Improving Your Practice Health with PCC Dashboard

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Users Conference 2017

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Agenda

- Some PCC Dashboard highlights
- Ten Ways To Use the Dashboard To Improve Practice Health
- Explore your own PCC Dashboard

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Goals

- Recognize specific PCC Dashboard reports that are important to the health of my practice
- Realize the attainable value from using the PCC Dashboard to discover opportunity for growth and improvement of my practice
- See how you measure up to other PCC practices

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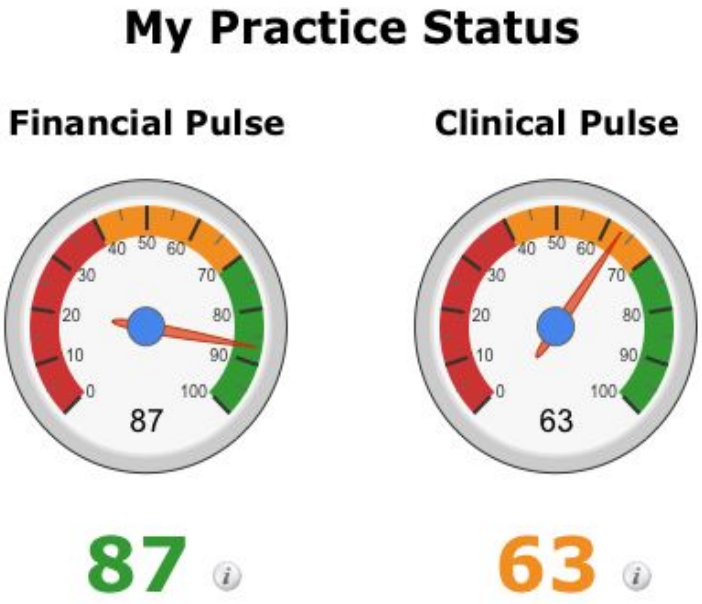
PCC Dashboard

"a tool to inform all PCC clients of their financial and clinical health, based on relative performance in a variety of areas."



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PCC Dashboard Basics

- One login for each practice
- Data collected on the first Sunday of every month. Loaded into production a few days after that
- Pediatric-specific benchmarks

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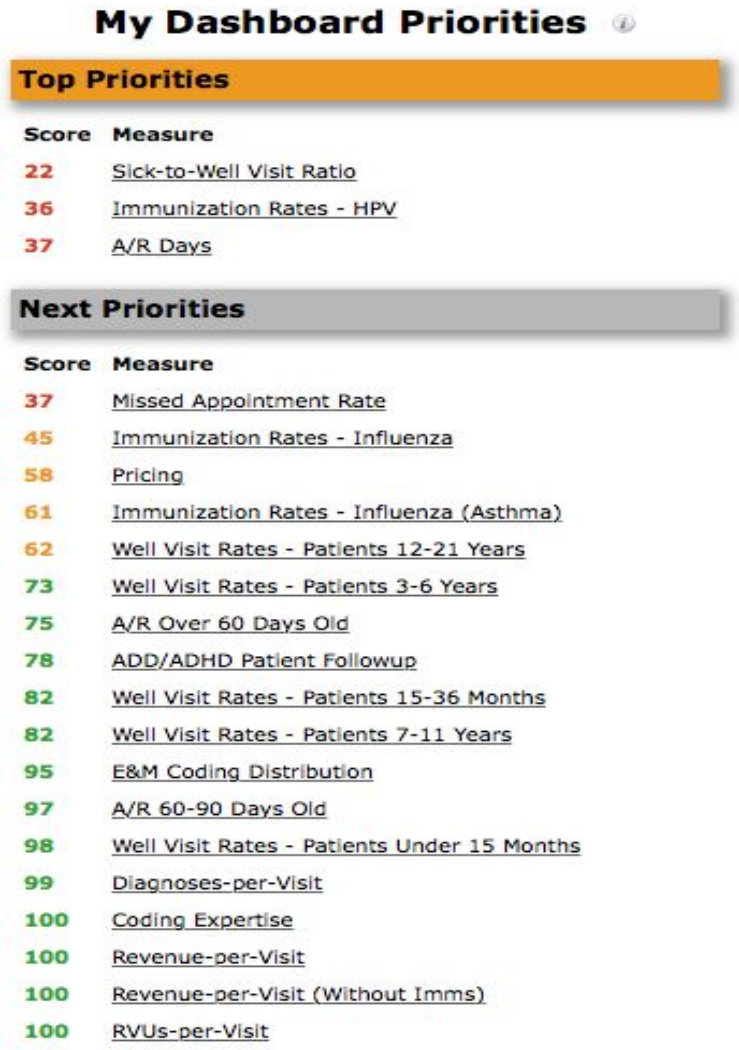
PCC Dashboard Scoring

- Over 20 measures are calculated and scored based on your relative performance
- Prioritized list of results on home page



