El Rio Health

Tucson, Arizona
Mission & Values

Improving the health of our community through comprehensive, accessible, affordable, quality and compassionate care.

**Step Up**
I am accountable for making El Rio a world class health center.

**I Matter**
I make a difference by voicing my opinions and knowing I am heard.

**Break Boundaries**
I work with others to achieve success.

**Value Health**
I take time for my own health to promote yours.

**Create Tomorrow**
I embrace effective change and seek innovative solutions.

**Honor Patients**
I always put the patients first.
About Us

History

1970- Opened in October
- Serving patients as El Rio Santa Cruz Neighborhood Health Center

1971- A Federally Qualified Health Center
- Organization that receives a grant under section 330 of the Public Health Service.

1974- A Non-for-Profit
- Managed by a Community Board of Directors – CEO/Executive Director and Senior Staff.

A Nationally Recognized Organization

2010- Joint Commission
- El Rio was accredited for both Clinical and Diagnostic Laboratory Services

2010- National Committee for Quality Assurance (NCQA)
- El Rio was granted a Level-3 Patient Centered Medical Home (PCMH)

2018- Healthcare Equality Index (HEI)
- El Rio was recognized as leaders in LGBTQ Healthcare Equality Index
Our Practice

2017 UDS Data

- Total # of Patients Served: 101,563
- Total # of Patient Visits: 389,303
- # of Employees: 1,156
- # of Unique Clinic Sites: 14
- Number of Providers: 211
  - 140 Medical Providers
  - 31 Dental
  - 24 Behavioral Health
  - 16 Clinical Pharmacists

El Rio Patients by Race/Ethnicity

- Hispanic/Latino: 22%
- White: 22%
- American Indian: 7%
- African American: 4%
- Other: 4%

Patients by Payer Source

- Medicaid: 55%
- Private: 21%
- Uninsured: 12%
- Medicare: 11%

- 64% of patients live below the Federal Poverty Line

Source

- Medicaid: 55%
- Private: 21%
- Uninsured: 12%
- Medicare: 11%
EL RIO HEALTH HAS MULTIPLE LOCATIONS IN TUCSON TO SERVE YOU AND YOUR FAMILY.

More than 95,000 people in Tucson come to El Rio Health for medical, dental, behavioral health & other health care services.

1. Birth & Women's Health Center
   5979 E. Grant Road, #107

2. Broadway Health Center
   1101 E. Broadway Blvd.

3. Cherrybell Health Center
   1538 E 22nd St.

4. Congress Health Center
   839 W. Congress Street

5. El Pueblo Health Center
   101 W. Irvington Rd, Bldg #100

6. HealthOn Broadway
   One West Broadway Blvd.

7. Northwest Health Center
   320 W. Prince Road

8. OB / GYN Associates
   225 W. Irvington Rd.

9. Pascua Yaqui Health Center
   7490 S. Camino de Oeste

10. Southeast Health Center
    6950 E. Golf Links

11. Southwest Health Center
    1500 W. Commerce Court

12. Special Immunology Associates
    1701 W. St. Mary's Road, #160

EL RIO HEALTH

El Rio Health is a Certified Health Center Recognized by NQHIA.
2018 Key Results

WORLD CLASS EXPERIENCE FOR PATIENTS AND EMPLOYEES

- **Patient World Class Experience**
  - Overall satisfaction at patient appointment [Poor, Fair, Good, Excellent, NA].
    - Baseline = 90.6 Mean Score
    - 2018 Goal = 93 Mean Score
      - Length of time to get an appointment
      - Courtesy of person with whom you spoke
      - Courtesy and helpfulness of check-in staff
      - Length of time waiting to see the provider

- **Employee World Class Experience**
  - Increase employee quarterly survey response.
    - Baseline = 325
    - 2018 Goal = 500

HEALTHIER PATIENTS AND EMPLOYEES

- **Healthier Patients**
  - Decrease Emergency Room Visits
    - 2018 Goal = 600/1,000
  - Decrease Hospital Readmissions (w/in 30 days)
    - 2018 Goal = 8.9%
  - Increase Patient Portal Use (minimum 1 bidirectional interaction)
    - 2018 Goal = 30,000
  - Decrease overall patient “no-show” percentages across El Rio
    - 2018 Goal = 12%

- **Healthier Employees**
  - Decrease Emergency Room Visits
    - 2018 Goal = 290
  - Increase Employee Patient Portal Use (minimum 1 bidirectional interaction)
    - 2018 Goal = 500

POSITIVE FINANCIAL RESULTS

- **Operating Margin**: Achieve an Operating Margin of 4.5%. Stretch goal 5.5% for 2018.
## Integrated Cascading Dashboard

