PCC Resources For PCMH

Tim Proctor

Users Conference 2016

PCC Pediatric EHR Solutions

Control Your Future™

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

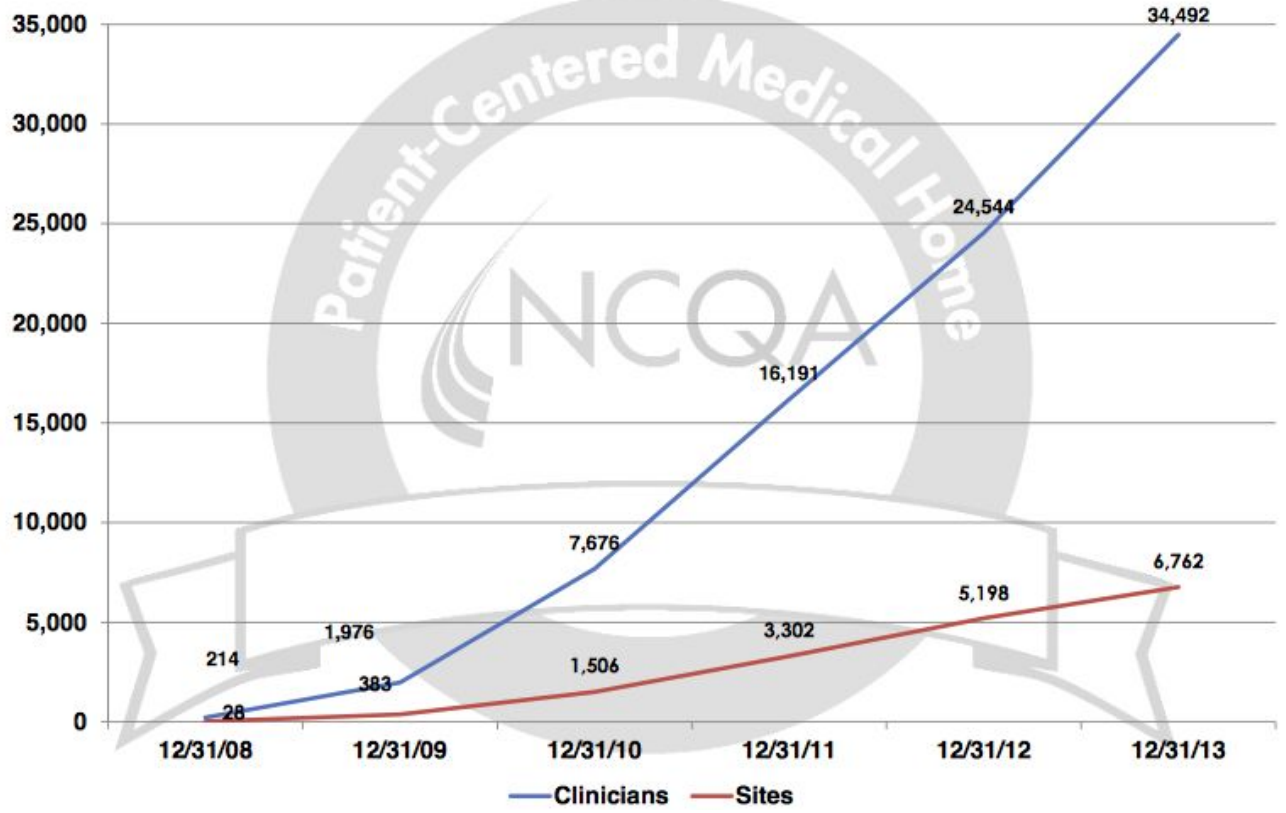
Current State of PCMH

- 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

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

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

PCC Pediatric EHR Solutions

Control Your Future™

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

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

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

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

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

PCC's PCMH Resources
(http://pcmh.pcc.com)

PCC Pediatric EHR Solutions

Control Your Future™

PCMH Reporting Examples

PCC Pediatric EHR Solutions

Control Your Future™

PCMH 1: Patient-Centered Access

Points	Standard/Element	Must-Pass = 50% Score
10	**PMCH 1: Patient-Centered Access**	
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

Providing Same-Day Appointments

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

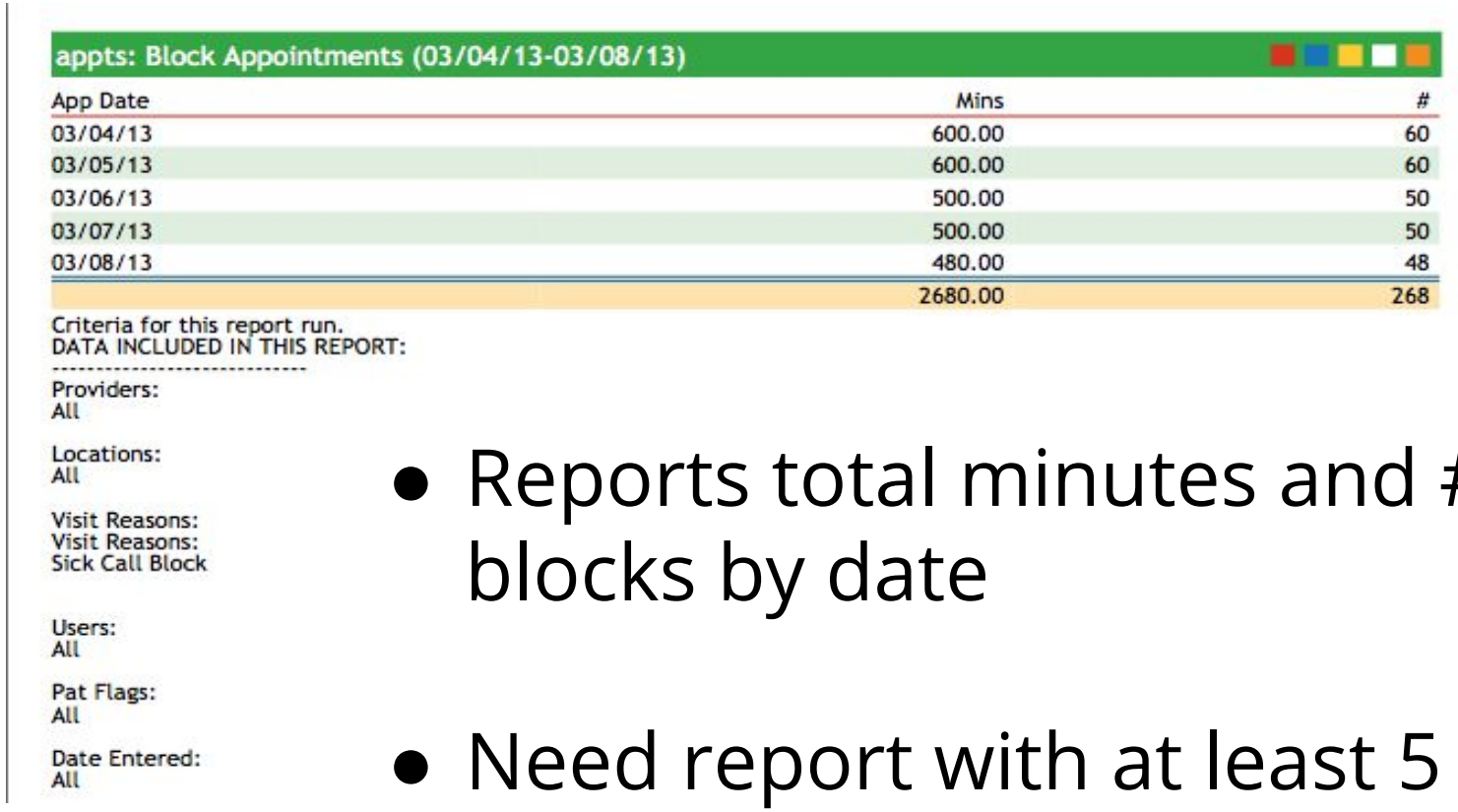
PCC Pediatric EHR Solutions

Control Your Future™

Providing Same-Day Appointments

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

Providing Same-Day Appointments



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

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

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

Providers:
All

Locations:
All

Visit Reasons:
Visit Reasons:
Sick Call Block

Users:
All

Pat Flags:
All

Date Entered:
All

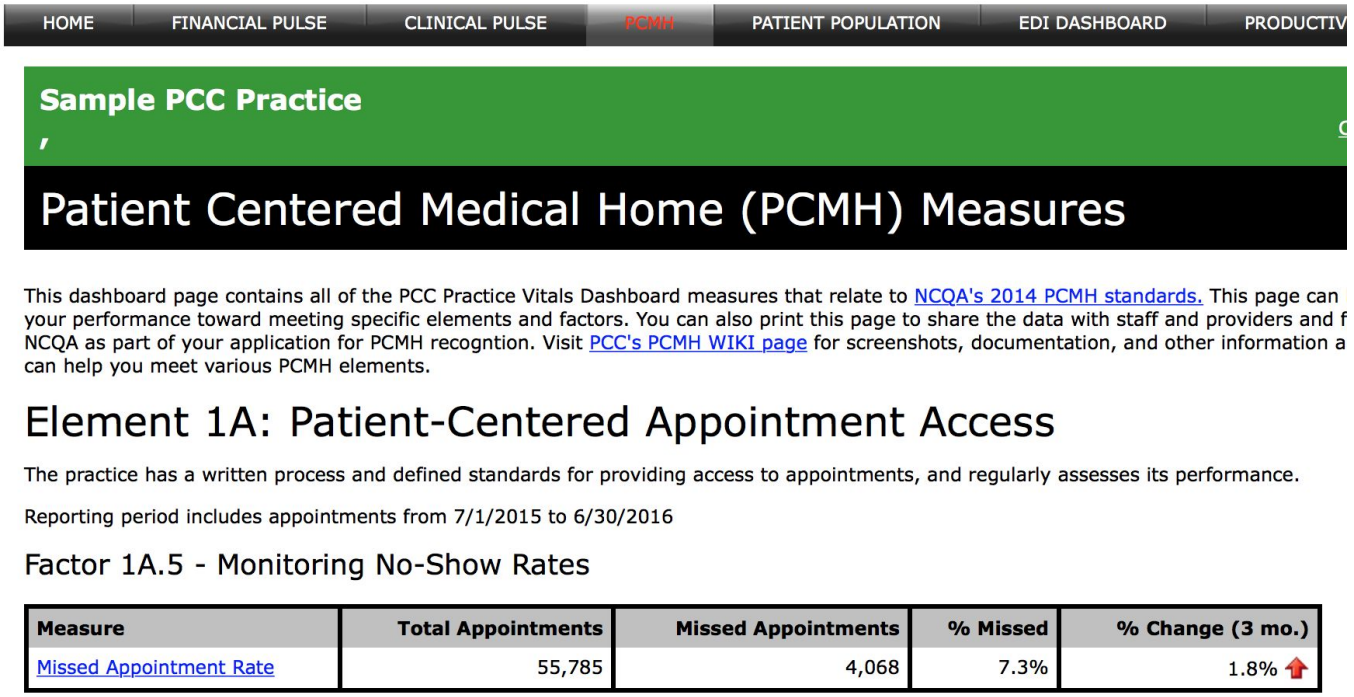
- Reports total minutes and # of sick blocks by date
- Need report with at least 5 days of data

