Welcome to Cherokee Health Systems!

Center for Care Innovations
Population Health Learning Network
Site Visit

September 19, 2018

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Goals and Topics for Discussion

Overview of Cherokee Health Systems

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Our Mission…

To improve the quality of life
for our patients through the blending of
primary care and behavioral health.

Together…Enhancing Life

Primary Service Area

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Strategic Emphases

- Population-based care
- Blended behavioral and primary care
- Go where the grass is brownest
- Outreach and care coordination
- Telehealth
- Training healthcare providers
- Value-based contracting
- Healthcare analytics

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Cherokee Health Systems

Current Number of Employees: 715

Current Annual Payroll: $41,390,679

Provider Staff:

Psychologists - 47
Primary Care Physicians - 27
NP/PA (Primary Care) - 53
Community Workers - 37

Cardiologist - 1
Nephrologist - 1
Pharmacists - 13
RNs - 81

Psychiatrists – 8
NP (Psych) – 9
LCSWs – 68
Dentists-2

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Giving our Best for Those Most in Need

Improving Access and Outcomes for the Underserved

Calendar Year 2017

78,611 Patients Seen

409,363 Services Provided

25,242 New Patients

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Populations/Communities Served

- Rural Appalachian
- Black/African American
- Migrant/Agricultural Farm Workers
- Latino/Hispanic
- Homeless
- Public Housing
- Refugee – Africa, Middle East, Eastern Europe/Russia

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3 Year (FY2014-FY2017) Penetration Rates

3 year penetration into the general population

Unduplicated patients	73,885
Total area population	691,293
Penetration	10.7%

3 year TennCare (Medicaid) penetration

Unduplicated Medicaid patients	31,569
Total Medicaid enrollment	134,117
Penetration	23.5%

3 year penetration into the uninsured population

Unduplicated patients	31,141
Total area population	90,998
Penetration	34.2%

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CY 2017 CHS Patient Services Integration

Patients with a Medical Visit

50,331

Saw a Behaviorist

39%

Patients with a Behavioral Health Service

35,048

Had a Medical Visit

56%

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Break

Clinical Model of Integration

Structure, Roles, Process

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Overview

- Definition
- Foundational Principles
- Structure
- Roles
- Process

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What is Integrated Care?

"The care that results from a practice ***team*** of primary care and behavioral health clinicians, ***working together*** with patients and families, using a systematic and ***cost-effective*** approach to provide ***patient-centered care*** for ***a defined population***. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization."

Peek CJ and the National Integration Academy Council. Executive Summary - Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-1-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. http://integrationacademy.ahrq.gov

An Integrated Team Based Model

- Functions of care delivery shared across team
- Access to BH expertise “where behavioral problems shows up”
- Improved communication
- Improved care coordination
- Expanded health management support
- Supported patient engagement

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Integration is a means to an end…

- Improve the health of a population
- Achieve health equity
- Improve access
- Focus on wellness and prevention
- Patient centered care
- Evidence based clinical and program decision making

Integrated Behavioral Health MUST Fulfill Functions of PRIMARY Care

- **Contact** – First line of access
- **Comprehensive** – Anything that walks through the door
- **Coordinated** - Organizes and synchronizes all elements of care
- **Continuous** – Episodes of care within context of longitudinal partnership

CHS' Behaviorally Enhanced Healthcare Home

- Behaviorist on Primary Care (PC) team
- Consulting Psychiatrist on PC Team
- Shared patient panel and population health goals
- Shared support staff, physical space, and clinical flow
- BH Access and collaboration at point of PC
- PC Team based co-management and care coordination
- Shared clinical documentation, communication, and treatment planning

Common Considerations for PCP Referral for Behavioral Health Consultation Services

- Diagnostic clarification
- Behavioral Interventions
- Treatment planning
- Facilitate consultation with psychiatry
- Behavior and mood management
- Suicidal/homicidal risk assessment
- Substance abuse assessment and intervention
- Trauma & Anxiety management
- Interim check of psychotropic medication response
- Co-management of somaticizing patients
- Parenting skills
- Stress Management
- Medication management
- Weight Management
- Chronic Pain Management
- Smoking Cessation
- Insomnia / Sleep Hygiene
- Psychosocial and Behavioral Aspects of Chronic Disease
- Any Health Behavior Change
- Management of Inappropriate Medical Utilization
- Anger management

Integrating Psychiatry into Primary Care: Strategies

- **Consultation** to PCP/BHC via phone or telemed
- **Fast-track access** to direct face to face consultation with patient for stabilization
- **Triage** and coordination with specialty psychiatry
- **Treatment Team** discussion
- **Trainings** for PCPs/BHCs “Stump the Chump”

Who is on the team?

Clinical Therapist/Psychologist/BHC

- Communicating with prescriber to clarify diagnosis and unify treatment plan
- Monitor symptoms and functioning and communicate concerns/progress to prescriber

PCP/Specialty Medical Provider

- Assessing and treating acute and chronic health problems with assistance of a BHC or specialty behavioral health, as clinically indicated

Psychiatric Provider

- Communicating with co-prescriber (PCP) regarding medication concerns
- Providing diagnostic clarification
- Offering psychotropic medication recommendations to PCP

Who is on the team?

Each team member has a unique role

Patient Service Representative

- Coordinating the scheduling of same-day appointments
- Obtaining medical/behavioral releases for outside agencies

Nurses

- Identifying presenting problems during visit
- Administering behavioral health screening tools
- Coordinating with multidisciplinary staff to manage clinic flow and delivery of multiple services on single date of service

Who is on the team?

Each team member has a unique role

Clinical Pharmacist

- Evaluate the appropriateness and effectiveness of the patient's medications.
- Follow the patient's progress to determine the effects of the patient's medications on his or her health.
- Advise the patient on how to best take his or her medications.

Community Health Coordinator (CHC)

- Improve treatment engagement, motivation, and adherence
- Assist patient in obtaining health coverage or access to needed care
- Create linkages with community resources
- Identify and problem-solve barriers to improved self-sufficiency

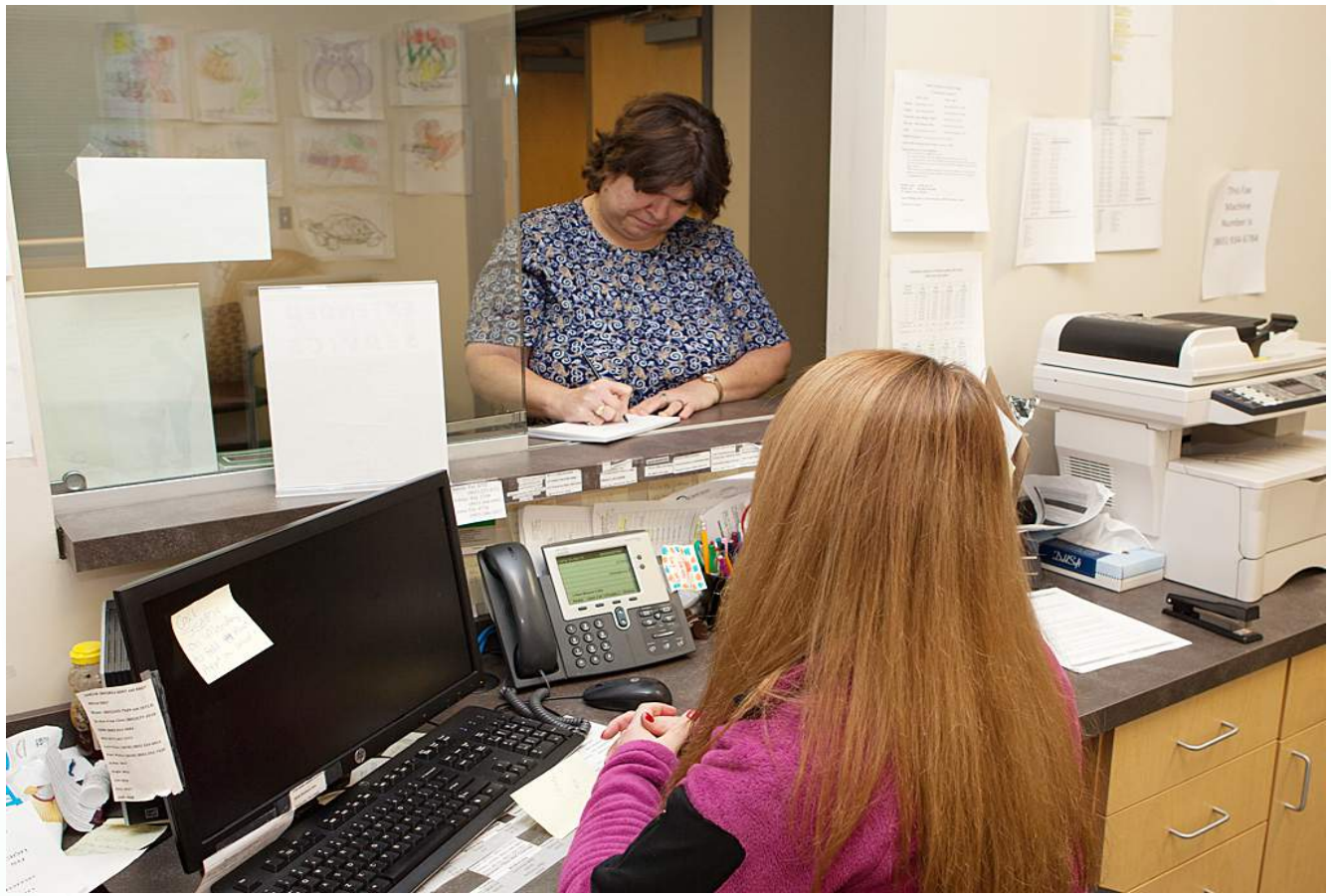
How The Team Coordinates And Communicates

- Patient Dashboard
- Morning Huddles
- Communication from Care Coordination in EHR
- Weekly Integrated Team Meetings
- Standing Orders
- Daily Opportunities Reporting on Care Gaps

So what does it look like in real life?

- *A picture is worth a thousand words…*

Patient Check-in



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Vitals -BP

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Vitals - BH

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Shared Space

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PCP with Patient

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PCP
Consults
BHC

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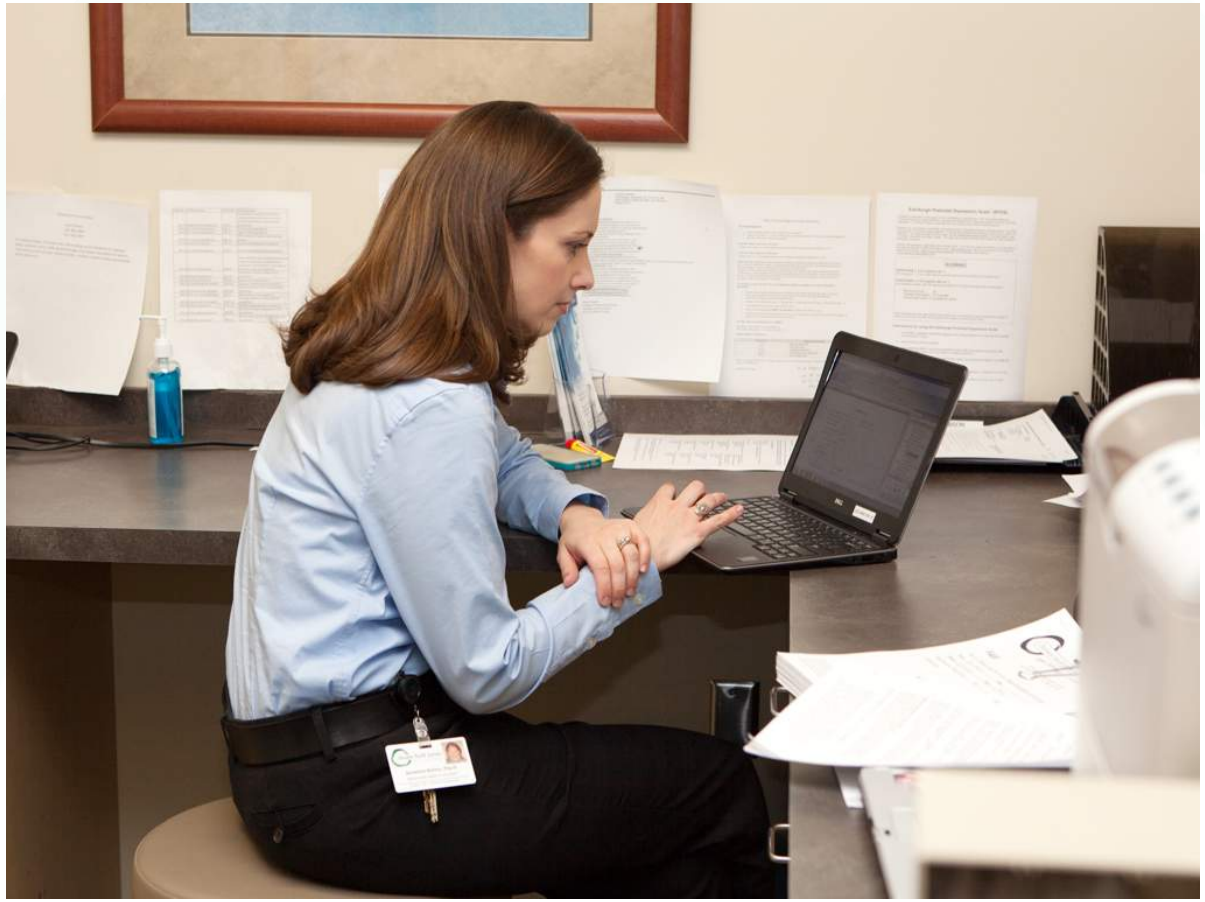
BHC Chart Review



