PCC Resources For PCMH

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Users Conference 2017

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Agenda

- Current state of PCMH and what's coming
- Exploration of how PCC functionality applies to new 2017 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

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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

- As of July 2013, ~6,700 sites and ~34,000 clinicians with PCMH recognition
- As of July 2017, >12,200 sites and ~58,000 clinicians recognized in 50 states
- At least 33 **PCC practices** have Level 3 recognition, 2 have Level 2 recognition, and another 24 are in the process of getting recognition

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New 2017 Standards

- 2014 standards are about to expire
- New 2017 standards and recognition program were released on 3/31/17
- Deadline for purchasing 2014 survey tool has passed

New 2017 Standards

- More flexibility with core requirements and the choice of other elective requirements
- Simplified reporting with less paperwork means less time and cost for transformation
- New digital platform
- Includes virtual review with NCQA staff dedicated to your practice
- No more renewals every 3 years. Will now require **annual** check-in from NCQA with some reporting

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New 2017 Standards

Six PCMH Concepts

- Team-Based Care and Practice Organization (TC)
- Knowing and Managing Your Patients (KM)
- Patient-Centered Access and Continuity (AC)
- Care Management and Support (CM)
- Care Coordination and Care Transitions (CC)
- Performance Measurement and Quality Improvement (QI)

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Getting Started With PCMH Recognition

- Visit NCQA's "Getting Started" Resources
- Visit practices who are already medical homes. Share strategies and experiences
- Resource Directory of Incentives for NCQA Clinical Recognition
- Patient-Centered Primary Care Collaborative

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Getting Started With PCMH Recognition

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

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PCC Prevalidation

- PCC was prevalidated to offer 7.5 credits under 2014 standards
- We expect to offer similar auto-credit under the 2017 standards
- You can attest for automatic credit just for using PCC software

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Practices Without PCMH Recognition

- Last day to purchase 2014 survey licenses was 3/31/17
- Last day to submit 2014 Corporate Survey was 5/31/17
- Last day to submit 2014 site surveys is 9/30/17
- Otherwise, you will be starting the PCMH transformation process under 2017 standards in the Commit phase
- NCQA Questionnaire to determine if you are eligible and ready to begin the PCMH recognition process

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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 was 5/31/17
- Full cost

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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
- For some criteria, you won't need to provide required evidence
- Review NCQA's Accelerated Renewal Table

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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 was 5/31/17
- Full cost

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Practices With 2014 Recognition

Option 3: If 2014 level 3 recognition, **transition** to the new redesigned process

- Bypass submission of evidence and skip directly to the **annual reporting** part of recognition
- Enroll in NCQA's new QPASS system
- Annual reporting begins 30 days prior to expiration of current recognition

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

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PCMH Reporting Examples

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Patient-Centered Access and Continuity (AC)

Patients/families/caregivers have **24/7 access to clinical advice** and appropriate care facilitated by their **designated clinician/care team** and supported by access to their medical record. The practice considers the **needs and preferences of the patient population** when establishing and updating standards for access.

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Same-day Appointments

AC 02 (Core): Provides same-day appointments for routine and urgent care to meet identified patient needs.	
GUIDANCE	**EVIDENCE**
The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine or for urgent care needs. The time frames allocated for these appointment types are determined by the practice and based on the needs of the patient population, as defined in AC 01. The report may include a 5-day schedule to demonstrate the appointments are available or a report demonstrating which same-day appointments were used. The report may be significant patient-reported access satisfaction, based on AC 01 data.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

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

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Providing Same-Day Appointments

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

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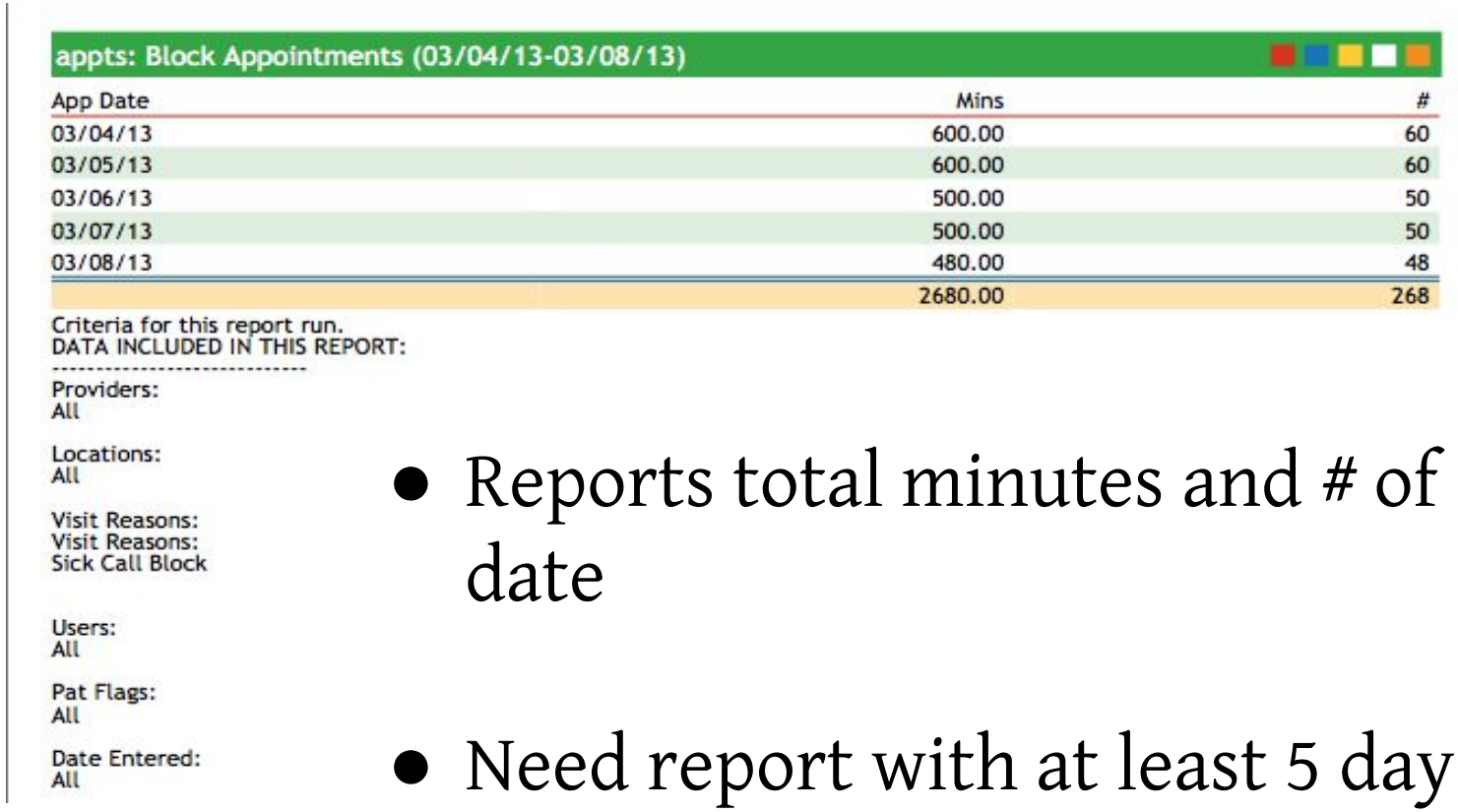
Providing Same-Day Appointments

- "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

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Timely Clinical Advice By Telephone

AC 04 (Core): Provides timely clinical advice by telephone.	
GUIDANCE	**EVIDENCE**
Patients can telephone the practice any time of the day or night and receive interactive (i.e., from a person, rather than a recorded message) clinical advice. **Clinical advice** refers to a response to an inquiry regarding symptoms, health status or an acute/chronic condition. Providing advice outside of appointments helps reduce unnecessary emergency room and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff, but may be communicated by any member of the care team, as permitted under state licensing laws. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7- days of such calls.	• **Documented process** ***AND*** • **Report**

- Show that you are tracking response times to phone calls
- Renewals: No documentation or evidence required

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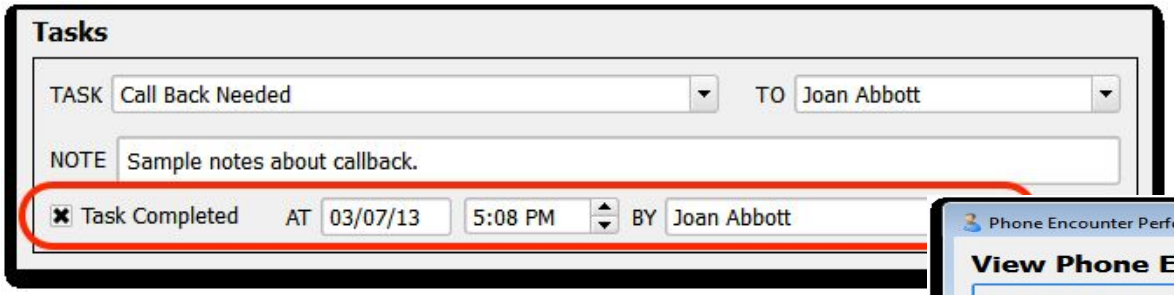
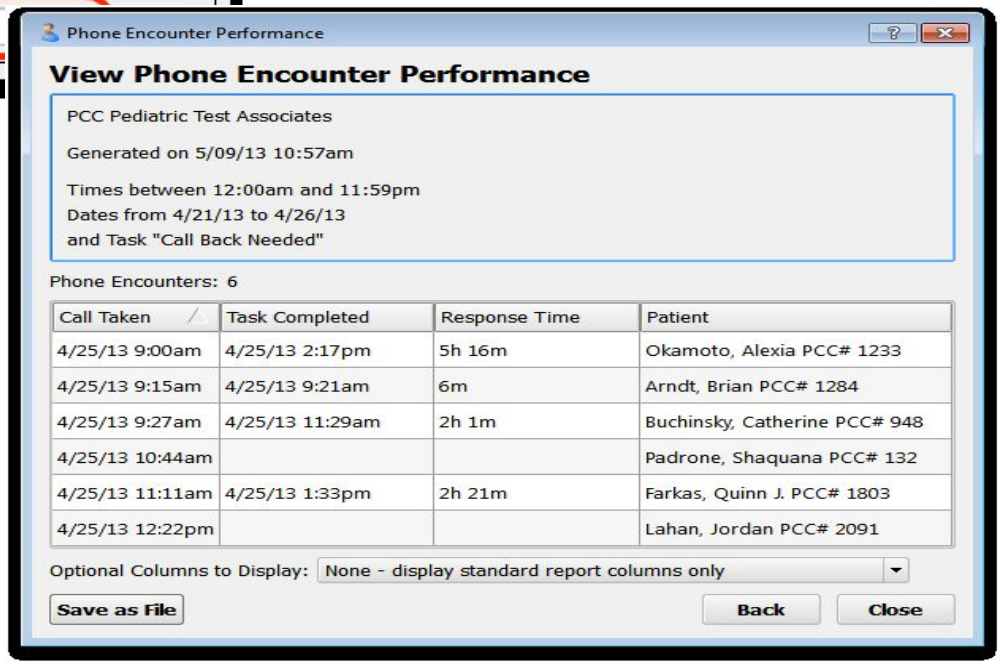
Timely Clinical Advice By Telephone





- PCC EHR → Reports → Phone Encounter Performance Report

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

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Timely Clinical Advice By Secure Electronic Msg

AC 08 (1 Credit): Has a secure electronic system for two-way communication to provide timely clinical advice.	
GUIDANCE	**EVIDENCE**
The practice has a secure, interactive electronic system (e.g., website, patient portal, secure e-mail system) that allows two-way communication between the practice and patients/families/ caregivers, as applicable for the patient. The practice can send and receive messages to and from patients. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7- days of such calls. The report may be system generated. The practice defines the time frame for a response and monitors the timeliness of response against the practice's time frame.	• **Documented process** ***AND*** • **Report**

- Renewals: No documentation or evidence required

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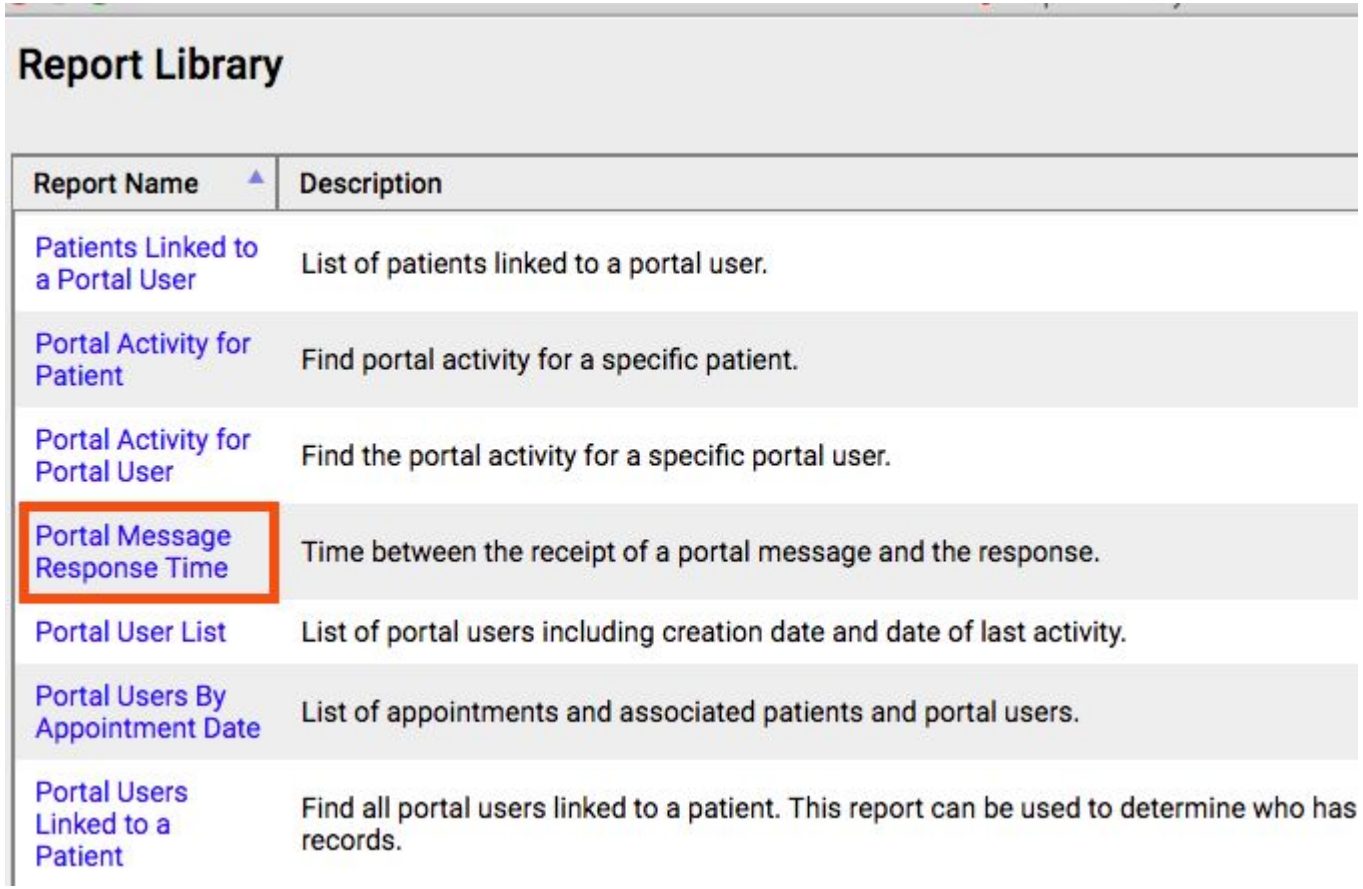
Use PCC's Patient Portal Functionality



Report Library

Report Name	Description
Patients Linked to a Portal User	List of patients linked to a portal user.
Portal Activity for Patient	Find portal activity for a specific patient.
Portal Activity for Portal User	Find the portal activity for a specific portal user.
Portal Message Response Time	Time between the receipt of a portal message and the response.
Portal User List	List of portal users including creation date and date of last activity.
Portal Users By Appointment Date	List of appointments and associated patients and portal users.
Portal Users Linked to a Patient	Find all portal users linked to a patient. This report can be used to determine who has records.

