Optimizing Value-Based Care

Strategies for Better Outcomes and Sustainable Growth

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Learning Objectives

- Recognize the importance of the shift to value-based care and what it means for the future of your health center.
- Understand how VBC initiatives, including care gap closure, medication adherence, risk adjustment, and more efficient patient visits, drive better outcomes and financial sustainability.
- Advocate for a proactive approach to implementing value-based care models by equipping your team with the right strategies and solutions.

What is Value-Based Care?

- Shift from paying providers for volume of services (FFS) and toward rewarding providers for measurable outcomes
- Emphasizes high-quality, efficient, patient-centered care
- Aligns provider incentives with patient outcomes, promoting better care quality, patient satisfaction, and reduced healthcare costs

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Fee-for-Service vs Value-Based Care: Example

Fee-for-Service

- A patient with diabetes visits their provider multiple times a year for complications, each visit billed separately.
- Limited care coordination leads to gaps in treatment and higher costs.
- Focus remains on treating symptoms rather than preventing complications.

Value-Based Care

- The diabetes patient is proactively managed, such as alerts for missed medications and A1C testing.
- Care is coordinated between specialists, primary care, and pharmacy for a holistic approach.
- The health center receives quality-based reimbursements for improving long-term patient outcomes.

CMS Innovation Center Strategy: Putting All Patients at the Center of Care

- CMS charted a path for the future of VBC
- **Vision:** "*A health system that achieves equitable outcomes through high quality, affordable, person-centered care.*"
- **Measuring progress:** By 2030, all Medicare FFS and the vast majority of Medicaid beneficiaries are expected to be in a care relationship with accountability for quality and total cost of care

CMS 5 Strategic Objectives & Provider Goals

1) **Accountable Care:** "Increase the capability of primary care providers, as well as specialists and other providers, to engage in accountable care relationships with beneficiaries through incentives and flexibilities to manage quality and total cost of care."

2) **Health Equity:** "Collect data on race, ethnicity, geography, disability, and other demographics and results will be reported to the Innovation Center to help providers address health disparities."

3) **Care Innovation:** "Leverage actionable, practice-specific data, detailed case studies, and other data to implement practice changes that deliver integrated, person-centered, and community-based care."

4) **Address Affordability:** "Better align provider and beneficiary incentives to increase use of high-value services that efficiently deliver and coordinate care, achieve the best outcomes for patients, and reduce utilization of duplicative or wasteful services."

5) **Achieve Health System Transformation:** "Be able to deliver more integrated care across settings and engage in more comprehensive and longitudinal care as a result of accountable care relationships and participation in total cost of care models."

Value-Based Care Initiatives

- **Let's explore the following examples of value-based care initiatives that your health center can implement:**
    - Care gap closure
    - Medication adherence
    - Risk adjustment
    - Streamlining new patient visits for better care management

Care Gap Closure

- Ensuring patients receive preventive screenings, follow-ups, and treatments by identifying and addressing missed care opportunities.
- **VBC Example:** A health center tracks patients for overdue colorectal cancer screenings and proactively schedules appointments, improving early detection rates.
- **Benefit:** Improve patient outcomes, enhance quality measure performance, increase payments in value-based contracts.

Care Gap Closure: Supporting Statistics

- **Only 8% of adults** receive all recommended preventive care services, nearly 5% receive none.
- A patient reported study showed **greater than 1 gap** in care coordination is associated with an increased odds of **greater than 1 preventable outcome**
- Care coordination efforts could save **$240B annually** on care costs in the U.S.
- Approximately **20% of all Medicare patients** discharged from a hospital subsequently returned to the hospital and were readmitted within 30 days, highlighting the importance of timely follow-up and coordinated care

Care Gap Closure: Processes to Consider

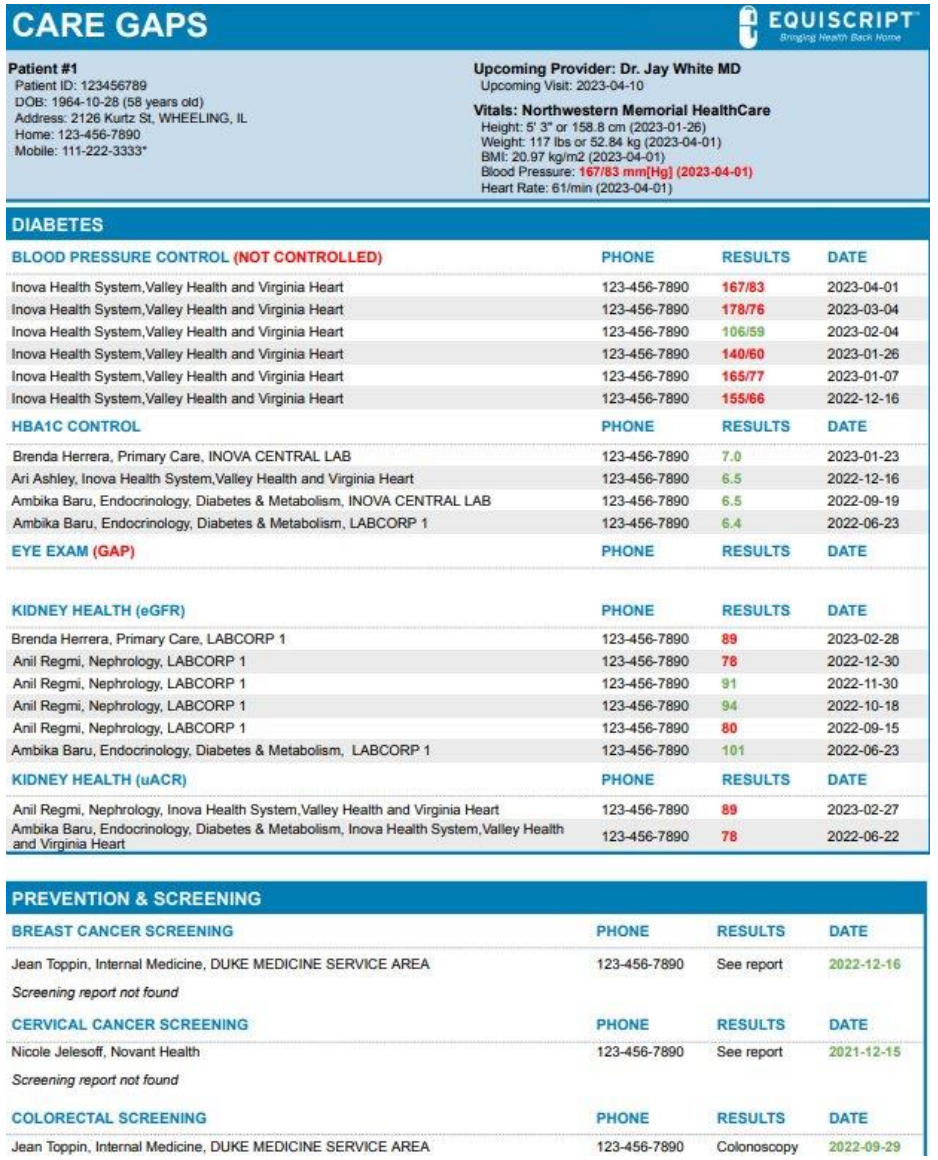
- ✓ Implement standardized patient outreach strategies, such as reminders, education, and follow-up workflows.
- ✓ Develop a data tracking system to monitor and measure care gap closure rates across different patient populations.
- ✓ Define and target at-risk populations to identify patients, investing in technology and analytics to aggregate patient data and facilitate timely information for improved care coordination.

