Clinical Oversight Reporting for Strategists

Tim Proctor

PCC Pediatric EHR Solutions

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Session Objectives

1. An introduction to:
   a. Operational and strategic clinical oversight reports
   b. Population management tools within PCC EHR and Dashboard

2. An understanding of EHR configuration and charting workflow that may be required to improve your clinical quality measure results

Clinical Operations Oversight

Information necessary to oversee routine clinical operations at your practice

- Appointment Status Timing
- Portal and Patient Communications
- Vaccine Reporting
- Orders

Clinical Quality Management

Information necessary to oversee the clinical health of your practice and quality improvement initiatives

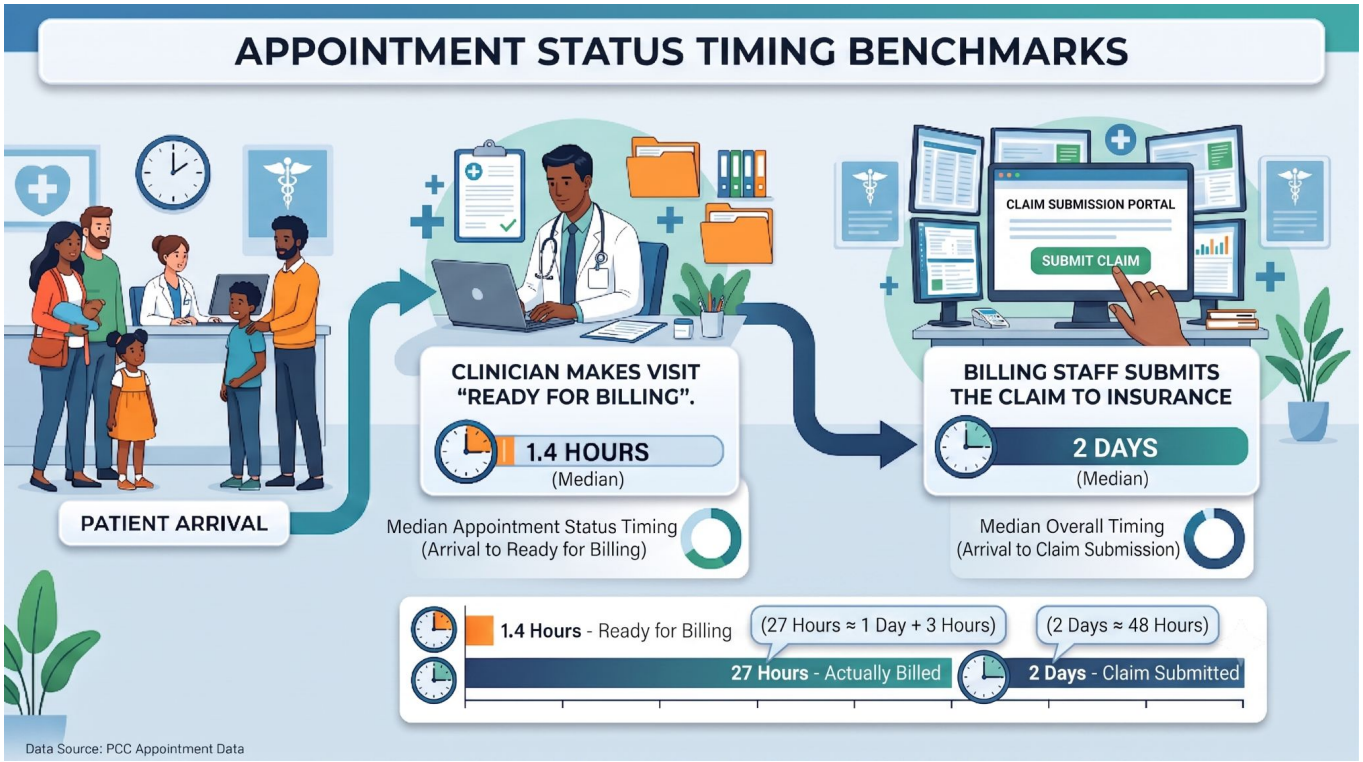
CQM Reports related to:

- Immunization
- Preventive Care
- Behavioral Health
- Chronic or Acute Care
- Care Coordination
- Health Care Costs

Population Health Management

Identifying patients who are in need of care and establishing an ongoing recall and outreach process

- Care Plan Oversight
- Patient Recall for:
  - Preventive Care
  - Chronic Care
  - Vaccinations
- Communication Logs



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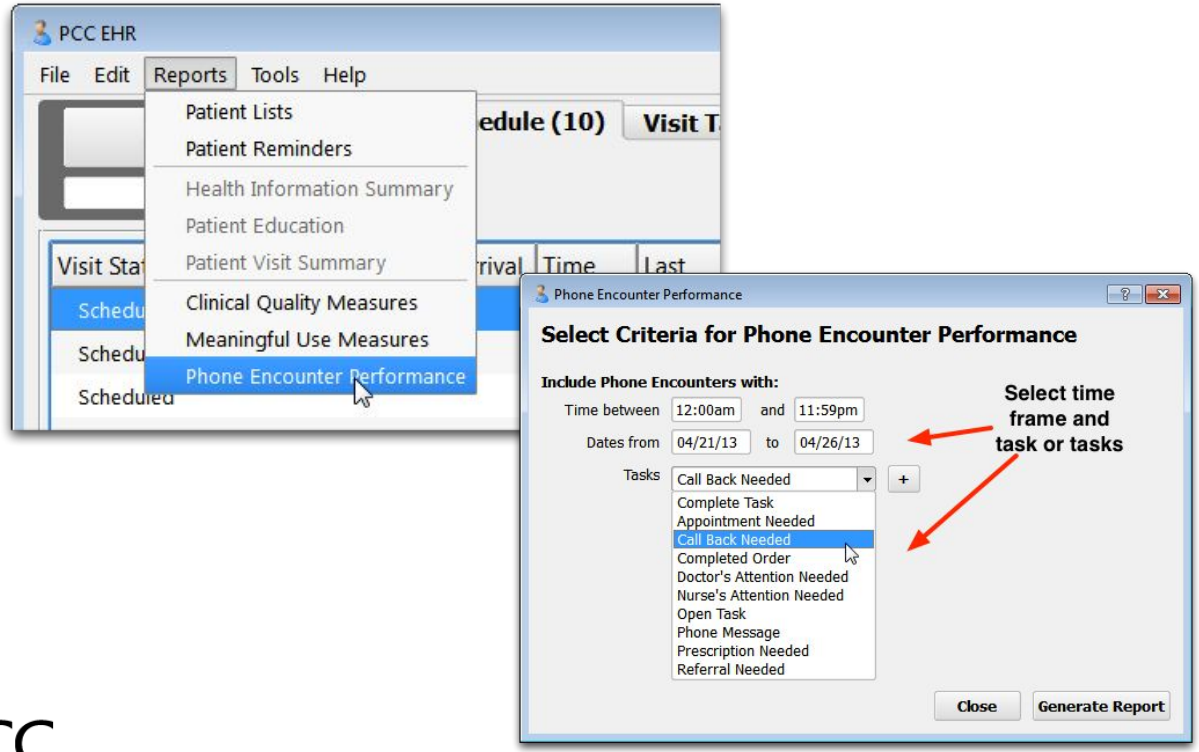
How Long For Initial Response to Phone Calls?



- Track how long it is taking for phone note tasks to be responded to
- Filter by task type to focus on response to just certain tasks (ie, “Doctor’s Attention Needed”, etc)

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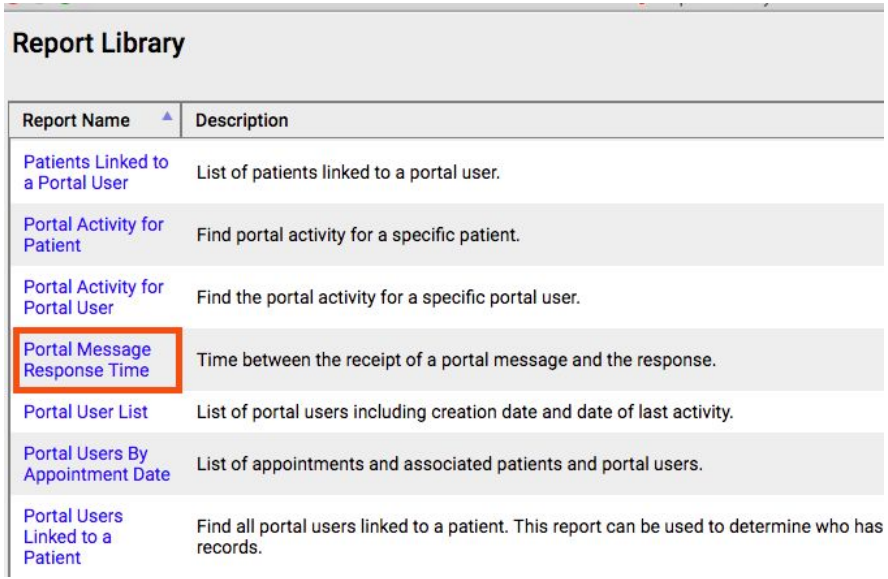
How Long For Initial Response to Phone Calls?

Optionally display user who took phone call, user who completed task, and other information

How Long For Initial Response to Portal Messages?

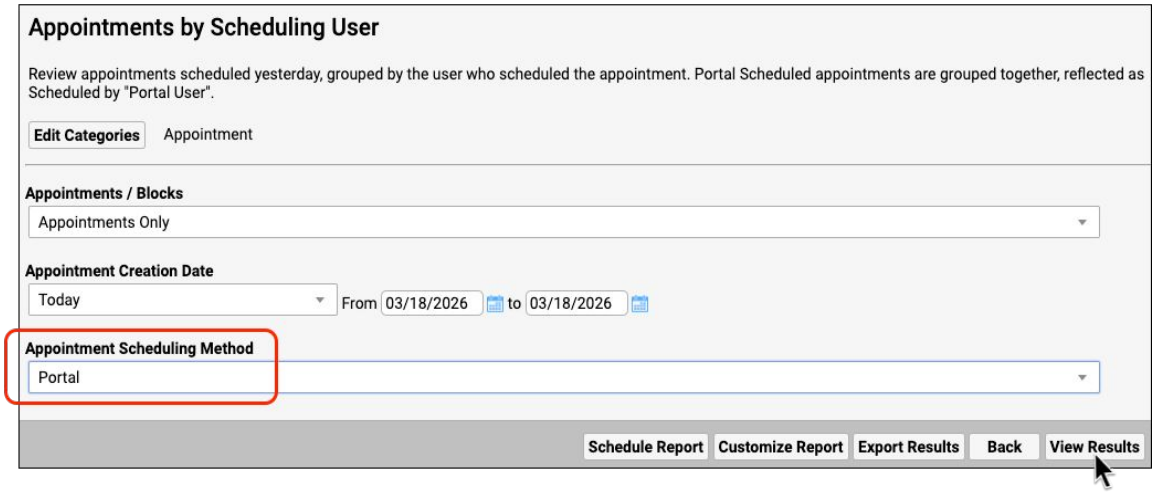


Report Library

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.

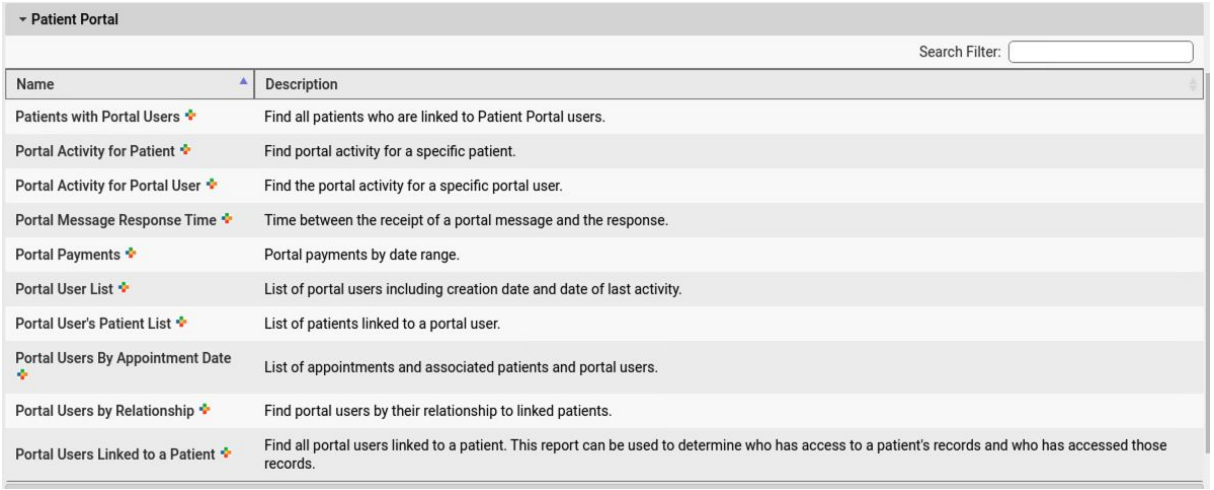
Use this report to track response time for family-initiated portal messages

Which Appointments were Scheduled by Portal Users?



