NCQA PCMH 2011 Documentation Standard 3 and Standard 4

Southeast Region Webinar

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May 8, 2014

CMS FQHC APCP Demonstration

QUALIS HEALTH

Advancing Healthcare
Improving Health

Learning Objectives

- Review documentation requirements for NCQA's Patient-Centered Medical Home Standards:
  - 3: "Plan and Manage Care"
  - 4: "Provide Self-Care Support and Community Resources"

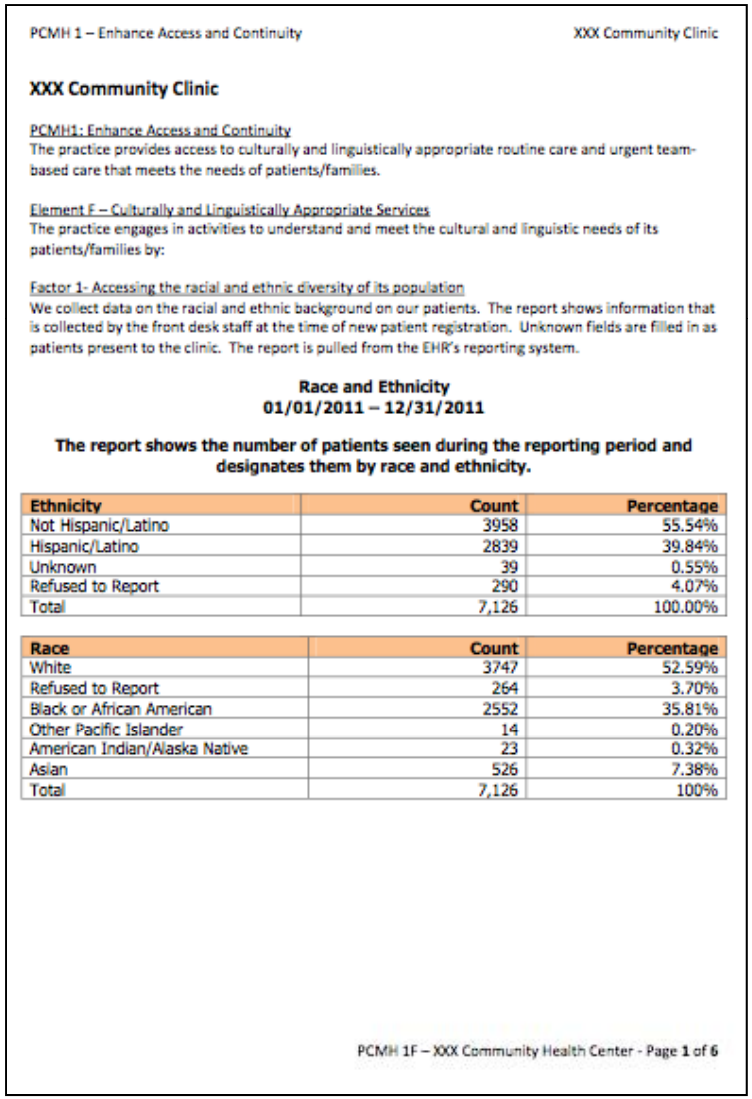
General Tips on Documentation

- Format in a clear and organized manner
- Highlight relevant information for the NCQA surveyor
- Include a ‘narrative description’ as a summary of information presented in the documentation
- Save documentation for a single element into one document

General Tips on Documentation (Cont'd)

- Reports: Include name of the report, reporting period, numeric values of the numerator and denominator
- Policies: Include date of most recent update
- Screen shots: use real patient data, de-identified
- Policies, procedures and job descriptions must not be younger than 3-months from date of submission. Data must not be older than 12-months.

Documentation Formatting



PCMH 1 – Enhance Access and Continuity XXX Community Clinic

XXX Community Clinic

PCMH1: Enhance Access and Continuity
The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

Element F – Culturally and Linguistically Appropriate Services
The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

Factor 1- Accessing the racial and ethnic diversity of its population
We collect data on the racial and ethnic background on our patients. The report shows information that is collected by the front desk staff at the time of new patient registration. Unknown fields are filled in as patients present to the clinic. The report is pulled from the EHR's reporting system.

Race and Ethnicity
01/01/2011 – 12/31/2011

The report shows the number of patients seen during the reporting period and designates them by race and ethnicity.

