Appendix

Additional Study Details

Focus Groups and Interviews: As noted in the text, we used focus groups and interviews to help design the program. Two members of the program leadership team (which consisted of six general internal medicine attending physicians, the Medical Center leadership, and a project manager) conducted interviews and focus groups with clinic patients, staff, and resident physicians to identify shortcomings with the clinic and potential solutions. Individual interviews were conducted with a convenience sample of 20 patients in the clinic waiting room on three separate days. Individual interviews were also conducted with 8 resident physicians who responded to an email inviting them to provide feedback about their clinic experience. In addition, two focus group sessions, each involving 8 existing clinic staff members who rotate through the clinic, were conducted during a staff meeting.

Informing Patients about Intervention: Patients were informed about the intervention during regular clinic visits. At these visits, resident physicians briefly described the new services and provided patients with a clinic card, a refrigerator magnet with the call center phone number, and a pamphlet describing the new services.

Care Coordinator Training: As noted in the text, both care coordinators are unlicensed personnel with experience working in health care settings. Both are fluent in English and Spanish and have access to an interpreter when working with patients who speak other languages. The care coordinators were trained by the program directors and received a one-day training session on clinic telephone service from a nurse consultant.

Training and Supervision of the Resident Physicians Conducting Telephone Triage and Assisting with Care Coordination: The resident physicians assigned to work with the care coordinators and provide telephone triage are provided with a brief introduction to telephone triage by one of the program directors prior to their first triage session. The resident physician performing telephone triage is supervised by an attending physician. The attending physician meets with the resident at least once during the telephone triage session to review cases and cosign notes. All triaged calls must be reviewed with an attending physician and the resulting notes cosigned. Access to a telephone interpreter is available for residents needing assistance communicating with non-English speaking patients.

Patient Survey Administration: Pre-intervention surveys were completed immediately prior to program implementation, while post-intervention surveys were completed 10-13 months afterwards during the same period in the academic year (it took approximately three months to conduct both the pre-intervention and post-intervention surveys). Patients who were unable to understand the questions due to cognitive difficulties were excluded, however patients were included if they were able to complete the survey with assistance from a research assistant or family member.

Resident Survey Administration: Pre-intervention surveys were completed immediately prior to program implementation, and post-intervention surveys were completed 11-12 months

afterwards during the same period in the academic year (it took approximately one-and-a-half months to conduct both the pre-intervention and post-intervention surveys).

Additional Details from the Process Evaluation: Calls to the center steadily increased throughout the year. In the first month, July 2011, the call center fielded approximately 4 patient cases which required a resident's attention per day and 2 routine case management requests. A year later in May and June 2012 the call center was fielding 15 patient cases per day which required resident attention and approximately 3 routine case management requests per day. Additionally, the care coordinators were making approximately 7 outreach calls from patients recently discharged from the hospital or ER and working on at least one case management request per day. The care coordinators were successful in reaching patients who were recently discharged from the hospital (or family members) by phone 18.7% of the time.

The reasons patients contacted the call center were fairly consistent throughout the year. Approximately 45% of cases were initiated by patients calling to discuss medical symptoms. Approximately, 25% of these cases were for prescription renewals between appointments. The final 30% of cases were non-symptom related calls, e.g. test results, medication education, glucose or blood pressure readings review, and system navigation questions.

The outcomes of patient calls varied throughout the year. In the first several months of the intervention 25% of callers' issues were addressed by advice over the phone from a resident. 50% spoke to a resident and were granted a clinic appointment within 24 hours. In the last several months of the intervention, as calls increased, callers' issues were addressed by advice over the phone from a resident or care coordinator 50% of the time, while only 20% of callers were granted a clinic appointment. This may reflect professional growth in triage skills among

residents and staff as well as an increase in call volume. The callers increased, but the amount (5 per day) of urgent care appointment slots stayed the same. Residents prescribed new or adjusted medication over the phone during approximately 5% of calls. Prescription renewal calls represented 15%-20% of calls throughout the year.

Throughout the year we were able to expand our ties with sub-specialists and the radiology department. During the year we handled approximately 150 urgent case management requests for specialists. Of these, 41% were radiology services such as CT, MRI, or guided biopsies. 56% were sub specialist initial consultations, with a focus on Oncology. 3% of the cases needed services such as surgery or small procedures.

Impact of the Intervention on HbA1C and LDL Control Among Patients with Diabetes:

As noted in the main manuscript, one component of our intervention involved renewing medications by telephone. This presumably made it easier for patients to have their medications renewed, leading to improved medication compliance. Over time this may improve some metrics of chronic disease control, for example HbA1C and LDL control in patients with diabetes. We felt that this improvement would like to take considerable time to be realized and thus did not expect to observe a benefit during the one year study period. Still, we performed an analysis to examine the impact of our intervention on HbA1C and LDL control among patients with diabetes.

We conducted this analysis as follows: we measured HbA1C control and LDL control among patients with diabetes in the intervention clinic and the control clinics in the one year period prior to program implementation and in the one year period afterwards. Inclusion criteria were the same as for the ER and hospitalization analysis except that only patients with diabetes,

defined as a mean HbA1C>6.5%, were included. For this analysis, the proportion of patients with a mean HbA1C<9.0% and a mean LDL<130 was determined. All A1c and LDL measurements during the study period were used in calculating the averages. There was a mean of 1.96 A1c measurements and 1.69 LDL measurements during the study period.

As anticipated, our data did not suggest that our intervention improved these metrics in the first year following implementation. A Table summarizing the results is listed below:

Table: Diabetes Management in the Intervention and Control Clinics

Outcome	Intervention Clinic		Control Clinics		Difference in Differences	P Value[a]
	Baseline (N=4,296)	Post-Intervention (N=4,679)	Baseline (N=7,821)	Post-Intervention (N=8,899)		
ercentage of Patients with iabetes with HbA1C<9.0%	52	51	54	50	+2[b]	0.56
ercentage of Patients with iabetes with LDL<130	83	83	84	84	+2[b]	0.68

[a]P values represent adjusted values from the regression analysis.
[b]Positive numbers represent an increase in utilization rates in the intervention clinic vs. controls.

Qualitative Assessment of Whether Calls Prevented Emergency Room, Hospital, and Clinic Visits:

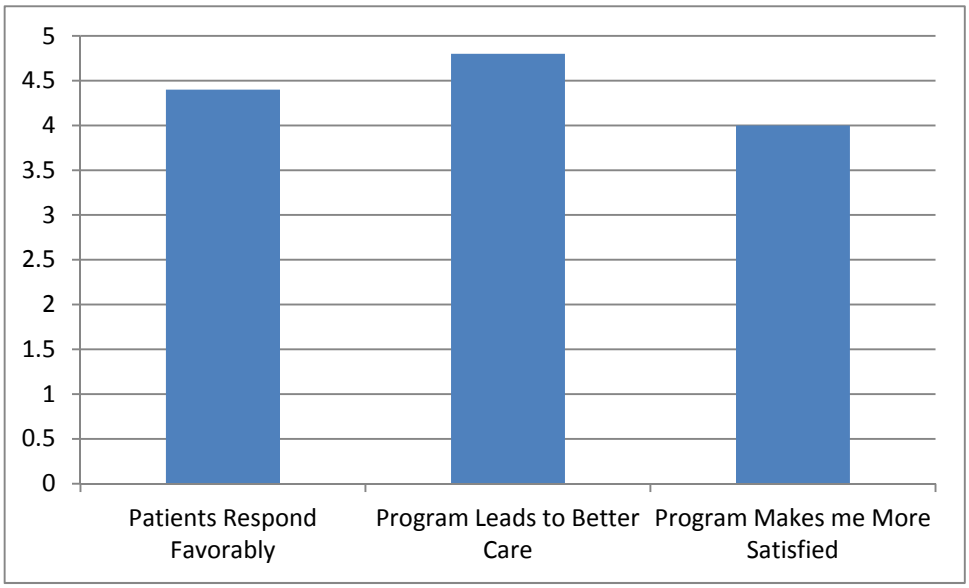
We conducted a qualitative analysis for quality improvement purposes to determine whether qualitatively it appeared that the telephone triage service was preventing inappropriate ER or clinic visits. Although our summative analysis did not suggest that our intervention was reducing ER utilization, we thought that perhaps the telephone triage system was preventing inappropriate ER visits -- which were replaced by appropriate ER visits resulting from referrals to the ER from the call center. In addition, we thought it was possible that our intervention was preventing unnecessary clinic visits by handling certain problems by telephone, obviating the need for a clinic visit.

For this qualitative analysis, two resident physicians independently reviewed 150 consecutive patient calls. They were instructed to assess whether, in their judgment based on their review of the case from the documentation, they felt it was likely that the call had prevented an ER or hospital visit or clinic visit. After each resident completed his independent assessments, the two met to resolve discrepancies. They were instructed to discuss each case for which they provided discrepant assessments until they came to an agreement about which assessment was correct.

For this analysis, inter-rater agreement between the two residents was low, however after resolution of discrepancies the reviewing residents judged that 26% (95% CI 19%-34%, kappa 0.58, 95% CI 0.44-0.73) of the calls, may have prevented an ER visit while 60% (95% CI 52%-68%, kappa 0.46, 95% CI 0.33-0.60), may have prevented a clinic visit.

