Center for Primary Care Informatics (CPCI)

- A statewide reporting and analytics solution for NY’s FQHCs
- Developed by CHCANYs in 2011 in close partnership with Azara (www.azarahealthcare.com) and utilizing the DRVS (“Drives”) analytics platform
- Reporting is available for mandated & regulatory reporting (UDS, Meaningful Use, HEDIS), PCMH support, grants, patient registries, patient visit planning
- Currently 45 New York State health centers are live on CPCI, with several centers in process or in the pipeline to connect
CPCI Connects FQHCs Across New York State
Total Centers as of Nov 2015 = 45
# List of CPCI Connected FQHCs

<table>
<thead>
<tr>
<th>Health Center</th>
<th>Location</th>
<th>EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACACIA</td>
<td>Bronx</td>
<td>NextGen</td>
</tr>
<tr>
<td>ACCESS CHC</td>
<td>NYC</td>
<td>eCW</td>
</tr>
<tr>
<td>ANTHONY JORDAN</td>
<td>Rochester</td>
<td>eCW</td>
</tr>
<tr>
<td>BEACON CHRISTIAN</td>
<td>Staten Island</td>
<td>Success EHS</td>
</tr>
<tr>
<td>BEDFORD STUYVESANT</td>
<td>Brooklyn</td>
<td>eCW</td>
</tr>
<tr>
<td>BETANCES</td>
<td>NYC</td>
<td>eCW</td>
</tr>
<tr>
<td>BORIKEN</td>
<td>NYC</td>
<td>eCW</td>
</tr>
<tr>
<td>BRIGHTPOINT HEALTH</td>
<td>NYC</td>
<td>eCW</td>
</tr>
<tr>
<td>BROOKLYN PLAZA</td>
<td>Brooklyn</td>
<td>eCW</td>
</tr>
<tr>
<td>BROWNSVILLE</td>
<td>Brooklyn</td>
<td>eCW</td>
</tr>
<tr>
<td>CHAUTAUQUA</td>
<td>Dunkirk</td>
<td>Allscripts</td>
</tr>
<tr>
<td>CHC BUFFALO</td>
<td>Buffalo</td>
<td>eCW</td>
</tr>
<tr>
<td>CHC OF THE NORTH COUNTRY</td>
<td>Staten Island</td>
<td>eCW</td>
</tr>
<tr>
<td>CHC RICHMOND</td>
<td>Staten Island</td>
<td>eCW</td>
</tr>
<tr>
<td>COMMUNITY HEALTHCARE NETWORK</td>
<td>NYC</td>
<td>eCW</td>
</tr>
<tr>
<td>DAMIAN</td>
<td>Briarwood</td>
<td>eCW</td>
</tr>
<tr>
<td>EZRA MEDICAL CENTER</td>
<td>Brooklyn</td>
<td>NextGen</td>
</tr>
<tr>
<td>EZRAS CHOLIM HEALTH CENTER</td>
<td>Monroe</td>
<td>Allscripts</td>
</tr>
<tr>
<td>FAMILY HEALTH NETWORK OF CENTRAL NY, INC.</td>
<td>Cortland</td>
<td>GE Centricity</td>
</tr>
<tr>
<td>FINGER LAKES</td>
<td>Penn Yan</td>
<td>eCW</td>
</tr>
<tr>
<td>GREATER HUDSON VALLEY FHC</td>
<td>Newburgh</td>
<td>GE Centricity</td>
</tr>
<tr>
<td>HARLEM UNITED</td>
<td>NYC</td>
<td>eCW</td>
</tr>
<tr>
<td>HEALTHCARE CHOICES</td>
<td>Brooklyn</td>
<td>eCW</td>
</tr>
<tr>
<td>HOMETOWN</td>
<td>Schenectady</td>
<td>eCW</td>
</tr>
<tr>
<td>HOUSINGWORKS</td>
<td>Brooklyn</td>
<td>eCW</td>
</tr>
<tr>
<td>HUDSON HEADWATERS</td>
<td>Glens Falls</td>
<td>Athena</td>
</tr>
<tr>
<td>HUDSON RIVER HEALTH CARE</td>
<td>Peekskill</td>
<td>eCW</td>
</tr>
<tr>
<td>INSTITUTE FOR FAMILY HEALTH</td>
<td>NYC</td>
<td>EPIC</td>
</tr>
<tr>
<td>LUTHERAN</td>
<td>Brooklyn</td>
<td>eCW</td>
</tr>
<tr>
<td>MORRIS HEIGHTS</td>
<td>Bronx</td>
<td>eCW</td>
</tr>
<tr>
<td>NOCHSI</td>
<td>Pulaski</td>
<td>Intergy</td>
</tr>
<tr>
<td>NORTH COUNTRY FHC</td>
<td>Watertown</td>
<td>GE Centricity</td>
</tr>
<tr>
<td>OAK ORCHARD CHC</td>
<td>Brockport</td>
<td>eCW</td>
</tr>
<tr>
<td>OPEN DOOR FMC</td>
<td>Ossining</td>
<td>eCW</td>
</tr>
<tr>
<td>PROJECT RENEWAL</td>
<td>NYC</td>
<td>eCW</td>
</tr>
<tr>
<td>REFUAH</td>
<td>Spring Valley</td>
<td>eCW</td>
</tr>
<tr>
<td>RPCN</td>
<td>Rochester</td>
<td>eCW</td>
</tr>
<tr>
<td>SETTLEMENT</td>
<td>NYC</td>
<td>GE Centricity</td>
</tr>
<tr>
<td>SOUTHERN TIER CHC NETWORK</td>
<td>Elmira</td>
<td>eCW</td>
</tr>
<tr>
<td>URBAN</td>
<td>Bronx</td>
<td>eCW</td>
</tr>
<tr>
<td>WHITNEY M. YOUNG, JR. CHC</td>
<td>Albany</td>
<td>eCW</td>
</tr>
<tr>
<td>WILLIAM F. RYAN</td>
<td>NYC</td>
<td>eCW</td>
</tr>
</tbody>
</table>

