Focus…on HealthFocus

Practice-Savvy Features of the Population Management Tool

NPO has started the process of introducing primary care practices to the HealthFocus application, a tool designed to support practice population management efforts via the aggregation of patient health information, captured from a variety of data sources, into a single, comprehensive health record.

The information presented, below, is intended as a high-level overview of the HealthFocus features practices may find most useful. For more detailed information, please refer to the relevant section of the HealthFocus User's Guide (ⓘ). A complete copy of the User's Guide can also be found at Tools > User Guide in HealthFocus.

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Manage Care Management (Incentives)

Care Management Incentive

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Practice Use:

Monitor care management incentive program progress (BCBSM PDCM, Priority Health)

HF Location(s) and Processes:

HealthFocus Feature	HealthFocus Process
Care Management Incentive	Pathway ▪ Dashboard > “Care Mgmt Incentive” tab > Care Management Incentive

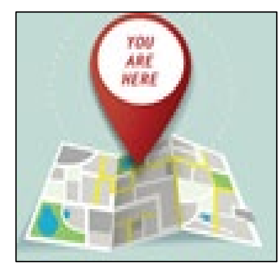
Feature in 5:

1. Access information specific to the BCBSM (PDCM) and Priority Health (Medicare Advantage) care management incentive programs
2. Bar graphs illustrate the current position of the practice (engagement rate achieved YTD), relative to a 5% target threshold, for each incentive program
3. The number of patients still needed, to reach the engagement threshold, is given to help the practice gauge its proximity to the program target
4. Generate a current list of “Eligible Patients” by clicking on the (underlined) link for each program; patient lists can be exported and printed
5. To focus care management efforts, click on the “Patients with one billing code” (underlined) link to generate a list of patients already seen once for care management

PCMH Pointer(s):

Use the data in the Care Management Incentive section to maximize success in the care management incentive programs (PCMH Domain 4)

- Use the “Eligible Patients” and “Patients with one billing code” lists to target patients for Care Management (The monthly PDCM patient list is the source for the “Eligible Patients” listed in the BCBS PDCM section)
- Monitor, and improve, engagement rates, to reach thresholds required for payment awards



Know Where You Are (And Need to Go) on the Quality Performance Road

Quality Summary Reports (QSR)

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Practice Use:

1. Monitor quality measure performance rates
2. Identify patient gaps in care

HF Location(s) and Processes:

HealthFocus Feature	HealthFocus Process
Quality Summary Report (QSR)	1. Pathway ▪ Dashboard > "Quality Summary Report" (Quality Summary tab) ▪ Scroll to the desired quality measure in the QSR ♦ HealthFocus defaults to the "Network" view, which displays practice-level data for single practice users ♦ To identify non-compliant patients attributed to a specific provider, click the "Provider" tab > Click "Edit Filters" > Select the desired measure from the "Measures" filter > Click "Update Filters" ▪ Click on the link (underlined value) in the "Not Met" column ▪ Export (to Excel) or print resulting patient list 2. Alternate Pathway ▪ Dashboard > Reports > Quality Summary ♦ HealthFocus defaults to the practice-level view ♦ To identify non-compliant patients attributed to a specific Provider, select the Provider from the "Provider" filter ▪ Scroll to desired quality measure in the QSR ▪ Click on the value in the "Needed for Goal" column to generate a list of patients non-compliant for the measure

Feature in 5:

1. Quality measure performance rates can be viewed at the PO, Practice and Provider levels
    - For single practice users, HealthFocus defaults to the practice-level view
    - The population-level (all NPO practices) performance rate, for each measure, is indicated in the "Network" column

- The practice- or provider-level performance rate, for each measure, is indicated in the “Current” (Dashboard QSR) or “Rate to Date” (“Reports” tab QSR) columns

2. Generate patient lists for measure-specific gaps-in-care by clicking on the underlined values in the “Not Met” (Dashboard QSR) or “Needed for Goal” (“Reports” tab QSR) columns

3. Use the “Needed for Goal” value (“Reports” tab QSR) to gauge proximity to a measure incentive program target; data can be filtered to show payer-specific results