Ethnicity	Count	Percentage
Not Hispanic/Latino	3958	55.54%
Hispanic/Latino	2839	39.84%
Unknown	39	0.55%
Refused to Report	290	4.07%
Total	7,126	100.00%

Race	Count	Percentage
White	3747	52.59%
Refused to Report	264	3.70%
Black or African American	2552	35.81%
Other Pacific Islander	14	0.20%
American Indian/Alaska Native	23	0.32%
Asian	526	7.38%
Total	7,126	100%

PCMH 1F – XXX Community Health Center - Page 1 of 6

Header with clinic name, NCQA Standard

Information on NCQA Standard, Element and Factor demonstrated in this documentation

Narrative description of how clinic meets NCQA factor

Report or other documentation to be shown to NCQA

Footer with NCQA Standard and Element, and page number of total pages

Standard 3
Plan and Manage Care

Elements:

A. Implement Evidence-Based Guidelines
B. Identify High-Risk Patients
C. Care Management ***(Must Pass)***
D. Medication Management
E. Use Electronic Prescribing

PCMH 3A: Implement Evidence-Based Guidelines

Practice implements evidence-based guidelines through point-of-care reminders for patients with:

Factors:

1. The first important condition
2. The second important condition
3. The third condition, related to unhealthy behaviors or mental health or substance abuse *(Critical Factor)*

PCMH 3A
Documentation Example

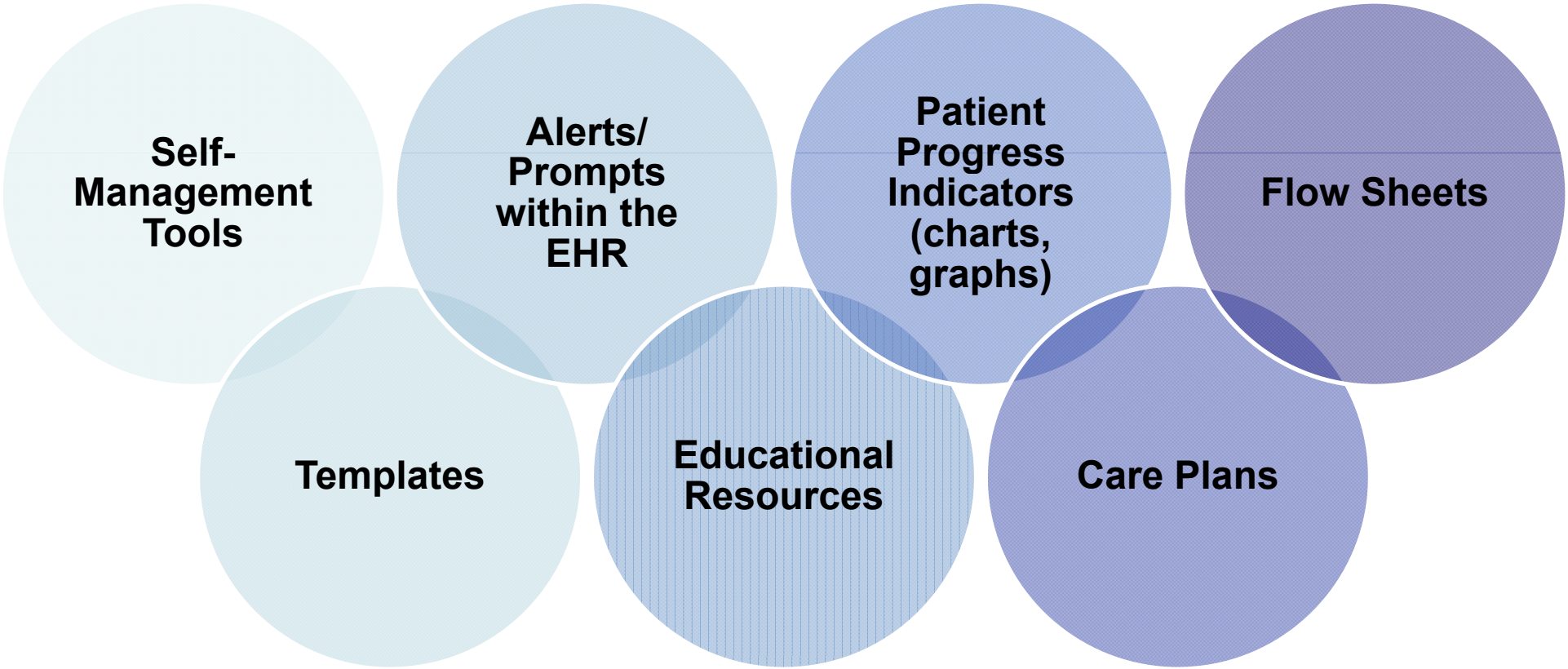
Example of format:

XXX Clinic's Three Important Conditions:

1. Name First Condition Here (ex. Diabetes) – List **name and source** of evidence-based guidelines for first condition
2. Name Second Condition Here – List **name and source** of evidence-based guideline for second condition
3. Name Third Condition Here – List **name and source** of evidence-based guideline for third condition, related to unhealthy behavior, mental health or substance abuse

PCMH 3A-1, 3A-2, or 3A-3

Documentation Examples to Consider…



PCMH 3B: Identify High-Risk Patients

To identify high-risk or complex patients, the practice:

Factors:

1. Establishes criteria and a systematic process to identify high-risk or complex patients
2. Determines the percentage of high-risk patients in its population.

PCMH 3B-1
Documentation Example

High-Risk Patient

Definition: Patients with co-morbidities of diabetes and hypertension

Process for Identification: Patients diagnosed with diabetes and hypertension will receive a “high-risk” flag in the EHR. Once a month, the Nurse Manager will run a report to determine if there are any patients newly meeting this criteria. If so, the Nurse Manager will designate these patients within the EHR with a “high-risk” flag.

PCMH 3B-2 Documentation Example

High Risk Population

Condition 1	Condition 2	Total Patients
Diabetes	Hypertension	198

Total High Risk Patients	198
Total Active Patients	1203
Percentage of High Risk Patients	**16 %**

Element 3C: Care Management
(Must Pass)

The care team performs the following for at least **75 percent** of the patients identified in Elements A and B.

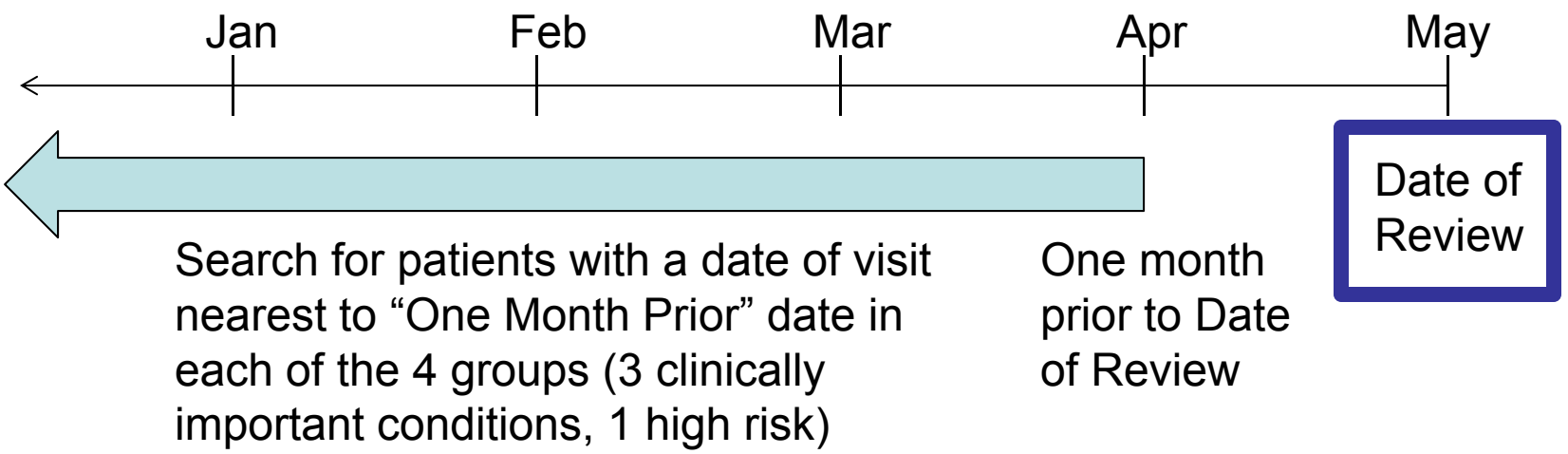
Factors:

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
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

