What You Need to Know About Documentation for the Must Pass Elements for NCQA PCMH Recognition

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HIVMHRC
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Disclaimer

- Presentation was originally a webinar developed in response to TA requests from participants in Strategic Planning Workshops

- Not an endorsement of NCQA process

- We have no formal affiliation with NCQA

- Examples of documentation were utilized /adapted from NCQA training (Facilitating Patient-Centered Medical Home Recognition)

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Objectives:

- Understand the Must-Pass elements in the NCQA process

- Identify the components of acceptable documentation for recognition as PCMH

- Identify the Must-pass elements where your practice is ready to document performance versus focus on transformation of practice

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Acceptable Forms of Documentation

- **Documented Process** – written procedures, protocols, processes, workflow forms
- **Reports** – aggregated data showing evidence
- **Records or files** – patient files or registry entries documenting action taken; data from medical record of patients with important conditions
- **Materials** – information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources
- **Screen shots** – electronic "copy" may be used as examples (EHR capability), materials (web site resources) or records; helps to show specific to the practice and not a vendor demo page

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National Committee on Quality Assurance (NCQA) Recognition

- **6 Standards**
  - Enhance Access and Continuity
  - Identify and Manage Patient Populations
  - Plan and Manage Care
  - Provide Self-Care Support and Community Resources
  - Track and Coordinate Care
  - Measure and Improve Performance

- **Each standard has multiple elements**

- **Each element has multiple factors**

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NCQA language

- 1. PCMH Standards (there are 6 Standards)
  - A. Elements (each Standard has from 2 to 7 Elements given letters A-G)
    - 1. Factors (each element has from 3 to 10 factors numbered 1-10)

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6 Must Pass Elements: PCMH 1

- **PCMH 1: Enhance Access and Continuity**
  - Element A: Access During Office Hours
    1. <u>Providing same-day appointments</u>
    2. Providing timely clinical advice by telephone during office hours
    3. Providing timely clinical advice by secure electronic messages during office hours
    4. Documenting clinical advice in the medical record

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Scoring: Access During Office Hours

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors, including factor 1	The practice meets 2 factors, including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

* **Requires a documented process and a report.**

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PCMH 1: Enhance Access and Continuity Self Assessment Questions

- Is access to care identified in your mission statement, organizational value?

- Is there capacity for patients to be seen if they decide they want to be seen?

- What is the process that keeps at least 2 same-day appointments in the template?

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6 Must Pass Elements: PCMH 1

- **PCMH 1: Enhance Access and Continuity**
  - Element A: Access During Office Hours
    1. Providing same-day appointments
    2. Providing timely clinical advice by telephone during office hours
    3. Providing timely clinical advice by secure electronic messages during office hours
    4. Documenting clinical advice in the medical record

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Document ID ABC123	Title Access During Office Hours/Providing Same Day Appointments	Print Date
Revision 0.1	Prepared By Denise Anderson-Carr	Date Prepared 05/15/2008
Effective Date: mm/dd/yyyy	Reviewed By Steven Bromer, MD	Date Reviewed 05/30/2008
	Approved By	Date Approved 06/01/2008
Applicable Standard: N/A		

Policy:

Patients may call or present themselves in any department to request an appointment with a provider. The patient representative of the unit will make every effort to schedule the appointment as requested by the patient/family for specific day and time. These open slots are not limited in any way and can include well visits, return visits, or any other request for a visit made by the patient.

Explanation provided:

The open access report is generated every two weeks by searching each provider's schedule for the third open appointment slot that can be given to a patient for any reason without need for triage or further explanation.

Reports are created for each clinician, aggregated by site, and then aggregated again to provide an organization wide metric. This data is shared biweekly with each site leader, and monthly with our Board of Directors, which is composed of a majority of patients of the Health Center by design of the Community Health Center program.

To insure availability of same day visits when the practice's Time to Third Appointment is greater than 0-1, the practices also maintain same day appointment slots that are NOT counted in the Open Access Report. These are used by our patient representative staff on the day of appointment for sick visits, as well as by the nursing staff to schedule patients after triage.

Document ID ABC123	Title Monitoring Use of Same Day Visits	Print Date
Revision 0.1	Prepared By Denise Anderson-Carr	Date Prepared 05/15/2008
Effective Date: mm/dd/yyyy	Reviewed By Steven Bromer, MD	Date Reviewed 05/30/2008
	Approved By	Date Approved 06/01/2008
Applicable Standard: N/A		

Policy: Once a month the office manager evaluates 2 random half days in the scheduling system to ensure that the capacity to schedule at least two same day visits is maintained. This data is tabulated every six months to ensure compliance with our policies. If we are not in compliance, the staff is re-educated at the monthly staff meeting.