4. Visualize performance trends (“Reports” tab > Quality Summary; see PCMH Links section, below) to monitor practice transformation efforts

5. Financial information (“$Available”, “$Earned”, and “$Remaining”; Dashboard QSR) identifies the incentive program (monetary) value of each measure

PCMH Pointers:

1. Use quality measures in the Quality Summary Report as tracking parameters in preventive and chronic disease registries (PCMH Domain 2)

Registry	QSR Quality Measure
Preventive (Pediatric)	Adolescent Immunizations Combo 2
Preventive (Adult) Chronic Disease (Adult, All)	Adults Access to Healthcare
Preventive (Adult) Chronic Disease (Adult, All)	Advance Care Planning
Depression	Anti-Depression Effective Acute Phase Treatment
Depression	Anti-Depression Effective Continuation Phase Treatment
Choosing Wisely	Appropriate Testing for Pharyngitis
Choosing Wisely	Appropriate Treatment for URI
Asthma	Asthma Medication Ratio (AMR)
Choosing Wisely	Avoidance of Antibiotics for Bronchitis
Preventive (Adult)	Breast Cancer Screening
Preventive (Adult)	Cervical Cancer Screening
Preventive (Pediatric)	Child and Adolescent Well-Care Visits: 03-11 Years
Preventive (Pediatric)	Child and Adolescent Well-Care Visits: 12-17 Years
Preventive (Pediatric)	Child and Adolescent Well-Care Visits: 18-21 Years
Preventive (Pediatric)	Childhood Immunizations Combo 10
Preventive (Pediatric)	Childhood Immunizations Combo 3
Preventive (Adult, Pediatric)	Chlamydia Screening
Care Management	CMCC: BCBS PDCM
Care Management	CMCC: PH CM
Preventive (Adult)	Colorectal Cancer Screening
Preventive (Adult) Chronic Disease (Adult, All)	COVID-19 Vaccination
Diabetes	Diabetes: A1c Control (<8%)
Diabetes	Diabetes: A1c Control (<=9%)
Diabetes	Diabetes: A1c Testing
Diabetes	Diabetes: Blood Pressure Control
Diabetes	Diabetes: Monitoring for Nephropathy
Diabetes	Diabetes: Retinal Eye Exam
ADHD (Pediatric)	Follow-Up Visits During Continuation and Maintenance Phase for ADHD

ADHD (Pediatric)	Follow-Up Visits for Initiation Phase for ADHD
Hypertension	Hypertension: Blood Pressure Control
Choosing Wisely	Imaging Studies for Low Back Pain
Preventive (Pediatric)	Lead Screening
Choosing Wisely	Non-Recommended Cervical Cancer Screening in Adolescent Females
Osteoporosis	Osteoporosis Management in Women Who Had a Fracture
Preventive (Adult) Osteoporosis	Osteoporosis Screening in Older Women
Preventive (Adult) Chronic Disease (Adult, All)	Pneumococcal Vaccination Status for Older Adults
CAD	Statin Therapy (CVD): Received Statin Therapy
CAD	Statin Therapy (CVD): Statin Adherence (80%)
Diabetes	Statin Therapy (DM): Received Statin Therapy
Diabetes	Statin Therapy (DM): Statin Adherence (80%)
Chronic Disease (Adult, All)	Transitions of Care - Medication Reconciliation Post-Discharge
Chronic Disease (Adult, All)	Transitions of Care - Patient Engagement After Inpatient Discharge
Preventive (Pediatric) Obesity (Pediatric)	WCC: BMI Percentile
Preventive (Pediatric) Obesity (Pediatric)	WCC: Nutrition Counseling
Preventive (Pediatric) Obesity (Pediatric)	WCC: Physical Activity Counseling
Preventive (Pediatric)	Well Child Visits in the First 30 Months: 0-15 Months
Preventive (Pediatric)	Well Child Visits in the First 30 Months: 15-30 Months

2. Measures in the Quality Summary Report (QSR) incorporate evidence-based guidelines in that the measures are HEDIS-based and address parameters, as referenced in MQIC guidelines, deemed relevant to the management of chronic disease conditions and preventive care programs (PCMH Domain 2)

