

# Using the Disease Registry to Drive Patient Care

- Mercy Family Care – Marysville
  - A presentation by
  - Robert Camara DO
- Nancy Mason – Office Manager

# Team Members

- Nancy Mason – Office Manager
  - Kate May RN – Educator
- Christy Markel – Lead Medical Assistant
- Cindy Closs – Lead Medical Office Assistant
  - Robert Camara DO
  - Dawn Lambrecht MD

# About Mercy Family Care

- Small town practice in Marysville, MI
- Two family practice physicians - aligned with Mercy Trinity PHO (137 physicians)
- Four MA's (two full time and two part time)
- Three Office Assistants (3 full time)
- Outreach Specialist (part time)
- Certified DM Educator ( ½ day 2 X weekly)
- Practice Load – 1000 patient visits monthly

# The Mercy Family Care Marysville Team



ST. JOSEPH MERCY  
PORT HURON

SAINT JOSEPH MERCY HEALTH SYSTEM





# Mercy Family Care - Marysville

**Dr. Robert Camara**



**Dr. Dawn Lambrecht**

**Our support  
staff**



**Our Medical  
Assistants**



**Our  
Diabetes  
Educator**



# How Registry Used

- The registry is used for all patients at every visit.
- The registry incorporates Evidence-Based Care Guidelines
- The registry allows the MA to review services needed, pertaining to the patients medical history.
- Each illness has a care plan which outlines the services needed with time frames.
- The care plans are for Chronic disease management, health maintenance and preventative services.

# How Registry Used

- The Medical Assistants play a key role in collection and communication of these services.
- With the creation of standing orders the MA's are able to carry out the services listed at the start of the patient entering the exam room.
- The services are logged by checking the task boxes for: Done – Ordered – Discussed – N/A
- The standing orders can be given to the patient for education and planning for future needs.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's date: \_\_\_\_\_

### DIABETES

#### Laboratory Tests

- Hemoglobin A1c - every 3 months, if over 6.8, every 3-6 months, if less than 6.9
- Urine Microalbumin (UMALBRN) - annually
- Lipid panel (all of the following) - annually
  - Cholesterol
  - HDL
  - LDL
  - Triglycerides
- ALT/AST - annually
- Fasting Glucose
- 2 hour GTT

#### Immunizations

- Flu Vaccine - annually
- Pneumococcal Vaccination - 1 lifetime dose for all pts 65 and older
- Tetanus - every 10 years

#### Services/Screening

- Diabetes Education - Comprehensive classes - Individual consult \_\_\_\_\_
- Medical Nutrition Therapy \_\_\_\_\_
- Dilated Eye Exam - annually
- Foot Exam (monofilament) - annually
- Smoking Cessation

#### Supplies

- Blood Glucose meter
- Test Strips and lancets (times testing per day)
  - 1x  2x  3x  4x  5x  6x  7x  8x
- Insulin Syringes (injections per day)
  - 1x  2x  3x  4x  5x  6x
- Insulin Pen needles (injections per day)
  - 1x  2x  3x  4x  5x  6x

#### Preventative Care

- PSA - annually
- Mammogram (women 40-65) - annually

### ASTHMA

- Spirometry - annually

#### Immunizations

- Flu Vaccine - annually
- Pneumococcal Vaccination - 1 lifetime dose for all pts 65 and older
- Tetanus - every 10 years

#### Services/Screening

- Smoking Cessation
- Medical Nutrition Therapy \_\_\_\_\_

#### Preventative Care

- PSA - annually
- Mammogram (women 40-65) - annually

### CORONARY ARTERY DISEASE

#### Laboratory Tests

- Lipid panel (all of the following) - annually
  - Cholesterol
  - HDL
  - LDL
  - Triglycerides
- Fasting Glucose - every 3 years for CVD or Heart Failure pts

#### Immunizations

- Flu Vaccine - annually
- Pneumococcal Vaccination - 1 lifetime dose for all pts 65 and older
- Tetanus - every 10 years

#### Services/Screening

- Medical Nutrition Therapy \_\_\_\_\_
- Smoking Cessation

#### Preventative Care

- PSA - annually
- Mammogram (women 40-65) - annually

### CONGESTIVE HEART FAILURE

#### Laboratory Tests

- Lipid panel (all of the following) - annually
  - Cholesterol
  - HDL
  - LDL
  - Triglycerides

#### Immunizations

- Flu Vaccine - annually
- Pneumococcal Vaccination - 1 lifetime dose for all pts 65 and older
- Tetanus - every 10 years

#### Services/Screening

- Medical Nutrition Therapy \_\_\_\_\_
- Smoking Cessation

#### Preventative Care

- PSA - annually
- Mammogram (women 40-65) - annually

Physician name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature

Date



# Efficiency of Time = Increased Physician Satisfaction

- . The MA's complete the built-in protocols for each condition and automatically update the patient history for the physician to review upon meeting with the patient. This allows more time for the physician to focus on the most important aspects of the care plan and expand on the education provided.

# Care Management Module

- Captures visits, lab values, communication with the Diabetic Educator, clinical team and patient self-management goals etc.
- Details enable Care Manager and physicians to see a complete picture and provide effective care.
- Module contains all the clinical protocols and will also flag missing or out-of-range values.



