NCQA PCMH Overview

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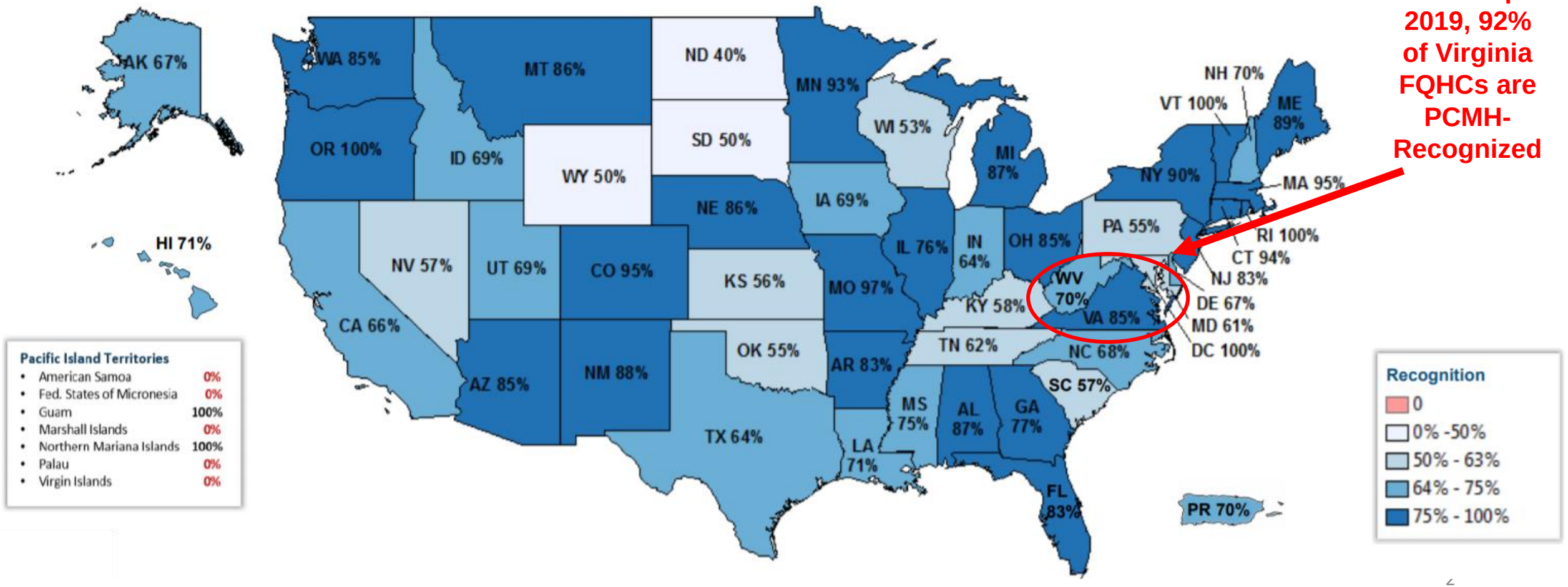
Community Health Solutions

National FQHC PCMH Recognition Status

(75% as of December 31, 2018)



Pacific Island Territories

American Samoa	0%
Fed. States of Micronesia	0%
Guam	100%
Marshall Islands	0%
Northern Mariana Islands	100%
Palau	0%
Virgin Islands	0%

As of Sept. 2019, 92% of Virginia FQHCs are PCMH-Recognized

Source: HRSA Accreditation and Patient-Centered Medical Home Report, 2019

Why PCMH?

Reduce Fragmentation

- The PCMH model emphasizes team-based care, communication, and coordination, which has been shown to lead to better care

Align with Payers

- Many payers acknowledge PCMH recognition as a hallmark of high-quality care. As a result, many payers provide incentives for PCMH-recognized practices.

Improve Staff Satisfaction

- The PCMH model is associated with better staff satisfaction. One analysis found implementation of NCQA PCMH Recognition to increase staff work satisfaction while reported staff burnout decreased by more than 20%.

Improve Patient Experience

- A Hartford Foundation study found that the PCMH model resulted in a better experience for patients, with 83% of patients saying being treated in a PCMH site improved health.

Why PCMH?

Better Manage Chronic Conditions

- The PCMH model has been shown to help better manage patients' chronic conditions

Align with State/Federal Initiatives

- As more emphasis is placed on value-based care, many state and Federal programs are embracing the patient-centered model of care.

