Improving Primary Care Physician Visit Compliance

HVCS QI Team

November 16, 2017

QI Team

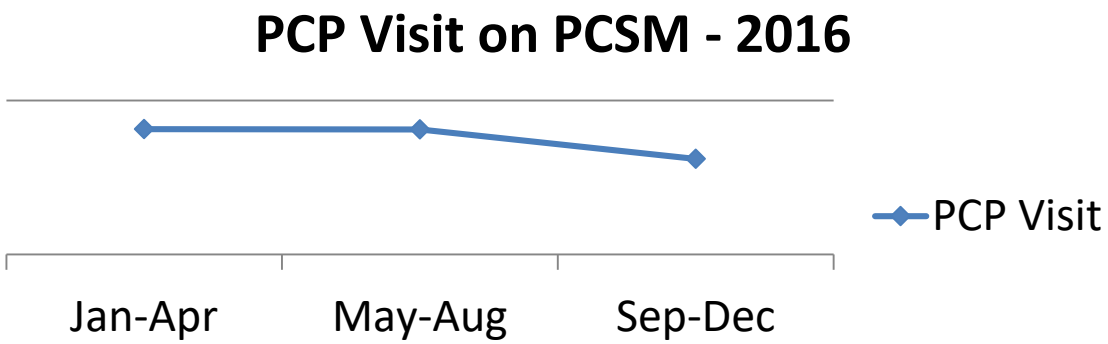
- Elizabeth Hurley, Assistant Director of Client Services
- LaShonda Cyrus, Senior Program Supervisor
- Kevin Smedman Jr., Program Supervisor
- Pat Jacobs, Case Manager
- Sandra Katz, Quality Improvement Specialist

About HVCS

- Operate in 7 counties in the Hudson Valley
  - Westchester, Putnam, Rockland, Orange, Dutchess, Sullivan and Ulster
- Medical Case Management, Transportation, THRIVES Nutrition, Housing, Behavioral Health
- Health Home
- Education and Prevention: Substance use outreach, Syringe Exchange, HIV/HCV/SDT testing

QI Question

Why did timely attendance to PCP visits decline according to the eSHARE Primary Care Status Measures?



Goal: Increase PCP Compliance to 85%

Background

Regular PCP appointments are important to ensure clients:

- can discuss medical or medication concerns
- obtain latest viral loads and CD4 counts
- uncover new medical issues before they become more complicated

Plan

Task	Who?
Compare eSHARE PCSM dates against actual date of the last PCP visit	CQI
Share report and reconcile dates	MCM team
Amend private tracker to include last and upcoming PCP visit	CQI and Program Supervisor
Identify clients with past due visits. Reduce barriers to arrange a PCP visit	CM
Run private tracker and eShare generated Scheduling/Reporting report to compare results	CQI and MCM team

Baseline Data

eShare Report – PCSM		
Client ID	Last Form Update	Result for PCP
Client 1	12/6/2016	Not Late
Client 2	11/21/2016	Late
Client 3	11/20/2016	Late
Client 4	12/7/2016	Not Late
Client 5	12/2/2014	Group
Client 6	12/21/2016	Not Late
Client 7	10/03/2012	Group
Client 8	12/7/2016	Group

HVCS Tracker – PCP Visit		
Client ID	Tracker Form Update	Result for PCP
Client 2	11/21/2016	Late
Client 3	11/20/2016	Late
Client 9	2/3/2017	Late
Client 10	1/3/2017	Late
Client 11	9/14/2016	Late
Client 12	1/6/2017	Late
Client 13	3/16/2017	Late
Client 14	12/7/2016	Late
Client 15	8/2/2016	Late

Result: Our trackers agreed that 2 clients were late with PCP visits
Based on the actual data in eShare for PCP visits, we had 9 clients with late visits

Intervention

New

Intake Date	Last Reassess./ CSP	Next Reassess. / CSP Due	Reassess. due in days	Last Home Visit	Last face-to-face w/CM	Release signed date	Date of Med.CC	PCSM entered in eShare	Current PCP Visit	Upcoming PCP Visit	VL Count	VL Test Date
5/2/13	10/12/17	4/10/18	-160.00	10/12/17	10/12/17	10/12/17	12/1/15	8/2/2017	12/27/16	scheduling	20.00	9/29/2016
12/7/12	6/1/17	11/28/17	-28.00	9/21/17	9/21/17	12/9/16		10/13/2017	9/8/17	scheduling	20.00	9/8/2017
2/20/14	7/17/17	1/17/18	-77.00	5/19/16	5/19/16	12/29/16	2/24/17	6/27/2017	9/17/17	3/17/18	928.00	2/7/2017
12/29/15	6/1/17	11/28/17	-28.00	6/1/17	6/1/17	12/9/16		8/4/2017	8/4/17	2/18/18	20.00	8/4/2017
2/28/11	10/2/17	3/31/18	-150.00	4/7/17	4/7/17	4/7/17	4/11/17	8/22/2017	8/1/17	2/1/18	20.00	2/3/2017
7/27/11	10/4/17	4/2/18	-152.00	3/19/12	10/11/17	8/2/17	4/19/17	10/11/2017	10/2/17	1/2/18	20.00	10/2/2017

May Data

eShare Report - PCSM		
Client ID	**Expected Service Date**	**Result for PCP**
Client 1	4/3/2017	Late
Client 2	3/29/3017	Not Late
Client 3	4/3/3017	Late
Client 4		Not Late (Group)
Client 5		Not Late (Group)
Client 6		Not Late (Group)
Client 7		Not Late (Group)

HVCS Tracker – PCP Visit		
Client ID	**Expected Service Date**	**Result for PCP**
Client 1	4/3/2017	Late
Client 3	4/3/3017	Late
Client 8	4/28/2017	Late
Client 9	4/15/2017	Late

May Summary

eShare:

- 7 clients categorized as late on PCSM
  - 4 were group clients
  - 2 agree PCP visit late; 1 PCSM late

HVCS Tracker:

- 2 additional clients had late PCP

Overall PCP Compliance:

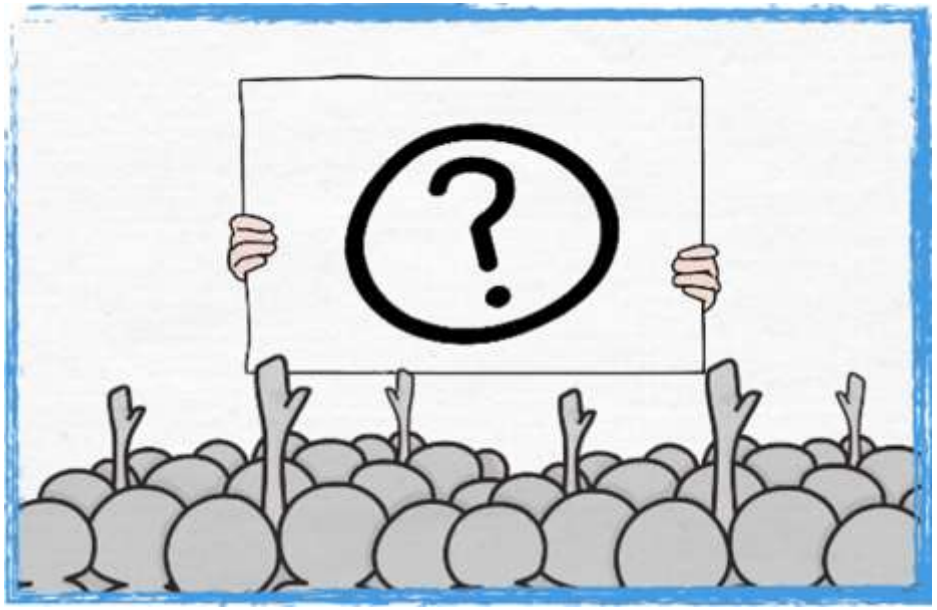
29 out of 33 – 88%

Act

- Amend private tracker: “Next PCP visit” and color coded
- Supervisors review with care managers

- Clients who are not visiting PCP may face suspension of other services

Example: Transportation provided to physician (no support groups until compliance) or THRIVES clients see physician before next distribution of food etc.



THANK YOU!

Development and Utilization of Custom Food and Nutrition Services (FNS) Program Database for Quality Monitoring and Improvement

Kavitha Balakumar, MPH, Program Manager

Esther Fleharty, Assistant Program Coordinator

Rebecca Lindner, QI Analyst

Mount Sinai

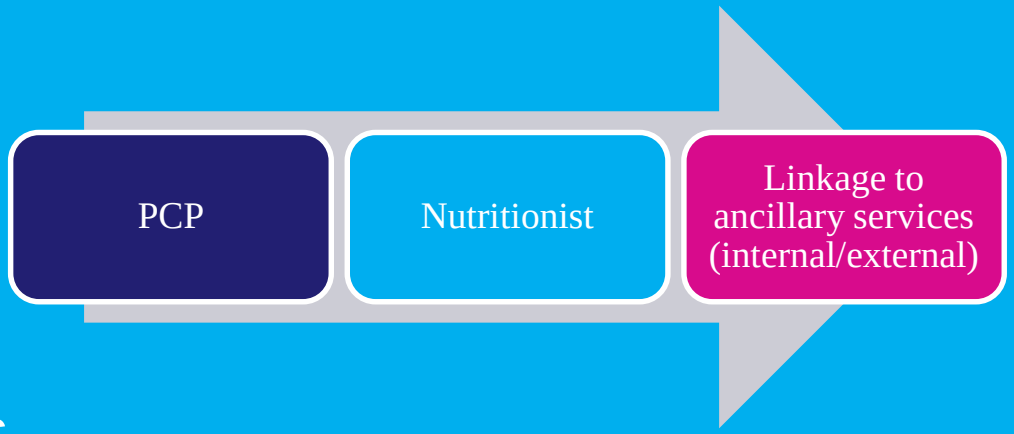
Institute for Advanced Medicine

Who We Are

- Five-site network of hospital and community-based clinics caring for more than 13,000 patients with and at-risk for HIV/AIDS
- Co-located, comprehensive services to reduce barriers and increase a patient centered approach to care
- The Food and Nutrition Services (FNS) Program is based out of our Morningside and Samuels clinics attached to Mount Sinai St. Luke's and Mount Sinai West Hospitals

About Us

- Food and Nutrition Services (FNS) Program at IAM
  - We are the only hospital-based FNS program in NYC
  - Unique service-delivery model



- CQI Goals

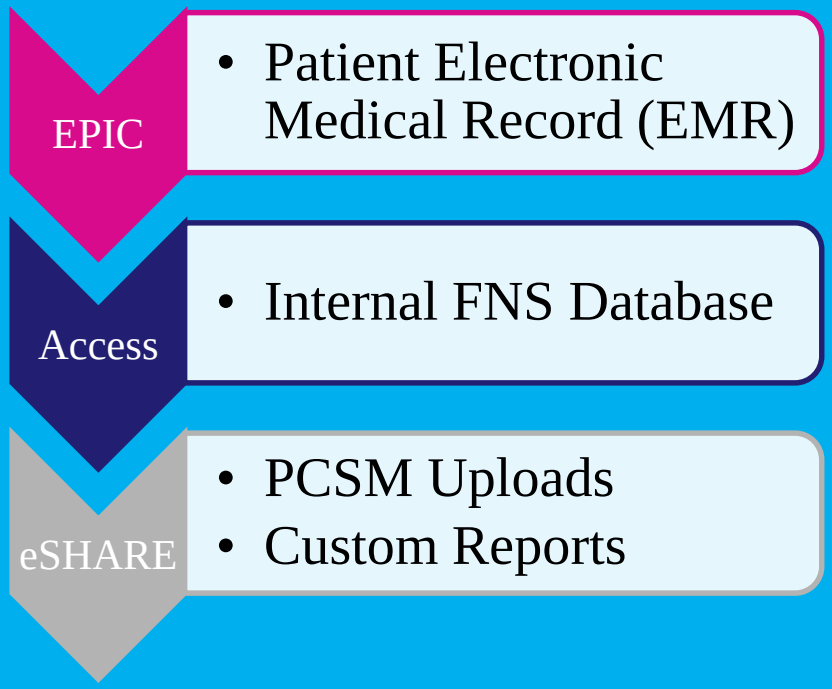
  Goal 1: Increase adherence to nutritional treatment plan (measured by reassessments conducted within appropriate window)

  Goal 2: Increase linkage of primary care and nutrition appointments

  Goal 3: Develop systems that facilitate efficient and accurate data collection and entry

Custom Access Database

- Internal tracking system adapted to our unique service delivery model
- Direct crosswalk between EPIC and Access
- Expands upon the functionality of eSHARE
  - Displays clinical data alongside programmatic data
- Facilitates more robust tracking of linkage to care
- Systematizes data entry pieces



