

SHIP Data Analytics Use Cases – Clinical Users

USE CASE – Clinical - Care Gap Closure – Care Gap Identification and Presentation		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
The Population Health Coach / Case Manager is responsible for monitoring the health of a cohort of patients and taking appropriate intervention steps.	<ol style="list-style-type: none"> 1. Identify cohort / population of patients. 2. Stratify cohort by attribution method. 3. Stratify cohort by measure. 4. Identify patients with care gaps that need focused attention. 5. Prioritize those with multiple care gaps or greatest severity. 6. Coordinate with care team, contact or notify those with care gaps in order to take action to close the care gap. 7. Export data into a report. 	<ol style="list-style-type: none"> 1. Identify individuals in a given cohort. 2. Stratify patients based upon agreed upon attribution. 3. Stratify patients by measure. 4. Identify patients with Care Gaps 5. Sort patients with multiple care gaps to the top. 6. Sort care gaps by severity, ex: HbA1c descending. 7. Sort by multiple indicators. 8. Provide notification tool to notify those with care caps to assist in taking action in closing the gap. 9. Ability to export data.
		<p><u>Added Benefit*</u></p> <ol style="list-style-type: none"> 1. Drill down to contact information. 2. Track who was contacted, when, and by whom. 3. Evaluate available data: <ol style="list-style-type: none"> a. Last Visit Date b. Provider c. Lab/Diagnostic Data d. f-name, l-name, phone, address, gender, dob e. Payer

* For all of the sections that note “Added Benefit,” SHIP is exploring if these items can be done within the current data analytics contract scope.

USE CASE – Clinical - Care Gap Closure – EMR Workflow Integration		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
The Population Health Coach / Case Manager would benefit from the ability to integrate data or reports into their clinical workflow.	<ol style="list-style-type: none"> 1. Use individual organizational EMR to manage PHC workflow. 2. Track contacts, follow ups, and care gap closures. 	<ol style="list-style-type: none"> 1. Stratify patients based upon agreed upon attribution. 2. Export of minimum data set as defined within the “Standard Minimum and Expanded Record Sets” Use Cases. 3. Export of extended data sets as defined within the “Standard Minimum and Expanded Record Sets” Use Cases.
	<u>Added Benefit</u> <ol style="list-style-type: none"> 1. Ability to send notification of PHC contacts, follow ups, care gaps closures and PHC assignments by individual to the reporting database. 	<u>Added Benefit</u> <ol style="list-style-type: none"> 1. Receipt of PHC contacts, follow ups, care gap closures, and PHC assignments by patient from clinical sites so that they are reflected in future care gap reports.

USE CASE – Clinical – Standard Minimum and Expanded Record Sets		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
There must be a minimum and expanded record set for transport between HealthTech and each Clinical Site	1. Identify minimum record set.	Minimum Record Set <ol style="list-style-type: none"> 1. Institutional MRN 2. First Name 3. Last Name 4. Phone - all the phone numbers ever reported listed in descending order most recent first 5. Complete Address 6. Date of Birth 7. Gender
Expanded Record Set: NQF 0059 Diabetes Hemoglobin A1C in Poor Control	1. Identification of expanded record set for NQF 0041 – Diabetes Management	Clinically Relevant <ol style="list-style-type: none"> 1. Last preventive Visit <ol style="list-style-type: none"> a. Date of service b. Location of Service/ Point of Care 2. Last two non-preventive visits. <ol style="list-style-type: none"> a. Date of service b. Location of Service/ Point of Care c. A1C Lab value d. Date of last lab
Expanded Record Set: NQF 0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	1. Identification of expanded record set for NQF 0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Clinically Relevant <ol style="list-style-type: none"> 1. Measure <ol style="list-style-type: none"> a. Smoke Y/N b. Cessation Intervention Y/N c. Date of service d. Location of Service 2. Last Visit <ol style="list-style-type: none"> a. Date of Service b. Point of Care
Expanded Record Set: NQF 0421 Preventive Care & Screening: Body Mass Index (BMI) and Follow Up	1. Identification of expanded record set for NQF 0421 Preventive Care & Screening: Body Mass Index (BMI)	Clinically Relevant <ol style="list-style-type: none"> 1. Last Measure <ol style="list-style-type: none"> a. Height b. Weight

