I Got a Fever…

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Pivotal Moment Consulting

The purpose for measurement

- What the problem we're trying to solve?
  - The guy has a fever…how do we know, we measured
- Act on the data
  - Provide more cowbell

How do we identify problems?

- Acute exacerbation
- Patient tells us
- Receive some piece of information
- I know what my patient needs

Why measure, I know my patients

"It takes 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients, plus 10.6 hours to manage all chronic conditions adequately"

I have a small panel of patients

- Detailed measurements is not for me
  - I only have 50 diabetic patient on my panel
  - I have taken care of them for years

- Ask yourself
  - When were they last seen?
  - What were there last 3 A1C values? Were they trending in the right direction?
  - When was the last foot exam? (73,000 amputations per year – CDC)
  - When was the last eye exam? (1 in 3 have diabetic retinopathy – CDC)
  - Etc.

Let’s play a game

Please memorize this string of numbers

1 – 914 – 191 – 81 – 93 – 919 – 4 – 5

Take no more than 15 seconds…

Say the numbers in order

1 – 914 – 191 – 81 – 93 – 919 – 4 – 5

YOU WANT TO TRUST YOUR MEMORY?

Other challenges

- Data is too hard to get
- It’s not accurate
- It’s not timely
- It’s not actionable
- I have too much to do already

Clinica Family Health

CASE STUDY

What's the problem we are trying to solve?

- Provide excellent quality of care for our patients to prevent further spread of disease, focus on prevention and makes lives better

- To do this, we needed to understand our population of patients

Incremental Change

Sunday	Monday	Tuesday	Friday	Saturday
Week #1	Prenatal Chronic Pain Pap Mngt CM D	CM Dep BHP Dep Blue PR Dep		
Week #2	ADHD Coumadin Diabetes(half)	CM Dep BHP Dep Green PR Dep		
Week #3	Prenatal HTN Missing Pap	CM Dep BHP Dep Red PR Dep		
Week #4	Coumadin Diabetes(half)	CM Dep BHP Dep Orange PR Dep		

Guided Decision Making

High Risk

Last Name	First Name	DOB	Visit	BP Sys	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
	Bonnie	/1952	11/13/2008	122	80	Current	08/01/2007	11/13/08	05/15/2008	04/03/2008	59		
Group Visit	No											11/13/2008	7.80
												09/04/2008	8.00
												07/17/2008	8.00
	Angelica	/1975	03/26/2009	115	69	Never		12/11/08	03/26/2009	02/15/2008	90		
Group Visit	Yes											03/26/2009	8.90
												12/11/2008	9.50

Last Name	First Name	DOB	Visit	BP Syst	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
Diabetes Planned Care Ruler			If more than six months, make appt. Otherwise, see BP, LDL & A1c rules	If above 130, appt every month	If above 80, appt every month	If current smoker, CM to review for Tobacco Cessation counseling	If not within one year, put on list for DM Eye Exam GV	If not within one year, CM to set goal with patient	If not within one year, make appt	If not within one year, make appt	If above 130, appt every month. If 100-130, appt every 3 months	If not within 3 months, make appt (6 months okay if last value less than 7.0)	If above 9, appt every month. If 7.0 - 9.0, appt every 3 months. If below 7.0, appt every 6 months

	Teresita	/1974	03/26/2009	110	72	Never	10/10/2008	1/30/09	10/16/2008	01/30/2009	76		

