PCC Resources
For PCMH

Tim Proctor
Users Conference 2015
Goals and Takeaways

• Introduction to NCQA's 2014 PCMH. What is it? Why get recognition?
• Show how PCC functionality and reports can be used for PCMH Recognition
• Introduction to PCC's online PCMH resources: http://pcmh.pcc.com
What is a PCMH?

-Delivers “whole-person” coordinated care to transform primary care into “what patients want it to be”
-Values clinician-patient relations (not disjointed visits) to keep patients healthy between visits
-Supports team-based care
-Aligns with Meaningful Use and use of I/T

Source: http://ncqa.org
Trends/Changes in PCMH

• Triple Aim: Improve **cost, quality, patient experience**
• Population management
  • Keeping healthy patients healthy
  • Managing chronically-sick patients
• Integrating care
  • Referrals, connecting w/ community resources
• Care transition and self-care support
Why NCQA PCMH?

• Increased savings per patient
• Higher quality of care
• Reduced cost of care
• Most widely adopted model for transforming primary care practices to medical homes

Source: NCQA PCMH 2014: Behind the Enhancements  http://ncqa.org
States With Initiatives That Use NCQA's PCMH

Source: NCQA PCMH 2014: Behind the Enhancements  http://ncqa.org
NCQA PCMH Growth 2008-2013

- As of April 2015, >10,000 sites and ~50,000 clinicians recognized in 50 states
State-by-State PCMH Resource

Patient-Centered Primary Care Collaborative

• https://www.pcpcc.org/initiatives

• Interactive maps showing public and private PCMH initiatives for your state

• Good place to start if considering PCMH recognition

PCC
Pediatric EHR Solutions

Control Your Future™
PCMH and MOC Credit

- Pediatricians who have achieved PCMH Recognition (2011 or 2014) can now get Maintenance of Certification (MOC) Part 4 credits
- Attest to “meaningful participation in quality improvement (QI) projects”
- 40 credits
- [https://www.abp.org/content/how-to-earn-credit](https://www.abp.org/content/how-to-earn-credit)
Prevalidation

• PCC prevalidated to offer 6.5 credits under 2014 standards (likely more coming!)

• Skip those elements. You'll automatically get credit

• Here's what you'll need when you submit to NCQA:
  • Approval Table (see handout)
  • NCQA Letter of Product Autocredit Approval (coming soon)
  • Letter of Product Implementation (contact PCC)
PCC's PCMH Resources
(http://pcmh.pcc.com)
PCMH Reporting Examples
Patient-Centered Appointment Access

• The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on providing same-day appointments for routine and urgent care

• Element 1A.1
Providing Same-Day Appointments

- Show proof of reserving time in schedule for same-day sick
Providing Same-Day Appointments

- "Appointment Summarizer" (appts) report identifying Block Appointments
Providing Same-Day Appointments

<table>
<thead>
<tr>
<th>App Date</th>
<th>Mins</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/04/13</td>
<td>600.00</td>
<td>60</td>
</tr>
<tr>
<td>03/05/13</td>
<td>600.00</td>
<td>60</td>
</tr>
<tr>
<td>03/06/13</td>
<td>500.00</td>
<td>50</td>
</tr>
<tr>
<td>03/07/13</td>
<td>500.00</td>
<td>50</td>
</tr>
<tr>
<td>03/08/13</td>
<td>480.00</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>2680.00</td>
<td>268</td>
</tr>
</tbody>
</table>

Criteria for this report run:
DATA INCLUDED IN THIS REPORT:

Providers:
All

Locations:
All

Visit Reasons:
All

Sick Call Block:
All

Users:
All

Pat Flags:
All

Date Entered:
All

- Reports total minutes and # of sick blocks by date
- Need report with at least 5 days of data
Patient-Centered Appointment Access

• To provide consistent access and help understand true demand, show how you monitor no-show rates.

• Element 1A.5

• Monthly and annual data available practice-wide and per-provider in Dashboard
Dashboard Missed Appointment Rate

Provider Breakdown
From: 6/1/2014 to 5/31/2015

<table>
<thead>
<tr>
<th>Provider</th>
<th>Missed Appointments</th>
<th>Total Appointments</th>
<th>Missed Appointment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Providers</td>
<td>3,382</td>
<td>50,575</td>
<td>6.7%</td>
</tr>
<tr>
<td>Provider 15</td>
<td>6</td>
<td>446</td>
<td>1.4%</td>
</tr>
<tr>
<td>Provider 2</td>
<td>140</td>
<td>3,218</td>
<td>4.4%</td>
</tr>
<tr>
<td>Provider 16</td>
<td>91</td>
<td>1,228</td>
<td>7.4%</td>
</tr>
<tr>
<td>Provider 24</td>
<td>10</td>
<td>94</td>
<td>10.6%</td>
</tr>
<tr>
<td>Provider 25</td>
<td>5</td>
<td>121</td>
<td>4.1%</td>
</tr>
<tr>
<td>Provider 17</td>
<td>169</td>
<td>2,770</td>
<td>6.1%</td>
</tr>
<tr>
<td>Provider 30</td>
<td>33</td>
<td>182</td>
<td>18.1%</td>
</tr>
<tr>
<td>Provider 27</td>
<td>14</td>
<td>255</td>
<td>5.5%</td>
</tr>
<tr>
<td>Provider 32</td>
<td>1</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>Provider 6</td>
<td>315</td>
<td>4,263</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

