Transitioning from PCMH 2014 to PCMH 2017:
Commit, Transform, Succeed

November 2, 2017
Orlando, FL

<u>NCQA Mission Statement</u>

To improve the quality of health care.

<u>NCQA Vision Statement</u>

To transform health care quality through
measurement, transparency and accountability.

Program Contact & Support

NCQA Customer Support   888-275-7585

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- General Information
- Educational Seminar Registration
- Publications Center

NCQA Web Site
www.ncqa.org

NCQA Physician Recognition Programs
http://www.ncqa.org/Programs/Recognition.aspx

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https://my.ncqa.org/

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NCQA Content Expert Certification
http://www.ncqa.org/EducationEvents/SeminarsandWebinars/PCMHContentExpertCertification.aspx

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Seminar Information

Transitioning from PCMH 2014 to PCMH 2017:
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Thursday, November 2, 2017

1:00 p.m. – 1:05 p.m.	**Welcome and Program Goals / Introduction of Faculty** Jennifer D'Alessandro, MPA **Faculty** Patricia Barrett, MHSA, PCMH CCE Vice President, Product Design & Support NCQA Mina Harkins, MBA, BSMT, PCMH CCE Assistant Vice President, Recognition Programs NCQA William F. Tulloch, MA, PCMH CCE Director, Government Recognition Initiatives NCQA
1:05 p.m. – 1:20 p.m.	**Standards Overview and Scoring** • Program Highlights • Standards Structure • 2017 Standards: Concepts Patricia Barrett, MHSA, PCMH CCE
1:20 p.m. – 1:40 p.m.	**Discuss and Analyze the PCMH Recognition Requirements** • Team Based Care and Practice Organization Mina Harkins, MBA, BSMT, PCMH CCE
1:40 p.m. – 2:20 p.m.	**Discuss and Analyze the PCMH Recognition Requirements continued** • Knowing and Managing Your Patients William F. Tulloch, MA, PCMH CCE
2:20 p.m. – 2:40 p.m.	**Break**
2:40 p.m. – 3:00 p.m.	**Discuss and Analyze the PCMH Recognition Requirements** • Patient-Centered Access and Continuity Mina Harkins, MBA, BSMT, PCMH CCE

3:00 p.m. – 3:20 p.m.	**Discuss and analyze the PCMH Recognition Requirements**
	• Care Management and Support
	Patricia Barrett, MHSA, PCMH CCE

3:20 p.m. – 3:40 p.m.	**Discuss and analyze the PCMH Recognition Requirements**
	• Care Coordination and Care Transitions
	William F. Tulloch, MA, PCMH CCE

3:40 p.m. – 4:00 p.m.	**Discuss and Analyze PCMH Recognition Requirements**
	• Performance Measurement and Quality Improvement
	Patricia Barrett, MHSA, PCMH CCE

4:00 p.m. – 4:20 p.m.	**Recognition Process**
	• Annual Reporting and Evidence
	• Audit and Requirements
	• Accelerated Renewal
	• Pathways
	Mina Harkins, MBA, BSMT, PCMH CCE

4:20 p.m. – 4:30 p.m.	**Q&A Regarding Content Addressed During the Program/Conclusion**

schedule is subject to change without notice

Objectives

At the completion of this seminar, participants will be able to:

- ❖ Provide an overview of PCMH (2017 Edition)
- ❖ Define the six concepts
- ❖ Explore core and elective criteria with emphasis on new requirements
- ❖ Provide an overview of the Recognition Process

Continuing Education

In support of improving patient care, the National Committee for Quality Assurance (NCQA) is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the healthcare team.

NCQA designates this live educational activity for a maximum of **2.75** *AMA PRA Category 1 Credits*[TM]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This educational activity is approved for **2.75** nursing education contact hours.*

This program is sponsored by The National Committee for Quality Assurance. The National Committee for Quality Assurance is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a Provider of continuing pharmacy education. The assigned universal program number(s): **0850-9999-17-063-L04-P**. This program provides **7.75** CPE contact hours.

Upon successful completion of this program (attending the full session and completing a program evaluation), participants will access CPE Monitor on the ACPE website to locate and track their CPE statement of credit.

* Please note – You must attend the entire program to be eligible for total number of contact hours.

Disclosure of Relevant Financial Relationships with Commercial Companies/Organizations

Transitioning from PCMH 2014 to PCMH 2017:
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November 2, 2017

The National Committee for Quality Assurance (NCQA) endorses the Standards of the Accreditation Council for Continuing Medical Education which specify that sponsors of continuing medical education activities and presenters at and planners for these activities disclose any relevant financial relationships either party might have with commercial companies whose products or services are discussed in educational presentations.

For sponsors, relevant financial relationships include large research grants, institutional agreements for joint initiatives, substantial gifts, or other relationships that benefit the institution. For presenters or planning committee members, relevant financial relationships include the receipt of research grants from a commercial company, consultancies, honoraria, travel, or other benefits, or having a self-managed equity interest in a company; or having an immediate family member or partner with such a relationship.

Disclosure of a relationship is not intended to suggest or condone bias in any presentation, but is made to provide participants with information that might be of potential importance to their evaluation of a presentation.

Relevant financial relationships exist with the following companies/organizations:

Patricia Barrett:	**None**
Michael S. Barr:	**None**
Rebecca Best:	**None**
Christina Borden:	**None**
Tina Bridgeport:	**None**
Crissy Crittenden:	**None**
Jennifer D'Alessandro:	**None**
Mina Harkins:	**None**
Sarah Lee:	**None**
Rita Lewis:	**None**
Jacquelyn Lombos:	**None**
Nicole Mason:	**None**
Peggy Reineking:	**None**
William Tulloch:	**None**

Program content was peer reviewed to ensure that it is fair-balanced and free from commercial bias.
This program was developed in part by NCQA staff.

Planning Committee

Patricia Barrett, MHSA, PCMH CCE
Vice President, Product Development
NCQA
Washington, DC

Michael S. Barr, MD MBA, MACP
Vice President, Quality Measurement &
Research Group
NCQA
Washington, DC

Rebecca Best, PCMH CCE
Policy Manager, Recognition Programs
Policy & Resources
NCQA
Washington, DC

Christina Borden, PCMH CCE
Assistant Director, Recognition
Programs Policy & Resources
NCQA
Washington, DC

Tina Bridgeport, RN, MHSA, PCMH CCE
Assistant Director, Recognition Programs
NCQA
Washington, DC

Crissy Crittenden, MSA, PCMH CCE
Program Manager, Clinician Education
NCQA
Washington, DC

Jennifer D'Alessandro, MPA
Assistant Director, Clinician Education
NCQA
Washington, DC

Mina Harkins, MBA, BSMT, PCMH CCE
Assistant Vice President, Recognition Programs
Policy & Resources
NCQA
Washington, DC

Sarah Lee, MPA, PCMH CCE
Policy Manager, Recognition Programs
Policy & Resources
NCQA
Washington, DC

Rita Lewis, MPH, PCMH CCE
Manager, Product Development
NCQA
Washington, DC

Jacquelyn Lombos, MS, PCMH CCE
Assistant Director, Education Faculty Relations
NCQA
Washington, DC

Nicole Mason, MA, PCMH CCE
Policy Manager, Recognition Programs
Policy & Resources
NCQA
Washington, DC

William Tulloch, MA, PCMH CCE
Director, Government Recognition Initiatives
NCQA
Washington, DC

Faculty

Patricia Barrett, MHSA, PCMH CCE
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NCQA
Washington, DC

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NCQA
Washington, DC

William Tulloch, MA, PCMH CCE
Director, Government Recognition Initiatives
NCQA
Washington, DC

Faculty Biographies

Patricia Barrett, MHSA, PCMH CCE

Patricia Marine Barrett joined NCQA in 2008. As the Vice President for Product Design & Support she is responsible for exploring new product concepts and evolving existing products to meet the needs of a changing health care environment. She also ensures proper development, communication and interpretation of NCQA Accreditation standards, HEDIS measures and Clinician Recognition programs.

Prior to joining NCQA, Ms. Barrett worked with Health Alliance Plan (HAP) in Detroit Michigan where she began as a quality analyst in 1993. During her 14 years with HAP she served in a variety of roles including Manager of Research, Analysis and Program Development, Acting Director of Managed Care Information and Director of Quality Management. As Director of QM, she had responsibility for all clinical quality improvement and disease management programs as well as HEDIS production and NCQA accreditation for the organization as a whole. In addition, Ms. Barrett was a member of the NCQA HEDIS Policy Panel and served as the Chairperson for the Measurement Committee of the Michigan Quality Improvement Consortium (MQIC). In her final four years with HPA she served as lead consultant to General Motors on managed care performing evaluations of the quality and efficiency of GM's HMO offerings nationally and establishing supplier development activities to drive improved performance. In this role she participated on the NCQA Purchaser Advisory Council, The National Business Coalition on Health eValue8 Steering Committee and served as an author and scorer for the eValue8 RFI.

Ms. Barrett attended the University of Michigan receiving her Bachelor's degree in Sociology and a Master's Degree in Health Services Administration from the School of Public Health.

Mina Harkins, MBA, BSMT, PCMH CCE

Mina L. Harkins has been with the National Committee for Quality Assurance (NCQA) for 10 years as Assistant Vice President, Recognition Programs Policy and Resources, in Washington DC. In this position, she is responsible for the content of and resources to support all Recognition Programs. The Recognition programs are focused on evaluating quality management of chronic conditions, such as Diabetes and Ischemic Vascular Disease, and the systems and processes utilized in clinical practices including the Patient-Centered Medical Home, the Patient-Centered Specialty Practice program, Patient-Centered Connected Care in the neighborhood and Accountable Care Organization Accreditation.

Before joining NCQA, she directed a medical laboratory accreditation program, administered a large anatomic pathology operation, managed several units in a multi-specialty group practice and a multi-site laboratory operation for a staff model HMO.

Ms. Harkins earned her BA in Medical Technology at the University of Pittsburgh and her MBA at Johns Hopkins University's Carey School of Business.

Faculty Biographies

William Tulloch, MA, PCMH CCE

William "Bill" Tulloch is NCQA's Director of Government Recognition Initiatives, and has been with NCQA since 1997. In his role, Bill manages the operations of several government contracts aimed at promoting the Medical Home concepts in federal health centers and military facilities. Bill is a PCMH Certified Content Expert with NCQA.

Prior to this position, Bill was the Director of Customer Resources, providing educational assistance to organizations seeking to improve the quality of care and service they provided. Bill was also previously Director of the Privacy Certification for Business Associates (PCBA) program, a joint offering of NCQA and the Joint Commission on Accreditation of Healthcare Organizations. Bill helped develop both the PCBA and other new assessment programs in the health care field and improving existing NCQA products as part of the Product Development team. Earlier in his tenure at NCQA Bill served as a Senior Accreditation Manager participating in and coordinating surveys for the MCO, CVO, and MBHO programs. In addition to his other work, Bill has been a frequent faculty member for educational presentations for NCQA, and is a member of the internal team that developed and maintains the Interactive Survey System.

Bill attended Williams College for his undergraduate work, and has a Master's in Economics from the University of Maryland. For seven years prior to joining NCQA, Bill worked with a health care consulting firm, HTA (now Covance), in Washington, DC, helping medical product manufacturers work in the managed care setting. During his undergraduate years, Bill co-authored two papers on the psychology of juror decision-making, based on original research.

Presentations

Transitioning from PCMH 2014 to PCMH 2017: Commit, Transform, Succeed

PCMH Congress
November 2, 2017
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Learning Objectives

Provide an overview of PCMH (2017 Edition)
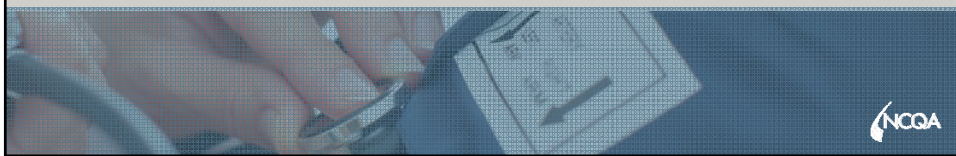
Define the six concepts

Explore core and elective criteria with emphasis on new requirements

Provide an overview of the Recognition Process

PCMH 2017

Standards Overview & Scoring

NCQA

Program Highlights

Provides focus and flexibility
- Core/elective approach allows practices to tailor program to their unique population
- Accommodates a spectrum of practices (basic-complex, small-large)

Supports continuous practice transformation
- Includes activities necessary to achieve stated aims and drive improvement
- Focuses on whether the intent was achieved and care was improved

Allows for flexibility with multiple evidence types
- Allows a variety of response options that demonstrate a requirement is met
- Introduces the virtual review process

Emphasizes comprehensive, integrated care
- Understanding behavioral needs and social determinants included in core
- Deeper integration and community connections included in electives

NCQA

PCMH Redesign

Commit

Practice completes an online guided assessment.

▼

Practice works with an NCQA representative to develop an evaluation schedule.

▼

Practice works with NCQA representative to identify support and education for transformation.

▼

New NCQA PCMH online education resources support the transformation process.

Transform

Practice submits initial documentation and checks in with its evaluator

▼

Practice submits additional documentation and checks in with its Evaluator.

▼

Practice submits final documentation to complete submission and begin NCQA evaluation process.

▼

Practice earns NCQA Recognition.

Succeed

Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).

▼

Practice demonstrates continued readiness and high quality performance through annual reporting to NCQA.

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2017 Standards Format
Structure – Concepts, Competencies, Criteria

Concepts: Over-arching components of PCMH

Competencies: Ways to think about and/or bucket criteria

Criteria: The individual things/tasks you do that make you a PCMH

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2017 Standards

Concepts

Team-Based Care and Practice Organization (TC)

- Practice leadership
- Care team responsibilities
- Orientation of patient/families/caregivers

Knowing and Managing Your Patients (KM)

- Data collection
- Medication reconciliation
- Evidence-based clinical decision support
- Connection with community resources

Patient-Centered Access and Continuity (AC)

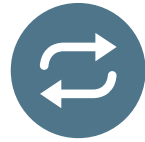- Access to practice and clinical advice
- Care continuity
- Empanelment

2017 Standards

Concepts

Care Management and Support (CM)

- Identifying patients for care management
- Person-centered care plan development

Care Coordination and Care Transitions (CC)

- Management of lab/imaging results
- Tracking and managing patient referrals
- Care transitions

Performance Measurement & Quality Improvement (QI)

- Collecting and analyzing performance data
- Setting goals
- Improving practice performance
- Sharing practice performance data

2017 Standards
Structure - Example

Competency: A brief description of criteria subgroup, organized within the broader concept.

Concept: A brief title describing the criteria; uses a two-letter abbreviation (XX).

Evidence: Proof that a practice meets the criteria. Evidence can be demonstrated by submitting documentation (e.g., policies and procedures, examples, data, reports) and through a virtual review of a practice's systems and electronic capabilities

CONCEPT: TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)

Intent: The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

TC 01 (Core) Designates a clinician lead and a staff person to manage the PCMH transformation and medical home activities.

Evidence:
- Details about the clinician lead
AND
- Details about the PCMH manager

Criteria: A brief statement highlighting the PCMH requirements. All criteria are numbered consecutively within their respective concept. Criteria are also labeled with their scoring designation:
- Core= Core criteria
- 1 Credit= Elective criteria
- 2 Credits= Elective criteria worth 2 Credits

Icon indicates evidence that is shareable across practice sites

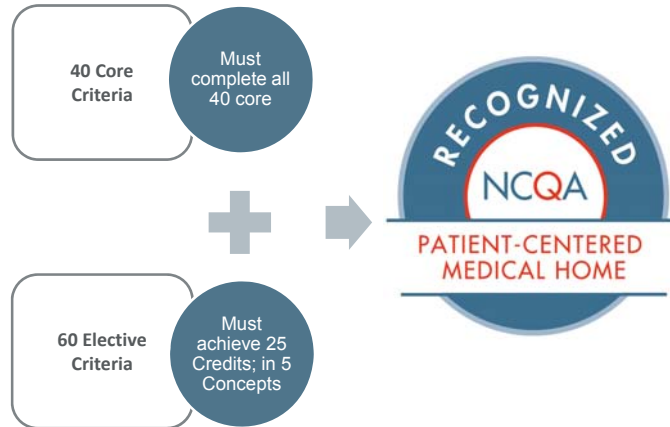**Intent:** A brief statement describing the concept goals and intent

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2017 Standards Recognition
Changes to Levels

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2017 Standards Scoring
Changes to Points

40 Core Criteria — Must complete all 40 core

+

60 Elective Criteria — Must achieve 25 Credits; in 5 Concepts

RECOGNIZED
NCQA
PATIENT-CENTERED
MEDICAL HOME

2017 Distinction Modules
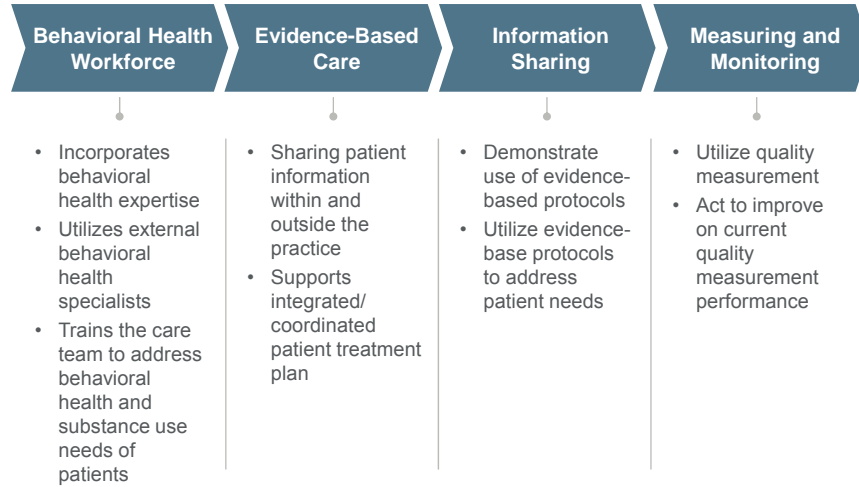*Practice Opportunities to Show Excellence*

Distinction in Patient Experience Reporting

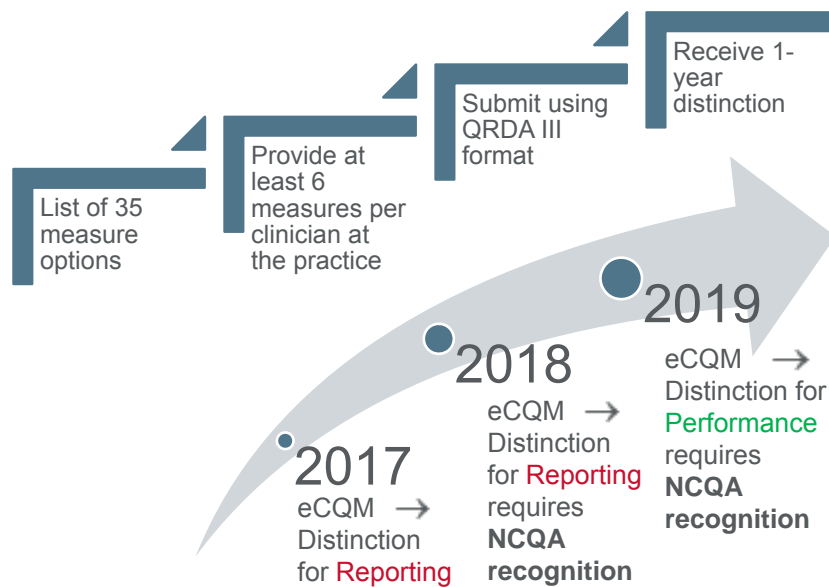*Distinction in Behavioral Health Integration*

Distinction in Electronic Measure Reporting

Behavioral Health Integration Distinction Module

Module Competencies

Behavioral Health Workforce	Evidence-Based Care	Information Sharing	Measuring and Monitoring
• Incorporates behavioral health expertise • Utilizes external behavioral health specialists • Trains the care team to address behavioral health and substance use needs of patients	• Sharing patient information within and outside the practice • Supports integrated/ coordinated patient treatment plan	• Demonstrate use of evidence-based protocols • Utilize evidence-base protocols to address patient needs	• Utilize quality measurement • Act to improve on current quality measurement performance

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eCQM Distinction Module

List of 35 measure options

Provide at least 6 measures per clinician at the practice

Submit using QRDA III format

Receive 1-year distinction

2017
eCQM → Distinction for Reporting

2018
eCQM → Distinction for Reporting requires **NCQA recognition**

2019
eCQM → Distinction for Performance requires **NCQA recognition**

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Prevalidation Program
Overview

NCQA prevalidated Health IT solutions have successfully demonstrated that their technology solution has functionality that **supports or meets one or more criteria in the PCMH standards**
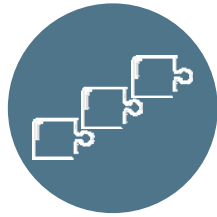
Evaluation can result in approved **fully met criteria** and **partially met criteria** that are transferable to eligible client practices submitting for recognition and acknowledgment of **practice support functionality**
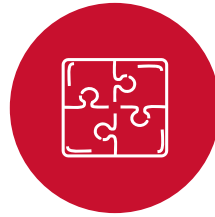

PCMH
Commit, Transform, Succeed

NCQA

Sustaining Recognition

Engage practices in annual reporting providing confirmation of continuing commitment and performance

Each practice demonstrates that changes made during the initial recognition effort are part of their culture, and practice is becoming more patient-centered

NCQA will update or review annual requirements each year to assure continued relevance supporting ongoing quality improvement

PCMH Redesign
Impact

Flexibility

Personalized service

User-friendly approach

Continuous improvement

Aligns with changes

ncqa.org/redesign

Moving Forward… 2017+

Let's continue to grow the Patient-Centered Medical Neighborhood!

✓ PCMH 2017 & Q-PASS launched on April 3, 2017

✓ Bringing PCSP and other recognition programs into new process (2018+)

✓ Moving forward with NCQA eMeasure Certification of vendors and evolving Distinction for Electronic Measure Reporting for practices

✓ Oncology Medical Home was launched at the end of the first quarter in 2017

✓ School-Based Medical Home coming soon!

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PCMH
Standards Content

NCQA
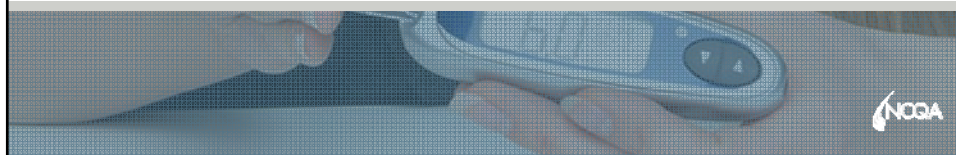
Documentation Key

Presentation documentation key:

- (r) - Report
- (e) - Evidence
- (p) - Process
- (l) - List
- (s) - Source
- (a) - Agreement
- (t) - Protocol
- (b) - RRWB
- (w) - Worksheet
- ✱ - 2 Credit Electives

PCMH

Owning Your Transformation Process

Owning Your Transformation Process

Documenting your process

Information practices must share to demonstrate performance against specific criteria.

- Evidence should focus on the intent and demonstrate performance
- Share how your practice meets the intent of each criteria
- Demonstrate transformation by meeting core & elective criteria in document form or virtual review
- Practice evaluation will be based on the review of evidence prepared or shared during the virtual review
- Evidence listed for each criterion is not prescriptive
- May be acceptable alternatives

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Owning Your Transformation Process

Types of Evidence

Documented Processes - written statements describing the practice's policies and procedures

- Protocols
- Practice guidelines
- Agreements
- Other documents describing actual processes or forms (e.g., Referral forms, checklists and flowsheets)

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Owning Your Transformation Process

Types of evidence

Evidence of Implementation – a means of demonstrating systematic uptake and effective demonstration of required practices including:

- Reports
- Materials
- Screen shots
- Attestation
- Transfer credit
- Data entered into Q-PASS

- Patient records
- Examples
- Virtual demonstration
- eCQMs
- Survey
- Not applicable

Criteria Evidence Options

Q-PASS Documents

- Documents* (upload for off-site review)
- Weblinks
- Text

Virtual Review

- Reports (create in advance)
- System demo
- Patient examples

Either Option

- Practice decision*

*All PHI should be removed from documents uploaded in Q-PASS

"*We Have Different Evidence*"

- Flexibility is encouraged
- Suggested evidence not exhaustive
- Meet intent in creative ways
- Not sure? Ask NCQA

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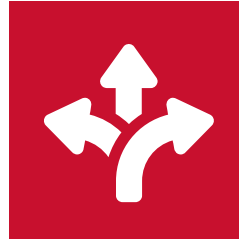
Team-based Care & Practice Organization

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care

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COMPETENCY A

The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions

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Team-Based Care and Practice Organization

TC 01-02: Core Criteria

Competency A

NEW

Designates a clinician lead of medical home, & staff to manage the PCMH transformation and medical home activities ⓔ

Defines practice organizational structure & staff responsibilities/skills to support key PMCH functions ⓔ

PCMH

Structure and Staff Responsibilities

TC 02: Example

Providers
Oversee management of practice and direct patient care

Office Manager
Daily business management

Clinical Team
Coordinate care plan; self-management support

Front Office
Coordination of visit

Billing
Financial

Care Coordinator
Coordinate and manage high risk population

Triage Nurse
Leader of daily huddle and communication

Medical Assistant
Support clinical team and facilitate patient care

Check in
Pre-visit planning

Check out
Follow-up and scheduling

Referrals
Coordination

Coding
Reimbursement

Team-Based Care and Practice Organization

TC 02: Example

Role	Responsibilities
Health Information Technologist	• Creates and generates reports and dashboards from the EMR. • Assists in the coordination of UDS, Meaningful Use, and PCMH measures and metrics. • Active member on QI committee to improve processes and meet UDS goals.
Medical Records and Privacy Coordinator	• Ensures patient information is added to chart in a timely fashion • Provides confidential patient information counseling to staff. • Processes event reports in order to improve processes within the organization.
AmeriCorps – PCMH and Community Wellness Coordinator	• Works with after school programs to educate students on healthy lifestyles. • Assists with PCMH efforts by educating staff; presenting survey questions; assisting Care Manager in recall lists. • Coordinating employee wellness activities.
Help Team Member	• Assists patients in the healthcare marketplace. • Utilizes resources in the community. • Assists with outreach services.
Spanish Interpreter	• Assists patients during appointments with understanding provider and paperwork. • Acts as a liaison for staff. • Provides cultural support for patients.
Registration Professional	• Provides patients the necessary paperwork for their appointment and per the organization. • Assists with the Healthy Neighbor Plan (sliding fee scale) application. • Confirms patient demographics, insurance, and completes check-in or patients; communicates with patients about payments.

Team-Based Care and Practice Organization

TC 03-05: Elective Criteria

Competency A

The practice is involved in external collaborative activities

NEW

* **Patient/family is involved in governance** structure/ stakeholder committees

NEW

* **Practice uses a certified EHR** system & security risk analysis

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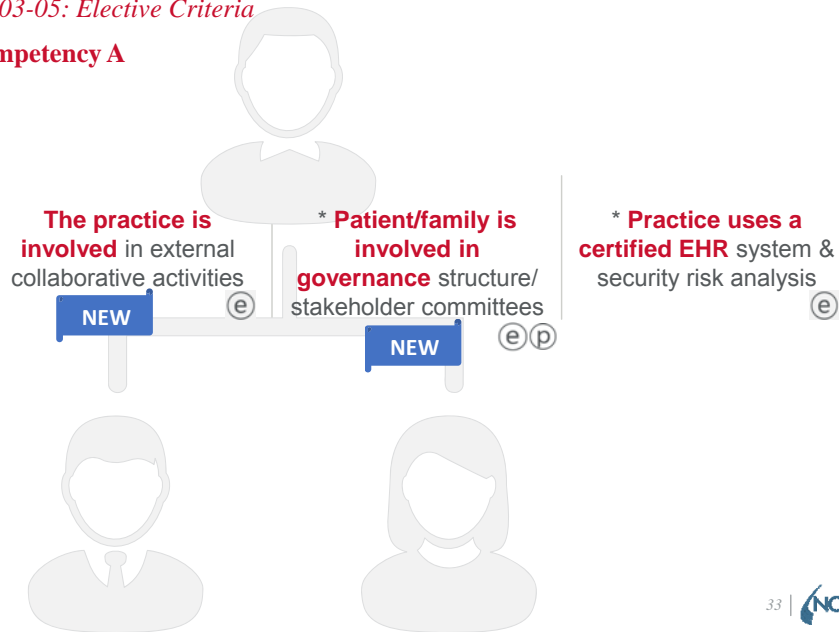
External PCMH Collaborations

TC 03: Example

TC 03

Primary Care Practice participates in the Health Center Controlled Network of NY in collaboration with CHCANYS. Our clinical measure performance data is shared with the other 42 participating health centers in a data warehouse called CPCI or Azara DRVS. Please see below for full descriptions.

STATEWIDE HEALTH IT

Health Center Controlled Network of NY

HEALTH CENTER NETWORK
N E W Y O R K

CARING FOR OUR COMMUNITIES TOGETHER

The Health Center Network of New York (HCNNY) is a federally designated health center controlled network dedicated to ensuring that its members have the ability to effectively leverage information technology to provide high quality, cost effective, patient focused primary health care to the communities they serve. HCNNY was founded in 2007 by six (6) health centers and the Community Health Care Association of New York State (CHCANYS), and today is comprised of eight member health centers and CHCANYS. As of July 1, 2013, HCNNY is operating as an independent 501(c)(3) organization.

HCNNY provides resources for its members for electronic health record implementation and on-going optimization, customized training, workflow development, and reporting to position members to take advantage of payment reform initiatives, recognition opportunities and available incentives. The Network is governed by its board of directors comprised of executives from member centers, and operational efforts are led by clinical, finance and IT committees that meet regularly to identify priorities and share best practices surrounding common challenges. Quality improvement efforts are enhanced by a data warehouse containing demographic and clinical information on the nearly 260,000 patients served network-wide.

Team-Based Care and Practice Organization

TC 04: Example

BY-LAWS
Revised November 2015, Approved by the Board of Directors 11/18/2015

Article 1. NAME AND LOCATION

b. User Members. The majority (51%) of Directors shall be individuals who are served by the Corporation and who, as a group, represent the individuals being served by the Corporation in terms of demographic factors such as race, ethnicity, and gender. User members should utilize the Corporation as their principal source of primary care and

4.2 Duties and Responsibilities.

The Board of Directors shall have specific responsibility for:

4.4 Annual Election of Directors/Board Members.

The Board of Directors shall nominate, at least thirty (30) days prior to the Annual Meeting, a slate of qualified candidates to replace Directors whose terms are set to expire and/or to fill vacant positions. The slate of candidates shall be included with the notice of the Annual Meeting. At the Annual Meeting, any member of the Board of Directors may nominate other candidates for the available Director positions, provided that the nominees agree to serve if elected. At the conclusion of

5.2 Regular Meetings.

The Board of Directors shall have regular meetings at least monthly to accomplish the business of the Corporation. The schedule of regular meetings shall be determined by the President. Notice of such meetings shall be given by any reasonable means, including electronic mail.

d. Quality Assurance Committee. The Quality Assurance Committee shall be responsible for monitoring and making recommendations for the implementation and improvement of the quality assurance/quality improvement program of the Corporation. In addition to Board member

NCQA

COMPETENCY B

Communication among staff is organized to ensure that patient care is coordinated, safe and effective
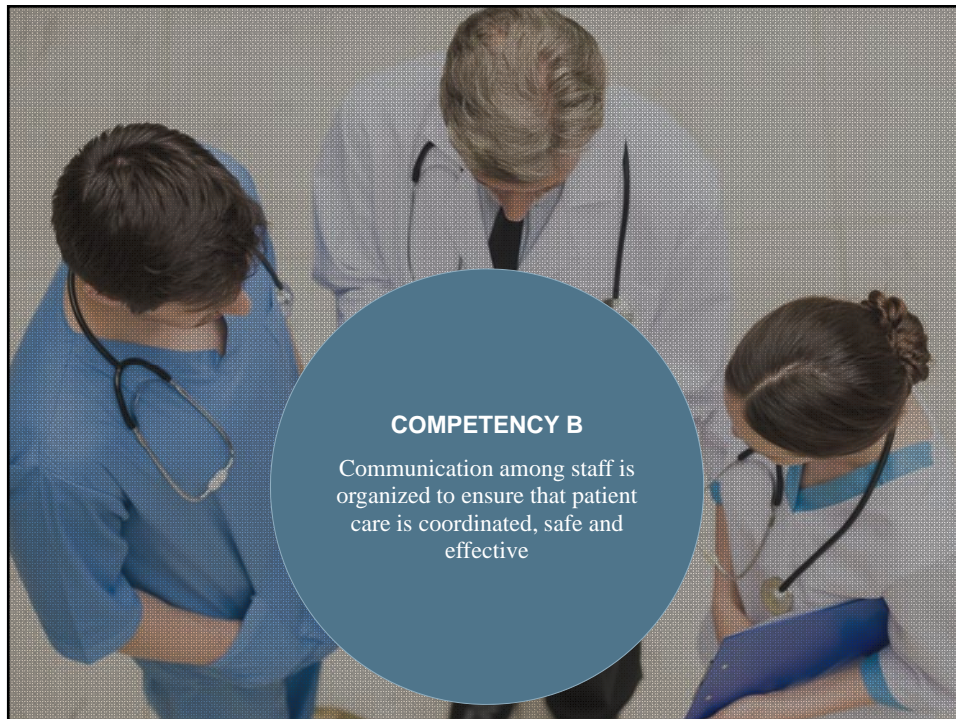
Team-Based Care and Practice Organization

TC 06-07: Core Criteria

Competency B

Has regular care team meetings or a structured communication process focused on individual patient care ⓔⓟ

Involves care team staff in practice's performance evaluation and quality improvement activities ⓔⓟ

Team-Based Care and Practice Organization

TC 06: Example

SUBJECT: Daily Huddles

PURPOSE: Each primary care site at _____ conducts a structured team meeting at least daily. The brief "huddle" is scheduled by the site manager or a designated staff member to occur at the same time each day. The purpose of these meetings is to proactively anticipate and plan actions based on patient need and available resources.

RESPONSIBILITY: It is the responsibility of the entire team to attend the meetings and ensure the outcomes/decisions made at the meetings are carried out. It is the responsibility of the site manager to insure that the huddles are conducted daily and appropriate documentation is completed.

PROCEDURE: The care team meets at the same time daily to efficiently and effectively plan the day and to discuss known or potential patient needs. The team:

- Reviews the daily schedule
- Focuses on those patients with known chronic illnesses
- Monitors the need for health maintenance and/ or preventive care services
- Arranges for any special services that may be needed
- Provides any follow up discussion related to care provided on the previous day
- Discusses needs specific to the team's daily workflow including staff flexibility, special patient needs, sick calls, contingency plans, and proactive planning for the next day
- Documents on a Daily Huddle form (filed in a binder at the site for a minimum of 3 months)

Team-Based Care and Practice Organization

TC 06: Example

Team-Based Care and Practice Organization

TC 07: Example

Date: 01/01/2017

SBCHC Staff Process Improvement (PI) Committee
The SBCHC Staff Process Improvement Committee will consist of SBCHC staff from a variety of departments. The Staff PI Committee will meet monthly to review event reports, department metrics, satisfaction survey results, and comment cards. The Staff PI Committee will support quality improvement and risk management work through discussion of trends, identification of improvement needs, and development of improvement cycles to address negative trends. The Staff PI Committee is led by the COO. Staff PI Committee members will support the integrity of QI and risk management work that is done within their work departments.

SBCHC Medical Quality Improvement Team
The Medical Quality Improvement Team will consist of at least two staff Registered Nurses, the COO, the electronic health record superuser and the Executive Assistant. This Team will meet every other week to focus on medical quality of care data and discuss and plan for system changes to make improvements to medical data. It is anticipated this Team will transition in 2017 to focus on overall Health Center clinical measures. The Team's work is shared with the medical staff at monthly meetings and with the staff PI committee.
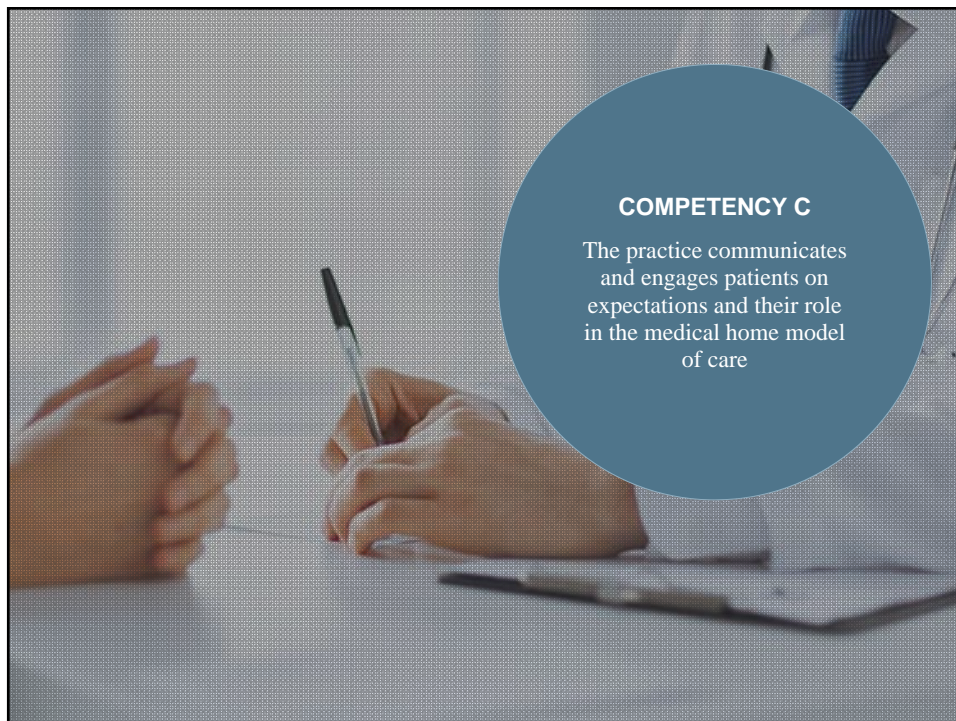
Team-Based Care and Practice Organization

TC 08: Elective Criteria

Competency B

NEW

* **The practice has at least one care manager qualified** to identify and coordinate behavioral health needs ⓔ

COMPETENCY C

The practice communicates and engages patients on expectations and their role in the medical home model of care

Team-Based Care and Practice Organization

TC 09: Core Criteria
Competency C

Has a process for informing patients/ families/caregivers about the role of the medical home and provides materials that contain the information ⓔⓟ

PCMH

Medical Home Information

TC 09: Example

What type of services does my Medical Home provide for me and my family?
We provide comprehensive, compassionate and continuous care for newborns, children, and teens.

- Same day appointments
- Preventive care and physicals (health risk assessments, sports and school physicals)
- Acute care for illness and injuries
- Well child visits, screening and vaccinations
- 24x7 phone access to your care team
- Online electronic access to your medical records
- Referrals to top specialists and mental health providers
- Management of multi-specialty care plans including mental health

WHAT WE OFFER:

- Adult Medicine
- Pediatric Care
- Chronic Care for Diabetes, Asthma, Hypertension, and Behavioral Health
- Referrals to Specialty Care when needed
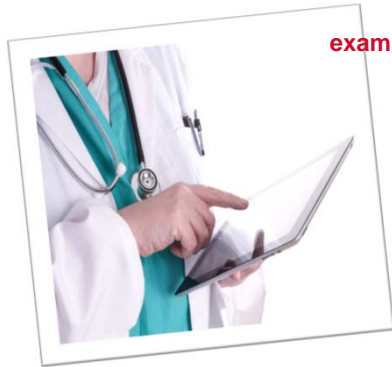- Assistance with Substance Abuse addictions

INSURANCE REQUIREMENTS

You don't need insurance to be seen at our clinic

- If you do have insurance, please bring your information with you
- If you do not have insurance, we still want to see you. We have staff that will assist you in signing up for insurance

Knowing & Managing Your Patients

The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services

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COMPETENCY A

Practice routinely collects comprehensive data on patients to understand background and health risks of patients.

Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals

Knowing and Managing Your Patients

KM 01-02: Core Criteria

Competency A

Documents an up-to-date problem list
(r) OR [KM 06]

Completes a comprehensive health assessment that includes the examination of all 9 items
(e)(p)

Medical history of patient & family

Mental health/ substance use history of patient & family

Family/social/cultural characteristics

Communication Needs

Behaviors affecting health

Social functioning [NEW]

Social determinants of health [NEW]

Developmental screening

Advanced care planning (NA for pediatrics)

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Knowing and Managing Your Patients

KM 02: Example

Initial Assessment:

The health care provider will initiate an assessment and complete the documentation of that assessment by the end of the **first patient visit**. When appropriate and with the patient's approval, data from family or caregiver will be included. Initial assessment includes review and integration of all available past medical history and records. The assessor will record relevant physical data to include:

1. Problem List
2. Operations/Hospitalizations/Urgent or Emergent Care (if affirmative, the health assistant will contact the appropriate health center for an emergency department report or hospital discharge summary).
3. Special Procedures, e.g., Colposcopies, colonoscopies, etc.
4. Allergies to medications, Latex, and Foods
5. Family History
6. Social History: Smoking, alcohol, and drug usage, History of domestic violence (in women)
7. Cardiac Rick Factors
8. Health care maintenance screening
9. Immunization status
10. Obstetric history (in women)
11. Focused Review of Systems

Current medication usage will be recorded on the Medication List if the patient has not been seen with the EMR. If the patient has been seen in the EMR current medication usage will be recorded in the medication module. The Medication list and/or medication module will be used to record changes in prescribed or over the counter medication usage, medication compliance with medications prescribed will be noted in the medication reconciliation section list of the Patient Check-In template.

If the patient responds in the affirmative to either of the depression screening questions, the health assistant will administer a full PHQ. Patients who answer that they have any degree of suicidal ideation will be further evaluated by behavioral health using a structured self-harm assessment.

All of these assessments are repeated by the health assistants at every visit as a part of the routine vital signs.

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Knowing and Managing Your Patients

KM 02 A&D: Example

Medical History
- ASSUMPTION OF CARE 5/24/2004
- HYPERTENSION
- GERD
- FIBROCYSTIC BREAST DISEASE
- HYPERLIPIDEMIA
- CORONARY ARTERY DISEASE
- DIABETES MELLITUS TYPE 2
- CHROINCH LYMPH NODE LEFT POSTERIOR CERVICAL CHAIN

KM 02 A

Family

☐ No relevant family history ☐ Adopted - no family history known

Relationship	Family Member Name	Deceased	Age at Death	Condition
Brother		N		Alive and well
Father		Y	81	Neurodegen disease
Father		Y		
Maternal grandmother		Y	80	Cancer -breast
Maternal grandmother		Y		
Mother				Obesity
Mother				Atrial Fibrillation
Sister	x7	N		Alive and well

KM 02 D

| Insurance | Additional Patient Data | Related Accounts | Contacts/Communications | Notes |

Chart#: [   ] [...] Patient Status: MULTIPLE EXIST Cell: [

Patient Statuses

Existing Patient Statuses:

Status	Date Assigned	Assigned By	Options
SLIDE LEVEL E	03/22/16	GWINGEN	
SPANISH INTERPRETE	06/04/14	YBELTRAN	
HEARING IMPAIRED	06/04/14	YBELTRAN	

OK Cancel Add Delete

Knowing and Managing Your Patients

KM 03: Core Criteria

KM 04: Elective Criteria

NEW

Competency A

Conducts depression screenings using a standardized tool
ⓔ & ⓡ OR ⓟ

Conducts behavioral health screenings and/or assessments (implement two or more)

- Anxiety
- Alcohol use disorder
- Substance use disorder
- Pediatric behavioral health screening
- Post-traumatic stress disorder
- ADHD
- Postpartum depression
ⓔⓟ

Knowing and Managing Your Patients

KM 03: Example

Behavioral Health Screening

KM 04: Example

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Resource: http://www.integration.samhsa.gov/images/res/CAGEAID.pdf

Knowing and Managing Your Patients

KM 05-08: Elective Criteria

Competency A

NEW

Assesses & provides necessary oral health services or coordinates with oral health partners (e)(p)

NEW

Identifies the predominant conditions & health concerns of patient population ①

* **Understands social determinants of health** for patients, monitors at population level & implements care interventions (r)(e)

NEW

Evaluates patient population demographics/communication preferences/health literacy & distribution of patient materials (r)(e)

NEW

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Oral Health Assessment and Services

KM 05: Example

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name:_____ Date of Birth:_____ Date:_____
Visit: ☐6 month ☐9 month ☐12 month ☐15 month ☐18 month ☐24 month ☐30 month ☐3 year ☐4 year ☐5 year ☐6 year ☐Other_____

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
⚠ Mother or primary caregiver had active decay in the past 12 months ☐Yes ☐No	• Existing dental home ☐Yes ☐No	⚠ White spots or visible decalcifications in the past 12 months ☐Yes ☐No
• Mother or primary caregiver does not have a dentist ☐Yes ☐No	• Drinks fluoridated water or takes fluoride supplements ☐Yes ☐No	⚠ Obvious decay ☐Yes ☐No
• Continual bottle/sippy cup use with fluid other than water ☐Yes ☐No	• Fluoride varnish in the last 6 months ☐Yes ☐No	⚠ Restorations (fillings) present ☐Yes ☐No
• Frequent snacking ☐Yes ☐No	• Has teeth brushed twice daily ☐Yes ☐No	• Visible plaque accumulation ☐Yes ☐No
• Special health care needs ☐Yes ☐No		• Gingivitis (swollen/bleeding gums) ☐Yes ☐No
• Medicaid eligible ☐Yes ☐No		• Teeth present ☐Yes ☐No
		• Healthy teeth ☐Yes ☐No

ASSESSMENT/PLAN			
Caries Risk: ☐Low ☐High	**Self Management Goals:** ☐Regular dental visits	☐Wean off bottle	☐Healthy snacks
Completed: ☐Anticipatory Guidance	☐Dental treatment for parents	☐Less/No juice	☐Less/No junk food or candy
☐Fluoride Varnish	☐Brush twice daily	☐Only water in sippy cup	☐No soda
☐Dental Referral	☐Use fluoride toothpaste	☐Drink tap water	☐Xylitol

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Social Determinants of Health

KM 07: Example

PCMH KM 07 Social Determinants of Health

We receive referrals from New Ground Shelter. A registry of shelter patients is maintained annually. Patient/Family members that seek health insurance are directed to visit the clinic when our Children's Health Insurance Program counselors are on site.

