Care Insights: Actionable Information and High-Yield Care Opportunities in Population Health Management

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NCHICA Predictive Analytics for Population Health Management
June 2, 2015
Federally Qualified Health Centers

- Federally Qualified Health Centers – Who are we?
- Toward Accountable, Value-Based Care – How did we get here?
- Medicare Shared Savings Program – What does it represent for us?
- Data Needs for Value-Based Success
Federally Qualified Health Centers – Who are we?

• Located in or serve a high need community (designated Medically Underserved Area or Population).

• Governed by a community board composed of a majority (51% or more) of health center patients who represent the population served.

• Provide comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.

• Provide services available to all with fees adjusted based on ability to pay.

• Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.
Federally Qualified Health Centers – Who are we?

Footprint
• 1,198 Community Health Centers (34 in NC)
• 8,912 delivery sites (186 in NC)
• > 21 million patients (>460,000 in NC)

> 7 in 10 NC health center patients live at or below the poverty line.

Federally Qualified Health Centers – Who are we?

North Carolina FQHC Payer Mix

Source:
BPHC, HRSA, DHHS, 2012 Uniform Data System (UDS)
Toward Accountable, Value-Based Care – How did we get here?

- 2009: Affordable Care Act
- 2010: NCCHCA unification strategy and focus on PCMH
- 2012: PCMH-Informatics Grant from NC BCBS Foundation
- 2013: Carolina Medical Home Network (IPA)
- 2013: BPHC (HRSA) Health Center Controlled Network Grant
- 2014: Carolina Medical Home Network ACO Formed (MSSP)
Toward Accountable, Value-Based Care – How did we get here?

Carolina Medical Home Network ACO
- 2015 Starter
- 4 / 34 NC FQHCs participating
- 12,000 attributed lives
- Unique Medicare mix

Proportion: Person-Years per Assigned Beneficiary Medicare Enrollment Type - CMHN ACO

- End Stage Renal Disease
- Disabled
- Aged/Non-Dual
- Aged/Dual

CCNC SERVICES improving care through shared knowledge
Toward Accountable, Value-Based Care – How did we get here?

And along the way – a landscape of disparate clinical systems…

- Wake Health Services
- Rural Health Group
- Goshen Medical Center
- Roanoke Chowan CHC

NCCHCA Data Warehouse
CCNC ClinicalInsights
MSSP – What does it represent for us?

- Improving quality and patient outcomes as cohesive unit
  - Shared learning to determine and replicate best practices

- Better use of data to drive clinical, operational, and financial decisions
  - From the population to individual level
  - Increased insight – financial and utilization data via claims data

- Participation in a national model for transformation
  - The opportunity to develop capabilities without risk
Needs for Data-Driven Success

- Integrate disparate clinical systems across participating health centers
  - Meet reporting and population health management needs

- Integrate clinical (EMR and PM) data with other sources (claims data, etc.)

- Synthesize actionable information from these various data sources
  - Currently depend on data (Uniform Data System) - nearly one year old
  - Like driving while looking through rearview mirror

_We need to know our patients better NOW, How they will engage the health care system in the FUTURE, and Who will benefit most from more high-touch, acute engagement_
Predictive Analytics: What’s the Purpose?

- Risk Scores predict the likelihood of a given event.
  - They predict events/outcomes as part of usual care (i.e., if we didn’t intervene, what might be expected to happen). The dependent variable in the predictive models are typically events (e.g., hospital utilization) or costs.

- Impactability Scores identify members who will benefit the most from a given intervention.
  - The dependent variable in the predictive models are the estimated savings from care management interventions, based on rigorous, controlled real-world evaluations.
Care Management (CM) Impactability Score:
General Overview of Methodology

“Impactability” predicts how much change can be expected when intervened.

“Risk” predicts where a person is expected to be in the future.
Impactability Concept

Historically, care management efforts have been targeted at the highest risk.

Total Enrolled Population

● = Potentially preventable hospital costs for an individual
Impactability Concept

$0 $1K $2K $3K $4K $5K $6K $7K $8K $9K $10K $11K $12K $13K $14K $15K $16K $17K $18K $19K $20K

Total Enrolled Population

= Potentially preventable hospital costs for an individual
This person would likely benefit from care management; however, under conventional flagging methodology, this person would have been missed.

