

Patient-Centered Medical Home 2014 Standards Frequently Asked Questions

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Click the page number in the table of contents to navigate to a specific standard, element or factor. All questions and resources in these FAQs outlined in black address pediatric-specific inquiries.

For more resources pertaining to both adult and pediatric policies, procedures, templates and evidence-based guidelines, visit <http://www.ncqa.org/recognitionprogramsresources>.

Submit additional questions via the Program/Policy Clarification System at <https://my.ncqa.org/>.

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Standard 1: Patient-Centered Access

Element 1A: Patient-Centered Appointment Access

Factor 1

Are practices required to measure their capacity to see patients or to measure the utilization of same-day appointments (i.e., number of patients seen)?

For factor 1, practices are expected to show both availability (which can be a demonstration of open appointment slots at the beginning of the day) and use of same-day appointments for a period of five consecutive days. Practices should also monitor the availability of same-day appointments against their documented process. Practices may use utilization of same-day appointment access as an indication of patient need.

Are practices required to reserve separate same-day appointment slots for routine *and* urgent visits?

Practices must show appointment slots that are available for both urgent/acute and routine care, but may have a policy to accommodate patients with urgent/acute care needs first.

Are practices required to provide a minimum number of same-day appointments?

NCQA does not require a minimum number of same-day appointments per day for practices, and not all clinicians must offer same-day appointments. Practices must have a written policy or process for staff to ensure availability of same-day appointments and how patients can get them, and must provide a report of 5 days of the availability of same-day appointments.

Our clinic has walk-in appointments available every day. Do these count as same-day appointments?

No. Clinics must have scheduled same-day appointments to meet the requirements of the factor. Same-day appointments offer patients the opportunity to schedule a routine or urgent visit at a specific time to enable more patient-centered and convenient access; this prevents the need to wait for the next available provider at the clinic. Practices must provide a report showing the availability and use of same-day appointments for at least five days.

May practices block nurse practitioners' schedules for same-day appointments?

Yes. Practices may use nonphysician members of the clinical care team, such as nurse practitioners or physician assistants (PA) who have their own panel of patients, to plan for same-day appointments. There is no requirement for all providers to have same-day appointment slots available every day.

Factor 2

Our practice is open from 8 am–5 pm. Would opening from 7 am–4 pm meet the requirements of this factor? How does NCQA define “regular business hours”?

“Regular business hours” are the usual hours of operation. The intent of factor 2 is that practices provide appointments outside regular business hours, not that they shift business hours. Therefore, if a practice’s regular business hours are 8 am–5 pm, Monday–Friday, providing extended hours (e.g., opening at 7 am; staying open until 7 pm) on certain days or having appointments on Saturday mornings meets the requirement. NCQA does not prescribe specific regular and extended hours; practices establish their own regular business hours and extended hours.

Our practice is open one evening a week. Does this meet the requirement for “outside regular business hours”?

Yes, being open one evening a week meets the requirement for outside regular business hours.

May practices refer patients to an associated urgent care site or facility for care outside regular business hours?

Practices may refer patients to associated urgent care sites or facilities (i.e., facilities with which the practice has a relationship or an agreement to work together) to meet the intent of factor 2, but must provide a documented process demonstrating how patients are referred to facilities for scheduled routine and urgent appointments, and must provide a report demonstrating that patients are obtaining such appointments. The facility must have access to patient medical records outside regular business hours.

We are a hospital-owned practice; the ED serves as an after-hours clinic. Does this meet the requirements?

No. Factor 2 requires practices to offer appointment hours outside regular business hours for both routine and urgent care. Using the ED for after-hours care does not meet the requirement since patients cannot schedule and access routine appointments at the ED.

How do practices document that they provide appointments outside regular business hours?

Practices may provide a documented process or policy that demonstrates how they arrange for routine and urgent appointments outside of business hours, and either a report showing the availability and use of appointments outside regular hours or materials, such as a brochure or a screenshot of a Web site, showing practice hours.

If a practice cannot provide care outside regular hours, it must provide a documented process for arranging for care with other facilities.

Factor 3

What are “alternative clinical encounters”?

“Alternative clinical encounters” are scheduled clinical encounters between patient and clinician in lieu of a traditional, one-on-one, in-person office visit; for example:

- A scheduled telephone clinical visit.
- A scheduled clinical home visit.
- A scheduled clinical group visit where clinical care is provided (not an educational class).
- A scheduled clinical video chat visit.

Do diabetes educational classes meet the requirement for “alternative appointment”?

No, educational classes do not meet the requirement. Scheduled group visits with a clinician to discuss care management and where clinical care is provided qualify as an alternative appointment. The clinician providing care must hold a current, unrestricted license as a doctor of medicine (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN) or PA. APRNs (including nurse practitioners and clinical nurse specialists) and PAs who do not have or share a panel of patients do not qualify as clinicians.

Our practice has a contract with a telehealth company that provides primary care to patients when they cannot come into the office. Does this meet the requirement for an alternative clinical encounter?

Yes, this meets the requirement if the telehealth provider is a clinician and has access to practice systems and the patient's medical record.

A behavioral healthcare practitioner is integrated with our practice and provides telepsychiatry visits. Does this meet the requirement for an alternative clinical encounter?

Yes. NCQA accepts telepsychiatry visits as an alternative clinical encounter if the behavioral healthcare practitioner is at least partially integrated with the practice site (i.e., sharing at least partial access to the same systems and patient records). Because integration of behavioral healthcare is a critical part of patient care, NCQA accommodates practices' efforts at innovative solutions to access.

If a pediatrician sees more than one child from the same family during one visit, does this meet the requirement for an alternative clinical encounter?

Yes. Practices must provide:

- A documented process for scheduling alternative clinical encounters and the types of encounters provided.
- A report of alternative clinical encounters in a recent 30 calendar-day period, and encounter dates.

Factor 4

Our practice has an open access policy for available appointment slots and the same standard for appointment wait times, regardless of appointment type (zero days for all appointments). May we submit one data point to demonstrate appointment availability?

Yes. One data point reported for five consecutive days meets factor 4 if a practice does not distinguish between appointment types in its documented process and has a standard appointment wait time. The data must compare actual appointment wait time (availability) with the standard specified in the documented process.

Element 1B: 24/7 Access to Clinical Advice

Factors 1, 2

Our practice offers night and weekend clinical advice coverage to patients through a phone service staffed by RNs. Does this meet the requirement for access to clinical advice?

Yes, if the phone service can provide after-hours access (factor 2) and can access the patient's medical record either directly or through an available on-call provider with direct access (factor 1).

Note: For factors 1 and 2, practices must provide a documented process and submit a report tracking response times for at least seven days during business hours and after hours for factor 2.

- **AAP practice transformation resources—telephone care:**
 - <https://www.aap.org/en-us/professional-resources/practice-support/Telephone-Care/Pages/Telephone-Care.aspx>

Factor 3

Our patient portal has a message telling patients that the office will respond to requests for clinical advice on the next business day *and* that patients should contact the on-call provider if the office is closed. Does this meet the requirement?

Yes. The requirement is met if the response time is documented when a patient submits an electronic request for clinical advice and the practice communicates to patients that an on-call provider is available to address urgent issues by telephone after hours. Practices must have a documented process for addressing electronic advice and telephone advice; for factor 3, practices must submit a report tracking response times to electronic requests for at least seven days during operating hours and after hours.

How does NCQA define “timely” phone or e-mail clinical advice? Are practices required to document response time?

Practices define “timely” advice after considering the needs of their population. Practices must submit their written policy for responding to calls and e-mails, which may categorize the types of requests and appropriate response times.

