

OBCM Supervisor Use of CMIS Reports for Program Quality



My Team Case Status / OB Case Load Report



- **The “My Team Case Status” view on the Home Page allows users to view the same information as in the OB Caseload Report for Heavy, Medium, Light, Pending and Pending >30 Days**
- **Available to users with Site Administrator or Restricted Site Administrator access**
- **Customizable to view up to 10 users current OB Caseloads in your assigned team**
- **Toggle to select correct program**

My Team Case Status / OB Case Load Report



- Shows a snapshot of individual case manager's current case load
- The sub-report for each OB case status can be viewed by clicking on the **blue** number. The sub-report shows the last completed, last attempted and next pending task for each patient.
- Ensure timely outreach is occurring for patients in pending status
- Ensure outreach efforts are ongoing for patients pending over 30 days; determine a plan of action if needed.
- Ensure patients on the caseload have a pending task reflecting planned care management activity with or on behalf of the patient
 - The autogenerated "*Case Review / Chart Audit*" task from the Goals tab should not be the only pending task, as it does not reflect any care management interventions with or on behalf of the patient.

My Team Case Status / OB Case Load Report



Case Management Information System version 8.6.6
Community Care of North Carolina

Home Reports Administration Resources

WELCOME

Home Tasks Notifications Messages My Tasks Practice Home Announcements

My Team Case Status

	H	M	L	P	P>30
OB	[8]	[53]	[20]	[10]	[0]

	H	M	L	P	P>30
OB	[1]	[54]	[15]	[0]	[0]

	H	M	L	P	P>30
OB	[6]	[26]	[51]	[9]	[1]

	H	M	L	P	P>30
OB	[0]	[40]	[18]	[6]	[0]

	H	M	L	P	P>30
OB	[0]	[38]	[101]	[1]	[0]

My Priority Patients

Disease Management

No records to display.

My Unread Messages

Inbox [8]

My Case Load By Practice

Team Referrals from 8/1/2013

My Faxes from 8/18/2013

Population Care Management

OB Case Load Activity Report



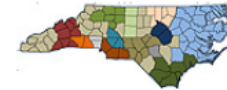
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- **Displays case status, task, and intervention information for all patients on the caseload of the selected user(s).**
 - **Review regularly to evaluate care management activity during the selected time period.**
 - **Review “Unique Patients Touched”**
 - “Unique Patients Touched” indicates the number of patients on the user’s caseload that had at least one completed or attempted task during the selected time period.
 - This number includes all patients on the caseload with at least one completed OR attempted task, including those in Pending and/or Deferred status.
 - **Review “Unique Patients OB Heavy, Medium & Light”**
 - Unique Patients OB Heavy, Medium & Light indicates the number of patient’s on the user’s **active** caseload for whom there was at least one attempted or completed task during the selected time period.
 - Compare to “OB Case Load at Start/End of Reporting Period”

OB Case Load Activity Report



OB User Case Load Activity Report

Jun 01, 2013 - Jun 30, 2013



Total Attempted Tasks: 59

Unique Patients Touched: 131 (based on completed and attempted tasks)

Unique Patients OB Heavy, Medium & Light: 92

Case Load at Start of Reporting Period: OB Heavy: 3 OB Medium: 25 OB Pending: 1 OB Light: 97

Case Load at End of Reporting Period: OB Heavy: 3 OB Medium: 27 OB Pending: 2 OB Light: 102

OB Deferred:

Unable to participate in CM at this time	<u>0</u>	Well linked:	<u>0</u>	Deceased	<u>0</u>
Unable to Contact (at least 3 documented attempts)	<u>0</u>	Refused Services	<u>0</u>	Does Not Meet Screening Criteria	<u>5</u>
Identified Needs/Goals Have Been Met	<u>0</u>	Postpartum period ended	<u>5</u>	Rolled-Off	<u>0</u>
Is Not Adherent to Care Plan or Goals	<u>0</u>				
Not Impactable due to Severity of Disease State	<u>0</u>				