Under conventional flagging methodology, all of these people might have been flagged; care management would likely have had minimal impact for most of them.
Impactability Concept

CRG#1
- Actual-to-Expected Difference

CRG#2
- Actual-to-Expected Difference

CRG#3
- Actual-to-Expected Difference
High Risk Does NOT Mean High Impactability

- Patients with the Highest CM Impactability Scores
- Patients with the Highest Risk of an Inpatient Admission

Approximately 40% of the most impactable patients would get flagged just based on risk of a future inpatient visit. However, the Care Management Impactability Score is able to identify an additional 60% of the most impactable patients. This “crescent” represents patients with high risk but low impactability.
## Impactability vs. Risk: Impact on ROI

<table>
<thead>
<tr>
<th>Received Care Management Intervention?</th>
<th>N</th>
<th>Costs PMPM PRE</th>
<th>Costs PMPM POST</th>
<th>Difference</th>
<th>Net Effect</th>
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<tbody>
<tr>
<td><strong>Highest Impactable Patients</strong></td>
<td></td>
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<tr>
<td>(Patients with a CM Impactability Score of 300+)</td>
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<tr>
<td>NO</td>
<td>1219</td>
<td>$2,276</td>
<td>$2,294</td>
<td>$18</td>
<td>-$785</td>
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<tr>
<td>YES</td>
<td>2865</td>
<td>$2,930</td>
<td>$2,163</td>
<td>-$767</td>
<td>-$785</td>
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<tr>
<td><strong>Highest Risk Patients</strong></td>
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<tr>
<td>(Patients with a 40% risk of an inpatient admission in the next 12 months)</td>
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<tr>
<td>NO</td>
<td>1369</td>
<td>$2,627</td>
<td>$2,516</td>
<td>-$111</td>
<td>-$489</td>
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<tr>
<td>YES</td>
<td>3019</td>
<td>$3,387</td>
<td>$2,786</td>
<td>-$601</td>
<td>-$489</td>
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</table>

Targeting the most impactable patients generates almost **twice** as much savings as targeting the highest risk patients.
Time to First Readmission for Patients Receiving Transitional Care Vs. Usual Care

Lighter shaded lines represent time from initial discharge to second and third readmissions

(Significant Chronic Disease in Multiple Organ Systems, Levels 5 & 6; ACRG3 = 65-66)
But Positive Return on Investment for Transitional Care Requires Intelligent Targeting!

Example of a lower risk cohort that doesn’t benefit from transitional care management
(History of Significant Acute Disease, all severity levels; ACRG3 = 20-25)
Impactability Scores and Resource Planning

- Impactability Score values represent expected average savings from defined intervention. For example, a patient with a **CM Impactability Score** of ‘300’ is a patient for whom, if care managed, one could expect to achieve savings of $300 PMPM over the next 6 months, or $1,800 total.
- Helpful for resource planning to optimize return on investment.

Example ROI Calculator

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
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<tbody>
<tr>
<td>Task category</td>
<td>Minutes</td>
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<tr>
<td>Home Visit</td>
<td>90</td>
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<tr>
<td>Other Face to Face Encounters</td>
<td>65</td>
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<tr>
<td>Pharmacist</td>
<td>45</td>
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<tr>
<td>Non Face to Face Encounter BY a Care Manager</td>
<td>35</td>
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<tr>
<td>Non Face to Face Encounter BY Non Clinician</td>
<td>30</td>
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<tr>
<td>Travel (in miles one-way)</td>
<td>50</td>
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<tr>
<td>Total</td>
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</table>

### How much savings can you expect?

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<th></th>
<th>High TC</th>
<th>Low TC</th>
<th>ED-Supers</th>
<th>PPL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>678</td>
<td>550</td>
<td>220</td>
<td>150</td>
<td><strong>1,598</strong></td>
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<tr>
<td>Cost per patient</td>
<td><strong>$449</strong></td>
<td>$146</td>
<td><strong>$449</strong></td>
<td>$399</td>
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<tr>
<td>Savings per patient</td>
<td>$4,000</td>
<td>$1,500</td>
<td>$1,800</td>
<td>$1,400</td>
<td></td>
</tr>
<tr>
<td>ROI per patient</td>
<td><strong>$3,551</strong></td>
<td><strong>$1,354</strong></td>
<td><strong>$1,351</strong></td>
<td><strong>$1,001</strong></td>
<td></td>
</tr>
<tr>
<td>ROI per Quarter</td>
<td><strong>$2,407,323</strong></td>
<td><strong>$744,599</strong></td>
<td><strong>$297,137</strong></td>
<td><strong>$150,094</strong></td>
<td><strong>$3,599,153</strong></td>
</tr>
</tbody>
</table>