New GROUND

Year 2016		Pediatrics / Shelter Patient List		
Visit Date	Name Last, First	Parent/Guardian	MR #	Insurance
02/01/2016			15	Healthfirst
05/26/2016			177	United Healthcare
07/6/2016			70	Healthfirst

COMPETENCY B

The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met

Knowing and Managing Your Patients

KM 09-10: Core Criteria

Competency B

Assesses the diversity of its population (r)

Assesses the language needs of its population (r)

Diversity and Language

KM 09-10: Example

Date Range: January 1, 20▮ - December 1, 20▮

Race	Asian	African American	Native American	Caucasian	More than one Race	Refused to Report
	5	25	289	1603	29	6

Ethnicity	Hispanic	Non-Hispanic	Refused to Report
	162	1697	99

Veterans	Veterans
	39

Date Range - January 1, 20▮ - December 31, 20▮

Patients better served in a language other than English

Patients	English	Spanish
1957	1858	99
100%	94.9%	5.1%

Knowing and Managing Your Patients

KM 11: Elective Criteria

Competency B

Based on the diversity of population and community, the practice recognizes and addresses their needs (demonstrate at least two):

Target population health mgmt on disparities in care
ⓔ OR QI 05 & QI 13
NEW

Address health literacy of practice staff
ⓔ

Educate staff on cultural competence
ⓔ
NEW

Population Needs - Health Literacy

KM 11:B Example

Example of assessing health literacy at the patient level using a standardized assessment embedded in the EHR.

Health Literacy Score = 1: Patient never needs help reading instructions from doctor or pharmacist.

Example of training materials used to educate staff on topics related to health literacy.

Teach-back:
A Health Literacy Tool to Ensure Patient Understanding

Educational Module for Clinicians

from the

Iowa Health System Health Literacy Collaborative

Teach-back is...

- Asking patients to repeat **in their own words** what they need to know or do, in a non-shaming way.
- **Not** a test of the patient, but of how well *you* explained a concept.
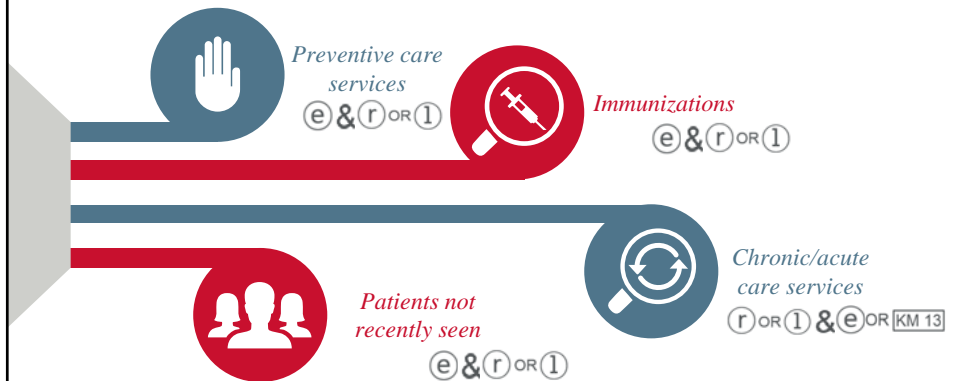- A chance to check for understanding and, if necessary, re-teach the information.

COMPETENCY C

The practice proactively
addresses the care needs of the
patient population to ensure
needs are met

Knowing and Managing Your Patients

KM 12: Core Criteria

Competency C

Proactively & routinely identifies populations of patients and reminds
them about needed care services (must report at least three items):

Preventive care services ⓔ&ⓡ ᴏʀ ①

Immunizations ⓔ&ⓡ ᴏʀ ①

Chronic/acute care services ⓡ ᴏʀ ① &ⓔ ᴏʀ KM 13

Patients not recently seen ⓔ&ⓡ ᴏʀ ①

Population Health Management

Transformed in the PCMH

Competency C

Current View	New Population View
30 Patients Per Day	2500 Patient Population
14 have Chronic Conditions	900 have Chronic Conditions
Unknown Health Risks	1100-1250 have Mod-High Health Risk
Visits Too Short for Coaching	Care Teams Leveraged by HIT

Volume-Based/Episodic → **Value-Based/Continuous**

Knowing and Managing Your Patients

KM 12: Example

MRN/Pat Name	Pat Acct No	Pat Type	Hospital Service	Patient Area Code	Patient	2015	2	2016	2014 Cases	Address
		Ou	IC ADULT HEALTH CENTER					1	0	
		Ou	IC ADULT HEALTH CENTER					1	0	
		Ou	IC ADULT HEALTH CENTER					1	0	
		Ou	IC ADULT HEALTH CENTER					1	0	
								1	0	
								1	0	
								1	0	
								1	0	
								1	0	
								1	0	

Dear Patient

Our records indicate you have not been to the office recently.

Please phone the office at (973) 555-5555 to schedule your appointment witl ABC Health Center.

For the visit to be as beneficial as possible, we will need your help in preparing for it.

Your participation is vital for good health. Thanks for taking care of yourself and helping to prepare for your visit.

Please bring your current medications list to your checkup. And be prepared to discuss your healthcare goals.

Sincerely,
ABC Health Center

Excellence in Performance

KM 13: Elective Criteria

Competency C

* **Using evidence-based care guidelines,** the practice demonstrates excellence in benchmarked/ performance-based recognition program

NEW

(r)

COMPETENCY D

The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers

Knowing and Managing Your Patients

KM 14-15: Core Criteria

Competency D

Reviews and reconciles medications for more than 80 percent of patients received from care transitions

(r)

Maintains an up-to-date list of medications for more than 80 percent of patients

(r)

Knowing and Managing Your Patients

KM 16-19: Elective Criteria

Competency D

Assesses understanding & provides education on new prescriptions

(r)(e)

Assesses & addresses response to medications & barriers to adherence

(r)(e)

NEW

Reviews controlled substance database for relevant medications (e)

NEW

* Systematically obtains prescription claims data (e)

COMPETENCY E

The practice incorporates evidence- based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients

---

Knowing and Managing Your Patients

KM 20: Core Criteria

Competency E

Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four items):

A. Mental health condition ⓢⓔ

B. Substance use disorder ⓢⓔ

C. A chronic medical condition ⓢⓔ

D. An acute condition ⓢⓔ

E. A condition related to unhealthy behaviors ⓢⓔ

F. Well child or adult care ⓢⓔ

G. Overuse/appropriateness issues ⓢⓔ

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Clinical Decision Support – Mental Health

KM 20 A: Example

SCREENSHOT of TEMPLATE where tool information entered into EHR.

rm: 2016 ADULT Encounter Note ☑ Auto Neg ☑ Uncheck All

MA Immunizations & Refusals | MA Check In | MA Screening | **MA & PCP: Screenings** | PCP: HPI & Soc/Fam/PMH/PSH | PCP: ROS | PCP: PE | PCP: Asthr

☐ Y **COLECTOMY**
☐ Y **Mastectomy BILATERAL**
☐ Y **Mastectomy RIGHT Breast**
☐ Y **Mastectomy LEFT Breast**

FREE TEXT DATE OF
SURGERY, LOCATION, &
RESULTS OF PATHOLOGY

IMPORTANT SCREENINGS
☐ Y Hx of Fecal Occult Blood
☐ Y Hx of Complete Colonoscopy
☐ Y Hx of Cervical Pap Smear
☐ Y Hx of Mammogram Screening

Enter Date Completed in Box, then
FREE TEXT LOCATION, RESULTS,
AND DATE NEXT SCREENING IS DUE

PHQ9 Total Score (MA SHOULD FREE TEXT RESULT)

PCP NEEDS TO SELECT FOLLOW-UP PLAN BELOW BASED ON SCORE
IF PHQ-9 IS 15 OR GREATER, ADDRESS THE FOLLOWING THREE REQUIREMENTS
☐ Y Positive for Mod-Sev Depression (PHQ9 = 15+)
☐ Y Referred to BHS
GO TO "Orders & Charges" to INITIATE TASK labelled PHQ-9 = 15+

IF PHQ-9 IS 14 OR BELOW CLICK THE FOLLOWING
☐ Y Negative for Mod-Sev Depression (PHQ9 < 15)
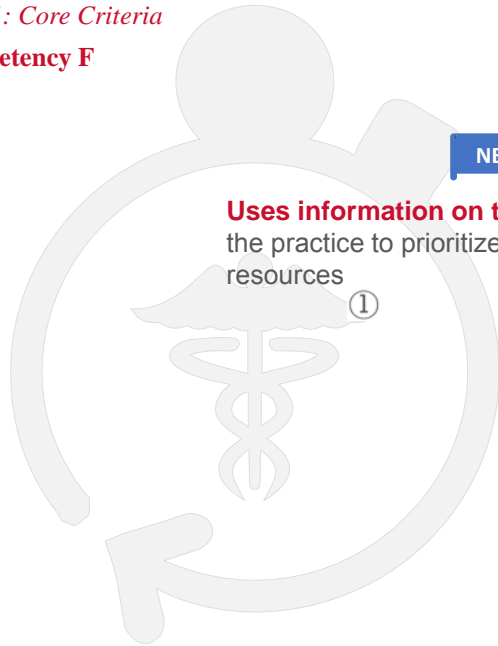

COMPETENCY F

The practice identifies/
considers and establishes
connections to community
resources to collaborate and
direct patients to needed
support

Knowing and Managing Your Patients

KM 21: Core Criteria

Competency F

NEW

Uses information on the population served by the practice to prioritize needed community resources ①

Knowing and Managing Your Patients

KM 22-27: Elective Criteria

Competency F

NEW

Provides access to educational materials ⓔⓟ

Offers oral health education resources ⓔ

Adopts shared decision-making aids ⓔ

Engages with schools or intervention agencies ⓔⓟ

Routinely maintains a current community resource list ①

Assesses usefulness of community support resources ⓔ

NEW

Access to Educational Resources

KM 22: Example

Blood Pressure Log

Name: _____

Level of Severity	Systolic	Diastolic
Normal	120	80
Mild Hypertension	140 - 160	90 - 100
Moderate Hypertension	160 - 200	100 - 120
Severe Hypertension	Above 200	Above 120

Date	AM		PM		Notes
	Blood Pressure	Pulse	Blood Pressure	Pulse	

Knowing and Managing Your Patients

KM 23: Example

Dental Resource

Re: Updated Community Resource List

Special Instructions: Please print and maintain copies for distribution to staff and patients

Dental Services

DHWP Dental Care Services
    Telephone:
    Dental Adults
    Dental Pediatr

Mission: Pediatric Oral Health and Cancer Screening Management provide Primary and Comprehensive Oral Care that is preventive and Therapeutic. Dental Services offered are; Oral Health and Education , Sealants, Restorative and Oral Surgery, Oral Conscious Sedation and Nitrous Oxide, Assessment and Support for Child Psychological Needs, Referral to specialty dental care clinics

Pharmacy Services

The Pharmacy & Pharmacology Division of Detroit
    Telephone: 24 Hour Automated Refill Manager

Shared Decision-Making Aids
KM 24: Example

School/Intervention Agency Engagement
KM 25: Example

Knowing and Managing Your Patients

KM 28: Elective Criteria

Competency F

NEW

* **Regularly include external parties in "case conferences"** for the purpose of sharing information and discussing care plans for high-risk patients ⒠ⓟ

Patient-Centered Access & Continuity

The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/ care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access
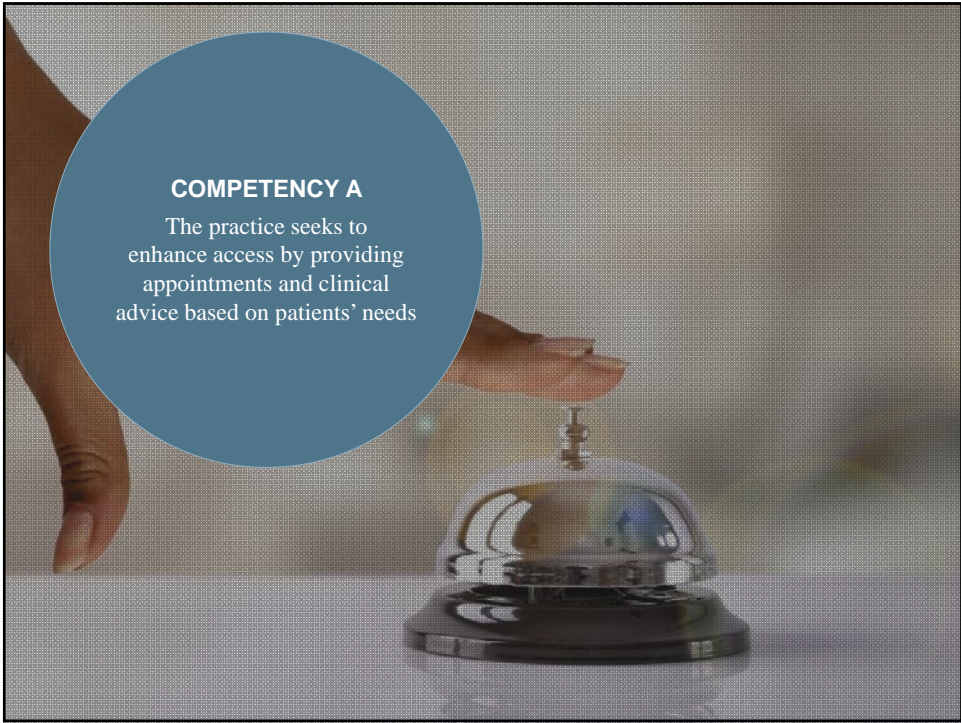
COMPETENCY A

The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs

---

Patient-Centered Access and Continuity

AC 01-05: Core Criteria

Competency A

NEW *Assesses patient access needs* (e)(p)

Provides same day appt. availability (e)(p)

Extended hours are available for appts. (e)(p)

Timely clinical advice by phone (r)(p)

Documents clinical advice in EHR (e)(p)

Patient-Centered Access and Continuity

AC 01 : Example

NCQA

Patient-Centered Access and Continuity

AC 02 : Example

Jones Medical Center

Explanation: The practice reserves time for same-day appointments. This report shows the number of days to the *third next available* appointment for each day from 10/14/20XX through 10/18/20XX as measured first thing each morning as the clinic day began.

Provider	Monitoring Date	Days
Jones, MD	10/14/20XX	1
Jones, MD	10/15/20XX	0
Jones, MD	10/16/20XX	0
Jones, MD	10/17/20XX	1
Jones, MD	10/18/20XX	2
	Average # of days	0.8

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Patient-Centered Access and Continuity

AC 03 : Example

Contact Us

Our location

Suburban Family Healthcare

Get in touch

Phone: (Also for After Hours)
Fax:
Email:
(office manager – only for non-medical issues)

Our hours

Monday 8:30a.m. – 12:00p.m., 1:00p.m. – 5:30p.m.
Tuesday 10:00 a.m. – 7:00p.m
Wednesday 8:30a.m. -12:00p.m., 1:00p.m. – 5:00p.m.
Thursday 8:30a.m. – 12:00p.m.
Friday 7:30a.m. – 12:00p.m., 1:00p.m. – 3:00p.m.

Walk in hours 8:30-9:30 am Monday and Fridays (existing patients only) and 1st and 3rd Saturdays of the month from 9-12 by appointment only.

Patient-Centered Access and Continuity

AC 04 : Example

Clinical Advice telephonic response 7 days' log

Patient	Doctor	Date Called	Time Called	Urgent Y/N	Date Responded	Time Responded
		04/11/2016	2:48 PM	Y	04/11/2016	3:04 PM
		04/13/2016	10:55 AM	N	04/13/2016	11:25 AM
		04/14/2016	10:55 AM	N	04/14/2016	11:25 AM
		04/15/2016	2:26 PM	N	04/15/2016	2:37 PM
		04/18/2016	7:26 PM	N	04/18/2016	7:36 PM
		04/21/2016	8:23 PM	N	04/21/2016	8:50 PM

Patient-Centered Access and Continuity

AC 06-08: Elective Criteria

Competency A

Practice uses phone or other technology supported mechanisms to provide scheduled routine & urgent care appointments (r)(p)

Secure electronic system is available for patient requests for appointments, prescription refills, referrals and test results (e)

Timely clinical advice is provided using a secure electronic system for two-way communication (r)(p)

Patient-Centered Access and Continuity

AC 09: Elective Criteria

Competency A

NEW

Practice assesses equity of access that considers health disparities by using information about the population served (e)

Medicaid

COMPETENCY B
Practices support continuity through empanelment and systematic access to the patient's medical record

---

Patient-Centered Access and Continuity
AC 10-11: Core Criteria

Competency B

Assists in the selection and/or change of the patients/families/caregivers personal clinician choice and documents information in EHR Ⓟ

Practice establishes goals and monitors the % of patient visits with selected clinician/team Ⓡ

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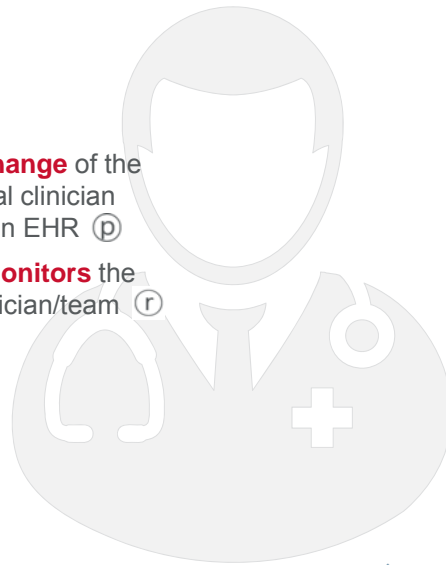
Patient-Centered Access and Continuity

AC 12-14: Elective Criteria

Competency B

* **Continuity of medical record information** when the office is closed ⓟ

Review and actively manage panel sizes ⓡⓟ **NEW**

Review and reconcile panels based on external data ⓔⓟ **NEW**
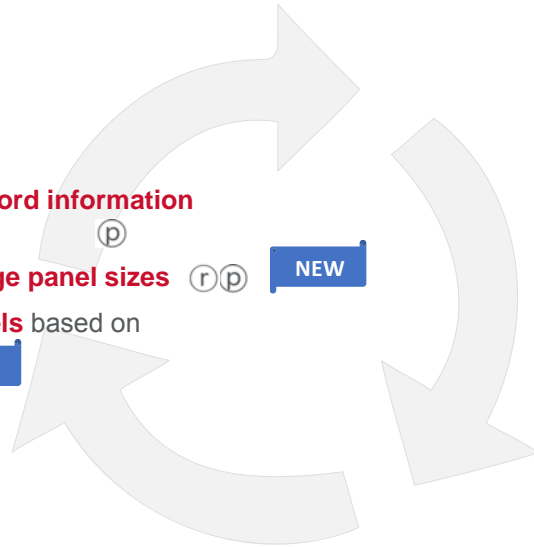
Patient-Centered Access and Continuity

Examine Supply/Demand

To manage clinician supply/patient appointment demand

To determine number of patients it's possible to take care of:

$$\frac{(\text{provider visits/day})(\text{days in clinic/year})}{(\text{patient visits/year})} = \text{\# patients}$$

$$\frac{(18)(210)}{(3.6)} = \text{\# patients}$$

Fill in values, for example:

- Provider visits/day = 18
- days in clinic/year = 210
- patient visits/year = 3.6

$$1,050 = \text{\# patients}$$

~ Mark Murray, MD

Also compare **appointment demand** with **backlog or wait time for appointments**

Panel Size Review and Management

AC 13: Example

What's Your Number ? ? ?   Determining the Right Panel Size

In the process of empanelment, it is important to understand the number of patients that a provider can reasonably support. This number is linked to provider availability and must be understood before the empanelment process begins. This number should be recalculated whenever the provider's availability to see patients changes significantly.

1. Select a provider in your practice/clinic who provides care at least 3 days per week.   Provider Name: (insert name)

2. For this provider, determine the following:

Encounter volume

A.	Total number of encounters for the past two years NOTE: Do not count nurse-only visits	

Unduplicated Patients

B.	Number of unduplicated patients seen in the last year	
C.	Number of unduplicated patients seen in the year *prior* to last year	
D.	Number of unduplicated patients seen in the last two years	
E.	Number of *new* unduplicated patients seen last year	

Average Visits per Patient per Year

F.	Calculate: [A / D] = AVPY (Total number of encounters for the past two years / Number of unduplicated patients seen in the last two years) = Average Visits per Patient per Year	#DIV/0!

Appointment Availability

G.	Length of appointment slots (in minutes) NOTE: If your practice/clinic has more than one appointment slot length, use the average appointment length. For example, your clinic uses 15 minute and 30 minute appointment slots. The average will be 22 minutes.	
H.	Number of appointment slots available on the schedule last year	

Practice site/clinic: (insert name)	Provider: (insert name)	
	FORMULA	**RESULT**
DEMAND Appointment needs of current population	**B X F** Number of unduplicated patients seen in the last year X Average Visits per Patient per Year	#DIV/0!
SUPPLY Provider availability	**H** Number of appointment slots available on the schedule last year	0
RIGHT PANEL SIZE The number of patients the provider can support based on current availability	**H / F** Number of appointment slots available on the schedule last year / Average Visits per Patient per Year	#DIV/0!
%GROWTH	**[B – C] ÷ C** (Number of unduplicated patients seen in the last year- Number of unduplicated patients seen in the year prior to last year) ÷ Number of unduplicated patients seen in the year prior to last year	#DIV/0!

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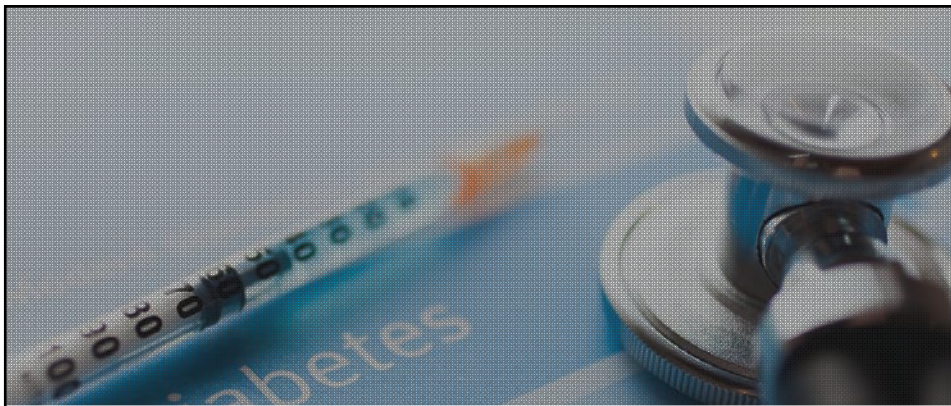
Care Management & Support

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk

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COMPETENCY A

The practice systematically identifies patients who may benefit from care management

---

Care Management and Support
CM 01-02: Core Criteria

Competency A

❖ The practice must include at least three categories in its criteria

High cost/high utilization

Social determinants of health

Behavioral Health conditions

Poorly controlled or complex conditions

Referrals by outside organizations

CM 01 - (t) OR CM 03

CM 02 - (r)
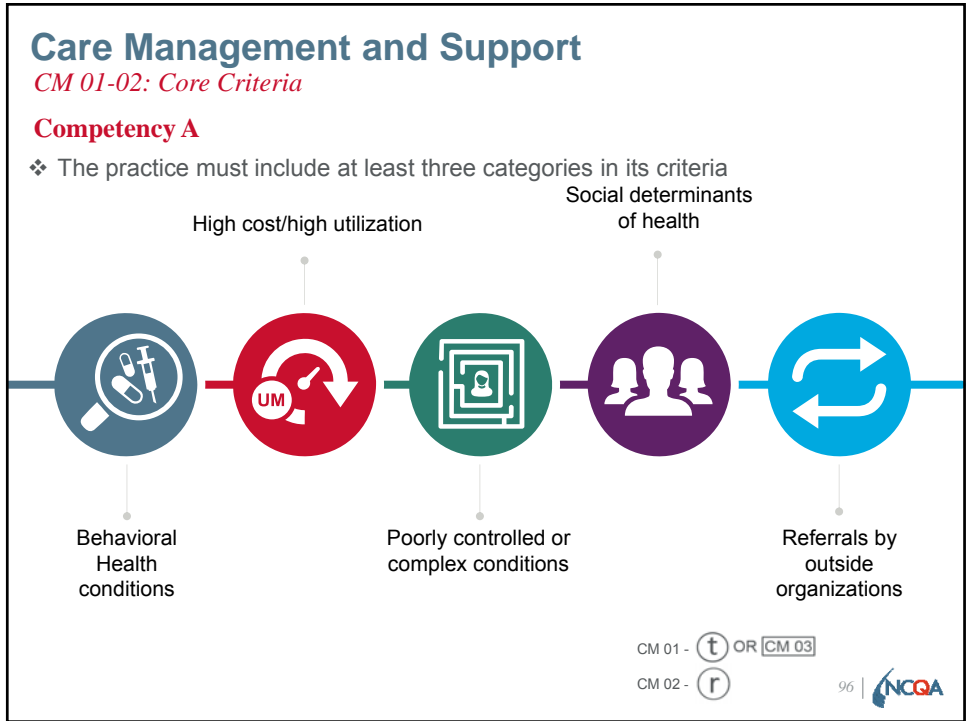
Identifying & Monitoring Patients for Care Mgmt
CM 01: Example

- Behavioral health patients identified – positive PHQ 9
- High utilizers – two or more ER visits in 6 months
- Two or more hospital admissions in past year
- Poorly controlled (multiple co morbidities) – HgbA1C > 9; uncontrolled hypertension
- Social determinants of health – education level < grade 8

Utilizing the criteria outlined above and in our Patient Care Planning and Management protocol, it is determined that 83 patients or 9% of the population serviced at the Ashland center could benefit from care management.

Denominator = 893 patients

Numerator = 83 patients

Percentage of patients identified as benefiting from care management = 5%

Care Management and Support
CM 02: Example

Patients Needing Care Management

	Behavioral Health	High Cost/ Utilization	Poor Control/ Complex	Social Determinants of Health	Referrals	Total Patients
Patients in Registry (may be listed more than once)	120	35	200	10	10	375
Unique Patients in Registry	-	-	-	-	-	343
Total Patients in Practice	-	-	-	-	-	3000
Patients Needing Care Management	-	-	-	-	-	11.4% (343 patients)

Care Management and Support

CM 03: Elective Criteria
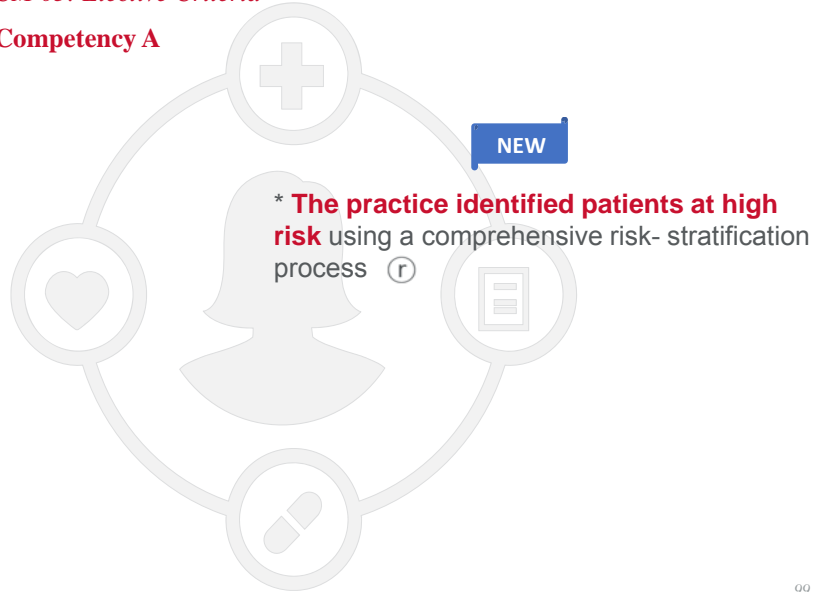
Competency A

NEW

* **The practice identified patients at high risk** using a comprehensive risk- stratification process (r)

COMPETENCY B

For patients identified for care management, the practice consistently uses patient info. & collaborates with patients/ families/caregivers to develop a care plan that addresses barriers & incorporates patient preferences & lifestyle goals documented in the patient's chart. Demonstration may be through reports, file review or live demonstration of case examples

Care Management and Support

CM 04-05: Core Criteria

Competency B

A person-centered care plan is established for care management patients

(r) OR (b) & (e)

The practice provides a written care plan to patients/families/caregivers under care management

(r) OR (b) & (e)

Care Management and Support

CM 05: Example

Patient is provided a copy of individualized care plan

CLINICAL SUMMARY PRINT	☒ Print Patient Copy	☒ Copy Provided to Patient
CARE PLAN PRINT	☒ Print Patient Care Plan	

Electronically Signed By: _____ LPN- OPD

Date: 10112016 Time: 1117   VTB3

RTC Appointment Date/Time: _____

Care Management & Support

CM 06-09: Elective Criteria

Competency A

Documents patient preferences & functional/lifestyle goals (r) OR (b) & (e)

Addresses identified & potential barriers (r) OR (b) & (e)

Care plans include a self-management plan (r) OR (b) & (e)

NEW **Care plans are shared across care settings** (e) (p)

Care Management & Support

CM RRWB: Example

Organization Name:	
Completion Date:	

Patient Number		Care Planning and Self-Care Support				
		CM 04	CM 05	CM 06	CM 07	CM 08
		Establishes a person-centered care plan for patients identified for care management	Provides written care plan to the patient/family/ caregiver for patients identified for care management	Documents patient preference and functional/lifestyle goals in individual care plans	Identifies and discusses potential barriers to meeting goals in individual care plans	Includes a self-management plan in individual care plans
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						

Care Management & Support

CM 08: Example

COPD Action Plan

When you are well, be aware of the following:	Action
• How much activity you can do each day	• Have something to look forward to each day
• What your breathing is like when you are resting and when you are active	• Plan ahead - pace yourself and allow enough time to do things
• How much phlegm you cough up and what colour it is	• Exercise every day
• Anything that makes your breathing worse	• Eat a balanced diet and drink plenty of fluids
• What your appetite is like	• Avoid things that make your condition worse
• How well you are sleeping	• Take your medication as directed by your doctor
• Do you have any swelling to your feet/ankles	• Never allow your medications to run out

The following are signs that your symptoms are getting worse:	Action
• Feeling more breathless or wheezy than usual	• Increase your reliever medication
• Reduced energy for daily activities	• Contact your _____
• Coughing up more phlegm	on _____ for advice
• Change in colour of phlegm	• Consider starting your 'standby' antibiotics and/or Prednisolone
• Poor sleep and/or symptoms waking you in the night	• 'Standby' medication details (see next page)
• Starting to cough or increased cough	• Antibiotics: to use if your sputum becomes coloured or the amount increases due to infection
• You may also have loss of appetite	• Prednisolone (Steriod): to reduce inflammation in the lungs when your breathing is bad
• New or increased swelling to feet/ankles	

The following are signs of a severe attack:	Action
• Breathlessness and cough getting worse	• If you have not done so already, start your 'standby' medication
• You are not able to carry out your normal daily activities	• Phone your nurse or doctor if you have started 'standby' medication - and you are not improving - for an urgent appointment or home visit
• Your medications are not working	

The following are signs of a severe attack:	Action
• Very short of breath when you are at rest, with no relief from medication	• Dial 999 for an ambulance or ring the GP Out of Hours service
• Chest pains • High fever (temperature)	
• Feelings of agitation, fear, drowsiness or confusion	

Norfolk Community Health and Care NHS Trust COPD action plan

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Care Coordination & Care Transitions

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood

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COMPETENCY A

The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result

---

Care Coordination & Care Transitions

CC 01: Core Criteria

Competency A

Manages lab & imaging tests systematically by:

Tracking, flagging & following-up on overdue tests

Flagging abnormal test results

Notification of test results

ⓔⓟ

Evidence For Test Tracking & Follow-Up
Competency A

To Minimize Errors:

A decade of research shows that 6 errors are the most widely documented in ambulatory care, leading to hospitalizations, complications, minor physical harm, psychological harm, lost patient pay, physical injury and death. Of these, **two are**

Diagnostic errors such as missed, delayed and wrong diagnoses

Laboratory errors such as missed, delayed and wrong diagnoses

Source: "Research in Ambulatory Patient Safety 2000-2010: A 10-year review," American Medical Association, December 2011 (https://psnet.ahrq.gov/resources/resource/23742/research-in-ambulatory-patient-safety-2000-2010-a-10-year-review)

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Care Coordination & Care Transitions
CC 01: Example

EFFECTIVE DATE: November 1, 2014   SUPERSEDES: ISSUE DATE: 8/15/14

Procedure:

1. The provider orders the lab and/or diagnostic in the patient EMR along with diagnosis, diagnosis code and timeframe the test is due.
2. The LPN/MA will generate and print the requisition for labs/diagnostics. The requisition will be given to the patient for those offices that cannot receive the orders via fax.
3. Each LPN/MA will track lab and diagnostic orders using the **OSIS Crystal Report**. Obtain the report from EMR, File, System/Practice Template, Practice, All, OSIS Crystal Report.
4. The LPN/MA will follow up monthly by running the OSIS Crystal Report.
5. At the end of each month, the LPN/MA will confirm the tests have been done by checking the patient records or the Fairfield Medical Center (FMC) portal for results.
6. If the test has NOT been completed, the patient is called by the LPN/MA to find out the reason for the missed lab or diagnostic test. If the patient agrees to reschedule the test, an appointment is rescheduled while patient is on the phone.
7. If LPN/MA is unable to reach the patient on the first call, then a second will be placed no more than seven days later; if no response, a letter will be sent to the patient asking the patient to contact the office. At this time the LPN/MA will inform the provider and request a verbal order to cancel the lab or diagnostic test. The provider may reorder the lab and or diagnostic test again at the patient next appointment.
8. The LPN/MA will document in the patient chart using the **order management** template all attempts to contact the patient by phone and the date the letter has been sent.
9. Providers will receive the test results in their Provider Approval Queue once tests are completed and will require provider signature after reviewing.
10. Provider will order additional tests, medication or follow up in the patients chart and task those orders to either the LPN/MA to carry out and inform patient.
11. LPN/MA will select in Order Management "results received" and the result of the lab value will be entered in the action/comment box.
12. LPN/MA will perform orders written by provider based upon results being normal or abnormal and document in the telephone template in patient chart once patient has been notified.
13. Paper reports received by mail will be reviewed by the triage nurse. Normal results will be scanned into the patients chart within 3 days for the provider to review and sign. Abnormal results or critical results will be given to the provider immediately to address. Once the provider

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Care Coordination & Care Transitions

CC 01 A-B: Example

Order	Action/Comment	Status	Order
Lab & Diagnostics Tracking Report : February 1-15,			
SPINE, LUMBAR		result receive	
ELECTROCARDIOGRAM, COMPLETE	due in 3mos. Left msg for pt to call back.	ordered	
X-RAY EXAM OF KNEES Bilateral		completed	
Chlamydia/GC, DNA Probe		completed	
Fasting Glucose, Serum		completed	
HEMOGLOBIN A1C		completed	
HPV, high+low-risk		completed	
PAP, thin prep		completed	
urine for gonorrhea and chlamydia		completed	
CMP		completed	
LIPID PANEL		completed	
ELECTROCARDIOGRAM, COMPLETE		result receive	
CBC		completed	
CBC WITHOUT DIFF		completed	
CMP		completed	
LIPID PANEL		completed	
TSH		completed	
CT LUMBAR SPINE W/O DYE		cancelled	
US liver and gallbladder		scheduled	
ECHO TRANSTHORACIC		result receive	
ELECTROCARDIOGRAM, COMPLETE	letter mailed	ordered	
MRI ABDOMEN W/O & W/DYE liver		completed	

Care Coordination & Care Transitions

CC 01 E: Example

Normal Lab Results of lab work left as message

Telephone Encounter

Telephone Encounter Info

Author	Note Status	Last Update User	Last Update Date/Time
Phillip Andrew, MD	Signed	Phillip Andrew, MD	3/15/ 2:04 PM

Telephone Encounter

Left VM informing him testosterone levels were normal. Also wanted to check in on how the adderall taper is going but didn't get ahold of him; will f/u in 2 weeks at our next appointment

Provider called patient with results of radiology exam

Telephone Encounter

Telephone Encounter Info

Author	Note Status	Last Update User	Last Update Date/Time
MD	Signed	MD	1/27/ 1:59 PM

Telephone Encounter

I spoke to patient on the phone. X-ray is not consistent with severe OA. Symptoms are now more intermittent. Advised him to cancel appointment in Ortho clinic and we will evaluate further at his upcoming appointment

Care Coordination & Care Transitions

CC 01 F: Example

Care Coordination & Care Transitions

CC 02: Elective Criteria

Competency A

Follows up on newborn hearing and blood-spot screening with hospitals and/or other inpatient facilities

ⓔⓟ

Care Coordination & Care Transitions

CC 02: Example

Documentation required
- **Documented** process for follow-up on newborn **hearing** tests/blood spot screening.
- Example

Care Coordination & Care Transitions

CC 03: Elective Criteria

Competency A

NEW

* **Clinical protocols are established** based on evidence-based guidelines to determine when imaging and lab tests are necessary ⓔ

COMPETENCY B

The practice provides important information in referrals to specialists and tracks referrals until the report is received

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Care Coordination & Care Transitions

CC 04: Core Criteria

Competency B

A.	**B.**	**C.**

- Clinical question
- Required timing
- Type of referral

- Demographic & clinical data
  - Test results
  - Care plan

- Track referral until available
- Flag overdue reports
- Follow-up overdue reports

ⓔ ⓟ

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Care Coordination & Care Transitions

CC 05-07: Elective Criteria

Competency B

* **Clinical protocols are used** to identify necessary specialist referrals (e)   **NEW**

Commonly used specialists/specialty types are identified (e)   **NEW**

Considers available performance information on consultants/specialists (s)(e)

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Care Coordination & Care Transitions

CC 07: Example

Age	Clinic	ReferringProvider	Referral Type	Referral Date	Appt Date	Wait Time Days	Status
67.3	Urology (Peds): Montefiore: Hutchinson C		Urology	01/05/2015	04/23/2015	108	Consult
28.0	Headache: Montefiore: Hutchinson Camp		Neurology	01/06/2015	04/01/2015	85	Canceled by clinic
23.0	Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/09/2015	03/11/2015	61	Patient no-show
69.0	Urology (Peds): Montefiore: Hutchinson C		Urology	01/09/2015	05/05/2015	116	Created
37.0	Plastic Surgery: Montefiore: Hutchinson C		Plastic Surgery	01/13/2015	02/24/2015	42	Patient no-show
36.6	Urology (Peds): Montefiore: Hutchinson C		Urology	01/15/2015	04/02/2015	77	Patient no-show
58.3	Cardiology: Montefiore-Einstein Heart Cer		Cardiology	01/20/2015	02/17/2015	28	Canceled by clinic
23.8	Plastic Surgery: Montefiore: Hutchinson C		Plastic Surgery	01/20/2015	02/02/2015	13	Created
50.6	Allergy: Montefiore - Hutchinson Campus,		Allergy	01/21/2015	03/27/2015	65	Patient no-show
24.8	Endocrine (Peds): Montefiore - Hutchinso		Endocrine	01/22/2015	06/12/2015	141	Consult notes received
58.6	Infectious Disease: Montefiore: Hutchinso		Infectious Diseases	01/22/2015	02/19/2015	28	Consult notes received
74.7	Dermatology: Montefiore: Hutchinson Car		Dermatology	01/24/2015	02/18/2015	25	Canceled by patient
40.6	Dermatology: Montefiore: Hutchinson Car		Dermatology	01/26/2015	05/04/2015	98	Created
36.5	Urology (Peds): Montefiore: Hutchinson C		Urology	01/28/2015	06/09/2015	132	Created
53.3	Urology (Peds): Montefiore: Hutchinson C		Urology	01/28/2015	03/11/2015	42	Created
32.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/13/2015	03/05/2015	51	Canceled by patient
32.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/13/2015	04/06/2015	83	Consult notes received
29.0	Family Planning: Montefiore - AECOM, 16		Family Planning	01/14/2015	03/02/2015	47	Patient no-show
28.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/28/2015	03/12/2015	43	Patient no-show
28.2	Family Planning: Montefiore - AECOM, 16		Family Planning	01/28/2015	05/28/2015	120	Kept Not Seen
35.9	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/09/2015	11	Patient no-show
35.9	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/19/2015	21	Canceled by clinic
38.8	Family Planning: Montefiore - AECOM, 16		Family Planning	01/29/2015	02/02/2015		Consult notes received
31.9	URO-GYN: AECOM		URO-GYN	01/08/2015	03/06/2015	57	Canceled by patient
31.9	URO-GYN: AECOM		URO-GYN	01/08/2015	05/07/2015	119	Patient no-show
32.7	URO-GYN: AECOM		URO-GYN	01/08/2015	03/02/2015	53	Patient no-show
33.8	Genetics - AECOM		Genetics	01/13/2015	02/10/2015	28	Canceled by patient
27.2	Ultrasound: AECOM		Ultrasound	01/15/2015	02/09/2015	25	Consult notes received
25.8	Fetal Echo: AECOM		ECHO	01/20/2015	02/23/2015	34	Consult notes received
63.1	Hematology: Albert Einstein College of Me		Hematology	01/20/2015	03/25/2015	64	Created
24.6	Ultrasound: AECOM		Ultrasound	01/22/2015	03/05/2015	42	Consult notes received
37.1	Genetics - AECOM		Genetics	01/23/2015	03/03/2015	39	Consult notes received
33.1	OB/GYN: MFAC - AECOM		OB/GYN	01/29/2015	02/10/2015	12	Canceled by patient
33.1	OB/GYN: MFAC - AECOM		OB/GYN	01/29/2015	02/12/2015	14	Consult notes received
34.9	Neurology: Montefiore North - Medical Vill		Neurology	01/07/2015	05/13/2015	126	Created
63.6	Neurology: Montefiore North - Medical Vill		Neurology	01/08/2015	06/11/2015	154	Created
40.3	Mammogram: MMC - North		Mammogram	01/11/2015	02/10/2015	30	Patient no-show
43.1	Ultrasound: Montefiore - Wakefield Campi		Ultrasound	01/15/2015	02/13/2015	29	Patient no-show

This report is periodically generated from TRMS, a web-based tracking database used by the practice for subspecialty referrals. It shows the total number of referrals to subspecialties for adult patients generated (electronically) in January 2015, appointments scheduled and the location (mostly within), the number of days/waiting period, and the status of those appointments.

Out of a total of 319 referrals, 76 of them were not scheduled within Medical Center, 76% were.

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Performance Information for Specialist Referrals
CC 07: Example

Care Coordination & Care Transitions
CC 08-09: Elective Criteria

Competency B

The practice sets expectations for patient care and sharing information when working with:

> Non-behavioral healthcare specialists (p)(a)

> * Behavioral healthcare providers

(e) & (p) OR (a)

Behavioral Health Referral Expectations

CC 09: Example

Care Coordination & Care Transitions

CC 10: Elective Criteria

Competency B

* **A behavioral health provider** is integrated into the practice's care delivery system

(e)(p)

Care Coordination & Care Transitions

CC 11-13: Elective Criteria
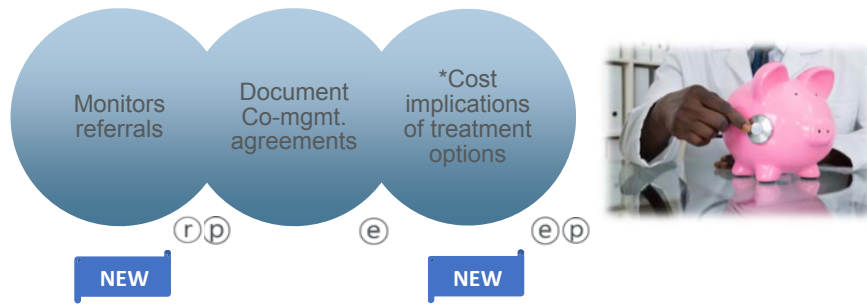
Competency B

Monitors referrals

Document Co-mgmt. agreements

*Cost implications of treatment options

(r)(p) (e) (e)(p)

NEW **NEW**

COMPETENCY C

The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care

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Care Coordination & Care Transitions

CC 14-16: Core Criteria

Competency C

Identifies patients with unplanned admissions and ED visits
ⓡⓟ

Shares clinical information with inpatient facilities
ⓔⓟ

Contacts patients/families/ caregivers for follow-up care
ⓔⓟ

Care Coordination & Care Transitions

CC 14-16, 18-19: Example

Procedure:

CC 14 ➤ • Hospital census is obtained daily by fax or from an offsite electronic Health Information System from local hospitals by the Care Coordinator or Nurse Care Manager.

CC 15 ➤ • Communication with local hospitals is completed daily.

CC 19 ➤ • Discharge records are faxed to the CHCCM from the hospital or pulled from an offsite Health Information System by the Care Coordinator or Nurse Care Manager.

CC 18 ➤ • Local hospitals are contacted if additional information is needed.

• After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.

• Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.

CC 16 ➤ • Nurse Care Manager or Care Coordinator (if designated) will be responsible for contacting patient's that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient's chart, schedule follow up appointment's if needed and obtain additional information as needed.

Care Coordination & Care Transitions
CC 14: Example

Referred Registration is an admission
Inpatient Discharge is a hospital discharge
Emergency Discharge is discharge from the ED.

Care Coordination & Care Transitions
CC 16: Example

10:26 AM Telephone	Description: **45 year old female**
MRN	Provider: Department:

Reason for Call
Follow-up since

Call Documentation
10:32 AM Signed
Following up with patient after visit to ER for abdominal Pain. Pt states that she was discharged and that her CT Scan and labs were fine. Still c/o some slight pain today but that overall it is better. Was told last night that it could be because of her nerves. The ER MD increased zoloft for this and pt states that she has made the changes recommended. Would like to follow up with PCP to make sure that dose will work for her. Schedule F/U in 1 week. Pt voices no further needs at this time.