### Table: Key Performance Indicators

<table>
<thead>
<tr>
<th>Measure</th>
<th>Objective</th>
<th>Below Threshold</th>
<th>Meets or Exceeds Threshold</th>
<th>Meets or Exceeds Target</th>
<th>Meets or Exceeds Stretch Goal</th>
<th>Notes</th>
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</table>
| Quality | Admission Wound Care Visits (11-21) | Increase the percentage of patients aged 12-21 who have one or more comprehensive wound care visits during the measurement year | 59.6% | 64.7% | 56.4% | 47.4% | 51.5% | 53.4% | 51.5% | 51.5% | Target = 2014 HEDIS Measures (69.0%) mean stretch goal = internally selected goal
| Quality | Asthma Pharmacotherapy (5-65) | Increase the percentage of children patients aged 4-65 who were prescribed an asthma medication during the measurement year | 87.5% | 89.5% | 82.1% | 86.1% | 83.3% | 82.1% | 83.3% | 83.3% | Target = 2014 HEDIS Measures (80.0%) mean stretch goal = internally selected goal
| Quality | Breast Cancer Screening (25-54) | Increase the percentage of female patients aged 50-64 who received a mammogram in the previous 2 years | 78.6% | 74.2% | 70.2% | 74.2% | 74.2% | 71.8% | 76.2% | 79.0% | Target = 2014 HEDIS Measures (80.0%) mean stretch goal = internally selected goal
| Quality | Colorectal Cancer Screening (50-64) | Increase the percentage of female patients aged 50-64 who received a sigmoidoscopy in the previous 10 years | 72.3% | 72.3% | 71.6% | 71.6% | 71.6% | 71.6% | 71.6% | 71.6% | Target = 2014 HEDIS Measures (80.0%) mean stretch goal = internally selected goal
| Quality | Coronary Artery Disease (CAD) Lipid Therapy (18-75) | Increase the percentage of patients with CAD who were prescribed a lipid-lowering therapy during the measurement year | 61.0% | 66.3% | 59.2% | 66.3% | 66.3% | 66.3% | 66.3% | 66.3% | Target = 2014 HEDIS Measures (70.0%) mean stretch goal = internally selected goal
| Quality | Depression Screening and Follow up (12+1) | Increase the percentage of patients aged 12+ who were screened for depression and followed up as needed within 12 weeks of the screening | 63.2% | 76.9% | 61.2% | 76.9% | 61.2% | 76.9% | 61.2% | 76.9% | Target = 2014 HEDIS Measures (65.0%) mean stretch goal = internally selected goal
| Quality | Diabetes Eye Exam (16-75) | Increase the percentage of adult patients aged 16-75 who received an eye exam during the measurement year | 25.2% | 30.4% | 25.2% | 30.4% | 30.4% | 30.4% | 30.4% | 30.4% | Target = 2014 HEDIS Measures (50.0%) mean stretch goal = internally selected goal
| Quality | Diabetes Foot Care (16-75) | Increase the percentage of diabetic patients aged 16-75 whose most recent HbA1c reading was 7% | 64.8% | 67.7% | 61.2% | 67.7% | 61.2% | 67.7% | 61.2% | 67.7% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
| Quality | Flu Vaccination (18-64) | Increase the percentage of patients aged 18-64 who received flu vaccine during the measurement year’s flu season (September 1 - March 31) | 41.2% | 45.8% | 41.2% | 45.8% | 45.8% | 45.8% | 45.8% | 45.8% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
| Quality | Flu Vaccination - Infants (12/2014) | Increase the percentage of infants who received flu vaccine during the measurement year’s flu season (September 1 - March 31) | 82.7% | 61.8% | 61.8% | 61.8% | 61.8% | 61.8% | 61.8% | 61.8% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
| Quality | High Blood Pressure Control (16-75) | Increase the percentage of hypertensive patients aged 16-75 whose most recent blood pressure measurement was <140/90 | 72.7% | 67.2% | 71.2% | 67.2% | 67.2% | 67.2% | 67.2% | 67.2% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
| Quality | Hypertensive Vascular Disease (HVD) Therapy (18+) | Increase the percentage of patients aged 18+ who were discharged for Acute Care (ICU) or at home who were prescribed a blood pressure medication during the measurement year | 89.6% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
| Quality | Kidney Dialysis (18+) | Increase the percentage of "sustained" renal patients aged 18+ who received dialysis on a permanent (first) dialysis within the measurement year | 47.1% | 61.2% | 61.2% | 61.2% | 61.2% | 61.2% | 61.2% | 61.2% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
| Quality | Prematurity Screening (19+4) | Increase the percentage of premature patients aged 19+4 who were placed on prematurity medication | 89.8% | 88.8% | 88.8% | 88.8% | 88.8% | 88.8% | 88.8% | 88.8% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
| Quality | Tobacco Use Screening and Intervention (12+1) | Tobacco use within 12 months of their most recent HP visit who received tobacco use screening and/or pharmaceutical therapy if identified to be at risk | 61.2% | 61.2% | 61.2% | 61.2% | 61.2% | 61.2% | 61.2% | 61.2% | Target = 2014 HEDIS Measures (60.0%) mean stretch goal = internally selected goal
Relevant Cascading Dashboard (HbA1c)
Create Tomorrow Quality Improvement Projects

