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

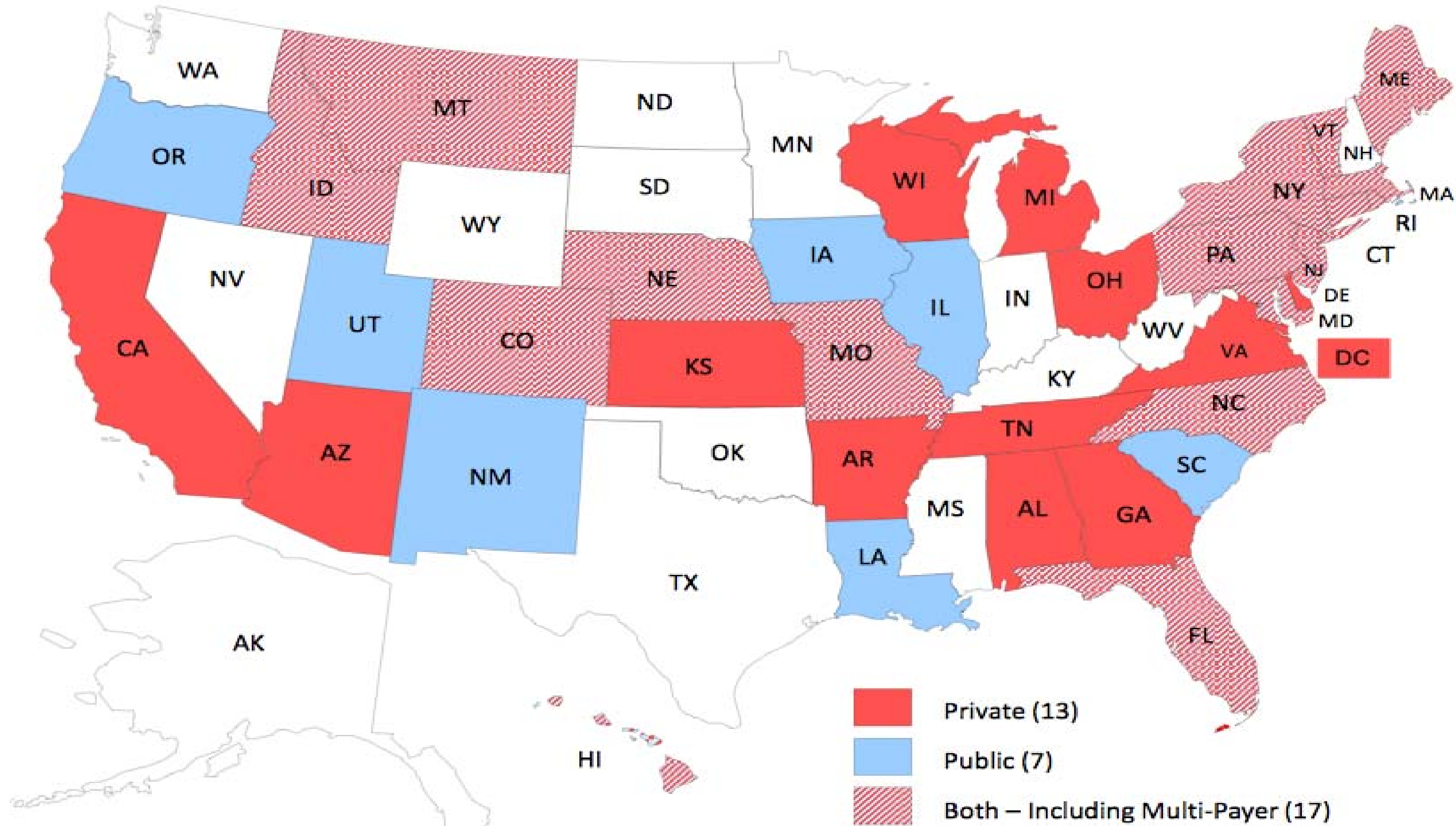
Why NCQA PCMH?