*CCNC SERVICES* improving care through shared knowledge.
# Indicators of High Yield Care Opportunities

<table>
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<tr>
<th>Indicator</th>
<th>Description</th>
<th>Lightweight Option?*</th>
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<tbody>
<tr>
<td>Transitional Care Impactability Score &amp; Home Visit Priority Flag</td>
<td>Indicates expected savings that may be achieved through intensive care management after hospital discharge; flag for patients expected to receive substantial incremental benefit from home visit</td>
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<tr>
<td>Outpatient Follow-Up Priority</td>
<td>Indicates optimal interval for outpatient follow-up appointment after hospital discharge</td>
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<tr>
<td>Care Management Impactability Score</td>
<td>Indicates expected savings that may be achieved through comprehensive care management under the CCNC model.</td>
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</tr>
<tr>
<td>Palliative Care Priority</td>
<td>Indicates high 12-month risk of mortality; patient likely to benefit from end of life planning</td>
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<tr>
<td>Chronic Pain Priority</td>
<td>Indicates pattern of chronic opiate use with frequent ED utilization; patient likely to benefit from coordinated care plan</td>
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</tr>
<tr>
<td>ED Visit Risk Score</td>
<td>Indicates risk of ED visit in next 90 days</td>
<td></td>
</tr>
<tr>
<td>Composite Risk Score</td>
<td>Indicates overall risk of hospital admissions and drug therapy problems; identifies patients likely to benefit from care team assessment with clinical pharmacy review</td>
<td>✓</td>
</tr>
<tr>
<td>12-month admission Risk Score</td>
<td>Indicates risk percentile for hospital admission within the next year</td>
<td>✓</td>
</tr>
<tr>
<td>30-day admission Risk Score</td>
<td>Indicates risk percentile for hospital admission within the next 30 days</td>
<td>✓</td>
</tr>
<tr>
<td>Drug Therapy Problem Risk Scores</td>
<td>Indicates risk percentile of finding a drug therapy problem. Includes component risk scores for risk of drug interaction, duplication, or adherence problems</td>
<td>✓</td>
</tr>
</tbody>
</table>

✓ Can be implemented quickly using pharmacy data alone, utilizing finder file of enrolled/attributed patients
High Yield Care Opportunities

CCNC Priority patients only. Groups selected in the visualization will be used to filter patients displayed in the table below.

Top 100 CCNC Priority Patients (by Admit Risk Score)
Care Impact: Care Opportunities Dashboard

Current Hospital Visits and Transitional Care Opportunities Dashboard

Visualization is a filter. Groups selected in the visualization will be used to filter patients displayed in the table below.

Most Recent Inpatient Visits from Patients in TC Priority Group

*Note: the “More Info” field is colored by the patient’s Home Visit Priority status (Orange = Medium, Red = High).*
Care Impact: Member Dashboard
Care Impact: Inpatient Utilization
Care Impact: ED Utilization

