PCMH Standards and Guidelines

NCQA Customer Support: 888-275-7585

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PCMH PUBLICATION SYMBOL LEGEND		
Symbol	**Meaning**	**Description**
	**Site-Specific**	For organizations with multiple sites, criteria require evidence to be demonstrated for each site.
	**Shared**	For organizations with multiple sites, criteria may be demonstrated once and credit for the component shared across all sites. ***Note:*** *If an organization shares criteria within or between programs, it is attesting that all practices pursuing or holding Recognition status follow the same policies and procedures, use the same systems and uniformly conduct the activities at all practices and specialties.*
NYS	**New York State PCMH Required Criterion**	The "NYS" icon indicates 1 of the 11 elective criteria that must be completed to achieve NYS PCMH Recognition. Refer to Appendix 7 for information.
	**Cross-Program Shared Credit Option**	Criteria may be shared between programs for organizations seeking PCMH Recognition: • With an existing Recognition status (e.g., PCSP) ***or*** • With other Recognition programs concurrently. Specific shared-credit alignment is noted next to the symbol. ***Note:*** *If an organization shares criteria within or between programs, it is attesting that all practices pursuing or holding Recognition status follow the same policies and procedures, use the same systems and uniformly conduct the activities at all practices and specialties.*

Team-Based Care and Practice Organization (TC)

The practice provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home.

Competency A: The Practice's Organization. The practice commits to transforming the practice into a sustainable patient-centered practice. Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice's organizational structure.

TC 01 (Core) PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the transformation and ongoing patient-centered care.

GUIDANCE	EVIDENCE
The practice identifies the clinician lead *and* the transformation manager (the person leading the PCMH transformation). This may be the same person. Identification of the lead/manager includes: • Name. • Credentials. • Roles/responsibilities. Practice transformation is successful when there is support from a clinician lead. The lead's support sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinical and operational support and resources to implement the PCMH model.	• **Details about the clinician lead** ***AND*** • **Details about the PCMH manager**

TC 02 (Core) Structure and Staff Responsibilities: Defines the practice's organizational structure and staff responsibilities/skills to support key practice functions.

GUIDANCE	EVIDENCE
The practice provides an overview of practice staff roles and an outline of duties staff will execute as part of the medical home and explains how it will support and train staff to complete these duties. Structured tasks and stated staff responsibilities enable a practice to ensure that staff are providing efficient medical care and have training for the skills necessary to support the functions of the medical home.	• **Staff structure overview** ***AND*** • **Description of staff roles, skills and responsibilities**

TC 03 (1 Credit) External PCMH Collaborations: The practice is involved in external PCMH-oriented collaborative activities.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it is involved in at least one state or federal initiative (e.g., CPC+, care management learning collaborative led by the state) or population-based care learning collaborative. Participation in an ACO, a clinically integrated network, or a health information exchange (HIE) does not meet this requirement. A PCMH collaborative activity must be external to the practice, involve multiple practices, be ongoing (not a short-term activity), cover multiple aspects of patient-centered care and involve a level of collaboration between practices to learn and share best practices with their peers.	• **Description of involvement in external collaborative activity**

TC 04 (2 Credits) Patients/Families/Caregivers Involvement in Governance: Patients/families/ caregivers are involved in the practice's governance structure or on stakeholder committees.	
GUIDANCE	**EVIDENCE**
The practice either: • Creates a role for patients/families/ caregivers in the practice's governance structure or Board of Directors, ***or*** • Organizes a Patient and Family Advisory Council (PFAC) (stakeholder committee). The practice specifies: • How patients/families/caregivers are selected for participation. • The patient/family/caregivers' role. • Frequency of meetings. Patients are more than consumers in their care, they are partners. Involving patients/families/ caregivers in the practice's governance can provide additional input to improve patient services and help engage patients in the care they receive from the practice.	• **Documented process** ***AND*** • **Evidence of implementation**

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TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.	
GUIDANCE	**EVIDENCE**
The practice enters the names of the electronic systems it implements. Only systems the practice is actively using should be entered. Use of an EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently. https://chpl.healthit.gov/#/search	• **CEHRT name**  ***PCSP TC 05*** 

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Competency B: Team Communication. Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.	
GUIDANCE	**EVIDENCE**
The practice has a structured communication process or holds regular care-team meetings (such as huddles) for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care-team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented Process Only***
TC 07 (Core) Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice describes staff roles and involvement in the performance evaluation and improvement activities. Improving quality outcomes involves all members of the practice staff and care team. Engaging the team in review and evaluation of the practice's performance is important to identifying opportunities for improvement and developing meaningful improvement activities.	• **Documented process** ***AND*** • **Evidence of implementation** 

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TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.	
GUIDANCE	**EVIDENCE**
The practice identifies the behavioral healthcare manager and provides their qualifications. The care manager has the training to support behavioral health needs in the primary care office and coordinates referrals to specialty behavioral health services outside the practice. The practice demonstrates that it is working to provide meaningful behavioral health services to its patients by employing a care manager who is qualified to address patients' behavioral health needs. The behavioral healthcare manager may conduct duties through telehealth. ***Note:*** *The care manager may be a clinician, but is not required to be. The person in this position must possess the training, as defined by the practice, to support behavioral health needs in the primary care setting and coordinate care to behavioral health services.*	• **Identified behavioral healthcare manager**

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Competency C: Medical Home Responsibilities. The practice defines and communicates its role and the patient's role in the medical home model of care.

TC 09 (Core) Medical Home Information: Has a process for informing patients/families/ caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.	
GUIDANCE	**EVIDENCE**
The practice has a process for informing and providing patients/families/caregivers with information about its role and responsibilities at the start of care and throughout the care trajectory. Reminding patients periodically ensures that they have ready access to essential information and available resources. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. The practice explains to patients the importance of maintaining comprehensive information about their health care and describes how and where (e.g., specialty practice, primary care office, ED) to access the care they need. At minimum, materials include: • Names and phone numbers of practice points of contact. • Instructions for reaching the practice after office hours. • A list of services offered by the practice. • A list of resources for patient education and self-management support. • Indication that the practice uses evidence-based care. If appointments are conducted using telehealth, the practice may consider a process for informing patients about telehealth availability, including how and when to use the technology.	• **Documented process** ***AND*** • **Evidence of implementation**

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Knowing and Managing Your Patients (KM)

The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

Competency A: Collecting Patient Information. The practice routinely collects comprehensive patient data and uses the data to understand patients' backgrounds and health risks.

KM 01 (Core) Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses.	
GUIDANCE	**EVIDENCE**
Up-to-date means that the most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician, or by querying the patient—are added to the problem list. The report shows that the practice updates patients' problem lists at least annually. The patient's active problem list or diagnoses should include acute and chronic conditions, behavioral health diagnoses and oral health issues, as well as past diagnoses that are relevant to the patient's current care. Implementing KM 01 is a foundation for understanding health risks.	• **Report** ***OR*** • **KM 06—predominant conditions and health concerns**

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KM 02 (Core) Comprehensive Health Assessment: Comprehensive health assessment includes (all items required):

A. Medical history of patient and family.
B. Mental health/substance use history of patient and family.
C. Family/social/cultural characteristics.
D. Communication needs.
E. Behaviors affecting health.
F. Social functioning.
G. Social determinants of health.
H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.)
I. Advance care planning. (NA for pediatric practices.)

GUIDANCE	EVIDENCE
A comprehensive patient assessment includes an examination of the patient's social and behavioral influences in addition to a physical health assessment. The practice uses evidence-based guidelines to determine how frequently the health assessments are completed and updated. Comprehensive, current data on patients provides a foundation for supporting population needs. As part of the comprehensive health assessment, the practice: **A. Medical history of patient and family.** Collects patient and family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patient and "first-degree" relatives (who share about 50% of their genes with a specific family member). **B. Mental health/substance use history of patient and family.** Collects patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression). **C. Family/social/cultural characteristics.** Evaluates social and cultural needs, preferences, strengths and limitations. Examples include family/household structure, support systems, and patient/family concerns. Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities).	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 02 (Core) Comprehensive Health Assessment (all items required) *continued*	
GUIDANCE	**EVIDENCE**
D. Communication needs. Identifies whether a patient has specific communication requirements due to hearing, vision or cognition issues. ***Note:*** *This does not address language; refer to KM 10 for language needs.* **E. Behaviors affecting health.** Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure. **F. Social functioning.** Assesses a patient's ability to interact with other people in everyday social tasks and to maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, social interactions and so on. **G. Social determinants of health.** Collects information on social determinants of health: conditions in a patient's environment where people live, learn, work, and play that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental risk factors; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). **H. Developmental screening using a standardized tool.** For newborns through 30 months, uses a standardized tool for periodic developmental screening. If there are no established risk factors or parental concerns, screens are done by 24 months. **I. Advance care planning.** Documents patient/family preferences for advance care planning (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. Patients with an advance directive on file meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation**