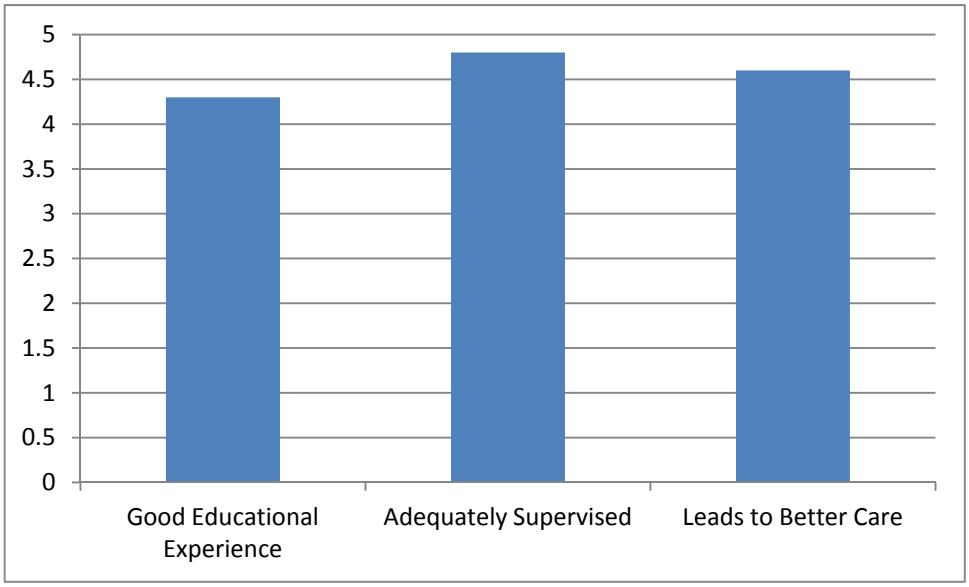
Feedback Surveys for Clinic Staff and Residents Performing Telephone Triage: As noted in the text, for quality improvement purposes, we conducted feedback surveys among 16 consecutive resident physicians who triaged patient calls and worked with the care coordinators. We also collected feedback surveys from clinic staff. The results of these feedback surveys are presented below:

A: Clinic Staff Feedback[a]



[a]Out of 11 clinic staff members eligible to participate, responses were obtained from 7, 8, and 7 members, respectively, for the three questions.

B: Triage Resident Feedback[b]



[b]Out of 16 resident physicians eligible to participate, responses were obtained from 16, 8, and 8, respectively, for the three questions. (Some residents misunderstood how to respond to the second and third questions.)

Modified Patient and Resident Surveys

Questions that were added to the survey are bolded. Questions that were omitted are listed at the bottom.

Patient Survey

1. Do you have one main doctor whom you see regularly at this clinic, or do you have multiple different doctors?
A. One main doctor
B. Multiple different doctors

2. In the last 12 months, when you visit this clinic, how often do you see your regular doctor (as opposed to another doctor in the clinic)?
1 Never
2 Sometimes
3 Usually
4 Always
5 I don't have a regular doctor at this clinic

3. In the last 12 months, how many times did you visit this doctor to get care for yourself?
1 None
2 1 time
3 2
4 3
5 4
6 5 to 9
7 10 or more times

4. Do you believe that patients should be able to call their clinic and get advice about medical problems over the phone?
1 strongly agree
2 agree
3 neutral
4 disagree

5. Do you believe that patients should be able to schedule appointments within 24 hours when a new medical problem arises?
1 strongly agree
2 agree
3 neutral
4 disagree

6. In the last 12 months, did you phone this doctor's office to get an appointment for an illness, injury or condition that needed care right away?
1 Yes
2 No

7. In the last 12 months, when you phoned this doctor's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you thought you needed it?
1 Never
2 Sometimes
3 Usually
4 Always
5 I never phoned this doctor for care I needed right away

8. In the last 12 months, did you make any appointments for a check-up or routine care with this doctor?
1 Yes
2 No

9. In the last 12 months, when you made an appointment for a check-up or routine care with this doctor, how often did you get an appointment as soon as you thought you needed it?
1 Never
2 Sometimes
3 Usually
4 Always
5 I never made an appointment for a check-up or routine care with this doctor

10. In the last 12 months, did you phone this doctor's office with a medical question during regular office hours?
1 Yes
2 No

11. In the last 12 months, when you phoned this doctor's office during regular office hours, how often did you get an answer to your medical question that same day?
1 Never
2 Sometimes
3 Usually
4 Always
5 I never phoned this doctor's office with a medical question during regular office hours

12. In the last 12 months, did you phone this doctor's office with a medical question after regular office hours?
1 Yes
2 No

13. In the last 12 months, when you phoned this doctor's office after regular office hours, how often did you get an answer to your medical question as soon as you needed?
1 Never
2 Sometimes
3 Usually
4 Always

5 I never phoned this doctor's office with a medical question after regular office hours

14. In the last 12 months, how often did this doctor seem to know the important information about your medical history?
1 Never
2 Sometimes
3 Usually
4 Always

15. In the last 12 months, when this doctor ordered a blood test, x-ray or other test for you, how often did someone from this doctor's office follow up to give you those results?
1 Never
2 Sometimes
3 Usually
4 Always
5 I never had a blood test, x-ray or other test in the last 12 months

16. In the last 12 months, when your doctor ordered a blood test, x-ray or other test for you, did you have difficulty completing the test?
1 Never
2 Sometimes
3 Usually
4 Always
5 I never had a blood test, x-ray or other test in the last 12 months

17. In the last 12 months, when your doctor referred you to a specialist (such as a heart specialist), did you have difficulty making this appointment?
1 Never
2 Sometimes
3 Usually
4 Always
5 I never was referred to a specialist in the last 12 months

18. In general, how would you rate your overall health?
1 Excellent
2 Good
3 Fair
4 Poor

19. Overall, how would you rate the care you received at this clinic over the past 12 months?
1 Excellent
2 Good
3 Fair
4 Poor

20. What is your age?
1 18 to 24
2 25 to 34
3 35 to 44
4 45 to 54
5 55 to 64
6 65 to 74
7 75 or older

21. Are you male or female?
1 Male
2 Female

22. What is the highest grade or level of school that you have completed?
1 8th grade or less
2 Some high school, but did not graduate
3 High school graduate or GED
4 Some college or 2-year degree
5 4-year college graduate
6 More than 4-year college degree

23. Are you of Hispanic or Latino origin or descent?
1 Yes, Hispanic or Latino
2 No, not Hispanic or Latino

24. What is your race? Please mark one or more.
1 White
2 Black or African American
3 Asian
4 Native Hawaiian or Other Pacific Islander
5 American Indian or Alaskan Native
6 Other

25. Did someone help you complete this survey?
1 Yes
2 No

26. How did that person help you? Mark all that apply.
1 Read the questions to me
2 Wrote down the answers I gave
3 Answered the questions for me
4 Translated the questions into my language
5 Helped in some other way

Omitted Questions

Our records show that you got care from the provider named below in the last 12 months.

Name of provider label goes here

Is that right?

1 Yes
2 No

Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

1 Yes
2 No

How long have you been going to this provider?

1 Less than 6 months
2 At least 6 months but less than 1 year
3 At least 1 year but less than 3 years
4 At least 3 years but less than 5 years
5 5 years or more

Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this provider within 15 minutes of your appointment time?

1Never
2 Sometimes
3 Usually
4 Always

In the last 12 months, how often did this provider explain things in a way that was easy to understand?

1Never
2 Sometimes
3 Usually
4 Always

In the last 12 months, how often did this provider listen carefully to you?

1Never
2 Sometimes
3 Usually
4 Always

In the last 12 months, did you talk with this provider about any health questions or concerns?

1Yes
2 No

In the last 12 months, how often did this provider give you easy to understand information about these health questions or concerns?

1 Never
2 Sometimes
3Usually
4 Always

In the last 12 months, how often did this provider show respect for what you had to say?

1Never
2 Sometimes
3 Usually
4 Always

In the last 12 months, how often did this provider spend enough time with you?

1 Never
2Sometimes
3Usually
4 Always

Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

0 Worst provider possible
1
2
3
4
5
6
7
8
9
10 Best provider possible

In the last 12 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

1Never
2 Sometimes
3 Usually
4 Always

In the last 12 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

1Never
2 Sometimes
3 Usually
4 Always

In general, how would you rate your overall mental or emotional health?