Utilization by Practice Dashboard

Return to Main Page  Tally by Patient  Visit List

ED Visits

Count of Patients returned: 3,256  Count of visits returned: 7,221

View Graph by CA PCP Name or Billing Provider Name:
  CA PCP Name

ED Visits by CA PCP Name

Select CA PCP Name to see patient details

GO SHEN MEDICAL CENTER - FAISON
1,043  $239  $206  $280  $280  $277,598  $174,631

GO SHEN MEDICAL CENTER - BEULAVILLE
635  $219  $249  $249  $206  $135,106  $147,491

RURAL HEALTH GROUP AT SCOTLAND NECK
603  $219  $249  $249  $206  $135,106  $147,491

RURAL HEALTH GROUP AT TWIN COUNTY
587  $219  $249  $249  $206  $135,106  $147,491

RURAL HEALTH GROUP OF ENFIELD
477  $219  $249  $249  $206  $135,106  $147,491

RURAL HEALTH GROUP AT WHITAKER
435  $219  $249  $249  $206  $135,106  $147,491

GO SHEN MEDICAL CENTER - WARSAW
322  $219  $249  $249  $206  $135,106  $147,491

GO SHEN MEDICAL CENTER - COMMUNITY
208  $219  $249  $249  $206  $135,106  $147,491

GO SHEN MEDICAL CENTER - WARSAW WELLNESS
184  $219  $249  $249  $206  $135,106  $147,491

GO SHEN MEDICAL CENTER - TRENTON
99  $219  $249  $249  $206  $135,106  $147,491

GO SHEN MEDICAL CENTER - PLAINVIEW
85  $219  $249  $249  $206  $135,106  $147,491

RURAL HEALTH GROUP AT WELDON ELEMENTARY

OK 1K 2K 3K 4K
Visits $0.00 $200.00 $400.00 $600.00 $800.00 $1,000.00 $2,000.00 $4,000.00 $6,000.00 $8,000.00
Avg. Paid Amount
Paid Amount

Date of Service (Admit Date)
4/12/2013 6/15/2014
Paid Date
4/16/2013 6/30/2014
Visit Type
ED
Emergent
(All)
Billing Provider Name
(All)
Primary DX Cat.
(1st Level)
(All)
Transitional Care Priority
(All)
CCNC Priority
(All)
Palliative Care Indicator
(All)
Age
0
Mental Health Condition
(All)
Select Condition 1:
No Filter
AND
Select Condition 2:
No Filter
AND
Select Condition 3:
No Filter
**CareAIM: Population Health Applications**

**Functionality:** Incorporation of multi-sourced information into comprehensive view of evidence-based population health dashboards/utilities to facilitate systematic approaches to improve care.

**ACO Quality Reporting**
- Application to view and analyze applicable measures sets including MSSP
- Ability to submit data for program results

<table>
<thead>
<tr>
<th>Measure</th>
<th>Provider 1</th>
<th>Provider 2</th>
<th>Provider 3</th>
<th>Provider 4</th>
<th>Provider 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Control (BP530G)</td>
<td>224</td>
<td>227</td>
<td>226</td>
<td>225</td>
<td>224</td>
</tr>
<tr>
<td>Fasting Glucose (BP531G)</td>
<td>103</td>
<td>110</td>
<td>119</td>
<td>118</td>
<td>109</td>
</tr>
<tr>
<td>Hemoglobin A1C (%)</td>
<td>8.5</td>
<td>8.5</td>
<td>8.5</td>
<td>8.5</td>
<td>8.5</td>
</tr>
<tr>
<td>Antihypertensives</td>
<td>129</td>
<td>129</td>
<td>129</td>
<td>129</td>
<td>129</td>
</tr>
</tbody>
</table>

**Population Health**
- Chronic Disease Registries (MU Certified)
- Pediatric Preventive Care
- Patient Centered Medical Home
- Custom Measure Sets
Clinical Data Processing

Data Normalization and Harmonization, Master Data Management

- Prior to processing data, CCNC normalizes the data set including mapping to standard code sets (LOINC, RxNorm, etc.), handles any data exceptions (special characters, alphanumerics), parses data from xml / standard documents (Continuity of Care Documents). Additionally, patient, providers and entities are processed into the master data indices.

Data Repository

- Care Insights is a relational database based on the healthcare Reference Information Model. This design allows for the infrastructure to decouple the ever-changing reporting requirements from the core healthcare data and transactions.

Healthcare Rules Engine

- Using a Clinical Measure Processing Framework, the rules engine evaluates the provider and facility performance for clinical quality measures and evidence-based guidelines.
# Patient Population Management

