**The Webinar will begin promptly at 10:00am**

Due to the number of participants, you will be automatically placed on mute as you join to ensure good quality sound. If you would like to comment or ask a question, please use the "chat feature"

Send your questions to the host via the chat window in the Zoom meeting.

Q+A will open at the end of the presentation.

**Follow-up questions?**

**Contact**

Elaine Henry
ehenry@healthmanagement.com

# USING DISEASE REGISTRIES TO IMPROVE YOUR PRACTICE POPULATION'S HEALTH



HMA ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

**PRESENTED BY:**

- **Kima Taylor, MD, MPH**
- **Lori Raney, MD**
- **Tracy Knight, LICSW – Bread for the City**
- **Stephanie Brown – CRISP DC HIE**

**Thursday,**
**July 15, 2021**
10:00 – 11:00am EST

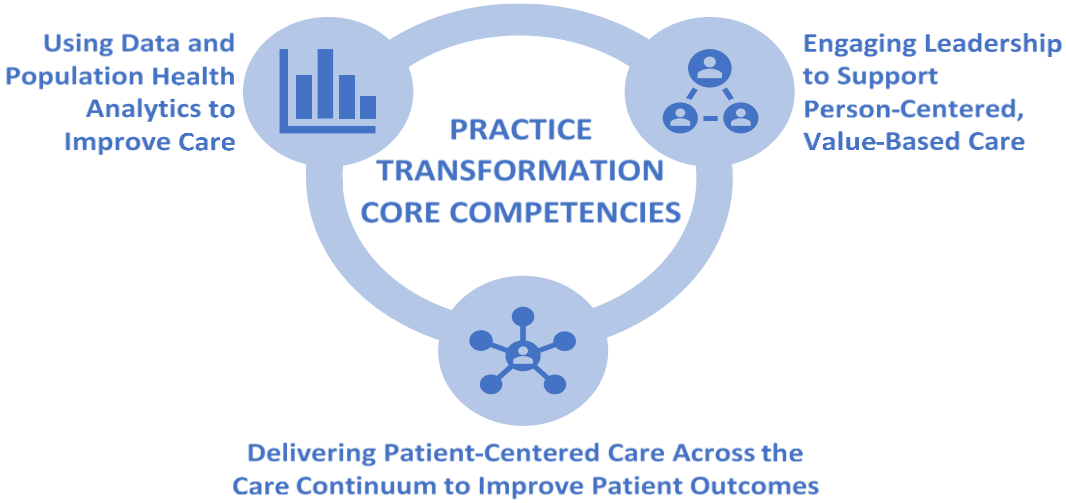
The Integrated Care Technical Assistance Program (ICTA) is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

# WHAT IS THE ICTA PROGRAM?

- The Integrated Care Technical Assistance Program (ICTA) is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

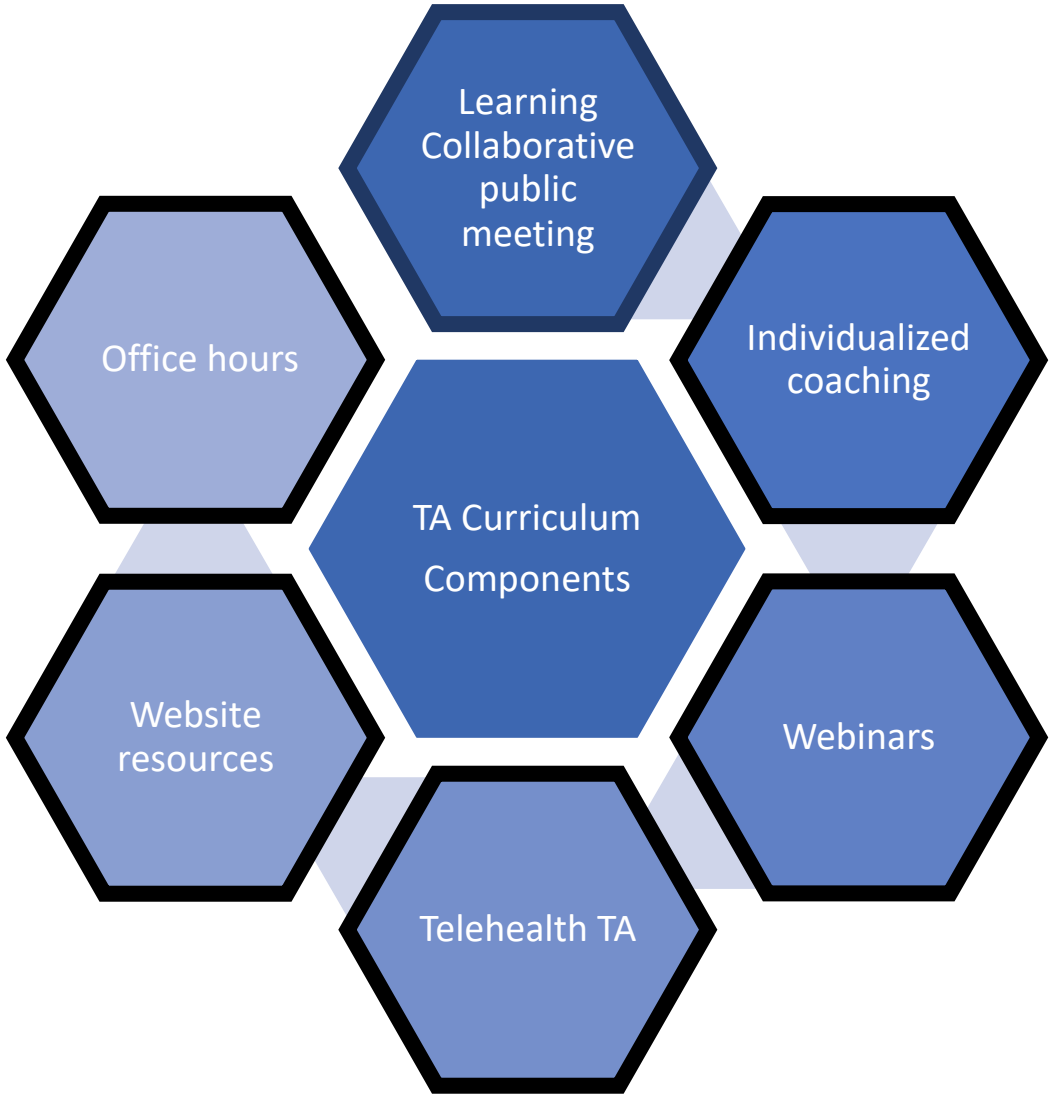
- The ICTA Program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