Pending > 30 days 0

Tasks

Case Review/Chart Audit:	<u>33</u>	Practice Encounter:	<u>23</u>	Professional Encounter:	<u>0</u>
Claims Review:	<u>0</u>	Group Medical Visit:	<u>0</u>	Call Center Phone Call:	<u>0</u>
Community Encounter:	<u>0</u>	Other:	<u>131</u>	TC Community Encounter:	<u>0</u>
Home Visit:	<u>0</u>	DD - Diabetes Education Class:	<u>0</u>	TC Phone Call:	<u>0</u>
Hospital Visit:	<u>0</u>	DD - Home Visit (Lay Health Adv):	<u>0</u>	TC Home Visit:	<u>0</u>
Multi-Disc Team Mtg:	<u>0</u>	DD - Community Event:	<u>0</u>	TC Hospital Visit:	<u>0</u>
Phone Call:	<u>124</u>	DD - Faith Organization Event:	<u>0</u>	TC Practice Encounter:	<u>0</u>
Chart Note:	<u>0</u>	DD - Individual Session:	<u>0</u>	TC Professional Encounter:	<u>0</u>
Class:	<u>0</u>	DD - Other Sponsored Activities:	<u>0</u>	TC Chart Note:	<u>0</u>
Correspondence:	<u>50</u>	DD - Group Medical Visit:	<u>0</u>	TC Correspondence:	<u>0</u>
				TC Case Review/Chart Audit:	<u>0</u>

OB Case Load Activity Report



Tasks

Case Review/Chart Audit:	<u>33</u>	Practice Encounter:	<u>23</u>	Professional Encounter:	<u>0</u>
Claims Review:	<u>0</u>	Group Medical Visit:	<u>0</u>	Call Center Phone Call:	<u>0</u>
Community Encounter:	<u>0</u>	Other:	<u>131</u>	TC Community Encounter:	<u>0</u>
Home Visit:	<u>0</u>	DD - Diabetes Education Class:	<u>0</u>	TC Phone Call:	<u>0</u>
Hospital Visit:	<u>0</u>	DD - Home Visit (Lay Health Adv):	<u>0</u>	TC Home Visit:	<u>0</u>
Multi-Disc Team Mtg:	<u>0</u>	DD - Community Event:	<u>0</u>	TC Hospital Visit:	<u>0</u>
Phone Call:	<u>124</u>	DD - Faith Organization Event:	<u>0</u>	TC Practice Encounter:	<u>0</u>
Chart Note:	<u>0</u>	DD - Individual Session:	<u>0</u>	TC Professional Encounter:	<u>0</u>
Class:	<u>0</u>	DD - Other Sponsored Activities:	<u>0</u>	TC Chart Note:	<u>0</u>
Correspondence:	<u>50</u>	DD - Group Medical Visit:	<u>0</u>	TC Correspondence:	<u>0</u>
				TC Case Review/Chart Audit:	<u>0</u>

Interventions: *(based on completed & attempted tasks)*

Advocacy:	<u>0</u>	Assessment:	<u>0</u>	Follow-up/Monitor:	<u>232</u>
Consultation:	<u>0</u>	Contract:	<u>0</u>	Prior Approval/Authorization:	<u>0</u>
Education:	<u>10</u>	Diabetes Disparities:	<u>0</u>	TC Education:	<u>0</u>
Living Healthy:	<u>0</u>	Med List:	<u>0</u>	TC Follow Up:	<u>0</u>
Med Review:	<u>0</u>	Patient Tool Kit:	<u>0</u>	TC Medication List:	<u>0</u>
				TC Medication Reconciliation:	<u>0</u>
Referral Sent:	<u>5</u>	Referral Received:	<u>1</u>	TC Medication Review:	<u>0</u>
Screenings:	<u>25</u>	Service Coordination:	<u>0</u>	TC Patient Tool Kit:	<u>0</u>
CHA:	<u>0</u>	Medical Reconciliation:	<u>0</u>	TC Service Coordination:	<u>0</u>
Scheduling:	<u>0</u>	Tele-Health Mgmt:	<u>0</u>	TC Other:	<u>0</u>
Palliative Care:	<u>0</u>	Pregnancy Assessment:	<u>89</u>	Brief Intervention (CM):	<u>0</u>
A+ KIDS:	<u>0</u>	Life Skills Progression (LSP):	<u>0</u>	Brief Intervention (Provider):	<u>0</u>