- Use this new report to track response time to portal messages before and after hours
- Report for at least 7 calendar days

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Tracking Primary Care Provider

AC10 (Core) - Help patient/family/caregivers select or change personal clinician

AC11 (Core) - Set goals and monitor the percentage of patient visits with the selected clinician or team

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Tracking Primary Care Provider

- 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
- Renewals: No documentation or evidence required

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 Client Advocate for assistance with generating this spreadsheet
- There is no expected % to reach, but you must show documented goal

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Knowing and Managing Your Patients (KM)

The practice **captures and analyzes information** about the patients and community it serves and uses the information to **deliver evidence-based care** that supports population needs and provision of **culturally and linguistically appropriate services**

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Documenting Up-to-Date Problem List

KM 01 (Core) - Documents an up-to-date problem list for each patient with current and active diagnoses

- Use PCC MU Report “Stage 1 - Problem List”
- No required % threshold
- Renewals: No documentation or evidence required

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Adolescent Depression Screening

KM 03 (Core) - Conducts depression screenings for adults and adolescents using a standardized tool

- Use PCC's CQM report - "Screening for Clinical Depression and Follow-Up Plan"
- See "CQM Reporting in PCC EHR" UC 2017 presentation
- No % threshold is required
- Must identify standardized screening tool
- Evidence and report or documented process required

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Assess Oral Health Needs

KM 05 (1 Credit) - Assesses oral health needs and provides necessary services based on evidence-based guidelines or coordinates with oral health partners

- Incorporate oral health assessment into protocols
- Consider doing fluoride varnish
- Document referrals to oral health partners
- Evidence and documented process required

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Assess Oral Health Needs

Measure: Fluoride Varnish Rate

Choose a measure

Dashboard reports updated as of 7/2/2017

Your Score: **0** out of 100

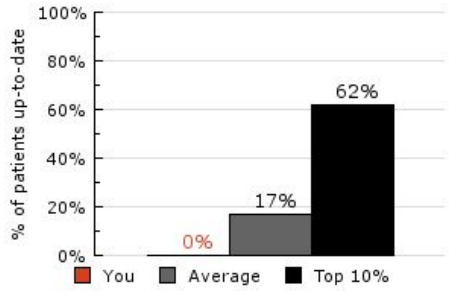
The AAP's Bright Futures Guidelines recommend the application of fluoride varnish to all children every 3-6 months once teeth are present through age 5. For active patients 1-5 years old with a well visit in the past year, this measure tracks how many of those patients also had a recommended fluoride varnish application billed with CPT code 99188, D1206, or 99429 within the last year. See how you measure up to other PCC clients and also see a breakdown of your performance by age and insurance group.

You have **779** active patients between 1 year and 5 years of age who have had a well visit in the past year.

0 of these patients received a fluoride varnish application within the past year.

How You Compare

View Age and Insurance Breakdown



Your Practice	PCC Client Average	Top Performers
0%	17%	62%

(% of active patients 1-5 years old having recent fluoride varnish)

Monitor Fluoride Varnish Rate in Dashboard

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Identify Predominant Conditions

KM 06 (1 Credit) - Identifies the predominant conditions and health concerns of the patient population

- Generate PCC report showing predominant diagnoses for each provider
- KM 06 credit also counts for KM 01 (up-to-date problem list)
- Renewals: No documentation or evidence required

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Identify Predominant Conditions

	A	B	C	D	E
1	Title: Predominant diagnoses used by provider				
2					
3	Service Provider Name: Provider 1				
4	Service Provider Name	Diagnosis Code	Diagnosis Name	Number of Procedures	Charge Amount
5	Provider 1	Z23	Encounter for immunization	1251	$43,387.33
6	Provider 1	Z00.129	Encntr for routine child health exam w/o abnormal findings	690	$71,805.00
7	Provider 1	Z00.121	Encounter for routine child health exam w abnormal findings	337	$35,352.00
8	Provider 1	J02.0	Streptococcal pharyngitis	183	$13,743.00
9	Provider 1	J02.9	Acute pharyngitis, unspecified	180	$10,514.00
10	Provider 1	J06.9	Acute upper respiratory infection, unspecified	132	$15,805.00
11	Provider 1	R30.0	Dysuria	71	$3,666.00
12	Provider 1	B34.9	Viral infection, unspecified	46	$4,172.00
13	Provider 1	Z00.00	Encntr for general adult medical exam w/o abnormal findings	30	$5,035.00
14	Provider 1	Z38.00	Single liveborn infant, delivered vaginally	29	$4,465.00
15	Provider 1	H66.001	Acute suppr otitis media w/o spon rupt ear drum, right ear	20	$2,447.00
16	Provider 1	H66.002	Acute suppr otitis media w/o spon rupt ear drum, left ear	18	$2,146.00
17	Provider 1	N76.0	Acute vaginitis	14	$780.00
18	Provider 1	N89.8	Other specified noninflammatory disorders of vagina	14	$877.00
19	Provider 1	F41.9	Anxiety disorder, unspecified	12	$1,567.00
20	Provider 1	R50.9	Fever, unspecified	12	$805.00
21	Provider 1	K59.00	Constipation, unspecified	11	$1,335.00
22	Provider 1	P92.9	Feeding problem of newborn, unspecified	11	$1,459.00
23	Provider 1	F90.2	Attention-deficit hyperactivity disorder, combined type	10	$1,181.00
24	Provider 1	L50.9	Urticaria, unspecified	10	$700.00
25	Provider 1	R05	Cough	10	$1,310.00
26	Provider 1	Z38.01	Single liveborn infant, delivered by cesarean	10	$940.00
27	Provider 1	Z48.02	Encounter for removal of sutures	10	$952.00
28					
29	Name: Provider 2				
30	Service Provider Name	Diagnosis Code	Diagnosis Name	Number of Procedures	Charge Amount
31	Provider 2	Z23	Encounter for immunization	2580	$91,145.10
32	Provider 2	Z00.129	Encntr for routine child health exam w/o abnormal findings	1157	$120,089.02
33	Provider 2	Z00.121	Encounter for routine child health exam w abnormal findings	1027	$118,217.00
34	Provider 2	J06.9	Acute upper respiratory infection, unspecified	262	$27,472.00
35	Provider 2	J02.0	Streptococcal pharyngitis	230	$17,324.00
36	Provider 2	J02.9	Acute pharyngitis, unspecified	157	$10,361.00
37	Provider 2	F90.2	Attention-deficit hyperactivity disorder, combined type	117	$16,251.00
38	Provider 2	F41.9	Anxiety disorder, unspecified	113	$15,446.00
39	Provider 2	J21.9	Acute bronchiolitis, unspecified	74	$7,669.00
40	Provider 2	Z38.00	Single liveborn infant, delivered vaginally	72	$11,205.00
41	Provider 2	Z00.00	Encntr for general adult medical exam w/o abnormal findings	71	$10,294.01
42	Provider 2	B34.9	Viral infection, unspecified	61	$4,837.00

- Spreadsheet output based on custom srs charge report showing top ICD-10 codes billed
- Contact Client Advocate for assistance

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Evaluate Patient Communication Preferences

KM 08 (1 Credit) - Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials

- Report and evidence of implementation required
- Use PCC report showing total patients for each communication preference (text, email, cell, etc)

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Evaluate Patient Communication Preferences

Total Active Patient Breakdown by Communication Preference	
Filter	
Method	
Cell Phone	1358
Email	487
Home Phone	607
No Preference	706
Text	570
Work Phone	5
Total Result	**3733**

- Spreadsheet output based on custom recaller report showing primary communication preference for each patient
- Contact Client Advocate for assistance

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Assess Diversity of Population

KM 09 (Core) - Assess the diversity (race, ethnicity, and one other aspect)

KM 10 (Core) - Assess the language needs

- Reports for this coming in EHR Report Library in Fall 2017. Until then, contact PCC for assistance
- Renewals: No report required

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Assess Diversity of Population

	A	B	C	D	E	F	G
1	Based on patients seen 1/12/17 – 4/12/17						
2							
3							
4							
5	Filter				Filter		
6							
7	Race		% of Total		Ethnicity		% of Total
8	(empty)	25	2.3%		Not Hispanic or Latino	816	76.0%
9	American Indian or Alaska Native	1	0.1%		Prefers not to answer	106	9.9%
10	American Indian or Alaska Native, Black or African American, White	2	0.2%		(empty)	78	7.3%
11	Asian	30	2.8%		Hispanic or Latino	73	6.8%
12	Asian, White	27	2.5%		Total Result	1073	100.0%
13	Black or African American	21	2.0%				
14	Black or African American, Native Hawaiian or Other Pacific Islande	1	0.1%				
15	Black or African American, White	9	0.8%				
16	Native Hawaiian or Other Pacific Islander	1	0.1%				
17	Native Hawaiian or Other Pacific Islander, White	3	0.3%				
18	Prefers not to answer	25	2.3%		Filter		
19	White	927	86.4%				
20	White, Prefers not to answer	1	0.1%		Sex		
21	Total Result	1073	100.0%		(empty)		0.0%
22					Female	490	45.7%
23	Filter				Male	583	54.3%
24					Total Result	1073	100.0%
25	Preferred Language						
26	(empty)	16	1.5%				
27	English	1057	98.5%				
28	Total Result	1073	100.0%				

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Identify Populations and Recall

KM 12 (Core): Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):

A. Preventive care services.

B. Immunizations.

C. Chronic or acute care services.

D. Patients not recently seen by the practice.

- Identify patients in need of care (Dashboard, recaller, MU report detail)
- Remind patients of needed services (notify, recaller)
- Report and outreach materials required

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KM 12.A: Choosing Preventive Care Services

- PCC Dashboard:
  - Patients overdue for well visits (pick an age group to focus on)
- 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

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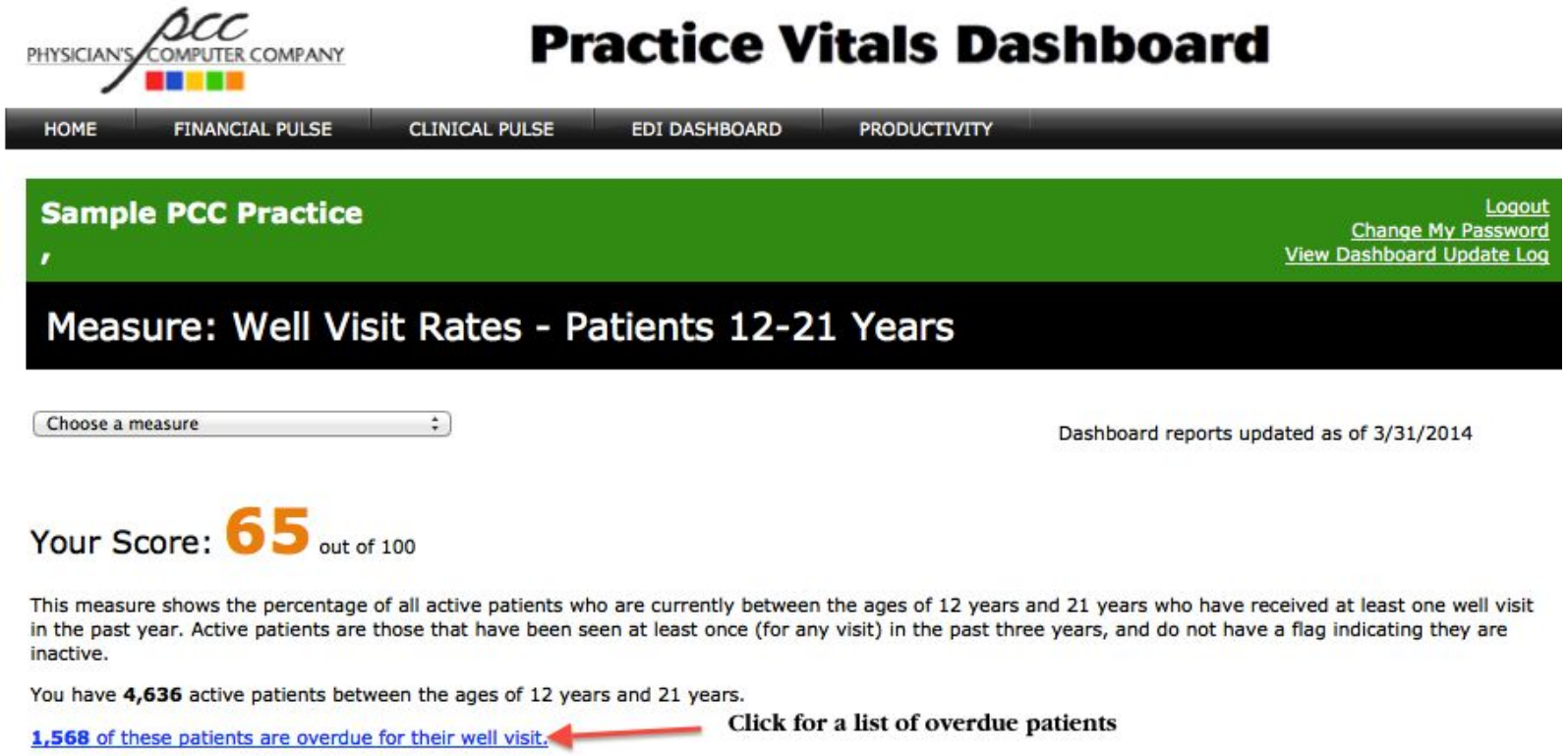
Dashboard Overdue Lists