Record Review Workbook

- Provided by NCQA, download from your ISS/RAS
- Review and **assess documentation in patient medical records**
- 48 patient records
- Supports:
  - 3C: Care Management ***(Must Pass)***
  - 3D: Medication Management
  - 4A: Support Self-Care Process ***(Must Pass)***

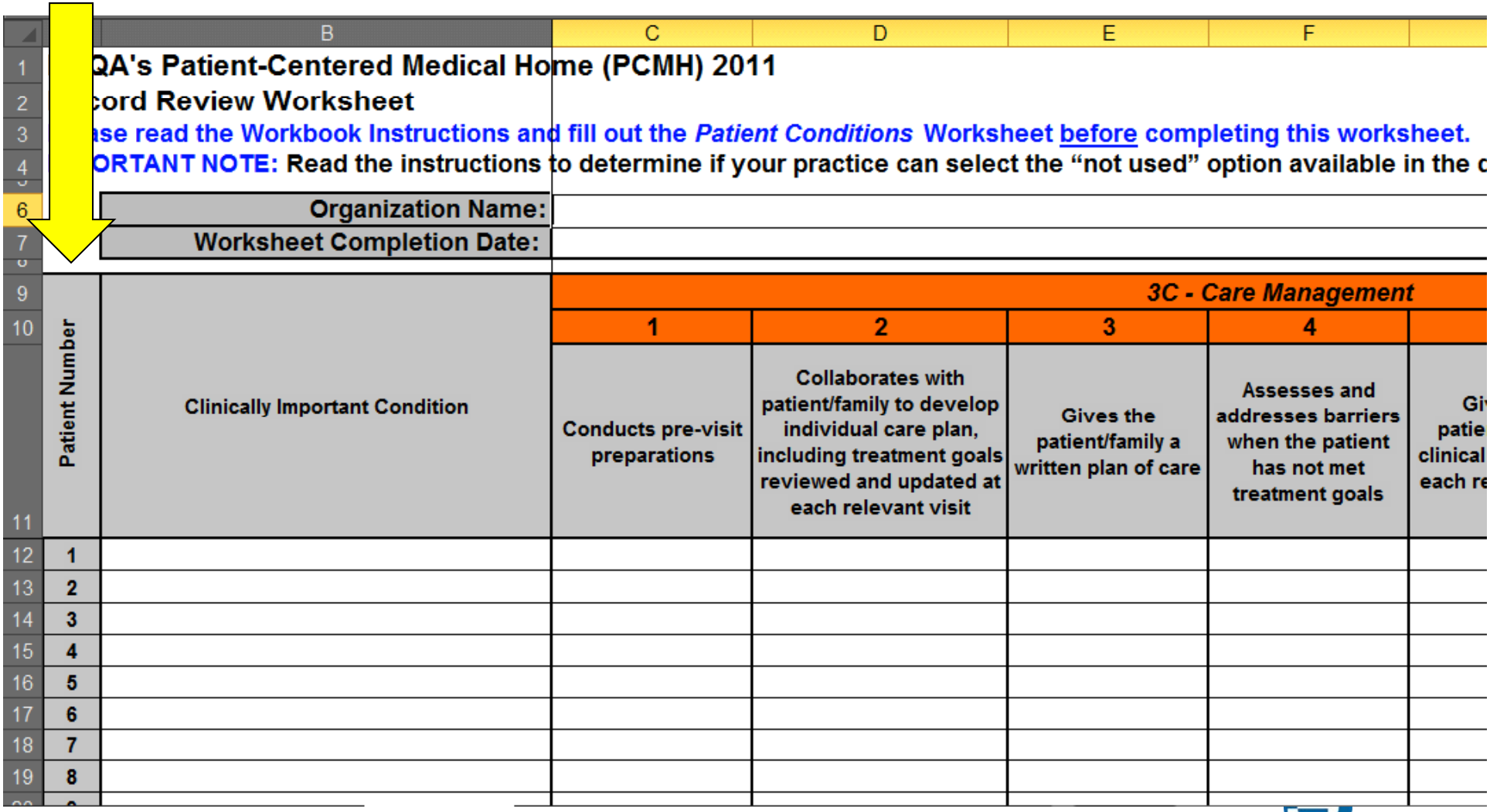
Record Review Workbook



Record Review Workbook

	A	B	C	D	E	F
1	**NCQA's Patient-Centered Medical Home (PCMH) 2011**					
2	**Record Review Worksheet**					
3	**Please read the Workbook Instructions and fill out the *Patient Conditions* Worksheet before completing this worksheet.**					
4	**IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the c**					
6		**Organization Name:**				
7		**Worksheet Completion Date:**				
9			***3C - Care Management***			
10			**1**	**2**	**3**	**4**
11	**Patient Number**	**Clinically Important Condition**	**Conducts pre-visit preparations**	**Collaborates with patient/family to develop individual care plan, including treatment goals reviewed and updated at each relevant visit**	**Gives the patient/family a written plan of care**	**Assesses and addresses barriers when the patient has not met treatment goals**