[Change Password](#) | [Log Out](#)

Appointments	Patient	Encounter	Care Management	Reports (5 new)
Help				

### Care Management Plans - Patient Status

Patient #

Name:  Age: 58 Y Gender: F Phone:

Plan:

Metric	Goal	Achieved	Performed
LDL Screening	In range <= 100 over last 1 measure(s) within 365 days.	√	39.6 on 2010-03-10
Hemoglobin A1C	In range <= 7.0 over last 2 measure(s) within 365 days.	√	5.70 on 2010-09-08 5.90 on 2010-06-10
Diabetic Foot Exam	Performed >= 1 time(s) within 365 days.	√	2010-06-10
Diabetic Eye Exam	Performed >= 1 time(s) within 365 days.	√	2010-10-27
UMA	In range <= 30 over last 1 measure(s) within 365 days.	-	
Blood Pressure	In range < 130/80 over last 1 measure(s) within 90 days.	-	128/82 on 2010-09-07
Body Mass Index	In range < 30 over last 2 measure(s) within 90 days.	√	28.5 on 2010-09-07

5 of 7 achieved (71.43%)



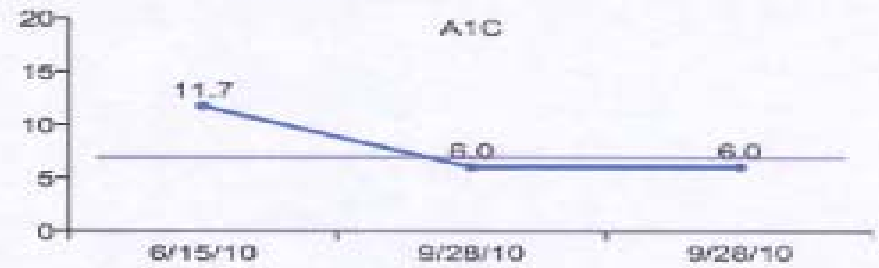
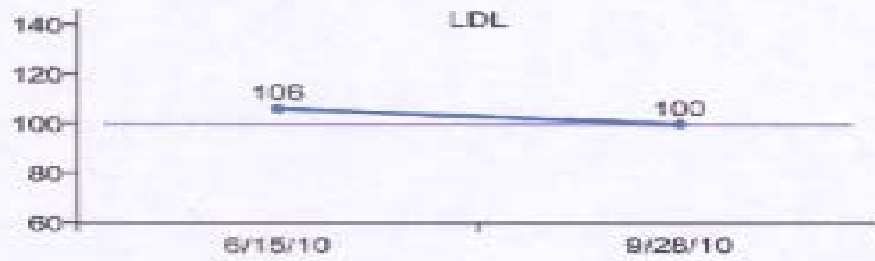
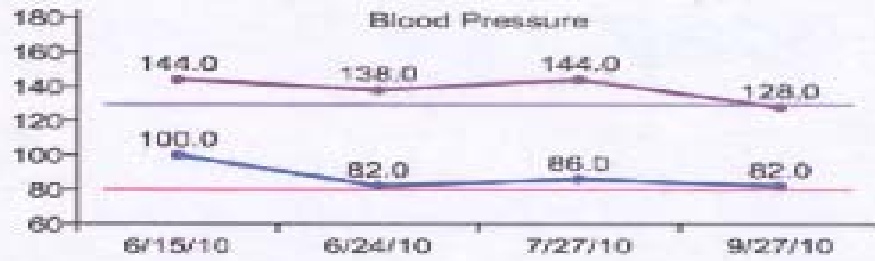
● Encounter   
 ● Lab/Service   
 ● Vital   
 ● Note   
 ● Appraisal

# Patient Satisfaction is Key to Success

- To engage the patient in the management of their care, a patient friendly summary report is generated to illustrate their status on key health indicators and to inform them of the services they will need in the future.
- This summary is provided to the patient as each visit.
- Prevention through education and monitoring

Patient Health Summary - Confidential

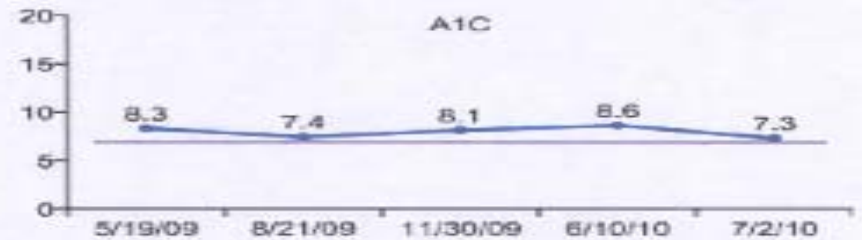
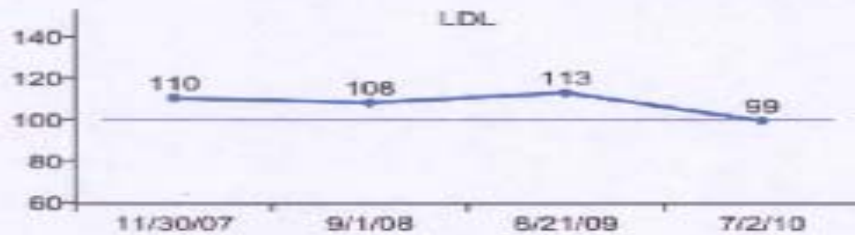
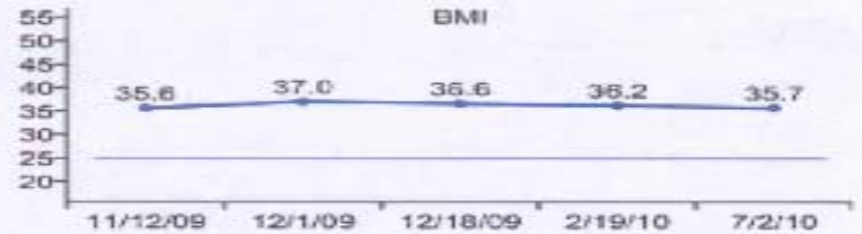
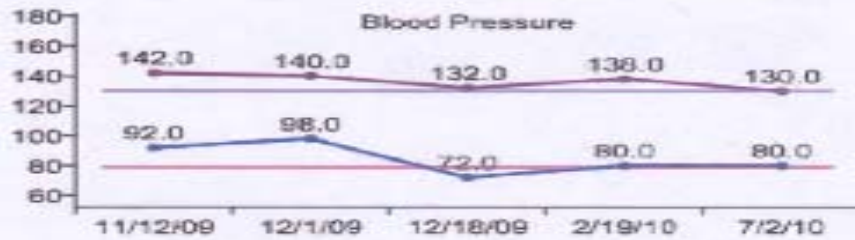
DOB: 3/17/84