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

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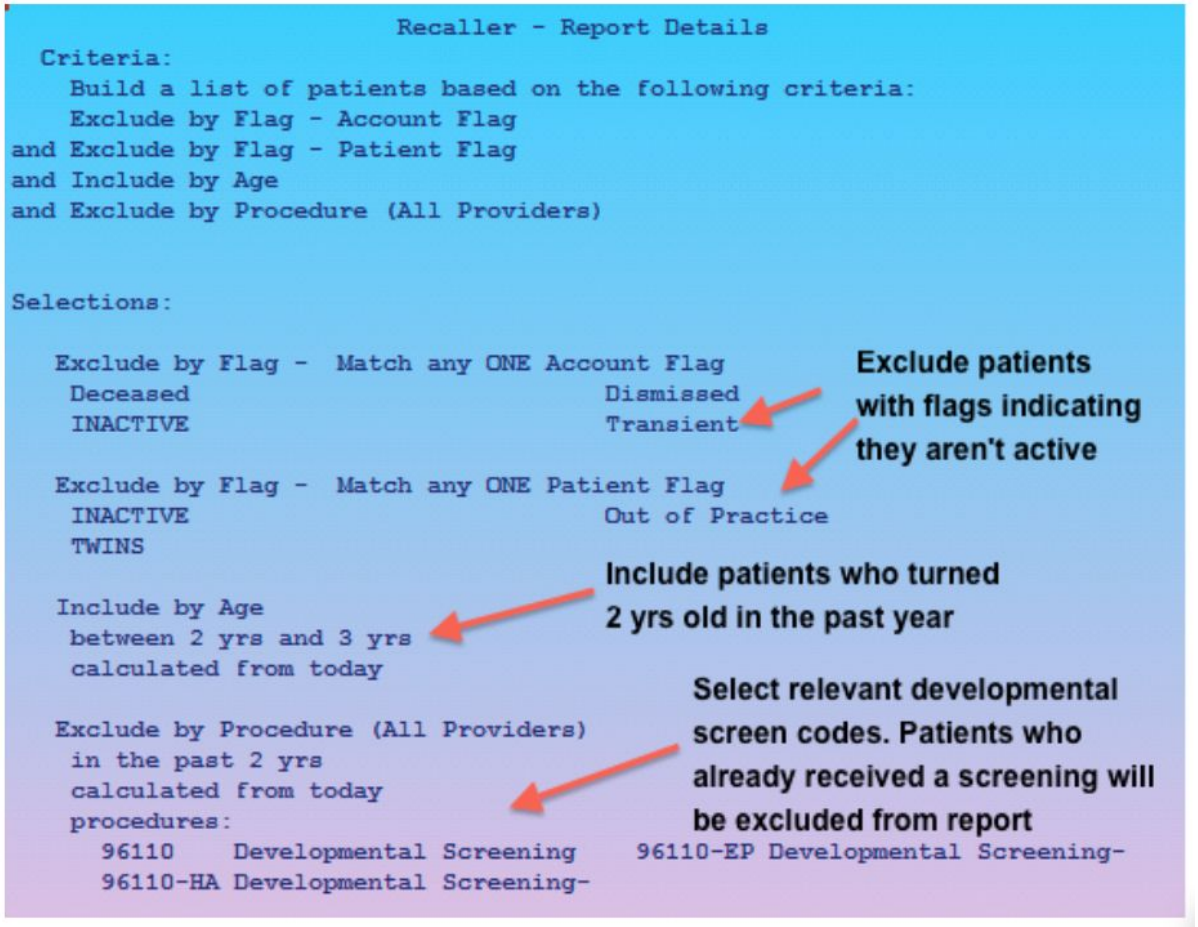
Recaller Overdue Lists



- 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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KM 12.B: 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

KM 12.B: Choosing 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.

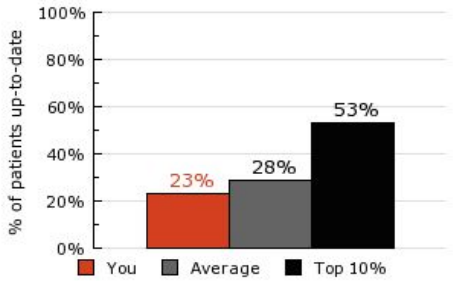
You have **2,665** active patients between 13 years and 17 years of age.

2,049 of these patients are due for at least one HPV vaccine.

Click for list of overdue patients

How You Compare

View Age and Sex Breakdown



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

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

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KM 12.B: Choosing 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

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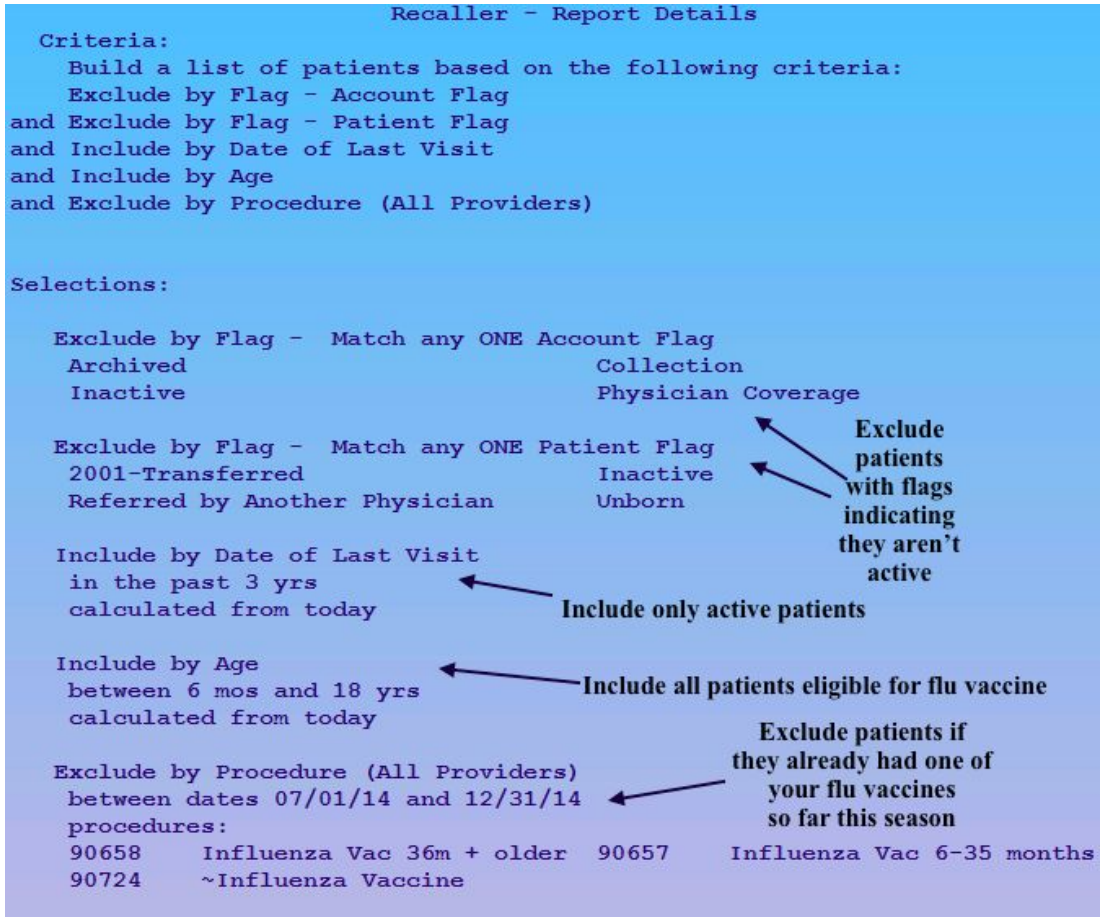
KM 12.B: Choosing Immunization Services



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

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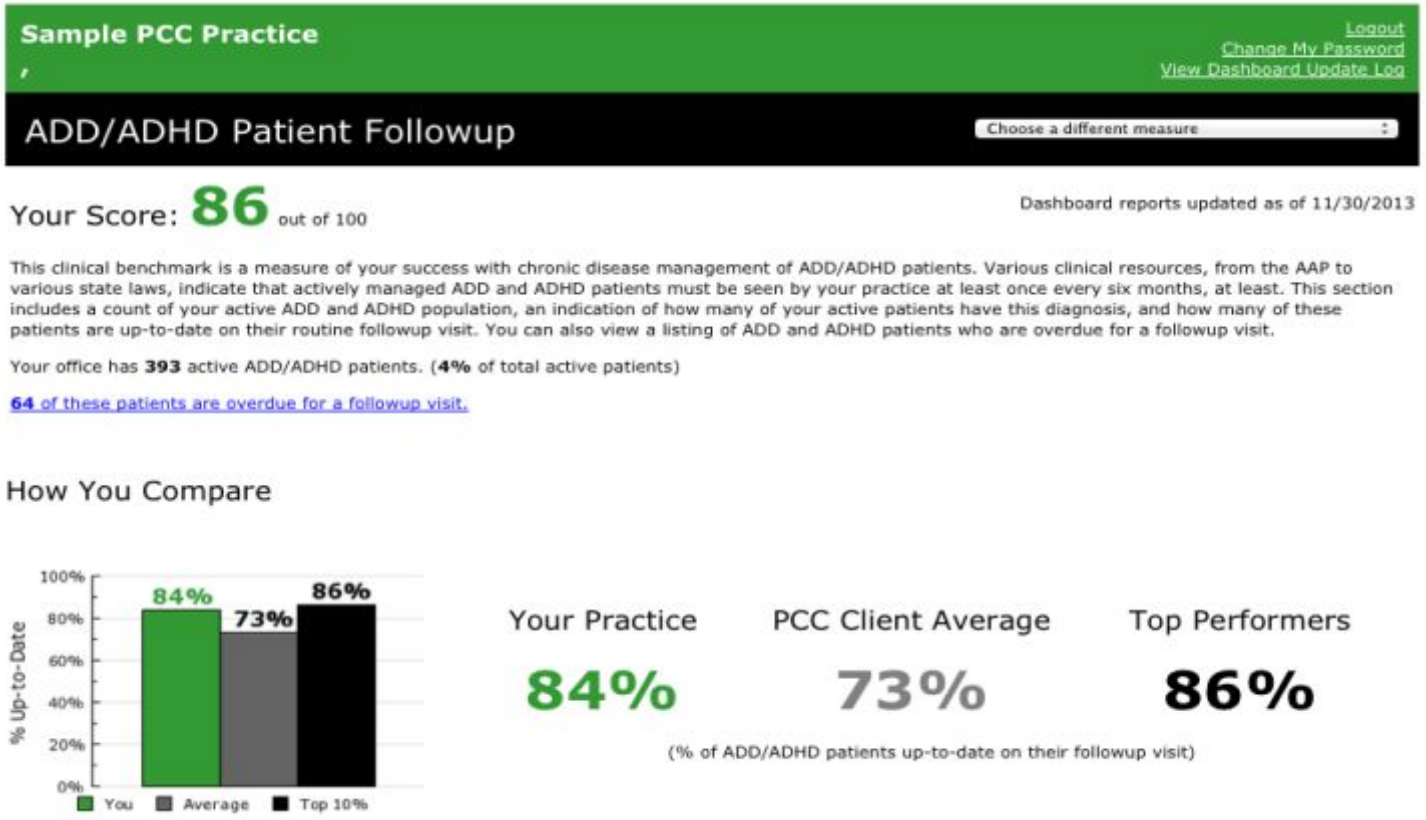
KM 12.C: Choosing Chronic/Acute Services

- 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

PCC Pediatric EHR Solutions

KM 12.C: Choosing Chronic/Acute Services



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

PCC Pediatric EHR Solutions

KM 12.C: Choosing 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

PCC Pediatric EHR Solutions

KM 12.C: Choosing 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

PCC Pediatric EHR Solutions

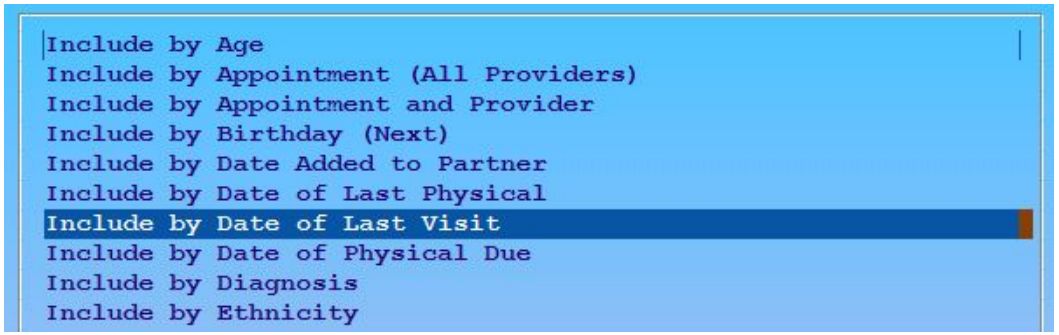
KM 12.C: Choosing Chronic/Acute Services