- Abnormal lab and results Tracking
- Human DX/IPE NACHC Collaborative
- At-Risk Teen Project
- National Collaborative for Transforming Primary Care for LGBTQ People
- Team-Based Care Learning Collaborative
- STI Screening in Teens
- HIV/HEP-C Screening Opt Out Program
- Six Sigma Projects:
  - Diabetic HbA1c >9 Control
  - Provider Capacity
  - Eligibility & Coding Error Denials
El Rio IT Department- Quick Facts

- All IT functions are in-house – close to 50 employees
- Host our own data center
- NextGen EHR system for 10 years
  - Medical
  - Dental
- IT Leadership team
  - Deep knowledge of FQHC’s
  - Health IT
  - Data analytics
- Knowledge resource for other agencies
- Clinical and operational leadership work collaboratively with IT on QI
Other Innovative Healthcare IT Projects

- Telehealth/Virtual visits
- Collection of SDOH and other clinical data on a tablet-entered by patient
- Patient self check-in through Kiosks
- Online scheduling, form completion, and check-in
- HIE and other interoperability partnerships (API’s) – care coordination, continuity of care, closing gaps in care, and is linked to increased value based payments
Diabetic Retinopathy Screening in the Primary Care Setting
Local Problem: Retinopathy Leading Cause of Blindness in Patients with Diabetes and Adherence with Screening at El Rio is About 30%
Possible Solution: *Embrace technology* that will allow specialty services to become integrated into the primary care workflow, to improve health outcomes and quality measures, for people living with diabetes.
Total estimated cost of diagnosed diabetes in 2017 was $327 billion ($237 billion in direct medical costs and $90 billion in reduced productivity)

http://care.diabetesjournals.org/content/diacare/early/2018/03/20/dci18-0007.full.pdf
(published online March 22, 2018)
Financial Implications

- Camera Costs $31,500
- Payment to EyePACS for telemedicine reading services
  - 2016 $23,610
  - 2017 $58,293
  - 2018 (through May 2018) $21,498
- Personnel costs for El Rio staff not represented
- Not a covered service by Medicaid plans
- Variable reimbursement from Medicare and Commercial payers
  - Billable revenue collected to date: $22,534.58
Over 17,000 patients in our system with diabetes diagnosis  
Approximately 30% of patients complete retinopathy screening  
Lack of education regarding importance of screening  
Poor patient adherence with recommendation for screening  

In February 2015, following numerous interdisciplinary discussions and reviews of supporting data showing the need for better screening for diabetic retinopathy, El Rio spearheaded an initiative

Retinopathy Leading Cause of Blindness in Patients with Diabetes

Plan | Do
Study | Act

How could adherence with screening be improved while avoiding issues identified previously?  
Started with addressing significant quality concerns with existing on-site camera on loan  
Began search for camera options

EyePACS. Provided contract options, disseminated training materials prior to visit, completed on-site training, on-going telephonic and web based support, identified partnering providers, established accounts for user and program director  
El Rio. Purchased three cameras after approval by board, worked with clinic leadership to identify staff, identified space, determined and remodeled locations, evaluated security concerns, set up i2i accounts and training, established scheduling templates, provided education, developed standing orders, developed workflow documents, credential providers

EL RIO HEALTH
Product Selection

HORUS DEC200
Digital Fundus Camera

5MP Image Resolution
45° Field of View
Product Selection

- Diagnostic Camera
- Screening Camera
- Portable
- Semi-Portable
- Size
- Ease of use
- Telemedicine
- Local providers
- Affordability
- Provider staff as readers
Program Director Considerations

- Understands the why
- Passionate about changing the way patients receive care
- Can perform a needs assessment (independently or after reviewing data provided)
  - number of patients with diabetes (DM)
  - those in need of retinopathy screening
  - population of DM patients at various locations
  - payer mix/insurance
- Ability to carve out time or be given time
  - start up (anticipate approximately 4-8 hours/wk)
  - on-going program maintenance (anticipate approximately 2 hours/month)
- Willingness to collaborate and develop a best practice workflow
- Access to data or ability to review data extracted for purposes of tracking progress
The Where and Why...
Role of Analytics

Diabetes by El Rio Site

- Percent Diabetic: Percent G0108(01)
- Percent of Patients at Location with Diabetes
- Percent of Diabetics with DME Visit

- Congress (n = 22,989): 15% 12%
- El Pueblo (n = 18,024): 15% 8%
- Northwest (n = 11,021): 18% 11%
- Southwest (n = 10,383): 15% 12%
- Southeast (n = 7,684): 12% 14%
- OB GYN (n = 3,418): 2% 0%
- Health On Broadway (n = 3,139): 6% 6%
- Broadway (n = 3,056): 18% 12%
- Pascua (n = 2,828): 27% 21%
- Birth Center Midwives (n = 2,065): 1% 10%
- SIA (n = 1,541): 14%
- Overall (n = 86,148): 13% 12%
Bringing Technology Into Primary Care
Bringing Technology Into Primary Care
EyePACS Workflow

