Division of TennCare

STATE OF TENNESSEE

PCMH Documentation 2:

Record Review Workbook and Quality Measurement and Improvement Worksheet for NCQA 2017 PCMH Recognition

Presenter: Rick Walker, TN Coach Lead, PCMH CCE

March 28, 2019

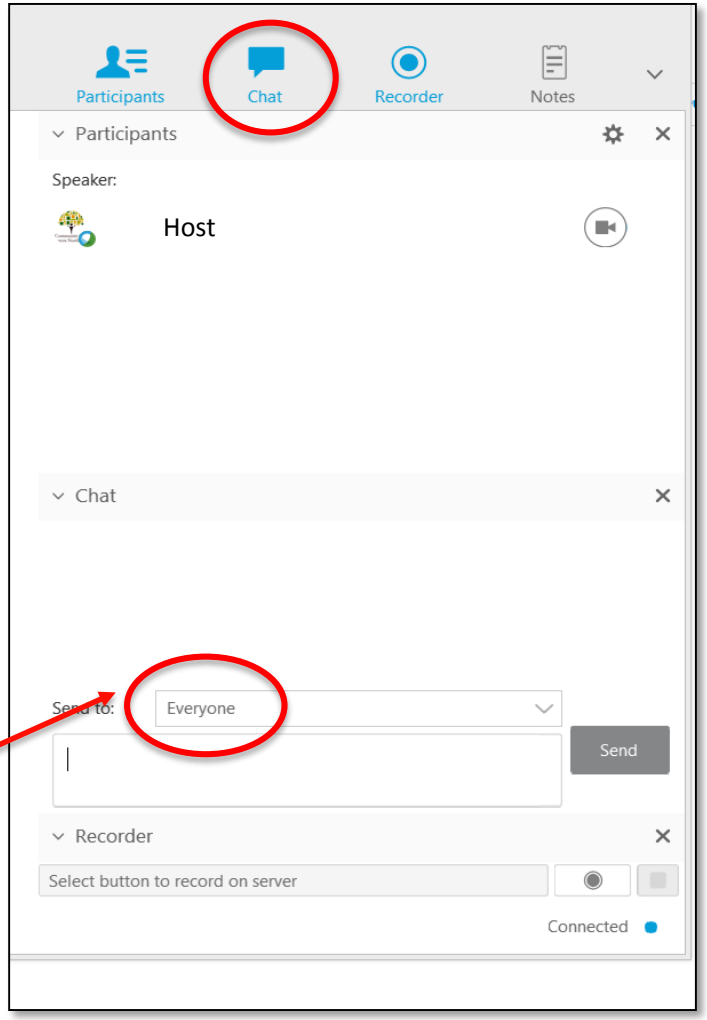
Introduction to the Webinar

Chat Box During the Presentation

Send:

- Best Practices
- Challenges
- Novel Ideas
- Questions

Select “Everyone” and enter your question or comment



Quick Review: PCMH 2017 Terminology

Concepts:

- CM: Care Management and Support
- QI: Performance Measurement and Quality Improvement

Today's Agenda

- 11:00-11:05 (CT)
  - Introduction
    - Purpose of Record Review Workbook and Quality Measurement and Improvement Worksheet
- 11:05-11:25am (CT)
  - Review
    - CM 01-03
  - Record Review Workbook
    - CM 04-08
- 11:25-11:50am (CT)
  - Quality Measurement and Improvement Worksheet
    - QI 08-12
- 11:50am-12pm (CT)
  - Facilitated Discussion
    - Questions, Best Practices, Challenges and Novel Ideas
  - Wrap-up

Additional Presenters

- Amber Bain – BlueCross BlueShield of Tennessee
  - THCII PCMH Consultant, PCMH CCE
- Steven Thomas – Navigant
  - PCMH Consultant

Purpose of Record Review Workbook and Quality Measurement and Improvement Worksheet

Purpose of NCQA's PCMH Record Review Workbook

- The Record Review Workbook calculates the data entered and scores each criterion based on a sample of patient records.
- Of particular interest is the assessment and identification of patients who would benefit from care management.
- These criteria (CM 04-08) assess how the practice uses patient information and collaborates with patients/families/caregivers to develop care plans that address barriers, and incorporates patient preferences and lifestyle goals documented in the patient chart.