## Providers in Practice - Performance View

<table>
<thead>
<tr>
<th>Measure</th>
<th>Eligible Patients</th>
<th>Period %</th>
<th>Goal %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Control (&lt;140/80)(DM)</td>
<td>234</td>
<td>61</td>
<td>80</td>
</tr>
<tr>
<td>BMI screening and followup(DM)</td>
<td>237</td>
<td>25</td>
<td>80</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>189</td>
<td>2</td>
<td>80</td>
</tr>
<tr>
<td>Foot Exam</td>
<td>189</td>
<td>26</td>
<td>80</td>
</tr>
<tr>
<td>HbA1c Control (&lt;8.0%)</td>
<td>189</td>
<td>66</td>
<td>80</td>
</tr>
<tr>
<td>HbA1c Poor Control (&gt;9.0%)</td>
<td>189</td>
<td>25</td>
<td>80</td>
</tr>
<tr>
<td>HbA1c Test Performed</td>
<td>189</td>
<td>90</td>
<td>80</td>
</tr>
<tr>
<td>Influenza Immunization(DM)</td>
<td>183</td>
<td>68</td>
<td>80</td>
</tr>
<tr>
<td>IVD: Aspirin or Another Antithrombotic Use(DM)</td>
<td>24</td>
<td>50</td>
<td>80</td>
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<tr>
<td>IVD: Complete Lipid Panel and LDL Control(DM)</td>
<td>24</td>
<td>50</td>
<td>80</td>
</tr>
<tr>
<td>LDL Control (&lt;100)</td>
<td>189</td>
<td>46</td>
<td>80</td>
</tr>
<tr>
<td>LDL Test Performed</td>
<td>189</td>
<td>66</td>
<td>80</td>
</tr>
</tbody>
</table>

**Practice Performance**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1</td>
<td>33% met, 67% not met</td>
</tr>
<tr>
<td>Provider 2</td>
<td>25% met, 75% not met</td>
</tr>
<tr>
<td>Provider 3</td>
<td>25% met, 75% not met</td>
</tr>
<tr>
<td>Provider 4</td>
<td>50% met, 50% not met</td>
</tr>
<tr>
<td>Provider 5</td>
<td>15% met, 85% not met</td>
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</tbody>
</table>

**Practice Trend**

- Trend line from 07/01/2012 to 03/31/2015.
- Data points for each provider from 06/30/2010 to 03/31/2015.

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**CCNC SERVICES: improving care through shared knowledge**
### Patient Population Management

**Provider, Organization & Facility Performance View**

#### Blood Pressure Control
- **Organization**: 32%
- **Facility**: 45%
- **Provider**: 63%

**Improvement Trend**

**Blood Pressure Control**: 50% Met
## Patient Population Management

### Provider List View

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Blood Pressure Control (≤140/90) (DM)</th>
<th>BMI screening and followup(DM)</th>
<th>Eye Exam</th>
<th>Foot Exam</th>
<th>Hba1c Control (≥8.0%)</th>
<th>Hba1c Poor Control (&lt;9.0%)</th>
<th>Hba1c Test Performed</th>
<th>Influenza Immunization(DM)</th>
<th>IVD: Aspirin or Another Antithrombotic Use(DM)</th>
<th>IVD: Complete Lipid Panel and LDL Control(DM)</th>
<th>LDL Control (≤100)</th>
<th>LDL Test Performed</th>
<th>Tobacco Use Screening(DM)</th>
<th>Urine Protein Screening(DM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
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- **Aspirin Use**
- **LDL Control**
- **Tobacco Use Screen**
Patient Population Management

Patient List View

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<tr>
<th>Patient Name</th>
<th>Patient ID</th>
<th>Gender</th>
<th>Age</th>
<th>DOB</th>
<th>Provider Name</th>
<th>Blood Pressure Control (&lt;140/90)(DM)</th>
<th>BMI screening and followup(DM)</th>
<th>Eye Exam</th>
<th>Foot Exam</th>
<th>HbA1c Control (&lt;8)</th>
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</tbody>
</table>
Patient Population Management

Patient Longitudinal Record

- Problem List
  - Acq absence cervicesusus
  - Benign hypertension
  - DMII wo cmp rt st uncontr
  - Mixed hyperlipidemia
  - Screen mammogram NEC

- Care Guidelines
  - Diabetes Blood Pressure
  - Diabetes BMI calculation
  - Diabetes Diabetes Eye Exam
  - Diabetes Influenza vaccination

- Vitals
  - BMI 45.24
  - BP Diastolic 82 mmHg
  - BP Systolic 147 mmHg
  - Height 63
  - Weight 255.4

- Labs
  - ChlO
  - Cholesterol 105 (mmol/L)
  - Cholesterol in HDL 67 (mg/dL)
  - Cholesterol in LDL 147 (mg/dL)
  - Cholesterol in VLDL 12 (mg/dL)

- Active medication list
  - LOVASTATIN
  - Hydrochlorothiazide + lisinopril

- Allergies and Adverse Reactions
  - 300076005
  - 78554009
Discussion
Community Care of North Carolina

