

# PCC Resources For PCMH

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Users Conference 2016

# Agenda

- Current state of PCMH and what's coming
- Exploration of how PCC functionality applies to PCMH factors
- PCC Resources for PCMH

# Takeaways

- A basic understanding of NCQA's PCMH Recognition and why it might benefit your practice
- An understanding of how PCC reports and functionality can be used to meet specific PCMH requirements
- Recognition of how your existing workflow and processes may need to change in order to meet PCMH requirements

# Current State of PCMH

- Focus on improving **patient access**
- Emphasis on **team-based care**
- Consistent **population management** of patients
- **Care management** focus on high-need populations
- **Coordinating care** and **transitions**
- Integration of **behavioral health**
- Aligns with **Meaningful Use** and use of **I/T**
- Alignment of **quality improvement** activities



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# Why NCQA PCMH?

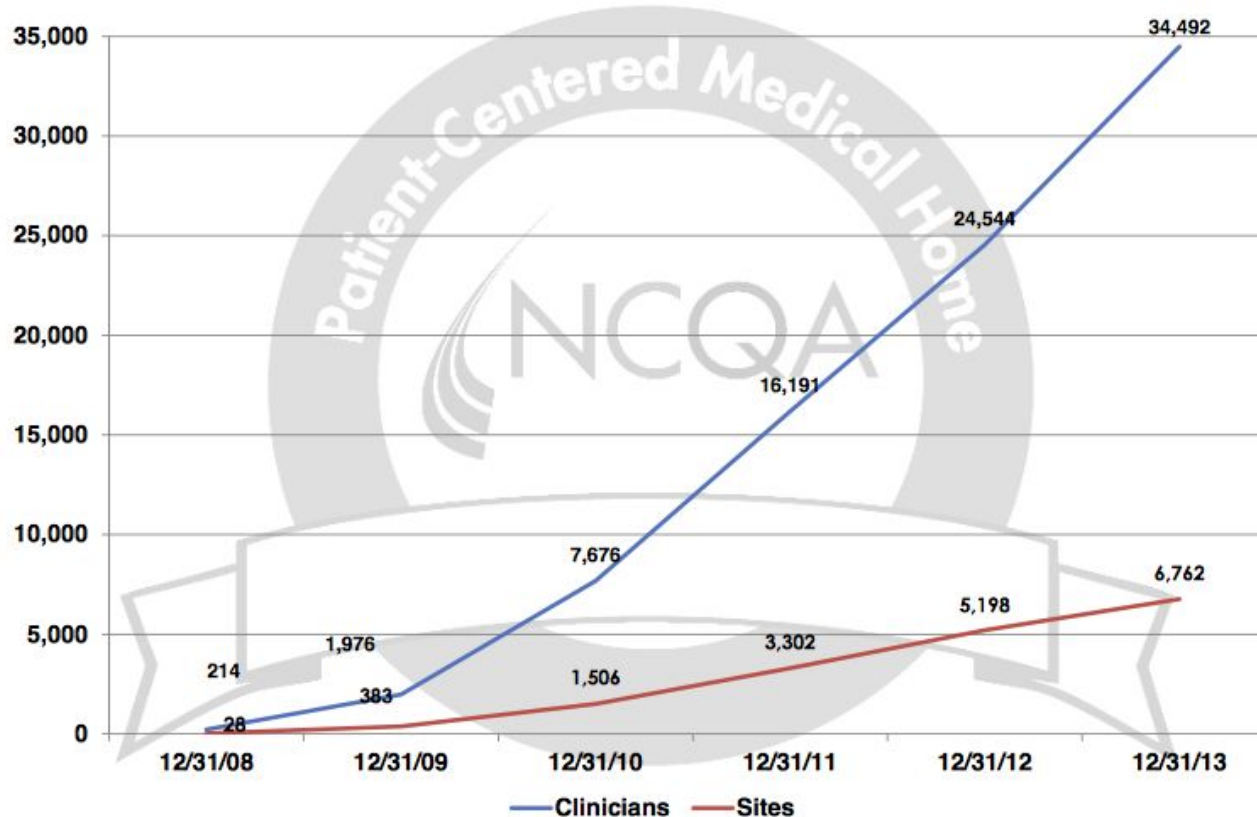
- Most widely adopted model for transforming primary care practices to medical homes
- May be financially worthwhile depending on region and payor mix
- Streamlined workflow and operations



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# NCQA PCMH Growth 2008-2013



- As of June 2016, >11,500 sites and ~58,000 clinicians recognized in 50 states
- At least 28 **PCC practices** have Level 3 recognition, 4 have Level 2 recognition, and another 18 are in the process of getting recognition



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# Getting Started With PCMH Recognition

- Research the requirements. Download and read through NCQA's standards
- NCQA ["start to finish" guide](#)
- Visit practices who are already medical homes. Share strategies and experiences
- [Patient-Centered Primary Care Collaborative](#)



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# Getting Started

- First time getting recognition or renewing?
- Single site or multi-site?
  - If 3 or more locations, need special multi-site approval from NCQA
- Work with PCC and [Patient-Centered Solutions \(PCS\)](#)
  - Gap analysis survey
  - Project management
  - Document review

# PCC Prevalidation

- PCC is prevalidated to offer 7.5 credits under 2014 standards
- You can attest for automatic credit just for using PCC software
- Here's what you'll need when you submit to NCQA:
  - Approval Table
  - NCQA Letter of Product Autocredit Approval
  - Letter of Product Implementation (Contact PCC)

# What's Coming for PCMH

- Redesign to a new “sustained” recognition program will be launched on 3/31/17
- Simplified reporting with less paperwork
- Includes virtual review with NCQA staff
- No more renewals every 3 years. Will now require **annual** check-in from NCQA with some reporting
- Last date to purchase 2014 survey tool is 3/31/17



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# Practices Without PCMH Recognition

- Last day to purchase 2014 survey licenses is 3/31/17
- Last day to submit 2014 Corporate Survey is 5/31/17
- Last day to submit 2014 site surveys is 9/30/17
- New 2017 standards become available on 3/31/17



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# Practices With 2011 Recognition

Option 1: **Convert** to PCMH 2014 recognition

- Need 2011 Level 3 recognition
- Gets you 1 additional year of recognition
- Only 6 elements require documentation
- Expiration date for submission is 9/30/17
- Cost is less



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# Practices With 2011 Recognition

## Option 2: **Streamlined renewal** under PCMH 2014

- Need 2011 level 2 or level 3 recognition
- Gets you 3 additional years of recognition
- 11 elements require documentation
- Expiration for corporate survey is 5/31/17
- Full cost

# Practices With 2011 Recognition

Option 3: Renew under **redesigned** program after 3/31/17

- Previously earned PCMH 2011 credit will be applied to aspects of 2017 standards

# Practices With 2014 Recognition

Option 1: **Sustain** under **redesigned** program after 3/31/17

- Previously earned PCMH 2014 credit will be applied to aspects of 2017 standards

Option 2: **Streamlined renewal** under PCMH 2014

- Gets you 3 additional years of recognition
- 11 elements require documentation
- Expiration for corporate survey is 5/31/17
- Full cost



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# PCC's PCMH Resources

(<http://pcmh.pcc.com>)

# PCMH Reporting Examples



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# PCMH 1: Patient-Centered Access

Points	Standard/Element	Must-Pass = 50% Score
10	<b>PMCH 1: Patient-Centered Access</b>	
4.5	Element A Patient-Centered Appointment Access	✓
3.5	Element B 24/7 Access to Clinical Advice	
2	Element C Electronic Access	

- The practice provides 24/7 access to team-based care for both routine and urgent needs of patients/families/caregivers.

