MARYLAND
Health Care
Commission

A Learning Network Event

Using Data To Manage Patient Populations

MARCH 21, 2024

CME and Disclosures

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society (MedChi) and the Maryland Health Care Commission (MHCC). MedChi is accredited by the ACCME to provide continuing medical education for physicians
- MedChi designates this virtual online educational activity for a maximum of *1 AMA PRA Category 1 Credits*™
- Physicians should claim only the credit commensurate with the extent of their participation in the activity
- The planners and reviewers for this activity have reported no relevant financial relationships to disclose
- The presenters have reported no relevant relationships to disclose

Learning Objectives

- Identify data available in CRISP reports that can be used to manage patient populations
- Understand how ambulatory practices use the data to enhance care delivery
- Recognize actual practice level improved patient outcomes from using data to manage patient populations

AGENDA

I. **Gene Ransom**, *MedChi*, Opening Remarks

II. **Melanie Cavaliere**, *MHCC*, Overview of Maryland Landscape and MHCC Practice Transformation Activities

III. **Audrey Speter**, *hMetrix*, Subject Matter Expert

IV. **Mara Holton, MD**, *AA Urology*, Practice Perspective

V. **George Bone, MD**, *IC Care*, Practice Perspective

VI. Q&A

Gene Ransom

CEO

MedChi, The Maryland State Medical Society (MedChi)

Snapshot of Maryland

- 6.18 million people *(Source: United States Census Bureau)*
- 16.9% of population is age 65 and over *(Source: United States Census Bureau)*

Advancing Practice Transformation

Background

- Advancing practice transformation has been an MHCC strategic priority for more than a decade
- Maryland law tasked MHCC with implementation and management of the Maryland Multi-Payor PCMH Program from 2011 through 2016
- The MHCC, MedChi, and the University of Maryland School of Medicine Department of Family and Community Medicine partnered with the New Jersey Innovation Institute to complete practice transformation activities in Maryland as part of federal initiative, the Transforming Clinical Practice Initiative, from 2015 to 2019
- The MHCC contributes to planning and policy development for the Maryland Primary Care Program since its inception in 2017

Health Equity Practice Roundtable

- The MHCC convened a Health Equity Practice Roundtable (Roundtable) in March 2022 with representatives from advanced care delivery practices to identify challenges and opportunities for practices seeking to address key health equity concerns in their communities
- The goal of the Roundtable was to advance health equity in ambulatory practices in Maryland through the development of practice resources informed by HE Roundtable feedback
- Feedback from the Roundtable informed a Health Equity Symposium in March 2023 focused on strategies for identifying patterns of need in the community, building referral networks for services related to social needs, and connecting patients to resources
- More information about the Roundtable is available at: mhcc.maryland.gov/mhcc/pages/apc/apc_icd/apc_icd_learning_networks.aspx

Advancing Practice Transformation in Ambulatory Practices

- The MHCC released an Announcement for Grant Applications in May 2021 to identify a Care Transformation Organization (CTO) to engage eligible primary care and specialty practices (practices) in a practice transformation program (program)
- Grant objectives include:
  - Preparing practices to deliver efficient, high-quality care while improving health outcomes
  - Laying the foundation for practices to provide team-based, patient-centered care, and efficient use of health information technology
  - Supporting Total Cost of Care model goals by readying practices to participate in value-based care (VBC) models

Advancing Practice Transformation Program Overview

- In June 2021, MedChi CTO was competitively selected to complete transformation activities
- A crucial role of MedChi CTO is providing practice coaching on specific transformation topics and approaches, such as quality improvement and tools to help sequence and manage change essential to succeed in a VBC model
- Program milestones:
  - Milestone 1 – Readiness Assessment
  - Milestone 2 – Workflow Redesign
  - Milestone 3 – Training
- Approximately 45 practices completed the program in June 2023
- An additional 27 practices are projected to complete Round 2 by June 2024

Learning Network Events

- The MHCC convenes peer learning network events in collaboration with local and national health care leaders on topics such as health equity, advanced care delivery, and practice transformation
- More information on learning network events is available at: mhcc.maryland.gov/mhcc/Pages/apc/apc_icd/apc_icd_learning_networks.aspx

Advanced Care Delivery Events

- Prior events available on the **Learning Network** include:

Audrey Speter
Director, Health Policy
hMetrix

hMetrix

Content

- Introduction to Population Health
- Phases of Population Health Initiatives
- Impact of Using Data for Population Health: Case Study of Health Quality Partners (HQP)
- Bringing Population Health Analytics to Maryland through CRISP Shared Services

hMetrix

Introduction to Population Health

- Need for population health is growing
  - ↑ Prevalence of ***chronic conditions***
  - ↑ Health care ***costs***
  - ↓ ***Health status***
- Promote value-based care instead of fee-for-service
- Breakdown care “silos” and manage across the spectrum
- Incorporate interdisciplinary care teams

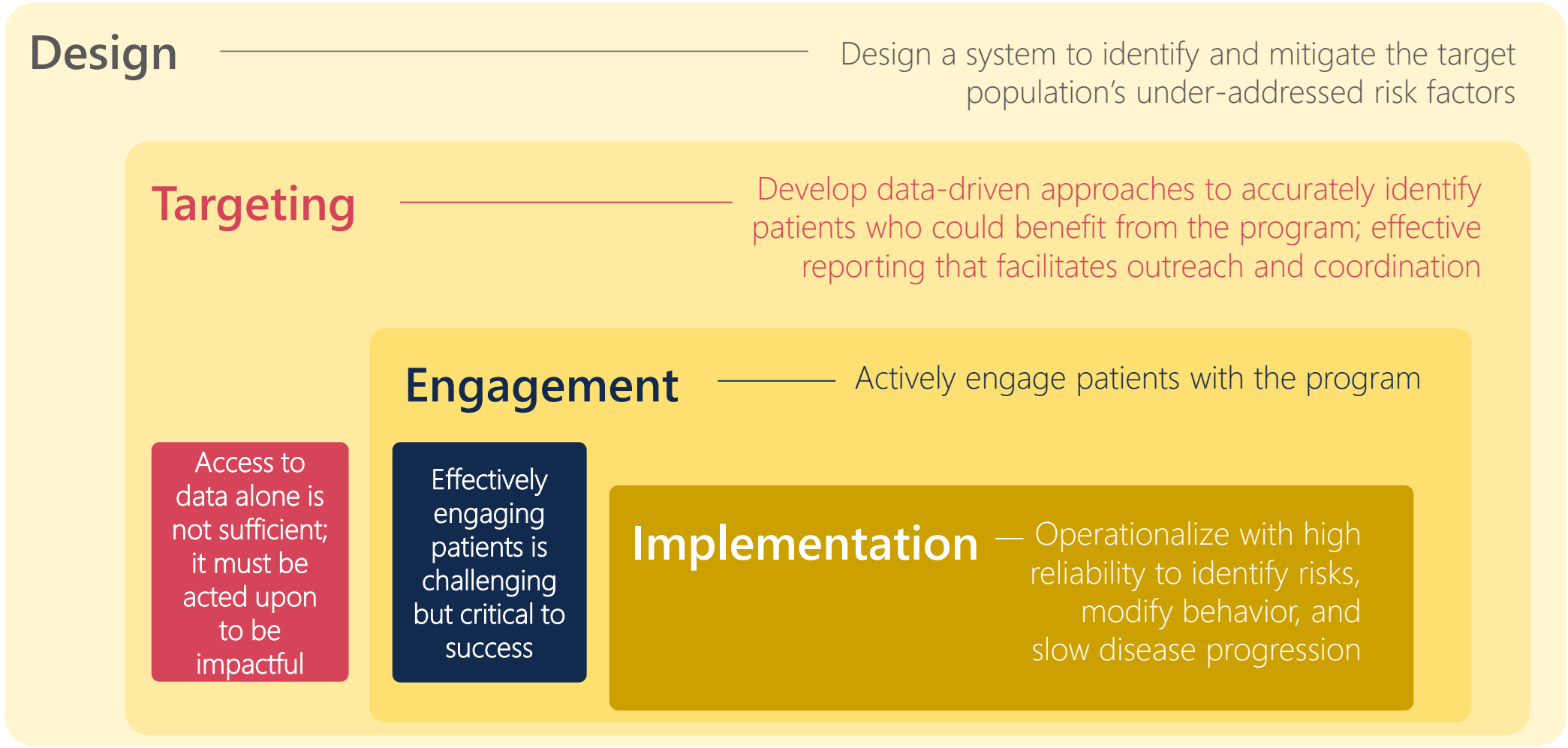
hMetrix

Role of Data

- Critical component of Population Health initiatives:
  - Targets populations in need of care
  - Improves focus for care management initiatives
  - Contains management system with data to ensure reliable delivery and tracking of the care model
  - Identifies SDOH
- Variety of data sources available:
  - Claims
  - EHR (clinical)
  - Medication
  - Labs
  - Socioeconomic
  - Patient-generated
- Right data for the right initiative

hMetrix

Phases of Successful Population Health Initiatives



hMetrix

Impact of Using Data for Population Health

CASE STUDY OF HEALTH QUALITY PARTNERS (HQP)

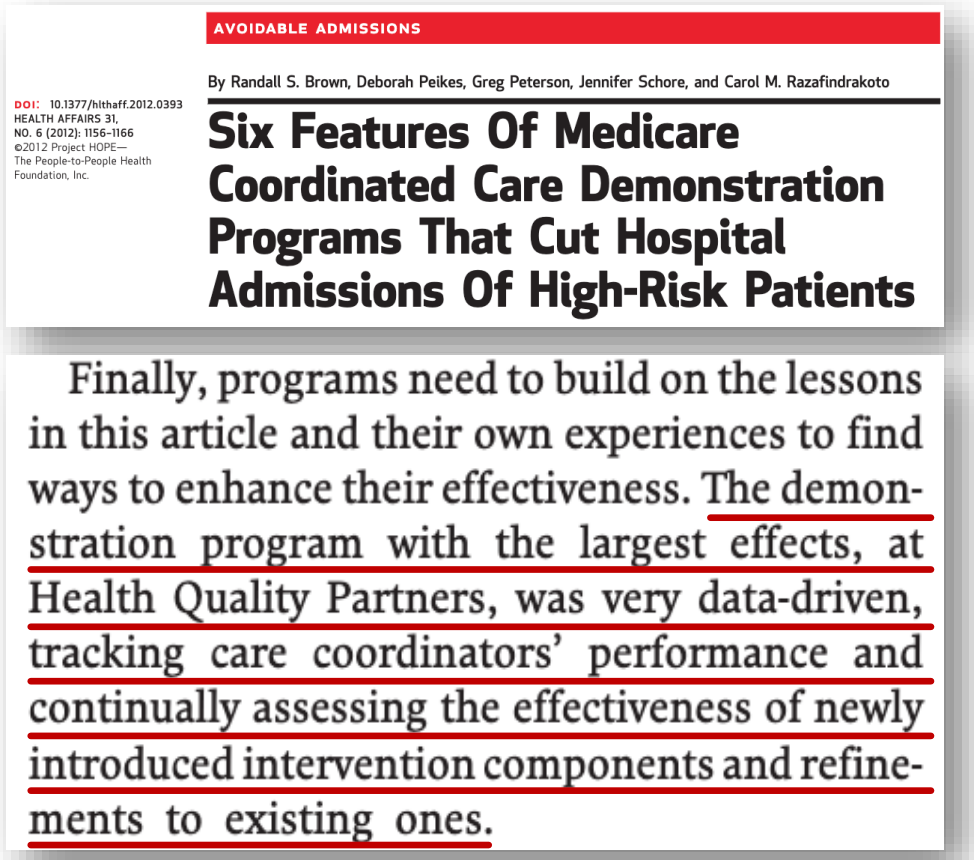
hMetrix

Health Quality Partners (HQP)

- Non-profit, research-oriented organization that designs, tests, and disseminates scientifically-validated systems of preventive care, care coordination, and care management for clinically vulnerable populations
  - Integrated Advanced Preventive Care (iAPC) model seeks to mitigate the impacts of chronic conditions, while sustaining and enhancing the quality of life of those with complex comorbidities
- HQP and hMetrix developed SPERO® over a decade partnership
  - Supports the practical, operational tasks related to providing direct services to patients
  - Web-enabled platform provides an intuitive workflow to record data, while generating notifications that enable care management nurses to keep patient relationship-building manageable and on-track
  - Care managers easily access pre-designed reports
    - ***Program-level*** reports to show whether the program is improving care quality and health of the enrolled population
    - ***Management-level*** reports to assess reliability of program implementation and identify unwarranted process variation
    - ***Patient-level*** reports to track outcomes for an individual and link changes in intermediate outcomes with behavior/life changes

hMetrix

HQP Integrated Advanced Preventive Care (iAPC) Model



AVOIDABLE ADMISSIONS

DOI: 10.1377/hlthaff.2012.0393
HEALTH AFFAIRS 31,
NO. 6 (2012): 1156–1166

By Randall S. Brown, Deborah Peikes, Greg Peterson, Jennifer Schore, and Carol M. Razafindrakoto

Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients

Finally, programs need to build on the lessons in this article and their own experiences to find ways to enhance their effectiveness. The demonstration program with the largest effects, at Health Quality Partners, was very data-driven, tracking care coordinators' performance and continually assessing the effectiveness of newly introduced intervention components and refinements to existing ones.

