

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

The screenshot displays the Clinigence web application interface. At the top left is the Clinigence logo. At the top right, the user name "Greg Imhoff" is shown next to a user icon and a refresh icon. Below this is a dark blue navigation bar with the following tabs: "Browse Programs", "Patients", "ACO Tools", "Reports", and "Configuration". Under the "Patients" tab, there is a sub-navigation bar with "Patient Search", "Patients at Risk", and "Chart Abstraction Tool". The "Patient Search" sub-tab is currently selected. Below the sub-navigation bar, the "Patient Search" section is visible, containing a search form with two input fields: "Patient Name and/or ID" and "Date of Birth". Below these fields is a link "show more options" and a blue "Search" button. An orange arrow points from a text box on the right to the "Chart Abstraction Tool" tab in the sub-navigation bar.

Clinigence

Greg Imhoff

Browse Programs Patients ACO Tools Reports Configuration

Patient Search Patients at Risk Chart Abstraction Tool

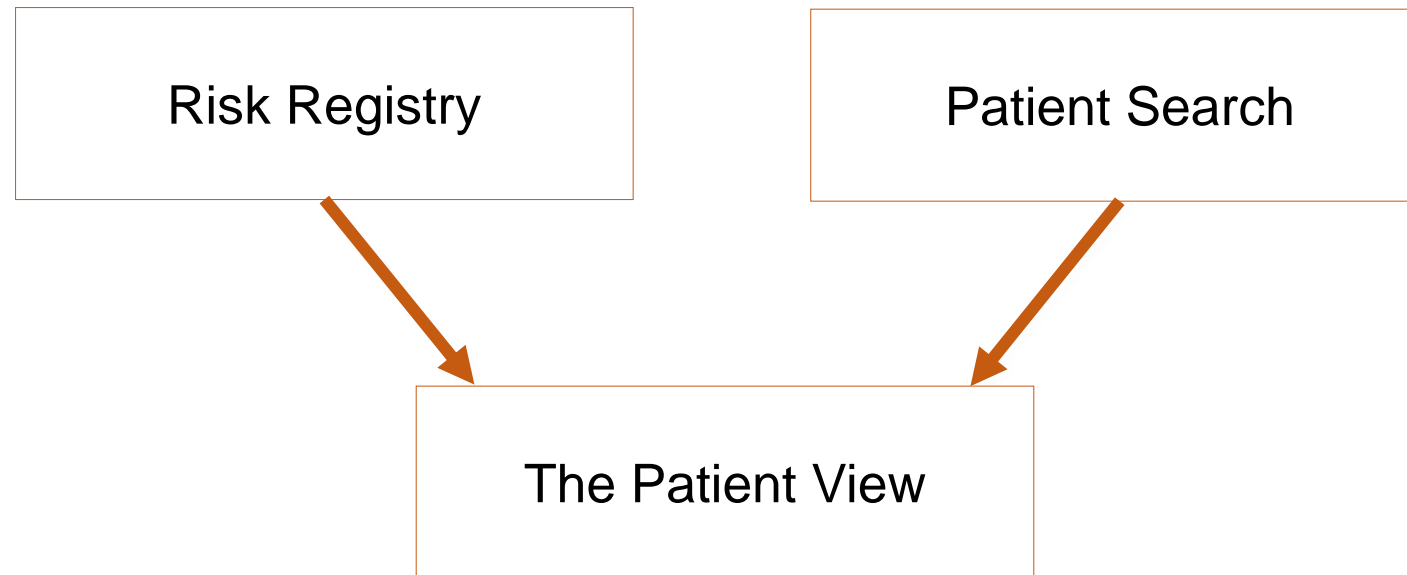
Patient Search

Patient Name and/or ID Date of Birth

show more options Search

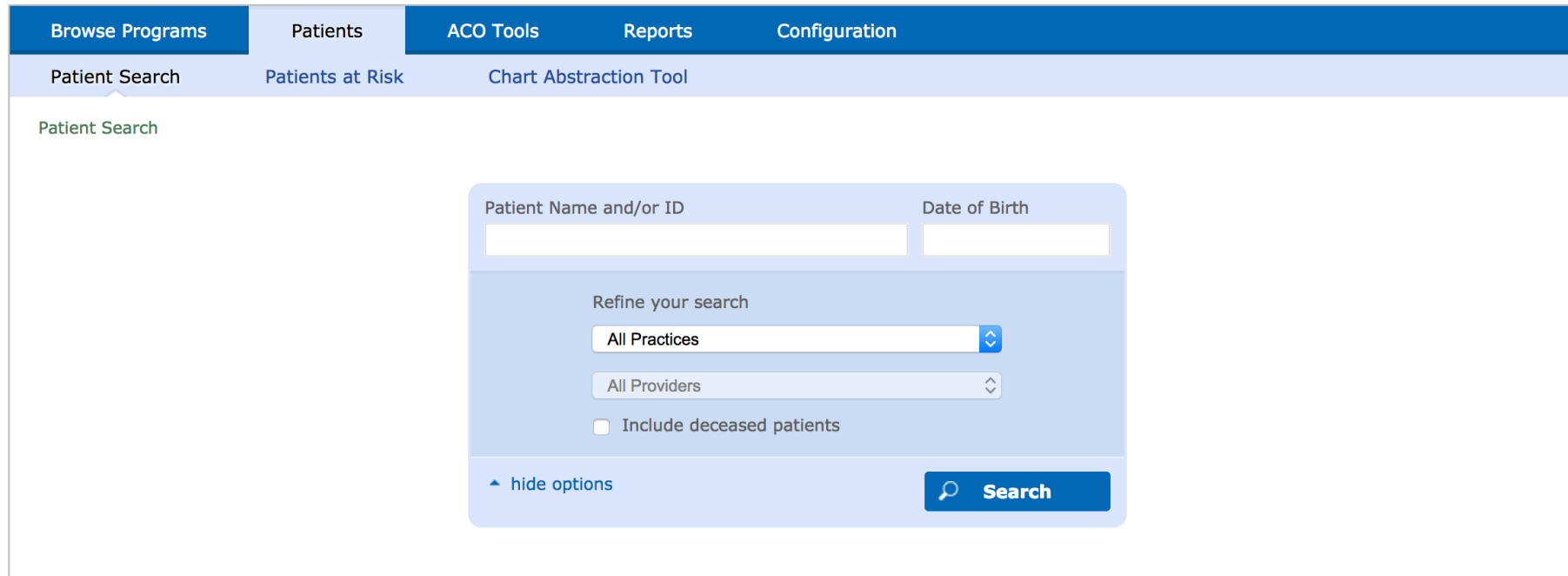
Depending on how your organization is configured and your own access rights, the navigation bar will vary.

