



# **Standards and Guidelines for NCQA's Patient-Centered Medical Home (PCMH) 2011**

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## The PCMH Advisory Committee

NCQA began planning for the next version of the PPC-PCMH standards shortly after the original standards were released in January 2008. From the release date, we solicited, received and catalogued suggestions for future modifications. In the latter half of 2009, we created the PCMH Advisory Committee, a diverse, 22-member committee composed of practice, medical association, physician group, health plan and consumer and employer group representatives. The committee met throughout 2010 to discuss and analyze draft standards, PPC-PCMH data analysis and public comment results.

The committee was charged with “raising the bar” by emphasizing continuity and coordination of care, making standards and explanations more inclusive of pediatric practices and streamlining the documentation requirements.

The importance of this committee cannot be overstated. Its members gave their time, energy, enthusiasm and a willingness to hear and compromise on opposing perspectives. The PCMH 2011 standards are a reflection of their hard work and collaboration.

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# Overview



# NCQA's Patient-Centered Medical Home 2011

## Overview

NCQA's Patient-Centered Medical Home (PCMH) 2011 is an innovative program for improving primary care. In a set of standards that describe clear and specific criteria, the program gives practices information about organizing care around patients, working in teams and coordinating and tracking care over time. The PCMH 2011 standards build on the success of earlier standards and make the program even more responsive to patients' needs. Although the standards have always pointed practices toward using systems—including electronic health records—to support tracking care, the new program aligns closely with many specific elements of the federal program that rewards clinicians for using health information technology to improve quality (CMS Meaningful Use Requirements).

### Improving Quality of Care by Organizing Care Around Patients

Primary care is a foundation of the health care system. The NCQA PCMH standards reflect elements that make primary care successful. Primary care clinicians are often the first point of contact for an individual; thus, patient access to care is an important issue. Clinicians must have a broad knowledge of many health care conditions and often follow their patients over years; thus, the quality of the clinician/patient relationship and the clinician's ability to track care over time are also important. Many primary care clinicians need to refer patients to specialists, making communication among providers important—and often challenging.

Although the earlier PCMH program addressed many of these issues, PCMH 2011 strengthens and adds to existing elements. We revised the standards to be clearer and more specific and some practices will find the program more challenging. Through a comprehensive review of new evidence on effective care practices, NCQA PCMH Advisory Committee discussions, feedback from our earlier programs and a public comment period, we have taken the program to a new level.

Robust patient-centeredness is an important program goal:

- There is a stronger focus on integrating behavioral healthcare and care management
- Patient survey results help drive quality improvement
- Patients and their families are involved in quality improvement.

We have added a new, standardized patient experience survey, paired with a standardized methodology. Although it is not required, practices that use this survey and requisite methodology may receive additional acknowledgement. The survey lays the groundwork for broader reporting and benchmarking. It is a tool to track patients' ratings of their care and is available to PCMH program sponsors across the country.

### Coordinating Care and Managing Information

Just as patient-centeredness is an integral part of the program, so too is a practice's ability to track care over time and across settings. The amount of clinical information for some patients—particularly those with chronic illnesses—and the fragmented nature of the U.S. health system make this aspect of primary care challenging. Experts agree that health information technology can help clinicians coordinate patient care, but merely having an electronic health record system in a practice is not enough. The health information system itself must be useful, and practices must use it to achieve the goals of coordination and high quality of care.

We recognize that the federal government is making a major investment in encouraging clinicians to use health information technology to improve the quality of care, and where possible we have aligned the PCMH 2011 standards with government laws and regulations. We want to reinforce incentives for clinicians to invest in improving quality.

Another of the PCMH program's strengths is that it clearly communicates an action plan for becoming a patient-centered medical home. The PCMH standards are available on the NCQA Web site at no cost, and we conduct educational programs around the country that discuss the program and how it works. By the end of 2010, participation in the PPC-PCMH Recognition Program had skyrocketed: more than 7,600 clinicians at more than 1,500 practices across the country had earned PCMH Recognition. NCQA's PPC-PCMH program is acknowledged as the primary standardized method for evaluating a practice's capability of performing as a patient-centered medical home. Across the country, public and private payers, purchasers and clinicians have created pilot and demonstration programs. Many programs provide financial incentives, such as pay for performance and reimbursement for services beyond the patient visit, which have motivated primary care practices to engage in the transformation that leads to Recognition as a medical home.

As practices work on system redesign to meet the NCQA standards, many have noted the effect—both on their practice and on their patients. A few comments from practices:

- “The medical home design will revitalize primary care by improving the efficacy of our efforts while more fairly rewarding its inherent value.”
- “The medical home allows physicians to do reliably and consistently the things they want to do anyway.”
- “The medical home...[is] just better care, helping patients and staff.”

## **Early Evidence Suggests That PCMH Improves Quality and Returns Savings**

The Patient-Centered Primary Care Collaborative (PCPCC) recently released a report that summarized findings from PCMH demonstrations (Grumbach and Grundy, 2010, <http://www.pcpcc.net/content/pcmh-outcome-evidence-quality>) and concluded that this body of work shows success in increasing the quality of care and in reducing cost of care on some measures. In the academic literature, a recent article also found reduced use of hospitalization and emergency room visits and overall savings (Fields, Leshen, Patel, 2010). Another study evaluating a PCMH demonstration project in an integrated group practice showed significant improvement in patient and provider experiences and in the quality of clinical care (Reid, 2009). A study of the impact of the PCMH model on costs of care indicated a relationship between practices with established systems/processes and a decreased use of inpatient and emergency care by diabetic patients (Flottemesch, under review).

## **PCMH 2011**

### **Development**

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While early work on the medical home concept was done by pediatricians and focused on care of children with special needs, the medical home concepts were further developed by a collaboration of the primary care physician societies—the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA). These concepts were articulated in the 2007 Joint Principles of the Patient-Centered Medical Home and are reflected in NCQA's 2008 Physician Practice Connections®—Patient-Centered Medical Home™ (PPC®-PCMH™) standards. These Joint Principles continue to serve as a foundation to the NCQA PCMH 2011.

NCQA's goal is for the PCMH 2011 standards to move the transformation of primary care practices forward while ensuring that Recognition is within reach of practices of varying sizes, configurations (e.g., solo, multi-site, community health center), electronic capabilities, populations served and locations (e.g., urban, rural).

Standard development 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 interviews with NCQA Recognized practices.

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## The Consumer Perspective

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In developing the PCMH 2011 standards, we were guided by a strong consensus that we must expand the patient-centered perspective. To ensure that we captured this vantage point, the advisory committee included representatives of consumer organizations and researchers working on related patient-centered areas, and we encouraged consumer participation during the public comment process.

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## Public Comment

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We posted the draft standards on the NCQA Web site and solicited comments from a wide group of stakeholders. We received comments from more than 200 respondents, including health care providers, health plans, consumer groups and government agencies. There was a high degree of support for the proposed standards, especially the increased emphasis on patient-centered, team-based care coordinated across the health care system.

In addition to the formal public comment period, we received useful suggestions from others for further revisions and changes, which we incorporated into the final version of the standards after review by our stakeholder advisory committee and the NCQA Board of Directors. Many organizations expressed interest in using the new standards, including primary care associations, community health centers, the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC), the Veterans Administration, the Department of Defense Tri-Care Services, state-led demonstration projects and multi-payer demonstration projects.

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## The Standards

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The PCMH 2011 program's six standards align with the core components of primary care.

1. PCMH 1: Enhance Access and Continuity
2. PCMH 2: Identify and Manage Patient Populations
3. PCMH 3: Plan and Manage Care
4. PCMH 4: Provide Self-Care Support and Community Resources
5. PCMH 5: Track and Coordinate Care
6. PCMH 6: Measure and Improve Performance

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## The Must-Pass Elements

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Six must-pass elements are considered essential to the patient-centered medical home, and are required for practices at all recognition levels. Practices must achieve a score of 50% or higher on must-pass elements:

1. PCMH 1, Element A: Access During Office Hours
2. PCMH 2, Element D: Use Data for Population Management
3. PCMH 3, Element C: Care Management
4. PCMH 4, Element A: Support Self-Care Process
5. PCMH 5, Element B: Referral Tracking and Follow-Up
6. PCMH 6, Element C: Implement Continuous Quality Improvement

## Recognition Levels and Point Requirements

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There are three levels of NCQA PCMH Recognition; each level reflects the degree to which a practice meets the requirements of the elements and factors that comprise the standards. For each element's requirements, NCQA provides examples and requires specific documentation.

The NCQA Recognition levels allow practices with a range of capabilities and sophistication to meet the standards' requirements successfully. The point allocation for the three levels is as follows.

- **Level 1: 35–59 points and all 6 must-pass elements**
- **Level 2: 60–84 points and all 6 must-pass elements**
- **Level 3: 85–100 points and all 6 must-pass elements**

## Initial Recognition vs. Renewal

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To acknowledge that practices with current NCQA Level 2 or Level 3 Recognition have taken steps toward practice redesign and have systems in place that enabled their existing recognition level, NCQA offers a streamlined process for renewal through reduced documentation requirements. Practices that satisfactorily demonstrated basic medical home transformation can focus on more advanced aspects of redesign for their renewal applications.

**Note:** *Even though some elements do not require a practice to submit documentation, the practice must be able to produce documentation if it is selected for audit.*

## Optional Recognition for Use of Standardized Patient Experience Survey

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Beginning in 2012, NCQA will offer special acknowledgment for practices reporting results from a standardized patient experience survey. This option will require practices to use the Medical Home version of the CAHPS Clinician and Group Survey (currently in development by the research team sponsored by the federal Agency for Healthcare Quality and Research [AHRQ], with collaboration from NCQA). Practices can earn further recognition or distinction for collecting data using the standardized survey, following the defined methods and reporting the results to NCQA. Because there are no national data sources for benchmarking performance on patient-experience results using this new tool, results will not initially be publicly reported or used to score practices.

**Table 1: Summary of NCQA PCMH 2011 Standards**

Standard	Content Summary
PCMH 1: Enhance Access/Continuity	<ul style="list-style-type: none"> <li>• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours</li> <li>• The practice provides electronic access</li> <li>• Patients may select a clinician</li> <li>• The focus is on team-based care with trained staff</li> </ul>
PCMH 2: Identify/Manage Patient Populations	<ul style="list-style-type: none"> <li>• The practice collects demographic and clinical data for population management</li> <li>• The practice assesses and documents patient risk factors</li> <li>• The practice identifies patients for proactive reminders</li> </ul>
PCMH 3: Plan/Manage Care	<ul style="list-style-type: none"> <li>• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems</li> <li>• Care management emphasizes:               <ul style="list-style-type: none"> <li>– Pre-visit planning</li> <li>– Assessing patient progress toward treatment goals</li> <li>– Addressing patient barriers to treatment goals</li> </ul> </li> <li>• The practice reconciles patient medications at visits and post-hospitalization</li> <li>• The practice uses e-prescribing</li> </ul>
PCMH 4: Provide Self-Care Support/Community Resources	<ul style="list-style-type: none"> <li>• The practice assesses patient/family self-management abilities</li> <li>• The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources</li> <li>• Practice clinicians counsel patients on healthy behaviors</li> <li>• The practice assesses and provides or arranges for mental health/substance abuse treatment</li> </ul>
PCMH 5: Track/Coordinate Care	<ul style="list-style-type: none"> <li>• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)</li> <li>• The practice manages care transitions</li> </ul>
PCMH 6: Measure/Improve Performance	<ul style="list-style-type: none"> <li>• The practice uses performance and patient experience data to continuously improve</li> <li>• The practice tracks utilization measures such as rates of hospitalizations and ER visits</li> <li>• The practice identifies vulnerable patient populations</li> <li>• The practice demonstrates improved performance</li> </ul>

**Table 2: Integration of PCMH 2011 Development Goals Into Standards**

PCMH 2011 Goals	Goal Integration in the Standards
Increase patient-centeredness	<p><b>PCMH 1: Enhance Access and Continuity</b></p> <ul style="list-style-type: none"> <li>• Provide continuity of care with the same provider</li> <li>• Provide information to patients about the medical home</li> <li>• Provide access to care during and after office hours</li> <li>• Provide patient materials and services that meet the language needs of patients</li> </ul> <hr/> <p><b>PCMH 3: Plan and Manage Care</b></p> <ul style="list-style-type: none"> <li>• Collaborate with the patient/family to develop and manage a plan of care</li> <li>• Reconcile medication with the patient/family</li> </ul> <hr/> <p><b>PCMH 4: Provide Self-Care Support and Community Resources</b></p> <ul style="list-style-type: none"> <li>• Provide resources to support patient/family self-management</li> </ul> <hr/> <p><b>PCMH 6: Measure and Improve Performance</b></p> <ul style="list-style-type: none"> <li>• Involve patients/families in quality improvement</li> <li>• Obtain performance data for key vulnerable populations</li> </ul>
Align the requirements with processes that improve quality and eliminate waste	<p><b>PCMH 3: Plan and Manage Care</b></p> <ul style="list-style-type: none"> <li>• Conduct medication reconciliation and management</li> <li>• Use electronic prescribing</li> </ul> <hr/> <p><b>PCMH 5: Track and Coordinate Care</b></p> <ul style="list-style-type: none"> <li>• Identify patients with hospital admission or emergency department visits</li> </ul>
Increase the emphasis on patient feedback	<p><b>PCMH 6: Measure and Improve Performance</b></p> <ul style="list-style-type: none"> <li>• Expand the survey categories (access, communication, coordination, self-management support, whole person orientation, comprehensiveness, shared decision-making) and practice requirements</li> <li>• Use patient survey results for quality improvement</li> <li>• Involve patients/families in quality improvement</li> </ul> <p><i>Note: In addition to the standards, there will be an optional Recognition for reporting results using a standardized patient experience survey and methodology.</i></p>
Enhance the use of clinical performance measure results	<p><b>PCMH 6: Measure and Improve Performance</b></p> <ul style="list-style-type: none"> <li>• Increase the number of performance measures</li> <li>• Add a requirement to monitor utilization/overuse data</li> <li>• Add a requirement for practices to demonstrate improved PCMH status.</li> </ul>
Integrate behaviors affecting health, mental health and substance abuse	<p><b>PCMH 1: Enhance Access and Continuity</b></p> <ul style="list-style-type: none"> <li>• Comprehensive assessment includes depression screening for adolescents and adults</li> </ul> <hr/> <p><b>PCMH 3: Plan and Manage Care</b></p> <ul style="list-style-type: none"> <li>• One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition.</li> </ul> <hr/> <p><b>PCMH 5: Track and Coordinate Care</b></p> <ul style="list-style-type: none"> <li>• Track referrals and coordinate care with mental health and substance abuse services</li> </ul>
Enhance coordination of care	<p><b>PCMH 5: Track and Coordinate Care</b></p> <ul style="list-style-type: none"> <li>• Arrange for information exchange with facilities, including after-hours care providers</li> <li>• Coordinate referrals</li> <li>• Coordinate with community service agencies</li> </ul>

**Table 2: Integration of PCMH 2011 Development Goals Into Standards *continued***

PCMH 2011 Goals	Goal Integration in the Standards
Enhance applicability to pediatric practices	Throughout the standards <ul style="list-style-type: none"> <li>• Incorporate “family” where appropriate</li> <li>• Use “NA for pediatric practices” where appropriate</li> <li>• Use pediatric examples and explanations</li> <li>• Reference Bright Futures</li> </ul>
	<b>PCMH 1: Enhance Access and Continuity</b> <ul style="list-style-type: none"> <li>• Explanation addresses unique pediatric issues, such as teen privacy and guardianship</li> </ul>
	<b>PCMH 2: Identify and Manage Patient Populations</b> <ul style="list-style-type: none"> <li>• Include pediatric clinical data, health assessment requirements and age appropriate immunizations and screenings</li> <li>• Include age-appropriate screenings (e.g., developmental, adolescent depression)</li> </ul>
	<b>PCMH 3: Plan and Manage Care</b> <ul style="list-style-type: none"> <li>• Explanation specifies relevant pediatric clinical conditions, including well-child care and children/youth with special health care needs</li> </ul>
	<b>PCMH 4: Provide Self-Care Support and Community Resources</b> <ul style="list-style-type: none"> <li>• Population specific referrals includes parenting and respite care</li> </ul>
	<b>PCMH 5: Track and Coordinate Care</b> <ul style="list-style-type: none"> <li>• Communicate with facilities for newborn lab test results</li> <li>• Collaborate to develop a written care plan for patients transitioning from pediatric care to adult care</li> </ul>
	<b>PCMH 6: Measure and Improve Performance</b> <ul style="list-style-type: none"> <li>• Preventive measures include developmental screening, immunizations and depression screening</li> </ul>

## Resources

- American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs, February 2011. Advance copy.
- AAFP, AAP, ACP, AOA. *Joint Principles of the Patient-Centered Medical Home*. February 2007. <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home> (February 18, 2011)
- Barr, M. The Patient-Centered Medical Home: Aligning Payment to Accelerate Construction. *Med Care Res Rev OnlineFirst*. May 6, 2010: XX(X)1–8.
- Berwick, D.M., T.W. Nolan, J. Whittington. 2008. The Triple Aim: Care, Health, And Cost *Health Affairs*, 27, no. 3:759–69.
- Bitton, A., C. Martin, B. Landon. 2010. A Nationwide Survey of Patient Centered Medical Home Demonstration Projects. *J Gen Intern Med*. 25(6):584–92.
- Bodenheimer, T., H. Pham. 2010. Primary Care: Current Problems and Proposed Solutions. *Health Affairs*. 29(5):799–805.
- Centers for Medicare and Medicaid Services (CMS). Electronic Health Records and Meaningful Use. <http://healthit.hhs.gov/portal/server.pt?open=512&objID=2996&mode=2> (January 12, 2011)
- Diedhiou, A., J. Probst, J. Hardin, et al. Relationship Between Presence of a Reported Medical Home and Emergency Department Use Among Children With Asthma. *Med Care Res Rev OnlineFirst*. May 4, 2010:XX(X)1–26.
- Fields, D., E. Leshen, K. Patel. 2010. Driving Quality Gains and Cost Savings Through Adoption of Medical Homes. *Health Affairs*. 29(5):819–26.
- Flottemesch, T., S.H. Scholle, P.J. O’Connor, L. Solberg, S. Asche, L.G. Pawlson. 2010. Are Characteristics of the Medical Home Associated with Diabetes Care Costs? Under review.