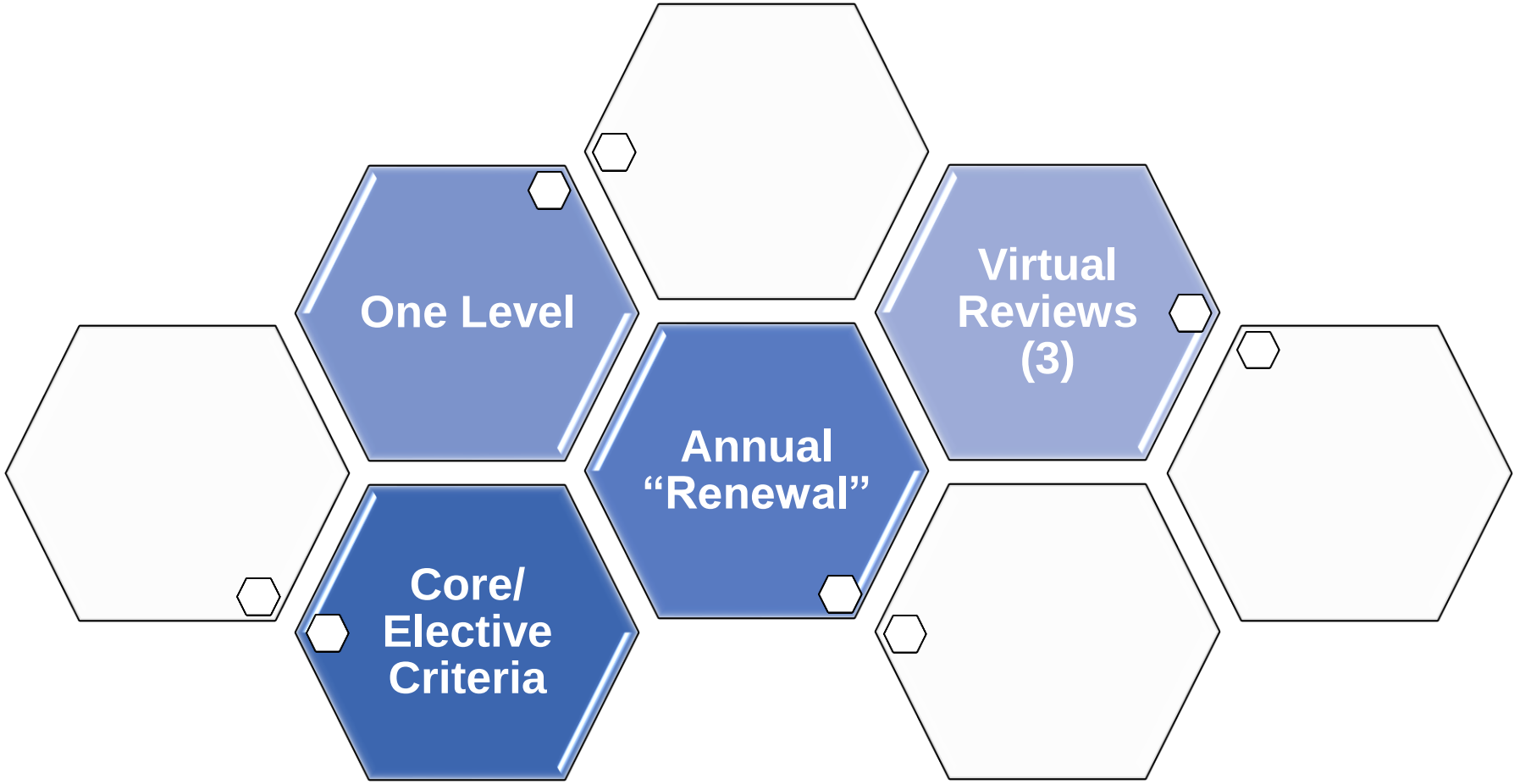
Lower Health Care Costs

- PCMH Recognition is associated with lower overall health care costs.

Improve Patient-Centered Access

- PCMHs emphasize the use of health information technology and after-hours access to improve overall access to care when and where patients need it.

NCQA PCMH Program – Key Highlights



NCQA PCMH Guidelines - Structure

Concepts, Competencies, and Criteria

Concepts: Over-arching components of PCMH

Competencies: Ways to think about and/or categorize criteria

Criteria: The individual things/tasks you do that make you a PCMH

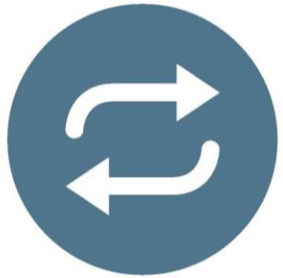
NCQA PCMH Guidelines - Concepts

Team-Based Care and Practice Organization

Knowing and Managing Your Patients

Patient-Centered Access and Continuity

Care Management and Support



Care Coordination and Care Transitions

Performance Measurement & Quality Improvement

NCQA PCMH Guidelines - Concepts

Team-Based Care and Practice Organization (TC)

The practice provides **continuity of care**, **communicates roles and responsibilities** of the medical home to patients/families/ caregivers, and organizes and **trains staff** to work to the top of their license and provide effective team-based care.

Knowing and Managing Your Patients (KM)

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

Patient-Centered Access and Continuity (AC)

The practice **provides 24/7 access to clinical advice and appropriate care** facilitated by their designated clinician/care team, **considers the needs and preferences of the patient population** when modeling standards for access.

NCQA PCMH Guidelines - Concepts

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**.

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.

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.**

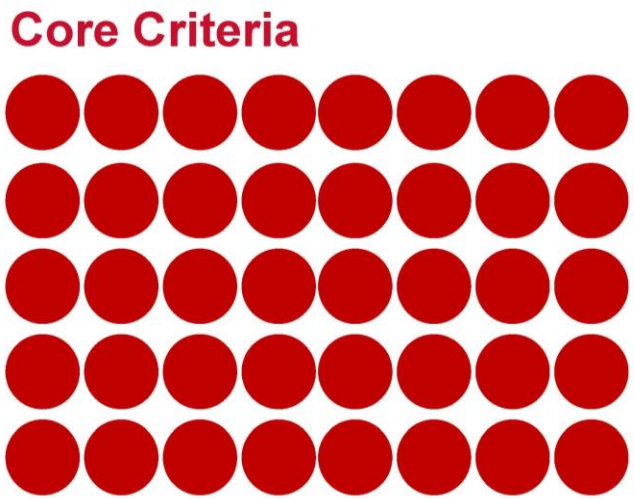
NCQA PCMH Guidelines - Scoring

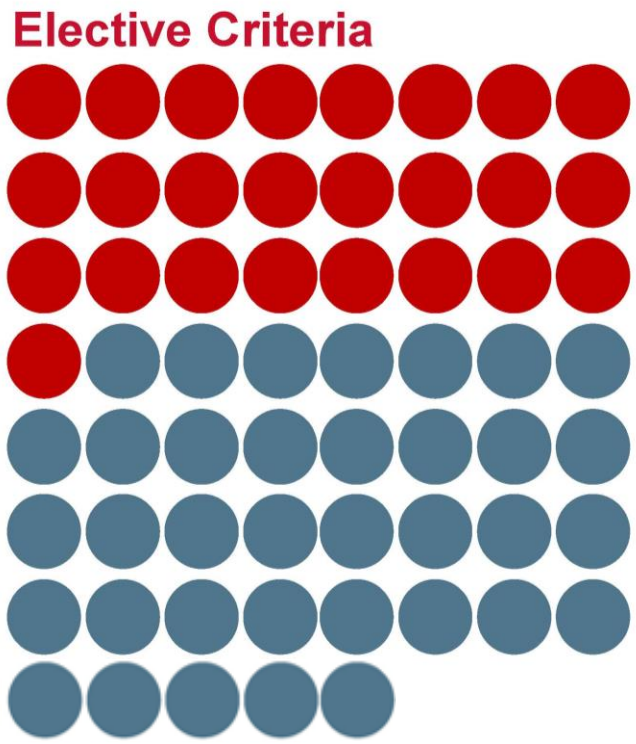
- 101 Criteria in total, **40 of which are Core criteria.**
- Total of 84 credits across the **61 Elective criteria**.
  - There are 39 criteria worth 1 credit.
  - There are 21 criteria worth 2 credits
  - One criterion is worth a maximum of 3 credits.

- Need to implement all 40 Core criteria, plus **25 elective credits from 5 of the 6 concepts**.

