Clinigence Population Health and Chronic Care Management

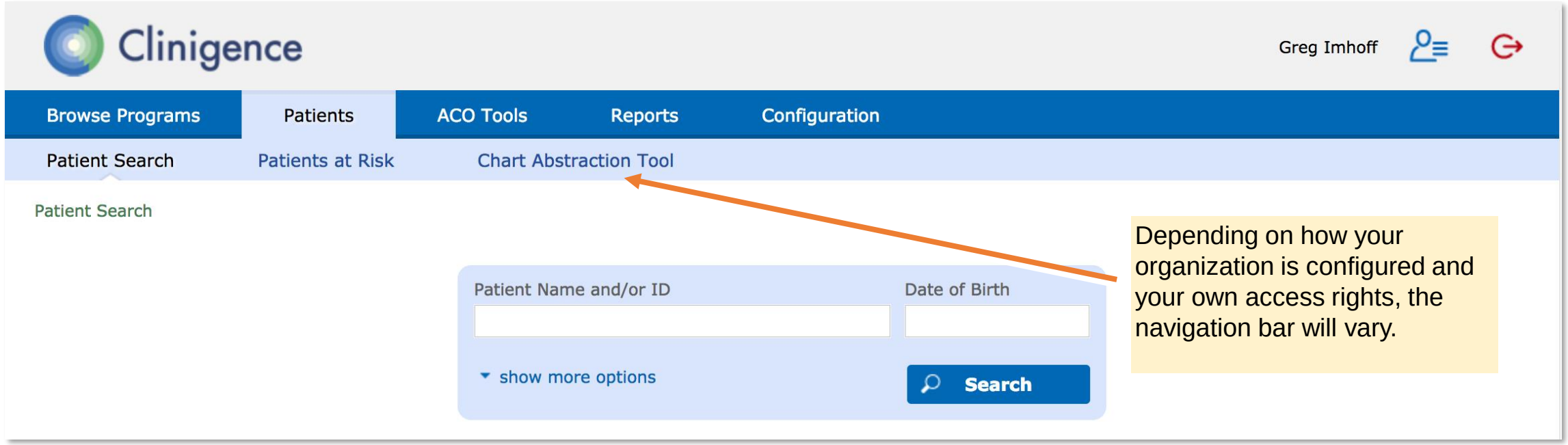
Agenda – Population Health and CCM

- Patient Population Tools
- Searching for Patients
- The Patient View
  - Summary
  - Programs
  - Problems
  - Medications and Immunizations
  - General Information
  - Activity Log
    - Chronic Care Management tasks
  - Documents
- Risk Registry
- Questions

Patient Population Tools

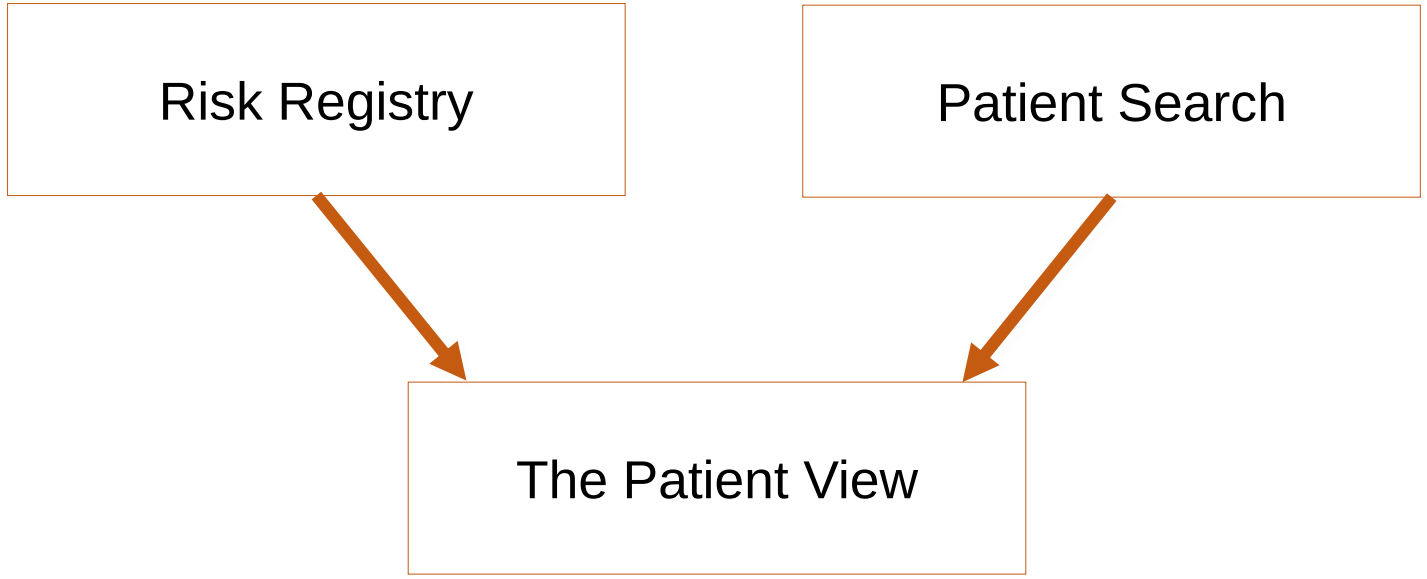
- Designed in partnership with Nurse Care Coordinators and Health Coaches from practices using multiple EHR systems
- Answers the interoperability challenges associated with care coordination across practices
- Targets patient populations based-on Gaps in Care, Chronic Conditions, and ER Utilization
- Displays an individual patient's data sourced from multiple EMR's

Where to Start



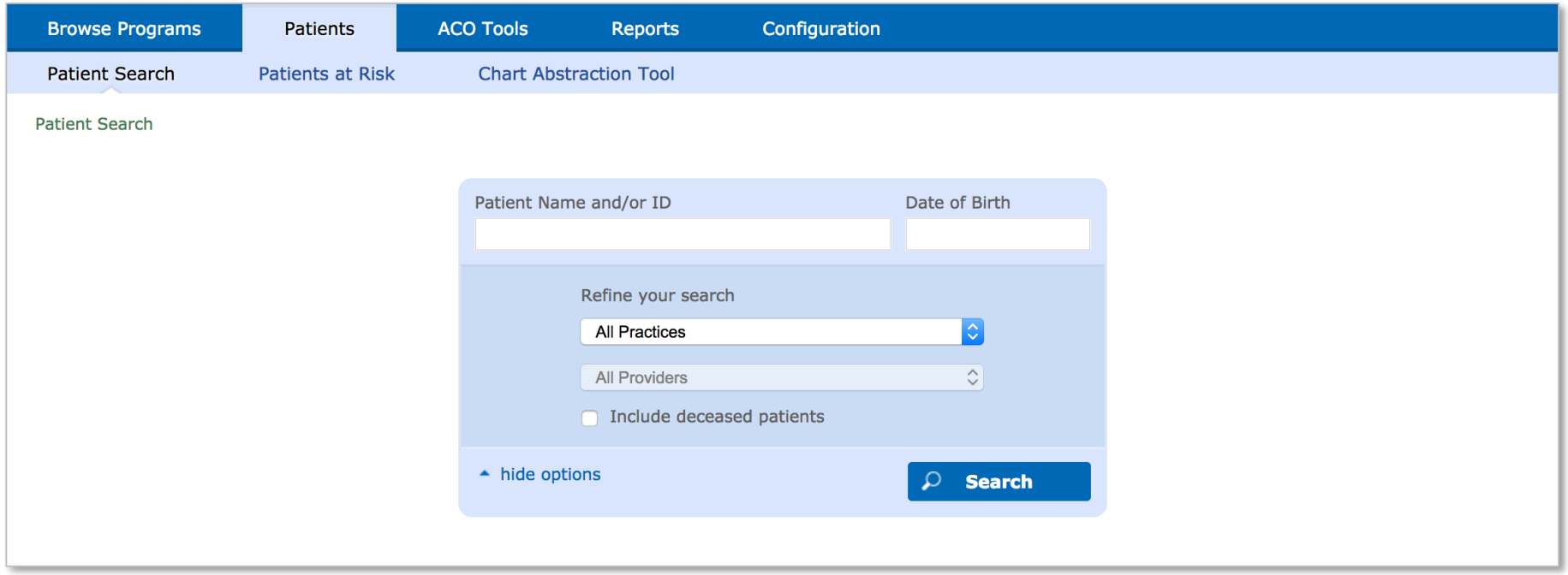
Depending on how your organization is configured and your own access rights, the navigation bar will vary.

Patient Population Tools



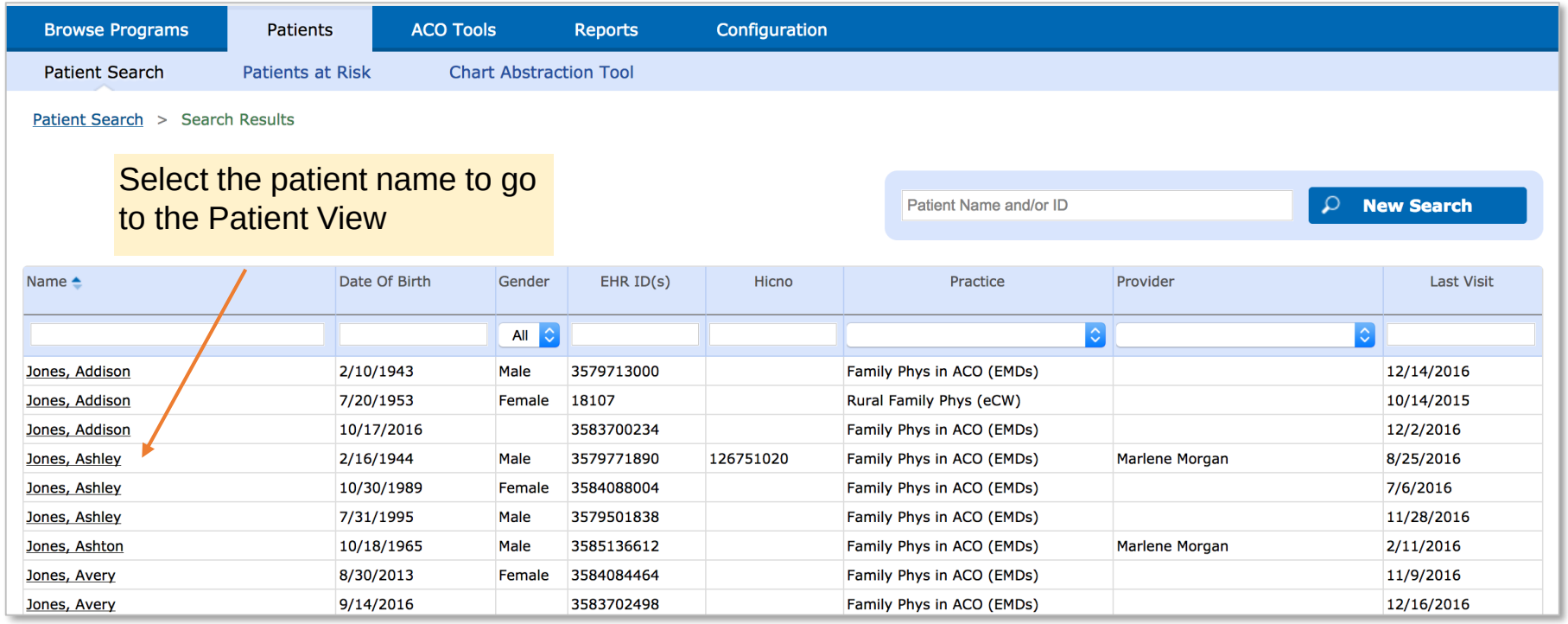
Searching for Patients Across Multiple EHRs

- Search by patient name, partial name, or EHR ID
- Search by date of birth
- Search within a specific practice or all practices