Practices must also monitor and demonstrate their documented process defining response times to a nonurgent message and a report summarizing response times.

Factor 4

After receiving a call overnight, the on-call provider calls our practice on the next morning to report the call, and the primary care practitioner’s nurse documents a note in the patient’s medical record. Does this meet the requirement?

Yes. The information does not have to be entered into the medical record in “real time,” but it is essential that it is entered into the patient’s medical record as soon as possible on the following day after the provider speaks with the patient. This method should be outlined in a practice’s documented process.

Element 1C: Electronic Access**Factor 1**

Does factor 1 require that more than 50 percent of patients access their health information and view it?

No. Factor 1 only requires that more than 50 percent of patients have timely online access to their health information after the information being available to the practice. Consistent with CMS requirements, providing online access to more than 50 percent of patients in this factor refers to “providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.”

The denominator should include all unique patients who were seen by the practice during the reporting period (at least three months of recent data, as defined in the standards and guidelines).

For information about Meaningful Use requirements, go to: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>.

Note: *To align with the Meaningful Use Modified Stage 2 Final Rule Objective 8 (Patient Electronic Access [VDT]) released in October 2015, practices may provide a report showing timely access; the Stage 2 Final Rule required access be provided within four business days of the information being available to the practice but that specific time frame is no longer required. Practices define “timely.”*

Our practice makes lab and test results available upon patient request. Does measuring the time frame for responding to a patient's request for this information meet the requirement?

This factor addresses patient access to health information online rather than patient requests for information. NCQA expects practices to have patient health information available to patients, but accepts that there is more than one way to make information available to patients.

Note: Refer to Element 5A for information about notifying patients of lab and test results.

How do practices account for adolescent confidentiality issues; for example, if an adolescent asks that information not be shared with a parent?

Pediatric practices are not penalized for not sharing information with parents if an adolescent requests that information not be shared, but applicants must explain the exclusion of adolescent patients in the associated documentation. The denominator must include only legitimate requests for information based on state and federal confidentiality requirements.

- **AAP resources:**

- Confidentiality considerations in the care of young adolescents, AAP News 2008;29;15:
<http://aapnews.aappublications.org/cgi/reprint/29/7/15.pdf>

Factor 2**Must 5 percent of a practice's patients view, download *and* transmit health information to a third party to meet the requirement for this factor?**

No. To align with the Meaningful Use Modified Stage 2 Final Rule released in October 2015, NCQA will accept a screen shot demonstrating use or capability (Objective 8 – Patient Electronic Access [VDT]). NCQA will also accept a report but practices no longer need to demonstrate the “more than 5 percent” threshold.

For information about Meaningful Use requirements, go to: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>.

Where can practices find information about the number of housing units with broadband availability?

CMS states in the Modified Stage 2 Final Rule that any eligible provider who “conducts 50 percent or more of patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period” may be excluded from the measure. Information is available on the National Broadband Map, which can be found at: <http://www.broadbandmap.gov/>.

If CMS makes changes to the MU2 requirements, will NCQA change the standards to align with the changes?

NCQA tracks proposed changes and considers whether changes will be made to PCMH requirements. NCQA will not change requirements to align with MU changes without internal review.

Factor 3**What constitutes a “clinical summary”? What types of information meet this standard, including for well-child visits?**

For a visit covering acute or chronic conditions, an electronic clinical summary might include a child’s diagnosis, medications, recommended treatment and follow-up, and information about home management of an acute or chronic condition, when appropriate.

For a well-child visit, an electronic clinical summary might include the child’s anticipated developmental milestones based on age, and anticipatory guidance (e.g., well-child handouts with information specific to the child and the visit, such as length/height, weight, immunizations and developmental expectations).

Is a clinical summary necessary for pediatric acute care visits? It is likely that a patient will have almost recovered within three business days.

Yes, a clinical summary is necessary. Practices must document that clinical summaries are provided to patients upon request. This requirement was updated in response to the Meaningful Use Modified Stage 2 final rule released in October 2015. As of November 2015, NCQA accepts a report demonstrating provision of clinical summaries, but the previous threshold requirement of “more than 50 percent” is no longer required.

Ideally, summaries are distributed immediately following the visit, but it is up to the practice to determine the appropriate follow-up time based on patient need. The clinical summary for acute care visits may include warnings and instructions about prescriptions, complicating conditions, when to follow up, when to escalate the need for care and so on.

- **AAP resources:**

- Bright Futures Visit Parent/Patient Education Handouts and Visit Documentation forms (spanning infancy, early childhood, middle childhood, and adolescent care visits): http://brightfutures.aap.org/tool_and_resource_kit.html
- AAP Consumer Education Brochures (e.g., Common Childhood Infections, Acute Ear Infections and Your Child): <http://shop.aap.org/aap-store/categories/patient-education/>
- Special Requirements of Electronic Health Record Systems in Pediatrics, Pediatrics; Vol. 119 No. 3 March 2007, pp. 631-637: <http://pediatrics.aappublications.org/content/119/3/631>

Factors 5, 6**Does a screenshot of the Web page showing available practice activities meet the requirements for factors 5 and 6?**

Documentation is a “screen shot demonstrating system capability.” This could be multiple screenshots (one of the Web portal page and screenshots for each factor) or one screenshot showing evidence of capabilities required by both factors (secure two-way communication, requesting medication refills, appointments and requesting a referral or test). The screenshot must clearly represent an active Web site.

Standard 2: Team-Based Care

Element 2A: Continuity

Factor 1

How should residency clinics handle clinician selection?

Residency clinics should give patients the option to choose a care team that is under the direction of a staff or supervising physician. The personal clinician would not be a resident because residents do not stay at one location and will no longer be associated with the clinic when their rotation ends.

Is there a specific threshold or percentage of patients who are required to have a selected personal physician?

No. NCQA does not have a specific expectation regarding the percentage of patients who have a personal clinician; however, practices should have a process to notify patients about the importance of choosing a personal clinician or care team, and the choice should be documented in all patient records.

Factor 2

Urgent care visits or visits during extended hours may not be available with a patient's primary care clinician. Does NCQA require a particular percentage of visits must be with a selected primary care clinician?

No. NCQA does not prescribe a percentage, nor does it expect patients to be seen by their selected primary care clinician for a specific percentage of visits.

Factor 4

How can nonpediatric practices (adults only or family) demonstrate a plan to facilitate physician transitions if they either do not transition patients or have patients who keep the same physician?

Yes. All practices are required to support patient transitions from pediatric care to adult care. Pediatric practices must show a written plan for patient transitions. Internal medicine must show materials and a process for reviewing a transitioned patient. Family medicine practices must show materials and a process to contact transitioning patients to initiate their own care, whether or not they change their primary care clinician.

The practice should inform patients and families about the medical home concept and the importance of having a primary care clinician to provide regular, evidence-based preventive care and acute adolescent care management. Sensitivity to teen privacy concerns should be incorporated into information provided to teens.

Does transitioning from pediatric care to adult care occur when patients turn 13, 18 or 21?

NCQA is not prescriptive regarding the age children/adolescents should transition to adult care. Ideally, children should transition to adult-oriented health care between the ages of 18 and 21 years but some practices have been known to start talking to them as early as age 12 about assuming more responsibility for their healthcare, forming a personal relationship with their PCP and talking to them about sensitive events or issues they may be afraid to talk to others about. However, it is up to the practice to determine at what age and/or circumstance transition planning is initiated.

Element 2B: Medical Home Responsibilities**Is a practice brochure sufficient documentation for this element?**

This element requires both a documented process describing how information is distributed to patients, and patient materials that include the content from each factor in Element 2B. If the practice's documented process is included in a patient brochure, that brochure could be sufficient documentation for the element.