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

Resident Survey

Q1: Agree or disagree: "Patient flow from check in through check out runs smoothly at the site of my continuity clinic" (1=disagree strongly; 3=neutral; 5=agree strongly)

Q2: Agree or disagree: "Nursing support in my continuity clinic is adequate" (1=disagree strongly; 3=neutral; 5=agree strongly)

Q3: Agree or disagree: "Case management support in my continuity clinic is adequate" (1=disagree strongly; 3=neutral; 5=agree strongly)

Q4: Agree or disagree: "Referrals of my patients to subspecialty clinics occurs in a timely manner." (1=disagree strongly; 3=neutral; 5=agree strongly)

Q5: Agree or disagree: "Tests I order get completed in a timely manner." (1=disagree strongly; 3=neutral; 5=agree strongly)

Q6: Agree or disagree: "I feel adequately supported in my clinic by the ancillary staff (nurses, case managers, medical assistants." (1=disagree strongly; 3=neutral; 5=agree strongly)

Pre - Intervention

&

Controls

PCMH 2011 Standards

NCQA PCMH 2011

6 Standards, 27 Elements, 149 Factors

Points	Standard and Element	No. Factors	Must Pass 50% score
20	**1 Enhance Access and Continuity**	34	5
4	A Access During Office Hours	4	x 0
4	B Access After Hours	5	1
2	C Electronic Access	6	0
2	D Continuity	3	1
2	E Medical Home Responsibilities	4	0.5
2	F Culturally and Linguistically Appropriate Services (CLAS)	4	1.5
4	G Practice Organization	8	1
17	**2 Identify and Manage Patient Populations**	35	7
3	A Patient Information	12	3
4	B Clinical Data	9	2
4	C Comprehensive Health Assessment	10	2
5	D Using Data for Population Management	4	x 0
17	**3 Plan and Manage Care**	23	0.75
4	A Implement Evidence-Based Guidelines	3	0
3	B Identify High-Risk Patients	2	0
4	C Manage Care	7	x 0
3	D Manage Medications	5	0
3	E Electronic Prescribing	6	0.75
9	**4 Provide Self-Care and Community Support**	10	0
6	A Self-Care Process	6	x 0
3	B Referrals to Community Resources	4	0
18	**5 Track and Coordinate Care**	25	16.5
6	A Test Tracking and Follow-up	10	4.5
6	B Referral Tracking and Follow-up	7	x 6
6	C Coordinate with Facilities/Care Transitions	8	6
20	**6 Measure and Improve Performance**	22	5.75
4	A Measures of Performance	4	1
4	B Patient/Family Feedback	4	1
4	C Implements Continuous Quality Improvement	4	x 0
3	D Demonstrates Continuous Quality Improvement	4	1.5
3	E Performance Reporting	3	2.25
2	F Report Data Externally	3	0
100 Points	Total: 35	**149 Factors**	**6 MP Elements**

PCMH 1: Enhance Access and Continuity — 20 points

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

Element A: Access During Office Hours — 4 points
MUST-PASS

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

Scoring

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

Explanation

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

Patients can access the clinician and care team for routine and urgent care needs by office visit, by telephone and through secure electronic messaging. Practice staff considers patient care needs and preferences when determining the urgency of patient requests for same-day access. For all factors, the practice must provide their defined standards or policies and demonstrate they have monitored performance against the standards they have defined.

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

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

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

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

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

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

Examples

Documentation

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

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

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

Factor 4: The practice has a documented process for staff to follow for entering phone and electronic message clinical advice in the patient record *and* has at least three examples of clinical advice documented in a patient record.

Element B: After-Hours Access — 4 points

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

Scoring

100%	75%	50%	25%	0%
The practice meets all 5 factors, including factor 3	The practice meets 4 factors, including factor 3	The practice meets 3 factors, including factor 3	The practice meets 1-2 factors	The practice meets no factors

Explanation

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

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

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

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

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

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

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

Examples

Documentation

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

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

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

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

Factor 5: The practice has a documented process for staff to follow for documenting after-hours clinical advice in the patient record *and* has at least three examples of clinical advice documented in the patient record *or* a report identifying how often advice is documented. The report may be system generated or may be based on a spot check of calls and electronic messages for at least one week.

Element C: Electronic Access — 2 points

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

Scoring

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

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

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

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

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

Factor 3: An **electronic clinical summary** is a summary of a visit that includes, when appropriate, diagnoses, medications, recommended treatment and follow-up. Federal meaningful use rules require that summaries be provided to more than 50 percent of patients within three business days, either by secure electronic message or as a printed copy from the practice's electronic system at the time of the visit. Patients may be notified that the information is available through a secure, interactive system such as a Web site or patient portal.

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

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

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

Examples

Documentation

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

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

Factor 3: The practice has a report showing the percentage of patients who received electronically-generated clinical summaries of an office visit within three business days.

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

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

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

Element D: Continuity — 2 points

The practice provides continuity of care for patients/families by:	Yes	No
1. Expecting patients/families to select a personal clinician	☑	☐
2. Documenting the patient's/family's choice of clinician	☐	☑
3. Monitoring the percentage of patient visits with a selected clinician or team.	☑	☐

Scoring

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

Explanation

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

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

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

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

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

Examples

Documentation

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

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

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

Element E: Medical Home Responsibilities — 2 points

The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following.	Yes	No
1. The practice is responsible for coordinating patient care across multiple settings	☐	☑
2. Instructions on obtaining care and clinical advice during office hours and when the office is closed	☐	☑
3. The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice	☑	☐
4. The care team gives the patient/family access to evidence-based care and self-management support	☐	☑

0.5

Scoring

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

Explanation

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

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

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

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

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

Examples

Documentation

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

NCQA encourages the practice to highlight the information in its materials that meets each factor before submitting materials to NCQA.

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

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families.	Yes	No	NA
1. **Assesses the racial and ethnic diversity of its population**	☑	☐	
2. **Assesses the language needs of its population**	☑	☐	
3. **Provides interpretation or bilingual services to meet the language needs of its population**	☑	☐	
4. **Provides printed materials in the languages of its population**	☐	☑	☐

1.5

Scoring

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

Explanation

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

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

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

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

Examples **Documentation**

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

Factor 3: The practice has an invoice or agreement from an interpretive service, or has a policy or statement that it uses bilingual staff. The policy or statement explains the practice's procedures when a patient needs assistance in a language not spoken by bilingual staff.

Factor 4: The practice has materials in languages other than English or a link to online materials or a Web site in languages other than English.

Element G: The Practice Team — 4 points

The practice provides a range of patient care services by:	Yes	No
1. Defining roles for clinical and nonclinical team members	☑	☐
2. Having regular team meetings and communication processes	☑	☐
3. Using standing orders for services	☑	☑
4. Training and assigning care teams to coordinate care for individual patients	☐	☑
5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change	☐	☑
6. Training and assigning care teams for patient population management	☐	☑
7. Training and designating care team members in communication skills	☐	☑
8. Involving care team staff in the practice's performance evaluation and quality improvement activities	☐	☑

Scoring

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

Explanation

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

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

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

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

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

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

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

Factor 6: Care team members are trained in the concept of population management and proactively addressing needs of patients and families served by the practice. **Population management** is assessing and managing the health needs of a patient population such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations).

Factor 7: Care team members are trained on effective patient communication, particularly with 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 includes information on health literacy, which may be based on Ask Me 3, Rapid Estimate of Adult Literacy in Medicine (REALM-R), Wide Range Achievement Test-Revised (WRAT-R) or other evidence-based approaches to addressing communication needs.

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

Examples

Documentation

Factors 1, 4, 5, 6, 7: The practice provides staff position descriptions describing roles and functions.

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

Factor 3: The practice has written standing orders.

Factors 4, 5, 6, 7: The practice has a description of its training process and training schedule or materials showing how staff are trained in each area identified in the factors.

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

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

PCMH 2: Identify and Manage Patient Populations — 16 points

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

Element A: Patient Information — 3 points

The practice uses an electronic system that records the following as structured (searchable) data for more than 50 percent of its patients.	Yes	No	NA
1. Date of birth*	☑	☐	
2. Gender*	☑	☐	
3. Race*	☑	☐	
4. Ethnicity*	☑	☐	
5. Preferred language*	☑	☐	
6. Telephone numbers	☑	☐	
7. E-mail address	☐	☑	
8. Dates of previous clinical visits	☑	☐	
9. Legal guardian/health care proxy	☑	☐	
10. Primary caregiver	☐	☑	
11. Presence of advance directives (NA for pediatric practices)	☐	☑	☐
12. Health insurance information	☑	☐	

3

Scoring

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

Explanation

***Core meaningful use requirement**

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

Factor 1: The practice records patient date of birth.

Factor 2: The practice records patient gender.

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

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

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

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

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

Factor 9: A **legal guardian** or **health care proxy** is an individual designated by the patient or family or by the courts to make health care decisions for the patient if the patient is unable to do so.

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

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

This factor may be marked "NA" if the practice sees only pediatric patients, and the practice will be considered to have met the factor.

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

Examples

Documentation

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

Calculating a percentage requires a numerator and a denominator. The practice should query its system to obtain data as follows:

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

Element B: Clinical Data — 4 points

The practice uses an electronic system to record the following as structured (searchable) data.	Yes	No	NA
1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients	☐	☑	
2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients	☑	☐	
3. Blood pressure, with the date of update for more than 50 percent of patients	☐	☑	
4. Height for more than 50 percent of patients	☑	☐	
5. Weight for more than 50 percent of patients	☑	☐	
6. BMI for more than 50 percent of adult patients	☐	☑	☐
7. Length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) for more than 50 percent of pediatric patients, with the capability to plot changes over time	☐	☐	☑
8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients	☐	☑	☐
9. List of prescription medications with the date of updates for more than 80 percent of patients	☑	☐	

Scoring

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

Explanation

All factors **are core meaningful use requirements.** 4/8 2

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

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

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

Factor 3: All blood pressure readings are dated.

Factor 6: A calculated BMI is recorded as structured data in the medical record.

Factor 7: Length, weight and head circumference are plotted on a growth chart for children younger than 2 years. Head circumference in children under 2 is a vital growth parameter that provides a guide to a child's health, development, nutritional status and response to treatment. For patients 2–20 years, BMI is calculated using height and weight and plotted on the appropriate CDC BMI-for-age growth chart to obtain a percentile ranking, and is recorded as structured data in the medical record. Percentiles are the most commonly used indicator to assess size and growth patterns.

