



# 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  
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HHS IT Domain 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.



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# 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?



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# Why do we do this?

FOR THE PATIENT

FOR THE FAMILY

FOR THE COMMUNITY

FOR THE POPULATION



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# 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

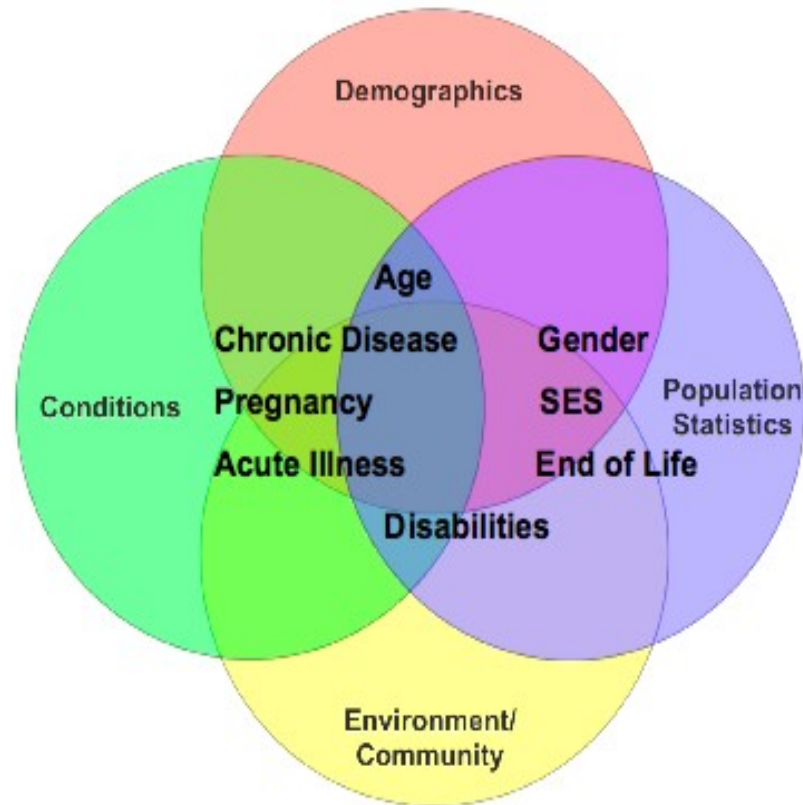


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# A Broader Picture of Health

- 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



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# 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



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# 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



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# 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



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# 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?



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# 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



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# 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



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# 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



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# 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



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# 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



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# 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



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# 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.



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# 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



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# 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



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## 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

## COMMUNITY ALERTS

Community Alerts provide deidentified visit data related to high-profile diagnoses that occurred within the past 30 days and may affect other patients in your community. The Alert categories are:

1. CDC Nationally Notifiable Infectious Diseases (CDC NND)
2. Suicidal Behavior Related Incidents

Community	Type	Diagnosis	Number of Cases	Most Recent Occurrence
BIRDAK ACR	CDC NND	Chlamydia		1 Jul 01, 2009
		Measles		2 Jun 29, 2009
		Q Fever		2 Jun 29, 2009
		Toxic Shock Syndrome, Non-Strep		1 Jun 26, 2009
		West Nile Virus		2 Jun 25, 2009
BIG COVE	Suicidal Behavior	Completion		1 Jun 14, 2009
BIRDTOWN	CDC NND	Botulism, foodborne		1 Jul 01, 2009
		Gonorrhea		1 Jun 14, 2009
BRYSON CITY	Suicidal Behavior	Completion		1 Jun 11, 2009
GEORGIA UNK	CDC NND	Measles		1 Jul 01, 2009
PAINTTOWN		Chlamydia		1 Jun 13, 2009
ROBBINSVILLE		Syphilis, Primary		1 Jun 29, 2009
ROBBINSVILLE		Syphilis, Secondary		1 Jun 28, 2009
WILMINGTON		Cryptosporidiosis		1 Jun 23, 2009
WILMINGTON		Hepatitis		1 Jun 04, 2009
WILMINGTON	CDC NND	Hepatitis		1 Jun 01, 2009
WILMINGTON	Suicidal Behavior	Completion		1 Jun 01, 2009

# iCare – Opening View

**RPMS iCare - JARVIS,PATRICK - 2010 DEMO HOSPITAL** Shared

File Edit View Tools Window Help Quick Patient Search:

**Panel List** Flag List Community Alerts Nat'l Measures CMET Meaningful Use

New Open Delete Repopulate Modify Share Copy

	Panel Name	Panel Description	# of Pts	Last Updated	Last Updated By	Owner	
	Active Diabetics > 50	Big Cove	14	Jul 27, 2011 11:05 AM	JARVIS,PATRICK	JARVIS,PATRICK	
	WH	WH Visits in past year	7	Jul 27, 2011 11:05 AM	JARVIS,PATRICK	JARVIS,PATRICK	
	>=70 Active	1/1/2010 - 3/1/2010	309	Mar 17, 2011 11:40 AM	JARVIS,PATRICK	JARVIS,PATRICK	
	>=70 Inactive Female	1/1/2010 - 3/1/2010	312	Mar 17, 2011 11:31 AM	JARVIS,PATRICK	JARVIS,PATRICK	
	Active patients Big Cove		12	Jul 27, 2011 11:05 AM	JARVIS,PATRICK	JARVIS,PATRICK	
♥	Allergies	Dr. St. Cyr's Allergy Patients	2	Feb 15, 2011 03:56 PM	ST CYR,DONNA	ST CYR,DONNA	
▶	Arlis Acord Patients		2	May 26, 2011 11:28 AM	JARVIS,PATRICK	JARVIS,PATRICK	
	Asthma	demo	567	May 06, 2011 02:22 PM	JARVIS,PATRICK	JARVIS,PATRICK	
	Children 10 and under		14	Jul 27, 2011 11:07 AM	JARVIS,PATRICK	JARVIS,PATRICK	
	CMET Tracked Events Patients - 10/27/2010 2:45:06 PM	Selected patients panel created on 10/27/2010 by KELSEY,JOANNA	52	Oct 27, 2010 02:45 PM	KELSEY,JOANNA	KELSEY,JOANNA	
♥	Count		25,459	May 07, 2010 03:17 PM	JARVIS,PATRICK	JARVIS,PATRICK	
♥	Diabetes	Proposed or Accepted Tag	2,221	Jun 28, 2011 12:53 PM	JARVIS,PATRICK	JARVIS,PATRICK	
	Elders		129	Jun 04, 2010 07:52 AM	ACORD,ARLIS L	ACORD,ARLIS L	

Selected Rows: 1 Visible Rows: 31 Total Rows: 31

# iCare – Panel Creation

RPMS iCare - demo panel - Panel Definition

Definition | Layouts | Sharing | Preview | Auto Repopulate Options

**\*Panel Name:** demo panel

**Panel Description:**

Population Search Options

- No Predefined Population Search - Add Patients manually
- My Patients
- Patients Assigned to
- Scheduled Appts
- QMan Template
- RPMS Register
- EHR Personal List
- Ad Hoc Search

Parameters - n/a

Filters

Patient

Age: greater than or equal to 40 YRS Beneficiary: INDIAN/ALASKA NATIVE

Sex: Female

Category

☒ Living ☐ Deceased ☐ Both Date of Death: (none) to (none)

Community

☒ By Taxonomy ☐ By Name With At Least One Patient

Selected Taxonomy Includes:

Diagnostic Tag

Tag	Accepted	Not Accepted	Proposed	No Longer Valid	Superseded
Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreDM Metabolic Syndrome	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use AND? ☐

+ Visit (None)

+ Other (None)

# iCare – Diagnostic Tags

Parameters - n/a

Filters

Patient
Age:
Sex:
Community
By Taxonomy

Diagnostic Tag
Edit

Asthma  
COPD  
CVD At Risk  
CVD Highest Risk  
CVD Significant Risk  
HIV/AIDS  
Hypertension  
Obese  
PreDM Metabolic Syndrome  
Tobacco Users (Smokers)

Tag	Accepted	Not Accepted	Proposed	No Lo Val
CVD Known	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Use AND?

**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

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!



# 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.

RPMS iCare - Anticoagulation - Panel View

File Edit **Patients** Tools Window Help

Quick Patient Search:

**Anticoagulation** Total Patients = 31

*Next 30 days* Patient List Last Updated: Jul 07, 2009 05:37 PM  
by GEBREMARIAM, CINDY

Properties

**Patient List** Flags Reminders Reminders Aggregated Natl Measures Natl Aggregated Diagnostic Tags Care Mgmt

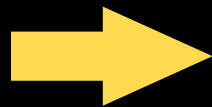
Add Open Remove Repopulate Copy Cut Paste Modify Share Layout




