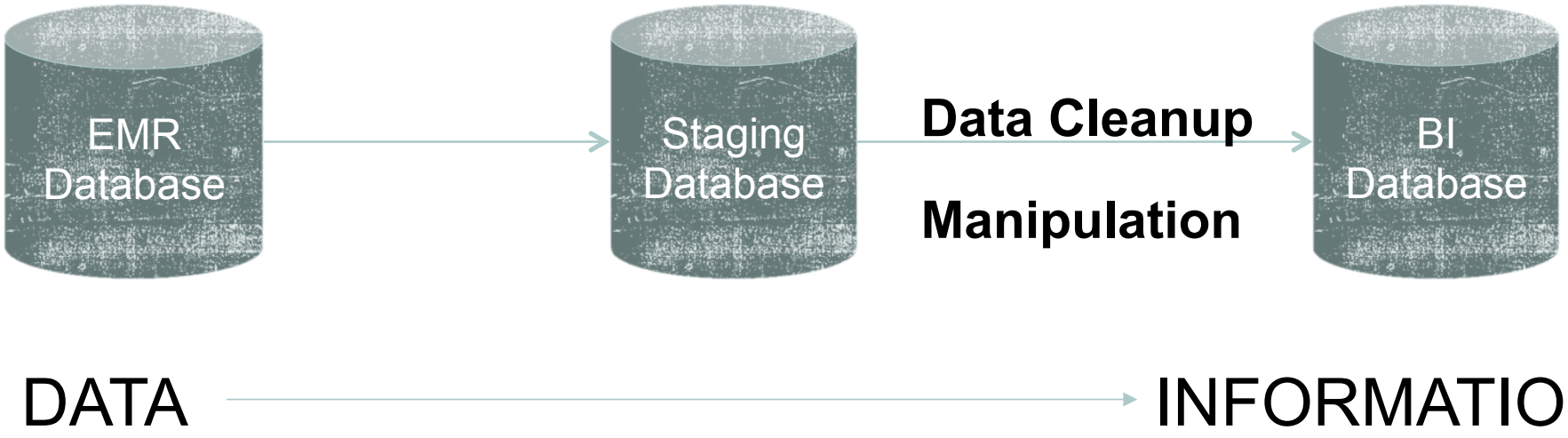
Data rich but information poor

- Having an EMR and collecting data does not translate into action

- EMRs
  - Thousands of data points
  - Visually aggregates the data points on EMR screens
  - Providers and teams mentally evaluate the data to convert it into information that drives patient care

