

PCMH 2014 Standards and Guidelines

PCMH 1: Patient-Centered Access

10.00 points

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

| Element A: Patient-Centered Appointment Access (MUST-PASS) | | 4.50 points | |
|---|--|--------------------------|--------------------------|
| | | Yes | No |
| The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: | | | |
| 1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR) | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Providing routine and urgent-care appointments outside regular business hours. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Providing alternative types of clinical encounters. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Availability of appointments. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Monitoring no-show rates. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Acting on identified opportunities to improve access. | | <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 1 factor (including factor 1) | The practice meets 0 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.**

All practices, including those with walk-in access, must make same-day scheduled appointments available and must monitor their availability. **Walk-in access** is an approach to patient appointment scheduling that allows established patients to be seen by a member of the care team during regular office hours, without prior notice.

The practice has a written policy for making appointments available for both urgent and routine issues. The policy states time requirements and defines “routine” and “urgent.” For example, the practice has a policy that urgent issues are seen immediately and routine visits (e.g., new-patient physicals, return-visit exams to monitor mild acute and chronic conditions) are scheduled within seven days.

The practice triages patients to determine the urgency of a request for a same-day appointment; triage considers patient care need and preference.

Patients access the clinician and care team for routine and urgent care needs by office visit, by telephone or through secure electronic messaging.

Factor 1: Factor 1 is a critical factor and must be met for practices to receive a score on this element. Since this is also a must pass element, failure to meet factor 1 will result in denial of recognition.

The practice reserves time for same-day appointments (also referred to as “same-day scheduling”) for routine and urgent care based on patient preference and need.

Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement.

The practice has a process for scheduling same-day visits for patients with routine and urgent needs, and monitors use of same-day appointments to ensure that patients are able to use this feature.

Factor 2: The practice schedules appointments outside a typical daytime schedule. For example a practice may open for appointments at 7am or remain open until 8 pm on certain days or it may be open two Saturdays each month.

Providing extended access does not include:

- Opening daytime appointments when a practice would otherwise be closed for lunch (on some or most days).
- Opening daytime appointments when a practice would otherwise close early (e.g., a weekday afternoon or holiday).

Practices are encouraged to first assess the needs of their patients for appointments outside normal business hours and then to evaluate if these appointment times meet the needs of the patients. 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 3: An **alternative type of clinical encounter** is a scheduled meeting between patient and clinician using a mode of real-time communication in lieu of a traditional one-on-one in-person office visit; for example, standalone communication or a combination of telephone, video chat and secure instant messaging. Group visits where the patient is one of several patients scheduled for care and education at the same time also qualifies as an 'alternative type of clinical encounter.'

Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, Web site) during office hours do not meet the requirement.

Factor 4: The practice has standards for appointment availability. Availability standards may be established and measured for a variety of appointment types, including urgent care, new patient physicals, routine exams and return-visit exams or the practice may set a single standard across all appointment types (e.g. open access for all). One common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type, 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 the clinician's schedule. The Institute for Healthcare Improvement (IHI) identified third next available appointment tracking as "a more sensitive reflection of true appointment availability." IHI has set a goal of zero days for primary care.

<http://www.ihl.org/knowledge/Pages/Measures/ThirdNextAvailableAppointment.aspx>). A clinician's panel may be closed, but appointment availability may not be based on payer.

Factor 5: To provide consistent access and help understand true demand, practices monitor no-show rates. **No-show rates** may be calculated by taking the number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e. a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during the same period of time (Primary Care Development Corporation).

Factor 6: To expand access and capacity, the practice uses information gathered from reports in factors 1–5 to identify opportunities to improve access.

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/>.

Documentation

*For all factors that require a **documented process** for staff, the documented process for staff includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.*

Factor 1: NCQA reviews a documented process for scheduling same-day appointments that includes defining their appointment types. NCQA reviews a report with at least five days of data, showing the availability and use of same-day appointments for both urgent and routine care.

Factor 2: NCQA reviews 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 provided to patients demonstrating that the practice provides regular extended hours. NCQA reviews a report with at least five days of data, showing availability and use of appointments outside the normal hours of operation. A process for arranging after-hours access is not required if the practice has regular extended hours.

Factor 3: NCQA reviews a documented process for arranging appointments for alternative types of encounters (e.g., telephone, group visits, video chat). NCQA reviews a report of encounter types and dates that includes frequency of scheduled alternative encounter types in a recent 30-calendar-day period.

Ad hoc telephone or email exchanges do not meet the requirement.

Factor 4: NCQA reviews a documented process defining the practice's standards for timely appointment availability (e.g., within 14 calendar days for physicals, within 2 days for follow-up care, same day for urgent care needs) and for monitoring against the standards. NCQA reviews a report with at least five days of data showing **appointment wait times**, compared with defined standards.

Factor 5: NCQA reviews a documented process for monitoring scheduled visits. NCQA reviews a report from a recent 30-calendar-day period showing number of scheduled visits; number of patients actually seen, number of no-shows; and a calculated rate using scheduled visits as the denominator and patients seen as the numerator or by taking the number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e. a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during the same period of time.

Factor 6: NCQA reviews a documented process for selecting, analyzing and updating its approach to creating access to appointments that considers appointment supply and patient demand by:

- Including criteria for selecting areas of focus.
- Describing how the practice monitors areas of focus.
- Describing how the practice sets targets for improvement.
- Specifying how often criteria for creating greater access to appointments are revisited.
- Outlining when targets may be adjusted.

NCQA reviews a report showing the practice has evaluated data on access, selected at least one opportunity to improve access and took at least one action to create greater access.

Element B: 24/7 Access to Clinical Advice 3.50 points

| The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on: | Yes | No | NA |
|--|--------------------------|--------------------------|--------------------------|
| 1. Providing continuity of medical record information for care and advice when office is closed. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Providing timely clinical advice by telephone. (CRITICAL FACTOR) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Providing timely clinical advice using a secure, interactive electronic system. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Documenting clinical advice in patient records. | <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 2) | The practice meets 2 factors (including factor 2) | The practice meets 1 factor (or does not meet factor 2) | The practice meets 0 factors |

Explanation **Factor 1:** The practice makes patient clinical information available to on-call staff, external facilities, and other clinicians outside the practice when the office is closed . Access to the medical record may include direct access to the paper or electronic record or by arranging a telephone consultation with a clinician who has access to the medical record.

If care is provided by a facility that is not affiliated with the practice or does not have access to patient records, the practice provides patients with an electronic or printed copy of a clinical summary of their medical record. One option may be for patients to convey needed information via individualized care plans or portable personal health records, or through patient access to an electronic health record (EHR).

Telephone consultation with the primary clinician or with a clinician who has access to the patient’s medical record meets the requirement. The practice’s process for ensuring access includes a method for ensuring access by practice clinicians when the office is closed.

Factors 2, 3: Factor 2 is a critical factor and must be met for practices to score higher than 25% on this element.

Patients can seek and receive interactive (i.e., questions are answered by a person, rather than by a recorded message) clinical advice by telephone (factor 2) or secure electronic communication (factor 3) (e.g., electronic message, Web site) when the office is open and closed.

Clinicians return calls and respond to secure electronic messages in the time frame defined by the practice to meet the clinical needs of the patient population.

The practice may have different standards for when the office is open and when the office is closed and may have different standards for electronic versus telephonic communications.

Factor 3: If patients can submit requests for clinical advice after office hours, the practice has an obligation to provide a timely response. The practice defines the types of inquiries that should be made electronically, and its response time frame (e.g., a secure message sent after hours receives an automatic reply informing the sender that urgent situations require a phone call and that “routine” electronic messages will be responded to the next business day).

Factor 3 is NA if the practice cannot communicate electronically with patients. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool. The practice must also respond 'No' to Element 1C factor 5.

Factor 4: The practice documents all clinical advice in the patient record, whether it is provided by phone or by secure electronic message during office hours and when the office is closed. If a practice uses a system of documentation outside the medical record for after-hours clinical advice, it reconciles this information with the medical record on the next business day.

Documentation

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factor 1: NCQA reviews a documented process for giving staff and patients access to medical record information for care and advice when the office is closed.

Factor 2: NCQA reviews a documented process for providing timely clinical advice to patients by telephone, whether the office is open or closed.

The practice:

- Defines the time frame for a response.
- Monitors the timeliness of the response against the practice's time frame.

NCQA reviews a report summarizing the practice's response times for at least seven calendar days, during office hours and when the office is closed. The report may be system generated.

Factor 3: NCQA reviews a documented process for providing timely clinical advice to patients using a secure interactive electronic system, whether the office is open or closed.

The practice:

- Defines the time frame for a response.
- Monitors the timeliness of the response against the practice's time frame.

NCQA reviews a report summarizing the practice's response times for at least seven calendar days. The report may be system generated.

Factor 4: NCQA reviews a documented process for recording clinical advice in the patient record. NCQA reviews at least three examples of clinical advice documented in the patient record; at least one example shows documentation of advice provided when the office was closed and at least one example shows documentation of advice provided during office hours.

| Element C: Electronic Access | | 2.00 points | | |
|---|--|--------------------------|--------------------------|--------------------------|
| The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system. | | Yes | No | NA |
| 1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice. + | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party. + | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits. + | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. A secure message was sent by more than 5 percent of patients. + | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Patients have two-way communication with the practice. + | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Patients can request appointments, prescription refills, referrals and 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 0 factors |

Explanation + Stage 2 Core 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 can view their medical record, access services and communicate with the health care team electronically. Practices with a Web site or patient portal provide the URL to their patients.

Factor 1: Patients (and others with legal authorization to the information) have online access to their health information within four business days of when the information is available to the practices. This includes all data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Note: Factor 1 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 can view their health information electronically and download it or transmit it to a third party.

According to CMS, if "50 percent or more of patient encounters are in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability, [the measure] may be excluded." The practice may enter NA in this situation, and provide a written explanation.

To receive credit for this factor, at least 5 percent of the practice's patients must have access (i.e., the ability to view, download and transmit) to their health information.

Note: The practice has discretion to withhold certain information, per CMS and ONC guidelines.

Factor 3: A **clinical summary** is provided to patients/families/caregivers through a personal health record (PHR), a patient portal on the practice's Web site, secure e-mail, electronic media (e.g., a CD or USB fob [electronic memory stick/flash drive]) or a printed copy. Patients may be notified that the information is available through a

secure, interactive system such as a Web site or patient portal. By request, patients can receive a paper copy of their clinical summary if usually provided electronically.

Federal **Meaningful Use** rules require that summaries be provided for *more than 50 percent* of office visits within *one business day*, either by secure electronic message or as a printed copy from the practice's electronic system.

