Population Health Management Infrastructure

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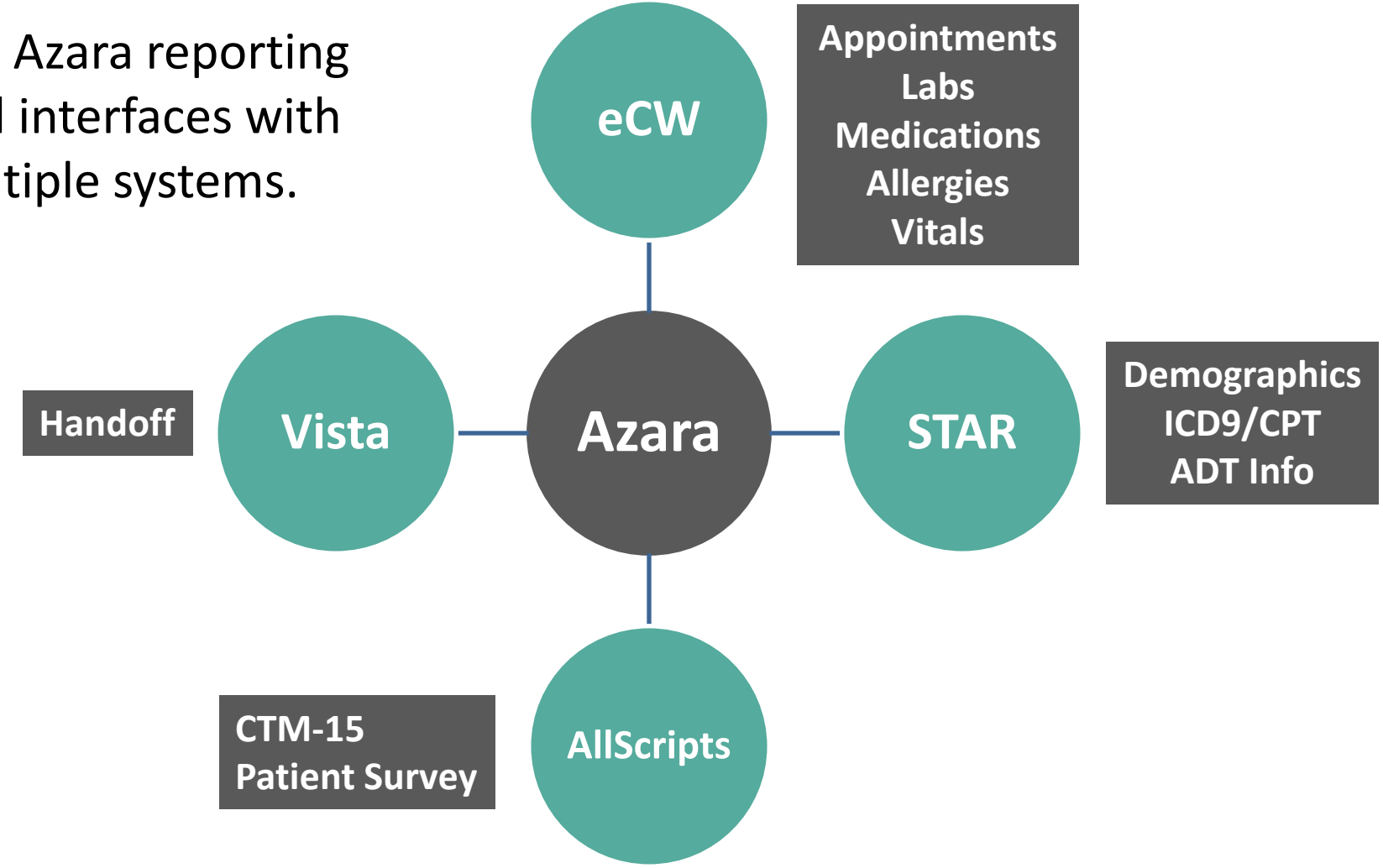
Interfaces

- The Azara reporting tool interfaces with multiple systems.

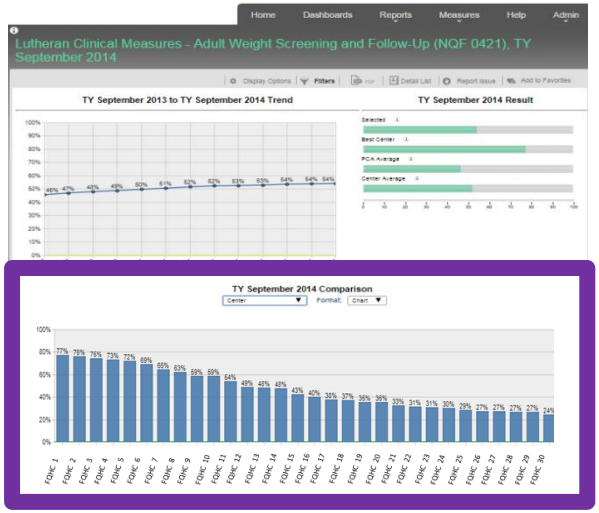


UDS

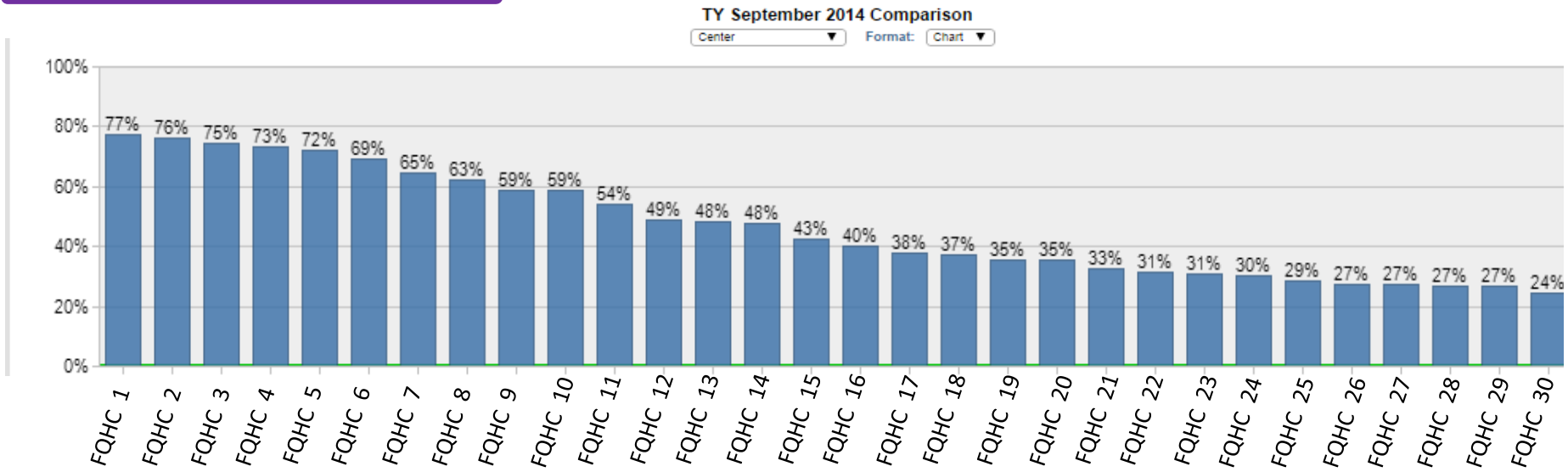
Measure
Screening for Clinical Depression and Follow-Up Plan
Adult Weight Screening and Follow-Up (UDS)
Asthma Pharmacological Treatment (UDS)
CAD Lipid Therapy (UDS)
Weight Assessment and Counseling for Children and Adolescents (UDS)
Childhood Immunizations (UDS)
Colorectal Cancer Screening (UDS)
New HIV Cases With Timely Follow Up (UDS)
HIV and Pregnant (UDS)
Hypertension BP < 140/90 (UDS)
IVD Use of Aspirin (UDS)
Pap Tests (UDS)
Prenatal Care (UDS)
Tobacco Use Assessment and Cessation (UDS)

- Yearly submission of performance of core metrics is required of all grantees of HRSA primary care programs.

