Improving Your Practice Health with PCC Dashboard

Tim Proctor (tim@pcc.com)

Users Conference 2019

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THRIVING THROUGH CHANGE

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

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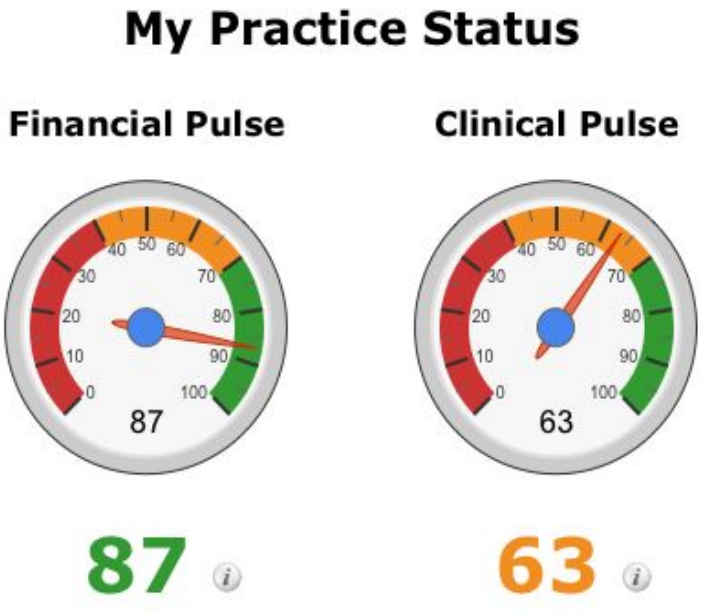
Goals

- 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."



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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

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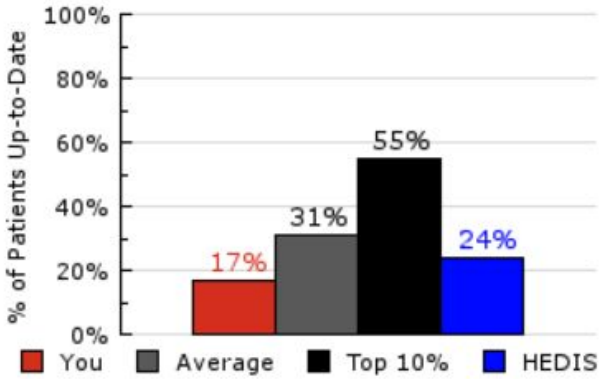
Benchmarks

- PCC AVG and "Top Performers" (90th percentile)
- New! HEDIS benchmarks

How You Compare



Your Practice	PCC Client Average	Top Performers	HEDIS® Commercial HMO
17%	31%	55%	24%

(% of active patients 13 years old up-to-date)

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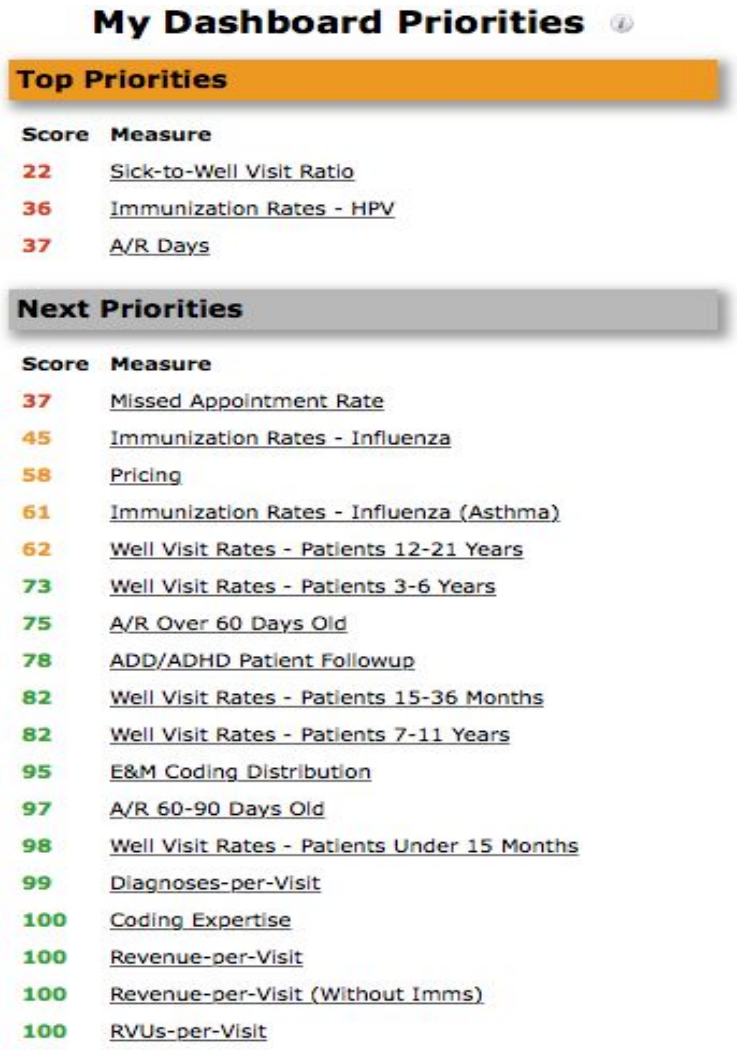
PCC Dashboard Scoring

- Over 20 measures are calculated and scored based on your relative performance
- Prioritized list of results on home page



My Dashboard Priorities

Top Priorities

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

Next Priorities

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

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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

Provider Breakdown

For some measures, there are additional breakdowns by provider (typically PCP).