CMS states:

- A practice is “permitted to limit the measure to those patients whose records are maintained using CEHRT.”
- “The provision of the clinical summary is limited to the information contained within the CEHRT.”
- If the patient is offered a clinical summary and declines, “that patient may be included in the numerator.”

Factor 4: The practice demonstrates that a secure message was sent by more than 5 percent of its patients. Patients may be notified that the information is available through a secure, interactive system such as a Web site or patient portal.

According to CMS, if “50 percent or more of patient encounters are in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability, the measure may be excluded.” The practice may enter NA in this situation, and provide a written explanation.

Factor 5: The practice has a secure, interactive electronic system, such as a Web site, patient portal or a secure e-mail system that allows two-way communication between patients/families/caregivers, as applicable for a patient, and the practice.

Factor 6: Patients can use the secure electronic system (e.g., Web site or patient portal) to request appointments, medication refills, referrals to other providers and get test results.

Documentation

Factors 1–4: NCQA reviews a report with at least three months of recent data in the practice's electronic system.

Factor 1: NCQA reviews a report showing the percentage of patients who have online access to their health information within four business days of when the information is available to the practice.

- *Denominator* = Number of unique patients seen by the practice.
- *Numerator* = Number of patients in the denominator who have online access to their health information within four business days.

Factor 2: NCQA reviews a report showing the percentage of patients who view their health information, download it or transmit it to a third party.

- *Denominator* = Number of patients seen by the practice.
- *Numerator* = Number of patients in the denominator who view their online health information, download it or transmit to a third party.

Factor 3: NCQA reviews a report showing the percentage of clinical summaries provided to patients with a threshold of more than 50 percent of office visits required to meet the factor. If a patient opts not to receive a clinical summary of the visit, the practice notes this in the medical record and may include the patient in the numerator.

- *Denominator* = Number of office visits.
- *Numerator* = Number of office visits in the denominator for which patients were provided (or offered) a clinical summary of their visit within one business day.

Factor 4: NCQA reviews a report showing that a secure message was sent to more than 5 percent of patients.

- *Denominator* = Number of patients seen by the practice.
- *Numerator* = Number of patients in the denominator who were sent a secure message.

Factor 5: NCQA reviews a screen shot of the practice's Web page, demonstrating the practice's capability for two-way communication with patients/families/caregivers.

Factor 6: NCQA reviews a screen shot of the practice's Web page where patients can request appointments and prescription refills, and read test results. The screen shot contains the URL of the site or portal.

PCMH 2: Team-Based Care

12.00 points

The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.

| Element A: Continuity | | 3.00 points | |
|--|--|--------------------------|--------------------------|
| | | Yes | No |
| The practice provides continuity of care for patients/families by: | | | |
| 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Monitoring the percentage of patient visits with selected clinician or team. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Having a process to orient new patients to the practice. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care. | | <input type="checkbox"/> | <input type="checkbox"/> |

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

Explanation

Patients and their families can select a personal clinician who works with a defined health care team. The selection is documented in the patient’s record. Practice staff are aware of a patient’s personal clinician or team and work to accommodate visits and communication. The practice monitors the percentage of patient visits with the designated clinician or team.

A **team** is a primary clinician and associated clinical (including behavioral healthcare providers) and support staff who work with the clinician. A personal clinician may represent a physician/mid-level clinician or medical residency group under a supervising physician, who share a panel of patients.

Note: Solo practitioners mark “yes” for factors 1 and 2 and indicate they are the only clinician available to patients at the practice in the Support Text/Notes box in the Survey Tool.

Factor 1: The practice provides patients/families/caregivers with information about the importance of having a personal clinician and care team responsible for coordinating care, and assists in the selection process. The practice documents the patient/family’s choice of clinician.

If patient-preference or staffing arrangement results in the need for more than one clinician to be identified, the practice may document a defined pairing of clinicians (e.g. physician and nurse practitioner or physician and resident) or a **practice team**.

Factor 2: The practice monitors the percentage of patient visits that occur with a personal clinician, including structured electronic visits (e-visits) and phone visits. The practice may determine the appropriate rate of continuity, based on the practice design, staffing model and patient preferences.

Factor 3: The practice has an orientation process for patients new to the practice. Orientation provides information about the medical home model, medical home responsibilities and patient responsibilities and expectations.

Factor 4: For pediatric practices transitioning patients to adult care, the practice provides a written care plan to the adult practice that may include:

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

Internal medicine practices receiving patients from pediatricians are expected to review the transition plan provided by pediatric practices and ensure that continued care is provided to adolescent and young adult patients.

For family medicine practices that do not transition patients from pediatric to adult care, the practice should instead inform patients and families about the concept of the medical home, and the importance of having a primary care clinician to provide regular, evidence-based preventive care and acute adolescent care management. Sensitivity to teen privacy concerns should be incorporated into information provided to teens.

Documentation

Factor 1: NCQA reviews the practice's documented process for patient and family selection of a personal clinician, and reviews an example of a patient record that documents patient/family choice of personal clinician.

Factor 2: NCQA reviews a report with at least five days of data, showing the total percentage of patient encounters that occurred with personal clinicians.

Factor 3: NCQA reviews the practice's documented process for orienting patients to the practice.

Factor 4: For pediatric practices, NCQA reviews an example of a written transition plan from pediatric to adult care.

For family medicine practices, NCQA reviews a documented process and materials for outreach to adolescent and young adult patients to ensure continued preventive, acute and chronic care management.

For internal medicine practices, NCQA reviews a documented process and materials for receiving adolescent and young adult patients that ensures continued preventive, acute and chronic care management.

| Element B: Medical Home Responsibilities | | 2.50 points | |
|---|--|--------------------------|--------------------------|
| The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: | | Yes | No |
| 1. The practice is responsible for coordinating patient care across multiple settings. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Instructions for 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 provide a complete medical history and information about care obtained outside the practice. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The care team provides access to evidence-based care, patient/family education and self-management support. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. The scope of services available within the practice including how behavioral health needs are addressed. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. The practice provides equal access to all of their patients regardless of source of payment. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. The practice gives uninsured patients information about obtaining coverage. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Instructions on transferring records to the practice, including a point of contact at the practice. | | <input type="checkbox"/> | <input type="checkbox"/> |

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

Explanation

The practice has a documented process for giving patients/families/caregivers information about the role and responsibilities of the medical home:

- Specific services patients can expect from the practice.
- Whom to contact for specific concerns, questions and information.
- The roles of the care team.

The practice is encouraged to provide information in multiple formats to accommodate patient preference and language needs.

Factor 1: The practice coordinates care across settings (i.e., specialists, hospitals, rehab centers and other facilities), including for behavioral health.

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.
- Instructs its patients to give their other providers or facilities the personal clinician’s information when they seek care outside the practice.

Factor 3: To be an effective medical home, the practice has comprehensive patient information about 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/families/caregivers can expect evidence-based care from their clinician and team, as well as support for self-management of their health and health care, including educational resources and current literature regarding specific health issues.

Factor 5: The practice is concerned with the whole person care, which includes behavioral healthcare. The practice informs patients/families/caregivers how behavioral healthcare needs are met (i.e., by the practice or in coordination with another practice).

Factor 6: The practice evaluates and meets the needs of patients:

- Considers accepting Medicare/Medicaid/uninsured patients.
- Provides equal access to for all patients accepted into the practice, regardless of insurance status.

Factor 7: The practice provides information (e.g., brochures, point of contact information) to patients/families/caregivers about potential sources of insurance coverage (e.g., state Medicaid or CHIP [Children's Health Insurance Program] office), to raise patient awareness of the availability of public health insurance and financial support for care needs.

Factor 8: The practice guides and helps new patients migrate their personal health record from their former provider, including capturing a point of contact at the transferring practice to help coordinate the transition.

Documentation

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–8: NCQA reviews:

- A documented process for giving patients information and **materials** about the role of a medical home.
- Patient materials:
 - Patient brochure.
 - Letter to the patient/family/caregiver.
 - Web materials.
 - A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
 - A sample record transfer request form.

Element C: Culturally and Linguistically Appropriate Services 2.50 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 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 0 factors |

Explanation

Factor 1: The practice uses data to assess the diversity and needs of its population so it can meet those needs adequately. Data may be collected by the practice from all patients directly or may be data about the community served by the practice.

Diversity is a meaningful characteristic of comparison for managing population health that accurately identifies individuals within a non-dominant social system who are underserved. These characteristics of a group may include, but are not limited to, race, ethnicity, gender identity, sexual orientation and disability.

Note: Patient race and ethnicity are tracked in Element 3A: Clinical Data.

Factor 2: The practice uses data to assess the linguistic needs of its population so it can meet those needs adequately. Data may be collected by the practice from all patients directly or may be data about the community served by the practice.

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.

Asking a friend or family member to interpret for a 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. The practice receives credit for this factor if services are available through multilingual staff and contractors, without regard to the level of need in the practice’s population.

Factor 4: The practice identifies languages spoken by at least 5 percent of its patient population and makes materials available in those languages, with regard to patient need (e.g., reading level). For patients with limited proficiency in English, forms that patients are expected to sign, complete or read for administrative or clinical needs are provided in their native language.

Factor 4 is NA if the practice provides documentation that no language (other than English) is spoken by 5 percent or more of its patient population.

Documentation

Factors 1, 2: NCQA reviews a report of the practice’s assessment of the diversity (including racial, ethnic and at least one other meaningful characteristic of diversity) and language composition of its patient population.

Factor 3: NCQA reviews documentation showing that interpretive services are available at the practice, or has a dated policy or statement that the practice uses

bilingual staff. The policy states how the practice helps patients who speak a language that is not spoken by bilingual staff.

Factor 4: NCQA reviews materials in languages other than English, a screenshot showing system capabilities or a link to online materials or a Web site in languages other than English.

Element D: The Practice Team (MUST-PASS) 4.00 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. Identifying the team structure and the staff who lead and sustain team based care. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL FACTOR) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Using standing orders for services. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Training and assigning members of the care team to coordinate care for individual patients. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Training and assigning members of the care team to manage the patient population. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Holding scheduled team meetings to address practice functioning. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Involving care team staff in the practice’s performance evaluation and quality improvement activities. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Involving patients/families/caregivers in quality improvement activities or on the practice’s advisory council. | <input type="checkbox"/> | <input type="checkbox"/> |

| Scoring | 100% | 75% | 50% | 25% | 0% |
|---------|--|---|---|--------------------------------|--------------------------------|
| | The practice meets all 10 factors (including factor 3) | The practice meets 8-9 factors (including factor 3) | The practice meets 5-7 factors (including factor 3) | The practice meets 2-4 factors | The practice meets 0-1 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.**

Managing patient care is a team effort that involves clinical and nonclinical staff (i.e., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) interacting with patients and working as a team to achieve stated objectives. The clinician leading the team is integral to determining and enacting the processes established by the practice.