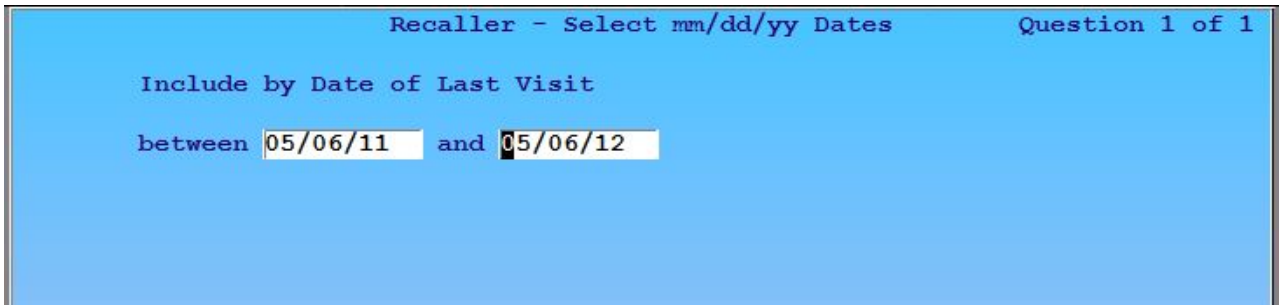
- Use appointment types specific to the checkup type
  - Example: “Asthma Recheck”, “ADHD Recheck”, “Allergy Recheck”, etc

- Allows for more accurate recaller reporting
  - Restrict by appointment to exclude patients who already had a specific appointment type scheduled

KM 12.D: Patients Not Recently Seen

Use recaller restricting by “Date of last visit”





PCC Pediatric EHR Solutions

Addressing Medication Safety and Adherence

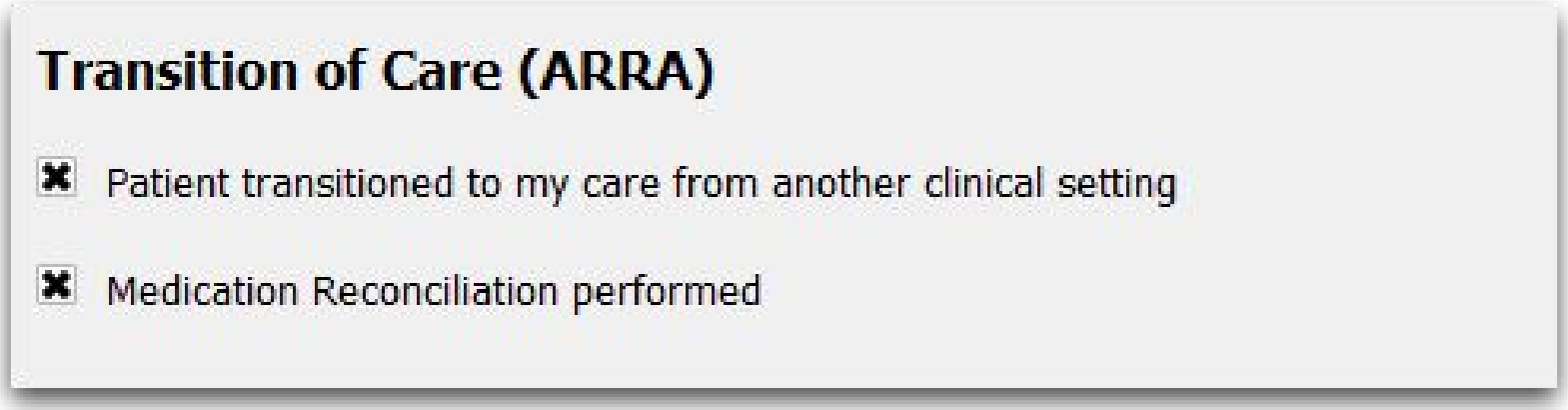
KM 14 (Core) - Reviews and reconciles meds for more than 80% of patients received from care transitions

- Use PCC's Modified Stage 2 "Medication Reconciliation" MU report
- Renewals: No report required

PCC Pediatric EHR Solutions

Medication Reconciliation

Use special component in EHR to indicate medications are reconciled for patients transitioning to you



PCC Pediatric EHR Solutions

Addressing Medication Safety and Adherence

KM 15 (Core) - Maintains an up-to-date list of medications for more than 80% of patients

- Use PCC's Stage 1 "Medication List" MU report
- Renewals: No report required

PCC Pediatric EHR Solutions

Implement Evidence-Based Decision Support

KM 20 (Core): Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria):

A. Mental health condition.
B. Substance use disorder.
C. A chronic medical condition.
D. An acute condition.
E. A condition related to unhealthy behaviors.
F. Well child or adult care.
G. Overuse/appropriateness issues.

- Demonstrate at least four of the seven criteria
- Identify conditions, source of guidelines, and evidence of implementation

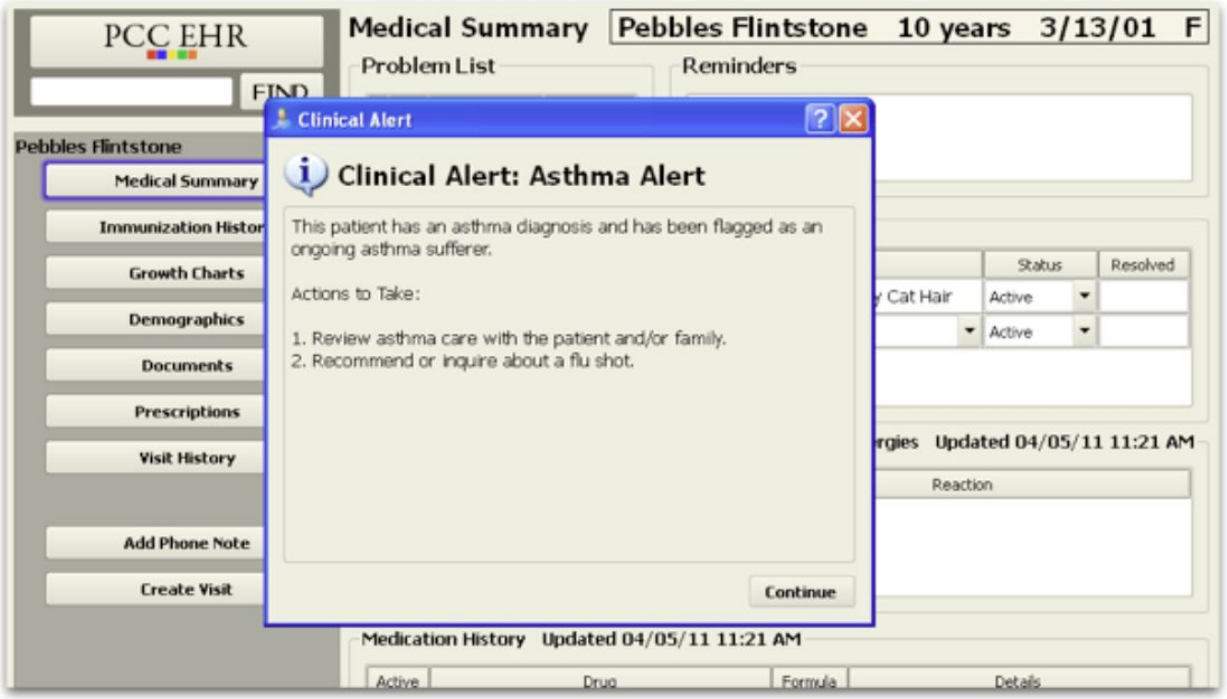
PCC Pediatric EHR Solutions

Implement Evidence-Based Decision Support

- PCC expects to have autocredit for the following conditions:
  - ADHD for KM20.A (related to mental health condition) if using built-in protocol following AAP's Clinical Practice Guidelines
  - Well Child Care for KM20.F if using Bright Futures protocols
- Consider using Pediatric Obesity for KM20.E (related to unhealthy behaviors)
- Consider asthma, otitis media, or allergic rhinitis for KM20.C or KM20.D (related to chronic or acute condition)

PCC Pediatric EHR Solutions

Implement Evidence-Based Decision Support



- Use Clinical Alerts for point-of-care reminders

PCC Pediatric EHR Solutions

Care Management and Support

CM 01 (Core): Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):

A. Behavioral health conditions.
B. High cost/high utilization.
C. Poorly controlled or complex conditions.
D. Social determinants of health.
E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.

- Include at least three of the five criteria
- Provide protocol for identifying patients for care management

PCC Pediatric EHR Solutions

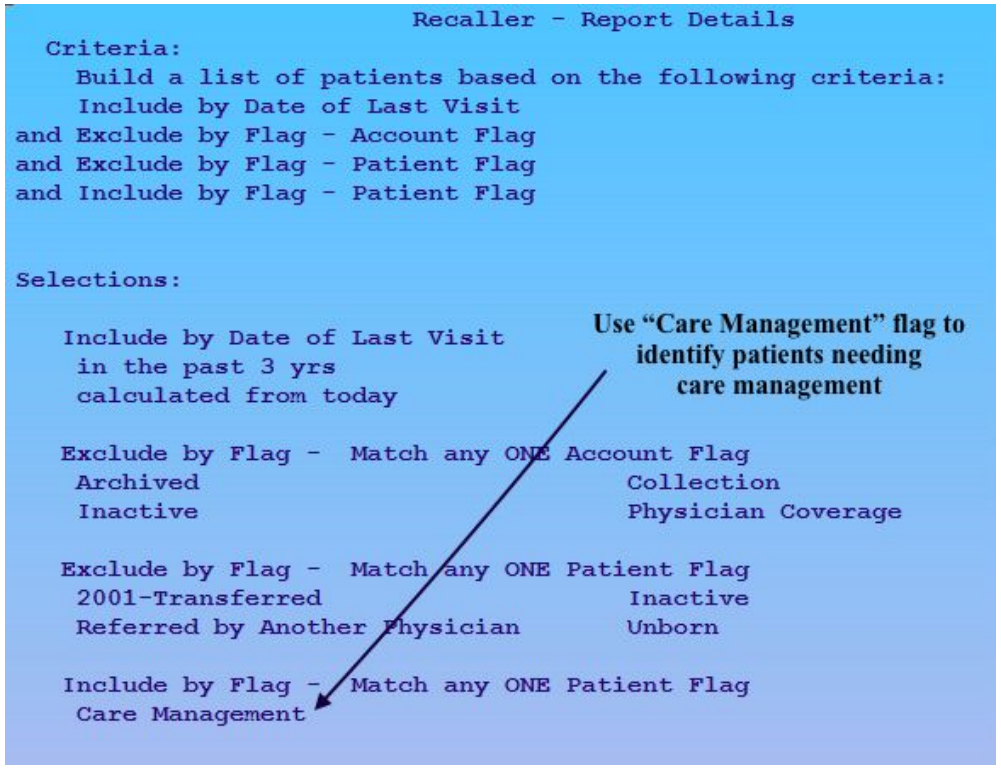
Care Management and Support

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

PCC Pediatric EHR Solutions

Care Management and Support

CM 02 (Core): Monitors the percentage of the total patient population identified through its process and criteria.



- Use recaller to monitor population of kids needing care management

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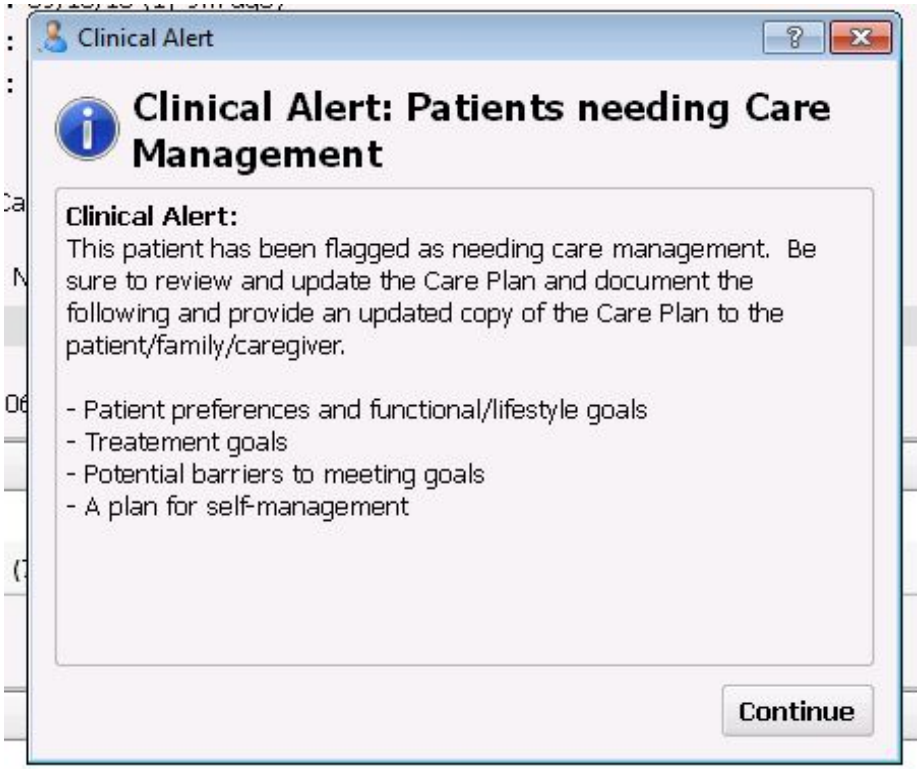
Care Management and Support