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

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

Examples

Documentation

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

Calculating a percentage of use for each factor requires a numerator and a denominator. The practice should query its system to obtain data as follows:

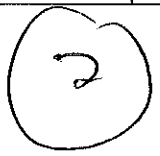
- *Denominator* = Number of patients seen by the practice at least once in the last three months (for factors 7 and 8, include only patients who meet the age parameters)
- *Numerator* = Number of patients for whom the specified data are entered for each data element.

Element C: Comprehensive Health Assessment — 4 points

To understand the health risks and information needs of patients/ families, the practice conducts and documents a comprehensive health assessment that includes:	Yes	No	NA
1. Documentation of age- and gender-appropriate immunizations and screenings	☑	☐	
2. Family/social/cultural characteristics	☐	☑	
3. Communication needs	☐	☑	
4. Medical history of patient and family	☑	☐	
5. Advance care planning (NA for pediatric practices)	☐	☑	☐
6. Behaviors affecting health	☑	☐	
7. Patient and family mental health/substance abuse	☑	☐	
8. Developmental screening using a standardized tool (NA for adult-only practices)	☐	☐	☑
9. Depression screening for adults and adolescents using a standardized tool.	☐	☑	

Scoring

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



Explanation

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

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

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

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

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

Factor 5: **Advance care planning** refers to practice guidance and documentation of patient/family preferences for care at the end of life or for patients who are unable to speak for themselves. This may include discussing and documenting a plan of care with treatment options and preferences. Factor 5 applies primarily to adult populations and may be marked "NA" by practices that see only pediatric patients, and the practice will be considered to have met the factor. Documentation in the field that the patient declined to provide the information counts toward the numerator.

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

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

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

Factor 9: The USPSTF recommends:

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

The practice responds "no" to this factor if necessary support systems are not in place.

Examples

Documentation

Factors 1–9: The practice provides a report or a completed patient assessment (de-identified) specific to the factors documented during the health assessment.

NCQA encourages practices to highlight the information in the documentation that meets each factor. Do not send large portions of a medical record.

Element D: Use Data for Population Management — 5 points
MUST-PASS

The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/ families and clinicians of services needed for:	Yes	No
1. At least three different preventive care services**	☐	☑
2. At least three different chronic care services**	☐	☐
3. Patients not recently seen by the practice	☐	☑
4. Specific medications	☐	☑

Scoring

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

0

Explanation

****Menu meaningful use requirement**

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

The practice demonstrates that it can produce lists of patients needing preventive care and chronic care services, patients not seen recently and patients on specific medications. The practice uses information from reports (a report may combine identified services needed) to manage specific patient populations.

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

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

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

Factor 1: The practice generates three lists of patients who have not received needed preventive services or screenings according to their age or gender (e.g., well-child visits, pediatric screenings, immunizations, mammograms, fasting blood sugar, stress test).

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

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

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

Examples

Documentation

The practice provides a report showing lists of patients (de-identified) within the past 12 months. Data provided from one or more health plans that account for at least 75 percent of the practice's patient population are acceptable.

Factor 1: The practice has lists or a summary report of patients who need preventive screenings or immunizations. Reports must contain at least three different immunizations or screenings.

Factor 2: The practice has lists or a summary report of patients who need acute or chronic care services. Reports must contain at least three different services.

Factor 3: The practice has lists or a summary report of patients who have not had recent appointments.

Factor 4: The practice has lists or a summary report of patients on specific medications.

The practice also provides materials demonstrating how it notifies patients of needed services ***for each factor*** (e.g., letters sent to patients, scripts or descriptions of phone reminders, screen shots of electronic notices).

PCMH 3: Plan and Manage Care — 17 points

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

Element A: Implement Evidence-Based Guidelines — 4 points

The practice implements evidence-based guidelines through point-of-care reminders for patients with:	Yes	No
1. The first important condition*	☐	☑
2. The second important condition	☐	☑
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.	☐	☑

Scoring

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

Explanation

***Core meaningful use requirement**

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

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

To receive a 50% or 100% score, at least one identified condition must be related to unhealthy behaviors (e.g., obesity, smoking), substance abuse (e.g., drug addiction, alcoholism) or a mental health issue (e.g., depression, anxiety, ADHD).

When selecting conditions, practices should consider the following:

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

Pediatric populations

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

Examples

Documentation

The practice:

- Identifies the three important conditions
- Provides the name and source of evidence-based guidelines for each condition
- Demonstrates how the guidelines for each condition are implemented in patient care, using chart tools, screen shots or workflow organizers.

Guideline implementation

- Paper-based organizers such as algorithms for developing treatment plans, flow sheets or templates for documenting patient progress.
- Electronic system organizer (e.g., registry, EHR, other system) screenshots showing templates for treatment plans and documenting progress.

Note: *Guideline implementation must be through a certified EHR to meet the requirements of meaningful use.*

Element B: Identify High-Risk Patients — 3 points

To identify high-risk or complex patients, the practice:	Yes	No
1. Establishes criteria and a systematic process to identify high-risk or complex patients	☐	☑
2. Determines the percentage of high-risk or complex patients in its population.	☐	☑

Scoring

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

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

Explanation

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

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

- High level of resource use (e.g., visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care (e.g., two or more visits in the last six months)
- Frequent hospitalizations (i.e., two or more in last year)
- Multiple co-morbidities, including mental health
- Noncompliance with prescribed treatment/medications
- Terminal illness
- Psychosocial status, lack of social or financial support that impedes ability for care
- Advanced age, with frailty
- Multiple risk factors

Pediatric populations

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

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

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

Factor 2: This factor calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage.

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

Examples

Documentation

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

Factor 2: The practice has a number and percentage of its total population identified as high risk or complex.

Element C: Care Management — 4 points
MUST-PASS

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

Scoring

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

0

Explanation

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

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

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

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

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

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

- Important or chronic conditions, including well-child visits for practices with pediatric patients
- Visits that result in a change in treatment plan or goals

- Additional instructions or information for the patient/family
- Visits associated with transitions of care.

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

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

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

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

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

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

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

Examples

Documentation

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

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

Method 1

Query the practice's electronic registry, practice management system or other electronic systems. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number of patients seen at least once by the practice in the last three months
- *Numerator* = Number of patients for whom each item is entered in the medical record

Method 2

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

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

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

Element D: Medication Management — 3 points

The practice manages medications in the following ways.

Enter the percentage of patients for each factor

1. **Reviews and reconciles medications with patients/families for more than 50 percent of care transitions****
2. **Reviews and reconciles medications with patients/families for more than 80 percent of care transitions**
3. **Provides information about new prescriptions to more than 80 percent of patients/families**
4. **Assesses patient/family understanding of medications for more than 50 percent of patients**
5. **Assesses patient response to medications and barriers to adherence for more than 50 percent of patients**
6. **Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates**

Scoring

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

Explanation

****Menu meaningful use requirement**

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

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

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

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

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

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

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

Examples

Documentation

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

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

Method 1

Query the practice's electronic registry, practice management system or other electronic systems. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number of patients who were seen at least once by the practice in the last three months
- *Numerator* = Number of patients for whom each item is entered.

Method 2

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

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

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

Element E: Use Electronic Prescribing — 3 points

The practice uses an electronic prescription system with the following capabilities.	Yes	No
1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies*	☐	☑
2. Generates at least 75 percent of eligible prescriptions*	☐	☑
3. Integrates with patient medical records	☐	☑
4. Performs patient-specific checks for drug-drug and drug-allergy interactions*	☑	☐
5. Alerts prescribers to generic alternatives	☐	☑
6. Alerts prescribers to formulary status**	☐	☑

Scoring

100%	75%	50%	25%	0%
The practice meets 5-6 factors, including factor 2	The practice meets 4 factors, including factor 2	The practice meets 2-3 factors, including factor 2	The practice meets 1 factor	The practice does not have an electronic system

0.75

Explanation

***Core meaningful use requirements**

****Menu meaningful use requirement**

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

Factor 2: At least 75 percent of eligible prescriptions are generated electronically, including new prescriptions and renewals. If all of the practice's prescriptions are generated electronically, the practice must provide a report showing use of the system for 75 percent of patients. An e-prescribing system that includes e-faxing is acceptable if the prescriptions are not hand written.

This factor makes a distinction between generating prescriptions electronically and generating them *and* transmitting them electronically. Practices may be able to create and produce prescriptions electronically without being able to transmit them to pharmacies.

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

Factor 3: The practice's electronic prescribing system is integral to patient records, allowing it to view patient medications, enter new medications or make changes and identify documented allergies. The practice uses the electronic prescribing system to create an accurate list of the medications prescribed to its patients.

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

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

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

Examples

Documentation

Factors 1 and 2: The practice provides reports from the electronic system.

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

- *Denominator* = Patients in the practice's system who had a prescription in the last 12 months
- *Numerator* = Number of eligible prescriptions written with the practice's prescribing system in the last 12 months

Factors 3–6: The practice provides reports from the electronic system or screen shots demonstrating the system's capabilities.