Potential challenge for health center: Data interoperability. Lacking the technology infrastructure & resources to coordinate and track care across multiple providers and healthcare settings.

Care Gap Closure: EQ Connect

How we can help

- Identify, document, and close gaps in care
- Review quality measures tailored to patient population
- Quality gaps and uncontrolled measures highlighted in red
- Supporting clinical results available, also color-coded



CARE GAPS — EQUISCRIPT Bringing Health Back Home

Patient #1
Patient ID: 123456789
DOB: 1964-10-28 (58 years old)
Address: 2126 Kurtz St, WHEELING, IL
Home: 123-456-7890
Mobile: 111-222-3333*

Upcoming Provider: Dr. Jay White MD
Upcoming Visit: 2023-04-10

Vitals: Northwestern Memorial HealthCare
Height: 5' 3" or 158.8 cm (2023-01-26)
Weight: 117 lbs or 52.84 kg (2023-04-01)
BMI: 20.97 kg/m2 (2023-04-01)
Blood Pressure: 167/83 mm[Hg] (2023-04-01)
Heart Rate: 61/min (2023-04-01)

DIABETES

BLOOD PRESSURE CONTROL (NOT CONTROLLED)	PHONE	RESULTS	DATE
Inova Health System,Valley Health and Virginia Heart	123-456-7890	167/83	2023-04-01
Inova Health System,Valley Health and Virginia Heart	123-456-7890	178/76	2023-03-04
Inova Health System,Valley Health and Virginia Heart	123-456-7890	106/59	2023-02-04
Inova Health System,Valley Health and Virginia Heart	123-456-7890	140/60	2023-01-26
Inova Health System,Valley Health and Virginia Heart	123-456-7890	165/77	2023-01-07
Inova Health System,Valley Health and Virginia Heart	123-456-7890	155/66	2022-12-16

HBA1C CONTROL	PHONE	RESULTS	DATE
Brenda Herrera, Primary Care, INOVA CENTRAL LAB	123-456-7890	7.0	2023-01-23
Ari Ashley, Inova Health System,Valley Health and Virginia Heart	123-456-7890	6.5	2022-12-16
Ambika Baru, Endocrinology, Diabetes & Metabolism, INOVA CENTRAL LAB	123-456-7890	6.5	2022-09-19
Ambika Baru, Endocrinology, Diabetes & Metabolism, LABCORP 1	123-456-7890	6.4	2022-06-23

EYE EXAM (GAP)	PHONE	RESULTS	DATE

KIDNEY HEALTH (eGFR)	PHONE	RESULTS	DATE
Brenda Herrera, Primary Care, LABCORP 1	123-456-7890	89	2023-02-28
Anil Regmi, Nephrology, LABCORP 1	123-456-7890	78	2022-12-30
Anil Regmi, Nephrology, LABCORP 1	123-456-7890	91	2022-11-30
Anil Regmi, Nephrology, LABCORP 1	123-456-7890	94	2022-10-18
Anil Regmi, Nephrology, LABCORP 1	123-456-7890	80	2022-09-15
Ambika Baru, Endocrinology, Diabetes & Metabolism, LABCORP 1	123-456-7890	101	2022-06-23

KIDNEY HEALTH (uACR)	PHONE	RESULTS	DATE
Anil Regmi, Nephrology, Inova Health System,Valley Health and Virginia Heart	123-456-7890	89	2023-02-27
Ambika Baru, Endocrinology, Diabetes & Metabolism, Inova Health System,Valley Health and Virginia Heart	123-456-7890	78	2022-06-22

PREVENTION & SCREENING

BREAST CANCER SCREENING	PHONE	RESULTS	DATE
Jean Toppin, Internal Medicine, DUKE MEDICINE SERVICE AREA	123-456-7890	See report	2022-12-16
Screening report not found			

CERVICAL CANCER SCREENING	PHONE	RESULTS	DATE
Nicole Jelesoff, Novant Health	123-456-7890	See report	2021-12-15
Screening report not found			

COLORECTAL SCREENING	PHONE	RESULTS	DATE
Jean Toppin, Internal Medicine, DUKE MEDICINE SERVICE AREA	123-456-7890	Colonoscopy	2022-09-29

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Care Gap Closure: Case Study

Equiscript Client → Utilized EQ Connect to identify and track colorectal screenings across 500 patients

Findings → EQ Connect data uncovered 204 out of 500 patients had a recent colorectal screening documented in external records that the client previously lacked visibility into

Impact → 41% gap closure through automated technology, with supporting clinical documentation

Results found	Count
Encounter for screening for malignant neoplasm of colon	352
Colonoscopy	50
Colonoscopy flx dx w/collj spec when pfrmd	7
Screening for malignant neoplasm of colon	4
Screening colonoscopy	3
Colonoscopy stoma dx including collj spec spx	1
Lower GI hemoglobin IA QI (Stl)	1
Colon ca scrn not hi rsk ind	1
Colsc flx w/rmvl of tumor polyp lesion snare tq	1
Colonoscopy w/biopsy single/multiple	1
Colorectal scrn; hi risk ind	1
Grand Total	**422**

Medication Adherence

- Ensuring patients pick up and take their medications as prescribed to improve health outcomes and reduce complications.
- **VBC Example:** A health center identifies patients with hypercholesterolemia who have not refilled their simvastatin prescription, outreaching to patients to remind them of fills and understand the reason for gap in pick up.
- **Benefit:** Reduces hospitalizations, prevents disease progression, and helps achieve better value-base care performance metrics.

