

COMMUNITY HEALTH CARE ASSOCIATION of New York State

CHCANYS NYS-HCCN presents

The Road to Interoperability: Connecting Data, Patients, and Policies

Day 3 - Patient Data January 19, 2023

For more information, please email Anita Li at ali@CHCANYS.org



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Zoom Guidelines

- You have been muted upon entry. Please respect our presenters and stay on mute if you are not speaking.
- Please share your questions in the chat.
 CHCANYS staff will raise your questions to our speakers and follow up as needed if there are unanswered questions.
- The webinar is being recorded.
- Slides and recording links will be sent following the event.



Agenda

- Welcome
- Patient Data
 - Self Measured Blood Pressure (SMBP) Program
 - Patient Matching

Schedule of Events

Day 1 (1/17)

 National Perspective on Interoperability

Day 3 (1/19)

- Patient Data
 - RPM
 - Patient Matching

Day 5 (1/23)

- National Data Modernization
 n Initiative
- Open Forum: RPM











Day 2 (1/18)

State
 Perspective on Interoperability

Day 4 (1/20)

- Health Equity & Interoperability
- Open Forum: SDOH



Self Measured Blood Pressure (SMBP) Program

Damian Family Care Centers

- ❖ Sadia Choudhury, MPA, PCMH CCE, Lean Six Sigma Green Belt | Chief Corporate Compliance & Quality Assurance Officer
- ❖ Bob O'Connor | Chief Information Officer
- Lysna Paul, MA, CHES | Hypertension Program Manager/Health Educator





Self Measured Blood Pressure (SMBP) Program Damian Family Care Centers

CHCANYS Interoperability Lunch & Learn Series
January 19, 2023



Sadia Choudhury, MPA PCMH CCE Lean Six Sigma Green Belt

Chief Quality & Compliance Officer



Lysna Paul, MA CHES

Hypertension Program Manager/Health Educator



Bob O'Connor

Chief Information Officer

Presentation Topics

- Who is Damian?
- HRSA Grant
- Partner Selection Process
- Patient Outreach & Enrollment
- SMBP Workflow
- Outcomes & Success Stories
- Future Plan & Sustainability
- Questions

Damian Mission Statement

- ☐ Improve the health status of our patients;
- Provide staff who are culturally sensitive and appropriately credentialed to diagnose and treat our patients;
- Provide care to the underserved populations;
- ☐ Provide safe quality primary and specialty services regardless of language, cultural barriers or ability to pay.





14 Health Center Locations with NYS PCMH along with Behavioral Health Distinction Recognition

Queens - Damian Family Health Center
Firehouse Family Health Center
Richmond Hill Health Center
Long Island City Health Center
Myrtle Avenue Family Health Center

Manhattan – 121st Street Family Health Center Wards Island Family Health Center 53rd Street Health Center

Bronx – Third Avenue Family Health Center

Highbridge Health Center

Brooklyn - Ralph Avenue Health Center

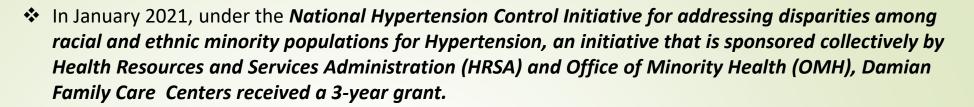
Ulster County - Ellenville Health Center

Dutchess County - Rhinebeck Health Center

Suffolk County – Ronkonkoma Family Health Center

We serve over 11,000 unique patients with over 105,000 visits yearly (clinic and virtual)

Scope of Services: ☐ Adult Medicine ☐ Pediatric Medicine OBGYN Dental ■ Mental Health Services ☐ HIV Primary Care & Prevention Cardiology ☐ PrEP/PEP Services Cardiology ■ Gastroentorology □ Hepatology ■ Neurology Optometry ■ Pain Management ■ Physical Therapy Podiatry ■ Medication Assisted Treatment (MAT) for substance use ☐ 340B Program ☐ Heath Education and Nutrition