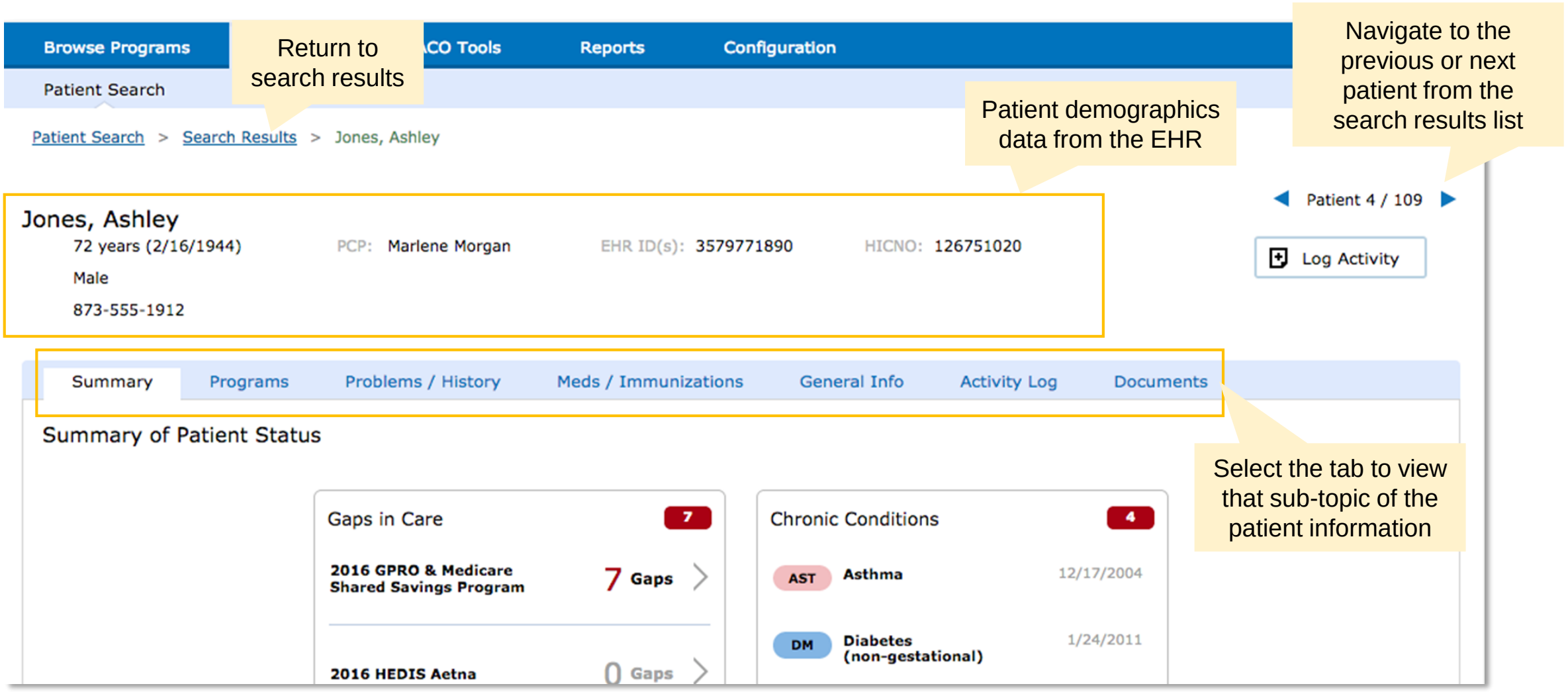


Searching for Patients – Multiple Results

- If your search returns multiple results, a list of possible matches appears.
- Information is provided for each patient, such as DOB, EHR ID's, and associated providers to help identify the correct patient.



The Patient View



Patient View – General Organization

The Problem List from the integrated EHR systems

Documents uploaded to Clinigence

The patient's list of measures and their status in each measure

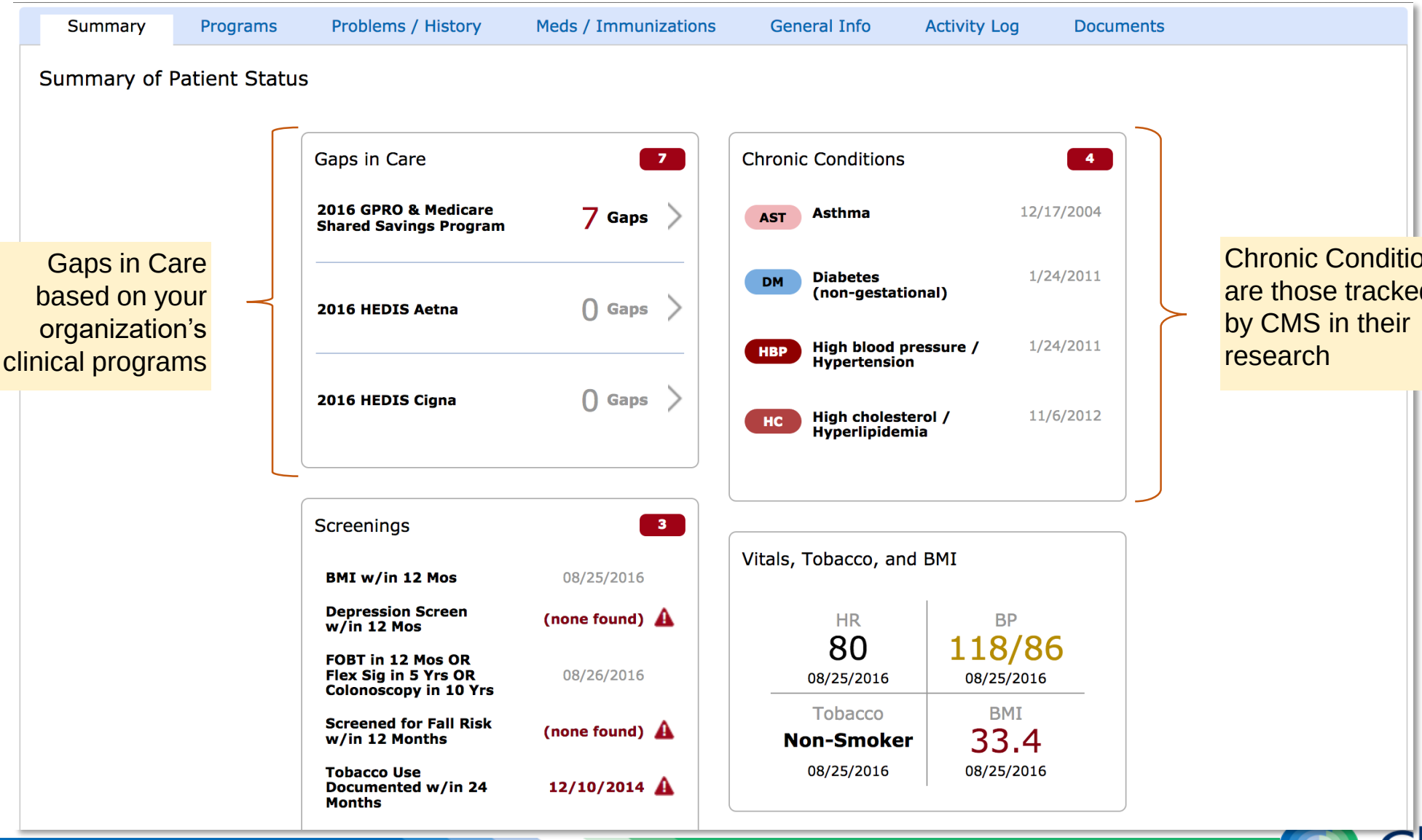
Medications and Immunizations

Activities logged in Clinigence

Gaps in Care, Screenings Status, Chronic Conditions, Vitals, Tobacco, and BMI

Additional Contact Information, Known Providers, CMS Attributions

Patient View – Summary



Gaps in Care based on your organization's clinical programs

Chronic Conditions are those tracked by CMS in their research

CMS Chronic Conditions

AD/D:	Alzheimer's/Dementia
ART:	Arthritis (including rheumatoid and osteoarthritis)
AST:	Asthma
AF:	Atrial Fibrillation
ASD:	Autism Spectrum Disorders
C-B:	Cancer - Breast
C-C:	Cancer - Colorectal
C-L:	Cancer – Lung
C-P:	Cancer – Prostate
CKD:	Chronic Kidney Disease
COPD:	Chronic Obstructive Pulmonary Disease
CHD:	Coronary Heart Disease/Ischemic Heart Disease
DP:	Depression
DM:	Diabetes (excluding diabetic conditions related to pregnancy)
HF:	Heart Failure
HBP:	High blood pressure / Hypertension
HC:	High cholesterol/Hyperlipidemia
OSP:	Osteoporosis
PD:	Parkinson's disease
STRK:	Stroke
TIA:	Transient ischemic attack

Patient View – Summary

Best practice screenings keyed to gender and age

Gaps in Care — 7

2016 GPRO & Medicare Shared Savings Program	**7 Gaps**
2016 HEDIS Aetna	**0 Gaps**
2016 HEDIS Cigna	**0 Gaps**

Screenings — 3

BMI w/in 12 Mos	08/25/2016
Depression Screen w/in 12 Mos	**(none found)** ⚠
FOBT in 12 Mos OR Flex Sig in 5 Yrs OR Colonoscopy in 10 Yrs	08/26/2016
Screened for Fall Risk w/in 12 Months	**(none found)** ⚠
Tobacco Use Documented w/in 24 Months	**12/10/2014** ⚠

Chronic Conditions — 4

AST	**Asthma**	12/17/2004
DM	**Diabetes (non-gestational)**	1/24/2011
HBP	**High blood pressure / Hypertension**	1/24/2011
HC	**High cholesterol / Hyperlipidemia**	11/6/2012

Vitals, Tobacco, and BMI

HR **80** 08/25/2016	BP **118/86** 08/25/2016
Tobacco **Non-Smoker** 08/25/2016	BMI **33.4** 08/25/2016

Most recent readings of key measurements

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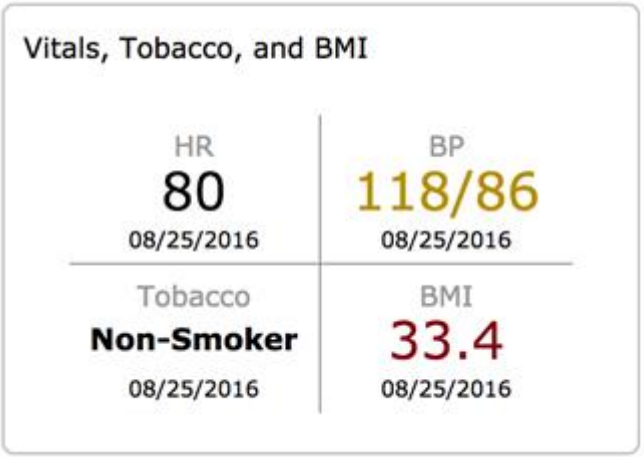
Best Practice Screenings

Screening	Cited Authority	Criteria	Frequency
BMI	NQF 0421, PQRS 128	>= 18 years	12 months
Bone Mass	HEDIS OMW	female, 65 yrs or older with index fracture	based on a related HEDIS/Anthem measure
Breast Cancer	PQRS 112	Female, 50-74 years	24 month frequency stated in the measure
Cervical Cancer	NQF 0032, PQRS 309	Female, 21-64 years	24 month frequency
Colorectal	NQF 0034, PQRS 113	51-75 years	
Depression Screen	NQF 0418, PQRS 134		12 months
Fall Assessment	NQF 0101, PQRS 318	>= 65 years	12 months
Tobacco	NQF 0028, PQRS 226	>= 18 years	24 months

Vital Signs Warning Thresholds



- The Vitals will highlight readings in yellow for a warning and red text when reaching the alert threshold.

