If funding were available for you to have a PEA in your practice, what tasks or projects would you like to see her accomplish, toward improving the quality of patient care or facilitating practice-based research?

1. Assist in reaching patients who have not showed for appointments and getting them in.
2. Find those who are not up to date with well child checks and get them in.
3. Find resources for our patients with problems, such as asthma, cp, mr, diabetes, and so forth.
4. Put a good check and balance in place regarding our charting, by doing occasional chart reviews.

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1. Help us improve our health maintenance and preventive health processes.
2. Improve our disease management capabilities for diabetes, CAD, asthma.
3. Help put a plan in place to insure maximum rates of immunizations for kids.
4. Create a systematic ("cookbook") approach to obese patients.
5. Help us more consistently identify and address depression in our patients.

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1. Assist in setting up quality reports within EMR for each provider.
2. Assist is surveying patients as to their perceptions about the timing and content of care.
3. Help me find repeatedly missed opportunities for prevention care and billing.
4. Help my office staff improve the no show rate.

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1. Help with budget projections for utilizing my registry. It is great to drill down and get a list of patients who need, say, their lipids, but what is the most cost effective way to a) call them all, b) send a reminder postcard (at 41 cents now for postage, that's a killer), c) email them, etc. and how do you track who you reached and who is scheduled and did they show up? All chronic disease models are now pushing the use of a registry, which I have; I just don't quite know how to use it effectively.
2. Help me customize my cardio metabolic program where I have the current literature, handouts, and documentation format at my fingertips.

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1. Automating screening and processing. Whether it is colonoscopies, mammographies, immunizations, etc, institute a process to detect and refer

patients and track the findings to associate this with relevant follow-up. Also, tracking this on an ongoing basis to ensure annual patient follow-up, etc. An EMR obviously would be ideal to search and manage, but those of us with paper charts have a challenge as we work with one patient at a time.

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1. I agree with what pretty much everyone here has said. To me, finding a way to catch those who fall through the cracks regarding screenings. This may be wellness issues such as mammography, colonoscopy, vaccination, or disease-based such as hemoglobin A1c, lipid panel, PSA, etc... I have problems with those who are "worked-in" for a very quick consultation during a hectic day that I later discover have not had a wellness exam in over five years, no prior mammogram, no lab exam in 10-15 years, and don't even think about colonoscopy. Then, of course, I feel like a heel because I didn't address it when this person comes in with a sprained ankle.
2. Also, is there a way to somehow obtain information from the patient who sees Dr. A for cardiology, Dr. B for gynecology, and me for routine family care? For example, Mrs. Smith presents today for routine diabetes check-up. I show that it is time for a hemoglobin A1c, lipid panel, ALT, urine micro albumin. She throws a fit because Dr. A just drew blood and Dr. B. checked her urine. I have no idea what tests were run, and I know she doesn't want to have to pay because Medicare denies because the other providers ran these. I am faced with the dilemma of do I send her home and wait for the results from Drs. A&B knowing I won't see her again for at least another 3 months, or chance it knowing she will probably have to eat the bill? Ahhhh, the joy of primary care. Gotta love it. There needs to be a simplified way for all providers to centralize lab/radiology reports that does not violate HIPPA.

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1. Review charts and recall patients for such items as DEXA bone density, mammograms, Pap smears, immunizations, diabetes follow-up, hypertension follow-up.
2. Establish a diabetic teaching program for our 5-physician group.
3. Establish a weight reduction/exercise program for our group.

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1. Use the EMR to run reports on how each resident and faculty member is doing at meeting the benchmarks for DM, asthma, CAD, HTN, etc.
2. Assist in using the Part IV module for our maintenance of certification program with quality assurance with our patients. Use this similar to the way we are currently using our SAM’s workshops to get our members full credit for completing the module.

3. Assist in reporting to Medicare how the clinic is doing to meet the pay for performance requirements, to capture the extra billing for the clinic that Medicare pays for P4P reporting.