COLORADO MEDICAID
PRIMARY CARE PHYSICIAN PROGRAM
EXTERNAL QUALITY REVIEW FOCUSED STUDY
LEGISLATIVE SUMMARY

August, 2000

Prepared by First Peer Review of Colorado
For the State of Colorado
Department of Health Care Policy and Financing

This study is in partial fulfillment of a contract between First Peer Review of Colorado (FPRC) and the Colorado Department of Health Care Policy and Financing ("the Department" or HCPF) to evaluate the quality of health services provided to Medicaid clients in Colorado. The purpose of this study was to examine aspects of the Colorado Medicaid Primary Care Physician Program (PCPP) including physician adherence to program requirements. The PCPP is an important part of Colorado's current efforts to control utilization, improve the quality of the care, and provide Medicaid beneficiaries with a primary provider.

The purpose of the PCPP, according to the 1995 Colorado Primary Care Provider Protocol, is to provide "…a health care delivery system that requires a physician gatekeeper to assume responsibility for the provision and coordination of primary medical services to Medicaid eligible recipients." As of January 1, 2000, all Colorado Medicaid beneficiaries must participate in the PCPP or enroll with a Medicaid Managed Care Organization (HMO), unless they have exempt or voluntary enrollment status. Twenty-one percent (21%) of all Colorado Medicaid clients were enrolled in the PCPP as of September 1, 1999.

This study examines three aspects of the PCPP: access to care, quality of care, and provider adherence to PCPP guidelines; each designed to evaluate different aspects of the PCPP. Table 1 presents an overview of the three study areas that will be addressed, the corresponding study question(s), and the method of data collection for each part.

Table 1. PCPP Study Components

PART	STUDY QUESTION	DATA COLLECTION METHOD
I. Access to PCP	Are PCPP providers available on a 24 hour a day, 7 days a week basis?	Telephone Survey
II. Quality of Care	Do PCPP providers' medical records conform to medical record keeping quality standards?	Medical Record Review
	Is care management documented in the client's medical record as needed?	Medical Record Review
III. Provider Compliance with PCPP Guidelines	Do PCPP provider office processes and protocols facilitate adherence to PCPP guidelines?	On-site Review

Population

To enhance the efficiency and representativeness of the sampling design, the population for this study was all primary care physicians with 25 or more clients enrolled in the program as of September 1, 1999. This criterion was met by 431 PCPs.

PART I. ACCESS TO PCPS

Part I of the study was designed to analyze the availability of participating providers. The PCPP requires provider availability twenty-four (24) hours a day, seven (7) days a week (24/7). The guarantee of twenty-four (24) hour accessibility may be an important element for encouraging Medicaid clients to rely more on their PCP and less on emergency departments to obtain primary care services, according to Flanagan (1997). This study question was designed to determine if specific Medicaid requirements are being met:

Study Question #1: Are PCPP providers available twenty-four (24) hours a day, seven (7) days a week?

Survey Process

Telephone surveys were conducted to assess telephone coverage, medical accessibility, and provider backup for the sampled PCPs. Each sampled PCP' s office was randomly assigned a time period during which an FPRC staff member placed a telephone call to the contact number provided by HCPF. Time periods for placing the calls represented time frames in which providers' offices are generally closed, during which they rely on an alternative method, such as voice messages or an answering service, to receive client calls.

FPRC obtained the providers' information (name, address, and telephone number) for this study from the HCPF database during February and March 2000. FPRC called each provider sampled for this study to verify provider information. In an oversampling of 140 PCPs, a total of 117 phone numbers and contact information were verified.

PART I—RESULTS

Of the 117 calls placed, 114 were answered either by direct voice contact or by a recorded voice message, one was a wrong number, and two numbers were not answered. The breakdown of the method of response is as follows (Table 2):

Table 2. Telephone Survey Response

Method of response	Number of Providers	% of total providers
Direct Voice Contact (answering svc, PCP, mid-level)	67	57.3
Recorded Message	47	40.2
Wrong Number	1	0.8
No Answer	2	1.7
Total	**117**	**100%**

Direct Voice Contact

Of the 67 practices with an initial direct voice contact:

- 62 were answering services;
- 3 were answered directly by the PCP his or herself; and
- 2 were contacts with a nurse or other mid-level provider.