Chronic care status	Most recent	Status	Next Due
<i>CAD</i>			
CAD and DM - Statin prescribed	6/24/10	Complete	6/24/11
<i>Diabetes</i>			
Depression Screening	7/27/10	Complete	7/27/11
Diabetic Foot Exam	6/15/10	Complete	6/15/11
Diabetic A1C	9/26/10	Complete	3/27/11
Diabetic Eye Exam		Discussed	Due
Annual Microalbuminuria Screening	6/15/10	Complete	6/15/11
Fasting Lipid Profile	9/26/10	Complete	9/26/11
<i>Preventive</i>			
Pneumovax for Diabetics	7/27/10	Complete	7/27/15
Preventive care status	Most recent	Status	Next Due
<i>Preventive</i>			
Complete Physical Exam		Discussed	Due
Cholesterol Screening	9/26/10	Complete	9/26/11
Patient Provider Agreement	6/15/10	Complete	
Tobacco Use Assessment	6/15/10	Complete	6/15/11
Tetanus/Pertussis Booster	7/27/10	Complete	7/26/17
Seasonal Flu Vaccine	9/27/10	Complete	2/24/11



COB: 4/11/62



Chronic care status	Most recent	Status	Next Due
<i>CAD</i>			
CAD and DM - Statin prescribed	7/2/10	Complete	7/2/11
<i>Diabetes</i>			
A1C Management Change	7/2/10	Due Now	
Diabetic A1C	7/2/10	Complete	12/29/10
LDL Management Change	7/2/10	Complete	12/31/10
Diabetic Foot Exam	7/2/10	Complete	7/2/11
Depression Screening	7/2/10	Complete	7/2/11
Annual Microalbuminuria Screening	7/2/10	Complete	7/2/11
Diabetic Eye Exam	6/10/10	Complete	6/10/11
Moderate Dose Statin for Patients with Diabetes	7/2/10	Complete	7/2/11
Fasting Lipid Profile	7/2/10	Complete	7/2/11
<i>Hypertension</i>			
Hypertension and DM - ACE/ARB prescribed	7/2/10	Complete	7/2/11
<i>Preventive</i>			
Pneumovax for Diabetics		Discussed	Due
Preventive care status	Most recent	Status	Next Due
<i>Preventive</i>			
Complete Physical Exam		Discussed	Due
Cholesterol Screening	7/2/10	Complete	7/2/11
Patient Provider Agreement	6/21/09	Complete	
Prostate Screening Exam		Discussed	Due
Tetanus/Perdussis Booster	6/21/09	Complete	6/20/16
PSA	11/30/09	Complete	11/30/10
Seasonal Flu Vaccine	2/19/10	Due Now	

# Staff is Key to Continued Success

- As with all new projects, excitement and focus wanes after time.
- Communication must be constant with evidence of benefits for effort and time commitment.
- Constant staff support and review of roles.
- Job satisfaction increases as the process becomes routine and successes are celebrated.

**Mercy Family Care - Marysville**

Count of DM patients 18-75 yo

Pct of DM patients with latest BP <130/80

Pct of DM patients with eye exam

Pct DM pts w/ medical attention for nephropathy

Pct of DM patients with latest BP <140/90

Pct of DM patients with latest LDL <130

Pct of DM patients with current flu vaccination

Pct of DM patients with SM Goal

Pct of DM pts with pneumo vacc

Pct of DM patients referred for eye exam

Pct of DM patients with ≥=1 A1Cs

Goal	Dec-19
	247
70	36.437
80	57.49
80	68.016
80	70.446
80	57.688
70	41.286
50	
80	14.576
80	
50	85.62