June 2012

- Face-to-face care manager contact with patients
- Face-to-face care manager contact with physicians
- Evidence-based patient education
- Management of care setting transitions
- Facilitation of communications across providers
- Medication management

hMetrix

Outcomes

"HQP uses a much more data-driven approach to manage patients and the program itself than [others]."

- Results among high-risk beneficiaries:*
  - 39% fewer annualized hospitalizations
  - 36% lower Part A and B expenditures (or reduction of $511 per month)
  - $397 lower Part A and B expenditures after including fees
  - 34% reduction in all-cause mortality over 5 years

*All statistically significant; randomized controlled trial design.

The Washington Post

SUNDAY, April 28, 2013

BUSINESS

THE NURSE'S HOUSE CALL:

IF THIS WERE A PILL, YOU'D DO ANYTHING TO GET IT

AMANDA VOISARD/THE WASHINGTON POST

DELIVERING CARE: Patty Graefe, a nurse with Health Quality Partners, makes her weekly visit to Paul and Betty Bradfield at their home near Doylestown, Pa.

Fourth & Fifth Reports to Congress on the Evaluation of the Medicare Coordinated Care Demonstration.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Schore_Fourth_Eval_MCCD_March_2011.pdf
https://www.cms.gov/priorities/innovation/files/reports/medicarecoordinatedcaredemortc.pdf

hMetrix

Bringing Population Health Analytics to Maryland through CRISP

hMetrix

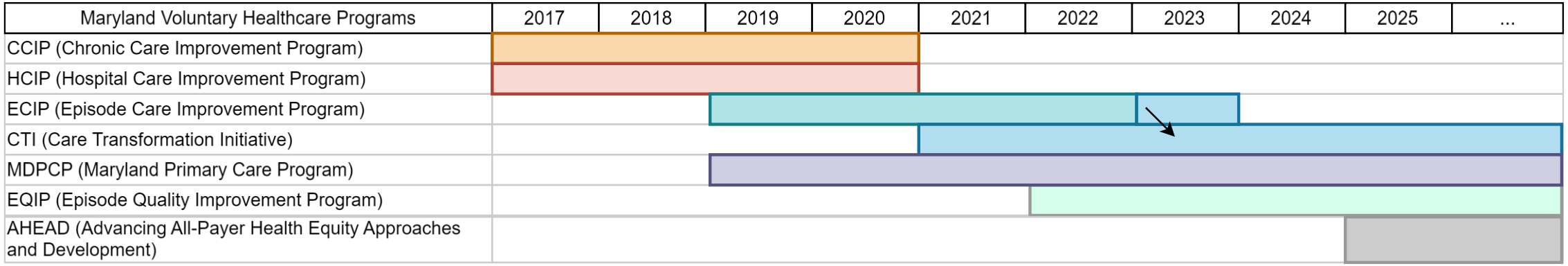
Analytics in Maryland with CRISP

- Maryland has several statewide programs aiming to reduce cost and improve outcomes
- As the HIE for Maryland, CRISP facilitates providers' success in their population health initiatives by providing data

hMetrix

Voluntary Programs Adapted from National Initiatives

- Program evolution emphasizes value-based care while allowing participants to customize the program that is most suited to their initiatives



hMetrix

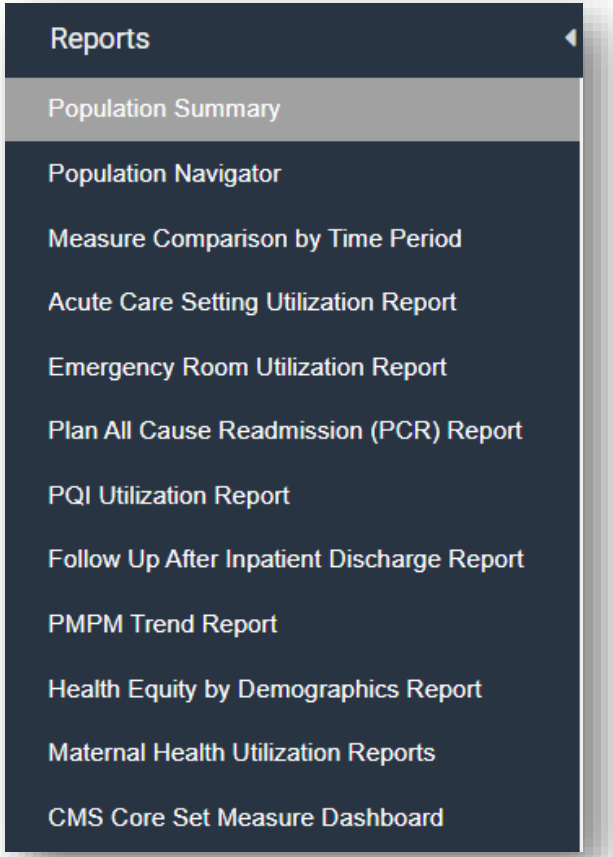
Mandatory Healthcare Programs

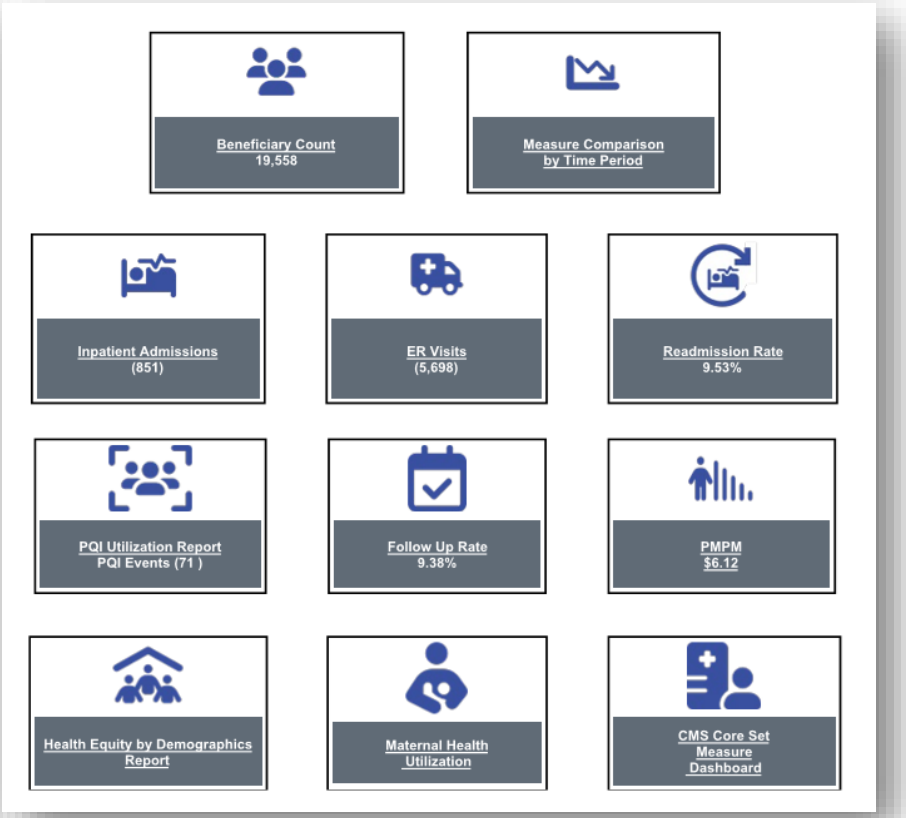
- Mandatory programs are focused more on financial impact to hospitals than facilitating care management
  - Statewide Integrated Health Improvement Strategy (SIHIS)
  - Maryland Hospital Acquired Conditions (MHAC)
  - Quality Based Reimbursement (QBR)
    - IP Mortality, Timely Follow-Up (TFU) & TFU Disparity, Total hip arthroplasty/total knee arthroplasty (THA/TKA), Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAPHS), etc.
  - Readmission Reduction Incentive Program (RRIP)
  - Potentially Avoidable Utilization (PAU)
  - Patient Adversity Index (PAI)

hMetrix

Using Data to Support Participants

- Clinicians/care managers need data to target beneficiaries for population health initiatives
- CRISP partners with hMetrix to provide data-driven tools
- Multi-Payer Reporting suite (MPR) represents the first report in CRISP Reporting Services (CRS) to include claims data for ***both Medicare and Medicaid beneficiaries*** in a single suite

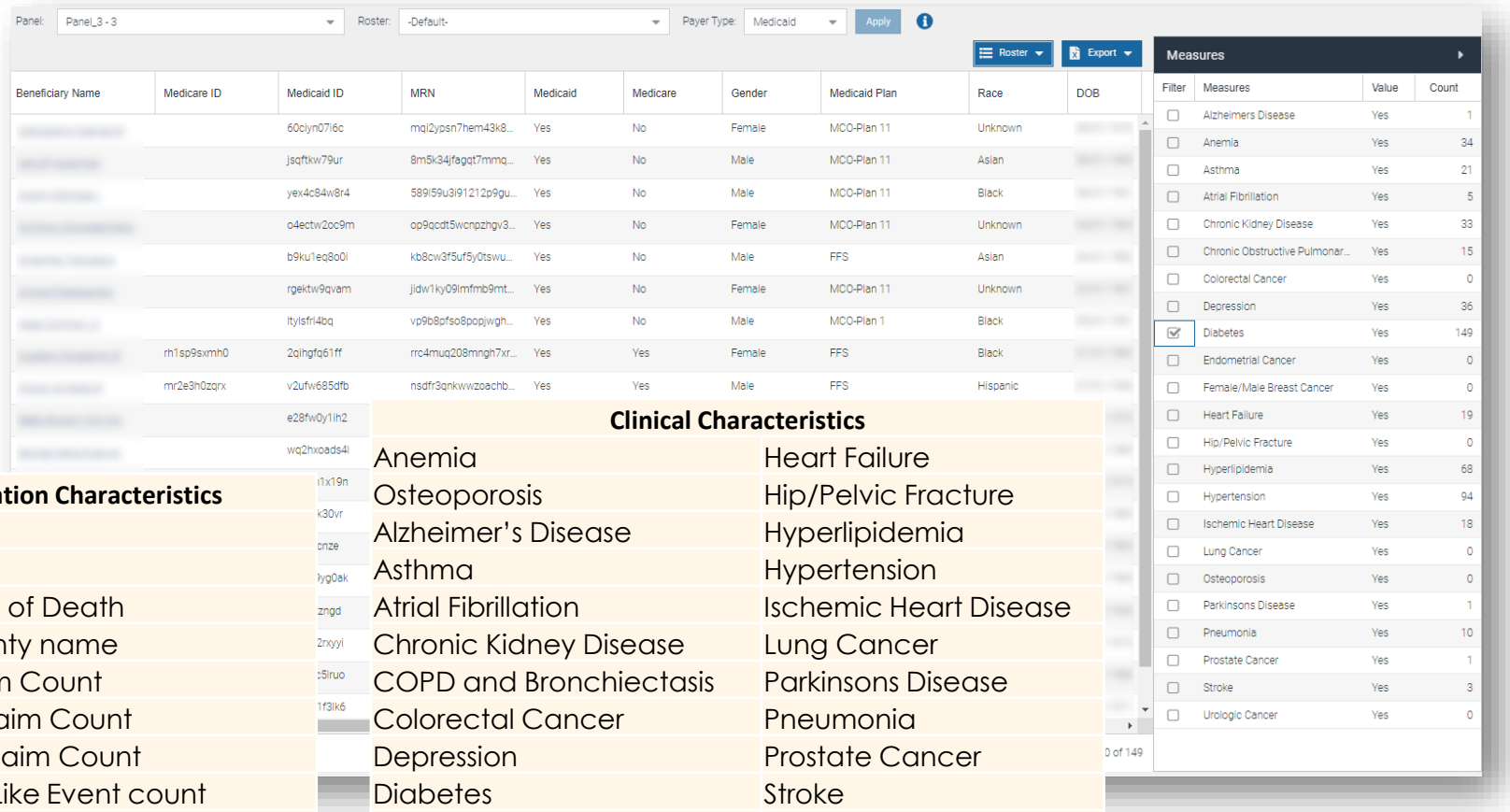




hMetrix

Population Navigator and Rosters

- Mechanism to explore populations by filtering or sorting by clinical and demographic characteristics
- Create rosters to isolate sub-populations; focus reporting to those populations



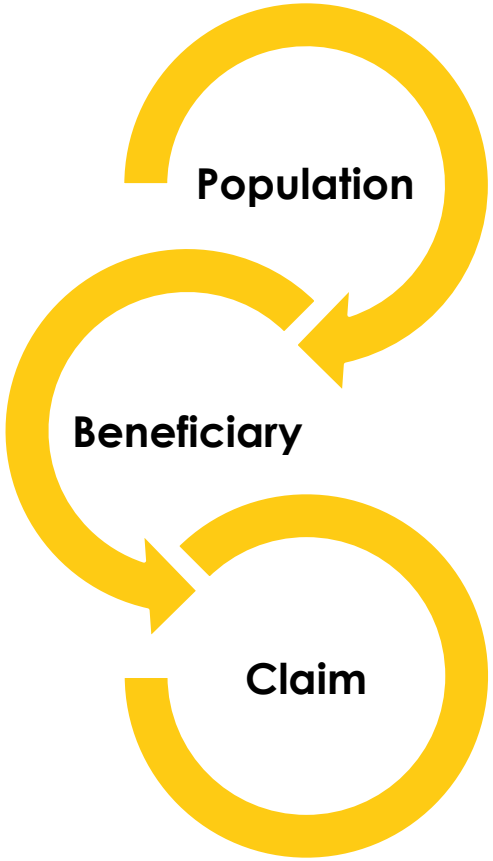
Demographic / Utilization Characteristics	
Beneficiary Name	DOB
Medicare ID	Age
Medicaid ID	Date of Death
First Name	County name
Middle Name	Claim Count
Last Name	IP Claim Count
Medicaid	ER Claim Count
Medicare	PQI-Like Event count
Gender	Claim Payment Amount
Race	