12	**1**					
13	**2**					
14	**3**					
15	**4**					
16	**5**					
17	**6**					
18	**7**					
19	**8**					

Record Review Workbook



	B	C	D	E	F
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7	**Worksheet Completion Date:**				
9					*3C - Care Management*
10		1	2	3	4
11	**Patient Number** / **Clinically Important Condition**	**Conducts pre-visit preparations**	**Collaborates with patient/family to develop individual care plan, including treatment goals reviewed and updated at each relevant visit**	**Gives the patient/family a written plan of care**	**Assesses and addresses barriers when the patient has not met treatment goals**
12	1				
13	2				
14	3				
15	4				
16	5				
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Record Review Workbook

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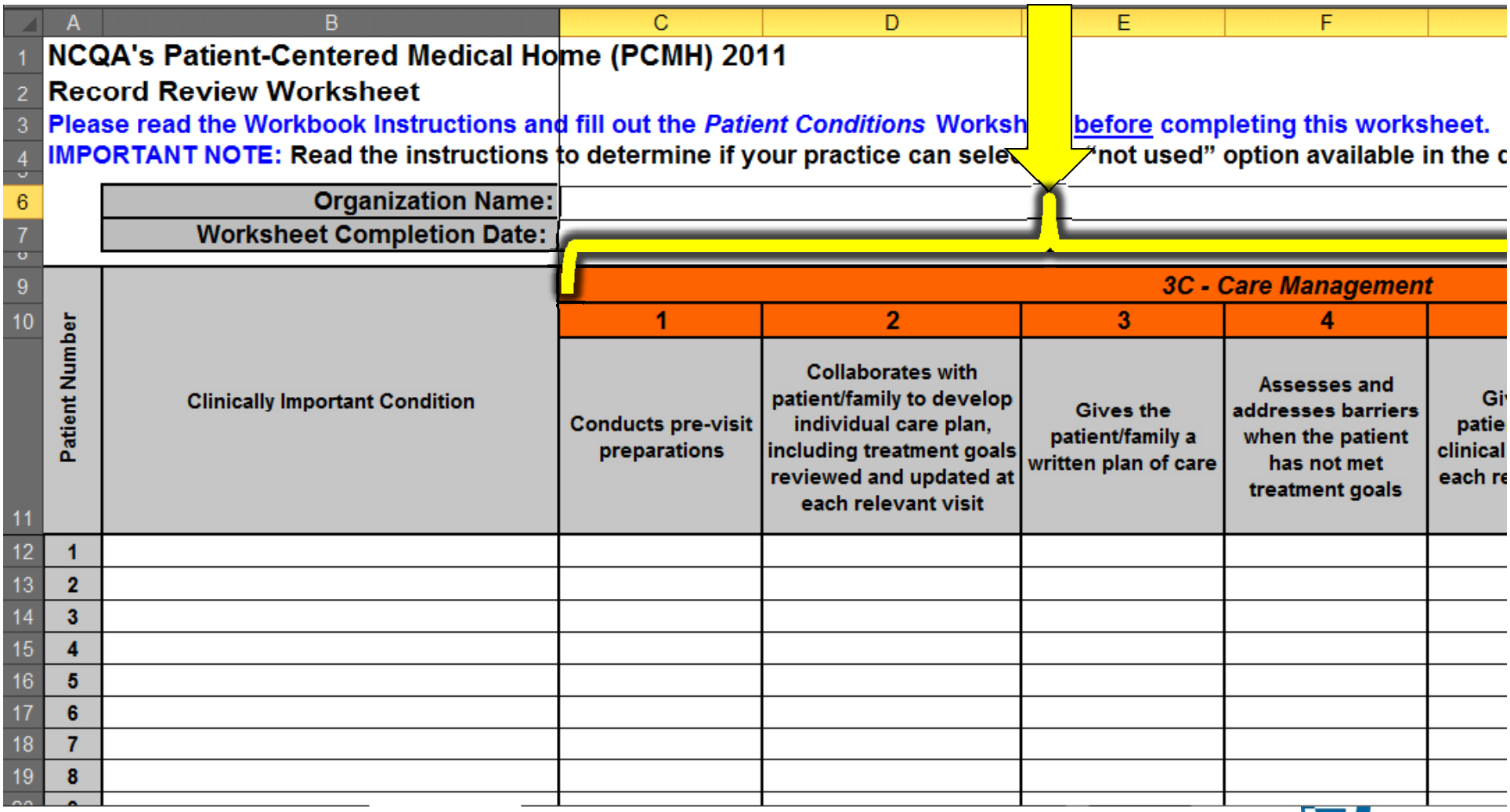
12	1					
13	2					
14	3					
15	4					
16	5					
17	6					
18	7					
19	8					

