HIE Policy Board Meeting

April 20, 2017

DC HIE: Our Vision & Mission

Vision

To advance health and wellness for all persons in the District of Columbia by providing actionable information whenever and wherever it is needed.

Mission

To facilitate and sustain the engagement of all stakeholders in the secure exchange of useful and usable health-related information to promote health equity, enhance care quality, and improve outcomes in the District of Columbia.

Agenda

- Roll Call and Announcement of Quorum
- Review and Approval of Minutes
- Updates since February HIEPB Meeting
- Designation Subcommittee Update
- Sustainability Subcommittee Update
- CRISP Demonstration on HIE Tools
- MAP Meeting on Social Determinant Debrief
- Next Meeting

Roll Call and Minutes

- Roll Call and Announcement of Quorum
- Review and Approval of Minutes

UPDATES SINCE FEBRUARY HIEPB MEETING

Enhanced HIE Grant & HIT TA and Outreach Contract

- *Enhanced HIE grant*: 4 new HIE tools, including a patient care profile, population health dashboard, and quality measure tool (*demo later in the agenda*)
  - $2.93 million to CRISP in partnership with DCPCA, Health EC, and Zane Networks
  - Concludes September 30, 2017

- *Health IT technical assistance (TA) and outreach contract* providing outreach and TA to District providers to help them attest for Meaningful Use (MU)
  - Base year award of $997K to DCPCA and Clinovations GovHealth
  - Up to 5 year contract through 2021, which CMS has approved
    - Will Promote Use Of CEHRT In DC, Provide TA, And Conduct Environmental Scan To Update The State Medicaid Health Information Technology Plan (SMHP)

CMS Awards MEIP Extension thru June 30

- Providers can receive up to $63,750 for full participation in the MEIP
  - Including $21,250 to adopt, implement or upgrade (AIU)
- Requirements:
  - MD/DO, Dentist, NP, or Nurse Midwife
  - Medicaid patient volume threshold 30% (20% for pediatric)
  - AIU federally certified health IT by June 30
- More information on technical assistance:
  - Contact eHealthDC staff directly at contact@e-healthdc.org or 202-552-2331
- Please help us spread the word!

HIT Contract: Potentially Eligible Providers in DC for AIU/MEIP Outreach

	MD/DO	Dentist	Nurse Practitioner	Nurse Midwife	Total
Total Universe of Potential and Current DC MEIP providers	2,401	158	965	42	3,566
- Total EPs who have received SLR/EUA payments	1,602	59	111	15	1,787
- Total EPs in Processing	144	60	34	11	249
Total # of EPs for AIU Outreach	655	39	820	16	1,530

- Provider outreach goal by September:
  - Reach 750 providers
  - Enroll 350 providers into the MU program

DESIGNATION SUBCOMMITTEE UPDATE

HIE Designation Subcommittee

Mission

Provide recommendations to DHCF regarding the establishment of a formal Designation process for HIEs operating in the District.

Goals

Elicit feedback on specific Designation requirements (e.g., Technical, Privacy, Security, etc.) and make recommendations to the HIE Policy Board regarding the legislative process.

HIE Designation Subcommittee Update

- **Subcommittee Members:**
  - Andersen Andrew (DOH)
  - Christian Barrera (EOM)
  - Evan Carter (CRISP)
  - Dena Hasan (DHS)
  - Brian Jacobs (CNMC)
  - Katheryn Lawrence (DCAS)
  - Mike Noshay (Verinovum)
  - Justin Palmer (DC Hospital Association)
  - LaRah Payne (DHCF)
  - Donna Ramos-Johnson (DCPCA)
  - Barney Krucoff (OCTO)

- **Monthly subcommittee meetings**
  - Meetings to date: 3/21, 4/11
  - Next meeting: 4/27

HIE Designation Subcommittee Update

Current Activity

- Developing formal definition of HIE
- Reviewed other states' approaches to HIE designation
  - Including Maryland, New York, Pennsylvania, Minnesota
- Using Maryland regulations as the foundation for developing the District's regulations

Timeline

- Draft HIE designation rule (April/May 2017)
- BSA Approval (July 2017)
- Executive Order of the Mayor re: Designation (August 2017)
- Submit Rule (September 2017)

HIE Designation Subcommittee Update

Eight features of HIE designation policy design:

1) Accreditation/Certification
2) Business Operations
3) Performance Monitoring
4) Policies/Procedures
5) Security and Encryption
6) Technical
7) Incorporate social determinants and education data
8) Consumer/patient engagement

High-level "guide rail" issues for consideration during the HIE designation process

1) privacy/security
2) data breach response
3) access/use/disclosure of PHI
4) auditing/training/enforcement
5) consumer rights and engagement

SUSTAINABILITY SUBCOMMITTEE UPDATE

Outreach Meetings: Progress to Date

Organization	HIEPB Attendees	Dates
KPMAS	Erin Holve, Mary Jones Bryant, Allison Viola	Meeting held 12/4/1
BridgePoint Hospital	Alison Rein, Erin Holve	Meeting held 1/30/17
AmeriHealth Caritas	Pete Stoessel, Erin Holve	Meeting held 3/16/17

- Very collegial discussions
- Materials are at right level - questions generate good conversation
- Based on early feedback, are developing some 'use cases' to facilitate discussion (e.g. for members/non-members; for policy and planning, etc.)
- Some groups at very early stage of HIE; great opportunity to continue a dialogue

Outreach Meetings: Up Next….

Organization	HIEPB Attendees	Dates
CareFirst	Claudia Schlosberg, Christian Barrera, Erin Holve	Scheduled 4/25, 10a – 11a
GWU Hospital/MFA	Alison Rein, Erin Holve	Scheduling for April/May
Gerald Family Care	TBD	Scheduling for April/May
Sibley Hospital	TBD	Scheduling for April/May
MedStar Health	TBD	Scheduling for April/May
Providence Hospital	TBD	Scheduling for April/May
DC DBH	TBD	Scheduling for April/May
DC FEMS	TBD	Scheduling for April/May
DC DHS	TBD	Scheduling for April/May
DC DOH	TBD	Scheduling for April/May
DC Hospital Association	TBD	Scheduling for April/May
DC Nursing Association	TBD	Scheduling for April/May
DC Health Care Association	TBD	Scheduling for April/May
DC Primary Care Association	TBD	Scheduling for April/May

Upcoming Subcommittee Meetings

- Sustainability Subcommittee Meeting
  - Next Meeting: Early June, TBD

- Special Meeting of HIE Policy Board on Sustainability – late June

ENHANCED HIE TOOL DEMONSTRATION

CRISP

DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

DHCF 2017 DC Enhanced Health Information Exchange (HIE) Project

2017.04.20

7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046
877.952.7477 | support@crisphealth.org
www.crisphealth.org

Agenda

- DC Enhanced HIE Project Background
- DC Enhanced HIE Project Initiatives
  - Dynamic Patient Care Profile
  - Analytical Patient Population Dashboard
    - DCPCA Reports
    - CRISP Reports
  - Electronic Clinical Quality Measurement Tool and Dashboard
  - Obstetrics/Prenatal Specialized Registry
  - Analytical Patient Population Dashboard
    - DCPCA Reports
    - CRISP Reports
  - Ambulatory Connectivity and Support
- Next Steps
- Addendum
  - Alignment to DHCF Goals

DC Enhanced HIE Project Background

On March 28, 2017 the Government of the District of Columbia's Department of Health Care Finance (DHCF) signed an agreement with Chesapeake Regional Information for our Patients (CRISP) to implement five health information exchange (HIE) initiatives to bolster the exchange and integration of data associated with population health, social determinants of wellbeing, clinical care and health-related service utilization throughout the care continuum. CRISP will work with DC Primary Care Association (DCPCA) to implement the following:

- Dynamic Patient Care Profile
- Analytical Patient Population Dashboard
- Electronic Clinical Quality Measurement Tool and Dashboard
- Obstetrics/Prenatal Specialized Registry
- Ambulatory Connectivity and Support

DC Enhanced HIE Project Initiatives Overview

#	Initiative	Initiative Description
1	Dynamic Patient Care Profile	Design and implement an 'on-demand' web based document accessible to eligible professionals (EPs) and eligible hospitals (EHs) (in addition to members of their care team) that would display an aggregation of both clinical and non-clinical data for a selected patient
2	Analytical Patient Population Dashboard	Design and develop a population-level dashboard accessible by EPs and EHs for patient panel management.
3	Electronic Clinical Quality Measurement Tool and Dashboard	Design and implement an electronic clinical quality measurement (eCQM) tool that aggregates and analyzes data captured through Continuity of Care Documents (CCDs) submitted by EPs and EHs to calculate their performance against quality measures for their empaneled patient population

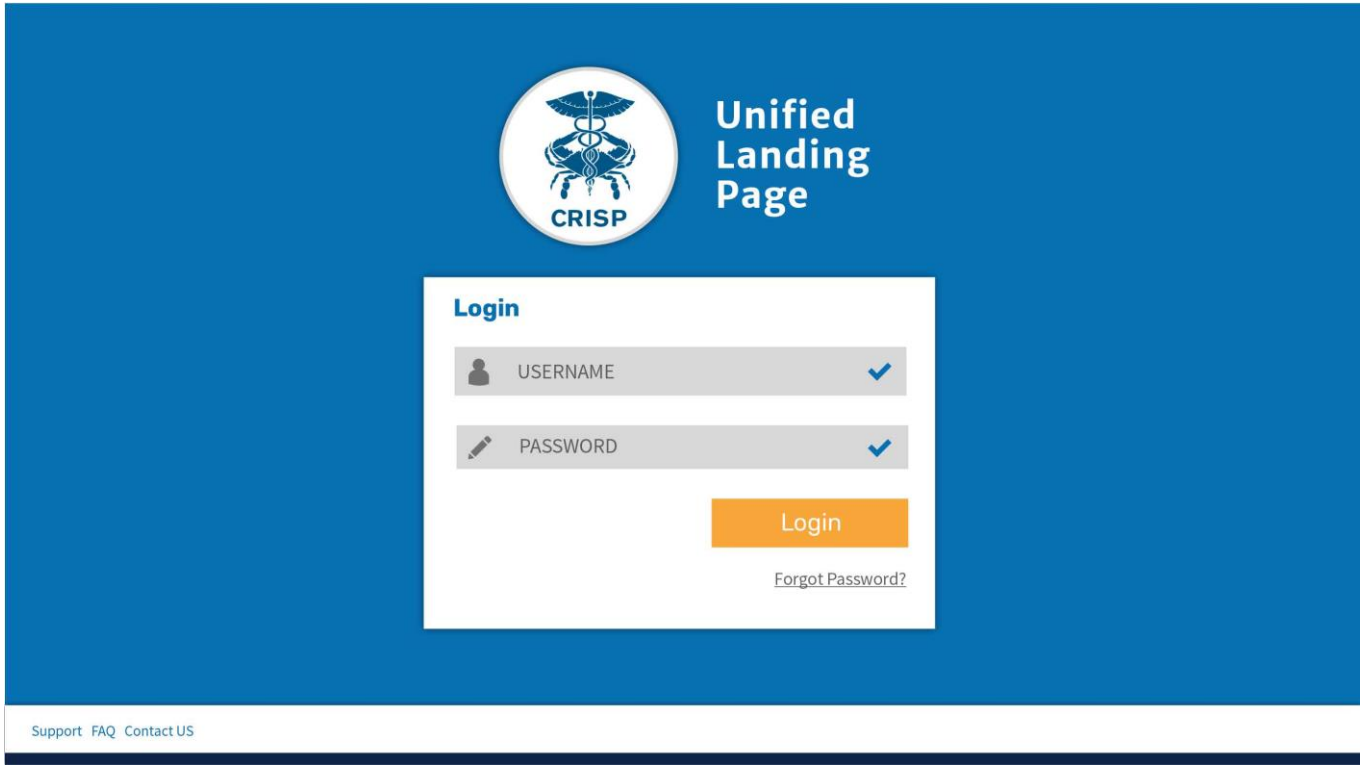
DC Enhanced HIE Project Initiatives Overview