	and Follow Up	<ul style="list-style-type: none"> c. BMI 2. Last Visit <ul style="list-style-type: none"> a. Date of Service b. Point of Care
Expanded Record Set: NQF 0024 Weight Assessment & Counseling For Children and Adolescents	Identification of expanded record set for NQF 0024 Preventive Care & Screening: Body Mass Index (BMI) and Follow Up	Clinically Relevant <ul style="list-style-type: none"> 1. Last Measure <ul style="list-style-type: none"> a. Height b. Weight c. BMI 2. Last Primary Care or OB/GYN Visit (based on procedure code) <ul style="list-style-type: none"> a. Date of Service b. Point of Care

USE CASE – Master Level Attribution Methodology		
Persona / Role Master Level Attribution Methodology		
Scenario:	Task:	Requirement:
It is necessary for SHIP to define a Master Level Attribution Methodology to facilitate distribution and analysis of relevant data amongst SHIP participants, SHIP, CMS, and other external consumers.	<ol style="list-style-type: none"> 1. Define a currently implementable Attribution Method to attribute a patient to a specific provider, clinic and/or clinic organization. 	<ol style="list-style-type: none"> 1. Future ability to provide multiple attribution based on membership in a given program, PCMH, ACO, Payer, etc.

USE CASE – Clinical - In Clinic Workflow		
Identification of Patients with Multiple Care Gaps		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
<p>The Population Health Coach / Case Manager or others will use measure/ disease / status reports to facilitate appropriate interventions and management of at risk populations.</p> <p>The Population Health Coach / Case Manager or others will have increased benefit from being able to identify patients who have multiple care gaps.</p>	<ol style="list-style-type: none"> 1. Identify patients attributed to your practice who have multiple care gaps. 2. Sort item 1 above by number of care gaps per patient, descending. 3. Identify those most at risk who are in greatest need of timely intervention. <p>Internal Activity</p> <ol style="list-style-type: none"> 1. Confirm patient is attributed properly. Has patient been seen yes/no? 2. Provide prioritized list to scheduler for follow up or counseling. 	<ol style="list-style-type: none"> 1. Identify patients who fall into the measures. 2. Stratify patients based upon agreed upon attribution. 3. Present report PHC that: <ol style="list-style-type: none"> a. Identifies attributed patients who fall into multiple measures. b. Provides ability to stratify by attributed provider and by measure c. Contains the minimum data set as defined within the “Standard Minimum and Expanded Record Sets” Use Cases. d. Ability to drill down into data from the expanded clinical data set for each measure as defined the “Standard Minimum and Expanded Record Sets” Use Cases. <ol style="list-style-type: none"> 1. Last Visit 2. Lab Value 3. Etc. 4. Ability to sort in a cascading manner. Ex: sort by measure value, then by last value date, then by last visit, etc. 5. Ability to print a report up to and including items 1 through 4 above. 6. Ability to extract or download data file containing the information referenced in items 1 through 4 above.
	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> 1. Track activity and workflow of Population Health Coach/ Case Manager / Scheduler in institutional EMR. 2. Ability to send notification of PHC contacts, follow ups, care gaps 	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> 1. Export Data referenced in items 1 through 4 above to which patients are attributed to. 2. Export of minimum clinical data set as defined within this set of use cases. 3. Export of extended data sets as defined within this set of use cases.