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:	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 Dashboard or srs Appointment Report - “Appointment Totals by Status”

Dashboard Missed Appointment Rate



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

PCC Pediatric EHR Solutions

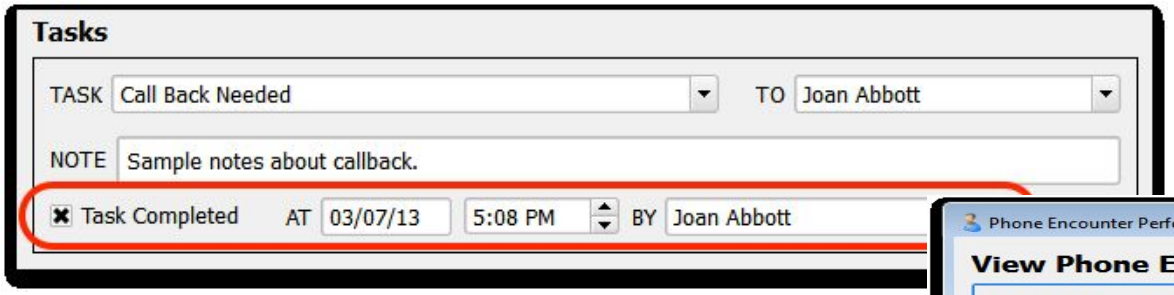
Control Your Future™

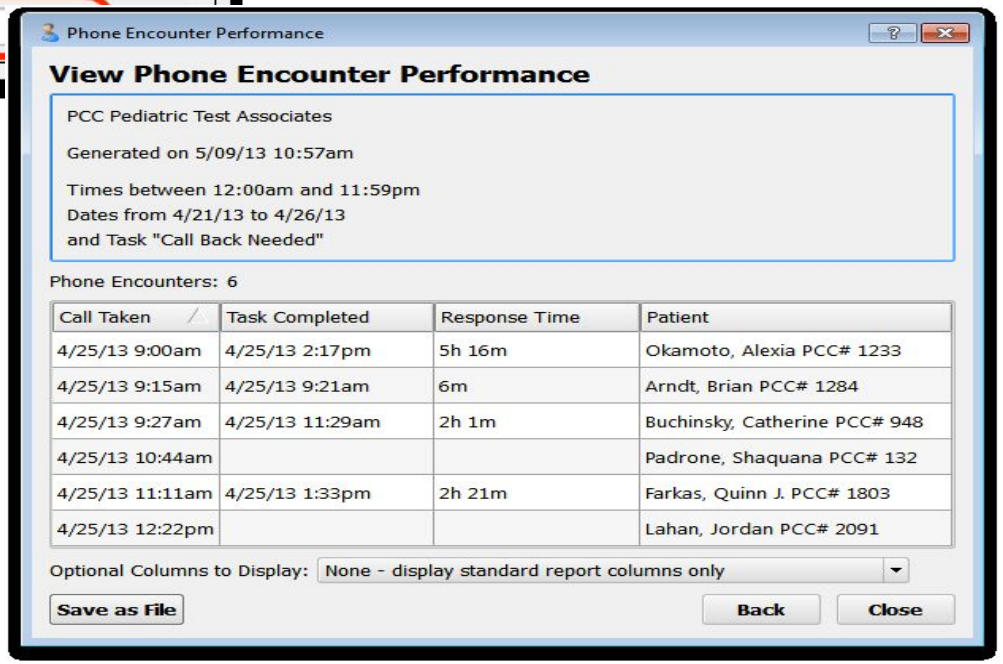
Timely Clinical Advice By Telephone

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:	**Yes**	**No**	**NA**
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.	☐	☐	

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

Timely Clinical Advice By Telephone





- PCC EHR → Reports → Phone Encounter Performance Report

- Run for at least 7 calendar days including times when office is open and closed

PCC Pediatric EHR Solutions

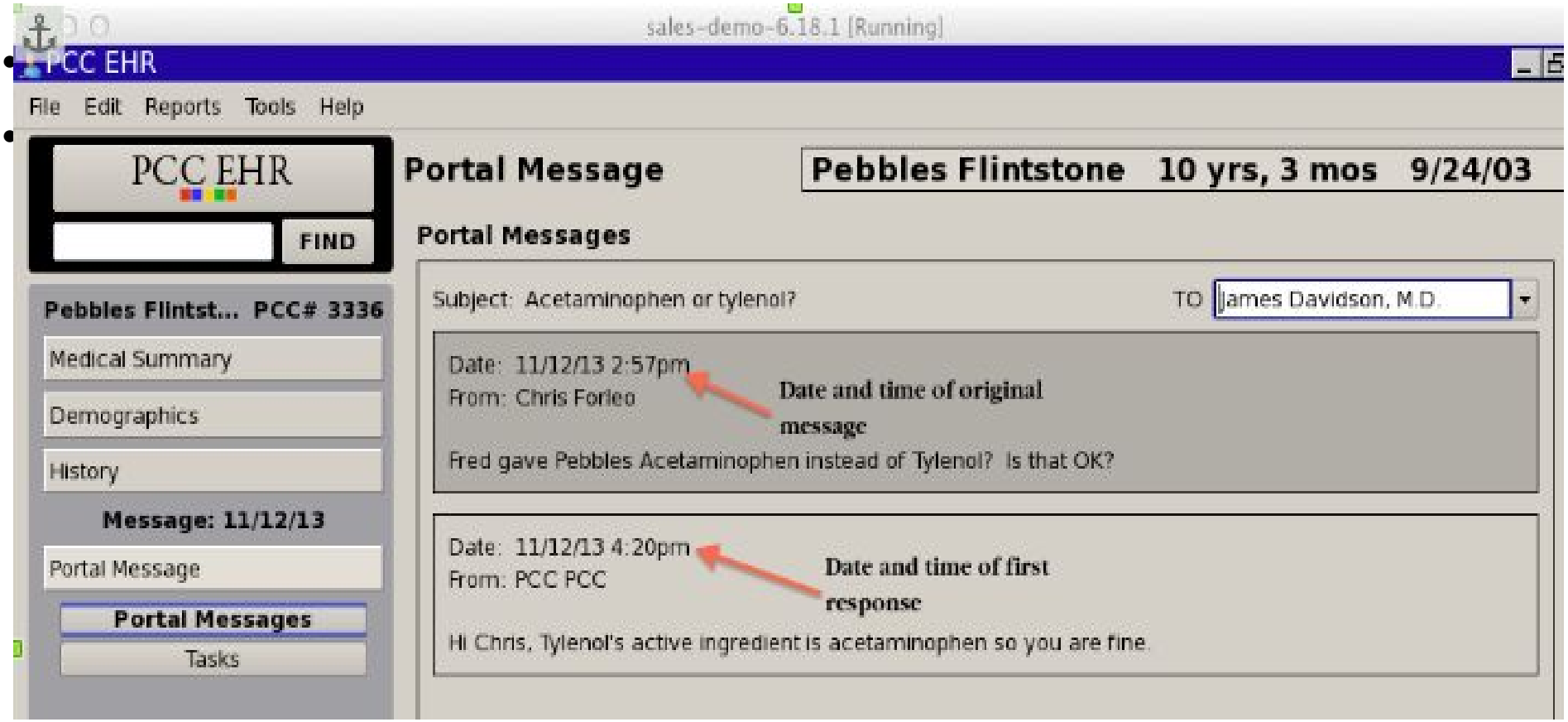
Control Your Future™

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:	**Yes**	**No**	**NA**
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.

Timely Clinical Advice By Secure Electronic Msg



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. +	☐	☐	
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. +	☐	☐	☐
3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits.	☐	☐	
4. A secure message was sent by more than 5 percent of patients. +	☐	☐	☐
5. Patients have two-way communication with the practice.	☐	☐	
6. Patients can request appointments, prescription refills, referrals and test results.	☐	☐	

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

PCC Pediatric EHR Solutions

Control Your Future™

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	Update – 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	Update – 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	Update – 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

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:	Yes	No
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.	☐	☐

- 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

Monitoring % of Visits With Selected Clinician

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

- Report based on srs appointment report
- Contact PCC support for assistance with generating this spreadsheet
- There is no expected % to reach for this factor

PCC Pediatric EHR Solutions

Control Your Future™

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.	☐	☐	
2. Assessing the language needs of its population.	☐	☐	
3. Providing interpretation or bilingual services to meet the language needs of its population.	☐	☐	
4. Providing printed materials in the languages of its population.	☐	☐	☐

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

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 Preferr		% 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 Oth	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	**Total Result**	**1968**			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%		**Total Result**	**1968**	
27	Not Hispanic or Latino	1296	66%				
28	Prefers not to answer	107	5%				
29	**Total Result**	**1968**					

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.	☐	☐	
2. Assessing the language needs of its population.	☐	☐	
3. Providing interpretation or bilingual services to meet the language needs of its population.	☐	☐	
4. Providing printed materials in the languages of its population.	☐	☐	☐

- 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.	☐	☐	
2. Sex.	☐	☐	
3. Race.	☐	☐	
4. Ethnicity.	☐	☐	
5. Preferred language.	☐	☐	
6. Telephone numbers.	☐	☐	
7. E-mail address.	☐	☐	
8. Occupation (NA for pediatric practices).	☐	☐	☐
9. Dates of previous clinical visits.	☐	☐	
10. Legal guardian/health care proxy.	☐	☐	
11. Primary caregiver.	☐	☐	
12. Presence of advance directives (NA for pediatric practices).	☐	☐	☐
13. Health insurance information.	☐	☐	
14. Name and contact information of other health care professionals involved in patient's care.	☐	☐	

- 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

PCC Pediatric EHR Solutions

Control Your Future™

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%

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.	☐	☐	
2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.	☐	☐	
3. Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.	☐	☐	☐
4. Height/length for more than 80 percent of patients.	☐	☐	
5. Weight for more than 80 percent of patients.	☐	☐	
6. System calculates and displays BMI.	☐	☐	
7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0–20 years) (NA for adult practices).	☐	☐	☐
8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.	☐	☐	☐
9. List of prescription medications with date of updates for more than 80 percent of patients.	☐	☐	
10. More than 20 percent of patients have family history recorded as structured data.	☐	☐	
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.	☐	☐	