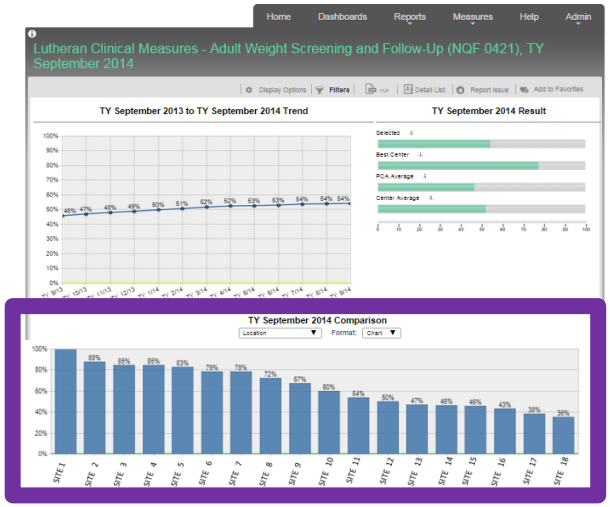
UDS



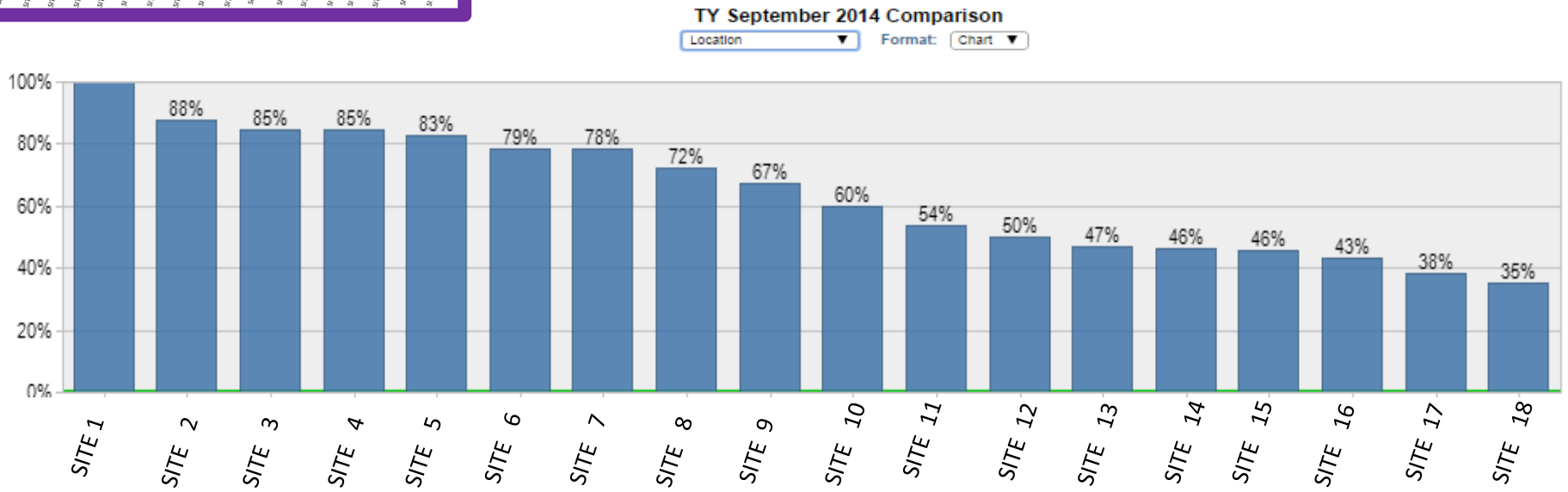
- The Azara tool facilitates comparison among all participating FQHCs.



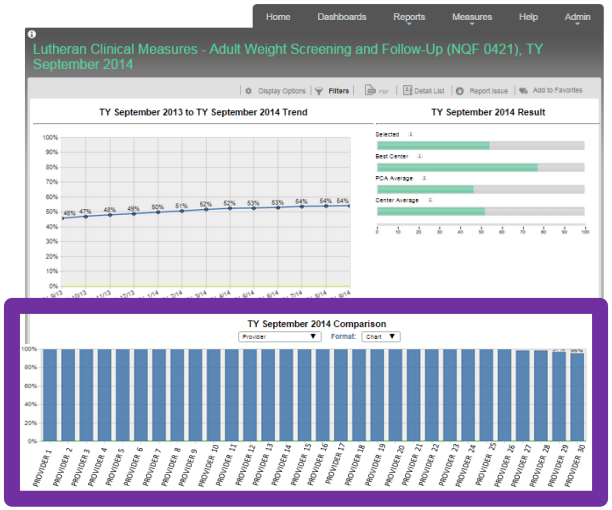
UDS



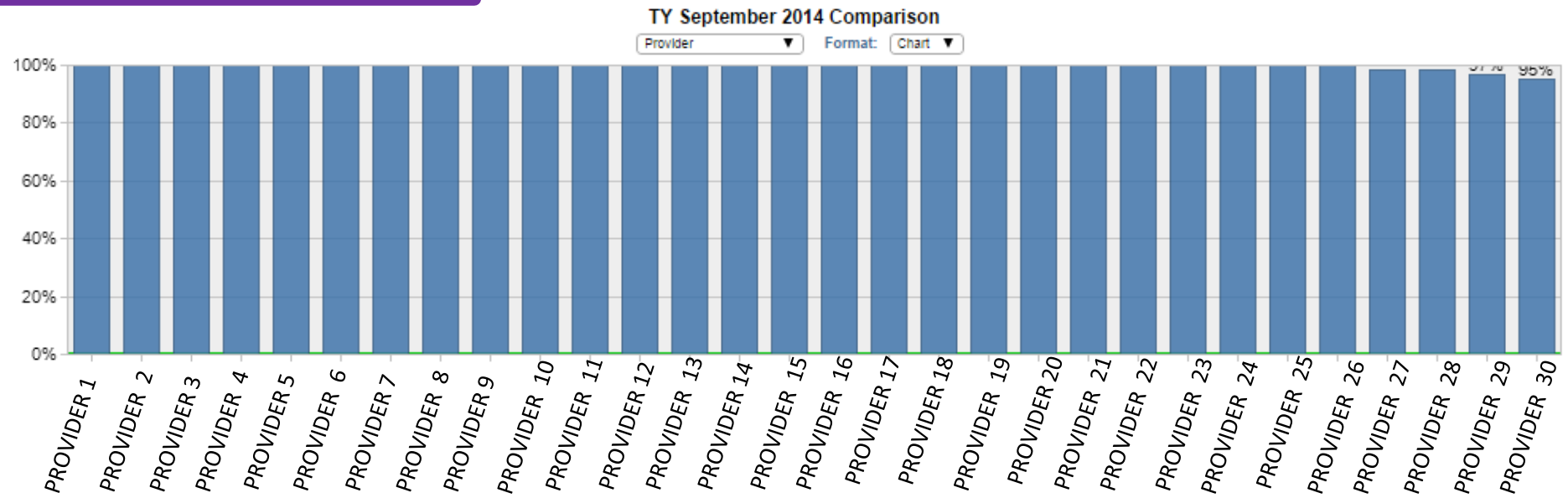
- As well as comparison among all LFHC centers