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



The screenshot displays the Clinigence software interface for patient search. At the top, a navigation bar includes 'Browse Programs', 'Patients' (selected), 'ACO Tools', 'Reports', and 'Configuration'. Below this, a sub-navigation bar shows 'Patient Search' (selected), 'Patients at Risk', and 'Chart Abstraction Tool'. The main content area is titled 'Patient Search' and contains a search form. The form has two input fields: 'Patient Name and/or ID' and 'Date of Birth'. Below these fields is a section titled 'Refine your search' which includes two dropdown menus: 'All Practices' and 'All Providers'. There is also a checkbox labeled 'Include deceased patients'. At the bottom of the form, there is a link to 'hide options' and a blue 'Search' button with a magnifying glass icon.

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.

Browse Programs | **Patients** | **ACO Tools** | **Reports** | **Configuration**

Patient Search | **Patients at Risk** | **Chart Abstraction Tool**

[Patient Search](#) > [Search Results](#)

Select the patient name to go to the Patient View

Patient Name and/or ID

Name	Date Of Birth	Gender	EHR ID(s)	Hicno	Practice	Provider	Last Visit
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Jones, Addison	2/10/1943	Male	3579713000		Family Phys in ACO (EMDs)		12/14/2016
Jones, Addison	7/20/1953	Female	18107		Rural Family Phys (eCW)		10/14/2015
Jones, Addison	10/17/2016		3583700234		Family Phys in ACO (EMDs)		12/2/2016
Jones, Ashley	2/16/1944	Male	3579771890	126751020	Family Phys in ACO (EMDs)	Marlene Morgan	8/25/2016
Jones, Ashley	10/30/1989	Female	3584088004		Family Phys in ACO (EMDs)		7/6/2016
Jones, Ashley	7/31/1995	Male	3579501838		Family Phys in ACO (EMDs)		11/28/2016
Jones, Ashton	10/18/1965	Male	3585136612		Family Phys in ACO (EMDs)	Marlene Morgan	2/11/2016
Jones, Avery	8/30/2013	Female	3584084464		Family Phys in ACO (EMDs)		11/9/2016
Jones, Avery	9/14/2016		3583702498		Family Phys in ACO (EMDs)		12/16/2016

The Patient View

The screenshot displays the Clinigence Patient View interface. At the top, a blue navigation bar contains links for 'Browse Programs', 'ACO Tools', 'Reports', and 'Configuration'. Below this, a light blue bar features a 'Patient Search' button. A breadcrumb trail shows the path: 'Patient Search > Search Results > Jones, Ashley'. A callout points to the 'Return to search results' link in the breadcrumb. Another callout points to the 'Patient demographics data from the EHR' section, which includes the patient's name, age, gender, PCP, EHR ID, and HICNO. A third callout points to the 'Patient 4 / 109' navigation and the 'Log Activity' button. Below the demographics, a tabbed interface allows switching between 'Summary', 'Programs', 'Problems / History', 'Meds / Immunizations', 'General Info', 'Activity Log', and 'Documents'. A callout points to these tabs. The 'Summary' tab is active, showing a 'Summary of Patient Status' with two main sections: 'Gaps in Care' (7 gaps) and 'Chronic Conditions' (4 conditions). The 'Gaps in Care' section lists '2016 GPRO & Medicare Shared Savings Program' with 7 gaps and '2016 HEDIS Aetna' with 0 gaps. The 'Chronic Conditions' section lists 'AST Asthma' (12/17/2004) and 'DM Diabetes (non-gestational)' (1/24/2011).

