Health Management Associates

Making Data Work for You

Million Hearts Learning Collaborative

November 17, 2021

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- Mary’s Center: Dashboard Best Practices
- Making Data Work for You
- Q & A

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- **Are you currently using a dashboard to support quality improvement?**
  - Million Hearts
  - Other disease management activities
  - Not yet
  - No/Not Sure
- **If yes, drop the name of the tool in the chat box!**

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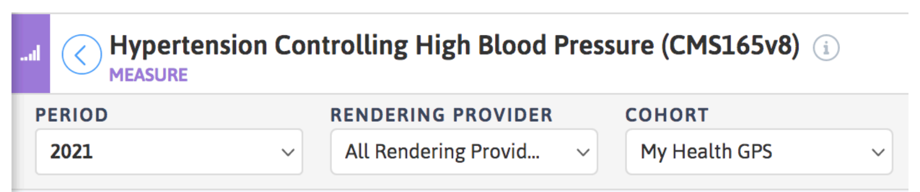
Care Coordination Dashboard on AZARA

AZARA

- Introduced at Mary’s Center in 2019
- **Needs**
  - Population health management tool
  - Improved access to participant aggregate data for reporting
  - Participant visit planning
- **How it works**
  - Connects to Mary’s Center EMR
  - Data is pulled through diagnosis or CPT codes, structured data in progress notes, specific queries
  - Value sets
    - Use of numerator, denominator, and exclusions
  - Measures are set based on HEDIS, comparison to other organizations



Hypertension Controlling High Blood Pressure (CMS165v8)

Endorser: None
Steward: NCQA

Patients 18-85 years of age who had an active diagnosis of hypertension during or prior to the measurement period and whose most recent blood pressure during the measurement period was adequately controlled (<140/90mmHg).

Numerator:
Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period*

- Most recent systolic blood pressure in measurement period < 140 mmHg
- Most recent diastolic blood pressure in measurement period < 90 mmHg

*If multiple readings are taken on the same day, measure will look for the lowest diastolic and lowest systolic values from all readings. The Detail List includes a "Multiple BP" column that shows the lowest systolic and lowest diastolic readings. This means the final reported diastolic and systolic numbers may be a composite of values from different readings. For example, on reading of 150/95 and another of 135/100 would result in a reported value of 135/95.