# Same-day Appointments

## Element A: Patient-Centered Appointment Access (MUST-PASS)

4.50 points

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

Yes No

1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR)

☐☐

2. Providing routine and urgent-care appointments outside regular business hours.

☐☐

3. Providing alternative types of clinical encounters.

☐☐

4. Availability of appointments.

☐☐

5. Monitoring no-show rates.

☐☐

6. Acting on identified opportunities to improve access.

☐☐

- Use PCC reports to show that you use same-day sick blocks
- Renewals: documentation is required



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# 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

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



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# 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:**  
First by: **Date of Appointment**  
then by: **Length of the Appointment (in**  
then by:  
then by:

**Totals?**  
**X**

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



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# 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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# Monitor No-Show Rates

## Element A: Patient-Centered Appointment Access (MUST-PASS)

4.50 points

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

1. Providing same-day appointments for routine and urgent care.  
(CRITICAL FACTOR)

☐
☐

2. Providing routine and urgent-care appointments outside regular business hours.

☐
☐

3. Providing alternative types of clinical encounters.

☐
☐

4. Availability of appointments.

☐
☐

5. Monitoring no-show rates.

☐
☐

6. Acting on identified opportunities to improve access.

☐
☐

- Use PCC Dashboard or srs Appointment Report - "Appointment Totals by Status"



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# Dashboard Missed Appointment Rate

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

## Sample PCC Practice

### 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 help you 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 NCQA as part of your application for PCMH recognition. Visit [PCC's PCMH WIKI page](#) for screenshots, documentation, and other information that 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 7/1/2015 to 6/30/2016

#### Factor 1A.5 - Monitoring No-Show Rates

Measure	Total Appointments	Missed Appointments	% Missed	% Change (3 mo.)
<a href="#">Missed Appointment Rate</a>	55,785	4,068	7.3%	1.8% ↑

- Dashboard reports for full year. Use srs report for custom date range

# Timely Clinical Advice By Telephone

## Element B: 24/7 Access to Clinical Advice

3.50 points

The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

1. Providing continuity of medical record information for care and advice when office is closed.
2. Providing timely clinical advice by telephone. (CRITICAL FACTOR)
3. Providing timely clinical advice using a secure, interactive electronic system.
4. Documenting clinical advice in patient records.

Yes	No	NA
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	

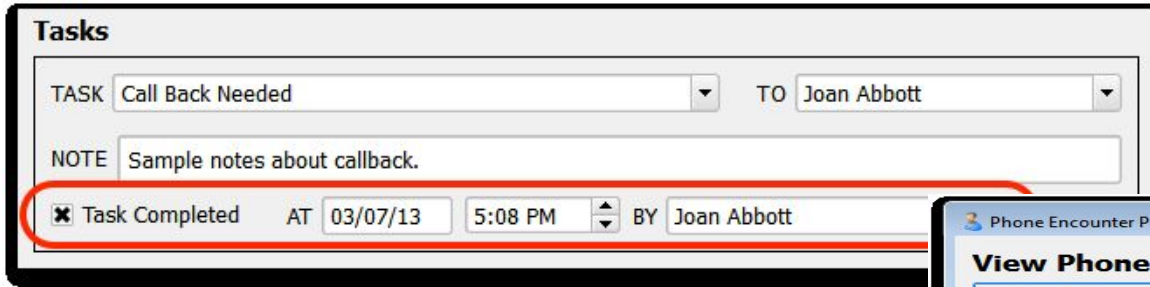
- Show that you are tracking response times to phone calls
- Renewals: No documentation required for 1B



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# Timely Clinical Advice By Telephone