- The 3-year grant funding was for \$144,660
- Under this grant, DFCC would commit to do the following:
 - ☐ Increase provider and staff engagement in implementing evidence-based practices for hypertension.
 - ☐ Ensure access to and support use of Bluetooth or wireless-enabled SMBP devices for *more than*50% of hypertensive patients.
 - ☐ Use patient specific data to inform hypertension treatment plans
 - ☐ Increase the number of adult patients with controlled hypertension (UDS performance on "Controlling High Blood Pressure" measure).
 - ☐ Semi-annual reporting to HRSA on progress in implementing proposed activities outlined in grant application.



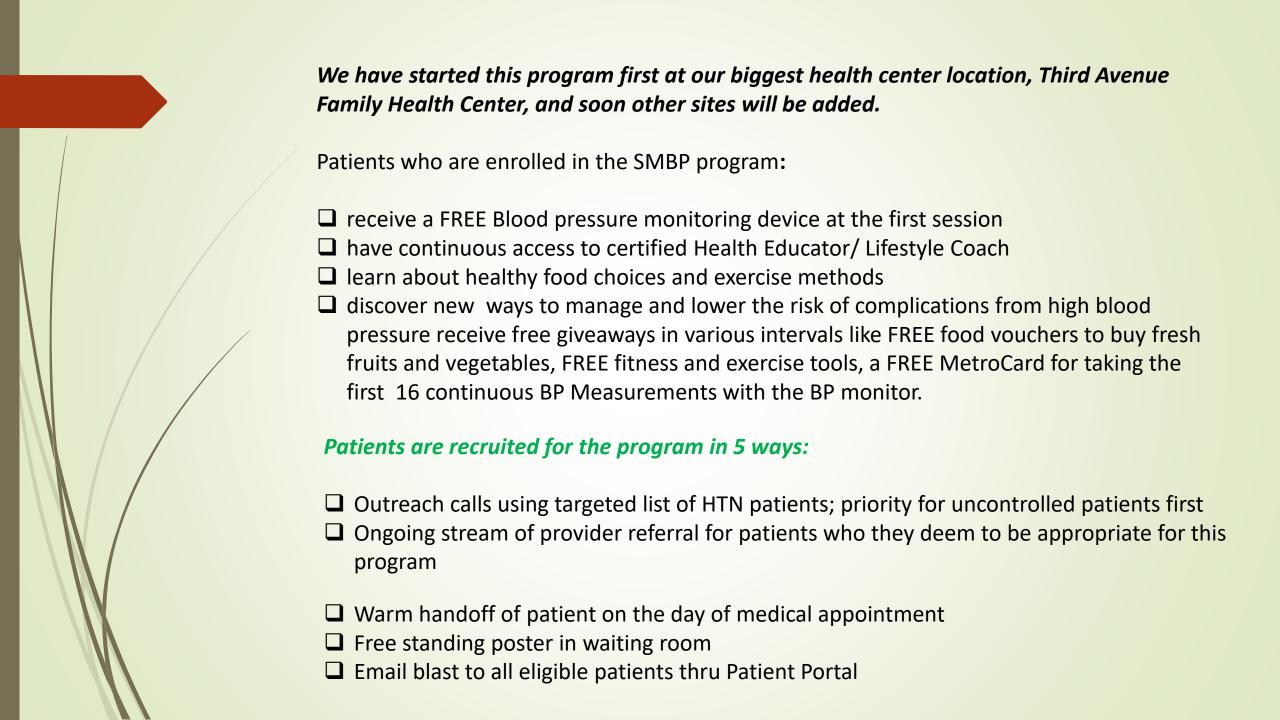


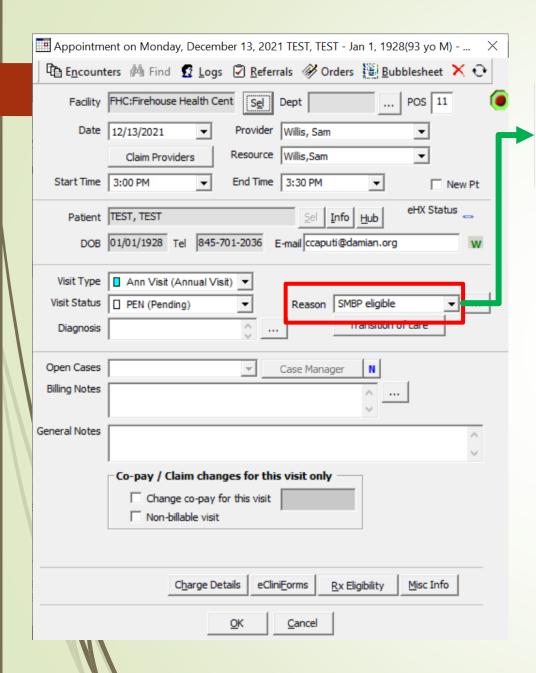
iHealth as Remote Patient Monitoring (RPM) Vendor

- ☐ BP Monitoring devices shipped directly to Damian (we can get up to 4 devices per patient which includes BP monitor, glucometer, weight scale, pulse ox)
- ☐ In person resource available for patients' technical onboarding during enrollment sessions
- ☐ Full access to iHealth Unified Care platform
- ☐ Alert generations in platform, immediate notification thru smartphone app to provider for very high BP and access to monthly billing reports
- ☐ If needed, iHealth care management support can be available too











- iHealth onsite resource checks the scheduled appointments the day before to identify SMBP eligible patients (HTN diagnosis, 18 and up, mostly uncontrolled, have smartphone)
- 2. "SMBP eligible" is noted in "reason" field of appointment screen, in addition to what already is there (if any)
- 3. It populates in "Chief Complaint" of the progress note, which is reminder for the PCP to do warm handoff of the patient to our on site HTN program manager/health educator





- Patients are scheduled in group sessions of maximum 7-8 for SMBP program enrollment
- iHealth Rep provides technical onboarding support in person during these enrollment sessions.