- 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

PCC Pediatric EHR Solutions

Control Your Future™

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	Update – Only a screenshot showing capability is required

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

PCMH 3D: Use Data For Population Mgt

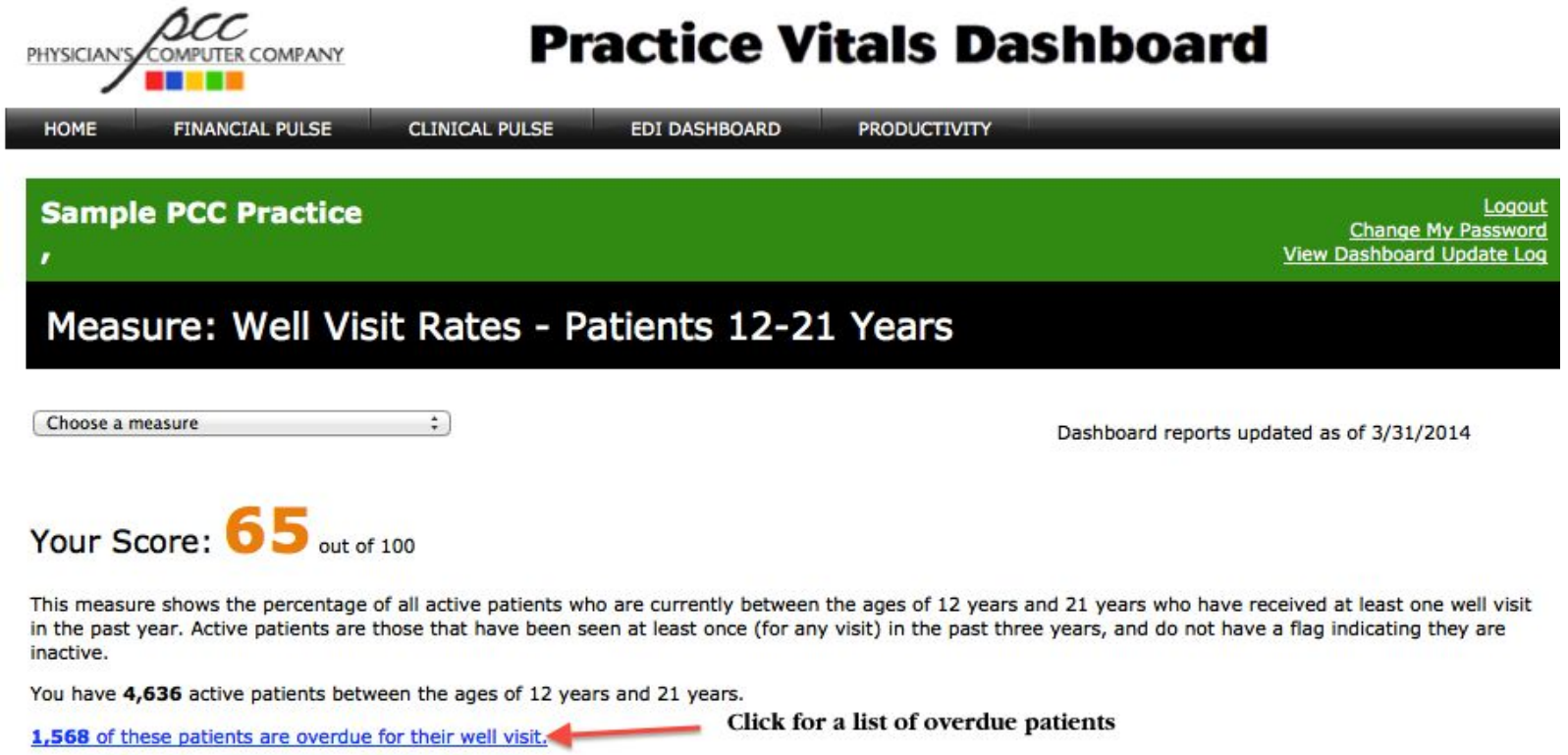
Element D: Use Data for Population Management (MUST-PASS)		5.00 points
At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines, including:	Yes	No
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.	☐	☐

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

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

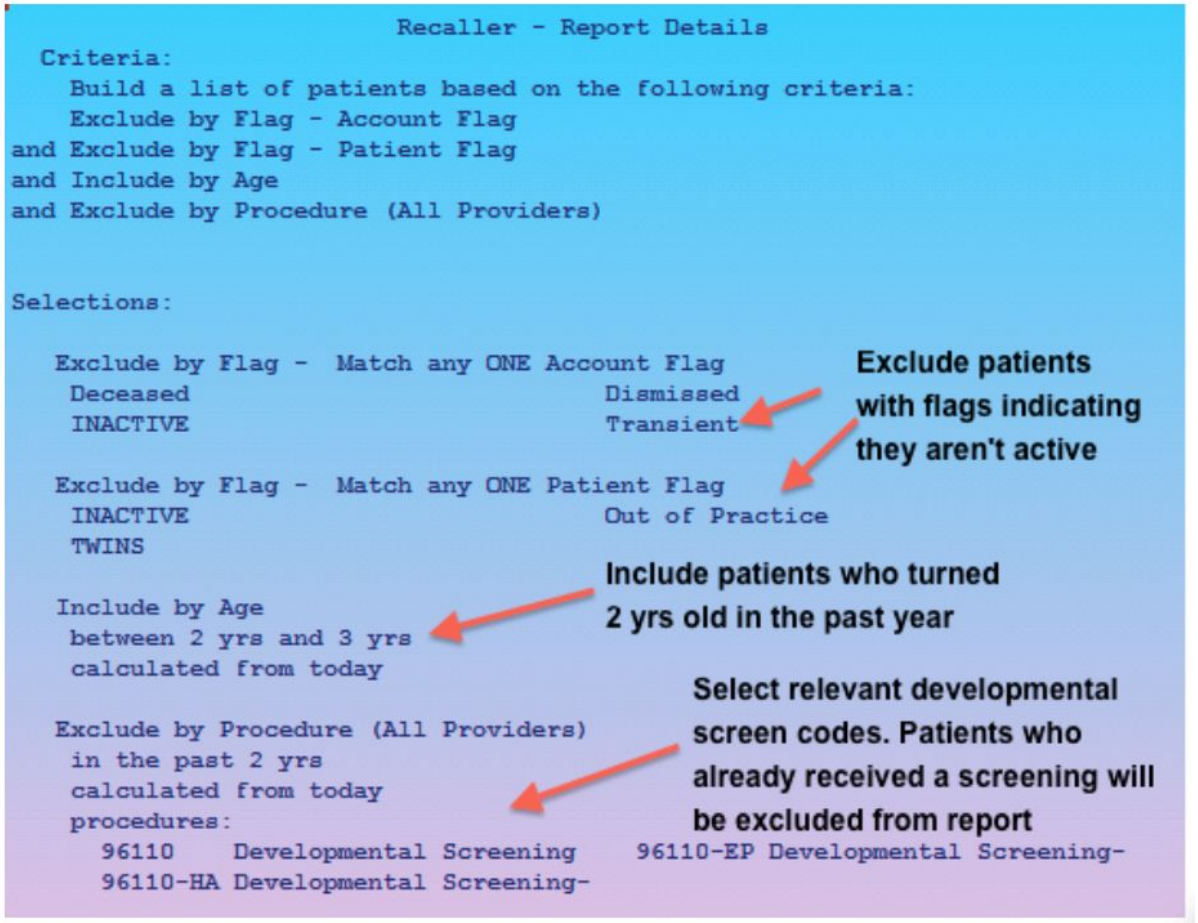


- Report well visit rates, overdue listing and trends for kids under 15 months, 15-36mos, 3-6yrs, 7-11yrs, or 12-18yrs.

PCC Pediatric EHR Solutions

Control Your Future™

PCMH 3D.1: Preventive Services



- 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

PCC Pediatric EHR Solutions

Control Your Future™

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

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.

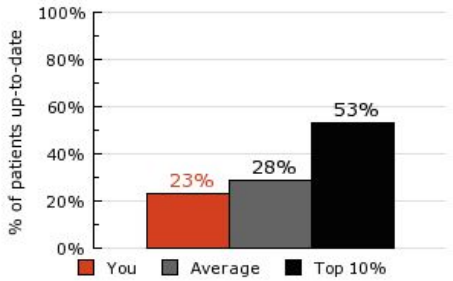
You have **2,665** active patients between 13 years and 17 years of age.

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	PCC Client Average	Top Performers
23%	29%	53%

