- **Element 6A: Measure Performance**
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- Every PCC client has access to the Practice Vitals Dashboard which is a web-based tool tool for tracking and reporting their practice's financial and clinical health based on relative performance in a variety of areas. The dashboards provide a series of graphs, reports and other statistical data to help each practice evaluate and improve their performance in a variety of financial and clinical areas. The Dashboard data for each PCC client is updated on a monthly basis, allowing the practice to measure their monthly progress in performance measures. The clinical dashboards are specifically designed to help practices identify patients in need of a clinical response, from well visits to flu shots to ADHD checks and more.
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- Every PCC client also has access to the `recaller` program within Partner, the Practice Management System. This reporting tool provides the ability to generate counts, lists, and contact information for patients based on certain preventive or chronic care measures. PCC clients use these lists to communicate with their patients individually and collectively, providing their own population management as suits their practice.
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- In this section, we have documented examples of measures available to PCC clients from the web-based Practice Vitals Dashboard application and the `recaller` program within the Practice Management System. **All PCC clients have full access to both of these reporting features.**
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- **Factor 1: The practice measures or receives data on at least three preventive care measures**
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- The Practice Vitals Dashboard and `recaller` reporting tools accessible to all PCC clients provide the ability to measure their performance on a variety of preventive care measures including:
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- **Preventive Measure #1: Patients overdue for well visits**
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- The Dashboard reports the percentage of patients up-to-date on their recommended well visit in accordance with NQF measures and the Bright Futures periodicity schedule. Well visit compliance rates are reported for the following five age groups with the specified criteria:
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- Under 15 months old - Patients are up-to-date if they have had six or more well visits by the time they are 15 months old.
- 15 – 36 months old - Patients are up-to-date if they have had at least one well visit in the past six months

- 3 – 6 years old - Patients are up-to-date if they have had at least one well visit in the past year
- 7 – 11 years old - Patients are up-to-date if they have had at least one well visit in the past year
- 12 – 21 years old - Patients are up-to-date if they have had at least one well visit in the past year
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- The practice would pick one age group to focus on depending on the relevance for the practice. Also it would be best for the practice to pick an age range where there is opportunity for improvement. This will be useful for PCMH element 6D where they would need to show improvement in measure results.
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- Here is a Dashboard screenshot of what a user would see when viewing their current performance for the "Well Visit Rates – Patients 3 – 6 Years" measure (and any of the other age ranges):
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- 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.
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- Further down the page is a practice trends section that looks like this:

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.

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- 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.
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- For each well visit measure age group, the Dashboard also gives the practice the ability to measure and graph performance for each individual clinician as shown in the following screenshot:
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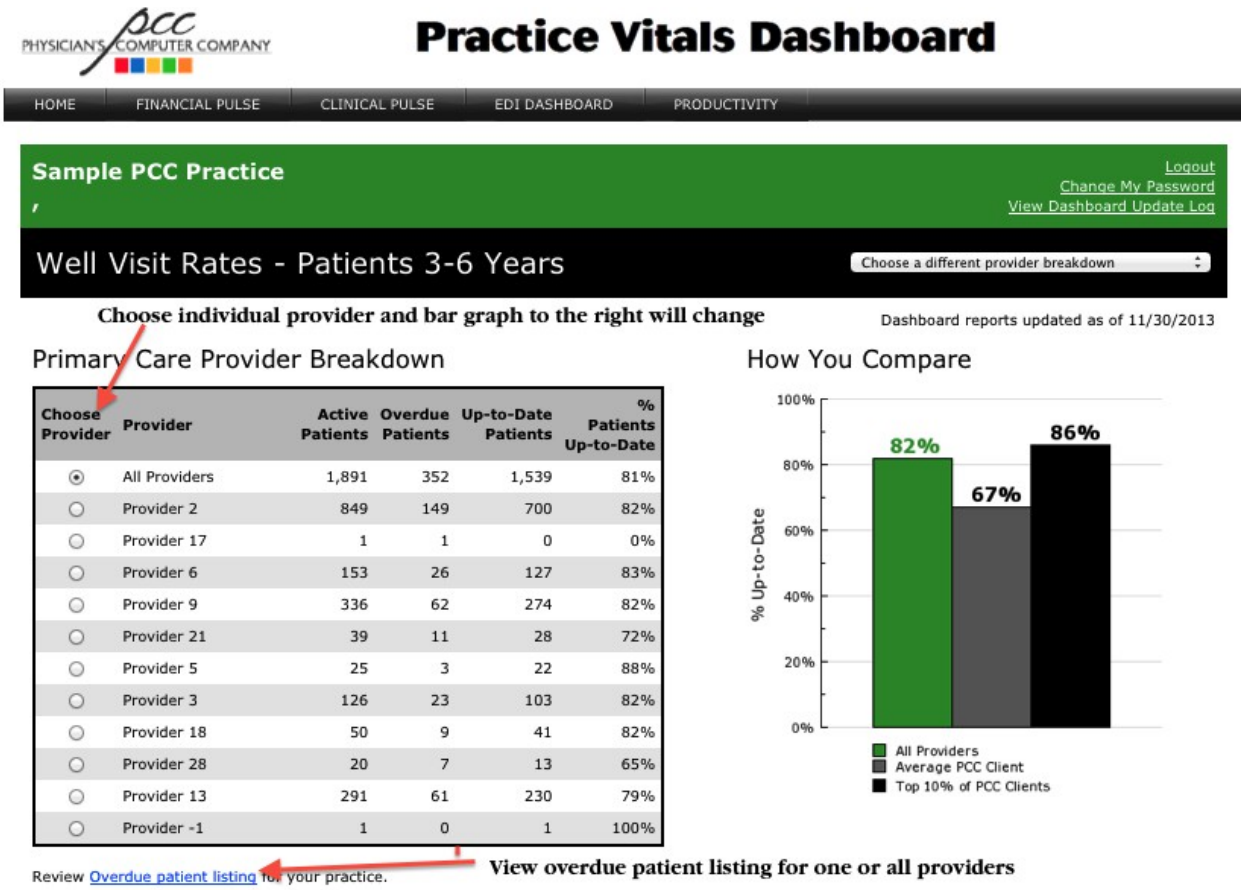

