NCQA’s Patient-Centered Medical Home (PCMH) 2011 Standards

11/21/11
PCMH 1: Enhance Access and Continuity 20 points

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

### Element A: Access During Office Hours

**MUST-PASS**

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providing same-day appointments</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Providing timely clinical advice by telephone during office hours</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Providing timely clinical advice by secure electronic messages during office hours</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Documenting clinical advice in the medical record.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

#### Scoring

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>The practice meets all 4 factors</td>
</tr>
<tr>
<td>75%</td>
<td>The practice meets 3 factors, including factor 1</td>
</tr>
<tr>
<td>50%</td>
<td>The practice meets 2 factors, including factor 1</td>
</tr>
<tr>
<td>25%</td>
<td>The practice meets factor 1</td>
</tr>
<tr>
<td>0%</td>
<td>The practice meets no factors or does not meet factor 1</td>
</tr>
</tbody>
</table>

#### Explanation

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

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

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

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

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

**Factors 2 and 3:** Clinicians return calls or respond to secure electronic messages in a timely manner, as defined by the practice to meet the clinical needs of the patient population. Factors 2 and 3 require the practice to define the time frame for a response, and monitor the timeliness of the response against the practice's standard.
Patients can seek and receive interactive clinical advice by telephone (factor 2) and secure electronic communication (factor 3) (e.g., electronic message, Web site) during office hours. Interactive means that questions are answered by an individual, not just a recorded message.

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

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

**Documentation**

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

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

Factor 2 requires the practice to:
- Define the time frame for a response, and
- Monitor the timeliness of the response against the practice’s standard.

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

Factor 3 requires the practice to:
- Define the time frame for a response, and
- Monitor the timeliness of the response against the practice’s standard.

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

- Denominator = Number of patients receiving clinical advice
- Numerator = Number of patients with clinical advice documented in the medical record
Element B: After-Hours Access

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

<table>
<thead>
<tr>
<th>1. Providing access to routine and urgent-care appointments outside regular business hours</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Providing continuity of medical record information for care and advice when the office is not open</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>3. Providing timely clinical advice by telephone when the office is not open</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>5. Documenting after-hours clinical advice in patient records.</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Scoring**

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 5 factors, including factor 3</td>
<td>The practice meets 4 factors, including factor 3</td>
<td>The practice meets 3 factors, including factor 3</td>
<td>The practice meets 1-2 factors or meets 3-4 factors but not factor 3</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

**Explanation**

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

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

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

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

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

Factor 4 is NA if the practice does not have the capability to communicate electronically with patients.
Factor 5: After-hours clinical advice must be documented in the patient record, whether it is provided by telephone or secure electronic message.

Documentation

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

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

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

Factor 3 requires the practice to:
- Define the time frame for a response, and
- Monitor the timeliness of the response against the practice’s standard.

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

Factor 4 requires the practice to:
- Define the time frame for a response, and
- Monitor the timeliness of the response against the practice’s standard.

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

- Denominator = Number of patients receiving after-hours clinical advice
- Numerator = Number of patients with after-hours clinical advice documented in the medical record
### Element C: Electronic Access

The practice provides the following information and services to patients and families through a secure electronic system.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>More than 50 percent of patients who request an electronic copy of their</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>health information (including problem list, diagnoses, diagnostic test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>results, medication lists, allergies) receive it within three business days*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>At least 10 percent of patients have electronic access to their current</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>health information (including lab results, problem lists, medication lists,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and allergies) within four business days of when the information is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>available to the practice**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Clinical summaries are provided to patients for more than 50 percent of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>office visits within three business days*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Two-way communication between patients/families and the practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Request for appointments or prescription refills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Request for referrals or test results</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Scoring

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>The practice meets 5-6 factors</td>
</tr>
<tr>
<td>75%</td>
<td>The practice meets 3-4 factors</td>
</tr>
<tr>
<td>50%</td>
<td>The practice meets 2 factors</td>
</tr>
<tr>
<td>25%</td>
<td>The practice meets 1 factor</td>
</tr>
<tr>
<td>0%</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

### Explanation

*Core meaningful use requirement

**Menu meaningful use requirement

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

**Factor 1:** More than 50 percent of patients (and others with legal authorization to the information) who request an electronic copy of their health information (including problem lists, diagnoses, diagnostic test results, medication lists, allergies) are given one within three business days. Factor 1 addresses the capabilities of the electronic system used by the practice; it does not address legal issues of access to medical record information, such as by guardians, foster parents or caregivers of pediatric patients, or teen privacy rights. If a practice has no requests from patients or families for an electronic copy of patient health information during the EHR reporting period the practice may respond N/A. If N/A is selected for Factor 1, the practice must provide an explanation.