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

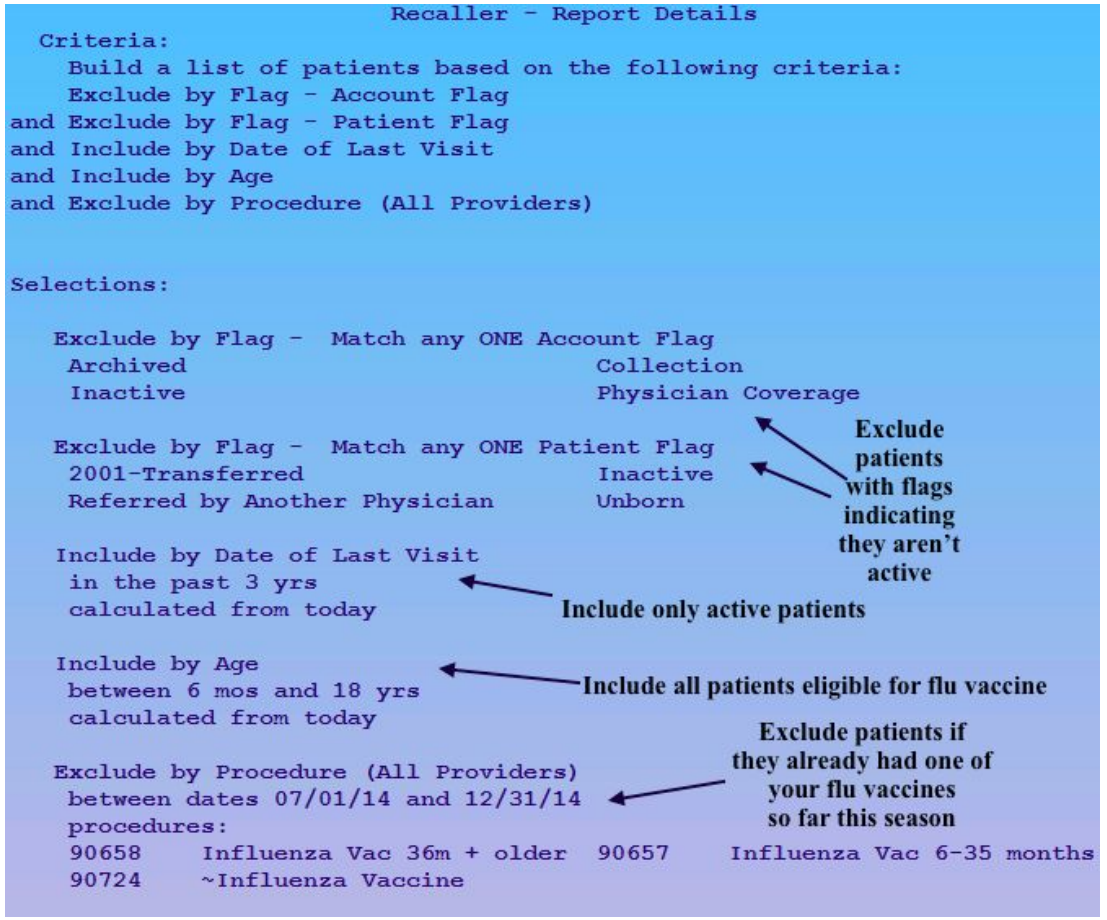
PCC Pediatric EHR Solutions

Control Your Future™

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%	127 patients overdue
IPV	3	609	545	89%	64 patients overdue
MMR	1	609	535	88%	74 patients overdue
HIB	3	609	544	89%	65 patients overdue
Hep B	3	609	474	78%	135 patients overdue
Varicella	1	609	531	87%	78 patients overdue
Pneumococcal	4	609	507	83%	102 patients overdue
Hep A	1	609	514	84%	95 patients overdue
Rotavirus	2	609	519	85%	90 patients overdue
Influenza	2	609	351	58%	258 patients overdue
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

PCMH 3D.2: Immunization Services



- For listing of patients overdue for seasonal flu vaccine, use recaller report

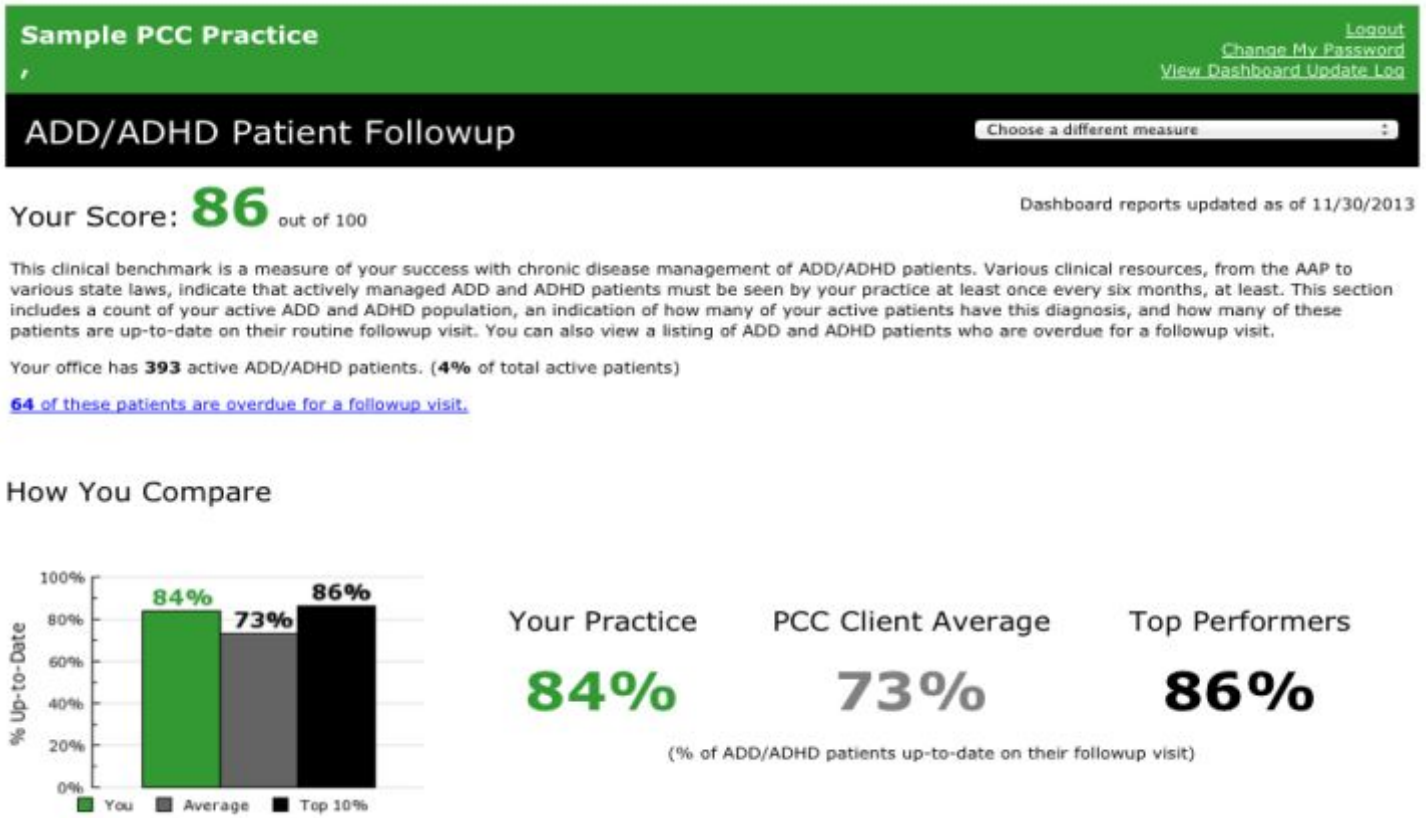
PCC Pediatric EHR Solutions

Control Your Future™

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

PCMH 3D.3: Chronic/Acute Services



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

PCC Pediatric EHR Solutions

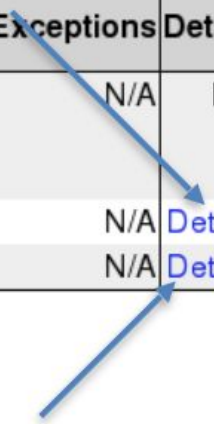
Control Your Future™

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	Details
		Continuation and Maintenance Phase	0	7	N/A	7	N/A	Details



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	Details
		• Stratification 1 - Age 5-11yrs	3	4	75%	0	N/A	Details
		• Stratification 2 - Age 12-18yrs	2	3	67%	0	N/A	Details
		• 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

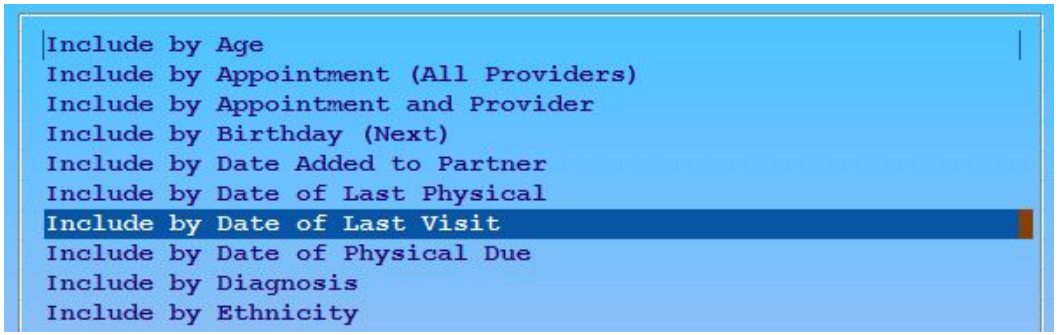
PCMH 3D.3: Chronic/Acute Services

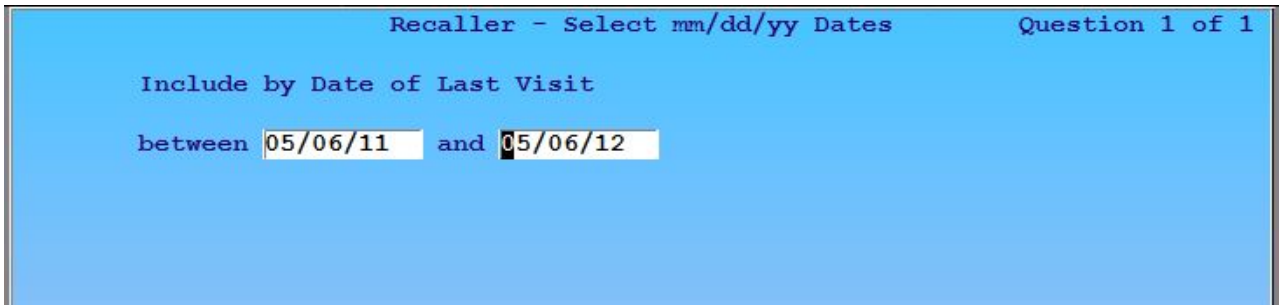
- Use appointment types specific to the checkup type
  - Example: “Asthma Recheck”, “ADHD Recheck”, “Allergy Recheck”, etc

- 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”