- Reporting these results by individual clinician would be useful for PCMH element 6E where the practice needs to track and share results by individual clinician and across the practice (All providers).
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- A key element of this dashboard measure is the list of overdue children. Many practices tend to dismiss clinical reports until they see the details of who is affected. Our experience and data show that once the physicians see and understand their data, their behavior changes. After clicking on the "Overdue patient listing" link in the above screenshot and choosing a desired age of patients to view, the Dashboard user will be presented with a report of patient details as shown in the screenshot below:
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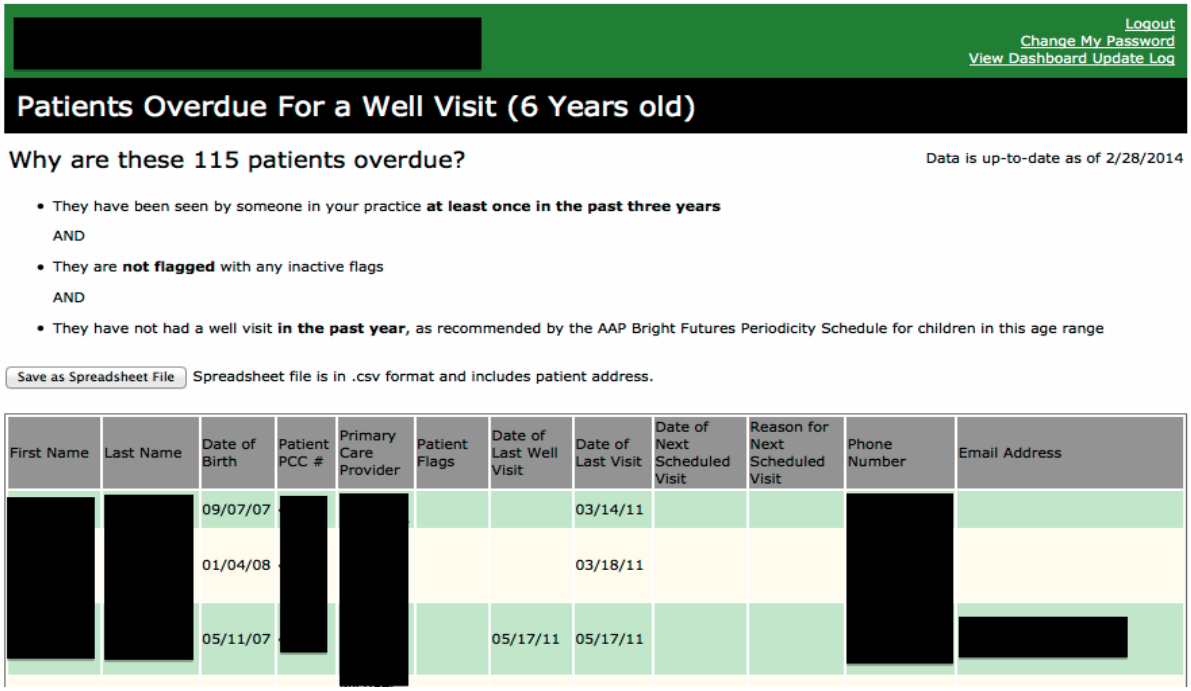

