VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

# Tips to Protect Patient Confidentiality During the Medical Home Recognition Process

- To protect patient confidentiality during the medical home recognition process, **ALL protected health information (PHI) in documents must be blinded before leaving your practice**. Before VCHIP review of binder and before documents are emailed or faxed to VCHIP protected health information must be blinded.

- **PHI includes:**
  - **Names**
  - **All geographic subdivisions smaller than a state (street address, city, zip code)**
  - **All elements of dates smaller than a year (birth, admission, discharge, death & all ages over 89)**
  - **Telephone and facsimile numbers**
  - **Email addresses**
  - **Social security numbers**
  - **Medical record numbers**
  - **Health plan beneficiary numbers**
  - **Any other account numbers**
  - **Certificate/License numbers**
  - **Device ID numbers**
  - **Full-face photographic images**
  - **Any other unique identifying number, characteristic, or code**

- Blind PHI as you gather your documentation

- Blind PHI electronically before printing screenshots or reports

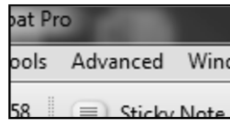
- **DO NOT** email PHI or documents containing PHI

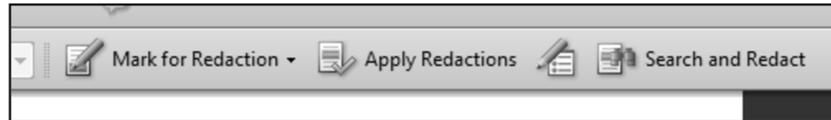
- It may be surprising to blind data that will be used as evidence of your processes. NCQA requests many documents that inherently contain PHI (reports, screenshots, lists), and you have to blind it! However, documents you provide as evidence can be used *without* the PHI by adding labels or a thorough description.

- In some cases it is important to be able to follow a patient example. This can be difficult to do without PHI (e.g. a case example that follows a patient from the ER through an inpatient stay to a nursing home or a same day appointment request that results in the patient being scheduled). Highlight and use labels such as “Patient A” or “Example 1”. Examples can be followed without PHI. **It is very important that PHI does not leave your practice.**

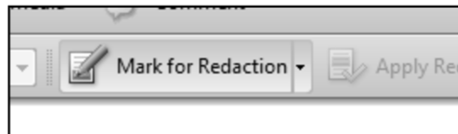
- Options to blind PHI when providing electronic documentation:
  - Blind the PHI in whatever capture tool you are using, *before* inserting a screenshot into a word document
  - Blind PHI in your Word document before saving as a PDF
  - Delete PHI from reports in Excel (leave column heading(s) but delete the PHI)
  - For PDF files, use the Adobe redaction tool
  - Any other method (such as covering with a text box) is not effective at blinding PHI

- **Instructions for Using Redaction Tool in Adobe Acrobat (not Adobe Reader) to Blind Electronic PHI**
  - Add the redaction tool to your toolbar for easy access
    - From the “Advanced” tab, select “Redaction” and “Show Redaction Toolbar”. The redaction tools then appear in your toolbar.

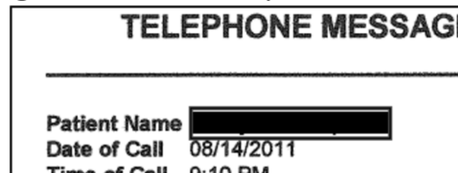


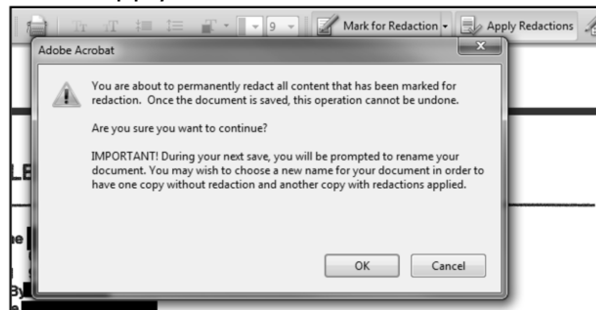

  - To redact PHI, select “Mark for Redaction”



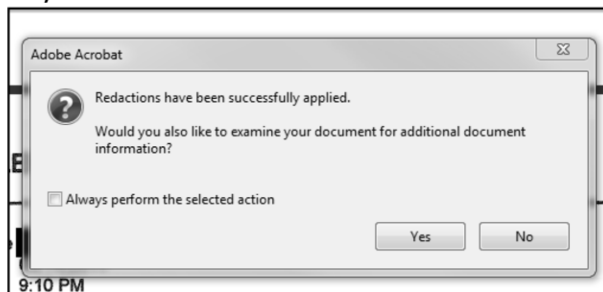

  - Using the cursor, drag a rectangle around the PHI you wish to blind/redact




  - Continue to select all PHI in the document
  - Once all PHI is selected, select “Apply Redactions”. You will receive the following message.