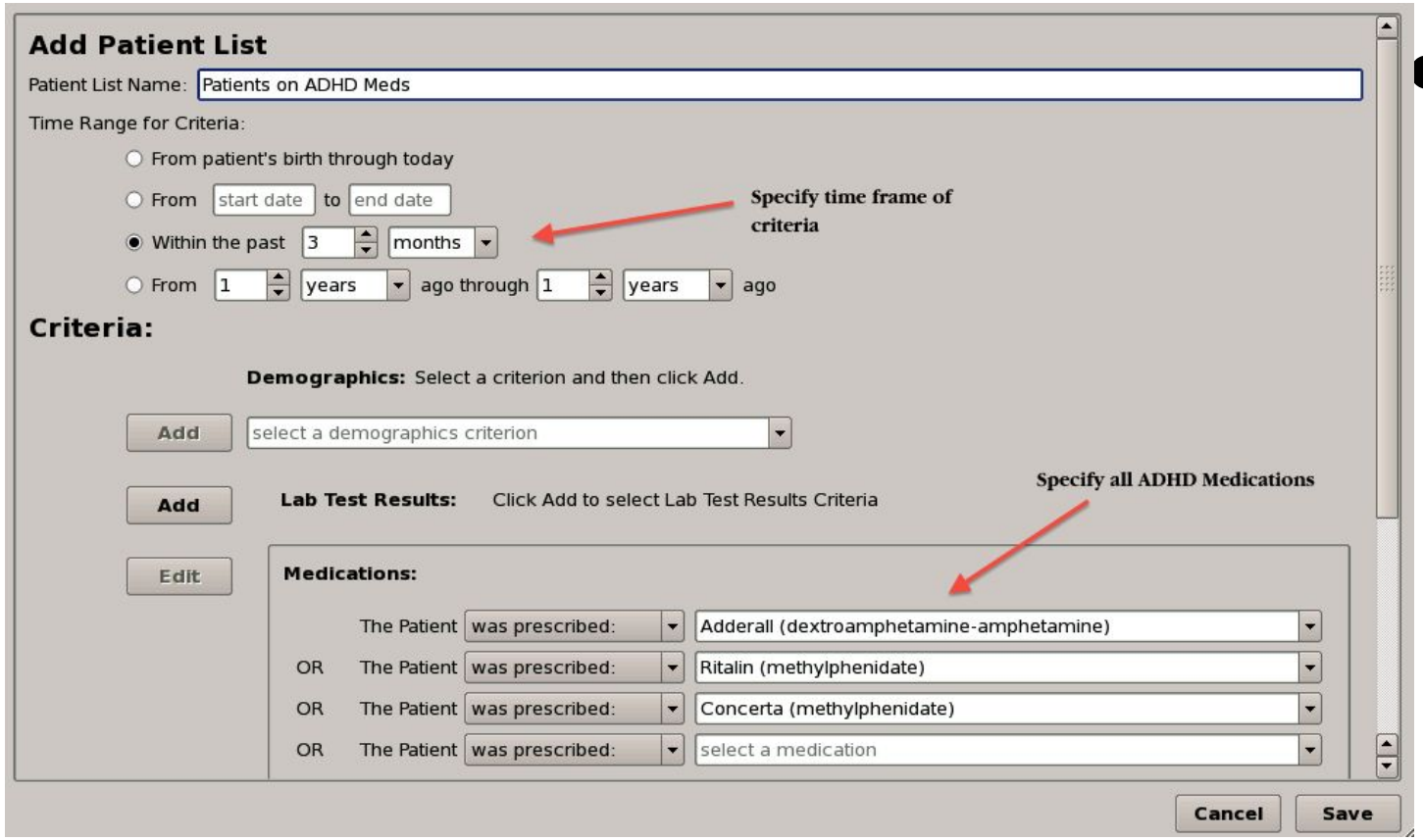




PCC Pediatric EHR Solutions

Control Your Future™

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



- Use EHR Patient Lists reporting restricted by medication

PCC Pediatric EHR Solutions

Control Your Future™

PCMH 3E: Implement Evidence-Based Decision Support

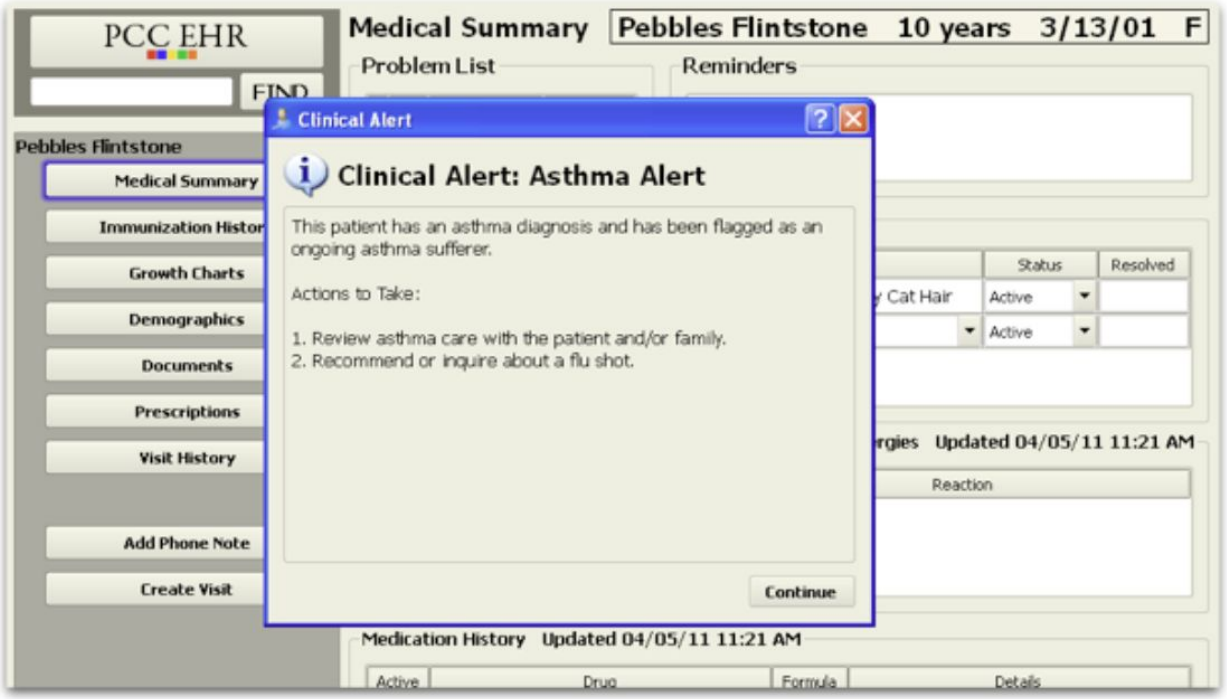
Element E: Implement Evidence-Based Decision Support	4.00 points	
The practice implements clinical decision support+ (e.g., point-of-care reminders) following evidence-based guidelines for:	Yes	No
1. A mental health or substance use disorder. (CRITICAL FACTOR) +	☐	☐
2. A chronic medical condition. +	☐	☐
3. An acute condition. +	☐	☐
4. A condition related to unhealthy behaviors. +	☐	☐
5. Well child or adult care. +	☐	☐
6. Overuse/appropriateness issues. +	☐	☐

- 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

PCC Pediatric EHR Solutions

Control Your Future™

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:	**Yes**	**No**
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. +	☐	☐

- Example: Prescribing generic vs brand name Rxs (Use "Drug Volume" report in PCC eRx)

PCMH 4: Care Management and Support

Points	Standard/Element	Must-Pass = 50% Score
20	**PCMH 4: Care Management and Support**	
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)	☐	☐

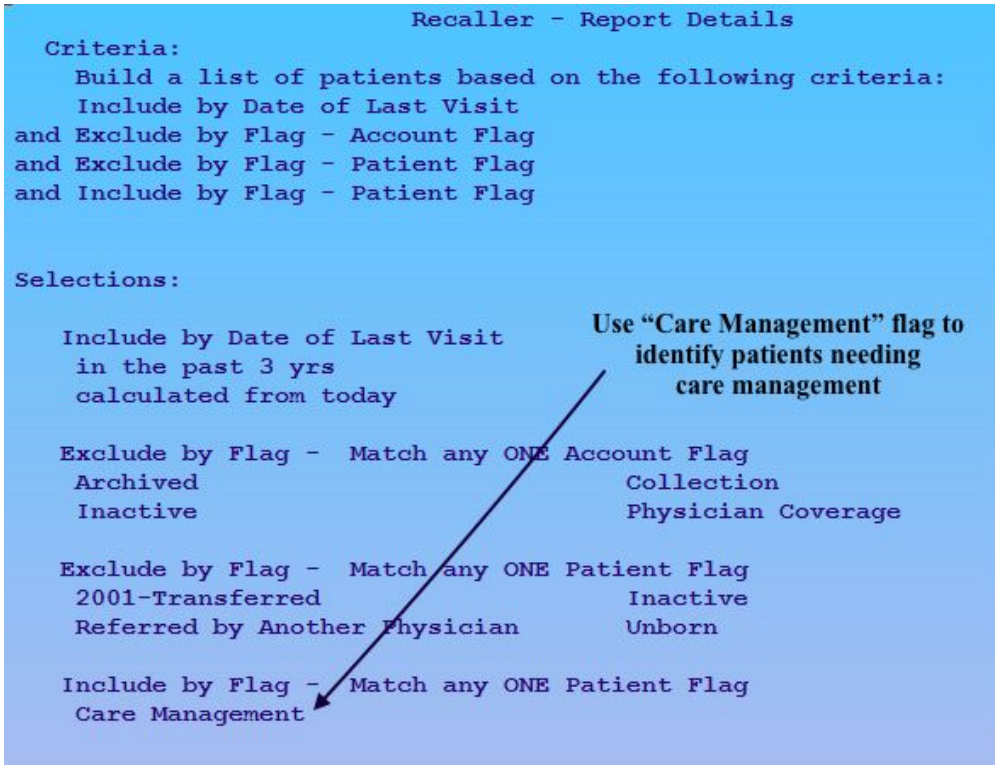
- Renewals: Documentation is required for 4A

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

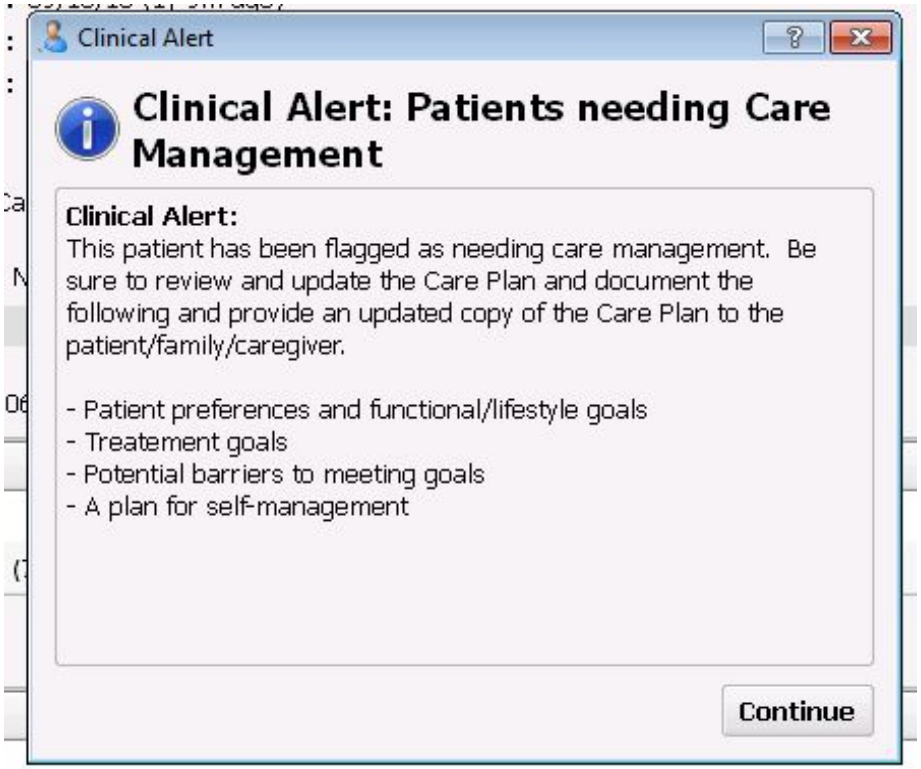
PCMH 4A: Identify Patients for Care Management