- The list includes details for overdue patients, dates of recent and upcoming visits, and contact information. A Dashboard user can work from this list to contact patients reminding them that they are overdue for a routine well visit.
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- A spreadsheet 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* to automatically contact families to schedule their child for an overdue well visit.
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- **Preventive Measure #2: Childhood Immunization Rates**
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- A second preventive measure reported in the Dashboard for every PCC client is the percentage of patients who are up-to-date on the series of vaccines recommended by age two based on the "Childhood Immunization Status" Meaningful Use measure NQF 0038. Here is a screenshot example showing what the practice will see in the Dashboard for this measure:
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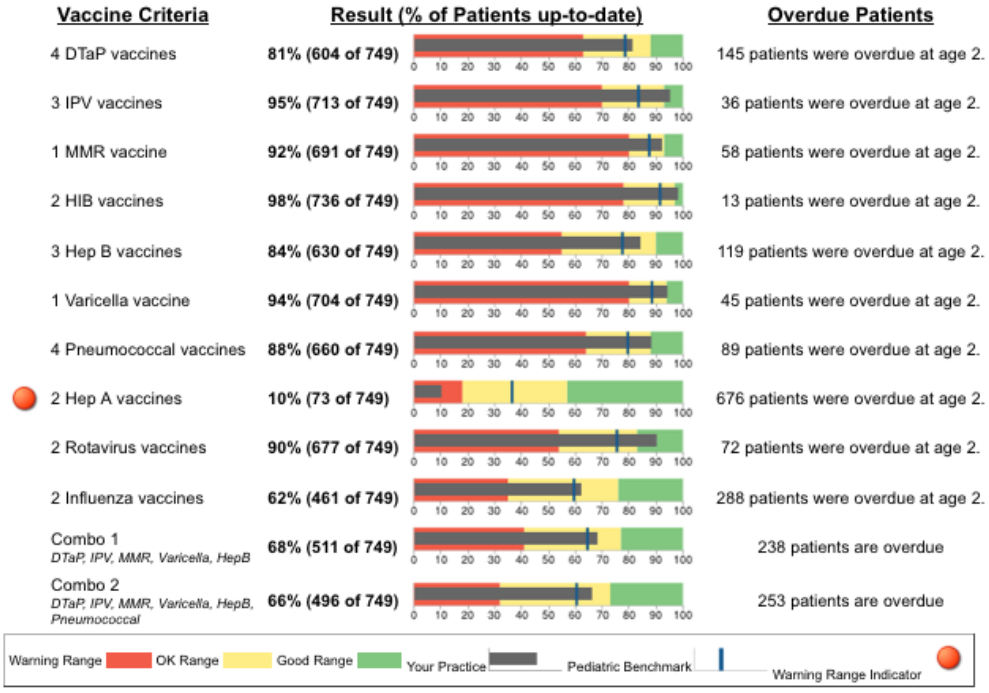
Measure: Childhood Immunization Status

This measure is an alternate core clinical quality measure that pediatric practices will need to report in order to demonstrate Meaningful Use. In 2012, you had 749 active, unflagged children that turned two years old. The measures below show the percentage of these children who were up-to-date on the following vaccines by their second birthday. Please note that this is meant to be a retrospective measure of immunization rates. Some patients who appear in the list as overdue at age two may have since been caught up on their vaccination schedule.



- For each vaccine criteria, the practice will see their current performance with a graphical comparison showing how they compare to the pediatric benchmark based on average performance among all of PCC's pediatric clients. A link will appear in the "Overdue Patients" column allowing the practice to see a listing of children who are overdue for each recommended vaccination series.
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- **Preventive Measure #3: Preschool Vision Screening in the Medical Home (NQF Measure 1412)**
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- This is an important preventive measure since early detection of vision problems increases the likelihood of effective treatment and allows for actions to decrease the negative impact of the disorders.
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- The numerator and denominator for this measure are described below:
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- Numerator: Number of preschool children (ages 1-4 years old) who were seen for a preventive visit (CPT code 99392 or 99382) who also had a vision screening (CPT 99173 or 99174) performed.