11/6/2015  www.chcanys.org
CPCI Usage Highlights

- Looking at the past 3 months (July – September 2015):
  - Almost all connected health centers are active on CPCI
  - More than half of connected centers have at least 4 users logging in and running reports on CPCI
  - A wide range of reports were accessed (150 + reports)

- Most used reports include:
  - Patient Visit Planning
  - Diabetes reports
  - UDS reports
  - Cancer Screening Reports
Improving Patient Outcomes through Data

CPCI Super User Training
November 6, 2015
Agenda

- How to Log In
- The Home Screen and General Navigation
- Reports vs. Measures
- Compliance Reports
- The Measures Analyzer
- Clinical Registry Reports
- Patient Visit Planning
- Help
- UDS Reporting
Who should have access to CPCI?

- Quality Director and Quality Improvement Staff
- MA's / LPN's
- RN's / RN Care Managers
- Providers
- IT / Applications Staff
- Health Home Director
- Behavior Health Consultants
- Clinical Leadership
- Executive Director and Leadership
Logging In – Welcome Email

After an account has been created, the user will receive an email that will guide them through account confirmation and setting their password.

- The user must confirm their account within 72 hours of receiving their welcome email.

---

Welcome to DRVS

support@azarahealthcare.com  
Saturday, June 20, 2015 at 1:32 PM
To: Gregory Augustine

Welcome to Azara DRVS

A user account has been created for you in DRVS. Please follow the link below to confirm your email and complete the account registration process

Confirm My Email

Thanks, Azara Healthcare
Logging In – Establishing a Password

Welcome to DRVS

support@azarahealthcare.com
Saturday, June 20, 2015 at 1:32 PM
To: Gregory Augustine

Welcome to Azara DRVS

A user account has been created for you in DRVS. Please follow the link below to confirm your email and complete the account registration process

[Confirm My Email]

Thanks, Azara Healthcare

---

Reset your password.

