Apicha Community Health Center

Measuring Engagement in Care (EiC) through Documented PCP Visits

INTRODUCTION

NYCDOHMH annual quality indicators for Care Coordination programs include primary care physician (PCP) visits as documented in the PCSM form. Regular PCP visits demonstrate consistent patient engagement in care (EiC); emphasizing the importance of ensuring patients have regular PCP visits, and for the program to know when PCP visits occur and to document them accurately.

According to the quality indicator report for contract year March 2015- February 2016, Apicha's documented PCP visit rate was 85%, while the minimum expectation for Care Coordination programs is to be above 90%

AIM

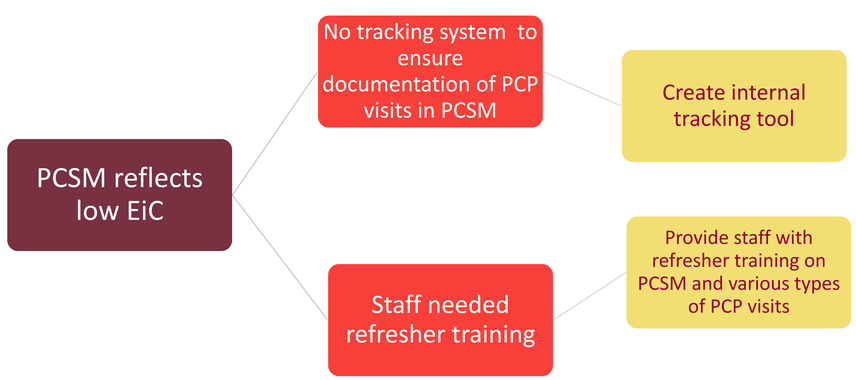
The QI team decided to focus on increasing clients' EiC, and to ensure that all PCP visits were being recorded in the PCSM form.

The goal of this project is to increase PCP documentation 5%, from 85% to 90%.

ROOT CAUSE ANALYSIS

Program staff conducted root cause analysis in May 2016, and identified two major issues.

1. No tracking system was in place to ensure documentation of client's PCP visits.
2. Staff members are not familiar with all the various types of PCP visits.



METHODS

The quality improvement intervention consists of the following strategies:

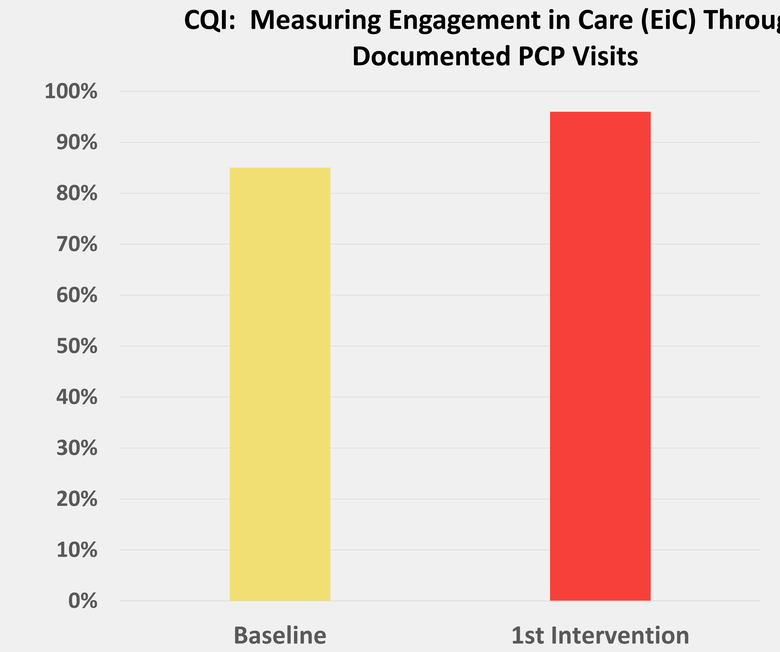
i) Tracking Tool – An Excel spread sheet was created in which staff entered PCP visits, monitored by Care Coordinators.

ii) Staff Refresher Training - All care coordination staff members were given a refresher training in June 2016 by the Program Manager for Support Services to emphasize the importance of the PCSM form and protocol pertaining to documentation of PCP visits. Staff were re-trained to document the following types of PCP visits in the PCSM form:

a) Initial visit
b) Monitoring visit
c) Annual visit
d) Office visit
e) Sick visit

QI Project team members agreed on an intervention period, which was set to be for 4 months to track, document, and monitor PCP visits. The intervention period for the project was July 2016 through October 2016.

RESULTS



RESULTS

Initial results showed an 11% increase from the baseline (85%), a **96%** successful rate of documentation of PCP visits in the PCSM, exceeding the project goal.

With the help of the monitoring tool, as well as the refresher training, Patient Navigators and Care Coordinators were able to accurately record each client's PCP visits and demonstrate Apicha's actual EiC rate.

NEXT STEPS/LESSONS LEARNED

Program staff shared the improved results (85% to 96%) during a team meeting.
Among the lessons learned:

1) MCM staff now understand the importance of utilizing a tracking tool for quality improvement. Care Coordinators reviewed PCSM form submissions in Excel periodically and they showed Patient Navigators were successfully maintaining an average of above 90% of clients with documented PCP visits.
2) Staff will continue to update the PCSM form at each PCP visit, initiation, or change of medication. Care teams will continue to use the tracking tool to monitor clients' medical appointment adherence.
3) Care Coordinators have agreed to provide refresher training annually to ensure Patient Navigators understand how to record and document PCP visits in accord with PCSM requirements.

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