PCC EHR
Customizations & Workflows for Pediatric Medical Homes

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Session Goals

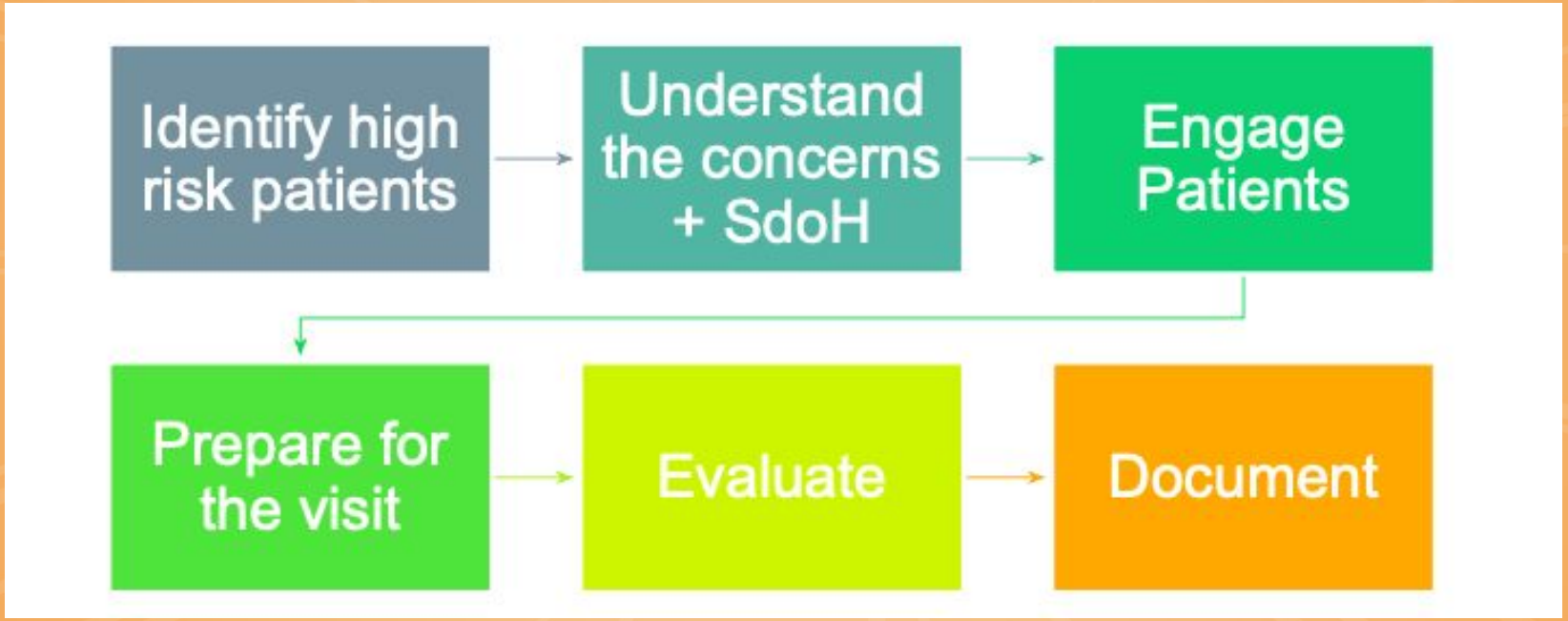
1. Learn to navigate PCC tools to improve operational workflows.
2. Apply relevant daily tasks for your staff.
3. Implement best-practices for large-scale patient management.

What Exactly Does “all of that” Mean?