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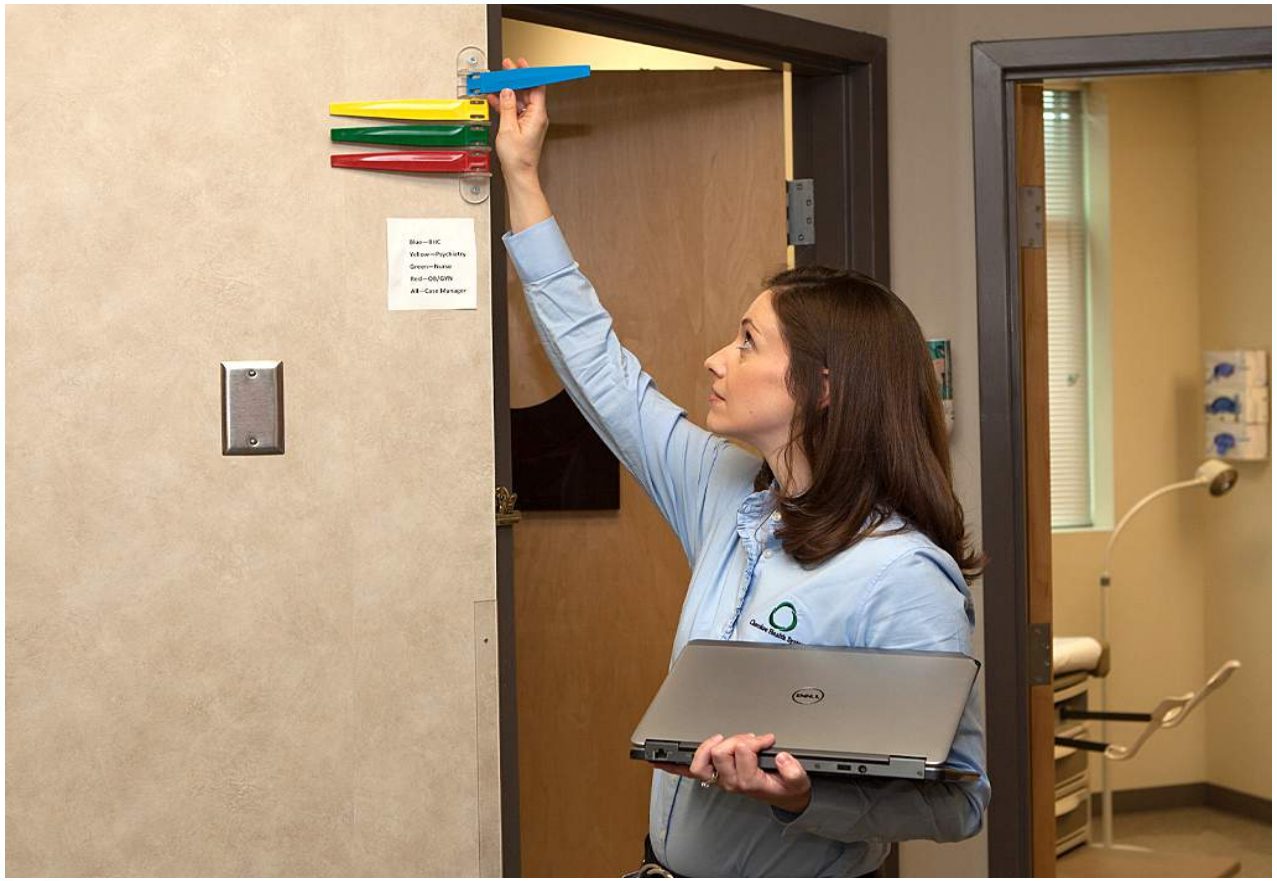
BHC Transition



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BHC Consultation with Patient

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BHC Feedback to PCP

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Patient and BHC Coordinate Follow –Up Plan

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Questions?

Population Health Management

Bio-Psycho-Social Assessment (BPSA)

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Managing an Assigned Population

- 35,000 assigned Medicaid lives
- Value-based contracts put us at risk (both upside and downside) for quality targets and cost targets (quality bonus and shared savings)
- Who are these patients?
- What is driving their use of services? Medical? Psych? SDOH?
- Who are the sickest and what resources do they need?
- Who are *next* sickest and what resources do they need?

Model description

- Biopsychosocial Algorithm of Patient Complexity
- Quantifies patient complexity from biological, psychological, and social domains
- Points assigned to conditions are combined into overall BPSA score by patient

Patient Information

- Age, Income, BMI, Language, Living Arrangement
- Appointment No-Show Rate, Care Plan Engagement

Claims / Utilization

- Medical and Behavioral Diagnoses
- Prescriptions, BHC Visits, Hospital IP/ER Use

Social Factors

- Support System, Isolation, Legal, Culture, Access to Health Care
- Transportation, Housing, Access to Food, Education, Employment

BPSA Score

Medical (Bio) factors (EHR and claims)

- Asthma
- Myocardial Infarction
- Cerebrovascular Disease
- Diabetes
- Leukemia
- Low Back Pain
- AIDS
- Etc.

Psychological factors (EHR and claims)

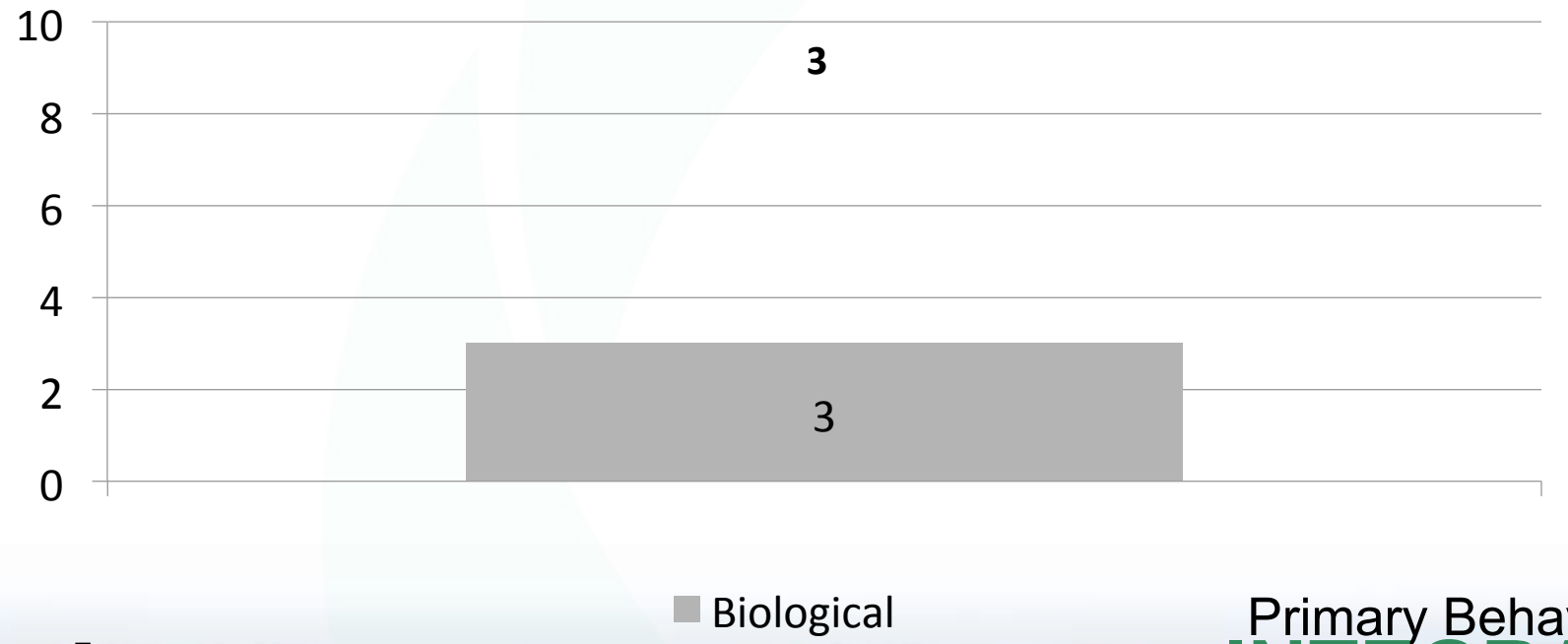
- Anxiety
- Trauma/PTSD
- Eating Disorder
- Major Depression
- Bipolar Disorder
- Etc.

Social factors (taken/discussed at visit – entered into record)

- Income below federal poverty guidelines
- Homeless or unstable housing
- Transportation barriers
- Employment barriers
- Issues with primary support system
- Legal problems
- Lack of access to food/clothing
- Social isolation
- Language/cultural barriers

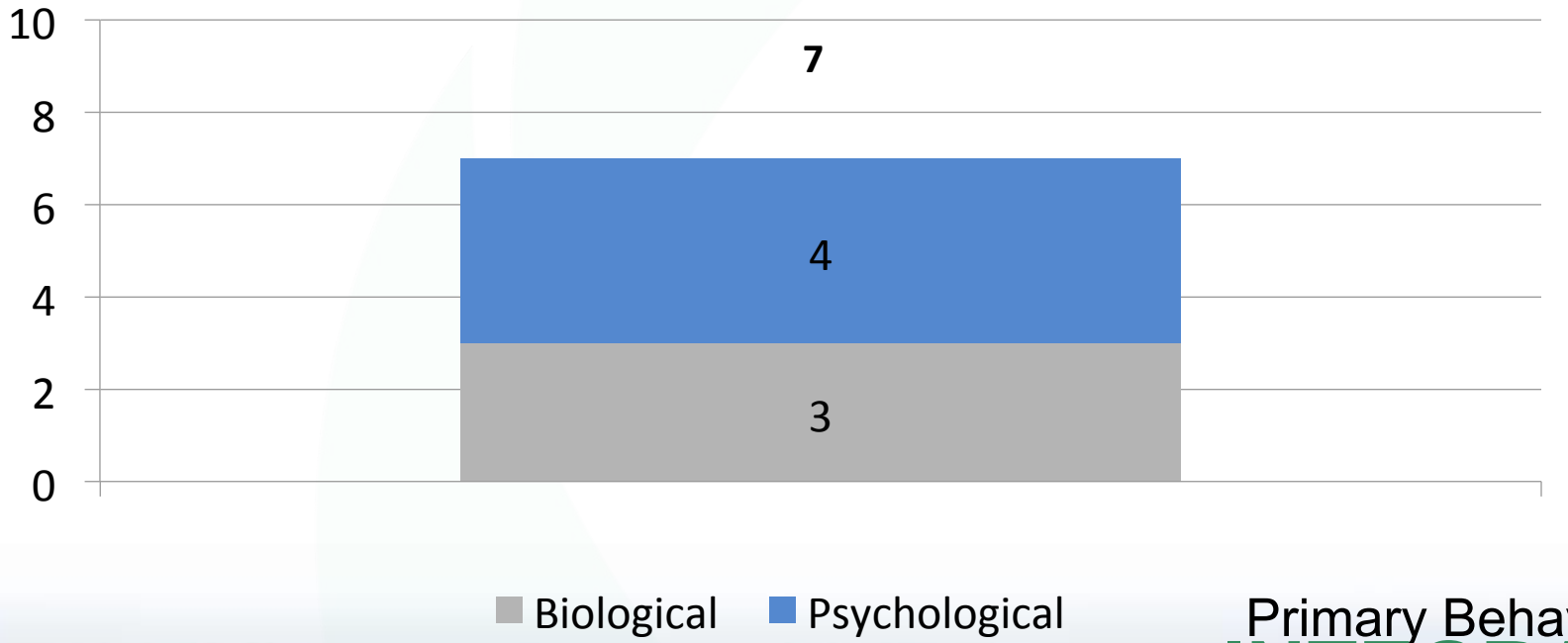
BPSA Score: Biological (medical diagnoses from claims/records)

