Healthcare IT and the Ecology of Medical Care: Leave No Doc Behind

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The Ecology of Medical Care

Reprinted from
The New England Journal of Medicine
265:885–892, 1961

Kerr L. White, MD, T. Franklin Williams, MD, and Bernard G. Greenberg, PhD

Chapel Hill, North Carolina

Figure 1. Monthly Prevalence Estimates of Illness in the Community and the Roles of Physicians, Hospitals, and University Medical Centers in the Provision of Medical Care.

Data are for persons 16 years of age and older. Reprinted from the 1961 report by White et al.†
For North Carolina Medicaid recipients:
- A majority of practices see <500 Medicaid patients
- Sicker patients are disproportionately cared for in smaller practices (higher case mix index)
Who Provides Primary Care Medical Homes for NC Medicaid Recipients?

- Large Health System Owned Practices
- Other Hospital Owned Practices
- Federally Qualified Community Health Centers
- Other Safety Net (RHC, LHD, other)
- Independents
Safety Net and Independent Practices Tend to Provide High-Value Care!

On a risk-adjusted basis, NC Medicaid recipients in Community Health Centers and Independent Practices have lower costs and lower hospitalization rates than those in hospital-owned practices.
Similar observations have been made elsewhere...

- For commercial HMO members, total expenditures per patient for were higher in hospital-owned compared to physician-owned physician organizations
  - Robinson et al. JAMA 2014;312(16):1663-1669

- Small primary care practices (1-2 or 3-9 physicians) have lower rates of preventable hospital admissions than larger practices (10-19 physicians)
  - Casalino et al. Health Affairs Sept 2014;33(9):1680-1688

- In general, larger practice size is not associated with better quality of care in primary care. Smaller practice size is associated with better patient satisfaction with access.
  - Ng et al. British Journal of General Practice Sept 2013;e604-610

- Nationally, 18% of primary care physicians practice solo, and 60% practice at sites with 10 or fewer physicians
Primary Care Practices and Meaningful Use of HIT

Primary Care Practices That Share Resources, Are Part of Integrated Systems, Are Eligible for Financial Incentives, or Have 20 or More Physicians Are More Likely to Use Electronic Medical Records, 2012

Percent using electronic medical records

- Has arrangements to share resources with other practices: 83
  - No arrangements: 59

- Part of an integrated system: 87
  - Not part of integrated system: 63

- Eligible for financial incentives: 76
  - Not eligible for incentives: 65

- 20+ physicians in practice: 90
  - Solo practice: 49


www.commonwealthfund.org
Primary Care Practices and Meaningful Use of HIT

- Although federal funds have led to a rapid expansion of health information technology, solo practices continue to lag in adoption
  - Twice as many physicians in integrated delivery systems reported having high HIT functionality, but only one-fourth of physicians said they practice in such a setting
    - 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians
- Fewer than half of independent physicians felt the financial and care benefits of EHRs exceeded the costs
  - 2013 survey of 1,200 physicians (Epocrates users) by athenahealth
- EHR utilization for population health management lags farther behind
  - 83% of office based physicians use an EHR in some way (recording patient history, ordering prescriptions).
  - But only 58% have computerized capabilities to generate lists of patients with particular health conditions; 57% to provide reminders for guideline-based interventions
    - CDC/NCHS, 2013 National Ambulatory Medical Care Survey, Electronic Health Record Survey.
Public Investment in Health Information Technology

More than $30.88 BILLION in Medicare and Medicaid EHR Incentive Program payments have been made since January 2011.

Combined Medicare and Medicaid Payments by State Graph

Medicare and Medicaid Provider Payments
January 2011 to July 2015

Public Investment in EHR Adoption
Approaching $1B in North Carolina

About 30% from Medicaid, 70% Medicare
What’s the point?

• Efforts to transform healthcare must take into account that small and independent practice sites represent a sizable share of primary care practices
  – More to the point…. They are the primary point of contact for most of the population!