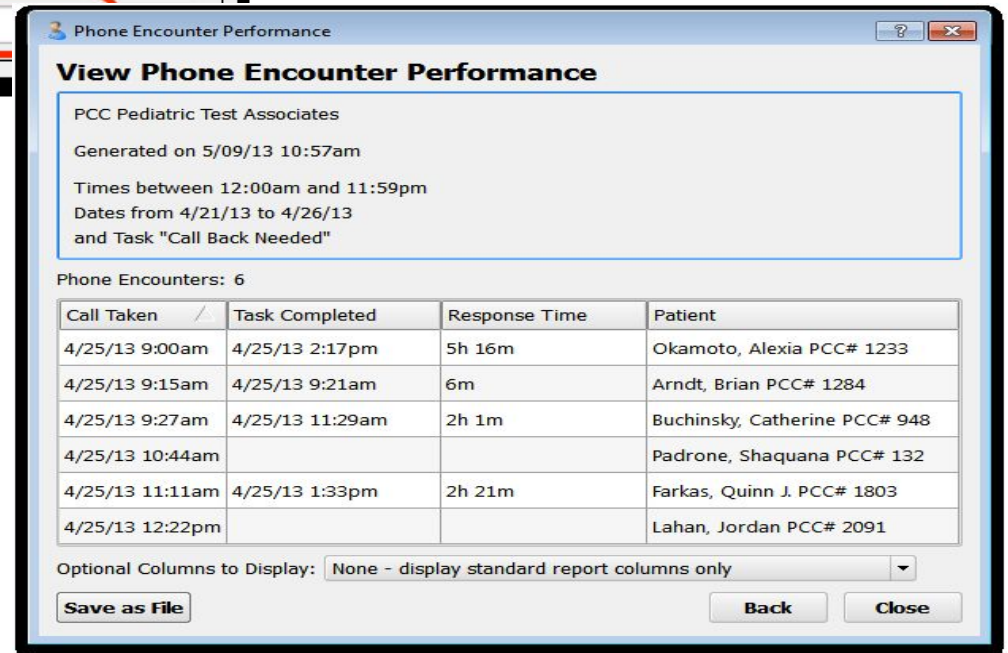
**Tasks**

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



**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

# Timely Clinical Advice By Secure Electronic Msg

## Element B: 24/7 Access to Clinical Advice

3.50 points

The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

1. Providing continuity of medical record information for care and advice when office is closed.

☐☐

2. Providing timely clinical advice by telephone. (CRITICAL FACTOR)

☐☐

3. Providing timely clinical advice using a secure, interactive electronic system.

☐☐☐

4. Documenting clinical advice in patient records.

☐☐

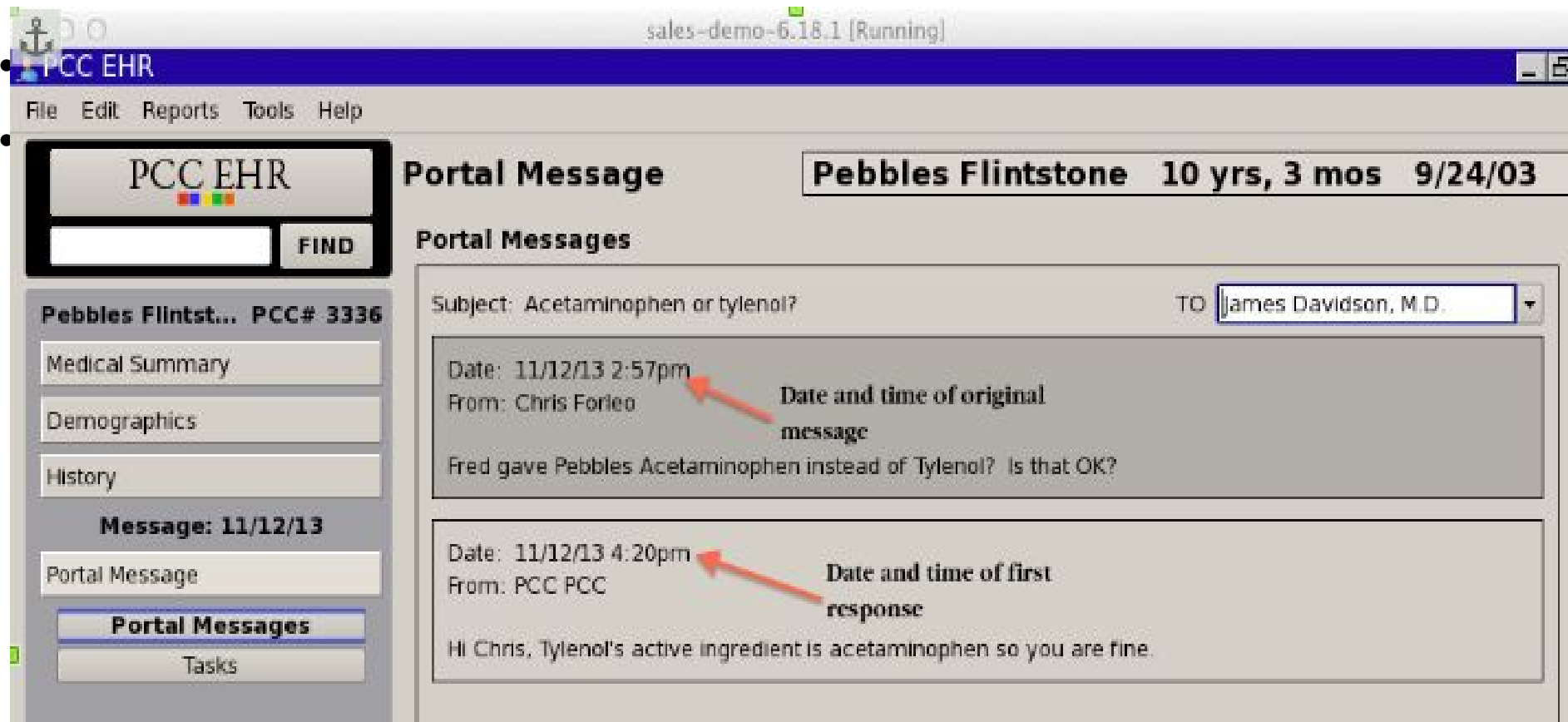
- Use PCC's patient portal functionality - My Kid's Chart
- Need to provide report showing response times to portal messages before and after-hours.
- Report for at least 7 calendar days.



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# Timely Clinical Advice By Secure Electronic Msg



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# Portal Use and PCMH

## Element C: Electronic Access

2.00 points

The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system.

	Yes	No	NA
1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice. +	<input type="checkbox"/>	<input type="checkbox"/>	
2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits.	<input type="checkbox"/>	<input type="checkbox"/>	
4. A secure message was sent by more than 5 percent of patients. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Patients have two-way communication with the practice.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Patients can request appointments, prescription refills, referrals and test results.	<input type="checkbox"/>	<input type="checkbox"/>	

- Renewals: No documentation required for 1C
- Use PCC MU reports for factors 1-4
- PCC Autocredit for factor 5 if using portal



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# Portal Use and PCMH

Meaningful Use Objective	PCC MU Report	2014 PCMH Standards	
		Element	Requirement
Modified Stage 2 Objective 8: Patient Electronic Access	Modified Stage 2 – Timely Online Access	1C.1	50% of all patients seen have online access within 4 business days
	Modified Stage 2 – View, Download, Transmit (VDT)	1C.2	<b>Update</b> – For 2016, only one patient needs to view, download, or transmit health information
Stage 2: Provide Clinical Summaries to Patients for Each Visit	Stage 2 – Clinical Summaries	1C.3	<b>Update</b> – Report needed but you don't need to meet 50% threshold
Modified Stage 2 Objective 9: Secure Messaging	Modified Stage 2 – Secure Electronic Messaging (Sent)	1C.4	<b>Update</b> – Only a screenshot showing capability is required

- 1C.1 - Need 50% of patients seen to have portal account (need at least 3 month reporting period)
- 1C.2 - Only one patient needs to log into portal to view info
- 1C.3 - Just need to report MU measure, don't need to provide clinical summaries to 50% of patients
- 1C.4 - Only need screenshot showing secure electronic message capability



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# Portal Use and PCMH

- Get patients signed up for the portal
- Train patients on using the portal
- PCC's user guide:

<http://learn.pcc.com/Content/MyKidsChart/PortalUserGuide.htm>

# PCMH 2: Team-Based Care

Points	Standard/Element	Must-Pass = 50% Score
12	PMCH 2: Team-Based Care	
3	Element A Continuity	
2.5	Element B Medical Home Responsibilities	
2.5	Element C Culturally and Linguistically Appropriate Services (CLAS)	
4	Element D The Practice Team	✓

- The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.

# PCMH 2A: Continuity

## Element A: Continuity

3.00 points

The practice provides continuity of care for patients/families by:

1. Assisting patients/families to select a personal clinician and documenting the selection in practice records.
2. Monitoring the percentage of patient visits with selected clinician or team.
3. Having a process to orient new patients to the practice.
4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care.

Yes No

☐ ☐☐ ☐☐ ☐☐ ☐

- Renewals: No documentation required for 2A
- 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



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# 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
<b>Total Result</b>		<b>701</b>	<b>764</b>	<b>922</b>	<b>814</b>	<b>637</b>	<b>723</b>	<b>937</b>	<b>5498</b>
	% 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
- There is no expected % to reach for this factor



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# PCMH 2C: CLAS

## Element C: Culturally and Linguistically Appropriate Services

2.50 points

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

	Yes	No	NA
1. Assessing the diversity of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Assessing the language needs of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Providing interpretation or bilingual services to meet the language needs of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Providing printed materials in the languages of its population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Renewals: No documentation required for 2C
- Assess race, ethnicity, and preferred language for your population (Contact PCC for report assistance)



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# Stratify Race, Ethnicity, Language

	A	B	C	D	E	F	G
1	Filter						
2							
3	Race		% of Total		Filter		
4	(empty)	477	24%				
5	American Indian or Alaska Native	11	1%		Primary Preferred		% of Total
6	American Indian or Alaska Native, Asian	1	0%		(empty)	506	26%
7	Asian	62	3%		Amharic	69	4%
8	Asian, Black or African American	3	0%		Arabic	3	0%
9	Asian, White	1	0%		Bambara	1	0%
10	Black or African American	1227	62%		Bengali	9	0%
11	Black or African American, Native Hawaiian or Other Pacific Islander	1	0%		Burmese	18	1%
12	Black or African American, Prefers not to answer	1	0%		Chinese	1	0%
13	Black or African American, Some other race	6	0%		English	1274	65%
14	Black or African American, White	14	1%		Ewe	1	0%
15	Native Hawaiian or Other Pacific Islander	1	0%		French	13	1%
16	Prefers not to answer	31	2%		Gujarati	5	0%
17	Some other race	38	2%		Haitian	1	0%
18	White	93	5%		Igbo	3	0%
19	White, Some other race	1	0%		Karen	9	0%
20	<b>Total Result</b>	<b>1968</b>			Nepali	5	0%
21					Oromo	6	0%
22	Filter				Somali	30	2%
23					Spanish	8	0%
24	Ethnicity		% of Total		Tigrinya	2	0%
25	(empty)	496	25%		Vietnamese	4	0%
26	Hispanic or Latino	69	4%		<b>Total Result</b>	<b>1968</b>	
27	Not Hispanic or Latino	1296	66%				
28	Prefers not to answer	107	5%				
29	<b>Total Result</b>	<b>1968</b>					



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# PCMH 2C: CLAS

## Element C: Culturally and Linguistically Appropriate Services

2.50 points

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

	Yes	No	NA
1. Assessing the diversity of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Assessing the language needs of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Providing interpretation or bilingual services to meet the language needs of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Providing printed materials in the languages of its population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Autocredit for 2C.4 if using PCC EHR

# PCMH 3: Population Health Management

Points	Standard/Element	Must-Pass = 50% Score
20	PCMH 3: Population Health Management	
3	Element A Patient Information	
4	Element B Clinical Data	
4	Element C Comprehensive Health Assessment	
5	Element D Use Data for Population Management	✓
4	Element E Implement Evidence-Based Decision Support	

- The practice provides evidence-based decision support and proactive care reminders based on complete patient information, health assessment and clinical data.