Detailed Breakdown: Primary Care Provider

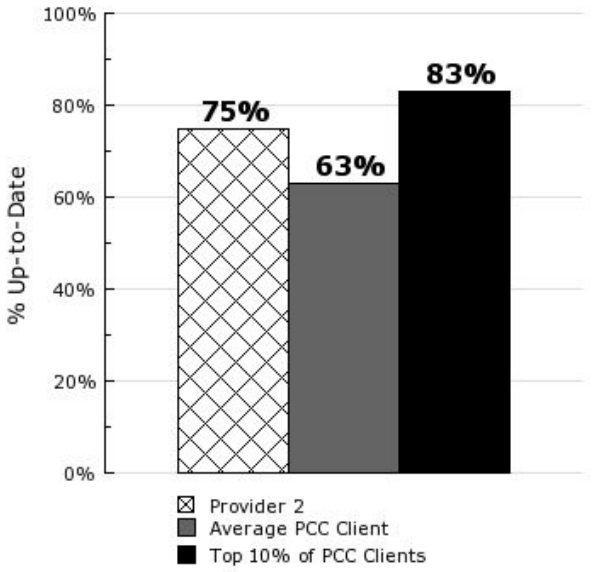
Show Breakdown By: Primary Care Provider

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

Review ADD/ADHD Overdue patient listing for your practice.

How You Compare

Compare: Provider 2



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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?

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Immunization Rates - Adolescents

Measure: Immunization Rates - Adolescents

Choose a measure

Dashboard reports updated as of 6/1/2019

Your Score: **25** out of 100

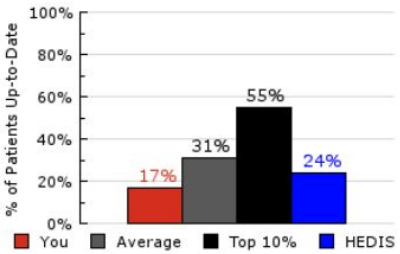
This measure assesses the provision of critical immunizations in adolescents by their 13th birthday and is based on the Immunizations for Adolescents HEDIS® measure. This shows the percentage of active patients currently thirteen years of age who are up-to-date on the following series of three vaccines by their thirteenth birthday: one tetanus, diphtheria, and acellular pertussis (TdaP), one meningococcal, and at least two human papillomavirus (HPV) vaccines.

As of 6/1/2019 you have **1,636** active patients who are currently thirteen years old.

1,364 of these patients were overdue for at least one vaccine series by their thirteenth birthday.

See a breakdown by vaccine showing the number of patients overdue for each vaccine and overdue lists.

How You Compare



Your Practice	PCC Client Average	Top Performers	HEDIS® Commercial HMO
17%	31%	55%	24%

(% of active patients 13 years old up-to-date)

Percentage of active 13-year-old patients having TdaP, Meningococcal, and HPV series by age 13

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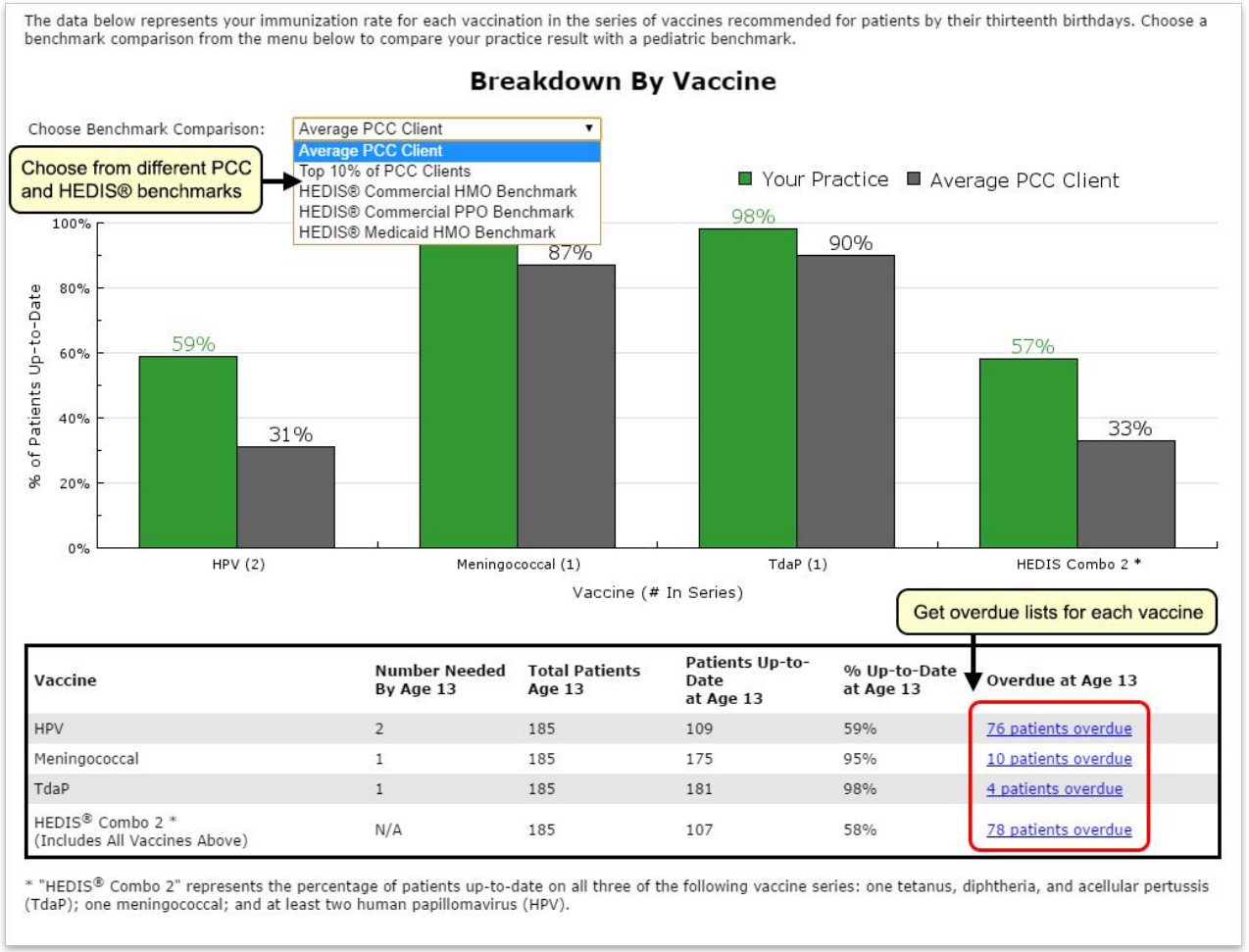
Immunization Rates - Adolescents