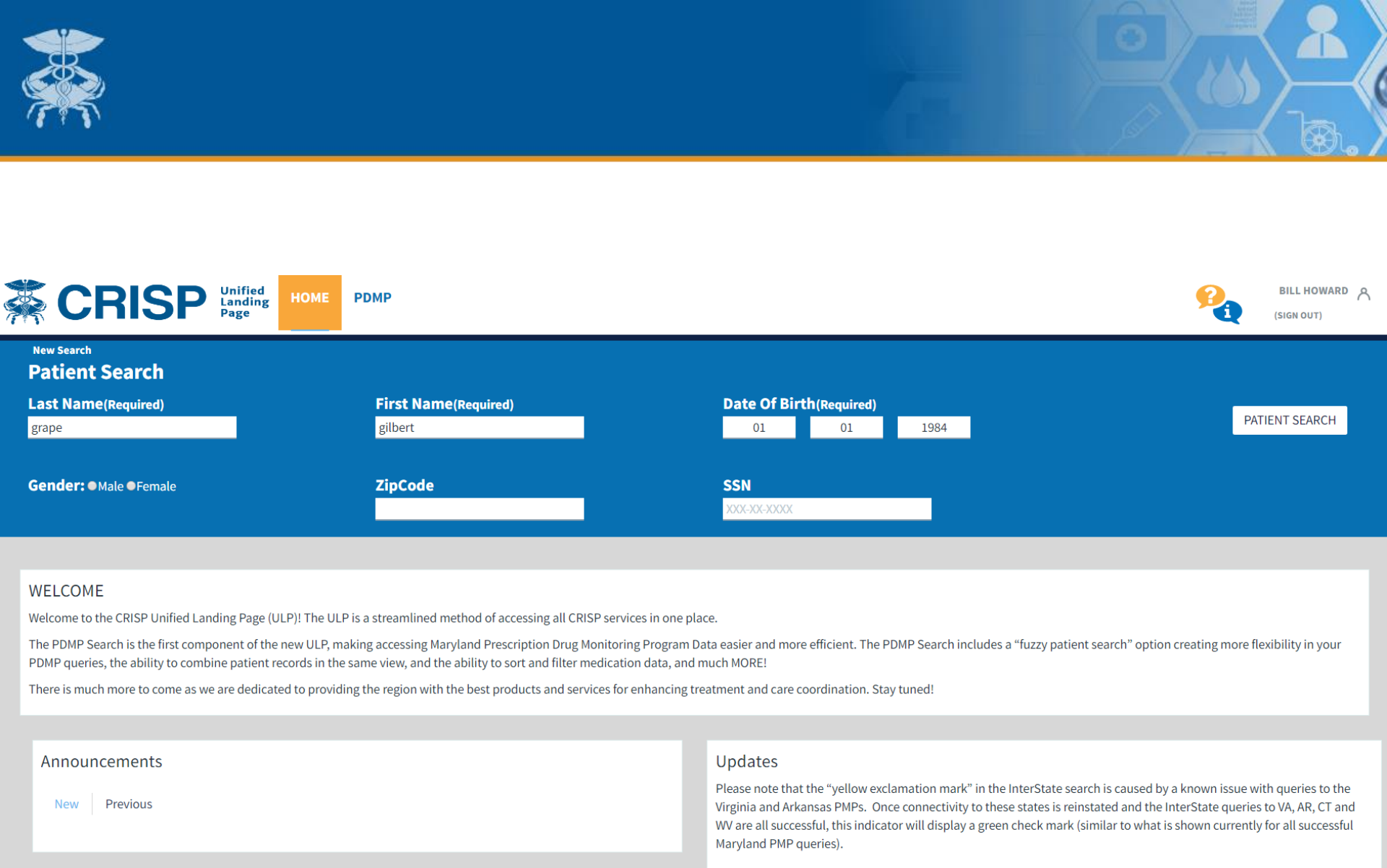
#	Initiative	Initiative Description
4	Obstetrics/Prenatal Specialized Registry	Design and develop an electronic form within a District-specified electronic health record (EHR) environment, along with a separate web-based accessible outside of that EHR system, that enables EPs and EHs to directly enter and submit data associated with prenatal screenings and assessments to the District's OB/Prenatal Specialized Registry.
5	Ambulatory Connectivity and Support	Engage EPs and support their connection to the DC HIE, including technical assistance aimed at the advanced use of HIE services.

Dynamic Patient Care Profile

CRISP Unified Landing Page Approach

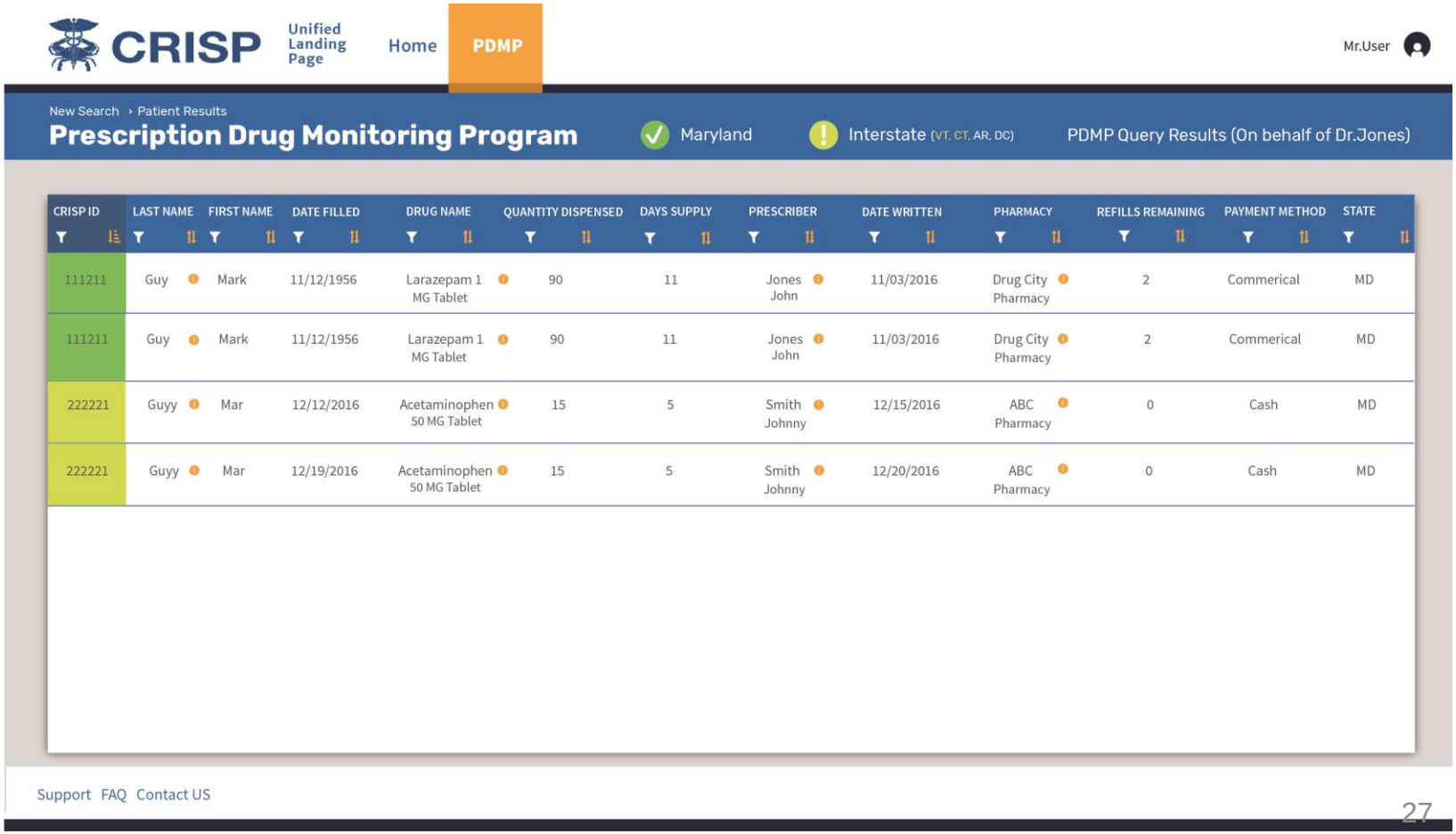
- The care profile will be developed within CRISP's current Unified Landing Page (ULP); a web application that allows users to access multiple data types.
- ULP will make "calls" for data stored in multiple locations.
- Initially, those data will include Medicaid claims data, ENS subscriber data, and information from the DHS Homeless Management Information System.




CRISP
Unified Landing Page
HOME
PDMP
BILL HOWARD
(SIGN OUT)
New Search
Patient Search
Last Name(Required)
grape
First Name(Required)
gilbert
Date Of Birth(Required)
01
01
1984
PATIENT SEARCH
Gender: Male Female
ZipCode
SSN
XXX-XX-XXXX
WELCOME
Welcome to the CRISP Unified Landing Page (ULP)! The ULP is a streamlined method of accessing all CRISP services in one place.
The PDMP Search is the first component of the new ULP, making accessing Maryland Prescription Drug Monitoring Program Data easier and more efficient. The PDMP Search includes a "fuzzy patient search" option creating more flexibility in your PDMP queries, the ability to combine patient records in the same view, and the ability to sort and filter medication data, and much MORE!
There is much more to come as we are dedicated to providing the region with the best products and services for enhancing treatment and care coordination. Stay tuned!
Announcements
New
Previous
Updates
Please note that the "yellow exclamation mark" in the InterState search is caused by a known issue with queries to the Virginia and Arkansas PMPs. Once connectivity to these states is reinstated and the InterState queries to VA, AR, CT and WV are all successful, this indicator will display a green check mark (similar to what is shown currently for all successful Maryland PMP queries).

Dynamic Patient Care Profile

The screen below shows a current view CRISP has created within ULP for Maryland's prescription drug monitoring program.



Mock-Up of Relevant Content

Table Key	
	Data Currently available
	Data Avaiable in the future

CARE PROFILE VIEW - MOCK UP

PATIENT DEMOGRAPHICS
Name : John X. Smith
DOB : 04/09/1954
Address: 3700 Massachusetts Ave NW, Washington DC, 20016
Phone: 202-444-7777
Phone: 202-555-3232

SUBSCRIBERS OF ENCOUNTER INFO		
Organization	POC	Phone
Bread for the City	Dr. X	2025556688
Trusted Health Plan		
MFA	Dr. O	2025679876

HOUSING STATUS		CHRONIC CONDITIONS		IMMUNIZATIONS		MEDICATIONS	
Status	Date	Type	Date	Type	Date	Type	Date
Permanent Supportive Housing	10/10/2010	COPD	3/21/2008	MMR	6/6/2015	Metformin	2/15/2014
		Diabetes	8/22/1982	Influenza	11/11/2014	Levalbuterol	6/11/2009
						Insulin	11/23/1985

CARE MANAGEMENT								
Name	Phone Number	Email	Start Date	End Date	Short / Long term	Type	Organization	Care Plan available
Ms. Mary Von	443-410-4100	mvon@hcc.org	2/1/2014	2/1/2016	Long term	Diabetes control	Trusted Health Plan	Yes, click HERE to view
Sally Brown	443-555-8787	sallyomailey@cfmp.org	3/1/2014	6/1/2014	Short	COPD	Providence Hospital	Yes, click HERE to view

RISK STRATIFICATION		
Risk Type	Score	Band
Redmission	51	Medium
Re-ED visit	70	High

ADVANCE DIRECTIVE	
Date	Facility
4/11/2007	myadvancedirectives.com

ENCOUNTER NOTIFICATIONS

HOSPITAL ADT IN THE LAST 60 DAYS		
Date	Facility	Visit Type
6/15/2014	Providence Hospital	ER visit
7/2/2015	Howard University Hospita	OBV visit

AMBULATORY ADT IN THE LAST 60 DAYS		
Date	Facility	Visit Type
6/15/2014	MFA	
7/2/2015	Bread for the City	

PAST 12 MONTH DC MEDICAID CLAIMS DATA (MM-DD-YYYY - MM-DD-YYYY)

Patient Total at All Hospitals

Total Charges	$423,868
Total Visits	38
Total Hospitals	11
Zip on Last Visit	20001

Primary Payer: Medicaid fee for service

Secondary Payer: Other

Conditions

- Chronic Obstructive Pulmonar
- Chronic: Asthma
- Chronic: Chronic Kidney Dise
- Chronic: Diabetes
- Chronic: Heart Failure
- Chronic: Hyperlipidemia
- Chronic: Hypertension
- Mental Health: Depression