Pct of DM patients with latest A1C >9

Pct of DM patients with latest LDL <100

Pct DM pts w/ smoking cessation counseling

Pct of DM patients with latest A1C <7

Pct of DM patients with ≥=1 LDLs

Pct of DM patients with foot exam

Pct of DM patients aged 40-75 on aspirin

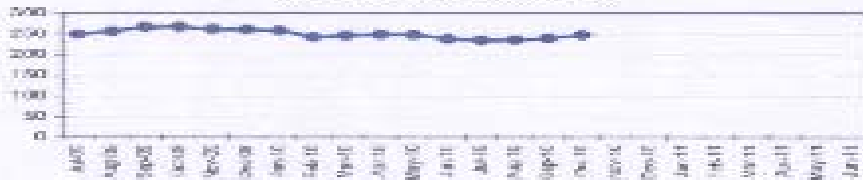
Pct of DM pts 55-75 taking ACE/ARB

Pct of DM pts prescribed a statin

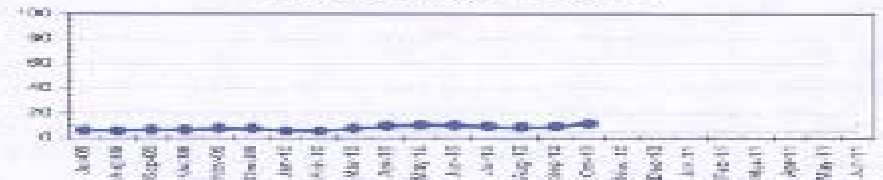
Pct of DM patients queried about tobacco use

Goal	
5	11.336
70	34.818
90	23.077
75	42.915
90	79.757
90	72.066
85	13.761
75	
80	72.018
90	72.47

Count of DM patients 18-75 yo



Pct of DM patients with latest A1C >9



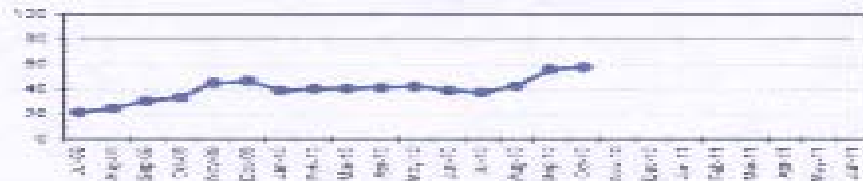
Pct of DM patients with latest BP <130/80



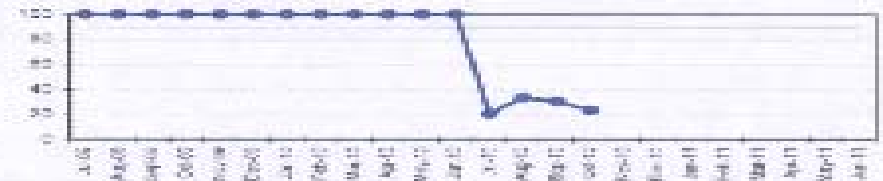
Pct of DM patients with latest LDL <100



Pct of DM patients with eye exam



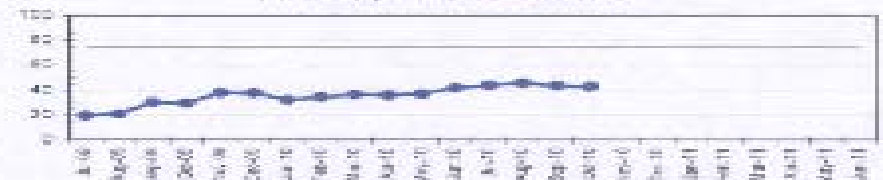
Pct DM pts w/ smoking cessation counseling



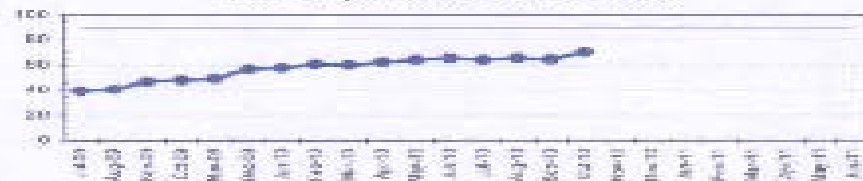
Pct DM pts w/ medical attention for nephropathy



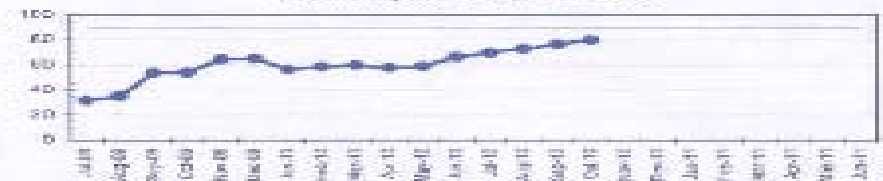
Pct of DM patients with latest A1C <7



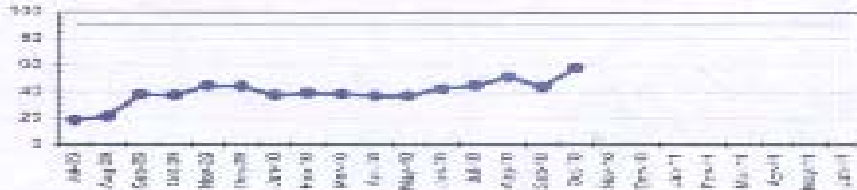
Pct of DM patients with latest BP <140/90