3. Performance rates for quality measures constitute a performance report for that measure, and performance rates for measures addressing Choosing Wisely recommendations are included (PCMH Domain 3)

4. Performance charts (trends) can be generated, for any measure in the QSR, to view performance rates over time and compare rates for consecutive measurement years (PCMH Domain 3)

HealthFocus Feature	**HealthFocus Process**
Performance Chart	Pathway ▪ Dashboard > “Reports” tab > “Quality Summary” ▪ Click on the name of an individual quality measure ♦ The Performance Chart generates, for the current measurement year, in the lower right-hand corner of the page ♦ Toggle the button, at the top of the chart, to see trend graphs for both the current and previous measurement years ▪ To see the Performance chart for a different time, select the desired month and year from the filters at the top of the Quality Summary Report ♦ Click on the name of a quality measure to generate the Performance chart for the selected time

	♦ Toggle the button, at the top of the Performance Chart, to generate trend graphs for both the selected and previous years

5. The identification of patient care gaps guides the Provider and clinical staff in the provision of chronic disease and preventive care health services and helps with preparation for patient planned visits (PCMH Domains 4 & 9)

Your Patients in a Nutshell

Patient Point of Care Page/Form & Reminder Letter

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Practice Use:

1. Prepare for upcoming patient visits by reviewing past healthcare service information and current care gaps
2. Communicate with patients regarding health services due

HF Location(s) and Processes:

HealthFocus Feature	HealthFocus Process
Point of Care Page/Form	1. Pathway ▪ Dashboard > Patient List > Click on Patient's Name > "Point of Care" page ▪ Click "Print" ▪ Select the "Point of Care Form" ▪ Select the information to include (e.g., all information or just services needed) ▪ Click "Print" again 2. Alternate pathway ▪ Dashboard > "Tools" tab > "Batch Print" ▪ Select/Add Patient Names ("Patients to be printed") ▪ Select "Point of Care Form" and services to include ("Sections to include") ▪ Click "Print"
Reminder Letter	1. Pathway ▪ Dashboard > Patient List/Search > Click on Patient's Name > "Point of Care" page ▪ Click "Print" ▪ Select the "Reminder Letter" ▪ Select the "Due Services to Include" ▪ Click "Print" again 2. Alternate Pathway ▪ Dashboard > "Tools" tab > "Batch Print" ▪ Select/Add Patient Names ("Patients to be printed") ▪ Select "Reminder Letter" and "Due Services to Include" ▪ Click "Print"

Feature in 5:

1. The Patient Point of Care page combines demographic, care plan and past measure data to update and alert the Provider to the patient's current healthcare needs. The following information displays in the body of the page:

    - Demographics and Insurance
    - Last Visit and Vitals
    - Annual Immunizations
    - Associated Chronic Disease Measures
    - Adult Preventive Screenings
    - ED and Inpatient Admissions

2. Details include last service dates, values, and compliance statuses; click on the "History" icons to view specific data sources

3. Menu tabs, at the top of the page, contain additional patient information, including:

    - Priority Attention (ADT-related notices)
    - Risk (Details pertaining to assessed risk level)
    - Conditions (Diagnoses coded in previous and current years)
    - Care Team (Providers seen by the patient)
    - Campaigns (Add patient to a campaign)

4. Print, or batch print, the Point of Care form(s) for chart prep and use at the point of care; pink sections identify services due

5. A corresponding Letter template, which also lists services due, is available to print and distribute to the patient

PCMH Pointer(s):

1. The Point of Care form can be used to incorporate registry information and evidence-based guidelines at the point of care (PCMH Domains 2 & 9)

    - The POC form lists all preventive and chronic disease gaps in care, identified according to evidence-based guidelines, associated with the patient

    - The POC form can be generated from any registry, and for any patient, prior to an upcoming appointment