Encounter Messages
No messages in this encounter

Contacts

	Type	Contact	Phone
10:26 AM	Phone (Outgoing)		

Created by
10:26 AM

Patient Instructions
None

Care Coordination & Care Transition

CC 17-21: Elective Criteria

Competency C

* **Coordinate** with acute care settings after hours (e)(p) **NEW**	**Exchange** patient info. during hospitalization (e)(p)	**Obtain** discharge summaries from inpatient facilities (e)(p)
Collaborates on care plan for complex patients transferring in/out of the practice (e)	**Electronic exchange of information** with external entities on 1 or more (max 3 credits): A. RHIO or HIEs B. Immunization registries or similar C. Summary of care to other providers or facilities for care transitions (e)	
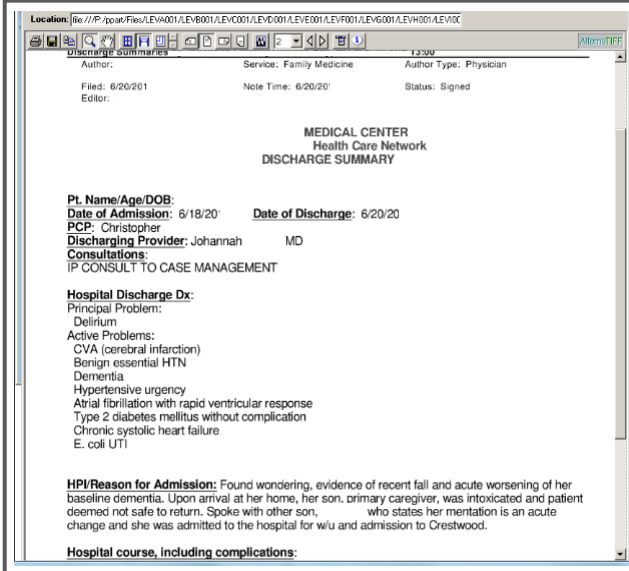
Care Coordination & Care Transition

CC 19: Example

Performance Measurement & Quality Improvement

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities

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COMPETENCY A

The practice measures to understand current performance and to identify opportunities for improvement

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Performance Measurement & Quality Improvement

QI 01: Core Criteria

Competency A

The practice monitors at least 5 clinical quality measures
(must monitor at least one measure of each type):

Immunization measures

Other preventive care measures

Chronic or acute clinical care measures

Behavioral health measures
ⓡ NEW

Performance Measurement & Quality Improvement

QI 02-03: Core Criteria

Competency A

The practice **monitors at least two measures of resource stewardship** (must monitor at least 1 measure of each type):

Care coordination measures

Measures affecting **health care costs**
ⓡ

Assesses performance on availability of **major appointment types**
ⓡⓟ

Performance Measurement & Quality Improvement

QI 01 A-D: Example

Health Maintenance Topic 1/1/ – 12/31/	In compliance	Overdue	Total
Breast Cancer Screening	51.05% 1,381	48.95% 1,324	100% 2,705
Colon Cancer Colonoscopy	63.35% 1,965	36.65% 1,137	100% 3,102
Pneumococcal Vaccine	83.11% 743	28.36% 350	100% 1,234
Depression screening	74.84% 992	25.16% 350	100% 1,232
Hemoglobin A1C	71.64% 884	28.36% 350	100% 1,234
Urine Microalbumin/Creatinine Ratio	67.13% 825	32.87% 404	100% 1,229

Performance Measurement & Quality Improvement

QI 02 B: Example
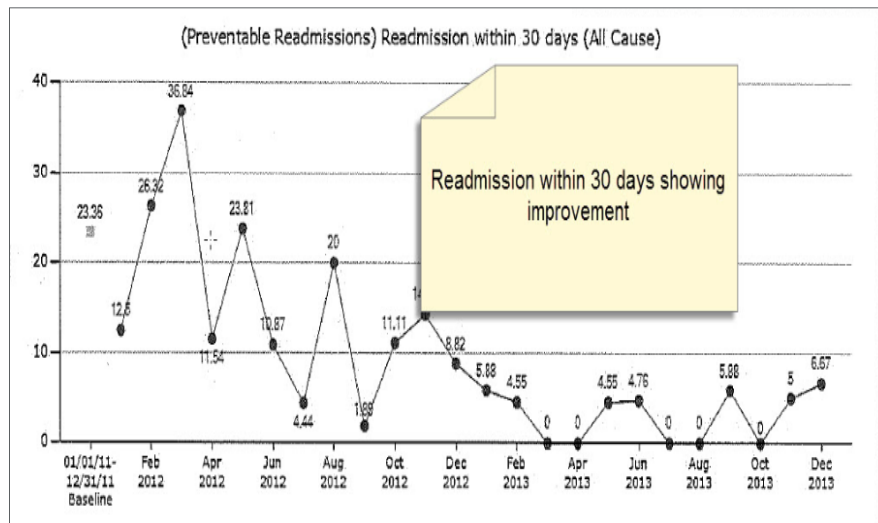
Performance Measurement & Quality Improvement

QI 04 A-B: Core Criteria

Competency A

Monitors patient experience through **quantitative data** (across at least three categories) ⓡ

Access

Communication

Coordination

Whole-person care, self-management support and comprehensiveness

Monitors patient experience through **qualitative methods** ⓡ

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Performance Measurement & Quality Improvement

QI 04 B: Example

NEW PATIENT PHONE SURVEY   Provider_____

Did your Provider meet and satisfy your needs?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					

Caller identifies possible vulnerabilities prior to phone survey.

ABC Health would like to be your "Patient Centered Medical Home". Overall, how was your experience?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					

Are you aware we have walk-in hours for acute care if you are unable to get in with your provider today?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					

Are you aware that ABC Health offers Pharmacy & Dental services? Able to get your meds today?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					

Do you have any suggestions or comments on how we can increase quality and your satisfaction?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					

Providers – You will receive a copy of this survey each time it fills. The Patient Satisfaction Coordinator (PSC) calls all new patients a few days after their first visit to provide immediate feedback as well as recognizing vulnerable subgroups. The PSC will provide care coordination as needed when identified. All findings are kept by the Chief Quality Officer for use in QA/QI activities.

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Performance Measurement & Quality Improvement

QI 05: Elective Criteria

Competency A

Assesses health disparities using performance data (must choose one from each section):

- Clinical quality
- Patient experience

(r) OR (W)
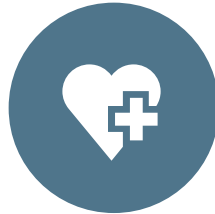
Performance Measurement & Quality Improvement

QI Worksheet: Example

NCQA PCMH Quality Measurement and Improvement Worksheet

PURPOSE: This worksheet helps practices organize the measures and quality improvement activities that are outlined in PCMH AC 01-03, AC 06 and QI 08-14. Refer to PCMH AC and QI in the PCMH 2017 Standards and Guidelines for additional information.

NOTE: Practices are not required to submit the worksheet as documentation; it is provided as an option. Practices may submit their own report detailing their quality improvement strategy but should consult the QI Worksheet Instructions for guidance.

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS

1. **Identify measures for QI.** Select aspects of performance to improve:
   - Must Demonstrate (Core Criteria)
     - *PCMH QI 01:* At least five clinical quality measures
     - *PCMH QI 02:* At least two resource stewardship measures
     - *PCMH QI 03:* Assess availability of major appointment types
     - *PCMH QI 04:* Monitors patient experience
   - Optional (Elective Criteria):
     - *PCMH QI 05:* At least two measures for vulnerable populations (one clinical quality, one patient experience)

2. **Identify a baseline performance assessment.** Choose a starting measurement period **(start and end date)** and identify a baseline performance measurement for each measure.
   - *For PCMH QI 08-11 and 13,* use performance measurements from the reports provided in PCMH QI 01-05.

   The baseline measurement period *must be* **within 12 months** before evidence submission for check-in, or **within 24 months**, if there is a remeasurement period. The performance measurement *must be* a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

3. **Establish a performance goal.** Generate at least one performance goal for each identified measure. The specific goal *must be* a rate or number greater than the baseline performance assessment. Simply stating that the practice intends to improve does not meet the objective. **(Applies to QI 08-11 and 13)**
   For multi-sites: Organizational goals and actions for each site may be used if remeasurement and performance relate to the practice. Each practice must have its own baseline and performance results.

4. **Determine actions to work toward performance goals.** List at least one action for each identified measure and the **activity start date**. The action date *must occur* after the date of the baseline performance measurement date. You may list more than one activity, but are not required to do so. **(Applies to QI 08-11 and 13)**

5. **Remeasure performance based on actions taken.** Choose a remeasurement period and generate a new performance measurement after action was taken to improve. The remeasurement date *must occur* after the date of implementation and *must be* within **12 months** before evidence submission for check-in. The performance measurement *must be* a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

6. **Assess actions taken and describe improvement.** Briefly describe how your practice site showed improvement on measures. Describe the assessment of the actions; correlate actions and the resulting improvement. **(Applies to QI 12 and 14)**

Performance Measurement & Quality Improvement

QI 06-07: Elective Criteria

Competency A

Uses a standardized, validated survey tool (r)

* Obtains feedback on vulnerable patient groups (r)

Vulnerable Patient Feedback

QI 07: Example

14. The MD/NP/PA I saw today is skillful and helpful.	44.2%	41.9%	0.0%	9.3%	0.0%
15. The MD/NP/PA I saw today communicates well and cares about me.	46.5%	39.5%	0.0%	11.6%	0.0%
16. I am confident that I can take care of and control most of my health problems.	32.6%	44.2%	2.3%	9.3%	2.3%
17. I would recommend this doctor's office/van to family or friends.	41.9%	39.5%	2.3%	4.7%	4.7%
18. Clinic hours are convenient for me.	4.7%	0.0%	0.0%	0.0%	0.0%
19. The clinic space is clean and inviting.	0.0%	0.0%	0.0%	0.0%	0.0%
Total Sex Not Indicated	0.0%				
Total Transgender	0.0%				
Total Male	100.0%				
Totale Female	0.0%				
Insured Yes	0.0%				
Insured No	0.0%				
Less than 50	2.3%				
50 and over	4.7%				

Feedback on Vulnerability – Transgender and patients over the age of 50
In our patient population patient over the age of 50 are considered vulnerable. The societal burden of long term homelessness ages the physical body. Men are disproportionately more likely to be homeless than women.

COMPETENCY B

The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies

---

Performance Measurement & Quality Improvement

QI 08-11: Core Criteria

Competency B

Sets goals and acts to improve upon at least three measures across at least three of the four categories (r) OR (w)

Sets goals and acts to improve upon at least one measure of resource stewardship (r) OR (w)

Sets goals and acts to improve availability of major appointments types to meet patient needs (r) OR (w)

Sets goals and acts to improve on at least one patient experience measure (r) OR (w)   NEW

Performance Measurement & Quality Improvement

QI 12-14: Elective Criteria

Competency B

* Achieves improved performance on **at least 2 performance measures**

(r) OR (W)

Disparities in care or services

Sets goals and acts to improve at least one measure   (r) OR (W)

*Achieves improved performance in at least one measure

NEW   (r) OR (W)

COMPETENCY C

The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section

HEALTH

Performance Measurement & Quality Improvement

QI 15: Core Criteria

Competency C

Reports practice-level or individual clinician performance results within the practice for measures reported by the practice

ⓔ ⓟ

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Performance Measurement & Quality Improvement

QI 16-19: Elective Criteria

Competency C

Reports practice-level or individual clinician performance results publicly or with patients

ⓔ ⓟ

* Involves patient/family/careg iver in quality improvement activities

ⓔ ⓟ

* Reports clinical quality measures to Medicare or Medicaid agency

ⓔ

Practice is engaged in Value-Based Contract Agreement (max 2 credits)

NEW

ⓐ ⓔ

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Reporting Performance Publicly/Patients
QI 16: Example

Dear

Enclosed in this letter you will find the performance results for your individual clinician, Dr   nd
practice-level,   MD PC, on the important preventive and chronic measures including Depression
Screening and Hemoglobin A1C testing. We are working diligently to increase Individual clinician and Practice-
level screenings of important preventive and chronic measures.

	Individual Clinician	Practice-level
Depression Screening	38.44 %	39.08 %
Hemoglobin A1c testing	74.02 %	74.15 %

Our practice also would like share with you patient satisfaction information. Based on patients survey that
practice conducted in May and November of 2016, patients mostly complained via the survey that they have
to wait to being called while they are waiting in waiting room. Please see numbers listed below.

	First time: May 2016	Second time: November 2016
Survey results	21%	18%

Practice supplies this information to make sure you aware of how your individual clinician,   and
entire practice are doing. We really encourage our patients to take an active and involved roll in their
healthcare.

Sincerely

Recognition Process

Q-PASS
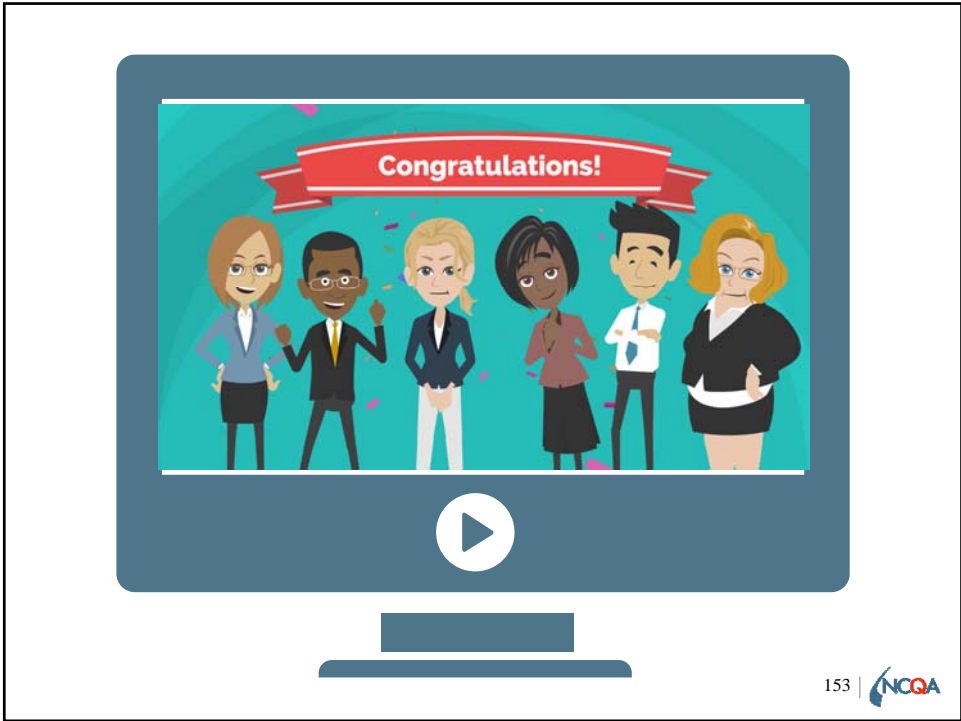
Recognition Process
3 Pathways

New Customer	*Recognized PCMH 2011 Levels 1-3 & PCMH 2014 Levels 1-2*	*Recognized PCMH 2014 Level 3*
Full Transform Process	Accelerated Renewal Process (Transform w/ Attestation)	Bypass Transform Direct to Sustaining Process

New Customers

Transform Steps

Complete Eligibility/Readiness Survey	Discover Educational Resources	Create Q-PASS Account(s)
Enroll Sites	Meet with NCQA Representative	Provide Evidence during Review

Existing Customers

Transform Steps

~~Complete Eligibility/Readiness Survey~~	Discover Educational Resources	Claim Q-PASS Account(s)
Enroll Sites	Meet with NCQA Representative	Provide Evidence during Review

Organization set-up
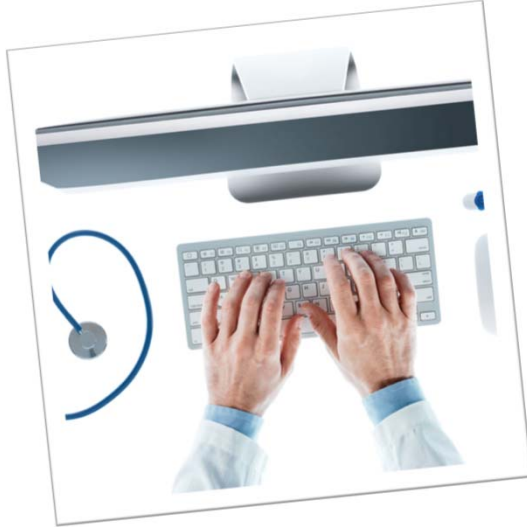
New Organizations

- Create Organization in Q-PASS
- Provide Organization details (address, phone, Tax ID)
- Save Organization

Existing Organizations

- Authorized users – See "My Organizations" tab
- To "claim" an organization otherwise, contact NCQA

Enrollment

Organization needs the following to enroll

- Site information, including NPI
- Clinician information, including NPI & Boards/specialties
- Authorized signatory for agreements
- Payment method

Enrollment

Step-by-Step process in Q-PASS

- Choose sites
- Choose product(s)
- Add/create clinicians
- Sign agreements
- Pay (can't pay until agreements signed)

PCMH Fee Schedule
PCMH 2017

Single Site Practice

Clinician Tier	Fee Per Clinician
1-12	$500.00
13+	$50.00

Succeed

1-12	$120.00
13+	$12.00

Partners in Quality Sponsored Single Site Practice

Clinician Tier	Fee Per Clinician
1-12	$400.00
13+	$40.00

Succeed

1-12	$120.00
13+	$12.00

Multi-Site Practice

Clinician Tier	Fee Per Clinician
1-12	$250.00
13+	$25.00

Succeed

1-12	$120.00
13+	$12.00

Partners in Quality Sponsored Multi-Site Practice

Clinician Tier	Fee Per Clinician
1-12	$200.00
13+	$12.00

Succeed

1-12	$120.00
13+	$12.00

After Enrollment
Subtitle

NCQA will assign a representative to the practice
The practice should then address:
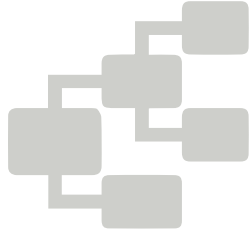
Transfer credit	**Shared credit**

• Pre-validated vendors & transfer-credits
  − Choose vendor with existing auto-credit
  − Vendor supplies implementation letter confirming eligibility
  − Criteria set as "Met" after confirmation by Representative
	• Organizations with multiple sites
	• Share evidence/credit for criteria done the same
	• Create sub-groups if share different EHR/processes

Multi-Site Process

- **Organizations with 3+ sites**
- **Shared EHR**, processes and evidence across sites
- **Identify shared criteria** from "sharable list"
- Identify primary site
  - Full review only for this site
  - Shared criteria auto-populate in subsequent sites

Corporate Credit Transition

Multi-sites with a completed PCMH 2011 or PCMH 2014 corporate survey

- **Credit earned** from an organization's **previous corporate survey tool** can be used to earn recognition for their practices at an accelerated pace.

- **Organizations can attest to meeting certain criteria** without providing the evidence required of practices seeking recognition for the first time.

Corporate Credit Transition Expectations

Multi-sites with a completed PCMH 2011 or PCMH 2014 corporate survey

Criteria Marked Attestation	Criteria Requiring Evidence	PCMH 2014 Level 3 Practices
Organizations may attest that they: • Have already demonstrated & met the equivalent criteria in their previous PCMH 2011 or 2014 corporate survey • Are still performing PCMH activities in these criteria.	Practices should: • Follow the current PCMH Standards & Guidelines • Submit evidence in Q-PASS, as indicated. • Prepare to demonstrate virtual review-eligible evidence during the virtual review.	Practices that have achieved PCMH 2014 Level 3 recognition may: • Bypass submission of evidence for criteria • Proceed directly to the Annual Reporting phase of recognition.

Shared & Site-Specific Evidence

What is the difference?

Shared evidence may be submitted once for all sites or site groups.

Some criteria is labeled **"Partially Shared"** indicates that the documented process may be shared across all practice sites, but all other evidence must be site-specific.

Site-specific data may be collected and submitted once on behalf of all sites or site groups if the evidence is stratified by site.

Transform "Check-in" process

Up to 3 "Check-ins" During Review

Determine Criteria to Address

- Focus on core & documented processes first
- Identify criteria for 25 elective credits

Provide Documents for Offsite Review

- Policies, procedures & protocols
- Website links
- Public information
- Attestation

Provide Evidence during Virtual Review

- Communicate with Evaluator
- Substitute evidence if not sufficient
- Demo systems
- Provide reports

Criteria Evidence Options

Q-PASS Documents

- Documents* (upload for off-site review)
- Weblinks
- Text

Virtual Review

- Reports (create in advance)
- System demo
- Patient examples

Either Option

- Practice decision*

*All PHI should be removed from documents uploaded in Q-PASS

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"*We Have Different Evidence*"

- Flexibility is encouraged
- Suggested evidence not exhaustive
- Meet intent in creative ways
- Not sure? Ask NCQA

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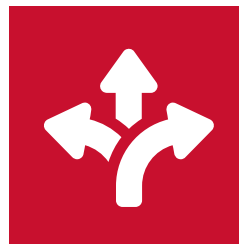
After Check-In

- Evaluator marks criteria "met"
- Practice can work on "not met" criteria
- NCQA staff will review questions arising from check-in

After 3 Check-Ins

Practice meets all core criteria & 25 elective credits, results are forwarded to Review Oversight Committee (ROC)

If required criteria is not met in 3 virtual check-ins, an additional check-in is available for purchase

If the survey process is not completed within 12 months, additional time can be purchased

Accelerated Renewal
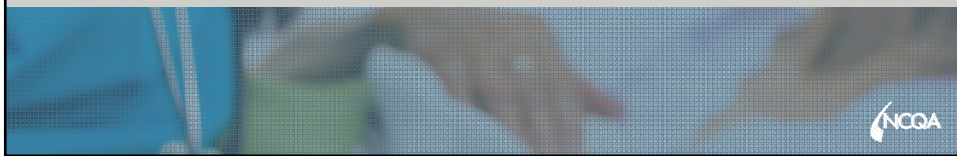
Accelerated Renewal
Eligibility

Practices can earn recognition at an accelerated pace that achieved recognition in:

- PCMH 2011
  Levels 1, 2, & 3

- PCMH 2014
  Levels 1 & 2

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Accelerated Renewal
What is expected for criteria?

For criteria identified as review practices should:
- Follow standards & guidelines
- Submit evidence in Q-PASS
- Prepare to demonstrate virtual review-eligible evidence

For criteria marked attestation the practice should:
- Attest that your practice is still performing PCMH activities
- You will not need to demonstrate documentation or evidence

Criteria are identified as shared or site specific

Accelerated Renewal
Review & attestation by the numbers

	Core	Electives		
		1 Credit	2 Credits	3 Credits
Review	22 criteria	12 criteria	14 criteria	0 criteria
Attestation	18 criteria	26 criteria	7 criteria	1 criterion
Total Criteria (100 criteria)	40 criteria	39 criteria	21 criteria	1 criterion

"Review or Attestation" indicates which criteria require submission of evidence and which criteria simply allow attestation

Succeed

Annual Reporting

Succeed Annual Reporting Process

Practice's recognized PCMH 2014 Level 3 or after Transform process must:

Attest to previous performance	Confirm practice information and make any clinician changes
Provide evidence demonstrating continuing PCMH Activities	Annual fee payment

Annual Reporting Date

- **30 days** before Anniversary Date
- Must complete all Succeed steps prior to anniversary date

- **Date set upon initial Recognition**
  − Or 2014 Level 3 expiration date

- **Flexibility** to meet practice needs

Annual Reporting Date – Multi-sites

All practices in multi-site group have the same annual reporting date, unless otherwise organization requests differently

The annual reporting date for multi-site group is based on the date of 1st Recognized practice

Evidence & Annual Reporting
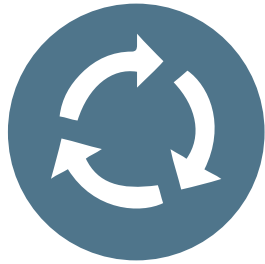
- **Evidence can be provided** at any point within the year

- NCQA will only review after:
  - **Reporting date has passed**
  - **Annual fee is paid**

Audit and New Requirements

Audit
- Sample of Succeed practices selected
- Still meeting key Transform criteria?
- Selection after Annual Reporting complete

New Requirements
- Announced 6 months ahead
- Practice must meet at next reporting date

Questions

NCQA

Thank you

Seminar Resources

Resources: Table of Contents

A. Standards & Guidelines

NCQA Patient-Centered Medical Home (PCMH) Standards and Guidelines

2017 Edition, Version 2 (Effective September 30, 2017)

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PCMH 2017 Standards

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Appendix 2: PCMH Glossary

Appendix 3: Record Review Workbook Instructions

Appendix 4: Distinction in Behavioral Health Integration

Appendix 5: Distinction in Electronic Quality Measures (eCQMs) Reporting—*Coming Soon*

Appendix 6: Distinction in Patient Experience Reporting

The PCMH Advisory Committee and Clinical Programs Committee

The Patient-Centered Medical Home (PCMH) 2017 update aligned the program standards with the transformation of NCQA's recognition programs' processes which establishes a new relationship with practices pursuing recognition. NCQA convened the PCMH 2017 Advisory Committee in late 2015 to outline a set of guiding principles to curate the modified requirements based on current data on medical home practices, feedback from the field and the collective expertise of the committee. The 27-member committee is composed of representatives from practices, medical associations, physician groups, health plans and consumer and employer groups. The committee met throughout 2016 to discuss and analyze draft standards, PCMH Recognition data and public comment results. NCQA also consulted its Clinical Programs Committee which is a diverse, standing multi-stakeholder panel of experts that review and approve NCQA's recognition program requirements.

These committees shaped updates to accomplish the following in PCMH 2017:

1. Drive achievement of the triple aim.[1]
2. Focus on outcomes instead of processes.
3. Accommodate a spectrum of practices (e.g., small vs large).
4. Detect true practice transformation.

The importance of these committees cannot be overstated. The members gave their time, energy, enthusiasm and a willingness to hear and compromise on opposing perspectives. The PCMH 2017 standards are a reflection of their hard work and collaboration.

PCMH 2017 Advisory Committee

Yul Ejnes, MD, MACP, Chair
Coastal Medical

Jean Antonucci, MD
Physician

Alicia Berkemeyer, BS
Arkansas Blue Cross and Blue Shield

Suzanne Berman, MD, FAAP
Plateau Pediatrics

Kelly Cronin, MPH, MHP
Office of the National Coordinator for Health Information Technology

Susan Davis, MSN, APRN, CPNP-PC
Community Health Network of CT, Inc

Patrick Gordon, MPA
Rocky Mountain Health Plans

Karen Handmaker, MPP
IBM/Phytel

Jeffery Harris, BS, RCP, RCPT
Patient Advocate

Scott Hines, MD
Crystal Run Healthcare

Donald Liss, MD
Independence Blue Cross

Adriana Matiz, MD, FAAP
Columbia University Medical Center

Leslie Milteer, PA-C, MPAS, DFAAPA
Saint Catherine University

Mary Minniti, BS, CPHQ
Institute for Patient and Family Centered Care

Amy Mullins, MD, CPE, FAAP
American Academy of Family Physicians

Deborah Murph, MBA, BSN, RN
Cherokee Health Systems

Ann O'Malley, MD, MPH
Mathematica

Lori Raney, MD
Health Management Associates

Judith Steinberg, MD, MPH
UMass School of Medicine

William F. Streck, MD
Healthcare Association of New York State

Clinical Programs Committee

Overview

NCQA's Patient-Centered Medical Home

Patient-centered medical homes (PCMH) transform primary care practices into what patients want: health care that focuses on them and their needs. PCMHs get to know patients in long-term partnerships, rather than through hurried, sporadic visits. They make treatment decisions with their patients, based on patient preference. They help patients become engaged in their own healthy behaviors and health care.

Everyone in the practice—from clinicians to front desk staff—works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not performing tasks that can be accomplished by other staff, and helps avoid costly and preventable complications and emergencies through a focus on prevention and managing chronic conditions.

A growing body of evidence documents the many benefits of medical homes, including better quality, patient experience, continuity, prevention and disease management. Studies show lower costs from reduced emergency department (ED) visits and hospital admissions. Studies also show reduced disparities in care and lower rates of provider burnout. PCMHs' power to improve the quality, cost and experience of primary care only sets a foundation for the broad change our health care system needs. Other providers and facilities must build on the PCMH foundation to establish patient-centered care throughout the health care system. This already occurs in patient-centered specialty practices, which help specialists become part of the medical home neighborhood by improving quality and access.

Medical homes are the foundation for a health care system that achieves the "Triple Aim" of better quality, experience and cost. This is the overview to our vision for achieving that goal; it chronicles the PCMH evolution to date, the challenges that lie ahead and potential solutions to those challenges—some already underway, some yet to be developed.

NCQA PCMH Evolution 2003–2014

The American Academy of Pediatrics introduced the medical home concept in 1967. A generation later, in 2004, the specialty of family medicine called for all patients to have a "personal medical home." In 2003, NCQA launched Physician Practice Connections, a PCMH precursor program. In 2007, leading primary care associations released the Joint PCMH Principles. In 2008, NCQA launched the first PCMH Recognition program, with updates to raise the bar in 2011 and 2014. NCQA further advanced its PCMH program with updates through Recognition Redesign. NCQA's PCMH program is the largest, with more than 60,000 clinicians at 12,000 sites as of March 2017—about 18 percent of all primary care clinicians. To earn NCQA Recognition, practices must meet rigorous standards for addressing patient needs; for example, offering access after office hours and on line so patients get care and advice, where and when they need it.

Year	Version	Elements of the Program
2003	Physician Practice Connections (PPC®)	This PCMH precursor recognized use of systematic processes and health IT to: • Know and use patient history. • Follow up with patients and other providers. • Manage patient populations and use evidence-based care. • Employ electronic tools to prevent medical errors.
2008	Physician Practice Connections—Patient-Centered Medical Home (PPC®-PCMH™)	The first PCMH model implemented the Joint Principles, emphasizing: • Ongoing relationship with personal physician. • Team-based care. • Whole-person orientation. • Care coordination and integration. • Focus on quality, safety and enhanced access.
2011	PCMH 2011	• Explicitly incorporated health information technology Meaningful Use criteria. • Added content and examples for pediatric practices on parental decision making, age-appropriate immunizations, teen privacy and other issues. • Added voluntary distinction for practices that participate in the CAHPS PCMH survey of patient experience and submit data to NCQA. • Added content and examples for behavioral healthcare.
2014	PCMH 2014	• More integration of behavioral healthcare. • Additional emphasis on team-based care. • Focus care management for high-need populations. • Encourage involvement of patients and families in QI activities • Alignment of QI activities with the Triple Aim: improved quality, cost and experience of care. • Alignment with health information technology Meaningful Use Stage 2.

Goals for PCMH 2017 and Beyond

NCQA PCMH Recognition is the most widely-used way to transform primary care practices into medical homes. The patient-centered medical home is a way of organizing primary care using teamwork and technology to improve quality and patients' experience of care, and to reduce costs. In 2015, NCQA initiated a process to revamp the PCMH requirements and recognition process called Recognition Redesign. NCQA based the redesign on feedback from practices, policy makers, payers, patients and other stakeholders. The new 2017 PCMH Standards focus on identifying best practices and core activities, signaling that a primary care practice functions as a medical home. Additionally, the new standards promote measurement and improvement at the clinician and practice level. It makes the program more manageable as it continues to concentrate on performance and quality improvement. It also reduces paperwork and increases practice interaction with NCQA.

The recognition process offers:

- **Flexibility.** Practices take the path to recognition that suits their strengths, schedule and goals.

- **Personalized service.** Practices get more interaction with NCQA, and are assigned an NCQA Representative who works with them throughout the recognition process and is a consistent point of contact.

- **User-friendly approach**. Requirements remain meaningful, but with simplified reporting and less paperwork.

- **Continuous improvement.** Annual check-ins help practices strengthen as medical homes. By reviewing your progress more often, we keep performance improvement at the top of your priorities list.

- **Alignment with changes in health care.** The program aligns with current public and private initiatives and can adapt to future changes

The underlying principles of PCMH remain the same. Evidence shows that the PCMH model of care can result in reduced costs and healthier and more satisfied patients. Evidence demonstrates that PCMH improves staff satisfaction. The patient-centered, team based approach of PCMH creates deeper connections both between patients and providers as well as between staff members. Improvements in practice infrastructure and personnel also bolsters efficiency and teamwork, creating a sense of ownership and fulfillment. The redesigned process focuses more on performance and quality improvement, and aligns with many other major national initiatives that impact practices, such as MACRA.

The medical neighborhood. Although primary care is the foundation for delivery system transformation, PCMHs cannot change the entire system alone. Data sharing among primary care, specialists, hospitals and other providers is needed to maximize coordination and management. Our current payment system drives greater use of services, especially high-volume services for hospitals and many specialists. Primary-care spending is low and a small share of the total spend on healthcare, compared with other providers, which limits access to capital for information technology and other systems to support outreach, patient engagement and analysis. Other parts of the system must also have strong incentives to change if we are to realize better outcomes.

Patient-centered specialty practices. Specialty-care clinicians provide many services and many patients seek specialists' care directly without primary care consultation. For patients with certain chronic conditions, specialists serve as primary-care providers for extended periods. Creating better ways for information to flow effectively among primary-care clinicians and specialists is critical for care coordination and reducing duplicate care. In 2016, NCQA updated the Patient-Centered Specialty Practice (PCSP) program which recognizes specialists that use systems and processes needed to support patient-centered care, including strong communication with other providers. The updates addressed the needs of self-referred patients, clarified the intent around agreements with and connecting patients to primary care. This program will be aligned with the new recognition redesign process and re-launched in 2018.

MACRA. The Medicare Access and CHIP Reauthorization Act (MACRA) created a new payment program from the Centers for Medicare and Medicaid Services (CMS) that makes patient-centered care the key to success for physicians and other clinicians. It rewards clinicians for quality care through two value-based payment models: The Merit-Based Incentive Payments System (MIPS) and Alternative Payment Models (APMs). MACRA transitions the nation's largest payer—Medicare—to paying for the value of care, instead of the volume. On the MIPS track, clinicians will get bonuses or penalties based on their performance in four measure areas: Quality; Advancing Care Information (formerly Meaningful Use); Improvement Activities; Resource Use Measures. Under the final rule, clinicians in practices that earn NCQA Recognition will automatically get full credit in the Improvement Activities category. Clinicians in NCQA PCMHs & PCSPs will likely do well in all other MIPS categories because of their commitment to high-quality, efficient, patient-centered care coordinated with the help of certified electronic health records

Clinically Integrated Networks. Clinically integrated networks (CIN), such as ACOs, are bringing communities of doctors, hospitals and other providers together to improve outcomes and lower costs. PCMHs provide the solid foundation that these networks must build on to ensure quality and patient-centered care. While CIN/ACOs build on a solid PCMH foundation to coordinate doctors, hospitals, pharmacies, other providers and community resources, there is a shift from the use of defined CIN/ACOs toward broader systems-based models of care. NCQA is exploring how to increase alignment and collaborative strategies between CIN/ACOs. This process includes exploring ways to incorporate measurement and update the evaluation process to align with current industry needs.

Behavioral healthcare. This is critical for better integration, particularly in Medicaid, where many high-cost enrollees have co-morbid behavioral conditions. Unaddressed behavioral conditions can exacerbate physical conditions, which increases disability and cost. NCQA developed a distinction module to provide a special recognition to practices that demonstrate advanced levels of behavioral health integration and focus quality measurement on behavioral health concerns.

Public health: Bringing complementary strengths of public health and primary care together has great potential. Some public health providers—school-based, HIV and community health centers—provide primary care and can be PCMHs. The Health Resources and Services Administration (HRSA) helps community health centers become PCMHs. North Carolina uses public health staff to visit at-risk pregnant women in their homes, to help primary care providers engage these patients and get them better prenatal care. Vermont connects its PCMHs and providers of long-term services and supports, to deliver much-needed information and care coordination to patients. Going forward, it will be critical to help all PCMHs connect with community resources that can also improve health.

Work site, retail and urgent care clinics. In 2015, NCQA launched the Patient-Centered Connected Care program to recognize the role work-site and retail clinics, pharmacies, urgent care and other ancillary care facilities in the care of patients. Work-site clinics increasingly serve as employees' main primary care setting. Retail clinics that treat minor problems in drug stores and other convenient settings are expanding to address wellness, health promotion and chronic care management. Many refer patients back to community primary-care clinicians for follow-up. Pharmacies are also taking on new roles with immunizations, health and wellness screenings, adherence and other medication management services. This program recognizes practices that support clinical integration and communication, creating a roadmap for how sites delivering intermittent or (non-PCMH) outpatient treatment can effectively communicate and connect with primary care and fit into the medical home "neighborhood."

Broad support. Many public- and private-sector initiatives support PCMH transformation. The Department of Health and Human Services is helping hundreds of community health centers and Federally Qualified Health Centers to become PCMHs. The Office of the National Coordinator for Health Information Technology's Regional Extension Centers provide technical assistance to practices. Congress passed legislation to move Medicare beyond demonstration programs in selected states to support PCMHs nationwide, with new payments to reward value and non-face-to-face chronic care management services. In addition, states and private insurers have programs in place to support PCMHs in more than three dozen states.

Attributes for success. There are many paths to becoming a successful PCMH—they do not all look alike and generally consider local circumstances and preferences. NCQA has identified several attributes that contribute to PCMH success:

- Financial assistance, technical assistance, or both, to help create and sustain the transformation. Practices value practical examples and support for meeting requirements, and worry about maintaining their financial viability.

- Organization leadership, a team-based approach, health information technology and delegating self-management education and proactive care reminders to non-physician team members.

- Involving patients and families in practice improvement efforts through advisory committees, ombudsmen or navigators.

- A systems approach to QI that results in data, standard measurements, technical assistance, leadership and personnel.

PCMH Program Update

What's New

The redesigned PCMH requirements focus on assessing a practice's transformation into a medical home and specify goals for improvement. Along with changes to the process of recognition, NCQA has created a new format for articulating the PCMH standards: concepts, competencies and criteria.

- Concepts are the foundation on which a practice builds a medical home.

- Competencies organize the criteria in each concept area.

- Criteria are the individual structures, functions and activities that indicate a practice is operating as a medical home.

Changes to PCMH also include the elimination of recognition levels, points and must-pass elements. To achieve recognition under the new PCMH program, practices must 1) meet all core criteria and 2) earn 25 credits in elective criteria across 5 of 6 concepts. This ensures a minimum set of capabilities and gives practices the flexibility to focus on activities that not only mean the most to their patient population, but are feasible to accomplish with regard to their resources and the resources of their community.

The changes also complement the redesign of the overall program and of the recognition process specifically. Of note is the introduction of a series of virtual reviews to achieve recognition. Rather than coordinating and submitting many documents for evaluation by a reviewer, practices may present evidence of implementation in other ways and "tell the story" of their PCMH transformation. Practices will demonstrate continued PCMH recognition through annual reporting instead of the current program's three-year recognition cycle. Each year, the practice checks in with NCQA to show that its ongoing activities are consistent with the PCMH model of care. The annual check-in includes attesting to certain policies and procedures and submission of key data. This process will sustain the practice's recognition.

The PCMH standards include detailed guidance, evidence requirements and relevant examples to guide practices through their recognition. The PCMH content update was a rigorous process that included significant research; input from an engaged, multi-stakeholder advisory committee and from many others; results of an open public comment period; and surveys of PCMH Certified Content Experts.

Public Comment

We posted the draft standards on the NCQA Web site and solicited comments from a wide group of stakeholders. We received more than 1,300 comments from more than 90 respondents, including health care providers, health plans, consumer groups and government agencies. There was a high degree (nearly 90 percent of comments received) of support for the proposed standards, especially the new program format, flexibility and focus on key features of the medical home.

In addition to the formal public comment period, we received useful suggestions from many others for revisions and changes, which we incorporated into the final version of the standards after review by our multi-stakeholder advisory committee, NCQA's Clinical Programs Committee and the NCQA Board of Directors.

The Standards

The PCMH recognition program's six concepts align with the principles of primary care.

Table 1: Summary of NCQA PCMH Standards

Concept	Brief Concept Description
Team-Based Care and Practice Organization (TC)	The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.
Knowing and Managing Your Patients (KM)	The practice uses information about the patients and community it serves to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
Patient-Centered Access and Continuity (AC)	The practice provides 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team, considers the needs and preferences of the patient population when modeling standards for access.
Care Management and Support (CM)	The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.
Care Coordination and Care Transitions (CC)	The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.
Performance Measurement and Quality Improvement (QI)	The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/ caregivers in quality improvement activities.

The Criteria and Credits Toward Recognition

As part of the redesign of PCMH recognition, the new PCMH program removes recognition levels and moves to a single recognition status. The intent of the single level of recognition is to bring a clear meaning to what PCMH recognition represents: transformation into a medical home.

To receive recognition, practices must complete at least 25 elective credits in addition to the 40 core criteria. A mix of 1-credit and 2-credit electives may be completed to meet the elective minimum. Practices must also select a mix of elective criteria from at least 5 of the 6 program concepts. Each criterion in the standards is noted with its assigned value (e.g., core, 1 credit, 2 credit).

Optional Distinctions

NCQA offers special acknowledgment for practices that excel in specific areas. Practices may receive distinction in behavioral health integration, reporting of electronic quality measures (eCQMs) or patient experience reporting. These distinctions signify to the public and others how the practices are going above and beyond the standards of the medical home by demonstrating their additional commitment.

Table 2: PCMH Distinction Modules

Distinction Name	Distinction Details
Behavioral Health Integration	The Behavioral Health Integration Module calls for a care team in primary care that can manage the broad needs of patients with behavioral health related conditions. The expectation of this model is integration of behavioral health expertise including staff to enhance the care provided in a primary care setting and to improve access, clinical outcomes and patient satisfaction.
Electronic Quality Measures (eCQM) Reporting	The eCQMs distinction module uses a curated list of 35 electronic clinical quality measures relevant for primary care practices. Practices must submit measures in the industry standard QRDA III format. This program will evolve over the years to include actual performance results demonstrating excellence and/or meaningful improvement. Distinction will be awarded for one year to PCMH practice sites that submit, for each clinician in the practice, at least 6 measures from our list of 35. This approach is consistent with MIPS reporting requirements.
Patient Experience Reporting	NCQA has developed the Distinction in Patient Experience Reporting to gather feedback on patient experiences using HEDIS®[2] specifications for the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS®[*3] 3.0), with or without the PCMH Supplemental Item Set, known by NCQA as the "HEDIS Survey for PCMH." The collection and reporting of data from the HEDIS Survey for PCMH is voluntary.

Resources

For additional references maintains a summary of available PCMH-related evidence on www.NCQA.org.

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[2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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Recognition Programs Policies and Procedures

Section 1: Commit—Recognition Eligibility and Recognition Process

The NCQA Recognition programs are clinical practice site-based evaluations for clinicians and care organizations who provide care to patients as part of the medical neighborhood. Each program evaluates how care is provided to all patients in the practice based on the role of the entity as a medical home/ neighbor.

Definitions

Practice	One or more clinicians (including all eligible primary care clinicians) who practice together and provide patient care at a single geographic location and must include all eligible primary care clinicians at the site. "Practicing together" means that all the clinicians in a practice:

* Follow the same procedures and protocols.
* Have access to (as appropriate) and share medical records (paper and electronic) for all patients treated at the practice site.

Electronic and paper-based systems and procedures support clinical and administrative functions (e.g., scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up).

Multi-site group	Three or more primary care practice sites using the same systems and processes, including an electronic medical record system.

Eligibility

Clinicians who qualify for PCMH

* Clinicians who hold a current, unrestricted license as a doctor of medicine (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or physician assistant (PA).

* Only clinicians who can be selected by a patient/family as a personal clinician are eligible to be listed, in addition to the practice Recognition, on NCQA's Web site.
  – The practice can define a "personal clinician" as:
    ▪ A residency group under a supervising clinician or faculty physician (residents are not identified individually for selection as personal clinicians).
    ▪ A combination physician and APRN or PA who share a panel of patients.

* Physicians, APRNs (including nurse practitioners, clinical nurse specialists) and PAs who practice internal medicine, family medicine or pediatrics, with the intention of serving as the personal clinician for their patients.
  These clinicians will be identified individually with the recognized practice.

* Physician-led practices applying with identified APRNs or PAs:
  – Patients may choose the APRN or PA as their primary care clinician, *or*
  – ARPNs or PAs share a panel of patients as a primary care team with the physician.

Note: Clinicians who are part of the practice but are not considered personal clinicians (e.g., behavioral healthcare clinicians, dentists, OB/GYNs) will not be identified individually, but their work on behalf of patients can be used to demonstrate the practice meets PCMH criteria.

Clinicians who do not qualify	• Nonprimary care specialty clinicians and APRNs and PAs who do not have a panel of patients.

Special circumstances	• Practices that do not have a physician with a panel of patients at the site may achieve NCQA Recognition with the following considerations:
	  – It is allowed according to the scope of practice determined by state law.
	  – Practices are reviewed against the same requirements as physician-led practices.

Note: Physicians providing oversight of a practice where required by state law do not need to be identified in the practice application unless they actively practice in the site and patients are able to choose them as their primary care clinician.

Fee Schedule Information

There are three fee schedules.

1. **Single-Site Pricing** applies to practices applying for the first time and for annual recognition thereafter that do not qualify for multi-site pricing.

2. **Multi-Site Group Pricing** applies to practices applying for the first time and for annual recognition thereafter that:

   • Have three or more practice sites operating under the same legal entity.
   • Share an EHR system.
   • Have at least some of the same policies and procedures.

3. **Discounted Partners in Quality Pricing** applies to single or multi-site practices applying for the first time that provide an assigned discount code from a qualifying initiative.

NCQA periodically updates fee schedules on the program Web site and in resources published in the application materials. Survey pricing is determined by the fee schedule in effect when a practice enrolls in PCMH Recognition on Q-PASS. Current PCMH Recognition Pricing is available online at: www.ncqa.org.

Recognition Program Partners in Quality

What is a Partner in Quality?	Entities providing support services without charging a fee for practices seeking NCQA Recognition are acknowledged as NCQA PCMH Recognition Program Partners in Quality for as long as they provide support. An NCQA Partner in Quality initiative encourages eligible MDs, DOs, nurse practitioners, PAs, practices, members and program participants to achieve NCQA Recognition, by providing additional recognition, learning collaborative support, onsite training, coverage of application fees or other financial rewards. The recognition programs Partners in Quality may support include PCMH, PCSP, PCCC, ACO, DRP and HSRP.
Who can lead an initiative?	Initiatives may be led by a health plan, a coalition of plans, state medical societies, regional extension centers or other government entity, a business coalition, a collaboration of plans and businesses, a professional organization or a nonprofit quality improvement or disease awareness organization. Some initiatives are funded by grants or legislation and are part of a broader health care strategy. NCQA supports these positive collaborations among clinicians and organizations by offering a discount on recognition fees.

Caveats	• Only eligible clinicians and practices are accepted for evaluation.
	• NCQA shares clinician or practice status with the initiative, to the extent authorized by the supported clinician or practice.
	• NCQA approves the Recognition Program Partner in Quality's external communications regarding its initiative, to ensure alignment with NCQA policies and procedures.
Discounted recognition fee	NCQA offers a discount to applicants sponsored by NCQA Partners in Quality (health plans, employers and other organizations that provide resources and services to support practices in pursuit of true transformation). Request a discount code from your sponsor organization.
	Practices seeking recognition for the first time pay the recognition fee at the time of enrollment. Thereafter, they pay the recognition fee at the time of their annual report date.

Q-PASS Account

Once a practice is eligible and ready, the next step is to enroll in a Recognition Program through the Quality Performance Assessment Support System (Q-PASS). Q-PASS includes a series of dashboards to manage organizations, sites and programs to pursue recognition. Once an organization account is created, the user can enroll one or more affiliated sites in the NCQA PCMH program or other Recognition Programs available in Q-PASS.

A user's email address is their account log-in identification for Q-PASS. Users that access other NCQA systems may already have an account in Q-PASS. If a user does not have an account, they can create one. Both an organization and any individuals working on its behalf, must set up accounts in Q-PASS. A user working with multiple organizations can view all of their organization and practice site dashboards from one log-in. In order to access Q-PASS, all users must sign a license agreement.

Within Q-PASS, users will set up practice sites and multi-site groups providing information on the clinicians associated with each site. For the PCMH program, organizations should only add primary care clinicians (MDs, DOs, NPs, and PAs) that manage a panel of patients to their practice sites. These clinicians will determine the practice's program cost. Residents should not be included.

Currently, only PCMH 2017 is available on Q-PASS. For organizations that previously obtained Recognition for practices, their organization information, including organization and practice site details as well as affiliated clinicians will be available in Q-PASS.