Email: greg.augustine@azarahealthcare.com

Password: ********

Confirm password: ********

[Reset]

Reset password confirmation.

Your password has been reset. Please [click here to log in]

Login
Logging In

- Launch a web browser and in the address field enter:
  https://DRVS.azarahealthcare.com/apicha

- At the Log In Screen enter the following:
  - User Name: <email address>
  - Password: <password>
After logging into CPCI, the Home Screen is displayed. There are two (2) main sections on this page plus the left navigation bar.
Home Screen Preferences

Click on the ‘Preferences’ link below your login to change the Scorecard Widget on your home page.

User Preferences

- Default Scorecard Panel: 2014 General Practice CQMs

Profile Information

- First name: Greg
- Last name: Augustine
- Title: Azara Employee

Save or Delete options available.
Navigation within CPCI

**Main Navigation Bar**
- On the left-hand side of all screens
- Quickly find and run reports and measures
- Collapsible / Expandable

**9-Dot Utility Menu**
- Located in the right-hand corner
- Contains a set of common utilities including
  - Add to Favorites
  - Excel (Export)
  - PDF (Export)
  - Report Issue
- May vary slightly depending on the type of screen/report
Reports and Measures

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

- There are three (3) basic types of Reports in CPCI
  - Compliance 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)
  - Clinical Operations
    - Patient Visit Planning

- The 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
Compliance Reports

CHCANYs centers currently have access to Compliance Reports for:

- UDS
- Meaningful Use
- PCMH
- CHCANYs Projects
  - CDC Cancer Grant
  - NYS-HCCN Grant
  - ABCS

- CDC Cancer Grant
- NYS-HCCN Grant
- Tables 3a & 3b
- Table 4
- Table 6a
- Table 6b
- Table 7
- Adult Diabetes
- Adult Preventive
- Pediatric Asthma
- Pediatric Preventive
- Stage 1 Core and Menu Set
- Stage 2 Core and Menu Set
- Core CQMs
- Dental CQMs
- Diabetes CQMs
- General Practice CQMs
- HIV CQMs
- Heart CQMs
Compliance reports typically displayed as a Scorecard which includes:

- Measure
- Stopeight Grade
- Target (%)
- Result (%)
- Numerator
- Denominator
- Exclusions

Meaningful Use - 2014 General Practice CQMs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Result</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening (NQF 0031)</td>
<td>0 %</td>
<td>65 %</td>
<td>535</td>
<td>822</td>
<td>0</td>
</tr>
<tr>
<td>Cervical Cancer Screening (NQF 0032)</td>
<td>0 %</td>
<td>65 %</td>
<td>787</td>
<td>1,218</td>
<td>0</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (NQF 0034)</td>
<td>0 %</td>
<td>35 %</td>
<td>513</td>
<td>1,479</td>
<td>0</td>
</tr>
<tr>
<td>Falls Screening for Future Fall Risk (NQF 0101)</td>
<td>0 %</td>
<td>34 %</td>
<td>426</td>
<td>1,238</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan (NQF 0418)</td>
<td>0 %</td>
<td>75 %</td>
<td>3,329</td>
<td>4,440</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan 12-17 yrs (NQF 0418)</td>
<td>0 %</td>
<td>76 %</td>
<td>295</td>
<td>387</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan 18+ yrs (NQF 0418)</td>
<td>0 %</td>
<td>75 %</td>
<td>3,034</td>
<td>4,053</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Clinical Depression (NQF 0418 Modified)</td>
<td>0 %</td>
<td>80 %</td>
<td>3,559</td>
<td>4,440</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Patients With Depression (NQF 0418 Modified)</td>
<td>0 %</td>
<td>0 %</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hypertension: Improvement in Blood Pressure</td>
<td>0 %</td>
<td>0 %</td>
<td>98</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>
Consistent tabs, links, and graphics help you easily find the features, functions, and tools you need to easily navigate and use CPCI:

- Measures highlighted in blue are clickable links that allow the ability to drill down into Measure Analyzer.
- Information buttons found throughout the system give more specific information about the measure or data.
- Supporting detail behind each measure can be directly exported to Excel.