PCMH 4: Provide Self-Care Support and Community Resources — 9 points

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

Element A: Support Self-Care Process — 6 points
MUST-PASS

The practice conducts activities to support patients/families in self-management:

Enter the percentage of patients for each factor

1. **Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management** —
2. **Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate**** —
3. **Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families** —
4. **Documents self-management abilities for at least 50 percent of patients/families** —
5. **Provides self-management tools to record self-care results for at least 50 percent of patients/families** —
6. **Counsels at least 50 percent of patients/families to adopt healthy behaviors** —

Scoring

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

0

Explanation

****Menu meaningful use requirement**

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

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

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

Factor 1: Educational programs and resources may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, Web site links and pamphlets, as well as community resources (e.g., programs, support groups). Based on the practice's assessment of languages spoken by its patients (PCMH 2, Element A), materials in languages other than English should be available for patients/families, if appropriate.

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

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

Factor 3: The practice works with patients to develop a self-care plan that addresses a patient's condition and includes goals *and* a way to monitor self-care. NCQA expects the practice to have documentation that it provides written self-care plans to patients, families or caregivers. One example for pediatric practices is an asthma action plan.

Research supports the importance of practices developing a self-care plan in collaboration with patients that may be used by patients and families to manage care at home. Thus, Factor 3 has been identified as a **critical factor** and is required for practices to receive more than 25 percent of the available points in this element.

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

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

A copy of the educational materials the practice makes available to patients does not meet the intent of this factor; the medical record must indicate that the practice provided materials to the patient.

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

Examples

Documentation

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

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

Method 1

Query the practice's electronic registry, practice management system or other electronic systems. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number (all) of patients seen at least once by the practice in the last three months
- *Numerator* = Number of patients for whom each activity is documented

Method 2

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

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

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

Element B: Provide Referrals to Community Resources — 3 points

The practice supports patients/families that need access to community resources:	Yes	No
1. Maintains a current resource list on five topics or key community service areas of importance to the patient population	☐	☑
2. Tracks referrals provided to patients/families	☐	☑
3. Arranges or provides treatment for mental health and substance abuse disorders	☐	☑
4. Offers opportunities for health education and peer support.	☐	☑

Scoring

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

Explanation

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

- Smoking cessation
- Weight loss
- Exercise/physical activity
- Nutrition
- Parenting
- Dental
- Other, such as:
  - Transportation to medical appointments
  - Noncommercial health insurance options
  - Obtaining prescription medications
  - Falls prevention
  - Meal support

- Hospice
- Respite care

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

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

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

Factor 4: Alternative approaches may include peer-led discussion groups or shared medical appointments. In a **shared medical appointment** or **group visit,** multiple patients meet in a group setting for follow-up or routine care. These types of appointments may offer access to a multidisciplinary care team and allow patients to interact with and learn from each other.

Examples

Documentation

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

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

Factors 3, 4: The practice has processes and a list of available resources.

PCMH 5: Track and Coordinate Care — 18 points

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

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

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

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	No scoring option	The practice meets fewer than 3 factors

Explanation

****Menu meaningful use requirement**

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

Factors 1 and 2: The practice tracks at least 75 percent of lab and imaging tests from the time they are ordered until results are available, and the electronic system flags test results that have not been made available. **Flagging** is a systematic method of drawing attention to results that have not been received by the practice. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center and, if necessary, the patient, to determine why results are overdue. The expected time that results are made available to the practice varies by test and is at the discretion of the practice.

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

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

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

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

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

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

Factor 10: Imaging results are electronically integrated into the medial record. A scanned PDF of imaging results in the medical record, which allows the practice to retrieve and review the image, is acceptable.

Examples

Documentation

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

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

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

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

6

Scoring

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

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

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

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; for example, a referral to a breast surgeon for examination of a potentially malignant tumor, a referral to a mental health specialist for a patient with depression, a referral to a pediatric cardiologist for an infant with a ventricular septal defect. This factor includes referrals to medical specialists, mental health and substance abuse specialists and other services.

Factor 1: Referrals include:

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

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

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

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

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

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

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

Factor 6: The practice demonstrates the capability for electronic exchange of key clinical information with other clinicians.

Factor 7: The practice provides an electronic summary-of-care record for more than 50 percent of referrals to the referred specialist(s).

Examples

Documentation

The practice provides:

Factors 1–5: Reports or logs demonstrating data collected in the tracking system used by the practice. A paper log or a report from the electronic system meets the requirement; screen shots of a patient record do not meet the requirement. The report may be system generated or may be based on a spot check of at least one week of referrals, with de-identified patient data.

Factors 3–5: The practice has a documented process, evidenced by at least three examples.

Factors 6 and 7: The practice has reports from its electronic system.

Element C: Coordinate With Facilities and Care Transitions — 6 points

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

6

Scoring

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

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

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

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

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

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

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

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

Factor 6: During the transition from pediatric to adult care, it is important to promote health, disease prevention and psychosocial adjustment to adulthood. The practice's written care plan focuses on obtaining adult primary, emergency and specialty care and can include a summary of medical information (e.g., history of hospitalizations, procedures, tests), a list of providers, medical equipment and medications for patients with special health care needs, identified obstacles to transitioning to an adult care clinician and arrangements for release and transfer of medical records to the adult care clinician.

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

Factor 8: The practice can provide an electronic summary of the patient care record to other care settings (e.g., long-term care facilities, hospitals) for more than 50 percent of transitions of care.

Examples

Documentation

The practice provides:

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

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

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

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

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

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

Factor 7: A report illustrating electronic information exchange.

Factor 8: An electronic report summarizing more than 50 percent of transitions of care.

PCMH 6: Measure and Improve Performance — 20 points

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

Element A: Measure Performance — 4 points

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

Scoring

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

Explanation

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

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

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

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

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

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

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

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

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

Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.

Examples **Documentation**

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

Element B: Measure Patient/Family Experience — 4 points

The practice obtains feedback from patients/families on their experiences with the practice and their care.	**Yes**	**No**	**NA**
1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: • **Access** • **Communication** • **Coordination** • **Whole-person care**	☑	☐	
2. The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician Group survey tool	☐	☑	☐
3. The practice obtains feedback on the experiences of vulnerable patient groups	☐	☑	
4. The practice obtains feedback from patients/families through qualitative means.	☐	☑	

Scoring

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

Explanation

The practice may use a telephone, paper or electronic survey, and uses survey feedback to inform its quality improvement activities. The patient survey must represent the practice population, not just patients of one clinician or data from a single payer (unless it's reflective of the entire practice).

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

- Access to routine and urgent care
- Communication with the practice, clinicians and staff
- Coordination of care, including specialists, medications and lab or imaging
- Whole person care, including provision of comprehensive care and self-management support and emphasizing spectrum of care needs such as mental health; routine and urgent care; advice, assistance and support for making changes in health habits and making health care decisions.

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

Note: *The* Patient-Centered Medical Home version of the CAHPS Clinician Group *Survey Tool has an anticipated release date of July 2011. At that time, it may be used by practices to collect patient experience data, but Factor 2 may be marked NA until January 1, 2012. In January 2012, practices will be able to receive distinction from NCQA for collecting data using the specified survey and methods and reporting the results to NCQA.*

Factor 3: The practice uses survey data or other means to assess quality of care for its vulnerable subgroups.

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.

Factor 4: Qualitative feedback methods may include focus groups, individual interviews, patient walkthrough and suggestion boxes.

Examples

Documentation

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

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

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

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 no factors

Explanation

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

The practice must have a clear and ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer the practice an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers.

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

The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action.

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

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

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

Factor 3: The practice identifies areas of disparity based on race, ethnicity or language, sets goals and acts to improve performance in these areas.

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

Examples **Documentation**

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

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

Element D: Demonstrate Continuous Quality Improvement — 3 points

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

	Yes	No
1. Tracking results over time	☑	☐
2. Assessing the effect of its actions	☑	☐
3. Achieving improved performance on one measure	☐	☑
4. Achieving improved performance on a second measure	☐	☑

Scoring

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

1.5

Explanation

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

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

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

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

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

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

Examples **Documentation**

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

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

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

Element E: Report Performance	3 points

The practice shares performance data from Element A and Element B:	Yes	No
1. Within the practice, results by individual clinician	☑	☐
2. Within the practice, results across the practice	☑	☐
3. Outside the practice to patients or publicly, results across the practice or by clinician.	☐	☑

Scoring

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

2.25

Explanation

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

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

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

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

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

Examples

Documentation

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

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

Element F: Report Data Externally — 2 points

The practice electronically reports:	Yes	No
1. Ambulatory clinical quality measures to CMS*	☐	☑
2. Data to immunization registries or systems**	☐	☑
3. Syndromic surveillance data to public health agencies.**	☐	☑

Scoring

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

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

Factor 1: The practice reports CMS ambulatory clinical quality measures selected by CMS to CMS, in the manner specified by CMS. Reporting by attestation is required in 2011; electronic reporting is required in 2012.

For requirements and electronic specifications related to individual ambulatory clinical quality measures, refer to:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopofPage

Factor 2: The practice submits electronic data to immunization registries or information systems and follows up the submission according to applicable law and practice.

Factor 3: The practice submits electronic syndromic surveillance data to public health agencies, according to applicable state law and practice.

Examples

Documentation

The practice provides reports demonstrating data transmission to CMS and public health agencies.