Methods

HIV Indicators

- Linkage to HIV Primary Care
- ARTs
- Retention in HIV Care
- CD4 Count
- Viral Load
- PCP appointments

FNS CQI Indicators

- Reassessment Window
- Linkage of Primary Care and Nutrition Services
- Adherence to Nutritional Treatment Plan
- FNS Program Exposure

Linkage to Other Services at IAM

- Care Coordination
- Mental Health Services
- Substance Abuse Treatment
- Integrative Medicine (acupuncture, massage, yoga, meditation)

Other Clinical Quality Measures

- Tobacco Screening & Counseling
- BMI
- HCV Co-Infection Screening &Treatment

Implementation

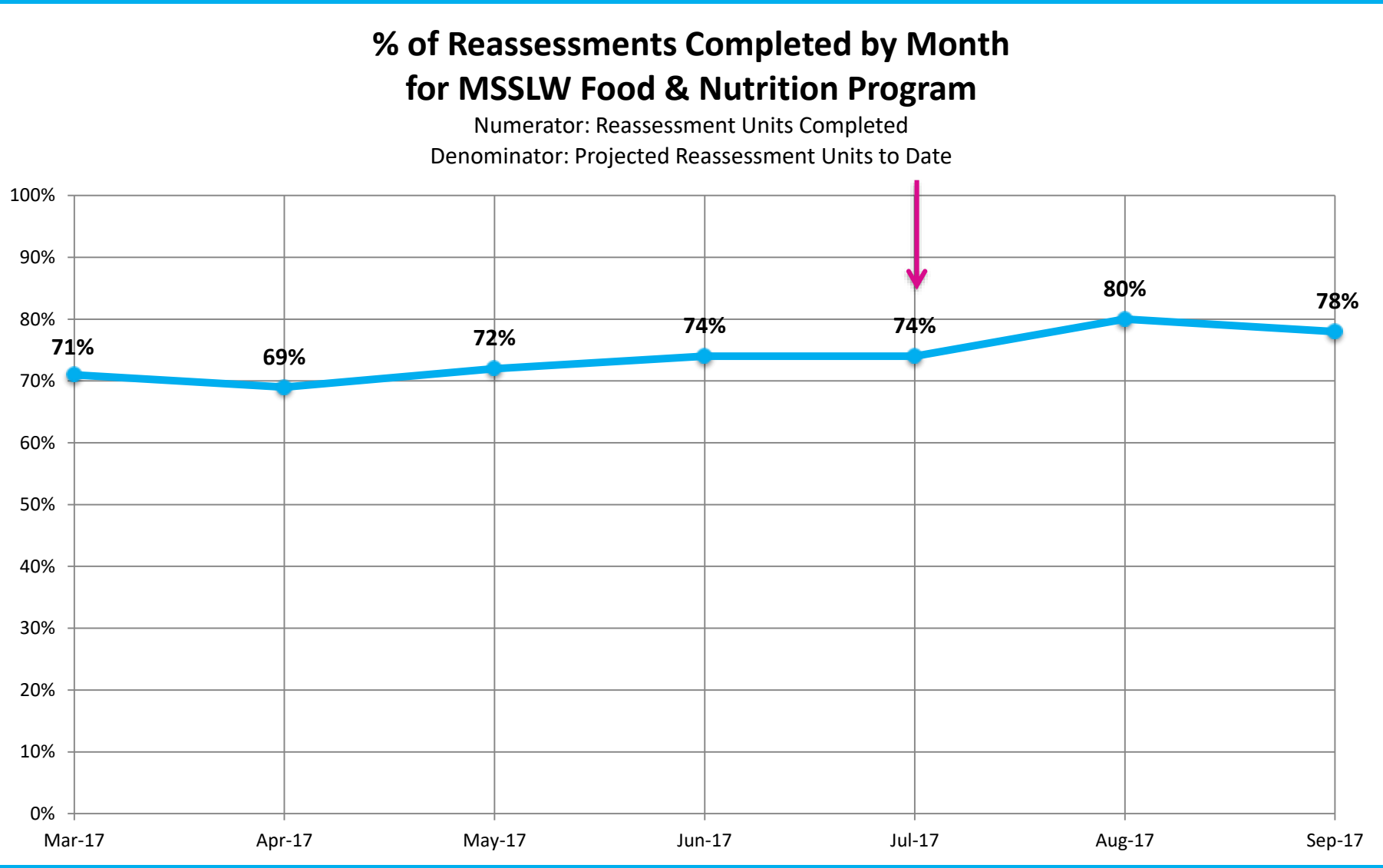
Mount Sinai

FNS Reassessments

Tuesday, July 18, 2017
4:28:57 PM

MRN	Last Name	First Name	DOB	Phone Number	Intake Date (Epic)	Last Reassess. Date (Epic)	Start of Reassess. Period	End of Reassess. Period	Next Scheduled PCP Visit
Reassessment Period Open									
111111	KNOPE	Leslie	1/2/2000	(999) 111-1111	10/20/2016		2/20/2017	7/19/2017	
222222	WYATT	Ben	1/3/1999	(999) 222-2222	3/2/2016	10/26/2016	2/26/2017	7/25/2017	7/19/2017
333333	DWYER	Andrew	3/2/1988	(999) 999-9999	5/24/2016	11/7/2016	3/7/2017	8/6/2017	7/18/2017
000000	HAVERFORD	Tom	1/1/2000	(999) 999-9999	6/15/2016	12/10/2016	4/10/2017	9/8/2017	8/25/2017
444444	LUDGATE	April	2/3/1989	(999) 444-4444	1/19/2017		5/19/2017	10/18/2017	8/8/2017
555555	SWANSON	Ron	5/6/1977	(999) 777-7777	7/11/2016	2/16/2017	6/16/2017	11/15/2017	
666666	PERKINS	Ann	7/1/1999	(999) 555-5555	2/16/2017		6/16/2017	11/15/2017	
777777	TRAEGER	Chris	12/1/1954	(999) 555-5555	11/11/2015	2/22/2017	6/22/2017	11/21/2017	7/31/2017

Results


% of Reassessments Completed by Month
for MSSLW Food & Nutrition Program
Numerator: Reassessment Units Completed
Denominator: Projected Reassessment Units to Date
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
69%
72%
74%
74%
80%
78%
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17

Future Directions

- Opportunities for expanding CQI initiatives
  - Viral load suppression
- Document additional clinic-based CQI initiatives pertaining to FNS patients
  - Opportunities to expand indicators in the database
- Opportunities for research
  - Longitudinal analysis on health indicators

Questions?

