CHCANYS NYS-HCCN presents

Interoperability: What’s Next and Why it Matters

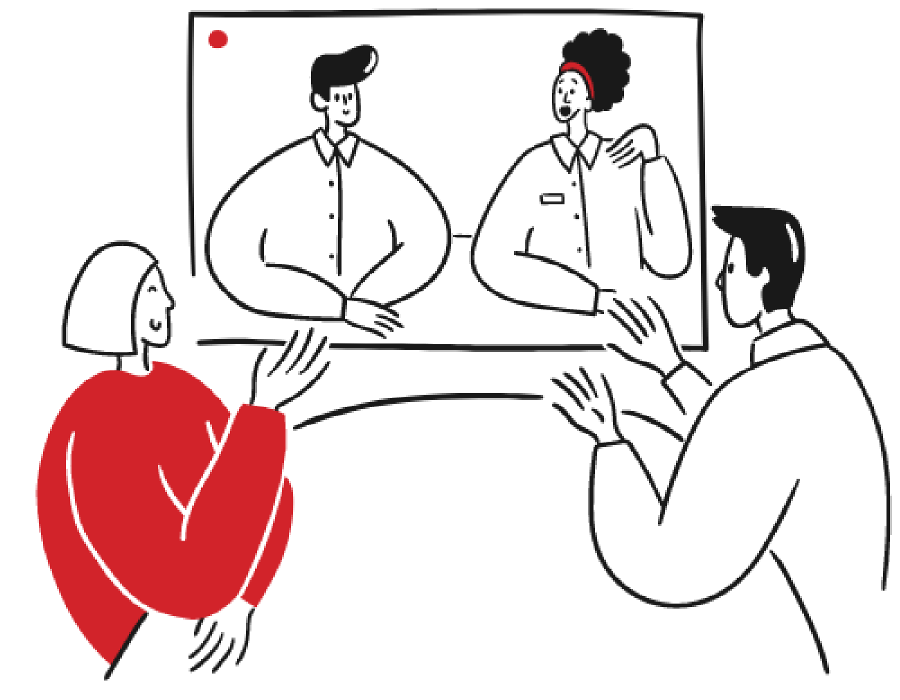
Day 2
November 8, 2023

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

This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award to CHCANYS' New York State Health Center Controlled Network (NYS-HCCN) totaling $3,666,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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 workshop is being recorded and will be shared after the session along with the slide deck.



Agenda

- Introductions
- Data for Better Health
- Transitions of Care: Best Practices & Lessons Learned
- Strategies for Validation and Information Exchange
- Q&A
- Closing & Evaluations

New York State HCCN Objectives

Project Period 2022-2025

2022-2025 Project Period

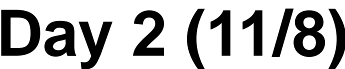
- Patient Engagement
- Patient Privacy & Cybersecurity
- Social Risk Factor Intervention
- Disaggregated Patient-level Data (UDS+)
- Interoperable Data Exchange & Integration
- Data Utilization
- Leveraging Digital Health Tools
- Health IT Usability & Adoption
- Health Equity and REaL Data Collection*
- Improving Digital Health Tools- Closed Loop Referrals*

** - Applicant Choice Objective*
Bold- Objective Carried over into 2022-2025

Schedule of Events

Day 1 (11/1)

- Interoperability Overview & Readiness



Day 2 (11/8)

- **Data for Better Health**
- **Closing Care Gaps and Transitions of Care Promising Practices**

Day 3 (11/15)

- RHIO Conversations
  - HEALTHeLINK
  - Rochester RHIO
  - HealtheConnections

Day 4 (11/16)

- RHIO Conversations
  - HIXNY
  - Healthix
  - Bronx RHIO

An Introduction to Data for Better Health

Lauren Riplinger, JD

Chief Public Policy and Impact Officer

American Health Information Management Association (AHIMA)

An Introduction to Data for Better Health

Lauren Riplinger, Chief Public Policy and Impact Officer, AHIMA

Health Equity

The situation in which everyone has a fair and just opportunity to be as healthy as possible

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Health Equity is *NOT* Health Equality

Source: Robert Wood Johnson Foundation

Health Equity is *MORE THAN* Race and Ethnicity

- Gender
- Age
- Geography
- Sexual orientation
- Education
- Jobs with fair pay
- Food
- Housing
- Healthcare
- Discrimination
- Sexism
- Racism

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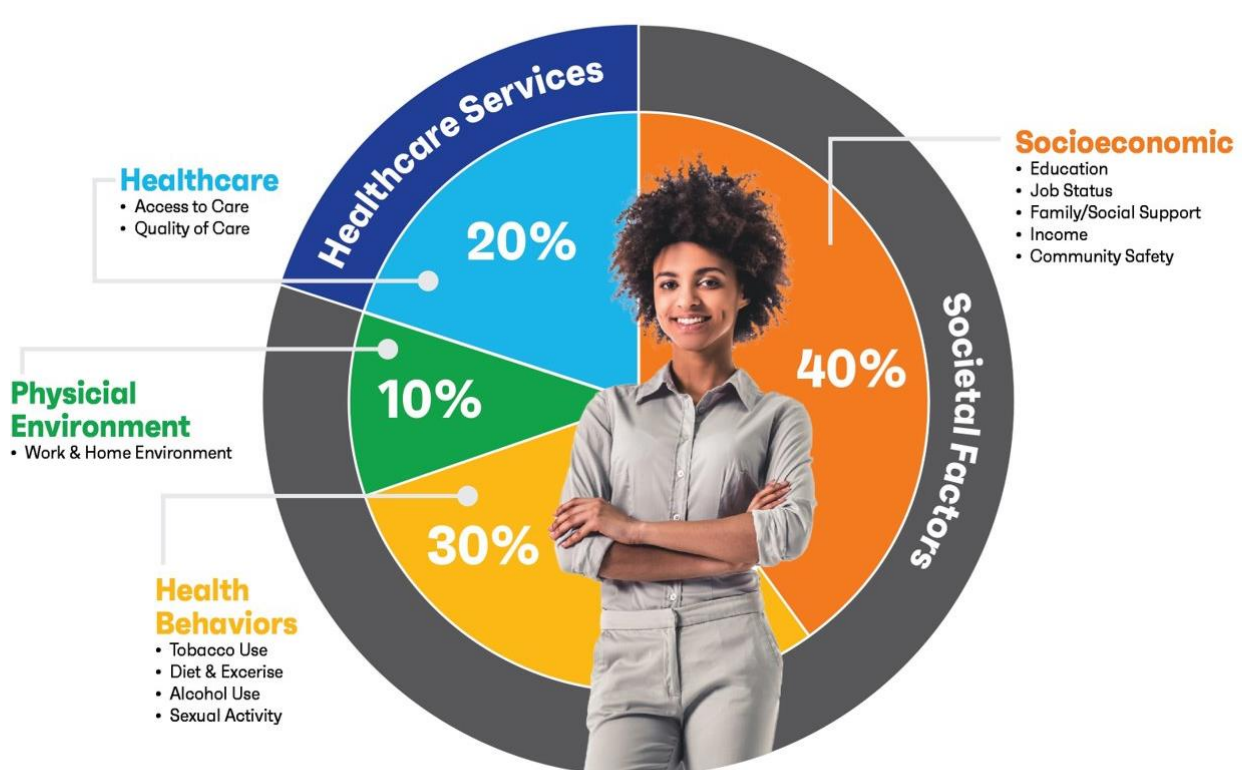
Health Equity is *NOT JUST* Healthcare



20% of health is related to access to care and quality of health care services

80% percent is determined by societal factors

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Health Equity is *NOT JUST* Healthcare

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available here.

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Social Determinants of Health

- The conditions in the environments where people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality-of-life outcomes and risks
- Crucial factor in addressing health equity

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Why This Work Matters

Angie Hoffman

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Why This Work Matters

Rebecca Smith

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Why This Work Matters

Dr. Carla Sanchez

SDOH Data Use and Collection Survey: *Key Objectives*

- Better understand how SDOH data are collected, coded, and used
- Inform the development of educational tools and resources needed by HI professionals
- Inform the development of policy recommendations to further the standardization and use of SDOH data

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SDOH Data Use and Collection Survey: *Descriptions and Specifications*

- The SDOH data use and collection survey is a 27-question survey fielded to a convenience sample of AHIMA membership mailing list.
- The survey explored the following topics:
  - Data collection
  - Data use and integration
  - Data governance

- N = 2,637
- Convenience Sample:
- Unweighted
- AHIMA HI Members and Non-Members
- Mode: Web, all devices
- Fielding dates: 8/24 - 9/9

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SDOH Data Use and Collection Survey: *Key Findings*

There are challenges to collecting, sharing, and use of complete and accurate data, including:

- **Lack of standardization and integration** of the data into an individual's medical record
- **Insufficient training and education** on how to capture, collect, code, and use the data
- **Limited use of the data to communicate** between healthcare providers and community-based referral organizations

DATA FOR BETTER HEALTH™

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Prevalence of SDOH Collection

NOTE: Totals may not equal 100 percent due to rounding. **QUESTION:** Does your organization collect SDOH data? (N=2,637). **SOURCE:** The 2022 AHIMA SDOH survey fielded by NORC and completed by 2,637 AHIMA members and non-members, Aug. 24–Sept. 9, 2022.

