

Care Gaps Module Manual

MDLand International, Inc.

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Modified By:

Approved By:

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Preface



Purpose

The *Care Gaps Module* is designed to help your practice visualize, understand and close care-gaps across various measurements and metrics. The tools included aim to streamline your practice's ability to prevent missed revenue opportunities, as well as improve healthcare outreach, continuity, and outcomes for your patients. This document describes how to use the *Care Gaps Module* and any related changes.

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Authors:	Himel Das, Daisy Ho, Andy Peng, Micheal Swierszcz
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Clinic

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Software Development

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Dashboard Overview

The **Care Gaps** button shows how many patients with open gaps there are from the start of the measurement year. Clicking on the Care Gaps button will take the user to the Care Gaps Dashboard.

	🔒 Dashl	poard			
Dashboard	CCM	RPM	Hospital	Care Gaps	
Waiting	23 23	0 38	0 0-0	73	
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Register					
Patient Home					

The Dashboard is comprised of two sections, "Gap Reports" and "Gap List".

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Gap Reports

Gap Reports has 3 reports, Progress over time, Measures with Most Care Gaps, and Status.



Progress over time

"Progress over time" report shows the percent of qualified patients who are compliant (in the numerator) for a particular measure (BMI chosen in this case) over monthly increments.



The drop-down shows other quality measures (or all measures at once) the user can monitor, as well as see performance for different outreach attempts (texting, phone encounters, or scheduling).

Note: more quality measures and metrics will be added to this dashboard over time.

All Measures
AWV. Annual Well Visit
BCS. Breast Cancer Screening
BMI. BMI Assessment
CCS. Cervical Cancer Screening
COL. Colorectal Cancer Screening
CDC-8. Diabetes Care - HbA1c Exisits
All OutReach Attempts
Text Messages Sent
Phone Encounters Created
Appointments Scheduled

All Measure V

Measures with the most care gaps

The "Measures with the most care gaps" report shows the top 5 measures with the most open care gaps. The number for each measure represents the patients who have that particular gap open.



Status

The status report shows the number of gaps open/closed, as well as patients with gaps who have/haven't scheduled a future appointment.





Gap List

The Gap List represents the list of patients who has open gaps. The list can be sorted by using the various filters on the left.

70 august	Patient DOB	Provi	der	DOS	Future A	oppt Gap Value	Risk	Score	Status/Log	Last	Attempt
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01 #7 030	# E Patient #	DOB-T	Provider	Last DOS	Future Appt 0	Geg	Value:	Risk Score	Status/Log	Last Attempt	
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All • Care Gap All •	5 Zai, Ari (73,7) 133, 455 2000 (Huma) 449, 999, 4877 (Mobile) Fright	04/05/1945	Samith, Connor Parts Medical	05/37/2018		AWV. Atmust Wall Visit RCS, Breast Carder Streening ARF, Abust Access to Preventive/Ambulebox realth Services COA. Care for Older Abuts - Advance care planning	65	18			Message •
All •	a WANG, BAO XIANG (54,M) 817-701-6861 (Home)	10/01/3964	Cheng, Janvilar April Carls Montolic anoun NC	06/04/2018		COL, Coloractal Cancer Screening AAR, Adults' Acress to Preventive/Ambulatory Health Services					Actions
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Al • Fravider	6 Claston, Jenny (16,44) 6 Claston, Jenny (16,44) African languages	11/12/2039	Lies, Ture Hy Dies	80/05/2018		MML MML Assessment ASA, Alluit MML Assessment AWC, Adolescent Well-Care Visita	к.	14			Actions .
All • Ibik Level All •	7 941-295-1223 (Home) Drg(uh	03/23/3953	Lin, Tan Tan Lin HD PC	05/02/2018		BCS. Break Cartar Scheming COL. Colorestal Cartar Scheming ARP. Addit's Acteus to Presentee/Ambulatory Health Services COL. Care for Other Adults - Advance care alemans		1			Artists
Sfice Visit Alert	 HE, CHUNXE (38,H) 381-822-0555 (Hzms) 196-772-0144 (Mobile) 	02/87/1999	san, fan My Dine	06/13/2018		AAR Adults' Access to Prevention/Ambulatory Health Services ProC. Palant Health Greatiantists Destructor access					Actions

Some notable column headers are as follows:

Patient - Shows name, and any available phone numbers (i.e. work, mobile, home) and preferred language (i.e. Spanish). The checkbox in patient header/cells can be used to select all or some patients in the list for batch texting (see pg. 8). Clicking on a patient name will take the user to the corresponding QM List of the patient (see pg. 15).

Provider - Shows the provider (and location) to which the patient belongs.

Last DOS - The last date of service recorded for this patient.

