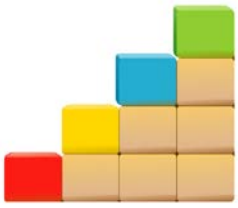

The 10 Building Blocks of Primary Care

Sample curriculum: Sample registry exercise

Background and Description

One activity in our Panel Management curriculum is the Chronic Care Registry exercise. This activity helps participants learn and understand the guidelines for routine chronic care tests, including how often patients with diabetes are required to get the test and the recommended control goals for patients with diabetes. Participants will look at a sample chronic care registry report to identify which patients have care gaps and will learn how to risk stratify a small panel of patients.

Instructions

Use the Chronic Care Registry Report table to answer the questions in Exercise 1 and 2. Note that the dates on the Chronic Care Registry report may need to be updated when you do this activity.

UCSF Center for Excellence in Primary Care

The Center for Excellence in Primary Care (CEPC) identifies, develops, tests, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, reduce the cost of care, and restore joy and satisfaction in the practice of primary care.

Acknowledgments

The UCSF Center for Excellence in Primary Care would like to acknowledge Thomas Bodenheimer, MD, MPH and Amireh Ghorob, MPH for their contribution to this work.

UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

Panel Management and Chronic Care

Guidelines for Routine Chronic Care Measures

The American Diabetes Association national guidelines indicate that patients with diabetes in poor control should have an A1c test every 3 months, and patients with diabetes in good control should have an A1c test every 6 months. Many other reputable agencies also have guidelines around chronic care measures. Each clinic needs to decide which guidelines to use. The guidelines should be put into writing by the medical director or by the agreement of all the clinicians.

Chronic Care Registry Report

Specific search criteria can be used to create a registry report that identifies a particular panel of patients with particular characteristics (clinic, clinician, last blood pressure, LDL or HbA1c value).

Exercise 1: Reading registry reports

1. How many patients are in this panel?
2. What search criteria did the panel manager use to create this report?
3. Which patients have missing data?
4. What does this mean?
5. Which patients have HbA1c greater than 7?
6. What does this mean?
7. Which patients have BP greater than 130/80?

8. What does this mean?

9. Which patients have LDL greater than 100 and are diabetic?

10. What does this mean?

11. Which patients have LDL greater than 130 and are not diabetic?

12. What does this mean?

13. Which patients have not been seen at the clinic in the past year?

14. What does this mean?

Exercise 2: Risk Stratify a Panel with Chronic Care Gaps

1. Review the values for patients A, B, C, and D.
    a. Which of these patients would you invite to a group blood pressure clinic appointment?
    b. Identify care gaps for these patients (include name of measure and date it was due).

    c. Which of these patients are you most concerned about? Why?

Chronic Care Registry Report

Name	DOC SM	BP DATE	BP/s	BP/d	LDL Date	LDL	A1c DATE	A1c	DIABETIC	SMOKER	DATE ASKED IF SMOKES
Patient A	NO	3/5/2014	127	70	2/22/2013	135			NO	NO	12/15/2012
Patient B	YES	2/15/2014	110	55	1/2/2014	145	1/2/2014	11.3	YES	YES	7/25/2013
Patient C	NO	4/20/2014	158	87	4/12/2014	81	4/12/2014	6.7	YES	NO	6/28/2010
Patient D	YES	11/9/2013	148	95	10/30/2013	170	10/30/2013	8.9	YES	YES	4/2/2013
Patient E	NO	5/27/2014	129	72	5/17/2012	54	5/17/2014	9.6	YES	YES	6/28/2012
Patient F	NO	8/20/2013	155	88	8/20/2012	125			NO		
Patient G	YES	2/24/2012	149	85	3/16/2011	102			NO		3/16/2011
Patient H	NO	6/9/2014	147	90	5/19/2013	81	5/19/2013	12.1	YES	NO	8/15/2013
Patient I	NO	6/3/2013	120	64	1/3/2013	165			NO	NO	11/22/2004
Patient J	YES	10/13/2013	117	81	9/23/2013	112	9/13/2013	5.9	YES	YES	3/24/2013
Patient K	YES	12/10/2012	152	85	12/10/2012	157			NO		
Patient L	NO	5/14/2014	138	65	2/27/2014	111	12/3/2013	7.8	YES		
Patient M	NO	6/1/2014	119	71	3/2/2014	177			NO	NO	6/1/2014
Patient N	YES	1/4/2014	105	66	12/19/2014	108					
Patient O	NO	12/28/2013	132	67	11/8/2013	149	11/8/2013	14.3	YES	NO	12/28/2013
Patient P	YES	10/17/2013	114	87	9/27/2013	109	9/27/2013	10.1	YES	YES	1/25/2013

Guidelines for Routine Chronic Care Measures		
Measure	Frequency	Goal
HbA1c	Every 3 months if not at goal	HbA1c < 7% Frail patients: HbA1c < 8%
	Every 6 months if at goal	
Blood Pressure	Every 3 months if not at goal	Systolic < 140 Diastolic < 80 (BP <130/80)
	Every 6 months if at goal	
LDL	Every 3 months if not at goal	Diabetics and/or CHD: LDL < 100 All other: LDL < 130
	Every year if at goal	
Smoking	Every year	"No"