Is a written agreement required for this element?

No. A written agreement, or form signed by the provider and the patient agreeing to their mutual medical home responsibilities, is not required.

Factor 4**How can practices demonstrate that they provide access to evidence-based care to patients and their families?**

Practices are expected to provide patients with care that is based on current evidence and treatment guidelines. Information about care can be provided to patients through materials that include brochures, flyers or information posted on the practice Web site.

Element 2C: Culturally and Linguistically Appropriate Services**Factor 1****How does NCQA define “another characteristic of diversity”?**

The standards and guidelines state, “Diversity is a meaningful characteristic of comparison for managing population health that accurately identifies individuals within a non-dominant social system who are underserved.” Examples include, but are not limited to, first ancestry, age, marital status, employment status, education level, housing status and income.

How can practices demonstrate that they assess the diversity of their population?

Practices must submit dated reports summarizing race, ethnicity and one other characteristic of diversity in their patient population.

Are statewide data acceptable for documenting race and ethnicity?

No. Data must reflect the local community served by the practice.

Factor 2**How can we best collect language needs information from all patients in our large population?**

Practices can use two methods to collect language need information:

1. Collect data from all patients and their families to create a report showing language needs.
2. Obtain data from an external source (e.g., data about the local community or its patient population).

Patients who do not speak English and patients from racial/ethnic minority groups may be less inclined to provide this information. Care should be taken to request the information using methods that respect multi-cultural differences.

- **Resources:**

- NCQA's 2010 Multicultural Health Care Standards (Abbreviated) E-Pub, Free:
<http://www.ncqa.org/tabid/1157/Default.aspx>

- **Pediatric-specific resources:**

- Medical Home Data Portal state pages: <http://www.childhealthdata.org/browse/medicalhome>
- KIDS COUNT Data Center: <http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=103>

Factor 4

Where can practices find pediatric-specific handouts in other languages?

The intent of Element 2C is that practices assess their population and determine whether handouts in specific languages are necessary. Practices can use the resources listed below for help developing patient materials.

- **AAP resources:**

- National Center for Medical Home Implementation Web site, Care Partnership Support resources on cultural competence and health literacy: http://www.medicalhomeinfo.org/how/care_partnership_support.aspx#culturally_competent
- Bright Futures has tools in Spanish for patient visits from infancy through adolescence: http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html
- Culturally Effective Toolkit on AAP Practice Transformation Pages PMO: <http://practice.aap.org/content.aspx?aid=2990>

- **Other resources:**

- MEDLINEplus, Children's Health Resources (resources also available in Spanish): <http://www.nlm.nih.gov/medlineplus/childrenshealth.html>
- Immunization Action Coalition offers vaccine information statements in multiple languages: <http://www.immunize.org/vis/>

Element 2D: The Practice Team

Factors 1, 2

What's the difference between factors 1 and 2? Will the same documentation satisfy both?

Factor 1 asks practices to provide documentation of staff roles and responsibilities; these may be job descriptions that relate to a team approach. Factor 2 asks practices to show how these roles work together, how the team is structured and who holds each role in patient care.

Practices may use the same documentation to meet factors 1 and 2 if the same materials demonstrate compliance.

- **AAP resources:**

- National Center for Medical Home Implementation Web site, Care Delivery Management page provides information and links to various resources regarding preparing office staff and creating medical home care teams: http://www.medicalhomeinfo.org/how/care_delivery/#office.
- The EQIPP: Medical Home for Pediatric Primary Care course helps pediatric health care providers create plans for improvement, and includes a module on developing a highly functioning, multidisciplinary quality improvement team: <http://eqipp.aap.org>

Factor 3**Are practices required to have daily, structured meetings with the entire care team? Is the clinician required to attend?**

Factor 3 requires practices to engage in frequent communication to discuss care for patients scheduled for a visit on that day or, if the meeting is held in the afternoon, on the next day. **Note:** *The meeting is not to discuss practice transformation activities or vacation schedules.* This requirement can be satisfied by scheduled team meetings or scheduled electronic team communication that all members of the practice care team, including clinicians, attend.

There must be regular communication between team members who work together to provide care for a group of patients. Practices are required to provide a documented process and at least three examples of meeting materials (e.g., meeting summaries, checklists, appointment notes).

- **Examples:**

- Army Medical Department PCMH Huddle Video: <http://www.youtube.com/watch?v=q84aAeMV4C4>
- Small Practice Planned Care Huddle: <http://www.youtube.com/watch?v=Wttxm7jAnb4>

- **AAP resources:**

- National Center for Medical Home Implementation Creating Efficiency: Team huddles video: http://medicalhomeinfo.org/about/medical_home/media.aspx
- Resources from the National Center on Medical Home Implementation on Preparing the Office for Team Based Care, which includes information about Team Huddles: http://www.medicalhomeinfo.org/how/care_delivery/

Our clinical staff teams are on different schedules, so they often meet in separate teams to discuss patients. Does this meet factor requirements?

The factor requirements are met if teams have shared patients and meet separately, but share questions or concerns about shared patients via regular, structured communication (such as the EHR). The intent of the factor is for all members of the care team to be involved in communication about patient care.

Factors 5–7**What does NCQA consider “adequate” care team training?**

NCQA does not prescribe a specific method for training care team members—training should address services described in each factor and the practice should define the staff members assigned to each team. Training may be part of staff orientation or may be given at regularly scheduled intervals.

May practices use training materials that are older than 12 months?

Yes, although training materials should reflect the most current evidence-based guidelines. It is important that position descriptions and training materials are dated and have been in place for at least three months. NCQA does not specify that training must occur at defined intervals. Practices determine how frequently care team members are trained and retrained. Training should accommodate new team members.

Are practices required to train all members of the care team?

Although not all care team members perform the services in factors 5–7, practices should assign and train staff for these responsibilities as part of their job description. NCQA looks for staff assignment of responsibilities in factor 1; this information should identify the staff to be trained for factors 5–7.

Factors 5–7 emphasize the need to identify and train care team members for specific patient care services within the medical home. For documentation of these factors, the practice must provide a description of the training **and** training schedule or materials demonstrating how staff have been trained (e.g., a PowerPoint presentation or training booklet).

Factor 10**May parent members of a practice’s advisory council participate in council meetings by telephone?**

Yes. This method of participation must be included in the practice’s documented process for involving patients and their families on QI teams or practice advisory councils.

- **AAP resources:**

- National Center for Medical Home Implementation Web site (resources on family advisory groups): http://www.medicalhomeinfo.org/how/care_partnership_support.aspx#groups
- Building Your Medical Home Toolkit (Quality Improvement Basics and associated teamwork pages include information on building teams and including families, along with meeting minutes and agenda templates): www.pediatricmedhome.org.
- National Center for Medical Home Implementation Building a Stronger Pediatric Medical Home: Family Advisory Groups video and Enhancing Collaboration with Families: Care Partnership Support video: http://www.medicalhomeinfo.org/about/medical_home/media.aspx

Standard 3: Population Health Management

Element 3A: Patient Information

Factor 8

Does collection of patient job status (e.g., full-time, part-time) meet the requirement of documenting “occupation” in the patient record?

No. Collecting only a patient’s job status does not meet the requirement of the factor. The intent of factor 8 is that practices capture patients’ field of employment. This information can help assess exposure to risks at work and enable the practice to provide patient-centered care based on patient-specific needs.

How does “occupation” apply to pediatrics? Does NCQA look for a specific response?

NCQA does not look for a specific response. If a patient is unemployed, identifying what constitutes the unemployment status (e.g., the patient is a minor or a student) is acceptable.