The emphasis is on ongoing interactions of team members to discuss roles, responsibilities, communication and patient hand-off, working together to provide and enhance the care provided to patients.

All clinical staff (i.e., physicians, nurse practitioners, behavioral healthcare specialists) are members of the team. Involvement of the patient/family/ caregiver with care team members is critically important to patient-centeredness.

This element applies to all types of practices.

When training and assigning roles to care team members, the practice references ongoing measurement activities chosen in PMCH 6 Elements A–C. For example, a team member could lead an effort to conduct outreach and provide updated immunizations to a specific population, which the practice measures in PCMH 6A, factor 1.

Factor 1: Job roles and responsibilities emphasize a team-based approach to care and support each member of the team being trained to meet the highest level of function allowed by state law.

Factor 2: The practice delineates responsibilities for sustaining team-based care, and specifies how care teams align to provide patient-centered care. Specific team units may focus on providing care coordination across and beyond the practice (factor 5). An organizational chart may be used to illustrate how a care team fits in the practice.

Factor 3: Factor 3 is a critical factor and must be met for practices to score higher than 25% on this element.

Team meetings may be informal daily meetings or review daily schedules, with follow-up tasks. A structured communication process may include regular e-mail exchanges, tasks or messages about a patient in the medical record and how the clinician or team leader is engaged in the communication structure.

Factor 4: 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 5: Care coordination may include obtaining test and referral results and communicating with community organizations, health plans, facilities and specialists.

Factor 6: Care team members are trained in evidence-based approaches to self-management support, such as patient coaching and motivational interviewing.

Factor 7: Care team members are trained in managing the patient population and addressing needs of patients and families proactively. **Population management** assesses and manages 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).

Care team members are trained on effective communication with 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 co-morbid 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 practice holds scheduled team meetings routinely to improve care for all patients (factor 3 addresses care of specific patients). Meetings include clinical staff (e.g., physicians and nurse practitioners) and nonclinical staff. The purpose of these meetings is to discuss practice and staff functions —what is working well and what may need improvement. For example, there could be an ongoing discussion about staff roles and responsibilities, performance measurement data and related quality improvement efforts, team member training and areas for improvement. Meeting frequency can vary (e.g., monthly, bimonthly, quarterly) but are part of the practice's routine operations.

Factor 9: The practice has a documented process for quality improvement activities that includes a description of staff roles and involvement in the performance evaluation and improvement process.

The care team receives performance measurement and patient survey data to identify areas and methods for quality improvement. The team may participate in regular quality improvement meetings or in action plan development.

Factor 10: 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

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1, 5, 6, 7: NCQA reviews dated descriptions of staff positions or policies and procedures describing staff roles and functions. The practice may provide an organizational chart or description of the team structure and team members.

Factor 2: NCQA reviews an overview of the staffing structure for team-based care.

Factor 3: NCQA reviews the practice's documented process for structured communication between the clinician and other care team members, which states the frequency of communication; and reviews at least three samples of meeting summaries, checklists, appointment notes or chart notes for evidence that the practice follows its process.

Factor 4: NCQA reviews at least one example of written standing orders.

Factors 5–7: The practice provides a description of its training and training schedule or materials showing how staff has been trained in each area identified in the factors.

Factor 8: NCQA reviews a description of team meetings, the frequency of these meetings and at least one example of meeting minutes, agendas or staff memos.

Factor 9: NCQA reviews the practice's documented process for quality improvement.

Factor 10: NCQA reviews the organization's documented process for involving patients/families/caregivers in QI teams or on an advisory council (e.g. meeting notes, agenda, committee structure).

PCMH 3: Population Health Management

20.00 points

The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

| Element A: Patient Information | 3.00 points | | |
|--|--------------------------|--------------------------|--------------------------|
| The practice uses an electronic system to record patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients: | Yes | No | NA |
| 1. Date of birth. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Sex. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Race. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Ethnicity. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Preferred language. + | <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. Occupation (NA for pediatric practices). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Dates of previous clinical visits. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Legal guardian/health care proxy. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Primary caregiver. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Presence of advance directives (NA for pediatric practices). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Health insurance information. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Name and contact information of other health care professionals involved in patient’s care. | <input type="checkbox"/> | <input type="checkbox"/> | |

| Scoring | 100% | 75% | 50% | 25% | 0% |
|---------|----------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| | The practice meets 10-14 factors | The practice meets 8-9 factors | The practice meets 5-7 factors | The practice meets 3-4 factors | The practice meets 0-2 factors |

Explanation + Stage 2 Core Meaningful Use Requirement

The practice uses a practice management, EHR or other electronic system that collects and records patient information for factors 1–13 in searchable data fields. To meet this element, the practice must generate a report by factor (items 1–13), showing the percentage of patients seen by the practice for whom data were entered. **Documentation** in the medical record of “none,” “no” or “patient declined to provide information” counts toward the numerator. A blank field does not count toward the numerator. A practice may provide documentation and receive credit for factors 1–5 without a certified EHR.

Searchable data is information entered into a field in an electronic system that allows the practice to conduct data searches and create reports.

Structured data fields have specified data type and response categories within the record or file.

Factors 1: The practice records date of birth in MM/DD/YYYY format.

Factor 2: The practice records sex, using M/F or Male/Female.

Factors 3, 4: The practice records patient race, ethnicity and other diversity data. Race and ethnicity categories may be aligned with those used by the Office of Management and Budget (OMB). The practice considers aspects of **diversity** beyond race and ethnicity.

Blank fields are not acceptable; data entry must capture refusals. The numerator may include patients who do not provide race/ethnicity if there is documentation in the record that the patient declined to provide the information. The practice asks patients to provide this information, rather than entering data based on observation.

Factor 5: The practice documents the patient's preferred spoken/written language, which helps identify patients who need interpretation and translation services. A blank field does not mean that the patient's preferred language is English. The practice documents in the patient's record 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.

Factor 6: The primary telephone number may be a mobile number. A blank field does not indicate that a patient has no telephone number.

Factor 7: The practice enters "none" in the field e-mail field if a patient does not have an e-mail address or declines to provide one. This counts toward the numerator.

Factor 8: For a patient who is unemployed, the practice indicates a specific status (i.e., retired, disabled, unemployed, student). Job status and work conditions provide background on exposure to health risks, which creates an opportunity for population-based interventions.

This factor is met if the practice sees only pediatric patients and documents "NA" in the field. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

Factor 9: The practice enters all office, electronic and telephone visits into the system. Visits (i.e., scheduled, structured encounters) are distinguished from medical advice given electronically or by telephone.

Factor 10: A **legal guardian or health care proxy** is an individual designated by the patient, family or court to make health care decisions for a patient, if the patient is unable to do so.

Factor 11: A primary caregiver provides day-to-day care for a patient and receives instructions about care. Primary care givers are documented in the health care record. The practice enters "none" if there is no caregiver. This counts toward the numerator.

Factor 12: There is documentation in the medical record that the patient/family gave the practice an **advance directive** (e.g., living will, 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 is met if the practice sees only pediatric patients and documents "NA" in the field. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

Factor 13: The practice documents the patient/family health insurance coverage (e.g., health plan name, Medicare, Medicaid, "none").

Factor 14: The practice records the name and contact information for the patient's other health care clinicians providing care (e.g. behavioral healthcare clinicians, oral health providers, OB/GYN). Collecting the information in the electronic patient chart or electronic care plans is acceptable.

Note: This factor does not require the field to be searchable or structured data.

Documentation

Factors 1–13: NCQA reviews reports from the electronic system showing the percentage of all patients for each populated data field. Reports contain all required data elements so that it can be determined how many elements are entered in the practice’s electronic system consistently.

The practice calculates a percentage based on at least three months of recent data. The practice may use the following methodology to calculate the percentage:

- *Denominator* = Number of patients seen by the practice at the practice location at least once during the reporting period (for factors 8 and 12, include only those who meet the age parameter).
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

NCQA reviews the numerator and denominator, and the percentage and dates used in the calculation.

Factor 14: This factor does not need to be captured in structured data fields. NCQA reviews:

- The practice’s documented process for capturing the data.

Three examples demonstrating implementation of the process.

Element B: Clinical Data **4.00 points**

| The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 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. +++ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Allergies, including medication allergies and adverse reactions,* for more than 80 percent of patients. +++ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Height/length for more than 80 percent of patients. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Weight for more than 80 percent of patients. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. System calculates and displays BMI. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices). + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. List of prescription medications with date of updates for more than 80 percent of patients. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. More than 20 percent of patients have family history recorded as structured data. ++ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit. ++ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Scoring | 100% | 75% | 50% | 25% | 0% |
|---------|---------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| | The practice meets 9-11 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**
- +Stage 2 Core Meaningful Use Requirement
 - ++Stage 2 Menu Meaningful Use Requirement
 - +++ CMS Meaningful Use Requirement

The practice collects patient clinical information through an EHR or other electronic system (e.g., a practice management system, billing system). The system 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.

To qualify for Meaningful Use, the practice must meet the related factors using a *certified* EHR. A practice may provide documentation and received credit for factors 3-8, 10 and 11 without a certified EHR.

Searchable data is information entered into a field in an electronic system that allows the practice to conduct data searches and create reports.

Structured data fields have specified data type and response categories within the record or file.

Factor 1: The patient's current and active problem list or diagnoses. Including acute and chronic conditions, behavioral health diagnoses and oral health issues.

Factor 2: Allergies (i.e., medication, food, environmental) and associated reactions are recorded as searchable data.

Factor 3: Dated blood pressure readings for patients 3 years and older; NA for practices with no patients 3 years and older. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

Factors 4, 5: Height/length and weight are documented and dated for more than 80percent. This is applicable to all patients.

Factor 6: The practice electronic system calculates and displays BMI in the medical record.

Note: This factor does not require the field to be searchable or structured data.

Factor 7: The electronic system plots and displays length, weight and head circumference on a growth chart for patients 0–2 years of age, and BMI percentile for patients 2–20 years of age.

Note: This factor does not require the field to be searchable or structured data.

This factor is met if the practice has no pediatric patients and documents "NA" in the field. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

Factor 8: Data on smoking status and tobacco use are collected as a separate factor to emphasize importance to overall health.

This factor is met if the practice sees no patients 13 years of age and older and documents "NA" in the field. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

Factor 9: The practice maintains a list of the current prescription medications prescribed by the patient's clinicians, including clinicians outside the practice and records dates of updates.