KM 03 (Core) Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool.	
GUIDANCE	**EVIDENCE**
The documented process includes the practice's screening process and approach to follow-up for positive screens. The practice reports the screening rate and identifies the standardized screening tool. **Screening for adults,** Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. **Screening for adolescents (12–18 years),** Screening adolescents for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. In caring for the whole person, the medical home recognizes the impact depression can have on a patient's physical and emotional health. The practice uses a standardized screening tool (e.g., PHQ-9) and acts on the results.	• **Documented process *or*** • **Report** ***AND*** • **Evidence of implementation**

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KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression.	
GUIDANCE	**EVIDENCE**
Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Practice staff have been trained on the use of standardized tools to ensure accurate diagnosis, treatment and follow-up. The documented process includes the practice's screening process and approach to follow-up for positive screens. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. The National Institute on Drug Abuse created a chart of Evidence Based Screening Tools for Adults and Adolescents for opioid screening, as well as alcohol and substance use tools. **A.** The practice conducts assessment for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders (generalized anxiety disorder, panic disorder and social anxiety disorder) are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked to chronic medical conditions (e.g., heart disease, chronic pain disorders). **B.** The USPSTF recommends screening adults 18 years or older for alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking; the Drug Abuse Screening Test (DAST); Cutting down, Annoyance by criticism, Guilty feeling and Eye-openers Questionnaire (CAGE), CAGE AID for substance abuse; or another validated	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 04 (1 Credit) Behavioral Health Screenings *continued*	
GUIDANCE	**EVIDENCE**
screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth). **C.** Assessing for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to address the patient's substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients' access to the necessary treatments toward sobriety. Available screening tools may include the CAGE AID or DAST-10 instruments, which assess a variety of substance use conditions. Bright Futures recommends clinicians screen all adolescents for substance use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or DAST-20). **D.** Pediatric screening for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have lasting effects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC). **E.** The practice uses standardized tools to determine if patients have developed post-traumatic stress disorder (PTSD). This condition develops in patients who have experienced a severe and distressing event. This event causes the patient to subsequently re-live the traumatic experience, causing mental distress. Assessments for PTSD support the practice in recognizing the ailment, so it can either provide treatment or referrals to appropriate specialists.	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 04 (1 Credit) Behavioral Health Screenings *continued*	
GUIDANCE	**EVIDENCE**
F. Attention deficit/hyperactivity disorder (ADHD) makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood but symptoms can persist through adolescence and adulthood. The Vanderbilt Assessment Scale or the DSM V ADHD checklist for adults or children/ adolescents are examples of screening tools used to determine if a patient has ADHD. Screening to identify patients with ADHD can lead to earlier diagnosis and treatment and may and reduce its impact on patients/families/ caregivers. **G.** The USPSTF recommends screening of adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF guidelines suggest screening during and after pregnancy. The AAP's Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-child care schedule. Validated screening tools may include PHQ-2, PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools and may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits. For a list of screening tools, visit drugabuse.gov, or for a list of pediatric screening tools, visit the American Academy of Pediatrics website.	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 05 (1 Credit) Oral Health Assessment and Services: Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	
GUIDANCE	**EVIDENCE**
The practice conducts patient-specific oral health risk assessments and keeps a list of oral health partners such as dentists, endodontists, oral surgeons and/or periodontists from which to refer. Poor oral health can have a significant impact on quality of life and overall health. Primary care practices are uniquely positioned to improve oral health, oral health awareness through education, preventive interventions (e.g., fluoride application for pediatric patients) and timely referrals. Asking patients for the date of their last visit to the dentist or providing a list of dentists who are accepting patients does not meet the intent.	• **Documented process** ***AND*** • **Evidence of implementation**

KM 06 (1 Credit) Predominant Conditions and Concerns: Identifies the predominant conditions and health concerns of the patient population.	
GUIDANCE	**EVIDENCE**
The practice analyzes diagnosis codes or problem lists to identify its patients' most prevalent and important conditions and concerns. Although the general conditions treated in primary care are similar across practices, each medical home has a unique population that influences how the practice organizes work and resources. Knowing its population's top concerns allows the practice to adopt guidelines, focus decision support and outreach efforts, identify specialties to establish clear referral relationships and determine what special services to offer (e.g., group sessions, education, counseling).	• **List of top priority conditions and concerns**

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KM 07 (2 Credits) Social Determinants of Health: Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.	
GUIDANCE	**EVIDENCE**
After the practice collects information on social determinants of health, it demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the ongoing needs of its population. Routine collection of data on social determinants of health (as required in KM 02) is an important step, but the real benefit to the population comes when the practice uses the information to continuously enhance care systems and community connections to systematically address needs. 	• **Report** ***AND*** • **Evidence of implementation**

KM 08 (1 Credit) Patient Materials: Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.	
GUIDANCE	**EVIDENCE**
The practice demonstrates an understanding of the patients' communication needs by utilizing materials and media that are easy for their patient population to understand and use. The practice considers patient demographics such as age, language needs, ethnicity and education when creating materials for its population. The practice may consider how its patients like to receive information (i.e., paper brochure, phone app, text message, email), in addition to the readability of materials (e.g., general literacy and health literacy). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety and establish processes that address health literacy to improve patient health behaviors and safety in the practice setting. Reducing barriers to the patient's ability to access, understand and absorb health information supports their ability to comply with their care. 	• **Report** ***AND*** • **Evidence of implementation**

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KM Competency B: Patient Diversity.

Competency B: Patient Diversity. The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services.

KM 09 (Core) Diversity: Assesses the diversity of its population (all items required): **A. Race.** **B. Ethnicity.** **C. Gender identity.** **D. Sexual orientation.** **E. One other aspect of diversity.**	
GUIDANCE	**EVIDENCE**
Assessing the diversity of its population can help a practice identify subpopulations with specialized needs or that are subject to systemic barriers, leading to disparities in health outcomes. Although it is voluntary for individuals to report these aspects of diversity, the practice must attempt to collect it. The practice may collect data directly at points of interaction with individuals and through multiple mechanisms, using as many channels as available. The practice directly collects information on how patients identify in at least five areas that include: **A, B: Race and Ethnicity.** The practice must be able to report race/ ethnicity data using Office of Management and Budget (OMB) categories, including the response option of "Other." The OMB recommends a two-question format, asking individuals for ethnicity before race, which includes the following minimum categories: • Race (select one or more): – Black or African American. – Native Hawaiian or Other Pacific Islander. – White. – Asian. – American Indian or Alaska Native. – Some other race. – (Declined). • Ethnicity: – Hispanic or Latino. – Not Hispanic or Latino. – (Declined).	• **Reports**

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KM 09 (Core) Diversity: Assesses the diversity of its population (all items required): *continued* **A. Race.** **B. Ethnicity.** **C. Gender identity.** **D. Sexual orientation.** **E. One other aspect of diversity.**	
GUIDANCE	**EVIDENCE**
The practice may also use a combined format to collect race and ethnicity, asking individuals to select all categories that apply, that includes the following minimum categories: • American Indian or Alaska Native. • Asian. • Black or African American. • Hispanic or Latino. • Native Hawaiian or Other Pacific Islander. • White. • Other, please specify: _____. • (Declined). If the practice uses more granular subcategories of race/ethnicity, it must have a consistent process to aggregate responses into the OMB categories. **C. Gender identity.** The practice must be able to report the following response options, at a minimum: • Male. • Female. • Transgender male/trans man/female-to-male (FTM). • Transgender female/trans woman/male-to-female (MTF). • Genderqueer, neither exclusively male nor female. • Additional gender category or other, please specify. • Choose not to disclose. Additional options, as the practice deems appropriate.	• **Report**

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KM 09 (Core) Diversity: Assesses the diversity of its population (all items required): *continued* A. Race. B. Ethnicity. C. Gender identity. D. Sexual orientation. E. One other aspect of diversity.	
GUIDANCE	**EVIDENCE**
D. Sexual orientation. The practice must be able to report the following response options, at a minimum: • Lesbian or gay or homosexual. • Straight or heterosexual. • Bisexual. • Something else, please describe. • Don't know. • Choose not to disclose. Additional options, as the practice deems appropriate. **E. One other aspect of diversity**, which may include, but is not limited to, religion, occupation, geographic residence, pronouns, disability status, veteran status. Neither age nor gender are acceptable as a fifth aspect of diversity. The practice must collect data directly from patients.	• **Report**
KM 10 (Core) Language: Assesses the language needs of its population.	
GUIDANCE	**EVIDENCE**
The practice identifies the prevalent language needs of its population. It must collect data directly from all patients and document all languages spoken. All responses (e.g., patient declined to provide language information, primary language is English, patient does not need language services) must be recorded; a blank field does not mean the patient's preferred language is English. Documenting patients' preferred spoken and written language helps the practice identify the language resources required to serve the population effectively (e.g., materials in prevalent languages, translation services, bilingual staff).	• **Report**

NYS

KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two):

A. Targets population health management on disparities in care.

B. Educates practice staff on health literacy.

C. Educates practice staff in cultural competence.

GUIDANCE	EVIDENCE
The practice recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs. The practice: **A.** Identifies disparities in care and implements actions to reduce the disparity. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population. The practice should use its data to identify any disparity in care/service for a vulnerable group when compared to the general population of the practice. The actions taken should be specific to that vulnerable group to reduce the disparity. **B.** Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels, utilize the AHRQ or Alliance for Health Reform Health Literacy toolkit). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes. **C.** Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures. It supports practice staff to become respectful and responsive to the health beliefs and cultural and linguistic needs of patients. **Health literacy resources** IOM: Ten Attributes of Health Literate Health Care Organizations https://nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf AHRQ: Health Literacy Universal Precautions Toolkit: https://www.ahrq.gov/health-literacy/quality-resources/tools/literacy-toolkit/index.html Alliance for Health Reform Toolkit: http://www.allhealth.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf	• **A: Evidence of implementation** ***OR*** • **A: QI 05 *and*** • **A: QI 13** • **B: Evidence of implementation** • **C: Evidence of implementation**

KM Competency C: Addressing Patient Needs.

