

Improving Your Practice Health with PCC Dashboard

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Users Conference 2015

Goals

- Gain better understanding of the purpose of the Dashboard and how it will be useful to you
- See some of the new and upcoming features of the Dashboard
- See how you measure up to other PCC practices

Agenda

- Highlights of the Dashboard
- Dashboard demo
- Explore your own Dashboard



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

Financial and Clinical Pulse

- One score to summarize your financial and clinical performance

My Practice Status

Financial Pulse



87 

Clinical Pulse



63 

Dashboard Scoring

- Each measure is also scored based on your relative performance
- Prioritized list of results on home page

My Dashboard Priorities

Top Priorities

Score	Measure
22	Sick-to-Well Visit Ratio
36	Immunization Rates - HPV
37	A/R Days

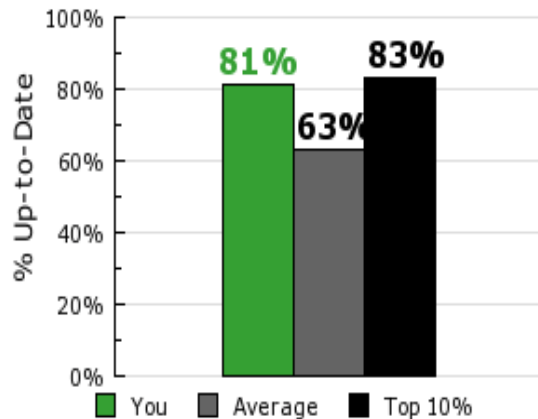
Next Priorities

Score	Measure
37	Missed Appointment Rate
45	Immunization Rates - Influenza
58	Pricing
61	Immunization Rates - Influenza (Asthma)
62	Well Visit Rates - Patients 12-21 Years
73	Well Visit Rates - Patients 3-6 Years
75	A/R Over 60 Days Old
78	ADD/ADHD Patient Followup
82	Well Visit Rates - Patients 15-36 Months
82	Well Visit Rates - Patients 7-11 Years
95	E&M Coding Distribution
97	A/R 60-90 Days Old
98	Well Visit Rates - Patients Under 15 Months
99	Diagnoses-per-Visit
100	Coding Expertise
100	Revenue-per-Visit
100	Revenue-per-Visit (Without Imms)
100	RVUs-per-Visit

Benchmarks

- PCC AVG and “Top Performers” (90th percentile)

How You Compare



Your Practice

81%

PCC Client Average

63%

Top Performers

83%

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

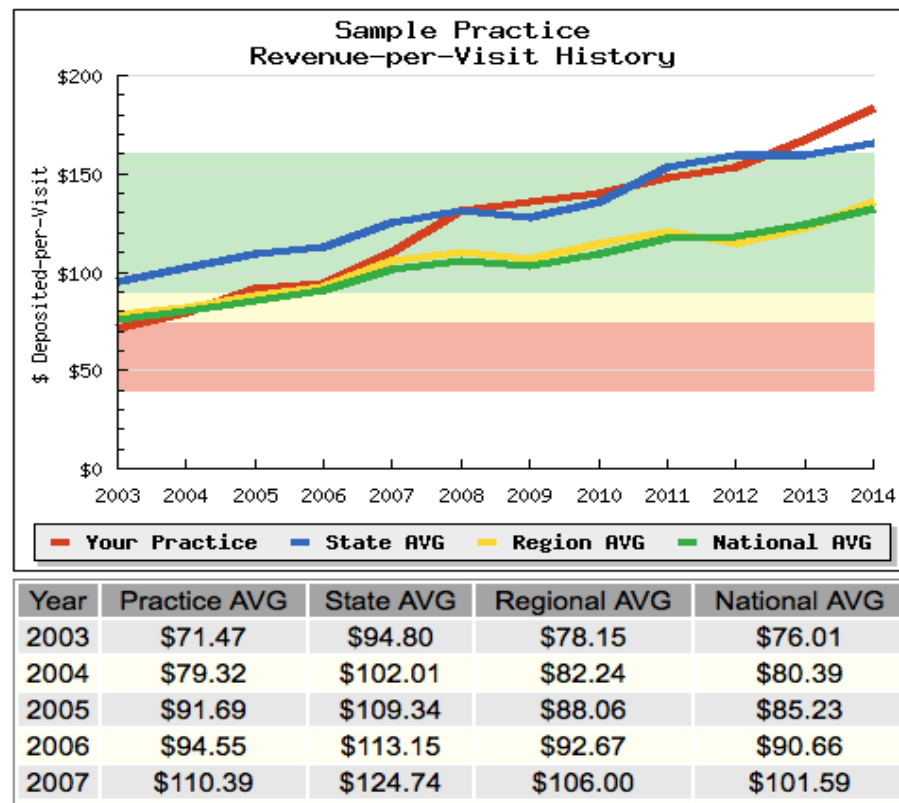


Pediatric EHR Solutions

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Benchmarks

- National and regional benchmarks



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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.



