Paving Your Way Through NCQA's PCMH Supporting Documentation Requirements

Presented by:

Candace J. Chitty, BSN, MBA, CPHQ, LHRM

President, Quality First Healthcare Consulting, Inc.

Chief Clinical Consultant, Mid-Atlantic Association of Community Health Centers

Serving Communities In Need

Mid-Atlantic Association of Community Health Centers

- The Mid-Atlantic Association of Community Health Centers (MACHC) is a 29-year old non-profit membership organization, whose members consist of community, migrant and homeless health centers, local non-profit and community-owned healthcare programs.
- MACHC is *the* Regional Primary Care Association in Maryland and Delaware and provides technical assistance and training services.

Mid-Atlantic Association of Community Health Centers

- MACHC Offers Technical Assistance in the following areas:
  - Board Governance
  - Community Development
  - Environmental Assessments
  - Emergency Preparedness
  - Fiscal Management
  - Clinical Performance Improvement

Housekeeping

- A question and answer period is allocated at the end of this session.
- A replay of this session will be available on the MACHC website.
- Completion of an evaluation survey is appreciated at the end of this training.

LEARNING OBJECTIVES

To gain understanding of:

- Types of supporting documentation expected by NCQA in support of the standards – key definitions
- NCQA's 2011 PCMH supporting documentation requirement by standard
- Best strategies to present valid content
- Common pitfalls to avoid
- Useful tools and resources in creating supporting documentation
- Other resources

Mid-Atlantic Association of Community Health Centers

Community Health Centers need to have:

- Email
- Internet Access
- Microsoft Word
- Microsoft Excel
- Adobe Acrobat Reader
- Access to the electronic systems used by the health center (practice management, patient registry, electronic prescribing, electronic health record, web portals, etc)
- Staff skilled in use of the above

Components of a standard and relationship to valid supporting documentation

- Statement of the Standard
- Elements
- **Factors**
- Scoring
- **Explanation**
- **Documentation**

Importance of Factors

Element B: After-Hours Access			**4 points**
The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:	**Yes**	**No**	**NA**
1. Providing access to routine and urgent-care appointments outside regular business hours	☐	☐	
2. Providing continuity of medical record information for care and advice when the office is not open	☐	☐	
3. Providing timely clinical advice by telephone when the office is not open	☐	☐	
4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open	☐	☐	☐
5. Documenting after-hours clinical advice in patient records.	☐	☐	

Factors

Scoring

100%	75%	50%	25%	0%
The practice meets all 5 factors, including factor 3	The practice meets 4 factors, including factor 3	The practice meets 3 factors, including factor 3	The practice meets 1-2 factors **or** meets 3-4 factors but not factor 3	The practice meets no factors

Critical Factor

Importance of Explanations

Explanation	
	Factor 1: The practice offers access to routine and non-routine care beyond regular business hours, such as early mornings, evenings or weekends. Appointment times are based on the needs of the patient population. If the practice does not provide care beyond regular office hours (e.g., a small practice with limited staffing), it may arrange for patients to receive care from other (non-ER) facilities or clinicians.
	Factor 2: Patient clinical information is available to on-call staff and external facilities for after-hours care. Information may be provided by patients with individualized care plans or portable personal health records, or may be accomplished through access to an electronic health record (EHR). If care is provided by a facility that is not affiliated with the practice or does not have access to patient records, the practice makes provisions for patients to have an electronic or printed copy of a clinical summary of their medical record. Telephone consultation with the primary clinician or with a clinician with access to the patient's medical record is acceptable.
	Factors 3 and 4: Patients can seek and receive interactive clinical advice by telephone (factor 3) and secure electronic communication (factor 4) (e.g., electronic message, Web site) when the office is closed. **Interactive** means that questions are answered by an individual, not just a recorded message.
	The ability of patients to receive clinical advice from the practice or others, such as a service, designated by the practice when the office is not open reduces patient use of the emergency room and provides more patient-centered care. Thus, Factor 3 has been identified as a **critical factor** and must be met for practices to score higher than 25 percent on this element.
	Factor 4 is NA if the practice does not have the capability to communicate electronically with patients.
	Factor 5: After-hours clinical advice must be documented in the patient record, whether it is provided by telephone or secure electronic message.