- Grumbach, K., P. Grundy. *Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States*. November 16, 2010. [http://www.pcpcc.net/files/evidence\\_outcomes\\_in\\_pcmh.pdf](http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf) (January 12, 2011)
- Grundy, P., K. Hagan, J.C. Hansen, et al. 2010. The Multi-Stakeholder Movement For Primary Care Renewal and Reform. *Health Aff.* 29(5):791–8.
- Holmboe, E., G. Arnold, W. Weng, et al. 2010. Current Yardsticks May Be Inadequate For Measuring Quality Improvements From The Medical Home. *Health Affairs.* 29(5):859–66.
- Homer, C., R. Baron. 2010. How to Scale Up Primary Care Transformation: What We Know and What We Need to Know? *J Gen Intern Med.* 25(6):625–9.
- Howell, J. 2010. Reflections on the Past and Future of Primary Care. *Health Affairs.* 29(5):760–5.
- Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press, Washington, DC.
- Institute of Medicine. 2005. *Building a Better Delivery System: A New Engineering/Health Care Partnership*. National Academies Press, Washington, DC.
- Landon, B., J. Gill, R. Antonelli, et al. 2010. Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home. *Health Affairs.* 29(5):827–34.
- Merrell, K., R. Berenson. 2010. Structuring Payment for Medical Homes. *Health Affairs.* 29(5):852–8.
- Margolius, D., T. Bodenheimer. 2010. Transforming Primary Care: From Past Practice to The Practice of The Future. *Health Aff.* 29(5):779–84.
- McClellan, M., A. McKethan, J. Lewis, et al. 2010. A National Strategy to Put Accountable Care Into Practice. *Health Aff.* 29(5):982–90.
- Naylor, M., E. Kurtzman. 2010. The Role of Nurse Practitioners in Reinventing Primary Care. *Health Affairs.* 29(5):893–9.
- Pham, H. 2010. Good Neighbors: How Will the Patient-Centered Medical Home Relate to the Rest of the Health-Care Delivery System? *J Gen Intern Med.* 25(6):630–4.
- Reid, R., P. Fishman, O. Yu, T. Ross, J.T. Tufano. 2009. Patient-Centered Medical Home Demonstration: A prospective, quasi-experimental, before and after evaluation. *American Journal of Managed Care.* 15(9), e71-e87.
- Rittenhouse, D., S. Shortell, E. Fisher. 2009. Primary Care and Accountable Care—Two Essential Elements of Delivery-System Reform. *N Engl J Med.* 361(24):2301–3.
- Rittenhouse, D., D. Thom, J. Schmittiel. 2010. Developing a Policy-Relevant Research Agenda for the Patient-Centered Medical Home: A Focus on Outcomes. *J Gen Intern Med.* 25(6):593–600.
- Roby, D.H., N. Pourat, M.J. Pirritano, et al. Impact of Patient-Centered Medical Home Assignment on Emergency Room Visits Among Uninsured Patients in a County Health System. *Med Care Res Rev OnlineFirst.* June 2, 2010:XX(X)1–19.
- Shortell, S., L. Casalino. 2010. Implementing Qualifications Criteria and Technical Assistance for Accountable Care Organizations. *J Amer Med Assoc.* 303(17):1747–8.
- Stange, K., P. Nutting, W. Miller, et al. 2010. Defining and Measuring the Patient-Centered Medical Home. *J Gen Intern Med.* 25(6):601–12.
- Wagner, E.H., B.T. Austin, C. Davis, M. Hindmarsh, J. Schaefer, A. Bonomi. 2001. Improving chronic illness care: translating evidence into action. *Health Aff (Millwood).* 20:64–78.
- Wagner, E.H. 1998. [Chronic disease management: what will it take to improve care for chronic illness?](#) *Eff Clin Pract.* 1:2–4.

# **Policies and Procedures**



## Policies and Procedures

### Section 1: PCMH 2011 Eligibility and the Application Process

The Patient-Centered Medical Home (PCMH) 2011 Recognition program is NCQA's update of its groundbreaking PPC-PCMH standards released in 2008. This program recognizes eligible outpatient primary care practices for a duration of three years. The practice must provide primary care for all of the patients in its practice, not just selected patients. A practice is one or more clinicians who practice together and provide patient care at a single geographic location. Practicing together means that, for all the clinicians in a practice:

- The practice care team follows the same procedures and protocols
- Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians, as appropriate
- The same systems—electronic and paper-based—and procedures support both clinical and administrative functions, for example: scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up
- A facility, such as a rehabilitation facility or a hospital cannot receive PCMH Recognition; however, hospital-based primary care practices and residency clinics are eligible.

#### **Primary care practices that qualify for PCMH evaluation**

- An incorporated group of three clinicians in an office site who use the same systems and staff, as described above.
- An individual clinician, whether sharing an office with other clinicians or not, who maintains his or her own systems.
- A group of clinicians at one location that is part of a larger medical group with several locations.
- A practice within a multi-site group; NCQA defines a multi-site group as 3 or more practice sites using the same systems and processes including an electronic medical record system shared across all practice sites.
- A subset of primary care clinicians within a multi-specialty practice.

#### **Eligible primary care clinicians who qualify for PCMH evaluation**

- Only clinicians that a patient/family can select as a Personal Clinician are eligible for Recognition and listed on NCQA's website
- Clinicians who are typically eligible for PCMH evaluation include physicians, nurse practitioners and physician assistants who practice in the specialty of internal medicine, family medicine, or pediatrics and with the intention of serving as the personal, primary care clinician for their patients
- Clinicians who are not typically eligible for PCMH evaluation include specialty physicians, nurse practitioners and physician assistants who do not have their own panel of patients or who do not practice in primary care
- All eligible clinicians practicing together at practice site applying for recognition must be included in the PCMH Application
- Physician-led practices applying with nurse practitioners or physician assistants:
  - Patients must be able to choose the nurse practitioner or physician assistant as their primary care practitioner
  - Nurse practitioners or physician assistants must have their own panel of patients

- Nurse practitioner (NP) practices (NP-led practices) without a physician can 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.
- Applicants must have an active unrestricted license as a doctor of medicine, doctor of osteopathy, nurse practitioner or physician assistant.

## Fee Schedule Information

NCQA periodically updates the fee schedules applicable to its recognition programs on the program Web site and in the resources published in the application materials. Organizations purchasing a Survey Tool will be notified of changes in the fee schedule 30 days prior to any change. The fee schedule in effect when a practice submits its Survey Tool for evaluation determines the pricing.

An application fee is due for each practice site undergoing a survey and is based on the number of eligible clinicians that intend to be listed for the practice site if they achieve NCQA Recognition. If clinicians are listed at more than one practice site, they are considered in the fee calculation for each site.

There are four fee schedules.

1. **Standard Survey Pricing** applies to a practice applying for the first time or for renewal.
2. **Discounted Survey Pricing** applies to practices that are sponsored by an approved organization and applying for the first time or for renewal.
3. **Multi-Site Group Survey Pricing** includes a multi-site survey fee based on the number of practices and a discounted survey fee for each site included in the group
4. **Add-On Survey or Upgrade Survey Pricing** is only applicable to practices with a current recognition status and allows a practice to advance to a higher level or from PPC-PCMH 2008 to PCMH 2011.

## Sponsoring a PCMH Initiative

A sponsoring organization or entity (e.g., a state) encourages its network of physicians, nurse practitioners, physician assistants, practices, members or program participants to achieve NCQA Recognition in return for an additional recognition, promotion or reward. A sponsor can be a health plan, a coalition of plans, a government entity, a business coalition, a collaboration of plans and businesses, a professional organization or a non-profit quality improvement or disease awareness organization. Some sponsors 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 acknowledging sponsors and offering a discount on application fees.

Potential sponsors should contact NCQA to ensure alignment with NCQA policies and procedures.

- Only eligible clinicians and practices can be accepted for evaluation
- NCQA shares the clinician or practice status with sponsors to the extent authorized by the clinician or practice
- NCQA must approve external communications, including an announcement or specifications to ensure alignment with our policies

NCQA posts the names of sponsors on its Web site and is available to coordinate additional training or orientation programs. *The sponsor and practice must identify the approved sponsor on the application to qualify for a discounted application fee.*

## The PCMH 2011 Online Application Process

NCQA uses a Web-based module (the online application) for the PCMH Recognition application process. Applicants use this system to submit applications and to set up multi-site submissions including multi-site Survey Tool orders.

The online application contains the following components.

- **Account Information.** The practice provides relevant demographic information, including the account name, the contact person, the telephone number and the address of the organization.
- **NCQA Legal Documents.** Before submitting the application, the practice must complete:
  - The PCMH Recognition Program Agreement
  - The HIPAA Business Associate Agreement.
- **Practice Site Information.** The practice provides the name and address of each site in the organization, the sponsor identification (if applicable), the site contact information and the mailing address.
- **Multi-Site Group Self-Assessment Questionnaire. For practices considering a multi-site evaluation, completing this self-assessment questionnaire will** determines if the practice group is eligibility for the Multi-Site Survey process. It is appropriate for practices with multiple sites that use the same medical record system and processes.
- **Clinician Information.** The practice provides the number and name of each eligible clinician and links them to each practice site where they deliver care. Changes may be made to the clinicians linked to a practice site any time during the recognition period.
- **Application Form.** In the online application form, the practice enters the license number of the Survey Tool, the important conditions (i.e., conditions with evidence-based clinical guidelines on which the practice concentrates its care management; more details are provided in PCMH 3A) used in the Survey Tool, the practice specialty and practice type (e.g., multi-site, academic medical clinic, residency clinic) for *each* site.
- **Multi-Site Group Self-Assessment Questionnaire. For practices considering a multi-site evaluation, completing this self-assessment questionnaire will** determines if the practice group is eligibility for the Multi-Site Survey process. It is appropriate for practices with multiple sites that use the same medical record system and processes.

## The PCMH 2011 Multi-Site Application

The multi-site application process is an option for organizations or medical groups with three or more practice sites that share the same policies and procedures and an electronic health record system (EHR) across all of the practice sites applying for NCQA PCMH 2011 Recognition at one time.

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

- An organization partially completes a group Survey Tool for shared responses
- The organization partially completes a site-specific Survey Tool for each site with responses to the remaining elements
- NCQA merges the group and practice site Survey Tool responses after submission to create one fully completed Survey Tool for each site.

## Determine Multi-Site Eligibility

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**A multi-site application requires that the practice have at least three sites.**

An organization uses the PCMH online application system to enter the number of sites applying for recognition and answer three eligibility questions. The application system automatically indicates if the organization is eligible based on responses to the following:

What is the number of practice sites in your organization applying for recognition?

**Note:** Responses must reflect processes and systems currently in place

To qualify for a multi-site application, the practice must answer “yes” to all of the following questions:

1. Are all of the practice sites applying for recognition able to be included under one PCMH program agreement (i.e. can your organization sign one agreement to cover all sites)?
2. Do at least 3 of the practice sites applying for recognition currently share and use in the same way, an electronic practice management registry or electronic health record system to document basic patient information for administration and billing purposes? (Practices must share and use in the same way for a minimum of 3 months if responding “yes”)
3. Do at least 3 of the practice sites applying for recognition currently share and use in the same way, an electronic health record system for documenting clinical patient information? (Practices must share and use in the same way for a minimum of 3 months to respond “yes”)

Eligible organizations can use the online Application Portal to access instructions and FAQs about the application process. These documents are a guide through the multi-site application process and the Survey Tool purchase.

## Multi-Site Survey Tool Submission Options

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**Note:** Multi-site practices should complete the application before purchasing the required Survey Tools.

It is not necessary to purchase all of the required Survey Tools at one time; the organization may purchase them in accordance with the option it selects for submission of the Survey Tools.

**Option 1** Submit the group Survey Tool and wait for the NCQA score and reviewer comments for only that tool. A recognition decision will not be issued based on the group Survey Tool alone.

**Note:** NCQA strongly recommends that a practice choose this option before submitting the site-specific Survey Tools.

Organizations that choose this option have 12 months from the date of the group Survey Tool submission to submit all of the practice site tools.

Organizations that submit a group Survey Tool under the 2008 PPC-PCMH standards must submit the group Survey Tool by December 31, 2011, and must submit the site Survey Tools within 12 months, or by June 30, 2012, *whichever is earlier*.

NCQA will notify organizations in advance of any change to the current process.

**Option 2** Submit the group Survey Tool and one or two practice sites and wait for the final recognition decision on the sites. This is for an organization that wants to see the final recognition decision and the reviewer comments for the sites before it submits the remaining site Survey Tools.

**Option 3** Submit the group Survey Tool and all site tools without waiting for an NCQA score or Recognition decision.

## Practice Readiness Evaluation

Practices can conduct a readiness self-evaluation on the PCMH standards and elements before submitting the Survey Tool to NCQA. To be most accurate, the evaluation should thoroughly assess the practice's systems, including responses to questions, completed worksheets (as needed) and evaluation of supporting documentation. The Survey Tool estimates the score for each standard and element and provides an overall preliminary score.

While a practice is conducting its readiness evaluation, NCQA surveyors do not have access to the Survey Tool, any data or any referenced documentation. The information is secure and confidential and for the practice's use only. NCQA has access to the Survey Tool *only* after it has been submitted for review.

## Complete the Application

### **Step 1** *Order the PCMH 2011 Online Application from NCQA.*

PCMH application materials can be obtained at no charge online at <http://www.ncqa.org/Communications/Publications/index.htm> or by contacting NCQA's Customer Support staff at 888-275-7585.

You will receive confirmation e-mails from NCQA with the subjects *Publication Order Confirmation* and *Accessing Your NCQA PCMH Recognition Online Application*. If you do not receive these e-mails, check with the e-mail contact provided at the time of the application order before contacting NCQA.

### **Step 2** *Access the PCMH online application system* by following the instructions in the e-mail with the subject *Accessing Your NCQA PCMH Recognition Online Application*.

Order a PCMH 2011 Survey Tool for each practice site you are submitting for PCMH 2011 Recognition. Refer to *Multi-Site Applications* for information on the multi-site application process.

### **Step 3** *Sign the program agreement and the Business Associate Agreement* electronically or submit signed agreements to NCQA before you submit the application.

### **Step 4** *Submit the online application to NCQA.* You must submit the application before you submit the Survey Tool.

NCQA requires one week to process the application. You will receive a confirmation e-mail from NCQA when we receive your application, and a separate e-mail indicating that your Survey Tool is ready for document upload and survey submission.

### **Step 5** *Submit the application fee* to NCQA before or concurrently with your PCMH Survey Tool. NCQA cannot review your Survey Tool for Recognition until payment is received.

## Complete the Survey Tool

Practices should review the PCMH standards to determine if they perform the functions required by the elements under each standard. To help determine the capabilities of the practice, review the Explanation section of each element.