- 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



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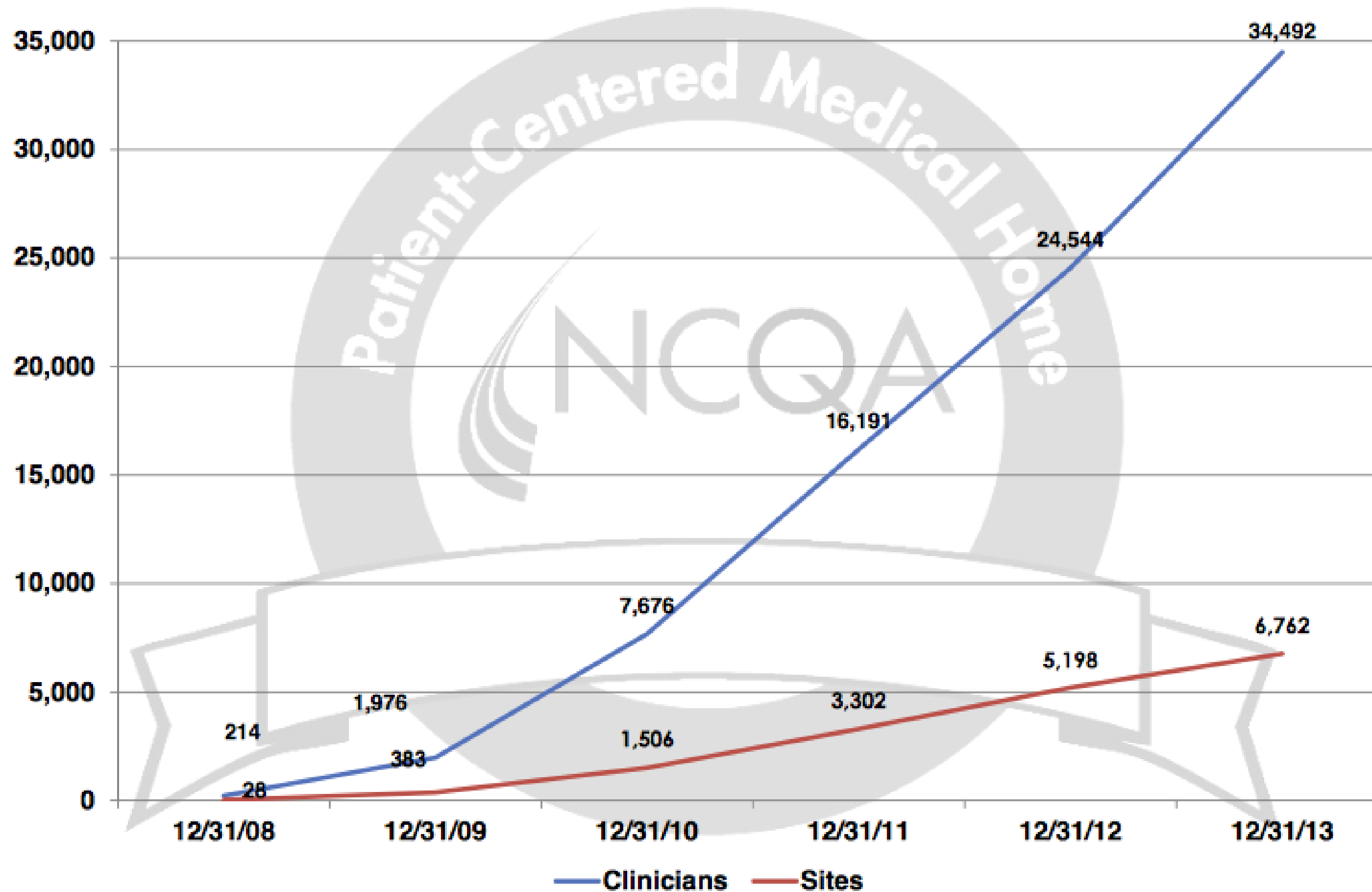
NCQA PCMH Growth 2008-2013



- 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

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

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

Day view of schedule. Times with "Same Day Blocks" are reserved for sick appointments to be scheduled when that day arrives.

Dr. Davidson
Fri Mar 22, 2013

Time	Block	Code	Length
8:30a			15
8:45a			15
9:00a	Same Day Block	B15	
9:15a	Same Day Block	B15	
9:30a			15
9:45a			15
10:00a	Same Day Block	B15	
10:15a	Same Day Block	B15	
10:30a			15
10:45a			15
11:00a	Same Day Block	B15	
11:15a	Same Day Block	B15	
11:30a			15
11:45a			15
12:00p			OUT
12:15p			OUT
12:30p			OUT
12:45p			OUT
1:00p	Same Day Block	B15	
1:15p	Same Day Block	B15	
1:30p			15
1:45p			15
2:00p	Same Day Block	B15	
2:15p	Same Day Block	B15	
2:30p			15

- Show proof of reserving time in schedule for same-day sick

Providing Same-Day Appointments

Appointment Summarizer

Show Me Appointments From 03/21/13 to 03/28/13

Report On All: Block Appointments

Show Details? No

Restrict By Date Entered? No

Include Appts For:
All providers? Yes
All places of service? Yes
All Visit Reasons? No
All Users? Yes
All Pat Flags? Yes

Sort Appointments: Totals?
First by: Date of Appointment
then by: Length of the Appointment (in X
then by:
then by:

Select "Block Appointments" when reporting total Sick Blocks and "All Appointments" when reporting total sick appointments

For reporting total sick blocks, select relevant "Sick Blocks" when prompted. For reporting total sick appointments, select relevant "Sick" visit reasons when prompted.

- "Appointment Summarizer" (appts) report identifying Block Appointments

Providing Same-Day Appointments

appts: Block Appointments (03/04/13-03/08/13)

App Date	Mins	#
03/04/13	600.00	60
03/05/13	600.00	60
03/06/13	500.00	50
03/07/13	500.00	50
03/08/13	480.00	48
	2680.00	268

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

Providers:
All

Locations:
All

Visit Reasons:
Visit Reasons:
Sick Call Block

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

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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

Sample PCC Practice
,

Logout
Change My Password

Measure: Missed Appointment Rate

Choose a measure

Dashboard reports updated as of 6/7/2015

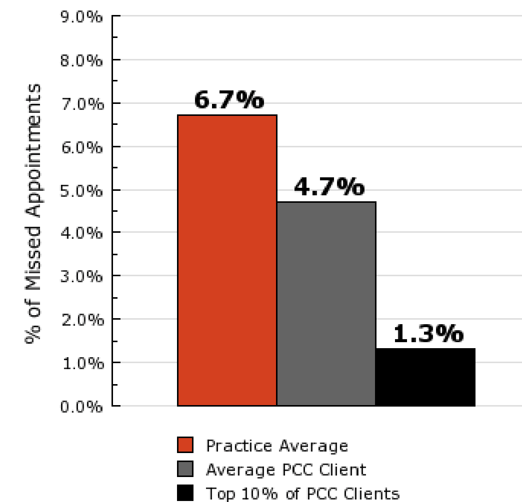
Provider Breakdown

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

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

How You Compare

Compare: All Providers



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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

Tasks

TASK: Call Back Needed | TO: Joan Abbott

NOTE: Sample notes about callback.