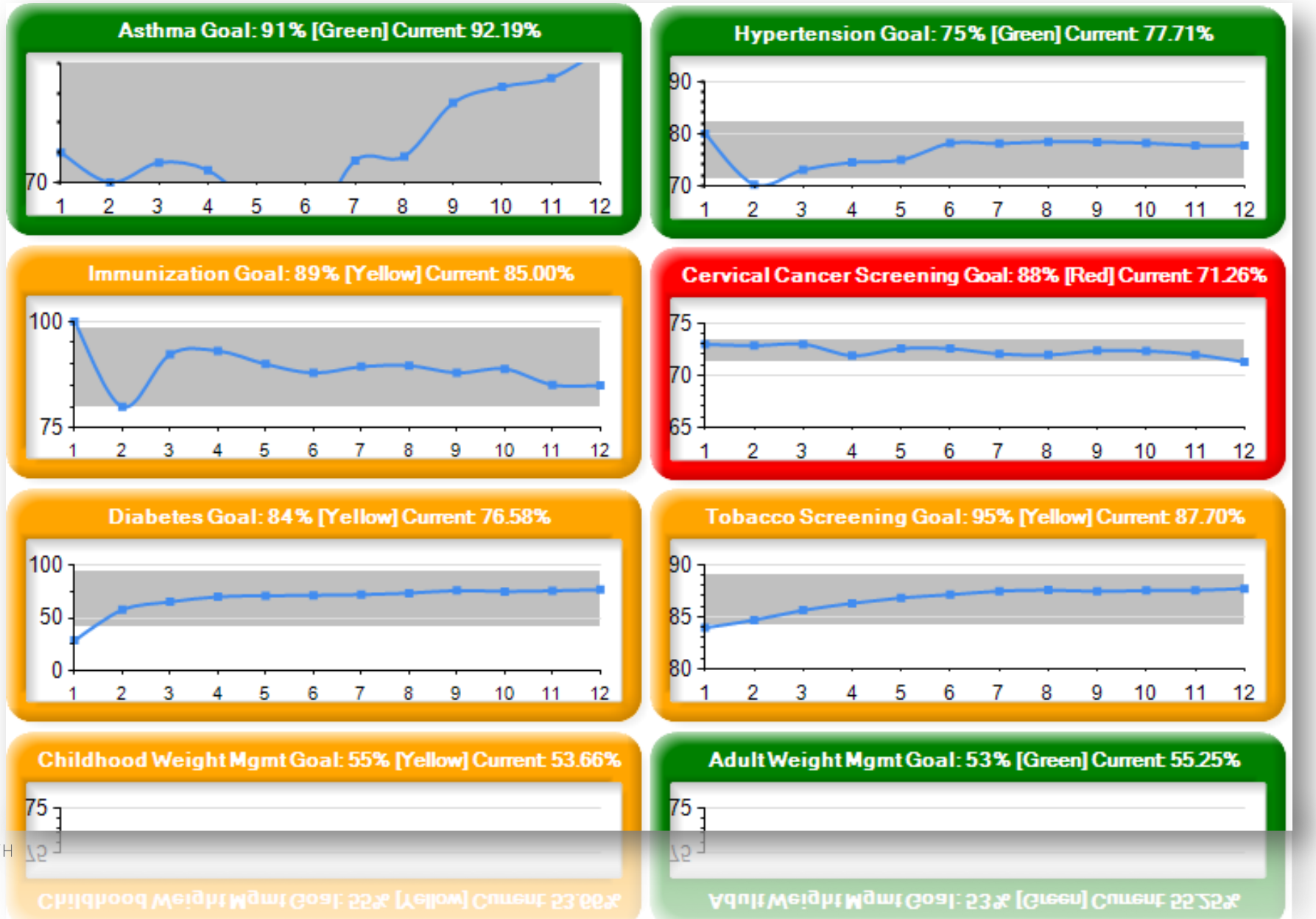
Data vs. Information

Warehousing

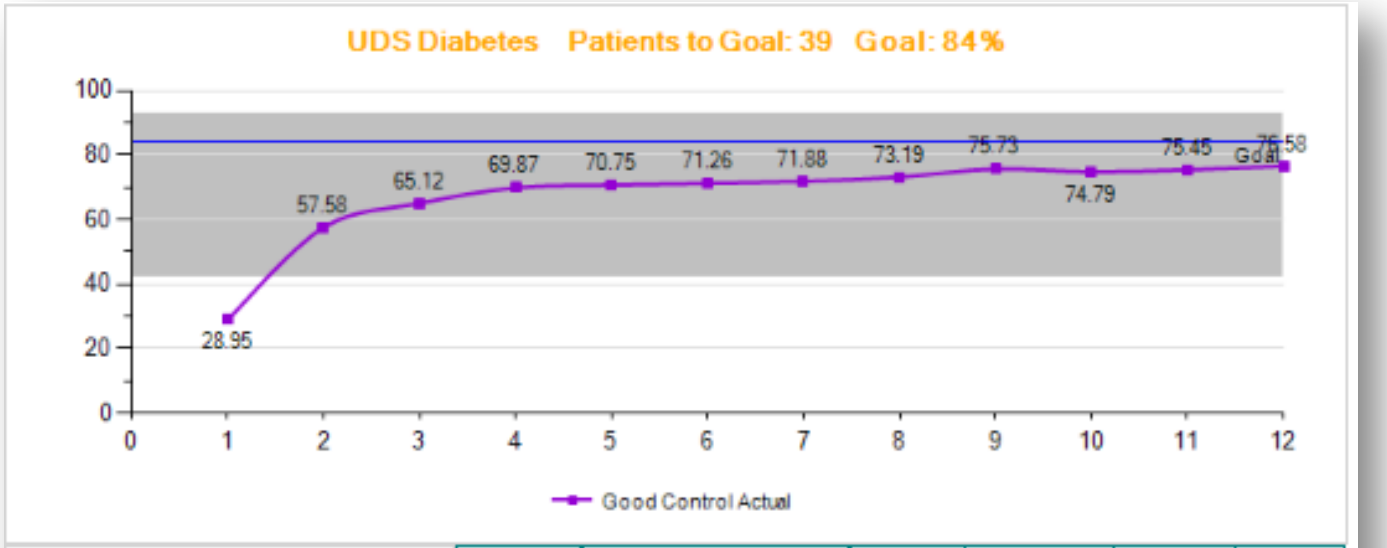


Start with the big picture

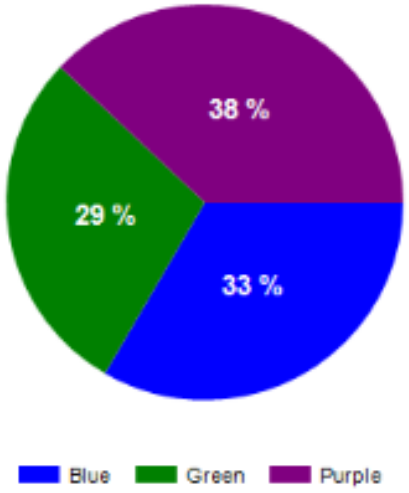
Cascade the message



Make it manageable



UDS Diabetes Population for Site



	Provider	Meets Measure	Population	Percent	Patients to Goal
	Click on the physician name to launch the outreach tool				
Blue	Dryden, Kevin	30	43	70%	7
	Freedman, Ira	36	42	86%	0
	Greer, Emily	51	69	74%	7
	Smith, Jennifer	15	20	75%	2
	Blue Total	**132**	**174**	**76%**	**15**
Green	Alper, Amy	6	9	67%	2
	Ambrose, Christa Elizabeth	35	45	78%	3
	Barnak, Emily	26	35	74%	4
	Fryer, Angela	7	9	78%	1
	Hess, Rachel	37	51	73%	6
	Green Total	**111**	**149**	**74%**	**15**
Purple	Brock, Corinne	33	41	80%	2
	Daniel, Michael	16	19	84%	0

Make it actionable

Planned Care Registry Outreach

REPORT SPECIFICATIONS

SHOWING PATIENTS WITH DIABETES ALERT(S)

