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

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Barbara Hood, William F. Ryan CHC

Lisa Perry, CHCANYs
LuAnn Kimker, Azara Healthcare

CHCANYs Annual Conference
October 25, 2017
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
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.

Aggregate data

Social determinants
- Claims
- Electronic health record
- Biometrics
- Home health monitoring device data

Aggregate

Normalize Data

- Claims
- EHR
- Other

Segment Population

- Condition
- Risk Scores
- Screenings
- Other

Disease registries
- Hypertension
- Diabetes
- Smokers

Stratify health risk

Individualize care plans for different risk levels

Care coordination and outreach

Clinical outcomes

Reporting

- Quality and Care Gaps
- Cost and Utilization

Care Management

- Provider based
- Provider defined

Data sources

Care
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

Define Organization Goals

- List out your goals for the next 1-5 years

Prioritize Goals

- Rank each goal to identify the top priorities

Identify Key Data Sources and Tools / Outputs to Meet Priority Goals

- For each goal map out the needed data sources, tools & outputs

Create BI Blueprint for Building, Buying and/or Partnering for Key Data / Tools

- Evaluate and select BI models
- Put the four decisions together in your blueprint
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

Before...

Requires
- Time
- Talent
- Treasure

...After

Data
Information
Analysis
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

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

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

33–66% of the sites 5%+ Improvement

3 – 22% Relative Change
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
Pts with F2F Encounters

Inactive Pts (No visit in past year)
TY September 2017
3,705
Pts without Qualifying Encounter in past 12 months

Panel Age Stratification
September 2017

<table>
<thead>
<tr>
<th>Age</th>
<th>Numerator</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>1,593</td>
<td>13</td>
</tr>
<tr>
<td>26-45</td>
<td>3,826</td>
<td>32</td>
</tr>
<tr>
<td>3-6</td>
<td>747</td>
<td>6</td>
</tr>
<tr>
<td>46-64</td>
<td>2,706</td>
<td>23</td>
</tr>
<tr>
<td>65+</td>
<td>606</td>
<td>5</td>
</tr>
<tr>
<td>7-17</td>
<td>2,119</td>
<td>18</td>
</tr>
<tr>
<td>&lt;= 2</td>
<td>217</td>
<td>2</td>
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</tbody>
</table>

Provider Continuity, Past Yr
September 2017

Usual Provider Assigned
TY September 2017

Patient Risk
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Numerator</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>871</td>
<td>90.8%</td>
</tr>
<tr>
<td>Low</td>
<td>13</td>
<td>1.4%</td>
</tr>
<tr>
<td>Moderate</td>
<td>75</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Graph showing trends over time and usage of usual providers.
Attribution and TME

Attributed Members

13,470
Members Eligible During the Period

Unmatched Members

9,454
Unmatched Members

Matched Members Group By Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Match Rate</th>
<th>Matched Members</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 2</td>
<td>30%</td>
<td>72</td>
<td>241</td>
</tr>
<tr>
<td>3-6</td>
<td>30%</td>
<td>258</td>
<td>867</td>
</tr>
<tr>
<td>7-17</td>
<td>31%</td>
<td>753</td>
<td>2,430</td>
</tr>
<tr>
<td>18-25</td>
<td>30%</td>
<td>550</td>
<td>1,844</td>
</tr>
<tr>
<td>26-45</td>
<td>30%</td>
<td>1,284</td>
<td>4,321</td>
</tr>
<tr>
<td>46-64</td>
<td>29%</td>
<td>877</td>
<td>3,072</td>
</tr>
<tr>
<td>65+</td>
<td>32%</td>
<td>222</td>
<td>695</td>
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</table>

Matched Members Group By Cost

<table>
<thead>
<tr>
<th>Cost Group</th>
<th>Match Rate</th>
<th>Matched Members</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Cost Data</td>
<td>29%</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>$0-5k</td>
<td>30%</td>
<td>3,821</td>
<td>12,837</td>
</tr>
<tr>
<td>$5k-10k</td>
<td>20%</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>$10k-25k</td>
<td>36%</td>
<td>50</td>
<td>138</td>
</tr>
<tr>
<td>$25k-50k</td>
<td>30%</td>
<td>127</td>
<td>420</td>
</tr>
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</table>