☒ Task Completed AT 03/07/13 5:08 PM BY Joan Abbott

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

Phone Encounter Performance

View Phone Encounter Performance

PCC Pediatric Test Associates

Generated on 5/09/13 10:57am

Times between 12:00am and 11:59pm
Dates from 4/21/13 to 4/26/13
and Task "Call Back Needed"

Phone Encounters: 6

Call Taken	Task Completed	Response Time	Patient
4/25/13 9:00am	4/25/13 2:17pm	5h 16m	Okamoto, Alexia PCC# 1233
4/25/13 9:15am	4/25/13 9:21am	6m	Arndt, Brian PCC# 1284
4/25/13 9:27am	4/25/13 11:29am	2h 1m	Buchinsky, Catherine PCC# 948
4/25/13 10:44am			Padrone, Shaquana PCC# 132
4/25/13 11:11am	4/25/13 1:33pm	2h 21m	Farkas, Quinn J. PCC# 1803
4/25/13 12:22pm			Lahan, Jordan PCC# 2091

Optional Columns to Display: None - display standard report columns only

Save as File | Back | Close

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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

sales-demo-6.18.1 [Running]

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File Edit Reports Tools Help

PCC EHR

FIND

Portal Message

Pebbles Flintstone 10 yrs, 3 mos 9/24/03

Pebbles Flintst... PCC# 3336

Medical Summary

Demographics

History

Message: 11/12/13

Portal Message

Portal Messages

Tasks

Portal Messages

Subject: Acetaminophen or tylenol? TO James Davidson, M.D.

Date: 11/12/13 2:57pm
From: Chris Forleo

Date and time of original message

Fred gave Pebbles Acetaminophen instead of Tylenol? Is that OK?

Date: 11/12/13 4:20pm
From: PCC PCC

Date and time of first response

Hi Chris, Tylenol's active ingredient is acetaminophen so you are fine.

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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

Monitoring % of Visits With Selected Clinician

Count - Pat		Provider							
Patient assigned PCP?	Appt w/ PCP?	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	Provider 6	Provider 7	**Total Result**
No	No	16	28	17	23	24	28	16	**152**
Yes	No	231	593	287	188	498	343	147	**2287**
	Yes	454	143	618	603	115	352	774	**3059**
Total Result		**701**	**764**	**922**	**814**	**637**	**723**	**937**	**5498**
	% of Appts where PCP is assigned	98%	96%	98%	97%	96%	96%	98%	97%
	% of Appts where PCP=Appointment Provider	65%	19%	67%	74%	18%	49%	83%	56%

- Report based on srs appointment report
- Contact PCC support for assistance with generating this spreadsheet

Cultural and Linguistically Appropriate Services

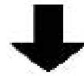
- The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by **assessing the diversity** (2C.1) and **language needs** (2C.2) of its population
- Use recaller or contact PCC for assistance with getting a spreadsheet summary
- Autocredit for 2C.4 (provide printed materials in language of its population) if using PCC EHR

Cultural and Linguistically Appropriate Services

Use recaller:

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

Cultural and Linguistically Appropriate Services

Race		% of Total
(empty)	477	24%
American Indian or Alaska Native	11	1%
American Indian or Alaska Native, Asian	1	0%
Asian	62	3%
Asian, Black or African American	3	0%
Asian, White	1	0%
Black or African American	1227	62%
Black or African American, Native Hawaiian or Oth	1	0%
Black or African American, Prefers not to answer	1	0%
Black or African American, Some other race	6	0%
Black or African American, White	14	1%
Native Hawaiian or Other Pacific Islander	1	0%
Prefers not to answer	31	2%
Some other race	38	2%
White	93	5%
White, Some other race	1	0%
Total Result	**1968**	

Ethnicity		% of Total
(empty)	496	25%
Hispanic or Latino	69	4%
Not Hispanic or Latino	1296	66%
Prefers not to answer	107	5%
Total Result	**1968**	

Primary Preferr		% of Total
(empty)	506	26%
Amharic	69	4%
Arabic	3	0%
Bambara	1	0%
Bengali	9	0%
Burmese	18	1%
Chinese	1	0%
English	1274	65%
Ewe	1	0%
French	13	1%
Gujarati	5	0%
Haitian	1	0%
Igbo	3	0%
Karen	9	0%
Nepali	5	0%
Oromo	6	0%
Somali	30	2%
Spanish	8	0%
Tigrinya	2	0%
Vietnamese	4	0%
Total Result	**1968**	

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:

Date of birth	Dates of previous clinical visits
Sex	Legal guardian/health care proxy
Race	Primary caregiver * **(consider skipping)**
Ethnicity	Prescense of Advance Directives (NA for Peds)
Preferred Language	Health insurance Info
Telephone Numbers	Name and contact info of health care professionals involved in patient's care * **(consider skipping)**
Email Address	
Occupation (NA for Peds)	

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:

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

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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)
- Examples: http://pcmh.pcc.com/index.php/2014_-_PCMH3D

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.