Record Review Workbook



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6		Organization Name:				
7		Worksheet Completion Date:				
9						3C - Care Management
10			1	2	3	4
11	Patient Number	Clinically Important Condition	Conducts pre-visit preparations	Collaborates with patient/family to develop individual care plan, including treatment goals reviewed and updated at each relevant visit	Gives the patient/family a written plan of care	Assesses and addresses barriers when the patient has not met treatment goals
12	1					
13	2					
14	3					
15	4					
16	5					
17	6					
18	7					
19	8					

Record Review Workbook

10	Patient Number	Clinically Important Condition	1	2	3
11			Conducts pre-visit preparations	Collaborates with patient/family to develop individual care plan, including treatment goals reviewed and updated at each relevant visit	Gives the patient/family a written plan of care
58	47		No	Yes	
59	48		Yes	No	
60					
61	Count of Patients Met (Yes + NA)		33	40	0
62	Count of Patients Not Met (No + Not Used)		15	8	0
63	Total Count of Patients (Met + Not Met)		48	48	0
65	% of Patient that Meet Factor Criteria		69%	83%	
72	Result for Input Into ISS		No	Yes	< 48 Patients

PCMH 3D: Medication Management

The practice manages medications in the following ways:

Factors:

1. Reviews and reconciles medications with patients/families for more than 50% of care transitions *(Critical Factor)*
2. Reviews and reconciles medications with patients/families for more than 80% of care transitions
3. Provides information about new prescriptions to more than 80% of patients/families
4. Assesses patient/family understanding of medications for more than 50% of patients with date of assessment
5. Assesses patient response to medications and barriers to adherence for more than 50% of patients with date of assessment
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50% of patients/families, with the date of updates

Record Review Workbook

NCQA's Patient-Centered Medical Ho
Record Review Worksheet
Please read the Workbook Instructions an
IMPORTANT NOTE: Read the instructions

Organization Name:	
Worksheet Completion Date:	

Patient Number	Clinically Important Condition	*3D - Medication Management*				
		1	2	3	4	5
		Reviews and reconciles medications with patients/families		Provides information about new prescriptions to patients/families	Assesses patient/family understanding of medications for patients with date of assessment	Assesses patient response to medications and barriers to adherence for patients with date of assessment
1						
2						
3						
4						
5						
6						
7						
8						

Instructions | Patient Conditions | Record Review

PCMH 3E: Use Electronic Prescribing

The practice uses e-prescribing system with the following capabilities:

Factors:

1. Generates and transmits at least 40% of eligible prescriptions to pharmacies
2. Generates at least 75% of eligible prescriptions (*Critical Factor*)
3. Enters electronic medication orders into the medical record for more than 30% of patients with at least one medication in their medication list
4. Performs patient-specific checks for drug-drug and drug-allergy interactions
5. Alerts prescribers to generic alternatives
6. Alerts prescribers to formulary status

PCMH 3E-1
Documentation Example

MEANINGFUL USE REPORT

Date Run: Wednesday, October 10, 2013

Reporting Period: October 1, 2012 – September 30, 2013

ID	*Measure Name*	*Goal*	*Result*	*Score*
Core	Generate and transmit permissible prescriptions electronically (eRx).	40%	☑	90.31% (382/423)