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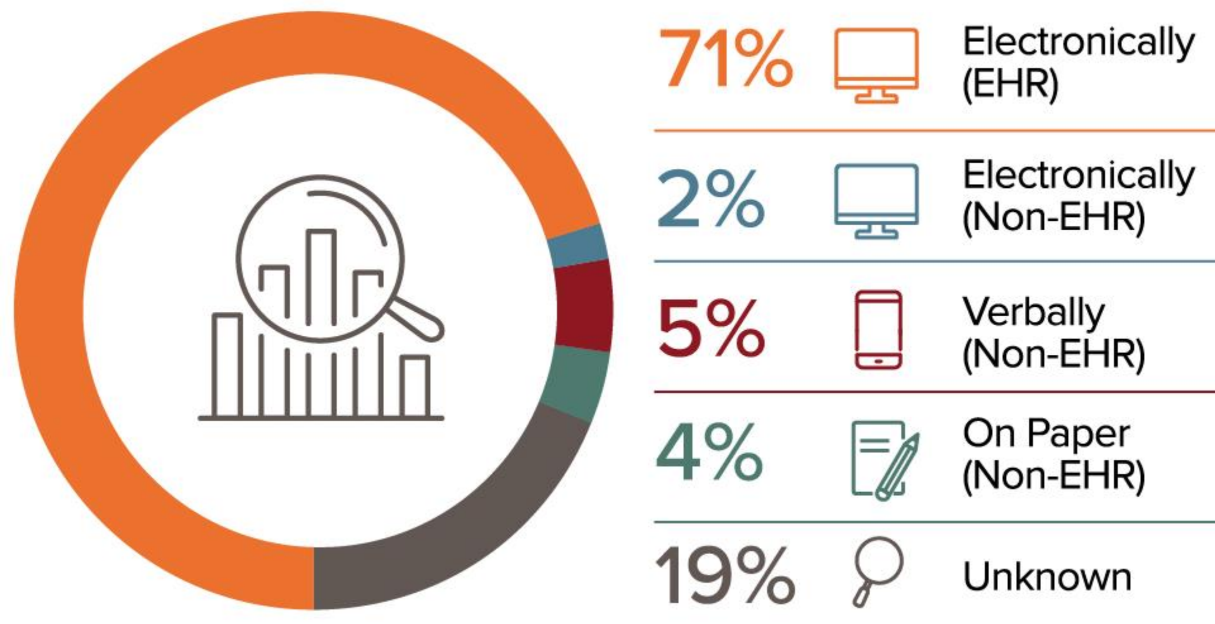
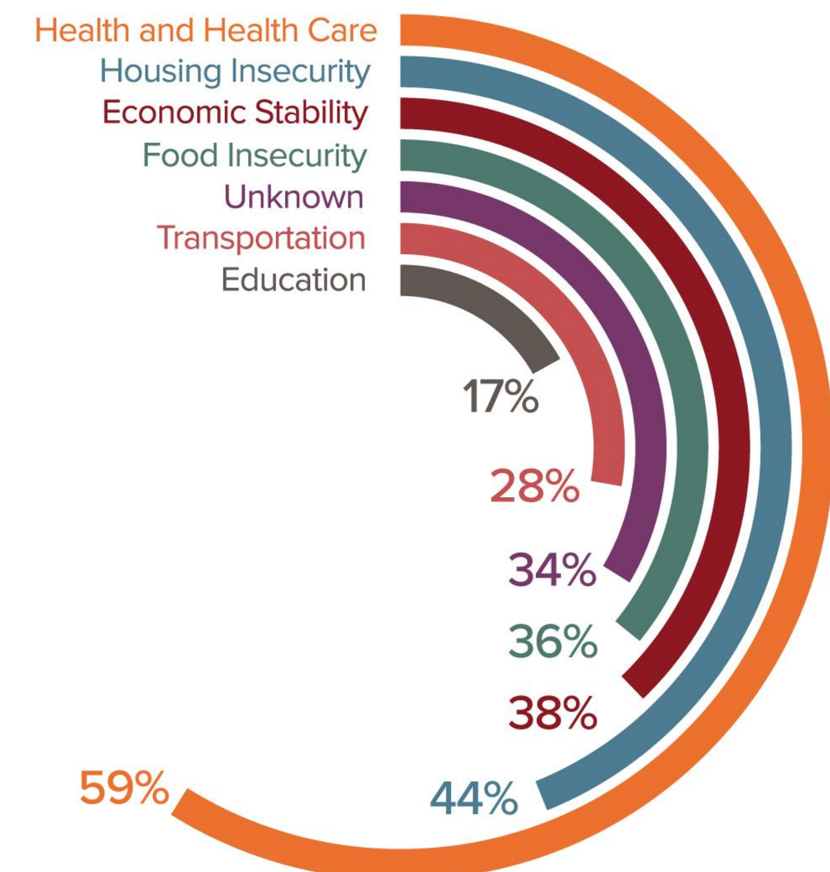
Primary Mechanism for Capturing SDOH Data



SDOH Domains

- Prioritization of different SDOH data elements is uneven across the healthcare sector.
- Insurance coverage and health behavior information are (e.g., smoking, alcohol consumption, etc.) prioritized at higher levels.



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Common Screening Tools

Screening Tool	Percentage
CMS AHC Core Domains	19%
CMS AHC Supplemental Domains	9%
UDS Measures	9%
National Academy of Medicine Domains	7%
Healthy Leads Screening Tools	5%
Healthy People	5%
Upstream Risk Screening Tools	3%
PREPARE	1%

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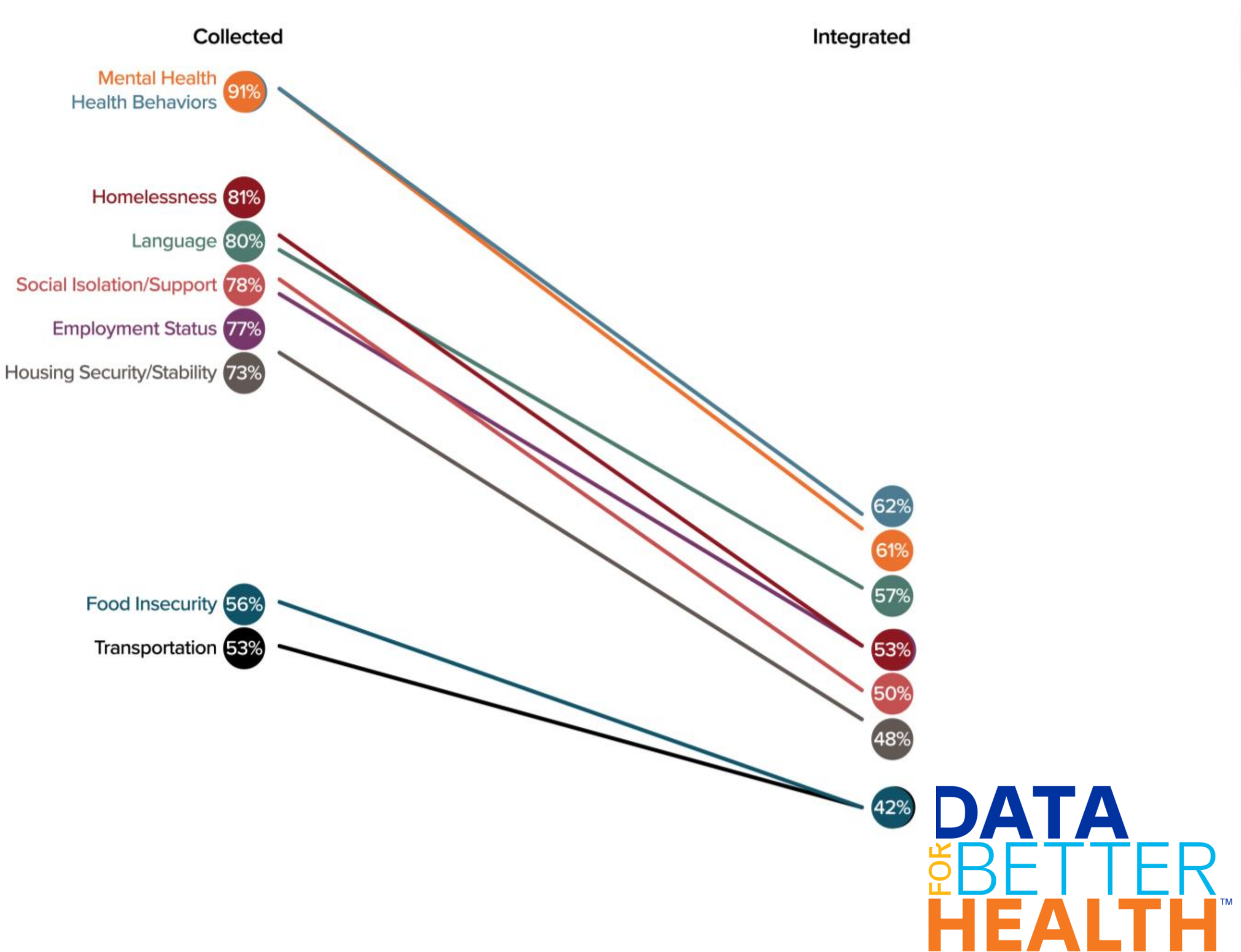
Collection vs. Integration

While individual SDOH data elements are being captured, these data are not necessarily integrated into EHRs.