- Teach back/demonstration
- Patient receives Orientation package which includes following: (all available in English & Spanish):
 - ☐ SMBP Infographic
 - ☐ SMBP Brochure
 - ☐ Blood Pressure Log
 - ☐ SMBP Participant Action Plan
 - Patient BP Check Competency Validation Form
 - SMBP Authorization Agreement
 - ☐ Pill Card



Damian Family Care Centers Self-Measured Blood Pressure Program Patients' Agreement Form

By signing this form, I have thoroughly been explained and understand the following:

- I understand that Damian Family Care Centers, Inc. wishes me to engage in the Self-Measured Blood Pressure monitoring program. This means that Physicians at Damian Family Care Centers will be able to manage my treatment protocol using the telecommunication-ready device and equipment.
- I understand that the laws that protect privacy and confidentiality of medical information also apply to this remote monitoring and that no information obtained in the use of remote monitory that identifies me will be disclosed to researchers or other entities without my consent.
- I understand that there is no cost to me for using the remote monitoring devices.
- 4. I understand that systems, including telephone services and other equipment, can break down at times. Therefore, I will not hold my provider, individuals acting upon their behalf, or its vendor responsible for any services for any consequences that may arise from the delivery of such prescribe services or from system breakdown.
- I understand that I am to provide accurate answers to inquiries concerning my condition and correct answer.
- I understand that I may expect to anticipate benefits from the use of remote monitoring in my care, but no result can be guaranteed or assured.
- I understand that I have the right to withhold or withdraw my authorization to the use of remote
 monitoring in the course of my care at any time, without affecting my right to future care and
 treatment.