Navigation Bar: Browse Programs, ACO Tools, Reports, Configuration

Patient Search: Patient Search

Breadcrumb: Patient Search > Search Results > Jones, Ashley

Return to search results

Patient demographics data from the EHR: Jones, Ashley, 72 years (2/16/1944), Male, 873-555-1912, PCP: Marlene Morgan, EHR ID(s): 3579771890, HICNO: 126751020

Patient 4 / 109

Log Activity

Summary of Patient Status

Summary of Patient Status:

- Gaps in Care (7 Gaps):**
 - 2016 GPRO & Medicare Shared Savings Program: 7 Gaps
 - 2016 HEDIS Aetna: 0 Gaps
- Chronic Conditions (4 Conditions):**
 - AST Asthma: 12/17/2004
 - DM Diabetes (non-gestational): 1/24/2011

Select the tab to view that sub-topic of the patient information

Patient View – General Organization

[Patient Search](#) > [Search Results](#) > Jones, Ashley

Jones, Ashley

72 years (2/16/1944)

PCP: Marlene Morgan


EHR ID(s): 3579771890

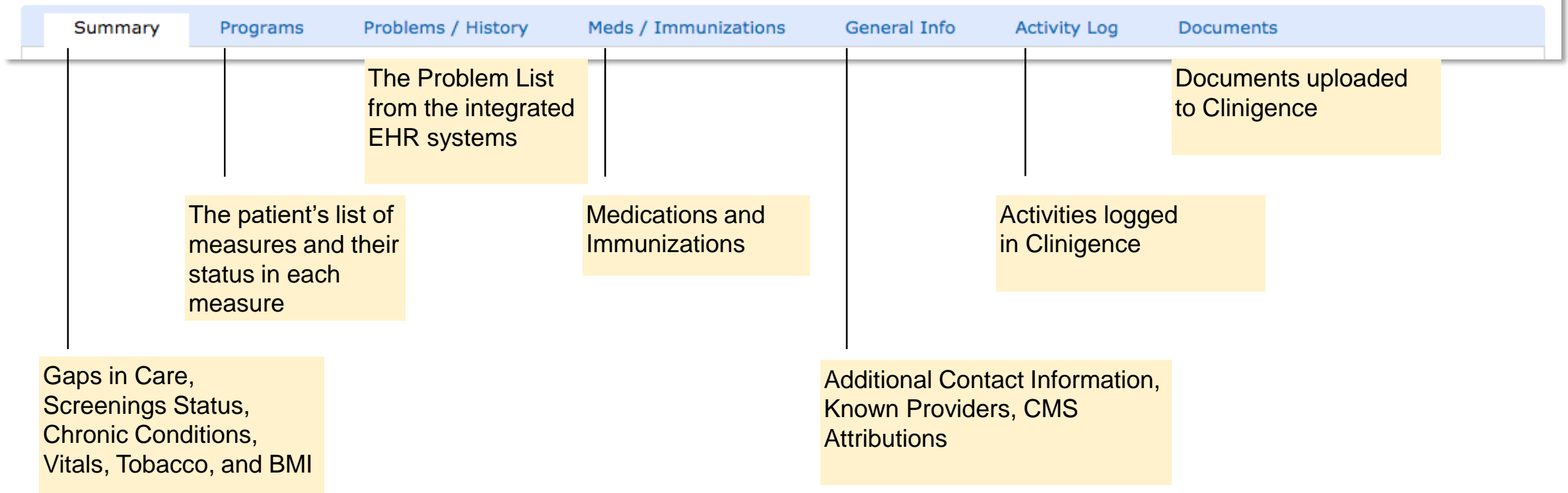
HICNO: 126751020

Male

873-555-1912

◀ Patient 4 / 109 ▶

 Log Activity



Patient View – Summary

Summary

Programs

Problems / History

Meds / Immunizations

General Info

Activity Log

Documents

Summary of Patient Status

Gaps in Care

7

2016 GPRO & Medicare Shared Savings Program

7 Gaps

>

2016 HEDIS Aetna

0 Gaps

>

2016 HEDIS Cigna

0 Gaps

>

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

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 ⚠

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

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

Patient View – Summary

Gaps in Care

7

2016 GPRO & Medicare
Shared Savings Program

7 Gaps >

2016 HEDIS Aetna

0 Gaps >

2016 HEDIS Cigna

0 Gaps >

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

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 ⚠

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

Best practice screenings
keyed to gender and age

Most recent readings
of key measurements

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

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



Patient View – Programs View

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

The screenshot displays the 'Programs' tab in a patient's clinical record. The top navigation bar includes 'Summary', 'Programs', 'Problems / History', 'Meds / Immunizations', 'General Info', 'Activity Log', and 'Documents'. The 'Programs' section lists two clinical programs:

- 2016 GPRO & Medicare Shared Savings Program**: Indicated by a red badge with the number '7' and the text 'Gaps in Care'.
- CARE-2 Falls: Screening for Future Fall Risk**:
 - Measure: Pts \geq 65 Yrs Screened for Fall Risk w/in 12 Mos
 - To Meet Target Criteria: **Screened for Fall Risk w/in 12 Months**
 - Eligible Population: Pts \geq 65 Yrs w/ at Least 1 Visit w/in 12 Mos
 - Status: **X Gap in Care**
- CARE-3 Documentation of Current Medications in the Medical Record**:
 - Measure: Visits for Pts \geq 18 Yrs When Provider Attests to Documenting All Current Medications
 - To Meet Target Criteria: **Visits where EP attests to documenting list of current meds**
 - Status: **X Gap in Care**

A yellow callout box on the right side of the screenshot states: "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.

The screenshot displays a web interface for a patient's medical record. At the top, there is a navigation bar with tabs: Summary, Programs, Problems / History (selected), Meds / Immunizations, General Info, Activity Log, and Documents. Below the navigation bar, the main content area is titled "Problems and History". It is divided into two columns. The left column, titled "Active Problems", lists four conditions, each with a date (05/16/2014) and the patient's name (Doris Sanders): COPD, Diabetes Mellitus type II, HTN [Hypertension], and Hyperlipidemia. The right column, titled "Full History", contains a large, empty rectangular box, indicating that no historical problems are currently displayed.