PHYSICIAN'S COMPUTER COMPANY

Practice Vitals Dashboard

HOME | FINANCIAL PULSE | CLINICAL PULSE | EDI DASHBOARD | PRODUCTIVITY

Sample PCC Practice

,

Logout
Change My Password
View Dashboard Update Log

Measure: Well Visit Rates - Patients 12-21 Years

Choose a measure

Dashboard reports updated as of 3/31/2014

Your Score: **65** out of 100

This measure shows the percentage of all active patients who are currently between the ages of 12 years and 21 years who have received at least one well visit in the past year. Active patients are those that have been seen at least once (for any visit) in the past three years, and do not have a flag indicating they are inactive.

You have **4,636** active patients between the ages of 12 years and 21 years.

1,568 of these patients are overdue for their well visit. ← **Click for a list of overdue patients**

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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 - Report Details
  Criteria:
    Build a list of patients based on the following criteria:
    Exclude by Flag - Account Flag
and Exclude by Flag - Patient Flag
and Include by Age
and Exclude by Procedure (All Providers)


Selections:

   Exclude by Flag -  Match any ONE Account Flag
    Deceased                               Dismissed
    INACTIVE                               Transient

   Exclude by Flag -  Match any ONE Patient Flag
    INACTIVE                               Out of Practice
    TWINS

   Include by Age
    between 2 yrs and 3 yrs
    calculated from today

   Exclude by Procedure (All Providers)
    in the past 2 yrs
    calculated from today
    procedures:
      96110    Developmental Screening    96110-EP Developmental Screening-
      96110-HA Developmental Screening-
```

Exclude patients with flags indicating they aren't active

Include patients who turned 2 yrs old in the past year

Select relevant developmental screen codes. Patients who already received a screening will be excluded from report

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

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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

Measure: Immunization Rates - HPV

Choose a measure

Dashboard reports updated as of 6/7/2015

Your Score: **36** out of 100

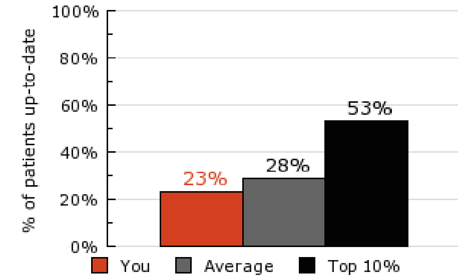
The CDC's Advisory Committee on Immunization Practices (ACIP) recommends a series of three HPV vaccines for both males and females beginning at age 11 or 12. This measure tracks your HPV vaccination rates for all patients 13-17 years of age, showing the percentage of these patients who have received 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

View Age and Sex Breakdown



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

(% of active patients 13-17 years old having three HPV vaccines)

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Immunization Measure: Seasonal Influenza Vaccine Rates

```
                         Recaller - Report Details
  Criteria:
    Build a list of patients based on the following criteria:
    Exclude by Flag - Account Flag
and Exclude by Flag - Patient Flag
and Include by Date of Last Visit
and Include by Age
and Exclude by Procedure (All Providers)


Selections:

   Exclude by Flag -  Match any ONE Account Flag
    Archived                            Collection
    Inactive                            Physician Coverage

   Exclude by Flag -  Match any ONE Patient Flag
    2001-Transferred                    Inactive
    Referred by Another Physician       Unborn