How You Compare
Compare: All Providers

- Practice Average: 6.7%
- Average PCC Client: 4.7%
- Top 10% of PCC Clients: 1.3%
24/7 Access to Clinical Advice

• 1B.2 – Providing timely clinical advice by telephone

• 1B.3 – Providing timely clinical advice using a secure, interactive electronic system
Providing Timely Clinical Advice by Telephone

- PCC EHR → Reports → Phone Encounter Performance Report
- Run for at least 7 calendar days including times when office is open and closed

PCC Pediatric EHR Solutions
Control Your Future™
Providing Timely Clinical Advice by Secure Electronic Msg

• Use PCC's patient portal functionality - My Kid's Chart
  http://learn.pcc.com/mykidschart

• Need to provide report showing response times to portal messages before and after-hours.

• Report for at least 7 calendar days.
Providing Timely Clinical Advice by Secure Electronic Msg
Portal Use and PCMH

- Online access to health information
- 1.C.1 - 50% of patients need online access to health info w/in 4 days
- 1.C.2 - 5% of patients actually need to view their information in the portal
- 1.C.4 - 5% of patients actually need to send secure messages in the portal
- 1.C.5 – patients have two-way communication with practice (autocredit if using portal)
Portal Use and PCMH

• Get patients signed up for the portal
• Train patients on using the portal
• Point patients to PCC's user guide:
  http://learn.pcc.com/Content/MyKidsChart/PortalUserGuide.htm
Continuity of Care

• The practice provides continuity of care for patients/families by monitoring the percentage of patient visits with selected clinician or team

• Element 2.A.2

• Track a PCP for all patients if you aren't already

• Need to report % of visits for each clinician where visit provider is the PCP

• There is no expected % to reach for this measure

PCC Pediatric EHR Solutions

Control Your Future™
### Monitoring % of Visits With Selected Clinician

<table>
<thead>
<tr>
<th>Count - Pat</th>
<th>Provider 1</th>
<th>Provider 2</th>
<th>Provider 3</th>
<th>Provider 4</th>
<th>Provider 5</th>
<th>Provider 6</th>
<th>Provider 7</th>
<th>Total Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient assigned PCP?</td>
<td>Appt w/ PCP?</td>
<td>No</td>
<td>16</td>
<td>28</td>
<td>17</td>
<td>23</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>231</td>
<td>593</td>
<td>287</td>
<td>188</td>
<td>498</td>
<td>343</td>
<td>147</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>454</td>
<td>143</td>
<td>618</td>
<td>603</td>
<td>115</td>
<td>352</td>
<td>774</td>
</tr>
<tr>
<td><strong>Total Result</strong></td>
<td></td>
<td>701</td>
<td>764</td>
<td>922</td>
<td>814</td>
<td>637</td>
<td>723</td>
<td>937</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Appts where PCP is assigned</th>
<th>Provider 1</th>
<th>Provider 2</th>
<th>Provider 3</th>
<th>Provider 4</th>
<th>Provider 5</th>
<th>Provider 6</th>
<th>Provider 7</th>
<th>Total Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Appts where PCP=Appointment Provider</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>% of Appts where PCP=Appointment Provider</td>
<td>65%</td>
<td>19%</td>
<td>67%</td>
<td>74%</td>
<td>18%</td>
<td>49%</td>
<td>83%</td>
<td>56%</td>
</tr>
</tbody>
</table>

- Report based on srs appointment report
- Contact PCC support for assistance with generating this spreadsheet
Cultural and Linguistically Appropriate Services

• The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by assessing the diversity (2C.1) and language needs (2C.2) of its population

• Use recaller or contact PCC for assistance with getting a spreadsheet summary

• Autocredit for 2C.4 (provide printed materials in language of its population) if using PCC EHR
Cultural and Linguistically Appropriate Services

Use recaller:

- **Include by Race**
  - Exclude by Race

- **Include by Ethnicity**
  - Exclude by Ethnicity

- **No Race Selected**
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
  - Some other race
  - Prefers not to answer

- **No Ethnicity Selected**
  - Hispanic or Latino
  - Not Hispanic or Latino
  - Prefers not to answer

PCC Pediatric EHR Solutions
Control Your Future™
Cultural and Linguistically Appropriate Services

Include by Preferred Language
Exclude by Preferred Language

Include by Preferred Language

No Preferred Language Selected
- Prefers not to answer
- Abkhazian
- Afar
- Afrikaans
- Akan
- Albanian
- American Sign Language
- Amharic
- Arabic
- Aragonese
- Armenian
- Assamese
- Avaric
- Avestan
- Aymara
- Azerbaijani
- Bambara

PCC
Pediatric EHR Solutions
Control Your Future ™
### Cultural and Linguistically Appropriate Services