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Primary Person Responsible for Collecting SDOH Data

Nurses
24%
Physicians
15%
Administrative Staff
12%
Social Workers
9%
Case Managers
8%
Coding Professionals
3%
Other
2%
Patient Navigator
1%
Unknown
26%

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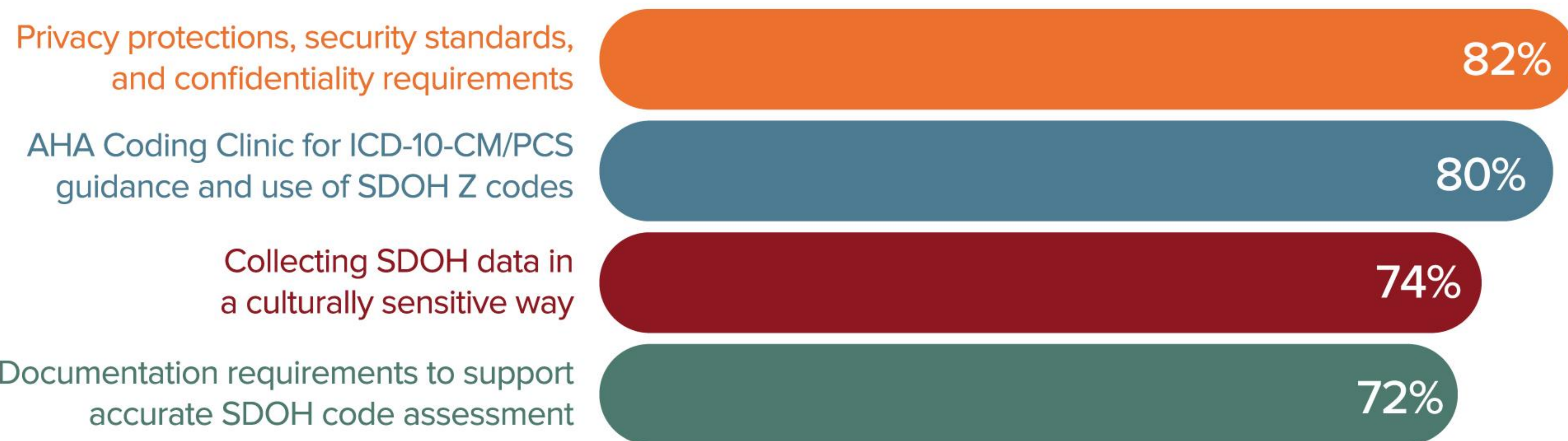
Education & Training Offered



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Challenges Experienced in Collecting SDOH Data

Collecting	
Lack of trained workforce	93%
Lack of organizational policy	87%
Patient distrust	73%
Inability to address SDOH needs	41%
Other	4%

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Challenges Experienced in Coding SDOH Data

Coding	
Staff training	83%
Inability to find SDOH information in patient record	78%
SDOH not collected by frontline staff	59%
Limited space on claims form	51%
No ICD-10 equivalent for a social screening item	21%
Organization prohibits coding for SDOH data	5%
Other	4%

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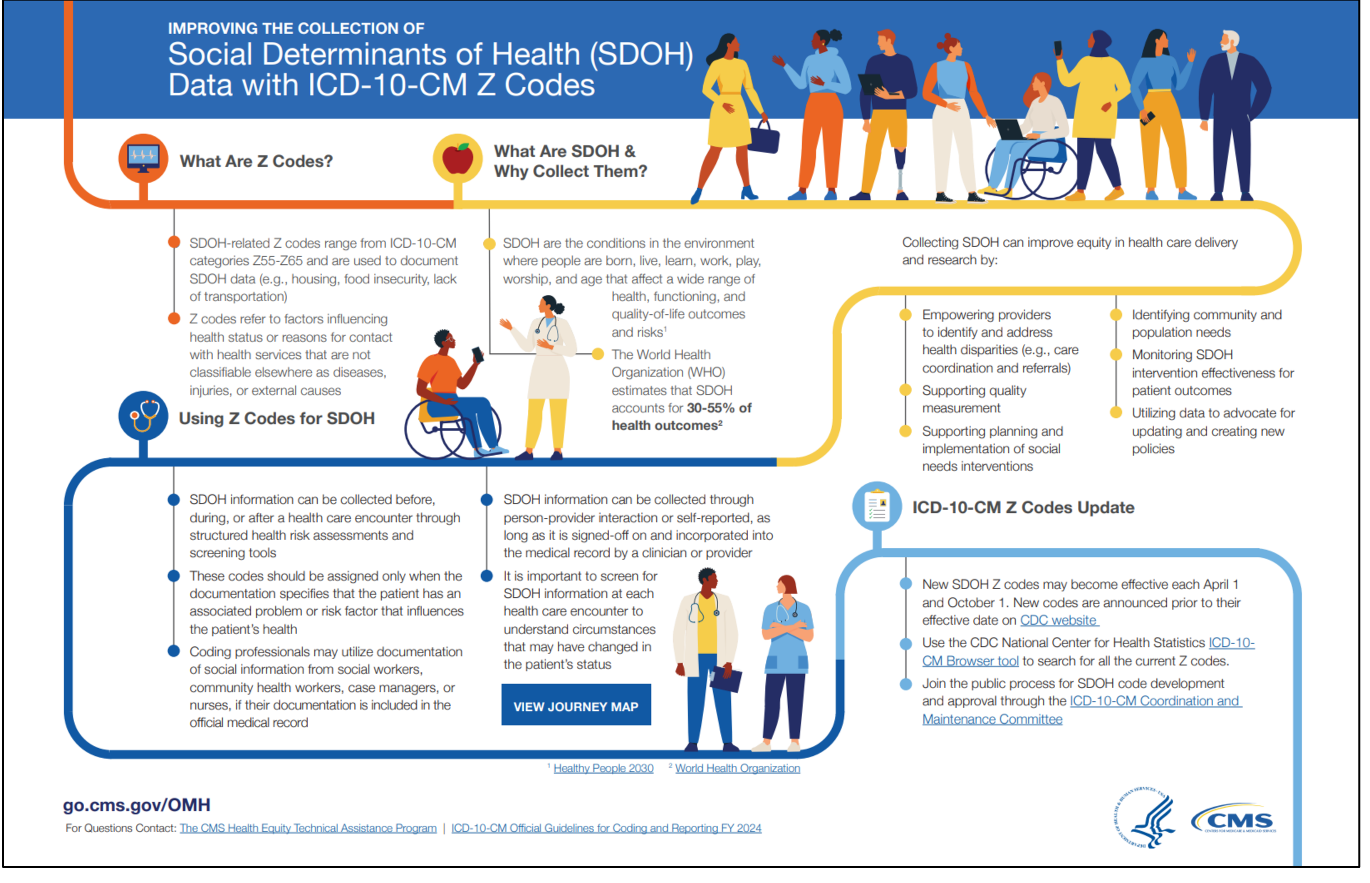
CMS Infographic: Using Z Codes to Document SDOH



Available at: https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

Organization Goals & Activities

Survey respondents indicated that communication and integration between the health and social services sectors is often limited and inconsistent.

32%
Patient referrals to community-based organizations

31%
Identify and assess community-level needs

25%
Track Population health

24%
Identify and create facility-run services to address social needs

16%
Build reports to share with government or nonprofit entities, or the public

17%
Inform support for local, state, or federal policy initiatives

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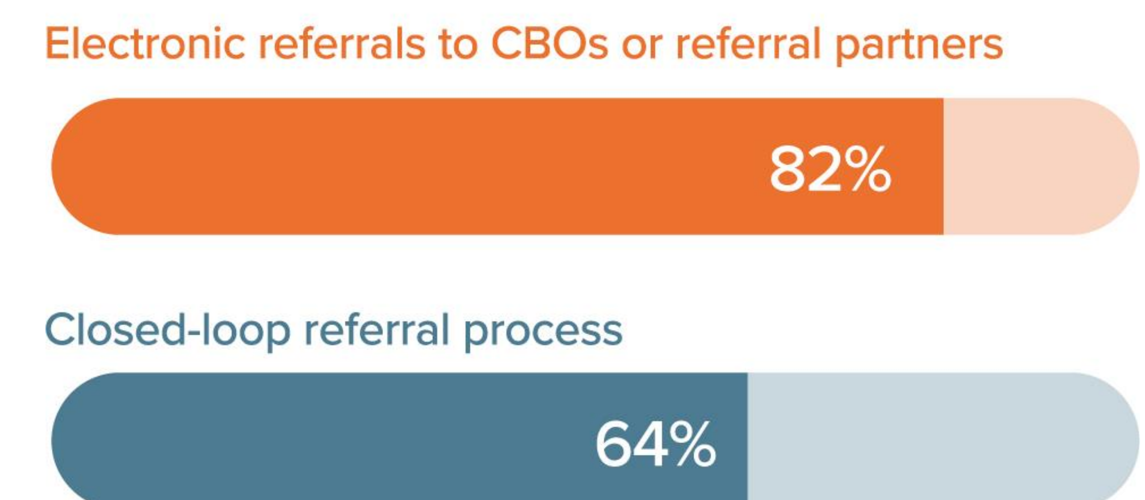
Organizations' Referral Processes

Organizations were more likely to make electronic referrals to community-based organizations (CBOs) or referral partners than to have a closed-looped referral process.



Data for Better Health

AHIMA is launching Data for Better Health to increase awareness of how collecting, using, and sharing SDOH data can improve individual and community health and healthcare outcomes.