   Include by Date of Last Visit
    in the past 3 yrs
    calculated from today

   Include by Age
    between 6 mos and 18 yrs
    calculated from today

   Exclude by Procedure (All Providers)
    between dates 07/01/14 and 12/31/14
    procedures:
    90658    Influenza Vac 36m + older   90657    Influenza Vac 6-35 months
    90724    ~Influenza Vaccine
```

Exclude patients with flags indicating they aren't active

Include only active patients

Include all patients eligible for flu vaccine

Exclude patients if they already had one of your flu vaccines so far this season

- For listing of overdue patients, use recaller report

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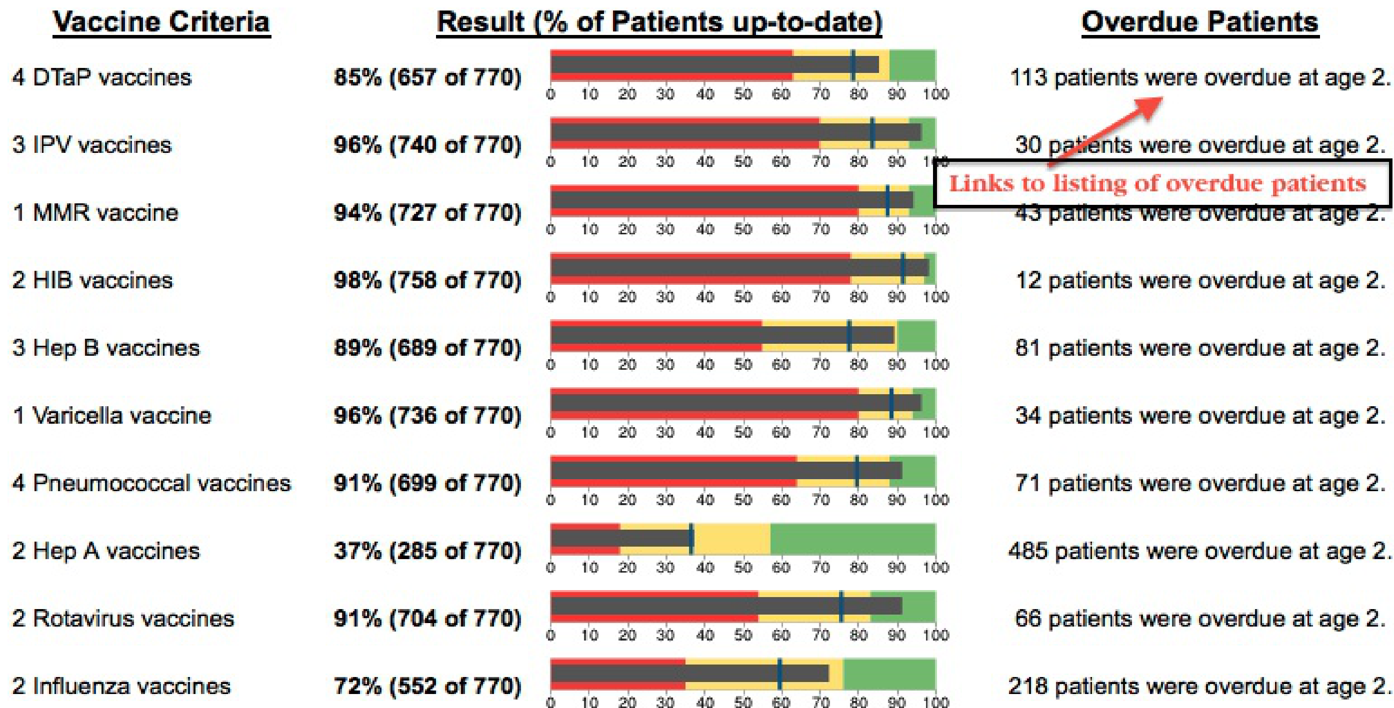
Identify Patients in Need of Immunizations



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

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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

Sample PCC Practice

Logout
Change My Password
View Dashboard Update Log

ADD/ADHD Patient Followup

Choose a different measure

Your Score: **86** out of 100

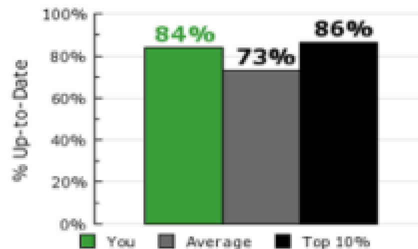
Dashboard reports updated as of 11/30/2013

This clinical benchmark is a measure of your success with chronic disease management of ADD/ADHD patients. Various clinical resources, from the AAP to various state laws, indicate that actively managed ADD and ADHD patients must be seen by your practice at least once every six months, at least. This section includes a count of your active ADD and ADHD population, an indication of how many of your active patients have this diagnosis, and how many of these patients are up-to-date on their routine followup visit. You can also view a listing of ADD and ADHD patients who are overdue for a followup visit.

Your office has **393** active ADD/ADHD patients. (**4%** of total active patients)

64 of these patients are overdue for a followup visit.

How You Compare



Your Practice	PCC Client Average	Top Performers
84%	73%	86%

(% of ADD/ADHD patients up-to-date on their followup visit)

- Dashboard example measuring % of ADHD patients seen in past six months

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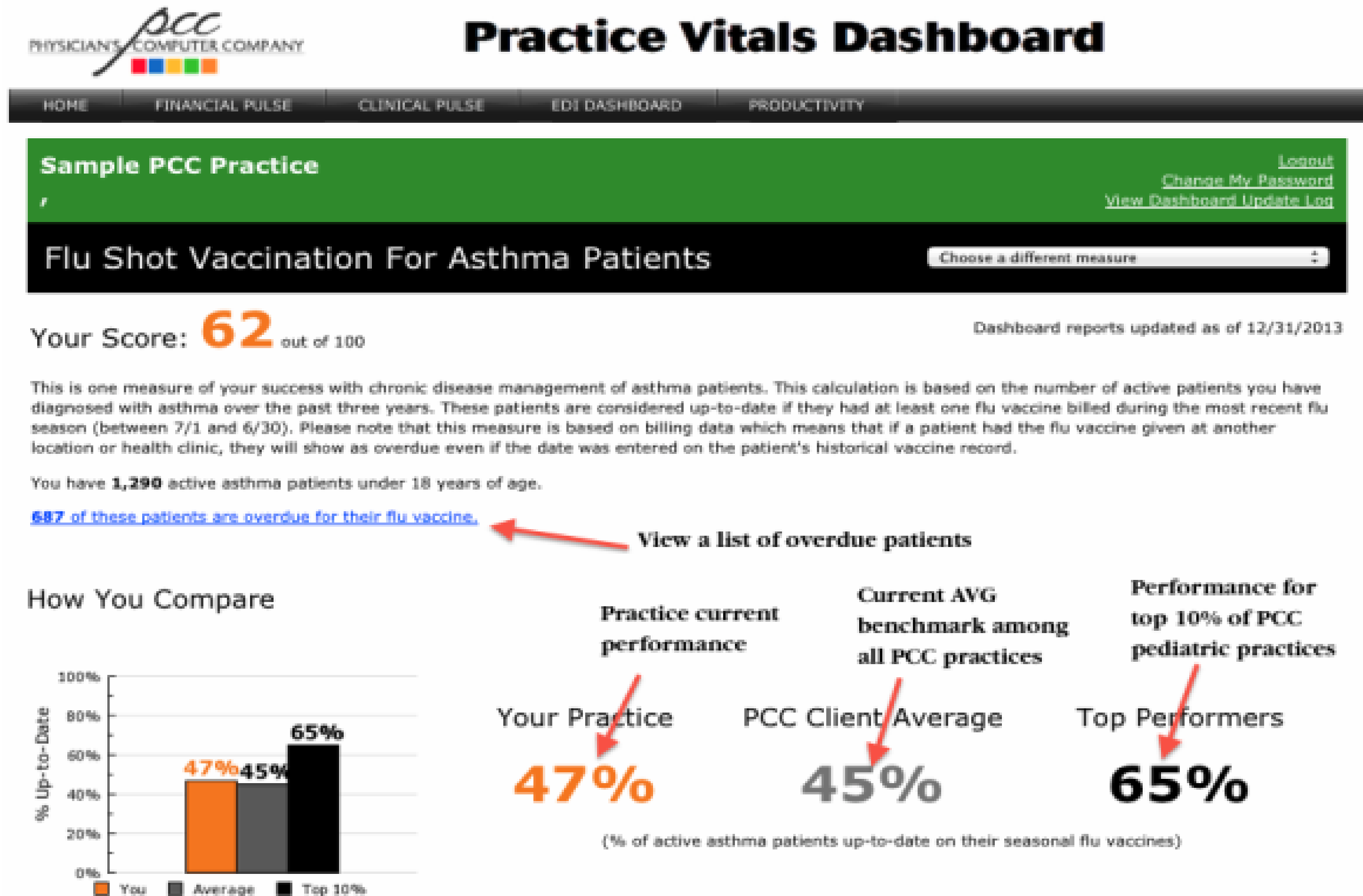
Chronic/Acute Measure: Influenza Vaccination for Asthma Patients



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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

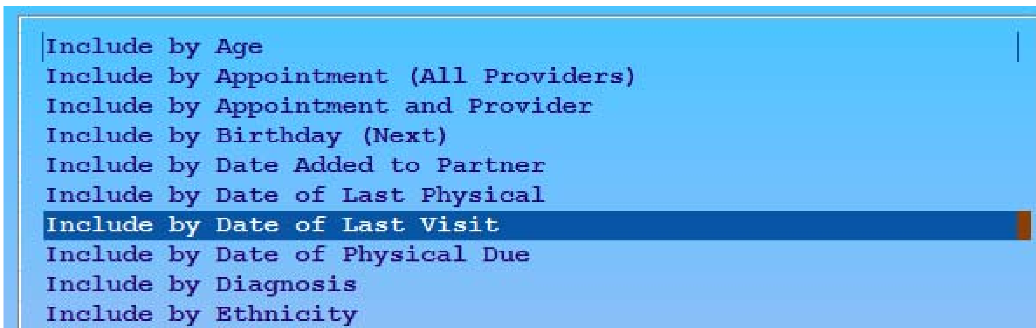
- Use appointment types specific to the checkup type
- Example: “Asthma Recheck”, “ADHD Recheck”, “Allergy Recheck”, etc
- Allows for more accurate recaller reporting
    - Restrict by appointment to exclude patients who already had a specific appointment type scheduled

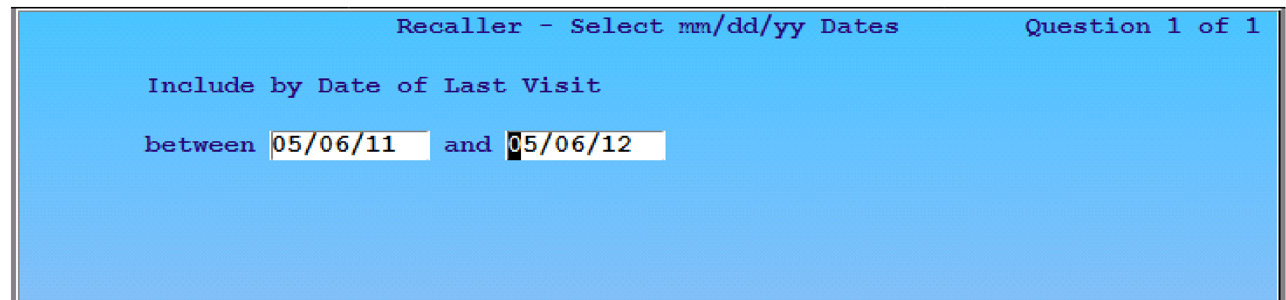
Use Data for Population Management

- 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)