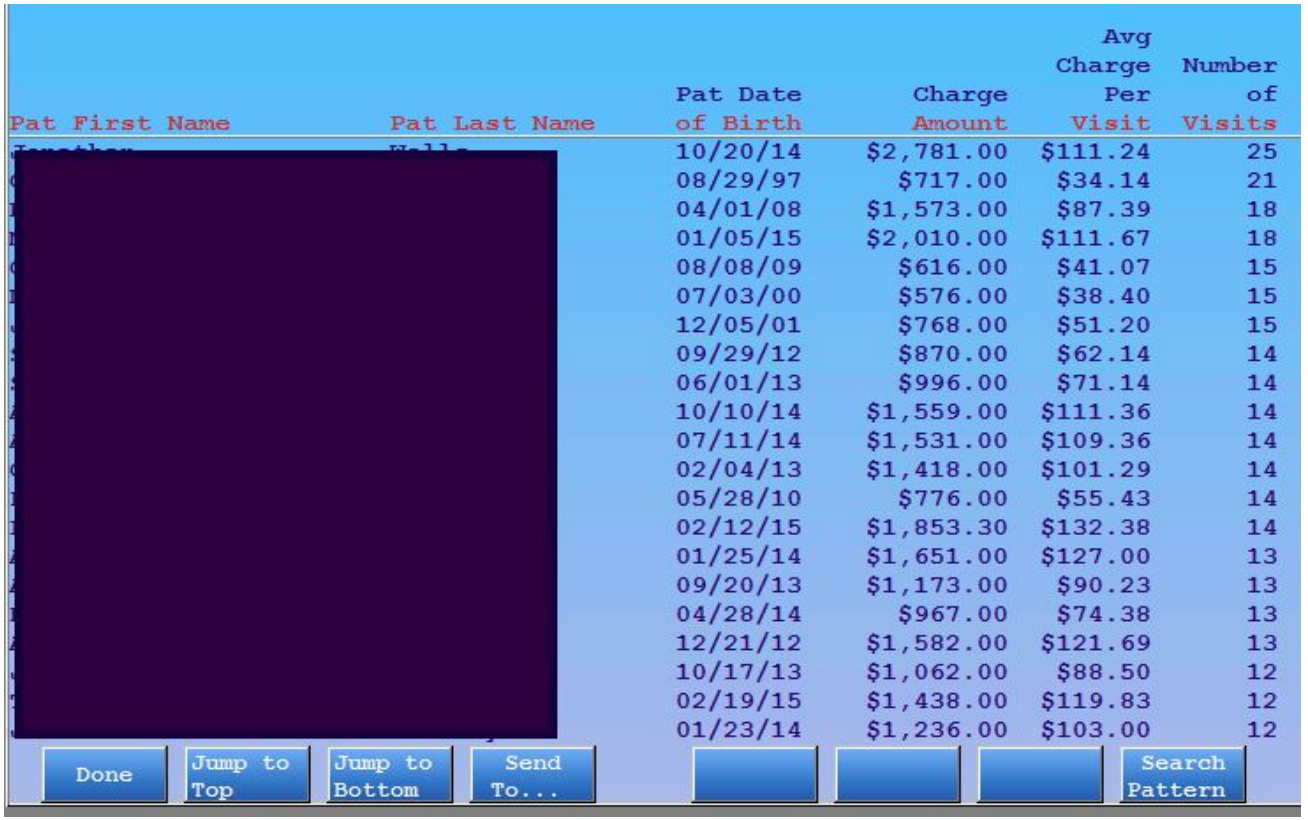
- Use clinical alert in EHR to remind about updating Care Plan



PCC Pediatric EHR Solutions

Identify High Cost/High Utilization Patients

- Contact PCC for help with a custom srs report to identify patients who utilize service most (in terms of $ chg and/or visits)



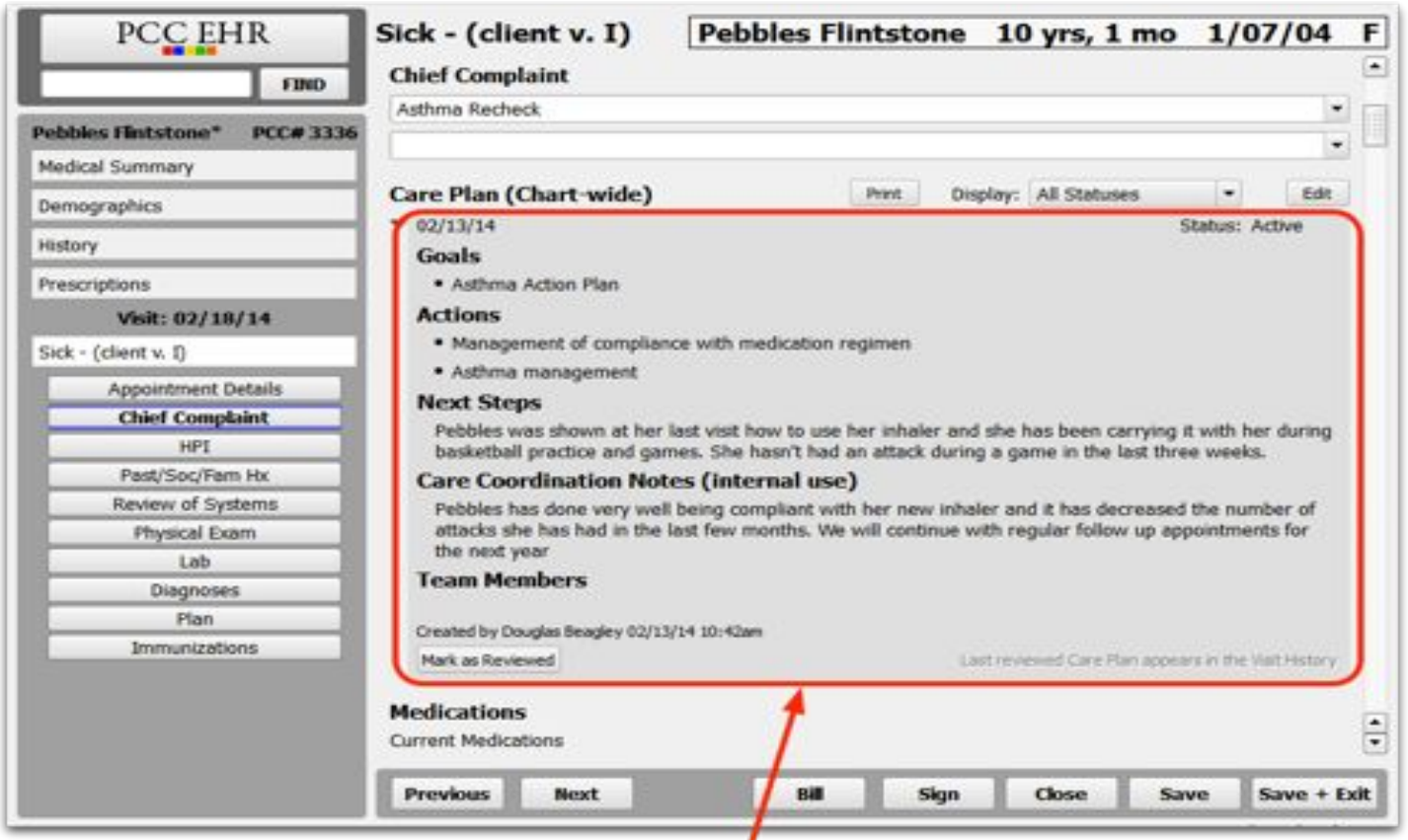
Pat First Name	Pat Last Name	Pat Date of Birth	Charge Amount	Avg Charge Per Visit	Number of Visits
[redacted]		10/20/14	$2,781.00	$111.24	25
		08/29/97	$717.00	$34.14	21
		04/01/08	$1,573.00	$87.39	18
		01/05/15	$2,010.00	$111.67	18
		08/08/09	$616.00	$41.07	15
		07/03/00	$576.00	$38.40	15
		12/05/01	$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

PCC Pediatric EHR Solutions

Care Management and Support

CM 04 (Core): Establishes a person-centered care plan for patients identified for care management.



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

- Use PCC's Care Plan component
- EHR Report coming soon to identify all patients with a Care Plan

PCC Pediatric EHR Solutions

Care Management and Support

CM05 (Core): Provides a written care plan to the patient/family/caregiver for patients identified for care management

CM06 (1 Credit): Documents patient preference and functional/lifestyle goals in individualized care plans

CM07 (1 Credit): Identifies and discusses potential barriers to meeting goals in individual care plans

CM08 (1 Credit): Includes a self-management plan in individual care plans

- Use Record Review Workbook
- Renewals: Reports and examples not required

PCC Pediatric EHR Solutions

Care Coordination and Care Transitions

CC 01 (Core): The practice systematically manages lab and imaging tests by:

A. Tracking lab tests until results are available, flagging and following up on overdue results.
B. Tracking imaging tests until results are available, flagging and following up on overdue results.
C. Flagging abnormal lab results, bringing them to the attention of the clinician.
D. Flagging abnormal imaging results, bringing them to the attention of the clinician.
E. Notifying patients/families/caregivers of normal lab and imaging test results.
F. Notifying patients/families/caregivers of abnormal lab and imaging test results.

- PCC likely will get autocredit for CC01.A-D
- Documented process and evidence of implementation required

PCC Pediatric EHR Solutions

Referral Tracking and Follow-up

CC 04 (Core): The practice systematically manages referrals by:

A. Giving the consultant or specialist the clinical question, the required timing and the type of referral.

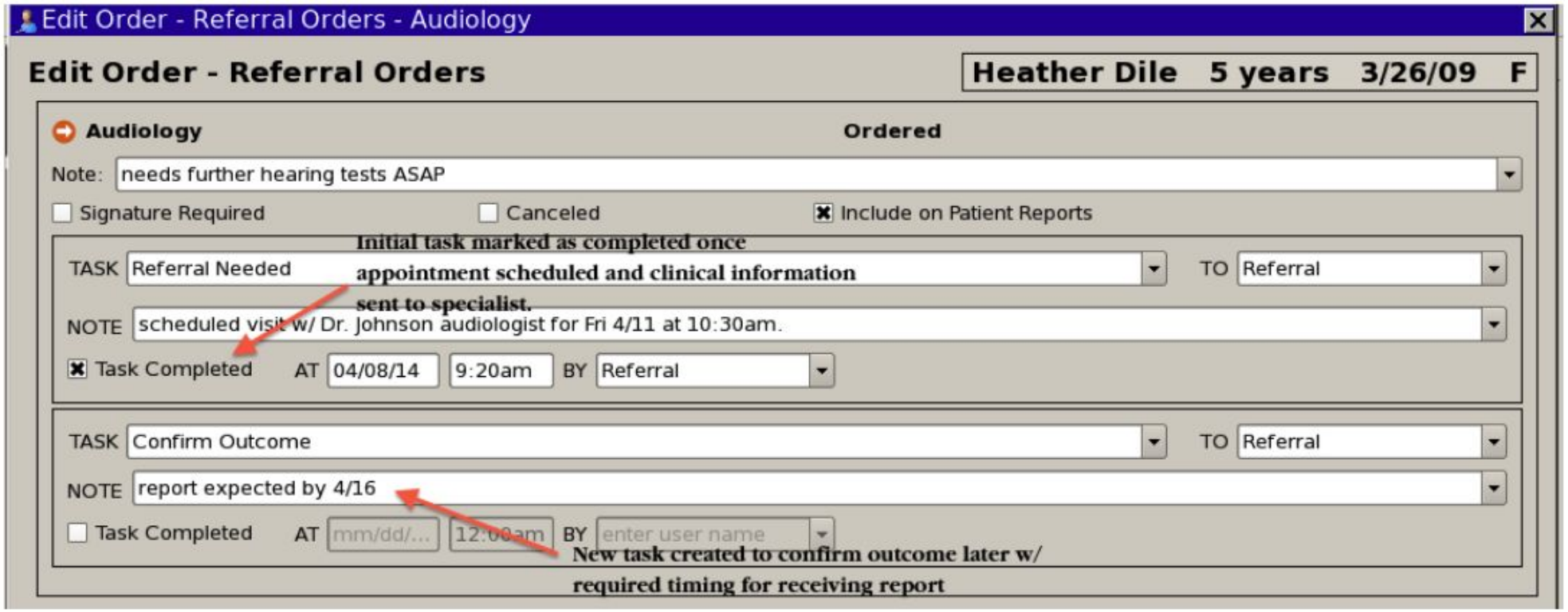
B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.

C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

- Documented process and evidence of implementation required
- Use Visit Summary report or Summary of Care Record to send to specialist

PCC Pediatric EHR Solutions

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)