> **If the organization does not have an existing account, the user will be able to create the organization in Q-PASS. You must have organization details, name, address, telephone, tax ID number and HRSA H-code (if a HRSA grantee) to complete the creation process.**

NCQA PCMH Recognition and HIPAA Business Associate Agreements. The legal agreements establish the terms and conditions that clinicians and practices must accept in order to participate in the NCQA PCMH Recognition program. The practice must complete the Agreement for NCQA PCMH Recognition Program and the HIPAA Business Associate Agreement. The practice may also need to complete a legal agreement for optional distinctions. NCQA does not accept edits to its agreements and requires all applicants to participate on the same terms and conditions. If your practice has a statutory conflict with any particular term or provision you can submit evidence of the conflict to NCQA for review and consideration of a waiver or revision. If the user is not authorized to sign agreements for the organization, the user can invite the appropriate individual to sign for the practice. The authorized individual will receive an email asking them to sign the agreements, along with log in information. You cannot continue without signing the legal agreements.

Additional Multi-Site Details

The multi-site application process is an option for organizations or medical groups with three or more practice sites that share an electronic record system and standardized policies and procedures across all practice sites. Practice sites do not all have to submit in Q-PASS at the same time or be the same specialty or size.

The multi-site application process does not allow organization-wide recognition; instead, it relieves eligible organizations from providing repetitive responses and evidence that would be the same for all sites.

Determining Multi-Site Eligibility

Organizations use their recognition account to link sites in Q-PASS for Multi-Site submission.

Practices must answer "yes" to these questions

- Can your organization sign one PCMH program agreement to cover all sites applying for recognition?
- Do all the practice sites applying for recognition share and use in the same way, a practice management system, registry or EHR to document patient care for administration and billing?
- Do all the practice sites applying for recognition operate under at least some of the same policies and procedures?

Introduction to NCQA Representative

NCQA assigns an NCQA Representative to a practice after the practice signs the legal agreements electronically and submits payment through Q-PASS. The NCQA Representative assists the practice to coordinate their schedule, navigate resources and is the liaison between the practice and NCQA. The Representative will schedule an initial call with the practice to introduce themselves, discuss the virtual check-in process and outline a practice's initial PCMH transformation plan. The transformation plan is a recommended pathway through the requirements. The Representative will additionally suggest education and training applicable to the practice.

Section 2: Transform—The Evaluation Process

Transformation Period and NCQA Evaluation

After the introductory call with the NCQA Representative the practice will enter the transform phase demonstrating their progress toward recognition by submitting evidence and data through Q-PASS as well as showing aspects virtually, designed to reduce paperwork and administrative hassles.

The Evaluation

Over the course of the transformation period, each practice or multi-site group will have up to three (3) check-ins that must be completed within a twelve-month period. Practices that exceed the twelve-month period or need additional check-ins to achieve recognition must pay an additional fee to continue.

A check-in is conducted virtually online with an NCQA Evaluator who will evaluate the practice's progress towards recognition and provide immediate personalized feedback. The timing of each check-in is flexible and up to the practice to determine. Prior to each check-in, the practice will gather and prepare evidence. The practice must attach some evidence prior to each virtual check-in session. At each virtual check in session, the practice will share their computer screen with the NCQA Evaluator and discuss evidence and completion of the requirements together.

Practices participating in a Multi-Site submission, must identify within Q-PASS evidence for the requirements that are shared across the practice sites. The remaining requirements are reviewed at the site-specific level.

The NCQA Representative monitors the practice's progress over the course of the 12 months to see if the practice is on track.

Upon completion of the final check-in, NCQA's peer review committee, the RP-ROC, will review the evaluation for a final determination of recognition. Once confirmed, the practice is notified of its recognition status.

NCQA will publish the practice and clinicians in the list of Recognized Patient-Centered Medical Homes on NCQA's Web site.

Now the final phase of the process, Succeed. Each year, you check in with us and demonstrate that your practice is functioning as patient-centered medical home and is committed to high quality performance. Your Representative will assign your annual reporting date and provide more details about the process when you reach this stage.

Inside the PCMH 2017 Standards

There are six PCMH concepts within the program standards. Each concept is composed of specific criteria to outline the features of the practice's transformation and how NCQA evaluates a practice's ability to function as a patient-centered medical home.

1. Team-Based Care and Practice Organization (TC).
2. Knowing and Managing Your Patients (KM).
3. Patient-Centered Access and Continuity (AC).
4. Care Management and Support (CM).
5. Care Coordination and Care Transitions (CC).
6. Performance Measurement and Quality Improvement (QI).

The Standard's Structure

Concept A brief title describing the criteria; uses a two-letter abbreviation (XX).

Concept Description A brief statement of the intent of the concept.

Competency A brief description of criteria subgroup, organized within the broader concept. This level is used for organization of the criteria into more meaningful groupings. Practices are not scored at this level.

Criteria A brief statement highlighting PCMH requirements.

This is the scorable aspect of a concept that provides details about performance expectations. NCQA evaluates each completed criterion to determine how well the practice meets the requirements.

Each criterion is allocated a credit value:

- **Core:** Must be completed by all practices seeking recognition

- **Elective:** A selection of additional criteria a practice may choose from to indicate it is functioning as a medical home. electives will be noted with their credit value.

Of the 100 criteria in PCMH, 40 are core and 60 are electives. Refer to *The Recognition Guidelines* below.

Guidance The guidance provides information to the practice about the intent or expectation of each criterion, how the criterion relates to practice transformation or other criteria, terminology used and aspects of the criterion evaluation process.

When guidance notes inclusion of a goal, source, standard response time, description, or specific detail expected by the criterion, those should appear in the demonstrated evidence. Note if a specific number of examples is expected.

Evidence Describes the evidence practices must submit to demonstrate performance against specific criteria. The list of evidence in each criterion is not prescriptive, nor does it exclude other potential types of evidence. There may be acceptable alternatives that demonstrate performance either in document form or through the virtual review.

Practices are encouraged to implement and document process-based criteria early in their transformation so the process will be implemented at least 3 months prior to demonstrating implementation and completing the recognition process. Generally, reported data should be no more than 12 months old.

Types of evidence Practices may use the following types of evidence to demonstrate performance.

1. *Documented process.* Written statements describing the practice's policies and procedures (e.g., protocols, practice guidelines, agreements or other documents describing actual processes or forms [e.g., referral forms, checklists, flow sheets]). The documented process must include a date of implementation and provide practice staff with instructions for following the practice's policies and procedures.

2. *Evidence of implementation.* A means of demonstrating systematic uptake and effective demonstration of required practices, including but limited to:

   a. Reports. Aggregated data with a numerator, denominator and rate; showing evidence of action, including manual and computerized reports the practice produces to measure its performance or data to manage its operations (i.e., list of patients who are due for a visit or test).

   b. Patient records. Actual patient records or registry entries that document an action. A record review is measured using the sample selection process provided by NCQA—instructions for choosing a sample and a log for reviewing records are in the Record Review Workbook.

   c. Materials. Informational materials typically prepared for and made available to patients or clinicians (e.g., clinical guidelines, self-management and educational resources such as brochures, Web sites, videos and pamphlets).

   d. Examples. A sample of the expected submitted by the practice to demonstrate performance of specific criteria.

   e. Screen shots. An image that shows the required criteria on a computer display that's captured by the practice as a means of demonstrating its performance.

   f. Virtual demonstration. Live display of evidence using screen sharing technology during an NCQA check-in session with an Evaluator.

   g. Attestation. A declaration acknowledging and/or validating the implementation of certain criteria.

   h. Electronic Clinical Quality Measures (eCQM). Measurement data submitted through electronic health records (EHR) to NCQA in support of a practice's recognition process. eCQMs may be submitted through and EHR, health information exchanges, qualified clinical data registries (QCDRs) and data analytics companies if they can use the electronic specifications as defined by CMS for ambulatory quality reporting programs.

   i. Transfer Credit. The application of credit towards criteria or facets of a criterion, received for use of a pre-validated HIT vendors.

   j. Surveys. A systematic collection or sampling of data on opinions taken and used for the analysis of some aspect of a population group. One of the most common surveys is the patient satisfaction survey, conducted on a continuous basis to measure performance from the patient's perspective to be used in evaluating the delivery of health care services within medical practices.

   k. Data entered directly in Q-PASS. A practice's response related to required criteria entered in text boxes provided within the survey platform.

   l. Not applicable (NA). Specific criteria or facets of a criterion that may be scored NA if they do not apply to the practice, as determined by NCQA and identified in the guidance where applicable. The NA meets the requirement in a core criteria. A practice may not achieve score for an elective criterion with NA as evidence.

Note

- *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 to NCQA, unless NCQA requests the information. If NCQA requests an aspect of PHI (e.g., a date of service), include <u>only</u> the minimum information necessary to satisfy the intent of the criteria. Do not include additional patient identifiers as part of the evidence (e.g., a member's chart number or account number).*

- *NCQA does not require (and practices should never submit) evidence with patient names, social security numbers, dates of birth, street addresses, email addresses or telephone numbers.*

- *If the best evidence is a screen shot from a computer the practice uses, **only submit de-identified patient data and examples.** Create a Word document; cut and paste screen shots to the document; or scan documents and create a PDF. Save Word documents using text boxes to block PHI as read-only. For more information, refer to the definitions of* PHI *and* de-identify *in the Glossary.*

- *During the virtual reviews, NCQA and the practice will use screen sharing. NCQA may see PHI during the virtual check-ins. NCQA does not record the session or download or save files shared during a virtual check-in.*

Recognition Guidelines

Recognition	To receive recognition, practices must complete all core criteria and at least 25 elective credits.

A mix of 1-credit and 2-credit electives may be completed to meet the elective minimum. Practices must also select elective criteria from at least 5 of the 6 program concepts. |
| **Calculating the recognition score** | Q-PASS confirms all core criteria are met and adds the value of the elective criteria met to determine if the minimum score and concept distribution requirement was met. |

The NCQA Recognition Program Review Oversight Committee (RP-ROC) reviews findings and makes scoring decisions which generates the practice's results.

RP-ROC members are physicians who have expertise in practice systems and who, as determined by NCQA, have no conflict of interest with the practice.

Certificates	NCQA issues an electronic Recognition Certificate (with the ability to print-on-demand) acknowledging that the practice met the standards.
Duration of status	Recognition status continues indefinitely and is contingent upon the continued submission of annual reporting requirements.
Reporting results	
…to the practice	NCQA gives the practice a final decision and access to the final results for each of the criterion.
…to the public	Recognized practices and associated eligible clinicians are added to the Recognition Directory, a list of practices and eligible clinicians on NCQA's Web site (https://reportcards.ncqa.org)

NCQA does not report practices whose status is Not Recognized.

NCQA reserves the right to release and to publish, and authorize others to publish, results of the practice's performance under specific competencies, criteria, and reporting categories, including distinctions. |

…to organizations   NCQA periodically provides data about enrolled practices and eligible clinicians to organizations that use or reward NCQA Recognition.

Data may include type of recognition program, progress toward achieving recognition, effective dates, practice site address, tax identification number, clinician names, specialties, state, license number and NPI.

Section 3: Succeed—Keeping Your Recognition

Annual Reporting

The practice continues to implement and enhance its PCMH model to improve how it meets the needs of patients. Each year, the practice will show that its ongoing activities are consistent with the PCMH model of care. At the annual reporting date, a practice will submit select information, attest to continuing to meet PCMH criteria, and submit key data and documentation that covers six PCMH concept areas as well as special topics. This process will sustain the practice's recognition and is designed to foster continuous improvement. This process exhibits how the practice succeeds in strengthening its transformation, and as a result, patient care.

Practice renewal is one year after earning NCQA recognition. The annual reporting date is set for one month prior to their recognition anniversary date for the practice submission. For a multi-site group, all associated practices may share the same reporting date. The annual reporting date is based on the date the first practice earned recognition. Practices recognized as PCMH 2014 Level 3 will renew on the end date of their current recognition and are eligible to sustain Recognition through the annual reporting process.

Practices will use Q-PASS to confirm or update clinician demographic information and submit evidence that supports meeting requirements annually. Data submission and attestation are all done through Q-PASS and will not require a virtual check-in unless selected for audit. An annual reporting fee is due at the time of submission. NCQA reviews the evidence and notifies practices of their sustained recognition status. Sustained recognition will be based on a practice's overall performance.

If a practice misses their annual reporting date, the recognition will be suspended. The practice then has up to three months to pay a reinstatement fee and submit the requirements for annual reporting.

During the review process, some practices will be selected for an audit. Practices selected must provide evidence that demonstrate meeting the requirements for which the practice attested. NCQA may conduct audits by email, teleconference, webinar or other electronic means, or onsite review.

If a practice does not pass the audit, the practice will be suspended for three months, which will allow the practice to improve performance or provide additional evidence for requirements. If the requirements are met within the three month window, the recognition continues. If a practice chooses not to update the submission within three months of their annual reporting date, the practice will lose their recognition status. A practice will have the option to restore their Recognition status through an abbreviated Transform process.

Note: *Even though some criteria do not require a practice to submit evidence, practices must be able to produce evidence if selected for audit.*

Reconsideration

Practices may request Reconsideration of any NCQA decision. Practices must submit a formal Reconsideration request to NCQA via email within 30 days after a practice is notified of an adverse decision. The decision receipt date will govern as the start of the 30-day reconsideration request window.

A Reconsideration fee is required in accordance with the fee schedule in effect at the time of the Reconsideration request. The fee schedule can be found on NCQA's website, along with instructions for remitting payment via the Recognition Programs Payment Portal. The portal provides the ability to pay securely online via credit card, and also includes instructions for mailing in a paper check.

For the Reconsideration requests, the practice must describe the reason for requesting the Reconsideration and list criteria for which it requests Reconsideration. Additional evidence may not be submitted.

NCQA refers Reconsideration requests to the Reconsideration Committee, made up of NCQA staff and Review Oversight Committee (RP-ROC) members who were not involved in making the original

Recognition decision and do not have a conflict of interest with the practice. The Reconsideration Committee members review the evidence and make a Reconsideration decision. The Reconsideration Committee's decision is final and is sent to the practice via email. No further right to appeal exists.

NCQA updates a practice's evaluation to reflect the new status, if applicable, and if the Reconsideration results in Recognition, the practice will be considered Recognized and the NCQA Web site and data feeds are updated accordingly.

Applicant Obligations

By submitting the PCMH application to NCQA, the applicant agrees to the following:

- To the best of its knowledge and belief, the information submitted for survey is true, accurate and correct and was obtained using procedures specified in the PCMH Recognition program standards.

- To release the information to NCQA that NCQA deems pertinent.

- To read and agree to abide by the terms and conditions of the NCQA PCMH Recognition program. The terms are established in the signed legal agreements, PCMH Recognition program standards, NCQA's guidelines for advertising PCMH recognition, these policies and procedures, and all other published NCQA policies, procedures and rules governing NCQA's PCMH Recognition program.

- To function in a manner consistent with the Joint Principles for Patient Centered Medical Homes (AAFP, AAP, ACP, AOA, 2007), modified to focus on team-based care led by an eligible clinician operating within the appropriate scope of practice of the state.

- For any clinician identified with the practice's recognition, to notify NCQA within 30 calendar days of receiving notice of a final determination by a state or federal agency with respect to an investigation, request for corrective action, imposition of sanctions or change in licensure or qualification status.

- To notify NCQA of any change in submitted clinicians listed with the practice's recognition. Addition of clinicians under a current recognition is subject to the same approval process and eligibility verification as that used with the initial set of clinicians applying for recognition. Added clinicians must be of the same specialty type as one or more currently recognized clinicians. If they are not, this is considered a separate survey.

- To notify NCQA of any material changes in the structure or operation of the practice, or merger, acquisition or consolidation of the practice, in accordance with these policies.

- To continue to meet the requirements of PCMH Recognition program standards as updated by NCQA, and be prepared to demonstrate such during the period of recognition.

The Audit

NCQA reserves the right to audit a practice that has NCQA Recognition. This will take place during the Succeed phase (annual check-in). Audit validates evidence, procedures and responses of a Q-PASS submission. NCQA audits a sample of practices, either by specific criteria or randomly. Audits may be completed by email, teleconference, webinar or other electronic means, or onsite review.

Practice sites selected for audit are notified and sent instructions. The first level of review is verification of the Q-PASS submission. The practice may be asked to forward copies of the source documents and explanations, to substantiate the information in the Q-PASS submission.

- *If an audit requires a virtual or on-site review,* NCQA conducts the review within 30 calendar days of notifying the practice of its intent to conduct an audit.

- *If audit findings indicate that information submitted by the practice is incorrect or evidence does not meet the PCMH standards,* the application for NCQA Recognition may be denied, credits may be reduced or additional evidence may be required.

NCQA notifies the practice of audit findings and the recognition status within 30 days after conclusion of the audit. Failure to agree to an audit or failure to pass an audit may result in a status of "Not Recognized."

Section 4: Additional Information

Complaint Review Process

NCQA accepts written complaints from members of the public, including patients, members and practitioners, regarding recognized clinicians and practices. Upon receipt of such a complaint, NCQA will:

1. Review the complaint to determine that the clinician or practice is recognized by NCQA.

2. Determine if the complaint is germane to the recognition held by the clinician or practice.

3. Obtain a release to share the complaint with the clinician or practice, if the complaint involves PHI or quality of care.

4. Forward the complaint to the clinician or practice within 30 calendar days, with a request that the clinician or practice review and respond directly to the individual filing the complaint, and copy NCQA on the response.

5. Review the response from the clinician or practice to determine whether the complaint was handled in accordance with NCQA requirements and whether all issues raised in the complaint have been addressed.

Failure to comply with NCQA's complaint review process is grounds for suspension or revocation of recognition status.

Reporting Hotline for Fraud and Misconduct

NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program.

NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level).

How to Report

- **Toll-Free Telephone:**
    – English-speaking USA and Canada: **844-440-0077** (not available from Mexico).
    – Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).

- **Web Site:** https://www.lighthouse-services.com/ncqa

- **Email:** reports@lighthouse-services.com (must include NCQA's name with the report).

- **Fax:** 215-689-3885 (must include NCQA's name with the report)

Discretionary Survey

At its discretion, NCQA may review a practice while a Recognized status is in effect. The purpose of such a review is to validate the appropriateness of an existing Recognition decision.

Structure	Discretionary surveys are targeted to address issues indicating that a practice may not continue to meet the NCQA standards in effect at the time of recognition.
	The scope and content of the review are determined by NCQA and may be completed by email, teleconference, Webinar or other electronic means, or done by onsite review. NCQA conducts the discretionary review using the standards in effect at the time of the practice's last submission.
	If a discretionary survey requires an on-site review, NCQA conducts the review within 60 calendar days of the notification by NCQA of the intent to conduct a discretionary survey.
	Review costs are borne by the practice and correspond to the complexity and scope of the review and NCQA pricing policies in effect at the time of survey.
Change in status	NCQA may suspend the practice's Recognized status pending completion of a discretionary survey. Upon completion of the review and after the RP-ROC's decision, the practice's status may remain the same as it was before notification of the review, or it may change. The practice has the right to Reconsideration of the determination if its Recognized status changes because of the discretionary survey.

Suspension of Recognition

Grounds for suspending a practice's Recognized status pending a Discretionary Survey include, but are not limited, to the following circumstances:

- Facts or allegations suggest an imminent threat to the health and safety of patients.
- Allegations of fraud or other improprieties in information submitted to NCQA to support recognition.
- The practice has been placed in receivership or rehabilitation.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the practice's operations.

A practice's PCMH Recognition status may also be suspended when the practice does not:

- Submit its annual reporting requirements by the annual reporting deadline. The practice's recognition status will be **suspended** if the practice does not submit the annual reporting requirements by the assigned date.

- Satisfy the annual reporting requirements. The practice's recognition status will be **suspended** if it does not meet the annual reporting requirements. The practice will have 30-days from the date it is notified it has not satisfied its annual reporting requirements to resubmit and demonstrate it has met the unsatisfactory annual reporting requirements to reinstate recognition.

Revoking Recognition

NCQA may revoke PCMH recognition in the following circumstances:

- The practice submits false data.
- The practice misrepresents the credentials of a clinician.
- The practice misrepresents its NCQA PCMH Recognition status.
  - When communicating with patients, third-party payers, health plans and others, practices that earn PCMH recognition may represent themselves as having been recognized by NCQA for meeting PCMH standards, but may not characterize themselves as "NCQA approved," "NCQA endorsed" or "NCQA Certified." Mischaracterization or other similarly inappropriate statements are grounds for revocation of status.
- An eligible clinician is suspended or the professional license is revoked.
- The practice has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the practice's operations.
- NCQA identifies a significant threat to patient safety or care.
- The practice fails to remain in compliance with PCMH standards.
- The practice does not submit annual reporting requirements within 30-days of the annual reporting deadline. After 30 days, the practice's recognition will be suspended.
- The practice does not provide required evidence to maintain Recognition after 60 days, the practice's recognition status will be revoked.

Reportable Events

Recognized practices must report to NCQA any merger, change in practice location, acquisition or consolidation activity in which they are involved. NCQA considers the circumstances and determines the need for additional information and for further evaluation.

Revisions to Policies and Procedures

At its sole discretion, NCQA may amend any PCMH policy and procedure. Notice of and information about modifications or amendments are posted publicly on NCQA's Web site 30 calendar days before the effective date of the modification or amendment. Practices that do not agree with policy changes may withdraw from the recognition program, but fees paid to NCQA will not be refunded.

Disclaimer

A recognition decision and the resulting status designation are based on the exercise of NCQA's professional evaluative judgment and the determination of the ROC.

NCQA is not bound by any numerical or quantitative scoring system or other quantitative guidelines or indicators that in its sole discretion it may have used, consulted or issued to assist reviewers and others during the course of the evaluative process.

NOTE

NCQA RECOGNITION DOES NOT CONSTITUTE A WARRANTY OR ANY OTHER REPRESENTATION BY NCQA TO THIRD PARTIES (INCLUDING, BUT NOT LIMITED TO, EMPLOYERS, CONSUMERS OR PATIENTS) REGARDING THE QUALITY OR NATURE OF THE HEALTH CARE SERVICES PROVIDED OR ARRANGED FOR BY THE PRACTICE. THE PROVISION OF MEDICAL CARE IS SOLELY THE RESPONSIBILITY OF THE PRACTICE AND ITS CLINICIANS. RECOGNITION IS NOT A REPLACEMENT FOR THE PRACTICE'S EVALUATION, ASSESSMENT AND MONITORING OF ITS PROGRAMS AND SERVICES.

PCMH Standards and Guidelines

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Team-Based Care and Practice Organization (TC)

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

TC 01 (Core) PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	
GUIDANCE	**EVIDENCE**
The practice identifies the clinician lead *and* the transformation manager (the person leading the PCMH transformation). This may be the same person. The practice provides details including the person's name, credentials and roles/responsibilities. PCMH transformation is successful when there is support from a clinician lead. Their support sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinician and leadership support to implement the PCMH model and to acknowledge the role of staff in the practice's everyday operations.	• **Details about the clinician lead** *AND* • **Details about the PCMH manager**

TC 02 (Core) Structure and Staff Responsibilities: Defines practice's organizational structure and staff responsibilities/skills to support key PCMH functions.	
GUIDANCE	**EVIDENCE**
The practice provides an overview of practice staff; an outline of duties the staff are expected to execute as part of the medical home; and how the practice will support and train staff to complete these duties. Structured tasks and stated staff responsibilities enable a practice to ensure that staff are providing efficient medical care and have training for the skills necessary to support medical home functions.	• **Staff structure overview** *AND* • **Description of staff roles, skills and responsibilities**

= Evidence sharable across practice sites

TC 03 (1 Credit) External PCMH Collaborations: The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).

GUIDANCE	EVIDENCE
The practice demonstrates involvement in at least one state or federal initiative (e.g., CPC+, care management learning collaborative led by the state, two-way data exchange with a local health information exchange; population-based care or learning collaborative) or participates in a health information exchange. The practice recognizes the value of participation in external collaboration and has the support of leadership to implement collaborative activities.	• **Description of involvement in external collaborative activity**

TC 04 (2 Credits) Patients/Families/Caregivers Involvement in Governance: Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.

GUIDANCE	EVIDENCE
The practice demonstrates involvement by: • Giving patients/families/caregivers a role in the practice's governance structure or Board of Directors. • Organizing a patient and family advisory council (i.e., stakeholder committee). At a minimum, the process specifies how patients/families/caregivers are selected for participation, their role and frequency of meetings. Patients are more than consumers in their care, they are partners. Involving patients/families/caregivers in the practice's governance can provide additional input to improve patient services and help engage patients in the care they receive from the practice.	• **Documented process** *AND* • **Evidence of implementation**

TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology system (CEHRT).

GUIDANCE	EVIDENCE
The practice enters the name of the electronic system(s) implemented in the practice. Only systems the practice is actively using should be entered. Use of an EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently. https://chpl.healthit.gov/#/search	• **Certified electronic health record system (EHR) name**

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= Evidence sharable across practice sites

Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.	
GUIDANCE	**EVIDENCE**
The practice maintains a structured communication process, sharing information about patients, care needs, concerns for the day and other information that encourages efficient patient care and practice flow. The process may include tasks or messages in the medical record, regular email exchanges, or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care-team meetings (such as huddles) provide a forum for practice staff to communicate about upcoming appointments, patient needs and workflow updates.	• **Documented process** *AND* • **Evidence of implementation** ⬙ Documented process only

TC 07 (Core) Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities.	
GUIDANCE	**EVIDENCE**
The documented process for quality improvement activities includes a description of staff roles and staff involvement in the performance evaluation and improvement process. Improving quality outcomes involves all members of the practice staff and care team. Engaging the team to review and evaluate the practice's performance is important to identifying opportunities for improvement and developing meaningful improvement activities.	• **Documented process** *AND* • **Evidence of implementation** ⬙

TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.	
GUIDANCE	**EVIDENCE**
The practice identifies the behavioral healthcare manager and provides their qualifications. The care manager has the training to support behavioral healthcare needs in the primary care office and coordinates referrals to specialty behavioral health services outside the practice. The practice demonstrates that it is working to provide meaningful behavioral healthcare services to its patients by employing a care manager who is qualified to address patients' behavioral health needs.	• **Identified behavioral healthcare manager** ⬙

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Competency C: The practice communicates and engages patients on expectations and their role in the medical home model of care.

<table>
<tr>
<td colspan="2">TC 09 (Core) Medical Home Information: Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.</td>
</tr>
<tr>
<td align="center">GUIDANCE</td>
<td align="center">EVIDENCE</td>
</tr>
<tr>
<td>The documented process includes providing patients/families/caregivers with information about the role and responsibilities of the medical home. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs.

The information that the practice provides should at minimum include information on after-hours access, practice scope of services, evidence-based care, availability of education and self-management support and practice points of contact.

As a medical home, the practice helps patients understand the importance of having comprehensive information about all their healthcare activity and how and where to access the care they need coordinated by their personal clinician and care team.</td>
<td>• Documented process
AND
• Evidence of implementation</td>
</tr>
</table>

⬙ = Evidence sharable across practice sites

Team-Based Care and Practice Organization (TC)

Knowing and Managing Your Patients (KM)

The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

Competency A: Practice routinely collects comprehensive data on patients to understand the background and health risks of patients. Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals.

KM 01 (Core) Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses.	
GUIDANCE	**EVIDENCE**
Up-to-date means that the most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician, or by querying the patient—are added to the problem list. Report shows patients with a problem list that has been updated at least annually. The patient's active problem list or diagnoses should include acute and chronic conditions, behavioral health diagnoses and oral health issues, as well as past diagnoses that are relevant to the patient's current care. Implementing KM 01 is a foundation for understanding health risks.	• **Report** *OR* • **KM 06—predominant conditions and health concerns**

= Evidence sharable across practice sites

KM 02 (Core) Comprehensive Health Assessment: Comprehensive health assessment includes (all items required):

A. **Medical history of patient and family.**
B. **Mental health/substance use history of patient and family.**
C. **Family/social/cultural characteristics.**
D. **Communication needs.**
E. **Behaviors affecting health.**
F. **Social functioning.**
G. **Social determinants of health.**
H. **Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.)**
I. **Advance care planning. (NA for pediatric practices.)**

GUIDANCE	EVIDENCE
A comprehensive patient assessment includes an examination of the patient's social and behavioral influences in addition to a physical health assessment. The practice uses evidence-based guidelines to determine how frequently the health assessments are completed and updated. Comprehensive, current data on patients provides a foundation for supporting population needs.	• **Documented process** *AND* • **Evidence of implementation**
As part of the comprehensive health assessment the practice:	**PCMH PRIME**
A. Collects patient and family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patient and "first-degree" relatives (i.e., who share about 50% of their genes with a specific family member).	**B, E, H:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only.
B. Collects patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression).	
C. Evaluates social and cultural needs, preferences, strengths and limitations. Examples include family/household structure, support systems, and patient/family concerns. Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities).	
D. Identifies whether a patient has specific communication requirements due to hearing, vision or cognition issues. ***Note:*** *This does not address language; refer to KM10 for language needs.*	*Documented process only*

⬙ = Evidence sharable across practice sites

Knowing and Managing Your Patients (KM)

KM 02 (Core) Comprehensive Health Assessment (all items required): *continued*	
GUIDANCE	**EVIDENCE**
E. Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure.	• **Documented process** *AND* • **Evidence of implementation**
F. Assesses a patient's ability to interact with other people in everyday social tasks and to maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, social interactions and so on.	**PCMH PRIME** **B, E, H:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only.
G. Collects information on **social determinants of health:** conditions in a patient's environment that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental **risk factors**; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020).	
H. For newborns through 30 months, uses a standardized tool for periodic developmental screening. If there are no established risk factors or parental concerns, screens are done by 24 months.	
I. Documents patient/family preferences for **advance care planning** (i.e., care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet the requirement.	*Documented process only*

　　= Evidence sharable across practice sites

Knowing and Managing Your Patients (KM)

KM Competency A

KM 03 (Core) Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool.	
GUIDANCE	**EVIDENCE**
The documented process includes the practice's screening process and approach to follow-up for positive screens. The practice reports the screening rate and identifies the standardized screening tool. **Screening for adults:** Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. **Screening for adolescents (12–18 years):** Screening adolescents for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. In caring for the whole person, the medical home recognizes the impact depression can have on a patient's physical and emotional health. The practice uses a standardized screening tool (e.g., PHQ-9) and acts on the results.	• **Documented process *or*** • **Report** ***AND*** • **Evidence of implementation** --- **PCMH PRIME** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation with an explanation. *Documented process only*

= Evidence sharable across practice sites

KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.)

A. Anxiety.

B. Alcohol use disorder.

C. Substance use disorder.

D. Pediatric behavioral health screening.

E. Post-traumatic stress disorder.

F. Attention deficit/hyperactivity disorder.

G. Postpartum depression.

GUIDANCE	EVIDENCE
Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Practice staff have been trained on the use of standardized tools to ensure accurate diagnosis, treatment and follow-up.	• **Documented process** *AND* • **Evidence of implementation**
A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization.	**PCMH PRIME** **A-C, G:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only.
The National Institute on Drug Abuse created a chart of [Evidence Based Screening Tools for Adults and Adolescents](#) for opioid screening, as well as alcohol and substance use tools.	
A. The practice conducts assessment for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders (generalized anxiety disorder, panic disorder and social anxiety disorder) are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked with medical conditions (e.g., heart disease, chronic pain disorders).	
B. The USPSTF recommends screening for adults aged 18 years or older for alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking, the Drug Abuse Screening Test (DAST), Cutting down, Annoyance by criticism, Guilty feeling and Eye-openers Questionnaire (CAGE) or another validated screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth).	*Documented process only*

= Evidence sharable across practice sites

Knowing and Managing Your Patients (KM)

KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
C. Assessing for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to address the patient's substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients' access to the necessary treatments toward sobriety. Available screening tools may include the CAGE AID or DAST-10 instruments, which assess a variety of substance use conditions. Bright Futures recommends clinicians screen all adolescents for substance use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or DAST-20).	• **Documented process** *AND* • **Evidence of implementation** --- **PCMH PRIME** **A-C, G:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only.
D. Pediatric screening for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have lasting effects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC).	
E. The practice uses standardized tools to determine if patients have developed PTSD. This condition develops in patients who have experienced a severe and distressing event. This event causes the patient to subsequently re-live the traumatic experience causing mental distress. Assessments for PTSD support the practice in recognizing the ailment so it can either provide treatment or referrals to appropriate specialists.	
F. ADHD makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood but symptoms can persist through adolescence and adulthood. The Vanderbilt Assessment Scale or the DSM V ADHD checklist for adults or children/adolescents are examples of screening tools used to determine if a patient has Attention Deficit/ Hyperactivity Disorder (ADHD). Screening to identify patients with ADHD can lead to earlier diagnosis and treatment and may and reduce the impact of the condition on patients/families/caregivers.	*Documented process only*

Table of Contents   = Evidence sharable across practice sites

KM Competency A

KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
G. The USPSTF recommends screening of adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF guidelines suggest screening during and after pregnancy. The AAP's Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-child care schedule. Validated screening tools may include PHQ-2, PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools, and may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits. For a list of screening tools, visit SAMHSA.gov, or for a list of pediatric screening tools, visit the American Academy of Pediatrics website. (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx)	• **Documented process** *AND* • **Evidence of implementation** --- **PCMH PRIME** **A-C, G:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only. *Documented process only*

KM 05 (1 Credit) Oral Health Assessment and Services: Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	
GUIDANCE	**EVIDENCE**
The practice conducts patient-specific oral health risk assessments and keeps a list of oral health partners such as dentists, endodontists, oral surgeons and/or periodontists from which to refer. Poor oral health can have a significant impact on quality of life and overall health. Primary care practices are uniquely positioned to improve oral health, oral health awareness through education, preventive interventions (e.g. fluoride application for pediatric patients) and timely referrals.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

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KM Competency A

KM 06 (1 Credit) Predominant Conditions and Concerns: Identifies the predominant conditions and health concerns of the patient population.

GUIDANCE	EVIDENCE
The practice identifies its patients' most prevalent and important conditions and concerns, through analysis of diagnosis codes or problem lists. Although the general conditions treated in primary care are similar across practices, each medical home has a unique population that influences how the practice organizes their work and resources. Knowing its population's top concerns allows the practice to adopt guidelines, focus decision support and outreach efforts, identify specialties to establish clearer referral relationships and determine what special services to offer (e.g., group sessions, education, counseling) that align with those needs.	• **List of top priority conditions and concerns**

KM 07 (2 Credits) Social Determinants of Health: Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.

GUIDANCE	EVIDENCE
After the practice collects information on social determinants of health, it demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the on-going needs of its population. Routine collection of data on social determinants of health (as required in KM 02) is an important step, but the real benefit to the population comes when the practice uses the information to continuously enhance care systems and community connections to systematically address needs.	• **Report** *AND* • **Evidence of implementation**

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KM Competency A

KM 08 (1 Credit) Patient Materials: Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.	
GUIDANCE	**EVIDENCE**
The practice demonstrates an understanding of the patients' communication needs by utilizing materials and media that are easy for their patient population to understand and use. The practice considers patient demographics such as age, language needs, ethnicity and education when creating materials for its population. The practice may consider how its patients like to receive information (i.e., paper brochure, phone app, text message, email), in addition to the readability of materials (e.g., general literacy and health literacy). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and establish processes that address health literacy to improve patient health behaviors and safety in the practice setting. Reducing barriers to the patient's ability to access, understand and absorb health information supports their ability to comply with their care.	• **Report** *AND* • **Evidence of implementation**

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KM Competency B

Competency B: The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met.

KM 09 (Core) Diversity: Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.

GUIDANCE	EVIDENCE
The practice collects information on how patients identify in at least three areas that include: 1. Race. 2. Ethnicity. 3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence. Assessing the diversity of its population can help a practice identify segments of the population with specialized needs or subject to systemic barriers leading to disparities in health outcomes. Data may be collected from all patients directly or the practice may use data about the community served by the practice (such as inputting data from zip code analysis or accessing census data from their specific community).	• **Report**

KM 10 (Core) Language: Assesses the language needs of its population.

GUIDANCE	EVIDENCE
The practice documents in its records whether the patient declined to provide language information, that the primary language is English or that the patient does not need language services. A blank field does not mean the patient's preferred language is English. Documenting patients' preferred spoken and written language helps the practice identify the language resources required to serve the population effectively such as materials in prevalent languages, translation services, and availability of bilingual staff. Data may be collected by the practice from all patients directly or may be data about the community served by the practice.	• **Report**

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KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two):

A. Targets population health management on disparities in care.

B. Educates practice staff on health literacy.

C. Educates practice staff in cultural competence.

GUIDANCE	EVIDENCE
The practice recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs.	• **A*: Evidence of implementation** *OR* • **A*: QI 05** *and* • **A*: QI 13**
The practice:	
A. Identifies disparities in care and implements actions to reduce the disparity. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population.	• **B: Evidence of implementation** • **C: Evidence of implementation**
B. Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels, utilize the AHRQ or Alliance for Health Reform Health Literacy toolkit). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes.	
C. Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures. It supports practice staff to become respectful and responsive to the health beliefs and cultural and linguistic needs of patients.	
Health literacy resources	
• Institute of Medicine: Ten Attributes of Health Literate Health Care Organizations http://www.ahealthyunderstanding.org/ Portals/0/Documents1/IOM_Ten_Attributes_ HL_Paper.pdf	
• Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit: http://www.ahrq.gov/professionals/ quality-patient-safety/quality-resources/tools/literacy-toolkit/ healthliteracytoolkit.pdf	
• Alliance for Health Reform Toolkit: http://www.allhealth.org/publications/ Private_health_insurance/Health-Literacy-Toolkit_163.pdf	

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Competency C: The practice proactively addresses the care needs of the patient population to ensure needs are met.

KM 12 (Core) Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):

A. Preventive care services.

B. Immunizations.

C. Chronic or acute care services.

D. Patients not recently seen by the practice.

GUIDANCE	EVIDENCE
The practice uses lists or reports to manage the care needs of specific patient populations. Using collected data on patients, the practice addresses a variety of health care needs using evidence-based guidelines, including missing recommended follow-up visits. The practice implements this process at least annually to proactively identify and remind patients, or their families/caregivers, before they are overdue for services.	• **A, B, D: Report/list** *and* • **A, B, D: Outreach materials** • **C: Report/list** *and* • **C: Outreach materials** *OR* • **C: KM 13**

KM 13 (2 Credits) Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.

GUIDANCE	EVIDENCE
At least 75 percent of eligible clinicians have earned NCQA HSRP or DRP Recognition. Alternatively, the practice demonstrates that it is participating in a program that uses a common set of measures to benchmark participant results, has a process to validate measure integrity and publicly reports results. The practice shows (through reports) that clinical performance is above national or regional averages. Examples of programs may include MN Community Measures, Bridges to Excellence, IHA or other performance-based recognition programs.	• **Report** *OR* • **HSRP or DRP recognition for at least 75% of eligible clinicians**

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Competency D: The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.

KM 14 (Core) Medication Reconciliation: Reviews and reconciles medications for more than 80 percent of patients received from care transitions.	
GUIDANCE	**EVIDENCE**
The practice reviews all prescribed medications a patient is taking and documents this in the medical record. Conflicts or potential discrepancies in medications are identified and addressed by clinical staff. Medication review and reconciliation occurs at transitions of care, or at least annually. Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. Medication reconciliation is an important safety net for patients received from care transitions, because they are more likely to be elderly, use multiple pharmacies, multiple providers and have co-morbid conditions. **Medication reconciliation** is the process of obtaining and maintaining an accurate list of all medications a patient is taking and addresses any potential conflicts including name, dosage, frequency and drug-drug interactions.	• **Report**

KM 15 (Core) Medication Lists: Maintains an up-to-date list of medications for more than 80 percent of patients.	
GUIDANCE	**EVIDENCE**
The practice routinely collects information from patients about medications they take and keeps up-to-date lists of patients' medications. Medication data should be captured in searchable fields. The list should include the date when it was last updated, prescription and nonprescription medications, over-the-counter medications and herbal and vitamin/mineral/dietary (nutritional) supplements.	• **Report**

KM 16 (1 Credit) New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.	
GUIDANCE	**EVIDENCE**
The practice uses patient-centered methods, such as open-ended questions (i.e., teach-back collaborative method), to assess patient understanding. Educational materials are designed with regard to patient need (e.g., reading level). Lack of understanding, due to low health literacy or communication barriers, leads to poorer health outcomes and compromises patient safety.	• **Report** *AND* • **Evidence of implementation**

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KM Competency D

KM 17 (1 Credit) Medication Responses and Barriers: Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.

GUIDANCE	EVIDENCE
The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed. If a patient is not taking a medication as prescribed, the practice determines why. Patients cannot get the full benefit of their medications if they do not take them as prescribed.	• **Report** *AND* • **Evidence of implementation**

KM 18 (1 Credit) Controlled Substance Database Review: Reviews a controlled substance database when prescribing relevant medications.

GUIDANCE	EVIDENCE
The practice consults a state controlled-substance database—also known as a Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP)—before dispensing Schedule II, III, IV and V controlled substances. The practice follows established guidelines or state requirements to determine frequency of review. This can prevent overdoses and misuse, and can support referrals for pain management and substance use disorders. For a list of PDMPs by state: http://www.pdmpassist.org/content/state-pdmp-websites	• **Evidence of implementation**

KM 19 (2 Credits) Prescription Claims Data: Systematically obtains prescription claims data in order to assess and address medication adherence.

GUIDANCE	EVIDENCE
The practice systematically obtains prescription claims data or other medication transaction history. This may include systems such as SureScripts e-prescribing network, regional health information exchanges, insurers or prescription benefit management companies. The practice uses prescription claims data to determine whether a patient is adhering to the medication treatment plan.	• **Evidence of implementation**

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Knowing and Managing Your Patients (KM)

Competency E: The practice incorporates evidence- based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients.

KM 20 (Core) Clinical Decision Support: Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria):

A. Mental health condition.

B. Substance use disorder.

C. A chronic medical condition.

D. An acute condition.

E. A condition related to unhealthy behaviors.

F. Well child or adult care.

G. Overuse/appropriateness issues.

GUIDANCE	EVIDENCE
The practice utilizes systems in its day-to-day operations that integrate evidence-based guidelines (frequently referred to as clinical decision support [CDS]). **CDS** is a systematic method of prompting clinicians to consider evidence-based guidelines at the point of care. CDS encompasses a variety of tools, including, but not limited to: • Computerized alerts and reminders for providers and patients. • Condition-specific order sets. • Focused patient data reports and summaries. • Documentation templates. • Diagnostic support. • Contextually relevant reference information. Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS. **A. Mental health** • The practice uses evidence-based guidelines to support clinical decisions related to at least one mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's) in the care of patients. **B. Substance use disorder treatment** • The practice uses evidence-based guidelines to support clinical decisions related to at least one substance misuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism) in the care of patients.	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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KM 20 (Core) Clinical Decision Support: *continued*	
GUIDANCE	**EVIDENCE**
C. A chronic medical condition • The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic medical condition (e.g., arthritis, asthma, cardiovascular disease, COPD, diabetes) in the care of patients. **D. An acute condition** • The practice uses evidence-based guidelines to support clinical decisions related to at least one acute medical condition (e.g., acute back pain, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis, urinary tract infection) in the care of patients. **E. A condition related to unhealthy behaviors** • The practice uses evidence-based guidelines to support clinical decisions related to at least one unhealthy behavior (e.g., obesity, smoking) in the care of patients. **F. Well child or adult care** • The practice uses evidence-based guidelines to support clinical decisions related to well-child or adult care (e.g., age appropriate screenings, immunizations) in the care of patients. **G. Overuse/appropriateness issues** • The practice uses evidence-based guidelines to support clinical decisions related to overuse or appropriateness of care issues (e.g., use of antibiotics, avoiding unnecessary testing, referrals to multiple specialists) in the care of patients. The American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support (http://www.choosingwisely.org).	• **Identifies conditions, source of guidelines** *AND* • **Evidence of implementation**

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Knowing and Managing Your Patients (KM)

Competency F: The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support.

KM 21 (Core) Community Resource Needs: Uses information on the population served by the practice to prioritize needed community resources.	
GUIDANCE	**EVIDENCE**
The practice identifies needed resources by assessing collected population information. Practice may assess social determinants, predominant conditions, emergency department usage and other health concerns to prioritize community resources (e.g. food banks, support groups) that support the patient population.	• **List of key patient needs and concerns**

KM 22 (1 Credit) Access to Educational Resources: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	
GUIDANCE	**EVIDENCE**
Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy. The practice provides three examples of how it implements these tools for its patients. • **Educational programs and resources** may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups). • **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings. The practice provides or shares available **health education classes,** which may include alternative approaches such as **peer-led discussion groups** or **shared medical appointments** (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and facilitate patients to interact with and learn from each other.	• **Evidence of implementation**

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KM Competency F

KM 23 (1 Credit) Oral Health Education: Provides oral health education resources to patients.	
GUIDANCE	**EVIDENCE**
The practice provides an example of how it provides patients with educational and other resources that pertain to oral health and hygiene. Oral disease is largely preventable with knowledge and attention to hygiene. Poor oral health can complicate the care for chronic conditions such as diabetes and heart disease.	• **Evidence of implementation**

KM 24 (1 Credit) Shared Decision-Making Aids: Adopts shared decision-making aids for preference-sensitive conditions.	
GUIDANCE	**EVIDENCE**
The care team has, and demonstrates use of, at least three shared decision-making aids that provide detailed information without advising patients to choose one option over another. The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Engaging patients in understanding their health condition and in shared decision making helps build a trusting relationship. More information and resources can be found through the International Patient Decision Aid Standards Collaboration (IPDASC).	• **Evidence of implementation**

KM 25 (1 Credit) School/Intervention Agency Engagement: Engages with schools or intervention agencies in the community.	
GUIDANCE	**EVIDENCE**
The practice develops supportive partnerships with social services organizations or schools in the community. The practice demonstrates this through formal or informal agreements or identifies practice activities in which community entities are engaged to support better health.	• **Documented Process** *AND* • **Evidence of implementation**

Knowing and Managing Your Patients (KM)

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KM 26 (1 Credit) Community Resource List: Routinely maintains a current community resource list based on the needs identified in KM 21.

GUIDANCE	EVIDENCE
The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population. The list includes services offered outside the practice and its affiliates. Include a date to demonstrate that the list is regularly updated or otherwise demonstrate how the list is maintained. Maintaining a current resource list that prioritizes the central needs and concerns of the population can help a practice guide patients to community resources that support their health and well-being from that additional support.	• **List of resources**

KM 27 (1 Credit) Community Resource Assessment: Assesses the usefulness of identified community support resources.

GUIDANCE	EVIDENCE
The practice assesses the usefulness of resources by requesting and reviewing feedback from patients/families/caregivers about community referrals. Community referrals differ from clinical referrals, but may be tracked using the same system. When a practice's patients have unmet social needs, the practice can refer patients to useful community support resources. Meeting the patient's social needs, supports their self-management and reduces barriers to care.	• **Evidence of implementation**

KM 28 (2 Credits) Case Conferences: Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).

GUIDANCE	EVIDENCE
The practice uses "case conferences" to share information and discuss care plans for high-risk patients with clinicians and others outside its usual care team. **Case conferences** are planned, multidisciplinary meetings with community organizations or specialists to plan treatment for complex patients.	• **Documented process** *AND* • **Evidence of implementation**

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Patient-Centered Access and Continuity (AC)

The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

Competency A: The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs.

AC 01 (Core) Access Needs and Preferences: Assesses the access needs and preferences of the patient population.