Report can be limited to show appointments scheduled by portal users

Portal Administration



Patient Portal

Search Filter:

Name	Description
Patients with Portal Users	Find all patients who are linked to Patient Portal users.
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 Payments	Portal payments by date range.
Portal User List	List of portal users including creation date and date of last activity.
Portal User's Patient List	List of patients linked to a portal user.
Portal Users By Appointment Date	List of appointments and associated patients and portal users.
Portal Users by Relationship	Find portal users by their relationship to linked patients.
Portal Users Linked to a Patient	Find all portal users linked to a patient. This report can be used to determine who has access to a patient's records and who has accessed those records.

Portal reports provide information on portal accounts and activity:

- Portal user and activity audits
- Portal payment details
- Portal message audits
- Patients who do/don't have portal users

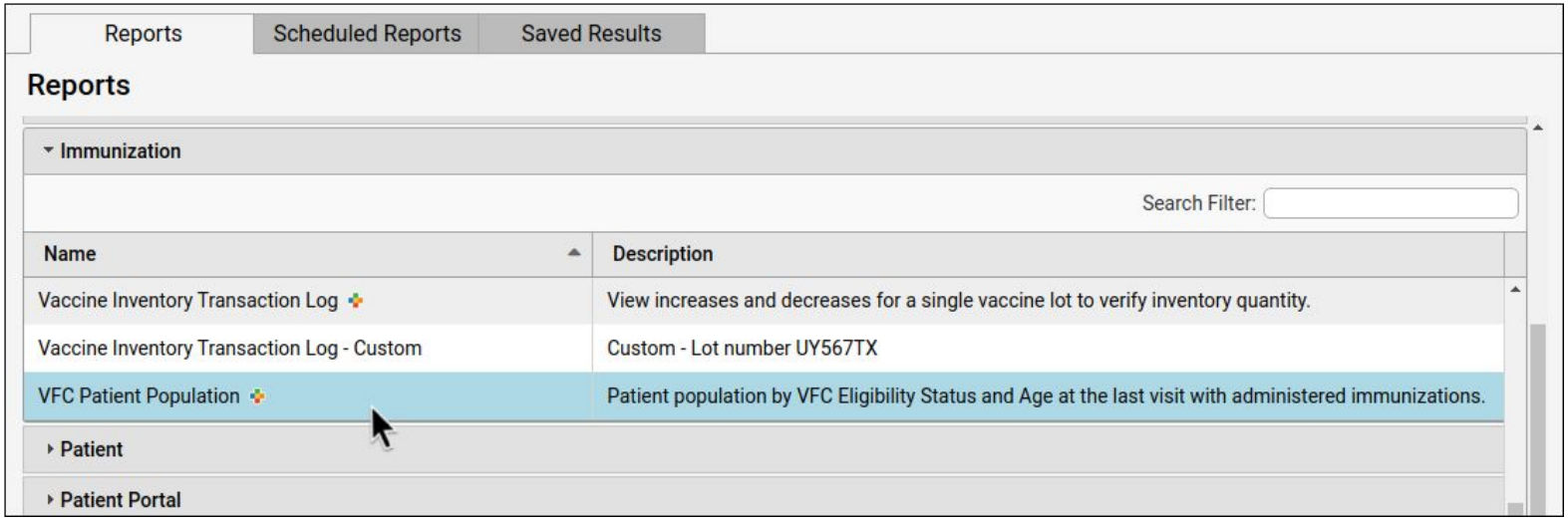
Portal User and Activity Audits

Report	Purpose
Portal Activity for a Patient	Determine portal logins and access for a specific patient
Portal Users Linked to a Patient	See login and access details, and a list of who is connected to a specific patient
Portal User List	A larger audit of who has been created and added to the portal user list during a specific period

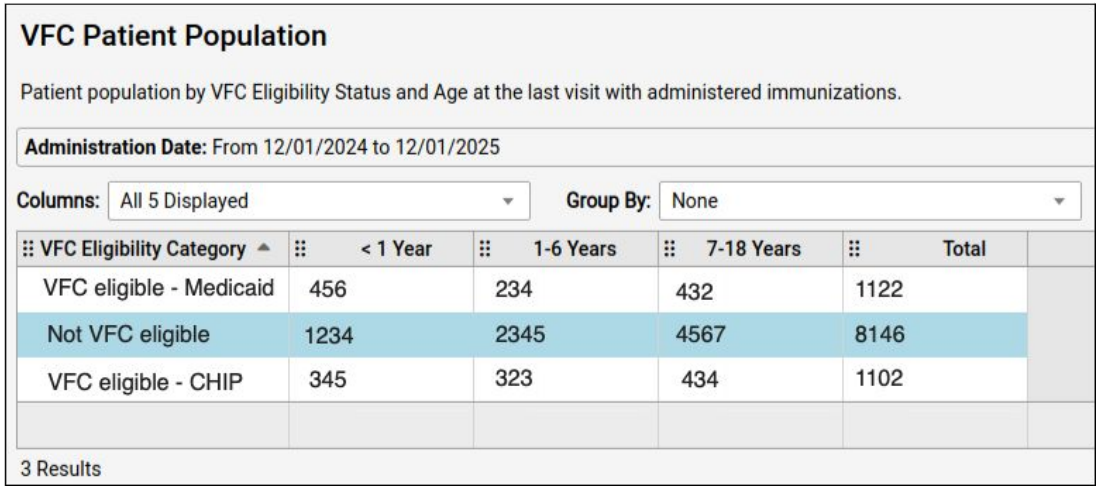
Portal User and Activity Audits

Report	Purpose
Patients with Portal Users	Provides a full list of patients who do and do not have portal users. You can send a broadcast message to these groups to improve sign-ups, announce changes to the portal (like adopting pre-check-in, self-scheduling), etc.
Portal Users by Appointment Date	Useful for determining who needs a portal user added ahead of an upcoming appointment (for pre-check-in, as an example)
Portal Users by Relationship	Need to know if you have set up your teenagers appropriately for CHADIS? This report can help.

VFC Patient Population Report



VFC Patient Population Report



VFC Patient Population

Patient population by VFC Eligibility Status and Age at the last visit with administered immunizations.

Administration Date: From 12/01/2024 to 12/01/2025

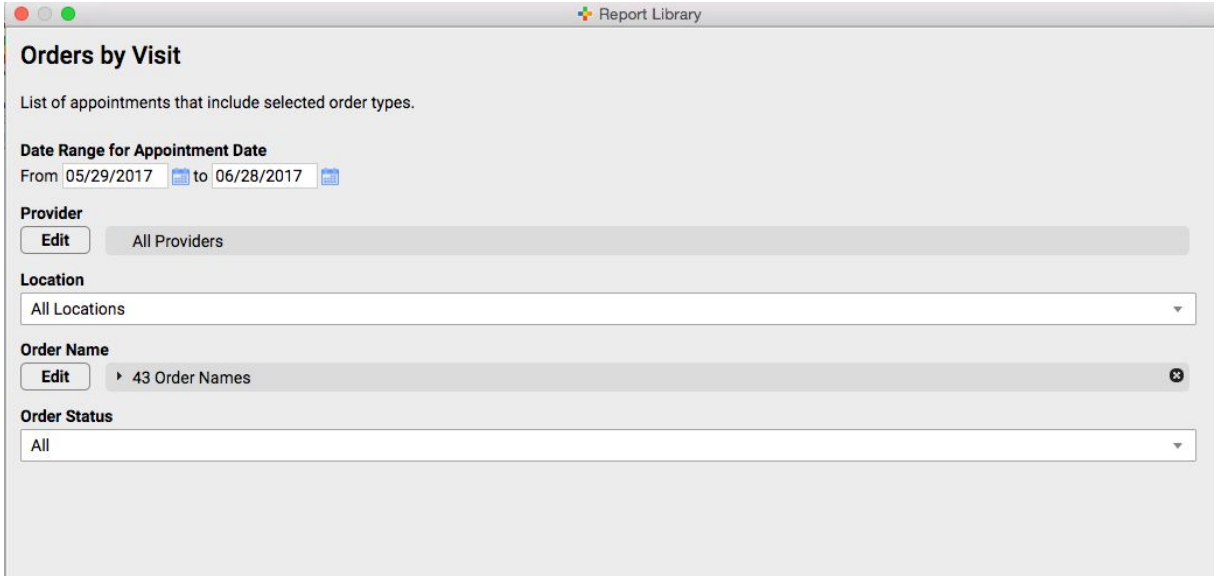
Columns: All 5 Displayed **Group By:** None

VFC Eligibility Category	< 1 Year	1-6 Years	7-18 Years	Total
VFC eligible - Medicaid	456	234	432	1122
Not VFC eligible	1234	2345	4567	8146
VFC eligible - CHIP	345	323	434	1102

3 Results

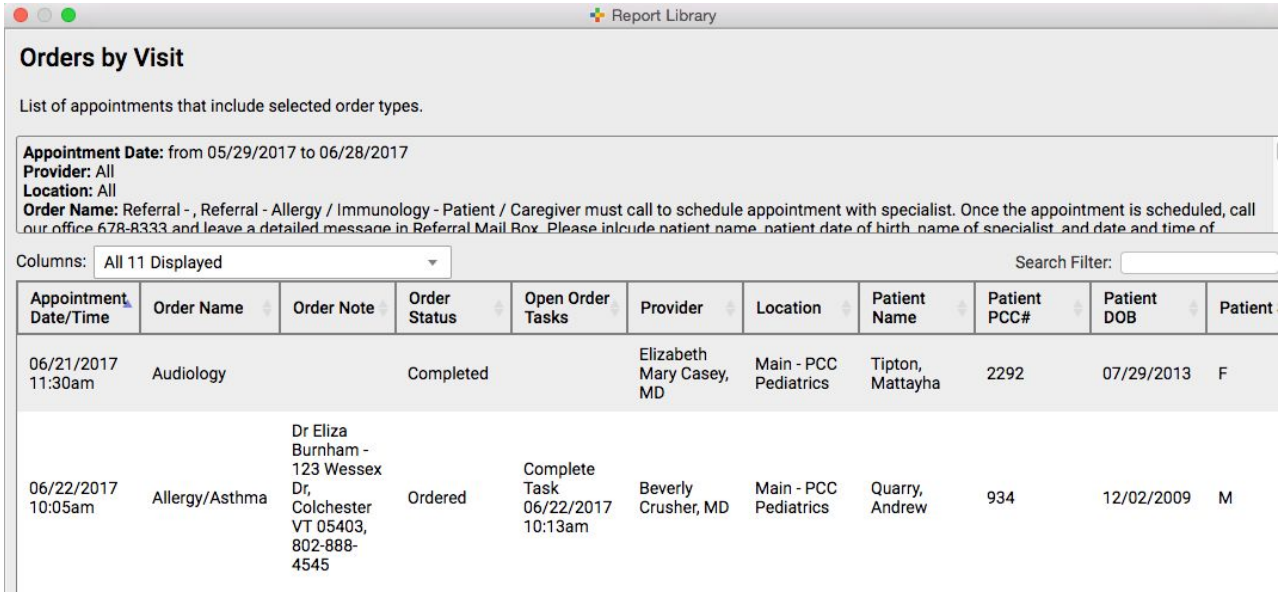
- Based on eligibility category selected at the most recent visit with administered immunizations, within the selected date range.
- Includes only administered imms

Orders by Visit



Use this to generate a report of encounters with selected order types

Orders by Visit



Appointment Date/Time	Order Name	Order Note	Order Status	Open Order Tasks	Provider	Location	Patient Name	Patient PCC#	Patient DOB	Patient
06/21/2017 11:30am	Audiology		Completed		Elizabeth Mary Casey, MD	Main - PCC Pediatrics	Tipton, Mattayha	2292	07/29/2013	F
06/22/2017 10:05am	Allergy/Asthma	Dr Eliza Burnham - 123 Wessex Dr, Colchester VT 05403, 802-888-4545	Ordered	Complete Task 06/22/2017 10:13am	Beverly Crusher, MD	Main - PCC Pediatrics	Quarry, Andrew	934	12/02/2009	M

Can show referrals, screenings, medical procedures, radiology, labs ordered with associated tasks

SECTION 2: LEVERAGING CLINICAL QUALITY MEASURE (CQM) REPORTING

COLLECT & TRACK QUALITY DATA

DATA COLLECT

Measure key pediatric quality indicators (e.g., Immunization Rates, ADD/ADHD Follow-up).