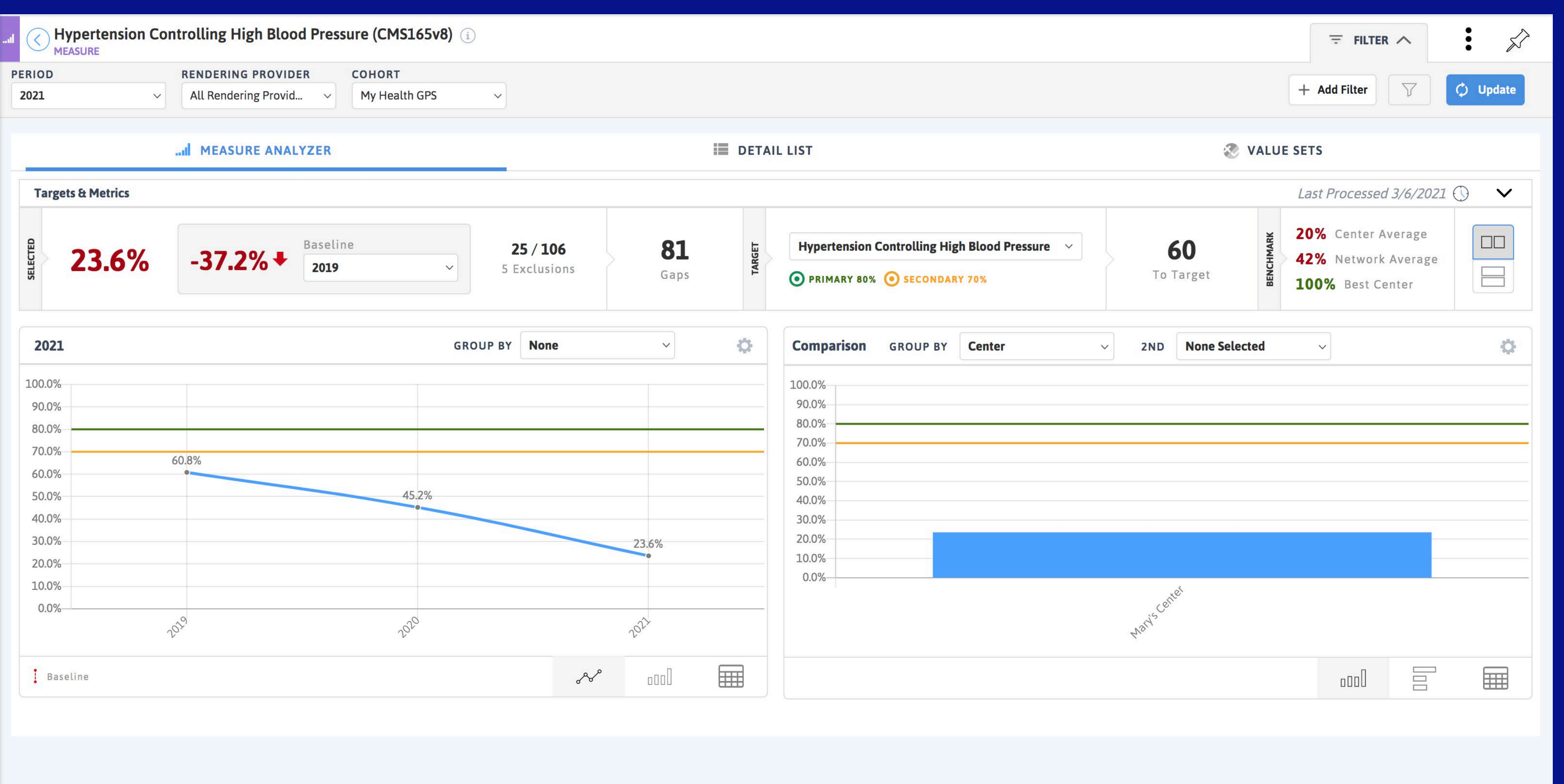
Denominator:
Patients 18-85 years of age who had an active diagnosis of essential hypertension during the measurement period.

- Age >=18 and <85 at the start of the measurement period
- Active diagnosis of Essential Hypertension prior to or during the measurement period
- Measure qualifying visit in the last 12 months (see value set tab and technical specifications for qualifying visit codes)

Exclusions:
- Active Pregnancy during the measurement period
- End Stage Renal Disease before or during the measurement period
- Chronic Kidney Disease, Stage 5
- Dialysis, Kidney Transplant recipient before or during the measurement period
- Hospice Care overlapping the measurement period
- Age >= 65 and <81 at start of period, AND the following in the two years before the measurement period end
  - Evidence of frailty, AND
    - > 1 outpatient visit with a diagnosis of Advanced Illness
    - OR
    - Active medication for dementia
- Age > 80 at start of period, and evidence of frailty in the two years before the measurement period end

AZARA (CONT.)

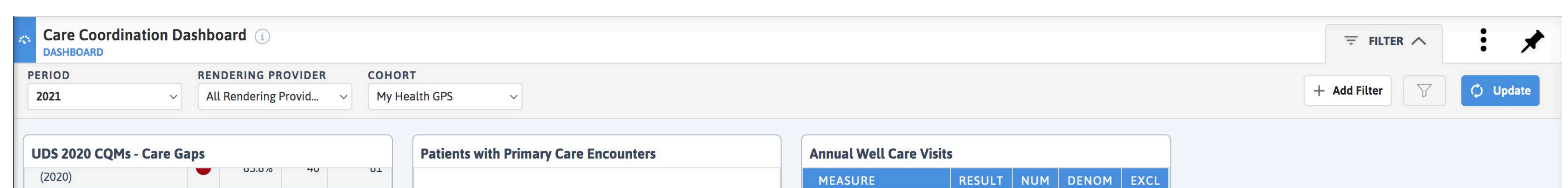
- **Capabilities**
  - Individual level
    - Care Management Passport
    - Identify care gaps
    - Identify participants for outreach
    - Care coordination
  - Population level
    - Panel management
    - Review how participant cohorts are performing on selected health measures
    - Identify cohort-wide care caps
    - Displays trends in participant data over time