Intervention

PCMH 2011 Standards

NCQA PCMH 2011

6 Standards, 27 Elements, 149 Factors

Points	Standard and Element	No. Factors	Must Pass 60% score
20	**1 Enhance Access and Continuity**	34	11.5
4	A Access During Office Hours	4	x 3
4	B Access After Hours	5	2
2	C Electronic Access	6	0
2	D Continuity	3	1
2	E Medical Home Responsibilities	4	1.5
2	F Culturally and Linguistically Appropriate Services (CLAS)	4	2
4	G Practice Organization	8	2
17	**2 Identify and Manage Patient Populations**	35	7
3	A Patient Information	12	3
4	B Clinical Data	9	2
4	C Comprehensive Health Assessment	10	2
5	D Using Data for Population Management	4	x 0
17	**3 Plan and Manage Care**	23	5.75
4	A Implement Evidence-Based Guidelines	3	0
3	B Identify High-Risk Patients	2	3
4	C Manage Care	7	x 2
3	D Manage Medications	5	0
3	E Electronic Prescribing	6	0.75
9	**4 Provide Self-Care and Community Support**	10	0
6	A Self-Care Process	6	x 0
3	B Referrals to Community Resources	4	0
18	**5 Track and Coordinate Care**	25	16.5
6	A Test Tracking and Follow-up	10	4.5
6	B Referral Tracking and Follow-up	7	x 6
6	C Coordinate with Facilities/Care Transitions	8	6
20	**6 Measure and Improve Performance**	22	12.25
4	A Measures of Performance	4	3
4	B Patient/Family Feedback	4	2
4	C Implements Continuous Quality Improvement	4	x 2
3	D Demonstrates Continuous Quality Improvement	4	3
3	E Performance Reporting	3	2.25
2	F Report Data Externally	3	0
100 Points	Total: 53	**149 Factors**	**6 MP Elements**

PCMH 1: Enhance Access and Continuity — 20 points

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

Element A: Access During Office Hours — 4 points
MUST-PASS

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

	Yes	No	NA
1. Providing same-day appointments	☑	☑	☐
2. Providing timely clinical advice by telephone during office hours	☑	☐	☐
3. Providing timely clinical advice by secure electronic messages during office hours	☑	☑	☐
4. Documenting clinical advice in the medical record.	☑	☐	☐

Scoring

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

Explanation

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

Patients can access the clinician and care team for routine and urgent care needs by office visit, by telephone and through secure electronic messaging. Practice staff considers patient care needs and preferences when determining the urgency of patient requests for same-day access. For all factors, the practice must provide their defined standards or policies and demonstrate they have monitored performance against the standards they have defined.

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

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

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

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

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

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

Examples

Documentation

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

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

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

Factor 4: The practice has a documented process for staff to follow for entering phone and electronic message clinical advice in the patient record *and* has at least three examples of clinical advice documented in a patient record.

Element B: After-Hours Access — 4 points

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

2

Scoring

100%	75%	50%	25%	0%
The practice meets all 5 factors, including factor 3	The practice meets 4 factors, including factor 3	The practice meets 3 factors, including factor 3	The practice meets 1-2 factors	The practice meets no factors

Explanation

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

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

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

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

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

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

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

Examples

Documentation

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

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

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

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

Factor 5: The practice has a documented process for staff to follow for documenting after-hours clinical advice in the patient record *and* has at least three examples of clinical advice documented in the patient record *or* a report identifying how often advice is documented. The report may be system generated or may be based on a spot check of calls and electronic messages for at least one week.

Element C: Electronic Access — 2 points

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

Scoring

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

0

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

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

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

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

Factor 3: An **electronic clinical summary** is a summary of a visit that includes, when appropriate, diagnoses, medications, recommended treatment and follow-up. Federal meaningful use rules require that summaries be provided to more than 50 percent of patients within three business days, either by secure electronic message or as a printed copy from the practice's electronic system at the time of the visit. Patients may be notified that the information is available through a secure, interactive system such as a Web site or patient portal.

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

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

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

Examples

Documentation

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

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

Factor 3: The practice has a report showing the percentage of patients who received electronically-generated clinical summaries of an office visit within three business days.

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

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

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

Element D: Continuity — 2 points

The practice provides continuity of care for patients/families by:	Yes	No
1. Expecting patients/families to select a personal clinician	☑	☐
2. Documenting the patient's/family's choice of clinician	☐	☑
3. Monitoring the percentage of patient visits with a selected clinician or team.	☑	☐

Scoring

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

Explanation

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

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

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

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

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

Examples

Documentation

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

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

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

Element E: Medical Home Responsibilities — 2 points

The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following.	Yes	No
1. **The practice is responsible for coordinating patient care across multiple settings**	☑	☐
2. **Instructions on obtaining care and clinical advice during office hours and when the office is closed**	☑	☐
3. **The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice**	☑	☐
4. **The care team gives the patient/family access to evidence-based care and self-management support**	☐	☑

1.5

Scoring

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

Explanation

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

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

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

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

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

Examples

Documentation

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

NCQA encourages the practice to highlight the information in its materials that meets each factor before submitting materials to NCQA.

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

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families.	Yes	No	NA
1. Assesses the racial and ethnic diversity of its population	☑	☐	
2. Assesses the language needs of its population	☑	☐	
3. Provides interpretation or bilingual services to meet the language needs of its population	☑	☐	
4. Provides printed materials in the languages of its population	☑	☐	☐

2

Scoring

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

Explanation

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

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

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

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

Examples **Documentation**

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

Factor 3: The practice has an invoice or agreement from an interpretive service, or has a policy or statement that it uses bilingual staff. The policy or statement explains the practice's procedures when a patient needs assistance in a language not spoken by bilingual staff.

Factor 4: The practice has materials in languages other than English or a link to online materials or a Web site in languages other than English.

Element G: The Practice Team — 4 points

The practice provides a range of patient care services by:	Yes	No
1. Defining roles for clinical and nonclinical team members	☑	☐
2. Having regular team meetings and communication processes	☑	☐
3. Using standing orders for services	☐	☑
4. Training and assigning care teams to coordinate care for individual patients	☑	☑
5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change	☐	☑
6. Training and assigning care teams for patient population management	☐	☑
7. Training and designating care team members in communication skills	☐	☑
8. Involving care team staff in the practice's performance evaluation and quality improvement activities	☑	☐

Scoring

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

Explanation

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

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

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

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

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

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

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

Factor 6: Care team members are trained in the concept of population management and proactively addressing needs of patients and families served by the practice. **Population management** is assessing and managing the health needs of a patient population such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations).

Factor 7: Care team members are trained on effective patient communication, particularly with 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 includes information on health literacy, which may be based on Ask Me 3, Rapid Estimate of Adult Literacy in Medicine (REALM-R), Wide Range Achievement Test-Revised (WRAT-R) or other evidence-based approaches to addressing communication needs.

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

Examples

Documentation

Factors 1, 4, 5, 6, 7: The practice provides staff position descriptions describing roles and functions.

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

Factor 3: The practice has written standing orders.

Factors 4, 5, 6, 7: The practice has a description of its training process and training schedule or materials showing how staff are trained in each area identified in the factors.

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

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

PCMH 2: Identify and Manage Patient Populations 16 points

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

Element A: Patient Information 3 points

The practice uses an electronic system that records the following as structured (searchable) data for more than 50 percent of its patients.	Yes	No	NA
1. Date of birth*	☑	☐	
2. Gender*	☑	☐	
3. Race*	☑	☐	
4. Ethnicity*	☑	☐	
5. Preferred language*	☑	☐	
6. Telephone numbers	☑	☐	
7. E-mail address	☐	☑	
8. Dates of previous clinical visits	☑	☐	
9. Legal guardian/health care proxy	☑	☐	
10. Primary caregiver	☐	☑	
11. Presence of advance directives (NA for pediatric practices)	☐	☑	☐
12. Health insurance information	☑	☐	

3

Scoring

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

Explanation

***Core meaningful use requirement**

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

Factor 1: The practice records patient date of birth.

Factor 2: The practice records patient gender.

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

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

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

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

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

Factor 9: A **legal guardian** or **health care proxy** is an individual designated by the patient or family or by the courts to make health care decisions for the patient if the patient is unable to do so.

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

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

This factor may be marked "NA" if the practice sees only pediatric patients, and the practice will be considered to have met the factor.

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

Examples

Documentation

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

Calculating a percentage requires a numerator and a denominator. The practice should query its system to obtain data as follows:

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

Element B: Clinical Data — 4 points

The practice uses an electronic system to record the following as structured (searchable) data.	Yes	No	NA
1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients	☐	☑	
2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients	☑	☐	
3. Blood pressure, with the date of update for more than 50 percent of patients	☐	☑	
4. Height for more than 50 percent of patients	☑	☐	
5. Weight for more than 50 percent of patients	☑	☐	
6. BMI for more than 50 percent of adult patients	☐	☑	☐
7. Length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) for more than 50 percent of pediatric patients, with the capability to plot changes over time	☐	☐	☑
8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients	☐	☑	☐
9. List of prescription medications with the date of updates for more than 80 percent of patients	☑	☐	

Scoring

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

Explanation

All factors **are core meaningful use requirements.** 4/8 + 2

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

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

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

Factor 3: All blood pressure readings are dated.

Factor 6: A calculated BMI is recorded as structured data in the medical record.

