QUALITY WATCH

Assoc. Director of Nursing

KEEPING OUR GOALS IN SIGHT

Name:

Month:

PHASE DASHBOARD

	My Result	Agency Result	High	Low
How many PHASE eligible patients, seen in the last 12 months are assigned to my site? Tab: PHASE patients / Filter: Site				
How many PHASE eligible patients are not enrolled in PHASE? Tab: Population Management / Filter: Site, Enrolled in PHASE = 'no'				
How many PHASE eligible patients *Not At Goal* are due For Case Management? Tab: Population Management / Filter: Site, Case Management 'due', At Goal = 'No'				
How many PHASE eligible patients are on an ASA who also have an ASA exclusion? Tab: QA-ASA exclude				
How many PHASE eligible patients have not been seen in over a year? Tab: Office Visit Recall List / Filter: Site, Last Office Visit = 'NULL' and 'greater than 12 months'				
What percent of my PHASE eligible patients who are *Not At Goal* have Case Management complete? Tab: Case Management Complete Filter: Site, At Goal = 'No'				
What percent of my PHASE eligible patients, who do not have an ASA exclusion, have ASA on their med list? Tab: Percent of ASA / Filter: Site				

DIABETES DASHBOARD

	My Result	Agency Result	High	Low
What percent of my DM patients have an A1C less than or equal to 9%?: Tab: DM Clinical Outcome / Filter: Site				
What percent of my DM patients with an A1C greater than 9% have had a DM Care Plan complete in the last 12 months?: Tab: DM Clinical Outcome / Filter: Site				

MONTHLY RN CHECKLIST

Measure	Result		Measure	Result
Number of open Telephone Encounters assigned to me:	☐		Number of transition care patients with a risk score <20	☐
Date of the oldest Telephone Encounter assigned to me:	☐		ED f/u calls complete:	☐
Number of open Documents assigned to me:	☐		Daily provider jelly management support: (Es, Ds, TEs, Ls)	☐
Date of the oldest Document assigned to me:	☐		Pap and Mammo Tracking complete:	☐
Number of open Labs assigned to me:	☐		Reconciled tracked labs complete:	☐
Date of the oldest Lab assigned to me:	☐		Performed medication reconciliation: (ER, Hospitalizations, Consult notes)	☐
Do I have any referrals assigned to me?:	☐		Coumadin management per protocol complete:	☐
Number of active IOPCM Patients:	☐		No show/cancellation follow-up complete:	☐
IOPCM Items completed:	☐		Monthly care team meeting: (at minimum)	☐
Number of transition care patients with a risk score > 20.	☐		Monthly check-in with CTMA:	☐
Number of patients with 4 pillars complete for patients with a risk score > 20. (Face-to-face visit + 4 f/u calls)	☐		Chart prep attended huddles: (PARS, goal setting for patients being seen)	☐

Questions, actions, support, best practices