	closures and PHC assignments by individual to the reporting database.	4. Receipt of PHC contacts, follow ups, care gap closures, and PHC assignments by patient from clinical sites so that they are reflected in future care gap reports.
USE CASE – Clinical - Top Down Reporting Configuration		
Persona / Role Health Systems and Clinic Administration		
Scenario:	Task:	Requirement:
<p>Health System and Clinic Administrators need a top down view of how their organizations are doing in impacting the defined SHIP measures.</p> <p>They must be able to view measures for the overall organization that they represent as well as drill down progressively into their organization all the way to the provider level.</p>	<ol style="list-style-type: none"> 1. Identify patients attributed to your health system / provider practice. 2. Identify clinics and providers who are improving in meeting defined quality measures and those who are not. 3. As an administrator in any one of the multiple layers in an organization, view quality measures for patients attributed to the providers that are under my purview. <p>Internal Activity</p> <ol style="list-style-type: none"> 1. Identify provider champion(s). Identify practices and providers who need improvement. 	<ol style="list-style-type: none"> 1. Identify patients who fall into the measures. 2. Stratify patients based upon agreed upon attribution and by measure 3. Present report to consumer that: <ol style="list-style-type: none"> a. Initially presents measure values at the highest level viewable by the viewer. b. Drills down from Health System → Practices → Providers → Panel → Patient. c. Provides comparisons at each level (current rates, the trending direction of the rate, as well as the percent difference between two dates). Ex: Compare two practices within the same Health System or two providers within the same practice. d. Has a link to the specification for each measure. 4. Present report to consumer that: <ol style="list-style-type: none"> a. Monitors utilization of reports. 5. Present report to consumer that: <ol style="list-style-type: none"> a. Provides comparison of success in effecting measures between each level in his or her Health System. 6. Ability to extract or download data file containing the information referenced in items 1 through 5 above. Ability to print reports references in items 1 through 5 above.
	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> 1. Track activity and workflow of Population Health Coach/ Case Manager / Scheduler in 	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> 1. Export Data referenced in items 1 through 4 above into institutional EMRs to which patients are attributed to.

	<p>institutional EMR.</p> <p>2. Ability to send notification of PHC contacts, follow ups, care gaps closures and PHC assignments by individual to the reporting database.</p>	<p>2. Transport of minimum clinical data set as defined within this set of use cases.</p> <p>3. Transport of extended data sets as defined within this set of use cases.</p> <p>4. Receipt of PHC contacts, follow ups, care gap closures, and PHC assignments by patient from clinical sites so that they are reflected in future care gap reports.</p>
USE CASE – Clinical – In Clinic Workflow - NQF 0059 Diabetes: Hemoglobin A1C Poor Control		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
<p>The Population Health Coach / Case Manager or others will use measure/ disease / status reports to facilitate appropriate interventions and management of at risk populations.</p> <p>NQF 0059: Diabetes: Hemoglobin A1C Poor Control: The Population Health Coach / Case Manager has a need to identify and intervene on diabetic patients identified as being in poor control of their diabetes by falling into the numerator of the above measure.</p>	<p>1. Identify diabetic patients attributed to your practice who have a Hemoglobin A1C equal to or greater than the numerator specification in the chosen measure.</p> <p>2. Identify those most at risk who are in greatest need of timely intervention.</p> <p><u>Internal Activity</u></p> <p>1. Confirm patient is attributed properly.</p> <p>2. Has patient been seen yes/no?</p> <p>3. Provide prioritized list to scheduler for follow up or counseling.</p> <p>4. Schedule and administer intervention.</p> <p>5. Document Intervention or exception.</p>	<p>1. Identify patients who fall into the measure.</p> <p>2. Stratify patients based upon agreed upon attribution.</p> <p>3. Present report to consumer that:</p> <p>a. Identifies attributed patients who fall into the measure</p> <p>b. Provides ability to stratify by attributed provider.</p> <p>c. Contains the minimum data set as defined within this set of use cases.</p> <p>d. Contains the expanded clinical data set for the measure as defined within this set of use cases.</p> <p>4. Ability to sort in a cascading manner. Ex: sort by measure value, then by last value date, then by last visit, etc.</p> <p>5. Ability to print a report up to and including items 1 through 4 above.</p> <p>6. Ability to extract or download data file containing the information referenced in items 1 through 4 above.</p>
	<p><u>Added Benefit</u></p> <p>1. Track activity and workflow of Population Health Coach/ Case Manager / Scheduler in institutional EMR.</p>	<p><u>Added Benefit</u></p> <p>1. Export Data referenced in items 1 through 4 above into institutional EMRs to which patients are attributed to.</p> <p>2. Transport of minimum clinical data set as defined</p>

