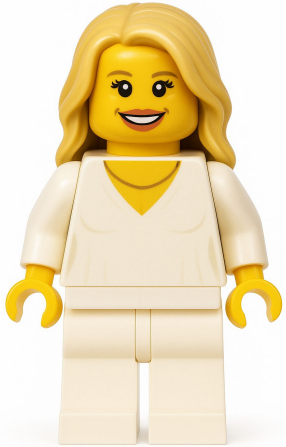
PCC EHR Configurations & Workflow for Medical Homes

Amanda Ross, MPH, Owner PCS
Kate Taylor, Client Advocate, PCC



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Session Goals

1. Learn to navigate PCC tools to improve operational PCMH workflows
2. Apply relevant daily tasks for your staff
3. Implement best-practices for large scale patient management.
4. Sneak peak into NCQA PCMH Annual Reporting Requirements for 2026

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
- Streamline complex patient care
- Tips & tricks on configuration settings
- Customization to reduce free-text
- Run reports for PCMH

PCMH Points

- **Document everything**
- Follow **deadlines** for NCQA/Payers
- **Remove PHI** for NCQA
- Reference **standards** on your documentation as needed
- Prepare for **audits**
- Understand the individual reviewing your project has **no pediatric experience** – use basic terms and over explain. DO NOT assume they know what you mean

Basics of Documentation

- Use structured data fields – problem list/med list
- Both problem list and medication reconciliation are on NCQA AR 2026
  - Do not use reminders or medical summary for these items
- SDoH if you do not know what is relevant to your population - assess
- If you're not sure where to put something, at least put it in a phone message and close. That is better than no where.
- There is a difference between
  - Go to ED for further evaluation *AND*
  - Advised patient to go to ED for further work-up. Called one-stop transfer line, report given to nurse.

PCMH 2026 Reports

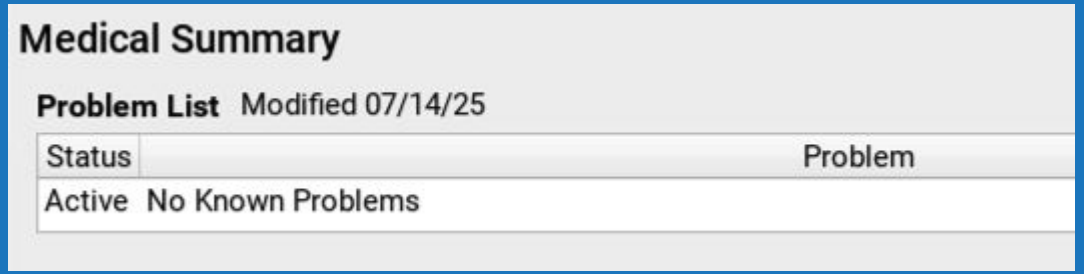
1. AR-KM1 Problem List
    a. Use MU stage 1 report OR
    b. KM06 Predominant conditions
2. AR-KM2 Language Report
    a. Use PCMH Language report
    b. If multisite, might be worth custom building a report
3. AR-KM3 Medication Reconciliation
    a. Use old MU stage 1 report
    b. Difference between medication list and medication reconciliation
    c. **CHANGE**: **90%** [WAS 80%]

ARRA Component in PCC templates

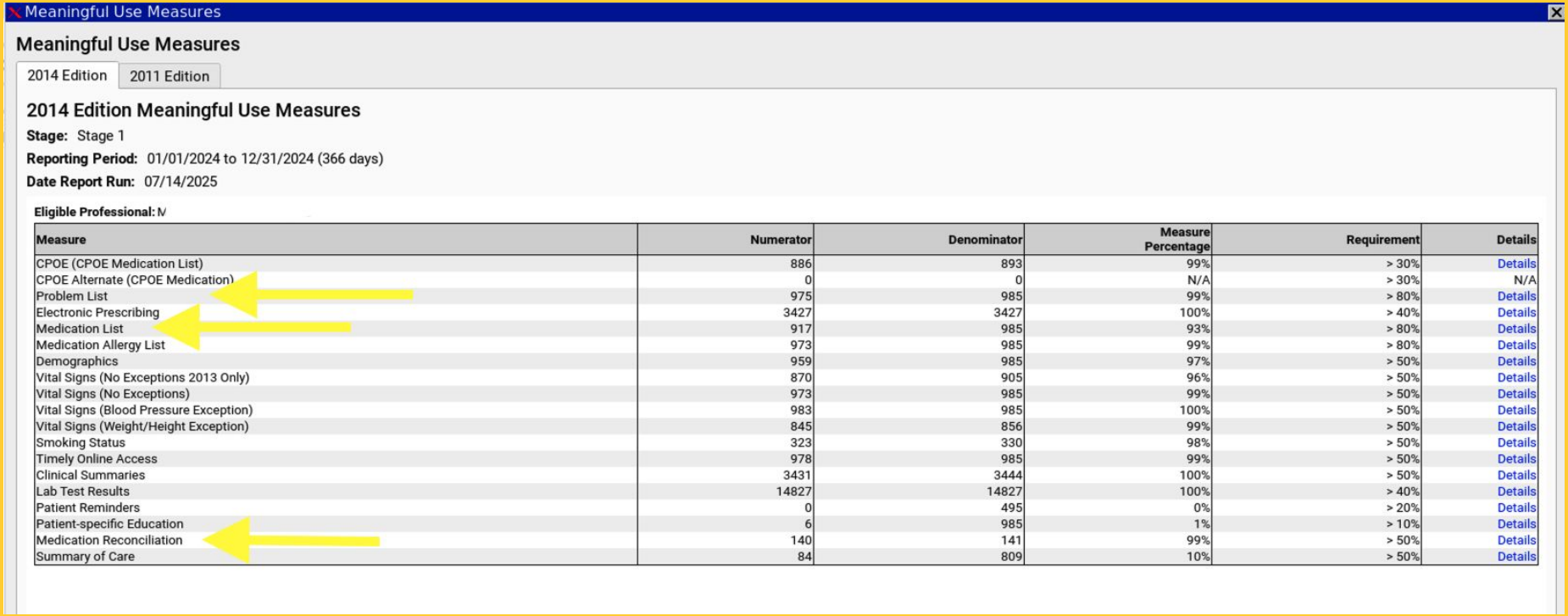
You must check BOTH boxes, where appropriate