<table>
<thead>
<tr>
<th>Filter</th>
<th>% of Total</th>
<th>Filter</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td>Primary Preference</td>
<td></td>
</tr>
<tr>
<td>(empty)</td>
<td>477</td>
<td>(empty)</td>
<td>506</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>11</td>
<td>Amharic</td>
<td>69</td>
</tr>
<tr>
<td>American Indian or Alaska Native, Asian</td>
<td>1</td>
<td>Arabic</td>
<td>3</td>
</tr>
<tr>
<td>Asian</td>
<td>62</td>
<td>Arabic</td>
<td>3</td>
</tr>
<tr>
<td>Asian, Black or African American</td>
<td>3</td>
<td>Arabic</td>
<td>3</td>
</tr>
<tr>
<td>Asian, White</td>
<td>1</td>
<td>Ewe</td>
<td>1</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1227</td>
<td>English</td>
<td>1274</td>
</tr>
<tr>
<td>Black or African American, Native Hawaiian</td>
<td>1</td>
<td>English</td>
<td>1274</td>
</tr>
<tr>
<td>or Other Pacific Islander</td>
<td></td>
<td>English</td>
<td>1274</td>
</tr>
<tr>
<td>Black or African American, Prefers not to</td>
<td>1</td>
<td>English</td>
<td>1274</td>
</tr>
<tr>
<td>answer</td>
<td></td>
<td>English</td>
<td>1274</td>
</tr>
<tr>
<td>Black or African American, Some other race</td>
<td>6</td>
<td>English</td>
<td>1274</td>
</tr>
<tr>
<td>White</td>
<td>93</td>
<td>Ewe</td>
<td>1</td>
</tr>
<tr>
<td>White, Some other race</td>
<td>1</td>
<td>Ewe</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Result</strong></td>
<td><strong>1968</strong></td>
<td><strong>Total Result</strong></td>
<td><strong>1968</strong></td>
</tr>
</tbody>
</table>

### Additional Information

- **PCC Pediatric EHR Solutions**: Control Your Future™
Population Health Management – Patient Info

- 3A.1 - The practice uses an electronic system to record patient information for more than 80 percent of its patients (up from 50% for 2011 PCMH)
- Track various patient demographic information including **race, ethnicity, preferred language**
Population Health Management – Patient Info

- Track this info for at least 80% of patients. Only need to meet 10 of these 14 factors to achieve full score for this element:

<table>
<thead>
<tr>
<th>Date of birth</th>
<th>Dates of previous clinical visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Legal guardian/health care proxy</td>
</tr>
<tr>
<td>Race</td>
<td>Primary caregiver <em>(consider skipping)</em></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Presence of Advance Directives (NA for Peds)</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>Health insurance Info</td>
</tr>
<tr>
<td>Telephone Numbers</td>
<td>Name and contact info of health care professionals involved in patient's care <em>(consider skipping)</em></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td>Occupation (NA for Peds)</td>
<td></td>
</tr>
</tbody>
</table>
Population Health Management – Patient Info

• Report needed showing % of patients seen who have information tracked
• Use date range of at least 3 months of visits
Population Health Management – Patient Info

• Contact PCC for help reporting on this measure. We can generate spreadsheet output like this:

<table>
<thead>
<tr>
<th>#</th>
<th>Date of Birth</th>
<th># patients with data</th>
<th># patients seen in last 3 months</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Date of Birth</td>
<td>1895</td>
<td>1895</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>Gender</td>
<td>1895</td>
<td>1895</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>Race</td>
<td>1411</td>
<td>1895</td>
<td>74%</td>
</tr>
<tr>
<td>4</td>
<td>Ethnicity</td>
<td>1387</td>
<td>1895</td>
<td>73%</td>
</tr>
<tr>
<td>5</td>
<td>Language Preference</td>
<td>1380</td>
<td>1895</td>
<td>73%</td>
</tr>
<tr>
<td>6</td>
<td>Telephone</td>
<td>1895</td>
<td>1895</td>
<td>100%</td>
</tr>
<tr>
<td>7</td>
<td>Email address</td>
<td>83</td>
<td>1895</td>
<td>4%</td>
</tr>
<tr>
<td>8</td>
<td>Date of previous visits</td>
<td>1895</td>
<td>1895</td>
<td>100%</td>
</tr>
<tr>
<td>9</td>
<td>Legal Guardian</td>
<td>1895</td>
<td>1895</td>
<td>100%</td>
</tr>
<tr>
<td>10</td>
<td>Primary caregiver</td>
<td>0</td>
<td>0</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>11</td>
<td>Advance Directives*</td>
<td>1895</td>
<td>1895</td>
<td>100%</td>
</tr>
<tr>
<td>12</td>
<td>Health insurance coverage</td>
<td>1846</td>
<td>1895</td>
<td>97%</td>
</tr>
</tbody>
</table>
Population Health Management – Clinical Data

• The practice uses an electronic system to record clinical data as structured (searchable) data (3B)

• Reportable from PCC Meaningful Use report

• Autocredit for 3B.6 and 3B.7 related to built-in growth chart tracking in PCC EHR

• See WIKI or learn.pcc.com for document describing how to meet these measures with PCC EHR
  • http://pcmh.pcc.com/index.php/PCMH2B
  • http://learn.pcc.com/Content/PCCEHR/Reports/MeetingMeaningfulUse.htm
Use Data for Population Management

- At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:

  - At least two different preventive care services.
  - At least two different immunizations.
  - At least three different chronic or acute care services.
  - Patients not recently seen by the practice.
  - Medication monitoring or alert.
Use Data for Population Management

- Element 3D
- Identify patients in need of care: (Dashboard, recaller)
- Remind them about needed services (notify, recaller, EHR patient reminders)
Preventive Care Measure: Well Visit Rates

- Dashboard: Report well visit rates, overdue listing and trends for kids under 15 months, 15-36mos, 3-6yrs, 7-11yrs, or 12-18yrs.
Preventive Care Measure: Developmental Screening Rates

- Coming to Dashboard in 6.29
- Three screening rates: Infancy, Early Childhood, Adolescent
- View list of overdue patients
Identify Patients in Need of Preventive Care

- Other examples (use recaller for these):
  - 4-5 year olds needing hearing screening
  - Newborns needing hearing screening
  - Patients recently discharged from the hospital / ER needing follow up
  - Children overdue for tobacco and/or alcohol/substance abuse counseling
Identify Patients in Need of Preventive Care

- Recaller Example:
  Restrict by procedure or Dx code to focus on patients having certain CPT codes billed or having certain conditions

Selections:
- Exclude by Flag - Account Flag
  Deceased
  INACTIVE
- Exclude by Flag - Patient Flag
  Dismissed
  Transient
- Exclude by Procedure (All Providers)
  In the past 2 yrs
  Developmental Screening
  96110
  96110-EP
  96110-HA
- Include by Age
  between 2 yrs and 3 yrs old in the past year
- Select relevant developmental screen codes. Patients who already received a screening will be excluded from report

PCC
Pediatric EHR Solutions
Control Your Future™
Use Data for Population Management

• At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:
  • At least two different preventive care services.
  • **At least two different immunizations.**
  • At least three different chronic or acute care services.
  • Patients not recently seen by the practice.
  • Medication monitoring or alert.
Immunization Measure: HPV Vaccination Rates

The CDC’s Advisory Committee on Immunization Practices (ACIP) recommends a series of three HPV vaccines for both males and females beginning at age 11 or 12. This measure tracks your HPV vaccination rates for all patients 13-17 years of age, showing the percentage of these patients who have received three HPV vaccines by the time of data collection. See how you measure up to other PCC clients and view a list of patients who have not received all three recommended HPV doses. View the Age and Sex Breakdown report to compare HPV vaccination rates for two age ranges, males and females, and to exclude patients with a current insurance of Medicaid.

You have 2,665 active patients between 13 years and 17 years of age.
2,049 of these patients are due for at least one HPV vaccine.

Click for list of overdue patients

How You Compare

Your Practice: 23%
PCC Client Average: 29%
Top Performers: 53%

(\% of active patients 13-17 years old having three HPV vaccines)
Immunization Measure: Seasonal Influenza Vaccine Rates

- For listing of overdue patients, use recaller report.
Identify Patients in Need of Immunizations

- Dashboard example reporting 2yo patients in need of vaccines.
- Contact PCC support for assistance with reporting for patients over 2 years old

**Vaccine Criteria**

<table>
<thead>
<tr>
<th>Vaccine Criteria</th>
<th>Result (% of Patients up-to-date)</th>
<th>Overdue Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 DTaP vaccines</td>
<td>85% (657 of 770)</td>
<td>113 patients were overdue at age 2.</td>
</tr>
<tr>
<td>3 IPV vaccines</td>
<td>96% (740 of 770)</td>
<td>30 patients were overdue at age 2.</td>
</tr>
<tr>
<td>1 MMR vaccine</td>
<td>94% (727 of 770)</td>
<td>43 patients were overdue at age 2.</td>
</tr>
<tr>
<td>2 Hib vaccines</td>
<td>98% (758 of 770)</td>
<td>12 patients were overdue at age 2.</td>
</tr>
<tr>
<td>3 Hep B vaccines</td>
<td>89% (689 of 770)</td>
<td>81 patients were overdue at age 2.</td>
</tr>
<tr>
<td>1 Varicella vaccine</td>
<td>96% (736 of 770)</td>
<td>34 patients were overdue at age 2.</td>
</tr>
<tr>
<td>4 Pneumococcal vaccines</td>
<td>91% (699 of 770)</td>
<td>71 patients were overdue at age 2.</td>
</tr>
<tr>
<td>2 Hep A vaccines</td>
<td>37% (285 of 770)</td>
<td>485 patients were overdue at age 2.</td>
</tr>
<tr>
<td>2 Rotavirus vaccines</td>
<td>91% (704 of 770)</td>
<td>66 patients were overdue at age 2.</td>
</tr>
<tr>
<td>2 Influenza vaccines</td>
<td>72% (552 of 770)</td>
<td>218 patients were overdue at age 2.</td>
</tr>
</tbody>
</table>

Links to listing of overdue patients
Use Data for Population Management

- At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:
  - At least two different preventive care services.
  - At least two different immunizations.
  - **At least three different chronic or acute care services.**
  - Patients not recently seen by the practice.
  - Medication monitoring or alert.
Chronic/Acute Care Measure: ADHD Patient Followup Rate

- Dashboard example measuring % of ADHD patients seen in past six months
Chronic/Acute Measure: Influenza Vaccination for Asthma Patients

This is one measure of your success with chronic disease management of asthma patients. This calculation is based on the number of active patients you have diagnosed with asthma over the past three years. These patients are considered up-to-date if they had at least one flu vaccine billed during the most recent flu season (between 7/1 and 6/30). Please note that this measure is based on billing data which means that if a patient had the flu vaccine given at another location or health clinic, they will show as overdue even if the date was entered on the patient’s historical vaccine record.