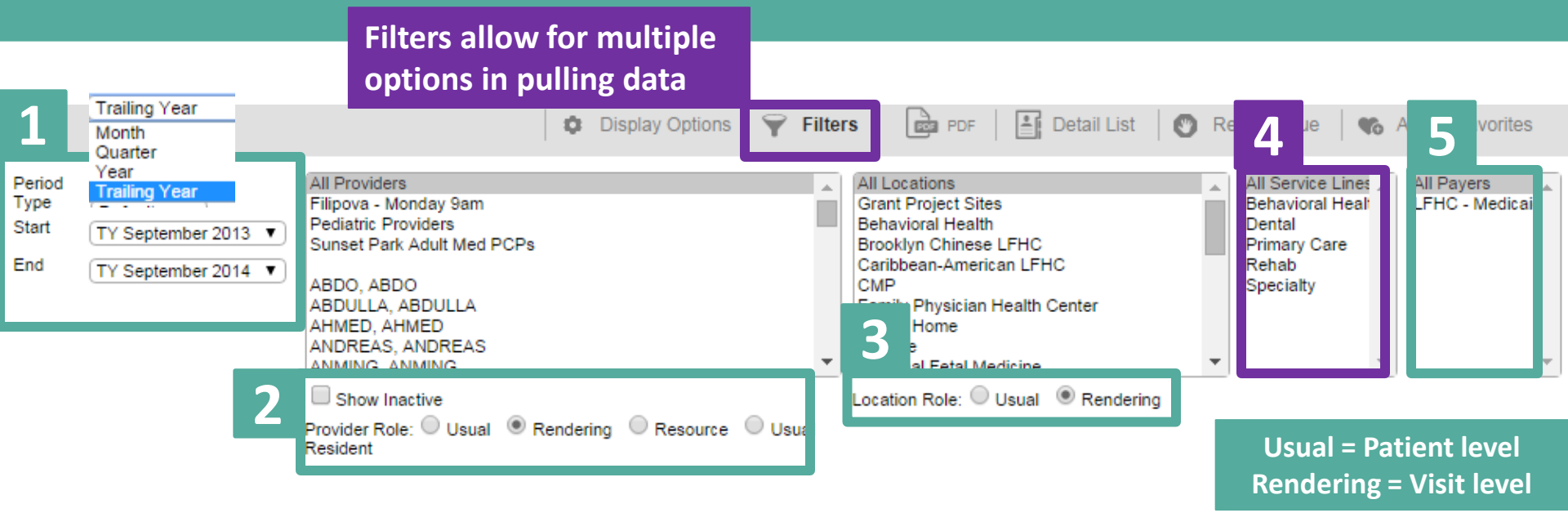
UDS



- And the ability to drill down to individual providers at each site and export patient-specific data to Excel

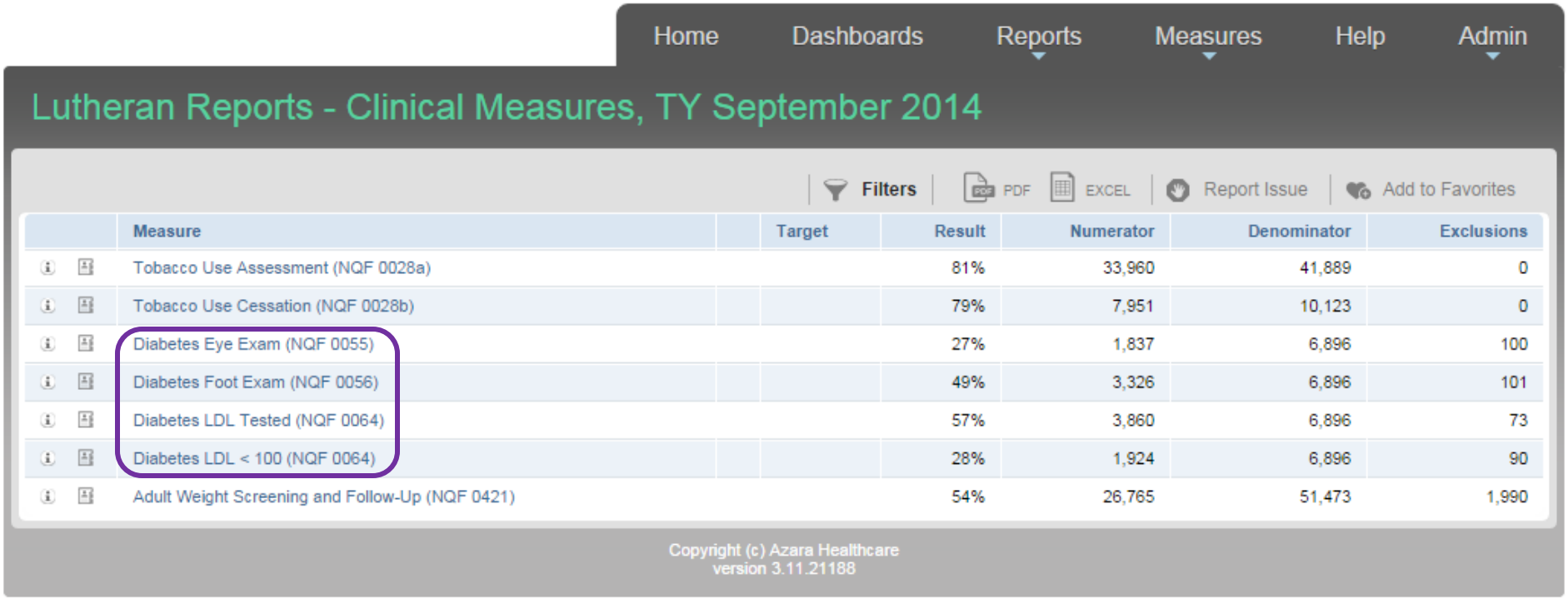


Filters and Service Lines



1. Flexibility of data extraction time interval
2. Pull data based on PCP(s) or appointment provider(s)
3. Select location based where the visit took place
4. Filter data for patients seen in Primary Care
5. Filter data based on payer mix