Thank you!

Kavitha.Balakumar@mountsinai.org

Esther.Fleharty@mountsinai.org

Rebecca.Lindner@mountsinai.org

Acknowledgements

Jennifer Irwin, MPA

Jill Pace, MPH

Shruti Ramachandran, MPH, MID

MSSL/MSW FNS Staff

Department of Special Projects Staff

A quality improvement project to improve quality improvement: *Lessons from one organization's quest for the most accurate data*

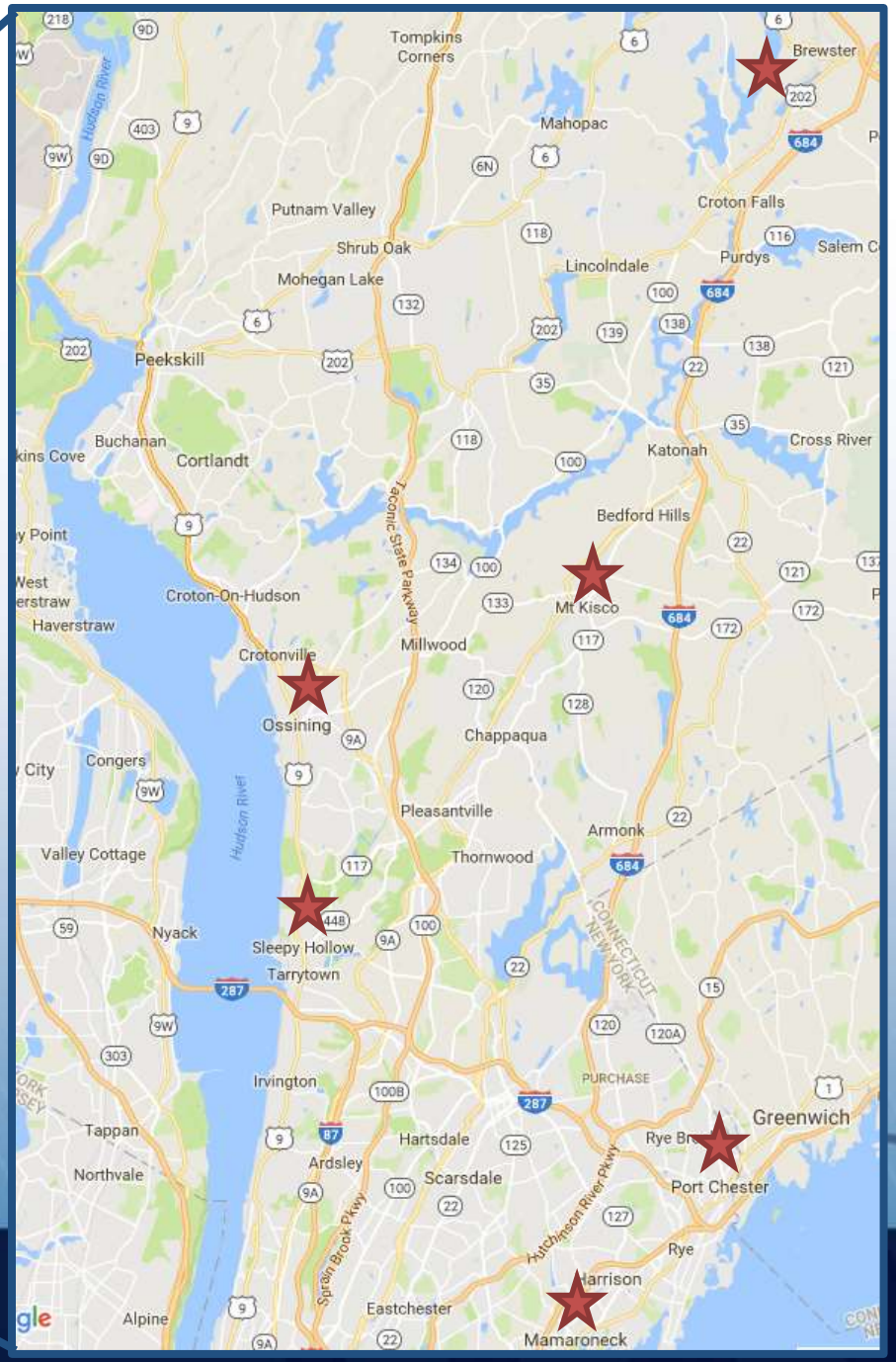
Karen Mandel, LMSW
Director of Care Coordination Programs
Open Door Family Medical Centers