The results are extracted from this data:

Same day appointment availability. Semiannual review.			
Period	# of ½ days evaluated	# with same day appointments available	% compliance
06/2009-12/2009	12	12	100%
01/2010 – 06/2010	12	10	83%
07/2010 – 12/2010	12	12	100%
01/2011 – 06/2011	12	12	100%

Time to Third RV (days)					
Provider	3/1/2011	3/20/2011	4/12/2011	4/26/2011	5/10/2011
1	0	4	1	3	1
2	0	0	0	0	0
3	2	2	2	3	2
4	0	0	1	3	1
5	0	1	1	0	0
6	2	4	1	1	0

Access to Care Standard
Special Challenges: HIV clinic in a university practice

- HIV clinic as part of large ambulatory outpatient medical group
- Most providers are Infectious Disease physicians and see patients ½ to 1 day per week
- Some patients have additional primary care provider and others use the HIV clinic as their source for primary care

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6 Must Pass Elements: PCMH 2

- **PCMH 2: Identify and Manage Patient Populations**
  - Element D: Use Data for Population
     Management
    1. At least three different preventive care services.
    2. At least three different chronic care services
    3. Patients not recently seen by the practice
    4. Specific medications

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Scoring: Use Data for Population Management

100%	75%	50%	25%	0%
The practice uses information to take action on all 4 factors	The practice uses information to take action on 3 factors	The practice uses information to take action on 2 factors	The practice uses information to take action on 1 factor	The practice uses information to take action on no factors

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PCMH 2: Identify and Manage Patient Populations Self Assessment Questions

- Does your practice look at preventive and chronic care issues at the population level?
- What is the process that addresses these issues in your practice?
- How do you communicate with patients about needed services?
- Have you ever had to notify patients about a drug recall or other medication related issue?

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6 Must Pass Elements: PCMH 2

- **PCMH 2: Identify and Manage Patient Populations**
  - Element D: Use Data for Population Management
    1. At least three different preventive care services.
    2. At least three different chronic care services
    3. Patients not recently seen by the practice
    4. Specific medications

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Document ID ABC123	Title **Use Data for Population Management**	Print Date
Revision 0.1	Prepared By **Denise Anderson-Carr**	Date Prepared **05/15/2008**
Effective Date: **mm/dd/yyyy**	Reviewed By **Steven Bromer, MD**	Date Reviewed **05/30/2008**
	Approved By	Date Approved **06/01/2008**
Applicable Standard: N/A		

Policy:

Monthly MedCare creates the lists for diabetes patients and the letter below is sent to the patients generated on the list as a reminder to get their A1C tested or make an appointment to address HgA1c>9 or have their eye exam. In the past year MedCare has sent letters to patients needing reminders for preventive care, including seasonal Flu vaccine, mammograms, and immunizations. The same process is used to alert patients when they are due for lab tests, follow-up appointments, missed appointments and when special instructional programs are scheduled on wellness topics.

July 1, 2012

Dear <<FirstName>> <<LastName>>,

MedCare has checked its record and noted that we do not have a recent Hemoglobin A1C results for you according the frequency in the guidelines followed for your diabetic care. As we're sure you are aware, maintaining control of your level is important in preventing complications to your diabetes.

Please contact us at (888) 275-7585 to make an appointment to have your blood drawn for this test as soon as possible. If you have any questions, please contact us at the same number.

Sincerely,
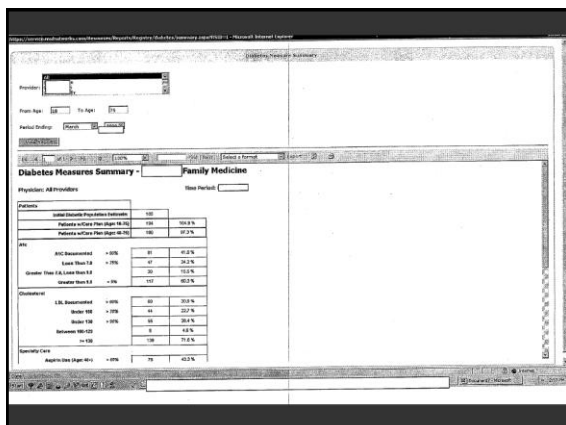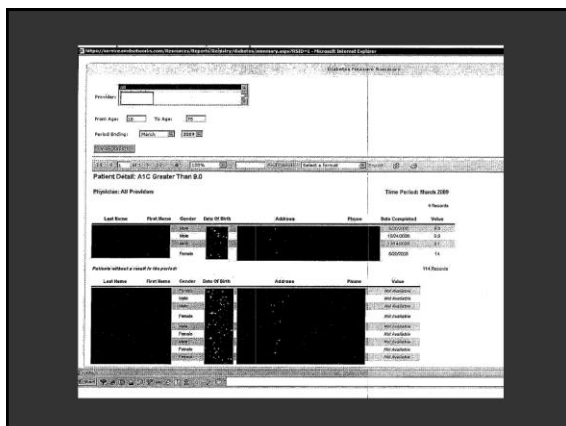
6 Must Pass Elements: PCMH 3