# ICTA TECHNICAL ASSISTANCE

- The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.
- All material is available on the project website: Integratedcaredc.com
- Educational credit is offered at no cost to attendees for select elements.



# PRESENTERS

**Kima Taylor, MD, MPH**
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*Bread for the City*
Social Services Director

**Stephanie Brown**
*CRISP DC HIE*
Program Director

# DISCLOSURES

| Faculty | Nature of Commercial Interest |
|---|---|
| Kima Taylor, MD, MPH | Dr. Taylor discloses that she is an employee of Anka Consulting Firm, LLC. She discloses that she is a subcontractor for the Foundation for Opioid Response Efforts. |
| Lori Raney, MD | Dr. Raney discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. |
| Tracy Knight, LICSW | Ms. Knight discloses that she is an employee of Bread for the City. |
| Stephanie Brown | Ms. Brown discloses that she is an employee of CRISP DC. |
| Elizabeth Wolff, MD, MPA<br>CME Reviewer | Dr. Wolff discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. |

# AGENDA

HMA ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

## Using Disease Registries to Improve your Practice Population's Health

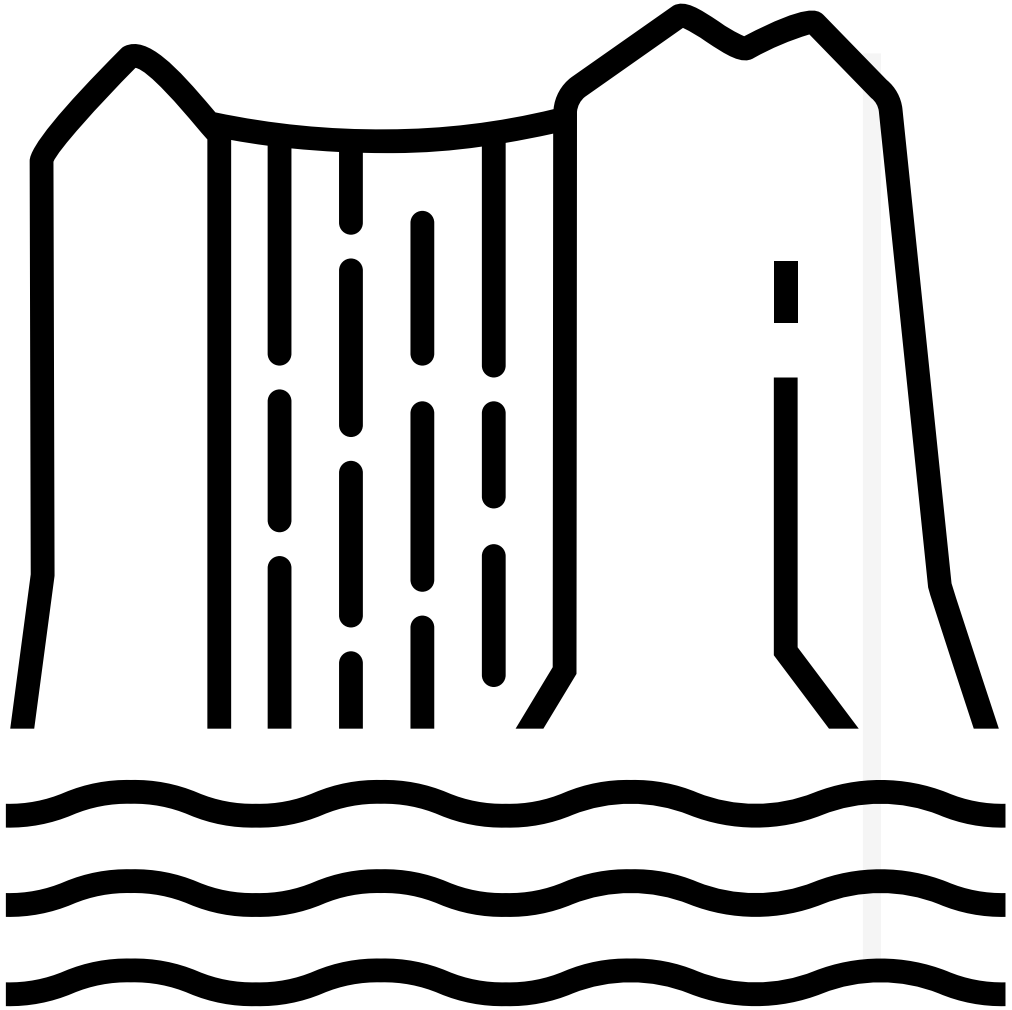
- Welcome
- What is a registry?
- Why use a registry?
- Using CRISP to populate the registry
- Closing Remarks/Questions