Learn more and engage at: www.DataforBetterHealth.com

Goals

- **Engage Healthcare Professionals Working with SDOH** to understand the business case for the collection of SDOH data and share strategies for success.
- **Educate and Engage with Consumers** to build trust and a greater understanding of SDOH data and the benefits of sharing SDOH information with healthcare professionals.
- **Advance Policy and Advocacy Among Policy Makers** by developing and promoting a SDOH data advocacy agenda.
- **Support Innovation within the Healthcare Ecosystem** to accelerate adoption of best practices and new models.

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Data for Better Health Data Breaks

- Webinar series featuring case studies from organizations that are collecting, using, and sharing SDOH data
  - **March 3:** Setting the Stage for Collecting, Using, and Sharing SDOH Data; Available here
  - **May 5:** Screening for and Collecting SDOH Data; Available here
  - **July 14:** Using SDOH Data; Available here
  - **Sept. 15:** Sharing SDOH Data; Available here

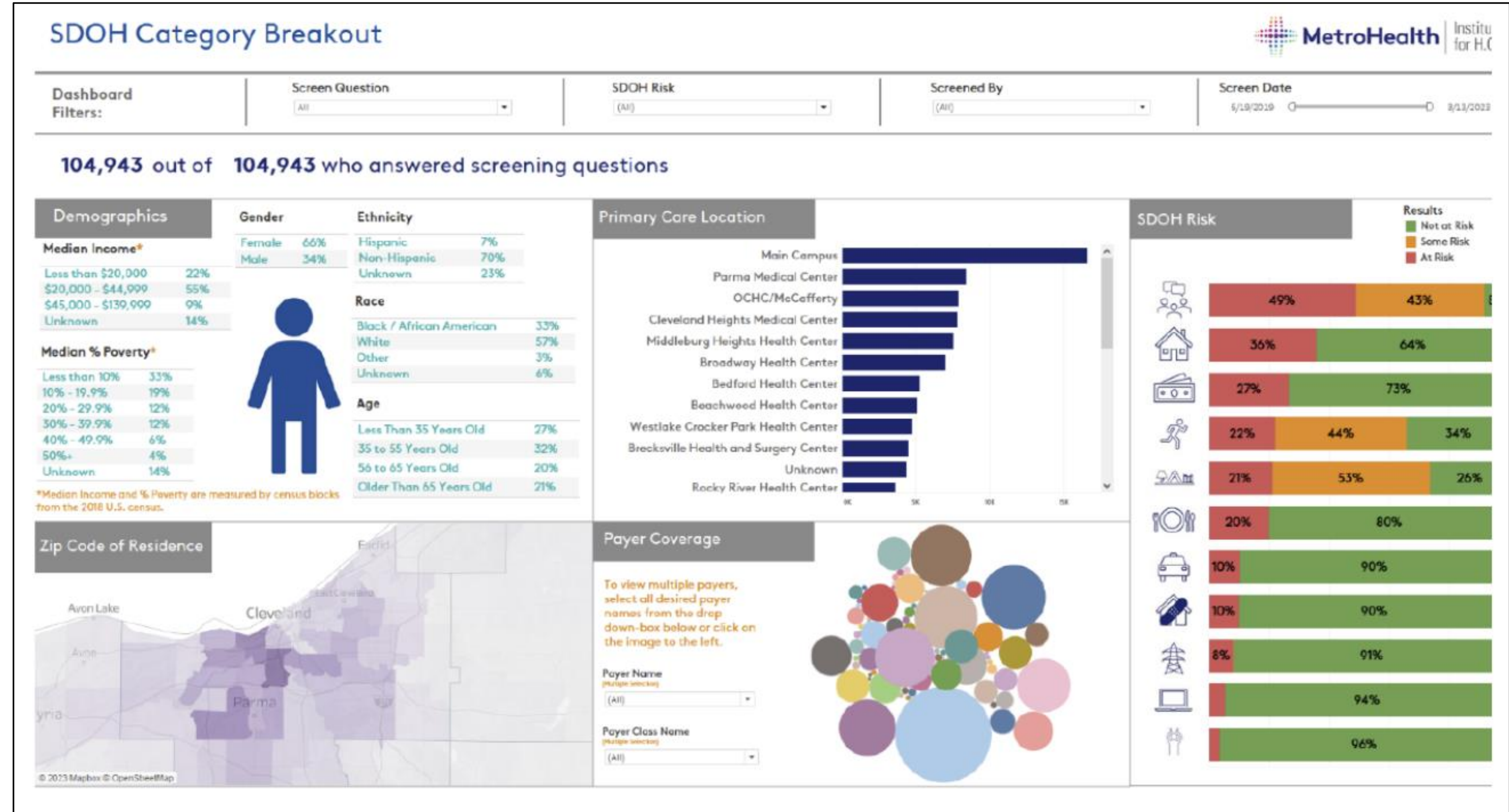
This is a very informative webinar that shows the importance of SDOH both for the patients and our health systems.

Everyone in HIM, Compliance, Coding, Rev Cycle, Equity, and Top Level Admin would benefit from a review of this Webinar.

As an HIM student in New Mexico, this webinar has provided me with a new perspective on my future career.

Journal of AHIMA

MetroHealth Institute of H.O.P.E



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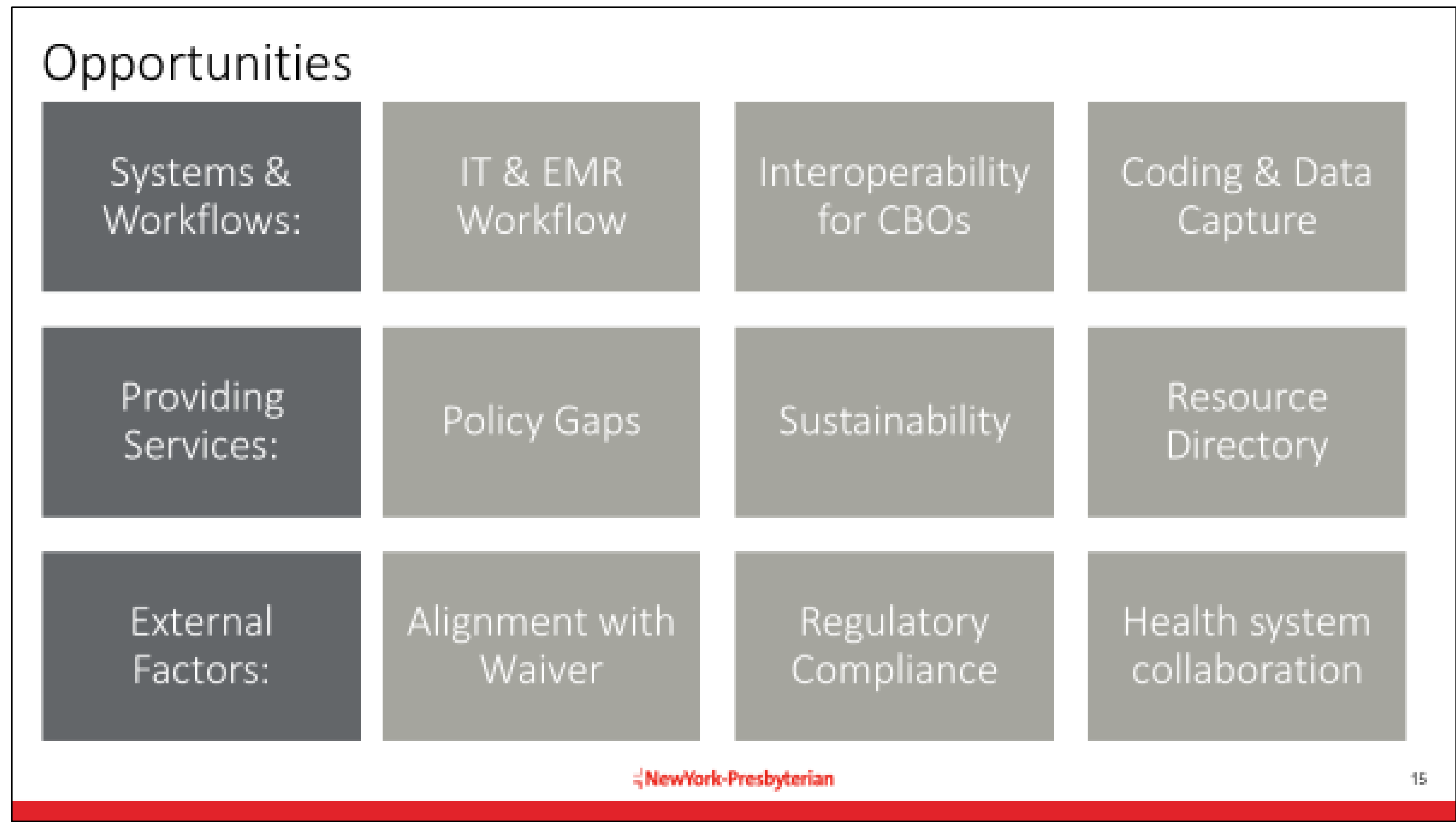
NewYork-Presbyterian



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Learn and engage at:

www.DataforBetterHealth.com

Engage with AHIMA: SDOH Data Breaks

- Join us for our next SDOH Data Break on December 1, 2023 at 1 pm ET
  - Registration link available at www.DataforBetterHealth.com
  - Speaker: Alisahah Jackson, MD, president, Lloyd H. Dean Institute for Humankindness & Health Justice at CommonSpirit
  - In this fireside chat, we will discuss how we can leverage science, data, trust, and kindness to accelerate health equity

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Share Your Story!