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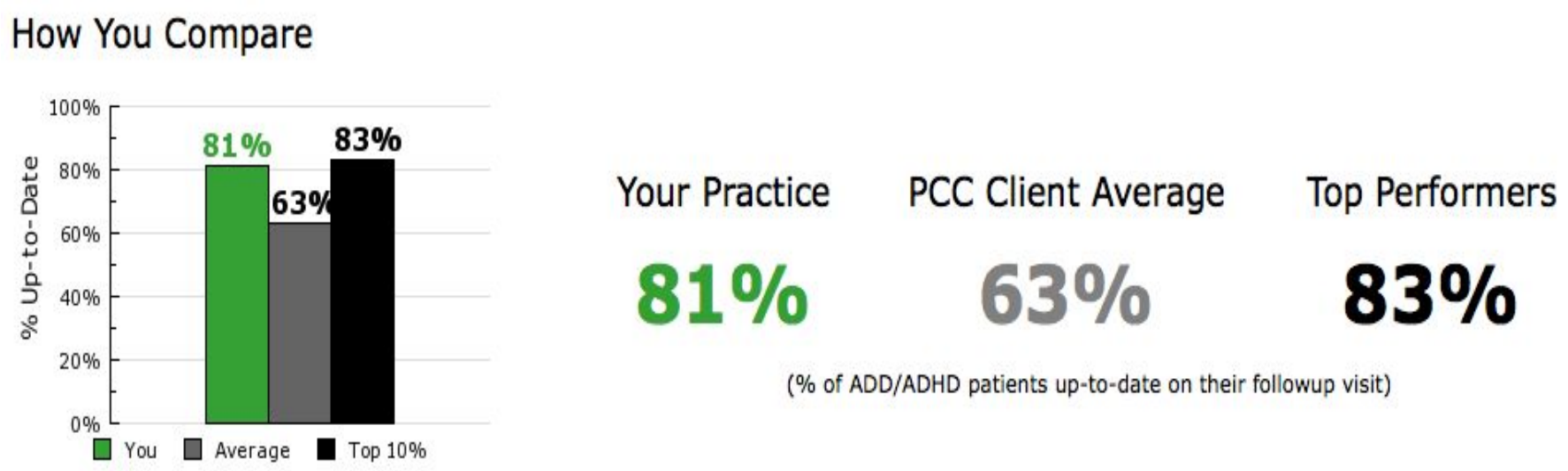
Benchmarks

PCC AVG and "Top Performers" (90th percentile)



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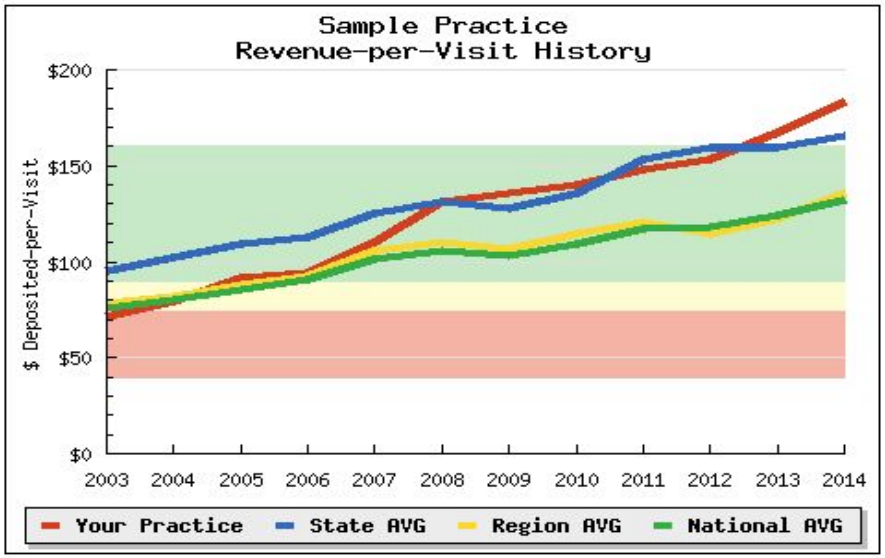
Benchmarks

National and regional benchmarks



Year	Practice AVG	State AVG	Regional AVG	National AVG
2003	$71.47	$94.80	$78.15	$76.01
2004	$79.32	$102.01	$82.24	$80.39
2005	$91.69	$109.34	$88.06	$85.23
2006	$94.55	$113.15	$92.67	$90.66
2007	$110.39	$124.74	$106.00	$101.59

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Provider Breakdown

For some measures, there are additional breakdown by provider.

Detailed Breakdown: Primary Care Provider

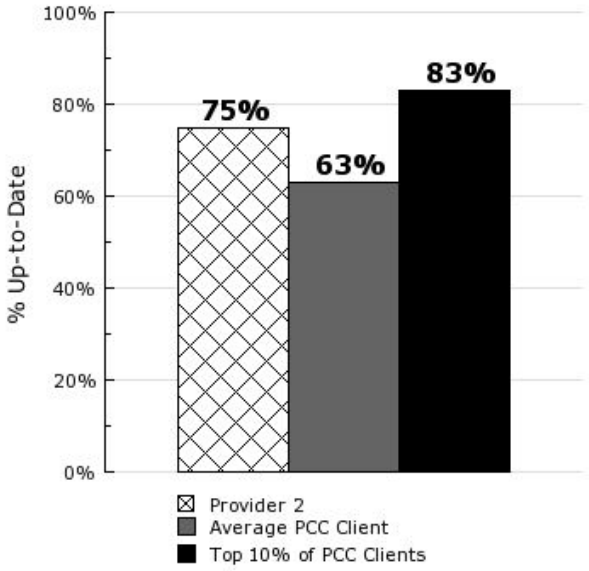
Show Breakdown By: Primary Care Provider