Clinical Characteristics	
Anemia	Heart Failure
Osteoporosis	Hip/Pelvic Fracture
Alzheimer's Disease	Hyperlipidemia
Asthma	Hypertension
Atrial Fibrillation	Ischemic Heart Disease
Chronic Kidney Disease	Lung Cancer
COPD and Bronchiectasis	Parkinsons Disease
Colorectal Cancer	Pneumonia
Depression	Prostate Cancer
Diabetes	Stroke
Endometrial Cancer	Urologic Cancer
Female/Male Breast Cancer	

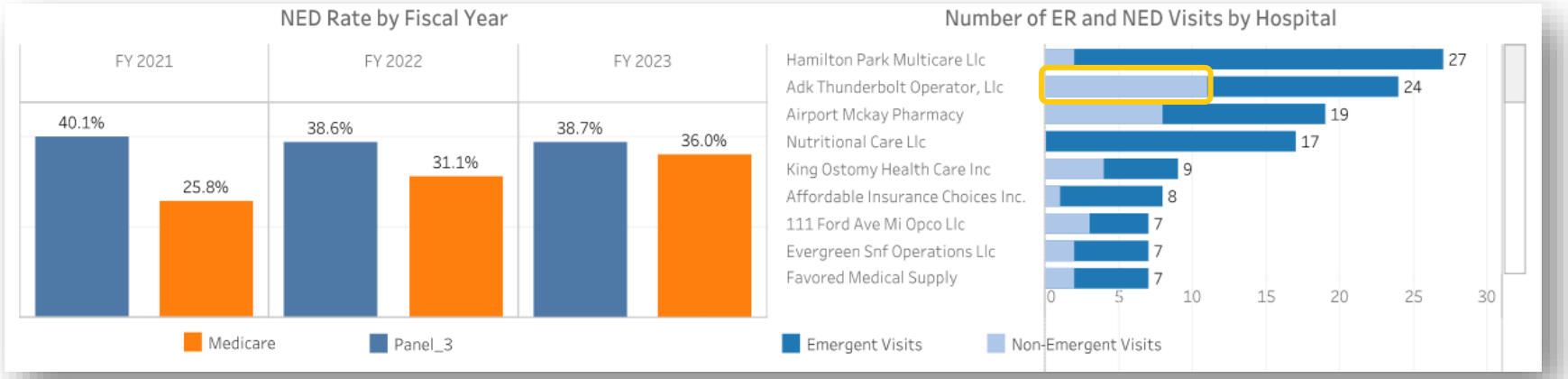
(Data are fictitious; does not contain PHI)

hMetrix

Importance of Flexible Reporting

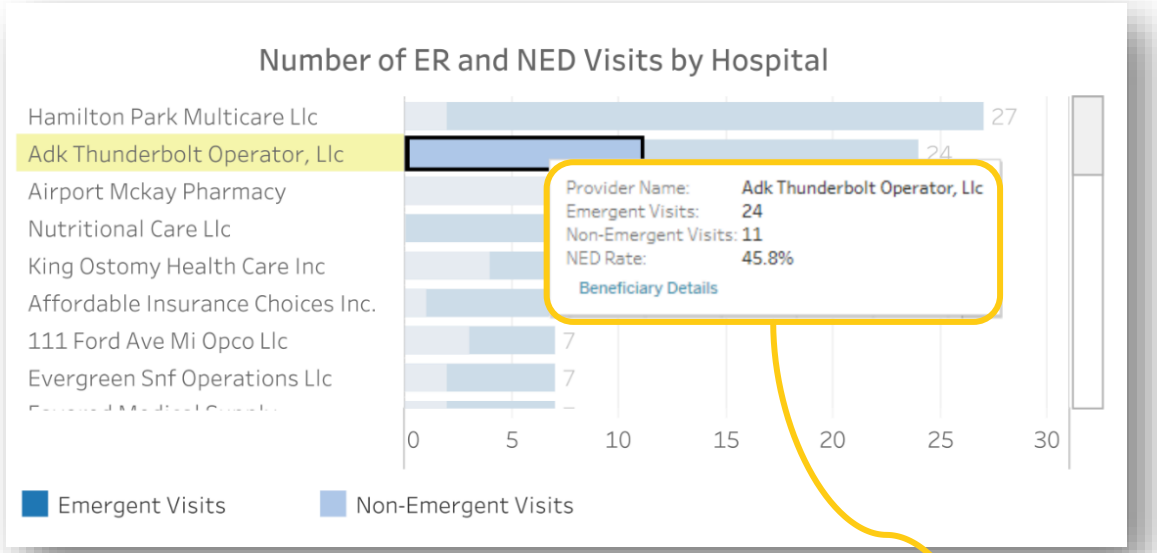


- CRISP reports contain flexible reporting to meet variety of use cases
- All reports start with population-level (aggregate) information
- Users can identify and select a data point of interest

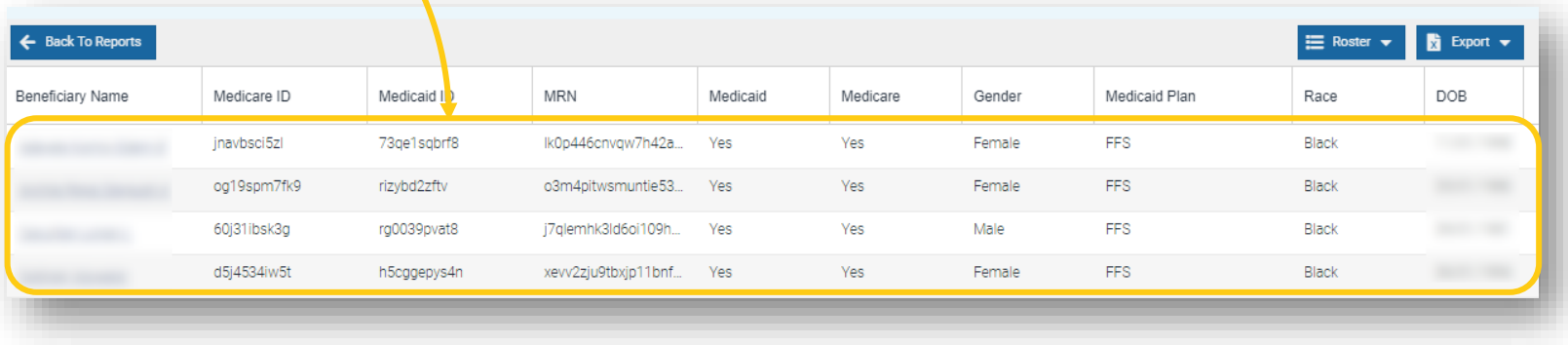


hMetrix

Aggregate Reporting → Patient Details



- Aggregate data leads to Beneficiary-level details identifying those patients with the utilization of interest

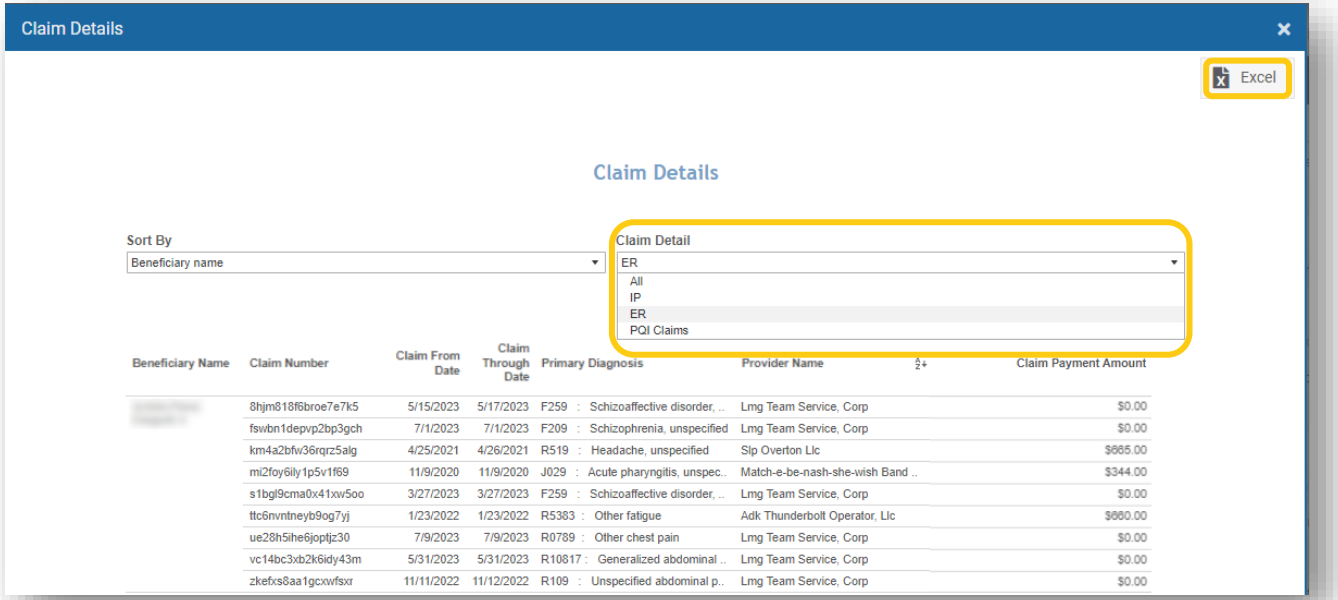


(Data are fictitious; does not contain PHI)

hMetrix

Patient Details → Claim Details

- Having identified patients of interest, drill through further into their claim history
- Select claims by type and sort by any column in the table
- Export the data to for future reference and analytics outside the suite

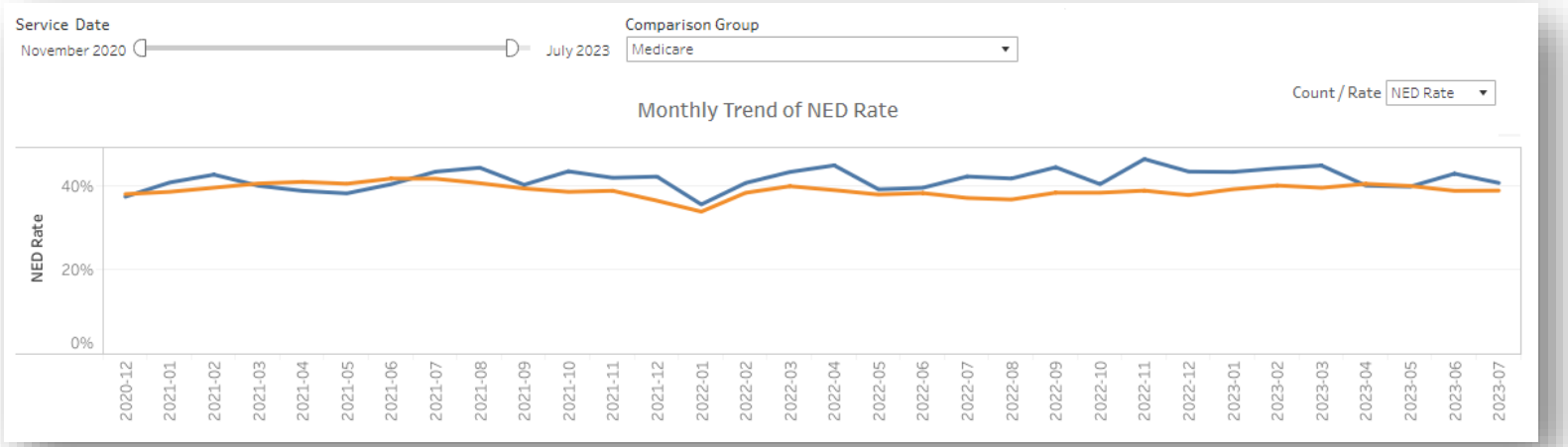


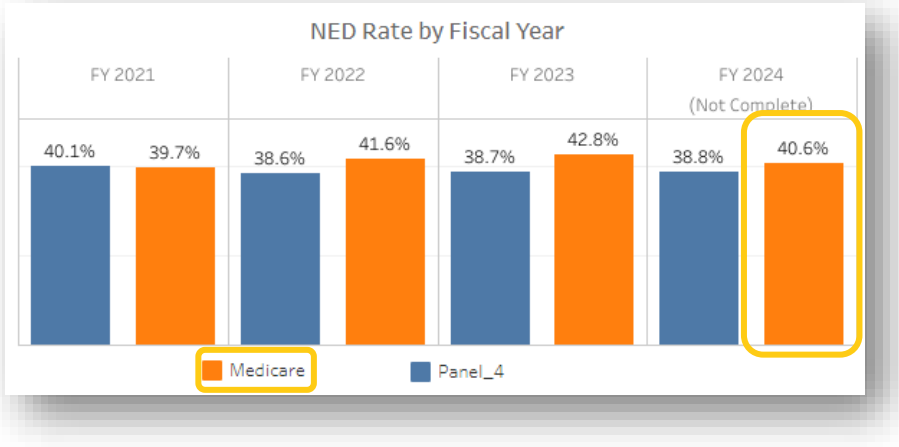
(Data are fictitious; does not contain PHI)

hMetrix

Use of Comparison Groups

- View population trends relative to comparison groups to establish context
- Often provided for the overall state, overall program, or by payer
- MDPCP reports have curated comparison groups to match the demographic characteristics of the attributed population





Conclusions

hMetrix

Conclusions

- Population Health initiatives around the country have informed best practices for program implementation
- Data is the cornerstone for success, but programs require ***robust care model design*** that incorporate systems thinking, active and strenuous ***engagement of clinical teams and patients,*** as well as ***methodical implementation of program interventions***
- Data are not one-size fits all; pick the data source that is best for the initiative
- Flexible reporting with both aggregate and patient-level details enables a variety of users (administrators, care managers, physicians) to act on the reports and target their engagement
  - Comparison groups provide helpful context to evaluate performance

Thank you!