Factor 12

Is a signed copy of a patient’s advance directive required to be included in the medical record?

No, the signed directive does not need to be included directly in the patient’s medical record; however, the information must be directly accessible at the practice site (i.e., the practice should not have to call another site or person to obtain the information). The patient medical record should include information that the patient has an advance directive on file (or has declined to provide one), and the practice should be able to access the information in the directive immediately if needed.

Element 3C: Comprehensive Health Assessment

Is a completed health assessment required to be from one patient, or may practices use different sections from multiple patients?

Practices that use the Record Review Workbook to submit data for this element must also provide an example of how each factor is documented in the medical record—a “completed patient assessment (de-identified) documenting the factors included in the health assessment.” If it is not possible to show this information for a single patient, practices may demonstrate how the information is documented with de-identified examples from patient records. If the patient population includes adult and pediatric patients, practices are encouraged to provide documentation for both.

Note: Practices are not required to provide examples if they elect to provide a report for Element 3C.

May a “smart form” be used for the comprehensive health assessment?

Forms or processes demonstrating that a practice conducts, collects and documents a comprehensive health assessment for each factor must clearly show how these factors are collected consistently. Although a documented process is not required for this element, practices should follow a standard protocol to explain how the forms are used and to ensure they are updated regularly. Submitting a blank form does not meet the requirement.

What is the required frequency for a patient health assessment?

NCQA does not prescribe a frequency; practices determine the time frame for conducting patient health assessments according to a protocol that suits their patient population. The element assesses the components and comprehensiveness of the assessment.

Factor 5

How is advance care planning different from advance directives?

Advance care planning is an ongoing process that can occur when a patient is well or sick; the advance care plan can be updated as circumstances or health status changes. The practice assesses the patient's preferences and the plan of care when the time comes that the patient cannot speak for him or herself. Advance care planning can include advance directives, but the two are not synonymous. An advance directive in the patient's file meets the requirement for advance care planning.

An advance directive (Element 3A, factor 12) is a standing legal document that goes into effect if a patient is incapacitated and cannot make medical decisions. The directive includes the patient's assent to or refusal of health care and may name a representative to make decisions on the patient's behalf.

Factor 7

Are medical records required to include both mental health *and* substance abuse history for patients *and* their families?

Medical records should contain a note that the patient has been asked about personal *and* family history of mental health (MH) *or* substance abuse including a notation that there is no history of MH issues or SA or that the patient declined to answer; practices do not lose credit if there is no history or the patient declines to answer. The intent of this element is that practices regularly collect and update this information.

Practices respond "yes" in the Record Review Workbook if the patient *and* family MA or SA history was collected, and respond "no" if there is no clear indication that the MH or SA history was discussed.

- **AAP resources:**

- Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Addressing-Mental-Health-Concerns-in-Primary-Care-A-Clinicians-Toolkit.aspx>

Factor 8

What documentation demonstrates use of a developmental screening tool?

Practices must submit:

- The Record Review Workbook.
- An example of the factor documented in the patient record, *and*
- A de-identified, completed developmental screening form.

or

- A report, *and*
- A de-identified, completed developmental screening form.

Our practice sees both adult and pediatric patients. We want to use the Record Review Workbook to report 3C, but no pediatric patients were identified in Element 4A. Should we select “NA” for factor 8 (developmental screening)?

No. Practices that see pediatric patients may not select “NA” for factor 8. If the sample selected in Element 4A does not include pediatric patients and the RRWB is marked NA for all patients, practices submit a report in lieu of the RRWB.

Note: Practices must also submit a de-identified, completed developmental screening form to receive credit for factor 8; however, a family/pediatric practice sees no patients between 0 and 3 years of age (when developmental screening is appropriate) may select NA for the factor.

Factor 9**Clarify “screening for adults for depression when staff-assisted depression care support systems are in place to assure accurate diagnosis, effective treatment and follow-up.”**

The U.S. Preventive Services Task Force (USPSTF) states that adults and adolescents should be screened for depression when a practice has access to services that can be used for follow-up if there is a positive result (i.e., mental health providers within the practice or external to the practice to whom the practice can refer patients). Responding “NA” is appropriate only if the practice is unable to provide resources to positively screened patients. If the practice can provide resources and does not screen for depression, “NA” is not an option; the practice must respond “no.”

May practices determine frequency of depression screening if it is within the parameters of clinical guidelines?

Yes. Practices determine screening frequency, but should follow evidence-based guidelines.

Factor 10**How do practices assess health literacy?**

There are tools and tool kits available on the AHRQ Web site: <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html#short>.

Note: Practices are not required to report literacy scores to NCQA, but recording the score in patient records may be helpful in generating a report demonstrating if patients were assessed.

Are there health literacy training programs tailored to pediatric practices?

No. Health literacy training programs are only a suggested approach for addressing communication needs of patients and their families.

- **AAP resources:**

- AAP Pedialink course on health literacy: <http://pedialink.aap.org/visitor/cme/cme-detail?guid=7dfcb8a9-1008-4eff-86c2-24f4321c3940>

- **Other resources:**

- HRSA: Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency: <http://www.hrsa.gov/publichealth/healthliteracy/>

Element 3D: Use Data for Population Management

How many reports are practices required to submit to meet factors 1–5?

For factors 1–5, practices should submit (1) reports or lists of patients needing services, generated within the past 12 months, and (2) materials showing how patients are notified of the needed service.

Practices may run one report for all factors if the report indicates the date when it was run and the service for which the patient is due.

Our practice is renewing under PCMH 2014. How do we meet the requirements of this element if we have not conducted annual outreach since our last submission?

As of November 2015, renewing practices *are not* required to provide evidence of annual outreach for 2 years. Practices must provide evidence of patient identification and outreach for each service in the element from within the 12 months prior to survey submission but are expected to conduct *annual* outreach.

Are practices required to provide a separate letter, phone script or other method for each service needed?

No. Practices may use the same documentation if:

- The same method is used for each service.
- Practices provide an example of the outreach used.

Practices must include information about how the letter, phone script or other method is modified for each service reminder.

Factor 1

The standards and guidelines state, “Assessments and immunizations do not meet the requirements of this factor,” but a falls risk assessment is an acceptable preventive care service. Clarify.

Preventive care assessments (e.g., falls risk assessment) may be used to meet the requirements of the factor. This factor focuses on preventive care services for a population of patients in the practice (e.g., mammograms, well-child visits, pediatric screenings, risk assessment for falls).

May practices use annual exams for adults *and* well-child visits?

No. Practices that see both adult and pediatric patients may not use two age groups of patients for the same service; they may use one group for wellness visits and must select another service as the second preventive care service.

May practices use HbA1c measurement for factor 1?

No. Factor 1 focuses on preventive care services. HbA1c measurement is appropriate for patients with diabetes and meets criteria for factor 3 (chronic care services).

May practices use depression screening for factor 1 and factor 3?

No. Services must be discrete and distinct.

Give examples of adult preventive services or screenings.

Adult practices may identify lists of patients needing screenings (e.g., mammograms, colorectal screenings), check-up visits, annual lab testing or well-woman visits.

Preventive measures must encompass a practice's entire appropriate population (not only patients with chronic conditions [factor 3]). The intent of preventive measures is that practices use their systems to identify specific groups of patients in need of services and to improve the quality of care for all patients in the practice.

Give examples of pediatric preventive care services.