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

**Factor 3:** An **electronic clinical summary** is a summary of a visit that includes, when appropriate, diagnoses, medications, recommended treatment and follow-up. Federal meaningful use rules require that summaries be provided for more than 50 percent of office visits within three business days, either by secure electronic message or as a printed copy from the practice’s electronic system. Patients may be notified that the information is available through a secure, interactive system such as a Web site or patient portal. If the summary is available electronically, the practice must provide the patient with a paper copy upon request.
Factor 4: The practice has a secure, interactive electronic system, such as a Web site, patient portal or a secure e-mail system, allowing two-way communication between patients/families and the practice.

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

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

Documentation

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

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

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

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

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

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

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

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

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

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

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

The practice provides continuity of care for patients/families by:

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.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The practice meets all 3 factors</td>
<td>No scoring option</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

**Explanation**

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

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

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

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

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

**Documentation**

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

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

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

2 points

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

Yes  No

1. The practice is responsible for coordinating patient care across multiple settings  
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

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>The practice meets 3 factors</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

Explanation

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

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

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

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

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

Documentation

- The practice has a **process** for giving patients information and materials about the obligations of a medical home, **and**

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

NCQA requests that the practice highlight, label or otherwise identify the information relevant to each factor in the documentation.
### Element F: Culturally and Linguistically Appropriate Services (CLAS)

<table>
<thead>
<tr>
<th>The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessing the racial and ethnic diversity of its population</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. Assessing the language needs of its population</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3. Providing interpretation or bilingual services to meet the language needs of its population</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>4. Providing printed materials in the languages of its population</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>The practice meets 3 factors</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

#### Explanation

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

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

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

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

#### Documentation

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

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

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

The practice uses a team to provide a range of patient care services by:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Defining roles for clinical and nonclinical team members</td>
<td>☐</td>
</tr>
<tr>
<td>2.</td>
<td>Having regular team meetings or a structured communication process</td>
<td>☐</td>
</tr>
<tr>
<td>3.</td>
<td>Using standing orders for services</td>
<td>☐</td>
</tr>
<tr>
<td>4.</td>
<td>Training and assigning care teams to coordinate care for individual patients</td>
<td>☐</td>
</tr>
<tr>
<td>5.</td>
<td>Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change</td>
<td>☐</td>
</tr>
<tr>
<td>6.</td>
<td>Training and assigning care teams for patient population management</td>
<td>☐</td>
</tr>
<tr>
<td>7.</td>
<td>Training and designating care team members in communication skills</td>
<td>☐</td>
</tr>
<tr>
<td>8.</td>
<td>Involving care team staff in the practice’s performance evaluation and quality improvement activities</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Scoring**

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The practice meets 7-8 factors, including factor 2</td>
<td>The practice meets 5-6 factors, including factor 2</td>
<td>The practice meets 4 factors, including factor 2</td>
<td>The practice meets 2-3 factors or meets 3-7 factors but not factor 2</td>
<td>The practice meets 0-1 factors</td>
</tr>
</tbody>
</table>

**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](http://idahopca.org/programs-services/patient-centered-medical-home-initiative/patient-centered-medical-home-resources)). A structured communication process may include regular e-mail exchanges, tasks or messages about a patient in the medical record.

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

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

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

**Factor 5:** Care team members are trained in evidence-based approaches to self-management support, such as patient coaching and motivational interviewing.
Factor 6: Care team members are trained in the concept of population management and proactively addressing needs of patients and families served by the practice. **Population management** is assessing and managing the health needs of a patient population such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations).

Factor 7: Care team members are trained on effective patient communication for all segments of the practice’s patient population but particularly the vulnerable populations. **Vulnerable populations** are “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability,” (AHRQ) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalizations or ER visits. Training may include information on health literacy, or other approaches to addressing communication needs.

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

**Documentation**

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

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

Factor 3: The practice has written standing orders.