# OBJECTIVES

| | |
|---|---|
| Define | registries and how they can be used to manage a population's health |
| Explain | the importance of having registries and how they can be used at the individual patient and population level |
| List | key data collection elements for setting up a registry and formats for managing the data |


Image permitted by DC Department of Health Care Finance

# CHATTERFALL



- Are you currently using any kind of tracking mechanism for clinical outcomes?
- Wait to press enter

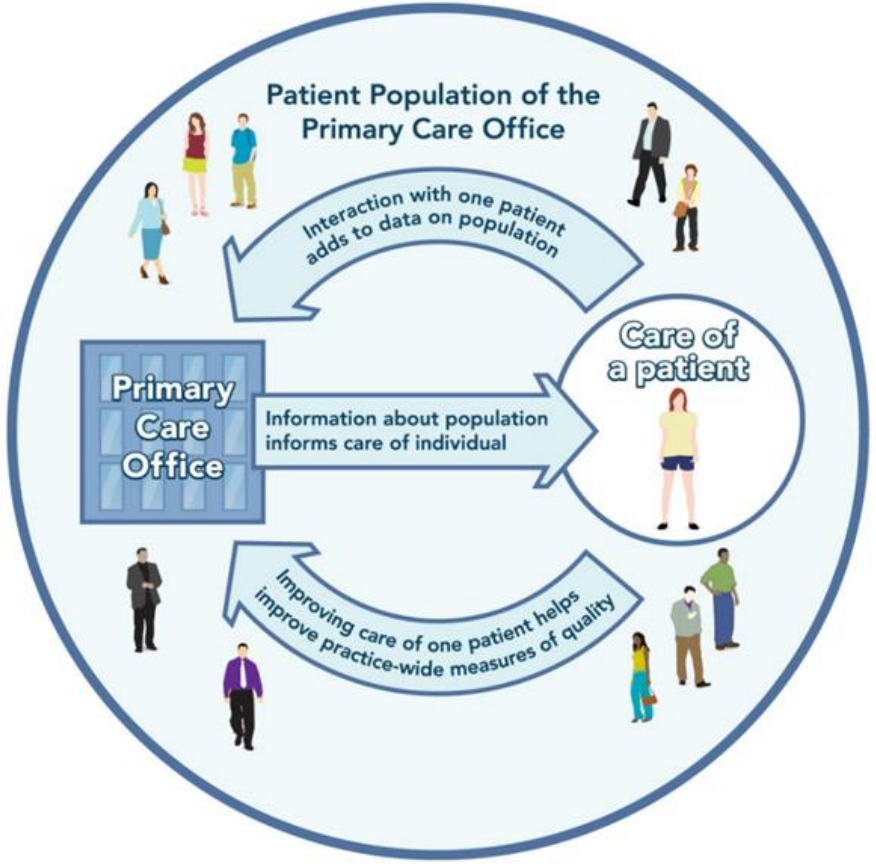
# PRACTICE – BASED POPULATION HEALTH

Evolving from reacting to the ad hoc needs of individual patients to proactive management of a practice's patient panel.