**Step 1 Respond to questions.** Indicate the response for each factor that corresponds to the practice's capabilities.

**Step 2 Complete the worksheets (if applicable).** Two optional worksheets are attached to the Survey Tool, The Quality Measurement and Improvement Worksheet and The Record Review Workbook. You may need to complete one or both of them.

If you plan to use the worksheets, download them, save them to your computer and label them with the name of your practice. Enter the requested information and then reattach them to the Survey Tool following the directions provided in the Survey Tool.

- **The Quality Measurement and Improvement Worksheet (in Microsoft Word).**  
The worksheet relates to PCMH 6C and 6D and is a method of documenting quality measurement and improvement efforts.
- **The Record Review Workbook (RRWB) (in Microsoft Excel)—(PCMH 3C, 3D, 4A).**  
The worksheet is used to document patient medical record reviews. It allows the practice to review selected patient records following NCQA methodology and then enter medical record information in the worksheet for PCMH 3, Elements C and D and PCMH 4, Element A. The worksheet calculates the percentage of patients with documentation of required functions in the medical record. Refer to the *Instructions* tab in the Record Review Workbook for details about patient selection methodology.

An alternative to the Record Review Workbook is a report the practice creates based on a query of their electronic system. Details of the data needed in the report are described in the *Explanations* section of the specified elements.

**Step 3 Attach documentation.** All elements require the practice to attach documents to demonstrate how it meets the elements. Each element provides explanations and describes the documentation required.

NCQA requests that no more than three documents be attached per element. Some elements will only require one document. Multiple document sources may be combined into a single document (e.g., one Word document with several reports or examples or one PDF). The ISS cannot accept documents in HTML format. Information in the documents that meets the standard should be identified or highlighted. Only legible documents will be considered.

The Survey Tool provides instructions for attaching documentation. Once the documents are attached, they are listed in a document library and referenced by element.

Until the Survey Tool is submitted, practices can revise responses, enter comments and update or change the attached documents.

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**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, specifically patient identifiers unless the Survey Tool indicates otherwise. NCQA does not request PHI, but, to the extent that it is inadvertently included in documentation materials, NCQA's use and access to this information is governed by the HIPAA Business Associate Agreement.
- Practices may provide Web links to data or Web sites.
- For many elements, the best documentation is a screen shot from a computer the practice uses. Create and then cut and paste the screen shots to a single Word document or scan documents and create a portable document format (PDF). Save Word documents using text boxes to block PHI as read only.

**Step 4 Submit the application and the application fee.**

**Note:** You may not complete your submission until NCQA receives your application and establishes an electronic link between your Survey Tool and the NCQA server.

**Step 5 Upload documents.** This step enables you to upload your attached documents to the NCQA server (similar to attaching a document to an e-mail) for review. The Survey Tool has instructions for uploading documents.

**Step 6 Submit the Survey Tool with the attached documentation.** The date when you submit the Survey Tool to NCQA is the date when NCQA officially begins its survey of your data.

You can view your copy of the completed Survey Tool and all of the attached documents and can modify the Survey Tool for your own purposes, but the official copy sent to NCQA, and all the data in it, are considered final for NCQA evaluation. You will not have access to NCQA's copy of your completed Survey Tool and you cannot change data after submission or view NCQA's review of the results until NCQA has finished.

NCQA sends an e-mail confirming its receipt of the Survey Tool and the start of the evaluation period. NCQA staff review and assess the completeness of application data and Survey Tool materials and might notify you if additional information is required.

All practice locations must submit a PCMH Survey Tool to receive NCQA Recognition and to be listed on NCQA's Web site. NCQA also lists eligible clinicians for practices that receive recognition; an eligible clinician can be listed at more than one practice site. NCQA adds eligible clinicians to an application or removes them during the review process, before the recognition decision. After the decision, the practice must submit updated clinician information to [pcmh@ncqa.org](mailto:pcmh@ncqa.org) if it wants to delete or add additional eligible clinicians. All additional eligible clinicians will be listed on NCQA's Web site.

## Section 2: The Recognition Process

### NCQA Review of the Survey Tool

#### The Offsite Survey

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Trained NCQA internal and external surveyors access the Survey Tool after the practice submits it to NCQA. The surveyors evaluate the responses and documentation against program standards and determine scores for each relevant element and standard. NCQA makes its final scoring decision within 60 days of receiving a completed Survey Tool.

If the practice is one of a group of practices participating in a Multi-Site Survey, NCQA reviews the standards in the Multi-Site Group Survey first and applies the results to all practices in the group, then reviews the Survey Tools with site-specific data.

#### The Audit

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NCQA reserves the right to audit any practice that has applied for NCQA Recognition while the practice's application is under review. An audit validates documentation, stated procedures and responses given by a practice in its application and Survey Tool. NCQA audits 5 percent of practices, either by specific criteria or randomly,<sup>1</sup> before making a decision about whether the practice meets PCMH requirements. Audits may be completed by e-mail, teleconference, Webinar, onsite review or by other electronic means. Failure to agree to an audit, failure to pass an onsite audit or failure to pass an audit of Survey Tool responses and documented elements may result in a status of "Not Recognized."

Practice sites selected for audit are notified and sent instructions. The first level of review is verification of the Survey Tool submitted by the practice. The practice may be asked to forward copies of the source documents and explanations, to substantiate the information in the Survey Tool submitted with its application.

If the application is verified and no issues are discovered, the practice is notified that the audit is complete and the application for Recognition is processed.

If an audit requires an onsite 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 the information submitted by the practice is incorrect or that the documentation does not meet the PCMH standards, the application for NCQA Recognition may be denied, scores may be reduced or additional documentation may be required. NCQA staff notify the practice of audit findings and the recognition decision within 30 days after conclusion of the audit.

A practice whose application for recognition is denied because of an audit may request Reconsideration of the decision. Refer to *Reconsideration* for more information.

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<sup>1</sup>Random selection of applications is based on a predetermined target to achieve a 5 percent audit rate.

## PCMH 2011 Standards

There are six PCMH standards with one overall score. Each standard consists of several specific elements. Standards evaluate a practice's ability to function as a patient-centered medical home.

1. PCMH 1: Enhance Access and Continuity
2. PCMH 2: Identify and Manage Patient Populations
3. PCMH 3: Plan and Manage Care
4. PCMH 4: Provide Self-Care Support and Community Resources
5. PCMH 5: Track and Coordinate Care
6. PCMH 6: Measure and Improve Performance

## A Standard's Structure

<b>Standard name</b>	Brief statement of the standard's purpose.
<b>Element name</b>	Description of performance being evaluated.
<b>Element</b>	<p>The scored component of a standard that provides details about performance expectations. NCQA evaluates each element in a standard to determine how well the practice meets the element's requirements.</p> <p>Of the 27 elements in PCMH 2011, 6 are must-pass elements. Refer to <i>The Must-Pass Elements</i> in the <i>Overview</i>.</p>
<b>Factor</b>	<p>A scored item in an element. For example, an element may require the practice to demonstrate that its policies and procedures include four specific items; each item is a factor. When an element includes multiple numbered factors, the scoring indicates the number of factors that the practice must meet to achieve each scoring level.</p> <p><i>Critical factor</i> is a factor that is required for practices to receive more than minimal or, for some factors, any points. Critical factors are identified in the scoring section of the element.</p>
<b>Scoring</b>	The level of performance the practice must demonstrate to receive a specified percentage of element points. Each element has up to five possible scoring levels (100%, 75%, 50%, 25%, 0%).
<b>Explanation</b>	Specific requirements that the practice must meet and guidance for demonstrating performance against the factor. The explanation provides detailed information to the practice about what NCQA looks for, how the element relates to other elements, terms used and the evaluation process.
<b>Examples</b>	<p>Required documentation. Describes the evidence practices need to submit to demonstrate their performance related to specific elements. The list of documentation sources in each element is not prescriptive, nor does it exclude other potential sources. The practice may have acceptable alternative methods that demonstrate performance.</p> <p>The practice must show documentation of policies and processes that have been in place for at least 3 months. Data should be no more than 12 months old.</p>

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

1. Documented process—Written statements describing the practice’s policies, and procedures. The statements may include protocols or other documents that describe actual processes or forms the practice uses in work flow such as referral forms, checklists and flow sheets. The documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCMH 2011 Survey Tool.
2. Reports—Aggregated data showing evidence of action, including manual and computerized reports the practice produces to manage its operations, such as a list of patients who are due for a visit or test.
3. Records or files—Actual patient files or registry entries that document an action taken. The files are a source for estimating the extent of performance against an element. There are two ways to measure this performance:
  - A query of electronic files yielding a count, or
  - The sample selection process provided by NCQA—instructions for choosing a sample and a log for reviewing records are in the Record Review Workbook, attached to the PCMH Web-based Survey Tool.
4. Materials—Prepared materials the practice provides to patients or clinicians including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets.

### Scoring Guidelines

<b>Elements</b>	The Survey Tool multiplies the element’s scoring level by its weight in points to determine the element score. As determined by NCQA and provided for in the explanation within the Standards, some elements may be scored NA if they do not apply to the practice.
<b>Calculating the standard score</b>	The Survey Tool adds the scores received for all elements in a standard to determine the score received for the standard.
<b>Calculating the overall score</b>	The Survey Tool adds the scores received for all standards to determine the final score.

### CMS Meaningful Use Requirements

To the extent possible, the PCMH standards are aligned with the Centers for Medicare & Medicaid Services (CMS) Meaningful Use (MU) requirements. Individual factors are identified in the standards as either Core or Menu MU requirements and are designated with asterisks (i.e., \*Core, \*\*Menu).

Refer to *Appendix 2: NCQA’s Patient-Centered Medical Home (PCMH) 2011 and CMS Stage 1 Meaningful Use Requirements* for additional information.

## Final Decision and Recognition Levels

The practice's recognition determination is based on its overall performance (numeric score) against the standards and achievement of each must-pass element at the 50% scoring level.

Recognition Level	Points	Must-Pass Elements
Level 1	35–59 points	6 of 6
Level 2	60–84 points	6 of 6
Level 3	85–100 points	6 of 6

Scoring decision results are shown in the Final Results section of the Survey Tool. This section consists of tabular findings on:

- Scores for each element and standard
- Number of must-pass elements achieved
- The total score.

The NCQA RP-ROC (Recognition Program Review Oversight Committee) reviews findings, makes final scoring decisions and incorporates scores into the final version of the Survey Tool, which generates the practice's results. RP-ROC members are clinicians who have expertise in practice systems and who, as determined by NCQA, have no conflict of interest with the practice.

<b>Certificates</b>	NCQA issues an official Recognition certificate acknowledging that the practice met the standards.
<b>Duration of status</b>	Recognition status lasts three years. A practice that wants to achieve a higher level of recognition status can apply for an Add-On Survey (see below).
<b>Reporting results...</b>	
<i>...To the practice</i>	NCQA gives the practice a final version of the Survey Tool that includes the final status and level, as well as numerical scores and reviewer comments on all elements and all standards.
<i>...To the public</i>	Recognized practices and associated clinicians are added to the list of practices and clinicians on NCQA's Web site ( <a href="http://www.ncqa.org/programs/pcmh">www.ncqa.org/programs/pcmh</a> ). NCQA does not report practices whose status is Not Recognized.
<i>...To organizations</i>	NCQA sends a list of recognized practices and clinicians and the levels they achieve to organizations that reward NCQA PCMH Recognition.

## Recognition Levels

<b>Recognized</b>	All must-pass elements were met and the score determined the level of recognition achieved.
<b>Not Recognized</b>	Indicates that must-pass elements were missed or that the total score was not high enough to pass any level needed to achieve a status of Recognized. NCQA does not report Not Recognized status on its Web site or to any other organization. The practice may reapply after the submission of its original completed application.

## Section 3: Additional Information

### Add-On Survey or Upgrade Survey

Practices have two options to improve their recognition level: add-on or upgrade.

**PCMH 2011 Recognized Practices** Practices that receive Level 1 or Level 2 Recognition status may apply for an Add-On Survey within the 3-year recognition period, to move to Level 2 or Level 3 Recognition. For each Add-On Survey, the practice requests and receives an updated Survey Tool with a new license number to submit data for elements for which it earned a score of 75% or below. NCQA evaluates data for the elements submitted and produces a new total score for the standards.

NCQA evaluates the submitted elements according to the process described in this document and sends the results to the practice. If the practice achieves recognition at a new level, NCQA reports the new level.

**PPC-PCMH Recognized Practices** Practices with Level 2 or 3 Recognition under the 2008 PPC-PCMH standards may apply for an upgrade to the PCMH 2011 standards before the current status ends. An upgrade does not extend the end date of the current recognition status. Instructions for an upgrade from the 2008 PPC-PCMH standards to the PCMH 2011 standards are posted on NCQA's Web site and in the online application materials.

### Renewing Recognition

To acknowledge that practices with current NCQA Level 2 or Level 3 Recognition have taken steps toward practice redesign and have systems in place that enabled their recognition level, NCQA offers a streamlined process for renewal through reduced documentation requirements. Practices that satisfactorily demonstrated basic medical home transformation can focus on more advanced aspects of redesign for their renewal applications.

To take advantage of the reduced documentation requirements for selected elements, renewing practices must follow renewal instructions in the online application materials.

### Reconsideration

A practice may request Reconsideration of any NCQA Recognition Level or Not Recognized status decision. NCQA must receive a Reconsideration request within 30 days after the practice is notified that it has received a specific recognition level or a status of Not Recognized. The practice must describe the reason for requesting the Reconsideration and list standards or elements for which it requests Reconsideration. It may not submit additional documentation at this time, but may state how it believes NCQA misinterpreted the original documentation.

NCQA refers Reconsideration requests to the Reconsideration Committee. The Recognition Programs assistant vice president or Recognition programs director will review the request and make a recommendation to a group of three RP-ROC members who were not involved in making the initial recognition decision and do not have a conflict of interest with the practice; these members will compose the Reconsideration Committee and make a decision on the request. A fee of \$500 or the cost of an Add-On Survey, whichever is less, is required at the time of request for Reconsideration.

The Reconsideration Committee reviews information in the Web-based Survey Tool. The Reconsideration Committee's decision is final and is sent to the practice in writing. There is no further right of appeal.

## 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 correct and was obtained using procedures specified in the PCMH Survey Tool and PCMH Policies and Procedures
- To release the information to NCQA that NCQA deems pertinent.
- To hold NCQA, its directors, officers, employees, agents and representatives harmless from any claims related to 1) third party claims for malpractice or injury by the practice; 2) the practice's failure to achieve desired results under the PCMH survey; and 3) payment and network decisions made by third parties based on the practice's status as PCMH Recognized.
- To abide by the terms of the signed application agreement and the guidelines for advertising PCMH Recognition, these procedures and instructions and all other published NCQA policies, procedures and rules.
- 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 which may include a physician or a nurse practitioner operating within the appropriate scope of practice of the state.
- To notify NCQA of the final determination by a state or federal agency with respect to an investigation, request for corrective action, imposition of sanctions or changes in licensure or qualification status. Such notification must be sent to NCQA no later than 30 days after the practice receives notice of such action.
- To accept all NCQA determinations regarding the practice's PCMH status.
- To agree that NCQA makes no warranties or representations to others and that the provision of health care advice is solely the responsibility of the clinician or practice or a third party.
- To agree that a PCMH status by NCQA does not constitute a warranty or any other representation by NCQA to any third parties (including, but not limited to, employers, consumers or payers) regarding the quality or nature of the health-related services provided or arranged for by the clinician or practice.
- To agree that any information created as a part of the PCMH survey of the practice by NCQA shall be kept confidential, except as indicated in the section *Reporting Results*, unless otherwise agreed to by NCQA.
- To agree that the PCMH program is not a replacement for a practice's evaluation, assessment and monitoring of its own services and programs.
- To not misrepresent its PCMH status (including, but not limited to, the scope and meaning of such status as defined herein) or suggest that it has received a PCMH status by NCQA when such representation is not accurate.
- 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 notify NCQA of any change in submitted clinicians listed with the Recognition of the practice.

If NCQA identifies a deficiency in a practice's operations that poses a threat to patient or public health or safety, it may notify the applicable regulatory agencies, following notice to the clinician or the chief executive officer or medical director of the group.

## **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. The decision to initiate a Discretionary Survey is made by the Vice President of Product Delivery who oversees PCMH program operations, and the NCQA general counsel.

**Structure** Discretionary Surveys are specifically targeted to address issues indicating that a practice may not continue to meet the NCQA standards that were in effect at the time of Recognition. The scope and content of the review are determined by NCQA. Discretionary Surveys may consist of an offsite document review, an onsite review or a teleconference.