Matched Members Group By Last Encounter

<table>
<thead>
<tr>
<th>Last Encouter</th>
<th>Matched Members</th>
<th>% Total</th>
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</thead>
<tbody>
<tr>
<td>No Encounter</td>
<td>691</td>
<td>17%</td>
</tr>
<tr>
<td>0-180</td>
<td>1,460</td>
<td>30%</td>
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<tr>
<td>181-365</td>
<td>889</td>
<td>22%</td>
</tr>
<tr>
<td>366-720</td>
<td>800</td>
<td>20%</td>
</tr>
<tr>
<td>&gt;720</td>
<td>176</td>
<td>4%</td>
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<tr>
<td>Totals</td>
<td>4,046</td>
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### Member Matching / Enrollment Dashboard

#### Filtered by: InverseNumerator

<table>
<thead>
<tr>
<th>Plan</th>
<th>Name</th>
<th>Member Number</th>
<th>Matched</th>
<th>Eligibility Start</th>
<th>Eligibility End</th>
<th>EHR MRN</th>
<th>Age</th>
<th>DOS</th>
<th>Age Group</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Plan</td>
<td>HILLSETH, CONNIE</td>
<td>4089A</td>
<td>N</td>
<td>5/27/2015</td>
<td>5/30/2017</td>
<td>10</td>
<td>12/27/2000</td>
<td>5-12</td>
<td>M</td>
<td></td>
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<tr>
<td>Group Health</td>
<td>GOLD, KIMIKO</td>
<td>4095A</td>
<td>N</td>
<td>2/23/2017</td>
<td>8/4/2017</td>
<td>8</td>
<td>7/17/2006</td>
<td>5-12</td>
<td>F</td>
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<tr>
<td>United Health Plan</td>
<td>KARABIN, ARMULFO</td>
<td>4098A</td>
<td>N</td>
<td>7/25/2016</td>
<td>8/27/2017</td>
<td>46</td>
<td>12/28/1977</td>
<td>45-64</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Group Health</td>
<td>HEININGER, GERARD</td>
<td>4160A</td>
<td>N</td>
<td>4/12/2017</td>
<td>7/4/2017</td>
<td>38</td>
<td>8/21/1978</td>
<td>35-44</td>
<td>M</td>
<td></td>
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<tr>
<td>United Health Plan</td>
<td>KAYS, FRED</td>
<td>4163A</td>
<td>N</td>
<td>3/7/2017</td>
<td>6/1/2017</td>
<td>52</td>
<td>5/20/1960</td>
<td>45-64</td>
<td>F</td>
<td></td>
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<tr>
<td>United Health Plan</td>
<td>BELLUE, HYMAN</td>
<td>4206A</td>
<td>N</td>
<td>8/1/2017</td>
<td>8/5/2017</td>
<td>61</td>
<td>3/17/1966</td>
<td>45-64</td>
<td>M</td>
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<tr>
<td>Group Health</td>
<td>BECKLEY, RUFUS</td>
<td>4242A</td>
<td>N</td>
<td>5/22/2016</td>
<td>8/30/2017</td>
<td>6</td>
<td>4/27/2011</td>
<td>5-12</td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Quality – HEDIS Member vs Patient Measures

Dashboards - Cervical CA - Member vs Pt Results

- # 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
  - Graph showing percentages over time

- Cervical CA Screen (CCS) Pt Based
  - TY September 2017
  - Graph showing percentages over time
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

<table>
<thead>
<tr>
<th>Patient Risk</th>
<th>Denominator</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>1,687</td>
<td>94%</td>
</tr>
<tr>
<td>Low</td>
<td>7</td>
<td>0%</td>
</tr>
<tr>
<td>Moderate</td>
<td>110</td>
<td>6%</td>
</tr>
<tr>
<td>Totals</td>
<td>1,804</td>
<td></td>
</tr>
</tbody>
</table>