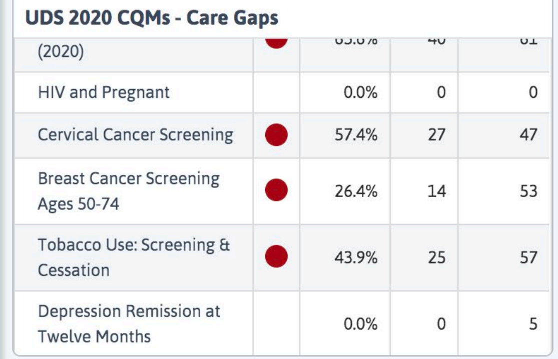


Hypertension Controlling High Blood Pressure (CMS165v8)
MEASURE
FILTER
PERIOD
2021
RENDERING PROVIDER
All Rendering Provid...
COHORT
My Health GPS
Add Filter
Update
MEASURE ANALYZER
DETAIL LIST
VALUE SETS
Targets & Metrics
Last Processed 3/6/2021
SELECTED
23.6%
-37.2%
Baseline
2019
25 / 106
5 Exclusions
81
Gaps
TARGET
Hypertension Controlling High Blood Pressure
PRIMARY 80%
SECONDARY 70%
60
To Target
BENCHMARK
20% Center Average
42% Network Average
100% Best Center
2021
GROUP BY
None
60.8%
45.2%
23.6%
2019
2020
2021
Baseline
Comparison
GROUP BY
Center
2ND
None Selected
Mary's Center

CARE COORDINATION DASHBOARD

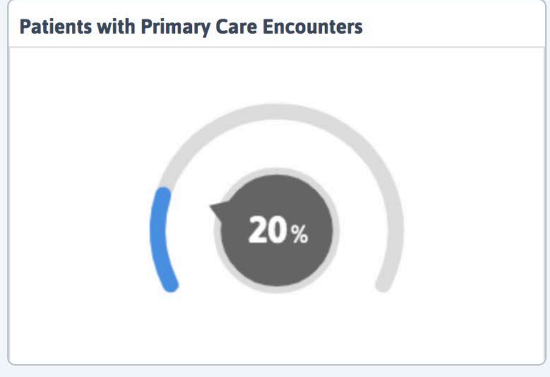
- Developed at Mary's Center to review key metrics that care coordination teams are most frequently monitoring or measuring for their cohorts
  - HTN Control
  - UDS measures
  - Annual wellness exams
- Use of registries
  - Cohorts are created in AZARA for specific participant group
- Ability to select the metric and see individual participant names





UDS 2020 CQMs - Care Gaps

(2020)	●	65.6%	40	61
HIV and Pregnant		0.0%	0	0
Cervical Cancer Screening	●	57.4%	27	47
Breast Cancer Screening Ages 50-74	●	26.4%	14	53
Tobacco Use: Screening & Cessation	●	43.9%	25	57
Depression Remission at Twelve Months		0.0%	0	5



Annual Well Care Visits

MEASURE	RESULT	NUM	DENOM	EXCL
Medicare AWV	0.0%	0	42	0
Well-Child Care Visits (3-6 Yrs)	0.0%	0	0	0
Well-Child Care Visits (12-21 Yrs)	50.0%	1	2	0
Well-Child Care Visits (<=15 months)	0.0%	0	0	0
Well-Child Care Visits	0.0%	0	0	0

Diabetes Scorecard

MEASURE		RESULT	NUM	DENOM	EXCL
DM Eye Exam	●	0.0%	0	61	0
DM Foot Exam	●	0.0%	0	60	1
DM BP < 130/80		14.8%	9	61	0
DM BP < 140/90		29.5%	18	61	0
DM Depression Screening		32.6%	14	43	18
DM Tobacco Use					

A1c Cascade

MEASURE	RESULT	NUM	DENOM
DM A1c >= 7 and A1c <= 8	8.2%	5	61
DM A1c > 8 and A1c <= 9	11.5%	7	61
DM A1c > 9	26.2%	16	61
DM A1c < 7	14.8%	9	61
DM A1c does not exist	39.3%	24	61

Uncontrolled A1c (lower is better)

100%
80%
60%
40%
20%
0%
2020
2021

HTN Control

MEASURE		RESULT	NUM	DENOM	EXCL
HTN Controlling High BP	●	23.1%	21	91	3
HTN BP >= 140/90		26.4%	24	91	3

HCL Control

PTS W/ DIABETES	61	
DM LDL < 100	6	10%
DM LDL >= 100 AND < 130	5	8%
DM LDL >= 130	2	3%
DM LDL Untested	48	79%

AZARA & CARE COORDINATION DASHBOARD

- **Lessons learned/recommendations**
  - Requires an extensive validation process
  - Measures don't always align with our organization's clinical workflow or may come out prior to one being developed
  - Ongoing quality assurance
  - Can be overwhelming to users based on number of reports available
  - Slow adoption
  - Data does not always match internal reporting

AZARA & CARE COORDINATION DASHBOARD (CONT.)