BENCHMARK PERFORMANCE

PERFORMANCE

Compare against internal and external standards. Identify gaps in care.

DRIVING CARE IMPROVEMENTS

QUALITY COORDINATOR

Translate data into action. Enhance patient health and experience.

1. ESTABLISH MEASURES
2. ANALYZE RESULTS
3. OPTIMIZE CARE

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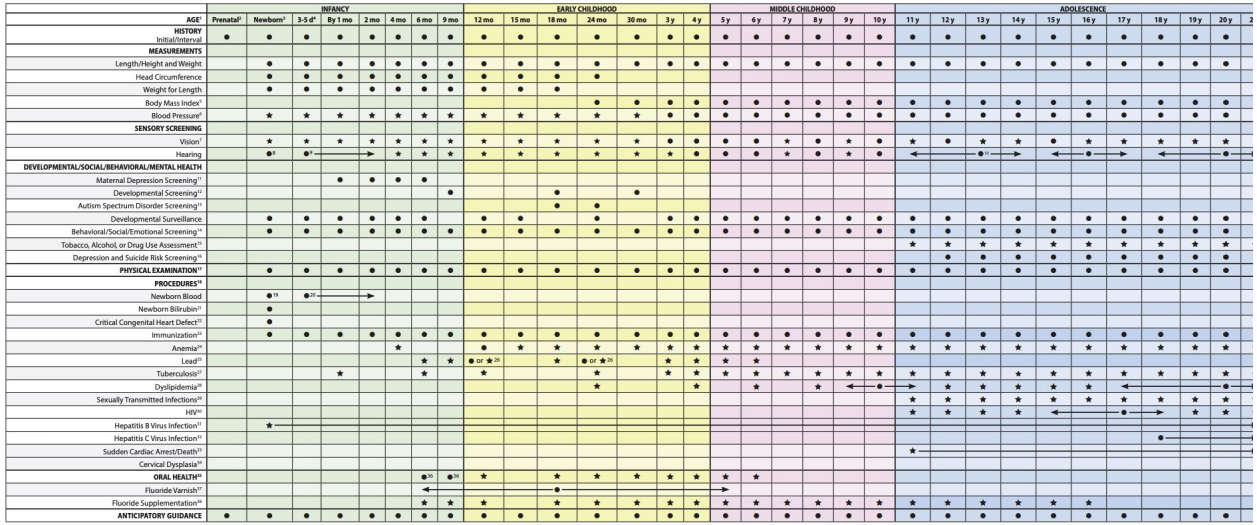
AAP Bright Futures Guidelines

https://www.aap.org/periodicityschedule

Are you missing any recommended preventive care opportunities?



AGE[1]	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	
Hearing		●[8]	●[9]	⟶	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	⟵	⟵	⟵	⟵	⟵	●[17]	⟶	⟵	●	⟶	⟵	●
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]					●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	
Depression and Suicide Risk Screening[16]																						●	●	●	●	●	●	●	●	●	●	
PHYSICAL EXAMINATION[18]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
PROCEDURES[19]																																
Newborn Blood		●[19]	●[20]	⟶																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Dyslipidemia[28]												★			★		★		★	⟵	●	★	★	★	★	★	⟵				●	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★		
HIV[30]																						★	★	★	★	⟵	●	⟶	★	★		
Hepatitis B Virus Infection[31]		★	⟶																													
Hepatitis C Virus Infection[32]																													●	⟶		
Sudden Cardiac Arrest/Death[33]																						★	⟶									
Cervical Dysplasia[34]																																
ORAL HEALTH[35]							●[35]	●[35]	★		★	★	★	★	★	★	★															
Fluoride Varnish[37]							⟵				●	⟶																				
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	

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NCQA PCMH Standardized Measure Reporting

2026 PCMH Annual Reporting Criteria

AR-QI 1 (Required): Clinical Quality Measures

Site-specific

Measures Reporting Tile

At least annually, the practice monitors at least five clinical quality measures across the four categories (at least one measure of each type):

- Immunization.
- Other preventive care.
- Chronic/acute care.
- Behavioral health.

2026 PCMH Annual Reporting Criteria

AR-QI 2 (Required): Resource Stewardship Measures

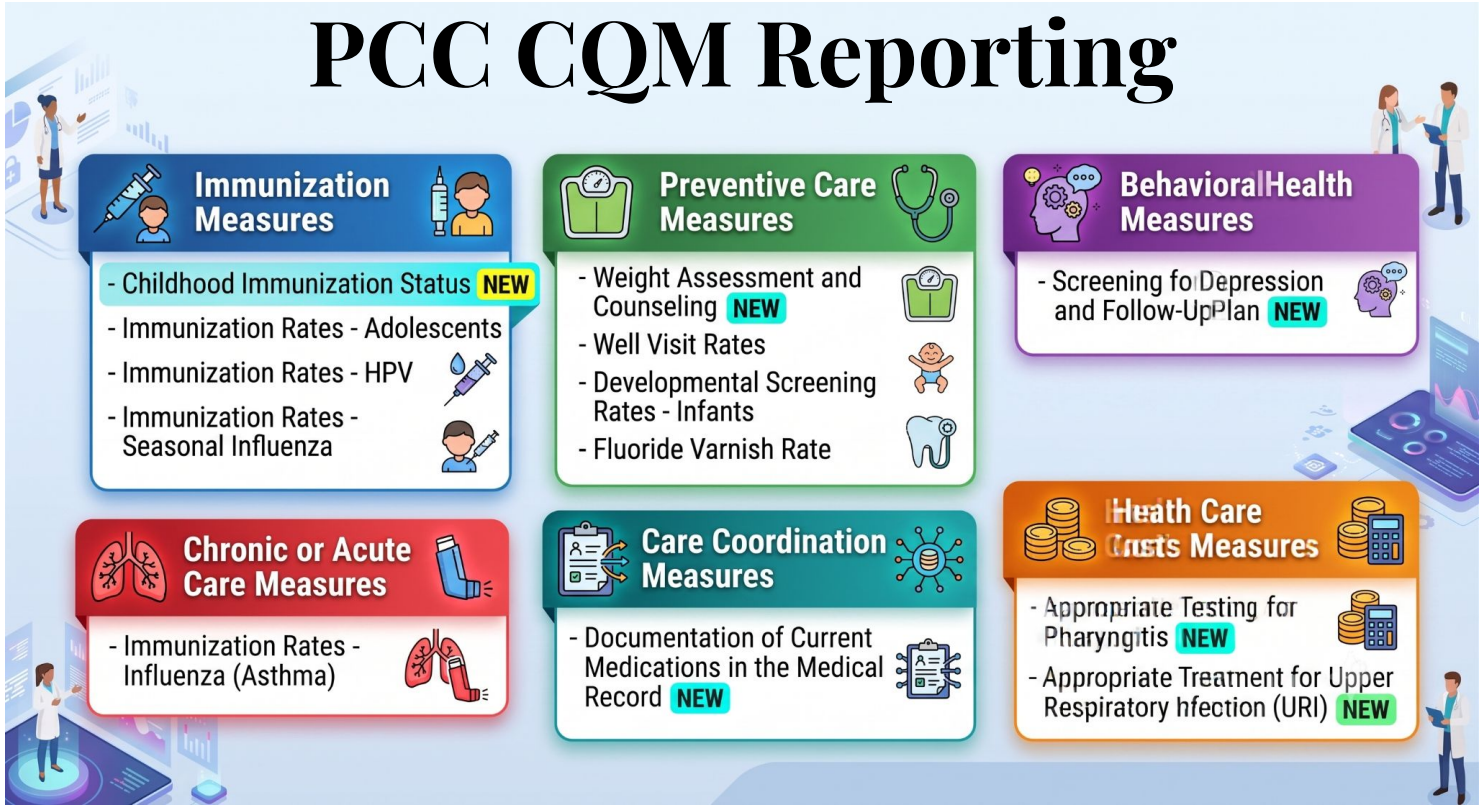
Site-specific

Measures Reporting Tile

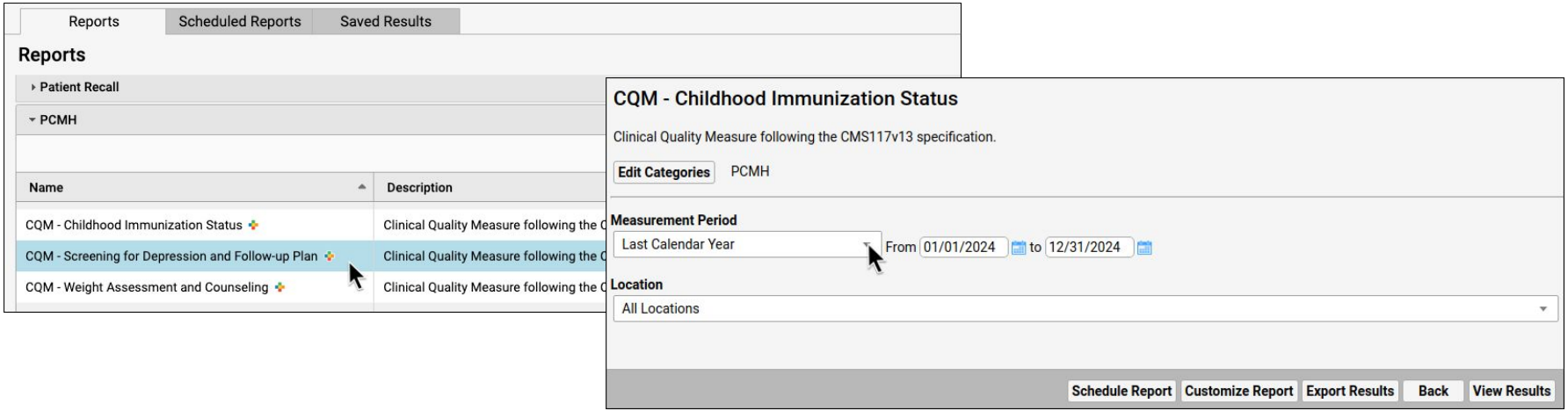
At least annually, the practice monitors at least two measures of resource stewardship (at least one measure of each type):

- Measures related to care coordination.
- Measures affecting health care costs.

PCC CQM Reporting



PCC CQM Reporting



- Use any desired measurement period
- Filter by location. CQM calculations attribute patients to the location of their most recent eligible encounter

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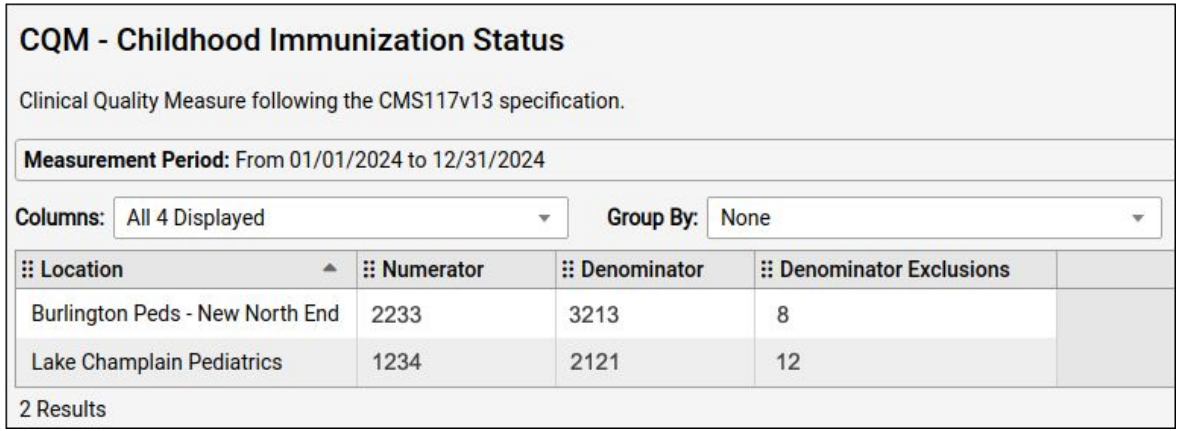
PCC CQM Reporting



CQM - Childhood Immunization Status

Clinical Quality Measure following the CMS117v13 specification.