- Please reach out to us if you would like to share your experiences with SDOH Data

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Transitions of Care
Best Practices & Lessons Learned

Ashley Klimavicius, MA

Director of Care Transitions, Population Health

Community Healthcare Network

Transitions of Care
Best Practices & Lessons Learned

Community Healthcare Network

Ashley Klimavicius, MA
Director of Care Transitions, Population Health

Today's Presentation

About Community Healthcare Network

Transitions of Care

- Program Goals
- Process
- Scheduling
- Performance Metrics
- Documentation
- Program Development
- Lessons Learned

About Community Healthcare Network

CHN has been providing quality health care since the 1960's. CHN started offering family planning services and in 1998 expanded to providing primary care, mental health and social service.

CHN is a not-for profit network of 14 Federally Qualified Health Centers, including 2 School Based Health Centers and a fleet of Medical Mobile Vans.

CHN's mission is to provide access to community based primary care, mental health and social services for low-income people in underserved communities throughout NYC, regardless of ability to pay.

Community
Healthcare Network

Open Weekdays and Evenings

Visit us at: chnnyc.info/locations

Mobile Health Vans

Primary Care, Birth Control, Plan B, HIV & STD Testing, PrEP/PEP, Optometry

For information, times, & locations: **212-545-2495**

Bronx

Manhattan

1 Washington Heights
511 West 157th Street
New York, NY 10032
212-781-7979

2 Phoenix SBHC
511 West 157th Street
New York, NY 10032
917-521-3130

3 Harlem
81 West 115th Street
New York, NY 10026
212-426-0088

4 Lower East Side
255 East Houston Street
New York, NY 10002
212-477-1120

5 Seward Park SBHC
350 Grand Street, Rm 240
New York, NY 10002
212-634-7550

6 Williamsburg
94-98 Manhattan Avenue
Brooklyn, NY 11206
718-388-0390

7 Crown Heights
1167 Nostrand Avenue
Brooklyn, NY 11225
718-778-0198

8 East New York / DBS
999 Blake Avenue
Brooklyn, NY 11208
718-277-8303

9 East New York Hub
25-81 Atlantic Avenue, FL 1
Brooklyn, NY 11207
718-495-6700

10 Tremont
4215 Third Avenue, FL 2
Bronx, NY 10457
718-294-5891

11 South Bronx
975 Westchester Ave
Bronx, NY 10459
718-320-4466

12 Long Island City
36-11 21st Street
Long Island City, NY 11106
718-482-7772

13 Sutphin Boulevard
97-04 Sutphin Boulevard
Jamaica, NY 11435
718-657-7088
*Currently under construction

14 Jamaica
89-44 164th Street
Jamaica, NY 11432
718-523-2123

Care you feel good about.

866.246.8259

CHN Services

We offer quality healthcare at a low-cost to the whole family and we never turn anyone away. Some of our services are:

- Healthcare for adults, teens, and children
- School check-ups (school physicals)
- Shots and vaccines
- Women's healthcare (gynecology)
- Care for pregnant women and new moms
- Family planning care and health education
- Birth control and Plan B
- STI testing and treatment
- Behavioral healthcare and psychiatry
- Social work services
- Nutrition counseling
- Wellness services
- Dental care
- Foot care (podiatry)
- LGBTQ+ healthcare, programs, and services
- Health Homes Program (Care Coordination)

Televideo visits are also available.

Transitions of Care Metrics

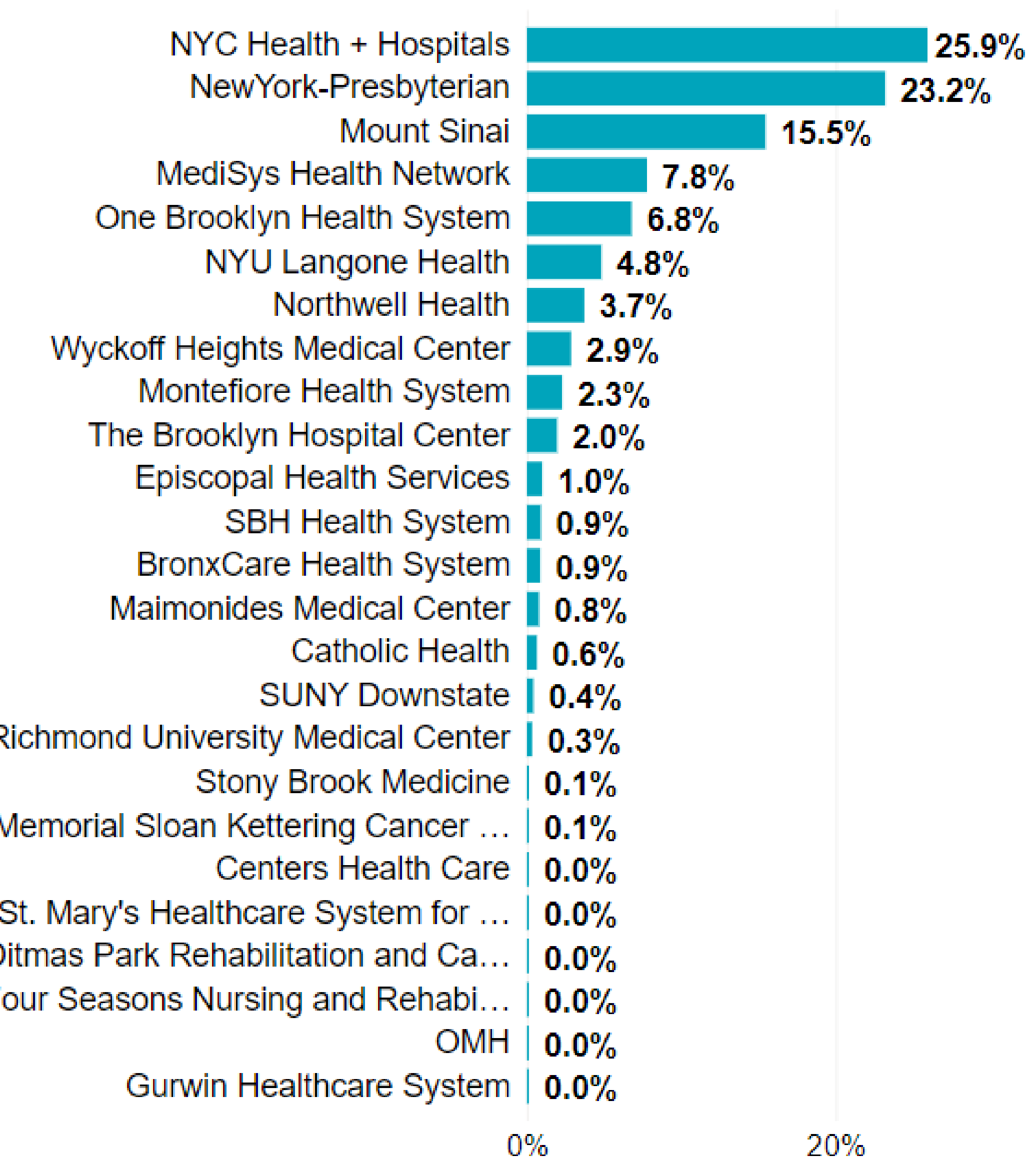
Data from 10/1/2022 – 9/30/2023

15,140 ED Discharges

- **3,229** 7-Day Follow Up Visits Scheduled (24%)
- **1,764** 7-Day Follow Up Visits Completed (13%)

3,098 Inpatient Discharges

- **1,019** 7-Day Follow Up Visits Scheduled (34%)
- **457** 7-Day Follow Up Visits Completed (16%)



Transitions of Care Program Goals

Engage the patient within 2 business days of an ED/IP visit to schedule a follow-up and assess immediate needs.

Increase patient follow-up visits completed within 7 days of a discharge.

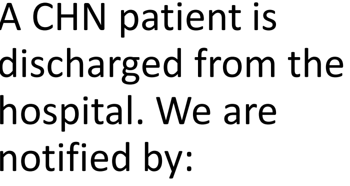
Improve care coordination by collecting the discharge summary and sharing it with the patient's provider.

Reduce the number of patients readmitted to the ED or IP within 30 days of a discharge.

Transitions of Care Performance Metrics

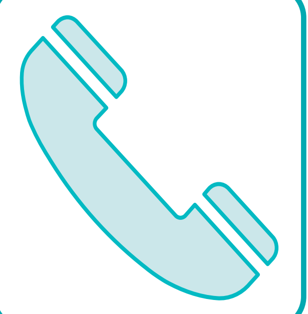
Process Measures	Outreach within 2 business days of discharge
	7-day follow up visit scheduled
	7-day follow up visit completed
	Discharge Summary Collection Post-ED or IP Visit
	Medication Reconciliation Post-ED or IP Visit
	Referral to Social Work or Care Coordination to Address Social Determinants of Health
Outcome Measures	Plan All Cause Readmissions (PCR)
	30-Day Readmissions and 6-Month Readmissions

Transitions of Care Process



A CHN patient is discharged from the hospital. We are notified by:

- Internal referrals to the ED
- RHIO hospitalization alerts received in Azara



Outreach efforts begin within 2 business days of discharge with the goal of scheduling a follow-up visit in 7 days. Outreach is conducted by:

- Population Health Outreach Specialists
- RN Managers
- IPA Nurse
- Health Home Program

Best efforts are made to obtain the hospital discharge summary and upload it into to the patient's chart via:

- Direct access to hospital EHR systems
- Requesting patients sign a release of information

Additional care team members at CHN are notified of the hospitalization, such as:

- Prenatal Coordinators
- Behavioral Health Therapists
- Psychiatry
- Care Management

Patient completes a follow-up visit with the appropriate provider.