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

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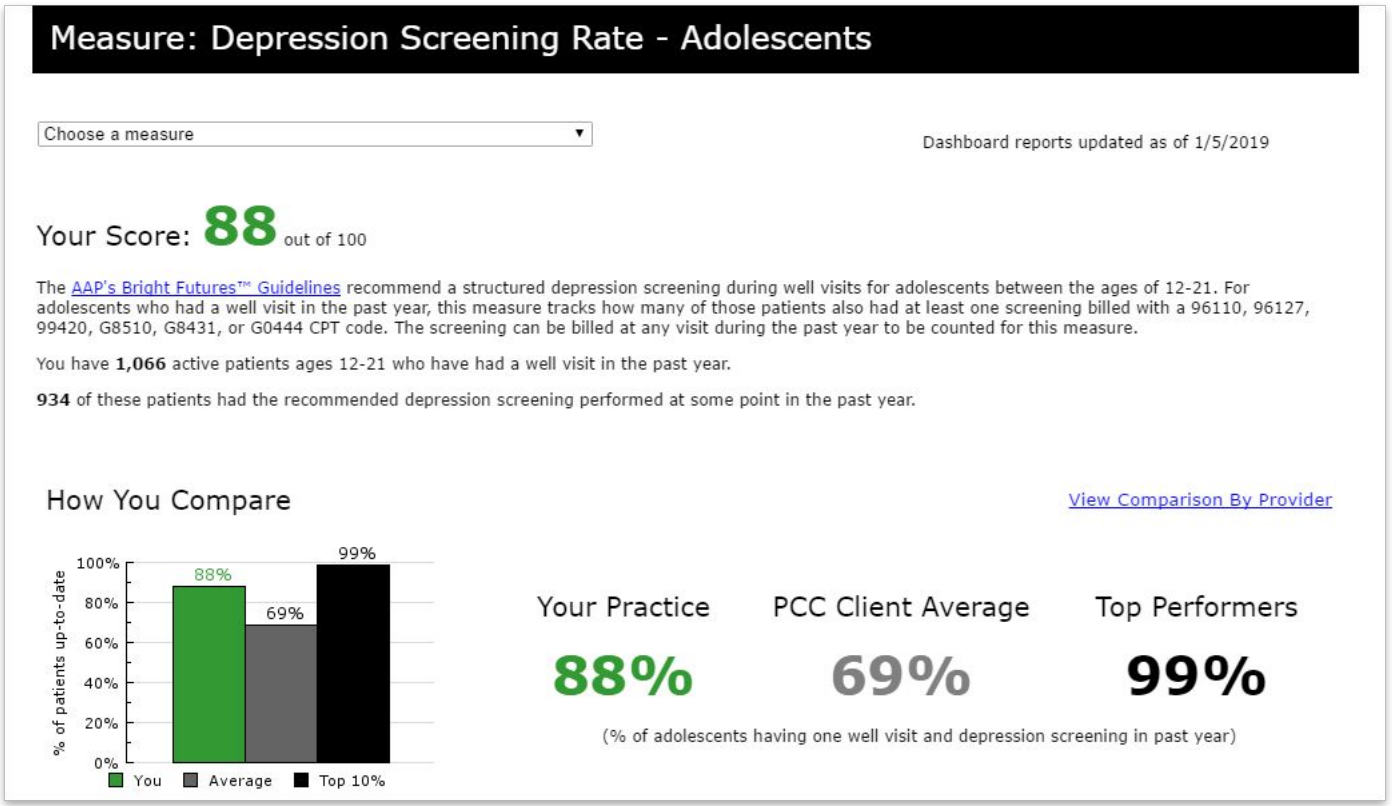
Depression Screening Rate - Adolescents



- Measure name has been changed to "Depression Screening Rate – Adolescents"
- Now considers 12-21 age range (used to be 11-21)

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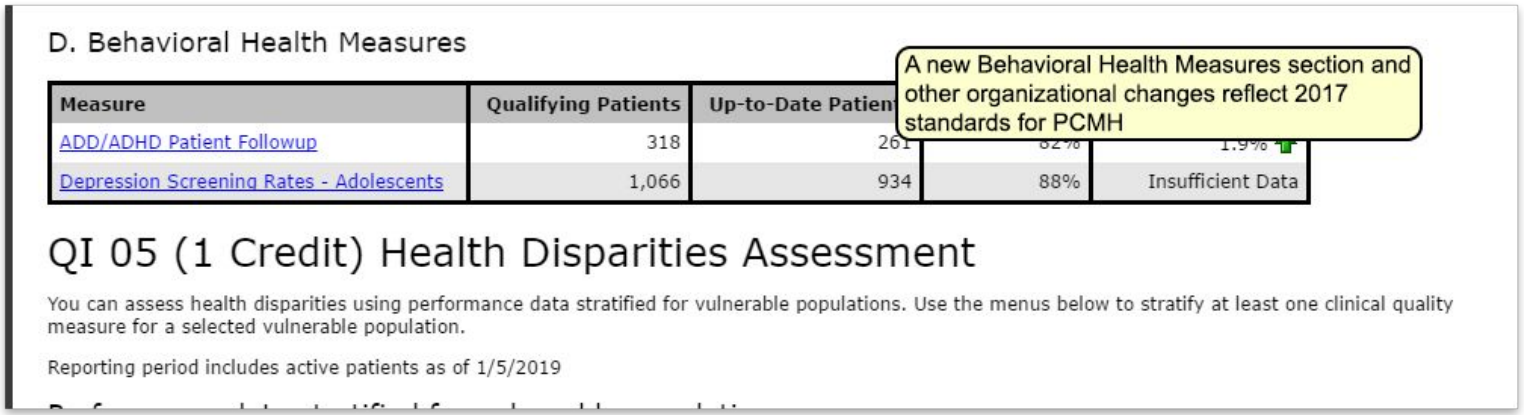
PCMH Dashboard Update



D. Behavioral Health Measures

A new Behavioral Health Measures section and other organizational changes reflect 2017 standards for PCMH

Measure	Qualifying Patients	Up-to-Date Patien		
ADD/ADHD Patient Followup	318	261	82%	1.9%
Depression Screening Rates - Adolescents	1,066	934	88%	Insufficient Data

QI 05 (1 Credit) Health Disparities Assessment

You can assess health disparities using performance data stratified for vulnerable populations. Use the menus below to stratify at least one clinical quality measure for a selected vulnerable population.

