

NCQA Diabetes Certification

One practice's journey

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Dryden Family Medicine

The Application:

Dryden Family Medicine (a small group practice of 2 family physicians, an internist, and a physician assistant) in the Finger Lakes Region began the process of application in the fall of 2009. We elected to apply as a practice but entered data by physician. The two family physicians' patient base served as the data source. We elected to enter data working backwards from our start date until the requisite data for 30 patients per physician were acquired.

The task of data acquisition and entry was assigned to a clinical staff member who was particularly savvy about web systems. Our office manager in conjunction with our EHR vendor created the necessary reports which were derived from our electronic health record system (Medent) which we had used since 2003. Reports included a list of patients with any diagnosis of diabetes, over age 18, seen in the prior 3 months, and listed in reverse chronological order.

As recommended by NCQA a paper data sheet was used for each patient. The EHR filled in some fields automatically. However, setting up electronic reporting for all the required fields was more difficult, so only data fields for labs, vitals and demographics were created. The criteria for inclusion in the study appeared at the top of the sheet for easy reference. The electronic report drew out of the EHR each patient's clinical data, and demographics printing it on their data acquisition sheet. As suggested by NCQA data were not entered into the interactive webpage until data acquisition and documentation were completed on all patients. Once that was accomplished we were ready to fill in the interactive web form and submit to NCQA. All paper data sheets (including those which did not meet inclusion criteria) were kept for reference in case of audit or technical difficulties with our submission and we did, in fact, use them.

Data required by the study that were not extractable from the EHR were: retinal eye exams, foot exams (including neuropathy and skin status), and smoking status (including cessation advice given). Reasons for this centered on the difficulty in reporting using data fields which were not specifically set up for it and a lack of uniformity amongst practitioners regarding the EHR data fields to be used for these particular items. Data acquisition for these items had to be collected manually, looking at individual patient charts and searching for each data item. A benefit of participating in the study was that we subsequently created specific data fields for these clinically important items and increased our uniformity in documentation. The process also led us to create prompts in the disease management feature of the EHR for clinically relevant items which increased our compliance with evidence based guidelines for diabetes

care. Subsequent to achieving certification these prompts have been expanded to include other relevant items such as aspirin therapy, and relevant vaccinations.

Most challenging of the data fields were:

Blood pressure – Our system would default to the first blood pressure at a visit for the patient which most commonly is the nurse's. Often patients are less at rest and more agitated as they are brought into a room. Our system would not automatically report a subsequent blood pressure done by the practitioner. We had to acquire these manually.

Retinal exams - Documentation of retinal exams by an eye care professional was often lacking in our charts, not because the patient had not had an exam but rather due to the infrequent reporting of the consultant back to us. In addition, our notes would often indicate that the patient had been advised of the need for an eye exam, or that it had been done but not by whom. Due to the certification process we modified our procedure by creating a formal referral to eye care professionals which asks them to send us their assessment. We now have a record of when and to whom the patient was to go and in most cases the consultant's report.

Smoking status – This element had a dedicated field in our system but documentation of cessation counseling inconsistently used its data field.

Foot nephropathy screening - This information was similarly difficult to access but by creating a dedicated data field, and a disease management formula with automatic prompts for completion, we were more successful in reporting.

As a long term benefit these data fields continue to be used and by having the formula pop up reminders at routine visits we are able to maintain timely preventive measures for this and other parameters.

The Submission:

Once our paper data sheets were completed and we were confident we had a sufficient number of charts to submit, our staffer entered the data into the interactive web tool and it was submitted to NCQA by the Academy through the NYS Diabetes Campaign.

Hearing back from NCQA took months. We submitted in January and heard in May.

Communication with NCQA was problematical. We only learned of our recognition through a newsletter from the NYS Diabetes Campaign; official NCQA notification took much longer.

When NCQA did report our certification they posted our practice name on their web page and only subsequently did we get a letter from NCQA.

Part IV ABFM credit for Board Recertification:

Once we knew we had received recognition we contacted ABFM, since we knew the NCQA DM certification qualifies as a practice improvement project. Having the ABFM accept it though has

been difficult. The problem was that NCQA listed our recognition under our practice name and not under the names of the two physicians who completed it. This became evident after accessing NCQA's website. The NYS Diabetes Campaign had issued certificates to each of us physicians individually certifying our completion; but the ABFM was not prepared to accept this proof and needed documentation directly from NCQA. NCQA required a form to release information to ABFM but once the form was submitted to the NCQA no action was taken. Repeated inquiries from Janet Lindner at the Academy led nowhere. Resubmission of the release form to NCQA and further copies of the NYS certification documents, and a personal letter both to NCQA and ABFM asking for resolution was done in Mid January 2011. In early February we learned that ABFM had received the NCQA information required and we were invited to log on to our ABFM "Maintenance of Certification" web page and activate the certification which also requires a fee to payable to ABFM.

The Lessons Learned:

IF we were to do it all over again we would want upfront clarification of the process to get recognized and get part IV credit. We would be aware of the ABFM fee for registering our part IV credit. We would be aware of the months that it takes for NCQA to notify us and that initially they would not notify us directly but only through a posting on their website. We would be aware of the problem of recognition as an office versus as physicians. However, Dr. Robert Morrow expressed surprise when told we were recognized as an office since he had heard that only physicians are recognized. He understands that the NCQA prefers offices to be recognized since if a physician leaves an office it is not a given that his/her performance in DM indicators will continue! This seems to be a tacit statement regarding office systems rather than of the individual physicians involved.

Actions Post Recognition (the benefits)

We have displayed the logo for our recognition in ads, in our office, on our web site with links to a document explaining what it stands for, and touted it as we recruit a new associate to join us. So far it has had minimal impact in any concrete way. It has not been a cause for any increase in reimbursement from third party payers although we will push the issue when renewal times come. Enhanced reimbursement is a leap of faith and as Dr. Morrow says: why should they pay us for something they can get for free? Yet, these systems are expensive in the staff and professional time to create and maintain them and the electronic systems needed to maximize their effectiveness. The savings in deferred or avoided disease related costs accrue to the insurer and they should be sharing the savings with the practitioner through enhanced reimbursement and a bending of the premium price curve downward.

For our office certification has been a source of pride. Recognition for hard work well done is always helpful and while we try to recognize our staff as often as we can it helps to have an outside body complement us.