eHEALTHDC
A DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION PROGRAM

Helping Healthcare Providers Adopt Digital Health Technologies and Achieve HIE Connectivity in the District

DCPCA
DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION

ARPA Home and Community Based Services (HCBS) Digital Health Technical Assistance (TA) Program

August Learning Community:

PopHealth Analytics for Home and Community-Based Service Organizations

Learning Community Expectations

- **Full Participation** (Required): Attendees are required to be present for the entire duration of the Learning Community. Note that facilitators will be soliciting reactions and responses to discussion topics from all participants.

- **Interactive Contribution** (Required): Actively contribute to the Learning Community through chat or audio interactions. Your insights and questions contribute to the collective learning experience.

- **Camera Presence** (Strongly Encouraged): We encourage attendees to turn on their cameras for a more interactive and engaging experience. While it's not mandatory, having your camera on enhances the sense of community and connection.

How to Engage

- Use **CHAT** to share comments and questions with group

- Use **RAISE HAND** function to be queued up for commenting/ unmuting and share your comments with the group

Agenda

- Welcome and Objectives
- PopHealth & Role Manager Overview
- Introducing Population Navigator, NED and Follow-up Post-Acute Setting Discharge Reports

PopHealth Analytics

About PopHealth

- PopHealth Analytics offers safe and secure access to healthcare data and related analytics tools to assist healthcare institutions improve patient care throughout the District of Columbia.
- PopHealth allows for population and panel-level management based on clinical and administrative data.

The Reports

- The PopHealth suite of reports is intended for and designed with a diverse group of DC HIE users in mind to support their analyses and interventions.
- The analytics can help users plan and develop care coordination initiatives for specific chronic conditions, beneficiaries of interest, and more!

Report Utility

- Analyze aggregate demographic data.
- Stratify, compare and drill down data points for populations by chronic disease, SDOH, high risk, timeframes and other classifications.
- Monitor progress on nationally recognized quality measures.
- Visualize data to help strengthen communication across clinical and non-clinical settings.

PopHealth Data Flow

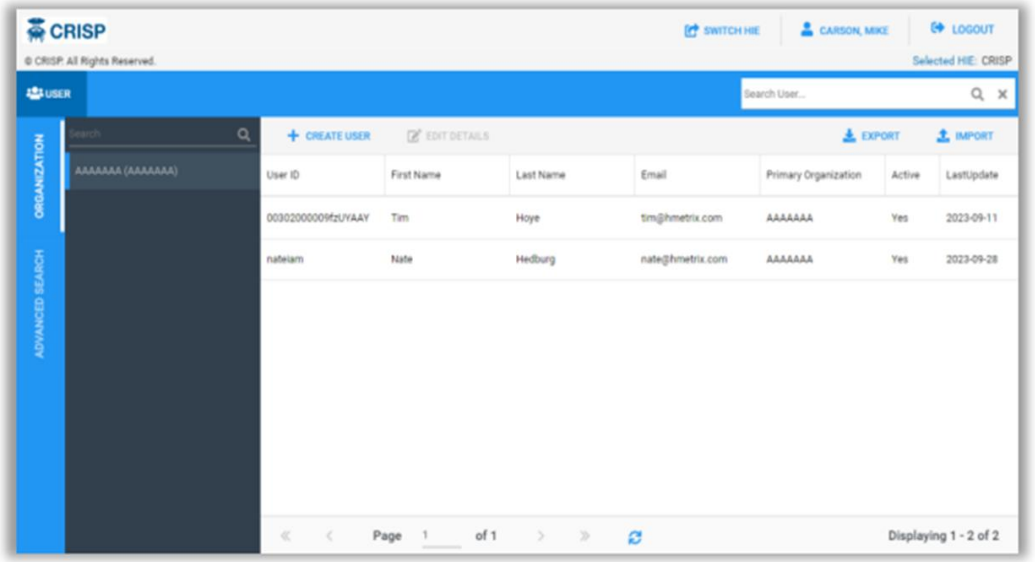
The reports are based on the DC claims data the CRISP and hMetrix receive from the DC Department of Health Care Finance.