If a Discretionary Survey requires an onsite review, NCQA conducts the review within 60 calendar days of the notification by NCQA of the intent to conduct a Discretionary Survey.

## **Revoking Decisions**

NCQA may revoke a PCMH decision if:

- The practice submits false data
- The practice misrepresents the credentials of any clinician
- The practice misrepresents its PCMH status
- Any of the practice's clinicians experiences suspension or revocation of professional licensure
- 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.

When communicating with patients, third-party payers, health plans and others, practices who receive 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.” The use of this mischaracterization or other similarly inappropriate statements is grounds for revocation of status.

## **Mergers, Acquisitions and Consolidations**

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 a 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 sent to practices 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 surveyors and others during the course of the evaluative process.

**NOTE**

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# **NCQA's Patient-Centered Medical Home (PCMH) 2011 Standards**

3/28/11



## PCMH 1: Enhance Access and Continuity

20 points

The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

### Element A: Access During Office Hours **MUST-PASS**

4 points

The practice has a written process and defined standards, <i>and</i> demonstrates that it monitors performance against the standards for:	Yes	No	NA
1. Providing same-day appointments	<input type="checkbox"/>	<input type="checkbox"/>	
2. Providing timely clinical advice by telephone during office hours	<input type="checkbox"/>	<input type="checkbox"/>	
3. Providing timely clinical advice by secure electronic messages during office hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Documenting clinical advice in the medical record.	<input type="checkbox"/>	<input type="checkbox"/>	

#### Scoring

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors, including factor 1	The practice meets 2 factors, including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

#### Explanation

**MUST-PASS** elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

Patients can access the clinician and care team for routine and urgent care needs by office visit, by telephone and through secure electronic messaging. Practice staff considers patient care needs and preferences when determining the urgency of patient requests for same-day access. For all factors, the practice must provide their defined standards or policies with a date of implementation (must be in effect at least 3 months) **and** demonstrate they have monitored performance against the standards they have defined.

Factor 1: The practice reserves time for same-day appointments (also referred to as “open access,” “advanced access” or “same-day scheduling”) for routine and urgent care based on patient preference or triage. Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement.

An example of a measure of access is “third next available appointment,” with an open-access goal of zero days (same-day availability). **Third next available appointment** measures the length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on his/her clinician’s schedule. The practice may measure availability for a variety of appointment types including urgent care, new patient physicals, routine exams and return-visit exams.

Factor 1 has been identified as a **critical factor** and must be met for practices to receive any score on the element.

Factors 2 and 3: Clinicians return calls or respond to secure electronic messages in a timely manner, as defined by the practice to meet the clinical needs of the patient population. Factors 2 and 3 require the practice to define the time frame for a response, **and** monitor the timeliness of the response against the practice’s standard.

Patients can seek and receive interactive clinical advice by telephone (factor 2) and secure electronic communication (factor 3) (e.g., electronic message, Web site) during office hours. **Interactive** means that questions are answered by an individual, not just a recorded message.

Factor 3 is NA if the practice does not have the capability to communicate electronically with patients.

Factor 4: Clinical advice must be documented in the patient record, whether it is provided by phone or secure electronic message.

### **Documentation**

Factor 1: The practice has a documented process for staff to follow for scheduling same-day appointments **and** has a report that covers at least five days showing the availability of same-day appointments throughout the practice. The practice may provide a report showing the average third next available appointment.

Factor 2: The practice has a documented process for staff to follow for providing timely clinical advice by telephone (including the practice's definition of 'timely') **and** has a report summarizing its actual response times. The report may be system generated or collected based on at least five days of calls.

Factor 2 requires the practice to:

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

Factor 3: The practice has a documented process for staff to follow for providing timely clinical advice using a secure, interactive electronic system (including the practice's definition of 'timely') **and** has a report summarizing its actual response times. The report may be system generated or collected based on at least one week of electronic messages.

Factor 3 requires the practice to:

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

Factor 4: The practice has a documented process for staff to follow for entering phone and electronic message clinical advice in the patient record **and** provides at least three examples of clinical advice documented in a patient record **or** generates a report identifying how often advice is documented in the medical record. The report must provide the percentage of patients with clinical advice documented in the medical records of those patients who received clinical advice within **a recent one-month period**.

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

**Element B: After-Hours Access 4 points**

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

**Scoring**

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

**Explanation**

Factor 1: The practice offers access to routine and non-routine care beyond regular business hours, such as early mornings, evenings or weekends. Appointment times are based on the needs of the patient population. If the practice does not provide care beyond regular office hours (e.g., a small practice with limited staffing), it may arrange for patients to receive care from other (non-ER) facilities or clinicians.

Factor 2: Patient clinical information is available to on-call staff and external facilities for after-hours care. Information may be provided by patients with individualized care plans or portable personal health records, or may be accomplished through access to an electronic health record (EHR). If care is provided by a facility that is not affiliated with the practice or does not have access to patient records, the practice makes provisions for patients to have an electronic or printed copy of a clinical summary of their medical record. Telephone consultation with the primary clinician or with a clinician with access to the patient’s medical record is acceptable.

Factors 3 and 4: Patients can seek and receive interactive clinical advice by telephone (factor 3) and secure electronic communication (factor 4) (e.g., electronic message, Web site) when the office is closed. **Interactive** means that questions are answered by an individual, not just a recorded message.

The ability of patients to receive clinical advice from the practice or others, such as a service, designated by the practice when the office is not open reduces patient use of the emergency room and provides more patient-centered care. Thus, Factor 3 has been identified as a **critical factor** and must be met for practices to score higher than 25 percent on this element.

Factor 4 is NA if the practice does not have the capability to communicate electronically with patients.

Factor 5: After-hours clinical advice must be documented in the patient record, whether it is provided by telephone or secure electronic message.

### Documentation

Factor 1: The practice has a documented process for staff to follow for arranging after-hours access with other practices or clinicians **and** provides a report showing after-hours availability **or** materials communicating practice hours. A process for arranging after-hours access is not required if the practice has regular extended hours.

Factor 2: The practice has a documented process for staff to follow for making medical record information available for after-hours care.

Factor 3: The practice has a documented process for staff to follow for providing timely clinical advice by telephone when the office is closed **and** has a report summarizing its actual response times. The report may be system generated or collected based on at least five days of calls.

Factor 3 requires the practice to:

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

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

Factor 4 requires the practice to:

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

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

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

**Element C: Electronic Access** **2 points**

The practice provides the following information and services to patients and families through a secure electronic system.	Yes	No	NA
1. More than 50 percent of patients who request an electronic copy of their health information (including problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem lists, medication lists, and allergies) within four business days of when the information is available to the practice <sup>**</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Two-way communication between patients/families and the practice	<input type="checkbox"/>	<input type="checkbox"/>	
5. Request for appointments or prescription refills	<input type="checkbox"/>	<input type="checkbox"/>	
6. Request for referrals or test results	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 5-6 factors	The practice meets 3-4 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

**Explanation**    **\*Core meaningful use requirement**

**\*\*Menu meaningful use requirement**

Element C assesses the practice’s ability to offer information and services to patients and their families via a secure electronic system. Patients should be able to view their medical record, access services and communicate with the health care team electronically. Practices with a Web site or patient portal should provide the URL.

Factor 1: More than 50 percent of patients (and others with legal authorization to the information) who request an electronic copy of their health information (including problem lists, diagnoses, diagnostic test results, medication lists, allergies) are given one within three business days. Factor 1 addresses the capabilities of the electronic system used by the practice; it does not address legal issues of access to medical record information, such as by guardians, foster parents or caregivers of pediatric patients, or teen privacy rights.

Factor 2: Patients are provided timely electronic access to their health information (including lab results, problem lists, medication lists, allergies). To receive credit for this factor, at least 10 percent of the practice’s patients must have access to the practice’s electronic system (e.g., be registered on the practice Web site or portal) within four business days of when the information is available to the practice.

Factor 3: An **electronic clinical summary** is a summary of a visit that includes, when appropriate, diagnoses, medications, recommended treatment and follow-up. Federal meaningful use rules require that summaries be provided for more than 50 percent of office visits within three business days, either by secure electronic message or as a printed copy from the practice’s electronic system. Patients may be notified that the information is available through a secure, interactive system such as a Web site or patient portal. If the summary is available electronically, the practice must provide the patient with a paper copy upon request.

Factor 4: The practice has a secure, interactive electronic system, such as a Web site, patient portal or a secure email system, allowing two-way communication between patients/families and the practice.

Factor 5: Patients can use the secure electronic system (e.g., Web site or patient portal) to request appointments or medication refills.

Factor 6: Patients can use the secure electronic system (e.g., Web site or patient portal) to request referrals or test results.

### **Documentation**

Factors 1–3: The practice provides a report based on a numerator and denominator for a recent 12 months of data in the electronic system. If the practice does not have 12 months of data (e.g., due to more recent system implementation), it may use a recent 3-month period for the calculation.

Factor 1: The practice provides a report showing the percentage of patients who got an electronic copy of health information within three business days of their request.

- *Denominator* = Number of patients who request an electronic copy of their electronic health information
- *Numerator* = Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

Factor 2: The practice provides a report showing the percentage of patients who were given electronic access to requested health information within four business days of it being available to the practice.

- *Denominator* = Number of patients seen by the practice
- *Numerator* = Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information.

Factor 3: The practice provides a report showing the percentage of office visits for which electronically-generated clinical summaries were provided to patients within three business days.

- *Denominator* = Number of office visits
- *Numerator* = Number of office visits in the denominator for which patients were provided a clinical summary of their visit within three business days.

Factors 4–6: Require the practice to provide a screen shot demonstrating system capability.

Factor 4: The practice provides a screen shot of the secure two-way communication system demonstrating its implementation in the practice.

Factor 5: The practice provides a screen shot of a Web page where patients can request medication refills or appointments, demonstrating its implementation in the practice.

Factor 6: The practice provides a screen shot of a Web page where patients can request referrals or test results, demonstrating its implementation in the practice.

**Element D: Continuity** **2 points**

- The practice provides continuity of care for patients/families by:
- |  |                          |                          |
|--|--------------------------|--------------------------|
| <b>1. Expecting patients/families to select a personal clinician</b>                     | Yes                      | No                       |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>2. Documenting the patient’s/family’s choice of clinician</b>                         | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3. Monitoring the percentage of patient visits with a selected clinician or team.</b> | <input type="checkbox"/> | <input type="checkbox"/> |

	100%	75%	50%	25%	0%
<b>Scoring</b>	The practice meets all 3 factors	No scoring option	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

**Explanation** A **team** is a primary clinician and the associated clinical and support staff who work with the clinician. A team may also represent a medical residency group assigned under a supervising physician.

The practice provides continuity of care by allowing patients and their families to select a personal clinician who works with a defined health care team, and by documenting the selection. All practice staff are aware of a patient’s personal clinician or team and work to accommodate visits and other communication. The practice monitors the proportion of patient visits with the designated clinician or team.

**Note:** Solo practitioners should mark “yes” for each factor and indicate in the survey tool Comments/Text box that there is only one primary clinician in the practice.

Factors 1 and 2: The practice notifies patients about the process for choosing a personal clinician and care team and supports the selection process by discussing the importance of having a clinician and care team responsible for coordinating care. The practice documents the patient/family’s choice of clinician and practice team.

Factor 3: The practice monitors the percentage of patient visits that occur with the selected clinician and team. The practice may include structured electronic visits (e-visits) or phone visits within these statistics if relevant.

**Documentation**

Factor 1: The practice has a documented process for patient/family selection of a personal clinician.

Factor 2: The practice has a screen shot from its electronic system, showing documentation of patient/family choice of clinician.

Factor 3: The practice has a report with at least one week of data, showing the total proportion of patient encounters that occurred with the selected personal clinician or team.

**Element E: Medical Home Responsibilities** **2 points**

The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following.

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| 1. The practice is responsible for coordinating patient care across multiple settings   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Instructions on obtaining care and clinical advice during office hours and when the office is closed   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The care team gives the patient/family access to evidence-based care and self-management support   | <input type="checkbox"/> | <input type="checkbox"/> |

**Scoring**

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

**Explanation**

The practice has a process for giving patients/families information on the obligations of the medical home and the responsibilities of the patient and family as partners in care. Care team roles are explained to patients/families. The practice is encouraged to provide information in multiple formats to accommodate patient preference and language needs.

Factor 1: The practice is concerned about the range of a patient's health (i.e., "whole person" orientation, including behavioral health) and is responsible for coordinating care across settings.

Factor 2: The practice provides information about its office hours; where to seek after-hours care; and how to communicate with the personal clinician and team, including requesting and receiving clinical advice during and after business hours.

Factor 3: To effectively serve as a medical home, the practice must have comprehensive patient information such as medications; visits to specialists; medical history; health status; recent test results; self-care information; and data from recent hospitalizations, specialty care or ER visits.

Factor 4: Patients can expect evidence-based care from their clinician and team, as well as support for self-management of their health and health care.

**Documentation**

- The practice has a **process** for giving patients information and materials about the obligations of a medical home, **and**
- Has **materials it provides to patients**, such as:
  - Patient brochure
  - Written statement for the patient and family
  - Link to online video
  - Web site
  - Patient compact (a written agreement between the patient/family and the practice specifying the role of the medical home practice and the patient/family)

NCQA requests that the practice highlight, label or otherwise identify the information relevant to each factor in the documentation.

**Element F: Culturally and Linguistically Appropriate Services (CLAS) 2 points**

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:	Yes	No	NA
1. Assessing the racial and ethnic diversity of its population	<input type="checkbox"/>	<input type="checkbox"/>	
2. Assessing the language needs of its population	<input type="checkbox"/>	<input type="checkbox"/>	
3. Providing interpretation or bilingual services to meet the language needs of its population	<input type="checkbox"/>	<input type="checkbox"/>	
4. Providing printed materials in the languages of its population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets all 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

**Explanation** Factors 1 and 2: The practice uses data to assess the cultural and linguistic needs of its population in order to address those needs adequately. This may be information collected by the practice directly from all patients or by using data that is available about the local community it serves.

Factor 3: Language services may include third-party interpretation services or multilingual staff. Under Title VI of the Civil Rights Act, clinicians who receive federal funds are responsible for providing language and communication services to their patients as required to meet clinical needs. Requiring a friend or family member to interpret for the patient does not meet the intent of this standard. Studies demonstrate that patients are less likely to be forthcoming with a family member present, and the family member may not be familiar with medical terminology. A third party tends to be more objective.

Factor 4: The practice identifies individual languages spoken by at least 5 percent of its patient population and makes materials available in those languages. The practice provides the forms that patients are expected to sign, complete or read for administrative or clinical needs to patients with limited English proficiency in the native language of the patient.

Factor 4 is NA if the practice provides documentation that no single language (other than English) is spoken by 5 percent or more of its patient population. The practice must provide a written explanation for an NA response.

**Documentation**

Factors 1 and 2: The practice provides a report showing its assessment of the racial, ethnic and language composition of its patient population.

Factor 3: The practice provides documentation the availability of interpretive services, or has a policy or statement that it uses bilingual staff. The policy or statement explains the practice's procedures when a patient needs assistance in a language not spoken by bilingual staff.

Factor 4: The practice provides or shows access to materials in languages other than English, a screenshot of a link to online materials or a Web site in languages other than English.

**Element G: The Practice Team** **4 points**

The practice uses a team to provide a range of patient care services by:	Yes	No
1. Defining roles for clinical and nonclinical team members	<input type="checkbox"/>	<input type="checkbox"/>
2. Having regular team meetings or a structured communication process	<input type="checkbox"/>	<input type="checkbox"/>
3. Using standing orders for services	<input type="checkbox"/>	<input type="checkbox"/>
4. Training and assigning care teams to coordinate care for individual patients	<input type="checkbox"/>	<input type="checkbox"/>
5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change	<input type="checkbox"/>	<input type="checkbox"/>
6. Training and assigning care teams for patient population management	<input type="checkbox"/>	<input type="checkbox"/>
7. Training and designating care team members in communication skills	<input type="checkbox"/>	<input type="checkbox"/>
8. Involving care team staff in the practice's performance evaluation and quality improvement activities	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets 7-8 factors, including factor 2	The practice meets 5-6 factors, including factor 2	The practice meets 4 factors, including factor 2	The practice meets 2-3 factors <b>or</b> meets 3-7 factors but not factor 2	The practice meets 0-1 factors

**Explanation** Managing patient care is a team effort that involves clinical and nonclinical staff (e.g., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) interacting with patients and working to achieve stated objectives.

Factor 1: Job descriptions and responsibilities emphasize a team-based approach to care.