Primary Care Provider	Active Patients	Overdue Patients	Up-to-Date Patients	% Patients Up-to-Date
All Providers	477	99	378	79%
Provider 2	281	70	211	75%
Provider 6	45	9	36	80%
Provider 9	51	4	47	92%
Provider 21	4	1	3	75%
Provider 5	3	1	2	67%
Provider 3	37	8	29	78%
Provider 18	10	1	9	90%
Provider 28	2	0	2	100%
Provider 13	44	5	39	89%

Review ADD/ADHD Overdue patient listing for your practice.

How You Compare

Compare: Provider 2



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10 Ways to Use the Dashboard to Improve Practice Health

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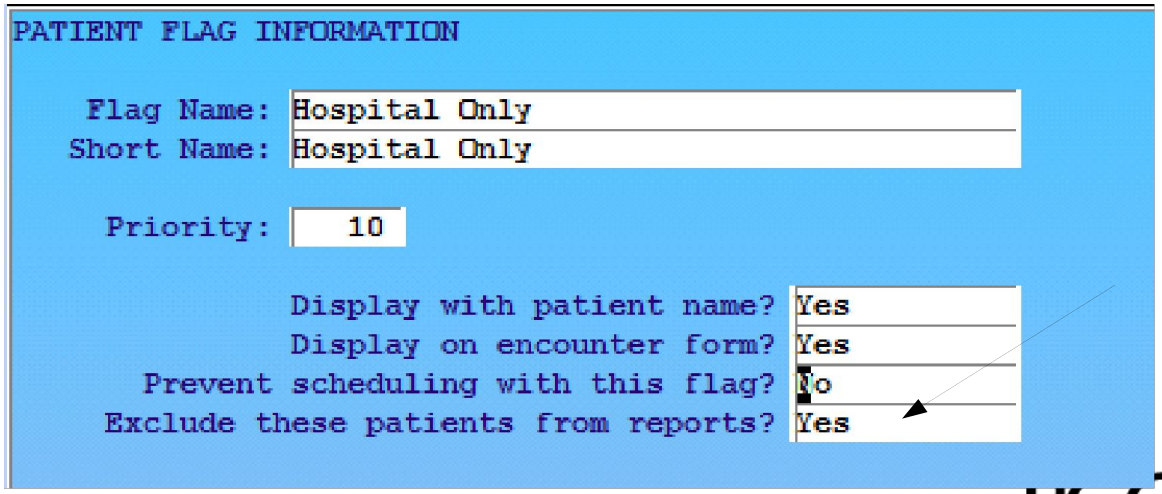
#10 - Maintaining Patient Flags

- Patients with certain flags are excluded from Dashboard clinical measures and overdue lists
- Review patient and account flags table. If the last question, “Exclude these patients from reports” is set to “Yes”, then patients with these flags are excluded from PCC Dashboard clinical measures



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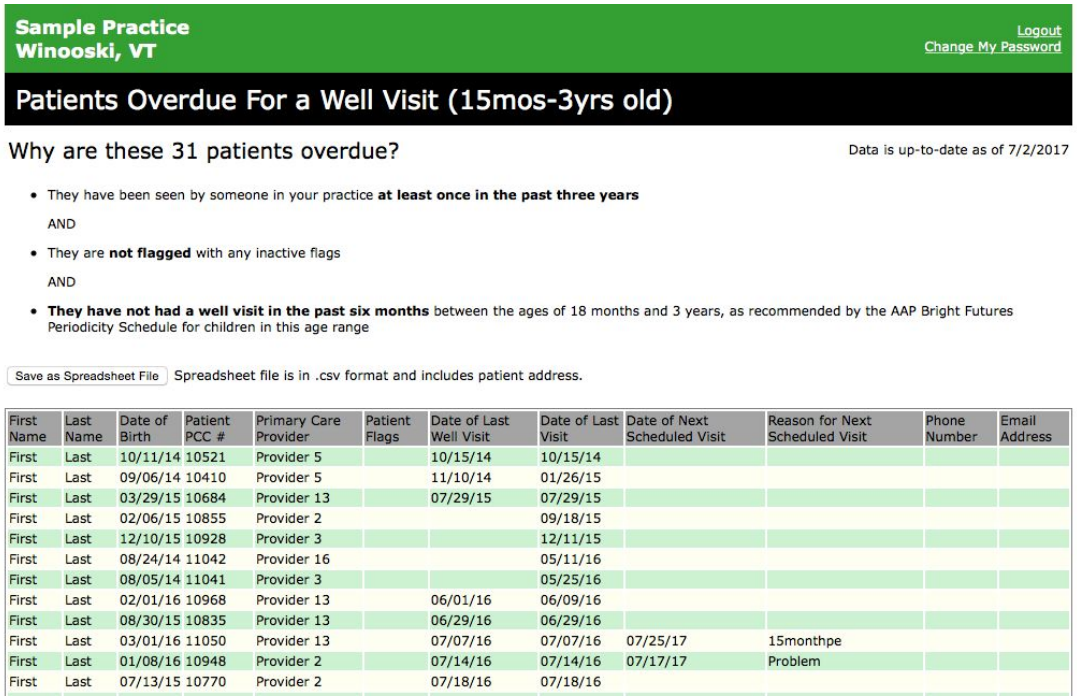
#10 - Maintaining Patient Flags

- Be sure to routinely flag patients that shouldn't be included on your reports (Hospital Only, Transferred, etc)
- Monitor using Dashboard overdue lists



Sample Practice
Winooski, VT

Logout
Change My Password

Patients Overdue For a Well Visit (15mos-3yrs old)

Why are these 31 patients overdue?