Clinical Measures

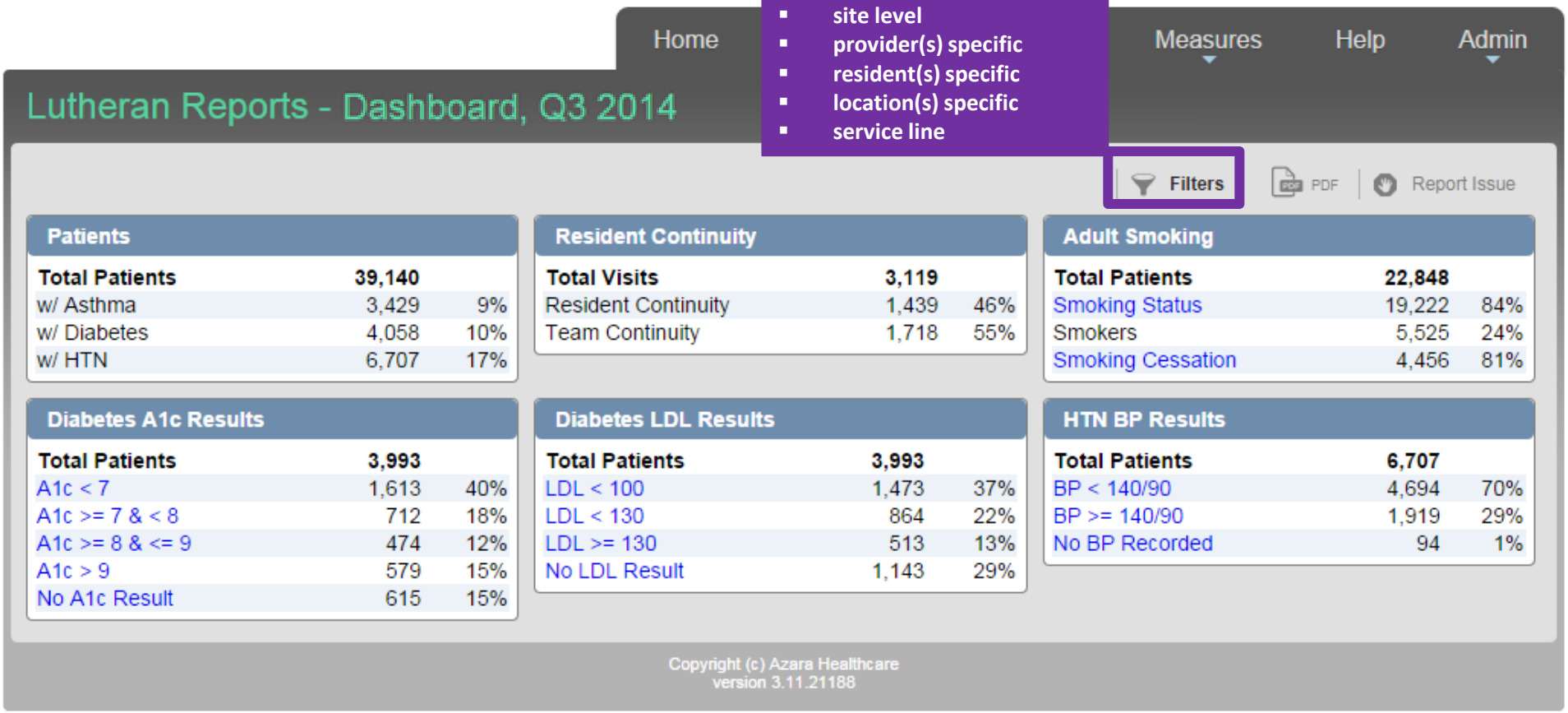


- Expansion of the UDS metrics utilizing NQF-endorsed measure criteria, which also align with CMS Meaningful Use measures.

Dashboard

Filters allow options in pulling data at

- **network level**
- **site level**
- **provider(s) specific**
- **resident(s) specific**
- **location(s) specific**
- **service line**



Patients		
Total Patients	**39,140**	
w/ Asthma	3,429	9%
w/ Diabetes	4,058	10%
w/ HTN	6,707	17%

Resident Continuity		
Total Visits	**3,119**	
Resident Continuity	1,439	46%
Team Continuity	1,718	55%

Adult Smoking		
Total Patients	**22,848**	
Smoking Status	19,222	84%
Smokers	5,525	24%
Smoking Cessation	4,456	81%

Diabetes A1c Results		
Total Patients	**3,993**	
A1c < 7	1,613	40%
A1c >= 7 & < 8	712	18%
A1c >= 8 & <= 9	474	12%
A1c > 9	579	15%
No A1c Result	615	15%

Diabetes LDL Results		
Total Patients	**3,993**	
LDL < 100	1,473	37%
LDL < 130	864	22%
LDL >= 130	513	13%
No LDL Result	1,143	29%

HTN BP Results		
Total Patients	**6,707**	
BP < 140/90	4,694	70%
BP >= 140/90	1,919	29%
No BP Recorded	94	1%

Diabetes Foot Exam PDSA

Adult Medicine
PDSA
(Plan - Do - Study - Act)

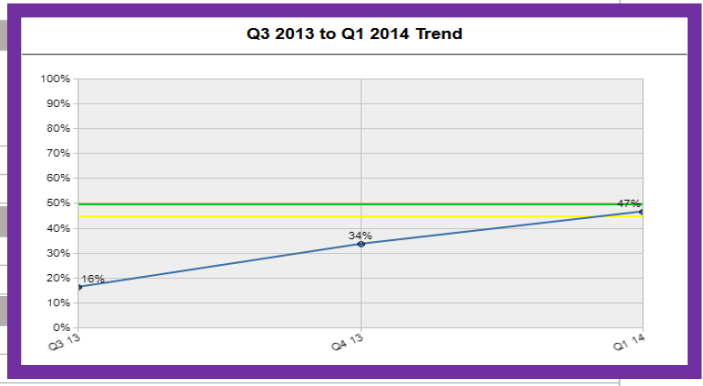
Indicator for Improvement:	Increased number of foot exams on diabetic patients
Problem Statement:	Low compliance rate on diabetic foot exams: 30% in December 2013

Preceptor	Residents	QI Support
Dr. Olga Filipova, MD	Dr. Andrew Ciancimino, MD Dr. Edris Alderwish, MD Dr. Hemal Bhatt, MD	Doreen Colella Kerianne Neu Regina Zilber Sadia Choudhury

Potential Challenges:	How we plan to address challenges:
1. Lack of documentation in structured fields	1. Educate the residents with documentation screenshots. 2. Direct mentoring/supervision from preceptor
2. Foot exams are not consistently part of physical exam	1. Patient reminders 2. Provider reminders 3. Monthly faculty meetings (all IM doctors, nurses, & administration) 4. CPCI statistics distribution to providers
3. Patient refusal to get foot exam (noncompliant patients)	Provide patient education

What Happened?