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.

Add | select a demographics criterion

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

Specify all ADHD Medications

Edit | **Medications:**

The Patient was prescribed: Adderall (dextroamphetamine-amphetamine)

OR The Patient was prescribed: Ritalin (methylphenidate)

OR The Patient was prescribed: Concerta (methylphenidate)

OR The Patient was prescribed: select a medication

Cancel | Save

- Use EHR Patient Lists reporting restricted by medication

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)

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.
4. Social determinants of health.
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."

(Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, American Academy of Pediatrics, 3rd Edition, 2008, p. 18.)

Identify Patients for Care Management

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

Recaller - Report Details

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

Exclude by Flag - Match any ONE Patient Flag
2001-Transferred
Inactive
Referred by Another Physician
Unborn

Include by Flag - Match any ONE Patient Flag
Care Management

Use "Care Management" flag to identify patients needing care management

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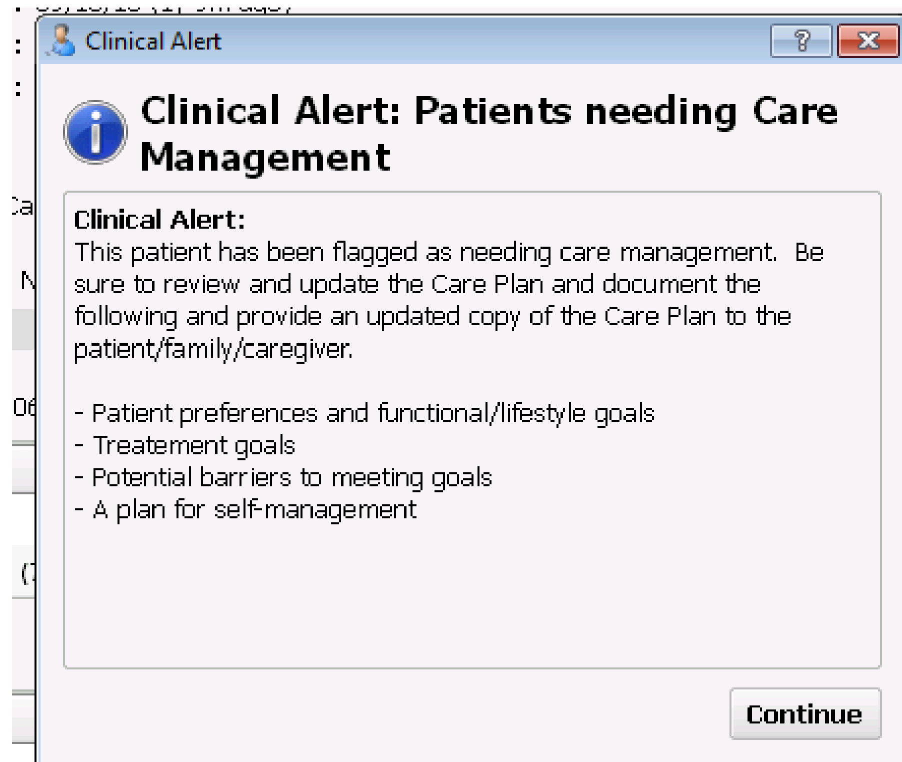
Identify Patients for Care Management

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



Identify Patients for Care Management

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

Pat First Name	Pat Last Name	Pat Date of Birth	Charge Amount	Avg Charge Per Visit	Number of Visits
		10/20/14	$2,781.00	$111.24	25
		08/29/97	$717.00	$34.14	21
		04/01/08	$1,573.00	$87.39	18
		01/05/15	$2,010.00	$111.67	18
		08/08/09	$616.00	$41.07	15
		07/03/00	$576.00	$38.40	15
		12/05/01	$768.00	$51.20	15
		09/29/12	$870.00	$62.14	14
		06/01/13	$996.00	$71.14	14
		10/10/14	$1,559.00	$111.36	14
		07/11/14	$1,531.00	$109.36	14
		02/04/13	$1,418.00	$101.29	14
		05/28/10	$776.00	$55.43	14
		02/12/15	$1,853.30	$132.38	14
		01/25/14	$1,651.00	$127.00	13
		09/20/13	$1,173.00	$90.23	13
		04/28/14	$967.00	$74.38	13
		12/21/12	$1,582.00	$121.69	13
		10/17/13	$1,062.00	$88.50	12
		02/19/15	$1,438.00	$119.83	12
		01/23/14	$1,236.00	$103.00	12

Done | Jump to Top | Jump to Bottom | Send To... | Search Pattern

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

PCC EHR

FIND

Pebbles Flintstone* **PCC# 3336**

Medical Summary

Demographics

History

Prescriptions

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

Sick - (client v. I) **Pebbles Flintstone 10 yrs, 1 mo 1/07/04 F**

Chief Complaint

Asthma Recheck

Care Plan (Chart-wide) Print Display: All Statuses Edit

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

Last reviewed Care Plan appears in the Visit History

Medications

Current Medications

Previous Next Bill Sign Close Save Save + Exit