- **Provider or staff member** identifies need for retinopathy screening
- **Patient Visit**
  - **Patient Eligible**
    - Yes*: Complete exam in primary care clinic and use secure web based portal to read images remotely
    - No: Follow established process for referral to outside provider
- **Engaged patients and staff**
- **Contracted provider reads images remotely within 72 hours and posts results to EyePACS web site**
- **Organization billed monthly based on contracted fee**

**Eligibility**
- Over 18 years of age
- Has diabetes
- Has NOT had screening exam in the last year
- Does NOT have diagnosis of retinopathy

**Technology utilized to bring specialty services into primary care**

**Crimson technology utilized to link specialty services in Tucson to patients referred from primary care**
El Rio Workflow

Patient Visit

Provider or staff member identifies need for retinopathy screening

Patient Eligible

Yes*

Complete exam in clinic or schedule at designated El Rio location with camera

MA walks patient to MOR desk to be added to scheduling template and be checked in

Photographer is contacted

Patient waits in waiting room and completes intake form

Case created in i2i

Photographer takes four images per eye

Images uploaded to EyePACS for interpretation same day

Associate Pharmacy Director randomly monitors outcomes

Teleconferences used to trouble shoot with staff members

Photographer completes the case with all required communication within 72 hours

*Eligibility
- Over 18 years of age
- Has diabetes
- Has NOT had screening exam in the last year
- Does NOT have diagnosis of retinopathy

Follow established process for referral to outside provider

i2i IT population health tool utilized
Example of EyePACS Portal Report

<table>
<thead>
<tr>
<th>Case #</th>
<th>Patient Name</th>
<th>Medical Record #</th>
<th>Site Name</th>
<th>Case Registered Date</th>
<th>Case Status</th>
<th>Diagnoses</th>
<th>Referral/Return Status</th>
<th>Referral/Return Time Frame</th>
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<tbody>
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<td>1</td>
<td>Martha Levy</td>
<td>10/03/2018</td>
<td>Congress Health Center</td>
<td>10/05/2018</td>
<td>Reviewed but not printed, Julie Sophia Kwan 10/03/2018</td>
<td>No Apparent Diabetic Retinopathy</td>
<td>Continue Yearly Routine Eye Examinations</td>
<td>Return for retinal exam in 1 Year</td>
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<tr>
<td>2</td>
<td>Blanca Molen</td>
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<td>10/05/2018</td>
<td>Reviewed but not printed, Scott Kwan 10/05/2018</td>
<td>No Apparent Diabetic Retinopathy</td>
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<td>Return for retinal exam in 1 Year</td>
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Example of i2i EyePACS Report

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</tbody>
</table>
Example of Relevant Report

HEDIS - Diabetic Eye Exam

Compliance:
- 4,758 out of 9,758 (49%)
- 5 exclusions

Target:
- No filters selected

Compliance by Location:
- Coronado St Marys Hospital: 100%
- Southwest: 73%
- Congress: 58%
- El Paseo: 52%
- Health on Broadway: 45%
- Paseo: 43%
- Northwest: 39%
- Sea: 35%
- Birth Center: 33%
- Southside: 32%
- Old Town: 28%
- Broadway: 26%
- Homeless: 21%
- Location Not Assigned: 2%

Compliance by Provider

Measurement period: October 1, 2017—September 30, 2018
Example of Relevant Report

HEDIS - Diabetic Eye Exam

Compliance:
- 18%
- 13 out of 71
- 0 exclusions

Target:
- Providers: Mark, Kelly

Compliance Trend:
- Graph showing compliance over time

Compliance by Location:
- Broadview: 21%
- Homeless: 0%

Compliance by Provider:
- Color-coded chart showing provider-wise compliance

Measurement period: October 1, 2017—6

EL RIO HEALTH

Recognized Practice
National Committee for Quality Assurance (NCQA) Accredited
LGBT Healthcare Equality Index

Leader in Quality 
Leadership 
Inclusive 
Equity
## Example of Relevant Report

### Measure Results

<table>
<thead>
<tr>
<th>Measure</th>
<th>Start Date</th>
<th>End Date</th>
<th>Patient Name</th>
<th>MRN</th>
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<th>DOB</th>
<th>Provider Name</th>
<th>Location</th>
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<td>09/30/2018</td>
<td>Monika, Holly</td>
<td>3.0</td>
<td>1.0</td>
<td></td>
<td>Homeless</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEDIS - Diabetic Eye Exam</td>
<td>10/01/2017</td>
<td>09/30/2018</td>
<td>Monika, Holly</td>
<td>4.0</td>
<td>1.0</td>
<td></td>
<td>Homeless</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEDIS - Diabetic Eye Exam</td>
<td>10/01/2017</td>
<td>09/30/2018</td>
<td>Monika, Holly</td>
<td>4.0</td>
<td>2.0</td>
<td></td>
<td>Homeless</td>
<td>N</td>
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<tr>
<td>HEDIS - Diabetic Eye Exam</td>
<td>10/01/2017</td>
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<td>Homeless</td>
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</tr>
<tr>
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<td>4.0</td>
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<td>Homeless</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEDIS - Diabetic Eye Exam</td>
<td>10/01/2017</td>
<td>09/30/2018</td>
<td>Monika, Holly</td>
<td>4.0</td>
<td>5.0</td>
<td></td>
<td>Homeless</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEDIS - Diabetic Eye Exam</td>
<td>10/01/2017</td>
<td>09/30/2018</td>
<td>Monika, Holly</td>
<td>4.0</td>
<td>6.0</td>
<td></td>
<td>Homeless</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEDIS - Diabetic Eye Exam</td>
<td>10/01/2017</td>
<td>09/30/2018</td>
<td>Monika, Holly</td>
<td>4.0</td>
<td>7.0</td>
<td></td>
<td>Homeless</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEDIS - Diabetic Eye Exam</td>
<td>10/01/2017</td>
<td>09/30/2018</td>
<td>Monika, Holly</td>
<td>4.0</td>
<td>8.0</td>
<td></td>
<td>Homeless</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EyePACS Reports