Data	Data Input Frequency	Source	Report Refresh Frequency
DC Medicaid claims	Twice a month	DHCF	Monthly
DC Medicaid Redetermination data	Weekly	Conduent, DC MMIS	Weekly
Active NF and CSR Data	Monthly	DHCF	Monthly
Lead Report data	Weekly	CRISP DC/DOEE	Weekly
SDOH Z-codes	Monthly	CRISP DC	Monthly
Lab (LOINC codes) data	Monthly	CRISP DC	Monthly
ADT, CCD, and No Diagnosis data	Weekly	CRISP DC	Weekly

PopHealth Role Manager

All Role Manger POCs are provisioned with access to the HIE Admin Tool. Training on the HIE Admin Tool will be provided separately and as needed for users who are unfamiliar with the tool.

- Searching for users and organizations
- Creating, editing, activating and deactivating users
- Exporting and Importing Users



Clinical Care Management Scenario

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Community Health Center

Background:

Dr. Jane Doe is a primary care provider at a community health center that serves a large homeless population. Many of her patients struggle with chronic conditions such as hypertension, which can be difficult to manage due to their unstable living conditions. To improve patient outcomes and reduce healthcare costs, Dr. Doe's clinic has started using PopHealth Analytics to better track and manage their patient's health.

Scenario:

Dr. Doe recently noticed an increase in non-emergent emergency department (ED) visits and readmissions among her patients with hypertension. She wants to create a targeted intervention to improve the management of hypertension within her homeless patient population. To do this, she decides to use PopHealth Analytics to identify and track these patients, monitor their hospital readmissions, non-emergent ED visits, and follow-up care post-acute discharge.

Step-by-Step Workflow: Population Navigator

1. **Logs into PopHealth:**
    - Dr. Doe logs into the PopHealth Analytics tool using her clinic's credentials.
2. **Creates a Roster:**
    - Navigates to the **"Population Navigator Tool"** within PopHealth.
    - Uses the **"Measures"** filtering options to select patients with a diagnosis of hypertension.
    - Further refines the search by selecting **"homeless"** under the social needs category.
    - Saves this cohort as a roster named **"Homeless Patients with Hypertension."**

LET's APPLY!

Demo

Population Navigator Demo

Let's Discuss!

Are there specific conditions that may require different follow-up approaches/interventions?

Key Considerations: Population Navigator

June Learning Community :

- Create prioritized lists of patients to monitor via CSS Event Notification Delivery
- Align patients to care managers and care programs based on selected measures

July Learning Community :

- Utilize “Measures” within Population Navigator to develop actionable Care Alerts
- Utilize “Social Needs Category” to facilitate referrals to Community Based Organizations

Step-by-Step Workflow: Data Analysis – NED Report

Scenario:

Once Dr. Doe has compiled her patient roster, she now needs to conduct a thorough analysis of her patient population to determine the trends, disparities, spikes, and other potential actionable insights.

Analyzing Monthly Trends:

- Access the **"Utilization & Quality Dashboard"** within PopHealth.
- Select the **"Non-Emergent ED Visit Dashboard"**.
- Access the **"Monthly Trends"** report to observe patterns in non-emergent ED visits and readmissions among the rostered patients.
- Visually identify any spikes or consistent trends in healthcare utilization.
- Drill down to beneficiary and claims details.