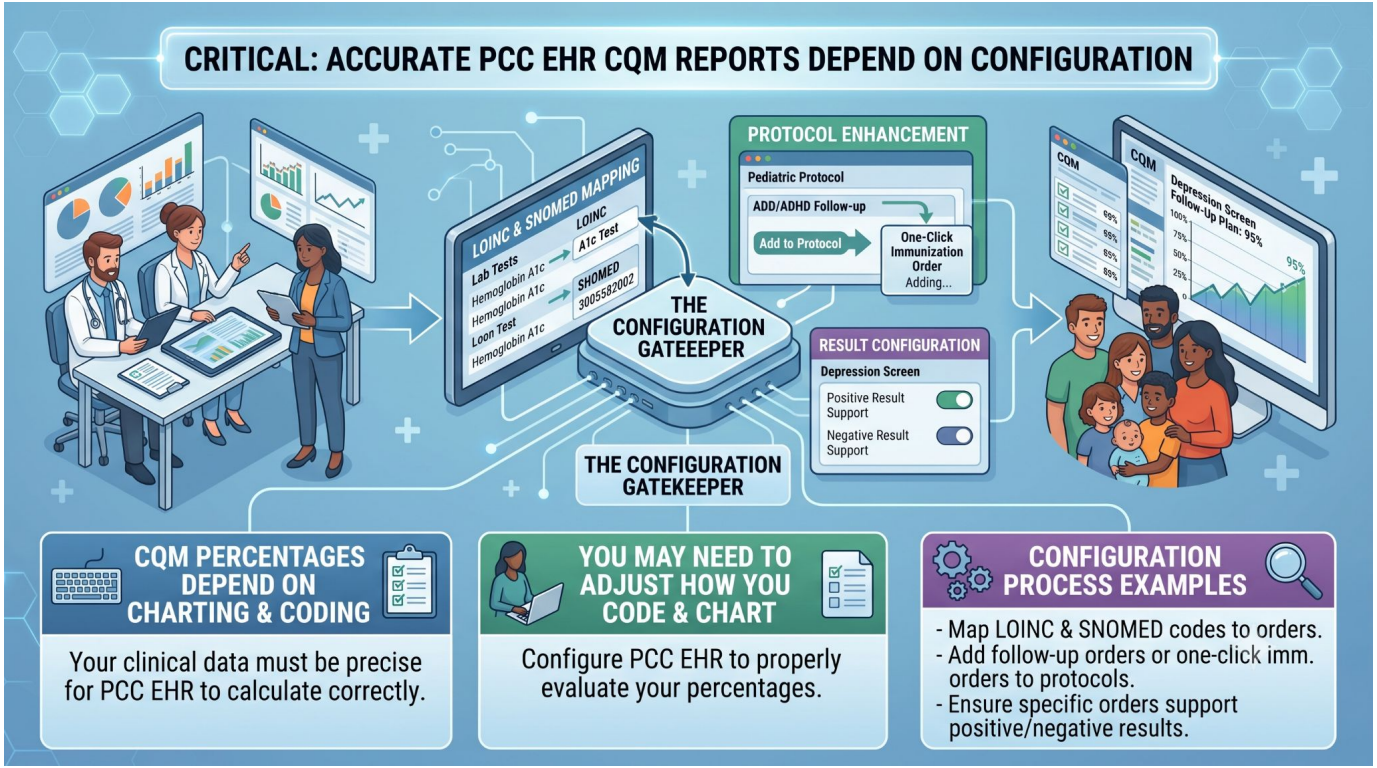
Measurement Period: From 01/01/2024 to 12/31/2024

Columns: All 4 Displayed **Group By:** None

Location	Numerator	Denominator	Denominator Exclusions
Burlington Peds - New North End	2233	3213	8
Lake Champlain Pediatrics	1234	2121	12

2 Results

- Use the numerator, denominator, and exclusions in the report to calculate your percentages.
- Final Denominator = Denominator – (Exclusions + Exceptions)
- (Numerator/Final Denominator) x 100 = Percentage for Reporting



Need guidance?

Refer to PCC Learn: [How to Chart for Clinical Quality Measures in PCC EHR]

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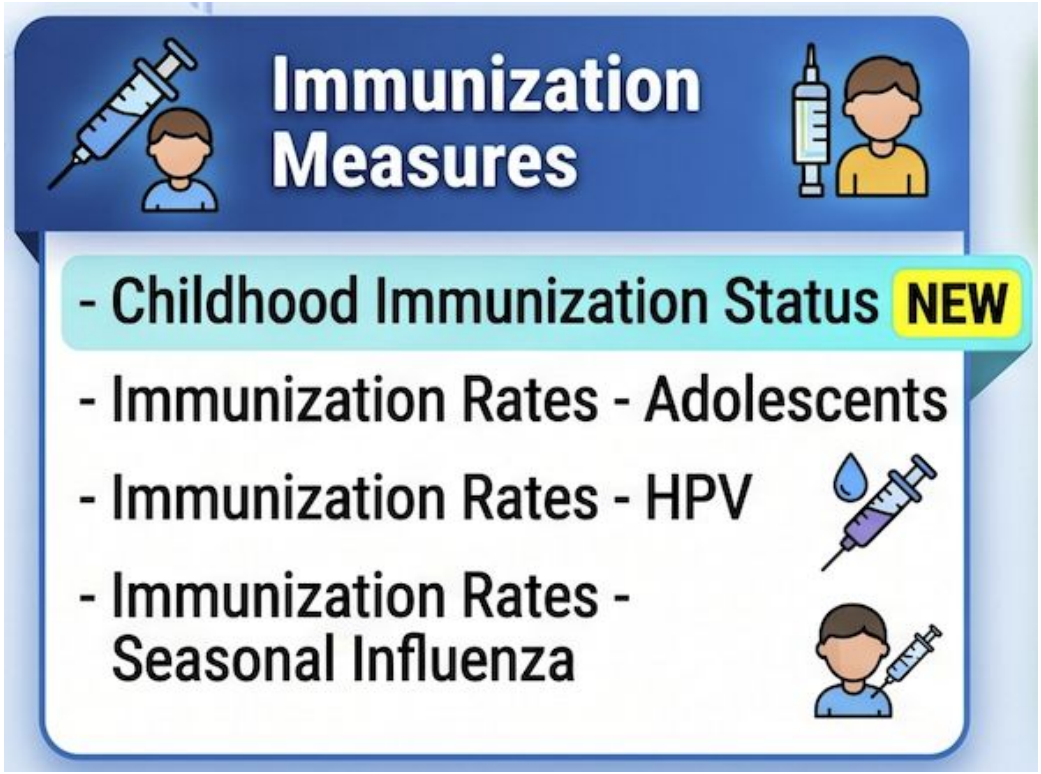

Immunization Measures
- Childhood Immunization Status NEW
- Immunization Rates - Adolescents
- Immunization Rates - HPV
- Immunization Rates - Seasonal Influenza

CQM - Childhood Immunization Status

Clinical Quality Measure following the CMS117v13 specification.

Measurement Period: From 01/01/2024 to 12/31/2024

Columns: All 4 Displayed **Group By:** None

Location	Numerator	Denominator	Denominator Exclusions
Burlington Peds - New North End	2233	3213	8
Lake Champlain Pediatrics	1234	2121	12

2 Results

- Denominator = # patients turning two years old in reporting period with an eligible encounter during reporting period
- Numerator = # patients having full series of recommended vaccines within the appropriate schedule by age two
- Exclusions = # patients diagnosed as being in hospice care or history of immunodeficiency Dx

Childhood Immunization Status

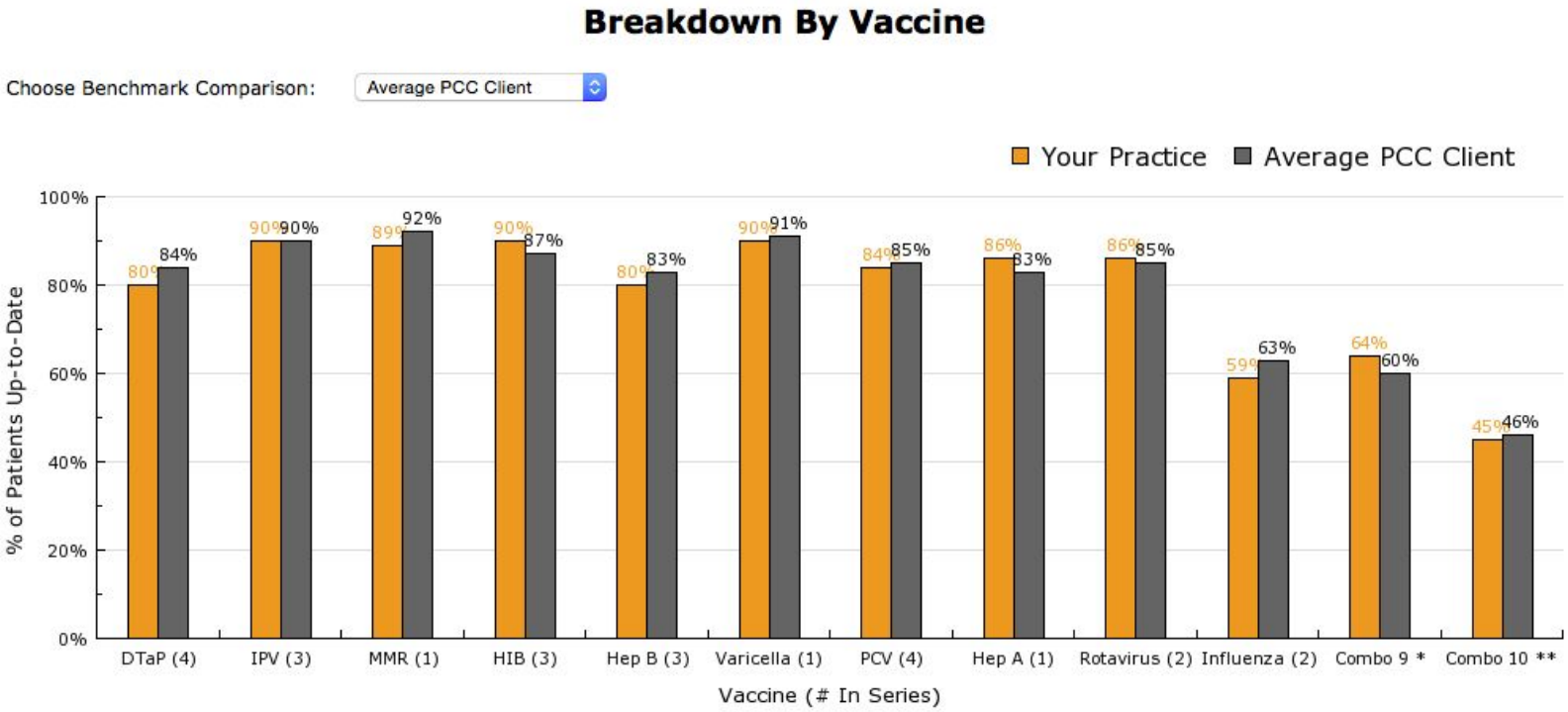
To meet the measure by a patient's second birthday, document the administration or history of these vaccines: **4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2–3 RV, and 2 influenza**. Patients with indicated vaccine refusals do not meet the measure.

Dashboard 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% ↑

- Patients with “Inactive” flags (on patient or guarantor record) are excluded from Dashboard measures **but not from EHR CQM reports**
- Historical and administered immunizations are included in these calculations

Dashboard – Childhood Immunization Rates



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Dashboard – Adolescent Immunization Rates

Measure: Immunization Rates - Adolescents

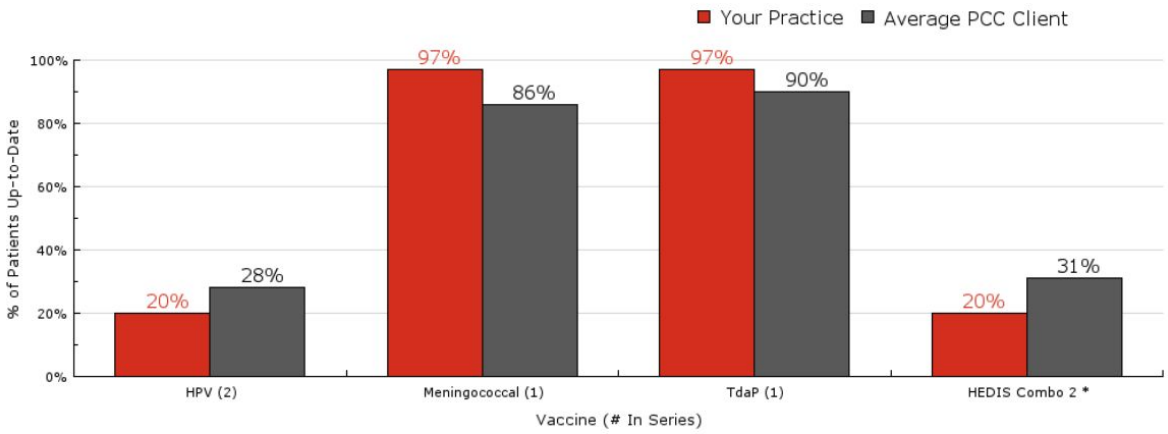
Choose a measure

Dashboard reports updated as of 6/1/2019

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

Choose Benchmark Comparison: Average PCC Client



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Behavioral Health Measures
- Screening for Depression and Follow-Up Plan
NEW

CQM - Screening for Depression and Follow-up Plan

Clinical Quality Measure following the CMS2v14 specification.