Competency C: Addressing Patient Needs. The practice proactively addresses the care needs of the patient population to ensure that the population's needs are met.

KM 12 (Core) Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them or their families/caregivers about needed services (must report at least three categories): **A. Preventive care services.** **B. Immunizations.** **C. Chronic or acute care services.** **D. Patients not recently seen by the practice.**	
GUIDANCE	**EVIDENCE**
The practice uses lists or reports to manage the care needs of specific patient populations. Using collected data on patients, the practice addresses a variety of health care needs using evidence-based guidelines, including missing recommended follow-up visits. The practice implements this process at least annually to proactively identify and remind patients, or their families/caregivers, before they are overdue for services.	• **A, B, D: Report/list, *and*** • **A, B, D: Outreach materials** • **C: Report/list, *and*** • **C: Outreach materials** ***OR*** • **C: KM 13** 
KM 13 (2 Credits) Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.	
GUIDANCE	**EVIDENCE**
At least 75% of eligible clinicians have earned NCQA HSRP or DRP Recognition. Alternatively, the practice demonstrates that it is participating in a program (e.g., MN Community Measures, IHA, performance-based recognition program) that uses a common set of measures to benchmark participant results, has a process to validate measure integrity and publicly reports results. The practice shows (through reports) that clinical performance is above national or regional averages. ***Note:*** *Recognition must be awarded at the site level. A multisite organization that receives Recognition at the organization level does not meet the intent.*	• **Report** ***OR*** • **HSRP or DRP recognition for at least 75% of eligible clinicians** 

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KM Competency D: Medication Management.

Competency D: Medication Management. The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.

KM 14 (Core) Medication Reconciliation: Reviews and reconciles medications for more than 80% of patients received from care transitions.	
GUIDANCE	**EVIDENCE**
The practice reviews all prescribed medications a patient is taking and documents this in the medical record. Conflicts or potential discrepancies in medications are identified and addressed by clinical staff. Medication review and reconciliation occurs at transitions of care, or at least annually. Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. Medication reconciliation is an important safety net for patients received from care transitions, because they are more likely to be elderly, use multiple pharmacies, multiple providers and have co-morbid conditions. **Medication reconciliation** is the process of obtaining and maintaining an accurate list of all medications a patient is taking and addresses any potential conflicts including name, dosage, frequency and drug-drug interactions.	• **Report**

KM 15 (Core) Medication Lists: Maintains an up-to-date list of medications for more than 80% of patients.	
GUIDANCE	**EVIDENCE**
The practice routinely collects information from patients about medications they take and keeps up-to-date lists of patients' medications. Medication data should be captured in searchable fields. The list should include the date when it was last updated, prescription and nonprescription medications, over-the-counter medications and herbal and vitamin/mineral/dietary (nutritional) supplements.	• **Report**

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KM 16 (1 Credit) New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50% of patients/families/caregivers.	
GUIDANCE	**EVIDENCE**
The practice uses patient-centered methods, such as open-ended questions (teach-back collaborative method), to assess patient understanding of new medications prescribed by the primary care provider. Educational materials are designed with regard to patient need (e.g., reading level). According to the CDC, medication for chronic conditions is not taken as prescribed 50% of the time.[1] Barriers to adherence, such as not understanding directions and confusion among multiple medication regimens, lead to poorer health outcomes and compromise patient safety. [1]https://www.cdc.gov/diabetes/professional-info/health-care-pro/diabetes-pharmacy-health.html	• **Report** ***AND*** • **Evidence of implementation**

KM 17 (1 Credit) Medication Responses and Barriers: Assesses and addresses patient response to medications and barriers to adherence for more than 50% of patients, and dates the assessment.	
GUIDANCE	**EVIDENCE**
The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed. If a patient is not taking a medication as prescribed, the practice determines why. Patients cannot get the full benefits of their medications if they do not take them as prescribed.	• **Report** ***AND*** • **Evidence of implementation**

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KM 18 (1 Credit) Controlled Substance Database Review: Reviews a controlled substance database when prescribing relevant medications.	
GUIDANCE	**EVIDENCE**
The practice consults a state controlled-substance database—also known as a Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP)—before dispensing Schedule II, III, IV and V controlled substances. The practice follows established guidelines or state requirements to determine frequency of review. This can prevent overdoses and misuse, and can support referrals for pain management and substance use disorders. For a list of PDMPs by state, visit: http://www.pdmpassist.org/content/state-pdmp-websites	• **Evidence of implementation** ***PCSP KM 13***

KM 19 (2 Credits) Prescription Claims Data: Systematically obtains prescription claims data in order to assess and address medication adherence.	
GUIDANCE	**EVIDENCE**
The practice systematically obtains prescription claims data or other medication transaction history. This may include systems such as SureScripts e-prescribing network, regional health information exchanges, insurers or prescription benefit management companies. The practice uses prescription claims data to determine whether a patient is adhering to the medication treatment plan.	• **Evidence of implementation** ***PCSP KM 14***

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KM Competency E: Evidence-Based Care.

Competency E: Evidence-Based Care. The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served.

KM 20 (Core) Clinical Decision Support: Implements clinical decision support following evidence-based guidelines for care of (practice must demonstrate at least four criteria):

A. A mental health condition.
B. A substance use disorder.
C. A chronic medical condition.
D. An acute condition.
E. A condition related to unhealthy behaviors.
F. Well-child or adult care.
G. Overuse/appropriateness issues.

GUIDANCE	EVIDENCE
The practice integrates evidence-based guidelines in its day-to-day operations (frequently referred to as clinical decision support [CDS]). **CDS** is a systematic method of prompting clinicians to consider evidence-based guidelines at the point of care. CDS encompasses a variety of tools, including, but not limited to: • Computerized alerts and reminders. • Condition-specific order sets. • Documentation template. • Reference information (i.e., info buttons). Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS. **A. Mental health.** The practice uses evidence-based guidelines to support clinical decisions related to at least one mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's) in the care of patients. **B. Substance use disorder treatment.** The practice uses evidence-based guidelines to support clinical decisions related to at least one substance misuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism) in the care of patients.	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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KM 20 (Core) Clinical Decision Support *continued*	
GUIDANCE	**EVIDENCE**
C. A chronic medical condition. The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic medical condition (e.g., arthritis, asthma, cardiovascular disease, COPD, diabetes) in the care of patients. **D. An acute condition.** The practice uses evidence-based guidelines to support clinical decisions related to at least one acute medical condition (e.g., acute back pain, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis, urinary tract infection) in the care of patients. **E. A condition related to unhealthy behaviors.** The practice uses evidence-based guidelines to support clinical decisions related to at least one unhealthy behavior (e.g., obesity, smoking) in the care of patients. **F. Well child or adult care.** The practice uses evidence-based guidelines to support clinical decisions related to well-child or adult care (e.g., age appropriate screenings, immunizations) in the care of patients. **G. Overuse/appropriateness issues.** The practice uses evidence-based guidelines to support clinical decisions related to overuse or appropriateness of care issues (e.g., use of antibiotics, avoiding unnecessary testing, referrals to multiple specialists) in the care of patients. The American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support (http://www.choosingwisely.org).	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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KM Competency F: Connecting With Community Resources.

Competency F: Connecting With Community Resources. The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support.