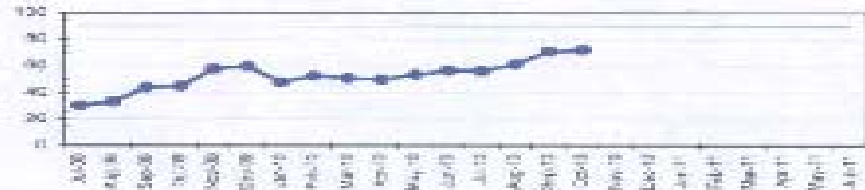
Pct of DM patients with ≥=1 LDLs



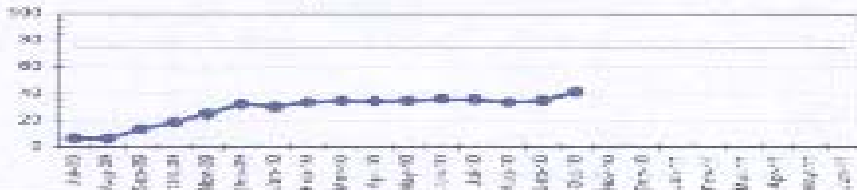
Pct of DM patients with latest HbA1c <100



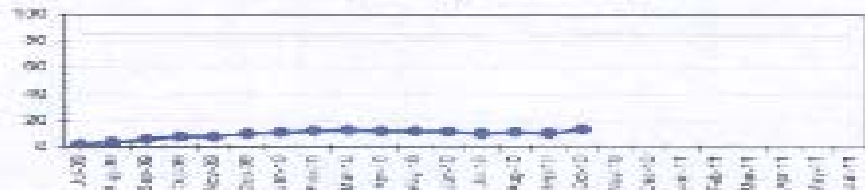
Pct of DM patients with foot exam



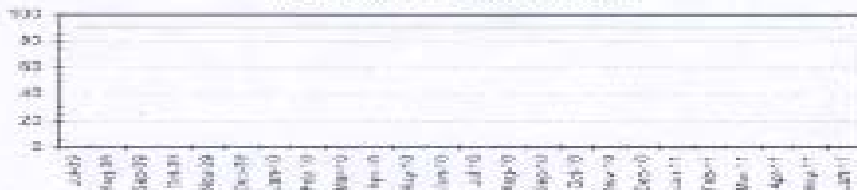
Pct of DM patients with current flu vaccination



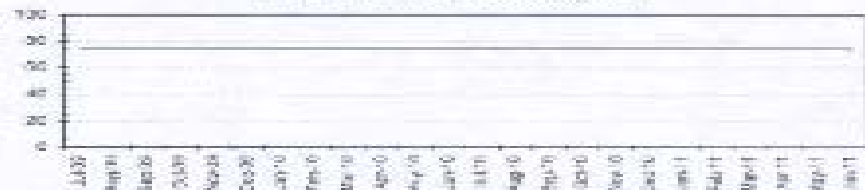
Pct of DM patients aged 40-75 on aspirin



Pct of DM patients with BMI <30



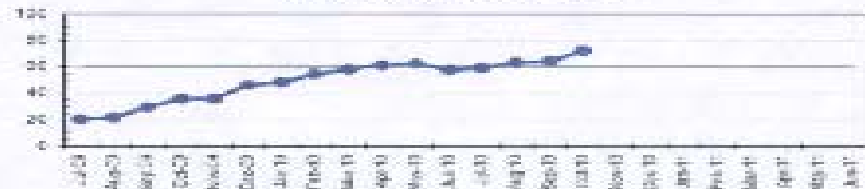
Pct of DM pts 45-75 taking ACE/ARB



Pct of DM pts with previous visit



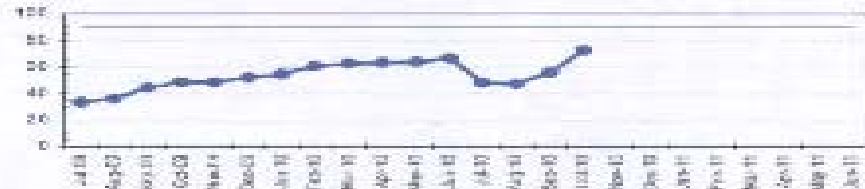
Pct of DM pts prescribed a statin



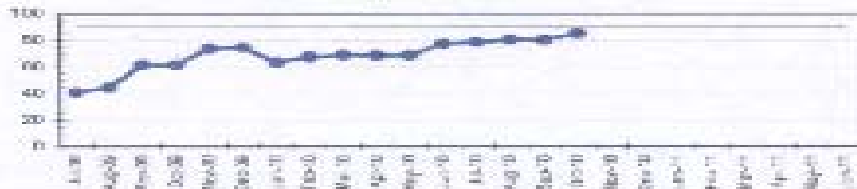
Pct of DM patients referred for eye exam