Future Appt - Shows any future appointment the patient has with the practice.

Gap - Shows the list of open gaps the patient has.

Value - A proprietary qualitative score that represents potential value for closing a patient's gaps. We base this scoring on information from various sources such as insurance plans, IPAs/PPSs and other organizations.

Risk Score - Risk stratification enable providers to identify the right level of care and services for distinct subgroups of patients. The higher the risk score, the higher chance a patient will face a negative outcome regarding his/her health. The risk stratification scoring is based on comorbidities, polypharmacy, and utilizations documented in the patient's health record.

Last Attempt - The last time an outreach (text message sent, phone encounter created, or appointment scheduled) was attempted for this patient through this dashboard.

Status/Log - Shows the status of a patient's outreach and care, such as if an SMS was sent or if the patient's care is in progress or completed. Any custom notes regarding this patient will also show in this column.

Actions - Allows the user to take individual actions towards a patient, such as sending a single text message, documenting a telephone encounter to the patient's record, scheduling an appointment and more.

Filters:

From 1/1/2017	
Plan Type	
All	۲
Patient Panel	
All	۲
Care Gap	
AWV. Annual Wellness	۰.
Patient Status	
All	٠
Future Appointment	
No future appointment	٠
Office Location	
All	٠
Provider	
All	٠
Risk Level	
High Risk	٠
Office Visit Alert	
8	

The filter panel is a powerful tool that lets you target subsets of your gappatient population, such as patients who belong to a certain provider, or perhaps a particular risk stratum (i.e. Low Risk: 0-6, Moderate Risk: 7-12, Moderate-High Risk: 13-15, High Risk: >16).

A use case can be that you want to target High-Risk patients who are due for an Annual Well Visit, but don't have a future appointment set in the scheduler, as shown on the left.

Actions:

Various tasks can be performed by clicking on "**Action**" dropdown located towards the right of each patient row. Message, Phone, Appointment, and Edit Status can be performed (see pgs. 16-19).



Sending Batch Texts

In the patient column, checkmark individual patients or checkmark the patient header to select all patients. Click the **"Send Batch Text**" button on the right. Fill the form and click "Send SMS".

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ū	esh Close									Total:73	Smil liatch Test
ä	Patient =	DOB 1	Provider 0	Last DOS	Future Appt	Gap	Value	Risk Score	Status/Log	Last Attempt	
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Sea. S	Daivy, Smith (28,F) 531-511-5222 (None) 237-591-6359 (Mobile) Dimese	01/01/1980	SHITH, HARRY Ma Chec	11/17/2018	11/30/2018	CDC Competensive Diabetes Care - Received All Three Table CDC-1. Comprehensive Diabetes Care - Heinopolities allC CDC-2. Comprehensive Diabetes Care - His/Lo Centrol (CDC-3. Comprehensive Diabetes Care - His/Lo Centrol (CAC-5. Comprehensive Diabetes Care - His/Lo Centrol (CAC-5. Comprehensive Diabetes Care - His/Lo Centrol (CAC-5. Comprehensive Diabetes Care - His/Lo Centrol	55	18	Conceptional Conception	3 days age	Actions •
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		Pre	view							
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IS GA			Burns, Jazzmyn		English	987-654-321	SMITH, HAR	RY d		
DOS/I			Zai, Aysha		English	718-309-148	5 SMITH, HAR	RY d		
* DOS			Daisy, Smith		English	212-363-800	SMITH, HAR	RY d		
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All			545-855-4677 (Moh	Phys.		03/03/1945	Contraction of the second s	03/07/12019	AAP	HOUIS ACCEL



Send a Single Text

In the "Gap List," for any patient, choose "**Message**" in the "Actions" (dropdown). The "SMS" (pop-up) will show. Fill the form and press "Send SMS".

						Close
end SMS Cu	stomize Close					
Message Type	Appointments	۲				
Template						
Language	English					
Message						
						4
	Preview					
Send To	Pat	tient 🕆	Language 🕀	Phone 🗄	Physician 🗧	Status
	Test, Apple f		English	718-309-1487	SMITH, HARRY d	





Make a Phone Encounter

In the "Gap List," for any patient, choose "**Phone**" in the "Actions" (dropdown). The "Phone Encounter" (pop-up) will show. Fill the form to document the encounter and press "Save".