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



PCMH 4A: Identify Patients for Care Management

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



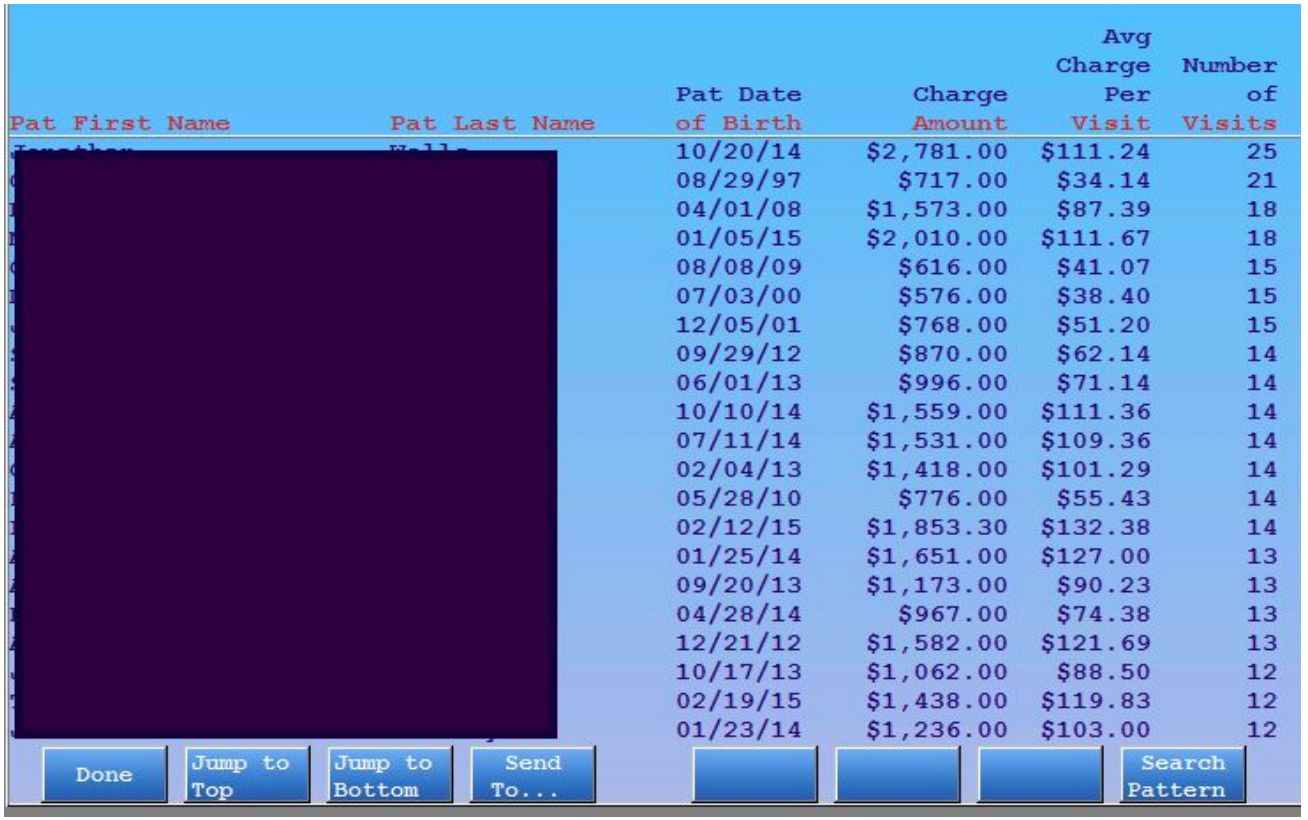
PCMH 4A: Identify Patients For Care Management

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

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

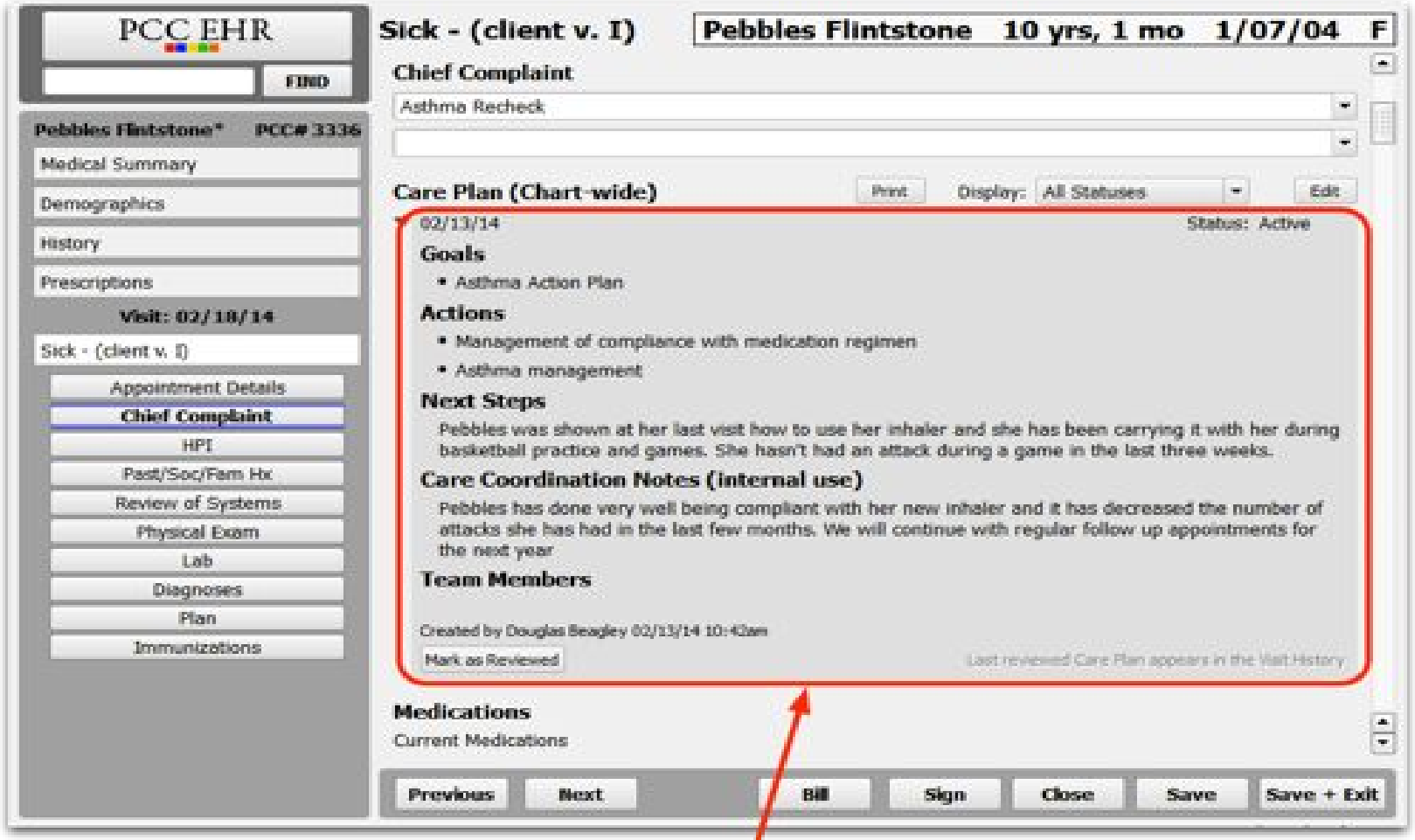
Done | Jump to Top | Jump to Bottom | Send To... | Search Pattern

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

PCMH 4B: Care Planning



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

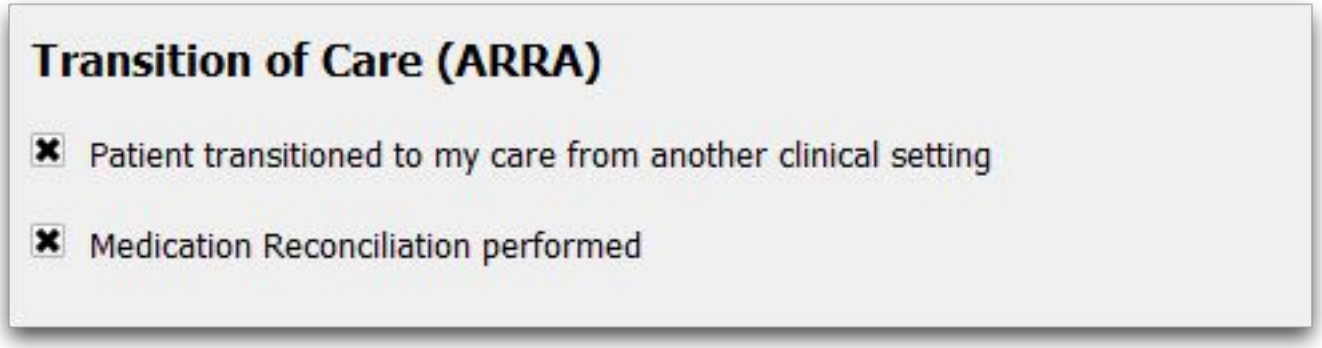
PCMH 4C: Medication Management

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)	☐	☐
2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	☐	☐
3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.	☐	☐
4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.	☐	☐
5. Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.	☐	☐
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.	☐	☐

- 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



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)	☐	☐	
2. Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR)	☐	☐	
3. Flags abnormal lab results, bringing them to the attention of the clinician.	☐	☐	
4. Flags abnormal imaging results, bringing them to the attention of the clinician.	☐	☐	
5. Notifies patients/families of normal and abnormal lab and imaging test results.	☐	☐	
6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).	☐	☐	☐
7. More than 30 percent of laboratory orders are electronically recorded in the patient record. +	☐	☐	☐
8. More than 30 percent of radiology orders are electronically recorded in the patient record. +	☐	☐	☐
9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.	☐	☐	☐
10. More than 10 percent of scans and tests that result in an image are accessible electronically.	☐	☐	☐