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

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

NCQA encourages the practice to highlight the information relevant to each factor in the documentation.
PCMH 2: Identify and Manage Patient Populations  
16 points

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

### Element A: Patient Information  
3 points

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Date of birth*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Gender*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Race*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ethnicity*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Preferred language*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Telephone numbers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. E-mail address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Dates of previous clinical visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Legal guardian/health care proxy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Primary caregiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Presence of advance directives (NA for pediatric practices)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Health insurance information</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scoring**

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 9-12</td>
<td>The practice meets 7-8</td>
<td>The practice meets 5-6</td>
<td>The practice meets 3-4</td>
<td>The practice meets 0-2</td>
</tr>
<tr>
<td>factors</td>
<td>factors</td>
<td>factors</td>
<td>factors</td>
<td>factors</td>
</tr>
</tbody>
</table>

**Explanation**

*Core meaningful use requirement*

The practice uses a practice management, EHR or other electronic system that collects and records patient information for factors 1-12 in searchable data fields. To meet this element the practice must generate a report showing the percentage of patients seen by the practice for whom data were entered. "Documentation in the medical record of “none”, “no”, “none” or “patient declined to provide information” counts toward the numerator. A data field should not be blank. Fields that have no data do not count. To qualify for Meaningful Use, the practice must meet the related factors using a certified EHR.

**Factor 1:** The practice records patient date of birth.

**Factor 2:** The practice records patient gender.

**Factors 3 and 4:** The practice records race and ethnicity data, in addition to language and age, which contributes to its ability to understand its patient population. The practice may align race and ethnicity categories with those used by the Office of Management and Budget (OMB). Patients who prefer not to provide race/ethnicity may be counted in the numerator if the practice documents their decision to decline to provide the information.
Factor 5: The practice documents the patient’s preferred language. Patients are not required to discuss their language needs, but documentation helps identify patients who need interpretation and translation services. The practice must document that the patient declined to provide language information, that the patient’s primary language is English or that the patient does not need language services. A blank field cannot be assumed to mean that the patient speaks English.

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

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

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

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

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

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

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

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

Documentation

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

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

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Blood pressure, with the date of update for more than 50 percent of patients 2 years and older*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Height for more than 50 percent of patients 2 years and older*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Weight for more than 50 percent of patients 2 years and older*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. System calculates and displays BMI (NA for pediatric practices)*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. System plots and displays growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices)*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients (NA for pediatric practices if all patients &lt;13 years)*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. List of prescription medications with the date of updates for more than 80 percent of patients*</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Scoring**

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 9 factors</td>
<td>The practice meets 7-8 factors</td>
<td>The practice meets 5-6 factors</td>
<td>The practice meets 3-4 factors</td>
<td>The practice meets 0-2 factors</td>
</tr>
</tbody>
</table>

**Explanation**

*Core meaningful use requirement*

The practice collects clinical information on its patients through an EHR. It uses a system that can be searched for each factor and can create reports. Documentation in the medical record of “none” or “patient declined to provide information” counts toward the numerator. To qualify for Meaningful Use, the practice must meet the related factors using a **certified** EHR.

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

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

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

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

**Factor 6:** The practice demonstrates the ability of its electronic system to calculate and display BMI within the medical record. NA may be used for pediatric practices. The practice must provide a written explanation for an NA response.
Factor 7: The practice demonstrates the capability of its electronic system to plot and display length, weight and head circumference on a growth chart for children younger than 2 years. Head circumference in children under 2 is a vital growth parameter that provides a guide to a child’s health, development, nutritional status and response to treatment.

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

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

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

Documentation

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

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

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

Factors 6 and 7: Screen shots demonstrating capability of the electronic system to calculate and display BMI (factor 6) and plot and display growth charts and BMI percentile (factor 7).
**Element C: Comprehensive Health Assessment**  
4 points

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

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.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 8-9 factors</td>
<td>The practice meets 6-7 factors</td>
<td>The practice meets 4-5 factors</td>
<td>The practice meets 2-3 factors</td>
<td>The practice meets 0-1 factors</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation**

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

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

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

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

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

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

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

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

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

Factor 9: The USPSTF recommends:
- **Adults**: Screening adults for depression when staff-assisted depression care support systems are in place to assure accurate diagnosis, effective treatment and follow-up.
- **Adolescents (12–18 years)**: Screening for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up.

**Documentation**

Factors 1–9: The practice provides a process showing how the information is consistently collected or a completed patient assessment (de-identified) of the factors documented during the health assessment. NCQA encourages practices to highlight or otherwise indicate the information in the documentation that meets each factor. Do not provide large portions of a medical record.
Element D: Use Data for Population Management 5 points

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

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

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice uses information to take action on all 4 factors</td>
<td>The practice uses information to take action on 3 factors</td>
<td>The practice uses information to take action on 2 factors</td>
<td>The practice uses information to take action on 1 factor</td>
<td>The practice uses information to take action on no factors</td>
</tr>
</tbody>
</table>

Explanation **Menu meaningful use requirement

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

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

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

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

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

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

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

**Factor 3:** The practice generates lists of patients who may have been overlooked and who have not been seen recently. The practice may use its own criteria, such as a care management follow-up visit or an overdue periodic physical exam.
Factor 4: The practice generates lists of patients on specific medications; the lists may be used to manage patients who were prescribed medications with potentially harmful side effects, to identify patients who have been prescribed a brand name drug instead of a generic drug or to notify patients about a recall.