Medical Details

- Years With Diabetes: 11-15 years
- Pregnant Now or Within 6 Months: Not necessary
- Pupil Dilation: Not necessary
- Hemoglobin A1c: Unknown
- Cholesterol: High/Low Average
- Triglycerides: Not sure
- Hypertension: Not sure
- Referring Provider: Unknown
- Medications: Right Eye 20/20, Left Eye 20/20, Pinhole
- Visual Acuity
- IOP

Consult Details

- Image Observations:
  - Right Eye: Cotton wool, numerous intraretinal hemorrhages and microaneurysms, definite venous beading, hard exudates within 1500 microns of fovea
  - Left Eye: Cotton wool, numerous intraretinal hemorrhages and microaneurysms, definite venous beading, hard exudates within 1500 microns of fovea

- Other referable conditions:
  - Image Quality: Excellent

Assessment and Recommendations:
- Refer to eye specialist within 1 month
- Return for retinal imaging within 1 year

Diagnosis:
- Severe Nonproliferative Diabetic Retinopathy, Clinically Significant Macular Edema

Refractive Status:
- Refer to specialist for specific condition

Refractive Time Frame:
- 1 Month
- Return Time Frame: 1 Year

Comments About This Case

New comments:

Submit Comment

Request Email Consult
Email reports & images to patient
Print Report
Return To List
El Rio Follow Up Workflow

Results available

Report is posted to EyePACS and i2i account for documented photographer

Photographer checks personal accounts daily

Photographer opens report

Report is printed and sent to HIM to be scanned to PAQ

Task sent to provider requesting (STAT) referral

Photographer coordinates care with referral clerk

Abnormal letter generated from i2i

Abnormal letter mailed to patient

Care guidelines updated

Normal letter generated from i2i

Normal letter mailed to patient

Copy of referral mailed to patient along with abnormal letter

Patient is called to review abnormal finding and need for follow up
# EyePACS Productivity

Table 1. Total EyePacs Encounters by Month (February 2016 – March 2017)

<table>
<thead>
<tr>
<th>Month</th>
<th>Congress</th>
<th>El Pueblo</th>
<th>Southwest</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2016</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>March 2016</td>
<td>38</td>
<td>45</td>
<td>17</td>
<td>100</td>
</tr>
<tr>
<td>April 2016</td>
<td>70</td>
<td>41</td>
<td>4</td>
<td>115</td>
</tr>
<tr>
<td>May 2016</td>
<td>94</td>
<td>57</td>
<td>6</td>
<td>157</td>
</tr>
<tr>
<td>June 2016</td>
<td>115</td>
<td>43</td>
<td>22</td>
<td>180</td>
</tr>
<tr>
<td>July 2016</td>
<td>76</td>
<td>33</td>
<td>15</td>
<td>124</td>
</tr>
<tr>
<td>August 2016</td>
<td>111</td>
<td>51</td>
<td>16</td>
<td>178</td>
</tr>
<tr>
<td>September 2016</td>
<td>98</td>
<td>47</td>
<td>52</td>
<td>197</td>
</tr>
<tr>
<td>October 2016</td>
<td>109</td>
<td>54</td>
<td>50</td>
<td>213</td>
</tr>
<tr>
<td>November 2016</td>
<td>160</td>
<td>78</td>
<td>72</td>
<td>310</td>
</tr>
<tr>
<td>December 2016</td>
<td>169</td>
<td>113</td>
<td>72</td>
<td>354</td>
</tr>
<tr>
<td>January 2017</td>
<td>110</td>
<td>116</td>
<td>67</td>
<td>293</td>
</tr>
<tr>
<td>February 2017</td>
<td>106</td>
<td>78</td>
<td>56</td>
<td>240</td>
</tr>
<tr>
<td>March 2017</td>
<td>134</td>
<td>123</td>
<td>68</td>
<td>325</td>
</tr>
<tr>
<td>Overall</td>
<td>1,282</td>
<td>793</td>
<td>496</td>
<td>2,571</td>
</tr>
</tbody>
</table>
Figure 1. Total EyePacs Encounters by Month (February 2016 – March 2017)
Percent of Completed Appointments by Time to Scheduled Appointment