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

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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

Transition of Care (ARRA)

☒ Patient transitioned to my care from another clinical setting

☒ Medication Reconciliation performed

Test Tracking and Followup

- Autocredit for 5A.1 – 5A.4 for clients using PCC EHR
  - Lab and imaging orders tracked and abnormals 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).**

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

Performance Data Stratified for Vulnerable Populations

Sample PCC Practice
,

Logout
Change My Password
View Dashboard Update Log

Measure: Well Visit Rates - Patients 12-21 Years

Choose a measure

Dashboard reports updated as of 2/28/2014

Detailed Breakdown: Primary Insurance

Show Breakdown By: Primary Insurance

Primary Insurance	Active Patients	Overdue Patients	Up-to-Date Patients	% Patients Up-to-Date
All Insurance	4,609	1,464	3,145	68%
Medicaid	101	44	57	56%
Aetna	251	93	158	63%
Blue Cross/Blue Shield	727	249	478	66%
Cigna	152	47	105	69%
GHI-CBP	417	147	270	65%
Vytra (Choice Care)	11	4	7	64%
Oxford	319	95	224	70%
United Healthcare	295	75	220	75%
1199 National	128	58	70	55%
Other	3	1	2	67%
Information Needed	3	1	2	67%

- 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

Additional Options

Change Password: Change your signature password

Configure Formularies: add PCC eRx insurance formularies for this practice.

Favorite Prescription: Add or modify commonly used prescriptions

Manage My Agents: List, authorize, or revoke privileges of my Provider Agents

Pharmacy Data: add or modify the practice pharmacy list.

Preferences -- user: set PCC eRx options for yourself.

Activity Report: print a record of all recent prescription activity for your practice.

Drug Report: see what patients are taking a given drug.

Decision Report: examine safety and formulary choices for you

Periodic Report: note recent prescription activity for this provide

Pharmacy Report: display entire practice pharmacy list for print

Decision Report

Print Back

Report: Drug Volume

Provider: All Providers

Date: All

Today Last 3 days Last 7 days Last 14 days Last 30 days

Range Nov 19 2013 to Dec 19 2013

Create Report

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Utilization Measures Affecting Costs

Drug Volume Report for All Providers from 11/19/2013 to 12/19/2013	
Group	Volume
All	772
Drugs	
amoxicillin	89
Concerta	83
Adderall XR	36
Vyvanse	35
fluoxetine	22
azithromycin	17
Xopenex HFA	16
Flovent HFA	14
inhalational spacing device	14
albuterol sulfate	13
mupirocin	13
triamcinolone acetonide	12
cephalexin	11
Orapred	10
ranitidine hcl	10
sertraline	10
Ortho Tri-Cyclen	8
Ventolin HFA	8
melatonin	8
methylphenidate	8

Generic drugs begin with a lower-case letter

Utilization