- 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

PCC Pediatric EHR Solutions

Control Your Future™

PCMH 5B: Referral Tracking and Follow-up

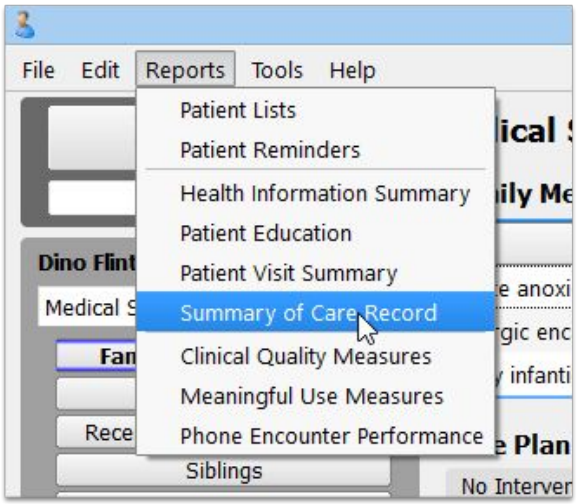
Element B: Referral Tracking and Follow-Up (MUST-PASS)			6.00 points
The practice:	Yes	No	NA
1. Considers available performance information on consultants/specialists when making referral recommendations.	☐	☐	
2. Maintains formal and informal agreements with a subset of specialists based on established criteria.	☐	☐	
3. Maintains agreements with behavioral healthcare providers.	☐	☐	
4. Integrates behavioral healthcare providers within the practice site.	☐	☐	
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral.	☐	☐	
6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.	☐	☐	
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. +	☐	☐	☐
8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL FACTOR)	☐	☐	
9. Documents co-management arrangements in the patient's medical record.	☐	☐	
10. Asks patients/families about self-referrals and requesting reports from clinicians.	☐	☐	

- 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

PCC Pediatric EHR Solutions

Control Your Future™

PCMH 5B.7: Summary of Care



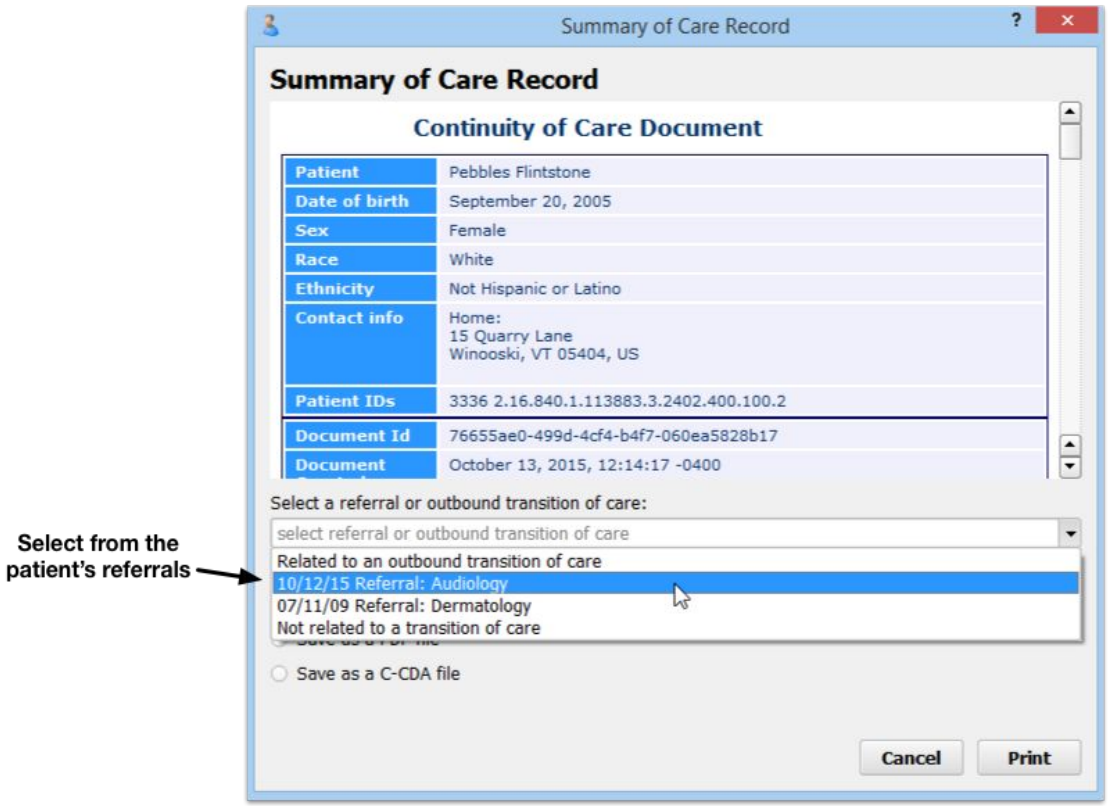
- The PCC Summary of Care Record report produces a C-CDA-formatted chart summary for a patient.

- 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

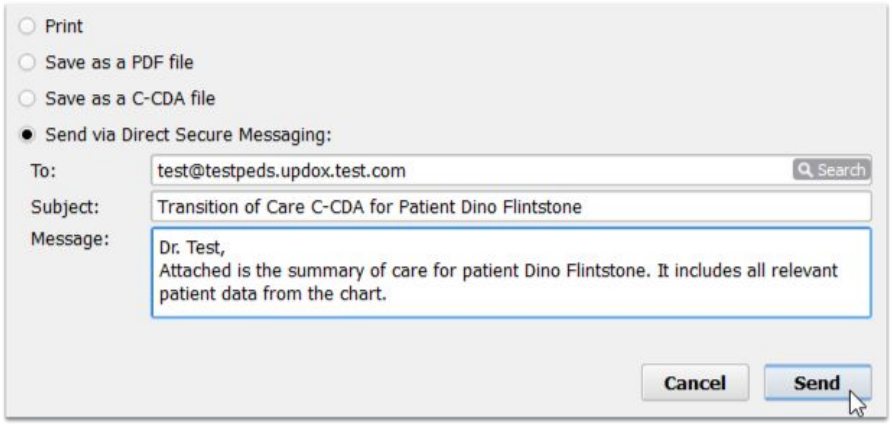
PCC Pediatric EHR Solutions

Control Your Future™

PCMH 5B.7: Summary of Care



Select from the patient's referrals

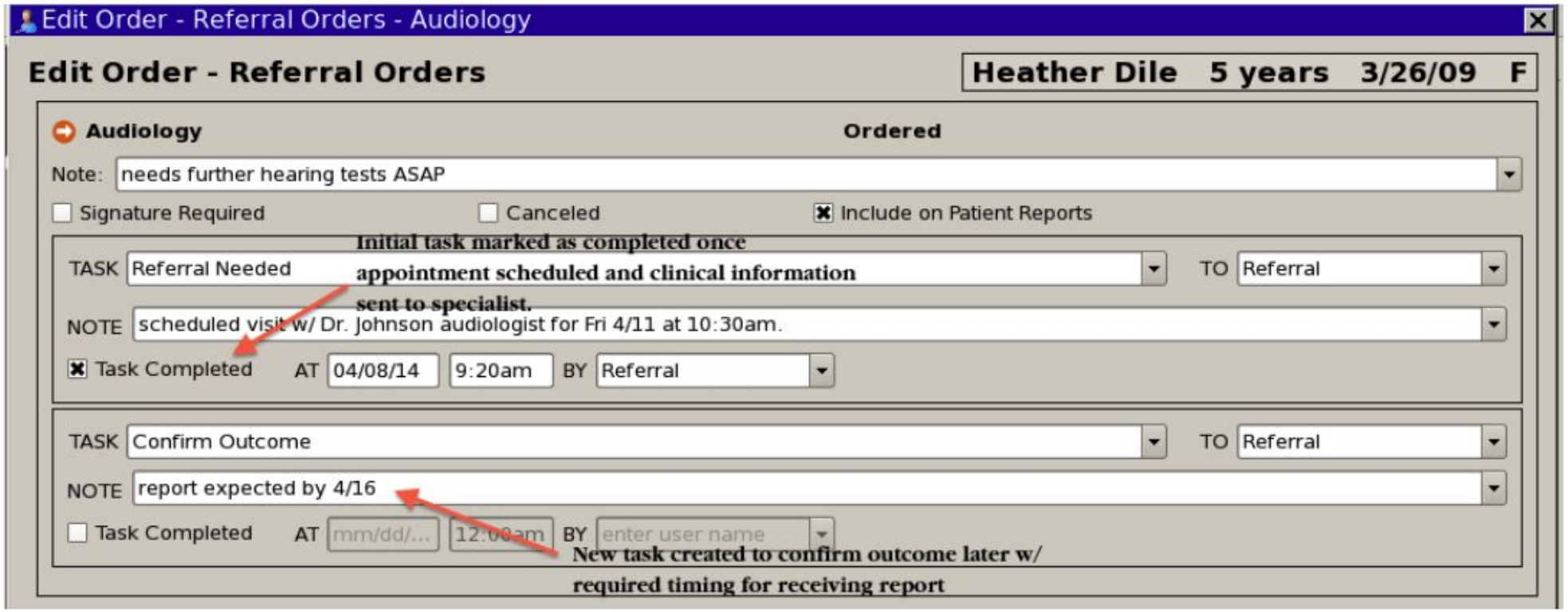


- Transmit Summary of Care Record via Direct Secure Messaging
- Contact PCC Support for assistance with getting DSM configured and working