Measurement Period: From 01/01/2025 to 12/31/2025

Columns: All 5 Displayed **Group By:** None

Location	Numerator	Denominator	Denominator Exceptions	Denominator Exclusions
[redacted] Pediatrics	63	870	10	3

1 Results

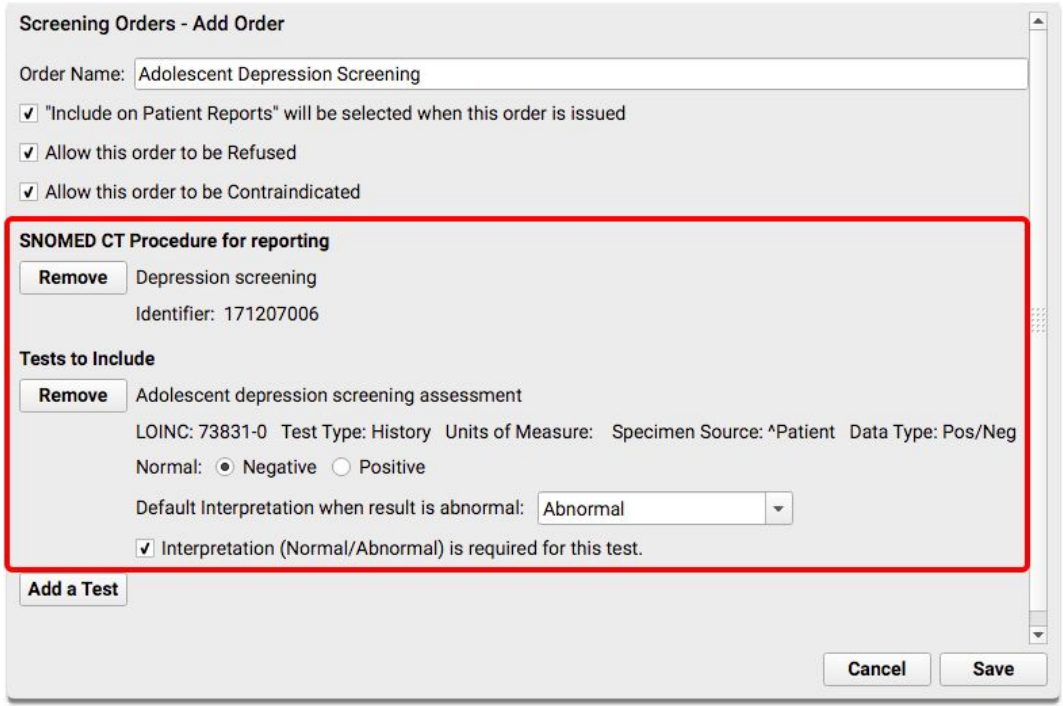
Denominator: Patients ≥12 years old with an eligible encounter during the reporting period.

Numerator: Denominator patients screened for depression within 14 days prior to the encounter. If positive, a follow-up plan must be documented within two days of the encounter.

Exclusions: Patients with a prior diagnosis of bipolar disorder.

Exceptions: Patient refusal or documented medical reason for not screening.

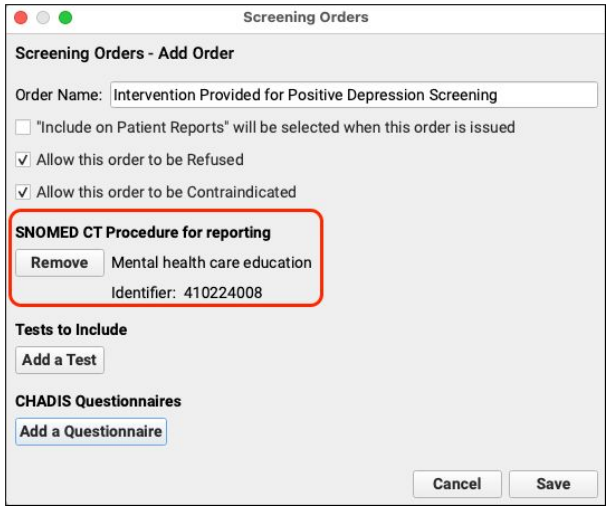
Depression Screening Orders



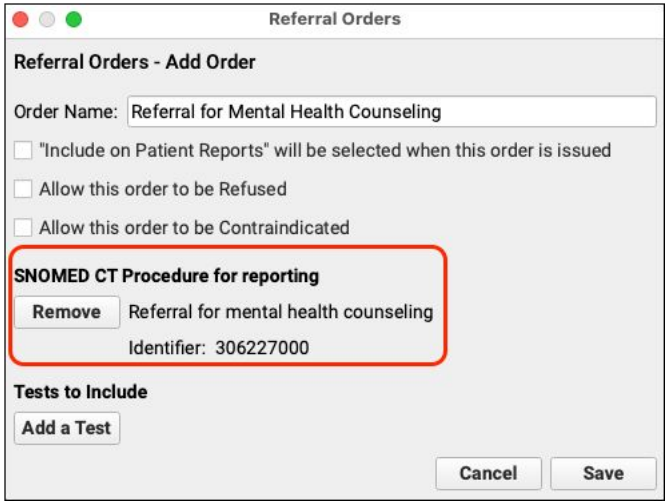
- EHR Configuration -> Protocols -> Component Builder -> Screening Orders

- Use LOINC 73831-0 on all adolescent depression screening orders. 73832-8 LOINC for all adult depression screening orders

Follow-up for Positive Screenings



If screening result is positive, you must use an order to track that **intervention was provided** or **referral was made**



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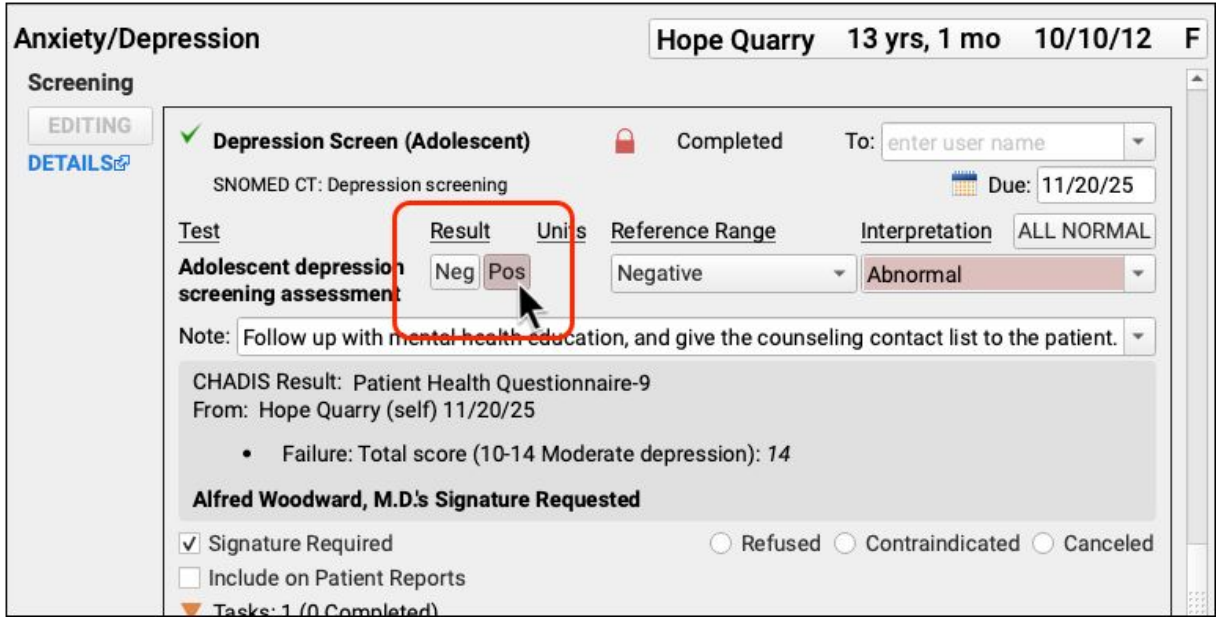
Follow-up for Positive Screenings

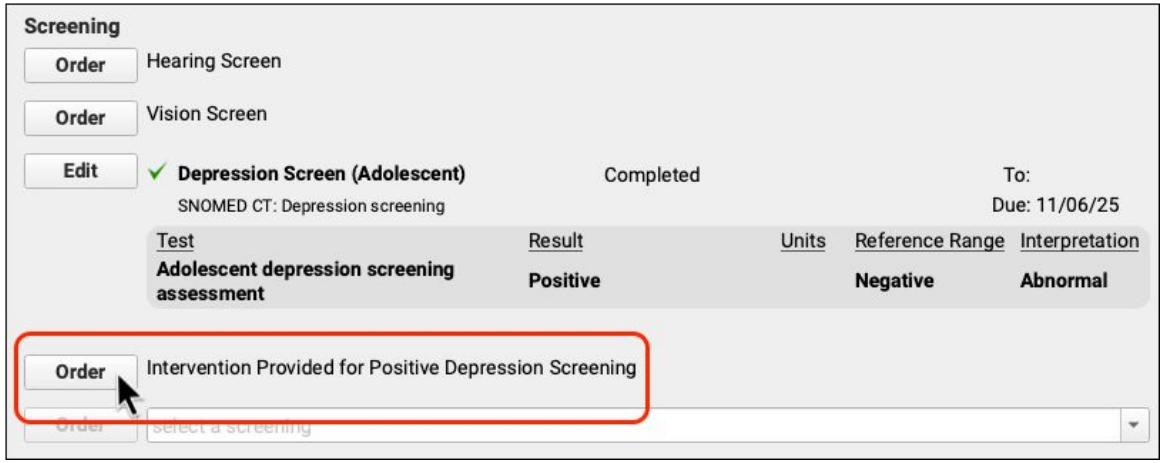
Here are some of the valid SNOMED codes to use with an order to indicate that a follow-up was documented

CODE SET	CODE	DESCRIPTION	NOTES
SNOMED	41022408	Mental health care education	Link this code to an "Intervention provided for positive depression screening" follow-up or screening order
SNOMED	81294000	Patient referral for psychotherapy	Link this code to the relevant referral order
SNOMED	306227000	Referral for mental health counseling	Link this code to the relevant referral order
SNOMED	75516001	Psychotherapy	Link this code to the relevant follow-up or referral order
SNOMED	385726000	Emotional support education	Link this code to the relevant follow-up order