1. Utilized previsit planning and identified patients with missing foot exams.
Discussed in morning huddles.
MAs would provide patients, who were missing foot exams, with the red foot cards to give to providers
MAs would instruct patients to take their socks/shoes off when they see the provider
2. Provided education to providers so they can perform proper foot exams and document in appropriate structured fields
3. Diabetic foot exam compliance increased from 30% (115/379) in December 2013 to 46% (165/358) in February 2014



What data will you need to collect to show the strategy is working?

CPCI

Pre visit planning report

Next Steps/Potential Next PDSA's

1. Educate residents about importance of diabetic foot exams and how to perform proper foot exams
2. Continuous monitoring of proper documentation at the time of the visit
3. Provision of each primary care provider and PCP to have personalized date about their performance

- Azara data facilitates pre- and post-PDSA data analysis.
- PDSA results documented in PBWorks online collaborative platform.
- Teams document asynchronously, set reminders, and leave feedback.

PDSA Projects

- "Lessons learned" were shared at multiple forums.
- Other PDSA projects currently underway include:
  - Tobacco Cessation
  - Diabetics with LDL < 100

Case Management

Goal

- Better patient outcomes
- Improved patient experience
- Reduced health care cost

Staff

- 15 care managers
- 2 nurse case manager
- 2 social work case manager
- 4 community health workers
- Embedded at 8 LFHC sites

Staff Roles

Care Managers

- Pre-Visit planning and hospital admission and discharge follow-up.
- Ongoing Care Management that aims to motivate patients to make lifestyle changes to improve health outcomes.
- Address unmet social service needs that impact on treatment compliance.

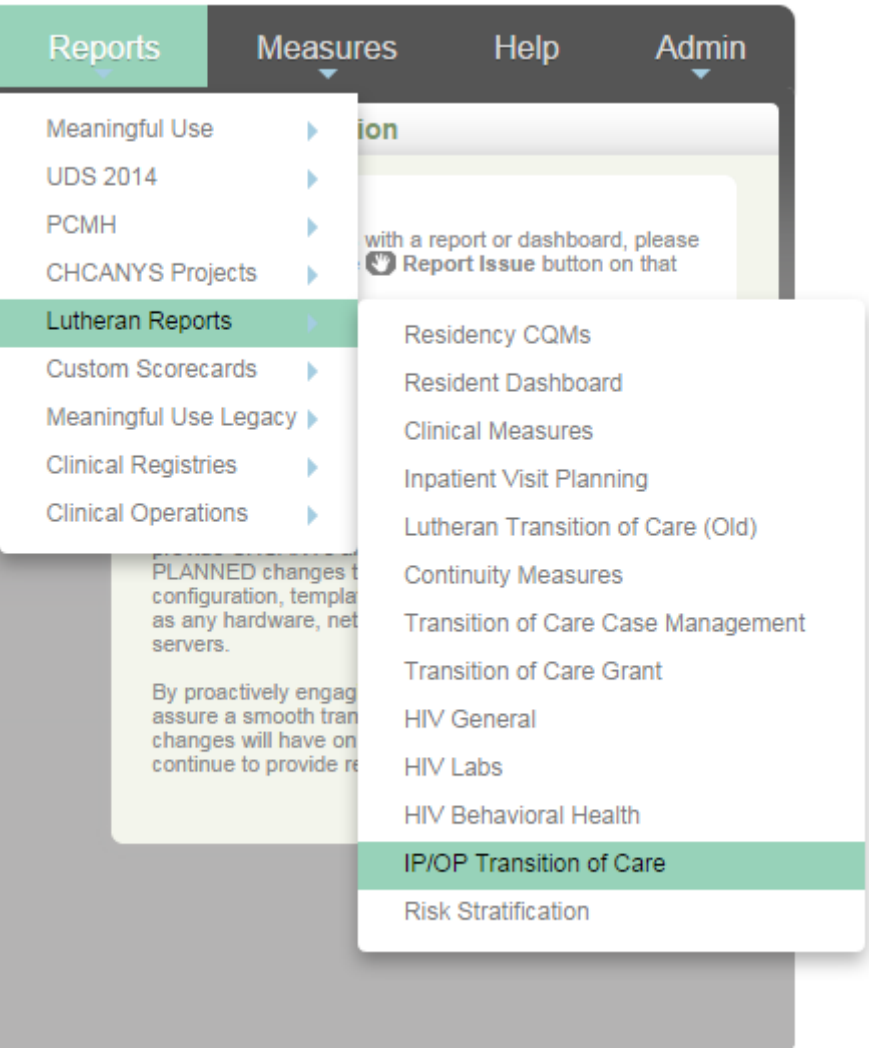
Nurse and Social Work Case Managers

- Engage patients with complex medical conditions and/or psychiatric disorders
- Address functional deficits that impact on the patient's ability to care for self and participate in treatment.

Community Health Workers

- Case Management's "Feet on the Street" or Emergency Response Team
- Accompany patients to medical, behavioral health, chemical dependency or other social service appointments
- Locate community resources
- Provide intimate knowledge of cultural dynamics

IP/OP Transition of Care Report: Admitted Patients



Inpatient CM

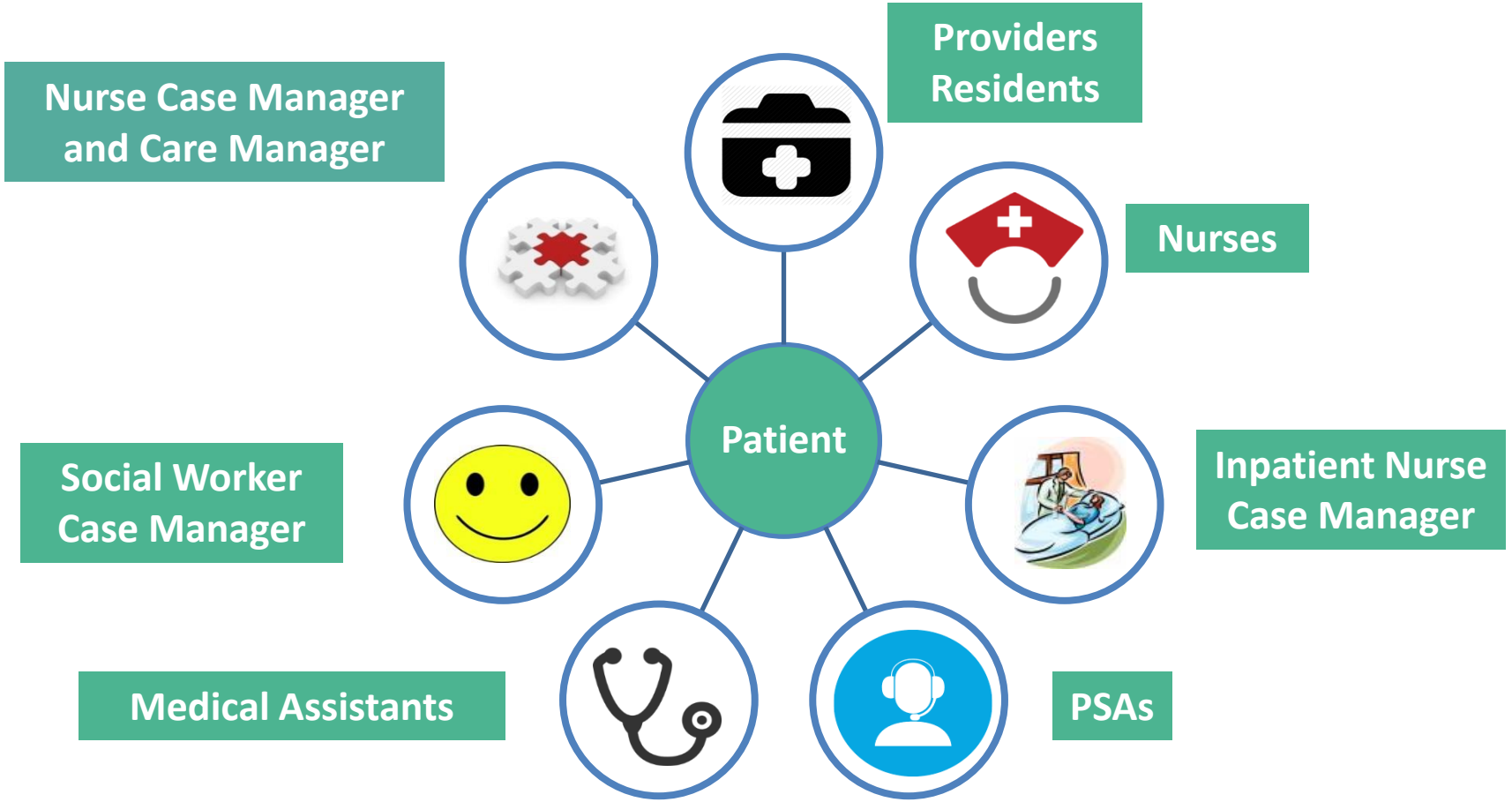
- Identifies high risk patient hospital admissions
- Ensures 48h follow-up appt. with PCP