# Track Patient Information

## Element A: Patient Information

3.00 points

The practice uses an electronic system to record patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients:

	Yes	No	NA
1. Date of birth.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Sex.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Race.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ethnicity.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Preferred language.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Telephone numbers.	<input type="checkbox"/>	<input type="checkbox"/>	
7. E-mail address.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Occupation (NA for pediatric practices).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Dates of previous clinical visits.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Legal guardian/health care proxy.	<input type="checkbox"/>	<input type="checkbox"/>	
11. Primary caregiver.	<input type="checkbox"/>	<input type="checkbox"/>	
12. Presence of advance directives (NA for pediatric practices).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Health insurance information.	<input type="checkbox"/>	<input type="checkbox"/>	
14. Name and contact information of other health care professionals involved in patient's care.	<input type="checkbox"/>	<input type="checkbox"/>	

- Renewals: No documentation required for 2A
- Track at least 10 of these patient demographic elements for at least 80% of patients
- Use at least 90-day period to determine patients to include



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# Track Patient Information

- 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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# PCMH 3B: Clinical Data

## Element B: Clinical Data

4.00 points

The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 as structured (searchable) data.

	Yes	No	NA
1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Height/length for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Weight for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
6. System calculates and displays BMI.	<input type="checkbox"/>	<input type="checkbox"/>	
7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0–20 years) (NA for adult practices).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. List of prescription medications with date of updates for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
10. More than 20 percent of patients have family history recorded as structured data.	<input type="checkbox"/>	<input type="checkbox"/>	
11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.	<input type="checkbox"/>	<input type="checkbox"/>	

- Renewals: No documentation required for 3B
- Refer to PCC MU reports for factors 1, 2, 8, 9, 10, 11
- PCC Autocredit for factors 6 and 7
- Use at least 90-day period



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# PCMH 3B: Clinical Data

Meaningful Use Objective	PCC MU Report	2014 PCMH Standards	
		Element	Requirement
Stage 1: Maintain Up-to-date Problem list with current and active diagnoses	Stage 1 – Problem List	3B.1	80%
Stage 1: Maintain active medication allergy list	Stage 1 – Medication Allergy List	3B.2	80%
Stage 1: Record and Chart Changes in Vital Signs (Blood Pressure)	N/A - Use EHR Patient Lists	3B.3	Blood Pressure for kids 3 and older - 80%
Stage 1: Record and Chart Changes in Vital Signs (Height/Length)	N/A - Use EHR Patient Lists	3B.4	Height/length - 80%
Stage 1: Record and Chart Changes in Vital Signs (Weight)	N/A - Use EHR Patient Lists	3B.5	Weight - 80%
Stage 2: Record Smoking Status for patients 13 years and older	Stage 2 – Smoking Status	3B.8	80%
Stage 1: Maintain active medication list	Stage 1 – Medication List	3B.9	80%
Stage 2: Record patient family health history as structured data	Stage 2 – Family Health History	3B.10	20%
Stage 2: Record electronic notes in patient records.	Stage 2 – Electronic Notes	3B.11	<b>Update</b> – Only a screenshot showing capability is required

- Refer to crosswalk above for PCMH factor->PCC MU Report

# PCMH 3D: Use Data For Population Mgt

## Element D: Use Data for Population Management (MUST-PASS)

5.00 points

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:

1. At least two different preventive care services.
2. At least two different immunizations.
3. At least three different chronic or acute care services.
4. Patients not recently seen by the practice.
5. Medication monitoring or alert.

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- Renewals: Documentation is required for 3D
- Identify patients in need of care (Dashboard, recaller, MU report detail)
- Remind patients of needed services (notify, recaller)



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# PCMH 3D.1: Choosing Preventive Care Services

- PCC Dashboard:
  - Patients overdue for well visits
- PCC recaller
  - Adolescents needing depression screening
  - Infants needing developmental screening
  - 4-5 year olds needing vision or 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

# PCMH 3D.1: Preventive Services

**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](#)

- Report well visit rates, overdue listing and trends for kids under 15 months, 15-36mos, 3-6yrs, 7-11yrs, or 12-18yrs.

# PCMH 3D.1: Preventive Services

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  
INACTIVE  
Dismissed  
Transient

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

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-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

96110-EP Developmental Screening-

- Use PCC's recaller to generate lists of overdue patients
- Restrict by procedure or Dx code to focus on patients having certain CPT codes billed or having certain conditions



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# PCMH 3D.2: Choosing Immunization Services

- Dashboard reports:
  - Patients overdue for HPV vaccine
  - Patients overdue for Meningococcal vaccine
  - Patients overdue for Tdap vaccine
  - Asthma patients overdue for seasonal flu vaccine (this can be used as imm measure or chronic/acute measure, but not both)
  - 2 year old patients in need of vaccines
- recaller reports:
  - Patients overdue for seasonal flu vaccine



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# PCMH 3D.2: Immunization Services

## 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.

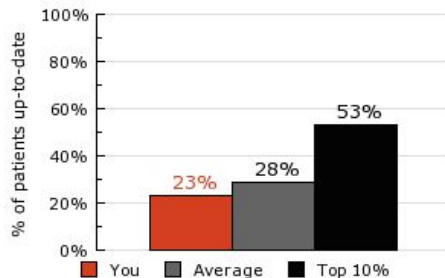
You have **2,665** active patients between 13 years and 17 years of age.

[Click for list of overdue patients](#)

[2,049 of these patients are due for at least one HPV vaccine.](#)

### How You Compare

[View Age and Sex Breakdown](#)



Your Practice

**23%**

PCC Client Average

**29%**

Top Performers

**53%**

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



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# PCMH 3D.2: Immunization Services

Vaccine	Number Needed By Age 2	Total Patients Age 2	Patients Up-to-Date at Age 2	% Up-to-Date at Age 2	Overdue at Age 2
DTaP	4	609	482	79%	<a href="#">127 patients overdue</a>
IPV	3	609	545	89%	<a href="#">64 patients overdue</a>
MMR	1	609	535	88%	<a href="#">74 patients overdue</a>
HIB	3	609	544	89%	<a href="#">65 patients overdue</a>
Hep B	3	609	474	78%	<a href="#">135 patients overdue</a>
Varicella	1	609	531	87%	<a href="#">78 patients overdue</a>
Pneumococcal	4	609	507	83%	<a href="#">102 patients overdue</a>
Hep A	1	609	514	84%	<a href="#">95 patients overdue</a>
Rotavirus	2	609	519	85%	<a href="#">90 patients overdue</a>
Influenza	2	609	351	58%	<a href="#">258 patients overdue</a>
Combo 9 * (Includes All Vaccines Above Except Influenza)	N/A	609	377	62%	232 patients overdue
Combo10 ** (Includes All Vaccines Above)	N/A	609	267	44%	342 patients overdue



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# PCMH 3D.2: Immunization Services

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  
Inactive  
Collection  
Physician Coverage

Exclude by Flag - Match any ONE Patient Flag  
2001-Transferred  
Referred by Another Physician  
Inactive  
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 patients overdue for seasonal flu vaccine, use recaller report



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# PCMH 3D.3: Choosing Chronic/Acute Services

- Dashboard reports:
  - ADHD patients overdue for followup visit
- recaller reports:
  - Asthma patients overdue for checkup
  - Patients with depression overdue for checkup
  - Patients with Obesity overdue for checkup
  - Patients with allergic rhinitis overdue for checkup
- PCC EHR Clinical Quality Measure (CQM) Reports
  - Followup Care for ADHD Patients
  - Asthma patients in need of medication checkup



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# PCMH 3D.3: Chronic/Acute Services