This factor is met if the practice documents "NA" in the field because the patient does not take prescribed medications.

Factor 10: Family health history (e.g., history of chronic disease or event [e.g., diabetes, cancer, substance abuse, hypertension]) for "first-degree" relatives (i.e., who share about 50 percent of their genes with a specific family member).

The practice may document "unknown" for patients who do not know their family health history. Family health history may include history of chronic diseases or events (e.g., diabetes, cancer, mental health or substance use disorders, myocardial infarction, hypertension).

Factor 11: Progress notes are text-searchable; non-searchable notes do not meet the intent of this factor. Following the CMS definition, the practice may make its own determinations and guidelines defining what progress notes are necessary to communicate individual patient circumstances. The practice coordinates new progress notes with previous documentation of patient observations, treatments and results.

This factor has an N/A option for practices without this capability until 1/1/2015.

Documentation

Factors 1–5, 8–11: NCQA reviews reports from the electronic system showing the percentage of all unique patients for each populated data field (not only patients with identified important conditions or who are in a disease-specific **registry**). Reports contain all required data elements so that it can be determined how many elements are entered in the practice's electronic system consistently.

For factors 3 and 8, include only patients meeting the age parameter.

The practice calculates a percentage based on at least three months of recent data. The practice may use the following methodology to calculate the percentage:

- *Denominator* = Number of patients seen by the practice at the practice location at least once during the reporting period (for factors 8 and 12, include only those who meet the age parameter).
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

Factors 6, 7: NCQA reviews screen shots demonstrating that the electronic system can calculate and display BMI (factor 6) and plot and display growth charts and BMI percentile (factor 7).

For factor 7, include only patients meeting the age parameter.

Element C: Comprehensive Health Assessment**4.00 points**

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

| | Yes | No | NA |
|---|--------------------------|--------------------------|--------------------------|
| 1. 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. Mental health/substance use history of patient and family. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients). | <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"/> | <input type="checkbox"/> |
| 10. Assessment of health literacy. | <input type="checkbox"/> | <input type="checkbox"/> | |

Scoring

| 100% | 75% | 50% | 25% | 0% |
|---------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| The practice meets 8-10 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 patient assessment includes an examination of social and behavioral influences. The practice determines how frequently it updates the health assessment, using **evidence-based guidelines**. Patients with an active diagnosis or aspect of care listed in the problem list of their care summary are reassessed at each relevant visit.

The practice should consider how its comprehensive health assessment helps establish criteria and supports a systematic process for identifying patients for care management in PCMH 4 Element A.

Factor 1: The practice implements age/gender-appropriate screenings and immunizations, when possible, using immunizations identified by the U.S. Preventive Services Task Force (USPSTF); the Centers for Medicare & Medicaid Services (CMS) in 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. Broad considerations should be made for a variety of characteristics (e.g., poverty, homelessness, unemployment, sexual orientation, gender, education level, social support).

Factor 3: The practice identifies whether the patient has specific communication requirements due to hearing, vision or cognition issues. This does not address language, see PCMH 3A factor 5.

Factor 4: Family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, substance abuse, hypertension]) for “first-degree” relatives (i.e., who share about 50 percent of their genes with a specific family member).

The practice may document “unknown” for patients who do not know their family medical history.

Factor 5: The practice documents patient/family preferences for **advance care planning** (i.e., care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences.

This factor is met if the practice sees only pediatric patients and documents “NA” in the field. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool. Documentation that the patient declined to provide information counts toward the numerator.

Factor 6: Assessment of risky and unhealthy behaviors goes beyond physical activity and smoking status; it may include nutrition, oral health, dental care, familial behaviors, risky sexual behavior and secondhand smoke exposure.

Factor 7: The practice assesses whether the patient or the patient’s family has mental health/behavioral 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 uses a standardized screening test. If there are no established risk factors or parental concerns, screens are done by 24 months.

This factor is met if the practice sees only adult patients and documents “NA” in the field. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

Factor 9: The U.S. Preventive Services Task Force (USPSTF) states that adults and adolescents should be screened for depression when the practice has access to services that can be used if there is a positive result (e.g., mental health providers in the practice or external to the practice and to whom the practice can refer patients).

- *Screening for adults:* Screening adults for depression when staff-assisted depression care support systems are in place to assure accurate diagnosis, effective treatment and follow-up. Practices use a standardized screening tool (e.g., PHQ-9). A **standardized tool** collects information using a current evidence-based approach that has been developed, field-tested and endorsed by a national or regional organization.
- *Screening for 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.

This factor is met if the practice sees no adolescent or adult patients and documents “NA” in the field. The practice must provide a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

This factor is not met if the practice does not screen for depression or if screening is not performed with a standardized tool.

Factor 10: The practice assesses the patient/family/caregiver’s ability to understand the concepts and care requirements associated with managing their health.

Documentation

Factors 1–10: Documentation requires the practice to provide:

1) Practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor. The report must indicate that data was entered in the medical record for more than 50 percent in order for the practice to respond “yes” to each factor in the survey tool.

OR

2) Review the patient records selected for the medical record review as required in elements 4B and 4C and document presence or absence of the information in the Record Review Workbook.

Factors 8, 9: In addition to the report as described above, the practice must provide a completed form (de-identified) for each factor.

Element D: Use Data for Population Management (MUST-PASS) 5.00 points

At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:

- | | | |
|---|--------------------------|--------------------------|
| 1. At least two different preventive care services. + | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. At least two different immunizations. + | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. At least three different chronic or acute care services. + | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Patients not recently seen by the practice. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Medication monitoring or alert. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

| 100% | 75% | 50% | 25% | 0% |
|--------------------------------|------------------------------|------------------------------|-----------------------------|------------------------------|
| The practice meets 4-5 factors | The practice meets 3 factors | The practice meets 2 factors | The practice meets 1 factor | The practice meets 0 factors |

Explanation

+Stage 2 Core 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 ensures that practices use registries and proactive reminders to address a variety of health care needs.

The practice creates lists or reports of:

- Patients who need preventive care.
- Patients who need immunization and chronic care services.
- Patients who have not been seen recently.
- Patients who take specific medications.

Reports may include multiple services needed. The practice uses the lists or reports to manage specific patient populations. Practices are encouraged to offer a complete approach to patient care, which may require an expanded list of immunizations or other preventive and chronic services to meet the needs of the patient population. These factors are intended to assure practices use registries and proactive reminders to address a variety of health care needs.

The practice may use mail, telephone or e-mail, directly or through external providers (e.g., vendors, HIE) to remind patients when services are due.

Renewing practices: The practice is required to meet the factors in this element at least annually. Renewing practices can show at least two factors have been met during each year of recognition, prior to their renewal.

Factors 1–3 blend two Meaningful Use criteria in each factor:

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

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

consider the practice's entire population and are not limited to a population with chronic conditions.

Assessments and immunizations do not meet the requirements of this factor.

Factor 2: The practice generates lists of patients and uses the lists to remind identified patients about at least two different immunizations, appropriate to patient age or gender. Practices may not use the same immunization for two different age groups.

Factor 3: The practice generates lists (registries) of patients who need chronic care management services and uses the lists to remind identified patients of at least three chronic care services:

- *For adults:* Examples include diabetes care, coronary artery disease care, lab values outside normal range and post-hospitalization follow-up appointments.
- *For children:* Examples include services related to chronic conditions such as asthma, ADHD, ADD, obesity and depression.

Chronic care management services consider a practices entire population. Practices may focus on three chronic care services related to one condition.

Factor 4: The practice generates lists of patients who are overdue for an office visit or service (e.g., care management follow-up visit, overdue periodic physical exam) and acts to remind them.

Factor 5: The practice generates lists of patients on specific medications. Lists may be used to:

- Manage patients prescribed medications with potentially harmful side effects.
- Identify patients prescribed a brand-name drug instead of a generic drug.
- Notify patients about a medication recall or warning.
- Remind patients about necessary monitoring because of specific medications (e.g., warfarin, liver function test for patients on selected medications, growth hormone).
- Inform patients about drug-drug or dosage concerns.

Documentation

NCQA reviews reports used by the practice in the previous 12 months to remind patients of needed services specified in the factors, and reviews reminders sent to patients.

The practice demonstrates that during the past 12 months 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, meet the requirement of this element. The practice must perform these functions at least annually and make documentation of each reminder available to NCQA upon request.

Factors 1–5: NCQA reviews:

- Reports or lists of patients needing services generated within the previous 12 months.
- NCQA reviews the identified services.

NCQA reviews materials showing how patients were notified for each service (e.g., call logs with successful contact vs. unsuccessful contact, examples of blinded letters sent to patients, a script or description of phone reminders, screen shots of electronic notices).

Examples AAP resources

- Recommendations for Preventive Pediatric Health Care (PDF):
<http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>
- Interactive Periodicity Schedule (AAP Pediatric Care Online- Web resource):
<https://www.pediatriccareonline.org/pco/ub/periodicity>
- Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition (Web site and links to associated text/materials):
<http://brightfutures.aap.org/index.html>

Element E: Implement Evidence-Based Decision Support**4.00 points**

The practice implements clinical decision support+ (e.g., point-of-care reminders) following evidence-based guidelines for:

Yes No

1. A mental health or substance use disorder. (CRITICAL FACTOR) +

2. A chronic medical condition. +

3. An acute condition. +

4. A condition related to unhealthy behaviors. +

5. Well child or adult care. +

6. Overuse/appropriateness issues. +

 Scoring

| 100% | 75% | 50% | 25% | 0% |
|---|---|------------------------------|--------------------------------|------------------------------|
| The practice meets 5-6 factors (including factor 1) | The practice meets 4 factors (including factor 1) | The practice meets 3 factors | The practice meets 1-2 factors | The practice meets 0 factors |

Explanation**+ Stage 2 Core Meaningful Use Requirement**

Factor 1 is a critical factor and must be met for practices to receive a 75% or 100% score.

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 use registries that identify and engage patients in need of important services proactively (as in PCMH 3, Element D). Clinical data collected in PCMH 3, Element B supports the practice's approach to meeting criteria in this element. When selecting conditions, the practice considers:

- Diagnoses and risk factors prevalent in patients seen by the practice.
- The availability of evidence-based clinical guidelines.
 - American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support (www.choosingwisely.org).

Other resources for evidence-based guidelines include:

- Up-to-Date - www.uptodate.com
- National Guideline Clearinghouse - <http://www.guideline.gov/>

Factor 1: The practice has evidence-based guidelines it uses for clinical decision support related to at least one mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's) or substance abuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism).

Factor 2: The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic medical condition. Relevant chronic conditions may include, but are not limited to, arthritis, asthma, cardiovascular disease, COPD, diabetes and eczema.