	Next A...	Hom...	Patient Na...	Age	S	Active DX Tags	Communi...	Last VL	DOB
	Jul 16, 2009	555-555-5555	UPSILON,BETA	66 YRS	M	CVD AHR (P); DM (A); HTN (P)	ROBBINSVILLE	Jun 29, 2009	Nov 18, 19
	Jul 16, 2009	555-555-5555	SIGMA,BETA	60 YRS	F	Asthma (A); CVD AHR (P); DM (A); HTN (P)	SNOWBIRD	Oct 14, 2008	Oct 23, 19
	Jul 23, 2009	555-555-5555	ALPHA,SIGMA	20 YRS	M	CVD AHR (A); DM (A)	SPRINGFIELD	Jul 05, 2009	Apr 15, 19
	Jul 10, 2009	555-555-5555	GAMMA,IOTA	20 YRS	F	Asthma (A); CVD AHR (P); DM (A); Obese (P)	SPRINGFIELD	Mar 31, 2008	Jun 12, 19
	Jul 10, 2009	555-555-5555	LAMDA,IOTA	19 YRS	F	Asthma (A); Obese (P)	SPRINGFIELD	Aug 18, 2007	Mar 10, 19
	Jul 21, 2009	555-555-4034	DEMO,MICHELL E	50 YRS	F		TENNESSEE UNK	Jun 10, 2008	Mar 31, 19
	Jul 13, 2009	555-555-5555	LAMBDA,ALPHA	36 YRS	M	CVD ASR (P); HTN (P); Obese (P)	WOLFTOWN	May 02, 2008	Jun 14, 19
	Jul 10, 2009	555-555-5555	ETA,KAPPA	33 YRS	F	Asthma (P); CVD AHR (P); DM (A); Obese (P)	WOLFTOWN	May 02, 2008	Apr 09, 19

Ready. Selected Rows: 1 Visible Rows: 31 Total Rows: 31

# Clinical Decision Support – Reminder Views

Users select  
Reminders  
display



Patient List		Flags	Reminders	Reminders Aggregated	Natl Measures	Natl Aggregated	Diagnostic Tags	Care Mgmt		
 Copy Patient(s)		 Layout	     							
Reminders data current as of: Jul 07, 2009 12:19 PM										
	 	Patient Name 	DOB 	Age 	Sex 	BLOOD PRESSURE 	WEIGHT 	TD-ADULT 	PNEUMOVA X 	COLORECTAL CA SCRIN-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

Patient List	Flags	Reminders	Reminders Aggregated	Natl Measures	Natl Aggregated	Diagnostic Tags	Care Mgmt
Reminders Aggregate data current as of: Jul 07, 2009 12:19 PM							
	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 SCRIN-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



Patient List

Flags

Reminders

Reminders Aggregated

Natl Measures

Natl Aggregated

Diagnostic Tags

Care Mgmt

Copy Patient(s)

Layout

Patient List   Flags   Reminders   Reminders Aggregated   Nat'l Measures <b>Nat'l Aggregated</b> Diagnostic Tags   Care Mgmt									
National Performance Measures data from CRS 2009 current as of: Jul 07, 2009 07:18 PM									
	Clinical Group	Measure Name	# Patients in Denominator	# Patients in Numerator	% Met	2009 Goal	IHS National 2008 Performance	2010 Goal	
PRA	Cancer-Related	Pap Smear Rates 21-64	4	1	25.0%	59%	59%	90.0%	
	Immunizations	Influenza IZ 65+	14	2	14.3%	62%	62%	90.0%	
		Pneumovax Ever 65+	14	9	64.3%	82%	82%	90.0%	
	CVD-Related	IHD: LDL Assessed (Comp Assessment)	4	3	75.0%		90%	85.0%	
	Immunizations	Peds IZ 4:3:1:3:3 Active Clinical	0	0			68%	80.0%	
		Peds IZ 4:3:1:3:3 Active IMM	0	0		78%	78%	80.0%	

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.

Family HX								
Snapshot	Flags	Reminders	BP Prompts	Natl Measures	Summ/Supp	PCC	Problem List	Care Mgmt
Performance Measures data from CRS 2009 current as of: Jul 07, 2009 07:20 PM								
Clinical Group	Measure Name	Performance Status	Adherence Value					
Cancer-Related	Colorectal Cancer Screen 51-80 (No Refusals)	(All)						
	Tobacco Cessation: Counseling or RX (No Refusals)	(Custom)						
CVD-Related		(Blanks)						
		(NonBlanks)						
	IHD: BMI Measured (Comp Assessment) (No Refusals)	0	LDL: 10/03/06 TOB: 05/21/09: TOBACCO USER DEP: DEP SCF					
CVD-Related	IHD: Comp CVD Assessment (No BMI Refusals)	1	LDL: 10/03/06 TOB: 05/21/09: TOBACCO USER DEP: DEP SCF					
		N/A						
Behavioral Health	Depression: Diagnosis Only 18+	NO	DEP SCRIN:05/21/09					
Cancer-Related	Colorectal Cancer Screen 51-80	NO						
	Colorectal Cancer Screen 51-80: FOBT/FIT	NO						

# 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.



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# Care Management Event Tracking (CMET)

