Member Level Opportunities

Overall Gaps in Care Analysis

（患者毎のｷﾞｬｯﾌﾟ内容）

ケアギャップインデックスには16項目あり
高、中、低の分類がある

Gaps

Severity Level	Gap#	Condition	Gap
HIGH	12084	Chest pain-related ER Visits	Patients without primary physician or cardiologist follow-up office visit within 2 weeks of the ER visit.
	8861(E)	Chest pain-related ER visit (E)	Patients without a follow-up office visit within 2 weeks of the ER visit.
	8861	Chest pain-related ER visit	Patients without a follow-up office visit within 2 weeks of the ER visit.
MEDIUM	3071	Diabetes	Patients without serum creatinine in the last 12 months.
	3063(E)	Diabetes (E)	Patients without HbA1c test in the last 12 months.
	3064(E)	Diabetes (E)	Patients without retinal eye exam in the last 12 months.
	3069(E)	Diabetes (E)	Patients without statin drugs in the last 12 months.
	4003(E)	Diabetes - HEDIS analog (E)	Patients without retinal eye exam in the last 12 months.
	3072(E)	Diabetes (E)	Patients without micro or macroalbumin screening test in the last 12 months.
	3072	Diabetes	Patients without micro or macroalbumin screening test in the last 12 months.
	6003(E)	>=50 years old (E)	Patients without any colorectal cancer screening in the last 24 months.
LOW	3396(E)	Diabetes (E)	Patients without semiannual HbA1c test in the last 24 months.
	3002(E)	Asthma (E)	Patients without inhaled corticosteroids or leukotriene inhibitors in the last 12 montl
	3002	Asthma	Patients without inhaled corticosteroids or leukotriene inhibitors in the analysis peri
	12088	Asthma	Patients without spirometry testing in the last 12 months.

The Care Gap Index of 16 is comprised of multiple high, medium and low risk gaps in care. Gaps extend beyond lab tests and drugs (e.g. lack of office visits following ER utilization). Opportunities for behavior change and provider engagement.

（ギャップ内容の事例）
救急搬送後2週間以内に経過診断を受けていない患者

医師別にケアギャップインデックスがわかるようになっている

Provider Level Opportunities

Physician Registry Ranked by Care Gap Risk

Physician Registry by Gap in Care Risk

医師名

	# of Individuals	Average Individual Age	Most Prevalent Disease	CGI	Allowed PMPM
	100	53.48	Hypertension	3.01	$793.24
	37	46.09	Hypertension	3.00	$674.56
	31	49.81	Hypertension	3.00	$962.02
	31	53.80	Hypertension	2.97	$635.69
	36	47.14	Cancer	2.64	$484.73
	92	53.76	Cancer	2.60	$5,702.91
	56	41.22	Hypertension	2.59	$662.25
	40	55.97	Back Pain	2.48	$681.64
	35	41.46	Hypertension	2.43	$2,232.98
	33	59.80	Hypertension	2.36	$729.49
	55	50.15	Hypertension	2.35	$965.37

Dr. Magana is managing larger count of patients and has a higher care gap risk score than her peers

この医師の場合、同僚医師たちより多くの患者の診療を行っているが、ケアギャップインデックスが大きい

ケアギャップの観点から行った医師の個人別課題分析

Provider Level Opportunities

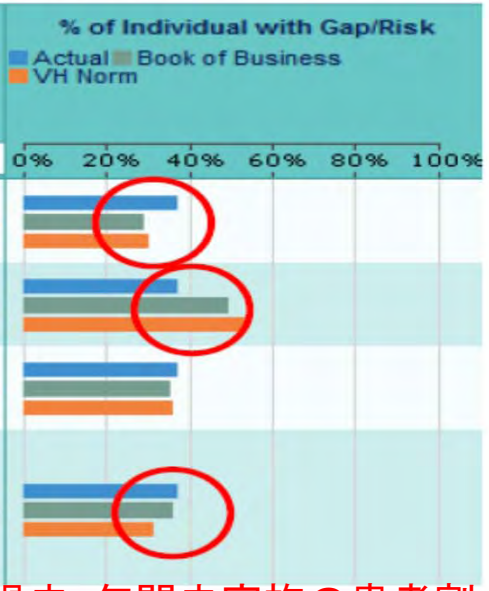
Gaps in Care Analysis

Physician	[redacted]
Specialty	Internal Medicine
Provider ID	330544837
# of Individuals Assigned	100
Average Individual Age	53.48

Filter: Current

Records 1-25 of 69 1 2 3

Condition	Description	Actual	Norm
Diabetes (E)	Patients without serum creatinine in the last 12 months.	36.36%	29.21%
Diabetes (E)	Patients without statin drugs in the last 12 months.	36.36%	53.13%
Diabetes (E)	Patients without lipid profile test in the last 12 months.	36.36%	35.51%
Patients with Diabetes in the analysis period, with > 2 prescriptions filled for TZD medications (pioglitizone, rosiglitizone) in the last 12 months. (E)	Patients without Liver function tests in the last 12 months	36.36%	30.49%



血清クレアチニン検査を過去1年間未実施の患者割合

スタティン薬投与を過去1年間未実施の患者割合

脂質検査を過去1年間未実施の患者割合

肝機能検査を過去1年間未実施の患者割合

Provider engagement facilitated through feedback and benchmarking.
[redacted] actually outperforms her peers and a norm on statin compliance but under performs on serum creatinine and liver function testing.

