Purpose of the Record Review Workbook
There are three elements in PCMH 2014 that require an accurate estimate of the percentage of patients for whom the practice has documented the required information in its medical records. The RRWB calculates the data entered and scores each factor based on a sample of patient records. The elements are:

PCMH 3C—Comprehensive Health Assessment:
PCMH 4B—Care Planning and Self-Care Support: Must-Pass Element
PCMH 4C—Medication Management: Factor 1 is a Critical Factor and thus required for the practice to score any points for PCMH 4C.

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

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 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 elements, you can enter the responses directly into the Survey Tool 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 elements and must complete the RRWB. You may respond to some elements with Method 1 and others with Method 2; you may respond to some factors within an element with Method 1 and others with Method 2. If using a combination of Method 1 and 2, for factors 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., 3C #3 - indicate "Not Used" if the practice does not conduct or document in the medical record communication needs.) When selecting the "Not Used" response, always select it in the first patient row in the sample (row 12). "Not Used" scores as a "no".
See Report = Practice is submitting an electronic report for documentation for this factor and is uploading it to the document library in ISS and linking to this report in the ISS survey tool. "See Report" scores as a "no" in the workbook. Only select this option if providing alternate documentation outside the workbook to meet the factor.
Not Applicable = This is one option in the drop-down menu for specific factors in Elements 3C and 4C. Please see details in the Element 3C and 4C instructions below. "Not Applicable" scores as a "yes".

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 (or no) shading indicates that input is required.
The RRWB 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.

Step-by-Step Instructions for Completing the Record Review Workbook

Overview of Steps
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 three elements you will document using this file. Remember: PCMH 4B is 1 of 6 Must Pass elements. Your practice must use one of the two methods in the Explanation in the Survey Tool to document performance for these factors and elements.
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 RRWB for each applicable factor and element.
5. Record the "Yes" or "No" response and percent for each factor calculated by the Workbook in the Survey Tool for 3C, 4B or 4C.
6. Link the Record Review Workbook to the elements (3C, 4B, 4C) in the Survey Tool for which you used the Record Review Workbook. Once you have linked the workbook for one element, such as PCMH 3C, you may use the options in the survey tool to link it to 4B and 4C.

**Detailed Record Review Worksheet Instructions**

**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 RRWB to document information for all three elements (PCMH 3C, 4B, 4C).
PCMH 3C, 4B and 4C require 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 RRWB for a particular factor, 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 factor. This will gray the column and indicate to NCQA that you are not going to use the worksheet for that factor of the element. "Not Used" and "See Report" are scored as a "no."

**NOTE:** See the NCQA PCMH 2014 Standards and Guidelines for documentation requirements for each factor. For some elements, additional documentation beyond the RRWB is required.

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

1. **Identifying Patients for Care Management (PCMH 4A)**
The intent of the element is that the practice uses defined criteria to identify true vulnerability—a single criterion, such as cost, may not be an appropriate indicator of need for care management.

*Factor 6 is a critical factor and is required for practices to receive a score above 0% on this element.
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 3, Element C) supports establishing criteria and a systematic process for identifying patients for care management.
The practice receives credit for each factor (1–5) included in its criteria for identification of patients for care management. A patient may fall into more than one category (factor) and may be included in some or all of these counts. The practice uses criteria 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 4 Element A. These will be the patients reviewed in your medical record review. You will review the same 30 patient files for all three of the elements in this Record Review Workbook. There must be a total of 30 patients. The identified criteria for the patients in the sample must match those identified in PCMH 4 Element A.

3. **Patient Selection**

**Patient Selection Using Visit Date**
Choose patients meeting the criteria from PCMH 4 Element A, 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 criteria from PCMH Element 4A and who had a care visit related to any one or more of the selected criteria. Continue to go back one day at a time until you have identified 30 patients for your sample.

**Patient Selection Using Another Method of Random Selection**
Any other method of random selection of patients must be pre-approved 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 Elements 4B and 4C. The practice determines how often information is updated in Element 3C, 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.
Step 4: Review the patient records and enter responses in the Record Review Worksheet.

