



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS

Sample Reports  
From the  
METRIC Program  
For  
Group Leaders

Effective April 2011

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## **METRIC: Measuring, Evaluating, and Translating Research Into Care**

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The METRIC program is a flexible, online performance improvement activity with clinical topics relevant to office-based, primary care practices, including: asthma, COPD, coronary artery disease, diabetes, geriatrics, depression (MDD), and hypertension. The program supports your group(s) as the common structure for assessment and change for improvement.

As a practice manager, administrator, medical director, or program director with accountability for quality and patient safety, METRIC has resources that enable you to:

- Enroll the individuals as a group or groups in one quality improvement program so that they follow the same project pathway
- Track participants' progress through the program
- Receive group data reports that aggregate all the assessments and the selected interventions across your group(s)
- Receive custom reports individually suited to your needs
- Communicate easily with all participants
- Choose from billing options

The following pages display a few sample reports from data in METRIC:

Group Tracking Report

Group Intervention Selections

Performance Measure Data

Practice Assessment Data

To discuss your unique needs, please contact the METRIC staff at 800-274-2237, ext. 4132, or [metric@aafp.org](mailto:metric@aafp.org).

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METRIC Program Manager



The **METRIC Tracking Report** is designed for the group leader in order to determine the progress of each participant. Because the report includes participant e-mail addresses, the group leader is able to communicate with all participants easily. Request a report by e-mail to [metric@aafp.org](mailto:metric@aafp.org) as often as you need one.

**LEGEND:**

**Parent Group** = created to link all groups together in one report. Participants in child groups can be in different modules or the same module.

**Child Group, or Group** = a group of 3 or more participants in the same module. Participants can be in a group by module, by location, or by profession [physicians, physician residents, NPs, PAs, or other healthcare professionals]. A participant can be a member of only one group at a time.