Outpatient CM

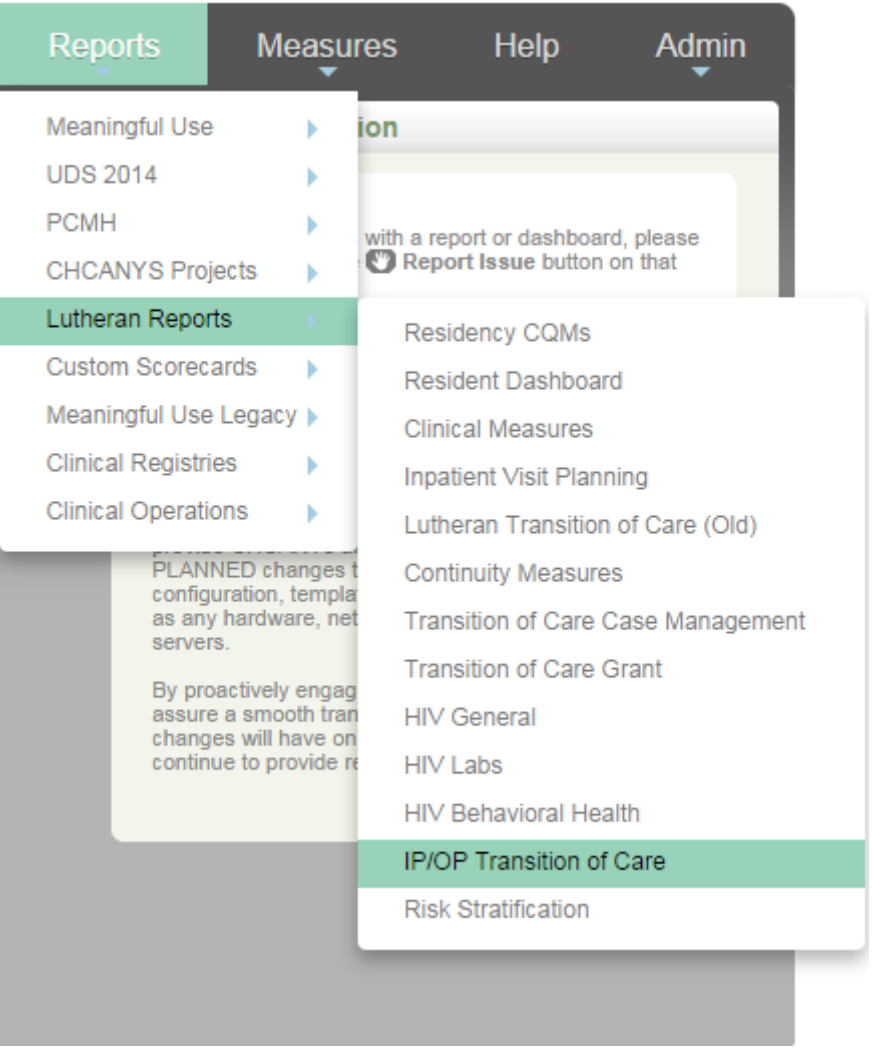
- Notifies FHC care team at the huddle and via email/EHR
- Care team reviews cases and identifies avoidable hospitalizations
- Referral for ongoing CM determined

Care Team

Morning Huddles



IP/OP Transition of Care Report: Discharged Patients



Case Management

- Completes 24h follow-up call
- Administers the CTM-15 survey
- Confirms medical appointment
- Addresses transportation needs
- Alerts patient service coordinator if health concerns reported
- Deploys community health worker if assistance required