I hereby authorize Damian Family Care Centers to provide remote monitoring services to me. The details of such services have been discussed with me and my provider will direct such details and the frequency of these services. I state further that I have read the above authorization. Questions that I may have regarding the devices or use of the devices for my medical care have been answered to my satisfaction. I have had the alternatives of remote monitoring explained to me and I am fully familiar with the contents of this authorization. I understand the devices I will receive will be in good working condition and I agree to keep the device in such condition. I hereby agree to participate in a treatment care remote monitoring program under the terms described herein.

I authorize to contact my emergency contacts for unstable measurements during my
monitoring period, in the event that I am unable to be reached by phone. I give permission to
contact my Pharmacy, Medicaid Caseworker, Home Health Agency, and/or Aid if needed.

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Signature of Patient	Date
(Alternatively, person authorized to sign for Patient)	

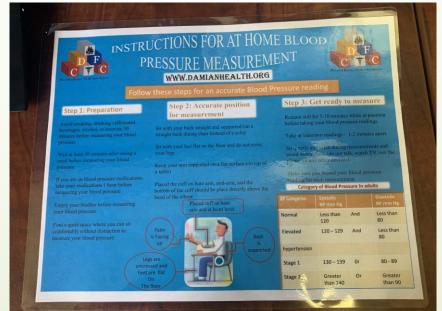


Damian Family Care Centers Self-Measured Blood Pressure Program Patient Competency Validation Form

home.	Patient understands and can state the purpos	e for utilizing remote monitoring devices in their
	and the state of the state of the state of the state of	
Patient	understands basic requirements for the devices:	
	Keep out of the reach of children.	
	 Do not let others use the devices. 	
	 Do not use cleaning products on the devices. 	
	 Do not place food or beverages on or near th 	e devices.
	Devices must be used on a stable surface.	
	_ Devices are not intended for emergency resp	onse use. Call 911 in an emergency situation.
Patient u	inderstands the basic procedures in using the de	evices:
	Willing to respond honestly to assessment qu	uestions.
	Reviews Patient Instruction Sheet.	
	Demonstrates ability to properly position and	d use (check applicable):
	Blood pressure device and cuff	
	Scale	
	_ Sp02	
	Glucometer	
		om Damian Family Care Centers, Inc. to take home,
with serv	rices directed by my physician and administered	by providers and clinical staff. I
understa	nd that I am responsible for keeping this device	in good condition and report any malfunction with
the devi	e to my health care team.	
Patient N	lame	Last 4 Digits of SS#
Patient S	ignature	Date
Witness		Date







Resources provided during SMBP Initial enrollment session

Damian Hypertension Self-Monitoring Blood Pressure Program Office Hours & After Hours Protocol



Damian Family Care Centers

Hypertension Self-Monitoring Blood Pressure (SMBP) Program Protocol

Office hours (9am-5pm) After hours (5pm-9am):

High BP:

Level 1:

SBP > or equal to 140 and /or DBP > or equal to 90:

Office hours & After hours:

- Show on alert tab in iHealth portal. No immediate notification to on call provider.
- Lysna will check portal periodically throughout the day, contact patients and schedule them to see PCP within next 2-3 weeks.
- Lysna will document in iHealth platform and in eCW as telephone encounter

Level 2:

SBP> or equal to 150-170 and/or DBP > or equal to 100-110

- Show on alert tab in iHealth portal. No immediate notification to on call provider.
- Lysna will check portal periodically throughout the day, contact patients and schedule them to see PCP within one week. Patient's treatment plan and medications would need to be reviewed during PCP visit
- · Lysna will document in iHealth platform and in eCW as telephone encounter.

