Create a Patient Registry Report

The Patient Registry displays a tabular Member list with relevant Risk, Demographic, Utilization, and Clinical data. Only Members seen in the past seven days appear by default on this list.

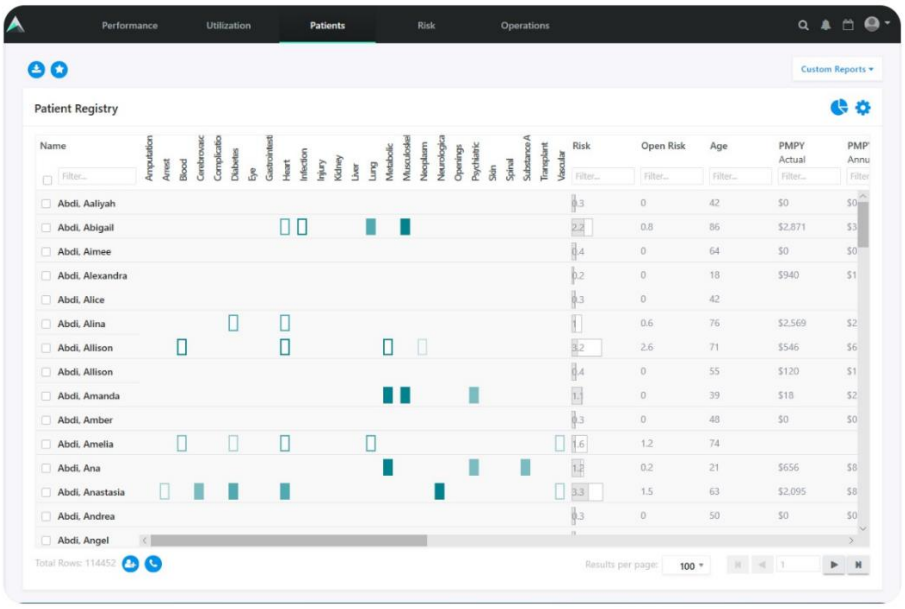
Recommendation: Use the global filters to expand the reporting date range. **Expanding the date range to at least one month is highly recommended** since the report defaults only to Members seen in the past seven days.

Examples may include:

- I want to run a report for Members living with diabetes and without complications
- I want to run a report for Members who have either a kidney OR heart condition and have high-cost medication
- I want to run a report for Members living with diabetes AND a diabetic eye condition

Punch Card View

The first section of the Patient Registry is a "punch card" that provides functionality to track and manage gaps in risk-adjustment. Please view the Patient Registry page for details on navigating the punch card.



Punch Care View continued.

Each color represents the severity of the condition. The darker the color the more severe the condition. For example, a Member living with diabetes without complications will have a punch card with a lighter color than a Member living with diabetes with complications.

A category with open risk documentation is presented as an empty box on the punch card. Open risk documentation refers to evidence of an assessment of a risk condition that occurred prior to the current calendar year.

Closed risk documentation is represented with a filled in box and refers to evidence of an assessment of a risk condition that occurred in the current calendar year based on current claims and/or payer data.

While this report is exportable to CSV, the columns representing each condition on the punch card will be split into a State and a Severity column rather than a colored punch card.

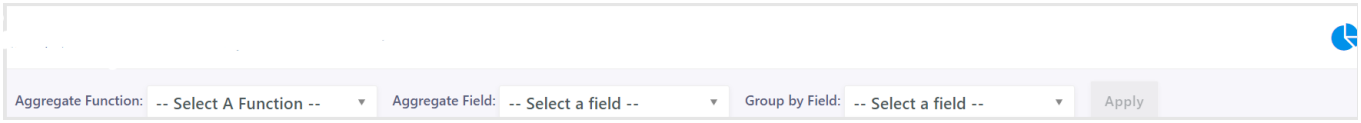
Global Filters (see reports details for specific steps)

Selecting different conditions in the Condition History global filter will dynamically update the report columns with related clinical content.

Ex: Reporting on Members living with diabetes – add A1C, BP, Eye Exam, HDL, LDL, and Microalbumin data elements to the registry.

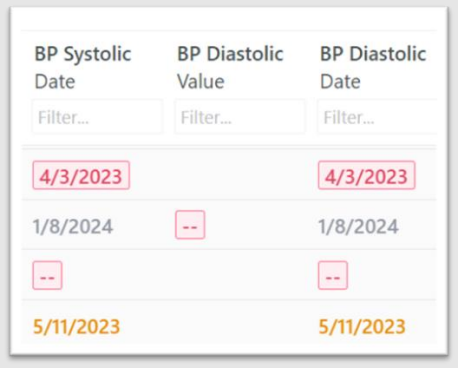
Aggregate

Using the Aggregate Results drop-down, the user can apply aggregating functions, such as SUM/COUNT/AVG for any field on the report. Graphs summarizing the selected function can be seen by selecting a field to aggregate and a field to group by. This works like chart functionality in spreadsheet programs like Excel.



Formatting Key

This report uses conditional formatting to indicate whether recorded dates and/or values are out of range or, for dates, within 30 days of becoming overdue. These ranges are based on clinical best practices. When no value has been recorded and clinical best practices dictate that one should have been, **--** will be displayed.



Dates in red represent overdue/or will be red if a value is out of range. Dates in orange are within a month of being overdue. When no value has been recorded and best practices dictate that one should have been, **--** will display.