### Meaningful Use - 2014 General Practice CQM's

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Result</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening (NQF 0031)</td>
<td>0 %</td>
<td>65 %</td>
<td>535</td>
<td>822</td>
<td>0</td>
</tr>
<tr>
<td>Cervical Cancer Screening (NQF 0032)</td>
<td>0 %</td>
<td>65 %</td>
<td>787</td>
<td>1,218</td>
<td>0</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (NQF 0034)</td>
<td>0 %</td>
<td>35 %</td>
<td>513</td>
<td>1,479</td>
<td>0</td>
</tr>
<tr>
<td>Falls Screening for Future Fall Risk (NQF 0101)</td>
<td>0 %</td>
<td>34 %</td>
<td>426</td>
<td>1,238</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan (NQF 0418)</td>
<td>0 %</td>
<td>75 %</td>
<td>3,329</td>
<td>4,440</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan 12-17 yrs (NQF 0418)</td>
<td>0 %</td>
<td>76 %</td>
<td>295</td>
<td>387</td>
<td>0</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan 18+ yrs (NQF 0418)</td>
<td>0 %</td>
<td>75 %</td>
<td>3,034</td>
<td>4,053</td>
<td>0</td>
</tr>
</tbody>
</table>
Filtering Results

- Results can be filtered based:
  - Time periods
  - Provider(s) – Rendering or Usual/PCP
  - Location(s) where service was rendered
  - Payer Group – custom grouping of health insurance plans

- To customize your analysis, choose the filters / parameters, and click the **Update** button
  - The filter panel can be collapsed by clicking the button.
Measure Calculations

Overall Patient Population
Total Patients in EPM/EHR

Active Patient Population
Patients Seen in Last 18 Months

Denominator
Initial Base Measure Population

Numerator
Denominator Patients Compliant with Measure

Exclusions
Patients Removed From the Denominator

Measure Calculation: Numerator / (Denominator - Exclusions)

UDS removes exclusions prior to calculation; patient will not be displayed in patient detail reports.
Reporting Periods

There are four (4) main “Period Types” to run a Scorecard Report or individual measure in the Measure Analyzer

- Year (Calendar)
- Trailing Year
- Quarter
- Month

Specifications, however, are typically written for a calendar year period.
Reporting Period Types

All period types follow and adhere to the same specification with regards to:

- The length of the measurement period
- Patient age / gender criteria
- Lookback period for a specific lab, diagnostic image or screening

Azara applies the specifications the same across all period types within CPCI with the following key differences:

- **Trailing Year**
  - The measurement period start and end dates are shifted
    - The period for TY September 2014 is 10/1/13 thru 9/30/14

- **Quarter and Month**
  - The measurement period start and end dates are shifted
    - The period for Q3 2014 is 7/1/14 thru 9/30/14
  - The patient must have a visit in the quarter (or month) – between 7/1/14 and 9/30/14
**Example: Breast Cancer Screening (MU)**

**Denominator:**
- Patients at least 42 and no more than 69 years at the end of the measurement period who had an outpatient encounter within the year prior to the end of the measurement period
  - AND who have not had either a bilateral mastectomy or two (2) unilateral mastectomies