PCMH 3E-2
Documentation Example

Generated Eligible Prescriptions

Reporting Period: October 1, 2012 - September 30, 2013
Report Date: 10-Oct-13

Eligible Prescriptions Generated Using eRx	Eligible Prescriptions Written	%
411	423	97%

PCMH 3E-3
Documentation Example

MEANINGFUL USE REPORT

Date Run: Wednesday, October 10, 2013

Reporting Period: October 1, 2012 – September 30, 2013

ID	*Measure Name*	*Goal*	*Result*	*Score*
Core	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	30%	☑	90.31% (382/423)

PCMH 3E-4, 3E-5, 3E-6 Documentation

Screen shots from your electronic system showing **system alerts**

3E-4	**Drug-drug AND drug-allergy**
3E-5	**Generic alternatives**
3E-6	**Formulary status**

Standard 4

Provide Self-Care Support and Community Resources

Elements:

A. Support Self-Care Process ***(Must Pass)***

B. Provide Referrals to Community Resources

PCMH 4A: Support Self-Care Process *(Must Pass)*

The practice conducts activities to support patients/families in self-management:

Factors:

1. Provides educational resources or refers at least 50% of patients/families to educational resources to assist in self-management
2. Uses an EHR to identify patient-specific education resources and provide the to more than 10% of patients, if appropriate
3. **Develops and documents self-management plans and goals in collaboration with at least 50% of patients/families** ***(critical factor)***
4. Documents self-managements abilities for at least 50% of patients/families
5. Provides self-management tools to record self-care results for at least 50% of patients/families
6. Counsels at least 50% of patients/families to adopt healthy behaviors

Documentation 4A: Record Review Workbook

- 48 patient records
  - Equal number for each condition (and high risk group if applicable)
- Must have a condition related to mental health, substance abuse or unhealthy behaviors in Element 3A
- Must have documentation in record for at least 50% of patient records to meet factors 1, 3-6; 10% for factor 2
- *May use reports instead of Record Review Workbook if available (e.g. MU reports)*

Record Review Workbook

	A	B	R	S	T	U	V
1	NCQA's Patient-Centered Medical Ho						
2	Record Review Worksheet						
3	Please read the Workbook Instructions and						
4	IMPORTANT NOTE: Read the instructions						
6		Organization Name:					
7		Worksheet Completion Date:					
9			4A - Support Self-Care Process				
10			1	2	3	4	5
11	Patient Number	Clinically Important Condition	Provides educational resources or refers patient/families to educational resources to assist in self-management	Uses an EHR to identify patient-specific education resources and provide them to patients, if appropriate	Develops and documents self-management plans and goals in collaboration with patients/families	Documents self-management abilities for patients/families	Provides self-management tools to record self-care results for patients/families
12	1						
13	2						
14	3						
15	4						
16	5						
17	6						

PCMH 4B: Provide Referrals to Community Resources

Practice support patients who need access to community resources:

Factors:

1. Maintains current resource list covering five (5) community service areas
2. Tracks referrals provided to patients
3. Arranges for or provides treatment for mental health/substance abuse disorders
4. Offers opportunities for health education and peer support

PCMH 4B-1
Documentation Example

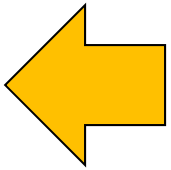
Community Resources

Safety/Shelter	Phone Number	Email Address	Street Address
Homeless Shelter	000-000-0000	email@address.com	123 Main St. Anytown, USA
Catholic Charities	000-000-0000	email@address.com	123 Main St. Anytown, USA
Dental			
Parker Dental	000-000-0000	email@address.com	123 Main St. Anytown, USA
Dental Care Spring	000-000-0000	email@address.com	123 Main St. Anytown, USA
Nutrition/Exercise			
Main St. Community Center	000-000-0000	email@address.com	123 Main St. Anytown, USA
Healthy Starts	000-000-0000	email@address.com	123 Main St. Anytown, USA

List would need to include at least 2 more “service areas” to meet the minimum requirement of 5

PCMH 4B-2 Documentation Example

Tracking Community Resources	
April 1, 2012 - April 30, 2012	
Agency	**Patients Referred**
Safety / Shelter	
Homeless Shelter	12
Catholic Charities	45
Subtotal	**57**
Dental	
Parker Dental	122
Dental Care Spring	47
Subtotal	**169**
Nutrition / Exercise	
Main St. Community Center	29
Healthy Starts	42
Subtotal	**71**
Total	**297**