Documentation

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

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

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

and

- *Materials* showing how patients are notified of needed services (e.g., letters sent to patients, a script or description of phone reminders, screen shots of electronic notices).
PCMH 3: Plan and Manage Care

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**

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

1. The first important condition
   - Yes
   - No

2. The second important condition
   - Yes
   - No

3. The third condition, related to unhealthy behaviors or mental health or substance abuse.
   - Yes
   - No

**Scoring**

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 3 factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No scoring option</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice meets 2 factors, including factor 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice meets 1 factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice meets no factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 (frequently referred to as clinical decision support) and by using registries that proactively identify and engage patients who are lacking important services (as in PCMH 2, Element D).

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

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

When selecting conditions, practices should consider the following:

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

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

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

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets both factors</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>The practice meets 1 factor</td>
<td>The practice does not meet either factor</td>
</tr>
</tbody>
</table>

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

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

**Pediatric populations**

- Practices may identify children and youth with special health care needs who are defined by the U.S. Department of Health and Human Services Maternal and Child Health Bureau (MCHB) as children “who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who require health and related services of a type or amount beyond that required generally.” (Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, American Academy of Pediatrics, 3rd Edition, 2008, p. 18.)

- Additional care management guidelines for children and youth with special needs are included in the following publication: Caring for Children Who Have Special Health-care Needs: A Practical Guide for the Primary Care Practitioner. Matthew D. Sadof and Beverly L. Nazarian, *Pediatr. Rev.* 2007;28;e36-e42 http://pedsinreview.aappublications.org/cgi/content/full/28/7/e36

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

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

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

**Documentation**

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

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

- **Denominator** = Total number of patients in the practice
- **Numerator** = Patients identified in the denominator as high risk or complex
### Element C: Care Management

**MUST-PASS**

The care team performs the following for at least 75 percent of the patients identified in Elements A and B.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Enter Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conducts pre-visit preparations</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3. Gives the patient/family a written plan of care</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>4. Assesses and addresses barriers when the patient has not met treatment goals</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>5. Gives the patient/family a clinical summary at each relevant visit</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6. Identifies patients/families who might benefit from additional care management support</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>7. Follows up with patients/families who have not kept important appointments</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

### Scoring

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 6-7 factors</td>
<td>The practice meets 5 factors</td>
<td>The practice meets 3-4 factors</td>
<td>The practice meets 1-2 factors</td>
<td>The practice meets no factors</td>
<td></td>
</tr>
</tbody>
</table>

### 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. If there are no changes in the care plan at relevant visits, the practice must document this in the medical record.

**Relevant visits** are determined by the practice and the clinician, but should be with regard to:
• Important or chronic conditions, including well-child visits for practices with pediatric patients
• Visits that result in a change in treatment plan or goals
• Additional instructions or information for the patient/family
• Visits associated with transitions of care.

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

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

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

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

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

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

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

**Documentation**

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

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

**Method 1**

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

• **Denominator** = Total number of patients with important conditions and patients identified as high-risk or complex who had at least one visit related to the important condition in a recent three month period
• **Numerator** = Number of patients identified in the denominator for whom each item is entered in the medical record
Method 2

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

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

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

**Element D: Medication Management 3 points**

The practice manages medications in the following ways.

