Teaching Exercise: Chronic Care Registry

This table is a sample patient registry. Use this mock patient data to learn how to identify care gaps based on the chronic care guidelines you’ve implemented in your practice. After reviewing the patient data sample, test your knowledge by taking the quiz below. *Please note that practice guidelines frequently change. This is only an example and may not include the latest recommendations.*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient name | Date of BP | Systolic BP | Diastolic BP | Date of LDL | LDL | Date of HbA1c | HbA1c | Diabetic | Smoker | Date asked if smokes |
| *e.g., John Doe* | *4/2/2014* | *110* | *55* | *4/2/2014* | *145* | *4/2/2014* | *11.3* | *Yes* | *Yes* | *4/2/2014* |
| Patient A | 12/5/2013 | 127 | 70 | 12/5/2013 | 93 |  |  | No | No | 12/5/2013 |
| Patient B | 4/2/2014 | 110 | 55 | 4/2/2014 | 145 | 4/2/2014 | 11.3 | Yes | Yes | 4/2/2014 |
| Patient C | 3/12/2014 | 158 | 87 | 3/12/2014 | 81 | 3/12/2014 | 6.7 | Yes | No | 3/12/2014 |
| Patient D | 5/1/2014 | 148 | 95 | 5/1/2014 | 170 | 5/1/2014 | 8.9 | Yes | Yes | 4/2/2011 |
| Patient E | 3/18/2014 | 129 | 72 | 3/18/2014 | 54 | 3/18/2014 | 9.6 | Yes | Yes | 3/28/2014 |
| Patient F | 9/5/2013 | 125 | 88 | 9/5/2013 | 125 |  |  | No |  |  |
| Patient G | 1/20/2014 | 149 | 85 | 1/20/2014 | 102 |  |  | No | No |  |
| Patient H | 2/27/2014 | 147 | 90 | 2/27/2014 | 81 | 2/27/2014 | 12.1 | Yes | No | 3/5/2011 |
| Patient I |  |  |  | 11/3/2011 | 65 |  |  | No | No | 11/3/2011 |
| Patient J | 2/22/2014 | 117 | 81 | 2/22/2014 | 122 | 2/22/2014 | 5.9 | Yes | Yes | 2/22/2014 |
| Patient K | 7/24/2008 | 152 | 85 | 7/14/2008 | 157 |  |  | No |  |  |

*Note: For purposes of this table and the quiz below, assume today’s date is June 1, 2015.*

Chronic care guidelines

This is an example of chronic care guidelines that your staff may use as a cheat sheet.

*(Please note that practice guidelines frequently change. This is only an example and may not include the latest recommendations. Update these guidelines to reflect those currently used in your practice before using this table and the associated quiz for training your staff. Panel managers in your practice should use the guidelines adopted in your practice.)*

|  |  |  |
| --- | --- | --- |
| **Chronic Care Routine Measures** | | |
| **Routine Measure** | **Frequency** | **Goal** |
| **HbA1c** | Not at goal: Every 3 months | HbA1c < 7%  Frail patients:  HbA1c < 8% |
| At goal: Every 6 months |
| **Blood Pressure (BP)** | Not at goal: Every 3 months | Systolic < 140  Diastolic < 90  (BP <140/90) |
| At goal: Every 6 months |
| **Low-density lipoprotein (LDL)** | Not at goal: Every 3 months | Diabetics and/or CHD: LDL < 100  All other: LDL < 130 |
| At goal: Every year |
| **Smoking** | Every year | “No” |

Chronic care registry quiz

Have each trainee in your practice answer the following questions individually, then discuss answers as a group.

1. How many patients are in this panel?
2. What information is available on each patient?
3. Why are some of the fields blank for Patient A?
4. Why might Patients F’s and K’s smoking fields be blank?
5. Why are some of Patient I’s fields blank?
6. Which patients have HbA1c > 7?
7. Do those patients with HbA1c > 7 have a care gap? What might they need?
8. How often should HbA1c be measured if the patient is at goal? If not at goal?
9. Which patients have BP > 130/80?
10. Based on the guidelines provided here, do those patients with BP > 130/80 have a care gap?
11. How often should BP be measured if the patient is at goal? If not at goal?
12. Which patients have an LDL > 100 and diabetes?
13. Do those patients with LDL > 100 and diabetes have a care gap?
14. How often should LDL be measured if a patient with diabetes has an LDL at goal? If not at goal?
15. Which patients have an LDL > 130 and do not have diabetes?
16. Do those patients with LDL > 130 and no diabetes have a care gap?
17. How often should LDL be measured if the patient does not have diabetes and is at goal? If not at goal?