"I have a feeling……."

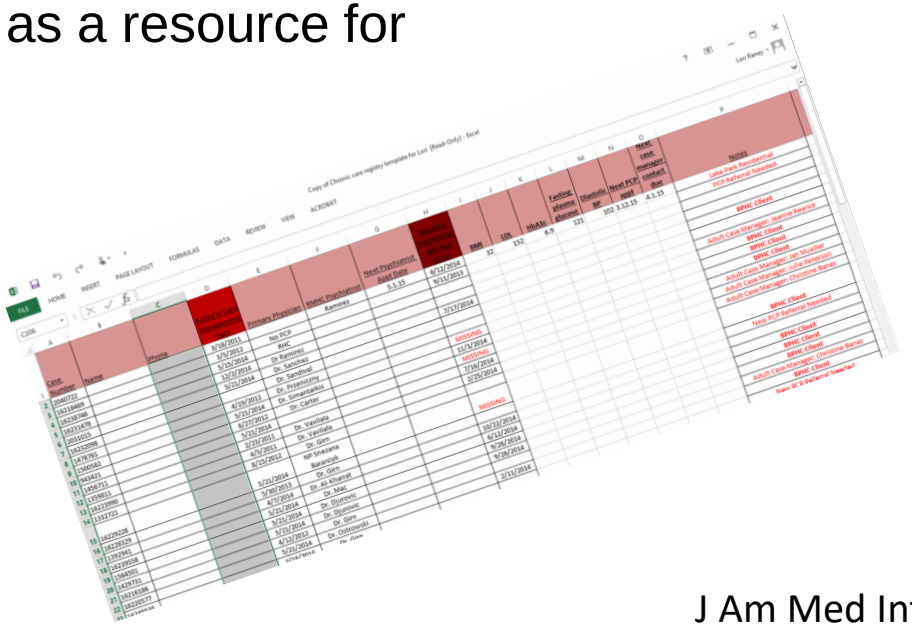
# BIDIRECTIONAL CONNECTION: BETWEEN THE INDIVIDUAL PATIENT AND PRACTICE POPULATION

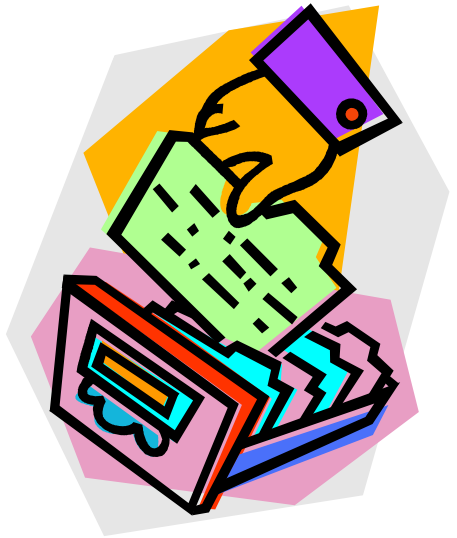
- Interaction with one patient adds to data on a population
- Information about a population informs care of the individual patient
- Improving care of one patient helps improve measures of quality and long- term patient outcomes across a practice's patient population
- Understanding population outcomes is important to prepare for value based or incentivized payments



# REGISTRY

- Systematic collection of a clearly defined set of health and demographic *data* for patients with specific health characteristics — either behavioral, physical, or both
- Held in a central *database* for a predefined purpose
- Medical registries can serve *different purposes*—for instance, as a tool to monitor and improve quality of care including risk stratification, or as a resource for epidemiological research





J Am Med Inform Assoc. 2002 Nov-Dec; 9(6): 600–611

# HOW CAN A REGISTRY HELP?

- ✓ Keep track of all clients so no one “falls through the cracks”
  - Up-to-date client contact information
  - Referral for services completion
- ✓ Tells us who needs additional attention
  - High risk individuals in need of immediate attention
  - Clients who are not following up
  - Clients who are not improving
  - Reminders for clinicians & managers
  - Customized caseload reports
- ✓ Facilitates communication, specialty consultation, and care coordination
- ✓ Helps to select
  - » chronic disease
  - » cohort of consumers and interventions most likely to have the greatest effect on improving the management of chronic disease
- ✓ Choose the initiative most likely to have significant impact and use to focus educational efforts
- ✓ Use for VBP- performance bonuses, incentive payments, etc.

