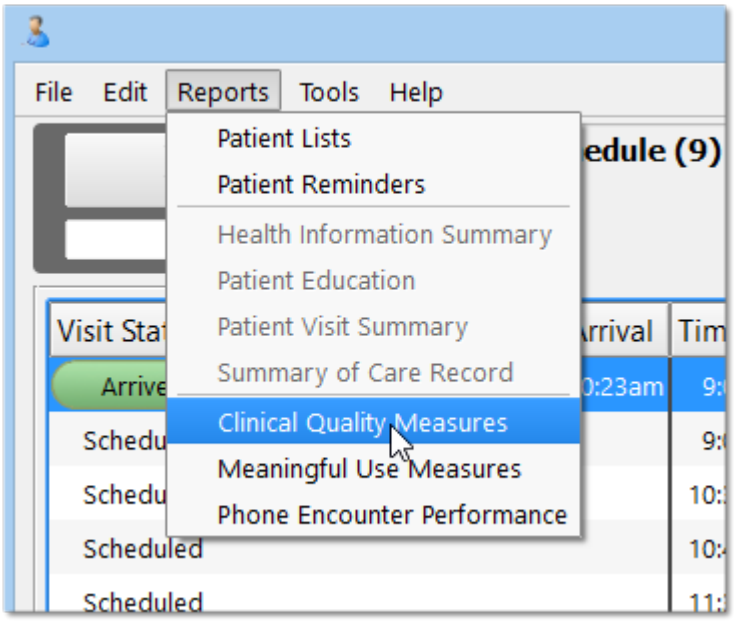
Factor 3: The practice measures or receives data on at least three chronic or acute care clinical measures

The Clinical Quality Measures report within PCC EHR calculates your clinician and/or practice-wide performance on a variety of chronic and acute care measures including:

- Use of Appropriate Medications for Asthma
- ADHD: Followup Care for Children Prescribed ADHD Medication
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection (URI)

These CQM reports can be found within the reports menu of PCC EHR...



...and can be run for any reporting period.

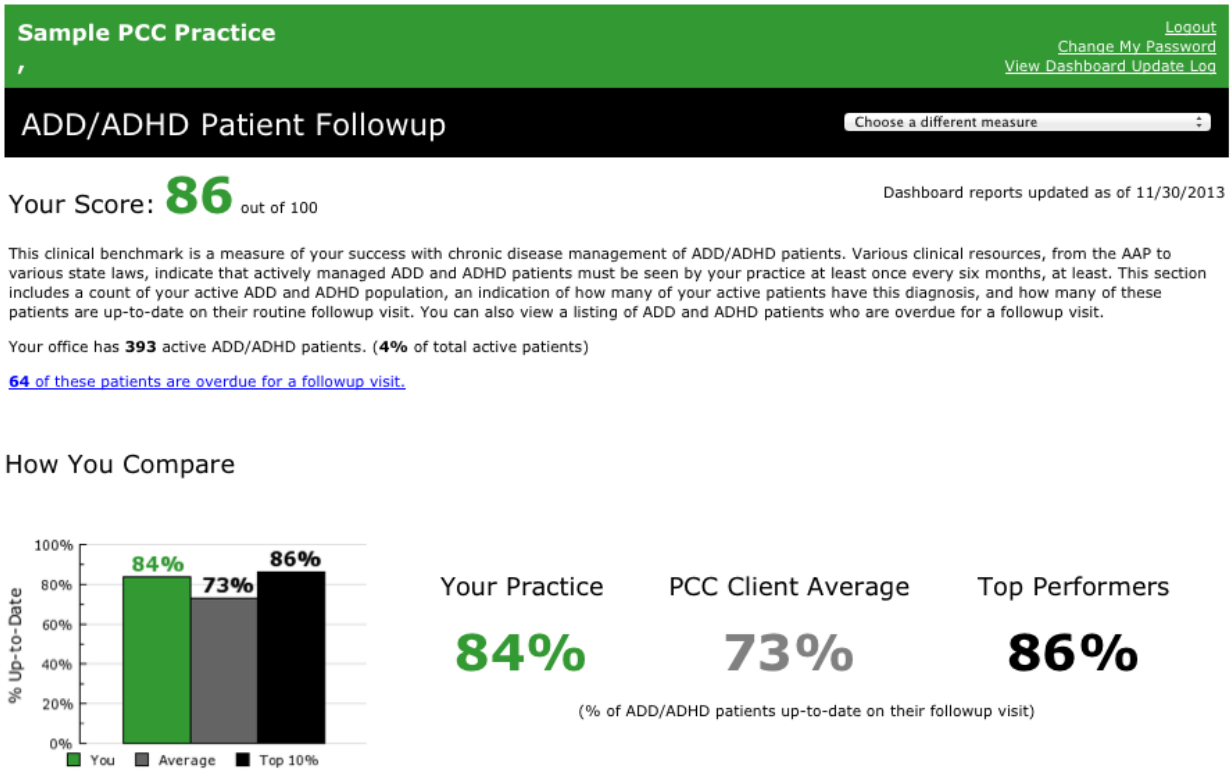
Additionally, the Practice Vitals Dashboard and `recaller` reporting tools give PCC clients the ability to measure their performance on a variety of chronic or acute care measures including:

- **Chronic Measure #1: ADD/ADHD patient followup**

Various clinical resources, from the AAP to various state laws, indicate that actively managed ADD and ADHD patients must be seen by your practice at least once every six months.

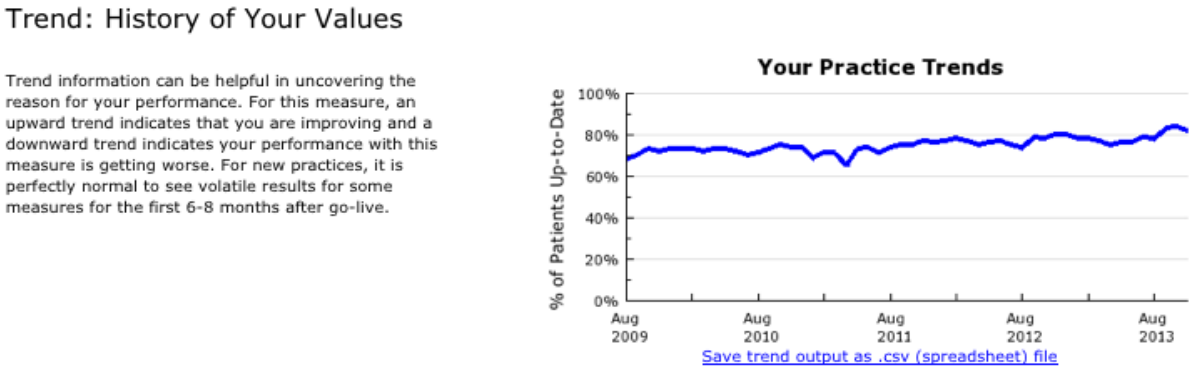
The Dashboard reports the practice's success with chronic disease management of ADD or ADHD patients by reporting the percentage of active patients with ADD or ADHD who have had a followup visit (of any type) in the past six months.

Here is a screenshot example showing what the practice will see in the Dashboard for this measure:



As with other measures in the Dashboard, reported on this page is the practice's current month value for the measure along with two benchmarks: the average and 90th percentile value among all of PCC's pediatric clients.

Further down the page is a practice trends section that looks like this:



This trend graph allows the practice to see their monthly trends over time. A downloadable .csv file is accessible below the graph which shows their actual monthly values that can be used to show improvement which would be applicable to PCMH element 6D.

As with other clinical measures, the Dashboard also gives the practice the ability to measure and graph performance for each individual clinician as shown in the following screenshot:

PHYSICIAN'S COMPUTER COMPANY

Practice Vitals Dashboard

HOME | FINANCIAL PULSE | CLINICAL PULSE | EDI DASHBOARD | PRODUCTIVITY

Sample PCC Practice

Logout
Change My Password
View Dashboard Update Log

ADD/ADHD Patient Followup

Choose a different provider breakdown

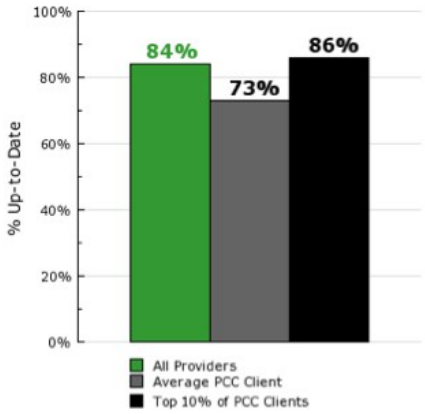
Dashboard reports updated as of 11/30/2013

