HEALTH & HUMAN SERVICES

IT DOMAIN PROGRAM MANAGEMENT OFFICE

Promoting the advancement of the Health, Safety, and Well-Being of the American People

The Role of Informatics in New Healthcare Delivery Organizations: Medical Home and ACOs

MEBI 590 - Autumn 2011
Biomedical and Health Informatics Lecture Series
December 6, 2011
Theresa Cullen, MD, MS
HHS IT Doman PMO
HHS

DISCUSSION

- Developing a health informatics road map to support redesigned delivery models is essential to achieving the goal of health equity.
- The success of Patient Centered Medical Homes and Accountable Care Organizations is dependent upon appropriate information technology support.
- Further assessment is needed to determine what program needs and functions are currently met as well as what is needed to transform and increase meaningful use, improve quality, and further overall community health.

Health Care Action Imperative

- **Usual approaches to change are inadequate**
  - Current health care model is unsustainable
  - High innovation and success in scientific advances
  - Little innovation and success in transforming care delivery model
  - Most HIT only mimics what you used to do, not what we should do
    - Technology doesn't match workflow
    - Technology doesn't augment workflow
    - Workflow may be the problem
- **Little innovation and success in care delivery model**
- **Historically limited success in health care delivery demonstration models**
  - Difficult to isolate predictors for success from medical home pilots
  - Relationship to underutilizing IT infrastructure
    - Is it the right infrastructure
- **Proposed New Models- Medical Home/ Accountable Care Organizations**
    - Novel? New? Old model with new name?

Why do we do this?

FOR THE PATIENT

FOR THE FAMILY

FOR THE COMMUNITY

FOR THE POPULATION

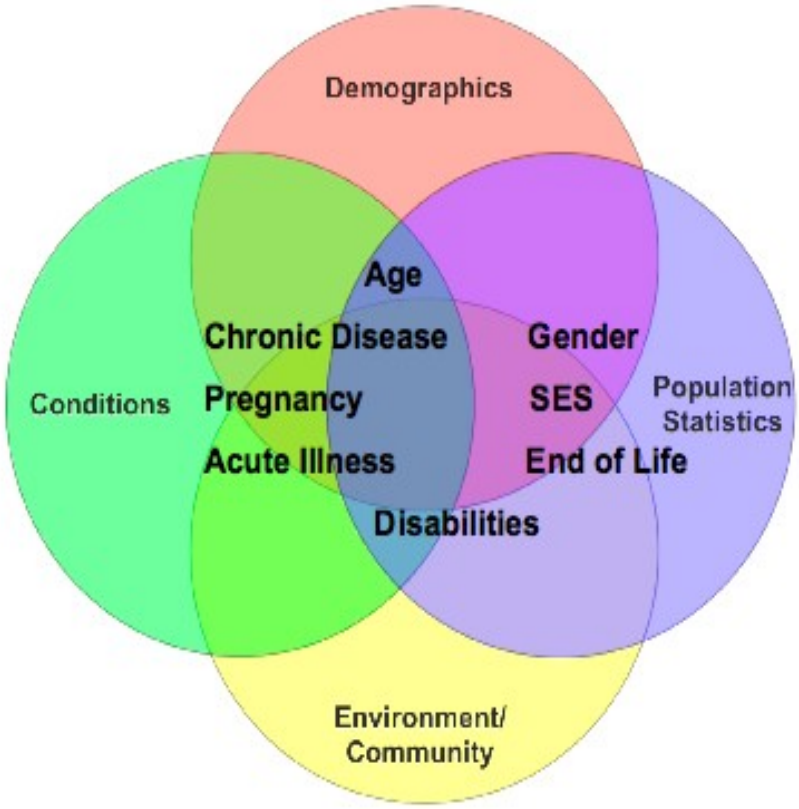
Health and HIT

THERE IS MAGIC HERE!

- This is a long, arduous journey
- Innovative HIT makes a difference
- Key Elements of Success in HIT system
  - Broad Picture of Health
  - Clinical Voice at the Table
  - Attention to the Family and Community
  - Making it Work

A Broader Picture of Health

- Personal Health
- Family Health
- Community Health
- Public Health
- Population Health
- Transparency of Data



Patient and community sharing of information- demographics, environment, population data, and health conditions

Henry Ford Moment

- True innovation of a new model of care
  - Lots of people doing innovation
  - Need high velocity change
  - Need art
- What is/are the new delivery model(s)
  - Patient
  - Provider
  - Family
  - Community

What do we know is required to change the outcome ?

- Access to primary care
- Access to specialists
- Access to medications
- Sharing of information with providers
- Electronic health records
- Registries (or equivalent functionality)
- Performance measures
- Electronic reminders

All required but insufficient

- Radical Change
  - Go beyond tweaks
  - Innovation muted due to systemic flaws, slow cycle of development, wrong people at the table, suboptimal implementation and operation
- What do you really need to transform outcomes?
  - What is the right question to ask
- Systematized way of recording, aggregating and integrating health records
  - Inclusion of narrative medicine
- Scientific and humanistic decision making
- Care manager
- Sense of stability; piece of mind; optimism; touch

Key IT Questions For Programs

- What are the priorities that would change our investment goals?
- What are the program needs and functions that are not being met?
  - Can you standardize the question and the response?
- Which systems need to work better together?
  - What is the mechanism to share the data between and within
- What do we need to communicate better to make our systems or processes more useful?
  - What 'data' needs to be shared and how
- How to improve our systems? What should we add, what should we remove?
- What can we do to transform and increase meaningful use, improve quality, and further overall community health?

Principles of the PCMH

- ***Personal physician (or health care team)***
- ***Physician / Team directed medical practice***
- ***Whole person/family/ community orientation***
- ***Care is coordinated and/or integrated***
- ***Quality and safety***
  - Practices advocate appropriately for their patients
  - Evidence-based medicine and clinical decision-support tools guide decision making.
  - Continuous quality improvement
  - Patients and families actively participate in decision-making
  - Information technology supports optimal patient care, performance measurement, patient education, and enhanced communication..
  - Patients and families participate in quality improvement activities at the practice level.
- ***Enhanced access*** to care
- ***Payment*** recognizes the value provided to patients who have a patient-centered medical home

Using IT to Support PCMH
Resources that Matter

- Workflow and care must drive HIT
  - Ideal workflow and care
- Systems that support Redesign
  - For access, delivery, assessment, continuity
- Access to care
  - Mobile applications, telemedicine, changes in data access for decision making
- Health Information System
  - Robust, point of care, ability to on the fly assess data sets and return results
- Decision Support
  - At point of care, timely, comprehensive
- Self Management and Care Planning
  - Of patient, family and community

PCMH 2011

PCMH 1: Enhance Access and Continuity

- Provide method to designate primary provider
- Create care teams
- Monitor appointment wait times and office visit times
- Monitor access to specialists

PCMH 2: Identify and Manage Patient Populations

- Create defined panel lists
- Create and distribute reminders
- Use of diagnostic tags to monitor disease/conditions
- Use of disease/condition-specific registries equivalents
- Provide demographic information
- Facilitate Community outreach

PCMH 3: Plan and Manage Care

- Access to Health IT data from various system components
- Plan care through use of reminders
- Provide risk factor assessment, including falls
- Facilitation of care management
- Monitor continuity of PCP and team care
- Include robust behavioral health care components
- Care Plan functionality (under development)

PCMH 4: Provide Self-Care Support and Community Resources

- Provide summary care pages and reports
- Referral to online resources, health promotion and education
- Facilitate Community Health Rep outreach

PCMH 5: Track and Coordinate Care

- Create care teams
- Create defined panel lists
- Create and distribute reminders
- Monitor continuity of PCP and team care

PCMH 6: Measure and Improve Performance

- National Measures, MU, Improving Patient Care, ACO
- Patient, provider, facility and community level measurements
- Monitor ER and UC usage; readmission
- Monitor local patient/caregiver experience

Accountable Care Organizations

- Approach that embodies the triple aim
  - improvements in patient outcome/ quality
  - Improvements in population health
  - Cost efficiency
- Virtual integration through information
- Primary care/specialty/ sub-specialty/ hospital
- Integrated with medical home
- Shared financial risk
- Transformation to integrated care model

ACO challenges

- Incent by value
- Focus on individual as well as population (not a secondary use of data)
- Level of integration
- FFS to ACO: Cultural transformation of delivery model as well as payment model
- Shared savings distribution

What do you need for ACO

- ACO requirements based on final rule
  - HIT system is a weighted quality metric
  - 33 measures in 4 domains
  - Flexible start date in 2012

- HIT system needs
  - Clinical Information and POC information
  - Identify management/ MDM
  - HIE
  - Patient engagement
  - Care management and coordination
  - Performance management

Salient Points

- Connecting IT to the patient and the community requires IT that is pertinent to the patient and the community
- Once a need is identified, IT must respond quickly to these needs of the patient and community
- Understanding context and integrative effects is necessary for impact, change, and improving equity

One example: IHS Patient Centered Medical Home

- Elements of the Indian health medical home:
  - Care is centered on the patient and family – health programs design their services to put the patient and family at the center of care.
  - A "care team" approach applies to highly functioning teams coordinating care to meet the needs of the patient.
  - Access and continuity of care – Every patient has a relationship with a provider and care team, and has consistent and reliable access to that provider and care team.
  - A community focus guides all activities.

iCare Population Management

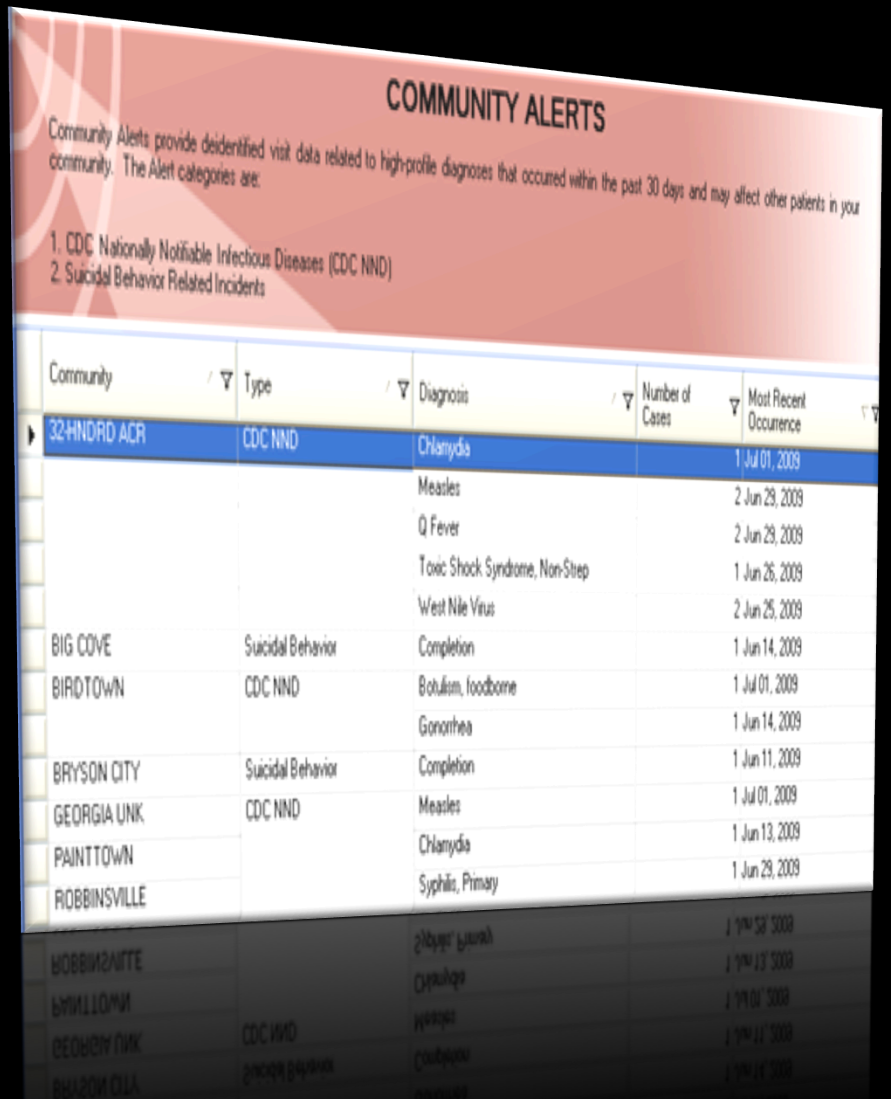
- Provides an intuitive, integrated view into diverse patient data elements for populations as well as individuals
- Facilitates the proactive identification and management of populations
- Supports easy creation and customization of panels of patients
- Nationally deployed in May 2007
- Iterative, phased development
- Active workgroup, change control board and Subject Matter Expert involvement

