Proactive Care Coordination Assistant (PCCA) Integration Guide

To be used by PCN Improvement Facilitator to plan clinic-specific processes related to a new PCCA starting at a clinic.

Contents

Introduction to the PCCA Role

Proactive Care Coordination Assistants (PCCAs) are administrative staff who work "behind the scenes", using a clinic's EMR. This position is offered to all ESPCN clinics with EMRs, which allow us to pull reports, and is offered in addition to their MDT budget.

The PCCA program is a safety net to prevent vulnerable patients from falling through the cracks in our health system.

Physicians receiving PCCA support observe improvements in their EMR preventative health screening rates, patient continuity of care, and panel accuracy.

On a 12-week schedule, PCCAs rotate between multiple clinics for blocks of time, from 1-12 weeks, as determined by a clinic's panel size.

PCCAs find patients who are due for care or screening, including patients:

- Who are under 18 years of age and have not had an appointment in 2 years or more
- Who are 18-74 years of age and have not had an appointment in 3 years or more
- who are 75+ years of age or have a chronic disease and have not had an appointment in 1 year or more
- who are due for screening for: breast/cervical/colorectal cancer, diabetes, or plasma lipid profile.

PCCAs call patients to offer an appointment with their physician or the appropriate MDT, or a screening requisition, depending on the process the clinic develops with their IF.

Timeline for Integrating a PCCA into a New Clinic

Timeline	Involved	Actions
Prior to PCCA Starting	Improvement Facilitator and Primary Care Manager	**1.** IF and PCM meet with clinic to discuss role. Discuss **Clinic Requirements for PCCA Services.** 2. IF may work with EMR-C to complete EMR Assessment (excel template) and Guiding Questions on Clinic Processes (Optional) 3. IF will complete Process Checklist (required) and inform PCC Lead of clinic's readiness. 4. IF will add clinic information into PCCA Weekly Tracking Sheet (excel template), including tab for Clinic Process Manual (see template).
	PCC-Lead	1. Match PCCA to clinic, considering language, rotation requirements. 2. Update PCCA Rotation Schedule with new clinic.
	IF & PCM & Clinic	1. IF or PCM will also ensure clinic arranges an EMR account with remote access, and Netcare access.
	EMR-C	1. Develop EMR queries related to all required reports. 2. Activate EMR alerts for the 5 diagnostic preventative health screens. 3. Create task templates for tracking chart reviews and outreach calls. 4. Save screenshots of EMR queries into PCCA Teams folder.
PCCA Initial Visit	PCCA	1. Join IF for initial visit, meet clinic team and sign into EMR. 2. Follow instructions in Clinic Process Manual in Weekly Tracking Sheet and order of work outlined in PCCA Rotation Checklist (within PCCA Manual).
	IF	1. Share relevant findings with clinic, gain feedback, and modify processes accordingly.
Quarterly	PCCA	1. Continue following instructions in Clinic Process Manual in Weekly Tracking Sheet and order of work outlined in PCCA Rotation Checklist (within PCCA Manual).
	IF	1. Email quarterly data to physicians. 2. Share relevant findings with clinic, gain feedback, and modify processes accordingly.

Clinic Requirements for PCCA Services

- ✓ Clinics must allow PCCA to perform outreach phone calls to arrange appointments or offer patients screening requisitions.
- ✓ Clinics must define who they consider an attached patient and have a process to differentiate consultative or walk-in patients.
- ✓ PCCAs will confirm on **Netcare** that screening has not been completed elsewhere. If previous screens have been completed, the chart will be updated to satisfy EMR Notification.
- ✓ EMR must allow reports to be generated.
- ✓ Clinics will set up EMR login for EMR Consultant and PCCA, with remote login and appropriate access enabled.
- ✓ Clinics will arrange Netcare access for PCCA.

Guiding Questions on Clinic Paneling Processes

Discussion between IF and Clinic Office Manager

Questions	Recommended Process
Walk-ins How does the team differentiate walk-in from panelled patients in EMR?	Ensure clinic is using accurate paneling processes.
Statuses What EMR statuses (most EMRs) or End Date Reasons (HQ) does the clinic use? • Name of status: • Purpose: • Does the clinic use End Date? (HQ)	Some HQ clinics do not *End Date* patients, as they need to be searched by PHN if they return. These clinics may use an alternate status for inactive patients.
Chart Transfers Have any physicians *joined* the practice, transferring charts from a previous clinic? If so, how did the charts transfer over (was information scanned into one file, or did it integrate into current EMR chart)?	Ensure we are capturing correct panel by pulling a doctor's active patients. Ensure details in charts will pull into our reports (last visit date, results).

Primary Physician How are default doctors/primary care providers assigned in the EMR? Does the clinic confirm attachment with each patient visit? What do they ask patients? How is it done in the EMR?	Explain benefits of recommended process of confirming attachment, demographics, and validating in EMR at every visit.

PCCA Process Checklist

Physician: _____

Initial Panel Clean-up of Patients with no visit in 3+ years (all ages):

☐ Batch inactivate without calling ***OR***

☐ Clinic will review list and indicate which patients should be inactivated by PCCA ***OR***

☐ PCCA will contact patients to confirm attachment and offer an appointment (confirm list is <500 patients)

Booking Rules

Main Process

☐ PCCA will call and book appointment (preferred) ***OR***

☐ PCCA will call and encourage patients to call the clinic back to book appointment ***OR***

☐ PCCA will send tasks to the front staff to call patients.