Category	Biological	Psychological	Social	BPSA
Patient #1	3	4	2	9



BPSA Score: Biological + Psychological (diagnoses from claims/record)

Category	Biological	Psychological	Social	BPSA
Patient #1	3	4	2	9



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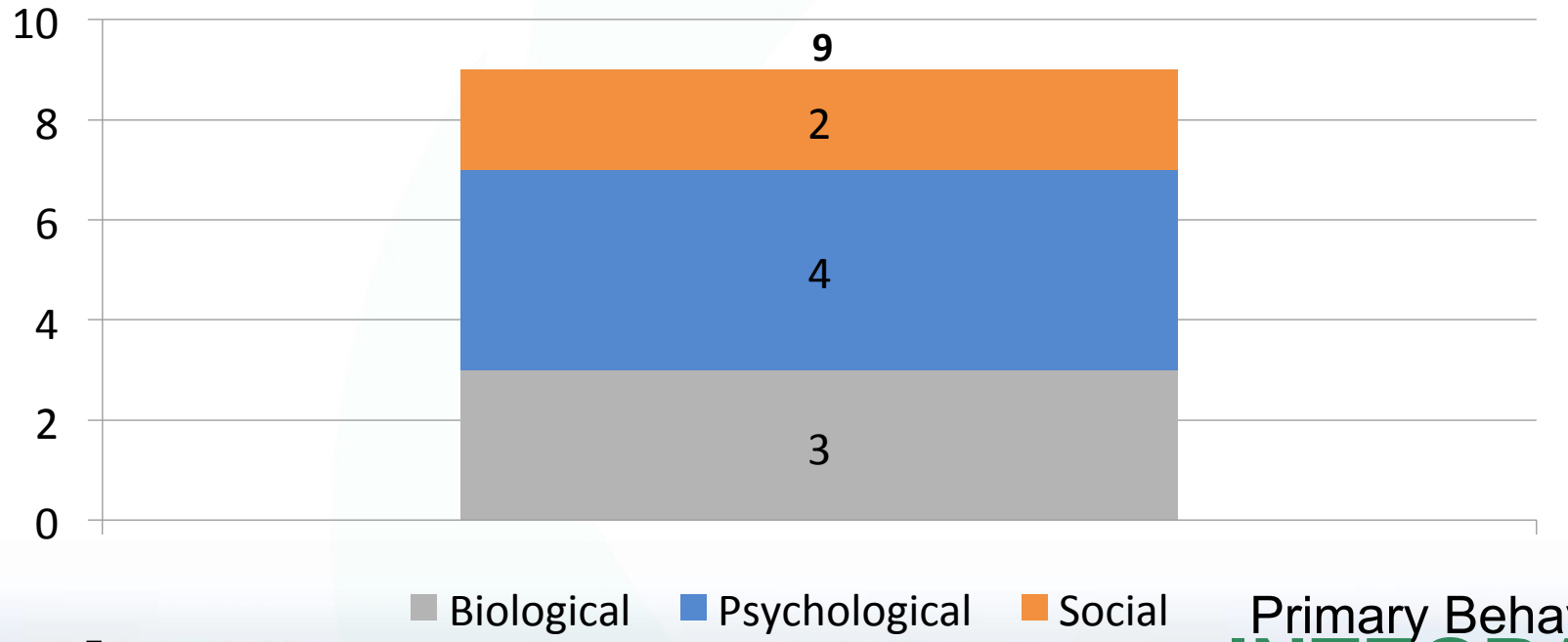
BPSA Score: Biological + Psychological + Social

Category	Biological	Psychological	Social	BPSA
Patient #1	3	4	2	9



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BPSA Results: CHS 10 Highest Ranked Active Patients (mean = 5)

Rank	MRN	Bio	Psych	Sdoh	Total Score	Last MED DOS	Last BH DOS	Financial Class
1	xxxxx	11	19	12	42	20150616	20140311	Medicaid
2	xxxxx	17	11	12	40	20150630	20150413	Medicaid
3	xxxxx	15	19	5	39	20150605	20150511	Medicaid
4	xxxxx	5	19	15	39	20150624	20150225	Medicare
5	xxxxx	14	18	6	38	20150421	20150709	Medicaid
6	xxxxx	14	17	7	38	20150417	20120927	Medicare
7	xxxxx	21	11	5	37	20090323	20150420	Medicaid
8	xxxxx	11	17	9	37	20150618	20140206	Medicare
9	xxxxx	16	13	8	37	20120313	20121108	Medicaid
10	xxxxx	11	17	9	37	20141104	20140925	Medicare

CHS 20 Highest Ranked Assigned PCP

Rank	Provider	Patients	Avg Score
1	A	501	40.1
2	B	1,698	39.2
3	C	508	38.6
4	D	625	38.5
5	E	1,490	37.6
6	F	1,175	36.8
7	G	1,501	34.4
8	H	1,034	33.9
9	I	921	32.0
10	J	1,476	32.0

Rank	Provider	Patients	Avg Score
11	K	954	30.4
12	L	445	30.1
13	M	1,387	29.1
14	N	735	27.5
15	O	829	25.9
16	P	902	25.2
17	Q	1,633	24.8
18	R	413	24.5
19	S	914	23.8
20	T	851	23.1

Quality Metrics

Measure	NCQA 75th Percentile (2013)	TennCare Target 2014	Proposed Target
Childhood Immunization Status, Combo 10 (CIS 10)	38%	n/a	___%
Treatment for Children with Upper Respiratory Infection (URI)	90%	84%	___%
Breast Cancer Screening (BCS)	58%	55%	___%
Controlling High Blood Pressure (CBP)	63%	64%	___%
Diabetic HbA1C Testing (CDC HbA1C)	87%	n/a	___%
Diabetic LDL-C Screening (CDC LDL)	81%	n/a	___%
Postpartum Care / Visits (PPC)	71%	71%	___%
Follow up Visit Within 7 Days of Discharge from Acute MH Admission	69%	n/a	___%
Antidepressant Medication Management -Acute Phase, First 60 Days	56%	n/a	___%
Follow-Up Care for Children Prescribed ADHD Medication	46%	n/a	___%

Cherokee Health Systems — Patient Dashboard

Go to BH Home Page | Go to BH Consult | Go to PC Home Page | Add Care Plan Note | Send Task

Version 1.2.1 | Patient Portal Enrollment Status: **Token Issued**

Care Team

Type	Provider
PCP	Grieve PA-C, Heather
PSY	Phillips PMHNP-BC, Rebekah Marie
TPR	FREEMAN PHD, DENNIS
TX	FREEMAN PHD, DENNIS

Future Appointments

Provider	Event	Time	Date
FREEMAN PHD, DENNIS	BH 30 Therapy	09:30	02/16/2016
Serrell MD, Paul Burt	PC Nephrology FU	10:00	03/03/2016
Phillips PMHNP-BC, Rebekah Marie	BH Est Psy 15	09:30	03/30/2016

Past Appointments

Provider	Event	Status	Date
FREEMAN PHD, DENNIS	BH 30 Therapy	Kept	01/19/2016
FREEMAN PHD, DENNIS	BH 30 Therapy	Cancelled	01/07/2016
Yates MD, James Douglas	PC Cardio Fol Up	Kept	01/07/2016

Self Management

Goal	Status	Start Date
Walk 30 mins 3 x a week	Ongoing	02/11/2016

Allergies

Description	RXN Desc
NO KNOWN DRUG ALLERGIES	

Hospital ER/Admissions *(Last 90 Days)*

Description	Date
None	

Care Coordination

Care Intervention
CHC outreach when indicated

Point of Care

Preventative Care

Protocol	Status	Last Date	Due Date
Mammogram	Due	07/19/2012	07/19/2013
PAP		09/18/2013	09/18/2016
Pneumococcal		11/26/2012	01/14/2034

Health Management

Protocol	Status	Last Date	Due Date
ACT	Due		02/15/2016
Eye Exam		08/25/2015	08/25/2016
Hemoglobin A1c		11/10/2015	05/10/2016
Lipid Panel		09/25/2015	09/25/2016
Microalbumin	Due	11/01/2011	11/01/2012

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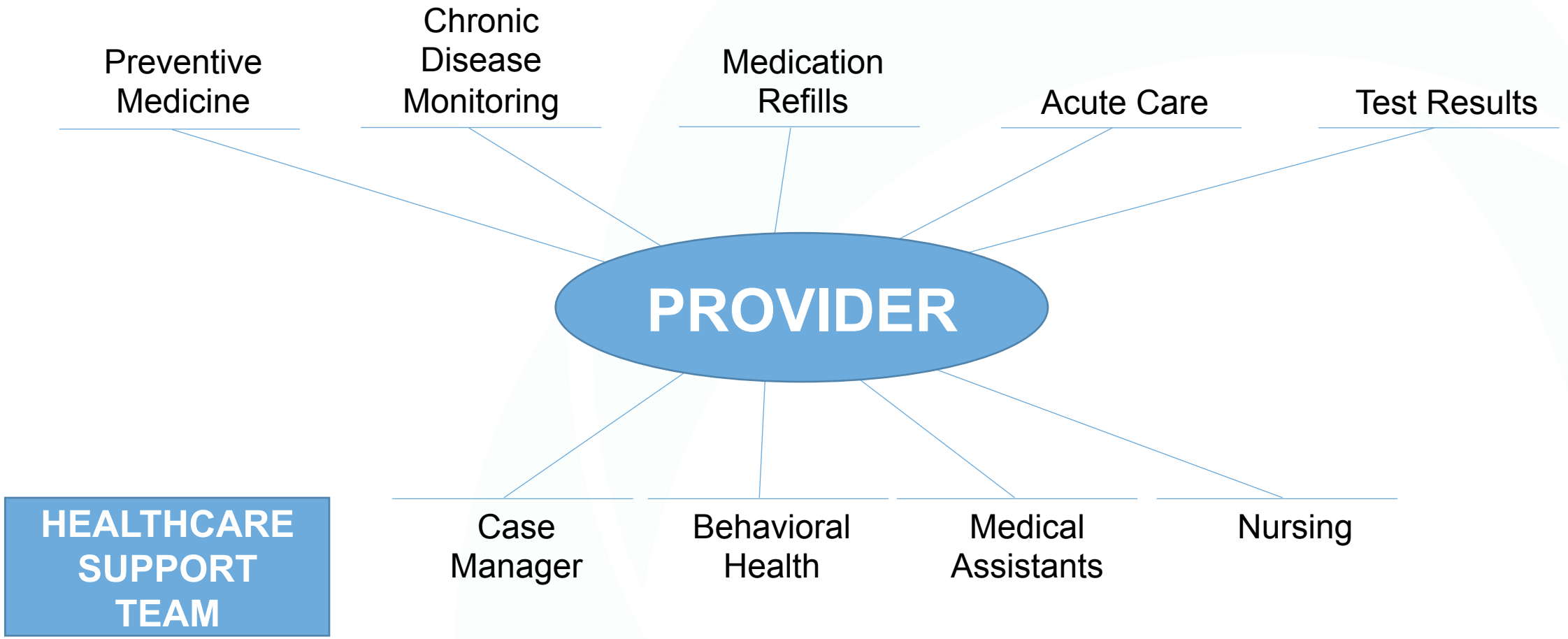
Traditional Primary Care Work Flow