Summary	Programs	Problems / History	Meds / Immunizations	General Info	Activity Log	Documents
Problems and History						
Active Problems						
05/16/2014	COPD	Doris Sanders				
05/16/2014	Diabetes Mellitus type II	Doris Sanders				
05/16/2014	HTN [Hypertension]	Doris Sanders				
05/16/2014	Hyperlipidemia	Doris Sanders				
Full History						

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.

SummaryProgramsProblems / HistoryMeds / ImmunizationsGeneral InfoActivity LogDocuments

Medications and Immunizations

Immunizations

Administered ▼	Immunization ▲
11/22/2005	Influenza, split virus (3+ years dose)
10/11/2004	Td adult

Medications

☒ Show Current Meds Only

Prescribed ▼	Medication	Dosage ▲	Freq./Route	Ordered By
06/23/2015	L Lysine Vit B12	L Lysine Vit B12		
06/23/2015	Xalatan	Latanoprost		
11/17/2010	Prilosec OTC	Omeprazole		
11/02/2007	Zithromax	Azithromycin		
07/09/2007	Flonase	Fluticasone Propionate		
07/09/2007	Vicodin	Hydrocodone/Acetaminophen		
08/14/2006	Vicodin	Hydrocodone/Acetaminophen		
09/07/2005	Flagyl	Metronidazole		
08/19/2005	Glucosamine 500mg Capsules 2 po qd	Glucosamine		
05/06/2003	C-Pap 11 cm	C-Pap 11 cm		

Patient View – General Info View

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

Summary	Programs	Problems / History	Meds / Immunizations	General Info	Activity Log	Documents
---------	----------	--------------------	----------------------	--------------	--------------	-----------

General Info

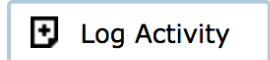
Personal/Contact Information	Known Providers	Known Attributions
Race: White	01/05/1944	Sonia Murphy
Ethnicity: Unknown		Rural Family Phys (eCW)
Patient Address: 7578 Lincoln Street Forest View, AZ 38500		
Phone: 973-555-9856		

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.

Franklin, Morgan
72 years (1/3/1944) PCP: EHR ID(s): 18103 HICNO: 394269006
Female
973-555-9856

◀ Patient 4 / 321 ▶





 Log Activity

Activities are entered using this button.

Summary Programs Problems / History Meds / Immunizations General Info **Activity Log** Documents

Activity Log

CCM-related columns

Activity Date ▼	Activity Type ▲	Author	Time Spent	CCM Activity	Comments	
07/18/2016	Education of patient / caregiver	G Imhoff	3 min	Yes	Fielded questions from patient on new medications.	 Delete
07/13/2016	Identify community / health resources	G Imhoff	6 min	Yes	Arranged Silver Sneakers application for patient to help them with exercise goals.	 Delete
07/13/2016	Identify community / health resources	G Imhoff	5 min	Yes	Arranged transportation for the patient to their exercise class.	 Delete
07/08/2016	Identify community / health resources	G Imhoff	10 min	Yes	Arranged transportation for the patient to their exercise class.	 Delete

Logging an Activity

n, Morgan
years (1/3/1944) PCP:
male
-555-9856

Primary Programs Problem

ty Log

Activity Date	Activity Type
18/2016	Education of patient / caregiver
13/2016	Identify community / health resources
13/2016	Identify community / health resources
08/2016	Education of patient / caregiver
06/2016	Health outcomes (lab reviews, status updates ...)
14/2016	Patient outreach

Patient 4 / 321

Log Activity

Log Care Activity

Enter the details of the activity

Activity Date:* 08/02/2016

Activity Type:*

Care plan related

CCM:
Coordinating care with other providers
Education of patient / caregiver
Health outcomes (lab reviews, status updates ...)
Identify community / health resources
Medication reconciliation / management
Patient outreach

Comments:

250 characters remaining

* indicates required field

Log Activity Cancel

Activity types are configurable for your organization

Logging an Activity

Log Care Activity [X]

Enter the details of the activity

Activity Date:* 08/02/2016

Activity Type:* Care plan related [v]

CCM: ☒ Flag as CCM taking 5 minutes work

Comments: Updated the goals status on the patient's Care Plan. This time included calling the patient for status, talking with her about how she felt, and updating the Care Plan. The patient indicated the the initial meds side effects have abated.