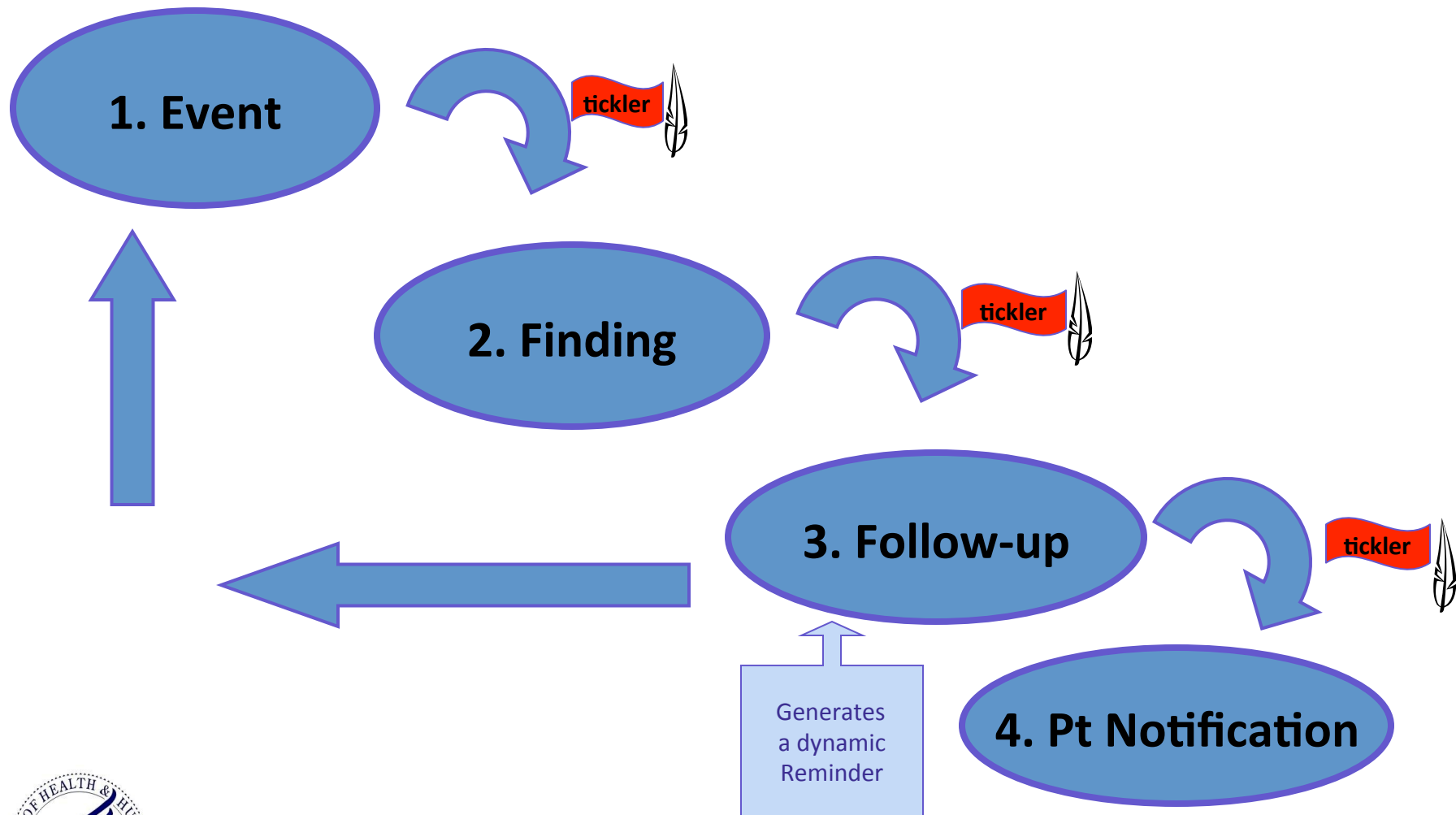
- Track and manage screening events by retrieving information from the database and presenting it in a useable way
- Minimize the “fall through the cracks” syndrome common in many clinical practices
- Minimize or eliminate the need for duplicative entries into EHR
- Replaces tracking functions of other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



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# CMET Workflow



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# 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”.

Flag List Community Alerts CMET

Events Tracked Events Follow-up Events

Tip:  
CMET Events that have a status of "Tracked" can be viewed and processed from this tab. Activity related to Findings, Follow-ups, and Patient Notifications can be entered using the CMET Worksheet. The checkmark icons indicate steps that have been completed and feather icons indicate steps that are overdue. The Main view displays all Tracked events at your site. Suggestion: For easier management of your patients' CMET activity, create and work from a smaller Panel view rather than this Main view.