Primary Care Provider Breakdown

Choose Provider	Provider	Active Patients	Overdue Patients	Up-to-Date Patients	% Patients Up-to-Date
◉	All Providers	393	64	329	84%
○	Provider 2	245	38	207	84%
○	Provider 6	39	9	30	77%
○	Provider 9	35	1	34	97%
○	Provider 21	3	0	3	100%
○	Provider 5	1	1	0	0%
○	Provider 3	36	7	29	81%
○	Provider 18	3	1	2	67%
○	Provider 13	31	7	24	77%

Review ADD/ADHD Overdue patient listing for your practice.

How You Compare



Reporting these results by individual clinician would be useful for PCMH element 6E where the practice needs to track and share results by individual clinician and across the practice (All providers).

Furthermore, the Dashboard includes access to a listing of ADD/ADHD patients overdue for a followup. Clicking on the "overdue patient listing" in the above screenshot would load an actual overdue patient listing that can be used for recall purposes.

[redacted]

Logout
Change My Password
View Dashboard Update Log

ADD/ADHD Patients Overdue For Followup

Why are these 87 patients overdue?

Data is up-to-date as of 2/28/2014

- They had at least one visit billed **with a diagnosis of ADD (314.00) or ADHD (314.01)** (primary or secondary) in the past three years

  AND

- They have not **had a visit (of any type) in the past six months**

  AND

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

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
[redacted]						09/13/10	06/06/11				
						08/05/11	08/05/11				
						11/16/09	11/18/11				

- **Chronic Measure #2: Obesity patients up-to-date on checkup**

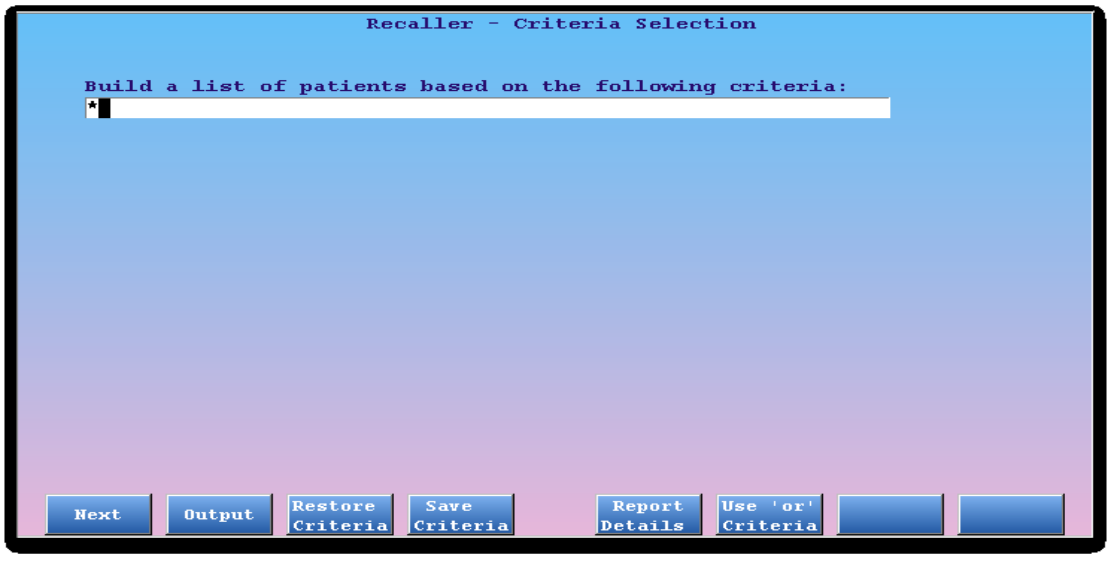
For patients who were recently given an obesity diagnosis or who had a high BMI percentile documented, it is recommended that they followup within a six month time frame to monitor their nutritional and exercise habits. To generate results for this chronic measure, the practice would use PCC's `recaller` program accessible to all PCC clients from within Partner, the Practice Management System.