- **PCMH 3: Plan and Manage Care**
  - Element C: Care Management
    1. Conducts pre-visit preparations
    2. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
    3. Gives the patient/family a written plan of care
    4. Assesses and addresses barriers when the patient has not met treatment goals

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6 Must Pass Elements: PCMH 3 (Cont.)

5. Gives the patient/family a clinical summary at each relevant visit

6. Identifies patients/families who might benefit from additional care management support

7. Follows up with patients/families who have not kept important appointments

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Scoring: Care Management

100%	75%	50%	25%	0%
The practice meets 6-7 factors	The practice meets 5 factors	The practice meets 3-4 factors	The practice meets 1-2 factors	The practice meets no factors

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PCMH 3: Plan and Manage Care Self Assessment Questions

- How do you organize planned visits? Letter to patient, robust calling, pre-visit worksheet
- Do the case managers have a written Care Plan?
- Is that plan built with patient input?
- Do patients get a written copy of the plan?
- Is the Care Plan used as an ongoing tool to monitor progress?

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PCMH 3: Documentation Pointers

Care Management Components:	Documentation Pointer:
Pre-visiting planning for all upcoming appointments	Care management activities must be performed for at least 75% of patients with identified conditions. A policy cannot confirm the patient has received pre-visit planning, therefore it must be documented in the patient's record.
Individualized care plans	The factor requires documented review and update at each relevant visit, even documentation of no change in goals, even if goals are met.
Treatment goals	The patient must be provided with a written document to confirm no change in the care plan and this provision must be documented.

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PCMH 3: Documentation Pointers (Cont.)

Care Management Components:	Documentation Pointer:
Making progress toward treatment goals	The patient should be assessed at each relevant visit for barriers, as goals are not yet achieved and this assessment is documented
Patient does not need additional care management support	If care management is not indicated and no referral is appropriate, documentation in the record should support the conclusion
Patient has not missed important appointments	If no follow up is required because patient has not missed important appointments, respond N/A

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PCMH 3: Plan and Manage Care Special Challenges—Outside Case Management

- You are a RWCA Part C grantee who provides medical care to HIV patients but Case Management is provided by a CBO, not your agency and is under a different roof.

- Can you document Case Management services?

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6 Must Pass Elements: PCMH 4

- **PCMH 4: Provide Self-Care Support and Community Resources**

   - Element A: Support Self-Care Process

   1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management

   2. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate

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6 Must Pass Elements: PCMH 4 (Cont.)

3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families*

4. Documents self-management abilities for at least 50 percent of patients/families

5. Provides self-management tools to record self-care results for at least 50 percent of patients/families

6. Counsels at least 50 percent of patients/families to adopt healthy behaviors

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Scoring: Support Self-Care Process

100%	75%	50%	25%	0%
The practice meets 5-6 factors, including factor 3	The practice meets 4 factors, including factor 3	The practice meets 3 factors, including factor 3	The practice meets 1-2 factors or meets 3-5 factors but not factor 3	The practice meets no factor

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PCMH 4: Provide Self-Care Support and Community Resources Self Assessment Questions

- How do you support self-management strategies with your patients?

- How do you engage patients in their care?

- Are patients given specific written tools to use for self-management? Action plans?

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6 Must Pass Elements: PCMH 4

- **PCMH 4: Provide Self-Care Support and Community Resources**

  - Element A: Support Self-Care Process

  1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management

  2. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate

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6 Must Pass Elements: PCMH 4 (Cont.)

3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families*

4. Documents self-management abilities for at least 50 percent of patients/families

5. Provides self-management tools to record self-care results for at least 50 percent of patients/families

6. Counsels at least 50 percent of patients/families to adopt healthy behaviors

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6 Must Pass Elements: PCMH 5

- **PCMH 5: Track and Coordinate Care**
  - Element B: Referral Tracking and Follow-Up
    1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information
    2. Tracking the status of referrals, including required timing for receiving a specialist's report
    3. Following up to obtain a specialist's report

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6 Must Pass Elements: PCMH 5 (Cont.)