Factor 2: Team meetings may include daily huddles or review of daily schedules, with follow-up tasks. A **huddle** is a team meeting to discuss patients on the day's schedule. (Idaho Primary Care Association, <http://idahopca.org/programs-services/patient-centered-medical-home-initiative/patient-centered-medical-home-resources>). A structured communication process may include regular e-mail exchanges, tasks or messages about a patient in the medical record.

Excellent communication and coordination among the members of the team has been found to be a critical feature of successful patient-centered practices. Thus, Factor 2 has been identified as a **critical factor** and must be met for practices to score higher than 25 percent on this element.

Factor 3: Standing orders (e.g., testing protocols, defined triggers for prescription orders, medication refills, vaccinations, routine preventive services) may be clinician preapproved or may be executed without prior approval of the clinician as permitted by state law.

Factor 4: Care coordination may include obtaining test and referral results and communicating with community organizations, health plans, facilities and specialists.

Factor 5: Care team members are trained in evidence-based approaches to self-management support, such as patient coaching and motivational interviewing.

Factor 6: Care team members are trained in the concept of population management and proactively addressing needs of patients and families served by the practice.

**Population management** is assessing and managing the health needs of a patient population 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).

Factor 7: Care team members are trained on effective patient communication for all segments of the practice's patient population but particularly the vulnerable 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) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalizations or ER visits. Training may include information on health literacy, or other approaches to addressing communication needs.

Factor 8: The care team receives performance measurement and patient survey data and is given the opportunity to identify areas for improvement and establish methods for quality improvement. This can include regular participation in quality improvement meetings or action plan development.

### **Documentation**

Factors 1, 4–7: The practice provides staff position descriptions describing roles and functions.

Factor 2: The practice provides a description of its structured team communication processes that occur regularly *and* samples of meeting summaries, agendas or memos to staff.

Factor 3: The practice has written standing orders.

Factors 4–7: The practice has a description of its training process and training schedule or materials showing how staff is trained in each area identified in the factors.

Factor 8: The practice has a description of staff roles in the practice evaluation and improvement process, or minutes from team meetings showing staff involvement and describing staff roles.

NCQA encourages the practice to highlight the information relevant to each factor in the documentation.

**PCMH 2: Identify and Manage Patient Populations****16 points**

The practice systematically records patient information and uses it for population management to support patient care.

**Element A: Patient Information****3 points**

The practice uses an electronic system that records the following as structured (searchable) data for more than 50 percent of its patients.

	Yes	No	NA
1. Date of birth <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Gender <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Race <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ethnicity <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Preferred language <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Telephone numbers	<input type="checkbox"/>	<input type="checkbox"/>	
7. E-mail address	<input type="checkbox"/>	<input type="checkbox"/>	
8. Dates of previous clinical visits	<input type="checkbox"/>	<input type="checkbox"/>	
9. Legal guardian/health care proxy	<input type="checkbox"/>	<input type="checkbox"/>	
10. Primary caregiver	<input type="checkbox"/>	<input type="checkbox"/>	
11. Presence of advance directives (NA for pediatric practices)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Health insurance information	<input type="checkbox"/>	<input type="checkbox"/>	

**Scoring**

100%	75%	50%	25%	0%
The practice meets 9-12 factors	The practice meets 7-8 factors	The practice meets 5-6 factors	The practice meets 3-4 factors	The practice meets 0-2 factors

**Explanation****<sup>+</sup>Core meaningful use requirement**

The practice uses a searchable practice management, EHR or other electronic system that collects patient information. To assess compliance with this element, the practice must provide a report by individual factor (items 1–12) showing the percentage of patients seen by the practice for whom data were entered. The report should indicate the practice entered valid data in the system's fields, or should indicate "none," "no" or "NA," was entered as appropriate. The field should not be blank. Fields that have no data do not count. To qualify for Meaningful Use, the practice must meet the related factors using a certified EHR.

Factor 1: The practice records patient date of birth.

Factor 2: The practice records patient gender.

Factors 3 and 4: The practice records race and ethnicity data, in addition to language and age, which contributes to its ability to understand its patient population. The practice may align race and ethnicity categories with those used by the Office of Management and Budget (OMB). Patients who prefer not to provide race/ethnicity may be counted in the numerator if the practice documents their decision to decline to provide the information.

Factor 5: The practice documents the patient's preferred language. Patients are not required to discuss their language needs, but documentation helps identify patients who need interpretation and translation services. The practice must document that the patient declined to provide language information, that the patient's primary language is English or that the patient does not need language services. A blank field cannot be assumed to mean that the patient speaks English.

Factor 6: The patient's primary telephone number may be a mobile number.

Factor 7: The practice records patient e-mail addresses and should enter "none" in the field for patients who do not have an e-mail address or decline to provide one. This will count toward the numerator.

Factor 8: The practice enters dates of all office, electronic and telephone visits into the system. Visits (i.e., scheduled, structured encounters) are distinguished from electronic or telephone advice.

Factor 9: A **legal guardian** or **health care proxy** is 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.

Factor 10: A **primary caregiver** provides day-to-day care for the patient and must receive instructions about care. Documentation of the primary caregiver should be in the health care record. The practice should enter "none" in the field if there is no caregiver. This will count toward the numerator.

Factor 11: There is documentation in the medical record that the patient/family gave the practice an advance directive (includes living wills, Physician Orders for Life Sustaining Treatment [POLST], durable power of attorney, health proxy). Practices with adult and pediatric patients may exclude pediatric patients from the denominator for this factor. Documentation in the field that the patient declined to provide the information counts toward the numerator.

This factor may be marked "NA" if the practice sees only pediatric patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

Factor 12: The practice has documentation of its patients' health insurance coverage (e.g., health plan name, Medicare, Medicaid, "none").

### **Documentation**

Factors 1–12: The practice provides reports from the electronic system showing the percentage of *all* patients for each populated data field. This is not limited to patients with the three identified important conditions or those in a disease-specific registry. The report contains each required data element to determine how many elements are consistently entered in the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Number of patients seen by the practice at least once during the reporting period (for factor 11, include only those who meet the age parameters)
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

**Element B: Clinical Data** **4 points**

The practice uses an electronic system to record the following as structured (searchable) data.	Yes	No	NA
1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Blood pressure, with the date of update for more than 50 percent of patients 2 years and older <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Height for more than 50 percent of patients 2 years and older <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Weight for more than 50 percent of patients 2 years and older <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. System calculates and displays BMI (NA for pediatric practices) <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. System plots and displays growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices) <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients (NA for pediatric practices if all patients <13 years) <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. List of prescription medications with the date of updates for more than 80 percent of patients <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets all 9 factors	The practice meets 7-8 factors	The practice meets 5-6 factors	The practice meets 3-4 factors	The practice meets 0-2 factors

**Explanation** <sup>+</sup>Core meaningful use requirement

The practice collects clinical information on its patients through an EHR. It uses a system that can be searched for each factor and can create reports. Documentation in the medical record of “none” or “patient declined to provide information” counts toward the numerator.

Factor 1: The patient’s current and active problem list includes acute and chronic diagnoses.

Factor 2: Allergies (including medication, food or environmental allergies) and any associated reactions are recorded as structured data.

Factor 3: All blood pressure readings are documented and dated. Per the Stage 1 meaningful use requirement, this is applicable to patients 2 years and older. Practices *may* choose meet the NCQA requirement with an age definition of **3 years and older** if able to generate a report for this alternative age group.

Factors 4 and 5: Height and weight are documented and dated. This is applicable to patients 2 years and older. NA may be used for practices with no patients greater than 2 years. The practice must provide a written explanation for an NA response.

Factor 6: The practice demonstrates the ability of its electronic system to calculate and display BMI within the medical record. NA may be used for pediatric practices. The practice must provide a written explanation for an NA response.

Factor 7: The practice demonstrates the capability of its electronic system to plot and display length, weight and head circumference on a growth chart for children younger than 2 years. Head circumference in children under 2 is a vital growth parameter that provides a guide to a child's health, development, nutritional status and response to treatment.

For patients 2–20 years, BMI is calculated using height and weight and plotted on the appropriate CDC BMI-for-age growth chart to obtain a percentile ranking and displayed within the medical record. Percentiles are the most commonly used indicator to assess size and growth patterns. NA may be used for practices with no pediatric patients. The practice must provide a written explanation for an NA response.

Factor 8: Data on smoking status and tobacco use are collected as a separate factor to emphasize its importance in relation to overall health. NA may be used if the practice has **no** patients 13 years and older. The practice must provide a written explanation for an NA response.

Factor 9: Current prescription medications prescribed by clinicians seen by the patient (including those outside the practice) and updates are recorded as structured data in the medical record. The practice indicates in the record if the patient is not prescribed any medication.

### **Documentation**

Factors 1–5, 8, 9: The practice provides reports from the electronic system showing the percentage of *all* unique patients for each populated data field. This is not limited only to patients with the three identified important conditions or who are in a disease-specific registry. The report contains each required data element to determine how many elements are consistently entered in the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Number of patients seen by the practice at least once during the reporting period (for factors 3, 4, 5 and 8; only those meeting the age parameters are included)
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

Factors 6 and 7: Screen shots demonstrating capability of the electronic system to calculate and display BMI (factor 6) and plot and display growth charts and BMI percentile (factor 7).

**Element C: Comprehensive Health Assessment****4 points**

To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes:

	Yes	No	NA
1. Documentation of age- and gender-appropriate immunizations and screenings	<input type="checkbox"/>	<input type="checkbox"/>	
2. Family/social/cultural characteristics	<input type="checkbox"/>	<input type="checkbox"/>	
3. Communication needs	<input type="checkbox"/>	<input type="checkbox"/>	
4. Medical history of patient and family	<input type="checkbox"/>	<input type="checkbox"/>	
5. Advance care planning (NA for pediatric practices)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Behaviors affecting health	<input type="checkbox"/>	<input type="checkbox"/>	
7. Patient and family mental health/substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	
8. Developmental screening using a standardized tool (NA for adult-only practices)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Depression screening for adults and adolescents using a standardized tool.	<input type="checkbox"/>	<input type="checkbox"/>	

**Scoring**

100%	75%	50%	25%	0%
The practice meets 8-9 factors	The practice meets 6-7 factors	The practice meets 4-5 factors	The practice meets 2-3 factors	The practice meets 0-1 factors

**Explanation**

In addition to a physical assessment, a standardized, comprehensive assessment of a patient includes an examination of social and behavioral influences.

Factor 1: Specific age/gender-appropriate screenings and immunizations are not specified by NCQA, but may be those identified by the U.S. Preventive Services Task Force (USPSTF) or the Centers for Medicare & Medicaid Services (CMS) in the Provider Quality Reporting System (PQRS), NCQA's Child Health measures, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), preventive care and screenings for children and for women as recommended by the Health Resources and Services Administration (HRSA) or other standardized preventive measures, including those identified in Bright Futures for pediatric patients.

Factor 2: The health assessment includes an evaluation of social and cultural needs, preferences, strengths and limitations. Examples of these characteristics can include family/household structure, support systems, household/environmental risk factors and patient/family concerns.

Factor 3: The practice identifies whether the patient has specific communication requirements (e.g., because of hearing or vision issues).

Factor 4: The practice obtains and documents the relevant medical history of its patients and their families.

Factor 5: **Advance care planning** refers to practice guidance and documentation of patient/family preferences for 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. Factor 5 applies primarily to adult populations and may be marked "NA" by practices that see only pediatric patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

Documentation in the field that the patient declined to provide the information counts toward the numerator.

Factor 6: Assessment of risky and unhealthy behaviors should go beyond physical activity and smoking status. Assessment may include nutrition, oral health, dental care, familial behaviors, risky sexual behavior and secondhand smoke exposure. Unhealthy behaviors are often linked to the leading causes of death—heart disease, stroke, cancer, diabetes and injury. (CDC BRFSS)

Factor 7: The practice assesses whether the patient or the patient's family has any mental health conditions or substance abuse issues (e.g., stress, alcohol, prescription drug abuse, illegal drug use, maternal depression).

Factor 8: For newborns through 3 years of age, periodic developmental screening is done using a standardized screening test. If there are no established risk factors or parental concerns, screens are done by 24 months. Factor 8 may be marked "NA" by practices that serve only adult patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

Factor 9: The USPSTF recommends:

- **Adults:** Screening adults for depression when staff-assisted depression care support systems are in place to assure accurate diagnosis, effective treatment and follow-up.
- **Adolescents (12–18 years):** Screening for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up.

### **Documentation**

Factors 1–9: The practice provides a process showing how the information is consistently collected **or** a completed patient assessment (de-identified) of the factors documented during the health assessment. NCQA encourages practices to highlight or otherwise indicate the information in the documentation that meets each factor. Do not provide large portions of a medical record.

**Element D: Use Data for Population Management**  
**MUST-PASS**

5 points

The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/families and clinicians of services needed for:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. At least three different preventive care services** | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. At least three different chronic care services**    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Patients not recently seen by the practice          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Specific medications                                | <input type="checkbox"/> | <input type="checkbox"/> |

## Scoring

100%	75%	50%	25%	0%
The practice uses information to take action on all 4 factors	The practice uses information to take action on 3 factors	The practice uses information to take action on 2 factors	The practice uses information to take action on 1 factor	The practice uses information to take action on no factors

## Explanation

**\*\*Menu meaningful use requirement**

**MUST-PASS** elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

The practice demonstrates that it produces lists of patients needing preventive care and chronic care services, patients not seen recently and patients on specific medications. The practice uses the lists or report(s) (*a report may include multiple services needed*) to manage specific patient populations.

The practice shows how it uses reports to remind patients of needed services. For example, in addition to a report showing the number of patients eligible for mammograms, the practice must provide evidence or a brief statement describing how it reminds patients to get mammograms. The practice may use mail, telephone or e-mail to remind patients when services are due.

Factors 1 and 2 blend two meaningful use criteria in each factor.

- *Generate lists of patients:* Generate at least one report listing patients with a specific condition to use for quality improvement, reduction of disparities and outreach.
- *Send reminders:* More than 20 percent of all patients 65 years or older or 5 years or younger are sent an appropriate reminder for preventive or follow-up care.

Factor 1: The practice generates lists of patients and uses the lists to remind patients of at least three preventive care services needed appropriate to the patients' age or gender (e.g., well-child visits, pediatric screenings, immunizations, mammograms, fasting blood sugar, stress test).

Factor 2: The practice generates lists of patients who need chronic care management services and uses the lists to remind patients of at least three chronic care services needed. Examples include diabetes care, coronary artery disease care, lab values outside normal range and post-hospitalization follow-up appointments. Examples for children include services related to chronic conditions such as asthma, ADHD, ADD, obesity and depression.

Factor 3: The practice generates lists of patients who may have been overlooked and who have not been seen recently. The practice may use its own criteria, such as a care management follow-up visit or an overdue periodic physical exam.

Factor 4: The practice generates lists of patients on specific medications; the lists may be used to manage patients who were prescribed medications with potentially harmful side effects, to identify patients who have been prescribed a brand name drug instead of a generic drug or to notify patients about a recall.

**Documentation**

The practice demonstrates that during the past year it proactively identified and provided outreach to patients in need of services (as described in each factor). Data provided from one or more health plans that account for at least 75 percent of the practice's patient population are acceptable.

Factors 1–4: For each factor, the practice provides:

- *Reports or lists* of patients needing services generated within the past 12 months. For factors 1 and 2, documentation must identify at least three different services.

**and**

- *Materials* showing how patients are notified of needed services (e.g., letters sent to patients, a script or description of phone reminders, screen shots of electronic notices).

**PCMH 3: Plan and Manage Care****17 points**

The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.

**Element A: Implement Evidence-Based Guidelines****4 points**

The practice implements evidence-based guidelines through point-of-care reminders for patients with:

	Yes	No
1. The first important condition <sup>†</sup>	<input type="checkbox"/>	<input type="checkbox"/>
2. The second important condition	<input type="checkbox"/>	<input type="checkbox"/>
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets all 3 factors	No scoring option	The practice meets 2 factors, including factor 3	The practice meets 1 factor	The practice meets no factors

**Explanation** <sup>†</sup>**Core meaningful use requirement**

The practice maintains continuous relationships with patients through care management processes based on evidence-based guidelines. A key to successful implementation of guidelines is to embed them in the practice's day-to-day operations (frequently referred to as clinical decision support) and by using registries that proactively identify and engage patients who are lacking important services (as in PCMH 2, Element D).

The practice analyzes its entire population to determine the required important conditions, which may be chronic or recurring conditions such as COPD, hypertension, hyperlipidemia, HIV/AIDS, asthma, diabetes or congestive heart failure.