- Developmental screenings, autism screening, well-child checkups (well-child visits [ages 0–10]) that occur quarterly for ages 0–2 and then annually, **or**
- Adolescent well visits (ages 11–21) that occur annually and include required screenings (e.g., chlamydia, depression, dyslipidemia at specific ages).
- **AAP resources:**
 - Recommendations for Preventive Pediatric Health Care (PDF): <https://brightfutures.aap.org/materials-and-tools/PerfPrevServ/Pages/default.aspx>
 - Interactive Periodicity Schedule (AAP Pediatric Care Online- Web resource): <https://www.pediatriccareonline.org/pco/ub/periodicity>
 - Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition (Web site and links to associated text/materials): <http://brightfutures.aap.org/index.html>

Factor 2

What immunizations may practices identify for adult patients?

Adult practices may identify lists of patients needing immunizations (e.g., flu shots, pneumonia vaccine, shingles vaccine, tetanus). Practices with both adult and pediatric patients may use a specific immunization for only one age group (not the same one for pediatric patients *and* for adults).

Does a list of pediatric patients from two age groups (e.g., 2-year-olds and 6-year-olds) that are “behind” on immunizations meet the requirements of this factor?

No. Practices may not use the same immunization for two age groups, and must identify two different immunizations for this factor.

Do Tdap and DTaP count as two different immunizations?

No. Although the immunizations are different formulations, Tdap and DTaP are integrally related. For this reason, NCQA considers them the same immunization for different age groups and does not accept them as two different immunizations.

Factor 3**May practices remind patients of three services based on only one chronic condition?**

Yes. Practices may use one chronic condition for all three distinct chronic care services, or may use two or three conditions and focus on services related to those conditions.

Give examples of pediatric acute care services.

A reminder to schedule a follow-up visit related to an infection (e.g., otitis media, pharyngitis, urinary tract infection) or an injury (e.g., fracture, burn or cut requiring stitches) applies as an acute care service.

Factor 4**Is “patients who are managed care patients but have ‘never been seen’ by the practice” an acceptable registry of patients for factor 4?**

No. Patients who have not been seen by any physician or clinician in a practice cannot be considered part of the practice’s patient population.

Why would our practice recall pediatric patients, if not for preventive care, immunizations or acute/chronic care services? Give pediatric-specific examples.

Factors 1–3 refer to needed services and are intended for routine, proactive reminders.

Factor 4 addresses patients who miss routine visits, annual exams or follow-up appointments and need to be reminded to visit the practice for services.

Factor 5**What types of medications are appropriate for medication monitoring or alerts?**

Medications for which the Food and Drug Administration has issued a recall or safety warning are appropriate for monitoring and alerts. Practices should also be aware of potentially serious side-effects of medications they prescribe and conduct regular monitoring for those medications (e.g., anticoagulants or pain medications). Practices can identify patients who are taking higher-risk medications and contact them to reconcile medications, assess the length of time they have taken the medication and discuss the medication’s potential side effects.

If a patient does not pick up prescription refills for a chronic condition, this might signify lack of adherence to the treatment plan. Does monitoring medication refills meet the requirements of factor 5?

No. The intent of this factor is not to track noncompliant patients; adherence is addressed in Element 4C, factor 5. Factor 5 requires practices to generate lists of patients on specific medications and to proactively inform or remind them about drug interactions, dosage problems, the need for special monitoring, potentially harmful side-effects and the option to use generic medications rather than brand-name medications. The purpose of the requirements is to determine if a practice can use its medication data to contact a specific group of patients.

Element 3E: Implement Evidence-Based Decision Support**Does documentation used to attest to MU2 Core Objective #6 (clinical decision support) meet the documentation requirements?**

Yes. In addition to the MU reports, examples of guideline implementation are required for all factors in the element.

Our practice earned credit for Element 3A, factor 3 in PCMH 2011, but the factor has been split into two factors (1, 4) in Element 3E for PCMH 2014. We are pursuing streamlined renewal. May we attest to both factors?

Yes. All of Element 3E in PCMH 2014 is available for attestation for practices that earned Level 2 or 3 recognition and are eligible for streamlined renewal. Practices must answer the factors based on their current performance. Practices that are eligible for attestation are not required to provide documentation for any factor to which they attest, unless they are audited.

For information about streamlined renewals and requirements for attestation vs. documentation, go to <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/after-keep-it-pcmh/pcmh-2014-renewal-requirements>.

What type of tool is not acceptable as an example of demonstrating implementation of clinical decision support?

Flow charts, copies of guidelines and empty templates or flow sheets do not demonstrate implementation of clinical decision support. These items show the guideline, but do not show its use at the point of care. In addition to the condition and source of the guideline used for clinical decision support, the practice must provide a patient example demonstrating the guideline is used at the point of care.

Factor 1**Does use of the PHQ-2 or PHQ-9 meet the requirements of this factor?**

The intent of Element 3E is that the provider is alerted when a specific service or action is needed at the point of care, based on evidence-based guidelines. Practices that use an evidence-based tool that is built into the EHR or is part of a workflow and used according to clinical guidelines can meet the requirements if they provide the guideline and an example of the guidelines implementation (i.e., the tool's use). Use of PHQ-2/PHQ-9 meets the requirement if practices provide the evidence-based guideline for its use in monitoring depression treatment they use and an example of the tool's implementation in clinical care and decision making. The intent of this factor is to monitor progress during treatment, not for screening or diagnosis.

Factor 6**What qualifies as an overuse or inappropriateness issue?**

Practices must implement evidence-based guidelines via a clinical decision-support tool for each factor. Factor 6 requires evidence-based guidelines on appropriate use of services (e.g., appropriate laboratory test ordering, avoiding the use of MRI as a first-line diagnostic test for back pain, appropriate use of antibiotics).

NCQA encourages practices to look at ABIM's Choosing Wisely Web site for information on overuse/ appropriateness (www.choosingwisely.org). Examples include use of antibiotics for pediatric ear infections and referral to an orthopedist for acute, uncomplicated low back pain.

Standard 4: Care Management and Support

Element 4A: Identify Patients for Care Management

Factor 1

Does tobacco use count as a behavioral health condition?

No. While tobacco use is an unhealthy behavior, it does not meet the requirement to identify a behavioral health condition. Practices need to identify behavioral health-related criteria pertinent to their specific patient population, which could include other (non-tobacco-related) substance use treatment, a behavioral health diagnosis, a positive screening result from a standardized behavioral health screener, or psychiatric hospitalizations.

Factor 3

Does our practice meet the requirements if we use 65 years of age and older as the criterion for patients with poorly controlled or complex conditions?

No. Using only this age group does not meet the requirements. Identification of poorly controlled or complex patients can include older patients (e.g., >65 years) who also meet other high-risk criteria such as co-morbid conditions, frequent hospitalizations, mental health problems or frailty.

Factor 4

Give examples of social determinants of health.

Social determinants of health are conditions in the environment that affect a wide range of health, functioning and quality-of-life outcomes and risks and include:

- Availability of resources to meet daily needs.
- Access to educational, economic and job opportunities.
- Public safety, social support.
- Social norms and attitudes.
- Exposure to crime, violence and social disorder.
- Socioeconomic conditions.
- Residential segregation.

Source: *Healthy People 2020*: <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health>.

May practices use “limited or no family/caregiver support” as a social determinant of health?

Yes. For 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 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.”

Factor 5**Does a patient referral for care management from an ED meet the requirements of this factor?**

Yes. This factor requires a documented process for handling referrals made by outside organizations (e.g., insurers, health system, ACO, other providers), practice staff or patient/family/caregiver for patients that might need additional care management support; an ED is an outside organization.

Note: A report or patient list of referrals is not required for this factor.

What constitutes a referral by the patient/family/caregiver?

Patients, caregivers or family members are not likely to request care management services unless they are health care professionals; however, caregivers or family members may acknowledge the patient's inability to self-manage care or to follow clinician instructions, or a patient may acknowledge his or her own inability to manage care, and that might lead a practice to consider the patient for care management services.