Stratify & Compare Data:

- **Comparison of Annual NED Rate**
- **Number of NED Visits per Beneficiary**
- **Number of ED and NED Visits by Hospital**
- **Number of NED Visits by Primary Diagnosis**
- **Number of NED Visits by Age**
- **Number of NED Visits by Gender**

Step-by-Step Workflow: Data Analysis

Tracking Inpatient Discharges and Follow-ups:

- Use the **"Follow-up Post-Acute Setting Discharge"** report within PopHealth to monitor the number of inpatient patient discharges and the rate of follow-up within 7-14 days.
- Identify patients who did not receive follow-up care and may be at higher risk for readmission.
- Identify and review top diagnoses with and without follow-up to assess prevalent conditions among patients.

LET's APPLY!

Demo

NED and Follow-Up Post Discharge

Let's Discuss!

Are there demographic disparities in follow-up care? Can the reports help you identify such disparities?

What are some targeted interventions for diagnoses with low follow-up rates?

Key Considerations: Non-Emergent ED Use

June Learning Community :

- Create prioritized lists of high utilizers to monitor via CSS Event Notification Delivery (CEND)
- Identify hospital sources to engage based number of ED and NED visit
- Monitor encounters within CEND based on Primary Diagnosis

July Learning Community :

- Create care alert aligned with targeted intervention(s) based on patients with highest number of NED encounters

Key Considerations: Follow Up Post Acute Discharge

June Learning Community :

- Create prioritized lists of patients with now follow-up to monitor future admissions and discharges via CSS Event Notification Delivery (CEND)
- Monitor encounters within CEND based on Top Diagnosis having No Follow Up

July Learning Community :

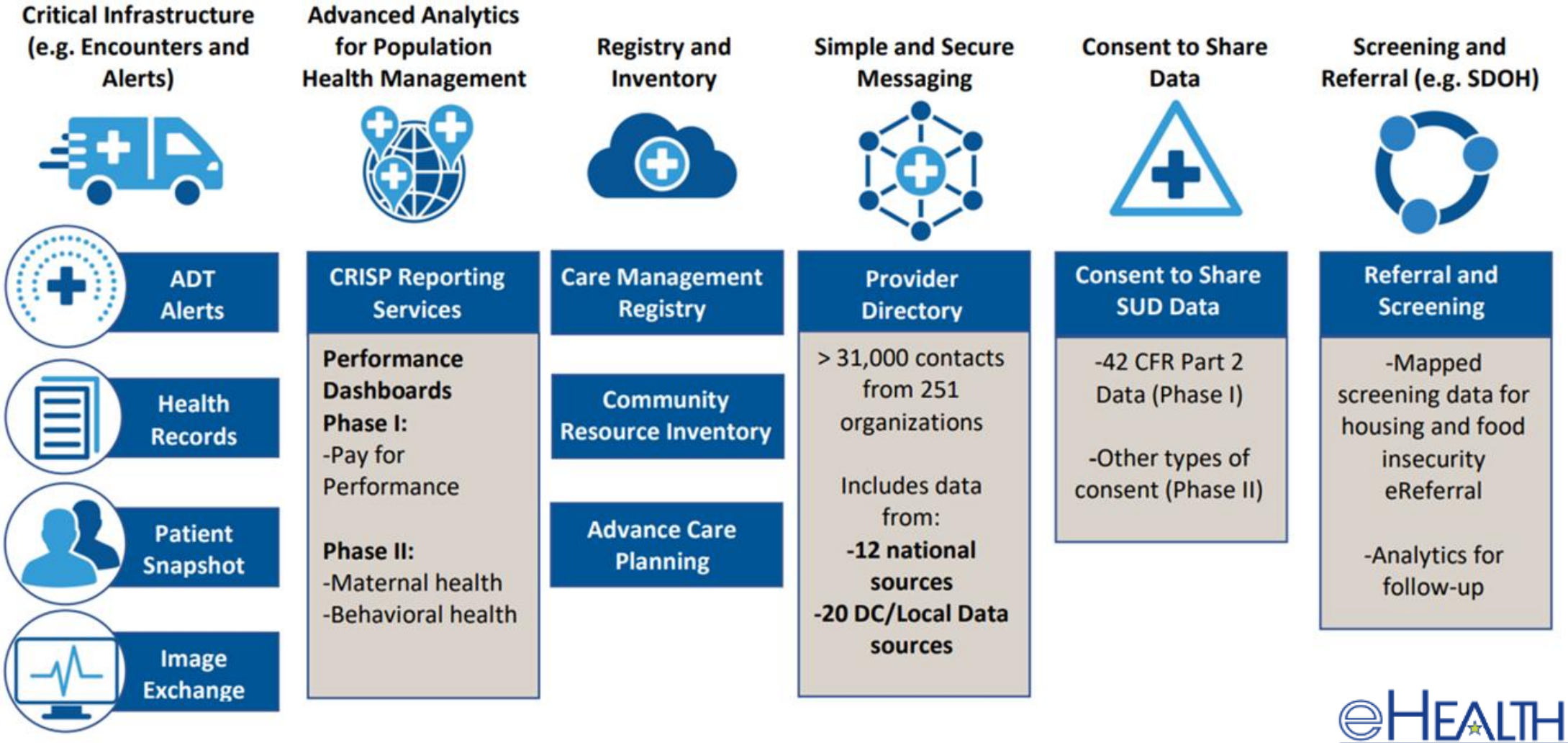
- Create care alert aligned with targeted intervention(s) based on patients/beneficiaries with No Follow up
- Create care alert aligned with targeted intervention(s) based on patients/beneficiaries