You have 1,290 active asthma patients under 18 years of age.

687 of these patients are overdue for their flu vaccine.

View a list of overdue patients

How You Compare

Your Practice: 47%
PCC Client Average: 45%
Top Performers: 65%
Identify Patients in Need of Chronic/Acute Care

- Other examples (use recaller for these):
  - Asthma patients overdue for checkup
  - Patients with depression overdue for checkup
  - Patients with allergic rhinitis overdue for checkup
Scheduling Chronic-Disease Mgt Visits

• Use appointment types specific to the checkup type
• Example: “Asthma Recheck”, “ADHD Recheck”, “Allergy Recheck”, etc
• Allows for more accurate recaller reporting
  • Restrict by appointment to exclude patients who already had a specific appointment type scheduled
Use Data for Population Management

- At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:
  - At least two different preventive care services.
  - At least two different immunizations.
  - At least three different chronic or acute care services.
  - Patients not recently seen by the practice.
  - Medication monitoring or alert.
Identify Patients Not Recently Seen

• Use recaller restricting by “Date of last visit”
Use Data for Population Management

- At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:
  - At least two different preventive care services.
  - At least two different immunizations.
  - At least three different chronic or acute care services.
  - Patients not recently seen by the practice.
  - **Medication monitoring or alert.**
Identify Patients On Specific Medication(s)

- Use EHR Patient Lists reporting restricted by medication

Add Patient List

Patient List Name: Patients on ADHD Meds

Time Range for Criteria:
- From patient's birth through today
- From start date to end date
- Within the past 3 months
- From 1 years ago through 1 years ago

Specify time frame of criteria

Criteria:

Demographics: Select a criterion and then click Add.

Lab Test Results: Click Add to select Lab Test Results Criteria

Specify all ADHD Medications

Medications:
- Adderall (dextroamphetamine-amphetamine)
- Ritalin (methylphenidate)
- Concerta (methylphenidate)
- Select a medication

PCC
Pediatric EHR Solutions
Control Your Future™
Implement Evidence-Based Decision Support

• 3E: The practice implements clinical decision support+ (e.g., point-of-care reminders) following evidence-based guidelines for:

1. A mental health or substance use disorder.
2. A chronic medical condition.
3. An acute condition.
4. A condition related to unhealthy behaviors.
5. Well child or adult care.
6. Overuse/appropriateness issues.
Implement Evidence-Based Decision Support

- Autocredit for **ADHD** as mental health condition (3E.1) if using built-in protocol following AAP's Clinical Practice Guidelines
- Autocredit for **Well Child Care** for 3E.5 if using Bright Futures (trademark?) protocols
- Possible future autocredit: **Obesity** as condition related to unhealthy behavior (3E.4)

PCC
Pediatric EHR Solutions Control Your Future™
Identify Patients for Care Management

The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

1. Behavioral health conditions.
2. High cost/high utilization.
3. Poorly controlled or complex conditions.
5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver.
6. The practice monitors the percentage of the total patient population identified through its process and criteria. CRITICAL FACTOR)
Identify Patients for Care Management

• How do you define child with special health care needs?

• Add flags for patients needing care management. Create clinical alerts reminding clinicians when working with these patients.
Identify Patients for Care Management

Pediatric populations

Practices may identify children and adolescents with special health care needs, defined by the U.S. Department of Health and Human Services Maternal and Child Health Bureau (MCHB) as children “who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who require health and related services of a type or amount beyond that required generally.”

Identify Patients for Care Management

- 4A.6 – Use recaller to monitor population of kids needing care management

Criteria:
- Build a list of patients based on the following criteria:
  - Include by Date of Last Visit
  - Exclude by Flag - Account Flag
  - Exclude by Flag - Patient Flag
  - Include by Flag - Patient Flag

Selections:
- Include by Date of Last Visit in the past 3 yrs calculated from today
- Exclude by Flag - Match any ONE Account Flag
  - Archived
  - Inactive
- Include by Flag - Match any ONE Patient Flag
  - 2001-Transferred
  - Referred by Another Physician
  - Inactive
- Include by Flag - Match any ONE Patient Flag
  - Care Management

Use “Care Management” flag to identify patients needing care management
Identify Patients for Care Management

- Use clinical alert in EHR to remind about updating Care Plan

Clinical Alert: Patients needing Care Management

Clinical Alert:
This patient has been flagged as needing care management. Be sure to review and update the Care Plan and document the following and provide an updated copy of the Care Plan to the patient/family/caregiver:

- Patient preferences and functional/lifestyle goals
- Treatment goals
- Potential barriers to meeting goals
- A plan for self-management

Control Your Future™
Identify Patients for Care Management

- 4A.2 – use custom srs report to identify patients who utilize service most (in terms of $ chg and visits)