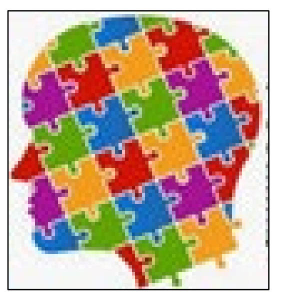
2. The Point of Care form can be used to prepare the Provider and clinical staff for an upcoming planned patient visit, including the scheduling and provision of preventive and chronic disease health services (PCMH Domains 4 & 9)

3. The Reminder Letter provides an additional option for communication with patients regarding preventive and chronic disease gaps in care (PCMH Domains 2 & 13)

    - The Reminder Letter lists health services due and may be distributed to the patient via mail, hand-delivery, upload to patient portal, etc.

    - The Reminder Letter can be one component of the written transition plans developed for patients leaving the practice

4. Reminder Letters can be generated to notify patients about screening eligibility (e.g., a Reminder Letter, listing colorectal cancer screening now due, can be sent to patients turning 50 years old during the measurement year) (PCMH Domain 9)



Who? What? Where?
Claims Information Completes the Patient Puzzle

Labs, Pharmacy & Claims

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Practice Use:

Use claims information to view outside lab results, verify prescription fills, identify health services performed at other locations and investigate the source of diagnosis codes

HF Location(s) and Process:

HealthFocus Feature	HealthFocus Process
Labs, Pharmacy, Claims	Pathway ▪ Dashboard > Patient List > Click on Patient's Name > "Point of Care" page > ▪ Click on "Labs, Pharmacy & Claims tab ▪ User can toggle between Labs, Pharmacy & Claims ▪ Search data by typing in the desired search field, or click on the associated carat to access a drop-down list of included data ▪ User can display "Source Name" for data elements

Feature in 5:

1. The Labs, Pharmacy & Claims tabs contain information from external and internal (EMR) lab feeds, and payer facility, pharmacy, and professional claims

2. Only claims from payers holding contracts with NPO are included (Currently: BCBSM Commercial and Medicare Advantage, BCN Commercial and Medicare Advantage and Priority Health Medicare Advantage; Medicare claims for DCE practices will eventually be included)

3. Click the "Labs" tab to view lab test data (e.g., Date, Provider, Code Description, Result, and Source Name); search "Labs" for services completed during a specific timeframe, by provider name, and/or by code description using the relevant search field(s) on the page

4. Click the "Pharmacy" tab to view information for prescription fills (e.g., Date, Provider, Medication Name, Dose, Route, Quantity, Days Supply, Cost/Price, source Name); search Pharmacy data for prescriptions dispensed during a specific timeframe and/or by medication name using the relevant search field(s) on the page

5. Click the "Claims" tab to view health service information captured from professional and facility claims (Date, Provider, Procedure, Diagnosis, Payer, Quantity, Amount Paid and Source Name);

search claims data for services provided during a specific timeframe, by Provider, Procedure and/or Diagnosis Description using the relevant search field(s) on the page

PCMH Pointer(s):

1. The inclusion of claims data means that data displayed in HealthFocus (including performance rates and non-compliant patient lists derived from QSR quality measures) includes clinical information for health services performed at other sites (PCMH Domains 2 and 3)

    - Other sites and service types are defined as labs, inpatient admissions, ER, UCC and pharmaceuticals

2. The inclusion of claims data also means that data displayed in HealthFocus includes clinical information for services provided by specialists and sub-specialists (PCMH Domain 3)

3. Clinical information from claims and lab feeds is another source for identifying outside patient health encounters (PCMH Domain 9)

Take the “Risk” Out of “Risk

Risk Rank/Types and HCC Conditions

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Practice Use:

Incorporate the review of patient risk rank and type, and the address/coding of HCC diagnoses, into medical decision-making and billing to accurately report the health of each patient

HF Location(s) and Processes:

HealthFocus Feature	HealthFocus Process
Risk Rank	Pathway ▪ Any patient list > Click on the data link in the “Risk Rank” column to view risk details (Source, Type, Date and Stratification)
Risk (Tab)	Pathway ▪ Dashboard > Patient List > Click on Patient’s Name > “Point of Care” page ▪ Click on the “Risk” tab to view risk details (Source, Type, Date and Stratification)
Conditions (Tab)	Pathway ▪ Dashboard > Patient List > Click on Patient’s Name > “Point of Care” page ▪ Click on the “Conditions” tab ♦ Identified HCC and General Conditions are listed ♦ A red “x” identifies HCC Conditions coded in previous, but not the current, measurement year(s) ♦ A green “√” identifies HCC conditions coded in both the previous and current measurement years

Feature in 5:

1. HealthFocus assigned every patient a Risk Rank (High, Medium, or Low), determined from calculations based on multiple risk types, patient demographics and HCC diagnosis codes

2. The patients’ Risk Ranks can be set to display in any patient list; click on the Risk Rank (underlined) link to view the details determining the rank

3. Risk Rank details can also be viewed from the “Risk” tab on the patient’s Point of Care page

4. The “Conditions” tab on the patient’s Point of Care page lists HCC and/or General Condition diagnoses captured from EMR, ADT and Claims data; ⊗ identifies diagnoses coded in previous years which have not yet been addressed, if applicable, in the current year

5. The HCC diagnoses, listed in this section, are provided as suggested conditions only. The relevance, and address, of each is left to the discretion of the Provider.

PCMH Pointer(s):

1. Risk Ranks and Risk types can be used to identify patients at risk for the development, or worsening, of chronic disease (PCMH Domains 2 & 9)

    - Use the Risk Rank(s) and Risk Type(s) filters to generate a list of patients meeting the specified criteria

2. Risk Ranks and Risk Types can also be used to identify patients that may benefit from care management services (PCMH Domain 4)

Track … Patient Populations and Gaps in Care

Patient Lists

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Practice Use:

Identify specific patient populations for outreach and management efforts

HF Location(s) and Processes:

HealthFocus Feature	HealthFocus Process
Patient List	1. Pathway ▪ Dashboard > Click on Practice/Provider name > "Patient Summary" List ▪ Click "Edit Filters" ▪ Select desired filters ▪ Click "Save Filters" (top of page) ▪ Export (to Excel), print, or save (as Campaign) patient list, if desired 2. Alternate Pathway ▪ Dashboard > "Tools" tab > "Generate Patient List" ▪ Select Filters ▪ Click "Generate" ▪ Export/Print and/or Save as Campaign

Feature in 5:

1. Quickly generate a practice- or provider-specific all-patient list by clicking on the appropriate (underlined) link on the Dashboard page (or generate a list from the Tools menu)
2. "Patient Summary" list displays one patient per row; Toggle to "Patient Measures" list to see all measures associated with each patient, including compliance status and last service date and result
3. Use filters (click "Edit Filters") to focus a patient list by specific criteria. Filter types include:

   - Patient Demographics — Identify patients by gender, age, PCP, payer
   - Conditions (General, HCC) — Identify patients with specific diagnoses
   - Risk (Rank, Type) — Identify patients by risk stratification level or risk type
   - Measures/ Compliance — Identify patients with specific gaps in care

6. Date range filters can be used to identify patients with specific health services completed during a defined period

7. Multiple filters can be enabled to generate a well-defined, actionable list of patients for follow-up and closure of gaps in care

PCMH Pointer(s):

1. Generate a list of patients, not seen regularly in the practice, as a source for patient and PCMH outreach (PCMH Domains 1 and 2)

    - Use the PCMH Patient Encounter with a PCP" patient list filter to identify attributed patients who have not seen the PCP within the past 3 years

    - In contrast, the "Adults Access to Healthcare" quality measure identifies attributed patients who have not seen any health care provider, including the PCP, within the current measurement year

    - The HealthFocus patient attribution method includes incorporation of payer membership lists, so patients assigned by managed care plans are included in provider membership panels, and those that have not established themselves with the practice should show up on this patient list

2. Generate lists of patients with specific chronic disease diagnoses (PCMH Domain 2)

    - The "General Conditions" and "HCC Conditions" patient list filters allow for the identification of multiple chronic disease patient populations, including:

Chronic Disease	"General Conditions" Filter	"HCC Conditions" Filter
ADD/ADHD	ADD/ADHD	-
Asthma	Asthma	-
CAD	CAD	▪ Acute Myocardial Infarction ▪ Angina Pectoris ▪ Unstable Angina and Other Acute Ischemic Heart Disease
CHF	CHF	Congestive Heart Failure
CKD	-	▪ Chronic Kidney Disease, Severe (Stage 4) ▪ Chronic Kidney Disease (Stage 5) ▪ Dialysis Status
COPD	COPD	Chronic Obstructive Pulmonary Disease
Diabetes	Diabetes	▪ Diabetes with Acute Complications ▪ Diabetes with Chronic Complications ▪ Diabetes Without Complication ▪ Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
Hypertension	HTN	-
Mental Health - Depression	-	Major Depressive, Bipolar and Paranoid Disorders
Obesity (Adult)	-	Morbid Obesity
Obesity (Pediatric)	BMI >+95%	
Substance Use/Abuse	-	▪ Drug/Alcohol Dependence ▪ Drug/Alcohol Psychosis
Vascular Disease	-	▪ Vascular Disease ▪ Vascular Disease with Complications

3. Use demographic filters to generate age- or gender-specific patient lists (PCMH Domains 2 & 9)

  - View patient demographics (name, DOB) on any patient list

  - Demographic filters for patient lists include Patient Name, Gender and DOB ("DOB From" and "DOB To") fields

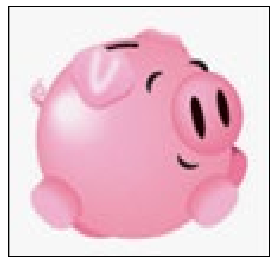
  - E.g., a patient list can be generated to identify all patients turning 50, and therefore eligible for colorectal cancer screening, during the measurement year

4. Use Risk Rank(s) and Risk Type(s) filters to identify patients at risk for developing chronic disease and/or as potential care management candidates (PCMH Domains 2, 9 & 13)

  - HealthFocus includes internal and external risk scores in the clinical information associated with each patient

  - To set a Risk Type filter, a Risk Rank (i.e., Low, Medium and/or High) must also be selected)

- E.g., the "Diabetes Risk Factor" Risk Type can be used to identify patients at risk for developing Diabetes (based on BMI and Blood Glucose values)



Create & Save (Because Time Is Money)

Campaigns

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Practice Use:

Save filter configurations for the future re-generation of criteria-specific patient lists

HF Location(s) and Processes:

HealthFocus Feature	HealthFocus Process
Campaigns	Pathway ▪ Dashboard > Click on Practice/Provider name > “Patient Summary” List ▪ Click “Edit Filters” ▪ Select desired filters ▪ Click “Save Filters” (top of page) ▪ Click the “New Campaign” tab ▪ Complete the information in the 4 sections (tabs) ♦ General (Name, Description, Specify view (Patient Summary or Measures) ♦ Filters (Set desired filters, or keep the filters already displayed) ♦ Privileges (Specify which users can view/run and/or edit the campaign) ♦ Tag Patients (Manually add patients to track in a campaign) ▪ Click “Create” Alternate Pathway ▪ Dashboard > “Campaigns” link (top menu bar) ▪ Click the “New Campaign” tab ▪ Complete the information in the 4 sections (tabs), as described above ▪ Click “Create”

Feature in 5:

1. Campaigns allow filter configurations to be saved, so that patient lists can be generated, according to the same specified criteria, at future dates

2. Create a campaign from any patient list, or from the “Campaigns” link on the top menu bar; Campaigns can be shared with others or kept private (viewable only by the user that created it)

3. Click on the “Campaigns” link to view a list of all campaigns accessible to the user

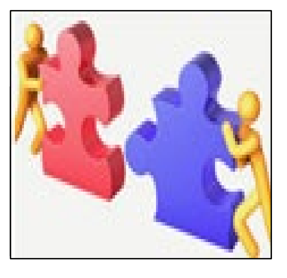
4. Designate “favorite” campaigns by clicking on the associated star icon