	<ol style="list-style-type: none"> Ability to send notification of PHC contacts, follow ups, care gaps closures and PHC assignments by individual to SHIP. Ability to add parameters to reports from available data in order to more discreetly define an intervention. 	<ol style="list-style-type: none"> within this set of use cases. Transport of extended data sets as defined within this set of use cases. Receipt of PHC contacts, follow ups, care gap closures, and PHC assignments by patient from clinical sites so that they are reflected in future care gap reports. Ability to add parameter to care gap reports from minimum or expanded data sets.
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USE CASE – Clinical – In Clinic Workflow - NQF 0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
<p>The Population Health Coach / Case Manager or others will use measure/ disease / status reports to facilitate appropriate interventions and management of at risk populations.</p> <p>NQF 0028: Preventive Care Screening: Tobacco Use: Screening & Cessation Intervention</p> <p>The Population Health Coach / Case Manager has a need to identify and intervene on patients who are active smokers to administer or facilitate smoking cessation interventions.</p>	<ol style="list-style-type: none"> Identify patients attributed to your practice who are active smokers. Identify those patients who are active smokers who did not receive a tobacco cessation intervention. <p><u>Internal Activity</u></p> <ol style="list-style-type: none"> Confirm patient is attributed properly. Has patient been seen yes/no? Provide prioritized list to scheduler for intervention. Schedule and administer intervention. Document a follow up plan within the EMR or document exception. <p><u>Added Benefit</u></p> <ol style="list-style-type: none"> Track activity and workflow of Population Health Coach/ Case Manager / Scheduler in institutional EMR. 	<ol style="list-style-type: none"> Identify patients who fall into the measure. Stratify patients based upon agreed upon attribution. Present report to consumer that: <ol style="list-style-type: none"> Identifies attributed patients who fall into the measure Provides ability to stratify by attributed provider. Contains the minimum data set as defined within this set of use cases. Contains the expanded clinical data set for the measure as defined within this set of use cases. Ability to sort in a cascading manner. Ex: sort by measure value, last value date, then by last visit, etc. Ability to print a report up to and including items 1 through 4 above. Ability to extract or download data file containing the information referenced in items 1 through 4 above. <p><u>Added Benefit</u></p> <ol style="list-style-type: none"> Export Data referenced in items 1 through 4 above into institutional EMRs to which patients are attributed to. Transport to practice minimum clinical data set as

	<ol style="list-style-type: none"> Ability to send notification of PHC contacts, follow ups, care gaps closures and PHC assignments by individual to SHIP. Ability to add parameters to reports from available data in order to more discreetly define an intervention. 	<ol style="list-style-type: none"> defined within this set of use cases. Transport to practice extended data sets as defined within this set of use cases. Receipt of PHC contacts, follow ups, care gap closures, and PHC assignments by patient from clinical sites so that they are reflected in future care gap reports. Ability to add parameter to care gap reports from minimum or expanded data sets.
USE CASE – Clinical – In Clinic Workflow - NQF 0024 Weight Assessment & Counseling For Children and Adolescents		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
<p>The Population Health Coach / Case Manager or others will use measure/ disease / status reports to facilitate appropriate interventions and management of at risk populations.</p> <p>NQF 0024: Weight Assessment & Counseling For Children & Adolescents: The Population Health Coach / Case Manager has a need to identify and intervene on pediatric patients identified as requiring weight, nutrition, or other counseling.</p>	<ol style="list-style-type: none"> Identify pediatric patients attributed to your practice who have received one primary care or OB/GYN visit (based on procedure code) in the measurement period and have height, weight, and BMI recorded. Identify those most at risk who are in greatest need of timely intervention. <p><u>Internal Activity</u></p> <ol style="list-style-type: none"> Confirm patient is attributed properly. Has patient been seen yes/no? Provide prioritized list to scheduler for follow up or counseling. Document a follow up plan within the EMR or document exception. 	<ol style="list-style-type: none"> Identify patients who fall into the measure. Stratify patients based upon agreed upon attribution. Present report to consumer that: <ol style="list-style-type: none"> Identifies attributed patients who fall into the measure Provides ability to stratify by attributed provider. Contains the minimum data set as defined within this set of use cases. Contains the expanded clinical data set for the measure as defined within this set of use cases. Ability to sort in a cascading manner. Ex: sort by measure value, then by last value date, then by last visit, etc. Ability to print a report up to and including items 1 through 4 above. Ability to extract or download data file containing the information referenced in items 1 through 4 above.
	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> Track activity and workflow of Population Health Coach/ Case Manager / Scheduler in institutional EMR. 	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> Export Data referenced in items 1 through 4 above into institutional EMRs to which patients are attributed to. Transport of minimum clinical data set as defined