# BREAD FOR THE CITY DEPRESSION REGISTRY

*Tracy Knight, LICSW*
*Social Services Director*
*NW Center, Bread for the City*

# IDENTIFY CARE GAPS AND ACT!

- Compare Combined Disease Registry Data to accepted Clinical Quality Indicators – HEDIS, etc
- *Identify Care Gaps – where is it?*
- Sort patient groups with care gaps into agency specific *To-Do* lists
- Set up indicated visits and pass on info with request to treat

| | DM PATIENTS | | | | | | |
|---|---|---|---|---|---|---|---|
| | ALL PROVIDERS | Provider A | Provider B | Provider C | Provider D | Provider E | All providers Aug-08 |
| DM Pt's A1C <7.0, **GOAL 40%** | **48%** | **51%** | **41%** | **43%** | **61%** | **0%** | **47%** |
| DM Pt's A1c <9.0, **GOAL 68%** | **75%** | **80%** | **72%** | **78%** | **70%** | **100%** | |
| DM Pt's, BP <130/80, **GOAL 25%** | **35%** | **41%** | **32%** | **47%** | **21%** | **0%** | |
| DM Pt's, LDL <100 mg/dl, **GOAL 36%** | **42%** | **42%** | **44%** | **35%** | **42%** | **100%** | **27%** |
| DM Pt's Annual Dilated Eye exam, **GOAL 40%** | **7%** | **9%** | **3%** | **4%** | **9%** | **100%** | **0%** |
| DM Pt's Annual Foot Exam, **GOAL 80%** | **96%** | **93%** | **95%** | **100%** | **91%** | **100%** | **24%** |
| DM Pt's Annual Nephropathy, **GOAL 80%** | **95%** | **93%** | **92%** | **100%** | **94%** | **100%** | **24%** |
| DM Pt's Smoking Status documented and/or advised Treatment, **GOAL 80%** | **93%** | **96%** | **92%** | **96%** | **94%** | **100%** | **55%** |

# IDENTIFYING SUBPOPULATIONS

- Where to start?
  - What Data do you currently have?
  - Where do the prevalent conditions lead you?
- Examples of ways to identify populations:
  - Patients at risk
  - Gaps in care analysis
  - Not meeting management goals

# CREATE DISEASE REGISTRY

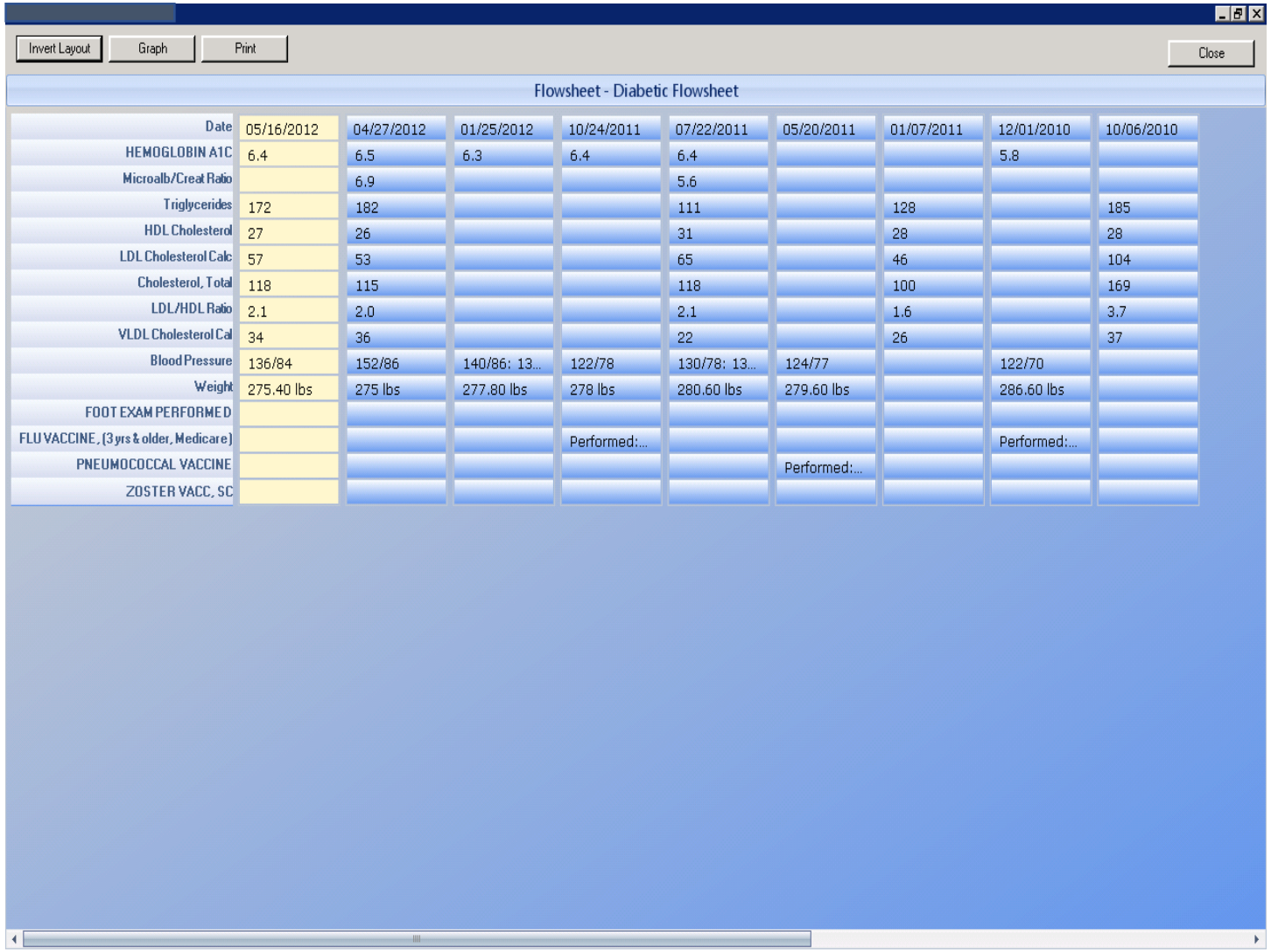
- Get Historic Diagnosis from Claims data
- Get Clinical Values from Metabolic Screening, clinical evaluation and management, care plans, HRA, EMR, payment, pharmacy data, registries, etc
- Combine into EHR Disease Registry
- It is good if you have access to online data (instead of looking through charts)