13 characters remaining

* indicates required field

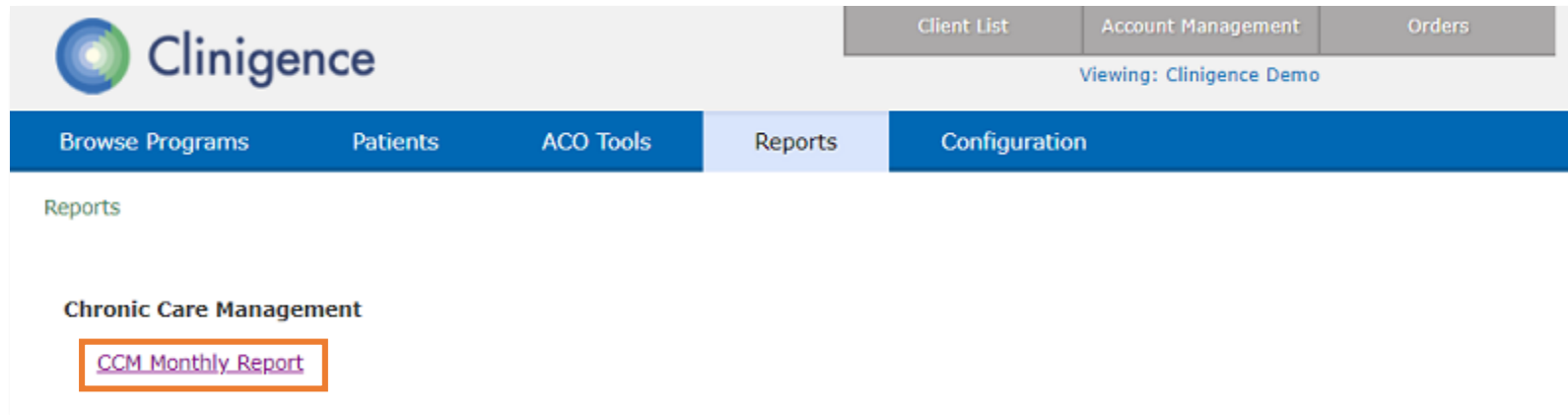
Log Activity Cancel

Background text: Morgan, (1/3/1944), PCP: 55-9856, Log, Activity Type, 2016, Education of patient / caregiver, Identify community / he resources, Health outcomes (lab reviews, status updates), Patient outreach, Patient 4 / Log Activit, Documents

If your organization uses the CCM Module, you indicate a CCM activity here and enter the time spent in minutes

CCM Monthly Reports

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



CCM Monthly Reports

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

Browse Programs **Patients** **ACO Tools** **Reports** **Configuration**

[Reports](#) > CCM Monthly Report

CCM Monthly Report

Clinigence Demo

Practice:

Month:

[Export to CSV](#)

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

Page 1 of 1

Select Export to CSV to
generate a spreadsheet file

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.

The screenshot displays the 'Documents View' for a patient named Morgan Franklin. At the top, patient details are shown: 'Franklin, Morgan', '72 years (1/3/1944)', 'Female', and '973-555-9856'. To the right, it indicates 'Patient 4 / 321' and includes a 'Log Activity' button. Below this is a navigation bar with tabs for 'Summary', 'Programs', 'Problems / History', 'Meds / Immunizations', 'General Info', 'Activity Log', and 'Documents'. The 'Documents' tab is currently selected. The main content area is titled 'Documents' and is divided into three sections: 'Care Plans', 'Consent Forms', and 'Miscellaneous'. The 'Care Plans' section shows a document titled 'Morgan_1803_Care_Plan' by 'G. Imhoff' dated '12/23/2016 1:06:49 PM' with '1 Version'. It includes 'Update' and 'Delete' icons and an 'Add New' button. The 'Consent Forms' section is currently empty, showing '(None)', and also has an 'Add New' button. An orange arrow points from a yellow text box to this 'Add New' button. The 'Miscellaneous' section also features an 'Add New' button.

Franklin, Morgan
72 years (1/3/1944)
Female
973-555-9856

PCP: EHR ID(s): 18103 HICNO: 394269006

Patient 4 / 321

Log Activity

Summary Programs Problems / History Meds / Immunizations General Info Activity Log Documents

Documents

Care Plans: + Add New

[Morgan_1803_Care_Plan](#)

G. Imhoff (12/23/2016 1:06:49 PM)
1 Version

Update Delete

Consent Forms: + Add New

(None)

Miscellaneous: + Add New

A document can be added by first selecting the Add New Button in the appropriate category

Uploading a Document

Patient at Risk > Franklin, Morgan

Franklin, Morgan
72 years (1/3/1944)
Female

PCP:

Problem:

Documents

Care Plans:

Morgan 1803 Care Plan
G. Imhoff (12/23/2016 1:06:49 PM)
1 Version

Miscellaneous:

Patient 4 / 321

Add a New Consent Form

1. Select the file you wish to upload (docx, rtf, pdf, png, or jpeg)
2. Give the file a name to display in the patient view

32 characters max

Use the Browse Button to locate the desired file on the local hard drive

Supported file types are listed

Uploading a Document

Patient at Risk > Franklin, Morgan

Franklin, Morgan
72 years (1/3/1944)
Female
973-555-9856

PCP:

Log Activity

Patient 4 / 321

Documents

+ Add New

Care Plans:

Morgan 1803 Care Plan

G. Imhoff (12/23/2016 1:06:49 PM)
1 Version

Miscellaneous: + Add New

Update Delete (None)

Add a New Consent Form

1. Select the file you wish to upload (docx, rtf, pdf, png, or jpeg)
 Morgan_1803_CCM-Consent-Form.docx
2. Give the file a name to display in the patient view

32 characters max

Give your document a display name, if you don't want to use the file name

Updating a Document

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

Update Care Plan

Upload New Version | **Restore Previous Version**

1. Select the file you wish to upload (docx, rtf, pdf, png, or jpeg)
 Morgan_1803_Care_Plan_Rev.docx
2. Give the file a name to display in the patient view

32 characters max

The existing display name can be used or changed, if needed

Franklin, Morgan
72 years (1/3/1944)
Female
973-555-9856

Summary Programs Pr

Morgan_1803_Care_Plan

G. Imhoff (12/23/2016 1:06:49 PM) G. Imhoff (12/23/2016 1:12:02 PM)

Updating a Document

[Patient at Risk](#) > Franklin, Morgan

Franklin, Morgan

72 years (1/3/1944)

PCP:

EHR ID(s): 18103

HICNO: 394269006

Female

973-555-9856

◀ Patient 4 / 321 ▶

 Log Activity

Summary

Programs

Problems / History

Meds / Immunizations

General Info

Activity Log

Documents

Documents

Care Plans:

 Add New

 [Morgan 1803 Care Plan](#)

 Update

 Delete

G. Imhoff (12/23/2016 1:14:01 PM)

[2 Versions](#)

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

Consent Forms:

 Add New

 [CCM Consent Form 2016](#)


 Update

 Delete

G. Imhoff (12/23/2016 1:12:02 PM)

1 Version

Miscellaneous:

 Add New

Restoring a Previous Version of a Document

Patient at Risk > Franklin, Morgan

Franklin, Morgan
72 years (1/3/1944)
Female
973-555-9856

Summary Programs Pr

Log Activity

Patient 4 / 321

Update Care Plan

Upload New Version Restore Previous Version

Select the file you wish to restore as the current version.

Version	Uploaded	Uploaded By	File Display Name
2	12/23/2016 1:14:01 PM	G. Imhoff	Morgan_1803_Care_Plan
<input checked="" type="radio"/> 1	12/23/2016 1:06:49 PM	G. Imhoff	Morgan_1803_Care_Plan

† indicates a version created via a previous restore process

Restore Selected Cancel

Previous versions are listed. Select the version you wish to become the new current version

Morgan_1803_Care_Plan

G. Imhoff (12/23/2016 1:14:01 PM)
2 Versions

Miscellaneous: + Add New

1 Version

Add New Delete

The Risk Registry

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

Browse Programs	Patients	ACO Tools	Reports	Configuration
Patient Search	Patients at Risk			

Patients at Risk help ?

Export Patients

Filters: Age, Gaps in Care, Number of Conditions | Sort By: Gaps in Care ▾, Patient Name ▲

Patient Name ID(s)	Gender	Age	Gaps in Care	Chronic Conditions	ER Visits (Last 12 mo)	Last Medicare Annual Exam	Provider	Last Visit
Armstrong, Jeffrey Patient ID: 17770 HICNO: 226893122	Male	92	11	5 COPD CHD HF HBP HC	0	8/27/2014 ⚠	Leonard Fowler	4/20/2016
Campos, Madison Patient ID: 17095 HICNO:	Male	79	11	5 COPD CHD DM HBP HC	0	1/7/2016	Leonard Fowler	1/7/2016
Jenkins, Carter Patient ID: 16425 HICNO: 310526442A	Male	68	11	4 CHD DM HBP HC	0	2/17/2015 ⚠	Joyce Lawrence	7/7/2015

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.

Patients at Risk

Export Patients

Filters: Age, Gaps in Care, Number of Conditions | Sort By: Gaps in Care ▾, Patient Name ▲

Patient Name ID(s)	Gender	Age	Gaps in Care	Chronic Conditions	ER Visits (Last 12 mo)	Last Medicare Annual Exam	Provider	
Armstrong, Jeffrey Patient ID: 17770 HICNO: 226893122	Male	92	11	5 COPD CHD HF HBP HC	0	8/27/2014 ⚠	Leonard Fowler	
Campos, Madison Patient ID: 17095 HICNO:	Male	79	11	5 COPD CHD DM HBP HC	0	1/7/2016	Leonard Fowler	1/7/2016
Jenkins, Carter Patient ID: 16425 HICNO: 310526442A	Male	68	11	4 CHD DM HBP HC	0	2/17/2015 ⚠	Joyce Lawrence	7/7/2015

help ?

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.

The screenshot shows a 'Filter Settings' dialog box with a title bar and a close button. Inside, a message states 'Multiple selections will be AND'ed together.' The dialog is organized into sections for different filter types:

- Gender:** A dropdown menu set to 'All'.
- Age:** A radio button for 'No threshold applied' is unselected. A selected radio button is followed by a dropdown set to 'greater than', a text input with '65', and the unit 'years'.
- Gaps in Care:** A radio button for 'No threshold applied' is unselected. A selected radio button is followed by a dropdown set to 'less than', a text input with '12', and the unit 'gaps'.
- Chronic Conditions:** A text input field is empty, followed by a dropdown arrow and an 'Add' button. Below this, a tag 'Diabetes (non-gestational)' with an 'X' to remove it is shown.
- Number of Conditions Displayed:** A radio button for 'No threshold applied' is unselected. A selected radio button is followed by a dropdown set to 'greater than or equal to', a text input with '2', and the unit 'conditions'.
- ER Visits:** A radio button for 'No threshold applied' is selected.

At the bottom right, there are two buttons: 'Save and Refresh List' and 'Cancel'.