Recommended Charting For Depression Screens



Follow-up for Positive Screenings



and/or

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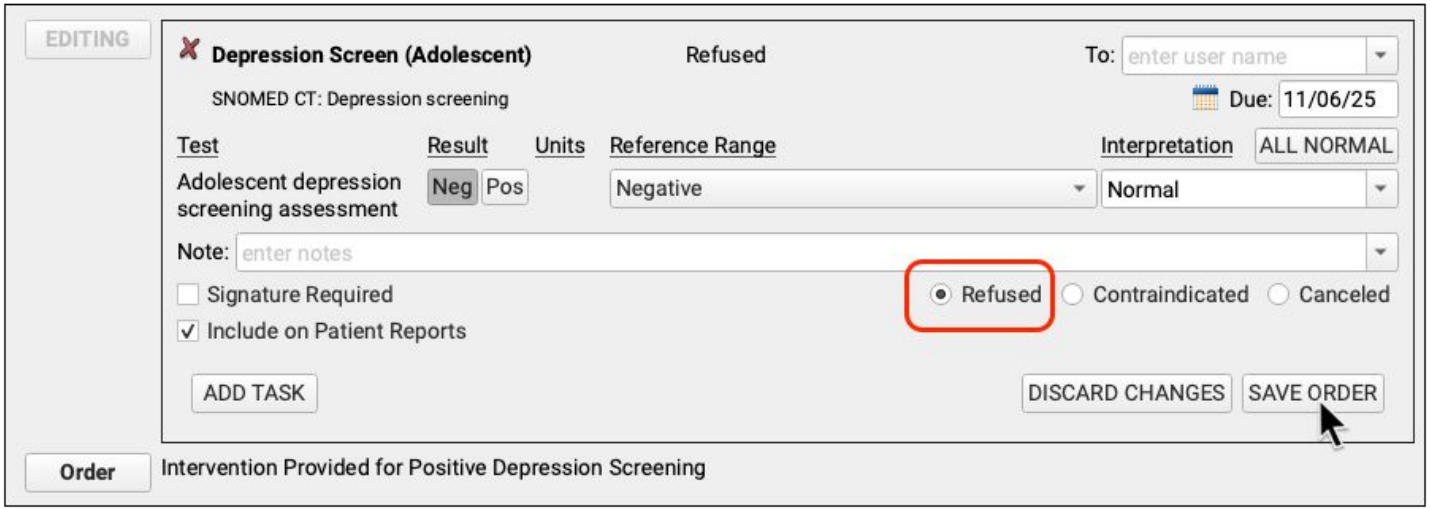
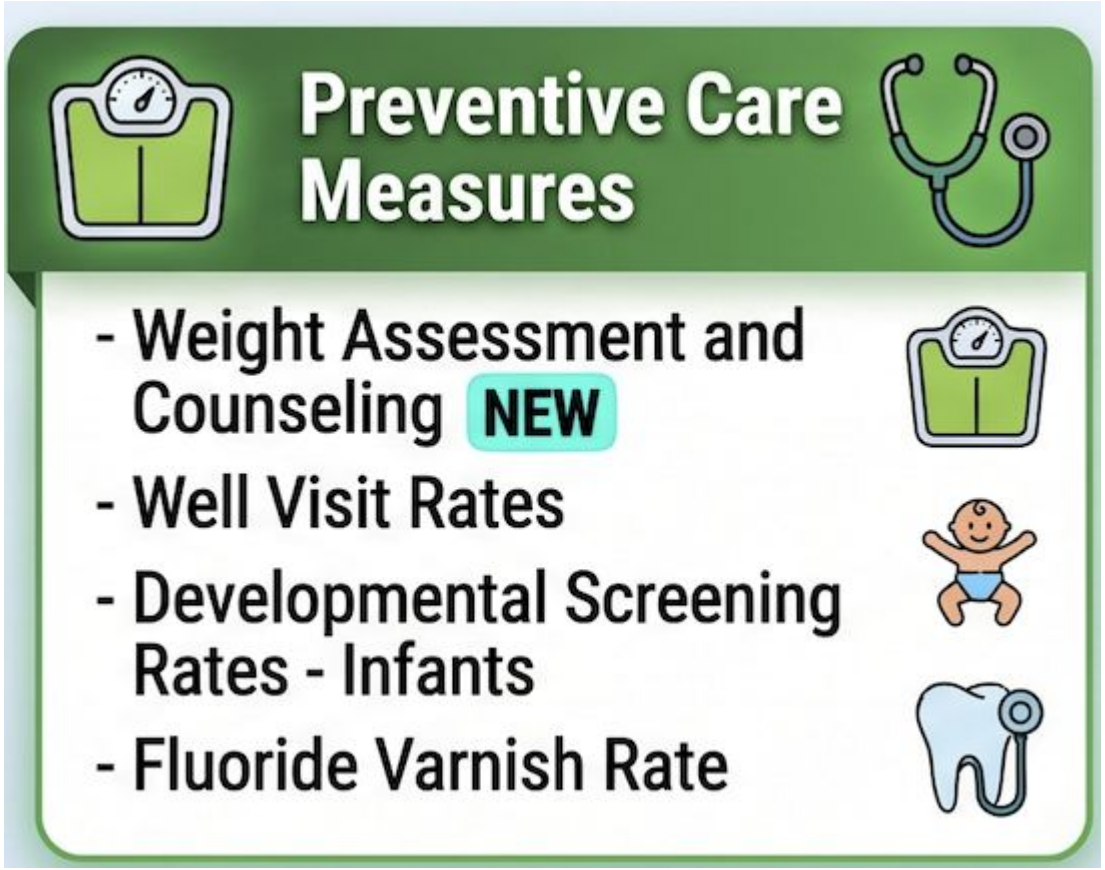
Measure Exceptions



Marking a screening as “Refused” or “Contraindicated” will count as measure “Exception”


Preventive Care Measures
- Weight Assessment and Counseling NEW
- Well Visit Rates
- Developmental Screening Rates - Infants
- Fluoride Varnish Rate

CQM - Weight Assessment and Counseling

Clinical Quality Measure following the CMS155v13 specification.

Measurement Period: From 01/01/2025 to 12/31/2025

Columns: All 6 Displayed **Group By:** None

Location	BMI Recorded (Numerator 1)	Nutrition Counseling (Numerator 2)	Physical Activity Counseling (Numerator 3)	Denominator	Denominator Exclusions
[redacted]	1989	1866	1866	1998	0

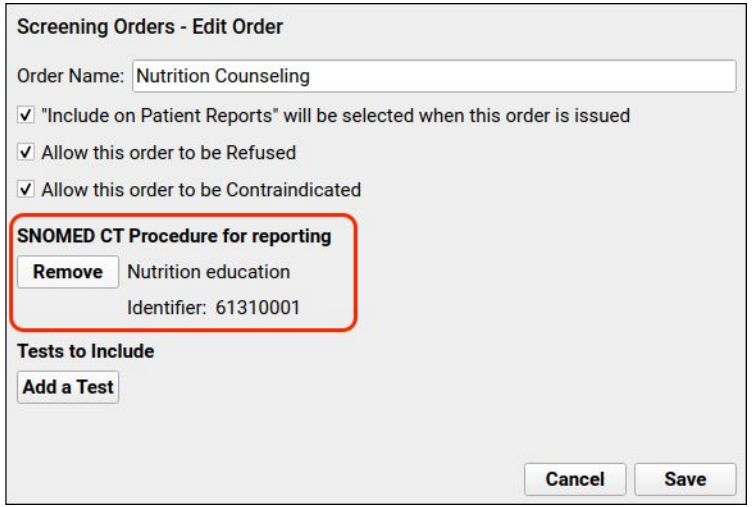
1 Results

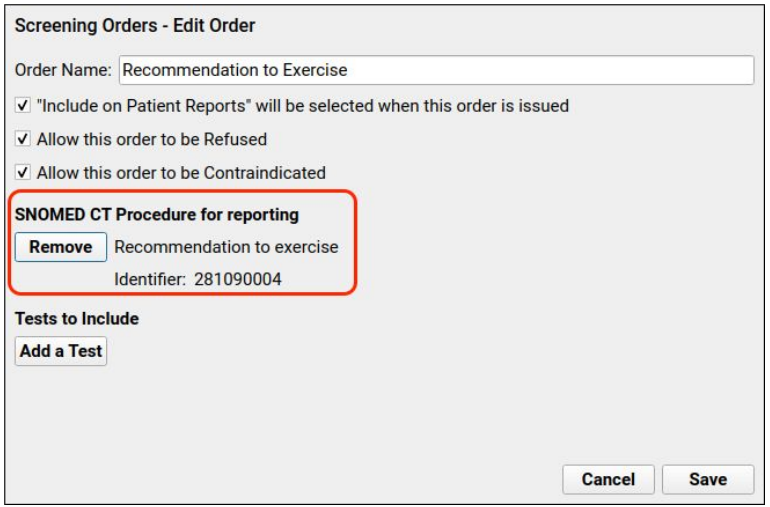
Denominator: Patients 3–17 with an eligible encounter during the reporting period.

Numerators: Patients in the denominator with documented height, weight, and BMI percentile (Numerator 1), plus counseling for nutrition (Numerator 2) and physical activity (Numerator 3) at least once during the measurement period.

Exclusions: Patients in hospice or with an active pregnancy diagnosis during the measurement period.

Configure screening orders for nutrition and exercise counseling linked to appropriate SNOMED codes

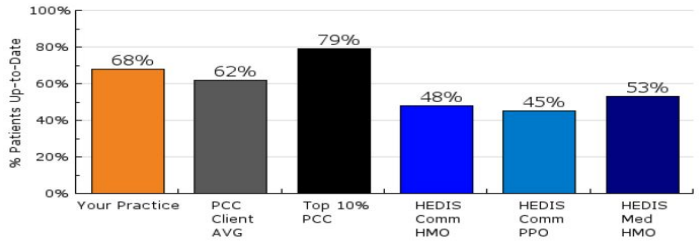




Dashboard - Well Visit Rates

Well Visit Rates - Patients 12-21 Years

This measure shows the percentage of all active patients between the ages of 12 years and 21 years who have received at least one well visit in the past year.



Your Score: **63** out of 100

Up-to-Date Patients: 1,303
Qualifying Patients: 1,912
Percentage: **68%**

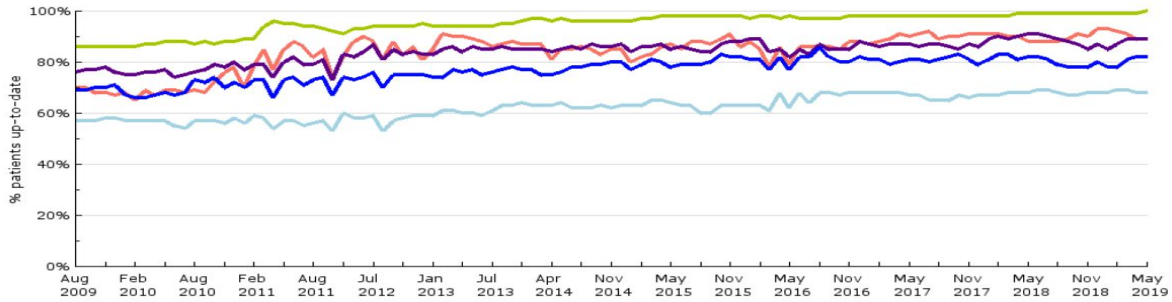
View overdue patient list - 609 patients overdue

View Detailed Breakdown for Age Group

View PCC Client Distribution

Your Practice Trends

Save as spreadsheet



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Dashboard – Well Visit Rates

- Indicator of recall effort and preventive care focus at your practice
- Only “active” patients (seen in past three years) are counted
- Patients with “Inactive” flags (on patient or account record) are omitted
- Low % of patients up-to-date indicates opportunity for more well visits
- Use the EHR Report Library for up-to-date recall lists of overdue patients

Dashboard – Well Visit Rates by Insurance and PCP

Detailed Breakdown: Primary Insurance

Show Breakdown By: Primary Insurance

Primary Insurance	Active Patients	Overdue Patients	Up-to-Date Patients	% Patients Up-to-Date
All Insurance	5,364	1,870	3,494	65%
Medicaid	92	50	42	46%
Aetna	291	116	175	60%
Blue Cross/Blue Shield	869	307	562	65%
Cigna	186	60	126	68%
GHI-CBP	392	176	216	55%
Oxford	206	84	122	59%

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	5,365	1,870	3,495	65%
Provider 2	2,778	945	1,833	66%
Provider 6	853	373	480	56%
Provider 34	1	0	1	100%
Provider 40	19	11	8	42%
Provider 9	383	94	289	75%

- See breakdown of well visit rates by insurance or primary care provider
- Compare these results with your payor-reported performance

Clinical Oversight Leads to Revenue Opportunity

- Does your practice have a recall process?
- How many of your active patients are overdue for a well visit?
- How can you fit these patients into your schedule?

Patient Age	# Patients Overdue for a well visit	AVG $ Deposited per well visit *	Annual Revenue Opportunity
3 - 6 Years	200	$243	$49,000
7 - 11 Years	300	$221	$66,000
12 - 18 Years	400	$276	$110,000

* Benchmarks based on national PCC client data

Infant Developmental Screening

	INFANCY							
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●
MEASUREMENTS								
Length/Height and Weight		●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●
Weight for Length		●	●	●	●	●	●	●
Body Mass Index[5]								
Blood Pressure[6]		★	★	★	★	★	★	★
SENSORY SCREENING								
Vision[7]		★	★	★	★	★	★	★
Hearing		●[8]	●[9] →			★	★	★
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH								
Maternal Depression Screening[11]				●	●	●	●	
Developmental Screening[12]								●

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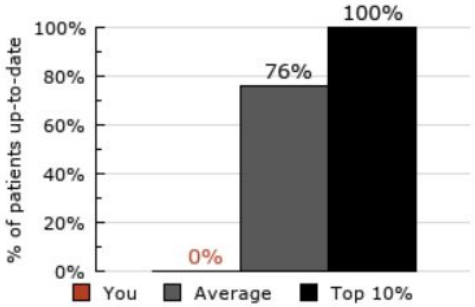
Dashboard - Infant Developmental Screening Rate

How You Compare



View Comparison By Provider

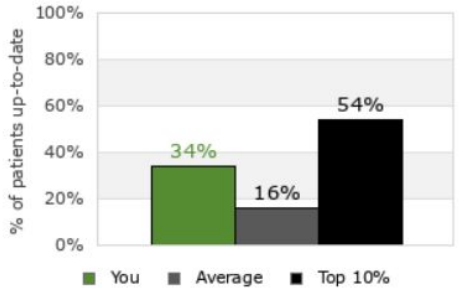
Your Practice	PCC Client Average	Top Performers
0%	76%	100%

(% of patients having one developmental screening between 6 - 12 months of age)

- Measure of infants getting developmental screening between 6-12 months of age
- Based on billing codes (96110, G0444, or 96127 for infants)
- Includes breakdown by provider (PCP)

Dashboard – Fluoride Varnish Rate

How You Compare



View Age and Insurance Breakdown

Your Practice	PCC Client Average	Top Performers
34%	16%	54%

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

- Based on billing codes (99188, D1206, or 99429 billed in last year)
- Includes breakdown by age and insurance

Health Care Costs Measures
- Appropriate Testing for Pharyngitis NEW
- Appropriate Treatment for Upper Respiratory Infection (URI) NEW

CQM - Appropriate Testing for Pharyngitis

Clinical Quality Measure following the CMS146v14 specification.