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

Purpose of NCQA's PCMH Quality Measurement and Improvement Worksheet

- This worksheet helps practices organize the measures and QI activities related to:
  - Clinical quality measures
    QI 08 - core
  - Resource stewardship
    QI 09 – core
  - Appointment access
    QI 10 - core
  - Patient experience
    QI 11 – core
  - Improved performance
    QI 12 – 2 credits
- Additional information:
  - Practices may submit their own report detailing their quality improvement strategy but should consult the Quality Improvement Worksheet Instructions for guidance.

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

Care Management and Support (CM)

CM 01 – Identify Patients for Care Management (core) *Example of a Protocol*

{Insert Practice name} considers the following patient categories among the group that would benefit from care management:

1. Asthma (High Cost-High Utilization): As part of our PHIIT participation, we generate a report of the asthma patients that are seen by each provider in the practice each quarter. Chart review is done on about 10 charts per provider and the goal is to ensure that all asthma patients have an asthma action plan, counseling and education is provided at the visit, and follow up appointments are scheduled. (Last PHIIT asthma report)

2. Obesity (Poorly Controlled-Complex Condition): BMI is calculated based on the height and weight entered at each visit. If a patient is diagnosed as being obese, education is provided, counseling on both nutrition and physical activity is conducted, labs are drawn and follow up appointments are scheduled to monitor. For children from 3 years to 17 years, this includes BMI > 85th percentile, and for patients 18 years and older, this includes BMI of 30 or greater.

3. Behavioral health needs are assessed during Well Child Exam and in new patients. If there is a behavioral health condition such as ADHD or depression diagnosed, counseling is provided, medication management is conducted, and school and parents are involved in the care plan.

Date of Implementation: 01/2017

TN

Source: Practice example

CM 02 – Monitoring Patients for Care Management (core)
Example of a Monitoring Tool

	High Cost-Utilization: Asthma	Poorly Controlled-Complex: Obesity	Behavioral Health	Social Determinants Of Health	Referrals	Total Patients
Patients in Care Management	30	150	70	25	25	300
Total Patients in Practice						4044
Patients Needing Care Management						7.4% (300 Patients)

Source: Practice example

CM 01 and 02 – Combined Document

Identifying & Monitoring Patients for Care Mgmt

- Behavioral health patients identified – positive PHQ 9
- High utilizers – two or more ER visits in 6 months
- Two or more hospital admissions in past year
- Poorly controlled (multiple co morbidities) – HgbA1C > 9; uncontrolled hypertension
- Social determinants of health – education level < grade 8

Utilizing the criteria outlined above and in our Patient Care Planning and Management protocol, it is determined that 83 patients or 9% of the population serviced at the Ashland center could benefit from care management.

