Purpose of the Record Review Workbook (RRWB)

There are three elements in PCMH 2014 that require an accurate estimate of the percentage of patients for whom practices have documented the required information in the medical records of patients.

- **PCMH 3C – Comprehensive Health Assessment**
- **PCMH 4B – Care Planning and Self-Care Support**
- **PCMH 4C – Medication Management**

There are two methods for collecting data for these elements.

Method 1. Query your electronic medical records or other electronic patient records to obtain the information, via report of at least three months of recent data.

Method 2. Review of sample of 30 patient records selected per NCQA criteria to obtain the information. (Note: patient records may be a registry or electronic records or paper medical records).

Refer to each element in the PCMH 2014 Standards and Guidelines for details about scoring PCMH 3C, PCMH 4B and PCMH 4C.

If you use Method 1 (described above) to respond to these elements, you can enter the responses directly into the Survey Tool and you do not need to use/complete the RRWB.

If you cannot use Method 1, you must use Method 2 to response to these elements. You must fill out the Patients Conditions and Record Review Worksheets.

You may respond to some elements with Method 1 and others with Method 2. Similarly, you may respond to some factors with Method 1 and others with Method 2 within the same element. In that case, you will indicate “See Report” in the RRWB for those factors for which you are submitting a report (Method 1).

**PCMH 3C – Comprehensive Health Assessment**

To understand the health risk and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Age- and gender appropriate immunizations and screenings
2. Family/social/cultural characteristics
3. Communication needs
4. Medical history of patient and family
5. Advance care planning (NA for pediatric practices)
6. Behaviors affecting health
7. Mental health/substance use history of patient and family
8. Development screening using a standardized tool (NA for practices having no pediatric patients)
9. Depression screening for adults and adolescents using a standardized tool
10. Assessment of health literacy

In addition to a physical assessment, a standardized, comprehensive patient assessment includes an examination of social and behavioral influences. The practice determines how frequently it updates the health assessment, using evidence-based guidelines. Patients with an active diagnosis should be reassessed at each relevant visit.

The practice should consider how its comprehensive health assessment helps establish criteria and supports a systematic process for identifying patients who may benefit from care management (PCMH 4).

Review the patient records selected for the medical record review (as required in elements PCMH 4B and PCMH 4C) and document the presence or absence of the information in the RRWB. For each factor to which the practice responds “yes” provide one example of how the practice meets the factor. For each factor, the practice must respond “yes” to more than 50% of the records reviewed.

1. Age- and general appropriate immunizations and screenings – the practice implements age/gender appropriate immunizations and screenings recommended by an evidence-based resource, for example
   - US Preventive Services Task Force (USPSTF)
   - Centers for Medicare & Medicaid Services (CMS) in Provider Quality Reporting System (PQRS)
   - NCQA’s Child Health measures
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
   - Health Resources and Services Administration (HRSA)
   - Bright Futures for pediatric patients

2. Family/social/cultural characteristics – the health assessment includes an evaluation of social and cultural needs, preferences, strengths and limitations. Examples of these characteristics include:
   - Family/household structure
   - Support systems
   - Household/environmental risk factors
   - Patient/family concerns
   Broad considerations should be made for a variety of characteristics (eg, poverty, homelessness, unemployment, sexual orientation, gender, education level, social support)

3. Communication needs – the practice identifies if the patient has specific communication requirements due to hearing, vision or cognition issues. This does not address language, which is addressed in PCMH 3A-5.

4. Medical history of patient and family – family medical history (eg, history of chronic disease or even [diabetes, cancer, substance abuse, hypertension]) for “first degree” relatives (ie, those
sharing 50% of their genes). The practice may document “unknown” for patients who do not know their medical history.

5. Advance care planning – the practice documents patient/family preferences for advance care planning (ie, care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet this requirement. Documentation that the patient declined to provide information counts toward the numerator. For pediatric practices document “NA” in this field, and provide a written explanation for the NA response in the Support Text/Notes box in the Survey Tool.

6. Behaviors affective health – assessment or risky and unhealthy behaviors goes beyond physical activity and smoking status; it may include nutrition, oral health, dental care, familial behaviors, risky sexual behavior and secondhand smoke exposure.