KM 21 (Core) Community Resource Needs: Uses information on the population served by the practice to prioritize needed community resources.	
GUIDANCE	**EVIDENCE**
The practice identifies needed resources by assessing collected population information. It may assess social determinants, predominant conditions, ED use and other health concerns to prioritize community resources (e.g., food banks, support groups) that support the patient population. The priority needs list should be used to identify the resources list in KM 26.	• **List of key patient needs and concerns**

KM 22 (1 Credit) Access to Educational Resources: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	
GUIDANCE	**EVIDENCE**
Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy. The practice provides three examples of how it implements these tools for its patients. • **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, website links and pamphlets, as well as community resources (e.g., programs, support groups). • **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings.	• **Evidence of Implementation**

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KM 22 (1 Credit) Access to Educational Resources *continued*	
GUIDANCE	**EVIDENCE**
The practice provides or shares available **health education classes,** which may include alternative approaches such as **peer-led discussion groups** or **shared medical appointments** (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and facilitate patients to interact with and learn from each other.	• **Evidence of implementation** 
KM 23 (1 Credit) Oral Health Education: Provides oral health education resources to patients.	
GUIDANCE	**EVIDENCE**
The practice provides an example of how it provides educational and other resources to patients pertaining to the importance of oral health and hygiene to encourage healthy oral health practices. Oral disease is largely preventable with knowledge and attention to hygiene. Poor oral health can complicate the care for chronic conditions such as diabetes and heart disease.	• **Evidence of implementation** 
KM 24 (1 Credit) Shared Decision-Making Aids: Adopts shared decision-making aids for preference-sensitive conditions.	
GUIDANCE	**EVIDENCE**
The care team has, and demonstrates use of, at least three shared decision-making aids that provide detailed information without advising patients to choose one option over another. The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Helping patients understand their health condition and engaging them in shared decision making helps build a trusting relationship. **Shared decision-making resources** • International Patient Decision Aid Standards Collaboration (IPDASC) http://ipdas.ohri.ca/index.html • AHRQ's SHARE Approach https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html	• **Evidence of implementation** 

KM 25 (1 Credit) School/Intervention Agency Engagement: Engages with schools or intervention agencies in the community.	
GUIDANCE	**EVIDENCE**
The practice develops supportive partnerships with social services organizations or schools in the community. The practice demonstrates this through formal or informal agreements or identifies practice activities in which community entities are engaged to support better health.	• **Documented Process** ***AND*** • **Evidence of implementation** 
KM 26 (1 Credit) Community Resource List: Routinely maintains a current community resource list based on the needs identified in KM 21.	
GUIDANCE	**EVIDENCE**
The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population. The list includes services offered outside the practice and its affiliates, and an update/maintenance date to demonstrate that the list is regularly updated. Maintaining a current resource list that prioritizes the central needs and concerns of the population can help a practice guide patients to community resources that support their health and well-being from that additional support.	• **List of resources** 
KM 27 (1 Credit) Community Resource Assessment: Assesses the usefulness of identified community support resources.	
GUIDANCE	**EVIDENCE**
The practice assesses the usefulness of resources by requesting and reviewing feedback from patients/families/caregivers about community referrals. Community referrals differ from clinical referrals, but may be tracked using the same system. When a practice's patients have unmet social needs, the practice can refer patients to useful community support resources. Meeting the patient's social needs supports self-management and reduces barriers to care.	• **Evidence of implementation** 

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KM 28 (2 Credits) Case Conferences: Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).	
GUIDANCE	**EVIDENCE**
The practice uses "case conferences" to share information and discuss care plans for high-risk patients with clinicians and others outside its usual care team. **Case conferences** are planned, multidisciplinary meetings with community organizations or specialists to plan treatment for complex patients. 	• **Documented process** ***AND*** • **Evidence of implementation**

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KM Competency G: Additional Patient Collaborations.

Competency G: Additional Patient Collaboration. The practice collaborates with patients to support their specific needs.

KM 29 (1 Credit) Opioid Treatment Agreement: Incorporates opioid treatment agreement for patients prescribed Schedule II opioid prescriptions into the patient medical record.	
GUIDANCE	**EVIDENCE**
For patients on long-term chronic opioid therapy, a treatment agreement is established between the clinician and patient to support safe prescribing of opioids. Patients prescribed a Schedule II opioid require a treatment agreement signed by both parties that, at a minimum: • Outlines joint expectations and responsibilities of both clinician and patient. • Includes the patient's pain management plan, to prevent development of an opioid dependency. • Is included in the patient's medical record. Patients with a signed opioid treatment agreement have shown improved guideline adherence and reduced addiction risk. This criterion aligns with Quality Payment Program final policies for CY 2019 to address efforts to improve treatment of opioid use disorders. **Opioid Agreement Resources** • National Institute on Drug Abuse https://www.drugabuse.gov/sites/default/files/SamplePatientAgreementForms.pdf • Hegmann KT, et al., eds. "Opioids Guideline." Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers. Reed Group, 2017 https://acoem.org/acoem/media/News-Library/Opioid-Treatment-Contract.pdf • Rhode Island Department of Health http://health.ri.gov/publications/bytopic.php?parm=Addiction%20and%20Overdose#Healthcare%20Providers	• **Evidence of implementation**

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Patient-Centered Access and Continuity (AC)

The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

Competency A: Patient Access to the Practice. The practice enhances patient access by providing appointments and clinical advice based on patients' needs.

AC 01 (Core) Access Needs and Preferences: Assesses the access needs and preferences of the patient population.	
GUIDANCE	**EVIDENCE**
The practice evaluates patient access to appointments from collected data, such as a survey, to determine if existing access methods are sufficient for its population. The data collected must be specific to patient access and actionable so that the practice can make changes based on the findings. If the practice is able to determine that patient needs are met, it may consider other opportunities to address access through clinical advice by telephone or correspondence through the portal; for example, evening/weekend hours and appointment types. Qualitative patient-feedback collection may meet (comment box, patient interview), but must include directions on giving feedback specific to access. AC 01 focuses on assessing existing access needs and preferences specific to appointments, not general patient access through a patient survey (QI 04).	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented Process Only***

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AC 02 (Core) Same-Day Appointments: Provides same-day appointments for routine and urgent care to meet identified patient needs.	
GUIDANCE	**EVIDENCE**
The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine and for urgent care needs. The time frames allocated for these appointment types are determined by the practice and based on the needs of the patient population, as defined in AC 01. Same-day appointments may be conducted for each site through telehealth. Evidence may include: • A 5-day schedule to demonstrate that appointments are available. • A report demonstrating that same-day appointments were used. • Significant patient-reported satisfaction with access, based on AC 01 data.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented Process Only***

AC 03 (Core) Appointments Outside Business Hours: Provides routine and urgent appointments outside regular business hours to meet identified patient needs.	
GUIDANCE	**EVIDENCE**
The practice recognizes that patients' care needs are not confined to normal operating hours, and therefore offers routine and urgent care appointments outside typical business hours. For example, a practice may open for appointments at 7 a.m. or remain open until 8 p.m. on certain days or open on alternating Saturdays. A documented process is not required if extended hours are provided at the practice site. A practice that cannot provide care outside regular business hours (e.g., a small practice with limited staffing) may arrange for patients to schedule appointments with other facilities or clinicians. The practice may use an urgent care center in the same health system for urgent and routine appointments outside regular business hours, or an urgent care center in the community that has access to patient records. Conducting appointments outside business hours using telehealth is permitted.	• **Documented process** ***AND*** • **Evidence of implementation** 

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AC 03 (Core) Appointments Outside Business Hours *continued*	
GUIDANCE	**EVIDENCE**
Providing extended access does not include: • Offering appointments when the practice would otherwise be closed for lunch. • Offering daytime appointments when the practice would otherwise close early (e.g., a Friday afternoon or holiday). • Utilizing an ED. • Utilizing an urgent care facility that is unaffiliated with the practice.	• **Documented process** ***AND*** • **Evidence of implementation**

AC 04 (Core) Timely Clinical Advice by Telephone: Provides timely clinical advice by telephone.	
GUIDANCE	**EVIDENCE**
Patients can telephone the practice any time of the day or night and receive interactive (from a person, rather than a recorded message) clinical advice. **Clinical advice** refers to a response to an inquiry regarding symptoms, health status or an acute/chronic condition. Patient inquiries regarding prescription refills or appointment requests are not considered clinical advice. Providing advice outside of appointments helps reduce unnecessary emergency room and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff but may be communicated by any member of the care team, as permitted under state licensing laws. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response, both during and after office hours. The practice must present data on at least 7 days of such calls. Organizations that utilize a central call center for clinical advice may aggregate and submit data as shared evidence. If each site in an organization is responsible for phone calls, the organization submits data at the site level.	• **Documented process** ***AND*** • **Report** ***PCSP AC 02*** ***Documented Process Only***

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AC 05 (Core) Clinical Advice Documentation: Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient's medical record.	
GUIDANCE	**EVIDENCE**
The practice documents all clinical advice in the patient record, whether it is provided by phone, during a telehealth visit or by secure electronic message. Evidence includes two examples of documenting clinical advice (one during office hours and one after normal business hours as defined in AC 03). If a practice uses a system of documentation outside the medical record for after-hours clinical advice or provides after-hours care without access to the patient's record, it reconciles this information with the medical record on the next business day. The reconciliation evaluates if clinical advice or care provided after hours conflicts with advice and care needs previously documented in the medical record and addresses any identified conflicts.	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP AC 04*** ***Documented Process Only***

