Factor 2: Generate lists of patients and proactively remind patients/families and clinicians of services needed for at least three different chronic care services

PCC's Dashboard and recaller tool have the ability to easily generate lists of patients overdue for the following chronic care services:

- ADD/ADHD followup care (Dashboard)
- Flu vaccination for asthma patients (Dashboard)
- Asthma patient followup care (recaller)
- Obese patient followup care (recaller)
- Depression patient followup care (recaller)
- Allergic Rhinitis patient followup care (recaller)
- Down syndrome patient followup care (recaller)

Just as we described above for the well-child care measure, the Dashboard measure detail page includes a link to a list of patients in need of followup care.

The list includes details for overdue patients including dates of recent and upcoming visits, and contact information. A Dashboard user can work from this list to contact patients reminding them that they are overdue for a routine well visit.

A spreadsheet in .csv output can also be generated from the Dashboard, allowing the practice to manage and distribute the lists to other practice staff or to integrate with a third party notification tool like *Televox* or *Phonetree*.

When using recaller for the condition-specific criteria mentioned above, you would add a diagnosis restriction:

```
Include by Date Added to Partner
Include by Date of Last Physical
Include by Date of Last Visit
Include by Date of Physical Due
Include by Diagnosis
Include by Ethnicity
Include by Flag - Account Flag
Include by Flag - Patient Flag
```

and then specify a time period for the diagnosis followed by the actual diagnosis entries you are restricting on.

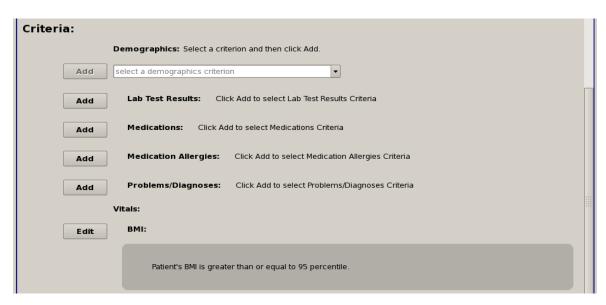
For example, if you are focusing on generating a list of patients with a recent history of obesity (in the last two years) that need followup care, you would add the following criteria if your criteria was to see these patients once every six months:

- Include by diagnosis specify patients with an obesity or elevated BMI ICD-9 code billed in the past two years.
- Include by date of last visit specify a last visit date range ending six months ago (this would indicate their last visit was more than six months ago)

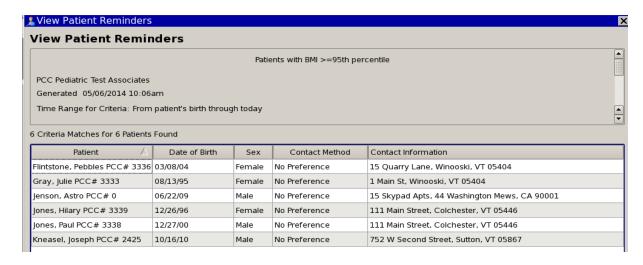
The "Patient Reminders" functionality in PCC EHR also allows PCC clients to generate lists of patients based on complex clinical criteria including:

- Patients with a particular lab test result
- Patients having a particular medication prescribed
- Patients having a particular medication allergy
- Patients having a particular diagnosis or problem assigned
- Patients having a particular BMI, height, weight, blood pressure, temperature, head circumference, pulse, respiratory rate, or 02 saturation.
- Patients with a certain race, ethnicity, or preferred language

When creating reminders, you would first specify your desired criteria. In this example, we are including patients who have a documented BMI in the 95th percentile or higher:

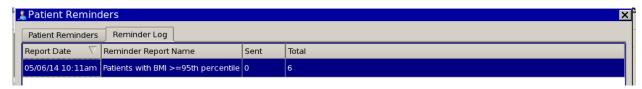


The output includes a listing of patients that meet the criteria:

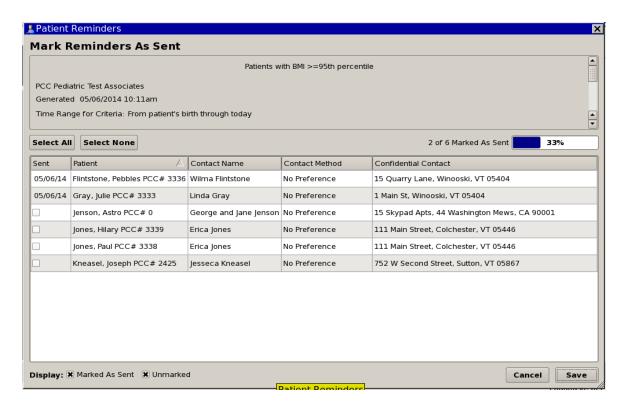


The output can be saved in .csv format to be opened in a spreadsheet application where the data can be managed or used for mail merge.

Use the Reminder Log tab to review previous reminder runs that you saved to file:



You can open a log and mark reminders as sent, in order to record that you contacted the patient or family:



The reminder log functionality provides a work list of reminders that you've already sent and those that still need to be sent.