Source: Southcentral Foundation, Anchorage AK

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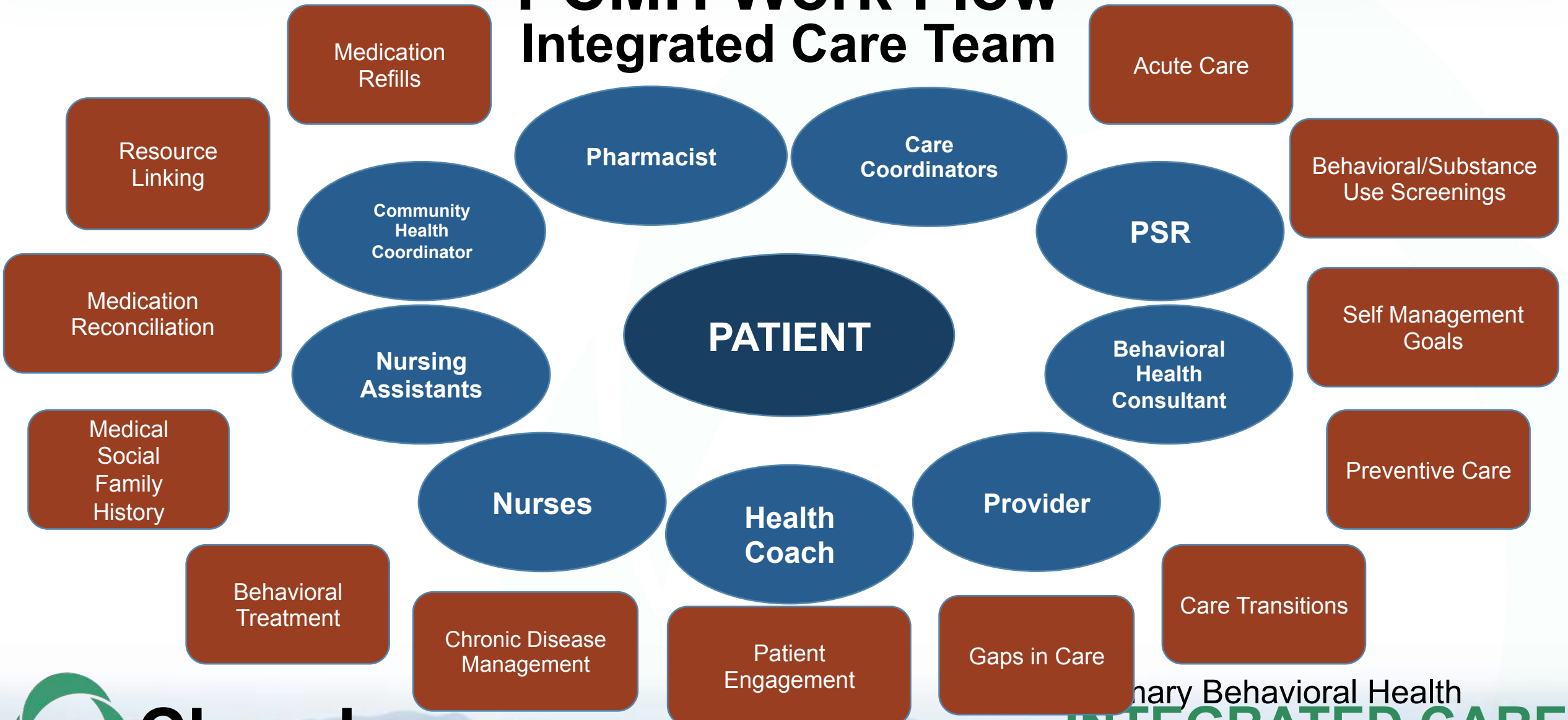
PCMH Work Flow
Integrated Care Team



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Integrated Care Team

- Resource Linking
- Medication Refills
- Medication Reconciliation
- Medical Social Family History
- Behavioral Treatment
- Chronic Disease Management

- Pharmacist
- Care Coordinators
- Community Health Coordinator
- Nursing Assistants
- Nurses
- Health Coach
- Provider

- PSR
- Behavioral Health Consultant

- Acute Care
- Behavioral/ Substance Use Screenings
- Self Management Goals
- Preventive Care
- Care Transitions
- Gaps in Care

Patient Engagement

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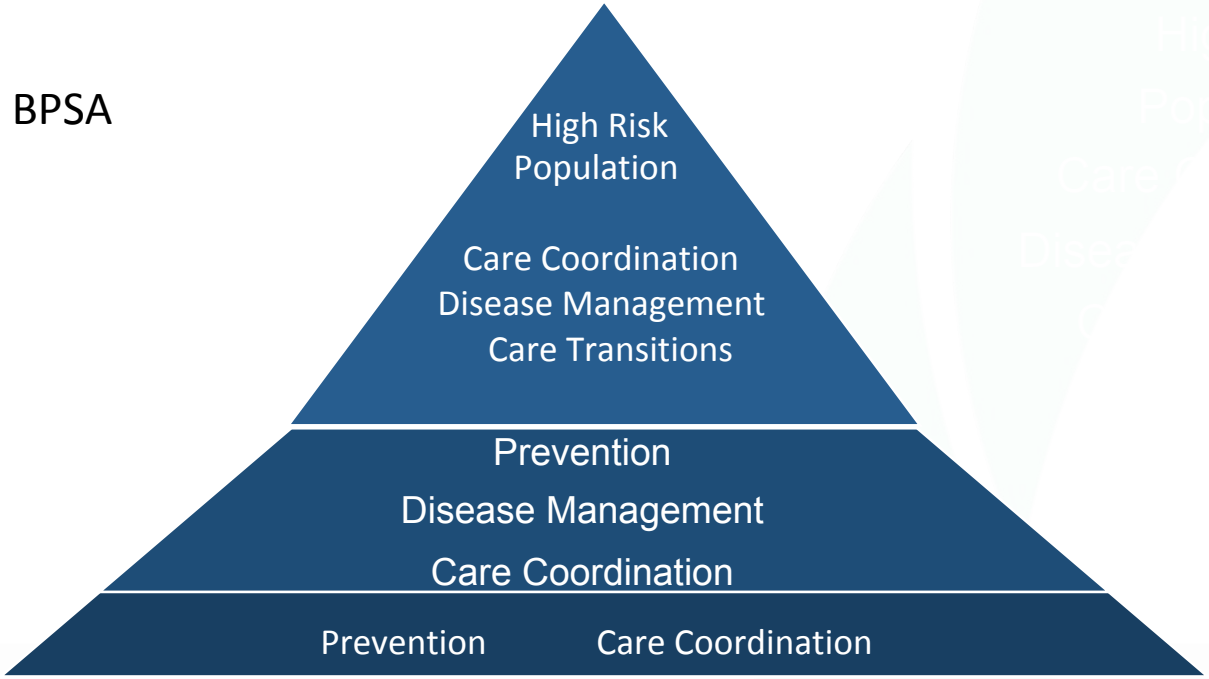
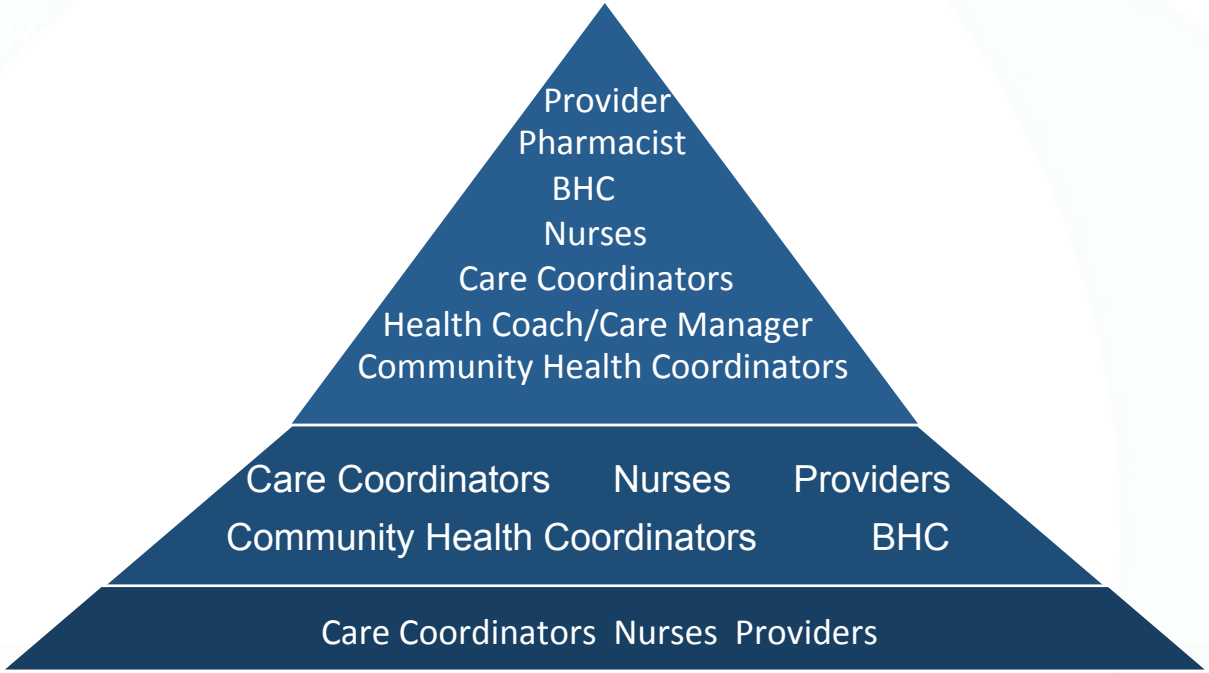
Patient Population Management

Stratification of Patient Population

BPSA





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Integrated Care for Addiction

Discussion of Enhanced Health Home Model for Addiction Continuum of Care, Including MAT

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Working Lunch – Continued Discussion

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Break

Population Health Management

Clinical Informatics
Optimizing NextGen (EHR)

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Health Information Technology

Implementation and Optimization

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IT Staffing Profile

- IT Helpdesk - (4)
- EHR Team - (5)
  + Clinical Leadership (Behavioral Health)
  + Clinical Leadership (Primary Care)
- Senior Level Infrastructure Support - (4)
- Reporting and Software Development - (5)
- Clinical Informatics - (1)

Mobility in Integrated Care

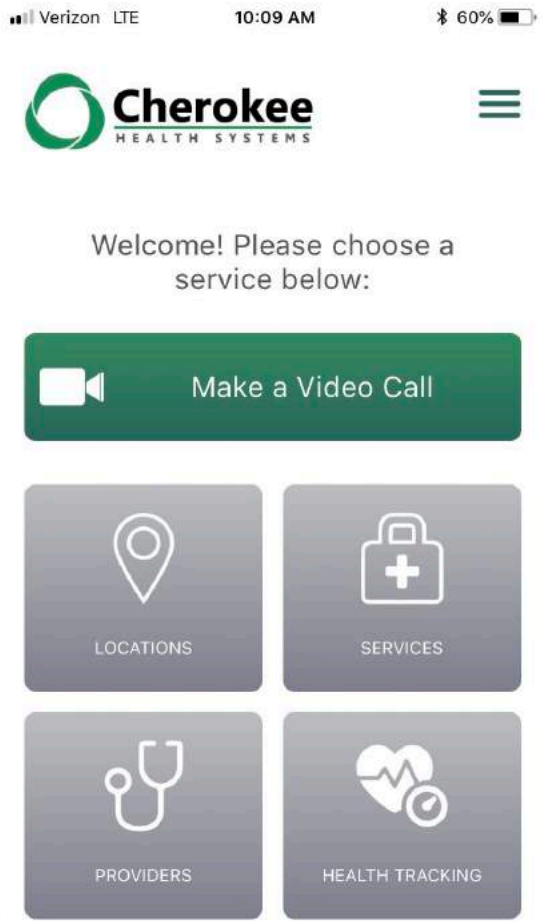
iPads and Laptops:

- Provides EHR Access
- Improves timeliness of documentation
- Provides Telemedicine capabilities for high-risk patients
- Increases patient access to all CHS services and care team

Telemedicine/Video Conferencing

- Primary Care
- Specialty Mental Health
- BHC Consults
- Pharmacy
- Discharge/Aftercare Planning
- Mobile Crisis
- Mental Health Hospital Admission (Second Certification)
- Interpretation
- Treatment Teams
- Supervision
- Hypertension Groups
- Coumadin Groups
- Nutritional counseling
- Community Health Coordinators
- Parent-Child Interactive Therapy
- CHS App (coming soon)

CHS Mobile App for Population Mgmt.



