Improving Your Practice Health with PCC Dashboard

Tim Proctor (tim@pcc.com)
Users Conference 2019
Agenda

- PCC Dashboard features
- What’s new to PCC Dashboard
- Ten ways to use the Dashboard to improve practice health
- Explore your own PCC Dashboard
Goals

- Discover new Dashboard features added in the past year
- Recognize specific PCC Dashboard reports that are important to the health and growth of my practice
- See how you measure up to other PCC practices
PCC Dashboard

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

My Practice Status

Financial Pulse

Clinical Pulse

87

63
PCC Dashboard Basics

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

- PCC AVG and “Top Performers” (90\textsuperscript{th} percentile)
- New! HEDIS benchmarks

How You Compare

<table>
<thead>
<tr>
<th>% of Patients Up-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>You</td>
</tr>
<tr>
<td>17%</td>
</tr>
</tbody>
</table>

- Your Practice: 17%
- PCC Client Average: 31%
- Top Performers: 55%
- HEDIS\textsuperscript{®} Commercial HMO: 24%

(\% of active patients 13 years old up-to-date)
PCC Dashboard Scoring

- Over 20 measures are calculated and scored based on your relative performance
- Prioritized list of results on home page
How Does Dashboard Scoring Work?

● For each measure, PCC defines the values that correspond to a score of 0 and 100

● For each measure, your score is based on:
  ○ How far your measure value is from the “zero-score” measure value
  ○ The variance between “zero-score” and “100-score” measure values
Location-Adjustments

- Apply to Revenue-per-Visit, RVU-per-Visit, and Pricing measures
- Allows for comparison to benchmark regardless of practice geographic location
- Uses current RVU geographic practice cost index (GPCI) values for your location
- Relatively high cost-of-living and malpractice expense = negative adjustment
- Relatively low cost-of-living and malpractice expense = positive adjustment
For some measures, there are additional breakdowns by provider (typically PCP).

### Detailed Breakdown: Primary Care Provider

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

Review ADD/ADHD Overdue patient listing for your practice.

### How You Compare

- Provider 2: 75%
- Average PCC Client: 63%
- Top 10% of PCC Clients: 83%
Provider Breakdown

Provider breakdown available for the following measures:

- Immunization Rates - Influenza (Asthma)
- ADD/ADHD Patient Followup
- Well Visit Rates
- Missed Appointment Rate
- Developmental and Depression Screening Rates
- Sick-to-Well Visit Ratio
- E&M Coding Distribution
What’s New to PCC Dashboard?
Percentage of active 13-year-old patients having TdaP, Meningococcal, and HPV series by age 13
Immunization Rates - Adolescents

The data below represents your immunization rate for each vaccination in the series of vaccines recommended for patients by their thirteenth birthdays. Choose a benchmark comparison from the menu below to compare your practice result with a pediatric benchmark.

- **Includes breakdown by vaccine**
- **Includes overdue patient list**
- **Includes HEDIS benchmarks**

### Breakdown By Vaccine

#### Choose Benchmark Comparison:
- Average PCC Client
- Average PCC Client Top 10% of PCC Clients
- HEDIS® Commercial HMO Benchmark
- HEDIS® Commercial PPO Benchmark
- HEDIS® Medicaid HMO Benchmark

#### Get overdue lists for each vaccine

#### Breakdown Table:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Number Needed By Age 13</th>
<th>Total Patients Age 13</th>
<th>Patients Up-to-Date at Age 13</th>
<th>% Up-to-Date at Age 13</th>
<th>Overdue at Age 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV</td>
<td>2</td>
<td>185</td>
<td>106</td>
<td>59%</td>
<td>26 patients overdue</td>
</tr>
<tr>
<td>Meningococcal (1)</td>
<td>1</td>
<td>185</td>
<td>175</td>
<td>95%</td>
<td>10 patients overdue</td>
</tr>
<tr>
<td>Tdap (1)</td>
<td>1</td>
<td>185</td>
<td>181</td>
<td>98%</td>
<td>4 patients overdue</td>
</tr>
<tr>
<td>HEDIS® Combo 2 * (Includes All Vaccines Above)</td>
<td>N/A</td>
<td>185</td>
<td>107</td>
<td>58%</td>
<td>28 patients overdue</td>
</tr>
</tbody>
</table>

*HEDIS® Combo 2* represents the percentage of patients up-to-date on all three of the following vaccine series: one tetanus, diphtheria, and acellular pertussis (Tdap); one meningococcal; and at least two human papillomavirus (HPV).
Measure name has been changed to “Depression Screening Rate – Adolescents”

Now considers 12-21 age range (used to be 11-21)
**PCMH Dashboard Update**

- PCMH Dashboard updated to reference NCQA 2017 standards and guidelines

---

**D. Behavioral Health Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Qualifying Patients</th>
<th>Up-to-Date Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD Patient Followup</td>
<td>318</td>
<td>261</td>
</tr>
<tr>
<td>Depression Screening Rates - Adolescents</td>
<td>1,066</td>
<td>934</td>
</tr>
</tbody>
</table>

A new Behavioral Health Measures section and other organizational changes reflect 2017 standards for PCMH.
Weight Assessment and Counseling

For patients 3-17 years old, measure of how often the following are documented:

- BMI
- Nutritional counseling
- Physical activity counseling

- Includes HEDIS benchmarks

---

Measure: Weight Assessment and Counseling for Nutrition and Physical Activity

This set of three measures indicates how often your practice assesses body mass index (BMI) for your 3-17 year-old patient population and, separately, how often you provide nutritional and physical activity counseling to these patients.