Contact: audrey@hmetrix.com

hMetrix

AA-Urology

Care Compassion Community

Mara R. Holton, MD

CEO, AAUrology

Chair, LUGPA Health Policy

CARE NAVIGATION

Faulty Input

Garbage In

Faulty Output

Garbage Out

WHICH DATA POINTS?

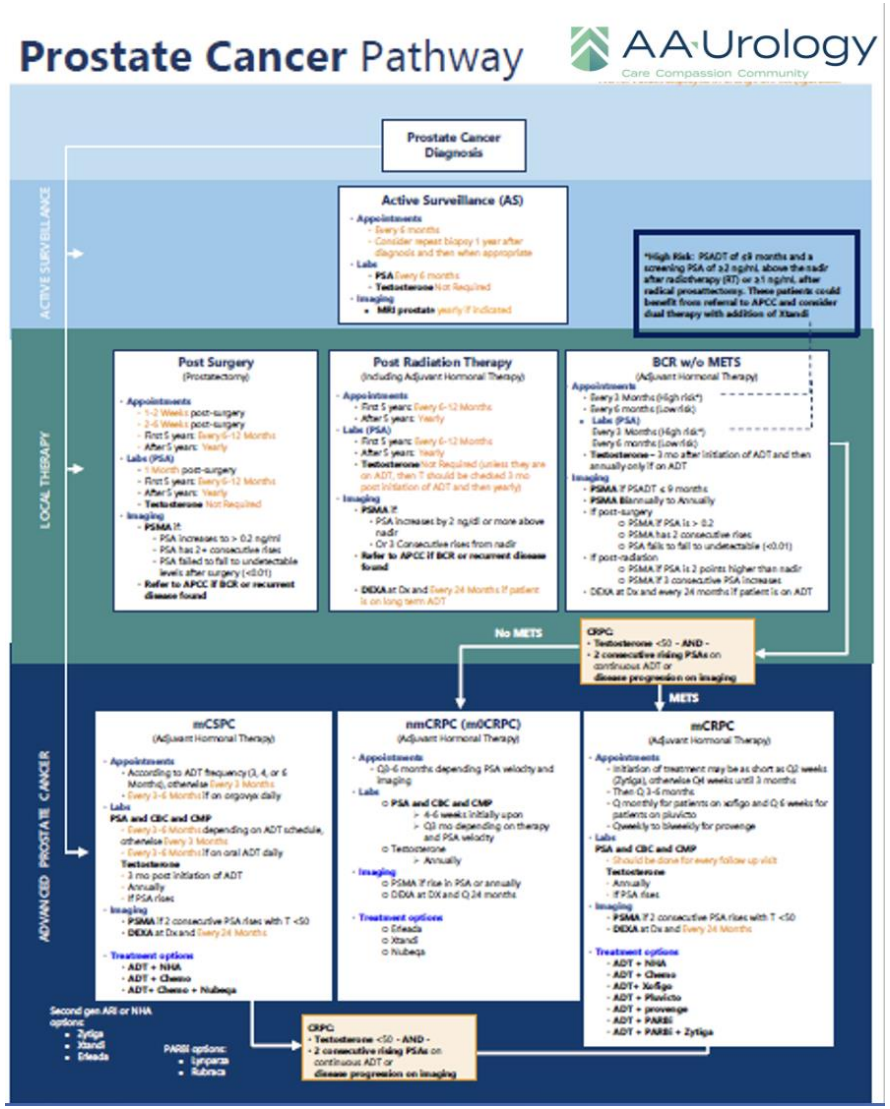
WHERE TO COLLECT?

WHO & HOW TO GET BEST INFO?

WHAT DOES IT MEAN?

Why APC?

- Clinically complex care algorithm
- Patient population at risk of ‘falling through the cracks’
- Rapid evolution of novel therapies and treatment protocols
- Well established outcome metrics

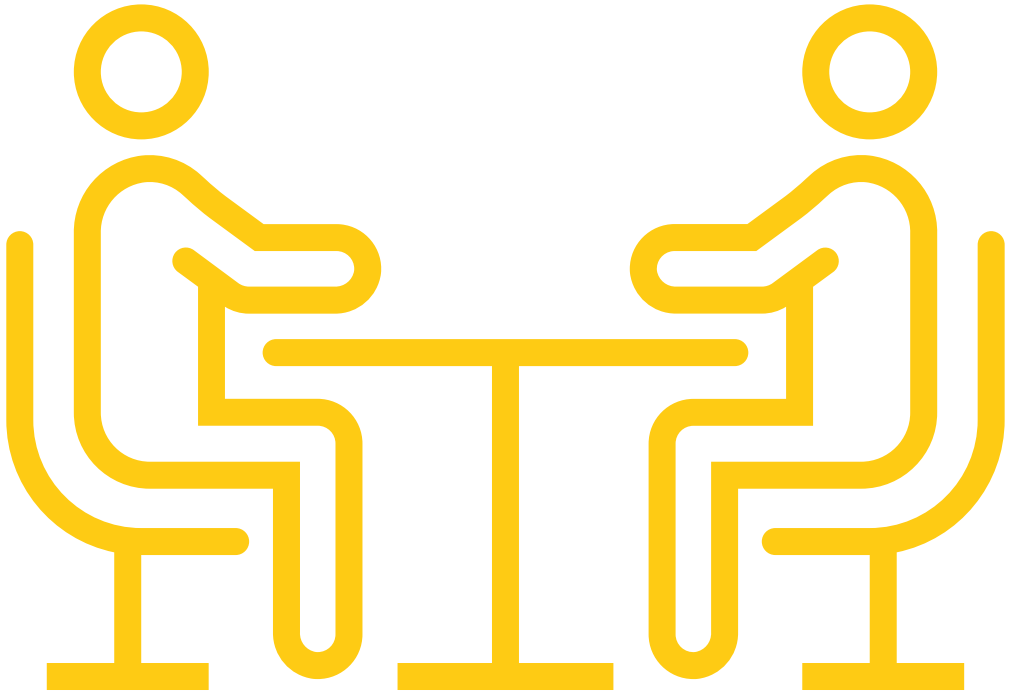


DATA DRIVEN CARE EXAMPLE (APC)

- Pathway Driven Clinical Care Protocol
- Data Collection
  - EHR(s) lookback
  - Surveys
- Combination: Patient completed and Staff Facilitated
  - Outreach in person & via phone/text
- Measurable Outcomes

VENDOR PARTNER

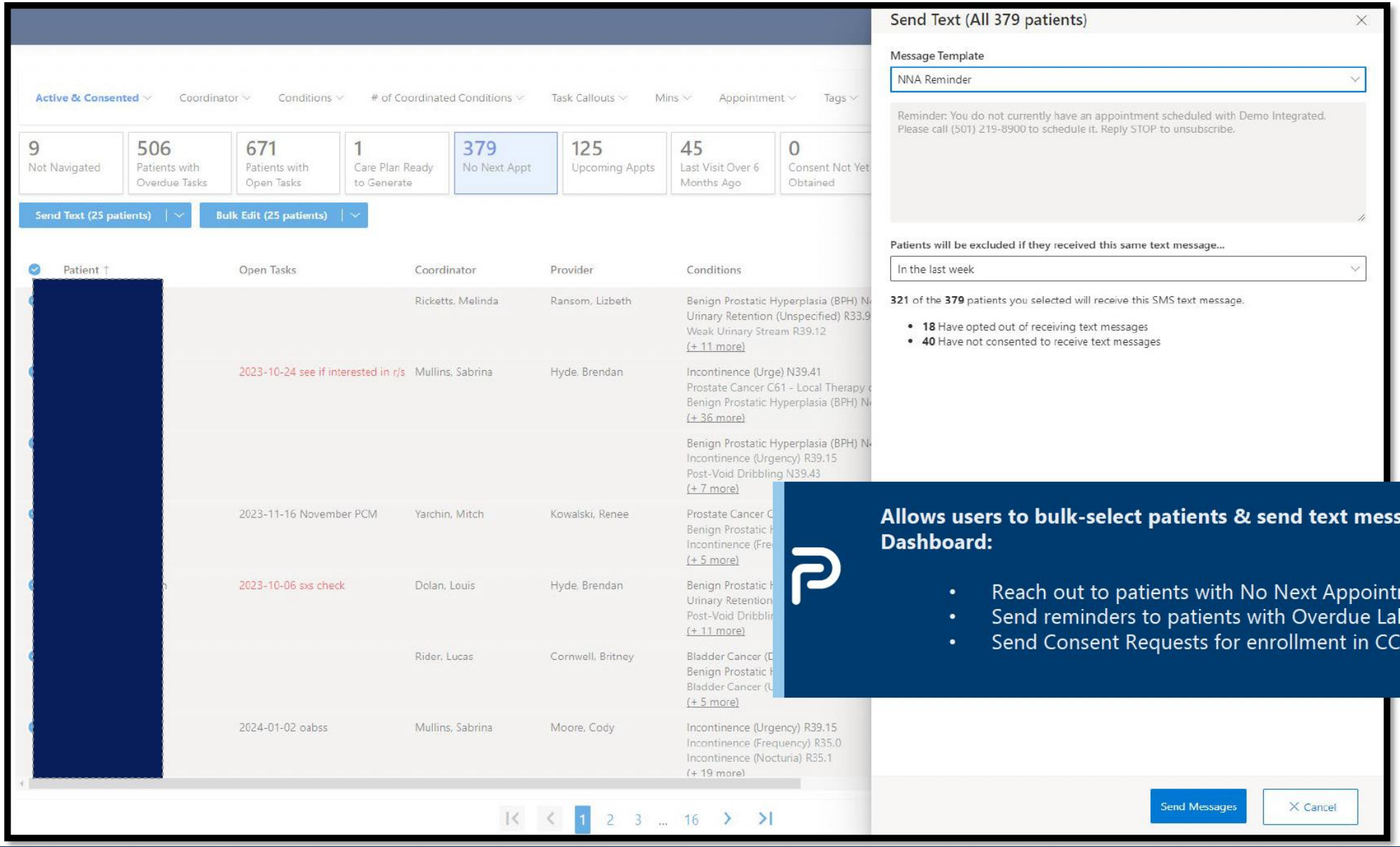
- Data is cumbersome
- EHRs are notoriously finicky & idiosyncratic
- Generally, private practices have limited specialized staff
  - IT
  - Data collection
  - Data analytics



ORAL ONCOLYTIC SURVEY IMPACT SINCE 9/2023

AA Urology
Care Compassion Community

SMS Text Feature



Allows users to bulk-select patients & send text messages from any Dashboard:

- Reach out to patients with No Next Appointment
- Send reminders to patients with Overdue Labs
- Send Consent Requests for enrollment in CCM Program

AA-Urology
Care Compassion Community

2023 Improved Patient Outcomes

2,179
Net Patients Consented

1,317
Unique Patients Navigated

Ensure all patients have a next appointment

- **64%** (842) all patients navigated have a next appointment

% of patients seen in 2023 that have a next appointment scheduled

Identify Cancer Progression

- **20%** (50) PCa patients navigated had cancer or cancer progression detected

Treatment Identification

- **38%** (503) all patients navigated had new treatment identified

Care Management

Month-in-Review
July 2023

AA Urology
Care Compassion Community

BROADEN MEASURES

EXPAND
ELIGIBLE/APPLICABLE
CLINICAL DISEASE STATES

ONGOING REFINEMENT
DATA COLLECTION
PROCESS

THANK YOU.

contact: mholton@aaurology.com.

George Bone, MD

Medical Director

IC Care Inc.