Upon identifying direct contact with the 62 answering service respondents or 2 mid-level providers, that is, when contact was with other than the PCP directly, the reviewer then inquired as to the arrangements in place to contact the PCP or other on-call physician. All 64 respondents reported that the provider on-call would be contacted by the answering service and would, in turn, contact the client directly.

Of the 62 answering service respondents, 17 refused to continue the survey, even though the answering service indicated that the provider on-call would be contacted by the answering service and would, in turn, contact the client directly. As a courtesy, no further attempts were made to contact these on-call providers.

Based on the survey protocol, on-call coverage was confirmed for the remaining 45 answering service respondents continuing the survey as follows (Table 3):

Table 3. Answering Service Response to Call Coverage for On-Call Provider

# of respondents	% of total (62)	Provider for Call Coverage
39	62.9	PCP or other provider in practice
5	8.1	Nurse or other mid-level practitioner*
1	1.6	PCP and advice nurse

*access for the mid-level provider was confirmed

Voice Messages

The 47 voice messages were reviewed for detailed instructions to determine if the PCP could be accessed by following the instructions and to determine if insufficient information was provided (indicated by * and ** in Table 4). The elements reviewed and the distribution of findings are presented in Table 4.

Table 4. Voice Message Instructions

Element of Instruction	Number of Practices
Dial another number to reach the person on-call [1]	38
Call 911 for emergency*	1
Leave a voice message*	2
Other**	6

*No other instructions were given.

** Instructions excluded how to access person on-call

Nine (9) messages did not instruct the caller on how to access the person on-call.

[1] At the end of the recorded message, some practices instructed the caller to press a number or a series of numbers to have the call forwarded to the on-call physician or answering service.

PART I—SUMMARY

- Analyses of the telephone survey data indicate that 103 of the 117 (88%) PCPP practices provide satisfactory on-call coverage either through direct voice contact or voice messages.

PART II. QUALITY OF CARE AS REFLECTED IN MEDICAL RECORDS

Part II reviewed the quality of care as reflected in PCPP provider medical record documentation and encompasses Study Questions #2 and #3.

METHODOLOGY-- QUESTIONS #2 AND #3

Study Question #2: Do PCPP providers' medical records conform to medical record keeping quality standards?

Study Question #3: Is care management documented in the client's medical record as needed?

Population and Medical Record Sampling

One hundred twelve (112) PCPP physicians of the 117 sampled providers for Part I were the sample for Part II of the study. Random sampling techniques were used to select client records from the sample of PCPs. Clients had to meet specific criteria for inclusion in the medical record review process. A total of 244 client medical records were reviewed.