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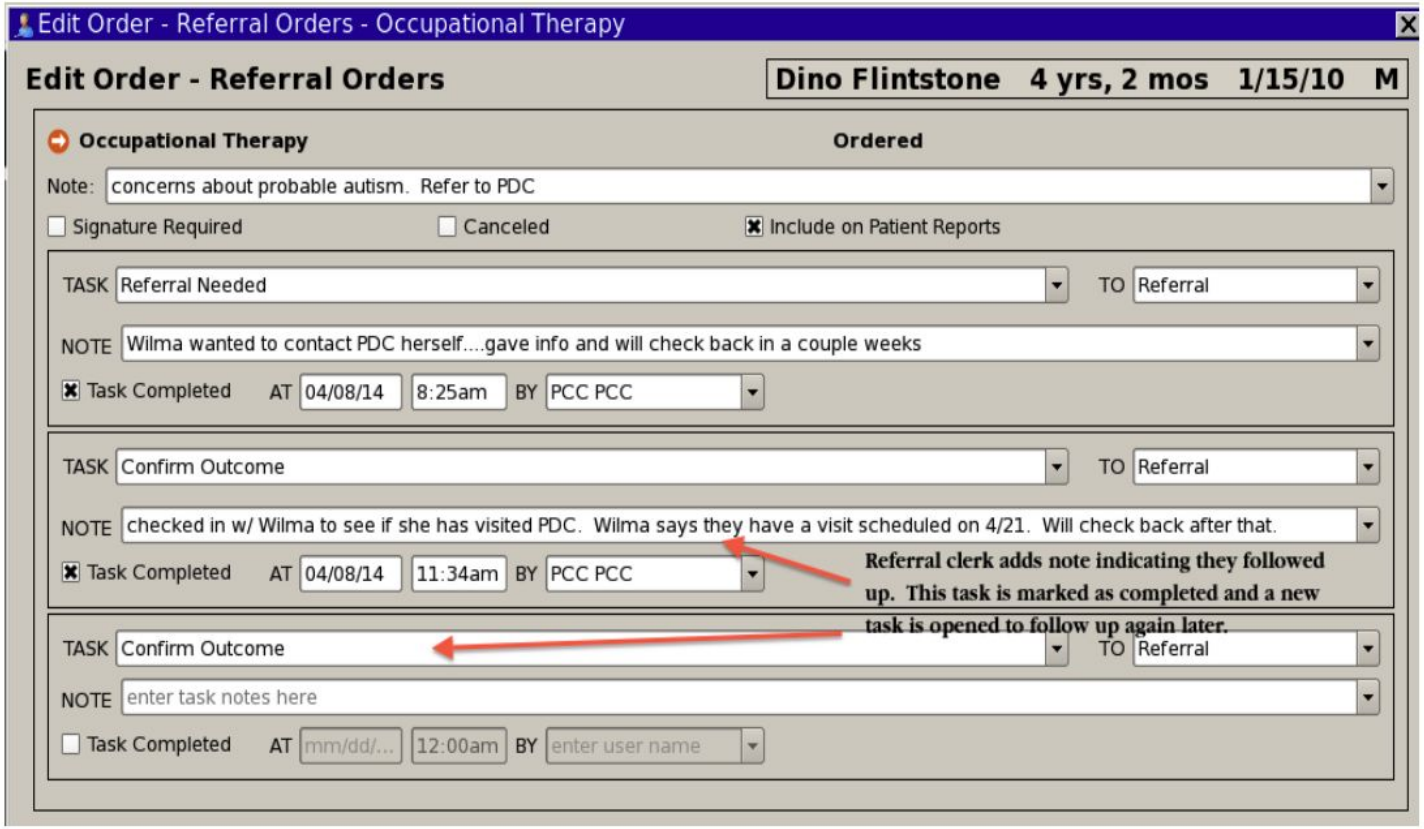
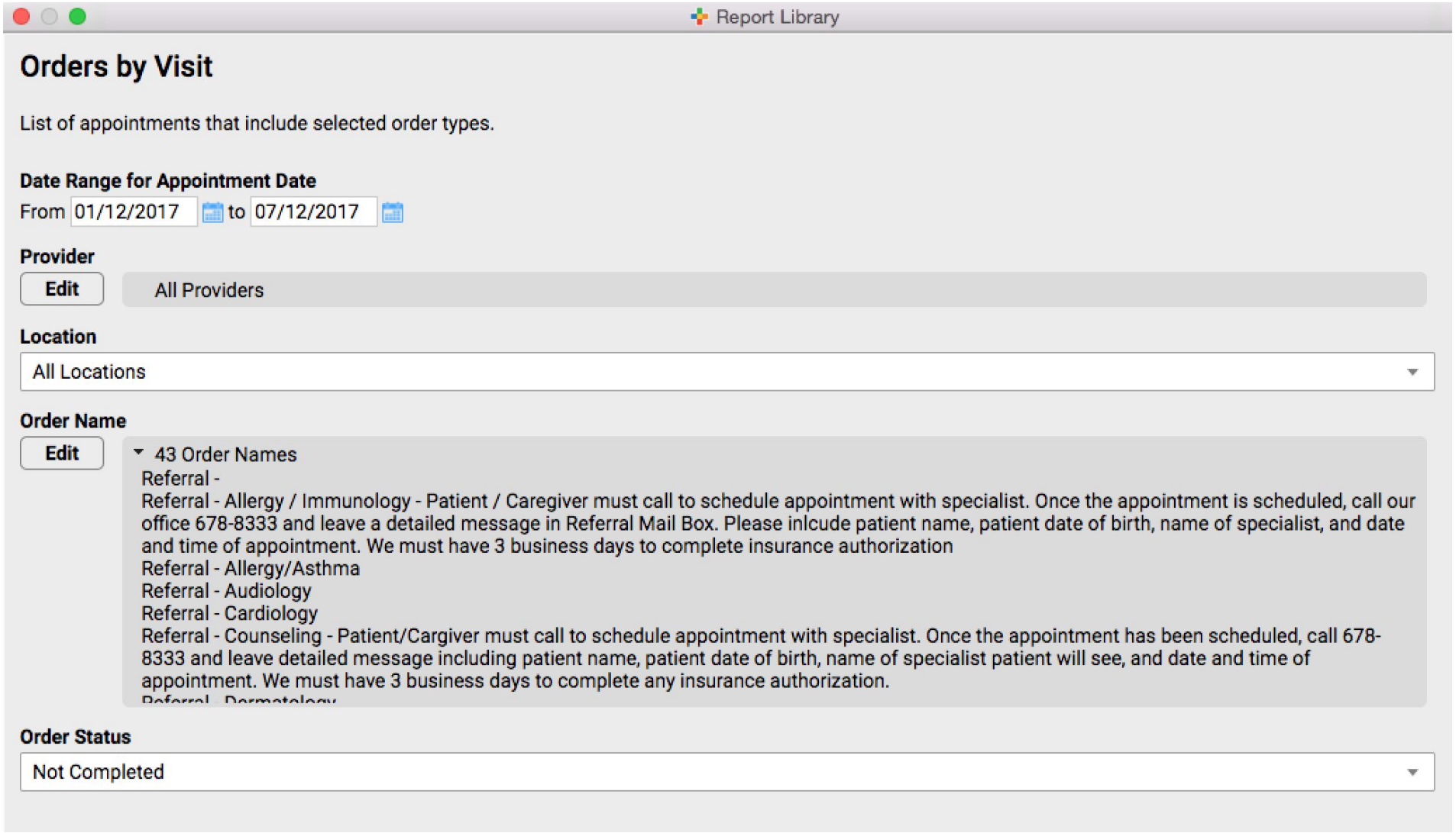
Tracking and Following Up on Referrals



- Refer to referral tracking workflow documented in PCMH WIKI

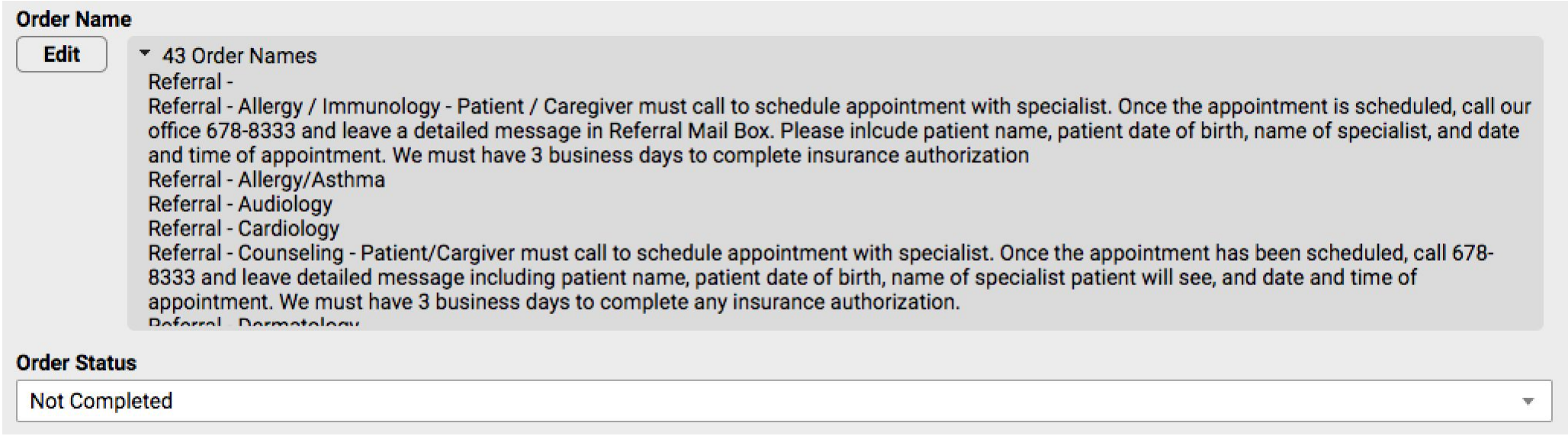
PCC Pediatric EHR Solutions

Report Outstanding Referral Orders



PCC Pediatric EHR Solutions

Report Outstanding Referral Orders



- Use “Orders by Visit” report in EHR Report Library
- Specify all referral orders (search for “referral” and “Select All”)
- Specify “Order Status = Not Completed” to see all outstanding referral orders

PCC Pediatric EHR Solutions

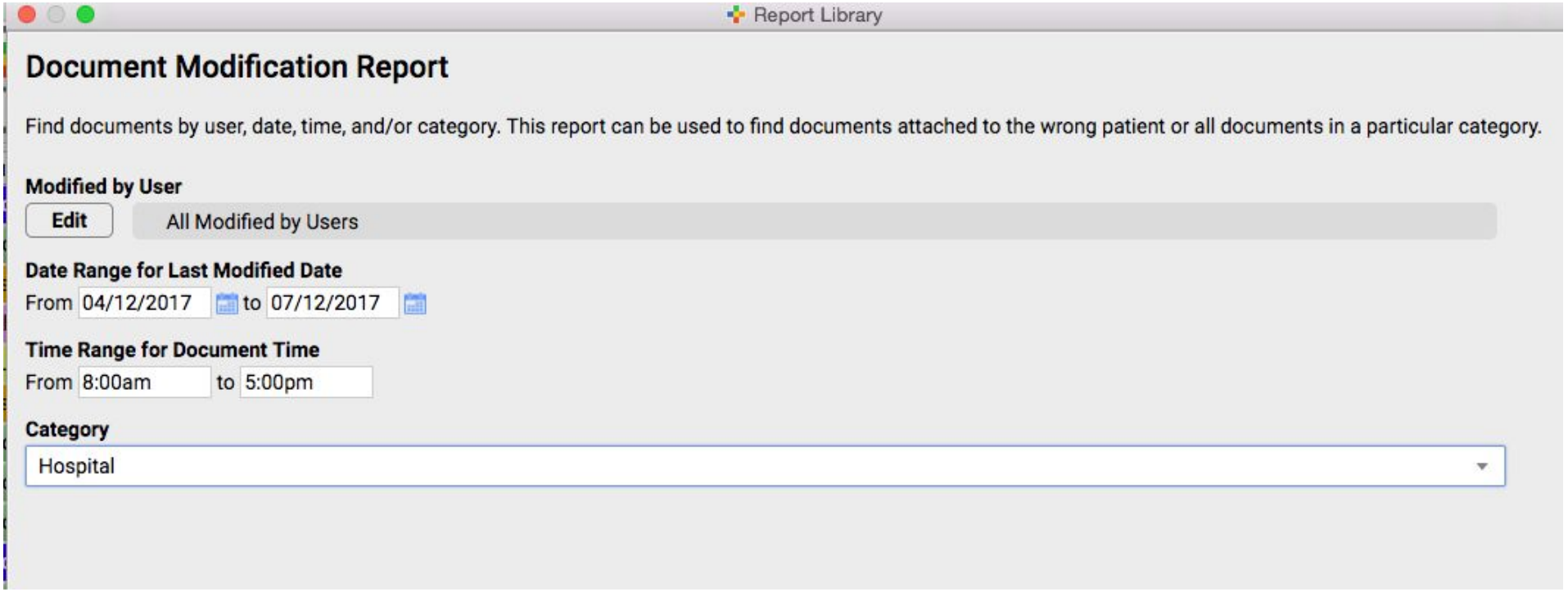
Identify Patients With Unplanned Hospital/ED Visits

CC 14 (Core): Systematically identifies patients with unplanned hospital admissions and emergency department visits

- Scan faxed hospital summaries into EHR and use “Document Modification Report” to identify these patients
- Renewals: Reports and examples not required

PCC Pediatric EHR Solutions

Identify Patients With Unplanned Hospital/ED Visits



- Scan these documents into a special “Hospital” category
- Use “Document Modification Report” in EHR Report Library, filtered to show only patients with documents in this “Hospital” Category

PCC Pediatric EHR Solutions

Identify Patients With Unplanned Hospital/ED Visits

Document Modification Report

Find documents by user, date, time, and/or category. This report can be used to find documents attached to the wrong patient or all documents in a particular category.

Modified by User: All
Last Modified Date: from 04/12/2017 to 07/12/2017
Document Time: from 8:00am to 5:00pm
Category: Hospital

Columns: All 11 Displayed Search Filter:

Modified Date/Time	User Name	Patient Name	PCC #	Patient DOB	Patient Sex	Title	Visit History Date	Category	Notes	Pages
07/12/2017 12:07pm	PCC PCC	Martin, Abigail	2271	02/16/2009	F	ED Visit Summary	07/12/2017	Hospital	Abigail's summary from her 7/10/17 visit at Fletcher Allen	1
07/12/2017 12:08pm	PCC PCC	Martin, David	1784	01/14/2016	M	6/16/17 Hospital admission	06/18/2017	Hospital		1
07/12/2017 12:09pm	PCC PCC	Maines, Gabrielle	2678	07/19/2015	F	ED VIsit Summary	05/08/2017	Hospital	Gabrielle was seen in the ED for broken leg that occurred while playing soccer	1