NCQA PCMH Guidelines - Scoring

40 Core Criteria **+** **25 Credits from the 61 Elective Criteria**



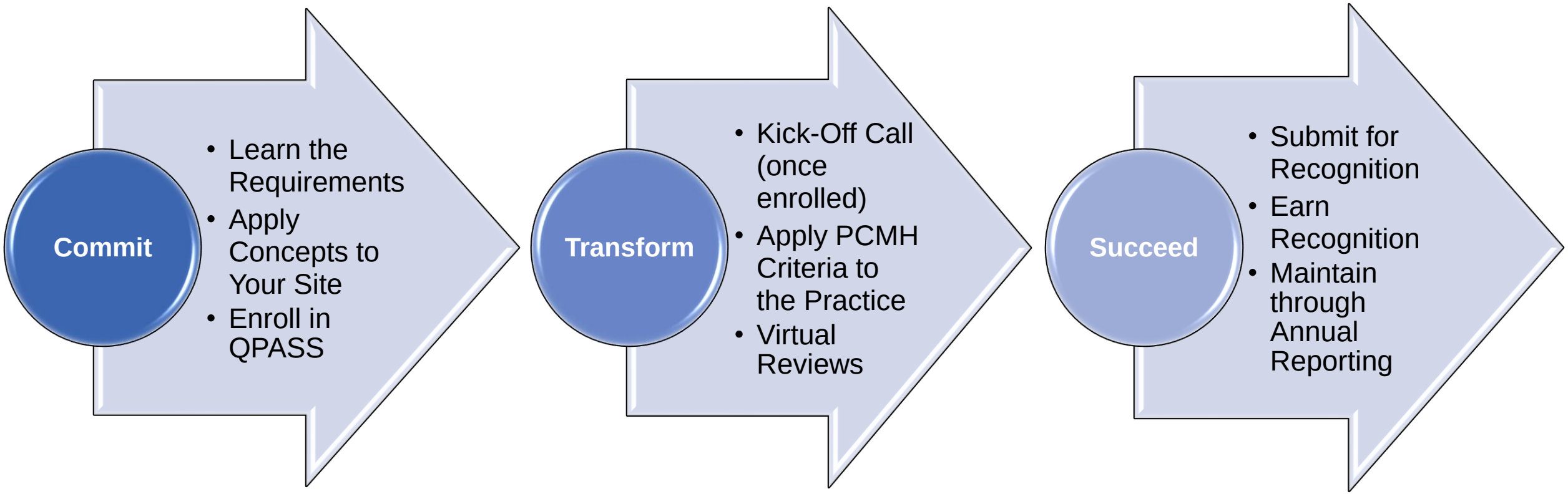


In this example (red dots) you could choose 25 criteria, each worth 1 credit

NCQA PCMH Guidelines - Scoring

40 Core Criteria, by Concept

NCQA PCMH Process



Overview of the Day

- There is a segment on the agenda for each of the 6 concepts

Timing	Concept	Format
8:50 – 9:25	Team-Based Care and Practice Organization (TC)	The format of each segment will be as follows: • Present Slides • Q&A • Table Discussion and Self-Assessment
9:25 – 10:20	Knowing and Managing Your Patients (KM)	
10:35 – 11:15	Patient Centered Access and Continuity (AC)	
11:15 – 11:55	Care Management and Support (CM)	
1:20 – 2:10	Performance and Quality Improvement (QI)	
2:25 – 3:00	Coordinating Care and Care Transitions (CC)	

- During the slide presentation, feel free to make notes on your self-assessment. There is also dedicated time in each segment.

Resources

Relevance of resources is indicated using the following:

Site's next step is Annual Reporting. Has already received PCMH recognition under redesigned process (2017 -) or Level 3 from 2014 Standards.

Site is transitioning from existing 2014 Level 1 or 2 PCMH Recognition to PCMH recognition in the redesigned process.

Site is pursuing new recognition and does not have existing recognition that is active.

Transfer

New

Timeline of Tasks for PCMH Recognition

Community Health Solutions

Timeline and Tasks for New NCQA PCMH Recognition

	Pre-App	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	On-going
Commit														
Learn it. Download the NCQA standards and guidelines and begin learning the concept areas and required criteria. *NOTE: Even if you have a copy already, it is good practice to redownload one because NCQA makes updates periodically.* http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-andguidelines-epub/														
Assemble your team. Get leadership support, identify a PCMH lead, then educate staff about the strategic reason for PCMH and get staff buy-in.														
Schedule regular meetings. Determine a frequency for meeting and discussing PCMH progress.														
Self-Assessment. Download the *CHS PCMH Tracker* https://chcleadership.com/chs-pcmh-tracker-2017/ Use it to do a self-assessment of where you are on various criteria. Here you just want to focus on what criteria are already in practice - do not worry yet about the documentation.														
Create an action plan. Based on the self-assessment/readiness assessment, - Do you have sufficient criteria and credits already identified as being "in place"? - Are there additional criteria you may need to implement in order to achieve recognition? - The list of criteria you have or plan to implement is your pathway/roadmap														
Determine your timeline. Determine your goal for achieving recognition. What is the timeline, and are there any influencing funding opportunities or deadlines that would impact this timeline? Is that timeline feasible based on the results of your self-assessment?														
Begin implementation of your action plan. Apply PCMH concepts and criteria to your existing processes. Consider using this Implementation Priorities Pathway as a way to get started. Begin development if any criteria are still needed https://chcleadership.com/pathway-for-core-criteria-implementation/.														
Funding. Apply to HRSA for funding of recognition application costs. This is called the Notice of Intent. You will apply for this through your FQHC's HRSA Electronic Handbook (EHB).														
Enroll through Q-PASS. Once you enroll (register in Q-PASS), NCQA assigns a representative to guide your practice through the recognition process. Enrolling in Q-PASS (https://qpass.ncqa.org/Home/Welcome) involves the following steps: Choose sites, Choose product(s), Add/create clinicians, Sign agreements, and Pay (can't pay until agreements are signed) - here you would enter the discount code you received from your NOI so that HRSA foots the bill. Make sure to click Pay Invoice (even though the invoice will be $0). NOTE: The 12-month "clock" starts as soon as you either enter your key you received from the NOI (HRSA is footing the bill) or you enter your own payment method.													
Single site or Multi-site: Organizations may apply as a multi-site if they have 3+ practice sites, they share an EHR, and use the same processes. Applying as a multi-site allows the organization to submit certain documentation/evidence once on behalf of all sites under the application, which saves time. If your organization does not meet these multi-site criteria, each site would apply separately. *NOTE: If you have 2 sites, you could use the same processes but they must be uploaded separately with the site name.*														
Explore Auto-credits. Is your EHR prevalidated? (http://www.ncqa.org/programs/recognition/prevalidation-program) If so, you will obtain a letter from your EHR vendor and upload it in Q-PASS. This will allow you auto-credit for some of the criteria. *NOTE: You should only attest to those auto-credits where you have implemented that function in your EHR and are using it according to the intent outlined in the criteria.*														
NCQA Questionnaire. Complete an online initial questionnaire through Q-PASS.														
Transform														
Review Policies. Review current policies and procedures to assess which might be consistent with criteria requirements. Here you are starting with those criteria you identified as being "in place" to some extent in your readiness assessment. Beginning with the core criteria, then moving to elective.														

Helps address the following:

1. How long does it take to get PCMH recognition?
2. What steps and tasks are involved?
3. How do we create a workplan from start to finish?