Filters  
Optional filters can be used to focus your view of events

Category: Edit

BREAST  
CERVICAL  
SKELETAL  
COLON

State:  
OPEN

Time Frame:  
1 year

Community: Edit

By Taxonomy  
By Name Create

With At Least One P

Get Events

Save current settings to User Preferences?  
Save  
Restore to User Pref

Resopen Close Batch Process Open CMET Worksheet Create A Panel

Category	1-Event	Event Date	Result	2-Finding(s)	Interpretation	3-Follow-up(s)	4-Patient Notification(s)	State	Patient Name	HAN	DOE
BREAST	MAMMOGRAM SCREENING	Mar 08, 2011		✓	Normal	✓	✓	OPEN	BRUCE, JAMES PAUL	11/11/10	Oct 2
	MAMMOGRAM SCREENING	Mar 08, 2011		✓				OPEN	BRUCE, JAMES PAUL	11/11/10	Feb 1
	MAMMOGRAM SCREENING	Mar 08, 2011		✓				OPEN	BRUCE, JAMES PAUL	11/11/10	Nov
	MAMMOGRAM SCREENING	Mar 08, 2011		✓				OPEN	BRUCE, JAMES PAUL	11/11/10	Nov
	MAMMOGRAM SCREENING	Mar 08, 2011		✓	Incomplete	✓	✓	OPEN	BRUCE, JAMES PAUL	11/11/10	Mar 1
	MAMMOGRAM SCREENING	Mar 08, 2011		✓	Normal			OPEN	BRUCE, JAMES PAUL	11/11/10	Jun 1
	MAMMOGRAM SCREENING	Mar 08, 2011		✓				OPEN	BRUCE, JAMES PAUL	11/11/10	Aug
	BREAST ULTRASOUND	Mar 18, 2010	Mar 18, 2010	✓	Abnormal	✓	✓	OPEN	BRUCE, JAMES PAUL	11/11/10	Sep
	MAMMOGRAM DX: UNILATERAL	Mar 18, 2010	Mar 18, 2010	✓	Abnormal	✓	✓	OPEN	BRUCE, JAMES PAUL	11/11/10	Sep
	BREAST ULTRASOUND	Mar 18, 2010	Mar 18, 2010	✓	Normal	N/A	✓	OPEN	BRUCE, JAMES PAUL	11/11/10	Jul 11
	BREAST ULTRASOUND	Mar 18, 2010	Mar 18, 2010	✓				OPEN	BRUCE, JAMES PAUL	11/11/10	Aug
	MAMMOGRAM DX: UNILATERAL	Mar 18, 2010	Mar 18, 2010	✓	Abnormal	✓	✓	OPEN	BRUCE, JAMES PAUL	11/11/10	Aug
	MAMMOGRAM SCREENING	Mar 18, 2010		✓	Normal	N/A	✓	OPEN	BRUCE, JAMES PAUL	11/11/10	Aug 1



# Main View CMET: Follow-up Events

Flag List

Community Alerts

CMET

Events

Tracked Events

Follow-up Events

Tips

Follow-up Events are generated by the recommendation(s) made for the follow-up of a "Tracked" CMET event. A CMET Reminder is also generated by the same recommendation(s). The Main view displays all recommendations for the follow up of Tracked events at your site. Suggestion: For easier management of your patients' CMET activity, create and work from a smaller Panel view rather than this Main view.

Filters

Optional filters can be used to focus your view of events

Category:

Edit

BREAST

CERVICAL

SKELETAL

COLON

Time Frame:

6 months

Community:

Edit

By Taxonomy

By Name

Create

With At Least One F

Get Events

Save current settings to User Preferences?

Save

Restore to User Pref

Open CMET Worksheet

Create A Panel

Category	Follow-up Event Name	Follow-up Event Date	Preceding Event	Patient Name	HRN	DOB	Age	Sex	Community
BREAST	MAMMOGRAM DX BILATERAL	Aug 13, 2011	Feb 11, 2010	BIG Y PATIENT NAME		May 22, 1971	39 YRS	F	BIG Y
	BREAST ULTRASOUND	May 12, 2011	Mar 18, 2010	BIG Y PATIENT NAME		Sep 24, 1954	56 YRS	F	BIG COVE
	BREAST ULTRASOUND	May 12, 2011	Mar 18, 2010	BIG Y PATIENT NAME		Aug 21, 1963	47 YRS	F	WHITTIER
	MAMMOGRAM SCREENING	Apr 01, 2011	Mar 08, 2011	BIG Y PATIENT NAME		Mar 31, 1947	63 YRS	F	SYLVA
	BREAST ULTRASOUND	Mar 25, 2011	Mar 08, 2010	BIG Y PATIENT NAME		Apr 07, 1965	45 YRS	F	BRYSON CITY
	BREAST MRI	Mar 24, 2011	Dec 19, 2005	BIG Y PATIENT NAME		Apr 07, 1965	45 YRS	F	BRYSON CITY
	MAMMOGRAM UNSPECIFIED	Mar 17, 2011	Mar 08, 2011	BIG Y PATIENT NAME	RA	Oct 28, 1942	68 YRS	F	ANDREWS
CERVICAL	PAP SMEAR	Sep 08, 2011	Sep 08, 2010	BIG Y PATIENT NAME		Mar 19, 1985	25 YRS	F	BIG COVE
	PAP SMEAR	Jul 13, 2011	Feb 23, 2010	BIG Y PATIENT NAME		Feb 02, 1959	52 YRS	F	PAINTTOWN
	PAP SMEAR	May 18, 2011	May 18, 2009	BIG Y PATIENT NAME		Jan 12, 1972	39 YRS	F	MURPHY
	GYNECOLOGY ONCOLOGY CONSULT	Apr 11, 2011	Jan 28, 2010	BIG Y PATIENT NAME		Sep 09, 1941	69 YRS	F	BIRDTOWN
	PAP SMEAR	Apr 10, 2011	Mar 08, 2011	BIG Y PATIENT NAME		Aug 09, 1954	56 YRS	F	TOWSTRING