Blood Pressure (BP)

Normal: Systolic <= 120 / Diastolic <= 80

Warning: Systolic 121 to 139 / Diastolic 81 to 89

Alert: Systolic 140 and higher / 90 and higher

Heart Rate (HR)

Normal: <= 100

Warning: 101 and higher

Alert: Not Applicable

Body Mass Index (BMI)

Normal: 18.5 to 24.9

Warning: less than 18.5 OR 25 to 29.9

Alert: 30 or greater

Tobacco

Normal: Non-Smoker

Warning: Not Applicable

Alert: Smoker or data missing

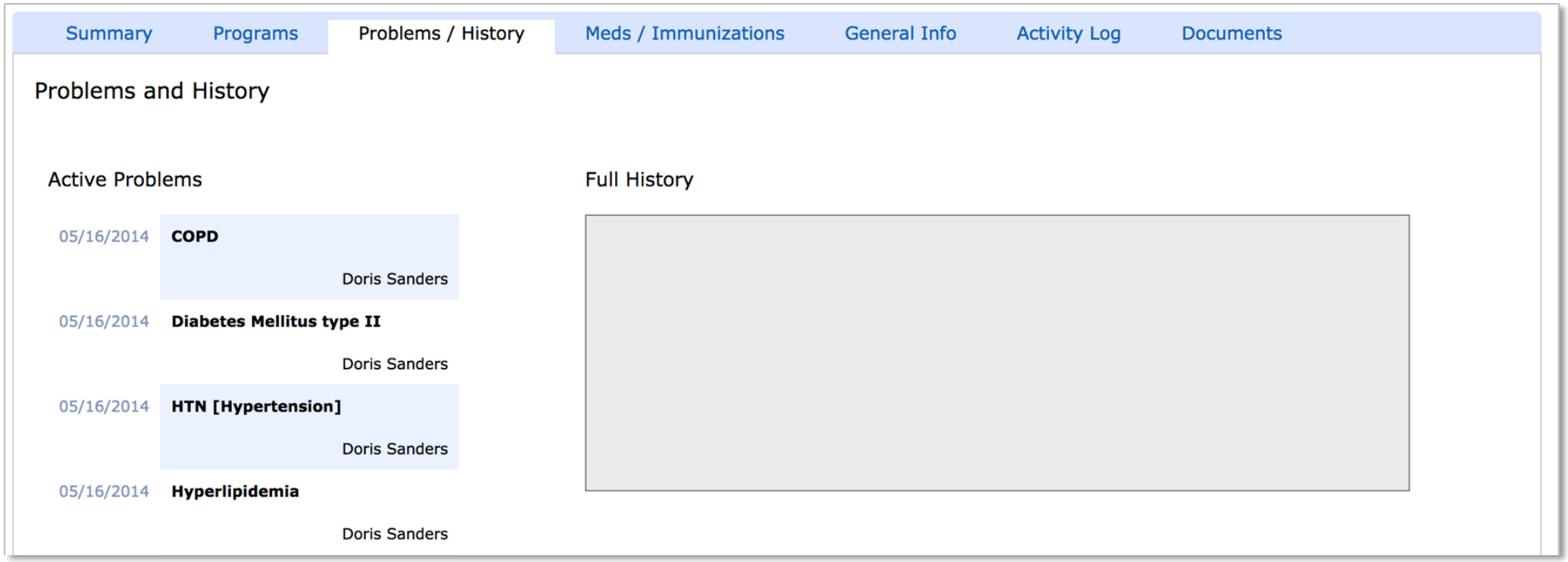
Patient View – Programs View

- The Programs View lists all the clinical programs and measures for which the patient qualifies.

When the patient doesn't meet the measurement target criteria, a Gap in Care flag appears.

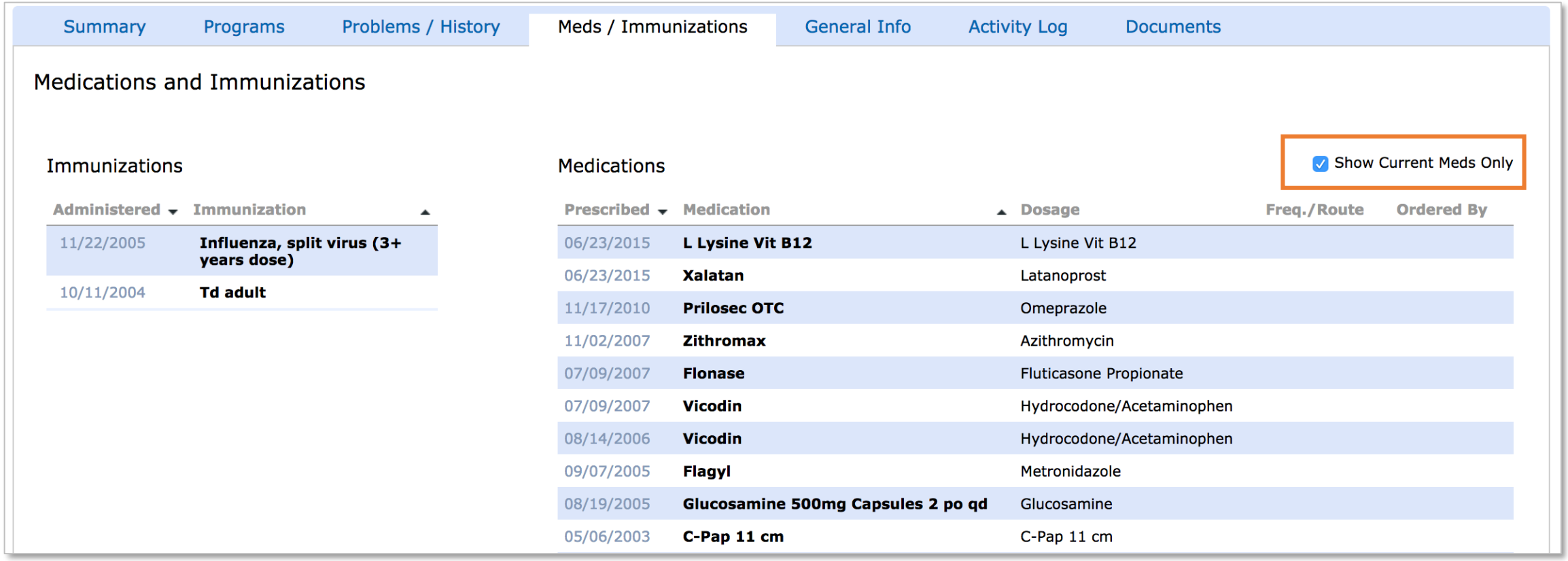
Patient View – Problems View

- The Problems View displays the active problems listed for the patient in the organization's various EHR systems.



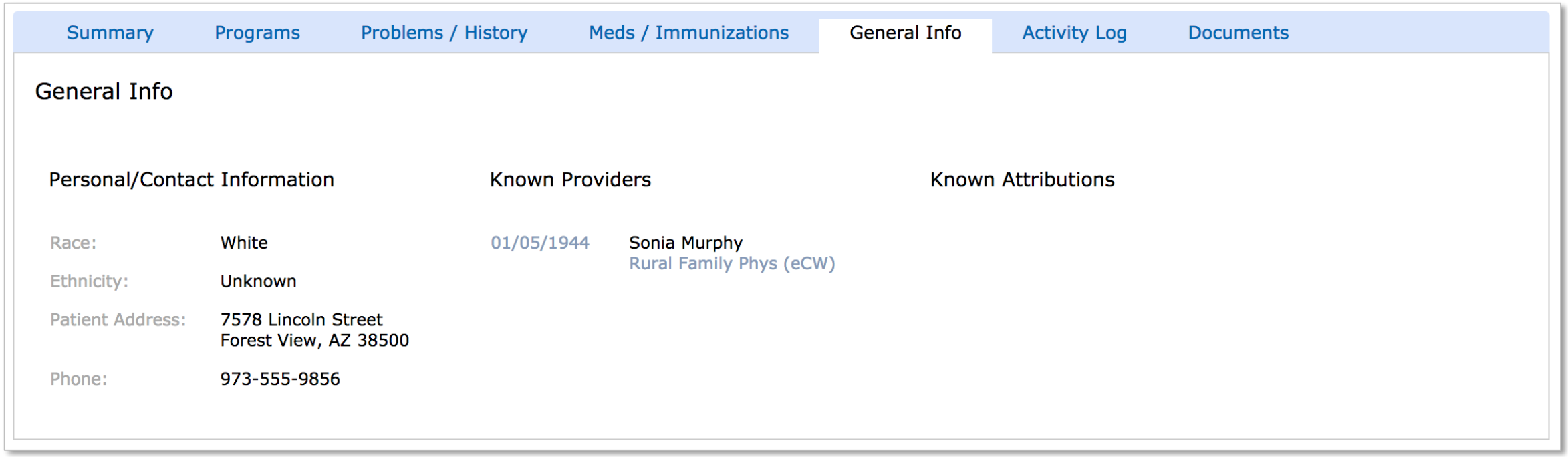
Patient View – Meds and Immunizations View

- The Meds / Immunizations View lists all the medications and immunizations found for the patient in the organization's EHR systems. By default only the active medications are shown. Unchecking the associated checkbox will show the full list of medications.



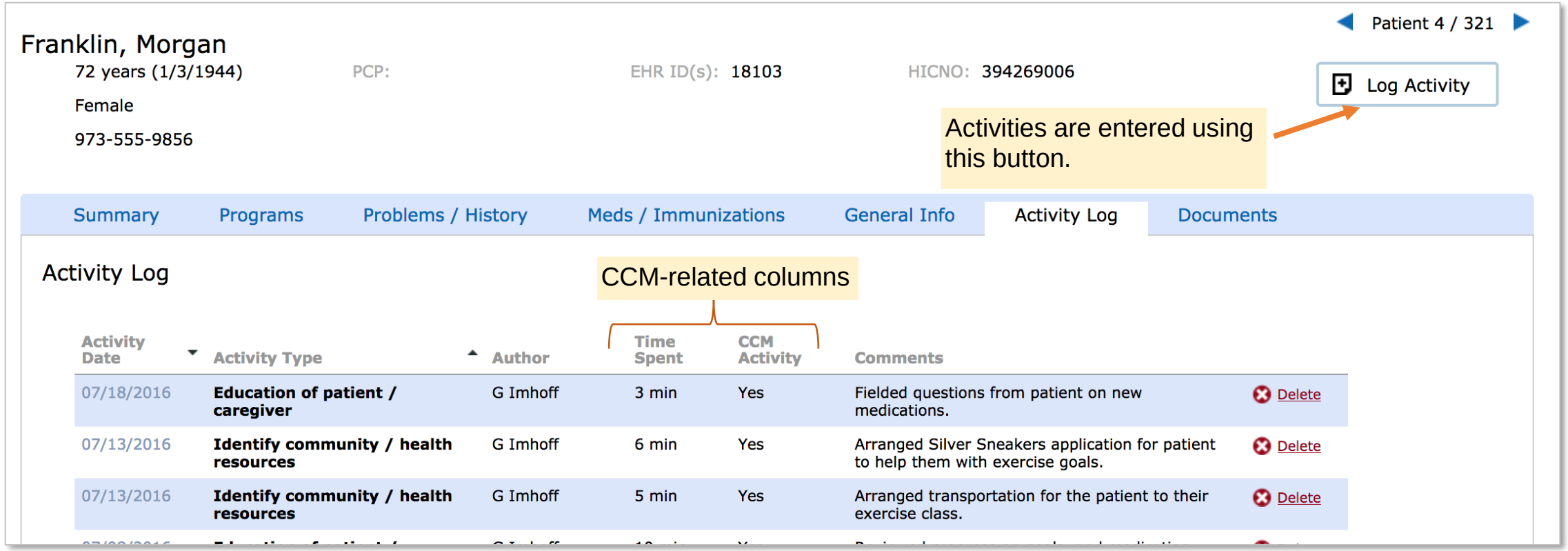
Patient View – General Info View

- The General Info View contains additional personal and contact information, known providers, and CMS attributions (if they apply).