A count and listing of active, obese patients can be generated from the Partner `recaller` report by considering a subset of patients given an obesity diagnosis or having a high BMI percentile documented in a given six month time frame. Likewise, a count and listing can be generated for these patients who have followed up with another office visit in the subsequent six month month time frame. Conversely, a count and listing can be generated for patients overdue for a followup visit which can be used for recall purposes. As noted earlier, the overdue listing can be customized to include the desired demographic output.

When running the `recaller`, you begin by adding one or more criteria to limit the output. The criteria determine which patients will be included in the output.

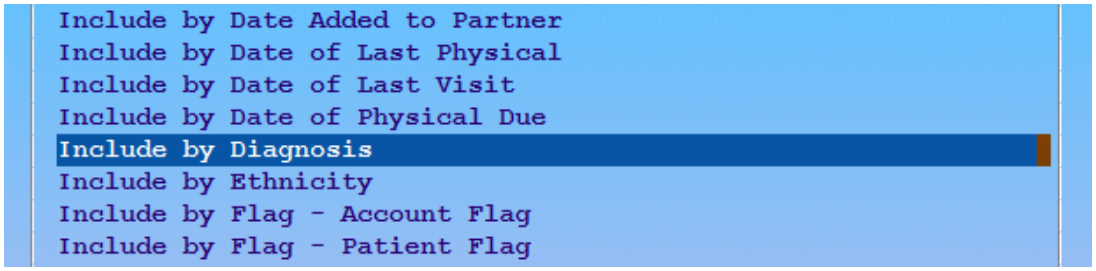
Here is a step-by-step description of how to use the Partner `recaller` report to report on the **Obesity patients up-to-date on checkup** chronic measure with criteria as described above:

First, start by typing an asterisk to begin searching for criteria:



For the first criteria selection, you will include by diagnosis to restrict the report to include only patients with an obesity or high BMI percentile diagnosis within a specified time period.

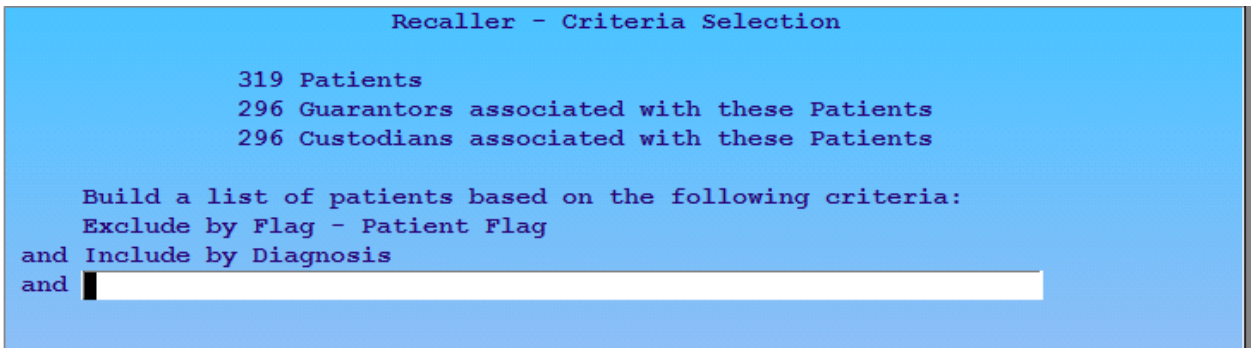
Select the “Include by Diagnosis” criteria:



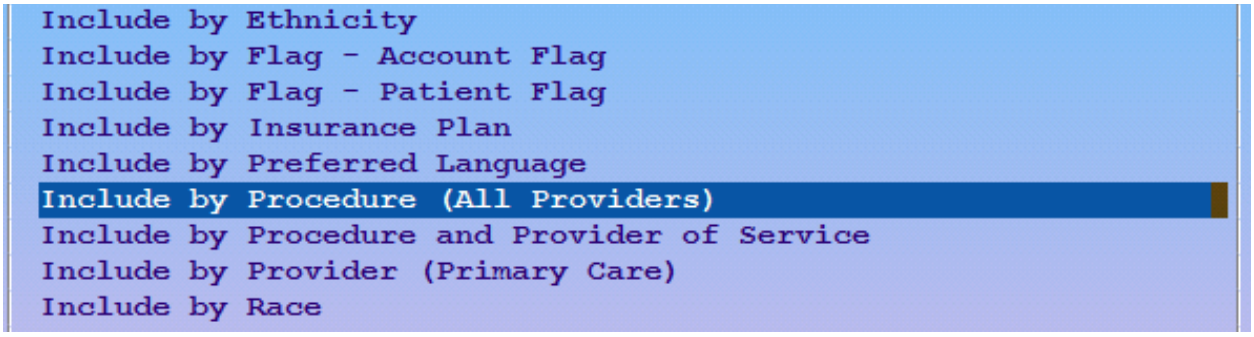
You will then be prompted for a diagnosis time period to use. Press <F7> to use specific dates. Use a six month date range going back one year. For example, if today is 12/17/13 you'd select a date range of 12/17/12 – 6/17/13.