# REGISTRY EXAMPLE PRIMARY CARE– DEPRESSION REMISSION AT 12 MONTHS

HMA ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

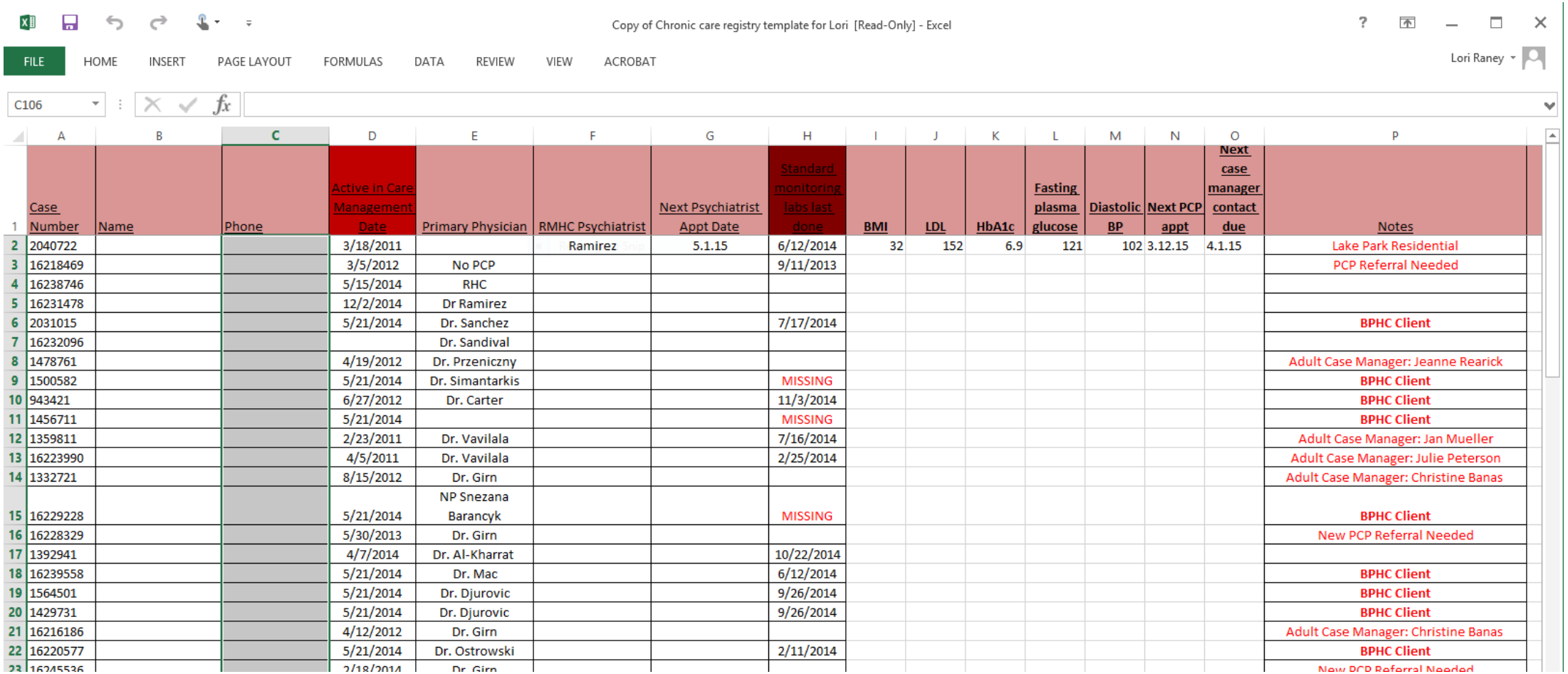
| | | | Behavioral Heatlh | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Treatment Status | | | | | PHQ-9 | | | | GAD-7 | | | |
| MRN | Treatment Status | Name | Date of Initial Assessment | Date of Most Recent Contact | Number of Follow-up Contacts | Weeks in Treatment | Average # Contacts per month | Initial PHQ-9 Score | Last Available PHQ-9 Sco | % Change in PHQ-9 Score | Date of Last PHQ-9 | Initial GAD-7 Score | Last Available GAD-7 Sco | % Change in GAD-7 Score | Date of Last GAD-7 |
| 1234501 | Active | Bryson Clay | 2/28/2018 | 10/1/2018 | 9 | 30 | 1.20 | 21 | 9 | -57.1% | 10/1/2018 | 10 | 4 | -60.0% | 10/1/2018 |
| 1234502 | Active | Kayla Ho | 3/15/2018 | 9/30/2018 | 8 | 28 | 1.14 | 13 | 17 | 30.8% | 9/30/2018 | 5 | 5 | 0.0% | 9/30/2018 |
| 1234503 | Active | Reed Snow | 2/7/2018 | 9/3/2018 | 9 | 29 | 1.24 | 10 | 4 | -60.0% | 9/3/2018 | 18 | 14 | -22.2% | 9/3/2018 |
| 1234504 | Active | Princess Hull | 4/22/2018 | 9/17/2018 | 9 | 21 | 1.71 | 18 | 18 | 0.0% | 9/17/2018 | 19 | 18 | -5.3% | 9/17/2018 |
| 1234505 | Active | Ignacio Tanner | 4/17/2018 | 10/1/2018 | 9 | 23 | 1.57 | 14 | 8 | -42.9% | 10/1/2018 | 16 | 14 | -12.5% | 10/1/2018 |
| 1234506 | Active | Jan Jacobson | 2/20/2018 | 10/2/2018 | 8 | 32 | 1.00 | 11 | 4 | -63.6% | 10/2/2018 | 19 | 18 | -5.3% | 10/2/2018 |
| 1234507 | Active | Eddie Wu | 2/19/2018 | 9/17/2018 | 8 | 30 | 1.07 | 16 | 8 | -50.0% | 9/17/2018 | 10 | 18 | 80.0% | 9/17/2018 |
| 1234508 | Active | Ulises Rosales | 7/30/2018 | 9/15/2018 | 4 | 6 | 2.67 | 17 | 16 | -5.9% | 9/15/2018 | 4 | 3 | -25.0% | 9/15/2018 |
| 1234509 | Active | Freddy Keith | 7/21/2018 | 10/15/2018 | 13 | 12 | 4.33 | 22 | 18 | -18.2% | 10/15/2018 | 5 | 3 | -40.0% | 10/15/2018 |
| 1234510 | Active | Grayson Mcgee | 12/19/2017 | 10/15/2018 | 7 | 42 | 0.67 | 14 | 4 | -71.4% | 10/15/2018 | 7 | 17 | 142.9% | 10/15/2018 |

