

# Improving Your Practice Health with PCC Dashboard

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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



**87** i

Clinical Pulse



**63** i

# PCC Dashboard Basics

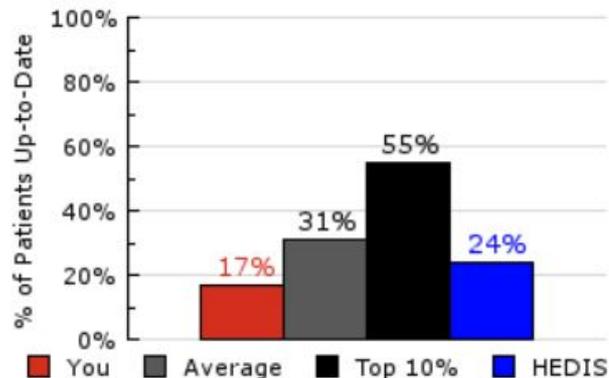
- One login for each practice
- Data collected on the first Saturday of every month. Loaded into production a few days after that
- Pediatric-specific benchmarks



# Benchmarks

- PCC AVG and “Top Performers” (90<sup>th</sup> percentile)
- **New!** HEDIS benchmarks

## How You Compare



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

(% 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

## My Dashboard Priorities

### Top Priorities

Score	Measure
22	<a href="#">Sick-to-Well Visit Ratio</a>
36	<a href="#">Immunization Rates - HPV</a>
37	<a href="#">A/R Days</a>

### Next Priorities

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

# 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

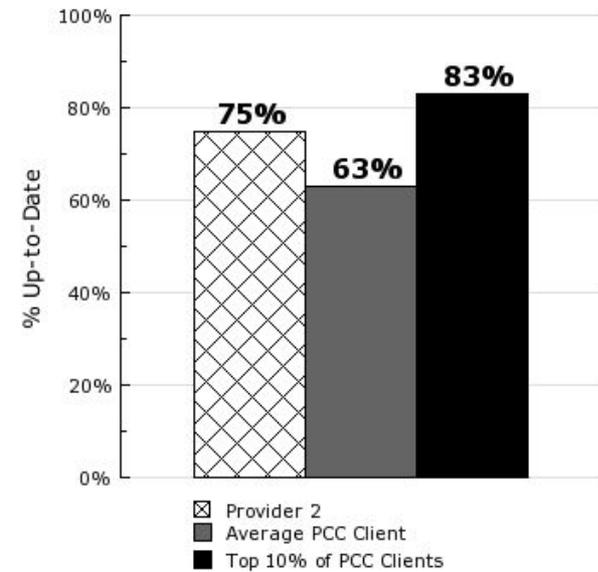
Show Breakdown By:

Primary Care Provider	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 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?



# 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.

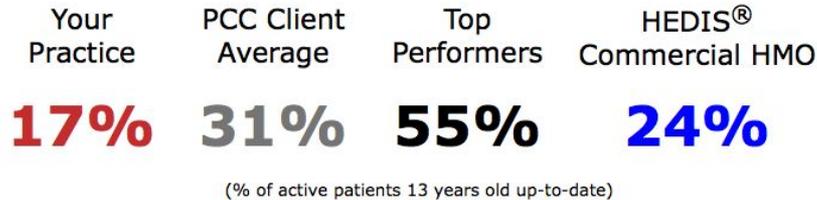
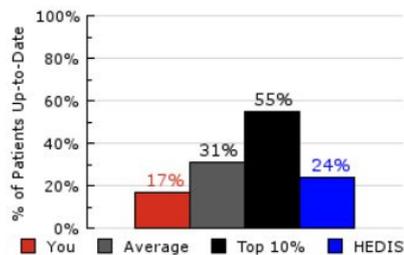
As of 6/1/2019 you have **1,636** active patients who are currently thirteen years old.