	<ol style="list-style-type: none"> Ability to send notification of PHC contacts, follow ups, care gaps closures and PHC assignments by individual to SHIP. Ability to add parameters to reports from available date in order to more discreetly define an intervention. 	<ol style="list-style-type: none"> within this set of use cases. Transport of extended data sets as defined within this set of use cases. Receipt of PHC contacts, follow ups, care gap closures, and PHC assignments by patient from clinical sites so that they are reflected in future care gap reports. Ability to add parameter to care gap reports from minimum or expanded data sets.
USE CASE – Clinical – In Clinic Workflow - NQF 0421 Preventive Care & Screening: Body Mass Index (BMI) and Follow Up		
Persona / Role Population Health Coach / Case Manager (PHC)		
Scenario:	Task:	Requirement:
<p>The Population Health Coach / Case Manager or others will use measure/ disease / status reports to facilitate appropriate interventions and management of at risk populations.</p> <p>NQF 0421 Preventive Care & Screening: Body Mass Index (BMI) and Follow Up:</p> <p>The Population Health Coach / Case Manager has a need to identify and intervene on patients identified as being outside of normal values for their age.</p>	<ol style="list-style-type: none"> Identify adult patients attributed to your practice who have a BMI lesser or greater that what is considered normal for their age as defined within the chosen measure. Identify those most at risk who are in greatest need of timely intervention. <p>Internal Activity</p> <ol style="list-style-type: none"> Confirm patient is attributed properly. Has patient been seen yes/no? Provide prioritized list to scheduler for follow up or counseling. Document a follow up plan within the EMR or document exception. 	<ol style="list-style-type: none"> Identify patients who fall into the measure. Stratify patients based upon agreed upon attribution. Present report to consumer that: <ol style="list-style-type: none"> Identifies attributed patients who fall into the measure Provides ability to stratify by attributed provider. Contains the minimum data set as defined within this set of use cases. Contains the expanded clinical data set for the measure as defined within this set of use cases. Ability to sort in a cascading manner. Ex: sort by measure value, then by last value date, then by last visit, etc. Ability to print a report up to and including items 1 through 4 above. Ability to extract or download data file containing the information referenced in items 1 through 4 above.
	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> Track activity and workflow of Population Health Coach/ Case Manager / Scheduler in institutional EMR. Ability to send notification of PHC 	<p><u>Added Benefit</u></p> <ol style="list-style-type: none"> Export Data referenced in items 1 through 4 above into institutional EMRs to which patients are attributed to. Transport of minimum clinical data set as defined within this set of use cases.

	<p>contacts, follow ups, care gaps closures and PHC assignments by individual to SHIP.</p> <p>3. Ability to add parameters to reports from available date in order to more discreetly define an intervention.</p>	<p>3. Transport of extended data sets as defined within this set of use cases.</p> <p>4. Receipt of PHC contacts, follow ups, care gap closures, and PHC assignments by patient from clinical sites.</p> <p>5. Ability to add parameter to care gap reports from minimum or expanded data sets.</p>
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