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Charge Amount</th>
<th>Charge Per Visit</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samantha</td>
<td>10/20/14</td>
<td>$2,781.00</td>
<td>$111.24</td>
<td>25</td>
</tr>
<tr>
<td>John</td>
<td>08/29/97</td>
<td>$717.00</td>
<td>$34.14</td>
<td>21</td>
</tr>
<tr>
<td>Taylor</td>
<td>04/01/03</td>
<td>$1,573.00</td>
<td>$87.39</td>
<td>18</td>
</tr>
<tr>
<td>Peter</td>
<td>01/05/15</td>
<td>$2,010.00</td>
<td>$111.67</td>
<td>18</td>
</tr>
<tr>
<td>Michael</td>
<td>08/08/09</td>
<td>$616.00</td>
<td>$41.07</td>
<td>15</td>
</tr>
<tr>
<td>Edward</td>
<td>07/03/00</td>
<td>$576.00</td>
<td>$30.40</td>
<td>15</td>
</tr>
<tr>
<td>Hannah</td>
<td>12/05/01</td>
<td>$780.00</td>
<td>$51.20</td>
<td>15</td>
</tr>
<tr>
<td>Olivia</td>
<td>09/29/12</td>
<td>$870.00</td>
<td>$62.14</td>
<td>14</td>
</tr>
<tr>
<td>Thomas</td>
<td>06/01/13</td>
<td>$996.00</td>
<td>$71.14</td>
<td>14</td>
</tr>
<tr>
<td>Daniel</td>
<td>10/10/14</td>
<td>$1,559.00</td>
<td>$111.36</td>
<td>14</td>
</tr>
<tr>
<td>Robert</td>
<td>07/11/14</td>
<td>$1,531.00</td>
<td>$109.36</td>
<td>14</td>
</tr>
<tr>
<td>Emily</td>
<td>02/04/13</td>
<td>$1,418.00</td>
<td>$101.29</td>
<td>14</td>
</tr>
<tr>
<td>Sarah</td>
<td>05/28/10</td>
<td>$776.00</td>
<td>$55.43</td>
<td>14</td>
</tr>
<tr>
<td>Kevin</td>
<td>02/12/15</td>
<td>$1,651.00</td>
<td>$127.00</td>
<td>13</td>
</tr>
<tr>
<td>Alex</td>
<td>01/25/14</td>
<td>$1,651.00</td>
<td>$127.00</td>
<td>13</td>
</tr>
<tr>
<td>Emma</td>
<td>09/20/13</td>
<td>$1,173.00</td>
<td>$90.23</td>
<td>13</td>
</tr>
<tr>
<td>Carlos</td>
<td>04/28/14</td>
<td>$967.00</td>
<td>$74.38</td>
<td>13</td>
</tr>
<tr>
<td>Anthony</td>
<td>12/21/12</td>
<td>$1,582.00</td>
<td>$121.69</td>
<td>13</td>
</tr>
<tr>
<td>Stephanie</td>
<td>10/17/13</td>
<td>$1,062.00</td>
<td>$88.50</td>
<td>12</td>
</tr>
<tr>
<td>Cameron</td>
<td>02/19/15</td>
<td>$1,438.00</td>
<td>$119.83</td>
<td>12</td>
</tr>
<tr>
<td>Rachel</td>
<td>01/23/14</td>
<td>$1,236.00</td>
<td>$103.00</td>
<td>12</td>
</tr>
</tbody>
</table>
Care Planning and Self-Care Support

• 4B - care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A:
  • Patient preferences and functional/lifestyle goals
  • Treatment goals
Care Planning and Self-Care Support

• develop and update an individual care plan...including following features for at least 75 percent of the patients identified in Element A:
  
  • Assesses and addresses potential barriers to meeting goals.
  
  • Includes a self-management plan.
  
  • Care plan is provided in writing to the patient/family/caregiver.
Care Planning and Self-Care Support

• Document these features in Care Plan in PCC EHR for patients identified in 4A as needing care management
• Use NCQA Record Review Workbook to track and report results
Care Plan in PCC EHR

Visit: 02/18/14
Sick - (client v. I)
Appointment Details
Chief Complaint
HPI
Past/Soc/Fam Hx
Review of Systems
Physical Exam
Lab
Diagnoses
Plan
Immunizations

Pebbles Flintstone
10 yrs, 1 mo 1/07/04 F

Chief Complaint
Asthma Recheck

Care Plan (Chart-wide)
02/13/14
Status: Active

Goals
- Asthma Action Plan

Actions
- Management of compliance with medication regimen
- Asthma management

Next Steps
Pebbles was shown at her last visit how to use her inhaler and she has been carrying it with her during basketball practice and games. She hasn’t had an attack during a game in the last three weeks.

Care Coordination Notes (internal use)
Pebbles has done very well being compliant with her new inhaler and it has decreased the number of attacks she has had in the last few months. We will continue with regular follow up appointments for the next year.

Team Members
Created by Douglas Beagley 02/13/14 10:42am
Mark as Reviewed

Medications
Current Medications

If you add the Care Plan component to chart notes, you can review, update, print, and mark interventions as reviewed during a visit.
Medication Management

• 4C.1 - Review and reconcile medications for more than 50 percent of patients received from care transitions.