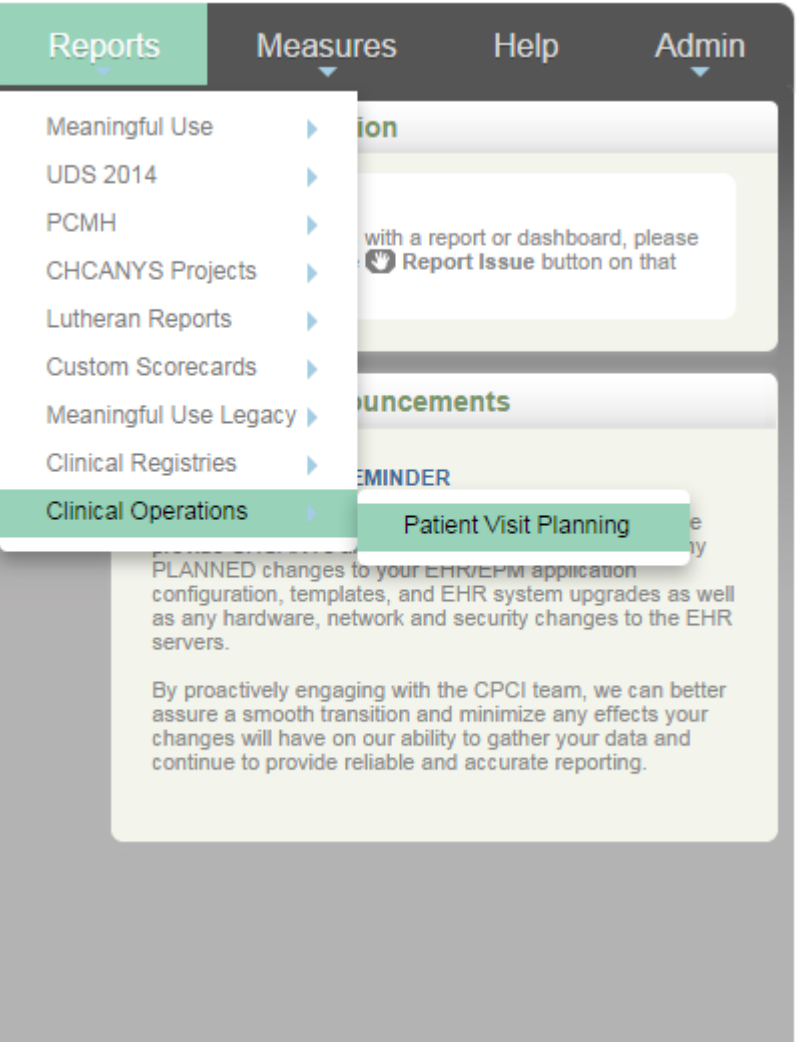
Hospital Admissions/Discharge Reports

Period
- ○ Most Recent E/D Admission
- ○ Most Recent E/D Discharge
- ○ Most Recent I/P Admission
- ◉ Most Recent I/P Discharge

Filters | PDF | EXCEL | Report Issue | Add to Favorites

Name	MRN	Age	Last Encounter	Next Appt	Medication Reconciliation	Risk	Last ED Admission	Last ED Discharge	ED Discharge Disp	Last IP Admission	Readmission	IP Adm Ct	Last IP Discharge	IP Discharge Disp
LUT														
Brooklyn Chinese LFHC														
[redacted]	[redacted]	52	12/13/2011		11/16/2011	High	8/22/2014	8/22/2014	60	9/20/2014	False	3	9/24/2014	01
[redacted]	[redacted]	39	5/12/2009		5/12/2009	Low				9/25/2014	False	1	9/29/2014	01
[redacted]	[redacted]	72	8/4/2014	10/2/2014	8/4/2014	Low				8/5/2014	False	1	9/30/2014	01
[redacted]	[redacted]	53	9/26/2014		7/15/2014	Moderate				9/26/2014	False	1	9/28/2014	01
Caribbean-American LFHC														
[redacted]	[redacted]	65				Low	4/1/2014	4/1/2014	60	9/19/2014	False	7	9/21/2014	01
[redacted]	[redacted]	50	6/6/2014			Moderate				9/12/2014	False	2	9/26/2014	03
[redacted]	[redacted]	66	9/16/2014	10/2/2014	9/16/2014	High	5/4/2013	5/4/2013	60	9/19/2014	True	2	9/30/2014	06
[redacted]	[redacted]	78				High				9/29/2014	True	3	9/26/2014	01
[redacted]	[redacted]	56	8/15/2014		7/11/2014	Moderate				9/24/2014	False	1	9/26/2014	01
Family Physician LFHC														
[redacted]	[redacted]	58				Low	1/9/2014	1/9/2014	60	9/18/2014	False	3	9/26/2014	01

Pre-Visit Planning



Case Management

- Outreaches 24 hours prior to appt.
- Confirms or reschedules appt.
- Reviews outstanding labs and prompt patient to complete
- Addresses barriers to appointment compliance, i.e. travel
- Posts high risk alerts

Pre-Visit Planning Report

Thursday, October 02, 2014

10:15 AM [redacted] — Low Risk — M, 3 — INTERPRETER NOT NEED — PCP: PAIK, JOON; Prim. Loc.: Sunset Park 5610 Children's Health; Risk Factors:

MRN: [redacted]

Alert Type	Message	Most Recent Date	Most Recent Result
Flu	Missing		

10:15 AM [redacted] — High Risk — F, 67 — AM SIGN LANG INTRPR — PCP: OO, MYA MYA; Prim. Loc.: Sunset Park Family Health Center Adult Medicine; Risk Factors: SMIP

MRN: [redacted] — Asthma Depression

Alert Type	Message	Most Recent Date	Most Recent Result
Mammogram	Overdue	10/15/2010	
Asthma Severity	Missing		
Depression Screening	Overdue	7/10/2012	
E/D Admission	Occurrence	9/17/2014	
Flu	Overdue	11/1/2010	

10:45 AM [redacted] — Moderate Risk — M, 62 — SPANISH INTERPRETER — PCP: LEFF, JOHN; Prim. Loc.: Needs Update; Risk Factors:

MRN: [redacted] — Hypertension

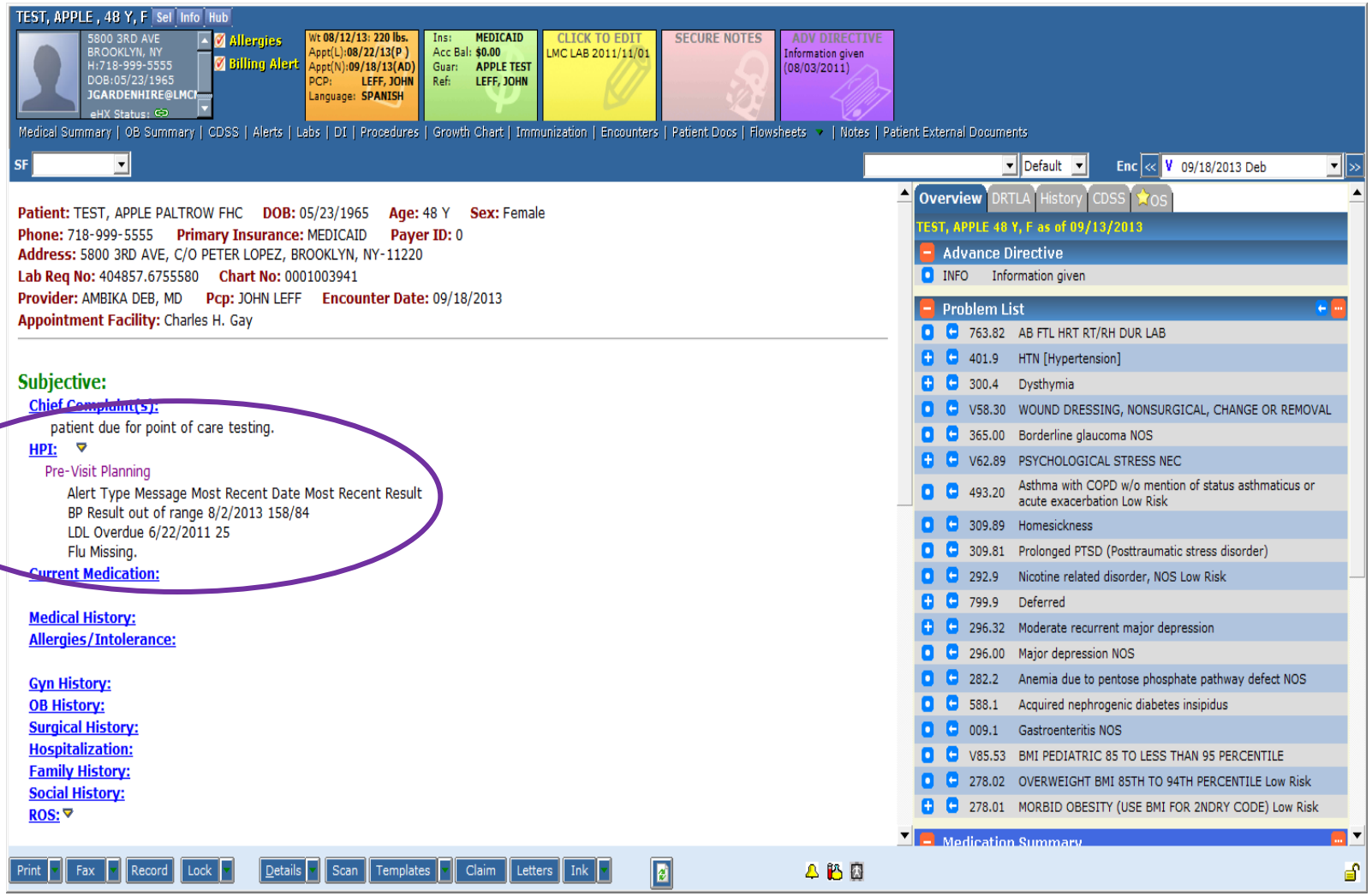
Alert Type	Message	Most Recent Date	Most Recent Result
Depression Screening	Overdue	9/15/2010	
BP	Overdue	9/15/2010	154/94
LDL	Overdue	7/21/2010	85.00
Flu	Overdue	12/5/2008	