Reporting period includes active patients as of 1/5/2019

- PCMH Dashboard updated to reference NCQA 2017 standards and guidelines

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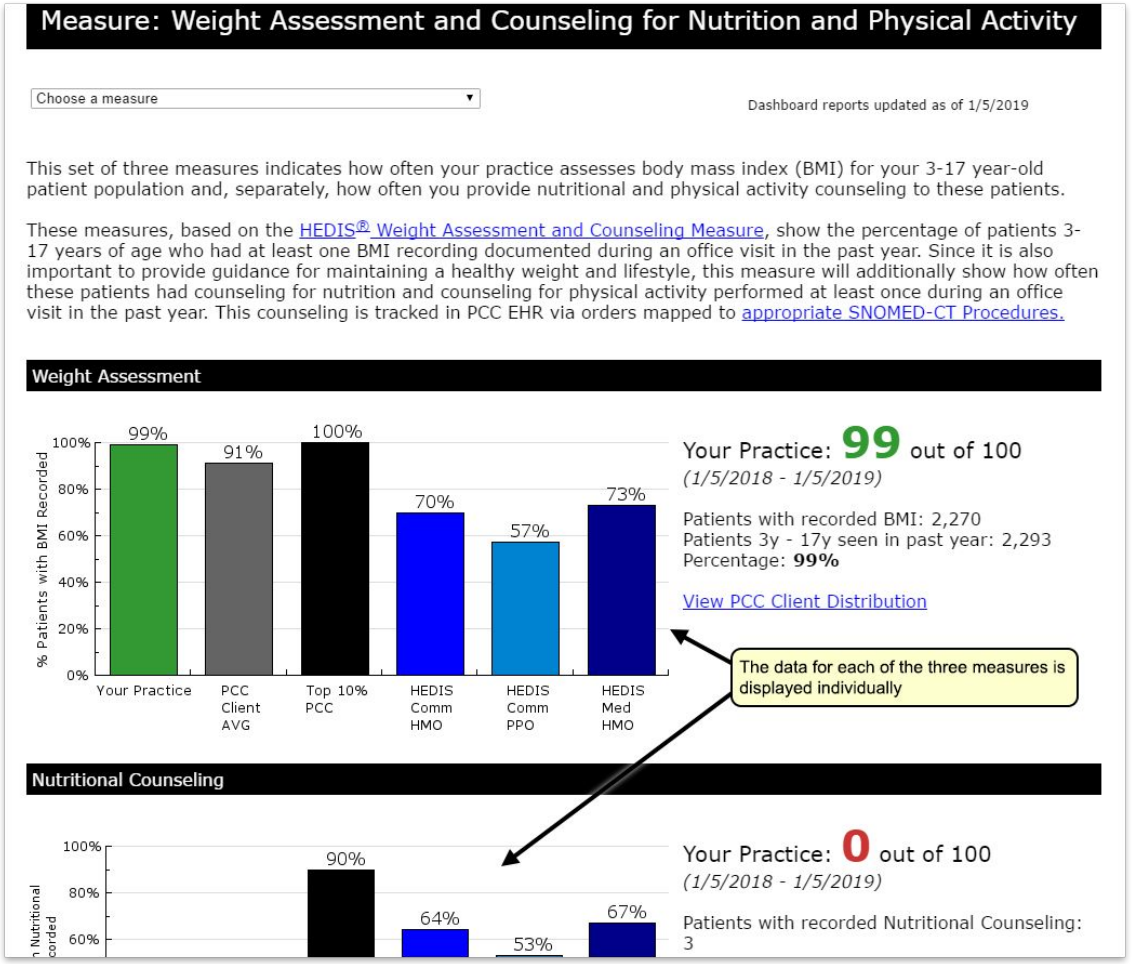
Weight Assessment and Counseling



- For patients 3-17 years old, measure of how often the following are documented:
  - BMI
  - Nutritional counseling
  - Physical activity counseling
- Includes HEDIS benchmarks

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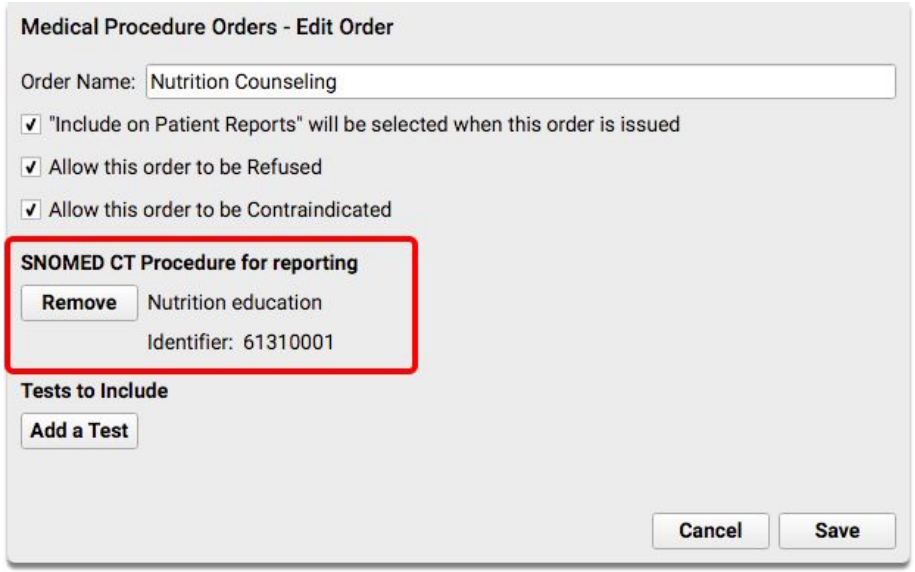
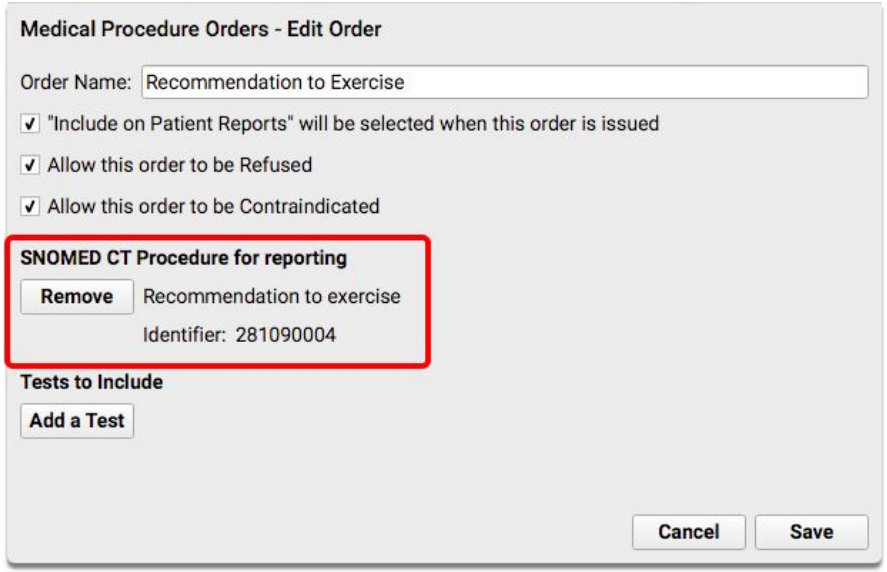
Weight Assessment and Counseling