	Track Red: SBP> or equal to 170 and/or DBP > or equal to 110
Office Hours	 iHealth will send immediate notification/alert to primary care doctor and Lysna thru the App. PCP or Lysna should call patient to see if patient is doing okay and advise them to come to office for blood pressure check Patient should be advised to go to ER immediately if patient denies to come to office for BP check or if patient complains of any concerning clinical symptoms. Lysna will follow up with patient and schedule PCP visit within 2-3 days. Patient's treatment plan and medications would need to be reviewed during PCP visit. Lysna will document in iHealth platform and in eCW as telephone encounter

		•	On call providers assigned for that given week will keep notifications on for the app for that week.
After Hours			Keep the "on call" mode/feature on during after-hours duty.
	•	iHealth will send immediate notification to primary care doctor, doctor on call, and Lysna	
	After	•	On call provider will call and triage patient, and should advise to visit ER immediately if needed,
	•	Lysna will follow up next day and schedule patient to come see PCP within 2-3 days. Patient's	
		treatment plan and medications would need to be reviewed during PCP visit.	
		•	Lysna will document in iHealth platform and in eCW as telephone encounter

Low BP:

	SBP < or equal to 100 and/or DBP < or equal to 60		
Office Hours	 iHealth will send immediate notification/alert to primary care doctor and Lysna thru the App. PCP or Lysna should call patient to see if patient is doing okay and advise them to come to office for blood pressure check if there are symptoms such as: dizziness on standing, fainting. If there are no significant symptoms, patient should still be advised to come see PCP within 2-3 days. Lysna will follow up with patient and schedule PCP visit within 2-3 days. Patient's treatment 		
	plan and medications would need to be reviewed during PCP visit. • Lysna will document in iHealth platform and in eCW as telephone encounter		
After Hours	 On call providers assigned for that given week will keep notifications on for the app for that week. Keep the "on call" mode/feature on during after-hours duty. iHealth will send immediate notification to primary care doctor, doctor on call, and Lysna On call provider should call patient to see if patient is doing okay and advise them to come to office next morning for blood pressure check if there are symptoms such as: dizziness on standing, 		
	 fainting. If there are no significant symptoms, patient should still be advised to come see PCP within 2-3 days. Lysna will follow up next day and schedule patient to come see PCP within 2-3 days. Patient's treatment plan and medications would need to be reviewed during PCP visit. 		
	Lysna will document in iHealth platform and in eCW as telephone encounter		

Limitations:

iHealth Triage in app or real time call can only happen for following:

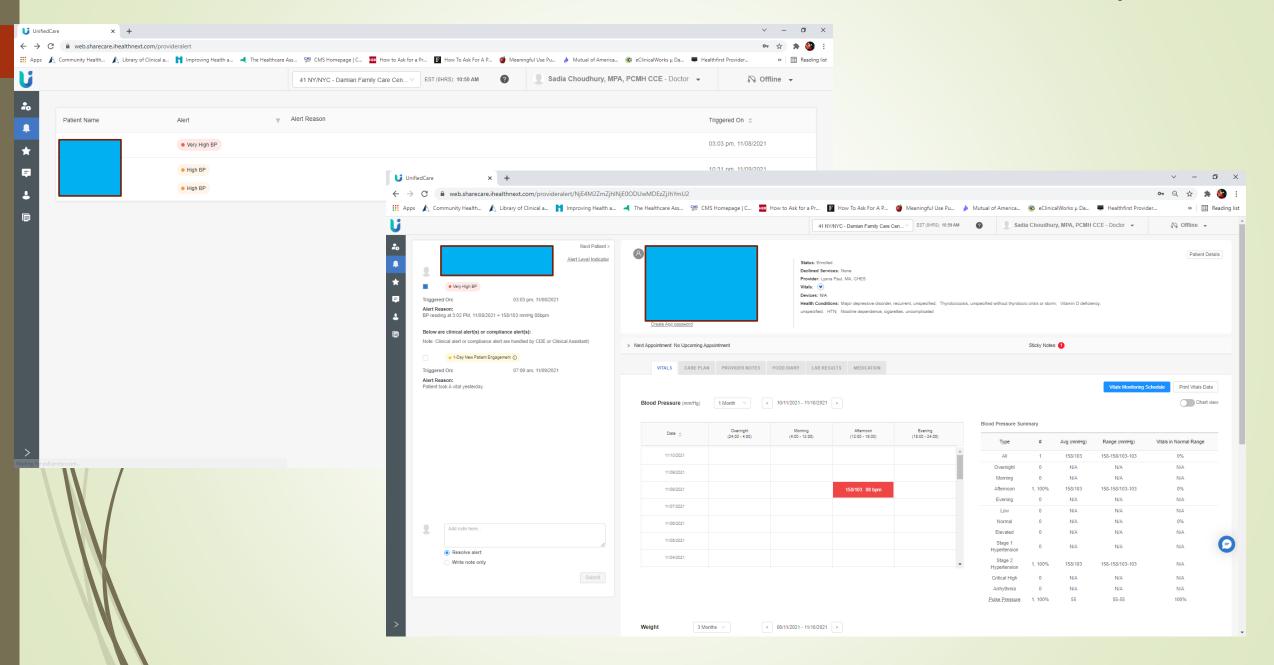
- SBP>180 or DBP>120
- or if patient had 7 day average of SBP>150 and DBP >90
- of if patient had 30 day average of SBP>140 and DBP>90