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Optimizing EHR for Integrated Care and Population Mgmt.

- Integrated Clinical Record
- Communication
- Coordination
- Patient Dashboard

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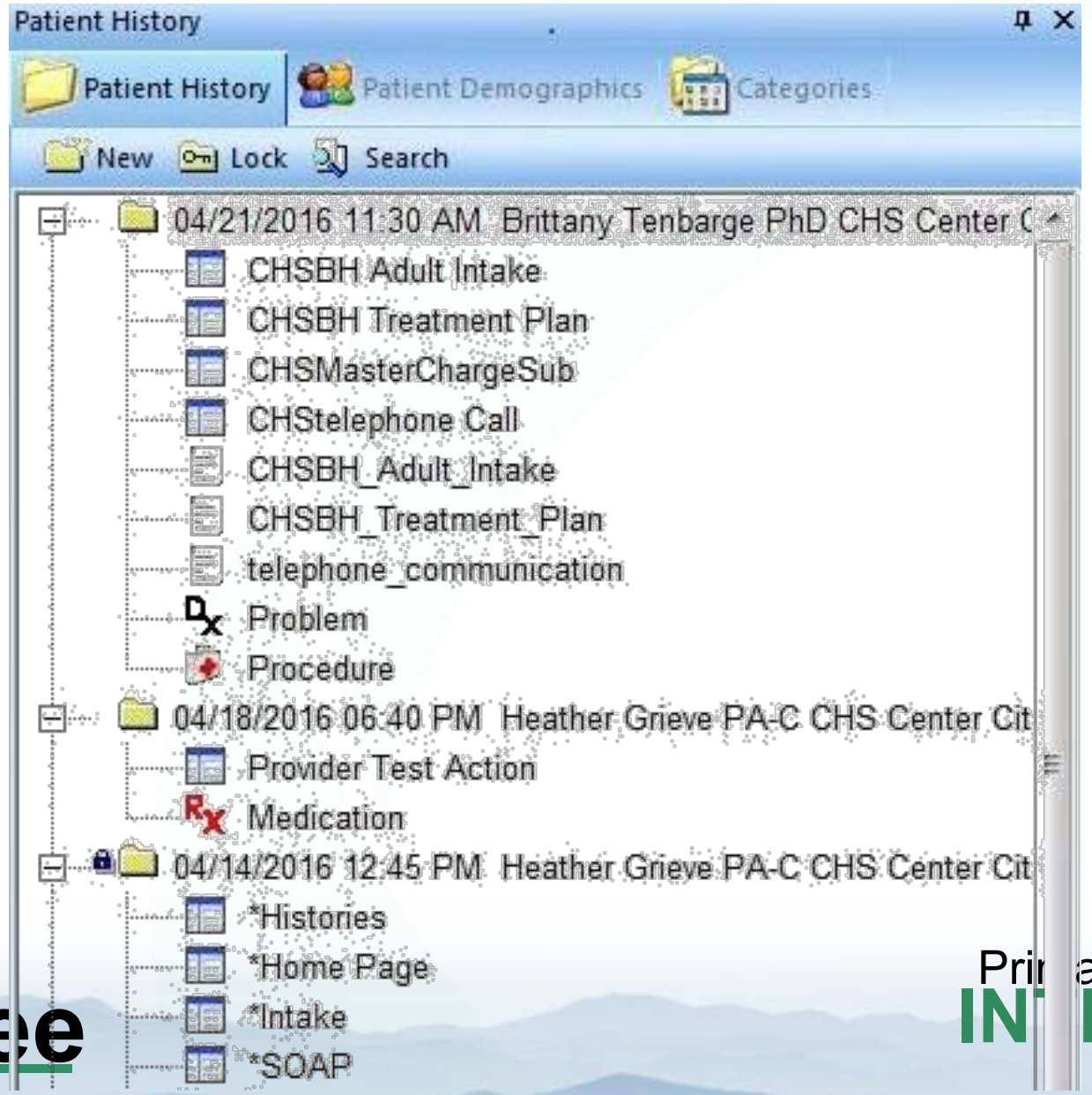
Integrated Clinical Record



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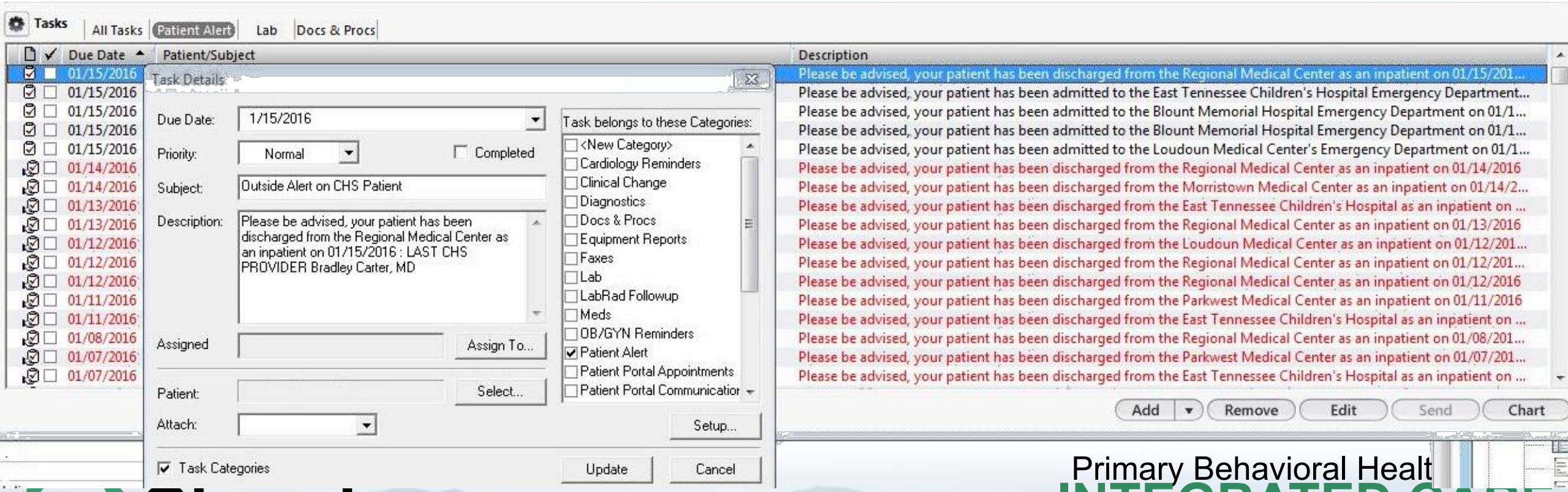
Communication

HIE & Payor Data Integration with EHR

Automated tasks created for admissions, discharges and transfers

Appears on Patient Dashboard



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Cherokee Health Systems — Patient Dashboard

CHS Master Home (Old) | BH Home (New) | BH Consult | PC Home Page
Clinical Change Request | THL Enrollment Form | Add Care Plan Note

Version 1.2.4 | Patient Portal Enrollment Status: **Token Issued**

Tennessee Health Link Enrollment

MCO Assigned	Consent Form Signed	Attestation Submitted	Enrollment Date
No	No	No	--/--/----

Million Hearts Enrollment

Eligible	Enrollment Date	Letter Given	ASCVD Score
Yes	05/18/2017	Yes	6.0

Care Team

Type	Provider
PCP	Rice, Jr FNP, Paul Michael

Future Appointments

Provider	Event	Time	Date
None			

Past Appointments

Provider	Event	Status	Date
Rice, Jr FNP, Paul Michael	PC Planned Est 15m	Kept	04/24/2018
Rice, Jr FNP, Paul Michael	PC Planned Est 15m	Cancelled	04/13/2018
Cupp FNP, Jennifer Christina	PC Planned Est 15m	No Show	10/06/2017

Self Management

Goal	Status	Start Date
None		

Diagnoses

Chronic Conditions

Code	Description
I10	Essential (primary) hypertension

Behavioral

Code	Description	Axis	Date
296.33	Major Depression, Recurrent, Severe	Ia	10/20/2008
309.81	Post-traumatic Stress Disorder	Ib	10/20/2008
300.21	Agoraphobia w/ Panic disorder	Ic	10/20/2008
799.9	Deferred / Pending More Information	IIa	10/20/2008
	"stomach problems", anemic, headaches, acid reflux	IIIc	10/20/2008

Hospital ER/Admissions *(Last 90 Days)*

Description	Date
None	

BPSA Score - Last Screen: 04/24/2018

BPSA	Low	Medium	High
Medical	5		
Behavioral	5		
Social	3		
Total	13		

Care Coordination

Care Intervention
Letter sent 2/7/2018 due f/u appt.

Point of Care

Preventative Care

Protocol	Status	Last Date	Due Date
Colonoscopy		11/11/2011	11/11/2021
Mammogram	Due		04/28/2018
Pneumococcal	Due		04/24/2018