• Small, independent, and safety net practices need more assistance adopting delivery system innovations
  – Creative solutions include sharing resources for care management, quality improvement, and health information technology

• We want these practices to succeed in value-based healthcare reform. This is a public health issue!
Federally Qualified Health Centers

- Federally Qualified Health Centers – Who are we?
- From EMR Adoption to Accountable, Value-Based Care
- 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 (38 in NC)
• 8,912 delivery sites (>200 in NC)
• > 21 million patients (>480,000 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

- Uninsured: 47%
- Medicare: 14%
- Private: 15%
- [CATEGORY NAME]: 25%

Source: BPHC, HRSA, DHHS, 2012 Uniform Data System (UDS)
NC Health Center EMR Landscape

- 34 Unique Health Center Organizations
- 17 Different EMR Systems
From EMR Adoption to Accountable, Value-Based Care

- 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)
Carolina Medical Home Network ACO

- 2015 MSSP Starter
- 6 / 38 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: 1%
- Disabled: 31%
- Aged/Dual: 17%
- Aged/Non-Dual: 51%
And along the way – a landscape of disparate clinical systems…

Wake Health Services
Centricity
Rural Health Group
eClinicalWorks
Goshen Medical Center
Allscripts
Roanoke Chowan CHC
Epic

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*
Connecting Practices to Meaningful Tools for Managing Populations

- 1,090 NC practices are establishing EHR connections to the CCNC Informatics Center for use of population health management applications
  - This includes 669 independent practices
- 237 are safety net practices (FQHC, Rural Health Center, School Based Health Clinic, Health Department)

*This is a work in progress!*

- Over 1.5 million patients from over 350 clinical practice locations are already live in our clinical data applications
- We have rolled out our clinical disease registries and quality measure dashboards to an initial user group of 88 FQHC practice sites
  - Larger scale rollout planned in 2015Q4
Clinical Data Processing

Integrated over 1.5 million patients, 300 + sites

Electronic Medical Records

Data Normalization

Data Repository

Measure Calculations
To date, CCNC has integrated over 20 EMR’s across 350 locations

Data Included:
- Encounters
  - Demographics
  - Procedures
  - Diagnoses
- Lab Results
- Medications
- Allergies
- Vitals (BP, BMI, etc.)
- Social History (smoking)
- Encounter Notes

Received via
- HL7 Batch files developed through database queries (includes historical datasets)
- Continuity of Care (CCD) documents transmitted and then parsed
Clinical Data Processing

Data Normalization

In our normalization process, we have create automated scripts to parse and to review data fields for completeness and to determine if any new concepts are present.

We then align these data fields to standardized dictionaries via mapping function.

Coding system lookups to normalize free text fields include

- **Meds/Allergies** (RxNorm/Medispan)
  - Custom reference table with \textbf{277k} rows
- **Labs/Vitals** (LOINC)
  - Custom reference table with \textbf{120k} rows
- **Additional Lookups**
  - Social History (Snomed)
  - NPI
  - Ethnicity
  - Race
  - Gender
  - Patient Class
  - Language
  - Marital Status
Clinical Data Processing

Data Normalization

Additionally, we enrich the data where needed when the presenting format is unique or completeness is sparse:
- Splitting of values & units into separate fields (i.e., 20mg, 139/87)
- Standardization of units for vitals (metric or US)
- Calculation of BMI
- Facility Name and ID assignment
- Scrubbing of special characters and other “junk”

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Avg per Patient</th>
<th>Standard Dictionary</th>
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<tr>
<td>Procedures</td>
<td>13</td>
<td>CPT</td>
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<tr>
<td>Diagnosis</td>
<td>19</td>
<td>ICD-9</td>
</tr>
<tr>
<td>Labs</td>
<td>54</td>
<td>LOINC, mapped</td>
</tr>
<tr>
<td>Vitals</td>
<td>25</td>
<td>LOINC, mapped</td>
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<td>Medications</td>
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<td>Multiple, mapped</td>
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<td>Allergies</td>
<td>3</td>
<td>RxNorm (current), mapped</td>
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<td>Social History</td>
<td>8</td>
<td>SNOMED, mapped</td>
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<tr>
<td>Encounter Notes</td>
<td>5</td>
<td>NA</td>
</tr>
</tbody>
</table>
After we normalize the data elements, they flow into our data repository. We currently house approximately 1.5 millions clinical patients records from over 350 locations.
Clinical Data Processing

The rules engine uses a standard template to develop numerator and denominator statements based on the clinical standard coding set built during the mapping process.