Case Mix Data Through: August 2015

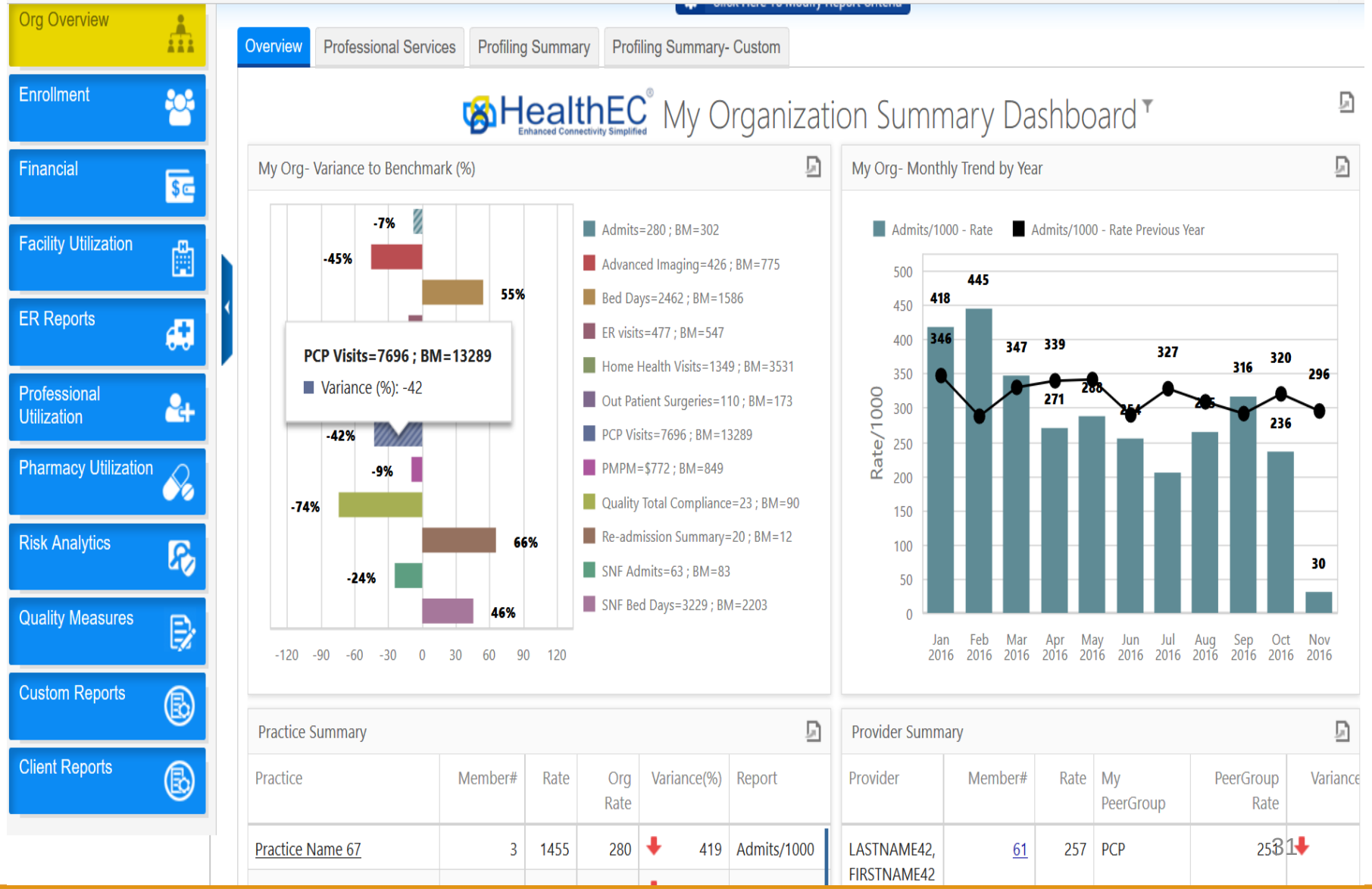
Admit Date	Discharge Date	Hospital Name	MRN	Visit Type	IP Re admit	Pqi	DRG	DRG Description	SOI	Dx1Description	Dx1	Dx2	Dx3	Dx4
9/25/2015	9/25/2015	Hospital 1	123456789	IP	Yes	Yes	048	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	3	"DIAB NEURO MANIF TYPE II"	25060	40391	3441	5856
9/25/2015	9/25/2015	Hospital 2	987654321	OBV		Yes				"DIAB NEURO MANIF TYPE II"	25060	5363	5856	V4511
9/25/2015	9/25/2015	Hospital 1	123123123	ED						"ABDOM PAIN GENERALIZED (Begin 1994)"	78907	7295	25000	V5867
9/25/2015	9/25/2015	Hospital 3	123456789	IP	Yes		460	RENAL FAILURE	3	"HYP RENAL NOS W REN FAIL (Begin 1989)"	40391	2761	4168	5363
9/25/2015	9/25/2015	Hospital 1	987654321	OBV		Yes				"DIAB NEURO MANIF TYPE II"	25060	5363	V58..	40391
9/25/2015	9/25/2015	Hospital 3	987654321	OBV						"GASTROPARESIS (Begin 1994)"	5363	3441	40391	5856
9/25/2015	9/25/2015	Hospital 1	654321	IP	Yes	Yes	048	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	3	"DIAB NEURO MANIF TYPE II"	25060	40391	3441	2761

Reporting and Analytics

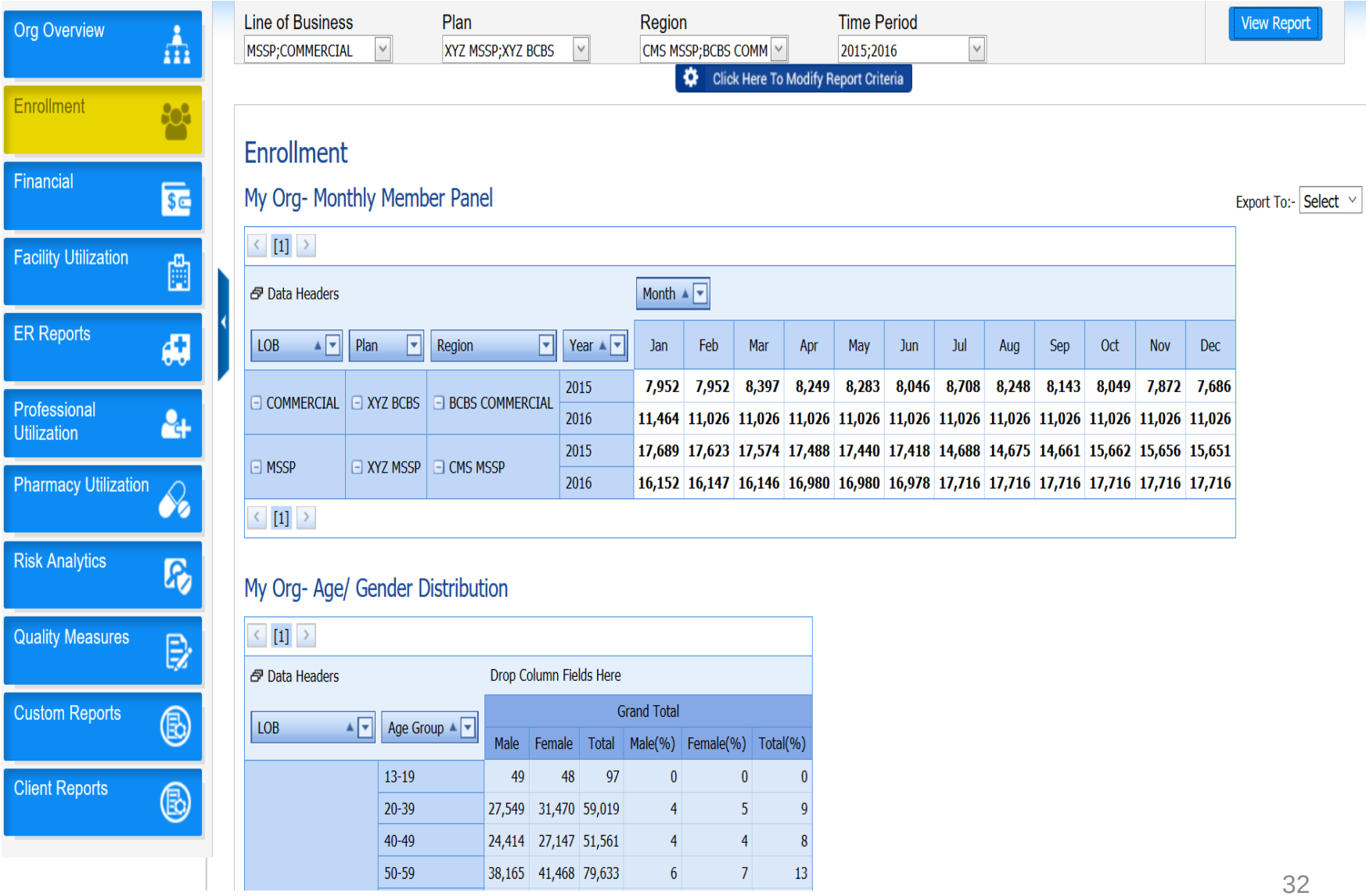
Analytical Patient Population Dashboard

- DCPCA has 100+ standard reports to meet providers current needs and can be rolled out to a broader group
- CRISP has developed customized dynamic reports and virtualizations so end-users can interact with their data