Sample PCC Practice [Logout](#)  
[Change My Password](#)  
[View Dashboard Update Log](#)

ADD/ADHD Patient Followup

Your Score: **86** out of 100

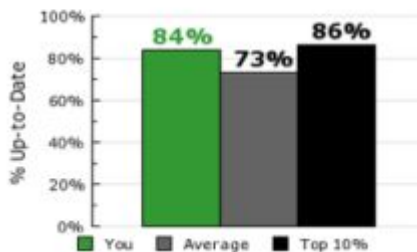
Dashboard reports updated as of 11/30/2013

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

**84%**

PCC Client Average

**73%**

Top Performers

**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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# PCMH 3D.3: Chronic/Acute Services

## PCC EHR CQM Report: ADHD Followup Care for Children Prescribed ADHD Medication

- Use “Details” links to see list of overdue patients who need followup care after starting ADHD medication

Measure#	NQF	Measure	Numerator	Denominator	Performance Rate	Exclusions	Exceptions	Details
CMS136v4	0108	ADHD: Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	N/A	N/A	N/A	N/A	N/A	N/A
		Initiation Phase	6	50	67%	41	N/A	<a href="#">Details</a>
		Continuation and Maintenance Phase	0	7	N/A	7	N/A	<a href="#">Details</a>



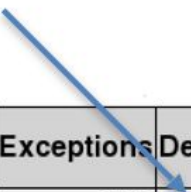
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# PCMH 3D.3: Chronic/Acute Services

## PCC EHR CQM Report: Use of appropriate medications for Asthma

- Use “Details” links to see list of patients with persistent asthma who are in need of medication checkup



Measure#	NQF	Measure	Numerator	Denominator	Performance Rate	Exclusions	Exceptions	Details
CMS126v3	0036	Use of Appropriate Medications for Asthma (Summary)	5	7	71%	0	N/A	<a href="#">Details</a>
		• Stratification 1 - Age 5-11yrs	3	4	75%	0	N/A	<a href="#">Details</a>
		• Stratification 2 - Age 12-18yrs	2	3	67%	0	N/A	<a href="#">Details</a>
		• Stratification 3 - Age 19-50yrs	0	0	N/A	0	N/A	N/A
		• Stratification 4 - Age 51-64yrs	0	0	N/A	0	N/A	N/A



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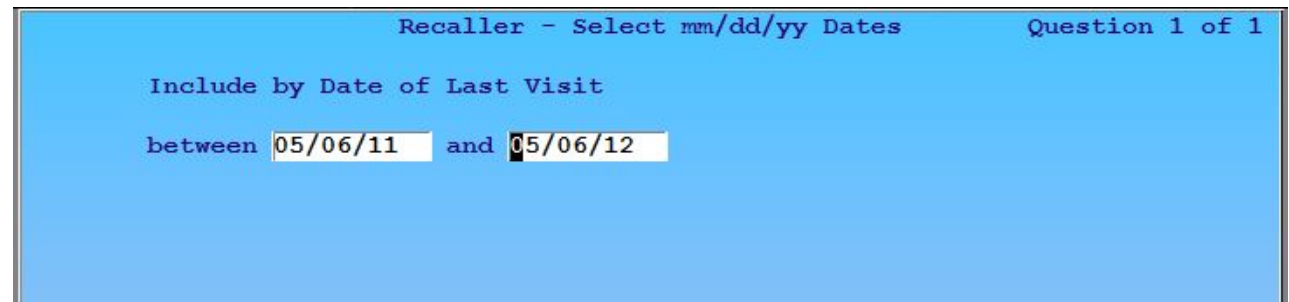
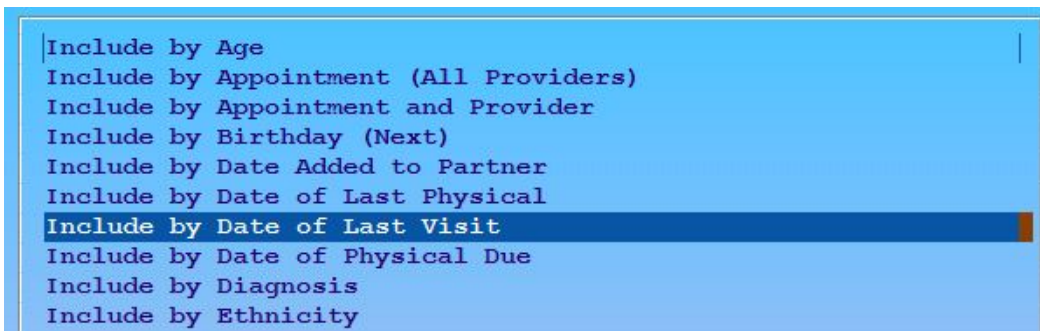
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# PCMH 3D.3: Chronic/Acute Services

- 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

# PCMH 3D.4: Identify Patients Not Recently Seen

Use recaller restricting by “Date of last visit”



# PCMH 3D.5: Identify Patients On Specific Medication(s)

**Add Patient List**

Patient List Name:

Time Range for Criteria:

☐ From patient's birth through today

☐ From  to

☒ Within the past

☐ From   ago through   ago

**Criteria:**

**Demographics:** Select a criterion and then click Add.

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

**Medications:**

The Patient

OR The Patient

OR The Patient

OR The Patient

- Use EHR Patient Lists reporting restricted by medication



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# PCMH 3E: Implement Evidence-Based Decision Support

## Element E: Implement Evidence-Based Decision Support

4.00 points

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. (CRITICAL FACTOR) +
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. +

Yes No

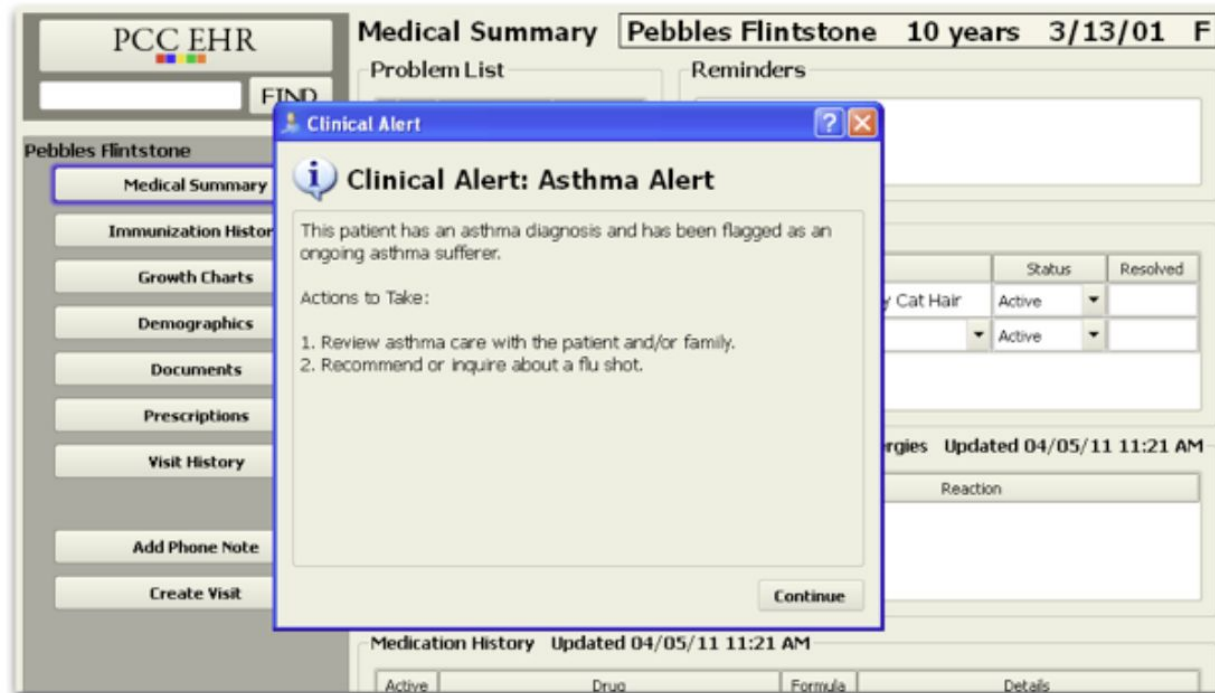
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- Renewals: Documentation is not required for 3E