**Numerator:**
- Pts with a breast cancer screening within 2 years prior to the end of the measurement period

**Application of the specification within CPCI for each period type:**

<table>
<thead>
<tr>
<th>Period</th>
<th>Year (2015)</th>
<th>Trailing Year (TY Feb 15)</th>
<th>Month (Feb 15)</th>
<th>Quarter (Q1 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td>OP Encounter w/in the year prior to 12/31/15</td>
<td>OP Encounter w/in the year prior to 2/28/15</td>
<td>OP Encounter w/in the year prior to 2/28/15</td>
<td>OP Encounter w/in the year prior to 3/31/15</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>AND</td>
<td>AND</td>
<td>AND</td>
<td>AND</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>Pt at least 42 and not more than 69 as of Dec 31</td>
<td>Pt at least 42 and not more than 69 as of Feb 28</td>
<td>Pt at least 42 and not more than 69 as of Feb 28</td>
<td>Pt at least 42 and not more than 69 as of Mar 31</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>AND</td>
<td>AND</td>
<td>AND</td>
<td>AND</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>OP Encounter between 1/1/15 and 12/31/15</td>
<td>OP Encounter between 3/1/14 and 2/28/15</td>
<td>OP Encounter between 2/1/15 and 2/28/15</td>
<td>OP Encounter between 1/1/15 and 3/31/15</td>
</tr>
<tr>
<td><strong>Exceptions:</strong></td>
<td>Bilateral Mastectomy or 2 Unilateral Mastectomies at any time prior to 12/31/15</td>
<td>Bilateral Mastectomy or 2 Unilateral Mastectomies at any time prior to 2/28/15</td>
<td>Bilateral Mastectomy or 2 Unilateral Mastectomies at any time prior to 2/28/15</td>
<td>Bilateral Mastectomy or 2 Unilateral Mastectomies at any time prior to 3/31/15</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td>Screening (Mammography) w/in 2 years prior to 12/31/15</td>
<td>Screening (Mammography) w/in 2 years prior to 2/28/15</td>
<td>Screening (Mammography) w/in 2 years prior to 2/28/15</td>
<td>Screening (Mammography) w/in 2 years prior to 3/31/15</td>
</tr>
</tbody>
</table>
CHCANYS centers currently have access to a large number of measures across multiple categories:

- UDS
- Meaningful Use
- PCMH
- CHCANYS Projects

The Measure Analyzer can be accessed directly from the Navigation Bar or by ‘drilling’ into Measures from Scorecard Reports.
The Measure Analyzer screens contain three (3) graphical components:

1. Multi-Period Trends
2. Benchmarks
3. Comparison Charts
Measure Analyzer – Multi-Period Trend

- The graph of the Multi-Period Trend allows you to look at the filtered measure value as a trend line over a period of time.
- For those measures where a threshold has been established, the primary and secondary targets are displayed as a green and yellow lines for comparison.
This chart shows the selected measure results for the most recent time period against Best and Average benchmarks.

- **Selected**: Result for filters (e.g., providers) selected
- **Best Center**: Result for the center in the PCA with the best results
- **PCA Average**: Average result for all centers in the PCA
- **Center Average**: Average result for all providers at your center
Measure Analyzer – Comparisons

- Displays Comparison data in chart or table form.
- Clicking on the bars in the bar chart or the highlighted links in the table ‘drills’ down into the measure for more detail and a new Measure Analyzer is displayed.

Click to drill down to another level.
Measure Analyzer – Filtering

- As in the Scorecard Reports, results can be filtered based on a period of time, specific providers or specific locations.
- To customize your analysis, choose the filters / parameters, and click the **Update** button.
  - The filter panel can be collapsed by clicking the ▼ button.
The Measure Analyzer supports access to the patient data behind the results. This is done by toggling the view to **Detail List**.

- **View:** Measure Analyzer | Detail List

The resulting Patient Detail List is sortable, filterable and may be exported as either a PDF or an Excel spreadsheet.

<table>
<thead>
<tr>
<th>Name</th>
<th>MRN</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Usual Provider</th>
<th>Inactive</th>
<th>Denote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dixon, Elaine</td>
<td>8259446</td>
<td>F</td>
<td>3/7/1986</td>
<td>Rabbit, Jessica</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Lawrence, Bertha</td>
<td>7555576</td>
<td>F</td>
<td>10/4/1952</td>
<td>Cranston, Bill</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Cortez, Maureen</td>
<td>1198398</td>
<td>F</td>
<td>7/2/1973</td>
<td>Gunther, Eric</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Espinoza, Kelly</td>
<td>9014874</td>
<td>F</td>
<td>5/22/1954</td>
<td>Crowley, Patrick</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Martin, Nora</td>
<td>4585337</td>
<td>F</td>
<td>11/19/1990</td>
<td>Cranston, Bill</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
Clinical Registry & Operations Reports