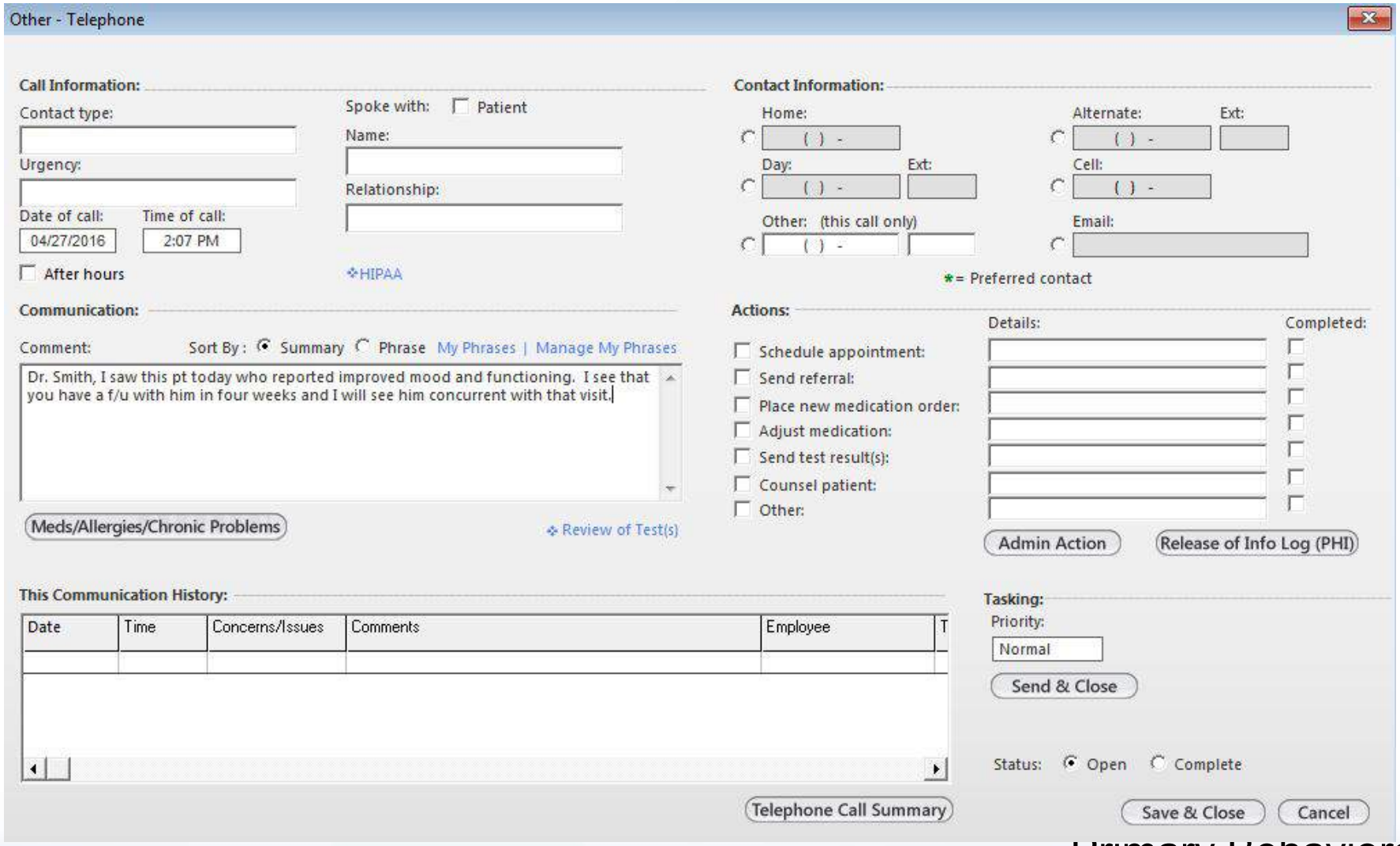
Health Management

Protocol	Status	Last Date	Due Date
None			

Required Measures

Description	Status	Source	Date
None			

Coordination



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Using the Data

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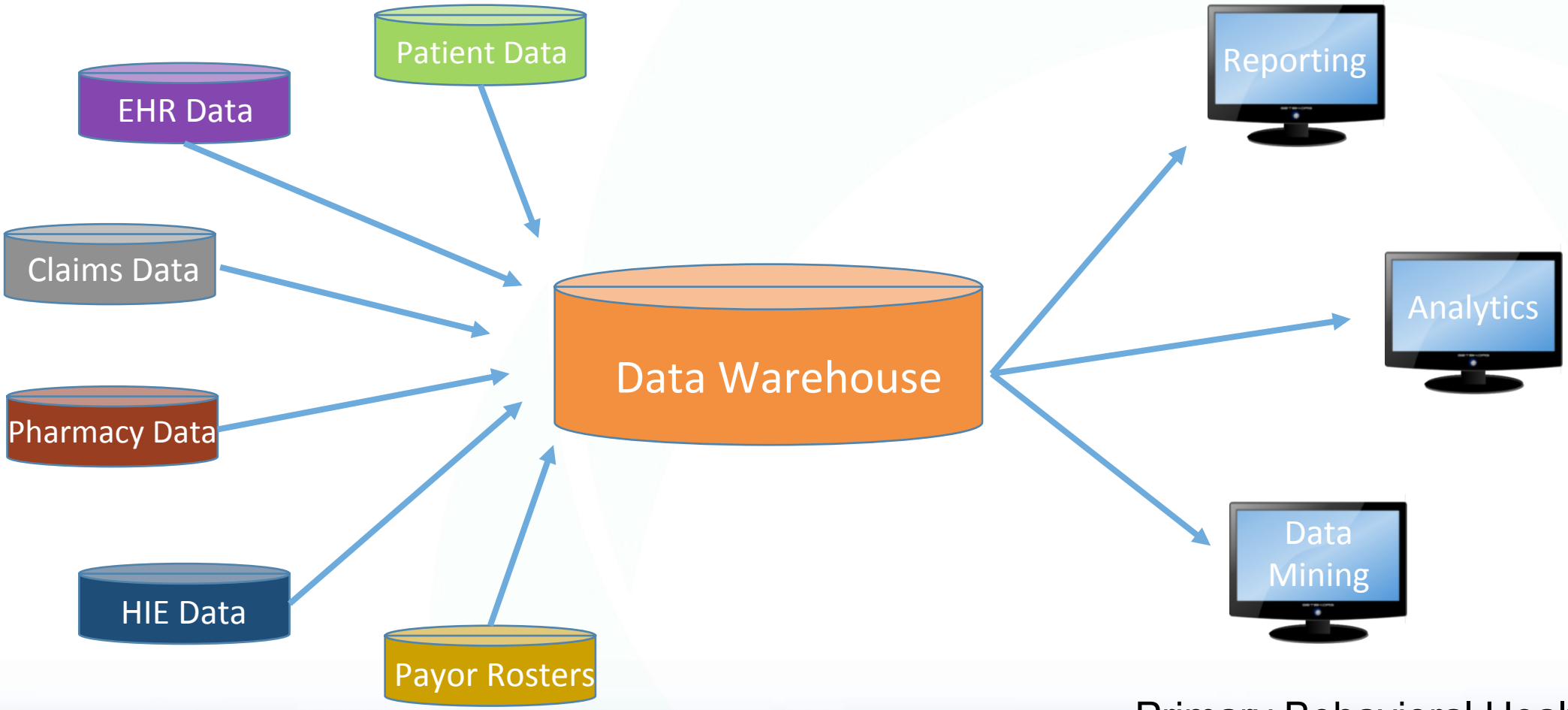
CHS Data Warehouse



Cherokee HEALTH SYSTEMS

Primary Behavioral Health
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CHS Data Warehouse

Provides interactive on-demand reporting

- Quality metrics
- Meaningful Use
- UDS
- Central Business Office (Financial)
- Outreach reports for non-compliant patients
- Executive summary dashboard reports
- Population Management and Care Coordination

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HEALTH SYSTEMS

Primary Behavioral Health
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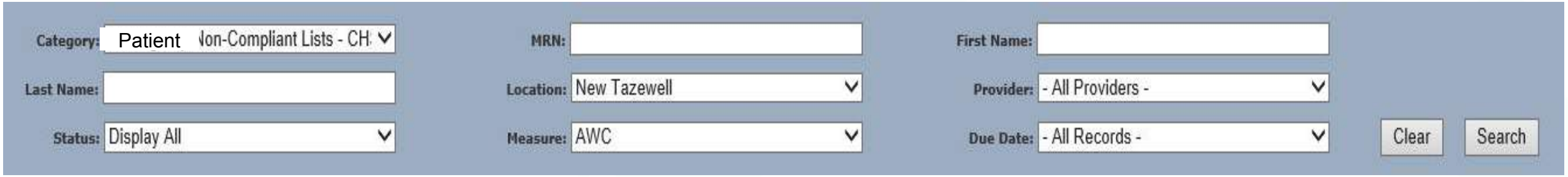
Population Management

- CHS Outreach application is utilized by our centralized care coordination team to identify gaps in care/non-compliant patients.

Population Mgmt./Care Coordination



Last Rev Date	Status	MRN	Member ID	Name	DOB	Phone	Category Desc	Measure	Measure Details	Last Date	Due Date
02/01/2016							Non-Compliant Lists - CHS	AWC			01/01/2016

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Population Mgmt./Care Coordination

Last PC Appointment: - Pearman DO, Suzanne Michele at New Tazewell **Next PC Appointment:** N/A **Last BH Appointment:** - KARNS PHD, BRENDA M at New Tazewell

Next BH Appointment: - KARNS PHD, BRENDA M at New Tazewell **Measure Related Information:** No measure related information found for selected patient.

Care Coordination Notes:

Date	Problem	Intervention	Status
12/28/2015	pt on Amerigroup gap in care for needing WCC	pt called & rescheduled WCC for 1-21-16	Continued
11/23/2015	pt on Amerigroup gap in care for needing WCC	pt has been scheduled for WCC on 12-28-15	New
02/01/2016	pt on Amerigroup gap in care list for WCC	pt seen in office toady for WCC	Complete

New Note View All(3)

Problem:

Intervention:

Completed Cancel Submit

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Population Management & Care Coordination

- Daily automated non-compliant patient reports emailed to practice administrators, CHCs and BHCs

CHS Real-Time Interactive Dashboard

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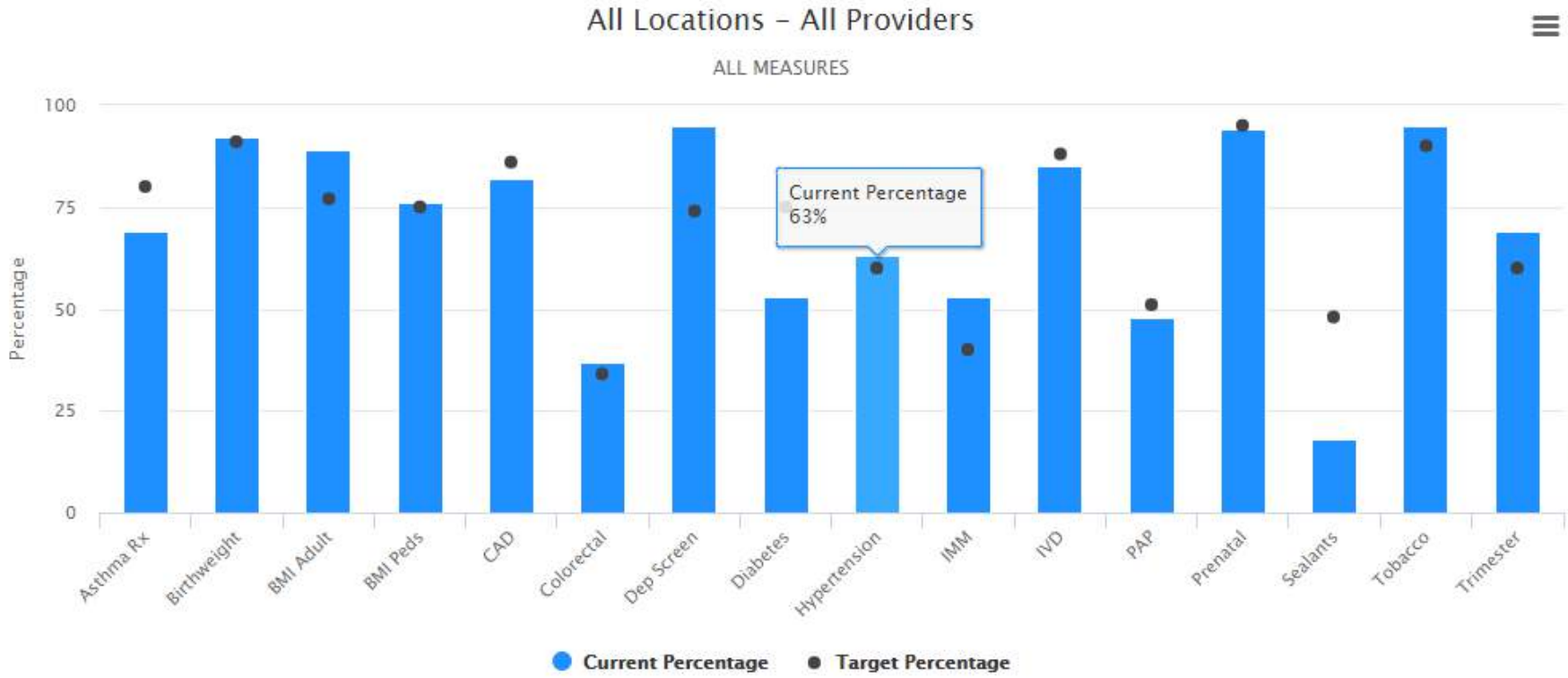
CHS Real-Time Interactive Dashboard