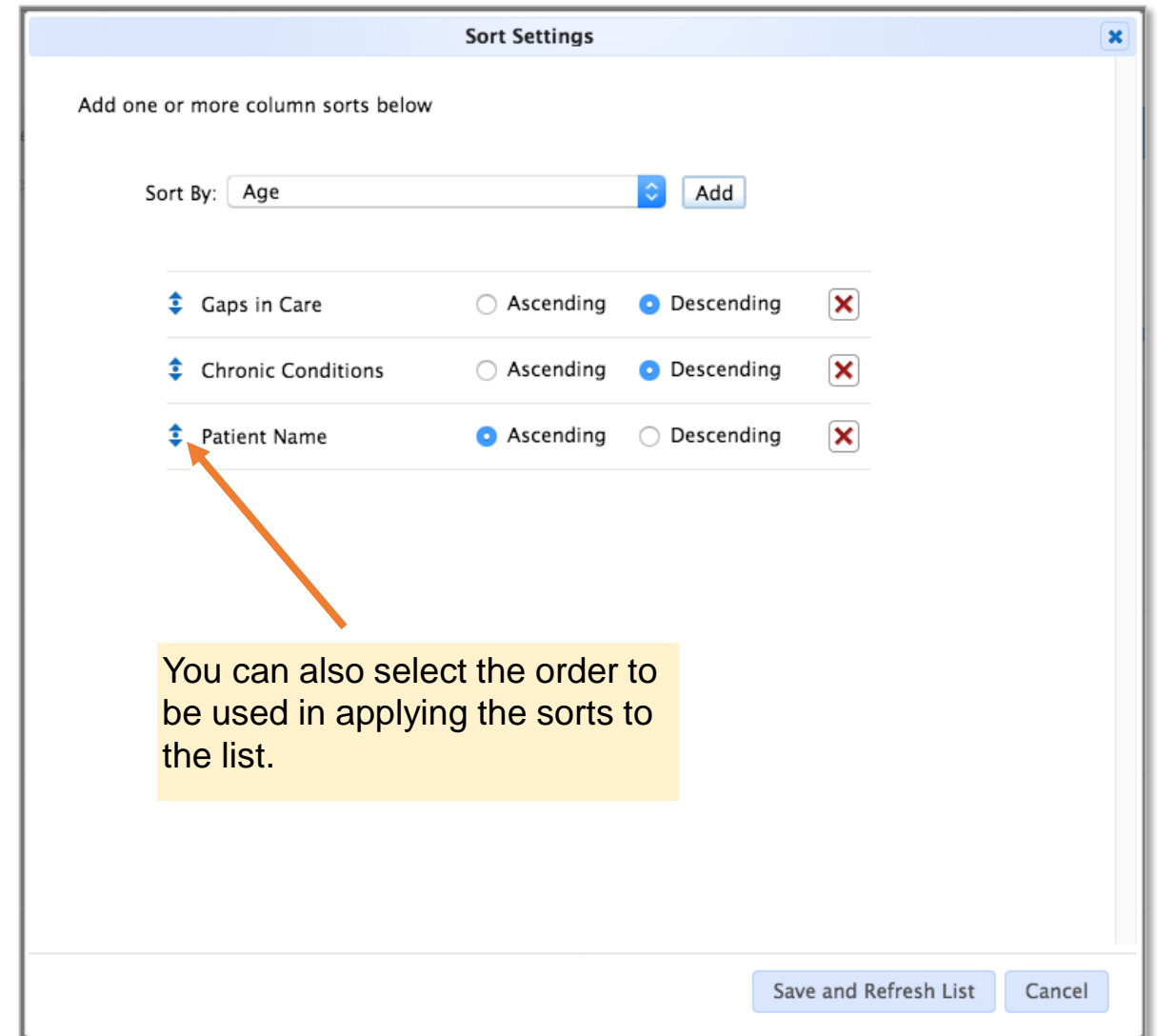
Risk Registry – Filters

- 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



Sort Settings

Add one or more column sorts below

Sort By: Age

<input checked="" type="radio"/> Gaps in Care	<input type="radio"/> Ascending <input checked="" type="radio"/> Descending	<input type="button" value="X"/>
<input checked="" type="radio"/> Chronic Conditions	<input type="radio"/> Ascending <input checked="" type="radio"/> Descending	<input type="button" value="X"/>
<input checked="" type="radio"/> Patient Name	<input checked="" type="radio"/> Ascending <input type="radio"/> Descending	<input type="button" value="X"/>

You can also select the order to be used in applying the sorts to the list.

The Risk Registry

<div> Browse Programs Patients ACO Tools Reports Configuration </div>									
<div> Patient Search Patients at Risk </div>									
<div> <div>Patients at Risk</div> <div> <div>Export Patients</div> <div> After filtering the list, select Export Patients to generate a spreadsheet file </div> <div> Filters: Age, Gaps in Care, Number of Conditions Sort By: Gaps in Care </div> <div> <div>help ?</div> <div> Select the Help icon to access the online Help for the Risk Registry </div> </div> </div> </div>									
Patient Name ID(s)	Gender	Age	Gaps in Care	Chronic Conditions	ER Visits (Last 12 mo)	Last Medicare Annual Exam	Pi		
Armstrong, Jeffrey Patient ID: 17770 HICNO: 226893122	Male	92	11	5 <div> <div>COPD</div> <div>CHD</div> <div>HF</div> <div>HBP</div> <div>HC</div> </div>	0	8/27/2014 ⚠	Leonard Fowler	4/20/2016	
Campos, Madison Patient ID: 17095 HICNO:	Male	79	11	5 <div> <div>COPD</div> <div>CHD</div> <div>DM</div> <div>HBP</div> <div>HC</div> </div>	0	1/7/2016	Leonard Fowler	1/7/2016	
Jenkins, Carter Patient ID: 16425 HICNO: 310526442A	Male	68	11	4 <div> <div>CHD</div> <div>DM</div> <div>HBP</div> <div>HC</div> </div>	0	2/17/2015 ⚠	Joyce Lawrence	7/7/2015	

The Risk Registry

- After you have 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.

