Patient-Centered Medical Home 2014 (PCMH) and Patient-Centered Specialty Practice (PCSP)
Document Preparation Tips

NOTE: The information in section immediately below is very important. It includes a definition of Protected Health Information (PHI) and explains why NCQA requires practices to remove PHI from any documentation it provides in the PCMH or PCSP Survey Tool to NCQA.

IMPORTANT: **Remove Protected Health Information (PHI) from Documents**
• Protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations, **must be removed or blocked** out from documents submitted, including patient identifiers, unless the Survey Tool specifically requests the information. If an element or factor requests an aspect of PHI, such as a date of service, please include only the minimum information necessary to satisfy the intent of the element or factor and do not include additional identifiers as part of the documentation, such as a member's chart or account number. • ***NCQA does not require, and the practice should never submit, documentation with patient names, social security numbers, dates of birth, street addresses, email addresses or telephone numbers.*** For many elements, the best documentation is a screen shot from a computer the practice uses. 1. ***Only submit de-identified patient data and examples.*** Create and then cut and paste the screen shots to a single Word document or scan documents and create a PDF. Save Word documents using text boxes to block PHI as read-only. 2. For more information please see the definition of *PHI* and *de-identify* in the PCMH and PCSP Glossaries. 3. Practices may provide Web links to data or Web sites. **Refer to NCQA's presentation to learn "How to block PHI"

NCQA offers the following document preparation tips to practices applying for either PCMH or PCSP Recognition. These suggestions are NOT exhaustive nor are they prescriptive of how your practice documents that it meets the standards. Instead these tips are guidelines to assist practices in efficiently preparing documents that effectively illustrate the practices' operations and care management.

PREPARING DOCUMENTATION

TYPES OF DOCUMENTS USED IN THE STANDARDS

Types of Documents	Examples/Explanation
Documented process	Written procedures, protocols, processes, workflow forms (not explanations); the ***practice name and date of implementation*** should be included.
Reports	Aggregated data showing evidence; the ***reporting period*** should be included.
Records or files	Patient files or registry entries documenting action taken; data from medical records
Materials	Information for patients or clinicians E.g. clinical guidelines, self-management and educational resources
NOTE: Screen shots, i.e., electronic "copy", may be used as: *1) examples* (system capabilities of an electronic health record-- EHR), *2) materials* (Web site resources), *3) reports* (logs, patient lists) or *4) records* (e.g., documentation of clinical advice in the medical record)	

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DOCUMENTATION TIME PERIODS

Type of Documentation	Time Period
Report Data, files, examples and materials	Current within the last 12 months.
Documented Process	Policies, procedures and processes must be in place for at least 3 months prior to submitting the survey tool
Meaningful Use reporting period	12 months, or 3 months if 12 months is not available.
Reporting period (log or report)	Refer to documentation guidelines for each element in the PCMH or PCSP Standards and Guidelines for other references to minimum data for logs and reports (e.g., one week, one month)
NOTE: *All documents* must include date of implementation, data collection or reporting period	

ORGANIZE SUPPORTING DOCMENTS

1. **Create a folder** on your network drive for documents the practice MAY want to attach
2. **Develop a checklist** of documents already used in the practice and documents that need to be prepared
3. **Refer to published standards** and use to identify what the practice has and what needs to be created
4. **Save a copy** of the Record Review Workbook and/or Quality Measurement and Improvement Worksheet to your document folder
5. **Consider putting multiple examples** in one document for a single element, e.g. screenshots
6. **Identify documents** that may be applicable for more than one element

NOTE: NCQA advises a target of three (3) documents or fewer per element (some elements require more, others just one). This will depend on the number of factors in the element and the diversity of document types included.

MANAGE THE DOCUMENTS

1. Use a unique naming convention for each document, that is, don't use the same name for multiple documents
2. Use a logical organizing principle such as:
   - PCMH 1 A—Name of Document.docx
   - PCMH 1 B—Name of Document.xls
3. Avoid special characters and punctuation in document name (e.g. quotation marks, question marks, commas, apostrophes, ampersands). NCQA's system will not accept the documents.
4. Don't put the same document in two different places in the document library; instead, enter it once and link to multiple elements
5. Use text boxes, arrows or other methods to identify important sections; briefly explain the importance to the element(s).
6. If N/A is marked, explain the reason in Text/Notes section in the Survey Tool.

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TIPS IN SUMMARY

Make the most of the documents provided to NCQA in the Survey Tool. Use the documents to tell the story about your practice.

1. **Be efficient** – use only what is needed.
   - Read the documentation requirements and provide only what is necessary.
   - Try to limit the documentation to one document per element for multiple factors.
2. **Make sure documentation is legible.** Legibility impacts NCQA's review.
3. **Clearly explain the documents** and the section you want NCQA to see.
   - Label documents with the appropriate title
   - Make use of text boxes to explain, highlight, box in a targeted section or information and use arrows.
   - Do not handwrite notes on documents to explain data, and then scan them into your computer. Handwritten notes are difficult to read.
   - When using textboxes to hide information in non-PDF documents, save the documents as "read-only," or convert to PDF. Otherwise, textboxes can moved and PHI revealed.
   - For screen shots, print screens and scan, or paste print screen as a picture into a Word document or PowerPoint slide.
4. **Combine "like" documents whenever possible.**
   - E.g., multiple policies written in MS Word may be combines into one document; refer to page number for individual elements.
5. **Block PHI on all documents.** Do not submit any protected health information. Keep a master list of patient files submitted in case of an NCQA audit. Physician names/information can remain on the files.
6. **Do <u>not</u> use a flash drive (USB device)** as the file path for your linked documents.