What it is NOT

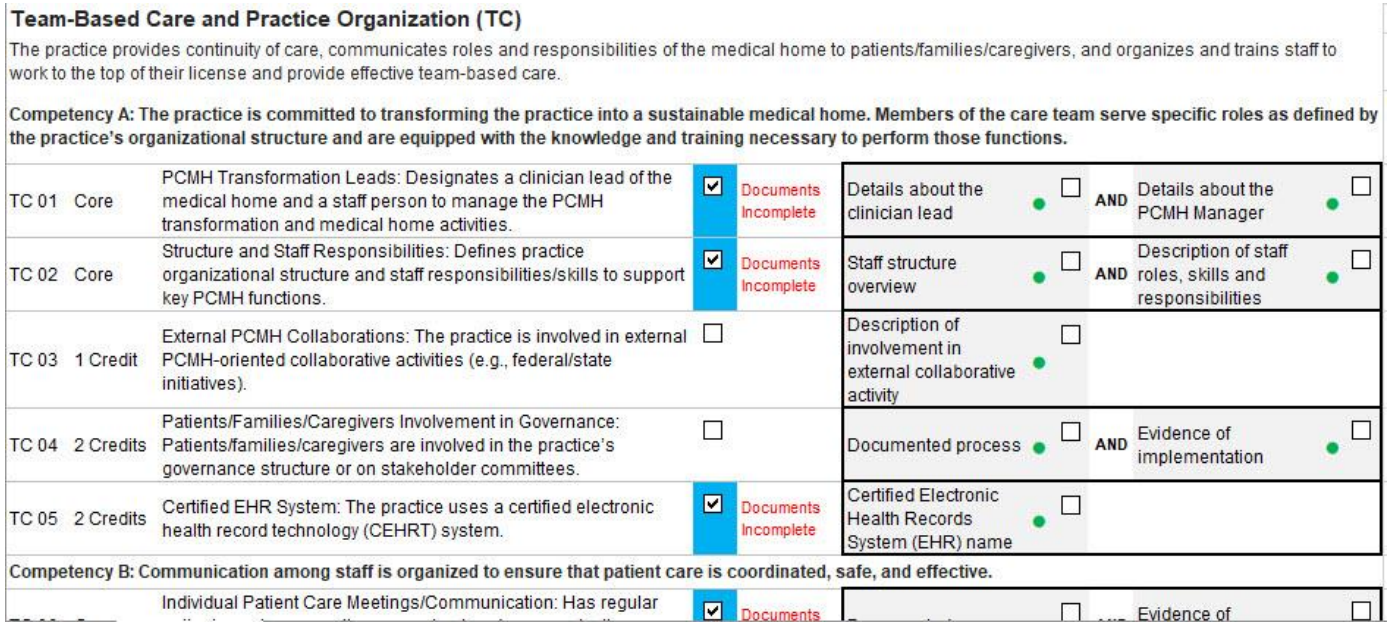
- Not designed to help select criteria (see next slide).

https://chcleadership.com/timeline-and-tasks-for-pcmh-recognition/

Jump Start Pathway to PCMH Recognition (Including Elective Criteria)

Transfer

New



Team-Based Care and Practice Organization (TC)

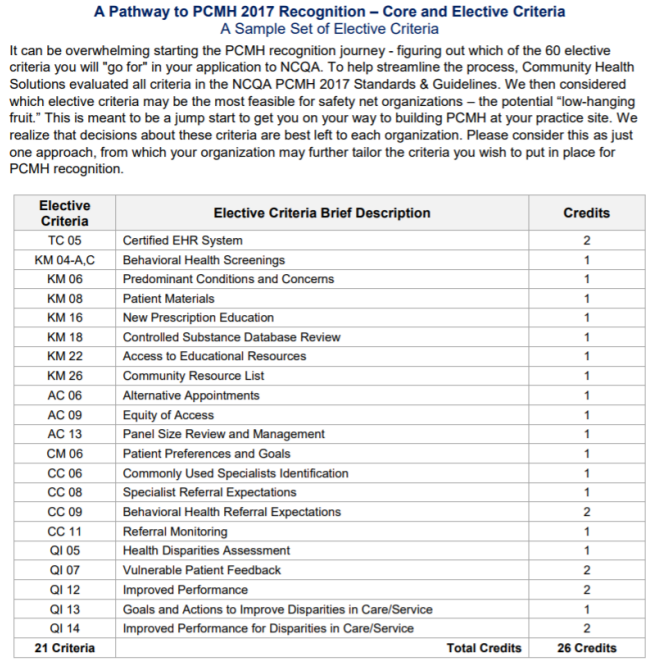
The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

TC 01	Core	PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	☑	Documents Incomplete	Details about the clinician lead	☐	AND Details about the PCMH Manager	☐
TC 02	Core	Structure and Staff Responsibilities: Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.	☑	Documents Incomplete	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 (e.g., federal/state initiatives).	☐		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.	☐		Documented process	☐	AND Evidence of implementation	☐
TC 05	2 Credits	Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.	☑	Documents Incomplete	Certified Electronic Health Records System (EHR) name	☐		

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

		Individual Patient Care Meetings/Communication: Has regular	☑	Documents		☐	AND Evidence of	☐



A Pathway to PCMH 2017 Recognition – Core and Elective Criteria

A Sample Set of Elective Criteria

It can be overwhelming starting the PCMH recognition journey - figuring out which of the 60 elective criteria you will "go for" in your application to NCQA. To help streamline the process, Community Health Solutions evaluated all criteria in the NCQA PCMH 2017 Standards & Guidelines. We then considered which elective criteria may be the most feasible for safety net organizations – the potential "low-hanging fruit." This is meant to be a jump start to get you on your way to building PCMH at your practice site. We realize that decisions about these criteria are best left to each organization. Please consider this as just one approach, from which your organization may further tailor the criteria you wish to put in place for PCMH recognition.

Elective Criteria	Elective Criteria Brief Description	Credits
TC 05	Certified EHR System	2
KM 04-A,C	Behavioral Health Screenings	1
KM 06	Predominant Conditions and Concerns	1
KM 08	Patient Materials	1
KM 16	New Prescription Education	1
KM 18	Controlled Substance Database Review	1
KM 22	Access to Educational Resources	1
KM 26	Community Resource List	1
AC 06	Alternative Appointments	1
AC 09	Equity of Access	1
AC 13	Panel Size Review and Management	1
CM 06	Patient Preferences and Goals	1
CC 06	Commonly Used Specialists Identification	1
CC 08	Specialist Referral Expectations	1
CC 09	Behavioral Health Referral Expectations	2
CC 11	Referral Monitoring	1
QI 05	Health Disparities Assessment	1
QI 07	Vulnerable Patient Feedback	2
QI 12	Improved Performance	2
QI 13	Goals and Actions to Improve Disparities in Care/Service	1
QI 14	Improved Performance for Disparities in Care/Service	2
21 Criteria	Total Credits	26 Credits

Helps address the following:

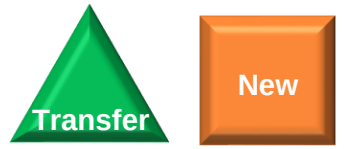
- Which elective criteria may be most feasible for FQHCs?