MHCC/MedChi Spring Forum

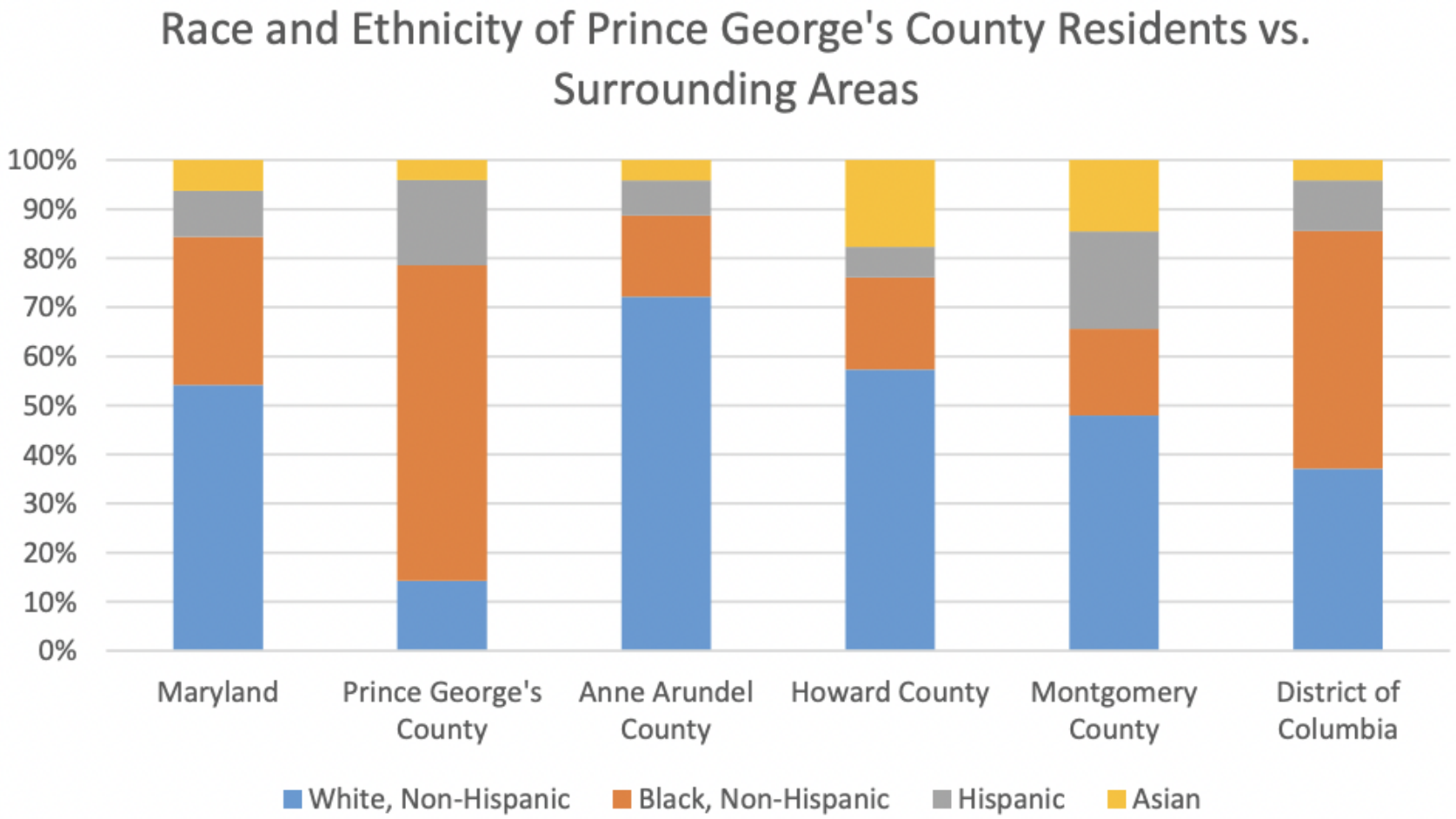
Using Data to Manage Patient Care Populations at IC Care Inc. & Prince Georges County

George H. Bone, MD, Medical Director, IC Care Inc.

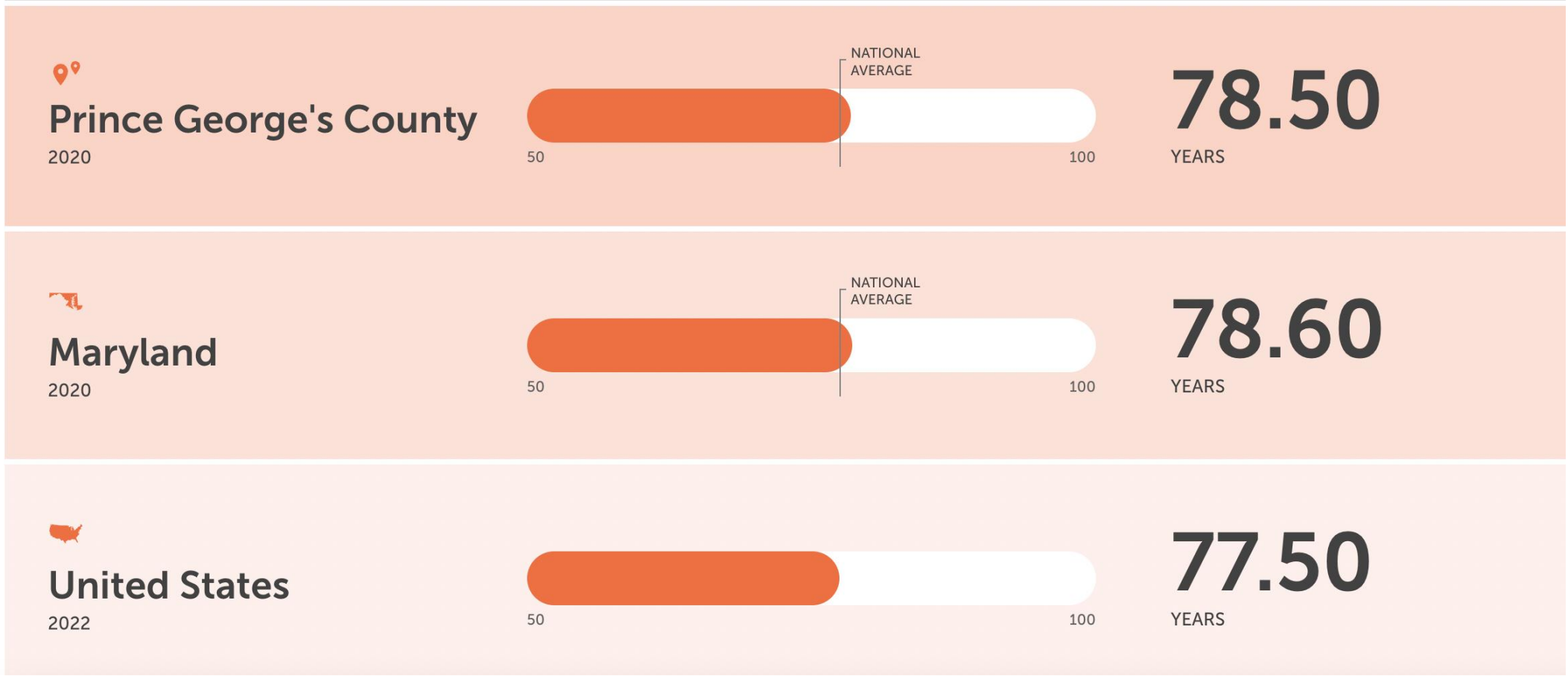
Populations Under Care: Broad-strokes

	Age	Ethnicity	Insurance
IC Care	Range: 21 to 97 yo Average: 65.3 Median 66.5 Age > 78yo = 19%	Black: 99 % White: < 1 % Hispanic: < 1% Asian: < 1 %	Medicare: 70 % Commercial: 27 % Medicaid: 3% Cash/Un-insured: < 1 %
Prince Georges County	Range: 0 to 102 yo Median 36.7 yo Age > 78yo = 2.8 %	Black: 70 % White: 12 % Hispanic: 12 % Asian: 6 %	Medicare & Medicaid: 29 % Commercial: 68.4 % Cash/Un-insured: 2.3 %

PG County Ethnic Make-up



Mortality in PG County



Using Data to Manage Patient Care

IC Care data sources

- MIPS - Merit-Based Incentive Payment System
- MDPCP - Maryland Primary Care Program
- CRISP - Chesapeake Regional Information System for our Patients
- Salesforce / ZH - Blue EHR
- Maryland ImmuNet

$4.25 Trillion

Whoa! That's a big number, aren't you proud?

Key drivers of U.S. health care spending

Administrative costs account for **8%** of total health care spending, compared with **1-3%** for other countries

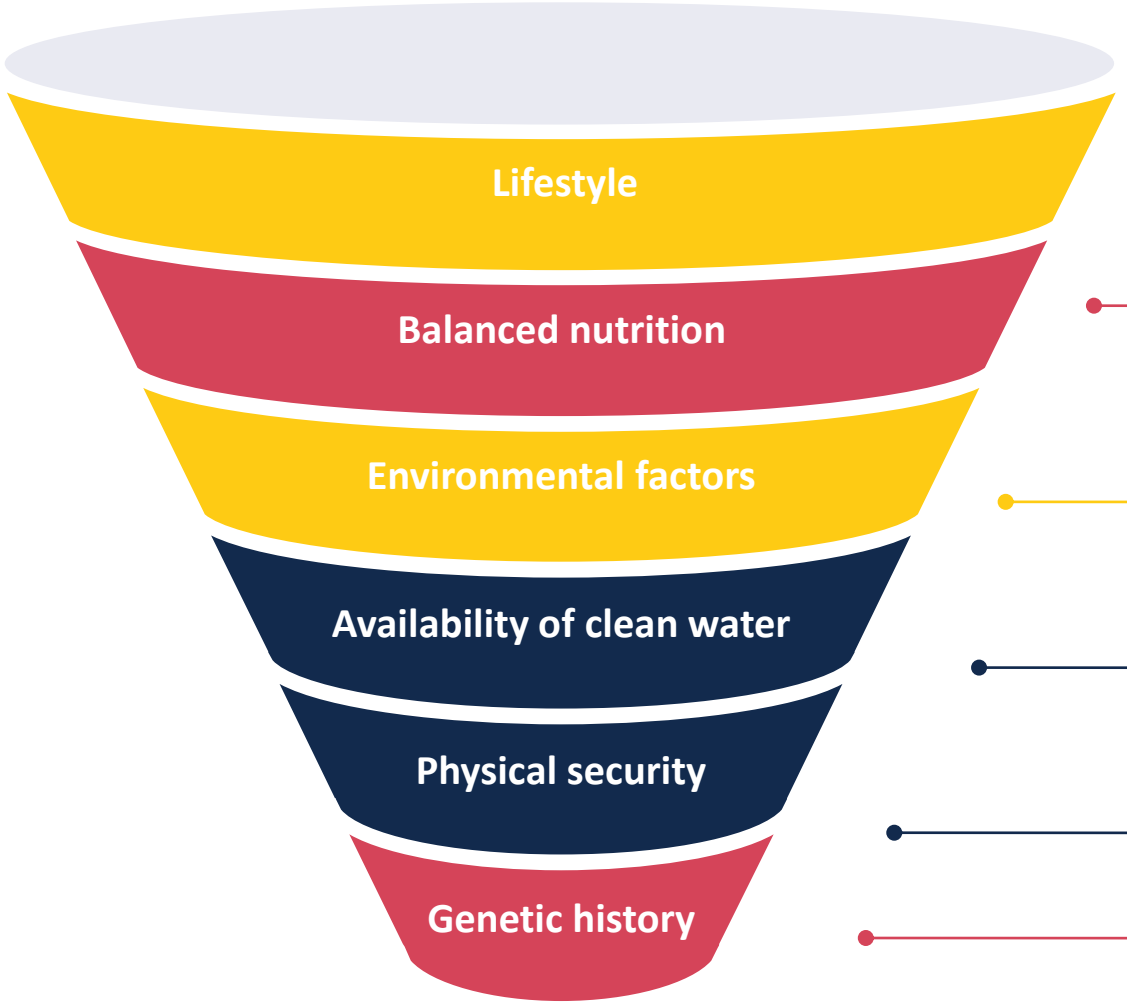
Per capita spending for pharmaceuticals was **$1,443** in the U.S. and **$466-$939** in other countries.

Average salary for a general practice doctor was **$218,173** here and **$86,607-$154,126** in other countries.

Source: Harvard T.H. Chan School of Public Health, Harvard Global Health Institute, London School of Economics. Credit: Rebecca Coleman/Harvard Staff

“ What’s a Doc to do”??