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- Denominator: Number of preschool children (ages 1-4 years old) were were seen for a preventive visit (CPT code 99392 or 99382).
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- PCC clients can use the `recaller` reporting tool to count how many patients are in the numerator and denominator for this measure. The user would first restrict by procedure performed to gather a count of patients having a preventive visit (99392 or 99382) performed within a specified date range. This will be the count for the denominator. Start by typing an asterisk to begin searching for criteria:
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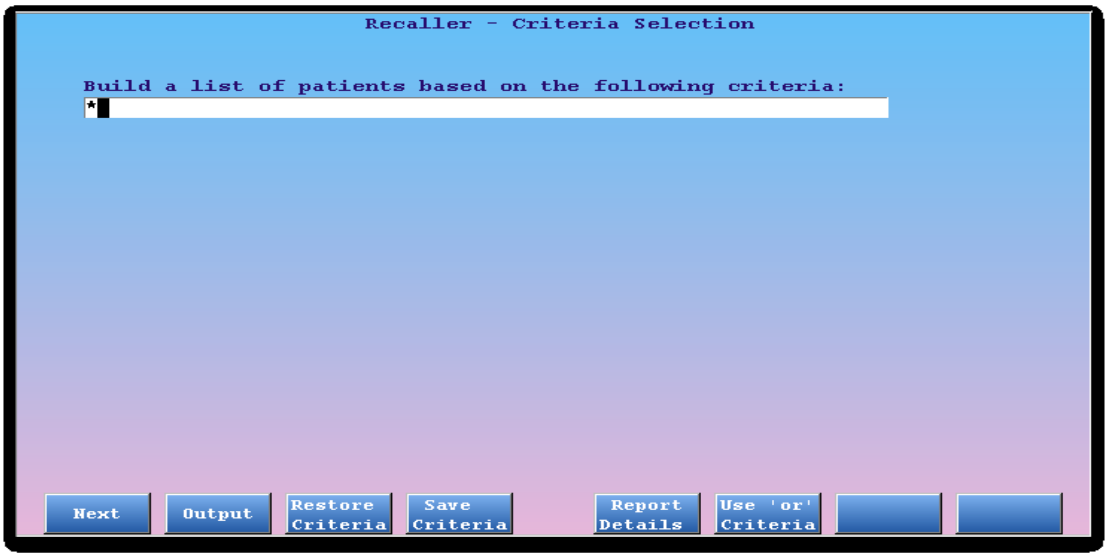

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- Then choose the criteria for “Include by Procedure (All Providers)”:
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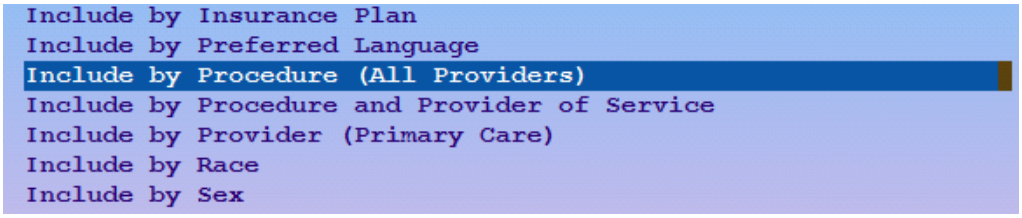

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- The user will then be prompted to specify a date range and a list of billable procedures to include. When prompted, specify a date range, preferably a range of at least six months to capture a good sample of data:
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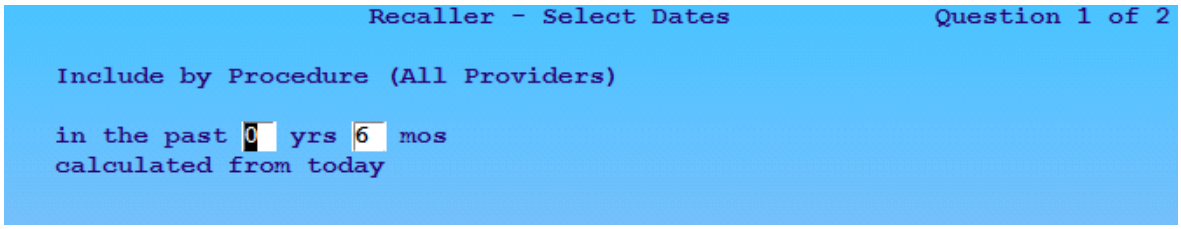