Face-to-Face Encounters: 23

Community Encounter:	<u>0</u>	Home Visit:	<u>0</u>
Practice Encounter:	<u>23</u>		

IP Referrals:

Received : In-Network:	<u>0</u>	Sent : In-Network:	<u>0</u>
Received : Out of Network:	<u>0</u>	Sent : Out of Network:	<u>0</u>

Initial Risk Screening Form Report



- **This report provides statistics about the initial risk screening forms entered into CMIS for patients residing in your county during a selected time period.**
 - Statistics include timeframe for patient contact and assessment, case status, deferral reasons, and prevalence of each priority risk factor
- **Allows the county to assess the timeliness of contact with priority patients and of engaging these patients in active care management.**
- **Provides a real time monitoring of key indicators.**
 - Use the report to identify areas of needed improvement and take action based on your findings.
 - This allows the data to be used proactively for quality improvement activities to improve OBCM Dashboard Measures.

Using the Initial Risk Screening Form Report for Quality Improvement



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- The **NEW** Sub-reports ([blue hyperlinks](#)) within the Initial Risk Screening Form Report provide numerous opportunities:
 - Review Patients “Touched” and “Engaged”
 - How many patients have timely contact? Is there a staff member who has a higher rate of “touches” ? If so, what are their strategies?
 - Who has not had timely contact? Why?
 - What percentage of patients have been “engaged” during the time period? Are you seeing progress month to month in the amount of patients that are being “engaged” and the timeliness of engagement?
 - Opportunity to discuss strategies for “touching” and “engaging” more patients/ triaging highest risk patients for priority when reaching out to patients.
 - Review patients who have been deferred
 - Are there any patients that were deferred inappropriately, (e.g., a patient with priority risk factors that was deferred for not meeting screening criteria)?
 - Deferred - Refused Services: are these patients shared equally among staff members or does one staff member “stand out” with more refusals than others?
 - Unable to contact (at least 3-5 documented attempts): Again, does one staff member “stand out” with more unable to contact?

Using the Initial Risk Screening Form Report for Quality Improvement



Initial Risk Screening Details: case status Deferred Does Not Meet Screening Criteria :

NOTE: The information below is based on the patient's most recent initial risk screening form during the selected date range (this will only apply in date ranges wide enough to include more than one pregnancy). The OB information (case status, OBCM, prenatal care provider) is based on the most recent updates in CMIS as of today, not on the information from the time of the initial risk screening form.

Patient Name	Due Date	Most Recent OB CM	Most Recent Prenatal Care Provider	Most Recent OB Case Status	Most Recent Initial Risk Screening Date	Priority Factors
XXXXXXXX	2/3/2014	XXXXXXXX	XXXXXXXX	Deferred Does Not Meet Screening Criteria	7/10/2013	
XXXXXXXX	8/1/2013	XXXXXXXX	XXXXXXXX	Deferred Does Not Meet Screening Criteria	6/27/2013	Chronic condition, Hospital Utilization, Late entry to PNC, Tobacco use
XXXXXXXX	3/12/2014	XXXXXXXX	XXXXXXXX	Deferred Does Not Meet Screening Criteria	7/2/2013	
XXXXXXXX	1/19/2014	XXXXXXXX	XXXXXXXX	Deferred Does Not Meet Screening Criteria	7/3/2013	Chronic condition, Hospital Utilization
XXXXXXXX	2/3/2014	XXXXXXXX	XXXXXXXX	Deferred Does Not Meet Screening Criteria	7/1/2013	Tobacco use
XXXXXXXX	12/25/2013	XXXXXXXX	XXXXXXXX	Medium	7/31/2013	Provider request
XXXXXXXX	12/30/2013	XXXXXXXX	XXXXXXXX	Pending	6/24/2013	Hospital Utilization
XXXXXXXX	1/9/2014	XXXXXXXX	XXXXXXXX	Deferred Does Not Meet Screening Criteria	6/28/2013	
XXXXXXXX	12/10/2013	XXXXXXXX	XXXXXXXX	Deferred Does Not Meet Screening Criteria	6/13/2013	
XXXXXXXX	1/20/2014	XXXXXXXX	XXXXXXXX	Pending	7/8/2013	Hospital Utilization