• Use special component in EHR to indicate medications are reconciled for patients transitioning to you
Test Tracking and Followup

• Autocredit for 5A.1 – 5A.4 for clients using PCC EHR
  • Lab and imaging orders tracked and abnormalities flagged for followup

• Use MU reports for other 5A factors
Measure Clinical Quality Performance

- Element 6A
- At least annually, the practice measures or receives data on:
  - At least two immunization measures.
  - At least two other preventive care measures.
  - At least three chronic or acute care clinical measures.
  - Performance data stratified for vulnerable populations (to assess disparities in care).
Measure Clinical Quality Performance

• Possible autocredit coming soon for 6A

• Use same measures you chose for 3D - “Use Data for Population Management”

• Use the measures included in the Dashboard (the monthly reporting is done for you)
Measure Clinical Quality Performance

- Element 6A
- At least annually, the practice measures or receives data on:
  - At least two immunization measures.
  - At least two other preventive care measures.
  - At least three chronic or acute care clinical measures.
  - **Performance data stratified for vulnerable populations (to assess disparities in care).**

PCC
Pediatric EHR Solutions
Control Your Future™
Performance Data Stratified for Vulnerable Populations

- For Dashboard ADHD Followup and Well Visit Rates, data is stratified by the following criteria:
  - Ethnicity
  - Preferred Language
  - Primary Care Provider
  - Primary Insurance
  - Race
  - Sex
Performance Data Stratified for Vulnerable Populations

- See “Detailed Breakdown” link in the “Related Tools” section of the measure detail page:

**Recommendations**

PCC’s client data shows that the practices who have the healthiest patients and the healthiest bottom line are those who place a strong emphasis on recall and chronic disease management.

Your teenage population represents a large portion of your overdue patients. You also face an additional challenge in that it is easy for these teenagers to get “sports physicals” elsewhere. They can get them for next to nothing at a retail clinic, and for free at the local high school. Consider the following suggestions to improve your recall process:

- In addition to the listing of overdue patients available here in the Dashboard, PCC's notify tool makes it incredibly easy to automatically call, email, or text patients who are overdue. Partner’s recaller will help you generate letters or postcards.

- Maintaining a clinical relationship with patients as they get older is crucial to the success of your practice so you should make an extra effort when marketing towards your teenage population. We recommend you create a specific letter to send to these overdue teenagers emphasizing the important work you do (and that you and the AAP recommend be done).

- When a patient checks out after a well visit, schedule the next well visit before they leave the office, even if it is six months or a year later. More and more practices are learning how expensive it is to fill their schedules.

---

**Related Tools**

- View overdue patient listing
- Detailed Breakdown – Well Visit Rates
- View immunization rates and overdue patients

---

PCC
Pediatric EHR Solutions

Control Your Future™
Performance Data Stratified for Vulnerable Populations

Example: show well visit rates for Medicaid patients (vulnerable population) vs. all other insurance.
Utilization Measures Affecting Costs

• At least annually, the practice measures or receives quantitative data on:
  • At least two measures related to care coordination.
  • At least two utilization measures affecting health care costs.

• Element 6.B.2
Utilization Measures Affecting Costs

• Example Reports:
  • After-hours visits seen for complex patients (who would have otherwise likely gone to the ER)
  • PCC eRx – Generic vs Brand Rx
  • PCC eRx - Utilization of non-formulary medications
Utilization Measures Affecting Costs

• After-hours visit report
  • Contact PCC support for assistance with creating custom srs report
  • Restrict by procedure (to identify after-hours visits)
  • Restrict by diagnosis (to identify complex visits)
Utilization Measures Affecting Costs

- Generic vs Brand Rx reporting. Run “Drug Volume” report
Utilization Measures Affecting Costs

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>772</td>
</tr>
<tr>
<td>Generic drugs begin with</td>
<td></td>
</tr>
<tr>
<td>amoxicillin</td>
<td>89</td>
</tr>
<tr>
<td>Concerta</td>
<td>83</td>
</tr>
<tr>
<td>Adderall XR</td>
<td>36</td>
</tr>
<tr>
<td>Vyvanse</td>
<td>35</td>
</tr>
<tr>
<td>fluoxetine</td>
<td>22</td>
</tr>
<tr>
<td>azithromycin</td>
<td>1.7</td>
</tr>
<tr>
<td>Xopenex HFA</td>
<td>1.6</td>
</tr>
<tr>
<td>Flovent HFA</td>
<td>1.4</td>
</tr>
<tr>
<td>inhalational spacing device</td>
<td>1.4</td>
</tr>
<tr>
<td>albuterol sulfate</td>
<td>1.3</td>
</tr>
<tr>
<td>mupirocin</td>
<td>1.3</td>
</tr>
<tr>
<td>triamcinolone acetonide</td>
<td>1.2</td>
</tr>
<tr>
<td>cephalexin</td>
<td>1.1</td>
</tr>
<tr>
<td>Orapred</td>
<td>1.0</td>
</tr>
<tr>
<td>ranitidine hcl</td>
<td>1.0</td>
</tr>
<tr>
<td>sertraline</td>
<td>1.0</td>
</tr>
<tr>
<td>Ortho Tri-Cyclen</td>
<td>8</td>
</tr>
<tr>
<td>Ventolin HFA</td>
<td>8</td>
</tr>
<tr>
<td>melatonin</td>
<td>8</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>8</td>
</tr>
</tbody>
</table>