☐ Maximum number of complete physicals/screening appointments per day: _____

☐ Clinic/physician-specific rules around scheduling: _____

☐ Other: _____

How clinic will manage tasks left by PCCA:

☐ Front staff will follow-up with patient, per instructions in the task/worklist

☐ Other: _____

How will patients be inactivated:

☐ Remove Primary Provider/Default Doctor ***OR***

☐ End Date or End Date Reason ***OR***

☐ Change Status ***OR***

☐ Process for patients with no active contact information on file: _____

☐ Maximum number of calls to be made before inactivation: _____

Pediatric Outreach of patients with no visit in 2+ years (0-17):

☐ PCCA to contact patient and confirm attachment with family doctor and pediatrician, and offer appointment if needed
☐ PCCA to record pediatrician name in the EMR: _____

Adult Outreach of patients with no visit in 3+ years (18-74):

☐ PCCA will contact patients to confirm attachment and offer an appointment.
☐ PCCA will inactivate patients who have never had a visit.

High risk patients with no visit in 1+ year:

- ✓ **Patients age 75+**
- ✓ **Patients with diabetes, hypertension, COPD, CHF, heart disease, or kidney disease**

☐ PCCA will check Netcare and inactivate patients who are in long term care or deceased.
☐ Would physician like to also be notified by worklist/task? ☐ yes ☐ no
☐ Appointment type for recall (e.g., complete medical exam): _____
☐ Any other type of chronic diseases to include?: _____

Screening Outreach

☐EMR-C will activate EMR notifications for patients due for the 5 preventative health screens.
Fit Interval ___ years (1 or 2)

PCCA will:
☐ Recall all patients overdue for screening ***OR***
☐ Recall patients overdue for screening and not seen in 1 year

☐ Download external results in to EMR ***OR,***
☐ Type information into template/task
    ☐ Investigation date only
    ☐ Investigation date and results including name of ordering physician.
☐ Inform physician about abnormal results via task/worklist
☐ Recall patients who are due for preventative screening.

Screens	Appointment Type
Mammo, CRC, Diabetes, Lipids, Pap	☐ Book complete medical exam or screening appointment with MD, as appropriate. ☐ Book Paps with RN ☐ Requisition Protocol*
*Requisition Protocol	☐ Mammogram ☐ FIT Test for Colorectal Cancer (CRC) ☐ Diabetes ☐ Lipids ☐ eFax requisition to patients' preferred lab/imaging ☐ Print for patient pick up from clinic ☐ Send through patient portal ☐ Other: _____

CII/CPAR

Onboarding status
☐ Clinic not participating
☐ Clinic is Live

Access Administrator
☐ MD
☐ Clinic Manager

Panel Administrator (PA)
☐ Clinic staff
☐ PCCA

Conflict Management Process
☐ PA will call patients to confirm attachment.
☐ PA will eFax letter to conflicting clinic to request patient to be unpaneled.
☐ PA will worklist/task the front staff to fax letter to conflicting provider.
☐ PA will unpanel patients who confirm attachment elsewhere.

Demographic Mismatch Process
☐ Report shared with clinic to be worked on opportunistically.

Data management process
☐ PCCA works off downloaded list and does not save.
☐ PCCA saves the list under a test patient as an attachment.
☐ PCCA saves list in their work OneDrive for the duration of the rotation (deletes end of rotation)
☐ Other _____

Data Sharing
☐ As PCN funding requirement, PCCA will collect panel and screening data, and send to PCN to be aggregated (all identifying information removed) and submitted to Alberta Health
☐ Date IF and physician will meet to review data and modify plans: _____
☐ Can we request HQCA proxy panel on behalf of the doctor? Best email:_____

Clinic Requests Outside of Standard PCCA Protocol

IFs may encounter requests that are outside of standard recommendations. Some can be accommodated if they achieve the purpose of supporting at-risk or vulnerable populations. Others may be redirected back to clinics to support, particularly if their intention is to generate financial revenue, or they are not evidence-based. Common requests are detailed below.

1. Clinics request a longer interval for calling patients who have not been to their clinic, such as 5 years instead of 3. Typically, 95% of patients not seen in 3 years are no longer active. We do still call these patients as we want to capture that 5% but extending this is not a good use of the PCCA's time. If the clinic feels this is a priority, we can provide their staff the list of patients not seen in over 4 years, to review and call.
2. Physician requests to review the lists before a PCCA calls a patient. The IF should inquire what the concerns behind this request are and address them by: introducing the PCCA to the physician, explaining their training and role, reassure the physician that the PCCA will always defer to them if there are any clinical decisions. If the doctor still wants to review the list first, we would support them in pulling the list, but would wait until they have reviewed and returned this list before starting PCCA work at the clinic. If the PCCA has already started and the list is not ready, the PCCA may end their rotation early, and support another clinic.
3. Clinic/Physician requests all patients be recalled for yearly physicals, regardless of whether they are due for screens: IF should explain that the PCCA role is to focus on higher risk groups. If the clinic also wants to complete yearly physical outreach, they could work on this separately. Our EMR-C can help them build a report or EMR alert to identify these patients.
4. Physician requests additional criteria (e.g., all patients over 50 to be called annually, all patients due for PSA, all patients due for CMEs): IF should inform that PCCA role is to focus first on our high risk groups and provincially identified maneuvers. IF may seek clarification from QI Manager if additional group fits into PCCA scope of practice. For screening beyond 5 diagnostic screens that PCCA recalls (e.g., PSA, AAA) or immunizations, we may offer to turn on EMR alerts so the clinic can capture these patients opportunistically.
5. Physician requests variations to outreach criteria (e.g., cervical cancer screening to start at 30 instead of 25): If these variations do not violate screening guidelines, they can be accommodated. We will still collect quarterly data using provincial eligibility criteria. If request appears to violate screening guidelines (e.g., cervical cancer screening to start at 20 instead of 25), IF may discuss with clinic, referencing guidelines, and that PCCA would not be able to support this work. IF may consult with QI Manager about specific requests.