Pct of DM patients queried about tobacco use

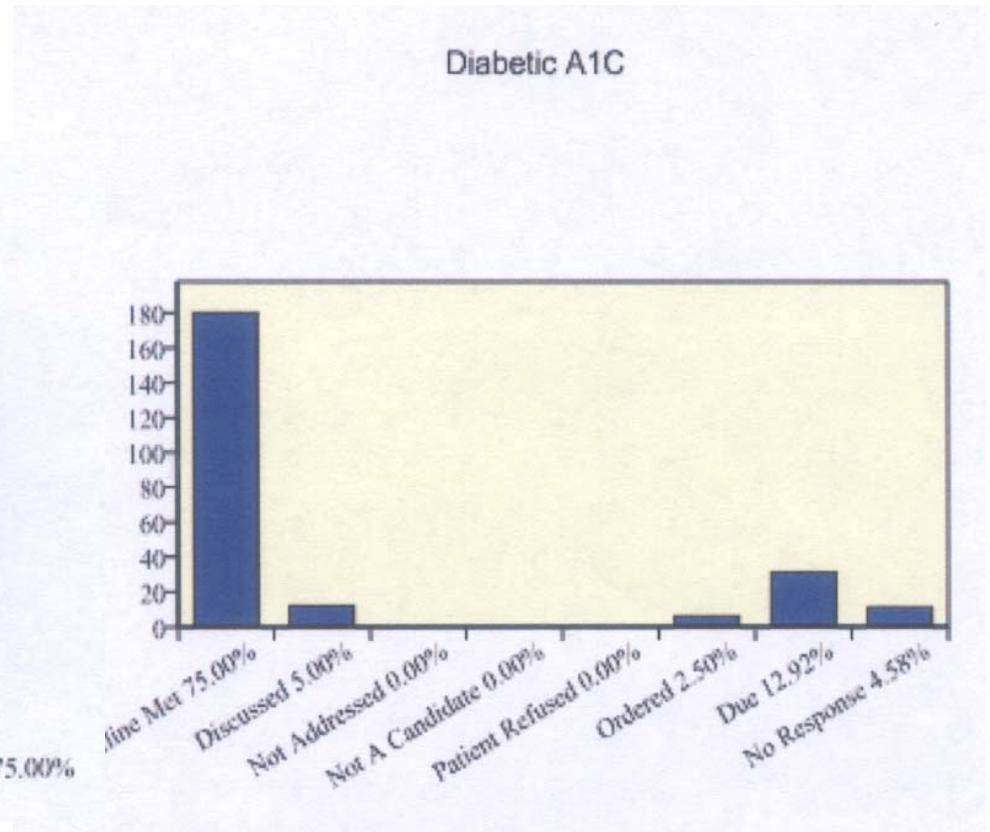
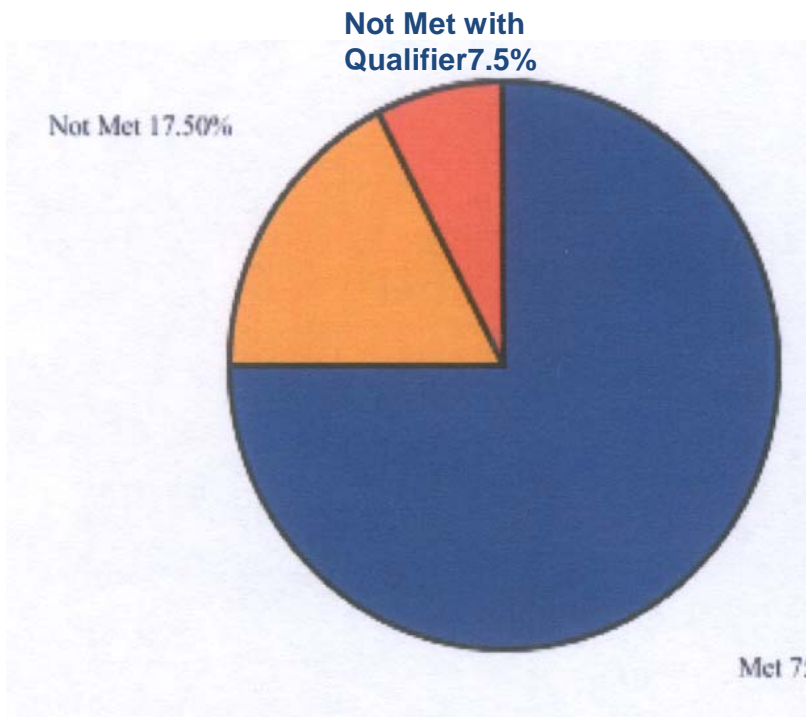