PCC Pediatric EHR Solutions

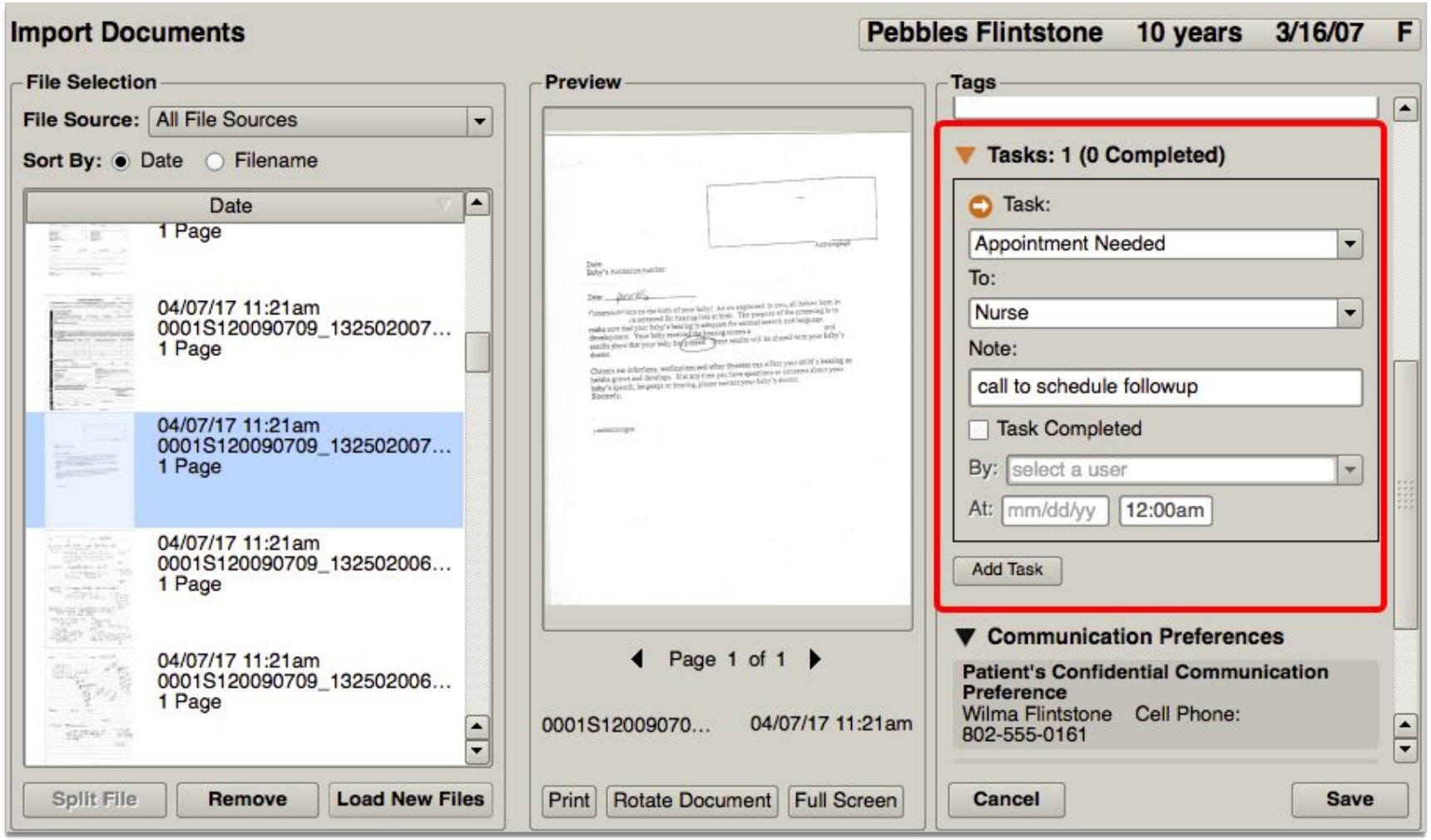
Contact Patients For Followup After Hospital or ED

CC 16 (Core): Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or ED visit

- Once hospital summary is received, add task for follow-up care
- View tasks on messages queue
- Renewals: Documented process and evidence not required

PCC Pediatric EHR Solutions

Contact Patients For Followup After Hospital or ED



Pediatric EHR Solutions

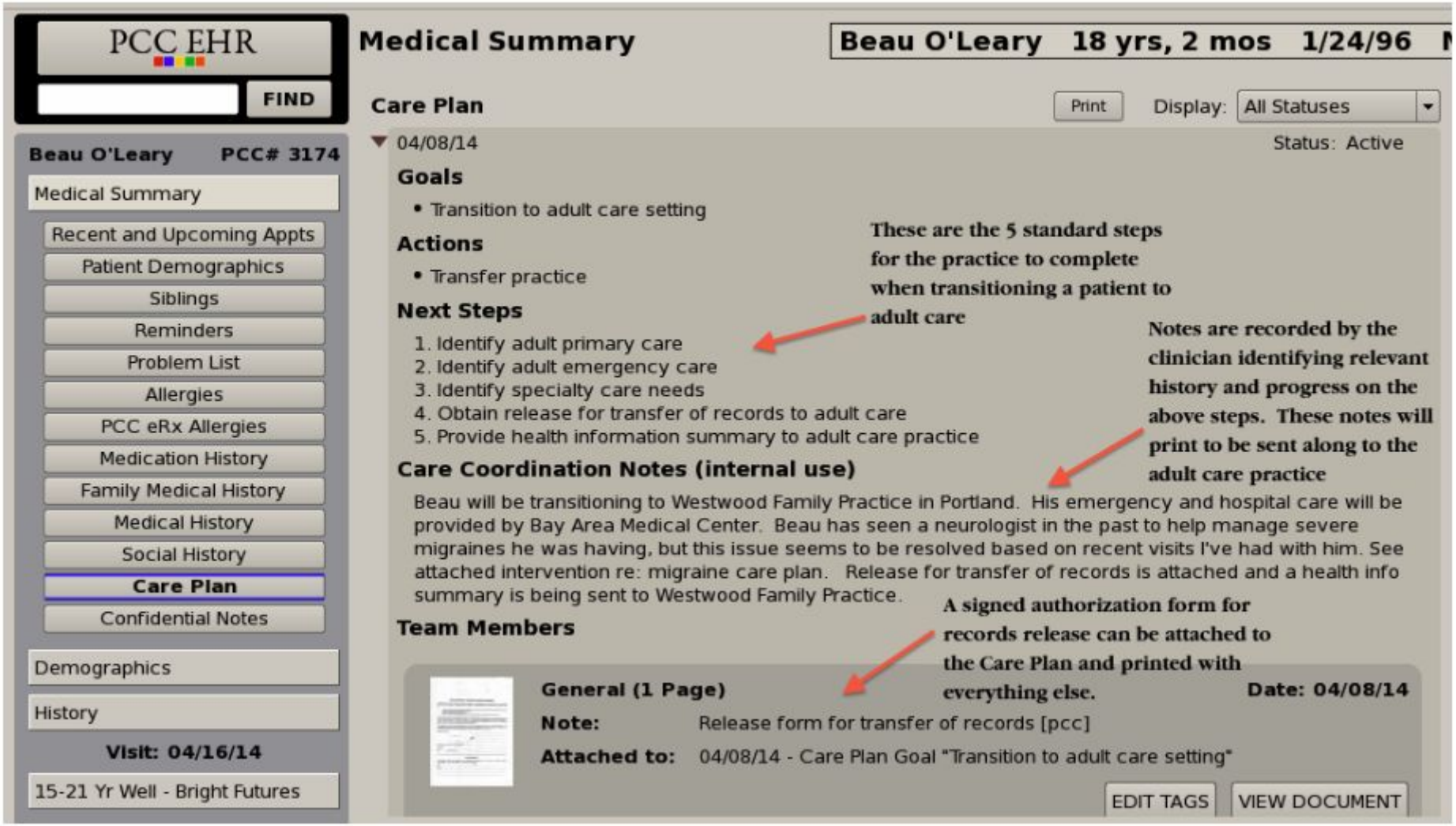
Care Plan for Patients Transitioning Out

CC 20 (1 Credit): Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice

- Use Care Plan to document transition to adult care setting
- Care Plans can be printed
- Renewals: Documented process and evidence not required

PCC Pediatric EHR Solutions

Care Plan for Patients Transitioning Out



PCC Pediatric EHR Solutions

Electronic Exchange of Information

CC 21 (*Maximum* 3 Credits): Demonstrates electronic exchange of information with external entities, agencies and registries (May select one or more):

A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit)

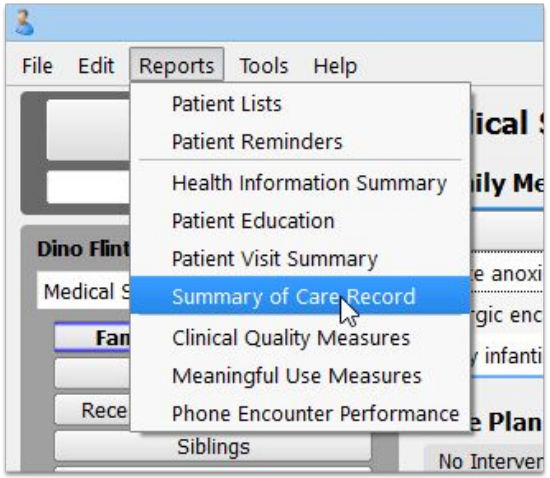
B. Immunization registries or immunization information systems. (1 Credit)

C. Summary of care record to another provider or care facility for care transitions. (1 Credit)

- Participation with Immunization Registry meets CC21.B
- Use Direct Secure Messaging for CC21.C
- Renewals: Evidence not required

PCC Pediatric EHR Solutions

Electronic Exchange of Information

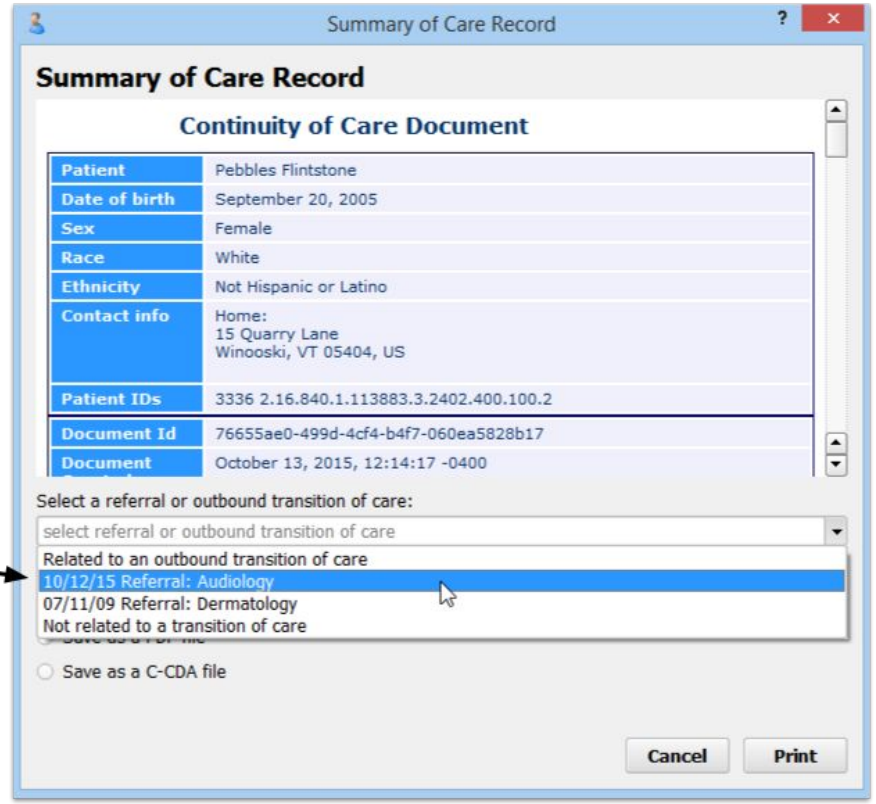


- The PCC Summary of Care Record report produces a C-CDA-formatted chart summary for a patient.

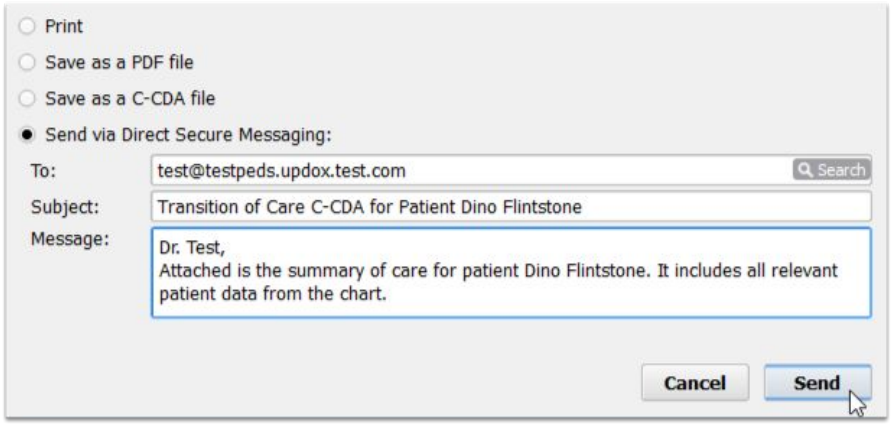
- Use this report as a transition of care document. Can be printed, saved as .pdf or sent to another clinician or practice via Direct Secure Messaging

PCC Pediatric EHR Solutions

Electronic Exchange of Information



Select from the patient's referrals



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

PCC Pediatric EHR Solutions

Monitor Clinical Quality Measures

QI 01 (Core): Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

A. Immunization measures.

B. Other preventive care measures.

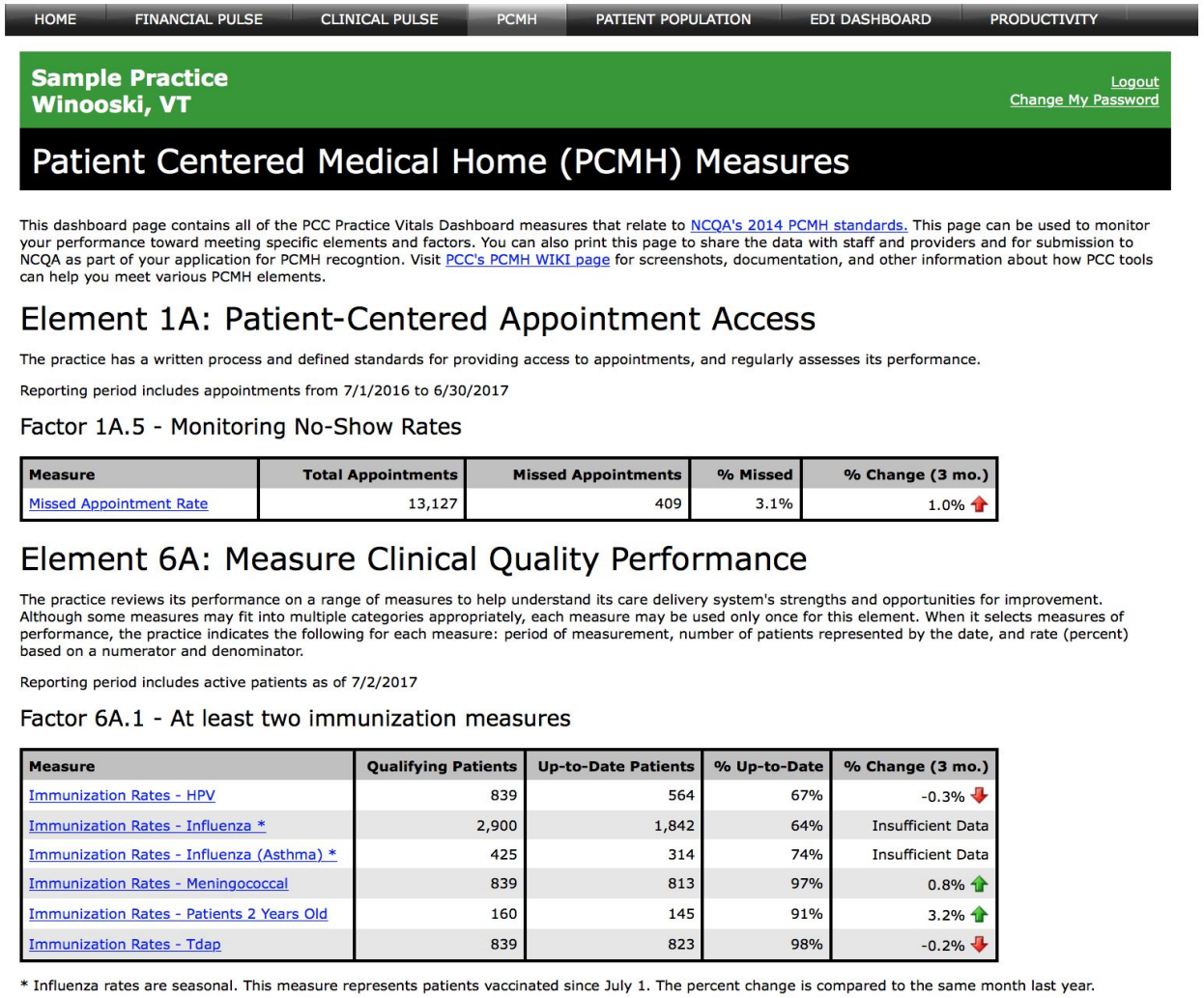
C. Chronic or acute care clinical measures.