4. Establishing and documenting agreements with specialists in the medical record if co-management is needed.

5. Asking patients/families about self-referrals and requesting reports from clinicians

6. Demonstrating the capability for electronic exchange of key clinical information (e.g. problem list, medication list, allergies, diagnostic test results) between clinicians

7. Providing an electronic summary of the care record to another provider for more than 50 percent of referrals

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Scoring: Referral Tracking and Follow-Up

100%	75%	50%	25%	0%
The practice meets 5-7 factors	The practice meets 4 factors	The practice meets 3 factors	The practice meets 1-2 factors	The practice meets no factors

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PCMH 5: Track and Coordinate Care Self-Assessment Questions

- What is your process for tracking referrals?
- How do you assure the right information goes with the patient?
- How do you assure the referral occurs?
- How do you assure the information you get back from the referral is integrated into patient's care?
- Do your patients see providers you don't know about?

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PCMH 5: Documentation Pointers

- Information included in the referral communication to the specialist includes:
  - Reason for and urgency of the referral
  - Relevant clinical information (pt. family/social
    hx, clinical findings and current treatment)
  - General purpose of the referral and necessary
    follow-up communication or information

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PCMH 5: Documentation Pointers (Cont.)

- The referral tracking system includes the date when the referral was initiated and the timing indicated for receiving the report

- If the practice does not receive a report from the specialist, it contacts the specialist's office about the report's status and the expected date for receiving the report and documents the effort to retrieve the report in a log or electronic system

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6 Must Pass Elements: PCMH 6

- **PCMH 6: Measure and Improve Performance**
  - Element C: Implement Continuous Quality Improvement
    1. Set goals and act to improve performance on at least three measures from Element A
    2. Set goals and act to improve performance on at least one measure from Element B
    3. Set goals and address at least one identified disparity in care or service for vulnerable populations

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6 Must Pass Elements: PCMH 6 (Cont.)

4. Involve patients/families in quality improvement teams or on the practice's advisory council

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Scoring: Implement Continuous Quality Improvement

100%	75%	50%	25%	0%
The practice meets 3-4 factors	No scoring option	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

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PCMH 6: Measure and Improve Performance Self-Assessment Questions

- When is the last time you reviewed your Quality Management Plan?
- Do you have a broad range of measures that include process, outcomes, operational and patients experience measures?
- Has your practice set goals and made improvements on measures?
- How are patient's involved in quality work?

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6 Must Pass Elements: PCMH 6

- **PCMH 6: Measure and Improve Performance**
  - Element C: Implement Continuous Quality Improvement
    1. Set goals and act to improve performance on at least three measures from Element A
    2. Set goals and act to improve performance on at least one measure from Element B
    3. Set goals and address at least one identified disparity in care or service for vulnerable populations

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6 Must Pass Elements: PCMH 6 (Cont.)

4. Involve patients/families in quality improvement teams or on the practice's advisory council

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PCMH 6: Documentation Pointers

- The practice must have a clear and ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks
- The practice set goals and establishes a plan to improve performance on clinical quality and resource measures and patient experience measures

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PCMH 6: Documentation Pointers (Cont.)

- The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action

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HIV WCHC Quality Management Plan
December 15, 2011

HIV Quality Management Plan
West County Health Centers
2011-2012

Quality Statement

West County Health Centers, Inc. (WCHC) envisions creating culturally appropriate, patient centered medical homes for people living with HIV in Sonoma County where every contact with the medical home is an opportunity to partner in building healthy lives, families and communities. At WCHC quality *is doing the right thing, at the right time, for the right reasons*. The Quality Management Plan (QMP) supports this vision by increasing the capacity of our sites to systematically monitor, evaluate and continuously improve the quality of HIV care assuring that services are in concert with current Department of Health and Human Services (DHSS) guidelines.

Authority and Responsibility

Quality of care for patients in the HIV program is the responsibility of the HIV Program Medical Directors at each site. They are accountable to the agency medical
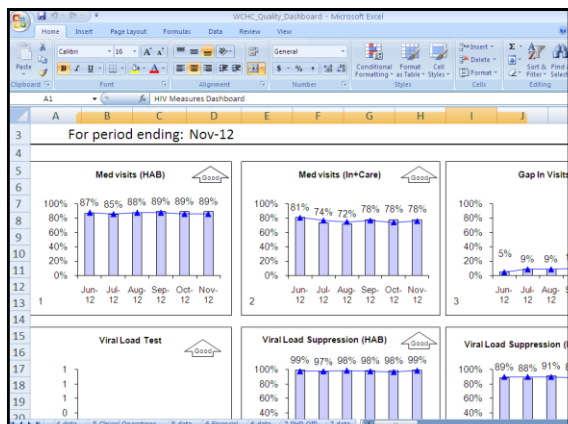
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Conclusions

- Documentation can be an opportunity to assess your practice
- Chance to codify
- Can be overwhelming but if you take it apart piece by piece – it is manageable
- QUESTIONS

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