

# PCMH QA Education Webinar

## Questions and Answers

MAY 6, 2015

### PROBLEM LIST QUESTIONS

**Q: Does the problem list have to be inclusive of every problem, or only the chronic problem(s) being addressed or of concern to the physician and family?**

A: Yes, the problem list needs to be inclusive of the patient's significant problems that are active and relevant to the current medical care, whether they are chronic or acute.

**Q: Are there specific problems that need to be focused on within the care plans, or can the initial care plan and follow-up care plan be on a different problem?**

A: The current (active) problems need to be addressed on the initial care plan and the update.

**Q: Does the problem list have to be an actual separate list, or can the problems be identified within the notes?**

A: The problem list can be within the notes as long as it is identified as such. We do not dictate where the problem list is located, just that there is a current problem list with each care plan.

**Q: Does the initial care plan have to address all active problems or just problems addressed at that visit? Same question for the update?**

A: Yes, the problem list is all-inclusive of the patient's problems, both chronic and acute. You are treating the whole patient; all problems should be addressed on both the initial and updated care plan. The problem list shouldn't be self-limited; it should include short- and long-term management.

**Q: Does the update have to include every chronic condition on the problem list?**

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A: The problem list should be inclusive of the patient’s problems, both chronic and acute. We are treating the whole patient; therefore, their problems should be addressed in both the initial and updated care plan.

**Q: What if the patient doesn’t have a chronic condition, but is just a “frequent flyer”? We are a pediatric clinic.**

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A: I wouldn’t think the patient would be selected as a high-priority beneficiaries (HPB) patient if they don’t have the diagnosis to support it. The patient may have an underlying issue that needs treating. You need to address whatever reason the patient is being seen for on the initial care plan and the update.

**Q: This presentation seemed to imply that we needed to address these problems at every visit. Our feeling is that we should address these concerns at the care plan visit and not at each visit. Which is correct?**

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A: Best practices say that you review the entire problem list at each visit; however, for the PCMH manual requirements, you must address the patient’s current and chronic problems on the initial and updated care plan twice a year. There should be documentation to support monitoring of chronic and active problems and any changes to existing therapy that needs adjustment. Your practice would need to determine the process that works best.

## **INSTRUCTIONS FOR FOLLOW-UP**

**Q: For follow-ups, will “call in 2-3 days if not better” work?**

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A: No. The HPB would require ongoing management on a routine basis.

## **ASSESSMENT OF PROGRESS TO DATE**

**Q: If the first care plan is done for a fever, does the follow-up care plan need to be for the same diagnosis?**

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A: The care plan should address all current problems and the update needs to be the same. If the fever is still active, then it would need to be addressed. If it is resolved, then it should be listed as such.

**Q: Request for clarification: Our focus has been the chronic condition(s) which makes the patient a HPB on our care plan. If an attention deficit hyperactivity disorder (ADHD) patient is in for a sore throat, our care plan for this child would focus on ADHD, not the sore throat. Is this an incorrect approach?**

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A: Remember that the care plan doesn’t have to be completed every visit. There has to be an initial plan and an update, and for those two occurrences, all active problems need to be addressed. The problem list is inclusive of the patient’s problems, both chronic and acute.

**Q: How in-depth does the progress-to-date need to be? Is “on this medication doing well” or “on this medication, poorly controlled, blood sugars remain high” sufficient or does it need to be more in-depth?**

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A: The progress should address the stability of the current problems. It should include the controlled and uncontrolled diagnosis and what may require changes in therapy.

**Q: For integrated care measures, can we submit specialist consult notes with the care plan for QA purposes or do we have to rewrite those findings/recommendations into the care plan?**

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A: Consult notes from the specialists may be included. An example could be documented as “patient’s heart failure remains unstable and being managed by cardiology.”

**Q: What do we document in the care plan if another provider is managing a high-risk diagnosis?**

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A: The provider that chooses the beneficiary as a HPB should be the “gatekeeper” for the patient. The primary care physician (PCP) should discuss the medical problem and who is managing that care.

**Q: What specific language are you looking for in the content of a care plan? For instance, can an update for progress-to-date just be stable, unstable or no change?**

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A: There is not any specific language that we look for; we are only looking to make sure all the components are addressed. An update for progress-to-date may include stable, unstable, resolved or no change.

## CARE PLAN UPDATES

**Q: To clarify, the two updates can be done in a 12-month period that is not a calendar year?**

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A: Yes. There should be an initial care plan with one update completed within a 12 month period. If there isn’t a need for an initial care plan, then there should be two updates to that existing care plan.