**3800 unique patients**
Early Experience

• Ninety-five screenings completed in 30 days
  • 70 read as normal
  • 25 abnormal
    • 5 cases have identified patients with sight threatening conditions
      • Proliferative diabetic retinopathy
      • Macular edema
      • Flame hemorrhage (uncontrolled blood pressure)
      • Severe cataracts
      • glaucoma
Total Eye Conditions Discovered Through EyePACS

**81% of patients had no detectable pathology**
Operational Oversight

• Presented to
  • Organizational department heads
  • Adult providers monthly meetings
  • Site specific meetings
  • Clinical Advisory Committee (CAC) dashboard review

• Senior leadership review
  • Every two weeks

• External partnerships
  • Accountable Care Organization (ACO) efforts for all partners
### Case statistics table

<table>
<thead>
<tr>
<th>Total encounters</th>
<th>1372</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average reviewed</td>
<td>23</td>
</tr>
<tr>
<td>Reviewed</td>
<td>1271</td>
</tr>
<tr>
<td>Printed</td>
<td>1033</td>
</tr>
<tr>
<td>with any IDR</td>
<td>396</td>
</tr>
<tr>
<td>with referable DR</td>
<td>365</td>
</tr>
<tr>
<td>with other referable conditions</td>
<td>365</td>
</tr>
<tr>
<td>Average time taken to review each case:</td>
<td>19 hours 41 minutes</td>
</tr>
<tr>
<td>Min time taken to attend a case:</td>
<td>4 minutes</td>
</tr>
<tr>
<td>Total encounters that went to back-up consultant</td>
<td>287</td>
</tr>
</tbody>
</table>

### Case diagnosis summary - Latest 12 months

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No diagnosis</td>
<td>384</td>
</tr>
<tr>
<td>Dystrophy</td>
<td>140</td>
</tr>
<tr>
<td>Subluxation</td>
<td>105</td>
</tr>
<tr>
<td>Traumatic</td>
<td>60</td>
</tr>
<tr>
<td>Cataract</td>
<td>90</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>27</td>
</tr>
<tr>
<td>Cones</td>
<td>0</td>
</tr>
<tr>
<td>Choroids</td>
<td>2</td>
</tr>
<tr>
<td>Retina</td>
<td>80</td>
</tr>
</tbody>
</table>

### Patient encounter summary - Latest 12 months

- New patient encounters: 3,411 (89%)
- Recurring patient encounters: 341 (11%)

### Patients not returned for retinal exam

- Overdue for more than 3 months & less than 1 year: 148
- Overdue for more than 1 year & less than 2 year: 33
- Overdue for more than 2 year & less than 3 year: 0
- Overdue for more than 3 year: 0
## Oversight and Feedback

<table>
<thead>
<tr>
<th>Photographer</th>
<th># of cases</th>
<th>score</th>
<th>rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>46.11</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>1136</td>
<td>45.67</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>388</td>
<td>48.43</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>50.69</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>36.67</td>
<td>Adequate</td>
<td></td>
</tr>
<tr>
<td>170</td>
<td>47.53</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>544</td>
<td>47.63</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>49.17</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>237</td>
<td>48.27</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>394</td>
<td>48.17</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>45.54</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>49.55</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>135</td>
<td>47.26</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>42</td>
<td>Adequate</td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>46.99</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>45</td>
<td>Good</td>
<td></td>
</tr>
</tbody>
</table>

![Bar Chart](image)
How Workflow Gaps Tracked

EyePacs QI Analysis

- Southwest: 100% Letter Sent to Patient, 63% Task Sent to Provider, 30% Referral to Specialist in EHR, 0% Notes from Specialist in EHR
- Congress: 97% Letter Sent to Patient, 70% Task Sent to Provider, 43% Referral to Specialist in EHR, 40% Notes from Specialist in EHR
- El Pueblo: 80% Letter Sent to Patient, 83% Task Sent to Provider, 87% Referral to Specialist in EHR, 40% Notes from Specialist in EHR
- Overall: 83% Letter Sent to Patient, 93% Task Sent to Provider, 79% Referral to Specialist in EHR, 38% Notes from Specialist in EHR

Legend:
- Orange: Letter Sent to Patient
- Blue: Task Sent to Provider
- Purple: Referral to Specialist in EHR
- Brown: Notes from Specialist in EHR
Before Technology

- Patient seen in clinic and provider identified need for exam after manual chart review
- Provider ordered referral and gave it to patient
- Patient would not complete recommended screening
- Screening rates low and abnormals undiagnosed
- Gaps not closed

Poor health outcomes

Inefficient

Poor quality

After Technology

- Population health tool utilized to generate gaps in care report prior to patients being seen
- Entire provider team takes ownership for completing gaps and aware of needs prior to visit
- Standing order allows retinopathy screening to be executed during primary care visit with use of new technology (EyePACS)
- Population health tool links primary care with specialty care through telehealth model
- Technology allows for rapid transfer of information to facilitate referrals with local specialists when abnormal identified that needs further evaluation
- Population health tool allows for easy tracking to identify opportunities to improve and an accountable workforce
- Screening completed as recommended
- Gaps closed