- Use medical procedure orders for charting nutrition and exercise counseling
- Map these orders to appropriate SNOMED entries

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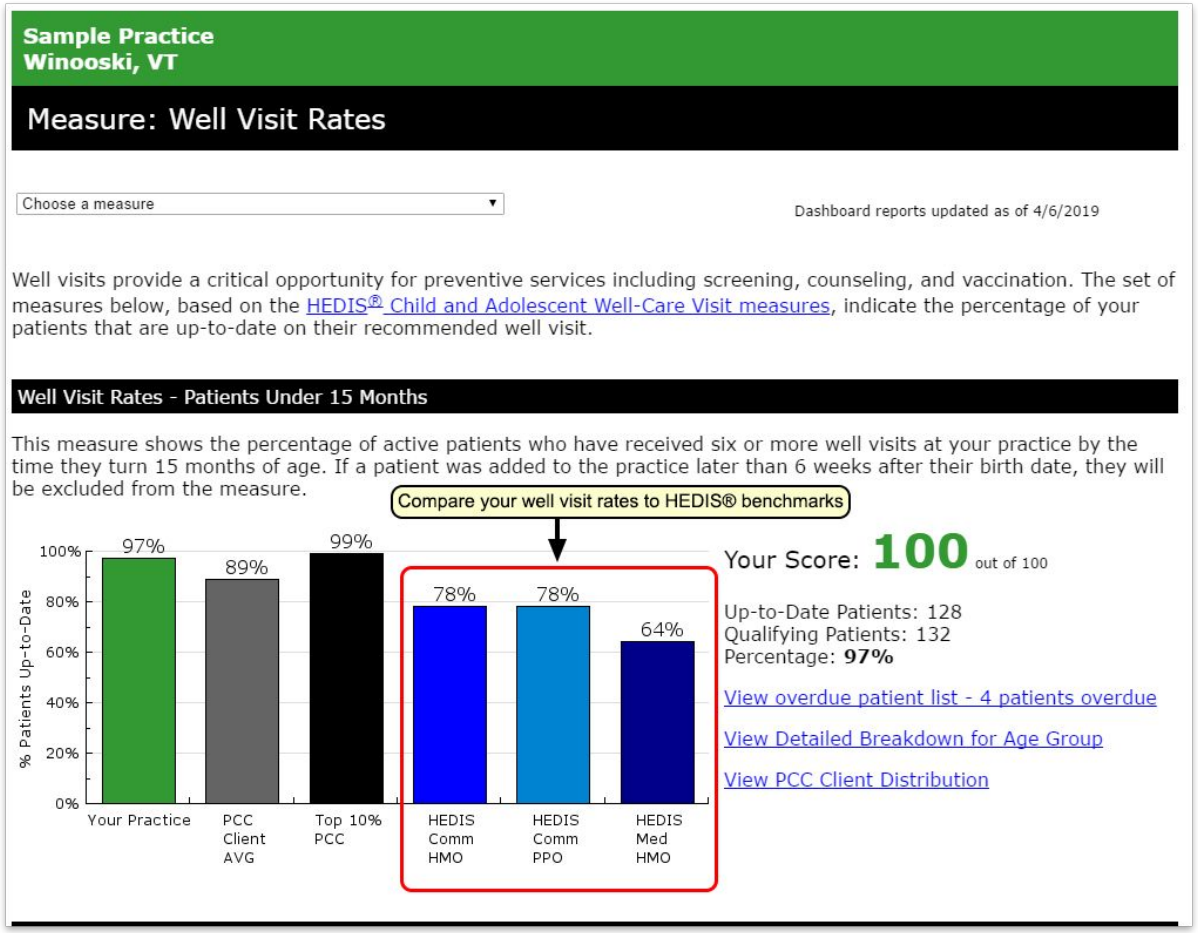
Well Visit Rate Measure Updates



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

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Missed Appointment Rate Measure

Measure: Missed Appointment Rate

Choose a measure

Dashboard reports updated as of 6/1/2019

Your Score: **88** out of 100

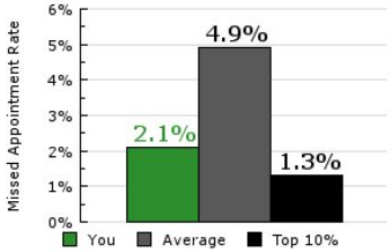
This measure shows the percentage of appointments at your practice that were missed. Missed appointments represent revenue loss and delayed patient care, along with stress and anxiety caused by uncertain schedules and the extra work involved with trying to fill those empty slots at the last minute. The 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

View Comparison By Provider



Your Practice	PCC Client Average	Top Performers
2.1%	**4.9%**	**1.3%**
	(Missed Appointment Rate)	

- Now based on appointments happening in past 3 months
- Will make it easier to monitor changes to no-show rate

