

8) Care Tracker – FINALIST

Signature Healthcare

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PROJECT DESCRIPTION

The Care Tracker program collates data from multiple sources, including billing claims, Meditech data from hospital/inpatient, the outpatient electronic medical record, and provider data. Using internal logic it presents data based upon age, sex, and disease state to the provider; last done, and next needed, such as pap smears, colonoscopy, and mammograms for cancer screening, as well as last diabetes HBAIC test, urine test, cholesterol, Prostate-specific antigen, and Ophthalmology visit. Key disease states, with diagnostic codes and medication list, are included to bring together a complete snapshot of the patient's health needs. Included in these synopses are wellchild visits for Family Practitioners.

The document is utilized by all primary care providers at all visits – it is printed prior to all patient encounters including physicals, chronic disease management visits, and same day urgent visits. Workflows have been established so that the Medical Assistant/ Nurse reviews the form and highlights for the provider the gaps in care that need to be attended to. The provider then will have discussion with the patient about the gaps and works toward ordering, booking etc., the care that is needed.

OUTCOMES ACHIEVED

To date:

- Every PCP has demonstrated >5% reduction in missing tests on at least 1 of the 6 measures
- 80% of PCPs improved on 4 of 6 measures
- 50% of PCPs improved on 5 of 6 measures
- In some cases, PCPs were able to reduce the percentage in missing tests in their patient panel by >40%.

LESSONS LEARNED

- This approach to population management is well suited to addressing the high prevalence of multiple chronic conditions.
- Although ambulatory locations and hospitals may use different electronic medical records systems, there is a possibility of integrating them to help patients with a comprehensive, preventative care plan.