Module 15: Documenting Your Work with Practices

B. Sample Practice Record

Encounter Notes

Clinic ALLOVERTHEPLACE			
Practice Facilitator (PF)	Lisa Helps A lot	Cell:	Email:
PF Standing Visit (day/time):	Mondays 1-4		
Practice status	Active		
Nominate as Exemplar on:			
Pneumococcal Vaccine delivery	80% of indicated vs. 20% in similar practices in area		

Improvement & Study Projects participating in:	Start date	End date	Description
1) Chronic Kidney Disease guideline implementation	9/1/12	10/2/13	Improve quality and outcomes for patients with CKD
2) Implement Care Teams	11/21/12	11/21/12	Implement care teams to support transformation to patient-centered medical home and to improve access and quality

Encounter Notes - Overview (date)	Practice Status 0=no progress, 1=some progress, 2=solid progress	Notes
9/1/12	2	CKD: Met with CKD champion for practice and his team; held project kick-off meeting; academic detailing on CKD guidelines and their use in primary care
9/8/12	1	CKD: Met with registry manager at request of Dr. Like Data. There are problems pulling eGFR data into the registry. Also, clinicians are coding CKD as
10/12/12	0	CKD: Dr. CKD not able to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to
10/22/12	0	CKD: No progress with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with
11/8/12	2	CKD: Met with Dr. CKD and reviewed performance data. Dr. CKD indicates that information on medications is probably inaccurate due to out of date
11/18/12	2	CKD: Provided 15 minute training to CKD improvement team on Model for Improvement; provided training also on effective meeting facilitation.

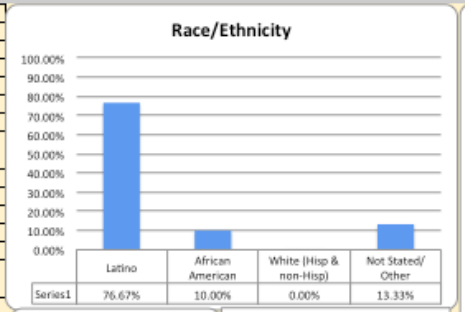
PRACTICE PROGRESS DASHBOARD PROJECT	CKD	
Overall Assessment Scales:		0 = No activity; 1 = Planning; 2 = Activity, no change; 3 = Testing; 4 = Implementation; 5 = Spread; 6 = Complete
A. Create Quality Improvement team/cmt and performance monitoring system	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:	4	
A1. Designate Project team leader	6	Dr. CKD is the champion.
A2. Identify performance metrics	6	
A3. Develop performance report generator using EHR and registry data	3	
A4. Map workflow for performance reporting & use	3	
A5. Train Project team on Model for Improvement and PDSA cycles	6	
A6. Review performance report monthly and carry-out PDSAs	0	
B. Use registry to manage target population	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:	3	
B1. Create registry	3	Underway, waiting for registry manager to return from vacation
B2. Populate registry		
B3. Assess & leverage existing population management resources		
B4. Train staff in population management		
B5. Map workflow for population management		
B6. Create reports templates/alerts to allow population management & planned care		
B7. Monitor use of registry to manage patient care and support population management		
C. Use templates	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:		
C1. Select template tool from registry/EHR (or create)	1	Dr. CKD plans to meet with EHR manager to create template.
C2. Map workflows to use template		
C3. Use template at every patient visit		
C4. Ensure registry/EHR updated after every patient visit		
C5. Monitor use of templates		
D. Standardize care	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:		
D1. Select protocol/guideline for clinical care issue	3	Dr. CKD and team have adopted the CKD guidelines provided by the project. Are discussing modifying lab requirements since some of the labs are expensive and hard to obtain for uninsured patients. Will help schedule virtual conference with Academic Detailer for Dr. CKD and his team to discuss this issue with him.
D2. Modify for use in safety net environment		
D3. Map workflow to implement/use protocol		
D4. Use protocol at every patient visit		
D5. Monitor use of protocol		
E. Self Management support	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:		
E1. Assess existing SMS resources at practice		

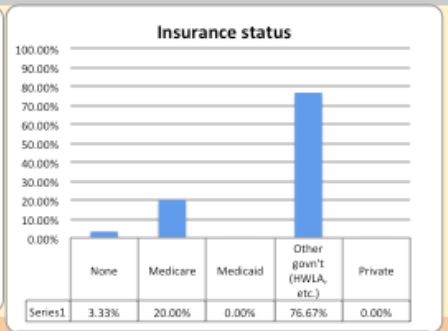
Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