**Q: With patients who do not show up for their follow-up visits, will documenting their noncompliance be enough to pass the care plan review?**

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A: If the patient doesn’t return after sufficient attempts to reach them and the documentation supports the efforts, then yes for the update. Documenting a “no show” will not be sufficient.

**Q: We were advised last year we were not able to attest with noncompliant patients. We ended at 69 percent due to multiple no-shows on care plan follow-ups. So how do we attest to these patients for 2015?**

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A: When attesting to care plans, there only has to be one update in a 12-month period. For patients that are no-shows or never come back after the initial care plan, documentation should be completed in the patient’s record regarding attempts to bring the patient back into the office. Documenting the patient’s

noncompliance will suffice as an update.

**Q: Can the updated care plan only reflect updated problems/plan of care with a reference to “see previous care plan” without having to repopulate the content?**

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A: It should be an update to the patient’s plan of care which must include all of the active problems. The plan of care isn’t just what is happening with the patient today; if the patient has diabetes on the first visit, they will still have it on the last visit, and it must be addressed.

## GENERAL CARE PLAN QUESTIONS

**Q: My understanding is that Comprehensive Primary Care Initiative (CPC) clinics do not select high-priority patients. Is this correct?**

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A: This is correct. CPC clinics do not need to maintain eligibility for practice support; therefore, these clinics are not required to complete the activities and metrics tracked for practice support.

**Q: Are we able to make changes to our HPB list, or is it set in stone after the March 31 deadline?**

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A: After the March 31 deadline, you will not be able to make changes to your HPB list.

**Q: Do you have a good care plan template I can share with my electronic medical record (EMR) team?**

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A: Please work with your practice transformation vendor to develop a template.

**Q: Where are the care plans recorded in the chart? Is it in the doctor’s encounter or should the template be separate?**

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A: We do not specify where the care plan is recorded. You can record it with the visit or use a template, whichever is easier, but all the metrics have to be included in what is submitted.

**Q: Will you use the same process when asking for random care plans? Will we be allowed to gather the charts, or do you choose the names of patients?**

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A: The process will be a random selection of the patients for whom you will need to submit care plans. The process will be shared once it has been finalized with the practice transformation vendors and reps.

**Q: After the remediation period ends Sept.30, will you be reviewing one care plan or two?**

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A: The process for the validation is still being finalized. Once it is final, we will share that information with the practice transformation vendors and provider reps to pass along to the clinics.

**Q: When will we be able to go back into the AHIN portal and indicate which patients we have care plans for?**

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A: For 2015 care plans, you may go into the portal anytime until Dec.31 to select your patients who have a care plan. If this question is referring to the 2014 care plans, due to the design of the AHIN portal, we are not able to open the 2014 data backup; therefore, you will not be able to go back and select care plans for 2014.

**Q: Have you considered doing an onsite review actually using the PCMH's EMR to ensure that absolutely all information is reviewed?**

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A: No. Because the review process is time-consuming and is also done by two different registered nurses (RNs) and then finalized by the physician (MD), so it cannot be done in the clinic.

**Q: It seems like creating a care plan is duplicating work from what a physician is already doing or elements already contained in the electronic health record (EHR). What is the intended purpose of a care plan? If we have all the information linked in our EHR, do we still need to spend time rewriting in a separate form?**

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A: The intended purpose of a care plan is to assist all who are involved in the patient's care. The goal is to document assessment and stability of active problems. The care plan doesn't have to be a separate document. If the metrics are all included in the notes or the EMR, then that is what needs to be submitted.

**Q: When you enter the AHIN portal, can you attest per care plan or do you have to attest when you have met the 80 percent?**

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A: You may attest to your care plans throughout the year; however, as of Dec. 31, you need to attest that at least 80 percent of your HPBs have a care plan in the medical record.

**Q: Does the care plan have to be generated from within the EMR?**

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A: No. We do not dictate where the care plan is generated from, only that the five specifications are all addressed.

**Q: We have an integrated electronic medical record and would like to see if auditors in the future could audit the entire medical record through access we can provide rather than us having to try and select all the components to fax or email.**

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A: As answered previously, the validation is done by three different people, so at this time that would not be possible.

**Q: Will the 2014 list be opened back up on the portal to re-attest to care plans on the 2014 patients?**

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A: No. Due to the design of the portal, we are unable to open the 2014 data. Also there is no need to attest to the 2014 care plans as we will not be looking at those any further.