Then select the diagnosis entries you use to indicate obesity or BMI greater than or equal to the 95th percentile. The corresponding ICD-9 codes for these are 278.00, 278.01, and V85.54.

Now the criteria includes active patients who were recently seen with an obesity diagnosis. On the main criteria selection screen, you'll see a count of total patients. Make note of this as it represents the denominator for this obesity followup measure:



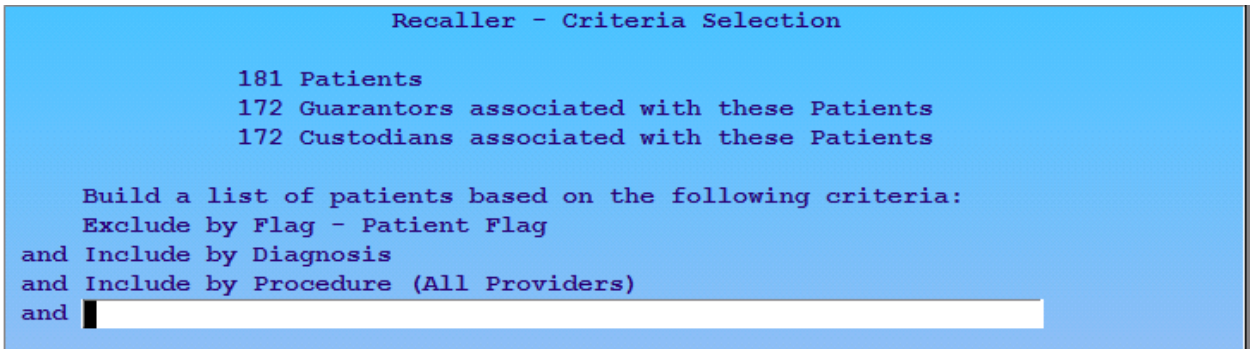
Type another asterisk to search for the second criteria of procedure (all providers). This will allow you to include only patients having an office visit procedure billed for any provider within a specified time period.



You will then be prompted for a procedure time period to use. Press <F7> to use specific dates and enter the past six months as a date range. For example, if today is 12/17/13 you'd select a date range of 6/17/13 – 12/17/13.

Then select the procedure entries you use for sick, well, consult, or counseling office visits. The corresponding CPT codes ranges for these visits are 99201-99215 (new or established sick visits), 99381-99395 (new or established well visits), 99241-99245 (office consultations), or 99401-99406 (preventive counseling).

Now you have built upon your previous criteria of active patients with a recent obesity diagnosis. For these patients, you are now including only those that have had at least one office visit six months after being diagnosed with obesity. This represents the numerator for this obesity followup measure.