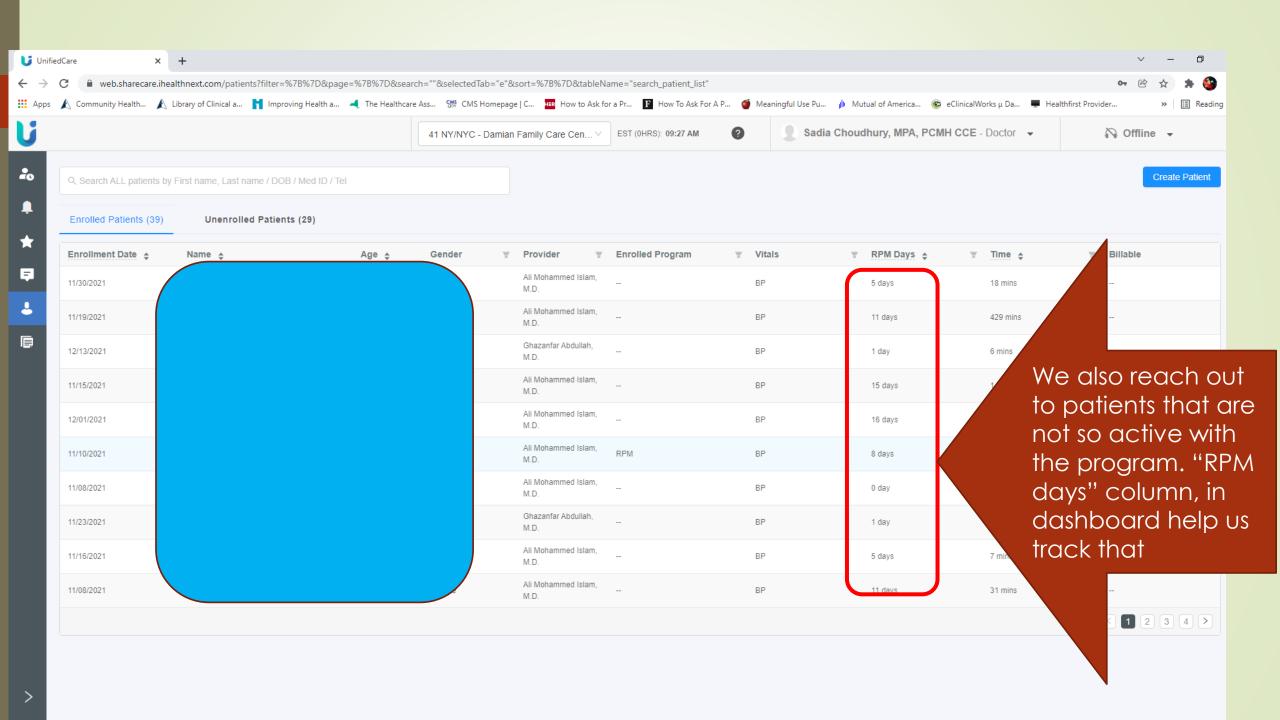
With our customized thresholds, their real time triage in app or call won't happen from iHealth.