Current Clinical Registry Reports include:

- Adult Female Primary Care
- Adult Male Primary Care
- Pediatric Primary Care
- Immunizations (Childhood)
- Diabetes Labs & Services
- Asthma Status & Management
- Hypertension
- HIV
- Depression

Clinical Operations

- Patient Visit Planning Report
Clinical Registry Reports

- Provide a method to manage chronic conditions, measure preventive clinical parameters, and analyze improvement.
- Clinical Registries allow you to 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.
- There is a common set of data elements in each report (e.g., Patient Name, MRN) and a set of data elements specific to the Chronic Disease or Preventive Care category.

![Clinical Registries - Diabetes](image-url)
Clinical Registry Reports

- The 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 and filtered using the filter box at the top of each column.
  - Click the filter bar options info button for an overview of how the search functionality works.

Clinical Registries - Diabetes

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>MRN</th>
<th>Primary Payer</th>
<th>Most Recent Med Enc</th>
<th>Provider</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnold, Melinda</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burgess, Lena</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garcia, Ana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reynolds, Darrin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guerrero, Roberta</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watts, Constance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Information:
- Usual Provider: Unassigned Provider
- Date of Birth: 09/15/1976
- Race: Pacific Islander
- Ethnicity: Hispanic/Latino
- Language: Unmapped
- Address: 559 Brighton Ave
Clinical Registry – Filtering

- Results can be filtered based on a period of time, specific providers or specific locations

- To customize your analysis, choose the filters / parameters, and click the **Update** button
  - Pressing the **More Filters** button from within the filters screen opens an additional popup screen of filtering options
  - The filter panel can be collapsed by clicking the button
What does the Visit Planning Report Do?

- Performs an **electronic chart audit** for chronic and preventative care action items for each scheduled patient.
- Facilitates **more efficient** pre-visit planning by allowing care teams to review patients’ preventative and chronic care alerts, in one report.
- Displays **only actionable items** to keep the team focused.
- Displays patients’ chronic illnesses and risk factors to help staff identify high need patients who need additional care coordination.
Clinical Operations - Patient Visit Planning

Facilitates more efficient pre-visit planning sessions by allowing care teams to review alerts for patients with upcoming appointments.

- Displays *only* relevant and actionable items to help teams prepare for visits.
- Displays active diagnoses and relevant risk factors.
- Alerts indicate whether particular clinical parameters, labs or screenings are (a) missing, (b) overdue or (c) not in “good” control.
- Alerts are *configurable*.

<table>
<thead>
<tr>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Diabetes</td>
</tr>
<tr>
<td>- Hypertension</td>
</tr>
<tr>
<td>- Asthma</td>
</tr>
<tr>
<td>- Depression</td>
</tr>
<tr>
<td>- HIV</td>
</tr>
<tr>
<td>- CHF</td>
</tr>
<tr>
<td>- CAD</td>
</tr>
<tr>
<td>- IVD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Tobacco User</td>
</tr>
<tr>
<td>- Pregnant</td>
</tr>
<tr>
<td>- Obesity (OBS)</td>
</tr>
<tr>
<td>- Severe Mental Illness or Psychoses (SMIP)</td>
</tr>
<tr>
<td>- Substance Abuse or Dependence (SAD)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>- A1c</td>
</tr>
<tr>
<td>- LDL</td>
</tr>
<tr>
<td>- Eye Exam</td>
</tr>
<tr>
<td>- Monofilament Exam</td>
</tr>
<tr>
<td>- Nephropathy Screen</td>
</tr>
<tr>
<td>- Flu</td>
</tr>
<tr>
<td>- PCV</td>
</tr>
<tr>
<td>- Blood Pressure</td>
</tr>
<tr>
<td>- Tobacco Status</td>
</tr>
<tr>
<td>- Tobacco Cessation</td>
</tr>
<tr>
<td>- Dental Visit</td>
</tr>
</tbody>
</table>