For example, children of a widower who relied on his spouse to help him manage a chronic condition might alert the practice that their father cannot manage his care and that they are not in a position to provide help.

Factor 6**How do practices produce the report required for factor 6? How does it relate to factors 1–5?**

Element 4A, factor 6 requires practices to create a process using criteria defined in factors 1–5 to identify patients for care management. The practice may use any method to identify these patients. For factor 6, practices need only provide a report showing the percentage of patients calculated from the number of patients identified using the defined criteria (numerator) in comparison to the entire patient population (denominator).

Note: Practices select one or more factors (from factors 1–5) to define the subset of the patient population for care management for factor 6, and identify a population for care management (at least 30 patients) so they can report Elements 4B and 4C. Practices receive credit for factors 1–5 only if criteria from those factors are represented in the population identified for factor 6.

Element 4B: Care Planning and Self-Care Support

How is advance care planning different from care planning?

Advance care planning supports patients identified for care management in Element 4A in managing their care to achieve target goals. Advance care planning is the care planning process with an end of life focus to address patient care when they cannot speak for themselves or are at the end of life.

How do practices select the patient population for this element?

Practices use the sample identified in Element 4A, factor 6 as the denominator for factors in Element 4B. To earn credit for each factor, practices must document the information listed in the factors for at least 75 percent of those patients. For documentation, practices must either complete the Record Review Workbook or submit a report.

- *Practices that submit the Record Review Workbook* must provide an example of each factor, demonstrating how providing information is documented in the medical record.
- *Practices that submit a report* must provide a report with at least three months of recent data showing the number of patients who had the factor-specific information documented in their medical record (numerator) out of the total number of patients identified in Element 4A, factor 6 (denominator).

If a patient sample for the Record Review Workbook includes both pediatric and adult patients, do practices need to provide an example of each patient population for each factor?

No. Practices with a patient sample that includes both pediatric and adult patients for reporting provide at least one pediatric example and at least one adult example for the element, but are not required to provide a pediatric example and an adult example for each factor. This is also true for Element 4C.

Factor 3**Are practices required to document that they assess *and* address patient barriers to meeting treatment goals?**

Yes. Practices must assess whether there are barriers to meeting goals and should address any identified barriers. Both components must be listed in the medical record in order to select “Yes” in the Record Review Workbook. If the practice assesses potential barriers and none are identified, the practice may answer “Yes.”

Note: Practices must provide an example of how they meet each factor and complete the Record Review Workbook. Examples are not required if a practice provides a report as documentation.

Factor 5**What are the parameters for a care plan?**

A care plan is based on the acute, chronic and preventive care needs of a patient and can include patient preferences and goals; treatment goals and status; assessment of barriers and strategies to address them; current problems and medications; allergies; and a self-care plan. This factor requires practices to document a patient-centered view of the care plan and share the plan with the patient between visits. A care plan does not need to be re-created at each visit but must be reviewed and updated as needed.

Does a clinical summary meet the requirement for a “plan of care”?

No, although a plan of care can be a component of a clinical summary. A clinical summary might include a diagnosis, medications, recommended treatment and follow-up, and information about home management of an acute or chronic condition, when appropriate. A plan of care is tailored for the patient’s use at home and to the patient’s understanding (e.g., an asthma action plan).

May practices make the individualized care plan available via patient portal, or are they required to provide the document in writing?

Although the care plan can be made available via the patient portal, it is essential that *all* patients have access to the document. If patients are not registered for the portal, they will not have access. Practices should use an alternative method to provide the written care plan to patients, to ensure that all patients have access after an appointment. Please note practices must document that the care plan is provided to the patient in the patient’s medical record.

Element 4C: Medication Management**How do practices select the patient population for this element?**

As with Element 4B, practices use the sample identified in Element 4A, factor 6 as the denominator for factors in Element 4C. To earn credit, practices must document the information in the factors for the specified threshold in each factor.

For documentation, practices must either complete the Record Review Workbook or submit a report.

- *Practices that submit the Record Review Workbook* must provide an example of each factor, demonstrating how providing information is documented in the medical record.
- *Practices that submit a report* must provide a report with at least three months of recent data showing the number of patients who had the factor-specific information documented in their medical record (numerator) out of the total number of patients identified in Element 4A, factor 6 (denominator).

Factors 1, 2**May practices use MU reports (instead of the Record Review Workbook) to meet the requirements of factor 1?**

Yes. Because factor 1 is aligned with MU requirements, a Meaningful Use report could meet the documentation requirements for this factor.

Note: *Practices that meet the 80th percentile can earn credit for both factors 1 and 2. Practices can use both the Record Review Workbook and reports to demonstrate different factors in Element 4C.*

How frequently must medication reconciliation occur?

Medication reconciliation must occur at least annually and at all transitions of care.

What is the difference between factors 1 and 2?

The percentage thresholds are different between these factors. In addition, factor 1 language aligns with the language in MU2. Although meeting the “more than 50 percent” threshold (factor 1) is commendable, the PCMH 2014 Advisory Committee wanted to create a separate factor to acknowledge practices that meet the threshold of “more than 80 percent” (factor 2).

Factor 3**Do excerpts from medical records indicating that new medications and side effects were reviewed with the patient/family/caregiver meet the requirement, or must practices submit a specific medication handout?**

Practices determine the best method for sharing new medication information with patients; however, for PCMH 2014 documentation purposes, practices must note in the medical record how they provided the information to the patient. To earn credit for this factor, practices must meet the threshold of more than 80 percent, and provide an example demonstrating how this information is recorded in the medical record.

Does supplying information on all new prescriptions duplicate information provided by a pharmacy?

No. Although it may be duplicate information, practices cannot assume that the pharmacy provided the information to the patient. Practices must ensure that patients/families/caregivers understand why medication was prescribed and its benefits and potential harms to the patient. Additionally, patients might not review prescription information provided by a pharmacy, and information might not be tailored to the needs of the patient/family/caregiver. Communication and partnership with patients are critical functions of the patient-centered medical home.

May practices provide new prescription information only for medications relevant to a specific disease of interest?

No. The requirement to provide new information applies to all new medications prescribed to a patient, especially for patients identified in 4A as needing care management. They may have multiple comorbidities and medications, so it is crucial that they receive information about all medications prescribed to them.

Factor 5

May practices assess response to medications relevant to treating a specific disease of interest?

No. Practices must ask about *all* medications prescribed to the patient and assess their efficacy, especially for patients identified in 4A as needing care management. They may have multiple comorbidities and medications, so it is crucial to evaluate their response and barriers to adherence for all medications prescribed to them.

Element 4D: Use Electronic Prescribing

Factor 3

Are patient-specific checks for drug-drug and drug-allergy interaction warnings required to be “pop-ups”?

A pop-up warning is one example of how a provider could perform a drug-drug or drug-allergy interaction but practices may use other methods; NCQA is not prescriptive about what method practices must use to perform this evaluation. A screen shot of this capability is sufficient for documentation, but practices may also submit a report.

Element 4E: Support Self-Care and Shared Decision Making

Factor 4

- **AAP resource:**
 - Shared Decision-Making in Pediatrics: A National Perspective Pediatrics 2010;126:306:
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3373306/>

Factor 6

- **AAP resource:**
 - National Center for Medical Home Implementation resources on Resources & Linkages with community organizations: <http://www.medicalhomeinfo.org/how/resources/index.aspx>

Standard 5: Care Coordination and Care Transitions

Element 5A: Test Tracking and Follow-Up

What is the minimal information required to meet the requirements of the 5A laboratory and radiology factors?