# EXAMPLES: DIABETES REGISTRY




| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Date | 05/16/2012 | 04/27/2012 | 01/25/2012 | 10/24/2011 | 07/22/2011 | 05/20/2011 | 01/07/2011 | 12/01/2010 | 10/06/2010 |
| HEMOGLOBIN A1C | 6.4 | 6.5 | 6.3 | 6.4 | 6.4 | | | 5.8 | |
| Microalb/Creat Ratio | | 6.9 | | | 5.6 | | | | |
| Triglycerides | 172 | 182 | | | 111 | | 128 | | 185 |
| HDL Cholesterol | 27 | 26 | | | 31 | | 28 | | 28 |
| LDL Cholesterol Calc | 57 | 53 | | | 65 | | 46 | | 104 |
| Cholesterol, Total | 118 | 115 | | | 118 | | 100 | | 169 |
| LDL/HDL Ratio | 2.1 | 2.0 | | | 2.1 | | 1.6 | | 3.7 |
| VLDL Cholesterol Cal | 34 | 36 | | | 22 | | 26 | | 37 |
| Blood Pressure | 136/84 | 152/86 | 140/86; 13... | 122/78 | 130/78; 13... | 124/77 | | 122/70 | |
| Weight | 275.40 lbs | 275 lbs | 277.80 lbs | 278 lbs | 280.60 lbs | 279.60 lbs | | 286.60 lbs | |
| FOOT EXAM PERFORMED | | | | | | | | | |
| FLU VACCINE, (3 yrs & older, Medicare) | | | | Performed:... | | | | Performed:... | |
| PNEUMOCOCCAL VACCINE | | | | | | Performed:... | | | |
| ZOSTER VACC, SC | | | | | | | | | |