Parent Group Name	Group Name	Module	First Name	Last Name	Email	Cycle: Baseline or Follow-Up	Current Step	Current Status	Chart Review Began	Chart Review Ended	Step 5: Interventions selected	Step 6: Start Reassessments	Completion	
Health System South	Child Group A - Location A	Diabetes: Improving Patient Care	Participant 1	Participant 1	Participant1@anci.com	Baseline	Cycle Complete	Cycle Complete	5/25/2010 9:45 AM	5/25/2010 9:54 AM	8/25/2010 9:54 AM	11/25/2010 9:54 AM	11/29/2010 10:53 AM	
	Child Group A - Location A	Diabetes: Improving Patient Care	Participant 1	Participant 1	Participant1@anci.com	Follow-up [1]	Award Certificate	Complete	11/29/2010 10:13 AM	11/29/2010 10:47 AM			11/29/2010 10:47 AM	
	Child Group A - Location A	Diabetes: Improving Patient Care	Participant 2	Participant 2	Participant2@anci.com	Baseline	Implement My Action Plan	Waiting for Reassessment	5/18/2010 8:57 PM	5/18/2010 9:00 PM	5/18/2010 9:00 PM	8/18/2010 9:00 PM		
	Child Group A - Location A	Diabetes: Improving Patient Care	Participant 3	Participant 3	Participant3@anci.com	Baseline	Add Suggested Interventions	In Progress	7/23/2010 12:57 PM	7/29/2010 12:57 PM				
	Child Group B - Location B	Diabetes: Improving Patient Care	Participant 4	Participant 4	Part.4@anci.com	Baseline	Cycle Complete	Cycle Complete	5/14/2010 5:58 PM	5/31/2010 5:58 PM	7/18/2010 6:17 PM	10/18/2010 6:17 PM		
	Child Group B - Location B	Diabetes: Improving Patient Care	Participant 4	Participant 4	Part.4@anci.com	Follow-up [1]	Practice Assessment (Follow-up)	In Progress						
	Child Group B - Location B	Diabetes: Improving Patient Care	Participant 6	Participant 6	Part.6@anci.com	Baseline	Implement My Action Plan	Waiting for Reassessment	5/14/2010 1:25 PM	5/14/2010 2:23 PM	5/18/2010 12:23 PM	8/18/2010 12:23 PM		
	Child Group C - Location C	Diabetes: Improving Patient Care	Participant 7	Participant 7	Participant7@rcch.org	Baseline	My Patient Chart Review (Baseline)	In Progress	5/25/2010 7:30 AM					
	Child Group C - Location C	Diabetes: Improving Patient Care	Participant 8	Participant 8	Participant8@rcch.org	Baseline	Implement My Action Plan	In Progress	6/7/2010 12:43 PM	6/7/2010 3:43 PM				
	Child Group C - Location C	Diabetes: Improving Patient Care	Participant 9	Participant 9	Participant9@rcch.org	Baseline	Implement My Action Plan	Waiting for Reassessment	6/7/2010 6:20 PM	6/7/2010 6:28 PM	6/7/2010 3:49 PM	9/7/2010 6:28 PM		
	Child Group D - Location D	Diabetes: Improving Patient Care	Participant 10	Participant 10	Part.10@resp.com	Baseline	Implement My Action Plan	Waiting for Reassessment	6/9/2010 4:57 PM	6/9/2010 5:00 PM	6/9/2010 5:30 PM	9/9/2010 5:00 PM		
	Child Group D - Location D	Diabetes: Improving Patient Care	Participant 10	Participant 10	Part.10@resp.com	Follow-up [1]	Implement My Action Plan	Waiting for Reassessment	9/9/2010 5:00 PM					
	Child Group D - Location D	Diabetes: Improving Patient Care	Participant 11	Participant 11	Part.11@resp.com	Baseline	Add Suggested Interventions	In Progress	6/9/2010 9:36 PM	6/9/2010 10:36 PM				
	Child Group D - Location D	Diabetes: Improving Patient Care	Participant 11	Participant 11	Part.11@resp.com	Baseline	Implement My Action Plan	Waiting for Reassessment	5/13/2010 8:25 PM	5/13/2010 8:30 PM	8/13/2010 8:30 PM	10/21/2010 4:00 PM		
	Child Group D - Location D	Diabetes: Improving Patient Care	Participant 12	Participant 12	Part.12@resp.com	Baseline	Assess My Performance (Baseline)	In Progress	5/13/2010 8:45 PM	5/13/2010 9:15 PM				
	Child Group D - Location D	Diabetes: Improving Patient Care	Participant 12	Participant 12	Part.12@resp.com	Baseline	Assess My Performance (Baseline)	In Progress	6/3/2010 9:05 PM	6/3/2010 9:35 PM				
	Child Group F - Location F	Hypertension: Improving Patient Care	Participant 16	Participant 16	Part.16@locF.com	Baseline	My Patient Chart Review (Baseline)	In Progress	5/13/2010 5:45 PM					
	Child Group F - Location F	Hypertension: Improving Patient Care	Participant 17	Participant 17	Part.17@locF.com	Baseline	Cycle Complete	Cycle Complete	7/29/2010 11:34 PM	7/29/2010 11:37 PM	8/29/2010 11:37 PM	10/31/2010 3:01 PM	11/1/2010 2:01 PM	
	Child Group F - Location F	Hypertension: Improving Patient Care	Participant 17	Participant 17	Part.17@locF.com	Follow-up [1]	Award Certificate	Complete	10/31/2010 2:08 PM	10/31/2010 2:18 PM				11/1/2010 2:01 PM
	Child Group F - Location F	Hypertension: Improving Patient Care	Participant 18	Participant 18	Part.18@locF.com	Baseline	Cycle Complete	Cycle Complete	11/1/2010 7:08 PM	11/1/2010 7:18 PM	11/1/2010 7:45 PM	12/19/2011 1:45 PM	1/1/2011 3:45 PM	
Child Group F - Location F	Hypertension: Improving Patient Care	Participant 18	Participant 18	Part.18@locF.com	Follow-up [1]	Award Certificate	Complete	12/26/2010 1:40 PM	12/26/2010 1:44 PM				1/1/2011 1:45 PM	
Child Group F - Location F	Hypertension: Improving Patient Care	Participant 19	Participant 19	Part.19@locF.com	Baseline	Cycle Complete	Cycle Complete	7/31/2010 2:09 AM	8/15/2010 2:09 AM	8/25/2010 2:09 AM	10/31/2010 2:17 PM	11/1/2010 9:00 AM		
Child Group F - Location F	Hypertension: Improving Patient Care	Participant 19	Participant 19	Part.19@locF.com	Follow-up [1]	Award Certificate	Complete	10/31/2010 02:15 PM	10/31/2010 2:17 PM				10/31/2010 3:00 PM	



Similar reports from the METRIC program are available for each module at your convenience.

The Diabetes: Improving Patient Care module has been selected for convenience.

## Sample Intervention Selection Report

### Description:

The **Intervention Selection Report** shows you how many participants selected each available intervention in the program module. The report lists the group name with which the participant is linked. This sample report for the parent group, Winsley Health Group, shows the two associated groups' participants and their selected intervention(s). This report is available for groups at one location as well.

### Parent Group: Winsley Health Group

Interventions Selected	Group Name	Last Name	First Name
<b>Flow Sheets</b>	Pleasanton Clinic	Doe	Participant A
	Pleasanton Clinic	Jones	Participant B
	Pleasanton Clinic	Smith	Participant C
	Oakley Clinic	Johnson	Participant D
	Oakley Clinic	Brown	Participant E
	Oakley Clinic	Link	Participant F
<b>Total Participants</b>	<b>5</b>		
<b>Put Guidelines into Practice</b>	Pleasanton Clinic	Jones	Participant B
	Pleasanton Clinic	Smith	Participant C
<b>Total Participants</b>	<b>2</b>		
<b>Develop a Care Team</b>			
	Oakley Clinic	Link	Participant F
<b>Total Participants</b>	<b>1</b>		
This report continues listing all interventions			



Similar reports from the METRIC program are available for each module at your convenience.

The Diabetes: Improving Patient Care module has been selected for convenience.

## Sample Performance Measure Group Report

### Description:

The **Performance Measure Group Report** provides the average performance across all participants in the group for each of the performance measures in either the baseline cycle, the follow up cycle or both.

This sample report shows the average for one group, and a data report for a parent group with "child" groups at various locations can be generated as well.

### **Parent Group: Winsley Health Group**

Performance Measure	Cycle	Group Average	National Peer Group from Module
Percentage of Smokers Receiving Cessation Counseling	Baseline	6.6%	95.0%
Patient Is a Smoker	Baseline	12.0%	17.0%
Received Eye Exam in the Past 12 Months	Baseline	26.0%	46.0%
Received Foot Exam in the Past 12 Months	Baseline	30.0%	64.0%
Received Flu Vaccination in the Past 12 Months	Baseline	38.0%	50.0%
Received Aspirin Therapy Recommendation	Baseline	42.0%	60.0%
Received Microalbumin Protein Screen in the Past 12 Months	Baseline	64.0%	63.0%
Received Lipid Panel in the Past 12 Months	Baseline	74.0%	88.0%
Received A1C Exam in the Past 12 Months	Baseline	94.0%	95.0%
Blood Pressure Measured in the Past 12 Months	Baseline	96.0%	99.0%
This report continues listing all performance measures			



Similar reports from the METRIC program are available for each module at your convenience.

The Diabetes: Improving Patient Care module has been selected for convenience.

**Sample Group Practice Assessment Report**

**Description:** This report provides a group average of all responses to each of 16 questions in the practice assessment questionnaire. The practice assessment questionnaire assists participants in reviewing their healthcare delivery **systems** in place that lead to the outcomes they currently experience. This assessment tool is also presented in the reassessment stage, and participants view both results.

Baseline Practice Assessment Category	Answer #	Answer Choice - Group Average is noted by the number average and a star. ★ Peer Group [national] Average is noted by a circle. ●
Overall organization of diabetes care	<b>1.5 group average</b>	
	★ 1	is not well organized and we are unable to consistently give patients the time, effort and resources that are needed.
	2	focuses on problems as they emerge or as they become an emphasis of insurers, state efforts or other outside influences.
	● 3	involves the use of protocols and practice tools.
	4	includes an overall improvement strategy and we use it proactively to meet our practice goals.
Addressing patient self-management	<b>3.0 group average</b>	
	1	we do not consistently address self-management concerns of patients with diabetes and their families.
	● 2	we address self-management concerns of only specific patients with diabetes who seem to need it.
	★ 3	addressing self-management issues is part of the philosophy of the practice and is a part of each diabetes patient's visit.
	4	we have peer support groups in the practice or by referral to well-established programs.
Community partnerships	<b>2.5 group average</b>	
	1	do not exist.
	● ★ 2	are being considered but have not yet been implemented.
	3	are formed to develop supportive programs and policies.
	4	are actively sought to develop formal supportive programs and policies across the entire system.
Coordination of care	<b>1.5 group average</b>	
	1	is not done well.
	● ★ 2	is done reasonably well, but depends mostly on written communication between our office and subspecialists, case managers or disease management companies.
	3	is done quite well, with adequate oral and written communication between our office and subspecialists and other relevant providers.
	4	is a high priority and includes active coordination between our office, subspecialists and other relevant groups.
Diabetes registry	<b>2.5 group average</b>	
	● 1	is not available.
	★ 2	is used to maintain patient information such as name, diagnosis, contact information and date of last contact, either on paper or in a computer database.
	3	is used to identify patients regarding specific clinical information (for example, data collection for measuring/tracking, or identifying patients for planned visits or group visits).
	4	is tied to guidelines and provides prompts and reminders about needed services (for example, lab and other testing) and/or is an integral function of our electronic medical record.
<b>This report continues for all practice assessment questions.</b>		