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 with date of assessment
   
5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment
   
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates

<table>
<thead>
<tr>
<th>Scoring</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice</td>
<td>The practice</td>
<td>The practice</td>
<td>The practice</td>
<td>The practice</td>
<td>The practice</td>
</tr>
<tr>
<td>meets 5-6</td>
<td>meets 3-4</td>
<td>meets 2</td>
<td>meets factor 1</td>
<td>meets factor 1</td>
<td>meets no</td>
</tr>
<tr>
<td>factors,</td>
<td>factors,</td>
<td>factors,</td>
<td>factor 1</td>
<td>factors or</td>
<td>factors or</td>
</tr>
<tr>
<td>including</td>
<td>including</td>
<td>including</td>
<td></td>
<td>does not meet</td>
<td>does not meet</td>
</tr>
<tr>
<td>factor 1</td>
<td>factor 1</td>
<td>factor 1</td>
<td></td>
<td>factor 1</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Factors 1 and 2: It is important for the practice to review and document in the medical record all prescribed medications a patient is taking. The practice reviews and reconciles medications following visits to specialists, as well as ER visits and hospitalizations. Medication review and reconciliation should occur at transitions of care and at relevant visits, at least annually. The practice may define “relevant visit.”
Maintaining a current list of a patient’s medications and resolving any conflicts with medications reduces the possibility of duplicate medications, medication errors or adverse drug events. Having a process for medication reconciliation is essential for patient safety. Thus, Factor 1 has been identified as a critical factor and is required for practices to receive any score on the element.

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

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

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

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

Documentation

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

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

Method 1

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

- Denominator = Total number of patients with important conditions and patients identified as high-risk or complex who had at least one visit related to the important condition in a recent three month period
- Numerator = Number of patients identified in the denominator for whom each item is entered in the medical record

Method 2

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

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

Not Applicable is an option in the Record Review Workbook drop-down menu for each factor in this element and may be used for patients who have not been prescribed any medications.
Note: A patient may fall into more than one category (across the three conditions and the definition of “high risk” or “complex”), but each patient is counted only once. Factors must be successfully addressed for all conditions for the practice to respond “Yes.”

### Element E: Use Electronic Prescribing

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice uses an electronic prescription system with the following</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>capabilities.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies*  
2. Generates at least 75 percent of eligible prescriptions  
3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list*  
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

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>The practice meets 5-6 factors, including factor 2</td>
</tr>
<tr>
<td>75%</td>
<td>The practice meets 4 factors, including factor 2</td>
</tr>
<tr>
<td>50%</td>
<td>The practice meets 2-3 factors, including factor 2</td>
</tr>
<tr>
<td>25%</td>
<td>The practice meets 1 factor or meets 2-5 factors but not factor 2</td>
</tr>
<tr>
<td>0%</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

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

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

Since the remainder of the factors are only of value if the system is being actively used to write prescriptions, factor 2 has been designated as a critical factor required to receive more than 25 percent of the available points for this element.
Factor 3: The practice’s electronic prescribing system is integral to patient records, allowing it to view patient diagnoses, patient medications, enter new medications or make changes and identify documented allergies. The practice uses the electronic prescribing system to enter medications prescribed to its patients. If a practice writes fewer than 100 prescriptions during the reporting period the response in the survey tool may be NA. The practice must provide a written explanation for an NA response. The practice must enter the number of prescriptions written during the reporting period in the survey tool or a linked document to attest to exclusion from this requirement.

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

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

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

Documentation

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

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

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

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

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

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

Factor 2 alternate documentation

The practice provides:

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

and

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

and

- Explanation of how this calculation meets the 75% requirement
Factor 3: The practice provides reports from the electronic system.

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

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

Factors 4–6: The practice provides reports from the electronic system or screen shots demonstrating the system’s capabilities.
PCMH 4: Provide Self-Care Support and Community Resources

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

### Element A: Support Self-Care Process

**MUST-PASS**

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

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 5-6 factors, including factor 3</td>
<td>The practice meets 4 factors, including factor 3</td>
<td>The practice meets 3 factors, including factor 3</td>
<td>The practice meets 1-2 factors or meets 3-5 factors but not factor 3</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

### Explanation

**Menu meaningful use requirement**

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

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

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

Factor 1: Educational programs and resources may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, Web site links and pamphlets, as well as community resources (e.g., programs, support groups). Based on the practice's assessment of languages spoken by its patients (PCMH 2, Element A), materials in languages other than English should be available for patients/families, if appropriate.
Patients/families may be referred to resources outside the practice, with consideration that resources may not be covered by health insurance. Self-management programs may include asthma education, diabetes education and other classes or groups as well as referrals to community resources for the uninsured and underinsured or for transportation assistance to medical appointments for patients.

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

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

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

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

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

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

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

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

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

Method 1

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

Denominator = Total number of patients with important conditions and patients identified as high-risk or complex who had at least one visit related to the important condition in a recent three month period

- Numerator = Number of patients identified in the denominator for whom each item is entered in the medical record

Method 2

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

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

**Note:** A patient may fall into more than one category (across the three conditions and the definition of “high risk” or “complex”), but each patient is counted only once.
Element B: Provide Referrals to Community Resources

The practice supports patients/families that need access to community resources:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Maintains a current resource list on five topics or key community service areas of importance to the patient population
   
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Tracks referrals provided to patients/families
   
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Arranges or provides treatment for mental health and substance abuse disorders
   
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Offers opportunities for health education programs (such as group classes and peer support.)
   
