Appendix 3
Record Review Workbook Instructions

APPENDIX 3

NCQA'S PCMH RECORD REVIEW WORKBOOK GENERAL INSTRUCTIONS

Purpose of the Record Review Workbook

There are several assessment areas in PCMH that require an accurate estimate of the percentage of patients for whom the practice has documented the required information in its medical records. 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 would benefit from care management. The criteria included in this worksheet are PCMH CM 04-08. These criteria 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.

Refer to each criterion in the PCMH 2017 Standards and Guidelines for details about scoring.

There are two methods for collecting data for these criteria

Method 1 **Query your electronic medical records** or other electronic patient records to obtain the required information.

Method 2 **Review a sample of 30 patient records** to obtain the information.
Note: *Patient records may be a registry or electronic records or paper medical records.*

If you can use Method 1 (above) to respond to these criteria, you can enter the reports directly in Q-PASS and you do not need to use this Record Review Workbook. If you cannot use Method 1, you must use Method 2 to respond to these criteria and must complete the Record Review Workbook and provide examples to meet the criteria. You may respond to some criteria with Method 1 and others with Method 2. If using a combination of Method 1 and 2, for criteria where Method 1 is used, select "See Report" (see more below).

General Notes on the Record Review Worksheet

Entries in each worksheet cell must be made by either typing in a valid response or choosing a valid response from the cell's drop-down list. To see the drop-down list for each cell, click the down arrow that appears to the right of a cell when a cell is selected. Depending on the cell, valid responses may include the following.

- **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 use or does not document this information in any patient medical record (i.e., CM 06).
  - When selecting the "Not Used" response, always select it in the first patient row in the sample (row 12). "Not Used" scores as "Not Met."
- **See Report** = Practice is submitting an electronic report for documentation for this criterion and is uploading it to the document library in Q-PASS and linking to this report in Q-PASS. "See Report" scores as a "no" in the workbook. Only select this option if providing alternate documentation outside the workbook to meet the criteria.

The Record Review Workbook is color coded for your input as follows.

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

The Record Review Workbook is protected from inappropriate input; inappropriate entries are indicated by error messages.

To delete the contents of a cell, use the Backspace or Delete key. ***Do not use the space bar to empty the contents of a cell as it is an invalid entry and may prompt an error message.***

Instructions Overview

1. Download this file and save it to your computer with a new name of your choice. Your practice name and date are good naming conventions.
2. Decide and indicate which of the criteria you will document using this file. ***Remember:*** **PCMH CM 04 and CM 05 are Core criteria. Your practice must use one of the two methods in the Explanation to document performance for these criteria.**
3. Select the patient records to review using NCQA's sampling method. See "Step 3" below.
4. Review the patient records and record responses in the Record Review Workbook for each applicable criterion.
5. Record the "Met" response for each criterion in Q-PASS for which the workbook is the evidence for CM 04-08.
6. Attach the Record Review Workbook to the criteria in Q-PASS for which you used the Record Review Workbook. Once you have attached the workbook for one criterion, such as PCMH CM 05, you may use the options in Q-PASS to link it to the other criteria assessed in the Record Review Workbook.

How to Fill Out the Record Review Workbook

Step 1 **Download and save this file with a new name of your choice.**

We recommend that you name the file with your practice name and date.

Step 2 **Decide if you will use the Record Review Workbook to document information for Care Plan Management (CM 04-08).**

This assessment requires the practice to respond **YES or NO** that information was found clearly documented in the medical record for specified patients.

Important: *If you are not going to use the Record Review Workbook for a particular criterion, go to row 12 in the worksheet, click the drop-down box in row 12 and select "Not Used" OR "See Report" for that column for that criterion. This will gray the column and indicate to NCQA that you are not going to use the worksheet for that criterion. "Not Used" and "See Report" are scored as "Not Met."*

Note: *See the NCQA PCMH Standards and Guidelines for documentation requirements for each criterion. For practices using the Record Review Workbook for CM 04-08, an example for each criterion is required. The example shows how the practice documents the content of a criterion for patients in their medical record and can be demonstrated during virtual review.*

Step 3 **Select patient records for review.**

1. **Identifying Patients for Care Management (PCMH CM 01)**
   The intent of the criterion is that the practice uses defined guidelines to identify true vulnerability—a single indicator, such as cost, may not be an appropriate indicator of need for care management.