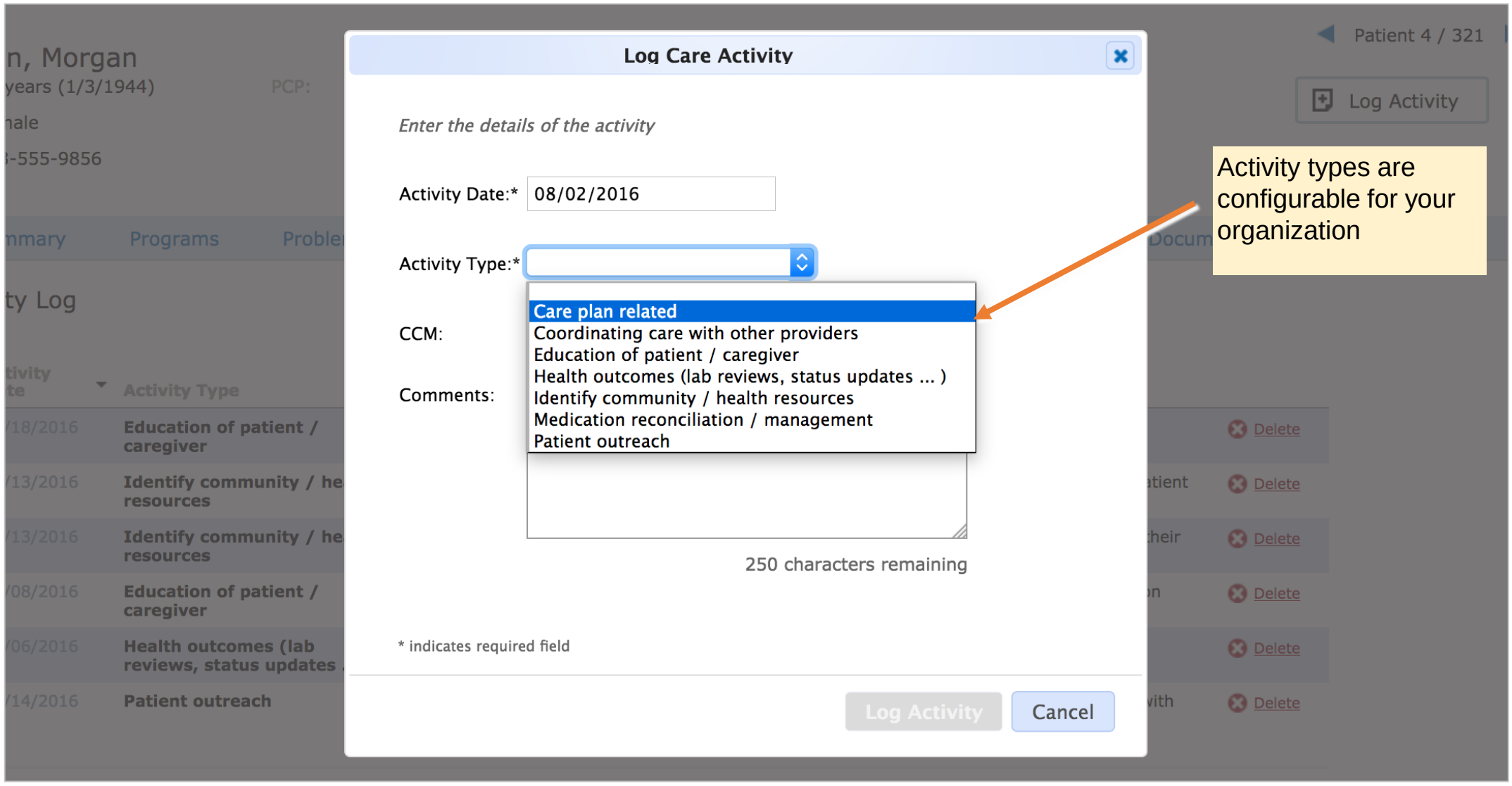


Patient View – Activity Log View

- The Activity Log displays any activities entered for the patient in Clinigence. Activities are entered by selecting the Log Activity Button from any of the Patient View sub-tabs.
- Chronic Care Management (CCM) related information can be documented, if your organization is using the CCM Module.



Logging an Activity



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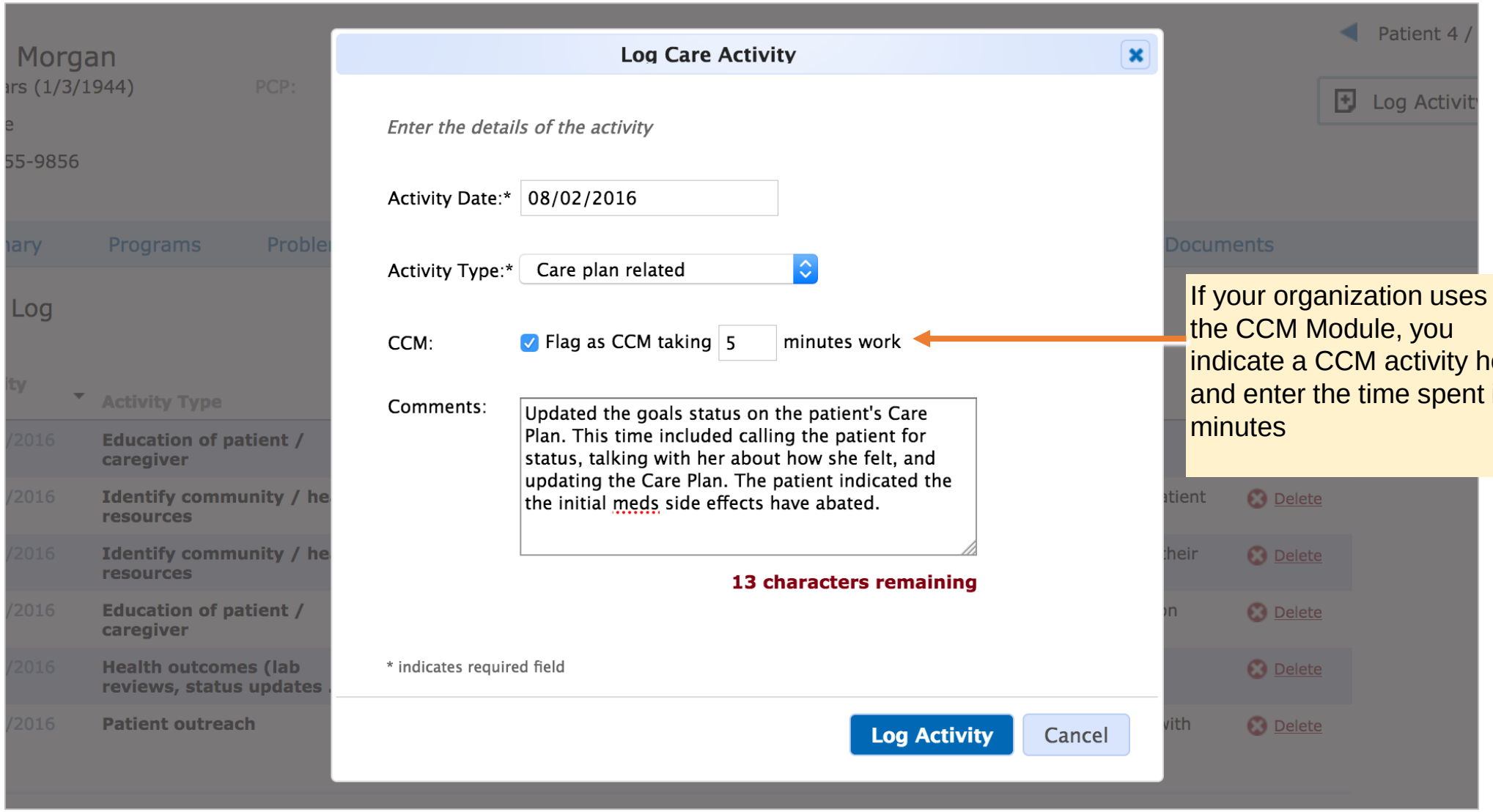
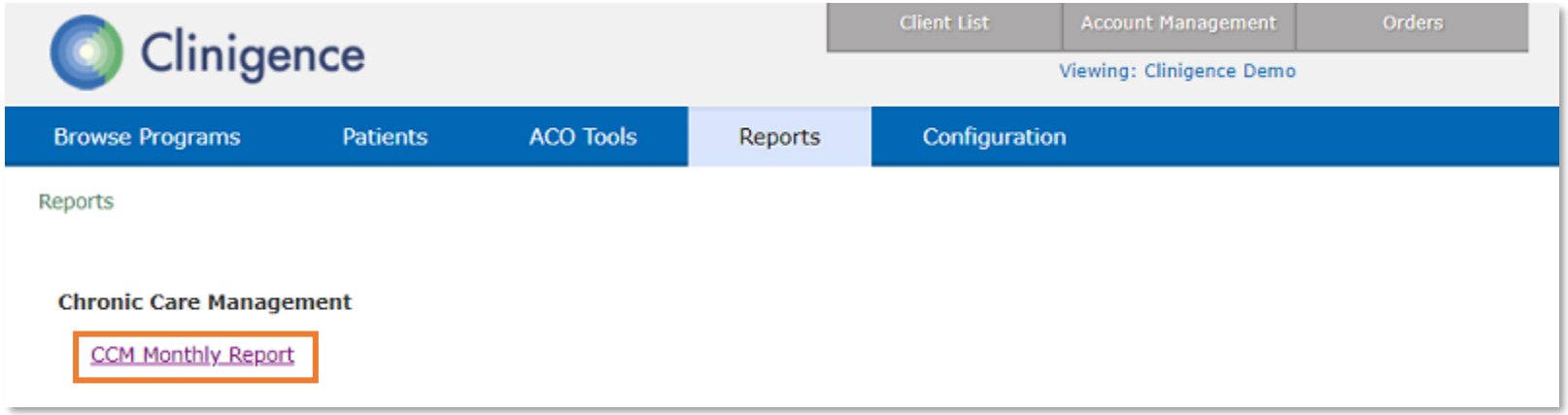
Logging an Activity



CCM Monthly Reports

- After you begin logging CCM activities in the Patient View, you can generate monthly reports.



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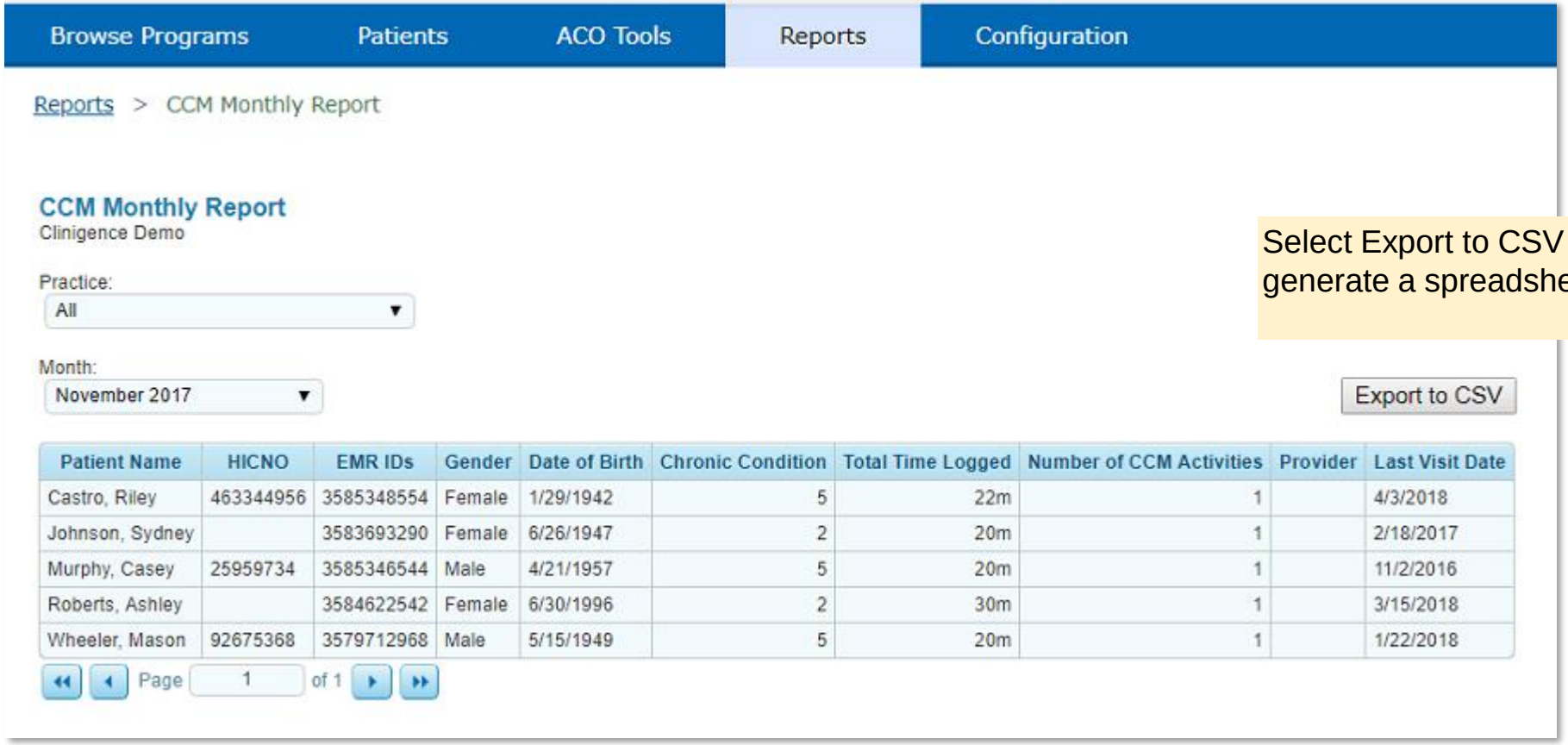
CCM Monthly Reports

- Select All practices or a specific practice
- Select the month



Patient Name	HICNO	EMR IDs	Gender	Date of Birth	Chronic Condition	Total Time Logged	Number of CCM Activities	Provider	Last Visit Date
Castro, Riley	463344956	3585348554	Female	1/29/1942	5	22m	1		4/3/2018
Johnson, Sydney		3583693290	Female	6/26/1947	2	20m	1		2/18/2017
Murphy, Casey	25959734	3585346544	Male	4/21/1957	5	20m	1		11/2/2016
Roberts, Ashley		3584622542	Female	6/30/1996	2	30m	1		3/15/2018
Wheeler, Mason	92675368	3579712968	Male	5/15/1949	5	20m	1		1/22/2018

