion dollar, MN based investment group

CPCI Functionality

- Health centers access to data
  - Secure, web-based user interface
  - Role-based, allows different levels of access
- Comprehensive Reporting Tool & Analytics
  - filterable on several variables
  - Multi-level drill-down capability: FQHC ➡ Site ➡ Provider ➡ Patient
  - ***90+ quality measures & key performance indicators*** including patient panel and care quality reports with the ability to view more detailed data, filterable on multiple criteria **(Standard 6, Element A, preventive & clinical measures)**
  - Clinical registries for retrospective analysis & prospective planning
  - Patient panel & exception reporting

CPCI Functionality, cont'd

- Measures & reports updated regularly to keep pace with changing regulations & definitions
  - Currently: 23 of 43 Meaningful Use CQMs, 18 UDS CQMs, and 28 HEDIS Measures
  - UDS Tables 6 & 7B; 3, 4, & 6A by end of 2012
  - ***NCQA Patient-Centered Medical Home-related reports***
- Statewide participation enables
  - Collaboration & exchange of best practices
  - Comparative Analysis & Benchmarking
  - Grant funding

CPCI Measures – Preventive Care

Primary Care: Adult Male

- Annual Physical
- BMI
- BP Entry
- PSA Entry

Primary Care: Adult Female

- Annual Physical
- BMI
- BP Entry
- Mammogram
- PAP

Primary Care: Pediatric

- BMI
- BP Entry
- Well Child Visit

Immunizations

- Immunizations Completed by Age 2
- Immunizations Complete

CPCI Measures – Chronic Care

Diabetes

- A1C
- BP Control
- BMI
- Cholesterol
- HDL
- Triglycerides
- LDL
- Foot Exam
- Nephropathy
- Retinopathy

Hypertension

- BMI
- BP Control
- BP Entry
- Cholesterol
- HDL
- Triglycerides
- LDL

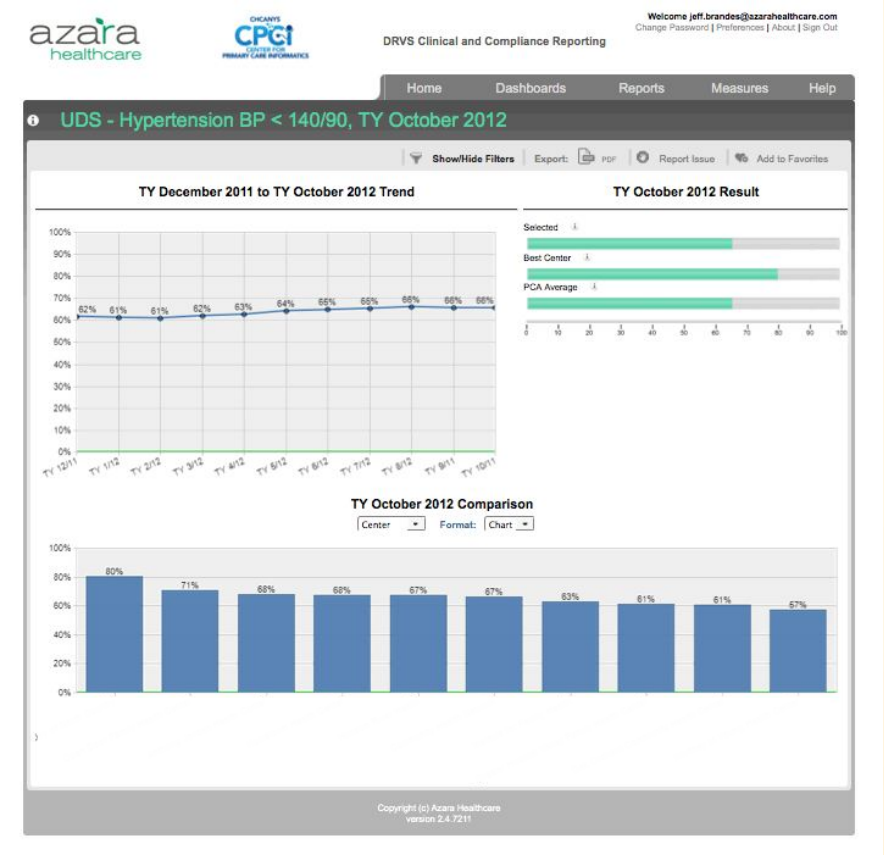
Asthma

- Control Med
- Rescue Med

HIV

- BP Entry
- CD4

Tracking Quality Measures Over Time



PCDC Sustainability Tool, Outcomes Tab

PCMH Sustainability Toolkit: Outcome				
Area	**Score 1**	**Score 2**	**Change: *indicate improved, same, or worsened**	**Sustainabilty Points**
Patient Experience Scores:				
	75	80	improved	1
Clincal Measures:				
1. A1C < 9	80%	90%	improved	1
2. Controlled BP 140/19	70%	70%	same	0
3. LDL/HDL				
Preventive Measures:				
1.adult immunizations	90%	88%	worsened	-1
2. pap smear	60%	60%	same	0
3. depression screening	50%	65%	improved	1
Staff Satisfaction Scores or Staff Turnover Rate:				
	80%	90%	**improved**	1
Total Sustainability Points:				**3**

Measures can be obtained from CPCI

Reports to support PCMH Sustainability

CHCANYS CPCI CENTER FOR PRIMARY CARE INFORMATICS

- CPCI reporting provides documentation to support many elements

***Example*:**

- Standard 1- Enhance Access & Continuity
  Element D – Continuity
  Factor 3 - Monitoring the percentage of patient visits with a selected clinician or team
- ***Standard 3 - Plan & Manage Care***
  Element C (Must Pass) - Care Management
  Factor 1 - Conduct Pre-Visit Preparations
- Standard 6 - Measure & Improve Performance
  Element D – Demonstrate Continuous Quality Improvement
  Factor 1 - Practice tracks results over time

PCDC Sustainability Tool Enhancements

- Discussions with PCDC re: potential to enhance the tool to provide score credit for use of CPCI reporting & tools

An example:
PCDC Sustainability Tool, Process Tab

PCMH Sustainability Toolkit: Process			
Question	**Response**	**Recommendation**	**Sustainability Points**
8. Does your practice maintain Care Management activities defined in your medical home submission?			[potential to auto-fill partial points if using CPCI tools]

An example: PCDC Sustainability Tool, Performance Care Management Tab

Care Management		
Factor 3C1	Activity 1:	Conduct pre-visits preparations via CPCI registry reporting for all patients with upcoming visits
	Is the site performing the activity? (1=yes, 0=no)	[potential to auto-fill partial points if using CPCI reporting]
	# of patients with at least 1 of the 3 clinically important conditions	
	Avg. # of minutes it takes to reconcile a patient chart	
	Total time for activity (minutes)	0
	Total time for activity (hours)	0
	Inputs	
	Staff responsible	
	Hourly wage	
	Hours for activity	0
	Total activity cost	$ -
	Cost per patient	#DIV/0!