AC 06 (1 Credit) Alternative Appointments: Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.	
GUIDANCE	**EVIDENCE**
The practice uses a mode of real-time communication (e.g., a combination of telephone, video chat, secure instant messaging) in place of a traditional in-person office visit with a clinician. The practice provides a report of the number and types of visits in a specified time period. These types of visits **do not** meet the requirement: • Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, website) during office hours. • Appointments with an alternative type of clinician (e.g., diabetic counselor). • Appointments restricted to a subset of patients (e.g., only patients identified for care management or patients with specific conditions). • Group visits and home visits.	• **Documented process** ***AND*** • **Report** ***Documented Process Only***

AC 07 (1 Credit) Electronic Patient Requests: Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.	
GUIDANCE	**EVIDENCE**
Patients can use a secure electronic system (e.g., website, patient portal, email) to request appointments, prescription refills, referrals and test results. The practice must demonstrate at least two functionalities or provide patients with guidelines for at least two types of these requests that can be made electronically. Electronic patient requests are another means to enhance patients' access to services that meet their needs and preferences.	• **Evidence of implementation**

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AC 08 (1 Credit) Two-Way Electronic Communication: Has a secure electronic system for two-way communication to provide timely clinical advice.	
GUIDANCE	**EVIDENCE**
The practice has a secure, interactive electronic system (e.g., website, patient portal, secure email system) that allows two-way communication between the practice and patients/families/ caregivers, as applicable for the patient. The practice can send messages to and receive messages from patients. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response, both during and after office hours. The practice must present data on at least 7 days of such activity. The report may be system generated. The practice defines the time frame for a response and monitors the timeliness of responses against the time frame.	• **Documented process** ***AND*** • **Report**

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AC 09 (1 Credit) Equity of Access: Uses information about the population served by the practice to assess equity of access that considers health disparities.	
GUIDANCE	**EVIDENCE**
Knowing whether groups of patients experience differences in access to health care can help practices focus efforts to address the inequity. The practice evaluates whether identified health disparities demonstrate differences in access to care. An example of how a practice may demonstrate this is through a report of how an identified group of patients has lower rates of access to same-day appointments, higher no-show rates, more ED use or lower satisfaction with access than the general patient population. Healthy People 2020 defines **health disparity** as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."	• **Evidence of implementation**

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Competency B: Empanelment and Access to the Medical Record. Practices support continuity through empanelment and systematic access to the patient's medical record.

AC 10 (Core) Personal Clinician Selection: Helps patients/families/ caregivers select or change a personal clinician.	
GUIDANCE	**EVIDENCE**
Giving patients/families/caregivers a choice of clinician emphasizes the importance of the ongoing patient-clinician relationship. The practice documents patients' choice of clinician, gives patients/families/caregivers information about the importance of having a personal clinician and care team responsible for coordinating care, and assists in the selection process. The practice may document a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a **practice team.** Single-clinician sites automatically meet this criterion.	• **Documented process**
AC 11 (Core) Patient Visits with Clinician/Team: Sets goals and monitors the percentage of patient visits with the selected clinician or team.	
GUIDANCE	**EVIDENCE**
The practice establishes a goal for the proportion of visits a patient should have with the primary care provider and care team. The goal should acknowledge that meeting patient preferences for timely appointments will sometimes be at odds with the ability to see their selected clinician. **Empanelment** is assigning individual patients to individual primary care providers and care teams, with sensitivity to patient and family preferences. It is the basis for population health management and the key to continuity of care: Patients can build a better relationship with a clinician or team they see regularly.	• **Report**

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AC 12 (2 Credits) Continuity of Medical Record Information: Provides continuity of medical record information for care and advice when the office is closed.	
GUIDANCE	**EVIDENCE**
The practice makes patient clinical information available to on-call staff, external facilities and clinicians outside the practice, as appropriate, when the office is closed or when appointments are conducted using telehealth technology. Access to medical records may include direct access to a paper or electronic record or arranging a telephone consultation with a clinician who has access to the medical record.	• **Documented process**  ***PCSP AC 05*** 

AC 13 (1 Credit) Panel Size Review and Management: Reviews and actively manages panel sizes.	
GUIDANCE	**EVIDENCE**
The practice has a process to review the number of patients assigned to each clinician and balance the size of each providers' patient panel. Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and clinician workload because supply is balanced with patient demand. The American Academy of Family Physicians provides a tool for practices to use when considering and managing panel sizes: https://www.aafp.org/pubs/fpm/issues/2007/0400/p44.html#fpm20070400p44-bt2	• **Documented process** ***AND*** • **Report**  ***Documented Process Only***

AC 14 (1 Credit) External Panel Review and Reconciliation: Reviews and reconciles panels based on health plan or other outside patient assignments.	
GUIDANCE	**EVIDENCE**
The practice receives reports from outside entities such as health plans, ACOs and Medicaid agencies on the patients that are attributed to each clinician. The practice has a process to review the reports and a process to inform those entities of the patients known or not known to be under the care of each clinician. Reconciling panels with health plans and other entities improves accountability, continuity and access.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented Process Only***

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Care Management and Support (CM)

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

Competency A: Identifying Care Managed Patients. The practice systematically identifies patients who may benefit from care management.

CM 01 (Core) Identifying Patients for Care Management: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):

A. Behavioral health conditions.

B. High cost/high utilization.

C. Poorly controlled or complex conditions.

D. Social determinants of health.

E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.

GUIDANCE	EVIDENCE
The practice defines a protocol to identify patients who may benefit from care management. Specific guidance includes the categories or conditions listed in A–E. Examples include, but are not limited to: **A.** Diagnosis of a serious mental illness, psychiatric hospitalizations, substance use treatment. **B.** Patients who experience multiple ER visits, hospital readmissions, high total cost of care, unusually high numbers of imaging or lab tests ordered, unusually high number of prescriptions, high-cost medications and number of secondary specialist referrals. **C.** Patients with poorly controlled or complex conditions such as, continued abnormally high A1C or blood pressure results, consistent failure to meet treatment goals, multiple comorbid conditions. **D.** Availability of resources such as food and transportation 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 (Healthy People 2020). **E.** Direct identification of patients who might need care management, such as referrals by health plans, practice staff, patient, family members or caregivers.	• **Protocol for identifying patients for care management** ***OR*** • **CM 03**

CM 02 (Core) Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.	
GUIDANCE	**EVIDENCE**
The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services. The practice uses the criteria defined in CM 01 to identify patients who fit defined criteria. The practice should ensure that criteria are specific enough for any identified patient to have their care managed. The practice must identify at least 30 patients in the numerator. Patients who fit multiple criteria count once in the numerator. With NCQA approval, small practices or satellite sites may share a care management population if fewer than 30 patients meet the criteria defined in CM 01.	• **Report**

NYS

CM 03 (2 Credits) Comprehensive Risk-Stratification: Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. The practice identifies and directs resources appropriately based on need. Risk stratification protocol used by the practice must include at least three categories outlined in CM 01. **Risk-stratification resources** • American Academy of Family Physicians' Risk Stratified Care Management Rubric. • CMS-Hierarchical Condition Categories (CMS-HCC) Risk Adjustment Model [If methodology is applied to entire practice population]. • Milliman Advanced Risk Adjusters (MARA).	• **Evidence of Implementation**

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Competency B: Care Plan Development. For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.

CM 04 (Core) Person-Centered Care Plans: Establishes a person-centered care plan for at least 75% of patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice has a process for consistent development of care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/lifestyle goals, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A **relevant visit** addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples** ***Report and Record Review Workbook*** ***Patient Examples***

CM 05 (Core) Written Care Plans: Provides a written care plan to the patient/family/caregiver for at least 75% of patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice provides the patient's written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient's health literacy and language preferences. (The patient version may use different words or formats from the version used by the practice team.) The care plan may be printed and given to the patient or made available electronically.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples** ***Report and Record Review Workbook*** ***Patient Examples***

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CM 06 (1 Credit) Patient Preferences and Goals: Documents patient preference and functional/lifestyle goals in at least 75% of individual care plans.	
GUIDANCE	**EVIDENCE**
The practice works with patients/families/ caregivers to incorporate patient preferences and functional lifestyle goals in the care plan. Including patient preferences and goals encourages a collaborative partnership between patient/family/ caregiver and provider, and ensures that patients are active participants in their care. **Functional/lifestyle goals** can be individually meaningful activities that a person wants to be able to perform but may be at risk due to a health condition or treatment plan. Identifying patient-centered functional/lifestyle goals is important because people are likely to make the greatest gains when goals focus on activities that are meaningful to them and can make a positive difference in their lives.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples** ***Report and Record Review Workbook*** ***Patient Examples***