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**Q: After the Sept. 30 review, will AFMC QA provide the patient name/ID and Medicaid ID?**

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A: The process has not been finalized yet, but we are working on making improvements to that process. Once the process has been finalized, we will distribute the information to the practices, practice transformation vendors and AFMC provider reps.

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**Q: How do we notify QA when an inactive patient no longer needs a care plan?**

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A: Please send QA an email at [PCMHQA@afmc.org](mailto:PCMHQA@afmc.org) letting us know the patient is inactive. You will also want to go into the portal and deselect that the patient has a care plan if you previously attested to that patient having a care plan. If you are choosing to remove the inactive patient from your caseload, please refer to Section 171.210 of the provider manual.

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**Q: If a HPB is not seen in their PCMH for the 12-month review period and the PCMH has documentation of contacting the patient to encourage an appointment, the patient no-shows and the PCMH has documentation that the HPB was contacted regarding the no-show, what would the expectation be for a care plan?**

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A: You wouldn't need to submit anything for that patient if there isn't a care plan. If a practice chooses to dismiss a HPB, the process should be followed as stated in the Medicaid manual under section 172.620

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**Q: What dates are we reviewing for this care plan review? Starting in April 2015? January 2015?**

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A: The review will be for patients seen in 2015 and the patients will be selected from those seen between June and December 2015.

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**Q: I would like to have a specific name and number to call to remove patients from list. I have called and tried, and even one particular patient died in 2013 and is still on the updated list. When is this actually supposed to be updated?**

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A: Please contact your practice transformation vendor (or AFMC provider rep if you do not have a practice transformation vendor) for assistance or refer to Section 171.210 of the provider manual.

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**Q: Will QA ask the practice at what date they implemented their new or updated care plan process and only randomly select care plans that were created after the date?**

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A: The QA will randomly select care plans for review. The dates could be anywhere from June through December.

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**Q: In pediatrics, Medicaid does not pay for a 7- or 9-year check. Should we ask patients to come in during those years or can phone calls be made?**

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A: The care plan and update doesn't have to be for the 7- or 9-year check. If the child is an HPB, I would complete the care plans on those visits.

**Q: We are developing one single document. We were confident that we had all components in the chart; however, they were in different areas and maybe not easily extracted or easily visible.**

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A: There is no specific mention in the PCMH manual that states that a care plan has to be a separate document. You must, however, be prepared to send in all documentation (no matter where it is located in the chart or EMR) to fulfill all five metrics listed in the manual.

## SCOPE OF PRACTICE QUESTIONS

**Q: Can the care plan be initiated by a physician assistant?**

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A: Yes.

**Q: We have some providers who are just starting to be all electronic or are part paper, part electronic, etc. My question is, is it ok if a licensed practical nurse (LPN) enters the care plan into the computer system as long as the provider is signing it?**

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A: The scope of practice in Arkansas doesn't support an LPN performing a patient assessment. The documentation should clearly support only appropriately licensed health providers creating the care plan.

**Q: Can care plans be entered into the EMR by a scribe/medical assistant (MA) as the MD discusses it with the patient?**

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A: The scope of practice in Arkansas doesn't support a scribe/MA performing a patient assessment. The documentation should clearly support only appropriately licensed health providers creating the care plan.

**Q: Can a paramedic initiate a care plan in Arkansas?**

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A: Please visit the website [EMS.org](http://EMS.org) for the answer to what is in their scope of practice.

**Q: If you are unable to confirm whether a scribe/MA can document the care plan while the MD is speaking with patient (rather than MD type into the EMR) how do we get the answer to this question?**

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A: You would need to go to the Arkansas state governing board for the specialty you are looking for.

**Q: I just want some clarification on what the LPN is allowed to do in regard to care plans. Can they reassess what goals have been set up?**

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A: The scope of practice in Arkansas doesn't support an LPN performing a patient assessment. The documentation should clearly support only appropriately licensed health providers creating the care plan.

**Q: Only licensed staff in Arkansas are allowed to update care plans, correct?**

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A: Please refer to the Arkansas State Board of Nursing for all rules and laws on this.

**Q: If a MD/RN/advanced practice registered nurse initiates a care plan, can a LPN do a telephone update?**

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A: The scope of practice in Arkansas doesn't support an LPN performing a patient assessment. The documentation should clearly support only appropriately licensed health providers creating the care plan.



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