What it is NOT

- Not meant to be prescriptive – decisions about implementation are up to the practice site.

https://chcleadership.com/jump-start-pathway-to-pcmh-recognition/

Choosing Criteria for Each Virtual Review (Core and Elective)



PCMH: Suggested Recognition Plan

NCQA

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)					
Competency A: The practice is committed to transforming into a sustainable medical home. Care team members serve specific roles, as defined by the practice's organizational structure, and are equipped with the knowledge and training necessary to perform the functions of their roles.			Virtual Review #		
			1	2	3
TC 01❖ (Core)	PCMH Transformation Leads	Designates a clinician lead for the medical home and staff (one person) to manage the PCMH transformation and medical home activities.	✓		
TC 02 (Core)	Structure & Staff Responsibilities	Defines the practice's organizational structure and staff responsibilities/skills to support key PCMH functions.	✓		
TC 03❖ (1 Credit)	External PCMH Collaborations	The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).			✓
TC 04 (2 Credits)	Patient/Family/Caregiver Involvement in Governance	Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.		✓	
TC 05 (2 Credits)	Certified EHR System	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis and implements security updates as necessary correcting identified security deficiencies.	✓		
Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.			Virtual Review #		
			1	2	3
TC 06 (Core) **	Individual Patient Care Meetings/ Communication	Has regular patient care team meetings or a structured communication process focused on individual patient care.	✓		
TC 07 (Core)	Staff Involvement in Quality Improvement	Involves care team staff in the practice's performance evaluation and quality improvement activities.	✓		
TC 08❖ (2 Credits)	Behavioral Healthcare Manager	Has at least one care manager qualified to identify and coordinate behavioral health needs.		✓	

Helps address the following:

- How might we decide which of the Core AND Elective criteria to demonstrate for each virtual review with NCQA?

NOTE: This tool was developed by NCQA. It is focused on a virtual review schedule, and not necessarily implementation prioritization of what is accomplished when in transformation (see prior slide). There are some differences in this tool and the one developed by CHS.

What it is NOT:

- Not meant to be prescriptive, decisions about implementation are up to the practice.
- Assumes practices are starting from scratch - sites who attested to criteria (e.g. if transitioning from a Level 1 or 2 existing recognition OR those with a pre-validated EHR may wish to adjust this timeline and move certain criteria to earlier check-ins).

https://chcleadership.com/choosing-criteria-for-each-virtual-review/

Core Criteria Implementation Priorities Pathway

A Pathway for Implementation of Core Criteria
NCQA PCMH 2017 Guidelines

There are 40 core/required criteria in the NCQA PCMH 2017 Standards and Guidelines. Based on our knowledge of implementation considerations for these criteria, we recommend a pathway and priority list below. This is not meant to be prescriptive but is one approach for practices to use as they work through implementation and transformation.

Core Criteria	Criteria Brief Description	Implementation Priority
TC 01	PCMH Transformation Leads	1
TC 02	Structure and Staff Responsibilities	1
AC 02	Same-Day Appointments	2
AC 03	Appointments Outside Business Hours	2
CM 01	Identifying Patients for Care Management	3
CM 02	Monitoring Patients for Care Management	3
CM 04	Person-Centered Care Plans	4
CM 05	Written Care Plans	4
TC 06	Individual Patient Care Meetings/Communication	5
KM 03	Depression Screening	6
KM 12	Proactive Outreach	6
CC 01	Lab and Imaging Test Management	7
CC 04	Referral Management	7
CC 14	Identifying Unplanned Hospital and ED Visits	8
CC 16	Post-Hospital/ED visit Follow-Up	8
CC 15	Sharing Clinical Information	9
TC 07	Staff Involvement in Quality Improvement	10
QI 01	Clinical Quality Measures	11
QI 08	Goals and Actions to Improve Clinical Quality Measures	11
QI 02	Resource Stewardship Measures	12
QI 09	Goals and Actions to Improve Resource Stewardship Measures	12
AC 01	Access Needs and Preferences	13
QI 03	Appointment Availability Assessment	13
QI 10	Goals and Actions to Improve Appointment Availability	13
QI 04	Patient Experience Feedback	14
QI 11	Goals and Actions to Improve Patient Experience	14
QI 15	Reporting Performance within the Practice	15
AC 04	Timely Clinical Advice by Telephone	16
AC 05	Clinical Advice Documentation	16
KM 20	Clinical Decision Support	17
KM 01	Problem Lists	18
KM 02	Comprehensive Health Assessment	18
AC 10	Personal Clinician Selection	19
AC 11	Patient Visits with Clinician/Team	19
KM 14	Medication Reconciliation	20
KM 15	Medication Lists	20
TC 09	Medical Home Information	21
KM 09	Diversity	22
KM 10	Language	22
KM 21	Community Resource Needs	23

Helps address the following:

1. How might we decide which of the CORE criteria to implement first, second, third, etc.?
2. How might we decide which of the CORE criteria to study/update first, second, third, etc. for sustaining or transferring recognition?

What it is NOT:

- Not meant to be prescriptive, decisions about implementation are up to the practice.

https://chcleadership.com/pathway-for-core-criteria-implementation/

The CHS PCMH Tracker

NCQA PCMH Version 5 - Concepts, Competencies, and Criteria as of 7.31.19

To achieve recognition for PCMH, practices must meet all core criteria and earn 25 credits in elective criteria across 5 of 6 concepts.

INSTRUCTIONS: Use the checkboxes to mark criteria and documentation as they are put in place at your organization. All core criteria are highlighted in red until marked. The "documents incomplete" message will appear once you mark a criterion as in place but the documentation is not yet marked.
The summary boxes below reflect the overall progress toward required criteria/credits, based on what has been marked in this *CHS PCMH Tracker*.
The ● symbol indicates where the documentation can be shared across practice sites (e.g. for multi-site applications).