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THRIVING THROUGH CHANGE

10 Ways to Use the Dashboard to Improve Practice Health

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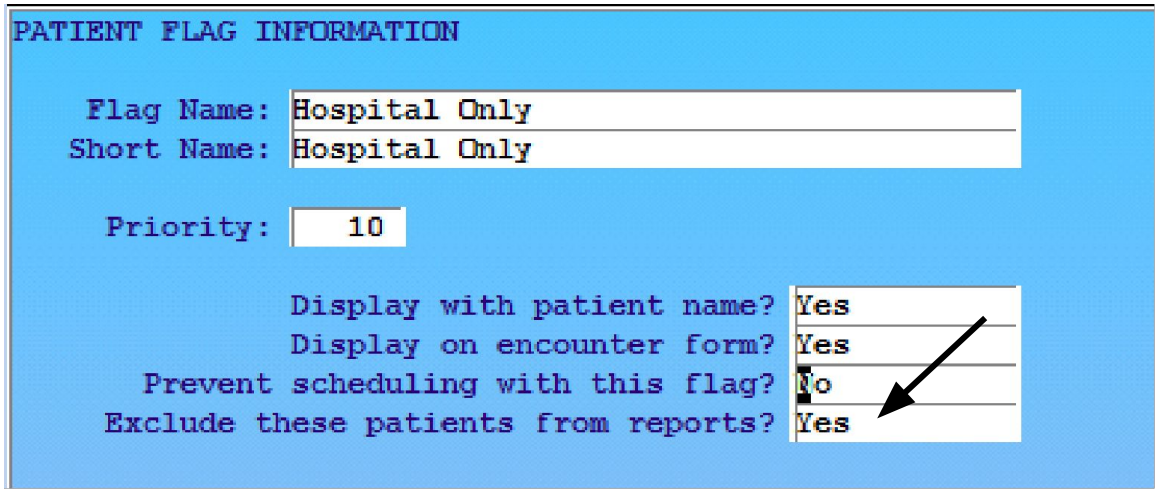
#10 - Maintaining Patient Flags

- 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



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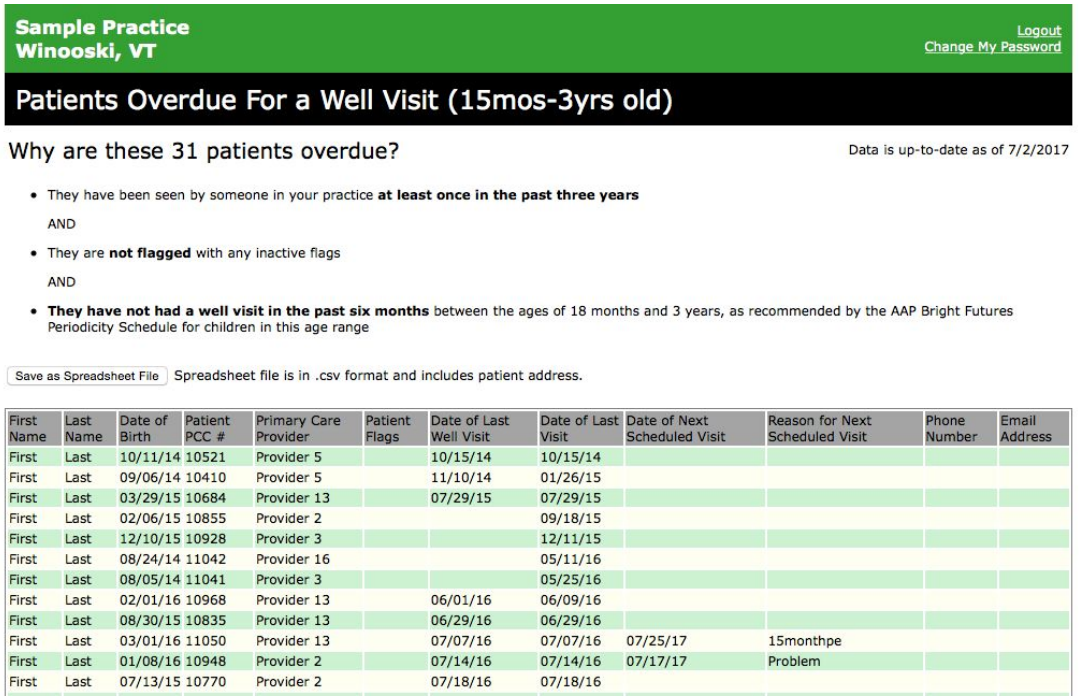
#10 - Maintaining Patient Flags

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



Sample Practice
Winooski, VT

Logout
Change My Password

Patients Overdue For a Well Visit (15mos-3yrs old)

Why are these 31 patients overdue?

Data is up-to-date as of 7/2/2017

- They have been seen by someone in your practice **at least once in the past three years**

  AND

- They are **not flagged** with any inactive flags

  AND

- **They have not had a well visit in the past six months** between the ages of 18 months and 3 years, as recommended by the AAP Bright Futures Periodicity Schedule for children in this age range

Save as Spreadsheet File Spreadsheet file is in .csv format and includes patient address.

First Name	Last Name	Date of Birth	Patient PCC #	Primary Care Provider	Patient Flags	Date of Last Well Visit	Date of Last Visit	Date of Next Scheduled Visit	Reason for Next Scheduled Visit	Phone Number	Email Address
First	Last	10/11/14	10521	Provider 5		10/15/14	10/15/14				
First	Last	09/06/14	10410	Provider 5		11/10/14	01/26/15				
First	Last	03/29/15	10684	Provider 13		07/29/15	07/29/15				
First	Last	02/06/15	10855	Provider 2			09/18/15				
First	Last	12/10/15	10928	Provider 3			12/11/15				
First	Last	08/24/14	11042	Provider 16			05/11/16				
First	Last	08/05/14	11041	Provider 3			05/25/16				
First	Last	02/01/16	10968	Provider 13		06/01/16	06/09/16				
First	Last	08/30/15	10835	Provider 13		06/29/16	06/29/16				
First	Last	03/01/16	11050	Provider 13		07/07/16	07/07/16	07/25/17	15monthpe		
First	Last	01/08/16	10948	Provider 2		07/14/16	07/14/16	07/17/17	Problem		
First	Last	07/13/15	10770	Provider 2		07/18/16	07/18/16				

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#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.