iCare – Background Processes

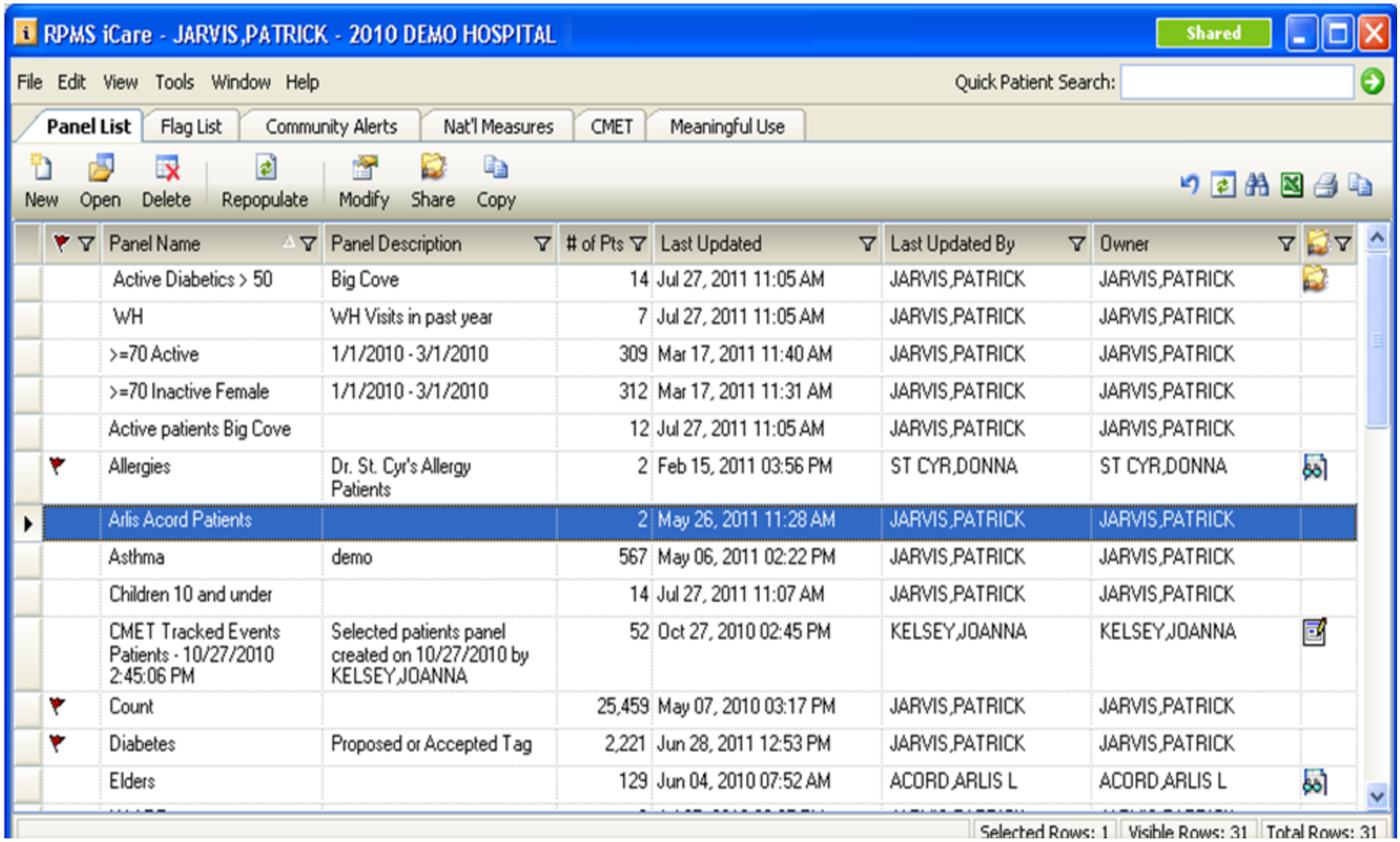
- Test
- Performed routinely - both nightly and weekly
- Allows for quick panel creation and data display
- Provides Clinical Decision Support
  - Community Alerts
  - Flags
  - Reminders
  - Performance Measures
  - Best Practice Prompts
  - Care Management Event Tracking
  - Meaningful Use

iCare – Community Alerts

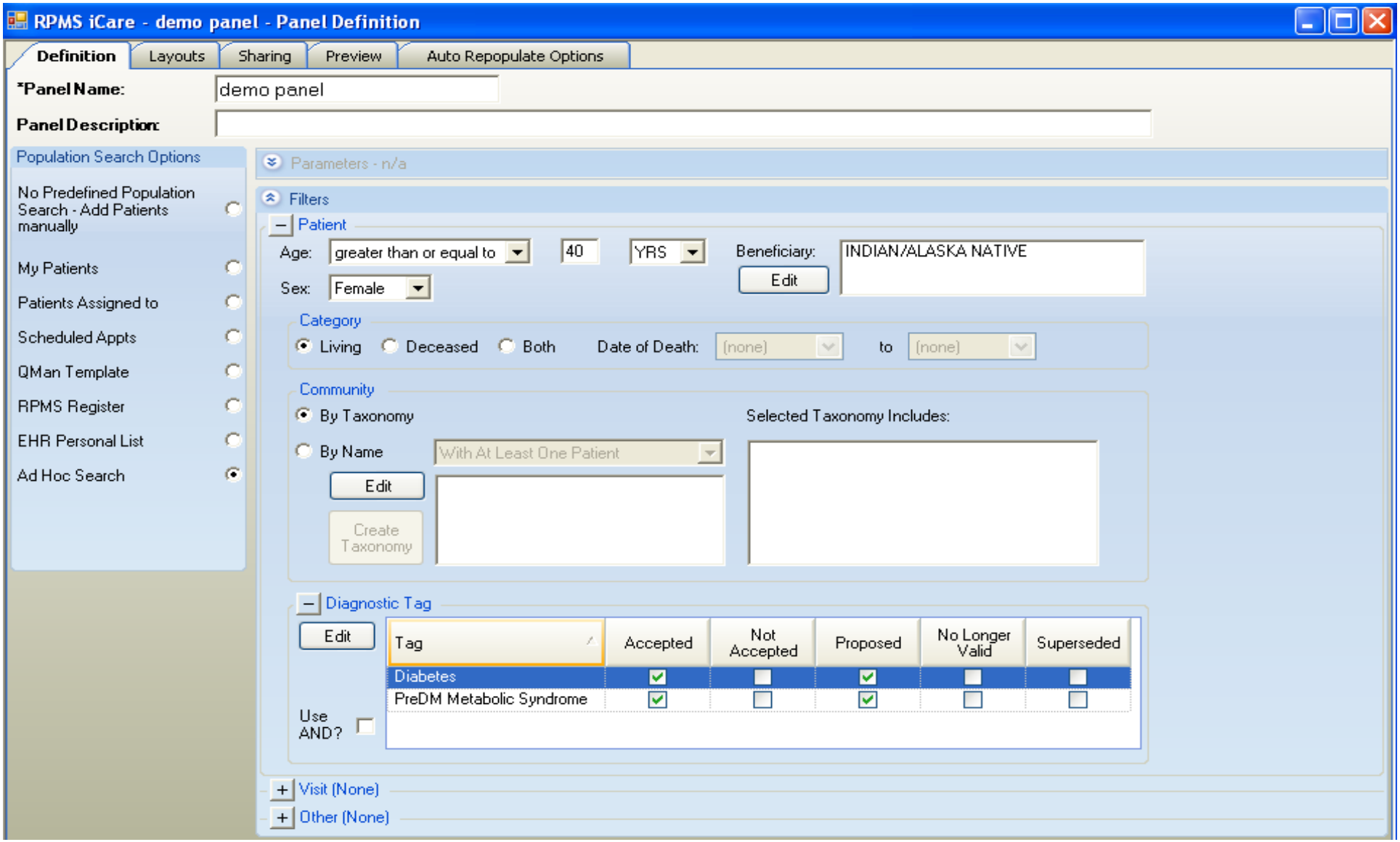
- Splash Screen at first login of the day
- Anonymous
- Related to Community of Residence
- Ready Access from many views: Opening View; Panel View; Patient Record
- User-defined display



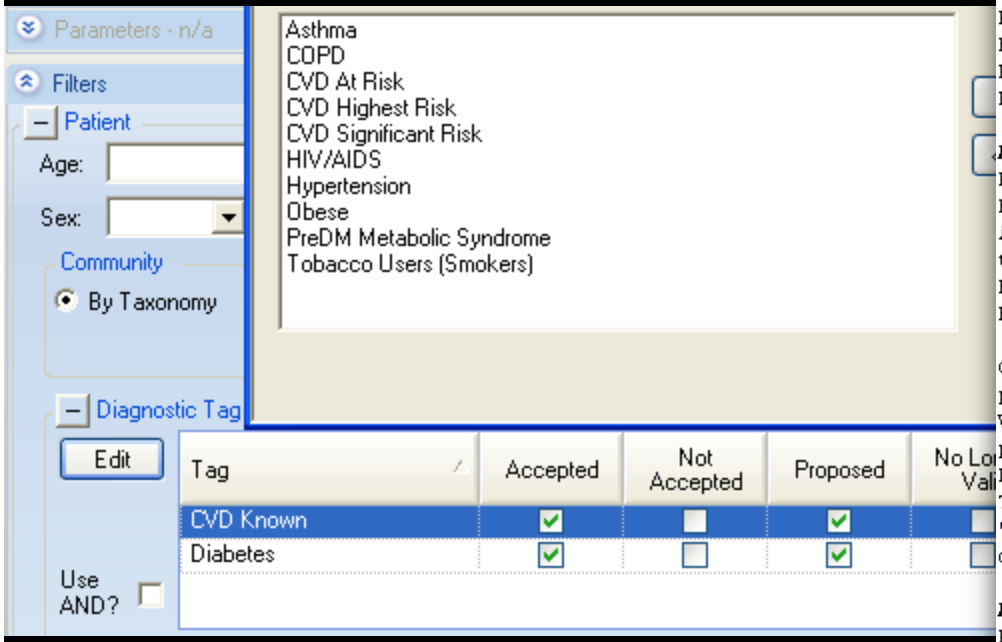
iCare – Opening View



iCare – Panel Creation



iCare – Diagnostic Tags



Currently ten DX tags available. Pregnancy will be added with version 2.3 due in October 2011. Always open to add more based on user feedback!

Diabetes **[DM]**
Patients with at least 2 primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or 1 instance on Active Problem List. Diabetes defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy).

HIV/AIDS **[HIV]**
Patients with at least 2 primary diagnosis POVs ever for ambulatory or hospitalization visits at least 60 days apart or 1 instance on Active Problem List; OR at least two CD4 or HIV Viral Load lab tests in the past two years, at least 60 days apart; OR positive result from an HIV screening test. HIV/AIDS defined as ICD 042. 44.9; 795.71; V08 (BGP HIV/AIDS DXS).

CD4 lab tests defined by the site as lab tests in BGP CD4 TAX, or predefined CPTs or LOINC (BGP CD4 CPTS or BGP CD4 LOINC CODES). HIV Viral Load lab tests defined by the site in BGP HIV VIRAL LOAD TAX, or predefined CPTs or LOINC codes (BGP HIV VIRAL LOAD CPTS or BGP VIRAL LOAD LOINC CODES). HIV screening test defined by the site in BGP HIV TEST TAX; positive result is defined as a value containing "p," "P," ">," or "+". (NOTE: CPTs and LOINC codes are not reviewed because they will not contain a result.)

Hypertension **[HTN]**
Patients with at least 2 primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or 1 instance on Active Problem List. Hypertension defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).

