PCMH QA

ARKANSAS FOUNDATION FOR MEDICAL CARE

Educational Webinar

May 6, 2015

Disclaimer

The speakers of this presentation have no financial, professional or personal conflict of interest to disclose.

Agenda

- Welcome and introductions
- Review results of Activity H: Medical Neighborhood Survey
- Update on 12-month activity validations
- High-priority beneficiary selection in AHIN
- Care plan validation results and remediation

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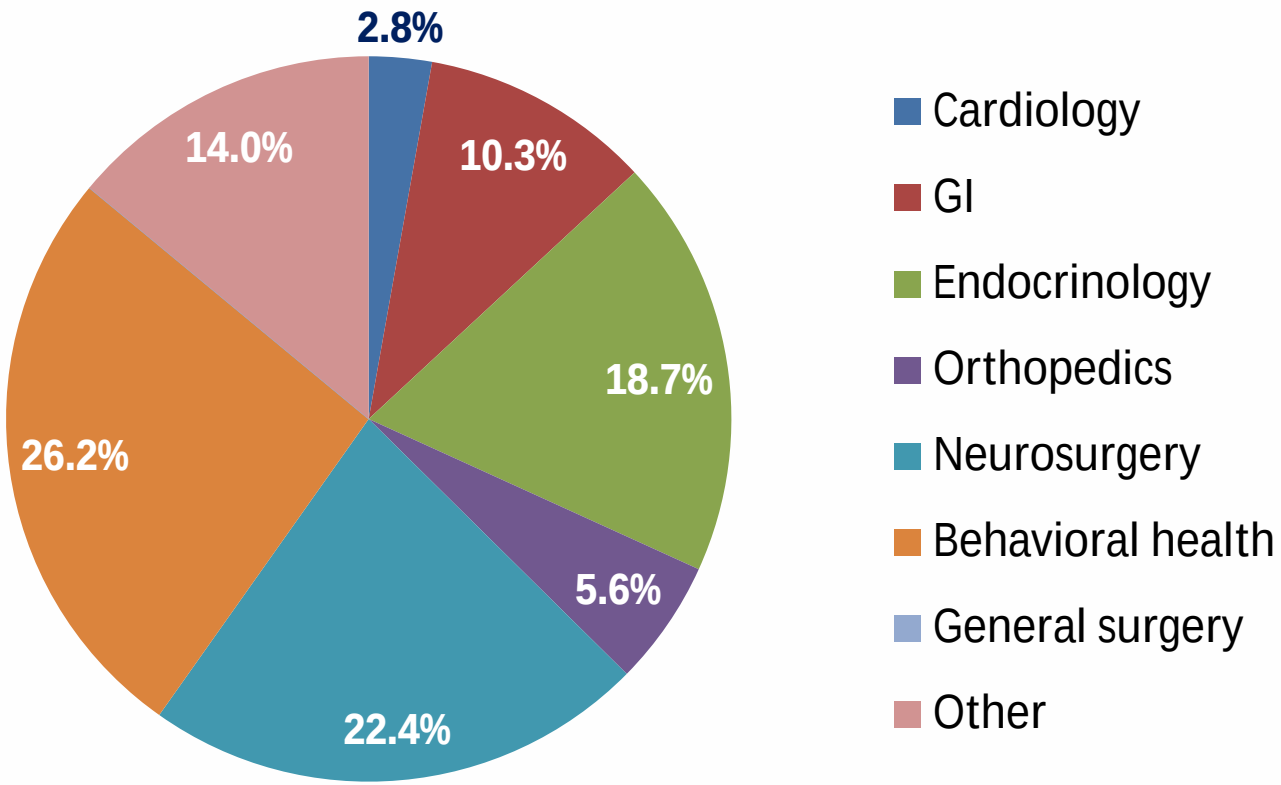
Activity H
Provider Survey Summary

Specialty-type patients have most trouble receiving timely appointments from:



How timely is communication back from the specialist?