But we have Lysna or on call provider for that.

For now, we don't want iHealth to do any triage or outreach call even when patients meet their original threshold criteria. We do not want patients to be overwhelmed with multiple calls. We will follow the attached protocol for now.

Some screenshots with alerts, vitals, documentation of action taken in iHealth Unified Care platform





Process & Outcome Metrics & Tracking



Enrollment to Date

- □ From Nov 8, 2021 till date, 341 patients got enrolled into Damian SMBP program (304 currently stayed enrolled)
- We track enrollment by source so we can allocate resources appropriately:

Method of outreach	enrollment #
Phone Outreach	135
Referral	39
Warm Hands off	145
Poster	19
Text Outreach	1
Email Outreach	1
Word Of Mouth	1
Pts enrolled	341
Pts Discharge	37
Pts currently Enrolled	304

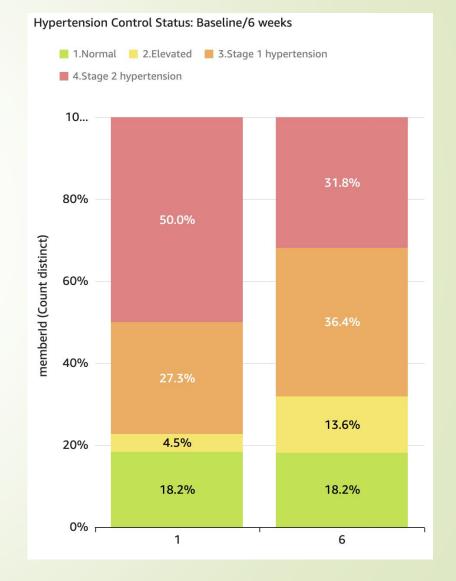
Damian Family Care Centers will also be featured nationally on American Heart Association's next 2023 quarterly newsletter



SUCCESS STORY

n=22

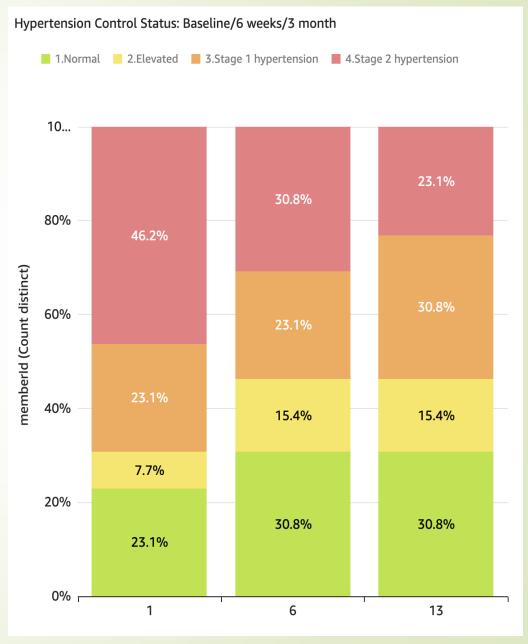
- ☐ We selected 22 patients for outcomes study who have been consistent with BP readings for steady 6 weeks.
- ☐ The number of patients whose blood pressure fell into HTN Stage 2 significantly decreased from 50.0% to 31.8 % within just 6 weeks of being in the program.



SUCCESS STORY, cont'd

n=13

- ☐ We conducted another study on 13 patients who stayed steady with program for 6 months.
- ☐ The number of patients whose blood pressure fell into HTN Stage 2 significantly decreased from baseline 46.2% to 30.8 % in 6 weeks and then to 23.1 % within 6 months of being into the program.
- At the same time, the number of patients whose blood pressure fell in controlled range increased from baseline 23.1% to 30.8% in just 6 weeks and stayed constant for 6 months.