Medication Adherence: Supporting Statistics

- **More than half** of medications prescribed for chronic diseases are not taken as directed
- Poor medication adherence costs the U.S. healthcare system up to **$300B annually**
- **An estimated 20%** of hospital readmissions are due to non-adherence
- No refills remaining is the leading cause of non-adherence **(45%)**

Medication Adherence: Processes to Consider

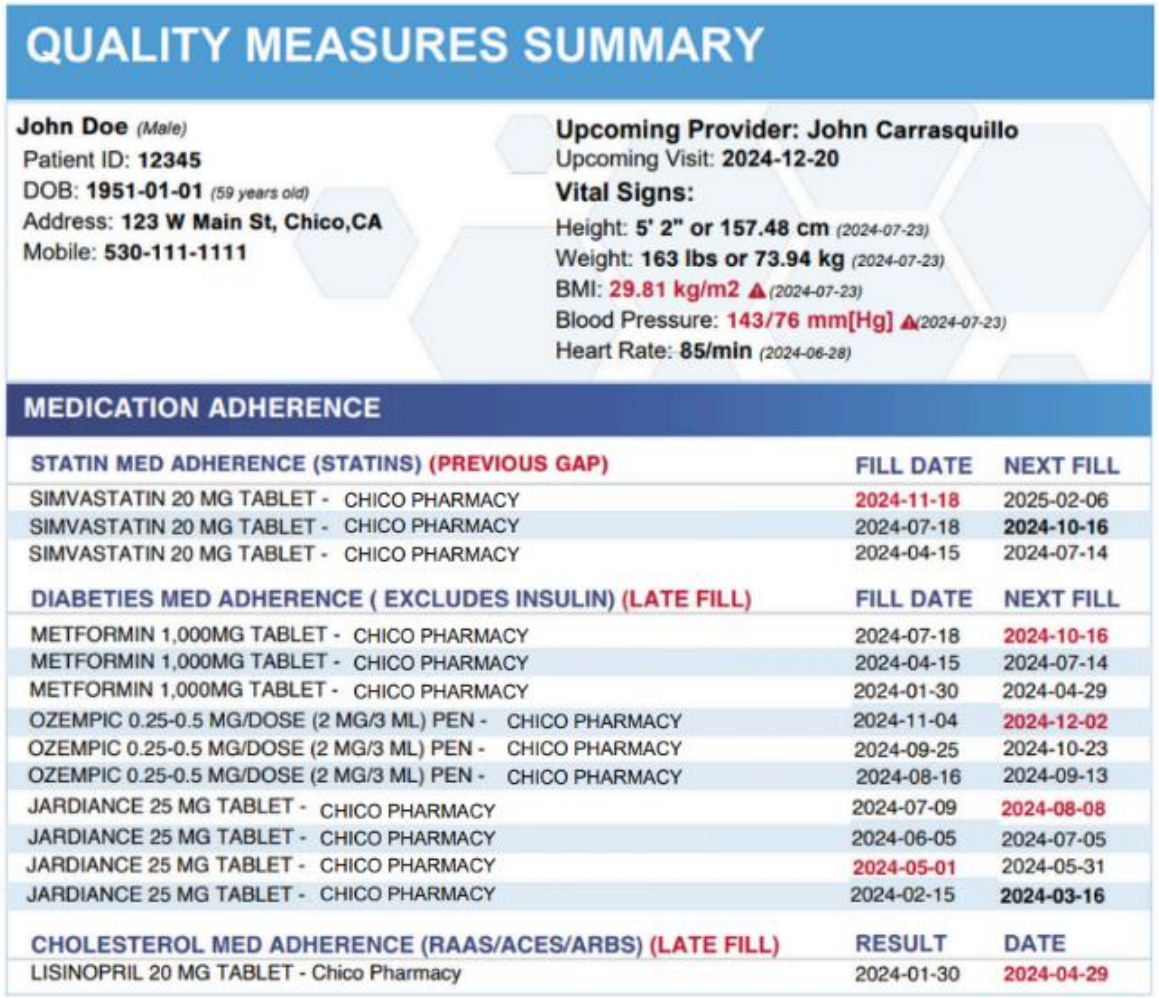
- ✓ Have providers review all medications, including ones from outside prescribers, during the patient visit. Make sure patients understand how and when to take them.
- ✓ Pull weekly reports with up-to-date information on medications prescribed, identifying patients due or late for a refill, calling them in for appointments if needed.
- ✓ Assign nursing supervisors to provide ongoing outreach to high-risk patients to check on adherence and provide education.
- ✓ Identify and address any factors that may be preventing patients from taking their medications, such as cost or lack of understanding.

Potential challenge for health center: Bridging the gap between what was prescribed in the EMR versus the pharmacy fill data, indicating if it was ultimately picked up or out of refills.

Medication Adherence: EQ Connect

How we can help

- **Individualized care summaries** with prescribed medication and adherence, using pharmacy data to indicate gaps in prescription pickup.
    - Easily spot-check and confirm prescription accuracy during visits
    - Missed pickups will be indicated in red
    - Even if the refill was picked up at a different pharmacy, we will capture that as filled
- **Summarized data** to review all non-adherent patients, engage with your patients, alert of fills when needed



QUALITY MEASURES SUMMARY

John Doe *(Male)*
Patient ID: **12345**
DOB: **1951-01-01** *(59 years old)*
Address: **123 W Main St, Chico,CA**
Mobile: **530-111-1111**

Upcoming Provider: John Carrasquillo
Upcoming Visit: **2024-12-20**
Vital Signs:
Height: **5' 2" or 157.48 cm** *(2024-07-23)*
Weight: **163 lbs or 73.94 kg** *(2024-07-23)*
BMI: **29.81 kg/m2** ▲ *(2024-07-23)*
Blood Pressure: **143/76 mm[Hg]** ▲*(2024-07-23)*
Heart Rate: **85/min** *(2024-06-28)*

