Here are some example measures that practices could use with some explanation of how to use PCC tools to measure them. As we think of others or come across PCC clients using others, we'll share those too.

Preventive care services

- **Patients overdue for well visits**, picking a certain age group to focus on depending on where there is opportunity for improvement. For example, children 3-6 years old who are overdue for a well visit. The Dashboard is the best place to get this information since the % is calculated and tracked monthly for you and you can get a listing of overdue patients. You can also get this information from recaller (with the exception of the under 15 mos measure since this counts # well visits performed before age 15mos which recaller can't do).
- **Asthma patients overdue for a seasonal flu shot.** The Dashboard is the best place to get this information since the % is calculated and tracked monthly for you and you can get a listing of overdue patients. The recaller could also be used to get this % and overdue listing.
- **Patients overdue for developmental screening.** There are a few options to focus on with this measure. These calculations and patient lists can be generated from the Partner recaller report by looking for the presence of the 96110 CPT code billed within a specific time period. This code should be used for any type of standardized developmental screening. If the practice wants to track different types of standardized screenings (Vanderbilt, MCHAT, etc), they would need to create a unique procedure table entry for each type of test and remember to select the appropriate procedure table entry when charting or billing.

  Here are some specific NQF-endorsed measures related to developmental screening, all of which could be done with recaller.

  - **Developmental Screening by 2 Years of Age**. The percentage of children who turned 2 years old during the measurement year who had a developmental screening performed between 12 and 24 months of age.
  - **Developmental Screening in the First Three Years of Life**. The measure is based on three, age-specific indicators:
    - Indicator 1: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 12 months of age
    - Indicator 2: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 24 months of age
    - Indicator 3: Children who screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 36 months of age
- **Patients overdue for immunizations**. The practice may want to pick a particular

immunization and age range to focus on. The Partner 'epidemic' program can be used to generate a list of patients overdue, although it does not report a % overdue and PCC support would need to configure the "rule set" depending on which immunization(s) and ages you wanted to focus on. There is a "Childhood Immunization" Meaningful Use report in PCC EHR that can show % of patients up-to-date on individual vaccines recommended to be given by age 2. However, this report does not show a list of overdue patients.

While the Dashboard has a "Childhood Immunization" report showing % and overdue patient lists, this is more of a retroactive measure in that the denominator of patients is always "patients turning two in the prior calendar year". The practice wouldn't be able to use this tool on a monthly basis, for example, to monitor how they are improving imms rates.

- **Newborn hearing screening.** This is an NQF-endorsed measure showing the percentage of children who turned 6 months old during the measurement year who had documentation in the medical record of a review of their newborn hearing screening results by their 3-month birthday. Although there is no built-in EHR report for this measure, a practice could potentially use recaller to look for the presence of a hearing screening CPT code given during the specific date and age range defined by the measure. With this and all other measures we'll describe, the recaller can be used but know that the recaller won't report a %. The recaller will generate a count for the numerator and a count for the denominator and the practice would divide to get the %.
- **Pre-School Vision Screening in the Medical Home**. This is an NQF-endored measure showing the percentage of pre-school aged children who receive vision screening. The recaller could be used to generate a count and list of patients who had a well visit and a CPT code indicating visual acuity testing or photoscreening.
- **Risky Behavior Assessment or Counseling by Age 13 Years**. This is an NQF-endorsed measure showing the percentage of children with documentation of a risk assessment or counseling for risky behaviors by the age of 13 Years. Four rates can be reported:
    - Risk Assessment or Counseling for Alcohol Use
    - Risk Assessment or Counseling for Tobacco Use
    - Risk Assessment or Counseling for Other Substance Use
    - Risk Assessment or Counseling for Sexual Activity.

  The practice may want to focus on measuring assessment or counseling for tobacco or alcohol/substance use since there are specific CPT codes that can be used for these. Using the CPT codes (or even fake unbillable codes to only use for tracking and measuring purposes) will allow recaller to capture a count and list of patients who got or did not get this particular assessment.

  Note that there is a "Tobacco Counseling" CQM report in the EHR which will provide a %, but that report does not provide a *listing* of patients who did not

get the counseling.

- **Sudden Infant Death Syndrome Counseling**. This is an NQF-endorsed measure showing the percentage of children who turned 6 months old during the measurement year who had Suddent Infant Death Syndrome (SIDS) counseling. While there is no report in the EHR to show this, and no official CPT code to use for this, the practice could theoretically create a fake CPT code that would get billed from the EHR along with the visit when this counseling is performed. This would allow for tracking and measuring using the recaller.

Chronic care services

- **ADHD patients overdue for checkup –** This is now reportable from the Dashboard. A % of patients overdue and a listing of overdue patients is available in the Dashboard.
- **Asthma patients overdue for checkup –** Reportable from the Partner recaller program.
- **Obesity patients overdue for checkup –** Reportable from the Partner recaller program.
- **Patients with depression overdue for checkup –** You could use the EHR "Patient Listing" feature to generate a list of patients:
    - Diagnosed with depression in a time frame
    - Who are also on depression meds (selecting appropriate meds)
    - Not seen for a visit during a certain time period. (Have not had a certain Dx code to indicate they were seen for a visit)
- **Patients with allergic rhinitis overdue for followup –** Reportable from the Partner recaller program.

All of the above are chronic care measures where counts, %'s, and lists of overdue patients can be generated from the Partner recaller program by restricting on patient diagnosis codes and last visit dates.

PCC EHR also has a set of CQM reports that address chronic care services such as "appropriate testing for kids with pharyngitis", "asthma pharmacologic therapy", and "use of appropriate medications for asthma". These measures will report counts and %'s, but will not produce an overdue patient listing.