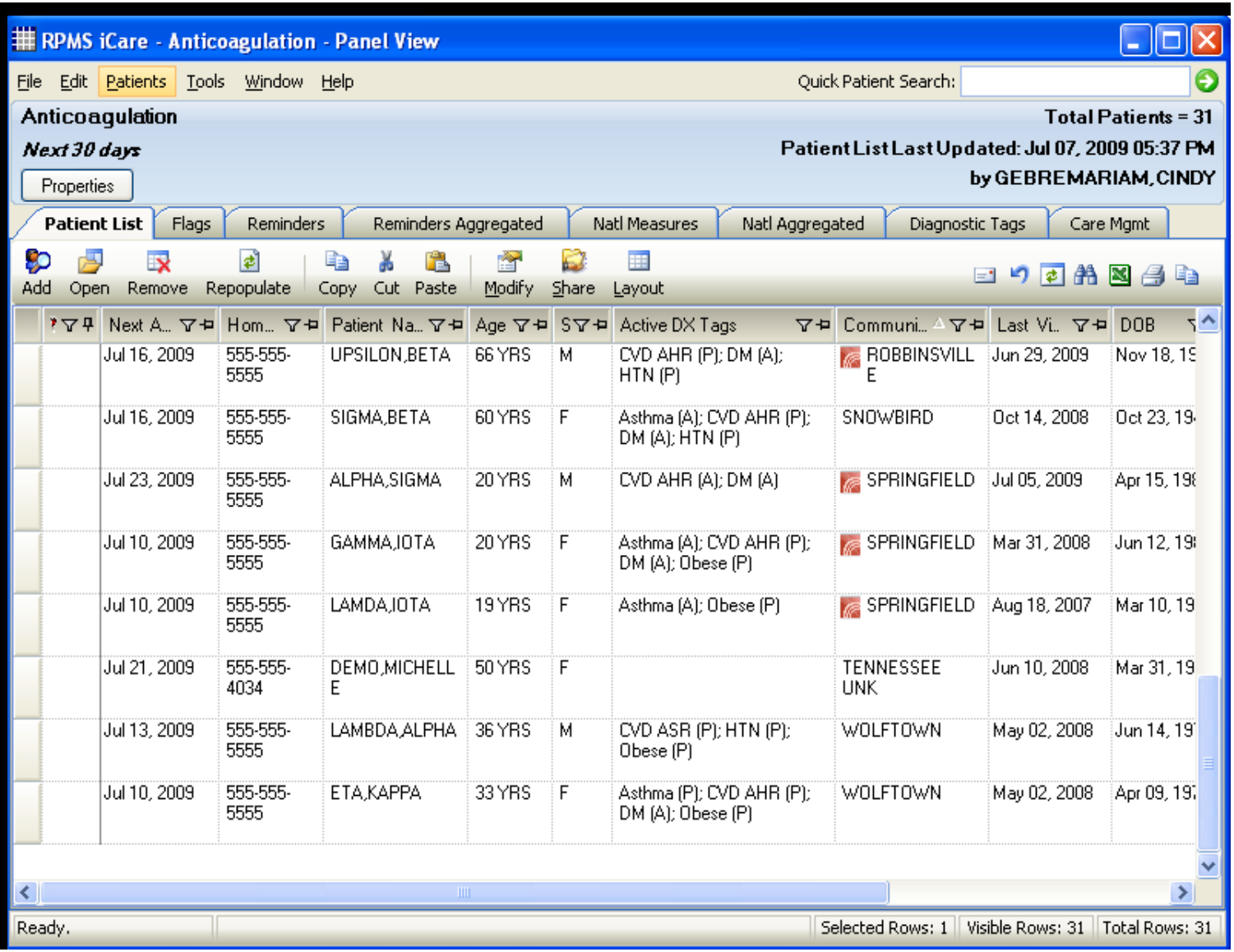
Obese **[Obese]**
Adult patients (ages 19 and older) with most recent adult BMI equal to or greater than 30. Values for patients ages 18 and under are based on standard tables. BMI is not a stored value but is calculated at the time the logic is run, based on the most recent height and weight data in the Measurement file. For ages 18 and under, a height and weight must be taken on the same day in the past year. For ages 19 through 49, height and weight must be recorded within the last 5 years, not required to be

iCare – Panel View/Patient List

Quick look at your patients.

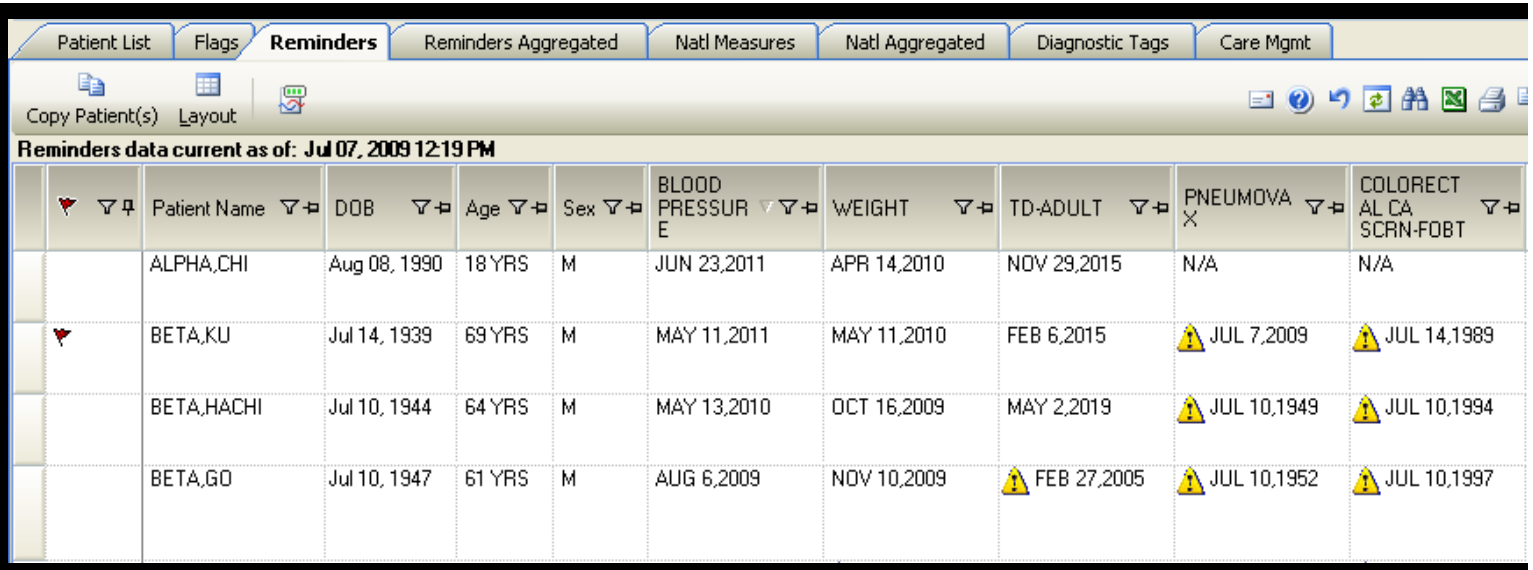
Customize the view to suit your needs.

Share your panels and custom layouts with others.

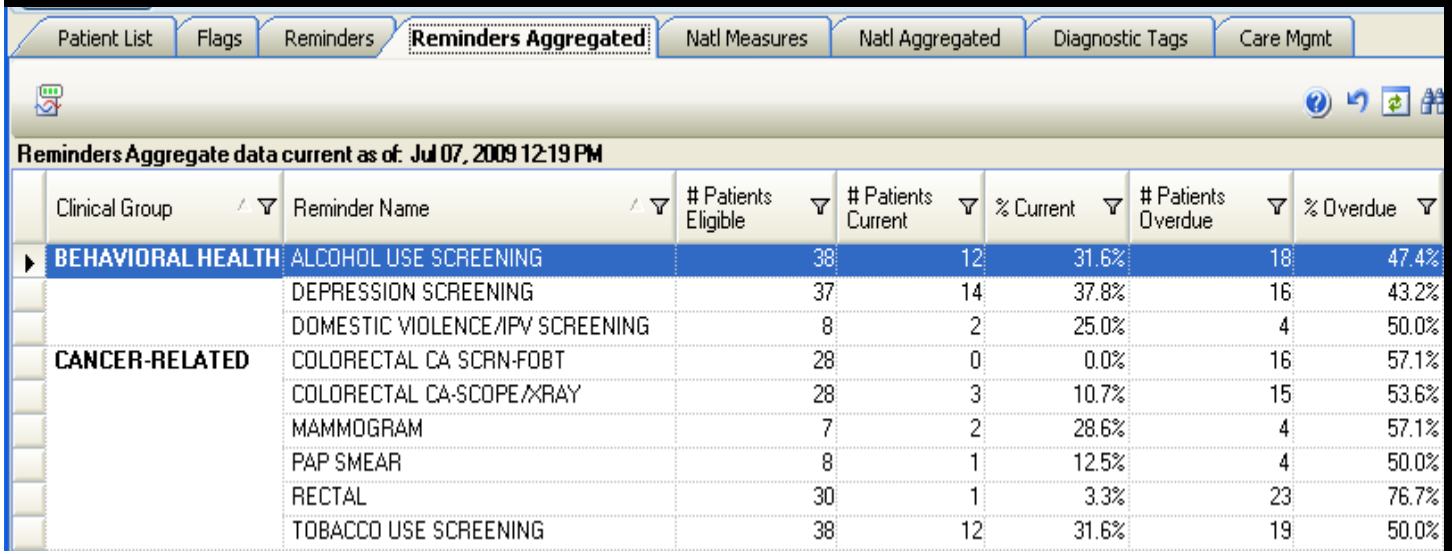


Clinical Decision Support – Reminder Views

Users select Reminders display



Patient Name	DOB	Age	Sex	BLOOD PRESSURE	WEIGHT	TD-ADULT	PNEUMOVAX	COLORECTAL CA SCRN-FOBT
ALPHA,CHI	Aug 08, 1990	18 YRS	M	JUN 23,2011	APR 14,2010	NOV 29,2015	N/A	N/A
BETA,KU	Jul 14, 1939	69 YRS	M	MAY 11,2011	MAY 11,2010	FEB 6,2015	⚠ JUL 7,2009	⚠ JUL 14,1989
BETA,HACHI	Jul 10, 1944	64 YRS	M	MAY 13,2010	OCT 16,2009	MAY 2,2019	⚠ JUL 10,1949	⚠ JUL 10,1994
BETA,GO	Jul 10, 1947	61 YRS	M	AUG 6,2009	NOV 10,2009	⚠ FEB 27,2005	⚠ JUL 10,1952	⚠ JUL 10,1997

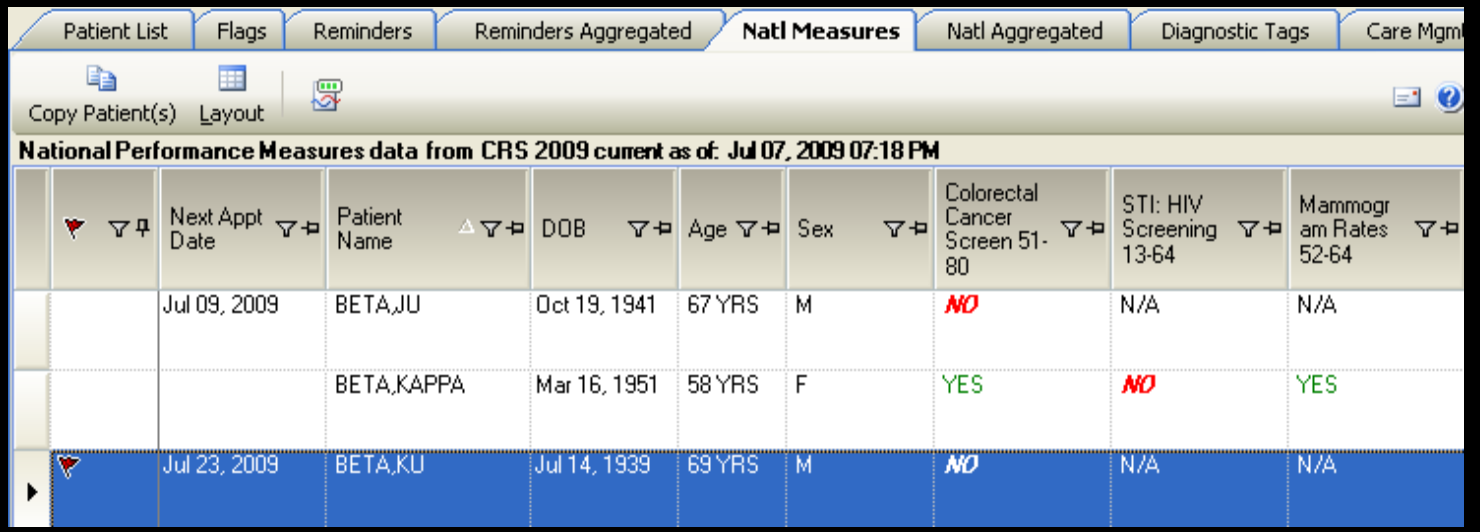


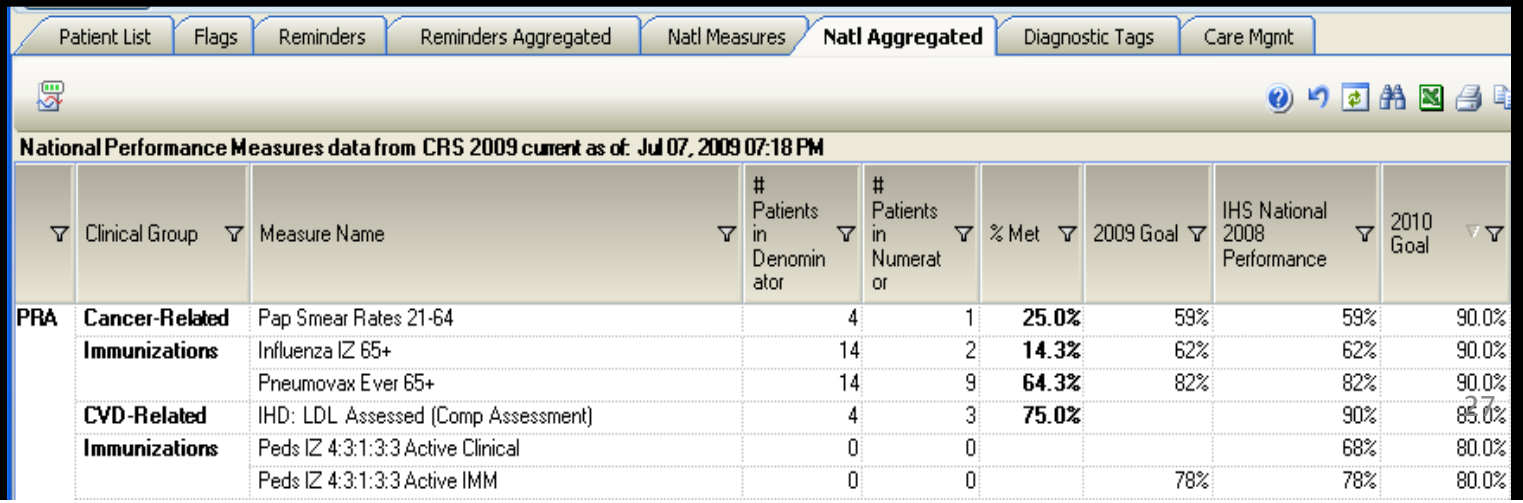
Clinical Group	Reminder Name	# Patients Eligible	# Patients Current	% Current	# Patients Overdue	% Overdue
BEHAVIORAL HEALTH	ALCOHOL USE SCREENING	38	12	31.6%	18	47.4%
	DEPRESSION SCREENING	37	14	37.8%	16	43.2%
	DOMESTIC VIOLENCE/IPV SCREENING	8	2	25.0%	4	50.0%
CANCER-RELATED	COLORECTAL CA SCRN-FOBT	28	0	0.0%	16	57.1%
	COLORECTAL CA-SCOPE/XRAY	28	3	10.7%	15	53.6%
	MAMMOGRAM	7	2	28.6%	4	57.1%
	PAP SMEAR	8	1	12.5%	4	50.0%
	RECTAL	30	1	3.3%	23	76.7%
	TOBACCO USE SCREENING	38	12	31.6%	19	50.0%