Using the Initial Risk Screening Form Report for Quality Improvement



PRIORITY PATIENTS "TOUCHED" (at least 1 home visit, phone call, practice encounter, or community encounter WITH PATIENT)							
	Completed		Attempted		None		
	#	%	#	%	#	%	
Within 7 days of screening:	<u>29</u>	19.59%	<u>4</u>	2.70%	<u>115</u>	77.70%	
Within 14 days of screening:	<u>52</u>	35.14%	<u>18</u>	12.16%	<u>78</u>	52.70%	
Within 30 days of screening:	<u>76</u>	51.35%	<u>29</u>	19.59%	<u>43</u>	29.05%	
Within 60 days of screening:	<u>85</u>	57.43%	<u>23</u>	15.54%	<u>40</u>	27.03%	

Patient Name	Due Date	Most Recent OB CM	Most Recent Prenatal Care Provider	Most Recent OB Case Status	Most Recent Initial Risk Screening Date	Priority Factors
XXXXXXXX	1/19/2014	XXXXXXXX	XXXXXXXX	Pending	7/9/2013	Chronic condition, Tobacco use
XXXXXXXX	10/18/2013	XXXXXXXX	XXXXXXXX	Medium	6/25/2013	Late entry to PNC, Provider request
XXXXXXXX	12/27/2013	XXXXXXXX	XXXXXXXX	Pending	7/18/2013	Low birth weight history, Preterm birth history,
XXXXXXXX	12/6/2013	XXXXXXXX	XXXXXXXX	Deferred Rolled Off		Hospital Utilization, Late entry to PNC
XXXXXXXX	12/23/2013	XXXXXXXX	XXXXXXXX	Deferred Rolled Off	7/10/2013	Late entry to
XXXXXXXX	2/2/2014	XXXXXXXX	XXXXXXXX	Pending	7/8/2013	Chronic condition, Preterm birth history, Provider request
XXXXXXXX	2/17/2014	XXXXXXXX	XXXXXXXX	Deferred Rolled Off		Tobacco use
XXXXXXXX	2/16/2014	XXXXXXXX	XXXXXXXX	Deferred Postpartum period ended	7/25/2013	Low birth weight history, Preterm birth history,
XXXXXXXX	2/11/2014	XXXXXXXX	XXXXXXXX	Deferred Rolled Off	7/17/2013	Alcohol/drug use, Chronic condition
XXXXXXXX	2/24/2014	XXXXXXXX	XXXXXXXX	Pending	7/22/2013	Chronic
XXXXXXXX	1/23/2014	XXXXXXXX	XXXXXXXX	Deferred Rolled Off	7/29/2013	Late entry to
XXXXXXXX	2/25/2014	XXXXXXXX	XXXXXXXX	Deferred Rolled Off	7/24/2013	Hospital

Using the Initial Risk Screening Form Report for Quality Improvement



April 2013

PRIORITY PATIENTS "ENGAGED"

(entered ACTIVE Case Status; e.g. OB Heavy, OB Medium, or OB Light)

	#	%
Engaged within 7 days of screening:	9	7.56%
Engaged within 14 days of screening:	25	21.01%
Engaged within 30 days of screening:	32	26.89%
Engaged within 60 days of screening:	48	40.34%

June 2013

PRIORITY PATIENTS "ENGAGED"

(entered ACTIVE Case Status; e.g. OB Heavy, OB Medium, or OB Light)

	#	%
Engaged within 7 days of screening:	27	18.24%
Engaged within 14 days of screening:	46	31.08%
Engaged within 30 days of screening:	66	44.59%
Engaged within 60 days of screening:	77	52.03%