MEDICATION ADHERENCE

STATIN MED ADHERENCE (STATINS) (PREVIOUS GAP)	FILL DATE	NEXT FILL
SIMVASTATIN 20 MG TABLET - CHICO PHARMACY	2024-11-18	2025-02-06
SIMVASTATIN 20 MG TABLET - CHICO PHARMACY	2024-07-18	**2024-10-16**
SIMVASTATIN 20 MG TABLET - CHICO PHARMACY	2024-04-15	2024-07-14
DIABETIES MED ADHERENCE (EXCLUDES INSULIN) (LATE FILL)	**FILL DATE**	**NEXT FILL**
METFORMIN 1,000MG TABLET - CHICO PHARMACY	2024-07-18	2024-10-16
METFORMIN 1,000MG TABLET - CHICO PHARMACY	2024-04-15	2024-07-14
METFORMIN 1,000MG TABLET - CHICO PHARMACY	2024-01-30	2024-04-29
OZEMPIC 0.25-0.5 MG/DOSE (2 MG/3 ML) PEN - CHICO PHARMACY	2024-11-04	2024-12-02
OZEMPIC 0.25-0.5 MG/DOSE (2 MG/3 ML) PEN - CHICO PHARMACY	2024-09-25	2024-10-23
OZEMPIC 0.25-0.5 MG/DOSE (2 MG/3 ML) PEN - CHICO PHARMACY	2024-08-16	2024-09-13
JARDIANCE 25 MG TABLET - CHICO PHARMACY	2024-07-09	2024-08-08
JARDIANCE 25 MG TABLET - CHICO PHARMACY	2024-06-05	2024-07-05
JARDIANCE 25 MG TABLET - CHICO PHARMACY	2024-05-01	2024-05-31
JARDIANCE 25 MG TABLET - CHICO PHARMACY	2024-02-15	**2024-03-16**
CHOLESTEROL MED ADHERENCE (RAAS/ACES/ARBS) (LATE FILL)	**RESULT**	**DATE**
LISINOPRIL 20 MG TABLET - Chico Pharmacy	2024-01-30	2024-04-29

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Medication Adherence: Case Study

Equiscript Clients→ Reviewed adherence rates across 4 clients

Parameters → Percentage of patients adherent (=>80% Adherence Score) per CE. Live patients, 65 years and older, on maintenance medications with an encounter.

Results → We found nearly 1 in 5 Medicare patients at these clinics are non-adherent with their medication therapy

COVERED ENTITY	% OF ADHERENT PATIENTS	% OF NONADHERENT PATIENTS
Client 1	78.8%	21.2%
Client 2	78.9%	21.1%
Client 3	77.1%	22.9%
Client 4	81.7%	18.3%

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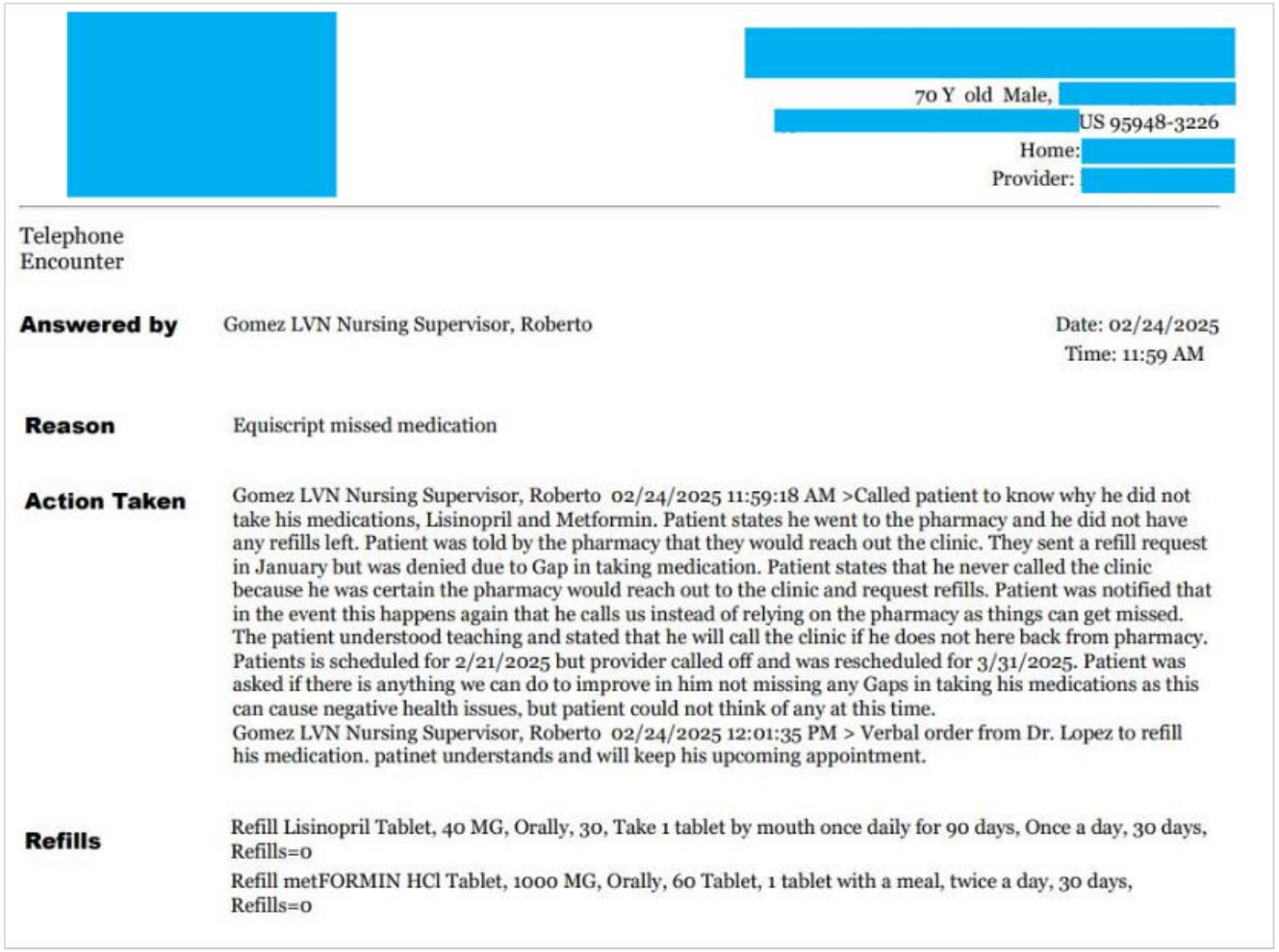
Taking Action

The power of EQ data → Our client was able to directly engage with their patients that we identified as non-adherent to their medication, documenting communication and providing medical guidance.