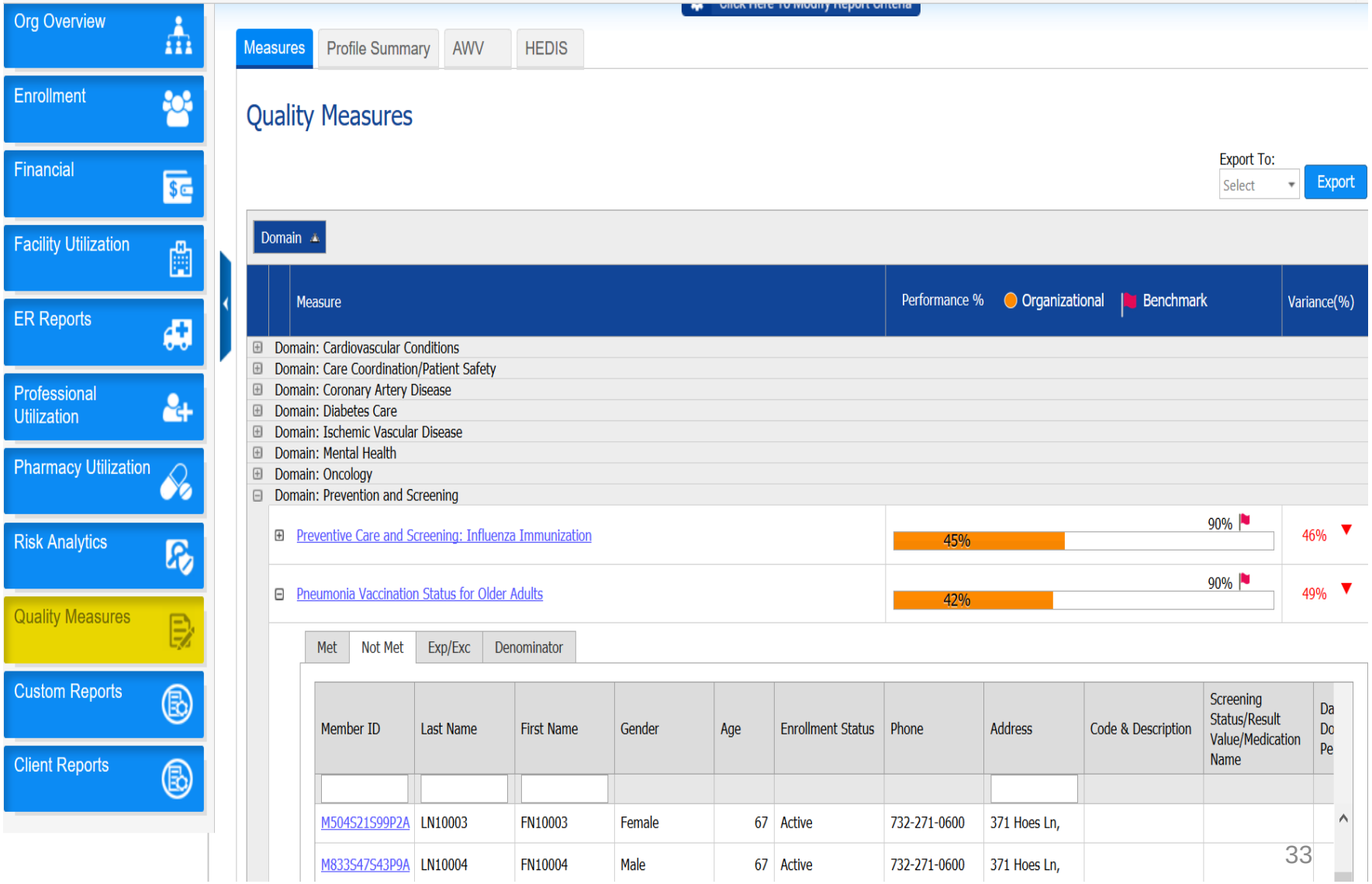
Organizational KPI Dashboard - DCPCA



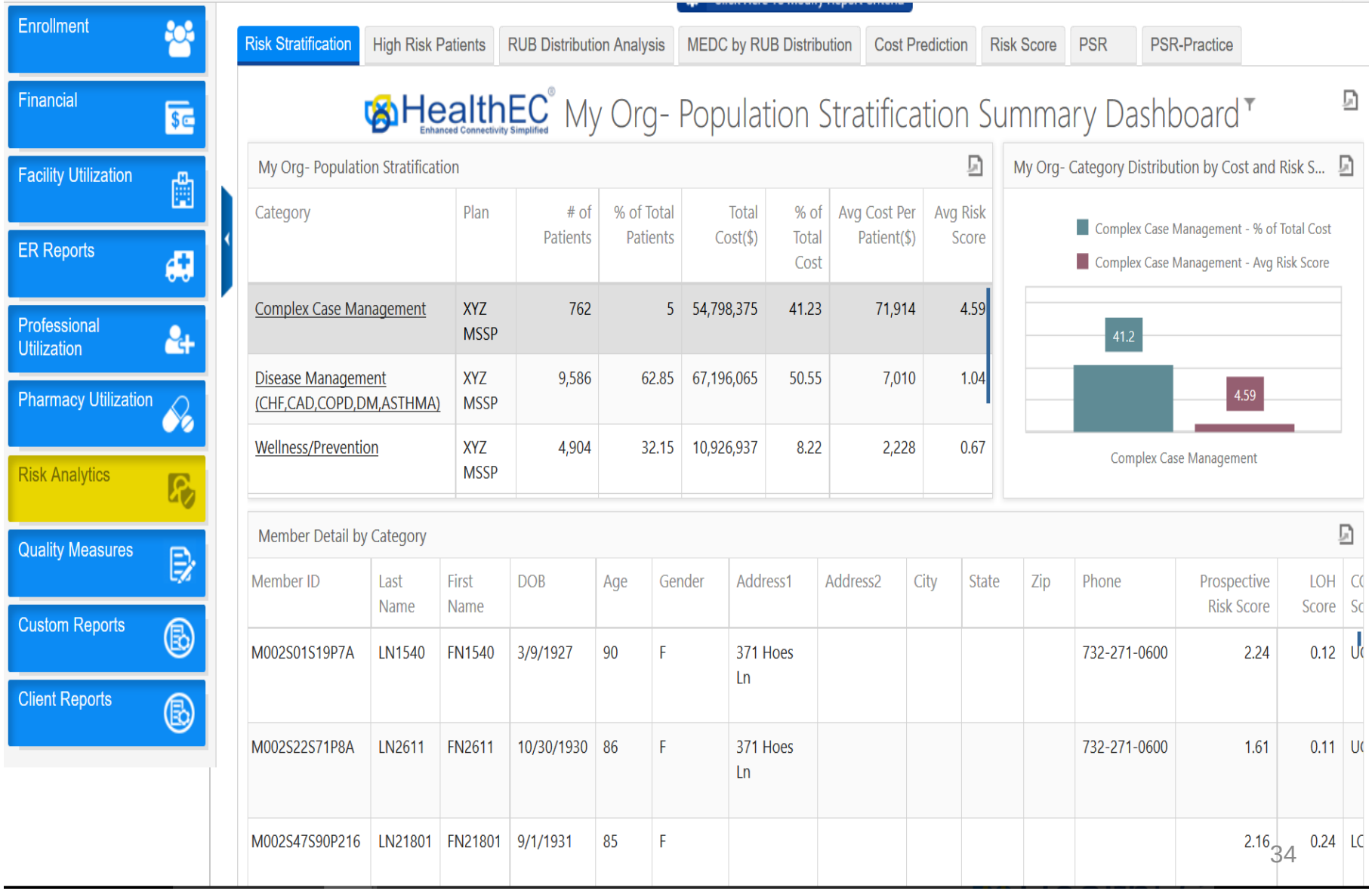
Monthly Enrollment by Facility and Payor - DCPCA



Quality Measures - DCPCA



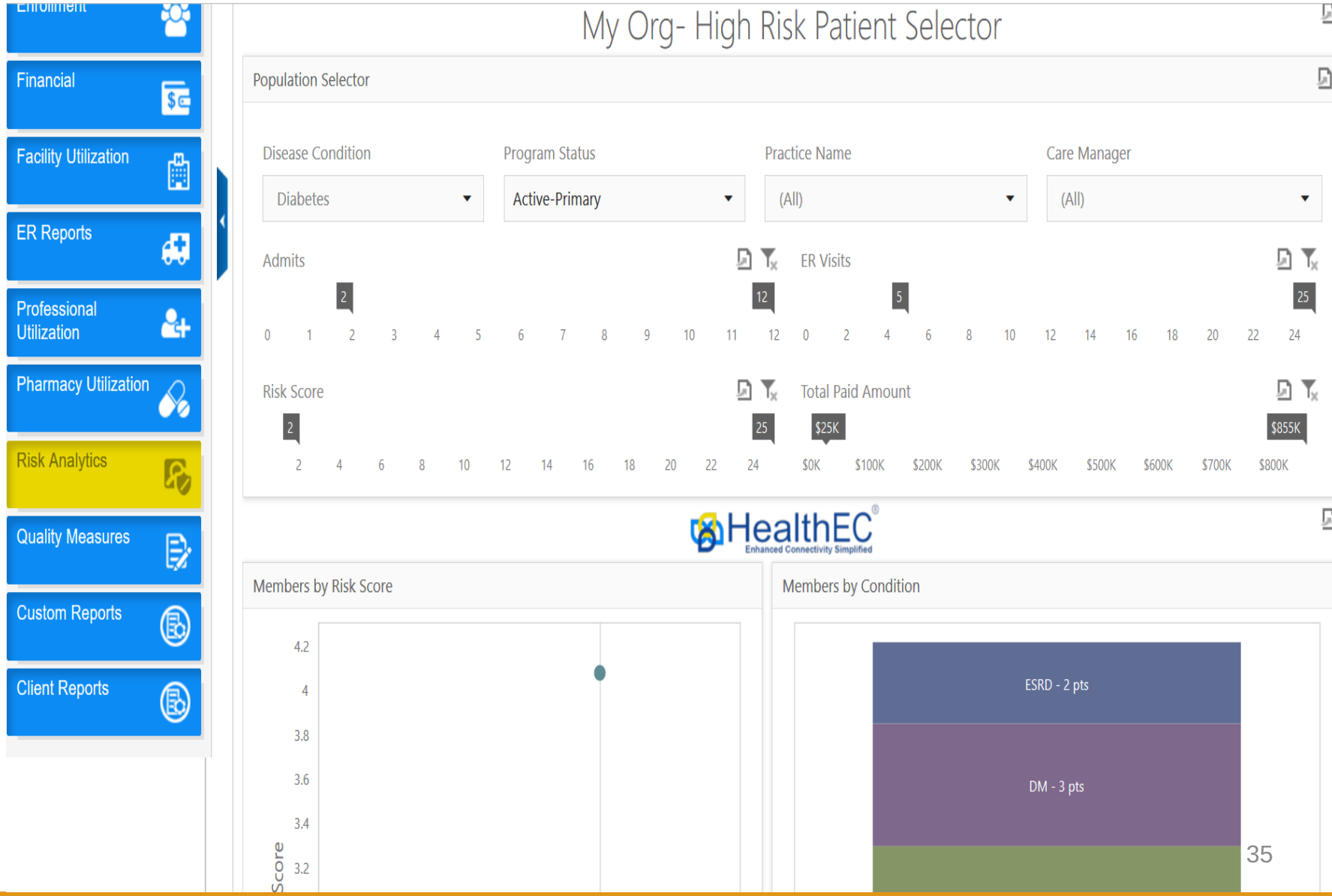
Population Risk Stratification Report - DCPCA



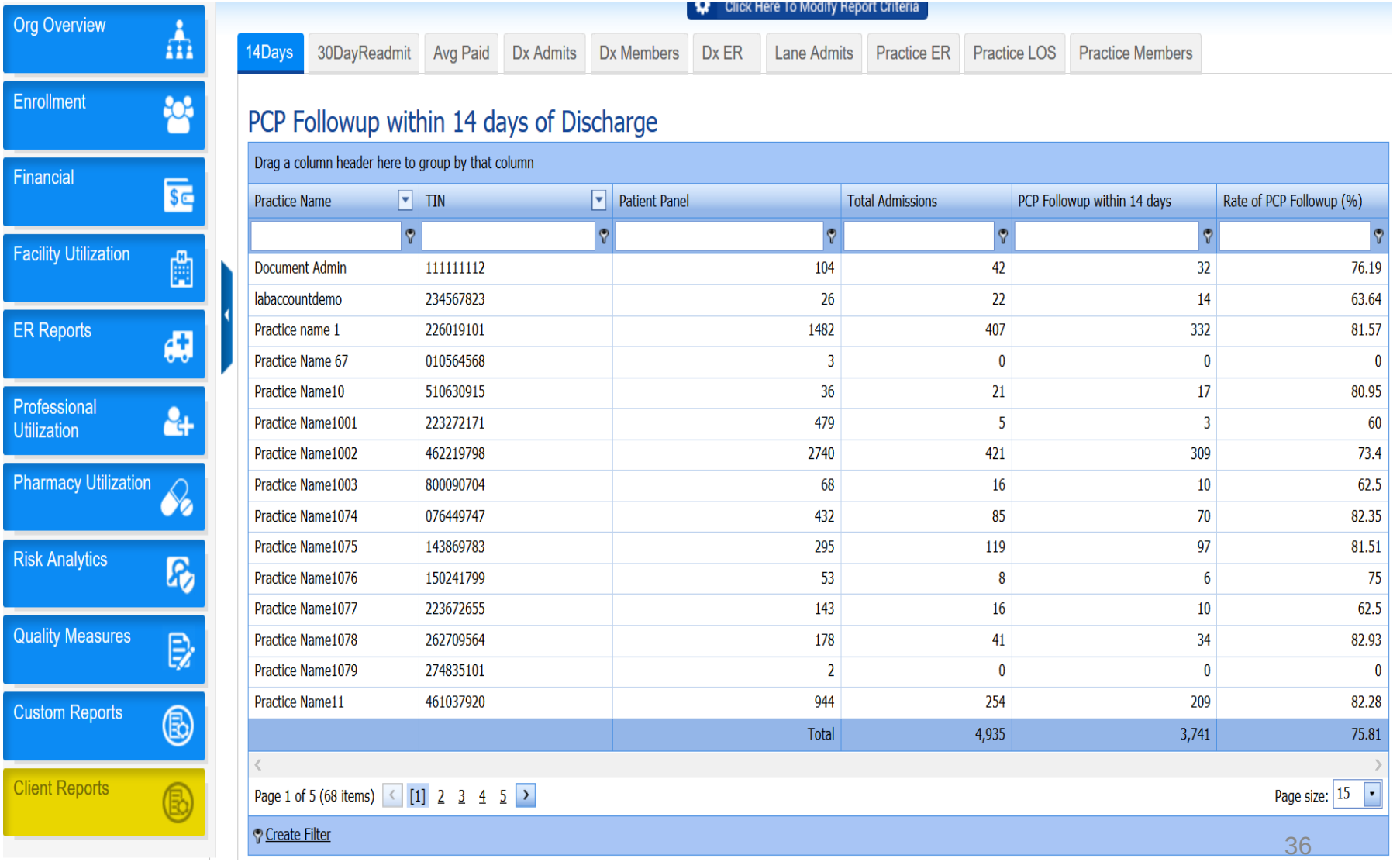
Category	Plan	# of Patients	% of Total Patients	Total Cost($)	% of Total Cost	Avg Cost Per Patient($)	Avg Risk Score
Complex Case Management	XYZ MSSP	762	5	54,798,375	41.23	71,914	4.59
Disease Management (CHF,CAD,COPD,DM,ASTHMA)	XYZ MSSP	9,586	62.85	67,196,065	50.55	7,010	1.04
Wellness/Prevention	XYZ MSSP	4,904	32.15	10,926,937	8.22	2,228	0.67