Importance of Accurate Interpretation of Required Documentation

Factor 4: The practice has a documented process for staff to follow for providing timely clinical advice using a secure interactive electronic system when the office is closed *and* has a report summarizing its actual response times. The report may be system generated or collected based on at least five days of electronic messages. Factor 4 requires the practice to:

- Define the time frame for a response, ***and***
- Monitor the timeliness of the response against the practice's standard.

Factor 5: The practice has a documented process for staff to follow for documenting after-hours clinical advice in the patient record *and* has at least three examples of clinical advice documented in the patient record ***or*** generates a report identifying how often advice is documented in the medical record. The report must provide the percentage of patients with clinical advice documented in the medical record of those patients who received after-hours clinical advice within a recent *one-month period*.

- *Denominator* = Number of patients receiving after-hours clinical advice
- *Numerator* = Number of patients with after-hours clinical advice documented in the medical record

Types of Documentation

Practices can use five basic types of documentation to demonstrate performance.

1. Documented process—Written statements describing the practice's policies, and procedures.
2. Reports—Aggregated data showing evidence of action, including manual and computerized reports the practice produces to manage its operations, such as a list of patients who are due for a visit or test.
3. Records or files—Actual patient files or registry entries that document an action taken.
4. Materials—Prepared materials the practice provides to patients or clinicians
5. Screen Shots – Electronic "copy" to demonstrate capability, materials, or records.

PCMH Supporting Documentation Matrix

Review of Supporting Documentation Matrix . Please refer to reference materials provided prior to this presentation to all attendees.

NCQA 2011 PCMH Standards
Supporting Documentation Matrix

PCMH 1: Enhance Access and Continuity					
Standard, Element, and Factor	**Description** *Core MU shaded in Green Menu MU shaded in orange*	**Documented Process** *Must be implemented for at least a period of 3 months prior to survey*	**Materials or Examples** *Shaded areas indicate system generated examples when practices use electronic systems*	**Report** *Shaded areas indicate system generated reports when practices use electronic systems*	**Screen Shot** *All screen shots are from electronic systems*
PCMH 1, Element A: 1 Critical Factor **Element A is MUST PASS**	**Same day appointments**	**X**		**X** **Represents at least 5 days**	
PCMH 1, Element A: 2	Timely clinical advice by telephone during office hours	X		X Summarizing response times for a period of at least 5 days	
PCMH 1, Element A: 3 **NA may apply**	Timely advice by secure electronic messaging during office hours	X		X Over a period of at least 1 week	
PCMH 1, Element A: 4	Documenting clinical advice in the medical record.	X	X At least three examples OR a report	X Over a recent 1 month period. Percentage of patients with clinical advice documented in medical records who received clinical advice	
PCMH 1, Element B: 1	Access to routine and urgent care appointments [illegible] business	X	X Examples of materials used to commu[illegible]fter-h[illegible]	X	

Useful Tools and Resources

- Adobe Acrobat *Free trial available*
- Microsoft Word – Text Boxes, Shapes
- Screen shot software