Browse Programs Patients ACO Tools Reports Configuration								
Patient Search Patients at Risk								
Patients at Risk help ?								
Export Patients Filters: Age, Gaps in Care, Number of Conditions Sort By: Gaps in Care Patient Name								
Patient Name ID(s)	Gender	Age	Gaps in Care	Chronic Conditions	ER Visits (Last 12 mo)	Last Medicare Annual Exam	Provider	Last Visit
Armstrong, Jeffrey Patient ID: 17770 HICNO: 226893122				5 COPD CHD HF HBP HC	0	8/27/2014	Leonard Fowler	4/20/2016
Campos, Madison Patient ID: 17095 HICNO:			11	5 COPD CHD DM HBP HC	0	1/7/2016	Leonard Fowler	1/7/2016
Jenkins, Carter Patient ID: 16425 HICNO: 310526442A	Male	68	11	4 CHD DM HBP HC	0	2/17/2015	Joyce Lawrence	7/7/2015

Select the patient name to access the Patient View for that patient

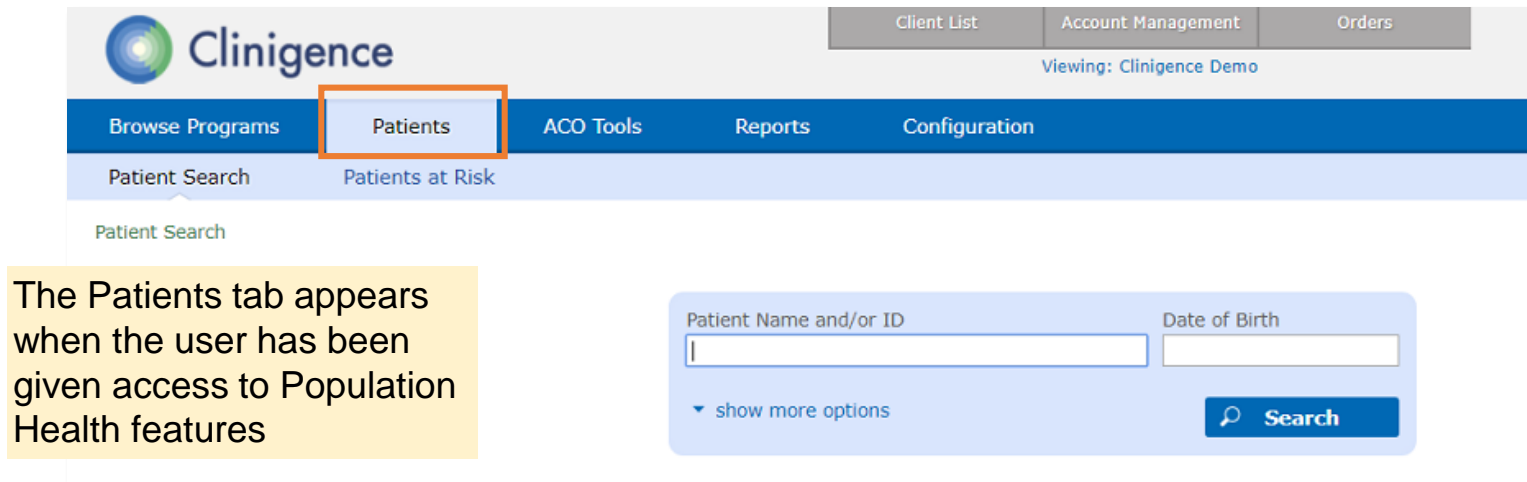
Accessing Pop Health & CCM

- 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.

The screenshot displays the Clinigence Help Desk interface. At the top, the Clinigence logo is on the left, and the text 'Clinigence Help Desk' is in the center. On the right, it says 'Welcome Beth Copenhaver' and 'Agent Portal | Edit profile - Sign out'. Below this is a navigation bar with 'Home', 'Solutions', 'Forums', and 'Tickets'. The main content area is titled 'How can we help you today?' with a search bar. Below the search bar, there's a section for 'Clinigence User Account FAQ' with a description: 'This section describes features which are applicable to users who have a valid email address and password and for administrators managing their organization.' There are three links: 'What should I do if I forgot my password?', 'How do I change my Clinigence password?', and 'Describe the Clinigence user roles.' The right sidebar shows the selected article: 'How do I add a new user with a Practice Administrator role?' with a 'Modified on: Thu, 17 May, 2018 at 2:50 PM' timestamp. The article content explains that Organization Administrators and Practice Administrators can add user credentials for the Practice Administrator role. It states that each practice should have at least one user designated as the Practice Administrator, who will be responsible for adding and maintaining other users' login credentials and can see patient data for all patients associated with the practice. It also notes that only an Organizational Administrator can add a new Practice Administrator. A 10-step list follows: 1. Login to the application. 2. Select the Configuration tab near the top of your screen. A list of Organizational Administrators appears in the top portion of the screen. Below that is a list of Practice Accounts. 3. Select Create Practice Administrator Account. 4. Select the practice this user belongs to from the dropdown list. 5. Enter the user's name, description, and email address. (Email address can only be used once in the Clinigence system, so it must be unique to that person.) 6. Select "Send Password Setup Link to Account Holder". The account holder will receive an email with a link that will allow them to setup their password. 7. If you want the user to be able to access the Configuration tab to be able to maintain users, update goal thresholds, or edit MIPS Renewal orders, select the Grant Configuration tab access checkbox. 8. If you want the user to be able to view scores for all other practices in the organization, select the Restricted Organization Access checkbox. This allows the user to see scores but will not allow the user to view the patient lists or other patient data at any practice but his "home" practice selected in step 4. 9. Optional: Enter the phone number. 10. Select Save. The article concludes with 'The new user will receive an activation email.'

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.



Let's give it a try in the application.

Questions?