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>The practice meets 3 factors</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>Practice does not provide services</td>
</tr>
</tbody>
</table>

Explanation

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

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

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

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

Factor 3: The practice provides treatment or identifies a treatment provider and helps patients get care for mental health and substance abuse problems, if needed.
Factor 4: The practice provides or makes available health education classes that may include alternative approaches such as peer-led discussion groups or shared medical appointments. In a shared medical appointment or group visit, multiple patients meet in a group setting for follow-up or routine care. These types of appointments may offer access to a multidisciplinary care team and allow patients to interact with and learn from each other.

**Documentation**

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

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

Factors 3 and 4: The practice has a documented process and a sample of available resources.
PCMH 5: Track and Coordinate Care  

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

Element A: Test Tracking and Follow-Up  

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Tracks lab tests until results are available, flagging and following up on</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>overdue results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Tracks imaging tests until results are available, flagging and following up</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>on overdue results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Flags abnormal lab results, bringing them to the attention of the clinician</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Flags abnormal imaging results, bringing them to the attention of the</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>clinician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Notifies patients/families of normal and abnormal lab and imaging test</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Follows up with inpatient facilities on newborn hearing and blood-spot</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>screening (NA for adults)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Electronically communicates with labs to order tests and retrieve results</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Electronically communicates with facilities to order and retrieve imaging</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Electronically incorporates at least 40 percent of all clinical lab test</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>results into structured fields in medical records**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Electronically incorporates imaging test results into medical records.</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Scoring

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>The practice meets 8-10 factors, including factors 1 and 2</td>
</tr>
<tr>
<td>75%</td>
<td>The practice meets 6-7 factors, including factors 1 and 2</td>
</tr>
<tr>
<td>50%</td>
<td>The practice meets 4-5 factors, including factors 1 and 2</td>
</tr>
<tr>
<td>25%</td>
<td>The practice meets 3 factors, including factors 1 and 2</td>
</tr>
<tr>
<td>0%</td>
<td>The practice meets fewer than 3 factors or does not meet factors 1 and 2</td>
</tr>
</tbody>
</table>

Explanation

**Menu meaningful use requirement

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

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

Ineffective management of laboratory and imaging test results can result in less than optimal care and may compromise patient safety. Thus, Factors 1 and 2 have been identified as critical factors and are required for practices to receive any credit for this element.
Factors 3 and 4: Abnormal results of lab or imaging tests are flagged or highlighted and brought to the attention of the clinician to ensure timely follow-up with the patient/family.

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

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

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

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

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

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

Documentation

Factors 1–8, 10: The practice has a written process or procedure for staff and an example of how the process is met for each factor.

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

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

• **Denominator** = Number of lab tests ordered during the reporting period with results expressed in a positive or negative affirmation or as a number

• **Numerator** = Number of lab tests whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
Element B: Referral Tracking and Follow-Up

**MUST-PASS** 6 points

The practice coordinates referrals by:

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

### Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 5-7 factors</td>
<td>The practice meets 4 factors</td>
<td>The practice meets 3 factors</td>
<td>The practice meets 1-2 factors</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

### 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.

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

**Factor 1:** Information included in the referral communication to the specialist includes:
- Reason for and urgency of the referral
- Relevant clinical information (e.g., patient’s family and social history, clinical findings and current treatment)
- General purpose of the referral (e.g., consultative, transfer of care, co-management) and necessary follow-up communication or information.

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

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

**Factor 3:** If the practice does not receive a report from the specialist, it contacts the specialist’s office about the report’s status and the expected date for receiving the report, and documents the effort to retrieve the report in a log or electronic system.
Factor 4: For patients who are regularly treated by a specific specialist, the primary care clinician and the specialist enter into an agreement that enables co-management of the patient’s care and includes timely sharing of changes in patient status and treatment plan. For co-managed patients, the primary clinician gives information to the specialist and receives information from the specialist within a period agreed to by both parties. This information is documented in the medical record.