Aggregate View

Clinical Decision Support – National Measure Views

Users select Nat'l Measure Display

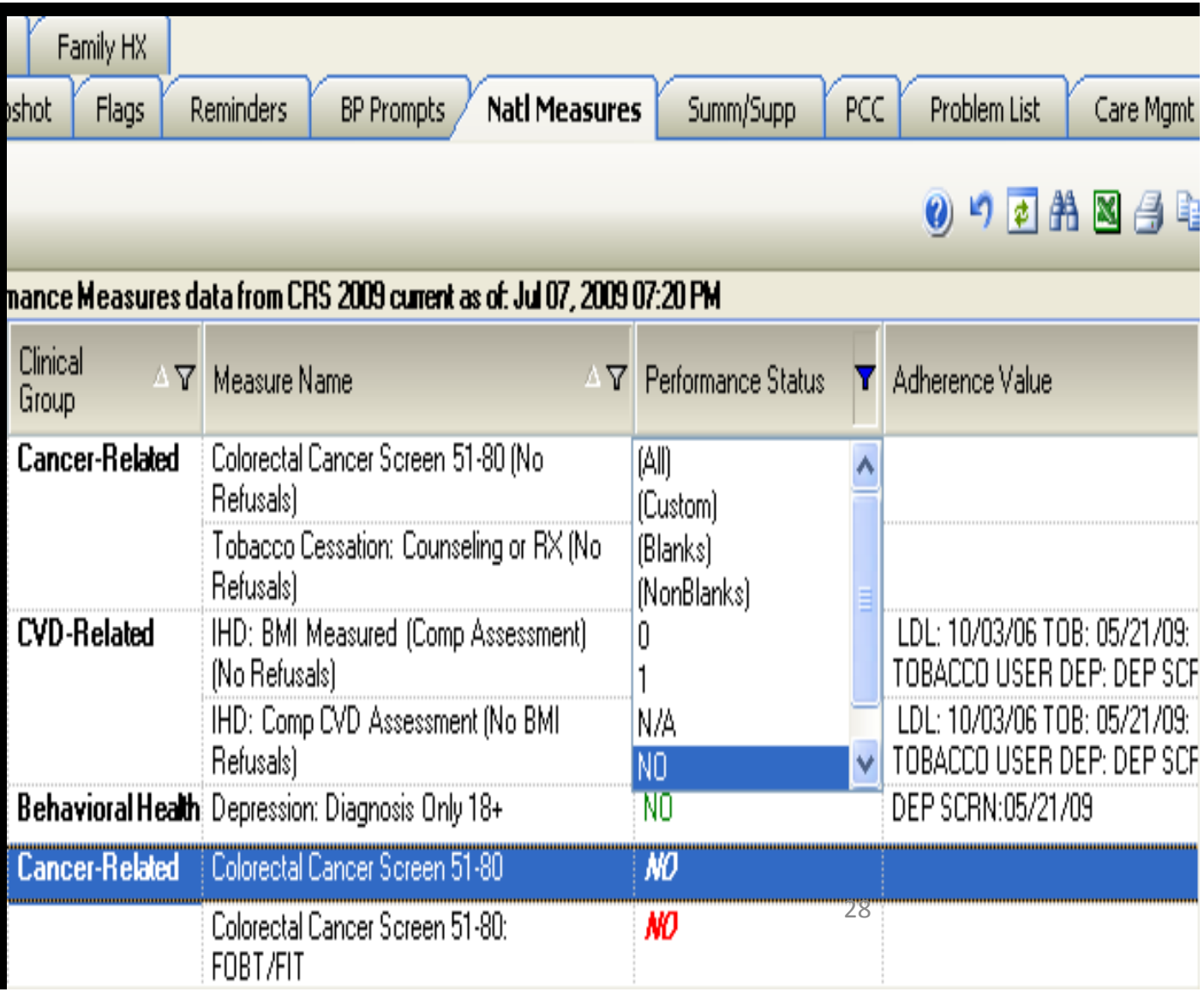




Aggregate View

iCare – Patient Record / National Measures

Through out iCare you can filter results to see only the data you are interested in focusing on.



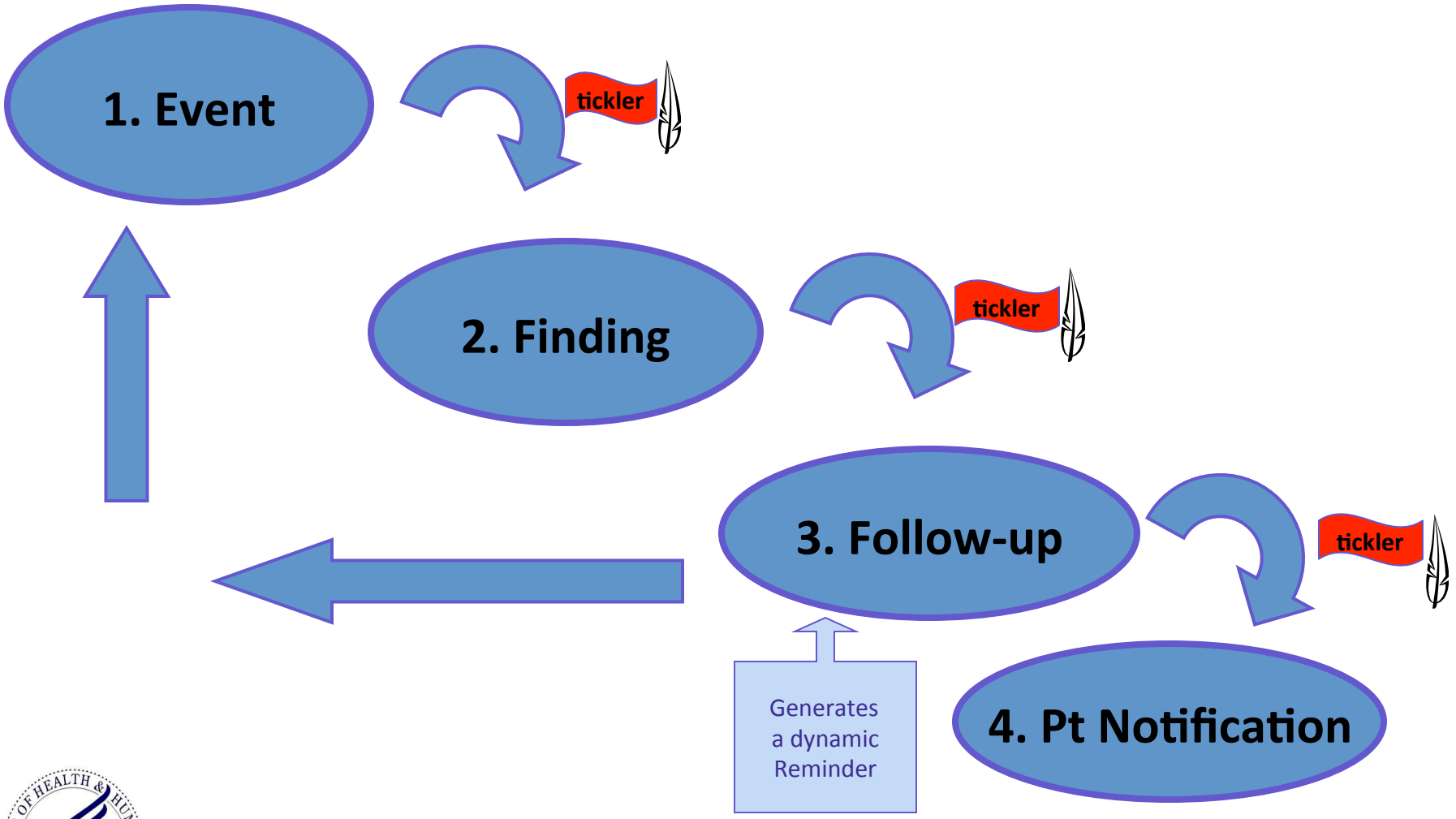
iCare v2.1 Introduced CMET

- CMET = Care Management Event Tracking
- Provides ability to track certain pre-defined events
  - Breast
  - Cervical
  - Colon
  - Skeletal health
- Workflow includes four steps
  - Event (a mammogram, for example)
  - Findings (Bi-Rad 3)
  - Recommendations for Follow-up (repeat mammogram in six months)
  - Patient Notification (documentation that the patient has been informed of the Findings and Recommendations).
  - CMET generates “ticklers” or reminders to ensure that the next step is followed
  - CMET work flow is available from all iCare views: Main View, Panel View, and Patient View.

Care Management Event Tracking (CMET)

- Track and manage screening events by retrieving information from the database and presenting it in a useable way
- Minimize the “fall through the cracks” syndrome common in many clinical practices
- Minimize or eliminate the need for duplicative entries into EHR
- Replaces tracking functions of other registry packages