D. Behavioral health measures.

- Refer to PCMH page in the Dashboard
- Need report including # of patients, rate, and measure source

PCC Pediatric EHR Solutions

Monitor Clinical Quality Measures



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

Sample Practice
Winooski, VT

Logout
Change My Password

Patient Centered Medical Home (PCMH) Measures

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

Element 1A: Patient-Centered Appointment Access

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

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

Factor 1A.5 - Monitoring No-Show Rates

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

Element 6A: Measure Clinical Quality Performance

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

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

Factor 6A.1 - At least two immunization measures

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

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

- PCMH page updated and replaced monthly
- Log your measure results monthly, including # patients

PCC Pediatric EHR Solutions

Monitor Resource Measures

QI 02 (Core): Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type):

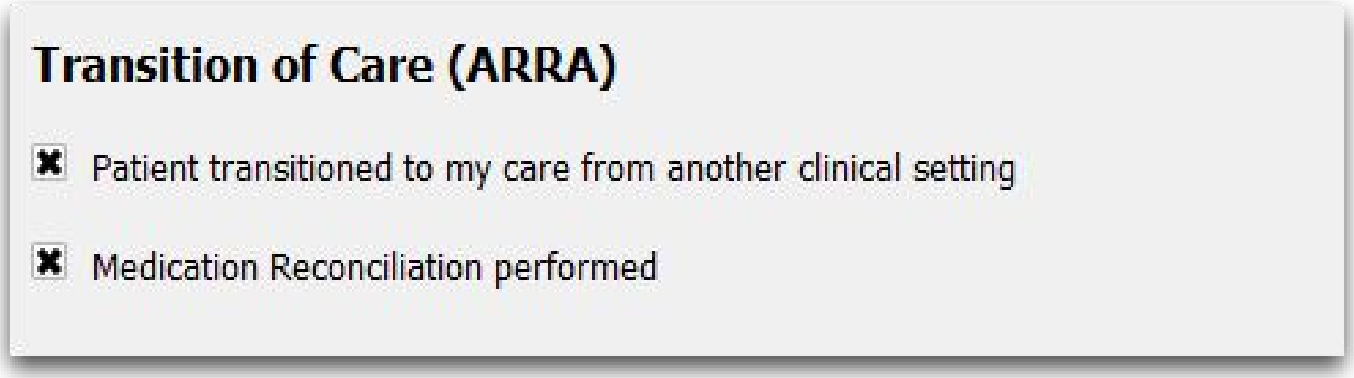
A. Measures related to care coordination.

B. Measures affecting health care costs.

- Report is required
- Use "Medication Reconciliation" MU measure report for QI 02.A
- 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

PCC Pediatric EHR Solutions

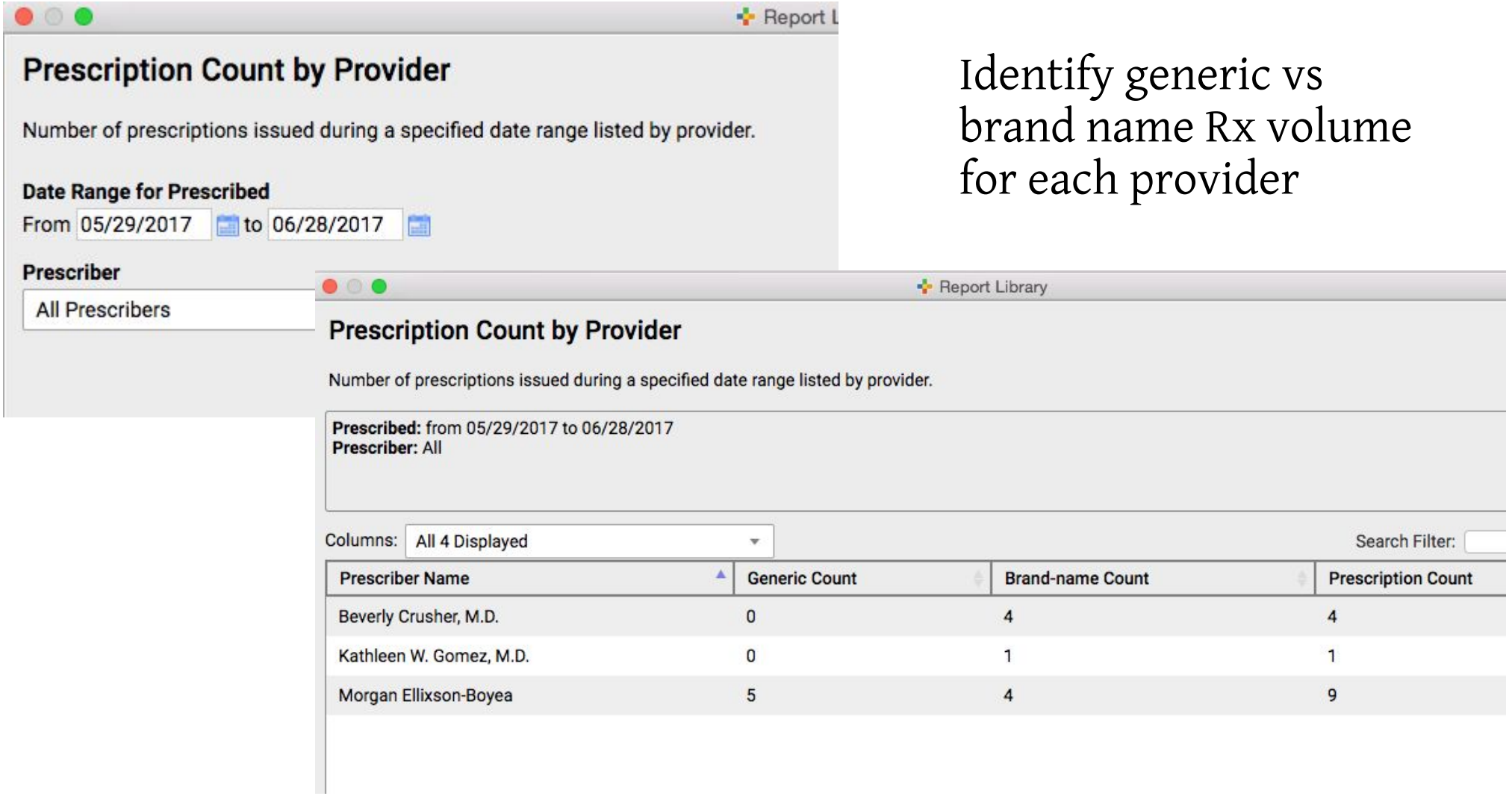
Medication Reconciliation Measure



- Insert "Transition of Care (ARRA)" component in protocols used for new patient visits, hospital visit followups, or other incoming transition of care visits
- Check off "Medication Reconciliation Performed" to count in numerator for this measure

PCC Pediatric EHR Solutions

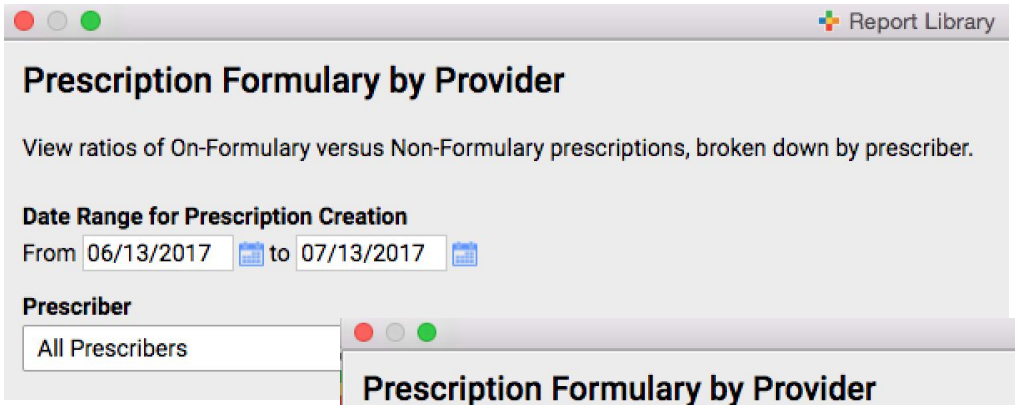
Generic vs Brand Rx



Identify generic vs brand name Rx volume for each provider

PCC Pediatric EHR Solutions

Formulary vs Non-Formulary Rx



Identify % of Rx On-Formulary for each provider

Report Library

Prescription Formulary by Provider

View ratios of On-Formulary versus Non-Formulary prescriptions, broken down by prescriber.

Prescription Creation: from 06/13/2017 to 07/13/2017
Prescriber: All

Columns: All 6 Displayed Search Filter:

Prescriber Name	Prescription Count	Formulary Not Known	On Formulary Count	Non Formulary Count	% On-Formulary
Bev	4	1	2	1	66.67 %
Dr. Gomez	1	0	0	1	0.0 %
Morgan	2	0	1	1	50.0 %
pcc	2	2	0	0	0 %
Sasha	2	0	2	0	100.0 %

PCC Pediatric EHR Solutions

Measure Appointment Availability

QI 03 (Core): Assesses performance on availability of major appointment types to meet patient needs and preferences for access.

- Produce report showing your appointment wait times compared with defined standards
- Use at least 5 days of data
- Report and documented process are required

PCC Pediatric EHR Solutions

Measure Appointment Availability

The information below measures appointment availability against the practice's standards by determining the third next available appointment for each appointment type within the 5 days.

Date range: 05/09/2016 to 05/13/2016
Appointment Type standards:

Well Child (preventive exam)- 14 calendar days
Follow Up Care-3 calendar days
Urgent Care- 0 calendar days (same-day appointments)

		Well Child Care		**Follow Up Care**		**Urgent Care (Sick)**	
	Report date	Date 3rd-next Appointment Available	Number of business days to 3rd-next	Date 3rd-next Appointment Available	Number of business days to 3rd-next	Date 3rd-next Appointment Available	Number of business days to 3rd-next
Day 1	05/09/16	05/18/16	7	05/10/16	1	05/09/16	0
Day 2	05/10/16	05/18/16	6	05/10/16	0	05/10/16	0
Day 3	05/11/16	05/20/16	7	05/11/16	0	05/11/16	0
Day 4	05/12/16	05/23/16	7	05/12/16	0	05/12/16	0
Day 5	05/13/16	05/23/16	6	05/13/16	0	05/13/16	0
		Avg. days	**6.6**	**Avg. Days**	**0.2**	**Avg. Days**	**0**

- For at least five days, document third next available appointment for well, followup, and sick appointments

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Performance Data Stratified for Vulnerable Populations

QI 05 (1 Credit): Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section):

A. Clinical quality.

B. Patient experience.

- Use vulnerable population reporting on PCMH Dashboard
- Renewals: Report not required

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Performance Data Stratified for Vulnerable Populations

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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Set Goals and Act to Improve

QI 08 (Core): Sets goals and acts to improve upon at least three measures across at least three of the four categories:

A. Immunization measures.
B. Other preventive care measures.
C. Chronic or acute care clinical measures.
D. Behavioral health measures.

QI 09 (Core): Sets goals and acts to improve performance on at least one measure of resource stewardship:

A. Measures related to care coordination.
B. Measures affecting health care costs.

- Identify measures that could be improved and monitor Dashboard results and trends monthly
- Report required

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Set Goals and Act to Improve

QI 10 (Core): Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.

QI 13 (1 Credit): Sets goals and acts to improve disparities in care or services on at least one measure.

- Identify measures that could be improved and monitor Dashboard results and trends monthly
- Report required

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Set Goals and Act to Improve

QI 12 (2 Credits): Achieves improved performance on at least two performance measures.

QI 14 (2 Credits): Achieves improved performance on at least one measure of disparities in care or service.

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% ↑

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Practice Shares Performance Data

QI 15 (Core): Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.

- Use Dashboard PCMH page to see breakdown by provider (PCP) for certain measures
- Documented process and evidence of implementation is required

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Practice Shares Performance Data

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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Reporting CQM data to Medicaid

QI 18 (2 Credits) - Reports clinical quality measures to Medicare or Medicaid agency

- If reporting CQMs with MU application, you get credit
- If not doing MU, contact Medicaid to see if they'll accept your CQMs
- Evidence of submission is required

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Review of PCC's PCMH Resources

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PCC PCMH Resources

http://pcmh.pcc.com

- Documentation and examples of relevant PCC reports and functionality related to 2014 and 2017 standards
- Also includes other NCQA resources
- PCC Prevalidation
    - PCC expects to soon achieve some level of autocredit under 2017 standards
    - Contact PCC for “Letter of Product Implementation”

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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!

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