Improved health outcomes

Efficiency

Quality

Healthy Outcomes
### Diabetic Eye Exam [18-75]: 3Q15 - 2Q18

<table>
<thead>
<tr>
<th>Goal</th>
<th>Increase the percentage of diabetic patients aged 18-75 who received an eye exam during the measurement year.</th>
</tr>
</thead>
</table>
| **Benchmark** | 54.9% (2016 HEDIS Medicaid HMO)  
70.4% (2016 HEDIS Medicare HMO)  
53.6% (2016 HEDIS Commercial HMO) |
| **Numerator** | 4,469 diabetic patients aged 18-75 received an eye exam during the measurement year. |
| **Denominator** | 9,672 diabetic patients aged 18-75 who were seen during the measurement year |
| **Quarter** | 2nd Quarter 2018 (April - June 2018) |
| **Interpretation** | Data represents a significant positive trend beginning in 1Q16 this is likely a result of staff training and implementation of Eye Pacs screening devices. |
| **Action Plan** | Continue to drive workflow to promote greater use of in clinic Eye Pacs screening devices and continue training of staff to expand screening services across the system. |

**Control Chart: Diabetic Eye Exam**

- **Control Limits (Special Cause Variation):**  
  - One point outside the upper or lower control limits (3σ)  
  - Two out of three successive points more than 2 σ from the mean on the same side of the center line  
  - Four out of five successive points more than 1 σ from the mean on the same side of the center line  
  - Eight successive points on the same side of center line  
  - Six successive points increasing or decreasing (a trend)

**Rule Violations**

<table>
<thead>
<tr>
<th>Month</th>
<th>Violation</th>
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<tbody>
<tr>
<td>3Q15</td>
<td>Less than -3σ. 2 points out of the last 3 below -2σ</td>
</tr>
<tr>
<td>4Q15</td>
<td>Less than -3σ, 2 points out of the last 3 below -2σ, 4 points out of the last 5 below -1σ</td>
</tr>
<tr>
<td>3Q16</td>
<td>Less than -3σ, 2 points out of the last 3 below -2σ</td>
</tr>
<tr>
<td>4Q16</td>
<td>Less than -3σ, 2 points out of the last 3 below -2σ, 4 points out of the last 5 below -1σ</td>
</tr>
<tr>
<td>3Q16</td>
<td>Greater than +3σ</td>
</tr>
<tr>
<td>4Q16</td>
<td>Greater than +3σ, 2 points out of the last 3 above +2σ, 4 points out of the last 5 above +1σ</td>
</tr>
<tr>
<td>3Q17</td>
<td>Greater than +3σ, 2 points out of the last 3 above +2σ</td>
</tr>
<tr>
<td>4Q17</td>
<td>Greater than +3σ, 2 points out of the last 3 above +2σ, 4 points out of the last 5 above +1σ</td>
</tr>
<tr>
<td>3Q18</td>
<td>Greater than +3σ, 2 points out of the last 3 above +2σ</td>
</tr>
<tr>
<td>3Q18</td>
<td>4 points out of the last 5 above +1σ</td>
</tr>
</tbody>
</table>

---

Eye Screening Implemented
How IT Helped to Impact Quality

- Ability to track workflow (507 cases in first 12 months)
- i2i allowed for objective feedback that could be used with staff
  - Was messaging sent to patient
  - Was task sent to provider
  - Was referral placed by provider for local evaluation
  - Was patient seen by local provider
- Allows for on-going quality improvement
- Helps to show staff is closing the loop
Success Stories

• Primary Care Based Initiative
  • Patients appreciative of having service available
  • Available at three primary care sites

• Quality
  • Most reports read within two hours of being submitted
  • i2i necessary for accountability and tracking
  • Great opportunity for staff to expand skills

• World Class Experience for Patients and Staff
  • i2i familiar to organization and made tracking easier
  • Support from El Rio IT staff exceptional
  • Having a positive impact on early detection of retinopathy daily
Lessons Learned

• Incorporation into primary care at time of service is key
• Initial volume significantly more than anticipated
• Initial screenings about 35 minutes (proficient photographer 15 minutes)
• Stress to patients that service is ONLY for retinopathy screening
• Medical Assistant staff may not be the best photographer option
  • HIM
  • Radiology
  • MOR
• Staff members at various stages of acceptance and engagement
• Contracts with payers need to be established for sustainability
• Very impactful service
Replication and Spread

Campaign for improved awareness within the organization and a partnership with the accountable care organization (ACO).
Future Directions