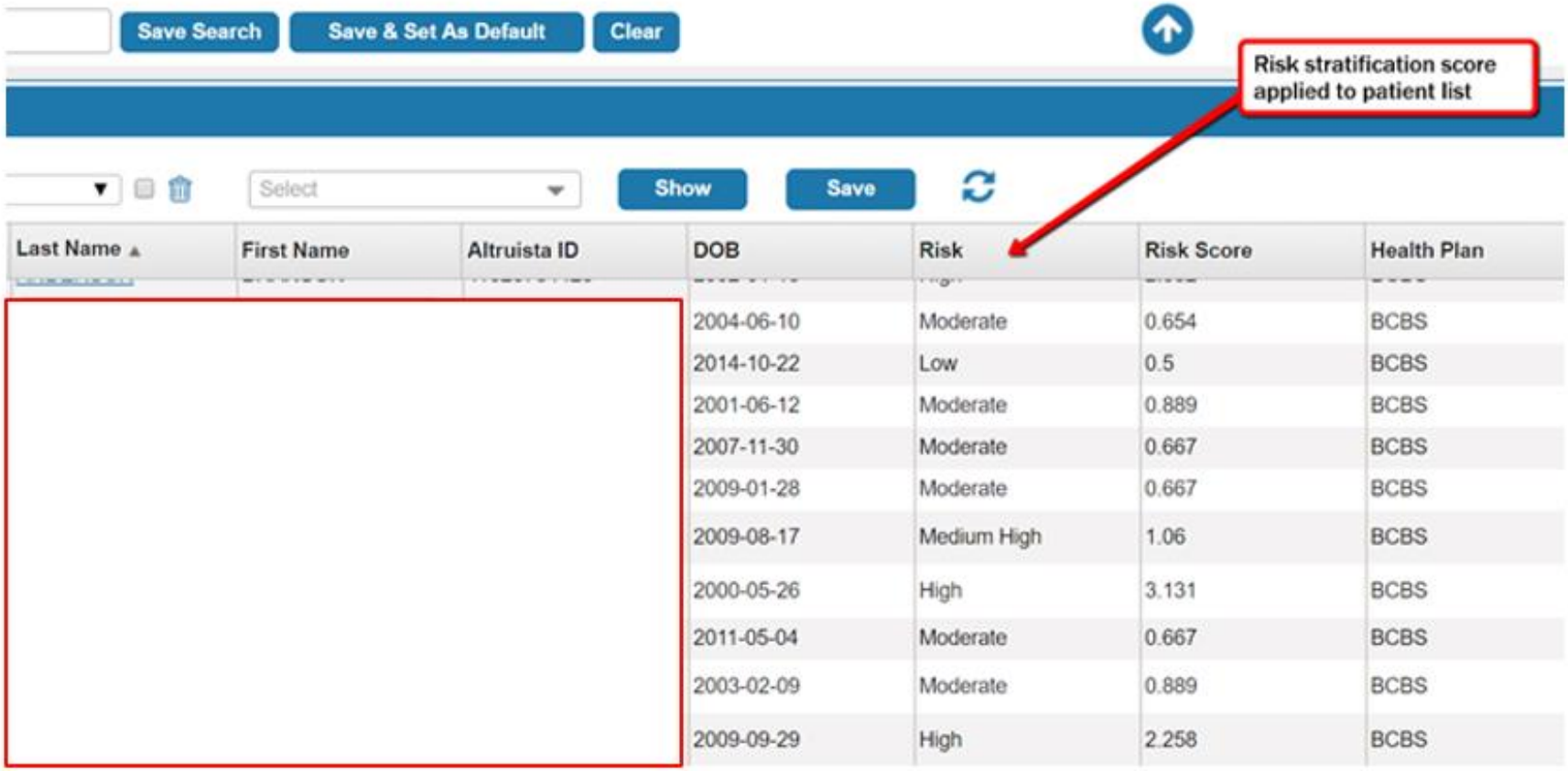
Denominator = 893 patients

Numerator = 83 patients

Percentage of patients identified as benefiting from care management = 5%

Source: NCQA example

CM 03 – Comprehensive Risk-Stratification (2 credits)
Example of a Screenshot



Source: Screenshot of TennCare/Altruista Care Coordination Tool (CCT)

Record Review Workbook
CM 04-08

CM 04 – 08: Criterion

- **CM 04 (Core)** Person-Centered Care Plans: Establishes a person-centered care plan for patients identified for care management.
- **CM 05 (Core)** Written Care Plans: Provides a written care plan to the patient/family/caregiver for patients identified for care management.
- **CM 06 (1 Credit)** Patient Preferences and Goals: Documents patient preference and functional/lifestyle goals in individual care plans.
- **CM 07 (1 Credit)** Patient Barriers to Goals: Identifies and discusses potential barriers to meeting goals in individual care plans.
- **CM 08 (1 Credit)** Self-Management Plans: Includes a self-management plan in individual care plans.

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

CM 04 – 08: Evidence

- Report

  OR

- Record Review Workbook (RRW) and
- Patient examples

- Only patient examples are shareable across sites
  - Must provide a report or RRW for each site

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

CM 04 – 08: Record Review Workbook

NCQA's Patient-Centered Medical Home (PCMH)
Record Review Worksheet
Please read the Workbook Instructions before completing this worksheet.
IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the drop-down boxes for Patient Number 1.

Organization Name:	
Completion Date:	