7. Mental health/substance use history of patient and family – the practice assesses whether the patient and the patient’s family has mental health/behavioral conditions or substance abuse issues (eg, stress, alcohol, prescription drug use, illegal drug use, maternal depression).

8. Developmental screening – for newborns through 3 years of age, periodic developmental screening uses a standardized screening test. If there are no established risk factors or parental concerns, screens are done by 24 months. For adult practices, document “NA” in this field, and provide a written explanation for the NA response in the Support Text/Notes box in the Survey Tool.

9. Depression screening for adults/adolescents – the US Preventive Services Task Force (USPSTF) states that adults and adolescents should be screened for depression when the practice has access to services that can be used if there is a positive result (eg, mental health providers in the practice or external to the practice to whom the practice can refer patients). This factor is not met if the practice does not screen for depression or if the screening is not performed with a standardized tool.

10. Assessment of health literacy – the practice assesses the patient/family/caregiver’s ability to understand the concepts and care requirements associated with managing their health. Alternatively, the practice demonstrates it is a health literate organization (eg, apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels, utilize AHRQs or Alliance for Health Reform’s Health Literacy toolkit, etc.).

**PCMH 4B – Care Planning and Self-Care Support (MUST PASS)**

The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified as “high risk” (PCMH 4A) who may benefit from care management:

1. Incorporates patient preferences and functional/lifestyle goals
2. Identifies treatment goals
3. Assesses and addresses potential barriers to meeting goals
4. Includes a self-management plan
5. Is provided in writing to the patient/family/caregiver, and is tailored to account for health literacy and language considerations

Review the patient records selected for the medical record review and document the presence or absence of the information in the RRWB. For each factor to which the practice responds “yes” provide one example of how the practice meets the factor. For each factor, the practice must response “yes” to more than 75% of the records reviewed.
The care team and patient/family/caregiver collaborate on developing and updating an individualized care plan that addresses whole-person care. The care plan specifies the services offered by and responsibilities of the primary care practices and, if appropriate, integrates with a care plan created for the patient by a specialists, to avoid potential overlap or gap in care.

A care plan considers and/or specifies various areas related to a patient’s care, which could include:

- Patient preferences and functional/lifestyle goals
- Treatment goals, developed on evidence based guidelines
- Assessment of potential barriers to meeting goals
- Care team members, including the primary care provider of record and team members beyond the referring/receiving providers
- Current problems (may include historical problems, at the practice’s discretion)
- Current medications
- Medication allergies
- A self-care plan that includes goals and a way to monitor self-care

The care plan should be reviewed and updated at relevant visits. A relevant visit addresses an aspect of care that will affect progress toward meeting existing goals or that requires modification of an existing goal.

**PCMH 4C – Medication Management**

The practice has a process for managing medications, and systematically implements the process in the following ways:

1. Reviews and reconciles medications for more than 50% of patients received from care transitions
2. Reviews and reconciles medications for more than 80% of care transitions
3. Provides information about new prescriptions to more than 80% of patients/families/caregivers
4. Assesses understanding of medications for more than 50% of patients/families/caregivers, including date of assessment
5. Assesses response to medications and barriers to adherence for more than 50% of patients, including date of assessment
6. Documents over the counter medications, herbal therapies and supplements for more than 50% of patients, including date of assessment

Review the patient records selected for the medical record review and document the presence or absence of the information in the RRWB. For each factor to which the practice responds “yes” provide one example of how the practice meets the factor.

- The practice reviews and documents in the medical record all prescribed medications the patient is taking. Medication review and reconciliation reduces the possibility of adverse drug events.
- The practice provides patients with information about new medication, including potential side effects, drug interactions, instructions for taking medication and the consequences of not taking it.
- The practice assesses how well patients understand information about the medications they are taking, and considers a patient’s health literacy.
• The practice asks patients about problems or difficulty taking medication, whether they are experiencing side effects and whether the medication is being taken as prescribed.

• At least annually, the practice reviews and documents in the medical record nonprescription medications, such as over-the-counter medications, herbal therapies and supplements to prevent interference with prescribed medication and to evaluate potential side effects.