CMET Workflow

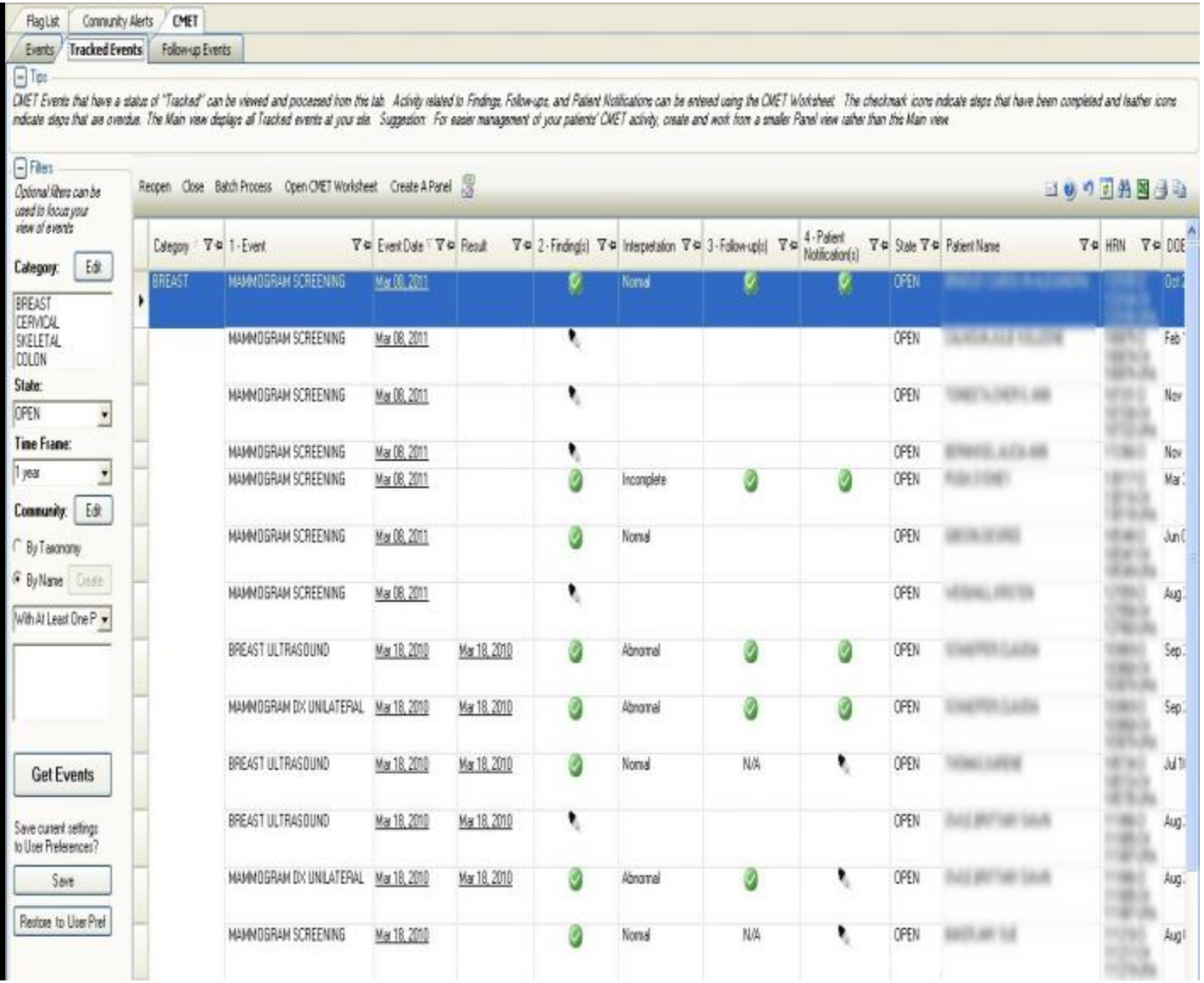


Main View CMET: Tracked Events

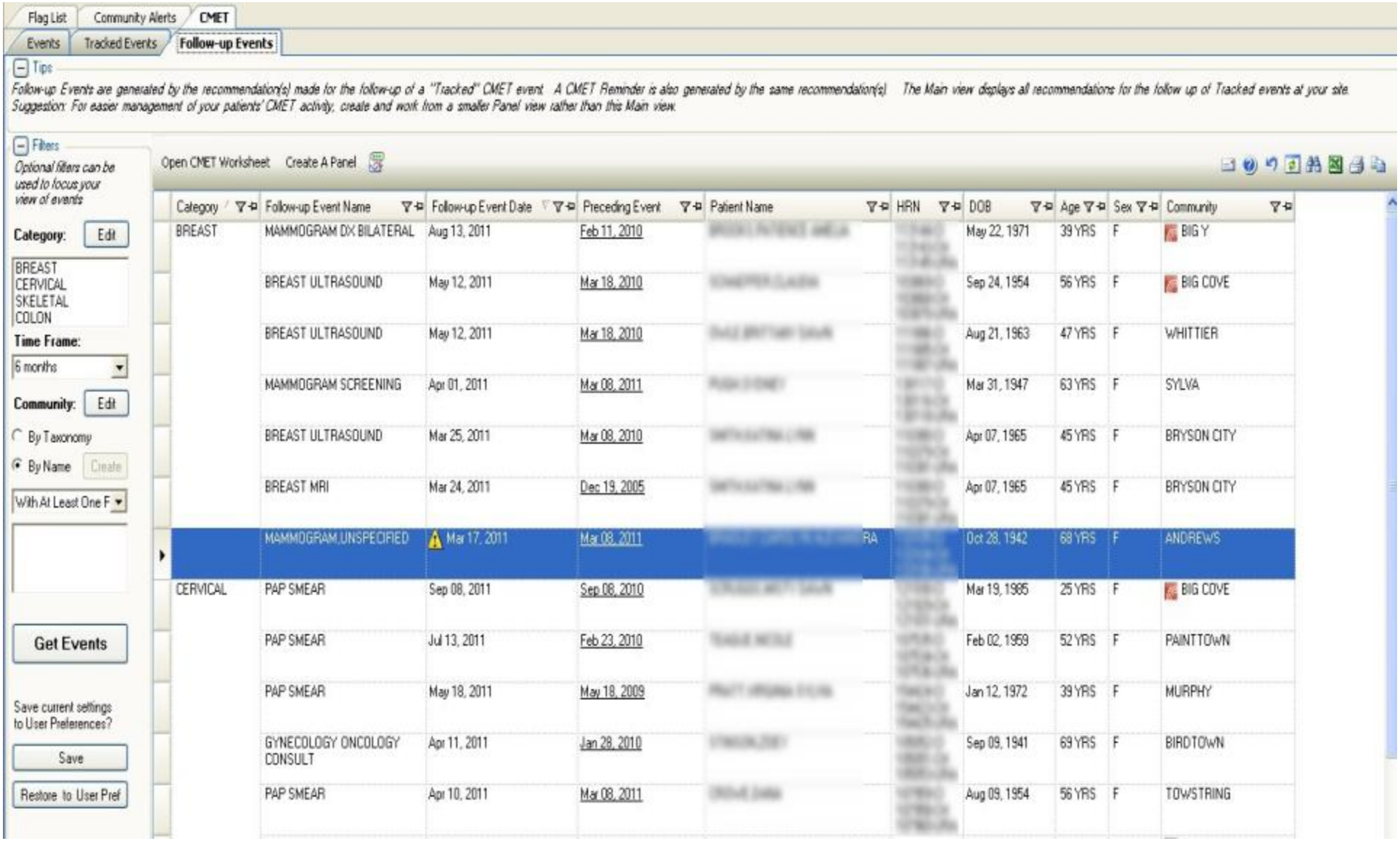
Keep track of patient status.

Organized work flow using “CMET Worksheet”.

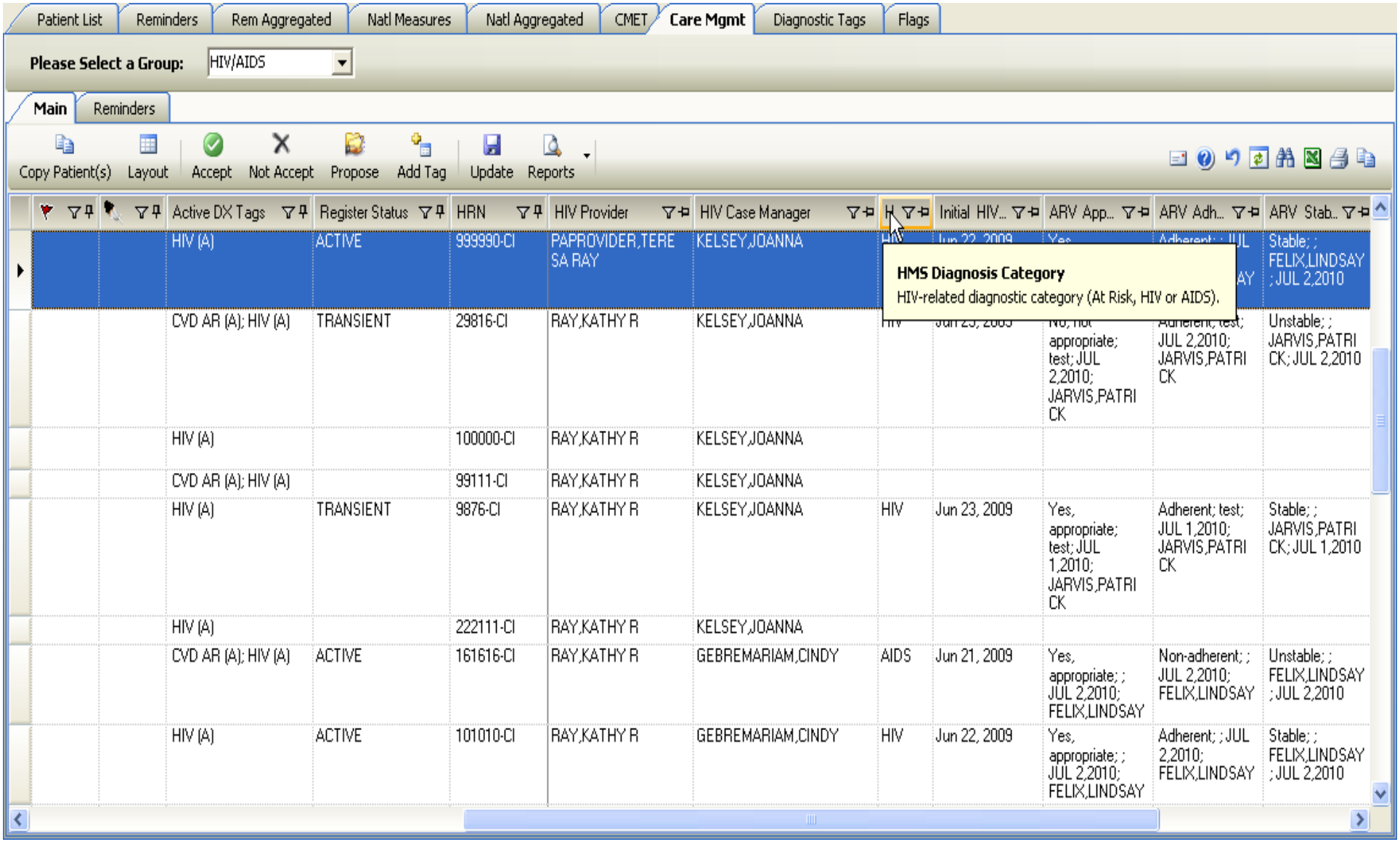
Feather “Ticklers” let you know when something is “Past Due”.



Main View CMET: Follow-up Events



HIV Management System – Main View



Active DX Tags	Register Status	HRN	HIV Provider	HIV Case Manager	H	Initial HIV...	ARV App...	ARV Adh...	ARV Stab...
HIV (A)	ACTIVE	999990-CI	PAPROVIDER,TERESA RAY	KELSEY,JOANNA					Stable; ; FELIX,LINDSAY ; JUL 2,2010
CVD AR (A); HIV (A)	TRANSIENT	29816-CI	RAY,KATHY R	KELSEY,JOANNA			No, not appropriate; test; JUL 2,2010; JARVIS,PATRICK	Adherent; test; JUL 2,2010; JARVIS,PATRICK	Unstable; ; JARVIS,PATRICK; JUL 2,2010
HIV (A)		100000-CI	RAY,KATHY R	KELSEY,JOANNA					
CVD AR (A); HIV (A)		99111-CI	RAY,KATHY R	KELSEY,JOANNA					
HIV (A)	TRANSIENT	9876-CI	RAY,KATHY R	KELSEY,JOANNA	HIV	Jun 23, 2009	Yes, appropriate; test; JUL 1,2010; JARVIS,PATRICK	Adherent; test; JUL 1,2010; JARVIS,PATRICK	Stable; ; JARVIS,PATRICK; JUL 1,2010
HIV (A)		222111-CI	RAY,KATHY R	KELSEY,JOANNA					
CVD AR (A); HIV (A)	ACTIVE	161616-CI	RAY,KATHY R	GEBREMARIAM,CINDY	AIDS	Jun 21, 2009	Yes, appropriate; ; JUL 2,2010; FELIX,LINDSAY	Non-adherent; ; JUL 2,2010; FELIX,LINDSAY	Unstable; ; FELIX,LINDSAY ; JUL 2,2010
HIV (A)	ACTIVE	101010-CI	RAY,KATHY R	GEBREMARIAM,CINDY	HIV	Jun 22, 2009	Yes, appropriate; ; JUL 2,2010; FELIX,LINDSAY	Adherent; ; JUL 2,2010; FELIX,LINDSAY	Stable; ; FELIX,LINDSAY ; JUL 2,2010

HIV Management System – Quality of Care Report

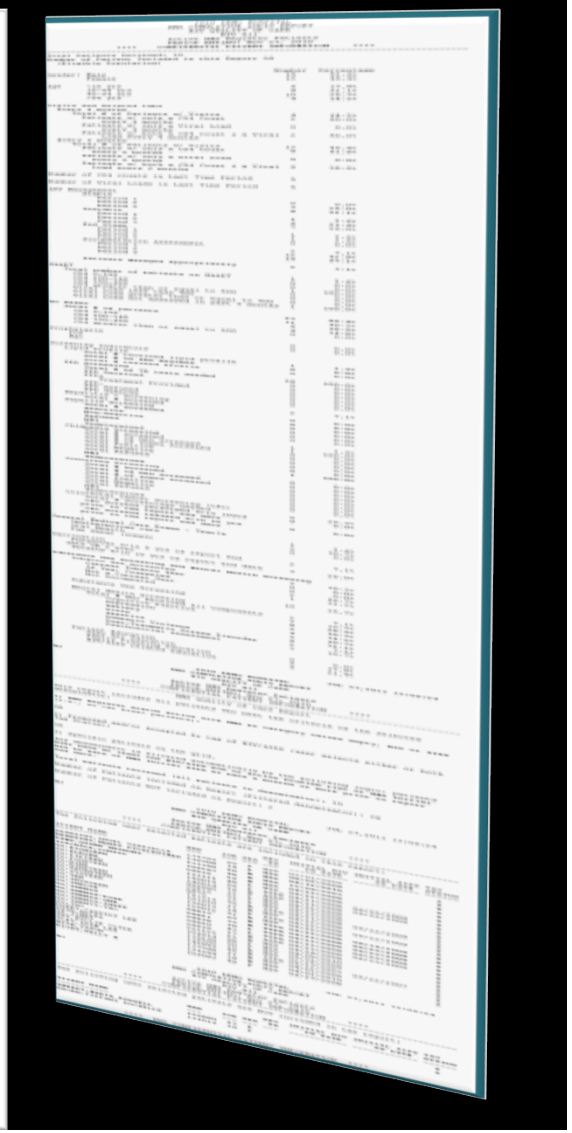
PMJ JUL 27,2011 13:05:24

2010 DEMO HOSPITAL
HMS CUMULATIVE AUDIT REPORT
HIV QUALITY OF CARE
HIV all
Active HMS Register Patients
PERIOD ENDING: Nov 27, 2010