# PCMH 3E: 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 protocols
- Consider using **Pediatric Obesity** for 3E.4 (related to unhealthy behaviors)
- Consider asthma, otitis media, or allergic rhinitis for 3E.2 and/or 3E.3 (related to chronic or acute condition)

# PCMH 3E: Implement Evidence-Based Decision Support



- Example: Point of care reminders



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# PCMH 3E: Implement Evidence-Based Decision Support

## Element E: Implement Evidence-Based Decision Support

4.00 points

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. (CRITICAL FACTOR) +
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. +

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- Example: Prescribing generic vs brand name Rx (Use “Drug Volume” report in PCC eRx)

# PCMH 4: Care Management and Support

Points	Standard/Element	Must-Pass = 50% Score
20	<b>PCMH 4: Care Management and Support</b>	
4	Element A Identify Patients for Care Management	
4	Element B Care Planning and Self-Care Support	✓
4	Element C Medication Management	
3	Element D Use Electronic Prescribing	
5	Element E Support Self-Care and Shared Decision Making	

- The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

# PCMH 4A: Identify Patients For Care Management

## Element A: Identify Patients for Care Management

4.00 points

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

Yes No

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) ☐ ☐

- Renewals: Documentation is required for 4A



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# PCMH 4A: Identify Patients for Care Management

- Add “Care Management” flag for patients needing care management
- Create clinical alerts reminding clinicians when working with these patients

# PCMH 4A: 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

Inactive

Collection

Physician Coverage

Exclude by Flag - Match any ONE Patient Flag

2001-Transferred

Referred by Another Physician

Inactive

Unborn

Include by Flag - Match any ONE Patient Flag

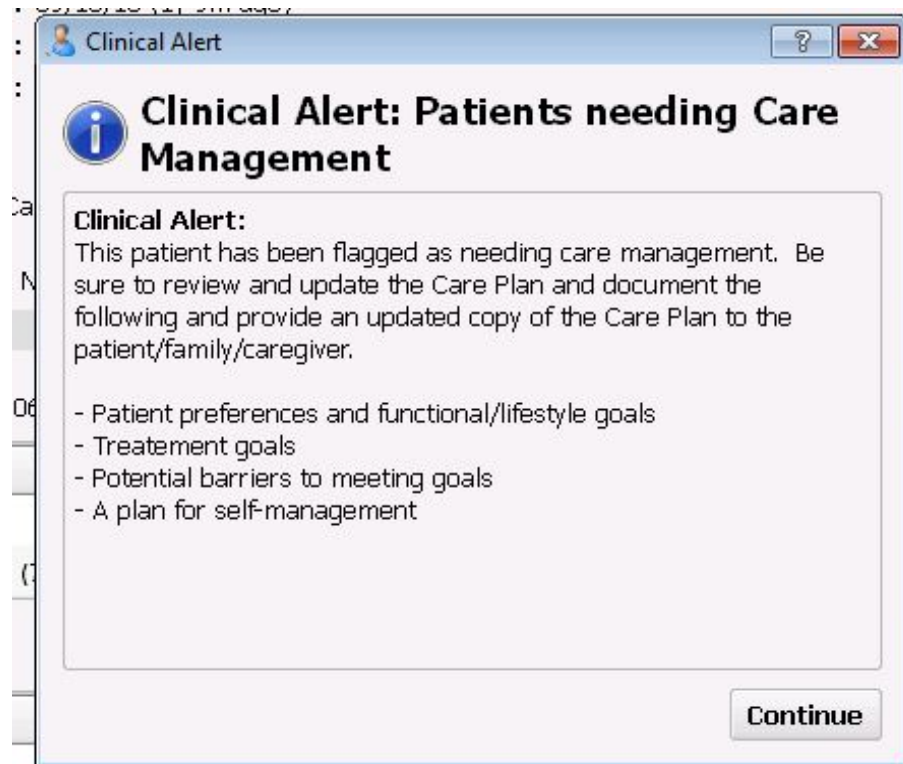
Care Management

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



# PCMH 4A: Identify Patients for Care Management

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



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# PCMH 4A: Identify Patients For Care Management

## Element A: Identify Patients for Care Management

4.00 points

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)

Yes

No

☐☐☐☐☐☐☐☐☐☐☐☐

- Renewals: Documentation is required for 4A



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# PCMH 4A: Identify Patients For Care Management

- 4A.2 – Contact PCC for help with a 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
Jonathan	Wells	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



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# PCMH 4B: Care Planning

## Element B: Care Planning and Self-Care Support (MUST PASS)

4.00 points

The 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:

Yes No

1. Incorporates patient preferences and functional/lifestyle goals.

☐☐

2. Identifies treatment goals.

☐☐

3. Assesses and addresses potential barriers to meeting goals.

☐☐

4. Includes a self-management plan.

☐☐

5. Is provided in writing to the patient/family/caregiver.

☐☐

- Renewals: Documentation is required for 4B
- Use PCC Care Plan functionality
- Use NCQA Record Review Workbook to track and report results



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# PCMH 4B: Care Planning

**PCC EHR**

**Pebbles Flintstone\*** PCC# 3336

Medical Summary  
Demographics  
History  
Prescriptions

Visit: 02/10/14  
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 Seagley 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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# PCMH 4C: Medication Management

## Element C: Medication Management

4.00 points

The practice has a process for managing medications, and systematically implements the process in the following ways:

	Yes	No
1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions.+ (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>
2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	<input type="checkbox"/>	<input type="checkbox"/>
3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.	<input type="checkbox"/>	<input type="checkbox"/>
4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.	<input type="checkbox"/>	<input type="checkbox"/>
5. Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.	<input type="checkbox"/>	<input type="checkbox"/>
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.	<input type="checkbox"/>	<input type="checkbox"/>

- Renewals: Documentation is required for 4C
- Use PCC's "Medication Reconciliation" MU report

# PCMH 4C: Medication Management

- 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



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# PCMH 5: Care Coordination and Care Transitions

Points	Standard/Element	Must-Pass = 50% Score
18	PCMH 5: Care Coordination and Care Transitions	
6	Element A Test Tracking and Follow-Up	
6	Element B Referral Tracking and Follow-Up	✓
6	Element C Coordinate Care Transitions	

- The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

# PCMH 5A: Test Tracking and Follow-up

## Element A: Test Tracking and Follow-Up

6.00 points

The practice has a documented process for and demonstrates that it:	Yes	No	NA
1. Tracks lab tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>	
3. Flags abnormal lab results, bringing them to the attention of the clinician.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Flags abnormal imaging results, bringing them to the attention of the clinician.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Notifies patients/families of normal and abnormal lab and imaging test results.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. More than 30 percent of laboratory orders are electronically recorded in the patient record. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. More than 30 percent of radiology orders are electronically recorded in the patient record. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. More than 10 percent of scans and tests that result in an image are accessible electronically.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Renewals:  
Documentation is not required for 5A
- Autocredit for 5A. 1 – 5A.4 for clients using PCC EHR
- Use PCC MU Reports for 5A.7 - 5A.9



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# PCMH 5B: Referral Tracking and Follow-up