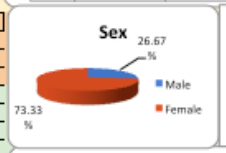
Baseline Performance Data

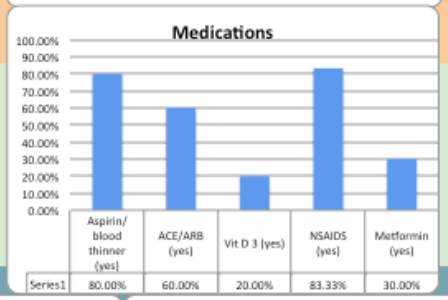
	Baseline		
N for performance data abstration	30	CKD pts seen at least 2x from 8-30-10 to 9-1-11	collected 10/24/11

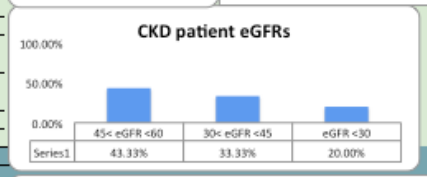
	%	#
Demographics		
Male	26.67%	8
Female	73.33%	22
Average age	61.07	
Age range	36-75	-
Latino	76.67%	23
African American	10.00%	3
White (Hisp & non-Hisp)	0.00%	0
Not Stated/Other	13.33%	4
Insurance status		
None	3.33%	1
Medicare	20.00%	6
Medicaid	0.00%	0
Other govn't (HWLA, etc.)	76.67%	23
Private	0.00%	0
CKD patients comorbidities/risk indicators		
DM Dx	3.33%	1
HTN Dx	13.33%	4
DM & HTN	80.00%	24
BP>130/80	53.33%	16
LDL<100		10
Calcium >8.5**		15
PO4 <4.6**		3
Smoker	3.33%	1
Smoking status missing	6.67%	2
CKD on problem list?		
Yes	93.33%	28
No	6.67%	2
Medication		
Aspirin/blood thinner (yes)	80.00%	24
ACE/ARB (yes)	60.00%	18
Vit D 3 (yes)	20.00%	6
NSAIDS (yes)	83.33%	25
Metformin (yes)	30.00%	9
Labs		
45< eGFR <60	43.33%	13
30< eGFR <45	33.33%	10
eGFR <30	20.00%	6
eGFR missing	0.00%	0
In the past 12 months:		
eGFR	96.67%	29
Referral if eGFR<30	33.33%	2
HbA1c	53.33%	16
Lipid panel	60.00%	18
Serum Ca++	86.67%	26
HGB	50.00%	15
25 hydroxy Vit D	50.00%	7
PTH	23.33%	7
Serum phosphate	20.00%	6
M/C	43.33%	13
Preventive care		
Flu vaccine last 12 months	40.00%	12
Pneumoccocal		