[redacted]

70 Y old Male, [redacted]
[redacted] US 95948-3226
Home: [redacted]
Provider: [redacted]

Telephone Encounter

Answered by Gomez LVN Nursing Supervisor, Roberto

Date: 02/24/2025
Time: 11:59 AM

Reason Equiscript missed medication

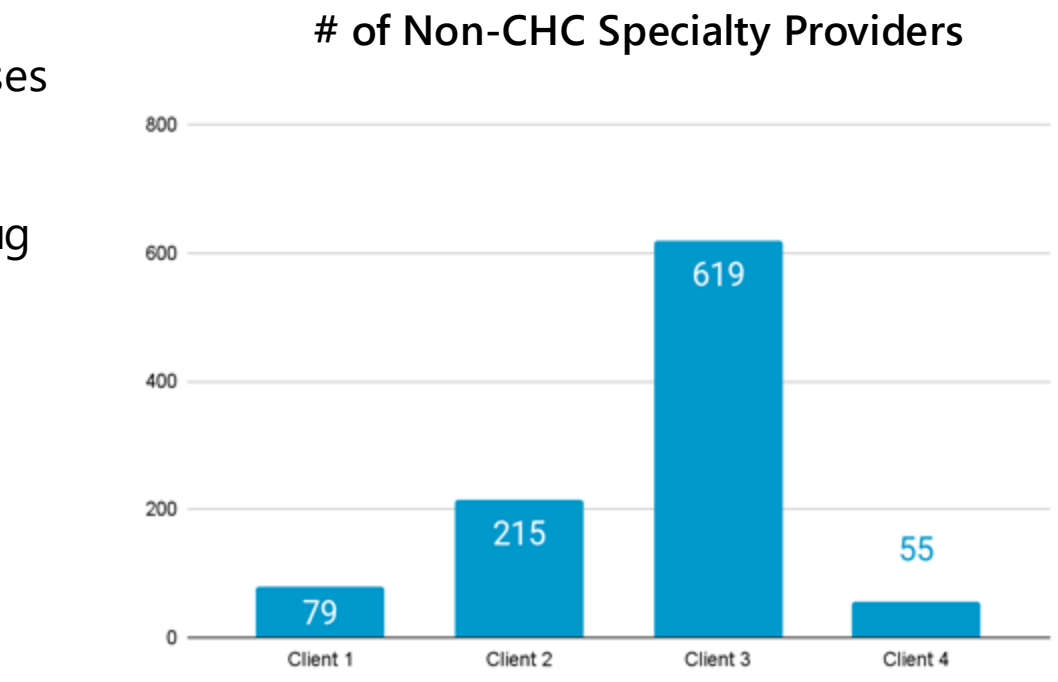
Action Taken Gomez LVN Nursing Supervisor, Roberto 02/24/2025 11:59:18 AM >Called patient to know why he did not take his medications, Lisinopril and Metformin. Patient states he went to the pharmacy and he did not have any refills left. Patient was told by the pharmacy that they would reach out the clinic. They sent a refill request in January but was denied due to Gap in taking medication. Patient states that he never called the clinic because he was certain the pharmacy would reach out to the clinic and request refills. Patient was notified that in the event this happens again that he calls us instead of relying on the pharmacy as things can get missed. The patient understood teaching and stated that he will call the clinic if he does not here back from pharmacy. Patients is scheduled for 2/21/2025 but provider called off and was rescheduled for 3/31/2025. Patient was asked if there is anything we can do to improve in him not missing any Gaps in taking his medications as this can cause negative health issues, but patient could not think of any at this time.
Gomez LVN Nursing Supervisor, Roberto 02/24/2025 12:01:35 PM > Verbal order from Dr. Lopez to refill his medication. patinet understands and will keep his upcoming appointment.

Refills Refill Lisinopril Tablet, 40 MG, Orally, 30, Take 1 tablet by mouth once daily for 90 days, Once a day, 30 days, Refills=0
Refill metFORMIN HCl Tablet, 1000 MG, Orally, 60 Tablet, 1 tablet with a meal, twice a day, 30 days, Refills=0

What Else Did We Learn? 340B Lift

- By running a medication history on our client's Medicare patients, we were able to identify new outside specialty providers writing script's for their patients, which increases referral capture opportunity

- Across all 4 clients, we also identified 8,863 specialty drug claims over a 12-month period
- EQ provides real-time, fact-based information on:
  - Which patients are on a specialty therapy
  - Who the prescriber is
  - Where it is being filled



Patients Submitted	**11,707**	**9,431**	**9,935**	**3,543**

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Risk Adjustment

- During an annual wellness visit, capturing the full complexity of the patient's health conditions to ensure appropriate reimbursement and care planning.
- **VBC Example:** A patient diagnosed with a spinal cord disease by a neurologist comes in for a visit with their primary care provider. The PCP documents this diagnosis code in the EMR of the patient's medical home. The condition is properly risk-adjusted, aligning care needs with appropriate reimbursement.
- **Benefit:** Better care management and higher risk-adjusted reimbursement, ensuring appropriate funding to manage high-risk populations.

Risk Adjustment: Supporting Statistics

- Medicare ACO program: A 3% increase in risk adjustment factor (RAF) equates to an average of **$101-$267 per member per year** (PMPY)
- Medicare Advantage: A 1% increase in RAF equates to an average of **$141-$282 PMPY**
    - Medicare Advantage is projected to **grow up to 60% by 2030**
- A strong single-provider relationship lowers risk-adjusted PMPM **costs by 15.3%**