Wrapping up PopHealth Analytics

Potential Analytical Takeaways:

- **Improved Identification:**
  - Better identification and monitoring of hypertensive patients within the homeless population.
- **Trends and Patterns:**
  - Analyzing monthly trends and top diagnoses helps to understand the underlying causes of non-emergent ED visits and readmissions.
- **Enhanced Care Coordination:**
  - Tracking follow-up rates and comparing them to overall clinic performance can help identify gaps in care coordination and implement strategies to improve follow-up care.
- **Population Health Management:**
  - Utilizing PopHealth Analytics enables data-driven approaches to manage a patient population, aligning with value-based care principles and improving overall health outcomes for a patient population.

The DC HIE is a Health Data Utility with Six Core Capabilities for Providers



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42 CFR Part 2 Updates- All Cohorts

- The new 42 CFR Part 2 Final Rule requires aspects of the current Part 2 provider form to change to allow for consent to be captured for purposes of treatment, payment and operations. Due to these changes, the current Part 2 Provider form will no longer be active and patients who wish to continue to share their 42 CFR Part 2 Data through the HIE will need to **re-consent** to having their data shared with the new form.

- The new Part 2 Provider form will be live in October 2024, for users to begin re-capturing consents from their clients for TPO purposes. The new consents captured will not be active until January 6, 2025 to give users time to collect the new consents while the old ones are still active.

- CRISP DC will be holding weekly Q&A sessions every Wednesday at 12pm and 12:30pm in September for any organizations to attend with questions regarding the new consent form, notice of privacy practices, and QSOA addendum.

Announcements/ What's Next

What's Next:

- All attendees & primary contact of your organization will receive:
  - a copy of today's presentation and copies of additional resources
  - instructions on how to submit the post-learning community worksheet
- The post-learning community worksheet, **must be submitted by Monday, August 26 at 11:59 pm** for Milestone 8 credit

42 CFR Part 2 Updates- SUD Providers

- Organizations providing services covered under 42 CFR Part 2 must update their **Notice of Privacy Practices** to align with the new rule and sign a new **QSOA Addendum**.
  - These documents have been updated by CRISP DC and will be shared with your organizations following this Learning Community.

- Both documents must be completed in order to continue sharing 42 CFR Part 2 data with the HIE and to be able to re-consent clients.

- CRISP DC will be holding weekly Q&A sessions every Wednesday at 12pm and 12:30pm in September for any organizations to attend with questions regarding the new consent form, notice of privacy practices, and QSOA addendum.

Questions?