Total Patients: 55

Person Nbr	Patient Details	Visits and Appointments	Outreach Details	Patient Care Alerts
Dryden, Kevin				
842791	**DOB:** **Age:** 49 **Preferred Contact Method:** **Home Phone:** **Day Phone:** **Alternate Phone:** **Secondary Phone:** **Email:** **Cell Phone:** **Language:**English **ACO:** N **Medicaid Nbr:** **My CLINICA Connection Status:** Enrolled **OB Status:** **Groups:**	**PCP:** Dryden, Kevin **PDP:** Missing PDP **Hygienist:** **Last Visit:** 11/18/2015 Dryden, K-DIA **Last WCC:** **Payer:** Medicaid FQHC **Next appt:** **Last Dental Visit:** **Next Dental Visit:**	**Clinical** **Date Reviewed:**12/17/2015 **Comments:** Lvm informing pt to RCTC and schedule apt for DM. IH **Call Attempt:**2nd Call **Call Status:**Left message **Dental** **Date Reviewed:** **Comments:** **Call Attempt:** **Call Status:**	**Clinical** Past Due - Diabetes Eye Exam Past Due - Diabetes Foot Exam Past Due - High Blood Pressure > = 140/90 (Diabetes,) Past Due - Last A1c > 9 on 11/18/2015 Past Due - LDL (Cholesterol) Lab Past Due - Tdap/TD Vaccine ACO Care Team Score is 3 **Dental**

Close the loop

Person Nbr	Patient Name	PCP/ Status	Phone Number	Age/ DOB	Gender	Last Visit	ACO
842791		PCP: Dryden, Kevin Status: Active Payer: Medicaid FQHC Group Visits: My CLINICA Connection Status: Enrolled		49 Year(s)	M	11/18/2015 Dryden, K Last WCC: CarePlan Rvw:	X

Alerts	Appts	Active Problem List
Past Due - Diabetes Eye Exam Past Due - Diabetes Foot Exam Past Due - LDL (Cholesterol) Lab Past Due - Last A1c > 9 on 11/18/2015 Past Due - High Blood Pressure > = 140/90 (Diabetes,) Past Due - Immunizations (Past Due - Tdap/TD Vaccine,) ACO Care Team Score is 3		11/18/2015 - Alcohol-induced chronic pancreatitis 11/18/2015 - Continuous chronic alcoholism 06/17/2014 - Alcoholism - 303.90 06/17/2014 - Iron deficiency anemia - 280.9 06/17/2014 - Methamphetamine abuse - 305.70 06/17/2014 - Pancreatitis - 577.0 06/17/2012 - Diabetes type 2, uncontrolled - 250.02

Active Medications

Start Date	Stop Date	Prescribed Elsewhere	Brand Name	Generic Name	Dose	Instructions
12/21/2015	12/20/2016		SURE COMFORT	PEN NEEDLE, DIABETIC	30 gauge X 5/16"	Inject 10 U of Levemir SQ HS
12/21/2015	12/19/2016		TRUETRACK TEST STRIP	BLOOD SUGAR DIAGNOSTIC		use 1 Strip by In Vitro route 1 - 3 times every day as needed to monitor blood glucose
12/21/2015	12/14/2016		THIN LANCETS	LANCETS		inject by Misc.(Non-Drug; Combo Route) route 1- 2 times every day for testing blood sugar.
12/03/2015	05/29/2016		WAVESENSE PRESTO	BLOOD-GLUCOSE METER		take 1 by Injection route 3 times every day for 365 days Check blood sugar TID
11/18/2015	11/11/2016		LEVEMIR FLEXTOUCH	INSULIN DETEMIR	100 unit/mL (3 mL)	inject 10 Unit by subcutaneous route every morning
11/18/2015	11/11/2016		LISINOPRIL	LISINOPRIL	5 mg	take 1 tablet by oral route every day
11/18/2015	11/11/2016		NOVOLOG FLEXPEN	INSULIN ASPART	100 unit/mL	inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization.
06/05/2015	06/19/2016		TRUETRACK BLOOD GLUCOSE SYSTEM	BLOOD-GLUCOSE METER		use 1 by Topical route every day for glucose monitoring

Diabetes - High Risk

Systolic	Diastolic	Eye Exam	Foot Exam	A1c (Last 3)
140	80			11/18/2015 - 11.5 03/10/2015 - 14.6 08/14/2014 - 14.6

Group Visit: No

Open Referrals	Future Labs	Diagnostics

What problem are YOU trying to solve?

- How patients qualify for cervical cancer screening? When were they last screened? How much outreach do you need to do to reach your goal?
- How many patients need dental sealants? What's the reduction of caries?
- How do you expand HIV services? Do you have a defined panel of patients? Do you know what they are due for and when in their treatment plan?
- What's my time to third? Are your templates setup to allow ease of scheduling? How are you tracking outreach? What is your schedule utilization?

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