Select Export to CSV to generate a spreadsheet file

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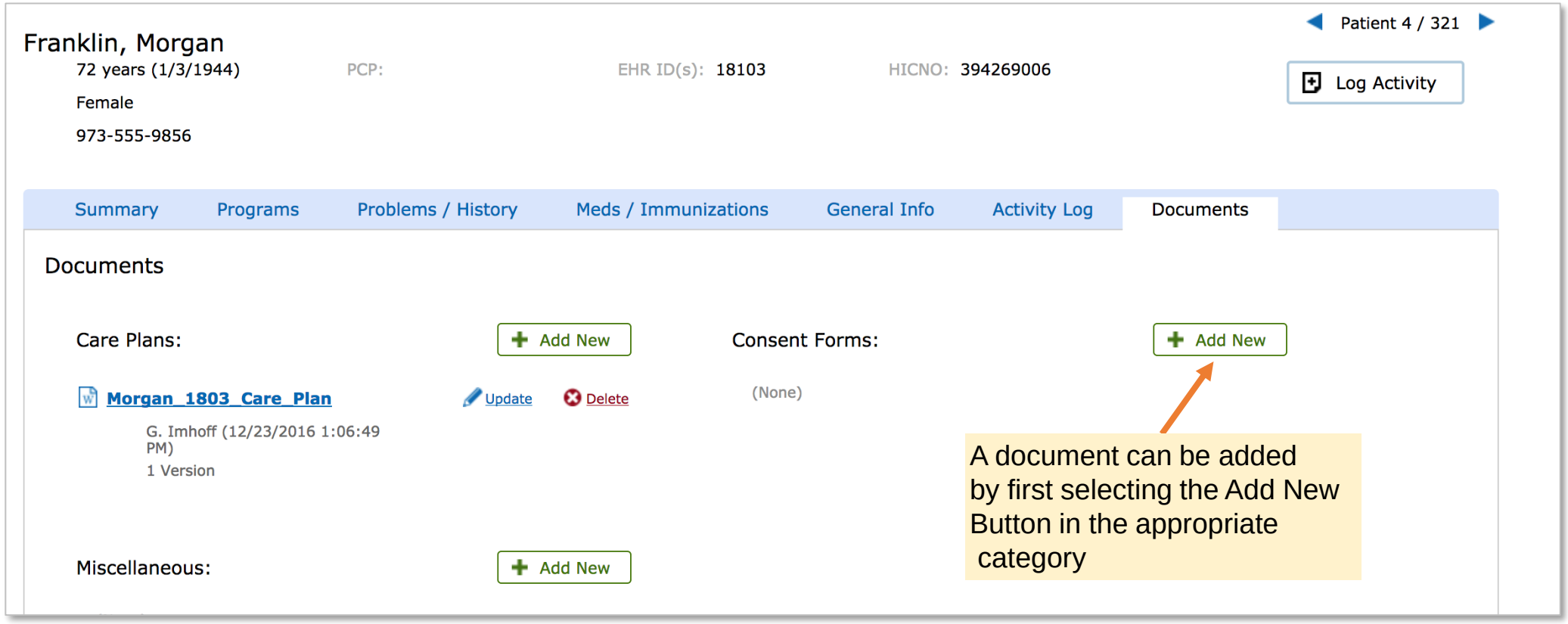
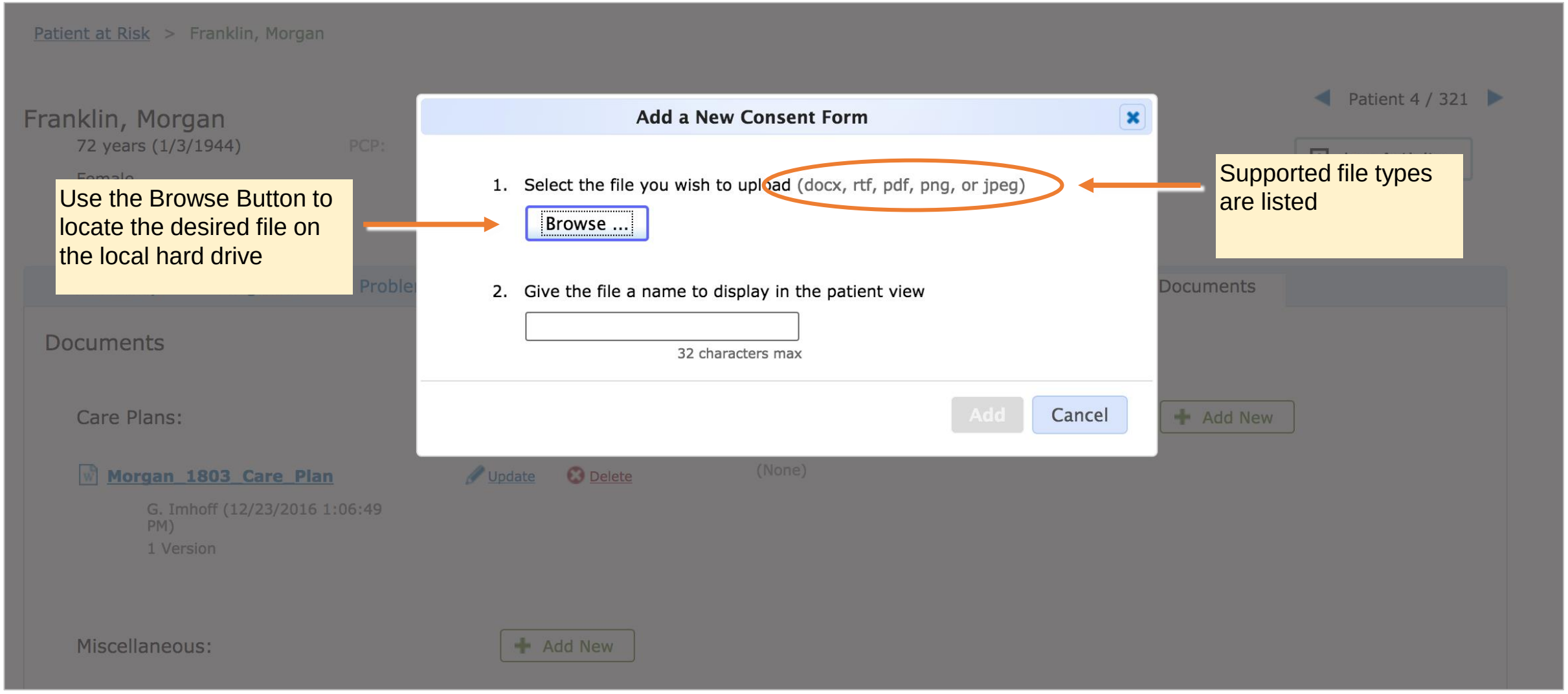
Patient View – Documents View

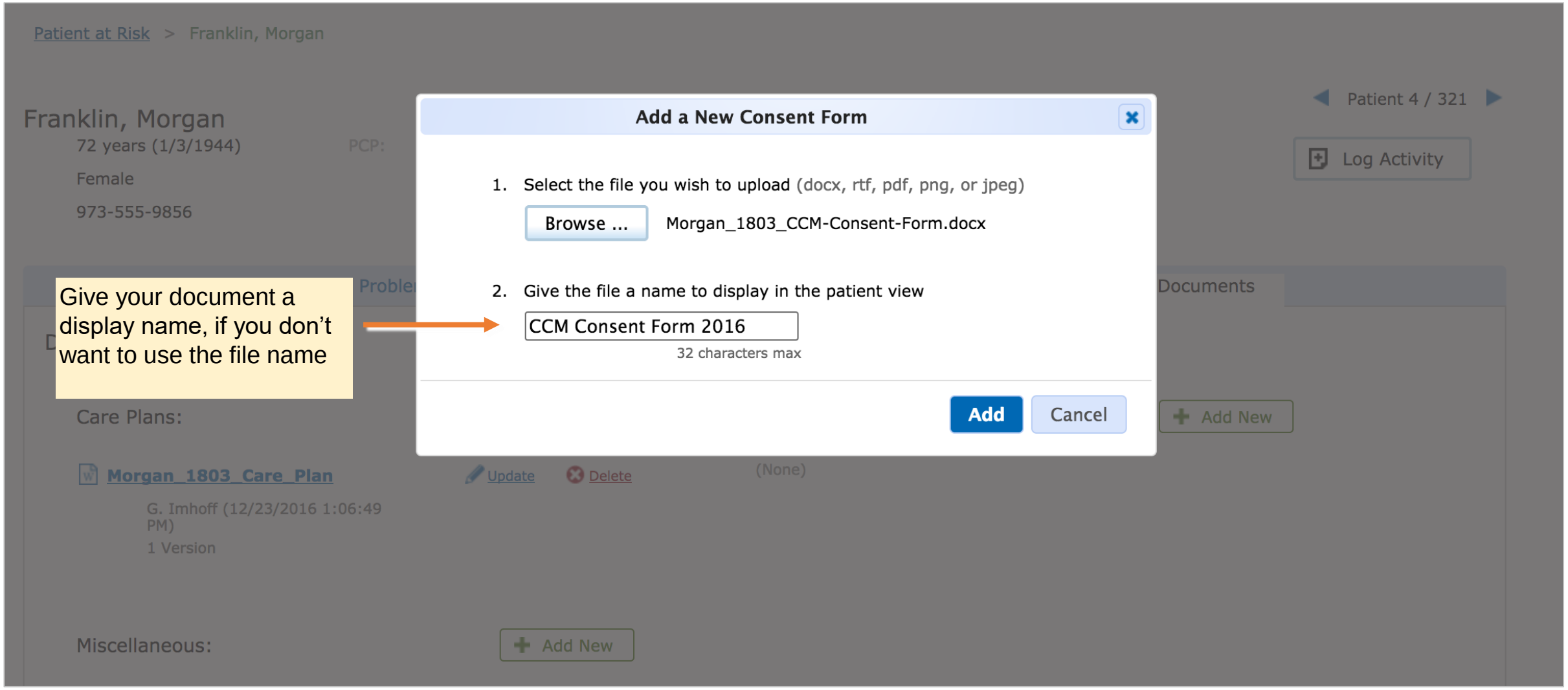
- The Documents View provides an area outside the EHR system to upload and store key documents such as Care Plans and Consent Forms. Having these files available to all team members providing care is a critical part of the CCM program requirements.