**** CONFIDENTIAL PATIENT INFORMATION ****

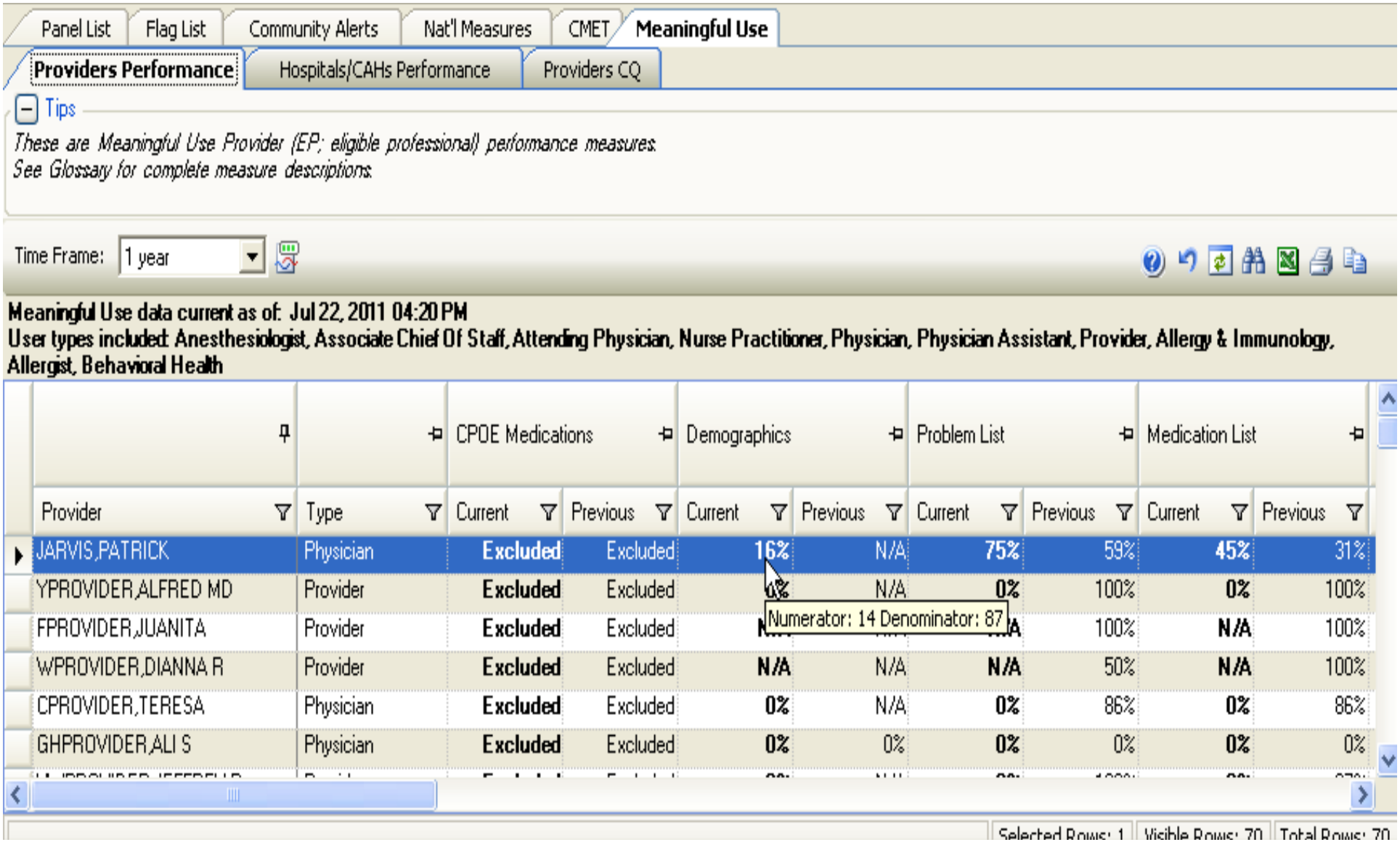
Total Patients Reviewed: 30
Number of Patient Included in this Report 28
(Eligible Population)

		Number	Percentage
Gender:	Male	15	53.6%
	Female	13	46.4%
Age	<15 yrs	5	17.9%
	15-44 yrs	9	32.1%
	45-64 yrs	10	35.7%
	>64 yrs	4	14.3%
Visits and Related Labs			
Every 4 months			
Total # of Patients w/ Visits		4	14.3%
Patients w/ only a CD4 Count every 4 months		2	50.0%
Patients w/ only a Viral Load every 4 months		0	0.0%
Patients w/ both a CD4 Count & a Viral Load every 4 months		2	50.0%
Every 6 months			
Total # of Patients w/ Visits		13	46.4%
Patients w/ only a CD4 Count every 6 months		8	61.5%
Patients w/ only a Viral Load every 6 months		0	0.0%
Patients w/ both a CD4 Count & a Viral Load every 6 months		5	38.5%
Number of CD4 counts in Last Time Period		5	
Number of Viral Loads in Last Time Period		5	