We’re going to show you how to:

- Quickly and accurately prep for your day and week as a pediatrician:
  - Maximizing the huddle sheet
  - Utilizing relevant clinical alerts
- Streamline complex patient care :
  - Tips & tricks on configuration settings
  - Customization to reduce free-text
  - Utilize protocols

PCMH Goal - Close Care Gaps



Pre-Visit Prep

Objective: providers to walk into the room one time

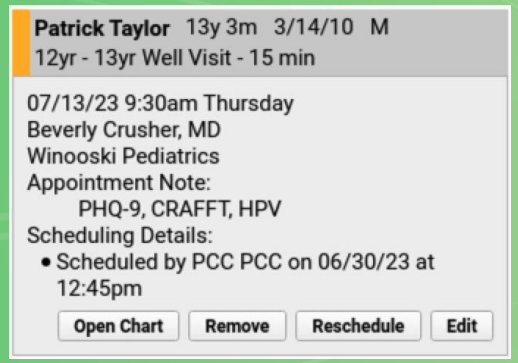
- Pre-scheduled appointments
- Prep charts the day before the appointment
- Staff will understand the daily plan
- Improve patient flow
- Prevent unnecessary follow-up visits

Appointment Note

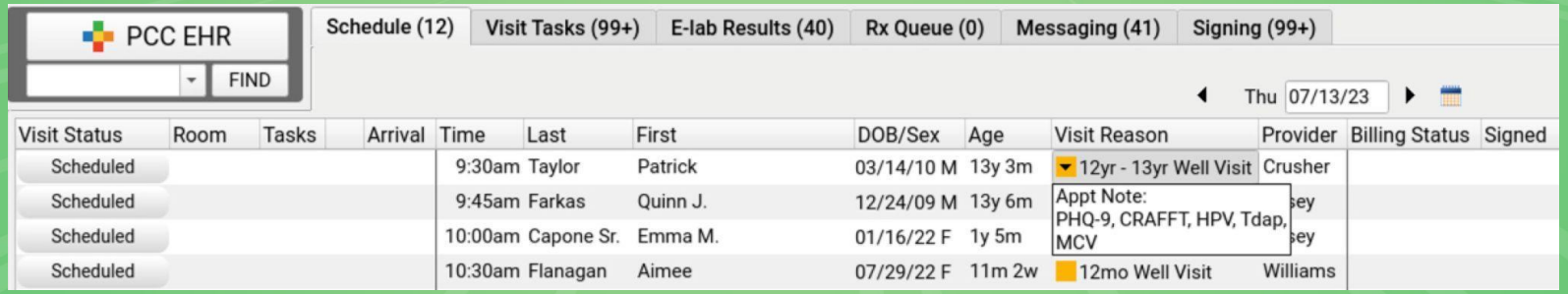
- Communication between departments
- Use snap-text standing orders by age for pre-scheduled appointments
- Same-day sick appointments need consistent details
- Populates onto the Huddle Sheet

Appointment Notes

Seen on the Appointment Book, the Schedule Screen, and the Huddle Sheet Report



Appointment Date	Appointment Time	Patient Age at Appointment	Patient DoB	Patient PCC #	Patient Name	Patient Sex	Appointment Reason	Appointment Note
07/13/2023 9:30am	9:30am	13y 3m	03/14/2010	3235	Taylor, Patrick	Male	12yr - 13yr Well Visit	PHQ-9, CRAFFT, HPV, Tdap, MCV



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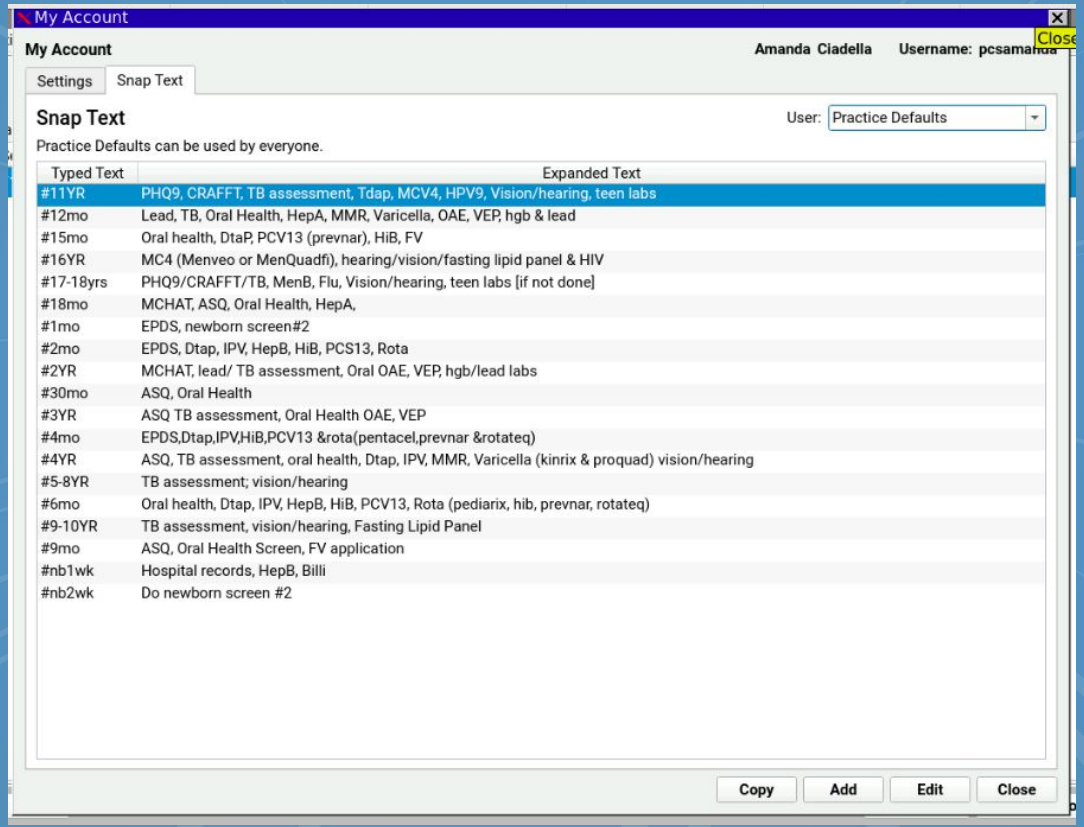
Example Appt Prep Snap Texts



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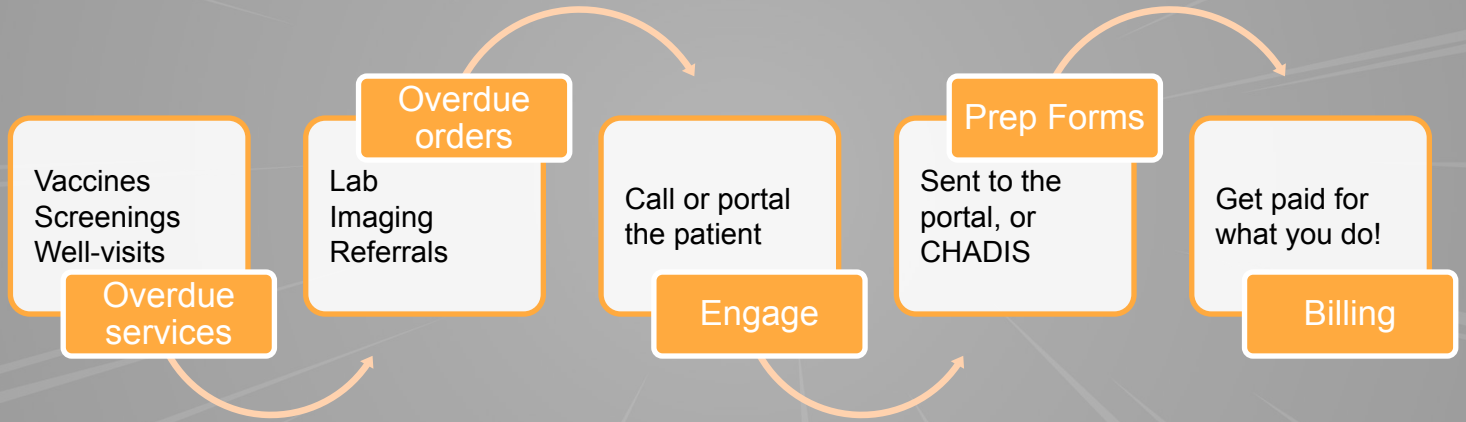
Pre-Visit Prep Process



Huddle Sheet Functionality

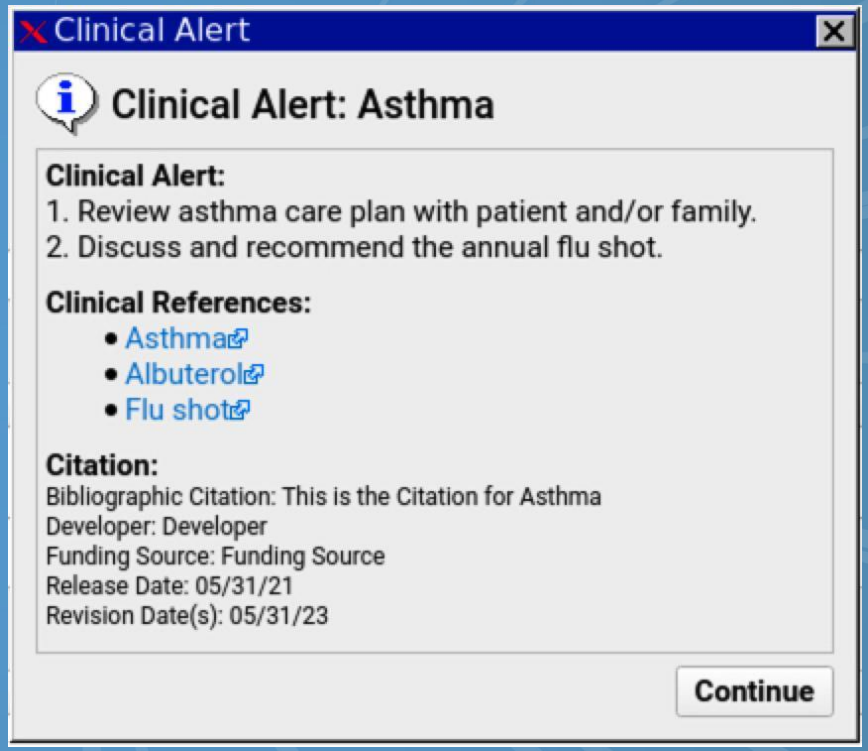
- Review Appointment Notes
- Check for Care Plans
- Review Patient Flags
- Quick daily financial view

Same-day/Sick-Visit Prep

- Receptionist to ask the ”why” of the visits and document in the appointment note field
- “Sick” is not a descriptive appointment note
  - Fever & vomiting for the last 24-hours gives details
- Allows provider to pull correct protocol
- Protocols can be configured with standard labs/testing
- Point of care testing can be completed before a provider enters the room
- **Getting the sick patient out of the office faster**

PCC Clinical Alerts

- Manageable reminders for identified complex patients
- Parameters are customizable
- 1st step of pre-visit prep!



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Proper Protocols for Comprehensive Wellness Visits

- Did you know PCC has pre-built templates built off of Bright Futures Guidelines?
- Make sure you're addressing the following
  - Medical history of the patient and family
  - Family/social/ characteristics
  - SDoH
  - Social functioning
  - Communication needs

Care Management

Care Management Terminology

Care Management:

Activities performed to improve patient outcomes

Care Coordination:

Organizing patient care between clinicians & facilities

Care Plans:

Individualized instructions given to the patient

Care Plans

What is a care plan?

Individualized instructions to accomplish goals between visits

Why is it needed?

Patients forget what the provider says

Accountability

Patient Criteria for Care Management

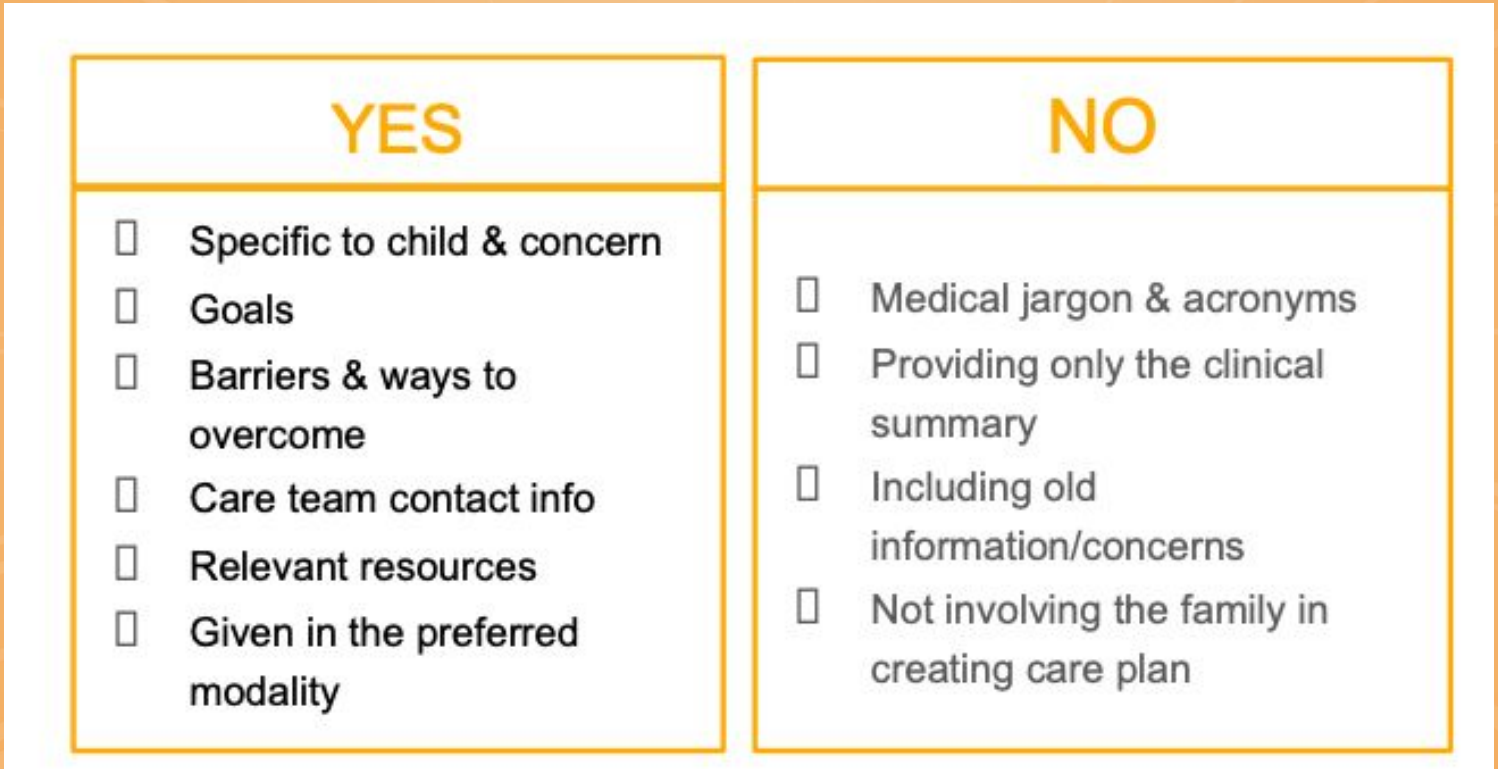
YES

- Food allergies + asthma with EpiPen & medications
- In need of home health or medical equipment
- Cardiac patient with specialist coordination
- Depression + ADHD & multiple medications

NO

- One-time constipation
- One-time ear infection
- Well-controlled intermittent asthmatic
- Acute illness [e.g., flu, COVID, strep, stomach virus]
- Manageable acne or eczema

Care Plan Components



Care Plan Tips

- Configure to show Active Care Plans in Portal
- Add to your Protocols to appear within your encounter
- Utilize Snap-text to help reduce free-text
- Professional Contacts as Team Members
- Care plans by date report for easy tracking
- Care plans mark as reviewed process

Care Plan Example - Medical Summary

Medical Summary — **Patient Test 12 yrs, 5 mos 01/28/12**

Care Plan — Print — Display: All Statuses

07/11/24 — Status: Active

Goals

- Asthma care plan

Actions

Next Steps

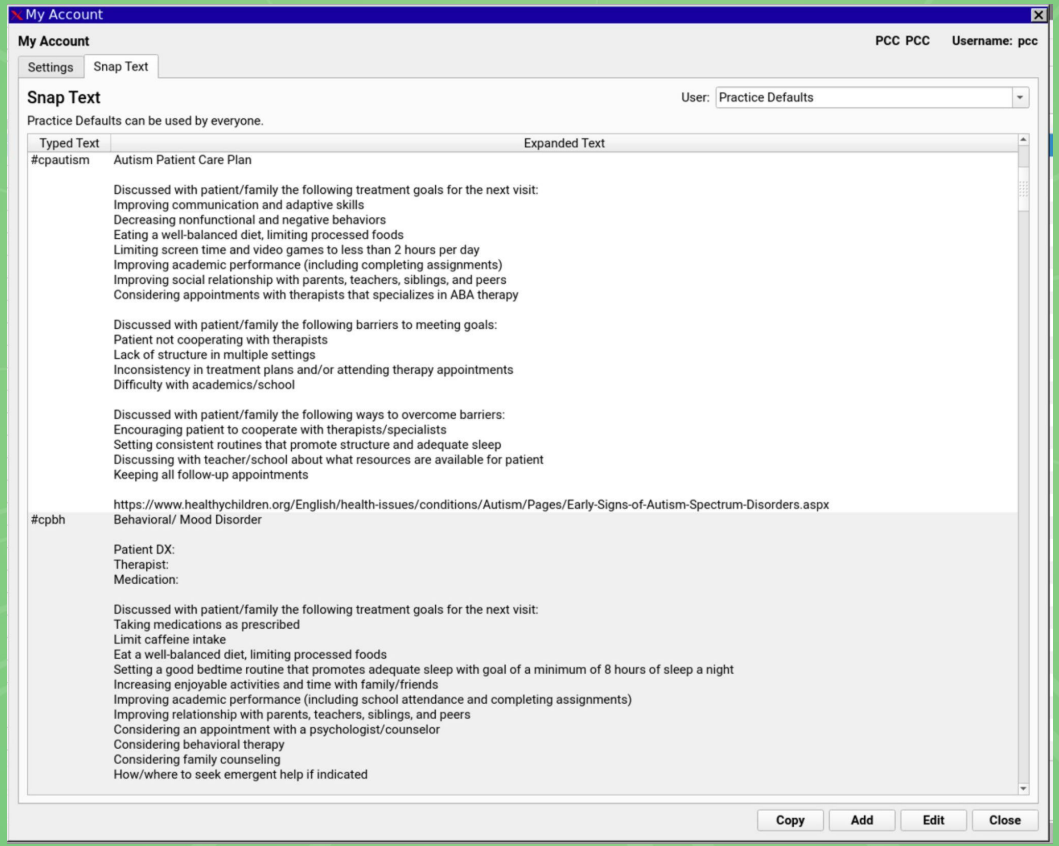
Discussed with patient/family the following treatment goals for the next visit:
1) Taking medications as prescribed with correct technique for inhalers
2) Limiting exposure to known asthma triggers [animals]
3) Fewer days absent from school or work - mother works night shift at local hospital & grandmother cannot drive child misses a lot of school b'c grandmoter says it's okay to skip school if child did not sleep well
4) Reduced emergency room or hospital visits for basic asthma care OR flare ups that could have been handled in office with maintenance care
5) Decreased need for quick-relief medicine
6) Playing basketball with friends again
7) Discuss cat with grandmother

Discussed with patient/family the following barriers to meeting goals:
1) Grandmother has a cat, refuses to put the cat outside
2) Family work schedule/ lack of transportation

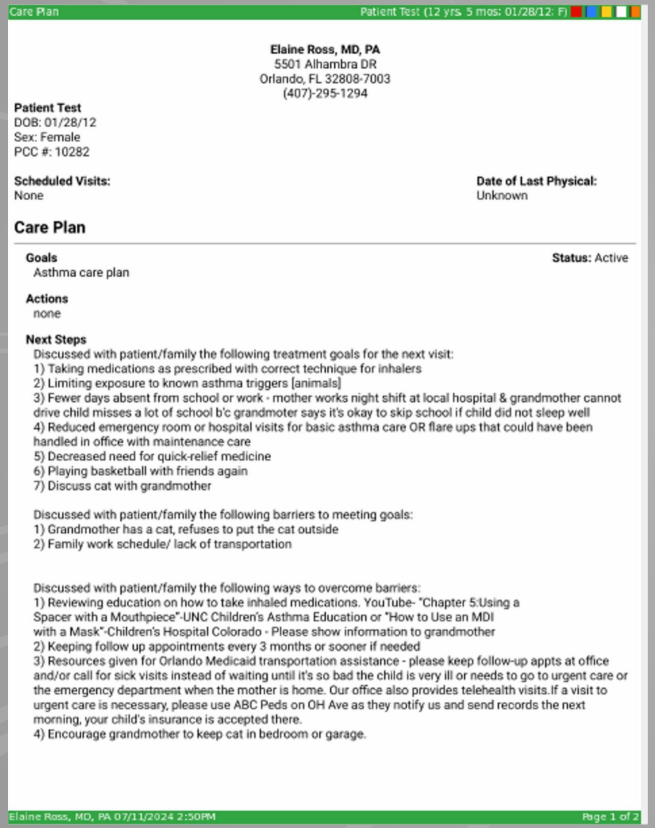
Discussed with patient/family the following ways to overcome barriers:
1) Reviewing education on how to take inhaled medications. YouTube- "Chapter 5:Using a Spacer with a Mouthpiece"-UNC Children's Asthma Education or "How to Use an MDI with a Mask"-Children's Hospital Colorado - Please show information to grandmother
2) Keeping follow up appointments every 3 months or sooner if needed
3) Resources given for Orlando Medicaid transportation assistance - please keep follow-up appts at office and/or call for sick visits instead of waiting until it's so bad the child is very ill or needs to go to urgent care or the emergency department when the mother is home. Our office also provides telehealth visits.If a visit to urgent care is necessary, please use ABC Peds on OH Ave as they notify us and send records the next morning, your child's insurance is accepted there.
4) Encourage grandmother to keep cat in bedroom or garage.

Orlando Medicaid Transportation: 123-456-7899
Our office has faxed over your child's demographics and care plan

Example Care Plan Snap Text from PCS



Care Plan Example - Patient Visit Summary



Care Plan — Patient Test (12 yrs. 5 mos: 01/28/12: F)

Elaine Ross, MD, PA
5501 Alhambra DR
Orlando, FL 32808-7003
(407)-295-1294

Patient Test
DOB: 01/28/12
Sex: Female
PCC #: 10282

Scheduled Visits:
None

Date of Last Physical:
Unknown

Care Plan

Goals
Asthma care plan

Status: Active

Actions
none

Next Steps
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Elaine Ross, MD, PA 07/11/2024 2:50PM — Page 1 of 2

Care Plan — Patient Test (12 yrs. 5 mos: 01/28/12: F)

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Team Members
none

Elaine Ross, MD, PA 07/11/2024 2:50PM — Page 2 of 2

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Care Plan Example - Patient Portal

Care Plan

Goals

- Asthma care plan

Actions

Next Steps

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Team Members

None

Care Plan FAQs

- I document all of this information in my plan section - why do I need a care plan?
  - Only the care plan section is a structured data that pulls to the care plan by date report
- Do my diagnoses for the day and referral orders count as care plans?
  - No, care plans are individualized instructions
- What constitutes a care plan?
  - Patient goals
  - Patient barriers
  - Ways to overcome
- Your HPI should match what is in your care plans
- How often should the care plan be updated?

Benefits of the PCC Patient Portal

- Complex patients should always have portal accounts
- Active Care Plans are available on the portal immediately
- Configuration settings and Messaging Templates
- PCC Education Tool and Portal Documents
- Pre-checkin demographics benefits

References

- https://learn.pcc.com
- https://patientcenteredsolutions.org/

What Questions Do You Have?

Later Viewing

This and all other PCC UC 2024 course recordings will be available for later viewing through the app.

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