Data is up-to-date as of 7/2/2017

- They have been seen by someone in your practice **at least once in the past three years**

  AND

- They are **not flagged** with any inactive flags

  AND

- **They have not had a well visit in the past six months** between the ages of 18 months and 3 years, as recommended by the AAP Bright Futures Periodicity Schedule for children in this age range

Save as Spreadsheet File Spreadsheet file is in .csv format and includes patient address.

First Name	Last Name	Date of Birth	Patient PCC #	Primary Care Provider	Patient Flags	Date of Last Well Visit	Date of Last Visit	Date of Next Scheduled Visit	Reason for Next Scheduled Visit	Phone Number	Email Address
First	Last	10/11/14	10521	Provider 5		10/15/14	10/15/14				
First	Last	09/06/14	10410	Provider 5		11/10/14	01/26/15				
First	Last	03/29/15	10684	Provider 13		07/29/15	07/29/15				
First	Last	02/06/15	10855	Provider 2			09/18/15				
First	Last	12/10/15	10928	Provider 3			12/11/15				
First	Last	08/24/14	11042	Provider 16			05/11/16				
First	Last	08/05/14	11041	Provider 3			05/25/16				
First	Last	02/01/16	10968	Provider 13		06/01/16	06/09/16				
First	Last	08/30/15	10835	Provider 13		06/29/16	06/29/16				
First	Last	03/01/16	11050	Provider 13		07/07/16	07/07/16	07/25/17	15monthpe		
First	Last	01/08/16	10948	Provider 2		07/14/16	07/14/16	07/17/17	Problem		
First	Last	07/13/15	10770	Provider 2		07/18/16	07/18/16				

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#9 - Monitor Measure Trends

- Review monthly trends for each Dashboard measure
- Download as .csv

Trend: History of Your Values

Trend information can be helpful in uncovering the reason for your performance. For this measure, an upward trend indicates that you are improving and a downward trend indicates your performance with this measure is getting worse. For new practices, it is perfectly normal to see volatile results for some measures for the first 6-8 months after go-live.

Save trend output as .csv (spreadsheet) file

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#8 - Review Suggestions for Improvements

For each measure, explanations and guidance are provided

Recommendations

PCC's recaller tool can help identify patients who are due for a flu vaccination. In addition to excluding patients with certain inactive flags, you can exclude by procedure to leave out patients who have already received a flu vaccination this season. You can also exclude by appointment to leave out patients who are scheduled for an upcoming flu vaccination appointment. PCC's notify tool can automatically call, email, or text patients on this list letting them know about upcoming flu clinics or appointment availability.

Consider setting up a flu clinic to immunize your patient population quickly and efficiently. Refer to PCC's recommendations on setting up a flu clinic to discover best practices for using PCC software appropriately based on your workflow.

If you are considering achieving PCMH Recognition with NCQA, keep in mind that this measure is a relevant preventive care service and you can use Dashboard screen shots to show you are tracking this data regularly. Refer to PCC's PCMH WIKI for details on how to use Partner and PCC EHR tools to achieve PCMH Recognition.

#7 - Review Related Tools/ Drill-Down Pages

- Related Tools section in bottom right of each measure detail page
- Additional benchmarks, provider breakdowns, and other related analysis

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Provider Breakdown

Provider breakdown available for the following measures:

- Immunization Rates - Influenza (Asthma)
- ADD/ADHD Patient Followup
- Well Visit Rates
- Missed Appointment Rate
- Developmental Screening Rates
- Sick-to-Well Visit Ratio
- E&M Coding Distribution

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#6 - Use the Dashboard for PCMH Recognition

HOME | FINANCIAL PULSE | CLINICAL PULSE | PCMH | PATIENT POPULATION | EDI DASHBOARD | PRODUCTIVITY

Sample Practice
Winooski, VT

Logout
Change My Password

Patient Centered Medical Home (PCMH) Measures

This dashboard page contains all of the PCC Practice Vitals Dashboard measures that relate to NCQA's 2014 PCMH standards. This page can be used to monitor your performance toward meeting specific elements and factors. You can also print this page to share the data with staff and providers and for submission to NCQA as part of your application for PCMH recogntion. Visit PCC's PCMH WIKI page for screenshots, documentation, and other information about how PCC tools can help you meet various PCMH elements.

Element 1A: Patient-Centered Appointment Access

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance.