For example, when calculating for tobacco screening, the data may present in a CCD as “smokes <1 pack per day”, which will be mapped to SNOMED code 230062009 representing a moderate cigarette smoker. When the rule is processed, it searches the repository patient table for a series of tobacco concepts representing smokers and non-smokers.

<table>
<thead>
<tr>
<th>Clinical Statement</th>
<th>ParentClinicalStatement</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
<td>Documented SNM code for Tobacco user</td>
<td>Patient was screened for tobacco use at least once within 24 months</td>
<td>Numerator statement(s)</td>
</tr>
<tr>
<td>Documented SNM code for Tobacco non user</td>
<td>Patient was screened for tobacco use at least once within 24 months</td>
<td>Numerator statement(s)</td>
</tr>
</tbody>
</table>
**Functionality:** Incorporation of multi-sourced information into comprehensive view of evidence-based population health dashboards/utilities to facilitate systematic approaches to improve care.

**Available Measure Sets**
- Chronic Disease Registries (MU Certified)
- eClinical Quality Measures
- Pediatric Preventive Care
- Patient Centered Medical Home
- ACO Quality MSSP
- Heart Health Now
- Custom Measure Sets
## Patient Population Management

**Provider, Organization & Facility Performance View**

### CareAIM

- **CATEGORIES:** Hypertension
- **ORGANIZATIONS:** Rexwoods Health Center

**REPORTING PERIOD:** 07/01/2014 - 06/30/2015

**FACILITIES:** Rexwoods Health Center

**PROVIDERS:** Lisa Gentry

### Provider Measures

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<th>Measure</th>
<th>Organization</th>
<th>Facility</th>
<th>Provider</th>
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<tbody>
<tr>
<td>Aspirin or another Antithrombotic Medication</td>
<td>6%</td>
<td>29%</td>
<td>38%</td>
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<tr>
<td>Blood Pressure Control (&lt;140/90)</td>
<td>78%</td>
<td>71%</td>
<td>45%</td>
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<tr>
<td>BMI screening and followup (HTN)</td>
<td>29%</td>
<td>55%</td>
<td>62%</td>
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<tr>
<td>Complete Lipid Profile Performed</td>
<td>38%</td>
<td>57%</td>
<td>43%</td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>38%</td>
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<tr>
<td>Diabetes Mellitus Screen</td>
<td>57%</td>
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<td>57%</td>
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<td>Dietary and Physical Activity Mod...</td>
<td>6%</td>
<td>4%</td>
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<td>Influenza Immunization (HTN)</td>
<td>91%</td>
<td>93%</td>
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<tr>
<td>IVD: Aspirin or Another Antithrombotic Med.</td>
<td>9%</td>
<td>73%</td>
<td>91%</td>
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<tr>
<td>IVD: Complete Lipid Panel and Lipid Profile</td>
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<td>73%</td>
<td>27%</td>
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<td>Pneumonia Vaccine for Older Adults</td>
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<td>97%</td>
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<td>Serum Creatinine Test Performed</td>
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<td>60%</td>
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<tr>
<td>Tobacco Use Screening (HTN)</td>
<td>1%</td>
<td>57%</td>
<td>1%</td>
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<tr>
<td>Urine Protein Screening</td>
<td>9%</td>
<td>90%</td>
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### Improvement Trend

- **Blood Pressure Control:** 78% Met
- **Organization:** 32%
- **Facility:** 45%
- **Provider:** 57%
# Patient Population Management

## Provider List View

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Blood Pressure Control (≤140/90) (%)</th>
<th>BMI screening and followup(DM)</th>
<th>Eye Exam</th>
<th>Foot Exam</th>
<th>HbA1c Poor Control (≥8.0%)</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>
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</table>

- **Aspirin Use**
- **LDL Control**
- **Tobacco Use Screen**
Patient Population Management

*Patient List View*

<table>
<thead>
<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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Patient Population Management

Patient Longitudinal Record

**Problem List**

<table>
<thead>
<tr>
<th>Problem</th>
<th>ICD Code</th>
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<th>Source</th>
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<tbody>
<tr>
<td>Acq absence cervicouterus</td>
<td>V88.01</td>
<td></td>
<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>Benign hypertension</td>
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<td></td>
<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>OMI w o comp rt st uncitr</td>
<td>250.00</td>
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<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>Mixed hyperlipidemia</td>
<td>272.2</td>
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<td>BCRHA - Lewiston</td>
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<tr>
<td>Screen mammogram NEC</td>
<td>V76.12</td>
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**Care Guidelines**