# CMHC REGISTRY EXAMPLE



Copy of Chronic care registry template for Lori [Read-Only] - Excel

FILE HOME INSERT PAGE LAYOUT FORMULAS DATA REVIEW VIEW ACROBAT

Lori Raney

C106

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Case Number | Name | Phone | Active in Care Management Date | Primary Physician | RMHC Psychiatrist | Next Psychiatrist Appt Date | Standard monitoring labs last done | BMI | LDL | HbA1c | Fasting plasma glucose | Diastolic BP | Next PCP appt | Next case manager contact due | Notes |
| 2 | 2040722 | | | 3/18/2011 | | Ramirez | 5.1.15 | 6/12/2014 | 32 | 152 | 6.9 | 121 | 102 | 3.12.15 | 4.1.15 | Lake Park Residential |
| 3 | 16218469 | | | 3/5/2012 | No PCP | | | 9/11/2013 | | | | | | | | PCP Referral Needed |
| 4 | 16238746 | | | 5/15/2014 | RHC | | | | | | | | | | | |
| 5 | 16231478 | | | 12/2/2014 | Dr Ramirez | | | | | | | | | | | |
| 6 | 2031015 | | | 5/21/2014 | Dr. Sanchez | | | 7/17/2014 | | | | | | | | BPHC Client |
| 7 | 16232096 | | | | Dr. Sandival | | | | | | | | | | | |
| 8 | 1478761 | | | 4/19/2012 | Dr. Przeniczny | | | | | | | | | | | Adult Case Manager: Jeanne Rearick |
| 9 | 1500582 | | | 5/21/2014 | Dr. Simantarkis | | | MISSING | | | | | | | | BPHC Client |
| 10 | 943421 | | | 6/27/2012 | Dr. Carter | | | 11/3/2014 | | | | | | | | BPHC Client |
| 11 | 1456711 | | | 5/21/2014 | | | | MISSING | | | | | | | | BPHC Client |
| 12 | 1359811 | | | 2/23/2011 | Dr. Vavilala | | | 7/16/2014 | | | | | | | | Adult Case Manager: Jan Mueller |
| 13 | 16223990 | | | 4/5/2011 | Dr. Vavilala | | | 2/25/2014 | | | | | | | | Adult Case Manager: Julie Peterson |
| 14 | 1332721 | | | 8/15/2012 | Dr. Girn | | | | | | | | | | | Adult Case Manager: Christine Banas |
| 15 | 16229228 | | | 5/21/2014 | NP Snezana Barancyk | | | MISSING | | | | | | | | BPHC Client |
| 16 | 16228329 | | | 5/30/2013 | Dr. Girn | | | | | | | | | | | New PCP Referral Needed |
| 17 | 1392941 | | | 4/7/2014 | Dr. Al-Kharrat | | | 10/22/2014 | | | | | | | | |
| 18 | 16239558 | | | 5/21/2014 | Dr. Mac | | | 6/12/2014 | | | | | | | | BPHC Client |
| 19 | 1564501 | | | 5/21/2014 | Dr. Djurovic | | | 9/26/2014 | | | | | | | | BPHC Client |
| 20 | 1429731 | | | 5/21/2014 | Dr. Djurovic | | | 9/26/2014 | | | | | | | | BPHC Client |
| 21 | 16216186 | | | 4/12/2012 | Dr. Girn | | | | | | | | | | | Adult Case Manager: Christine Banas |
| 22 | 16220577 | | | 5/21/2014 | Dr. Ostrowski | | | 2/11/2014 | | | | | | | | BPHC Client |
| 23 | 16245536 | | | 2/18/2014 | Dr. Girn | | | | | | | | | | | New PCP Referral Needed |

# DATA EXTRACTION FROM CRISP

*Stephanie Brown*
*Program Director*
*CRISP DC HIE*

# Q&A

# CONTACT US

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**Lori Raney, MD**
lraney@healthmanagement.com

# WRAP UP AND NEXT STEPS

- Please complete the online evaluation! **If you would like to receive CME credit, the evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar**.**

- The webinar recording will be available within a few days at: https://www.integratedcaredc.com/learning/

- **TA Office Hour:**
  - Monday, July 19, 2021, 10:00 – 11:00am EST Time with Dr. Kima Taylor, MPH
    *The Zoom link for this webinar will provide you access to the TA Office Hour

- **Upcoming Webinar:**
  - *Using Digital Solutions to Support Integrated Care – an extended webinar session, Tuesday, August 10, 2021, 12:00-1:30pm EST*

- For more information about the DC Integrated Care Technical Assistance Program, please visit: https://www.integratedcaredc.com/