	Care Planning and Self-Care Support				
	CM 04	**CM 05**	**CM 06**	**CM 07**	**CM 08**
Patient Number	Establishes a person-centered care plan for patients identified for care management	Provides written care plan to the patient/family/ caregiver for patients identified for care management	Documents patient preference and functional/lifestyle goals in individual care plans	Identifies and discusses potential barriers to meeting goals in individual care plans	Includes a self-management plan in individual care plans
1	Yes	Yes	Yes	No	Yes
2					
3					
4					
5					
6					
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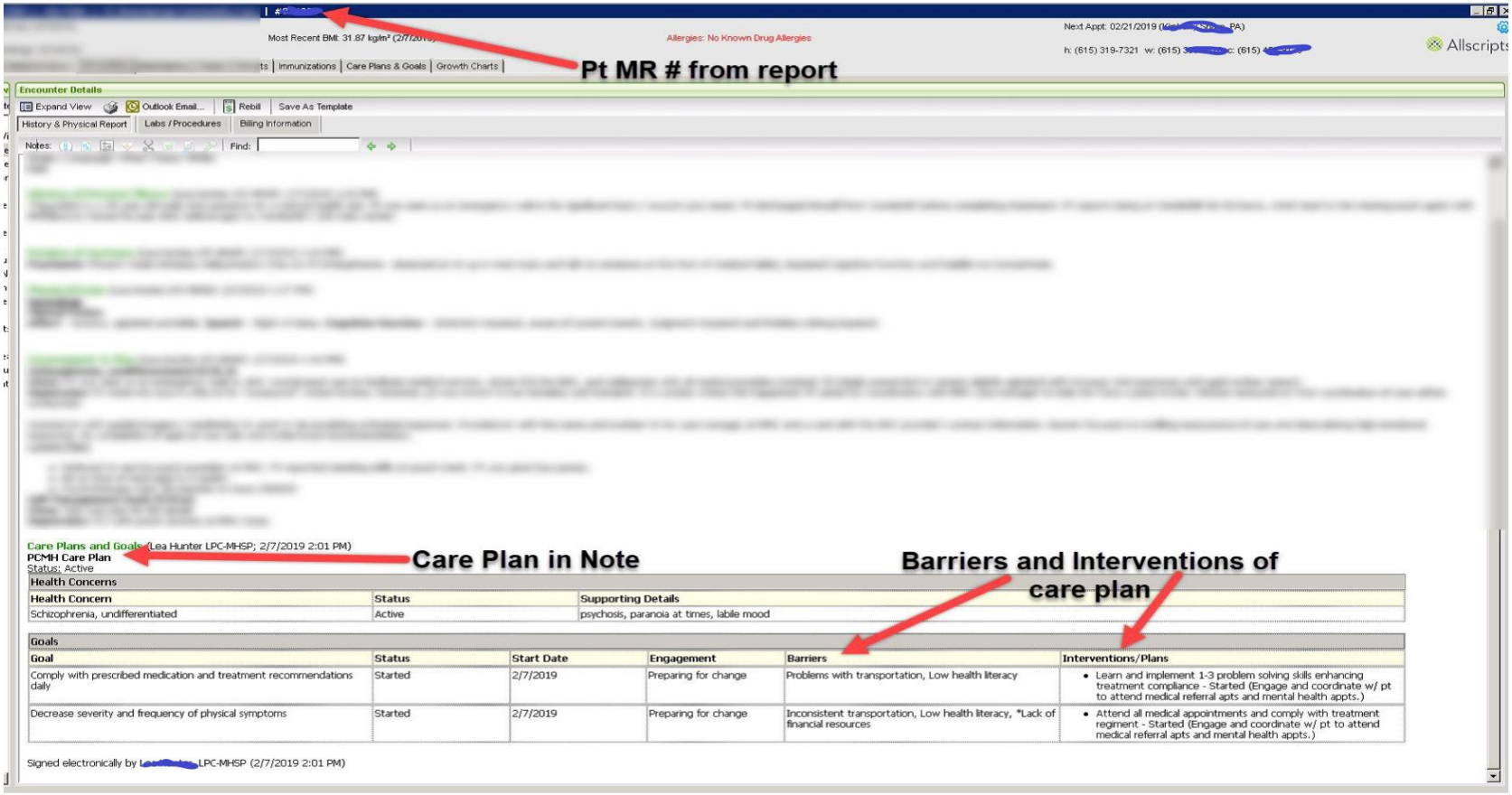
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
Count of Patients Met (Yes + NA)	1	1	1	0	1
Count of Patients Not Met (No + Not Used)	0	0	0	1	0
Total Count of Patients (Met + Not Met)	1	1	1	1	1
% of Patient that Meet Criteria	100%	100%	100%	0%	100%