Columns

Column Name	Description
Risk	Patients Risk Score
Open Risk	Patients Open Risk
Projected Risk	The total weight expected impact of risk events on the final risk score for the patient.
Arc Score	Arcadia Impact Score, calculated as of the current date. Scores are interpreted as a ranking mechanism and do not necessarily have an implicit value.
Arc Score Evidence	Arcadia Impact Score Evidence, presented according to level of significance in score calculation. In some cases, this field is overridden by a customized client configuration. See the Arcadia Impact Score documentation for more detail or see your Arcadia Analytics Administrator or Implementation Team for instance-specific details.
ED Visits 12 Months	Number of distinct emergency department visits in the last 12 months.
High Impact Cancer 24 Months	Indicator of the presence of high-impact cancer diagnosis in the last 24 months.
Hospice Flag 12 Months	Indicator of the presence of a Hospice-based event in the last 12 months.

Column Name	Description
Medication Count	Number of distinct prescriptions or medication fills in the last 12 months, with claims-based data adjusted for system-wide claim lag.
IP Admits 12 Months	Number of inpatient admissions in the last 12 months, adjusted for system-wide claim lag.

The following uses Johns Hopkins ACG System.

Column Name	Description
IP Probability	12-Month Inpatient Admit Probability. This probability (between 0 and 1) represents the likelihood that the Member will have an acute inpatient admission of any kind in the next 12 months.
Frailty Flag	This is an indicator of whether a Member (18 years of age or older) has a diagnosis representing conditions or problems associated with frailty. Conditions include: • Malnutrition or catabolic illness • Dementia • Severe vision impairment • Decubitus ulcer • Incontinence (urine and/or feces) • Loss of weight • Social support needs • Difficulty in walking • Falls
Care Coordination Risk	These markers indicate the likelihood of a coordination issue based on the number of distinct providers, generalists, and specialists seen during an observation period.
Care Density Ratio	This is a person-level measure of patient sharing across providers. Members who see providers who, in turn, see similar groups of patients (e.g., shared panels and integrated care), have higher care density ratios. Members who see multiple providers who then have very few patients in common have low care density ratios. The care density ratio ranges from 1.0 (no patient sharing) to 10.0 (identical patient sharing)
Pregnancy	Pregnancy Indicator. This is an indicator of whether the Member was pregnant during the observation period. Any diagnostic indication of pregnancy is used. Lab data are not used to inform this indicator. Values are 1 (pregnant during observation period) and 0 (not pregnant during observation period).

The following uses Preventative Care Gap specifications.

Care Gap	Description	Threshold
Annual Dental Care	Members who are two-20 years old, most recent dental visit along with date and data source.	Out of Range: Marked as out of range when last annual dental visit is more than 365 days old, or Member has none recorded.
High Risk Medication	Members who are over age 65 and are on a high-risk medication.	N/A
BMI	Members who are 18 and older, most recent BMI percentile with date and data source.	Out of Range: Result values are marked as out of range when the value not between 18.50 and 29.99.
Blood Pressure	Member's most recent blood pressure test result along with date.	Out of Range: For Members who are 18 and older. Most recent blood pressure reading has a diastolic value of >90 and/or a systolic value of >140. Overdue: Most recent blood pressure reading is more than 365 days old, or Member has no blood pressure recorded.
Colonoscopy	The most recent colonoscopy date for Members ages 45-75.	Overdue: Most recent colonoscopy is more than 10 years old, or Member has no colonoscopy recorded.
CT Colonography	Members 50-75 years old most recent CT colonography along with date and data source.	Overdue: Most recent screen is more than five years old, or Member has none recorded.
Depression Screening	Members over 12 years old most recent depression screening along with date and data source.	Overdue: Most recent depression screening is more than 365 days old, or Member has no depression screen recorded.
Fall Risk	Members who are 65 and older, most recent fall risk screening along with date and data source.	Overdue: Most recent fall risk screening is more than 365 days old, or Member has none recorded.
FIT-DNA	Members 45-75 years old most recent FIT-DNA along with date and data source.	Overdue: Most recent FIT-DNA is more than three years old, or Member has none recorded.
Flexible Sigmoidoscopy	Members 45-75 years old most recent flexible sigmoidoscopy along with date and data source.	Overdue: Most recent flexible sigmoidoscopy is more than five years old, or Member has none recorded.
Flu Vaccine	Members most recent flu vaccination along with date and data source.	Overdue: Most recent flu vaccination is more than 365 days old, or Member has no flu vaccination recorded.

Care Gap	Description	Threshold
FOBT	Members 50-75 years old most recent FOBT along with date and data source.	Overdue: Most recent FOBT is more than 365 days old, or Member has none recorded.
High Risk Medication	Members who are over 65 and older on a high-risk medication.	N/A
Lead Screen	Displays the date of the most recent lead screen for Members who are one-five years old.	N/A
Mammogram	Displays the date of the most recent mammogram for female Members 50-74 years old.	Overdue: Most recent mammogram is more than two years old, or Member has no mammogram recorded.
Medication Reconciliation	Members most recent medication reconciliation date.	Overdue: Most recent medication reconciliation is more than one year old, or Member has no medication reconciliation recorded.
PAP	Shows the most recent PAP screen for female Members between 21-65 years old	Overdue: Most recent PAP screen is more than three years old, or Member has no PAP screen recorded.
Physical Exam	Displays the date of the Members most recent physical exam.	N/A
Pneumococcal Vaccine	For Members 65 and older, displays the date of the Members' most recent pneumococcal vaccination.	Overdue: Member has no PCV immunization recorded.
Tobacco Cessation	For Members who are 18 and older, this displays the date of their most recent tobacco cessation counseling.	N/A
Tobacco Status	For Members who are 18 and older, this displays the date of their most recently recorded tobacco status.	Most recent tobacco status is more than 365 days old, or Member has no tobacco status recorded.
Osteoporosis Screen	Displays the date of the most recent Osteoporosis screen for female Members over 65 years old.	N/A
Wellness Exam	Member's most recent wellness exam.	For Members 65 and older, most recent wellness exam date - if no visit has occurred, the field will be blank.