Member ID	Last Name	First Name	DOB	Age	Gender	Address1	Address2	City	State	Zip	Phone	Prospective Risk Score	LOH Score	CC Sc
M002S01S19P7A	LN1540	FN1540	3/9/1927	90	F	371 Hoes Ln					732-271-0600	2.24	0.12	UC
M002S22S71P8A	LN2611	FN2611	10/30/1930	86	F	371 Hoes Ln					732-271-0600	1.61	0.11	UC
M002S47S90P216	LN21801	FN21801	9/1/1931	85	F							2.16	0.24	LC

High Risk Patient Selector - DCPCA



Post Discharge Follow-up Reports - DCPCA



PCP Followup within 14 days of Discharge

Drag a column header here to group by that column

Practice Name	TIN	Patient Panel	Total Admissions	PCP Followup within 14 days	Rate of PCP Followup (%)
Document Admin	111111112	104	42	32	76.19
labaccountdemo	234567823	26	22	14	63.64
Practice name 1	226019101	1482	407	332	81.57
Practice Name 67	010564568	3	0	0	0
Practice Name10	510630915	36	21	17	80.95
Practice Name1001	223272171	479	5	3	60
Practice Name1002	462219798	2740	421	309	73.4
Practice Name1003	800090704	68	16	10	62.5
Practice Name1074	076449747	432	85	70	82.35
Practice Name1075	143869783	295	119	97	81.51
Practice Name1076	150241799	53	8	6	75
Practice Name1077	223672655	143	16	10	62.5
Practice Name1078	262709564	178	41	34	82.93
Practice Name1079	274835101	2	0	0	0
Practice Name11	461037920	944	254	209	82.28
		Total	4,935	3,741	75.81

Page 1 of 5 (68 items) [1] 2 3 4 5 Page size: 15

Create Filter

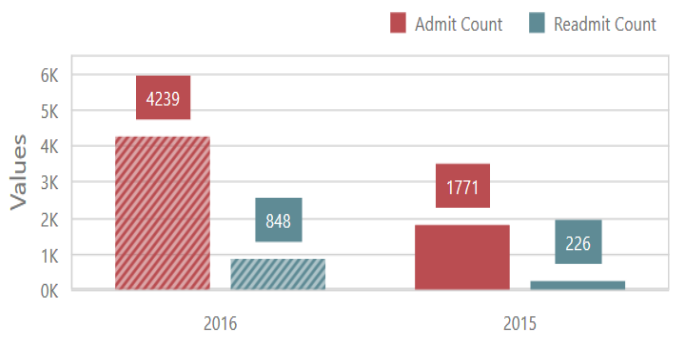
Hospital Readmissions by Diagnosis/Facility - DCPCA

- Enrollment
- Financial
- Facility Utilization
- ER Reports
- Professional Utilization
- Pharmacy Utilization
- Risk Analytics
- Quality Measures
- Custom Reports
- Client Reports

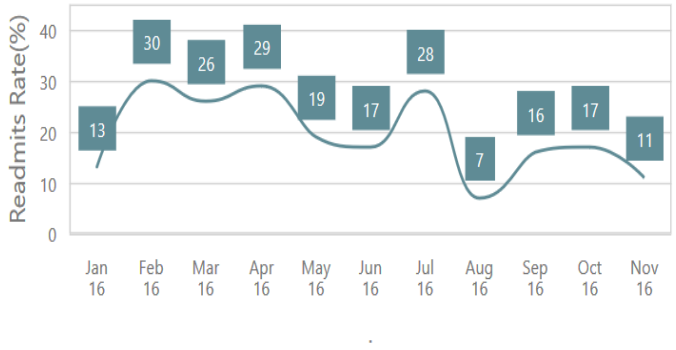
HealthEC Enhanced Connectivity Simplified

My Org- All Cause Readmission Summary 2016

My Org- Readmission Summary



My Org- Readmits Rate Monthly Trends



My Org- Readmits by DxG

Diag Group	Admissions	Re-Admissions	Re-Admit Rate By Diagnosis	All Admissions
Septicemia (except in labor)	316	78	24.68%	7.45%
Congestive heart failure; nonhypertensive	249	72	28.92%	5.87%
Cardiac dysrhythmias	149	40	26.85%	3.51%
Undefined DxGroup	216	32	14.81%	5.10%

My Org- Readmits by Facility

Facility Name	Admissions	Re-Admissions	Re-Admit Rate By Facility	All Admissions
LASTNAME4817	1760	350	19.89%	41.52%

Low Acuity Non Emergent (LANE) Hospital Admission Rates - DCPCA

- Org Overview
- Enrollment
- Financial
- Facility Utilization
- ER Reports
- Professional Utilization
- Pharmacy Utilization
- Risk Analytics
- Quality Measures
- Custom Reports
- Client Reports

14Days | 30DayReadmit | Avg Paid | Dx Admits | Dx Members | Dx ER | **Lane Admits** | Practice ER | Practice LOS | Practice Members

Lane Admits

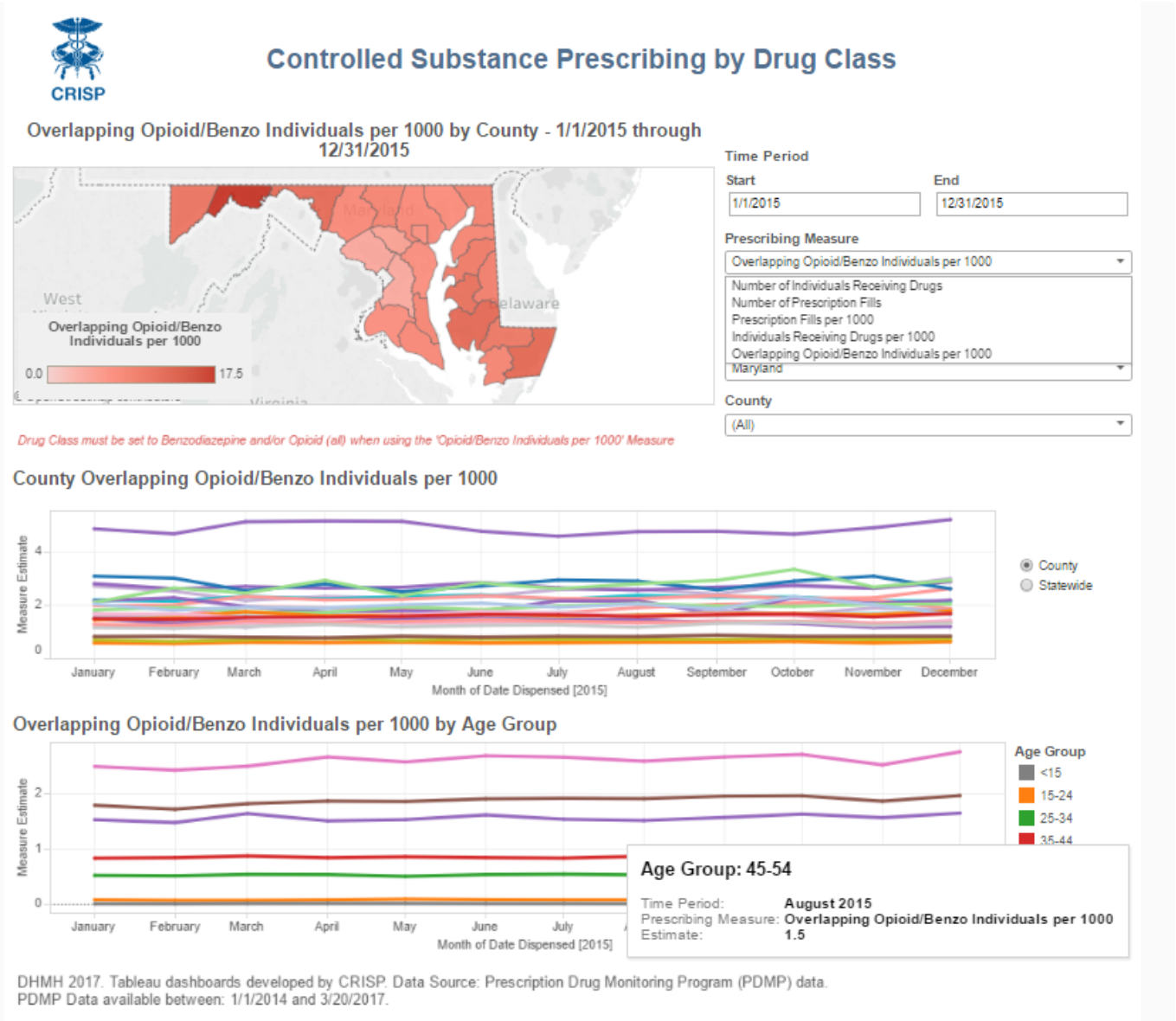
Drag a column header here to group by that column

Practice Name	TIN	Patient Panel	Total Admissions	LANE Code Admissions	LANE Admit Rate (%)	Top 10 LANE Codes
						pneumo
Document Admin	111111112	104	42	2	4.76	486-PNEUMO
Practice name 1	226019101	1482	407	10	2.46	486-PNEUMO
Practice Name1002	462219798	2740	421	7	1.66	486-PNEUMO
Practice Name1074	076449747	432	85	2	2.35	486-PNEUMO
Practice Name1075	143869783	295	119	1	0.84	486-PNEUMO
Practice Name1078	262709564	178	41	1	2.44	486-PNEUMO
Practice Name11	461037920	944	254	3	1.18	486-PNEUMO
Practice Name15	300210090	505	26	1	3.85	486-PNEUMO
Practice Name21	223846374	257	34	1	2.94	486-PNEUMO
Practice Name23	223785108	479	62	1	1.61	486-PNEUMO
Practice Name24	223782703	452	65	3	4.62	486-PNEUMO
Practice Name25	223748778	499	141	3	2.13	486-PNEUMO, 491.21-OBS
Practice Name27	223736706	924	92	2	2.17	486-PNEUMO
Practice Name29	223681937	808	67	2	2.99	486-PNEUMO
Practice Name30	223671927	625	88	1	1.14	486-PNEUMO
		Total	4,509	133	2.95	

Page 1 of 3 (39 items) [1] 2 3 Page size: 15

Contains([Top 10 LANE Codes], 'pneumo') Clear

Controlled Substance Prescribing by Drug Class - CRISP



DHMH 2017. Tableau dashboards developed by CRISP. Data Source: Prescription Drug Monitoring Program (PDMP) data.
PDMP Data available between: 1/1/2014 and 3/20/2017.