Problem List

This is important for children with no known problems. If you do not use the problem list, the child will be in the denominator but not the numerator.



Stage 1 Meaningful Use Report



Meaningful Use Measures

Meaningful Use Measures

2014 Edition | 2011 Edition

2014 Edition Meaningful Use Measures

Stage: Stage 1

Reporting Period: 01/01/2024 to 12/31/2024 (366 days)

Date Report Run: 07/14/2025

Eligible Professional: M

Measure	Numerator	Denominator	Measure Percentage	Requirement	Details
CPOE (CPOE Medication List)	886	893	99%	> 30%	Details
CPOE Alternate (CPOE Medication)	0	0	N/A	> 30%	N/A
Problem List	975	985	99%	> 80%	Details
Electronic Prescribing	3427	3427	100%	> 40%	Details
Medication List	917	985	93%	> 80%	Details
Medication Allergy List	973	985	99%	> 80%	Details
Demographics	959	985	97%	> 50%	Details
Vital Signs (No Exceptions 2013 Only)	870	905	96%	> 50%	Details
Vital Signs (No Exceptions)	973	985	99%	> 50%	Details
Vital Signs (Blood Pressure Exception)	983	985	100%	> 50%	Details
Vital Signs (Weight/Height Exception)	845	856	99%	> 50%	Details
Smoking Status	323	330	98%	> 50%	Details
Timely Online Access	978	985	99%	> 50%	Details
Clinical Summaries	3431	3444	100%	> 50%	Details
Lab Test Results	14827	14827	100%	> 40%	Details
Patient Reminders	0	495	0%	> 20%	Details
Patient-specific Education	6	985	1%	> 10%	Details
Medication Reconciliation	140	141	99%	> 50%	Details
Summary of Care	84	809	10%	> 50%	Details

Care Management

Care Management Terminology

- Care Management
  - Activities performed to improve patient outcomes
- Care Coordination
  - Organizing patient care between facilities
- Care Plans
  - Individualized instructions given to the patient/family

Care plans are meant to drive accountability and teach the patient/family how to take control of their health

Care Management Criteria

- ADHD/depression/anxiety
- Uncontrolled asthmatic that goes to ED instead of your office
- Premature infant
- Patients with multiple medications
- Families with SDoH
- High-cost situations
- Chronic skin condition such as rashes, eczema, acne – YES, there is a difference and they will look to see if it's deemed chronic.
- ADHD without meds or not managed in your office – probably not
- Patients you are only managing a 1x a year preventive exam & sick visits
- Patient with well controlled exercise induced asthma
- 1x constipation
- 1x ear infection
- Acute illnesses
- Typical/normal acne or eczema

Non-Negotiables of Care Plans

- Problem list – *don't worry this is on there with PCC visit summary*
- Expected outcome [treatment goal]
- Patient goals
- Medication list/management
- Schedule to review

- Expected outcome = Lose 3 pounds by next office visit
- Patient treatment goal = walk 30-minutes a day 4x a week and remove Coke, replace with water
- No meds – document no meds
- Use the problem list!
- Schedule to review? Weeks or months – do not do follow-up PRN or 1 year PE

Care Management Changes

- Care plans must be reviewed **twice** a year now
- NCQA is looking at **the visits** care plans are being done on
- Do not do an ADHD care plan on a sick visit for the stomach bug
- Suggestions:
  - Use snap-text care plan templates
  - Add the care plan to your encounter templates
  - Schedule next visits at check-out

Care Management Demonstration

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Pre-Visit Prep AKA PCMH AR-TC1