**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.

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

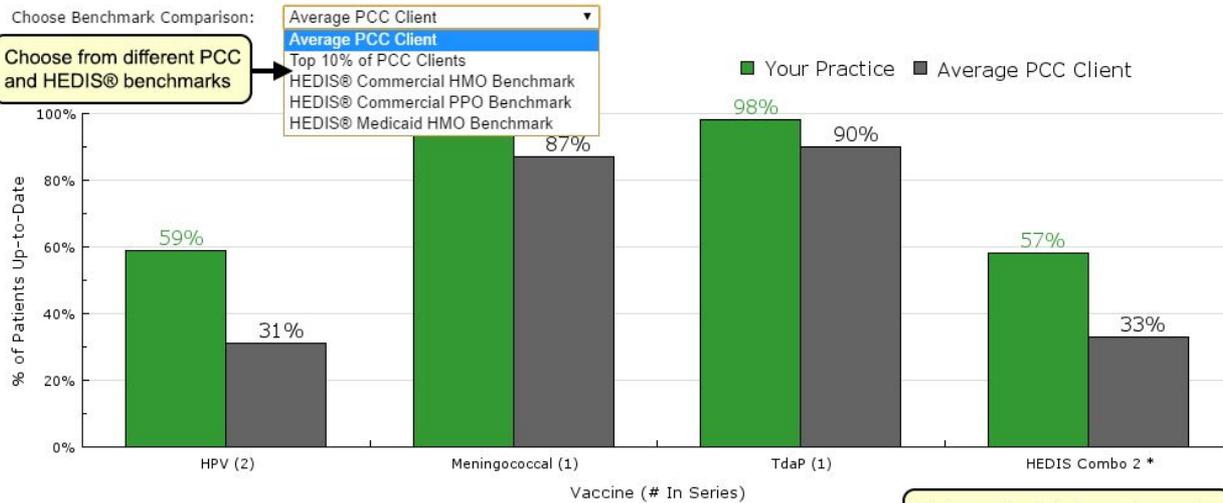
### How You Compare



# 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.

## Breakdown By Vaccine



Vaccine	Number Needed By Age 13	Total Patients Age 13	Patients Up-to-Date at Age 13	% Up-to-Date at Age 13	Overdue at Age 13
HPV	2	185	109	59%	76 patients overdue
Meningococcal	1	185	175	95%	10 patients overdue
Tdap	1	185	181	98%	4 patients overdue
HEDIS® Combo 2* (Includes All Vaccines Above)	N/A	185	107	58%	78 patients overdue

\* "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).

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



# Depression Screening Rate - Adolescents

## Measure: Depression Screening Rate - Adolescents

Choose a measure

Dashboard reports updated as of 1/5/2019

Your Score: **88** out of 100

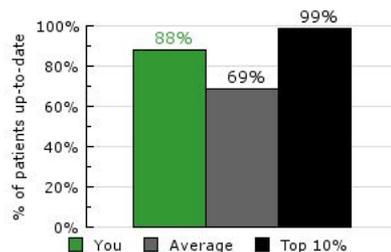
The [AAP's Bright Futures™ Guidelines](#) recommend a structured depression screening during well visits for adolescents between the ages of 12-21. For adolescents who had a well visit in the past year, this measure tracks how many of those patients also had at least one screening billed with a 96110, 96127, 99420, G8510, G8431, or G0444 CPT code. The screening can be billed at any visit during the past year to be counted for this measure.

You have **1,066** active patients ages 12-21 who have had a well visit in the past year.

**934** of these patients had the recommended depression screening performed at some point in the past year.

### How You Compare

[View Comparison By Provider](#)



Your Practice

**88%**

PCC Client Average

**69%**

Top Performers

**99%**

(% of adolescents having one well visit and depression screening in past year)

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



# PCMH Dashboard Update

D. Behavioral Health Measures

Measure	Qualifying Patients	Up-to-Date Patient		
<a href="#">ADD/ADHD Patient Followup</a>	318	261	82%	1.9%
<a href="#">Depression Screening Rates - Adolescents</a>	1,066	934	88%	Insufficient Data