- **Future plans**
  - Have a dedicated team member to help promote AZARA and provide training to staff members
  - Help departments and teams connect how it is relevant to their work
  - Identify quality champions for reporting measures

- Based on what you've heard from Mary's Center, does this sound familiar?
- What are your goals around optimizing data collection and use?

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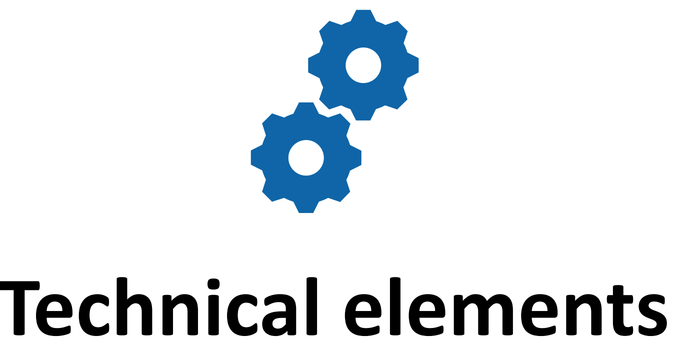

Technical elements

Operational

Workflow

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COMMON DATA ELEMENTS AND DATA STANDARDS

COMMON DATA ELEMENTS

STANDARDIZED OUTCOME MEASURES

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WORKFLOWS TO SUPPORT DATA CAPTURE

- Prioritizing patients based on risk stratification
- Enrollment of newly diagnosed patients into ongoing self-management
- Patient outreach and engagement
- Coordination for remote patient monitoring device needs
- Patient check in visits for BP updates, labs, etc.
- Ensuring appropriate PCP and specialist visits
- Addressing SDOH in helping to manage HTN
- Patient education

Hypertension Virtual Model Tool Kit Swim Lanes: Screening Workflow for Those with no HTN Diagnosis

Non-Clinical Support
Medical Assistant
Nurse
PCP

Patient Outreach
Select an adult without HTN dx from the prioritized patient list.[1]
Review EHR to identify other risk factors and any gaps in screening for those risk factors. Attempt to contact patient.
Patient Reached?
No
Document outreach attempt in EMR.[2]
Complete scripting, including identified gaps in risk screening, and guidelines on BP reading.[3]
Patient prefers and consents to virtual visit?
Yes
No
Patient agrees to participate in HTN screening program? This includes completing two home/drug store BP readings.[4]
Yes, BP elevated on 2 occasions
Yes, BP not elevated on 2 occasions
No
Next screened according to appropriate guidelines.[5]
Patient agrees to participate in Home BP monitoring for a week?[6]
No
Yes
Document patient decision in EHR. Schedule appointment in-person with PCP as clinically indicated. PCP may reintroduce HTN program in future visits.
COVID Protocol based on severity of symptoms.
Alert
(+)
COVID-19 Symptom Screening.
(-)
COVID Recovery
In-person visit
Call with patient to get instructions, establish parameters, and deliver patient education.[7]
BP readings collected and documented.[8]
Document findings in EHR
Patient meets criteria for HTN.[9]
No
Next screened according to appropriate guidelines[5]
Yes
Patient Enters HTN Monitoring Workflow. (Go to HTN Monitoring Workflow)

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WORKFLOWS TO SUPPORT DATA CAPTURE

Physician Assistant (PA) Office Visit

Patient
- Arrive and check in at reception
- Patient checks out

Nurse/MA/Clinical Support Staff
- Note patient has arrived on EHR schedule
- Greet and escort patient to exam area
- Measure patient's weight and height in hallway; write on paper
- Take patient to exam room and log into computer
- Click on patient name on schedule to open encounter
- Take vital signs
- Record vital signs and chief complaint(s)
- Review and verify allergies, tobacco, and current meds list in EHR
- Place any necessary orders per provider
- Secure the computer and leave room
- Support finishes with patient and completes documentation
- Print aftervisit summary and give to patient with any other printouts (Rx, etc.) Exit workspace