## Element B: Referral Tracking and Follow-Up (MUST-PASS) 6.00 points

The practice:	Yes	No	NA
1. Considers available performance information on consultants/specialists when making referral recommendations.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Maintains formal and informal agreements with a subset of specialists based on established criteria.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Maintains agreements with behavioral healthcare providers.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Integrates behavioral healthcare providers within the practice site.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.	<input type="checkbox"/>	<input type="checkbox"/>	
7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>	
9. Documents co-management arrangements in the patient's medical record.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Asks patients/families about self-referrals and requesting reports from clinicians.	<input type="checkbox"/>	<input type="checkbox"/>	

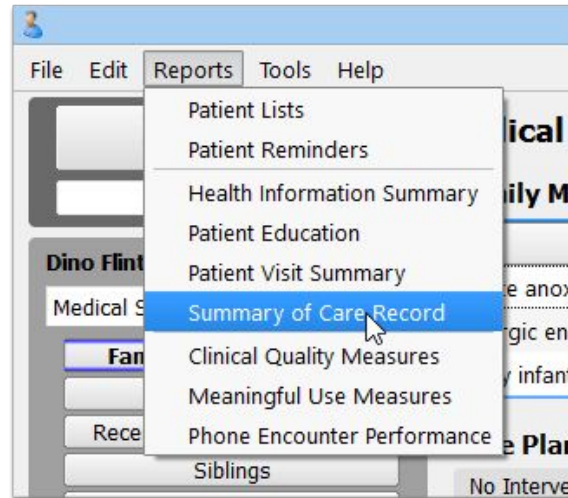
- Renewals:  
Documentation is required for 5B

- Use PCC MU Report "Summary of Care (Transmitted)" for 5B.7

- Requirement updated to be "more than 10%" to match MU changes

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# PCMH 5B.7: Summary of Care



- The PCC Summary of Care Record report produces a C-CDA-formatted chart summary for a patient.
- Use this report as a transition of care document. Can be printed, saved as .pdf or sent to another clinician or practice via Direct Secure Messaging

# PCMH 5B.7: Summary of Care

Summary of Care Record

### Summary of Care Record

#### Continuity of Care Document

<b>Patient</b>	Pebbles Flintstone
<b>Date of birth</b>	September 20, 2005
<b>Sex</b>	Female
<b>Race</b>	White
<b>Ethnicity</b>	Not Hispanic or Latino
<b>Contact info</b>	Home: 15 Quarry Lane Winooski, VT 05404, US
<b>Patient IDs</b>	3336 2.16.840.1.113883.3.2402.400.100.2
<b>Document Id</b>	76655ae0-499d-4cf4-b4f7-060ea5828b17
<b>Document</b>	October 13, 2015, 12:14:17 -0400

Select a referral or outbound transition of care:

select referral or outbound transition of care

- Related to an outbound transition of care
- 10/12/15 Referral: Audiology
- 07/11/09 Referral: Dermatology
- Not related to a transition of care

☐ Save as a C-CDA file

Cancel Print

Select from the patient's referrals

☐ Print

☐ Save as a PDF file

☐ Save as a C-CDA file

☒ Send via Direct Secure Messaging:

To: test@testpeds.updoox.test.com

Subject: Transition of Care C-CDA for Patient Dino Flintstone

Message: Dr. Test,  
Attached is the summary of care for patient Dino Flintstone. It includes all relevant patient data from the chart.

Cancel Send

- Transmit Summary of Care Record via Direct Secure Messaging
- Contact PCC Support for assistance with getting DSM configured and working

# PCMH 5B.8: Tracking and Following Up on Referrals

**Edit Order - Referral Orders - Audiology**

**Edit Order - Referral Orders** Heather Dile 5 years 3/26/09 F

**Audiology** Ordered

Note: needs further hearing tests ASAP

☐ Signature Required ☐ Canceled ☒ Include on Patient Reports

Initial task marked as completed once

TASK Referral Needed appointment scheduled and clinical information sent to specialist. TO Referral

NOTE scheduled visit w/ Dr. Johnson audiologist for Fri 4/11 at 10:30am.

☒ Task Completed AT 04/08/14 9:20am BY Referral

TASK Confirm Outcome TO Referral

NOTE report expected by 4/16

☐ Task Completed AT mm/dd/... 12:00am BY enter user name

New task created to confirm outcome later w/ required timing for receiving report

- Refer to [referral tracking workflow](#) documented in PCMH WIKI
- Consider prioritizing referral tasks within the task names (Example: Confirm Outcome P1, Confirm Outcome P2, etc)



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# PCMH 5B.8: Tracking and Following Up on Referrals

**Edit Order - Referral Orders - Occupational Therapy**

**Edit Order - Referral Orders** **Dino Flintstone 4 yrs, 2 mos 1/15/10 M**

**Occupational Therapy** **Ordered**

Note: concerns about probable autism. Refer to PDC

☐ Signature Required ☐ Canceled ☒ Include on Patient Reports

TASK: Referral Needed TO: Referral

NOTE: Wilma wanted to contact PDC herself....gave info and will check back in a couple weeks

☒ Task Completed AT: 04/08/14 8:25am BY: PCC PCC

TASK: Confirm Outcome TO: Referral

NOTE: checked in w/ Wilma to see if she has visited PDC. Wilma says they have a visit scheduled on 4/21. Will check back after that.

☒ Task Completed AT: 04/08/14 11:34am BY: PCC PCC

Referral clerk adds note indicating they followed up. This task is marked as completed and a new task is opened to follow up again later.

TASK: Confirm Outcome TO: Referral

NOTE: enter task notes here

☐ Task Completed AT: mm/dd/... 12:00am BY: enter user name

- Refer to [referral tracking workflow](#) documented in PCMH WIKI



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# PCMH 6: Performance Measurement and QI

Points	Standard/Element	Must-Pass = 50% Score
20	<b>PMCH 6: Performance Measurement and Quality Improvement</b>	
3	Element A Measure Clinical Quality Performance	
3	Element B Measure Resource Use and Care Coordination	
4	Element C Measure Patient/Family Experience	
4	Element D Implement Continuous Quality Improvement	✓
3	Element E Demonstrate Continuous Quality Improvement	
3	Element F Report Performance	
Not Scored	Element G Use Certified EHR Technology	

- The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

# PCMH 6A: Measure Performance

## Element A: Measure Clinical Quality Performance

3.00 points

At least annually, the practice measures or receives data on:

Yes No

1. At least two immunization measures.

☐ ☐

2. At least two other preventive care measures.

☐ ☐

3. At least three chronic or acute care clinical measures.

☐ ☐

4. Performance data stratified for vulnerable populations (to assess disparities in care).

☐ ☐

- Renewals: Documentation is not required for 6A
- Use measures included on new Dashboard PCMH page
- Refer to measures you chose for 3D

# PCMH 6A: Measure Performance

## Element A: Measure Clinical Quality Performance

3.00 points

At least annually, the practice measures or receives data on:

Yes No

1. At least two immunization measures.

☐ ☐

2. At least two other preventive care measures.

☐ ☐

3. At least three chronic or acute care clinical measures.

☐ ☐

4. Performance data stratified for vulnerable populations (to assess disparities in care).

☐ ☐

- Vulnerable population reporting on new Dashboard PCMH page

# PCMH 6A.4: Vulnerable Population Breakdown

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
Medicaid	92	38	41%
Aetna	291	166	57%
Blue Cross/Blue Shield	869	538	62%
Cigna	186	119	64%
GHI-CBP	392	202	52%
Oxford	206	108	52%
United Healthcare	331	194	59%
1199 National	115	67	58%
Other	5	3	60%
Empire Metrop.Life Insurance	748	440	59%
Self Pay	97	43	44%
Magnacare	100	56	56%
Multiplan	2	1	50%
Hip	95	71	75%
Great West	2	1	50%

- Define your vulnerable population and use Dashboard report
- Vulnerable population options:
  - Primary Insurance
  - Race
  - Ethnicity
  - Preferred Language