  - Click “OK”. The next time you save this document you will be prompted to save as a new document. Consider doing this. You might choose to save one version that you keep at your practice (the original), which contains the PHI, and one version (with PHI blinded) that you send with VCHIP. Your redactions will be permanent once saved.
  - You can allow Adobe to search the document automatically for similar PHI. This will work only if Adobe recognizes text in your document. Select “Yes” or “No” to accept or decline a search.




  - Save your document as a new version or overwrite your original. **Be sure to provide VCHIP with the redacted version.**

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# NCQA PCMH 2011 Chart Review for 3C, 3D, & 4A:
## Selecting Patient Charts & Planning for the Chart Review

### Overview

- Use chart review for PCMH 3C, 3D, 4A
- Total of 48 patient charts; Patients are selected from the 3 important conditions in 3A and, if using, high risk conditions in 3B
- One important condition must be related to unhealthy behaviors or mental health or substance abuse
- If practice identifies high risk patients in PCMH 3B, these patients must be included in the chart review

### Four Options:

| | |
|---|---|
| **Option 1**<br>• 12 important condition 1<br>• 12 important condition 2<br>• 12 important condition 3<br>• 12 high risk/complex | **Use if:**<br>• Identifying 3 important conditions (including 1 related to unhealthy behaviors or mental health or substance abuse)<br>• AND identifying high risk/complex patients in 3B |
| **Option 2**<br>• 16 important condition 1<br>• 16 important condition 2<br>• 16 important condition 3 | **Use if:**<br>• Identifying 3 important conditions (including 1 related to unhealthy behaviors or mental health or substance abuse)<br>• NOT identifying high risk/complex patients in 3B |
| **Option 3**<br>• 16 important condition 1<br>• 16 important condition 2<br>• 16 high risk/complex | **Use if:**<br>• Identifying 2 important conditions (including 1 related to unhealthy behaviors or mental health or substance abuse)<br>• AND identifying high/risk complex patient |
| **Option 4**<br>• 24 important condition 1<br>• 24 important condition 2 | **Use if:**<br>• Identifying 2 important conditions (including 1 related to unhealthy behaviors or mental health or substance abuse)<br>NOT identifying high risk/complex patients |

## Patient Selection

- **Consideration:** If you have a disproportionately low number of patients with one of the important conditions, start by selecting those patients to ensure you have enough for the chart review. Otherwise, begin with high risk patients (if including in chart review).
- **Option 1 - Using a condition-specific registry**, sort by date of last visit related to the important condition, beginning with the most current date. Go back one month in the visit dates and sequentially choose the number of patients (12, 16, or 24).
- **Option 2 - Using visit date**, go back one month in the visit schedule before the date of the chart review and choose the weekday nearest that date. Going backward in the visit schedule from that date, select the first 48 (or 36 if using high risk patients) patients who have any one or more of the three chosen clinically important conditions *and who had a care visit related to the selected conditions*. Choose the number of patients for each condition based on the number of conditions (12, 16, or 24).
- **High risk or complex patients**: from the registry (practice is responsible for generating a high-risk/complex patient registry) of your high risk or complex patients that includes the most current contact date, sort by date of last contact beginning with the most current date. Go back one month in time from the most current date and sequentially choose the 12 or 16 patients (depending on whether you have 2 or 3 important conditions).

## Planning for the Chart Review

- In order for VCHIP to conduct the chart review, your practice must have:
  - A **Business Associate Agreement (BAA)** in place with VCHIP
  - All primary care providers provide informed consent for the chart review signing the VCHIP **informed consent form.**
- VCHIP requires the list of patients (and paper charts, if applicable) be created ahead of chart review date. Please list more than one identifier for patients e.g. name and DOB or MRN. List (or pull) a few extra charts (3 or 4) per condition in case any charts may not be used (for instance the patient does not have one of the important conditions or wasn't seen on the scheduled date because their appointment was cancelled, etc.).
- VCHIP staff will need access to your electronic health records. We use our own laptops for data entry into the NCQA worksheet but typically require access to the EHR through your practice computer(s). Each VCHIP reviewer will need access to a separate workstation to access your EHR.
- It is important that VCHIP reviewers have appropriate access to view all components of the medical record relevant to the survey, including access to view when patients have missed important appointments or received care plan, visit summary or educational material.
- The chart review will take approximately 4 - 5 person-days. If two VCHIP reviewers are available and your practice can accommodate two reviewers (i.e. you have two computer workstations available), the chart review would be completed in approximately 3 days.
- Set a date with VCHIP for the chart review that is at least 1 month prior to your scoring date (i.e. if your VCHIP estimate is due to the Blueprint May 31, schedule your chart review for a date prior to May 1).
- Be prepared to have a practice staff member available for approximately 1 hour to orient VCHIP reviewers to your charts. After this initial orientation, please plan to have a staff member available periodically throughout the chart review for intermittent/infrequent questions.