Uploading a Document

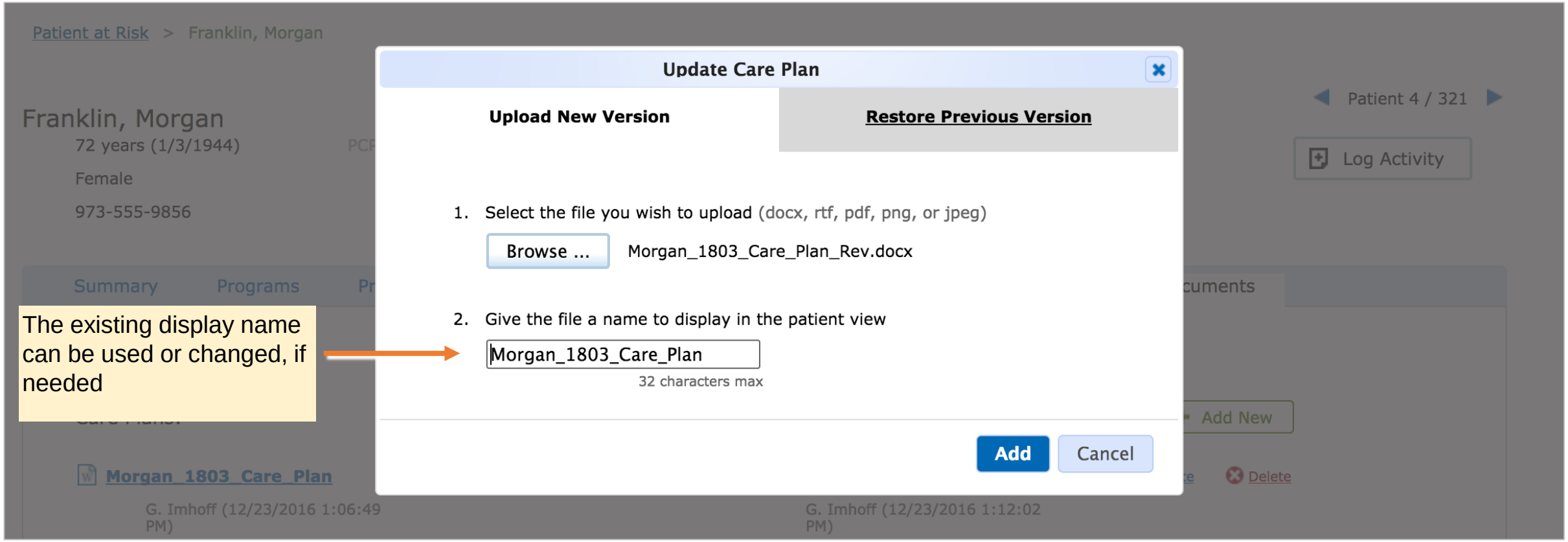


Uploading a Document

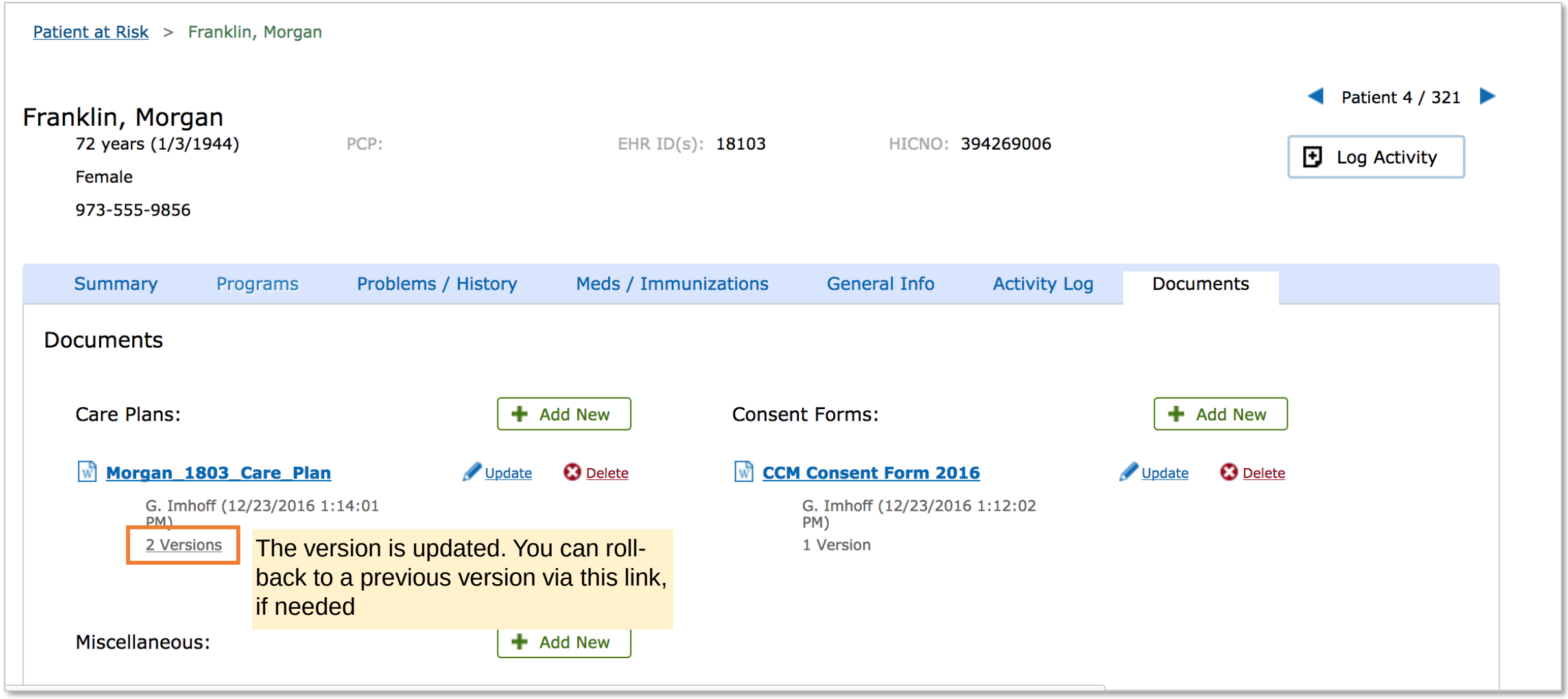


Updating a Document

- If you need to update a document that was previously uploaded, select the update link next to the document name.



Updating a Document



The version is updated. You can roll-back to a previous version via this link, if needed

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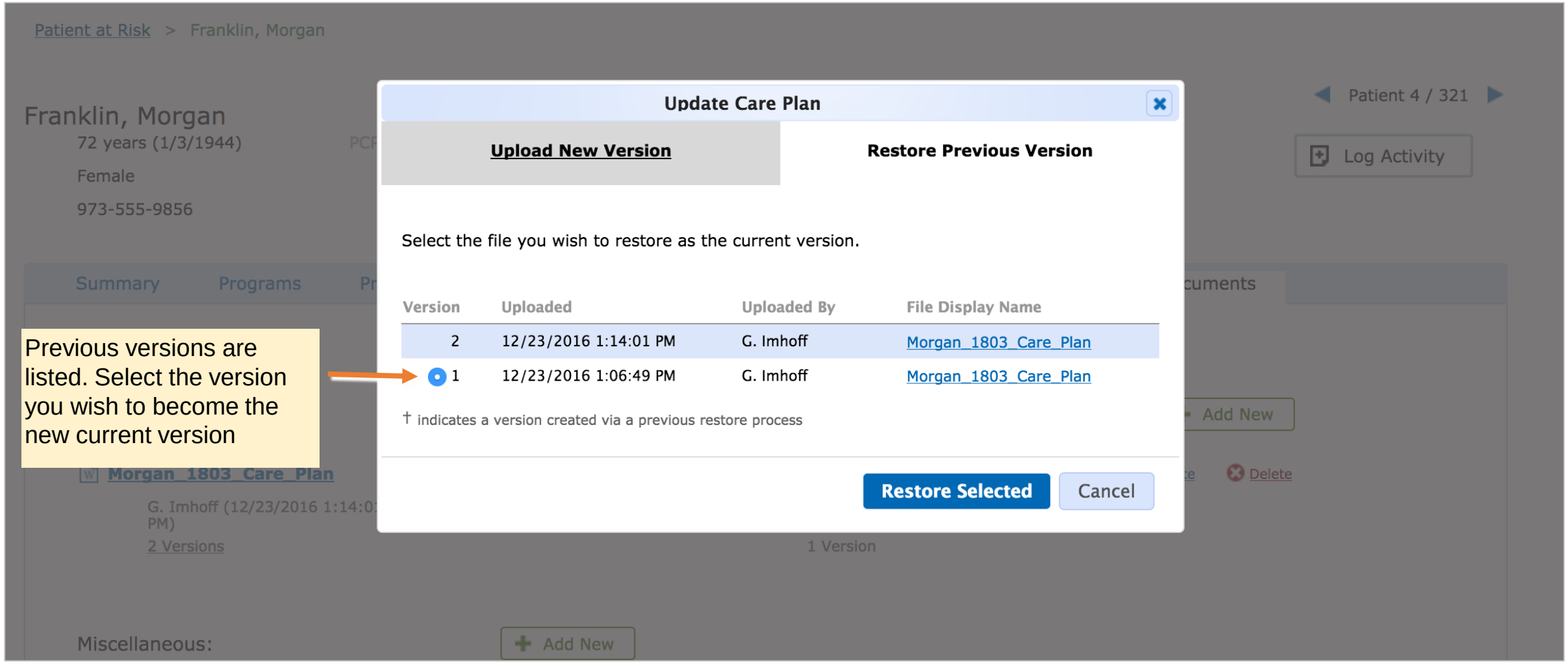
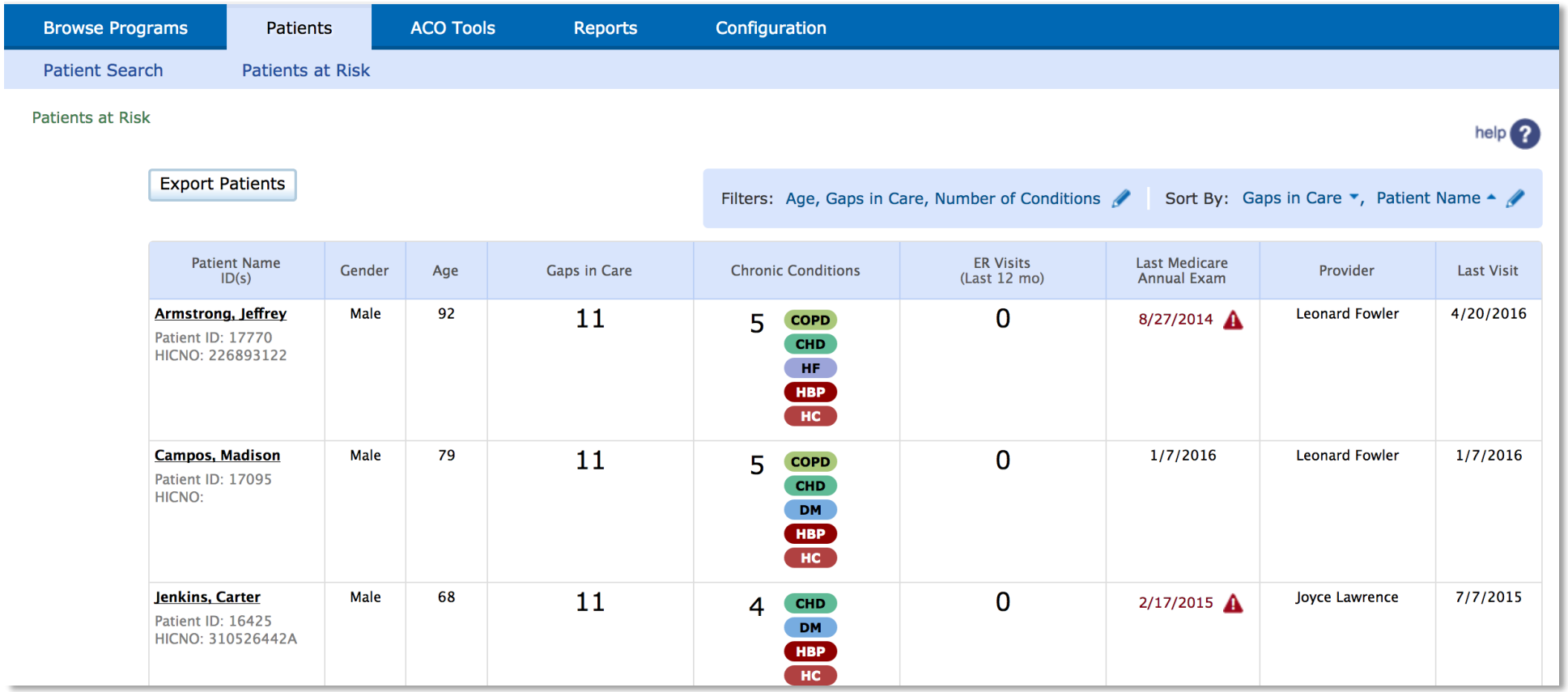
Restoring a Previous Version of a Document



The Risk Registry

- The Risk Registry gathers together patients at risk and in need of intervention.