Factor 7: Length, weight and head circumference are plotted on a growth chart for children younger than 2 years. Head circumference in children under 2 is a vital growth parameter that provides a guide to a child's health, development, nutritional status and response to treatment. For patients 2–20 years, BMI is calculated using height and weight and plotted on the appropriate CDC BMI-for-age growth chart to obtain a percentile ranking, and is recorded as structured data in the medical record. Percentiles are the most commonly used indicator to assess size and growth patterns.

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

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

Examples

Documentation

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

Calculating a percentage of use for each factor requires a numerator and a denominator. The practice should query its system to obtain data as follows:

- *Denominator* = Number of patients seen by the practice at least once in the last three months (for factors 7 and 8, include only patients who meet the age parameters)
- *Numerator* = Number of patients for whom the specified data are entered for each data element.

Element C: Comprehensive Health Assessment — 4 points

To understand the health risks and information needs of patients/ families, the practice conducts and documents a comprehensive health assessment that includes:	Yes	No	NA
1. Documentation of age- and gender-appropriate immunizations and screenings	☑	☐	
2. Family/social/cultural characteristics	☐	☑	
3. Communication needs	☐	☑	
4. Medical history of patient and family	☑	☐	
5. Advance care planning (NA for pediatric practices)	☐	☑	☐
6. Behaviors affecting health	☑	☐	
7. Patient and family mental health/substance abuse	☑	☐	
8. Developmental screening using a standardized tool (NA for adult-only practices)	☐	☐	☑
9. Depression screening for adults and adolescents using a standardized tool.	☐	☑	

Scoring

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

Explanation

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

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

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

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

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

Factor 5: **Advance care planning** refers to practice guidance and documentation of patient/family preferences for care at the end of life or for patients who are unable to speak for themselves. This may include discussing and documenting a plan of care with treatment options and preferences. Factor 5 applies primarily to adult populations and may be marked "NA" by practices that see only pediatric patients, and the practice will be considered to have met the factor. Documentation in the field that the patient declined to provide the information counts toward the numerator.

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

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

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

Factor 9: The USPSTF recommends:

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

The practice responds "no" to this factor if necessary support systems are not in place.

Examples

Documentation

Factors 1–9: The practice provides a report or a completed patient assessment (de-identified) specific to the factors documented during the health assessment.

NCQA encourages practices to highlight the information in the documentation that meets each factor. Do not send large portions of a medical record.

Element D: Use Data for Population Management — 5 points
MUST-PASS

The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/ families and clinicians of services needed for:	Yes	No
1. At least three different preventive care services**	☐	☑
2. At least three different chronic care services**	☐	☑
3. Patients not recently seen by the practice	☐	☑
4. Specific medications	☐	☑

Scoring

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

Explanation

****Menu meaningful use requirement**

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

The practice demonstrates that it can produce lists of patients needing preventive care and chronic care services, patients not seen recently and patients on specific medications. The practice uses information from reports (a report may combine identified services needed) to manage specific patient populations.

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

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

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

Factor 1: The practice generates three lists of patients who have not received needed preventive services or screenings according to their age or gender (e.g., well-child visits, pediatric screenings, immunizations, mammograms, fasting blood sugar, stress test).

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

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

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

Examples

Documentation

The practice provides a report showing lists of patients (de-identified) within the past 12 months. Data provided from one or more health plans that account for at least 75 percent of the practice's patient population are acceptable.

Factor 1: The practice has lists or a summary report of patients who need preventive screenings or immunizations. Reports must contain at least three different immunizations or screenings.

Factor 2: The practice has lists or a summary report of patients who need acute or chronic care services. Reports must contain at least three different services.

Factor 3: The practice has lists or a summary report of patients who have not had recent appointments.

Factor 4: The practice has lists or a summary report of patients on specific medications.

The practice also provides materials demonstrating how it notifies patients of needed services ***for each factor*** (e.g., letters sent to patients, scripts or descriptions of phone reminders, screen shots of electronic notices).

PCMH 3: Plan and Manage Care — 17 points

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

Element A: Implement Evidence-Based Guidelines — 4 points

The practice implements evidence-based guidelines through point-of-care reminders for patients with:	Yes	No
1. The first important condition*	☐	☑
2. The second important condition	☐	☑
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.	☐	☑

Scoring

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

Explanation

***Core meaningful use requirement**

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

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

To receive a 50% or 100% score, at least one identified condition must be related to unhealthy behaviors (e.g., obesity, smoking), substance abuse (e.g., drug addiction, alcoholism) or a mental health issue (e.g., depression, anxiety, ADHD).

When selecting conditions, practices should consider the following:

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

Pediatric populations

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

Examples

Documentation

The practice:

- Identifies the three important conditions
- Provides the name and source of evidence-based guidelines for each condition
- Demonstrates how the guidelines for each condition are implemented in patient care, using chart tools, screen shots or workflow organizers.

Guideline implementation

- Paper-based organizers such as algorithms for developing treatment plans, flow sheets or templates for documenting patient progress.
- Electronic system organizer (e.g., registry, EHR, other system) screenshots showing templates for treatment plans and documenting progress.

Note: *Guideline implementation must be through a certified EHR to meet the requirements of meaningful use.*

Element B: Identify High-Risk Patients — 3 points

To identify high-risk or complex patients, the practice:

	Yes	No
1. **Establishes criteria and a systematic process to identify high-risk or complex patients**	☑	☐
2. **Determines the percentage of high-risk or complex patients in its population.**	☑	☐

3

Scoring

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

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

Explanation

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

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

- High level of resource use (e.g., visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care (e.g., two or more visits in the last six months)
- Frequent hospitalizations (i.e., two or more in last year)
- Multiple co-morbidities, including mental health
- Noncompliance with prescribed treatment/medications
- Terminal illness
- Psychosocial status, lack of social or financial support that impedes ability for care
- Advanced age, with frailty
- Multiple risk factors

Pediatric populations

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

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

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

Factor 2: This factor calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage.

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

Examples

Documentation

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

Factor 2: The practice has a number and percentage of its total population identified as high risk or complex.

Element C: Care Management — 4 points
MUST-PASS

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

2

Scoring

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

Explanation

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

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

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

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

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

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

- Important or chronic conditions, including well-child visits for practices with pediatric patients
- Visits that result in a change in treatment plan or goals

- Additional instructions or information for the patient/family
- Visits associated with transitions of care.

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

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

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

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

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

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

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

Examples

Documentation

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

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

Method 1

Query the practice's electronic registry, practice management system or other electronic systems. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number of patients seen at least once by the practice in the last three months
- *Numerator* = Number of patients for whom each item is entered in the medical record

Method 2

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

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

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

Element D: Medication Management — 3 points

The practice manages medications in the following ways.

Enter the percentage of patients for each factor

1. **Reviews and reconciles medications with patients/families for more than 50 percent of care transitions****
2. **Reviews and reconciles medications with patients/families for more than 80 percent of care transitions**
3. **Provides information about new prescriptions to more than 80 percent of patients/families**
4. **Assesses patient/family understanding of medications for more than 50 percent of patients**
5. **Assesses patient response to medications and barriers to adherence for more than 50 percent of patients**
6. **Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates**

Scoring

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

Explanation

****Menu meaningful use requirement**

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

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

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

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

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

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

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

Examples

Documentation

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

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

Method 1

Query the practice's electronic registry, practice management system or other electronic systems. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number of patients who were seen at least once by the practice in the last three months
- *Numerator* = Number of patients for whom each item is entered.

Method 2

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

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

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

Element E: Use Electronic Prescribing — 3 points

The practice uses an electronic prescription system with the following capabilities.	Yes	No
1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies*	☐	☑
2. Generates at least 75 percent of eligible prescriptions*	☐	☑
3. Integrates with patient medical records	☐	☑
4. Performs patient-specific checks for drug-drug and drug-allergy interactions*	☑	☐
5. Alerts prescribers to generic alternatives	☐	☑
6. Alerts prescribers to formulary status**	☐	☑

Scoring

100%	75%	50%	25%	0%
The practice meets 5-6 factors, including factor 2	The practice meets 4 factors, including factor 2	The practice meets 2-3 factors, including factor 2	The practice meets 1 factor	The practice does not have an electronic system

0.75

Explanation

***Core meaningful use requirements**

****Menu meaningful use requirement**

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

Factor 2: At least 75 percent of eligible prescriptions are generated electronically, including new prescriptions and renewals. If all of the practice's prescriptions are generated electronically, the practice must provide a report showing use of the system for 75 percent of patients. An e-prescribing system that includes e-faxing is acceptable if the prescriptions are not hand written.

This factor makes a distinction between generating prescriptions electronically and generating them *and* transmitting them electronically. Practices may be able to create and produce prescriptions electronically without being able to transmit them to pharmacies.

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

Factor 3: The practice's electronic prescribing system is integral to patient records, allowing it to view patient medications, enter new medications or make changes and identify documented allergies. The practice uses the electronic prescribing system to create an accurate list of the medications prescribed to its patients.

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

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

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

Examples

Documentation

Factors 1 and 2: The practice provides reports from the electronic system.

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

- *Denominator* = Patients in the practice's system who had a prescription in the last 12 months
- *Numerator* = Number of eligible prescriptions written with the practice's prescribing system in the last 12 months

Factors 3–6: The practice provides reports from the electronic system or screen shots demonstrating the system's capabilities.