Pct of DM patients with HbA1c <7



# Performance Reports from Cielo

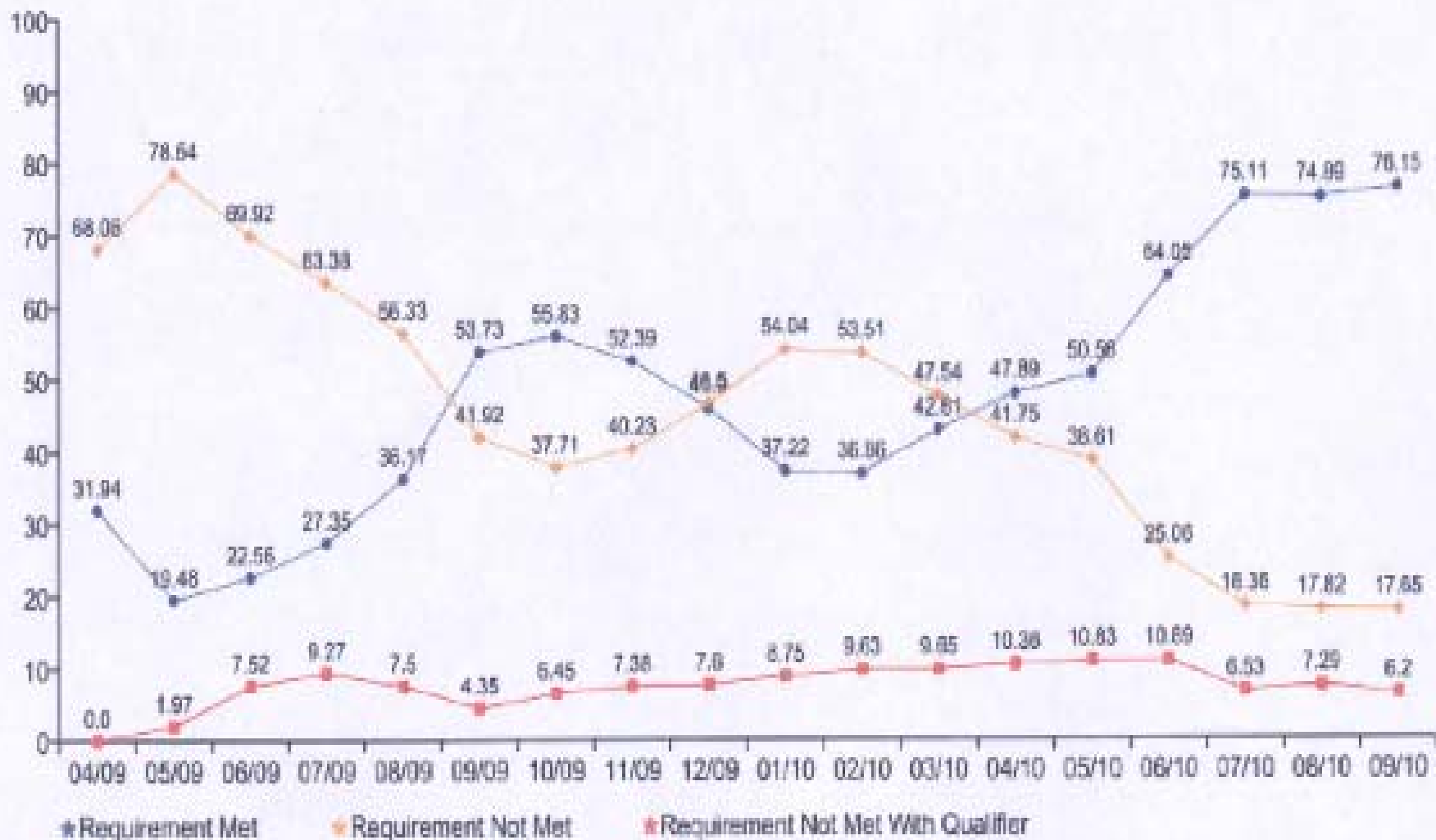
## Diabetic A1C – Performance Detail





# Performance Reports from Cielo

Diabetic A1C - Performance Over Time



# Clinical Performance Report

As Of 11/16/10

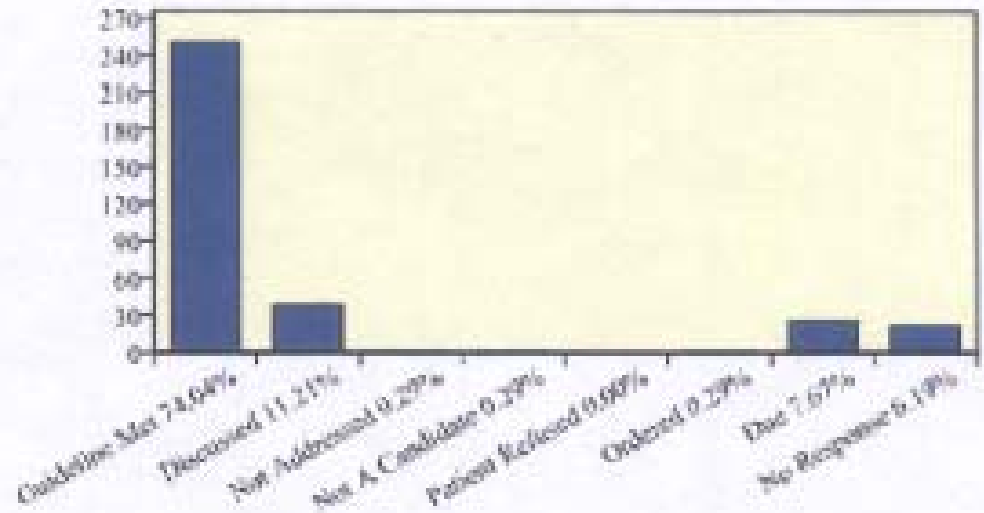
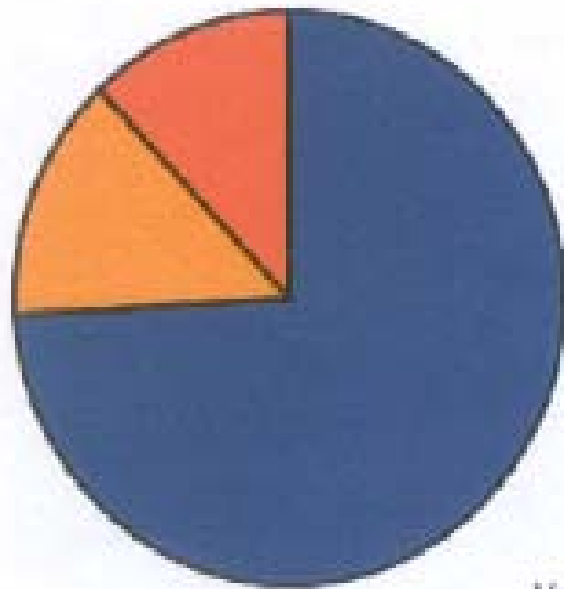
Patients Seen