Because Element 5A is not a must-pass element, there is no minimum data requirement. To earn all available points, practices must meet at least eight factors, including factors 1 and 2 (critical factors). Practices must consider the documentation requirements for each factor and determine if supporting documents meet the intent as described in the PCMH 2014 standards and guidelines.

Factors 7–9

Does NCQA accept information that was scanned into a chart?

No, retrieving information from another system or scanning results into a chart does not meet the requirements of the factor. Practices must order lab and imaging tests electronically to meet the requirements for factors 7 and 8 and must record lab results electronically to meet the requirements for factor 9.

Factor 10

Are practices required to store radiology images in the patient's medical record?

No. Practices are not required to store the actual image in the patient medical record, but it must be accessible via a direct link or scanned document in the system. Finding the image through a separate system does not meet the requirements of the factor.

Element 5B: Referral Tracking and Follow-Up

Factor 2

Are practices required to *only* refer to specialists with whom they have agreements, or is the requirement that an agreement be in place? Give an example of an agreement.

Practices are not restricted to referring patients only to practices with whom they have established agreements. NCQA reviews at least one example of a formal or informal agreement with a subset of specialists, but does not expect practices to have agreements with all specialists to whom they refer patients. The goal is that expectations are outlined in the agreement, in addition to expectations of timeliness/content of response from specialists.

Give an example of an informal agreement.

An informal agreement could be a few sentences in a referral form, e-mail or other method of communication containing expectations for the specialist, including, but not limited to, the time frame for reporting to the primary care physician and specifying lab or test results that should be included in the report. This information is essential to clarify the relationship between the primary care provider and specialist.

Our practice is part of an integrated health system. Do we need to show agreements between primary care providers and specialists?

Yes. Practices must have an agreement or documented process outlining the responsibilities of the referring provider and the specialist, even in an integrated system. It is essential that each provider understands the expectations and responsibilities of the referral, including the frequency and methods of communication.

Factor 4

Our practice has agreements with and shares patient records with behavioral healthcare providers, but we do not share the same EHR or physical location. Do we meet the requirement for integrating behavioral healthcare in our practice?

No. Although there is no requirement for a behavioral healthcare provider to be in the practice's office, the behavioral healthcare provider must have at least partial access to the practice's systems. Although the arrangements mentioned meet the intent of Element 5B, factor 3 (maintaining agreements with behavioral healthcare providers), they do not meet the requirements for this factor.

If a practice site in an organization has integrated behavioral healthcare, the other sites in the organization may receive credit for this factor if there is also a process for their patients to access those behavioral healthcare services.

- **AAP resource:**

- Strategies for System Change in Children's Mental Health: A Chapter Action Kit developed by the American Academy of Pediatrics (AAP) Task Force on Mental Health assists AAP chapters in addressing and improving children's mental health in primary care in their state. <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Chapter-Action-Kit.aspx>

Factor 6

How do practices document providing pertinent demographic and clinical information to a specialist if they use the same EHR?

Practices must provide a documented process for staff to follow to ensure that demographic and clinical data are available for the specialist, and either a report/log or an example showing that the process is followed (e.g., a screen shot of available information and how the information is made available to the specialist). If external referrals are made, the practice must specify the process for sharing information with those providers, as well.

**Does every referral to a specialist require sharing test results and a current care plan?
Pediatric patients may be referred to a specialist for an acute condition that does not require a care plan.**

If the condition is acute care management, the plan may be simpler than for a patient with a complex, chronic condition. The plan of care would include current medications, tests, treatment, patient/family self-care and important information about the family. The standards and guidelines encourage practices to develop a plan of care for *all* patients.

Factor 7**May practices use a report that combines referrals and care transitions?**

Yes. Practices may link the same document to Elements 5B and 5C. These factors were written to align with Meaningful Use Stage 2 (Core Objective #15), which addresses care transitions or referrals. In November 2015, NCQA published updates to align with the Meaningful Use Modified Stage 2 final rule (Objective #5), which focuses on care transitions or referrals, but with a threshold of “more than 10 percent.” If the MU report is used (from either Stage 2 or Modified Stage 2), results must be provided for the practice (or for at least 75 percent of the providers) and must show that an electronic summary of care is sent to another provider for more than 10 percent of referrals.

Factor 8**Are practices required to track every referral?**

No, but practices must track important referrals, such as those made for high-risk patients.

May practices use a “tickler file” for this factor?

No. The tracking system needs to include a record of both the order and receipt of results. A tickler system includes a copy of the order and is removed when results are received; it does not meet the requirement of the factor because it does not maintain a record of receiving results.

Our PCPs and specialists use the same integrated EHR. Do we need to show tracking and follow-up?

Yes. Practices that use integrated systems must demonstrate how specialists are notified of a referral request and how the referral status will be tracked (including the specialist’s report). Even if the same EHR is used by both the primary care practitioner and the specialist, documentation must clearly demonstrate how the requirements are met within the system.

Factor 9**How do practices document co-management arrangements?**

This factor refers to arrangements between the primary care provider and specialists regarding co-management of a patient and timely exchange of patient information. Documentation requires review of three examples demonstrating co-management arrangements, such as de-identified referral forms that include the arrangements or sections of the medical record specifying the clinician responsible for each component of care. For example, for a diabetic patient who is referred to a medical oncologist, the arrangement would identify which provider manages the diabetes and which provider manages the side-effects of the oncology treatment.

- **AAP resource:**
 - National Center for Medical Home Implementation Resources on Co-managing Care:
http://www.medicalhomeinfo.org/how/care_delivery/#co-managing

Element 5C: Coordinate Care Transitions

Factor 1

Are practices required to show they can identify all patients who have been admitted to the hospital and treated in the ED?

No, practices are not required to identify all patients admitted to the hospital or ED, but they must have a process for identifying patients admitted to target facilities used most often by their population. In addition to a documented process, practices must also submit a log or report demonstrating that patients were identified.

Do health plan hospitalization and ED visit data meet the requirements of this factor?

A practice may use timely (provided at least weekly) health plan data to identify patients if at least 75 percent of the patient population is represented by the health plan. The practice may use data from more than one health plan as long as the plans collectively represent at least 75 percent of the practice population.

Factor 6

Our practice does not work regularly with community partners. What documentation is required? Is this relevant only for pediatric patients?

NCQA reviews the practice's documented process for obtaining proper consent for release of information. Practices must have a process for working with community partners (e.g., detention centers, halfway houses, juvenile justice facilities, foster care, child or adult protective services or others) to obtain appropriate consent for release of information to treat and coordinate care with partners who have legal responsibility for certain patients. This is not limited to pediatric patients.

Factor 7

How do practices demonstrate capability for electronic exchange of key clinical information with facilities?

There must be interconnectivity between the practice and facilities in order to exchange clinical information. The practice can demonstrate this factor via screenshots showing a test of the capability of the certified EHR to exchange clinical information; however, if the facility does not have the capacity for electronic exchange, the test will only show the practice's system capability.

Documentation for this factor requires practices to submit a screenshot or document showing a test of capability, and a dated report of a recent three-month period with a numerator (number of transitions of care and referrals where a summary of care was provided electronically), denominator (number of transitions of care and referrals) and percentage.

Standard 6: Performance Measurement and Quality Improvement

Element 6A: Measure Clinical Quality Performance

We are a renewing practice that qualifies for streamlined renewal. Are we required to provide data showing that we collected patient experience data for two years?

No. Through streamlined renewal, several elements are available for attestation, including 6A and 6C. For these elements, a practice must be prepared to show documentation if audited but is not required to provide documentation at the time of submission.

May our practice use the CHIPRA Initial Core Set of Children’s Health Care Quality Measures?