Open Door
Family Medical Centers

Open Door Family Medical Centers

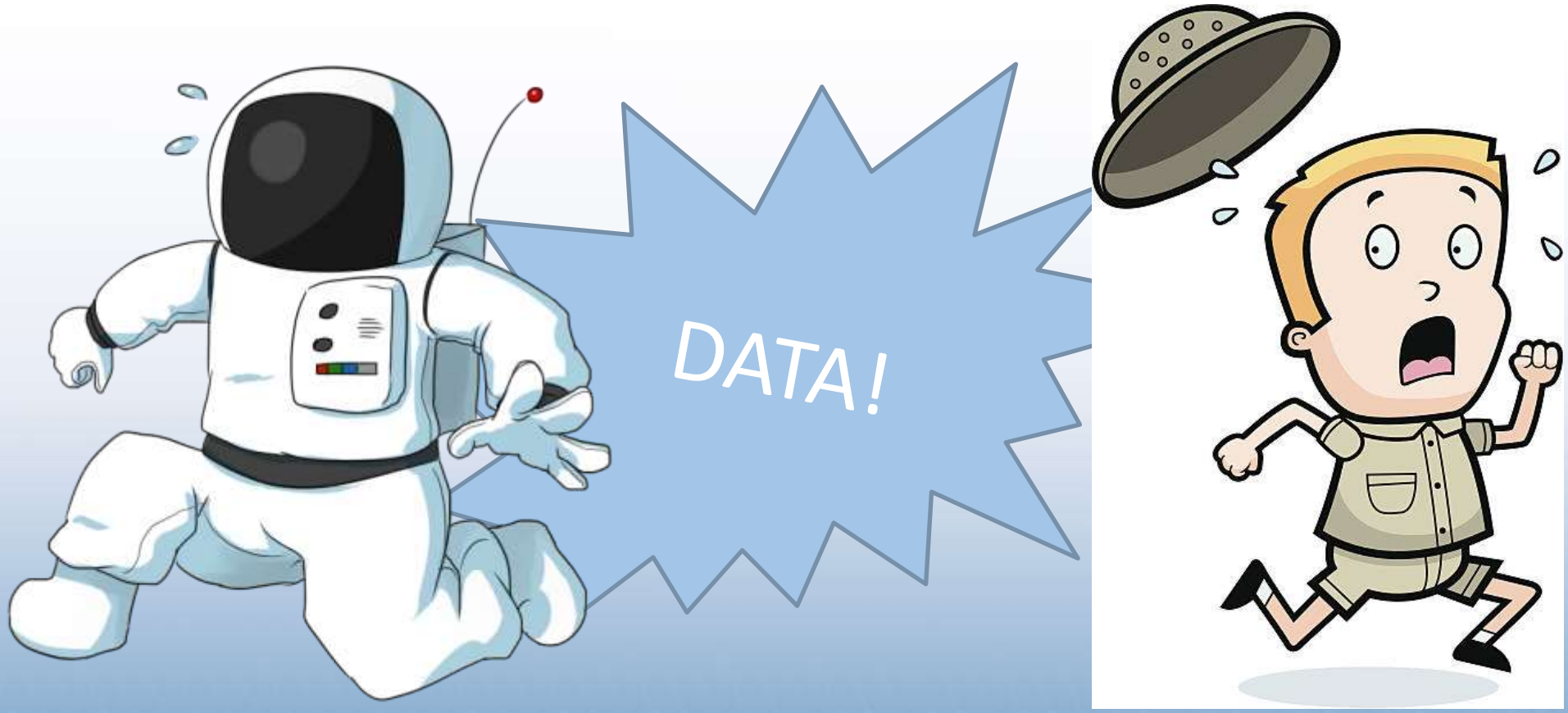
- Federally Qualified Health Center
- 6 community health centers (5 in Westchester County, 1 in Putnam County), 7 school based health centers (in 2 districts)
- Services include primary care and specialty care programs
- Demographics (2016)
  - 87% at 200% or below poverty level
  - 78% uninsured or Medicaid
  - 66% of our patients are better served in a language other than English
  - Majority Hispanic/Latino
  - Majority Elementary School Children (ages 5-11) and Adults (ages 25-49)


Newburgh
Danbury
Newtown
Ridgefield
Bridgeport
Fairfield
Norwalk
Hudson River
BRONX
MANHATTAN
New York
BROOKLYN
QUEENS
Hicksville
Hempstead
Commack
Long Island
Bay Shore
Great South Bay
Fire Island


Tompkins Corners
Brewster
Mahopac
Putnam Valley
Shrub Oak
Mohegan Lake
Croton Falls
Purdys
Lincolndale
Peekskill
Buchanan
Cortlandt
Katonah
Cross River
Bedford Hills
Croton-On-Hudson
Haverstraw
Mt Kisco
Millwood
Crotonville
Ossining
Chappaqua
Congers
Pleasantville
Armonk
Valley Cottage
Thornwood
Nyack
Sleepy Hollow
Tarrytown
Irvington
Tappan
Hartsdale
Ardsley
Northvale
Scarsdale
Greenwich
Port Chester
Rye
Harrison
Eastchester
Alpine
Mamaroneck
Hudson River
Taconic State Parkway
Sprain Brook Pkwy
Hutchinson River Pkwy
CONNECTICUT NEW YORK
PURCHASE

Disclosures

- I am not officially…
  - an IT expert
  - a data analyst
  - a statistician


DATA!

Overview

- Quality improvement initiatives are only effective if the data being utilized is accurate
- In order to obtain accurate data, quality improvement teams must consider matters pertaining to data input, system choice and output format, and validation strategy
- Organizational data systems need to be tailored for use with HIV care quality improvement initiatives

Overview

- Selecting a data system
- Identifying metrics
- Validating data

lecting a Data System

	G	H	N	O	P	Q	R	S	T	U
				If potential						
					Prenatal?	Month	Year	Screening tool used	If potential problem: was SW referral accepted?	Prenatal?
					Prenatal					
8	JA									
9	JAN									
10	JAN	OS2012								
11	JAN	OS2012-F-200								
12	JAN	OS2012-S1-2002								
13	JAN	OS2012-S2-2002	Sibling							
14	JAN	OS2012-S3-2002	Sibling-3							
15	JAN	OS2012-S4-2002	Sibling-4							
16	JAN	OS2012-2016	Target Child	258703						
17	JAN	OS2012-M-2016	Mother	213388						
18	JAN	OS2012-F-2016	Father	234366						
19	JAN	OS2012-S1-2016	Sibling-1							
20	JAN	OS2012-S2-2016	Sibling-2							
21	JAN	OS2012-S3-2016	Sibling-3							
22	JAN	OS2012-S4-2016	Sibling-4							
23	FEB	OS2012-2069	Target Child	218649						
24	FEB	OS2012-M-2069	Mother	129800						
25	FEB	OS2012-F-2069	Father	n/a						
26	FEB	OS2012-S1-2069	Sibling-1	141744						
27	FEB	OS2012-S2-2069	Sibling-2	260150						
28	FEB	OS2012-S3-2069	Sibling-3							
29	FEB	OS2012-S4-2069	Sibling-4							
30	FEB	OS2012-2070	Target Child	117756						
31	FEB	OS2012-M-2070	Mother	61698						
32	FEB	OS2012-F-2070	Father	210817						
33	FEB	OS2012-S1-2070	Sibling-1	67950						
34	FEB	OS2012-S2-2070	Sibling-2							
35	FEB	OS2012-S3-2070	Sibling-3							
36	FEB	OS2012-S4-2070	Sibling-4							

Selecting a Data System

- EXCEL
- EMR built-in reports
- Relevant Healthcare Technologies, Inc.: Web-based software for healthcare organizations
- Tableau: Multi-industry systems for data visualization
- Azara Healthcare, LLC: Data reporting and analytics for community health providers

Selecting a Data System

- Weigh your options
  - Cost
  - Compatibility with EMR
    - How much data can the system link to?
  - Where/how the data is housed/stored
  - Options
    - Patient-level data vs. aggregate data
    - Customizable time-frames
  - Usability
    - Do you have a “data person” or do you fill that role yourself?