Factor 3 has been identified as a **critical factor** and must be met for practices to receive a 50% or 100% score, at least one identified condition must be related to unhealthy behaviors (e.g., obesity, smoking), substance abuse (e.g., illegal drug use, prescription drug addiction, alcoholism) or a mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's).

When selecting conditions, practices should consider the following:

- Diagnoses and risk factors prevalent in patients seen by the practice (data from PCMH 2, Elements B and C)
- The importance of care management and self-management support in reducing complications
- The availability of evidence-based clinical guidelines
- Patients with the conditions selected in factors 1–3 will be used for the medical record review required in PCMH 3, Elements C and D, and in PCMH 4, Element A.

**Pediatric populations**

Relevant conditions may include, but are not limited to, asthma, obesity, eczema, allergic rhinitis, pharyngitis, bronchiolitis, sinusitis, otitis media and urinary tract infection. Well-child care is also an acceptable condition in pediatrics because there are established, comprehensive guidelines for children that include a variety of care needs, such as regular developmental assessments, anticipatory guidance and preventive care services. Well-child care should be specified by age group and may only be used as one important condition.

**Documentation**

The practice provides the following:

- Lists the three important conditions
- Provides the name and source of evidence-based guidelines for each condition
- Demonstrates how the guidelines for each condition are implemented in patient care, using chart tools, screen shots or workflow organizers.
- Examples of guideline implementation, organizers, flow sheets or templates based on condition-specific guidelines enabling the practice to develop treatment plans and document patient status and progress. These tools are used by the practice to manage patient care. Templates of the tools may be provided for documentation.
- Electronic system organizer (e.g., registry, EHR, other system) screenshots showing templates for treatment plans and documenting progress. .

**Element B: Identify High-Risk Patients 3 points**

<b>To identify high-risk or complex patients, the practice:</b>	<b>Yes</b>	<b>No</b>
1. Establishes criteria and a systematic process to identify high-risk or complex patients	<input type="checkbox"/>	<input type="checkbox"/>
2. Determines the percentage of high-risk or complex patients in its population.	<input type="checkbox"/>	<input type="checkbox"/>

<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets both factors	No scoring option	No scoring option	The practice meets 1 factor	The practice does not meet either factor

In the box to the right, enter the percentage of high-risk patients.

**Explanation** Factor 1: The practice has specific criteria and has a process based on these criteria to identify patients with complex or high-risk medical conditions for whole-person care planning and management.

The criteria for identifying complex or high-risk patients should come from a profile of resource use and risk in the practice’s population and may include the following, or a combination of the following.

- High level of resource use (e.g., visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care (e.g., two or more visits in the last six months)
- Frequent hospitalizations (i.e., two or more in last year)
- Multiple comorbidities, including mental health
- Noncompliance with prescribed treatment/medications

- Terminal illness
- Psychosocial status, lack of social or financial support that impedes ability for care
- Advanced age, with frailty
- Multiple risk factors

**Pediatric populations**

- Practices may identify children and youth with special health care needs who are defined by the U.S. Department of Health and Human Services Maternal and Child Health Bureau (MCHB) as children “who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who require health and related services of a type or amount beyond that required generally.” (Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, American Academy of Pediatrics, 3rd Edition, 2008, p. 18.)
- Additional care management guidelines for children and youth with special needs are included in the following publication: Caring for Children Who Have Special Health-care Needs: A Practical Guide for the Primary Care Practitioner. Matthew D. Sadof and Beverly L. Nazarian, *Pediatr. Rev.* 2007;28:e36-e42  
<http://pedsinreview.aappublications.org/cgi/content/full/28/7/e36>

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(s) represent at least 75 percent of the patient population.

**Note:** A sample of the patients identified as high risk or complex will be included in the medical record review required for Elements C and D, and for PCMH 4, Element A.

**Factor 2:** While this factor asks the practice to calculate a percent, the purpose is not to evaluate the actual percent which may be small, but rather for the practice to identify its high risk patients in comparison to the rest of its population of patients.

**Documentation**

**Factor 1:** The practice provides a process and criteria used to identify patients.

**Factor 2:** The practice provides a report that shows the number and percentage of its total patient population identified as high risk or complex. This factor calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage.

- *Denominator* = Total number of patients in the practice
- *Numerator* = Patients identified in the denominator as high risk or complex

**Element C: Care Management** **4 points**  
**MUST-PASS**

The care team performs the following for at least 75 percent of the patients identified in Elements A and B.	Yes	No	Enter Percent
1. Conducts pre-visit preparations	<input type="checkbox"/>	<input type="checkbox"/>	
2. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit	<input type="checkbox"/>	<input type="checkbox"/>	
3. Gives the patient/family a written plan of care	<input type="checkbox"/>	<input type="checkbox"/>	
4. Assesses and addresses barriers when the patient has not met treatment goals	<input type="checkbox"/>	<input type="checkbox"/>	
5. Gives the patient/family a clinical summary at each relevant visit	<input type="checkbox"/>	<input type="checkbox"/>	
6. Identifies patients/families who might benefit from additional care management support	<input type="checkbox"/>	<input type="checkbox"/>	
7. Follows up with patients/families who have not kept important appointments	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 6-7 factors	The practice meets 5 factors	The practice meets 3-4 factors	The practice meets 1-2 factors	The practice meets no factors

**Explanation** ***MUST-PASS*** elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

Assessment of this element is based on a sample of patients identified in Elements A and B. The sample is drawn from patients seen in the last three months. This sample is also used for the medical record review required in PCMH 3, Elements C and D, and in PCMH 4, Element A.

While patients may be identified for care management by diagnosis or condition, the emphasis of the care must be on the whole person over time and on managing all of the patient’s care needs. The practice adopts evidence-based guidelines and uses them to plan and manage patient care.

Factor 1: The practice asks patients (e.g., by letter or e-mail) to complete required paperwork before a scheduled visit, in addition to lab tests, imaging tests or referral visits. The practice reviews test results before the visit. This process can be part of the team daily huddle or a protocol, procedure or checklist.

Factor 2: Individualized care plans developed in collaboration with the patient/family address the patient’s care needs, the responsibilities of the medical home and of specialists to whom the patient is referred and the role of community services and support, if appropriate. Care plans must include treatment goals and may be based on a template.

At each relevant visit, the clinician uses indicators from evidence-based practice guidelines, such as lab test results (e.g., HbA1c), patient symptoms (e.g., depression symptoms), blood pressure or asthma functional score, to determine patient progress with the care plan and treatment goals, or documents deviation from established guidelines and includes the rationale. **Relevant visits** are determined by the practice and the clinician, but should be with regard to:

- Important or chronic conditions, including well-child visits for practices with pediatric patients
- Visits that result in a change in treatment plan or goals
- Additional instructions or information for the patient/family
- Visits associated with transitions of care.

Pediatric practices that use well-child visits as an important condition may use child development markers specified by the American Academy of Pediatrics to assess progress.

Factor 3: The practice gives the patient and/or family a care plan tailored for the patient's use at home and to the patient's understanding.

Factor 4: The clinician or care team assesses or talks with the patient/family to determine reasons for limited progress toward treatment goals, and to help the patient/family address barriers (e.g., patient's lack of understanding or motivation, financial need, insurance issues, adverse effects of medication or other treatment or transportation problems). The clinician or care team changes the treatment plan or adds treatment, if appropriate. A completed social history is acceptable as documentation that the clinician or care team has assessed the patient's progress and thus is meeting treatment goals. The practice may respond NA for this patient.

Factor 5: The practice provides a written clinical summary at relevant office visits. Relevant visits are determined by the practice and the clinician but be with regard to:

- Important or chronic conditions, including well-child care visits for practices with pediatric patients
- Visits that result in a change in treatment plan or goals
- Additional instructions or information for the patient or family.

Factor 6: The practice assesses and, when appropriate, refers patients to other resources (external or internal) for additional care management support, such as disease management (DM) programs or case management programs.

Factor 7: The practice follows up with patients who have not kept important appointments, such as for rechecks, preventive care or post-hospitalization. Systematic tracking of important appointments that patients have kept meets the intent of this factor. If the patient record shows that the patient has kept important appointments the practice may respond NA for this patient.

### **Documentation**

The practice provides reports from an electronic system or uses the Record Review Workbook, showing each required data element, to determine the number of data elements consistently entered in the practice's medical records.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:

#### **Method 1**

*Query the practice's electronic registry, practice management system or other electronic systems for the important conditions identified in Elements 3A and 3B. The practice may use this method if it can determine a denominator as described below.*

- *Denominator* = Total number of patients with one of the important conditions and the high-risk or complex patients seen at least once by the practice in a recent three month period
- *Numerator* = Number of patients identified in the denominator for whom each item is entered in the medical record

**Method 2**

Review a sample of medical records using the sampling method in NCQA’s Record Review Workbook. The practice must use the instructions in the Record Review Workbook to choose a sample of relevant patients and check for the relevant items. Note: to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice’s important conditions and those identified as high risk or complex.

- *Denominator* = The sample of patient medical records using NCQA’s sampling method in the Record Review Workbook Instructions
- *Numerator* = The patients from the medical record review for whom items are entered

**Note:** A patient may fall into more than one category (across the three conditions and the definition of “high risk” or “complex”), but each patient is counted only once. Factors must be successfully addressed for all conditions for the practice to respond “Yes” for each patient.

**Element D: Medication Management 3 points**

	Yes	No	Enter Percent
The practice manages medications in the following ways.			
1. Reviews and reconciles medications with patients/families for more than 50 percent of care transitions**	<input type="checkbox"/>	<input type="checkbox"/>	
2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions	<input type="checkbox"/>	<input type="checkbox"/>	
3. Provides information about new prescriptions to more than 80 percent of patients/families	<input type="checkbox"/>	<input type="checkbox"/>	
4. Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment	<input type="checkbox"/>	<input type="checkbox"/>	
5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment	<input type="checkbox"/>	<input type="checkbox"/>	
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 5-6 factors, including factor 1	The practice meets 3-4 factors, including factor 1	The practice meets 2 factors, including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

**Explanation \*\*Menu meaningful use requirement**

Assessment of this element is based on a sample of the patients identified in Elements A and B. The same patients are used for the medical record review required in PCMH 3, Elements C and D, and in PCMH 4, Element A.

Factors 1 and 2: It is important for the practice to review and document in the medical record all prescribed medications a patient is taking. The practice reviews and reconciles medications following visits to specialists, as well as ER visits and hospitalizations. Medication review and reconciliation should occur at transitions of care and at relevant visits, at least annually. The practice may define “relevant visit.”

Maintaining a current list of a patient's medications and resolving any conflicts with medications reduces the possibility of duplicate medications, medication errors or adverse drug events. Having a process for medication reconciliation is essential for patient safety. Thus, Factor 1 has been identified as a **critical factor** and is required for practices to receive any score on the element.

Factor 3: The practice provides patients/families with information about new medications, including potential side effects, drug interactions, instructions for taking the medication and the consequences of not taking it.

Factor 4: The practice assesses the patient's understanding of the information about the medication.

Factor 5: The practice asks the patient about problems or difficulty taking the medication and side effects; whether the patient is taking the medication as prescribed and if the patient is not taking the medication, possible reasons.

Factor 6: It is important that at least annually, the practice reviews and documents in the medical record that the patient is taking over-the-counter (OTC) medications, herbal therapies and supplements, to prevent interference with prescribed medication and to evaluate potential side effects.

### **Documentation**

The practice provides reports from an electronic system or uses the Record Review Workbook, showing each required data element, to determine the number of data elements consistently entered in the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage.

#### **Method 1**

*Query the practice's electronic registry, practice management system or other electronic systems for the important conditions identified in Elements 3A and 3B. The practice may use this method if it can determine a denominator as described below.*

- *Denominator* = Total number of patients with one of the important conditions and the high-risk or complex patients seen at least once by the practice in a recent three month period
- *Numerator* = Number of patients identified in the denominator for whom each item is entered in the medical record

#### **Method 2**

*Review a sample of medical records using the sampling method in NCQA's Record Review Workbook. The practice must use the instructions in the Record Review Workbook to choose a sample of relevant patients and check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions and those identified as high risk or complex.*

- *Denominator* = The sample of patient medical records using NCQA's sampling method in the Record Review Workbook Instructions
- *Numerator* = The patients from the medical record review for whom *items* are entered

***Not Applicable is an option in the Record Review Workbook drop-down menu for each factor in this element and may be used for patients who have not been prescribed any medications.***

*Note: A patient may fall into more than one category (across the three conditions and the definition of “high risk” or “complex”), but each patient is counted only once. Factors must be successfully addressed for all conditions for the practice to respond “Yes.”*

**Element E: Use Electronic Prescribing 3 points**

The practice uses an electronic prescription system with the following capabilities.	Yes	No	NA
1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Generates at least 75 percent of eligible prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	
3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Performs patient-specific checks for drug-drug and drug-allergy interactions <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Alerts prescribers to generic alternatives	<input type="checkbox"/>	<input type="checkbox"/>	
6. Alerts prescribers to formulary status <sup>**</sup>	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 5-6 factors, including factor 2	The practice meets 4 factors, including factor 2	The practice meets 2-3 factors, including factor 2	The practice meets 1 factor <b>or</b> meets 2-5 factors but not factor 2	The practice meets no factors

**Explanation**      <sup>+</sup>Core meaningful use requirements  
<sup>\*\*</sup>Menu meaningful use requirement

Factor 1: The electronic prescribing system generates and transmits at least 40 percent of eligible prescriptions directly to the pharmacy. Eligible prescriptions exclude prescriptions that are not allowed by law to be electronically conveyed to pharmacies (e.g., controlled substances).

Factor 2: At least 75 percent of eligible prescriptions are generated electronically, including new prescriptions and renewals which requires the practice to produce a denominator that encompasses the total number of prescriptions issued (by hand, by phone and electronically). If the practice is not able to produce such a report, it may, instead, provide 1) the practice’s prescribing process/policy including how the practice avoids the use of hand-written prescriptions and 2) information on the number of electronic prescriptions issued **and** total number of patients and 3) an explanation of how it represents at least “75 percent” of the total prescription volume.

Factors 1 and 2 distinguish between generating prescriptions electronically and generating them *and* transmitting them electronically. Practices may be able to create and produce prescriptions electronically without being able to transmit them to pharmacies.

Since the remainder of the factors are only of value if the system is being actively used to write prescriptions, factor 2 has been designated as a **critical factor** required to receive more than 25 percent of the available points for this element.

**Factor 3:** The practice's electronic prescribing system is integral to patient records, allowing it to view patient diagnoses, patient medications, enter new medications or make changes and identify documented allergies. The practice uses the electronic prescribing system to enter medications prescribed to its patients. If a practice writes fewer than 100 prescriptions during the reporting period the response in the survey tool may be NA. The practice must provide a written explanation for an NA response. The practice must enter the number of prescriptions written during the reporting period in the survey tool or a linked document to attest to exclusion from this requirement.

**Factor 4:** When a new prescription request is entered, the practice's electronic prescribing system alerts the clinician to potentially harmful interactions between drugs or to patient allergy to a drug. **Patient-specific information** is related or linked to a specific patient.

**Factor 5:** The system alerts the clinician to cost-effective, generic options.

**Factor 6:** The system connects with or downloads the formulary for the patient's health plan to identify covered drugs and the copayment tier, if applicable.

### **Documentation**

**Factor 1:** The practice provides reports from the electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Eligible prescriptions written by the practice
- *Numerator* = Eligible prescriptions generated **and** transmitted with the practice's electronic prescribing system

**Factor 2:** The practice provides reports from the electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Eligible prescriptions written by the practice
- *Numerator* = Eligible prescriptions generated by the practice using the practice's electronic prescribing system

### **Factor 2 alternate documentation**

The practice provides:

- Prescribing process/policy including how the practice ensures the avoidance of writing hand-written prescriptions

**and**

- Report showing the total number of patients seen in the past 12 months (or a recent 3-month period if the practice does not have 12 months of electronic data) and the number of eligible prescriptions generated by the practice using the electronic prescribing system during the same time period

**and**

- Explanation of how this calculation meets the 75% requirement

Factor 3: The practice provides reports from the electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Patients in the practice's system with at least one medication in their medication list
- *Numerator* = Number of patients in the denominator with at least one medication entered directly into the medical record using the practice's integrated electronic prescribing system

Factors 4–6: The practice provides reports from the electronic system or screen shots demonstrating the system's capabilities.

## PCMH 4: Provide Self-Care Support and Community Resources

9 points

The practice acts to improve patients' ability to manage their health by providing a self-care plan, tools, educational resources and ongoing support.