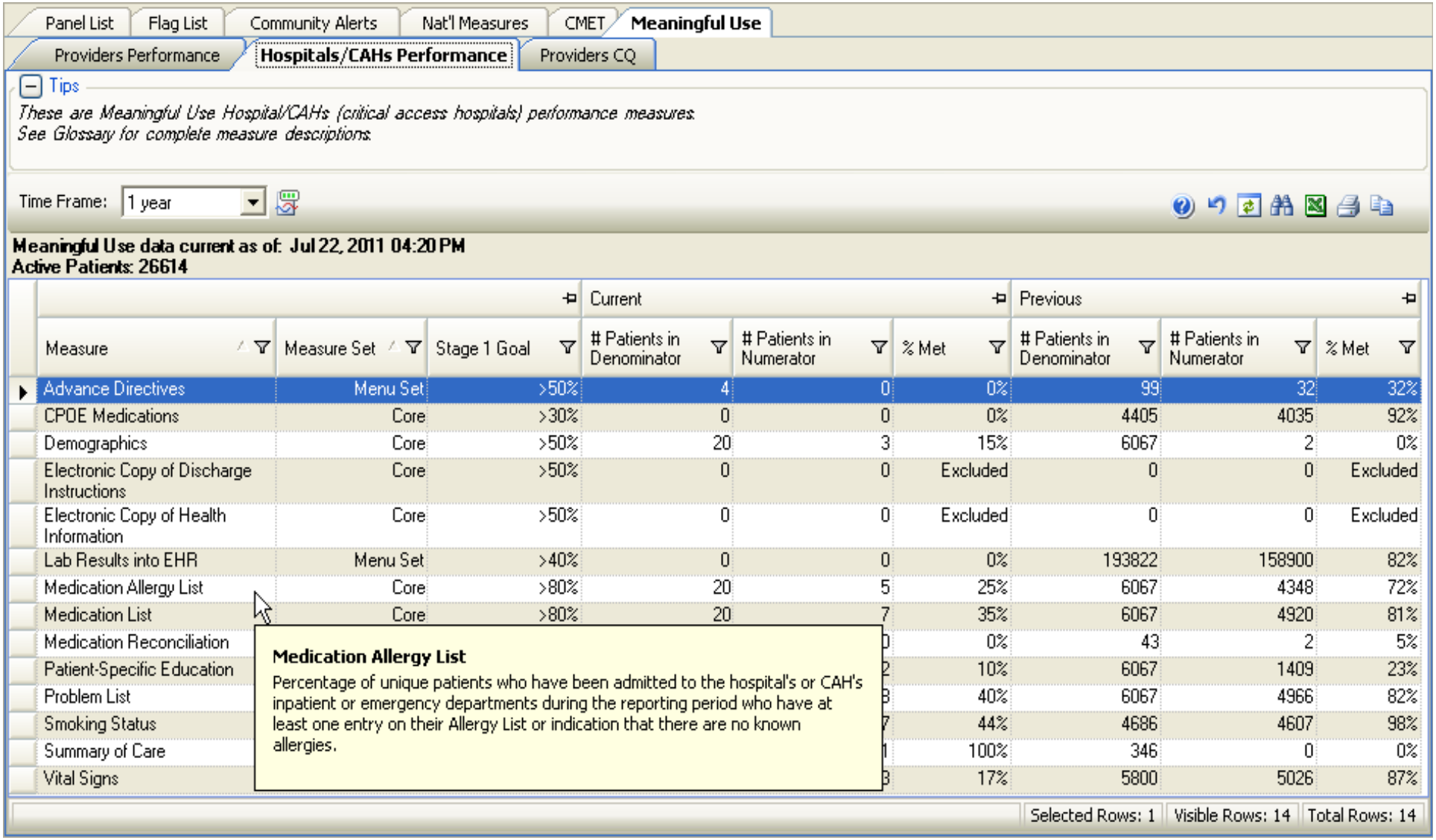
Main View: Meaningful Use Tab

Provider Performance Measures



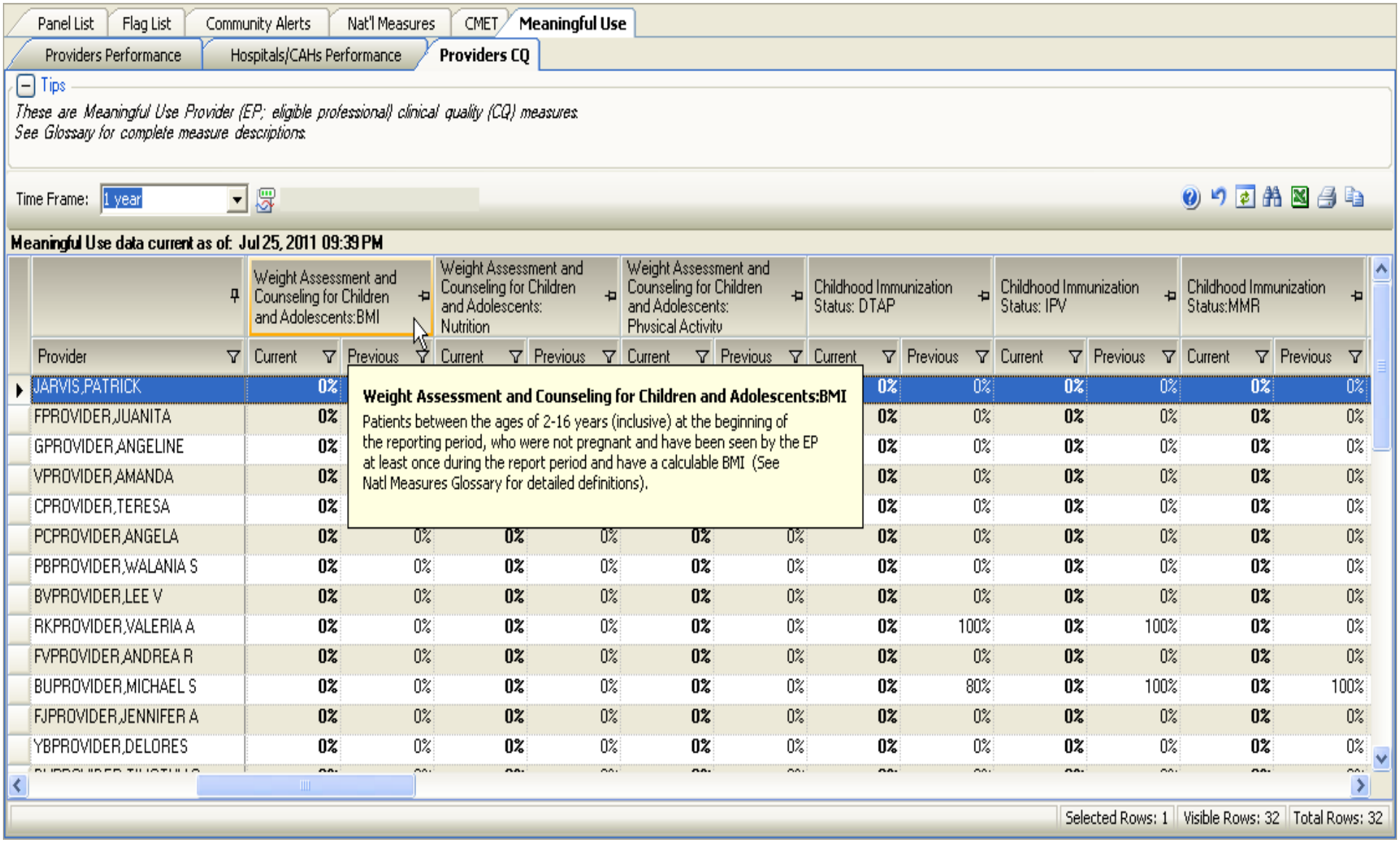
Main View: Meaningful Use Tab

Hospital/CAHs Performance



Main View: Meaningful Use Tab

Provider Clinical Quality



iCare v2.3

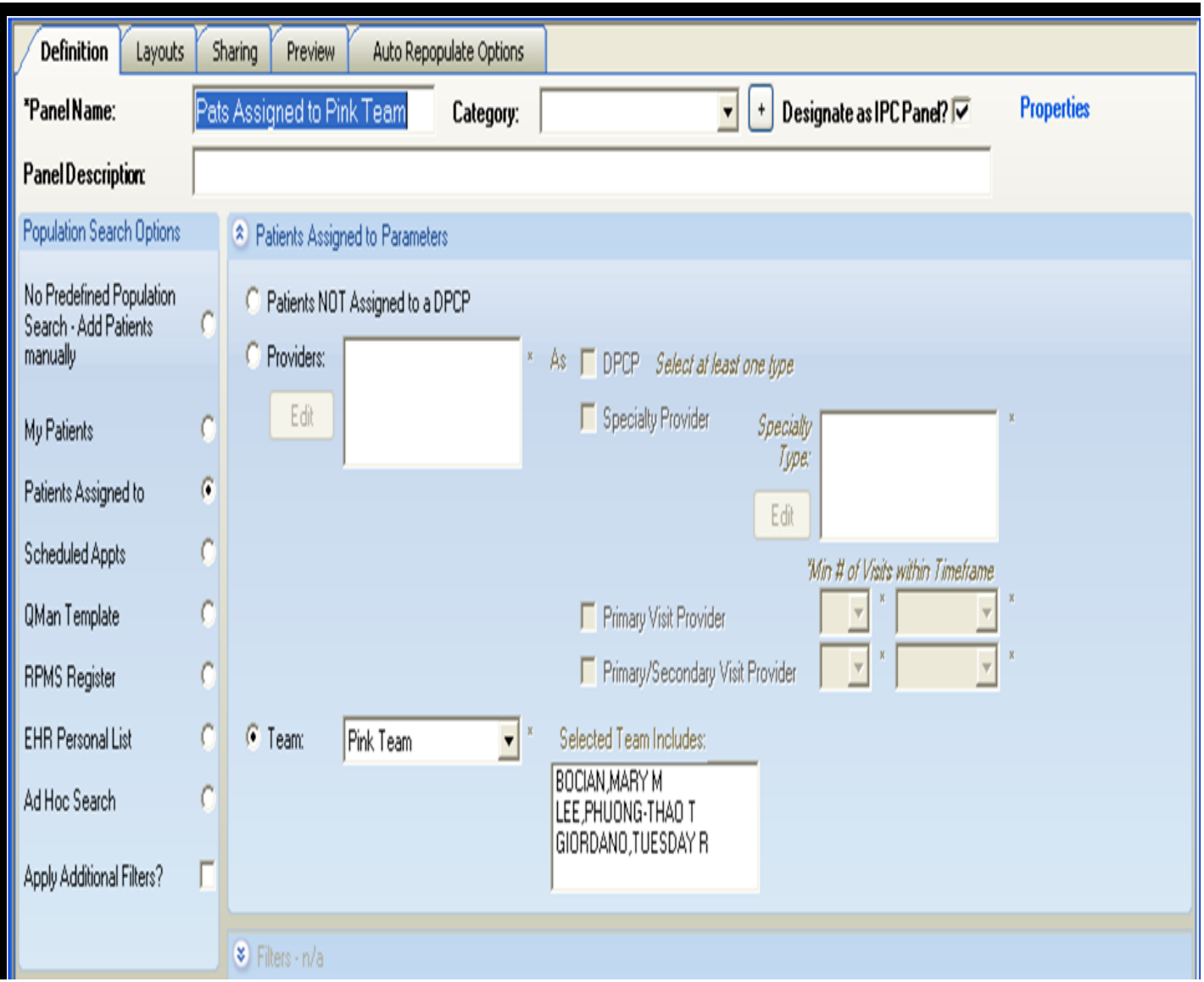
- Introduction of Improving Patient Care (IPC) view
- Creation of teams/microsystems for ‘agile change’
- Four specific tabs available
  - Patient Detail
  - Provider Detail
  - Provider Aggregated
  - Facility Aggregated

Team Panel Definition

Designate a panel as an “IPC” panel.

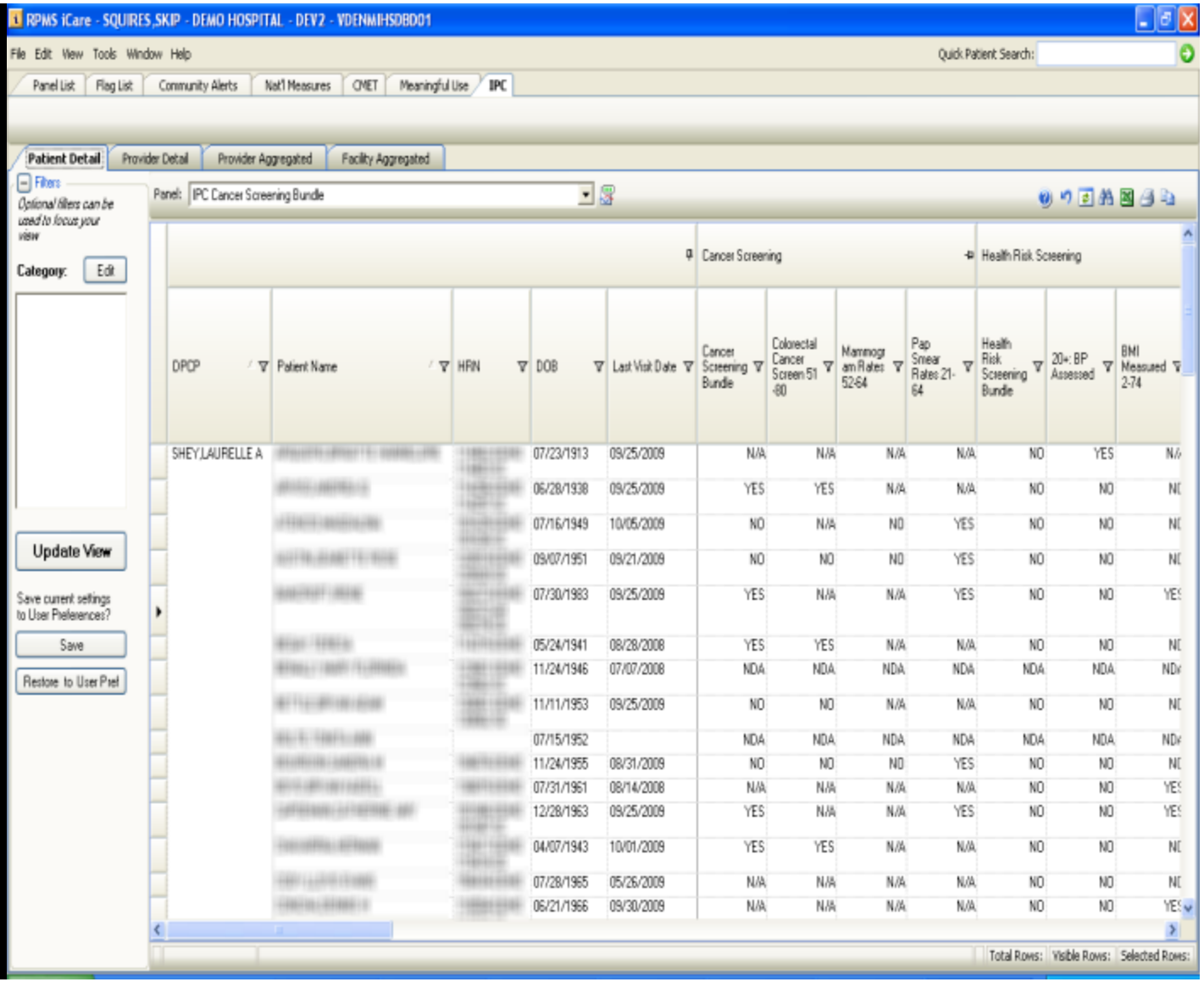
Enhanced Panel Definitions to accommodate teams and microsystems.

Additional filters will include “Labs” and “Medications”.

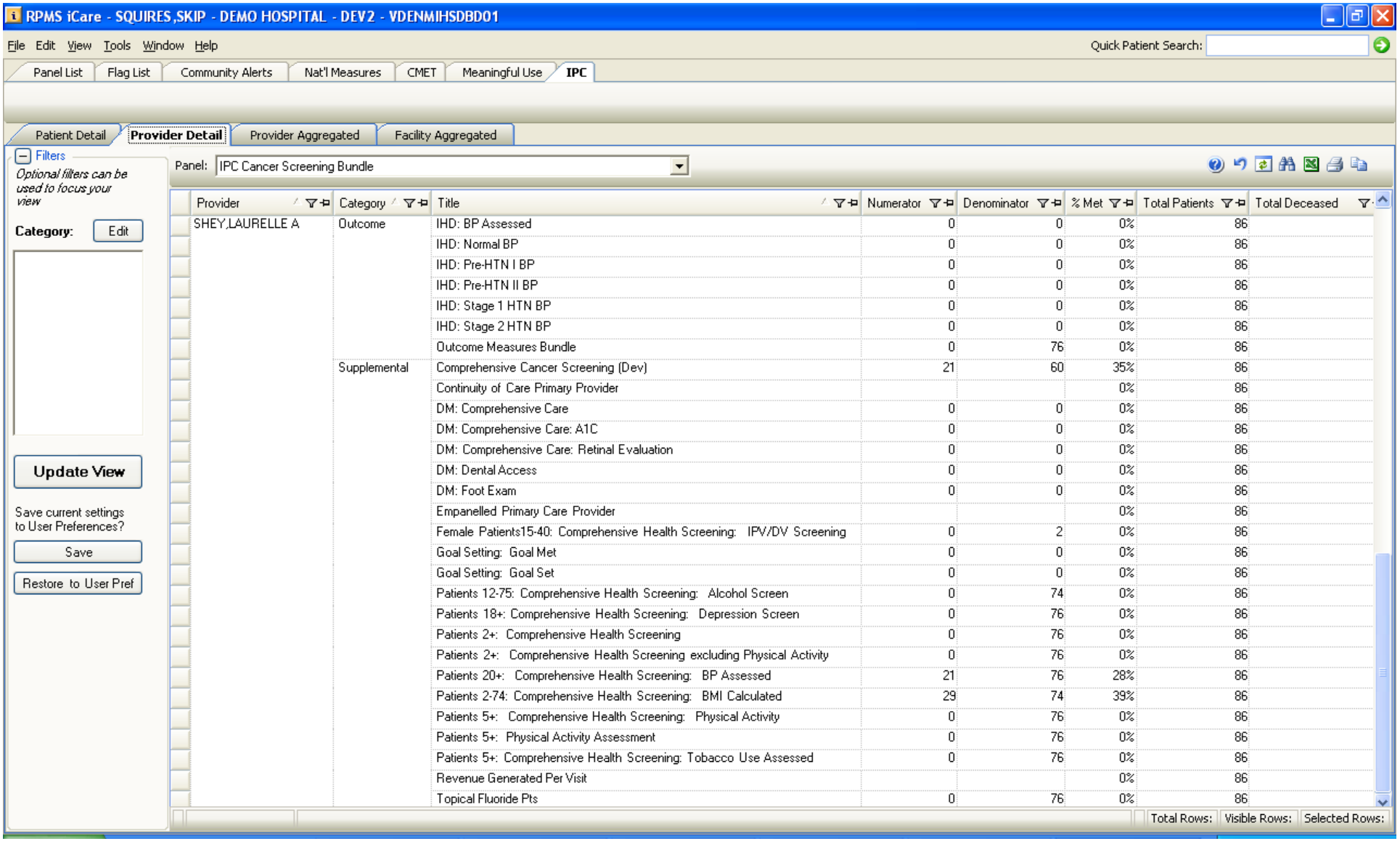


IPC/Patient Detail

Pull “IPC” panel data. Measures divided into Core measures.