Identifying Metrics

"How do the year end numbers look?"

Identifying Metrics

- Brainstorm all of the metrics you need
  - What data will you need for the next phase in the QI process addition to the current phase?
- Review and standardize data entry workflow proactively

Identifying Measures

- What do you want to measure?
  - Who are the patients, specify characteristics to limit the report by and where those characteristics are found in the EMR
  - What indicators do you need and where can those be found in the EMR
  - When—indicate time frame
  - Additional information to include and where to find it in the EMR
  - Individual-level data vs. aggregated data

Identifying Measures

- When you request a data report be prepared for you, be specific and clear

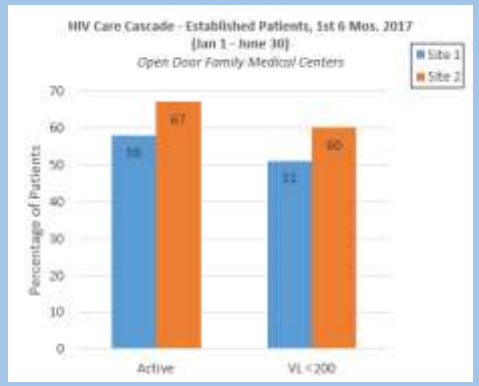
Request

I would like to calculate our agency's Viral Load Suppression Rate. Please can you run me a report with:

- Patients with an HIV diagnosis from clinician dx who have been to our agency from January 1 to June 30, 2017 for any type of visit
- Their last Viral Load within that same time period from the lab section of the EMR
- Please include the medical provider, care/case manager name and patient account number

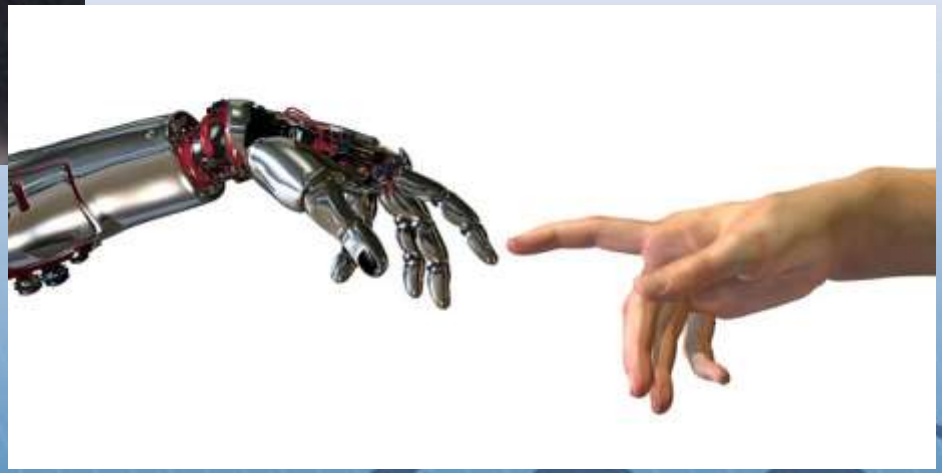
Result

Data to create the basics of a 6-month cascade



OPEN DOOR
FAMILY MEDICAL CENTERS

Validating Data



Validating Data

- Look for abnormalities in the data
- Select random charts to review
  - Where data is missing
  - Where data is accurate
- Do not stop old methods of data tracking until you are certain the new method works smoothly
  - Compare new to old
- Correct and validate again (and again, and again…)

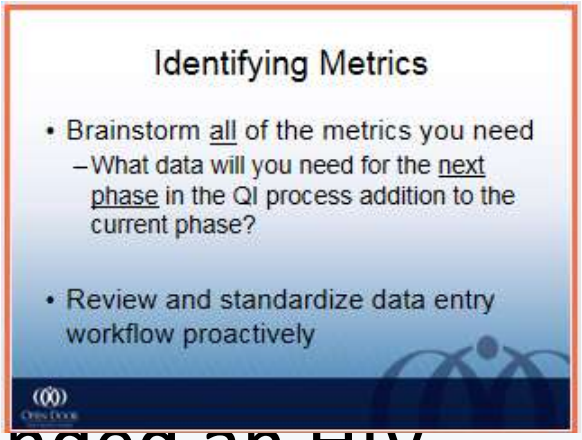
Case Example

- Standard of care at Open Door: Quarterly medical and case management visits for patients who are HIV+
- Question:
  - What % of active patients attended an HIV medical visit in each of the first two quarters of 2017 (Jan 1 – Mar 31, April 1 – June 30)?

Case Example: Selecting a Data System

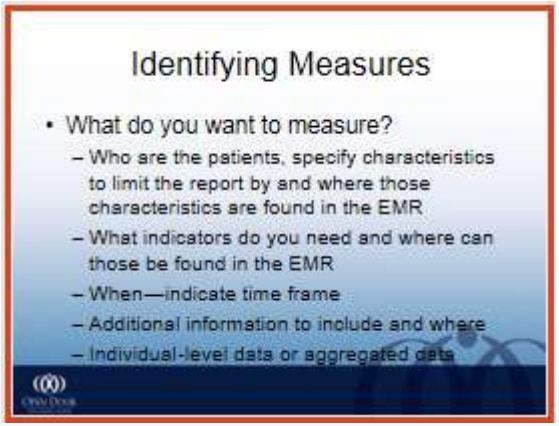
- Old system
  - EXCEL spreadsheet maintained by care/case managers
- New system
  - EMR—eCW
  - Relevant, reports function

Case Example: Identifying Metrics



- Current phase:
  - What % of active patients attended an HIV medical visit each of the first two quarters of 2017(Jan 1 – Mar 31, April 1 – June 30)?
- Next phase
  - After year-end, what % of patients attend all 4 quarterly visits? 3 visits? 2 visits? 1 visit? None?