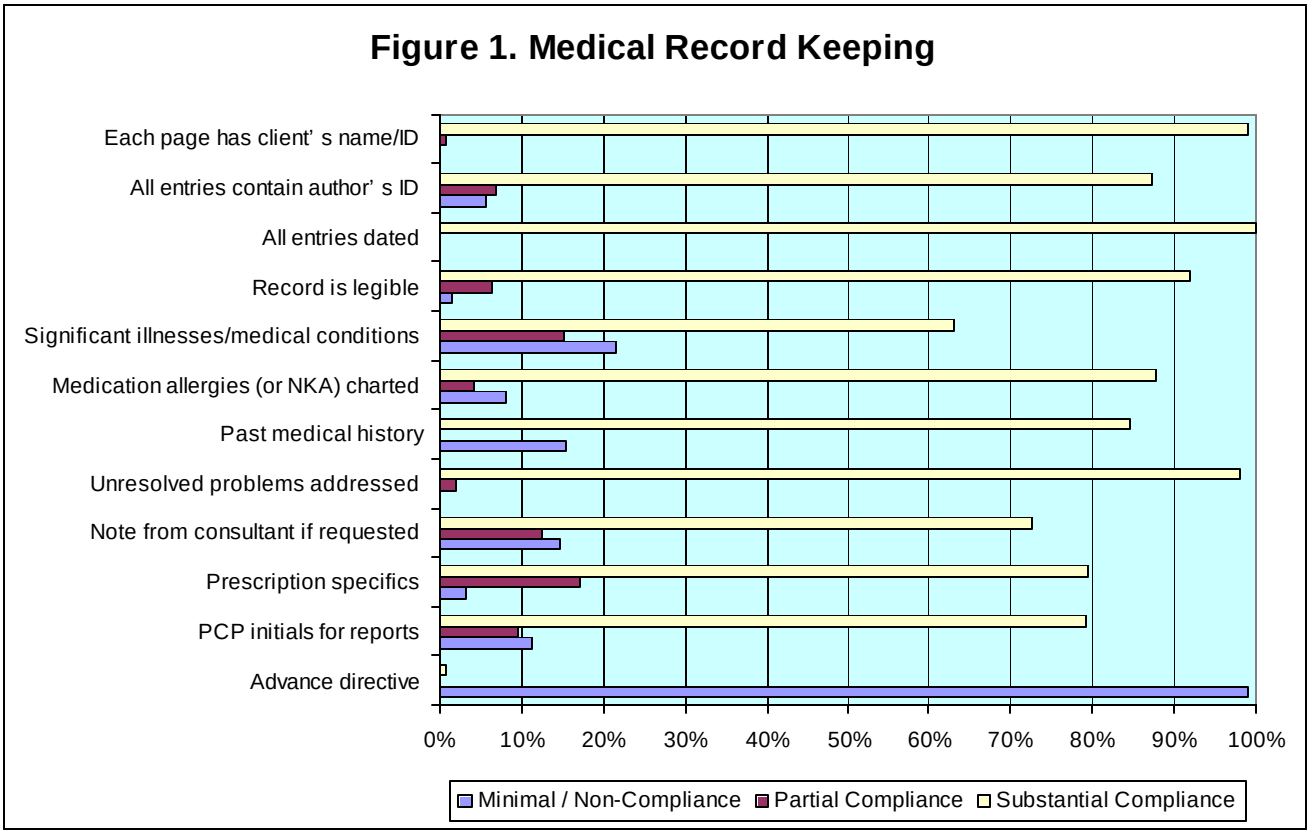
Review Process

Sixty-one (61) sites were randomly selected for on-site reviews, and the remaining 51 offices faxed or mailed specific client medical records to FPRC for desktop review. Client medical records were assessed for a variety of medical record items generally accepted as standard quality indicators by National Committee for Quality Assurance (NCQA) guidelines and the Medicaid Staff Manual Volume 8 (MSM) to address:

Study Question #2: Do PCPP providers' medical records conform to medical record keeping quality standards?

Results

Sampled medical records were reviewed for personal demographic data and twelve medical record keeping review items. Reviewed medical records with a ranking of "Substantial Compliance" accounted for at least 75% of applicable records for nine of the twelve quality review items. Figure 1 displays the twelve review elements and study results.



Study Question #3: Is care management documented in the client's medical record as needed?

Care management review included: assessment, planning, implementation, coordination, monitoring, and evaluation. Nurse reviewers scored each review item as "Yes", "Partial", "No" or "Not Applicable" ("NA"). "Yes" means that the record contained substantial evidence of the care management process item; "Partial" indicates there is incomplete record documentation, but some evidence of the care management process item; and "No" means no documentation of the care management item is in the medical record. "NA" indicates that the item does not apply to the reviewed record.

Results

"Yes" percentages for the 14 review items (see Table 5) range from 6.9% to 98.0%. Seven of the fourteen review items have "Yes" percentages above 90.0% which indicates that each item was present in 90% of the records reviewed. One area with a low score occurred in "Monitoring" related to use of special needs-based forms or tracking and trending devices. Another low compliance score occurred in "Assessment" regarding barriers to care. Overall, these scores indicate both strengths and weaknesses in each area, particularly in "Assessment" and "Monitoring".