GUIDANCE	EVIDENCE
The practice evaluates patient access from collected data (i.e., survey, patient interviews, comment box) to determine if existing access methods are sufficient for its population. Alternative methods for access may include evening/weekend hours, types of appointments or telephone advice.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

AC 02 (Core) Same-Day Appointments: Provides same-day appointments for routine and urgent care to meet identified patient needs.

GUIDANCE	EVIDENCE
The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine and for urgent care needs. The time frames allocated for these appointment types are determined by the practice and based on the needs of the patient population, as defined in AC 01. The evidence may include a 5-day schedule to demonstrate that appointments are available or a report demonstrating which same-day appointments were used. The evidence may be significant patient-reported satisfaction with access, based on AC 01 data.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

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AC 03 (Core) Appointments Outside Business Hours: Provides routine and urgent appointments outside regular business hours to meet identified patient needs.	
GUIDANCE	**EVIDENCE**
The practice recognizes that patients' care needs are not confined to normal operating hours, and therefore offers routine and urgent care appointments outside typical business hours. For example, a practice may open for appointments at 7 a.m. or remain open until 8 p.m. on certain days or open on alternating Saturdays. A documented process is not required if extended hours are provided at the practice site. A practice that cannot provide care outside regular business hours (e.g., a small practice with limited staffing) may arrange for patients to schedule appointments with other facilities or clinicians. The practice may use an urgent care center in the same health system for urgent and routine appointments outside regular business hours, or an urgent care center in the community that has access to patient records. Providing extended access does not include: • Offering appointments when the practice would otherwise be closed for lunch. • Offering daytime appointments when the practice would otherwise close early (e.g., a Friday afternoon or holiday). • Utilizing an ER or urgent care facility that is unaffiliated with the practice.	• **Documented process** *AND* • **Evidence of implementation**

 = Evidence sharable across practice sites

AC 04 (Core) Timely Clinical Advice by Telephone: Provides timely clinical advice by telephone.	
GUIDANCE	**EVIDENCE**
Patients can telephone the practice any time of the day or night and receive interactive (i.e., from a person, rather than a recorded message) clinical advice. **Clinical advice** refers to a response to an inquiry regarding symptoms, health status or an acute/chronic condition. Providing advice outside of appointments helps reduce unnecessary emergency room and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff, but may be communicated by any member of the care team, as permitted under state licensing laws. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7- days of such calls.	• **Documented process** *AND* • **Report**

AC 05 (Core) Clinical Advice Documentation: Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.	
GUIDANCE	**EVIDENCE**
The practice documents all clinical advice in the patient record, whether it is provided by phone or by secure electronic message during office hours and when the office is closed. If a practice uses a system of documentation outside the medical record for after-hours clinical advice, or provides for after-hours care without access to the patient's record, it reconciles this information with the medical record on the next business day. The evidence includes two examples of documenting the clinical advice (1 during office hours and 1 after normal business hours as defined in AC 03). The reconciliation evaluates if clinical advice or care provided after-hours conflicts with advice and care needs previously documented in the medical record and addresses any identified conflicts.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

= Evidence sharable across practice sites

AC Competency A

AC 06 (1 Credit) Alternative Appointments: Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.

GUIDANCE	EVIDENCE
The practice uses a mode of real-time communication (e.g., a combination of telephone, video chat, secure instant messaging) in place of a traditional in-person office visit with a clinician or care manager. The practice provides a report of the number and types of visits in a specified time period. Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, website) during office hours do not meet the requirement. An appointment with an alternative type of clinician (e.g., diabetic counselor) does not meet the requirement.	• **Documented process** *AND* • **Report** *Documented process only*

AC 07 (1 Credit) Electronic Patient Requests: Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.

GUIDANCE	EVIDENCE
Patients can use a secure electronic system (e.g., website, patient portal, email) to request appointments, prescription refills, referrals and test results. The practice must demonstrate at least two functionalities or provide patients with guidelines for at least two types of these requests that can be made electronically. Electronic patient requests provide another means to provide access for services meeting patient needs and preferences.	• **Evidence of implementation**

AC 08 (1 Credit) Two-Way Electronic Communication: Has a secure electronic system for two-way communication to provide timely clinical advice.

GUIDANCE	EVIDENCE
The practice has a secure, interactive electronic system (e.g., website, patient portal, secure email system) that allows two-way communication between the practice and patients/families/caregivers, as applicable for the patient. The practice can send and receive messages to and from patients. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7- days of such activity. The report may be system generated. The practice defines the time frame for a response and monitors the timeliness of responses against the practice's time frame.	• **Documented process** *AND* • **Report**

= Evidence sharable across practice sites

AC 09 (1 Credit) Equity of Access: Uses information about the population served by the practice to assess equity of access that considers health disparities.	
GUIDANCE	**EVIDENCE**
Knowing whether groups of patients experience differences in access to health care can help practices focus efforts to address the inequity. The practice evaluates whether identified health disparities demonstrate differences in access to care. An example of how a practice may demonstrate this is through a report of how an identified group of patients has lower rates of access to same day appointments, higher no show rates, greater ER use, or lower satisfaction with access than the general patient population. Healthy People 2020 defines **health disparity** as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."	• **Evidence of implementation**

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Competency B: Practices support continuity through empanelment and systematic access to the patient's medical record.

AC 10 (Core) Personal Clinician Selection: Helps patients/families/ caregivers select or change a personal clinician.	
GUIDANCE	**EVIDENCE**
Giving patients/families/caregivers a choice of practitioner emphasizes the importance of the ongoing patient-clinician relationship. The practice documents patients' choice of clinician, gives patients/families/caregivers information about the importance of having a personal clinician and care team responsible for coordinating care, and assists in the selection process. The practice may document a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a **practice team.** Single clinician sites automatically meet this criterion.	• **Documented process**

AC 11 (Core) Patient Visits with Clinician/Team: Sets goals and monitors the percentage of patient visits with the selected clinician or team.	
GUIDANCE	**EVIDENCE**
The practice establishes a goal for the proportion of visits a patient should have with the primary care provider and care team. The goal should acknowledge that meeting patient preferences for timely appointments will sometimes be at odds with the ability to see their selected clinician. **Empanelment** is assigning individual patients to individual primary care providers and care teams, with sensitivity to patient and family preferences. It is the basis for population health management and the key to continuity of care: Patients can build a better relationship with a clinician or team they see regularly.	• **Report**

AC 12 (2 Credits) Continuity of Medical Record Information: Provides continuity of medical record information for care and advice when the office is closed.	
GUIDANCE	**EVIDENCE**
The practice makes patient clinical information available to on-call staff, external facilities and clinicians outside the practice, as appropriate, when the office is closed. Access to medical records may include direct access to a paper or electronic record or arranging a telephone consultation with a clinician who has access to the medical record.	• **Documented process**

= Evidence sharable across practice sites

AC 13 (1 Credit) Panel Size Review and Management: Reviews and actively manages panel sizes.	
GUIDANCE	**EVIDENCE**
The practice has a process to review the number of patients assigned to each clinician and balance the size of each providers' patient panel. Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and provider workload because supply is balanced with patient demand. The American College of Family Physicians provides a tool for practices to use when considering and managing panel sizes: http://www.aafp.org/fpm/2007/0400/p44.pdf	• **Documented process** *AND* • **Report** *Documented process only*

AC 14 (1 Credit) External Panel Review and Reconciliation: Reviews and reconciles panels based on health plan or other outside patient assignments.	
GUIDANCE	**EVIDENCE**
The practice receives reports from outside entities such as health plans, ACOs and Medicaid agencies on the patients that are attributed to each clinician. The practice has a process to review the reports and a process to inform those entities of the patients known or not known to be under the care of each clinician. Reconciling panels with health plans and other entities improves accountability, continuity and access.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

= Evidence sharable across practice sites

Care Management and Support (CM)

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

Competency A: The practice systematically identifies patients who may benefit from care management.

CM 01 (Core) Identifying Patients for Care Management: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):

A. Behavioral health conditions.

B. High cost/high utilization.

C. Poorly controlled or complex conditions.

D. Social determinants of health.

E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/ family/caregiver.

GUIDANCE	EVIDENCE
The practice defines a protocol to identify patients who may benefit from care management. Specific guidance includes the categories or conditions listed in A–E. Examples include, but are not limited to:	• **Protocol for identifying patients for care management** *OR* • **CM 03**
A. Diagnosis of a serious mental illness, psychiatric hospitalizations, substance use treatment.	
B. Patients who experience multiple ER visits, hospital readmissions, high total cost of care, unusually high numbers of imaging or lab tests ordered, unusually high number of prescriptions, high-cost medications and number of secondary specialist referrals.	
C. Patients with poorly controlled or complex conditions such as, continued abnormally high A1C or blood pressure results, consistent failure to meet treatment goals, multiple comorbid conditions.	
D. Availability of resources such as food and transportation to meet daily needs; access to educational, economic and job opportunities; public safety; social support; social norms and attitudes; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020).	
E. Direct identification of patients who might need care management such as, referrals made from health plans, practice staff, patient, family members, or caregivers.	

= Evidence sharable across practice sites

CM Competency A

CM 02 (Core) Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.	
GUIDANCE	**EVIDENCE**
The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services. The practice uses the criteria defined in CM 01 to identify patients who fit defined criteria. The practice must identify at least 30 patients in the numerator. Patients who fit multiple criteria count once in the numerator. Small practices or satellite sites may share a care management population if less than 30 patients meet the criteria defined in CM 01.	• **Report**

CM 03 (2 Credits) Comprehensive Risk-Stratification Process: Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. Practice identifies and directs resources appropriately based on need.	• **Report**

The sidebar says "Care Management and Support (CM)"

Care Management and Support (CM)

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Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/ caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.

CM 04 (Core) Person-Centered Care Plans: Establishes a person-centered care plan for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice has a process to consistently develop patient care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/life style, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/ prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A **relevant visit** addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

CM 05 (Core) Written Care Plans: Provides a written care plan to the patient/family/caregiver for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice provides the patient's written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient's health literacy and language preference. (i.e., the patient version may use different words or formats from the version used by the practice team).	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

= Evidence sharable across practice sites

Care Management and Support (CM)

CM 06 (1 Credit) Patient Preferences and Goals: Documents patient preference and functional/lifestyle goals in individual care plans.	
GUIDANCE	**EVIDENCE**
The practice works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan. Including patient preferences and goals encourages a collaborative partnership between patient/family/caregiver and provider, and ensures that patients are active participants in their care. **Functional/lifestyle goals** can be individually meaningful activities that a person wants to be able to perform but may be at risk due to a health condition or treatment plan. Identifying patient-centered functional/lifestyle goals is important because people are likely to make the greatest gains when goals focus on activities that are meaningful to them and can make a positive difference in their lives.	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

CM 07 (1 Credit) Patient Barriers to Goals: Identifies and discusses potential barriers to meeting goals in individual care plans.	
GUIDANCE	**EVIDENCE**
Addressing barriers supports successful completion of the goals stated in the care plan. Barriers may include physical, emotional or social barriers. The practice works with patients/families/caregivers, other providers and community resources to address potential barriers to achieving treatment and functional/ lifestyle goals.	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

Care Management and Support (CM)

= Evidence sharable across practice sites

CM 08 (1 Credit) Self-Management Plans: Includes a self-management plan in individual care plans.	
GUIDANCE	**EVIDENCE**
The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition. The plan may include best practices or supports for managing issues related to a complex condition identified in the care plan. Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers toward meeting care plan goals.	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

CM 09 (1 Credit) Care Plan Integration: Care plan is integrated and accessible across settings of care.	
GUIDANCE	**EVIDENCE**
Sharing the care plan supports its implementation across all settings that address the patient's care needs. The practice makes the care plan accessible across external care settings. It may be integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement.	• **Documented process** *AND* • **Evidence of implementation**

Care Management and Support (CM)

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Care Coordination and Care Transitions (CC)

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

Competency A: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.

CC 01 (Core) Lab and Imaging Test Management: The practice systematically manages lab and imaging tests by:

A. Tracking lab tests until results are available, flagging and following up on overdue results.

B. Tracking imaging tests until results are available, flagging and following up on overdue results.

C. Flagging abnormal lab results, bringing them to the attention of the clinician.

D. Flagging abnormal imaging results, bringing them to the attention of the clinician.

E. Notifying patients/families/caregivers of normal lab and imaging test results.

F. Notifying patients/families/caregivers of abnormal lab and imaging test results.

GUIDANCE	EVIDENCE
Ineffective management of laboratory and imaging test results can result in less than optimal care, excess costs and may compromise patient safety. Systematic monitoring helps ensure that needed tests are performed and that results are acted on, when necessary. This is demonstrated by showing how the process is met across patients for each part of the criterion (a report, log, examples or electronic tracking system.) **A, B.** The practice tracks lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center (and the patient, if necessary) to determine why results are overdue, and documents follow-up efforts until reports are received. **C, D.** Abnormal results of lab or imaging tests are flagged and brought to the attention of the clinician, to ensure timely follow-up with the patient/family/caregiver. **E, F.** The practice provides timely notification to patients about test results (normal and abnormal). Filing the results in the medical record for discussion during a scheduled office visit does not meet the requirement. If frequent lab tests are ordered for a patient, the practice provides the patient/family/caregiver (as appropriate) with all initial results, clear expectations for follow-up results and a plan for handling abnormal findings.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

CC 02 (1 Credit) Newborn Screenings: Follows up with the inpatient facility about newborn hearing and blood-spot screening.	
GUIDANCE	**EVIDENCE**
The practice follows up with the hospital or state health department if it does not receive screening results. Most states mandate that birthing facilities perform a blood-spot test to screen for congenital conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. Early detection and treatment of congenital disorders can enhance health outcomes for newborns with positive (abnormal) screening results. Practices that do not see newborn patients are not eligible for this elective criterion.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

CC 03 (2 Credits) Appropriate Use for Labs and Imaging: Uses clinical protocols to determine when imaging and lab tests are necessary.	
GUIDANCE	**EVIDENCE**
Redundant or inappropriate use of imaging or lab tests leads to unnecessary costs and risks and does not enhance patient outcomes. The practice has established clinical protocols, based on evidence-based guidelines, to determine when imaging and lab tests are necessary. The practice may implement clinical decision supports to ensure that protocols are used (e.g., embedded in order entry system).	• **Evidence of implementation**

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CC Competency B

Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.

CC 04 (Core) Referral Management: The practice systematically manages referrals by:
A. Giving the consultant or specialist the clinical question, the required timing and the type of referral.
B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

GUIDANCE	EVIDENCE
It is important that the practice track patient referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services, as well as frustration for providers.	• **Documented process** *AND* • **Evidence of implementation**
Referrals tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist, for a patient with depression; referral to a pediatric cardiologist, for an infant with a ventricular septal defect).	
A. The referring clinician provides a reason for the referral, which may be stated as the **clinical question** to be answered by the specialist. The referring clinician indicates the type of referral, which may be a consultation or single visit; a request for shared- or co-management of the patient for an indefinite or a limited time, such as for treatment of a specific condition; or a request for temporary or long-term principal care (a transfer). The referring clinician clarifies the urgency of the referral and specifies the reasons for an urgent visit.	

B. Referrals include relevant clinical information, such as:
 	
  • Current medications.
  • Diagnoses including mental health, allergies, medical and family history, substance abuse and behaviors affecting health.
	Documented process only

= Evidence sharable across practice sites

CC 04 (Core) Referral Management: *continued*	
GUIDANCE	**EVIDENCE**
• Clinical findings and current treatment. • Follow-up communication or information. Including the referring primary care clinician's care and treatment plan in the referral, in addition to test results/procedures, can reduce conflicts and duplication of services, tests or treatment. If the practice sends the primary care plan with the referral, the specialist can develop a corresponding specialty plan of care. Ideally, the primary care plan, developed in collaboration with the patient/family/caregiver, is coordinated with the specialty plan of care, created in collaboration with the patient/family/caregiver and primary care. **C.** A tracking process includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist's office and documents its effort to retrieve the report in a log or an electronic system.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

CC 05 (2 Credits) Appropriate Referrals: Uses clinical protocols to determine when a referral to a specialist is necessary.	
GUIDANCE	**EVIDENCE**
The practice uses clinical protocols or decision support tools to determine if a patient needs to be seen by a specialist or if care can be addressed or managed by the primary care clinician. Unnecessary referrals can lead to overuse of tests and services, increase patient dissatisfaction and reduce accessibility to specialists when needed.	• **Evidence of implementation**

Care Coordination and Care Transitions (CC)

 = Evidence sharable across practice sites

CC 06 (1 Credit) Commonly Used Specialists Identification: Identifies the specialists/specialty types frequently used by the practice.

GUIDANCE	EVIDENCE
The practice monitors patient referrals to gain information about the referral specialists and specialty types it uses frequently. This information may help identify areas where the practice can adopt guidelines or protocols to manage patient care in the primary care practice, identify trends in the patient population, and can help identify opportunities for improved coordination and patient experience when specialty care is needed.	• **Evidence of implementation**

CC 07 (2 Credits) Performance Information for Specialist Referrals: Considers available performance information on consultants/specialists when making referrals.

GUIDANCE	EVIDENCE
It is important for the practice to make informed referrals to clinicians or practices that will provide timely, high-quality care. The practice consults available information about the performance of clinicians or practices to which it refers patients. The practice provides information or examples of the available performance data on the consultant/specialist with the practice team. Information gathered in CC 11 may be useful in this assessment of consultants/specialists.	• **Data source** *AND* • **Examples**

CC 08 (1 Credit) Specialist Referral Expectations: Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.

GUIDANCE	EVIDENCE
Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	• **Documented process** *OR* • **Agreement**

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CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.

GUIDANCE	EVIDENCE
Relationships between primary care practitioners and specialists support consistency of information shared across practices. The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content). A practice needs an agreement if it shares the same facility or campus as behavioral health professionals, but has separate systems (basic onsite collaboration). A practice may present existing internal processes as its agreement if there is partial integration of behavioral healthcare services. To receive credit for the criterion, the practice must show evidence across patients in a report, log or electronic tracking system. A notification demonstrating legal inability to receive a report that includes confirmation a behavioral health visit occurred meets the requirement.	• **Agreement** *OR* • **Documented process** *and* • *E***vidence of implementation** 🔺

CC 10 (2 Credits) Behavioral Health Integration: Integrates behavioral healthcare providers into the care delivery system of the practice site.

GUIDANCE	EVIDENCE
Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting. This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, have shared accountability and collaborative treatment and workflow strategies.	• **Documented process** *AND* • **Evidence of implementation** 🔺*Documented process only*

🔺 = Evidence sharable across practice sites

CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.

GUIDANCE	EVIDENCE
The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided appropriate information about the patient's diagnosis and treatment plan. The practice bases its definition of "timely" on patient need. On-going assessment and referral monitoring may be helpful in CC 07.	• **Documented process** *AND* • **Report** *Documented process only*

CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the patient's medical record.

GUIDANCE	EVIDENCE
When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co-management of the patient's care. Under the agreement, the primary care clinician and specialist share changes in the treatment plan and patient health status, in addition to entering information in the medical record within an agreed-on time frame. The practice must provide three examples of such arrangements to meet the criterion.	• **Evidence of implementation**

CC 13 (2 Credits) Treatment Options and Costs: Engages with patients regarding cost implications of treatment options.

GUIDANCE	EVIDENCE
Cost can play a major role in a patient's drug and treatment adherence; the practice understands this and talks to patients about treatment costs (e.g., adds a financial question to the clinical intake screening [do you have trouble affording the care or prescriptions prescribed? Y/N], directs patients to resources such as copay and prescription assistance programs; the clinician asks about prescription drug coverage, tells patients which services are critical and should not be skipped, recommends less expensive options, if appropriate).	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

= Evidence sharable across practice sites

Care Coordination and Care Transitions (CC)

Competency C: The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

CC 14 (Core) Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.	
GUIDANCE	**EVIDENCE**
The practice should develop a process for monitoring unplanned admissions and emergency department visits and states how often monitoring takes place. The practice works with local hospitals, EDs and health plans to identify patients with recent unplanned visits. The practice provides a report with the proportion of local admissions and ED visits (reported separately) to facilities where practices have an established notification exchange mechanism.	• **Documented process** *AND* • **Report** *Documented process only*

CC 15 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.	
GUIDANCE	**EVIDENCE**
The practice demonstrates timely sharing of information with admitting hospitals and emergency departments. Shared information supports continuity in patient care across settings. The practice provides three examples to meet the criterion.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

CC 16 (Core) Post-Hospital/ED visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	
GUIDANCE	**EVIDENCE**
The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice's policies define the appropriate contact period in addition to a log documenting systematic follow-up was completed. Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encouraging follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs.	• **Documented process** *AND* • **Evidence of follow-up** *Documented process only*

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CC 17 (1 Credit) Acute Care After Hours Coordination: Systematic ability to coordinate with acute care settings after office hours through access to current patient information.

GUIDANCE	EVIDENCE
The practice has a process to coordinate with acute care facilities when a patient is seen after the office is closed. Sharing patient information allows the facility to coordinate patient care based on current health needs and engage with practice staff. The practice provides at least one example of coordination with the facility.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

CC 18 (1 Credit) Information Exchange during Hospitalization: Exchanges patient information with the hospital during a patient's hospitalization.

GUIDANCE	EVIDENCE
The practice demonstrates that it can send and receive patient information during the patient's hospitalization. The practice provides at least three examples of the data exchange to meet the criterion. ***Note:*** *CC15 assesses the practice's ability to share information, but the focus of CC18 is two-way exchange of information.*	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

CC 19 (1 Credit) Patient Discharge Summaries: Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.

GUIDANCE	EVIDENCE
The practice has a process for actively attempting to receive patient discharge summaries. The process may include a local database or active outreach to ensure that the practice is notified when a patient is discharged from a hospital or other care facility. The practice provides the process for obtaining the summaries and at least three examples of obtaining the discharge summary or demonstrates participation in a local admission, discharge, transfer (ADT) system.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

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CC Competency C

<table>
<tr>
<td colspan="2">CC 20 (1 Credit) Care Plan Collaboration for Practice Transitions: Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).</td>
</tr>
<tr>
<td align="center">GUIDANCE</td>
<td align="center">EVIDENCE</td>
</tr>
<tr>
<td>The practice involves the patient/family/caregiver in the development or implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care. The written care plan may include:

A summary of medical information (e.g., history of hospitalizations, procedures, tests).
A list of providers, medical equipment and medications for patients with special health care needs.
Obstacles to transitioning to an adult care clinician.
Special care needs.
Information provided to the patient about the transition of care.
Arrangements for release and transfer of medical records to the adult care clinician.
Patient response to the transition.
Patient transition plan.

Internal medicine practices receiving patients from pediatricians are expected to request/review the transition plan provided by pediatric practices or develop a plan if one is not provided to support a smooth and safe transition.

For family medicine practices that do not transition patients from pediatric to adult care, should still educate patients and families about ways in which their care experience may change as the patient moves into adulthood. Sensitivity to privacy concerns should be incorporated into messaging.</td>
<td>• Evidence of implementation</td>
</tr>
</table>

= Evidence sharable across practice sites

CC Competency C

CC 21 (*Maximum* 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries (May select one or more):

A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit)

B. Immunization registries or immunization information systems. (1 Credit)

C. Summary of care record to another provider or care facility for care transitions. (1 Credit)

GUIDANCE	EVIDENCE
The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate this by: A. Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. B. Submitting electronic data to immunization registries to share immunization services provided to patients. C. Making the summary of care record accessible to another provider or care facility for care transitions. Practices may provide the required evidence for each of the criteria options for up to a total of 3 credits. Each option is part of CC 21 but is listed separately in Q-PASS for scoring purposes.	• **Evidence of implementation**

 = Evidence sharable across practice sites

Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

Competency A: The practice measures to understand current performance and to identify opportunities for improvement.

QI 01 (Core) Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type): A. Immunization measures. B. Other preventive care measures. C. Chronic or acute care clinical measures. D. Behavioral health measures.	
GUIDANCE	**EVIDENCE**
Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least: • One immunization measure. • One preventive care measure (not including immunizations). − A measure on oral health counts as a preventive clinical quality measure. • One chronic or acute care clinical measure. • One behavioral health measure. The data must include the measurement period, the number of patients represented by the data, the rate and the measure source (e.g. HEDIS, NQF #, measure guidance).	• **Report**
QI 02 (Core) Resource Stewardship Measures: Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type): A. Measures related to care coordination. B. Measures affecting health care costs.	
GUIDANCE	**EVIDENCE**
The practice reports at least two measures related to resource stewardship, including a measure related to health care cost and a measure related to care coordination. When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources.	• **Report**

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QI Competency A

QI 03 (Core) Appointment Availability Assessment: Assesses performance on availability of major appointment types to meet patient needs and preferences for access.	
GUIDANCE	**EVIDENCE**
Patients who cannot get a timely appointment with their primary care provider may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history. The practice consistently reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary (e.g., seasonal changes, shifts in patient needs, practice resources). A common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type.	• **Documented process** *AND* • **Report** *Documented process only*

QI 04 (Core) Patient Experience Feedback: Monitors patient experience through:
 	
A. **Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:**
 	
  • **Access.**
  • **Communication.**
  • **Coordination.**
  • **Whole-person care, self-management support and comprehensiveness.**
 	
B. **Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.**	

GUIDANCE	**EVIDENCE**

The practice gathers feedback from patients and provides summarized results to inform quality improvement activities. Patient feedback must represent the practice population (including all relevant subpopulations) and may not be limited to patients of one clinician (of several), or to data from one payer (of several).
 	
A. The practice (directly or through a survey vendor) conducts a patient survey to assess the patient/family/caregiver experience with the practice. The patient survey may be conducted as a written questionnaire (paper or electronic) or by telephone, and includes questions related to at least three of the following categories:
 	
  • Access (may include routine, urgent and after-hours care).
  • Communication with the practice, clinicians and staff (may include "feeling respected and listened to" and "able to get answers to questions").
	• **Report**

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QI 04 (Core) Patient Experience Feedback: *continued*	
GUIDANCE	**EVIDENCE**
• Coordination of care (may include being informed and up to date on referrals to specialists, changes in medications and lab or imaging results). • Whole-person care/self-management support (may include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, routine and urgent care, advice, assistance and support for changing health habits and making health care decisions). B. Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as "virtual" (e.g., telephone, videoconference) participation. Comments collected on surveys used to satisfy QI 04A do not meet this requirement.	• **Report**

QI 05 (1 Credit) Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): A. **Clinical quality.** B. **Patient experience.**	
GUIDANCE	**EVIDENCE**
The practice stratifies performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics (e.g., age, gender, language needs, education, income, type of insurance [Medicare, Medicaid, commercial], disability, health status). The intent of this criteria is for practices to work towards eliminating disparities in health and delivery of health care for their vulnerable patient populations. **Vulnerable populations** are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ).	• **Report** *OR* • **Quality Improvement Worksheet**

= Evidence sharable across practice sites

Performance Measurement and Quality Improvement (QI)

QI Competency A

QI 06 (1 Credit) Validated Patient Experience Survey Use: The practice uses a standardized, validated patient experience survey tool with benchmarking data available.	
GUIDANCE	**EVIDENCE**
The practice uses the standardized survey tool to collect patient experience data and inform its quality improvement activities. The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices. The practice may use standardized tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey, CAHPS-CG or another standardized survey administered through measurement initiatives providing benchmark analysis external to the practice organization. It may not be a proprietary instrument. The practice must administer the entire approved standardized survey (not sections of the survey) to receive credit.	• **Report**
QI 07 (2 Credits) Vulnerable Patient Feedback: The practice obtains feedback on experiences of vulnerable patient groups.	
GUIDANCE	**EVIDENCE**
The practice should identify a vulnerable group in their patient population where there is evidence of disparities of care or service. The practice then obtains patient feedback from representatives of that group to support quality improvement initiatives at the practice.	• **Report**

= Evidence sharable across practice sites

Competency B: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

QI 08 (Core) Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories:	
A. Immunization measures.	
B. Other preventive care measures.	
C. Chronic or acute care clinical measures.	
D. Behavioral health measures.	

GUIDANCE	EVIDENCE
Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Measures selected for improvement are chosen from the set of measures identified in QI 01. The goal is for the practice to reach a desired level of achievement based on a self-identified standard of care. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ Improvement Methods/HowToImprove/).	• **Report** *OR* • **Quality Improvement Worksheet**

Performance Measurement and Quality Improvement (QI)

= Evidence sharable across practice sites

QI Competency B

QI 09 (Core) Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship:

A. Measures related to care coordination.

B. Measures affecting health care costs.

GUIDANCE	EVIDENCE
The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. Measures selected for improvement may be chosen from the same set of measures identified in QI 02. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ ImprovementMethods/HowToImprove/).	• **Report** *OR* • **Quality Improvement Worksheet**

QI 10 (Core) Goals and Actions to Improve Appointment Availability: Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.

GUIDANCE	EVIDENCE
Knowing that a variety of factors (e.g., season, patient need, practice resource) can affect appointment availability, the practice can adjust to meet patient preferences and needs. After assessing performance on the availability of common appointment types (QI 03), the practice sets goals and acts to improve on availability. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.	• **Report** *OR* • **Quality Improvement Worksheet**

Table of Contents   = Evidence sharable across practice sites

QI Competency B

QI 11 (Core) Goals and Actions to Improve Patient Experience: Sets goals and acts to improve performance on at least one patient experience measure.	
GUIDANCE	**EVIDENCE**
After assessing performance on at least one patient experience measure (QI 04), the practice demonstrates that it set a goal for improving patients' experience of care and is working to meet the stated goal. The practice acts to reach a desired level of achievement based on its self-identified standard of care.	• **Report** *OR* • **Quality Improvement Worksheet**

QI 12 (2 Credits) Improved Performance: Achieves improved performance on at least two performance measures.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it has improved performance on at least two measures. Demonstration of improvement is determined by the goals set in QI 08, QI 09 or QI 11.	• **Report** *OR* • **Quality Improvement Worksheet**

QI 13 (1 Credit) Goals and Actions to Improve Disparities in Care/Service: Sets goals and acts to improve disparities in care or services on at least one measure.	
GUIDANCE	**EVIDENCE**
The practice identifies health disparities in care or services among vulnerable populations. The practice sets goals and acts to improve performance. After assessing performance on the disparities in care (QI 05), the practice sets goals and acts to improve on care or service.	• **Report** *OR* • **Quality Improvement Worksheet**

QI 14 (2 Credits) Improved Performance for Disparities in Care/Service: Achieves improved performance on at least one measure of disparities in care or service.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it has improved performance on at least one measure related to disparities in care or service. Demonstration of improvement is determined by the goals set in QI 13.	• **Report** *OR* • **Quality Improvement Worksheet**

Table of Contents   = Evidence sharable across practice sites

QI Competency C

Competency C: The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section.

QI 15 (Core) Reporting Performance within the Practice: Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.	
GUIDANCE	**EVIDENCE**
The practice provides individual clinician or practice level reports to clinicians and practice staff. Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

QI 16 (1 Credit) Reporting Performance Publicly or with Patients: Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.	
GUIDANCE	**EVIDENCE**
The practice shares individual clinician or practice level reports with patients and the public. Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan.	• **Documented process** *AND* • **Evidence of implementation** *Documented process only*

QI 17 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves patient/family/caregiver in quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice has a process for involving patients and their families in its quality improvement efforts or on the practice's patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	• **Documented process** *AND* • **Evidence of implementation**

= Evidence sharable across practice sites

QI Competency C

QI 18 (2 Credits) Reporting Performance Measures to Medicare/Medicaid: Reports clinical quality measures to Medicare or Medicaid agency.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it reports a minimum number of clinical quality measures to Medicare or to a state Medicaid agency: • At least one immunization measure. • One preventive care measure (not including immunizations). • One chronic or acute care clinical measure. • One behavioral health measure.	• **Evidence of submission**

QI 19 (*Maximum* 2 Credits) Value-Based Contract Agreements: Is engaged in Value-Based Agreement. **A. Practice engages in upside risk contract (1 Credit).** **B. Practice engages in two-sided risk contract (2 Credits).**	
GUIDANCE	**EVIDENCE**
The practice demonstrates it participates in a value-based program by providing information about their participation or a copy of agreement. Involvement in value-based contracts represent a shift from fee-for-service billing to compensating practices and providers for administering quality care for patients. Participation in these programs signals that a practice is willing to be accountable for the value of care provided rather than volume **Upside Risk Contract:** A value-based program where the clinician/practice receives an incentive for meeting performance expectations but do not share losses if costs exceed targets. **Two-Sided Risk Contract:** A value-based program where the clinician/practice incur penalties for not meeting performance expectations but receive incentives when the care requirements of the agreement are met. Expectations relate to quality and cost.	• **Agreement** *OR* • **Evidence of implementation**

  = Evidence sharable across practice sites

Appendix 1

PCMH Scoring

APPENDIX 1

PCMH SCORING

Scoring Summary

To achieve recognition under PCMH, practices must: 1) meet all core criteria in the program and 2) earn 25 credits in elective criteria across 5 of 6 concepts.

40 core critera, 60 elective criteria with 83 elective credits available

Concept	Core Criteria	Elective Credits Available
Team-Based Care and Practice Organization (TC)	5 core	7 credits
Competency A	2 core	5 credits
Competency B	2 core	2 credits
Competency C	1 core	No elective credits
Knowing and Managing Your Patients (KM)	10 core	22 credits
Competency A	3 core	6 credits
Competency B	2 core	1 credit
Competency C	1 core	2 credits
Competency D	2 core	5 credits
Competency E	1 core	No elective credits
Competency F	1 core	8 credits
Patient-Centered Access and Continuity (AC)	7 core	8 credits
Competency A	5 core	4 credits
Competency B	2 core	4 credits
Care Management and Support (CM)	4 core	6 credits
Competency A	2 core	2 credits
Competency B	2 core	4 credits
Care Coordination and Care Transitions (CC)	5 core	24 credits
Competency A	1 core	3 credits
Competency B	1 core	14 credits
Competency C	3 core	7 credits
Performance Measurement and Quality Improvement (QI)	9 core	16 credits
Competency A	4 core	4 credits
Competency B	4 core	5 credits
Competency C	1 core	7 credits

Appendix 2

Glossary

APPENDIX 2
GLOSSARY

advance directive
A document in which members can explain the type and extent of health care services they prefer if they become unable to make medical decisions. The document may identify another person who can make those decisions on behalf of the individual (e.g., about routine treatments and life-saving methods). Advance directives are frequently called "living wills."

adverse reaction
A noxious or unintended reaction to a drug that is administered in standard doses by the proper route for the purpose of prophylaxis, diagnosis or treatment.

allergy
An adverse reaction to a substance.

alternative type of clinical encounter
A scheduled meeting between the patient and a clinician, using a mode of real-time communication in lieu of an in-person office visit; for example, standalone communication or a combination of telephone, video chat and secure instant messaging.

appointment wait times
The period between the date/time a patient makes an initial request for an appointment and the actual appointment date/time) for both urgent and routine care.

Note: "Cycle times" (i.e., time from scheduled appointment to the patient actually being seen by the clinician) are not considered appointment wait times in these standards.

care coordination measure
A metric that uses an aspect of clinical performance or patient experience to identify "better" performance or "worse" performance, with respect to "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."

eCQM
Electronic Clinical Quality Measure. The electronic specifications of a Clincal Quality Measure that help measure and track the quality of health care services.These measues use electronic health records or other health information technology systems to report health care performance.

clinical summary
A summary of a visit that can be provided to patients/families/caregivers through a personal health record, a patient portal on the practice's Web site, secure e-mail, electronic media (e.g., a CD or USB fob [electronic memory stick/flash drive]) or a printed copy.

The summary, as defined by CMS, contains:
1. The patient's name.
2. The provider's name and office contact information.
3. The date and location of the office visit.
4. The reason for the office visit.
5. A list of current problems.
6. A list of current medications.
7. A list of current medications the patient is allergic to.
8. Procedures performed during the visit.
9. Immunizations or medications administered during the visit.

10. Vital signs taken during the visit (or other recent vital signs).
11. Laboratory test results.
12. A list of diagnostic tests pending.
13. Clinical instructions.
14. Future appointments.
15. Referrals to other providers.
16. Future scheduled tests.
17. **Demographic information** maintained in certified electronic health record technology (CEHRT) (sex, race, ethnicity, date of birth, preferred language).
18. Smoking status.
19. Care plan fields, including goals and instructions.
20. Recommended patient decision aids (if applicable to the visit).

care plan	A plan for day-to-day medical care and services. The plan can include:
	• A summary of medical information (e.g., history of hospitalizations, procedures, tests).
	• A list of providers, medical equipment and medications for patients with special health care needs.
	• Obstacles to transitioning to an adult care clinician.
	Arrangements for release and transfer of medical records to the adult care clinician.
certified EHR	An electronic health record that demonstrates compliance with the capability, functionality, and security specifications required by the Office of the National Coordinator for Health Information Technology (ONC).
	• Information on obtaining an ONC Certification ID at https://chpl.healthit.gov/#/overview
	• A list of Certified Health IT Products at https://chpl.healthit.gov/#/resources
	• Information on security risk assessment guidance by HealthIT.gov at https://www.healthit.gov/providers-professionals/security-risk-assessment
concept	An overaching foundation on which a practice builds a medical home.
competency	A brief description of criteria subgroup, organized within the broader concept. This level is used for organization of the criteria into more meaningful groupings.
core criterion	A criterion identified as central to the concept being addressed and must be met in order to earn PCMH recognition.
criterion	A brief statement highlighting PCMH requirements.
de-identify	Removal of individual identifiers. Under the HIPAA Privacy Rule, protected health information is de-identified if all individual identifiers are removed. There are 18 categories of identifiers that include name; street address and zip code; telephone and fax number; dates (except year) directly related to a person, including date of birth and dates of service; e-mail address and Web URL; Social Security Number; medical record number and account number; vehicle identifiers, including license plate number; device identifiers and serial number; and any other unique identifying number, characteristic or code.

demographic information	Information that includes at least ethnicity, gender, marital status, date of birth, type of work, hours of work and preferred language.
diversity	A meaningful characteristic of comparison for managing population health that accurately identifies individuals within a non-dominant social system who are underserved. These characteristics of a group may include, but are not limited to, race, ethnicity, gender identity, sexual orientation, disability (both physical and mental) and religious affiliation. ***Note:** There are many resources available on diversity in healthcare, learn more: http://www.ivygroupllc.com/executive-leader/dimensions-of-diversity/* *https://my.clevelandclinic.org/ccf/media/Files/Diversity/diversity-toolkit.pdf?la=en*
documented process	Written statements describing procedures. Statements may include protocols or other documents that describe actual processes or blank forms the practice uses in work flow (e.g., referral forms, checklists, flow sheets). Documented processes include an effective date.
elective criterion	A criterion that demonstrates capabilities and functions above and beyond that of a typical practice. Practices can choose among the items to tailor their activities to the community and population served. 1 or 2 credits can be earned for each elective, with the goal of achieving at least total 25 credits.
electronic clinical summary	A summary of a visit that includes, when appropriate, diagnoses, medications, recommended treatment and follow-up.
emergency admission	An unscheduled medical or behavioral healthcare event that results in either an emergency room visit or in hospital admission.
evidence based guidelines	Clinical practice guidelines based on scientific evidence; or in the absence of scientific evidence, professional standards; or in the absence of professional standards, expert opinion. See practice guidelines.
evidence of implementation	A document, report, prepared material or virtual demonstration that illustrates implementation of systems or processes by the practice.
legal guardian or health care proxy	An individual designated by the patient or family or by the courts to make health care decisions for the patient if the patient is unable to do so.
materials	Prepared information that the practice provides to patients, including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets.
multi-site group	Three or more practice sites using the same systems and processes, including an electronic medical record system shared across all practice sites. For a multi-site group, NCQA reviews some criterion once and applies the results to all practice sites in the group.
NCQA Representative	An NCQA employee who guides a practice through recognition and is the point of contact throughout the process, and after. Representatives also coordinate the annual check in.
no show appointments	A scheduled appointment that is not kept, unexpectedly and without notification.

no show rates	A specific ratio that compares the number of appointments scheduled versus no-show appointments.
	Number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e., a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during the same period of time
PHI	Protected health information. PHI is associated with an individual's past, present or future physical or mental health or condition, or with the provision of or payment for health care to a person, and identifies the individual. Under the HIPAA Privacy Rule, there are 18 categories of identifiers (e.g., name, street address, email address, telephone number, social security number, medical record number, health plan beneficiary or account number, birth date, dates of service and five-digit zip code). Age is not PHI, except for individuals older than 89 years; HIPAA allows the age for these individuals to be aggregated into a single category of "age 90 or above."
population management	Assessing and managing the health needs of a patient population rather than individual patients, such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations).
practice guidelines	Systematically developed descriptive tools or standardized protocols for care to support clinician and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.
practice team	A group of clinical and nonclinical staff (e.g., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) who manage patient care and population health by interacting with patients and working to achieve stated objectives.
primary caregiver	An individual who provides day-to-day care for a patient and must receive instructions about the patient's care.
records or files	Patient medical files or registry entries that document an action taken. The files are a source for estimating performance on a criterion.
registry	A searchable list of patient data that the practice proactively uses to assist in patient care.
reports	Aggregated data showing evidence of action; may include manual and computerized reports.
risk factors	Behaviors, habits, age, family history or other factors that may increase the likelihood of poor health outcomes.
sample	A statistically valid representation of the whole.

shared decision-making aid	Provides detailed information without advising the audience to choose one decision over another and helps prepare patients to make informed, values-based decisions with their care team.
	Note: *More information and resources can be found through the International Patient Decision Aid Standards Collaboration (IPDASC).*
social determinants of health	Conditions in the environment that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples of social determinants include: • Availability of resources to meet daily needs (e.g., safe housing and local food markets). • Access to educational, economic, and job opportunities. • Access to health care services. • Quality of education and job training. • Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities. • Transportation options. • Public safety. • Social support. • Social norms and attitudes (e.g., discrimination, racism, and distrust of government). • Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community). • Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it). • Residential segregation. • Language/literacy. • Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media). • Culture. More information on social determinants of health can be found on the Healthy People 2020 Web site at www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39.
social functioning	A person's ability to engage in social interactions, interpersonal relationships, and indepent living daily activities. One way this can be assessed is through social functioning questionaires or assessments. *Example of one questionnaire that can be used to assess social functioning:* http://studylib.net/doc/7105191/the-social-functioning-questionnaire-is
standardized tool	A means of collecting information, using a current, evidence-based approach, that has been developed, field-tested and endorsed by a national or regional organization.
virtual review	A live, online method of evaluation conducted via screen sharing technology.

vulnerable populations	People who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability" (AHRQ definition).
walk-in access	An approach to patient appointment scheduling that allows established patients to be seen by a member of the care team during regular office hours, without prior notice.
qualified behavioral health care manager	A trained person responsible for coordinating and supporting mental health care within the clinic and for coordinating referrals to clinically indicated services outside the clinic. It is encouraged but not required that the care manager has the training and meets the clinical licensure requirements to provide brief psychosocial interventions appropriate for primary care settings.

Typical licensures include:

- Licensed mental health counselor.
- Licensed marriage and family therapist.
- Licensed social worker.
- Registered nurse (BSN recommended).
- Nurse practitioner.
- Licensed psychologist.

For more information on behavioral health care managers:
https://aims.uw.edu/resource-library/care-manager-role-and-job-description

Appendix 3
Record Review Workbook Instructions

APPENDIX 3

NCQA'S PCMH RECORD REVIEW WORKBOOK
GENERAL INSTRUCTIONS

Purpose of the Record Review Workbook

There are several assessment areas in PCMH that require an accurate estimate of the percentage of patients for whom the practice has documented the required information in its medical records. The Record Review Workbook calculates the data entered and scores each criterion based on a sample of patient records. Of particular interest is the assessment and identification of patients would benefit from care management. The criteria included in this worksheet are PCMH CM 04-08. These criteria assess how the practice uses patient information and collaborates with patients/families/caregivers to develop care plans that address barriers and incorporates patient preferences and lifestyle goals documented in the patient chart.

Refer to each criterion in the PCMH 2017 Standards and Guidelines for details about scoring.

There are two methods for collecting data for these criteria

> **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 criteria, you can enter the reports directly in Q-PASS 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 criteria and must complete the Record Review Workbook and provide examples to meet the criteria. You may respond to some criteria with Method 1 and others with Method 2. If using a combination of Method 1 and 2, for criteria 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., CM 06).
  - When selecting the "Not Used" response, always select it in the first patient row in the sample (row 12). "Not Used" scores as "Not Met."

- **See Report** = Practice is submitting an electronic report for documentation for this criterion and is uploading it to the document library in Q-PASS and linking to this report in Q-PASS. "See Report" scores as a "no" in the workbook. Only select this option if providing alternate documentation outside the workbook to meet the criteria.

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

The Record Review Workbook 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.***

Instructions Overview

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 criteria you will document using this file. ***Remember:* PCMH CM 04 and CM 05 are Core criteria. Your practice must use one of the two methods in the Explanation to document performance for these criteria.**

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 Record Review Workbook for each applicable criterion.

5. Record the "Met" response for each criterion in Q-PASS for which the workbook is the evidence for CM 04-08.

6. Attach the Record Review Workbook to the criteria in Q-PASS for which you used the Record Review Workbook. Once you have attached the workbook for one criterion, such as PCMH CM 05, you may use the options in Q-PASS to link it to the other criteria assessed in the Record Review Workbook.

How to Fill Out the Record Review Workbook

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 Record Review Workbook to document information for Care Plan Management (CM 04-08).**

This assessment requires 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 Record Review Workbook for a particular criterion, 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 criterion. This will gray the column and indicate to NCQA that you are not going to use the worksheet for that criterion. "Not Used" and "See Report" are scored as "Not Met."

Note: See the NCQA PCMH Standards and Guidelines for documentation requirements for each criterion. For practices using the Record Review Workbook for CM 04-08, an example for each criterion is required. The example shows how the practice documents the content of a criterion for patients in their medical record and can be demonstrated during virtual review.

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

1. **Identifying Patients for Care Management (PCMH CM 01)**
The intent of the criterion is that the practice uses defined guidelines to identify true vulnerability—a single indicator, such as cost, may not be an appropriate indicator of need for care management.

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 KM 02) supports establishing criteria and a systematic process for identifying patients for care management.

The practice must include at least three options outlined in CM 01 for identification of patients for care management. A patient may fall into more than one option (A–E) and may be included in some or all of these counts. The practice uses these options 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 CM 01**. These will be the patients reviewed in your medical record review. You will review the same 30 patient files for all criteria using the Record Review Workbook. There must be a total of 30 patients. **The identified health indicators for the patients in the sample must match those identified in PCMH CM 01.**

3. **Patient Selection**
Using Visit Date: Choose patients meeting the health indicators from PCMH CM 01, 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 health indicator from PCMH CM 01 and who had a care visit related to any one or more of the selected health indicators. Continue to go back one day at a time until you have identified 30 patients for your sample.

Using Another Method of Random Selection: Any other method of random selection of patients must be preapproved 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 PCMH CM 04-08. The practice determines how often information is updated in KM 02 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.

Important: Keep this master list for the virtual check-in on these criteria, but do not send it to NCQA.

Step 4 **Review the patient records and enter responses in the Record Review Worksheet.**

1. Fill out patient data in the Record Review Worksheet

Yes: If the patient's medical record has documentation for the criterion choose "Yes" (from the drop-down list in each cell) for each criterion 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 criterion.