Physician Assistant
- Review EHR prior to entering the room
- Enter exam room and log into computer. Go to patient encounter
- Review information documented by support staff
- Interview patient and document in EHR progress note
- Perform exam and document in EHR progress note
- Continue progress note in documentation
- PA closes encounter
- Place orders in EHR with authorization of provider if necessary
- Enter followup information and/ or patient instructions in EHR
- Use followup section to CC encounter to supervising provider for review
- Complete progress note
- Will support staff need to document anything else?
- Yes
- No
- Print aftervisit summary and give to patient with any other printouts (Rx, etc.); exit workspace

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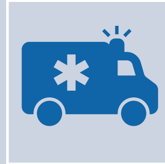
REGISTRY AND DASHBOARD OPPORTUNITIES

Use functionality housed within your EHR



Use a population health management data platform which integrates with your EHR (e.g., Azara)

Create a manual registry (e.g., Excel)

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Figure 1.

Welcome Margaret Basket from AMA Demo IHO: BP Initiative | Users | Logs | Files | Help | Log Out

IHO:BP POPULATIONMANAGER

Home | Patients | Patient Search | Populations | Metrics | Measures | Panels | Groups | Data

Population Snapshot

View > Ill, Beatriz

Measure Set > IHO: BP Initiative

Population > Hypertension = 482 Patients

Group > All

Current Results - Demo 3		482 Patients		%	
Blood Pressure Measurement [?]	BP screened within 12 months	366	116	76%	Compare
Blood Pressure Measurement (>=60 Years) [?]	BP screened within 12 months	67	20	77%	Compare
Blood Pressure Measurement (<60 Years) [?]	BP screened within 12 months	299	96	76%	Compare
Blood Pressure Control [?]	BP < 140/90	167	199	46%	Compare
Blood Pressure Control (>=60 Years) [?]	BP < 150/90	36	31	54%	Compare
Blood Pressure Control (<60 Years) [?]	BP < 140/90	140	159	47%	Compare
Blood Pressure Management [?]	BP < 140/90 OR >= 140/90 and on at least 2 anti-HTN meds	351	131	73%	Compare
Nutritional and Physical Activity Counseling [?]	Received nutrition and physical activity counseling	237	245	49%	Compare
Nutritional Counseling [?]	Received nutrition counseling	353	129	73%	Compare
Physical Activity Counseling [?]	Received physical activity counseling	335	116	74%	Compare

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EXCEL SPREADSHEET MANUAL ENTRY PATIENT REGISTRY

Patient Information		Enrollment Status and Actions			Contacts			Measurements				Physical Health Data								
MRN	Name	Treatment Status	Tickler	Episode Number (Episode of care/tx)	Date Follow-Up Due	Actual Contact Dates	Type of Contact	PHQ-9 Score (Target <5 within 5-7 months of initial elevated PHQ-9)	% Change in PHQ-9 Score (Target is -50% within 5-7 months of initial elevated PHQ-9)	GAD-7 Score (Target <10 within 5-7 months of initial elevated GAD-7)	% Change in GAD-7 Score (Target is -50% within 10 weeks of initial elevated PHQ-9)	Date	BMI/Weight	Date	SBP	DBP	Date	HbA1C	Date	LDL

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DISCUSSION

We are here to help you !

- ✓ One on one coaching on clinical workflow assessment for best data use practices
- ✓ Dashboard and registry design/optimization
- ✓ EHR optimization for best data strategies
- ✓ Other questions or ideas? Give us a call!

HEALTH MANAGEMENT ASSOCIATES

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1. To what extent did the session meet the stated objectives? (1 not at all to 5 met all objectives)
   - ✓Discuss current uses and strategies of dashboards/registries (case example)
   - ✓Describe key concepts in using the whole care team to optimize workflows for useful data capture
   - ✓Learn basic concepts of EHR optimization to support an effective data strategy
2. How would you rate the session overall? (from 1-5, where 1 is poor and 5 is excellent)

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