Table 5. Summary of Care Management Findings

ASSESSMENT	YES	PARTIAL	NO
Is there a summary list that includes all ongoing health problems for which the patient was seen?	62.4%	18.2%	19.4%
Is there a list of all regular medications, including over-the-counter drugs, taken by the client?	51.2%	25.2%	23.6%
Is there a summary list that includes the dates of service for preventive care and immunizations?	59.1%	16.9%	24.0%
Does the medical record include the results of objective findings and diagnostic tests that have been ordered?	95.2%	4.4%	0.4%
Are barriers to optimal health care assessed?	16.1%	64.9%	19.0%
PLANNING	**YES**	**PARTIAL**	**NO**
If the client is identified as having an acute or chronic health need(s), is an outcome-oriented treatment plan documented on the medical record?	96.2%	3.4%	0.4%
Is there evidence the client and/or family were involved in formulating treatment plan?	96.0%	2.9%	1.1%
If a referral(s) is documented, is the rationale and reason for the referral noted?	84.9%	6.8%	8.3%
IMPLEMENTATION	**YES**	**PARTIAL**	**NO**
If the client' s treatment plan involves the need for medications, products or services, is there documentation of actions taken to initiate the plan of care?	98.0%	2.0%	0%
Is there documentation of client/family education in relevant self-care measures and criteria for return visits?	90.5%	7.4%	2.1%
COORDINATION	**YES**	**PARTIAL**	**NO**
If the client' s treatment plan involves other providers, is there evidence of communication between the providers?	70.2%	19.4%	10.6%
MONITORING	**YES**	**PARTIAL**	**NO**
If the client has a chronic disease, does documentation include evidence of re-measurement of objective clinical parameters, with attention to abnormal variances noted?	97.0%	3.0%	0%
If the client has a chronic disease, does the record include special needs-based forms or tracking and trending devices?	6.9%	0%	93.1%
EVALUATION	**YES**	**PARTIAL**	**NO**
Are revisions and changes in the treatment plan(s), for acute or chronic problems, based on health outcomes and progress toward goals of treatment?	97.9%	2.1%	0%

An overall Care Management Score (CMS) was developed for each PCP. The overall CMS demonstrates that 99% of the PCPs reviewed are within "Optimal" to "Substantial" compliance categories, indicating high compliance in the care management processes.

PART III. PROVIDER COMPLIANCE WITH PCPP GUIDELINES

Part III of this focused study assessed provider awareness of the Colorado Medicaid PCPP rules and regulations as well as compliance efforts through established protocols. Study Question #4 was designed to evaluate PCPs' awareness of and efforts to adhere to the rules and regulations.

Study Question #4: Do PCPP providers' office processes and protocols facilitate adherence to PCPP guidelines?

Population and Sampling

The sample for Study Question #4 was a convenience sample of 61 practices randomly selected from the PCPs in the sample for Questions 1, 2, and 3.

Review Process/Scoring

A face-to-face interview was conducted with the PCP, practice manager, or designee and recorded on the review tool. For each question on the study tool, the total percent of "Yes" answers was calculated. The items on the review tool were: Colorado Primary Care Provider Protocol; Colorado HCPF Manual Volume 8; Current enrollment list of Medicaid clients; Maintain file of official HCPF communications; Written policies and procedures for PCPP; Medical record for each client; Protocol for maintenance of medical records; List of services for prior authorization/referral; Protocol to record authorized referrals; Protocol to notify HCPF when enrollee is removed.