- Specialists typically taking **less than a week**
  - General surgery (59.4%)
  - Cardiology (54.4%)
  - Orthopedics (53.3%)

- Specialists typically taking **more than a week**
  - Neurosurgery (63.5%)
  - Endocrinology (63.2%)
  - Gastroenterology (59.6%)
  - Behavioral Health (47.2%)

- 32.1% of PCMHs reported receiving **no communication** from behavioral health specialists

Top 3 methods listed for effectively overcoming the challenges/barriers

1. Change or broaden the specialists to whom you refer (72.9%)
2. Implement a referral tracking system (45.8%)
3. Assign practice personnel to obtain timely appointments for patients (43.9%)

Coordination with Behavioral Health Specialists

Top 3 barriers to effective coordination of care

1. Poor patient adherence to treatment plan/inadequate patient follow up (57.1%)
2. No communication of treatment plan from specialist to PCMH (48.6%)
3. Lack of specialist staff and time for investment in coordination (47.6%)

Top 3 methods listed for effectively overcoming the challenges/barriers

1. Assume more care of patients with behavioral health needs (55.2%)
2. Have dedicated care coordination staff in the PCMH (41.0%)
3. Connect to IT tools to share admission/discharge notices (25.7%)

Enhancing your care team

Care team member utilization

Top three used on at least a monthly basis

1. Pharmacist (86.9%)
2. Behavioral health specialists (82.2%)
3. Public health clinics (57.0%)

Top three **not** used at all

1. Faith-based organizations (69.2%)
2. Clinical educators (51.4%)
3. Community health workers(43.0%)

Care team member location

Top three care team members in-house

1. Clinical educators (30.2%)
2. Faith-based organizations (18.2%)
3. Dieticians (17.3%)

Top three care team members outside of facility

1. Community health workers and public health clinics (100%)
2. Substance use and abuse organizations (98.4%)
3. School-based health care (97.4%)

Top 3 care team members PCMHs would be willing to house

1. Clinical educators (75.7%)
2. Behavioral health specialists (71.0%)
3. Dieticians (65.4%)

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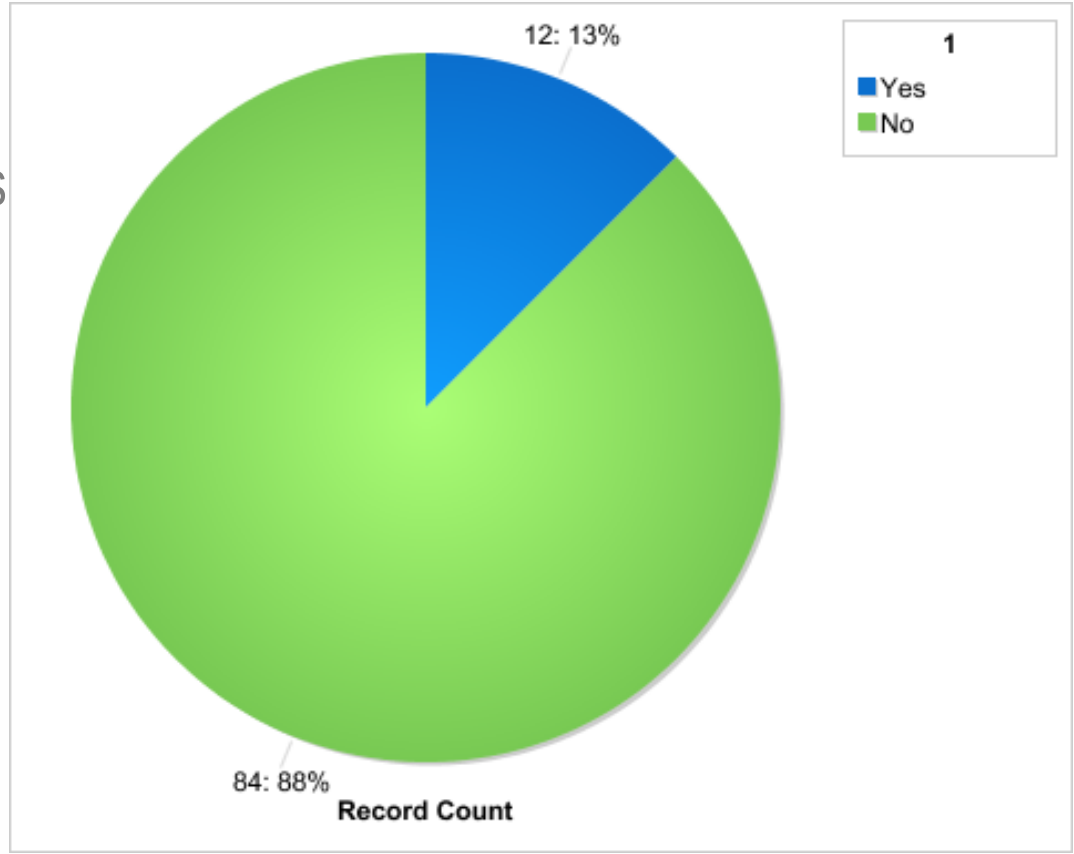
12-Month Activity Validation Update