- BMI |
- BMI Percentile |
- Mammogram |
- Pap Smear |
- Asthma Severity |
- Depression Screening |
- Nutritional Counseling |
- Physical Activity Counseling |
- Colorectal Cancer Screening |
- BMI and Follow-Up |
Visit Planning Alert Overview

- The report comes with alerts based on national standards (NCQA, MU, HEDIS, UDS), and *set to the strictest standard* where conflicts exist among them.
  - If you set an alert to the strictest standard, it increases your likelihood of success, and simplifies what the team has to focus on.

- Please read release notes! They contain valuable information about updates to the system, including updates to the Visit Planning report. Users receive these by email.

- In new releases of CPCI, newly created patient alerts are *turned off* (disabled) to avoid user confusion, so if your practice wants to use them- be sure to turn them on (enable) in the Admin Tab and let users know to expect to see them.
Patient Visit Planning

- Like the Clinical Registries, 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
- The report is organized by provider and appointment time and may be filtered by provider or location
- Reports may be exported and printed as a PDF tearsheet
Customizing the Pt Visit Planning Report

- Alerts can be configured to meet the needs of your center
  - Alerts can be turned on / off
  - Alerts can be associated with specific diagnoses
  - Lookbacks can be varied and modified
  - Min and Max values for labs and blood pressure can be changed
The Help Screen includes links to:

- The User Guide
- A mapping document detailing where data has been pulled from your source system for inclusion in CPCI
- Websites of compliance organizations (CMS)
Key Contact Information

- For technical support or to report data quality concerns, contact Azara Technical Support
  
support@azarahealthcare.com

- CPC URL
  
https://DRVSS.azarahealthcare.com/xxx

- **When you report an issue ... be specific!**
  
  - What Report / Measure were you running?
  - What Filters were you using?
  - Provide examples (e.g., MRN)?
  - What were you expecting?
UDS Reporting and CPCI

Current UDS Reports that exists in CPCI include:

- **Table 3a**: Patients by Age and Gender
- **Table 3b**: Patients by Ethnicity, Race and Language
- **Table 4**: Selected Patient Characteristics
- **Table 6a**: Selected Diagnoses & Services Rendered
- **Table 6b**: Quality of Care Indicators
- **Table 7**: Health Outcomes and Disparities
The finalized 2015 manual came out in mid-September!

Key changes include:

- Table 6b
  - Addition of an oral health measure in Section N, Dental Sealants for Children
- Table 7, Section C
  - Removal of the need to report on diabetics with an A1c between 8 and 9; All that is now required for submission is (a) A1c < 8 and (b) A1c > 9 or untested
- ICD-10 Transition
  - BPHC is making accommodations to receive 2015 UDS data drawn from both ICD-9 and ICD-10 codes
  - Additionally, HRSA has added language to the 2015 manual which will allow for the use of standardized code sets
    
    "... the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC) is encouraged for organizations capable of appropriately using this resource as defined below to support the data reporting of these quality of care measures."
Azara is addressing these items as follows:

- **Table 6b Addition**
  - The new Dental Sealant measure was included in our release this past weekend

- **Table 7, Section C Changes**
  - As was done with the 2014 changes, Azara will leave all the more detailed breakouts in place to allow centers to look at a greater set of detail which can then be easily added together at the time of submission

- **ICD-10 Transition**
  - HRSA added language to the 2015 manual allowing for the use of standardized code sets
  - Azara has adopted the ICD-10 code sets from the Value Set Authority Center (VSAC) that maintains the codes for the Meaningful Use CQMs
  - This is *critical* as the BPHC has publicly stated that in 2016 they will be *shifting* to the MU CQM specifications for the Table 6b measures
QUESTIONS?
Feedback Survey
THANK YOU!!