Case Example: Identifying Metrics

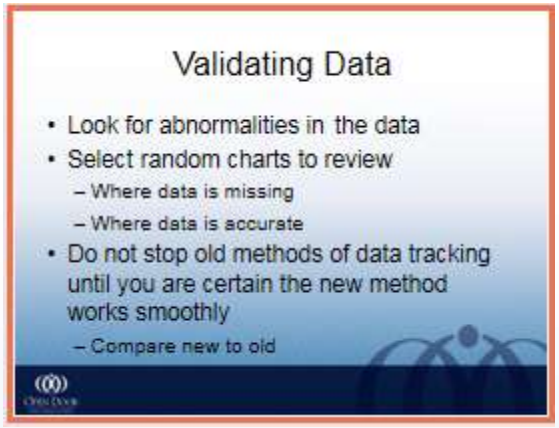


- Who: Patients with an HIV diagnosis from clinician dx, who have been to our agency from January 1 to June 30, 2017 for any type of visit
- What: Date of HIV medical visit (either monitoring or comprehensive exam) in each quarter, as indicated by CPT codes
- When: Jan 1 – Mar 31 and April 1 – June 30
- Additional information: Patient account #, PCP name, CM name
- Individual-level data

Case Example: Identifying Metrics

Pt Act #	PCP Name	CM Name	Date of HIV Med Visit Jan 1-Mar 31, 2017	Date of HIV Med Visit April 1-June 30, 2017
12345	Yam, MD	Parsnip	Feb 3, 2017	
67891	Parsley, MD	Squash	Mar 23, 2017	June 21, 2017

Case Example: Validating Data



Acct Number	Case/Care Manager	PCP	Last Visit of Any Type in Period	Qtrly Visit Date
112457	Squash	Parsley, MD	2017-05-10	Qtrly Visit: HIV Comp Exam on 2017-05-10
88255	Rutabaga	Yam, MD	2017-06-12	Qtrly Visit: HIV Comp Exam on 2017-06-12
211171	Parsnip	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
107966	Squash	Parsley, MD	2017-06-20	
272879	Parsnip	Yam, MD	2017-02-28	
323859	Melon	Parsley, MD	2017-06-09	Qtrly Visit: HIV Monitoring Exam on 2017-06-09
134031	Parsnip	Yam, MD	2017-06-14	Qtrly Visit: HIV Monitoring Exam on 2017-06-14
312454	Parsnip	Yam, MD	2017-04-21	Qtrly Visit: HIV Monitoring Exam on 2017-04-21
48510	Melon	Parsley, MD	2017-06-23	Qtrly Visit: HIV Monitoring Exam on 2017-06-23
211171	Mango	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
268054	Squash	Parsley, MD	2017-01-24	
147371	Squash	Parsley, MD	2017-04-18	Qtrly Visit: HIV Monitoring Exam on 2017-04-18
111111		Peach, MD	2017-05-05	
269642	Parsnip	Yam, MD	2017-06-19	Qtrly Visit: HIV Monitoring Exam on 2017-06-19
114473	Rutabaga	Yam, MD	2017-06-20	Qtrly Visit: HIV Comp Exam on 2017-06-20
315180	Squash	Parsley, MD	2017-04-07	Qtrly Visit: HIV Monitoring Exam on 2017-04-07

Case Example: Validating Data

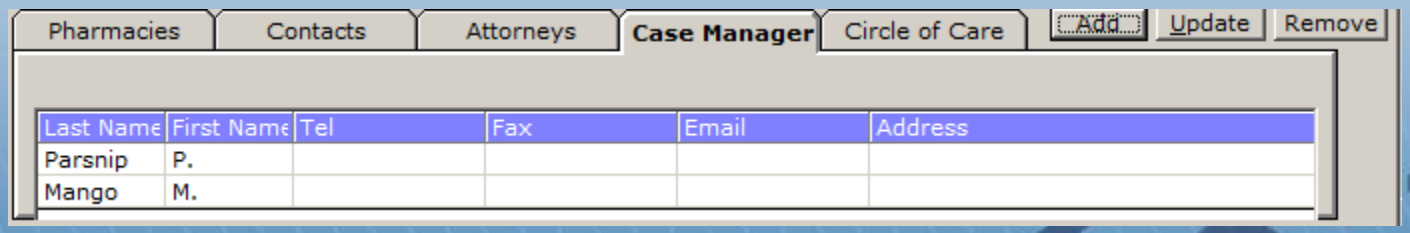
Acct Number	Case/Care Manager	PCP	Last Visit of Any Type in Period	Qtrly Visit Date
112457	Squash	Parsley, MD	2017-05-10	Qtrly Visit: HIV Comp Exam on 2017-05-10
88355	Rutabaga	Yam, MD	2017-06-12	Qtrly Visit: HIV Comp Exam on 2017-06-12
211171	Parsnip	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
107906	Squash	Parsley, MD	2017-06-20	6/20/2017
272879	Parsnip	Yam, MD	2017-06-26	6/26/2017
323859	Melon	Parsley, MD	2017-06-09	Qtrly Visit: HIV Monitoring Exam on 2017-06-09
134031	Parsnip	Yam, MD	2017-06-14	Qtrly Visit: HIV Monitoring Exam on 2017-06-14
312454	Parsnip	Yam, MD	2017-04-21	Qtrly Visit: HIV Monitoring Exam on 2017-04-21
48510	Melon	Parsley, MD	2017-06-23	Qtrly Visit: HIV Monitoring Exam on 2017-06-23
211171	Mango	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
208654	Squash	Parsley, MD	2017-01-24	No visit
147371	Squash	Parsley, MD	2017-04-18	Qtrly Visit: HIV Monitoring Exam on 2017-04-18
111111		Peach, MD	2017-05-05	No visit
269642	Parsnip	Yam, MD	2017-06-19	Qtrly Visit: HIV Monitoring Exam on 2017-06-19
114473	Rutabaga	Yam, MD	2017-06-20	Qtrly Visit: HIV Comp Exam on 2017-06-20
315180	Squash	Parsley, MD	2017-04-07	Qtrly Visit: HIV Monitoring Exam on 2017-04-07

CPT	M1	M2	M3	Name
99211				Office Visit, Est Pt., Level 1
99212				Office Visit, Est Pt., Level 2
99213				Office Visit, Est Pt., Level 3
99214				Office Visit, Est Pt., Level 4
99215				Office Visit, Est Pt., Level 5

CPT	M1	M2	M3	Name
99211				Comp Ann HIV Exam Est Lev1
99212				Comp Ann HIV Exam Est L2
99213				Comp Ann HIV Exam Est L3
99214				Comp Ann HIV Exam Est L4
99215				Comp Ann HIV Exam Est L5