Patient Testimonial

Patients also have great things to say about Damian and its SMBP program. Below is one of the patient testimonials:

"Before I got enrolled in the Self-Measured blood pressure program, I had a regular blood pressure machine. When I measured my blood pressure with this machine, I did not know if my blood pressure was too high or too low. It was very confusing. In the Damian program, I learned when my blood pressure is low, too low, elevated, high or normal. The best part is if it is too low or too high, I receive a phone call. Having the machine give me peace of mind because it lets me know what my blood pressure is on a daily basis. I do not have to wait until I go to the doctor to see how my blood pressure is. I am glad to be part of this blood pressure program. This program needs to be offered to everyone who have high blood pressure because it excellent."

- MJ, 59 year old female.

FUTURE PLAN & SUSTAINABILITY

- Expand program to Damian's other community health centers based on all the best practices and lessons learned
- ☐ Look for other funding sources to continue the program post HRSA grant
- ☐ Possibly adopt alternative payment model with RPM vendor. Value Based/ clinical outcomes based payment
- Explore eCW RPM more and consider purchasing BP devices separately



For questions, feel free to reach out to:

Sadia Choudhury (she/her), MPA, PCMH CCE Lean Six Sigma Green Belt Chief Corporate Compliance & Quality Assurance Officer

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Patient Matching

Matt Becker
Vice President of Interoperability
Kno2





Patient Matching

Matt Becker, VP of Interoperability



• • Kno2

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Why now?

Ground Rules

Patient Matching in Practice

Improving Patient Matching

Health Equity Next Steps



Why now?

National Frameworks (Carequality, TEFCA, Direct)

Rise of query/response, decrease in portal usage

Patients access to their own records

Information blocking enforcement

Ground Rules

Entity that holds the record decides the matching algorithm

"Never" events:

- Match on the incorrect patient
- Share the wrong information for a patient match

Don't penalize for incorrect demographics

"Reverse check" all matches

Have a common identifier? Sanity check

Patient Matching Algorithms

Each source of data can have a different algorithm

"Minimum" demographics:

Some algorithms available publicly

 Name, date of birth, gender, address, zip code

Example algorithm

• Table - PMC (nih.gov)

Demographic Match	Weight
Exact name (with or without middle initial)	10
Last name sounds like	5
Exact sex	1
Exact birth date	8
Birth date one digit difference	6
Birth date month and day or year	1
Exact phone	2
Exact e-mail address	2
Exact address	2
Similar address	1
Exact city	0.5
Exact zip	0.5



Improving **Patient** Matching as a requestor

Training data entry

- Enter ID information exactly as written
- All address data on first line

HIE matching, relationship

Working with close trading partners/vendors

Send all demographic information

Health Equity – Homeless Population





ADDRESS A KEY PART OF NEARLY ALL MATCHING ALGORITHMS WORKING WITH HIES/CLOSE TRADING PARTNERS

Health Equity – Gender-Affirming Care

Send multiple demographics

Gather as many demographics as possible

Weighting gender

Health Equity – National Patient Identifer

National patient identifier currently blocked by US law

Could help patient matching tremendously

Still need to sanity-check matches

Resources

- Sequoia Project: <u>Patient Matching The Sequoia Project</u>
- NIH study: <u>Accuracy of an Electronic Health Record Patient Linkage</u> <u>Module Evaluated between Neighboring Academic Health Care</u> <u>Centers - PMC (nih.gov)</u>







Continue the Conversation

Day 4 of this virtual event is taking place tomorrow **Friday**, **January 20th from 1:00 – 2:00 pm**

We hope to see you then!

Thank you for joining us today. Please share your feedback using the survey link in the chat, the QR code below, or the link in the follow up email!