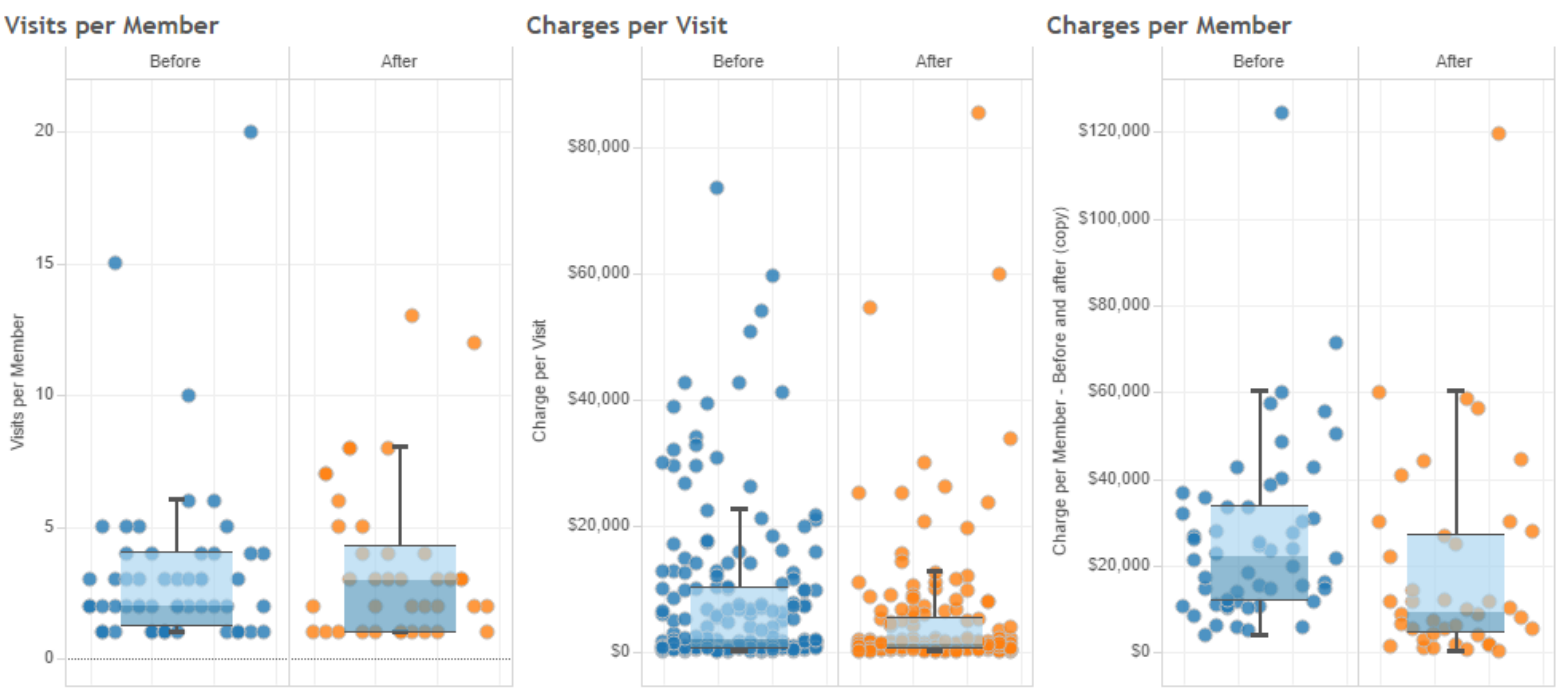
Analytical Patient Population Dashboard - CRISP

Uses Panel Information and Visits data to see distribution before and after interventions

Pre/Post Analysis

Analysis of 3 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.



Visit Type

- [x] (All)
- [x] ED
- [x] IP
- [x] OP

Apply Cancel

Hospital Name: (All)

Time Period: 3 Months

Program Name

- (All)
- 3CI
- 3CI-Engaged
- 3CI-NotEngaged
- BSB
- BSHEZ-Engaged
- BSHEZ-NotEngaged
- HCAM
- Healthy Howard - Discharged 6m...
- Healthy Howard - Discharged 12...
- Healthy Howard - Graduated 6mos
- Healthy Howard - Graduated 12m...
- SAH
- SJMC - Community Providers

- DHMH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Trend Analysis Before and After Enrollment into Program - CRISP

Summary | Panel Analysis | Overall Trend Analysis | Relative Trend Analysis | Distribution of Charges and Visits | Breakdown of Charges | Notes

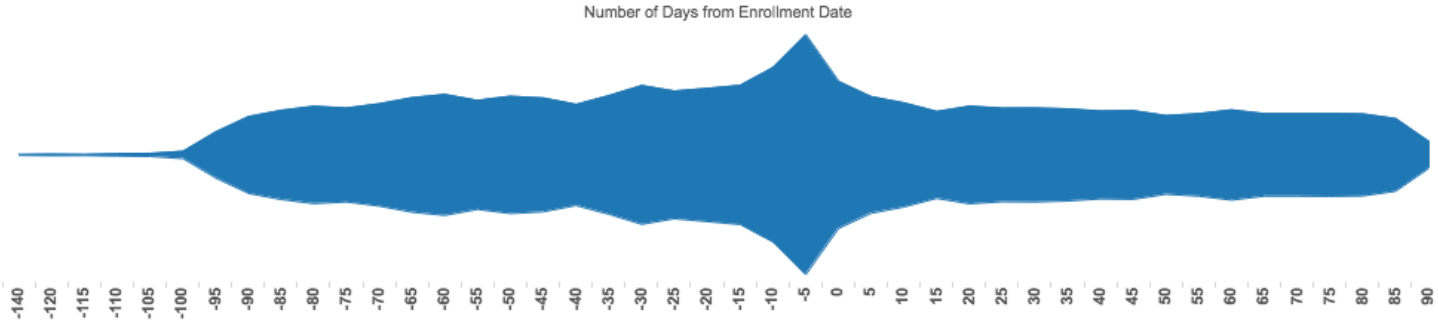
CRISP

Pre/Post Analysis

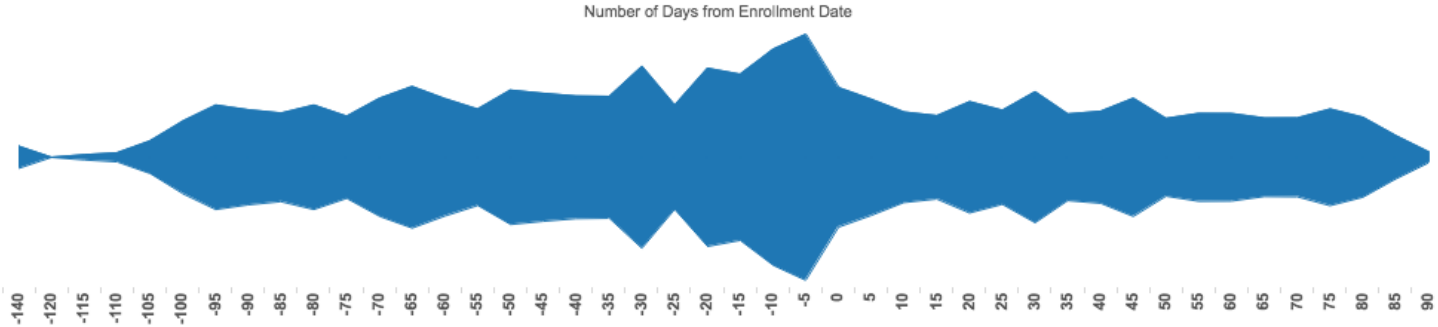
Analysis of 3 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Visits Trend



Charges Trend



- DHMH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Comparing 2 Programs - CRISP

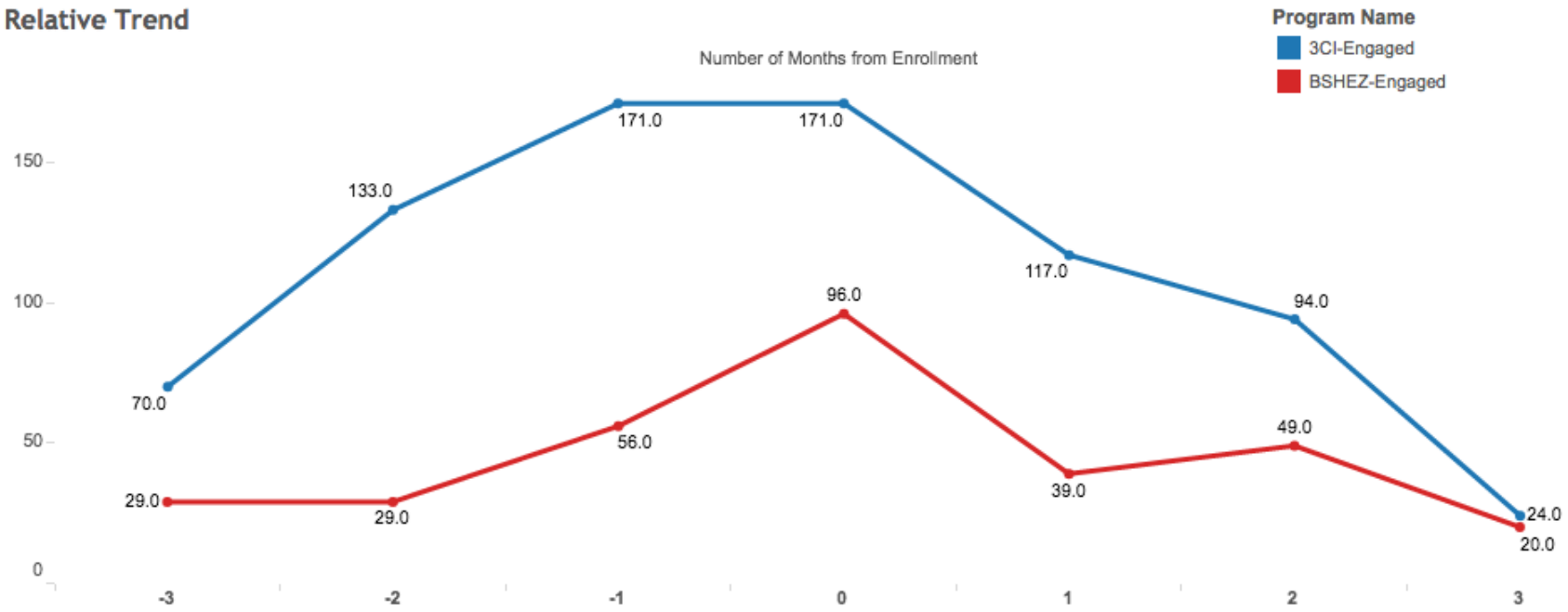
CRISP

Pre/Post Analysis

Analysis of 3 Months of Visits Before and After the Enrollment Date

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Relative Trend



- DHMH and HSCRC, 2016. Tableau dashboards developed by CRISP.

Service Line Breakdown of Charges Before and After Intervention - CRISP

Summary | Panel Analysis | Overall Trend Analysis | Relative Trend Analysis | Distribution of Charges and Visits | Breakdown of Charges | Notes