Fasting Lipid Profile for DM or CAD Patients - Detail View

Site	Team	Provider	Guideline Met	Guideline Not Met	Discussed	Not Addr.	Not Cand.	Ordered	Refused	Due	No Response	Total Patients
2	MFC	Robert Gamara	181	50	18	1	1	0	0	15	15	211
	MFC	Dawn Lambrecht	90	38	20	0	0	1	0	11	6	129
2	MFC Total		251	88	38	1	1	1	0	26	21	339

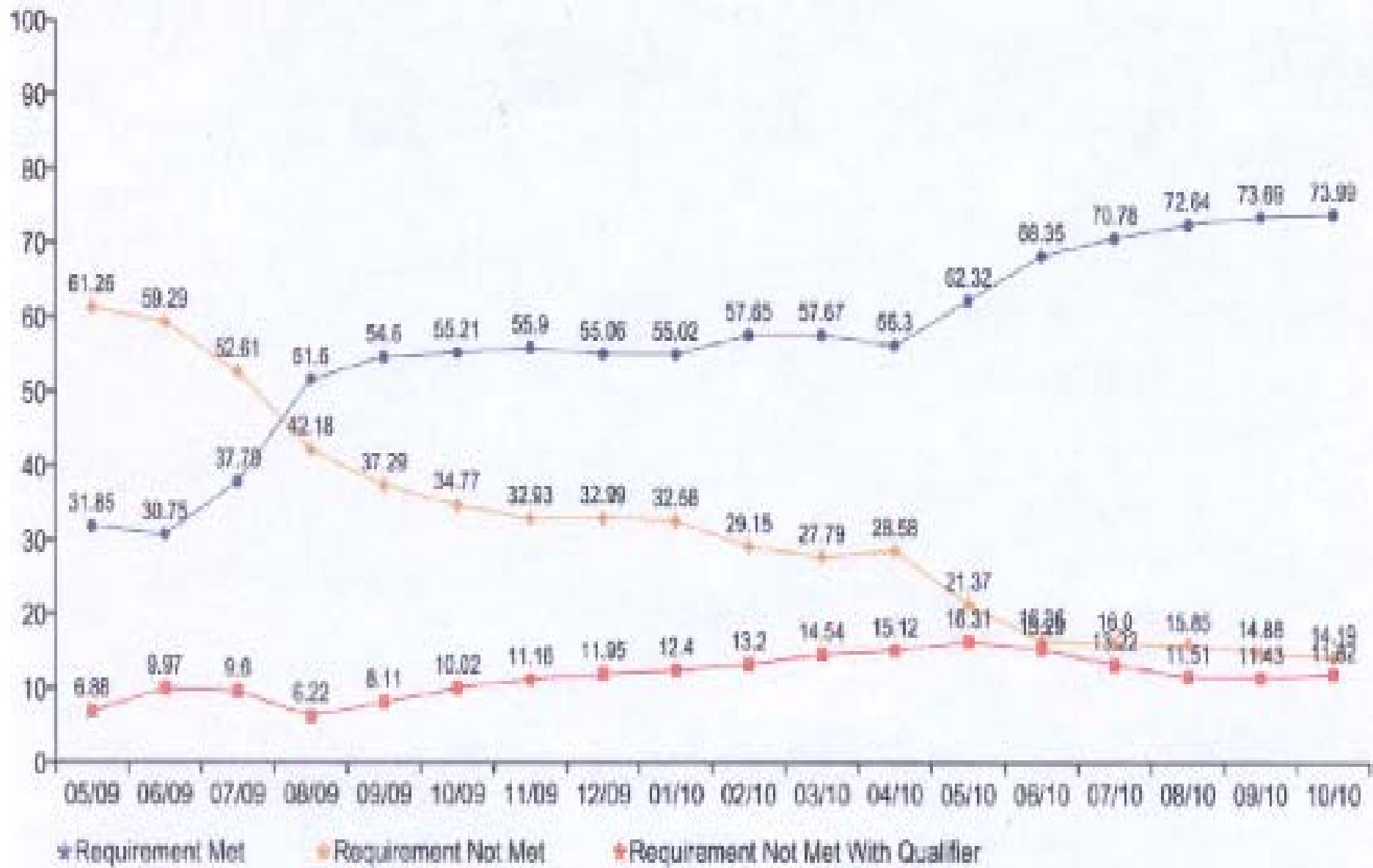
## Fasting Lipid Profile for DM or CAD Patients

Fasting Lipid Profile for DM or CAD Patients  
Not Met 13.86%



Met 74.04%

Fasting Lipid Profile for DM or CAD Patients - Performance Over Time



# **Show me the \$\$\$**

**2010 For 3 Trinity Employed Physicians**

Dollars from Managed Care HEDIS

Dollars from BCBSM PGIP (2 providers)

More than \$80,000.00

**Potential for more dollars as we have implemented a more intense outreach\***

\*Patients, identified by the registry, who haven't been in to see the physician.