4°			
	Phone Enco	unter	
	Save Close		
	Phone Encounter		
	Follow Up Type:	Phone Encounter 🔲 Send a message to Patient Portal	
	Call Date/Time:	11/27/2018 Today Time: 17 : 53 (HH:MM) Now	
	Caller:	Patient(LEE, BON,NY R) Clinic SMITH, HARRY d(Harry Other	
09/201	Call Taken By:	Patient(LEE, BON,NY R) Clinic SMITH, HARRY d(Harry Other	
03/203	Subject:	Template 🗸 🗘	
	Follow Up Date:	Need Follow Up Today Today	
DOB 04/0	Assign To:	All Employee List aaaaaa, testere t(gt)-MD abcs, admin(t)-MD adm, adm(adm)-MD Apple, Test C(CC)-MD Apple, Zhong(Apple)-MD aqzsad, aqzsad P(ks)-MD Assign To Employee List SMITH, HARRY d(Harry)-MD	Va \$
07/2	Notes:	Bailey-Ingram, Michele (MB)-MD reenii V O reenii I bin thy	10 ⁵⁵
01/0		antro al	\$\$
		(<140/90 mm Hg) CDC-8. Comprehensive Diabetes Care - Hemoglobin allC (>0)	



Scheduling an Appointment

In the "Gap List," for any patient, choose "**Appointment**" in the "Actions" (dropdown). The "Appointment" (pop-up) will show. Fill the form and click "Save" to schedule an appointment directly to the iClinic scheduler.

Appointment								Close
Save Cancel								
New Appointment								
Select doctor	CHEN, GAR	Y(GC)		•				
Select office location	GARY CHEM	GARY CHEN MEDICAL PC						
Reason of visit	Follow-up			•				
Select appointment date	Click the day	y in the cale	ndar to selec	t appointment	date.			
	Available	N	ot Available					
		Decembe	r 2018	Toda	y .			
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
							1	
9/1	2	3	4	5	6	7	8	
	9	10	11	12	13	14	15	
.7/1	16	17	18	19	20	21	22	
	23	24	25	26	27	28	29	
)5/1	30	31						
Select appointment time	8:30AM							
appointment diffe	0.00.01							
14/1 Notes								
Notes							1,	



The "Select appointment date" and "Select appointment time" fields will change based on availability and previous bookings/blocks as shown below:

Click the day	y in the cale	ndar to selec	t appointment	date.		
Available	N	ot Available				
٩	November	2018	🕨 Toda	У		
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	
	Click the day Available Sunday 4 11 18 25	Click the day in the cales Available N Sunday Monday 4 5 11 12 18 19 25 26	Click the day in the calendar to select Available Not Available November 2018 Sunday Monday Tuesday 4 5 6 11 12 13 18 19 20 25 26 27	Click the day in the calendar to select appointment of Available Not Available November 2018 Toda Sunday Monday Tuesday Wednesday 4 5 6 7 11 12 13 14 18 19 20 21 25 26 27 28	Click the day in the calendar to select appointment date. Available Not Available November 2018 Today Sunday Monday Tuesday Wednesday Thursday 1 4 5 6 7 8 11 12 13 14 15 18 19 20 21 22 25 26 27 28 29	Click the day in the calendar to select appointment date. Available Not Available November 2018 Today Sunday Monday Tuesday Wednesday Thursday Friday 1 2 4 5 6 7 8 9 11 12 13 14 15 16 18 19 20 21 22 23 25 26 27 28 29 30

Select appointment time	8:40AM	•
	8:30AM	
Notes	8:40AM	
	8:50AM	
	9:10AM	
	10:10AM	-
	10:20AM	
	11:20AM	
	11:30AM	
CMS2017 4 N N F	11:40AM	



Changing a Patient Status

The "Patient Status" feature allows the user to document the status of a patient's outreach/care. To edit a patient's status, go to a patient in the Gap List, click on the "**Edit Status**" option from the "Actions" (dropdown). The "Edit Patient Status" (pop-up) will appear. Choose a status and click "Save".

. Cervi 🔻			Measures V	Vith the Most Care
Edit	Patient St	atus		Close
Patien	t Status			
Patier	nt Refused	•		
Office	Visit Alert			
YES				
		Save	Close	

The office visit alert option will alert the practice the next time this patient is in the office.

Status/Log	Last Attempt ⇔
Patient Refused	2 days ago

Patient Status will show in "Status/Log"



QM List

The QM List is a feature within the Patient Home that helps the practice close gaps through a step-by-step process. The QM list can be accessed by clicking on a patient name in the Care Gaps dashboard or by clicking the QM tab in a Patient Home:

ar test, a	andy3 (06/27/2000 18y Male) DOS - 11/27/2018 Insurance: 1199	LOCAL BENEFIT FUND				Close	Reference
Attending SMI	TH, HARRY d Cover By md, andy (am) - MD * Room Waiting Room	ASB: Pain Location: HC	WHO(H: W: HC:) Refresh Edit	1: P3: HR: KK) 3	SPOZ:	Visit History Table View History Medical H Reconciliation Panel Docs/Forms/Labs
Referral Doe,	John Refresh Preview/Print Check Out Follow	v Up Action Patient Home S	ettings Close				
⊡Visit Hx	Visit History Medical History Current Visit Mag/Activity Doc51	ab Medication Message Patie	nt Portal				
Medical Hx	Quality Management Hide All View All		(MU/C	QM Report Period:	91/01/2018 - 1	2/31/2018)	Decision Support
[]Current Visit	Measure	Action Date	Due Date	Frequency	Result	Exclusions	Refresh Customize
Msg/Activity	😝 🖾 CH52 Depression Screening and F/U 😨	11/26/2018				-	(1) Decision Support Testing New[ICD-
	😝 🖾 CMS22 High Blood Pressure and Follow-Up 😨		Past Due				
0	V CMS58 Current Medications Documentation 0						(x) QA TELE HW(COPD Care Plan (Chine
	😝 🖬 CMS69 BMI Screening and Follow-Up Plan 😌		Past Due				
	😝 🗳 CMS138 Tobacco Screening and Cessation 😡		Past Due				
	📵 🗳 Integration of primary care and behavioral health services						
6°	🞯 🖬 Tobacco Use Cessation						
	😟 🖾 Chronic Disease Prevention						
	CAS SBIRT						

Clicking on sub-item within a measure allows you to open and complete some tasks for the measure, for example: Tobacco Use Screening

Quality Hanagement	Contraction of the second s						Decision support
	Measure	Action Date	Due Date	Frequency	Result	Exclusions	Refresh Customize
CMS2 Depression Screening	and F/U 📀	11/26/2018				*	(1) Decision Support Testing New(ICD-10 Only) [Appl
CM522 High Blood Pressure	and Follow-Up 😡		Past Due				(2) Of Test Hill(COTD Care New (Chinese)). [Analy]
CMS58 Current Medications	Documentation 💿						(a) (a) (a) test fiw(corp care Plan (chinese)) [Apply]
CMS69 BMI Screening and	follow-Up Plan 😨		Past Due				
CMS138 Tobacco Screening	and Cessation 🕢		Past Due				
Tobacco Use Screening				every 2 years			
Tobacco Use Cessation Cour	- 20			every 2 years			
Medication				every 2 years			
Integration of primary care	and behavior thealth services						
Tobacco Use Cessation	Olish an Tabana Usa R	and a little	ill an en the	Omerican/Tele		and an	
Tobacco Use Cessation	Click on Tobacco Use S	creening > it w	vill open the	Smoking/Tob	acco Scre	ening	
Tobacco Use Cessation Chronic Disease Prevention OAS SBIRT	Click on Tobacco Use S	creening > it w	vill open the	Smoking/Tob	acco Scre	ening	Local Action of the State of th
Tobacco Use Cessation Chronic Disease Prevention OAS SBIRT Adult BMI Assessment - 0	Click on Tobacco Use S	creening > it w	vill open the	Smoking/Tob	acco Scre	ening	Cles
Dobacco Use Cessation Chronic Disease Prevention OAS SBIRT Adult BMI Assessment - (Click on Tobacco Use S MS69v Smoking/Tobacco Sc Save Refreth Delete	creening > it w reening Print Save as Defe	vill open the	Smoking/Tob	acco Scre	ening	Clos
Tobacco Use Cessation Chronic Disease Prevention OAS SBIRT Adult BMI Assessment - (Click on Tobacco Use S MS69vr Smoking/Tobacco Sc Save Refresh Delete	creening > it w reening Print Save as Defa	vill open the	Smoking/Tob	acco Scre	ening	Clos
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Tobacco Use Cessation Chronic Disease Prevention OAS 561RT A Adult BMI Assessment - (Click on Tobacco Use S MS69v: Smoking/Tobacco Sc Save Refresh Delete Patient Name: test, andy3	creening > it w reening Print Save as Defa Smok Visit Date: 1	vill open the vit Crear C ing Ques 1/27/2018	Smoking/Tob 	acco Scre (If you	ening smoke.) Date and time: 11/27/2018 15:12
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Tobacco Use Cessation Chronic Disease Prevention OAS SBIRT Aduit BMI Assessment - (Click on Tobacco Use S Smoking/Tobacco Sc Save Refresh Delete Patient Name: test, andy3 Do you smoke? Total Score: From IV/C, DOH, gov at http://ww Do you want assistance with a smi	creening > it w recening Print Save as Defa Smok Visit Date: 1 w.nyc.gov/html/doh/do sking cessation plan?	vill open the ut Clear C ing Ques 1/27/2018	Smoking/Tob stionnaire	(If you	smoke.	Clos) Date and time: 11/27/2018 15:12 9 Yes @ No 9 Yes @ No



To edit a measure's settings, click on the measure name:



