

Session Goals

- Learn changes made to the PCMH program
- Utilize PCC tools to meet requirements
- Implement a workable plan





Annual Reporting 2025





No changes!

- Diversity reporting
- Data points clinical and resource
- Patient surveys at least once a year
- Care Management Care plans on high-risk patients





Tips for Success with PCMH

- Become familiar with Dashboard Reports
- Learn how to build and run custom reports in Report Library
- Assign proper privileges to staff
- Assess your patient population
- Edit protocols to fit your patient population





Structure and Staff Responsibilities

- Organizational Chart Reporting structure
- Job Descriptions description of staff roles, responsibilities and skills necessary to complete the job This is a required submission item!





Comprehensive Health Assessment

The practice continues to conduct and document comprehensive health assessments that include:

- Medical history of the patient and family.
- Mental health/substance use history of the patient and family.
- Family/social/cultural characteristics.
- Communication needs.
- · Behaviors affecting health.
- Social functioning.
- Social determinants of health.
- Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.)
- Advance care planning. (NA for pediatric practices.)





PCC Protocols

- PCC has a comprehensive set of age-based protocols, even those based on Bright Futures guidelines.
- Integration with CHADIS allows for developmental and depression assessments.
- PCC Community allows for PCC clients to share ideas and protocols they can be imported/exported from system to system
- Work with your PCC Client Advocate
 - Protocols should be regularly reviewed and refined, and PCC is here to help!





Protocol Anchor Example for 11-14yr Well Visit

- 1. Accompanied By:
- 2. Forms
- 3. Vitals
- 4. Vital Notes
- 5. BF4 HISTORY
- 6. BF4 Concerns and Questions:
- 7. BF4 Interval History:
- 8. BF4 Medical History
- 9. BF4 Areas reviewed and updated as needed
- 10. BF4 Past Medical History
- 11. BF4 Surgical History
- 12. Problem List
- 13. Medication History
- 14. Allergies
- 15. PCC eRx Allergies
- 16. BF4 Nutrition
- 17. BF4 Females
- 18. BF4 Dental Home
- 19. BF4 Sleep
- 20. BF4 Physical Activity
- 21. BF4 School
- 22. BF4 Activities
- 23. BF4 Tobacco, alcohol, and drug use

- 24. BF4 Sexual Orientation/Gender Identity
- 25. BF4 Sexual Activity
- 26. BF4 Mood
- 27. BF4 Development (Checked box= Normal development)
- 28. BF4 Social and Family History
- 29. BF4 Review of Systems (Focus area)
- 30. BF4 Review of Systems
- 31. BF4 Physical Examination (Focus area)
- 32. BF4 Physical Examination
- 33. Diagnoses
- 34. BF4 Assessment
- 35. Medical Procedure Orders
- 36. Lab Orders
- 37. Screening Orders
- 38. Medical Test Orders
- 39. Immunizations
- 40. BF4 Anticipatory Guidance
- 41. BF4 Plan
- 42. BF4 Immunizations
- 43. BF4 Universal Screening
- 44. BF4 Selective Screening (based on risk/previsit questionnaire)
- 45. Followup Orders
- 46. Visit Documents





Diversity

- Race, ethnicity, language
- Zip-code is a great option for "other"
- Sexual orientation/gender identity on 18 y/o+
- Reports need to be broken down by data point





Demonstration - PCC Diversity Tools & Reporting

- The new PCC Report Library SO/GI Report (release 9.7)
 - Only required for > 18 year old patients
 - No PHI provided in the report, strictly percentages of your patient population
- Properly Documenting and Configuring your SO/GI EHR Tools
 - This is a confidential component by default
 - Part of the Medical Summary
 - Configuring your Practice Preferences
 - Individual Patient Configuration





PCMH 2025





Pursuing PCMH?

- Full utilization of an EMR is required as of 01/01/2024
 - Hybrid will no longer be accepted
- Learn the NCQA terminology/lingo
- Expect heftier documentation requirements
 - Clear explanations
 - Understandable to the point policies
 - "By-the-book"





Nuances of PCMH

- Date EVERYTHING
 - Policies
 - Examples
 - Reports
 - Patient communications
- Date of implementation when did the process begin?
- Date of review needed when making updates
- Remove PHI NCQA will delete the documentation
- Prepare a few virtual review items
- Understand you will have to explain basic pediatric concepts to evaluator





Documentation Points

- Use structured data fields
- Do not use reminders or medical summary or other 'free text' fields in the chart or protocols – these will not pull into reports
- Patients medical Hx
- Social Hx
- Family medical Hx -including substance use/mental illness
- SDoH pick what is relevant to your population
- Notation of BH assessments with plan for positive assessments
 Clinical advice messages

• Care coordination

- All the details!
- Follow-up on referrals, labs, imaging
- Notification of test results
- ED/UC/Hospital follow-ups

Care management/care plans

- Individualized
- Matches reason for visit/conditio



Referral Management

Attestation item but PREPARE ALL documentation.

- Giving the consultant or specialist the clinical question, the required timing and the type of referral.
- Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
- Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.