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# PCMH 6B: Measure Resource Use

## Element B: Measure Resource Use and Care Coordination

3.00 points

At least annually, the practice measures or receives quantitative data on:

Yes No

1. At least two measures related to care coordination.

☐ ☐

2. At least two utilization measures affecting health care costs.

☐ ☐

- Renewals: Documentation is required for 6B
- Contact PCC for assistance with these reports:
  - Custom srs report showing 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



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# PCMH 6B: Measure Resource Use

- 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 your practice.
- [Periodic Report](#): note recent prescription activity for this provider.
- [Pharmacy Report](#): display entire practice pharmacy list for printing

**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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# PCMH 6B: Measure Resource Use

Drug Volume Report for All Providers from 11/19/2013 to 12/19/2013		
Group		Volume
All	Generic drugs begin with	772
Drugs	a lower-case letter	
amoxicillin	Utilization	89
Concerta		83
Adderall XR	Brand-name drugs are	36
Vyvanse	capitalized.	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 vs Brand Rx reporting

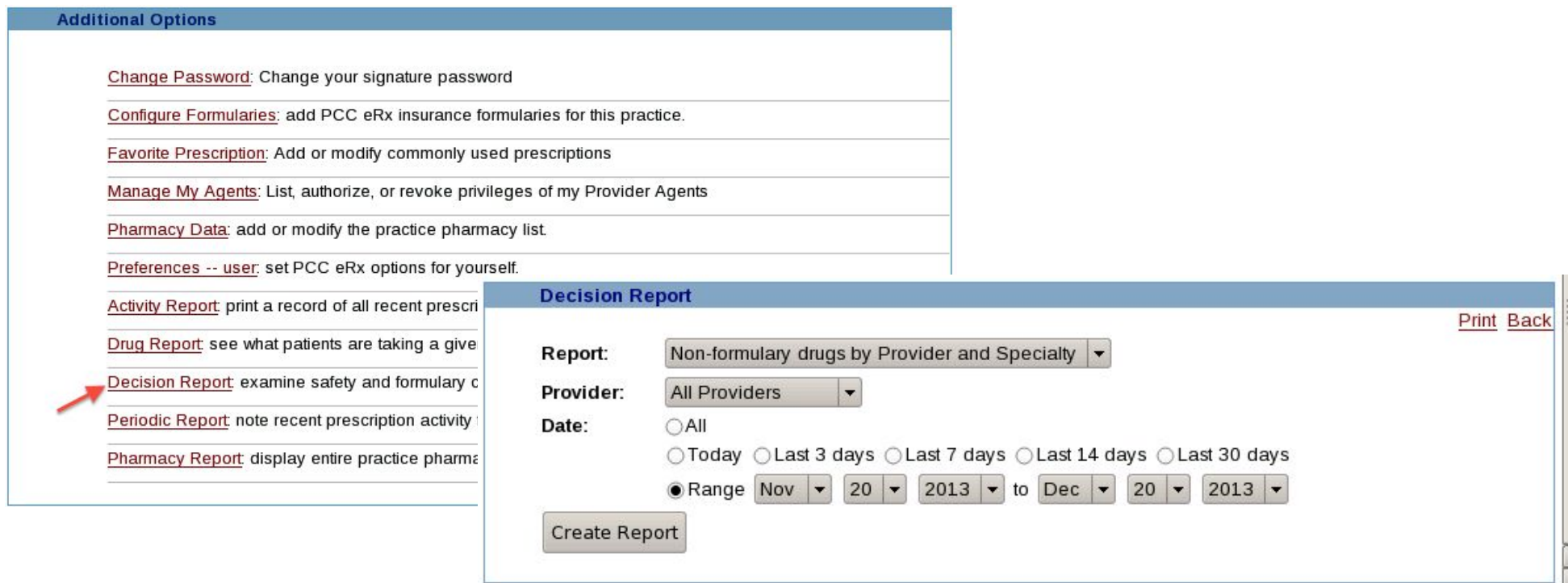


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# PCMH 6B: Measure Resource Use

- 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 prescriptions
- [Drug Report](#): see what patients are taking a given drug
- [Decision Report](#): examine safety and formulary compliance
- [Periodic Report](#): note recent prescription activity
- [Pharmacy Report](#): display entire practice pharmacy list

**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



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# PCMH 6B: Measure Resource Use

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

# PCMH 6E: Demonstrate Improvement

## Element E: Demonstrate Continuous Quality Improvement

3.00 points

The practice demonstrates continuous quality improvement by:

1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D.

2. Achieving improved performance on at least two clinical quality measures.

3. Achieving improved performance on one utilization or care coordination measure.

4. Achieving improved performance on at least one patient experience measure.

Yes No

☐ ☐☐ ☐☐ ☐☐ ☐

- Renewals: Documentation is required for 6E
- Use Dashboard PCMH page to see 3-month trend for each measure



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# PCMH 6E.2: Demonstrate Improvement

Factor 6A.2 - At least two preventive care measures

Measure	Qualifying Patients	Up-to-Date Patients	% Up-to-Date	% Change (3 mo.)
<a href="#">Developmental Screening Rates - Adolescents</a>	2,570	2,399	93%	-0.5% ↓
<a href="#">Developmental Screening Rates - Infants</a>	937	695	74%	1.1% ↑
<a href="#">Fluoride Varnish Rate</a>	3,590	2,268	63%	-1.0% ↓
<a href="#">Well Visit Rates - Under 15 Months</a>	1,659	1,252	75%	-1.0% ↓
<a href="#">Well Visit Rates - 15-36 Months</a>	1,754	1,143	65%	6.0% ↑
<a href="#">Well Visit Rates - 3-6 Years</a>	3,770	2,298	61%	0.0% ↑
<a href="#">Well Visit Rates - 7-11 Years</a>	4,349	2,171	50%	0.0% ↑
<a href="#">Well Visit Rates - 12-21 Years</a>	5,166	2,153	42%	1.0% ↑

- Look at “% change” and report on measures where you’ve improved

# PCMH 6F: Report Performance

## Element F: Report Performance

3.00 points

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

1. Individual clinician performance results with the practice.
2. Practice-level performance results with the practice.
3. Individual clinician or practice-level performance results publicly.
4. Individual clinician or practice-level performance results with patients.

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- Renewals: Documentation is not required for 6F
- Use Dashboard PCMH page to see breakdown by provider (PCP) for certain measures

# PCMH 6F: Report Performance

Factor 6F.1 - Report performance by individual clinician within the practice

Measure:

ADD/ADHD Patient Followup



ADD/ADHD Patient Followup			
Primary Care Provider	Qualifying Patients	Up-to-Date Patients	% Up-to-Date
Provider 2	287	219	76%
Provider 6	55	45	82%
Provider 34	1	1	100%
Provider 9	59	45	76%
Provider 21	3	2	67%
Provider 3	35	28	80%
Provider 18	16	14	88%
Provider 28	3	2	67%
Provider 38	1	1	100%
Provider 13	53	43	81%
Provider -1	2	1	50%

- Includes provider breakdown for the following measures:  
ADD/ADHD Patient Followup, Developmental Screening Rates,  
Well Visit Rates, and Influenza vaccination for asthma patients



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# **Review of PCC's PCMH Resources**

# PCC PCMH Resources

<http://pcmh.pcc.com>

- Documentation and examples of relevant PCC reports and functionality related to 2014 standards
- Also includes other NCQA resources
- PCC Pre-validation
  - 7.5 auto-credits that you can attest to for using PCC software
  - Contact PCC for “Letter of Product Implementation”

# PCC PCMH Resources

- PCC/PCS PCMH Program Project Management and PCMH Consulting Packages

<http://www.theverdengroup.com/our-services/patient-centered-solutions-services/>

- Contact PCC Support

Thank you!

Tim Proctor  
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