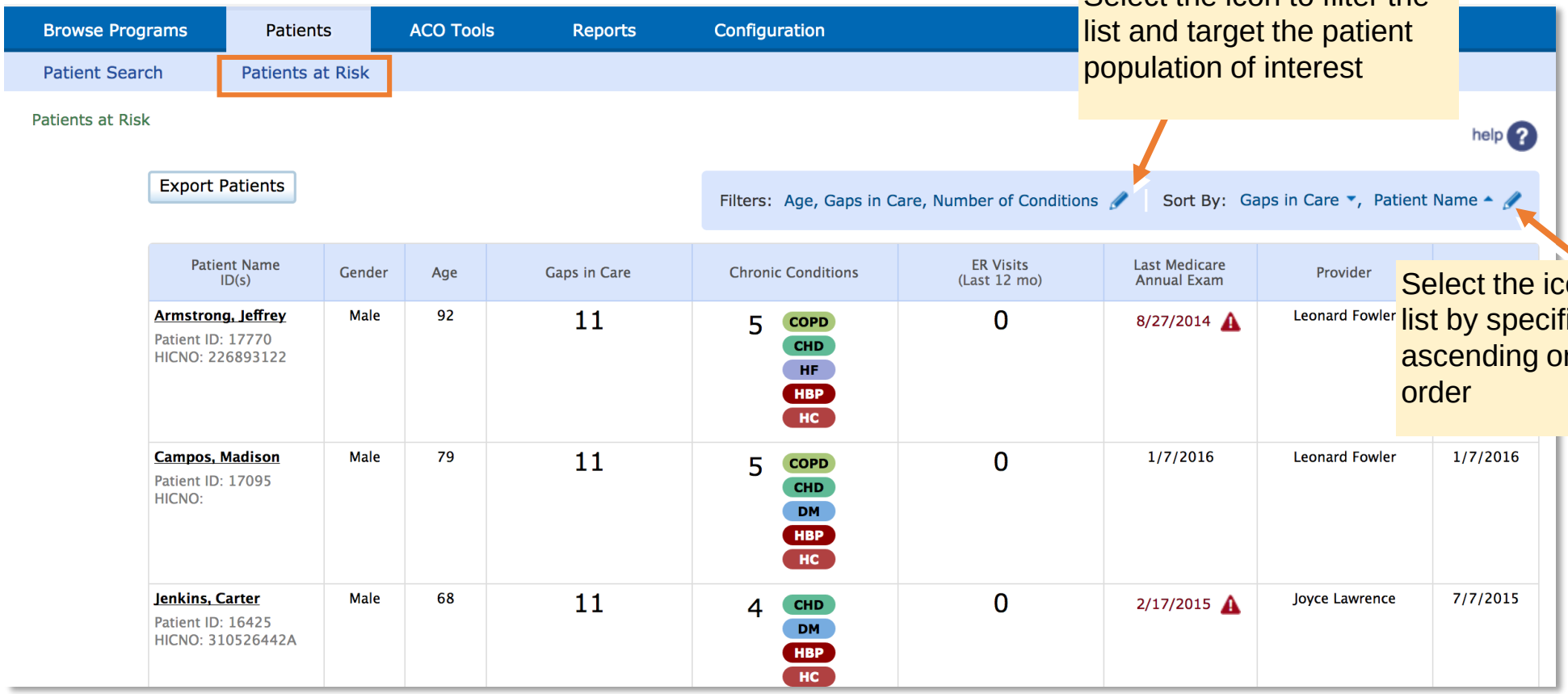
The Risk Registry

The Risk Registry provides a prioritized list of patients based on the following core risk factors:

- Gaps in Care - the number of Gaps in Care for the patient across all measures for which they are eligible
- Chronic Conditions - the number and kind of Chronic Conditions diagnosed for the patient
- ER Visits - the number of ED/ER visits in the last 12 months for the patient (requires claims integration)
- Last Annual Exam - the last Annual Medicare Exam on record for the patient

The Risk Registry

- Access the Risk Registry by selecting the Patients at Risk tab.



Select the icon to filter the list and target the patient population of interest

Select the icon to sort the list by specific criteria, in ascending or descending order

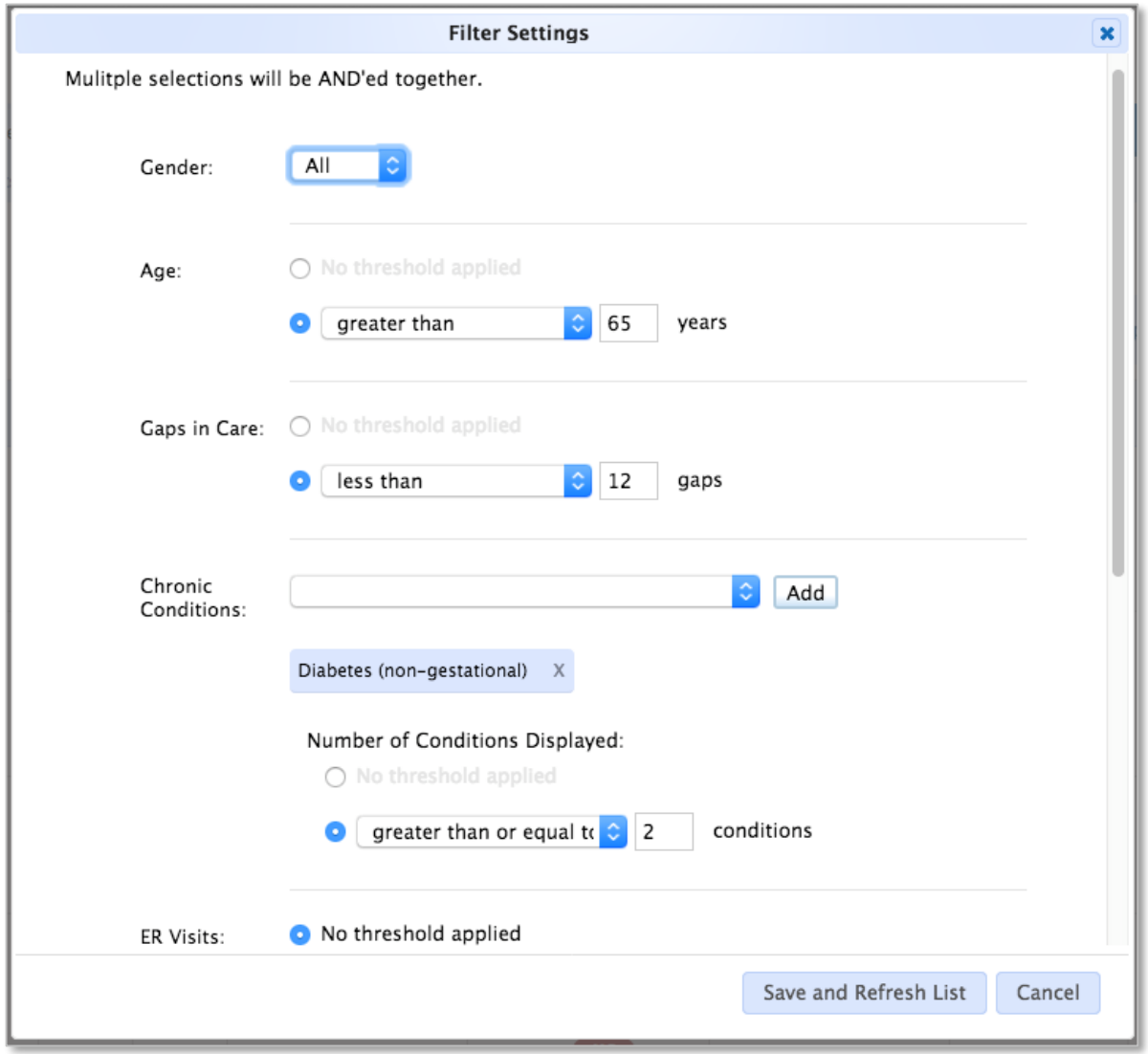
Risk Registry – Filters

Filters come in three general types: selections, thresholds, and date offsets.

Selections involve selecting properties of the patients you want to include in the result list.

Thresholds allow you to refine the list using a key numeric piece of data and define a rule with <, >, and equal to modifiers. An example of a threshold filter is "greater than 5 Gaps in Care”.

Date Offsets are available for date-based properties associated with the patient such as last office visit.



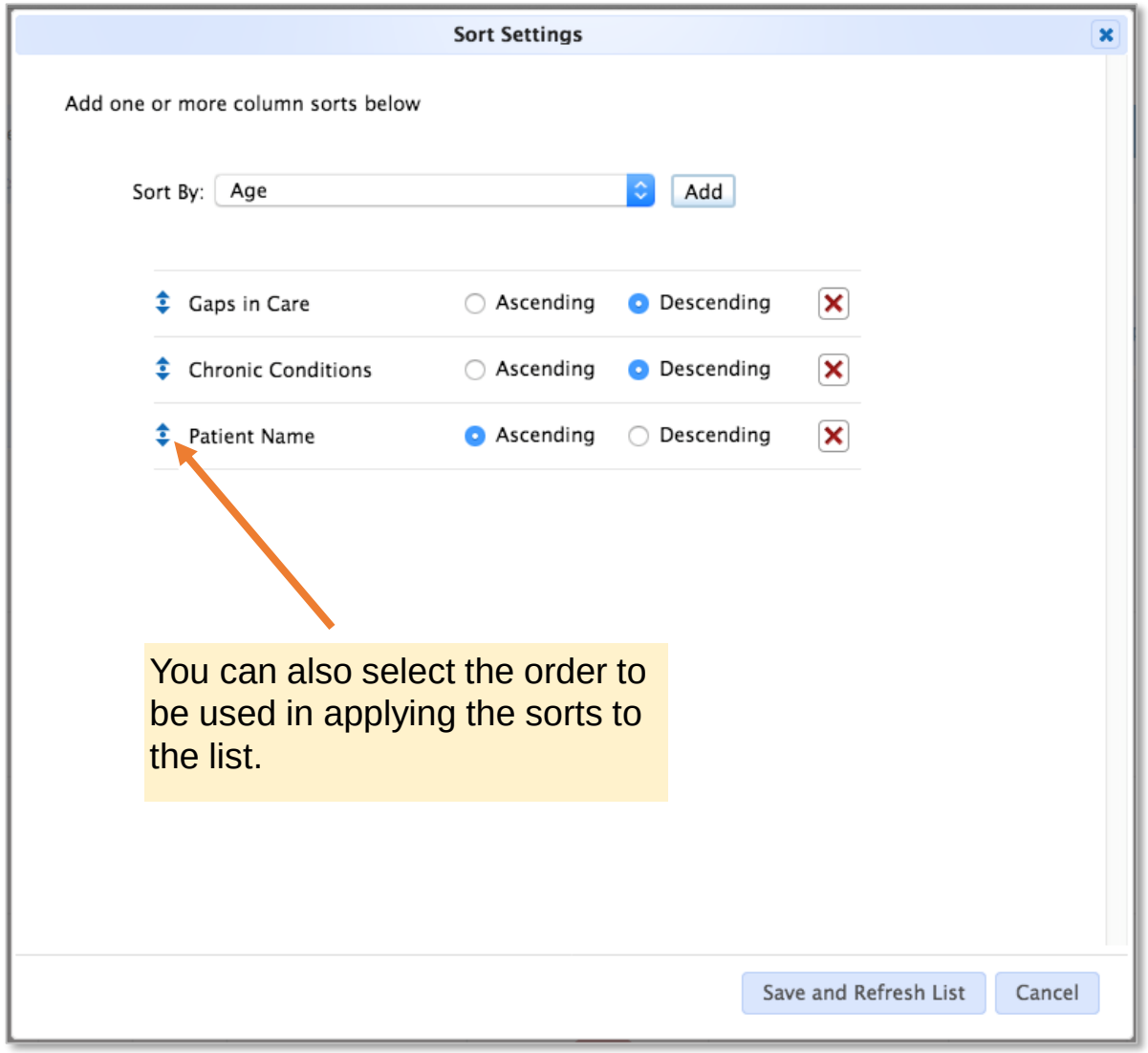
Risk Registry – Filters

- The patients that appear in the registry can be filtered by the following key fields:
  - **Gender** - A selection of one gender or both
  - **Age** - A threshold that can be set for >, >=, =, <, <=, or a range
  - **Gaps in Care** - A threshold that can be set for >, >=, =, <, <=, or a range
  - **ER Visits** - A threshold that can be set for >, >=, =, <, <=, or a range
  - **Last Annual Exam** - A date offset
  - **Last Office Visit** - A date offset
  - **Chronic Conditions** - two filters:
    - A selection of which conditions to include. Matching patients must have the selected condition. The included patients may have other comorbid conditions in addition to those selected.
    - A threshold for the number of conditions.