Save trend output as .csv (spreadsheet) file

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#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.

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#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

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#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

Measure	Qualifying Patients	Up-to-Date Patients	% Up-to-Date	% Change (3 mo.)
Immunization Rates - Adolescents	254	51	20%	Insufficient Data
Immunization Rates - HPV (Patients 13-17 Years)	1,119	651	58%	-2.8% ↓
Immunization Rates - HPV (Patients 13 Years)	254	92	36%	-5.0% ↓
Immunization Rates - Influenza *	4,741	3,093	65%	0.6% ↑
Immunization Rates - Influenza (Asthma) *	451	301	67%	-4.3% ↓
Immunization Rates - Meningococcal	1,119	1,088	97%	0.2% ↑
Immunization Rates - Patients 2 Years Old	317	241	76%	-0.1% ↓
Immunization Rates - Tdap	1,119	1,080	97%	0.7% ↑

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

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

Measure: ADD/ADHD Patient Followup

Breakdown By: Ethnicity

ADD/ADHD Patient Followup			
Ethnicity	**Qualifying Patients**	**Up-to-Date Patients**	**% Up-to-Date**
None Selected	12	8	67%
Hispanic or Latino	25	18	72%
Not Hispanic or Latino	243	164	67%
Prefers not to answer	13	10	77%

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 QI02-B.

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

Measure	Total Appointments	Missed Appointments	% Missed	% Change (3 mo.)
Missed Appointment Rate	5,272	112	2.1%	0.0% ↑

QI 15 (Core) Reporting Performance within the Practice

The practice provides individual clinician or practice-level reports 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

Measure: ADD/ADHD Patient Followup

ADD/ADHD Patient Followup			
Primary Care Provider	**Qualifying Patients**	**Up-to-Date Patients**	**% Up-to-Date**

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#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)

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#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

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#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

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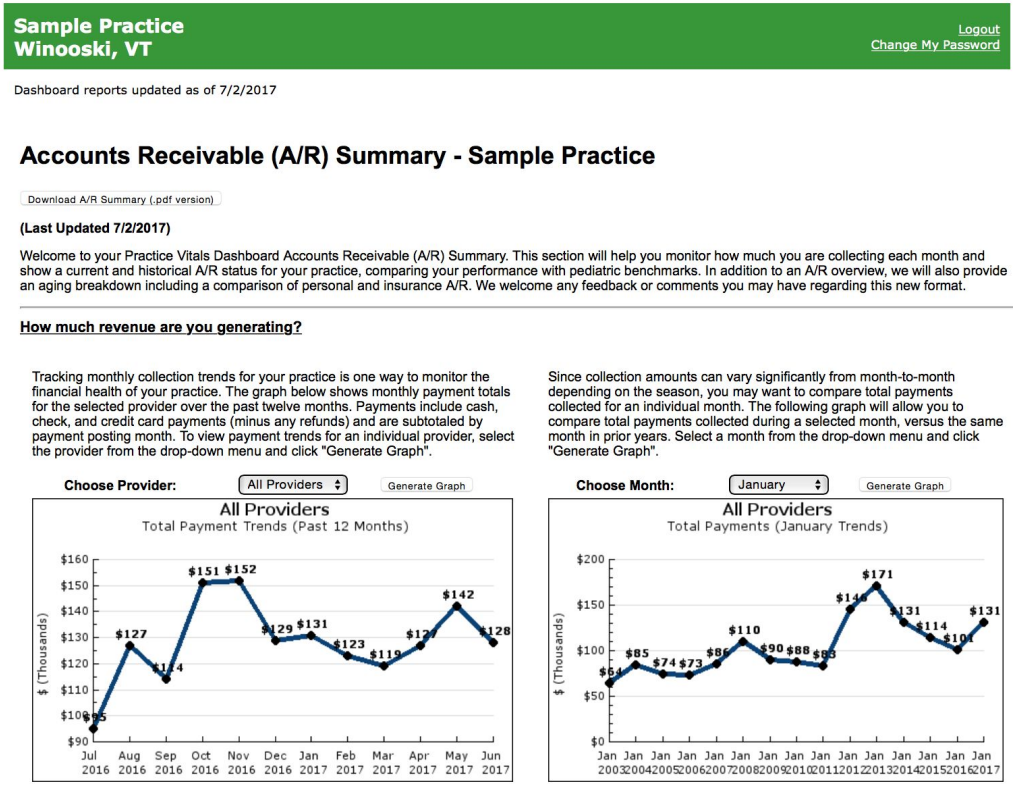
#4 - Generate A/R Summary Report

- Revenue trends
- A/R Days and benchmarks
- A/R Percentage by Aging Category
- Personal vs Insurance A/R
- Recommendations