Yes. Measures from the CHIPRA Initial Core Set apply to the requirements.

What does “annual” measurement mean?

The NCQA PCMH program asks practices to report at least once each year (“annually”). This does not require that data cover an entire 12-month period, but rather that the practice pulls a report demonstrating performance at least once each year. To meet the requirements for 6A–6C, practices must submit data from within the 12 months prior to survey submission. Renewing practices must measure at least once within the 12 months prior to survey submission and once prior to that 12-month period (this also applies to 6B, factor 2, and to 6C).

Factor 2

Which patient populations meet the specified measures for factor 2?

Preventive measures must encompass a practice’s entire population and not be limited to patients with chronic conditions.

Factor 3

Which patient populations meet the specified measures for factor 3?

Selection of chronic or acute care measures is determined by prevalent conditions identified by the practice and by evidence-based guidelines.

Factor 4

How can practices stratify data for vulnerable populations?

Practices select a vulnerable population for measurement using fields that are available in their practice system. Practices may use categories such as race, age, ethnicity, language needs, education, income, type of insurance, disability or health status to identify specific populations that may experience disparities in care.

Does a group of patients identified for care management in Element 4A meet the requirement to stratify for vulnerable populations?

Yes. If a measure in Element 6A, factors 1–3 for a practice’s total population also applies to the subset of patients identified in Element 4A, the practice may use the same group to stratify one or more measures in Element 6A, factor 4.

Element 6B: Measure Resource Use and Care Coordination

Our practice changed the measures we tracked. May we use streamlined renewal for this element if we do not have two years of data for the same measures?

Yes. NCQA asks practices to measure annually, but the measures do not have to be the same each year. Element 6B requires documentation to be submitted for streamlined renewal, and practices are required to submit one year of measurement data for Element 6B, factor 1 (once in the last 12 months) and 2 years of measurement data (once in the last 12 months and once in a previous year) for Element 6B, factor 2. The requirement is met if there are 2 years of data for at least 2 utilization measures per year, even if the same measures are not measured annually.

Note: *Renewing practices that did not previously report utilization measures may provide one report of data from within the 12 months prior to survey submission. Include an explanation for the reviewer in the survey tool.*

Factor 1

May practices use Meaningful Use reports to meet the intent of this factor?

Yes. Practices may submit MU reports for medication reconciliation (Stage 2 Core Objective #14 or Modified Stage 2 Objective 7) and summary care records (Stage 2 Core Objective #15 or Modified Stage 2 Objective 5) as documentation for factor 1, which would demonstrate two measures of care coordination.

Note: *The standards and guidelines do not include this language because NCQA did not want to imply that two measures of care coordination is an MU requirement. If practices submit under a multi-site application and this element is selected for the multi-site corporate Survey Tool, they must provide a report with data specified for each site in the corporate tool.*

May practices submit a measure for completed mammograms as a care coordination measure?

A measure evaluating completed mammograms qualifies as a care coordination measure if the practice is evaluating the rate of mammography results received (numerator) to mammographies ordered (denominator). In this factor, NCQA wants to evaluate gaps in communication or coordination between members of the care team (providers and patients). Measuring the practice’s mammography rates does not meet the intent of a care coordination measure, but measuring timely receipt of results of a referral meets the intent.

Factor 2

May “no show” rates be used as one measure affecting health care costs?

No. This factor focuses on utilization and health care costs in the health care spectrum, not at the practice level.

Element 6C: Measure Patient/Family Experience**Factor 1****Are practices required to use the CAHPS PCMH survey to meet factor 1?**

No. Practices may use any patient experience survey that includes questions related to three of the four categories specified in the standards (access, communication, coordination, whole-person care/self-management support).

How many patients are practices required to survey?

NCQA does not prescribe a sample size or frequency of surveying; however, the survey must represent the entire patient population and not focus on specific conditions or patient groups.

Factor 2**Does the CAHPS PCMH Survey meet both factors 1 and 2?**

Yes. The CAHPS PCMH Survey meets the requirements for factors 1 and 2.

Note: No modifications to the survey questions or length may be made.

May practices use CAHPS CG for factor 2?

Yes. As of July 2015, CAHPS CG meets the requirement for factor 2 and factor 1. Practices may use CAHPS PCMH, CAHPS CG or another standardized, non-proprietary survey administered through measurement initiatives that provides benchmark analysis external to the practice; practices must administer the entire approved standardized survey to receive credit.

Are practices required to use an NCQA-Certified survey vendor to administer CAHPS PCMH?

No. Practices only need to use an NCQA-Certified survey vendor if they would like to achieve Distinction in Patient Experience Reporting. Practices that use a survey vendor to administer the CAHPS PCMH survey earn credit for factors 1 and 2 in addition to earning distinction.

What is NCQA Distinction in Patient Experience Reporting?

NCQA developed the optional Distinction in Patient Experience Reporting to help practices capture patient and family feedback through the CAHPS PCMH Survey. To earn distinction, practices submit CAHPS PCMH data to NCQA using an NCQA-Certified survey vendor (to ensure a standardized method of data collection and reporting).

Is NCQA Distinction required for PCMH recognition?

No. Practices are not required to have NCQA Distinction in Patient Experience Reporting to earn PCMH recognition.

May practices that have not applied for PCMH recognition earn NCQA Distinction in Patient Experience Reporting?

No. A nonrecognized practice may submit data to NCQA following the requirements posted on NCQA's Web site (<http://www.ncqa.org/PublicationsProducts/OtherProducts/PatientExperienceReporting.aspx>), but earning distinction requires PCMH recognition.

Factor 4**What type of qualitative data and feedback are required to meet this factor?**

Practices may collect qualitative feedback through a suggestion box in the waiting room, by hosting focus groups or by conducting individual patient interviews. Practices can also meet the requirements of this factor if they have a patient advisory council and encourage feedback on patient satisfaction issues on the council agenda.

May practices use the “comments” section in the survey practices administer?

No. Comment sections or “free text” questions on a patient experience survey or patient comments do not meet the requirement as a method of collecting qualitative feedback from patients and their families.

Element 6D: Implement Continuous Quality Improvement**May “improve performance” be a stated performance goal?**

No. The performance goal must be quantified (e.g., a number or percentage signifying a specific performance level).

Factor 5**May practices focus on improving results of a specific question in a patient experience survey?**

Yes. Practices determine the area of patient experience on which to focus quality improvement efforts. This may be improvement of the results of a specific question on a survey, a section of a survey or the entire survey.

Element 6E: Demonstrate Continuous Quality Improvement**When remeasuring to show improvement, what is an acceptable period of time between the initial measurement and the follow-up measurement period?**

NCQA does not specify a time period required for remeasurement, but it must be long enough for the practice to implement a performance improvement plan and to assess results.

Factor 1**How do practices assess the effectiveness of improvement actions?**

Assessing effectiveness of improvement actions includes remeasurement to compare results over time and evaluation of what is driving change. Results may be quantitative (numerical data that demonstrate performance and can be compared to benchmarks) or qualitative (conceptual data that describe why performance is high or low), but practices must look at the goals set, actions taken to improve and previous or baseline results.

Element 6F: Report Performance**Is it acceptable to demonstrate only how reports from Element 6A are shared with staff, the public and patients?**

No. Practices must provide an example of sharing at least one report from *each* Element 6A, 6B and 6C for each of the factors (1-4) in Element 6F.

Element 6G: Use Certified EHR Technology

Why is this element included, if it is not scored?

These are Meaningful Use requirements. NCQA included them to be able to collect an overview of the practice's Meaningful Use capability and to assess level of technology implementation in PCMH practices. This information also assists in reviewing documentation throughout the standards.