  --Snag-It www.techsmith.com/snagit.com *Free trial available*

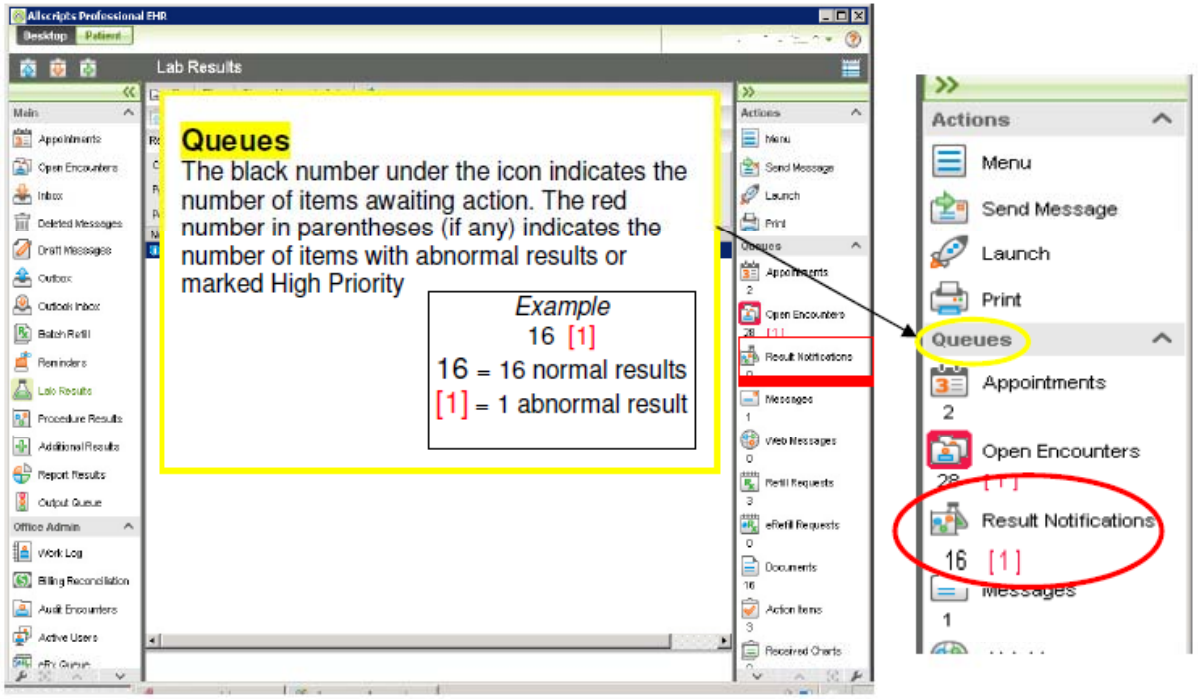
  --FastStone Capture www.fastonecapture.org *Free or Buy Lifetime License for full set of features*

  --Snipping Tool (Microsoft Product)

Example Annotated Document using Screen Shot Software

Flagging abnormal test results and bringing them to a clinician's attention is done with "Result Notifications"

Result Notifications are system-generated messages sent to the provider when lab, procedure, or other results are available in the patient chart and require review. Any abnormal test results are displayed in red.



Best Strategies

- Create a documentation project plan to track the progress of your supporting documentation from start to finish (ISS upload)
- Use documentation tools provided by NCQA (Record review workbook and Quality Measurement and Improvement Worksheet)
- Consider using CAHPS Patient-Centered Medical Home Survey (Distinction Award)
- Consolidate supporting documentation across multiple factors when at all possible (create scenarios)
- Clearly navigate (guide) a reviewer through your documentation. Narrate and guide the reviewer to what you wish them to find in your documentation.
- Make sure EHR screenshots are clear and large enough to read without distortion
- Consider an external resource to review your supporting documentation prior to the final application submission (Mock review)

Example Document Tracking Log

NCQA PCMH Document Tracking Log										Document Tracking Workflow							
#	Supporting Documentation Name	Standard and Element	Factor	Document Type	Responsible Person (s)	Completion Due Date	Status (%)	Follow-Up Date	Complete Date	Document File Name	Document Location	Date Document Filed	Date Document Annotated	Review Date for Content Validity	Document Ready for ISS (Y or N)	Date Document Loaded into ISS	Comments
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
11																	

Common Pitfalls

- Lack of understanding of documentation requirements
- Lack of process for tracking documentation
- Incomplete documentation
- Irrelevant and/or confusing documentation. If something may be confusing provide narrative in the support text or in the document itself
- Waiting too long to begin compiling your documentation
- Throwing the kitchen sink into documentation
- Inconsistent or contradictory documentation across standards

Other Resources

- Primary Care Association (MACHC) www.machc.com
- Controlled Health Center Networks (CHIP)
- NCQA, www.ncqa.org (Policy support and FAQs)
- NCQA Interactive Survey System Powerpoint www.ncqa.org/tabid/631/Default.aspx
- Patient-Centered Primary Care Collaborative www.pcpcc.net
- Healthcare Communities www.healthcarecommunities.org
- Primary Care Development Corporation www.pcdcny.org
- Transformed www.transformed.com
- American College of Physicians http://www.acponline.org/running_practice/pcmh/resources_tools/

Questions?

MACHC
Mid-Atlantic Association of Community Health Centers

PCMH Assist
Patient Centered Medical Home

Quality First Healthcare Consulting
Where Results Begin