Disease as Drivers in Health Care Costs: The China study



Contributes 80%

Insufficient fiber and micronutrients

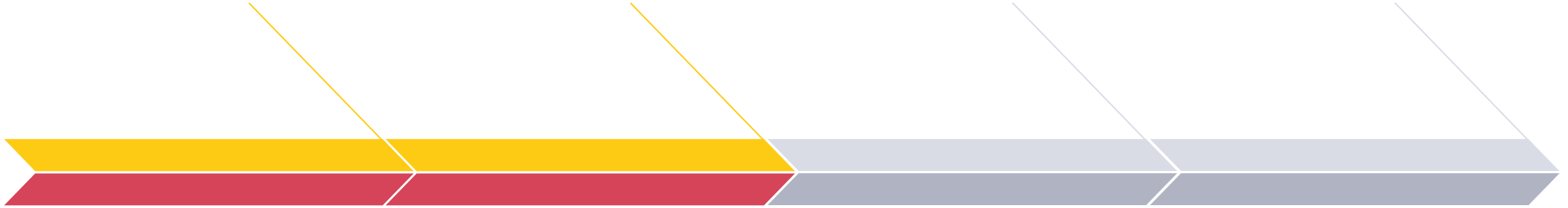
Air pollution & Living next to Factories

Usually Not a Significant problem

Estimates at less than 1%

As a function of the environment

Our process is easy :
Keep them healthy
& Reduce Total Cost of Care



Process Measure

Efficiency Measure

Outcome Measure

Reduced TCOC and increased longevity

Disease complexity and Total cost of care due to hospitalization and pharmaceutical use

Data Groups

Process measure: Screening	Efficiency measure: Disease Burden reduction	Treatment outcomes	Total cost of care and complexity
BMI	Medication adherence	BP control	
Bone density	Immunization	HbA1c reduction	
Colon cancer	Nutrition optimization	BMI reduction	
Breast cancer			

Using Data to Manage Patient Care

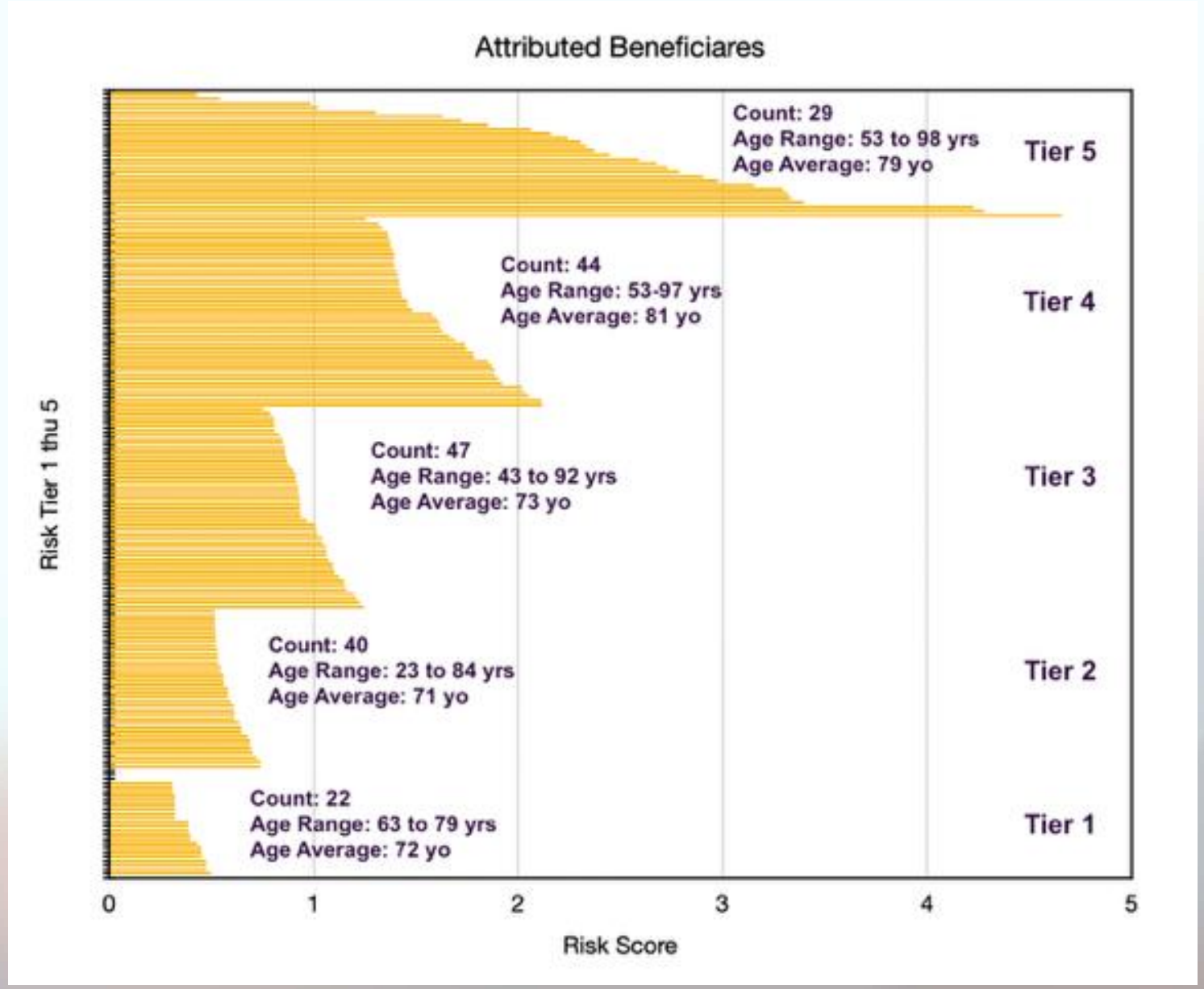
MDPCP

Beneficiaries Attributed this Quarter: 182

Cumulative Beneficiaries Attributed in 2024: 182

Number of Beneficiaries by Risk Tier		Risk Score Range	
Low Risk ($9 PBPM)	22	0 - 0.511	
Medium-Low Risk ($11 PBPM)	40	0.512 - 0.740	
Medium-High Risk ($19 PBPM)	47	0.741 - 1.251	
High Risk ($33 PBPM)	44	1.252 - 2.115	
Complex Risk ($100 PBPM)	29	0.428 - 4.657	2.116 +

MDPCP Data for IC Care



Using Data to Manage Patient Care

Tools available: Primary care physicians have **6** tools to effect disease manifestation and total cost of care

1. Accurate Diagnosis
2. Immunization
3. Nutrition Optimization
4. Medication Compliance
5. Treatment Outcome Monitoring
6. Workflow Efficiency

Efficiency

Key performance indicators - KPI
Physician data input

Standing orders

Immunization: Flu, Pneumococcal, Tetanus booster Shingles, and now RSV

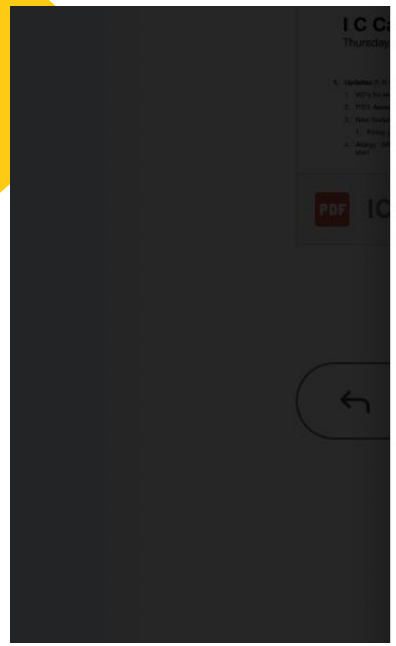
Disease screening :

HbA1c frequency q90 day, Fructosamine every 30 days if HbA1c >9, Mammogram every 24 months, Eye exam, Bone density, Colon cancer screening.

KPIs use Medical Assistant's Triage

Using Data to Manage Patient Care

KPI incorporating data collection



patient loads (GB 9-11, YC 13-15)

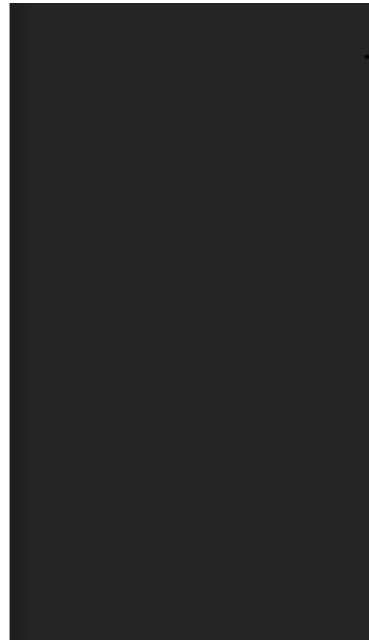
4. **Bi-weekly ZH Clarifications vs Patient Encounters** (yes/ 90%) upload bi-weekly
5. **Missed calls** + Call Backs
6. **Customer service** rating

3. **Hospital admit/releases & Pre-op tracking** (~5 pre week)
4. **A1C Wellness** Improvement (write monthly outreach, upload)
5. ***Allergy -** Patient Follow-up (10-12 calls bi-weekly)
6. **Customer**

team huddle agendas (upload)

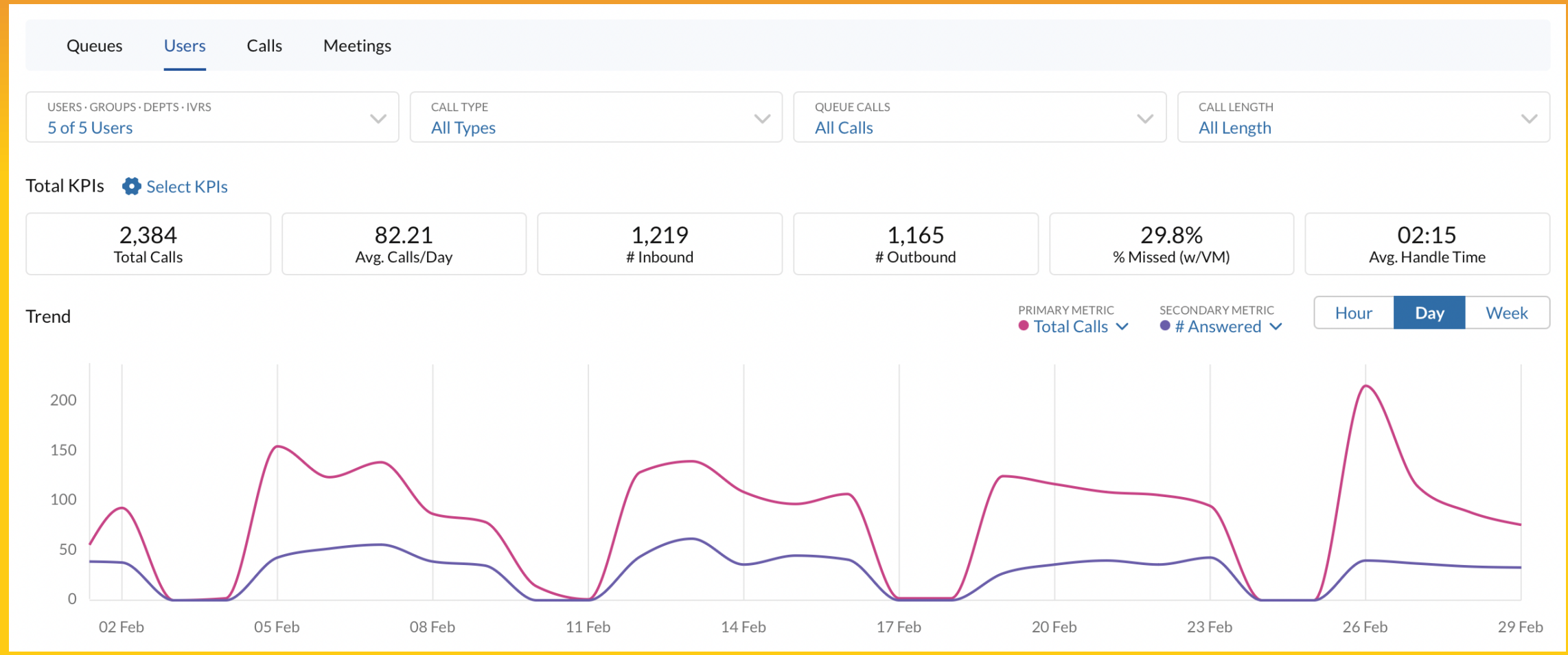
4. **Quarterly professional dev** course
5. **Injections** for flu & pneumonia (25 to 30 injections)
6. **SMD patient liaison** & on-boarding
7. **Customer service** rating

4. ***Allergy -** Patient identification by symptom for optimum care placement and tracking (2-0 green sheets missing)
5. Monthly Exam Room **inventory**
6. **Injections** for flu & pneumonia
7. **Customer service** rating



Using Data to Manage Patient Care

Telephone Calls



Using Data to Manage Patient Care

Immunization

ImmuNet

MIPS

Immunization

#493 - Adult Immunization Status *Strata 1:* Influenza Vaccine	1,308	414	372	0	42	89.86%
Strata 2: Td or Tdap Vaccine	1,308	414	7	0	407	1.69%
Strata 3: Zoster Vaccine	1,284	390	0	0	390	0%
Strata 4: Pneumococcal Conjugate or Polysaccharide Vaccine	1,161	267	42	0	225	15.73%
Strata 5: Overall	1,308	414				9.19%

* For measures with no existing CMS benchmarks, the measure is assigned a score of 3 points for clinicians who are part of a small practice.