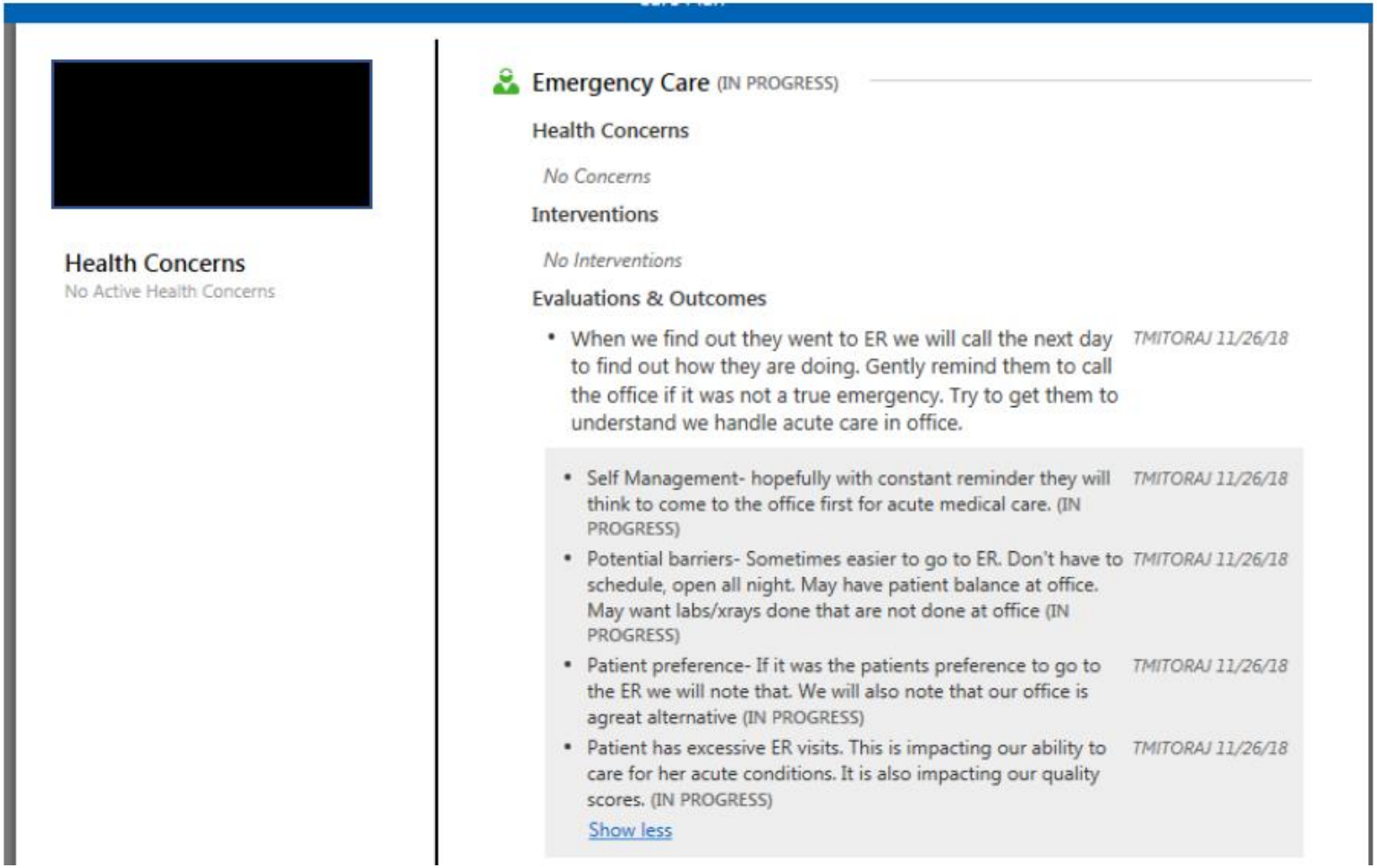
Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

CM 04 – 08: Patient Examples cont.