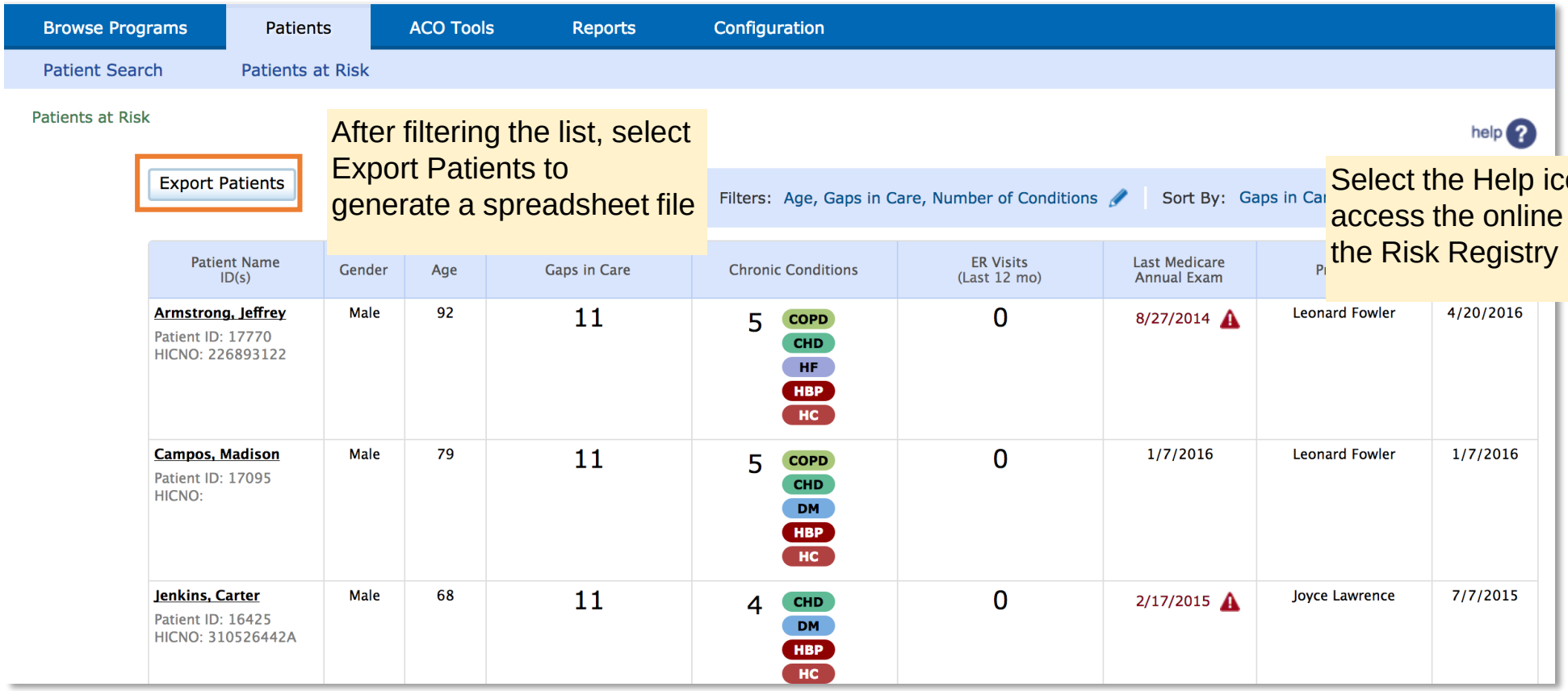
Risk Registry – Sorting

The following data can be used in sorting rules:

- Patient Name
- Gender
- Age
- Gaps in Care
- Chronic Conditions (number of conditions)
- ER Visits
- Last Annual Exam
- Provider
- Last Office Visit

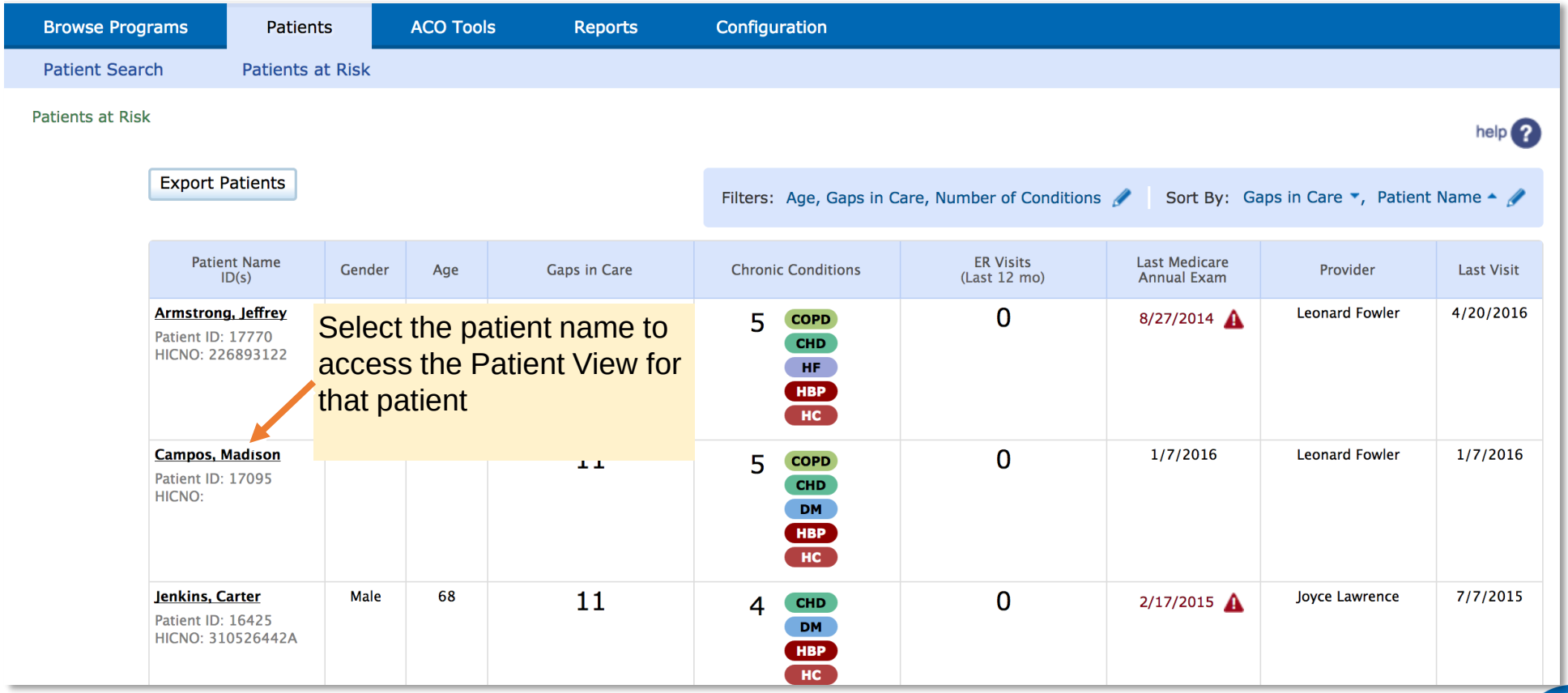


The Risk Registry



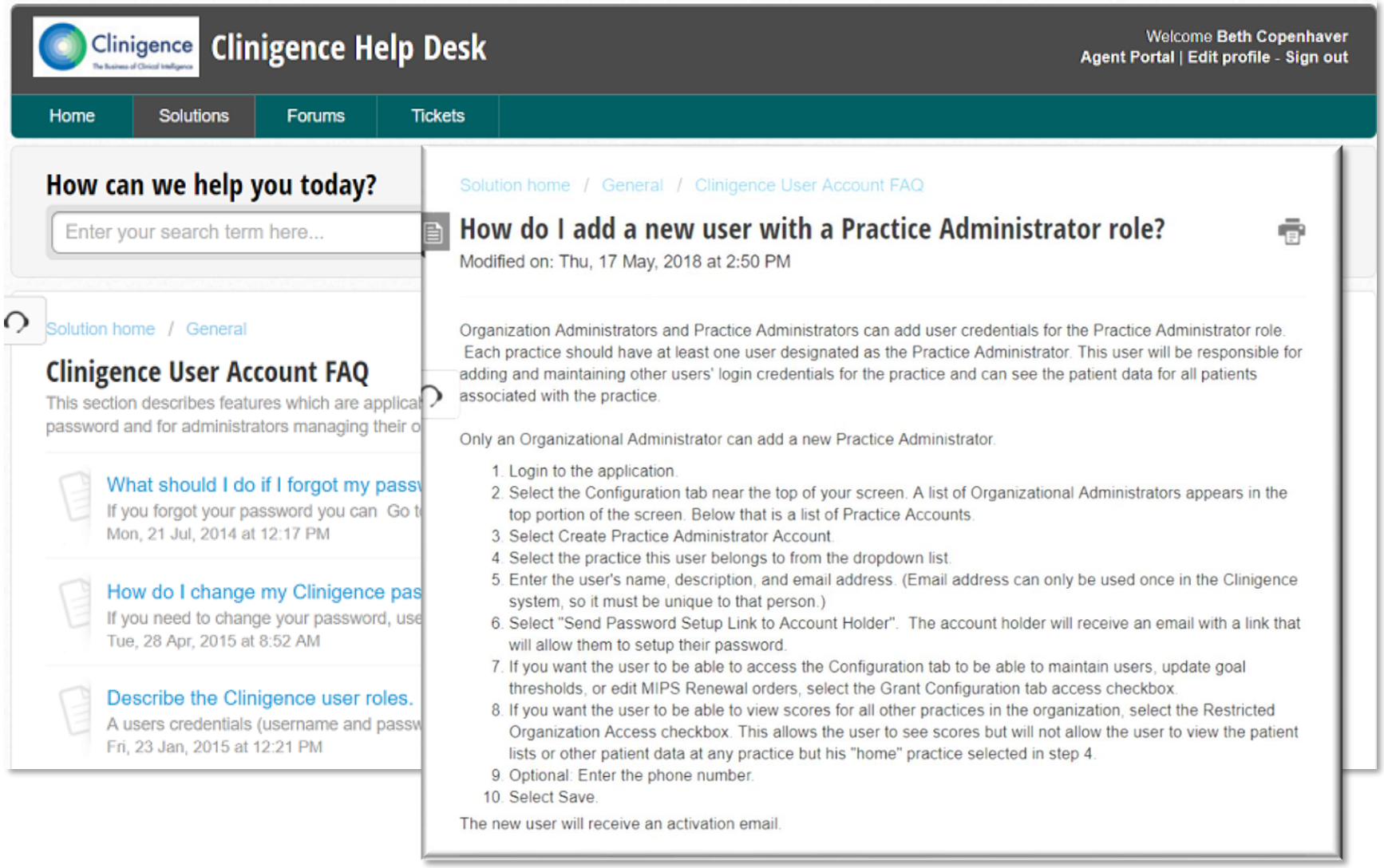
The Risk Registry

- After you have the generated the list of patients you want to review, you can select a patient in the list to view their Patient View. As with the search results, you can move through the filtered and sorted list of patients without returning to the registry.



Accessing Pop Health & CCM

- In order to access the Population Health and CCM features a user must first have credentials for Solutionweb (solution.Clinigence.com). Instructions for setting up new users can be found in the Help desk at support.Clinigence.com.



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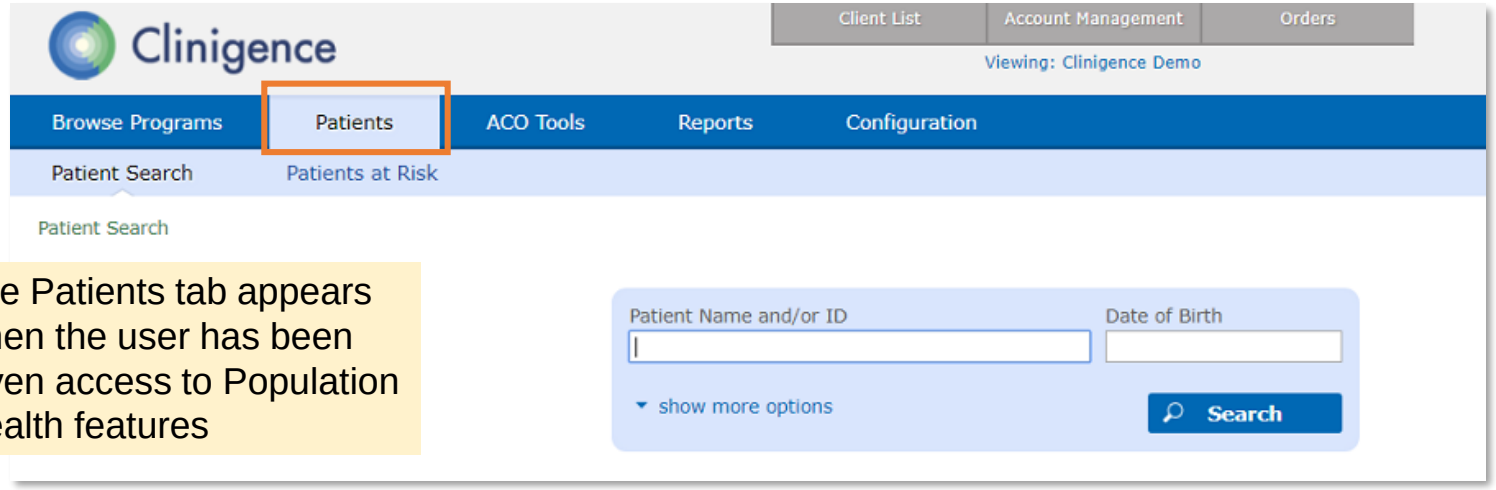
Accessing Pop Health & CCM

- After a user has a valid login for Solutionweb, notify support@Clinigence.com which users need access to Population Health and CCM. Clinigence support will update the users' access rights to allow them to access Population Health and, if needed, CCM features.



The Patients tab appears when the user has been given access to Population Health features

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Let’s give it a try in the application.

Questions?