### Element A: Support Self-Care Process **MUST-PASS**

6 points

The practice conducts activities to support patients/families in self-management:	Yes	No	Enter Percent
1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management	<input type="checkbox"/>	<input type="checkbox"/>	
2. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate**	<input type="checkbox"/>	<input type="checkbox"/>	
3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families	<input type="checkbox"/>	<input type="checkbox"/>	
4. Documents self-management abilities for at least 50 percent of patients/families	<input type="checkbox"/>	<input type="checkbox"/>	
5. Provides self-management tools to record self-care results for at least 50 percent of patients/families	<input type="checkbox"/>	<input type="checkbox"/>	
6. Counsels at least 50 percent of patients/families to adopt healthy behaviors	<input type="checkbox"/>	<input type="checkbox"/>	

### Scoring

100%	75%	50%	25%	0%
The practice meets 5-6 factors, including factor 3	The practice meets 4 factors, including factor 3	The practice meets 3 factors, including factor 3	The practice meets 1-2 factors <b>or</b> meets 3-5 factors but not factor 3	The practice meets no factors

### Explanation **\*\*Menu meaningful use requirement**

**MUST-PASS** elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

This element reviews patients with important conditions identified for the medical record review.

The practice provides patients with self-management support and tools beyond the counseling or guidance typically provided during an office visit, and provides or refers patients to self-management programs or classes. Programs may be offered through community agencies, a health plan or a patient's employer.

Factor 1: 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, Web site links and pamphlets, as well as community resources (e.g., programs, support groups). Based on the practice's assessment of languages spoken by its patients (PCMH 2, Element A), materials in languages other than English should be available for patients/families, if appropriate.

Patients/families may be referred to resources outside the practice, with consideration that resources may not be covered by health insurance. Self-management programs may include asthma education, diabetes education and other classes or groups as well as referrals to community resources for the uninsured and underinsured or for transportation assistance to medical appointments for patients.

Factor 2: The practice uses certified EHR to identify patient-specific educational resources and provides these resources to at least 10 percent of its patients, if appropriate.

CMS states, “Resources are identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.” Patients may be identified as candidates for patient-specific educational resources through the patient’s problem list, medication list, or laboratory test results. The practice uses certified EHR technology to suggest patient-specific educational resources but the clinician makes the final decision on the usefulness and relevance to a specific patient.”

Factor 3: The practice works with patients to develop a self-care plan that addresses a patient’s condition and includes goals *and* a way to monitor self-care. NCQA expects the practice to have documentation that it provides written self-care plans to patients, families or caregivers. One example for pediatric practices is an asthma action plan. Self-management for pediatric practices may involve anticipatory guidance focusing on parent management of breastfeeding, eating, sleeping or activity patterns. Research supports the importance of practices developing a self-care plan in collaboration with patients that may be used by patients and families to manage care at home. Thus, Factor 3 has been identified as a **critical factor** and is required for practices to receive more than 25 percent of the available points in this element.

If the patient is meeting treatment goals, documentation could be that the patient is meeting treatment goals with documentation that the patient was instructed to maintain the current self-care plan.

Factor 4: Patients and families who feel they can manage their condition, learn needed self-care skills or adhere to treatment goals will have greater success. Practices may use motivational interviewing to assess patient readiness to change and self-management abilities, including questionnaires and self-assessment forms. The purpose of assessing self-management abilities is that the practice can adjust self-management plans to fit patient/family capabilities and resources.

Factor 5: Self-management tools enable patients to collect health information at home that can be discussed with the clinician. For example, a practice gives its hypertensive patients a form or another systematic method of documenting daily blood pressure readings, along with information about blood pressure measurement and instructions for taking a reading. Patients can track their progress and potentially adjust the treatment or their behavior. For pediatric practices, patients with asthma may be asked to monitor peak flows and the self-management plan offers instructions for how to adjust medications accordingly.

Factor 6: The practice provides evidence-based counseling (e.g., coaching, motivational interviewing) to patients for adopting healthy behaviors associated with disease risk factors (e.g., tobacco use, nutrition, exercise and activity level, alcohol use).

**Documentation**

For all factors, the practice provides a report from an electronic system or uses the Record Review Workbook.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage.

**Method 1**

*Query the practice's electronic registry, practice management system or other electronic systems for the important conditions identified in Elements 3A and 3B. The practice may use this method if it can determine a denominator as described below.*

- *Denominator* = Total number of patients with one of the important conditions and the high-risk or complex patients based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.
- *Numerator* = Number of patients identified in the denominator for whom each item is entered in the medical record

**Method 2**

*Review a sample of medical records using the sampling method in NCQA's Record Review Workbook. The practice must use the instructions in the Record Review Workbook to choose a sample of relevant patients and check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions and those identified as high risk or complex.*

- *Denominator* = The sample of patient medical records using NCQA's sampling method in the Record Review Workbook Instructions
- *Numerator* = The patients from the medical record review for whom each activity is documented

**Note:** *A patient may fall into more than one category (across the three conditions and the definition of "high risk" or "complex"), but each patient is counted only once.*

**Element B: Provide Referrals to Community Resources 3 points**

The practice supports patients/families that need access to community resources:	Yes	No
1. Maintains a current resource list on five topics or key community service areas of importance to the patient population	<input type="checkbox"/>	<input type="checkbox"/>
2. Tracks referrals provided to patients/families	<input type="checkbox"/>	<input type="checkbox"/>
3. Arranges or provides treatment for mental health and substance abuse disorders	<input type="checkbox"/>	<input type="checkbox"/>
4. Offers opportunities for health education programs (such as group classes and peer support.)	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets all 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	Practice does not provide services

**Explanation** Factor 1: The key resource list is specific to the needs of *the practice’s population—not specific to patients with important conditions*—and includes programs and services to help patients in self-care or give the patient population access to care related to at least five topics or key community service areas of importance, which may include:

- Smoking cessation
- Weight management (under- and overweight)
- Exercise/physical activity
- Nutrition
- Parenting
- Dental
- Other, such as:
  - Transportation to medical appointments
  - Noncommercial health insurance options
  - Obtaining prescription medications
  - Falls prevention
  - Meal support
  - Hospice
  - Respite care
  - Child development
  - Immunization information
  - Child care,
  - Breastfeeding

Although the practice may provide one or more services, it must also identify services or agencies available in the community. The intent of the element is for the practice to connect patients with available community resources.

Factor 2: The practice tracks frequency and types of referrals to agencies to evaluate whether it has identified sufficient and appropriate resources for its population over time.

Factor 3: The practice provides treatment or identifies a treatment provider and helps patients get care for mental health and substance abuse problems, if needed.

Factor 4: The practice provides or makes available health education classes that may include alternative approaches such as peer-led discussion groups or shared medical appointments. In a **shared medical appointment** or **group visit**, 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 allow patients to interact with and learn from each other.

**Documentation**

Factor 1: The practice has a list of community services or agencies with specified categories (e.g., smoking cessation programs).

Factor 2: The practice has a log or report showing referral tracking over a minimum period of one month.

Factors 3 and 4: The practice has a documented process **and** a sample of available resources.

## PCMH 5: Track and Coordinate Care

18 points

The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

### Element A: Test Tracking and Follow-Up 6 points

The practice has a documented process for and demonstrates that it:	Yes	No	NA
1. Tracks lab tests until results are available, flagging and following up on overdue results	<input type="checkbox"/>	<input type="checkbox"/>	
2. Tracks imaging tests until results are available, flagging and following up on overdue results	<input type="checkbox"/>	<input type="checkbox"/>	
3. Flags abnormal lab results, bringing them to the attention of the clinician	<input type="checkbox"/>	<input type="checkbox"/>	
4. Flags abnormal imaging results, bringing them to the attention of the clinician	<input type="checkbox"/>	<input type="checkbox"/>	
5. Notifies patients/families of normal and abnormal lab and imaging test results	<input type="checkbox"/>	<input type="checkbox"/>	
6. Follows up with inpatient facilities on newborn hearing and blood-spot screening (NA for adults)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Electronically communicates with labs to order tests and retrieve results	<input type="checkbox"/>	<input type="checkbox"/>	
8. Electronically communicates with facilities to order and retrieve imaging results	<input type="checkbox"/>	<input type="checkbox"/>	
9. Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in medical records**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Electronically incorporates imaging test results into medical records.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 8-10 factors, including factors 1 and 2	The practice meets 6-7 factors, including factors 1 and 2	The practice meets 4-5 factors, including factors 1 and 2	The practice meets 3 factors, including factors 1 and 2	The practice meets fewer than 3 factors or does not meet factors 1 and 2

#### Explanation \*\*Menu meaningful use requirement

Systematic monitoring is important to ensure that needed tests are performed and that results are acted on when they indicate a need for action. The practice routinely uses a manual or electronic system to order, track and follow up on test results. The report must reflect a minimum of 1 week of tests ordered by the practice

**Factors 1 and 2:** The practice tracks the majority of lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. **Flagging** is a systematic method of drawing attention to results that have not been received by the practice. 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, if necessary, the patient, to determine why results are overdue. The expected time that results are made available to the practice varies by test and is at the discretion of the practice.

Ineffective management of laboratory and imaging test results can result in less than optimal care and may compromise patient safety. Thus, Factors 1 and 2 have been identified as **critical factors** and are required for practices to receive any credit for this element.

Factors 3 and 4: Abnormal results of lab or imaging tests are flagged or highlighted and brought to the attention of the clinician to ensure timely follow-up with the patient/family.

Factor 5: The practice gives normal and abnormal results to patients in a timely manner (defined by the practice). There must be evidence that the practice proactively notifies patients of normal and abnormal results. Filing the report in the medical record for a patient's next office visit does not meet the intent of the factor.

Factor 6: The practice follows up with the hospital or state health department if screening results are not received. Most states mandate that birthing facilities perform a newborn blood-spot screening for a number of conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. The practice may respond NA in adult-only practices. The practice must provide a written explanation for an NA response.

Factors 7 and 8: Labs and imaging tests are ordered and retrieved electronically from testing facilities.

Factor 9: Lab test results are electronically integrated into the electronic system in the patient's medical record rather than requiring a look-up in a separate system and manual data entry into the electronic medical record.

CMS provides the following additional information: "If the practice orders no lab tests whose results are in a positive or negative or numeric format during the reporting period an NA response may be entered." The practice must provide a written explanation for an NA response.

Factor 10: Imaging results which includes written report and may include the images are electronically integrated into the medial record rather than requiring a look-up in a separate system and manual data entry into the electronic medical record. A scanned PDF of imaging results in the medical record, which allows the practice to retrieve and review the image, is acceptable.

### **Documentation**

The practice provides a documented process or procedure *and* a report, log or other means of demonstrating that its process is followed. A paper log or screen shot showing electronic capabilities is acceptable.

Factors 1–6: The practice has a written process or procedure for staff *and* an example of how the process is met for each factor.

Factors 7, 8, 10: The practice has examples from its electronic system for each factor.

Factor 9: The practice provides reports from the electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Number of lab tests ordered during the reporting period with results expressed in a positive or negative affirmation or as a number
- *Numerator* = Number of lab tests whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.

**Element B: Referral Tracking and Follow-Up** **6 points**  
**MUST-PASS**

The practice coordinates referrals by:	Yes	No	NA
1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information	<input type="checkbox"/>	<input type="checkbox"/>	
2. Tracking the status of referrals, including required timing for receiving a specialist's report	<input type="checkbox"/>	<input type="checkbox"/>	
3. Following up to obtain a specialist's report	<input type="checkbox"/>	<input type="checkbox"/>	
4. Establishing and documenting agreements with specialists in the medical record if co-management is needed	<input type="checkbox"/>	<input type="checkbox"/>	
5. Asking patients/families about self-referrals and requesting reports from clinicians	<input type="checkbox"/>	<input type="checkbox"/>	
6. Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Providing an electronic summary of the care record to another provider for more than 50 percent of referrals. <sup>**</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets 5-7 factors	The practice meets 4 factors	The practice meets 3 factors	The practice meets 1-2 factors	The practice meets no factors

**Explanation** <sup>+</sup>Core meaningful use requirement  
<sup>\*\*</sup>Menu meaningful use requirement

**MUST-PASS** elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

The practice tracks referrals using a reporting log or electronic reporting system. The tracked referrals are those determined by the clinician to be important for a patient's treatment, or as indicated by practice guidelines; for example, a referral to a breast surgeon for examination of a potentially malignant tumor, a referral to a mental health specialist for a patient with depression, a referral to a pediatric cardiologist for an infant with a ventricular septal defect. This factor includes referrals to medical specialists, mental health and substance abuse specialists and other services.

Factor 1: Information included in the referral communication to the specialist includes:

- Reason for and urgency of the referral
- Relevant clinical information (e.g., patient's family and social history, clinical findings and current treatment)
- General purpose of the referral (e.g., consultative, transfer of care, co-management) and necessary follow-up communication or information.

Factor 2: The referral tracking system includes the date when the referral was initiated and the timing indicated for receiving the report.

Screen shots of a patient record do not meet the requirement. Documentation requires a paper or electronic tracking sheet or system showing referral tracking and follow-up of multiple patients (blinded).

Factor 3: If the practice does not receive a report from the specialist, it contacts the specialist's office about the report's status and the expected date for receiving the report, and documents the effort to retrieve the report in a log or electronic system.

Factor 4: For patients who are regularly treated by a specific specialist, the primary care clinician and the specialist enter into an agreement that enables co-management of the patient's care and includes timely sharing of changes in patient status and treatment plan. For co-managed patients, the primary clinician gives information to the specialist and receives information from the specialist within a period agreed to by both parties. This information is documented in the medical record.

Factor 5: Patients might see specialists without a referral from the medical home and without the medical home or clinician's knowledge. Clinicians should routinely ask patients if they have seen a specialist or are receiving care from a specialist and, if so, request a report from the specialist. The information should be documented in the medical record.

Factor 6: The practice is asked to show that its certified EHR technology has the capacity to electronically exchange key clinical information with facilities. That is, the practice needs to show its **capability** to send and receive key clinical information electronically (e.g., problem lists, medication lists, medication allergies, diagnostic test results) with other providers of care, with patient-authorized entities (such as health plans, an entity facilitating health information exchange among providers or a personal health record vendor identified by the patient). The key clinical information is based on the judgment of the clinician. There is no requirement for the practice to be able to exchange data on a regular basis now.

CMS provides the following additional information: "The electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. The transmission of actual patient data is not required for purposes of a test. When clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible."

Factor 7: The practice provides an electronic summary-of-care record for more than 50 percent of referrals to the referred specialist(s). If the practice does not refer patients to other providers, they may respond NA to this factor. The practice must provide a written explanation of the NA response.

CMS provides the following additional information: "The referring party must provide the summary of care record to the receiving party. The clinician can send an electronic or paper copy of the summary of care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably be expected to do so. If the provider to whom the referral is made has access to the medical record maintained by the referring provider, the summary of care record would not need to be provided and that patient should not be included in the denominator for transitions of care."

### **Documentation**

The practice provides:

Factors 1–3: Reports or logs demonstrating data collected in the tracking system used by the practice. A paper log or a report from the electronic system meets the requirement; screen shots of a patient record do not meet the requirement. The report may be system generated or may be based on at least one week of referrals, with de-identified patient data.

Factors 4–5: The practice has a documented process, evidenced by at least three examples.

Factor 6: Screenshot or other documentation showing a test of the capability of the certified EHR to exchange key clinical information

Factor 7: This element calls for calculation of a percentage that requires a numerator and a denominator. The practice provides reports from the electronic system. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

The practice may use the following methodology to calculate the percentage.

- *Denominator* = Number of referrals during the EHR reporting period
- *Numerator* = Number of referrals in the denominator where a summary of care record was provided.

**Element C: Coordinate With Facilities and Manage Care Transitions 6 points**

On its own or in conjunction with an external organization, the practice systematically:	Yes	No	NA
1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit	<input type="checkbox"/>	<input type="checkbox"/>	
2. Demonstrates its process for sharing clinical information with admitting hospitals and emergency departments	<input type="checkbox"/>	<input type="checkbox"/>	
3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities	<input type="checkbox"/>	<input type="checkbox"/>	
4. Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit	<input type="checkbox"/>	<input type="checkbox"/>	
5. Demonstrates its process for exchanging patient information with the hospital during a patient’s hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult-only practices)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Demonstrates the capability for electronic exchange of key clinical information with facilities	<input type="checkbox"/>	<input type="checkbox"/>	
8. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Activities include 5-8 factors	Activities include 4 factors	Activities include 2-3 factors	Activities include 1 factor	Activities include no factors

**Explanation**      \*Core meaningful use requirement  
                              \*\*Menu meaningful use requirement

Effective transitions of care—between primary care and specialist providers, between facilities, between physicians and institutional settings—ensure that patient needs and preferences for health services and sharing information across people, functions and sites are met over time. Enhancing care transitions across providers can improve coordination of care and its affect on quality and efficiency (Greiner/ABIM Fdn 2007).