Reporting period includes appointments from 7/1/2016 to 6/30/2017

Factor 1A.5 - Monitoring No-Show Rates

Measure	Total Appointments	Missed Appointments	% Missed	% Change (3 mo.)
Missed Appointment Rate	13,127	409	3.1%	1.0% ↑

Element 6A: Measure Clinical Quality Performance

The practice reviews its performance on a range of measures to help understand its care delivery system's strengths and opportunities for improvement. Although some measures may fit into multiple categories appropriately, each measure may be used only once for this element. When it selects measures of performance, the practice indicates the following for each measure: period of measurement, number of patients represented by the date, and rate (percent) based on a numerator and denominator.

Reporting period includes active patients as of 7/2/2017

Factor 6A.1 - At least two immunization measures

Measure	Qualifying Patients	Up-to-Date Patients	% Up-to-Date	% Change (3 mo.)
Immunization Rates - HPV	839	564	67%	-0.3% ↓
Immunization Rates - Influenza *	2,900	1,842	64%	Insufficient Data
Immunization Rates - Influenza (Asthma) *	425	314	74%	Insufficient Data
Immunization Rates - Meningococcal	839	813	97%	0.8% ↑
Immunization Rates - Patients 2 Years Old	160	145	91%	3.2% ↑
Immunization Rates - Tdap	839	823	98%	-0.2% ↓

* Influenza rates are seasonal. This measure represents patients vaccinated since July 1. The percent change is compared to the same month last year.

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#6 - Use the Dashboard for PCMH Recognition

- Identifying populations of patients (2014 PCMH Element 3D)
- Population Health Management (2014 PCMH Element 6A.1-3)
  - Tracking monthly trends
  - Review and print results monthly
- Provider-specific reporting (2014 PCMH Element 6F)
- Vulnerable population (race, ethnicity, insurance, language) breakdown for some measures (PCMH element 6A.4)

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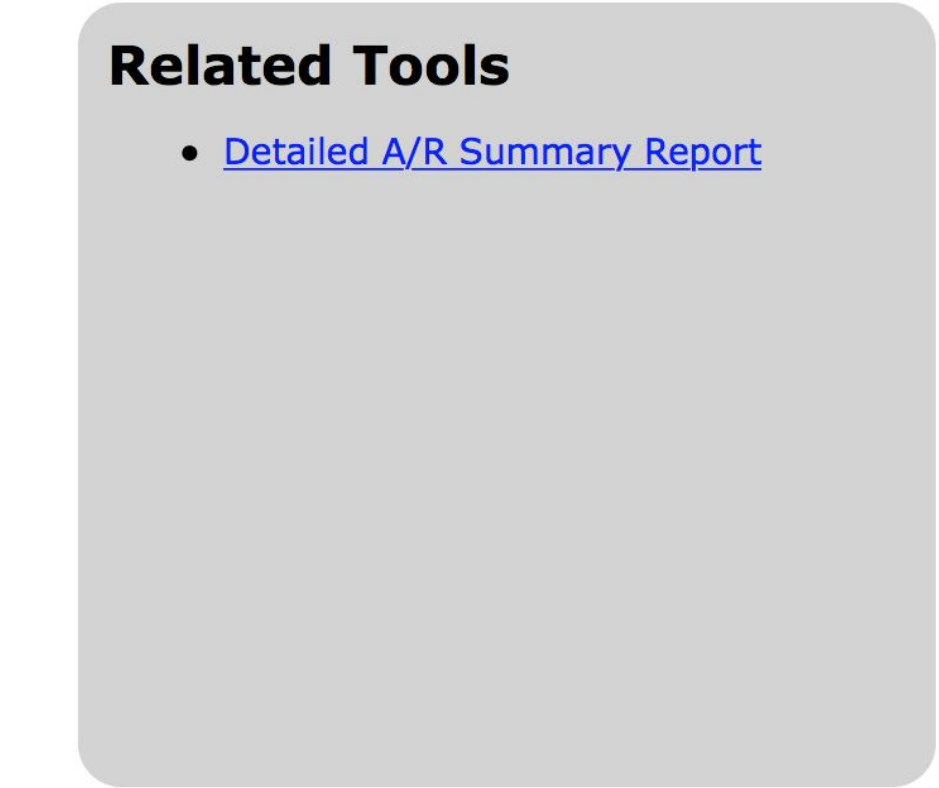
#5 - Share Dashboard Results

- Share results during staff/provider meetings
- Share results with your patients
- Copy/Paste graphs into presentations or other documents

#4 - Generate A/R Summary Report

- View or print A/R Summary Report updated monthly
- Found in the "Related Tools" section for each A/R measure