Population Analysis 活動のアウトカムの計測

Efficient Quality Initiatives

Outcomes Measurement

Monthly diabetes statin gap rate

Time Period	% of Individual With Gap/Risk
2012 Q1 FEB	40.18%
2012 Q1 JAN	41.12%
2011 Q4 DEC	41.67%
2011 Q4 NOV	41.92%
2011 Q4 OCT	41.49%
2011 Q3 SEP	41.44%
2011 Q3 AUG	40.61%
2011 Q3 JUL	40.49%
2011 Q2 JUN	40.31%
2011 Q2 MAY	39.94%
2011 Q2 APR	42.01%
2011 Q1 MAR	42.37%

糖尿病患者のうちｽﾀﾃｨﾝ投与未実施の患者割合

毎月のﾃﾞｰﾀを見ることによりﾌﾟﾛｸﾞﾗﾑが効果があるのか否かの方向感を出してくれる

Monthly trending provides directional indications of program impact.

Quality improvement as a year-round activity.

質の向上は1年くらいたたないとわからない

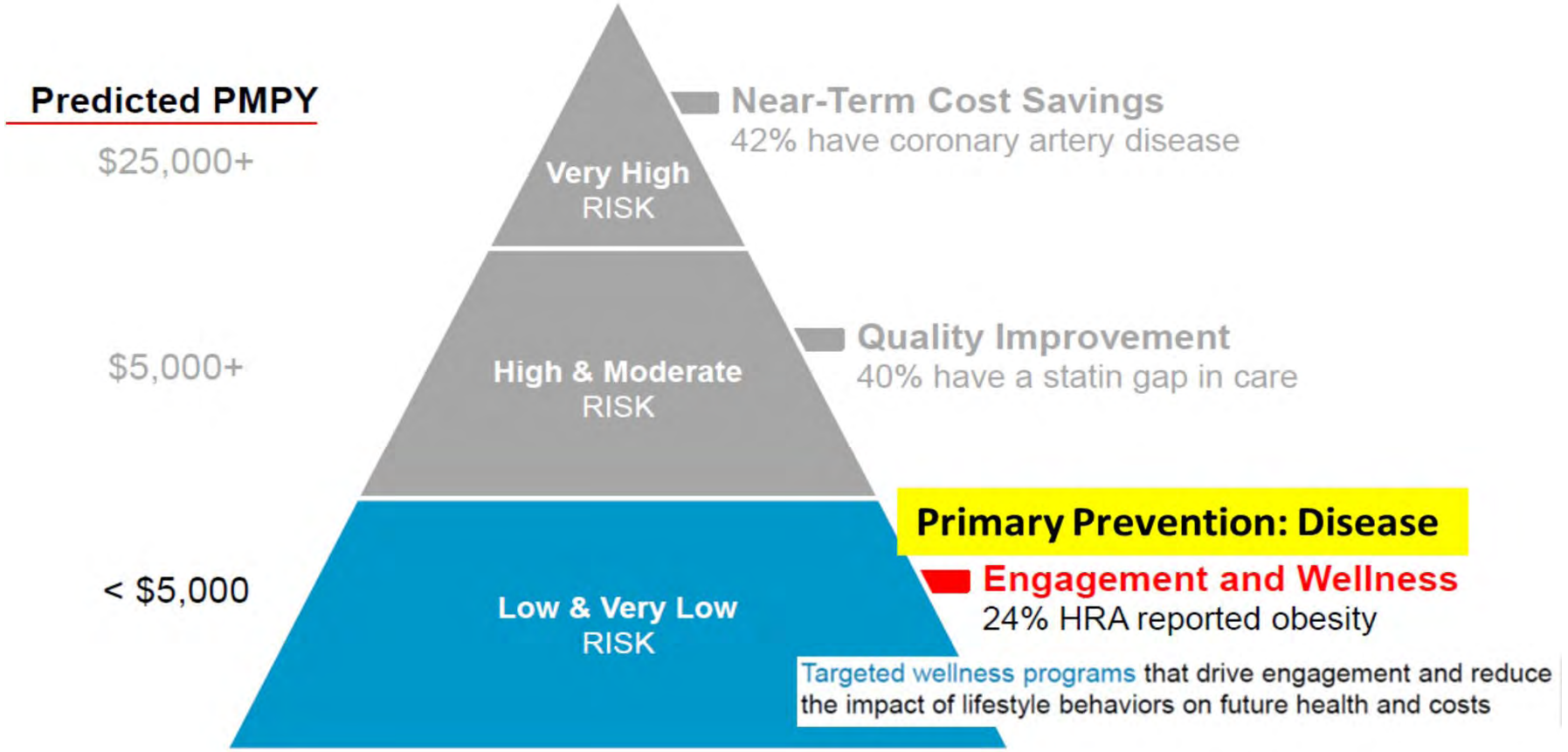
低リスクの人々に焦点を合わせたウエルネスプログラム

（目標）

ライフスタイルが将来の健康状態と医療費に与えるインパクトを減少させる

Targeted Wellness Programs

Focus on Low and Very Low Risk Groups



HRM= Health Risk Assessment