Objective: everyone is on the same page

- Pre-scheduled appointments
- Prep charts the day before the appointment
- Easy to remember workflows for all staff
- Improve patient flow
- Prevent unnecessary follow- up visits
- Sick visit prep - “fever with cough”

NCQA Requirements AR TC-1

2026 PCMH Annual Reporting Criteria	*(FOR REFERENCE ONLY)* Aligning Criteria PCMH Version 11: Transformation
AR-TC 1 (Required): Individual Patient Care Meetings/Communication *Site-specific* **Evidence Upload** The practice has regular patient care team meetings, or a structured communication process focused on individual patient care. **Upload:** An example demonstrating ongoing structured communication process. ***Examples of evidence may include, but are not limited to:*** • *Daily schedule with huddle notes.* • *Screenshot of structured communication within the EHR.*	**TC 06 (Core) Individual Patient Care Meetings/ Communication:** Has regular patient care-team meetings or a structured communication process focused on individual patient care. **Guidance:** The practice has a structured communication process or holds regular care-team meetings (such as huddles) a minimum of twice a week to share patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.

Huddle Sheet Functionality

- Review appointment note entries
- Check care plans – ding ding NCQA ☺️
- Review patient flags
- Quick glance at the daily financials
- It’s within PCC no need to print/scribble/save - but you can if you like paper

“Why use the huddle sheet and not scribble on a schedule?”

- Short answer is – it makes your life easier
- Populates on the huddle sheet --- this will work for NCQA ☺️
- Use snap-text for age-based reminders for preventive exams or structured appointments
- One-stop-shop visual for all staff

Team Meetings

Sharing Information with Staff

- Share data
- Patient surveys
- Team meetings should be detailed enough to know:
    - Who was there
    - Topics discussed
    - Action items and who is taking them
    - When are items are expected to be wrapped up
    - Nice to have: next meeting

- NCQA expects practices to share:
    - Clinical data
    - Resource data
    - Patient surveys
    - And discuss relevant workflows/QI

Suggestion:

Once a year run your surveys. Have a meeting to discuss the results and ask for feedback.

Pick a clinical metric and resource metric every year to be your “it” measures. Report- follow- update with staff.

AR-TC2

This item is directed more to your actual meeting notes, workflows, etc.

1) Do not use notes that are about PTO, office supplies or financials.

2) PCC workflow changes

3) Schedule changes

4) Clinical metrics/improvement

AR-TC 2 (Required): Staff Involvement in Quality Improvement *Shared* **Evidence Upload** The staff continues to be involved with the practice's performance evaluation and quality improvement activities. **Upload:** An example that demonstrates the staff's involvement in performance evaluation and improvement activities. ***Examples of evidence may include, but are not limited to:*** • *QI meeting notes.* • *PDSAs.*	**TC 07 (Core) Staff Involvement in Quality Improvement:** Involves care team staff in the practice's performance evaluation and quality improvement activities. **Guidance:** The practice describes staff roles and their involvement in performance evaluation and improvement activities. Improving quality outcomes involves all members of the practice staff and care team. Engaging the team in review and evaluation of the practice's performance at least annually, although quarterly is most common, is important to identifying opportunities for improvement and developing meaningful improvement activities.

AR-QI5

Reporting data points with all staff

1) NCQA wants proof data points are discussed with all staff members, not just providers/partners.
2) You must do all 3!!
3) Suggestion - do some metrics in tanden. For example - a patient satisfaction measure about hospital care coordination and then have a way of monitoring discharges to account for a resource measure.

AR-QI 5 (Required): Reporting Performance Within the Practice	QI 15 (Core) Reporting Performance Within the Practice: Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.
Shared **Evidence Upload** The practice provides individual clinician or practice-level reports to clinicians and practice staff that include a minimum of: • One clinical quality measure • One resource stewardship measure. • One patient experience measure. **Upload:** Documented process. ***AND*** An example of how the practice shares performance results. ***Examples of evidence may include, but are not limited to:*** • *Meeting minutes.* • *Newsletter entry.*	**Guidance:** At least annually, the practice provides individual clinician or practice-level reports to clinicians and practice staff that include a minimum of: • One clinical quality measure. • One resource stewardship measure. • One patient experience measure. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).

Exciting Things Coming Soon in PCC for PCMH!

Standardized Measures in the Report Library

Measure	Description
Screening for Depression and Follow-up Plan	Percentage of patients 12-17 yrs old seen in reporting period that are screened for depression **and have a follow-up plan for positive screening**
Childhood Immunization Status	Percentage of patients turning 2 in reporting period who are up-to-date on recommended vaccines - updated to CMS standards
Weight Assessment and Counseling for Nutrition and Physical Activity	Percentage of patients 3-17 yrs old seen in reporting period having height and weight assessed and counseling for nutrition and exercise provided
Documentation of Current Medications in Medical Record	Percentage of visits where a list of current medications are documented

What Questions Do You Have?

Please fill out the course survey in the app!