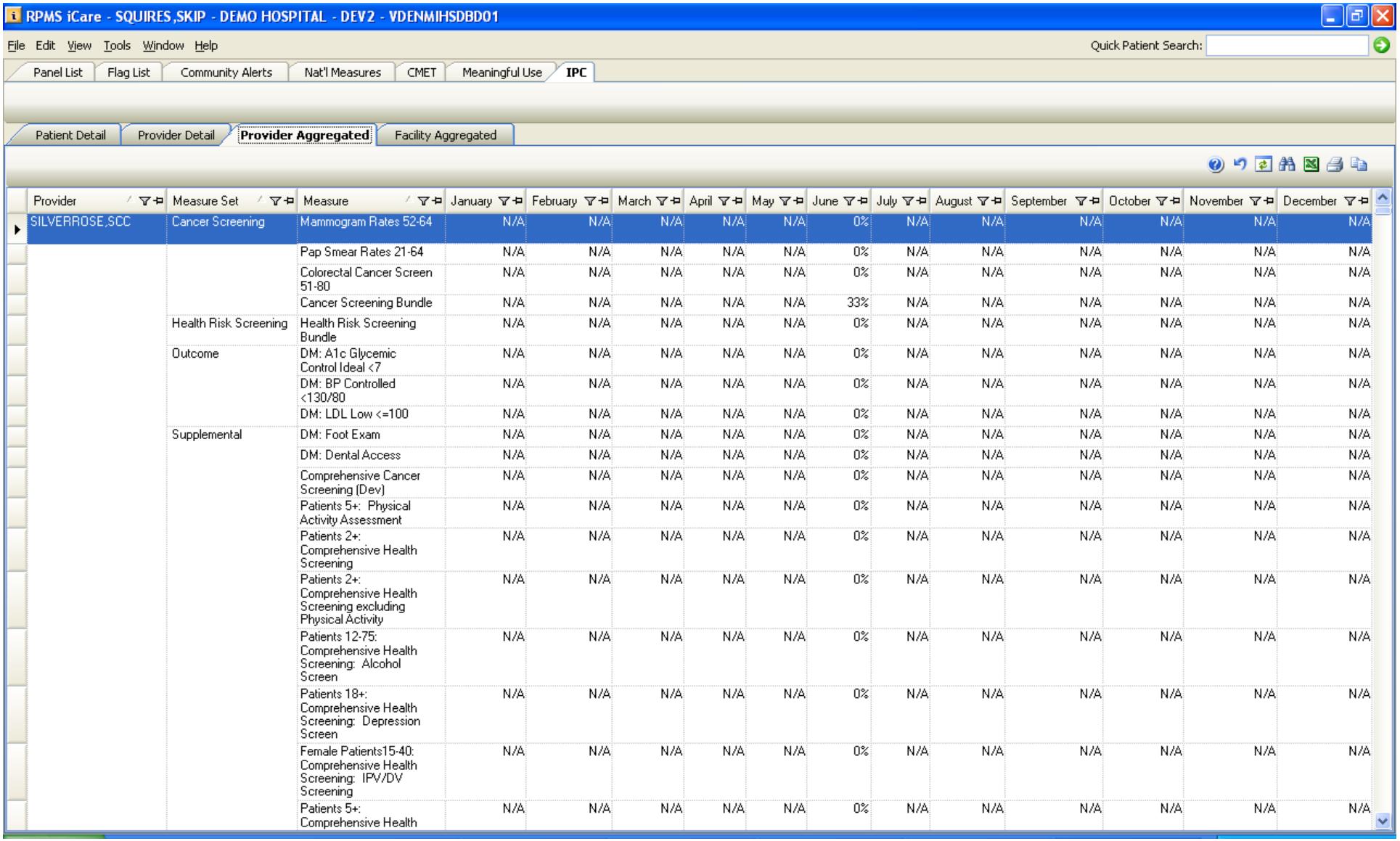


IPC/Provider Detail



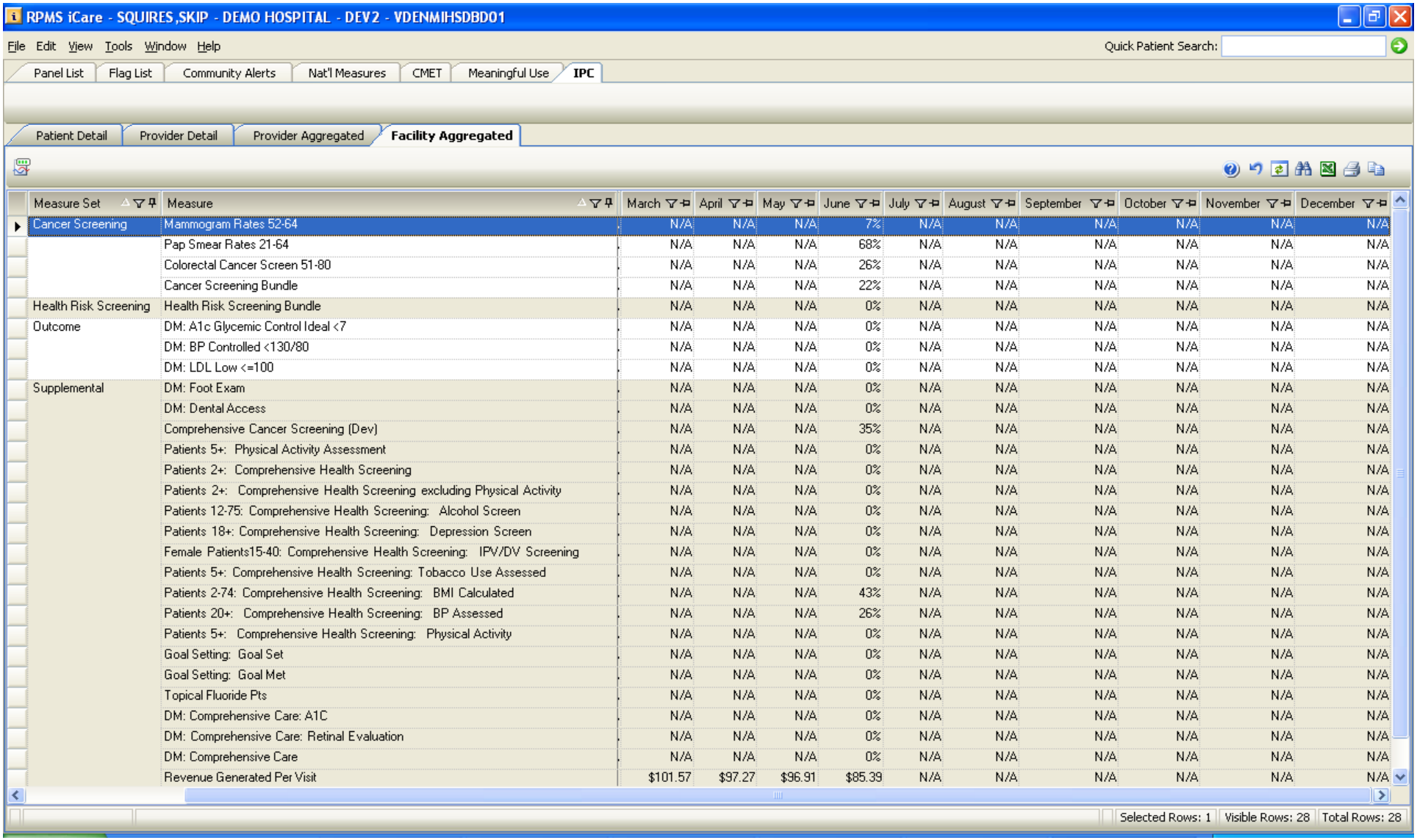
Provider	Category	Title	Numerator	Denominator	% Met	Total Patients	Total Deceased
SHEY,LAURELLE A	Outcome	IHD: BP Assessed	0	0	0%	86	
		IHD: Normal BP	0	0	0%	86	
		IHD: Pre-HTN I BP	0	0	0%	86	
		IHD: Pre-HTN II BP	0	0	0%	86	
		IHD: Stage 1 HTN BP	0	0	0%	86	
		IHD: Stage 2 HTN BP	0	0	0%	86	
		Outcome Measures Bundle	0	76	0%	86	
	Supplemental	Comprehensive Cancer Screening (Dev)	21	60	35%	86	
		Continuity of Care Primary Provider			0%	86	
		DM: Comprehensive Care	0	0	0%	86	
		DM: Comprehensive Care: A1C	0	0	0%	86	
		DM: Comprehensive Care: Retinal Evaluation	0	0	0%	86	
		DM: Dental Access	0	0	0%	86	
		DM: Foot Exam	0	0	0%	86	
		Empanelled Primary Care Provider			0%	86	
		Female Patients15-40: Comprehensive Health Screening: IPV/DV Screening	0	2	0%	86	
		Goal Setting: Goal Met	0	0	0%	86	
		Goal Setting: Goal Set	0	0	0%	86	
		Patients 12-75: Comprehensive Health Screening: Alcohol Screen	0	74	0%	86	
		Patients 18+: Comprehensive Health Screening: Depression Screen	0	76	0%	86	
		Patients 2+: Comprehensive Health Screening	0	76	0%	86	
		Patients 2+: Comprehensive Health Screening excluding Physical Activity	0	76	0%	86	
		Patients 20+: Comprehensive Health Screening: BP Assessed	21	76	28%	86	
		Patients 2-74: Comprehensive Health Screening: BMI Calculated	29	74	39%	86	
		Patients 5+: Comprehensive Health Screening: Physical Activity	0	76	0%	86	
		Patients 5+: Physical Activity Assessment	0	76	0%	86	
		Patients 5+: Comprehensive Health Screening: Tobacco Use Assessed	0	76	0%	86	
		Revenue Generated Per Visit			0%	86	
		Topical Fluoride Pts	0	76	0%	86	

IPC/Provider Aggregated



Provider	Measure Set	Measure	January	February	March	April	May	June	July	August	September	October	November	December
SILVERROSE,SCC	Cancer Screening	Mammogram Rates 52-64	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Pap Smear Rates 21-64	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Colorectal Cancer Screen 51-80	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Cancer Screening Bundle	N/A	N/A	N/A	N/A	N/A	33%	N/A	N/A	N/A	N/A	N/A	N/A
	Health Risk Screening	Health Risk Screening Bundle	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Outcome	DM: A1c Glycemic Control Ideal <7	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		DM: BP Controlled <130/80	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		DM: LDL Low <=100	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Supplemental	DM: Foot Exam	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		DM: Dental Access	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Comprehensive Cancer Screening (Dev)	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Patients 5+: Physical Activity Assessment	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Patients 2+: Comprehensive Health Screening	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Patients 2+: Comprehensive Health Screening excluding Physical Activity	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Patients 12-75: Comprehensive Health Screening: Alcohol Screen	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Patients 18+: Comprehensive Health Screening: Depression Screen	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Female Patients15-40: Comprehensive Health Screening: IPV/DV Screening	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
		Patients 5+: Comprehensive Health	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A

IPC/Facility Aggregated



Measure Set	Measure	March	April	May	June	July	August	September	October	November	December
Cancer Screening	Mammogram Rates 52-64	N/A	N/A	N/A	7%	N/A	N/A	N/A	N/A	N/A	N/A
	Pap Smear Rates 21-64	N/A	N/A	N/A	68%	N/A	N/A	N/A	N/A	N/A	N/A
	Colorectal Cancer Screen 51-80	N/A	N/A	N/A	26%	N/A	N/A	N/A	N/A	N/A	N/A
	Cancer Screening Bundle	N/A	N/A	N/A	22%	N/A	N/A	N/A	N/A	N/A	N/A
Health Risk Screening	Health Risk Screening Bundle	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
Outcome	DM: A1c Glycemic Control Ideal <7	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	DM: BP Controlled <130/80	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	DM: LDL Low <=100	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
Supplemental	DM: Foot Exam	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	DM: Dental Access	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Comprehensive Cancer Screening (Dev)	N/A	N/A	N/A	35%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 5+: Physical Activity Assessment	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 2+: Comprehensive Health Screening	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 2+: Comprehensive Health Screening excluding Physical Activity	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 12-75: Comprehensive Health Screening: Alcohol Screen	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 18+: Comprehensive Health Screening: Depression Screen	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Female Patients15-40: Comprehensive Health Screening: IPV/DV Screening	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 5+: Comprehensive Health Screening: Tobacco Use Assessed	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 2-74: Comprehensive Health Screening: BMI Calculated	N/A	N/A	N/A	43%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 20+: Comprehensive Health Screening: BP Assessed	N/A	N/A	N/A	26%	N/A	N/A	N/A	N/A	N/A	N/A
	Patients 5+: Comprehensive Health Screening: Physical Activity	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Goal Setting: Goal Set	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Goal Setting: Goal Met	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Topical Fluoride Pts	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	DM: Comprehensive Care: A1C	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	DM: Comprehensive Care: Retinal Evaluation	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	DM: Comprehensive Care	N/A	N/A	N/A	0%	N/A	N/A	N/A	N/A	N/A	N/A
	Revenue Generated Per Visit	$101.57	$97.27	$96.91	$85.39	N/A	N/A	N/A	N/A	N/A	N/A

iCare v2.4
March 2012

- Introduction of care plan functionality (create, track, update w/ automatic notification)
- Ability to search for patient that HAVE NOT had a particular test (e.g., mammogram, Pap, HIV screen)
- Charting of IPC measures over time
- Enhanced HIV care functionality
- Strong Heart calculator for CVD risk
- New diagnostic tags

A Vision

- A health care system that INCORPORATES family, population, public and community health as a cornerstone of personal health care delivery at the point of care
- Inclusion of non traditional data information into the traditional patient, provider, family and community perspective
- Involvement of community based research and translation of research as a model for improving health status and..
- The achievement of health equity

Questions?