11:30 AM [redacted] — Moderate Risk — F, 75 — INTERPRETER NOT NEED — PCP: EL ATAT, ALI; Prim. Loc.: Sunset Park Family Health Center Adult Medicine; Risk Factors: OBS SMIP

MRN: [redacted] — Asthma Hypertension Depression

Alert Type	Message	Most Recent Date	Most Recent Result
Asthma Severity	Missing		
Depression Screening	Overdue	11/6/2012	
BP	Result out of range	9/29/2014	157/66
LDL	Overdue	4/3/2013	139.00
Flu	Missing		

EHR-eCW Alerts



Current Risk Stratification

High

Patient has 1+ of 11 risk diagnoses

AND

2+ ED and/or IP visits in the past 6 months.

Moderate

Patient has 1+ of 11 risk diagnoses

AND

< 2+ ED and/or IP visits in the past 6 months.

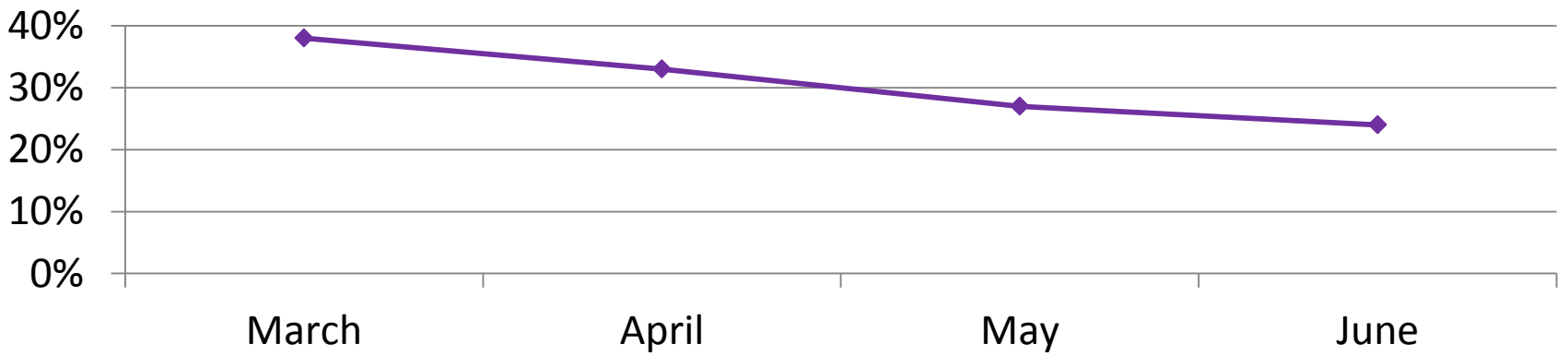
Low

Patient has none of 11 risk diagnoses.

11 Risk Diagnoses

- Asthma
- COPD
- Diabetes Mellitus
- Heart Failure
- Hypertension
- Obesity
- Alcohol Abuse
- Alcohol Dependency
- Drug Abuse
- Drug Dependence
- Severe Mental Illness

High-Risk Medicaid Readmissions



Month	Numerator	Denominator	Rate
March	42	112	**37.5%**
April	36	110	**32.7%**
May	23	84	**27.0%**
June	19	79	**24.0%**

Next Steps

- Develop and implement case management report card.
- Enhance risk stratification beyond current methodology.
- Auto-populate the risk alerts in providers' progress notes in eCW.
- Add admission and readmission alerts to admission, discharge and patient visit planning reports.
- Include pediatric and OB populations in Azara reporting tool.
- Develop HIV registry.

Expansion of HIV Registry

Filters | PDF | EXCEL | Report Issue | Add to Favorites

Name	MRN	Age	Last Encounter	Next Appt	Risk	CD4 Test	CD4 Result	CD4 Low	Dental Referral	Ophthalmology Referral	Medications Reviewed	Pap Test	Viral Load Test	Viral Load Result
LUT														
Behavioral Health														
[redacted]	[redacted]	45	9/26/2014	10/8/2014	Moderate						9/26/2014			
[redacted]	[redacted]	34	9/26/2014	10/8/2014	Moderate	7/9/2014	1.91	1		10/16/2013	9/26/2014		7/1/2013	2.0
Caribbean-American LFHC														
[redacted]	[redacted]	63	9/24/2014	12/8/2014	Moderate	9/23/2014	32.00	1		9/19/2014	7/18/2014	7/8/2014	2/19/2013	
[redacted]	[redacted]	50	9/27/2014	10/1/2014	Moderate	4/29/2014	7.00	7			9/27/2014			
[redacted]	[redacted]	63	9/24/2014	10/13/2014	Moderate	6/20/2014	33.00	1		9/18/2013	9/24/2014	8/26/2014	6/30/2011	1.9
[redacted]	[redacted]	36	9/22/2014	10/3/2014	Low	11/7/2011	2.36	2		8/4/2012	9/22/2014	3/27/2014	6/17/2010	3.2
[redacted]	[redacted]	32	9/24/2014	10/22/2014	Moderate	9/9/2014	50.00	1		9/24/2014	9/12/2014	2/18/2013	10/15/2012	3.2
[redacted]	[redacted]	50	9/24/2014	10/2/2014	Moderate	7/12/2014	25.00	1			9/13/2014	5/29/2012	9/24/2012	
[redacted]	[redacted]	58	9/23/2014	10/7/2014	Moderate	9/23/2014	12.00	12			9/23/2014			
[redacted]	[redacted]	52	9/27/2014	10/2/2014	Low	7/12/2014	29.00	12			9/27/2014			

Enhancement includes additional fields and 5 measures