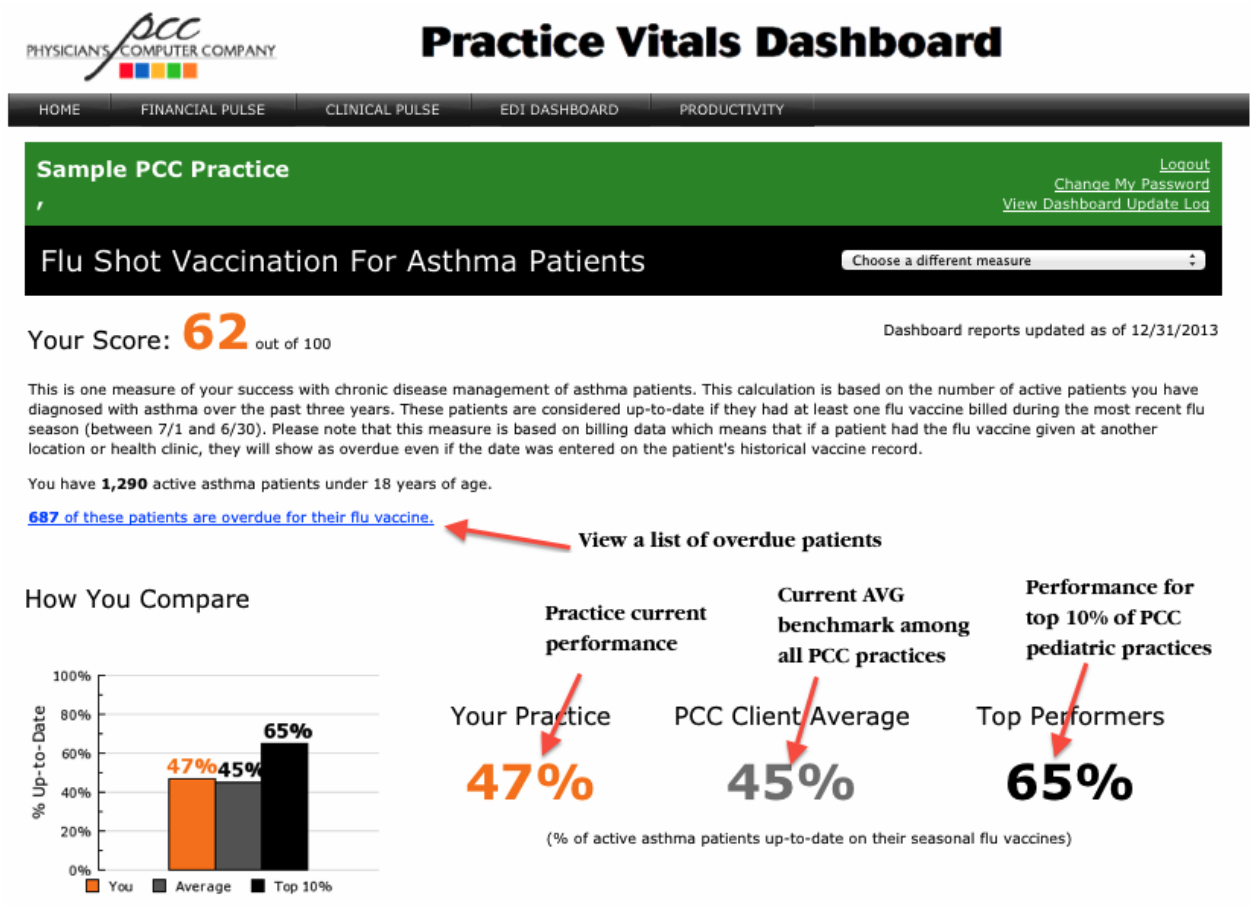
Based on this example, the practice has 181 out of 319 (57%) of active obese patients up-to-date on a followup visit. To monitor progress in this measure, the practice could run this `recaller` report on a regular basis updating the date ranges appropriately.

Furthermore, an additional restriction criteria of "Include by Provider (Primary Care)" could be added to gather these results for individual primary care clinicians which would be applicable for PCMH Element 6E.

- **Chronic Measure #3: Flu vaccination for asthma patients**

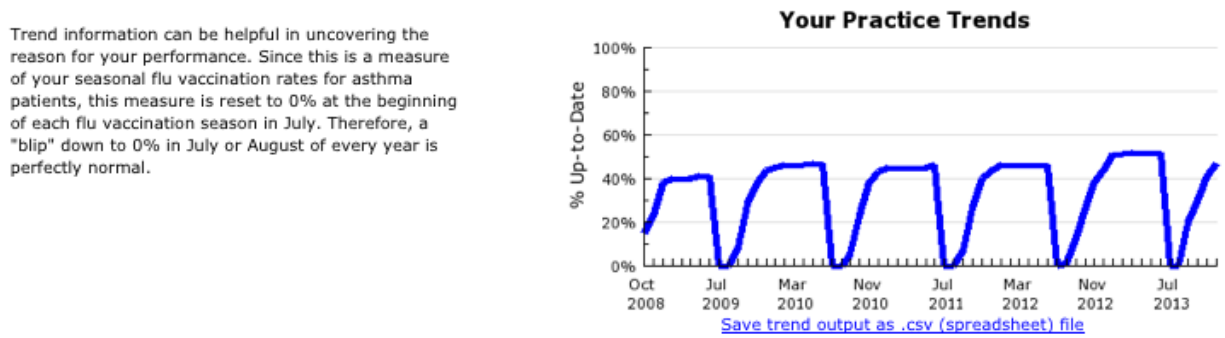
Another measure reported in the Dashboard for every PCC client is the percentage of active patients with asthma who are up-to-date on their seasonal flu vaccination. Patients are considered up-to-date if they had at least one flu vaccine billed during the most recent flu season (between 7/1 and 6/30).