Not Used: Review the list of criteria and determine if there are any that your practice does not use. If your practice does not use a particular criterion, 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 gray.

See Report: Review the list of criteria 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 criterion, 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 gray.

PCMH CM 04-08—Care Planning and Self-Care Support

Review each patient medical record for documentation for each of the 5 criteria. 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 criteria. The practice will then indicate Met or Not Met in Q-PASS for each of the 5 criteria. If your practice does not use a particular criterion for any patients, choose (from the drop-down list) **Not Used** in row 12 (patient #1) to blank out (gray) the entire column. **Not Used** is tallied as a **Not Met** response for all patients. If your practice will generate an electronic report to demonstrate it meets a particular criterion, chose (from the drop-down list) **See Report** in row 12 (patient #1) to blank out (gray) the entire column.

NOTE: CM 04 and CM 05 are Core *and thus required to be consistently documented for patients identified for care management for the practice to receive recognition.*

Step 5 **Link the Record Review Workbook to the Criteria in Q-PASS.**

Link the Record Review Workbook to the first criterion chosen in step 2 for which you entered data, then link it to each of the other criteria for which you entered data:

1. Go to the first criterion in Q-PASS for which you have used the Record Review Worksheet.

2. Click the *Documents* button.

3. Select and click the Link Document option.

Appendix 4

PCMH Distinction in Behavioral Health Integration

Distinction Purpose and Background

Behavioral health conditions (mental illnesses and substance use disorders) suffer from under and delayed diagnosis and treatment. For too long, patients and their primary care providers have lacked the integrated behavioral health services and interventions that can create more seamless care, leading to better treatment of behavioral health, better treatment of other chronic medical conditions, leading to overall better health outcomes.[1]

Historically, behavioral health care has been delivered separately from primary care. Evidence shows that this can lead to poorer health outcomes and higher total spending on patients with behavioral health conditions.[2] Behavioral health conditions can often be identified earlier in a primary care setting, and there is growing consensus that behavioral health should be well integrated into primary care.

NCQA's Behavioral Health Integration Distinction recognizes primary care practices that put the right resources, evidence-based protocols, standardized tools and quality measures in place to support the broad needs of patients with behavioral health related conditions within the primary care setting. This enhances the level of care provided in a primary care practice and improves access, clinical outcomes and patient experience for patients with behavioral health conditions.

Distinction in Behavioral Health Integration is a way for practices to highlight where they excel beyond the PCMH standards. This module calls for a care team in primary care that can manage the broad needs of patients with behavioral health related conditions and it incorporates criteria deemed meaningful by other programs and care models (e.g., the PCMH PRIME Certification program with the Massachusetts Health Policy Commission, the New York State Delivery System Reform Incentive Payment [DSRIP] Program and the Collaborative Care Model).

Practice Eligibility

All qualifying new and existing NCQA PCMH Recognized practices are eligible to apply for Distinction in Behavioral Health Integration.

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[1] Gerrity, M. Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015. New York, NY: Milbank Memorial Fund; 2016. (Accessed July 27, 2017 https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI-Exec-Sum.pdf)

[2] Hostetter, M, Klein S. In Focus: Integrating Behavioral Health and Primary Care. New York, NY: The Commonwealth Fund; August 2014. (Accessed July 28, 2017 http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus)

Requirements

The Distinction in Behavioral Health Integration module includes 18 criteria across 4 competencies related to behavioral health. Module criteria are labeled "Core" and "Elective." Their distribution across competencies is outlined below in Table 1.

Of the 18 criteria in the module, 7 are also included in the PCMH Recognition standards. This overlap is specifically noted in the relevant BH criteria that follow. Practices that complete these criteria will receive credit for the aligned criteria in both PCMH Recognition and the Behavioral Health Integration Distinction Module.

Table 1: Behavioral Health Integration Distinction Criteria Count

Competency	Number of Core Criteria	Number of Elective Criteria
Behavioral Health Workforce. The practice incorporates behavioral health providers at the site, utilizes behavioral health providers outside the practice and trains the care team to address the mental health and substance use concerns of patients.	4	2
Integrated Information Sharing. The practice shares patient information within and outside the practice to support an integrated/coordinated patient treatment plan.	1	3
Evidence Based Care. The practice uses evidence-based protocols to identify and address the behavioral health needs of patients.	4	0
Measuring and Monitoring. The practice utilizes quality measures to monitor the care of patients with behavioral health needs.	2	2
Total	*11*	*7*

Scoring

Practices seeking this distinction must meet ***all core criteria*** and ***two elective credits.***

Behavioral Health Integration

The practice has resources to support the needs of patients with behavioral health related conditions within the primary care practice. It integrates behavioral health trained staff (e.g., care managers, clinical social workers, psychiatrists) within the practice workflow and creates integrated/coordinated treatment plans that can be shared within and outside the practice. The practice identifies and addresses behavioral health needs using evidence-based guidelines and uses quality measures to monitor the care delivered. The intent is to enhance the care provided in a primary care setting and to improve access, clinical outcomes and patient experience.

Competency A: Behavioral Health Workforce. The practice incorporates behavioral health providers at the site, utilizes behavioral health providers outside the practice and trains the care team to address the mental health and substance use concerns of patients.

BH 01 (Core) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.	Same *as PCMH TC 08.*
GUIDANCE	**EVIDENCE**
The practice identifies the behavioral health care manager and provides qualifications. The care manager has the training to support behavioral healthcare needs in the primary care office and coordinates referrals to specialty behavioral health services outside the practice.	• **Identified behavioral health care manager**
The practice demonstrates that it is working to provide meaningful behavioral healthcare services to its patients by employing a care manager who is qualified to address patients' behavioral health needs.	

= Evidence sharable across practice sites

BH Competency A: Behavioral Health Workforce

BH 02 (Elective) Care Team Behavioral Health Resources and Training:

Provides resources and training for the care team to enhance its capacity to address the behavioral health needs of patients using: (Practices may miss only one applicable item.)

A. Skill development and support systems for care team members.

B. Clinical protocols to determine when to contact a consulting specialist to advise on cases.

C. Training to conduct screening and brief interventions for alcohol. (NA for practices that do not serve patients over the age of 12)

D. Training to conduct screening and brief interventions for depression. (NA for practices that do not serve patients over the age of 12)

E. Training on when to access a clinician for medication-assisted treatment (MAT) prescribing. (NA for pediatric practices)

F. CME opportunities or library of resources.

GUIDANCE	EVIDENCE
The practice trains primary care staff to use evidence-based practices in screening for and treating depression, alcohol use or abuse and other behavioral health conditions that can be effectively managed in primary care settings. Developing an infrastructure to support behavioral healthcare requires initial training and continued support and supervision.	• **A–F: Documented process** *AND* • **A–F: Evidence of implementation**

Note: Practices must demonstrate all applicable options, minus 1, to receive credit. Practices with adult patients are expected to meet 5 of 6 options while pediatric practices are expected to meet 4 of 5 options. Practices that treat only young children (under age 12) are expected to meet at least 2 of 3.

A. The practice supports staff skill development to enhance the behavioral health services and care systems it provides to patients. The practice defines the frequency of initial and subsequent retraining and establishes support and monitoring protocols to offer feedback on performance.

B. The practice trains staff to use clinical protocols to determine when consulting with or referral to a behavioral health specialist may be appropriate to determine a patient's scope of treatment or care. Training includes when to seek expert counsel and the appropriate resource.

C. The practice enhances staff capabilities to screen for alcohol and provide an evidence-based approach to treatment. Training may include the application of validated screening tools such as Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking, the Drug Abuse Screening Test (DAST), or Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers Questionnaire (CAGE).

= Evidence sharable across practice sites

BH Competency A: Behavioral Health Workforce

BH 02 (Elective) Care Team Behavioral Health Resources and Training: *continued*	
GUIDANCE	**EVIDENCE**
The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol and drug use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth). **D.** The practice enhances staff capabilities to screen for depression and provide an evidence-based approach to treatment. Training may include the application of validated screening tools such as PHQ-9. **E.** The practice trains staff to know when to contact a clinician to access MAT prescribing services. The prescribing clinician may be external to the practice. **F.** The practice has available or funds educational courses, resources and tools to enhance staff knowledge and skills. Such training must provide to the ability to obtain CME credit to qualify.	

BH 03 (Core) Behavioral Health Clinician in the Practice: Has at least one clinician located in the practice who can directly provide brief interventions on an urgent basis for patients identified with a behavioral health condition.	
GUIDANCE	**EVIDENCE**
A clinician within the practice has the training to provide brief interventions based on evidence-based guidelines. This clinician must be integrated into the workflow to be accessible when the need arises. Simple co-location does not meet the requirement. A clinician that is integrated into the practice workflow with telehealth capabilities would meet this criterion. Feedback provided during brief interventions focuses on explicit advice to change, emphasizes the patient's responsibility for change, and provides a variety of ways to enhance motivation toward healthy behavioral change. It also helps identify individuals who could benefit from specialty care referrals. The evidence identifies the name/title and qualifications of clinician(s) responsible for the brief intervention and describes how staff access the services when needed.	• **Evidence of Implementation**

 = Evidence sharable across practice sites

BH Competency A: Behavioral Health Workforce

BH 04 (Elective) Clinician Practicing Medication-Assisted Treatment: Has at least one clinician located in the practice who can support medication-assisted treatment (MAT), and provide behavioral therapy directly or via referral, for substance use disorders.

GUIDANCE	EVIDENCE
The practice has at least one clinician who provides treatment for substance use disorders with medication-assisted treatment (MAT) at the practice site. The practice shows an example of at least one patient prescribed relevant medication for opioid or alcohol use disorder and under behavioral therapy. Behavioral therapy may be provided either directly or via referral. The practice may meet this criterion by having a prescribing clinician who is accessible through telehealth, if the clinician is integrated into the practice's workflow for MAT (e.g., can exchange patient information with the practice site as appropriate). MAT combines FDA-approved pharmacological interventions (naltrexone, buprenorphine and/or methadone) with evidence-based behavioral therapies and social support to treat substance use disorders, including alcohol and opioid use disorders.	• **Evidence of implementation**

BH 05 (Core) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers, to set expectations for information sharing and patient care.
Same as PCMH CC 09.

GUIDANCE	EVIDENCE
Relationships between primary care practitioners and specialists support consistency of information shared across practices. The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content). A practice needs an agreement if it shares the same facility or campus as behavioral health professionals, but has separate systems (basic onsite collaboration). A practice may present existing internal processes as its agreement if there is partial integration of behavioral healthcare services. To receive credit for the criterion, the practice must show evidence across patients in a report, log or electronic tracking system. A notification demonstrating legal inability to receive a report that includes confirmation a behavioral health visit occurred meets the requirement.	• **Agreement** *OR* • **Documented process** *and* • **Evidence of implementation**

= Evidence sharable across practice sites

BH Competency A: Behavioral Health Workforce

BH 06 (Core) Behavioral Health Referral Relationship: Has a formal agreement/consultative relationship with a licensed behavioral health provider or practice group that acts as a resource for patient treatment, referral guidance and medication management.	
GUIDANCE	**EVIDENCE**
The practice maintains at least one formal agreement with a behavioral health specialist/ practice group for providing non-visit consultation including referral guidance and medication management. The agreement articulates the arrangements and availability of the behavioral health specialist/practice group to provide ad hoc discussions with the primary care provider. These non-visit consultations are intended to provide the primary care clinician with insight on how to address patient behavioral health needs. This may include, but is not limited to, when a referral to a behavioral health specialist is needed, available community resources serving patients with behavioral health needs, medication dosage advice or patient safety issues. Proper treatment or referral advice can ensure that patients receive timely and appropriate care with access to the "right care, at the right time, in the right place."	• **Documented process** *and* • **Evidence of implementation** *OR* • **Agreement**

 = Evidence sharable across practice sites

Competency B: Information Sharing. The practice shares patient information within and outside the practice to support an integrated/coordinated patient treatment plan.

BH 07 (Core) Behavioral Health Referrals Tracking and Monitoring: Tracks referrals to behavioral health specialists and has a process to monitor the timeliness and quality of the referral response.	
GUIDANCE	**EVIDENCE**
It is important that the practice track patient behavioral health referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services, as well as frustration for providers. A tracking report includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist's office and documents its effort to retrieve the report in a log or an electronic system. This criterion aligns with the requirements of PCMH 2017 CC 11 which assess how the practices monitors the timeliness and quality of all referrals at the practice. The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided appropriate information about the patient's diagnosis and treatment plan. The practice bases its definition of "timely" on patient need.	• **Documented process** *AND* • **Evidence of implementation** 📚

📚 = Evidence sharable across practice sites

BH Competency B: Information Sharing

BH 08 (Elective) Integrated Health Record: The practice has a single integrated health record for a patient's physical and behavioral health information or has a protocol for exchanging information.

GUIDANCE	EVIDENCE
The practice demonstrates implementation of a single health record containing shared physical and behavioral health information or documents all behavioral health information in the patient record, whether it is entered directly or received through various means of information exchange. If the practice and all referring behavioral health clinicians share access to the same EHR system, the practice has a method to ensure timely communication of information between the primary and specialty practices. This may include automated alerts when new information has been shared. ***Note:*** *Psychotherapy notes may be maintained in a separate system or housed in the integrated system with restricted access.*	• **Evidence of implementation**

BH 09 (Elective) Integrated Care Plan: Care plan is integrated and accessible by both primary care and specialty behavioral health providers.

GUIDANCE	EVIDENCE
The practice provides examples demonstrating implementation of an integrated care plan and exchange or sharing of the plan between primary care and behavioral health providers in and external to the practice site. The single care plan is developed in collaboration with the patient/family/caregiver. A care plan considers and/or specifies areas related to a patient's care, which could include: • Patient preferences and functional/lifestyle goals. • Treatment goals. • Assessment of potential barriers to meeting goals. • Strategies for addressing potential barriers to meeting goals. • Care team members, including the primary care provider of record and team members outside the referring or transitioning provider and the receiving provider. • Current problems (may include historical problems, at the practice's discretion). • Current medications. • Medication allergies.	• **Evidence of implementation**

= Evidence sharable across practice sites

BH 09 (Elective) Integrated Health Care Plan: *continued*	
GUIDANCE	**EVIDENCE**
Maintaining a single, integrated care plan between practices, in addition to exchanging test results/ procedures, can reduce duplication of services, tests or treatments and encourage integrated care for the whole person. The practice demonstrates details of the care plan are outlined in the same documents that both the primary care and behavioral health provider can update and manage. This plan will address both the physical and behavioral health needs of the patient.	• **Evidence of implementation**
BH 10 (Elective) Controlled Substance Database Review: Reviews controlled substance database when prescribing relevant medications. *Same as PCMH KM 18.*	
GUIDANCE	**EVIDENCE**
The practice consults a state controlled-substance database—also known as a Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP)—before dispensing Schedule II, III, IV and V controlled substances. The practice follows established guidelines or state requirements to determine frequency of review. This can prevent overdoses and misuse, and can support referrals for pain management and substance use disorders. For a list of PDMPs by state: http://www.pdmpassist.org/content/state-pdmp-websites	• **Evidence of implementation**

 = Evidence sharable across practice sites

Behavioral Health Integration (BH)

Competency C: Evidence-Based Care. *The practice uses evidence-based protocols to identify and address the behavioral health needs of patients.*

BH 11 (Core) Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool. *Same as PCMH KM 03.*	
GUIDANCE	**EVIDENCE**
The documented process includes the practice's screening process and approach to follow-up for positive screens. The practice reports the screening rate and identifies the standardized screening tool. **Screening for adults:** Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. **Screening for adolescents (12–18 years):** Screening adolescents for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. In caring for the whole person, the medical home recognizes the impact depression can have on a patient's physical and emotional health. The practice uses a standardized screening tool (e.g., PHQ-9) and acts on the results.	• **Documented process** *or* • **Report** **AND** • **Evidence of implementation** --- **PCMH PRIME** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit the documented process and evidence of implementation only. *Documented process only*

BH 12 (Core) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.)	
A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression. *Same as PCMH KM 04.*	
GUIDANCE	**EVIDENCE**
Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Practice staff have been trained on the use of standardized tools to ensure accurate diagnosis, treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization.	• **Documented process** **AND** • **Evidence of implementation** --- **PCMH PRIME** **A-C, G:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit the documented process and evidence of implementation only. *Documented process only*

BH 12 (Core) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**

<table>
<tr>
<td>
The National Institute on Drug Abuse created a chart of <u>Evidence Based Screening Tools for Adults and Adolescents</u> for opioid screening, as well as alcohol and substance use tools.

A. The practice conducts assessment for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders (generalized anxiety disorder, panic disorder and social anxiety disorder) are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked with medical conditions (e.g., heart disease, chronic pain disorders).

B. The USPSTF recommends screening for adults aged 18 years or older for alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking, the Drug Abuse Screening Test (DAST), Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers Questionnaire (CAGE) or another validated screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits using developmentally appropriate screening tools (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth).

C. Assessing for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to address the patient's substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients' access to the necessary treatments toward sobriety. Available screening tools may include the <u>CAGE AID</u> or <u>DAST-10</u> instruments, which assess a variety of substance use conditions. Bright Futures recommends clinicians screen all adolescents for substance use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or DAST-20).

D. Pediatric assessment for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have
</td>
<td valign="top">
- **Documented process**

AND

- **Evidence of implementation**

PCMH PRIME

A-C, G: Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit the documented process and evidence of implementation only.

Documented process only
</td>
</tr>
</table>

= Evidence sharable across practice sites

BH 12 (Core) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
lasting effects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC).	• **Documented process**
	AND
E. The practice uses standardized tools to determine if patients have developed PTSD. This condition develops in patients who have experienced a severe and distressing event. This event causes the patient to subsequently re-live the traumatic experience causing mental distress. Assessments for PTSD support the practice in recognizing the ailment so it can either provide treatment or referrals to appropriate specialists.	• **Evidence of implementation**
	PCMH PRIME
	A-C, G: Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit the documented process and evidence of implementation only.
F. ADHD makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood but symptoms can persist through adolescence and adulthood. The Vanderbilt Assessment Scale or the DSM V ADHD checklist for adults or children/adolescents are examples of screening tools used to determine if a patient has Attention Deficit/ Hyperactivity Disorder (ADHD). Screening to identify patients with ADHD can lead to earlier diagnosis and treatment and may and reduce the impact of the condition on patients/families/caregivers.	
G. The USPSTF recommends screening of adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF guidelines suggest screening during and after pregnancy. The AAP's Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-child care schedule. Validated screening tools may include PHQ-2, PHQ-9, Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools, and may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits.	
For a list of screening tools, visit SAMHSA.gov, or for a list of pediatric screening tools, visit the American Academy of Pediatrics website. (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx)	*Documented process only*

 = Evidence sharable across practice sites

BH Competency C: Evidence-Based Care

BH 13 (Core) Evidence Based Decision Support—Mental Health Condition: Implements clinical decision support following evidence-based guidelines for care of mental health conditions.
Same as PCMH KM 20A.

GUIDANCE	EVIDENCE
The practice utilizes systems in its day-to-day operations that integrate evidence-based guidelines (frequently referred to as "clinical decision support" [CDS]). **CDS** is a systematic method of prompting clinicians to consider evidence-based guidelines at the point of care. CDS encompasses a variety of tools, including, but not limited to: • Computerized alerts and reminders for providers and patients. • Condition-specific order sets. • Focused patient data reports and summaries. • Documentation templates. • Diagnostic support. • Contextually relevant reference information. Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS. **Mental health** The practice uses evidence-based guidelines to support clinical decisions related to at least one mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's) in the care of patients.	• **Identifies conditions, source of guidelines AND** • **Evidence of implementation**

BH 14 (Core) Evidence Based Decision Support—Substance Use Disorder: Implements clinical decision support following evidence-based guidelines for care of substance use disorders.
Same as PCMH KM 20B.

GUIDANCE	EVIDENCE
The practice utilizes systems in its day-to-day operations that integrate evidence-based guidelines (CDS). **Substance use disorder treatment** The practice uses evidence-based guidelines to support clinical decisions related to at least one substance misuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism) in the care of patients.	• **Identifies conditions, source of guidelines AND** • **Evidence of implementation**

 = Evidence sharable across practice sites

BH Competency D: Measuring and Monitoring

Competency D: Measuring and Monitoring. The practice utilizes quality measures to monitor the care of patients with behavioral health needs.

<table>
<tr><td colspan="2">BH 15 (Core) Monitor and Adjust—Mental Health or Substance Use Disorder: Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for patients who do not demonstrate improvement.</td></tr>
<tr><th>GUIDANCE</th><th>EVIDENCE</th></tr>
<tr><td>The practice provides a report demonstrating routine monitoring of patients screened and actions taken when they are not getting better for either mental health or substance use.

Successful treatments for patients with mental health or substance use conditions may require follow-up to find the best treatment regimen.

The practice recognizes the need to assess treatment efficacy for patients and to adjust the treatment plan, as needed. Adjusting treatment plans allows a greater chance of long-term success and remission, and may include changes to therapies or medications applicable to the condition. Tools to consider for monitoring of symptoms are the PHQ-9 for depression or the AUDIT for alcohol use.</td><td>• Identifies conditions, source of guidelines, and
• Evidence of implementation
OR
• BH 16</td></tr>
</table>

<table>
<tr><td colspan="2">BH 16 (Elective) Monitor and Adjust—Mental Health and Substance Use Disorder: Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for patients who do not demonstrate improvement. The practice monitors and assesses for both:

A. A mental health condition.
B. A substance use disorder.</td></tr>
<tr><th>GUIDANCE</th><th>EVIDENCE</th></tr>
<tr><td>The practice provides a report for each condition. Conditions include at least 1 mental health condition and at least 1 substance use disorder.

The practice demonstrates that it assesses treatment efficacy for patients and adjusts the treatment plan, as needed. Adjusting treatment plans allows a greater chance of long-term success and remission, and may include changes to therapies or medications applicable to the condition.</td><td>• Identifies conditions, source of guidelines
AND
• Evidence of implementation</td></tr>
</table>

Behavioral Health Integration (BH)

 = Evidence sharable across practice sites

BH Competency D: Measuring and Monitoring

BH 17 (Core) Monitors Performance—Behavioral Health Measures: Monitors performance using at least two behavioral health clinical quality measures.	
GUIDANCE	**EVIDENCE**
The practice seeks to understand the outcome of the behavioral health services it provides to patients. Quality measurement provides an objective way to understand where the practice may be excelling in clinical care and potential gap areas for it to improve how it provides comprehensive, safe and effective behavioral healthcare. Data include the measurement period, the number of patients represented, the rate and the measure source (e.g., HEDIS, NQF#, measure guidance).	• **Report**

BH 18 (Elective) Goals and Actions to Improve Behavioral Health Clinical Quality Measures: Sets goals and acts to improve upon at least two behavioral health clinical quality measures.	
GUIDANCE	**EVIDENCE**
The practice demonstrates a commitment to continued improvement in behavioral health by seeking ways to improve performance in clinical care. After assessing its performance on least 2 performance measures (BH 17), the practice demonstrates that it sets goals for improving care, based on its identified standards of care, and is working to meet stated goals. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ Improvement Methods/HowToImprove/).	• **Report** **OR** • **Quality Improvement Worksheet**

= Evidence sharable across practice sites

Appendix 5

PCMH Distinction in Electronic Quality Measure (eCQM) Reporting

Launching on Q-PASS in 2018

Distinction Purpose and Background

Health care continues to move toward a performance-based evaluation of practices, with an ever-increasing emphasis on quality measurement and quality improvement. NCQA supports this movement and has curated 35 electronic clinical quality measures (eCQM) that help primary care practices measure and improve care in key areas. By directly extracting data from EHRs, eCQMs reduce the time, expense and clinical burden that comes from manual data abstraction. Measures can be submitted through EHRs, health information exchanges, qualified clinical data registries and data analytics companies as long as they can use the electronic specifications as defined by CMS for the ambulatory quality reporting programs. Using eCQMs can also help practices earn and sustain NCQA PCMH Recognition, as there are specific criteria within the standards where performance measures may be used as evidence of meeting the criteria.

Eligibility

Practices with current NCQA PCMH Recognition are eligible for the optional distinction. Practices may pursue NCQA PCMH Recognition and Distinction in Electronic Quality Measures Reporting at the same time.

Requirements Description

Practices must submit approved measures in standard QRDA III format. For each clinician in the practice, PCMH practice sites submit at least 6 measures from the list of 35 measures listed in the table in this appendix. If practices submit fewer than 6 measures per clinician, the measures can be used as evidence to meet specific criteria in PCMH, but they will not earn distinction.

Measures cover a range of categories: Acute Care, Behavioral Health/Chronic Disease Care, Overuse, Immunization, Preventive Care, Administrative. Practices interested in submitting eCQMs can either:

- Use an NCQA Certified Vendor to create the appropriate QRDA III files, then:
  - The vendor uploads files on behalf of the practice through an application program interface (API) provided by NCQA (Q-Bridge).
  - The vendor provides QRDA III files to the practice and the practice uploads the files through Q-PASS, *or*
- Have and use Meaningful Use Certified Electronic Health Record Technology (CEHRT) or a data intermediary with the capability to produce CMS QRDA III files, then:
  - The practice uploads QRDA III files through Q-PASS.

Specifications

QRDA Category III files must conform to current eCQM specifications used for the Medicare and Medicaid EHR Incentive Programs (the "Meaningful Use" program) and the Quality Payment Program (QPP). Some vendors/data intermediaries may also build reports for other quality programs (e.g., the Physician Quality Reporting Program); these reports should not be used for this program.

Organizations that participated in the Medicare or Medicaid EHR Incentive Program in 2016 or the QPP in 2017 may choose to submit to NCQA their most recent QRDA III files that were submitted to CMS as part of either program.

The current eCQM measure specifications are found in the CMS eCQM library:
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html.

The CMS eCQM Library contains a number of other useful resources, including QRDA Implementation Guides and a link to the CMS helpdesk for questions regarding eCQM specifications, logic and QRDA reporting.

Reporting Period

NCQA will accept data from a 365-day reporting period or a 90-day period in the year prior to reporting to NCQA.

If an organization chooses to report for a 90-day period, it must provide a rationale for not reporting a full year's data (i.e., alignment with the Merit-based Incentive Payment System [MIPS]) and state whether the 90-day period was applied to the measure denominator, to the numerator and exclusions or only to the measure denominator.

Receiving Distinction/Scoring

Distinction will be awarded for one year to PCMH practice sites that submit at least 6 measures from our list of 35 for each clinician in the practice. This approach is consistent with MIPS reporting requirements.

Quality Measures Crosswalk for PCMH 2017ˇ

KEY TO TABLE SYMBOLS

ˇ NCQA intends to accept the results of these measures for the 2017 PCMH program. The specifications for these measures are available through CMS eCQM Library at: https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html

☞ Measure included in Quality Payment Program Merit-based Incentive Payment System (MIPS).

⌘ HEDIS and Medicare Star measure specifications differ from CMS eCQM specifications.

‡ HEDIS Measure included here though HEDIS specification is different than CMS eCQM specification and data collection methodology is via Electronic Clinical Data Systems Reporting (ECDS).

★ Medicare Stars measures: A version of this measure is included in the Medicare Stars program though the specifications and method of collection differ from the CMS eCQM version used for the PCMH 2017 program.

Measure Title	NQF # (CMS eCQM #)	Population	NCQA eMeasure Certification	CMS/AHIP Consensus Core Set ACO & PCMH	CPC+	HEDIS Plan Level & Medicare Star Rating System	NCQA PCMH 2017 Recognition Credit	Owner (Developer)
ACUTE CARE								
Appropriate Treatment for Children with Upper Respiratory Infection☞	69 (154)	Pediatric	✓			✓	QI 01C	NCQA[1]
BEHAVIORAL HEALTH/CHRONIC CARE								
ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication☞	108 (136)	Pediatric	✓			✓	QI 02A	NCQA
Dementia: Cognitive Assessment☞	NA (149)	Adult			✓		QI 01D	AMA PCPI[2]
Depression Remission at 12 Months (Outcome)☞	710 (159)	Adult	✓	✓	✓	✓‡	QI 01D	MNCM[3]
Depression Utilization of the PHQ-9 Tool☞	712 (160)	Adult	✓			✓‡	QI 01D KM 03	MNCM
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment☞	4 (137)	Adult/Adolescent			✓	✓	KM 04B, 04C QI 01D	NCQA
CHRONIC DISEASE CARE								
Controlling High Blood Pressure (Intermediate Outcome)☞	18 (165)	Adult	✓	✓	✓	✓★⌘	QI 01C	NCQA

Measure Title	NQF # (CMS eCQM #)	Population	NCQA eMeasure Certification	CMS/AHIP Consensus Core Set ACO & PCMH	CPC+	HEDIS Plan Level & Medicare Star Rating System	NCQA PCMH 2017 Recognition Credit	Owner (Developer)
Coronary Artery Disease: Beta-Blocker Therapy—Prior Myocardial Infarction or Left Ventricular Systolic Dysfunction (LVEF <40%)	NA (145)	Adult					QI 01C	AMA PCPI
Diabetes: Eye Exam	55 (131)	Adult	✓	✓	✓	✓★	QI 01C	NCQA
Diabetes: Foot Exam	56 (123)	Adult	✓	✓			QI 01C	NCQA
Diabetes: Hemoglobin A1c Poor Control (>9%) (Intermediate Outcome)	59 (122)	Adult	✓	✓	✓	✓	QI 01C	NCQA
Diabetes: Medical Attention for Nephropathy	62 (134)	Adult	✓	✓		✓	QI 01C	NCQA
Functional Status Assessments for Congestive Heart Failure	NA (90)	Adult					QI 01C	CMS (NCQA)[4]
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	2907 (135)	Adult					QI 01C	AMA PCPI
Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction	2908 (144)	Adult					QI 01C	AMA PCPI
Hypertension: Improvement in Blood Pressure (Intermediate Outcome)	NA (65)	Adult					QI 01C	CMS (NCQA)
Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet	68 (164)	Adult		✓			QI 01C	NCQA
Use of High-Risk Medications in the Elderly	22 (156)	Adult	✓		✓	✓	QI 01C	NCQA
OVERUSE								
Use of Imaging Studies for Low Back Pain	52 (166)	Adult	✓	✓	✓	✓	QI 02B	NCQA
IMMUNIZATION								
Childhood Immunization Status	38 (117)	Pediatric	✓			✓	QI 01A	NCQA
Preventive Care and Screening: Influenza Immunization	41 (147)	Adult/ Pediatric					QI 01A	AMA PCPI

Measure Title	NQF # (CMS eCQM #)	Population	NCQA eMeasure Certification	CMS/AHIP Consensus Core Set ACO & PCMH	CPC+	HEDIS Plan Level & Medicare Star Rating System	NCQA PCMH 2017 Recognition Credit	Owner (Developer)
PREVENTIVE CARE								
Breast Cancer Screening	2372 (125)	Adult	✓	✓	✓	✓★	QI 01B	NCQA
Cervical Cancer Screening	32 (124)	Adult	✓	✓	✓	✓	QI 01B	NCQA
Chlamydia Screening for Women	33 (153)	Adult/ Pediatric	✓			✓	QI 01B	NCQA
Colorectal Cancer Screening	34 (130)	Adult	✓	✓	✓	✓★	QI 01B	NCQA
Falls: Screening for Future Fall Risk	101 (139)	Adult			✓	✓	QI 01B	AMA PCPI
Maternal Depression Screening	NA (82)	Adult/ Pediatric					QI 01B	NCQA
Pneumococcal Vaccination Status for Older Adults	43 (127)	Adult				✓	QI 01A	NCQA
Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan	421 (69)	Adult		✓			QI 01B	CMS (QIP)[5]
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	418 (2)	Adult/ Pediatric	✓				QI 01B	CMS (QIP)
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	28 (138)	Adult		✓	✓		QI 01B	AMA PCPI
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	NA (74)	Adult/ Pediatric					KM 05 QI 01B	CMS (NCQA)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	24 (155)	Pediatric	✓			✓	QI 01B	NCQA
ADMINISTRATIVE								
Closing the Referral Loop: Receipt of Specialist Report	NA (50)	Adult/ Pediatric			✓		CC 04C QI 02A	CMS (NCQA)
Documentation of Current Medications in the Medical Record	419 (68)	Adult				✓	KM 15	CMS (QIP)

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Appendix 6

PCMH Distinction in
Patient Experience Reporting

Launching on Q-PASS in 2018

Distinction Purpose and Background

NCQA Distinction in Patient Experience Reporting acknowledges practices that excel in evaluating the experience of patients and their families or caregivers for quality improvement and accountability. The Agency for Healthcare Research & Quality (AHRQ) notes that improved patient experience is good for clinical outcomes and business goals.[1]

NCQA began offering this distinction program for recognized PCMH practices in 2012 to encourage standardized patient experience reporting, with a goal of moving to performance-based evaluation.

The distinction focuses on the use of the CG CAHPS 3.0® Survey for PCMHs, with the option to include supplemental PCMH items. The survey assesses several domains of patient experience: access, communication, coordination of care, office staff. If optional PCMH supplemental items are incorporated, the survey can also be used to assess self-management support. The survey lays the groundwork for measuring and improving a practice's delivery of care and assessing how well it achieves PCMH goals. Submitted data will be used to develop a benchmarking database that will allow comparison across practices.

Eligibility

All qualifying new and existing NCQA PCMH Recognized practices are eligible to apply for Distinction in Patient Experience Reporting.

Survey Vendor Eligibility

Practices seeking distinction in patient experience reporting must use an NCQA Certified Survey Vendor to submit the PCMH CG CAHPS 3.0 survey on their behalf.

Vendors who proctor the CG CAHPS 3.0 Survey must demonstrate the ability to:

- Capture patient experience data via the survey.
- Use a standardized sampling process and attain the minimum number of completed surveys.
- Use an approved data collection process.
- Submit survey data to NCQA using a specified file layout and data submission method.

NCQA trains and certifies survey vendors to collect survey results from practices per HEDIS protocols. To become an NCQA-Certified survey vendor, an organization must demonstrate that it has the capabilities, experience and trained personnel to accurately collect and report survey results. Once certified, survey vendors may enter into contracts with practices to survey patients.

The names and contact information of certified survey vendors are updated on NCQA's website annually. Although survey vendors enter into contracts with practices independent of NCQA, NCQA expects strict adherence to its procedures and protocols. Any deviation from or enhancement to the protocols must have prior written consent from NCQA.

Survey vendors can e-mail CAHPS-PCMH@ncqa.org for more information on NCQA CAHPS PCMH and applying for survey vendor certification.

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[1]https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/2-why-improve/index.html

Requirements Description

The CAHPS Survey for PCMH includes surveys and protocols for the CG CAHPS 3.0, with the option to include supplemental PCMH items. Survey vendors may submit data in April or September on behalf of their practice clients. The term of distinction for the practice is one year from the time of data submission.

The HEDIS Specifications for the CAHPS Survey for PCMH for vendors is available in the NCQA Store. Practices can access and review the CG CAHPS questions on the AHRQ website.

B. Quality Measures Crosswalk For PCMH 2017

Quality Measures Crosswalk for PCMH 2017✓

Reference Guide Produced by NCQA

Category	Measure Title	NQF # (CMS eCQM #)	Population	NCQA eMeasure Certification	CMS/AHIP Consensus Core Set ACO & PCMH	CPC+	HEDIS Plan Level & Medicare Stars	NCQA PCMH Recognition	Owner (Developer)
ACUTE	Appropriate Treatment for Children with Upper Respiratory Infection 🔖	69 (154)	Pediatric	✓			✓	✓	NCQA[1]
BEHAVIORAL HEALTH/ CHRONIC CARE	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder Medication 🔖	108 (136)	Pediatric	✓			✓	✓	NCQA
	Dementia: Cognitive Assessment 🔖	NA (149)	Adult			✓		✓	AMA PCPI[2]
	Depression Remission at Twelve Months (Outcome) 🔖	710 (159)	Adult	✓	✓	✓	✓‡	✓	MNCM[3]
	Depression Utilization of the PHQ-9 Tool 🔖	712 (160)	Adult	✓			✓‡	✓	MNCM
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 🔖	4 (137)	Adult/ Adolescent			✓	✓	✓	NCQA
CHRONIC DISEASE CARE	Controlling High Blood Pressure (Intermediate Outcome) 🔖	18 (165)	Adult	✓	✓	✓	✓★⌘	✓	NCQA
	Coronary Artery Disease: Beta-Blocker Therapy— Prior Myocardial Infarction or Left Ventricular Systolic Dysfunction (LVEF <40%) 🔖	NA (145)	Adult			✓		✓	AMA PCPI
	Diabetes: Eye Exam 🔖	55 (131)	Adult	✓	✓	✓	✓★	✓	NCQA
	Diabetes: Foot Exam 🔖	56 (123)	Adult	✓	✓			✓	NCQA
	Diabetes: Hemoglobin A1c Poor Control (>9%) (Intermediate Outcome) 🔖	59 (122)	Adult	✓	✓	✓	✓	✓	NCQA
	Diabetes: Medical Attention for Nephropathy 🔖	62 (134)	Adult	✓	✓		✓	✓	NCQA
	Functional Status Assessments for Congestive Heart Failure 🔖	NA (90)	Adult					✓	CMS (NCQA)[4]

Quality Measures Crosswalk for PCMH 2017

Reference Guide Produced by NCQA

	Measure Title	NQF # (CMS eCQM #)	Population	NCQA eMeasure Certification	CMS/AHIP Consensus Core Set ACO & PCMH	CPC+	HEDIS Plan Level & Medicare Stars	NCQA PCMH Recognition	Owner (Developer)
	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	2907 (135)	Adult					✓	AMA PCPI
	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction	2908 (144)	Adult					✓	AMA PCPI
	Hypertension: Improvement in Blood Pressure (Intermediate Outcome)	NA (65)	Adult					✓	CMS (NCQA)
OVERUSE	Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet	68 (164)	Adult		✓			✓	NCQA
	Use of High-Risk Medications in the Elderly	22 (156)	Adult	✓		✓	✓	✓	NCQA
	Use of Imaging Studies for Low Back Pain	52 (166)	Adult	✓	✓	✓	✓	✓	NCQA
IMMUNIZATION	Childhood Immunization Status	38 (117)	Pediatric	✓			✓	✓	NCQA
	Preventive Care and Screening: Influenza Immunization	41 (147)	Adult/Pediatric					✓	AMA PCPI
PREVENTIVE CARE	Breast Cancer Screening	2372 (125)	Adult	✓	✓	✓	✓★	✓	NCQA
	Cervical Cancer Screening	32 (124)	Adult	✓	✓	✓	✓	✓	NCQA
	Chlamydia Screening for Women	33 (153)	Adult/Pediatric	✓			✓	✓	NCQA
	Colorectal Cancer Screening	34 (130)	Adult	✓	✓	✓	✓★	✓	NCQA
	Falls: Screening for Future Fall Risk	101 (139)	Adult			✓	✓	✓	AMA PCPI

Quality Measures Crosswalk for PCMH 2017

Reference Guide Produced by NCQA

Measure Title	NQF # (CMS eCQM #)	Population	NCQA eMeasure Certification	CMS/AHIP Consensus Core Set ACO & PCMH	CPC+	HEDIS Plan Level & Medicare Stars	NCQA PCMH Recognition	Owner (Developer)
Maternal Depression Screening	NA (82)	Adult/Pediatric					✓	NCQA
Pneumococcal Vaccination Status for Older Adults	43 (127)	Adult				✓	✓	NCQA
Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan	421 (69)	Adult		✓			✓	CMS (QIP)[5]
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	418 (2)	Adult/Pediatric	✓				✓	CMS (QIP)
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	28 (138)	Adult		✓	✓		✓	AMA PCPI
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	NA (74)	Adult/Pediatric					✓	CMS (NCQA)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	24 (155)	Pediatric	✓			✓	✓	NCQA
ADMIN QMS Closing the Referral Loop: Receipt of Specialist Report	NA (50)	Adult/Pediatric			✓		✓	CMS (NCQA)
Documentation of Current Medications in the Medical Record	419 (68)	Adult				✓	✓	CMS (QIP)

⌃ NCQA intends to accept the results of these measures for the 2017 PCMH program. The specifications for these measures are available through CMS eCQM Library at: https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html

🅟 Measure included in Quality Payment Program Merit-based Incentive Payment System (MIPS)

⌘ HEDIS and Medicare Star measure specifications differ from CMS eCQM specification

‡ HEDIS Measure included here though HEDIS specification is different than CMS eCQM specification and data collection methodology is via Electronic Clinical Data Systems Reporting (ECDS)

★ Medicare Stars measures: A version of this measure is included in the Medicare Stars program though the specifications and method of collection differ from the CMS eCQM version used for the PCMH 2017 program.

Quality Measures Crosswalk for PCMH 2017[⌄]

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C. PCMH Behavioral Health Distinction Modules

PCMH Behavioral Health Distinction Module

The Behavioral Health Distinction Module is a way for practices to demonstrate integration of behavioral health care and services at their practice in addition to earning PCMH Recognition.

The PCMH criteria include various assessments of how a practice provides behavioral health services but the behavioral health distinction module is a way for practices to demonstrate advanced mechanisms, inclusion of additional staff and services to manage the behavioral health needs of their patients. The behavioral health module criteria include requirements that assess for multiple ways the practice works with behavioral health providers, such as, coordinating behavioral health needs for the patient, training staff on how to identify and address behavioral health needs, and established relationships with behavioral health consultant/providers.

The criteria are organized into four key competencies to highlight essential areas in behavioral health. The four competencies include:

- Behavioral Health Workforce
- Information Sharing
- Evidence-Based Care
- Measuring and Monitoring

The distinction module consists of 18 criteria: 11 Core and 7 Electives. Practices must demonstrate all core electives and 2 of the 7 electives to earn the distinction.

PCMH Behavioral Health Module Standards preview is a draft and subject to change. This document is obsolete after 6/23/17.

Page 1

Intent: The practice has resources to support the broad needs of patients with behavioral health related conditions within the primary care practice. The expectation of this model is integration of behavioral health trained staff (such as care managers, psychiatrists, etc.) and expertise within the workflow of the practice to enhance the care provided in a primary care setting and to improve access, clinical outcomes and patient satisfaction.

Competency A, Behavioral Health Workforce: The practice incorporates behavioral health providers at the practice, utilizes providers outside the practice behavioral health services and trains the care team to address the mental health and substance use needs of patients.

BH 01 (Core)	Has at least one care manager qualified to identify and coordinate behavioral health needs. *Aligns with PCMH TC 08.*
BH 02 (Elective)	Practice provides resources and training for the care team to enhance their capacity to address the behavioral health needs of the patients with: A. Skill development and support systems for care team members B. Access to consulting specialist to advise on cases C. Training to conduct screening and brief interventions for alcohol D. Training to conduct screening and brief interventions for depression E. Access to a clinician for medication assisted treatment (MAT) prescribing (NA for pediatric practices) F. CME opportunities or library of resources
BH 03 (Core)	Has at least one clinician located in the practice who can directly provide brief interventions on an urgent basis for patients identified with a behavioral health condition.
BH 04 (Elective)	Has at least one clinician located in the practice who can support medication-assisted treatment (MAT), including prescribing the medications and coordinating provision of behavioral therapy directly or via referral, for substance use disorder.
BH 05 (Core)	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care. *Aligns with PCMH CC 09.*
BH 06 (Core)	Has a formal agreement/consultative relationship with a behavioral health licensed provider(s)/practice group to act as resource for patient treatment, referral guidance and medication management.

PCMH Behavioral Health Module Standards preview is a draft and subject to change. This document is obsolete after 6/23/17.

Page 2

Competency B, Information Sharing: The practice shares patient information within and outside the practice to support an integrated/coordinated patient treatment plan.

BH 07 (Core)	Tracks referrals for patient compliance and has a process to monitor the timeliness and quality of the referral response.
BH 08 (Elective)	Integrated Health Record: The practice has a single record for a patient's physical and behavioral health information or has a protocol for exchanging information (*Not including psychotherapy notes*)
BH 09 (Elective)	Care plan is integrated and accessible by both primary care and specialty behavioral health providers.
BH 10 (Elective)	Reviews controlled substance database when prescribing relevant medications. *Aligns with KM 18.*

Competency C, Evidence-Based Care: The practice uses evidence-based protocols to identify and address the behavioral health needs of the patients.

BH 11 (Core)	Conducts depression screenings for adults and adolescents using a standardized tool. *Aligns with PCMH KM 03.*
BH 12 (Elective)	Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) *Aligns with PCMH KM 04.* 　A. Anxiety. 　B. Alcohol use disorder. 　C. Substance use disorder. 　D. Pediatric behavioral health screening. 　E. Post-traumatic stress disorder. 　F. Attention deficit/hyperactivity disorder. 　G. Postpartum depression
BH 13 (Core)	Implements clinical decision support following evidence-based guidelines for care of mental health conditions. *Aligns with PCMH KM 20 A.*
BH 14 (Core)	Implements clinical decision support following evidence-based guidelines for care of substance use disorders. *Aligns with PCMH KM 20 B.*

PCMH Behavioral Health Module Standards preview is a draft and subject to change. This document is obsolete after 6/23/17.

Page 3

Competency D, Measuring and Monitoring: The practice utilizes quality measures to monitor the care of patients with behavioral health needs.

BH 15 (Core)	Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for those patients who do not demonstrate improvement.

BH 16 (Core)	Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for those patients who do not demonstrate improvement.
	    A. Mental health condition.
	    B. Substance use disorder.

BH 17 (Core)	Monitors performance using at least two behavioral health clinical quality measures.
BH 18 (Elective)	Sets goals and acts to improve upon at least two behavioral health clinical quality measures.

PCMH 2017 Standards preview is a draft and subject to change.
This document is obsolete after 04/03/2017. Updated 2/27/2017.

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D. Workbooks

NCQA's Patient-Centered Medical Home (PCMH)
Record Review Workbook (RRWB) General Instructions
Updated 04.03.17

Purpose of the Record Review Workbook

There are several assessment areas in PCMH 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 criteria based on a sample of patient records. Of particular interest is the assessment and identification of patients would benefit from care management. The criteria included in this worksheet are PCMH CM 04-08. These criteria assess how the practice uses patient information and collaborates with patients/families/caregivers to develop care plans that address barriers and incorporates patient preferences and lifestyle goals documented in the patient chart.

Refer to each criteria in the PCMH 2017 Standards and Guidelines for details about scoring.
There are two methods for collecting data for these criteria
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 criteria, you can enter the reports directly in Q-PASS, 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 criteria and must complete the RRWB and provide examples to meet the criteria.
You may respond to some criteria with Method 1 and others with Method 2; If using a combination of Method 1 and 2, for criteria 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., CM 06)
When selecting the "Not Used" response, always select it in the first patient row in the sample (row 12). "Not Used" scores as "Not Met."
See Report = Practice is submitting an electronic report for documentation for this criteria and is uploading it to the document library in Q-PASS and linking to this report in Q-PASS. "See Report" scores as a "no" in the workbook. Only select this option if providing alternate documentation outside the workbook to meet the criteria.
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 criteria you will document using this file. *Remember:* **PCMH CM 04 and CM 05 are Core criteria. Your practice must use one of the two methods in the Explanation to document performance for these criteria.**
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 criteria.
5. Record the "Met" response for each criterion in Q-PASS for which the workbook is the evidence for CM 04-08.