# HIV Management System – Main View

Patient List   Reminders   Rem Aggregated   Natl Measures   Natl Aggregated   CMET   **Care Mgmt**   Diagnostic Tags   Flags

Please Select a Group: HIV/AIDS

Main   Reminders

Copy Patient(s)   Layout   Accept   Not Accept   Propose   Add Tag   Update   Reports

	Active DX Tags	Register Status	HRN	HIV Provider	HIV Case Manager	HMS Diagnosis Category	Initial HIV...	ARV App...	ARV Adh...	ARV Stab...
	HIV (A)	ACTIVE	999990-CI	PAPROVIDER, TERE SA RAY	KELSEY, JOANNA	HIV	Jun 22, 2009	Yes	Adherent; ; JUL 2, 2010;	Stable; ; FELIX, LINDSAY ; JUL 2, 2010
	CVD AR (A); HIV (A)	TRANSIENT	29816-CI	RAY, KATHY R	KELSEY, JOANNA	HIV	Jun 23, 2009	No, not appropriate; test; JUL 2, 2010; JARVIS, PATRI CK	Adherent; test; JUL 2, 2010; JARVIS, PATRI CK	Unstable; ; JARVIS, PATRI CK; 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, PATRI CK	Adherent; test; JUL 1, 2010; JARVIS, PATRI CK	Stable; ; JARVIS, PATRI CK; 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

I

# Main View: Meaningful Use Tab

## Provider Performance Measures

Panel List
Flag List
Community Alerts
Nat'l Measures
CMET
**Meaningful Use**

**Providers Performance**
Hospitals/CAHs Performance
Providers CQ

These are Meaningful Use Provider (EP; eligible professional) performance measures. See Glossary for complete measure descriptions.

Time Frame: 1 year

Meaningful Use data current as of: Jul 22, 2011 04:20 PM  
 User types included: Anesthesiologist, Associate Chief Of Staff, Attending Physician, Nurse Practitioner, Physician, Physician Assistant, Provider, Allergy & Immunology, Allergist, Behavioral Health

		CPOE Medications		Demographics		Problem List		Medication List	
Provider	Type	Current	Previous	Current	Previous	Current	Previous	Current	Previous
JARVIS,PATRICK	Physician	Excluded	Excluded	16%	N/A	75%	59%	45%	31%
YPROVIDER,ALFRED MD	Provider	Excluded	Excluded	0%	N/A	0%	100%	0%	100%
FPROVIDER,JUANITA	Provider	Excluded	Excluded	N/A	N/A	N/A	100%	N/A	100%
WPROVIDER,DIANNA R	Provider	Excluded	Excluded	N/A	N/A	N/A	50%	N/A	100%
CPROVIDER,TERESA	Physician	Excluded	Excluded	0%	N/A	0%	86%	0%	86%
GHPROVIDER,ALI S	Physician	Excluded	Excluded	0%	0%	0%	0%	0%	0%

Selected Rows: 1
Visible Rows: 70
Total Rows: 70

# Main View: Meaningful Use Tab

## Hospital/CAHs Performance

<div> <div>Panel List</div> <div>Flag List</div> <div>Community Alerts</div> <div>Nat'l Measures</div> <div>CMET</div> <div>Meaningful Use</div> </div>												
<div> <div>Providers Performance</div> <div>Hospitals/CAHs Performance</div> <div>Providers CQ</div> </div>												
<div> <div>Tips</div> <div>These are Meaningful Use Hospital/CAHs (critical access hospitals) performance measures. See Glossary for complete measure descriptions.</div> </div>												
<div> <div>Time Frame:</div> <div>1 year</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>												
<div> <div>Meaningful Use data current as of: Jul 22, 2011 04:20 PM</div> <div>Active Patients: 26614</div> </div>												
				Current				Previous				
Measure	Measure Set	Stage 1 Goal		# Patients in Denominator	# Patients in Numerator	% Met		# Patients in Denominator	# Patients in Numerator	% Met		
Advance Directives	Menu Set	>50%		4	0	0%		99	32	32%		
CPDE Medications	Core	>30%		0	0	0%		4405	4035	92%		
Demographics	Core	>50%		20	3	15%		6067	2	0%		
Electronic Copy of Discharge Instructions	Core	>50%		0	0	Excluded		0	0	Excluded		
Electronic Copy of Health Information	Core	>50%		0	0	Excluded		0	0	Excluded		
Lab Results into EHR	Menu Set	>40%		0	0	0%		193822	158900	82%		
Medication Allergy List	Core	>80%		20	5	25%		6067	4348	72%		
Medication List	Core	>80%		20	7	35%		6067	4920	81%		
Medication Reconciliation				0	0	0%		43	2	5%		
Patient-Specific Education				2	2	10%		6067	1409	23%		
Problem List				8	8	40%		6067	4966	82%		
Smoking Status				7	7	44%		4686	4607	98%		
Summary of Care				1	1	100%		346	0	0%		
Vital Signs				8	8	17%		5800	5026	87%		