CM 07 (1 Credit) Patient Barriers to Goals: Identifies and discusses potential barriers to meeting goals in at least 75% of individual care plans.	
GUIDANCE	**EVIDENCE**
Addressing barriers supports successful completion of the goals stated in the care plan. Barriers may include physical, emotional or social barriers. The practice works with patients/families/ caregivers, other providers and community resources to address potential barriers to achieving treatment and functional/lifestyle goals.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples** ***Report and Record Review Workbook*** ***Patient Examples***

CM 08 (1 Credit) Self-Management Plans: Includes a self-management plan in at least 75% of individual care plans.	
GUIDANCE	**EVIDENCE**
The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition. The plan may include best practices or supports for managing issues related to a complex condition identified in the care plan. Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers to meeting care-plan goals.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples** ***Report and Record Review Workbook*** ***Patient Examples***

NYS

CM 09 (1 Credit) Care Plan Integration: Care plan is integrated and accessible across settings of care	
GUIDANCE	**EVIDENCE**
Sharing the care plan supports its implementation across all settings that address the patient's care needs. The practice makes the care plan accessible across external care settings. It is integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement.	• **Documented process** ***AND*** • **Evidence of implementation**

CM 10 (1 Credit) Person-Driven Outcomes Approach: The practice collects and documents care plan goals using the person-driven outcomes approach in at least 75% of individual care plans.	
GUIDANCE	**EVIDENCE**
The person-driven outcomes approach helps practices meet the dual aims of pushing practice delivery toward more goal-oriented care and facilitating structured, valid and reliable measurement of whether care is personalized and aligned with patient goals. Person-driven outcomes are personalized, structured, measurable outcome goals, identified by the patient or caregiver as what matters most to them. There are four steps to this approach: 1. Elicit what is important to the patient. 2. Document a SMART goal (specific, measurable, attainable, relevant, time-limited). 3. Choose either a patient-reported outcome measure (PROM) or goal attainment scaling to track goal progress. • The PROM should best fit the goal or be related to a barrier that must be addressed for the patient to achieve or maintain the goal. 4. Create and document an action plan for achieving the goal to help the patient understand the pathway to goal achievement.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples** ***Patient Examples*** ***Report and Record Review Workbook***

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Care Coordination and Care Transitions (CC)

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

Competency A: Diagnostic Test Tracking and Follow-Up. The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.

CC 01 (Core) Lab and Imaging Test Management: The practice systematically manages lab and imaging tests by:

A. Tracking lab tests until results are available, flagging and following up on overdue results.

B. Tracking imaging tests until results are available, flagging and following up on overdue results.

C. Flagging abnormal lab results, bringing them to the attention of the clinician.

D. Flagging abnormal imaging results, bringing them to the attention of the clinician.

E. Notifying patients/families/caregivers of normal lab and imaging test results.

F. Notifying patients/families/caregivers of abnormal lab and imaging test results.

GUIDANCE	EVIDENCE
The practice demonstrates how it manages patient tests and test results (report, log, examples or electronic tracking system). If frequent lab tests are ordered for a patient, the practice provides the patient/family/caregiver (as appropriate) with all initial results, clear expectations for follow-up results and a plan for handling abnormal findings. Ineffective management of laboratory and imaging test results can result in less than optimal care, excess costs, and may compromise patient safety. Systematic monitoring helps ensure that needed tests are performed and that results are acted on, when necessary. **A, B.** The practice tracks lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center (and the patient, if necessary) to determine why results are overdue, and documents follow-up efforts until reports are received. **C, D.** Abnormal results of lab or imaging tests are flagged and brought to the attention of the clinician, to ensure timely follow-up with the patient/family/caregiver. **E, F.** The practice provides timely notification to patients about test results (normal and abnormal). Filing results in the medical record for discussion during a scheduled office visit does not meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP CC 05*** ***Documented Process Only***

CC 02 (1 Credit) Newborn Screenings: Follows up with the inpatient facility about newborn hearing and blood-spot screening.	
GUIDANCE	**EVIDENCE**
The practice follows up with the hospital or state health department if it does not receive screening results. Most states mandate that birthing facilities perform a blood-spot test to screen for congenital conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. Early detection and treatment of congenital disorders can enhance health outcomes for newborns with positive (abnormal) screening results. Practices that do not see newborn patients are not eligible for this elective criterion. 	• **Documented process** ***AND*** • **Evidence of implementation**
CC 03 (2 Credits) Appropriate Use for Labs and Imaging: Uses clinical protocols to determine when imaging and lab tests are necessary.	
GUIDANCE	**EVIDENCE**
The practice establishes clinical protocols based on evidence-based guidelines, to determine when imaging and lab tests are necessary. The practice may implement clinical decision supports to ensure that protocols are used (e.g., embedded in the order entry system). Inappropriate use of imaging or lab tests leads to unnecessary costs and risks and does not enhance patient outcomes. 	• **Evidence of implementation**

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Competency B: Referrals to Specialists. The practice provides important information in referrals to specialists and tracks referrals until the report is received.

CC 04 (Core) Referral Management: The practice systematically manages referrals by:

A. Giving the consultant or specialist the clinical question, the required timing and the type of referral.

B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.

C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

GUIDANCE	EVIDENCE
It is important that the practice track patient referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services, as well as frustration for providers. Referrals may be tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist, for a patient with depression; referral to a pediatric cardiologist, for an infant with a ventricular septal defect). **A.** The referring clinician provides a reason for the referral, which may be stated as the **clinical question** to be answered by the specialist. The referring clinician indicates the type of referral, which may be a consultation or single visit; a request for shared- or co-management of the patient for an indefinite or a limited time, such as for treatment of a specific condition; or a request for temporary or long-term principal care (a transfer). The referring clinician clarifies the urgency of the referral and specifies the reasons for an urgent appointment.	• **Documented process** ***AND*** • **Evidence of implementation**  ***PCSP CC 03*** ***Documented Process Only*** 

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CC 04 (Core) Referral Management: *continued*	
GUIDANCE	**EVIDENCE**
B. Referrals include relevant clinical information such as: • Current medications. • Diagnoses, including mental health, allergies, medical and family history, substance abuse and behaviors affecting health. • Clinical findings and current treatment. • Follow-up communication or information. Including the referring primary care clinician's care and treatment plan in the referral, in addition to test results and procedures, can reduce conflicts and duplicate services, tests and treatment. If the practice sends the primary care plan with the referral, the specialist can develop a corresponding specialty plan of care. Ideally, the primary care plan, developed in collaboration with the patient/family/caregiver, is coordinated with the specialty plan of care, created in collaboration with the patient/ family/caregiver and primary care. **C.** A tracking process includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist's office and documents its effort to retrieve the report in a log or an electronic system.	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP CC 03*** ***Documented Process Only***

CC 05 (2 Credits) Appropriate Referrals: Uses clinical protocols to determine when a referral to a specialist is necessary.	
GUIDANCE	**EVIDENCE**
The practice uses clinical protocols or decision-support tools to determine if a patient needs to be seen by a specialist or if care can be addressed or managed by the primary care clinician. Unnecessary referrals can lead to overuse of tests and services, increase patient dissatisfaction and reduce accessibility to specialists when needed.	• **Evidence of implementation**

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CC Competency B: Referrals to Specialists.

CC 06 (1 Credit) Commonly Used Specialists Identification: Identifies the specialists/specialty types frequently used by the practice.	
GUIDANCE	**EVIDENCE**
The practice monitors patient referrals to gain information about the referral specialists and specialty types it uses frequently. Specifying specialty type alone is not sufficient. This information may help identify areas where the practice can adopt guidelines or protocols to manage patient care in the primary care practice and identify trends in the patient population, and can help identify opportunities for improved coordination and patient experience when specialty care is needed.	• **Evidence of implementation**
CC 07 (2 Credits) Performance Information for Specialist Referrals: Considers available performance information on consultants/specialists when making referrals.	
GUIDANCE	**EVIDENCE**
It is important for the practice to make informed referrals to clinicians or practices that will provide timely, high-quality care. The practice consults available information about the performance of clinicians or practices to which it refers patients. The practice provides information or examples of the available performance data on the consultant/ specialist with the practice team. Information gathered in CC 11 may be useful in assessing consultants/specialists.	• **Data source** ***AND*** • **Examples**
NYS CC 08 (1 Credit) Specialist Referral Expectations: Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	• **Documented process** ***OR*** • **Agreement**

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CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support consistency of information shared across practices. The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content). A notification demonstrating legal inability to receive a report that includes confirmation a behavioral health visit occurred meets the content requirement. A practice needs an agreement if it shares the same facility or campus as behavioral healthcare professionals but has separate systems (basic onsite collaboration) or uses a contracted behavioral telehealth provider. The practice may present existing internal processes if there is partial integration of behavioral healthcare services.	• **Agreement** ***OR*** • **Documented process *and*** • ***E*vidence of implementation**

CC 10 (2 Credits) Behavioral Health Integration: Integrates behavioral healthcare providers into the care delivery system of the practice site.	
GUIDANCE	**EVIDENCE**
Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting. This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, have shared accountability and collaborative treatment and workflow strategies. Behavioral health integration using telehealth capabilities is acceptable if the behavioral telehealth provider is integrated into the workflow of the PCMH practice.	• **Documented process** ***AND*** • **Evidence of implementation**

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CC Competency B: Referrals to Specialists.

CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.	
GUIDANCE	**EVIDENCE**
The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided appropriate information about the patient's diagnosis and treatment plan. The practice bases its definition of "timely" on patient need. Ongoing assessment and referral monitoring may be helpful in CC 07.	• **Documented process** ***AND*** • **Report** ***Documented Process Only***
CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the patient's medical record.	
GUIDANCE	**EVIDENCE**
When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co-management of the patient's care. Under the agreement, the primary care clinician and specialist share changes in the treatment plan and patient health status, in addition to entering information in the medical record within an agreed-on time frame. The practice must provide three examples of such arrangements.	• **Evidence of implementation**

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CC 13 (2 Credits) Connects to Financial Resources: Engages with patients regarding cost implications of treatment options, provides information about current coverage and makes connections to financial resources as needed.	
GUIDANCE	**EVIDENCE**
Cost and coverage can play a major role in a patient's drug and treatment adherence. Going without necessary medical care can result in severe consequences, particularly in patients with chronic diseases. Staff are educated in engaging patients/families/caregivers in discussion about financial need. The practice: • Discusses the cost of recommended treatment options with patients and tells patients which services are critical and should not be skipped. If appropriate, the practice recommends less-expensive options. • Assesses patients' current financial resources (e.g., adds a financial question to the clinical intake screening [Do you have trouble affording the care or prescriptions prescribed? Y/N]; the clinician asks about prescription drug coverage. • Provides information about potential sources of coverage to uninsured patients (e.g., connects patients with state Medicaid, CHIP [Children's Health Insurance Program], healthcare.gov or other patient insurance assistance programs). • Maintains an updated list of available financial assistance resources and connects patients to appropriate services (e.g., directs patients to resources such as copay, deductible and prescription assistance programs).	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented Process Only***

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CC Competency C: Coordinating Care With Health Care Facilities.

Competency C: Coordinating Care With Health Care Facilities. The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

CC 14 (Core) Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.	
GUIDANCE	**EVIDENCE**
The practice has a process for monitoring unplanned admissions and ED visits, including their frequency. The practice works with local hospitals, EDs and health plans to proactively identify patients with recent unplanned visits, and demonstrates how it systematically receives notifications from facilities with which the practice has established mechanisms for exchange. Receiving timely notification of patients with unplanned hospital admissions and ED visits allows practices to provide support and coordinate with the hospital or ED. Relying on notification of discharge alone would not meet the intent.	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP CC 07*** ***Documented Process Only***
CC 15 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.	
GUIDANCE	**EVIDENCE**
The practice demonstrates timely sharing of information with admitting hospitals and EDs. The practice provides three examples as evidence of implementation. Shared information supports continuity in patient care across settings.	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP CC 08*** ***Documented Process Only***

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CC Competency C: Coordinating Care With Health Care Facilities.

CC 16 (Core) Post-Hospital/ED Visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	
GUIDANCE	**EVIDENCE**
The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice's policies define the appropriate contact period and systematically documents follow-up. Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encourage follow-up care, which may include, but is not limited to, physician counseling, telehealth visits, referrals to community resources and disease or case management or self-management support programs.	• **Documented process** ***AND*** • **Evidence of implementation**  ***PCSP CC 09*** ***Documented Process Only*** 

CC 17 (1 Credit) Acute Care After-Hours Coordination: Systematic ability to coordinate with acute care settings after office hours through access to current patient information.	
GUIDANCE	**EVIDENCE**
The practice has a process to coordinate with acute care facilities when a patient is seen after the office is closed. Sharing patient information allows the facility to coordinate patient care based on current health needs and engage with practice staff.	• **Documented process** ***AND*** • **Evidence of implementation**  ***PCSP CC 10*** ***Documented Process Only***  ***Documented Process Only***

CC 18 (1 Credit) Information Exchange During Hospitalization: Exchanges patient information with the hospital during a patient's hospitalization.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can send and receive patient information during a patient's hospitalization. ***Note:*** *CC 15 assesses the practice's ability to share information, but the focus of CC 18 is two-way exchange of information.*	• **Documented process** ***AND*** • **Evidence of implementation**  ***PCSP CC 11*** ***Documented Process Only*** 

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CC 19 (1 Credit) Patient Discharge Summaries: Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.	
GUIDANCE	**EVIDENCE**
The practice has a process for obtaining patient discharge summaries for patients following discharge from a hospital or other care facility. The practice shows that it obtains discharge summaries directly or demonstrates participation in a local admission, discharge, transfer (ADT) system. Actively gathering information about patient admissions, discharges or transfers from the hospital and other care facilities improves care coordination, safe handoffs and reduces readmissions.	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP CC 12*** ***Documented Process Only***

CC 20 (1 Credit) Care Plan Collaboration for Practice Transitions: Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).	
GUIDANCE	**EVIDENCE**
The practice involves the patient/family/caregiver in the development or implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care. The written care plan may include: • A summary of medical information (e.g., history of hospitalizations, procedures, tests). • A list of providers, medical equipment and medications for patients with special health care needs. • Obstacles to transitioning to an adult care clinician. • Special care needs. • Information provided to the patient about the transition of care. • Arrangements for release and transfer of medical records to the adult care clinician. • Patient response to the transition. • Patient transition plan.	• **Evidence of implementation**

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CC 20 (1 Credit) Care Plan Collaboration for Practice Transitions *continued*	
GUIDANCE	**EVIDENCE**
Internal medicine practices receiving patients from pediatricians are expected to request/review the transition plan provided by pediatric practices, or to develop a plan, if one is not provided, to support a smooth and safe transition. **For family medicine practices** that do not transition patients from pediatric to adult care, should still educate patients and families about ways in which their care experience may change as the patient moves into adulthood. Sensitivity to privacy concerns should be incorporated into messaging.	• **Evidence of implementation**

NYS

CC 21 (*Maximum* 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries (may select one or more): **A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit)** **B. Immunization registries or immunization information systems. (1 Credit)** **C. Summary of care record to another provider or care facility for care transitions. (1 Credit)**	
GUIDANCE	**EVIDENCE**
The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate this electronic exchange by: **A.** Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. **B.** Submitting electronic data to immunization registries, to share immunization services provided to patients. **C.** Making the summary of care record accessible to another provider or care facility for care transitions. **Electronically exchanging** means that clinical data can be both sent and received electronically. Practices may provide the required evidence for each criterion, for up to three credits. Each option is part of CC 21, but is listed separately in Q-PASS for scoring purposes.	• **Evidence of implementation** **NYS PCMH must also:** • **Indicate Qualified Entity** **A:** Practices in New York pursuing NYS PCMH Recognition must demonstrate connection to and exchange of patient information with a Statewide Health Information Network for New York (SHIN-NY) Qualified Entity (NYS regional health information organization) (https://www.nyehealth.org/shin-ny/connect-use/). ***PCSP CC 13***

Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

Competency A: Measuring Performance. The practice measures to understand current performance and to identify opportunities for improvement.

QI 01 (Core) Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

A. Immunization measures.

B. Other preventive care measures.

C. Chronic or acute care clinical measures.

D. Behavioral health measures.

GUIDANCE	EVIDENCE
Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least: • One immunization measure. • One preventive care measure (not including immunizations). – A measure on oral health counts as a preventive clinical quality measure. • One chronic or acute care clinical measure. • One behavioral health measure. The data must include the measurement period, the number of patients represented by the data, the rate and the measure source (e.g., HEDIS, NQF #, measure guidance). Measures include activities conducted during telehealth visits.	• **Report** **FUTURE STATE: Entering Measures Data** Enter measures data from the Measures Reporting tile on the Organization Dashboard. ***Note:*** *Standardized measures will be required starting in 2024. Refer to Appendix 5 for information.*

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QI 02 (Core) Resource Stewardship Measures: Monitors at least two measures of resource stewardship (must monitor at least one measure of each type): **A. Measures related to care coordination.** **B. Measures affecting health care costs.**	
GUIDANCE	**EVIDENCE**
The practice reports at least two measures related to resource stewardship, including a measure related to health care cost and a measure related to care coordination. When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources. Measures include activities conducted during telehealth visits.	• **Report** ***AND*** • **Indicate Measure Category** **FUTURE STATE: Entering Measures Data** Enter measures data from the Measures Reporting tile on the Organization Dashboard. ***Note:*** *Standardized measures will be required starting in 2024. Refer to Appendix 5 for information.*