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- Then proceed to the next question which will prompt for the billable procedures to be included. Press <F6> to "List by Pattern" which will allow you to find billable procedure entries for 99382 or 99392, the CPT codes used for new or established patient preventive visits for kids ages 1 to 4:
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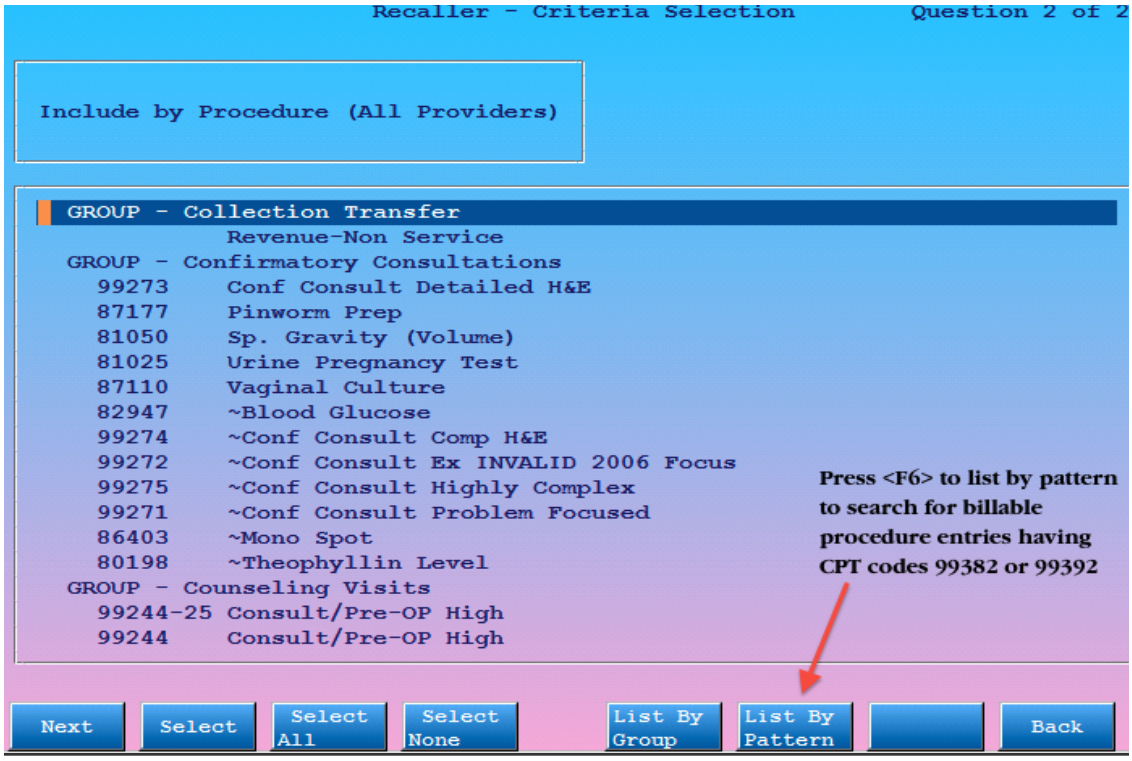

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- When prompted, select all billable procedure entries containing the 99382 or 99392 CPT codes. Be sure to include entries with modifiers.
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- *Note: If the user wanted to capture this preschool vision screening measure limited to just one provider, they would instead select the criteria "Include by Procedure and Provider of Service" above. This will also prompt them for provider of service in addition to the date range and selection of billable procedures. This would be useful for PCMH factor 6E where it will be necessary to report measure results specific to each provider.*
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- Proceed once all billable entries are selected and you will return to the `recaller` criteria selection screen. Here the user will see a count of patients at the top. Make note of this count since it represents the denominator for this measure indicating the number of preschool children (ages 1-4 years old) who had a preventive visit in the selected date range:
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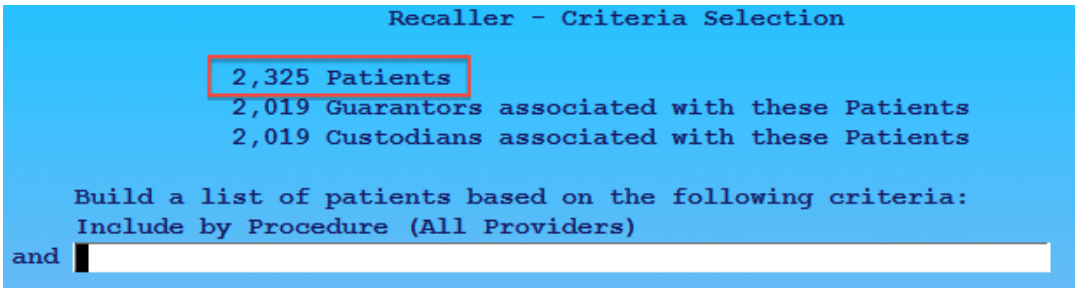