   Although patients can be identified for care management by diagnosis or condition, the emphasis of care must be on the whole person over time and managing all of the patient's care needs. The practice adopts evidence-based guidelines and uses them to plan and manage patient care.

   The practice may identify patients through a billing or practice management system or electronic medical record; through key staff members; or through profiling performed by a health plan, if profiles provided by the plan represent at least 75 percent of the patient population.

   The practice considers how its comprehensive health assessment (PCMH KM 02) supports establishing criteria and a systematic process for identifying patients for care management.

   The practice must include at least three options outlined in CM 01 for identification of patients for care management. A patient may fall into more than one option (A–E) and may be included in some or all of these counts. The practice uses these options to create a registry of patients identified as likely to benefit from care management. There may be more than one set of processes and criteria to identify specific types of patients.

2. **Number of Patients**
   You will be selecting 30 patients identified as appropriate for care management and who had a **care visit related to the selection criteria defined in PCMH CM 01**. These will be the patients reviewed in your medical record review. You will review the same 30 patient files for all criteria using the Record Review Workbook. There must be a total of 30 patients.
   The identified health indicators for the patients in the sample must match those identified in PCMH CM 01.

3. **Patient Selection**

   Using Visit Date: Choose patients meeting the health indicators from PCMH CM 01, based on visit dates. Go back one month from the date you are selecting your patient sample and choose the weekday nearest that date. Select the first 30 patients who meet the health indicator from PCMH CM 01 and who had a care visit related to any one or more of the selected health indicators. Continue to go back one day at a time until you have identified 30 patients for your sample.

   Using Another Method of Random Selection: Any other method of random selection of patients must be preapproved by NCQA. The requisite number of 30 patients still applies.

4. **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 for PCMH CM 04-08. The practice determines how often information is updated in KM 02 based on evidence-based guidelines.

5. **Create and Keep a List of Patients**
   Using any unique identifiers, you use internally, create a list and number the patients you have selected with the criteria sequentially from 1-30. Patients can be entered in the Record Review Worksheet in this order.

   Important: *Keep this master list for the virtual check-in on these criteria, but do not send it to NCQA.*

Step 4 **Review the patient records and enter responses in the Record Review Worksheet.**

1. Fill out patient data in the Record Review Worksheet

Yes: If the patient's medical record has documentation for the criterion choose "Yes" (from the drop-down list in each cell) for each criterion that has documentation. If the practice documented "none" or "not indicated" in the patient record it can be counted as a "Yes" response).

No: Type or choose (from the drop-down list in each cell) "No" in the Column when there is no documentation in the medical record specific to the criterion.

Not Used: Review the list of criteria and determine if there are any that your practice does not use. If your practice does not use a particular criterion, choose (from the in-cell drop-down list) "Not Used" in row 12 (patient #1) to blank out the entire column. "Not Used" is tallied as a "no" response for all patients. The column will turn gray.

See Report: Review the list of criteria and determine if there are any that your practice can generate an electronic report illustrating it meets the requirement. If your practice will generate an electronic report for a particular criterion, choose (from the in-cell drop-down list) "See Report" in row 12. (patient #1) to blank out the entire column. "See Report" is tallied as a "no" response for all patients. The column will turn gray.

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Review each patient medical record for documentation for each of the 5 criteria. Enter responses in the appropriate worksheet cell. Documentation found in the medical record determines the percentage of the selected patients that meet each of the criteria. The practice will then indicate Met or Not Met in Q-PASS for each of the 5 criteria. If your practice does not use a particular criterion for any patients, choose (from the drop-down list) **Not Used** in row 12 (patient #1) to blank out (gray) the entire column. **Not Used** is tallied as a **Not Met** response for all patients. If your practice will generate an electronic report to demonstrate it meets a particular criterion, chose (from the drop-down list) **See Report** in row 12 (patient #1) to blank out (gray) the entire column.

NOTE: CM 04 and CM 05 are Core *and thus required to be consistently documented for patients identified for care management for the practice to receive recognition.*

Step 5 **Link the Record Review Workbook to the Criteria in Q-PASS.**

Link the Record Review Workbook to the first criterion chosen in step 2 for which you entered data, then link it to each of the other criteria for which you entered data:

1. Go to the first criterion in Q-PASS for which you have used the Record Review Worksheet.
2. Click the *Documents* button.
3. Select and click the Link Document option.