Here is a screenshot example showing what the practice will see in the Dashboard for this measure:



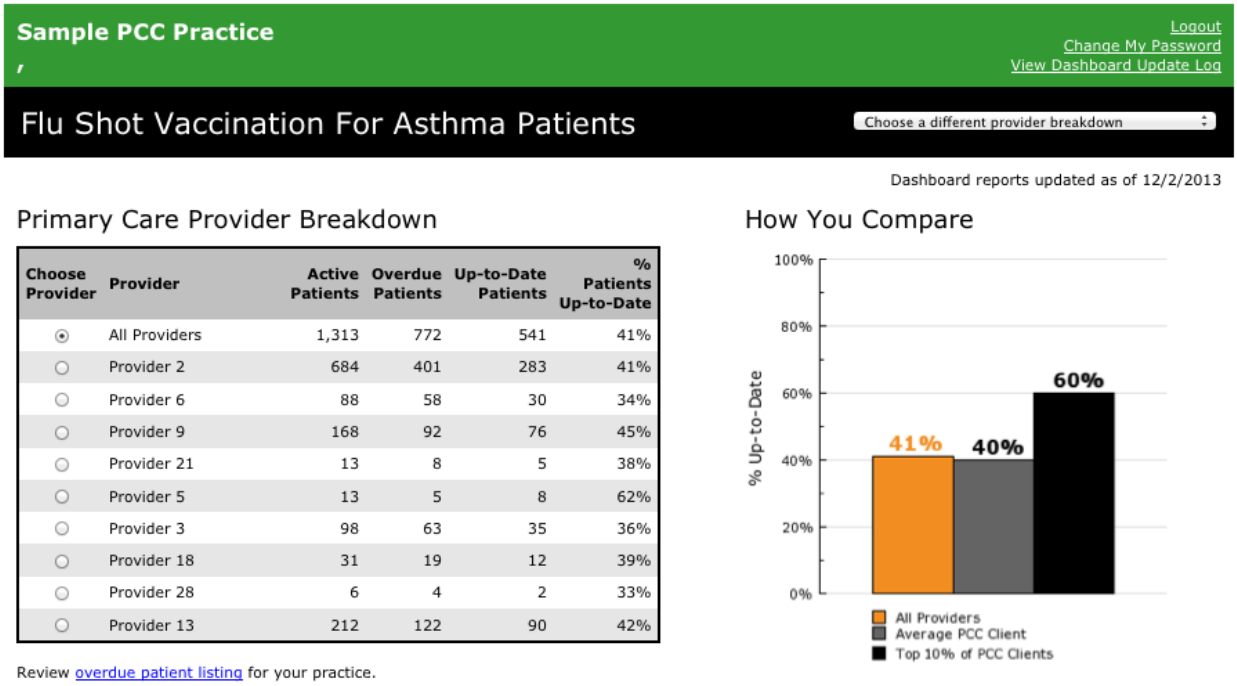
Reported on this page is the practice's current month value for the measure along with two benchmarks: the average and 90th percentile value among all of PCC's pediatric clients.

Further down the page is a practice trends section that looks like this:



This trend graph allows the practice to see their monthly trends over time. A downloadable .csv file is accessible below the graph and will allow the practice to see their actual monthly values to show improvement which would be applicable to PCMH element 6D.

For this preventive measure, the Dashboard also gives the practice the ability to measure and graph performance for each individual clinician as shown in the following screenshot:



Reporting these results by individual clinician would be useful for PCMH element 6E where the practice needs to track and share results by individual clinician and across the practice (All providers).