These measures, based on the HEDIS® Weight Assessment and Counseling Measure, show the percentage of patients 3-17 years of age who had at least one BMI recording documented during an office visit in the past year. Since it is also important to provide guidance for maintaining a healthy weight and lifestyle, this measure will additionally show how often these patients had counseling for nutrition and counseling for physical activity performed at least once during an office visit in the past year. This counseling is tracked in PCC EHR via orders mapped to appropriate SNOMED-CT Procedures.

---

**Weight Assessment**

- Your Practice: 99 out of 100
- Patients with recorded BMI: 2,270
- Patients 3y - 17y seen in past year: 2,293
- Percentage: 99%

**Nutritional Counseling**

- Your Practice: 0 out of 100
- Patients with recorded Nutritional Counseling: 3

*The data for each of the three measures is displayed individually.*
Weight Assessment and Counseling

- Use medical procedure orders for charting nutrition and exercise counseling
- Map these orders to appropriate SNOMED entries
Well Visit Rate Measure Updates

- Well visit rate measures consolidated to one Dashboard page
- HEDIS benchmark comparison added
- Calculation change for “Under 15 Months” age group
Missed Appointment Rate Measure

Measure: Missed Appointment Rate

Choose a measure

Your Score: 88 out of 100

This measure shows the percentage of appointments at your practice that were missed. Missed appointments represent revenue loss and delayed patient care, along with stress and anxiety caused by uncertain schedules and the extra work involved with trying to fill those empty slots at the last minute. The missed appointment rate is calculated by adding all missed appointments for the past three months and dividing by the number of total appointments during that time (excluding canceled and deleted appointments).

Your practice had a total of 5,272 appointments in the past three months that were not canceled or deleted.

112 of these appointments were marked as missed.

How You Compare

- Your Practice: 2.1%
- PCC Client Average: 4.9%
- Top Performers: 1.3%

Now based on appointments happening in past 3 months

Will make it easier to monitor changes to no-show rate
10 Ways to Use the Dashboard to Improve Practice Health
#10 - Maintaining Patient Flags

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

- Be sure to routinely flag patients who shouldn’t be included on your reports (Hospital Only, Transferred, etc)
- Monitor using Dashboard overdue lists
#9 - Monitor Measure Trends

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

**Trend: History of Your Values**

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

[Graph showing % sick visits coded as 99214/99215 over months February to June 2017]

**Save trend output as .csv (spreadsheet) file**
#8 - Review Suggestions for Improvements

For each measure, explanations and guidance are provided

---

**Recommendations**

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

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

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

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

Related Tools
- Annual State, Regional, and National benchmarks
- Quarterly View
- Compare Payor Visit and Revenue Trends
- View Payor Mix for one or all providers
- Daysheet Summary
#6 - Use the Dashboard for PCMH Recognition

QI 01 (Core) – Clinical Quality Measurement

To understand current performance and to identify opportunities for improvement, the practice monitors clinical quality measurement. 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.

Choose at least five clinical quality measures across the four categories (A-D) listed below. You must monitor at least one measure of each category, and you cannot use the same measure for different categories.

Reporting period includes active patients as of 6/1/2019

A. Immunization Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Qualifying Patients</th>
<th>Up-to-Date Patients</th>
<th>% Up-to-Date</th>
<th>% Change (3 mo.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization Rates - Adolescents</td>
<td>254</td>
<td>51</td>
<td>20%</td>
<td>Insufficient Data</td>
</tr>
<tr>
<td>Immunization Rates - HPV (Patients 13-17 Years)</td>
<td>1,110</td>
<td>651</td>
<td>58%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Immunization Rates - HPV (Patients 13 Years)</td>
<td>254</td>
<td>92</td>
<td>36%</td>
<td>-5.0%</td>
</tr>
<tr>
<td>Immunization Rates - Influenza *</td>
<td>4,741</td>
<td>3,093</td>
<td>65%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Immunization Rates - Influenza (Asthma) *</td>
<td>451</td>
<td>301</td>
<td>67%</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Immunization Rates - Meningococcal</td>
<td>1,119</td>
<td>1,080</td>
<td>97%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Immunization Rates - Patients 2 Years Old</td>
<td>317</td>
<td>241</td>
<td>76%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Immunization Rates - Tdap</td>
<td>1,119</td>
<td>1,080</td>
<td>97%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

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

QI 05 (1 Credit) Health Disparities Assessment

The practice assesses health disparities using performance data stratified for vulnerable populations. You must choose one clinical quality and one patient experience measure. Use the menu below to stratify one clinical quality measure for a selected vulnerable population.