Other process screening

#39 - Screening for Osteoporosis for Women Aged 65-85 Years of Age	342	342	106	0	236	30.99%
#112 - Breast Cancer Screening	473	473	407	0	66	86.05%
#113 - Colorectal Cancer Screening	1,039	1,039	867	0	172	83.45%
#117 - Diabetes: Eye Exam	284	284	214	0	70	75.35%
#128 - Body Mass Index (BMI) Screening and Follow-Up Plan	1,594	1,594	1,590	3	1	99.94%
#130 - Documentation of Current Medications in the Medical Record	2,509	2,509	2,508	1	0	100%

Treatment Outcome Monitoring

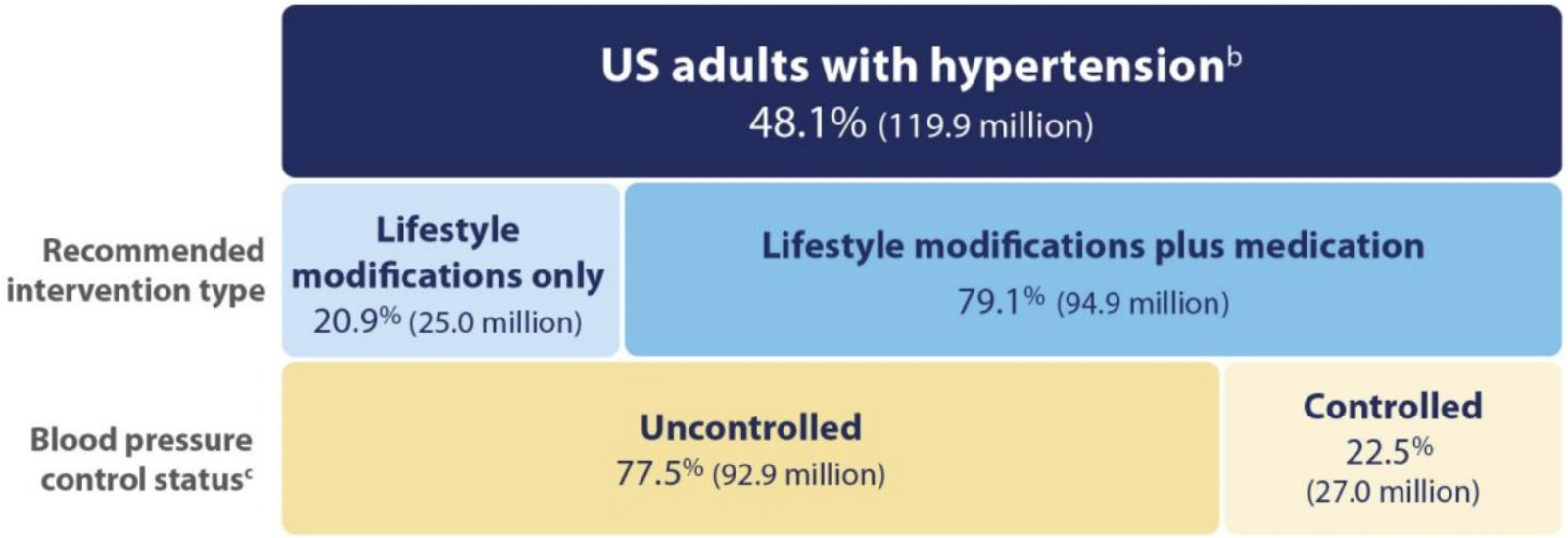
CRISP
MDPCP

Hypertension
Diabetes
Complexity & Cost

Using Data to Manage Patient Care

Estimated Hypertension Prevalence, Treatment, and Control (Blood Pressure <130/80 mm Hg) Among US Adults[a]

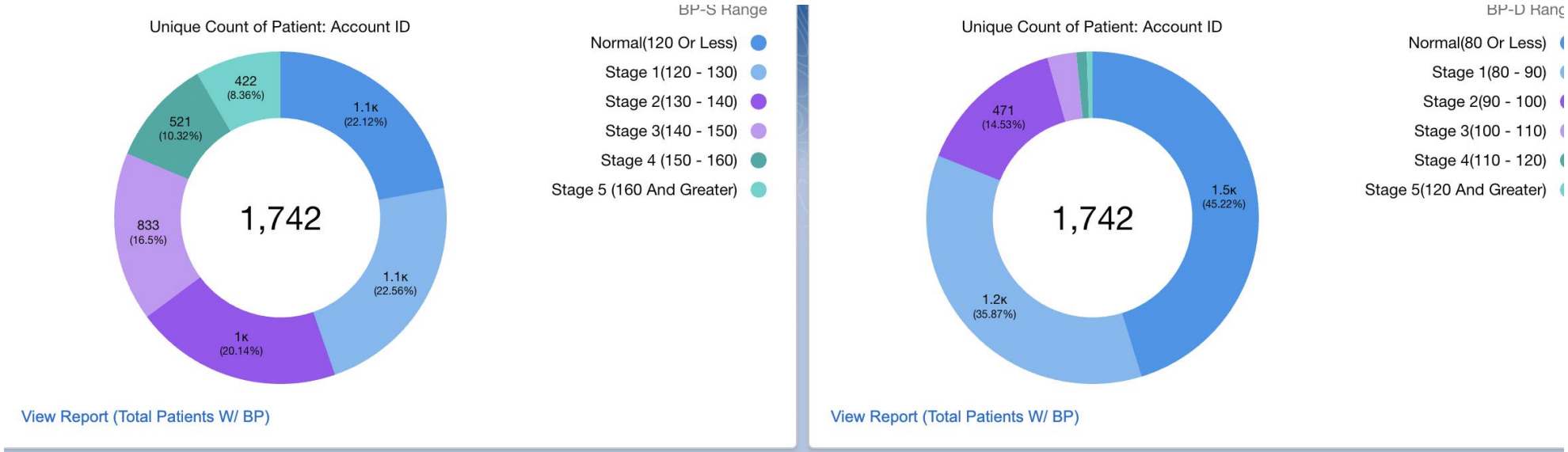
Applying the criteria from the American College of Cardiology and American Heart Association's (ACC/AHA) 2017 Hypertension Clinical Practice Guideline - NHANES 2017- March 2020

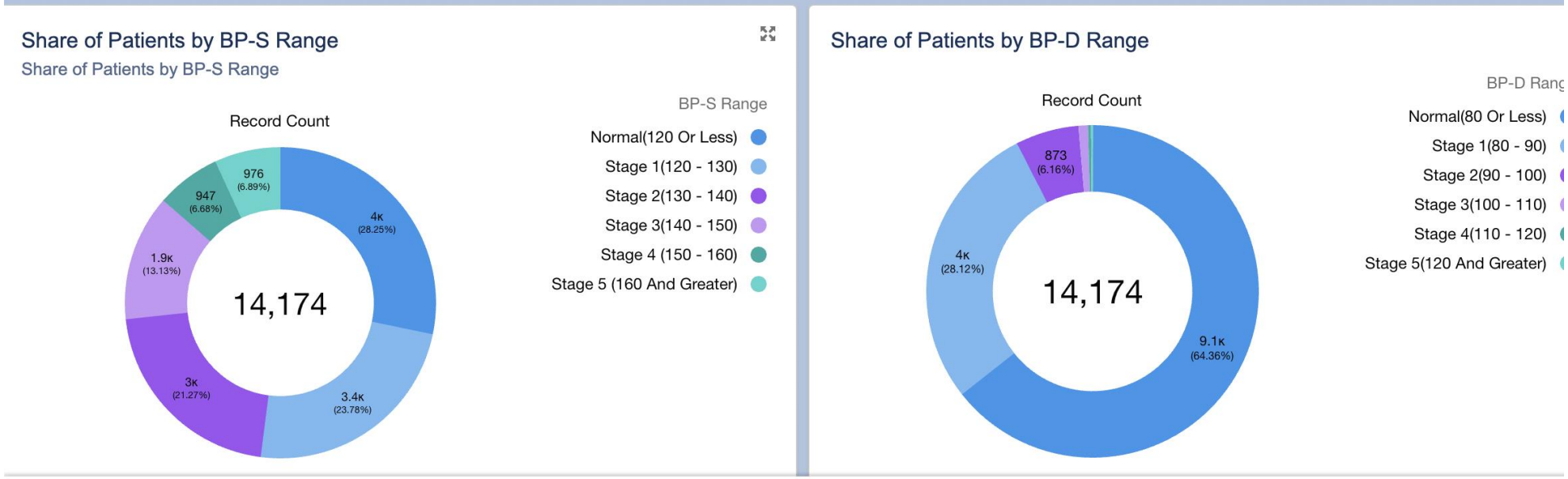


Data source: National Center for Health Statistics, Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES) 2019-March 2020. Definitions: ACC/AHA criteria adapted from Ritchey MD, Gillespie C, Wozniak G, et al. Potential need for expanded pharmacologic treatment and lifestyle modification services under the 2017 ACC/AHA Hypertension Guideline. *J Clin Hypertens*. 2018; 1377-1391. https://doi.org/10.1111/jch.13364

[a] Among adults aged 18 years and older; estimates may not equal 100% due to rounding.
[b] Blood pressure ≥130/80 mm Hg or currently using prescription to lower blood pressure.
[c] Controlled is defined as having a blood pressure <130/80 mm Hg. All adults recommended lifestyle modifications only are considered uncontrolled as their blood pressure is above the threshold.

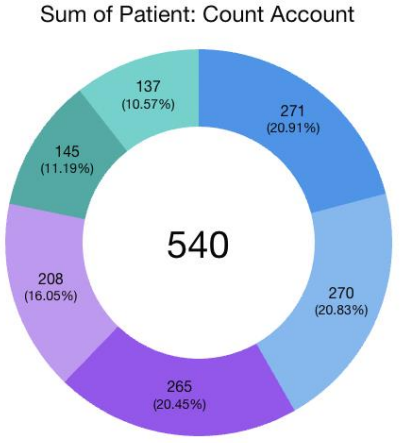
Hypertension prevalence - IC Care





Hypertension control - IC Care

Patients DX With Hypertension Systolic BP All Encounters

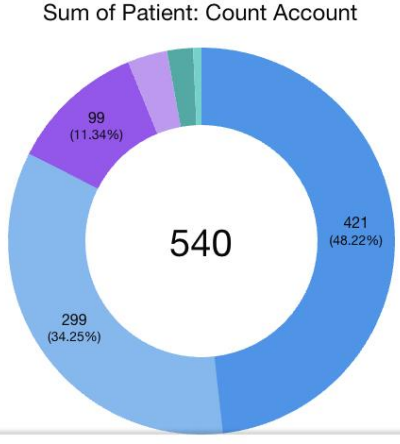


BP-S Range

- Normal(120 Or Less)
- Stage 1(120 - 130)
- Stage 2(130 - 140)
- Stage 3(140 - 150)
- Stage 4 (150 - 160)
- Stage 5 (160 And Greater)

View Report (Patients diagnosed with hypertension)

Patients DX With Hypertension Diastolic BP All Encounters



BP-D Range

- Normal(80 Or Less)
- Stage 1(80 - 90)
- Stage 2(90 - 100)
- Stage 3(100 - 110)
- Stage 4(110 - 120)
- Stage 5(120 And Greater)

Using Data to Manage Patient Care

#236 - Controlling High Blood Pressure	593	593	406	0	187	68.47%

MIPS BP report - IC Care

Total Patients
(HbA1c of < or = 5.7)

77

View Report (Patient's HbA1c of <or= 5.7)

Total Patients
(HbA1c of > 5.7 but < 6)

58

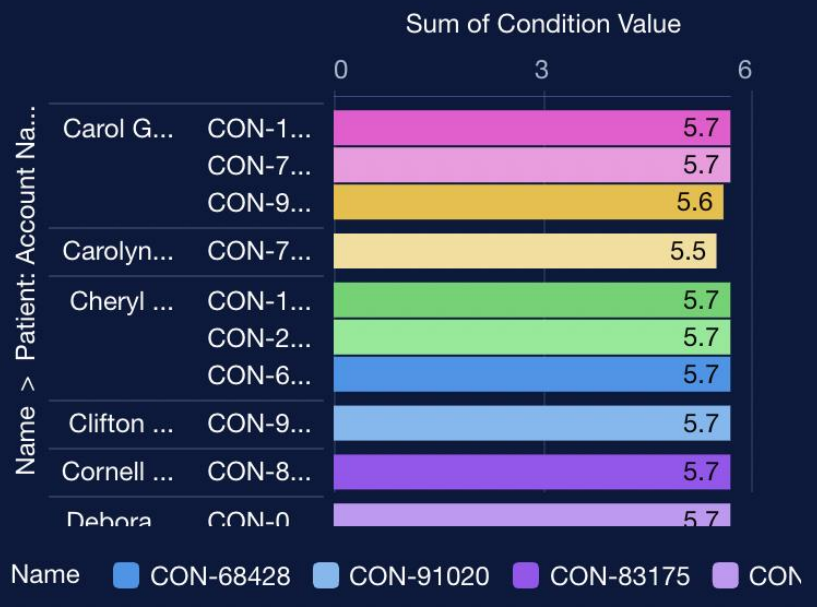
View Report (Patient's HbA1c of > 5.7 but < 6)

Total Number of Patients
(Hba1c of > or = 6 but < 7)