Well-child care is not an acceptable chronic condition for this factor.

Factor 3: The practice has evidence-based guidelines it uses for clinical decision support related to at least one acute medical condition. Relevant acute conditions may include, but are not limited to, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis and urinary tract infection.

Factor 4: The practice has evidence-based guidelines it uses for clinical decision support related to at least one unhealthy behavior (e.g., obesity, smoking).

Factor 5: The practice has evidence-based guidelines it uses for clinical decision support related to well-child or adult care (e.g. age appropriate screenings, immunizations).

Factor 6: The practice has evidence-based guidelines it uses for clinical decision support related to overuse or appropriateness of care issues (e.g. use of antibiotics, avoiding unnecessary testing, and referrals to multiple specialists).

Documentation

Factors 1–6: NCQA reviews:

The conditions that the practice identified for each factor.

The source of guidelines used by the practice, for each condition.

Examples of guideline implementation, such as tools to manage patient care, organizers, flow sheets or electronic system organizer (e.g. registry, EHR, or other system) templates based on condition-specific guidelines, enabling the practice to develop treatment plans and document patient status and progress.

PCMH 4: Care Management and Support**20.00 points**

The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

Element A: Identify Patients for Care Management**4.00 points**

The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

| | Yes | No |
|--|--------------------------|--------------------------|
| 1. Behavioral health conditions. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High cost/high utilization. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Poorly controlled or complex conditions. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Social determinants of health. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. The practice monitors the percentage of the total patient population identified through its process and criteria. (CRITICAL FACTOR) | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

| 100% | 75% | 50% | 25% | 0% |
|---|---|---|---|--|
| The practice meets 5-6 factors (including factor 6) | The practice meets 4 factors (including factor 6) | The practice meets 3 factors (including factor 6) | The practice meets 2 factors (including factor 6) | The practice meets 0-1 factors (or does not meet factor 6) |

Explanation

The intent of the element is that practices use defined criteria to identify true vulnerability—a single criterion, such as cost, may not be an appropriate indicator of need for care management.

Factor 6 is a critical factor and is required for practices to receive a score above 0% on this element.

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

The practice may identify patients through a billing or practice management system or electronic medical record; through key staff members; or through profiling performed by a health plan, if profiles provided by the plan represent at least 75 percent of the patient population.

The practice considers how its comprehensive health assessment (PCMH 3, Element C) supports establishing criteria and a systematic process for identifying patients for care management.

The practice receives credit for each factors (1–5) included in its criteria for identification of patients for care management. A patient may fall into more than one category (factor) and may be included in some or all of these counts. The practice uses criteria to create a registry of patients identified as likely to benefit from care management. There may be more than one set of processes and criteria to identify specific types of patients.

Factor 1: The practice has specific criteria for identifying patients with behavioral conditions for whole-person care planning and management.

Criteria are developed from a profile of patient assessments, and may include the following, or a combination of the following:

- A diagnosis of a behavioral issue (e.g., visits, medication, treatment or other measures related to behavioral health).
- Psychiatric hospitalizations (e.g., two or more in the past year).
- Substance use treatment.
- A positive screening result from a standardized behavioral health screener (including substance use).

Pediatric populations

Practices may identify children and adolescents with special health care needs, 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.)

Factor 2: The practice has specific criteria for identifying patients who experience high utilization or high cost. The practice may consider the following when establishing criteria:

- ER visits.
- Hospital readmissions.
- Unusually high numbers of imaging or lab tests ordered.
- Unusually high number of prescriptions.
- High-cost medications.
- Number of secondary specialist referrals.
- Reports, alerts or other notifications from health plans indicating high cost or high utilization.

Factor 3: The information and process for identifying high-cost/utilization patients may differ from the process for identifying poorly controlled patients (e.g., with continued abnormally high A1C or blood pressure results). Patients who consistently fail to meet treatment goals or with multiple comorbid conditions may be included in the criteria for this factor.

Factor 4: The practice has a process for identifying patients based on **social determinants of health**. Social determinants of health are conditions in the environment that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include: availability of resources to meet daily needs; access to educational; economic and job opportunities; public safety, social support; social norms and attitudes; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation and others (Healthy People 2020).

Factor 5: The practice has a process based on these criteria that is intended to allow for referrals by external entities and nominations by those closest to patients/families/caregivers.

Factor 6: Assessment of a combination of factors 1–5 results in a subset of the practice’s entire panel of patients identified as likely to benefit from care management.

Note: Patients identified in this element will be used to draw a **sample** for the medical record review required in PCMH 4, Elements B and C.

Documentation

Factor 1–5: NCQA reviews the practice's documented process that describes the criteria for identifying patients for each factor.

Factor 6: NCQA reviews a report showing the number and percentage of its total patient population identified as likely to benefit from care management, through one factor or through a combination of factors or criteria determined by the practice.

The practice calculates 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* = Number of unique patients identified in the denominator as likely to benefit from care management by the criteria in factors 1–5.

Element B: Care Planning and Self-Care Support (MUST PASS) 4.00 points

The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A:

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Incorporates patient preferences and functional/lifestyle goals. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Identifies treatment goals. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Assesses and addresses potential barriers to meeting goals. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Includes a self-management plan. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is provided in writing to the patient/family/caregiver. | <input type="checkbox"/> | <input type="checkbox"/> |

| Scoring | 100% | 75% | 50% | 25% | 0% |
|---------|----------------------------------|------------------------------|------------------------------|--------------------------------|------------------------------|
| | The practice meets all 5 factors | The practice meets 4 factors | The practice meets 3 factors | The practice meets 1-2 factors | The practice meets 0 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 care team and patient/family/caregiver collaborate on developing and updating an individualized care plan that addresses whole-person care. The care plan specifies the services offered by and responsibilities of the primary care practice and, if appropriate, integrates with a care plan created for the patient by a non-primary care specialty practice, to avoid potential overlap or gap in services and care.

A **care plan** considers and/or specifies:

- Patient preferences and functional/lifestyle goals.
- Treatment goals.
- Assessment of potential barriers to meeting goals.
- Strategies for addressing potential barriers to meeting goals.
- Care team members, including the primary care provider of record and team members beyond the referring or transitioning provider and the receiving provider.
- Current problems (may include historical problems, at the practice’s discretion).
- Current medications.
- Medication allergies.
- A self-care plan.

CMS defines a care plan as, “The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).”

Factor 1: The practice works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan and updates the plan at relevant visits. A relevant visit addresses an aspect of care that will affect progress toward meeting existing goals or that requires modification of an existing goal.

Factor 2: The practice works with patients/families/caregivers and other providers to develop treatment goals using evidence-based guidelines.

Factor 3: The practice works with patients/families/caregivers, other providers and community resources to assess and address potential barriers to achieving treatment and functional/lifestyle goals.

Factor 4: The practice works with patients/families/caregivers to develop a self-management plan. Patients/family/caregivers that manage complex conditions or may have other significant potential barriers (factor 3) are given instructions and resources, as appropriate.

The self-management plan includes goals and a way to monitor self-care.

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 5: The written individualized care plan is given to the patient/family/caregiver. When possible, the plan is tailored to account for health literacy and language considerations.

Documentation

Factors 1–5: NCQA reviews reports from the practice’s electronic system **OR** the Record Review Workbook **AND** examples demonstrating how each factor is documented.

The practice calculates a percentage that requires a numerator and a denominator using one of the following methods.

Method 1: Query the practice’s electronic registry, practice management system or other electronic systems for the patients identified in Element A. This method is used if the practice can determine a denominator, as described below.

- *Denominator* = Total number of patients identified through the criteria in Element A seen at least once for a relevant visit 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: Use the instructions in the Record Review Workbook to choose a sample of relevant patients and check for the relevant items. For each factor to which the practice responds “yes,” it provides an example of how it meets the factor.

Element C: Medication Management **4.00 points**

| | Yes | No |
|--|--------------------------|--------------------------|
| The practice has a process for managing medications, and systematically implements the process in the following ways: | | |
| 1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions.+ (CRITICAL FACTOR) | <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/caregivers. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates 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 (not just any 1 factor) | The practice meets 0 factors (or does not meet factor 1) |

Explanation

+Stage 2 Core Meaningful Use Requirement

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

Factors 1, 2: Factor 1 is a critical factor and is required for practices to receive a score on this element.

The practice reviews and documents in the medical record all prescribed medications the patient is taking. Medication review and reconciliation occurs, at least annually, at transitions of care and at relevant visits. The practice may use its own criteria to determine a relevant visit.

Maintaining a list of current medications and resolving medication conflicts reduces the possibility of duplicate medications, medication errors and adverse drug events. A process for reconciling medications is essential for patient safety.

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

Factor 4: The practice assesses how well patients understand the information about medications they are taking, and considers a patient’s health literacy (PCMH 2, Element C, factor 10).

Factor 5: The practice asks patients about a problem or difficulty taking a medication; whether they are experiencing side effects; and whether the medication is being taken as prescribed. If a patient is not taking a medication as prescribed, the practice determines why.

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

Documentation

Factors 1–6: NCQA reviews reports from the practice’s electronic system, **OR** the Record Review Workbook **AND** examples demonstrating how each factor is documented.

The practice calculates a percentage that requires a numerator and a denominator, using one of the following methods.

Method 1: Query the practice’s electronic registry, practice management system or other electronic systems for the patients identified in Element A. This method is used if the practice can determine a denominator, as described below.

- *Denominator* = Total number of patients identified through the criteria in Element A seen at least once for a relevant visit 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: Use the instructions in the Record Review Worksheet to choose a sample of relevant patients and check for the relevant items. For each factor to which the practice responds “yes,” it provides an example of how it meets the factor.

“NA” 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.

Element D: Use Electronic Prescribing 3.00 points

| The practice uses an electronic prescription system with the following capabilities: | Yes | No | NA |
|---|--------------------------|--------------------------|--------------------------|
| 1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Enters electronic medication orders in the medical record for more than 60 percent of medications. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Performs patient-specific checks for drug-drug and drug-allergy interactions. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Alerts prescribers to generic alternatives. | <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 0 factors |

Explanation

+Stage 2 Core Meaningful Use Requirement

Factor 1: More than 50 percent of eligible prescriptions written by the practice are:

- Compared with drug formularies to identify covered drugs and the copayment tier, if applicable, **and**
- Sent to pharmacies electronically.
 - The prescription is sent from the practice to the pharmacy electronically, not faxed to the pharmacy.

If a practice writes fewer than 100 prescriptions during the reporting period, the practice may select an NA response and provide a written explanation in the Support Text/Notes box in the Survey Tool.