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QI 03 (Core) Appointment Availability Assessment: Assesses performance on availability of major appointment types to meet patient needs and preferences for access.	
GUIDANCE	**EVIDENCE**
Patients who cannot get a timely appointment with their primary care provider may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history. The practice consistently reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary (e.g., seasonal changes, shifts in patient needs, practice resources). Major appointments may be conducted in person or via telehealth. A common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type.	• **Documented process** ***AND*** • **Report** ***Documented Process Only***

QI 04 (Core) Patient Experience Feedback: Monitors patient experience through: **A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:** • **Access.** • **Communication.** • **Coordination.** • **Whole-person care, self-management support and comprehensiveness.** **B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.**	
GUIDANCE	**EVIDENCE**
The practice gathers feedback from patients and provides summarized results to inform quality improvement activities. Patient feedback must represent the practice population (including all relevant subpopulations) and may not be limited to patients of one clinician (of several), or to data from one payer (of several). **A.** The practice (directly or through a survey vendor) conducts a patient survey to assess the patient/family/caregiver experience with the practice. The patient survey may be conducted as a written questionnaire (paper or electronic) or by telephone, and includes questions related to at least three of the following categories:	• **Report**

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QI 04 (Core) Patient Experience Feedback: *continued*	
GUIDANCE	**EVIDENCE**
• **Access to clinical care** (may include routine, urgent, after-hours and alternative appointments such as telehealth; ease of getting to the practice, scheduling an appointment or waiting room amenities would not be considered access questions). • **Communication with the practice, clinicians and staff** (may include "feeling respected and listened to" and "able to get answers to questions"). • **Coordination of care** (may include being informed and up to date on referrals to specialists, changes in medications and lab or imaging results). • **Whole-person care/self-management support** (may include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, routine and urgent care, advice, assistance and support for changing health habits and making health care decisions). **B.** Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as "virtual" (e.g., telephone, videoconference) participation. The practice provides a summarized report of collected feedback. The requirement is not met by: • Comments that were collected on surveys to satisfy QI 04, component A, ***and/or*** • Feedback collected by Patient and Family Advisory Committees (PFAC) that represent more than one practice and/or do not depict the entire patient population.	• **Report**

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QI 05 (1 Credit) Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): A. Clinical quality. B. Patient experience.	
GUIDANCE	**EVIDENCE**
The practice stratifies performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics (e.g., gender identity, language needs, education, income, type of insurance [Medicare, Medicaid, commercial], disability, health status). The intent of this criterion is for the practice to work toward eliminating disparities in health and delivery of health care for its vulnerable patient populations. Vulnerable populations include those who are socioeconomically disadvantaged, racial and ethnic minorities, the frail elderly, people experiencing homelessness and those who are geographically disadvantaged. When these social factors intersect with health, it can exacerbate chronic health conditions.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 06 (1 Credit) Validated Patient Experience Survey Use: The practice uses a standardized, validated patient experience survey tool with benchmarking data available.	
GUIDANCE	**EVIDENCE**
The practice uses the standardized survey tool to collect patient experience data and inform its quality improvement activities. The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices. The practice may use standardized tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) PCMH survey, CAHPS-CG or another standardized survey administered through measurement initiatives providing benchmark analysis external to the practice organization. It may not be a proprietary instrument. The practice must administer the entire approved standardized survey (not sections of the survey) to receive credit.	• **Report**

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QI Competency B: Setting Goals and Acting to Improve.

QI 07 (2 Credits) Vulnerable Patient Feedback: Obtains feedback from vulnerable patient groups on the experiences of disparities in care or services.	
GUIDANCE	**EVIDENCE**
The practice identifies a vulnerable population where data (clinical quality, resource stewardship, quantitative patience experience, access) show evidence of disparities of care or services. The practice obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives to close gaps in care.	• **Report**

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QI Competency B: Setting Goals and Acting to Improve.

Competency B: Setting Goals and Acting to Improve. The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

QI 08 (Core) Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories:

A. Immunization measures.

B. Other preventive care measures.

C. Chronic or acute care clinical measures.

D. Behavioral health measures.

GUIDANCE	EVIDENCE
Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Measures selected for improvement are chosen from the set of measures identified in QI 01. The goal is for the practice to reach a desired level of achievement based on a self-identified standard of care. 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. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx).	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI 09 (Core) Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship:

A. Measures related to care coordination.

B. Measures affecting health care costs.

GUIDANCE	EVIDENCE
The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. Measures selected for improvement may be chosen from the same set of measures identified in QI 02. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. 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. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx).	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 10 (Core) Goals and Actions to Improve Appointment Availability: Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.

GUIDANCE	EVIDENCE
Knowing that a variety of factors (e.g., season, patient need, practice resource) can affect appointment availability, the practice can adjust to meet patient preferences and needs. After assessing performance on the availability of common appointment types in QI 03, the practice sets goals and acts to improve on availability. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. Practices that have met their appointment-availability access goals in QI 03 and cannot reasonably adjust their goals or identify room for improvement (practices with open-access scheduling) may select another patient-access area (e.g., time spent in the waiting room, no show rates, extended hours, alternative visit types) as their focus.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI Competency B: Setting Goals and Acting to Improve.

QI 11 (Core) Goals and Actions to Improve Patient Experience: Sets goals and acts to improve performance on at least one patient experience measure.	
GUIDANCE	**EVIDENCE**
After assessing performance on at least one patient experience measure (QI 04), the practice demonstrates that it set a goal for improving patients' experience of care and is working to meet the stated goal. The practice acts to reach a desired level of achievement based on its self-identified standard of care.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 12 (2 Credits) Improved Performance: Achieves improved performance on at least two performance measures.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it has improved performance on at least two measures. Demonstration of improvement is determined by the goals set in QI 08, QI 09 or QI 11.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 13 (1 Credit) Goals and Actions to Improve Disparities in Care/Service: Sets goals and acts to improve performance on at least one measure of disparities in care or services.	
GUIDANCE	**EVIDENCE**
After assessing performance in care or services among vulnerable populations (QI 05), the practice identifies disparities, sets goals and acts to improve performance.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 14 (2 Credits) Improved Performance for Disparities in Care/Service: Achieves improved performance on at least one measure of disparities in care or service.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it has improved performance on at least one measure related to disparities in care or service. Demonstration of improvement is determined by the goals set in QI 13.	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI Competency C: Reporting Performance.

Competency C: Reporting Performance. The practice is accountable for performance and shares data within the practice, with patients and/or publicly for the measures and patient populations identified in the previous section.

QI 15 (Core) Reporting Performance Within the Practice: Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice provides individual clinician or practice-level reports to clinicians and practice staff that include a minimum of: • One clinical quality measure • One resource stewardship measure • One patient experience measure Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP QI 09*** ***Documented Process Only***

QI 16 (1 Credit) Reporting Performance Publicly or With Patients: Shares clinician-level or practice-level performance results publicly or with patients for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice shares individual clinician or practice-level reports with patients and the public that include a minimum of: • One clinical quality measure • One resource stewardship measure • One patient experience measure Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).	• **Documented process** ***AND*** • **Evidence of implementation** ***PCSP QI 10*** ***Documented Process Only***

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QI Competency C: Reporting Performance.

QI 17 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves the patient/family/caregiver in quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice has a process for involving patients and their families in its quality improvement efforts or on the practice's patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/ caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	• **Documented process** ***AND*** • **Evidence of implementation**

QI 18 (2 Credits) Electronic Submission of Measures: Electronically reports clinical quality measures to an external entity such as Medicare, a Medicaid agency or a health plan.	
GUIDANCE	**EVIDENCE**
The practice electronically produces and transmits clinical quality measures to an external entity such as Medicare, a state Medicaid agency or a health plan that include a minimum of: • One immunization measure. • One preventive care measure (not including immunizations). • One chronic or acute care clinical measure. • One behavioral health measure. Data submitted are not based on claims and include the entire relevant patient population, not a sample.	• **Evidence of submission**

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QI 19 (*Maximum* 2 Credits) Value-Based Payment Arrangements: Engaged in a value-based payment arrangement. **A. Practice engages in upside risk (1 Credit).** **B. Practice engages in two-sided risk (2 Credits).**	
GUIDANCE	**EVIDENCE**
The practice demonstrates it participates in a value-based arrangement by providing information about its participation or a copy of an executed agreement. Value-based arrangements represent a shift from fee-for-service billing to compensating practices and providers for administering quality care to patients. Participation in these programs signals that a practice is willing to be accountable for the value of care it provides, rather than volume of care. **Upside Risk:** The clinician/practice receives an incentive for meeting performance expectations but does not share losses if costs exceed targets. **Two-Sided Risk:** The clinician/practice receives incentives for meeting performance expectations regarding quality and cost but incurs penalties if it does not.	• **Agreement** ***OR*** • **Evidence of implementation**  ***PCSP QI 13*** 

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