6. Attach the Record Review Workbook to the criteria in Q-PASS for which you used the Record Review Workbook. Once you have attached the workbook for one criterion, such as PCMH CM 05, you may use the options in Q-PASS to link it to the other criteria assessed in the RRWB.

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 Care Plan Management (CM 04-08).
This assessment requires 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 criterion, 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 criterion. This will gray the column and indicate to NCQA that you are not going to use the worksheet for that criterion. "Not Used" and "See Report" are scored as "not Met."
<u>*NOTE: See the NCQA PCMH Standards and Guidelines for documentation requirements for each criterion. For practices using the RRWB for CM 04-08, an example for each criterion is required. The example shows how the practice documents the content of a criterion for patients in their medical record and can be demonstrated during virtual review.*</u>
Step 3: Select patient records for review.

1. Identifying Patients for Care Management (PCMH CM 01)
The intent of the criterion is that the practice uses defined guidelines to identify true vulnerability—a single indicator, such as cost, may not be an appropriate indicator of need for care management.
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 KM 02) supports establishing criteria and a systematic process for identifying patients for care management.
The practice must include at least 3 of the options outlined in CM 01 for identification of patients for care management. A patient may fall into more than one option (A-E) and may be included in some or all of these counts. The practice uses these options 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 CM 01**. These will be the patients reviewed in your medical record review. You will review the same 30 patient files for all criteria using the Record Review Workbook. There must be a total of 30 patients. **The identified health indicators for the patients in the sample must match those identified in PCMH CM 01.**

3. Patient Selection
Patient Selection Using Visit Date
Choose patients meeting the health indicators from PCMH CM 01, 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 health indicator from PCMH CM 01 and who had a care visit related to any one or more of the selected health indicators. 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 PCMH CM 04-08. The practice determines how often information is updated in KM 02 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.
IMPORTANT: KEEP THIS MASTER LIST FOR THE VIRTUAL CHECK-IN ON THESE CRITERIA, BUT DO NOT SEND IT TO NCQA.

Step 4: Review the patient records and enter responses in the Record Review Worksheet.

Fill out patient data in the Record Review Worksheet

Yes - If the patient's medical record has documentation for the criterion choose "Yes" (from the drop-down list in each cell) for each criterion 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 criterion.

Not Used - Review the list of criteria and determine if there are any that your practice does not use. If your practice does not use a particular criterion, 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 list of criteria 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 criterion, 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.

PCMH CM 04-08 - Care Planning and Self-Care Support

Review each patient medical record for documentation for each of the 5 criteria. 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 criteria. The practice will then INDICATE Met or Not Met in Q-PASS for each of the 5 criteria. If your practice does not use a particular criterion 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 **Not Met** response for all patients. If your practice will generate an electronic report to demonstrate it meets a particular criterion, chose (from the drop-down list) **See Report** in row 12 (patient #1) to blank out (grey) the entire column.

NOTE: CM 04 and CM 05 are Core and thus required to be consistently documented for patients identified for care management for the practice to receive recognition.

Step 5: Link the Record Review Workbook to the Criteria in Q-PASS.

Link the Record Review Workbook to the first criterion chosen in Step 2 for which you have entered data, then link it to each of the other criteria for which you entered data.

To link the Record Review Workbook to the first criterion:

1. Go to the first criterion in Q-PASS for which you have used the Record Review Worksheet.

2. Click the *Documents* button.

3. Select and click the Link Document option.

NCQA's Patient-Centered Medical Home (PCMH)

Record Review Worksheet

Please read the Workbook Instructions before completing this worksheet.

IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the drop-down boxes for Patient Number 1.

Organization Name:	
Completion Date:	

Patient Number	Care Planning and Self-Care Support				
	CM 04	CM 05	CM 06	CM 07	CM 08
	Establishes a person-centered care plan for patients identified for care management	Provides written care plan to the patient/family/caregiver for patients identified for care management	Documents patient preference and functional/lifestyle goals in individual care plans	Identifies and discusses potential barriers to meeting goals in individual care plans	Includes a self-management plan in individual care plans
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
Count of Patients Met (Yes + NA)	0	0	0	0	0
Count of Patients Not Met (No + Not Used)	0	0	0	0	0
Total Count of Patients (Met + Not Met)	0	0	0	0	0

NCQA PCMH Quality Measurement and Improvement Worksheet

PURPOSE: This worksheet helps practices organize the measures and quality improvement activities that are outlined in PCMH AC 01-03, AC 06, QI 08-14 and BH 17-18. Refer to PCMH AC and QI in the PCMH 2017 Standards and Guidelines and the Distinction for Behavioral Health Integration for additional information.

NOTE: Practices are not required to submit the worksheet as documentation; it is provided as an option. Practices may submit their own report detailing their quality improvement strategy but should consult the QI Worksheet Instructions for guidance.

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS

1. Identify measures for QI. Select **aspects of performance** to improve:

- Must Demonstrate: (Core Criteria)
  - *PCMH QI 01-QI 04*
  - *BH 17* (not required unless pursing the Behavioral Health Integration Distinction)*

- Optional (Elective Criteria):
  - *PCMH QI 05*

2. Identify a baseline performance assessment. Choose a starting measurement period **(start and end date)** and identify a baseline performance measurement for each measure. Use performance measurements from the reports provided in PCMH QI 01-05 and BH 17*.

- Must Demonstrate: (Core Criteria)
  - *PCMH QI 08-QI 11*

- Optional (Elective Criteria):
  - *PCMH QI 13 and BH 18**

The baseline measurement period *must be* within **12 months** before evidence submission for check-in, or **within 24 months**, if there is a remeasurement period. The performance measurement *must be* a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

3. Establish a performance goal. Generate at least one performance goal for each identified measure. The specific goal *must be* a rate or number greater than the baseline performance assessment. Simply stating that the practice intends to improve does not meet the objective. **(Applies to QI 08-11,13 and BH 18*)** *For multi-sites: Organizational goals and actions for each site may be used if remeasurement and performance relate to the practice. Each practice must have its own baseline and performance results.*

4. Determine actions to work toward performance goals. List at least one action for each identified measure and the **activity start date.** The action date *must occur* after the date of the baseline performance measurement date. You may list more than one activity, but are not required to do so. **(Applies to QI 08-11,13 and BH 18*)**

5. Remeasure performance based on actions taken. Choose a remeasurement period and generate a new performance measurement after action was taken to improve. The remeasurement date *must occur* after the date of implementation and *must be* within **12 months** before evidence submission for check-in. The performance measurement *must be* a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).

6. Assess actions taken and describe improvement. Briefly describe how your practice site showed improvement on measures. Describe the assessment of the actions; correlate actions and the resulting improvement. **(Applies to QI 12 and 14)**

- Optional (Elective Criteria):
  - *PCMH QI 12 and QI 14*

*BH 17 and 18 are part of the optional PCMH Distinction for Behavioral Health Integration.

NCQA PCMH Quality Measurement and Improvement Worksheet

EXAMPLE: HOW TO COMPLETE A ROW

Example: Clinical Measure

Measure 1: Colorectal cancer (CRC) screening	**1.** **Measure selected for improvement; reason for selection**	*Reason:* **The USPSTF has recommended screening for colorectal cancer as a preventive test for adults. We want to increase percentage of patients who receive screening for CRC.**
	2./3. **Baseline performance measurement; numeric goal for improvement *(QI 01)***	*Baseline Start Date:* **5/1/16** *Baseline End Date:* **5/30/16** *Baseline Performance Measurement (% or #):* **175/547 = 32.0%** *Numeric Goal (% or #):* **58%**
	4. **Actions taken to improve and work toward goal; dates of initiation *(QI 08)*** *(Only 1 action required)*	*Action:* **Pop-up reminders were added to our EMR for patients due/overdue screening** *Date Action Initiated:* **7/1/16** *Additional Actions:* **Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.**
	5. **Remeasure performance *(QI 12)***	*Start Date:* **5/1/17** *End Date:* **5/30/17** *Performance Remeasurement (% or #):* **380/550 = 69.1%**
	6. **Assess actions; describe improvement. *(QI 12)***	**Since July 2016, there has been an increase of 37.1 percentage points in patients receiving CRC screening due to incentivizing providers and use of clinical decision support of EMR to indicate when patients are due for screening.**

NCQA PCMH Quality Measurement and Improvement Worksheet

Example: Identify a Disparity in Care for a Vulnerable Population

Vulnerable population: Uninsured women receive fewer mammograms	1. Identify a disparity in care for a vulnerable population	*Describe a comparison of a vulnerable population against the general population in which the vulnerable population received care/service at a lower performance:* Uninsured patients receive fewer mammograms than insured patients
	2./3. Baseline performance measurement and numeric goal for improvement *(QI 05)*	*Baseline Start Date:* 07/2016 *Baseline End Date:* 12/2016 *Baseline Performance Measurement for Vulnerable Population (% or #):* 25/100 = 25% of uninsured women receive mammograms *Baseline Performance Measurement for General Population (% or #):* 600/1000 = 60% of insured women receive mammograms *Numeric Goal (% or #):* 50% of uninsured women receive mammograms
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 13)* *(Only 1 action required)*	*Action:* Identified community resources for free or low-cost mammograms and shared with uninsured patients *Date Action Initiated:* 1/2017 *Additional Actions:*
	5. Remeasure Performance (QI 14)	*Start Date:* *End Date:* *Performance Remeasurement (% or #):*
	6. Assess actions; describe improvement. (QI 14)	During a 1-year measurement period from July–Dec 2016, there was a 30-percentage point difference in screening rates between insured and uninsured women. After compiling a list of community resources and sharing the information with our uninsured population, we saw a 15-percentage point increase in the number of uninsured women receiving mammograms during the remeasurement period of Jan–July 2017.

NCQA PCMH Quality Measurement and Improvement Worksheet

Practice Name:

Date Completed:

Use ONE Access Measure Identified in QI 010	
Measure 1:	
1. Measure selected for improvement; reason for selection	*Reason:*
2./3. Baseline performance measurement; numeric goal for improvement (QI 03)	*Baseline Start Date:* *Baseline End Date:* *Baseline Performance Measurement (% or #):* *Numeric Goal (% or #):*
4. Actions taken to improve and work toward goal; dates of initiation (QI 10) *(Only 1 action required)*	*Action:* *Date Action Initiated:* *Additional Actions:*
5. Remeasure performance *Note: Continuing QI is encouraged, but is not required for QI 10.*	*Start Date:* *End Date:* *Performance Remeasurement (% or #):*
6. Assess actions; describe improvement. *Note: Continuing QI is encouraged, but is not required for QI 10.*	

NCQA PCMH Quality Measurement and Improvement Worksheet

Use FIVE Measures Identified in QI 08, QI 09 and QI 11	
Measure 1:	
1. Measure selected for improvement; reason for selection	*Reason:*
2./3. Baseline performance measurement; numeric goal for improvement *(From QI 01, QI 02 or QI 04)*	*Baseline Start Date:* *Baseline End Date:* *Baseline Performance Measurement (% or #):* *Numeric Goal (% or #):*
4. Actions taken to improve and work toward goal; dates of initiation (QI 08, QI 09, or QI 11) *(Only 1 action required)*	*Action:* *Date Action Initiated:* *Additional Actions:*
5. Remeasure performance (QI 12)	*Start Date:* *End Date:* *Performance Re-Measurement (% or #):*
6. Assess actions; describe improvement. (QI 12)	

NCQA PCMH Quality Measurement and Improvement Worksheet

Measure 2:		
1.	**Measure selected for improvement; reason for selection**	*Reason:*
2./3.	**Baseline performance measurement; numeric goal for improvement** *(From QI 01, QI 02 or QI 04)*	*Baseline Start Date:* *Baseline End Date:* *Baseline Performance Measurement (% or #):* *Numeric Goal (% or #):*
4.	**Actions taken to improve and work toward goal; dates of initiation (QI 08, QI 09 or QI 11) (Only 1 action required)**	*Action:* *Date Action Initiated:* *Additional Actions:*
5.	**Remeasure performance (QI 12)**	*Start Date:* *End Date:* *Performance Remeasurement (% or #):*
6.	**Assess actions; describe improvement. (QI 12)**	

NCQA PCMH Quality Measurement and Improvement Worksheet

Measure 3:			
1. Measure selected for improvement; reason for selection	*Reason:*		
2./3. Baseline performance measurement; numeric goal for improvement (From QI 01, QI 02 or QI 04)	*Baseline Start Date:*	*Baseline End Date:*	
	Baseline Performance Measurement (% or #):		
	Numeric Goal (% or #):		
4. Actions taken to improve and work toward goal; dates of initiation (QI 08, QI 09 or QI 11) (Only 1 action required)	*Action:*		
	Date Action Initiated:		
	Additional Actions:		
5. Remeasure performance (QI 12)	*Start Date:*	*End Date:*	
	Performance Remeasurement (% or #):		
6. Assess actions; describe improvement. (QI 12)			

NCQA PCMH Quality Measurement and Improvement Worksheet

Measure 4:		
1. Measure selected for improvement; reason for selection	Reason:	
2./3. Baseline performance measurement; numeric goal for improvement (From QI 01, QI 02 or QI 04)	Baseline Start Date:	Baseline End Date:
	Baseline Performance Measurement (% or #):	
	Numeric Goal (% or #):	
4. Actions taken to improve and work toward goal; dates of initiation (QI 08, QI 09 or QI 11) (Only 1 action required)	Action:	
	Date Action Initiated:	
	Additional Actions:	
5. Remeasure performance (QI 12)	Start Date:	End Date:
	Performance Remeasurement (% or #):	
6. Assess actions; describe improvement. (QI 12)		

NCQA PCMH Quality Measurement and Improvement Worksheet

Measure 5:		
1.	Measure selected for improvement; reason for selection	Reason:
2./3.	Baseline performance measurement; numeric goal for improvement (From QI 01, QI 02 or QI 04)	Baseline Start Date: Baseline End Date: Baseline Performance Measurement (% or #): Numeric Goal (% or #):
4.	Actions taken to improve and work toward goal; dates of initiation (QI 08, QI 09 or QI 11) (Only 1 action required)	Action: Date Action Initiated: Additional Actions:
5.	Remeasure performance (QI 12)	Start Date: End Date: Performance Remeasurement (% or #):
6.	Assess actions; describe improvement. (QI 12)	

NCQA PCMH Quality Measurement and Improvement Worksheet

Use ONE Measure Identified for Disparity in Care or Service

Vulnerable population:	*Describe a comparison of a vulnerable population against the general population in which the vulnerable population received care/service at a lower performance:*
Disparity:	
1. Measure selected for improvement; reason for selection	
2./3. Baseline performance measurement, numeric goal for improvement. (QI 05)	*Baseline Start Date:* *Baseline End Date:* *Baseline Performance Measurement for Vulnerable Population (% or #):* *Baseline Performance Measurement for General Population (% or #):* *Numeric Goal (% or #):*
4. Actions taken to improve and work toward goal; dates of initiation (QI 13) *(Only 1 action required)*	*Action:* *Date Action Initiated:* *Additional Actions:*
5. Remeasure performance. (QI 14)	*Start Date:* *End Date:* *Performance Re-Measurement (% or #):*
6. Assess actions and describe improvement. (QI 14)	

NCQA PCMH Quality Measurement and Improvement Worksheet

Use TWO Behavioral Health Measures Identified in BH 17

BH Measure 1:	Reason:				
1. Measure selected for improvement; reason for selection					
2./3. Baseline performance measurement; numeric goal for improvement (From BH 17)	Baseline Start Date: Baseline End Date: Baseline Performance Measurement (% or #): Numeric Goal (% or #):				
4. Actions taken to improve and work toward goal; dates of initiation (BH 18) (Only 1 action required)	Action: Date Action Initiated: Additional Actions:				
5. Remeasure performance Note: Continuing QI is encouraged, but is not required for BH 18.	Start Date: End Date: Performance Remeasurement (% or #):				
6. Assess actions; describe improvement. Note: Continuing QI is encouraged, but is not required for BH 18.					

NCQA PCMH Quality Measurement and Improvement Worksheet

BH Measure 2:		
1. Measure selected for improvement; reason for selection	*Reason:*	
2./3. Baseline performance measurement; numeric goal for improvement *(From BH 17)*	*Baseline Start Date:* *Baseline End Date:* *Baseline Performance Measurement (% or #):* *Numeric Goal (% or #):*	
4. Actions taken to improve and work toward goal; dates of initiation *(BH 18)* *(Only 1 action required)*	*Action:* *Date Action Initiated:* *Additional Actions:*	
5. Remeasure performance *Note: Continuing QI is encouraged, but is not required for BH 18.*	*Start Date:* *End Date:* *Performance Remeasurement (% or #):*	
6. Assess actions; describe improvement. *Note: Continuing QI is encouraged, but is not required for BH 18.*		

E. Recognition Process

NCQA PCMH Recognition Toolkit Webpage:

Toolkit: Getting Started

NCQA has developed a toolkit to help you get started on the PCMH Recognition process. In it you find information on:

- The PCMH model.
- NCQA program requirements and process.
- Enrolling in NCQA Recognition.
- Education and training resources.
- State and commercial support and initiatives.
- What to expect after Recognition.
- Glossary of common terms.

Get started with NCQA PCMH Recognition. Download the toolkit today.

http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/toolkit

NCQA PCMH Recognition Pricing Webpage:

NCQA has established pricing for the redesigned PCMH recognition program and standards released in 2017. You can find pricing information on:

- Single Site Pricing.
- Multi-Site Pricing.
- Partners in Quality Discount.

http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/getting-recognized/get-started/pcmh-pricing

Patient-Centered Medical Home (PCMH)
Accelerated Renewal (Review or Attestation) Table for Transition to the Redesigned Program

If you are an NCQA-Recognized PCMH practice approaching renewal, transition to the redesigned PCMH program will save you time. Practices that achieved recognition in PCMH 2011 at Level 1, 2 or 3, or PCMH 2014 at Level 1 or 2, can earn recognition at an accelerated pace. These practices will be able to attest to meeting certain criteria without providing the evidence required of practices seeking recognition for the first time.

To achieve recognition, practices must:
1. Meet all 40 core criteria *and*
2. Earn 25 credits in elective criteria across 5 of 6 concepts.

In the tables below, "Review or Attestation" (far right column) indicates which criteria require submission of evidence and which criteria simply allow attestation.

Note: *The evaluator may ask practices to verify a selection of attestation responses during a virtual review.*

To get started, enroll through the Q-PASS system at qpass.ncqa.org. You will be assigned an NCQA representative who will be your single point of contact and help schedule your evaluations.

What is expected for criteria that require evidence?

For criteria identified as "Review," practices should follow the current PCMH Standards & Guidelines and submit evidence in Q-PASS, as indicated. Practices should prepare to demonstrate virtual review-eligible evidence during the virtual review.

What is expected for criteria where attestation is allowed?

For criteria marked "attestation," all you have to do is attest that your practice is still performing PCMH activities in these criteria. You will not need to demonstrate documentation or evidence. For each attestable criterion, practices enter a title into the text box, label the name as *Accelerated Renewal—Attestation,* and enter the text below:

"Our practice achieved PCMH [201X] Level [X] recognition as a patient-centered medical home. We attest that our responses reflect our practice's current operations. Documentation to support these responses will be provided upon request."

You will not need to manually enter the attestation text for each criterion. After you enter the Attestation for the first criteria, you may select "Link Evidence" and type the title *Accelerated Renewal* into the text box for additional attestable criterion.

What if my practice is PCMH 2014, Level 3?

If you are a PCMH 2014 Level 3 practice, you may bypass submission of evidence for criteria entirely and skip directly to the Annual Reporting phase of recognition. Do this by enrolling in Q-PASS. You will be assigned an NCQA representative, who will explain the next steps.

Shared and Site-Specific Evidence

Some evidence (such as documented processes and demonstration of capability) may be submitted once for all sites or site groups. Other evidence (such as evidence of implementation, examples, reports, Record Review Workbooks and Quality Improvement Workbooks) must be site-specific. Site -specific data may be combined and submitted once on behalf of all sites or site groups. Some criteria require a combination of shared and site-specific evidence, which is labeled "Partially Shared" in the tables below.

	Core	Electives		
		1 Credit	2 Credits	3 Credits
Review	22 criteria	12 criteria	14 criteria	0 criteria
Attestation	18 criteria	26 criteria	7 criteria	1 criterion
Total Criteria (100 criteria)	40 criteria	38 criteria	21 criteria	1 criterion

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)			
Criteria	Criteria Title	Shared or Site-Specific?	Review or Attestation?
Competency A: Practice Organization, Team Roles and Training			
TC 01* (Core)	PCMH Transformation Leads	Shared	Review
TC 02 (Core)	Structure & Staff Responsibilities	Shared	Attestation
TC 03* (1 Credit)	External PCMH Collaborations	Shared	Attestation
TC 04* (2 Credits)	Patient/Family/Caregiver Involvement in Governance	Shared	Review
TC 05 (2 Credits)	Certified EHR System	Shared	Attestation
Competency B: Care Team Communication and Functioning			
TC 06 (Core)	Individual Patient Care Meetings/Communication	Partially Shared**	Review
TC 07 (Core)	Staff Involvement in Quality Improvement	Shared	Attestation
TC 08* (2 Credits)	Behavioral Health Care Manager	Shared	Review
Competency C: Patient/Family/Caregiver Orientation			
TC 09 (Core)	Medical Home Information	Shared	Attestation

*New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

KNOWING AND MANAGING YOUR PATIENTS (KM)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Review or Attestation?**
Competency A: Comprehensive Patient/Population Knowledge			
KM 01 (Core)	Problem Lists	Site-Specific	Attestation
KM 02 (Core) *F and G are new*	Comprehensive Health Assessment	Partially Shared**	Review
KM 03 (Core)	Depression Screening	Partially Shared**	Review
KM 04* (1 Credit)	Behavioral Health Screenings	Partially Shared**	Review
KM 05* (1 Credit)	Oral Health Assessment & Services	Partially Shared**	Review
KM 06* (1 Credit)	Predominant Conditions & Concerns	Shared	Attestation
KM 07* (2 Credits)	Social Determinants of Health	Site-Specific	Review
KM 08* (1 Credit)	Patient Materials	Shared	Review
Competency B: Cultural Competency			
KM 09 (Core)	Diversity	Site-Specific	Attestation
KM 10 (Core)	Language	Site-Specific	Attestation
KM 11 (1 Credit) *A and C are new*	Population Needs	Shared	Review
Competency C: Proactive Population Management			
KM 12 (Core)	Proactive Reminders	Shared	Review
KM 13* (2 Credits)	Excellence in Performance	Site-Specific	Review
Competency D: Medication Management			
KM 14 (Core)	Medication Reconciliation	Site-Specific	Attestation
KM 15 (Core)	Medication Lists	Site-Specific	Attestation
KM 16 (1 Credit)	New Prescription Education	Site-Specific	Attestation
KM 17 (1 Credit)	Medication Responses & Barriers	Site-Specific	Attestation
KM 18* (1 Credit)	Controlled Substance Database Review	Shared	Review
KM 19* (2 Credits)	Prescription Claims Data	Shared	Review
Competency E: Evidence-Based Decision Support			
KM 20 (Core)	Clinical Decision Support	Shared	Review
Competency F: Community Resources			
KM 21* (Core)	Community Resource Needs	Shared	Attestation
KM 22 (1 Credit)	Access to Educational Resources	Shared	Attestation
KM 23* (1 Credit)	Oral Health Education	Shared	Attestation
KM 24 (1 Credit)	Shared Decision-Making Aids	Shared	Attestation
KM 25* (1 Credit)	School/Intervention Agency Engagement	Shared	Review
KM 26 (1 Credit)	Community Resource List	Shared	Attestation
KM 27 (1 Credit)	Community Resource Assessment	Shared	Attestation
KM 28* (2 Credits)	Case Conferences	Shared	Review

 *New criteria in 2017 edition of PCMH Standards & Guidelines.
 **Documented processes may be shared, but all other evidence must be site-specific.

PATIENT-CENTERED ACCESS AND CONTINUITY (AC)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Review or Attestation?**
Competency A: Access to Clinical Advice and Appointments			
AC 01* (Core)	Access Needs & Preferences	Partially Shared**	Review
AC 02 (Core)	Same-Day Appointments	Partially Shared**	Review
AC 03 (Core)	Appointments Outside Business Hours	Shared	Attestation
AC 04 (Core)	Timely Clinical Advice by Telephone	Shared	Attestation
AC 05 (Core)	Clinical Advice Documentation	Partially Shared**	Review
AC 06 (1 Credit)	Alternative Appointments	Partially Shared**	Attestation
AC 07 (1 Credit)	Electronic Patient Requests	Shared	Attestation
AC 08 (1 Credit)	Two-Way Electronic Communication	Shared	Attestation
AC 09* (1 Credit)	Equity of Access	Site-Specific	Review
Competency B: Care Continuity and Empanelment			
AC 10 (Core)	Personal Clinician Selection	Shared	Attestation
AC 11 (Core)	Patient Visits with Clinician/Team	Site-Specific	Attestation
AC 12 (2 Credits)	Continuity of Medical Record Information	Shared	Attestation
AC 13* (1 Credit)	Panel Size Review & Management	Partially Shared**	Review
AC 14* (1 Credit)	External Panel Review & Reconciliation	Partially Shared**	Review

 *New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

CARE MANAGEMENT AND SUPPORT (CM)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Review or Attestation?**
Competency A: At-Risk Patients for Care Management			
CM 01 (Core)	Identifying Patients for Care Management	Shared	Review
CM 02 (Core)	Monitoring Patients for Care Management	Site-Specific	Review
CM 03* (2 Credits)	Comprehensive Risk-Stratification Process	Shared	Review
Competency B: Care Planning			
CM 04 (Core)	Person-Centered Care Plans	Site-Specific	Attestation
CM 05 (Core)	Written Care Plans	Site-Specific	Attestation
CM 06 (1 Credit)	Patient Preferences & Goals	Site-Specific	Attestation
CM 07 (1 Credit)	Patient Barriers to Goals	Site-Specific	Attestation
CM 08 (1 Credit)	Self-Management Plans	Site-Specific	Attestation
CM 09* (1 Credit)	Care Plan Integration	Shared	Review

*New criteria in 2017 edition of PCMH Standards & Guidelines.

CARE COORDINATION AND CARE TRANSITIONS (CC)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Review or Attestation?**
Competency A: Lab and Imaging Test Management			
CC 01 (Core)	Lab & Imaging Test Management	Partially Shared**	Review
CC 02 (1 Credit)	Newborn Screenings	Partially Shared**	Attestation
CC 03* (2 Credits)	Appropriate Use for Labs & Imaging	Shared	Review
Competency B: Patient Referral Management			
CC 04 (Core)	Referral Management	Partially Shared**	Review
CC 05* (2 Credits)	Appropriate Referrals	Shared	Review
CC 06* (1 Credit)	Commonly Used Specialists Identification	Site-Specific	Review
CC 07 (2 Credits)	Performance Information for Specialist Referrals	Shared	Review
CC 08 (1 Credit)	Specialist Referral Expectations	Shared	Attestation
CC 09 (2 Credits)	Behavioral Health Referral Expectations	Shared	Review
CC 10 (2 Credits)	Behavioral Health Integration	Partially Shared**	Attestation
CC 11* (1 Credit)	Referral Monitoring	Partially Shared**	Attestation
CC 12 (1 Credit)	Co-Management Arrangements	Site-Specific	Attestation
CC 13* (2 Credits)	Treatment Options & Costs	Partially Shared**	Review
Competency C: Coordinate Care Transitions			
CC 14* (Core)	Identifying Unplanned Hospital & ED Visits	Partially Shared**	Attestation
CC 15 (Core)	Sharing Clinical Information	Partially Shared**	Attestation
CC 16 (Core)	Post-Hospital/ED Visit Follow-Up	Partially Shared**	Attestation
CC 17* (1 Credit)	Acute Care After Hours Coordination	Partially Shared**	Review
CC 18 (1 Credit)	Information Exchange during Hospitalization	Partially Shared**	Attestation
CC 19 (1 Credit)	Patient Discharge Summaries	Partially Shared**	Attestation
CC 20 (1 Credit)	Care Plan Collaboration for Practice Transitions	Site-Specific	Attestation
CC 21 (Maximum 3 Credits)	External Electronic Exchange of Information	Shared	Attestation

 *New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT (QI)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Review or Attestation?**
Competency A: Performance Measurement			
QI 01 (Core) *D is New	Clinical Quality Measures	Site-Specific	Review
QI 02 (Core)	Resource Stewardship Measures	Site-Specific	Review
QI 03 (Core)	Appointment Availability Assessment	Partially Shared**	Review
QI 04 (Core)	Patient Experience Feedback	Site-Specific	Review
QI 05 (1 Credit)	Health Disparities Assessment	Site-specific	Attestation
QI 06 (1 Credit)	Validated Patient Experience Survey Use	Shared	Attestation
QI 07 (2 Credits)	Vulnerable Patient Feedback	Site-specific	Attestation
Competency B: Quality Improvement			
QI 08 (Core) *D is New	Goals & Actions to Improve Clinical Quality Measures	Site-Specific	Review
QI 09 (Core)	Goals & Actions to Improve Resource Stewardship Measures	Site-Specific	Review
QI 10 (Core)	Goals & Actions to Improve Appointment Availability	Site-Specific	Review
QI 11 (Core)	Goals & Actions to Improve Patient Experience	Site-Specific	Review
QI 12 (2 Credits)	Improved Performance	Site-Specific	Review
QI 13 (1 Credit)	Goals & Actions to Improve Disparities in Care/Service	Site-Specific	Attestation
QI 14 (2 Credits)	Improved Performance for Disparities in Care/Service	Site-Specific	Attestation
Competency C: Reporting Performance			
QI 15 (Core)	Reporting Performance Within the Practice	Partially Shared**	Review
QI 16 (1 Credit)	Reporting Performance Publicly or with Patients	Partially Shared**	Attestation
QI 17 (2 Credits)	Patient/Family/Caregiver Involvement in Quality Improvement	Shared	Review
QI 18 (2 Credits)	Reporting Performance Measures to Medicare/Medicaid	Shared	Attestation
QI 19* (Maximum 2 credits)	Value-Based Contract Agreements A. Up-Side Risk Contract B. Two-Sided Risk Contract	Shared	Attestation

 *New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

Review vs. Attestation (Core, 1 Credit, 2 Credits, 3 Credits) Table

	Core	Electives — 1 Credit	Electives — 2 Credits	Electives — 3 Credits
Review	TC 01*, TC 06, KM 02**, KM 03, KM 12, KM 20, AC 01*, AC 02, AC 05, CM 01, CM 02, CC 01, CC 04, QI 01**, QI 02, QI 03, QI 04, QI 08**, QI 09, QI 10, QI 11, QI 15	KM 04*, KM 05*, KM 08*, KM 11**, KM 18*, KM 25*, AC 09*, AC 13*, AC 14*, CM 09*, CC 06*, CC 17*	TC 04*, TC 08*, KM 07*, KM 13*, KM 19*, KM 28*, CM 03*, CC 03*, CC 05*, CC 07, CC 09, CC 13*, QI 12, QI 17	None
	22 criteria	12 criteria	14 criteria	0 criteria
Attestation	TC 02, TC 07, TC 09, KM 01, KM 09, KM 10, KM 14, KM 15, KM 21*, AC 03, AC 04, AC 10, AC 11, CM 04, CM 05, CC 14, CC 15, CC 16	TC 03*, KM 06, KM 16, KM 17, KM 22, KM 23*, KM 24, KM 26, KM 27, AC 06, AC 07, AC 08, CM 06, CM 07, CM 08, CC 02, CC 08, CC 11*, CC 12, CC 18, CC 19, CC 20, QI 05, QI 06, QI 13, QI 16	TC 05, AC 12, CC 10, QI 07, QI 14, QI 18, QI 19*	CC 21
	18 criteria	26 criteria	7 criteria	1 criterion
Total	40 criteria	38 criteria	21 criteria	1 criterion

*New criteria in 2017 edition of PCMH Standards & Guidelines.
**Part of the criteria is new in 2017 edition of PCMH Standards & Guidelines.

PCMH Accelerated Renewal Table (Last updated June 2017)

Redesign Goals

NCQA is redesigning our PCMH Recognition program. The redesigned program—to be launched April 3, 2017—includes ongoing status as a recognized practice with annual check-in and reporting, replacing the current program's three-year recognition cycle. Our redesigned program offers:

- **Flexibility.** Practices take the path to recognition that suits their strengths, schedule and goals.

- **Personalized service.** Practices get more interaction with NCQA. Each practice is assigned a NCQA Representative who'll serve as the primary NCQA contact and "go-to" guide.

- **User-friendly approach**. Reporting requirements remain meaningful, but with simplified reporting and less paperwork.

- **Continuous improvement.** Annual checks help practices strengthen as medical homes by frequently reviewing progress and encouraging performance improvement.

- **Alignment with changes in health care.** The program aligns with current public and private initiatives and can adapt to future changes.

Our recognition process has three parts:

1. **Commit.** When a practice signs up to work with NCQA, they complete an assessment online. The practice receives guidance from their NCQA Representative to determine their evaluation plan and schedule.

2. **Transform.** Practices gradually transform, building upon their prior success. During this time, they demonstrate progress by submitting documentation and data to be evaluated by NCQA. Practices submit through a newly streamlined system designed to reduce paperwork and administrative hassles.

   Along the way, NCQA conducts virtual reviews—check-ins—with the practice to gauge progress and to discuss next steps in the evaluation. The virtual reviews—conducted via screen sharing technology—give practices immediate and personalized feedback on what is going well and what needs to improve. This makes NCQA evaluations more educational and collaborative.

3. **Succeed.** The practice continues to implement and enhance their PCMH model to meet the needs of patients. Each year, the practice checks in with NCQA to demonstrate ongoing activities consistent with the PCMH model and the implementation of PCMH standards. This reporting includes attesting to certain policies and procedures and submission of key data.

New Online Platform

NCQA will launch a new online platform to support the new recognition process. Practices will be able to apply for recognition, sign agreements, access training and other resources, submit documentation, update and confirm data, track evaluations completed, print certificates and sustain their recognition using this system. The new platform will be released on April 3, 2017.

Sustaining Your Recognition

This document focuses on data reporting requirements for the annual check-in. Practices will demonstrate they continue to align with recognition requirements by submitting data and documentation on these critical aspects of PCMH:

- Patient-centered access.
- Team-based care.
- Population health management.
- Care management.

- Care coordination and care transitions.
- Performance measurement and quality improvement.

Practices will also have the opportunity to submit data and documentation on special topics, such as behavioral health.

Annual Check-In Process: Data Reporting, Audit and Decision

- Practices will use the new online platform for submission of documentation that supports reporting requirements at their annual check-in.
- Practices must complete a self-assessment at the annual check-in, verifying core features of the medical home have been sustained.
- Practices must meet the minimum number of requirements for each category.
- NCQA reviews submission and notifies practices of their sustained recognition status.
- NCQA will randomly select practices for audit to validate attestation and submitted documentation and data.
- Practices that do not submit data on time or fail to meet other requirements may have their recognition status suspended or revoked. That may include having their recognition status on NCQA's Web site changed to "Not Recognized."

Annual Check-in Requirements (Annual Assessment and Reporting Requirements)

Practices will attest to core criteria based on the current PCMH program, which consists of key expectations that recognized practices must meet as a medical home. In addition, the PCMH Annual Reporting Requirements table (starting on page 3 of this document) outlines reporting options for eligible recognized practices through successfully transformation and achievement of PCMH 2014 Level 3 recognition.

Annual reporting requirements may be removed, modified or added over time. Practices will be notified of changes and given time to prepare data and documentation.

Reporting Measures to NCQA?

NCQA has identified measures acceptable for annual reporting and will update this list periodically. The list of measures from which to choose can be found here.

Electronic Clinical Quality Measures

Electronic Clinical Quality Measures (eCQMs) are standardized performance measures from electronic health records (EHR) or health information technology systems. Beginning with launch of the PCMH 2017 program, practices will have the option to submit electronic clinical quality measures (eCQMs) to NCQA in support of their recognition process. The identified measures can be submitted through electronic health records, health information exchanges, qualified clinical data registries (QCDRs) and data analytics companies as long as they can use the electronic specifications as defined by the Centers for Medicare & Medicaid Services for the ambulatory quality reporting programs. More details about the submission process to NCQA will be forthcoming.

Patient-Centered Access

Has your practice continued to monitor appointment access?

Choose 1 option from the 3 below to submit for your annual check-in.

Option #	Requirements	Data/Documentation Required CD= Corporate Data Accepted SS = Site-Specific Data Required
1	**Monitor appointment access on patient experience survey**	If your patient experience survey includes questions related to access, provide the following: 1. Copy of the patient experience survey tool. Practices that use a CAHPS survey do not need to provide the survey. (Documentation, CD) 2. Number of patients surveyed in the past 12 months. (Data, SS) 3. Number of completed surveys in the past 12 months. (Data, SS) 4. A report with results from the access questions. (Documentation; CD, if report is stratified by site.)
2	**Provide third next available appointment**	1. Provide the third next available appointment for urgent appointments. (Data, SS) 2. Provide the third next available appointment for routine appointments (new patient physical, routine exam, return visit exam). For routine requests, exclude any appointments blocked for same-day or urgent visits (since they are "blocked off" the schedule). (Data, SS) Practices may use the Institute for Healthcare Improvement's (IHI) method to calculate the third next available appointment. • Sample all clinicians on the team once a week, on the same day, at the same time of day, *for at least one month* between annual check-ins. • Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. • Report the average number of days for all physicians sampled. ***Note:*** *Count calendar days (e.g. include weekends) and days off.*

Option #	Requirements	Data/Documentation Required CD= Corporate Data Accepted SS = Site-Specific Data Required
3	**Demonstrate other method of monitoring access for urgent and routine appointments**	1. Demonstrate a method used for enhanced patient scheduling/same-day service. (Documentation, SS) Examples may include: • A report showing monitoring of access to both urgent and routine (new patient physical, routine exam, return visit exam) appointments using a method other than option 2. The method must exclude use of appointment times from cancellations and no-shows and demonstrate a minimum of 5 consecutive days. • A summary or report of appointments designated for same-day urgent and routine visits. ***Note:*** *Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement. Conducting a walk-in clinic does not meet the requirement. There should be appointments available to allow for patient planning needs.*

Team-Based Care

Has your practice continued to use a team-based approach to provide primary care?
Choose 1 option from the 2 below to submit for your annual check-in.

Option #	Requirements	Data/Documentation Required CD= Corporate Data Accepted SS = Site-Specific Data Required
1	**Attest to pre-visit planning activities**	1. Does your practice anticipate and plan for upcoming visits? Check any of the following formats that your practice uses. (CD) ☐ Team meetings/huddles. ☐ Structured communication. ☐ Dashboard in the EHR. ☐ Checklist. ☐ Appointment notes. ☐ Other _____
2	**Measure team-based care in your employee experience/satisfaction survey (e.g., collaboration, communication, team dynamics)**	If your employee experience/satisfaction survey covers, at a minimum, collaboration, communication and team dynamics, provide the following: 1. Copy of the employee experience survey tool. (Documentation, CD) 2. Number of employees (staff/clinicians) surveyed in the past 12 months. (Data; CD, at least 1 employee from each site must be included) 3. Number of employees (staff/clinicians) who completed the survey in the past 12 months. (Data; CD, at least 1 employee from each site must be included) 4. Report of results for all questions related to collaboration, communication, team dynamics. (Documentation; CD, report does not need to be stratified by site)

Population Health Management

Has your practice continued to proactively remind patients of upcoming services?

Submit the information requested for your annual check-in.

	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required
Required	**Provide reminders for at least 5 different services across at least 2 categories below:** • Preventive care services. • Immunizations. • Chronic or acute care services. • Patients not seen regularly. • Patients who need medication monitoring or alerts.	For each reminder: 1. Identify the service for which patients received a reminder. (CD) • Preventive care services. • Immunizations. • Chronic or acute care services. • Patients not seen regularly. • Patients who need medication monitoring or alerts. 2. Provide frequency of identification of patients/sending reminders to patients (monthly, quarterly, annually, other). (CD) ***Note:*** *If 75 percent of clinicians have DRP or HSRP recognition, practice receives credit for three chronic care services.*

Care Management

Has your practice continued to identify patients who may benefit from care management?

Submit the information requested for your annual check-in.

	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required
Items 1 and 2 are required; items 3-5 are optional.	**Identify patients who may benefit from care management**	1. The practice selects which of the following are considered in their criteria for identifying patients who may benefit from care management. Practices must use at least two from the list below. (CD) • Behavioral health conditions. • High cost/high utilization. • Poorly controlled or complex conditions. • Social determinants of health. • Referrals by outside organizations, practice staff or patient/family/caregiver. 2. The number of patients who were identified for care management using the criteria selected above. (Data, SS) 3. The total number of patients in the practice. (Optional data, SS) 4. The number of patients who have had an encounter with the practice in the past year. (Optional data, SS) 5. The number of patients identified for care management who have had an encounter with the practice in the past year. (Optional data, SS)

Care Coordination and Care Transitions

Has your practice continued to coordinate care with labs, specialists, institutional settings or other care facilities?

Choose 1 option from the 4 below to submit for your annual check-in. You must also respond to the attestation questions.

Option #	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required	Manual Option

Response Required	Attest to test and referral tracking activities	The practice shares whether there is a process in place for referral tracking and follow-up, test tracking and follow-up and care transitions. (CD)
		
		1. Does your practice use a continuous process for the following? Check any that apply:
		
		   • Tracking labs.
		   • Tracking imaging tests.
		   • Transitions of care.
		
		2. Do you track labs until results are available, flagging and following up on overdue results?
		
		3. Do you track imaging tests until results are available, flagging and following up on overdue results?
		
		4. Do you track referrals until specialist reports are available, flagging and following up on overdue reports? (Tracking, flagging and following up on referrals is a required factor to achieve and sustain PCMH recognition.)
			No alternative reporting method available.

		Referral Tracking and Follow-Up	
1	Track percentage of referrals with a final report	The practice provides: 1. *Denominator:* The number of referral orders sent to specialists. (Data, SS) 2. *Numerator:* The number of consultant reports received from specialists from the referral order list above (count one report per referral). (Data, SS) 3. *Reporting period:* The number of months of data provided (3–12 months). (Data, SS)	**IF USING MANUAL DATA** 1. <u>Denominator: 30</u> How to select the referral request to specialists. Pick 30 consecutive referral orders to specialists from the past year (within 12 months prior to the reporting date). (Data, SS) 2. <u>Numerator: Number of consultant reports received back from orders.</u> Search the chart or tracking tool for the 30 referrals and report how many have a consultant report that came back to the practice from

Option #	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required	Manual Option
			the referral (one report per order). (Data, SS) **No alternative reporting method available.**
2	**Measure care coordination in patient experience survey**	If your patient experience survey includes questions related to care coordination, provide the following: 1. Copy of the patient experience survey tool. Practices that use a CAHPS survey do not need to provide the survey. (Documentation, CD) 2. Number of patients surveyed in the past 12 months. (Data, SS) 3. Number of completed surveys in the past 12 months. (Data, SS) 4. A report with results from the care coordination questions. (Documentation, CD, if report is stratified.)	

Test Tracking and Follow-Up

Option #	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required	Manual Option
3	**Track lab and imaging tests until results are available**	The practice provides (separately for lab and imaging orders/results): **Labs** 1. Denominator: The number of lab orders sent in the prior 12 months. (Data, SS) 2. Numerator: The number of reports received from lab orders (count one report per order, with full results, even if reports for individual portions of an order come back at different times). (Data, SS) 3. Reporting period: The number of months of data provided (3–12 months). (Data, SS) **Imaging** 1. *Denominator:* The number of imaging orders sent in the prior 12 months. (Data, SS) 2. *Numerator:* The number of reports received from imaging orders (count one report per order, with full results, even if reports for	**IF USING MANUAL DATA** (30 each for lab and imaging orders) 1. *Denominator:* 30 each for lab and imaging orders *(separate the lab orders from the imaging orders).* Pick 30 consecutive lab orders and 30 consecutive imaging orders from the past year (within 12 months prior to the reporting date). (Data, SS) 2. *Numerator:* Number of lab reports received back from orders. Search the chart or tracking tool for the 30 lab orders and report how many had a lab report that came back to the practice from the lab order (one report per order, full results of all tests). (Data, SS) 3. *Numerator:* Number of imaging reports received back from orders. Search the chart or tracking tool for the 30 imaging orders and report how many have an

Option #	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required	Manual Option
		imaging report that came back to the practice from the imaging order (one report per order, full results of all tests). (Data, SS) 3. *Reporting period:* The number of months of data provided (3–12 months). (Data, SS)	imaging report that came back to the practice from the imaging order (one report per order, full results of all tests). (Data, SS)
		Care Transitions	
4	**Measure percentage of care transitions for which a summary of care document or discharge instructions have been received**	1. *Denominator:* The number of patient transitions identified by the practice (transitioned by a facility, including hospitals, ERs, skilled nursing facilities and surgical centers) within the prior 12-month period. (Data, SS) ***Note:*** *Facilities other than hospitalizations and ED visits may be excluded.* 2. *Numerator:* The number of transitions in the denominator for which practice received discharge instructions or a summary of care document, including the following data, as applicable: transitioning provider contact information, procedures, encounter diagnosis, laboratory tests, vital signs, care plan goals and instructions, discharge instructions. (Data, SS) 3. *Reporting period:* The number of months of data provided (3–12 months). (Data, SS) ***Note:*** *This information is not required to be transmitted electronically.*	**IF USING MANUAL DATA** 1. *Denominator:* 30 How to select care transitions. Pick 30 consecutive care transitions from the past year (within 12 months prior to the reporting date). (Data, SS) 2. *Numerator:* Number of summary care documents/discharge instructions. Search the chart or tracking tool for the 30 care transitions and report how many have discharge instructions or a summary of care document associated with them. (Data, SS)

Performance Measurement and Quality Improvement

Has your practice continued to collect and use performance measurement data for quality improvement activities?

Practices must submit the information requested for your annual check-in.

Required	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required

Required	Measure performance	**Data/Drop-down boxes *or* supported by prevalidation**
		At least annually, the practice measures or receives data on:
		1. At least five clinical quality measures across two of three categories (*eCQMs may submit only three measures*):
		   • Immunizations.
		   • Other preventive care.
		   • Chronic/acute care.
		Note: *Clinical quality measures may not all come from one measure category.*
		2. At least one resource stewardship/utilization/health care cost measure (*eCQMs submit 1 measure*).
		3. At least one patient experience measure or documentation of using a patient advisory council or other method of patient feedback.
		
		For measures, submit:
		1. The measure category (drop-down box). (CD)
		2. The measure name. (CD)
		3. The denominator description for the measure. (CD)
		4. The numerator description for the measure. (CD)
		5. The number of patients in the denominator (after exclusions). (Data, SS)
		6. The number of patients in the numerator. (Data, SS)
		7. *Reporting period:* The number of months for which the denominator is calculated (3–12 months). (Data, SS)
		8. Was the measure a target for quality improvement in the past year? (Yes/No).

	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required
Required	Attest to quality improvement activities	Fill out the QI worksheet for the top three priorities. (CD) What are your practice's top three QI activities? [open field] 1. 2. 3.