Measurement Period: From 01/01/2025 to 12/31/2025

Columns: All 4 Displayed **Group By:** None

Location	Numerator	Denominator	Denominator Exclusions
[redacted]	82	97	12

1 Results

Denominator: Pediatric patients (ages 3–18) with pharyngitis or tonsillitis who received an antibiotic on or three days after an eligible encounter or ED visit.

Numerator: Denominator patients who received a group A streptococcus test between 3 days prior and 3 days after their pharyngitis diagnosis.

Exclusions: Patients on antibiotics in the 30 days prior to diagnosis, those in hospice care, or those with a competing diagnosis or comorbid condition within the specified timeframes.

CQM - Appropriate Treatment for Upper Respiratory Infection (URI)

Clinical Quality Measure following the CMS154v14 specification.

Measurement Period: From 01/01/2025 to 12/31/2025

Columns: All 4 Displayed **Group By:** None

Location	Numerator	Denominator	Denominator Exclusions
[redacted]	589	712	86

1 Results

Denominator: Visits during the reporting period for patients aged 3 months or older diagnosed with an Upper Respiratory Infection (URI) with an eligible encounter code.

Numerator: Visits from the denominator where no antibiotic was prescribed on or within 3 days of the visit.

Exclusions: Encounters are excluded if the patient took antibiotics in the 30 days prior to the URI diagnosis. Also excluded are patients in hospice care, those with a competing diagnosis on or within 3 days of the episode date, or those with a comorbid condition within the 12 months prior to or on the episode date.

Care Coordination Measures
- Documentation of Current Medications in the Medical Record
NEW

CQM - Documentation of Current Medications

Clinical Quality Measure following the CMS68v14 specification.

Measurement Period: From 01/01/2025 to 12/31/2025

Columns: All 4 Displayed **Group By:** None

Location	Numerator	Denominator	Denominator Exceptions
[redacted]	3811	4088	0

1 Results

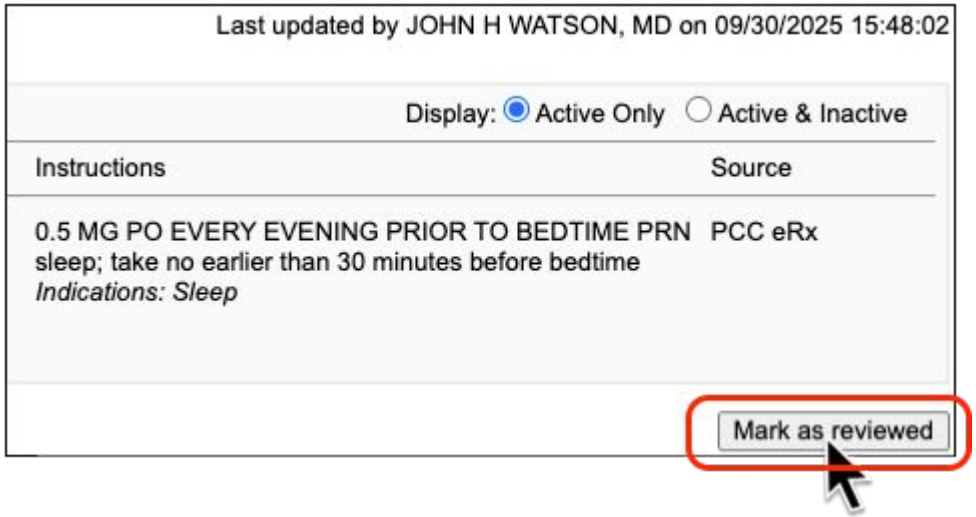
Denominator: Unique, billed electronic encounters during the reporting period (includes telehealth and phone).

Numerator: Unique encounters where patient medications were reviewed or updated the same day, even if none are taken.

Exceptions: Exclude encounters with SNOMED documentation of a medical reason for not reviewing/updating medications (e.g., urgent situations jeopardizing patient health).

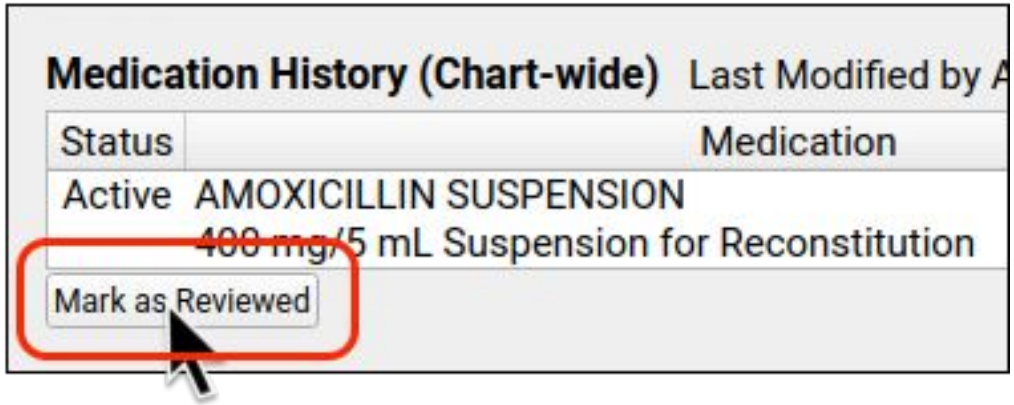
Medication Review

There are a few ways to mark a medication as reviewed for this measure:



Mark as reviewed in the “Medication History” section of PCC eRx

Medication Review



New as of 11.0!
You can now click “Mark as Reviewed” in the visit protocol's Medication History (Chart Wide) component if there are no medication changes, eliminating the need to open PCC eRx.

Medication Review

You can still click “Patient Takes No Meds” in PCC eRx, if that is your preferred workflow

Important: Clinicians must record their medication review on the day that the patient was seen in order for the visit to be counted toward this measure.

Population Health Management

Care Plan Oversight

Proactively identifying, tracking, and monitoring patients currently on a structured care plan.

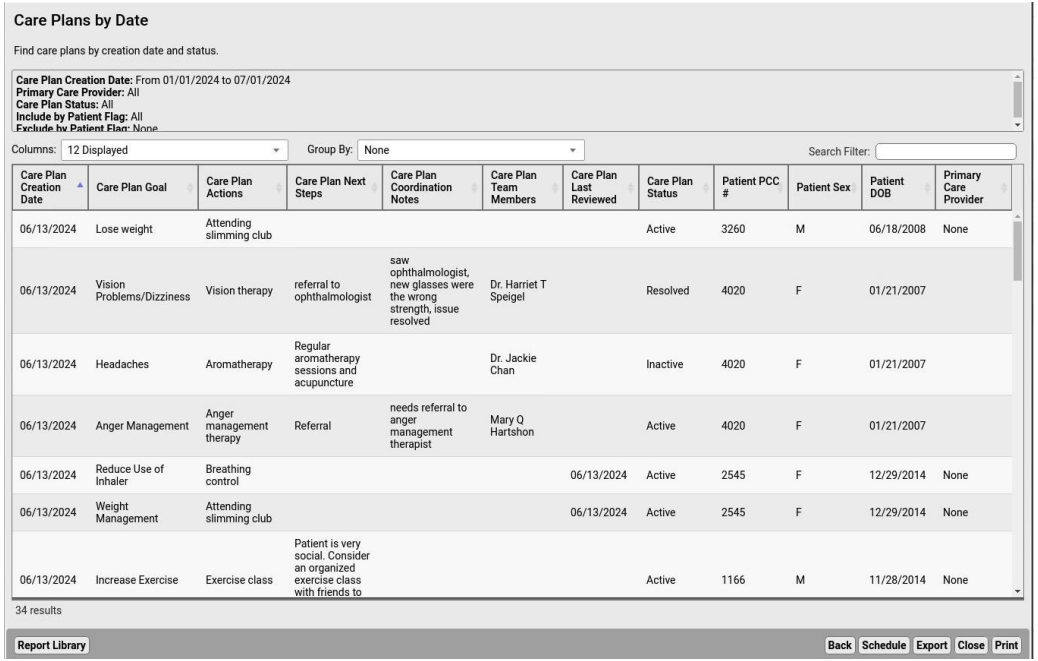
Preventive Gap Analysis

Identifying patients overdue for essential well visits, key immunizations, or chronic disease follow-ups.

Patient Outreach

Executing targeted patient recall campaigns, portal outreach, and coordinated messaging.

Care Plan Management



Care Plans by Date

Find care plans by creation date and status.

Care Plan Creation Date: From 01/01/2024 to 07/01/2024
Primary Care Provider: All
Care Plan Status: All
Include by Patient Flag: All
Exclude by Patient Flag: None

Columns: 12 Displayed | Group By: None | Search Filter:

Care Plan Creation Date	Care Plan Goal	Care Plan Actions	Care Plan Next Steps	Care Plan Coordination Notes	Care Plan Team Members	Care Plan Last Reviewed	Care Plan Status	Patient PCC #	Patient Sex	Patient DOB	Primary Care Provider
06/13/2024	Lose weight	Attending slimming club					Active	3260	M	06/18/2008	None
06/13/2024	Vision Problems/Dizziness	Vision therapy	referral to ophthalmologist	saw ophthalmologist, new glasses were the wrong strength, issue resolved	Dr. Harriet T Speigel		Resolved	4020	F	01/21/2007	
06/13/2024	Headaches	Aromatherapy	Regular aromatherapy sessions and acupuncture		Dr. Jackie Chan		Inactive	4020	F	01/21/2007	
06/13/2024	Anger Management	Anger management therapy	Referral	needs referral to anger management therapist	Mary Q Hartshon		Active	4020	F	01/21/2007	
06/13/2024	Reduce Use of Inhaler	Breathing control				06/13/2024	Active	2545	F	12/29/2014	None
06/13/2024	Weight Management	Attending slimming club				06/13/2024	Active	2545	F	12/29/2014	None
06/13/2024	Increase Exercise	Exercise class	Patient is very social. Consider an organized exercise class with friends to				Active	1166	M	11/28/2014	None

34 results

Report Library | Back | Schedule | Export | Close | Print

- Use RL Clinical Reports -> “Care Plans by Date” report to monitor patients with a care plan
- Is it time for a follow-up visit to check in on a patient’s care plan?

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Patient Recall in the EHR

- Use the “Preventive Care Recall” report in the EHR Report Library to generate customized, age-specific lists of patients overdue for well visits.
- Leverage PCC’s complimentary Broadcast Messaging to contact these patients directly
- Schedule recurring reports for ongoing efficiency.