- Reconcile medications
- Review labs and diagnostic imaging
- Make referrals for DME, home care, and social services when applicable

Patient Access: Scheduling Appointments

Tier	Appt. Type	Lead Time	Telehealth/ In-person	Scheduled	Slot to use
1	**Urgent/Sick**	Same day	Either	By: TTN/Nursing Triage	Convert to use any available slot (except 10-minute slots).
	Critical Lab Recalls	Same day	Either	By: TTN/Nursing Triage	
	Transition of Care (ED/Inpatient)	7 days or less post discharge from ED	Either	By: PHOS or Nursing, CCS, MOS	
	Newly diagnosed HIV	7 days or less	Either	By: PHOS, remote MOS, HED, HIV, HH outreach With: ID Provider	
	Newborns (less than 30 days)	Same or next day	In-person	By: PHOS, Nursing, CCS, MOS	
	PN Appt (13-24 weeks, no prior care)	7 days or less	In-person	By: CCS, MOS, HED, Prenatal	Convert to use any available slot. Schedule two 20 min back to back
	Medication Abortion (before 11 w 0 days of gestation)	7 days or less	In-person	By: MOS only for select providers @ LES, WIL, JAM	Medication Abortion Slot. If not available, convert to use any available slot. Schedule two 20 min back to back.

Telephone Encounter Template

Telephone Encounter TEST, Ashley N   Mar 13, 1995 (28 yo F)   Acc No. 649730

Test, Ashley, N , 28 Y , F   INFO   HUB   ASK EVA   ?
2450 Nostranud Avenue , Brooklyn , NY 11222
03/13/1995 | 929-500-9570 | 917-538-8490

Allergies   Billing Alerts

PCP: Benjamin, Taisha
Lang: English
Translator: No

Ins: UNITED HEALTHCA
Acc Bal: No Access
Guar: Test, Ashley N
Ren: Benjamin, Taisha

Medical Summary | CDSS | Rx | Labs | DI | Procedures | Growth Chart | Imm | T.Inj | Encounters | Patient Docs | Flowsheets | Notes

Answered By: Klimavicius, Ashley
Caller:
Reason: In-Patient Discharge
High Priority

Date/Time*: 04/04/2023 01:42 PM
Assigned To*: TOC Outreach
Provider*: Benjamin, Taisha
Perform Eligibility Check

Facility*: CHN Tremont
Pharmacy: RITE AID-1679 BE
Status: Open / Addressed / Addressed and Docs Reviewed / Address and Close

Messages | Rx | Labs/DI | Notes | Addendum | Log History | Virtual Visit

Messages   Complaints

Action Taken   Messenger   Action Taken

Klimavicius, Ashley 04/27/2023 10:15:49 AM > The patient went to the Emergency Dept at [HOSPITAL NAME] for [REASON FOR ED VISIT] and was discharged on [DISCHARGE DATE].

Please pull the discharge summary.

Print Script | Send Rx | Print Report | Progress Note | Document | OK | Cancel

Telephone Encounter Template

Medical Summary | CDSS | Rx | Labs | DI | Procedures | Growth Chart | Imm | T.Inj | Encounters | Patient Docs | Flowsheets

T 04/04/2023 TaBe In-Pa...

TEST, Ashley N Mar 13, 1995 (28 yo F) Acc. No. 649730

Subjective:

Chief Complaint(s):

In-Patient Discharge

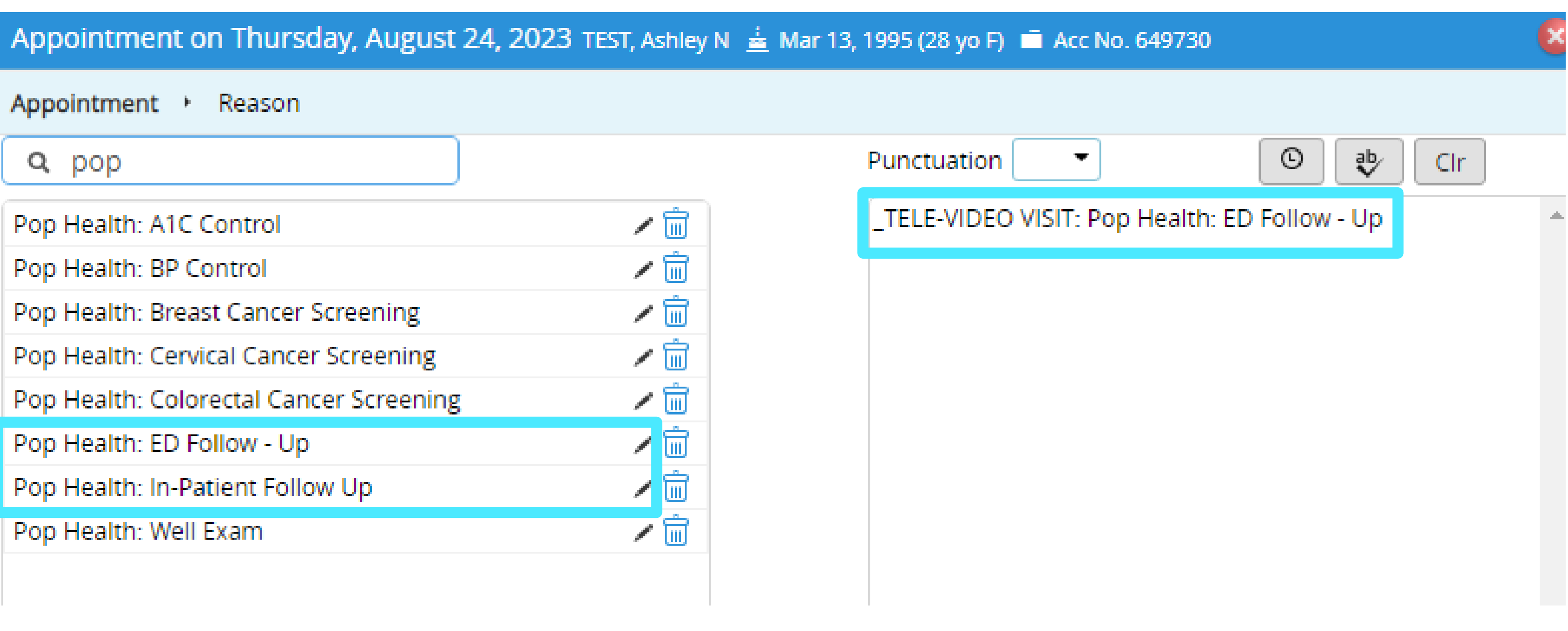
HPI:

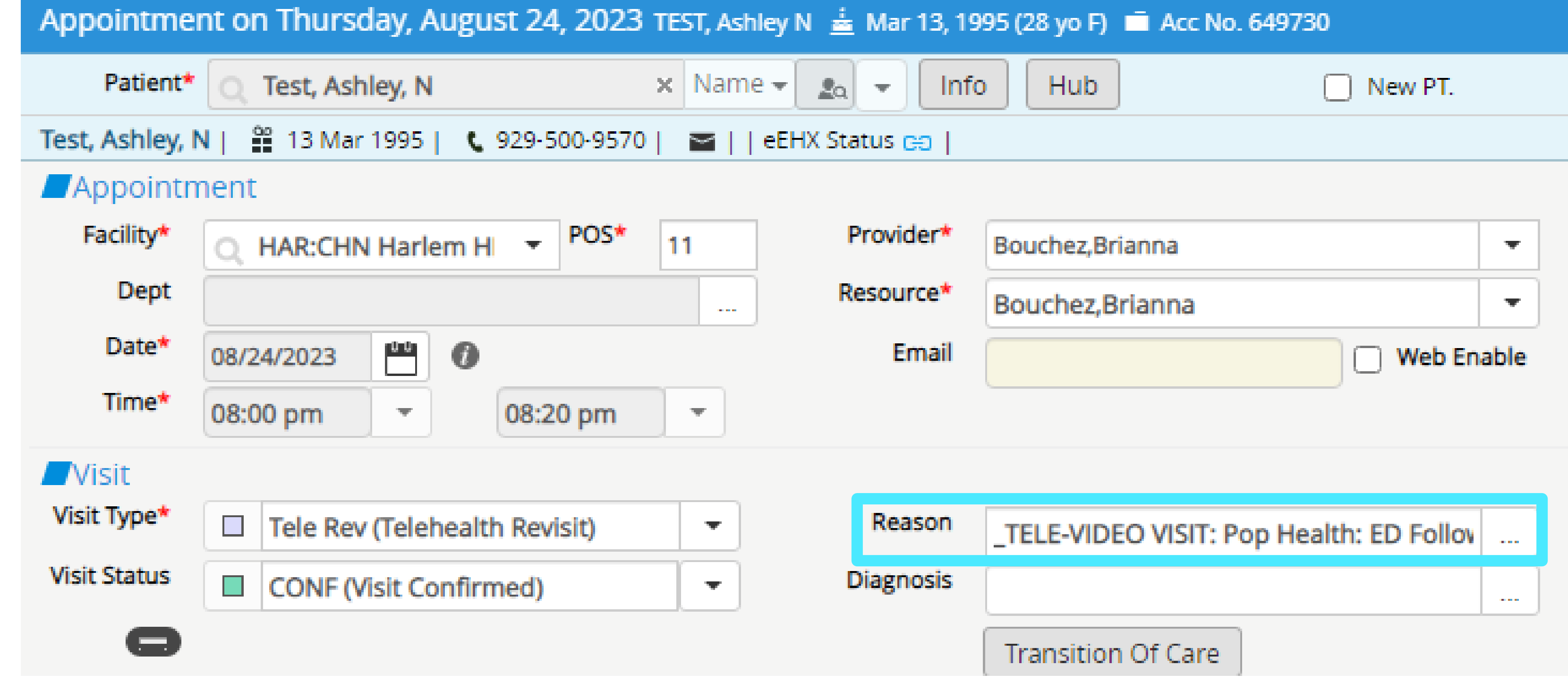
Hospitalization Follow-up

Outreach

Alert received from: *HIE Notification*
Alert Date: *04/27/2023*
Does the patient confirm the ED/In-patient visit? *Yes*
Hospital Visit Type: *In-Patient*
Admit Status: *Currently Admitted*
Is there a planned discharge date? *Yes*
In-patient Discharge Date: *04/28/2023*
Hospital Name/Location: *NYC Health + Hospitals - Elmhurst*
Reason For Hospitalization: *Medical*
Detailed Reason: *Shortness of breath and chest pain.*
Number of ED visits in the last 6 months: *3*
Number of In-patient visits in the last 6 months: *2*
TOC Outreach: *Attempt 1:*
Staff Name: *Ashley Klimavicius*
Department: *Health Homes*
Attempt 1 Date: *04/27/2023*
TOC Outreach Attempts Made: *1*
TOC Outreach Outcome: *Able to reach patient.*
Follow-up Appointment: *Scheduled follow-up appointment.*
Medication Needs: *Patient has all their medications and understands how to take them.*
DME Needs: *Patient has their durable medical equipment.*
Home Care Needs: *Patient has their home care set up.*
Patient Education: *Patient educated on how to prepare for their follow-up visit., Patient educated on CHN Telephone Triage RN services., Patient educated on patient portal., Patient educated on importance of keeping follow-up appointments and process for rescheduling if necessary*

Telephone Encounter Template





Transitions of Care Program Development

August 2022-Present	
	Developed TOC workflows and scripts.
	Expanded TOC outreach from internal ED referrals to include ED and Inpatients Discharges from HIE alerts.
	Health Homes began outreaching eligible patients recently discharged from ED or Inpatient.
	Increased access to discharge summaries to include NYC Health + Hospitals, Mount Sinai, New York-Presbyterian, and Jamaica Hospital.
	Collaborated with Prenatal and Behavioral Health to improve coordination across care teams.

Transitions of Care Program Development

August 2022-Present	
	Rolled out new TOC eCW encounter templates.
	Completed CHIPA pilot to engage patients with 3+ ED visits in last 6 months.
	Improved patient access to follow up appointments with priority scheduling and a dedicated Population Health Nurse Practitioner.
	Launched a Targeted Transitional Care Management pilot for patients with Heart Failure and ACO attributed patients with highest annual total cost.

Transitions of Care Lessons Learned

It is important to clearly define the population you want to engage.

Open access scheduling and telehealth are instrumental to improving availability for 7-day follow up visits.

Nurse Triage services and dedicated Population Health Telehealth visits were very helpful for addressing immediate medication needs or clinical concerns.

EHR templates and standardized documentation practices are necessary for process measure tracking.

Transitions of Care Contact Information

Ashley Klimavicius, MA

Director of Care Transitions, Population Health

Email: aklimavicius@chnnyc.org

For additional details about CHN and out services, you can visit our website: https://www.chnnyc.org/

Strategies for Validation and Information Exchange

Melissa Ramsey
Clinical Data Coordinator
The Chautauqua Center

Allison Rounds
QI Specialist
The Chautauqua Center

STRATEGIES FOR VALIDATION AND INFORMATION EXCHANGE

Using HEALTHeQUALITY to help us close reporting gaps

ABOUT US

The Chautauqua Center is a Federally Qualified Health Center (FQHC)

Our Mission

To deliver comprehensive high-quality patient-centered health and support services in the Chautauqua region

Our Vision

Our core principles are *access*, *treatment*, *education*, and *prevention* delivered by friendly and professional clinic and administrative teams.

Our clinic is very lucky in that we have a good EMR and we also have Azara to help us identify and fill gaps.

That is not the reality for a lot of small clinics. Navigation within the EMR can be cumbersome. Documentation is not always easily reportable. Pre-visit Planning might be prohibitively time consuming.

HEALTHeQUALITY is the first system I have worked in that is actively trying to bring the insurance claims information to the same information platform as the clinical results information and I think that is a great leap forward.

HEALTHeQUALITY gives a quick look at the gaps a patient might have by pulling information from insurance claims and from the feeds into HEALTHeLINK.

A lot of time is spent in our offices not just trying to pull results but trying to determine if there ARE any results to pull. Our offices spend A LOT of time just looking.

Our health information is siloed.

- The insurance company works from claims so if we don't get that A1c out the door on a claim as far as the insurance company is concerned it never happened.
- The Endocrinologist may have pulled an inhouse A1c and sent the claim to the insurance company but they may not reliably send consult notes to the PCP or feed in house testing results into HEALTHeLINK so the number isn't in our chart for reporting
- Results may be sent to the PCP as an unreportable pdf so the results are in the chart but not reportable.
- Our patients may not know what work was done so they may be sure that some work was recently done and may be resistant to what they consider unnecessary.

HEALTHeQUALITY is an effort to help connect all those siloes of information.

If a patient had a mammogram from a provider that did not feed results into HEALTHeLINK (say a provider from PA) the gap closure would still be noted in HEALTHeQUALITY because it would be reported on the insurance claim. Now you can follow up with the patient to determine where the gap was closed.

If a patient reports they had a hysterectomy, and the gap is still listed it is prompting the office to look deeper into what procedure was actually performed. To either find the supplemental data or explain to the patient that the procedure they had did not remove their cervix and they still need screening.

HEALTHeQUALITY allows the office to make sure that all of the records are in agreement.

PCP has the correct and reportable information in the chart

Insurance company has the correct and reportable information in their file

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Patient isn't getting mixed information and will hopefully have a better experience that allows for increased engagement.

Early this year HEALTHeLINK approached us for assistance with a validation project for their HEALTHeQUALITY system.

This was actually pretty timely for us.

- We had just acquired two small primary care offices that were on completely different EMRs and the data transfers were pretty bumpy
  - One of the EMRs was VERY difficult to work with and didn't coordinate well with the transfers.
  - CCDA imports were limited and incomplete and so required manual work.
  - Support staff turnover meant that some things were not merged in the best way
  - Athena Quality did not recognize what was manually satisfied in the other EMRs
  - Athena did not recognize all of the document labels from the other EMRs.
- We had recently identified a document labeling issue with our current EMR (Athena) that was creating a significant reporting issue.
  - If a human person has any hand in reviewing a Pap Smear at UPMC they label it "UPMC Cervical Cytology"
  - Athena has VERY specific rules about acceptable document labels for UDS and it took SEVERAL months to get them to agree that this label was acceptable.
  - Even after Athena agreed to accept the label going forward, we had to go back and find all of the patients that had this document to get it updated.
- Some offices are not great about sending results for colonoscopy or they will forward the intraoperative report.