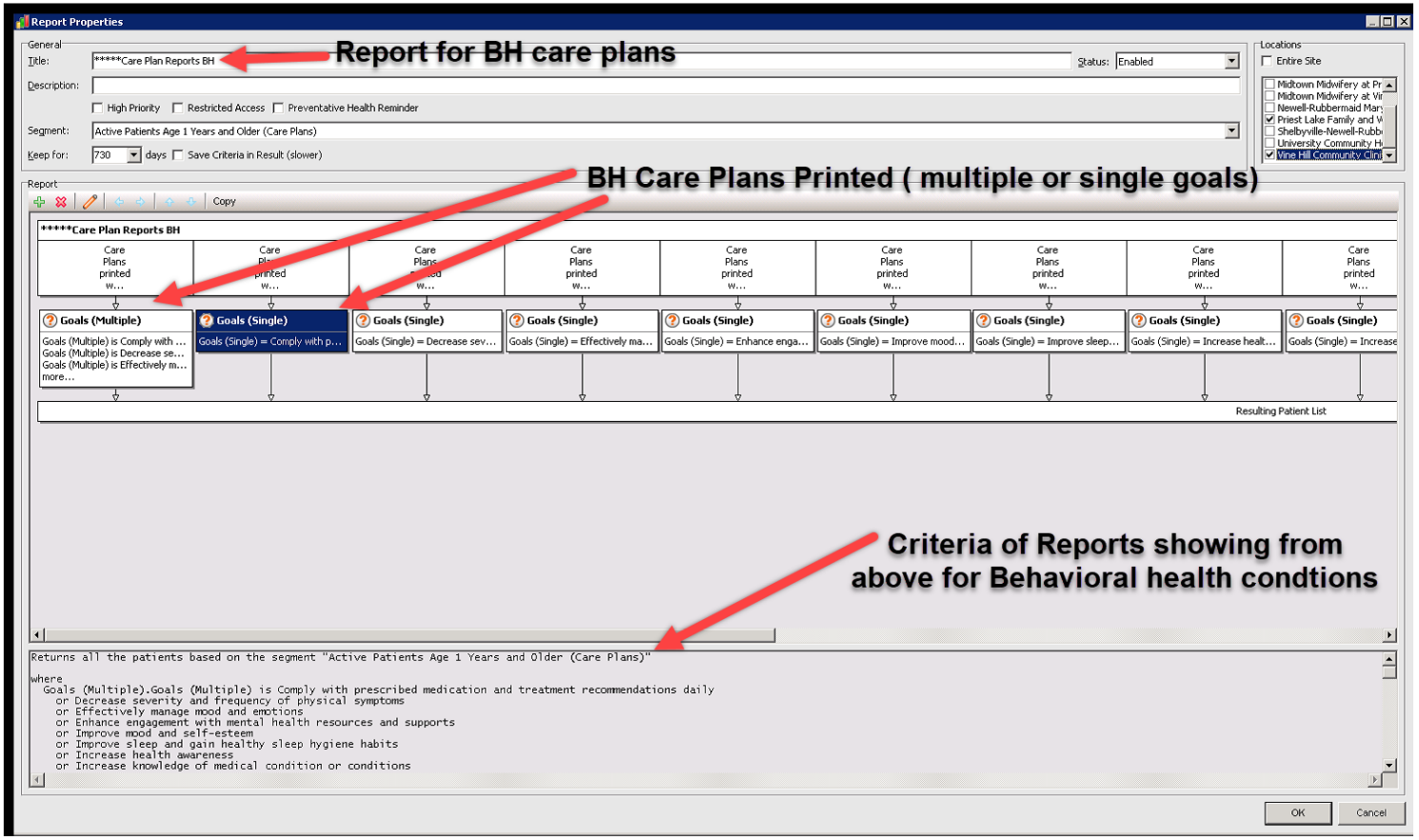
Source: Practice example

CM 04 – 08: Patient Examples cont.



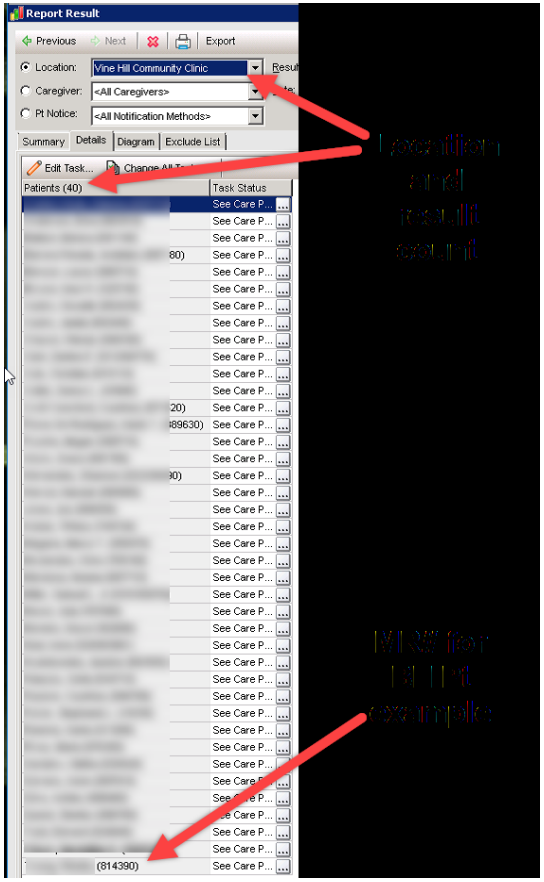
Source: Practice example

CM 04 – 08: Report
Example Behavioral Health Conditions



Source: Practice example

CM 04 – 08: Report
Example Behavioral Health Conditions



Source: Practice example

Quality Measurement and Improvement Worksheet

QI 08 – 12: Criterion

- **QI 08 (Core)** Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories:
  - Immunization measures
  - Other preventive care measures
  - Chronic or acute care clinical measures
  - Behavioral health measures