Update on 12-Month Activity Validations

Out of 96 validations completed to-date:

- 84 passed
- 12 failed



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2015 High-Priority Beneficiary Selection

2015 High-Priority Beneficiary Selection

- Selection of the 2015 high-priority beneficiaries in the AHIN provider portal was due March 31
- Recommend that practices review their HPB list in the AHIN portal again in May to ensure the list is correct

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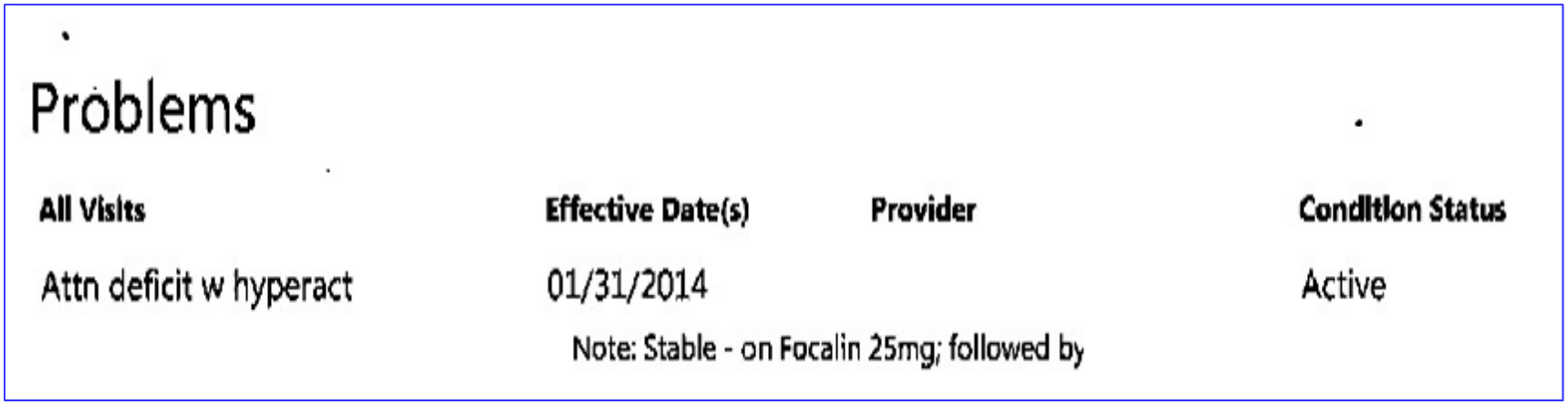
Let's talk about care plans!

Care Plan Metric (A)

- 70% of high-priority beneficiaries (identified in Section 241.000) whose care plan as contained in the medical record
  - Documentation of a beneficiary's current problems
  - Plan of care integrating contributions from health care team (including behavioral health professionals) AND from the beneficiary
  - Instructions for follow-up
  - Assessment of progress to date
  - The care plan must be updated at least twice a year

Documentation of a beneficiary's current problems

- Each visit-related encounter document should include a list of current problems
- **Pass Example:**



Problems

All Visits	Effective Date(s)	Provider	Condition Status
Attn deficit w hyperact	01/31/2014		Active
	Note: Stable - on Focalin 25mg; followed by		

Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary.