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

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

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

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

Documentation

The practice provides:

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

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

Factor 6: Screenshot or other documentation showing a test of the capability of the EHR to exchange key clinical information. To qualify for Meaningful Use, the practice must meet the related factors using a certified EHR.
Factor 7: This element calls for calculation of a percentage that requires a numerator and a denominator. The practice provides reports from the electronic system. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

The practice may use the following methodology to calculate the percentage.
- Denominator = Number of referrals during the EHR reporting period
- Numerator = Number of referrals in the denominator where a summary of care record was provided.

<table>
<thead>
<tr>
<th>Element C: Coordinate With Facilities and Manage Care Transitions</th>
<th>6 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>On its own or in conjunction with an external organization, the practice systematically:</td>
<td>Yes</td>
</tr>
<tr>
<td>1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit</td>
<td>☐</td>
</tr>
<tr>
<td>2. Demonstrates its process for sharing clinical information with admitting hospitals and emergency departments</td>
<td>☐</td>
</tr>
<tr>
<td>3 Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities</td>
<td>☐</td>
</tr>
<tr>
<td>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</td>
<td>☐</td>
</tr>
<tr>
<td>5. Demonstrates its process for exchanging patient information with the hospital during a patient’s hospitalization</td>
<td>☐</td>
</tr>
<tr>
<td>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 or family medicine practices)</td>
<td>☐</td>
</tr>
<tr>
<td>7. Demonstrates the capability for electronic exchange of key clinical information with facilities</td>
<td>☐</td>
</tr>
<tr>
<td>8. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care**</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities include 5-8 factors</td>
<td>Activities include 4 factors</td>
<td>Activities include 2-3 factors</td>
<td>Activities include 1 factor</td>
<td>Activities include no factors</td>
</tr>
</tbody>
</table>

### Explanation

**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. Adult-only practices or family practices that do not transition pediatric patients to another clinician may enter an NA response. The practice must provide a written explanation for an NA response.

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

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

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

The practice provides:

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

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

**Factor 3:** A documented process for obtaining hospital discharge summaries and at least three examples of a discharge summary.

**Factor 4:** A documented process that includes the practice’s period for patient follow-up after a hospital admission or ER visit; at least three de-identified examples of documented patient follow-up in the medical record, or a log with at least one week of data documenting systematic follow-up.

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

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

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

To qualify for Meaningful Use, the practice must meet the related factors using a certified EHR.

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

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

- **Denominator** = Number of transitions to another care setting during the EHR reporting period
- **Numerator** = Number of transitions of care in the denominator where a summary of care record was provided.
PCMH 6: Measure and Improve Performance

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

Element A: Measure Performance

<table>
<thead>
<tr>
<th>The practice measures or receives data on the following:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At least three preventive care measures</td>
<td></td>
<td>F</td>
</tr>
<tr>
<td>2. At least three chronic or acute care clinical measures</td>
<td></td>
<td>F</td>
</tr>
<tr>
<td>3. At least two utilization measures affecting health care costs</td>
<td></td>
<td>F</td>
</tr>
<tr>
<td>4. Performance data stratified for vulnerable populations (to assess disparities in care).</td>
<td></td>
<td>F</td>
</tr>
</tbody>
</table>

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>The practice meets 2-3 factors</td>
<td>No scoring option</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

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](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 one or more measures from 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 co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

Documentation

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

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

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

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/self-management support

2. The practice uses the CAHPS Patient-Centered Medical Home (PCMH) 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.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice meets 3 factors</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice meets 2 factors</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice meets 1 factor</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice meets no factors</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Explanation

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

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

- **Access** may include routine, urgent and after-hours care
- **Communication** with the practice, clinicians and staff may include feeling respected, listened to and able to get answers to questions
- **Coordination of care** may include being informed and up-to-date on referrals to specialists, changes in medications and lab or imaging results
- **Whole person care/self-management support** may include the provision of comprehensive care and self-management support and emphasizing the spectrum of care needs such as mental health; routine and urgent care; advice, assistance and support for making changes in health habits and making health care decisions.

Factor 2: The practice uses the standardized CAHPS Patient-Centered Medical Home (PCMH) survey tool to collect patient experience data.

Note

- The CAHPS Patient-Centered Medical Home (PCMH) Survey Tool was released September 30, 2011. At that time, practices may use it to collect patient experience data to meet Factor 2. Since it was not available until early fall, 2011, Factor 2 may be marked NA until April 1, 2012. As of April 1, 2012, the NA option will no longer be available.
- In addition, in April 2012, practices will be able to receive Distinction from NCQA for using the CAHPS PCMH survey to collect patient experience data and:
  - Using a specific methodology for collecting the data,
  - Using a certified vendor to collect the data and
  - Reporting the results to NCQA which will be used to benchmark patient experience data.