The same patient records are examined for the medical record review in PCMH 3 – Comprehensive Health Assessment; PCMH 4B – Care Planning and Self-Care Support; and PCMH 4C – Medication Management.

The 30 patients (per practice) are selected for record review from the list of patients identified as “high risk” and who may benefit from care management in PCMH 4A – Identify Patient for Care Management.

Select Patient Records for Review
Identify patients for care management (PCMH 4A). The intent of the element is that practices use defined criteria to identify true vulnerability – a single criterion, such as cost, may not be an appropriate indicator of need for care management.

The practice establishes a process and criteria for identifying patients, including consideration of: behavioral health conditions, high cost/high utilization, poorly controlled or complex conditions, social determinants of health and/or referrals by outside organizations (eg, insurers, health system, ACO, practice staff or patient/family/caregiver).

The practice selects 30 patients identified as appropriate for care management and who had a care visit related to the selection criteria defined in PCMH 4A. These will be the patients used in the medical record review.

The patients are selected based on visit date. Go back one month in the visit scheduled before the date of the record review and choose the weekday nearest that date. Going backward in the visit schedule from that date, select the first 30 patients who meet the criteria from PCMH 4A and who had a care visit related to one or more of the selected criteria.

*** Any other method of random selection of patients must be pre-approved by NCQA. ***

Create and keep a list of patients using unique identifiers you use internally. Create a list and number the patients you have selected with the criteria sequentially from 1 to 30. Patients are entered in the Record Review Worksheet in this order.

**IMPORTANT: KEEP THIS MASTER LIST IN CASE YOUR PRACTICE IS AUDITED, BUT DO NOT SEND IT TO NCQA**

Data Collection Period
The practice may go back 12 months (with a 2-month grace period) for documentation of each item in the patient’s medical record.

**Review Patient Records**

Entries in each worksheet cell must be made by entering a valid response:

- Yes = appropriate information present in the patient’s medical record
- No = information not present in the patient’s medical record
- Not Used = practice does not document this information (when selecting “not used” as a response always select it in the first patient row in the sample); Not Used scores as a “no”
- Not Applicable = this is only available for specific factors in PCMH 3C or PCMH 4C. You must provide a written explanation for an NA response in the Support Text/Notes box in the Survey Tool. Not Applicable scores as a “yes”.

The RRWB is color coded:

- Gray shading indicates that no input is required – you cannot enter data in these cells
- White (or no) shading indicates that input is required

Download the RRWB from the Survey Tool and save it to your computer with a new name (the practice name and date, for example).

Decide and indicate which of the three elements you will document using the RRWB.

Select the patient records to review using NCQA’s sampling method (see “Select Patient Records for Review” above).

Review the patient records, fill out the Patient Conditions Worksheet and record responses in the RRWB for each applicable factor and element.

Record the “yes” or “no” response for each factor. The percentage will be calculated at the bottom of the workbook page.

**PCMH 3C – Comprehensive Health Assessment**

Review each patient record for documentation for each of the 10 factors. The factor may be documented in the record anytime in the previous 12 months (for example, if the health assessment is done at an annual well visit).

**PCMH 4B – Care Planning and Self-Care Support**

Review each patient record for documentation of each of the 5 factors. The care plan should be reviewed and updated at each relevant visit, no less than once a year. The factor may be documented in the record anytime in the previous 12 months.
**PCMH 4C – Medication Management**

Review each patient record for documentation of each of the 6 factors. Medication reconciliation should be done at each transition of care and any relevant visit, no less than once a year. The factor may be documented in the record anytime in the previous 12 months. Factor 1 is a critical factor (medication reconciliation for at least 50% of patients received from care transitions) whereas Factor 2 is the same measure but with a higher threshold (medication reconciliation for at least 80% of patients received from care transitions).

Because Factor 1 is aligned with Meaningful Use requirements, a report could meet the documentation for factors 1 and 2. In this case “See Report” should be indicated in the RRWB for these factors.

The RRWB calculates the percentage of records meeting the criteria (ie, the percentage with a “yes” or “not applicable”) and will indicate if each factor meets NCQA requirement’s based on the calculated percentage in the “results” row.

Link the completed RRWB to the elements (PCMH 3C, PCMH 4B and PCMH 4C) in the Survey Tool.