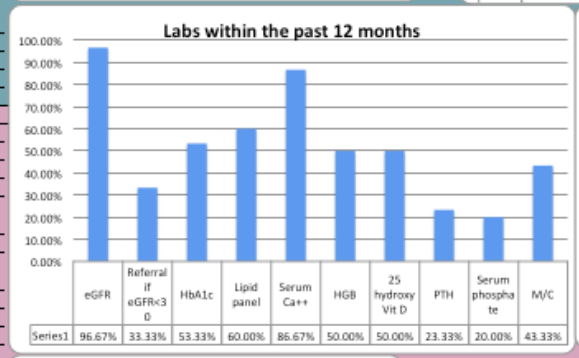


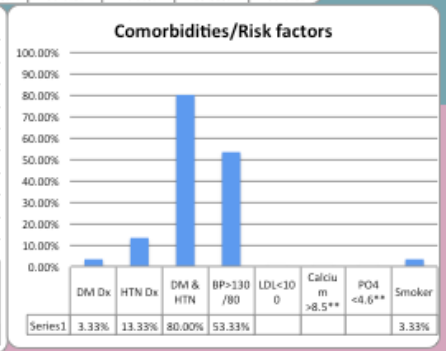


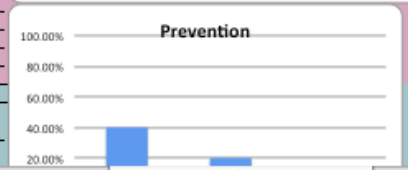












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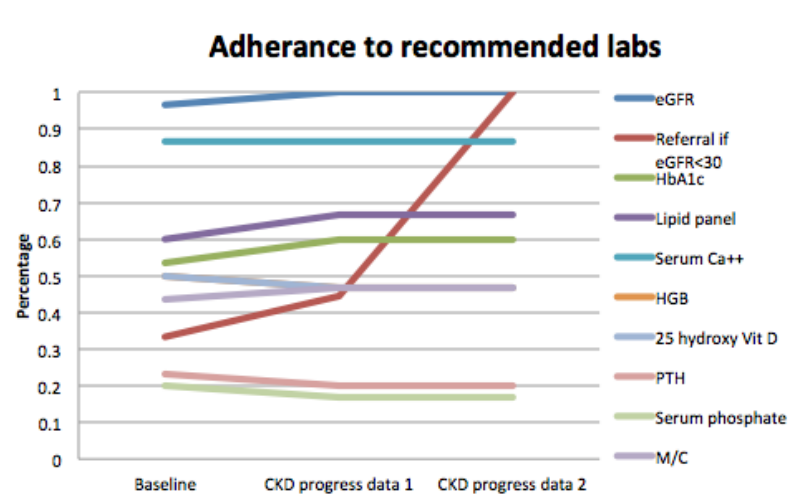
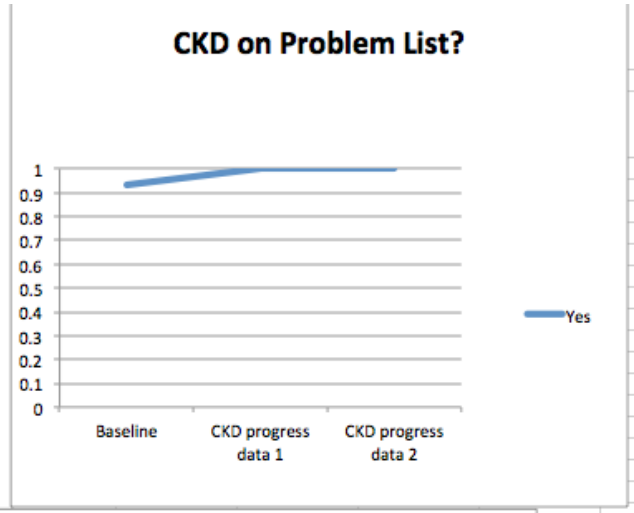
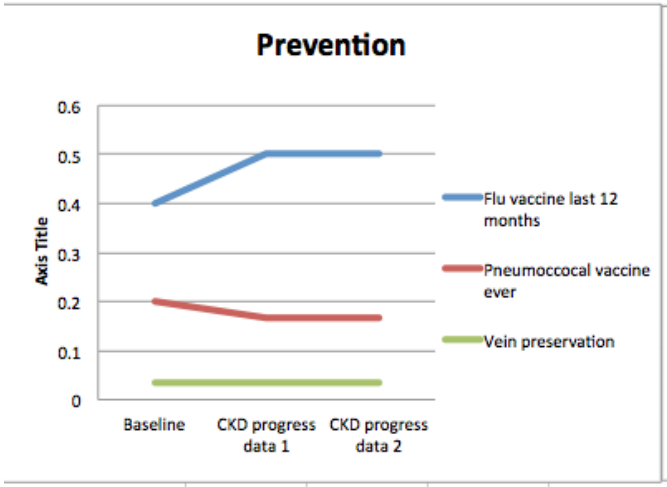
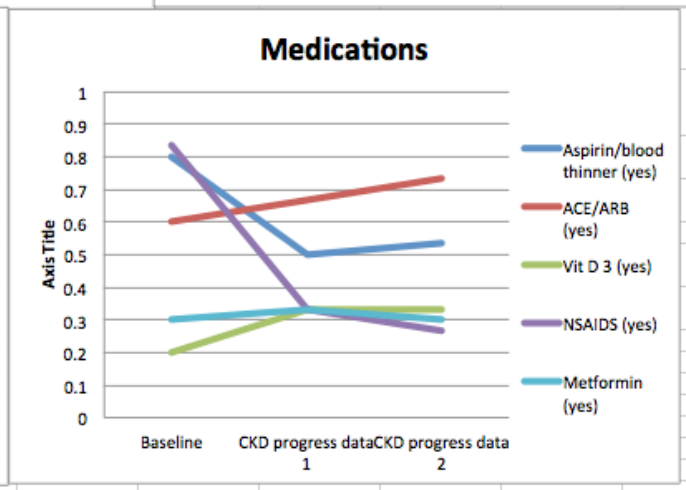
Performance Data Run Chart









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Plan Do Study Act Report

PLAN DO STUDY ACT (PDSA) REPORT

Aim: (overall goal you wish to achieve):			
Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Plan List the tasks needed to set up this test of	Person responsible	When to be done	Where to be done
Predict what will happen when the test is	Measures to determine if prediction succeeds		
Do: Describe what actually happened when you ran the test			
Study: Describe the measured results and how they compared to the predictions			
Act: Describe what modifications will be made to the plan for the next cycle based on what you learned			

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