Note: the resources on your tracking log for factor 2 **MUST** match the resources listed in factor 1

PCMH 4B-3 Documentation Example

Example Policy Excerpt– Behavioral Health Referral Procedures

Effective 12/10/2011

1. **Evaluation**
   - **Outpatient:** Patients who are assessed by their provider to be in need of Behavioral Health care will be evaluated by the Behavioral Health Consultant. Based on the outcome of that assessment, the Behavioral Health consultant will either resolve or agree to manage the patient within the clinic or arrange for or refer care to one of the resources listed below.
   - **Inpatient:** Following assessment by either their provider or the Behavioral Health Consultant, patients in need of voluntary psychiatric care will have their care coordinated by the care team. Refer to Inpatient Admission procedures for inpatient care coordination. If involuntary psychiatric admission is determined to be necessary, refer to the Involuntary Admission policy and procedure.

2. **Referrals**
   - Adults and adolescents who are experiencing psychiatric, emotional, behavioral and/or addictive disorders should be referred to the services provided by ABCD Hospital Center, unless the provider has identified another facility to meet the immediate needs of the patient.

PCMH 4B-3 Documentation

3 examples

of patients with mental health or substance abuse problems that either:

- Received treatment at your facility **or**
- Were directed to a treatment provider

PCMH 4B-4 Documentation Example

XYZ Community Health Center

Asthma Health Education Program

Group classes scheduled the first Tuesday of the month,

7-8:30pm

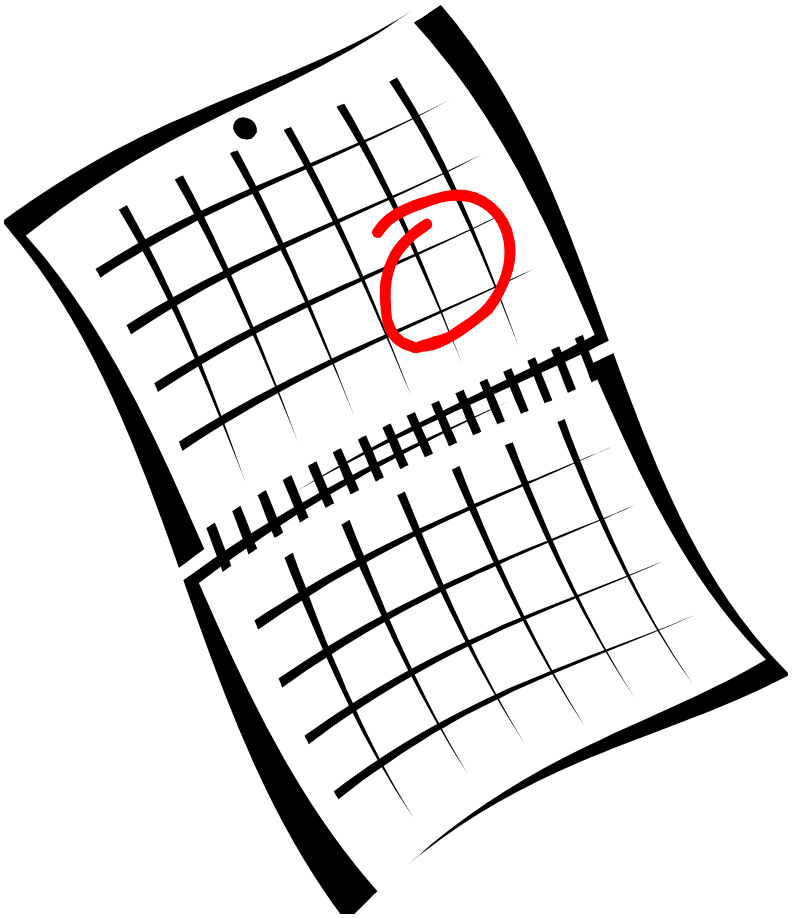
In this group class, you will have peer support, access to professional care specialists and educational materials to help them better understand and manage your asthma.

If you participate in the program, we can help you understand:

- Your asthma medications
- How to properly use an inhaler device and peak flow meter
- Understand the danger signs when you have symptoms

For more information, please call xxx-xxxx

PCMH 4B-4 Documentation



3 examples

of health education classes such as:

- Listing of events/ discussions
- Calendar of classes
- Schedule of programs

Questions

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