Medication Allergy List

Percentage of unique patients who have been admitted to the hospital's or CAH's inpatient or emergency departments during the reporting period who have at least one entry on their Allergy List or indication that there are no known allergies.

Selected Rows: 1

Visible Rows: 14

Total Rows: 14

# Main View: Meaningful Use Tab

## Provider Clinical Quality

Panel List   Flag List   Community Alerts   Nat'l Measures   CMET <b>Meaningful Use</b>													
Providers Performance   Hospitals/CAHs Performance <b>Providers CQ</b>													
<div> <b>Tips</b>            These are Meaningful Use Provider (EP; eligible professional) clinical quality (CQ) measures.            See Glossary for complete measure descriptions.         </div>													
Time Frame: <span>1 year</span> <div> </div>													
<b>Meaningful Use data current as of: Jul 25, 2011 09:39 PM</b>													
Provider	Weight Assessment and Counseling for Children and Adolescents: BMI		Weight Assessment and Counseling for Children and Adolescents: Nutrition		Weight Assessment and Counseling for Children and Adolescents: Physical Activity		Childhood Immunization Status: DTAP		Childhood Immunization Status: IPV		Childhood Immunization Status: MMR		
	Current	Previous	Current	Previous	Current	Previous	Current	Previous	Current	Previous	Current	Previous	
JARVIS, PATRICK	0%						0%	0%	0%	0%	0%	0%	
FPROVIDER, JUANITA	0%						0%	0%	0%	0%	0%	0%	
GPROVIDER, ANGELINE	0%						0%	0%	0%	0%	0%	0%	
VPROVIDER, AMANDA	0%						0%	0%	0%	0%	0%	0%	
CPROVIDER, TERESA	0%						0%	0%	0%	0%	0%	0%	
PCPROVIDER, ANGELA	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
PBPROVIDER, WALANIA S	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
BVPROVIDER, LEE V	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
RKPROVIDER, VALERIA A	0%	0%	0%	0%	0%	0%	0%	100%	0%	100%	0%	0%	
FVPROVIDER, ANDREA R	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
BUPROVIDER, MICHAEL S	0%	0%	0%	0%	0%	0%	0%	80%	0%	100%	0%	100%	
FJPROVIDER, JENNIFER A	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
YBPROVIDER, DELORES	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
...	...	...	...	...	...	...	...	...	...	...	...	...	

**Weight Assessment and Counseling for Children and Adolescents: BMI**  
 Patients between the ages of 2-16 years (inclusive) at the beginning of the reporting period, who were not pregnant and have been seen by the EP at least once during the report period and have a calculable BMI (See Nat'l Measures Glossary for detailed definitions).

Selected Rows: 1   Visible Rows: 32   Total Rows: 32



# 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



**HEALTH & HUMAN SERVICES**

IT DOMAIN PROGRAM MANAGEMENT OFFICE

# 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”.

The screenshot shows a software interface for defining a team panel. At the top, there are tabs: Definition, Layouts, Sharing, Preview, and Auto Repopulate Options. The 'Definition' tab is active.

Under the 'Definition' tab, there are several fields and options:

- Panel Name:** A text box containing 'Pats Assigned to Pink Team'.
- Category:** A dropdown menu.
- Designate as IPC Panel?** A checkbox that is checked.
- Properties:** A link to the right.
- Panel Description:** A large text area.

On the left side, there is a sidebar with 'Population Search Options' and a list of search criteria with radio buttons:

- No Predefined Population Search - Add Patients manually
- My Patients
- Patients Assigned to (selected)
- Scheduled Appts
- QMan Template
- RPMS Register
- EHR Personal List
- Ad Hoc Search
- Apply Additional Filters? (checkbox)

The main area is titled 'Patients Assigned to Parameters' and contains several sections:

- Patients NOT Assigned to a DPCP:** A radio button option.
- Providers:** A text box with an 'Edit' button.
- As:** A dropdown menu with 'DPCP' selected. A note says 'Select at least one type'.
- Specialty Provider:** A checkbox.
- Specialty Type:** A text box with an 'Edit' button.
- Min # of Visits within Timeframe:** Two dropdown menus with asterisks.
- Primary Visit Provider:** A checkbox.
- Primary/Secondary Visit Provider:** A checkbox.
- Team:** A dropdown menu with 'Pink Team' selected. A note says 'Selected Team Includes:'.
- Selected Team Includes:** A text box containing the following text:  
BOCIAN, MARY M  
LEE, PHUONG-THAO T  
GIORDANO, TUESDAY R

At the bottom, there is a status bar that says 'Filters - n/a'.