- **QI 09 (Core)** Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship:
  - Measures related to care coordination
  - Measures affecting health care costs

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

QI 08 – 12: Criterion, continued

- **QI 10 (Core)** Goals and Actions to Improve Appointment Availability:

  Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.

- **QI 11 (Core)** Goals and Actions to Improve Patient Experience:

  Sets goals and acts to improve performance on at least one patient experience measure.

- **QI 12 (2 Credits)** Improved Performance:

  Achieves improved performance on at least two performance measures.

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

QI Worksheet – Blank (QI 08, 09, 11)

Use FIVE Measures Identified in QI 08, QI 09 and QI 11		
Measure 1:	**1. Measure selected for improvement; reason for selection**	***Reason:***
	2./3. Baseline performance measurement; numeric goal for improvement ***(From QI 01, QI 02 or QI 04)***	***Baseline Start Date:*** ***Baseline End Date:*** ***Baseline Performance Measurement (% or #):*** ***Numeric Goal (% or #):***
	4. Actions taken to improve and work toward goal; dates of initiation ***(QI 08, QI 09, or QI 11) (Only 1 action required)***	***Action*:** ***Date Action Initiated*:** ***Additional Actions:***
	5. Remeasure performance ***(QI 12)***	***Start Date:*** ***End Date:*** ***Performance Re-Measurement (% or #):***
	6. Assess actions; describe improvement. (QI 12)	

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

QI Worksheet – Blank (QI 10)

Use ONE Access Measure Identified in QI 010		
Measure 1:	**1. Measure selected for improvement; reason for selection**	***Reason:***
	2./3. Baseline performance measurement; numeric goal for improvement *(QI 03)*	***Baseline Start Date*:** ***Baseline End Date*:** ***Baseline Performance Measurement (% or #):*** ***Numeric Goal (% or #):***
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 10)* ***(Only 1 action required)***	***Action*:** ***Date Action Initiated*:** ***Additional Actions*:**
	5. Remeasure performance ***Note: Continuing QI is encouraged, but is not required for QI 10.***	***Start Date:*** ***End Date*:** ***Performance Remeasurement (% or #):***
	6. Assess actions; describe improvement. ***Note: Continuing QI is encouraged, but is not required for QI 10.***	