- A visit-related encounter should include an entry that clearly summarizes the plan of care for the patient
- The problem assessment of diagnosis from the current problems could be included in the visit note or as a stand-alone documentation in a separate care plan template
- **Example Pass:**

S: This 9 year 8 month old female presents for follow-up of hospitalization at ACH for kidney stones.
History of kidney stones x 2 years. She had urologic procedure 8/6 - cystoscopy with bilateral ureteral stent placement and kidney stone removal.
Discharged home of Keflex and Ditropan. Returns in September for another urologic procedure.
Since discharge she has done okay. She had vomiting last night, she finally had large BM this morning.
Gross hematuria but is getting some lighter, parents were told gross hematuria would last 1-2 weeks post-procedure.
Returns to ACH tomorrow for appointments at Pulmonology and Ortho Spine clinics

Instructions for Follow-up

- Encounter/office visit should contain documentation that mentions future visit that is linked to a problem(s) that is under management
- The documentation should include a future visit linked to the problem
- **Pass Example:**

  Follow up in 1 month for AIC

  Follow up for WCC in 1 year
- **Fail Example:**

  Follow up PRN or as needed

  Follow up for worsening symptoms

Assessment of Progress to Date

- The encounter document should contain a problem-based assessment for all current and chronic problems.
- Documentation should include reference to the problem stability (ex.: improving, deteriorating, stable or resolved)

- **Example Pass:**

ASSESSMENT/PLAN:
1.HTN: elevated- Lisinopril 40 , Amlodipine 5 , Coreg 12.5 bid
-doing well .

2.HL: LDL 121, On statin prava 40
-- time for lipid checks.

3.DM: al c 12.6 , much bettter sugars now

4.TIA:no further symptoms

5. Palpitations: Holter monitor Shows that he has occasional pvcs , occasional bigeminy

Care plan must be updated at least twice a year

- There must be an initial care plan on the patient which includes all of the required components.
- There then needs to be an update to that care plan within 12 months. It doesn't have to be within the same calendar year.
- **Example: Initial care plan completed on 10/13/14 and update on 2/7/15.**
- The care plan can be initiated by the MD, APN or the RN.
- The update can be done in person or by phone.

Example of Care Plan Template

Date:	8/06/2014	10/03/2014
Diagnosis (Current Problem)	ADHD	ADHD
Phase of Care (Assessment of problem to date)	Follow-up Mom states the child is doing well in school. Starting 7th Grade Blytheville Middle School.	Follow-up Child has had school detention 3 x's in a week. Teachers feel his RX dosage needs to be increased
Medications (Current and any changes @ this visit)	Vyvanse 40 mg PO QD increased to 50 mg PO QD for one month	Vyvanse 40 mg PO QD increased to 50 mg PO QD Mother was advised to supervise pt's RX intake and ensure compliance. Mother was also counseled that PT needs to be wearing his glasses at all times as prescribed by Optometrist
Disciplines (Include contributions from beneficiary & family)	APRN Mother given Conner's forms to complete and have completed by school. Mother to contact Dr. Karen and let her know how the child is doing on Vyvanse 40 mg PO QD.	APRN Mother to contact Provider in 1 week to discuss any complications & decreased symptoms on new dosage of Vyvanse
Future Tests (Plan of care-follow-up)	Mother to return forms to clinic as soon as possible	Mother was advised to supervise pt's RX intake and ensure compliance. Mother was also counseled that PT needs to be wearing his glasses at all times as prescribed by Optometrist
Status	Stable	Exacerbation - If new dose is effective, pt is to follow up in 3 months.

Recommendations

- The deadline for all improvements to be implemented is September 30, 2015.
- There is not a need to correct any care plan that failed. The goal is for you to correct your processes not the previous care plans.
- If a template can be used, it is the best practice. You could work with your EHR vendor for possible upgrades or help with a template format.

Remediation Period

Section 243.000 of the PCMH provider manual states that, with regards to metrics tracked for practice support, practices must remediate performance before the end of the second full quarter after the date the practice receives notice that the target(s) have not been met

- Practices received notice of validation prior to April 1
- Practices must remediate care plan performance prior to September 30

Revalidation

- Will begin after September 30.
- Random selection of care plans will be obtained from each PCMH. They will be reviewed to determine if they pass or have still have deficiencies.

Questions?

CME for Attending

Accreditation Statements

Application for credit has been submitted to the American Academy of Family Physicians. Determination of credit is pending.

UAMS Department of Family and Preventive Medicine is an approved provider of continuing nursing education by South Central Accreditation Program, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

To receive your CME, please complete the program evaluation

Your certificate will be emailed to the address that you used for registration once the evaluation is complete.

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Thank you for attending!