If a practice does not have a pharmacy in its organization and no pharmacies within 10 miles of the practice accept electronic prescriptions, the practice may select an NA response and provide a written explanation in the Support Text/Notes box in the Survey Tool.

Factor 2: The practice’s electronic prescribing system is integrated with patient records, allowing the practice to view patient diagnoses and patient medications; enter new medications or make changes; and identify documented allergies. The practice enters more than 60 percent of prescribed medication orders in the integrated electronic prescribing system.

If a practice writes fewer than 100 prescriptions during the reporting period, the practice may select an NA response. The practice provides a written explanation for an NA response and enters the number of prescriptions written during the reporting period in the Support Text/Notes box in the Survey Tool or in a linked document, to attest to exclusion from this requirement.

Factor 3: When a new prescription request is entered, the practice’s electronic prescribing system alerts the clinician to potentially harmful, patient-specific interactions between drugs or to a patient’s drug **allergy**.

Factor 4: The system alerts the clinician to cost-effective, generic options to name-brand medications.

Documentation

Factor 1: NCQA reviews reports from the practice's electronic system **and** a screenshot displaying the formulary decision-support mechanism used by the practice.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- *Denominator* = Eligible prescriptions written by the practice.
- *Numerator* = Eligible prescriptions generated by the practice that are compared with drug formularies and transmitted to pharmacies from the practice's electronic prescribing system.

Factor 2: NCQA reviews reports from the practice's electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- *Denominator* = Number of medication orders created by the practice during the EHR reporting period.
- *Numerator* = Number of medication orders in the denominator recorded using the computerized physician order entry (CPOE) system integrated with the electronic medical record.

Factors 3, 4: NCQA reviews reports from the practice's electronic system **or** screenshots demonstrating the system's capabilities.

Element E: Support Self-Care and Shared Decision Making 5.00 points

| | | |
|--|--------------------------|--------------------------|
| The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice: | Yes | No |
| 1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients. + | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Provides educational materials and resources to patients. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Provides self-management tools to record self-care results. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Adopts shared decision making aids. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Offers or refers patients to structured health education programs, such as group classes and peer support. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Assesses usefulness of identified community resources. | <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 0 factors |

Explanation

+Stage 2 Core Meaningful Use Requirement

The practice offers patients tools and support to better enable self-care. This includes classes, educational aids and other resources. Programs may be offered through community agencies, a health plan or a patient’s employer. Even if the practice provides one or more services, it also identifies services or agencies available in the community that are relevant to the practice’s population.

Factor 1: The practice uses an EHR to identify patient-specific educational resources and provides the resources to at least 10 percent of its patients.

Factor 2: 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).

Materials in languages other than English are available for patients/families, if appropriate, based on the practice’s assessment of languages spoken by its patients (PCMH 3, Element A). The practice may refer patients/families to outside resources, even if resources may not be covered by health insurance.

Factor 3: 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, 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 adjusting medications.

Factor 4: When a complex decision involves multiple options with features that people may value differently, a **shared decision-making aid** provides detailed information without advising the audience to choose one decision over another. From time to time, scientific evidence about options is limited. The purpose of SDMs is to help prepare patients to make informed, values-based decisions with their care team.

More information and resources can be found through the International Patient Decision Aid Standards Collaboration (IPDASC).

Factor 5: The practice provides (or makes available) health education classes, which may include alternative approaches such as peer-led discussion groups or shared medical appointments (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and allow patients to interact with and learn from each other.

Factor 6: The resource list is specific to the needs of the practice's population—not necessarily specific to criteria and areas of focus a practice uses to identify patients likely to benefit from care management (identified in Element 4A), and includes programs and services to help patients in self-care or to give the patient population access to care related to at least five topics or key community service areas of importance such as:

- Smoking cessation.
- Weight management.
- Exercise/physical activity.
- Nutrition.
- Parenting.
- Dental.
- Transportation to medical appointments.
- Noncommercial health insurance options.
- Obtaining prescription medications.
- Falls prevention.
- Meal support.
- Hospice care.
- Respite care.
- Child development.
- Child care.
- Breastfeeding.

Factor 7: The practice reviews and requests feedback from patients/families/caregivers about community referrals, to evaluate whether it identified sufficient and appropriate resources for its population over time. Community referrals differ from clinical referrals, but may be tracked using the same system.

Documentation

Factor 1: NCQA reviews a report from the practice's electronic system, showing the percentage of patients provided educational resources.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- *Denominator* = Number of unique patients in the practice's system.
- *Numerator* = Number of patients in the denominator with at least one educational resource electronically recorded in the patient record.

Factors 2–5: For each factor, NCQA reviews at least three examples of resources, tools or aids.

Factor 6: NCQA reviews materials demonstrating that the practice offers at least five resources.

Factor 7: NCQA reviews a survey or other materials showing how the practice collects information on the usefulness of referrals to community resources.

PCMH 5: Care Coordination and Care Transitions **18.00 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 **6.00 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. (CRITICAL FACTOR) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR) | <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 the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. More than 30 percent of laboratory orders are electronically recorded in the patient record. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. More than 30 percent of radiology orders are electronically recorded in the patient record. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. More than 10 percent of scans and tests that result in an image are accessible electronically. ++ | <input type="checkbox"/> | <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 0-2 factors (or does not meet factors 1 and 2) |

Explanation

+Stage 2 Core Meaningful Use Requirement

++Stage 2 Menu Meaningful Use Requirement

Systematic monitoring helps ensure that needed tests are performed and results are acted on, when necessary.

Factors 1, 2: Factors 1 and 2 are critical factors and are required for practices to receive a score for this element.

Ineffective management of laboratory and imaging test results can result in less than optimal care and may compromise patient safety. The practice tracks lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center (and the patient, if necessary) to determine why results are overdue.

Factors 3, 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 is proactive in notifying patients about test results (normal and abnormal). Filing the report in the medical record for discussion during a scheduled office visit does not meet the requirement.

If frequent lab tests are ordered for a patient, the practice provides the patient/family/caregiver (as appropriate) with all initial results, clear expectations of follow-up results and a plan for handling abnormal results.

Factor 6: The practice follows up with the hospital or state health department if it does not receive screening results.

Most states mandate that birthing facilities perform a 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.

Adult-only practices may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.

Factors 7, 8: Lab and imaging test orders are recorded in the patient medical record electronically. CMS provides the following additional information: “If the practice writes fewer than 100 laboratory or radiology orders during the reporting period,” it may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.

Factor 9: The practice electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical records. Looking up the information in a separate system and manual data entry into the electronic medical record does not meet the requirement.

CMS provides the following additional information: “If the practice orders no lab tests whose results are in a positive or negative affirmation or numeric format during the reporting period,” it may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.

Factor 10: Imaging results that include a written report and may include images are integrated into the medical record electronically. Looking up information in a separate system and manual data entry into the electronic medical record does not meet the requirement.

A scanned PDF of the image (not of the report) in the medical record that can be retrieved and reviewed by the practice meets the requirement.

CMS states:

- “Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology (CEHRT).”
- A link to where the image and accompanying information is stored is available in CEHRT.”
- Images and imaging results that are scanned into the CEHRT may be counted in the numerator.”

CMS provides exclusions “for clinicians who order less than 100 tests during the reporting period whose result is an image or any clinician who has no access to electronic imaging results at the start of the reporting period.” Practices may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.

Documentation

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–6: NCQA reviews:

- a documented process *and*
- a report or log showing the tracking *and*
- examples of how the process is met for each factor.

Factor 7: NCQA reviews reports from the practice's electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- *Denominator* = Number of lab tests ordered during the reporting period.
- *Numerator* = Number of lab tests ordered that are electronically recorded in the patient record.

Factor 8: NCQA reviews reports from the practice's electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent period of at least three months:

- *Denominator* = Number of radiology tests ordered during the reporting period.
- *Numerator* = Number of radiology tests ordered that are electronically recorded in the patient record.

Factor 9: NCQA reviews reports from the practice's electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- *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.

Factor 10: NCQA reviews reports from the practice's electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- *Denominator* = Number of tests whose result is one or more images ordered during the reporting period.
- *Numerator* = Number of results in the denominator that are accessible in the practice electronic system.

| Element B: Referral Tracking and Follow-Up (MUST-PASS) | | 6.00 points | |
|---|--|--------------------------|--------------------------|
| The practice: | | Yes | No |
| 1. Considers available performance information on consultants/specialists when making referral recommendations. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Maintains formal and informal agreements with a subset of specialists based on established criteria. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Maintains agreements with behavioral healthcare providers. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Integrates behavioral healthcare providers within the practice site. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals. + | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL FACTOR) | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Documents co-management arrangements in the patient's medical record. | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Asks patients/families about self-referrals and requesting reports from clinicians. | | <input type="checkbox"/> | <input type="checkbox"/> |

| Scoring | 100% | 75% | 50% | 25% | 0% |
|---------|--|---|---|---|--|
| | The practice meets 9-10 factors (including factor 8) | The practice meets 7-8 factors (including factor 8) | The practice meets 4-6 factors (including factor 8) | The practice meets 2-3 factors (including factor 8) | The practice meets 0-1 factors (or does not meet factor 8) |

Explanation + Stage 2 Core 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.

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

Factor 1: The practice uses available data on the performance of clinicians and practices it refers its patients to. Examples include state physician report cards, health plan directories and the CMS website <http://www.medicare.gov/physiciancompare/>.

Factor 2: Agreements between primary care and the specialist may be formal or informal and may describe the expectations or embed them in a tool such as a referral request form. The agreement is an articulation of the arrangements for the exchange of information. Agreements typically indicate the type of information that will be provided when referring a patient to a specialist and expectations regarding timeliness and content of response from the specialist.

Factor 3: The practice maintains at least one agreement with a behavioral health specialist.

- A practice needs an agreement if it shares the same facility or campus as mental health professionals, but has separate systems (basic collaboration onsite).
- A practice uses existing internal processes as its agreement if there is partial or full integration of behavioral health care services.

Factor 4: The practice integrates partially (i.e., co-location with some systems in common) or fully (i.e., co-location with all systems shared) with behavioral health care. Refer to *Evolving Models of Behavioral Health Integration in Primary Care* (Millbank Memorial Fund) for descriptions of arrangements.

Factor 5: The referring clinician provides a succinct reason for the referral, which may be stated as “the clinical question” (i.e., the general purpose of the referral) to be answered by the specialist. The practice includes follow-up communication or information in the referral.

The referring clinician indicates the urgency of the referral in concrete terms and includes details about the reasons for an urgent visit.

Factor 6: Referrals include relevant clinical information; for example:

- Current medications.
- Diagnoses, including mental health, allergies, medical and family history, substance abuse and behaviors affecting health.
- The reason for the referral and evaluation details.
- Clinical findings and current treatment.
- Follow-up communication or information.