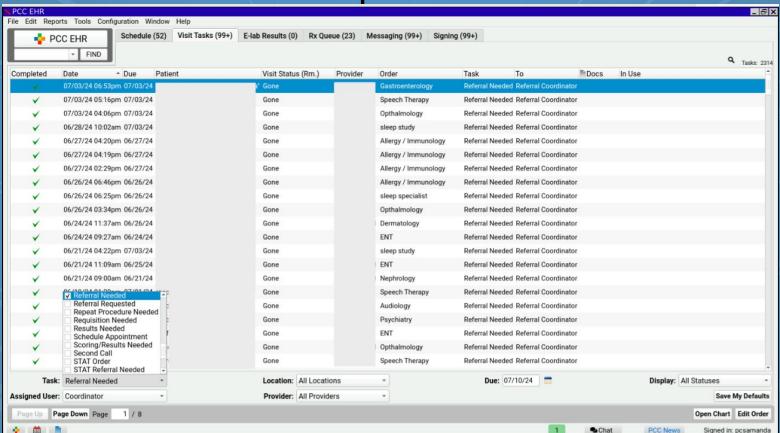
Tracking referrals

- Use orders by visit report
 - Stratify on "referrals"
 - Specific time frame
 - Status
- Task management system





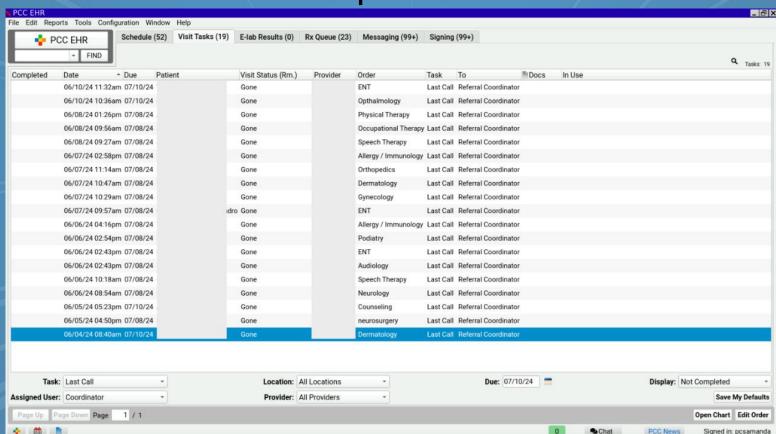
Referral Task Examples from PCC Client







Referral Task Examples from PCC Client







Hospital/ED Care Coordination Basics

- Proactively check hospital portals for your patients can use CDE
- Ask patients if they have visited other facilities add this to your protocols
 - AKA the ARRA Transition of Care Component in the PCC EHR
 - ONLY use this component when there is a transition of care
- Documentation
 - Hospital transitions
 - o If the hospital won't accept a call, send the patient with a clinical summary, and document
- Scan all documentation into EMR
- Call for hospital follow-up and document





Hospital/ED Care Coordination Requirements

Post hospital/ED discharge follow-up

The practice contacts patients/families/caregivers about follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.

Upload:

 Evidence of implementation on contacting patients following a hospital admission or emergency department visit.

Note: Although not every patient in the primary care practice may require a follow-up visit, all discharged patients should be contacted. The practice defines "appropriate period."





Care Management

- NCQA is reviewing content carefully
- Must individualize to patient
- Use templates, then make edits
- Keywords use the NCQA terms
 - Goals: patient goals NOT provider goals
 - Barriers: to achieving the patient goals
 - Ways to overcome barriers: education/tools to help
 - NEW: Include the visit summary to cover problem list, expected outcome/prognosis,
 treatment goals, medication management, schedule for review/update





Care Plans

- Care management patient criteria
- Acute conditions are not care management/high-risk
- Use SDoH and high-cost/high-utilization as "layers"
- What constitutes a good care plan?
 - No medical jargon
 - Complete information not relying on the template (i.e. Snap Text)
 - The parent should leave knowing what to do between appointments
 - Follow-up schedule





Quality Improvement

- Expect changes with clinical quality data
- NCQA is moving to standardized measures
- Standardized measures follow strict HEDIS guidelines
- Data requirements
 - Denominators must be 30 for any measure
 - Always include a reporting period
 - Keep baseline and re-measurement reporting periods consistent
- Pick at least 3 QI projects





QI Goals/Projects – New 2025

- Goals and actions for improvement spreadsheet is new to 2025
- Clinical
 - Consider payer goals
 - Special interest/soul projects
- Resource
 - Avoid URI/Strep
 - Lean towards operational improvements
- Use email as a method of communication easy documentation





What's Your PCMH Plan?

- Start early
- Identify challenges
- Submit NCQA tickets for questions
- Less is more... just joking...document everything!
- Continuously train/educate staff
- Audit your data for accuracy
- Align with your payer requirements





References and Resources

Resources:

- https://learn.pcc.com
- http://pcmh.pcc.com/index.php?title=PCC_PCMH_Resources
- Patient Centered Solutions Consulting
- Your PCC Client Advocate





What Questions Do You Have?





Later Viewing

This and all other UC2024 course recordings will be available for later viewing through the app.