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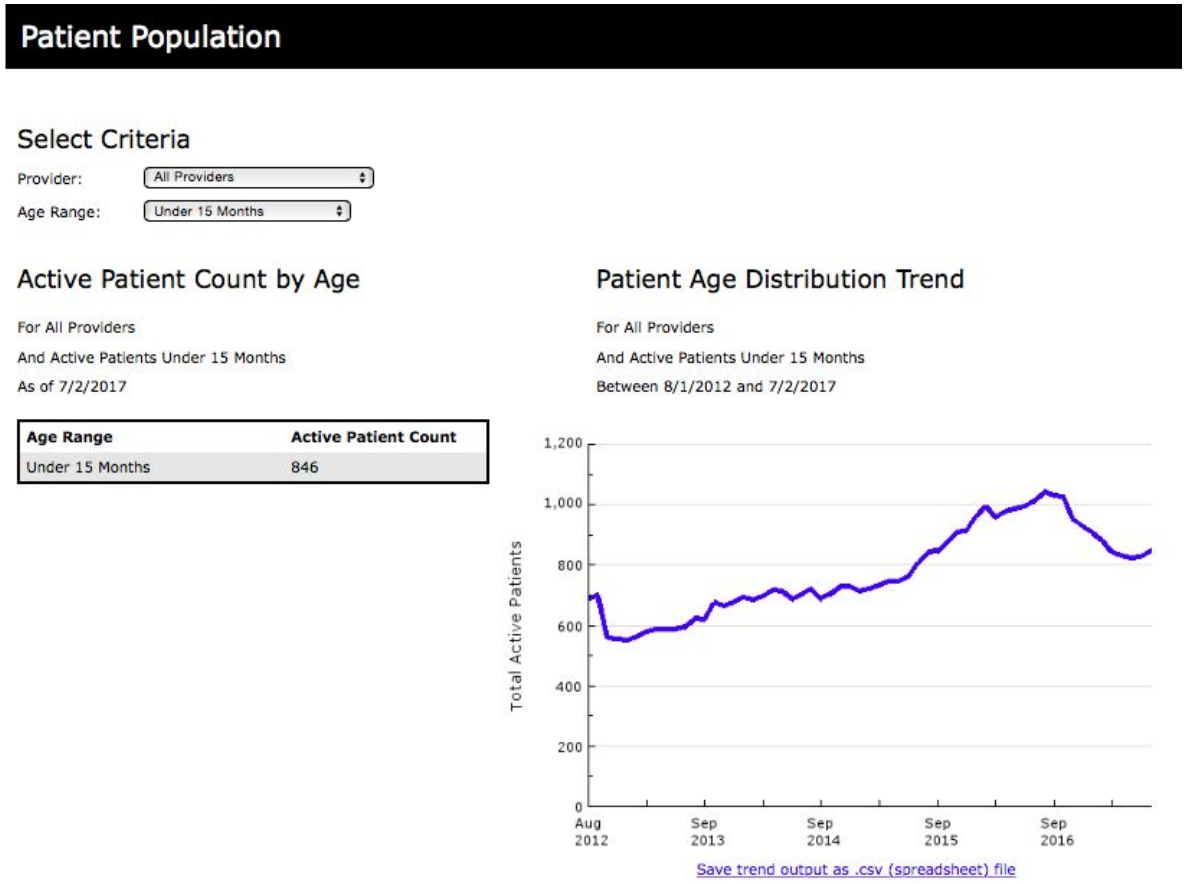
#3 - Monitor Patient Population Trends

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



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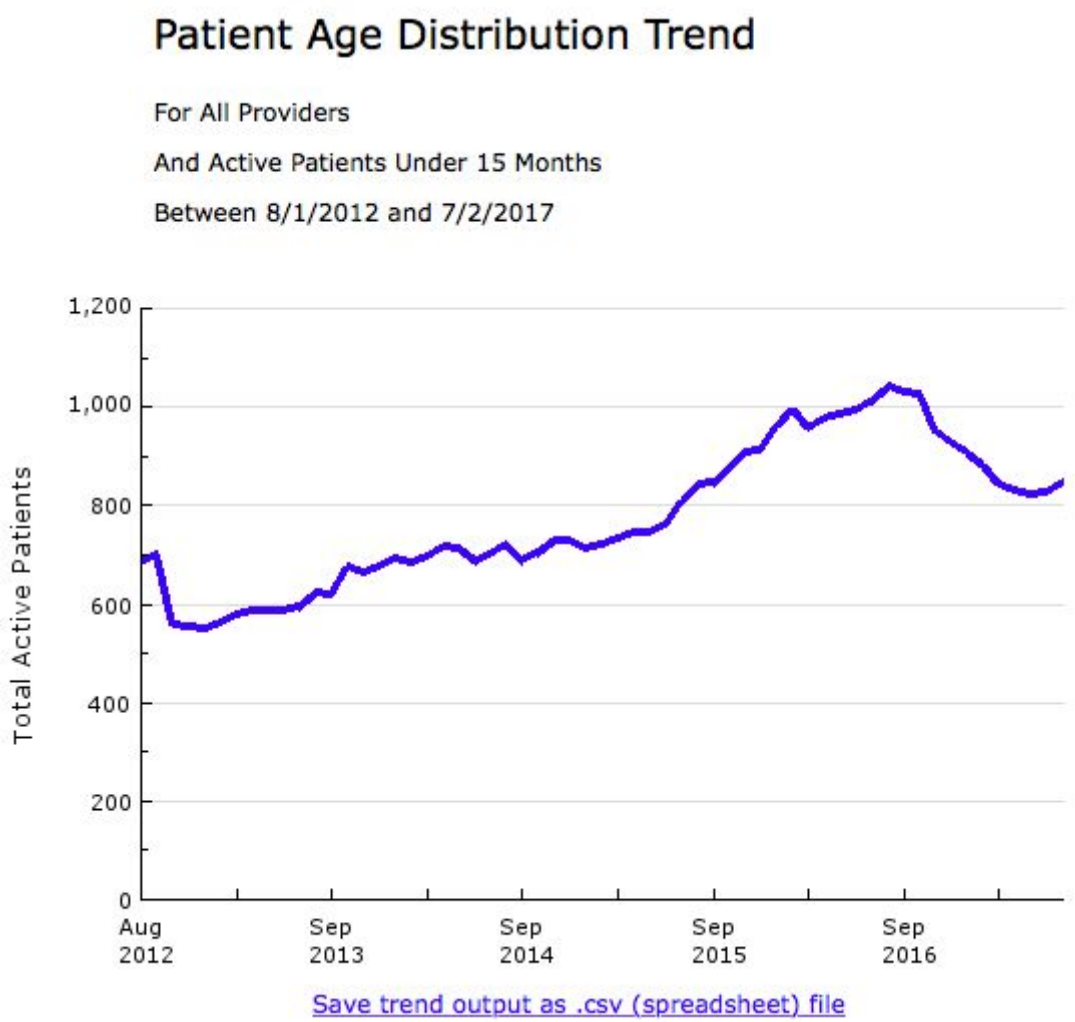
#3 - Monitor Patient Population Trends



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#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

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THRIVING THROUGH CHANGE

#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

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**
Other Insurance	38	21	55%
Medicaid	312	228	73%
BCBS	635	506	80%
Cigna	172	130	76%
MVP	125	90	72%
First Health	15	13	87%
Tricare	6	2	33%
CBA BLUE	19	16	84%
United HC	42	30	71%
AETNA	26	22	85%
BCBS OTHER	148	105	71%

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#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
  - Vaccinations
  - Screenings
  - Chronic Disease Management

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Dashboard Exercises

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