Provider Breakdown

- For some measures, there is additional breakdown by provider.

Detailed Breakdown: Primary Care Provider

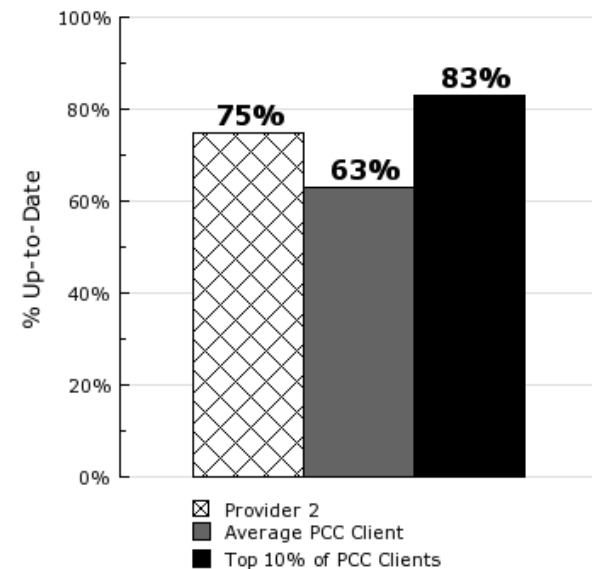
Show Breakdown By:

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 Breakdown

- Provider breakdown available for the following measures:
 - Immunization Rates - Influenza (Asthma)
 - ADD/ADHD Patient Followup
 - Missed Appointment Rate
 - Well Visit Rates
 - Sick-to-Well Visit Ratio
 - E&M Coding Distribution

Interactive Graphing

Productivity Measure

Total Visits

Provider

All Providers

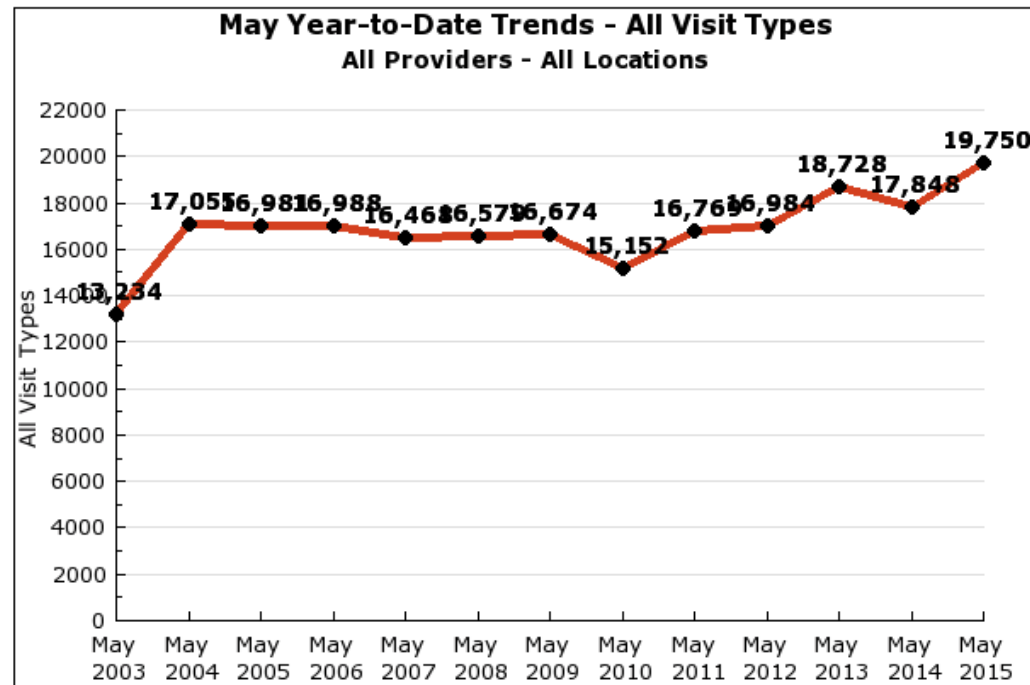
Month

May

Monthly or Year-to-Date?

Year-to-Date

Generate Graph



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Useful for PCMH

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