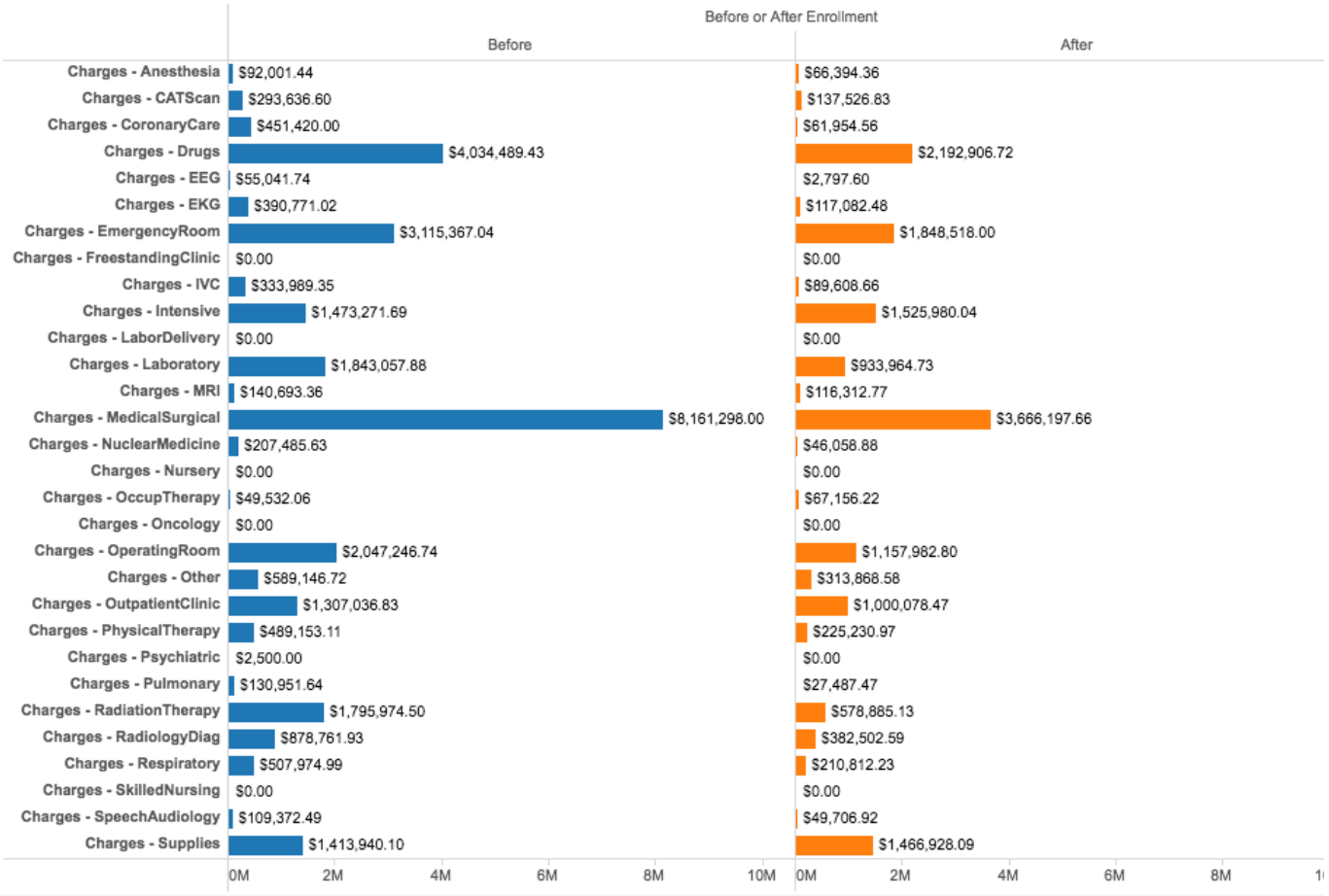
CRISP

Pre/Post Analysis

Analysis of 3 Months of Visits Before and After the Enrollment Date

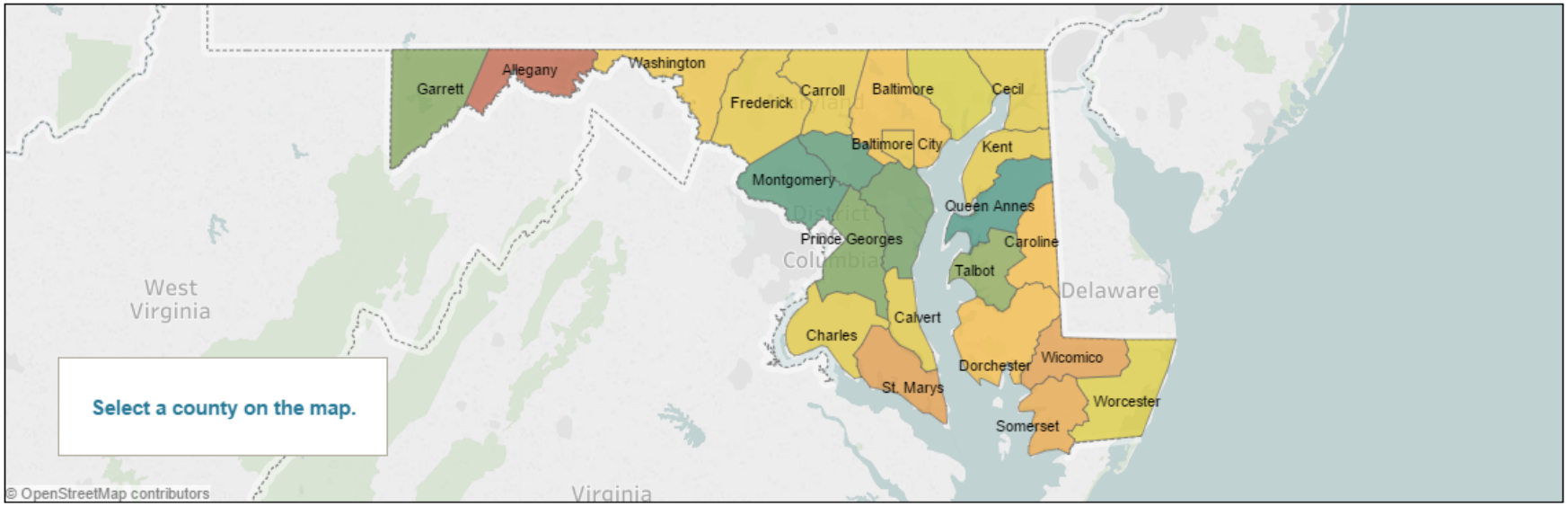
The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

Breakdown of Charges Sheet

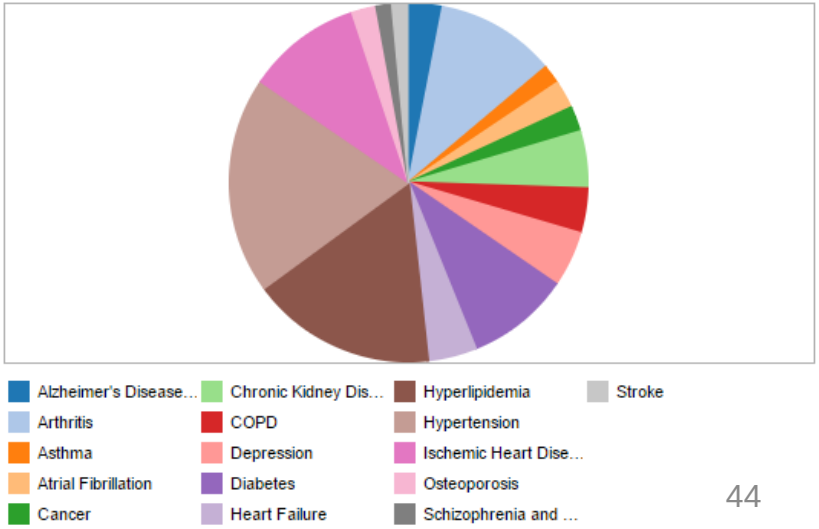


Analytical Patient Population Dashboard - CRISP

CMS' Medicare Chronic Condition Data - Prevalence in Maryland Counties



Chronic Conditions	Allegany	
	Chronic Condition Prevalence	Difference from Statewide Prevale..
Alzheimer's Disease/Dementia	10.07%	0.07
Arthritis	35.69%	6.60
Asthma	5.71%	0.77
Atrial Fibrillation	8.32%	0.44
Cancer	7.52%	-1.23
Chronic Kidney Disease	16.99%	0.67
COPD	13.33%	3.36
Depression	16.59%	2.69
Diabetes	30.72%	2.14
Heart Failure	14.50%	0.85
Hyperlipidemia	55.09%	5.82
Hypertension	64.71%	5.23
Ischemic Heart Disease	34.17%	5.66
Osteoporosis	7.33%	0.86
Schizophrenia and Other Psychotic Disorders	4.67%	1.30
Stroke	4.89%	0.49



Electronic Clinical Quality Measurement Tool and Dashboard

What are Clinical Quality Measures?

CMS.gov
Centers for Medicare & Medicaid Services

Clinical quality measures, or CQMs, are tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals (CAHs) within our health care system. These measures use data associated with providers' ability to deliver high-quality care or relate to long term goals for quality health care. CQMs measure many aspects of patient care including:

- health outcomes
- clinical processes
- patient safety
- efficient use of health care resources
- care coordination
- patient engagements
- population and public health
- adherence to clinical guidelines

Measuring and reporting CQMs helps to ensure that our health care system is delivering effective, safe, efficient, patient-centered, equitable, and timely care.

To participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs and receive an incentive payment, providers are required to submit CQM data from certified EHR technology.

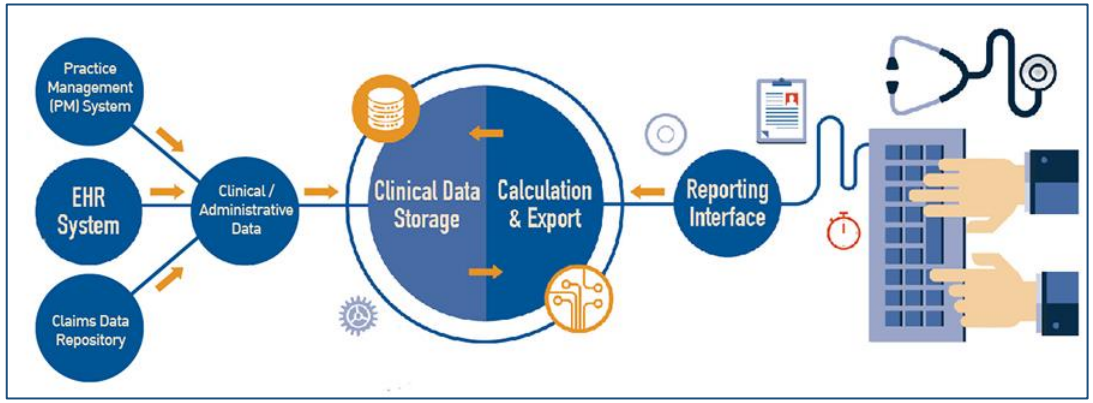
How can CQMs help?

CQM examples:

CMS eMeasure ID (For Reporting in 2016)	NQF #	Measure Title and CMS Domain	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	PQRS#
CMS165v4	0018	Controlling High Blood Pressure Domain: Clinical Process/ Effectiveness	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period	National Committee for Quality Assurance	236 GPRO HTN-2
CMS138v4	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Domain: Population/ Public Health	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period	American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	226 GPRO PREV-10
CMS125v4	Not Applicable	Breast Cancer Screening Domain: Clinical Process/ Effectiveness	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	Women with one or more mammograms during the measurement period or the year prior to the measurement period	Women 41-69 years of age with a visit during the measurement period	National Committee for Quality Assurance	112 GPRO PREV-5

What is CAliPHR?

CAliPHR is designed to calculate electronic clinical quality measures (eCQMs) at a provider, practice, payment arrangement, and community level to support incentive and value-based payment programs.



Highlights:

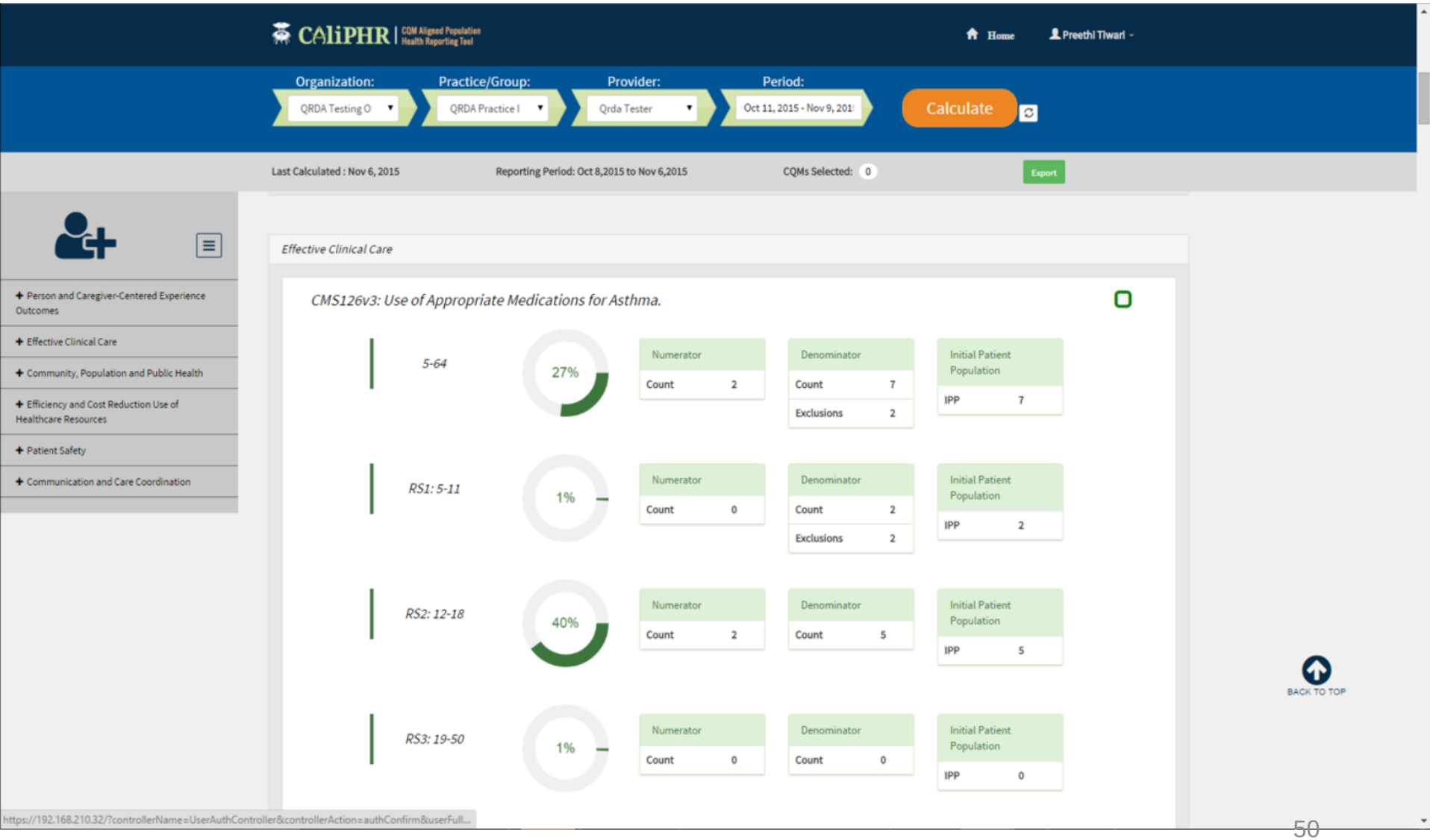
- ❑ Capable of calculating eCQMs from C-CDA or QRDA Category 1 files
- ❑ Achieved ONC 2014 Edition Certification for:
  - (c)(1) – Capture and Export
  - (c)(2) – Import and Calculate
  - (c)(3) – Electronic Submission
  - (d)(5) – Automatic Log-Off
  - (g)(4) – Quality Management System
- ❑ Multiple data collection methods
- ❑ Capable of accepting and calculating custom eCQMs