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- Next, the user would add another restriction criteria to capture patients who also had a vision screening during the same time period selected above. For this restriction, we will once again add the "Include by Procedure (All Providers)" criteria:
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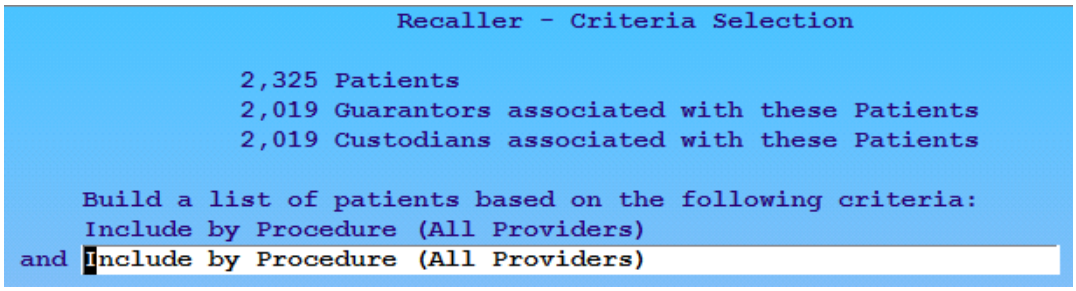

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- Then proceed selecting the same date range used when selecting preventive visits above. When prompted for procedures, select only the 99173 (vision acuity testing) and 99174 (ocular photoscreening) billable procedure codes. Next, the user will return to the criteria selection screen and will see another count of patients at the top. Make note of this since it represents the numerator for this measure indicating the number of preschool children (ages 1-4 years old) who had a preventive visit and also a vision screening (99173 or 99174) in the selected date range:
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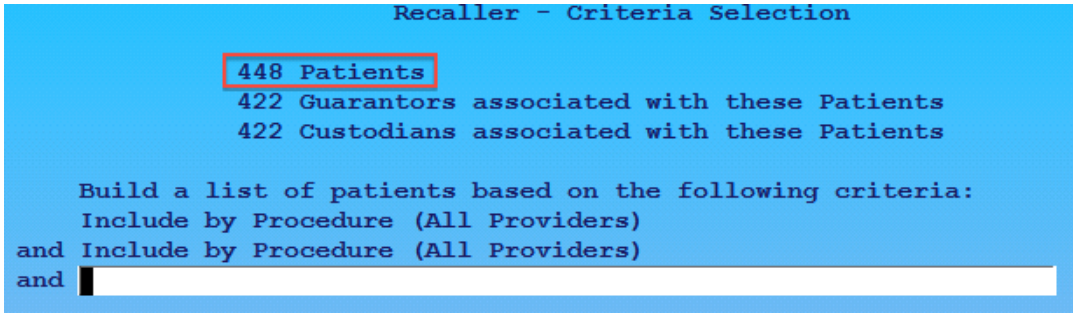

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- In our above example, the measure result would be 448 out of 2,325 pre-school patients (19%) with a preventive visit also had a vision screening performed.
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- Conversely, a count and listing of pre-school age children **overdue** for vision screening can be generated by simply **excluding** by procedure performed on the last criteria described above. By excluding patients who had a vision screening procedure billed, the result will effectively include all patients still in need of a vision screening.
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- Furthermore, the `recaller` report allows the user to customize the outputted patient listing to include the information they want to see using any combination of a set of hundreds of patient demographic and clinical variables. For example, the practice can choose to create an overdue patient list including demographic output such as name, address, contact info (phone numbers, email address, etc), date of last well visit, and much more. The list can even include specific clinical data on record including major diagnoses and allergies.
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- Other examples of preventive measures reportable using the recaller report as we have described above include:
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- Depression screening in adolescents
- Hearing screening in 4-5 year old children
- Hearing screening in newborns
- Tobacco or alcohol abuse counseling for adolescents
- Patients seen at the office within a week of ER or hospital discharge