UDS - YTD

All Locations | All Providers | ALL MEASURES | FQHC | Back | Reset Chart



Description	Den	Num	Percent
Asthma Rx	499	349	70%
Birthweight	67	62	93%
BMI Adult	19229	17122	89%
BMI Peds	5947	4534	76%
CAD	654	542	83%
Colorectal	9122	3442	38%
Dep Screen	8178	7846	96%
Diabetes	3206	1720	54%
Hypertension	10158	6402	63%
IMM	590	317	54%
IVD	1044	895	86%
PAP	7827	3830	49%
Prenatal	287	271	94%
Sealants	16	3	19%
Tobacco	18011	17205	96%
Trimester	315	218	69%

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
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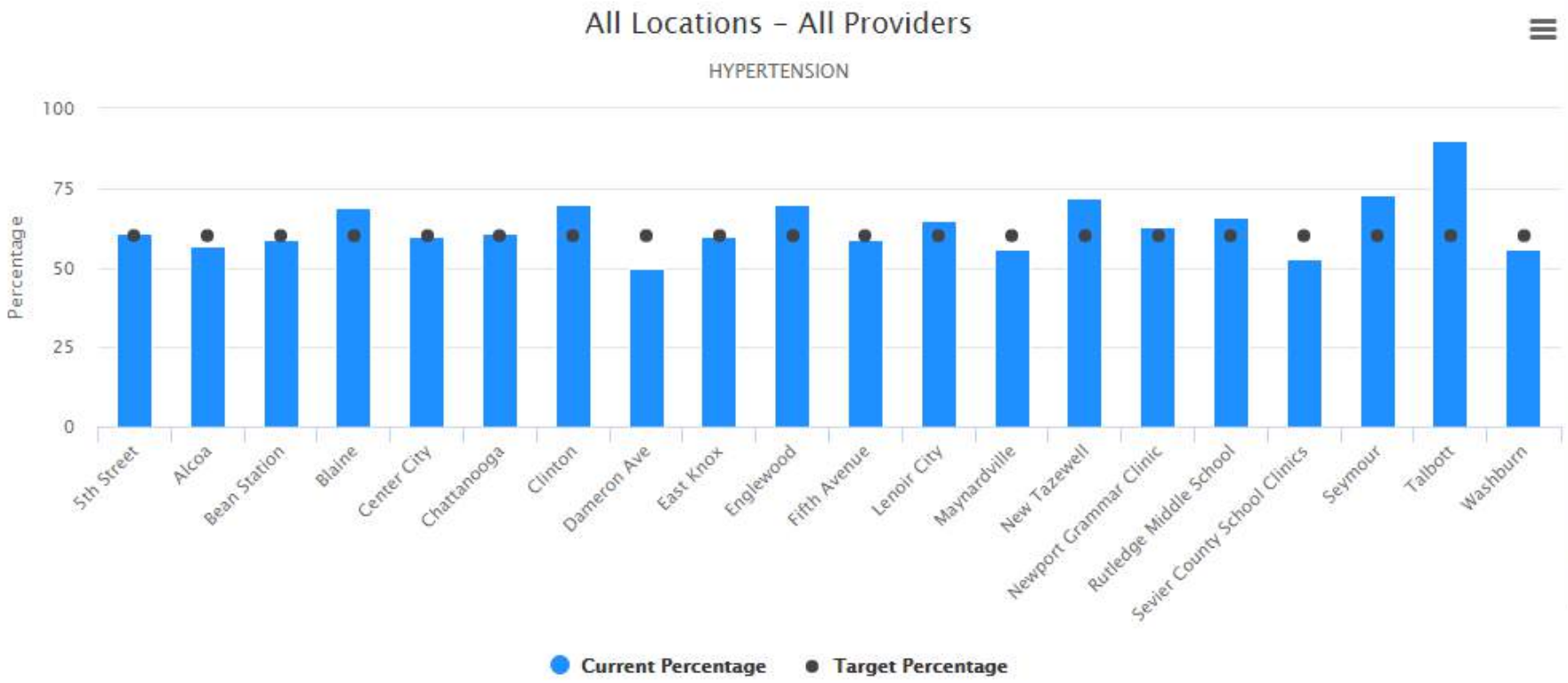
CHS Real-Time Interactive Dashboard

UDS - YTD

All Locations | All Providers | HYPERTENSION | FQHC | Back | Reset Chart



Description	Den	Num	Percent
5th Street	868	537	62%
Alcoa	568	326	57%
Bean Station	698	417	60%
Blaine	617	427	69%
Center City	1927	1175	61%
Chattanooga	594	368	62%
Clinton	313	221	71%
Dameron Ave	2	1	50%
East Knox	391	235	60%
Englewood	326	230	71%
Fifth Avenue	556	331	60%
Lenoir City	663	437	66%
Maynardville	990	561	57%
New Tazewell	449	325	72%
Newport Grammar Clinic	38	24	63%
Rutledge Middle School	3	2	67%
Sevier County School Clinics	39	21	54%
Seymour	805	588	73%
Talbott	11	10	91%
Washburn	291	164	56%

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
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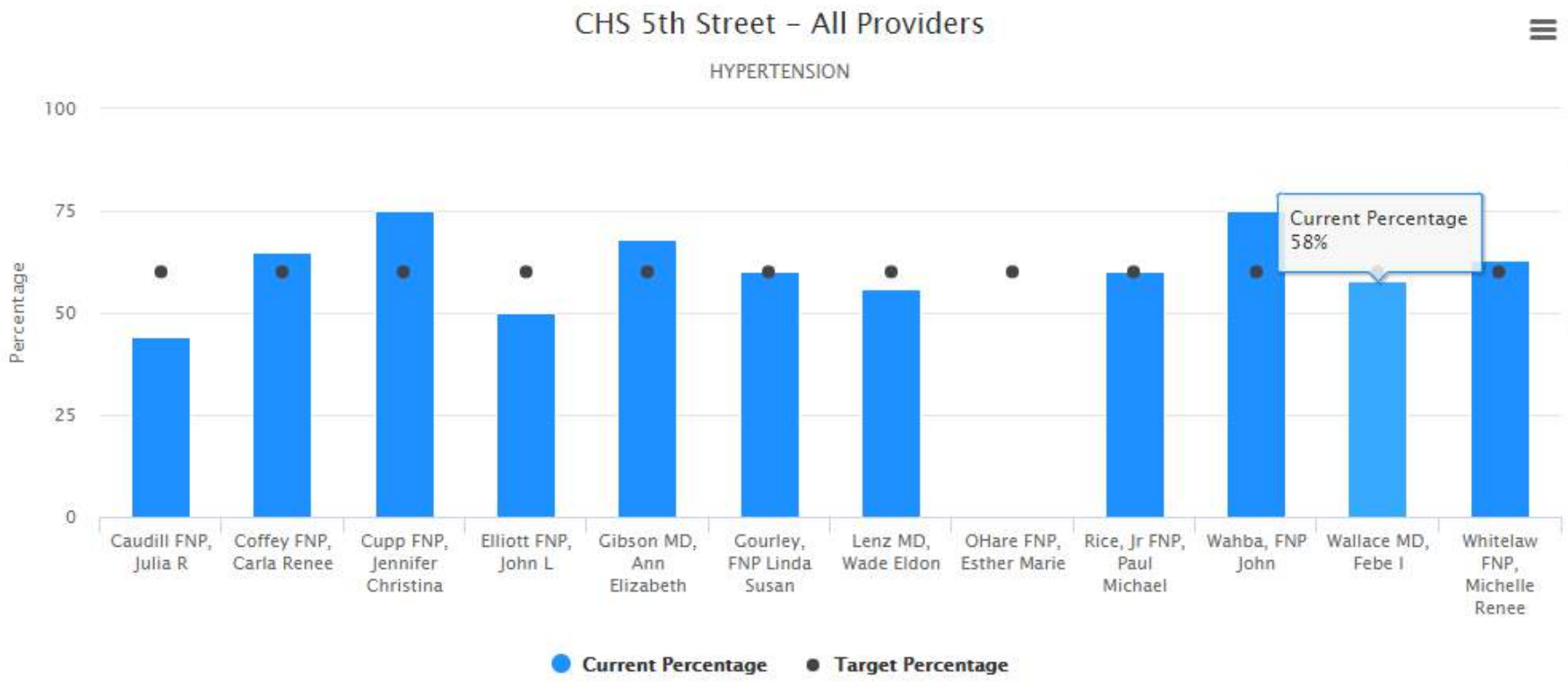
CHS Real-Time Interactive Dashboard

UDS - YTD

CHS 5th Street | All Providers | HYPERTENSION | FQHC | Back | Reset Chart



Description	Den	Num	Percent
Caudill FNP, Julia R	18	8	44%
Coffey FNP, Carla Renee	190	125	66%
Cupp FNP, Jennifer Christina	4	3	75%
Elliott FNP, John L	2	1	50%
Gibson MD, Ann Elizabeth	25	17	68%
Gourley, FNP Linda Susan	158	96	61%
Lenz MD, Wade Eldon	53	30	57%
OHare FNP, Esther Marie	1	0	0%
Rice, Jr FNP, Paul Michael	337	204	61%
Wahba, FNP John	29	22	76%
Wallace MD, Febe I	29	17	59%
Whitelaw FNP, Michelle Renee	22	14	64%

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CHS Real-Time Interactive Dashboard
Non Compliant List

UDS

Reporting Year: 2016 | UDS Measure: Hypertension | Provider: WALLACE MD, FEBE I — Export — Row Count: 50

MRN	Patient Name	DOB	Measure	Measure Details	Next Appt	Appt Type
			Hypertension	Most recent blood pressure reading out of a range - 143/83		
			Hypertension	Most recent blood pressure reading out of a range - 148/106		
			Hypertension	Most recent blood pressure reading out of a range - 155/86		PC Planned Est 15m
			Hypertension	Most recent blood pressure reading out of a range - 154/93		

Cherokee HEALTH SYSTEMS

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Provider Summary

Warden MD, Angela

Warden MD, Angela

Overview | AMG Detail | THL Detail | UDS Detail | Export Report

Clear Selection

Amerigroup
1/3 Compliant

Meaningful Use
11/11 Compliant

TN Health Link
5/9 Compliant

UDS
5/8 Compliant

Group	Description	Target %	Warden MD, Angela Compliant%	CHS Talbott Compliant%	CHS Average	Denominator	Numerator
AMG	Children Prescribed ADHC Meds	35%	100.00%	100.00%	45.45%	1	1
AMG	Adolescent Well Child Check (Ages 12-21)	47%	15.58%	18.00%	30.06%	77	12
AMG	Well Child Check (Ages 3-6)	70%	50.00%	43.00%	50.07%	38	19
Meaningful Use	CPOE Labs 3 (Medicaid)	30%	79.18%	79.00%	95.73%	711	563
Meaningful Use	CPOE Medications 3 (Medicaid)	60%	100.00%	100.00%	99.83%	463	463
Meaningful Use	CPOE Radiology 3 (Medicaid)	30%	100.00%	100.00%	97.78%	26	26
Meaningful Use	Eprescribing Exclude Narcotic	50%	98.14%	96.00%	94.07%	429	421
Meaningful Use	Eprescribing Include Narcotic	50%	98.13%	96.00%	92.35%	480	471
Meaningful Use	Health Information Exchange (Summary of Care)	10%	15.09%	18.00%	13.33%	53	8
Meaningful Use	Medication Reconciliation	50%	95.56%	93.00%	83.72%	45	43
Meaningful Use	Patient Electronic Access Part 1 Timely Access	50%	98.53%	88.00%	84.71%	614	605
Meaningful Use	Patient Electronic Access Part 2 VDT	0%	11.89%	9.00%	6.61%	614	73
Meaningful Use	Patient Specific Education	10%	82.57%	83.00%	82.64%	614	507
Meaningful Use	Secure Electronic Messaging	0%	7.49%	8.00%	8.68%	614	46
TN Health Link	Adolescent Well Child Check (Ages 12-21)	45%	23.00%	17.00%	38.00%	168	39
TN Health Link	Adult BMI Assessment	60%	75.00%	76.00%	74.00%	16	12
TN Health Link	Antidepressant Medication Mgt. - Acute Phase	55%	100.00%	88.00%	78.00%	2	2
TN Health Link	Antidepressant Medication Mgt. - Continuous Phase	40%	100.00%	88.00%	60.00%	2	2
TN Health Link	Antipsychotics in Children	99%	100.00%	100.00%	100.00%	26	26
TN Health Link	Well Care - BMI Percentile	30%	47.00%	48.00%	38.00%	152	72
TN Health Link	Well Care - Nutrition Counseling	30%	24.00%	24.00%	11.00%	152	36
TN Health Link	Well Care - Physical Activity Counsel	30%	21.00%	22.00%	9.00%	152	32
TN Health Link	Well Child Check (Ages 7-11)	55%	22.00%	23.00%	9.00%	54	12
UDS	Adult Weight Screening	77%	100.00%	94.30%	83.37%	20	20
UDS	Asthma Pharmacologic Therapy	80%	69.23%	69.44%	71.05%	13	9
UDS	Cervical Cancer Screening	51%	100.00%	80.92%	46.50%	1	1
UDS	Childhood Immunization	40%	73.47%	75.76%	38.63%	49	36
UDS	Patients Screened for Depression and Follow-Up	74%	100.00%	98.29%	79.23%	64	64
UDS	Table 7 - Hypertension	60%	50.00%	90.91%	62.16%	2	1
UDS	Tobacco Use Screening and Cessation	90%	100.00%	93.49%	90.76%	7	7
UDS	Weight Assessment/Counseling for Children	75%	63.17%	71.60%	77.08%	391	247