Summary:

Core Criteria Met (out of 40)	0
Elective Criteria Met (25 Credits required)	0

Must Choose Elective Criteria from 5 of 6 Concepts

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Team-Based Care and Practice Organization (TC)

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Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

TC 01	Core	PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	☐	Details about the clinician lead ● ☐	AND	Details about the PCMH Manager ● ☐
TC 02	Core	Structure and Staff Responsibilities: Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.	☐	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 (e.g., federal/state initiatives)	☐	Description of involvement in external ● ☐		

https://chcleadership.com/chs-pcmh-tracker-2017/

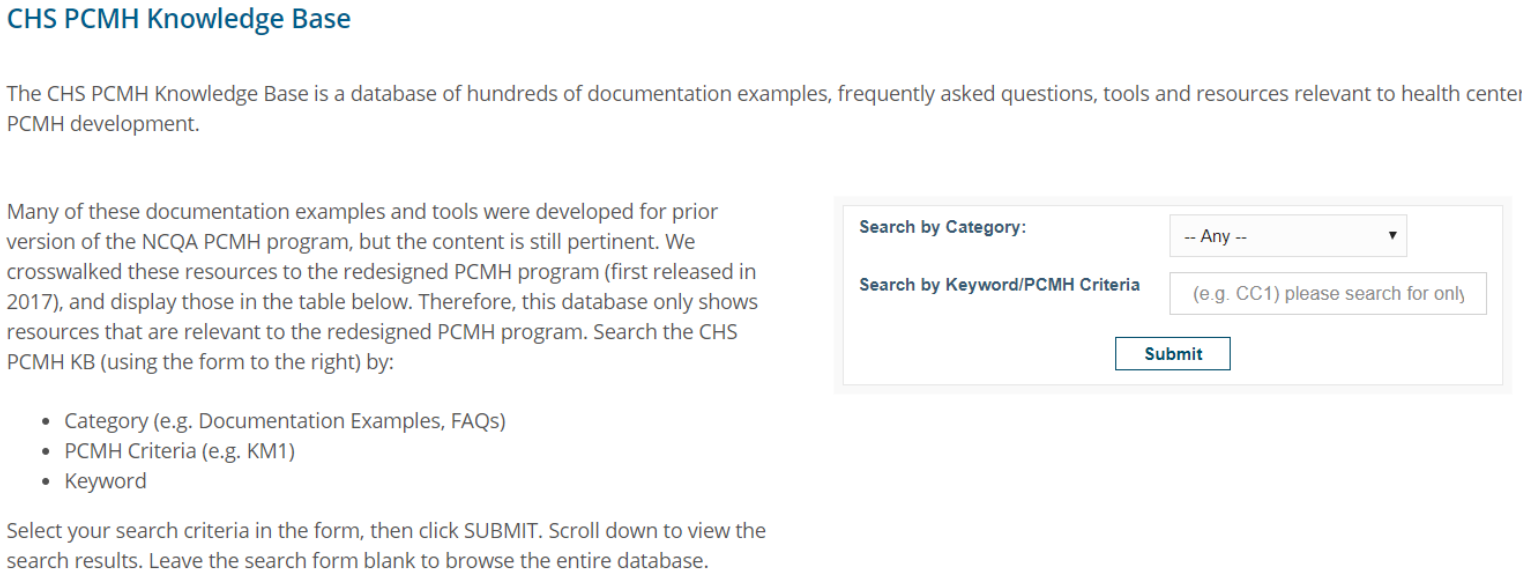
Helps address the following:

1. How might we do a self-assessment of where we stand on PCMH criteria?
2. How might we track our progress on implementation of criteria?
3. How might we keep track of the documentation and evidence that has been completed and is still outstanding?

What it is NOT

- Not linked to NCQA's online system, QPASS. It is meant to be an internal tool.

The CHS PCMH Knowledge Base



CHS PCMH Knowledge Base

The CHS PCMH Knowledge Base is a database of hundreds of documentation examples, frequently asked questions, tools and resources relevant to health centers' PCMH development.

Many of these documentation examples and tools were developed for prior version of the NCQA PCMH program, but the content is still pertinent. We crosswalked these resources to the redesigned PCMH program (first released in 2017), and display those in the table below. Therefore, this database only shows resources that are relevant to the redesigned PCMH program. Search the CHS PCMH KB (using the form to the right) by:

- Category (e.g. Documentation Examples, FAQs)
- PCMH Criteria (e.g. KM1)
- Keyword

Select your search criteria in the form, then click SUBMIT. Scroll down to view the search results. Leave the search form blank to browse the entire database.

Search by Category: -- Any --

Search by Keyword/PCMH Criteria (e.g. CC1) please search for only

Submit

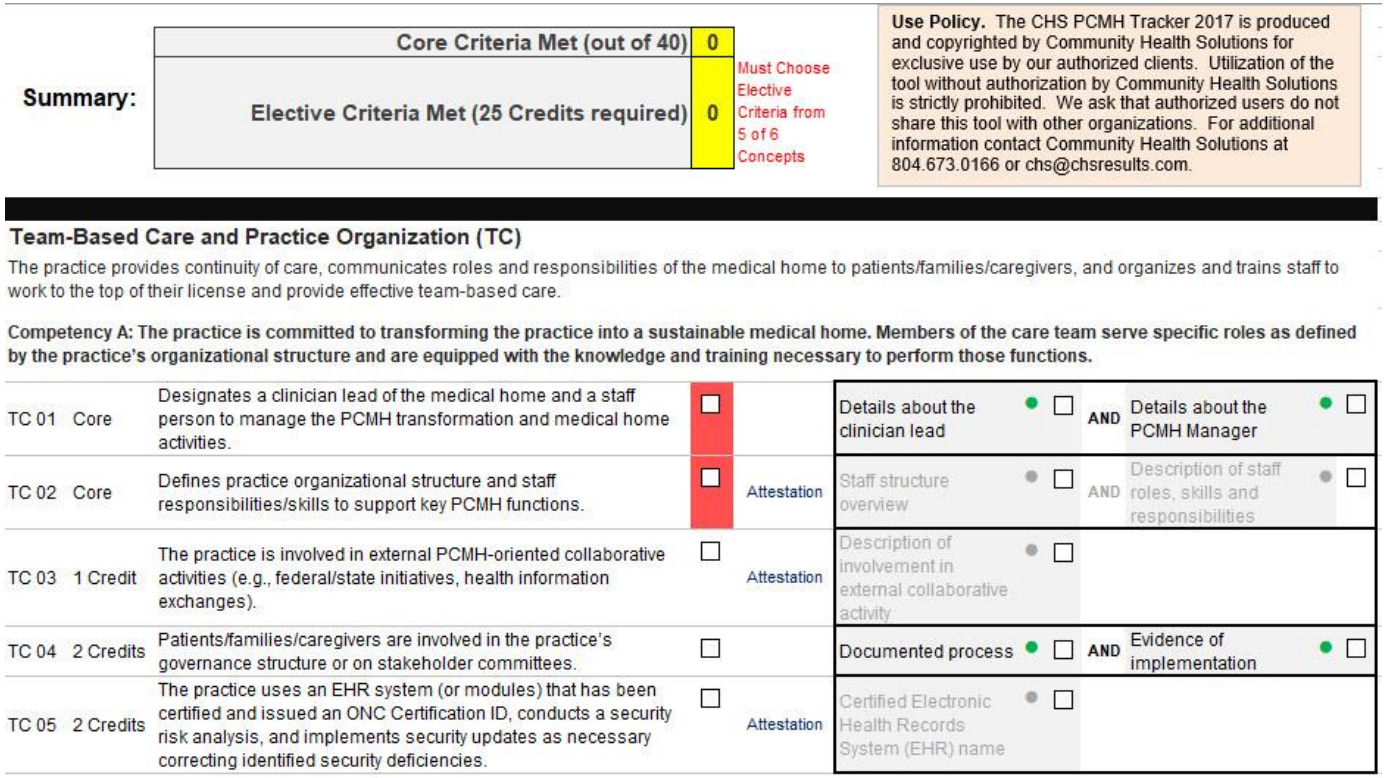
Helps address the following:

1. What are some examples of documentation and evidence that were successful?
2. Where can we find tools and resources to help us transform into a PCMH?

https://chcleadership.com/chs-pcmh-kb-2017/

NOTE: This resource was created and is maintained by CHS. Some resources may be from previous versions of the guidelines but are only included if still relevant.
For additional FAQs, NCQA maintains a database as well: http://ncqa.force.com/faq

Accelerated Renewal Version – The CHS PCMH Tracker



Summary:			
	Core Criteria Met (out of 40)	0	
	Elective Criteria Met (25 Credits required)	0	Must Choose Elective Criteria from 5 of 6 Concepts

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TC 01	Core	Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	☐		Details about the clinician lead	● ☐	AND	Details about the PCMH Manager	● ☐
TC 02	Core	Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.	☐	Attestation	Staff structure overview	● ☐	AND	Description of staff roles, skills and responsibilities	● ☐
TC 03	1 Credit	The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).	☐	Attestation	Description of involvement in external collaborative activity	● ☐			
TC 04	2 Credits	Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.	☐		Documented process	● ☐	AND	Evidence of implementation	● ☐
TC 05	2 Credits	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies.	☐	Attestation	Certified Electronic Health Records System (EHR) name	● ☐			

See these documents from NCQA:

More details on Accelerated Renewal https://chcleadership.com/wp-content/uploads/2018/03/PCMH-2014-Corporate-Credit-Transition-to-PCMH-V5-Shared-Credit-Table-July-2019.pdf

Crosswalk of PCMH 2014 to Redesigned PCMH: https://chcleadership.com/wp-content/uploads/2017/06/PCMH-V5-PCMH_2014_Crosswalk-July-2019.pdf

https://chcleadership.com/accelerated-renewal-2017/

Helps address the following:

1. How might we do a self-assessment of where we stand on PCMH criteria required for accelerated renewal?
2. How might we track our progress on implementation of criteria?
3. How might we keep track of the documentation and evidence that has been completed and is still outstanding?

What it is NOT

- Not linked to NCQA's online system, QPASS. It is meant to be an internal tool.

Sustain

Annual Reporting

- Once a practice receives recognition through this redesigned PCMH program, they will be required to go through annual reporting to sustain that recognition
- NCQA will continue to update the annual reporting requirements annually.
- Practices must submit the version of the annual reporting requirements based on the year in which they will report (i.e. if due for renewal by February 2020, then submit based on the 2020 Annual Reporting Requirements). *See next slide for resources.*

Sustain

Annual Reporting

Abbreviated Overview of Annual Reporting 2019 Requirements

Abbreviated Overview of 2019 PCMH Annual Reporting (AR) Requirements and Comparison to 2018

Community Health Solutions

Requirement	Documentation/Evidence	Change from 2018
Team-Based Care and Practice Organization (AR-TC)		
AR–TC 01: Pre-Visit Planning Activities	Indicate how you anticipate/plan for visits (check off items in a list provided)	Same as Option 1; Removed Option 2
Knowing and Managing Your Patients (AR-KM)		
AR–KM 01: Proactive Reminders	1. Yes or No to reminding patients of ≥ 3 service categories 2. Identify frequency for service categories	Renamed. Combined required items.
Patient-Centered Access and Continuity (AR-AC): Choose to report one of the following options		
AR–AC 01: Patient Experience Feedback—Access OR AR–AC 02: Third Next Available Appointment OR AR–AC 03: Monitoring Access—Other Method	1. Upload survey tool or indicate you used CAHPS 2. Enter number of patients surveyed (denominator), number completed (numerator) and reporting period 3. Upload report showing access results OR 1. Number of days for 3rd next available urgent appt. 2. Number of days for 3rd next available routine appt. OR Upload other evidence/report	--
Care Management and Support (AR-CM)		
AR–CM 01: Patients for Care Management	1. Indicate criteria used to identify patients (list provided) 2. Enter number of unique patients identified 3. Enter number of patients at the practice (site-specific) and define attribution method (if multi-site)	Same required items. Informational #3 in 2018 is now required. Removed #4 and #5
Care Coordination and Care Transitions (AR-CC): Report AC-CC 01 and one of the options (AR-CC 02-05)		
AR–CC 01: Care Coordination Processes Lab, Imaging and Transitions Track, Flag and Follow Up AND AR–CC 02: Patient Experience Feedback—Care Coordination OR AR–CC 03: Lab and Imaging Test Tracking OR AR–CC 04: Referral Testing OR AR–CC 05: Care Transitions	1. Indicate which written processes are used in list provided 2. Yes or No to lab result tracking, flagging, follow up 3. Yes or No to imaging result tracking, flagging, follow up 4. Yes or No to referral report tracking, flagging, follow up AND 1. Upload survey tool or indicate you used CAHPS 2. Enter number of patients surveyed (denominator), number completed (numerator) and reporting period 3. Upload report showing access results OR 1. Enter number of lab reports received (numerator), number ordered (denominator) and reporting period 2. Enter number of imaging reports received (numerator), number ordered (denominator) and reporting period OR 1. Enter number of referral reports received (numerator), number ordered (denominator) and reporting period 2. Yes or No to using CMS eCQM #50 OR Enter number of transition reports received (numerator), transitions identified (denominator), and reporting period	--
Performance Measurement and Quality Improvement (AR-QI)		
AR–QI 01: Clinical Quality Measures AR–QI 02: Resource Stewardship Measures AR–QI 03: Patient Experience Feedback	1. Upload Quality Improvement Worksheet or alternative (in the future, eCQMs). Show 5 measures from 4 categories. 2. Yes or No to whether you have the capability to submit eCQMs	Aligned AR-QI 01 with QI 01 (5 measures from 4 categories)
Special Topic: Behavioral Health (AR-BH)		
Behavioral Health	Answer all 6 informational queries	

Abbreviated Overview of Annual Reporting 2020 Requirements

Abbreviated Overview of 2020 PCMH Annual Reporting (AR) Requirements and Comparison to 2019

