QUALITY WATCH NURSE

KEEPING OUR GOALS IN SIGHT

Name:

Team:

Month:

PHASE DASHBOARD

How many PHASE eligible patients, seen in the last 12 months, are assigned to my team? My Result

Tab: PHASE patients / Filter: Rendering Provider

How many PHASE eligible patients are not enrolled in PHASE?

Tab: Population Management / Filter: Rendering Provider, Enrolled in PHASE = 'no'

How many PHASE eligible patients not at goal are due for Case Management?

Tab: Population Management / Filter: Rendering Provider

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

What percent of my PHASE eligible patients who are not at goal have Case Management complete? Goal My Result

Tab: Case Management Complete / Filter: Rendering Provider, 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 on ASA / Filter: Rendering Provider

How many PHASE eligible patients have not been seen in over a year?

Tab: Office Visit Recall List / Filter: Rendering Provider,

Last Office Visit = 'NULL' and 'greater than 12 months'

ISSUES AND OPPORTUNITIES

DIABETES DASHBOARD

What percent of my patient have their A1C less than or equal to 9%? Goal My Result

Tab: DM Clinical Outcome / Filter: Rendering Provider

What percent of my DM patients with an A1C greater than 9% have had a DM Care Plan in the last 12 months? Goal My Result

Tab: DM Clinical Outcome / Filter: Rendering Provider

Tab: DM Clinical Outcome / Filter: Rendering Provider

MONTHLY RN CHECKLIST

Measure	Result
Number of open Telephone Encounters assigned to me:	
Date of the oldest Telephone Encounter assigned to me:	
Number of open Documents assigned to me:	
Date of the oldest Document assigned to me:	
Number of open Labs assigned to me:	
Date of the oldest Lab assigned to me:	
Do I have any referrals assigned to me?:	
Number of active IOPCM Patients: IOPCM Items completed:	
Number of transition care patients with a risk score > 20.	
Number of patients with 4 pillars complete for patients with a risk score > 20. (Face-to-face visit + 4 f/u calls)	
Number of transition care patients with a risk score <20	
ED f/u calls complete:	

Measure	Result
Daily provider jelly management support: (Es, Ds, TEs, Ls)	
Pap and Mammo Tracking complete:	
Reconciled tracked labs complete:	
Performed medication reconciliation: (ER, Hospitalizations, Consult notes)	
Coumadin management per protocol complete:	
No show/cancellation follow-up complete:	
Monthly care team meeting: (at minimum)	
Monthly check-in with CTMA:	
Chart prep attended huddles: (PARS, goal setting for patients being seen)	

ISSUES AND OPPORTUNITIES