Risk Adjustment: Processes to Consider

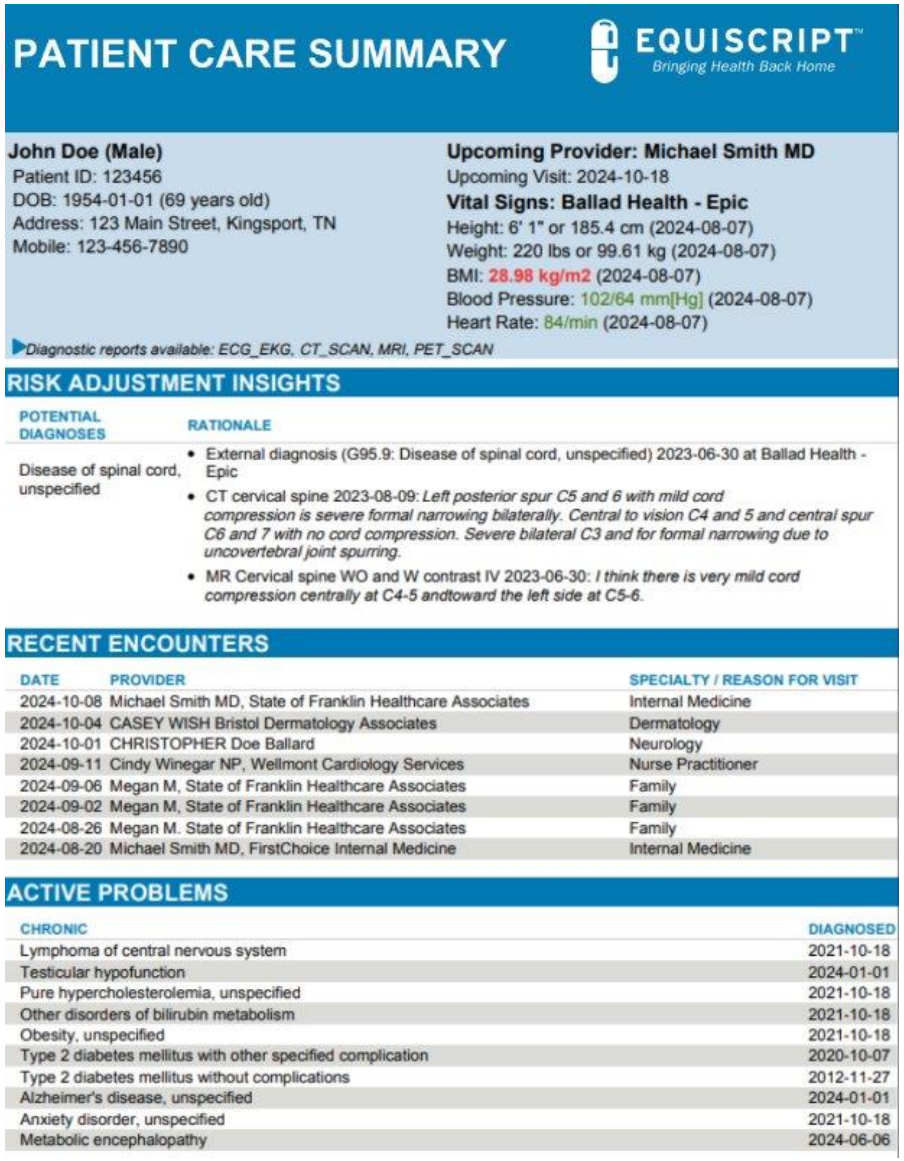
- ✓ Have clinical staff conduct pre-visit chart reviews the night before to flag potential diagnoses and equip providers with targeted insights for patient discussions
- ✓ Provide continued education to train staff on best practices for complete and accurate diagnosis documentation.
- ✓ Proactively identify patients with chronic conditions and documentation gaps (i.e. patients with labs indicating chronic kidney disease but no CKD diagnosis code).

Potential challenge for health center: Fragmented patient data across different providers makes it difficult to gather the necessary documentation, resulting in under-coded diagnoses.

Risk Adjustment: EQ Connect

How we can help

- Data specifically designed to help providers when seeing Medicare patients for their annual wellness visit
- Prompts for missing or under coded diagnoses that risk adjust
- Get paid for the full complexity of the patient with supporting clinical documentation and external specialist notes



PATIENT CARE SUMMARY

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John Doe (Male)
Patient ID: 123456
DOB: 1954-01-01 (69 years old)
Address: 123 Main Street, Kingsport, TN
Mobile: 123-456-7890

Upcoming Provider: Michael Smith MD
Upcoming Visit: 2024-10-18
Vital Signs: Ballad Health - Epic
Height: 6' 1" or 185.4 cm (2024-08-07)
Weight: 220 lbs or 99.61 kg (2024-08-07)
BMI: 28.98 kg/m2 (2024-08-07)
Blood Pressure: 102/64 mm[Hg] (2024-08-07)
Heart Rate: 84/min (2024-08-07)

Diagnostic reports available: ECG_EKG, CT_SCAN, MRI, PET_SCAN

RISK ADJUSTMENT INSIGHTS

POTENTIAL DIAGNOSES	RATIONALE
Disease of spinal cord, unspecified	• External diagnosis (G95.9: Disease of spinal cord, unspecified) 2023-06-30 at Ballad Health - Epic • CT cervical spine 2023-08-09: *Left posterior spur C5 and 6 with mild cord compression is severe formal narrowing bilaterally. Central to vision C4 and 5 and central spur C6 and 7 with no cord compression. Severe bilateral C3 and for formal narrowing due to uncovertebral joint spurring.* • MR Cervical spine WO and W contrast IV 2023-06-30: *I think there is very mild cord compression centrally at C4-5 andtoward the left side at C5-6.*

RECENT ENCOUNTERS

DATE	PROVIDER	SPECIALTY / REASON FOR VISIT
2024-10-08	Michael Smith MD, State of Franklin Healthcare Associates	Internal Medicine
2024-10-04	CASEY WISH Bristol Dermatology Associates	Dermatology
2024-10-01	CHRISTOPHER Doe Ballard	Neurology
2024-09-11	Cindy Winegar NP, Wellmont Cardiology Services	Nurse Practitioner
2024-09-06	Megan M, State of Franklin Healthcare Associates	Family
2024-09-02	Megan M, State of Franklin Healthcare Associates	Family
2024-08-26	Megan M. State of Franklin Healthcare Associates	Family
2024-08-20	Michael Smith MD, FirstChoice Internal Medicine	Internal Medicine

ACTIVE PROBLEMS

CHRONIC	DIAGNOSED
Lymphoma of central nervous system	2021-10-18
Testicular hypofunction	2024-01-01
Pure hypercholesterolemia, unspecified	2021-10-18
Other disorders of bilirubin metabolism	2021-10-18
Obesity, unspecified	2021-10-18
Type 2 diabetes mellitus with other specified complication	2020-10-07
Type 2 diabetes mellitus without complications	2012-11-27
Alzheimer's disease, unspecified	2024-01-01
Anxiety disorder, unspecified	2021-10-18
Metabolic encephalopathy	2024-06-06

New Patient Visits

- Driving better decision-making and health outcomes during the first visit by equipping providers with comprehensive patient medical history.
- **VBC Example:** A care team member reviews a patient's external records, medication history and specialist notes ahead of the visit. With this information, the provider identifies unmanaged chronic conditions including mobility limitations and sensorineural hearing loss, helping tailor care plans and improve quality measure performance.
- **Benefit:** Shorten appointment times & see more patients, improve care planning, and enhance patient satisfaction.