PCC Pediatric EHR Solutions

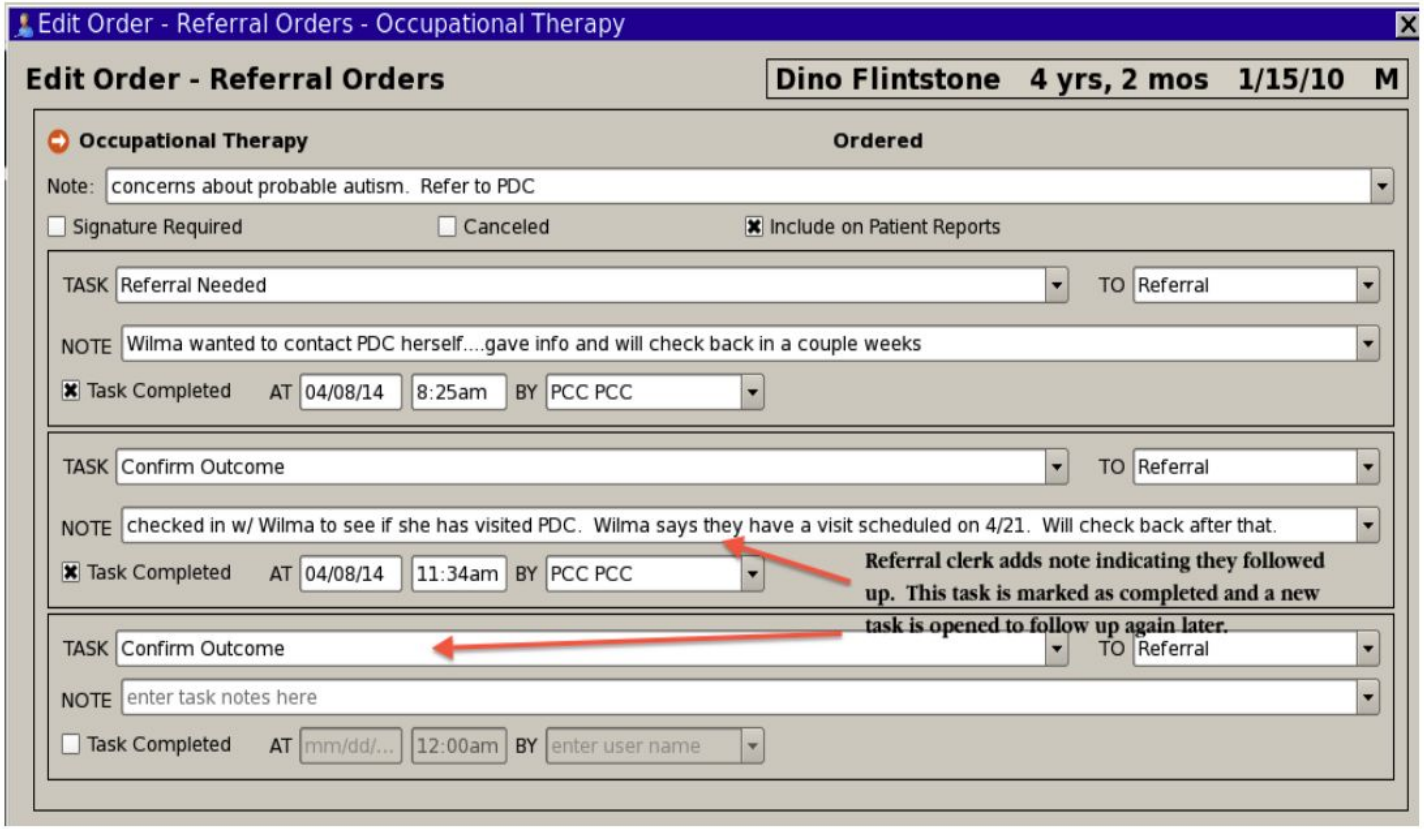
Control Your Future™

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



- 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)

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



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

PCMH 6: Performance Measurement and QI

Points	Standard/Element	Must-Pass = 50% Score
20	**PMCH 6: Performance Measurement and Quality Improvement**	
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

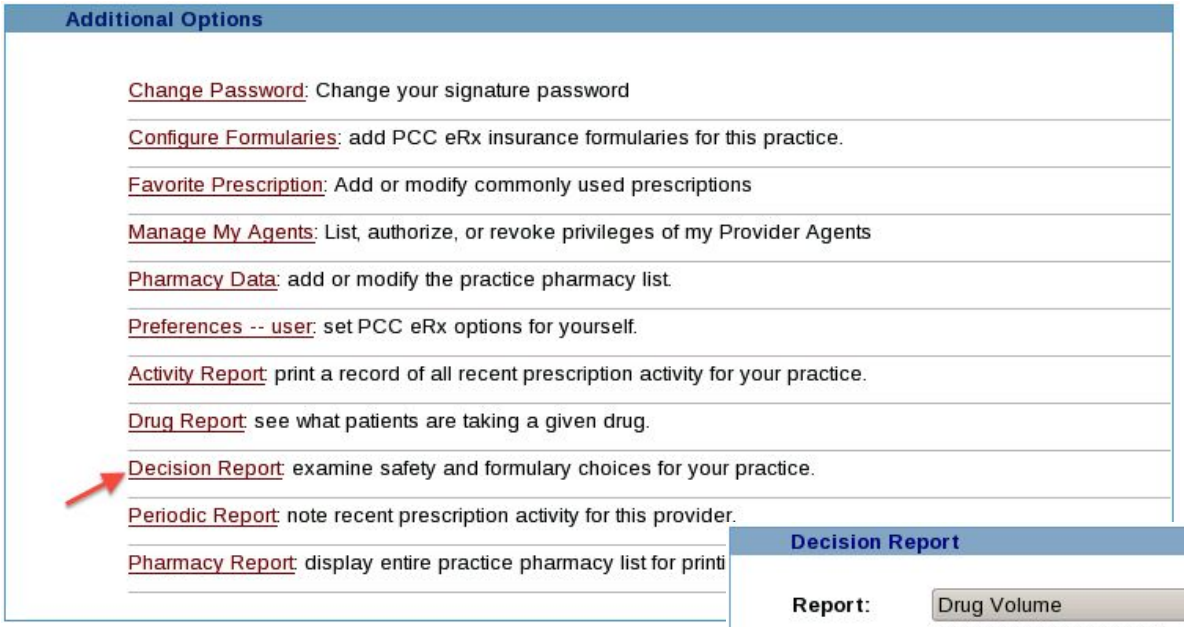
PCMH 6B: Measure Resource Use

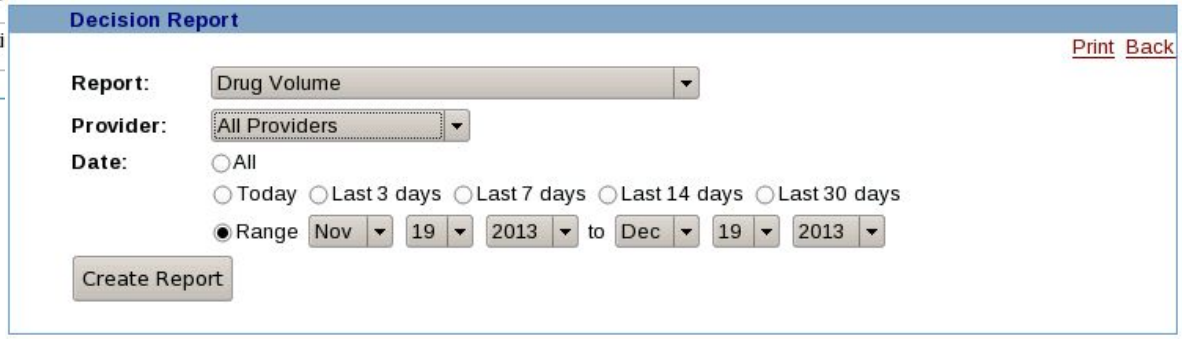
Element B: Measure Resource Use and Care Coordination	3.00 points	
At least annually, the practice measures or receives quantitative data on:	Yes	No
1. At least two measures related to care coordination.	☐	☐
2. At least two utilization measures affecting health care costs.	☐	☐

- 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

PCMH 6B: Measure Resource Use

- Generic vs Brand Rx reporting. Run “Drug Volume” report





PCC Pediatric EHR Solutions

Control Your Future™

PCMH 6B: Measure Resource Use

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

Generic drugs begin with a lower-case letter

Utilization

Brand name drugs are capitalized.

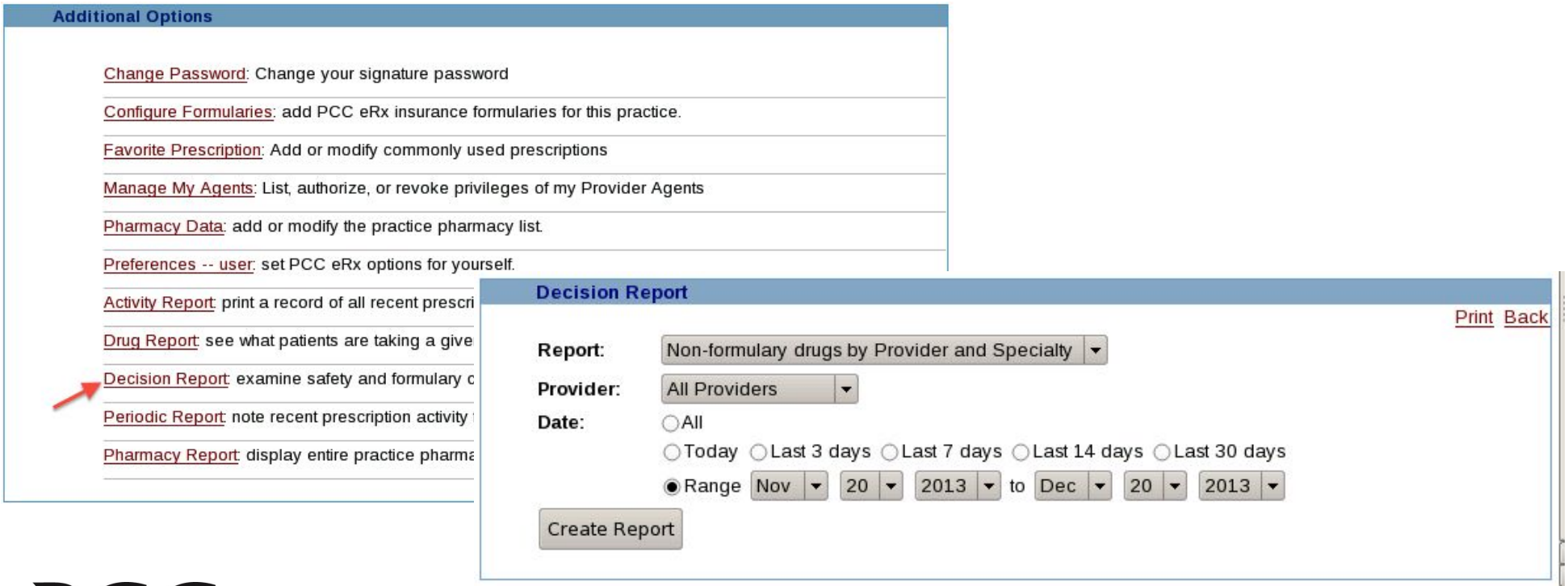
- Generic vs Brand Rx reporting

PCC Pediatric EHR Solutions

Control Your Future™

PCMH 6B: Measure Resource Use

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



PCC Pediatric EHR Solutions

Control Your Future™

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:	Yes	No
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.	☐	☐

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

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.)
Developmental Screening Rates - Adolescents	2,570	2,399	93%	-0.5% ↓
Developmental Screening Rates - Infants	937	695	74%	1.1% ↑
Fluoride Varnish Rate	3,590	2,268	63%	-1.0% ↓
Well Visit Rates - Under 15 Months	1,659	1,252	75%	-1.0% ↓
Well Visit Rates - 15-36 Months	1,754	1,143	65%	6.0% ↑
Well Visit Rates - 3-6 Years	3,770	2,298	61%	0.0% ↑
Well Visit Rates - 7-11 Years	4,349	2,171	50%	0.0% ↑
Well Visit Rates - 12-21 Years	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:	Yes	No
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.	☐	☐

- 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

Review of PCC's PCMH Resources

PCC Pediatric EHR Solutions

Control Your Future™

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
tim@pcc.com