Quality Measure Sets
Thirty three (33) measures across 9 domains

- **Patient Care Giver Experience**
  - Eight (8) measures
  - CAHPS survey

- **Care Coordination Patient Safety** with ten (10) measures
  - Eight (8) use claims, including 1 using claims and administrative data
  - Two (2) use clinical data

- **Preventive Health**
  - Eight (8) measures
  - All use clinical data
  - Six (6) measures can benefit from claims data

- **Six (6) At-Risk Domains** all use clinical data
  - Diabetes: two (2) measures
  - Hypertension: one (1) measure
  - Ischemic Vascular Disease: one (1) measure
  - Heart Failure: one (1) measure
  - Coronary Artery Disease: one (1) measure
  - Depression: one (1) measure
  - Four (4) measures can benefit from claims data
Preventive Measures

At least two different preventive care services:

- Cervical Cancer Screening
- Colorectal Cancer Screening
- Pregnant Women with HBsAg
- Preventive Care and Screening: LDL-C
- Preventive Care and Screening: LDL Risk Stratified
- Breast Cancer Screening
- BMI / Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Chlamydia Screening for Women
- 0-5 Years: Development Screening
- 18-30 Months: Austim Screening
- 3-10 Years: Vision Screening
- 4-10 Years: Hearing Screening
- 6 - 10 Years: School Age Development Screening
- 11 - 20 Years: Adolescent and Behavioral Screening
- 0 - 42 Months: Dental Varnishing
Immunizations, Patients Not Seen & Medication Monitoring Measures

At least two different immunizations
- Pneumonia Vaccination Status
- Asthma/COPD: Influenza Vaccination Status
- Childhood Immunization Status
- Preventive Care and Screening: Influenza Immunization

Patients not recently seen by the practice
- 50+ Year Olds Not Seen in Practice within past 24 months
- 50+ Year Olds Not Seen in Practice within past 12 months
- 5-17 Year Olds: Not Seen in Practice for Well-Child Visits

Medication monitoring or alert
- High Risk Meds
- Multiple Narcotics
- Coumadin Patients not seen within 6 months
- Use of High-Risk Medications in the Elderly
### Chronic or Acute Conditions Measures

<table>
<thead>
<tr>
<th>At Least Three Different Chronic or Acute Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Appropriate Treatment for Children with URI</td>
</tr>
<tr>
<td>✔ Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td>✔ ADHD: Follow-Up Care for Meds</td>
</tr>
<tr>
<td>✔ Diabetes: HbA1c Poor Control (&gt;9.0)</td>
</tr>
<tr>
<td>✔ Diabetes: HbA1c A1c Test</td>
</tr>
<tr>
<td>✔ Diabetes: HbA1c control (&lt;8.0)</td>
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<tr>
<td>✔ Diabetes: Low Density Lipoprotein (LDL) Management and Control</td>
</tr>
<tr>
<td>✔ Diabetes: LDL-C screening</td>
</tr>
<tr>
<td>✔ Diabetes: Blood Pressure In Control (&lt;140/90)</td>
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<tr>
<td>✔ Diabetes: Eye Exam</td>
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<td>✔ Diabetes: Foot Exam</td>
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<tr>
<td>✔ Diabetes: Urine Protein Screening</td>
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<tr>
<td>✔ Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
</tr>
<tr>
<td>✔ Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control</td>
</tr>
<tr>
<td>✔ Hypertension: Controlling High Blood Pressure</td>
</tr>
<tr>
<td>✔ Hypertension: Aspirin or antithrombotic Use</td>
</tr>
<tr>
<td>✔ Hypertension: Complete Lipid Profile</td>
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<tr>
<td>✔ Hypertension: Urine Protein Screening</td>
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<tr>
<td>✔ Hypertension: Annual serum creatinine testing</td>
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<tr>
<td>✔ Hypertension: Diabetes Mellitus annual screening</td>
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<tr>
<td>✔ Hypertension: Dietary and Physical Activity Modifications Appropriately Prescribed</td>
</tr>
<tr>
<td>✔ Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt;40%)</td>
</tr>
<tr>
<td>✔ Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
<tr>
<td>✔ Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
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<tr>
<td>✔ Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting</td>
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<tr>
<td>✔ Assessment of Asthma Control – Ambulatory Care Setting</td>
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