5. A Campaign automatically runs when the link (underlined name) is clicked

PCMH Pointer(s):

1. To avoid falling behind with patient registries, save successful searches as Campaigns, and generate patient lists on schedule with a single click

2. Campaigns ensure that PCMH work can go on when you are away from the office (Share the PCMH joy and let others click the link occasionally)



Transition Care the Easy(ier) Way

Transitions of Care and TCM Tracker

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Practice Use:

Use near real-time ADT data to coordinate and transition patient care, track patient populations, and identify patients for Care Management services

HF Location(s) and Processes:

HealthFocus Feature	HealthFocus Process
Transitions of Care	Pathway ▪ Dashboard > Transitions of Care (bottom of Dashboard page) ▪ To filter data, click “Edit filters” ▪ The following filters are available: ♦ Payer/Product ♦ Encounter type(s) (I.e., ED, IP, OB, SN) ♦ Care Management (Has patient been seen for a CM visit this calendar year?) ♦ Risk Rank(s) and Type(s) ♦ General Condition(s) ▪ Click “Update Filters” to display filtered results ▪ Click pencil icon to open the TCM tracker for TCM-eligible patients
TCM Tracker	Pathway Dashboard > “TCM” tab > “TCM Tracker”

Feature in 5:

1. ADT notifications display here. Updates are received every 10 minutes, and information fields auto-fill and update as data is received. The following ADT information is visible to the user:

    - Patient Info (Name, DOB, PCP, Insurance)
    - Admission Type (ED, IP, OB, SN)
    - Admission and Discharge Dates
    - Patient Risk Rank (High, Medium, Low; click to view risk rank details)
    - Rendering Facility Name
    - Diagnosis (Updated from Admission > Discharge)
    - Discharge Disposition

2. All ADT events associated with a patient display when the patient's name is selected (clicked)

3. Use filters to generate targeted lists of TOC patients for TCM, follow-up and Care Management services (Click "Edit Filters)

4. Patients eligible for TCM services are identified (pencil icon in Transitions of Care section, patient list in TCM Tracker)

5. TCM service data fields (Phone Call, Med Rec, Office Visit) autofill as information is captured, and patients fall off the list if readmitted within 30 days of discharge

PCMH Pointer(s):

1. The ADT information displayed can used to search for, and identify, patients who may benefit from care management services (based on clinical conditions and ED, inpatient and other service use) (PCMH Domain 4)

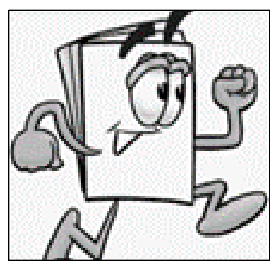
    - Use the filters associated with the Transitions of Care section to search for patients, with ADT encounters, with specific encounter types, Risk Rank/Type(s), General Conditions and/or previous Care Management encounters

2. The Transitions of Care section can be used to track inpatient utilization rates for various chronic disease patient populations (PCMH Domain 13)

3. The Transitions of Care section meets the criteria for participation in the Michigan statewide Admission, Discharge, Transfer (ADT) Notification Use Case (PCMH Domain 13)

4. Diagnosis information in the ADT data can be used as an alert, for Providers, regarding potentially time-sensitive patient issues (Domain 13)

5. The TCM Tracker helps practice Providers and clinical staff ensure that TCM-eligible patients receive individualized transition of care phone calls and face-to-face visits, following hospital discharge, within the defined periods of time (PCMH Domain 13)



Run, Report! Run!