Community Health Solutions

Requirement	Documentation/Evidence	Δ from 2019
Team-Based Care and Practice Organization (AR-TC)		
AR–TC 01: Pre-Visit Planning Activities	Indicate how you anticipate/plan for visits (check off items in a list provided)	
Knowing and Managing Your Patients (AR-KM)		
AR–KM 01: Proactive Reminders	1. Yes or No to reminding patients of ≥ 3 service categories 2. Identify frequency for service categories	
AR-KM 02: Depression Screenings	1. Identify tool used for depression screening. 2. Enter number of patients screened (numerator), eligible (denominator definition and #), and reporting period. 3. Attestation regarding NQF quality measurement *(recognition status not affected)*	*NEW*
Patient-Centered Access and Continuity (AR-AC)		
AR–AC 01: Access Needs and Preferences	1. Identify how practice monitors access needs and preferences 2. Identify access categories assessed for sufficiency of meeting patient needs	*NEW*
AR–AC 02: Access for Patients Outside Business Hours	1. Identify how practice provides clinical advice by telephone outside business hours 2. Identify how practice provides access to patients outside business hours	*NEW*
Care Management and Support (AR-CM)		
AR–CM 01: Patients for Care Management	1. Indicate criteria used to identify patients (list provided) 2. Enter number of unique patients identified (numerator), patients at practice (denominator), reporting period, and attribution definition for denominator.	*Same required items. Re-grouping.*
AR–CM 02: Care Plans for Care Managed Patients	1. Identify how practice develops care plans 2. Identify how practice provides access to written care plan	*NEW*
Care Coordination and Care Transitions (AR-CC): *Report AC-CC 1-3 and one of the options (AR-CC 4-5)*		
AR–CC 01: Care Coordination Processes	Indicate which written processes are used in list provided	*Changed from Yes/No*
AR–CC 02: Referral Management Process	Attest to practice processes for referrals and tracking	*NEW*
AR–CC 03: Care Coordination with Other Facilities Process	1. Attest to practice processes for external facilities coordination 2. Attestation regarding an Admissions, Discharge, and Transfer system *(recognition status not affected)*	*NEW*
AR–CC 04: Lab and Imaging Test Tracking OR AR–CC 05: Referral Tracking	1. Enter number of lab reports received (numerator), number ordered (denominator) and reporting period 2. Enter number of imaging reports received (numerator), number ordered (denominator) and reporting period OR Enter number of referral reports received (numerator), number ordered (denominator) and reporting period	*Formerly AR-CC 03* *Formerly AR-CC 04*
Performance Measurement and Quality Improvement (AR-QI): AR-QI 1-4 are required; AR-QI 5-8 informational		
AR–QI 01: Clinical Quality Measures	Upload Quality Improvement Worksheet or alternative report showing at least 3 measures across 3 of the categories	*Changed # of measures*
AR–QI 02: Resource Stewardship Measures	1. Identify methods of care coordination used to collect data 2. Identify categories of measures affecting health care costs 3. Upload QI Worksheet or report that shows at least 1 measure	*Slight revision*
AR–QI 03: Patient Experience Feedback	1. Identify categories used in patient experience measurement 2. Upload QI Worksheet or report that shows at least 1 measure	*Added categories*
AR–QI 04: Monitoring Access	Identify how practice monitors demand for appointments	*NEW*
AR–QI 05: 5 eCQMs *(informational)*	Identify whether practice has capability to submit eCQMs	*NEW*
AR–QI 06: Value-Based Payment Agreement *(informational)*	1. Identify whether the practice participates in value-based payment 2. Identify source and lists of payers	*NEW*
Special Topic: Social Determinants of Health (AR-SD) Informational: *Answer all informational queries*		

See more at: https://chcleadership.com/annual-reporting-pcmh-2017/

PCMH Development Resources List

"Quick" list of electronic PCMH development resources available from *chcleadership.com* and *NCQA*. Also includes list of resources for team development.

PCMH Development Resources		
Source	**Title**	**Description and Links**
VCHA	Virginia CHC Leadership Institute Portal	**Find PCMH Resources designed by CHS for VCHA member clinics @** https://chcleadership.com/pcmh-resources/ • About PCMH https://chcleadership.com/pcmh-resources/ • Webinar/ Office Hours Content https://chcleadership.com/pcmh-resources/ • Tools for PCMH https://chcleadership.com/pcmh-resources/ • Sample PCMH Resources ☐ *Jump Start Pathway to PCMH Recognition* ☐ *Core Criteria Implementation Priorities Pathway* ☐ *Applying PCMH 2014 Corporate Credits to 2017 New Recognition* ☐ *Navigating Q-PASS for Annual Reporting* ☐ *Accelerated Renewal to 2017* ☐ *Maintaining PCMH Promising Practices* ☐ *Crosswalk 2014 to 2017* ☐ *Annual Reporting for PCMH 2017* ☐ *How to Submit Notice of Intent (NOI) to HRSA*
VCHA	Virginia CHC Leadership Institute Portal	**CHS PCMH 2017 Knowledge Base**: *The CHS PCMH Knowledge Base is a database of hundreds of documentation examples, frequently asked questions, tools and resources relevant to health centers' PCMH development. Click here to access this resource:* https://chcleadership.com/chs-pcmh-kb-2017/
Source	**Title**	**Description and Links**
NCQA	Home Page for NCQA PCMH Recognition	*This page is the NCQA hub for PCMH development activities. From this page you can navigate to additional PCMH Development resources, including the ones I highlighted below.* http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh
NCQA	NCQA PCMH Recognition: The Process	*This page outlines the steps to recognition including links to specific resources.* https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/process/
NCQA	NCQA PCMH Recognition: Eligibility	*This page includes a brief questionnaire to help practices determine if you are eligible and ready to begin the PCMH Recognition process.* http://pcmhquestionnaire.ncqa.org/question/1/
NCQA	PCMH 2017 Standards and Guidelines	*Download a free electronic copy of the NCQA PCMH 2017 Standards and Guidelines. Please note: Guidelines are updated periodically (every 6 months or so). You can sign up for notifications of updates on the NCQA website.* http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html
NCQA	NCQA PCMH Recognition: Pricing and Payment Options	*NCQA PCMH Recognition pricing is based on a practice's eligibility for single site pricing or multi-site pricing, and on the number of clinicians in the practice.* https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/pricing/
NCQA	NCQA PCMH Recognition: Education and Training	*Links to Seminars, Webinars and On-demand Training (both free and paid)* https://www.ncqa.org/education-training/webinars-and-seminars/
NCQA	NCQA PCMH 2017 Standards and Guidelines Overview Presentations &	*This FREE series of recorded presentations introduce the background, overview, and description of each of PCMH 2017 Standards and How to Use the Record Review Workbook for PCMH 2017.* https://www.ncqa.org/education-training/webinars-and-seminars/patient-centered-medical-home-pcmh/?event=a0v41000002eJekAAE

See more at:
https://chcleadership.com/webinar-10-09-18/