New Patient Visit: Supporting Statistics

- Data-driven technology supports better patient care. **60%** of health care executives use health care data analytics in their organizations.
    - Of those, **42%** saw improved patient satisfaction and **39%** reported cost savings
- Understanding a new patient's medical history can lead to stronger patient-provider relationships. Patients with higher levels of trust in their healthcare providers are **2.6 times more likely** to adhere to their treatment plans.
- Having access to comprehensive medical history at the first visit enables more informed discussions and better care planning. Providers with a more "participatory decision-making style" are **30% less likely** to have patients leave their care.

New Patient Visit: Processes to Consider

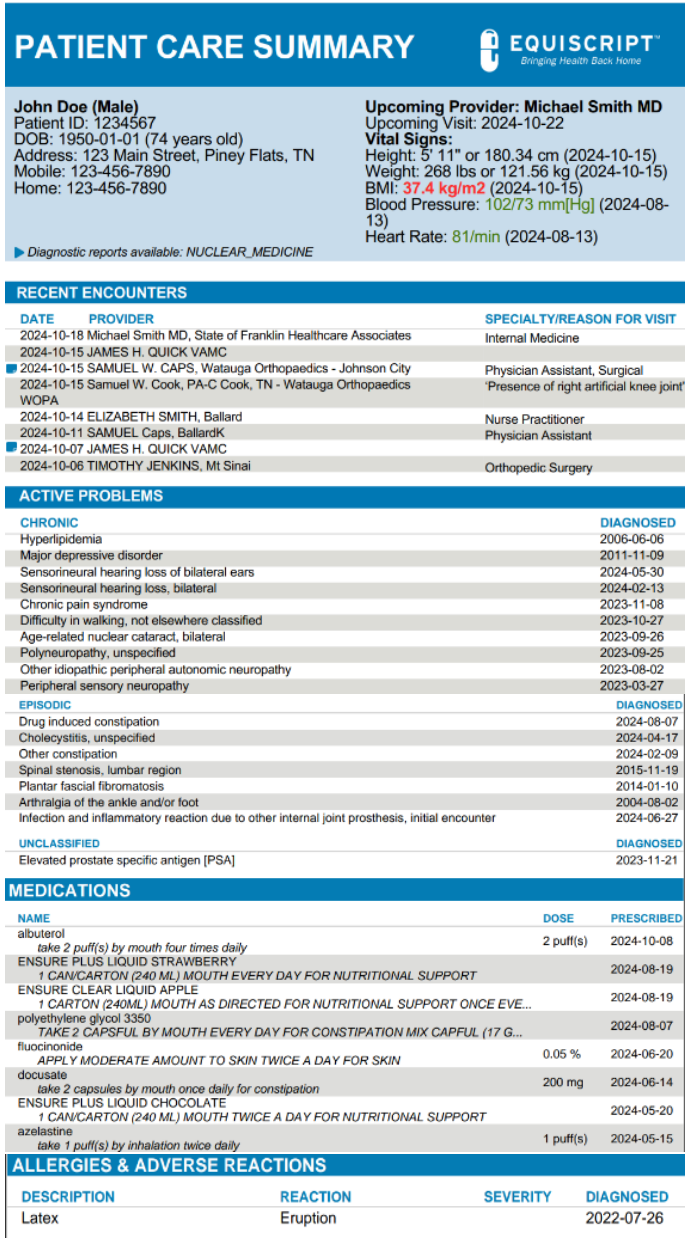
- ✓ Establish pre-visit planning workflows for your care teams such as collecting and reviewing external encounter data the day before the visit to ensure a complete understanding of patient history
- ✓ To optimize provider time, notify physicians of needs to be addressed in daily huddle or during chart prep
- ✓ Invest in health information technology to reduce administrative burdens and empower data-driven decision making

Potential challenge for health center: Time burdens placed on providers in gathering patient visit history prior to a well-informed visit. Furthermore, EHRs inadequately capture mental health diagnoses, visits, specialty care, hospitalizations, and medications.

New Patient Visit: EQ Connect

How we can help

- Access clinical notes for all care administered by outside providers
- Receive a focused patient care summary including a recent encounters with consult notes, active problems, medication list, and lab results
- Empower providers with up-to-day activity of patient medical history, saving time and resources
- Streamline visits and see more patients with readily available data



PATIENT CARE SUMMARY — EQUISCRIPT Bringing Health Back Home

John Doe (Male)
Patient ID: 1234567
DOB: 1950-01-01 (74 years old)
Address: 123 Main Street, Piney Flats, TN
Mobile: 123-456-7890
Home: 123-456-7890

Upcoming Provider: Michael Smith MD
Upcoming Visit: 2024-10-22
Vital Signs:
Height: 5' 11" or 180.34 cm (2024-10-15)
Weight: 268 lbs or 121.56 kg (2024-10-15)
BMI: 37.4 kg/m2 (2024-10-15)
Blood Pressure: 102/73 mm[Hg] (2024-08-13)
Heart Rate: 81/min (2024-08-13)

Diagnostic reports available: NUCLEAR_MEDICINE

RECENT ENCOUNTERS

DATE	PROVIDER	SPECIALTY/REASON FOR VISIT
2024-10-18	Michael Smith MD, State of Franklin Healthcare Associates	Internal Medicine
2024-10-15	JAMES H. QUICK VAMC	
2024-10-15	SAMUEL W. CAPS, Watauga Orthopaedics - Johnson City	Physician Assistant, Surgical
2024-10-15	Samuel W. Cook, PA-C Cook, TN - Watauga Orthopaedics WOPA	'Presence of right artificial knee joint'
2024-10-14	ELIZABETH SMITH, Ballard	Nurse Practitioner
2024-10-11	SAMUEL Caps, BallardK	Physician Assistant
2024-10-07	JAMES H. QUICK VAMC	
2024-10-06	TIMOTHY JENKINS, Mt Sinai	Orthopedic Surgery