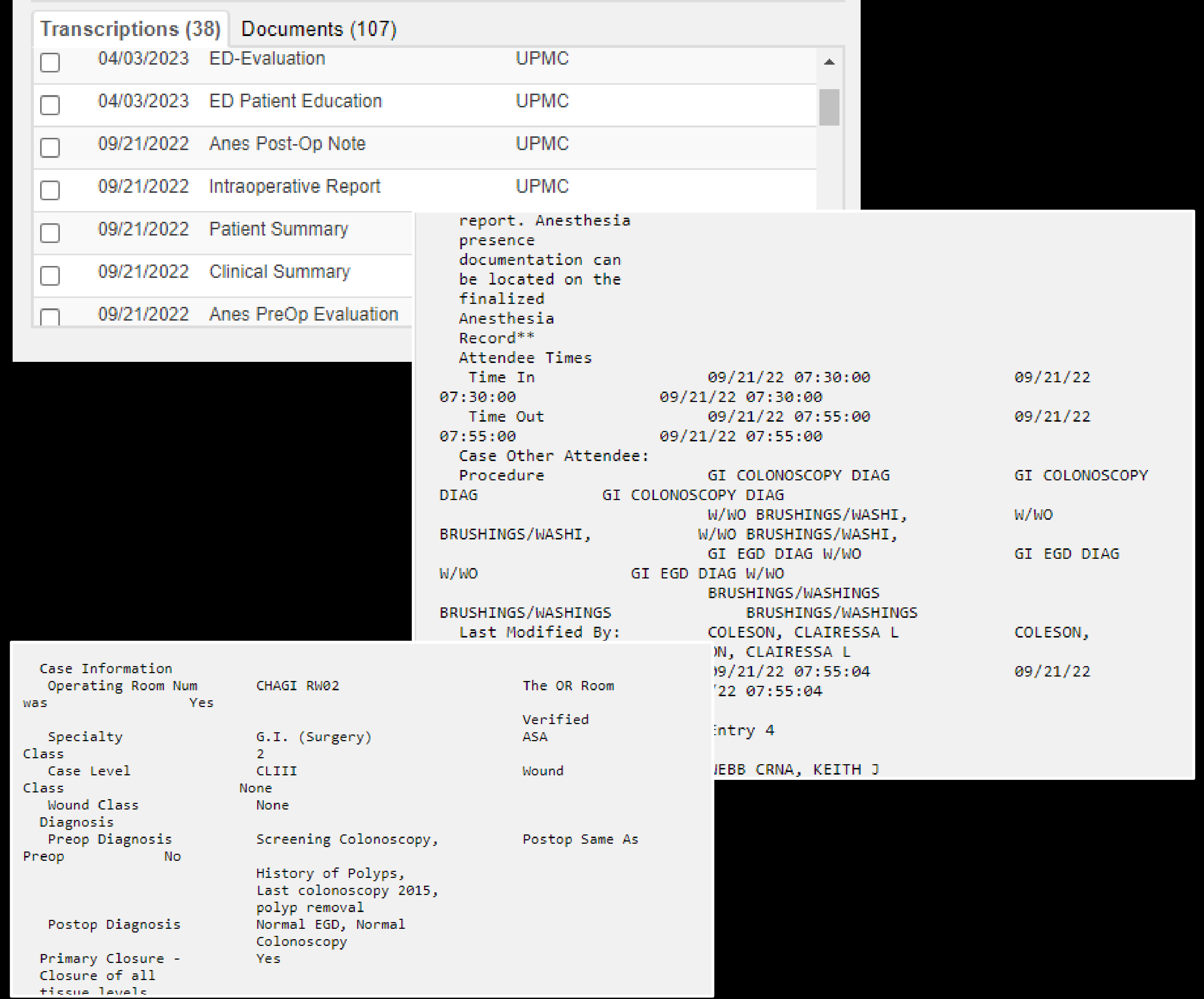
Intraoperative Report may be a hernia repair, a tonsillectomy or a colonoscopy.

The Rendering Provider's office has to actively push this report to our provider. That rarely happens because the standard is that the office will send a consult report. Unfortunately, this also rarely happens.

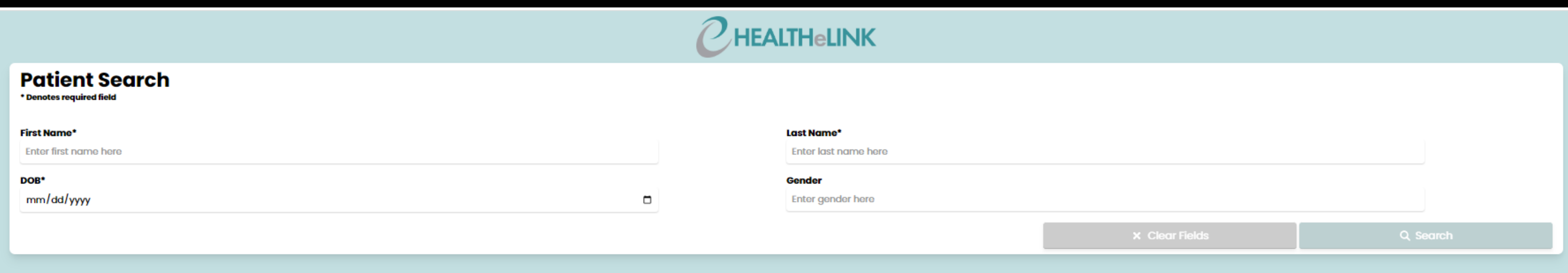
This means that our provider team must either

- call the Rendering office, request the report, hope that it was sent and received correctly and then process documents (super time consuming and full of potential issues)
- Pull up HEALTHeLINK and review the last ten years looking through every intraoperative report, then push the report and label the report correctly when received) Searching HEALTHeLINK is time consuming

If you pull up HEALTHeQUALITY you don't have to search for something that isn't there.



WHAT HEALTHEQUALITY LOOKS LIKE



Patient Search

Logout

Patient [redacted]

CID [redacted]

DOB

Gender
female

Ethnicity
Not Hispanic or Latino

Race
W

Address

Phone

Clinical Gaps in Care | Social Concerns | Pre-Visit Planning

Clinical Gaps in Care View Patient Profile

Displaying 7 records

- Not Meeting (0)
- Past Due (1)
- Coming Due (0)
- Meeting (6)
- Other (0)

Clinical Gaps in Care

View Patient Profile

Displaying 7 records

Not Meeting (0)

Past Due (1)

Date	Measure Name	Value
08/19/2021	Medicare Annual Wellness Visit (AWV) Custom (66+)	Patient did not receive an annual wellness visit inside the measurement period. Last wellness visit on 08/19/2021.

Coming Due (0)

Meeting (6)

Date	Measure Name	Value
09/06/2023	Adults' Access to Preventive/Ambulatory Health Services (Total) AAP HEDIS®MY 2023 - Adjusted, Certified	Appointment on 09/06/2023
09/06/2023	Adults' Access to Preventive/Ambulatory Health Services (65 and older) AAP HEDIS®MY 2023 - Adjusted, Certified	Appointment on 09/06/2023
05/14/2019	Colorectal Cancer Screening COL HEDIS® MY 2023 - Adjusted, Certified	Colonoscopy on 05/14/2019
09/19/2023	Controlling High Blood Pressure CMS165v11	120/74 on 09/19/2023.
N/A	COVID-19 Immunization Status: Primary Series	Primary series Complete: 03/19/2021, 10/10/2021 2/2 Pfizer-BioNTech
06/13/2023	Breast Cancer Screening BCS-E HEDIS® MY 2023 - Adjusted, Certified	Mammogram screening noted on 06/13/2023

THE VALIDATION PROJECT

measure	1/1/23-6/1/23	percentage		
breast	602/1090	55.23%	161 Pushed	
cervical	1108/2326	47.64%	398 pushed	
colorectal	1317/2663	49.46%	49 pushed	
poor A1c	512/876	58.45%	2 pushed	
BP control	1185/1920	61.72%	82 pushed	

measure	1/1/23-6/1/23		percentage
breast	763	1090	70.00%
cervical	1506	2326	64.75%
colorectal	1366	2663	51.30%
poor A1c	514	876	58.68%
BP control	1264	1920	65.83%

We were asked to validate Adult Access to Preventative Care but the Ambulatory visit date is way too broad to be useful in Primary Care. The dates given could be a trip to the Primary Care, Urgent Care, Emergency Room or Mental Health visit.

We literally pulled a report for all of our Primary Care and Pediatric Patients

In our EMR was the Measure:

Satisfied

Needs Work

Not Eligible

Then we looked at two things

- Did HEALTHeQUALITY agree with our EMR?

If not could we Identify which was correct

- If they did agree could we verify that it was or wasn't satisfied.

Yes. This was a very time-consuming project.

Yes. It was a worthwhile project. We found a lot of Gaps in our EMR that were actually filled. This will make a big difference in our UDS. This helped us identify a few errors on a couple of Insurance gap reports and send the supplemental data.

Our feedback provided insights into what wasn’t working or wasn’t valuable to our office.

- The HEALTHeQUALITY gaps don’t always apply to Fidelis Patients. They don’t have a claims feed from Fidelis so if their information was solely based on claims it was going to show a gap that wasn’t correct.
- The Ambulatory visit date is way too broad to be useful in Primary Care.
- It didn’t have a direct link to the patient’s HEALTHeLINK. You must enter the patient information for both.
- You had to enter the patient's name exactly as they have it in HEALTHeQUALITY. If Anne Marie was in HEALTHeQUALITY as AnneMarie that space would make the person not come up. If there was or wasn’t a hyphen in their last name it wouldn’t come up. HEALTHeLINK is much more forgiving on a person’s name if you also enter the DOB.

We are getting ready to do it all again!

We are bringing an OB/GYN office on board.

As a small private specialty, they do not have a great EMR.

(Their EMR is so basic that everything is manual. It is going to be ugly.)

We will pull a report for all the patients and start looking at the HEALTHeQUALITY.

We will push the documents that close the gaps from HEALTHeLINK. Because of the work we did most all of them will push with correct document labels (Intraoperative reports will still need extra work).

At the end, our numbers will accurately reflect the work our providers do. Our patients will not have to deal with redundant or confusing questions. Our Clinical Staff can spend their time on the medical instead of on the phone searching.

Q
&
A

Continue the Conversation

<u>RHIO Conversations</u> taking place on next week. There is a separate registration so don't miss it!

<u>Wed, Nov 15</u>

- HEALTHeLINK
- Rochester RHIO
- HealtheConnections

<u>Thurs, November 16</u>

- HIXNY
- Healthix
- Bronx RHIO

We hope to see you then!

Interoperability 101 Course

- Join the CHCANYS Hub!

Healthcare Interoperability

View Here

This **Healthcare Interoperability Learning Pathway** includes 3 courses and is designed for technology and EHR staff that are interested in learning the basics about interoperability in health care.

Learning Path: Healthcare Interoperability

3 Activities

2/5 Introduction to Interoperability

Show 5 Modules

2/5 Interoperability Landscape

Show 5 Modules

1/4 Interoperability in Practice

Show 4 Modules

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!