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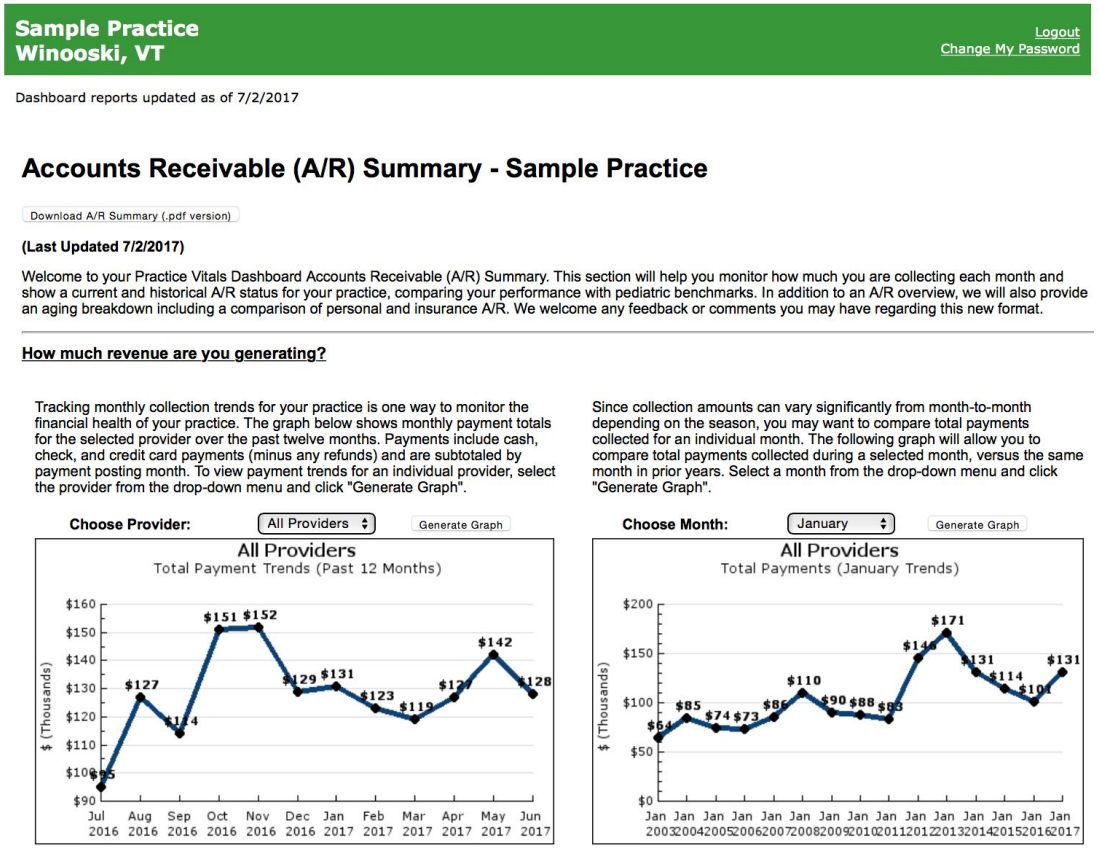
#4 - Generate A/R Summary Report

- Revenue trends
- A/R Days and benchmarks
- A/R Percentage by Aging Category
- Personal vs Insurance A/R
- Recommendations



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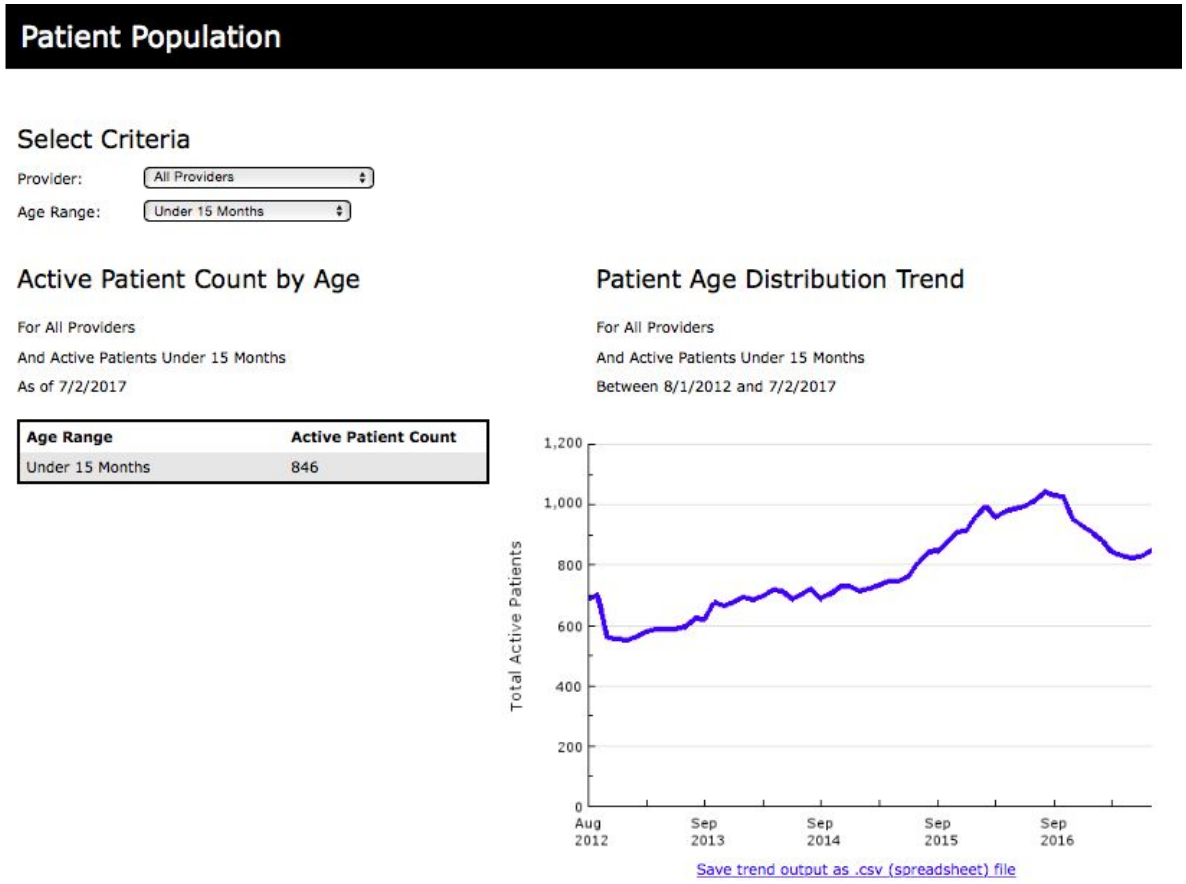
#3 - Monitor Patient Population Trends