CAliPHR - Certified eCQMs

eMeasure ID	NQF#	eMeasure Description Snapshot
CMS122	0059	Diabetes: Hemoglobin A1c Poor Control
CMS123	0056	Diabetes: Foot Exam
CMS124	0032	Cervical Cancer Screening
CMS125	N/A	Breast Cancer Screening
CMS126	0036	Use of Appropriate Medications for Asthma
CMS127	0043	Pneumonia Vaccination Status for Older Adults
CMS129	0389	Prostate Cancer: Avoidance of Overuse of…
CMS130	0034	Colorectal Cancer Screening
CMS131	0055	Diabetes: Eye Exam
CMS132	0564	Cataracts: Complications within 30 Days…
CMS133	0565	Cataracts: 20/40 or Better Visual Acuity…
CMS134	0062	Diabetes: Urine Protein Screening
CMS135	0081	Heart Failure: ACE Inhibitor or ARB Therapy…
CMS137	0004	Initiation and Engagement of Alcohol and…
CMS138	0028	Tobacco Use: Screening and Cessation…
CMS139	0101	Falls: Screening for Future Fall Risk
CMS140	0387	Breast Cancer: Hormonal Therapy for Stage…
CMS141	0385	Colon Cancer: Chemotherapy for AJCC Stage…
CMS142	0089	Diabetic Retinopathy: Communication with…
CMS143	0086	(POAG): Optic Nerve Evaluation
CMS144	0083	Heart Failure: Beta-Blocker Therapy for Left…
CMS145	0070	CAD: Beta-Blocker Therapy - Prior Myocardial…
CMS146	0002	Appropriate Testing for Children w/Pharyngitis
CMS147	0041	Influenza Immunization
CMS148	0060	Hemoglobin A1c Test for Pediatric Patients
CMS149	N/A	Dementia: Cognitive Assessment
CMS153	0033	Chlamydia Screening for Women
CMS154	0069	Appropriate Treatment for Children with URI

eMeasure ID	NQF#	eMeasure Description Snapshot
CMS155	0024	Weight Assessment and Counseling for…
CMS157	0384	Oncology: Medical and Radiation - Pain…
CMS158	N/A	Pregnant Women that had HBsAg Testing
CMS159	0710	Depression Remission at Twelve Months
CMS160	0712	Depression Utilization of the PHQ-9 Tool
CMS161	0104	Adult MDD: Suicide Risk Assessment
CMS163	N/A	Diabetes: LDL Management
CMS164	0068	(IVD): Use of Aspirin or Another Antithro…
CMS165	0018	Controlling High Blood Pressure
CMS166	0052	Use of Imaging Studies for Low Back Pain
CMS167	0088	Diabetic Retinopathy: Documentation of…
CMS169	N/A	Bipolar Disorder and Major Depression…
CMS177	1365	Child and Adolescent MDD: Suicide Risk…
CMS182	N/A	(IVD): Complete Lipid Panel and LDL Control
CMS2	0418	Screening for Clinical Depression and Follow…
CMS22	N/A	Screening for High Blood Pressure and Follow…
CMS50	N/A	Closing the Referral Loop: Receipt of Specialist..
CMS52	0405	HIV/AIDS: Pneumocystis Jiroveci Pneumonia
CMS56	N/A	Functional Status Assessment for Hip…
CMS62	N/A	HIV/AIDS: Medical Visit
CMS65	N/A	Hypertension: Improvement in Blood Pressure
CMS66	N/A	Functional Status Assessment for Knee…
CMS68	0419	Documentation of Current Medications in…
CMS69	0412	BMI Screening and Follow-Up Plan
CMS74	N/A	Primary Caries Prevention Intervention as…
CMS75	N/A	Children Who Have Dental Decay or Cavities
CMS77	N/A	HIV/AIDS: RNA Control for Patients with HIV
CMS82	N/A	Maternal Depression Screening
CMS90	N/A	Functional Status Assessment for Complex…

CAliPHR Screen Shot



DHCF CAliPHR Deployment

Identify DHCF Priority Measures

- eCQMs (Clinical)
- HEDIS/Claims
- Hybrid (Clinical and Claims)

Identify Potential DHCF Programs

- Medicaid EHR Incentive Program
- Quality Payment Program (QPP)
  - Merit-Based Incentive Payment System (MIPS)
  - Alternative Payment Models (i.e. ACO, CPC+, PCMH, etc.)
- DC Public Health Measures

OB Form and Web-Application

Obstetrics/Prenatal Specialized Registry

- The Obstetrics/Prenatal Specialized Registry will address infant mortality and poor birth outcomes.
- Will work with eClinicalWorks (eCW), the largest EHR vendor in the District, to develop a method in which providers can automatically capture and submit Medicaid-required prenatal assessment data from within the eCW platform.
- Form within eCW to allow users to complete and submit the District's current Obstetrical Authorization and Initial Assessment form (OB form).
- Secure website that allows non-eCW users to complete and submit the OB form.

Ambulatory Connectivity and Support

Ambulatory Connectivity and Support

- Many ambulatory providers do not have the connectivity, tools and skills needed to succeed in population-based quality and value-based health care payment models
- Technical assistance to directly engage with Medicaid ambulatory providers
- Assist providers with on-boarding activities associated with DC's growing Health Information Exchange (HIE) services, including those associated with DHCF's Health Home programs

Next Steps

- Develop draft of user stories and functional requirements
- Convene DHCF and other relevant stakeholders to review requirements
- Define claims data necessary to support requirements
- Obtain Medicaid Data Warehouse extract

Addendum

Alignment to DHCF Goals

Overall Vision for HIE in DC

Bolster the exchange/integration of data associated with population health, social determinants of wellbeing, clinical data and health-related service utilization throughout the care continuum to improve health outcomes, control health care costs, and enhance the patient experience of care received throughout DC. ROAD

ROAD MAP GOAL #1: Promote providers' ability to share structured reports on patient care management that promotes coordinated care, quality improvement programs, performance reporting, and public health initiatives, among other aims

Objective	Objective Description	Enhanced HIE Project
Objective A	Increase the ability for EPs and EHs to access key data captured outside of their practices/organizations to improve/manage the health of their patient populations	• Dynamic Patient Care Profile • Ambulatory Connectivity and Support • Analytical Patient Population Dashboard
Objective B	Create a single source for EPs and EHs to access critical patient information	• Dynamic Patient Care Profile • Ambulatory Connectivity and Support • Analytical Patient Population Dashboard
Objective C	Incorporate Medicaid claims data and real-time ambulatory connectivity, alongside existing hospital data networks, to enable greater insight into patient's current and future health beyond the data captured in the individual medical record	• Dynamic Patient Care Profile • Ambulatory Connectivity and Support • Analytical Patient Population Dashboard

Alignment to DHCF Goals

Overall Vision for HIE in DC

Bolster the exchange/integration of data associated with population health, social determinants of wellbeing, clinical data and health-related service utilization throughout the care continuum to improve health outcomes, control health care costs, and enhance the patient experience of care received throughout DC. ROAD

ROAD MAP GOAL #2: Enhance the sharing and use of patient histories in support of patient safety

Objective	Objective Description	Enhanced HIE Project
Objective A	Leverage technical integration and outreach support services to increase the use of practice-level HIE tools and service	• Obstetrics/Prenatal Specialized Registry • Ambulatory Connectivity and Support • Analytical Patient Population Dashboard
Objective B	Drive connectivity to ambulatory EPs and practices for clinical data sharing	• Obstetrics/Prenatal Specialized Registry • Ambulatory Connectivity and Support • Analytical Patient Population Dashboard
Objective C	Support practice-level connectivity through services such as baseline data exchange and clinical quality measurement	• Obstetrics/Prenatal Specialized Registry • Ambulatory Connectivity and Support • Analytical Patient Population Dashboard

Alignment to DHCF Goals

Overall Vision for HIE in DC

Bolster the exchange/integration of data associated with population health, social determinants of wellbeing, clinical data and health-related service utilization throughout the care continuum to improve health outcomes, control health care costs, and enhance the patient experience of care received throughout DC. ROAD

ROAD MAP GOAL #3: Develop and prioritize use cases critical for the improvement of population health and the management of special populations

Objective	Objective Description	Enhanced HIE Project
Objective A	Enhance EP and EHs' ability to capture risk based data on specific subsets of their patient populations	• Dynamic Patient Care Profile • Electronic Clinical Quality Measurement Tool and Dashboard • Analytical Patient Population Dashboard
Objective B	Implement electronic transmission of risk based data to help EPs and EHs better engage beneficiaries in improving their care	• Dynamic Patient Care Profile • Electronic Clinical Quality Measurement Tool and Dashboard • Analytical Patient Population Dashboard
Objective C	Ease provider and practice burden associated with quality reporting requirements	• Dynamic Patient Care Profile • Electronic Clinical Quality Measurement Tool and Dashboard • Analytical Patient Population Dashboard
Objective D	Implement eCQM measurement and reporting to help EPs and EHs meet mandatory reporting criteria	• Dynamic Patient Care Profile • Electronic Clinical Quality Measurement Tool and Dashboard • Analytical Patient Population Dashboard

MAPing (MEASURING, ASSESSING, PLANNING) THE USE OF SOCIAL DETERMINANTS OF HEALTH DATA IN THE DISTRICT

Four Goals for MAP!

- *"Level Set" within the District*
  - Share current and planned uses of social determinants of health (SDH) data
  - Identify tools and methodologies used to collect SDH data
- *Review national best practices* with respect to 3 use cases:
  - Care Planning/Care Management
  - Policy and Planning
  - Evaluation and performance measurement
- *Discuss opportunities and challenges* implementing the collection and use of SDH
- *Identify next steps*: develop strategies and tactics to improve health outcomes in the District

79 MAP Participants Representing Diverse Organizations

SDH Measure Domains

1. Housing
2. Social Isolation/Social Inclusion
3. Food Insecurity
4. Mental Health
5. Health Literacy

Transportation

7. Employment
8. Income

Education

Substance Use

ACEs

12. Access to Technology

Info to support trauma care

14. Demographics
15. Public Benefits
16. Resilience
17. Patient Activation
18. Intimate Partner Violence
19. Material Resources

NEXT MEETING:
JULY 20, 2017 10AM-NOON