Showing 1 to 31 of 31 entries

Provider Interactive Dashboard

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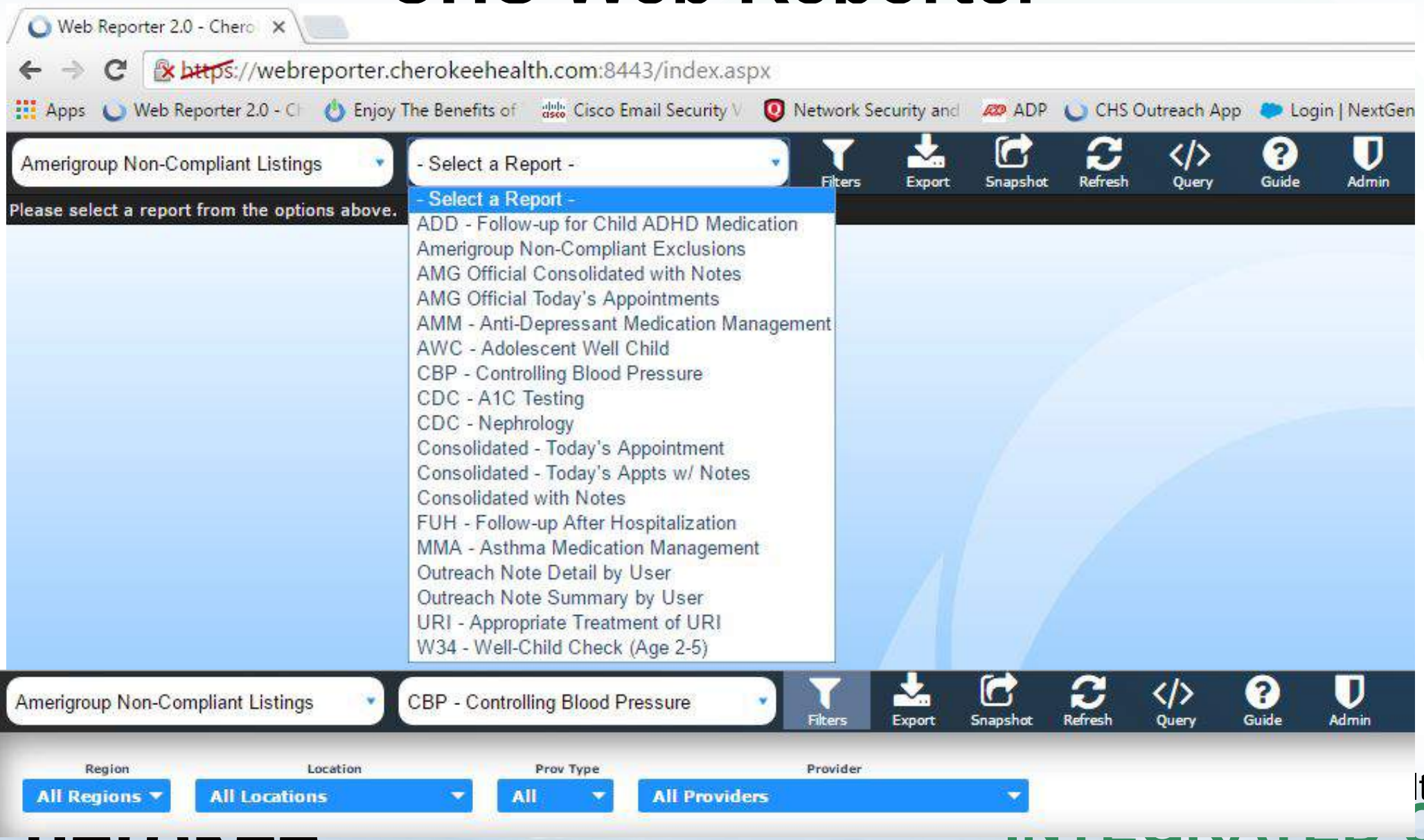
CHS Web Reporter



Population Health Management

Care Coordination

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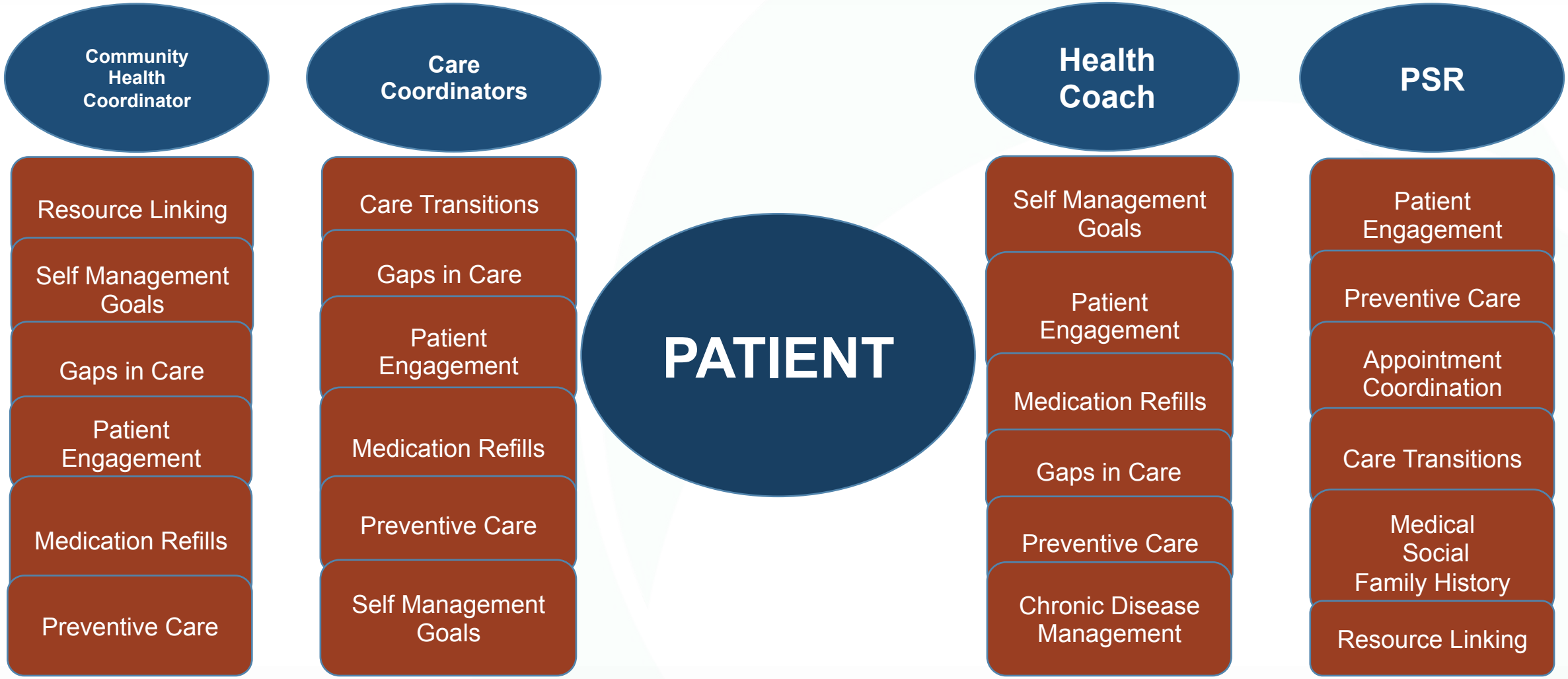
Integrated Care Team



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Care Coordination

- Centralized Care Coordination
  - Outreach Calls for Gaps in Care Closures/Education
  - Aftercare Scheduling of Post Hospital Stays/ER Visits
  - Patient Education on Preventive Needs
  - Utilization of External Database Programs for Tracking
  - Patient Outreach to Reengage Those not Seen in Over a Year

- Community Health Coordinators (Community Based)
  - Patient Education on Health Prevention
  - Coordination Between Healthcare Providers
  - Functional Needs Assessments
  - Care Planning and Identification and Interventions to Remove Care Barriers
  - Identify and Schedule Appointments for Identified Gaps in Care

How The Team Coordinates And Communicates

- Patient Dashboard
- Morning Huddles
- Communication from Care Coordination in EHR
- Weekly Integrated Team Meetings
- Standing Orders
- Daily Opportunities Reporting on Care Gaps

Care Team

Type	Provider
CHC	Lovain BA, Geraldine
PCP	Green FNP, Laura Ann
Therapist	Cobb PhD, Jean Eleanor
TPR Clinician	Cobb PhD, Jean Eleanor

Future Appointments

Provider	Event	Time	Date
Cobb PhD, Jean Eleanor	BHC	09:00 AM	10/10/2018
Larson MD, Tim Vernon	BH Est Psy 15	10:00 AM	10/10/2018

Past Appointments

Provider	Event	Status	Date
Cobb PhD, Jean Eleanor	BHC	Kept	08/15/2018
Green FNP, Laura Ann	PC Planned Est 15m	Kept	08/15/2018
Larson MD, Tim Vernon	BH Est Psy 15	Kept	08/15/2018

Self Management

Goal	Status	Start Date
Walk 30 mins 3 x a week	Ongoing	08/15/2018

Diagnoses

Chronic Conditions

Code	Description
I10	Essential (primary) hypertension
401.9	Hypertension, essential NOS
J45.40	Moderate persistent asthma, uncomplicated
E11.9	Type 2 diabetes mellitus without complications

Behavioral

Code	Description	Axis	Date
F31.30	Bipolar I disorder, current episode depressed	Ia	07/25/2018

Hospital ER/Admissions *(Last 90 Days)*

Description	Date
None	

BPSA Score - *PCMH Care Management* - Last Screen: 07/11/2018

BPSA	Low	Medium	High
Medical			13
Behavioral		12	
Social	2		
Total			27

Care Coordination

Care Intervention
Diabetes Outreach Patient stated recent DM Eye Exam at Uptown Vision. Obtain record release and request report at next office visit.

Point of Care

Preventative Care

Protocol	Status	Last Date	Due Date
Colonoscopy			08/06/2036
Mammogram			08/06/2036
PAP		07/08/2016	07/08/2019
Pneumococcal			08/06/2051

Health Management

Protocol	Status	Last Date	Due Date
ACT		08/15/2018	02/11/2019
Eye Exam	Due		09/17/2018
Foot exam	Due		08/20/2018
Hemoglobin A1c		08/16/2018	02/16/2019
Microalbumin		09/28/2017	09/28/2018

Required Measures

Description	Status	Source	Date

Break

Tour of Clinic

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Integration & Population Health

Discussion of Leadership, Strategy and Culture

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Wrap-Up