Case Example: Validating Data

Acct Number	Case/Care Manager	PCP	Last Visit of Any Type in Period	Qtrly Visit Date
112457	Squash	Parsley, MD	2017-05-10	Qtrly Visit: HIV Comp Exam on 2017-05-10
88355	Rutabaga	Yam, MD	2017-06-12	Qtrly Visit: HIV Comp Exam on 2017-06-12
211171	Parsnip	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
107906	Squash	Parsley, MD	2017-06-20	
272879	Parsnip	Yam, MD	2017-02-28	
323859	Melon	Parsley, MD	2017-06-09	Qtrly Visit: HIV Monitoring Exam on 2017-06-09
134031	Parsnip	Yam, MD	2017-06-14	Qtrly Visit: HIV Monitoring Exam on 2017-06-14
312454	Parsnip	Yam, MD	2017-04-21	Qtrly Visit: HIV Monitoring Exam on 2017-04-21
48510	Melon	Parsley, MD	2017-06-23	Qtrly Visit: HIV Monitoring Exam on 2017-06-23
211171	Mango	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
208654	Squash	Parsley, MD	2017-01-24	
147371	Squash	Parsley, MD	2017-04-18	Qtrly Visit: HIV Monitoring Exam on 2017-04-18
111111		Peach, MD	2017-05-05	
269642	Parsnip	Yam, MD	2017-06-19	Qtrly Visit: HIV Monitoring Exam on 2017-06-19
114473	Rutabaga	Yam, MD	2017-06-20	Qtrly Visit: HIV Comp Exam on 2017-06-20
315180	Squash	Parsley, MD	2017-04-07	Qtrly Visit: HIV Monitoring Exam on 2017-04-07



Case Example: Validating Data

Acct Number	Case/Care Manager	PCP	Last Visit of Any Type in Period	Qtrly Visit Date
112457	Squash	Parsley, MD	2017-05-10	Qtrly Visit: HIV Comp Exam on 2017-05-10
88355	Rutabaga	Yam, MD	2017-06-12	Qtrly Visit: HIV Comp Exam on 2017-06-12
211171	Parsnip	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
107906	Squash	Parsley, MD	2017-06-20	
272879	Parsnip	Yam, MD	2017-02-28	
323859	Melon	Parsley, MD	2017-06-09	Qtrly Visit: HIV Monitoring Exam on 2017-06-09
134031	Parsnip	Yam, MD	2017-06-14	Qtrly Visit: HIV Monitoring Exam on 2017-06-14
312454	Parsnip	Yam, MD	2017-04-21	Qtrly Visit: HIV Monitoring Exam on 2017-04-21
48510	Melon	Parsley, MD	2017-06-23	Qtrly Visit: HIV Monitoring Exam on 2017-06-23
211171	Mango	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
208654	Squash	Parsley, MD	2017-01-24	
147371	Squash	Parsley, MD	2017-04-18	Qtrly Visit: HIV Monitoring Exam on 2017-04-18
111111		Peach, MD	2017-05-05	
269642	Parsnip	Yam, MD	2017-06-19	Qtrly Visit: HIV Monitoring Exam on 2017-06-19
114473	Rutabaga	Yam, MD	2017-06-20	Qtrly Visit: HIV Comp Exam on 2017-06-20
315180	Squash	Parsley, MD	2017-04-07	Qtrly Visit: HIV Monitoring Exam on 2017-04-07

, HIV infection in mother during pregnancy, antepartum - 098.719

Case Example: Validating Data

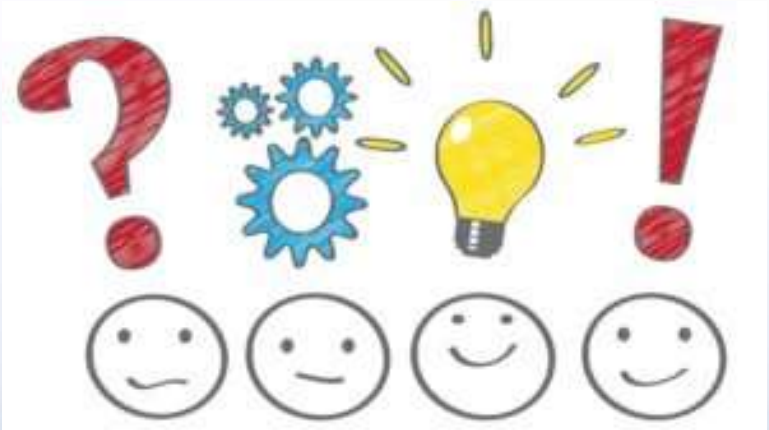
Acct Number	Case/Care Manager	PCP	Last Visit of Any Type in Period	Qtrly Visit Date
112457	Squash	Parsley, MD	2017-05-10	Qtrly Visit: HIV Comp Exam on 2017-05-10
88355	Rutabaga	Yam, MD	2017-06-12	Qtrly Visit: HIV Comp Exam on 2017-06-12
211171	Parsnip	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
107906	Squash	Parsley, MD	2017-06-20	6/20/2017
272879	Parsnip	Yam, MD	2017-06-26	6/26/2017
323859	Melon	Parsley, MD	2017-06-09	Qtrly Visit: HIV Monitoring Exam on 2017-06-09
134031	Parsnip	Yam, MD	2017-06-14	Qtrly Visit: HIV Monitoring Exam on 2017-06-14
312454	Parsnip	Yam, MD	2017-04-21	Qtrly Visit: HIV Monitoring Exam on 2017-04-21
48510	Melon	Parsley, MD	2017-06-23	Qtrly Visit: HIV Monitoring Exam on 2017-06-23
211171	Mango	Yam, MD	2017-05-30	Qtrly Visit: HIV Comp Exam on 2017-05-30
208654	Squash	Parsley, MD	2017-01-24	No visit
147371	Squash	Parsley, MD	2017-04-18	Qtrly Visit: HIV Monitoring Exam on 2017-04-18
269642	Parsnip	Yam, MD	2017-06-19	Qtrly Visit: HIV Monitoring Exam on 2017-06-19
114473	Rutabaga	Yam, MD	2017-06-20	Qtrly Visit: HIV Comp Exam on 2017-06-20
315180	Squash	Parsley, MD	2017-04-07	Qtrly Visit: HIV Monitoring Exam on 2017-04-07

Case Example: Validating Data

Conclusion

- Select the right data system for your agency
- Identify your metrics—who, what, when, where to find the data
- Validate the data

Questions?



Karen Mandel, LMSW

Director of Care Coordination Programs

Open Door Family Medical Centers

Office: (914) 502-1419

E-mail: kmandel@odfmc.org