1. Fill out patient data in the Record Review Worksheet for Element 3C, 4B and 4C.

- **Yes** - If the patient’s medical record has documentation for the factor choose "Yes" (from the drop-down list in each cell) for each factor 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 factor.
- **Not Used** - Review the factors of the element and determine if there are any that your practice does not use. If your practice does not use a particular factor, 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 grey.
- **See Report** - Review the factors of the element 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 factor, 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 grey.
- **Not Applicable** - NA is a fourth option in the drop-down menu for some questions. Where it is an option, the drop-down list will have the options "Yes/No/NA/Not Used/See Report." Please refer to the PCMH 2014 Standards and Guidelines for instructions on when NA may be selected. NA is tallied as a "Yes" response.

**PCMH 3C: Comprehensive Health Assessment**

Review each patient medical record for documentation for each of the 10 factors. 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 factors. The worksheet will indicate **YES or NO** that the practice met the requirements of the factor. The practice will then enter **YES or NO** in the survey tool for each of the 10 factors. If your practice does not use a particular comprehensive health assessment component for any patients, choose (from the drop-down list) **Not Used** in row 12 (patient #1) to blank out (grey) the entire column. **Not Used** is tallied as a **NO** response for all patients. If your practice will generate an electronic report to demonstrate it meets a particular comprehensive health assessment component, choose (from the drop-down list) **See Report** in row 12 (patient #1) to blank out (grey) the entire column. **See Report** is tallied as a **NO** response for all patients.

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

Review each patient medical record for documentation for each of the 5 factors. 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 factors. The worksheet will indicate **YES or NO** that the practice met the requirements of the factor. The practice will then enter **YES or NO** in the survey tool for each of the 5 factors. If your practice does not use a particular factor for any patients, choose (from the drop-down list) **Not Used** in row 12 (patient #1) to blank out (grey) the entire column. **Not Used** is tallied as a **NO** response for all patients. If your practice will generate an electronic report to demonstrate it meets a particular factor, choose (from the drop-down list) **See Report** in row 12 (patient #1) to blank out (grey) the entire column. **See Report** is tallied as a **NO** response for all patients.

**PCMH 4C: Medication Management**

Review each patient medical record for documentation for each of the 6 factors. Enter responses in the appropriate worksheet cell. Documentation found in the medical record determines the percentage of the selected patients that meet each factor. The worksheet will indicate the percentage for each factor and **YES or NO** that the practice met the requirements of the factor. The practice will then enter **YES or NO** in the survey tool for each of the 6 factors. If your practice does not use a particular factor for any patients, choose (from the drop-down list) **Not Used** in row 12 (patient #1) to blank out (grey) the entire column. **Not Used** is tallied as a **NO** response for all patients. If your practice will generate an electronic report to demonstrate it meets a particular factor, choose (from the drop-down list) **See Report** in row 12 (patient #1) to blank out (grey) the entire column. **See Report** is tallied as a **NO** response for all patients.

**Not Applicable** is an option in the drop-down menu for factors 5 and 8 in this element for practices without any pediatric patients. Not applicable is tallied as a **YES** response.

**NOTE:** Factor 1 is a Critical Factor and thus required for the practice to score any points.
Step 5: Enter Responses from the Worksheet in the Survey Tool
Responses must be entered for 30 patients for each factor of each element for which you have chosen to use the Record Review Workbook. If data on 30 patients is not present for a factor, the worksheet will not provide a Yes/No or percentage result for input into the Survey Tool and will indicate "<30 patients" in the results row.

Step 6: Link the Record Review Workbook to the Elements in the Survey Tool.
Link the Record Review Workbook to the first element chosen in Step 2 for which you have entered data, then link it to each of the other elements for which you entered data.
To link the Record Review Workbook to the first element:
1. Go to the first element in the Survey Tool for which you have used the Record Review Worksheet.
2. Click the Documents button.
3. Select and click the Link Document option.