- View current and past active patient counts for various age ranges
- Monitor intake of newborn patients to the practice
- Filter by primary care provider



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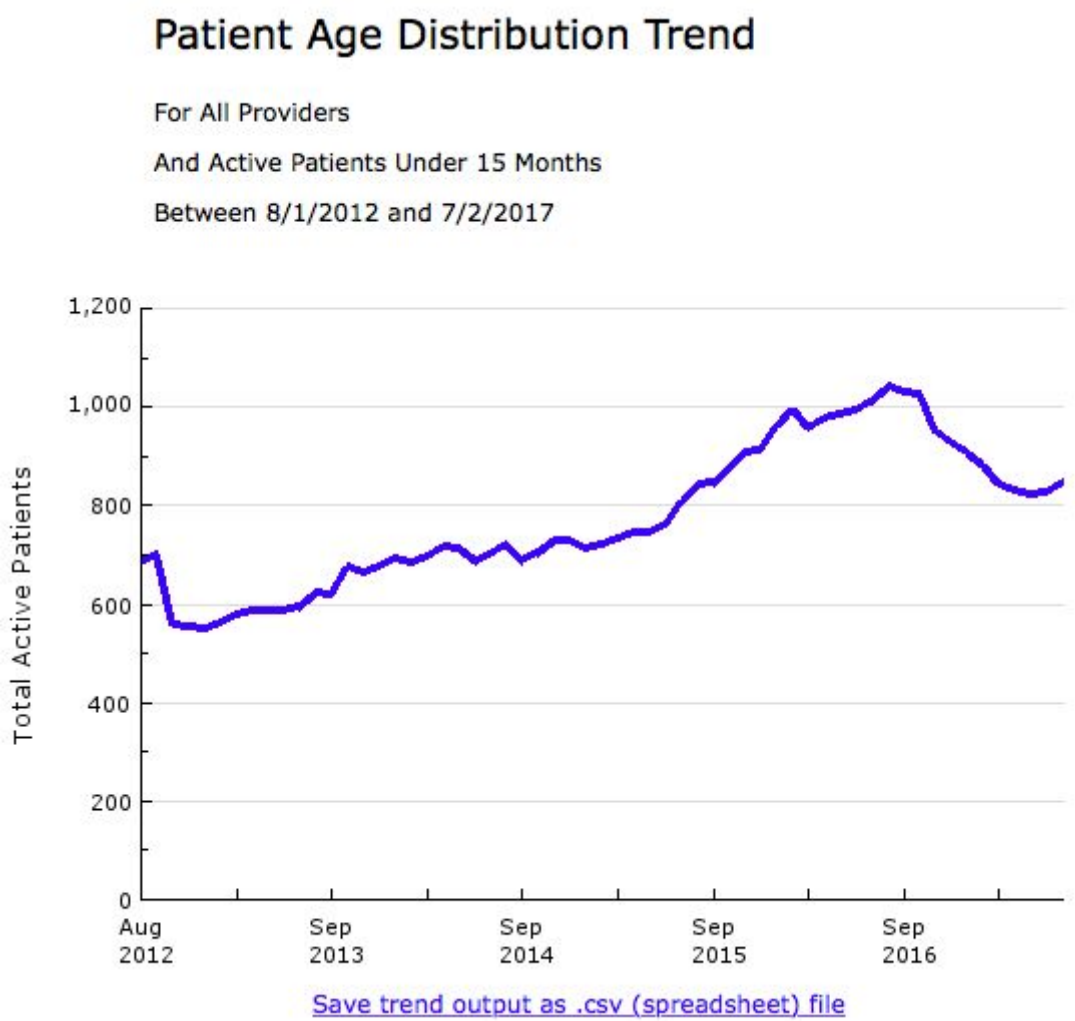
#3 - Monitor Patient Population Trends



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#2 - Use Dashboard to Keep Payors Honest

- Dashboard vs Payor report cards
  - Compare measure results
  - Compare overdue patient lists
  - Challenge payors by using Dashboard data
- Compare measure results by payor and use as leverage when negotiating

#2 - Use Dashboard to Keep Payors Honest

- PCMH Dashboard - measure results by primary insurance

Factor 6A.4 - Performance data stratified for vulnerable populations

Measure: Well Visit Rates - 12-21 Years

Breakdown By: Primary Insurance

Well Visit Rates - 12-21 Years			
Primary Insurance	**Qualifying Patients**	**Up-to-Date Patients**	**% Up-to-Date**
Other Insurance	26	16	62%
Medicaid	280	201	72%
BCBS	786	570	73%
Cigna	176	129	73%
MVP	88	70	80%
Medicaid PCPlus	15	9	60%
CBA	4	1	25%
First Health	34	22	65%
Tricare	6	3	50%
CBA BLUE	15	10	67%
United HC	42	30	71%

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#1 - Highlight Opportunities for Improved Patient Recall

You have **1,472** active patients between the ages of 12 years and 21 years.