Special Topic: Behavioral Health

Addressing the behavioral health needs of patients is an important aspect of comprehensive, whole-person care. In this section, NCQA seeks simply to understand the models used by recognized practices.

Practices must submit the information about behavioral health based on the information outlined below. This special topic section is to help move practices towards better integration of behavioral health, but is not evaluated/scored to sustain PCMH recognition.

Requirements	Options	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required
Informational	**BH1. Identify eCQMs**	1. Identify which eCQMs are monitored by the practice and reported. *(Note: drop-down menu will be available on the platform.)* (Data, SS)

Informational	**BH2. Identify how behavioral health needs of patients are addressed**	1. How does your practice address behavioral health needs of patients with the following behavioral health specialists? Check all that apply. (CD)
		
		a. Doctors of medicine (MD) or doctors of osteopathy (DO) who are state certified or licensed in psychiatry and/or addiction medicine
		  ☐ Agreements with external behavioral health specialists
		  ☐ Co-location with behavioral health specialist
		  ☐ Behavioral health specialist is integrated within the practice
		  ☐ None of the above
		  ☐ Other _____
		
		b. Advanced practice registered nurses (APRN) (including nurse practitioners and clinical nurse specialists)
		  ☐ Agreements with external behavioral health specialists
		  ☐ Co-location with behavioral health specialist
		  ☐ Behavioral health specialist is integrated within the practice
		  ☐ None of the above
		  ☐ Other _____
		
		c. Doctoral or master's-level psychologists who are state certified or licensed
		  ☐ Agreements with external behavioral health specialists
		  ☐ Co-location with behavioral health specialist
		  ☐ Behavioral health specialist is integrated within the practice
		  ☐ None of the above
		  ☐ Other _____

Requirements	Options	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required
		d. Doctoral or master's-level clinical social workers who are state certified or licensed. ☐ Agreements with external behavioral health specialists ☐ Co-location with behavioral health specialist ☐ Behavioral health specialist is integrated within the practice) ☐ None of the above ☐ Other _____ e. Doctoral or master's-level marriage and family counselors who are state certified, registered or licensed by the state to practice independently. ☐ Agreements with external behavioral health specialists ☐ Co-location with behavioral health specialist ☐ Behavioral health specialist is integrated within the practice ☐ None of the above ☐ Other _____ f. Doctoral or master's-level alcohol and drug counselors who are state certified, registered or licensed by the state to practice independently. ☐ Agreements with external behavioral health specialists ☐ Co-location with behavioral health specialist ☐ Behavioral health specialist is integrated within the practice ☐ None of the above ☐ Other _____ 2. Provide a description of the patient "hand-off" process.

	Requirements	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required	Manual Option
Informational	**BH3. Monitor access to appointments for behavioral healthcare (for all referrals combined)**	Include data for all patients referred to any behavioral health specialist and report the following data: 1. *Denominator:* The number of initial behavioral health referrals. Include referrals to integrated behavioral health specialists, as well as to specialists in the community. (Data, SS) 2. *Numerator:* The number of referrals for which an appointment was scheduled. (Data, SS) 3. *Numerator:* The number of completed appointments or patients seen within 10 days of the referral. If the practice has an integrated behavioral health specialist and performs a warm hand-off at the time of the referral (patient is seen by the specialist on the same day the referral is made) this counts as an initial appointment. (Data, SS) 4. *Reporting period:* The number of months of data provided (3–12 months). (Data, SS)	**IF USING MANUAL DATA** 1. *Denominator: 30* How to select behavioral health referrals. Pick 30 consecutive behavioral health referrals from the past year (within 12 months prior to the reporting date). (Data, SS) 2. *Numerator:* Number of referrals for which an appointment was scheduled. Search the chart or tracking tool for the 30 behavioral health referrals and report how many had an appointment scheduled. (Data, SS) 3. *Numerator:* Number of completed appointments/patient seen within 10 days of the referral. Search the chart or tracking tool for the 30 behavioral health referrals and report how many have appointments were completed or patients were seen within 10 days of the referral. (Data, SS)

Requirements	Options	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required
Informational	**BH4. Measure depression screening**	**May be supported by prevalidation.** **Identify tool.** Drop-down with validated tools. (Attestation, CD) • PHQ-2 • PHQ-9 • Other _____ The practice defines: 1. The patients included in the denominator (e.g., certain age groups, people without a history of depression). Open field. (Data, SS) The practice provides the following data: 2. *Denominator:* The number of patients. (Data, SS) 3. *Numerator:* The number of patients screened. (Data, SS) 4. Reporting period: Number of months (3-12 months) (Data, SS) ☐ Check here if you're using NQF-endorsed Measure 0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan to report the numerator and denominator.
Informational	**BH5. Measure anxiety screening**	**Identify tool.** Drop-down with validated tools. (CD) • *GAD-7 (Generalized Anxiety Disorder):* A seven-question screening tool that identifies whether a complete assessment for anxiety is indicated. • *PC–PTSD:* A four-item screen designed for use in primary care and other medical settings to screen for post-traumatic stress disorder. It is currently used by the VA. • Other _____ The practice defines: 1. The patients included in the denominator (e.g., certain age groups, people without a history of anxiety). (Data, SS) The practice provides the following data: 2. *Denominator:* The number of patients. (Data, SS) 3. *Numerator:* The number of patients screened. (Data, SS) 4. Reporting period: Number of months (3-12 months) (Data, SS)

Requirements	Options	Documentation/Data Required CD= Corporate Data Accepted SS = Site-Specific Data Required
Informational	**BH6. Provide decision support intervention for mental health or substance use disorder**	**May be supported by prevalidation (if the mental health/substance use disorder option is implemented).** 1. Which topics does your practice address with decision support based on evidence-based guidelines? *(Note: This requirement focuses on treatment guidelines, not on screening guidelines.)* (CD) *Mental Health Issues* ☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ ADHD/ADD ☐ Dementia/Alzheimer's ☐ Other _____ *Substance Use Issues* ☐ Illegal drug use ☐ Prescription drug addiction ☐ Alcoholism ☐ Other _____

PCMH 2014–PCMH 2017 Crosswalk

The table below compares NCQA's Patient-Centered Medical Home (PCMH) 2014 standards with NCQA's Patient-Centered Medical Home (PCMH) 2017 standards. The columns show where meeting 2014 factors meet 2017 criteria and where there are differences.

PCMH 2014	PCMH 2017	Alignment
PCMH 1		
1A1*	AC 02 (Core)	✓
1A2	AC 03 (Core)	✓
1A3	AC 06 (1 Credit)	AC 06 requires a technology-supported scheduled visit.
1A4	QI 03 (Core)	✓
1A5	No equivalent.	
1A6	QI 10 (Core)	✓
1B1	AC 12 (2 Credits)	✓
1B2*	AC 04 (Core)	✓
1B3	AC 08 (1 Credit)	AC 08 combines 1B3 and 1C5.
1B4	AC 05 (Core)	AC 05 includes reconciliation with the patient's medical record.
1C1-4	No equivalent.	
1C5	AC 08 (1 Credit)	See 1B3.
1C6	AC 07 (1 Credit)	✓
PCMH 2		
2A1	AC 10 (Core)	✓
2A2	AC 11 (Core)	AC 11 adds goal setting.
2A3	TC 09 (Core)	✓
2A4	CC 20 (1 Credit)	CC 20 focuses on "complex" patient' transitions.
2B1-5	TC 09 (Core)	✓
2B6-8	No equivalent.	
2C1	KM 09 (Core)	✓
2C2	KM 10 (Core)	✓
2C3-4	No equivalent.	
2D1-2	TC 02 (Core)	✓
2D3*	TC 06 (Core)	✓
2D4-8	No equivalent.	Supports TC 02.
2D9	TC 07 (Core)	✓
2D10	QI 17 (2 Credits)	✓
PCMH 3		
3A1-14	No equivalent.	
3B1	KM 01 (Core)	KM 01 measures the total practice population.
3B2-8, 10, 11	No equivalent.	
3B9	KM 15 (Core)	KM 15 combines 3B9 and 4C6.
3C1	No equivalent.	
3C2-8	KM 02 (Core)	F and G are new.
3C9	KM 03 (Core)	✓
3C10	KM 11B (1 Credit)	KM 11B focuses on the health literacy of the practice staff.
3D1-4	KM 12 (Core)	✓
3D5	No equivalent.	
3E1*, 2-6	KM 20 (Core)	✓
PCMH 4		
4A1-5	CM 01 (Core)	✓
4A6*	CM 02 (Core)	✓
4B1	CM 06 (1 Credit)	CM 06 is measured for all patients in care management.
4B2	CM 04 (Core)	CM 06 is measured for all patients in care management.

PCMH 2014	PCMH 2017	Alignment
4B3	CM 07 (1 Credit)	CM 07 is measured for all patients in care management.
4B4	CM 08 (1 Credit)	CM 08 is measured for all patients in care management.
4B5	CM 05 (Core)	CM 05 is measured for all patients in care management.
4C1*-2	KM 14 (Core)	✓
4C3-4	KM 16 (1 Credit)	✓
4C5	KM 17 (1 Credit)	✓
4C6	KM 15 (Core)	See 3B9.
4D1-4	No equivalent.	
4E1	No equivalent.	
4E2, 3, 5	KM 22 (1 Credit)	✓
4E4	KM 24 (1 Credit)	✓
4E6	KM 26 (1 Credit)	✓
4E7	KM 27 (1 Credit)	✓
PCMH 5		
5A1*, 2*, 3-5	CC 01 (Core)	✓
5A6	CC 02 (1 Credit)	✓
5A7-10	No equivalent.	
5B1	CC 07 (2 Credits)	✓
5B2	CC 08 (1 Credit)	✓
5B3	CC 09 (2 Credits)	✓
5B4	CC 10 (2 Credits)	✓
5B5-6, 8*	CC 04 (Core)	✓
5B7	CC 21C (1 of 3 Credits)	CC 21C combines 5B7 and 5C7.
5B9	CC 12 (1 Credit)	✓
5B10	No equivalent.	
5C1	CC 14 (Core)	✓
5C2	CC 15 (Core)	✓
5C3	CC 19 (1 Credit)	✓
5C4	CC 16 (Core)	✓
5C5	CC 18 (1 Credit)	✓
5C6	No equivalent.	
5C7	CC 21C (1 of 3 Credits)	See 5B7.
PCMH 6		
6A1-3	QI 01 (Core)	D is new.
6A4	QI 05 (1 Credit)	✓
6B1-2	QI 02 (Core)	✓
6C1	QI 04A (Core)	✓
6C2	QI 06 (1 Credit)	✓
6C3	QI 07 (2 Credits)	✓
6C4	QI 04B (Core)	✓
6D1-2	QI 08 (Core)	D is new.
6D3-4	QI 09 (Core)	✓
6D5-6	QI 11 (Core)	✓
6D7	QI 13 (1 Credit)	✓
6E1	No equivalent.	
6E2-4	QI 12 (2 Credits)	At least 2 of 5 measures.
6F1-2	QI 15 (Core)	✓
6F3-4	QI 16 (1 Credit)	✓
6G1-2	TC 05 (2 Credits)	✓
6G3-5	No equivalent.	

PCMH 2014	PCMH 2017	Alignment
6G6	QI 18 (2 Credits)	✓
6G7	CC 21B (1 of 3 Credits)	✓
6G8-9	CC 21A (1 of 3 Credits)	✓
6G10	KM 12 (Core)	At least 3 categories

*Critical factor in PCMH 2014.

New 2017 Criteria
TC 01 (Core)
TC 03 (1 Credit)
TC 04 (2 Credits)
TC 08 (2 Credits)
KM 02 (Core) *F and G are new*
KM 04 (1 Credit)
KM 05 (1 Credit)
KM 06 (1 Credit)
KM 07 (2 Credits)
KM 08 (1 Credit)
KM 11 (1 Credit) *A and C are new*
KM 13 (2 Credits)
KM 18 (1 Credit)
KM 19 (2 Credits)
KM 21 (Core)
KM 23 (1 Credit)
KM 25 (1 Credit)
KM 28 (2 Credits)
AC 01 (Core)
AC 09 (1 Credit)
AC 13 (1 Credit)
AC 14 (1 Credit)
CM 03 (2 Credits)
CM 09 (1 Credit)
CC 03 (2 Credits)
CC 05 (2 Credits)
CC 06 (1 Credit)
CC 11 (1 Credit)
CC 13 (2 Credits)
CC 17 (1 Credit)
QI 01 (Core) *D is new*
QI 08 (Core) *D is new*
QI 14 (2 Credits)
QI 19

Patient-Centered Medical Home (PCMH)
PCMH 2011 Corporate Credit Transition to PCMH 2017 Shared Credit Table

Multi-site organizations that completed a PCMH 2011 corporate survey tool with practices pursuing PCMH 2017 recognition may use this table to transition to the redesigned PCMH program. Practices can use credit earned from the PCMH 2011 corporate survey tool to earn recognition for their practices at an accelerated pace. These practices will be able to use shared credits to meet certain criteria without providing the evidence required of practices seeking recognition for the first time.

In the tables below, the "Eligible for Transfer of Shared Credit?" (far right column) indicates which criteria simply allow attestation in lieu of submission of evidence. The evaluator may ask practices to verify a selection of attestation responses during a virtual review.

To get started, enroll through the Q-PASS system at qpass.ncqa.org. You will be assigned an NCQA representative who will be your single point of contact and guide your organization through the recognition process.

What is expected for criteria that aligns with a factor in a PCMH 2011 corporate eligible element that your organization has met using a corporate survey where attestation is allowed?

For criteria marked "attestation," your organization may attest that they have already demonstrated and met the equivalent criteria in their previous PCMH 2011 corporate survey and that practices are still performing PCMH activities in these criteria. You will not need to demonstrate documentation or evidence. For each attestable criterion, practices enter a title into the text box, label the name as *PCMH 2011 Corporate Eligible Attestation*, and enter the text below:

"Our organization has achieved credit for this criterion using the PCMH 2011 corporate survey. We attest that our responses reflect our organization's current operations. Documentation to support these responses will be provided upon request."

You will not need to manually enter the attestation text for each criterion. After you enter the Attestation for the first criterion, you may select "Link Evidence" and type the title *PCMH 2011 Corporate Eligible Attestation* into the text box for additional attestable criterion.

What is expected for criteria that require evidence?

For criteria that is not eligible for Attestation, practices should follow the current PCMH Standards & Guidelines and submit evidence in Q-PASS, as indicated. Practices should prepare to demonstrate virtual review-eligible evidence during the virtual review.

What is the difference between shared and site-specific evidence?

Some evidence (such as documented processes and demonstration of capability) may be submitted once for all sites or site groups. Other evidence (such as evidence of implementation, examples, reports, Record Review Workbooks and Quality Improvement Workbooks) must be site-specific. Site-specific data may be collected and submitted once on behalf of all sites or site groups if the evidence is stratified by site. Some criteria require a combination of shared and site-specific evidence, which is labeled "Partially Shared" in the tables below and indicates that the documented process may be shared across all practice sites, but all other evidence must be site-specific.

PCMH 2011 Corporate Credit Transition		Electives			Total Criteria
	Core	1 Credit	2 Credits	3 Credits	
Shared (Eligible for Attestation of Shared Credit)	11 criteria (5 criteria)	16 criteria (2 criteria)	14 criteria (1 criterion)	1 criterion (1 criterion)	**42 criteria (9 criteria)**
Partially Shared	13 criteria	11 Criteria	2 criteria	0 criteria	**26 criteria**
Site-Specific	16 criteria	11 criteria	5 criteria	0 criteria	**32 criteria**
Total Criteria	**40 criteria**	**38 criteria**	**21 criteria**	**1 criterion**	**100 criteria**

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)			
Criteria	Criteria Title	Shared or Site-Specific?	Eligible for Attestation of Shared Credit?
Competency A: Practice Organization, Team Roles and Training			
TC 01* (Core)	PCMH Transformation Leads	Shared	
TC 02 (Core)	Structure & Staff Responsibilities	Shared	
TC 03* (1 Credit)	External PCMH Collaborations	Shared	
TC 04* (2 Credits)	Patient/Family/Caregiver Involvement in Governance	Shared	
TC 05 (2 Credits)	Certified EHR System	Shared	
Competency B: Care Team Communication and Functioning			
TC 06 (Core)	Individual Patient Care Meetings/Communication	Partially Shared**	
TC 07 (Core)	Staff Involvement in Quality Improvement	Shared	✓
TC 08* (2 Credits)	Behavioral Health Care Manager	Shared	
Competency C: Patient/Family/Caregiver Orientation			
TC 09 (Core)	Medical Home Information	Shared	✓

 *New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

KNOWING AND MANAGING YOUR PATIENTS (KM)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Comprehensive Patient/Population Knowledge			
KM 01 (Core)	Problem Lists	Site-Specific	
KM 02 (Core) *F and G are new*	Comprehensive Health Assessment	Partially Shared**	
KM 03 (Core)	Depression Screening	Partially Shared**	
KM 04* (1 Credit)	Behavioral Health Screenings	Partially Shared**	
KM 05* (1 Credit)	Oral Health Assessment & Services	Partially Shared**	
KM 06 (1 Credit)	Predominant Conditions & Concerns	Shared	
KM 07* (2 Credits)	Social Determinants of Health	Site-Specific	
KM 08* (1 Credit)	Patient Materials	Shared	
Competency B: Cultural Competency			
KM 09 (Core)	Diversity	Site-Specific	
KM 10 (Core)	Language	Site-Specific	
KM 11 (1 Credit) *A and C are new*	Population Needs	Shared	
Competency C: Proactive Population Management			
KM 12 (Core)	Proactive Reminders	Shared	✓
KM 13* (2 Credits)	Excellence in Performance	Site-Specific	
Competency D: Medication Management			
KM 14 (Core)	Medication Reconciliation	Site-Specific	
KM 15 (Core)	Medication Lists	Site-Specific	
KM 16 (1 Credit)	New Prescription Education	Site-Specific	
KM 17 (1 Credit)	Medication Responses & Barriers	Site-Specific	
KM 18* (1 Credit)	Controlled Substance Database Review	Shared	
KM 19* (2 Credits)	Prescription Claims Data	Shared	
Competency E: Evidence-Based Decision Support			
KM 20 (Core)	Clinical Decision Support	Shared	
Competency F: Community Resources			
KM 21* (Core)	Community Resource Needs	Shared	
KM 22 (1 Credit)	Access to Educational Resources	Shared	
KM 23* (1 Credit)	Oral Health Education	Shared	
KM 24 (1 Credit)	Shared Decision-Making Aids	Shared	
KM 25* (1 Credit)	School/Intervention Agency Engagement	Shared	
KM 26 (1 Credit)	Community Resource List	Shared	✓
KM 27 (1 Credit)	Community Resource Assessment	Shared	
KM 28* (2 Credits)	Case Conferences	Shared	

 *New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

PATIENT-CENTERED ACCESS AND CONTINUITY (AC)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Access to Clinical Advice and Appointments			
AC 01* (Core)	Access Needs & Preferences	Partially Shared**	
AC 02 (Core)	Same-Day Appointments	Partially Shared**	
AC 03 (Core)	Appointments Outside Business Hours	Shared	✓
AC 04 (Core)	Timely Clinical Advice by Telephone	Shared	
AC 05 (Core)	Clinical Advice Documentation	Partially Shared**	
AC 06 (1 Credit)	Alternative Appointments	Partially Shared**	
AC 07 (1 Credit)	Electronic Patient Requests	Shared	✓
AC 08 (1 Credit)	Two-Way Electronic Communication	Shared	
AC 09* (1 Credit)	Equity of Access	Site-Specific	
Competency B: Care Continuity and Empanelment			
AC 10 (Core)	Personal Clinician Selection	Shared	✓
AC 11 (Core)	Patient Visits with Clinician/Team	Site-Specific	
AC 12 (2 Credits)	Continuity of Medical Record Information	Shared	✓
AC 13* (1 Credit)	Panel Size Review & Management	Partially Shared**	
AC 14* (1 Credit)	External Panel Review & Reconciliation	Partially Shared**	

 *New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

CARE MANAGEMENT AND SUPPORT (CM)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: At-Risk Patients for Care Management			
CM 01 (Core)	Identifying Patients for Care Management	Shared	
CM 02 (Core)	Monitoring Patients for Care Management	Site-Specific	
CM 03* (2 Credits)	Comprehensive Risk-Stratification Process	Shared	
Competency B: Care Planning			
CM 04 (Core)	Person-Centered Care Plans	Site-Specific	
CM 05 (Core)	Written Care Plans	Site-Specific	
CM 06 (1 Credit)	Patient Preferences & Goals	Site-Specific	
CM 07 (1 Credit)	Patient Barriers to Goals	Site-Specific	
CM 08 (1 Credit)	Self-Management Plans	Site-Specific	
CM 09* (1 Credit)	Care Plan Integration	Shared	

*New criteria in 2017 edition of PCMH Standards & Guidelines.

CARE COORDINATION AND CARE TRANSITIONS (CC)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Lab and Imaging Test Management			
CC 01 (Core)	Lab & Imaging Test Management	Partially Shared**	
CC 02 (1 Credit)	Newborn Screenings	Partially Shared**	
CC 03* (2 Credits)	Appropriate Use for Labs & Imaging	Shared	
Competency B: Patient Referral Management			
CC 04 (Core)	Referral Management	Partially Shared**	
CC 05* (2 Credits)	Appropriate Referrals	Shared	
CC 06* (1 Credit)	Commonly Used Specialists Identification	Site-Specific	
CC 07 (2 Credits)	Performance Information for Specialist Referrals	Shared	
CC 08 (1 Credit)	Specialist Referral Expectations	Shared	
CC 09 (2 Credits)	Behavioral Health Referral Expectations	Shared	
CC 10 (2 Credits)	Behavioral Health Integration	Partially Shared**	
CC 11* (1 Credit)	Referral Monitoring	Partially Shared**	
CC 12 (1 Credit)	Co-Management Arrangements	Site-Specific	
CC 13* (2 Credits)	Treatment Options & Costs	Partially Shared**	
Competency C: Coordinate Care Transitions			
CC 14 (Core)	Identifying Unplanned Hospital & ED Visits	Partially Shared**	
CC 15 (Core)	Sharing Clinical Information	Partially Shared**	
CC 16 (Core)	Post-Hospital/ED Visit Follow-Up	Partially Shared**	
CC 17* (1 Credit)	Acute Care After Hours Coordination	Partially Shared**	
CC 18 (1 Credit)	Information Exchange during Hospitalization	Partially Shared**	
CC 19 (1 Credit)	Patient Discharge Summaries	Partially Shared**	
CC 20 (1 Credit)	Care Plan Collaboration for Practice Transitions	Site-Specific	
CC 21 (Maximum 3 Credits)	External Electronic Exchange of Information	Shared	✓ CC 21B and C Only+

*New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

+Only CC 21B and C are eligible for attestation. Organizations must still demonstrate evidence to meet CC 21A.

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT (QI)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Performance Measurement			
QI 01 (Core) *D is New*	Clinical Quality Measures	Site-Specific	
QI 02 (Core)	Resource Stewardship Measures	Site-Specific	
QI 03 (Core)	Appointment Availability Assessment	Partially Shared**	
QI 04 (Core)	Patient Experience Feedback	Site-Specific	
QI 05 (1 Credit)	Health Disparities Assessment	Site-specific	
QI 06 (1 Credit)	Validated Patient Experience Survey Use	Shared	
QI 07 (2 Credits)	Vulnerable Patient Feedback	Site-specific	
Competency B: Quality Improvement			
QI 08 (Core) *D is New*	Goals & Actions to Improve Clinical Quality Measures	Site-Specific	
QI 09 (Core)	Goals & Actions to Improve Resource Stewardship Measures	Site-Specific	
QI 10 (Core)	Goals & Actions to Improve Appointment Availability	Site-Specific	
QI 11 (Core)	Goals & Actions to Improve Patient Experience	Site-Specific	
QI 12 (2 Credits)	Improved Performance	Site-Specific	
QI 13 (1 Credit)	Goals & Actions to Improve Disparities in Care/Service	Site-Specific	
QI 14 (2 Credits)	Improved Performance for Disparities in Care/Service	Site-Specific	
Competency C: Reporting Performance			
QI 15 (Core)	Reporting Performance Within the Practice	Partially Shared**	
QI 16 (1 Credit)	Reporting Performance Publicly or with Patients	Partially Shared**	
QI 17 (2 Credits)	Patient/Family/Caregiver Involvement in Quality Improvement	Shared	
QI 18 (2 Credits)	Reporting Performance Measures to Medicare/Medicaid	Shared	
QI 19* (Maximum 2 credits)	Value-Based Contract Agreements A. Up-Side Risk Contract B. Two-Sided Risk Contract	Shared	

 *New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

Patient-Centered Medical Home (PCMH)
PCMH 2014 Corporate Credit Transition to PCMH 2017 Shared Credit Table

Multi-site organizations that completed a PCMH 2014 corporate survey tool with practices pursuing PCMH 2017 recognition may use this table to transition to the redesigned PCMH program. Practices can use credit earned from the PCMH 2014 corporate survey tool to earn recognition for their practices at an accelerated pace. These practices will be able to use attestation to meet certain criteria without providing the evidence required of practices seeking recognition for the first time.

In the tables below, the "Eligible for Attestation of Shared Credit?" (far right column) indicates which criteria simply allow attestation in lieu of submission of evidence. The evaluator may ask practices to verify a selection of attestation responses during a virtual review.

To get started, enroll through the Q-PASS system at qpass.ncqa.org. You will be assigned an NCQA representative who will be your single point of contact and guide your organization through the recognition process.

What is expected for criteria that aligns with a factor in a PCMH 2014 corporate eligible element that your organization has met using a corporate survey where attestation is allowed?

For criteria marked "attestation," your organization may attest that they have already demonstrated and met the equivalent criteria in their previous PCMH 2014 corporate survey and that practices are still performing PCMH activities in these criteria. You will not need to demonstrate documentation or evidence. For each attestable criterion, practices enter a title into the text box, label the name as *PCMH 2014 Corporate Eligible Attestation*, and enter the text below:

"Our organization has achieved credit for this criterion using the PCMH 2014 corporate survey. We attest that our responses reflect our organization's current operations. Documentation to support these responses will be provided upon request."

You will not need to manually enter the attestation text for each criterion. After you enter the Attestation for the first criterion, you may select "Link Evidence" and type the title *PCMH 2014 Corporate Eligible Attestation* into the text box for additional attestable criterion.

What is expected for criteria that require evidence?

For criteria that is not eligible for Attestation, practices should follow the current PCMH Standards & Guidelines and submit evidence in Q-PASS, as indicated. Practices should prepare to demonstrate virtual review-eligible evidence during the virtual review.

What if my organization has practices that are PCMH 2014, Level 3?

Practices that have achieved PCMH 2014 Level 3 recognition may bypass submission of evidence for criteria entirely and go directly to the Annual Reporting phase of recognition. Do this by enrolling in Q-PASS. You will be assigned an NCQA representative, who will explain the next steps.

What is the difference between shared and site-specific evidence??

Some evidence (such as documented processes and demonstration of capability) may be submitted once for all sites or site groups. Other evidence (such as evidence of implementation, examples, reports, Record Review Workbooks and Quality Improvement Workbooks) must be site-specific. Site-specific data may be collected and submitted once on behalf of all sites or site groups if the evidence is stratified by site. Some criteria require a combination of shared and site-specific evidence, which is

labeled "Partially Shared" in the tables below and indicates that the documented process may be shared across all practice sites, but all other evidence must be site-specific.

		Electives			Total Criteria
	Core	1 Credit	2 Credits	3 Credits	
Shared (Eligible for Attestation of Shared Credit)	11 criteria (4 criteria)	16 criteria (7 criteria)	14 criteria (4 criteria)	1 criterion (1 criterion)	**42 criteria (16 criteria)**
Partially Shared	13 criteria	11 Criteria	2 criteria	0 criteria	**26 criteria**
Site-Specific	16 criteria	11 criteria	5 criteria	0 criteria	**32 criteria**
Total Criteria	**40 criteria**	**38 criteria**	**21 criteria**	**1 criterion**	**100 criteria**

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)			
Criteria	Criteria Title	Shared or Site-Specific?	Eligible for Attestation of Shared Credit?
Competency A: Practice Organization, Team Roles and Training			
TC 01* (Core)	PCMH Transformation Leads	Shared	
TC 02 (Core)	Structure & Staff Responsibilities	Shared	
TC 03* (1 Credit)	External PCMH Collaborations	Shared	
TC 04* (2 Credits)	Patient/Family/Caregiver Involvement in Governance	Shared	
TC 05 (2 Credits)	Certified EHR System	Shared	✓
Competency B: Care Team Communication and Functioning			
TC 06 (Core)	Individual Patient Care Meetings/Communication	Partially Shared**	
TC 07 (Core)	Staff Involvement in Quality Improvement	Shared	
TC 08* (2 Credits)	Behavioral Health Care Manager	Shared	
Competency C: Patient/Family/Caregiver Orientation			
TC 09 (Core)	Medical Home Information	Shared	✓

*New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

KNOWING AND MANAGING YOUR PATIENTS (KM)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Comprehensive Patient/Population Knowledge			
KM 01 (Core)	Problem Lists	Site-Specific	
KM 02 (Core) *F and G are new*	Comprehensive Health Assessment	Partially Shared**	
KM 03 (Core)	Depression Screening	Partially Shared**	
KM 04* (1 Credit)	Behavioral Health Screenings	Partially Shared**	
KM 05* (1 Credit)	Oral Health Assessment & Services	Partially Shared**	
KM 06 (1 Credit)	Predominant Conditions & Concerns	Shared	
KM 07* (2 Credits)	Social Determinants of Health	Site-Specific	
KM 08* (1 Credit)	Patient Materials	Shared	
Competency B: Cultural Competency			
KM 09 (Core)	Diversity	Site-Specific	
KM 10 (Core)	Language	Site-Specific	
KM 11 (1 Credit) *A and C are new*	Population Needs	Shared	
Competency C: Proactive Population Management			
KM 12 (Core)	Proactive Reminders	Shared	✓
KM 13* (2 Credits)	Excellence in Performance	Site-Specific	
Competency D: Medication Management			
KM 14 (Core)	Medication Reconciliation	Site-Specific	
KM 15 (Core)	Medication Lists	Site-Specific	
KM 16 (1 Credit)	New Prescription Education	Site-Specific	
KM 17 (1 Credit)	Medication Responses & Barriers	Site-Specific	
KM 18* (1 Credit)	Controlled Substance Database Review	Shared	
KM 19* (2 Credits)	Prescription Claims Data	Shared	
Competency E: Evidence-Based Decision Support			
KM 20 (Core)	Clinical Decision Support	Shared	✓
Competency F: Community Resources			
KM 21* (Core)	Community Resource Needs	Shared	
KM 22 (1 Credit)	Access to Educational Resources	Shared	✓
KM 23* (1 Credit)	Oral Health Education	Shared	
KM 24 (1 Credit)	Shared Decision-Making Aids	Shared	✓
KM 25* (1 Credit)	School/Intervention Agency Engagement	Shared	
KM 26 (1 Credit)	Community Resource List	Shared	✓
KM 27 (1 Credit)	Community Resource Assessment	Shared	✓
KM 28* (2 Credits)	Case Conferences	Shared	

*New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

PATIENT-CENTERED ACCESS AND CONTINUITY (AC)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Access to Clinical Advice and Appointments			
AC 01* (Core)	Access Needs & Preferences	Partially Shared**	
AC 02 (Core)	Same-Day Appointments	Partially Shared**	
AC 03 (Core)	Appointments Outside Business Hours	Shared	
AC 04 (Core)	Timely Clinical Advice by Telephone	Shared	✓
AC 05 (Core)	Clinical Advice Documentation	Partially Shared**	
AC 06 (1 Credit)	Alternative Appointments	Partially Shared**	
AC 07 (1 Credit)	Electronic Patient Requests	Shared	✓
AC 08 (1 Credit)	Two-Way Electronic Communication	Shared	✓
AC 09* (1 Credit)	Equity of Access	Site-Specific	
Competency B: Care Continuity and Empanelment			
AC 10 (Core)	Personal Clinician Selection	Shared	
AC 11 (Core)	Patient Visits with Clinician/Team	Site-Specific	
AC 12 (2 Credits)	Continuity of Medical Record Information	Shared	✓
AC 13* (1 Credit)	Panel Size Review & Management	Partially Shared**	
AC 14* (1 Credit)	External Panel Review & Reconciliation	Partially Shared**	

 *New criteria in 2017 edition of PCMH Standards & Guidelines.
**Documented processes may be shared, but all other evidence must be site-specific.

CARE MANAGEMENT AND SUPPORT (CM)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: At-Risk Patients for Care Management			
CM 01 (Core)	Identifying Patients for Care Management	Shared	
CM 02 (Core)	Monitoring Patients for Care Management	Site-Specific	
CM 03* (2 Credits)	Comprehensive Risk-Stratification Process	Shared	
Competency B: Care Planning			
CM 04 (Core)	Person-Centered Care Plans	Site-Specific	
CM 05 (Core)	Written Care Plans	Site-Specific	
CM 06 (1 Credit)	Patient Preferences & Goals	Site-Specific	
CM 07 (1 Credit)	Patient Barriers to Goals	Site-Specific	
CM 08 (1 Credit)	Self-Management Plans	Site-Specific	
CM 09* (1 Credit)	Care Plan Integration	Shared	

*New criteria in 2017 edition of PCMH Standards & Guidelines.

CARE COORDINATION AND CARE TRANSITIONS (CC)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Lab and Imaging Test Management			
CC 01 (Core)	Lab & Imaging Test Management	Partially Shared**	
CC 02 (1 Credit)	Newborn Screenings	Partially Shared**	
CC 03* (2 Credits)	Appropriate Use for Labs & Imaging	Shared	
Competency B: Patient Referral Management			
CC 04 (Core)	Referral Management	Partially Shared**	
CC 05* (2 Credits)	Appropriate Referrals	Shared	
CC 06* (1 Credit)	Commonly Used Specialists Identification	Site-Specific	
CC 07 (2 Credits)	Performance Information for Specialist Referrals	Shared	✓
CC 08 (1 Credit)	Specialist Referral Expectations	Shared	✓
CC 09 (2 Credits)	Behavioral Health Referral Expectations	Shared	✓
CC 10 (2 Credits)	Behavioral Health Integration	Partially Shared**	
CC 11* (1 Credit)	Referral Monitoring	Partially Shared**	
CC 12 (1 Credit)	Co-Management Arrangements	Site-Specific	
CC 13* (2 Credits)	Treatment Options & Costs	Partially Shared**	
Competency C: Coordinate Care Transitions			
CC 14 (Core)	Identifying Unplanned Hospital & ED Visits	Partially Shared**	
CC 15 (Core)	Sharing Clinical Information	Partially Shared**	
CC 16 (Core)	Post-Hospital/ED Visit Follow-Up	Partially Shared**	
CC 17* (1 Credit)	Acute Care After Hours Coordination	Partially Shared**	
CC 18 (1 Credit)	Information Exchange during Hospitalization	Partially Shared**	
CC 19 (1 Credit)	Patient Discharge Summaries	Partially Shared**	
CC 20 (1 Credit)	Care Plan Collaboration for Practice Transitions	Site-Specific	
CC 21 (Maximum 3 Credits)	External Electronic Exchange of Information	Shared	✓ CC 21C Only+

 *New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

+Only CC 21C is eligible for attestation. Organizations must still demonstrate evidence to meet CC 21A and B.

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT (QI)			
Criteria	**Criteria Title**	**Shared or Site-Specific?**	**Eligible for Attestation of Shared Credit?**
Competency A: Performance Measurement			
QI 01 (Core) *D is New*	Clinical Quality Measures	Site-Specific	
QI 02 (Core)	Resource Stewardship Measures	Site-Specific	
QI 03 (Core)	Appointment Availability Assessment	Partially Shared**	
QI 04 (Core)	Patient Experience Feedback	Site-Specific	
QI 05 (1 Credit)	Health Disparities Assessment	Site-specific	
QI 06 (1 Credit)	Validated Patient Experience Survey Use	Shared	
QI 07 (2 Credits)	Vulnerable Patient Feedback	Site-specific	
Competency B: Quality Improvement			
QI 08 (Core) *D is New*	Goals & Actions to Improve Clinical Quality Measures	Site-Specific	
QI 09(Core)	Goals & Actions to Improve Resource Stewardship Measures	Site-Specific	
QI 10 (Core)	Goals & Actions to Improve Appointment Availability	Site-Specific	
QI 11 (Core)	Goals & Actions to Improve Patient Experience	Site-Specific	
QI 12 (2 Credits)	Improved Performance	Site-Specific	
QI 13 (1 Credit)	Goals & Actions to Improve Disparities in Care/Service	Site-Specific	
QI 14 (2 Credits)	Improved Performance for Disparities in Care/Service	Site-Specific	
Competency C: Reporting Performance			
QI 15 (Core)	Reporting Performance Within the Practice	Partially Shared**	
QI 16 (1 Credit)	Reporting Performance Publicly or with Patients	Partially Shared**	
QI 17 (2 Credits)	Patient/Family/Caregiver Involvement in Quality Improvement	Shared	
QI 18 (2 Credits)	Reporting Performance Measures to Medicare/Medicaid	Shared	
QI 19* (Maximum 2 credits)	Value-Based Contract Agreements A. Up-Side Risk Contract B. Two-Sided Risk Contract	Shared	

 *New criteria in 2017 edition of PCMH Standards & Guidelines.

**Documented processes may be shared, but all other evidence must be site-specific.

F. PCMH Content Expert Certification FAQ's

PCMH Content Expert Certification FAQs Webpage:

http://www.ncqa.org/Portals/0/Education/CEC/PCMH%20CEC%20FAQs%20Updated%2028%20Aug%20
2015%20(1).pdf

G. Policy Clarification Support (PCS) System Users Guide-External

Policy Clarification Support (PCS) System
Users Guide—External

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Access the PCS System

Step 1   [Click here](#) to register.

Step 2   Register with accurate information, then check your e-mail for your temporary password.

Step 3   Your **username** is your e-mail address. Use the **temporary password** for the initial log-in.

Step 4   To **change your password**, log out of the system. Log in again and enter your user name and new password.

NCQA
Measuring quality.
Improving health care.

Policy/Program Clarification Support

Welcome to the Policy Clarification Support area. To begin, please login using the form below.

If you do not have an account yet, you may register below. Please be sure to complete the entire form.

You will receive an email confirmation of your registration that will include a temporary password and a link to login. You'll be required to choose a new, unique password when you first login.

Questions? Please contact us for more information.

Register

First Name

Last Name

Email Address

Organization Name

Organization Type

Phone Number (enter numbers only)

Register

Login

Username

Login   Forgot Password?

Why do I have to register?

Manage Questions Page

This page contains the account owner's personal history of both open and closed questions.

On this screen, you can view open and closed questions or click the **Ask a New Question** button to go to the **Ask a New Question** page.

Ask a New Question Page

Step 1   Click on the **Ask A New Question** button.

Step 2   Select the applicable dropdown menu options.

Step 3   Summarize your question in the **Subject** field.

Enter your question in the **Question** text box and click **Submit Your Question**.

You will receive a confirmation e-mail verifying that NCQA has received your question along with the case number.

Add Additional Information About Your Question

This feature allows you to send the case owner additional information about your question without having to create another case. You can also view the case owner's comments.

To use this field enter the information you want send the case owner and click the **Submit Comment** button.

Note: there is a 500 character limit on this field.

Policy Clarification Support

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Logout

Question

Manage Questions

UM Denial Notices

I am having difficulty understanding the explanation of the element.

Information

Status: Open
Created: 04/10/2013
Modified: 04/10/2013
Case: 00002412
Publication Year: 2013

Additional Information About Your Question

If you need to add information about your question or if NCQA requests additional information, enter it in the field below. There is a 500-character limit.

*NOTE: Although NCQA will use this field to request information and discuss your question before it is resolved, NCQA's official response to your question will be sent to you via e-mail.

Subject Areas

HPA - Health Plan Accreditation

UM - Utilization Management

Denial Notices

500 characters remaining
Submit Comment

.

How to Reference a Closed Case

Note: This step can only be performed on closed cases.

Step 1   Click the **Closed Question** section on the **Manage Questions** page and select the ID number of the case.

Step 2   Select the **click here** option. When the new **Ask a Question** page opens, verify that the **Referenced Case** section is populated and complete the form. When the form is completed, the two cases will be linked automatically.

Notification E-Mails

You will receive a notification e-mail after you submit a new question, when NCQA adds additional information to an open case, when the case is sent to Policy review and when NCQA answers (closes) the case. The e-mail will include your case number and a link to the **Login** page.

H. The Reporting Hotline

The Reporting Hotline

- **NCQA takes fraud and misconduct seriously**
  - NCQA does not tolerate fraudulent, misleading, or improper information submitted by organizations as part of their survey process, or any other program

- **Submitting of any Falsified Document or Fraudulent Information may be grounds for suspension, denial or revocation of NCQA's status determination**
  - Falsified Documents are documents provided by an applicant that have been redrafted, reformatted or fabricated, in whole or in part, with false or misleading information to substantiate compliance with NCQA Standards and Guidelines.
  - Fraudulent Information includes oral statements made by an applicant or another accredited, certified or recognized person on behalf of the applicant to substantiate compliance with NCQA Standards and Guidelines or to otherwise influence the outcome of an NCQA survey, which are false or otherwise misleading.

Reporting Hotline Considerations

- **Key considerations include:**
  - Individuals have the option to report anonymously
  - The Reporting Hotline is set up through Lighthouse Services and is not equipped with caller identification, allowing for an anonymous reporting mechanism
  - NCQA is committed to protecting the identity of any individual who is alleged to have committed a violation as part of an investigation of the report

- **For general comments or complaints, including those around quality of care, individuals should continue to use the NCQA Customer Support line (M-F 8:30 - 5:00 ET / 888-275-7585), or submit their information through my.ncqa.org.**

Reporting Hotline Contact Information

- **Toll-Free Telephone:**
  - English speaking in USA and Canada: (855) 840-0070 (not available from Mexico)
  - Spanish speaking in North America: (800) 216-1288 (if calling from Mexico, dial 001-800-216-1288)

- **Website:** **https://www.lighthouse-services.com/ncqa**

- **E-mail: reports@lighthouse-services.com (must include NCQA's name with your report)**

- **Fax: (215) 689-3885 (must include NCQA's name with your report)**
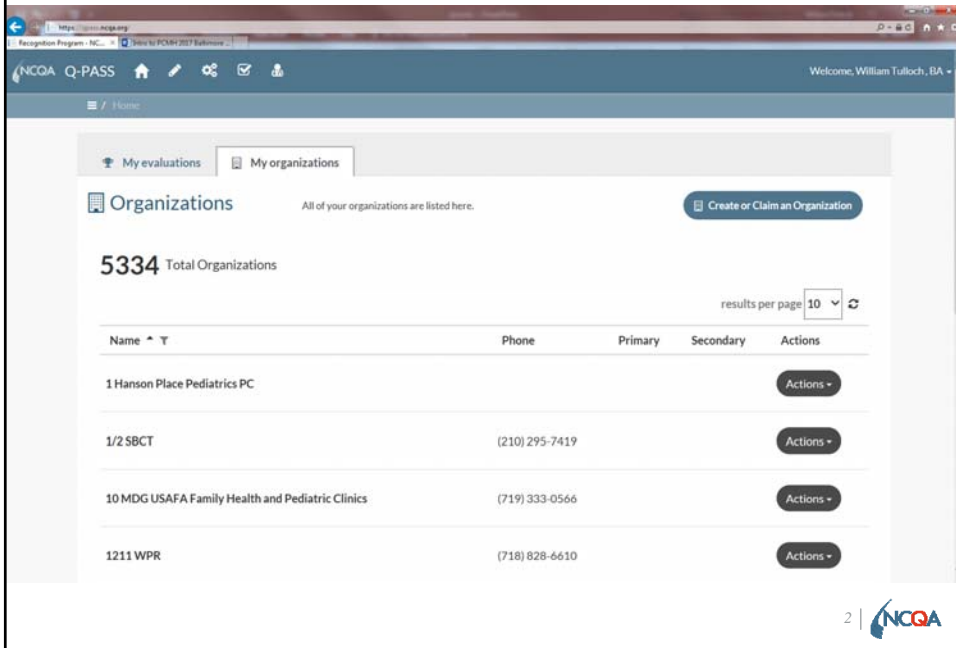
I. Q-Pass Screen Shots

Survey Platform
Q-PASS System
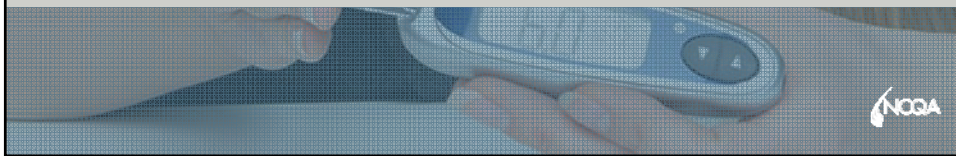
Q-PASS Organization Home Page

Adding an Organization to Q-PASS

Adding an Organization to Q-PASS II

Adding an Organization to Q-PASS III

Enrolling in Q-PASS

Enrollment – Choose Sites

Enrollment – Choose Products

Enrollment – Set Up Clinicians

Enrollment – Sign Agreements

Enrollment Invoicing

Multi-Sites Sharing Evidence/Credit

Choosing What to Share

PCMH Redesign

Each practice will have a Dashboard to manage their work

NCQA's Redesigned System - Q-PASS

ℹ️ Click on tiles below to expand and interact.

Check In Components for Review

TC : Team-Based Care and Practice Organization — collapse

PCMH / All PCMH Criteria / TC

Concept: The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, organizes and trains staff to work to the top of their license and provide effective team-based care.

| TC 01 : PCMH Transformation Leads (Core) | TC 02 : Structure & Staff Responsibilities (Core) | TC 03 : External PCMH Collaborations (1 Credit) | TC 04 : Patient/Family/Caregiver Involvement in Governance (2 Credits) |

| TC 05 : Certified EHR System (2 Credits) | TC 06 : Individual Patient Care Meetings/ Communication (Core) | TC 07 : Staff Involvement in Quality Improvement (Core) | TC 08 : Behavioral Health Care Manager (2 Credits) |

TC 09 : Medical Home Information (Core)

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NCQA's Redesigned System - Q-PASS

⚠️ MHIM : Medical Home Information and Materials

⚠️ MHIM-P : Medical Home Information and Materials Process

DESCRIPTION
The practice has a documented process to inform patients, families and caregivers about the role of the medical home and provide materials including that information.

SUGGESTED EVIDENCE

MHIM-P : Medical Home Information & Materials Process

The documented process includes providing patients, families and caregivers with information about the role and responsibilities of the medical home. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs.

The information that the practice provides may include, but is not limited to:

• Practice office hours and where to seek after-hours care.

• How to communicate with the personal clinician and team, including how to request and receive clinical advice during and after business hours.

• Whom to contact with questions about specific concerns.

• Care-team roles.

ACTIONS

❓ We need help

⊘ This is not applicable to us

🗒️ Ready for check in

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NCQA's Redesigned System - Q-PASS

Practices can select and link documents and present examples virtually

NCQA's Redesigned System - Q-PASS

Practices can select and link documents and present examples virtually