Well Visit Recall

- Use EHR Report Library - Patient Recall -> “Preventive Care Recall”

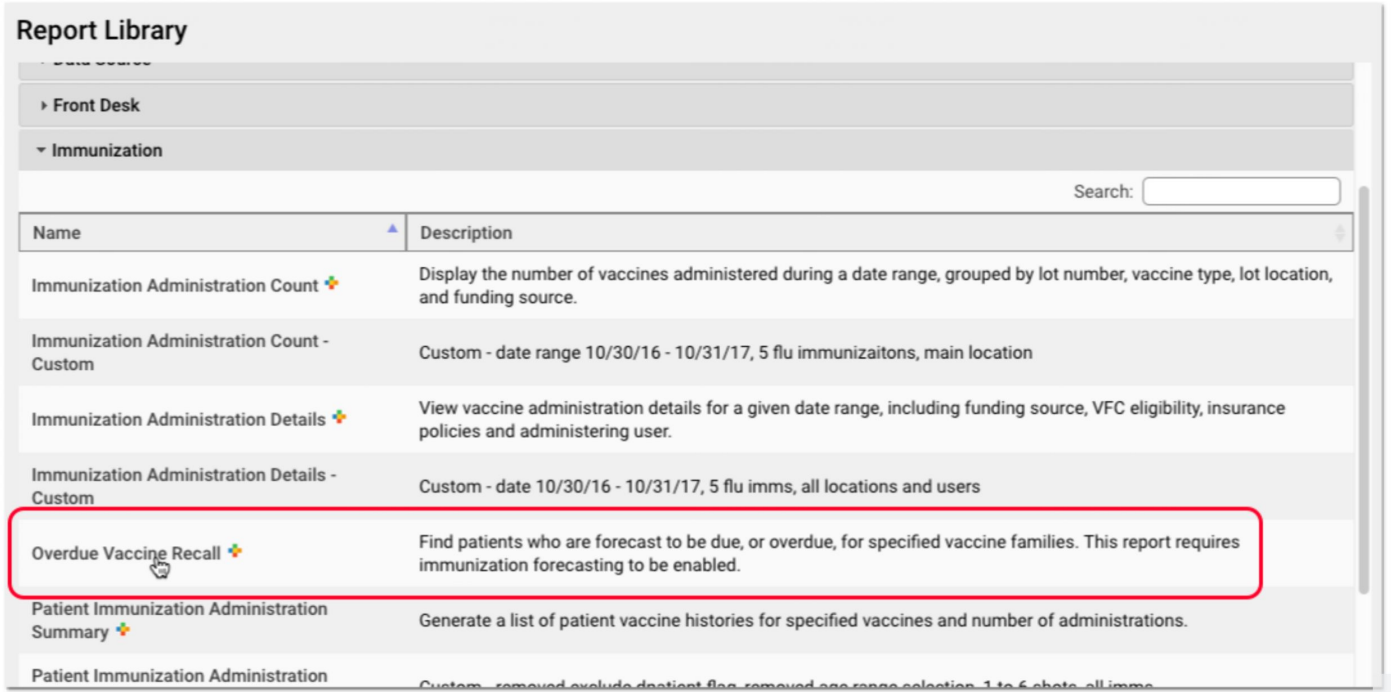
- Restrict on:
  - Visit date (last 3 yrs to include active patients)
  - Exclude by Patient flag (exclude pats w/ any type of inactive flag)
  - Patient age (focus on specific age range)
  - Physical due date (all past dates through next 90 days)
  - Exclude by scheduled appointment (exclude all well visit appointment types over next 365 days)

Chronic Condition Recall

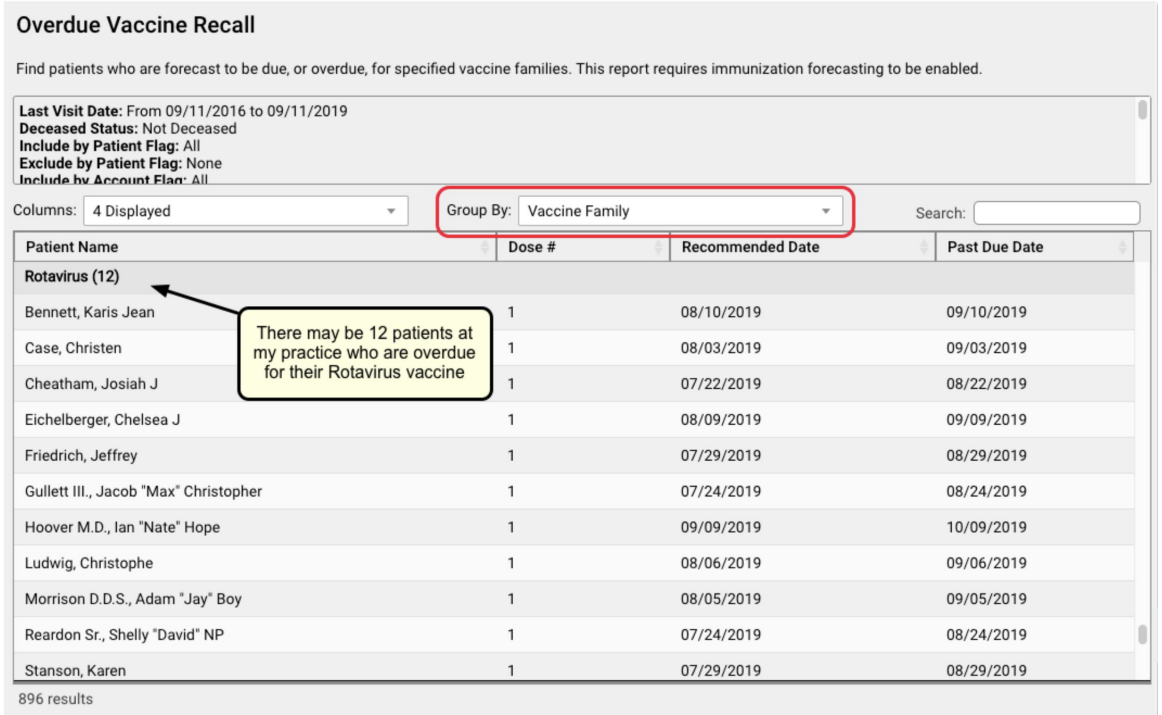
- Use EHR Report Library - Patient Recall -> “Chronic Condition Recall”

- Restrict on:
  - Visit date (last 3 yrs to include active patients)
  - Exclude by Patient flag (exclude pats w/ any type of inactive flag)
  - Patient age (focus on specific age range)
  - Clinical Diagnosis (include pats w/ specified diagnosis)
  - Exclude by scheduled appointment (exclude all appointment types over next 365 days)
  - Exclude by charges (exclude patients having any charge billed in past X months. If the patient was seen recently, they aren’t overdue)

Identify Patients Overdue for Vaccine



Identify Patients Overdue for Vaccine



Overdue Vaccine Recall

Find patients who are forecast to be due, or overdue, for specified vaccine families. This report requires immunization forecasting to be enabled.

Last Visit Date: From 09/11/2016 to 09/11/2019
Deceased Status: Not Deceased
Include by Patient Flag: All
Exclude by Patient Flag: None
Include by Account Flag: All

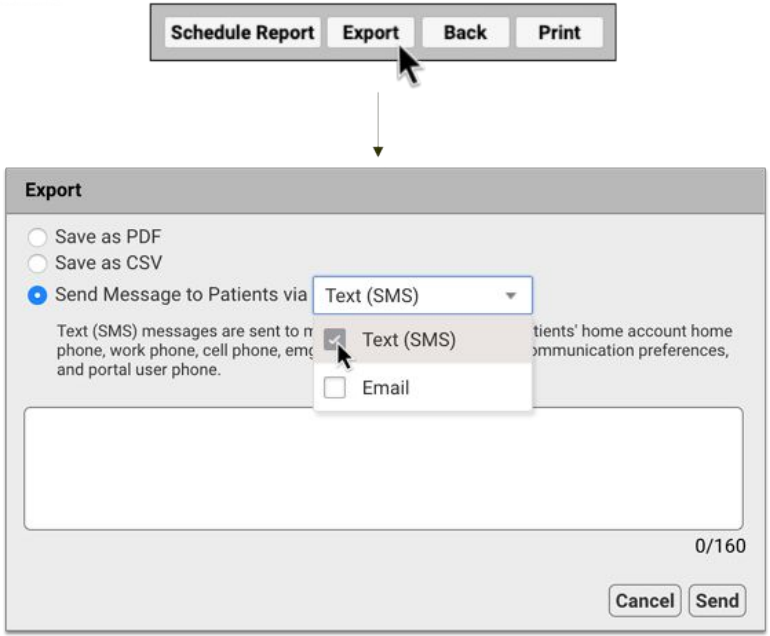
Columns: 4 Displayed | Group By: Vaccine Family | Search:

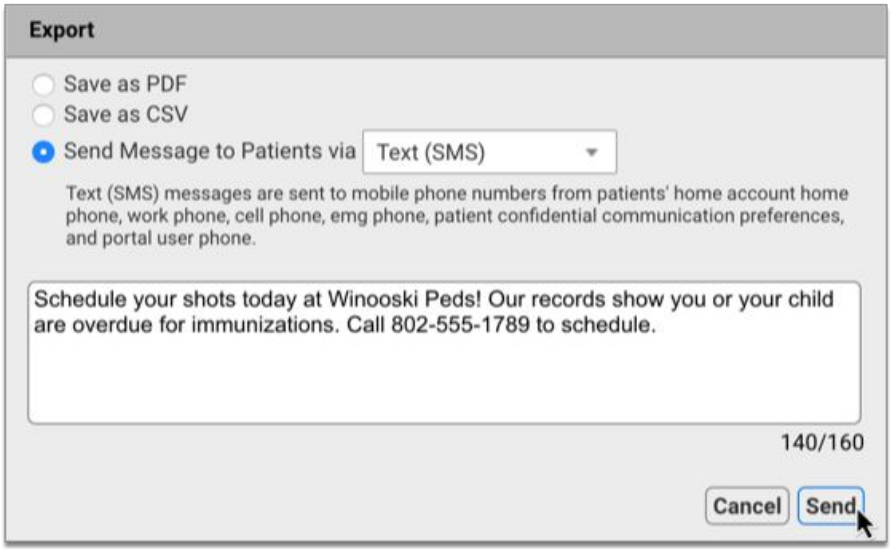
Patient Name	Dose #	Recommended Date	Past Due Date
Rotavirus (12)			
Bennett, Karis Jean	1	08/10/2019	09/10/2019
Case, Christen	1	08/03/2019	09/03/2019
Cheatham, Josiah J	1	07/22/2019	08/22/2019
Eichelberger, Chelsea J	1	08/09/2019	09/09/2019
Friedrich, Jeffrey	1	07/29/2019	08/29/2019
Gullett III., Jacob "Max" Christopher	1	07/24/2019	08/24/2019
Hoover M.D., Ian "Nate" Hope	1	09/09/2019	10/09/2019
Ludwig, Christophe	1	08/06/2019	09/06/2019
Morrison D.D.S., Adam "Jay" Boy	1	08/05/2019	09/05/2019
Reardon Sr., Shelly "David" NP	1	07/24/2019	08/24/2019
Stanson, Karen	1	07/29/2019	08/29/2019

896 results

There may be 12 patients at my practice who are overdue for their Rotavirus vaccine

Broadcast Messaging





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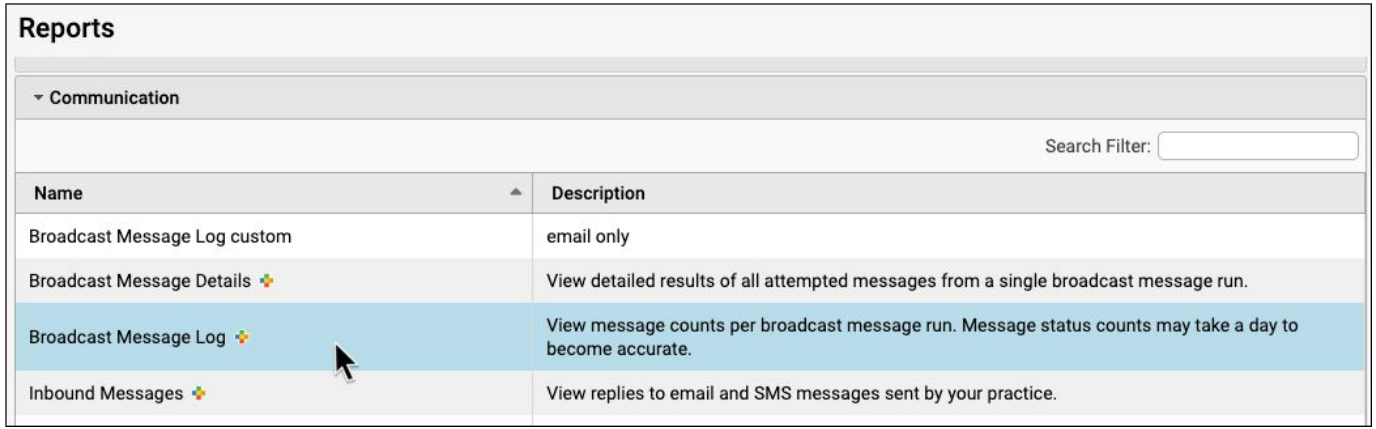
Broadcast Message Logs



Logs display the run date/time, sender, message content, and counts of successful versus failed attempts by message type.

Using Leading Metrics to Forecast Your Future

The Predictable Practice: Using Leading Metrics to Forecast Your Future

When: Friday 7/17 - 1:15 - 2:15

Who: Alex Meyer

Where: Amphitheater

PCC Pediatric EHR Solutions

UC 2026

Session Takeaways

1. New ideas and reports to use for clinical operations oversight

2. Configuration strategies to optimize CQM performance

3. Utilizing CQM results for PCMH standardized reporting

4. Financial implications of implementing a consistent recall process

Please complete the course survey in the UC App.

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Asking Questions:

Virtual attendees: Use the chat if you have a question that you want answered

In-person attendees: Go to the stationary microphone in your room.

CEUs:

You can request CEU codes for qualifying sessions using the form PCC shares out at the conclusion of the conference.

Do you have any questions?