ACTIVE PROBLEMS

CHRONIC	DIAGNOSED
Hyperlipidemia	2006-06-06
Major depressive disorder	2011-11-09
Sensorineural hearing loss of bilateral ears	2024-05-30
Sensorineural hearing loss, bilateral	2024-02-13
Chronic pain syndrome	2023-11-08
Difficulty in walking, not elsewhere classified	2023-10-27
Age-related nuclear cataract, bilateral	2023-09-26
Polyneuropathy, unspecified	2023-09-25
Other idiopathic peripheral autonomic neuropathy	2023-08-02
Peripheral sensory neuropathy	2023-03-27
EPISODIC	**DIAGNOSED**
Drug induced constipation	2024-08-07
Cholecystitis, unspecified	2024-04-17
Other constipation	2024-02-09
Spinal stenosis, lumbar region	2015-11-19
Plantar fascial fibromatosis	2014-01-10
Arthralgia of the ankle and/or foot	2004-08-02
Infection and inflammatory reaction due to other internal joint prosthesis, initial encounter	2024-06-27
UNCLASSIFIED	**DIAGNOSED**
Elevated prostate specific antigen [PSA]	2023-11-21

MEDICATIONS

NAME	DOSE	PRESCRIBED
albuterol *take 2 puff(s) by mouth four times daily*	2 puff(s)	2024-10-08
ENSURE PLUS LIQUID STRAWBERRY *1 CAN/CARTON (240 ML) MOUTH EVERY DAY FOR NUTRITIONAL SUPPORT*		2024-08-19
ENSURE CLEAR LIQUID APPLE *1 CARTON (240ML) MOUTH AS DIRECTED FOR NUTRITIONAL SUPPORT ONCE EVE...*		2024-08-19
polyethylene glycol 3350 *TAKE 2 CAPSFUL BY MOUTH EVERY DAY FOR CONSTIPATION MIX CAPFUL (17 G...*		2024-08-07
fluocinonide *APPLY MODERATE AMOUNT TO SKIN TWICE A DAY FOR SKIN*	0.05 %	2024-06-20
docusate *take 2 capsules by mouth once daily for constipation*	200 mg	2024-06-14
ENSURE PLUS LIQUID CHOCOLATE *1 CAN/CARTON (240 ML) MOUTH TWICE A DAY FOR NUTRITIONAL SUPPORT*		2024-05-20
azelastine *take 1 puff(s) by inhalation twice daily*	1 puff(s)	2024-05-15

ALLERGIES & ADVERSE REACTIONS

DESCRIPTION	REACTION	SEVERITY	DIAGNOSED
Latex	Eruption		2022-07-26

ENCOUNTER DETAILS

2023-08-07 Outpatient: Telephone encounter

Providers: Filip Matyjaszczyk MA, Centura Health, Orthopedic Surgery
Care Plans:
2023-09-17: DTaP. TDaP, and TD (2 - Td or Tdap)
2023-09-17: DTaP,Tdap,and Td Vaccines (2 - Td or Tdap)
Notes:
2023-08-07: Pt called MOA Triage Line and left a message requesting a referral to a provider to do his TAR since Dr. Bret Smith is gone. Tried to call him back and send referral to Dr. Mark Conklin at Panorama. No answer and Not able to leave a message.

2023-06-01 Outpatient: Office/outpatient new moderate mdm 45-59 minutes

Providers: Rebecca Goranson PA-C, Centura Health, Physician Assistant
Codes: Radex ankle complete minimum 3 views
Diagnosis: Pain in right ankle and joints of right foot
Care Plans:
2023-06-01: CT Ankle - right WO contrast
Notes:
2023-06-01 (truncated): ASSESSMENT and PLAN: 1. Arthritis of right ankle 2. Right ankle pain 3. Osteoarthritis of right ankle, unspecified osteoarthritis type 4. Arthritis of right subtalar joint 5. Osteoarthritis of talonavicular joint due to inflammatory arthritis I discussed condition pathophysiology, treatment options, expected treatment course with the patient in detail. Treatment options include both conservative and surgical intervention moving forward. Patient presents with right foot and ankle pain due to severe talonavicular and subtalar arthritic changes as well as end-stage arthritic changes within the ankle. Patient suffered a trauma that included a talus fracture with dislocation and since then, unfortunately, the patient has failed conservative measures over the years to get relief. These conservative measures have included steroid injection, PT/OT, rest, brace wear as well as the forementioned surgical intervention. We have spoken about ankle replacement surgery, but with his severe talonavicular and subtalar arthritic

LAB SUMMARY

CBC	Q3 2023	Q2 2023	Q1 2023	Q4 2022	Q3 2022
Hematocrit (Bld) [Volume fraction]			52 %		
Hemoglobin (Bld) [Mass/Vol]			18.1 g/dL		
MCV (RBC) [Entitic vol]			94 fl		
Platelets (Bld) [#/Vol]			251 10*3/uL		
WBC (Bld) [#/Vol]			7.0 10*3/uL		
CHEMISTRY	**Q3 2023**	**Q2 2023**	**Q1 2023**	**Q4 2022**	**Q3 2022**
ALP [Catalytic activity/Vol]			86 U/L		
ALT With P-5'-P [Catalytic activity/Vol]			67 U/L		
AST With P-5'-P [Catalytic activity/Vol]			49 U/L		
Albumin BCP dye [Mass/Vol]			4.0		
Anion gap [Moles/Vol]			15 mmol/L		
Average glucose Estimated from glycated hemoglobin (Bld) [Mass/Vol]			114 mg/dL		
Bilirubin [Mass/Vol]			0.5 mg/dL		
CO2 [Moles/Vol]			19 mmol/L		
Calcium [Mass/Vol]			9.5 mg/dL		
Chloride [Moles/Vol]			104 mmol/L		
Creatinine [Mass/Vol]			0.92 mg/dL		
GFR/1.73 sq M.predicted among non-blacks MDRD (S/P/Bld) [Vol rate/Area]			91 mL/min/{1.73_m2}		
Globulin (S) [Mass/Vol]			3.2 g/dL		
Glucose [Mass/Vol]			102 mg/dL		
Potassium [Moles/Vol]			4.3 mmol/L		

EQUISCRIPT
Bringing Health Back Home

Positioning Your Health Center for Long-Term Success

- Conclusion and key takeaways:
    - **Integrate data-driven strategies:** Using technology to improve documentation and track patient care is essential for long-term success in value-based care models.
    - **Enhance patient outcomes:** Focusing on care gap closure, medication adherence monitoring, and risk adjustment drive better health outcomes.
    - **Diversify revenue streams:** Value-based care presents opportunities to secure financial sustainability outside of just 340B.
    - **Be proactive:** With 100% of Medicare beneficiaries moving to accountable care by 2030, now is the time to implement technology & processes that align with value-based care models.

Let’s Build Your EQ Connect Pilot

Complimentary clinical data assessment on your patient population

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No commitment or EMR integration required

Get in touch:
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