- Quality
- Affordability
- Sustainability
# Replication and Spread in 2019

## Number of people with diabetes based on location

<table>
<thead>
<tr>
<th>Location</th>
<th>Type 1 Diabetes</th>
<th>Type 2 Diabetes</th>
<th>Diabetes Total</th>
<th>EyePACS Completed</th>
<th>Overall Patients</th>
<th>Percent of Patients with Diabetes</th>
<th>Percent of Diabetic Patients with Completed EyePACS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>28</td>
<td>884</td>
<td><strong>912</strong></td>
<td>105</td>
<td>8,519</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>Northwest</td>
<td>24</td>
<td>1,341</td>
<td><strong>1,365</strong></td>
<td>123</td>
<td>13,298</td>
<td>10%</td>
<td>9%</td>
</tr>
</tbody>
</table>

## EyePACS ordering by site providers and if appointment was scheduled

<table>
<thead>
<tr>
<th>Ordering Location</th>
<th>Total Unique Patients</th>
<th>Scheduled Appointment</th>
<th>Did not Schedule Appointment</th>
<th>Percent Scheduled Appointment</th>
<th>Percent Not Scheduled Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>220</td>
<td>39</td>
<td>181</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>Northwest</td>
<td>66</td>
<td>26</td>
<td>40</td>
<td>39%</td>
<td>61%</td>
</tr>
</tbody>
</table>

## EyePACS scheduled and result of scheduled appointment by location

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Appointments</th>
<th>Kept Appointment</th>
<th>No Showed</th>
<th>Patient Cancelled</th>
<th>Percent Kept</th>
<th>Percent No Showed</th>
<th>Percent Patient Cancelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>54</td>
<td>-</td>
<td>38</td>
<td>9</td>
<td>0%</td>
<td>70%</td>
<td>17%</td>
</tr>
<tr>
<td>Northwest</td>
<td>37</td>
<td>3</td>
<td>27</td>
<td>3</td>
<td>8%</td>
<td>73%</td>
<td>8%</td>
</tr>
</tbody>
</table>
## Getting Patients Care They Need

| DO | Images loaded | Images opened | Letter sent to patient | Abnormal message sent to provider | Provider generated referral | Referral processed and sent to pt | Apt scheduled and kept | Documentation in chart | Transportation | Language | Financial | Unaware of referral | Dilution | Schedule conflict | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4/14/2018 | 1 | 1 | 2 | 1 | 1 | 1 | 2 | 2 | | | | | | | | |
| 4/12/2018 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | | | | | | | | | |
| 4/10/2018 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | | | | | | | | | |
| 4/4/2018 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | | | | | | | | | |
| 3/30/2018 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | | | | | | | | | |
| 3/29/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | | | | | | | | | |
| 3/27/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | 2 | | | | | | | | | |
| 3/22/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | | | | | | | | | | |
| 3/16/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | 2 | | | | | | | | | |
| 3/14/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | | | | | | | | | | |
| 3/13/2018 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | | | | | | | | | |
| 3/13/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | 2 | | | | | | | | | |
| 3/9/2018 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | | | | |
| 3/5/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 2 | 2 | 1 | | | | | | |
| 3/5/2018 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | | | | | | |
| 3/2/2018 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | | | | | | | | | |
| 2/2/2018 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | | | | |

- **4/14/2018**: Pt has an pt on 11/1 at 9:15 w Dr. Muller as a new pt
- **4/12/2018**: Referral ordered 9/26/18, msg sent to MA to notify pt to schedule once referral is received
- **4/10/2018**: Referral ordered 9/26/18, msg sent to MA to notify pt to schedule once referral is received
- **4/4/2018**: Referral ordered 9/26/18, msg sent to MA to notify pt to schedule once referral is received
- **3/30/2018**: Referral ordered 9/26/18, msg sent to MA to notify pt to schedule once referral is received
- **3/29/2018**: Referral ordered 9/26/18, msg sent to MA to notify pt to schedule once referral is received
- **3/27/2018**: Pt hasn't been seen. Called pt, LM 9/22, 9/27, 10/1, no answer
- **3/22/2018**: Pt seen on 8/2018, Records requested on 9/25/18
- **3/16/2018**: Pt seen on 5/2018, records requested 9/22
- **3/14/2018**: Pt hasn't been seen. Per pt is full pay can’t afford visit.
- **3/13/2018**: Pt hasn’t been seen. Appt was cancelled by Office in 6/2018. Pt never called back to RS. She forgot. Referral mailed again.
- **3/9/2018**: Pt hasn’t been seen. Phone disconnected, unable to contact pt. 9/26/18
- **3/5/2018**: Pt hasn’t been seen. Referred to Dr. Jansky on 9/25/18, msg sent to MA to notify pt to schedule once referral is received
- **3/2/2018**: Pt hasn’t been seen. Referred to El Rio specialist. Unable to pay so is selfpay.
- **2/2/2018**: Pt hasn’t been seen. Spoke to pt he moved out state. 9/26/18
- **2/2/2018**: Pt seen on 6/18/18. Records requested 9/26/18
- **2/2/2018**: Referral ordered 9/27/18, msg sent to MA to notify pt to schedule once referral is received
- **2/2/2018**: Referral just ordered by Dr. Jansky on 9/25/18, msg sent to MA to notify patient and schedule an appt once referral is received
Questions