Patient demographic information includes:

- Communication needs.
- Primary language.
- Relevant cultural or ethnic information, in addition to:
 - Date of birth.
 - Sex.
 - Contact information.
 - Health insurance information.

Including the referring primary care clinician’s care and treatment plan in the referral, in addition to test results/procedures, can reduce duplication of services, tests or treatments. Having the primary care practice care plan can enable a specialist to develop a corresponding specialty plan of care. Ideally, there would be one care plan developed by primary care in collaboration with the patient/family/caregiver that would then be coordinated with the specialty plan of care, created in collaboration with the patient/family/caregiver and primary care.

Factor 7: The practice demonstrates the capability for electronic exchange of key clinical information with other clinicians and provides an electronic summary-of-care record for more than 50 percent of referrals to a referred specialist.

Factor 8: A tracking report includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist’s office and documents its effort to retrieve the report in a log or an electronic system.

Factor 9: 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 the treatment plan, as well as information to be entered in the medical record, within a period agreed to by both parties.

Factor 10: Patients might see specialists without a referral from the medical home and without the knowledge of the medical home or clinician. Clinicians 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, to be documented in the medical record.

Documentation

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factor 1: NCQA reviews examples of the type of information the practice team has available on specialist performance.

Factor 2, 3: For each factor, the practice provides at least one example.

Factor 4: The practice provides materials that explain how behavioral health is integrated with physical health.

Factor 5, 6, 8, 10: For each factor, NCQA reviews a documented process 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. The report may be system generated or may be based on at least one week of referrals, with de-identified patient data..

Factor 7: The practice provides a report from the electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent period of at least three months. The practice may use the following methodology to calculate the percentage:

- *Denominator* = Number of transitions of care and referrals.
- *Numerator* = Number of transitions of care and referrals in the denominator where a summary care record was provided electronically.

Factor 9: NCQA reviews at least three examples.

Element C: Coordinate Care Transitions 6.00 points

| The practice: | Yes | No | NA |
|---|--------------------------|--------------------------|--------------------------|
| 1. Proactively identifies patients with unplanned hospital admissions and emergency department visits. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Shares clinical information with admitting hospitals and emergency departments. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Consistently obtains patient discharge summaries from the hospital and other facilities. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Proactively contacts 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. Exchanges patient information with the hospital during a patient's hospitalization. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Scoring | 100% | 75% | 50% | 25% | 0% |
|---------|----------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|
| | The practice meets all 7 factors | The practice meets 5-6 factors | The practice meets 3-4 factors | The practice meets 1-2 factors | The practice meets 0 factors |

Explanation

+ Stage 2 Core 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 effect 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 patients.

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 has a two-way communication plan with hospitals to exchange information about hospitalized patients, enabling well-coordinated care during and after hospitalization.

Factor 6: The practice has a process for working with community partners, such as detention centers, halfway houses, juvenile justice facilities, foster care, child or adult protective services or others, to obtain appropriate consent for release of information to treat and coordinate care with those partners who have legal responsibility for certain patients.

Factor 7: The practice can send and receive key clinical information (e.g., problem list, medication list, medication allergies, diagnostic test results) electronically and via secure e-mail with other providers of care, with patient-authorized entities and with facilities (e.g., hospitals, ERs, extended care facilities, nursing homes).

Documentation

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factor 1: NCQA reviews the practice's documented process for identifying patients who have been hospitalized or have had an ER visit and reviews a log of patients receiving care from different types of facilities or a report listing patients seen in the ER or hospital.

Factor 2: NCQA reviews the practice's documented process for providing hospitals and ERs with clinical information, and reviews at least three de-identified examples of patient information sent to the hospital or ER.

Factor 3: NCQA reviews the practice's documented process for obtaining hospital discharge summaries, and reviews at least three examples of a discharge summary.

Factor 4: NCQA reviews the practice's documented process for patient follow-up after a hospital admission or ER visit, and reviews at least three de-identified examples of documented patient follow-up in the medical record, or a log documenting systematic follow-up.

Factor 5: NCQA reviews the practice's documented process for two-way communication with hospitals, and reviews an example of two-way communication.

Factor 6: NCQA reviews the practice's documented process for obtaining proper consent for release of information.

Factor 7: NCQA reviews a report illustrating information exchange or a screen shot showing a test of capability, and reviews a report with numerator, denominator and percentage from at least three months of transitions.

- *Denominator* = Number of transitions of care and referrals.
- *Numerator* = Number of transitions of care and referrals in the denominator where a summary care record was provided electronically.

If the practice does not transfer patients to another care setting they may respond NA to this factor. The practice must provide a written explanation for an NA response in the Support Text/Notes box in the Survey Tool.

CMS provides the following additional information: "The transferring party must provide the summary of care record to the receiving part. 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."

PCMH 6: Performance Measurement and Quality Improvement **20.00 points**

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

Element A: Measure Clinical Quality Performance **3.00 points**

| At least annually, the practice measures or receives data on: | Yes | No |
|--|--------------------------|--------------------------|
| 1. At least two immunization measures. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. At least two other preventive care measures. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. At least three chronic or acute care clinical measures. | <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 3 factors | The practice meets 2 factors | The practice meets 1 factor | The practice meets 0 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. Although some measures may fit into multiple categories appropriately, each measure may be used only once for this element.

The practice documents the period of measurement, the number of patients represented by the data and the patient selection process. When possible, the practice uses measures from existing sources and other reporting activities it is involved in (e.g., PQRS, Meaningful Use, UDS, HEDIS). The following are examples of broadly used, widely accepted measures:

- NQF-endorsed measures: Find information on the full set of NQF-endorsed measures at <http://www.qualityforum.org>. The complete specifications for NQF measures are available from the organization that developed and submitted the measures to NQF.
- Other standardized measures:
 - Measures developed by national accreditors (e.g., NCQA, JCAHO).
 - Measures developed by the AMA PCPI. Find the complete list of AMA PCPI measures at <http://www.ama-assn.org/ama/pub/category/4837.html>.
 - Measures developed by government agencies (e.g., CMS, AHRQ) or state agencies.

When selecting measurement activities, the practice considers the criteria and systematic process used in PCMH 4, Element A, to identify patients who may benefit from care management.

Factor 1: The practice measures rates of immunization appropriate to the populations it manages.

The practice uses measures that monitor for immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) or United States Preventative Services Task Force (USPSTF).

Factor 2: 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>)

Preventive measures encompass a practice’s entire population and are not limited to specific measures for a patient population with chronic conditions. The intent is that the practice develops activities to improve quality of care for all patients. Preventive measures include:

- Services recommended by the U.S. Preventive Services Task Force (USPSTF).
- Preventive care and screenings for children and for women, as recommended by the Health Resources and Services Administration (HRSA).
- Other standardized preventive measures, including those identified in Bright Futures for pediatric patients.

Additional immunizations do not meet the requirement. Examples of acceptable measures include:

- Cancer screening, including age- and sex-appropriate screenings, such as colorectal screening for men and mammograms for women.
- Developmental screening for pediatric patients.
- Osteoporosis screening for appropriate populations.
- Depression screening in adults or adolescents, or in patients with chronic conditions or co-morbidities.
- ADHD screening.
- Assessment of behaviors affecting health, such as smoking status, BMI, alcohol use and substance use disorders.

Factor 3: Chronic or acute care clinical measures may be associated with the conditions that are tracked by the practice (e.g., diabetes, heart disease, asthma, depression, chronic back pain, otitis media), based on evidence-based guidelines. The practice may choose one measure from each of three or more different conditions. Three or more measures related to a specific condition meet the requirement.

Practices where 75 percent or more of clinicians have earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP) or the Diabetes Recognition Program (DRP) receive automatic credit for factor 3 (for recognitions that are current when the practice submits its PCMH Survey Tool).

The practice includes a statement about the recognized clinicians, the name of the recognition program and the number or percentage of recognized clinicians in the practice in the Organization Background section of the PCMH ISS Survey Tool.

Factor 4: Data collected by the practice for one or more measures from factors 1–3 are 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 co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

Documentation

Factors 1-4: NCQA reviews reports or recognition results showing performance measures.

For Renewal Surveys: NCQA reviews reports showing that the practice has measured at least annually for two years.

Element B: Measure Resource Use and Care Coordination **3.00 points**

| | | |
|---|--------------------------|--------------------------|
| At least annually, the practice measures or receives quantitative data on: | Yes | No |
| 1. At least two measures related to care coordination. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. At least two utilization measures affecting health care costs. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

| 100% | 75% | 50% | 25% | 0% |
|----------------------------------|-----|-----------------------------|-----|------------------------------|
| The practice meets all 2 factors | | The practice meets 1 factor | | The practice meets 0 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. Performance data may be from internal or external sources. Data provided by an external source (such as a health plan) represent 75 percent of the practice's eligible population. Although some measures may fit into multiple categories appropriately, each measure may be used only once for this element.

The practice documents the period of measurement, the number of patients represented by the data and the patient selection process.

Factor 1: A care coordination measure assesses "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care." (AHRQ).

The NQF provides the following examples of care coordination performance measures:

- Cardiac rehabilitation patient referral from inpatient and outpatient settings.
- Patients with a transient ischemic event ER visit who had a follow-up office visit.
- Biopsy follow-up.
- Reconciled medication list received by discharged patients (inpatient discharge to home/self-care or any other site of care).
- Transition record, with specified elements received by discharged patients (inpatient discharge to home/self-care or any other site of care).
- Timely transmission of transition record (inpatient discharge to home/self-care or any other site of care).
- Transition record, with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self-care]).
- Melanoma continuity of care-recall system.
- Three-Item Care Transitions Measure (CTM-3).

Measuring adherence to agreements (see PCMH 5 Element B) may be used to meet the factor.

Factor 2: 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.

Documentation

Factors 1, 2: NCQA reviews reports showing practice performance. Reports compare “better” or “worse” results on specific metrics and may include aggregated information.

For Renewal Surveys: For factor 2, NCQA reviews reports showing that the practice has measured at least annually for two years.

Element C: Measure Patient/Family Experience **4.00 points**

At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 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"> • Access. • Communication. • Coordination. • Whole person care/self-management support. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. The practice obtains feedback on 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 0 factors |

Explanation

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

Factor 1: The practice or practice designee surveys patients to assess patient/family experience. The survey includes questions related to at least three of the following categories:

- Access (may include routine, urgent and after-hours care).
- Communication with the practice, clinicians and staff (may include “feeling respected and listened to” and “able to get answers to questions”).
- 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 CAHPS PCMH Survey Tool to collect patient experience data, and is not required to use a vendor to meet this factor.