Reports and Report Library

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Practice Use:

Select and run pre-configured, client-specific custom reports at will or when cued

HF Location(s) and Process:

HealthFocus Feature	HealthFocus Process
Reports (Tab)	Pathway ▪ Dashboard Page > “Reports” tab ♦ Click on “Quality Summary” to access another version of the QSR ♦ Click on “Quality Summary” to also access the Data Coverage Reference and Performance Chart features
Reports Library	Pathway ▪ Dashboard Page > “Reports” tab ▪ Click “Reports Library”

Feature in 5:

1. The Reports section contains pre-configured reports for practice use; The Quality Summary Report (QSR) in this section differs from the Dashboard version in that the user can also view performance rates for previous measurement years

2. The Data Coverage Reference and Performance Chart features are accessed by way of the “Reports” tab (on the “Quality summary” page)

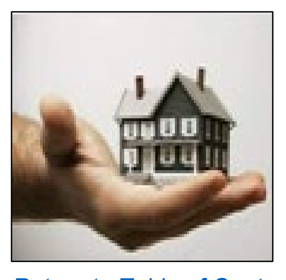
3. The Report Library contains client-specific custom reports that practices can run at will or when cued; Practice users may eventually see some of the reports routinely run by NPO in this location

4. Reports automatically run when the report name (underlined) link is clicked; practices can search for a specific report by typing in the search field

5. Patient lists generated from Reports can be exported and printed

PCMH Pointer(s):

Currently, not applicable



You've Got All of the Practice Users in Your Hands

Admin Tools

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Practice Use:

Set-up and manage HealthFocus access for users in your practice

HF Location(s) and Process:

HealthFocus Feature	HealthFocus Process
Admin Tools	Pathway ▪ Dashboard > Admin Tools tab (top menu bar) ▪ Click on "User Administration" ▪ To search for an existing user, type a name in the "Search for User" field ▪ To edit an existing user, click on the pencil icon, in the "Action" column, to the right of the user's name ▪ To add a new user, click the "+ User" tab and complete the information for the 3 sections (tabs) ♦ A dummy email can be used ("Info" section) ♦ The initial password assigned to the user can be generic, as the user will be required to change the password when logging in for the first time ♦ Each section must be completed before the next section can be accessed

Feature in 5:

1. Practices can configure and manage their own HealthFocus users
2. NPO and HealthFocus assist with the account set-up for the initial "Practice Administrator"
3. The Practice Administrator sets up the accounts for other practice users
4. There can be more than one Practice Administrator in a practice, if desired
5. The Practice Administrator can manage/edit a user's status, role, and permissions

PCMH Pointer(s):

Not applicable

The Data Train Keeps A-Chuggin'

Data Coverage Reference

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Practice Use:

Use the information in the "Data Coverage Reference" section to determine the age of your practice's data

HF Location(s) and Process:

HealthFocus Feature	HealthFocus Process
Data Coverage Reference	Pathway ▪ Dashboard > Reports > Quality summary Report > Data Coverage Reference (bottom of page) ♦ Displays data source names and types, load dates and "service through" dates

Feature in 5:

1. Data in HealthFocus is captured from multiple sources (MIHIN, outside lab feeds, payer claims, EMR data extractions), so the data available to each practice is comprehensive
2. The HealthFocus application updates nightly, to incorporate any data received that day and keep the practice data as current as possible; however, it is important to remember that each source has its own schedule for delivering data:
   - MIHIN (ADT) data updates in HealthFocus every 10 minutes
   - Outside lab data is transmitted to HealthFocus when it is available
   - EMR data (CCDAs) is currently extracted by HealthFocus monthly
   - Payer claims are delivered monthly (each payer has a different delivery date)
3. The "Data Coverage Reference" section allows the user to determine how old a particular piece of data is in HealthFocus
   - Last Load Date: Identifies the date on which data from a particular source was last uploaded into HealthFocus
   - Service Through Date: Identifies the most recent date of service included in a particular data set
   - Type: Identifies the type of data received (CCDA, Pharmacy claim, etc.)

- Source: Identifies the organization (abbreviated name) from which the data file was received (e.g., BCBS)

- Description: Identifies the organization (full name) from which the data file was received (e.g., Blue Cross Blue Shield)

4. Users should be aware of the age of their data in HealthFocus when generating patient lists, or reviewing measure/compliance information, in HealthFocus

5. Resolution of data discrepancies should begin with a review of the information in the Data Coverage reference section

PCMH Pointer(s):

Use the Data Reference Section to confirm the receipt of Labs, Pharmacy & Claims data, to verify the incorporation of clinical information from other sites and services, including services provided by specialists and sub-specialists