Results

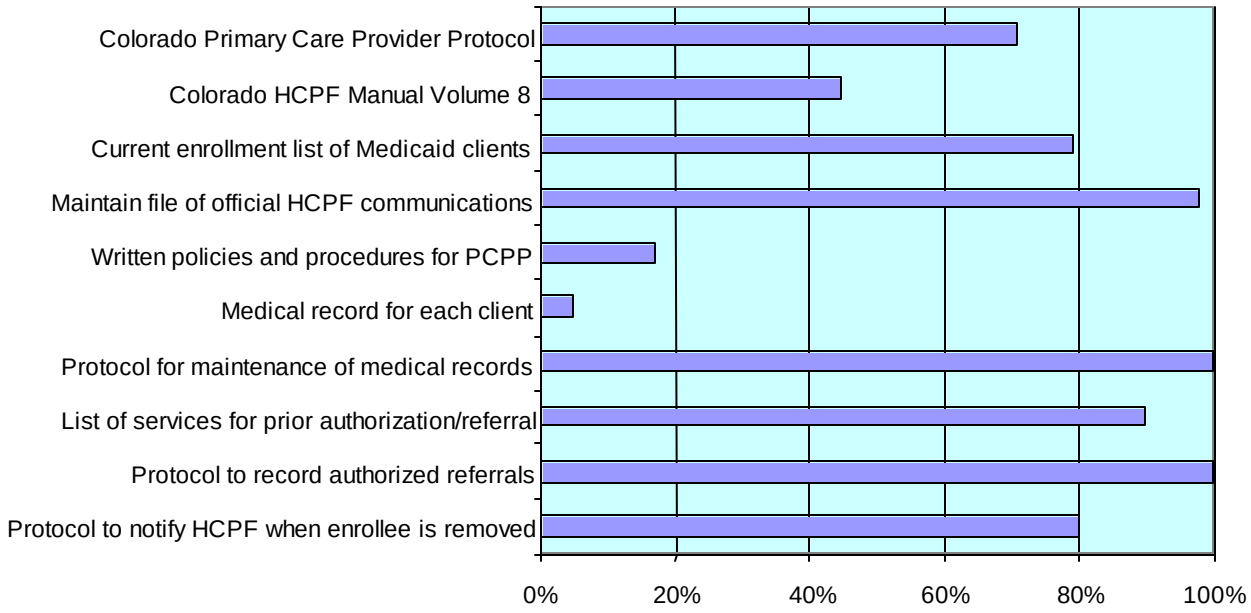
Based on analyses of the elements reviewed specific to PCPP guidelines, the majority of PCPP providers' office processes and protocols facilitate office practice in accordance with PCPP guidelines (see Figure 2).

As reflected in Figure 2, five (5) review element percentages were between 80%-100%. These five elements were: maintain file of official HCPF communications; protocol for maintenance of medical records; list of services for prior authorization/referral; protocol to record authorized referrals; and protocol to notify HCPF when enrollee is removed. Two (2) elements were between 71%-79% (Colorado Primary Care Provider Protocol, and current enrollment list of Medicaid clients); and three fell below 45% (Colorado HCPF Manual Volume 8; written policies and procedures for PCPP; and medical record for each client), with 5% as the lowest percentage. Results of face-to-face interviews with designated office personnel indicate that 45% of provider offices have a copy of HCPF Staff Manual Volume 8 and 71% have a copy of the Colorado Primary Care Provider Protocol available for reference.

Though the providers received overall high percentages, two opportunities for improvement were elucidated. The element related to written policies and procedures

describing methods to meet criteria for HCPF PCPP regulations was 17%. The lowest percentage (5%) related to having a medical record for all PCPP clients. The majority of PCP practices do not initiate a medical record until a client makes an initial visit.

Figure 2. PCP Adherence to PCPP Guidelines



BEST PRACTICES

As part of the on-site review process, FPRC reviewers were asked to identify provider best practices they encountered. The reviewers identified three offices, of the sixty-one visited, as exemplary. FPRC sent a letter to the Department, with a copy to the providers, acknowledging this recognition. These providers had all office systems in place including appropriate reference manuals and complete medical record documentation across all surveyed elements. The three physicians are:

- Khoi Duy Nguyen, DO
- Ingrid K. Rule, MD
- Mary D. Vostrejs, MD

SUMMARY OF STUDY RECOMMENDATIONS

PART I. ACCESS TO PCPs

1. Educate PCPP providers on the importance of 24-hour coverage.

The results of this study indicate that while most PCPP providers are available on a 24/7 basis with adequate on-call coverage, 12% of Colorado Medicaid PCPP providers do not meet the PCPP standards for provider access. Access to the PCPP provider is a critical element in adherence to standards, continuity of care for the client, and carries potential for cost savings through reduction of Emergency Room visits.

2. Encourage PCPP providers to eliminate unnecessary verbiage and steps when using a voice message system for directing clients who are attempting to access an on-call provider.

Reviewers conducting the study indicated that often the voice messages included a long and sometimes cumbersome "telephone tree" of instructions. A client caller, after listening to these instructions, would then have to take additional action to access a health care professional. Although this mode of access meets the PCPP requirements for on-call coverage, a more "user friendly" system may result from provider education. At a minimum, client information materials should provide information about the after-hours contact process, indicating that the process might involve more than one step.