PCMH 4: Provide Self-Care Support and Community Resources — 9 points

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

Element A: Support Self-Care Process — 6 points
MUST-PASS

The practice conducts activities to support patients/families in self-management:

Enter the percentage of patients for each factor

1. **Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management** _____
2. **Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate**** _____
3. **Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families** _____
4. **Documents self-management abilities for at least 50 percent of patients/families** _____
5. **Provides self-management tools to record self-care results for at least 50 percent of patients/families** _____
6. **Counsels at least 50 percent of patients/families to adopt healthy behaviors** _____

Scoring

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

Explanation

****Menu meaningful use requirement**

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

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

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

Factor 1: Educational programs and resources may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, Web site links and pamphlets, as well as community resources (e.g., programs, support groups). Based on the practice's assessment of languages spoken by its patients (PCMH 2, Element A), materials in languages other than English should be available for patients/families, if appropriate.

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

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

Factor 3: The practice works with patients to develop a self-care plan that addresses a patient's condition and includes goals *and* a way to monitor self-care. NCQA expects the practice to have documentation that it provides written self-care plans to patients, families or caregivers. One example for pediatric practices is an asthma action plan.

Research supports the importance of practices developing a self-care plan in collaboration with patients that may be used by patients and families to manage care at home. Thus, Factor 3 has been identified as a **critical factor** and is required for practices to receive more than 25 percent of the available points in this element.

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

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

A copy of the educational materials the practice makes available to patients does not meet the intent of this factor; the medical record must indicate that the practice provided materials to the patient.

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

Examples

Documentation

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

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

Method 1

Query the practice's electronic registry, practice management system or other electronic systems. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number (all) of patients seen at least once by the practice in the last three months
- *Numerator* = Number of patients for whom each activity is documented

Method 2

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

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

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

Element B: Provide Referrals to Community Resources — 3 points

The practice supports patients/families that need access to community resources:	Yes	No
1. Maintains a current resource list on five topics or key community service areas of importance to the patient population	☐	☑
2. Tracks referrals provided to patients/families	☐	☑
3. Arranges or provides treatment for mental health and substance abuse disorders	☐	☑
4. Offers opportunities for health education and peer support.	☐	☑

Scoring

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

6

Explanation

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

- Smoking cessation
- Weight loss
- Exercise/physical activity
- Nutrition
- Parenting
- Dental
- Other, such as:
  - Transportation to medical appointments
  - Noncommercial health insurance options
  - Obtaining prescription medications
  - Falls prevention
  - Meal support

- Hospice
- Respite care

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

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

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

Factor 4: Alternative approaches may include peer-led discussion groups or shared medical appointments. In a **shared medical appointment** or **group visit,** multiple patients meet in a group setting for follow-up or routine care. These types of appointments may offer access to a multidisciplinary care team and allow patients to interact with and learn from each other.

Examples

Documentation

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

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

Factors 3, 4: The practice has processes and a list of available resources.

PCMH 5: Track and Coordinate Care — 18 points

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

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

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

4.5

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	No scoring option	The practice meets fewer than 3 factors

Explanation

****Menu meaningful use requirement**

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

Factors 1 and 2: The practice tracks at least 75 percent of lab and imaging tests from the time they are ordered until results are available, and the electronic system flags test results that have not been made available. **Flagging** is a systematic method of drawing attention to results that have not been received by the practice. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center and, if necessary, the patient, to determine why results are overdue. The expected time that results are made available to the practice varies by test and is at the discretion of the practice.

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

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

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

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

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

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

Factor 10: Imaging results are electronically integrated into the medial record. A scanned PDF of imaging results in the medical record, which allows the practice to retrieve and review the image, is acceptable.

Examples

Documentation

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

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

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

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

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

6

Scoring

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

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

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

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; for example, a referral to a breast surgeon for examination of a potentially malignant tumor, a referral to a mental health specialist for a patient with depression, a referral to a pediatric cardiologist for an infant with a ventricular septal defect. This factor includes referrals to medical specialists, mental health and substance abuse specialists and other services.

Factor 1: Referrals include:

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

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

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

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

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

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

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

Factor 6: The practice demonstrates the capability for electronic exchange of key clinical information with other clinicians.

Factor 7: The practice provides an electronic summary-of-care record for more than 50 percent of referrals to the referred specialist(s).

Examples

Documentation

The practice provides:

Factors 1–5: Reports or logs demonstrating data collected in the tracking system used by the practice. A paper log or a report from the electronic system meets the requirement; screen shots of a patient record do not meet the requirement. The report may be system generated or may be based on a spot check of at least one week of referrals, with de-identified patient data.

Factors 3–5: The practice has a documented process, evidenced by at least three examples.

Factors 6 and 7: The practice has reports from its electronic system.

Element C: Coordinate With Facilities and Care Transitions — 6 points

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

6

Scoring

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

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

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

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

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

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

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

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

Factor 6: During the transition from pediatric to adult care, it is important to promote health, disease prevention and psychosocial adjustment to adulthood. The practice's written care plan focuses on obtaining adult primary, emergency and specialty care and can include a summary of medical information (e.g., history of hospitalizations, procedures, tests), a list of providers, medical equipment and medications for patients with special health care needs, identified obstacles to transitioning to an adult care clinician and arrangements for release and transfer of medical records to the adult care clinician.

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

Factor 8: The practice can provide an electronic summary of the patient care record to other care settings (e.g., long-term care facilities, hospitals) for more than 50 percent of transitions of care.

Examples

Documentation

The practice provides:

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

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

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

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

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

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

Factor 7: A report illustrating electronic information exchange.

Factor 8: An electronic report summarizing more than 50 percent of transitions of care.

PCMH 6: Measure and Improve Performance — 20 points

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

Element A: Measure Performance — 4 points

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

Scoring

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

3

Explanation

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

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

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

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

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

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

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

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

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

Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.

Examples **Documentation**

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

Element B: Measure Patient/Family Experience — 4 points

The practice obtains feedback from patients/families on their experiences with the practice and their care.

	Yes	No	NA
1. **The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:** • **Access** • **Communication** • **Coordination** • **Whole-person care**	☑	☐	
2. **The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician Group survey tool**	☐	☑	☐
3. **The practice obtains feedback on the experiences of vulnerable patient groups**	☐	☑	
4. **The practice obtains feedback from patients/families through qualitative means.**	☑	☐	

2

Scoring

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

Explanation

The practice may use a telephone, paper or electronic survey, and uses survey feedback to inform its quality improvement activities. The patient survey must represent the practice population, not just patients of one clinician or data from a single payer (unless it's reflective of the entire practice).

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

- Access to routine and urgent care
- Communication with the practice, clinicians and staff
- Coordination of care, including specialists, medications and lab or imaging
- Whole person care, including provision of comprehensive care and self-management support and emphasizing spectrum of care needs such as mental health; routine and urgent care; advice, assistance and support for making changes in health habits and making health care decisions.

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

Note: *The* Patient-Centered Medical Home version of the CAHPS Clinician Group *Survey Tool has an anticipated release date of July 2011. At that time, it may be used by practices to collect patient experience data, but Factor 2 may be marked NA until January 1, 2012. In January 2012, practices will be able to receive distinction from NCQA for collecting data using the specified survey and methods and reporting the results to NCQA.*

Factor 3: The practice uses survey data or other means to assess quality of care for its vulnerable subgroups.

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.

Factor 4: Qualitative feedback methods may include focus groups, individual interviews, patient walkthrough and suggestion boxes.

Examples

Documentation

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

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

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

2

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 no factors

Explanation

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

The practice must have a clear and ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer the practice an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers.

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

The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action.

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

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

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

Factor 3: The practice identifies areas of disparity based on race, ethnicity or language, sets goals and acts to improve performance in these areas.

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

Examples **Documentation**

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

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

Element D: Demonstrate Continuous Quality Improvement — 3 points

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

	Yes	No
1. Tracking results over time	☑	☐
2. Assessing the effect of its actions	☑	☐
3. Achieving improved performance on one measure	☑	☐
4. Achieving improved performance on a second measure	☑	☐

3

Scoring

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

Explanation

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

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

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

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

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

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

Examples **Documentation**

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

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

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

Element E: Report Performance — 3 points

The practice shares performance data from Element A and Element B:

	Yes	No
1. **Within the practice, results by individual clinician**	☑	☐
2. **Within the practice, results across the practice**	☑	☐
3. **Outside the practice to patients or publicly, results across the practice or by clinician.**	☐	☑

2.25

Scoring

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

Explanation

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

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

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

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

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

Examples

Documentation

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

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

Element F: Report Data Externally — 2 points

The practice electronically reports:	Yes	No
1. Ambulatory clinical quality measures to CMS*	☐	☑
2. Data to immunization registries or systems**	☐	☑
3. Syndromic surveillance data to public health agencies.**	☐	☑

Scoring

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

Explanation

***Core meaningful use requirement**

****Menu meaningful use requirement**

Factor 1: The practice reports CMS ambulatory clinical quality measures selected by CMS to CMS, in the manner specified by CMS. Reporting by attestation is required in 2011; electronic reporting is required in 2012.

For requirements and electronic specifications related to individual ambulatory clinical quality measures, refer to:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopofPage

Factor 2: The practice submits electronic data to immunization registries or information systems and follows up the submission according to applicable law and practice.

Factor 3: The practice submits electronic syndromic surveillance data to public health agencies, according to applicable state law and practice.

Examples

Documentation

The practice provides reports demonstrating data transmission to CMS and public health agencies.