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

### 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

# Weight Assessment and Counseling

## Measure: Weight Assessment and Counseling for Nutrition and Physical Activity

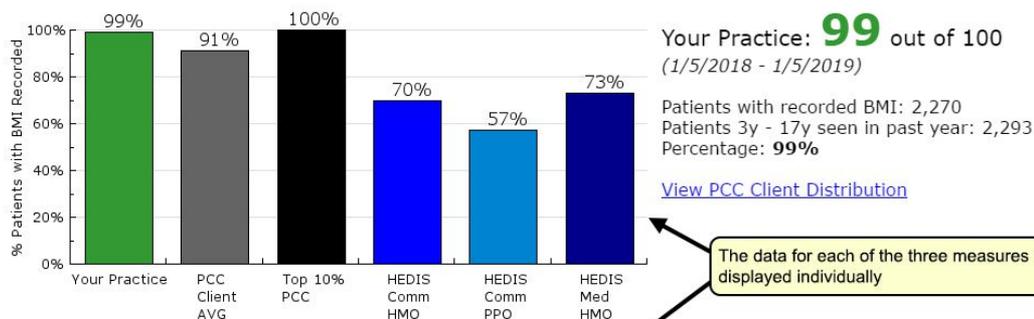
Choose a measure

Dashboard reports updated as of 1/5/2019

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.

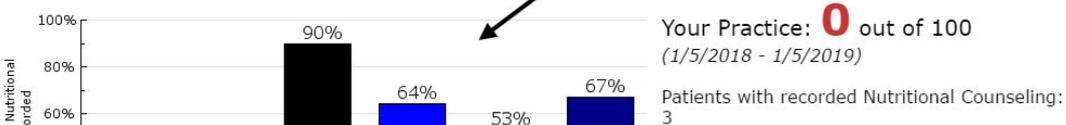
These measures, based on the [HEDIS® Weight Assessment and Counseling Measure](#), show the percentage of patients 3-17 years of age who had at least one BMI recording documented during an office visit in the past year. Since it is also important to provide guidance for maintaining a healthy weight and 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