Brand name drugs are capitalized.

- Generic vs Brand Rx reporting

Utilization Measures Affecting Costs

- Non-formulary medications report. Run "Non-Formulary drugs by Provider and Specialty"

Additional Options

Change Password: Change your signature password

Configure Formularies: add PCC eRx insurance formularies for this practice.

Favorite Prescription: Add or modify commonly used prescriptions

Manage My Agents: List, authorize, or revoke privileges of my Provider Agents

Pharmacy Data: add or modify the practice pharmacy list.

Preferences -- user: set PCC eRx options for yourself.

Activity Report: print a record of all recent prescription activity for your practice.

Drug Report: see what patients are taking a given drug.

Decision Report: examine safety and formulary choices for your p

Periodic Report: note recent prescription activity for this provider.

Pharmacy Report: display entire practice pharmacy list for printing

Decision Report

Print Back

Report: Non-formulary drugs by Provider and Specialty

Provider: All Providers

Date: All

Today Last 3 days Last 7 days Last 14 days Last 30 days

Range Nov 20 2013 to Dec 20 2013

Create Report

Utilization Measures Affecting Costs

Non-Formulary Report for All Providers from 11/20/2013 to 12/20/2013		
By Specialty		
Specialty	**Drug**	**Number**
Pediatrics	Total	18
	Aerochamber MV	4
	Flura-Drops	2
	Vivotif Berna Vaccine	2
	Vyvanse	2
	Triple Paste	1
	Mucinex	1
	Ventolin HFA	1
	Orapred ODT	1
	Cambia	1
	Portia	1
	Flovent HFA	1
	BreatheRite Rigid Spacer& Mask	1
By Provider		
Provider	Drug	Number
[redacted]	Total	7
	Aerochamber MV	4
	Vivotif Berna Vaccine	2
	Triple Paste	1
[redacted]	Total	3
	Mucinex	1
	Orapred ODT	1

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

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:

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- 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

Report Performance by Individual Clinician

Sample PCC Practice

,

Logout
Change My Password
View Dashboard Update Log

Measure: Flu Shot Vaccination For Asthma Patients

Choose a measure

Dashboard reports updated as of 3/31/2014

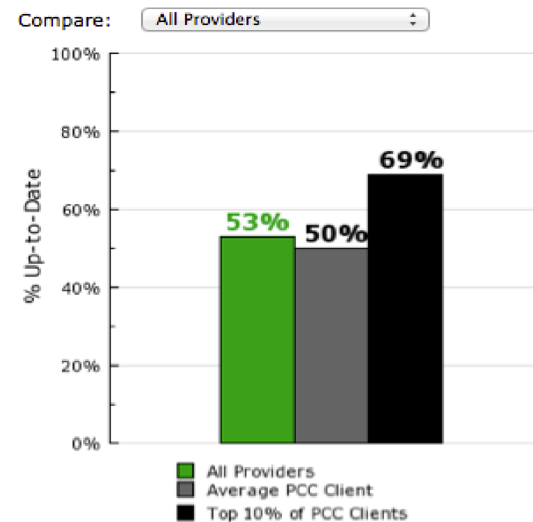
Detailed Breakdown: Primary Care Provider

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

Review overdue patient listing for your practice.

How You Compare

Compare: All Providers



- Includes interactive graphing tool to display results for individual clinicians

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Review of PCC's PCMH Resources

PCC Pediatric EHR Solutions

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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)
  - http://www.theverdengroup.com/our-services/patient-centered-solutions-services/
- Contact PCC Support

Thank you!

Tim Proctor

tim@pcc.com

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