<table>
<thead>
<tr>
<th>Category</th>
<th>Guideline</th>
<th>Most Recent</th>
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<tbody>
<tr>
<td>Diabetes</td>
<td>Blood Pressure</td>
<td>14782</td>
<td>BCRHA - Lewiston</td>
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<tr>
<td>Diabetes</td>
<td>BMI calculation</td>
<td>45.24</td>
<td>BCRHA - Lewiston</td>
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<tr>
<td>Diabetes</td>
<td>Diabetes Eye Exam</td>
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<td>BCRHA - Lewiston</td>
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<tr>
<td>Diabetes</td>
<td>Influnza Vaccination</td>
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<td>BCRHA - Lewiston</td>
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</table>

**Vitals**

<table>
<thead>
<tr>
<th>Vitals</th>
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<th>Date</th>
<th>Source</th>
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<tbody>
<tr>
<td>BMI</td>
<td>45.24</td>
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<td>BCRHA - Lewiston</td>
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<tr>
<td>BP Diastolic</td>
<td>82 mmHg</td>
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<td>BCRHA - Lewiston</td>
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<tr>
<td>BP Systolic</td>
<td>147 mmHg</td>
<td></td>
<td>BCRHA - Lewiston</td>
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<tr>
<td>Height</td>
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<td>BCRHA - Lewiston</td>
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<tr>
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**Labs**

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<tr>
<td>ChlOide</td>
<td>105 (mmol/L)</td>
<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>246 (mg/dL)</td>
<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>Cholesterol in HDL</td>
<td>87 (mg/dL)</td>
<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>Cholesterol in LDL</td>
<td>147 (mg/dL)</td>
<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>Cholesterol in VLDL</td>
<td>12 (mg/dL)</td>
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**Active medication list**

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<thead>
<tr>
<th>Medication</th>
<th>Qty</th>
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<th>Source</th>
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<tbody>
<tr>
<td>LOVASATIN</td>
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<td></td>
<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>Hydrochlorothiazide + lisinopril</td>
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<td></td>
<td></td>
<td>BCRHA - Lewiston</td>
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</table>

**Allergies and Adverse Reactions**

<table>
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<tr>
<th>Allergen</th>
<th>Reaction</th>
<th>Source</th>
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<tr>
<td>300076005</td>
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<td>BCRHA - Lewiston</td>
</tr>
<tr>
<td>78554099</td>
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<td>BCRHA - Lewiston</td>
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</table>
Care Impact: Member Dashboard

Member Dashboard

Cost and Utilization
This table makes calculations according to the filtered population and selections made in the ACO and zip code views.

- Total Patients: 46,714
- Avg. Medicaid Inpatient Visits: 0.17
- Avg. Behavioral Health - MCC IP Visits: 0.01
- Avg. Total IP Visits: 0.10
- Avg. Medicaid B&O Visits: 0.83
- Avg. Behavioral Health - MCC B&O Visits: 0.06
- Avg. Total B&O Visits: 0.36
- Avg. Inpatient Cost: $205,020.64
- Avg. Total Medicaid Cost: $40,430.73

Member Scatter Plot of Total Inpatient Visits by Total Medicaid Costs
Select a utilization measure in the dropdown to the right for y-axis values. Cost categories can be chosen on the right panel of x-axis values.

Average Total Medicaid Costs by PCP Zip Code
Click on a zip code area to filter dashboard by PCP zip. Hold ctrl and click to select multiple zip code areas.

Community Care of North Carolina
Improving care through shared knowledge
Care Impact: Hospital Utilization Dashboard
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).
Population Profiling: Targeting Patients for Intervention

Population Profiling:
Targeting Patients for Intervention

- Prioritize Patients with most need
- Identify best intervention based on data
- Deliver intervention guidance

Logistics Engine

CCNC SERVICES
improving care through shared knowledge

Population

Population To Touch

Need Generalized Med Management

How To Touch Them

Patient Needs

Intervention Selection

Actors-Settings

Interventions

Adherence/Coaching

Therapeutic Discrepancies

Therapeutic Considerations

Some Have More Specific Needs
The Traditional Approach of Patient Targeting

Traditional approaches focus on highest cost/highest risk patients for savings. With this approach, care management interventions may have little or no impact on the trajectory of health care costs for many patients.