The data for each of the three measures is displayed individually

### Nutritional Counseling



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

# Weight Assessment and Counseling

Medical Procedure Orders - Edit Order

Order Name: Nutrition Counseling

"Include on Patient Reports" will be selected when this order is issued

Allow this order to be Refused

Allow this order to be Contraindicated

**SNOMED CT Procedure for reporting**

Nutrition education  
Identifier: 61310001

Tests to Include

Medical Procedure Orders - Edit Order

Order Name: Recommendation to Exercise

"Include on Patient Reports" will be selected when this order is issued

Allow this order to be Refused

Allow this order to be Contraindicated

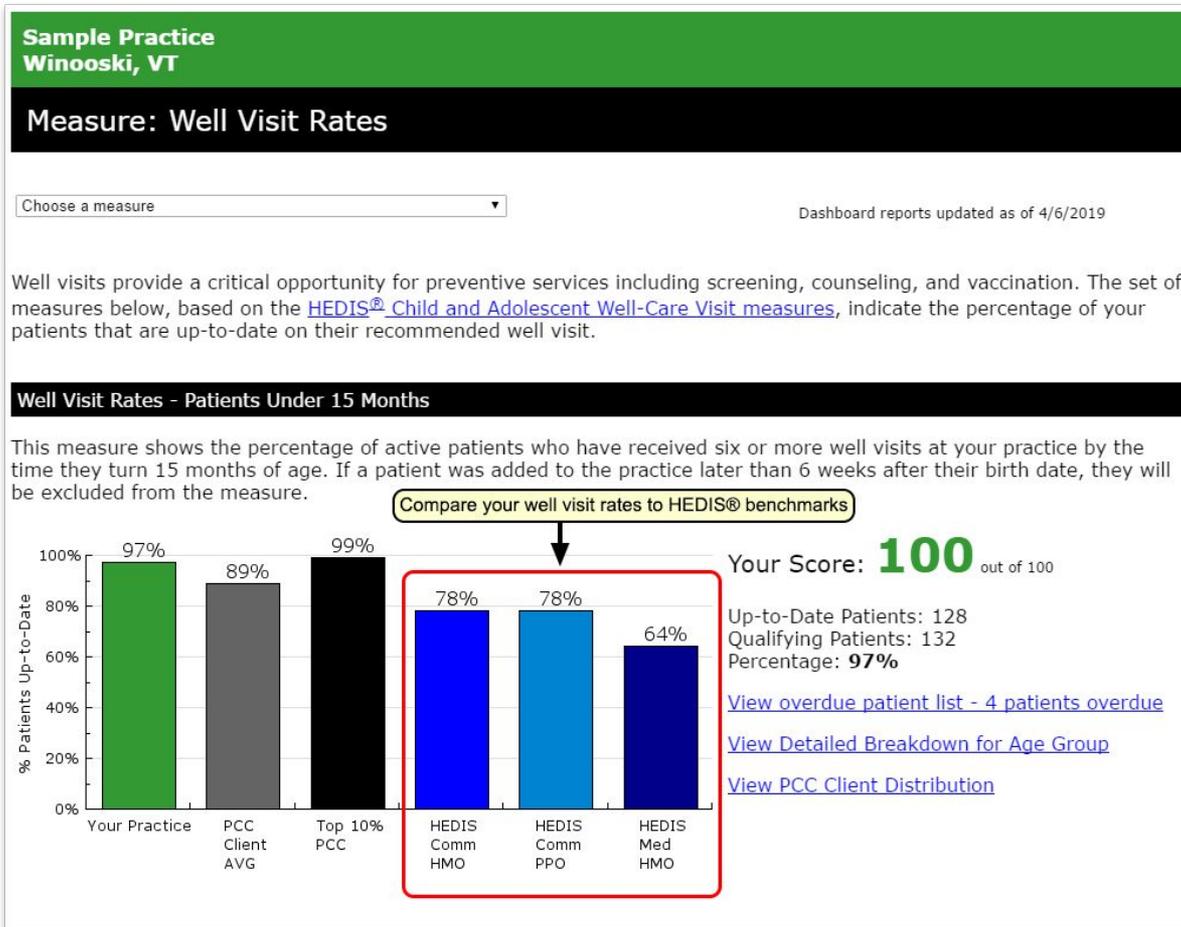
**SNOMED CT Procedure for reporting**

Recommendation to exercise  
Identifier: 281090004

Tests to Include

- 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

Dashboard reports updated as of 6/1/2019

Your Score: **88** out of 100

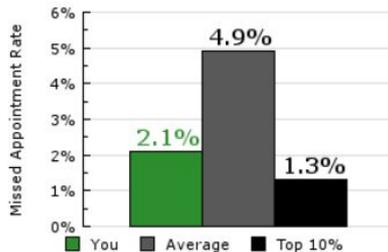
This measure shows the percentage of appointments at your practice that were missed. Missed appointments represent revenue loss and delayed patient care, along with stress and anxiety caused by uncertain schedules and the extra work involved with trying to fill those empty slots at the last minute. The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

**2.1%**

PCC Client Average

**4.9%**

(Missed Appointment Rate)

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

PATIENT FLAG INFORMATION

Flag Name: Hospital Only

Short Name: Hospital Only

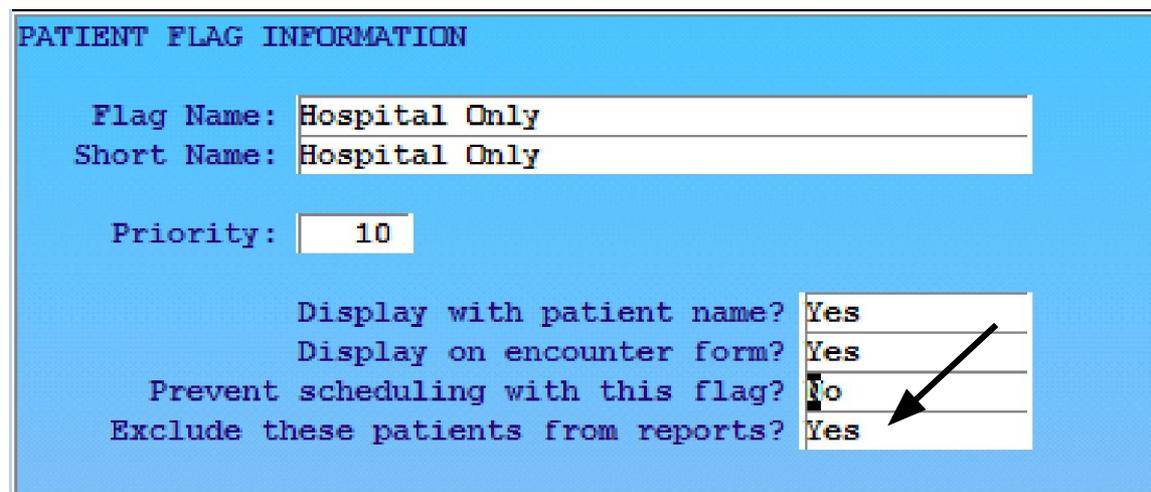
Priority: 10

Display with patient name? Yes

Display on encounter form? Yes

Prevent scheduling with this flag? No

Exclude these patients from reports? Yes



# #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				



# #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](#)

# #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

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

## 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:

Breakdown By:

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.)
<a href="#">Missed Appointment Rate</a>	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			
Primary Care Provider	Qualifying Patients	Up-to-Date Patients	% Up-to-Date

# #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

Sample Practice  
Winooski, VT

Logout  
Change My Password

Dashboard reports updated as of 7/2/2017

## Accounts Receivable (A/R) Summary - Sample Practice

[Download A/R Summary \(.pdf version\)](#)

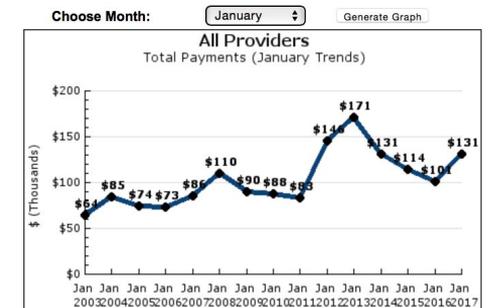
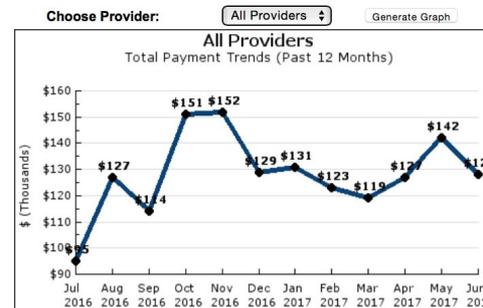
(Last Updated 7/2/2017)

Welcome to your Practice Vitals Dashboard Accounts Receivable (A/R) Summary. This section will help you monitor how much you are collecting each month and show a current and historical A/R status for your practice, comparing your performance with pediatric benchmarks. In addition to an A/R overview, we will also provide an aging breakdown including a comparison of personal and insurance A/R. We welcome any feedback or comments you may have regarding this new format.

### How much revenue are you generating?

Tracking monthly collection trends for your practice is one way to monitor the financial health of your practice. The graph below shows monthly payment totals for the selected provider over the past twelve months. Payments include cash, check, and credit card payments (minus any refunds) and are subtotalled by payment posting month. To view payment trends for an individual provider, select the provider from the drop-down menu and click "Generate Graph".

Since collection amounts can vary significantly from month-to-month depending on the season, you may want to compare total payments collected for an individual month. The following graph will allow you to compare total payments collected during a selected month, versus the same month in prior years. Select a month from the drop-down menu and click "Generate Graph".



# #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

## Patient Population

### Select Criteria

Provider:

Age Range:

### Active Patient Count by Age

For All Providers

And Active Patients Under 15 Months

As of 7/2/2017

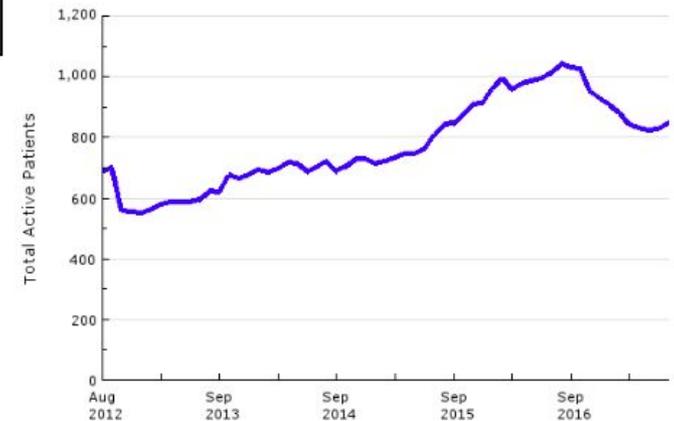
Age Range	Active Patient Count
Under 15 Months	846

### 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](#)

# #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

Measure:

Breakdown By:

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%

# #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