Note: Practices can earn Distinction from NCQA for using the CAHPS PCMH survey to collect patient experience data and for:

- Using a specific methodology to collect the data.
- Using a certified vendor to collect the data.
- Reporting results to NCQA, to be used to benchmark patient-experience data.

Factor 3: 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 co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

The practice uses a survey or another method to assess quality of care for its vulnerable subgroups. Patient self-identification in the survey may provide the basis for the subgroups.

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 (e.g., by phone or videoconference). Comments from surveys used to satisfy factors 1 and 2 do not meet this requirement.

Documentation

Factors 1–4: NCQA reviews reports with summarized results of patient feedback.

For Renewal Surveys: NCQA reviews reports showing that the practice has measured at least annually for two years.

Element D: Implement Continuous Quality Improvement (MUST-PASS) 4.00 points

| The practice uses an ongoing quality improvement process to: | Yes | No |
|---|--------------------------|--------------------------|
| 1. Set goals and analyze at least three clinical quality measures from Element A. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Act to improve at least three clinical quality measures from Element A. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Set goals and analyze at least one measure from Element B. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Act to improve at least one measure from Element B. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Set goals and analyze at least one patient experience measure from Element C. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Act to improve at least one patient experience measure from Element C. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

| 100% | 75% | 50% | 25% | 0% |
|----------------------------------|------------------------------|------------------------------|--------------------------------|------------------------------|
| The practice meets all 7 factors | The practice meets 6 factors | The practice meets 5 factors | The practice meets 1-4 factors | The practice meets 0 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 has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers.

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

Factors 1-6: The practice sets goals and acts to improve performance, based on clinical quality measures (Element A), resource measures (Element B) and patient experience measures (Element C). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

Factor 7: 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.

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

Documentation

Factors 1–7: NCQA reviews a report showing how the practice meets each factor, or reviews the PCMH Quality Measurement and Improvement Worksheet.

Element E: Demonstrate Continuous Quality Improvement 3.00 points

| The practice demonstrates continuous quality improvement by: | Yes | No |
|---|--------------------------|--------------------------|
| 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Achieving improved performance on at least two clinical quality measures. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Achieving improved performance on one utilization or care coordination measure. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Achieving improved performance on at least one patient experience measure. | <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 0 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 through comparison of performance results to demonstrate that the practice has gone beyond setting goals and taking action.

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

In factor 1, the practice identifies the steps it has taken in Element D and evaluates these steps to improve performance. The practice is not required to demonstrate improvement in this factor.

Factors 2–4: The practice demonstrates that its performance on the measures has improved over time, based on its assessment.

Documentation

Factors 1-4: NCQA reviews reports or a completed PCMH Quality Measurement and Improvement Worksheet that shows how the practice meets the requirements.

Element F: Report Performance**3.00 points**

The practice produces performance data reports using measures from Elements A, B and C and shares:

Yes **No**

- | | | |
|--|--------------------------|--------------------------|
| 1. Individual clinician performance results with the practice. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Practice-level performance results with the practice. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Individual clinician or practice-level performance results publicly. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Individual clinician or practice-level performance results with patients. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

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

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 reflect care provided to all patients in the practice (relevant to the measure), not only patients covered by a specific payer. Data are:

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

For each factor, the practice must report performance data using at least one measure from each of Elements A, B and C. Practices are not required to report all measures from each to meet requirements.

Practices where 75 percent or more of the eligible clinicians have earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP), Diabetes Recognition Program (DRP) automatically receive credit for Element A 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 in the Organization Background section of the PCMH ISS Survey Tool.

Factor 1: The practice provides individual clinician reports to clinicians and practice staff. Reports reflect the care provided by the care team. Measure results not available at the individual clinician level do not need to be included.

Factor 2: The practice provides practice-level performance results to all clinicians and practice staff.

Factor 3: The practice reports site-specific data on its Web site, or data are made public by a health plan or other entity.

Factor 4: The practice reports site-specific performance results to patients, or makes results available to patients. The practice may use patient communications (e.g., letter, e-mail, mass mailing) to notify patients that the information is available publicly.

Documentation

Factors 1: NCQA reviews reports provided to clinicians and practice staff showing individual clinician performance and explaining how results are disseminated.

Factor 2: NCQA reviews reports showing practice-level performance results and explaining how results are disseminated.

Factor 3: NCQA reviews an example of a performance report provided to the public.

Factor 4: NCQA reviews an example of a performance report provided to patients.

Element G: Use Certified EHR Technology 0.00 points

| The practice uses a certified EHR system. | Yes | No | NA |
|--|--------------------------|--------------------------|--------------------------|
| 1. The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID. +++ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies. + | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically. ++ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically. ++ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically. ++ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use. +++ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically. + | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The practice has access to a health information exchange. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. The practice has bidirectional exchange with a health information exchange. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care +. | <input type="checkbox"/> | <input type="checkbox"/> | |

| Scoring | 100% | 75% | 50% | 25% | 0% |
|---------|-------------------|-------------------|-------------------|-------------------|-------------------|
| | No scoring option | No scoring option | No scoring option | No scoring option | No scoring option |

Explanation

- + Stage 2 Core Meaningful Use Requirement
- ++ Stage 2 Menu Meaningful Use Requirement
- +++ Meaningful Use Requirement

Factors 1, 8 and 9 require comments in the Support Text/Notes box of the Survey Tool.

Factors 4, 5, and 7 require comments in the Support Text/Notes box of the Survey Tool if NA is selected.

This element is for data collection purposes only and will not be scored.

Note: The CMS EHR certification ID: http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms_ehr_certification_id.

The practice protects the privacy and security of the electronic health information within its certified EHR system (or modules). To meet the federal Core and Menu Meaningful Use requirements, practices must meet the designated factors (+ Core, ++ Menu) using a certified EHR that has undergone a security risk analysis, had necessary security updates and had identified security deficiencies corrected.

CMS states that objectives are as follows:

- “To protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.”
- “All of these capabilities could be part of the certified EHR technology or outside systems and programs that support the privacy and security of certified EHR technology.”

The following links provide additional information:

- U.S. Department of Health & Human Services, Health Information Privacy Web site: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html>.
- Stage 1 Core Meaningful Use requirement #15, Protect Electronic Health Information: <http://www.cms.gov/EHRIncentivePrograms/Downloads/15ProtectElectronicHealthInformation.pdf>.
- Stage 2 Core Meaningful Use requirement #17, Protect Electronic Health Information: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/14_Protect_Electronic_Health_Information.pdf.

Factor 1: The practice attests to using a certified EHR system and provides the CMS Certification ID number(s) of the software system (or modules) used by the practice. Since the practice may use more than one software system, **all** must be listed. CMS provides information on obtaining a Certification ID on their Web site at http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms_ehr_certification_id. A list of Certified Health IT Products can be found at <http://onccchpl.force.com/ehrcert?q=chpl>.

Factor 2: The practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies.

CMS requires eligible professionals to “conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security analysis updates as necessary and correct identified security deficiencies prior to or during the EHR reporting period.”

Factor 3: The practice attests that it has fulfilled the *CMS Meaningful Use Stage 2 Menu Measure 4* and it performs “successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.”

Factor 4: The practice attests that it has fulfilled the *CMS Meaningful Use Stage 2 Menu Set Measure 5*, indicating it has “successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.

Factor is NA for any practice that:

“(1) Does not diagnose or directly treat cancer;

(2) Operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period;

(3) Operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or

(4) Operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period.”

Factor 5: The practice attests that it has fulfilled the CMS Meaningful Use Stage 2 Menu Set Measure 6, indicating it has “successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.”

Factor 5 is NA for any practice that:

“(1) Does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which [any of the clinicians coming forward for recognition] are eligible, or the public health agencies in their jurisdiction;

(2) Operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which [any of the clinicians coming forward for recognition] are eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period;

(3) Operates in a jurisdiction where no public health agency or national specialty society for which [any of the clinicians coming forward for recognition] is eligible provides information timely on capability to receive information into their specialized registries; or

(4) Operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which [any of the clinicians coming forward for recognition] is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional [clinicians coming forward for recognition].”

Factor 6: The practice reports clinical quality measures to Medicare or a state (Medicaid program), as required for Meaningful Use by CMS Meaningful Use Stage 2 guidelines.

Factor 7: The practice attests that it has fulfilled the CMS Meaningful Use Stage 1 Menu Set Measure 9, indicating it has “performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful.”

Factor 7 is NA for practices that “[administer] no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.”

Factor 8: The practice attests that it has access to and can view information in a health information exchange (HIE).

Factor 9: The practice attests that it has bidirectional communication (i.e., can send and receive information) with an HIE.

Factor 10: The practice attests that it has fulfilled the CMS Meaningful Use Stage 2 Core Set Measure 12, indicating it can “[use] clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference... for [more] than 10 percent of all unique patients.”

Documentation

Factor 1: By entering a “yes” response in the PCMH Survey Tool, the practice attests to using a Certified Electronic Health Record and that it has been issued a CMS certification ID to perform the designated CMS Meaningful Use Core and Menu requirements.

Factor 2: By entering a “yes” response in the PCMH Survey Tool, the practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/14_Protect_Electronic_Health_Information.pdf

Factor 3: By entering a “yes” response in the PCMH Survey Tool, the practice attests to its “capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.” <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/10SyndromicSurveillanceDataSubmission.pdf>

Factor 4: By entering a “yes” response in the PCMH Survey Tool, the practice attests to its “capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.” http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPMenu_5_Report_CancerCases.pdf

Factor 5: By entering a “yes” response in the PCMH Survey Tool, the practice attests to its “capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.” http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPMenu_6_Report_SpecificCases.pdf

Factor 6: By entering a “yes” response in the PCMH Survey Tool, the practice attests that it reports clinical quality measures to Medicare or Medicaid, as required for Meaningful Use, and provides a copy of a report from the agency. <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html>

Factor 7: By entering a “yes” response in the PCMH Survey Tool, the practice attests to “its capability to submit electronic data to immunization registries or immunization information systems.” http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Immunization_Registries_Data_Submission.pdf

Factor 8: By entering a “yes” response in the PCMH Survey Tool, the practice attests to its capability to view HIE information. The practice provides the name(s) of the HIE.

Factor 9: By entering a “yes” response in the PCMH Survey Tool, the practice attests to its capability to both send and receive information from an HIE. The practice provides the name(s) of the HIE.

Factor 10: By entering a “yes” response in the PCMH Survey Tool, the practice attests to “using clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference...for [more] than 10 percent of all unique patients.”