Team activity

Pair each trainee with a partner to answer these questions. Then discuss with the whole group.

1. Review the values for Patients A, B, C and D.
   1. Which patient(s) would you call to schedule a blood pressure visit?
   2. Which patient(s) need to have labs done now? Which labs?
   3. Which patient(s) are you most concerned about and why?
2. Review values for Patients H and K: Which patient are you most concerned about? Why?

Chronic care registry exercise answer key

1. How many patients are in this panel? **11**
2. What information is available on each patient? **Name, date of blood pressure test and results, date LDL cholesterol test and results, date HbA1c test and results, whether or not the patient has diabetes, if the patient smokes and last date asked about smoking.**
3. Why are some of the fields blank for Patient A? **The patient does not have diabetes.**
4. Why are Patients F’s and Patient K’s smoking fields blank? **Either the patient was not asked or the patient was asked and the data was not entered.**
5. Why are some of Patient I’s fields blank? **The patient does not have diabetes and the BP was either not checked or not entered.**
6. Which patients have HbA1c > 7? **Patients B, D, E and H.**
7. Do those patients with HbA1c > 7 have a care gap? What might they need? **Yes,** **they have an outcome care gap and need health coaching (education, skills and a lifestyle-change action plan) and/or medication intensification. Patient E also has a process care gap and is due for an HbA1c check.**
8. How often should HbA1c be measured if the patient is at goal? If not at goal? **Based on the guidelines presented here, they need an HbA1c test every 6 months if at goal and every 3 months if not at goal.**
9. Which patients have BP > 130/80? **Patients C, D, F, G, H, J and K.**
10. Based on the guidelines provided here, do those patients with BP > 130/80 have a care gap? **They have an outcome care gap and need health coaching (education, skills and a lifestyle-change action plan) and/or medication intensification.**
11. How often should BP be measured if the patient is at goal? If not at goal? **Six months and 3 months. If goal is 130/80 or below, patients need to have both systolic and diastolic at or below goal. Your practice should decide on blood pressure goals, using Eighth Joint National Committee (JNC 8) or an alternative to JNC 8. Patient J is technically not at goal with a diastolic blood pressure of 81, but in reality, Patient J has an excellent blood pressure reading.**
12. Which patients have LDL > 100 and diabetes? **Patients B, D and J.**
13. Do those patients with LDL > 100 and diabetes have a care gap? **They have an outcome care gap and need health coaching (education, skills and a lifestyle-change action plan) and/or medication intensification. Patient J also has a process care gap and is due for an LDL check.**
14. How often should LDL be measured if a patient with diabetes is at goal? If not at goal? **At goal every year, if not at goal every 3 months.**
15. Which patients have LDL > 130 and do not have diabetes? **Patient K.**
16. Do those patients with LDL > 130 and no diabetes have a care gap? **This patient has an outcome care gap and needs health coaching (education, skills and a lifestyle-change action plan) and/or medication intensification.**
17. How often should LDL be measured if the patient is not diabetic and is at goal? If not at goal? **At goal every year, if not at goal every 3 months.**

18. Review the values for patients A, B, C and D.

a. Which patient(s) would you call to schedule a blood pressure visit? **Patients C and D.**

b. Which patient(s) need to get labs done now? Which labs? **Patient B needs LDL and HbA1c tested. Both are not in control and need to be tested every 3 months. Patient D is overdue for LDL and HbA1c tests. Patients A and C do not need tests now. Patient C is at goal, so HbA1c is due in 6 months and LDL in one year.**

c. Which of these patients are you most concerned about and why? **Patient D is a “quadruple threat”: high BP, LDL, HbA1c, and is a smoker. Patient B is also worrisome and is a “triple threat”: high LDL, high HbA1c, and is a smoker. Patient B’s HbA1c is also very high (11.3), suggesting this patient has prediabetes that warrants health coaching (education, skills and a lifestyle-change action plan).**

19. Review the values for Patients H and K: Which of these patients are you most concerned about and why? **We are concerned about both patients. Patient H has elevated BP and HbA1c and is considered a “double threat.” Patient K has not been to the practice since 2008 and is thus out of care so we don’t know anything about K’s current health status. Patient K presents an out-reach opportunity.**

*Source: AMA. Practice transformation series: panel management. 2015.*