411 of these patients are overdue for their well visit.

You have **839** active patients between 13 years and 17 years of age.

275 of these patients are overdue for at least one HPV vaccine.

- Use PCC's notify, recall, and EHR reporting tools to identify patients in need of:
  - Well visits - Screenings
  - Vaccinations - Chronic Disease Management

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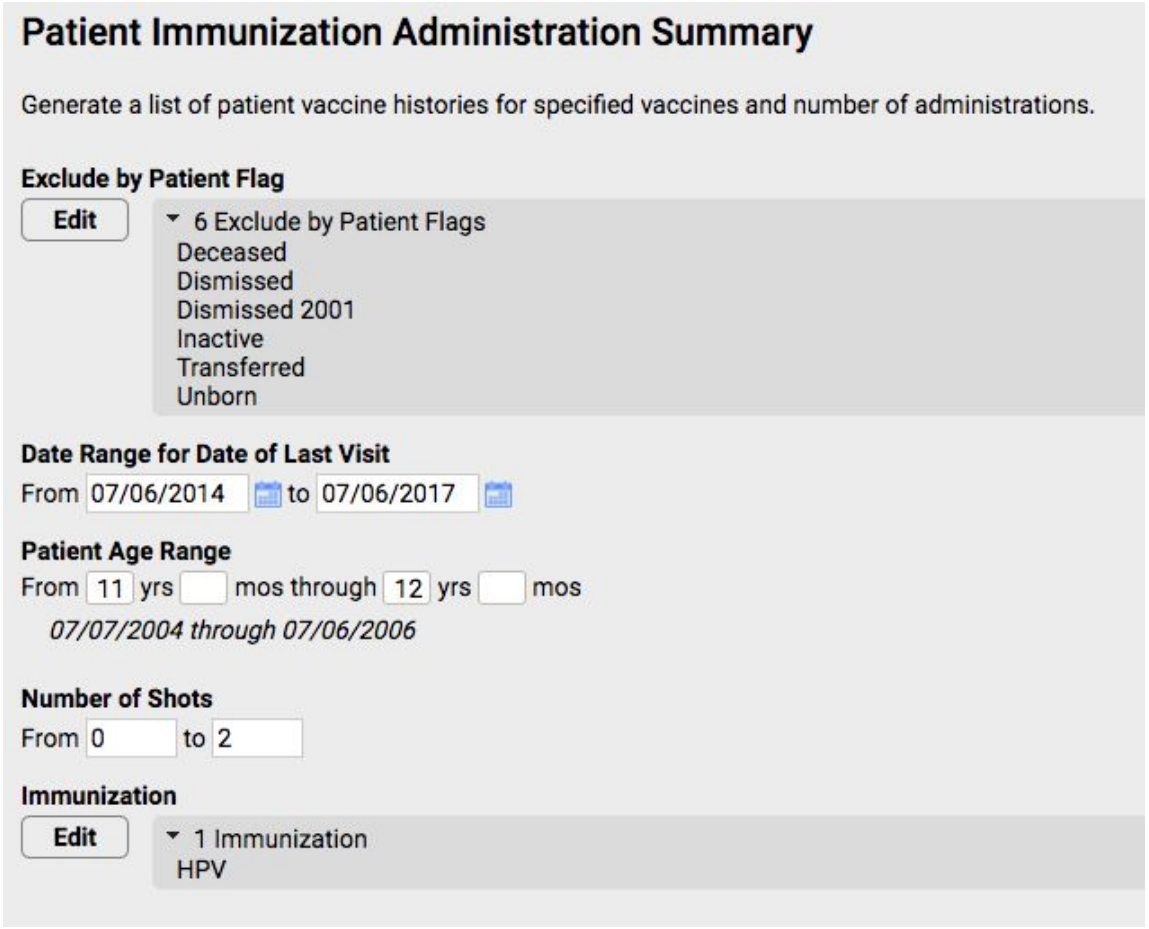
#1 - Highlight Opportunities for Improved Patient Recall



Patient Immunization Administration Summary

Generate a list of patient vaccine histories for specified vaccines and number of administrations.

Exclude by Patient Flag

Edit

6 Exclude by Patient Flags
Deceased
Dismissed
Dismissed 2001
Inactive
Transferred
Unborn

Date Range for Date of Last Visit

From 07/06/2014 to 07/06/2017

Patient Age Range

From 11 yrs mos through 12 yrs mos

07/07/2004 through 07/06/2006

Number of Shots

From 0 to 2

Immunization

Edit

1 Immunization
HPV

- **Coming soon!** EHR report to identify patients having a specified number of vaccines

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Dashboard Demo and Exercises

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