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

Vulnerable populations are “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability,” (AHRQ) and include people with multiple 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. Practices may use a feedback methodology conducive to its population of patients/families or parents, such as “virtual” participation such as by phone or video conference.

Documentation

Factors 1–4: The practice provides reports with summarized results of patient feedback. A blank Survey Tool does not meet the intent of this element.
**Element C: Implement Continuous Quality Improvement**

**MUST-PASS**

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

**Scoring**

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 3-4 factors</td>
<td>No scoring option</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

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

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

Vulnerable populations are “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability,” (AHRQ) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.
Factor 4: The practice has a process for involving patients and their families in its quality improvement efforts. At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team meetings.

Documentation

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

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

<table>
<thead>
<tr>
<th>Element D: Demonstrate Continuous Quality Improvement</th>
<th>3 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by:</td>
<td>Yes</td>
</tr>
<tr>
<td>1. Tracking results over time</td>
<td>☐</td>
</tr>
<tr>
<td>2. Assessing the effect of its actions</td>
<td>☐</td>
</tr>
<tr>
<td>3. Achieving improved performance on one measure</td>
<td>☐</td>
</tr>
<tr>
<td>4. Achieving improved performance on a second measure</td>
<td>☐</td>
</tr>
</tbody>
</table>

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>The practice meets 3 factors</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

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.


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

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

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

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

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

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

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

Element E: Report Performance 3 points

The practice shares performance data from Element A and Element B: Yes No

1. Within the practice, results by individual clinician

2. Within the practice, results across the practice

3. Outside the practice to patients or publicly, results across the practice or by clinician.

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 3 factors</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>No scoring option</td>
<td>The practice does not share performance data</td>
</tr>
</tbody>
</table>

Explanation

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

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

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

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

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

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

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

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

Element F: Report Data Externally

<table>
<thead>
<tr>
<th>The practice electronically reports:</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ambulatory clinical quality measures to CMS or states*</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Ambulatory clinical quality measures to other external entities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Data to immunization registries or systems**</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Syndromic surveillance data to public health agencies**</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice reports all 3-4 types of data</td>
<td>The practice reports 2 types of data</td>
<td>The practice reports 1 type of data</td>
<td>No scoring option</td>
<td>The practice does not report any type of data</td>
</tr>
</tbody>
</table>

Explanation

*Core meaningful use requirement

**Menu meaningful use requirement

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

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

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

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

Factor 4: The practice performed at least one test of the EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful. This factor will be NA if none of the public health agencies to which the practice submits such information has the capacity to receive the information electronically or if the practice did not collect any reportable syndromic information on their patients during the past 12 months (3 months if 12 months is not available). To qualify for Meaningful Use, the practice must meet the related factors using a certified EHR.
Factors 1 and 2: The practice provides reports demonstrating electronic data transmission to CMS, states, other entities and public health agencies.

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

Element G: Use Certified EHR Technology

This element is for your practice site Meaningful Use report only and will NOT be scored for your PCMH Recognition decision.

NOTE: Factor 1 requires comments.

To meet the federal Core and Menu Meaningful Use requirements:

1. The practice uses an EHR system (or modules) that has been certified and issued a Certified HIT Products List (CHPL) Number(s) under the ONC (Office of the National Coordinator for Health Information Technology) HIT certification program

2. The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules) and implementing security updates as necessary and correcting identified security deficiencies

Scoring

<table>
<thead>
<tr>
<th>Percentage</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No scoring option</td>
<td>Yes</td>
<td>No</td>
<td>Comment Needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explanation

"Core meaningful use requirement"

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

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

The following links provide additional information:

- Link for Core Meaningful Use requirement #15, Protect Electronic Health Information: http://www.cms.gov/EHRIncentivePrograms/Downloads/15ProtectElectronicHealthInformation.pdf

Factor 1: The practice provides the Certified HIT Products List (CHPL) Number(s) number(s) of the software system (or modules) used by the practice. Since the practice may use more than one software system, all must be listed.
Factor 2: The practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies.

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

Documentation

Factor 1: In the comment box in the survey tool, the practice enters the Certified HIT Products List (CHPL) Number(s) of all EHR systems (or modules) the practice uses to perform the designated Core and Menu Meaningful Use requirements.

Factor 2: By entering a “yes” response in the PCMH 2011 survey tool, the practice attests to: conducting the required security risk analysis of its certified EHR system (or modules) and implementing security updates as necessary and correcting identified security deficiencies.