Reporting period includes active patients as of 6/1/2019

Performance data stratified for vulnerable populations

<table>
<thead>
<tr>
<th>Measure:</th>
<th>ADD/ADHD Patient Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakdown By:</td>
<td>Severity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Qualifying Patients</th>
<th>Up-to-Date Patients</th>
<th>% Up-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>None Selected</td>
<td>12</td>
<td>8</td>
<td>67%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>25</td>
<td>18</td>
<td>72%</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>243</td>
<td>164</td>
<td>67%</td>
</tr>
<tr>
<td>Prefers not to answer</td>
<td>13</td>
<td>10</td>
<td>77%</td>
</tr>
</tbody>
</table>

QI 10 (Core) Setting goals and taking action to improve appointment availability

Practices may select no-show rates as an area of focus for improving patient access. You may also want to consider monitoring no-show rates as a health care costs measure (resource stewardship measure) relevant to PCMH element Q002-B.

The reporting period for this measure includes appointments from 3/1/2019 to 5/31/2019

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total Appointments</th>
<th>Missed Appointments</th>
<th>% Missed</th>
<th>% Change (3 mo.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed Appointment Rate</td>
<td>9,272</td>
<td>112</td>
<td>2.1%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

QI 15 (Core) Reporting Performance within the Practice

The practice provides individual clinician or practice-level report to clinicians and practice staff. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. Select a measure from the menu below to see clinician level reporting, broken down by primary care provider.

Reporting period includes active patients as of 6/1/2019

Performance data stratified for individual clinicians

<table>
<thead>
<tr>
<th>Measure:</th>
<th>ADD/ADHD Patient Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider</td>
<td>Qualifying Patients</td>
</tr>
</tbody>
</table>
#6 - Use the Dashboard for PCMH Recognition

- Identifying populations of patients (KM 12)
- Population Health Management (QI 01)
  - Tracking monthly trends
  - Review and print results monthly
- Provider-specific reporting (QI 15 and 16)
- Vulnerable population (race, ethnicity, insurance, language) breakdown for some measures (QI 05)
#5 - Share Dashboard Results

- Share results during staff/provider meetings
- Share results with your patients
- Share results with vaccine and insurance reps
- Copy/Paste graphs into presentations or other documents
#4 - Generate A/R Summary Report

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

Related Tools
- Detailed A/R Summary Report
#4 - Generate A/R Summary Report

- Revenue trends
- A/R Days and benchmarks
- A/R Percentage by Aging Category
- Personal vs Insurance A/R
- Recommendations
#3 - Monitor Patient Population Trends

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

Patient Age Distribution Trend

For All Providers
And Active Patients Under 15 Months
Between 8/1/2012 and 7/2/2017

Save trend output as .csv (spreadsheet) file
#2 - Use Dashboard to Keep Payors Honest

- Dashboard vs Payor report cards
  - Compare measure results
  - Compare overdue patient counts
  - Challenge payors by using Dashboard data

- Compare measure results by payor and use as leverage when negotiating
#2 - Use Dashboard to Keep Payors Honest

- PCMH Dashboard - measure results by primary insurance

QI 05 (1 Credit) Health Disparities Assessment

The practice assesses health disparities using performance data stratified for vulnerable populations. You must choose one clinical quality and one patient experience measure. Use the menus below to stratify one clinical quality measure for a selected vulnerable population.

Reporting period includes active patients as of 6/1/2019

Performance data stratified for vulnerable populations

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Qualifying Patients</th>
<th>Up-to-Date Patients</th>
<th>% Up-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Insurance</td>
<td>38</td>
<td>21</td>
<td>55%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>312</td>
<td>228</td>
<td>73%</td>
</tr>
<tr>
<td>BCBS</td>
<td>635</td>
<td>506</td>
<td>80%</td>
</tr>
<tr>
<td>Cigna</td>
<td>172</td>
<td>130</td>
<td>76%</td>
</tr>
<tr>
<td>MVP</td>
<td>125</td>
<td>90</td>
<td>72%</td>
</tr>
<tr>
<td>First Health</td>
<td>15</td>
<td>13</td>
<td>87%</td>
</tr>
<tr>
<td>Tricare</td>
<td>6</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>CBA BLUE</td>
<td>19</td>
<td>16</td>
<td>84%</td>
</tr>
<tr>
<td>United HC</td>
<td>42</td>
<td>30</td>
<td>71%</td>
</tr>
<tr>
<td>AETNA</td>
<td>26</td>
<td>22</td>
<td>85%</td>
</tr>
<tr>
<td>BCBS OTHER</td>
<td>148</td>
<td>105</td>
<td>71%</td>
</tr>
</tbody>
</table>
#1 - Highlight Opportunities for Improved Patient Recall

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

**411** of these patients are overdue for their well visit.

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

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

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