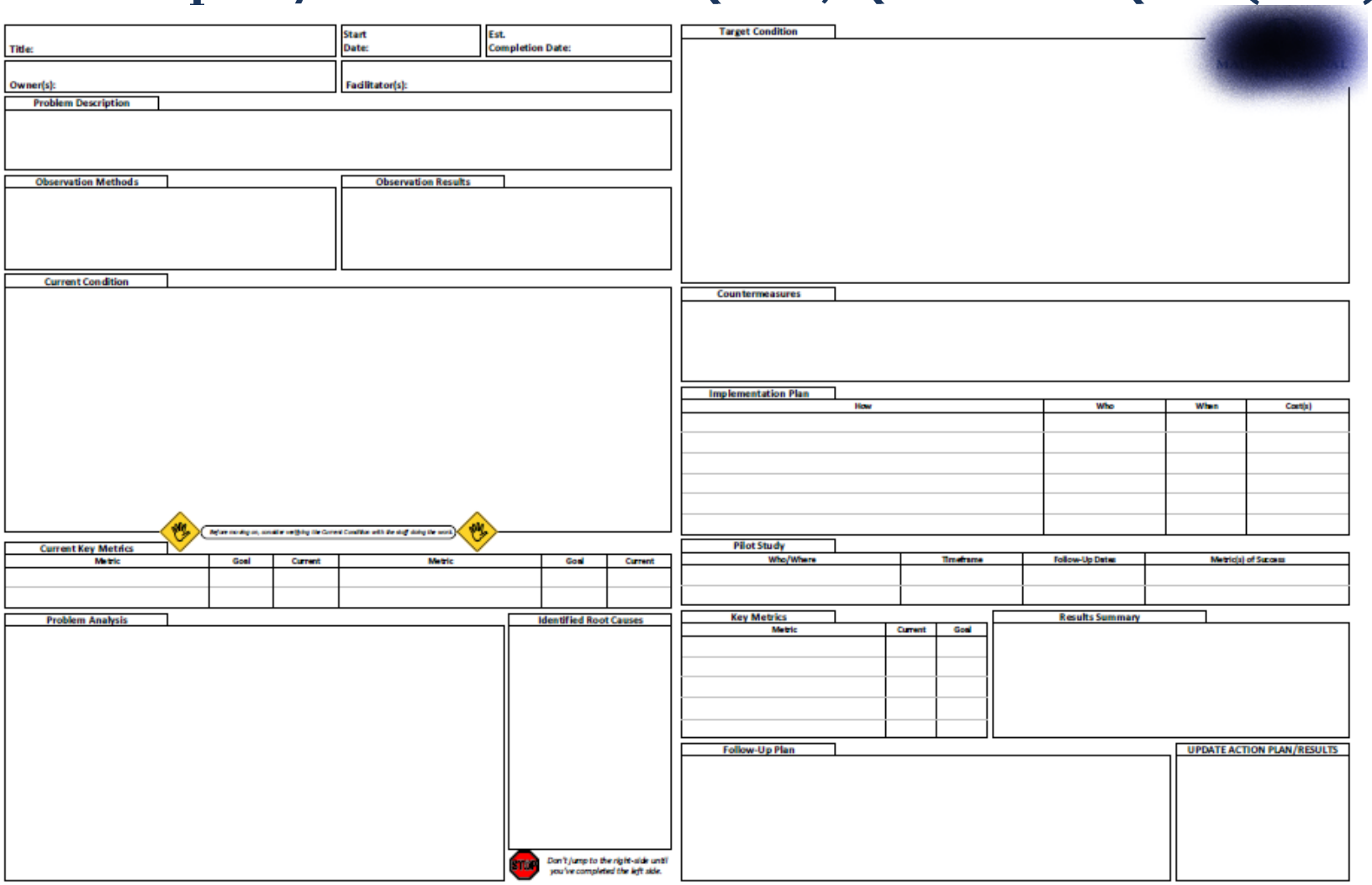
Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

Use FIVE Measures Identified in QI 08, QI 09 and QI 11 (core)
Example of a measure

Example: Clinical Measure		
Measure 1: **Colorectal cancer (CRC) screening**	**1. Measure selected for improvement; reason for selection**	***Reason:*** **The USPSTF has recommended screening for colorectal cancer as a preventive test for adults. We want to increase percentage of patients who receive screening for CRC.**
	2./3. Baseline performance measurement; numeric goal for improvement *(QI 01)*	***Baseline Start Date:*** **5/1/16** **Baseline End Date: 5/30/16** ***Baseline Performance Measurement (% or #):*** **175/547 = 32.0%** ***Numeric Goal (% or #):*** **58%**
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 08)* ***(Only 1 action required)***	***Action:*** **Pop-up reminders were added to our EMR for patients due/overdue screening** ***Date Action Initiated*****: 7/1/16** ***Additional Actions:*** **Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.**
	5. Remeasure performance *(QI 12)*	***Start Date:*** **5/1/17** ***End Date:*** **5/30/17** ***Performance Remeasurement (% or #):*** **380/550 = 69.1%**
	6. Assess actions; describe improvement. *(QI 12)*	**Since July 2016, there has been an increase of 37.1 percentage points in patients receiving CRC screening due to incentivizing providers and use of clinical decision support of EMR to indicate when patients are due for screening.**

Source: NCQA PCMH Standards and Guidelines, 2017 Edition, Version 4 (1/29/19)

Other report/document for QI 08, QI 09 and QI 11 (core)



Source: Practice example

Questions?

Collaborative Discussion

- Best Practices
- Challenges
- Novel Ideas
- Questions

Housekeeping

- Select “Everyone” and enter your question or comment
- The host will read comments from the chat box

PCMH Curriculum Module References

- Module 5A – QI 01, 02, 03, 04
- Module 5B – QI 08, 09, 10, 11, 12
- Module 9A – CM 01, 02, 03
- Module 10A – CM 04, 05, 06, 07, 08

Next Webinar

PCMH:

May 29, 2019

11am-12pm CT / 12-1pm ET

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