# IPC/Patient Detail

Pull "IPC" panel data. Measures divided into Core measures.

RPMS iCare - SQUIRES SKIP - DEMO HOSPITAL - DEV2 - VDENMHS08D01

File Edit View Tools Window Help Quick Patient Search:

Panel List Flag List Community Alerts Nat'l Measures ONET Meaningful Use IPC

Patient Detail Provider Detail Provider Aggregated Facility Aggregated

Filters: Optional filters can be used to focus your view

Category:

Panel: IPC Cancer Screening Bundle

DPCP	Patient Name	HRN	DOB	Last Visit Date	Cancer Screening				Health Risk Screening		
					Cancer Screening Bundle	Colorectal Cancer Screen 51-60	Mammogram Rates 52-64	Pap Smear Rates 21-64	Health Risk Screening Bundle	20+ BP Assessed	BMI Measured 2-74
	SHEY LAURELLE A		07/23/1913	09/25/2009	N/A	N/A	N/A	N/A	NO	YES	N/A
			06/28/1938	09/25/2009	YES	YES	N/A	N/A	NO	NO	NC
			07/16/1949	10/05/2009	NO	N/A	NO	YES	NO	NO	NC
			09/07/1951	09/21/2009	NO	NO	NO	YES	NO	NO	NC
			07/30/1983	09/25/2009	YES	N/A	N/A	YES	NO	NO	YES
			05/24/1941	08/28/2008	YES	YES	N/A	N/A	NO	NO	NC
			11/24/1946	07/07/2008	NDA	NDA	NDA	NDA	NDA	NDA	NDA
			11/11/1953	09/25/2009	NO	NO	N/A	N/A	NO	NO	NC
			07/15/1952		NDA	NDA	NDA	NDA	NDA	NDA	NDA
			11/24/1955	08/31/2009	NO	NO	NO	YES	NO	NO	NC
			07/31/1961	08/14/2008	N/A	N/A	N/A	N/A	NO	NO	YES
			12/28/1963	09/25/2009	YES	N/A	N/A	YES	NO	NO	YES
			04/07/1943	10/01/2009	YES	YES	N/A	N/A	NO	NO	NC
			07/28/1965	05/26/2009	N/A	N/A	N/A	N/A	NO	NO	NC
			06/21/1966	09/30/2009	N/A	N/A	N/A	N/A	NO	NO	YES

Total Rows: Visible Rows: Selected Rows:

# IPC/Provider Detail

RPMS iCare - SQUIRES,SKIP - DEMO HOSPITAL - DEV2 - VDENMIHSDBD01

File Edit View Tools Window Help Quick Patient Search:

Panel List Flag List Community Alerts Nat'l Measures CMET Meaningful Use **IPC**

Patient Detail **Provider Detail** Provider Aggregated Facility Aggregated

Filters  
Optional filters can be used to focus your view

Category:  Edit

Update View

Save current settings to User Preferences?

Save

Restore to User Pref

Panel: IPC Cancer Screening Bundle

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	

Total Rows: Visible Rows: Selected Rows:

# IPC/Provider Aggregated

RPMS iCare - SQUIRES,SKIP - DEMO HOSPITAL - DEV2 - VDENMIHSDBD01																
File Edit View Tools Window Help Quick Patient Search: <input type="text"/>																
Panel List Flag List Community Alerts Nat'l Measures CMET Meaningful Use IPC																
Patient Detail Provider Detail <b>Provider Aggregated</b> Facility 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		
	Supplemental	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		
		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 Patients 15-40: 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

RPMS iCare - SQUIRES,SKIP - DEMO HOSPITAL - DEV2 - VDENMIHSDBD01													
<div>File Edit View Tools Window Help</div> <div>Quick Patient Search: <input type="text"/></div> <div>Panel List Flag List Community Alerts Nat'l Measures CMET Meaningful Use <b>IPC</b></div>													
<div>Patient Detail Provider Detail Provider Aggregated <b>Facility Aggregated</b></div>													
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	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	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	N/A	
	Cancer Screening Bundle	N/A	N/A	N/A	22%	N/A	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	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	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	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	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	N/A	
	DM: Dental Access	N/A	N/A	N/A	0%	N/A	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	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	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	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	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	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	N/A	
	Female Patients 15-40: 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	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	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	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	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	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	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	N/A	
	Topical Fluoride Pts	N/A	N/A	N/A	0%	N/A	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	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	N/A	
	DM: Comprehensive Care	N/A	N/A	N/A	0%	N/A	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	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



**HEALTH & HUMAN SERVICES**

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# 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



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# Questions?



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