Factor 1: The practice works with local hospitals, ERs and health plans to identify patients who were hospitalized and patients who had ER visits.

Factor 2: The practice provides facilities with appropriate and timely information about the patient.

Factor 3: The practice or external organization has a process for obtaining patient discharge summaries from hospitals, ERs, skilled nursing facilities, surgical centers and other facilities.

Factor 4: The practice contacts patients to evaluate their status after discharge from an ER or hospital and to make a follow-up appointment, if appropriate. Proactive contact includes offering patients appropriate care to prevent worsening of their condition and encouraging follow-up care. In addition to scheduling an appointment, follow-up care includes, but is not limited to, physician counseling; referrals to community resources; and disease or case management or self-management support programs. The practice's policies define the appropriate contact period.

Factor 5: The practice develops a two-way communication plan with hospitals to exchange information about hospitalized patients, enabling well-coordinated care during and after hospitalization.

Factor 6: During the transition from pediatric to adult care, it is important to promote health, disease prevention and psychosocial adjustment to adulthood. The practice's written care plan focuses on obtaining adult primary, emergency and specialty care and 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, identified obstacles to transitioning to an adult care clinician and arrangements for release and transfer of medical records to the adult care clinician. The practice must provide a written explanation for an NA response.

Factor 7: The practice is asked to show that its certified EHR technology has the capacity to electronically exchange key clinical information with facilities. That is, the practice needs to show its **capability** to send and receive key clinical information electronically (e.g., problem lists, medication lists, medication allergies, diagnostic test results) with facilities (e.g., hospitals, ERs, extended care facilities, nursing homes other providers of care, The key clinical information is based on the judgment of the clinician. There is no requirement for the practice to be able to exchange data on a regular basis now.

Factor 8: The practice that transitions patients to another care setting provides a summary of care record to other care settings (e.g., long-term care facilities, hospitals) for more than 50 percent of transitions of care. If the practice does not transfer patients to another setting they may respond NA to this factor. The practice must provide a written explanation of the NA response.

CMS provides the following additional information: "The transferring party must provide the summary of care record to the receiving party. If the provider to whom the referral is made or to whom the patient is transitioned has access to the medical record maintained by the referring provider, the summary of care record would not need to be provided and that patient should not be included in the denominator for transitions of care."

## Documentation

The practice provides:

Factor 1: A documented process showing that it identifies patients who have been hospitalized or have had an ER visit; a log of patients receiving care from different types of facilities; or a report listing patients seen in the ER or hospital.

Factor 2: A documented process of how it provides hospitals and ERs with clinical information; at least three de-identified examples of patient information sent to the hospital or ER.

Factor 3: A documented process that includes the practice's period for patient follow-up after a hospital admission or ER visit; at least three de-identified examples of documented patient follow-up in the medical record, or a log with at least one week of data documenting systematic follow-up.

Factor 4: A documented process for obtaining hospital discharge summaries and at least three examples of a discharge summary.

Factor 5: A documented process for two-way communication with hospitals and an example of two-way communication.

Factor 6: A copy of a written transition care plan.

Factor 7: Screenshot or other documentation showing a test of the capability of the certified EHR to exchange key clinical information

Factor 8: This element calls for calculation of a percentage that requires a numerator and a denominator. The practice provides reports from the electronic system. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

The practice may use the following methodology to calculate the percentage.

- *Denominator* = Number of transitions to another care setting during the EHR reporting period
- *Numerator* = Number of transitions of care in the denominator where a summary of care record was provided.

**PCMH 6: Measure and Improve Performance****20 points**

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

**Element A: Measure Performance** **4 points**

The practice measures or receives data on the following:	Yes	No
1. At least three preventive care measures	<input type="checkbox"/>	<input type="checkbox"/>
2. At least three chronic or acute care clinical measures	<input type="checkbox"/>	<input type="checkbox"/>
3. At least two utilization measures affecting health care costs	<input type="checkbox"/>	<input type="checkbox"/>
4. Performance data stratified for vulnerable populations (to assess disparities in care).	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets all 4 factors	The practice meets 2-3 factors	No scoring option	The practice meets 1 factor	The practice meets no factors

**Explanation**

The practice reviews its performance on a range of measures to help it understand its care delivery system's strengths and opportunities for improvement. Data may be from internal or external sources. If an external source (such as a health plan) provides the data, the practice must state that the information represents 75 percent of its eligible population. While some measures may fit into multiple categories appropriately, each measure may be used only once for this element.

When it selects measures of performance, the practice must document the period of measurement, the number of patients represented by the data and the patient selection process.

Factor 1: Preventive measures include: 1) services recommended by the U.S. Preventive Services Task Force (USPSTF), 2) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), 3) preventive care and screenings for children and for women as recommended by the Health Resources and Services Administration (HRSA) or 4) other standardized preventive measures, including those identified in *Bright Futures* for pediatric patients. Examples of measures include:

- Cancer screening
- Developmental screening
- Immunizations
- Osteoporosis screening
- Depression screening
- Assessment of behaviors affecting health, such as smoking, BMI and alcohol use.

The CMS definition of preventive services is "routine health care that includes screenings, checkups and patient counseling to prevent illnesses, diseases or other health problems." <http://www.healthcare.gov/law/about/provisions/services/lists.html>

Factor 2: Chronic or acute care clinical measures may be associated with the three important conditions or others tracked by the practice (e.g., diabetes, heart disease, asthma, depression, chronic back pain, otitis media), based on evidence-based guidelines. Measures of overuse of potentially ineffective interventions, such as overuse of antibiotics for bronchitis, may also be used.

Practices where 75 percent or more of the clinicians have earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP), Diabetes Recognition Program (DRP) or Back Pain Recognition Program (BPRP) automatically receive credit for factor 2 for recognitions that are current when the practice submits its PCMH Survey Tool. The practice should include a statement about the recognized clinicians, the name of the recognition program and the number or percentage of recognized clinicians in the practice.

**Factor 3:** The practice uses resources judiciously to help patients receive appropriate care. The types of measures monitored for this factor are intended to help practices understand how efficiently they provide care, and may include ER visits, potentially avoidable hospitalizations and hospital readmissions, redundant imaging or lab tests, prescribing generic medications vs. brand name medications and number of specialist referrals. Practices may use data from one or more payers that cover at least 75 percent of patients, or may collect data over time.

**Factor 4:** The data collected by the practice for factors 1–3 is stratified by race and ethnicity or by other indicators of vulnerable groups that reflect the practice’s population demographics, such as age, gender, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status.

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) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.

**Documentation**

**Factors 1–4:** The practice provides reports showing performance on the required measures.

**Element B: Measure Patient/Family Experience 4 points**

The practice obtains feedback from patients/families on their experiences with the practice and their care.	Yes	No	NA
1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: <ul style="list-style-type: none"> <li>• Access</li> <li>• Communication</li> <li>• Coordination</li> <li>• Whole-person care/self-management support</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
2. The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician Group survey tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The practice obtains feedback on the experiences of vulnerable patient groups	<input type="checkbox"/>	<input type="checkbox"/>	
4. The practice obtains feedback from patients/families through qualitative means.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets all 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

**Explanation**

The practice may use a telephone, paper or electronic survey, and uses survey feedback to inform its quality improvement activities. The patient survey must represent the practice population including all relevant subpopulations and may not be limited to patients of only one of several clinicians or data from one payer when there are multiple payers.

Factor 1: The practice or practice designee surveys patients to assess patient/family experience. The survey must include 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, listened to and able to get answers to questions
- 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 the provision of comprehensive care and self-management support and emphasizing the spectrum of care needs such as mental health; routine and urgent care; advice, assistance and support for making changes in health habits and making health care decisions.

Factor 2: The practice uses the standardized Patient-Centered Medical Home version of the CAHPS Clinician Group survey tool to collect patient experience data.

**Note**

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- *The Patient-Centered Medical Home version of the CAHPS Clinician Group Survey Tool has an anticipated release date of July 2011. At that time, practices may use it to collect patient experience data to meet Factor 2. Since it will not be available until July, Factor 2 may be marked NA until January 1, 2012. As of January, the NA option will no longer be available.*
- *In addition, in January 2012, practices will be able to receive **special acknowledgement** from NCQA for using the PCMH version of the CAHPS-CG survey to collect patient experience data by:*
  - *Using a specific methodology for collecting the data,*
  - *Using a certified vendor to collect the data and*
  - *Reporting the results to NCQA which will be used to benchmark patient experience data.*

Factor 3: The practice uses survey data or other means to assess quality of care for its vulnerable subgroups. Patient self-identification in the survey may provide the basis for the sub-groups.

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) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.

Factor 4: Qualitative feedback methods may include focus groups, individual interviews, patient walkthrough and suggestion boxes. Practices may use a feedback methodology conducive to its population of patients/families or parents, such as “virtual” participation such as by phone or video conference.

**Documentation**

Factors 1–4: The practice provides reports with summarized results of patient feedback. A blank Survey Tool does not meet the intent of this element.

**Element C: Implement Continuous Quality Improvement** **4 points**  
**MUST-PASS**

<b>The practice uses an ongoing quality improvement process to:</b>	<b>Yes</b>	<b>No</b>
1. <b>Set goals and act to improve performance on at least three measures from Element A</b>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Set goals and act to improve performance on at least one measure from Element B</b>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Set goals and address at least one identified disparity in care or service for vulnerable populations</b>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Involve patients/families in quality improvement teams or on the practice’s advisory council.</b>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets 3-4 factors	No scoring option	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

**Explanation** *MUST-PASS* elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

The practice must have a clear and 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 the practice an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers.

The practice sets goals and establishes a plan to improve performance on clinical quality and resource measures (Element A) and patient experience measures (Element B).

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 and goes beyond setting goals and taking action.

**Resource:** One resource for the PDSA cycle is the Institute for Healthcare Improvement (IHI): <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>.

The practice may use NCQA Recognition Programs for clinical and resource measures if 75 percent of its clinicians have achieved NCQA Recognition.

Factors 1 and 2: The practice sets goals and acts to improve performance, based on clinical and resource measures (Elements A) and patient experience measures (Element B). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

Factor 3: The practice identifies areas of disparity among vulnerable populations, sets goals and acts to improve performance in these areas. Vulnerable groups should reflect the practice’s population demographics, such as age, gender, race, ethnicity, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status.

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) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.

**Factor 4:** The practice has a process for involving patients and their families in its quality improvement efforts. At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team meetings.

#### Documentation

**Factors 1–3:** The practice provides reports or a completed PCMH Quality Measurement and Improvement Worksheet.

**Factor 4:** The practice provides a process and examples of how it meets the process (e.g., meeting notes, agenda).

### Element D: Demonstrate Continuous Quality Improvement

3 points

The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by:

Yes No

1. Tracking results over time

2. Assessing the effect of its actions

3. Achieving improved performance on one measure

4. Achieving improved performance on a second measure

#### Scoring

100%	75%	50%	25%	0%
The practice meets all 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets no factors

#### Explanation

Quality improvement is a continual process that is built into the practice's daily operations and requires an ongoing effort of assessing, improving and reassessing. This element emphasizes ongoing quality improvement, by comparing performance results to demonstrate that the practice has gone beyond setting goals and taking action.

**Resource:** Solberg, L.I., G. Mosser, S. McDonald. 1997. The Three Faces of Performance Measurement: Improvement, Accountability and Research. *Journal on Quality Improvement*. 23(3);135-47.

**Factor 1:** The practice demonstrates that it collects clinical, resource (Element A) or patient experience (Element B) performance data and assesses the results over time. The number and frequency of the comparative data collection points (e.g., monthly, quarterly, biannually, yearly) are established by the practice.

The practice may use the process and data from NCQA clinical Recognition Programs to establish comparative data if 75 percent of its clinicians have achieved NCQA Recognition. Practices must show a comparison of at least two sets of DRP, HSRP or BPRP data or scores.

**Factor 2:** In Element C, the practice sets goals and acts to improve performance on clinical quality and resource measures (Element A) and on patient experience measures (Element B). In factor D, the practice identifies the steps it has taken and evaluates these steps to improve performance. The practice is not required to demonstrate improvement in this factor.

**Factors 3 and 4:** The practice must demonstrate that its performance on the measures has improved over time, based on its assessment.

**Documentation**

Factor 1: The practice provides reports, recognition results or a completed PCMH Quality Measurement and Improvement Worksheet showing performance measures over time.

Factor 2: The practice provides reports or a completed PCMH Quality Measurement and Improvement Worksheet on improvement activities and the results.

Factors 3 and 4: The practice provides reports, recognition results or a completed PCMH Quality Measurement and Improvement Worksheet showing improvement on performance measures.

**Element E: Report Performance 3 points**

The practice shares performance data from Element A and Element B:	Yes	No
1. Within the practice, results by individual clinician	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the practice, results across the practice	<input type="checkbox"/>	<input type="checkbox"/>
3. Outside the practice to patients or publicly, results across the practice or by clinician.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets all 3 factors	The practice meets 2 factors	The practice meets 1 factor	No scoring option	The practice does not share performance data

**Explanation**

The practice may use data that it produces or may use data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan. Performance results must reflect care provided to all patients the practice cares for (relevant to the measure), not only patients covered by a specific payer. Data are:

- Reported to individual clinicians and practice staff (e.g., via memos, staff meeting agendas, minutes)
- Reported publicly by the health plan
- Made available to patients.

Practices where 75 percent or more of the clinicians have earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP), Diabetes Recognition Program (DRP) or Back Pain Recognition Program (BPRP) automatically receive credit for performance data for recognitions that are current when the practice submits its PCMH Survey Tool. The practice should include a statement about the recognized clinicians, the name of the recognition program and the number or percentage of recognized clinicians in the practice.

Factor 1: The practice provides individual clinician reports to clinicians and practice staff. Reports reflect the care provided by the care team.

Factor 2: The practice provides practice-level reports to clinicians and practice staff.

Factor 3: Data are reported or made available to practice staff and patients or made public by a health plan or other entity. Reporting to patients may include posting in the practice’s waiting room, through a letter or e-mail, on the practice’s Web site or through a mass mailing to patients.

**Documentation**

Factors 1 and 2: The practice provides blinded reports to the practice or to clinicians and practice staff, showing summary practice or individual clinician performance, and explains how it provides results.

Factor 3: The practice provides an example of its reporting to patients or to the public.

**Element F: Report Data Externally** **2 points**

The practice electronically reports:	Yes	No	NA
1. Ambulatory clinical quality measures to CMS or states <sup>+</sup>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Ambulatory clinical quality measures to other external entities	<input type="checkbox"/>	<input type="checkbox"/>	
3. Data to immunization registries or systems <sup>**</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Syndromic surveillance data to public health agencies <sup>**</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice reports all 3-4 types of data	The practice reports 2 types of data	The practice reports 1 type of data	No scoring option	The practice does not report any type of data

**Explanation** <sup>\*</sup>Core meaningful use requirement

<sup>\*\*</sup>Menu meaningful use requirement

Factor 1: The practice reports ambulatory clinical quality measures required for Meaningful Use following CMS specifications to CMS or states. Reporting by attestation is required in 2011; electronic reporting is required in 2012.

**For requirements and electronic specifications** related to individual ambulatory clinical quality measures, refer to:

[http://www.cms.gov/QualityMeasures/03\\_ElectronicSpecifications.asp#TopofPage](http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopofPage)

Factor 2: The practice reports ambulatory clinical quality measures to entities other than reporting to CMS or the states for meaningful use such as the Health Resources and Services Administration (HRSA) uniform data set (UDS). To qualify the performance data must be transmitted electronically from the practice's source data system (e.g. EHR), NOT manually extracted.

Factor 3: The practice performed at least one test of the certified EHR technology's capacity to submit electronic data to immunization registries or immunization information systems and follow up submission if the test is successful. This factor will be NA if none of the immunization registries to which the practice submits such information has the capacity to receive the information electronically or if the practice administered no immunizations during the past 12 months (3 months if 12 months of data is not available).

Factor 4: The practice performed at least one test of the certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful. This factor will be NA if none of the public health agencies to which the practice submits such information has the capacity to receive the information electronically or if the practice did not collect any reportable syndromic information on their patients during the past 12 months (3 months if 12 months is not available)..

**Documentation**

Factors 1 and 2: The practice provides *reports* demonstrating electronic data transmission to CMS, states, other entities and public health agencies.

Factors 3 and 4: The practice provides *reports* demonstrating electronic data submittal to immunization registries and public health agencies or a *screen shot* demonstrating that the capability was tested.