HTN Provider vs Ctr

- Selected: 85%
- Center Average: 85%

HTN BP Control by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Result</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>73%</td>
<td>38</td>
<td>52</td>
</tr>
<tr>
<td>20-34</td>
<td>84%</td>
<td>509</td>
<td>606</td>
</tr>
<tr>
<td>35-44</td>
<td>86%</td>
<td>351</td>
<td>410</td>
</tr>
<tr>
<td>45-64</td>
<td>84%</td>
<td>522</td>
<td>618</td>
</tr>
<tr>
<td>65+</td>
<td>86%</td>
<td>102</td>
<td>118</td>
</tr>
</tbody>
</table>

HTN BP < 140/90

HTN Comorbidities

- Cerebral Palsy: 513
- Chronic Non-malignant Pain: 1,505
- COPD: 866
- Coronary Artery Disease: 1,484
- Coronary Artery Disease No MI: 1,382
- Depression/Bipolar: 1,320
- Diabetes: 1,136

HTN BP Control

- Pts w/ HTN: 1,804
- Pts w/ BP >= 140/90: 269 (15%)
### Selected Patients for Cervical Cancer Screening (NQF 0032)

<table>
<thead>
<tr>
<th>Center ID</th>
<th>Center Name</th>
<th>Name</th>
<th>MRN</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Medicaid-Number</th>
<th>Usual Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access Community Health</td>
<td>MCCONNAUGHY, BERRY</td>
<td>1866627</td>
<td>F</td>
<td>6/1/1979</td>
<td>2012846</td>
<td>Augustine, Greg</td>
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<tr>
<td>1</td>
<td>Access Community Health</td>
<td>BACKMAN, AVIS</td>
<td>6439768</td>
<td>F</td>
<td>8/19/1965</td>
<td>1754729</td>
<td>Bridgewater, Bill</td>
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<tr>
<td>1</td>
<td>Access Community Health</td>
<td>HARKRIDER, ANTONINA</td>
<td>4713471</td>
<td>F</td>
<td>10/5/1974</td>
<td>3098048</td>
<td>Winslow, Francine</td>
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<tr>
<td>1</td>
<td>Access Community Health</td>
<td>KINNARD, BRYANNA</td>
<td>5157110</td>
<td>F</td>
<td>2/1/1972</td>
<td>4250814</td>
<td>Fritz, Renata</td>
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<tr>
<td>1</td>
<td>Access Community Health</td>
<td>FORTUNE, FAITH</td>
<td>1574462</td>
<td>F</td>
<td>7/15/1989</td>
<td>2841939</td>
<td>Smith, Joe</td>
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<tr>
<td>1</td>
<td>Access Community Health</td>
<td>ANDAYA, TONISHA</td>
<td>4680516</td>
<td>F</td>
<td>7/2/1987</td>
<td>4439938</td>
<td>Decelles, Larry</td>
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<tr>
<td>1</td>
<td>Access Community Health</td>
<td>BRUSON, ROSALIA</td>
<td>7503505</td>
<td>F</td>
<td>3/27/1992</td>
<td>7478864</td>
<td>Augustine, Greg</td>
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<tr>
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<td>LANHAM, CIRA</td>
<td>6182670</td>
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<td>2164966</td>
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<td>1</td>
<td>Access Community Health</td>
<td>SITTO, LYNELL</td>
<td>6683797</td>
<td>F</td>
<td>10/27/1965</td>
<td>5342534</td>
<td>Gunther, Eric</td>
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<td>1</td>
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<td>HOULTON, CLARENCE</td>
<td>5918547</td>
<td>F</td>
<td>12/17/1962</td>
<td>2025085</td>
<td>Crowley, Patrick</td>
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<td>1</td>
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<td>MATUSZAK, MAIRA</td>
<td>1234939</td>
<td>F</td>
<td>4/14/1969</td>
<td>3462533</td>
<td>Winslow, Francine</td>
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## Dashboards - UDS 2016 vs Current

### UDS Performance - 2016

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

### UDS Performance - Current TY

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

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

“In the Heart of East Harlem, Living Just got Better”
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
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
For more information, please contact CHCANYS’ Quality & Technology Senior Team or Azara Healthcare

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