- Generic vs Brand Rx reporting

PCC Pediatric EHR Solutions
Control Your Future™
Utilization Measures Affecting Costs

- Non-formulary medications report. Run “Non-Formulary drugs by Provider and Specialty”
Utilization Measures Affecting Costs

- Report includes breakdown of non-formulary medications given by provider

### Non-Formulary Report for All Providers from 11/20/2013 to 12/20/2013

#### By Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Drug</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td><strong>Total</strong></td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Aerochamber MV</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Flura-Drops</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Vivotif Berna Vaccine</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Vyvanse</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Triple Paste</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mucinex</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Ventolin HFA</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Orapred ODT</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Cambia</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Portia</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Flovent HFA</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>BreatheRite Rigid Spacer &amp; Mask</td>
<td>1</td>
</tr>
</tbody>
</table>

#### By Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Drug</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Aerochamber MV</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Vivotif Berna Vaccine</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Triple Paste</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Mucinex</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Orapred ODT</td>
<td>1</td>
</tr>
</tbody>
</table>
Report Performance by Individual Clinician

The practice produces performance data reports using measures from Elements A, B and C and shares:

- Individual clinician performance results with the practice.
- Practice-level performance results with the practice.
- Individual clinician or practice-level performance results publicly.
- Individual clinician or practice-level performance results with patients.
Report Performance by Individual Clinician

- Element 6.F.1
- For some measures, Dashboard includes the ability to measure and graph performance for the whole practice or each individual clinician

**Recommendations**

PCC’s client data shows that the practices who have the healthiest patients and the healthiest bottom line are those who place a strong emphasis on recall and chronic disease management.

Your teenage population represents a large portion of your overdue patients. You also face an additional challenge in that it is easy for these teenagers to get “sports physicals” elsewhere. They can get them for next to nothing at a retail clinic, and for free at the local high school. Consider the following suggestions to improve your recall process:

- In addition to the listing of overdue patients available here in the Dashboard, PCC’s notify tool makes it incredibly easy to automatically call, email, or text patients who are overdue. Partner’s recall tool will help you generate letters or postcards.

- Maintaining a clinical relationship with patients as they get older is crucial to the success of your practice so you should make an extra effort when marketing towards your teenage population. We recommend you create a specific letter to send to these overdue teenagers emphasizing the important work you do (and that you and the AAP recommend be done).

- When a patient checks out after a well visit, schedule the next well visit before they leave the office, even if it is six months or a year later. More and more practices are learning how expensive it is to fill their schedules.
Report Performance by Individual Clinician

- Includes interactive graphing tool to display results for individual clinicians

Sample PCC Practice

Measure: Flu Shot Vaccination For Asthma Patients

Detailed Breakdown: Primary Care Provider

<table>
<thead>
<tr>
<th>Primary Care Provider</th>
<th>Active Patients</th>
<th>Overdue Patients</th>
<th>Up-to-Date Patients</th>
<th>% Patients Up-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Providers</td>
<td>1,288</td>
<td>607</td>
<td>681</td>
<td>53%</td>
</tr>
<tr>
<td>Provider 0</td>
<td>660</td>
<td>315</td>
<td>345</td>
<td>52%</td>
</tr>
<tr>
<td>Provider 1</td>
<td>94</td>
<td>49</td>
<td>45</td>
<td>48%</td>
</tr>
<tr>
<td>Provider 2</td>
<td>175</td>
<td>78</td>
<td>97</td>
<td>55%</td>
</tr>
<tr>
<td>Provider 3</td>
<td>13</td>
<td>5</td>
<td>8</td>
<td>62%</td>
</tr>
<tr>
<td>Provider 4</td>
<td>13</td>
<td>5</td>
<td>8</td>
<td>62%</td>
</tr>
<tr>
<td>Provider 5</td>
<td>90</td>
<td>42</td>
<td>48</td>
<td>53%</td>
</tr>
<tr>
<td>Provider 6</td>
<td>36</td>
<td>19</td>
<td>17</td>
<td>47%</td>
</tr>
<tr>
<td>Provider 7</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td>Provider 8</td>
<td>202</td>
<td>92</td>
<td>110</td>
<td>54%</td>
</tr>
</tbody>
</table>

Review overdue patient listing for your practice.
Review of PCC's PCMH Resources
PCC PCMH Resources

- http://pcmh.pcc.com
  - Documentation and examples of relevant PCC reports and functionality related to both 2011 and 2014 standards
  - Also includes other NCQA resources
- PCC Pre-validation
  - 6.5 auto-credits (possibly more coming soon) for certain elements just for using PCC's software
PCC PCMH Resources

- PCC/PCS PCMH Program Project Management and PCMH Consulting Packages (see handout)

- Contact PCC Support

Thank you!

Tim Proctor

tim@pcc.com

PCC
Pediatric EHR Solutions

Control Your Future™