○ = Individual patient health care cost
The **Impactability** approach uses clinical profiles to create >1100 peer groups for comparison of potentially preventable health care costs. This allows the identification of outliers that would most benefit from care management but might have been missed using conventional flagging methodology.

Example -
Peer Group 1: Asthma of low severity, no comorbidities
Peer Group 2: Advanced Coronary Artery Disease and Other Dominant Chronic Disease
Impactability scores predict how much change can be expected through care management, based on controlled real-world evaluation of interventions.

Risk scores predict where a person is expected to be in the future.

Care Manager Intervenes

Patient Profiling: Care Triage and Impactability Scores
CareTriage™ delivers patient-specific information to care managers and care givers

1. **Immediate Utility for Managing Risk.** Lightweight implementation using minimal data sets to drive analytics.

2. **Risk Profile.** Provides risk score for hospital admission and variety of drug therapy problems, with composite score reflecting the patient’s overall risk.

3. **Patient clinical needs and interventions.** Specific clinical needs of the patient along with the intervention(s) that could address these needs.

4. **Medication details.** Additional medication details that could be helpful to users in delivering the intervention or addressing the clinical need, such as a visual view of adherence to medications over time.
Anticipate savings. Scores indicate estimated per member per month savings through care management, based on real-world controlled evaluations.

Context-Specific. Separate scores indicate impactability through general care management outreach vs. transitional care after hospital discharge, with specific intervention guidance.

Facilitate Program Planning. Cost-benefit calculator informs optimal balance of care management staffing, customized to local context.

Maximize Return on Investment. Provides prioritized list of patients most likely to benefit from care management invention, to improve efficiencies and have the greatest impact.

Impactability Scores™ maximize return on investment for care management strategies.
Savings Impact of Care Management, by Targeting Strategy

Savings indicate total cost reduction over 6 months following initiation of complex care management, net of natural spending trend in matched controls.

Twofold-Threefold Return on Investment using Care Triage or Impactability Scores to target care management interventions.
MUST be targeted toward patients with multiple chronic or catastrophic conditions to optimize ROI

REQUIRES real-time notification of hospital admission/discharge, but historical claims are most valuable for risk segmentation

MOST EFFECTIVE as a community-level strategy with multidisciplinary care team approach

Volume of Medicaid Hospital Discharges, by Patient Risk of 90-day Readmission

- **TC Impactability Score >500**
  - Prioritized for High-Intensity support (home visit, RN + pharmacist)
  - NNT=3 to prevent 1 readmission
  - Avg. savings $4,000

- **TC Impactability Score >200**
  - Prioritized for Lower-Intensity support
  - NNT=6 to prevent 1 readmission
  - Avg savings $1,000

* Reflects distribution of discharges after excluding deliveries and newborns
## Indicators of High-Yield Care Opportunities

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
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</thead>
</table>
| Transitional Care Impactability Score       | A score ranging from 0-1,000 indicating the potential savings benefit from transitional care management.  

**TC Priority Flag**: Score of 200 or greater  

**TC Home Visit Priority Flag**: Score of 500 or greater. Indicates that the patient would particularly benefit from a home visit with comprehensive medication management. |
| Outpatient Follow-up Recommendation         | Evidence-based recommendation for optimal timing of outpatient follow-up visit after hospital discharge                                                                                                    |
| Palliative Care Indicator                   | Indicates high risk of mortality. Care management should include end-of-life planning.                                                                                                                       |
| Care Management Impactability Score         | A score ranging from 0-1,000 indicating the potential savings benefit from care management outreach.  

**CM Priority Flag** indicates score of 200 or greater. |
| ED Visit Risk Score                         | Indicates risk of ED visit in next 90 days                                                                                                                                                            |
| 12-month and 30-day admission Risk Scores   | Indicate risk percentiles for hospital admission within the next year and within the next 30 days                                                                                                |
| Drug Therapy Problem Risk Scores            | Indicates risk percentile of finding a drug therapy problem. Includes component risk scores for risk of **drug interaction**, **duplication**, or **adherence** problems |
| Chronic Pain Priority                       | Indicates pattern of chronic opiate use with frequent ED utilization; patient likely to benefit from coordinated care plan                                                                 |