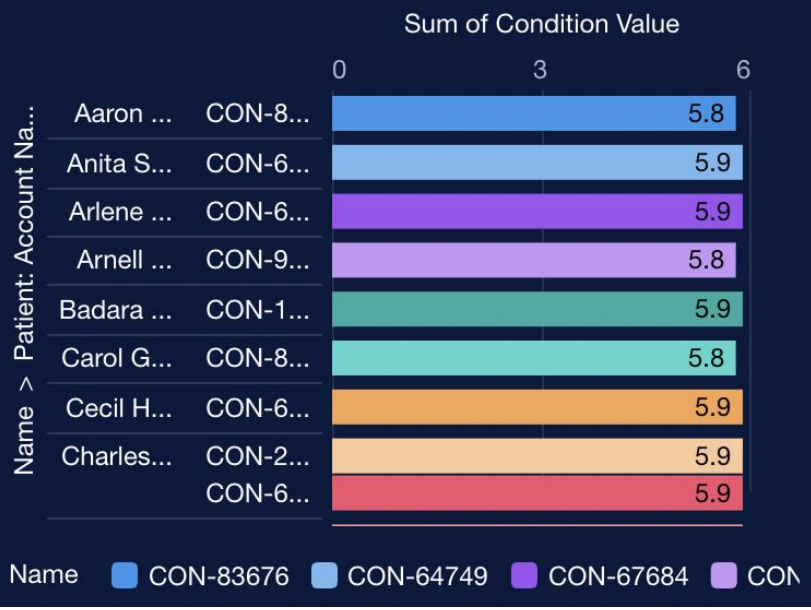
146

View Report (Patient's Hba1c of > or = 6 but < 7)

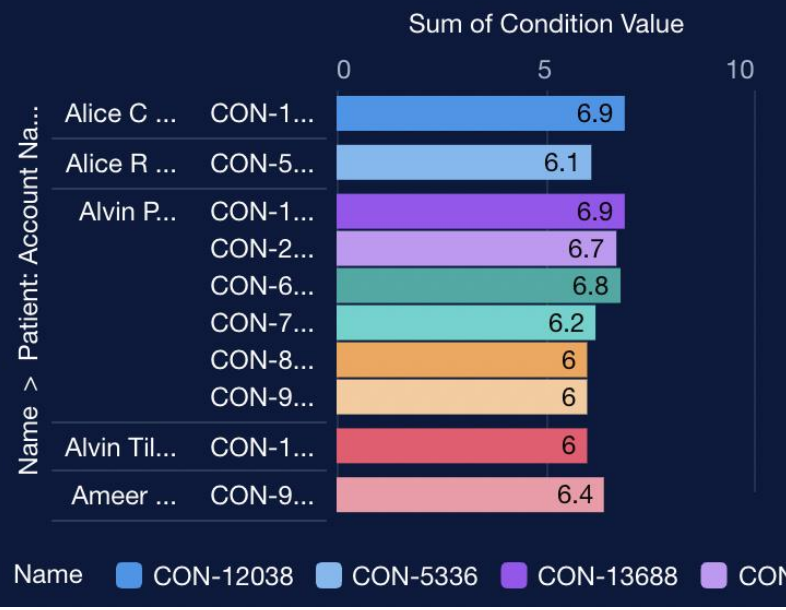
Patients by Conditions
(HbA1c of < or = 5.7)



Patients by Conditions
(HbA1c of > 5.7 but < 6)



Total Number of Patient
(Hba1c of > or = 6 but < 7)



Total Number of Patients
(HbA1c of > or = 7 but < 8)

70

View Report (Patient's HbA1c of > or = 7 but< 8)

Total Number of Patients
(HbA1c of > or = 8 but < 9)

25

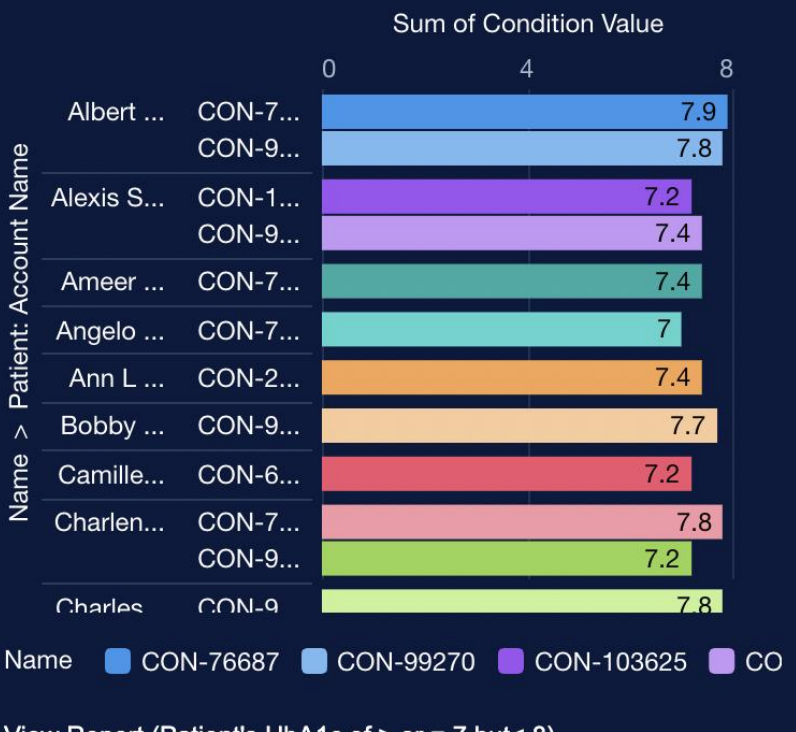
View Report (Patients HbA1c of > or = 8 but < 9)

Total Number of Patients
(HbA1c of > or = 9)

38

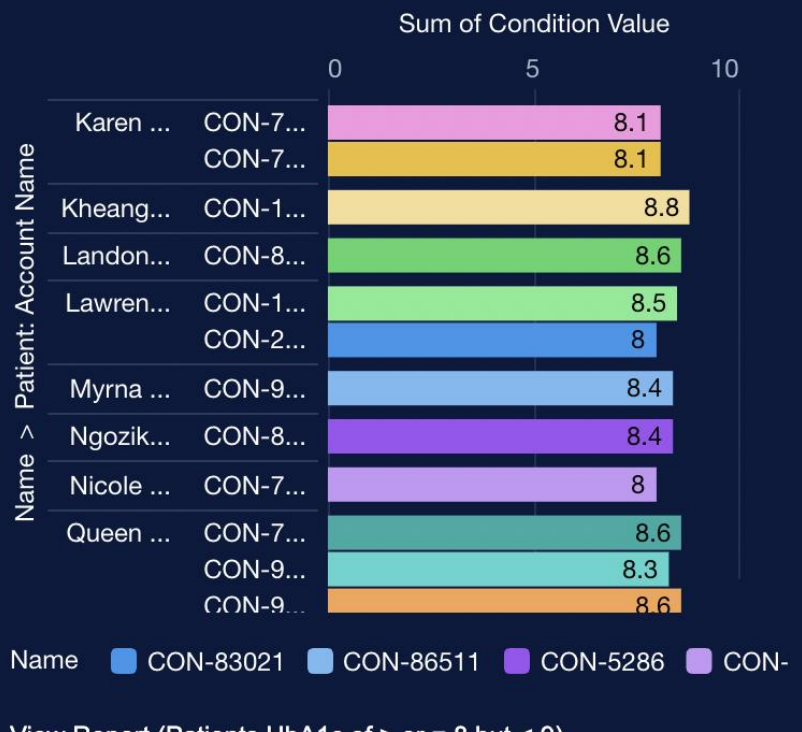
View Report (Patient's HbA1c of > or = 9)

Total Nmuber of Patients
(HbA1c of > or = 7 but < 8)



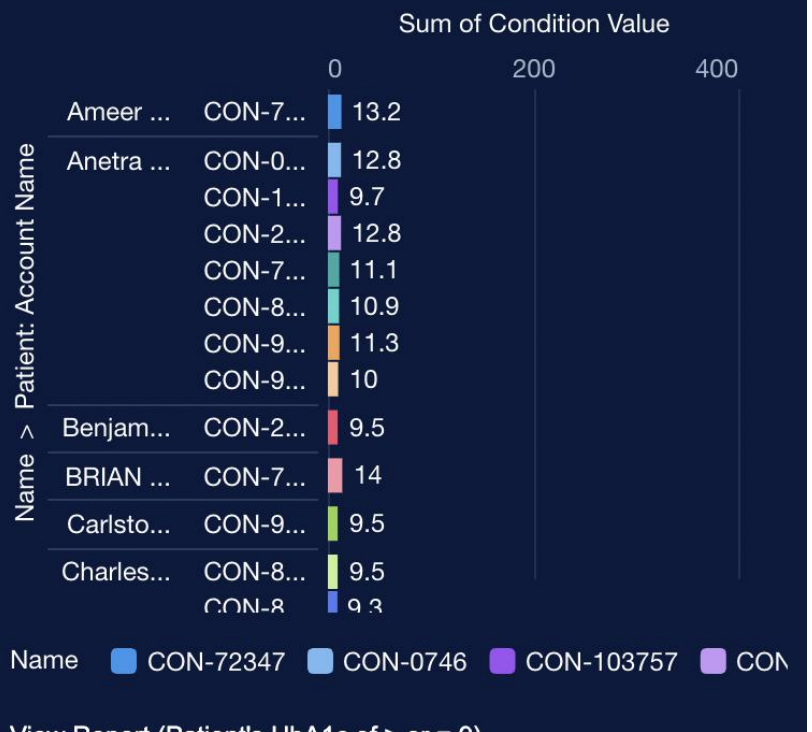
View Report (Patient's HbA1c of > or = 7 but< 8)

Total Number of Patient
(HbA1c of > or = 8 but < 9)



View Report (Patients HbA1c of > or = 8 but < 9)

Total Number of Patients
(HbA1c of > or = 9)



View Report (Patient's HbA1c of > or = 9)

Using Data to Manage Patient Care

Quality Performance Report

Quality Score: 30/30

George Bone

2023 (01/01 - 12/31)

Measure	Total Instances	Complete Instances	Met	Exclusions	Not Met	Performance Rate
#1 - Diabetes: Hemoglobin A1c Poor Control (>9%) *An inverse measure*	284	260	17	0	243	6.54%

MIPS Diabetes report - IC Care

In Closing

Convergence of four major innovations:

Precision genetic information

Advancements in deep learning

Cost reductions for collecting healthcare data

Understanding the socio demographic basis of disease

Credits

Special thanks to all the people who help and who coordinate these awesome resources:

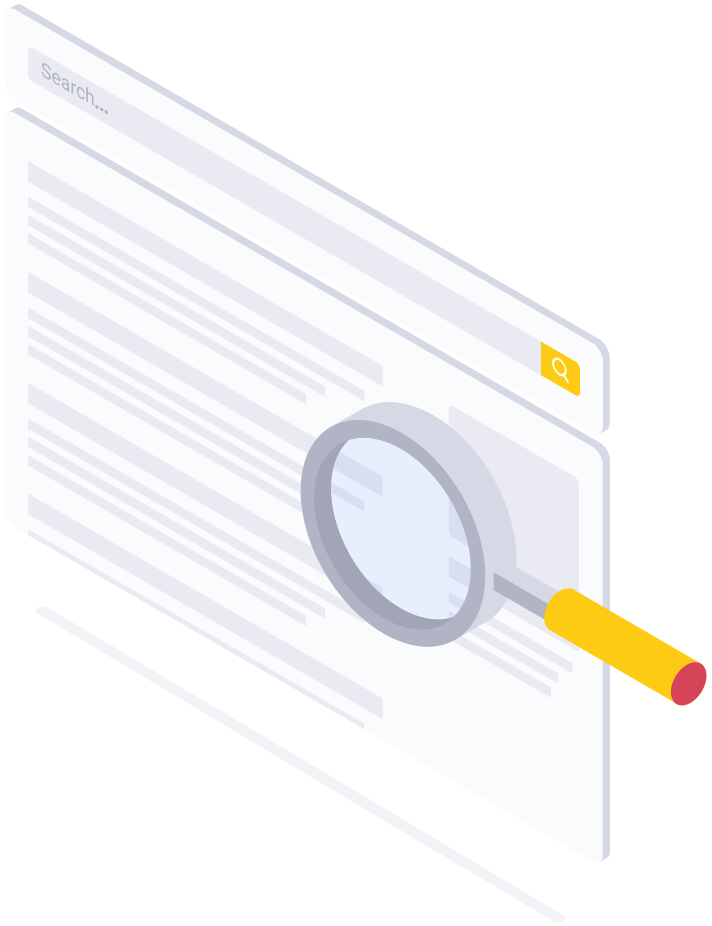
Data gathering by IC Care MA staff
Slide deck by Mastermind Graphics, MHCC and MedChi staff
Team management by Keiron Bone-Dormegnie
Population health data coordination by Rochelle McPhaul
Data from CRISP, MDPCP, MIPS, and the ZH-Blue EHR teams

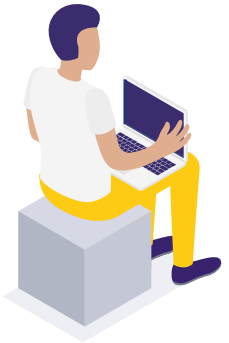
THANKS!

Any questions?

You can find me at:

- ihc.bone@iccare.us
- 301-773-9700





Q & A

THANK YOU

Melanie Cavaliere
Chief, Innovative Care Delivery
melanie.cavaliere@maryland.gov

mhcc.maryland.gov