3. Determine a method for verifying PCPP provider information on a regular basis to ensure accuracy and validity of the HCPF database and require PCPs to update at routine intervals (i.e. require PCPs to verify current information when submitting bills to HCPF) or upon a change in status (e.g., address or telephone).

PART II. QUALITY OF CARE AS REFLECTED IN MEDICAL RECORDS

4. The designated HCPF representative (PCP Administrator) should conduct provider education on HCPF PCPP rules and regulations specific to documentation requirements.

Areas of low compliance (below 80%) include documentation of significant illnesses and past medical conditions on the problem list, coordination of care, prescription information, PCP review of incoming client information (consults, labs, etc.), and providing information about advance directives.

5. Remind PCPs of the requirement to provide information to PCPP clients about advance directives.

Provide PCPs with client information resources about advance directives to facilitate availability of literature to clients. Send providers a copy of the "Your Right To Make Health Care Decisions" pamphlet which provides client information on the advance directives to include Medical Durable Power of Attorney, Living Wills, Cardiopulmonary Resuscitation, and Substitute Decision Makers and Guardians.

Contact Remy Kahus (Inventory Management Systems) at Hospital Shared Services (303-340-4803) and find out which providers currently order the pamphlets or provide a reminder of this resource contact number in e-mail, monthly bulletins, etc.

6. **Convene a panel of PCPs in the program, as well as providers within other health care systems (i.e., commercial HMOs) to develop standardized forms to specifically enhance medical record documentation as documented in the current HCPF rules. Ideally, solicit input from those providers identified as "best practices". This would be a function of the PCP Advisory Committee.**

   Three of the surveyed providers were identified as having best practices in place. These providers could offer the panel existing forms for comparison as well as instructions needed to complete the forms completely and accurately.

7. **Include methods for assessing multiple barriers to care in provider education.**

   Barriers to optimal health care may not always present in obvious ways. However, when a provider obtains a history from the patient, even one limited to the current problem, clues may exist that suggest a barrier to care. Educating providers in identifying barriers to care when performing routine assessments may enhance identification as well as intervention. A deviation from the expected "norm" may be an indicator of a barrier to care. For example, as a provider obtains a history from a client about the length of a significant acute problem and the client reports "weeks", further questioning may reveal a financial need, lack of transportation, adverse support system, disability, etc. Simply heightening providers' awareness of "hidden" clues of this type may prove valuable.

PART III. PROVIDER ADHERENCE TO PCPP GUIDELINES

8. **Ensure providers receive a copy of the HCPF Staff Manual Volume 8 and the PCPP Protocol upon entering the PCPP.**

   Most provider offices reported not having or never having seen one or both of these pertinent documents. Although FPRC conducted education on the importance of these manuals and how to obtain these documents, either by providing a mailing address or website address, many PCPs do not have Internet capability, and some do not have fax capability.

9. **Offer providers updated HCPF manuals relating to PCPP rules and regulations annually.**

10. **When conducting provider education, the PCP Administrator should include the importance and requirement of practices having written policies and procedures in place.**

    The majority of practices indicate having informal protocols that address compliance issues of the PCPP. It is difficult, at best, to evaluate the consistency of application as well as the accuracy of informal protocols. Develop sample templates of policies and procedures and make them available on the HCPF website and in monthly communication publications. Challenge providers who have developed extensive policies and procedures to teach and share with other providers about their policies and procedures. HCPF could consider making written policies and procedures a requirement, a practice consistent with requirements held by other State' s Medicaid agencies.

11. **Convene a workgroup to find out which physicians' practices have electronic e-mail capabilities. Gather e-mail addresses and broadcast routine messages to the providers. Many providers would more likely read their e-mail as opposed to sorting through voluminous papers received in the mail.**

    Additionally, although many offices do not have existing Internet/e-mail, there are "free" e-mail resources available, such as Hotmail, Yahoo, etc. A list of these resources, obtained from the web, could be made available to providers. Another consideration is that although these capabilities may not exist in offices, many providers may have the capabilities at home and prefer to receive pertinent updates through this avenue.